nrhi Network for Regional Healthcare Improvement

Pittsburgh Regional Health Initiative
Spreading Quality, Containing Costs.

Robert Wood Johnson Foundation

From VOLUME to VALUE

Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs

Recommendations of the 2008

NRHI Healthcare Payment Reform Summit

Pittsburgh, Pennsylvania

CONTENTS

EXECUTIVE SUMMARY

A major cause of the quality and cost problems in health care today is that payment systems encourage *volume-driven* health care rather than *value-driven* health care. Under current payment systems, physicians, hospitals and other health care providers have strong financial incentives to deliver *more* services to *more* people but are often financially penalized for providing *better* services and *improving health*. Research has shown that more services and higher spending do not result in better outcomes; indeed, they often produce exactly the opposite result.

Fortunately, many people now believe that there are better ways to pay for health care—ways that give health care providers more responsibility for increasing quality and controlling costs of services without penalizing them financially for treating sicker patients. "Episode-of-care payment" systems involve paying a single price (a "case rate") for all of the services needed by a patient for major acute episodes, such as a heart attack or a hip replacement, regardless of which providers are involved instead of multiple fees for each specific service provided. "Risk-adjusted global fee" and "condition-specific capitation" systems go a step further, paying health care providers a single fee for all of the outpatient care needed by their patients, particularly those with chronic diseases, in ways that reward the providers for keeping their patients healthy and for reducing duplicative and unnecessary health care services. (For more detail about these new payment systems, see "Better Ways to Pay for Healthcare" by Harold D. Miller, a report prepared for the 2008 Summit on Healthcare Payment Reform convened by the Network for Regional Healthcare Improvement and a part of the NRHI Healthcare Payment Reform Series.)

Implementing these kinds of improvements in payment systems holds significant promise for improving the quality and reducing the cost of health care. But there are a number of important issues that need to be addressed and a variety of challenges that need to be overcome in order to move these improvements from concept to reality. In particular:

- Which health care providers, if any, are able and willing to accept new payment structures and deliver value-based care?
- How should the use of high-value providers and services be encouraged? What protections are needed to ensure appropriate quality for patients?
- How can payers and providers be encouraged to participate in new payment and delivery systems? How similar do different payers' systems need to be?
- What kinds of pilot projects are needed to test new payment systems?
- What community-wide structures are needed to support payment reform?

More than 100 health care leaders from across the country—physicians; hospital administrators; health plan executives; academics; foundation leaders; regional coalition directors; federal, state and local government officials; executives of health care quality improvement organizations; and others engaged in efforts to move towards a more value-driven health care system—participated in the 2008 Summit on Healthcare Payment Reform convened by the Network for Regional Healthcare Improvement. Participants in the summit discussed these issues and challenges,

and they made a series of recommendations to help address them.

Payment Systems and Organizational Structures Needed to Improve Primary Care

There is growing agreement that there need to be significant improvements in the way America both delivers and pays for primary care services. For example, many states, regions, payers and providers are trying to improve the quality of primary care delivery by implementing the principles of the "patient-centered medical home" that were developed by a number of physician organizations. The basic concept of a medical home is that each patient has an ongoing relationship with a personal physician and a team of other health care professionals who collectively take responsibility for providing or arranging for all of the patient's health care needs in a coordinated way. Other concepts, such as the chronic care model, are also being pursued. However, most primary care providers cannot make the changes in care delivery envisioned in these models without improved payment systems to support them. Additionally, payers want assurances that the providers will reduce costs and/or improve quality before changing payment systems. How should both payment systems and provider structures evolve to meet these goals?

Recommendation 1.1: Payers should not require primary care providers to meet rigid certification or accreditation standards in order to participate in improved payment systems, but should instead encourage innovations that improve outcomes and control or reduce costs.

Recommendation 1.2: Payers should phase in changes to payment systems to support the changes in primary care needed to improve quality and cost outcomes, beginning with enhanced fees and moving toward more comprehensive payments.

Provider Organizational Structures Needed to Manage Bundled Payments and Warranties in Major Acute Episodes

A true episode-of-care payment system for major acute care involves paying a single price for all services delivered by all providers involved in a patient's care. But combining the services of hospitals, physicians and post-acute care providers into a single payment—known as "bundling"—presumes the existence of an entity that can serve as the recipient of the single payment and divide it among the individual providers in a manner acceptable to those providers. Episode-of-care payment also envisions the provision of warranties—commitments by health care providers to address errors or complications without charging for additional services—but this increases the challenges associated with bundled payments because of the difficulties of apportioning responsibility for the errors or complications among the multiple providers involved. What kinds of organizational structures can support payment bundling, and how can both payment systems and health care organizations evolve to achieve these goals?

Recommendation 2.1: Payers should make bundled payments to provider organizations and partnerships that demonstrate the capacity and expertise to manage the full episode of care and the associated payments.

Recommendation 2.2: Payers, providers, regional collaboratives and other organizations should take steps to facilitate the transition to bundled payments, including public reporting about the total cost of care, providing technical assistance to providers, and making transitional changes to payment systems.

Recommendation 2.3: Restrictions on providers' ability to divide bundled payments among themselves should provide an appropriate balance between protecting patients and encouraging innovation and should ensure a level playing field for negotiations among providers.

Encouraging Use of Higher-Value Providers and Services

In order to have a more value-driven health care system, payment systems need to assist and encourage patients to use higher-value providers and services. A provider delivers "higher value" if it delivers the same quality of services as another provider but at a lower cost or if it delivers higher-quality services at the same cost. When there are multiple providers that can deliver the care a patient needs or when there are different types of services available that vary in effectiveness or cost, how should payment systems encourage consumers to use the higher-value providers and services?

Recommendation 3.1: Consumers should have choices about which health care provider to use, but they should be required to pay significantly more if they choose lower-value providers when higher-value providers are available.

Recommendation 3.2: Consumers and providers should have valid and understandable information on the relative value of different options for diagnosing or treating a health condition, and consumers should be required to pay more if they choose lower-value options.

Protecting Patients in New Payment Systems

Episode-of-care and condition-specific capitation systems give health care providers greater responsibility for managing the overall cost of a patient's care. However, in doing so they also may provide a greater financial incentive for the provider to inappropriately limit services—particularly those services whose preventive value will manifest many years in the future—or refuse to care for patients who appear likely to have poor outcomes within a severity-adjusted category. How should patients be protected under such payment systems?

Recommendation 4.1: Health care providers should be required to deliver essential, evidence-based services to patients —unless the patients refuse—in order to receive payment and should be required to report publicly on the level and quality of services provided to patients, particularly to minority and disadvantaged populations.

Recommendation 4.2: A combination of effective severity/risk adjustment mechanisms and outlier payments must be included in new payment systems to protect both patients and providers.

Recommendation 4.3: Patients should receive financial incentives to use high-value preventive services and to adhere to effective care processes.

Piloting Payment Systems

Even where there is agreement on the general structure of improved payment systems, there are many details to be worked out and there is always the risk of unintended and unanticipated consequences. Pilot projects provide the opportunity to test new payment systems and their components so that refinements can be made before widespread implementation. However, there are also significant costs and challenges associated with organizing pilot projects. How should pilot projects be designed in order to most effectively advance the creation of value-driven payment systems?

Recommendation 5.1: Pilot projects for new payment systems should be designed to gain experience with care changes that will both improve quality and reduce or control costs.

Recommendation 5.2: Pilot projects should support care changes that can benefit large numbers of patients but should focus on specific patients and conditions with significant potential for improvements in value.

Recommendation 5.3: Pilot projects should phase in provider participation, beginning with the most interested and capable providers.

Recommendation 5.4: Pilot projects should be expected to provide aggregate cost savings within two to three years, but higher expenditures may be needed initially.

Recommendation 5.5: Participation by a critical mass of payers is essential to the success of pilot payment reform projects.

Encouraging Payers and Providers to Support New Payment Systems

Although there is growing agreement that fundamental reforms in payment systems are needed to solve the problems that exist in health care today, payers, providers, purchasers, and patients will all likely worry about the cost, effort, and potential negative consequences to them in transitioning to new payment systems and care delivery models. How can or should these concerns be mitigated? How can the inertia of existing systems be overcome? And if new payment systems achieve savings, who will gain and who will lose?

Recommendation 6.1: Purchasers of health care and health insurance must demand changes in payment systems that support high-value health care.

Recommendation 6.2: Hospitals and specialty providers should begin planning now to adapt to the changes resulting from value-driven health care.

Recommendation 6.3: Assistance should be provided to small physician practices to help them adapt to the changes resulting from value-driven health care.

Community-Wide Structures Needed to Support Payment Reform

Markets other than health care have a variety of structures to facilitate and regulate transactions among market participants and to protect consumers, e.g., consumer protection bureaus, financial rating agencies, etc. These structures and systems are independent of individual buyers and sellers but are designed to support them in their dealings in the marketplace. Similarly, many of the structures and activities needed to facilitate the transition to new health care payment systems are not specific to any one payer or provider and could be supported by regional, state, and national organizations other than payers and providers. A particular challenge in health care is finding ways to enable payers to align their payment systems without fear of violating antitrust laws.

Recommendation 7.1: Neutral public-private organizations at the regional or state level should encourage and assist payers to align their payment structures.

Recommendation 7.2: Systems for reporting on the quality and cost of health care providers and services should be established at the regional or state level in order to help payers and consumers identify higher-value providers and services, but the methodologies used should be consistent across the nation to the maximum extent possible.

Recommendation 7.3: Aggressive efforts are needed to educate consumers about the critical need for new payment systems and more value-driven care and to actively involve consumers in the process of designing and monitoring implementation of changes in payment and care.

Supporting Regional and State Payment Reform Efforts

The systems for delivering and paying for health care differ dramatically from region to region, so initiating payment reforms at the regional or state level is appropriate. What kinds of national support should be provided to facilitate the development, evaluation, and replication of regional payment reforms?

Recommendation 8.1: The federal government should provide funding to support regionally defined pilot projects and should authorize participation by Medicare.

Recommendation 8.2: The Network for Regional Healthcare Improvement should support regions in pursuing payment reform through information sharing and advocacy.

Moving From Concept to Reality

Major changes in health care payment systems are essential in order to achieve the kinds of improvements in health care quality and reductions in costs that the nation badly needs. These changes will require a significant investment of time and effort by all participants in the health care system, and these participants will face a number of significant challenges. However, as the recommendations above demonstrate, there are ways to overcome the challenges.

Ultimately, the ability to make the changes in both payment systems and health care delivery that are envisioned here will depend on the support and engagement of all of the stakeholders in the health care system—citizens, payers, providers, purchasers, regional coalitions, government officials, and others. The extensive and enthusiastic participation of so many stakeholders in the NRHI summits, and their ability to reach consensus on the types of bold recommendations described in this report, should be a cause for optimism that the kind of support and interest needed for true reform of health care payment systems may now be in place.

I. Introduction: Moving From Volume to Value

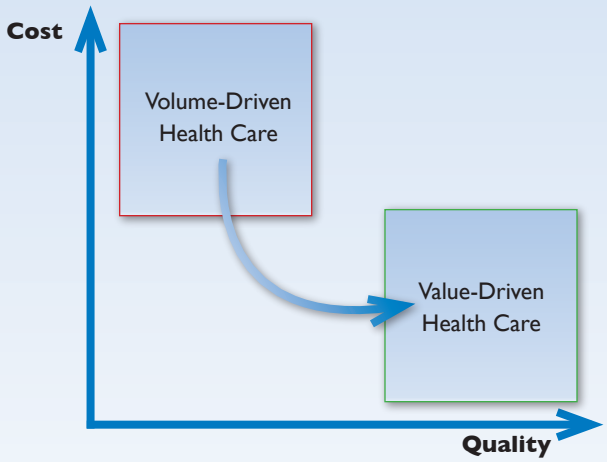
The rapid growth in health care costs is a major problem facing the U.S. economy. Although the majority of media and political attention has been focused on the growing number of people without health insurance, one of the main reasons for the growth in the number of uninsured is the high cost of insurance, and efforts to expand insurance coverage are unlikely to be sustainable if health care cost inflation isn't reduced.

Despite the large amount of money spent on health care, studies have shown that the overall quality of health care services in the United States is mediocre at best. Even among people with health insurance, many do not receive appropriate preventive health care, many are hospitalized unnecessarily, and many of those hospitalized suffer from preventable infections or errors.

A major cause of both of these serious problems is the way health care services are paid for in most parts of the country. Under current payment systems, physicians, hospitals and other health care providers gain increased revenues and profits by *delivering more services to more people*, which fuels the growth in health care costs. Yet research has shown that more services and higher spending do not improve outcomes; indeed, outcomes are often worse in regions with higher levels of services and spending. In addition, these payment systems often financially *penalize* health care providers for providing *better quality services*. In many cases, providers will lose revenues and experience lower profits if they keep people healthy, reduce errors and complications, and avoid unnecessary care.

In other words, current health care payment systems encourage *volume-driven health care* rather than what is really needed—*value-driven health care*.

Figure 1



This problem has been recognized for some time. However, the primary response to date has been the creation of a variety of pay-for-performance (P4P) programs, which add a new layer of rewards and incentives for quality improvement and cost containment on top of the existing payment systems. While well intended, there is growing agreement that most current pay-for-performance initiatives won't by themselves solve the fundamental problems and disincentives that are built into the underlying payment systems. Moreover, pay-for-performance systems may unintentionally cause an overly narrow focus on specific processes and may cause providers to lose sight of the true goal: improving patient outcomes.

