

MAKING REFORM A REALITY

Ways to Facilitate Better Healthcare Payment and Delivery Systems and Lower Healthcare Costs

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I. Paying for Value, Not Volume

There is widespread agreement that current methods of paying for healthcare contribute to both high costs and poor quality. Not only do they create strong incentives to increase the volume of services delivered, current payment methods often create barriers to delivering higher-quality and more efficient care and can even penalize healthcare providers for keeping people healthy, reducing errors and complications, and avoiding unnecessary services.

To date the only broadly implemented changes in payment systems to try and address these issues have been pay-for-performance (P4P) programs. Although P4P programs have encouraged some improvements in quality, most involve relatively small amounts of funding and focus on relatively few care processes. Most importantly, they do not correct the problems in the underlying payment systems, falling short of the reform needed to deliver true change.

Two fundamental types of reforms in payment systems are needed¹:

- **Episode-of-Care Payment**, i.e., paying a *single* amount to cover *all* of the services which are provided to a patient during a single episode of care (e.g., the treatment of a heart attack), rather than making separate payments to hospitals, physicians, and other providers and rather than paying more for services needed to address preventable complications. Episode-of-Care Payment gives the involved providers an incentive to coordinate their activities, eliminate unnecessary services, and avoid preventable complications.
- **Comprehensive Care Payment** (often called “global payment”), i.e., paying a single amount to cover all of the services needed to manage a patient’s conditions during a fixed period of time, regardless of how many separate episodes of care occur. This gives the providers involved in the patient’s care the flexibility to try innovative approaches and tailor services based on the patient’s needs, and it gives them an incentive to avoid hospitalizations and unnecessary or overly-expensive services.

Although there is now growing recognition that these kinds of payment reforms are *necessary* if significant improvements in healthcare quality and costs are to be achieved, the challenge has become convincing healthcare providers, payers, purchasers, and consumers that they are *feasible* and helping them overcome the significant hurdles to implementation. The changes are inherently complex and risky, and the payers, providers, and communities that are interested in pursuing them face many practical challenges in doing so.

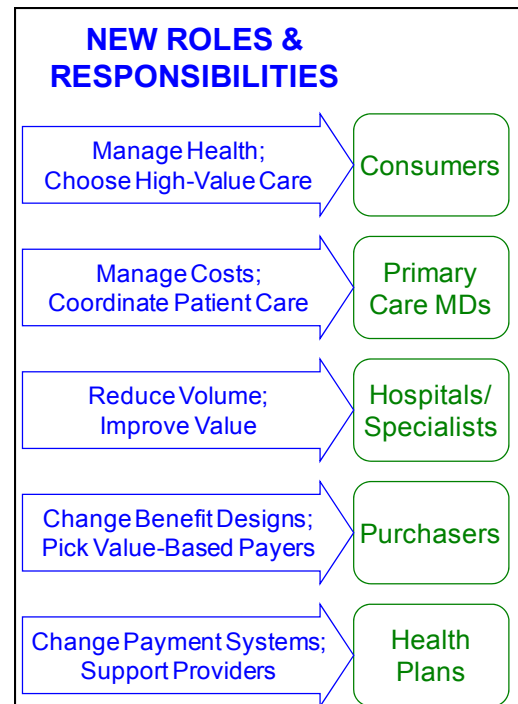
Moreover, while significant payment reforms are necessary, they alone are not *sufficient* to deliver the lasting change that is expected and needed. Many aspects of healthcare such as delivery systems, benefit structures, regulation and performance measurement will also need to change significantly to complement and support the changes in payment systems to achieve the goals of higher quality and lower-cost healthcare.

Because of the increasing awareness of these issues, the important developmental work that has been done to date, and the provisions of the recent federal Patient Protection and Affordable Care Act (PPACA), an unprecedented window of opportunity has opened for making progress on payment reform and transforming healthcare systems over the next few years. However, careful attention must be given to successfully managing the many implementation challenges if the tremendous promise of payment and delivery reform is to be realized.

II. How Healthcare Stakeholders Have to Change

At the heart of the challenge in implementing payment reforms is the fact that every major stakeholder will need to change – significantly – the way it has done things for decades.

- **Private health plans** will need to completely revamp their provider contracts and claims payment systems. Instead of detailed fee schedules, they will need to develop and implement new methods of paying providers, including such details as how payment levels will be adjusted for patient conditions and severity. Health plans will also need to develop and implement new benefit designs for consumers that are based on cost-sharing of bundled payments rather than individual services and that include incentives for value-based selection of providers and services. The transition costs will be significant, particularly for smaller plans, and these costs will create a competitive disadvantage for any plan that decides to “go first” if other plans continue to operate under current models. But beyond the direct changes in IT and other systems needed to support new payment systems and benefit designs, plans will also need to completely rethink their fundamental business models. Today, health plans compete on their ability to manage utilization of services; in the future, that responsibility will shift to “accountable care” providers. The skills health plans have developed in areas such as predictive modeling, care management, utilization review, and prior authorization will need to become services marketed to Accountable Care Organizations (ACOs) rather than to employers and other purchasers of insurance.
- **Physicians**, particularly primary care physicians, will need to develop new and improved skills in data analysis, population-level care management, management of financial risk, efficiency improvement, and methods of improving patient access. Small practices will need to form or join Independent Practice Associations (IPAs) or similar organizational structures to create a large enough volume of patients for adequate measurement of outcomes and management of financial risk. IPAs and larger practices will need to shift their skills from negotiation of contracts with health plans to improvement of practice efficiency and effectiveness. More primary care practitioners will be needed, and primary care practices will need to develop more formal relationships with specialists, hospitals, and other providers to ensure coordinated, efficient care of their patients.



- **Hospitals and many specialists** will need to restructure their operations to accommodate lower patient volumes, or at least slower growth in patient volumes. Capital budget planning will need to shift from how to assemble the capital for expansion to how to cover the unamortized costs of underutilized facilities and equipment and how to reorganize facilities for a different volume and mix of services. Bundled payment methods will require more coordinated relationships between hospitals and physicians, particularly in non-integrated systems and where effective Physician-Hospital Organizations (PHOs) do not exist. Some hospitals may need to close entirely, and some healthcare workers – ranging from specialist physicians to nurses and technicians – may lose their jobs or need to significantly change the focus or location of their work.
- **Consumers and Patients** will need to change the way they engage the healthcare system. Instead of picking health plans that shield them from the true costs of services and the differences among providers, consumers will need to choose providers and services based on their cost and quality, and they will need to work with a primary care “medical home” and, if necessary, a consistent, coordinated network of specialists to improve their health and manage their healthcare in an efficient and effective way.
- **Purchasers** (i.e., businesses and governments paying for healthcare or health insurance plans) will need to choose health plans and third party administrators (TPAs) that utilize value-based payment methods, implement value-based benefit designs for their employees, and ensure that all payers in the community use consistent payment methods and benefit structures so that healthcare providers can operate within a consistent set of incentives. In many cases, purchasers may need to develop value-based purchasing contracts directly with healthcare providers in the community, rather than through health plan intermediaries.

These are all very fundamental changes in business models, skills, and behaviors that have been developed and reinforced over decades by a dysfunctional healthcare payment and delivery system. Most of the stakeholders have never experienced any different approach, will have difficulty envisioning how it would work, and without proactive efforts to help them change, will likely tend to believe that the devil they know will be better than the devil they don't know.

Moreover, all of these changes need to happen simultaneously. For example, providers can't change the way they deliver care unless payment changes support the care changes, but payment systems can't change unless providers are organized to accept new forms of payment. Consumers can't choose providers intelligently without understandable information on cost and quality, and providers can't produce that information without assistance from health plans or community organizations that have access to the necessary data.

If these changes are not implemented well, particularly in the early stages, they could create the kind of backlash that led to the collapse of managed care systems in most parts of the country in the 1990s. The interconnection of all of the pieces means that there are

multiple potential sources of failure and resistance to change, each with a potential domino effect on the others.

Some of the biggest threats to success would appear to be:

- **Consumer fear and resistance.** Healthcare is one of the most personal and literally life-and-death issues that most consumers will deal with. The power of consumers to kill poorly-designed healthcare reform efforts in both the private sector and public sector has been well demonstrated. Considering the public furor exhibited during the recent federal health reform debates it should be expected that such popular energy and concern will be carried over into implementation.
- **Lack of physician skill and experience in coordinating care and taking accountability for the total costs of care.** The most direct interface with the consumer is the physician, and as noted above, new payment and delivery models expect physicians to function very differently than they do today, either directly or by subjecting themselves to management by other individuals or organizations which have the necessary skills. Lack of support by physicians for new payment and delivery models will also contribute to consumer resistance to those models.
- **Resistance and problems in downsizing/reinventing acute care services.** Healthcare in general, and hospitals in particular, have become major economic engines in most communities and have been one of the only sources of job growth nationally over the past two years. Thousands of young people and workers displaced from other industries have invested time and money preparing for jobs in healthcare based on projections and promises of continued job growth – projections that assume continuation of the very cost trend that the nation is trying to reverse. As a result, many hospitals and specialists will have both the incentive and community support to resist or impede change, both politically – through influencing Medicare policies, state regulations, and other mechanisms – and economically – through consolidation to allow monopoly power in pricing.
- **Inappropriate shifting of risk and reductions in quality service delivery.** One goal of payment reform is to shift performance risk from insurers to providers, while retaining insurance risk with insurers. Insurers would continue to take responsibility for costs resulting from patients developing unpreventable conditions, while providers would accept responsibility for efficiently and effectively treating those conditions when they occur. Conceptually, the distinction between insurance risk and performance risk is reasonably clear, but in practice, the boundary is inherently quite fuzzy. If a patient with diabetes has a stroke, is that an unpredictable insurance risk or a preventable complication resulting from poor diabetes care? If a patient loses weight under the guidance of their doctor and their diabetes symptoms disappear, is that a credit to the health plan's insurance risk or the provider's performance risk? Health plans will have a natural incentive to shift as much downside risk (i.e., cost) as possible to providers and retain as much upside risk (i.e., savings) as possible. If they do this inappropriately, it will create the threat of bankruptcy for providers, which are not capitalized to handle insurance risk; this is exactly what happened to a number of healthcare providers in the 1990s. Even if

health plans transfer an appropriate share of risk and accountability to providers, some providers may choose to manage costs by denying or rationing care, rather than improving their efficiency and quality. Even a few examples of this – which opponents will have an interest in finding and trumpeting – could undermine consumer confidence, just as it did with some capitation systems in the 1990s.

