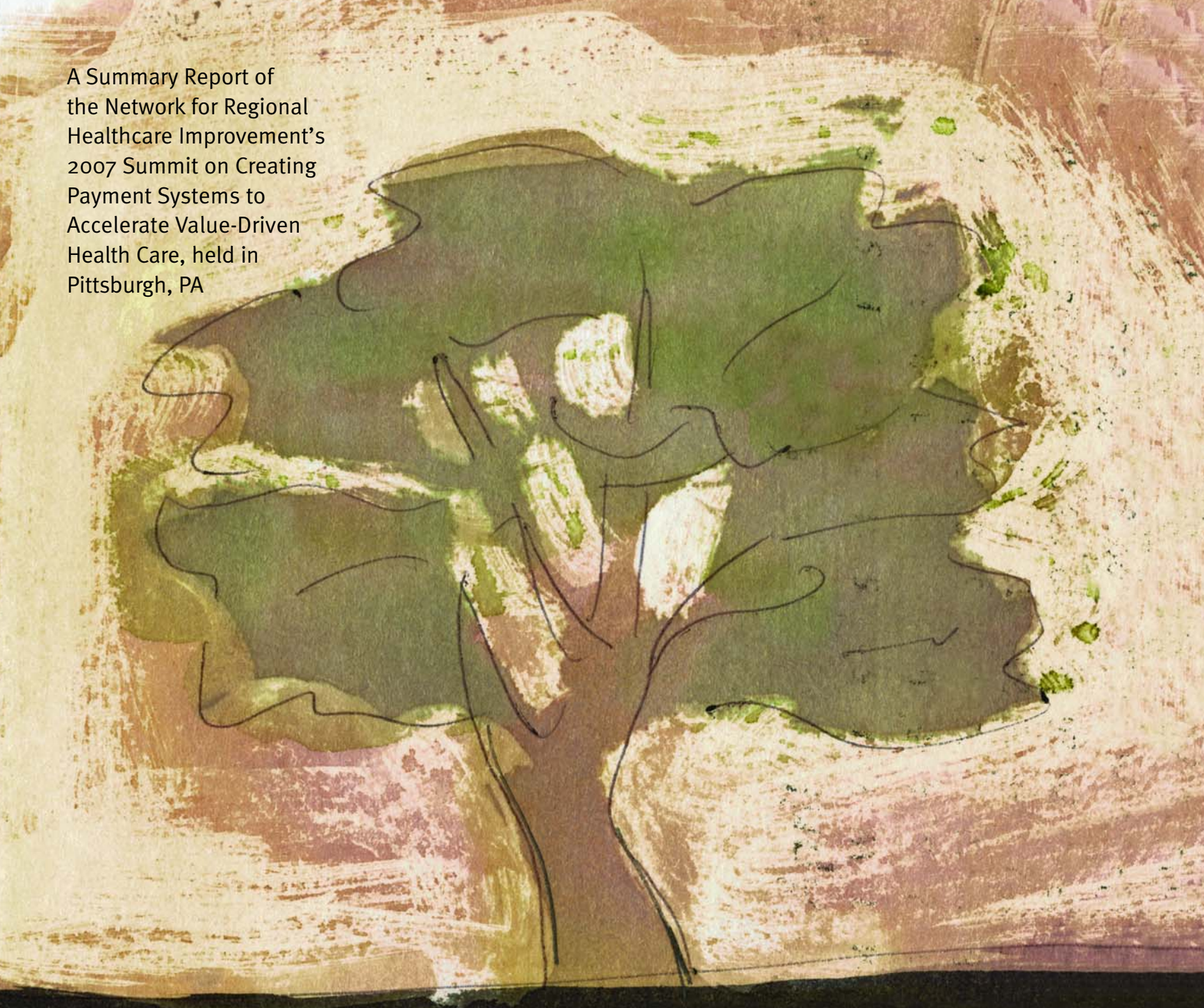
A Summary Report of the Network for Regional Healthcare Improvement's 2007 Summit on Creating Payment Systems to Accelerate Value-Driven Health Care, held in Pittsburgh, PA



INCENTIVES FOR EXCELLENCE:

REBUILDING THE HEALTHCARE PAYMENT SYSTEM FROM THE GROUND UP

ROOTS

HOW CAN WE EXPECT THE HEALTHCARE SYSTEM TO

HELP PEOPLE STAY HEALTHY…

…if we reward it most generously when people get sick?

HOW CAN WE EXPECT HEALTHCARE PROVIDERS TO AVOID

ERRORS AND INFECTIONS…

…if we pay them more for making mistakes?

HOW CAN WE EXPECT TO KEEP PEOPLE WITH

CHRONIC ILLNESSES OUT OF THE HOSPITAL…

…if we don't pay enough for good primary care?

HOW CAN WE EXPECT TO

CONTROL HEALTHCARE COSTS…

…if we give incentives for unnecessary tests and treatments?

ROOTS *is a special publication of the Jewish Healthcare Foundation and the Pittsburgh Regional Health Initiative.*

Many fine minds in health finance & administration, clinical quality, and health policy contributed to this publication. Special thanks to Harold D. Miller, Strategic Initiatives Consultant, for assembling and presenting these ideas so clearly and to Pamela Gaynor, Media Relations and Publications Manager, for her enhancements.

INTRODUCTION

The Network for Regional Healthcare Improvement's members – organizations dedicated to healthcare quality improvement and cost containment at the regional level – operate in different parts of the country. They each have taken different approaches to the cost and quality problems within their communities. And yet, they all have hit the same wall: the perverse incentives of health care. As diverse as their organizations and efforts have been, they also have come to a common conclusion: without reform of the nation's healthcare payment system, it is all but impossible to reform health care itself.

It is beyond doubt that U.S. health care needs systemic reform. Study after study has revealed gaping deficiencies in quality and outcomes. One of the most recent, a landmark report from the RAND Corporation, estimated that patients receive appropriate treatment only a little more than half – 55 percent – of the time.

Current healthcare payment systems do not always reward physicians and hospitals for their efforts to improve quality or lower costs. In fact, perversely, these efforts all too often carry financial penalties. In the past couple of years, healthcare purchasers and insurers have stepped up efforts to promote higher quality with Pay-for-Performance programs. But there is a growing concern that without fundamental redesign of the payment system, these new programs may merely add costs and administrative burdens to an old, misaligned system of incentives and the flawed care it perpetuates.

Under the current payment system, physicians are paid fees for each service they provide; hospitals typically get lump sum payments for each patient they admit. The fundamental flaw of these payment methods is that they reward doctors, hospitals, and other providers for how much care they deliver – the number of office visits, the number of tests, the number of treatments, the number of hospital admissions – not the quality of that care. Providers are rewarded for treatment, rather than prevention. Nor are there financial penalties when the care delivered is defective, whether because of errors, ill-chosen treatments, or for other reasons. In fact, insofar as poor outcomes lead to more treatments, which command more payments, the current payment system even rewards defective care, or at least provides no incentive to improve quality.

These perverse incentives do not exist in other sectors of the economy. Industries other than health care reward value, defined by the highest quality at the lowest possible cost. In health care, the wrong incentives lead to waste and, ultimately, higher costs. But the problems don't stop there. In addition to promoting quantity over quality, the current payment system encourages expensive forms of treatment, like invasive procedures and hospital stays, while paying much less, if at all, for certain kinds of care that may be more effective.

An ideal payment system would promote ideal health care – care that keeps as many people as possible from ever experiencing illness and averts hospitalization for as many illnesses as possible. Achieving the ideal depends on payments that emphasize a natural progression of care, beginning with prevention for those who are well, disease management for those with chronic illnesses such as asthma or diabetes, and hospital care only when all of the best practices of medicine are unable to avoid it. For medical crises that result in hospitalizations, incentives for safety, efficiency, and proven best practices could guarantee better outcomes at lower cost.

U.S. health care is far from the ideal. By comparison to other developed countries, it invests extraordinary resources in medical crises and comparatively little in wellness. A Commonwealth Fund study ranked U.S. healthcare performance below other industrialized countries on almost every measurement but cost, which was double the median as a percentage of GDP. Comparisons of physician compensation are just one indicator of the emphasis on hospital care and crisis interventions over preventive medicine and disease management. Cardio-thoracic surgeons earn an average of $470,000 a year, for example, while family practice physicians average $178,366, according to the American Medical Group Association's latest survey.

Mindful of all of this, an Institute of Medicine committee that looked at payment issues last year set forth three broad gauges of healthcare performance that should guide new payment systems. Payments, the committee said, should seek to advance clinical quality, including safety, efficacy, timeliness, and equity; patient-centeredness, which is dependent on well-informed choices, among other things; and efficiency, which was defined as the highest possible level of quality for the costs and resources involved.

Examples of the Problems Caused by Healthcare Payment Systems

At the risk of oversimplifying, one can define five major areas – prevention or progression of illness; diagnostic accuracy; appropriateness of care; avoidance of adverse events; and follow-up – where the performance of healthcare systems can affect patient outcomes and/or healthcare costs. The Jewish Healthcare Foundation (JHF) and the Pittsburgh Regional Health Initiative (PRHI) have collaborated with physicians who offered some examples of ways the current payment system affects care in these areas. (The actual identities of the doctors have been withheld.)

Prevention of Illness or Progression of Illness:

Dr. A's clinic receives $50 to $60 for her services from Medicare each time she sees one of her elderly patients for a routine visit. Each visit is scheduled for half an hour. In reality, however, the appointments invariably run over that time by 10 minutes or more, and for each, there's another 20 minutes spent on paperwork. That's because the patients, whose average age is around 81, typically suffer from about five different chronic conditions, such as osteoarthritis, hypertension, high cholesterol, diabetes, and maybe heart or kidney disease. Dr. A is able to give these complex patients the time they require only because her practice is subsidized by a major teaching institution. For doctors practicing outside such systems, "the reimbursement wouldn't come close to covering the costs" of a physician's salary, much less the overhead. Nor does care for many of these patients end with the visit. Dr. A said there is frequent telephone follow-up, often by nurses, to help patients manage their symptoms, medications, and other issues. The extended appointments and regular "care management" can lower overall costs by keeping many of these elderly patients well and out of hospitals, Dr. A noted, but "these are not billable services" so most physicians' offices can't afford to provide them.

Accuracy of Diagnosis/Prognosis:

About 20 percent of the Pap smears gynecologists perform miss the area of the cervix where cancers begin. Whether some doctors were never correctly trained to obtain the tissue samples, have forgotten the correct technique, or simply aren't careful enough is anybody's guess, though the reasons likely vary among physicians, according to Dr. B. Typically, she said, physicians in training learn to take samples by watching other physicians and listening to what those doctors teach. "But if someone tells you once or twice (in the course of training), what's the probability that you'll remember?" Gynecologists receive pathology reports when the samples they take are unclear. But if a cancer is simply missed, they don't know until it's caught on a subsequent exam. Because of the high error rate, Pap tests are usually given annually – despite inconvenience to patients and added costs of care. More than 60 million American women get the tests each year, so clearly the associated healthcare costs are high. Moreover, for women whose disease is missed until an advanced stage, the inaccurate diagnoses can be fatal. Payment system issues help perpetuate the inaccuracies, Dr. B said, because neither doctors nor labs are paid for the quality of their results. Instead, Paps and many other diagnostic tests are paid no differently than the "piece work" a seamstress does, she said. Not only is there no penalty for flawed results, there is payment for additional tests.

