

Healthcare Payment Reform

Alternative Payment Methodologies

June 2013

Table of Contents

Executive Summary 3

Introduction..... 5

The Current Payment System..... 5

Oregon’s Health System Transformation 6

Alternative Payment Models in Practice 8

Bundled Payments 9

Shared Savings14

Pay-For-Performance.....17

Patient Centered Medical Home Payment Models21

Understanding Payment Logistics 27

Total Cost of Care27

Determining the Financial Risk.....28

Implementing a New Payment Methodology 29

Ensuring Access to Timely Data30

Determining the Appropriate Financial Risk.....31

Aligning Incentives with Adequate Quality Measures31

Solving Contractual Issues.....33

Creating Collaboratives.....33

Transitional approach.....34

Conclusion..... 35

Executive Summary

Health care spending in the U.S. grew 3.9% in 2011 and continues to be a large part of the nation's Gross Domestic Product at 17.9%.¹ This concern is similarly significant in the state of Oregon where growth in health care spending increased at an average annual rate of 7.7% from 2001 through 2009. While much of the nation's health care system has responded to rising health care costs by reducing benefits, cutting provider and hospital payments, and dropping coverage all together, this is not a long-term solution.

Health care today relies heavily on a fee-for-service (FFS) payment system that rewards the volume of services provided rather than the value of the services provided. A predominately fee-for-service payment system can have the effect of creating incentives for delivering additional services regardless of their impact on health outcomes. Similarly, the undervaluation of preventive services and non-payment for care and services supporting patient-centered care and improved outcomes also have the effect of further diverting resources from quality of care. However, the Patient Protection and Affordable Care Act (PPACA) and the work of early adopters has presented payment reform opportunities that can be utilized by health care payers to create a system that rewards providers for rendering quality care in an efficient manner and has the potential to constrain the costs of healthcare while also leading to improved health outcomes.

Alternative Payment Methodologies

There are numerous examples of promising alternative payment methodologies (APMs) that exist and are increasingly being used by payers. As part of Oregon's current health care system transformation, newly developed Coordinated Care

Organizations (CCOs) that serve the state's Medicaid population will be encouraged to use these APMs that offer a constructive option in support of Oregon's three part aim of better care, better health, and lower costs. While there is a high level of consensus among Oregon stakeholders that a revised payment model should promote a value-based, patient-centered health care system, there has not been widespread adoption of such systems. However, some promising APMs with the potential to control health care costs and increase quality of care include bundled payment, shared savings, pay-for-performance (P4P), and patient centered medical home payments (PCMH) payments.

Promising Alternative Payment Methodologies

Bundled Payment

Providers are paid a set amount for all services rendered during a defined "episode" of care, including follow-up care.

Shared Savings

If providers meet or exceed cost-saving targets and quality measures, they can then share in a portion of the savings.

Pay-For-Performance

Providers are paid incentive payments based on quality indicators that are calculated as a percentage of the underlying fee-for service payment or a portion of claims paid withheld and then redistributed to providers.

Patient Centered Medical Home Payments

Additional activities and functions related to care management and population health are reimbursed by an extra fee that may be capitation or FFS based.

Payment Logistics and Challenges

As alternative payment methodologies are considered, payers will need to have a clear conception of the total cost of care in order to determine the most appropriate and effective payment methodology. Total cost of care factors include the number of care episodes and treatments patients may receive for various conditions. Each methodology then comes with an associated level of risk. Total cost of care and financial risk are two major logistical components of payment reform.

¹ Hartman M, Martin AB, Benson J, Catlin A, and the National Health Expenditure Accounts, Team. National Health Spending in 2011: Overall Growth Remains Low, But Some payers and Services Show Signs of Acceleration. *Health Affairs*, 32, no.1 (2013): 87-99.

In addition to logistical considerations, challenges to payment reform exist that may involve many significant barriers. Because of this, progress in changing payment systems that have been in place for decades has been slow. Oregon can prepare for these challenges by paying particular attention to ensuring access to timely data, determining the appropriate structure and level of financial risk, aligning financial incentives with adequate quality measures, solving contractual issues, and creating collaboratives in which to share best practices.

Conclusion

Many promising APMs exist that can be utilized by payers in Oregon's health care system. However, it is understood that transitioning to a different payment system may be challenging and can take time. The transitional phase can be guided by learning collaboratives or other forums that focus on identifying best practices and how different payment methodologies can be implemented. The state is currently developing a Transformation Center as a resource that will assist CCOs with learning collaboratives in addressing APMs and other critical aspects of health systems transformation. It is Oregon's intention to eventually spread successful transformation activities, and the coordinated care model in general, to the Public Employees Benefit Board (PEBB), the Oregon Educator's Benefit Board (OEBB), and Qualified Health Plans through the Exchange.

While a single method may be able to produce some improvement, multiple payment methods, coordinated and aligned between multiple payers to produce appropriate incentives, can work together to yield cost containment and improved quality and outcomes for health care services. The OHA believes that for most providers, the path from fee-for-service payment to comprehensive payment reform will transverse some intermediate ground wherein providers are paid in a mix of ways as they transition to greater accountability for outcomes, quality, and efficiency.

Introduction

Health care spending in the U.S. grew 3.9% in 2011 and continues to be a large part of the nation's Gross Domestic Product at 17.9%.² The health care system's response to rising costs in the recent past has been to reduce benefits, cut provider and hospital payments, and drop coverage all together. As this is not a long-term solution to the growing health care crisis, policy makers are now looking to payment reform as a constructive option that supports the triple aim goal of better care, better health, and lower costs.

Today, health care is rewarded for the volume of services provided rather than the value of the services provided. A predominately fee-for-service payment system can have the effect of creating incentives for delivering additional services regardless of their impact on health outcomes. Similarly, the undervaluation of preventive services and non-payment for care and services supporting patient-centered care and improved outcomes also have the effect of diverting resources from quality of care. Without payment reform, this structure will continue to perpetuate the growth of healthcare expenditures without necessarily improving the population's health.

In 2010, the Patient Protection and Affordable Care Act (PPACA) mandated several changes in existing compensation programs that have redirected the focus of provider payment systems from volume-based to value-based.³ With the opportunities that the PPACA has presented and the work of early adopters of payment reform initiatives, there are now numerous examples of promising *alternative payment methodologies (APMs)* being implemented at various levels in the health care delivery system with the potential to control health care costs improve health outcomes and increase quality of care.

As part of Oregon's current health care system transformation, newly developed Coordinated Care Organizations (CCOs) will be encouraged to use these APMs. CCOs are community-based organizations governed by a partnership among those sharing financial risk, providers of care, and community members. As a guide, this paper outlines the current payment system and alternative payment methodologies that can be utilized by health care payers, including CCOs, to create a system that rewards providers for rendering quality care in an efficient manner and has the potential to constrain the costs of healthcare while also leading to improved health outcomes.

The Current Payment System

Currently, the healthcare delivery system relies heavily on a fee-for-service (FFS) payment system in which a provider is paid a fee for rendering a specific service. Although seemingly straightforward, this system is built such that medical overutilization and resource inefficiency are rewarded.⁴ In addition, providers continuously struggle with understanding which fee schedule, claims edits, and payment rules apply.

During the 1980s and 1990s, the capitation was used to address some of the problems caused by a FFS health care system by controlling volume and penalizing poor quality. Capitation can be described as a prospective monthly payment for all covered services rendered for the continuous care of a patient. While capitation has provided some benefit, it also creates financial risks for providers that can result in the avoidance of patients

² Hartman M, Martin AB, Benson J, Catlin A, and the National Health Expenditure Accounts, Team. National Health Spending in 2011: Overall Growth Remains Low, But Some payers and Services Show Signs of Acceleration. *Health Affairs*, 32, no.1 (2013): 87-99.

³ Health Care Incentives Improvement Institute. *That was Then, This is Now*. 2006. Available at: <http://www.hci3.org/content/that-was-then-this-is-now>.

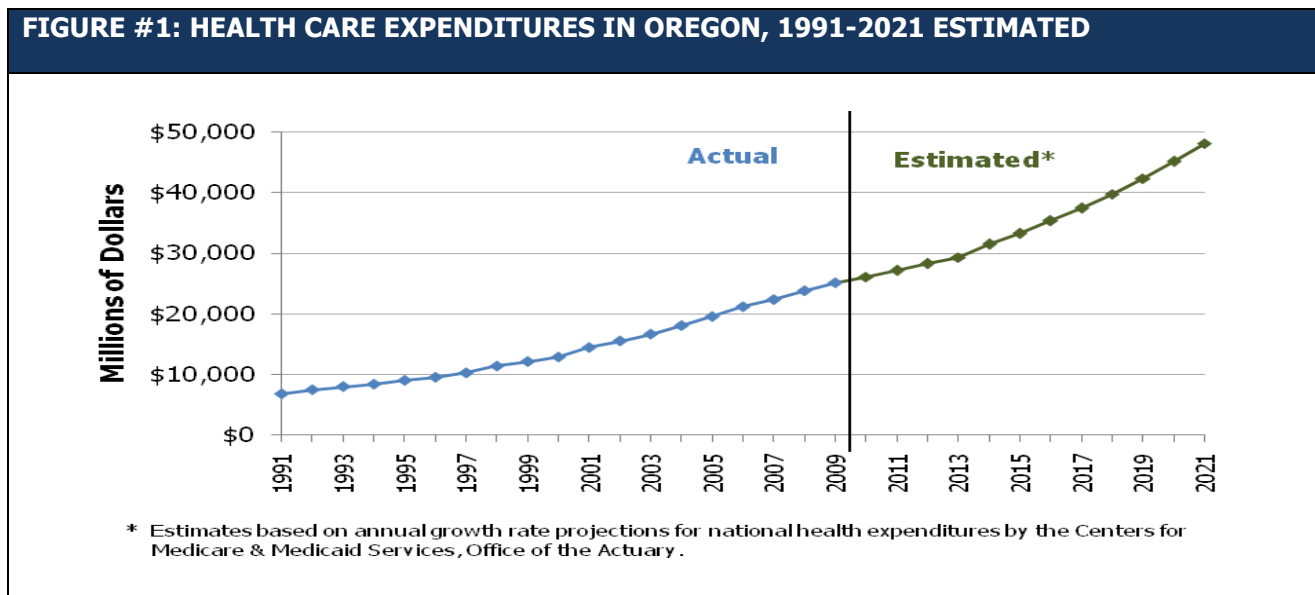
⁴ Schoen C, et al. *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*. The Commonwealth Fund. December 2007.

who have multiple or expensive-to-treat chronic conditions, or the underutilization of appropriate health services.

However, with support by the PPACA, many promising payment reform efforts are now being piloted and utilized through accountable care organizations that are integrating care by creating medical homes, bundling payments for episodes of care, and aligning payments with outcomes. Integrated models of care hold the promise of having providers work together to provide more efficient health care in a way that can be rewarded in a value-oriented way by aligning financial incentives with performance outcomes across all types of care (physical, behavioral, and oral).

Oregon's Health System Transformation

Oregon is no exception to rising health care spending. The state continues to suffer the effects of higher health care spending, increasing at an average of 7.7% annually between 2000 and 2009 (see Figure #1 below). In 1991, total health care expenditures in Oregon were \$6.8 billion, and in 2011, they are estimated to be at \$27 billion; quadrupling in 20 years. If no changes are made to the current spending patterns, health care expenditures in Oregon could reach \$33 billion by 2015.



Source: National Health Expenditure Data, Centers for Medicare & Medicaid Services. Available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>.

The impact of these increases are further compounded by the state's shrinking budget. But rather than cutting provider rates and benefits, Oregon is responding to the crisis by reforming the delivery system using a different model of integrated care built on the triple aim. This new model of care is now being implemented in Medicaid through Coordinated Care Organizations and encompasses key elements that include, but are not limited to:

- patient-centered primary care,
- robust quality measures for accountability,
- physical, mental and oral health integration, and of course,
- alternative payment methodologies.

Governed by partnerships among those sharing financial risk, providers of care, and community members, CCOs are community-based organizations that are the single point of accountability for quality of care and outcomes for enrolled members. They are also responsible reducing the fragmentation of mental health, substance abuse,

oral health, and long term health care services through greater care coordination. To help foster this coordination, CCOs have global budgets with the flexibility to institute their own payment and delivery reforms that will ultimately achieve the best possible outcomes for their membership. In addition, CCOs utilize Patient-Centered Primary Care Homes (PCPCHs) as an integral component of the delivery system as a way to enhance primary care and preventative services, manage chronic conditions, and provide care coordination across different types of care. While there are some differences in the governance and overall payment structure of CCOs, they have been described nationally as "Medicaid" Accountable Care Organizations (ACOs).

Oregon CCOs are paid using a global budget to finance the care for their Medicaid members across medical settings and they are also encouraged to use alternative payment methodologies in paying for services for members. CCOs transitioning to a different payment system may face challenges and it is understood that this transition may take time and will be a learning experience. However, the transitional phase can be guided by learning collaboratives identifying best practices and how different payment methodologies can be implemented.

In early 2013, the state was awarded a \$45 million State Innovation Model grant that will be used to support the Oregon Transformation Center, which is in the process of being developed and will work with payers, providers, community stakeholders and consumers to promote the successful implementation and spread of the key elements of reform and integration, including payment reform. The Transformation Center is a critical resource that will assist CCOs with learning collaboratives in addressing APMs and other critical aspects of health systems transformation. It is Oregon's intention to spread successful transformation activities, and the coordinated care model in general, to the Public Employees Benefit Board (PEBB), the Oregon Educator's Benefit Board (OEBB), and Qualified Health Plans through the Exchange. For now, this report is intended to provide a better understanding of payment reform models and to help guide all payers in selecting an appropriate method or "methods" that will work best for their members and providers to create better efficiency, increased value, and improved health outcomes.

