



Payment Reform to Improve Health Care

Ways to Move Forward

Ellen-Marie Whelan and Judy Feder June 2009

Center for American Progress



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In April, the Center for American Progress convened a group of experts to evaluate health care payment reform proposals, identify where there is sufficient evidence, consensus, and capacity to move forward and where there is not, and then develop recommendations for action in health reform legislation to move toward a value-based quality health care payment system. The participants in the meeting were:

- Robert Berenson, Urban Institute
- Paul Ginsburg, Center for Studying Health System Change
- Hoangmai Pham, Center for Studying Health System Change
- Elliott Fisher, Dartmouth Institute for Health Policy and Clinical Practice
- Harold Miller, Center for Healthcare Quality and Payment Reform
- William Scanlon, HealthPolicy R&D
- Stuart Guterman, Commonwealth Fund

The analysis of the monumental problems confronting our current health care payment system and the broad set of recommendations presented in this paper are drawn from our conversation and their expertise. I am grateful for their help in presenting the broad sets of problems facing our health care payment system today and in outlining the broad sets of recommendations needed to create a quality health care payment system, but I bear full responsibility for the specific recommendations. The outcome, I believe, is a great starting point for the health care debate now beginning in Congress.

—Ellen-Marie Whelan, Associate Director of Health Policy, Center for American Progress

Introduction and summary

Our health care system is broken. The United States spends more than twice as much on health care per person as all other developed countries yet we have some of the worst health outcomes, such as babies dying before their first birthday and overall life expectancy.¹ Nearly one in three people in our country are uninsured in a given two-year period² and another 25 million people in the nation are underinsured—devoting an inappropriate share of their incomes to medical costs.³ This unacceptable situation will continue to worsen unless we do something. We spent nearly 17 percent of our gross domestic product on health care last year but at the rate health care costs are growing we will spend 25 percent of GDP on health care by 2025. We cannot continue to have health care costs grow at this rate.

But the news is not all bad. Many experts argue that if we restructure how we pay for health care then we can slow the growth of health care costs while we improve the care Americans receive. The current health system reimburses doctors, hospitals, and other health care providers based on the number of visits and procedures that are done. As a result, health care providers' revenues and profits increase when they deliver more services and the cost of health care goes up.

But more services do not necessarily translate into better health care. In fact, they often produce worse outcomes. For many patients—especially the chronically ill, who account for more than 75 percent of health care costs⁴—spending more time face-to-face with a real person who helps them navigate the complicated health care system for the best overall care is what helps to improve their health and thus reduce health care costs.

Today we get what we pay for. When we pay for high-tech services and procedures, we get a health care system that emphasizes volume and intensity, paying for more services regardless of the value they provide. If we change the incentives by changing the health care reimbursement system so that we pay for value, not volume, then we have enormous potential to slow the growth in health care costs. Health care reform provides us with an opportunity to move in precisely this direction.

This paper is a result of a meeting convened by the Center for American Progress to evaluate payment reform proposals, identify where there is sufficient evidence, consensus, and capacity to move forward, and develop recommendations for action in health reform legislation to move toward a value-based system.

The experts we gathered together agree that the first step to reforming our health care system is to outline a vision of the health care system we want and write it into the legislation. This vision should then be used to guide and evaluate specific Medicare payment reforms, which in turn should be used as a template for payment reform across our health care system. This vision would promote value rather than volume through better coordinated care.

After agreeing to the importance of establishing a strong vision statement, we examined the most prominent payment reform proposals, among them:

- Rewarding the delivery of primary care through approaches such as the “medical home” and other care coordination programs that reimburse primary care practices to provide and coordinate patients’ care
- Bundling payment for episodes of care rather than paying for individual visits or procedures, again to coordinate care and improve outcomes
- Moving medical practices into integrated health delivery organizations and establishing payment arrangements that move toward so-called global capitation, which pays a single price for all the health care services needed by patients

The discussion revealed the opportunity and need for Medicare’s aggressive promotion and adoption of innovation. Specifically, our experts agree that Congress should authorize the Centers for Medicare and Medicaid Services, or CMS, to conduct a broad range of experimentation and then require its evaluation. Where success is evident from previous or new experiments, the group agreed that CMS should implement these reforms more broadly without additional legislation. These successful reforms could then be more effectively spread throughout the health care system.

To best stimulate innovation, CMS support for experimentation should not be limited to narrowly specified payment arrangements. Instead, subject to broad guidelines, CMS should encourage payment reform proposals from health care providers and insurers as well as develop and test its own ideas or collaborate on proposal development. This can be done through Section 646 of the 2003 Medicare Modernization Act, which provides a model for authorizing such broad-based experimentation. That authority has expired so Congress should reauthorize and expand it—both in the types of innovation CMS should pursue and in granting CMS authority for broader implementation.

Through this enhanced authority, CMS can then explore a wide variety of innovative health care payment arrangements to:

- Promote the delivery of primary care through the creation of medical homes and chronic care coordination programs

- Encourage the bundling of payments by episodes of care
- Develop shared savings and full or partial capitation payment approaches to expand coordinated and integrated care

In addition to expanded CMS authority, the group also largely agreed that Congress should move now to reduce inappropriate hospital readmissions, but recommended proceeding with care. There should be proper protections in place to protect vulnerable populations who may not have access to care after discharge. Policies should also target diagnoses for which a hospital readmission is often the result of poor care in the hospital or inadequate care after discharge rather than target particular hospitals. Because some readmissions reflect a transition problem—meaning that no health professional is responsible for the patient once he or she leaves the hospital—one solution is to focus on ways to promote the delivery of the care that should be delivered during that transition. Payment policy should therefore be revised to pay for transitional care that would ensure the coordination and continuity of health care as the patients move from the hospital to their home or another setting.

These proposals are detailed in the main body of this report. Slowing the growth in health care costs requires a transformation in the delivery of health care delivery—from the fragmented delivery of discrete services today to a true “system” of care that coordinates across the full set of services and providers. The path to that transformation lies in payment reform.

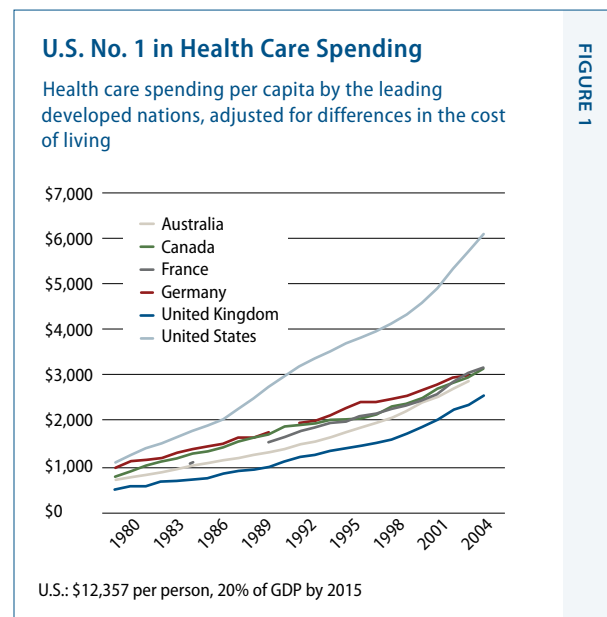
Our health care system is broken

The United States has by far the most expensive health system in the world. We spend nearly \$500 billion more than our peer nations, adjusting for wealth.⁵ The next most expensive system, Canada's, spends about half as much per person on health care (see Figure 1). The problem lies in the rate of growth in health care costs that the United States has experienced over the past 25 years. We spent about \$2.3 trillion on health care in 2007, which is twice what we spent in 1996.⁶ At this rate of growth the United States will spend 25 percent of GDP by 2025 and nearly 50 percent of GDP by 2082.⁷ This is clearly not sustainable. Peter Orszag, the Director of the Office of Management and Budget, says the single most important factor influencing the federal government long-term fiscal balance is the rate of growth in health care costs.⁸