Appropriateness of Care:

Dr. C runs a diabetes clinic at a Veterans Administration Hospital. It is a model of efficiency and adherence to recommended processes of care. At each hour-long appointment, patients at the clinic receive care from a team of clinicians, each with different expertise. A nurse educator begins the exam with a check of patients' hemoglobin A1c levels, the best measure of glucose control, and counseling on one of four crucial aspects of self-management. The patients also see a nutritionist for dietary counseling; a pharmacist for medication adjustments; a nurse practitioner who performs all of the recommended physical checkups, including foot exams and neurological tests; and finally, Dr. C, who makes any needed changes in care. The team approach has improved key health indicators for patients, who are referred to the clinic when their symptoms are badly out of control; it has improved efficiency, expanding the number of appointments that the clinic can schedule by 20 percent; and it has saved patients' time, because they now receive all of the care in a single visit that had previously taken two. Such regular and thorough care can spare diabetic patients severe complications, including blindness and amputations. It also could help avert hospital costs, which account for $65 billion – nearly half of the estimated $135 billion spent annually on care for diabetics. Still, Dr. C laments, he can't implement the model at the private hospital where he also practices because payment barriers stand in the way of the team approach: Medicare and other insurers won't reimburse visits with multiple clinicians for the same diagnosis on the same day.

Avoidance of Adverse Events:

Dr. D received a grant to reduce the rate of central line-associated blood-stream infections in one of his hospital's intensive care units. Results have been remarkable: the ICU, where he and a small team of clinicians used PRHI's Toyota-based training to find and remedy the causes, didn't just reduce the rate, it *eliminated* the infections, which are fatal in half of the patients who get them. Yet, proven training and techniques for prevention aren't gaining much traction and the incentives appear to run in the opposite direction: many hospitals might lose money if their infection rates fall significantly, according to preliminary findings from a PRHI analysis. For example, at another hospital where two elderly patients had central lines inserted while undergoing surgery for diverticulitis, Medicare paid $15,500 for the first, who was discharged 30 days later with no infection. But for the second patient who did get an infection and died after 39 days, Medicare paid $53,800. The hospital's extra expenses for the second woman's care were only $9,000 higher than for the first. Because of that, preventing her infection would actually have forced the hospital to forgo $29,000 of additional net income.

Follow-up Care:

For many elderly patients, care given in a hospital often is followed by a nursing home stay. The transitions are usually anything but smooth. Because hospitals get single lump sum payments to treat most patients, they make more money the faster patients are discharged. As a result, decisions to release patients often are made with little advance notice and usually that means "discharges are very rushed," said Dr. E. For patients to receive the best care in skilled nursing, a great deal of information should be transferred with them. But in the chaos of discharges, much of it can slip through the cracks. When that happens, outcomes suffer and patients may need to be readmitted. For example, a patient who is started on a new medication the day before discharge or even the morning of discharge may suffer side effects. If caregivers at the nursing home are unaware of the new medication, they may not check or may think the symptoms stem from some other problem. It's also not uncommon for there to be a day's lag time before medication orders catch up with patients transitioning to skilled nursing, which can lead to complications from missed doses. Medications and other physicians' orders aside, the list of issues that should be addressed upon discharge to a nursing home – from dietary needs and skin care to continence and cognitive status – are so many that they filled two pages on a standard checklist Dr. E helped develop. Without adequate information, Dr. E said nursing home caregivers often feel as though "they're getting these curve balls" because they don't have the necessary staff, much less special equipment, to receive the patients hospitals send them.

Healthcare Leaders Gather to Begin Crafting Solutions

Frustrated with payment methods that don't support quality improvement or cost containment, the Network for Regional Healthcare Improvement (NRHI) and its members convened 100 of the nation's healthcare thought leaders at an invitation-only Reimbursement Summit.

The Jewish Healthcare Foundation, the Commonwealth Fund and the California HealthCare Foundation provided guidance and financial support for the event, held in Pittsburgh in March, 2007. In addition, support for NRHI's overall agenda, including the Summit, was provided by the Robert Wood Johnson Foundation and JHF.

The Summit was designed to accelerate thinking about how healthcare payment systems can be redesigned to reward improved quality and lower costs. Rather than a typical "conference," the Summit was a highly proactive working meeting that brought together the people who must collaborate if innovative solutions will ever succeed: major healthcare payers, health plans, regional coalitions, researchers, and other thought leaders. Attendance included regional and national leaders from around the country who are working at the frontier of these issues.

The Summit goals were: to develop and share concepts for value-based purchasing; to build consensus among experts, providers, purchasers, and payers on the desirability and feasibility of these concepts; and to identify strategies for aligning market incentives and solving the key challenges in implementation.

Summit participants reviewed a detailed Framing Paper prepared by Harold D. Miller, Strategic Initiatives Consultant for the Pittsburgh Regional Health Initiative, which outlined the issues and options to be addressed for the Summit participants, and they reviewed a broad range of research literature on the problems with payment systems and a number of proposals for payment reform.

Elliott Fisher, MD, MPH (Professor of Medicine, Dartmouth Medical School), Peter Lee, JD (Chief Executive Officer of the Pacific Business Group on Health), and Mark McClellan, MD, PhD (Visiting Senior Fellow, AEI-Brookings Joint Center for Regulatory Studies and former Administrator of the Centers for Medicare and Medicaid Services) each gave opening remarks at the Summit describing the key issues.

NRHI MEMBERS

- Institute for Clinical Systems Improvement (Minnesota)
- Massachusetts Health Quality Partners
- Minnesota Community Measurement
- Pacific Business Group on Health
- Pittsburgh Regional Health Initiative
- Wisconsin Collaborative for Healthcare Quality

Summit participants then broke into four separate Work Groups, each focused on a particular type of patient and care: (1) preventive care and care of minor, unanticipated health problems – illnesses or injuries that require immediate attention, but can be quickly treated (usually in a doctor's office or emergency room) such as sinus infections, strep throats, or sprained ankles; (2) care of major acute conditions – serious illnesses or injuries that typically require hospitalization, (3) care of persons with stable chronic conditions – ongoing illnesses such as diabetes or asthma that are being well-managed and kept in check, and (4) care of persons with unstable chronic conditions – serious, ongoing diseases such as congestive heart failure or chronic obstructive pulmonary disease, whose symptoms are not under control and at end of life. The Work Groups discussed the issues and options described in the Framing Paper prepared for the Summit as well as additional issues and options identified by participants. They then developed recommendations for how payment systems should change to support better quality, lower-cost care.

Following the work sessions, attendees reconvened in the Closing Session to hear and discuss the findings and recommendations from each of the Work Groups and to develop recommendations on implementation.

The recommendations from the Work Groups and from all of the Summit participants at the Closing Session are the key focus of this report. The recommendations are based on the work of many researchers and practitioners, on a variety of published and unpublished reports and analyses, and on the presentations made at the Summit. References to some of these are noted in this report, but it is impossible to properly credit all of the sources of information about the problems with current payment systems and approaches to addressing them that formed the foundation for the recommendations at the Summit. A partial bibliography of source materials is available at www.nrhi.org.

THE SUMMIT PROCESS – FROM ISSUES TO ACTION RECOMMENDATIONS

Network for Regional Healthcare Improvement identifies current payment systems as major roadblocks

Issues Framing Paper

NRHI SUMMIT

"Creating Payment Systems to Accelerate Value-Driven Health Care"

WORK GROUP

Preventive care and care of minor acute episodes

WORK GROUP

Care of major acute episodes

WORK GROUP

Care of persons with stable chronic conditions

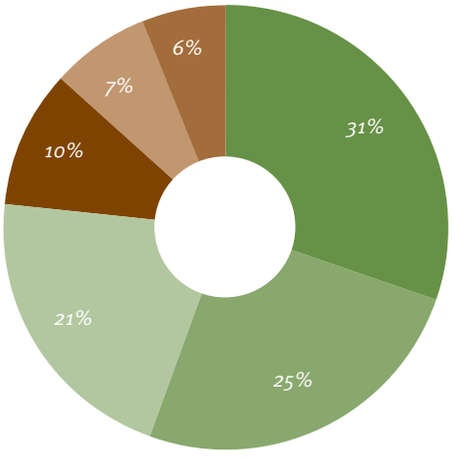
WORK GROUP

Care of persons with unstable chronic conditions or in end-of-life situations

ISSUES ---------- DISCUSSION ----------

HOSPITALIZATION ACCOUNTS FOR NEARLY ONE-THIRD OF ALL U.S. HEALTHCARE SPENDING

Estimates suggest hospital outlays could be greatly reduced with disease management



- *31% Hospital Care (Primarily Acute Illness and Injury)*
- *25% Other Spending ***
- *21% Physician and Clinical Services*
- *10% Prescription Drugs*
- *7% Program Administration and Net Costs*
- *6% Nursing Home Care*

*** Other spending includes dental services, other professional home health care, durable medical products, counter medicines and sundries, public health activities, research and construction.*

Source: Agency for Healthcare Research and Quality, 2004 Medical Expenditure Panel Survey.

ALL PARTICIPANTS

Discussion of group findings and recommendations for specific implementation strategies and actions

Summary Report of key conclusions and recommendations for public release (this report)

Regional demonstrations of new payment strategies

STRATEGIES ACTIONS

A GLOSSARY OF HEALTHCARE OPTIONS

Preventive care consists of actions that individuals can take to stay healthy and to prevent existing illnesses from getting worse, such as diet and lifestyle changes; counseling and assistance to help them identify and implement these actions; and routine tests and checkups to diagnose and treat illnesses at the earliest possible stages.

Chronic care, also called disease management, is care given for ongoing illnesses, such as diabetes, asthma, or high blood pressure that can be kept in check, but not cured. Typically chronic diseases can be managed with medication and/or changes in diet and health habits. When patients with chronic diseases don't have adequate disease management support or don't follow treatment regimens, they can suffer complications that result in acute illnesses requiring costly interventions and hospitalization.

Acute care is care given for injuries or illnesses that require immediate attention. Severe illnesses or injuries call for major acute care, typically given in hospitals and often resulting from complications of chronic conditions, as when patients with high blood pressure suffer heart attacks or strokes. Minor acute care, such as for sinus infections or sprained ankles, is typically delivered in doctors' offices, emergency rooms, or clinics.

GOALS

FOR IMPROVED HEALTHCARE PAYMENT SYSTEMS

In order to address the current problems with healthcare payment systems and to avoid the concerns about existing Pay-for-Performance systems, the following are twelve goals that revised payment systems should seek to achieve:

1. Payment systems should enable and encourage providers to deliver accepted procedures of care to patients in a high-quality, efficient, and patient-centered manner.
2. Payment systems should support and encourage investments, innovations, and other actions by providers that lead to improvements in efficiency, quality, and patient outcomes and/or reduced costs.
3. Payment systems should not encourage or reward overtreatment, use of unnecessarily expensive services, unnecessary hospitalization or re-hospitalization, provision of services with poor patient outcomes, inefficient service delivery, or choices about preference-sensitive services that are not compatible with patient desires.
4. Payment systems should not reward providers for under-treatment of patients or for the exclusion of patients with serious conditions or multiple risk factors.
5. Payment systems should not reward provider errors or adverse events.
6. Payment systems should make providers responsible for quality and costs within their control, but not for quality or costs outside of their control.
7. Payment systems should support and encourage coordination of care among multiple providers, and should discourage providers from shifting costs to other providers without explicit agreements to do so.
8. Payment systems should encourage involvement of patients in decision-making, and encourage patient choices that improve adherence to recommended care processes, improve outcomes, and reduce the costs of care.
9. Payment systems should not reward short-term cost reductions at the expense of long-term cost reductions, and should not increase indirect costs in order to reduce direct costs.
10. Payment systems should not encourage providers to reduce costs for one payer by increasing costs for other payers, unless the changes bring payments more in line with costs for both payers.
11. Payment systems should minimize the administrative costs for providers in complying with payment system requirements.
12. Different payers should align their standards and methods of payment in order to avoid unnecessary differences in incentives for providers.