Alternative Payment Models in Practice

Providers are typically not compensated appropriately based on care coordination and outcomes. As alternative payment methodologies are implemented, they should support the following objectives:

- Reimburse providers on the basis of health outcomes and quality instead of volume of care;
- Hold organizations and providers accountable for the efficient delivery of care;
- Reward good performance or create shared responsibility across sites of care and provider types;
- Create incentives for the prevention, early identification and early intervention of conditions that lead to chronic illnesses;
- Provide person-centered planning in the design and delivery of care, and use of patient-centered primary care homes; and
- Incentivize coordination across provider types and levels of care.

While there is a high level of consensus among Oregon stakeholders that a revised payment model should promote a value-based, patient-centered health care system, there has not been widespread adoption of such systems. In 2010 however, the Patient Protection and Affordable Care Act (PPACA) mandated several changes in existing compensation programs that have redirected the focus of provider payment system from volume-based to value-based.⁵ While payment systems for health care provider reimbursement have primarily utilized fee-for-service and capitation as the dominant payment methods, several *alternative payment methodologies* exist and some have the potential to control health care costs and increase quality of care. These methods are listed in the following table.

| PAYMENT METHODOLOGY | DESCRIPTION |
|--|--|
| Bundled Payment | Providers are paid a set amount for all services rendered during a defined “episode” of care. For example, a pre-determined amount may be paid to multiple providers for a patient undergoing a kidney transplant. This payment would cover the surgery and all services, including follow-up, associated with that “episode.” |
| Shared Savings | This model evaluates payments made over a period of time and sets cost-saving targets. If providers meet or exceed those targets, they can then share in a portion of the savings. The distribution of savings across multiple providers is typically tied to quality measures and outcomes. |
| Pay-For-Performance (P4P) | Incentive payments are built on a fee-for service base to reward structure, process, or health outcome achievements. These payments can be calculated as a percentage of the underlying fee-for service payment or a portion of claims paid can be withheld and then redistributed to providers based on quality indicators. |
| Patient Centered Medical Home Payment | Additional activities and functions related to care management, data/utilization management, and population health are reimbursed by an extra fee that may be capitation or FFS based. |

With the opportunities that the PPACA has presented and early adopters of payment reform initiatives, there are now numerous examples of alternative payment methodologies being implemented at various levels in the health care delivery system. The following is a description of some of these payment reform initiatives that promote the efficient provision of high-quality care.

⁵ Health Care Incentives Improvement Institute. op. cit.

Bundled Payments

Bundled payments can cover all services rendered during a defined “episode of care.” While not as common as FFS and capitation, bundled payment is not a new concept. For years, Medicare has paid hospitals predetermined amounts based on each patient’s clinical condition categorized as Diagnosis-Related Groups (DRGs). In addition, an early 1990s bundled payment demonstration in Medicare resulted in a 10% expenditure reduction for heart bypass surgeries.⁶ Labor and delivery has also historically been paid with a global fee that encompasses several related services. However, the difference is that these bundled payments have typically been paid to a single provider or entity, whereas the new approach is to lump multiple providers and service types together in a bundled payment arrangement that encourages providers to better coordinate care during an episode of care.

In general, bundled payment systems work to combine the services of various partners and build case rates for episodes of care based on historical claims data, allowing for only a portion of the costs associated with potentially avoidable complications. The models can be developed prospectively by providing a predetermined payment up front or retrospectively by developing a budgeted amount for an episode of care and either sharing the savings when there is a surplus, or sharing the losses. A Robert Wood Johnson Foundation (RWJF) study found that potentially avoidable costs constitute roughly 40% of the dollars spent on a set of chronic conditions that included congestive heart failure (CHF), coronary artery disease (CAD), Diabetes, Hypertension, chronic obstructive pulmonary disease (COPD), and Asthma.⁷

Bundled payments should act as an incentive for providers to work together to better coordinate their activities in a value-maximizing way. Despite inpatient care treatments being under the control of the physician, hospitals have been responsible for payments for devices, drugs and staffing. A bundled payment system would prompt the physician to better coordinate care and manage the utilization of services and resources to contribute to the greater good, thereby receiving a larger payment for their services. In combination with quality metrics and standards, these financial incentives can also promote better quality of care and result in less provider cost-shifting. Better quality of care and care management programs could reduce the need for home care and costly hospital readmissions. The Duke Clinical Research Institute estimated that proposed bundled payments for all heart failure care within 30 days of hospitalization, along with tested disease management programs to reduce readmissions, could lead to savings of \$347 per patient.⁸

Factors thwarting the implementation of bundled payment systems have been identified as fragmented provider networks, clearly defining episodes of care, administrative burdens associated with bundle packaging and payment distribution, and concerns about complications of chronic disease not being reflected in compensation. However, new provisions set forth within the PPACA supporting payment reform and technological advantages such as health information technology that can also work to advance care coordination have sparked payers’ interest in their ability to use the bundled payment model. Several promising bundled payment initiatives are described below.

Geisinger’s ProvenCare

ProvenCare is a Geisinger Health System (GHS), initiative that began with episode of care payments for coronary artery bypass graft (CABG) surgery. This approach requires that for each case, surgeons explicitly ensure that surgery is appropriate, document a shared decision-making process with the patient, and initiate post discharge follow-up to ensure compliance with medication and rehabilitation recommendations.⁹ To ensure evidence-based care, there are 40 benchmark steps involved in CABG surgery under ProvenCare.¹⁰ The key

⁶ Congressional Budget Office. Lessons from Medicare’s Demonstration Projects on Disease Management, Care Coordination, and Value-Based Purchasing. January 2012. Available: <http://www.cbo.gov/publication/42860>.

⁷ Francois de Brantes et al. Sustaining the Medical Home: How the Prometheus Payment Can Revitalize Primary Care.

⁸ Zubin J. Eapen, M.D., Shelby D. Reed, Ph.D., Lesley H. Curtis, Ph.D., et al. Do heart failure disease management programs make financial sense under a bundled payment system. *American Heart Journal* 161(5), pp. 916-922.

⁹ Lee TH. “Pay for Performance, Version 2.0?” *New England Journal of Medicine* 357, no.6 (2007): 531–533.

¹⁰ Information provided on Geisinger Health System’s website at: <http://www.geisinger.org/provencare/benchmarks.html>.

aspect of ProvenCare is a flat payment for surgery and all related care for 90 days after discharge. The flat rate assumes that GHS will reduce its historical complication rate by half. An evaluation of the first year's experience with Geisinger's ProvenCare coronary bypass bundled payment program showed a 10% reduction in readmissions, shorter average length of stay, reduced hospital charges, and a 44% decrease in hospital admissions over an 18 month period.¹¹ In the five-plus years since they first convinced their cardiac surgeons to adapt to standardized care, and aside from improving their methods for CABGs, Geisinger has expanded to bundled payment for elective coronary angioplasty (PCI), total hip replacement, bariatric surgery for obesity, perinatal care, and treatment for chronic conditions. The success of this program is also attributed to Geisinger's unique structure as a physician-driven, integrated delivery network with a system-wide electronic health record (EHR) and dominant market share.

Prometheus Payment Model

Developed in 2006, the Prometheus Payment Model packages payments around comprehensive episodes of medical care that cover all patient services related to a single illness or condition rather than paying for discrete visits, discharges, or procedures. To date, the Prometheus Payment model has developed numerous Evidence-Based Case Rates (ECRs) for these episodes that include hip and knee replacements, diabetes, asthma, congestive heart failure, and hypertension. These existing ECRs can potentially impact payment for almost 30% of the entire insured adult population and represent a significant amount of dollars spent by employers and plans.¹² This model encourages two behaviors that FFS discourages: 1) collaboration of physicians, hospitals, and other providers involved in a patient's care; and 2) active efforts to reduce avoidable complications of care (and the costs associated with them).¹³ It essentially works to eliminate cost related to potentially avoidable complications (PAC) under the provider's control such as hospitalizations resulting from an uncontrolled chronic condition or inappropriate wound care after a surgical procedure. For hip and knee replacements alone, one study found that 14% of total costs could be avoided in relation to PACs.¹⁴ Essentially, the Prometheus model creates a global price for a procedure, or an ECR, that differentiates between typical care and PACs and is adjusted based on the severity of the patient's injury or illness.

Since the Model was developed, several pilots supported by the RWJF have commenced. Three initial pilots resulted in lessons learned that have been formulated into an implementation toolkit developed by the Health Care Incentives Improvement Institute (HCI3) at <http://www.hci3.org/?q=node/101>. Dozens of payers and other agencies have used the tools created by the Institute to estimate the costs of their episodes of care. In June 2012, there were at least 19 pilots in the United States implementing bundled payment programs with public and private sector payers, and nearly half were using the PROMETHEUS Payment model. Of note, Maine's State Innovation Model identified that they will be using the PROMETHEUS model to evaluate episodes of care using their All Payer Claims Database (APCD) for their Medicare, Medicaid and the commercial population.

¹¹ Mechanic RE and Stuart HA. Payment Reform Options: Episode Payment is a Good Place to Start. *Health Affairs*, 28, no.2 (2009): w262-w271. (published online January 27, 2009; 10.1377/hlthaff.28.2.w262).

¹² Prometheus Payment, Inc. What is Prometheus Payment? An Evidence-Informed Model for Payment Reform. 2009. Available: <http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/06/what-is-prometheus-payment-.html>.

¹³ de Brantes F, Rosenthal MB, Painter M. Building a bridge from fragmentation to accountability —the Prometheus Payment Model. *N Engl J Med*. 2009;361(11):1033-1036.

¹⁴ Rastogi A, et al. Prometheus Payment Model: Application to Hip and Knee Surgery. *Clin. Orthop. Relat. Res.* 2009; Oct;467(10):2587-97.

Medicare Acute Care Episode Demonstration

The Acute Care Episode (ACE) Demonstration, tests the use of a bundled payment for both hospital (Medicare Part A) and physician services (Medicare Part B) for a select set of inpatient episodes of care that is limited to

ACE Demonstration Procedures

Orthopedic Procedures

Hip replacement
Knee replacement
Other lower extremity joint replacement

Cardiovascular Procedures

Coronary Artery Bypass Graft Surgery
Cardiac Valve Replacement Surgery
Cardiac Pacemaker Implantation and Replacement
Cardiac Defibrillator Implantation
Coronary Artery Angioplasty

Note: The ACE Diagnosis Related Groups (DRGs) are available for download at : <http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations-Items/CMS1204388.html>

orthopedic and cardiovascular procedures. The demonstration provides an opportunity for Medicare to share savings achieved through the demonstration with physicians and patients. The goals of this demonstration are to improve quality of care and outcomes for Medicare beneficiaries while providing a savings for beneficiaries, providers, and the Medicare program, and to improve decision making for beneficiaries and increased cooperation among providers. The ACE demonstration has already shown successful results. In a presentation at a Health Industry Forum in May 2011, the Baptist Health System reported that the demonstration resulted in hospital savings of \$4.3 million for Baptist from June 2009 through December 2010 and provided \$558,000 in gain sharing payments to physicians and \$646,000 in shared savings to Medicare patients (up to 50% of Medicare's savings, not to

exceed one year of Part B premiums ranging from \$200 to \$1,100).¹⁵ The Health System also experienced significant improvements in orthopedic quality metrics, including the increased utilization of standardized order sets.

Bundled Payments for Care Improvement Initiative

Through the PPACA, the newly created Center for Medicare and Medicaid Innovation (CMMI) is responsible for, among other things, launching a national bundled payment pilot program known as the *Bundled Payments for Care Improvement (BPCI) Initiative*.¹⁶ Under the BPCI Initiative, payments would be linked for multiple services patients receive during episodes of care defined by CMMI, but providers will have the flexibility to choose from 48 episodes of care and which services would be bundled together. In January 2013, over 100 participants were announced that will begin contracting with their partners to pilot four separate prospective and retrospective bundled payment models for inpatient-based episodes. Over the next three years, the CMMI will be monitoring the progress of the expansive pilots that includes more than 460 facilities across the U.S. The most common episodes chosen by the participants include major joint replacement of the lower extremity, percutaneous coronary intervention, coronary artery bypass graft and pacemaker device replacement or revision. Phase I of the initiative runs from January – July 2013 and is a no-risk preparation period. Phase II, beginning in July 2013, is the "risk-bearing implementation" period where participants move forward with implementation and assume financial risk, may enter into a Bundled Payments for Care Improvement Model agreement with CMS and begin Phase 2 of the Model. Since Phase II marks the beginning of the performance or risk-bearing period, findings will likely not be available until at least July 2014 assuming one year of initiative evaluation.

¹⁵ Baptist Health System. Lessons Learned from the Acute Care Episode Demonstration Program. Presented at the Health Industry Forum - Episode Payment: Private Innovation and Opportunities for Medicare. May 17, 2011. Available: <http://healthforum.brandeis.edu/meetings/materials/2011-17-may/Baptist-ACE.pdf>.

¹⁶ Information on *Bundled Payments for Care Improvement initiative* can be accessed at: <http://innovation.cms.gov/initiatives/bundled-payments/index.html>.

California Public Employees' Retirement System^{17,18}

In 2008, elective hip and knee replacements cost the California Public Employees' Retirement System (CalPERS) \$55 million. Because the hospital bills ranged from \$15,000 to \$110,000 with no discernible difference in quality, CalPERS limited what it would pay for knee and hip replacement surgeries to \$30,000. It found multiple high quality hospitals willing to stay within that threshold amount, and its average price per surgery dropped almost 28% to \$23,113 in 2011. Members of some of the CalPERS plans have 100% coverage, including the cost of travel, when electing to receive these procedures at a participating hospital or facility. In 2012, CalPERS applies thresholds to PPO outpatient hospital utilization for colonoscopies (\$1,500) cataract surgeries (\$2,000), and Arthroscopies (\$6,000). Members are required to pay any charges above the threshold when using outpatient hospitals instead of ambulatory surgical centers.