- **Lack of collaborative mechanisms for coordinating implementation and resolving problems.** As noted earlier, many different actions by multiple actors will need to proceed in a coordinated way in order to maximize the chances of successfully implementing major payment and delivery reforms. Yet there is no one “in charge” of all of these pieces, and mutual distrust among many of the stakeholders means that win-win solutions may not be found without support from some neutral party.

If major payment and delivery reforms are to be implemented successfully, actions will be needed to help mitigate these issues. Many stakeholders will face significant challenges in addressing the issues, and they could benefit from assistance from federal, state and local governments, civic leaders, private foundations and other organizations. The subsequent sections of this paper explore specific issues in each of the areas of concern which are particularly challenging, and outline potential actions which could be helpful to healthcare stakeholders in addressing those issues.

III. Increasing Consumer Support and Engagement

A. *Encouraging Consumer Support of Payment and Delivery Reforms*

The Issue

Payment reforms are designed to remove the undesirable incentives and barriers which impede healthcare providers from providing higher quality, less expensive care. But even with the best-designed payment system, many of the opportunities for healthcare cost reduction cannot be achieved without the active support and participation of consumers. It does little good to encourage healthcare providers to improve quality and reduce costs and to encourage the development of higher-quality, lower-cost services if consumers choose the higher-cost and/or lower-quality providers and services. And it is difficult for providers to successfully prevent the development of chronic conditions and manage those conditions cost-effectively without active support of the affected consumers.

Moreover, consumer support will likely be critical if dramatic payment changes are to be made successfully. Although it could be argued that much of the “consumer backlash” against managed care programs during the late 1990s was a result of poorly designed and overly aggressive efforts by insurance companies to cut costs, if consumers believe that the proposed payment reforms being discussed today will result in the same problems experienced before, they will strongly resist. Health plans compete for members and employers compete for employees, so payment systems or benefit designs that are viewed as undesirable by consumers will be seen as competitive disadvantages by both plans and purchasers. Although many have looked to the Medicare program for leadership on payment reform, policy decisions on Medicare payment and benefits are made by elected officials who depend heavily on the votes of seniors for re-election, making it difficult for federal agencies to push for innovations that seniors oppose.

Despite the importance of building consumer support, many of the policy discussions about payment and delivery reforms during the debates over the drafting of PPACA have already exposed significant consumer opposition. For example:

- Payment reforms are frequently described in terms of their ability to cut costs and reduce services, rather than to improve coordination and keep people well.
- The development of “medical homes” continues to be promoted even though there are indications that consumers may perceive that term negatively, and if consumers perceive that “accountable care organizations” will be accountable to someone other than them, they may shun them.

- Comparative effectiveness research is being described as a method for limiting benefits, rather than a way of helping doctors and patients make better decisions about care.

Even if payment and delivery system reforms would succeed in providing better quality care for consumers once fully implemented, those reforms may never have the opportunity to prove themselves if consumers perceive them as being undesirable and oppose them because of that. Interest groups which stand to lose under a higher-quality, lower-cost healthcare system will have a strong incentive to encourage those reactions.

Potential Ways to Address the Issue

Success in getting consumer support for significant changes in payment and delivery systems requires a completely different paradigm for communications – instead of “consumer education,” the approach will likely need to be closer to that of a political campaign or ballot initiative in the public sector or a major new product rollout in the private sector. Communications research is needed to help improve both the substance of payment and delivery reforms (e.g., what a medical home should do) and the perception of the reforms (e.g., what a medical home should actually be called).

The focus of this campaign approach should not be on Washington or Congress, although they could certainly be one target. The primary focus needs to be at the regional level, where the changes will actually have to be implemented, and in the context of local delivery and insurance structures.

What is needed is a process similar to the following:

- Conduct opinion research to determine how consumers will react to payment and delivery reform proposals. This would include:
 - Developing potential messages about healthcare delivery problems and proposed solutions;
 - Testing the messages with focus groups of consumers. Separate efforts would be needed in different parts of the country, soliciting input from consumers in different age, gender, racial, and ethnic groups, from those in different insurance programs (commercial, Medicare, Medicaid), and from both the healthy and ill;
 - Testing the messages with focus groups of providers, particularly doctors;
 - Restructuring the payment and delivery reform proposals as necessary, both in terms of content and labeling, based on feedback from these focus groups in order to ensure that the substance of the proposals and the way they are perceived will attract support from both consumers and providers;
 - Refining the messages based on the input from the focus groups and the program redesign; and
 - Testing the revised messages through opinion polling.

- Shape the payment and delivery reform proposal to ensure it is desirable for each market segment based on the goals and concerns most important to that segment using the information generated from the opinion research.
- Conduct an aggressive and well-funded campaign to build support for the changes, with communications customized and targeted at each key market segment. This might be done in two stages:
 - Demonstrate the ways that the current healthcare system is not delivering good quality or value to consumers; and then
 - Explain how the proposed changes will solve or mitigate those problems.

Effective opinion research is expensive. Large corporations can do it for new product development because they can recover the costs through more successful sales. Political campaigns can do it because they have an organization that recognizes the need and contributors who provide the finances to support it. The only players in healthcare with the resources to finance this type of opinion research are large health plans, large healthcare providers, provider associations, and some national consumer groups.

Government and foundation funding could be used as a catalyst to attract matching funds from health plans and provider associations to carry out such research. Moreover, having public and charitable funding sources involved would provide a mechanism to ensure that consumer interests are appropriately represented and that the results are used accurately by all parties, rather than having the results reported selectively or used inappropriately to advantage a particular stakeholder.

National opinion research could examine issues likely to be common to all markets, such as consumer perceptions of “medical homes” and “accountable care organizations (ACOs)” and the things that would encourage them to use a medical home or ACO consistently. Regional opinion research would focus on implementation issues that are unique to specific communities.

Both the national and regional research could be used to assist in implementation of payment and delivery reforms, such as:

- Redesigning specific aspects of payment models, benefit designs, care delivery structures, etc. in order to better respond to consumer needs and preferences; and
- Preparing educational materials to help consumers understand the ways payment and delivery systems will change and how they will benefit from those changes.

B. Encouraging Use of Medical Homes and Accountable Care Organizations

The Issue

A core element of healthcare reform strategies is encouraging the development and use of “patient-centered medical homes” and “accountable care organizations (ACOs)” for

improved delivery of care. Although payment changes are necessary to enable primary care practitioners to effectively play this role, and considerable work is underway to design and implement both payment changes and changes in primary care practices to implement these approaches, there has been little or no attention to the types of benefit designs and other mechanisms that would encourage consumers to use a medical home or ACO. This is an issue for both improving quality of care and for accurately measuring quality and cost, since if a medical home or ACO does not know who its patients are and the patients in turn do not know how to work with it, it will be very difficult for the medical home or ACO to manage the patients' care and accept accountability for outcomes.

Most discussions about the issue seem to be based on the implicit assumption that there are only two alternatives:

- Allowing consumers unfettered choice of doctors and then retrospectively assigning them to providers based on a statistical attribution rule that may bear little relationship to the physicians' actual relationship with the patients.
- "Locking in" consumers to a particular provider who will serve as a "gatekeeper" and determine whether the patient can receive any other services.

Yet there are clearly middle-ground options which could also be considered, such as educating consumers about the value of care models such as medical homes and ACOs, asking them to voluntarily designate a medical home, and creating modest copayment reductions for using one. Different options (and different medical home/ACO structures) may be needed for different types of consumers (e.g., Medicare vs. Medicaid recipients). These need to be tested and refined appropriately to identify which would be best so they can be adopted more broadly by Medicare, Medicaid programs, and private health plans.

Potential Ways to Address the Issue

Three different types of activities would be helpful to identify and refine these middle ground options:

1. **Consumer opinion research**, similar to any major product rollout in other industries. As described in more detail in the previous section, focus groups and polling could be conducted to identify consumers' attitudes toward medical homes and ACOs and how different incentives for using them would be perceived by consumers in order to guide employers and health plans in designing benefits and preparing education materials.
2. **Pilot projects, evaluations, and dissemination of results**. Some purchasers and payers may already be using consumer incentives for medical homes successfully, and others may be willing to test new models. Public and foundation funding could help support inventorying and disseminating information on current models, and help support design, implementation, and evaluation of alternative approaches.
3. **Consumer education materials**. Using some combination of opinion research and the results of evaluations of the effectiveness of medical homes, public and private funding could be used to prepare materials that ACOs, employers, health plans, and

others could use to encourage consumers to select and use high-quality medical home providers on a consistent basis.