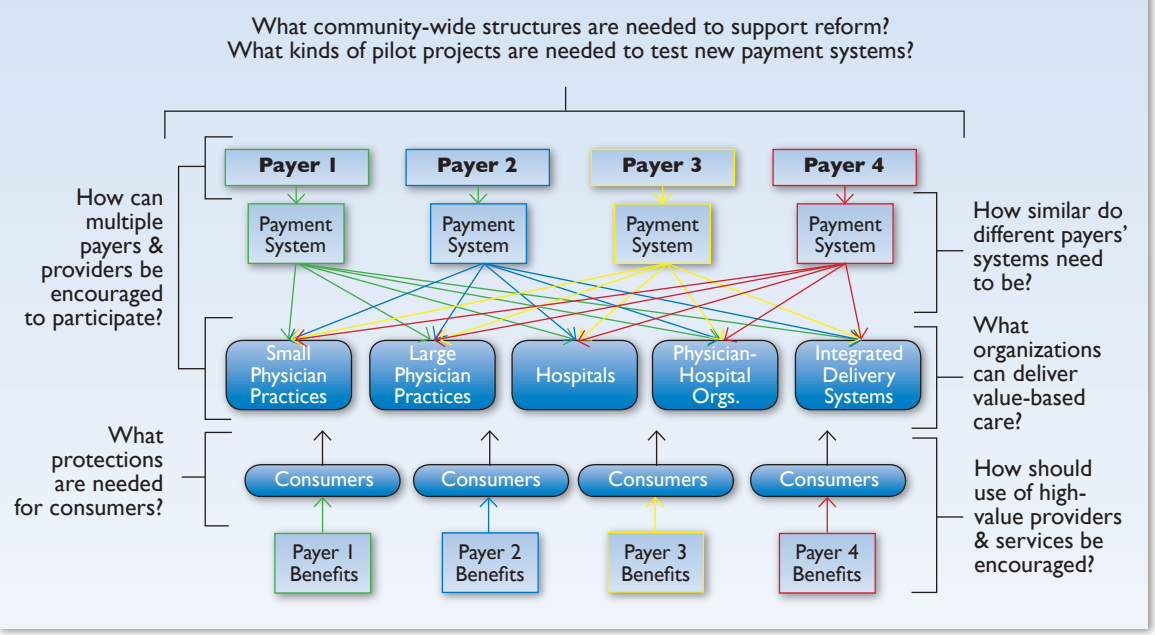
On March 29, 2007, the Network for Regional Healthcare Improvement (NRHI) convened a first-ever national Summit on Healthcare Pay-

ment Reform to accelerate thinking about how health care payment systems can be redesigned to reward rather than penalize improved quality and lower costs. The participants at the NRHI summit—health care providers and payers, regional coalitions, researchers, and other thought leaders—agreed that fundamental changes to payment systems rather than just pay-for-performance add-ons were essential, and they developed specific recommendations regarding the changes needed.

Summit participants recommended the use of "episode-of-care payment" for major acute episodes such as a heart attack or a hip replacement. This involves paying a single price (often called a "case rate") for all of the services needed by a patient regardless of which providers are involved instead of multiple fees for each specific service provided. They also recommended the use of "risk-adjusted global fee" or "condition-specific capitation" systems to pay for the care of patients with chronic diseases. This involves paying a health care provider a single fee for all of the outpatient care needed by their patients rather than multiple fees for individual services, as well as rewarding the provider for keeping their patients healthy and reducing the use of unnecessary health care services. In addition, the participants recommended that payment reforms needed to be initiated at the regional level rather than waiting for federal action, and that pilot projects were needed in order to design the details of implementation and identify and resolve unintended consequences before broad-based implementation of payment reforms was attempted. (A brief synopsis of the improved payment systems recommended at the 2007 summit is included in Appendix A. For more detail on these new payment systems and where they have been used, see "Better Ways to Pay for Healthcare" by Harold D. Miller, a report prepared for the 2008 NRHI Summit on Healthcare Payment Reform.)

Although these new payment systems hold significant promise for improving the quality

Figure 2



and cost of health care, there are a number of important issues that need to be addressed and a variety of challenges that need to be overcome in order to move them from concept to reality. Many of these issues and challenges stem from the number, diversity and complexity of organizations involved in health care. There are multiple payers, each with different payment methods and benefit structures, and a wide range of types of providers, all interacting in complex ways to deliver health care services to patients, as shown in Figure 2.

As depicted in Figure 2, there are a number of key questions that must be addressed in designing and implementing new payment systems:

- Which health care providers, if any, are able and willing to accept new payment structures and deliver value-based care?
- How should the use of high-value providers and services be encouraged? What protections are needed to ensure appropriate quality for patients?
- How can payers and providers be encouraged to participate in new payment and delivery systems? How similar do different payers' systems need to be?
- What kinds of pilot projects are needed to test new payment systems?
- What community-wide structures are needed to support payment reform?

To address these questions, NRHI held a second national Summit on Healthcare Payment Reform in Pittsburgh on July 31, 2008. The goals of the summit were to develop more detailed recommendations on how to move from the current volume-driven health care system to a truly value-driven health care system.

More than 100 individuals participated in the 2008 NRHI Summit on Healthcare Payment Reform. The participants came from 21 states and Washington, D.C., and included physicians; hospital administrators; health plan executives; academics; foundation leaders; regional coalition directors; federal, state and local government officials; executives of health care quality improvement organizations; and others engaged in efforts to move toward a more value-driven health care system. (A list of the participants is included in Appendix B.)

Prior to attending the summit, participants read a detailed Summit Framing Paper prepared by Harold D. Miller, President of Future Strategies, LLC and Strategic Initiatives Consultant for the Pittsburgh Regional Health Initiative, which outlined the issues and options to be addressed at the summit. (The paper is available online at *www.nrhi.org/downloads/2008NRHIPaymentReformSummitFramingPaper.pdf*.)

Opening presentations at the summit were given by three national leaders in new approaches to health care payment and delivery:

- Ann Robinow, President of Robinow Consulting, described the "Patient Choice" health care payment model as implemented in Minnesota and how it has encouraged increased value in health care delivery.
- Francois de Brantes, National Coordinator for PROMETHEUS Payment, described the PROMETHEUS payment system and how it is being implemented.
- David Share, Senior Associate Medical Director for Health Care Quality at Blue Cross Blue Shield of Michigan, described the Physician Group Incentive Program and the Patient-Centered Medical Home initiative in Michigan.

(Audio files and PowerPoint slides from the three presentations are available online at *www.nrhi.org/2008Summit.html*.)

Summit participants then divided into work groups to make recommendations for addressing the issues shown in Figure 2, using the options in the Summit Framing Paper as a starting point. The work groups were facilitated by Sophia Chang, Director of the Better Chronic Disease Care Program at the California HealthCare Foundation; Maulik Joshi, President and CEO of the Network for Regional Healthcare Improvement; David Lansky, President and CEO of the Pacific Business Group on Health; and Harold Miller. Following the work sessions, the participants convened in a plenary session to discuss and agree on overall recommendations from the summit.

The recommendations from the summit are described in the remainder of this report, which was prepared by Harold Miller, who also served as the overall summit coordinator.

Generous financial support for the 2008 NRHI Summit on Healthcare Payment Reform was provided by the Robert Wood Johnson Foundation. In addition, the Pittsburgh Regional Health Initiative served as the host for the summit and provided additional financial and in-kind support.

11. Organizational Structures Needed to Support Fundamental Payment Reforms

A primary goal of improved payment systems is to enable and encourage health care providers to go beyond delivering narrowly defined fee-based services to patients by taking on significantly greater responsibilities for managing the overall quality and cost of a patient's care, i.e., moving from *volume-driven* health care to *value-driven* health care. Although theoretically desirable, implementing these payment systems raises a fundamental question: ***Which health care providers, if any, are able and willing to accept such payments and the responsibilities associated with them?*** If a large number of providers can and will accept and manage the payments effectively, then the new payment system can be successful. But if few or no providers can do so, then, as a practical matter, the payment system cannot be implemented or will likely not achieve the desired improvements in value.

A. Payment Systems and Organizational Structures Needed to Improve Primary Care

These issues are central to current efforts to improve primary care delivery. Efforts are underway all across the country to encourage the adoption and implementation of processes consistent with the principles of the "patient-centered medical home," both broadly and for specific categories of patients. The basic concept of a medical home is that each patient has an ongoing relationship with a personal physician and a team of other health care professionals who collectively take responsibility for providing or arranging for all of the patient's health care needs in a coordinated way. Other concepts, such as the Chronic Care Model, are also being pursued. There are multiple goals for doing this, including improving patients' health and reducing preventable hospital admissions. (For a more detailed discussion of the medical home and other initiatives to improve primary care, see the discussion and references in Section III-A of the Summit Framing Paper.)

However, these efforts present a "chicken and egg" problem. Most primary care providers cannot implement the care changes required by these models without improved payment systems to support them, but payers want assurances that providers will reduce costs or improve quality before changing payment systems. The participants at the 2008 NRHI Summit on Healthcare Payment Reform discussed and developed the following recommendations regarding these issues.

Recommendation 11.1: Payers should not require primary care providers to meet rigid certification or accreditation standards in order to participate in improved payment systems, but should instead encourage innovations that improve outcomes and control or reduce costs.

a. Any organization that is focused on primary care and accepts accountability for patient outcomes and costs should be able to participate in payment systems designed to support medical homes or other improvements in primary care delivery.

b. Payers should wait for additional evaluations regarding which specific processes and structures produce better outcomes before establishing or utilizing strict standards for which organizations can serve as medical homes.

c. Payers should encourage innovative approaches to cost-effective primary care delivery and minimize barriers to participation in new payment systems, particularly for small physician practices and nonphysician-led providers.

The participants at the NRHI summit felt it was both impossible and inappropriate, at least at this point in time, to establish strict standards as to which health care providers could serve as patient-centered medical homes. Too little is known about which specific processes are essential to quality care and which are cost effective to justify expecting health care providers to meet detailed and potentially expensive requirements in order to participate in payment systems designed to support improved care. For example, while electronic health record (EHR) systems can be very helpful to physician practices in providing quality health care, merely having an EHR does not guarantee quality care. Additionally, many physician practices that do not have EHRs provide high-quality care, so it is probably inappropriate to *require* that providers have EHRs in order to serve as a medical home, at least at this point in time.

Many payers are currently using or planning to use the patient-centered medical home standards developed by the National Committee for Quality Assurance (NCQA) (*www.ncqa.org/tabid/631/Default.aspx*) to determine which physician practices should receive increased or modified payments designed to support improvements in primary care. The summit participants felt that while standards such as these could serve as helpful *guidelines* to providers in improving their care processes, it is impossible to say that a provider that meets the standards will deliver higher-value care than one that does not. Consequently, it was felt that while it was not inappropriate to have *some* pilot payment projects requiring physician practices to meet the NCQA standards, it would be undesirable if *all* pilot projects had such a requirement, since it would preclude the ability to determine whether providers meeting lesser or different standards could deliver equal or better value.

A motivation for payers to establish minimum standards is that proponents of the medical home clearly expect that not only will payments be made for services that are not paid for or provided today (e.g., case management by nonphysicians), but the total payment to a primary care provider for care of a patient will be *higher* than it is today. Payers, however, are understandably reluctant to pay more without assurances that outcomes will be *better* and that costs will be saved elsewhere (e.g., through reductions in preventable hospitalizations).

Summit participants agreed that higher expectations should accompany higher payment levels, but the expectations should be focused on achieving better *outcomes*, both in terms of quality and cost, rather than on complying with process standards that may or may not improve outcomes. It was felt that health care providers should be permitted and encouraged to develop innovative processes for improving outcomes rather than be micromanaged through detailed process standards by external organizations. Similarly, participants felt that there should be as few barriers as possible for organizations of different sizes and types to participate in medical home payment systems. In particular, small physician practices should be encouraged to participate, as should nonphysician providers (e.g., nurse practitioner-led providers). Because physicians in many parts of the country practice in solo or very small group practices, not allowing these physician practices to participate would result in relatively few patients being able to benefit from the improvements in care.

(Additional information on the issues and options discussed in reaching this recommendation is available under Issue 1.1 in the Summit Framing Paper.)

Recommendation 1.2: **Payers should phase in changes to payment systems to support the changes in primary care needed to improve quality and cost outcomes, beginning with enhanced fees and moving toward more comprehensive payments.**

a. **Ultimately, the current fee structure should be completely replaced, and primary care providers should receive a single, severity-adjusted comprehensive payment to cover all of the costs of a person's outpatient care, with a portion of the payment based on outcomes and costs. In addition, consumers should receive incentives for utilizing a primary care provider as a medical home.**

b. **In the near term, relatively few primary care providers will likely be able to effectively manage such comprehensive payments. To enable providers to make the transition, health care payers should modify current payment systems to support new or modified primary care services such as improved care management, but only if providers accept greater responsibility for maintaining or reducing patients' total cost of care. Consumer incentives should be phased in when there is a sufficient number of primary care providers available to support them.**

c. **At a minimum, all payers should change their payment systems to use similar measures and consistent performance expectations for primary care providers, so that providers can improve their care processes for all of their patients.**

Consistent with the recommendations of the 2007 NRHI Summit on Healthcare Payment Reform regarding payment systems for chronic disease care (see Appendix A), the participants in the 2008 summit felt that in the long run (i.e., within five to 10 years), primary care providers should receive a single payment for all of a person's outpatient care, completely replacing the current system of fees for individual services. The amount of the payment should be adjusted based on characteristics of the patient that affect the level of health care services needed, such as the number and types of chronic diseases they have and whether they have language barriers or disabilities. The payment amount should be adequate to compensate the provider for delivering high-quality care, and the provider should have the flexibility to use the payment for whatever combination of services will achieve the best outcomes for the patient, rather than being limited to the specific types of services defined in fee-for-service billing codes.