Arkansas Payment Initiative

Public and private health care payers in Arkansas are undertaking a multi-payer bundled payment initiative led by the Arkansas Department of Human Services to align financial incentives with quality outcomes. The initiative has identified several episodes of care that include hip/knee replacements, acute/post-acute chronic heart failure, ADHD, perinatal and more in which they make retrospective payments to a principal accountable provider (PAP). To identify a PAP, payers use claims data for each episode of care to determine which physician practice, hospital or other provider is most responsible and accountable for the quality and cost of care. If the PAP meets quality standards and has average costs below a specified threshold they will share in savings up to a 50% limit. Conversely, costs above a specified threshold will also be shared with the PAP at 50%. Savings from this initiative are expected to come across inpatient hospital, outpatient hospital, professional specialty care, diagnostic imaging / x-ray, laboratory services, DME, dialysis procedures, other professional (e.g., PT, OT, etc.), and prescription drugs categories. Reductions in volume for hospitals will be offset by gain sharing for more efficient hospitals and for some episodes, effective reimbursement will increase for high-quality, efficient physicians and other professional designated PAPs. For more information, see www.paymentinitiative.org.

BUNDLED PAYMENTS IN OREGON

Providence

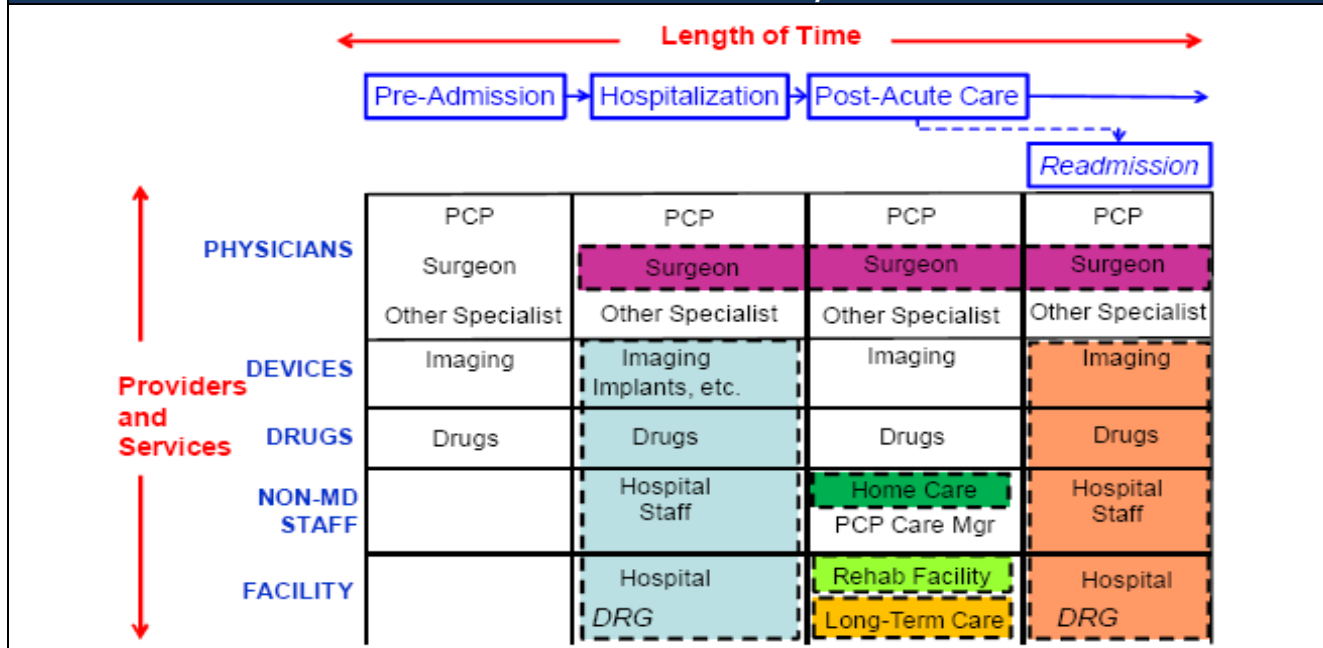
Providence has been working on a joint replacement pilot that bundles claims specific to the particular episode of care, which includes 60 days post surgery. The hospital is identified as the "bundle maker" and is responsible for distributing savings for joint replacement episodes costing less than a predetermined budgeted amount. Contracts between the hospitals and physicians specify how gainsharing will be done based on savings and quality outcomes that include patient expectations, length of stay, skilled nursing facility care upon discharge, and more. Providence is now working to expand this pilot to coronary artery bypass graft episodes of care.

While bundled payments show promising results, defining and coordinating episodes of care can be complicated. It is thought that payers should start with episodes of care with the highest volume and cost that have actionable standards of care. As identified in the examples above, bundled payments have generally involved episodes such as CAGBs and angioplasty, hip and knee replacements, chronic heart failure, and perinatal. Once an episode of care is selected, payers must work with provider groups and hospitals and assess the data to determine what services and supplies are necessary to provide quality and value-based care. In addition, it must also be established what types of post operative acute care would be included in the bundle for each episode and how much will be allowed for potentially avoidable complications. Figure #2 below provides a helpful visual of the potential elements involved in bundled payments for episodes of care.

¹⁷ Robinson JC, MacPherson K. Payers Test Reference Pricing And Centers Of Excellence To Steer Patients To Low-Price And High-Quality Providers. *Health Affairs* 31, No. 9 (2012): 2028–2036.

¹⁸ Donnenson K. California Public Employees Retirement System (CalPers). Bundled Payments: What's Happening? Presentation at the Healthcare Financial Management Association Southern California and San Diego/Imperial Chapter Fall Conference. September 9, 2012.

FIGURE #2: POTENTIAL ELEMENTS OF AN EPISODE PAYMENT FOR MAJOR ACUTE CARE, INCLUDING COMPONENTS ALREADY PAID ON AN EPISODE/CASE RATE BASIS



Source: The Center for Healthcare Quality and Payment Reform. Paths to Healthcare Payment Reform: Transitioning to Episode-Based Payment Available at: www.chqpr.org.

There are also a few barriers to consider. For instance, bundled payment systems do not prevent episodes from happening. While this payment methodology focuses on the course of treatment during an episode, there is no attention paid to preventing the episodes other than readmissions for preventable complications. Secondly, a majority of payers need to participate in bundled payment initiatives to change practice behavior. If only a subset of payers move away from FFS payment, providers that change care in a way that will be supported under improved payment systems will be penalized financially for those patients still being paid for under FFS. On the other hand, providers will fail financially for patients covered by the newer payment systems if they continue to deliver care consistent with traditional FFS incentives.¹⁹

Lastly, hospitals play a large role in episode of care coordination and payment. However, their willingness to participate in such payment models that work to reduce hospital admission has been tempered by their need for sustainability. Hospitals, while representing the largest share of total health care costs, are generally disadvantaged in payment reform efforts due to their need to support fixed costs. As a practical matter, if health care spending is to be reduced, some or even all hospitals in each region will have to experience a decrease in volume, and this can have a negative impact on those hospitals' operating margins, because with fewer admissions, a hospital's costs will decrease far less than will its revenues, particularly in the short run.²⁰ To foster hospital participation, efforts and agreements must address their unique needs and challenges. For example, payers may need to increase payment amounts for a transition period to reflect the fact that a hospital's unit costs will be higher with lower volumes, but hospitals must also aggressively look for ways to reduce their fixed costs and be more transparent about their cost structures.²¹ Hospitals may also need to find ways to increase their market share without the traditional means of competition amongst hospitals (e.g., purchasing the latest technology and remodeling facilities).

¹⁹ Miller HD. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. Center for Healthcare Quality and Payment Reform. December 2012.

²⁰ Miller HD. Methodology on adverse events. Health Affairs (Millwood). January/February 2007. 26(1):293.

²¹ Miller HD. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. op cit.

Shared Savings

There are opportunities for shared savings when members are healthy and not in need of high-cost care such as emergency room visits. As with bundled payments, shared savings has been gaining interest as an approach to healthcare payment reform. As mentioned above, this model typically evaluates payments made over a period of time and sets cost-saving targets for the ensuing period (most often a year). If providers meet or exceed those targets, they can then share in a portion of the savings referred to as “upside risk.” However, “downside risk” may be spread across the providers when targets are not achieved. The distribution of savings across multiple providers is typically tied to quality measures and outcomes. The desired outcome is that the payer spends less on unnecessary services and test and the provider get gets more for providing quality care. Several successful shared savings initiatives exist today and have shown positive results.

Medicare Shared Savings Program (ACOs)

The Medicare Shared Savings Program (MSSP) establishes rewards for participants who lower their growth in health care costs while meeting a detailed quality performance standard. Hospitals, providers, and suppliers providing care to Medicare Fee-For-Service (FFS) beneficiaries may participate in the MSSP by forming an Accountable Care Organization (ACO). The goals of the MSSP are to improve beneficiary outcomes and increase care value through promoting accountability via 33 quality measures for Medicare FFS beneficiary care, requiring coordinated care for all Medicare FFS services, and encouraging redesigned care processes and investment in infrastructure.²² Early participants in the MSSP are finding success and savings. A Commonwealth Fund report covering early adopters of the ACO model details NewHealth Collaborative (Summa Health System) lowering its 2011 Medicare Advantage costs by 8.4% largely through reduced hospital use including a 10% reduction in readmissions.²³ In addition to cost savings, NewHealth also reports increased physician engagement resulting from financial incentives, education, support, and an understanding of the value of infrastructure investments including electronic health records.

Blue Cross Blue Shield of Massachusetts Alternative Quality Contract

In 2009, Blue Cross Blue Shield of Massachusetts (BCBS) implemented a global payment system called the Alternative Quality Contract (AQC). Hospitals and physicians make up provider groups in the AQC system and take responsibility for the full continuum of care received by their patients—including the cost and quality of that care—regardless of where the care is provided. The participants bear financial risk (downside risk) share in savings (upside risk). These provider groups are also eligible to receive bonuses for quality. The AQC employs a population-based global budget coupled with significant financial incentives based upon performance on a broad set of quality measures. An analysis of the first year showed that the AQC was associated with significant quality improvement and 1.9% slower growth in medical spending in 2009 relative to the rest of the network not under an AQC. This figure includes incentives payments of approximately 3% on average. An analysis of the second year (2010) found a 3.3% slower growth in spending. BCBS of Massachusetts reports that savings were more dramatic among AQC groups that had been paid on a fee-for-service basis before the contract. AQC provider groups in this category achieved a first-year savings of 6.3% and second-year savings of almost 10%. For 2009 and 2010, the AQC groups were able to reduce spending largely by referring patients to lower-cost facilities for services, such as imaging and lab testing, and by reducing these areas of utilization.

CalPERS Shared Savings Pilot

At the suggestion of Blue Shield, CalPERS formed an Accountable Care Organization with its two Sacramento provider organizations in 2010. The providers agreed to hold 2010 payments to 2009 levels, a zero-cost increase, while maintaining quality care and patient satisfaction commitments for the 41,000 covered CalPERS members in the newly formed ACO. Blue Shield and the providers share a target per-member per-month cost goal, but earlier payment mechanisms are still honored with the hospital receiving fee-for-service payments and the physician group receiving capitation compensation. With a goal of achieving a 15.5 million dollar cost

²² The CMS Medicare Shared saving Program (SSP) website available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html>.

²³ Silow-Carroll S, Edward JN (Health Management Associates). Early Adopters of the Accountable Care Model: A Field Report on Improvements in Health Care Delivery. The Commonwealth Fund. March 2013.

savings for 2010, the three organizations integrated and utilized data to reduce hospital readmissions and inpatient days, coordinate and standardize care, rapidly disseminate patient medical information amongst the organizations, and monitor progress towards savings goals. First year results achieved the zero-cost increase, versus historical annual growth of 8-12% each year, through more than \$15.5 million in savings, including a 20% reduction in per-member-per-month costs for inpatient admissions. When compared with other Northern California CalPERS members, the results showed a 15% reduction in inpatient readmissions within 30 days and a half-day reduction in average patient length of stay.²⁴

Blue Cross Blue Shield of Illinois and Advocate Health Care

In 2011, BCBS IL began a shared savings program with Advocate Health Care, largest integrated health care system in the state, for members enrolled in fully-insured or self-insured commercial PPOs in the Chicago area. In order to receive shared savings payouts, the approximately 3,500 Advocate physicians in the pilot must: 1) have a cost trend that is lower than the risk adjusted trend of the non-participating PPO network, and 2) meet performance benchmarks on twelve quality measures. They are penalized if performance has declined.²⁵ AdvocateCare, the ACO run by Advocate and BCBS IL, reported that for the first six months of 2011, hospital admissions per member fell 10.6% compared with 2010 results, and emergency room visits were down 5.4%.²⁶

Texas Medicaid Gain Sharing Program and Quality Challenge Award²⁷

Medicaid managed care contracts in Texas require MCOs to conduct pilot “gain sharing” programs that focus on collaborating with network physicians and hospitals in order to allow them to share a portion of the MCO’s savings resulting from reducing inappropriate utilization of services, including inappropriate admissions and readmissions related to Potentially Preventable Events (PPE). These programs must include mechanisms for incentive payments to hospitals and physicians for quality care and include quality metrics required for incentives, recruitment strategies of providers, and a proposed structure for payment.