C. Encouraging Consumer Choice of High-Value Providers/Services

The Issue

Another important element of an overall strategy for reducing healthcare costs and improving quality will be encouraging the use of high-value providers and services. However, this faces tremendous marketing and communications hurdles, because consumers have been conditioned to believe that more care is better and that more expensive care is better still. The national conversations – and controversies – over comparative effectiveness research have demonstrated the challenge.

Most policy discussions would lead one to believe that there are only two options:

- Allowing consumers unfettered access to services and providers regardless of their cost; or
- Prohibiting payment for certain services deemed by a third party to be “low value.”

However, there are middle ground options that could be pursued, such as cost-sharing requirements designed to encourage consumer use of higher-value treatments rather than prohibitions on using lower-value treatments. Moreover, the *way* cost-sharing is done needs to change, so that consumers are made more sensitive to the “last dollar” of cost (i.e., the difference in price) rather than the “first dollar” of cost (as copayments, co-insurance, and deductibles are designed to do). This would help to resolve the conflict between the desire to raise cost-sharing requirements in order to increase consumer sensitivity to cost differences and the desire to lower cost-sharing requirements in order to remove barriers to treatment adherence.

Potential Ways to Address the Issue

Similar to the suggestions related to encouraging use of medical homes, three different types of activities could help in finding successful approaches:

1. **Consumer opinion research.** Focus groups and polling could be conducted to identify consumers’ attitudes toward more expensive providers and services and how different incentives for using higher-value services would be perceived. The results would help guide changes in benefit designs and the preparation of education materials describing the changes.
2. **Pilot projects, evaluations, and dissemination of results.** Some purchasers and payers are already using consumer incentives to encourage use of higher-value providers and services, and others may be willing to test new models. Public and foundation funding could be used to support inventorying and disseminating information on current models, and to support design, implementation, and evaluation of alternative approaches.

3. **Consumer education materials.** Using some combination of opinion research and the results of evaluations of the quality and cost of different providers and services, public and private funding could be used to prepare materials that physicians, employers, health plans, and others could use to encourage consumers to select and use high-value providers and services.

D. Encouraging Consumer Adherence with Wellness/Treatment Plans

The Issue

Many physicians and other healthcare providers are willing, in principle, to accept greater accountability for outcomes related to their own actions or inactions, but do not want to be held accountable for poor outcomes caused by lack of patient adherence to treatment plans.

Most discussions of patient adherence seem to be based on a presumption that adherence (more traditionally referred to as “compliance”) is primarily an issue of *lack of willingness* by the patient to adhere, which implies that it needs to be corrected through some combination of exhortation and financial incentives. Yet it is likely that a more important factor for many patients is a *lack of ability* to adhere, in which case most encouragement will have little impact. Lack of ability may stem from at least three different types of barriers:

- **Lack of understanding.** Patients may not have been effectively educated about either the importance of adhering with a treatment plan or how to properly do so;
- **Lack of skill or support.** For example, proper use of inhalers and nebulizers by individuals with asthma or chronic obstructive pulmonary disease (COPD) requires a series of complex steps which may be difficult or impossible for many individuals, particularly the elderly, to carry out properly. People who cannot drive and have no access to public transit may have difficulty getting prescriptions filled, attending rehabilitation sessions, etc.; or
- **Lack of financial resources.** Copayments, co-insurance, deductibles, or lack of insurance for medications and other services can force many people with chronic disease to forego the medications and services that are key components of their treatment plan. But financial barriers may go well beyond the direct costs of medications; for example, oxygen concentrators used by patients with COPD or other breathing difficulties can significantly increase electricity bills, which can be an impediment for people with limited incomes.

Even if there are programs ostensibly designed to help people overcome these barriers, they may be designed in ways that limit their effectiveness. For example, although all major pharmaceutical companies have programs to assist people who cannot afford medications, patients may not be aware of the programs, and even if they are, the programs typically involve complex and burdensome requirements (such as completing forms, waiting several weeks before approval is given, and requirements that medications be delivered to

physician offices, rather than to the patients' homes), which significantly increase the risk of hospital admissions, readmissions, and ER visits in the interim.

Potential Ways to Address the Issue

Patient adherence, and by extension, the success of medical homes and ACOs in improving the cost and quality of healthcare could be increased in several ways:

1. **Research.** More research is needed to determine the full range of barriers that patients face and the relative frequency and importance of those barriers. Much of this knowledge already resides in the minds of nurse care managers and other healthcare professionals across the country; what is needed is an organized way of tapping into this expertise to identify the full range of barriers and then prioritizing those barriers through a combination of the perceptions of care managers as to their relative importance and some direct consumer feedback. In addition, programs designed to overcome barriers need to be evaluated, both in terms of process (i.e., do they do what they say they do?) and outcome (i.e., are they effective in improving adherence?).
2. **Patient Education Materials.** In order to be effective, patient education materials need to be designed based on research showing the areas where patients are likely to be confused or misunderstand, and the materials should be tested to determine whether they are effective in creating patient understanding.
3. **Design of Comprehensive Programs to Improve Adherence.** It is unlikely that individual medical homes or ACOs will have the time or resources to inventory the research literature and design comprehensive programs to address adherence issues in a way that will be cost-effective, nor would it be efficient for each individual provider to do so on its own. Comprehensive programs need to be developed which could be implemented in a completely turnkey fashion. These programs could use existing program components (e.g., drug company assistance programs), but the goal should be to ensure a comprehensive, coordinated, yet efficient approach that could help maintain patients' health and reduce overall costs.

IV. Helping Healthcare Providers Transition

A. *Building Physician Skills in “Accountable Care”*

The Issue

Episode-of-care payments, comprehensive care payments, and even transitional payment reforms such as shared savings and efficiency-based pay-for-performance implicitly presume that physicians will be able to redesign care in a way that will reduce the need for or utilization of services that are not directly provided by those physicians. For example, the analyses conducted by PROMETHEUS Payment demonstrate high rates of potentially avoidable complications – predominantly hospital admissions and readmissions – for patients with chronic diseases such as congestive heart failure or COPD. Episode-of-care payment models, such as those developed by PROMETHEUS Payment, can provide a financial reward to physicians if they reduce these complications. Although these payment models provide a *financial incentive* to physicians to reduce preventable admissions, readmissions, and other complications, the physicians will have to develop the *skills* and *resources* to respond to that incentive. For example, they will need or likely need:

- Real-time data on things such as hospital admissions, ER visits, and the use of specialists in order to both measure their performance and to respond promptly to patient needs;
- Patient registries or other mechanisms to track patients and proactively ensure they are receiving the care they need;
- To redesign their practice operations in order to respond more promptly to patient calls for assistance;
- Additional resources, such as nurse care managers, to provide adequate patient education and self-management support to those at risk of hospitalization; and
- The ability to plan and monitor the financial value of improved outcomes relative to the costs of any investments they make in improving care, in order to ensure that there is a positive return-on-investment.

These are not skills that most physician practices have, primarily because there has been no need to develop them under current payment systems. Indeed, current payment systems actually disincentivize the kinds of behaviors that will be critical for success under new payment models. If physician practices do not obtain these skills, they will likely (a) resist implementation of the new payment models, (b) accept them but fail financially, and/or (c) be acquired by large health systems which claim to have the requisite systems and skills to succeed under new payment models (but may not, in fact, have those systems or skills). If physicians resist implementation, go bankrupt, or end up in undesirable employment arrangements, this will, in turn, cause consumers to resist or rebel against the

changes. Consequently, efforts to help physician practices develop the skills will be critically important for the success of payment and delivery reforms.

Potential Ways to Address the Issue

It seems likely that effective assistance to physicians would fall into at least four categories:

1. **Creating a “toolbox” of programs and actions that physician practices could use to immediately begin achieving reductions in hospitalizations or other high-utilization services.** It will be important for physician practices to focus on “quick wins” that reduce costs and improve quality within a month or year (i.e., the likely payment period for an episode-of-care payment or comprehensive care payment) and to utilize proven practices where they exist. This could be done through developing a series of modularized “how to” guides explaining the kinds of evidence-based programs and interventions that physician practices could mix and match in order to get under way quickly.

It is important that this toolbox be a *resource* that physicians can use to improve outcomes, and not turn into a set of accreditation standards defining how physician practices *must* be structured or function. Too little is known at this stage about what works and what doesn’t in the broad diversity of healthcare markets across the country to *require* providers to use any particular set of programs or processes; even where there is evidence that a particular type of program worked in a particular organization or community, there is generally little or no evidence that it can be easily replicated and achieve the same results in other settings. As long as the payment system is changed so that physicians are held accountable for *outcomes*, they should have the flexibility to determine *how* to best achieve those outcomes, rather than being forced to simultaneously meet accreditation standards which may drain time and resources away from the most effective ways of improving outcomes.

2. **Educating practices about the need for training in process improvement techniques and providing initial coaching assistance in implementing those techniques.** Although the guides to specific programs and interventions can help to get physician practices off to a quick start, the practices need to develop capabilities in continuous quality improvement processes in order to ensure the programs actually achieve the desired outcomes and to expand beyond the initial programs. For example, the Perfecting Patient CareSM program developed by the Pittsburgh Regional Health Initiativeⁱⁱ has successfully trained physicians, nurses, and other healthcare providers in the skills needed to do this. Physician practices need to be made aware of this kind of training, and they need assistance in finding the most appropriate training. Since many vendors offer process improvement training, it would be beneficial for physicians to have a guide to the types of services that will be most helpful in evaluating a vendor’s capabilities, and the likely cost of services. It could also be helpful to create a mechanism for physician practices to rate their experiences with vendors in order to help other practices in making the best choices. Practices serving low-income populations may need financial assistance in obtaining high-quality training and coaching services.