Importantly, this comprehensive payment should also include rewards and/or penalties based on the cost and quality outcomes achieved for the patients under the provider's care. One of the goals of these rewards/penalties should be to ensure that *total expenditures* by health care payers do not increase beyond levels that would have been expected otherwise for the same number and types of patients, even though the payments to the primary care providers might well be higher. For example, a key outcome of improved primary care should be reductions in preventable hospitalizations, so one approach would be to make higher payments to primary care providers whose patients have low rates of preventable hospitalizations than to providers with similar patient populations but higher rates of hospitalization.

However, the summit participants agreed that while some primary care providers might be

ready to accept such a new payment system today, others will not. For example, a significant amount of time and skill will be needed to retool the operations of many physician practices to meet the goals of the medical home; design or select and implement new billing, cash flow management, and other systems; and recruit and integrate nonphysician staff such as nurse care managers into their care teams. Since current health care payment systems primarily reward volume not quality or efficiency, it is likely that skills in designing and managing care processes to improve quality and control costs will be in short supply until the incentives change. Consequently, transitional improvements to payment systems will be needed to support health care providers during their transition to a more value-driven structure—a "co-evolution" of payment and organizational capacity.

There are several forms this transitional "enhanced fee-for-service system" might take. For example, new fees and billing codes could be created to pay for services and processes needed to deliver medical home capabilities, such as nurse care managers and phone contacts with patients, which are not reimbursed under the current fee-for-service system. Alternatively, providers could be paid a single additional fee on top of existing fees to cover all of these additional new services and processes. In either case, providers should also receive bonuses or penalties based on things such as the number of preventable hospitalizations, emergency room visits and hospital readmissions in order to assure payers that total expenditures will remain budget neutral.

It is very difficult, if not impossible, for a health care provider to significantly change its processes of care for only a small subset of its patients. Similarly, it is highly problematic for a provider to manage care for some patients who are paid for under a fee-for-service system that rewards volume and at the same time manage care for other patients who are paid for under a value-driven payment system. Consequently, it is highly desirable, if not essential, for a majority of payers to make changes in payment systems that will support and reward improved care. Although it would be ideal from the providers' perspective if all payers used identical methods of making payments, payers should, at a minimum, establish similar incentives and use consistent outcome measures, since the challenges of complying with multiple rules and systems can significantly increase administrative costs for providers.

Figure 3

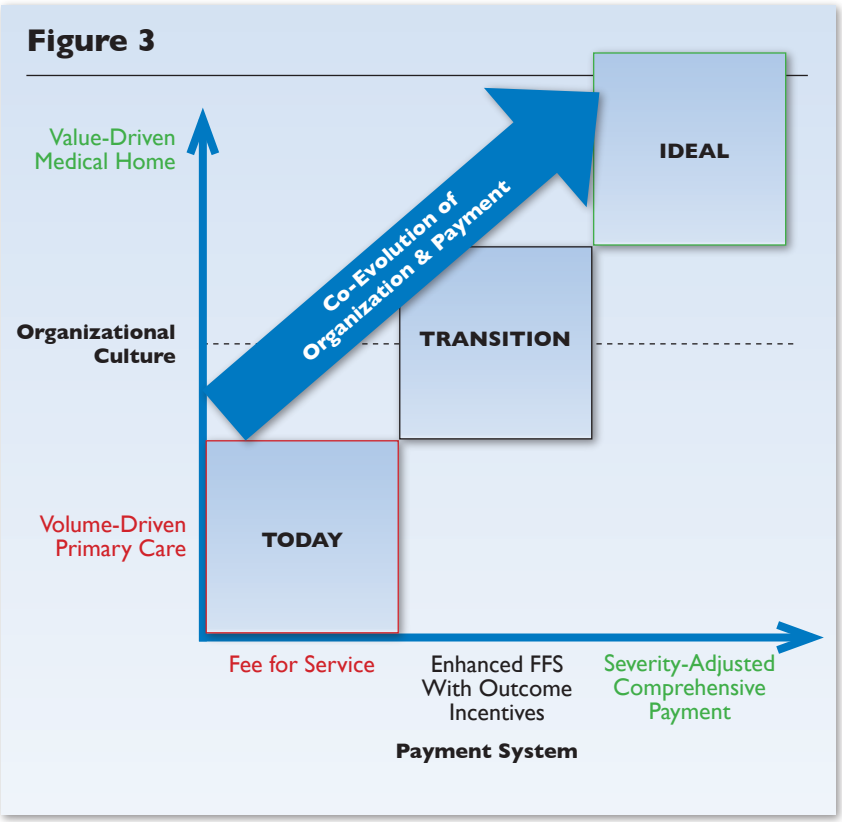
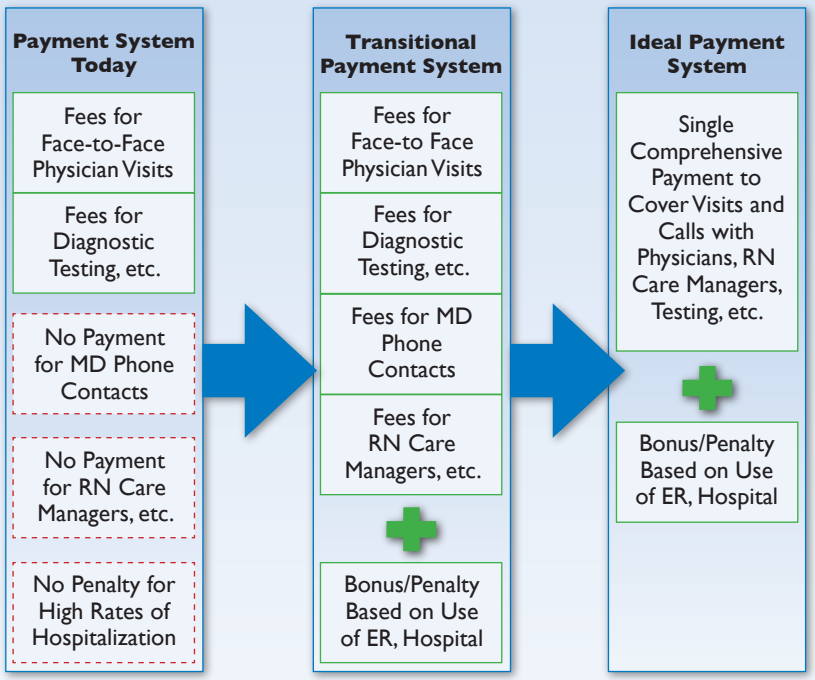


Figure 4



(*Additional information on the issues and options discussed in reaching this recommendation is available under Issues 1.2 and 6.2 in the Summit Framing Paper.*)

b. Provider Organizational Structures Needed to Manage Bundled Payments and Warranties in Major Acute Episodes

The participants at the 2007 NRHI Summit on Healthcare Payment Reform recommended that for a patient experiencing a major acute episode, the payer should make a *single* case rate payment for *all* of the services delivered to the patient by *all* health care providers during that episode of care, rather than paying *separate* fees to *individual* providers for each separate service. (See Appendix A for a more detailed description of episode-of-care payment.)

A number of individual health care providers, such as hospitals and surgeons, are already paid by many payers on an episode or case-rate basis rather than a fee-for-service basis. What does *not* routinely happen today is for the services of *different* providers to be "bundled" together into a single episode payment, even if all of those services are integral parts of a single patient's total episode of care. For example, if a patient requires hospitalization for surgery, the hospital and surgeons will be paid on an episode or case-rate basis but other physicians will be paid on a fee-for-service basis, and the hospital and each physician will be paid *separately*, not *jointly*. As a result, there is no financial incentive for *all* of the providers to coordinate their efforts on behalf of the patient, particularly if some of the providers are still subject to the undesirable incentives and limitations of the fee-for-service system. Moreover, there are laws that prohibit the providers from making arrangements among themselves that could create better incentives.

A true episode-of-care payment system bundles all payments for all of the providers' services into a single, comprehensive payment that covers *all* of the services involved in the patient's *complete* episode of care. (See Sections II-J and III-B of the Summit Framing Paper for a more detailed explanation of episode payments and bundling.) However, this presumes the existence of an organizational entity that can (a) serve as the recipient of the single payment and (b) divide that payment among the individual providers in a manner acceptable to those providers. An integrated health care

delivery system, if it employs physicians and operates both hospitals and post-acute care services, might seem best positioned to accept such payments. But most patients are not cared for by integrated health care delivery systems.

The participants at the 2008 NRHI Summit on Healthcare Payment Reform discussed and developed the following recommendations regarding the organizational structures and support systems needed to move toward bundled payments.

Recommendation 2.1: Payers should make bundled payments to provider organizations and partnerships that demonstrate the capacity and expertise to manage the full episode of care and the associated payments.

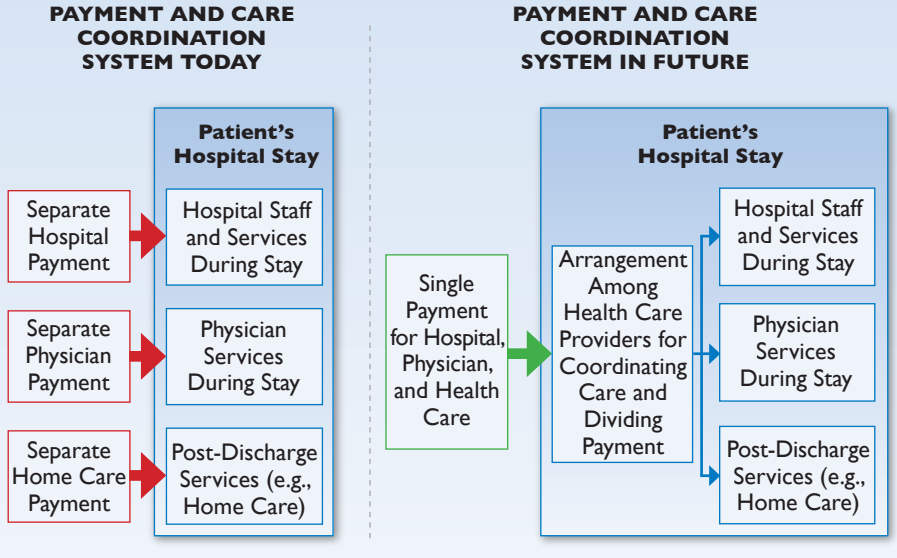
a. The criteria for providers' participation in a bundled payment system should be whether they demonstrate the commitment, relationships and administrative capacity to successfully manage such payments and deliver high-value care, not on any particular organizational structure per se. In particular, there needs to be significant buy-in and mutual trust from all participating providers, the capability to deliver services in the most cost-effective way and manage a patient's care in a coordinated way, and an administrative infrastructure to accept and divide payments among individual providers in an appropriate way.

b. Initially, integrated health care delivery systems may be more likely to meet the defined criteria, but nonintegrated providers should be encouraged to form innovative collaborations that meet the minimum criteria for participation. Regional health care collaboratives could facilitate discussions and agreements among nonintegrated providers.

c. Different payers should bundle payments in as similar a fashion as possible in order to facilitate providers' ability to manage care consistently for all patients.

There is no type of organizational structure that automatically guarantees successful implementation of a bundled payment system, nor is it possible to say that any particular type of organizational structure *cannot* be successful under such a system. Even an individual physician in a solo practice could, if they wished, develop the capacity and expertise to manage a patient's full episode of care and make payments to other providers involved in delivering that care.

Figure 5



The summit participants felt that the emphasis should be on whether providers meet key criteria for success, not whether they have a particular size or organizational form. These criteria include the following:

- There should be significant buy-in and trust among all of the parties who would be involved in the bundled payment system, particularly among all of the providers whose revenues would come from the bundled payment, as well as between the providers and the payer.

- The providers should have the capability of providing services in the most cost-effective way possible. For example, for many types of patients, providers with the capability of delivering at least some services in patients' homes will likely be able to achieve lower costs and better outcomes than those dependent on delivering care solely in institutional settings.

- The providers should have systems and processes in place for coordinating their respective services to maximize the quality and efficiency of care for individual patients, since a key rationale for creating a bundled payment is to support more coordinated care.

- The providers should have an administrative system for accepting and dividing the bundled payment among themselves in a way that rewards higher-quality, more efficient care and not inappropriate or inefficient care (see Recommendation 2.3).

It is likely that integrated health care delivery systems will be better able to meet the criteria for accepting bundled payments in the short run than nonintegrated providers. However, since most patients are not cared for by integrated delivery systems, it will be important to encourage the development of innovative collaborations of independent providers that can also participate in bundled payment systems. While innovative arrangements should be encouraged, the minimum criteria for participation should not be set too low; the success of the initial pilot projects will be critical in building support for continued implementation. Neutral organizations, such as regional health care collaboratives, may be helpful in facilitating discussions among nonintegrated providers in order to reach agreements on how to manage bundled payments in ways that are both fair to all providers and also improve outcomes for patients.