Texas Medicaid contracts also include a Quality Challenge Award whereby 5% of a MCO’s capitation can be withheld based on performance-based measures. Should an MCO not achieve those performance levels, future monthly capitation payments will be adjusted by an appropriate portion of the 5% at-risk amount. Unearned funds from the performance-based, at-risk portion of an MCO’s capitation rate are redirected to the MCO Program’s Quality Challenge Award (QCA) to annually reward MCOs that demonstrate superior clinical quality, service delivery, access to care, and/or member satisfaction. In the first year, readmissions-related savings could reach \$120 million, and the state expects even more savings for complications adjustments. The state found that mental health conditions were the most frequent reason for preventable readmissions.²⁸

Shared Savings in Medicaid ACO Programs²⁹

State Medicaid agencies are using the Medicare Shared Savings Program (MSSP) model as a basis for new ACO programs that seek to better align provider incentives to improve care for low-income populations. These shared savings approaches are being used in Minnesota and New Jersey with modifications to the MSSP methodology to account for differences in the populations served and the structure of their ACO programs, including adjustments for managed care delivery systems. These differences include altered minimum savings rates and alignment of patient attribution methods. Minnesota’s Health Care Delivery Systems (HCDS) Demonstration, a three-year demonstration approved by CMS in July 2012 through a state plan amendment

²⁴ Blue Shield of California. An Accountable Care Organization Pilot: Lessons Learned. 2012. Available at: https://www.blueshieldca.com/employer/documents/knowledge-center/features/EKH_ACO%20Lessons%20Learned%20Case%20Study.pdf .

²⁵ Bailit M, et. al. Shared-Savings Payment Arrangements in Health Care. Commonwealth Fund. August 2012.

²⁶ Hancock J, New Insurer-Hospital ACO Touts Early Success. Kaiser Health News. March 8, 2012. Accessed at: <http://capsules.kaiserhealthnews.org/index.php/2012/03/new-insurer-hospital-aco-touts-early-success/>.

²⁷ Texas Health and Human Services Commission. Texas Medicaid Managed care Quality Strategy: 2012-2016. Available at: www.hhsc.state.tx.us/1115-Quality-Strategy.shtml.

²⁸ National Association of Medical Directors. Spotlight on States: Texas’ Payment Adjustment Policies. July 23, 2012. Available at: <http://medicaiddirectors.org/node/481>.

²⁹ Houston R, McGinnis T. Adapting the Medicare Shared Savings Program to Medicaid Accountable Care Organizations. Center for Health Care Strategies, Inc. March 2013.

(SPA), builds on an existing patient-centered medical home (PCMH) initiative and aims to improve care coordination and move away from paying for volume to paying for value in health care services and includes a savings component that is similar to the MSSP model. The HCDS has two tracks for shared savings, though ACOs are assigned a track based on the structure of the organization. Non-integrated providers and organizations have a 50/50 upside risk-only model, while fully integrated systems participate in the integrated option, in which shared losses are gradually incorporated over the demonstration period. Six organizations were selected to participate in the first iteration of the program beginning January 1, 2013.

In New Jersey, communitywide Medicaid ACOs were created with shared savings arrangements. Under the initiative, the ACOs must apply for state certification and serve a defined geographic “designated area” with the written support of all general hospitals, 75% of Medicaid PCPs, and at least four behavioral health providers in the area. Applicants must be non-profit organizations serving at least 5,000 Medicaid patients. Certified ACOs are able to establish a gain-sharing arrangement with the Medicaid program and Medicaid managed care organizations (MCOs), but it is up to the parties to define the methodology that will govern their specific agreement; making health plans participation voluntary. The state partnered with the Rutgers Center for State Health Policy (CSHP) to develop an upside-only gain-sharing arrangement, largely based on the MSSP, to give the ACOs guidance in developing their shared savings methodology. New Jersey is operating this initiative under its existing managed care authority, and is also developing a method to enroll the state’s small FFS general assistance population.

SHARED SAVINGS IN OREGON

North Bend Medical Center

Last year, a 50-physician group practice clinic based in Coos Bay, the North Bend Medical Center, was announced by CMS as a Medicare ACO. All ACOs that succeed in reducing the rate of growth in the cost of care while providing high quality care may share in the savings to Medicare. To that end, the Medical Center is a participant in the Medicare SSP.

Coordinated Care Organizations

Oregon CCOs operate under a global budget to provide coordinated care to Medicaid members with the goal of improving care and reducing costs so that deeper reductions will not be necessary. As one method to support this goal, the OHA is using a shared savings approach in which 2% of the CCOs’ budget is withheld and placed in to a quality incentive pool. The portion of available quality pool funds that a CCO will receive is based on the number of CCO incentives measures on which it achieves either an absolute benchmark or demonstrates improvement from its own baseline (the “improvement target”). OHA has also set a floor so that, regardless of enrollment, each CCO is eligible to earn at least \$1 million dollars from the quality pool, if they meet improvement targets or achieve benchmark values on at least 75% of incentive measures and meet or exceed the benchmark or improvement target for an Electronic Health Record (EHR) measure. Quality pool incentives will be distributed mid-year 2014 for year one of CCO contracts. By keeping members at their healthiest and out of high-cost emergency rooms, providers would be paid more than if their members’ health did not improve. More information on CCO metrics is available at <http://www.oregon.gov/oha/news/Pages/Resources.aspx>.

Despite positive results from shared savings programs across the country, there are some concerns about negative impacts of this approach. Literature from the Center for Healthcare Quality and Payment Reform claims that the shared savings model as it is today is not sustainable because it does not change the underlying payment system, it can reward high spenders rather than high performers, and it can also result in a reduction in revenues for some providers and hospitals. However, the Center explains that shared savings could be done in a few ways: 1) with payers and providers sharing risk for value-improvement programs with a high return on investment and 2) by recalibrating hospital payment levels to allow for enhanced rates reflecting revised costs in order to discourage hospitals from raising rates to compensate for lost revenue from reduced admissions.³⁰

³⁰ The Center for Healthcare Quality and Payment Reform. Paths to Healthcare Payment Reform: Is “Shared Savings” the Way to Reform Payment? Available at: <http://www.chqpr.org/downloads/SharedSavings.pdf>.

Pay-For-Performance

Pay-for-performance (P4P) is a method of reimbursing providers based on the achievement of pre-determined measures of quality. Quality can be outcome-based and measured in terms of benchmarking, or quality can be process-based and measured in terms of improvement.³¹ There is a growing interest in these programs due to variation in quality across providers, difficulty within the current payment system to reward high-quality, cost-effective care, and the lack of incentive within the current system to encourage providing services with long-term health or cost savings payoffs.³² Proponents of P4P also argue that consumer choice alone does not provide sufficient incentive for providers to improve their quality of care and that consumers do not consistently use available information on quality to aid in their healthcare decision-making.³³

The most common form of P4P financial incentive is the bonus payment. Bonus payments are monetary sums paid to providers in addition to the usual fee associated with a service if the provider reaches certain quality goals. There are various types of bonus payments as well as a few additional methods of financial incentives used in P4P systems, identified in the table below.

| TYPE OF P4P | DESCRIPTION |
|--|---|
| Bonus or Withhold | Reward payments can be made through a bonus pool, disbursed at the end of the measurement period. Some payers use withholds and might withhold 5% or 10% of physicians' fees. Employers might withhold a small percentage of premiums paid to health plans. |
| Penalties | Payers may reduce payments to provider organizations and physicians who do not achieve an acceptable level or improvement of performance. |
| Fee Schedule Adjustment | Payers may adjust fee schedule payments up or down, depending on performance, by adjusting the conversion factor that translates fee schedule relative value units (RVUs) per service into dollar payments. |
| Per-Member Payment | In capitated environments, or plans in which patients are enrolled with primary care providers, a health plan might pay providers an additional or incremental per member per month or per member per year payment that is contingent on measured performance. |
| Differential Payment Update | Payers can reward provider organizations and physicians that perform well with an update factor to their payments that is higher than those given to provider organizations and physicians that perform poorly. |
| Payment for Provision of a Service | A payer can establish payment, or enhanced payment, for services that further the goals of the P4P program. |
| Payment for Participating/Reporting | Programs might pay provider organizations and physicians to engage in performance-enhancing activities, such as developing quality improvement action plans, attending continuing education programs, or implementing computerized physician order entry. Alternately, payers might pay provider organizations and physicians for reporting performance measures. |
| Lack of Payment for Poor Performance | Payers can deny payment for services that appear to be ineffective, harmful, or inefficient. |
| Shared Savings (previously described above) | Payers can give providers incentives to improve efficiency and generate savings by allowing them to share in the realized savings. |
| Quality Grants or Loans | A provider could apply to a payer for a grant to implement quality-enhancing infrastructure changes, such as an EMR or patient registry. |

Source: Cromwell J, Trisolini MG, Pope GC, et. al. Pay For Performance in Health Care: Methods and Approaches; pp50-52. Research Triangle Institute. March 2011.

³¹ Llanos K, Rothstein J, Dyer MB, et. al. Pay-for-Performance in Medicaid: A Guide for States. Center for Healthcare Strategies, Inc. March 2007.

³² Nichols LM, O'Malley AS. Hospital Payment Systems: Will Payers Like the Future Better Than The Past? Health Affairs. 2006; 25(1): 81-93.

³³ Rosenthal MB, Fernandopulle R, Song HR, et. al. Paying For Quality: Providers' Incentives For Quality Improvement. Health Affairs. 2004; 23(2): 127-141.

It has been shown that hospitals can gain up to 15% in additional revenue from the successful implementation of P4P programs, and it has not been demonstrated that these programs put hospitals at a large financial risk.³⁴ This is, however, heavily dependent upon how the program is designed. Generally speaking, public P4P initiatives tend to be budget neutral while programs in the commercial sector are not. For example, some private payers, such as BCBS of Michigan, make use of the bonus payment without an explicit source of funding such as a withhold.³⁵ In contrast, the national CMS demonstration project funded payment by reducing the yearly total base payments for all hospitals in the PPS by an amount equal to the total projected bonus payments.³⁶ States have used additional methods of funding bonus payments including budgeting specific pools of dollars; funding “challenge pools” where unearned bonus monies or unearned withheld capitation payments are paid out to those who excel; reallocating monies collected as penalties; linking rate increases to physicians meeting certain standards; and withholding a portion of an organization’s capitation payment and paying it back later contingent upon performance.³⁷ While the private sector has more experience than the public sector with P4P programs, several pilot projects have taken place at the state level for both Medicaid and Medicare.

Hospital Quality Incentive Demonstration

The Hospital Quality Incentive Demonstration (HQID) project was the nation’s largest hospital value-based purchasing demonstration, led by the Centers for Medicare & Medicaid Services (CMS) and the Premier healthcare alliance. Throughout the project, Premier collected data on more than 30 evidence-based clinical quality measures from more than 200 participating hospitals. Clinical areas included Acute Myocardial Infarction, Heart Failure, Isolated Coronary Artery Bypass, Pneumonia and Hip or Knee Total Replacement. The CMS/Premier HQID project served as testing ground for healthcare reform. With six years of experience as part of the program, participants helped to inform the legislation and implementing regulations for value-based purchasing (VBP). With VBP now a law under the ACA, hospitals that participated in the HQID have provided valuable lessons that can help others save lives and craft rules to govern their own value-based initiatives. Over the project’s six years, HQID participants:

- Raised their overall quality by an average of 18.6% based on more than 30 quality measures, such as the proper administration of Beta blockers and antibiotics, in six clinical areas.
- Administered approximately 962,540 additional evidence-based clinical measures to 2.7 million patients treated in the six clinical areas at the 216 participating hospitals.
- Saved the lives of an estimated 8,500 heart attack patients, according to a Premier analysis of mortality rates.
- Received incentive payments of more than \$60 million from CMS for performance, improvement, and attainment of quality goals.

In addition, 18 hospitals moved from the bottom to the top 20% of hospitals in one or more clinical areas, improving quality scores by an average of 29.2%. It is estimated that an expansion of this project to all acute care hospitals that are paid under the Medicare PPS would result in an estimated net savings of \$34.0 billion over 10 years. The impact to state and local governments would be a savings of \$0.8 billion over 10 years.³⁸ The estimated savings is predominately due to an expected decrease in readmissions for Medicare beneficiaries. It should be noted that these estimates are only based on P4P programs for inpatient services. If the program was expanded to all providers and all services, additional savings could be expected.

Integrated Healthcare Association

The Integrated Healthcare Association (IHA) P4P project is a collaborative that includes eight California health plans with more than 11.5 million commercial HMO enrollees. Participating health plans helped develop a uniform performance measure set that includes a set of 68 clinical quality, patient satisfaction, coordinated diabetes care, and investment in information technology measures. Since program inception, physician groups have improved in all measurement areas: clinical performance improved by an average of 3% annually and

³⁴ Rosenthal MB, op cit.

³⁵ Ibid.

³⁶ Schoen C, op. cit.

³⁷ Llanos K, op. cit.

³⁸ Schoen C., op. cit.

patient experience saw an initial jump of 2.2% and then leveled off. The greatest improvement has come in physician group use of information technology, with an average annual increase of 7% in the number of groups adopting specific IT activities. Financial incentives paid from 2004 through 2008 (for the prior measurement year) totaled approximately \$264 million.³⁹

BCBS of Michigan Value Partnership⁴⁰

The Hospital Pay-for-Performance program, or P4P, recognizes and rewards hospitals based on their efficiency, commitment to patient safety, performance on select quality indicators and participation in Collaborative Quality Initiatives (CQIs) that address some of the most common and costly areas of surgical and medical care. As of 2012, Blue Cross Blue Shield of Michigan is providing funding and leadership for 12 hospital-based CQIs that include readmissions reporting, timing of acute myocardial infarction – percutaneous coronary intervention, initial antibiotic selection for pneumonia, surgical care infection prevention for four surgery types (i.e., CABGs and cardiovascular, hip and knee replacements, colon, and hysterectomies), and minimizing elective induction of delivery between 37 and 39 weeks. The program has weighted ratings for quality indicators that are used for participating hospitals to earn, on average, an additional 5% on all inpatient and outpatient payments. Participation in the first QCI designed to improve care for patients who undergo angioplasty resulted in decreases in hospital deaths (20%), Emergent coronary artery bypass grafts (92%), Myocardial infarctions (64%), strokes (18%) since 2002.

