Robert Wood Johnson Foundation

Facilitators and Barriers to Payment Reform:
Market-based, governmental, organizational, and design considerations

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To learn more about the individual payment reform grantees referenced in this issue brief, along with other RWJF-supported payment reform activities, visit **RWJF's Payment Reform webpage**.

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Introduction

Fee-for-service, the predominant method of paying for health care in the United States, is an unsustainable payment approach that rewards volume, resulting in an increase in the number of health care services that are provided, regardless of the outcome of the service. Many believe this form of payment has contributed greatly to the ever-increasing costs of health care. Payment reform, which entails moving away from the fee-for-service system, is regarded as a promising strategy to lower the cost and improve the quality of the U.S. health care system. Payment reform is not an end itself, but rather a means to spark fundamental changes in health care delivery.

Payment reform efforts are underway across the United States. They vary in approach, scope, intensity—and the extent to which they result in a successful implementation of a new payment model. In some cases, payment reform progresses as a result of sustained commitment and a tenacity to overcome the many challenges that early adopters are facing. In other cases, the necessary variables for success are simply not in place and payment reform advances stall, sometimes to be reshaped as efforts to lay the groundwork for future payment reform. From market forces to the design of the payment innovation, many different factors can affect the likelihood of payment reform success. This issue brief draws upon the experience of Robert Wood Johnson Foundation (RWJF) payment reform grantees and other payment reform initiatives to identify the most common facilitators and barriers experienced by the grantees and others in the field. It is intended to inform providers, employers, and other parties interested in undertaking or supporting a payment reform effort.

To begin the process of identifying common facilitators and barriers to payment reform, we interviewed nine RWJF grantees that received financial support to implement payment reform within their communities. These projects were funded through two competitive calls for proposals, released in 2010 and 2011, that aimed to identify and support innovative payment models. The grantees were diverse, including, for example, quality improvement organizations, provider groups, and a state government body. In addition to the interviews, the authors drew upon their experiences with the RWJF *Aligning Forces for Quality* alliances, the experiences of other RWJF payment reform technical assistance providers, and the authors' independent work in payment reform.

RWJF supports several grants testing health care payment reforms, which are managed by AcademyHealth.

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The facilitators of and barriers to payment reform in this issue brief are organized into the following four categories.

1. **Market-based:** the composition and qualities of the marketplace, including qualities of key market participants (e.g., payer, provider, and purchaser);

2. **Governmental:** the role of the state as a convener of payment reform, a regulator of health care, and/or a purchaser of health care;

3. **Organizational:** the characteristics of the organization(s) leading or simply participating in the effort, including its internal structure and external influence; and

4. **Design:** the construction of the payment model itself, including its characteristics, relative complexity, and potential impact.

Common Payment Reform Facilitators and Barriers

Market-Based

Health care is truly local and the composition and qualities of providers, plans, and purchasers within any given market impact the ability of payment reform efforts to be successful. There are unique marketplace factors that affect the health care industry unlike other industries and that impact the willingness (or reticence) of providers and plans to change. In this section, we will address the general, provider, plan, and employer market characteristics that can be favorable and unfavorable to payment reform. The boldface text is color-coded to indicate whether the factor is a **facilitator**, a **barrier**, or could be **both**.

General market characteristics

The **existence of prior or simultaneous delivery and system payment reform efforts** in the marketplace can spur additional reform activity that extends beyond the initial participant. It's especially a facilitator when the reform builds upon existing infrastructure or lessons learned. A payer or provider may also feel a need to "keep up with the Joneses" when a competitor has moved towards payment reform. In addition, a plan or provider may see an opportunity to advance a reform based on an initiative begun by another party. One example may be found in Oregon where two RWJF grantees capitalized on the state's creation of Coordinated Care Organizations (CCOs) to serve its Medicaid program. CCOs are integrated provider organizations operating under performance-based global payment arrangements with the state. CCOs are required by contract to implement alternative payment models with their contracted providers. The two Oregon-based RWJF grantees have developed payment reform efforts that help the CCOs meet their payment reform obligations. Likewise, in 2011, the Minnesota Medicaid program introduced to providers the Health Care Delivery System Demonstration, a risk-based shared savings pilot, taking advantage of the fact that a significant number of commercial health plans had already introduced the same type of payment methodology with a largely common group of providers.