3. **Helping physician practices identify and use systems for identifying high-risk/high-utilization patients and monitoring their care.** In addition to their current skills in treating *individual* patients, it will be critical for physician practices to develop skills in the management of *populations* of patients. This could be facilitated through two types of information technology-based tools:
 - Predictive modeling to identify the patients most at risk of hospitalization, ER visits, and other high-cost services and therefore most appropriate for intensive care management services; and
 - Patient registry systems to track populations of patients and proactively intervene when appropriate treatments are not being delivered or milestones are not being met. Use of these tools can be facilitated if physicians have Electronic Health Records (EHRs), but having EHRs does not automatically mean that the physician will have predictive modeling or registry tools or know how to use them, nor is an EHR essential to utilizing such tools. Physician practices will need to be educated about the need for these tools, which options are available, and how to implement and use them. There may also be a need to encourage the development of new versions of these tools that are more cost-effective for small physician practices than those designed for health plans or large group practices.
4. **Providing physician practices with tools for analyzing the business case for interventions.** Financial success under more global payment models will depend on a physician practice's ability to design and implement interventions for which the cost is less than the resulting savings. For example, although nurse care managers providing patient education and self-management support can reduce preventable admissions and emergency room visits among patients, hiring nurse care managers to do this is only financially viable if the savings generated by the reduced admissions and ER visits is sufficient to cover the cost of the care managers. Most physician practices will not have the skill, experience, or tools to make these kinds of return-on-investment (ROI) calculations. User-friendly "ROI Calculators" could help both payers and healthcare providers define programs with financially viable and operationally feasible combinations of costs and outcomes.

B. Providing Real-Time Data on Outcomes and Processes

The Issue

The well-known management bromide "you can't manage what you can't measure" applies as well to healthcare as any other industry. Indeed, to a significant extent, many of the quality and cost problems in healthcare today exist because healthcare providers do not have access to the kinds of information that will tell them whether or not problems exist, if the problems are improving or worsening, or even if the solutions are being implemented as intended.

Although significant improvements in healthcare process and outcome measurement have been made in the past two decades, in most cases, the measures are only available many

months or even years after the events being measured have actually occurred. For example, it has taken 18-24 months for the 10 physician practices participating in the Medicare Physician Group Practice Demonstration to get feedback on whether the cost of care for their patients has increased, decreased, or remained the same. It does little good for a physician practice or hospital that implemented redesigned care processes *last month* to get measures on how its processes functioned *last year*; it needs to know *this* month how it did last month so that it can make any necessary adjustments and continue to improve.

Moreover, episode-of-care payment and comprehensive care payment systems require healthcare providers to manage not just the services they themselves deliver, but also the utilization and cost of services delivered by other providers. For example, most primary care physicians do not know whether their patients have visited emergency rooms and they frequently do not know that their patients have been hospitalized until after discharge, if at all.

Potential Ways to Address the Issue

To a significant extent, the reason for the long delays in getting performance data is that most measurement systems are based on claims data, and it typically takes many months for claims to be coded, submitted, processed by payers, cleaned and combined for measurement purposes, and made available to providers. Electronic Health Record (EHR) systems have the potential for making a broader array of data available more quickly; however, these systems are primarily designed for patient-by-patient information storage and retrieval, and many of them do a poor job of analyzing performance across multiple patients in ways that can help providers identify where quality problems exist and where process breakdowns are occurring.

Moreover, an EHR will only contain information about the services delivered by the providers who use that particular EHR; information about services delivered by other providers will only be available if they have a compatible EHR and a mechanism for sharing data between the two. Health Information Exchanges (HIEs) and Regional Health Information Organizations (RHIOs) can provide a mechanism for obtaining information on the full range of providers and services involved in patient care, but most of these systems are also primarily designed to provide real-time information about individual patients, not to assemble and analyze information across multiple patients.

Consequently, in addition to the resources currently being devoted to implementing EHRs and HIEs that improve provider access to patient-specific information, increased federal and state attention is needed to ensuring these systems provide the kinds of practice-wide, analytical information needed for quality and efficiency improvement by healthcare providers.

C. Creating Integration Without Consolidation

The Issue

Managing episode-of-care and comprehensive care payments successfully requires much greater coordination of care among primary care physicians, specialists, hospitals, and other healthcare providers than typically occurs today. This greater clinical integration is clearly highly desirable, and encouraging it is one of the major benefits of new payment methods.

The importance of this clinical integration, as well as the need for mechanisms to divide bundled payments among multiple practitioners, has led to a presumption by many that only vertically-integrated health systems will be able to successfully manage such payments. This has been reinforced by the fact that a few large integrated delivery systems, such as the Geisinger Health System, Intermountain Healthcare, and the Mayo Clinic have been repeatedly held up as models for the nation.

However, there are other large health systems that are not cited as models for either quality or efficiency or both. Although they have achieved *corporate* integration, many have done little to actually achieve meaningful *clinical* integration. In some cases, their size and integration have been used more as a way of controlling market share and increasing prices rather than reducing costs and improving quality. There is a serious risk that encouraging and supporting the development of more large, vertically-integrated systems will simply result in higher prices for care.

At the same time, there are providers in various parts of the country which have been able to significantly improve clinical integration while remaining organizationally independent. These providers may represent better models for the majority of the country than large integrated delivery systems. However, there is little awareness of their existence or understanding of their methods, nor has there been any systematic evaluation of their effectiveness.

Potential Ways to Address the Issue

Several things could be done to encourage models that promote clinical integration without monopolization:

- **Identify and Increase Awareness of Virtually Integrated Models.** A proactive effort is needed to identify physician practices, particularly small physician practices, which successfully manage capitation payments and other risk-based payment methods, and to help other physician practices understand the methods by which the model practices are paid and the processes they use to manage payments and coordinate care. As wide a range of structures and payment methods as possible should be identified and documented, so that physicians can study models that are as “close” as possible to the existing structures of payers and providers in their own community.

- **Evaluate Different Models.** Merely documenting the existence of different models will be helpful in encouraging broader thinking about how to improve clinical integration and manage global payments outside of vertically integrated systems, but it would clearly also be desirable to have a better understanding of how different “virtually integrated” models compare in terms of cost and quality outcomes, including comparisons to formally integrated structures.
- **Create a Toolbox of Methods for Clinical Integration.** Although knowing that a virtually integrated provider organization can successfully manage global or episode payments could help encourage a broader range of providers to consider accepting such payments, it does not directly give them the ability to do so. Rather than forcing providers to try and “reverse engineer” what successful virtually-integrated providers do, it would be extremely helpful to have a toolbox of some of the key building blocks that could be used, such as:
 - Sample contracts with specialists and hospitals that support coordinated care;
 - Systems for exchanging information between providers involved in a patient’s care, both electronic and non-electronic;
 - Methods for sharing resources, such as nurse care managers, across multiple providers;
 - Methods of compensating individual physicians and other healthcare practitioners; and
 - Methods of dividing payments among providers involved in a patient’s care.

D. Helping Hospitals Downsize Overcapacity Services

The Issue

Approximately 40% of the growth in total healthcare spending in recent years has been due to growth in hospital spending, and hospital care has been the second fastest growing component of healthcare services. One study found that spending on hospitals was the biggest reason that healthcare costs in the U.S. are higher than in other countries. Consequently, it will be virtually impossible to make a significant impact on total healthcare costs without finding ways to significantly reduce hospital admissions and the cost of hospital stays.

However, this will run directly counter to the goals, incentives, and community desires that have existed for decades; for example:

- Communities take pride in having large hospitals with a full array of services using the latest technologies.
- Hospitals are the largest employers in many communities and one of the only sources of job growth during the recession.

- Most hospital executives are trained and rewarded to focus on growth and expansion.

As a result, neither community attitudes nor hospital management skills will be aligned with what has to happen in the future for success.

Potential Ways to Address the Issue

Hospitals could be encouraged to begin pursuing rightsizing goals, and community leaders could be made aware of the desirability and feasibility of doing so, if there were programs to recognize and reward the hospitals that significantly reduce their utilization and costs. In addition, more hospitals might pursue such goals if assistance were available to help them develop and implement a strategic plan for restructuring their operations to respond to fewer admissions of chronic disease patients and reductions of high-utilization services. Assistance could include:

- Analyzing admission rates and simulating the effects of reductions in overutilization in the community;
- Using intensive Lean-type analyses to restructure hospital operations to respond to lower utilization;
- Developing new cost-based prices to serve as a basis for renegotiating payment rates with payers that support a different case mix and cost structure;
- Developing and implementing a human resources transition plan, a capital refinancing plan, etc. in order to create an acceptable “glide path” through a challenging restructuring process.

As elected officials and community leaders (particularly those who serve on hospital boards) see more examples of hospitals delivering high-quality care in a more efficient way, they can help promote a different vision of the future. Most civic leaders have not experienced hospitals in any community other than their own, and they will have become accustomed to measuring success and progress based on metrics of size, growth, and local market share. Seeing examples of high-value hospitals in other communities will help convince them that equivalent or better quality can be delivered at lower cost in their own communities, and that doing so is worth the short-term disruption that will occur.

V. Setting Payment Levels

Although there has been considerable attention to how to change the *method* of payment for providers, there has been relatively little attention directed to how to set an appropriate payment *level*, i.e., determining the price of care. Even if the payment method provides the right incentives, if the payment level is too low (i.e., below the minimum feasible cost of delivering care), providers will be unable to provide quality care, and if the payment level is too high, there will be no incentive for efficiency.