Bridges to Excellence

Bridges to Excellence (BTE) is a not-for-profit multi-stakeholder organization that has been working with physicians, hospitals, employers, and health plans on implementing incentives and rewards programs for more than five years in different geographic sites across the United States. In order to receive BTE recognition, eligible clinicians must pass a corresponding performance assessment program administered by one of the BTE-recognized Performance Assessment Organizations that includes the National Committee for Quality Assurance (NCQA). BTE measures quality of care in physician practices with programs that include all chronic conditions, physician office systems, and even medical home practices.⁴¹ One report suggests that physicians participating in BTE programs provided higher quality care at lower cost than nonparticipating physicians.⁴² The report found that the incremental benefit when a physician earns BTE recognition can be estimated to be roughly \$250 per patient for the health plan. BTE's analyses of claims data comparing patients that are seen by BTE-recognized physicians and those that go to non-recognized physicians shows conclusively that their average severity-adjusted cost of care is lower by about 10%.⁴³

In 2006, a number of Colorado health plans and employers joined together to implement the Bridges to Excellence (BTE) diabetes and cardiac programs. Under the leadership of the Colorado Business Group on Health (CBGH), these groups agreed to recognize and reward physicians who voluntarily applied to this national organization and who could demonstrate that most of their patients could meet rigorous standards for metrics on blood pressure, cholesterol, blood sugar and other vital statistics. By December 2011, 670 recognitions to 334 physicians had been awarded. Since 2006, CBGH has observed that for diabetes, BTE recognized physicians have lower cost and lower utilization in terms of a lower number of emergency room visits (7%), less total days spent in a hospital (18%), and a lower frequency of hospital admissions (15%).⁴⁴

³⁹ Integrated Healthcare Association. The California Pay for Performance Program. The Second Chapter Measurement Years 2006-2009. June 2009.

⁴⁰ Blue Cross Blue Shield of Michigan's Value Partnerships program. Information available at: <http://www.bcbsm.com/providers/value-partnerships/value-partnerships-overview.html>.

⁴¹ Bridges to Excellence. A vision to transform U.S. Health Care: The Programs that Make it a Reality. Health Care Improvement Incentives Institute Vision Brochure. 2009. Available at: http://www.hci3.org/what_is_bte/tools_and_resources.

⁴² Rosenthal MB, de Brantes FS, Sinaiko AD, et. al. Bridges to Excellence—recognizing high-quality care: analysis of physician quality and resource use. *Am J Manag Care*. 2008;14(10):670-677.

⁴³ Health Care Incentives Improvement Institute. Frequently Asked Questions. Available at: <http://www.hci3.org/content/frequently-asked-questions-faqs-media>.

⁴⁴ Colorado Business Group on Health. Colorado health Matter 2011-12: Quality Report: Physicians. 2012. Available at: www.ColoradoHealthOnline.org.

Medicare Physician Group Practice Demonstration⁴⁵

In April 2005, CMS launched its first value-based purchasing pilot or "demonstration" project- the Medicare Physician Group Practice (PGP) Demonstration. In the Medicare PGP demonstration, the CMS contracted with 10 large multispecialty groups with diverse organizational structures, including free-standing physician groups, academic faculty practices, integrated delivery systems, and a network of small physician practices. National benchmarks and group specific quality improvement targets were used to provide incentives for quality improvement as well as to recognize groups that are achieving high levels of performance. The PGPs earned performance payments of up to 80% of the savings they generated, while the Medicare Trust Funds retained at least 20% of the savings. In year five, quality scores increased from the baseline to an average of 11% on diabetes measures, 12% on heart failure measures, 6% on coronary artery disease measures, 9% on cancer screening measures, and 4% on hypertension measures. In year five alone, the groups received performance payments totaling \$29.4 million as their share of the \$36.2 million of savings generated for the Medicare Trust Funds in that year. This program has been said to be the model for health reform's ACO provisions.⁴⁶

New York Medicaid Quality-Based Bonuses

Since 2002, New York's Medicaid program has offered quality-based bonuses and auto-assignment incentives to health plans. Over the first four years of the program, New York paid approximately \$71.5 million in bonuses. The state has seen an increase in enrollment in plans that the state identifies as —high quality. A Commonwealth Fund study conducted after the incentives were implemented reported that appropriate postpartum care rose from 49% to 68%.⁴⁷

PAY-FOR-PERFORMANCE IN OREGON

Providence Health Plan Total Cost of Care Agreement

Providence Health Plan is working with an Oregon IPA serving a large number of Public Employees' Benefit Board (PEBB) members to create contract incentives around total cost of care and quality for the PEBB population. The initial two-year agreement aims to achieve a total cost of care trend reduction for the PEBB population residing in the counties represented by the IPA. The target was designed to compare 2012 total cost of care to 2011 total cost of care with adjustments for changes in covered services. The calculation covered almost all services including physician, hospital, pharmacy and ancillary and reflected a reduction in the total cost of care for that year. In 2013, there is an incentive pool that can be earned based on 2013 performance. The performance metrics are a combination of total cost of care target, comparing 2013 to 2012 total cost of care, and quality metrics aligned with CCO measures.

Providence Health and Services InfoRx Program

An InfoRx is an educational tool prescribed by a health care provider and used as a shared decision making tool for preference sensitive conditions. Providence is using InfoRx as a pilot for a limited set of high-impact conditions that have multiple treatment options: Low Back Pain, Large Joint Pain and Replacement, Stable Angina, and Cancer Screening. The tool helps patients choose the treatment which best aligns with their preferences at the primary care level, before time and energy has been used downstream in a specialists office. Non-Providence Medical Group doctors receive \$100 for each Providence Health Plan patient that completes the tool. However, financial incentives have not been the motivating factor. Instead it is what the doctors feel will help their patients most in their very limited time with them. Findings so far indicate high patient satisfaction, with over 78% saying they would recommend the tool to their friends or family. While provider adoption is a challenge, InfoRx integration into EMRs and workflows is a key way to increase usage. The pilot went live in January of 2012 and has been extended through at least 2014. Providence is working on adding additional health conditions to help several clinics reach a specific milestone for a grant in which they are participating.

⁴⁵ Centers for Medicare and Medicaid Services. Physicians Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay-for-Performance Demonstration (PGP Demonstration Fact Sheet). July 2011. Available at: <http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations.html>.

⁴⁶ Iglehart JK. Assessing an ACO Prototype — Medicare's Physician Group Practice Demonstration. *New England Journal of Medicine*. January 2011; 364:198-200.

⁴⁷ Commonwealth Fund, States in Action Newsletter. States in Action Archive: Medicaid Pay-for-Performance: Ongoing Challenges, New Opportunities. January/February 2007.

Despite some positive results, there are several limitations that must be addressed when considering P4P implementation. Especially for measures of care coordination and integration, quality outcomes measures need further development and validation. In addition, the wide range of measure used across a number of initiatives should be harmonized in order to provide consistent incentives and to simplify reporting strategies.⁴⁸ To start, encouraging payers to use the same quality measures would unify the system and simplify the reporting process for providers. It has also not been overwhelmingly documented that improvement in selected quality measures leads to better clinical outcomes. However, given that many P4P programs are process-oriented and encourage increased utilization of preventive procedures, these data may not be available for many years after implementation. An additional area of uncertainty lies in the bonus payment itself. In many cases it is unknown whether the potential bonuses will be sufficient to compensate for the collection of data or to motivate change in the way providers care for patients.⁴⁹

Patient Centered Medical Home Payment Models

The patient centered medical home (PCMH) is a care delivery model that facilitates coordination of patient treatment through their primary care physician. Care received through a medical home is patient centered, comprehensive in addressing all the needs of the patient, coordinated across the health system, and easier to access. Providing such care requires a team-based approach to care that involves physicians, nurses and medical assistants as well as pharmacists, nutritionists, social workers and care coordinators. The PCMH model also integrates behavioral and mental health and specialty services to provide better coordinated care for the patient.

Currently, these facilities provide essential primary care functions such as care coordination that are largely unpaid. The fee-for-service payment model fails to recognize the complexity and intensity of primary care, devalues the work of all members of the primary care team, contributes to overwork and burnout of clinicians, does not assess and reward quality care, and decreases opportunities for meaningful communication between patients and their health care teams. However, there are alternative payment models that support PCMHs by decreasing the cost of care, incenting and rewarding quality over quantity, and enabling practices to invest in infrastructure and supports (e.g., extended office hours and increased communication between providers and patients via email and telephone). Some states certify a site as a patient centered medical home, such as Oregon's Patient-Centered Primary Care Home program, while others seek certification through the National Committee for Quality Assurance or through individual health plans in order to participate in alternative payments. The Patient-Centered Primary Care Collaborative is broad-based national advocacy organization for the primary care PCMH, providing information and networking opportunities to facilitate support for the PCMH. Many states and health plans have used the work developed by the PCPC have developed model language for inclusion in health reform proposals to include the PCMH concept.

⁴⁸ Nichols LM, op. cit.

⁴⁹ Fisher ES. Paying for Performance – Risks and Recommendations. *New England Journal of Medicine*. 2006; 355(8): 1845-1847.

There are four types of Medical Home Alternative Payment Models that exist today:

| PAYMENT MODEL | DESCRIPTION | DETAILS |
|--|---|--|
| Enhanced FFS evaluation and management payments | Based on current FFS model but would pay providers more for visits to help pay for medical home activities like care coordination and prevention activities | <ul style="list-style-type: none"> • Assumption is that providers would feel less pressure to generate more visits, spend more time with patients at each visit, and support other medical home activities that are unsubsidized • Providers might try to generate more office visits or not invest in desired activities • Payers may add a mechanism to ensure that the enhanced payments are being used to support medical home activities • Enhanced payment should also reflect complexity of patient population • Administratively straight-forward |
| Additional codes for medical home activities within FFS payments | Based on FFS model but adds CPT codes for services not currently paid for such as transitions in care, expanded hours of services and care coordination | <ul style="list-style-type: none"> • Administratively straight-forward • Desired medical home activities (e.g., enhanced communication and access) may be hard to identify for providing additional fees • Easier to provide payments for palliative care conferences for families/patients or activities to improve transition from hospital to community at discharge |
| PMPM medical home payments to supplement evaluation and management FFS payments | Adds a capitation element (PMPM) into the FFS model | <ul style="list-style-type: none"> • Most commonly recommended by the four national physician specialty societies promoting PCPCHs as well as the Patient Centered Primary Care Collaborative (PCPCC) • FFS reimbursement continues at established rates. PMPM payment given to medical home that demonstrate PCPCH components • Would need to certify which practices are eligible for PMPM payments and also for which patients extra payments should be made • Sometimes a performance based payment is included based on quality, utilization or patient satisfaction measures |
| Risk-adjusted, comprehensive PMPM payment | A type of capitation but sets up a single payment to cover all primary care services not just medical home activities | <ul style="list-style-type: none"> • To avoid pitfalls associated with capitation, this approach could combine robust risk adjustment, substantial supplemental PMPM payments to support multi-disciplinary team-based medical home activities and P4P • Provides practice flexibility to invest in personnel and technology for primary care • Easy for payers to implement |

Source: Merrell K, Berenson RA. Structuring Payment for Medical Homes. *Health Affairs*, 29, no.5 (2010):852-858.

Almost all current and past medical home programs use a payment approach that is a combination of care coordination payments (usually PMPM) and performance based payments on top of existing FFS payments (the third payment model above). Performance based payments include paying practices for performance on different combinations of quality, utilization or patient satisfaction measures. Examples of medical home payment approaches are listed below.

Horizon Healthcare Services Inc (New Jersey)⁵⁰

There is an on-going collaboration between Horizon, a large insurance company and primary care providers and physician associations to develop a medical home program and transform practices into NCQA- recognized medical homes. The pilot program included 8 practices and looked at all Horizon members (24,000 members) served by those practices. Horizon paid practices a care coordination fee (\$2.00-\$3.50 PMPM) to support practice transformation and for the provision of additional services under the model. This payment was in

⁵⁰ Urvashi B. Patel, Carl Rathjen and Elizabeth Rubin. Horizon's Patient-Centered Medical Home Program Shows Practices Need Much More Than Payment Changes To Transform *Health Affairs*, 31, no.9 (2012):2018-2027.

addition to the existing fee-for-service reimbursement. Practices were also eligible for additional payments based on meeting quality and utilization-based outcomes. In addition to payments, practices received data and reports at the patient level that identified patients who might benefit from outreach. Horizon also hired population care coordinators to help practices with outreach and other work that were embedded within the practices. Early data results show improved performance on quality measures (increase in screenings, better diabetes control) and utilization measures (lower cost of care, lower rate of ER visits, hospital readmissions, patient admissions, higher use rate of use of generic prescriptions).

Currently, an expanded version of this program is being implemented that includes 48 practices serving 154,000 Horizon members. In this expanded model, practices receive a care coordination fee of \$3.00-\$5.00 PMPM. Practices are eligible for additional payments based on quality, utilization and patient experience measures at two levels. At the basic level, practices can receive between \$0.50-\$9.00 PMPM by showing improvement on quality, utilization and patient experience measures. At the advanced level, practices can directly participate in a shared savings model and receive a portion of the savings that Horizon achieves. In addition to these payments, practices receive a \$2.00-\$5.00 PMPM payment to fund the care coordinator position. Results from the expanded version of the model are not yet available.