Nor are we getting our money's worth. A recent Business Roundtable study found that compared to France, Germany, Japan, and the United Kingdom, U.S. workers and employers receive 23 percent less value from our health care system than the citizens of those key American allies. What's more, the United States spends \$1 for this less-valuable health care while these other four nations spend on average only \$0.63.⁹ Despite spending so much more than other countries on health care, our health outcomes on most measures are worse. The World Health Organization ranks the U.S. health care system 37th in the world, between Costa Rica and Slovenia.¹⁰

Moreover, we still have large numbers of Americans without health insurance—and those numbers are growing by the day. For every one-percentage-point rise in the unemployment rate, the number of uninsured grows by 1.1 million, according to research by the Kaiser Family Foundation.¹¹ Even employed workers are feeling the pain because as health care costs skyrocket, wages stagnate and even fewer employers are able to offer coverage. In addition, fewer employees can afford it when offered.

This trend too is worsening: According to a survey by Hewitt Associates, a national benefits management firm, 19 percent of employers are planning to stop offering health care benefits in the next two to five years.¹² Reforming our health care system so that every American is able to afford the coverage he or she needs and deserves is in everyone's interest.



Source: The Commonwealth Fund, calculated from OECD Health Data, 2006.

Can we slow cost growth while improving quality?

The U.S. health care system, with our “fee-for-service” payment system, pays for the volume and intensity of services, giving short shrift to primary care, prevention, or wellness. We pay for volume and not value; quantity and not quality. This payment system shapes the way health care is delivered. By under-reimbursing preventive care and primary care, and by not reimbursing many services provided by non-physician providers, we now possess a health care delivery system that just does not reward many cost-effective services. When it is more lucrative to order an expensive CT scan for a patient with a headache than to take time to ask him or her about what may be causing the symptoms, it is clear the reimbursement system is broken.

If our current use of high-volume, intense health care services produced better health for the nation, then reforming the payment system would be a controversial suggestion. But a range of research demonstrates that many of the services we use and pay for are, at best, unnecessary. Consider the evidence gleaned by the Dartmouth Atlas project, which highlights the regional distribution of potentially unnecessary care by examining the cost of services per Medicare beneficiary (see Figure 2). First, the researchers on this project, which was conducted by the Dartmouth Institute for Health Policy and Clinical Practice, found a 2.5-fold variation in Medicare spending between the areas that have the highest costs and those that have the lowest costs. Patients in the regions with the highest spending are neither sicker than those in other areas of the country nor do they prefer the additional care.¹³

What is most striking about this research is that in these high-cost areas where the most services are provided there seems to be an *inverse* relationship with quality—in the areas in which the most high-tech services are provided the patient outcomes tend to be worse. Not only is more not better, more could actually be harmful. Furthermore, patient satisfaction was lower in areas of high spending than in areas of low spending. Based on these findings, the researchers determined that, if the highest-cost areas could be brought down to the nationwide average, then Medicare spending could be reduced by up to 30 percent, with no apparent loss of quality. This is also consistent with findings compiled by the Rand Corporation.¹⁴ In short, we are paying too much, receiving too many services but without the quality outcomes we would expect.¹⁵

To truly stop this out-of-control growth in health care spending, to “bend the curve,” we need to address the problem that, in part, got us here—the health care reimbursement system. We must design new payment systems that refocus the health care delivery system to promote

Health Care Spending is Unrelated to Quality Care

Medicare spending per beneficiary in the United States in 2005 reveals the cost of health care bears no relation to the quality of care.

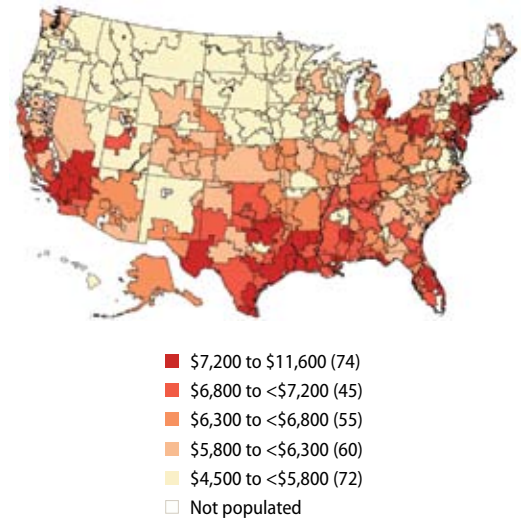


FIGURE 2

Source: Fisher, E., D. Goodman, et al. (2009). The Policy Implications of Variations in Medicare Spending Growth, The Dartmouth Institute for Health Policy & Clinical Practice. http://www.dartmouthatlas.org/atlases/Policy_Implications_Brief_022709.pdf

value-based quality health care. There is extraordinary consensus in Congress, as most recently demonstrated in the April 21 roundtable held by the Senate Finance Committee, that payment reform is both essential and feasible to slow cost growth and promote quality health care.¹⁶ Members of Congress increasingly recognize that paying for better value in our health care system will result in more efficient and better quality health care.

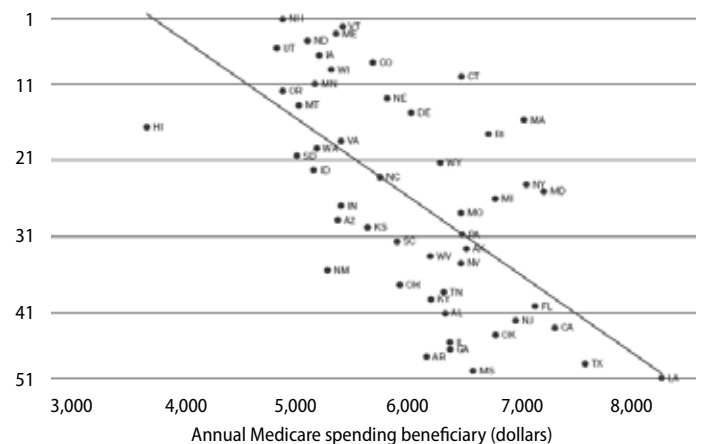
There is also consensus that Medicare, which is administered by the federal government and accounts for 19 percent of overall health care costs, is a critical part of the solution. Slowing the growth of Medicare costs is critical to reducing pressure on the federal budget and maintaining the viability of the program itself. And Medicare's payment practices have an enormous impact on payment practices throughout the health care delivery system. Changes in payment systems used by Medicare are critical to full-scale payment reform.

Though the remainder of this paper addresses new payment reform models, the experts acknowledge that one of the first steps to undertaking payment reform is to fix the current Medicare physician fee schedule. This is important for two reasons. First, some of the reform options discussed in this paper (such as bundled payments) will be built upon the current fee-for-service pricing system. Without changing the underlying payment inaccuracies for specific services (overpayment of some mostly technical services and underpaying others such as evaluation and management), any new payment scheme could similarly over- or underpay.

But even more important is that much of the following discussion explores ways to encourage new methods of delivering health care that would reward providers for improved quality and efficiency. Without substantial changes to the way we currently reimburse providers, new rewards will be insufficient to entice them to take advantage of these new proposed payment systems.¹⁷

Spending is Highest Where Quality Care is Lowest

Relationship between the quality of care and Medicare spending as expressed by overall quality ranking in 2000-2001.