In addition, an overarching goal is to have improved payment systems maintain or reduce healthcare costs, rather than increase them.

Key Elements Of Better Healthcare Payment Systems

INSTEAD OF:	PAYMENT SYSTEMS SHOULD:
Paying separate fees for each individual service provided	Make a single payment to cover the full range of services required for good quality care
Paying each health care provider separately, with no coordination	Make a single payment to all providers involved in a patient's care
Paying inadequately for time spent counseling, educating, and monitoring patients	Pay providers adequately for time spent counseling, educating, and monitoring patients in order to improve patient outcomes
Paying the same for a specific service regardless of the complexity of the patient's needs, while paying for multiple services that may not be needed	Vary payment levels depending on a patient's age, risk level, and other characteristics affecting the cost of care
Paying for a service regardless of the quality of the service provided or the outcomes achieved	Pay for services with a demonstrated relationship to desired outcomes, and give providers payment bonuses and/or penalties based on the outcomes they achieve for their patients, the satisfaction levels of the patients, and the patients' level of utilization of other health care services
Charging patients the same co-payments for services regardless of their relative value, and paying for additional services required because patients don't comply with preventive care	Give patients incentives for using higher-quality, lower-cost providers and for adhering to processes needed to insure good outcomes

A NEW PAYMENT MODEL FOR PREVENTING ILLNESSES AND PROMOTING HEALTH

Why the Current System Needs to Change

Current healthcare payment systems have a number of problems that discourage high-quality, efficient preventive care, including:

- Current fee-for-service systems generally do not pay adequately (or at all) for many elements of preventive care. In addition, low payment levels are believed to be discouraging physicians from entering primary care vs. specialty care.
- Some payers prohibit paying for multiple procedures on the same day or during the same patient visit, which can discourage efficient and coordinated delivery of care.
- Certain types of providers (e.g., nurse practitioners, pharmacists, etc.) or services (e.g., telephone or email follow-up and monitoring of health status) may not be covered separately under payment systems (even though the providers are licensed to provide the care and the services have been demonstrated to improve outcomes), reducing the likelihood that they will be used even if they are more appropriate than providers/services which are covered.
- Fee-for-service payment systems pay providers more for caring for patients who become sick than for keeping them healthy.
- Co-payments and deductibles may discourage or prevent individuals from obtaining desirable preventive care services.
- Many payers do not have mechanisms for encouraging or directing patients to providers who provide care at lower cost (for the same quality) or higher quality (at the same cost).
- Payers do not have an incentive to invest in preventive care since the payoff in terms of better health and lower costs occurs in the (distant) future and may accrue to other payers.

SUMMARY OF IMPROVED PAYMENT MODEL FOR PREVENTIVE CARE

- Either (1) licensed healthcare providers would be paid on a fee-for-service basis for providing preventive care services to patients, with fees sufficient to cover time spent counseling patients, conducting compliance monitoring/encouragement, and providing multiple services in a single visit; or (2) a single healthcare provider would be paid an annual Preventive Care Management Payment to cover the management of preventive care services for a patient, with the amount of the payment adjusted for the age and risk of the patient, in addition to separate fees for specific preventive services (e.g., immunizations).
- Healthcare providers would receive financial incentives from payers to identify and encourage individuals to use appropriate preventive services, and would receive financial rewards for improving significant health outcomes (e.g., reduced hospitalization, reduced mortality) among their patients by using preventive care services.
- Co-payments and other costs for patients would be reduced or eliminated to avoid discouraging or preventing the patients from using preventive care services, and patients would receive incentives and assistance from their payer to adhere to preventive care processes and to avoid behaviors that are root causes of serious health problems.

Comparison to Current Payment Systems

CURRENT PAYMENT SYSTEM	PROPOSED PAYMENT SYSTEM
Payments are based on services delivered, rather than outcomes achieved.	Payment would be based on (a) the delivery of services that have a demonstrable relationship to desired outcomes, and (b) actual outcomes achieved (adjusted for patient risk).
Fee amounts are low for time spent in counseling, educating, and monitoring patients about preventive care.	Fees would be increased to levels adequate to cover time spent counseling, educating, and monitoring patients, or an annual Preventive Care Management Payment would be paid to cover these services.
Providers are not permitted to bill separately for multiple services on the same patient visit.	Physicians would be able to provide and be paid for providing multiple services on a single patient visit.
Fees are only paid for services provided by physicians in face-to-face visits.	Services could be provided by nurses and other staff where appropriate, and through telephone or email contact where appropriate.
Patients have to pay co-payments for valuable preventive services.	Co-payments would be reduced or eliminated for high-value prevention services.

What an Improved Payment Model Would Look Like

A Work Group at the NRHI Summit developed a set of goals and principles that should be used to design an improved payment system for preventive care, and also developed two alternative approaches to improving payment for preventive care, recommending that both should be tested to better evaluate their relative effectiveness and disadvantages. Ninety-one percent of the Summit participants either supported the Work Group's recommendations for a majority of patients/conditions or said they could support the recommendations with modifications.

Design Principles

The principles that should govern the design of a revised payment system for preventive care are:

- The payment system should provide incentives and remove economic barriers to encourage all individuals to consume appropriate preventive services.
- The payment system should provide incentives to providers to identify and encourage both healthy and unhealthy individuals to use appropriate preventive services. Since providers are currently financially rewarded when patients become sick, it is important to make successful prevention more profitable than illness.
- Providers should be rewarded for improving health outcomes as measured across the complete group of the individuals for whom they provide preventive services, with appropriate adjustments for age, risk, etc.
- Payers should create incentives for the "mass customization" of preventive services that are patient-appropriate and current, and that are clearly related to achieving important health outcomes (e.g., reduced mortality, morbidity, and hospital admissions).
- Preventive services should be related to identifiable health outcomes. There should be measures of the outcomes as well as the processes designed to improve outcomes, and there should be measures applicable to both providers and consumers, so that both can be held responsible for their roles in improving outcomes.
- Payers should provide incentives to providers to invest in redesigning their work processes and structures in order to better achieve the other goals.

HOW THE IMPROVED PAYMENT MODEL WOULD WORK IN A HYPOTHETICAL CASE

Mr. Smith is a generally healthy middle-aged man, but he has a family history of heart disease. His insurance company pays his primary care provider an annual Preventive Care Management Payment to help him stay as healthy as possible in order to reduce his chances of heart attack and other preventable illnesses.

Mr. Smith's primary care provider has a team of physicians, nurse practitioners, and other staff who work with him (either in person or by phone, mail, or email) to establish and implement a health promotion plan that includes specific actions that he can and will take to maintain/improve his health (e.g., exercising and changing the composition of his diet to reduce his cholesterol) as well as the actions that the provider will take (e.g., seeing him periodically to check his cholesterol levels, monitor his weight, and conduct other preventive screening examinations). Mr. Smith understands that he does not need to see a doctor each time he comes to the office for checkups, since a nurse practitioner can perform all of the necessary checks and call in a physician when needed.

Mr. Smith pays no co-pays for his regular check-ups or routine testing. He receives a small cash payment from his insurance company if he meets the goals established in his care plan as measured by objective test results, such as cholesterol levels and weight. His primary care provider also receives a financial bonus from the insurance company if Mr. Smith meets the goals in the care plan.

The insurance company measures the number of hospitalizations that occur for heart attacks and other conditions for Mr. Smith and other patients for whom the provider is receiving Preventive Care Management Payments. If the rate of hospitalizations is below a pre-determined target level, the primary care provider receives a financial bonus, since they have saved the insurer money.

The Basic Concept

There is not sufficient experience or research to define a single ideal model of payment for preventive care. Either of the following models could potentially achieve the goals defined above:

Option 1: Licensed healthcare providers would continue to be paid on a fee-for-service basis for providing preventive care services to patients. However, fees would be changed so that they: (a) are sufficient to cover time spent counseling patients and conducting compliance monitoring/encouragement; (b) are not restricted to services provided by a physician in a face-to-face visit; and (c) allow multiple services to be provided on the same day/in the same visit.

Option 2: A single healthcare provider would be paid a periodic (e.g., annual) Preventive Care Management Payment to manage preventive care services for a patient, with the amount of the payment adjusted for the age and risk of the patient. The provider would still be paid separate fees for specific preventive services (e.g., immunizations) provided beyond basic care management. These payments would not be expected to cover either minor or major acute episodes. In addition, preventive care for patients with chronic illnesses would be paid through the payment system for chronically ill patients. (This model is similar to the payment concept for an Advanced Medical Home proposed in the paper "A System in Need of Change: Restructuring Payment Policies to Support Patient Care," by Neil Kirschner and Robert Doherty, American College of Physicians, 2006, available at http://www.acponline.org/hpp/statehc07_4.pdf.)

Provider Incentives for Improved Outcomes and Lower Costs

Healthcare providers would receive financial bonuses for identifying and encouraging individuals to use appropriate preventive services and for improving health outcomes (e.g., reduced hospitalization, reduced mortality) for the population of patients that they serve. Bonuses would be designed so that they offset some or all of the reductions in service-specific fees that the provider would experience due to improved health of the patient population – in effect, sharing the savings that the payer would experience as a result of the patients' lower use of acute care services. (Special efforts would be needed to apply these kinds of incentives to providers with small numbers of patients.)

By receiving bonuses based on outcomes, providers would have an incentive to deliver preventive care services efficiently and to focus on providing those preventive care services which have the biggest impact on outcomes. For example, there is evidence that for some groups of women (e.g., those who have had hysterectomies), annual Pap smears are unnecessary, and there is evidence for low risk women with a cervix that testing every three years is adequate. Under the current fee-for-service system, providers would lose revenue by testing less frequently, but under an annual Preventive Care Management Payment system with bonuses based on outcomes, providers would be able to maintain or improve both revenues and outcomes by providing tests only when necessary.

Patient Incentives for Improved Outcomes and Lower Costs

Patients would receive incentives (and disincentives where appropriate) and assistance from their payer to adhere to preventive care processes and to avoid behaviors that are root causes of serious health problems. For example, since co-payments for healthcare services can be a deterrent to using them, co-payments would be reduced or eliminated for services that are viewed as important to good outcomes, e.g., visits to the doctor for regular checkups. Patients could be given small financial rewards for reducing cholesterol, reducing weight, etc.

In addition to measures of patient outcomes, there should be measures of the processes that both providers and consumers take to improve outcomes, so that patients as well as providers can be held responsible for their role in improving outcomes.

Information on the price and quality of different providers would be made available to help patients choose high-quality/low-cost providers.

Issues and Challenges to Be Addressed

The Need for an Investment Model of Costs and Savings

The nature of prevention is such that the costs are incurred immediately but the benefits are realized later. In some cases, the time gap between costs and benefits may be relatively short (for example, flu shots are designed to prevent influenza cases from occurring during the current year), but in other cases, the gap may be very large (keeping cholesterol and weight low will likely reduce the incidence and magnitude of heart disease many years in the future). Moreover, the savings will likely be realized for different types of providers (e.g., hospitals and specialists) than where the costs are incurred (i.e., primary care providers). And in some cases, the benefits may be significant in terms of improved health or quality of life for patients, but result in little or no savings in expenditures on healthcare services.

Consequently, implementation of the model will likely not be "budget-neutral" in the short run, even though it should reduce costs in the long run. This will require payers to take a long-term view, and to evaluate changes based on their multi-year returns on investment, rather than on the immediate changes in expenditures. Some short-term savings may be possible (e.g., through prevention of hospitalizations from influenza, prevention of cardiovascular events through better blood pressure detection and control, etc.) and these would help to offset short-term increases in costs. There may also be ways to combine payment changes for preventive care with changes in other areas (such as chronic disease care) that do result in short-term savings, so that in combination, the initiatives maintain or reduce costs both in the short run and the long run.