Highly competitive marketplaces without a dominant plan and/or provider are rarely leading payment reform efforts. In fiercely competitive marketplaces, plans and providers work very hard to keep or gain market share and often plans are focused on recruiting small accounts to get ahead. The health plans lack large member volumes with provider organizations, thus making payment reform challenging. This environment is not conducive for multi-payer, multi-provider collaboration. The type of market described can be observed in St. Louis and elsewhere where the commercial insurance market is split among many competitors, making payment reform efforts particularly challenging.

Lastly, markets where there is a **culture of collaboration and trust** between organizations have helped to facilitate payment reform. Existing collegial relationships and mutual respect between leaders and organizations help set the foundation for longer-term payment reform efforts. The states of Vermont and New Hampshire benefit from such cultures, where key stakeholders know one another and how to collaborate, and are willing to make compromises to achieve a shared goal. Likewise, in Oregon the competing health plans and providers have demonstrated an ability to work together to plan and implement delivery system and payment reform efforts. Unfortunately, this marketplace quality cannot be created through short-term action and must be built up over many years.

Provider market characteristics

The most influential provider market characteristic is the willingness of one or several **dominant provider(s) of significant size**, especially if the provider is an **integrated delivery system capable of assuming risk**, to participate in payment reform. If the dominant provider is leading the payment reform effort, it may be more likely to be committed to the clinical delivery reform that often goes hand-in-hand with payment reform. It may also have the necessary financial and administrative resources to accommodate the change in payment. In addition, dominant provider participation in payment reform efforts can also create the "keeping up with the Joneses" effect mentioned as a general market facilitator. A number of the provider organizations that became Pioneer Accountable Care Organizations (ACOs) fall into this category, including Presbyterian Healthcare Services in New Mexico. Observers believe that Presbyterian's efforts have encouraged two other large provider systems in Albuquerque to make progress on payment reform efforts.

On the other hand, **small or safety-net providers** struggle to engage in payment reform efforts due to the lack of resources and infrastructure required to carry out payment reform activities. Payment reform can be a costly proposition for several reasons. First, providers need to have the infrastructure to collect and analyze data from electronic health records (EHRs) or claims data from health

plans. States, community quality organizations, and contractors can assist providers in collecting data and providing some analytical tools[1], but providers still need to have adequate staffing to analyze the data themselves and then apply the information. Specifically, after analyzing the data, providers need to be able to react to it and have quality improvement process knowledge to develop efficient and high-quality systems of care. These infrastructure needs may be difficult for small or safety-net providers that have very small or no operating margin to address financially. That said, AltaMed, a safety-net provider in Southern California and the largest federally qualified health center in the U.S., has invested many resources into implementing and using an EHR that meets the Meaningful Use standards. With an EHR, AltaMed is able to analyze clinical data and give providers real-time information on HEDIS quality measures to help improve delivery system performance.

Secondly, payment reform sometimes requires the provider to be able to accept a certain amount of financial risk. Many alternative payment models put provider payment at risk for performance and some small and safety-net providers often do not have enough financial assets to take on such risk. Large providers are better positioned to take on the financial hurdles.

Plan market characteristics

Similar to provider market characteristics, the willingness of one or several **dominant or large plan(s)** can help facilitate payment reform efforts. In some markets, health plans can have great influence over the market and providers will work hard to meet the requirements set forth by the largest payer. For example, the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract accelerated the pace of payment reform in Massachusetts across the commercial, Medicaid, and Medicare markets. However, this provider attention on the largest payer can limit the valiant efforts of smaller plans with less market share. In one Midwestern state, one health plan's efforts at payment reform resulted in no savings and poorer quality scores. The health plan thought that the providers' attention on the payment reform program of the plan's competitor (which has market dominance) may have weakened its own efforts. In Northeast Pennsylvania, Geisinger Health Plan's efforts at implementing new forms of reimbursement for patient-centered medical homes spurred replicating action not only by another regional health plan, but also by the state.

Not all dominant or large plans are alike, however. The existence of a large national plan, especially when it is the dominant plan in the marketplace, can sometimes stymie market-specific efforts. For example, the New Hampshire Accountable Care Project was a multi-payer, multi-provider collaborative effort that intended to develop and test a common methodology for global payments. Regional and national plans were involved at the outset of the project, and the combined efforts produced common budgets, attribution models, and quality measures. At the point of testing the new model with providers, corporate strategies took a national plan with significant market share in a different direction and it chose not to proceed further with the project. This withdrawal of commitment necessitated a change in project focus to support multiple payment reforms. Similarly, the Pacific Business Group on Health's bundled payment pilot experienced withdrawal of commitment from a national plan due to changing corporate strategies, causing providers to lose interest.