Source: Fisher, E., D. Goodman, et al. (2009). The Policy Implications of Variations in Medicare Spending Growth, The Dartmouth Institute for Health Policy & Clinical Practice. http://www.dartmouthatlas.org/atlas/Policy_Implications_Brief_022709.pdf

Changing health care delivery through payment reform

Health care reform begins with a vision. The experts we gathered agree that before outlining and proposing different health care delivery models, we should establish the vision of the health care system we want—one that promotes value rather than volume through better-coordinated care. This vision should be included in the health care reform legislation and be used as a guide to determine the direction of payment reform and help to decide which changes will best get us there. To our experts, a true health care “system” would:

- Help a patient get well and stay healthy
- Provide a clear entry point and continuous participation in health insurance that assures everyone affordable access to quality care
- Encourage providers to communicate regularly and practice collaboratively—whether in formal organizations or through more informal arrangements among providers in smaller practices
- Reward professionals and providers for quality health care, efficiently delivered and effectively coordinated
- Hold providers accountable, to the extent possible, for patient outcomes
- Enable all participants in the current health workforce to contribute to the full extent of their training

The initiation, adoption and modification of payment practices should be continually guided by and evaluated against their contributions to these goals.

Reform proposals focus generally on three ways of restructuring payment.¹⁸ The first is to change the reimbursement mechanisms to encourage primary care. Proposed measures include increases in reimbursement for primary care services and support for more coordinated care through the promotion of medical homes, preventive care, and promotion of wellness programs. This can be cost-effective, especially for patients with chronic illnesses.

The second is to shift from separate payments for each discrete service to a single payment based on episodes of care or a single payment for all of a patient’s needs for a specific period of time. Focusing on care delivered both outside as well as inside the hospital or paying for a significant part of or an entire episode rather than for each service separately will promote team-based care delivery or coordination of care, giving health care providers more accountability for efficiently promoting better quality outcomes.

The third is to encourage coordinated delivery systems—actual or virtual organizations of multiple health care providers who take on responsibility for all aspects of care for an enrolled population of patients. Here the goal is to encourage providers now operating on their own or with a small number of colleagues to become part of a broader delivery system. The more individual providers are connected to others and rewarded for the health of enrolled groups of patients, the more efficient and effective our health care system will be. This movement toward integration should occur with a movement away from fee-for-service payment toward payment mechanisms that reward efficient delivery through bonus payments, shared savings, or partial or full capitation arrangements.

Each of these new payment methods would be enhanced by better use of health information technology. This is not a topic covered in this paper; still, it is important to note that health IT systems should be designed in conjunction with payment reform policies. Properly developed, health IT has the potential to offer the health care team critical support in providing comprehensive preventive care, chronic-care disease management, improved coordination of care across providers, and patient education.¹⁹ In addition, if new payment systems will reimburse providers based on improved patient outcomes, health IT will provide the tools to actually measure those outcomes.

We will now consider each of these payment reform proposals in more detail.

Encourage primary care

One of the most often-discussed ways of changing the way we provide care is to move away from a focus on disjointed specialized care toward more emphasis on primary care so that responsibility for patients' needs is coordinated to improve the quality of care. True primary care consists of four key elements:²⁰

- Being the first-contact of care for each new health concern
- Providing a long-term relationship with the same health care provider
- Providing comprehensive care for all issues that do not need a specialist
- Coordinating across the team of health professionals providing the care

Studies consistently show that when health care is delivered with these elements, outcomes are better than care provided outside primary care systems.²¹

The delivery of effective primary care is actually discouraged in the current fee-for-service payment system. Some services, such as the time needed for physicians to diagnose and design treatment plans for patients with multiple conditions, are not adequately reimbursed. Other services, such as patient education and self-management support by non-physician staff, are not reimbursed at all. There is also no reimbursement for the time it takes teams of clinicians to coordinate the care and serve as the entry point in the health care system for new health problems.

It is important to distinguish the current effort to promote primary care from the managed care push that occurred in the 1990s. Then, the focus was too narrowly on controlling costs and shifting risk from insurers to health care providers, rather than improving outcomes and efficiency of care. In managed care, the primary care provider often ended up being a more of a gatekeeper than a coach to help the person navigate the complex health system.

The debate today focuses instead on improving the delivery of primary care—both its elements and the structure through which it is delivered—and uses changes in the payment system to enable those improvements. Whether the issue is primary care in general or chronic care in particular, the goal is on a team-based approach, with heavy emphasis on coordination.

Medical homes and chronic care management

The term “medical home” is now commonly used to describe a primary care practice that enables its health care providers to focus on primary care and serve as the focal point for the coordination of care. Its adoption is being strongly advocated by primary care physician professional organizations and by some large self-insured businesses.

The term was actually coined in 1967 by pediatricians to describe a method to deliver health care to children with special needs.²² Most simply, it means having a regular source of health care. More fully, the concept of a medical home is that each patient has an ongoing relationship with a primary provider and often a broader team of health professionals who collectively take responsibility for providing or arranging for all of a patient’s health care needs in a coordinated fashion.²³

One specific version of the “medical home” concept is the Patient-Centered Medical Home, or PCMH, which Congress chose as the first medical home demonstration to be implemented by CMS. The PCMH is a model designed by four physician groups with an evaluation system created by the National Committee for Quality Assurance, or NCQA, a non-profit group that develops measurement tools to assess quality of a variety of health care providers.²⁴

PCMH is defined as a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient’s family. Health care is facilitated by registries, information technology, health information exchange networks, and other means to assure that patients get the indicated care when and where they need and want it. This process was put in place to ensure that medical home practices address the needs of its patients, which in turn should help control health care costs by encouraging prevention and wellness as well as by coordinating.

The most controversial feature of the PCMH model is the criteria for participation. For a medical practice to be eligible to be a PCMH it must achieve a certain score on the NCQA copyrighted PCMH eligibility score. The elements required for participation tend to focus on specific structural elements of the practice, such as measuring physician performance and use of health information technology, and it may be difficult for smaller practices to qualify, even if they can produce quality health outcomes.

There are nine Physician Practice Connections standards, including 30 elements within the standards, with each standard assigned a different number of points. Ten of the elements must be present in every PCMH. A practice is evaluated by this tool and the provisions they have in place are tallied to come up with a total score for the practice. It is a three-level accreditation system, with Level 1 being 25 to 49 points but not having all 10 required elements, Level 2 being 50 to 74 points, and Level 3 being 75 to 100 points and having all 10 required elements. The elements heavily focus on technology services that can track and monitor the care delivered.

Although the PCMH criteria were designed as an accreditation process, many insurers have used them as criteria for increasing payment. Under these programs, practices that meet the NCQA standards receive an additional monthly coordinating fee per patient on top of the traditional fee-for-service payments, with higher payments given to those that reach the top level. They argue that the care coordination and focus on wellness and prevention will ultimately decrease health care costs to account for the extra bonus payments.

Congress in 2006 directed CMS to adopt PCMH elements as eligibility criteria for its demonstration program—a three-year project that will fund demonstration projects in eight states that is scheduled to take effect this year.²⁵ A successful PCMH will be determined based on slightly modified NCQA tiers, which include different “core capacities” of the practice. CMS identified a range of physicians who could participate in the medical home, including some specialty and sub-specialty providers. But because CMS based the provider qualifying specifications on the PCMH model, it specifically disallowed other primary care providers, such as nurse practitioners and physician assistants, to lead a medical home. This would be true even in states that have granted more independent authority to these kinds of health care providers, despite the fact that these states often face greater workforce shortages.