The Challenge of Price-Setting

As is well known, the market mechanisms used for price-setting in other industries do not exist or function effectively in healthcare. In most health insurance benefit designs, consumers pay only a small fraction of the total price of services, and in most cases, no one knows the total price of an episode of care until after it is actually delivered. Consumers have neither the necessary information nor a financial incentive to choose higher-value providers or services, and as a result, providers have little incentive to reduce their costs in order to charge lower prices. Consequently, many prices bear little relationship to the true or achievable costs of delivering services.

Episode-of-Care Payment and Comprehensive Care Payment systems will make it easier to compare prices across services and providers, and those payment systems could foster greater competition if implemented in conjunction with benefit designs that encourage consumers to choose higher-value providers and services. However, before this can happen, the payment levels/prices for services under these new systems need to be established, and this is not a simple thing to do. For example:

- Combining hospital payments and physician payments into a single, bundled episode-of-care payment for a hospital stay requires determining the “right” amount of both hospital and physician services. This is easier to do for surgeries (since the surgeon already receives a case rate and the hospital is paid by Medicare and many other payers under a diagnosis-related group (DRG)-based system) than for medical admissions (where there may be significant variation in the number of physicians involved and the amount of time they spend, even for patients in a single hospital DRG).
- Defining a comprehensive care payment for managing patients with a chronic disease requires estimating the lowest achievable rate of hospitalizations for those patients. Because hospitalizations are so expensive relative to primary care and even ambulatory specialty care, setting a price based on an underestimated rate of hospitalizations means that there may not be enough money to cover all of the services the patient needs.
- Under both episode-of-care payment and comprehensive care payment systems, different prices will need to be established for patients with different combinations

of conditions and different condition severity. Although a number of condition and severity adjustment systems exist, they have not been widely used for actual payment systems, and if they do not accurately identify differences in patient needs, they may lead to mispricing of services, particularly in the early stages of payment reform.

Last but not least, these types of “bundled” payment systems will not eliminate the need to have accurate prices for individual providers and services. As long as there are separately incorporated providers involved in the delivery of care, some mechanism of dividing up the episode or comprehensive care payment among them will be needed, and that will require prices (or the equivalent of prices) for each of the providers’ individual contributions.

The Need for Data to Set Prices

The starting point in setting prices under new payment models is having complete, current data on utilization and costs of services. Setting a price for an episode of care requires knowing which services are currently being delivered by which providers during such episodes, and gaining support for the episode price from the participating providers requires showing them how their share of the bundled payment is going to compare to the payments they currently receive. Defining episode-of-care payments also requires knowing the frequency with which adverse events (such as infections, complications, readmissions, etc.) occur, and defining comprehensive care payments requires knowing the rate at which patients receive services from providers which are not part of the organization that will be managing the payment (i.e., “out-of-network” providers).

The issues in accessing outcomes and process data described earlier (Section IV-B) are also relevant to pricing. Current data on utilization and costs are needed not only to set initial prices, but to monitor whether prices are tracking actual costs so that they can be adjusted before significant financial problems arise. Consequently, the strategies outlined for improving access to current outcomes and process data described earlier will also be important for accurate and sustainable pricing of care. In addition to data on which services are provided, information on the costs and/or prices of those services will also be needed. This will require linkages to information in healthcare claims data that may not be available in patient health records.

Other Problems in Setting Prices

Because of the undesirable incentives in current payment systems, a number of additional pricing problems are likely to arise in transitioning to more value-driven payment systems. In particular:

- It is widely recognized that current prices for many individual services differ significantly from the costs of delivering those services. This means that prices will need to increase for those services which are currently priced below achievable levels of cost if the sources of cross-subsidy are reduced or eliminated. Providers that deliver both over-priced and under-priced services (particularly those which use the former to subsidize the latter) will understandably resist reductions in

overpriced services without assurance that underpriced services will be paid for at appropriately higher rates.

- Prices may need to increase for services where utilization is decreased, since fixed costs will now have to be spread over a smaller volume of services. This will be an issue particularly for providers like hospitals with high levels of fixed costs that have long amortization periods (e.g., facilities and major equipment).
- Providers which hold monopoly service delivery positions in a particular community will be able to define prices and increase prices in ways that could disadvantage other providers included in a bundled episode or comprehensive care payment.

It seems likely that these types of problems will most often be associated with hospital-based care. Although all of the above issues can involve any provider, the biggest costs and the place where the most dramatic changes in utilization will need to occur in the future reside with hospitals. The following subsections describe several specific types of issues associated with the pricing of hospital services and of comprehensive care payments that cover hospitalizations.

A. Determining the True Costs of Hospital Services

The Issue

There is very little understanding today of the true costs of hospital services. Under the Medicare Inpatient Prospective Payment System (i.e., DRGs), hospitals receive the amount dictated by Medicare's pricing formulas regardless of the actual cost of care, and many commercial payers negotiate payment levels with hospitals based on a "percent of Medicare" rather than attempting to negotiate individual service prices based on actual costs. Although hospitals maintain detailed lists of charges for individual services, these charges are generally established based on factors that have little to do with the actual cost of services, such as making an annual inflationary adjustment to all charges, or increasing those charges which are paid disproportionately by the uninsured or by payers who negotiate payment based on a discount from charges.

There is evidence that the prices paid by Medicare for some types of hospital services (and thus, by extension, the prices paid by many other payers) differ significantly from the actual cost of services, and more importantly, that the ratio of prices-to-costs varies dramatically across different service categories. Most notably, the controversy over specialty hospitals has been driven less by disputes about the quality of care they provide than the fact that the specialty hospitals will take high-margin services (i.e., services where prices significantly exceed costs) such as cardiac surgery and orthopedic surgery away from general hospitals. This leaves the general hospitals to continue providing services that have low or negative margins (i.e., those where prices are less than costs) with fewer sources of cross-subsidy.

Clearly, the prices of services need to be better aligned with the true costs of delivering those services. To do that, however, requires an understanding of what those costs are. Today, most estimates of the “cost” of individual services are based on applying an overall average cost-to-charge ratio calculated at the hospital level to the charges for individual services. However, since the charges themselves were not set based on costs, this leads to a highly distorted picture of the costs of individual services. Indeed, hospitals have a strong incentive to maintain high charges for services that receive high payments, since otherwise there would be pressure to cut payments for those services, with no complementary willingness by payers to increase the payments for the under-priced services.

Moreover, the cost of a hospital service depends on how often it is being provided and what other services are also being provided, since the hospital has significant fixed costs that are shared by many individual service lines. For example, the cost of an individual MRI scan will depend on the total number of MRI scans done, since most of the cost of the MRI equipment is a fixed cost. As a result, it is likely that the cost of individual services will increase as volume decreases, since necessary fixed costs will have to be spread over a smaller volume. (This is simply the reverse of the widely understood and accepted phenomenon in other industries where expansion of production lowers unit costs.) If a hospital raises prices following a reduction in utilization, it will be important to distinguish whether that is a legitimate recalculation of the average cost of care in response to the lower levels of utilization, or merely a monopolistic effort to replace lost revenue.

A particular area of concern will be services that are viewed as essential to have available in a community, regardless of the level of utilization. Hospitals assert that the payments for services such as ERs and burn units do not cover their costs and so those services must be subsidized by other services such as cardiac surgery. Consequently, if a community wants to maintain essential, standby hospital services, it will need to determine how much they cost and how to pay for them.

Potential Ways to Address the Issue

Detailed cost-accounting analyses of specific types of services across multiple providers in various markets are needed to show how narrow or wide the range of costs is today and the factors affecting that, particularly the extent to which costs are affected by the volume of services provided and by external factors such as cost-of-living differences across regions. Hospitals with good cost-accounting systems likely have the relevant data; it is a matter of having them release the data for research purposes as well as the cost-accounting methodology they use. Hospitals will likely be more willing to do this if (a) enough hospitals are participating so that no individual hospital’s costs would become publicly known and lead to external pressures to reduce prices for certain services, (b) there is no financial disincentive to do so (e.g., if funding were available to cover the costs the hospital would incur in releasing the data, recomputing costs according to standardized methodologies, etc.), (c) the hospital will receive information back that could help it identify opportunities for cost reduction (e.g., through analyses showing where its costs appear to be unusually high compared to peers), (d) the hospital will receive support in obtaining higher payments for under-funded services and for services where utilization is

going to be reduced, and (e) the hospital's board and payers are educated about the value of participating in the research. Once a minimum critical mass of participating hospitals is obtained and the value of the work is demonstrated, it will hopefully be much easier to recruit additional participants.

At a minimum, this process would be equivalent to what is done today in blinded quality measurement and reporting processes, where data is collected from multiple providers in a common format or in formats that can be made equivalent, statistical measures of distribution are developed, and individual providers are shown how their own performance ranks on those measures. This could be done at either at the national level, playing a role for hospital costs similar to what the Dartmouth Atlas has done for service utilization among Medicare patients, and/or at a community or regional level, enabling an interested region to restructure services, costs, and payment levels among the hospitals in that area.

However, ideally, the work would proceed to a second and even more powerful level, namely, building a simulation model of hospital costs. Both hospital administrators and policy-makers need analytic tools to simulate the financial effects of various changes in variables such as pricing and utilization. For example, if a hospital were to be paid more for critical standby services (e.g., the burn unit) and less for overutilized services (e.g., cardiac bypass surgery), what changes in prices for different services would be needed to keep the hospital financially viable, where could costs be reduced to ensure that price increases were truly matching minimum achievable costs and not subsidizing inefficiencies, and how would the price changes affect total spending by individual payers? If two or more hospitals were to reconfigure their services to allow each hospital to concentrate on areas of excellence, how would costs change, how would prices need to change, and how would individual payers be affected? This policy simulation capability does not exist today in most hospitals, much less in the policy realm, and creating it would help to advance delivery system reforms and lower costs.