National-based plans are not devoid of alternative payment strategies; they are just less likely to be market-specific strategies. One national plan noted that participating in market-specific strategies does not provide a return on investment as it only maintains between 10-15 percent of market share in most markets. Along with so many local and unique efforts, all of which have different methodologies, national plans are both testing and implementing their own efforts in a growing number of markets. For example, Cigna reported in April 2013 that it had 58 "collaborative accountable care programs" in 24 states, covering more than 650,000 customers, with a goal of 100 such initiatives by 2014.[2]

Markets with a dominant **state-based "domestic" plan** sometimes tend to fare better than markets with large national plans. Arkansas, Minnesota, and Vermont are three examples of state markets in which state-based insurers have facilitated payment reform. In Arkansas, for example, Arkansas Blue Cross and Blue Shield and QualChoice, two local health plans, recognized the value of working together and coordinated with the state to develop a bundled payment methodology—the first of its kind within a Medicaid program. Yet there are also examples of dominant state-based domestic plans whose lack of action stymies any market change.

Lastly, **multi-payer efforts** can facilitate provider involvement in payment reform, as using an aligned approach or methodology can reduce administrative burden and make participation more compelling to providers. For example, the Colorado Multi-Payer Patient-Centered Medical Home Pilot was one of the first voluntary pilots of its kind in the country.[3] Preliminary results of this collaborative effort show significantly reduced emergency department visits and hospital admissions, and cost savings.[4] However, multi-payer efforts can at times also slow the progress of reform and sometimes bring the group to the lowest common denominator—which may be the least effective or least impactful change. They may also be less desirable approaches for some plans and providers who are concerned about competition and perceptions of antitrust activity.

Employer market characteristics

Most payment reform efforts to date have not typically been driven by employers. However, **employers of significant size and sophistication**, like Intel, have been successful at driving change within the marketplace. Intel, for example, has instituted risk-based contracts directly with providers in some markets.[5] In addition, Boeing showed impressive results from an Intensive Outpatient Care Program (IOCP) that engaged with three Seattle-area physician groups to offer high-intensity primary care in

exchange for monthly payments for each patient enrolled.[6] Other employers, however, often lack sufficient geographically concentrated numbers of employees and/or the staff knowledgeable in these complex issues to engage in this work. As a result, they may feel intimidated and disempowered by large provider and payer organizations.

Still, with the right kind of support, education, and teamwork, mid-sized to large employers can make an impact on payment reform efforts. For example, the National Business Coalition on Health (NBCH) developed an employer toolkit which includes an online calculator to help employers identify their greatest opportunities for savings relative to the most pressing health risks and chronic conditions typically found in an employed population. The toolkit also connects employers with various strategies, including payment reform strategies, which they can implement to capitalize on opportunities identified in the calculator. RWJF has teamed up with NBCH to provide *Aligning Forces for Quality* alliances with access to the tool.

Other organizations, including those that have received RWJF grant support, like the Maine Health Management Coalition (MHMC) and Catalyst for Payment Reform, are also working to assist employers. MHMC is making provider systems' performance transparent to purchasers and consumers and is helping employers and health systems enter into risk-based performance arrangements. It has fostered a collaborative environment that has empowered employers and supported their direct pursuit of payment reform with providers. Catalyst for Payment Reform works on behalf of large employers and other health care purchasers to catalyze improvements in how health care is paid for and to promote higher-quality care in the U.S.[7] It has developed a market assessment tool to help purchasers identify the market characteristics of their region and how those characteristics might impact options for payment reform initiatives.[8]

Governmental

Federal and state government are the largest purchasers of health care and their involvement can greatly influence the success of payment reform efforts. The Great Recession resulted in increased state efforts to restrain spending, and in many cases government purchasers have become more engaged in payment reform. While this section is devoted to the role of state governments in payment reform, it is worth noting that the federal government, through the Centers for Medicare and Medicaid Services, has been actively pursuing alternative payment arrangements and is facilitating payment reform across the country. For example, Medicare launched pilots testing ACOs and bundled payment models. In addition, the Center for Medicare and Medicaid Innovation awarded $300 million in grants to support the development and testing of state-based models for delivery system and payment reform through its State Innovation Model Initiative.