NCQA’s mandatory structural requirements for a PCMH may be very helpful to some providers in delivering quality primary care, but it will inevitably exclude other potentially successful medical home models. The Medicare Payment Advisory Commission, or MedPAC, an independent congressional advisory agency, recommends a more flexible model for the medical home. MedPAC defines the medical home similar to the PCMH as a “clinical setting that serves as a central resource for patient ongoing care,” but MedPAC establishes different criteria for identifying qualified medical homes. It recommends more functional rather than structural requirements as the basis for qualifying practices as medical homes. Primary care practices would be required to:

- Furnish primary care services, including coordination of appropriate preventive maintenance and acute health care services
- Use health information technology for active clinical decision support
- Offer care management services
- Maintain 24-hour patient communication and rapid access services
- Keep up-to-date records about patients' advance directives
- Have a formal quality improvement program.

Using these criteria, more practices would be eligible to be a medical home than the PCMH—especially smaller practices and those that may not have the resources to put many of the high-tech required elements in place.

Furthermore, unlike the PCMH approach, MedPAC would base extra payments to practices—not on the number and level of structural criteria they incorporate into the practice but rather on the clinical, patient-level process and outcome measures they achieve. Although the MedPAC medical home definition (like the PCMH) would include monthly, per-beneficiary payments to qualifying medical practices based on criteria that promote ongoing comprehensive care management, it would differ by including a pay-for-performance component, which is not part of the PCMH model.

The MedPAC approach to payment is similar to the reimbursement structure used by some of the current pay-for-performance and health IT programs now funded by CMS. These models may include an upfront bonus payment for certain process measures but then move to paying for the outcomes hoped to be obtained by the new structure. MedPAC also differs from PCMH by recommending that medical homes target efforts, at least initially, on patients with multiple chronic conditions and by allowing qualified nurse practitioners and physician assistants to lead a medical home.

Another approach to the medical home that would fit within the MedPAC guidelines and is showing great promise is the Guided Care model developed by Johns Hopkins University professor Chad Boulton.²⁶ Guided Care specifically targets older adults with complex chronic conditions and relies heavily on an interdisciplinary team approach to coordinating care. Guided Care nurses work closely with primary care physician practices and are responsible for coordinating care among health care providers, completing standardized comprehensive home assessments, and collaborating with physicians, patients, and caregivers to create evidence-based care guides and action plans, among other things, so that patients in their care receive more effective and more efficient quality care.

In the Guided Care model, nurses work with clients on a long-term basis, provide transitional care, and develop patients' self-management skills and educate them on accessing community-based services such as transportation services, Meals on Wheels, and other supportive services. The Guided Care approach allows for small practices to provide the chronic care elements of a medical home even if they cannot assume full risk for all health

care delivered. Thus far, the Guided Care program results show improved quality of care and reduced health care costs from fewer hospital admissions, hospital days, and emergency room visits.²⁷

There are also state-based medical home models that are not consistent with PCMH requirements but also have shown success in coordinating care and controlling costs. One is Community Care of North Carolina, which is an extension of the statewide primary care case management program for Medicaid beneficiaries in North Carolina.²⁸ This approach is more of a “virtual” medical home rather than a specific primary care practice or group of practices that qualify for entry. Here, individual primary care providers choose to enroll in a larger network and agree to serve as patients’ physician care managers—and help patients obtain access to more specialized services. In return, North Carolina’s Medicaid program agrees to pay these health care providers a modest monthly fee in addition to the usual fee-for-service—to assure that they are available around the clock as a way to decrease unnecessary emergency room visits.

In addition to paying a modest bonus to the primary care providers, management fees in this program are used to hire local case managers and pay for other resources necessary to manage enrollees. The program targets high-cost areas such as chronic diseases, pharmaceutical use, and emergency department utilization. Accountability is achieved at various levels through chart audits, practice profiles, care management reports on high-risk and high-cost patients, scorecards, and the monitoring of progress against benchmarks. Evaluations of Community Care of North Carolina to date have shown considerable quality improvement, in addition to significant cost savings.²⁹ Indeed, there is discussion taking place about expanding this from only Medicaid to include Medicare patients.

Issues and recommendations to encourage primary care payment reform

To most effectively move our health care delivery system toward primary care or “medical homes,” our experts agree that future policy should:

- Test a wide variety of medical home care models
- Tie payment to actual performance (if not from the outset, then over time)
- Evaluate models’ impact on quality and cost of care
- Facilitate widespread adoption of effective models by giving CMS authority to expand successful demonstrations, without the need for additional legislation

In our experts’ view, sole reliance on the NCQA standards-based approach to PCMH runs the risk of rewarding the process of care without a means to examine outcomes and hold providers accountable for their performance. Further, it is critical not to overemphasize the design or structure of a primary care practice at the expense of its actual ability to deliver quality coordinated primary care and improve patient outcomes.³⁰

Although the group recognizes the importance of specifying some “core elements,” as MedPAC does, it also favors having Congress authorize CMS to test different models simultaneously. Included in the experimentation should be models targeted at different populations, such as people with complex chronic conditions,³¹ frail elders, or Medicare/Medicaid dual-eligible patients, as well as models focused on use of certain types of providers, such as professionals who specifically deliver care in the home and nurse practitioners.³²

Our experts also suggest making providers more explicitly accountable for health care outcomes among their patients, whether through extra bonus payments, similar to rewards in current pay-for-performance and health IT models, or through “shared-savings” approaches—under which providers negotiate expected cost for care with the payers and agree to share any costs savings that come in lower than the predicted amount.³³ In using this approach, it is important to ensure that providers can get some resources they need upfront to provide improved services, rather than making payment changes completely contingent on short-term savings achieved.

These recommendations our experts favor and the path to implement them are consistent with many of the policy suggestions proposed by the Senate Finance Committee in its policy options white paper on payment reform³⁴ and the House Tri-Committee Health Reform discussion draft legislation.³⁵ First, our experts generally acknowledge that current reimbursement to primary care providers is insufficient, especially compared to most specialists. The primary care workforce is the lifeline to primary care delivery and a general payment increase would demonstrate an investment in this critical sector.

The Senate Finance Committee suggests one way to reward the delivery of primary care is to pay bonus payments to primary care providers—defined as those who furnish at least 60 percent of their services in certain types of primary care out-patient health care settings. These providers would receive a bonus of at least 5 percent over the fee schedule amount for providing certain primary care services. The House discussion draft includes language to provide bonus payments to primary care providers: 5 percent or 10 percent depending on where the primary care practitioner works. The definition of primary care services will be left up to the Secretary of Health and Human Services to define. The primary care practitioner will be defined by certain specialties and if 50 percent of their services are “primary care services.”

To promote aggressive experimentation, our experts and the Finance Committee favor broad demonstration authority, allowing the specifics of new models to be generated by those who are putting them into practice. The Medicare Health Care Quality Demonstration Program, created in Section 646 of the Medicare Modernization Act of 2003, is consistent with this approach. Unlike most other demonstrations, which are relatively limited in scope and intended to test specific types of changes in Medicare rules, Section 646 gave CMS broad flexibility to consider a range of payment systems designed to support significant changes in the organization of health care delivery.³⁶

In its solicitation under Section 646, CMS specified only general guidelines, which include identifying specific performance outcomes, how practices would be paid for meeting these outcomes, assurances that projects went to areas of the country that really needed them, and how all this could work within Medicare's laws and beneficiary protections. CMS also allows the applicants to develop the specific arrangements to be demonstrated, such as paying more for improved safety or quality or initiating shared decision making between providers and patients. Although few programs were authorized under this authority, our experts favor its reauthorization because of the renewed and considerable interest in innovation as part of health reform. Although the Finance Committee did not focus on primary care in its recommendation to reauthorize Section 646, our experts believe this approach can provide a framework for a range of payment innovation demonstrations.