Wellpoint Medical Home Pilots (Colorado and New Hampshire)⁵¹

Wellpoint participated in early collaborations between health plans and practices to transform primary care. In Colorado, as part of a much larger program called the Colorado Multipayer Patient-Centered Medical Home program, a pilot program targeted 6,200 Wellpoint patients. Wellpoint paid practices a care coordination fee and payment based on quality and utilization measures on top of the existing fee for service payments. The amount of the care coordination fee depended on the level of recognition the practice received through NCQA. Practices achieving the highest level of recognition could receive \$7.50 PMPM while practices with level 2 recognition received \$6.00 PMPM. In Colorado, patients in the pilot practices showed an 18% decrease in the rate of acute inpatient admissions over the study period compared to the control population as well as a 15% decrease in total ER visits and improvement across all measures of diabetes control.

A similar pilot in New Hampshire also provided a care coordination fee and performance based fee on top of existing fee for service payments and covered 10,00 Wellpoint patients. The care coordination fee was also based on the level of recognition the practice received through NCQA, \$2 PMPM for level 1, \$4 for level 2. Overall PMPM costs declined from the pre to the post study period while costs increased in the control group. The pilot population had a greater decline in ER visit rate.

HealthPartners Health Plan⁵²

HealthPartners Health Plan in Minnesota conducted a study of health plan enrollees that looked at the differences between enrollees using a patient-centered medical home (PCMH) clinic compared to those enrollees that do not. Findings revealed that enrollees using a single PCMH had fewer primary and specialty care visits and total lower primary costs compared to those who did not receive care at a single PCMH. Enrollees using a PCMH had an average of 4.53 total visits (primary + specialty care) compared to those without a PCMH that had an average of 6.04 total visits during the same time period. Enrollees using a PCMH had total average costs (primary + specialty care) of \$838.40 compared to average costs of \$1079.90 for those enrollees without a PCMH during the same period. Associated with the Health Plan, HealthPartners Medical Group in Minnesota implemented a PCHM model at its practices. The model included better care coordination and access to primary care. An evaluation study found a 39% decrease in emergency visits and 24% decrease in admissions after implementation of the PCMH model.

⁵¹ Raskas R, et. al. Early Results Show Wellpoint's Patient-Centered Medical Home Pilots Have Met Some Goals for Costs, Utilization and Quality. *Health Affairs*, 31, no.9 (2012):2002-2009.

⁵² Fontaine P, et. al. Is Consistent Primary Care Within a Patient-Centered Medical Home Related to Utilization Patterns and Costs? *Journal of Ambulatory Care Management*. January/March 2011.; vol. 34; no. 1: pp. 10-1.

Capital District Physicians' Health Plan (New York)⁵³

This health plan piloted a risk adjusted capitated payment model at three pilot provider practices to establish medical homes. One of the goals of the program was find savings in the health care system that could be used to increase the compensation of primary care physicians. Physicians received an upfront stipend of \$35,000 to help fund practice transformation and were eligible for bonuses of \$50,000 based on HEDIS quality measures and utilization measures such as hospital admissions, ER visits and imaging use. Physicians were offered a risk-adjusted PMPM payment that replaced the existing FFS model. A model called the Primary Care Activity Level Score was used to predict the amount of primary care resources historically needed by different patient types. An additional bonus was also offered: if the practice reported an amount less than what the model predicted, the health plan gave the practice the difference. After the first year, all three practices made improvements in different quality areas. Providers' salaries increased from \$45,000 to \$65,000 that year. The health plan expanded this risk-adjusted capitated model to 21 more practices in 2012.

Community Care of North Carolina

Community Care of North Carolina (CCNC) is a partnership between North Carolina Medicaid, a large funder of healthcare, primary care physicians, and other health care providers to achieve better outcomes for the management of care for Medicaid recipients in the state. The CCNC program has approximately 1,200 primary care practices (about 50% of all such practices in the state) that manage the care of 750,000 Medicaid patients across the state (about 10% of the total state population). All patients in the CCNC are linked to a medical home. Practices in the CCNC engage in quality improvement efforts, case manage high-risk patients and use quality data to plan interventions. Analyses looking at CCNC show savings in emergency department utilization (23% less than projected), outpatient care (25% less than projected) and pharmacy (11% less than projected).⁵⁴

Geisinger's Personal Health Navigator Initiative

Geisinger, as previously mentioned, is an integrated delivery system in Pennsylvania that has approximately 700 physicians across 55 practice sites that serve hundreds of thousands of patients. The Personal Health Navigator is Geisinger's patient-centered medical home initiative that aims to improve care coordination and access for patients. Components of the model include increased primary and specialty care access, a care coordinator at each practice site, and a focus on evidence-based to reduce hospitalizations. Geisinger makes monthly payments of \$1,800 per physician to recognize the expanded scope of practice and also provides monthly transformation stipends of \$5,000 per thousand Medicare members to the practice to help finance additional staff, support extended hours, and implement other practice-infrastructure changes.⁵⁵ The Health program also includes an incentive pool based on differences between the actual and expected total cost of care for medical home enrollees. During 2007, members enrolled in the program saw a 12 percent decrease in acute hospital admissions, an 11.7 percent decrease in hospital readmissions and an 8 percent difference in medical cost trend for primary care sites that offered the Personal Health Navigator program versus non-Navigator sites.⁵⁶ Geisinger Health Plan has been recognized, receiving "Outstanding Health Plan" for 2008 by the Disease Management Association of America, for its achievement in care for those with chronic conditions through the Health Navigator medical home program.

Medicare Advanced Primary Care Practice (MAPCP) Demonstration

Through the MAPCP demonstration, CMS is participating as a payer to existing state multi-payer reform initiatives that expand the patient centered medical home model. The demonstration program will pay a monthly care management fee (PMPM) for beneficiaries receiving primary care from medical homes. This fee is

⁵³ Feder JL. A Health Plan Spurs Transformation Of Primary Care Practices Into Better-Paid Medical Homes. *Health Affairs*. 30, March 2011:3397-399

⁵⁴ Steiner BD, et.al. Community Care of North Carolina: Improving Care Through Community Health Networks. *Annals of Family Medicine*. July 1, 2008; vol. 6; no. 4:361-367.

⁵⁵ Paulus RA, Davis K, Steele GD. Continuous Innovation In Health Care: Implications Of The Geisinger Experience. *Health Affairs*, 27, no.5 (2008):1235-1245.

⁵⁶ Geisinger Health Plan. GHP Named Outstanding Health Plan for 2008. News Release. February 9, 2009. Available at: <http://www.thehealthplan.com/news/2009/outstanding.cfm>.

intended to cover care coordination, improved patient access, patient education and other services to support chronically ill patients. The goal of this demonstration is to improve the quality and coordination of health care services. Eight states were chosen to participate in this demonstration and each state project is unique and conducted and coordinated by the individual states with Medicare paying its share.

One of the states chosen to participate was Pennsylvania and its Chronic Care Initiative (CCI).⁵⁷ The CCI was rolled out across the state in seven regions with regional differences in program and payment models across two phases. Under Phase I, different payment models for rewarding patient-centered medical homes were tested including lump sum payments to practices to cover start-up infrastructure costs, PMPM payments, and shared savings. Practices that achieved higher levels of NCQA recognition received higher payments than lower level practices. Under Phase II, all practices receive two PMPM payments for "Physician Coordinated Care Oversight Services" and "Coordinated Care Fees". Payments are age adjusted and meant to cover the expense of care coordinator positions found in the medical home model. Providers are also eligible for share savings payments based on care cost and quality metrics. Over time, the PMPM payments will decrease but the percentage of shared savings the practices are eligible for will increase. Detailed results will be coming in 2013 but early results show improvement on clinical measures such as diabetes control and asthma with reductions in emergency room visits and overall costs.⁵⁸

Comprehensive Primary Care Initiative

Led by the CMMI, the Comprehensive Primary Care initiative (CPCI) is a four year, multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. For the first two years, CMS is paying primary care providers a per-beneficiary, per-month (PBPM) amount that averages out to \$20 for improved and comprehensive care management. After two years, practices participating in the CPCI will have the opportunity to share in a portion of the total Medicare savings in their market. For years 3 and 4, the PBPM will be reduced to an average of \$15. Oregon is one of seven markets selected to participate in this four year, federal initiative (see ***Medical Home Payments in Oregon*** below for more details).

Arkansas Payment Initiative for Patient Centered Medical Homes

Under Arkansas' payment initiative described in the bundled payments section above, the state is also compensating PCMHs for care coordination and rewarding them for quality, utilization, and savings against a total cost of care.

MEDICAL HOME PAYMENTS IN OREGON

Public Employees' Benefit Board (PEBB)

Beginning in January 2013, PEBB will provide an age-adjusted per-member incentive payment to primary care homes in the Providence Choice plan that attain Tier 2 or Tier 3 recognition from the OHA's PCPCH program. In addition PEBB members in the PEBB Statewide plan will have lower cost share for primary care services when they access care through a recognized primary care home (from 10-15%).

Medicaid Health Home Enhanced Payments

Recognized PCPCHs in Oregon are eligible for supplemental per-member-per-month (PMPM) Medicaid payments to support the comprehensive care they provide to Medicaid patients (both FFS and MCO/CCO) who have certain chronic conditions. These payments are \$10-\$24 based on the practice's tier of recognition and are intended to support services such as care coordination and health promotion that are typically non-billable. These payments, authorized through the Affordable Care Act (Section 2703) for a two year period, are available through September 2013.

CareOregon's Payment Model for PCPCHs

CareOregon is offering additional payments to clinics recognized at Tier 3 by the OHA's PCPCH program. Payments are available at three levels; \$2.00 PMPM at Level 1, \$4.00 PMPM at Level 2 and \$6.00 PMPM at Level 3. All clinics start at

⁵⁷ National Academy for State Health Policy. Medical Homes and Health Homes; Pennsylvania. November 2012. Available at: <http://www.nashp.org/med-home-states/pennsylvania>.

⁵⁸ Torregrossa AS. Pennsylvania's Efforts to Transform Primary Care. February 2010. Available at: www.thehealthpolicy.org/webinars/20100223_atorregrossa_webinar.pdf.

Level 1 at the launch of the program and can come up to Levels 2 and 3 depending on future data submission. All levels require the clinic to participate in the CAHPS patient survey that is administered by Care Oregon and monthly reporting on up to 5 menu measures. At Levels 2 and 3, clinics need to show 3% improvement on at least 1 measure (Level 2) or at least 3 measures (Level 3). This model was launched late in 2012 and no results are yet available.

Comprehensive Primary Care Initiative in Oregon

In 2012, after a call for applications from the CMMI, nearly 70 Oregon primary care practices in Oregon were selected to participate in the CPCI initiative. Each practice is required to be recognized by the state as a patient-centered primary care home and to achieve certain CMS milestones over the four years. The Comprehensive Primary Care Initiative (CPCI) is expected to impact over 145,000 Oregonians including 49,000 Medicare beneficiaries. Enhanced payments to the selected practices began in November 2012 from CMS and five Oregon payers including Regence Blue Cross, Providence Health Plan, CareOregon, Tuality and OHA (Medicaid FFS). CMS is paying participating practices a risk adjusted, monthly care management fee for their Medicare FFS beneficiaries at approximately \$20 per member, per month during the first two years and then reduced to \$15 per member, per month in the final two years. Bonus payments and shared savings in Medicare FFS will also be available to practices that better coordinate care for their patients. The other payers have differing payment schedules with the practices.

Aetna Launches PCPCH Payment Program

Aetna is proud to be the first non-Oregon Health Authority contracted plan to offer per-member-per-month payment incentives using the PCPCH tiers. Starting on April 1, 2013, Aetna's Patient Centered Medical Home (PCMH) recognition program will be available to physician practices in Oregon that meet certain criteria: Directly contracted with Aetna; Received recognition by the NCQA or by the State of Oregon Patient Centered Primary Care Home program as a PCPCH; Have 10 or more attributed Aetna members; and be reimbursed at 100% of the Aetna Market Fee Schedule (AMFS).

Source: Payment incentives for payments available to Patient-Centered Primary Care Programs in Oregon. Available on the Oregon Primary Care Home website at www.primarcycarehome.oregon.gov.

The Oregon Health Policy Board believes that providing a primary care home for every Oregonian could move Oregon's health care system towards the "Triple Aim" goals of better care, better health, and lower costs. However, achieving these goals will require moving the entire primary care delivery system towards functioning as "advanced" primary care homes regardless of payer, size, or location. This can be a challenging for many practices, especially smaller, independent ones that do not have health system support. Supportive investments and education to help manage practice changes are critical. Requiring primary care clinics to meet advanced primary care home measures without additional resources or an adequate workforce will exacerbate existing workforce shortages and could worsen health disparities in underserved populations.