B. Controlling Monopoly Pricing and Anti-Competitive Practices

The Issue

In most healthcare markets, at least some services are delivered either by a single provider or by a provider that so dominates the market that it functions effectively as a monopoly. For example:

- In rural areas, there may be a single hospital within easy driving distance of the people living in those areas;
- In urban areas, there may be only one tertiary or quaternary care hospital that delivers certain advanced services such as transplants;

- In many areas, there may be a single or dominant hospital offering common services such as obstetrics, or a single children’s hospital specializing in pediatric care; and
- In many areas, there may be a single or dominant specialty physician group providing particular types of services.

In some cases, these situations arise because the market is not large enough to support multiple providers; in other cases, the providers may have intentionally consolidated to gain negotiating power. Regardless of the reason, however, the result can be monopoly pricing behavior, including charging far more than the actual costs of services, or maintaining high costs (and charging for them) even if costs can be reduced.

This could be a growing problem if efforts to reduce utilization of the services of these providers are successful. For example, if primary care physicians in the community are successful in reducing the rate at which chronic disease patients are hospitalized for exacerbations, the hospital in the community will lose admissions and revenue. Ideally, the hospital would seek to reduce its costs in response, but if it has the ability to do so, it will be far easier for it to simply raise its prices by an amount sufficient to offset the loss of revenue. To the extent that there are payers such as Medicare which cannot or will not pay higher prices, a monopoly provider could simply increase the prices disproportionately for the remaining payers (i.e., cost-shifting).

As noted earlier, there is a serious risk that efforts to encourage the development of ACOs will worsen the monopolization of healthcare delivery. Not only will vertically-integrated provider organizations find it easier to manage global payments, but many policy discussions have been leaning towards giving preference to such organizations in participating in global payment models. Unless special efforts are made to avoid it, this could accelerate the consolidation of providers in many markets, reducing the level of competition.

But, as was noted earlier, just because a hospital or other provider raises prices following a reduction in utilization does not mean that it is behaving inappropriately; in many cases, the prices of individual services will have to increase as volume decreases, since necessary fixed costs will have to be spread over a smaller volume of services. Consequently, the types of cost analyses suggested in the previous section will be helpful in determining if and when monopoly pricing behavior is actually occurring.

It may be that the only solution in certain markets and/or for certain services is to institute some form of price regulation for services where competition does not exist. At one time, many states had some form of all-payer price regulation for hospitals, and the State of Maryland still has such a system today. Even a credible threat of price regulation could prompt voluntary action by providers to reduce costs in order to avoid regulation, as demonstrated by the “Voluntary Effort” of the late 1970s. But the Voluntary Effort also demonstrated the inherently temporary nature of voluntary action if the prospect of regulation does not remain a continuous threat. The leaders of some large integrated systems have admitted that some type of price regulation might be appropriate given their

inherent inability to limit prices themselves, and some smaller systems have suggested that price regulation might result in more reasonable prices than they can negotiate with large payers.

There is a very clear parallel between the essential nature of hospital services to a community and the essential nature of electricity transmission and telephone services that have consistently been subject to public utility regulation in communities across the country. However, there is less of a parallel between the fixed community-wide infrastructure needed for power transmission that makes it a natural monopoly and the more flexible infrastructure needed for many types of hospital care. Moreover, the successful deregulation that occurred in the transportation industry demonstrates that competition can be better than regulation for services that are not natural monopolies. Determining how best to reconcile these competing analogies and learn from the experience of past hospital regulation efforts should become a higher priority for policy analysis than it has been recently.

Of course, higher prices are not the only way in which large providers can exercise their monopoly power. More insidious is refusal to contract. Rather than charging extremely high prices for a subset of essential services with no viable competitor, a monopoly hospital or other provider can simply refuse to provide those services at all unless a payer agrees to use *all* of the provider's services, including those where competitors exist, and unless the payer agrees to pay higher prices for all services than would be obtainable from competitors. For example, in some regions, large providers have contracts with payers forbidding the payers from implementing tiering structures that would encourage patients to use lower-cost systems or services. Solutions to this may require broader types of provider regulation or legislative action to prohibit such behaviors by charitable healthcare organizations.

Potential Ways to Address the Issue

Developing a better understanding of the achievable costs of hospital care would help by determining whether a monopoly hospital is over-pricing its services, and by providing the evidence to mobilize community pressure on the hospital to change.

Even where persistent over-pricing exists, it will never be possible to make a definitive conclusion as to whether or how price regulation in healthcare should be done. Debates over the appropriate nature of regulation in other industries have been ongoing for decades, and the nation has periodically cycled between "regulation" and "deregulation" in various industries, with both benefits and costs at each point in the cycle. However, these debates and cycles of regulation and deregulation have created an important body of knowledge and experience about the advantages and disadvantages of doing so in those other industries which is absent today from healthcare. Moreover, there is historical experience with price regulation in healthcare that needs to be re-examined.

Research and policy analysis is therefore needed in three specific areas:

1. Resurrecting the research and lessons from the state hospital price regulation programs of the 1980s and translating them into today's context;
2. Synthesizing the research and lessons from regulation in other industries and translating it into the context of healthcare;
3. Identifying and describing multiple policy levers which could be used to counteract monopoly behavior besides price regulation, such as limitations or obligations for non-profit hospitals in order to maintain 501(c)(3) status, restrictions on use of public funds or tax-exempt financing for services or facilities, additional requirements for accreditation or Medicare participation, etc.

C. Paying for Medical Education

The Issue

In most communities, the costs of graduate medical education at teaching hospitals are currently “bundled” into the prices charged for individual hospital services or episodes of hospital care. Medicare does this explicitly by computing a specific adjustment to its DRG payments to cover the costs of graduate medical education. Other payers do it implicitly either by basing payment on Medicare rates or on a percentage of the hospital's charges (which have the teaching costs bundled in).

This approach creates two problems:

1. To the extent that new payment models or benefit designs give incentives to either physicians or patients to use lower-cost providers, the higher price of a teaching hospital could put it at a serious disadvantage in attracting and retaining patients versus other hospitals that do not have the extra costs of teaching.
2. If the number of hospital admissions decreases at a teaching hospital (due to improved chronic disease management, reduction in overutilized procedures, etc.), there will be less revenue to cover the costs of medical education; spreading those costs over a smaller number of admissions will increase the price of each admission, exacerbating the first problem.

In addition, this problem will be felt disproportionately in regions with academic medical centers. Employers located in these regions already experience a competitive disadvantage by paying more on average for hospital care than employers located in regions without such centers. This is particularly true for regions with a concentration of such centers, even if the academic medical centers in those regions have lower costs than the academic medical centers in other regions.

Similar issues exist for medical research; it is likely that the costs of academic medical centers are higher because of efforts to foster medical research as well as teaching, and there will be natural concern about whether pricing changes or efforts to encourage competition will undermine hard-fought efforts to build cutting-edge capacity in research

and the potential economic development benefits that may generate for a particular community and for the nation as a whole.

Potential Ways to Address the Issue

A combination of research and policy analysis will be needed to help develop solutions to this problem. This could include at least three different types of work:

1. **Determination of the “true” costs of medical education.** This could be an extension of the cost accounting analyses proposed earlier, or an analysis focused just on the costs of teaching.
2. **Case studies of methods used in other states and countries to finance medical education.** For example, Minnesota has a statewide system for financing medical education that might be replicated in other states or at the national level.
3. **Analyses of alternative mechanisms of financing medical education.** The advantages and disadvantages of different approaches should be analyzed, both based on evaluations of models which already exist and on assessments of new concepts which may not have been tried. For example, if a community-wide financing mechanism is to be created, should it be a surcharge on healthcare expenses or insurance premiums, a more general tax, or some other method?

VI. Improving Severity/Risk Adjustment Systems

The Issue

Assuming the prices paid are appropriate, one major advantage of a fee-for-service payment system is that it does not penalize a healthcare provider for delivering more care to a patient who needs it. However, one of the major disadvantages of fee-for-service payment is that it rewards a provider for delivering more care to a patient who does *not* need it. To be successful, new payment methods need to preserve the first feature of fee-for-service payment while eliminating the second. This requires that the amount of the payment be adjusted based on the types of conditions, severity of conditions, and other characteristics of the patients being cared for, so that the provider is not forced to take on insurance risk.

Although current severity/risk-adjustment mechanisms are not perfect, they are much better than in the past, and they will likely improve more rapidly if they are used more broadly in payment systems. However, there are some specific issues that need to be addressed:

- **Lack of transparency in methodology.** Some severity/risk-adjustment methodologies have been developed by commercial firms and the methodology is proprietary, meaning they are a “black box” to providers. The only way to know if the methodology “works” is to test it or compare it to other methodologies, and this will be difficult for small payers and providers to do and inefficient for everyone to do independently.
- **Potential for gaming.** A downside of a transparent methodology is that it can encourage providers to change patient care or the characterization of a patient’s condition in ways that increase the severity rating assigned to the patient and thereby the amount of payment. For example, many severity adjustment systems use information on the prescription drugs a patient is taking to infer things about the conditions the patient has, but this could create incentives for physicians to prescribe drugs unnecessarily in order to justify higher payments.
- **Inconsistency in methodologies used by multiple payers.** Even if different payers are ostensibly using the same payment method, if the severity/risk adjustment systems are different, providers may be forced to spend more time assembling the data needed to support the different systems and verifying the patient classifications the systems generate, rather than actually improving the quality and efficiency of care they are delivering.
- **Lack of recognition for changes over time while under the provider’s care.** An effective severity/risk-adjustment system is intended to ensure that a provider is not penalized for taking on sicker patients who need more care, so the systems assign patients who are sicker to higher-severity/risk categories than patients who

are healthy. However, a key goal of healthcare payment reform is not only to compensate providers appropriately for high quality, efficient care, but also to reward them for *improving* patients' conditions, and by extension, to penalize them for allowing patients' conditions to deteriorate. Current severity/risk-adjustment systems do not support this goal effectively because they are not designed to measure *changes* in patients' conditions over time. For example, if a provider takes on a new patient who is obese, the provider should be paid more than for a new patient who is not obese, since the obese patient will likely have more health problems. But if the provider successfully helps the obese patient to lose weight, it would be inappropriate to penalize the provider by reducing the payment to the same level as for the patient who was not obese to begin with. Conversely, if a provider fails to prevent a patient with high cholesterol from developing heart disease, the provider should presumably not be rewarded with the same payment as for a patient who joins the practice after already having developed heart disease.