The Senate Finance Committee offered a valuable complement to this health care provider-initiated demonstration approach in an additional policy recommendation to allow CMS to define its own payment models for demonstration—independent of legislation. In its white paper, the Finance Committee suggested the establishment of a Chronic Care Management Innovation Center, where CMS would take the lead on determining the guidelines for new health care delivery projects. Though the Finance Committee limited this increased authority to the chronically ill, the concept clearly makes sense for the full set of payment innovations and populations.

The House put forth an extensive Medical Home Pilot Program. The pilot is based on two models that are very flexible in their design: the Independent Patient-Centered Medical Home led by a primary care physician, nurse practitioner or appropriate specialist for beneficiaries with chronic conditions, and the Community-Based Medical Home, which is established by a state-based or non-profit organization that uses non-physicians to assist primary care physicians to deliver Medical Home services. Both models focus on the chronically ill and provide bonus payments to the medical home providers. The pilot would be evaluated based on quality, hospital and emergency room use, outcomes, patient satisfaction, efficiency and program spending. It is important to note that the language gives the HHS Secretary the authority to expand successful pilot programs.

The House Tri-Committee, the Senate Finance Committee and our experts are all clear that the opportunity to innovate—whether as provider-initiated in Section 646 or CMS-initiated—should be accompanied by new authority for CMS to more broadly implement successful models, without seeking additional legislation. Too often good ideas are tested at CMS but stop after the demonstration period in the absence of congressional action.

Our experts express concerns, however, that inertia or political pressure might leave demonstrations unimplemented without additional structural changes. They therefore suggest that in addition to the provision of expanded authority for CMS to develop and implement broad experimental activities aimed at improving health care delivery and financing, Congress should:

- Establish explicit criteria for determining promising demonstrations and prioritizing projects to be developed and implemented
- Provide additional resources to CMS dedicated to reviewing applications for payment reform demonstrations under new authorities in a timely fashion
- Require CMS to publish, in a timely fashion, results from demonstrations and arguments as to whether or not to more broadly implement tested approaches
- Involve MedPAC in reviewing and commenting on evaluation data and similarly make the case as to whether or not they be more broadly implemented

These measures would assure transparency in decision making, promote decisions based on evidence and value, ensure that the decisions made are in the public's best interest, and facilitate rapid changes in health care delivery. CMS needs to be an engine of innovation. This is consistent with CMS's own vision outlined in the 2006-2009 CMS strategic action plan as "achieving a transformed and modernized health care system."³⁷ CMS proposes accomplishing this by transforming and modernizing America's health care system. Broadening authority is essential to help CMS fulfill this vision.

Bundled payments and episode payments

Bundling payments and episode payments are additional methods of payment reform often suggested as a way to coordinate care and decrease cost.³⁸ "Episode" payment generally means paying a provider a fixed amount for all of the services provided to a patient in a particular episode of illness, rather paying for the delivery of each specific service. For instance, hospitals have been paid on a partial episode basis for more than 25 years through the so-called Diagnosis Related Groups, or DRG, system (sometimes also referred to as the Medicare Severity DRG), which groups patients by condition for payment purposes. "Bundling" generally means paying two or more providers jointly for the services they provide during an episode of care (as opposed to paying for each visit and individual service the patient needs during that episode). Payment could be based on:

- A single acute episode of care, such as a hospitalization for an illness
- A discrete diagnosis, such as hip replacement
- More narrowly, on a portion of an episode, such as a specific period of time after hospital discharge
- More broadly, such as on treatment for a set period of time for all of the care needed for a specific condition, regardless of how many individual acute episodes may occur within that time period, such as a single fee for all costs incurred by a patient with diabetes over a period of months

Proponents suggest this payment approach would create incentives to have providers take more accountability for the care they provide and improve the coordination of care, thereby decreasing costs.

Our discussion included bundling for episodes of care and for hospitalization combined with follow-up, post-acute care. By providing a single payment for an entire episode of care, these models have the potential to reward the coordination of all the services delivered during that episode. It moves the incentive away from providing more individual services and rewards efficiency. Our experts expressed some concerns, however, about multiplication of episodes, appropriately tying rewards or penalties to the responsible providers, and whether penalizing overuse is appropriate in cases where services to prevent it may be inadequate. They agreed, however, that if well-designed and well-targeted, some kinds of bundling should be pursued.

Bundling by episode or condition

Bundling payments by condition is not a new concept. Under DRGs, which are used by Medicare to pay hospitals for inpatient care, payment for each stay is based on how much it costs to care for patients in the hospital depending on their condition. Reimbursement for each patient is determined based on diagnoses, procedures required during that hospital stay, age, gender, the presence of complications or comorbidities (the presence of one or more disorders) in the patient, and expected length of stay in the hospital. Each category is reimbursed with a fixed fee regardless of the actual costs incurred. This approach changed the way care was delivered in hospitals by significantly increasing attention to cost and decreasing the number of days patients spent in the hospital.

But bundling the payments of separate providers into a single payment has been done very rarely. Case in point: Medicare pays hospitals a single amount for an inpatient surgery episode and pays surgeons a single amount for their care of the patient throughout the episode (including post-discharge care), but Medicare pays the hospital and surgeon separately for their services—even though they are integrally related and must be coordinated in order to ensure the best outcomes and most efficient delivery of services.

CMS is now testing limited bundling of payment in its Acute Care Episode demonstration project. ACE was created to encourage improvements in both the efficiency and quality of care provided to Medicare beneficiaries by aligning hospitals' and physicians' incentives to work together to provide coordinated, cost-effective care by paying a single, global payment to cover both hospital and physician services during the inpatient stay. The demonstration sites were selected earlier this year and will be funded for a three-year period.

ACE will test the use of a global payment for an episode of care as an alternative approach to fee-for-service payment for service delivery. Payment under the demonstration will apply to specified cardiovascular and/or orthopedic procedures (including hip replacement surgery, cardiac valve replacement, and implantation of cardiac defibrillators), and the level of payment will be determined by bids submitted by each participating site. The goal of the ACE demonstration is to achieve savings to the Medicare program and give hospitals and physicians the flexibility to allocate resources as they determine to be most appropriate.

Geisinger Health System, a large, integrated health care delivery system operating in Pennsylvania, is experimenting with an episode-based payment structure for its coronary artery bypass grafting. It devised what has been referred to as a “warranty” that involves a global fee that covers the surgery and any additional work related to complications from the initial procedure for three months after.³⁹ This “ProvenCare” program, in effect, offers a 90-day warranty on elective heart surgery. If complications arise or the patient returns to the hospital, Geisinger bears the additional cost. By changing the reimbursement structure for the bypass surgery, Geisinger actually changed the way care was delivered—and not only did the costs come down, the outcomes improved. The percentage of patients discharged directly to home increased to 93 percent from 81 percent.⁴⁰ In addition, hospital readmissions for these patients dropped by 44 percent.⁴¹

But Geisinger has put systems in place that make this arrangement financially viable, including better control over both the hospital stay and the follow-up care provided in the post-discharge period. Geisinger’s ProvenCare program demonstrates how bundling can work in big integrated delivery systems, but the same model may not work for smaller community hospitals that do not have such relationships with the independent surgeons and physicians who treat their patients.

Issues and recommendations for episode-based bundled payments

In evaluating episode-based bundled payments, our experts express several concerns, especially whether this type of payment may encourage rather than discourage inappropriate health care delivery. Paying for discrete episodes, in effect, does nothing to control the overall number of episodes, and could actually encourage more episodes. Some point to Jack Wennberg and colleagues from Dartmouth University who found that the provision of some episodes of care such as total knee replacement are more sensitive to the number of providers in the area who treat the condition rather than what the beneficiaries in the area may actually need.⁴²

Aligning the incentives of all providers may encourage greater efficiency within the episode, but may also align their incentives to encourage more patients to obtain care—even if it is unnecessary. Furthermore, no matter how the episode is identified, the capacity for providers to create new types of “episodes,” or uniquely billable events, would persist.