As with other payment reforms, it is very difficult for health care providers to develop all of the processes needed to manage under bundled payment structures and change their care delivery and coordination systems if bundled payments are only provided for a subset of their patients, while other similar patients continue to be paid for under the fragmented fee-for-service system. Consequently, it is highly desirable, if not essential, for a majority of payers to use similar bundled payment approaches for the same types of patients and conditions.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 2.1 in the Summit Framing Paper.*)

Recommendation 2.2: Payers, providers, regional collaboratives and other organizations should take steps to facilitate the transition to bundled payments, including public reporting about the total cost of care, providing technical assistance to providers and making transitional changes to payment systems.

a. **Public reporting: Payers should compile information on the magnitude and variation**

of payments and distribute it to all of the various providers involved in an episode of care for patients with similar diagnoses.

b. **Technical assistance: Training and assistance should be made available to providers to help them improve the coordination of patient care and develop systems for managing bundled payments.**

c. **Transitional payment changes: Payers should pursue changes in payment systems that will provide a foundation for full bundling, such as paying more physicians on a case rate basis (not just surgeons) and providing incentives for both hospitals and physicians to reduce readmission rates.**

Although bundled payment is a desirable goal, it represents a dramatic change from current payment systems and raises a series of complex implementation issues. As a result, a series of actions should be taken to provide a stronger foundation for a true bundled payment system.

A logical first step is simply compiling and disseminating information about the number and types of providers who receive payments during individual episodes of care and the variation in the total amount of those payments for different patients with similar diagnoses. Because only payers generally have this type of information and different providers are paid through different systems, assembling all payments associated with a single patient episode can represent a significant challenge.

In addition, providers outside of integrated health care systems would likely benefit from technical assistance from a neutral party, such as a regional health care collaborative, in forming organizational structures and establishing operating procedures that facilitate coordination of care delivery. These organizational structures could ultimately enable the providers to effectively allocate a bundled payment among themselves if and when such a payment is provided.

Rather than moving directly from the current fragmented payment structure to a bundled payment system in a single leap, it is probably preferable to evolve payment systems toward bundled payment in a series of discrete steps. The kinds of intermediate steps that would better position both providers and payers for full-scale bundling would include:

- Creating a case rate—a single fee for all services provided during the episode—for *each provider* in each phase of an episode of care, e.g., paying each physician a single fee for a patient's hospital stay, not just surgeons
- Including a *warranty in each provider's case rate*, e.g., including the hospital costs of any related hospital readmissions in the hospital's DRG payment, including the physician fees for a hospital readmission in the physician's case rate, etc.
- Permitting *gain-sharing arrangements* between hospitals and physicians (see Recommendation 2.3)
- Bundling case rates for all providers in a particular *phase* of an episode of care, e.g., paying a single fee to both the hospital and physicians managing the hospital stay

Once these steps are taken, the case rates for *all phases* of an episode could be combined, resulting in the desired totally bundled payment.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 2.2 in the Summit Framing Paper.*)

Recommendation 2.3: **Restrictions on providers' ability to divide bundled payments among themselves should provide an appropriate balance between protecting patients and encouraging innovation and should ensure a level playing field for negotiations among providers.**

a. **At a minimum, the methodologies and mechanisms providers use for dividing bundled payments should be reported publicly, and there should be systems for monitoring and reporting on the quality of care delivered to patients under bundled payments.**

b. **Providers should be restricted in their ability to divide payments in ways that encourage overutilization of services, encourage under-provision of necessary care for patients or inappropriately disadvantage small providers.**

There is little practical difference between (a) a hospital and physicians jointly accepting a bundled payment and having arrangements for dividing it, and (b) a hospital and physicians accepting separate payments but having arrangements for sharing portions of those payments with each other. The latter is known as "gain-sharing," and there are currently tight federal restrictions on such arrangements involving Medicare or Medicaid patients. In particular, the Civil Money Penalty provisions of the federal law governing Physician Incentive Plans prohibit a hospital from knowingly making a payment to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. In addition, the Stark Law prohibits a physician from making referrals for health services paid by Medicare or Medicaid to entities where the physician has a financial relationship.

There is little value in bundling payments if providers cannot divide them in ways that will reward improvements in the quality or cost of care. Although the Office of Inspector General (OIG) in the U.S. Department of Health and Human Services has approved waivers under the Civil Money Penalty law on a case-by-case basis for programs that meet a number of criteria, particularly those where the specific cost savings expected will have no adverse effect on patient care (e.g., an agreement by all surgeons to use a particular medical device), this is a cumbersome and time-consuming process that does not support continuous quality improvement processes, and the criteria are much too narrow to support significant transformation in health care quality and costs.

The participants at the NRHI Summit on Healthcare Payment Reform felt that a better system for protecting patients would be to require full transparency by providers as to the mechanisms they use for dividing bundled payments and the quality of the care they provide to patients under the bundled payment arrangements. In addition, rather than prohibiting all gain-sharing arrangements except where exceptions are made, narrower prohibitions should be established against the specific types of arrangements that would be viewed as problematic. In particular, providers could be prohibited from rewarding physicians based on the rate of admissions to the hospital or facility involved in the bundled payment. They could also be restricted in their ability to divide bundled payments in ways that result in unusually high or low payments to some providers or that result in some providers being paid below accepted estimates of minimum costs for quality care.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 2.3 in the Summit Framing Paper.*)

III. Encouraging Use of Higher-Value Providers and Services

In order to have a more value-driven health care system, it is essential that payment systems assist and encourage patients to use higher-value providers and services. When it is clear that a patient needs a particular type of care and there are multiple providers who can provide that care, then to the extent that those providers differ in value, patients should be encouraged to receive their care from the higher-value providers rather than the lower-value providers. In situations where there are choices as to which type of care is selected and where the alternatives differ in terms of their effectiveness and their cost, it would be desirable to encourage patients to use the higher-value alternatives as well as to select the highest-value providers that deliver the higher-value alternatives.

The participants at the NRHI Summit on Healthcare Payment Reform developed two recommendations for achieving these goals.

Recommendation 3.1: **Consumers should have choices about which health care provider to use, but they should be required to pay significantly more if they choose lower-value providers when higher-value providers are available.**

a. **Consumers should be given information about both the costs and quality of different health care providers—both individual health care professionals and organizations of health care professionals—as well as training and assistance in using that information for decision making. Creative, proactive marketing efforts are needed to ensure consumers are aware of the information and understand the importance of using it. Health care providers should also be given information about the quality and cost of other providers so that their referrals and recommendations can be based on value.**

b. **Consumers should be required to pay all or a significant portion of the difference in cost between the providers if they choose a lower-value provider when a higher-value provider is available.**

c. **In regions where there are multiple providers of a particular service, those providers should be grouped into a small number of tiers based on the relative value in both cost and quality of the care they provide in order to simplify consumer information and cost-sharing.**

d. **Efforts should be made to encourage and assist providers to improve the value of the care they deliver so that consumers have greater access to higher-value providers.**

The first step in encouraging the use of higher-value providers is collecting and publishing good information on providers' quality and cost to enable their relative value to be compared. In addition to information that the U.S. Department of Health and Human Services is now providing about the quality of various Medicare providers, a growing number of payers, regions and states are establishing quality reporting programs for physicians, hospitals and other health care providers. Continuation and expansion of these efforts will provide a critical foundation for payment systems based on value, and there is some evidence that reporting alone

can encourage providers to improve the value of the care they deliver.

The participants at the NRHI Summit on Healthcare Payment Reform felt that public reporting, while essential, was insufficient to stimulate the significant transformation needed in health care and that financial incentives should be established for consumers to choose higher-value providers.

To some, it may seem counterintuitive to say that people should pay more for lower-value care and less for higher-value care, since it is generally believed that higher quality means higher cost. But many industries have demonstrated that quality can be improved significantly while maintaining or reducing costs, and there is growing consensus that this can also be true in health care. Indeed, as noted earlier, research has shown that higher costs in health care have not resulted in better outcomes. There is also growing consensus that one of the fundamental problems in the health care system is that consumers are too divorced from the costs of their choices.

The logic behind the recommendation becomes clearer if the concept of value is broken down into its constituent parts—cost and quality. If two providers have equivalent quality, but one has higher costs or charges more for its services, then the consumer should be responsible for paying all or a significant fraction of the difference in the cost between the two, just as they would with any other product or service that they purchase. If two providers have equivalent costs, but one has higher quality, then there would be no cost difference to consumers, but they would have a natural incentive to choose the provider that delivers higher-quality service (assuming the consumer knows about the quality difference). While the remaining scenario—one provider delivers higher quality than the other but charges a higher price—may seem more challenging, the only way to determine if the higher cost is justified by the higher quality is for the person making the choice to have some responsibility for the difference in cost as well as the opportunity to assess the difference in quality and the significance of that difference. (A service may be of "lower quality" but still adequate for the purpose of addressing the consumer's health care need.) Although experience is limited, there is some evidence that health care providers can and will respond to such a system by finding ways to reduce their costs without compromising quality, just as businesses in other competitive industries do.

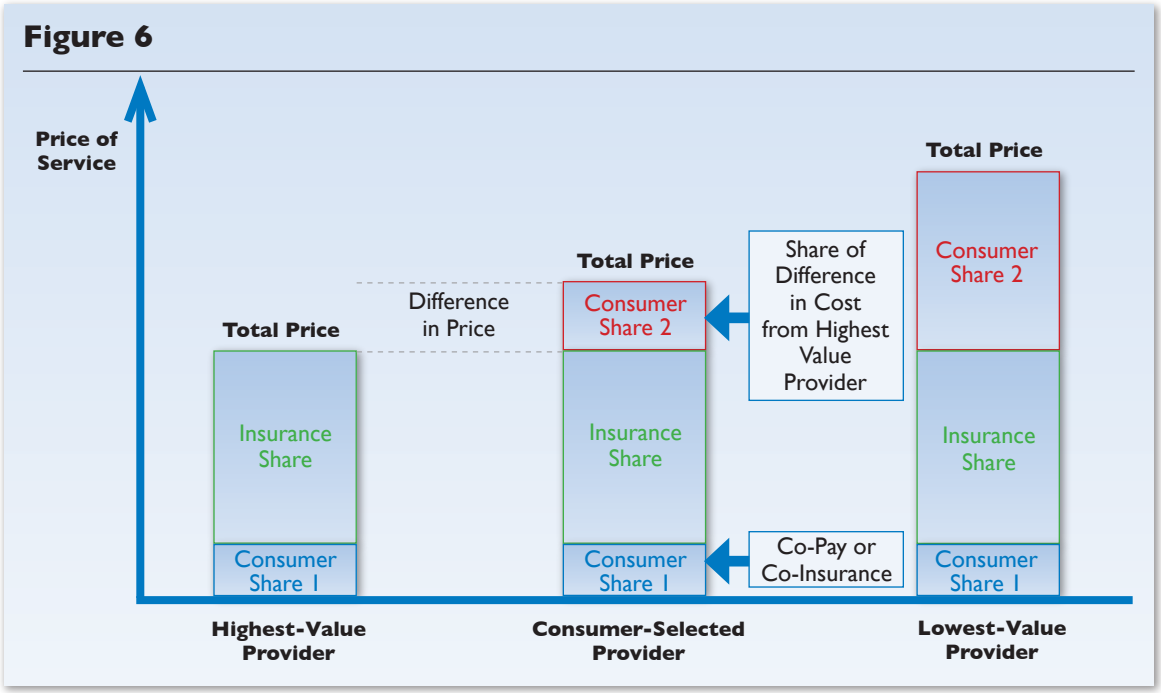
The traditional ways for consumers to share in the costs of health care services—copayments, co-insurance and deductibles with a maximum limit on the consumer's out-of-pocket expenditures—require the consumer to pay all or a portion of the "first dollar" that the provider charges. But for the purposes of implementing Recommendation 3.1, a more effective approach may be to make the consumer explicitly responsible for all or a portion of the "last dollar," i.e., the difference between the prices of higher-cost and lower-cost providers. It is important to understand that the "prices" referred to here are not the "charges" that many health care providers currently establish for their services but rarely collect. Rather, the price is the amount that the provider will actually be paid for a service. For example, as shown in Figure 6, in addition to any normal co-payment or co-insurance amount that the consumer would pay (Consumer Share #1), they could be charged a second amount based on the *difference in price between the provider* they select and the lowest-price provider available to them (Consumer Share #2). Although Figure 6 shows the consumer being responsible for the *full* amount of the difference in price between the selected provider and the highest-value pro-

vider, the consumer could be made responsible for only a *portion* of the difference.

In comparing providers on cost or price, adjustments will need to be made for the fact that some providers may have higher costs for socially desirable reasons that are unrelated to the costs of caring for individual patients. For example, academic medical centers and other teaching hospitals incur greater costs than community or nonteaching hospitals simply due to the additional personnel and time associated with teaching. Even if quality is the same, a teaching facility will be more expensive than a nonteaching facility. If patients are encouraged to use lower-cost facilities, it could jeopardize the ability of teaching hospitals to train new generations of physicians and other health care professionals. Medicare explicitly computes the portions of its hospital DRG payments that are attributable to medical education, but commercial payers generally do not. Some states, such as Minnesota, have established a separate community-wide mechanism for paying for medical education, but other states have not. Similar issues arise with rural hospitals and inner-city providers, which must incur higher costs for serving low patient volumes, providing greater security and caring for more uninsured patients.

Another issue is that if there are a large number of providers to choose from, there may be relatively small differences in the cost and/or quality measures between some of them, and even those differences in the quality measures may be due to random statistical variations rather than genuine differences in the quality that an individual patient will experience, particularly on a prospective basis. To address this, the summit participants recommended that providers be grouped into a small number of tiers with other providers that have similar but not necessarily identical quality and/or cost. Although a small number of tiers potentially allow variation in quality and/or cost inside of a tier with no formal recognition of the difference, the summit participants felt that the advantages of simplicity for consumers, at least during the

Figure 6



initial phases of implementation, outweighed any disadvantages in terms of achieving maximum value.