The Need for Multiple Models

Although the goals to be achieved from a revised payment structure seem clear, it is less clear exactly how the details of an improved payment system should be designed to maximize achievement of the goals and minimize unintended consequences. Moreover, one size may not fit all: different models may work better with different patient populations and in different regions of the country depending on the number and types of current providers. Consequently, multiple demonstrations of different models, with careful evaluation of the outcomes, will be needed. In light of the long-term nature of the outcomes from prevention, these demonstrations may well take many years before clear conclusions can be drawn.

A NEW PAYMENT MODEL FOR CARE OF PATIENTS WITH CHRONIC ILLNESSES

Why the Current System Needs to Change

Patients with chronic illnesses require ongoing advice, care, and assistance from healthcare providers to manage their conditions. Current healthcare payment systems have many problems associated with them that discourage high-quality, efficient care for such patients, including:

- Current fee-for-service systems generally do not pay adequately (or at all) for many elements of primary care and preventive care, particularly for the more complex care issues associated with the elderly and other people with chronic conditions.
- Fee-for-service systems may not pay adequately for the time needed by a provider to make an accurate diagnosis and to develop an appropriate care plan and discuss it with their patient and the patient's family members, particularly in complex or unusual cases. At the same time, providers are not financially penalized for ordering more tests, regardless of whether they are necessary to make an accurate diagnosis/prognosis.
- Fee-for-service systems generally do not pay providers more to manage the needs of patients with complex conditions, particularly through mechanisms other than office visits. Many patients need this on an ongoing basis, while others need it temporarily after discharge from the hospital (e.g., encouragement and assistance in complying with post-discharge instructions).
- Certain types of providers (e.g., nurse practitioners, pharmacists, etc.) or services (e.g., telephone or email follow-up and monitoring of health status) are generally not covered as reimbursable services under payment systems (even though the providers are licensed to provide the care and the services have been demonstrated to improve outcomes), reducing the likelihood that they will be used even if they are more appropriate than providers/services which are covered.
- Fee-for-service payment systems reward providers for providing more services, even if they are unnecessary or of low value.
- Payment systems reinforce fragmentation of care by paying multiple providers for multiple services or tests for the same patient, regardless of whether the care is coordinated or duplicative.
- Patients generally do not have a financial incentive to adhere to prevention and disease management recommendations that could improve outcomes and reduce healthcare costs. Moreover, they may have a financial *dis*incentive because of required co-payments or because some services are not covered by their health insurance plan.
- Many payers do not have mechanisms for encouraging or directing patients to providers which provide care at lower cost (for the same quality) or higher quality (at the same cost).

Comparison to Current Payment Systems

CURRENT PAYMENT SYSTEM	PROPOSED PAYMENT SYSTEM
Separate fees are paid for each individual service rendered.	A single Comprehensive Care Management Payment would be paid for care management, preventive care, and minor acute care during a particular period of time.
Fees are only paid for services rendered by a physician in a face-to-face visit.	The Comprehensive Care Management Payment could be used for any appropriate service provided by any individual trained or licensed to provide that service.
Providers receive the same payments for services, regardless of the quality of services or outcomes achieved.	Providers would receive payment bonuses or penalties based on the outcomes they achieve and patient satisfaction with services.
Patients pay the same amount for services, regardless of the cost or quality of the specific provider they use.	Patients would pay more for using higher-cost and lower-quality providers.
Patients experience minimal or no financial penalties for failing to adhere to care plans in ways that require the use of additional, expensive services.	Patients would receive financial incentives to adhere to care plans jointly developed with their care providers.

SUMMARY OF IMPROVED PAYMENT MODEL FOR PATIENTS WITH CHRONIC ILLNESSES*

- A periodic (e.g., monthly) Comprehensive Care Payment would be paid to a group of providers to cover all of the care management, preventive care, and minor acute services associated with the patient's chronic illness(es). (Major acute care and long-term care would be paid separately.)
- The Comprehensive Care Payment would vary based on the patient's characteristics – both the specific chronic illness(es) they have and other factors affecting the level of healthcare services they will need.
- The set of services to be covered by the Comprehensive Care Payment would be determined by a Regional Collaborative Organization. The Regional Collaborative Organization would also estimate the cost of providing those services for each type of patient, but provider groups would bid and negotiate the actual Comprehensive Care Payment they would receive.
- The provider group would receive payment bonuses or penalties based on (a) health outcomes for patients, (b) patient satisfaction levels, and (c) patient utilization of major acute care services.
- Patients would receive incentives to use higher-quality/lower-cost providers, and to adhere to care processes jointly developed by the patients and providers.

What an Improved Payment Model Would Look Like*

Two separate Work Groups at the NRHI Summit discussed how to create a payment model that would address these types of problems. One group focused on patients with "stable" chronic conditions (e.g., hypertension that is well-controlled with medication) and the other group focused on patients with "unstable" chronic conditions (who might be defined as patients sick enough that death within a year "would not be a surprise"). Although there are some different issues and challenges associated with the two patient populations, the basic recommendations for changes in the payment structure were similar between the two groups, and so they are combined here into a single concept. Eighty-one percent of the Summit participants either supported the Work Groups' recommendations for a majority of patients and conditions or said they could support the recommendations with modifications.

The Basic Concept

A primary care provider would be selected by the patient with the chronic illness (or illnesses) to provide the care they need for that chronic illness. The provider would either provide the care directly, or would arrange for access by the patient to other providers and coordinate that care for them. The amount and types of care would depend on the nature and complexity of the patient's conditions. For patients with simple, stable chronic conditions, care and care management would be more focused on preventive activities designed to maintain health, whereas for patients with complex or unstable chronic conditions, assistance might be more focused on symptom management (e.g., 24-hour pain management).

The payer (whether it is the patient directly or an insurer) would pay that provider a periodic (e.g., monthly or quarterly) "Comprehensive Care Payment." The Comprehensive Care Payment (CCP) would cover all of the care management services, preventive care, and minor acute care services needed by the patient to keep chronic illnesses in check. If healthcare providers other than the primary care provider were needed to provide specific services as part of the patient's care (e.g., a laboratory to do blood tests, or an ophthalmologist to do eye exams), the primary care provider would be responsible for paying for those services out of the CCP.

The costs of hospital and specialty care for major acute episodes associated with the chronic illness (e.g., an amputation necessitated by poor diabetes control), the costs of care that is unrelated to the chronic illness (e.g., injuries suffered in an automobile accident), and the costs of long-term care (e.g., a nursing home), would be paid for separately. However, the primary care physician's *management* of the patient's care in hospitals and long-term care facilities would still be expected to be covered by the CCP. In the longer run, or where integrated systems of hospitals, physicians and long-term care providers exist, an even more comprehensively bundled payment structure might be feasible.

* *This model is adapted from the concept described in "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," by Allan H. Goroll, Robert A. Berenson, Stephen C. Schoenbaum, and Laurence B. Gardner, Journal of General Internal Medicine, 2007, 22:410-415.*

How the Payment Amount Would be Determined

The amount of the Comprehensive Care Payment would vary depending on characteristics of the patient that are expected to significantly affect the types and frequency of healthcare services needed by the patient in order to achieve good healthcare outcomes. Although conceptually similar to "risk adjustment," the variables and methodology would be designed specifically to adjust for differences in the time and costs of healthcare services to be provided, rather than outcomes per se. So, for example, the CCP would be higher for a patient with multiple chronic conditions than for a patient with only one chronic condition (and there would be a single CCP payment for management of all of the conditions, instead of making separate CCP payments for each chronic condition). Similarly, the CCP would be higher for a patient who would likely require more active monitoring and encouragement to achieve compliance with care processes, or who required active symptom management; and the CCP would be higher if the patient had preexisting conditions (e.g., obesity) that required additional management and care.

A Regional Collaborative Organization in each geographic region, with participation from payers, providers, and patients, would develop the different categories and the patient characteristics defining them, and all payers in the region would agree to use these categories. (This is similar to the recommendations in *Administrative Simplification for Medical Group Practices*, Medical Group Management Association, June 2005.)

The Regional Collaborative Organization would also develop a recommendation as to exactly which sets of services would be expected to be covered by the Comprehensive Care Payment. Payers would agree that they would not pay separately beyond the CCP for any of those services, and providers would agree that they would not charge separately for these services beyond the CCP, regardless of how many such services were provided. (In addition, the providers would agree that they would deliver those services when needed, or pay for those services, when necessary, if delivered by other providers.)

Finally, the Regional Collaborative Organization would develop an estimate of what an appropriate CCP amount should be for each category of patient. This would be based on the set of services viewed as appropriate for caring for typical patients in this category (based on Clinical Practice Guidelines, if they exist) and the estimated cost of those services. This would not be a recommended or mandated price; the estimate would simply serve as a starting point to help providers in establishing their own price for a CCP and to help payers determine what a reasonable price might be, since there would be little or no market experience with costing/pricing this new service package. The actual prices that payers would pay providers would be subject to negotiations between them; the Regional Collaborative Organization's estimate would simply be one input to those negotiations.

There would be no adjustment in the CCP for specific "outlier" cases. It is expected that within any patient category, there will be patients who need higher-than-average levels of services and those who need lower-than-average levels of services. As evidence develops that there are significantly different subpopulations within a particular patient category, consideration could be given to splitting the category into two or more new categories. Special arrangements may be needed for small providers (or categories with small numbers of patients), where costs may only average out over longer periods of time.

HOW THE IMPROVED PAYMENT MODEL WOULD WORK IN A HYPOTHETICAL CASE

Mrs. Jones has diabetes. Her insurance company pays her primary care provider a monthly Comprehensive Care Payment to help her manage her diabetes and to address some of the complications which might arise from her diabetes.

Her primary care provider has physicians, nurse practitioners, and other staff working as a team to help Mrs. Jones. In addition, they have relationships with other healthcare providers that will need to provide some aspects of Mrs. Jones' care, such as laboratories and ophthalmologists. Mrs. Jones' primary care provider works with her to develop a plan of care that defines the actions that she can and will take (e.g., exercising, managing her diet, taking medications, etc.) as well as the actions that the provider will take (e.g., contacting her regularly by phone to see how she is doing; seeing her periodically to check her blood glucose and hemoglobin levels; checking her feet at every visit; etc.) in order to successfully manage her diabetes. Mrs. Jones understands that she does not need to see a doctor each time she comes to the office for checkups, since a nurse practitioner can perform all of the necessary checks and call in a physician when needed.

The costs of blood tests and any visits to specialists that she needs, such as periodic eye examinations by an ophthalmologist, are all paid by her primary care provider from the monthly Comprehensive Care Payment.

Mrs. Jones pays no co-pays for her regular checkups or routine testing. Mrs. Jones receives a small cash payment from her insurance company if she meets the goals established in her care plan as measured by objective test results, such as hemoglobin A1c levels. Her primary care provider also receives a financial bonus from the insurance company if Mrs. Jones meets the goals in the care plan.

The insurance company measures the number of hospitalizations that occur related to diabetes for Mrs. Jones and other patients like her that are under the care of the primary care provider. If the rate of hospitalizations is below a pre-determined target level, the primary care provider receives a financial bonus, since they have saved the insurer money.

Mrs. Jones is free at any time to switch to another primary care provider if she isn't happy with the care she is receiving. However, if she switches to a provider which has significantly poorer outcomes, rates of hospitalizations, and higher prices for care, her insurance company may require her to pay a co-pay in order to use that provider.