Potential Ways to Address the Issue

The importance of having effective severity/risk-adjustment systems, and the inefficiencies associated with attempting to independently assess the different systems by a large number of payers and providers, points to the desirability of having a central clearinghouse for disseminating information on alternative severity/risk adjustment systems, conducting evaluations of their capabilities, and sponsoring research and development on appropriate enhancements to methodologies. This would, in effect, be a combination of Consumer Reports and Underwriters Laboratory, certifying that systems meet basic standards and comparing their performance in areas where standards cannot yet be set. Although the operating costs of such a clearinghouse should ultimately be supported by payers and providers, seed funding may be needed to get it under way.

VII. Expanding Measurement and Reporting

Over the past two decades, there has been dramatic improvement in the ability of communities, states, and the federal government to measure and publicly report on the quality of healthcare services. This has not only helped to improve the quality of healthcare, but to demonstrate the need for payment reform.

Although current efforts at quality measurement and reporting should continue, efforts to implement new payment models suggest two areas where new or enhanced measurement and reporting efforts would be helpful. These are discussed in the following subsections.

A. Measuring Progress Toward Payment Reform

The Issue

If payment reform happens, it will need to happen in hundreds of individual regions around the country through payment arrangements between thousands of payers and providers. As with quality measurement, how will the country know whether progress is being made unless there is a way to measure whether new payment methods are being used? And as with quality reporting, it is likely that data showing other regions or other stakeholders within regions making more progress on payment reform will help to encourage laggards to accelerate their progress. Purchasers of healthcare who want to support payment reform could give preference to payers and health insurance products which use value-based payment methods if there were “payment system scorecards” that effectively measured and compared the use of improved payment methods.

As with any kind of measurement, there are challenges in measuring progress on payment reform. How does one compare the significance of simply bundling hospital and physician payment together for inpatient episodes versus creating a full-episode payment covering post-acute care and readmissions? How does one compare partial global payments versus full global payments? How does one compare incremental payment reforms applied to large numbers of patients versus more dramatic payment reforms applied to smaller groups of patients? As different payers and different regions embark on payment reform, it will be increasingly desirable to have a systematic taxonomy and scale that can be used to compare the different variations and approaches.

A complementary approach would be to measure the extent to which provider organizations in a particular region are becoming “accountable care organizations” i.e., accepting accountability for the cost and quality of care they deliver. Rather than focusing solely on payers, this approach could help to create pressure on providers to support and participate in more value-based payment models.

Potential Ways to Address the Issue

As with any measurement and reporting system, there would be two distinct sets of tasks that would need to be performed to create a system for measuring the implementation of payment systems and the development of ACOs. The first would be developing the methodology for the measures. The second would be collecting the information, analyzing it, and producing publishable results. The second task could be piggy-backed on existing measurement and reporting systems for health plans and providers, such as the eValue8 system used by many regional purchasing coalitions and the physician practice scorecards produced by many regional health improvement collaboratives, but this could only be done if a feasible measurement methodology existed. Government and foundation support for the research and consensus-building around the measurement methodology could be an effective catalyst.

B. Creating Quality Measurements for Bundled Payments

The Issue

In theory, the greater the responsibility a payment system gives a provider for managing the overall costs of care, the greater the incentive the provider has to inappropriately skimp on services. Existing quality measurement and reporting efforts will help to counteract tendencies toward skimping on care; however, depending on how they are implemented, more global payment models also provide the opportunity for simplifying billing and claims payment systems, which could eliminate some of the claims data that are currently used to create quality measures or further reduce the reliability of the claims data that are submitted. Consequently, there may be new tensions between a stronger desire for quality measurement and reporting than has existed in the past (to ensure quality is maintained under episode payments and global payments) and a desire to reduce administrative costs by eliminating the systems that provide the data which support those quality measurement systems.

A well-designed episode-of-care payment system can actually create stronger incentives for providers to improve some aspects of quality than exist in a fee-for-service system. If a service is necessary for good outcomes within the episode of care, then the provider will be penalized for failure to deliver that service either through poorer outcomes, higher expenditures (to rectify the problems caused by the failure to provide the service), or both. In contrast, under fee-for-service payment, the provider may actually get paid *more* to correct problems than to prevent them from occurring. An example of this in practice can be seen at the Geisinger Health System, which developed its own comprehensive set of measures and standards for care to accompany its ProvenCare warranty, and it is pushing hard for perfection on those measures because it now has a clear financial incentive to do so, not because of any externally established reporting or P4P system.

In contrast, the strongest incentive for providers to skimp on services or quality may well be associated with preventive care – services which, if provided now, will reduce the likelihood of poor outcomes many years in the future. Because episode-of-care or

comprehensive care payments would not ordinarily cover periods beyond a year, and because many patients may have changed providers or payers or both before the implications of undertreatment are manifested, the failure of providers to deliver preventive care services will likely affect future time periods or even different providers. For example, under fee-for-service, a physician is paid more for providing preventive services to diabetes patients that reduce the chances of complications in the distant future, but under a year-long episode or comprehensive care payment system, the payment could be the same whether those services are provided or not, and the physician may no longer be caring for the patient when the complications from inadequate care appear.

Another area where quality problems may increase is with minority and disadvantaged patients. To the extent that these individuals need different types or amounts of care than is captured in severity/risk-adjustment systems, providers might refuse to care for them since the provider will no longer receive higher fees for the extra services delivered to these patients, exacerbating disparities in care.

An area of measurement and reporting that is relatively underdeveloped today and that will be even more important in the future is the consumer's experience of care. Ideally, quality measurement and reporting should focus primarily on outcomes, rather than process measures. But other than rare and severe outcomes such as mortality, many types of outcomes are difficult to measure directly or comprehensively. One approach to addressing this is to measure consumers' experience with outcomes, such as how much more mobility they report having after orthopedic surgery, how many more activities they report being able to perform with the treatment they've received for congestive heart failure or COPD, etc. A key challenge is not just defining the measures, but finding cost-effective ways to collect the data, since consumer experience cannot be directly derived from either claims data or EHRs.

Potential Ways to Address the Issue

There are two important areas where concentrated attention is needed to address issues with quality measurements for bundled payments:

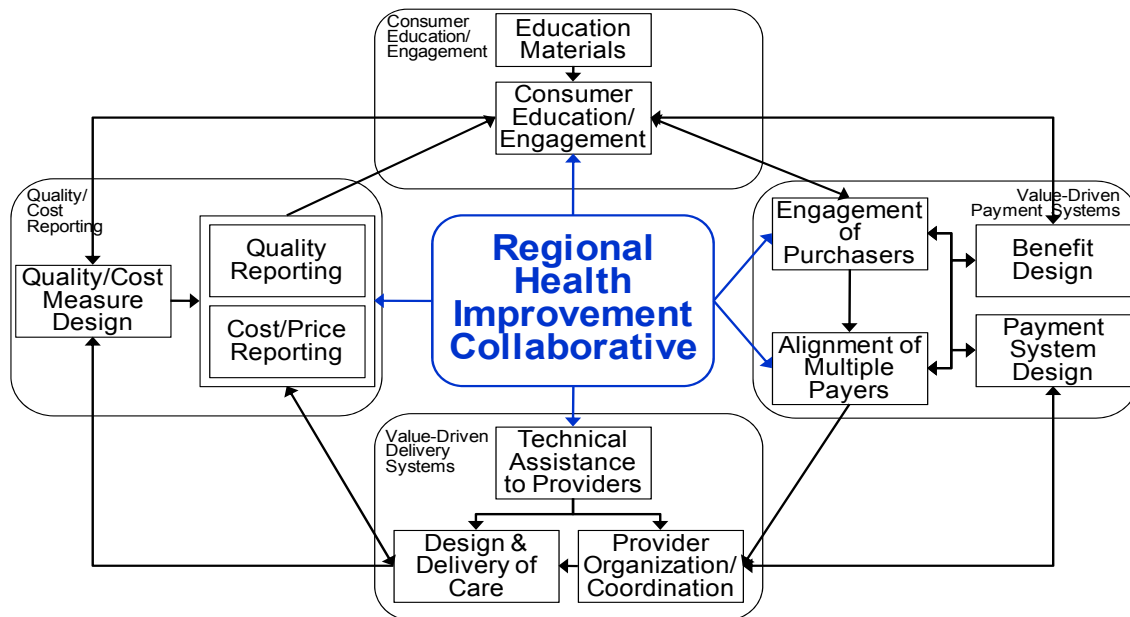
1. A careful re-examination of the quality measures that exist today and those currently under development with a goal of focusing efforts on the use of measures that (a) are associated with the kinds of quality problems least likely to be financially disincented by episode-of-care and comprehensive care payments, and (b) are least dependent on aspects of claims and billing systems that are not needed for bundled payments. This could include development of an explicit plan for the transition of measures over time as EHRs become more widely used and as it becomes possible to obtain an even richer array of quality data than are available through billing records, or even a plan for how complex billing systems can be reconfigured to focus on the features needed to support future payment and measurement systems.