Finally, the ability of consumers to choose higher-value providers is fundamentally constrained by the capacity and accessibility of those providers. Efforts need to be made to encourage lower-value providers to improve their quality and costs, and potentially encourage new higher-value providers to enter the market in order that all consumers have the ability to choose a high-value provider. Consumers should only be expected to pay more for using low-value providers if one or more higher-value providers are available to them.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 3.1 in the Summit Framing Paper.*)

Recommendation 3.2: **Consumers and providers should have valid and understandable information on the relative value of different options for diagnosing or treating a health condition, and consumers should be required to pay more if they choose lower-value options.**

a. **Both consumers and the health care providers advising them should receive good information on the relative value of diagnosis and treatment options, and both should be encouraged to engage in shared decision making about those options.**

b. **Consumers should have access to informed advice about options from a health care provider or other advisor without a financial interest in the choice the patient makes, and that advisor should be compensated appropriately for providing the advice.**

c. **In situations where diagnosis or treatment options are of similar quality or effectiveness but differing cost, consumers should pay all or a large share of the difference in cost between the options. Where options differ in quality or effectiveness as well as cost, consumers should pay some portion of the difference in costs.**

For many conditions, there are choices as to which type of care can be provided, and the alternatives differ in terms of their effectiveness and cost. The first step in ensuring that the highest-value options are chosen is to provide good information to both consumers and their physicians or other health care providers on the relative value of the different options.

Although there is a growing amount of information and evidence available about the relative value of different services and the relative quality of different providers, the current level of information and evidence falls well short of what is ideal, particularly for decision making by patients who have unique combinations of conditions or by those considering cutting-edge treatments and services.

Even where information and evidence are available, because of the complexity of the tradeoffs between quality and cost, many patients will not be willing or able to make the choice about which treatment or service to use—or whether to have treatment at all—without significant education and assistance, including the input of a physician or other health care advisor with no financial interest in the decision. Studies have shown that when health care providers inform patients about the alternatives and tradeoffs in preference-sensitive care, the patients are more likely to use more cost-effective alternatives. However, this requires extra time and skill on the part of the advisor to engage in this process, and this effort needs to be compen-

sated adequately. For example, elderly patients and patients with learning disabilities will often need special support in decision making, such as assistance from a social worker or other patient advocate.

As with the choice of providers in Recommendation 3.1, consumers should have financial incentives to choose higher-value treatment options. Although there is a natural incentive for them to choose options where effectiveness has been demonstrated to be greater, there also needs to be an incentive to select lower-cost options where effectiveness is similar, and to more explicitly consider the tradeoffs between cost and effectiveness when options differ on both dimensions.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 3.2 in the Summit Framing Paper.*)

IV. Protecting Patients in New Payment Systems

In theory, a payment system that gives a provider more responsibility for managing the overall costs of care can also give that provider a greater financial incentive to inappropriately skimp on services—particularly those whose preventive value will manifest many years in the future—or to refuse to care for patients who appear likely to have poor outcomes, within a severity-adjusted payment category. However, the proliferation of pay-for-performance systems demonstrates that even fee-for-service payment has not protected patients against this problem. The incentive to skimp on services relates more to the adequacy of the payment amount, the provider's efficiency in delivering services and the provider's systems for ensuring that appropriate processes have been followed than on the structure of the payment system *per se*. Moreover, a well-designed episode-of-care payment or global fee system also creates greater disincentives for providers to skimp on some kinds of care that exist today, since a provider that fails to provide high-quality services will be responsible for addressing some of the undesirable outcomes that result.

Nonetheless, as new payment models are being developed, it is appropriate to explicitly design mechanisms for ensuring that patients receive quality services and to protect them against being denied services inappropriately.

Recommendation 4.1: Health care providers should be required to deliver essential, evidence-based services to willing patients in order to receive payment—unless the patient refuses—and should be required to report publicly on the level and quality of services provided to patients, particularly to minority and disadvantaged populations.

a. **Where clinical practice guidelines exist that clearly indicate a certain treatment or process is essential for delivery of high-value care, health care providers should be expected to deliver that treatment or process in order to receive payment for care of the patient, unless there is clear documentation that the treatment or process is contraindicated for the patient, the patient is participating in a formal clinical trial of alternative treatments, or the patient has refused to accept the treatment or process.**

b. **National, state and regional quality measurement systems should collect and publicly report data on the level and quality of services individual providers deliver to their patients, with particular emphasis on underuse of evidence-based care processes and on the care of minority and disadvantaged populations. Both consumers and providers should be involved in defining the quality measures to be used, and providers should have adequate opportunities to ensure that the data are accurate.**

It would be ideal if there were evidence-based clinical practice guidelines that could be used to determine whether all patients are receiving exactly the care they need. However, such guidelines do not exist for the majority of conditions. Even where guidelines do exist, the level of evidence is sometimes relatively weak, making the guideline exactly that—a *guideline*—rather than an enforceable standard of care.

Consequently, a combination of approaches is needed. In those cases where there is clear evidence that a treatment or process should be

used as part of appropriate care for a patient's condition, a provider should not be paid for *any* of the care provided to the patient if that treatment or process is not delivered as part of the care, except where it is clearly contraindicated, where the patient is participating in a clinical trial explicitly to test new processes, or where the patient explicitly refuses to accept the service or refuses to adhere to the elements of the care. In other words, providers that take responsibility for the care of a patient should be viewed as having accepted an obligation to deliver or arrange for *all* of the essential services the patient should receive, and failure to do so would be, in effect, a breach of contract. In the remaining cases, where no such evidence-based guideline exists or where the evidence is not strong enough to *require* delivery of specific processes, quality measurement and reporting systems should be used to determine whether some providers are delivering fewer or lower-quality services, either in general or to subgroups of patients.

As discussed in more detail in Recommendation 7.2, the reports on the quality of providers and services should be produced not by providers themselves, but by regional or state organizations with the expertise to do so, ideally using methodologies that are consistent across the nation. Providers should have the opportunity to help define the quality measures, and they should also have adequate opportunity to review reports about their quality to ensure the reports are accurate before they are issued publicly. In addition, as discussed in more detail in Recommendation 7.3, consumers need to be engaged in defining the quality measures, since a principal purpose of reporting the measures is to help consumers choose higher-value providers.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 4.1 in the Summit Framing Paper.*)

Recommendation 4.2: A combination of effective severity/risk adjustment mechanisms and outlier payments must be included in new payment systems to protect both patients and providers.

a. **Development and continued refinement of severity/risk adjustment mechanisms for use in payment systems should be a national priority.**

b. **Outlier payments, reinsurance, etc. should be used in new payment systems as a fail-safe protection and a feedback mechanism while severity/risk adjustment systems are being improved.**

New payment models such as bundled payments, global fees, episode-of-care payments and condition-specific capitation are designed to remove the incentives providers currently have to deliver unnecessary services and replace them with incentives for keeping patients healthy. Although these systems substitute some form of *single* payment for what is paid for today through multiple payments, there is no expectation that this single payment should be the *same amount* for all patients, as has been the case under many traditional capitation systems. The amount of the payment should be higher for patients who have more diseases or conditions needing treatment and for patients who are at higher risk of developing such diseases or conditions in order to appropriately compensate health care providers for the additional treatment and preventive services they will need to deliver to those patients.

This means that payment systems will need to have an effective severity/risk adjustment system to determine which patients have

more severe conditions or are at greater risk of developing conditions. Although a variety of such severity/risk adjustment systems exist today, most have been developed for research or quality reporting purposes, so they will likely need to be adapted for use in payment systems.

Since effective severity/risk adjustment systems are critical to effective payment systems, the research needed to develop, evaluate, and continuously improve them should be a national priority.

However, no matter how good a severity/risk adjustment system is, it will be impossible for it to accurately identify all patients with unique needs or predict the appropriate cost of caring for them. Consequently, a system of outlier payments or stop-loss arrangements will be needed to assure providers that they will not be financially penalized for caring for these patients. In other words, if the number of services needed to properly care for a particular patient significantly exceeds what reasonably can be covered by the payment amount for that patient (i.e., the patient is an outlier compared to other patients with similar characteristics), the providers would receive an additional payment in order to reduce or eliminate the financial loss from delivering those additional services. These outlier/stop-loss payments could be made by the payer to those providers when such cases arise, or the providers could arrange for a reinsurance contract or establish a group self-insurance program to cover the outlier costs. In either case, providers would need to clearly document that the cases were truly outliers in terms of need or complexity, not simply situations where the provider's own inefficiency led to the use of unnecessarily large numbers of services.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 4.2 in the Summit Framing Paper.*)

Recommendation 4.3: **Patients should receive financial incentives to use high-value preventive services and to adhere to effective care processes.**

Since patients who fail to adhere to appropriate care may require more care and more expensive care than otherwise necessary, and to the extent that a provider is responsible for the costs of that care and can identify which patients are going to be least compliant, the provider will have a financial incentive to drop or avoid those patients. Consequently, in addition to discouraging providers from dropping or underserving patients, it is desirable to provide incentives to patients to take actions that can support improved quality and reduced cost.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issues 4.2 and 4.3 in the Summit Framing Paper.*)

V. Piloting New Payment Systems

There are many practical issues to be resolved in getting new payment systems from the design stage into actual operations. In some cases, there may simply be insufficient knowledge or experience as to how providers or patients will respond under different options in order to comfortably make a decision about which options should be used until they are tested. As with any kind of change, there will also likely be some unintended consequences and unexpected difficulties that will need to be identified and rectified before broader implementation is warranted.

Because of this, the overwhelming majority of the participants at the 2007 NRHI summit agreed that demonstrations and pilot projects at the regional level would be needed before new payment systems could be implemented on a widespread basis. In this context, "regional" was viewed as the area served by a regional health care improvement collaborative. Where such a collaborative does not exist, the region would be the local health care market, i.e., the geographic area in which most patients use a common group of tertiary and quaternary care providers, a common group of health insurance plans, or both, rather than an area defined solely by political boundaries.

However, there are many different issues and options that pilot projects could test, and so the participants at the 2008 NRHI summit developed the following recommendations on the types of pilot projects that should be priorities for regions to pursue.

Recommendation 5.1: Pilot projects for new payment systems should be designed to gain experience with care changes that will both improve quality and reduce or control costs.

As noted in the Introduction, the nation is facing serious problems with both the cost and quality of health care, and the flaws in current payment systems are believed to be a major cause of each of these problems. In light of the widespread concerns about cost, there is unlikely to be support for pilot projects that would increase costs, even if they would improve quality. Because of the concerns about quality, there will likely be resistance to pilot projects that would reduce costs at the expense of quality. Consequently, payment reform pilot projects need to pursue both quality improvement and cost reduction as joint goals.

In addition, a third goal for pilot projects is to gain experience with the changes in care delivery that are expected to improve quality and reduce costs. Payment changes are not an end in themselves, but merely a means to support and encourage higher-value care. Ideally, payment reform pilots will have the flexibility to continuously adapt both the payment changes and the care changes based on the experience gained during the implementation process.

(Additional information on the issues and options discussed in reaching this recommendation is available under Issue 5.1 in the Summit Framing Paper.)

Recommendation 5.2: Pilot projects should support care changes that can benefit large numbers of patients but should focus on specific patients and conditions with significant potential for improvements in value.

Although there are situations involving small numbers of patients where current payment systems may preclude or discourage higher-value care, addressing these issues in pilot projects will likely have small financial benefits relative to

the costs and challenges of implementation, and the lessons learned may have limited relevance to other patients and conditions. This, in turn, will make it more difficult to attract the support of purchasers and payers, which will be more interested in changes with broader applicability. Consequently, the participants at the NRHI Summit on Healthcare Payment Reform felt that priority should be given to pilot projects that support care changes applicable to large numbers of consumers or to patients who use large amounts of health care resources. "Large" would likely mean large enough that the potential savings in the pilot project outweigh the administrative costs of setting up the pilot and evaluating its results, thereby making it worthwhile to pursue.

At the same time, the return on investment from broadly applicable care changes will likely vary significantly among different types of patients. Since it is unlikely that providers will be able to uniformly improve care for all patients at once, it is possible that providers could unintentionally start with those patients where the care improvements will have lower potential for generating the cost savings needed to offset any increases in payment. This, in turn, could make the impact of the pilot project appear lower than its true potential. Consequently, consistent with Recommendation 5.1, it is desirable to focus the payment and care changes on subsets of patients where the largest return is likely.

For example, the types of medical home services contemplated in Section II-A would be of benefit to patients of all types, from those who are healthy to those who already have multiple chronic diseases. However, research suggests that there is a much greater opportunity to reduce costs more quickly by initially focusing those service improvements on patients who have chronic diseases, particularly patients who are being discharged from the hospital. The implication of Recommendation 5.2 for payment reform pilots designed to support medical homes is that they should focus on these latter subgroups, thereby increasing the opportunity to both improve quality and reduce costs.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 5.2 in the Summit Framing Paper.*)

Recommendation 5.3: Pilot projects should phase in provider participation, beginning with the most interested and capable providers.

Paying some providers under a new payment system but not others may create competitive advantages or disadvantages for each group. However, in a region with a large number of providers, particularly small physician practices, the sheer volume of effort involved in implementing changes for all providers could overwhelm a pilot project. Consequently, as a practical matter, a pilot project may need to start with a subset of providers and phase in others over a period of time.