The biggest driver of state-based payment reform efforts is a **Governor's commitment to payment reform**. No other single factor may be more important in determining state government's role than if the chief executive of the state makes health care payment reform a priority. A major contributing factor to the success of a bundled payment pilot in Arkansas was Governor Mike Beebe's commitment to the initiative. He said that the state's "goal is to align payment incentives to eliminate inefficiencies and improve coordination and effectiveness of care delivery." Second to gubernatorial influence is a **requirement or an opportunity for health plans or providers contracted with Medicaid or the state employee benefits program to implement alternative payment arrangements**. This requirement may be initiated by either the executive or legislative branch. Medicaid programs in Arkansas, Massachusetts, Minnesota and Oregon are aggressively advancing the use of alternative payment arrangements. Massachusetts' and Oregon's state employee benefits program are doing the same.

The Vermont Green Mountain Care Board is an independent entity created by the General Assembly to contain health care costs. It has required insurers to participate in payment reform pilots and has effectively served as a stakeholder convener to facilitate payer and provider discussions to plan and implement the pilots.

While strong support from the Governor and/or legislature influences reform efforts, a **lack of political willpower** can harm efforts—even if the political will is focused on health care reform. In many states, the individuals responsible for designing and implementing new state-based health care policy are limited in number and therefore are constrained in their capacity to take on new initiatives—especially when they are likely to encounter significant provider, health plan, and/or consumer resistance.

A barrier faced by many Medicaid agencies is the **dissonance in vision between disability providers, the advocate community, and the health care community**. While payment reform advocates may envision a payment and delivery model that integrates preventive, acute, and long-term care, disability advocates worry that this could result in the "medicalization" of long-term services and supports. In addition, while not a major impediment, there are **challenges in syncing Medicaid with commercial efforts** around performance measures due to the differences in population characteristics. For example, Medicaid programs are much more interested in assessing mental health and substance abuse services, social determinants of health, health disparities, and care for seniors and persons with disabilities than are employer purchasers and insurers—who are typically more inclined to focus interventions on high-cost services for their particular employee populations that can yield more immediate savings. In addition, some states like California face differences not only in Medicaid and commercial population characteristics, but also in the distinct and separate payers and providers of the Medicaid program and the commercial sector, making it even more difficult to align efforts.

Organizational

Payers, providers, employer coalitions, regional health care improvement organizations, and other types of organizations are driving payment reform efforts by acting as facilitators, negotiators, and leaders. This section addresses the characteristics of those organizations and how their external influence can contribute to or inhibit payment reform efforts.

The greatest organizational facilitator is having **strong, trusted leadership driving change.** This was echoed in each of the grantee interviews and reiterated by national payment reform experts. Payment reform can be a long process with many complicated moving parts. The commitment and dedication of a trusted leader who can help navigate the path is critical to success.

Having **access to and the ability to analyze data** is another vital success factor to payment reform. **Not having data** is also one of the most crippling barriers. Possessing meaningful data is especially a facilitator for purchaser and provider involvement because it allows them to understand the magnitude of risk and the potential for savings. It can identify cost saving and quality improvement opportunities, empower purchasers to make decisions, and give them leverage in negotiating with providers. Some payment reform efforts start by gathering data in order to frame the opportunities for improvement and make the business case for reform. For example, the South Central Pennsylvania Aligning Forces for Quality multi-payer bundled payment effort started by analyzing payer data. With support from RWJF, the Health Care Incentives Improvement Institute (HCI3) facilitated an analysis of payer data. One plan reported that upon sharing the analysis of potentially avoidable complications and framing opportunities for improvement with its providers, there was "shock and awe" at the extent of performance variation and the opportunities for improvement. In addition to up-front data, it is important for providers to have **timely feedback on ongoing performance** to help engender confidence in their ability to manage financial performance risk.

If the payment innovator is not a payer or provider, **having strong affiliations with a payer or provider** can assist payment reform efforts, while the **lack of affiliations** can hinder efforts. In addition, **trusted third-party entities** that facilitate the design and implementation of payment reform efforts can be successful if acting as a neutral party. Among the RWJF payment reform grantees, the Maine Health Management Coalition, the New Hampshire Citizens Health Initiative (Institute for Health Policy and Practice), and the Pittsburgh Regional Health Initiative (PRHI) have all acted as trusted third-party entities. Government can sometimes play this role too. For example, Chris Koller, the former health insurance commissioner of Rhode Island, helped to facilitate frank discussions on cost drivers of insurance premiums.