2. Development of consumer experience-of-care measures that can be effectively used to measure important outcomes, and development of reliable yet affordable methods of collecting the necessary data. There may well be significant economies of scale in collecting some elements of these data nationally, rather than or in addition to doing so separately in each community, and the advantages and disadvantages of different methodologies need to be carefully assessed.

VIII. Supporting Regional Action and Coordination

The Issue

The implementation of payment and delivery system reforms, and the utilization of the solutions to the many issues identified earlier, will primarily occur at the regional level in individual communities and states. Each of the different elements identified earlier – consumer engagement, reorganization of providers, redesign of care processes, design and implementation of payment systems and benefit designs, quality and cost measurement and reporting – cannot be developed or implemented independently, nor can a single “one-size-fits-all” approach be developed at the national level that could be successfully implemented everywhere. All of the elements must “co-evolve” in a coordinated way in the unique context of the structure of payers, providers, purchasers, and state regulations in each market. Since there is no individual or organization “in charge” of healthcare in any region, much less the nation as a whole, an entity that provides the leadership, planning, and coordination of all of these elements can be of great benefit.



An ideal entity to play this role is a multi-stakeholder Regional Health Improvement Collaborative. These are non-profit organizations that bring together payers, providers, purchasers, and consumers to develop a common vision of how healthcare quality and value should be improved in a specific geographic region of the country (typically either a metropolitan region or state) and to help define paths to those outcomes that “share the pain” in an equitable way.

There are currently over 50 Regional Health Improvement Collaboratives in the countryⁱⁱⁱ. Most were formed within the past five years, but some have been in existence for 10-15

years or longer. There has been a dramatic growth in the number of Regional Health Improvement Collaboratives in the past five years, partly due to the rapidly growing concern about healthcare costs and quality across the country, and partly due to proactive efforts to foster the creation of such entities by the Robert Wood Johnson Foundation (RWJF) through the Aligning Forces for Quality program and the U.S. Department of Health and Human Services through the Chartered Value Exchange program.

Examples of the important functions that Collaboratives can play in facilitating the implementation and payment and delivery system reforms include:

- **Convening:** In addition to building community consensus on goals and an implementation strategy, Regional Health Improvement Collaboratives can serve as a neutral convener to help interested providers come together and explore the possibility of working together as an ACO, and they can help develop payment methods and supporting elements (e.g., severity/risk-adjustment methods) that all payers in the community can support.
- **Coaching:** Collaboratives can arrange for expert training and technical assistance for providers to help them reinvent their operations to achieve higher quality and lower cost.
- **Communication:** Regional Health Improvement Collaboratives can reach all of the key stakeholders in their community and can customize communications to make them understandable and useful for each stakeholder.
- **Information/Analysis:** In order to define outcome targets and strategies for reaching them, providers need information about the *current* costs and outcomes associated with their patients. Because only payers generally have this type of information, and because it is fragmented across multiple payers, it is difficult for any provider or group of providers to know how they are doing today and where improvements may be possible. Collaboratives can help to bridge this gap, since many already have assembled multi-payer databases and work with providers to issue reports on the quality of care.
- **Problem Resolution:** No matter how much effort is put into designing new payment systems and delivery system reforms, problems will arise. A Regional Health Improvement Collaborative that is supported by all stakeholders and perceived as neutral by them can provide a critical mediation mechanism for resolving such problems quickly and effectively.

The challenge for current and future Regional Health Improvement Collaboratives is finding the resources and talent to carry out these complex and challenging functions in what are inherently uncharted waters. Most Collaboratives are thinly staffed and tenuously funded; financial pressures increased during 2009 and will likely continue in 2010 because of the slow recovery from the national recession. A major source of funding for many Collaboratives to date has been contributions from health insurance plans, and the combination of the recession and healthcare reform pressures from PPACA will likely reduce the willingness of health plans to continue making contributions at the same level

as in the past. The Agency for Healthcare Research and Quality (AHRQ) provides technical assistance to Regional Health Improvement Collaboratives, but there is no federal financial support for them. Only one private foundation (RWJF, through its Aligning Forces for Quality initiative) has provided significant operating support for multiple Collaboratives. Ideally, a Collaborative should not be overly dependent on funding from any one local stakeholder lest it be perceived as biased toward that particular stakeholder's positions, or financially at risk if that stakeholder's financial support decreases significantly.

Potential Ways to Address the Issue

There are at least four specific types of support Regional Health Improvement Collaboratives need to be successful that federal, state, and local governments and private foundations could provide:

- **Funding and technical assistance to facilitate planning for payment and delivery reforms in communities.** Most of the states and regions that have made the most progress in developing and implementing payment and delivery reforms have gone through a process of community education and consensus-building about payment reform. Regional Health Improvement Collaboratives are ideal vehicles for organizing these processes in communities, but they need financial resources to do so, and they could benefit from technical assistance from Collaboratives in other communities that have already done so.
- **Funding and technical assistance to help carry out specific tasks related to payment reform.** A variety of time-intensive and technical tasks are needed to help a community design and implement specific payment and delivery reforms, ranging from analysis of utilization and cost data to helping healthcare providers change their processes of care.
- **Funding to support their core operations.** As noted above, most Collaboratives have limited budgets and struggle to find the resources necessary to sustain their operations. Their existing programs, such as quality measurement and reporting, and technical assistance to providers for quality improvement, provide a strong foundation for payment and delivery reforms in the community. Although providing funding support to Collaboratives specifically for payment reform initiatives is necessary, it is important to also assure that the financial foundation for each Collaborative's *current* programs is secure.
- **Funding and technical assistance to support the development of additional Regional Health Improvement Collaboratives.** Although the number of communities with Regional Health Improvement Collaboratives has increased significantly in the past several years, large portions of the country still do not have one or have a relatively young Collaborative that does not yet have the experience and capacity to take on a major effort such as supporting payment reform. Consequently, it might be useful to help all parts of the country create or strengthen their existing Regional Health Improvement Collaboratives so they can serve as primary vehicles for supporting and coordinating payment and delivery reforms.

IX. Overarching Strategies for Success

All of the issues and actions described above would help to encourage and facilitate the implementation of significant payment reforms and more importantly, the fundamental transformation of healthcare delivery toward higher quality and lower costs.

Three overarching strategies seem essential for success:

- 1. Raise Awareness of Healthcare Stakeholders, Policy-Makers, and Funders About the Key Issues in Implementing Payment and Delivery System Reforms.** The need for payment reform has only achieved widespread awareness recently, so most policymakers, funders, and healthcare stakeholders have little or no appreciation for the many implementation issues involved. These issues will not be addressed if people are not aware they exist, and significant payment and delivery reforms (both those planned for in PPACA and those developed in individual regions) may well fail if the issues are not addressed before implementation begins. Consequently, it will be desirable to raise awareness about these issues through policy papers, conferences, and public discussions about implementation challenges and how to address them. As more policymakers and civic leaders become aware of the issues involved in payment and delivery system reforms, and as a broader range of stakeholders call for action on those issues, it is more likely that they will be addressed.
- 2. Help Willing Purchasers, Payers, and Providers Design and Implement Changes.** What most stakeholders want and need is help in understanding the concepts and issues associated with payment reform, delivery system reform, and cost reduction, followed by step-by-step help in how to implement changes in their own context. It does little good for busy physicians, hospital administrators, health plan executives, corporate benefit managers, or public officials to be given long bibliographies of research studies or detailed policy papers on specific issues; they need the information synthesized in a practical way that they can understand and use. Modularized material will be more likely to be used, since it is more easily absorbed and customized to the unique needs of individual organizations and markets. Frequent revisions and web-based publication will allow materials to remain more current than would be possible using traditional printed formats or peer-reviewed journals. Finally, dissemination and technical assistance is as important as development of materials; implementation efforts are most likely to be effective if informational materials get directly into the hands of the individuals who need them most, such as those purchasers, payers, and providers who want to change. And if those individuals can get at least some assistance from the developers of the materials on how to tailor the information to their own local circumstances, the potential for change becomes that much greater.

- 3. Support Regional Health Improvement Collaboratives to Aid Implementation.**

No matter how good the tools and resources to support payment reform are, they will only be effective if they are used. Even if the tools are developed in ways that they can be customized to individual circumstances, someone with the knowledge and experience to do so has to provide the necessary tailoring and support to match the unique structures and needs of individual healthcare markets and the specific approaches to payment and delivery reform being used in a particular region. Consequently, support for Regional Health Improvement Collaboratives that can provide such technical assistance is a logical and likely essential means of promoting, coordinating, and supporting the detailed design and implementation of comprehensive approaches to payment and delivery system reforms, and of achieving maximum leverage from investments made in developing tools and materials to support it.

Endnotes

ⁱ For more information about value-based payment methods in health care, see *Better Ways to Pay for Health Care: A Primer on Healthcare Payment Reform*, Network for Regional Healthcare Improvement and Robert Wood Johnson Foundation, January 2009. (<http://www.nrhi.org/downloads/NRHI-PaymentReformPrimer.pdf>)

ⁱⁱ See www.PRHI.org for more information about Perfecting Patient CareSM.

ⁱⁱⁱ See www.NRHI.org for a list of Regional Health Improvement Collaboratives.