Understanding Payment Logistics

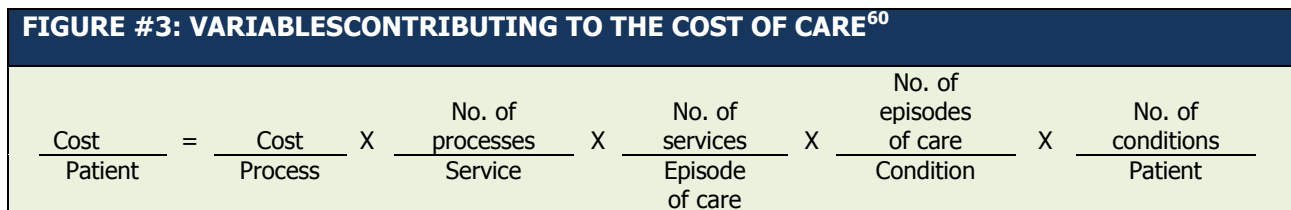
It is important to have a clear conception of the total cost of care in order to determine the most appropriate and effective payment methodology and its associated risk. Payers will need to determine the total cost of care in a way that includes factors regarding of the number of care episodes and treatment a patient may receive for various conditions. The total cost of care determination can then be used to decide which payment methodology would be the most effective at delivery quality results at a reduced cost. Each methodology then comes with an associated level of risk that will also need to be considered. The following two sections describe total cost of care and financial risk as they are two major logistical components of payment reform.

Total Cost of Care

Each alternative payment methodology has different effects on factors such as cost of care, differences in patient populations, and severity of illness that must be taken into account when constructing a payment system. According to Harold Miller, Executive Director of the Center for Healthcare Quality and Payment Reform, total per capita health care costs are driven by:

- The prevalence of health conditions in the population;
- The number of “episodes of care” they require per condition;
- The number and types of health care services a person receives in each episode;
- The number and types of processes, devices and drugs involved in each service; and finally,
- The cost of each individual process, device, and drug.⁵⁹

Inevitably, if any one of the above variables increases, the overall cost of care increases. The framework of which a payment system is designed depends on whether costs are paid for separately or whether one fee covers multiple services in a bundle as described in the previous section. Miller uses the formula in Figure #3 below as an illustration of how these variables work with one another.



It is important to note that not all costs are necessarily incurred during the same timeframe and not all of them are direct costs. One typically considers the cost of care to be those charges that are incurred at the time of service. This portion of the overall cost of care is referred to as short-run direct costs. However, one must also consider short-run indirect costs, the cost of lost productivity during recovery; long-run direct costs, future provider expenditures that are attributed to current care (or lack thereof); and long-run indirect costs, the cost of lost productivity in the future as a result of current care (or lack thereof). The total cost can be tabulated as the sum of each of these.⁶¹

⁵⁹ Miller HD. From Volume To Value: Better Ways To Pay For Health Care. *Health Affairs*, 28, no.5 (2009):1418-1428.

⁶⁰ Miller HD. Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. The Commonwealth Fund. September 2007.

⁶¹ Ibid.

The Overall Cost of Care

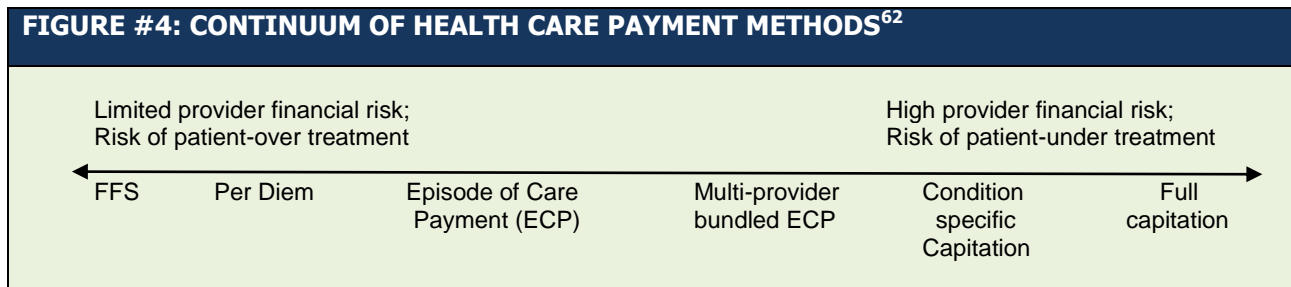
Short-run direct costs
 +
 Short-run indirect costs
 +
 Present value of long-run direct costs
 +
 Present value of long-run indirect costs

For example, a provider overlooks giving a patient a routine measles vaccine during an exam. As a result, the patient contracts measles at some point in the future. The total cost of care that can be associated with the initial exam visit is the cost for services provided at the visit plus the cost of all services relating to the measles treatment plus the cost of lost productivity (i.e. time off of work, etc.) during the patient’s recovery from measles. Under a FFS system, total expenditures will be greater for the payer since he is responsible for reimbursing the long-run direct costs. In this instance, the long-run direct cost is the cost of service for measles treatment. However, in a system that uses capitation for

reimbursement, the provider assumes responsibility for the total care of the patient, which would include treatment for measles. This care would be provided without any additional reimbursement by the payer. The value of considering long-run costs becomes increasingly apparent when tabulating the cost of care for preventive services. The long-run costs associated with a lack of available preventive services outweigh the short-run direct costs of providing many of those services.

Determining the Financial Risk

In addition to understanding the cost factors, it is imperative to consider the financial risk that is assumed by both payers and providers when determining a method of reimbursement. The level of financial risk for the total cost of care that is assumed by the provider can serve as the basis for encouraging more efficient provisions of care and each type of provider reimbursement method carries its own set of risks that are assumed either by the payer, the provider, or both. As a payment system moves down the continuum of healthcare payment methods from FFS toward full capitation, the risk shifts from payer to provider (see Figure #4 below).



As mentioned previously, FFS systems tend to provide financial incentives for providers to over-treat patients. The payer must assume the full risk of care in that the payments are made for as many services as the provider is willing to render. Episode-of-care payments put slightly more risk on the provider since it is unknown at the beginning of the “episode” exactly what services may be needed. Capitation creates incentives for providers to prevent illness in the patient and to treat any illness in an efficient manner. However, this also puts providers at risk if they treat populations that are sicker than average and may cause them to under-treat their patients unless the under-treatment will lead to care for which the provider is at risk (e.g., a provider not administering the measles vaccine).

⁶² Miller HD. *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*. op cit.

Implementing a New Payment Methodology

Even after determining the total cost of care and understanding what level of financial risk providers can reasonably be expected to bear, implementing Alternative Payment Methodologies can be challenging and may involve many significant barriers. Because of this, progress in changing payment systems that have been in place for decades has been slow. A transitional approach may be needed to overcome these barriers and work toward efficient, high-quality care. Harold Miller, Executive Director of the Center for Healthcare Quality and Payment Reform, identified ten major barriers to healthcare payment reform and possible solutions.

| BARRIERS | POSSIBLE SOLUTIONS |
|--|---|
| #1: Continued use of fee-for-service payment in payment reforms | <ul style="list-style-type: none"> Use episode-of-care payment for acute conditions and global payments for all patients to eliminate undesirable incentives under fee-for-service and to give providers the flexibility and accountability to reduce costs and improve quality |
| #2: Expecting providers to be accountable for costs they cannot control | <ul style="list-style-type: none"> Use risk adjustment and risk limits to keep insurance risk with payers but transfer performance risk to providers Use risk exclusions to give providers accountability only for the types of costs they are able to control Make provisions for contract adjustments to deal with unforeseen events |
| #3: Physician compensation based on volume, not value | <ul style="list-style-type: none"> Change physician compensation systems to match incentives under payment reform Modify federal and state fraud and abuse laws to permit gain-sharing between hospitals and physicians |
| #4: Lack of data for setting payment amounts | <ul style="list-style-type: none"> Give providers access to timely analyses of both utilization and costs through community multi-payer claims databases |
| #5: Lack of patient engagement | <ul style="list-style-type: none"> Ask patients to designate their primary care physicians rather than using statistical attribution rules based on fee-for-service claims to assign them retrospectively Use value-based benefit designs to enable and encourage patients to improve health, adhere to treatment plans, and choose high-value providers and services |
| #6: Inadequate measures of the quality of care | <ul style="list-style-type: none"> Develop quality measures for all of the conditions and procedures that drive significant amounts of cost Use outcome measures instead of process measures to give providers flexibility to redesign care and support effective patient choice Collect patient-reported information on outcomes |
| #7: Lack of alignment among payers | <ul style="list-style-type: none"> Ask physicians and other providers to define lower-cost, higher-quality ways to deliver care and the payment changes needed to support them Encourage employers to support regional payment reforms and to choose health plans which will implement them in a coordinated way Offer Medicare payment reforms to a broad range of providers on an ongoing basis Use state government and/or collaboratives to facilitate agreement among payers |
| #8: Negative impacts on hospitals | <ul style="list-style-type: none"> Reduce fixed costs and improve efficiencies in hospitals Change payment levels to hospitals to reflect higher costs per admission that may accompany lower admission rates Increase transparency about hospital costs to ensure that prices for hospital care are adequate, but not excessive |
| #9: Policies favoring large provider organizations | <ul style="list-style-type: none"> Remove anti-trust barriers to small physician practices joining together to manage new payment models Combat anti-competitive practices by large providers Avoid unnecessary standards for structure and processes in payment systems and accreditation systems that increase costs and favor large organizations |
| #10: Lack of neutral convening and coordination mechanisms | <ul style="list-style-type: none"> Support the creation and operation of multi-stakeholder Regional Health Improvement Collaboratives or other forums to facilitate discussions |

Source: Miller HD. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. Center for Healthcare Quality and Payment Reform. December 2012.

This analysis of barriers suggests that large scale changes are necessary to implement payment reform. However, there are a few areas in which change may occur more quickly; particularly in Oregon's current landscape. Areas that will require particular attention include ensuring access to timely data, determining the appropriate financial risk, aligning incentives with adequate quality measures, solving contractual issues, and creating collaboratives in which to share best practices and foster collaboration. Below are more detailed descriptions of each of these areas in the Oregon context.

Ensuring Access to Timely Data

For value-based health care to work, physicians, payers, hospitals, patients and other stakeholders must have the ability to share all relevant information, in an accessible manner that is integrated into the ordinary workflow, at the point of care. Many health care professionals and institutions lack the information and infrastructure they need to assess whether the services they provide and bill for care that actually improves the health of their patients. To this end, having access to the right data is critical in the assessment of how alternative payment methodologies will affect cost and utilization in various settings.

However, even if providers have access to claims data, most would not have the analytic capacity to assemble and analyze large claims databases, particularly if the data come from multiple payers.⁶³ Data and analytics require timely and actionable data to fuel the range of models needed to transform payment reform. As a statewide repository of health care data and statistics, the OHA's new Office of Health Analytics provides unique and valuable resources that can aid enhanced information sharing: all key health-related data sets containing claims/encounters; long-term services and support, and other services and supports outside of CCOs; surveys including CAHPS and BRFSS; and integrated data sets such as the All-Payer All-Claims (APAC) database, and the Client Process Monitoring System (CPMS), which contains clinical data for mental health/chemical dependency treatment services. The OHA's investment in data and analytic tools will allow for actionable data to enable testing of payment models.

The Oregon Health Care Quality Corporation is a non-profit, broad-based organization with collaboration involving health plans, physician groups, hospitals, public sector health care representatives, purchasers, health care providers, consumers and others engaged in quality improvement in the Oregon healthcare marketplace. Quality Corporation currently merges and aggregates claims and encounter data from the majority of commercial data suppliers in Oregon, and from fee for service Medicaid providers, and has the cooperation of Oregon primary care providers. Quality Corporation's current experience in collecting and public reporting of quality performance measures with their technical ability to incorporate claims and new efforts to import electronic medical record (EMR) data are essential for the sustainability of the OHA and health systems transformation. It is especially essential that the Quality Corporation already has strong relationships with Oregon providers and provider groups and experience with evidence-based research.

According to the American Medical Association's Innovators Committee, value-based health care requires significant improvements in the development of health information technology that can be divided into three stages:

- The **First Stage** includes mature technology, such as practice management systems, designed to improve scheduling, billing and coding accuracy, and revenue cycle management in an FFS environment.
- The **Second Stage** includes the development of Electronic Health Records (EHRs) and other data sharing systems designed to foster health information exchange (HIE) and clinical support, and
- The **Third Stage** includes population-based health management systems designed to integrate the practice management, patient stratification, clinical risk quantification, attribution methodologies and the HIE capabilities of the first two stages.⁶⁴

⁶³ Miller HD. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. op cit.

⁶⁴ American Medical Association Innovators Committee. Physician Payment Reform: Early Innovators Share What They Have Learned. American Medical Association. July 2012.

The health information technology stages identified by the AMA should not be confused with the stages of meaningful use of electronic health records (EHRs), as defined in the Centers for Medicare and Medicaid Services (CMS) regulations for the Medicare and Medicaid EHR Incentive Programs.⁶⁵ Participants in those programs must use certified EHR technology, that is, EHRs that meet technical standards set by the Office of the National Coordinator for Health IT (ONC). Together, the CMS and ONC regulations promote use of interoperable systems that support capturing and securely exchanging health information. Such technology is a building block for better communication of useable information, clinical decision support, improved care coordination and avoidance of duplicative services, and more advanced analytics. While various HIT efforts are an improvement in the infrastructure, there will also need to be efforts made to improve payment systems or align them with value-based care. This means a system will need to be configured to support making payments for episodes of care in addition to traditional FFS payment capabilities, which could be done by integrating claims and clinical data through a system such as a health information exchange (HIE). Oregon has launched its first phase of a statewide health information exchange (HIE), which offers Direct Secure Messaging services that allow providers to send messages and attachments to other providers in a HIPAA-compliant manner. However, the state is planning for the next phase of HIE services and expects to completed a draft framework in August 2013. In addition, some communities are developing or have launched regional exchange services.