Also somewhat troubling is that paying for individual episodes of care may not promote coordination across a patient’s full range of care. Theoretically, multiple episodes could be handled separately by different clinicians with no incentive for communication or coordination, though it must be noted that this is no worse than the current payment structure and may only be addressed by fully capitating payment.

Based on these concerns, most of our experts agreed that—at least for the time being—experimentation for selected episodes or conditions might be appropriate for episodes

thought to be nearly always “necessary”— such as pregnancy with the prenatal and labor and delivery period bundled, acute myocardial infarctions, and repairs of hip fractures. The House Tri-Committee recommends the expansion of the ACE demonstration programs to additional geographic areas and additional conditions, as defined by the HHS Secretary. The Medicare Section 646 demonstration programs could also be expanded to focus on episode-based bundled payments.

Bundling hospital care and post-hospital care

Models that look to bundling payments usually target savings by decreasing hospitalizations—either outright or readmission for the same episode or condition within a set period of time post-discharge. Studies indicate that many hospitalizations may be preventable, especially hospitalizations for conditions that we know can be cared for successfully by clinicians in their offices or in the patient’s home. Nearly 20 percent of hospitalized Medicare patients are readmitted within 30 days, generating an expense that experts argue can be reduced dramatically by doing things better both in the hospital and in the community, since many patients are readmitted soon after the first hospitalization either for mistakes made during their first stay or because the patient did not or could not receive appropriate care in the community following discharge.⁴³

Both the Obama administration and the Senate Finance Committee proposed two policies to help address the problem of unnecessary hospital readmissions. The first is a bundled payment that would cover both the hospital inpatient stay and care delivered in the period of time immediately following the hospital discharge. In his fiscal year 2010 budget, which begins this October, President Obama proposed to “promote efficient provision of acute care through bundled Medicare payments covering hospital and post-acute settings.” The proposal had no specifics, but the Senate Finance Committee proposes a similar policy with more details.

The Senate Finance Committee proposes a single fee paid to hospitals to cover the inpatient care and the post-acute services occurring in the 30 days after discharge from the hospital. They consider post-acute care to be care delivered in the home, in nursing homes, or in rehabilitation or other long-term care facilities. Admissions for certain conditions would be included for those that account for the top 20 percent to 50 percent of post-acute spending such as pneumonia, heart failure, and psychoses.

The payment would be calculated as a combination of the current DRG hospital payment plus an amount that is equivalent to the average costs of care provided in the 30 days after discharge across all post-acute care settings for treating patients admitted for that DRG. Hospitals would receive the full bundled payment regardless of whether a specific patient received any post-acute care outside of a hospital, but Medicare would also not pay for any additional services for the month following the inpatient hospital stay, including any

additional hospitalizations. The assumption behind this proposal is that, with hospitals accountable for all care related to that DRG for the month following discharge, they would promote more cost-effective services aimed at reducing the potential for readmission.

The House Tri-Committee, in the discussion draft, also addresses the problem of potentially preventable hospital readmissions and suggests bundling post-acute care with the hospital stay. But instead of outlining the details, the draft directs the Secretary of Health and Human Services to develop a plan to advance payment reforms in this area. Simply stated, the goal is to improve coordination, quality and efficiency and improve patient outcomes such as preventable readmissions. Authority is then granted to the HHS Secretary to conduct demonstrations based on the plan issued.

The second policy to reduce preventable hospitalizations is not a bundled payment but a penalty for hospitals that have higher than average readmission rates. Here again President Obama's 2010 budget was not specific, but the Senate Finance Committee has a similar proposal that would target hospitals that have high readmission rates for certain conditions that should be potentially preventable with the delivery of proper health care. Targeted hospitals would be those with readmission rates higher than the nation's average or higher than 75 percent of other hospitals. These hospitals would be subject to a "payment withhold" on their DRG hospital payments. Initially they would receive only 80 percent of the payment for those certain conditions. If the patients admitted for these conditions *do not* have a preventable readmission within 30 days of discharge, they would receive the additional 20 percent of their payment.

These two policies aimed at reducing preventable hospital readmissions are also seen as effective cost-saving measures. The Congressional Budget Office scored similar policies and estimated that the two together could save nearly \$26 billion over 10 years.⁴⁴

The House Tri-Committee penalty for potentially preventable readmissions is based on a different formula. The penalty is calculated based on each hospital's percentage of potentially preventable Medicare readmissions, focusing on conditions identified by the National Quality Forum. Hospitals with lower potentially preventable readmissions rates will have lower penalties. To encourage hospitals to continue to do better over time, the HHS Secretary could, in 2013, adjust the penalty to be based on a hospital's ranking in comparison to hospitals nationally. The proposal acknowledges that readmission responsibility is borne by more than just hospitals and also proposes to reduce payments to post-acute providers (such as nursing homes and home health agencies) for patients readmitted to the hospital within 30 days of an initial hospital discharge. These provisions have not yet been scored by the CBO.

Issues and recommendations for bundling hospital care and post-hospital care

Our experts are concerned about both of these hospital readmission policies, but more about the payment method that bundles the hospitalization and the post-acute care. Our skepticism of the bundling focused on the policy’s underlying assumption that making the hospital financially responsible for post-hospital care would decrease readmission. Questions were raised about both the incentives and control over care.

Financially, our experts note that making hospitals the recipient of the bundled payment might create a disincentive for them to arrange post-hospital care. Requiring the hospital to pay other health care providers to handle that post-hospital care would certainly be a disincentive, though a readmissions penalty could mitigate that effect.

Another concern is that hospitals often lack control over post-hospital treatment and patient behavior. The majority of hospital readmissions are for patients with chronic disease, and their admissions and readmissions to the hospital are more likely based on their ability to obtain their medications, to use their medications properly, to understand and manage their chronic conditions effectively—not on what the hospital did to help them recover from an exacerbation that required inpatient care. This is particularly true for hospitals serving disadvantaged populations of patients, such as those in low-income neighborhoods and where patients have more limited access to primary care providers outside the hospital. Another concern is access to appropriate nursing home care, since access may be limited for certain “unprofitable” patients.

Our experts also question what is the best approach to implementing a bundled payment. If the bundled payment includes an increased reimbursement for the hospital stay to account for the delivery of post-acute care, how much extra should the hospital receive upfront? Would this rate be based on the current DRG weightings? This does not seem advisable since the original DRG weightings were created to explain hospital inpatient care. A payment based only on this calculation could not accurately account for the post-acute services a patient would need after hospitalization to prevent the readmission. One solution: A new formula could be established to create new payments within the DRG structure to capture the outpatient care for specific diagnoses.

Although the House Tri-Committee’s discussion draft legislation directs the HHS Secretary to outline a plan to bundle hospitalization payments with post-acute services, the discussion draft outlines nine issues the plan must consider as the plan is designed. Many of the concerns addressed by the experts are included within these issue areas.

Our experts are more positive, albeit cautious, about the non-bundling, penalty-only proposal—the penalty for excessive readmissions. Again, there is concern about inappropriately penalizing hospitals that serve low-income or vulnerable groups of patients who

may have socioeconomic disadvantages that may cause some of the readmissions. These patients may end up back in the hospital because of a variety of issues not directly related to their disease or the care they received during the first hospitalization, such as access to services after discharge, social supports, and the ability to follow discharge instructions.