A phase-in approach also allows problems and unintended consequences to be identified early and corrected before full-scale implementation. Because of this, it makes sense to begin with the subset of providers who are most interested, able and willing to participate in the most experimental stage of the pilot project.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 5.3 in the Summit Framing Paper.*)

Recommendation 5.4: Pilot projects should be expected to provide aggregate cost

savings within two to three years, but higher expenditures may be needed initially.

a. **A business case demonstrating that the pilot project is likely to maintain or reduce aggregate spending should be developed to justify payer participation.**

b. **In most cases, care improvements cannot produce savings instantaneously. Consequently, purchasers and payers will need to recognize that higher expenditures may be needed initially to support upfront investments in order to achieve savings after implementation begins. In addition, for some types of pilot projects, health plans, purchasers and providers may need to commit to multiyear support and participation in order to maximize the continuity of patient-provider relationships.**

c. **Achieving aggregate cost savings will mean that in order for some providers (e.g., primary care providers) to experience increases in revenues, others (e.g., hospitals) will need to experience decreases in revenues.**

As noted earlier, in an environment of intense concern about the high and growing cost of health care, there will likely be resistance, if not opposition, to implementing payment system changes on a pilot basis if they will increase costs. However, there are many reasons why new payment systems will require increased costs in the short run, even if they promote savings in the long run. For example, new billing and payment software systems need to be put in place by providers and payers, often at considerable expense, and new infrastructure and personnel will need to be put in place by primary care providers to implement the medical home model.

Because of this, the participants at the NRHI Summit on Healthcare Payment Reform felt that it was unrealistic to expect that pilot payment reform projects could be cost neutral during the initial year or so of operation. Therefore, purchasers and payers need to be willing to make higher payments initially to cover the transition and infrastructure costs associated with changes to both payment systems and care delivery. However, it is also unreasonable to expect purchasers or payers to support these increased costs without a clear business case demonstrating that savings will be achieved within two to three years. This will likely preclude considering some prevention programs as part of initial pilot projects, simply because even if they succeed, the savings they will generate will be much farther in the future.

It is important to recognize that while *overall spending* should be reduced within this time frame, this does not mean that *each provider's* revenue will be reduced. New payment systems are expected to result in a shift in spending from acute care to prevention, from hospitals to primary care, etc.

(Additional information on the issues and options discussed in reaching this recommendation is available under Issue 5.4 in the Summit Framing Paper.)

Recommendation 5.5: **Participation by a critical mass of payers is essential to the success of pilot payment reform projects.**

a. **Ideally, all payers would participate in the payment changes in the pilot project, so that providers can make changes in care for all of their patients, regardless of payer, and receive the appropriate compensation and incentives for doing so.**

b. **At a minimum, participation is needed from a group of payers that have sufficient**

volume to significantly change the revenues and profitability of the providers. The specific number and type of payers will depend on the region and the types of patients involved in the pilot project.

It is difficult for a provider to change the way it delivers patient care, particularly when new staff or infrastructure are required, if only a portion of the provider's patients are paid for under a new payment system. For example, a key element of the medical home and chronic care models for patients with chronic diseases is to have a nonphysician care manager provide patient education and self-management support. A physician practice may have enough patients who can benefit from care management to justify hiring a full-time care manager, but if only a subset of those patients have coverage from payers who will reimburse for or otherwise support the cost of the care manager, the physician practice may lose money by hiring such an individual. Even if the practice had enough patients from participating payers to justify hiring a care manager solely for those patients, treating comparable patients differently based on payment also raises ethical and legal issues.

Although health care providers should be "payer neutral" in the way they care for patients, they can suffer financially from that approach if there are significant differences in the way different payers reimburse them for care. Consequently, to the maximum extent possible, a change in payment structure for a particular type of patient or condition should be adopted by all payers in a regional market.

The extent to which all-payer participation is feasible or desirable in a particular geographic area depends heavily on the number and size of payers and purchasers in that area. For example, it may be harder for national payers—either national health insurance companies or large, multistate self-insured companies—to make payment changes in a single market than for payers operating primarily in that area to do so. From a provider's perspective, it will be better to have one large payer change its payment system than to have several very small payers do so if more patients will be affected. Also, if getting all payers to participate requires compromising excessively on the changes in the payment system, it may be better to move forward on a better payment system with fewer payers rather than have more payers but fail to test the kinds of payment changes that are really needed.

In many areas and for many types of medical conditions, Medicare and/or Medicaid are the largest individual payers, so it may be difficult to get a critical mass of payers in some pilot projects without the participation of Medicare, Medicaid or both. Fortunately, it is not unusual for state Medicaid agencies, particularly in large, diverse states, to have different payment structures in different parts of the state. The Centers for Medicare and Medicaid Services (CMS) has pioneered a number of different payment structures through demonstration projects in specific communities around the country. Consequently, it is at least feasible to contemplate creating payment reform pilots that would include all payers, including Medicaid and Medicare.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issues 6.1 and 6.2 in the Summit Framing Paper.*)

VI. Encouraging Payers and Providers to Support New Payment Systems

Although there is growing agreement that fundamental reforms in payment systems are needed to solve the problems that exist in health care today, payers, providers, purchasers and patients will all likely worry about the cost, effort and potential negative consequences to them in transitioning to new payment systems and care delivery models. This may make some of them reluctant to participate and, in some cases, may cause them to actively oppose the changes. The participants at the NRHI Summit on Healthcare Payment Reform discussed how these challenges could be overcome and developed the following recommendations.

Recommendation 6.1: **Purchasers of health care and health insurance must demand changes in payment systems that support high-value health care.**

a. **Purchasers (e.g., businesses, individuals and governmental agencies that buy health insurance or directly pay for health services) should give preference to payers (health plans) that implement new payment systems that support high-value health care.**

b. **Purchasers should demand that payers use payment systems that provide similar incentives and use similar definitions in order to simplify provider participation.**

c. **Purchasers need to work together to create a critical mass of covered lives to participate in new payment systems to make it as cost-effective as possible for health plans and third-party administrators to implement payment changes.**

A considerable infrastructure is needed to support any type of payment system, including establishing definitions of patients/conditions to be paid for; methods for providers to submit claims and be paid; systems for measuring quality; and rules and processes for resolving ambiguities, disputes, and errors. Even with a detailed conceptual design for how a payment system should work, extensive effort is needed to resolve all of the details, program and test new computer systems, print manuals and forms, train staff, educate providers and patients, and many other steps. This work is expensive, particularly since the development work must be done in parallel with continued operation of the current payment system. Moreover, not just the *design* but even the *operations* of the new payment system may also need to proceed in parallel with the current payment system, since not all patients or providers may be participating in the new system, at least in the short run. Payers may feel that the benefits of new payment systems will accrue to purchasers and patients, making it difficult to create an internal business case supporting the changes. Payers may be particularly reluctant to participate in pilot projects, since they may need to incur all or most of the same costs that would be associated with full-scale implementation, yet the returns will be more limited and there is the chance that the pilot will end with a decision not to proceed to full implementation.

In the end, it is the ultimate purchasers of health care—the organizations and individuals who purchase health insurance or directly contract for care—and the consumers they represent who will benefit from the cost and quality improvements expected from health care payment changes, not health insurance plans.

Consequently, the pressure to change payment systems must come from those purchasers. They need to clearly indicate that they want their insurance plans or third-party administrators (TPAs) to use better payment systems and to participate in pilot projects, and, if necessary, they need to change plans or TPAs in order to use those who do.

In addition, purchasers have to demand not just that their plans and TPAs use better payment systems, but that those payment systems are fundamentally the same from a provider's perspective as the new payment systems used by other plans and TPAs in order to achieve the alignment of incentives called for in Recommendations 1.2, 2.1 and 5.5. This requires a coordinated effort on the part of purchasers as well as on the part of the plans and TPAs. Moreover, since any individual health plan or TPA will have multiple purchasers as customers, it will be helpful if as many of those customers as possible are calling for the same kinds of payment changes. It is much more cost effective for a plan or TPA to implement a change in a payment system for a large number of consumers. Coordinated efforts to change the structure of payment systems do not imply setting prices for services in a coordinated way, i.e., price-fixing, but clear guidelines from antitrust enforcement agencies may be needed to overcome fears of purchasers and health plans that they will be subject to penalties for pursuing such efforts.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 7.1 in the Summit Framing Paper.*)

Recommendation 6.2: **Hospitals and specialty providers should begin planning now to adapt to the changes resulting from value-driven health care.**

a. **Citizens, community leaders and health care providers should be educated about the likelihood that revenues for hospitals and specialty providers will decrease or grow more slowly in the future, depending on the region, and about the importance of constructively adapting to those changes.**

b. **Technical assistance should be made available to providers to help them eliminate waste and increase efficiency, and payers should modify or eliminate unnecessary administrative requirements on providers.**

c. **Hospitals and specialists should proactively pursue opportunities to support primary care and preventive care and to deliver higher-value services.**

d. **Payers should work collaboratively with providers to develop a plan for transitioning to new payment and care delivery structures, but providers should understand that the goal of purchasers and payers is to increase value, not to protect providers' revenues or profit margins.**

A key goal of new payment systems is to slow the growth in health care costs and ideally to achieve net reductions in health care spending on a per capita basis. Although cost reduction is often discussed in abstract terms, as a practical matter, lower health care costs mean lower revenues for at least some health care providers. Moreover, as noted under Recommendation 5.4, reductions or slowdowns in spending will not occur uniformly across all providers; some providers may gain revenues, while others will lose. In particular, there are widespread expectations that primary care physicians should receive more revenues under payment changes. The providers most likely to lose revenues are hospitals, particularly given the increasing focus

on payment changes designed to reduce or eliminate payments for preventable adverse events and readmissions and to reduce admissions for ambulatory sensitive conditions. Reductions in hospitalizations may also result in reduced revenues for some specialty physicians.

The participants at the NRHI Summit on Healthcare Payment Reform felt that it was important to educate citizens, community leaders and health care providers about the necessity for these kinds of changes to occur and to encourage health care providers to begin planning now for ways to constructively adapt to the changes rather than oppose or attempt to undermine them.

Although reductions in revenues for some providers may be inevitable, this need not translate directly into reductions in their profits or operating margins. If a hospital can find ways to deliver care more efficiently or reduce its costs, it may be able to offset some or all of the reduction in revenues. For example, a number of initiatives based on the Toyota Production System and "Lean" principles (e.g., the Pittsburgh Regional Health Initiative's Perfecting Patient Care℠ techniques and in-house projects conducted by hospitals such as Virginia Mason in Seattle and ThedaCare in Wisconsin) have shown significant results in reducing costs as well as improving quality. Helping providers obtain technical assistance to restructure their operations and reduce their costs could facilitate the transition process to new payment systems, as well as reduce the problems of personnel shortages that are facing many health care providers.

While reducing operating costs to match reduced revenues will be necessary in order for providers to continue with current service models, providers should also be thinking about ways to more fundamentally restructure their operations to support a value-driven health care system. For example, hospitals and specialists could pursue opportunities to deliver or support primary care and preventive care, and they should be rewarded for doing so by a payment system that emphasizes primary/preventive care rather than acute care.

Providers' ability to plan for and implement changes would be facilitated if it could be done in a collaborative fashion with payers. For example, there may be ways that the timing or details of payment systems could be modified to reduce problems for providers during the transition process. However, these collaborations should be designed only to facilitate the transition process, not to compromise on the fundamental goals of payment reform in order to protect providers' revenues.

(Additional information on the issues and options discussed in reaching this recommendation is available under Issue 7.2 in the Summit Framing Paper.)

Recommendation 6.3: **Assistance should be provided to small physician practices to help them adapt to the changes resulting from value-driven health care.**

a. **Technical assistance should be provided to help small physician practices manage care and finances under new payment models.**

b. **Small physician practices should be encouraged and assisted to join together in organizational structures that can facilitate quality improvement, share resources, and/or accept accountability for overall patient outcomes and costs.**

c. **Financial assistance should be provided to small physician practices to help them cover the costs of installing new infrastructure and transitioning to new care models.**

Although many people hope or expect that new payment models for chronic disease management and preventive services will increase the compensation to primary care physicians for the time they spend with patients, these payment models also presume or require that primary care physicians will significantly change the way they provide care for patients. Just as Recommendation 6.2 calls for recognition by hospitals and specialty providers of the need to transition to a smaller or different role in health care, primary care physicians will need to plan for the transition to a larger and more significant role in a value-driven health care system.

Small physician practices are likely to face the most significant challenges in making this transition. Since the majority of primary care physicians in the country are in small practices, new payment systems for primary and chronic care will not be successful unless small physician practices can make the transition successfully. As noted under Recommendation 1.1, there is currently no proven formula or standard for how to do this, and innovative approaches need to be supported to facilitate a better understanding of what will and will not work.

At a minimum, small practices will need technical assistance in redesigning their care processes and setting up systems for managing new forms of payment. In addition, the ability of small practices to efficiently and effectively deliver care will likely be enhanced if they can work with other small practices through collaborative organizational structures. For example, Blue Cross Blue Shield of Michigan's Physician Group Practice Incentive Program and Patient Centered Medical Home Program are helping small practices form or utilize collaborative organizations for quality measurement and improvement and for sharing resources such as care managers.

Primary care practices of any size will likely need to incur additional costs and experience temporary reductions in revenues as they purchase and install new infrastructure and reorganize their care processes to deliver better, higher-value care. Although these will create short-term financial challenges for all practices, the challenges will likely be greater for small practices. As a result, special financial assistance will be helpful to small physician practices in order to meet these challenges and successfully transition to better care delivery.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 7.3 in the Summit Framing Paper.*)

VII. Community-Wide Structures to Support Payment Reform

Markets other than health care have a variety of structures to facilitate and regulate transactions among market participants and to protect consumers, such as consumer protection bureaus and financial rating agencies. These structures and systems are independent of individual buyers and sellers but are designed to support them in their dealings in the marketplace.

Similarly, a variety of structures and activities will be needed to facilitate the transition to new health care payment systems. Many of these are not specific to any one payer or provider and could be facilitated through regional, state or national organizations other than payers and providers. The participants at the NRHI Summit on Healthcare Payment Reform identified some of the most important of these and developed the following recommendations.