Determining the Appropriate Financial Risk

Movement to an APM will involve managing risk while ensuring quality, accountability and equity across the provider network. Payment methodologies should adjust provider financial risk to account for inherently expensive patients or adjust for costs that the provider cannot control. The following methods to limit risk are being used:

- Condition/Severity Adjustments that would pay a provider different amounts depending on the type and severity of the member's health condition;
- Outlier Payments and Adjustments that would pay a provider more when the cost of caring for the member exceeds a defined threshold, or would reflect appropriate levels of accountability and outcomes measurement related to the total cost or quality of care when certain conditions are met;
- Risk Corridors that limit the extent to which the cost of actual service delivery for a group of patients far exceeds the payment typically allocated for defined conditions, services, and procedures; and
- Exclusions and Risk-Sharing arrangements that exclude the costs of services provided by certain outside providers from payments or having two providers accept accountability (and the associated payment) for different portions of the total costs of caring for a group of patients.

In addition to risk adjustments, payers need to consider being able to track a patient's health status over time. If a patient remains healthy as a result of care from a particular provider, the patients health status today will result in a lower payment under a risk-adjusted system that if the patient remained unhealthy. Improved risk adjustment systems that capture such changes over time will be needed, particularly if more providers and payers sign multi-year contracts to manage healthcare cost and quality.⁶⁶ In Oregon, the state is sharing risk with CCOs for high-risk patients using risk corridors. The state is also exploring ways to supplement federal reinsurance.

Aligning Incentives with Adequate Quality Measures

The ability to analyze and share data must be paired with quality measures, either performance or outcomes based, to maximize providers' ability to improve their performance and value to the system. It is imperative that when developing measures for a new payment methodology, the measures with which performance is assessed

⁶⁵ More information about the Medicaid EHR Incentive Programs is available at <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>.

⁶⁶ Miller HD, Ten Barriers to Healthcare Payment Reform and How to Overcome Them. op cit.

and payment are based, should be mutually agreed upon and appropriately aligned across providers and settings. It will also be important to ensure that providers and hospitals are capturing data and applying measures that are consistently and efficiently reported and that support improved quality of care and improved health outcomes at the practice level. There are a number of entities whose work in the area of physician quality performance is generally accepted, including but not limited to the following:

- **The Physician Consortium for Performance Improvement (PCPI)** - - A physician led initiative that includes methodological experts, clinical experts representing more than 50 national medical specialty societies, the Agency for Health Research and Quality, and the CMS. The PCPI's measures can be accessed through the American Medical Association's website at www.ama-assn.org.
- **The National Quality Forum (NQF)** – A measure endorsement entity that periodically reviews and endorsed quality measures developed by the PCPI and similar entities. The list of NQF endorsed measures can be accessed by visiting www.qualityforum.org.
- **National Medical Specialty Societies** – These societies have developed their own quality measures for their medical specialties that can be accessed through their respective websites or by contacting them directly.⁶⁷

On the other hand, measures that are outcomes-based provide an integrative assessment of quality reflective of multiple care processes across the continuum of care. There are a variety of types of outcome measures such as health or functional status, clinical measurements, adverse outcomes and complications, morbidity and mortality, patient-reported outcomes, patient experience with care, and others.⁶⁸ To foster higher quality and more efficient delivery of health care services in Medicaid, CCOs are awarded funds based on their performance on 17 initial outcomes and quality measures established through a statutorily mandated Metrics and Scoring committee with a public process and negotiations with CMS. CCOs are also encouraged to use alternative payment methodologies that will shift payments based on volume of service to payments based on outcomes measures. With other Oregon health care payers' interest in creating value-based payment systems, attention to using flexible multi-payer coordinated outcomes measures will work to minimize reporting burdens for providers and support consistent practice changes.

Aligning the right incentives to the appropriate outcomes is also a critical piece of the reimbursement puzzle and requires careful planning. Incentives should be considered that will help providers to perform the tasks necessary to be successful. A Robert Wood Johnson Foundation study⁶⁹ that tested the use of financial incentives to improve the quality of health care found that while financial incentives motivate change, they need to be large enough to make a difference. However, there is no real indicator of how much of an incentive is enough. Although, one of the projects included in the study conducted by the RWJF, led by General Electric, suggested that incentives should be a minimum of \$5,000 per physician per year in order to affect quality improvement. Others suggested incentives need to account for at least 10% of a physician's annual income. The study also found that merely providing support for additional staffing to make a physician's job easier or supporting infrastructure to supplement technology can motivate physicians to achieve quality targets.

⁶⁷ American Medical Association. Evaluating and negotiating Emerging Payment Options. 2012. Available at: <http://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/claims-revenue-cycle/managed-care-contracting/evaluating-payment-options.page?>

⁶⁸ The Physician Consortium for Performance Improvement Convened by the American Medical Association. Measures Development, Methodology, and Oversight Advisory Committee: Recommendations to PCPI Work Groups on Outcome Measures. August 2011. Available at: <http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement.page?>

⁶⁹ Brown MH. Rewarding Results: Aligning Incentives with High-Quality Health Care. Robert Wood Johnson Foundation. October 15, 2009. Available at: <http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/10/rewarding-results.html>.

Solving Contractual Issues

Transitioning to an alternative payment methodology can take time to implement and improvements in cost and care may not be seen immediately. To account for this, long-term contracts should be developed. Multi-year contracts provide a better opportunity for providers to make changes in care delivery that take time to implement and to reap returns on investments in preventive care and infrastructure, and they give payers greater ability to control the trend in health-care costs.⁷⁰ For example, the Alternative Quality Contract developed by Massachusetts Blue Cross Blue Shield is a five-year contract that was designed to slow the growth in spending rather than achieve immediate savings. However, contractual mechanisms must be considered to allow adjustments based on unforeseen changes in the market place, such as major shifts in health care policy.

Hospitals and providers also need to be made aware of the specific payment arrangements and what measures will be used in which to calculate payment amounts. In addition to measurement transparency, contracts will need to include other specifics to mitigate concerns regarding “gainsharing.” Gainsharing refers to hospitals giving providers a share of cost reductions for patient care attributable to a physician’s efforts that in some cases have limited services to Medicare or Medicaid beneficiaries. Consequently, gainsharing programs that are designed to reward physicians for reducing unnecessary services or unnecessary elements of services may be determined to violate the Civil Monetary Penalty statute and may in some circumstances implicate the federal Anti-Kickback statute.⁷¹ However, the Federal Trade Commission in collaboration with Medicare has established new safety zone in federal anti-trust enforcement as a means to encourage participation in the Medicare Shared Savings Program, and the Office of Inspector General has issued a series of waivers from certain fraud and abuse statutes.⁷²

Creating Collaboratives

Bringing health insurers, patients, employers, and physicians to the table would highlight opportunities to improve coordination and continuity of care; new paradigms for quality improvement that integrate assessment at the individual physician level and institution level could emerge.⁷³ Nationally, a growing number of communities are recognizing that Regional Health Improvement Collaboratives (RHIC) are an ideal mechanism for developing local or regional collaborative, such as multi-stakeholder solutions, to facilitate discussion regarding their healthcare cost and quality problems. These collaboratives provide a neutral, trusted mechanism through which the community can plan, facilitate, and coordinate the many different activities required for successful transformation of its healthcare system. This includes payment and delivery system reform. Representation on a RHIC generally includes health care providers, payers, purchasers of health care and consumers that work together to help the stakeholders in their community identify opportunities for improving healthcare quality and value, and facilitate planning and implementation of strategies for addressing those opportunities.

In Oregon, the Transformation Center plans to facilitate learning collaboratives with payers, providers, community stakeholders and consumers to promote the identification and replication of best practices and to address the challenges relating to key elements of health systems transformation, including payment reform. The Center will facilitate a council of clinical innovators that will play a role in bringing providers together to share clinical practices and innovations and provide peer to peer support for practice change. Some payers have found success in bringing surgeons together to discuss standards of care. In addition, physician leaders are in a position that could assist in translating opportunities and fostering support for quality and efficiency.

⁷⁰ Miller HD, Ten Barriers to Healthcare Payment Reform and How to Overcome Them. op cit.

⁷¹ See the July 1999 DHHS-OIG Special Advisory Bulletin, Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries. Available at:

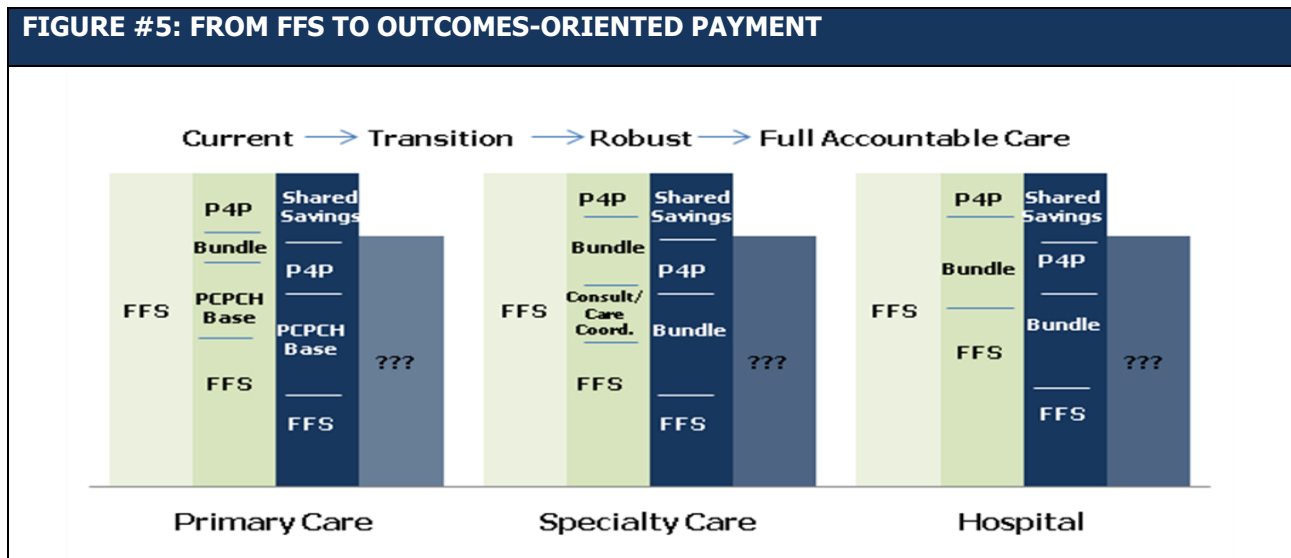
<http://oig.hhs.gov/fraud/docs/alertsandbulletins/gainsh.htm>.

⁷² American Medical Association Innovators Committee, op.cit.

⁷³ Wharam JF, Paasche-Orlow MK, Farber NJ, et. al. High Quality Care and Ethical Pay-for-Performance: A Society of General Internal Medicine Policy Analysis. *Journal of General Internal Medicine*. July 2009; 24(7): 854–859.

Transitional approach

Payment reform is not a one-size-fits-all-approach. Some payers and providers may be prepared to implement APMs immediately while others may need a flexible approach in order to transition to a truly value-based payment system. Payers and Providers could initially shift from FFS to shared savings and then work towards episode payments and more complicated risk arrangements. In March 2010, the Oregon Health Policy Board established the Health Incentives and Outcomes Committee to develop recommendations on transparent payment methodologies that provide incentives for cost-effective patient-centered care and that reduce variations in cost and quality of care. After thorough research and discussion, the committee recommended the use of P4P, bundled payment, and shared savings models with a vision of transformation from FFS to the more outcomes-oriented payment models. This vision is illustrated in the Figure #5 below for three major categories of providers: primary care practices, specialty practices, and hospitals.⁷⁴



⁷⁴ Oregon Health Policy Board, Office for Oregon Health Policy and Research. Health Incentives and Outcomes Committee Report and Recommendations. November 2010. Available at: <http://www.oregon.gov/oha/OHPR/HPB/pages/healthincentives/healthincentivesandoutcomescommittee.aspx>.

Conclusion

With Oregon's health care expenditures increasing at an annual average rate of 7.7%, health care payers must make efforts to move away from the traditional fee-for-service payment system that rewards volume rather than value. Re-aligning the priorities of Oregon's healthcare system using alternative payment methodologies will allow for provider incentives to include quality and efficiency in health care services and will result in a higher level of illness prevention, more accurate diagnoses/prognoses of conditions, more appropriate care reflecting patient preferences and engagement, avoidance of adverse events, and improvements in follow-up to care. All of these results will ultimately end up contributing to greater quality of care and lower health care costs due to a healthier population and reductions in hospital admissions.

Promising initiatives have paved the way for others in determining how best to implement an alternative payment methodology. Early examples such as Geisinger's ProvenCare has taught us that surgeons can not only work to improve care through evidence-based treatments, but they can use shared decision-making processes with patients and initiate explicit post discharge instructions that can result in a 10% decrease in hospital readmissions. Commercial efforts in bundled payments, such as the CalPERS effort, have shown us that bargaining power can result in savings without negatively affecting outcomes. The BCBS of Illinois shared savings program and the Bridges to Excellence P4P program under the Colorado Business Group on Health have long proven that incentives for providers to produce results in specific quality indicators can improve outcomes and also reduce hospital admissions. Furthermore, there has been particularly strong evidence of PCMH payment models enhancing quality of care and reducing hospital admissions by enabling practices to invest in needed infrastructure and rewarding their providers for quality rather than quantity.

As these payment reform initiatives and other national examples have shown promising results, more work will need to be done at the community level to prepare for comprehensive payment reform in Oregon. Areas that will require particular attention include ensuring access to timely data, determining the appropriate financial risk, aligning incentives with adequate quality measures, solving contracting issues, and creating collaboratives in which to share best practices and foster collaboration. While a single method may be able to produce some improvement, multiple payment methods, coordinated and aligned between multiple payers to produce appropriate incentives, can work together to yield cost containment and improved quality and outcomes for health care services. The OHA believes that for most providers, the path from fee-for-service payment to comprehensive payment reform will transverse some intermediate ground wherein providers are paid in a mix of ways as they transition to greater accountability for outcomes, quality, and efficiency.