Participants at the NRHI Summit recognized that the legality under anti-trust laws of the steps recommended in this subsection will need to be assessed. Although the recommendations do not contemplate having groups of providers or payers agreeing on the actual prices to be charged or paid, the process of standardizing methods and categories of payment could be viewed as inappropriate under current anti-trust laws.

Conditions for Provider Participation and Payment

In order for a provider to be eligible to receive a Comprehensive Care Payment, it would need to demonstrate that it had the structure and systems in place to provide the elements of care needed by patients in the ways that would most likely be successful. In particular, the provider would need to have an appropriate team of professionals available to provide care when needed, with information systems in place for appropriate tracking of patients (both to ensure good follow-up care with individual patients and to analyze ways to improve performance), and with established relationships with any other providers who would need to provide specific services needed as part of a comprehensive care plan. The goal should be for a patient's care to be provided in a fully comprehensive, coordinated way, whether or not the patient's primary care provider is part of a formally integrated system. (The requirements would likely be based in part on the "Wagner Model" for chronic care.)

In general, however, providers would not be *required* to provide specific types of services to patients in order to receive payment. Even if a specific set of services were used by the Regional Collaborative Organization in establishing the inclusions/exclusions and suggested payment levels for a particular category of patient, the provider would not have to document that those services were provided in order to receive payment. This would enable providers to continuously experiment with ways to adjust services to improve outcomes and efficiency. To the extent that evidence showed that specific processes were absolutely essential in all cases and that providers were inappropriately failing to provide them with undesirable frequency, then mandates to provide those processes might be considered.

Provider Incentives for Improved Outcomes and Lower Costs

Providers receiving Comprehensive Care Payments would receive bonus payments (and/or payment penalties) based on the extent to which their patients have better health outcomes, lower costs, and better patient satisfaction. For example, one measure that would affect bonuses/penalties would be the utilization of services that are paid separately from the Comprehensive Care Payment (e.g., hospital care for major acute episodes). While the provider would not be at risk for the full costs of these separate services, the bonus/penalty payments would put them at partial risk, in the sense that their total payments from insurers would be lower if utilization of these separate services were higher, and vice versa. For example, one of the goals of good care of diabetes is to avoid amputations. If a patient whose diabetes care had been paid for through a Comprehensive Care Payment needed an amputation, their primary care provider would not have to pay the full costs of that amputation, but would experience a small reduction in total payments (either through a reduced bonus or an increased penalty). This would provide an incentive for the primary care provider to work towards reducing the number of amputations occurring among their patients. In effect, the providers would share in the savings the payer experienced through reduced hospitalizations and share in the cost if hospitalizations increased. This could also help to reduce excess capacity in hospitals, nursing homes, etc.

There is general agreement that active participation by patients in care planning and decision-making is essential to improving their adherence to care plans and to reducing unnecessary services. While incentives are needed to encourage patient adherence (see below), the process of joint care planning starts with the provider taking the time to educate the patient about the options and discuss the decision that makes the most sense for them. Payments to providers need to be sufficient to compensate them adequately for this process.

In addition, providers would be expected to collect data on care processes delivered, outcomes achieved, and patient satisfaction, and to submit those data to a Regional Collaborative Organization or other mechanism which would publicize comparisons of the outcomes across different providers. This would also be expected to serve as an incentive for providers to improve their performance, as well as a mechanism for patients to choose the highest-performing providers.

As improved outcomes are widely achieved, the basis for incentive payments will need to change. In effect, the standard of care will have increased, and delivering that standard of care may become a condition for participation and payment, rather than a basis for extra rewards.

Patient Incentives for Improved Outcomes and Lower Costs

The responsibility for achieving successful outcomes rests as much with the patient as with his or her primary care provider. Patients who adhere to care plans are more likely to have better health and to avoid negative outcomes than those who do not. As noted above, providers can improve patient adherence by engaging them effectively in the preparation of care plans, educating them about how to follow the care plans, and monitoring their adherence. But beyond that, patient commitment and cooperation are essential. Consequently, payers would provide incentives (financial and non-financial) to patients for adherence with care processes and achievement of outcomes jointly developed with their primary care provider. For example, a diabetic might receive small financial rewards for maintaining appropriate blood glucose levels, reducing their weight, etc.

Since co-payments for healthcare services can be a deterrent to using them, co-payments would be reduced or eliminated for services that are viewed as very important to good outcomes, e.g., visits to the doctor for regular checkups.

Finally, some methods would be needed to encourage patients to choose high-quality/low-cost providers. For example, if a patient chooses the highest cost provider among a group of providers with equivalent quality, the patient could be required to share in the additional cost. If there are a sufficient number of high-quality providers to care for patients, and if there are some providers who provide significantly poorer quality based on objective measures, then the payer might refuse to pay for care from the poorest quality providers. These kinds of incentives would apply to specialty providers that the patient is referred to as well as the patient's primary care physician, e.g., if the patient needs to be referred to an ophthalmologist whose care would be covered under the Comprehensive Care Payment, the patient could be required to pay part of the cost if he or she wished to see a more expensive or lower-quality ophthalmologist.

Issues and Challenges to Be Addressed

The Need for Phase-In and Capacity Building

This payment model is premised on the existence of primary care practices that have staff with the appropriate training and skills, the necessary infrastructure (e.g., information systems), and the relationships with other providers which together would enable them to provide good quality care for patients with chronic illnesses, to accept Comprehensive Care Payments and manage the use of those funds to pay for their own costs as well as pay other providers involved in the care, and to regularly monitor and improve their outcomes and costs. Many primary care practices currently do not have this capacity. However, many would argue that this is due in substantial part to the fact that current payment systems do not adequately compensate or provide the appropriate incentives for practices to develop this capacity.

Consequently, two things will be necessary in order to successfully implement the improved payment model:

A multi-year phase-in period during which providers will have the opportunity to increase their capacity before the revised payment model is fully implemented. Rather than either (1) concluding that the revised payment structure is impractical, and settling for more incremental change, or (2) trying to implement the revised payment system immediately and expecting providers to respond immediately, payers will need to clearly define what they intend the payment system to be in the future and also define the timetable and process by which it will be phased in, and providers will need to accept that the payment system will change in this way and begin the process of transformation so that they have the appropriate capacity when it is required.

Investment by providers in building the necessary capacity. Many elements of the capacity-building needed by providers will be expensive and challenging. Many providers will need to make capital investments in improved information systems, and many providers will need to make commitments of both time and money to obtain training in areas such as geriatric care and end-of-life counseling. The time and money invested in this will pay off for patients in improved health outcomes and for payers in terms of reduced payments, but the risk will be with the providers, particularly if payers do not follow through with the payment system changes. Conversely, investments made by payers in improved payment systems may be lost if providers do not develop the capacity to respond appropriately. Consequently, it may make sense for payers and providers to jointly plan investments, and there may be ways that payers can help providers, particularly smaller providers, make the necessary investments, such as through loans with repayment contingent on implementation of new payment structures.

The Need for Improved Methods of Quality Measurement and Risk Adjustment

If the payment system is to be based on categories of patients grouped by their relative needs for services and on the outcomes achieved for those patients, significant improvements in methods for risk adjustment and outcome measurement will be needed. Here again, there will be a need to phase in payment changes in order to allow time for these improvements to be made.

In addition, methods will be needed to reconcile and prioritize objective measures of service quality (e.g., patient health outcomes) with subjective perceptions of quality (as measured by patient satisfaction), and for adjusting outcome measures based on the level of patient compliance. A patient may not want the care that science says they should have.

The Need for Experimentation and Testing

There are many details of the improved payment system which will have to be worked out and, for some of those details, it will be impossible to know which choice is best without pilots and demonstrations of alternative approaches, including careful evaluations of the benefits and unintended consequences. For example, while there is general agreement that there need to be better mechanisms of encouraging patients to adhere to care regimens and to choose better quality/lower-cost providers, there is little understanding of which mechanisms for doing so would be best. The only way to find out is to test the different alternatives and see. Because there are many different types of patients/conditions and many different types of providers, this will require many different demonstrations. The planning, implementation, and evaluation of these demonstrations will likely take several years.

The Need to Preserve Patient Choice

Chronically ill patients, like all patients, want the right to choose their providers and their care. While payment systems should be designed to improve coordination of care for patients and give them a clear "medical home," patients should not be locked in to particular providers. Preserving patient choice will inherently complicate payment systems, outcome measurement, and provider accountability. For example, if a patient switches primary care providers, and is later hospitalized for complications related to their chronic illness, which provider is responsible, and which should receive any performance bonuses or penalties based on the hospitalization? If a patient seeks a second opinion on a care recommendation, should that be covered by the payment to the patient's primary care provider, or by a separate payment?

Measuring Success

An implicit goal of an improved payment structure is to create an improved system of care for patients. So in addition to measuring patient-level outcomes, it will be important to measure whether the system itself is improving in ways that are believed to result in better patient care and better outcomes in the future. Some of the questions to be answered and measures to be developed include:

- Are we strengthening primary care?
  - Do more patients report that they have a primary care physician or team?
  - Do more patients report that they can find a primary care team easily?
  - Are patients able to communicate with their primary care team more readily?
  - Do more primary care physicians report "joy in work" and being "fairly paid?"
  - Has access to specialists, as reported by patients and primary care physicians, improved?
- Is primary care becoming more patient-centered?
  - Do more patients report that they are getting exactly the care they need, exactly when and as they need it?
  - Do more patients report that they fully understand their care, understand what they need to do to stay healthy, and that the care fully reflects their preferences?
  - Are decisions about payment and other issues more oriented toward patients' interests than providers' interests?
  - Do patients report that their providers coordinate services effectively?
- Is care of patients with chronic illness becoming more efficient?
  - Have expenditures for specific patients and conditions met the target levels?
  - Has the percentage of care managed without face-to-face contact and in single visits increased?
  - Have hospitalizations been reduced?
  - Has there been a decrease in the frequency of procedures that had been performed previously at a rate above the national average?
  - Has the rate of test repetition decreased?
  - Have patients reported any greater problems in accessing care?
- Are outcomes for chronically ill patients improving?
  - Have blood pressure levels improved?
  - Have Hemoglobin A1c levels improved?
  - Do patients experience fewer limitations affecting their quality of life?
- Are data being used for management and continuous improvement?
  - How many quality/outcome/cost measures are available?
  - How promptly are the measures available?
  - Does the managing board of the provider review the measures regularly?
  - Is the CEO compensation/performance plan tied to the measures?

A NEW PAYMENT MODEL FOR CARE OF PATIENTS EXPERIENCING MAJOR ACUTE EPISODES

Why the Current System Needs to Change

Most health plans currently pay hospitals on an "episode-of-care" basis, typically the Diagnosis-Related-Group (DRG) prospective payment system used by Medicare. However, physicians are paid separately, often on a fee-for-service basis, and other post-acute care providers (e.g., home health care agencies, rehabilitation hospitals, etc.) are also paid separately. These payment systems have a number of problems that discourage high-quality, efficient care for patients experiencing major acute episodes, including:

- Fee-for-service payments to physicians and per diem payment to hospitals pay more for more services, regardless of their quality or the outcomes achieved.
- Payment systems reinforce fragmentation of care by paying multiple providers for elements of the same episode of care for the same patient, regardless of whether the care is coordinated or duplicative.
- Many payment systems not only provide higher reimbursements for more expensive procedures, but also provide higher *profit margins* over providers' costs, thereby creating an incentive to use more expensive procedures.
- Payment is made to whichever inpatient care facility is chosen by a patient's physician (or by the patient based on where the physician practices), in many cases without regard to cost and/or quality.
- Payment systems generally pay for services regardless of whether all of the processes recommended in clinical practice guidelines are performed by the provider, and research has shown that large proportions of patients do not receive important elements of care.
- Episode-of-Care Payment systems can financially penalize providers for adding components of care that could improve long-term outcomes but increase short-term direct costs.
- For hospital care, physicians order the use of drugs and devices, but the costs associated with those drugs and devices are typically incurred by the hospital and must be absorbed within the payment made to the hospital, not by the physician.
- Payment systems do not explicitly reward providers for reducing indirect costs of care, such as length of time away from work (e.g., a worker's length of stay in the hospital, time spent waiting for a doctor's appointment or testing, etc.).
- Under most payment systems, providers are paid more for patients experiencing adverse events, particularly serious adverse events resulting in multiple complications, and the provider's "profits" on patients experiencing such events may actually be higher than on patients with no adverse events.
- Current payment systems generally do not pay hospitals or physicians more to manage the needs of patients with complex conditions after discharge from the hospital or to proactively work to encourage and assist the patient in complying with post-discharge instructions.