Adequate staffing and / or outside technical assistance to support the work are essential to a successful reform effort. Even in the right environment, payment reform requires a sustained commitment in both staff and resources. Some RWJF grantees reported having resources to devote 1-2 hours per week on the payment reform effort, which is far too few to orchestrate a complex undertaking. Often, **a failure to understand and / or estimate the amount of work required** slows efforts and enthusiasm for the process wanes over time.

Design

Critical to the success of payment reform is the design of the model itself. Some payment reform efforts have stalled or are unsuccessful due to poor designs. This section will address the characteristics, design, and complexity of payment reform models themselves.

Payment reform efforts have a better chance of being successful when **the clinical intervention has been proven to save money.** Providers and payers alike are reluctant to change clinical and payment processes for an intervention that is not likely to save money or improve patient outcomes. In some cases, payment reform efforts start with proving that there is a positive ROI for the clinical intervention model before reforming the underlying payment. For example, PRHI set out to prove that clinical nurse managers in hospitals working as care transition managers could improve outcomes for commercially-insured patients with Chronic Obstructive Pulmonary Disease (COPD). Focusing on the clinical intervention first, PRHI was able to document reduced readmissions and reduced admissions as a result of the program.

Payment reform designs that are **easy to understand** do better than designs that are overly **complex or difficult to explain.** "Easy to understand" does not necessarily mean the payment reform design needs to be simple, but that it can be communicated in a straightforward and transparent manner and can be comprehended by those asked to engage in the model's use. Overly complex models that are difficult to implement or explain can contribute to lengthy implementation processes that may lose momentum over time.[9]

Payment reform efforts are more successful when they **fit within the context of their environment** and may fail to launch if they do not. For example, among the payment reform grantees, the Institute for Clinical and Economic Research (ICER) attempted to implement a fee-for-service payment innovation in Massachusetts at the same time rapid market transformation toward global payments was occurring. As a result of this (and other barriers), the fee-for-service innovation was never implemented.

Lastly, if the **design affects too small of a patient population** because of its narrow scope, there may not be enough momentum to implement it or enough potential dollars to save. It may also be impossible to evaluate statistical impact. ICER's fee-for-service payment innovation focused on a single condition that was relatively infrequent among a commercial population. Health plans determined that the costs of reprogramming claims systems for this condition outweighed potential savings.[10] Similarly, if the **providers participating in the pilot have too small of a population,** the results of the pilot may not be statistically significant; this can make widespread adoption of the reform more difficult.

Overcoming Barriers

Employers, providers, payers, and any other parties interested in, or already taking action on payment reform may want to capitalize on the aforementioned facilitators and/or work to reduce the barriers. There are an infinite number of permutations of facilitators and barriers that could exist within one marketplace and it would be nearly impossible to discuss all of them.

The facilitators and barriers to payment reform are interactive. Very few barriers are independent factors that could be the sole source of failure of an effort. In addition, what may contribute to a failure to progress in one market may not necessarily do so in another market. For example, achieving payment reform without market pressure from employer purchasers is challenging. Still, even without employer leadership, payment reform has progressed at a significant pace in Massachusetts in recent years as a result of multiple facilitators, including strong health plan executive leadership, sustained attention and action by the executive and legislative branches of state government, and support of consumer advocates. These facilitators outweighed the barrier posed by the lack of an activated employer community.

Before launching a payment reform effort, it is necessary for a payment innovator to analyze the environment and assess what types of barriers exist. Below in Table 1 is a list of the barriers identified through this research effort, categorized by the degree to which they can be influenced by outside parties. For those barriers that are subject to influence, the table identifies strategies that innovators might take to reduce the likelihood that the barriers will negatively influence a payment reform effort.

Table 1. Payment Reform Barriers Categorized by Sensitivity to Influence

For those barriers that are more readily subject to influence, this table identifies strategies that innovators might take to reduce the likelihood that the barriers will negatively influence a payment reform effort. In some cases, and especially for those barriers that are very difficult to influence, strategies are still being identified to help overcome the barrier.