Moreover, hospitals should be held more responsible for readmissions due to complications resulting from the care during the initial admission, such as surgical site infections, rather than recurrent exacerbations of a chronic disease that should be addressed by better primary care and community support rather than by the hospital. For these types of cases, our experts worry that because the kinds of exacerbations that can result in readmission can as easily occur before or after an arbitrary time cutoff of 30 days, penalties focused on a specific period of time could force hospitals to create short-term disease management programs that do not address long-term problems, and readmissions could simply be delayed until after the 30 days ends. To attempt to address this concern, we suggest that readmission rates could be aggregated at the hospital level to lessen the incentive to game the system with any individual patient.

There is general agreement among the members of our panel that any hospital penalty should target diagnoses in which, with appropriate care, readmissions should be largely avoidable, such as congestive heart failure or pneumonia—these are sometimes referred to as Ambulatory Care Sensitive Conditions. For these diagnoses, the socioeconomic status of the patient still needs to be taken into account, though good inpatient care and discharge planning and education and post-hospital follow-up will usually reduce rates of readmission. Since these diagnoses often account for the majority of hospital readmissions, this policy could be applied to all hospitals, not just those that have unusually high readmission rates. To address the point that all hospital readmissions cannot be avoided, we suggest that a readmission might be reimbursed but at a reduced rate instead or not at all. Alternatively a higher payment could be made for the initial hospital admission to pay for the care that would be needed upon discharge to avoid rehospitalization.

Our panel also is concerned about assigning any penalty appropriately. We worry whether the penalty will be leveled at the hospital responsible for the initial treatment rather than, as sometimes happens, a different hospital used for the readmission.

The House Tri-Committee addressed many of these concerns in the discussion draft. First, all hospitals will be subjected to the penalty, not just those with high readmission rates. The draft acknowledges there are factors outside a hospital's control that will affect rehospitalizations and these may disproportionately affect certain hospitals, especially those that serve low-income patients or those in rural areas. For these hospitals, the House Tri-Committee proposal includes protections so they are not unfairly penalized and provides funding for additional services for their patients, such as care coordinators, translators, and services offered by discharge planners. The penalty will focus on readmissions for a limited number of diagnoses initially identified by the National Quality Forum, with instruction

to the HHS Secretary to expand the number of diagnoses over time. The payments will be aggregated at the hospital level and the length of time the penalty is in effect from initial hospitalization to readmission will be determined by the HHS Secretary.

In our experts' view, however, simply focusing on making payment changes and assuming that the most appropriate delivery changes will automatically occur will fall short of needed policy. To the extent that readmissions reflect a transition problem—meaning that no health care providers ultimately will be responsible for the care delivered once the patient leaves the hospital—one solution is to focus on care that should be delivered during that transition. There are a few well-tested models that demonstrate having a health professional (usually a nurse) meet the patient in the hospital and coordinate care across all settings including hospital, post-acute care, and the patient's primary health care provider can significantly decrease avoidable hospital readmission.⁴⁵

Paying for this transition care not only decreases readmissions but also decreases hospitalizations for new problems. This has also been shown to improve health outcomes and patient satisfaction while also resulting in cost-savings to the system. With strong studies demonstrating these positive outcomes over many years, we believe that CMS should start paying for this transitional care. Care must be taken, however, not to create new silos of care delivery, separate from other members of the patient's health care team. To address this concern, we suggest that coordination with a beneficiary's primary care provider should be a condition of payment.

This approach is similar to the Senate Finance Committees proposal to reimburse care management activities performed by nurse-care managers for patients with one of six major chronic diseases—congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, asthma, diabetes, and depression—as they are discharged from the hospital. Along these lines, the Finance Committee also proposes that Medicare pay a modest supplemental fee directly to primary care practices for chronically ill patients who they care for and who are *not* readmitted to the hospital for that same chronic condition they are managing.

The House Tri-Committee proposal takes a different approach to address transitional care. It directs the HHS Secretary to study how physicians can be included in a preventable hospital readmission policy since access to a physician (or lack thereof) is also important to avoiding a readmission.

Integrated care and global capitation

Our experts are strongly in favor of looking at new models of care that reimburse coordinated care among many different health care providers. In a true health care system, patients would have their full needs assessed when they seek care at a clear entry point

and receive the care they need (and no more) from a coordinated team—and those teams would be encouraged and rewarded for providing high-quality and efficient health care. The ultimate goal: Help the patient get well and stay healthy.

This vision works best when a single health care provider or a team of providers are available to coordinate the care the patient receives at many different medical visits during episodes of care. Most health care analysts believe this system of care would improve outcomes and could cost less than what we are paying now. What is needed is proper infrastructure to allow this care delivery and financial incentives to encourage this team approach.

Not surprisingly, there are big health care providers who have an advantage when trying to deliver such coordinated care. There are entities such as Kaiser Permanente in California that are both a payer and a provider, so have payment responsibility as an incentive to manage costs. There are also other big health systems that because of their sheer scale may be better at providing and managing multiple aspects of a patient's care within the same organization. Examples often noted are the Geisinger Health System, Mayo Clinic, and Cleveland Clinic.

The challenge in moving most health care providers toward such an integrated system now is that typically most health care is not delivered on such a large scale. About 80 percent of physicians practice in small practices with fewer than five other physicians and do not have a close relationship with the hospital system that serves their patients.⁴⁶ The challenge for payment reform is to enable the physicians in smaller practices to communicate, coordinate, and collaborate with the broad range of professionals their patients rely on—whether or not they are formally part of a larger organization.

There is no guarantee that just being part of a big network creates such collaboration. The consolidation of health systems in the 1990s was typically focused on maximizing revenues rather than increasing quality, access, and efficiency.⁴⁷ Any new model for integrated care must be designed to assure quality, access, and efficiency.

“Global capitation,” health insurance parlance for comprehensive care payment that pays a single price for all the health care services needed by a specific patient for a fixed period of time, is one way to pay for care delivered in large integrated systems.⁴⁸ Partial capitation, in which payments are made for a subset (but not all) of the care provided to a patient, such as in a primary care medical home or bundled payments that blend the global rate with fee-for-service payments, may be a more attractive payment method for smaller practices and could be used a step toward global capitation.

Another payment method that begins to move along the spectrum from fee-for-service to global capitation is found in a “shared savings” approach. With shared savings, the payer does not determine reimbursement rates up front. Instead, a payment (either as a bonus

payment or the entire payment) is negotiated between the health care providers and the insurer. If the care is delivered for less than the negotiated cost, the savings are shared with the providers.

Our experts believe that these payment mechanisms can encourage better, more efficient care delivery by existing loosely connected small physician practices as well as by newly created organizations. Independent practice associations, or IPAs, may provide an example of how small practices can participate in more integrated systems on a somewhat less formal basis. IPAs are associations that allow separate medical practices to join together for various reasons such as contracting, providing better quality improvement, and managing costs. Some of these practices perform well as integrated-care organizations, even though the physicians have not formally come together into a multispecialty group.⁴⁹

Some IPAs encourage their practices to provide quality improvement activities and use electronic health records for individual practices while ensuring interoperability across practice sites. Other IPAs employ chronic-care management professionals who can interact with physicians in virtual teams to support patients with chronic conditions and the frail elderly at home. IPAs provide an example of how smaller independent providers can move toward more integrated care systems.