Recommendation 7.1: **Neutral public-private organizations at the regional or state level should encourage and assist payers to align their payment structures.**

a. **The appropriate organization and geographic level will depend on the specific structure of the health care system in a particular location and the existence of regional health care collaboratives or other similar organizations.**

b. **Involvement of a broad range of stakeholders is highly desirable, but efforts to ensure representation of all interested parties should not be allowed to unnecessarily delay implementation or limit the extent of the innovations pursued.**

As noted under Recommendations 1.1, 2.1 and 5.5, participation by all or most payers, and their use of similar, if not identical, payment structures, will be important to the success of new payment models. However, because of antitrust concerns, even if payers are willing to agree on a common payment structure, it will be difficult or impossible for them to have direct discussions to achieve that agreement.

To address this, neutral organizations should provide a forum for developing payment reform proposals with input from payers, purchasers, providers, consumers and others. Purchasers, consumers and community leaders can then encourage each payer to adopt and implement the consensus proposals, thereby achieving the desired alignment of payment systems.

The appropriate organization to do this will vary from region to region. One option is for a nonprofit organization to play this role; another is for state government to do so. For example, in Minnesota the Institute for Clinical Systems Improvement worked with payers to develop multipayer support for the DIAMOND initiative to improve the quality of care for patients with depression. In Pennsylvania, the Governor's Office of Health Care Reform worked with payers to develop a multipayer demonstration of the chronic care model in the southeastern corner of the state. In Rhode Island, Quality Partners of Rhode Island worked with payers to develop a multipayer initiative to implement the advanced medical home and chronic care model.

Ideally, the organizations or groups playing these roles will involve a wide range of stakeholders

from both the public and private sectors. However, with broader involvement, it may be more difficult to achieve unanimity on all aspects of payment changes. Particularly in the case of pilot projects, a key goal is to identify problems and unintended consequences through the implementation process, so it will be important to not let the desire to achieve consensus trump the goal of implementing truly innovative reforms.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 6.3 in the Summit Framing Paper.*)

Recommendation 7.2: **Systems for reporting on the quality and cost of health care providers and services should be established at the regional or state level in order to help payers and consumers identify higher-value providers and services, but the methodologies used should be consistent across the nation to the maximum extent possible.**

As noted in earlier recommendations, a fundamental complement to a new payment system is an effective mechanism for measuring and reporting to the public the quality and cost of health care providers and services. A growing number of regions and states have created organizations to perform this function. This trend needs to continue, and adequate and predictable financial support needs to be available to both start and maintain the programs and disseminate their results to the public.

Although the data collection and reporting systems should be managed by organizations at the regional or state level, the methodologies they use for collection, auditing, severity-adjustment, etc. should ideally be consistent across the country. This does not mean that regional or state organizations should wait for national standards in order to move forward. Indeed, the innovations in developing methodologies have come from the regional and state organizations that have pioneered the field. But as experience with the methodologies grows, it would be desirable to achieve consistency across regions and states both to facilitate inter-regional comparisons and to simplify the reporting processes for multiregion providers. The Quality Alliance Steering Committee (QASC), which was formed in 2006 as a voluntary, multistakeholder collaboration to provide national coordination for activities designed to enable value-driven health care (*www.brookings.edu/projects/qasc.aspx*), could play an important role in encouraging common standards without slowing progress or deterring innovation.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issue 8.1 in the Summit Framing Paper.*)

Recommendation 7.3: **Aggressive efforts are needed to educate consumers about the critical need for new payment systems and more value-driven care and to actively involve consumers in the process of designing and monitoring implementation of changes in payment and care.**

a. **The case for change and the urgency for action need to be described in ways that more effectively demonstrate their relevance and importance for consumers, and proactive marketing and communication efforts are needed to disseminate that information.**

b. **Consumer surveys and consumer advisory committees are desirable but insufficient methods for involving consumers. A more fundamental paradigm shift is needed in which consumers are actively involved in**

the definition of "quality" and "value," the design and evaluation of payment systems to support delivery of high-value services, and management of their own health.

Although the issues in designing and implementing payment reforms are understandably focused on providers and payers, the fundamental goal of payment reforms is to improve the quality and affordability of care for consumers and patients. It is quite conceivable that a new payment and care delivery structure could be developed that is perfectly satisfactory from the perspectives of payers and providers but unacceptable to a significant number of consumers and patients, either because of the actual problems it creates for them or because of the problems they *perceive* it will create for them. The history of managed care systems in the United States demonstrates that consumer acceptance of payment and care delivery systems can be critically important.

Consumers first need to understand the need for change in both care delivery systems and payment systems and the importance of moving aggressively to implement these changes. Although there is growing recognition by health care professionals of the key role that health care payment systems play in fostering the cost and quality problems plaguing the health care system, this causal relationship is not widely understood by consumers. For example, although research has shown that more care and higher costs do not result in better patient outcomes, it's likely that most consumers still believe that they do. Moreover, merely producing information for consumers is not enough. Truly proactive efforts to ensure that consumers receive and understand the information are critical to success, since a core component of a truly value-driven health care system is a greater consumer role in decision making about providers and services.

However, efforts to engage consumers need to go well beyond one-way communication about what health care professionals feel is needed. Consumers need to be actively involved in the planning and implementation of changes, since they will not only reap the rewards of success but bear the brunt of failure. Genuine involvement of consumers means more than merely surveying them for their opinion or having token consumer representatives on advisory committees. An entirely new paradigm is needed. In particular, if consumers are going to be asked to choose providers based on value and pay more for using lower-value providers, then it will be important for "value" to be defined based on what consumers believe is value, not just what health plans or other payers define as value. Similarly, if providers are going to be paid based on outcomes, since many outcomes depend as much on what consumers do (e.g., adherence to medication regimens) as what providers do, clear definitions of the roles and responsibilities of consumers in management of their health will be needed, defined in ways that consumers believe is feasible and appropriate for them to carry out.

(*Additional information on the issues and options discussed in reaching this recommendation is available under Issues 8.2 and 8.3 in the Summit Framing Paper.*)

VIII. Supporting Regional and State Payment Reform Efforts

Regions and states are already moving forward to design and implement payment reforms. The systems for delivering and paying for health care differ dramatically from region to region, so initiating payment reforms at the regional or state level is appropriate. However, this does not mean that payment reform should be a parochial enterprise. Regional initiatives across the country should work to coordinate their efforts, and national organizations should support the development, evaluation and replication of regional payment demonstrations.

Recommendation 8.1: The federal government should provide funding to support regionally defined pilot projects and should authorize participation by Medicare.

a. **The Department of Health and Human Services could accelerate efforts to implement payment reforms by providing funding support to regional collaboratives and other organizations to take the actions needed to design pilot projects.**

b. **Because of the importance of having as many payers as possible participating in payment reform projects, Congress should authorize Medicare to participate in regionally defined pilot projects.**

A number of regional organizations are interested and willing to push for payment reforms in their areas and play lead roles in educating, convening and involving payers, purchasers and consumers as envisioned in Recommendations 6.1, 7.1 and 7.3 and/or providing the kinds of technical assistance and support to providers as envisioned in Recommendations 6.2 and 6.3. However, substantial time, energy and expertise are needed to play these roles effectively, and financial support is needed from sources other than providers and payers. The federal government, as well as national foundations, could help accelerate the payment reform process by providing financial assistance to regional collaboratives and other organizations willing to play these roles.

In addition, as Recommendation 5.5 makes clear, participation in payment reform pilots by the largest payers can be critical to their success. For many providers, Medicare is one of the largest payers for their patients. Although Medicare has been proactive about developing payment reforms and is currently pursuing cutting-edge demonstrations of payment concepts similar to those recommended at the NRHI summits, these demonstrations are defined by Medicare alone and generally do not involve other payers in the locations where they are implemented. Consequently, it would be desirable if Medicare could also participate in *regionally defined* pilot projects, joining together with other payers to create the critical mass of payer involvement called for in Recommendation 5.5. This will likely require both enabling legislation from Congress and funding to enhance the Centers for Medicare and Medicaid Services' capacity to engage in multiple, additional pilot projects.

Recommendation 8.2: The Network for Regional Healthcare Improvement should support regions in pursuing payment reform through information sharing and advocacy.

a. **NRHI should hold another Summit on Healthcare Payment Reform in 2009, with**

a focus on sharing regions' experiences in designing and implementing value-based payment systems and pilot projects.

b. **NRHI should organize and support advocacy efforts for national actions needed to support regional payment reform efforts.**

c. **NRHI should establish a national learning network for regions pursuing payment reform initiatives.**

The purpose of pilot payment reform projects is to identify and solve problems and unintended consequences and overcome implementation challenges. It makes no sense for regions and states to reinvent the wheel if they can learn from the experiences of others. The Network for Regional Healthcare Improvement has attempted to foster information sharing about payment reforms and care delivery improvements through its two Summits on Healthcare Payment Reform and its Learning Network, and the participants at the 2008 summit urged that NRHI continue and expand those efforts in the future. The participants also called for NRHI to play a role in organizing and supporting advocacy efforts for national actions, such as those defined in Recommendations 7.2 and 8.1.

IX. Conclusion: Moving From Concept to Reality

Major changes in health care payment systems are essential in order to achieve the kinds of improvements in health care quality and the kinds of reductions in health care costs that the nation badly needs. These changes will require a significant investment of time and effort by all participants in the health care system, and these participants will face a number of significant challenges. However, as the recommendations in this report demonstrate, there are ways to overcome the challenges.

Ultimately, the ability to make the changes in both payment systems and health care delivery that are envisioned here will depend on the support and engagement of all of the stakeholders in the health care system—citizens, payers, providers, purchasers, regional coalitions, government officials and others. The extensive and enthusiastic participation of so many stakeholders in the NRHI summits, and their ability to reach consensus on the types of bold recommendations described in this report, should be a cause for optimism that the kind of support and interest needed for true reform of health care payment systems may now be in place.

NRHI is committed to carrying out the roles described in Recommendation 8.2 and more generally to increasing public and leadership awareness of the need for payment reform and the ways it can be supported. NRHI welcomes both suggestions and support from other organizations to help it do so as successfully as possible.

Appendix A: Synopsis of the Recommendations of the 2007 NRHI Summit on Healthcare Payment Reform

The following is a synopsis of some of the key recommendations from the 2007 NRHI Summit on Healthcare Payment Reform. More details on the recommendations are available in the report, "Incentives for Excellence: Rebuilding the Healthcare Payment System From the Ground Up," published by the Jewish Healthcare Foundation and available at www.nrhi.org/summit.html.

Paying for Major Acute Episodes

Participants at the 2007 summit recommended using **episode-of-care payment** for major acute episodes such as a heart attack or a broken or arthritic hip, which are characterized by the patient needing a complex mix of often expensive interventions within a relatively brief period of time. For example, once a patient has a heart attack, under an episode-of-care payment system a single payment would be made to a health care provider or group of providers for all of the care needed by that patient for the heart attack. This single payment is also frequently called a case rate, i.e., there is a single payment for the *case* rather than *multiple fees* paid *separately* to *multiple providers* for each of the specific services provided within that case.

The following specific elements of this system were recommended:

- A single, bundled, episode-of-care payment would be paid to a group of providers to cover all of the services needed by the patient during the episode of care. (Combining the payments for multiple providers into a single payment is generally referred to as "bundling" payment.) This case rate would be paid instead of individual fees or DRG payments.

- The group of providers would include all of the hospitals, physicians, home health care agencies, etc. involved in the patient's care for that episode. The providers would be encouraged to create joint arrangements for accepting and dividing up the episode-of-care payment among themselves.

- The amount of the episode-of-care payment would vary based on the patient's diagnosis and other patient-specific factors. However, there would be no increase in payment to cover preventable adverse events such as errors and infections.

- The amount of the episode-of-care payment would be prospectively defined (i.e., it would be established *before* the care actually took place), but would include a retrospective adjustment based on the level of outcomes achieved by the provider group. For example, if the provider group had an unusually high mortality rate, even after adjusting for patient severity and risk, its payment would be reduced. There would be some adjustments in payment made for cases requiring unusually high levels of service, but only if improved outcomes were achieved through those higher levels of service.

- A regional collaborative organization would estimate the cost of providing good-quality

care for each type of patient, but provider groups would bid and negotiate the amount of the actual episode-of-care payment they would receive for each type of patient and condition.

- Patients would receive incentives to use higher-quality/lower-cost providers and would also receive incentives to adhere to care processes jointly developed by the patients and providers.

An example of how this system might work for an individual patient is described in the sidebar.

Why would this be better than current payment systems?

- Hospitals would have an incentive to prevent adverse events, prevent readmissions, and use the right combination of in-patient and post-acute care.
- Physicians would no longer be paid more for longer hospital stays, more procedures and adverse events.
- Physicians and hospitals would have an incentive to cooperate in optimizing care quality and cost.
- Providers would have the funding flexibility to use the best combination of facilities and services for maximum value.
- Patients would have an incentive to choose the facility and services that provide the best value (i.e., better quality and/or lower cost).

Paying for Chronic Disease Care

For many patients, their condition does not end in a fixed period of time; they may need care over an extended period of time. For example, people with chronic diseases such as asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and diabetes will generally live with those conditions for the rest of their lives. Many of them are hospitalized multiple times with no fundamental change in their underlying condition. But the rates at which they are hospitalized can be significantly affected by the type of care they receive outside the hospital.

How Episode-of-Care Payment Would Work in a Hypothetical Case

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

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

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

Ms. Brown receives a small rebate on her share of the costs of her care if she achieves the rehabilitation goals and complies with the post-discharge plan that she develops jointly with her physicians.