Barrier	Very Difficult to Influence	More Readily Influenced
Market Characteristics: General		
• Highly competitive marketplace with no dominant plans or providers	X	
• Rural market	X	
Market Characteristics: Employers		
• Disengaged, intimidated, or disempowered employers		• While labor and time-intensive, employers can be educated and supported to the point that they are ready to take action to advance payment reform
Market Characteristics: Providers		
• Small providers and safety-net providers	• Small providers and safety-net providers can be provided with technical support to help with clinical and financial transition planning	
• General provider risk aversion		• Create safe "bridge" strategies (e.g., shared savings and no immediate timeframe for downside risk) and step providers into risk assumption in the future • Innovators may have to make participation very attractive for risk-averse providers to engage
Market Characteristics: Health Plans		
• Existence of large national plans, especially when it is the dominant player in the market	• Large national employer accounts might be engaged to help engage the plan in a market-specific strategy	
Governmental Barriers		
• Political will focused on other issues	X	
• Dissonance in vision between disability providers, the advocate community, and the health care community	• Consumer advocates and disability services providers must be convinced that payment reform won't "medicalize" care for their population	
• Difficulty syncing Medicaid efforts with commercial efforts	• Many population health commonalities can serve as the focus for coordination efforts	
• State acting as a facilitator when it is not a trusted partner	X	
Participating Organization Characteristics		
• Misunderstanding of required time and effort		• Use the experience of other payment reform efforts to identify the amount of time and effort required and/or obtain experienced technical assistance
• Insufficient staff resources to support the work		• Secure necessary funding (based on the experience of other payment reform efforts) to staff the work prior to launching the project • Identify the necessary content expertise and process management skills required
• Third-party convener or payment model designer lacking strong support from plans and / or providers		• Substitute convening organizations if another reputable organization can play the role
• Participating organizations with separate initiatives pulling for their attention	X	
• Lack of necessary data to frame opportunities for improvement or provide timely feedback to providers		• Payer-based payment reform innovators may have more control over access to data and can distribute data to key entities (e.g., providers or employers) • Facilitators with strong payer affiliations can do the same

Table 1. Payment Reform Barriers Categorized by Sensitivity to Influence *(continued)*

Barrier	Very Difficult to Influence	More Readily Influenced
Payment Reform Model Design		
• Not having a payment model		• Explain how foundational work around care delivery transformation or measurement will segue to payment reform
• Complicated approaches are poorly designed and / or difficult to explain		• Careful analysis pre-implementation and a review of past successful efforts may help overcome poorly designed approaches • Multi-stakeholder engagement in the payment reform model design may help avoid the development of a model that is overly complicated or difficult to explain
• Not having a payment reform methodology that fits the environment		• Gather input from potential payment reform partners to confirm their sincere interest and willingness to collaborate
• Design affects too small of a population		• Identify the size of the population through careful analysis pre-implementation
• Participating providers have small patient population		• Payment reform models can aggregate providers and patients into statistically significant-sized pools. This may add a layer of complexity to the model, but can allow smaller providers to participate in payment reform programs
General Barriers		
• Payment reform pioneers don't know what works best	• Only time and experience can reveal what will work best	

Appendix A

Interviewed Organizations
Institute for Clinical and Economic Research
Maine Health Management Coalition
Oregon Primary Care Association
Pacific Business Group on Health
Physicians Choice Foundation
Pittsburgh Regional Health Initiative
UPMC For You
University of New Hampshire, Institute for Health Policy and Practice
Vermont Green Mountain Care Board

Endnotes

1. Some make the case that low-cost analytical tools exist to help small providers identify those high-risk patients who should be a provider's top priority. See "Even for Smallest ACOs, Analyzing Claims Data Could Be Less Daunting Than You Think." *ACO Business News*, pp.1-4, June 2013.

2. "Cigna Continues Expansion of Collaborative Accountable Care to Improve Health and Lower Costs", Cigna news release, April 3, 2013. Accessed on May 24, 2013.

3. Harbrecht MG and Latts LM. "Colorado's patient-centered medical home pilot met numerous obstacles, yet saw results such as reduced hospital admissions." *Health Affairs.* Vol. 31, No. 9. September 2012.

4. Ibid.

5. Bailit Health Purchasing, LLC. "The Employer ROI for Payment Reform: Four Payment Models," Robert Wood Johnson Foundation, February 2013.

6. Bailit Health Purchasing, LLC. "The ROI for High-Intensity Primary Care Payment," Robert Wood Johnson Foundation, February 2013.

7. Catalyst for Payment Reform. Accessed June 20, 2013.

8. Ibid.

9. Identified by the University of Washington Payment Reform Evaluation Project team on behalf of the Robert Wood Johnson Foundation. August 2012.

10 Identified by the University of Washington Payment Reform Evaluation Project team on behalf of the Robert Wood Johnson Foundation. August 2012.