Comparison to Current Payment Systems

CURRENT PAYMENT SYSTEM	PROPOSED PAYMENT SYSTEM
Physicians are paid on a fee-for-service basis for care to a patient during a major acute episode, but hospitals are paid on a prospectively-defined episode-of-care basis (i.e., DRGs).	All providers, including physicians, would be paid a prospectively-defined Episode-of-Care Payment for all services provided during a major acute episode, with the amount based on the patient's diagnosis and other factors associated with the level of services needed.
Hospitals, physicians, home health care agencies, and other providers are each paid separately for services provided during a major acute episode.	A single "bundled" Episode-of-Care Payment would be defined to cover all of the providers involved in an episode of care. Ultimately, a single organization representing the group of providers would receive the payment and divide it among them.
Providers are paid the same amount regardless of whether all recommended services are provided.	The Episode-of-Care Payment would not be paid unless specific services viewed as essential were provided.
Providers are paid the same amount regardless of whether the patient outcomes they achieve are better or worse than those achieved by other providers.	The Episode-of-Care Payment would be retroactively adjusted up or down based on the level of patient outcomes and patient satisfaction that the group of providers achieved.
Providers are generally paid more for patients who experience hospital-acquired infections or other adverse events, particularly if they result in significant complications.	The Episode-of-Care Payment would not be increased because of an adverse event or the complications resulting from the adverse event.
Payment for care is made to whichever group of providers a patient uses, regardless of their relative quality or cost.	Patients would have to pay more if they use the lowest-quality, highest-cost providers.
Poor outcomes or hospital readmissions may occur because patients do not adhere to post-discharge instructions.	Patients would receive financial incentives to adhere to post-discharge care plans jointly developed with their care providers.

What an Improved Payment Model Would Look Like

A Work Group at the NRHI Summit developed recommendations for a payment model that would address these types of problems. Eighty-four percent of the Summit participants supported the Work Group's recommendations for a majority of patients/conditions or said they could support the recommendations with modifications.

The Basic Concept

A single Episode-of-Care Payment would be paid for all of the services needed by a patient to address a single "episode of care," i.e., from initial diagnosis of their condition to completion of treatment of that condition. (For patients with a chronic illness, treatment may be required on a long-term basis, so for purposes of the Episode-of-Care Payment, the episode of care would end when the major acute exacerbation had been resolved to the level where "normal" chronic disease management would again be appropriate.)

The single payment would be designed to cover all providers providing services required to address the episode of care (i.e., their individual payments would be "bundled" into a single payment). This would include all of the hospitals, physicians, home healthcare agencies, etc. involved in the patient's care for that episode. (If some portions of the care are covered by the patient's healthcare payer and some are not, then the payer could decide to limit the single payment to those providers and services which are covered, or it could decide to expand the payment to cover all providers and services viewed as necessary to achieving the desired outcomes.)

This is similar to the model proposed in "PROMETHEUS: Provider Payment for High Quality Care; A White Paper," by Prometheus Payment, Inc.

How the Payment Amount Would be Determined

The Episode-of-Care Payment would vary based on the patient's diagnosis and other patient-specific factors associated with different amounts of care. The payment would be prospectively defined, but would include a retrospective adjustment based on the level of outcomes achieved by the provider group (see below).

A Regional Collaborative Organization (with representation from payers, providers, and patients) would develop an estimate of what an appropriate Episode-of-Care Payment would be for each category of diagnosis and patient severity, based on a study to estimate the cost of delivering good quality care for those types of patients. This would not be a recommended or mandated price; the estimate would simply serve as a starting point to help providers in establishing their own price for the Episode-of-Care Payment and to help payers determine what a reasonable price might be, since there would be little or no market experience with costing/pricing this new service package. The actual prices that payers would pay providers would be subject to individual negotiations between them; the Regional Collaborative Organization's estimate would simply be one input to those negotiations.

SUMMARY OF IMPROVED PAYMENT MODEL FOR PATIENTS WITH MAJOR ACUTE EPISODES

- A single Episode-of-Care Payment would be paid to a group of providers to cover all of the services needed by the patient.
- The group of providers would include all of the hospitals, physicians, home healthcare agencies, etc. involved in the patient's care for that episode. The providers would be encouraged to create joint arrangements for accepting and dividing up the Episode-of-Care Payment among themselves.
- The Episode-of-Care Payment would vary based on the patient's diagnosis and other patient-specific factors. However, there would be no increase in payment to cover preventable adverse events (errors, infections, etc.)
- The payment would be prospectively defined, but would include a retrospective adjustment based on the level of outcomes achieved by the provider group. There would be some adjustments in payment made for cases requiring unusually high levels of services, but only if improved outcomes are achieved for those higher levels of service.
- A Regional Collaborative Organization would recommend the amount of the Episode-of-Care Payment for each type of patient, based on a study to estimate the cost of good quality care, but provider groups would bid and negotiate the actual payment they would receive.
- Patients would receive incentives to use higher-quality/lower-cost providers, and to adhere to care processes jointly developed by the patients and providers.

Payment levels would not be expected to cover the additional costs of providers with special characteristics, such as teaching hospitals. Instead, all of the payers in the region would agree to make separate payments to these facilities to cover these additional costs. The revenues for this could come from a uniform surcharge on all Episode-of-Care Payments (or all types of payments) in the region. This would ensure that the prices for the same types of care could be compared for teaching hospitals and non-teaching hospitals.

Some adjustments in payments would be made for "outlier cases," i.e., cases requiring unusually high levels of services. However, this adjustment would also reflect whether improved outcomes were being achieved for the higher levels of services and costs.

There would be no increase in payment to cover preventable adverse events (errors, infections, etc.) or the complications resulting from such events.

Participants at the NRHI Summit recognized that the legality under anti-trust laws of the steps recommended in this subsection will need to be assessed. Although the recommendations do not contemplate having groups of providers or payers agreeing on the actual prices to be charged or paid, the process of standardizing methods and categories of payment could be viewed as inappropriate under current anti-trust laws.

Conditions for Provider Participation and Payment

In the long run, groups of providers would be expected to define a single accountable payee for receiving and allocating a payment among themselves. However, in the short run, where no such arrangement has been defined, payers would allocate the payment to individual providers based on a standard allocation determined during the process of setting the base payment level. Incentives would be created, however, to encourage groups of providers to create joint arrangements for accepting and dividing up the Episode-of-Care Payment among themselves (e.g., the payer could charge a percentage administrative fee on the bundled payment if the payer has to make the division of payment among providers).

Providers would be free to work out their own arrangements as to how any profits or losses incurred on individual cases would be divided among themselves.

The Regional Collaborative Organization would define those processes that would be considered (based on medical evidence) as mandatory for patients in a particular diagnosis/severity category, and providers would only be paid if those processes were delivered, unless there was clear documentation that the processes were contraindicated for the patient, or that the patient was participating in a clinical trial of alternative processes.

Provider Incentives for Improved Outcomes and Lower Costs

Payers would give providers bonus payments (and/or payment penalties) based on the extent to which their patients have better health outcomes and better patient satisfaction.

In addition, payers would provide financial incentives to providers to encourage patient involvement in care planning.

Patient Incentives for Improved Outcomes and Lower Costs

Part of the responsibility for achieving successful outcomes rests with the patient. Patients who adhere to post-discharge care plans are more likely to have better outcomes than those who do not. Providers can improve patient adherence by engaging them effectively in the preparation of care plans, educating them about how to follow the care plans, and monitoring their adherence. But beyond that, patient commitment and cooperation are essential. Consequently, payers would provide incentives (financial and non-financial) to patients for adherence with care processes jointly developed with their provider. Since co-payments for healthcare services can be a deterrent to using them, co-payments might be reduced or eliminated for post-discharge services that are viewed as very important to good outcomes, e.g., follow-up visits to the doctor or hospital to monitor wound healing.

Patients would also be given financial incentives to choose high-quality/low-cost providers. For example, if a patient chooses the highest-cost provider among a group of providers with equivalent quality, the patient could be required to share in the additional cost. If there are a sufficient number of high-quality providers to care for patients, and if there are some providers who provide significantly poorer quality based on objective measures, then the payer might refuse to pay for care from the poorest quality providers.

HOW THE IMPROVED PAYMENT MODEL WOULD WORK IN A HYPOTHETICAL CASE

Ms. Brown falls and breaks her hip and goes into the hospital for surgery to implant a prosthetic hip. Each of the hospitals in the community has defined a price that it will charge Ms. Brown's insurance company for performing the surgery and providing all of the post-operative care for a woman of Ms. Brown's age and health status. That price will cover Ms. Brown's hospital care, her surgeon's fees, the cost of her prosthetic hip, her care by any other physicians who are involved (e.g., anesthesiologists, intensivists, etc.), her post-hospital rehabilitation, and any home care she may need to make sure she can return home safely. The hospital will be responsible for dividing up the payment among all of those providers. If Ms. Brown develops an infection in the hospital following surgery, the hospital and its physicians will be responsible for treating that infection at no additional charge.

The insurance company measures the outcomes (e.g., mortality rate, complication rate, infection rate, range of motion following rehab, etc.) that the hospital achieves for hip replacements on patients similar to Ms. Brown, and it adjusts the payment to her hospital up or down by a certain percentage based on whether the hospital's outcomes are above or below a standard established by the insurance company.

Ms. Brown will be responsible for paying a co-payment for her care. The co-payment will be lower if Ms. Brown selects a hospital that charges a price lower than the average of other hospitals in the area and/or with quality ratings above the average for the region for patients similar to Ms. Brown.

Ms. Brown receives a small rebate on her co-payment or co-insurance amount if she achieves the rehabilitation goals and complies with the post-discharge plan that she develops jointly with her physicians.

Issues and Challenges to Be Addressed

The Need for Demonstration and Pilot Projects

Although the new payment structure described above would address many of the problems caused by the current payment system, there may also be unintended new problems created in their place. The best way to learn what those unintended consequences may be, and to design ways to mitigate or avoid them, is to design and implement demonstration projects. In addition, while it is clear that the revised payment system needs to have certain components, such as methods of incentivizing patient adherence to care plans, it is not clear which specific approach to that component would be best. So again, this requires pilot tests of the different approaches.

Rather than trying to make large-scale changes in payment structures, demonstration and pilot projects should be focused on payment changes for limited, specific groups of patients/conditions, where there is a reasonable degree of homogeneity across patients and where a reasonable degree of transparency in cost and quality already exists.

Demonstrations and pilot projects should be pursued at the regional level (e.g., by multiple payers in a particular community) and also at the national level (e.g., by Medicare in multiple sites). The concepts for the demonstrations should be developed through a "bottom-up" approach – addressing issues and goals that a particular community has chosen – rather than top-down.

The Need for Incentives to Do Demonstrations

Designing and implementing a demonstration project which significantly changes payment structures is a challenging task for both payers and providers.