Or consider the Physician Group Practice Demonstration, a Medicare demonstration program authorized in 2000 that might improve the incentives provided in the context of traditional fee-for-service payment. Like the medical home model, this demonstration emphasizes primary care but offers more powerful incentives to move toward integrated care with the shared-savings approach. In this demonstration, 10 large multi-specialty group practices were provided with an incentive to reduce total Medicare costs for their patients by being eligible for a share of the savings they achieved. An increasing portion of the bonuses available to each practice were to be based on the accomplishment of quality improvement according to a set of pre-established metrics. When the physician groups provide “better” care—for example, through care coordination activities that are not reimbursed in the current fee-for-service program and thus save money by reducing hospitalizations and through other means—then the physicians share in the savings.⁵⁰

Elliott Fisher of Dartmouth University and Mark McClellan at the Brookings Institution offer a model of shared savings that they refer to as Accountable Care Organizations.⁵¹ ACOs are (actual or virtual) organizations that would include doctors and hospitals organized to accept responsibility for the effectiveness and efficiency of their patients’ care and agree to be subject to alternative payment mechanisms, including shared savings payments or even capitated payments for all services. Their goal is to foster shared accountability among all providers involved in patient care in a given area. While large, integrated systems should be in the best position to handle this type of approach, the ACO model allows for the creation of “virtual” integrated delivery systems, consisting of smaller groups of providers agreeing to collaborate to accept joint responsibility for providing more integrated care for their patients.

The ACO approach would establish a spending benchmark for each organization. If an ACO can maintain or improve quality while slowing spending growth, it receives shared savings from insurers. A wide variety of collaborations among health care providers could become ACOs, assuming they are willing to be held accountable for overall patient care and operate within a particular payment and performance measurement framework. Examples include existing integrated delivery systems, physician networks such as independent practice associations, physician-hospital collaborations, and multispecialty group practices.

In addition, as a virtual organization, smaller office practices could participate in ACOs to take advantage of larger networks. Or alternatively, primary care groups or other organizations that provide basic care could contract with specialized groups that provide high-quality referral services with fewer costly complications. It is assumed in this model that all providers must assume some financial risk.

Issues and recommendations on integrated care and global capitation

Our experts agree not only on the desirability of integrating individual or small physician practices into broader health care delivery systems but also on facilitating and encouraging rather than forcing that integration. Differences of opinion exist, however, over whether the best way to move is through a capitation structure or shared-savings approach. The advantage of capitation is that payments are paid upfront as the care is being provided and are not restricted to specific service codes. In this way, practices have both the flexibility and the resources available to invest in elements of care with an aim to improved outcomes, including nutritionists, care coordinators, and technology to help track the care delivered to their patients.

In contrast, shared-savings models provide the financial reward after the care is delivered and only after the savings and quality measures are already attained. This should also encourage better outcomes but is more difficult for smaller practices that do not have the ability to make the initial capital investments.

To move as rapidly as possible to a redesigned global payment system, our experts thought that there should be experimentation with multiple payment approaches that promote coordination so that health care practices with different levels of capability could begin accepting as much accountability as possible. CMS should also have the authority to expand successful models more broadly without the need for congressional action. Successful Acute Care Episode, or ACE demonstrations, and Physician Group Practice, or PGP demonstrations are examples of programs that could be readily expanded. In addition, there should be the opportunity for new ideas to be developed, implemented, and expanded when they are found to provide better outcomes and increased efficiencies. The Section 646 demonstrations or CMS-initiated paths described above could provide such opportunities.

The House Tri-Committee proposal specifically instructs the HHS Secretary to conduct a pilot program to test different payment incentive models, including ACOs, that are designed to reduce costs and improve health outcomes. Here again the HHS Secretary would ultimately determine the criteria for participation for a qualifying ACO. The ACO would qualify for an incentive payment if expenditures for beneficiaries are less than a target spending level. There is also a special consideration made to encourage smaller organizations to participate so that they are able to focus exclusively on high-cost patients. The pilot program covers between 3-to-5 years but the HHS Secretary has the authority to expand the pilot as necessary to fully implement the program. To facilitate the implementation of this pilot, the House Tri-Committee proposal directs the HHS Secretary to help transition current physician group practice demonstration programs that would like to participate in this new demo.

The Senate Finance Committee also recommends expanding the PGP demonstration beyond large physician groups to different practice configurations as a way to implement the ACO concept. The PGP demonstration was limited to large practices; by expanding who is eligible to participate, smaller providers could partner with larger health care institutions that can better afford some upfront costs. Practice arrangements in such a system could include individual physician practices, larger networks of practices, and practices that work in collaboration with hospitals.

Under the Senate Finance Committee proposal, participating provider groups whose two-year average expenditures were at least 2 percent below a benchmark—based on the past three years of beneficiary spending—would be eligible to share in the savings generated. To qualify for the incentive payments, the practice would be required to measure clinical processes and outcomes, patient perspectives on care, and utilization and costs. This new policy would also grant CMS the authority to transition the ACO payments from fee-for-service to fully- or partially-capitated payment structures. For organizations successfully reaching their goals, CMS would continue this at least at the same terms and perhaps evolve more specifically toward full capitation.

Medical practices that are already using an integrated-care approach, such as those in an IPA, are in a good position to further explore new payment models by participating in either of these new CMS demonstration programs or other shared-savings payment structures. Regardless of approach, though, our experts believe in the need for providing the flexibility and incentives for health care providers to enter into new financing arrangements at the stage appropriate for them. It may be that smaller primary care practices can begin to increase integration and move toward global capitation as an enhanced primary care practice, such as a medical home with a payment structure that encourages the coordination care for their patients. The incentive for managing total costs and quality could begin with a system of bonus payments, and then the providers could transition to a more comprehensive care payment with greater accountability for the outcomes that can be attained by the delivery of better primary care.

Conclusion

From its inception, the Center for American Progress has emphasized that the American health care system is in need of major reform, but we are also well aware of the complexities involved in making such changes. This is why we convened a meeting of health care experts to evaluate payment reform proposals as a means to changing the health care delivery system. The \$2.3 trillion health care system will not be easily changed, nor is there a single best way to produce this change. There are stakeholders who have been very successful in the system as currently designed. But change is no longer an option—it has become a mandate. As OMB Director Peter Orszag has said, “The single most important factor influencing the federal government long term fiscal balance is the rate of growth in health care costs.” If this expensive system created the health outcomes we desired, the task might be even more difficult. But it does not.

We now have the opportunity to change the health care delivery system to one that produces better outcomes at a lower cost. Though in most markets this might seem an oxymoron, it is not in health care. We know the problems volume-driven health care has created and know that emphasizing primary care, prevention, and coordinated care will improve outcomes and save money. Payment reform is the path to this transformation.

The attendees at our meeting agreed that despite the enormity of the task, there is sufficient evidence and capacity to move forward toward creating a value-based health care system. The most important recommendation is that quality, cost-effective innovation must be rewarded and best practices identified and ramped up when found to be successful. To accomplish this, CMS must have expanded authorities and necessary resources. CMS must be allowed to develop and implement payment reforms that have the greatest potential to move us from a volume-driven system to one that rewards values and improved outcomes. To take full advantage of this new charge, CMS must be able to move on these ideas without the need for additional Congressional action.

Reform must allow different providers to use different models, at different speeds. While enhanced primary care delivery through the medical home or care-coordination models might be the best starting point for some, others may embrace bundled payment programs, shared savings models or organize as an ACO. To assure that cost-effectiveness is not achieved by withholding care from patients, outcomes should be monitored and ultimately payment should be determined based on these outcomes. While these payment

options are explored and implemented, health IT systems should be designed simultaneously to facilitate the collection and use of patient data to optimize the delivery of care. These new health IT systems will enable the entire health team to maximize their ability to deliver better coordinated health care.

There are a variety of creative ideas that have been tried both in Medicare and in the private sector. And these were created in a payment environment that did not reward such innovation. Just imagine what great ideas might develop and flourish in an environment that pays for enhanced primary care and improved outcomes. For these ideas to move from individual demonstration models, the federal government must begin rewarding the delivery of value over volume and quality over quantity. The payment reform recommendations detailed in this paper can achieve that smart, compassionate end.

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