For these patients, paying for each hospitalization on an episode-of-care basis may help to control the costs of each hospitalization, but it does nothing to control the number of episodes (hospitalizations) that the person experiences. Moreover, there will likely not be a clear endpoint to each episode, making the definition of the payment for the episode particularly challenging. Therefore, it makes sense to pay providers for all of the care that the patient needs *over a fixed period of time*, including as many or few episodes as are needed during that period of time. This approach can be called **condition-specific capitation** or **risk-adjusted global fees**. Condition-specific capitation means that while there is a single payment for a patient, the amount of that payment varies depending on the specific condition that the patient has, unlike traditional capitation systems that pay the same amount for each patient regardless of how many or what types of conditions they have. The term "global" is intended merely to indicate that *all providers* and *all services* are covered by a single fee or payment. Regardless of the name, the idea is that the provider is paid a case rate rather than individual service fees. In contrast to episode-of-care payment, though, the case rate is for an inherently arbitrary period of time (e.g., a calendar year), rather than being defined by a resolution to the patient's condition.

The following specific elements of this system were recommended:

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

An example of how this system might work for an individual patient is described in the sidebar.

Why would such a system be better?

- Physicians would no longer be restricted by fee codes and amounts as to what services they can provide and be paid for.
- Physicians would have an incentive to maintain or improve a patient's health, prevent hospital admissions and coordinate care among multiple providers.
- Physicians would have the funding flexibility

How Condition-Specific Capitation Would Work in a Hypothetical Case

Mr. Jones has diabetes. His insurance company pays his primary care provider a monthly comprehensive care payment to help him manage his diabetes and address some of the complications that might arise from his condition.

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

The costs of blood tests and any visits to specialists that Mr. Jones needs, such as periodic eye examinations by an ophthalmologist, are all paid by his primary care provider from the monthly comprehensive care payment.

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

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

Mr. Jones is free to switch to another primary care provider at any time if he isn't happy with the care he is receiving. However, if he switches to a provider that has significantly poorer outcomes, rates of hospitalizations and/or higher prices for care, his insurance company will require him to pay more in order to use that provider.

to use the best combination of providers and services for maximum value.

- Patients would have an incentive to choose providers and services that provide the best value (i.e., better quality and/or lower cost) and to adhere to recommended care.

Implementing Payment Changes

Moving from the current payment systems to these proposed new payment systems will be a complex and challenging endeavor. But participants at the 2007 NRHI summit agreed that this transition was essential in order to achieve efficient, effective and sustainable improvements in the quality and costs of the health care system, and they made several recommendations as to how the concepts outlined above should be advanced towards implementation:

- **Payment systems need to be improved without increasing overall health care costs.** Many studies have shown high levels of waste and unnecessary services in health care systems, and establishing payment systems that encourage the reduction of waste and unnecessary services could reduce health care costs as well as improve quality. However, the transition to a new payment system and to the organizational structures needed to support it, even if it reduces costs and improves quality in the long run, will likely require significant transition costs for both payers and providers.

- **The goals of payment system changes need to be clearly defined.** Changes in payment systems are not ends in themselves but means to achieving improved health care quality and lower costs. Therefore, the success of a new payment

system is not determined by whether it is implemented as designed but by whether it achieves the goals that were intended. Consequently, it is essential that clear goals—in terms of improved quality, reduced cost or both—are established as part of any change in payment systems.

- **Pilot tests and demonstrations of new payment systems should be developed, implemented and evaluated in order to make progress on payment reform.** Even where there is agreement on the general structure of improved payment systems, there are many details to be worked out. In other cases, there is insufficient knowledge or experience to identify the preferred option. There will likely be unintended consequences and unexpected difficulties that need to be identified and rectified before broad-based implementation is warranted, and there will likely be differences in the structure of payment systems needed from region to region in response to differences in the number and type of providers available. Consequently, a wide variety of payment demonstrations are needed.

- **Demonstrations should be developed and implemented at the regional level.** The systems for delivering and paying for health care differ dramatically from region to region. However, this does not mean that payment reform should be a parochial enterprise. Regional initiatives across the country should work to coordinate their efforts, and national organizations should support the development, evaluation and replication of regional payment demonstrations.

- **Incentives should be aligned across multiple payers within the constraints of antitrust laws.** It is difficult, if not impossible, for health care providers to redesign their processes of care to respond to improved payment system incentives if only a small subset of payers change their approach to payment. Moreover, if most payers change payment systems in ways that are similar but different in the details, it will be more difficult and expensive for providers to respond. Although having multiple payers and multiple providers agree to use the same payment structure would still allow competition on price, it will be important to insure that discussions and agreements on changes in payment systems are carried out in ways that are permissible under federal and state antitrust laws.

- **Regional health care collaboratives should take the lead in payment restructuring wherever possible.** Because both payers' payment systems and providers' processes of care need to change in order to achieve the goals of improved quality and reduced cost, a neutral convener can help reach consensus on payment system changes that are workable for both payers and providers, as well as patients. Regional health care collaboratives, where they exist, can play a key role in finding win-win solutions for payment reform.

- **Improvements should be made in provider capacity and coordination as well as in payment systems.** The ability to implement many improvements in payment systems will be dependent on having providers operating in a coordinated fashion with the capacity to do sophisticated patient care management. Conversely, the ability and willingness of providers to coordinate their efforts and improve patient care will depend on having supportive payment systems. Consequently, in addition to developing demonstrations of payment system changes, there will

also need to be efforts to encourage and assist providers to make investments in improved care management infrastructure (e.g., staffing and information systems) and to enter into coordination agreements with other providers for both payment and quality improvement.

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

Appendix B: Attendees at the 2008 NRHI Summit on Healthcare Payment Reform

Laura Adams, President and Chief Executive Officer, Rhode Island Quality Institute

Stuart H. Altman, Ph.D., Dean, Heller School for Social Policy and Management, Brandeis University

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

Peter Benner, Board Member, Institute for Clinical Systems Improvement

Robert A. Berenson, M.D., Senior Fellow, The Urban Institute

Barry Bershow, M.D., Medical Director, Quality and Informatics, Fairview Health Services

Leah Binder, CEO, The Leapfrog Group

Kent Bottles, M.D., President, Institute for Clinical Systems Improvement

Craig Brammer, Senior Research Associate, University of Cincinnati

Niall Brennan, Senior Research Associate, The Brookings Institution

Jane Brock, M.D., M.S.P.H., Medical Officer, Quality Improvement Services, Colorado Foundation for Medical Care

Melissa Buckley, Investment Advisor, Health Evolution Partners

Sophia Chang, M.D., Director, Chronic Disease Care Program, California HealthCare Foundation

James Chase, Executive Director, Minnesota Community Measurement

Nancy Clarke, Executive Director, Oregon Health Care Quality Corporation

Guy Clifton, M.D., Senior Research Fellow, New America Foundation

James Costlow, Chairman, Premier Medical Associates

Patrick T. Courneya, M.D., Associate Medical Director for Delivery Systems, HealthPartners Health Plan

Andrew Croshaw, Senior Advisor, Office of the Secretary, U.S. Department of Health and Human Services

Michael Culyba, M.D., Vice President, Medical Affairs, UPMC Health Plan

Francois de Brantes, Chief Executive Officer, Bridges to Excellence

Cheryl DeMars, Chief Executive Officer, The Alliance

Terrisca Des Jardins, Senior Program Manager, Save Lives Save Dollars, Greater Detroit Area Health Council

Douglas Emery, Operations Manager, Prometheus Payment, Inc.

Kate Farley, Executive Director, Pennsylvania Employees Benefit Trust Fund

Karen Wolk Feinstein, Ph.D., President and Chief Executive Officer, Pittsburgh Regional Health Initiative

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

Adam Gordon, M.D., President, Allegheny County Medical Society

Allan H. Goroll, M.D., Professor of Medicine, Harvard Medical School

Richard L. Gundling, Vice President, Healthcare Financial Management Association

Kevin Hamler-Dupras, C.M.A., Actuarial Services Administrator, Oregon Department of Human Services

A. J. Harper, President, Hospital Council of Western Pennsylvania

Dianne Hasselman, Associate Vice President, Center for Health Care Strategies

Oliver W. Hayes, D.O., F.A.C.E.P., Vice President and Chief Medical Officer, Heritage Valley Health System

Nikki Highsmith, Senior Vice President, Center for Health Care Strategies

Shelley B. Hirshberg, Executive Director, P2 Collaborative of Western New York

David Hopkins, Ph.D., Director, Quality Measurement and Improvement, Pacific Business Group on Health

George J. Isham, M.D., Medical Director and Chief Health Officer, HealthPartners, Inc.

William A. Jesserer, Vice President, Aetna, Inc.

William G. Johnson, Ph.D., Professor, Biomedical Informatics; Director, Center for Health Information and Research, Arizona State University

Karen Jones, M.D., Physician Champion, Chronic Care Initiative, Wellspan Health

Maulik S. Joshi, Dr.P.H., Former President and Chief Executive Officer, Network for Regional Healthcare Improvement

Melinda Karp, Director of Programs, Massachusetts Health Quality Partners

David Kelley, M.D., Chief Medical Officer, Office of Medical Assistance, Pennsylvania Department of Public Welfare

Dianne Kiehl, Executive Director, Business Health Care Group

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

Jack Krah, Executive Director, Allegheny County Medical Society

Brad Kuhnhausen, President, AIM Administration

John LaCasse, President and CEO, Medical Care Development, Inc.

David Lansky, Chief Executive Officer, Pacific Business Group on Health

Judith Lave, Ph.D., Professor of Health Policy Management, University of Pittsburgh

Lisa Letourneau, M.D., M.P.H., Chair, Quality Counts

Chet Loftus, Assistant Director, Regulatory and Legislative Affairs, Regence Blue Cross Blue Shield

Oscar Lucas, A.S.A., M.A.A.A., Vice President and General Manager, Health Care Economics and Knowledge Services, Premera Blue Cross

Harold S. Luft, Ph.D., Director, Palo Alto Medical Foundation Research Institute

David Malone, Principal, Gateway Financial

Robert Mandel, M.D., Vice President, Blue Cross Blue Shield of Massachusetts

Peter McNair, M.P.H., Harkness Fellow, University of California San Francisco

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

Dwight McNeill, Ph.D., Vice President, Education and Research, National Quality Forum

Bruce McPherson, President and CEO, Alliance for Advancing Nonprofit Health Care

Mary McWilliams, Executive Director, Puget Sound Health Alliance

Gregg Meyer, Senior Vice President, Center for Quality and Safety, Massachusetts General Hospital

Harold D. Miller, President, Future Strategies LLC; Strategic Initiatives Consultant, Pittsburgh Regional Health Initiative

Ann Monroe, President, Community Health Foundation of Western and Central New York

Michael P. Nardone, Deputy Secretary, Office of Medical Assistance, Pennsylvania Department of Public Welfare

Steve Nielsen, President, Ceon Health

Christie North, Facilitator, Utah Partnership for Value-Driven Health Care

Jason Ormsby, Ph.D., Associate Director, Federal Relations, The Joint Commission

Brian Osberg, Assistant Commissioner, Health Care Administration, Minnesota Department of Health and Human Services

Michael W. Painter, J.D., M.D., Senior Program Officer, Robert Wood Johnson Foundation

Michael D. Parkinson, M.D., M.P.H., President, American College of Preventive Medicine

Barbara Prowe, Executive Director, Oregon Coalition of Healthcare Purchasers

Helen Riehle, Executive Director, Vermont Program for Quality in Health Care

Ann Robinow, President, Robinow Consulting

Shannon Robshaw, Executive Director, Louisiana Health Care Quality Forum

Joachim Roski, Managing Director, High Value Healthcare Project, The Brookings Institution

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

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

Cynthia Schlough, Director of Member Services and Strategic Partnerships, Wisconsin Collaborative for Healthcare Quality

Ralph Schmeltz, M.D., F.A.C.P., F.A.C.E., Member, Pennsylvania Chronic Care Commission

Stephen Schoenbaum, M.D., Executive Vice President for Programs, The Commonwealth Fund

David Share, M.D., Senior Associate Medical Director, Health Care Quality, Blue Cross Blue Shield of Michigan

Gregg Shibata, Associate Director, Center for Health Improvement

Wells Shoemaker, M.D., Medical Director, California Association of Physician Groups

Barbara Spivak, M.D., President, Mount Auburn Cambridge IPA

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

Ann S. Torregrossa, Esq., Deputy Director and Director of Policy, Pennsylvania Governor's Office of Health Care Reform

Micky Tripathi, President and Chief Executive Officer, Massachusetts eHealth Collaborative

Tom Valdivia, President, Carol, Inc.

Stephen Walker, M.D., Medicaid Medical Director, Louisiana Department of Health and Hospitals

Lisa Walsh, Partner, Bain & Company

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

Anne Weiss, Senior Program Officer, Robert Wood Johnson Foundation

Joel Weissman, Health Policy Advisor to the Secretary, Massachusetts Executive Office of Health and Human Services

Caroline Whalen, Program Project Director, Department of Executive Services, King County

Christine Whipple, Executive Director, Pittsburgh Business Group on Health

Janice Whitehouse, Senior Vice President, Save Lives Save Dollars, Greater Detroit Area Health Council

Matthew Wiandt, Product Development Lead, Carol, Inc.

Nancy Wilson, M.D., M.P.H., Senior Advisor, Agency for Healthcare Research and Quality and U.S. Department of Health and Human Services

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

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

Kathie Yakopovich, Director, Decision Support and Systems Implementation, Highmark, Inc.

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