From the providers' perspective, expensive and time-consuming changes in billing systems, work processes, etc. will likely be needed, yet because the changes are merely part of a "demonstration" project, there is no certainty that those investments will pay off. Consequently, payers may need to provide incentives in order to encourage provider participation, such as:

- Paying providers a bonus for participating;
- Paying explicitly to offset higher administrative costs;
- Reducing the administrative costs/requirements associated with other payment systems during the demonstration (e.g., if a provider agrees to operate under a new payment model for a subset of patients/conditions, the payer(s) might agree to relax some of the paperwork requirements associated with the standard payment system for the remaining patients/conditions);
- Making a clear commitment that this type of payment system is going to be implemented after the demonstration period is complete, rather than this merely being a test of a possible concept.

From the payers' perspective, expensive and time-consuming changes in computer systems, retraining of staff, etc. will be needed to implement a payment demonstration, and the payer will have to run two systems in parallel during the demonstration period. If the payer is national or multi-state in scope, it may be faced with several different demonstrations in different regions, each requiring separate system changes. If a payment system to be tested penalizes specific providers, those providers may threaten to withdraw from participation with a payer involved in the demonstration. In turn, the loss of providers could damage the payer's market share. Consequently, payers also may need incentives to participate. The most likely source of those incentives is the ultimate purchasers of the health payers' product, i.e., employers, in the case of private health plans, and elected officials, in the case of Medicaid and Medicare.

Designing demonstrations on a regional basis, with involvement of multiple payers and providers, could help to alleviate some of these impediments through economies of scale.

The Need for Rapid Evaluation and Dissemination of Demonstration Project Results

In order to advance the goal of payment reform most efficiently and effectively, it is important that there be sharing of information about plans for demonstration projects and about the results of demonstration projects that have been implemented. There is no need for one region to "reinvent the wheel" if another region has already developed or tested a particular payment approach, and a broader range of concepts can be tested/demonstrated if different regions pursue different demonstrations.

The Need to Clearly Define the Goals of Payment Demonstration Projects

Changes in payment systems are not ends in themselves, but means to achieving improved healthcare quality and lower costs. The success of a payment demonstration project, therefore, is not determined by whether it is implemented as designed, but whether it achieves what was intended. Consequently, it is essential that clear goals – in terms of improved quality, reduced cost, or both – are established as part of any demonstration.

Demonstrating Value With a Warranty

In a bid to improve quality and win better health plan contracts, Danville, PA-based Geisinger Health System took a cue from the nation's retail sector that turns traditional healthcare reimbursement on its head: it began offering the retail equivalent of 90-day warranties on open-heart bypass surgery as a first step toward guaranteeing results for other kinds of care.

Before the experiment, Geisinger, like other healthcare providers, billed insurers for additional care whenever patients suffered complications, such as infections, as a result of their hospital stays. Under the warranty, Geisinger bills for the original treatment, but agrees to absorb costs of any follow-up needed within the next 90 days.

To guard against losses that might otherwise stem from such quality improvements, Geisinger, which initiated the experiment with its own health insurance subsidiary, bills a flat fee for bypass surgery, plus a portion of the extra care costs insurers had earlier been forced to pay.

The experiment augurs well for reforming a system of payment that often perversely rewards lapses of care and fails to provide incentives for high quality. Since beginning the warranty policy more than a year ago, the health system reported that its open-heart bypass patients have been returned to ICUs less frequently, have spent fewer days in the hospital and have been discharged directly home more frequently, reducing the need for follow-up care in nursing homes.

The results stem largely from standardization of practices – a concept borrowed from industry. The health system's heart surgeons agreed on 40 essential steps that should be followed with each bypass patient and devised methods to ensure they were followed no matter which doctor was operating, or at which of Geisinger's three hospitals.

In a New York Times article about the novel approach, Arnold Milstein, MD, Medical Director for the Pacific Business Group on Health, remarked that Geisinger "is one of the few systems in the country that is beginning to understand the lessons of global manufacturing."

One uncommon characteristic that enabled Geisinger to experiment with a warranty is that it directly employs most of the doctors who admit patients to its hospitals. Fragmentation elsewhere in health care, where doctors have admitting privileges at hospitals, but still maintain independent practices, could make it more difficult for other institutions to implement similar care protocols or payment methods.

IMPLEMENTING CHANGES IN PAYMENT SYSTEMS

Fundamental Changes in Payment Systems Are Difficult, But Essential

Moving from the current payment systems to the proposed new payment systems for chronic care, preventive care, and major acute care described in the previous sections will be complex and challenging endeavors. The reason that payment reform efforts to date have concentrated on incremental pay-for-performance add-ons is because so much work is required to reinvent the underlying payment systems.

However, there is growing realization and agreement that in order to achieve the most efficient, effective, and sustainable improvements in quality and reductions (or slowing the growth) in costs of the healthcare system, the penalties and disincentives in current healthcare payment systems need to be eliminated or modified, in addition to adding rewards or incentives. At NRHI's March 2007 Summit, 48 percent of participants said that fundamental changes in the payment system are *essential* to improving the quality and cost of health care. Another 39 percent said that fundamental changes were desirable, but very difficult, and that attention should also be paid to incremental (pay-for-performance, or P4P) changes while fundamental reforms are being designed and implemented. Only 9 percent of participants said that incremental P4P changes should take priority, and only 3 percent said that payment changes were not essential to improving quality.

The Need to Improve Payment Systems Without Increasing Overall Costs

In light of the deep national concern about the affordability of health care, it makes sense to develop demonstration projects that are "budget neutral," i.e., projects which do not increase healthcare spending, and ideally decrease it. Fourty-six percent of the participants at the NRHI Summit felt that budget neutrality was essential, and only 19 percent felt it was not essential.

Many studies have shown high levels of waste and unnecessary services in healthcare systems, and establishing payment systems which encourage the reduction of waste and unnecessary services could reduce health care costs as well as improve quality. A key question, however, is the time period in which costs are measured – some changes in practice might require increases in spending in the short run but result in reduced spending in the longer-run.

Moreover, designing and implementing a new payment system is a challenging task for both payers and providers, and both payers and providers may need incentives and assistance to encourage them to pursue such changes. Incentives for providers would need to come from payers and patients; incentives for payers would likely come from purchasers (e.g., employers for private insurance, and elected officials and taxpayers for public programs) and patients. Similarly, carrying out objective evaluations of payment reform demonstrations requires significant time and money, and the availability of funding sources to cover these costs will increase the likelihood that evaluations will be conducted and disseminated.

The Need for (Many) Regional Demonstrations

There is also general agreement that *pilot tests and demonstrations* of new payment systems must be developed, implemented, and evaluated in order to make progress on payment reform. Even where there is agreement on the general structure of improved payment systems, there are many details to be worked out. In some cases, a particular approach may seem preferable, but concerns exist about potential unintended consequences.

In other cases, there is simply insufficient knowledge or experience as to how providers or patients will respond to enable a preferred option to be identified. There will likely be unintended consequences and unexpected difficulties which will need to be identified and rectified before broader implementation is warranted. This uncertainty is due to the fact that there have been relatively few cases across the

A PAYMENT CHANGE THAT IMPROVED OUTCOMES AND LOWERED COSTS

When Starbucks, one of the biggest employers in Seattle, realized that costs for treating back injuries were far higher at Virginia Mason Health System than they were at competing providers, the coffee retailer asked Aetna Inc. to drop the institution from its network. Because dropping providers can limit a health plan's marketability, Aetna instead helped Virginia Mason analyze the reasons for the big cost difference. The heart of the health system's problem was much higher use of MRIs and neurological consults, even for patients whose back pain could be readily explained by an injury. So, Virginia Mason worked with the insurer to make physical therapy the first treatment option. Almost immediately, the health system began seeing faster recovery times for patients (which, in the case of occupational injuries, meant less time on workers' comp) and dramatically lower costs for employers because physical therapy costs so much less than MRIs and neurological workups. However, the steep reduction in MRIs and neurological consults also took a toll on Virginia Mason's finances. Instead of generating several thousand dollars for treating a back injury, it saw its income drop to a few hundred dollars on each case, which was not enough to cover its costs. Neither Aetna nor Starbucks ever intended to put Virginia Mason out of business, so they did something that instead was a win-win. They restructured payments to reward appropriate care. Instead of staking claim to the entire savings, Starbucks and Aetna took only a portion and directed the rest toward increased reimbursement for physical therapy, which, up to that point, had been a money loser for Virginia Mason.

nation where significantly different payment systems have been attempted, and even fewer where thorough evaluations have been conducted. There will also likely need to be differences in the structure of payment systems from region to region in response to differences in the number and type of providers available.

Consequently, a wide variety of payment demonstrations are needed. Not only are there many different issues, and multiple options for resolving each of those issues, but every region of the country is different in terms of the number, types, and relationships of healthcare purchasers, payers, and providers, so there may not be a single type of payment system that will work in all parts of the country. Just as experimentation and evaluation is a hallmark of evidence-based medicine, experimentation and evaluation will also likely be needed in order to develop the most effective cure for the ills of the payment system.

The overwhelming majority of the participants at the NRHI Summit – 96 percent – agreed that regional demonstrations were the most desirable way to move forward. Health care is a fundamentally regional enterprise, since most payers and providers operate exclusively or primarily in metropolitan regions or states.

However, this does not mean that payment reform should be a parochial enterprise. Indeed, just as medicine itself advances the state-of-the-art through local innovations that are supported, replicated, and evaluated nationally, so too can payment reform be more successful if there is national support for the development, evaluation, and replication of regional payment demonstrations. Participants at the NRHI Summit felt strongly that there needed to be better ways of sharing information about payment reform demonstrations across the country; this may be an important role that NRHI itself can play. Seventy-two percent of the participants recommended that NRHI convene another Summit within a year, and many participants suggested that smaller meetings be convened more frequently.

The Need to Clearly Define the Goals of Payment Demonstration Projects

Changes in payment systems are not ends in themselves, but means to achieving improved health care quality and lower costs. The success of a payment demonstration project, therefore, is not determined by whether it is implemented as designed, but whether it achieves what was intended. Consequently, it is essential that clear goals – in terms of improved quality, reduced cost, or both – are established as part of any demonstration.

The Need to Align Incentives While Addressing Anti-Trust Compliance

There is also widespread agreement that in addition to *changing* the current incentives in the payment system, it is essential to *align* incentives across payers. It is difficult, if not impossible, for healthcare providers to redesign their processes of care if only a small subset of their payers change their approach to payment. And even if all or most payers change their approach to payment, if each payer creates a different structure of payment (e.g., different episode-of-care categories, different combinations of services bundled together, etc.), it will be more difficult and expensive for providers to respond. Consequently, it would be much more efficient and effective if each payer changed their payment systems in the same basic way and at the same time.

Because of this, the majority of participants at the Summit (54 percent) felt that it was essential that most, if not all, payers in the region participate in such regional demonstrations in order to make them successful. However, one-third of the participants felt that such regional demonstrations were sufficiently important that they should be pursued even if only one payer participates. The majority of participants (60percent) also felt that while participation by Medicare was desirable, it was not essential in order for regional payment demonstrations to be successful, although the need for Medicare's participation depended on the type of patients and conditions to be addressed. Similarly, the majority of participants (66 percent) felt that participation by Medicaid was desirable, but not essential, for regional payment demonstrations, again depending on the types of patients and conditions to be addressed. Special efforts will likely be needed to get national payers (both public and private) to participate in multiple regional demonstrations.

Having multiple payers and multiple providers agree to use the same *payment structure* does not mean that they would need to agree to charge or pay the same *prices*. For example, everyone could agree that chronic care management should be paid through a Comprehensive Care Payment (CCP) with common definitions of patient categories and the services to be included and excluded within that payment, but each provider could still establish a different *amount* for that CCP in its negotiations with payers.

However, it is not clear whether these kinds of agreements on changing *payment structures* would be permissible under current federal and state anti-trust laws. Clarification of this is urgently needed; otherwise fear of prosecution under anti-trust laws will likely have a chilling effect on the willingness of payers, providers, and regional collaborative organizations to pursue payment reform initiatives with aligned incentives.

Leadership From Regional Collaboratives

Who should take the lead in advancing payment restructuring? At the NRHI Summit, 44 percent of participants said that the lead role should be taken by Regional Collaboratives of payers and providers working in a national network. Because both payers' payment systems and providers' processes of care need to change in order to achieve the goals of improved quality and reduced cost, a neutral convener can help to reach consensus on payment system changes that are workable for both payers and providers as well as patients. Regional Collaboratives, where they exist, can play a key role in finding win-win solutions for payment reform. However, in order to be successful, Regional Collaboratives will need cooperation from payers and providers, and they will need a sustainable source of funding to support their efforts.

Where Regional Collaboratives do not exist or do not take the lead, payers (purchasers and/or health plans) should take the lead role. However, there was almost universal agreement that clinicians had to be engaged in payment system redesign, and that purchasers (e.g., employers), not just health plans, needed to be involved as well.

The Need for Improvements in Provider Capacity and Coordination

Although the Summit focused on the changes needed in payment systems, there was recognition by the Summit participants that in order to achieve the desired improvements in quality and cost, there would also need to be changes/improvements in the capacity and coordination of providers to deliver high-quality, cost-effective care. Indeed, implementation of several of the proposed changes in payment systems, such as bundled payments for major acute episodes and chronic care management payments, would be dependent on being able to identify a single healthcare provider to pay for the full range of services needed for an episode of care or for chronic disease management.

To some extent, changes in payment systems and changes in provider organization and coordination are a "chicken and egg" issue – each is dependent on the other. So in addition to developing demonstrations of payment system changes, there will likely also need to be efforts to encourage and assist providers to do things such as improving their care management infrastructure (e.g., staffing and information systems) and entering into coordination agreements with other providers for both payment and quality improvement. Some approaches to addressing this have been proposed (see, for example, "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," by Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum, and Daniel J. Gottlieb, *Health Affairs* Vol. 26, no. 1, pp. w44-w57, January/February 2007), and tests of these approaches could be part of payment reform demonstration projects.

The Need for Improved Methods of Outcome Measurement and Risk Adjustment

Creating payment systems that focus more on outcomes will require improved systems of measuring outcomes and improved systems of categorizing different levels of patient risk and severity associated with different levels of healthcare services required to achieve certain outcomes. Although research programs and consensus-building systems for this exist at both the regional and national levels, the scope and speed of these systems will likely need to be increased in order to support improved payment systems.

CREATING A REGIONAL PAYMENT DEMONSTRATION IN PITTSBURGH

The Jewish Healthcare Foundation and the Pittsburgh Regional Health Initiative are committed to developing a demonstration project in Pittsburgh that changes payment systems in order to support improved quality and lower-cost health care.

PARTICIPANTS AT THE 2007 NRHI SUMMIT

Laura Adams
President and Chief Executive Officer
Rhode Island Quality Institute

Rose Almon-Martin
Vice President for Performance Excellence and Marketing Services
Medrad, Inc.

Gail M. Amundson, MD
President and Chief Executive Officer
Quality Quest

Michael H. Bailit, MBA
President
Bailit Health Purchasing, LLC

Dennis Batey, MD
Senior Vice President and Chief Medical Officer
Fallon Community Health Plan

Howard Beckman, MD
Medical Director
Rochester Individual Practice Association

Robert A. Berenson, MD
Senior Fellow
The Urban Institute

JudyAnn Bigby, MD
Secretary
Massachusetts Executive Office of Health and Human Services

Gifford Boyce-Smith, MD
Senior Medical Director
Blue Shield of California

Samuel E. Carlson, MD
Executive Vice President and Chief Medical Officer
Park Nicollet Health Services

Sophia Chang, MD
Director, Chronic Disease Care Program
California HealthCare Foundation

James Chase
Executive Director
Minnesota Community Measurement

Patrick T. Courneya, MD
Medical Director for Delivery Systems
HealthPartners Health Plan

Terrisca Des Jardins
Senior Program Manager
Greater Detroit Area Health Council

Marie Dotseth
Program Director
National Institute of Health Policy

Debra A. Draper, PhD
Associate Director
Center for Studying Health System Change

Karen Wolk Feinstein, PhD
President and Chief Executive Officer
Jewish Healthcare Foundation; Pittsburgh Regional Health Initiative

Michelle Ferrari
Project Manager
Minnesota Community Measurement

Donald R. Fischer, MD
Senior Vice President and Chief Medical Officer
Highmark, Inc.

Elliott Fisher, MD
Professor of Medicine
Dartmouth Medical School

Stephen Foreman, PhD, JD, MPA
Associate Vice President of Academic Affairs
Robert Morris University

Allan H. Goroll, MD
Professor of Medicine
Harvard Medical School

Allison Hamblin
Program Officer
Center for Health Care Strategies

Stephen Halpern
Chairman
Jewish Healthcare Foundation Board of Trustees

A. J. Harper
President
Hospital Council of Western Pennsylvania

Nikki Highsmith
Senior Vice President
Center for Health Care Strategies

David Hopkins, PhD
Director, Quality Measurement and Improvement
Pacific Business Group on Health

Stephen F. Jencks, MD
Senior Advisor
Centers for Medicare and Medicaid Services

William A. Jesserer
Vice President of Sales and Service
Aetna, Inc.

William G. Johnson
Professor
Arizona State University

Jeff Kamil, MD
Vice President and Chief Medical Officer
Blue Cross of California

Wishwa Kapoor, MD
Chief, Division of General Internal Medicine
University of Pittsburgh Medical Center

David Kelley, MD
Medical Director, Office of Medical Assistance
Pennsylvania Department of Public Welfare

Neil M. Kirschner, PhD
Senior Associate, Regulatory and Insurer Affairs
American College of Physicians

Lance H. Lang, MD
Vice President and Senior Medical Director
Health Net of California

Judith Lave, PhD
Professor of Health Policy Management
University of Pittsburgh

Peter V. Lee, Esq.
Chief Executive Officer
Pacific Business Group on Health

Karen Linscott
COO
The Leapfrog Group

Cal R. Ludeman
Commissioner
Minnesota Department
of Human Services

Joanne Lynn, MD
Office of Clinical Standards
and Quality
Centers for Medicare
and Medicaid Services

Tania Lyon, PhD
Associate Director
Chronic Care Initiatives
Pittsburgh Regional Health Initiative

Sanne Magnan, MD, PhD
President
Institute for Clinical
Systems Improvement

Linda M. Magno
Director, Medicare Demonstration
Program Group
Centers for Medicare and
Medicaid Services

David Malone
President and Chief Executive Officer
Gateway Financial Group

Robert Mandel, MD
Vice President
Blue Cross Blue Shield
of Massachusetts

Mark McClellan, MD, PhD
Visiting Senior Fellow
AEI-Brookings Joint Center
for Regulatory Studies

Peggy McNamara
Senior Analyst for the Center for
Delivery, Organization, and Markets,
Agency for Healthcare Research
and Quality

Ateev Mehrotra, MD
Health Policy Researcher
RAND Corporation

Harold D. Miller
Strategic Initiatives Consultant
Pittsburgh Regional Health Initiative

Dawn S. Milliner, MD
Professor of Medicine
Mayo Clinic

Frances Murphy, MD, MPH
Senior Fellow
Robert Wood Johnson Foundation

Michael W. Painter, JD, MD
Senior Program Officer
Robert Wood Johnson Foundation

Carolyn Pare
Chief Executive Officer
Buyers Health Care Action Group

David W. Plocher, MD
Chief Medical Officer
Blue Cross Blue Shield of Minnesota

Christopher Queram
President and Chief Executive Officer
Wisconsin Collaborative for
Healthcare Quality

Barbra G. Rabson
Executive Director
Massachusetts Health Quality Partners

S. Ramalingam, MD
Senior Medical Director
UPMC Health Plan

Helen Riehle
Executive Director
Vermont Program for
Quality in Health Care

Ann Robinow
Consultant
Medica

Duncan Ross
Vice President, Network
Strategy and Operations
Blue Shield of California

John J. Sakowski
Chief Operating Officer
Institute for Clinical
Systems Improvement

Dennis P. Scanlon, PhD
Associate Professor of
Health Policy Administration
Pennsylvania State University

Sidna Scheitel
Chair, Primary Care Committee
Mayo Clinic

Jeffrey S. Schiff, MD, MBA
Medical Director
Minnesota Department
of Human Services

Ralph Schmeltz, MD, FACP, FACE
The Washington Hospital;
Chair, Health and Public Policy
PA Chapter ACP;
Reimbursement Committee
PA Medical Society

Kevin Schoeplein
Executive Vice President
OSF Healthcare System

Cliff Shannon
President
SMC Business Councils

Anthony Shih, MD, MPH
Senior Program Officer for Quality
Improvement and Efficiency
The Commonwealth Fund

Wells Shoemaker, MD
Medical Director
California Association
of Physician Groups

Martha J. Smith
Vice President, Health Plan
Network Management
Health Net

Leif I. Solberg, MD
Associate Medical Director
HealthPartners Research Foundation

Melony Sorbero
Policy Researcher
RAND Corporation

Barbara Spivak, MD
President
Mount Auburn Cambridge IPA

Margaret Stanley
Executive Director
Puget Sound Health Alliance

Anthony Stanowski
Vice President
National Accounts, Thomson Healthcare

Robyn I. Stone, DrPH
Executive Director
Institute for the Future of Aging Services

Don Storey, MD
Senior Medical Director
Aetna, Inc.

Sarah S. Thomas
Deputy Director
Medicare Payment Advisory Commission

Thomas P. Timcho
President and
Chief Executive Officer
Jefferson Regional Medical Center

Sandra R. Tomlinson
Senior Vice President for
Provider Services
Highmark, Inc.

Christopher Tompkins, PhD
Associate Professor, Heller School
for Social Policy and Management
Brandeis University

Ann S. Torregrossa, Esq.
Senior Project Manager
Pennsylvania Governor's Office
of Health Care Reform

Cristie Upshaw Travis
Chief Executive Officer
Memphis Business Group on Health

Micky Tripathi
President and Chief Executive Officer
Massachusetts eHealth Collaborative

Ann Tynan
Health Researcher
Center for Studying Health
System Change

Margaret VanAmringe
Vice President, Public Policy
and Government Relations
The Joint Commission

Marc P. Volavka
Executive Director
Pennsylvania Health Care
Cost Containment Council

Stanley S. Wallack, PhD
Executive Director, Schneider
Institutes for Health Policy
Brandeis University

Andrew Webber
President and Chief Executive Officer
National Business Coalition on Health

Christine Whipple
Executive Director
Pittsburgh Business Group on Health

Janice Whitehouse
Senior Vice President
Greater Detroit Area Health Council

Flossie Wolf
Director of Health Policy Research
Pennsylvania Health Care
Cost Containment Council

Mark Wynn
Director, Payment Policy
Demonstrations Division
Centers for Medicare
and Medicaid Services

Phyllis Yale
Partner
Bain & Company

Nancy Zionts
Vice President of Program
and Planning
Jewish Healthcare Foundation

Design: *Mizrahi Design Associates, Inc.*

Centre City Tower, Suite 2400
650 Smithfield Street
Pittsburgh, PA 15222
Phone: (412) 594-2550
Fax: (412) 232-6240
Email: info@jhf.org
www.jhf.org

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