

Value over Volume

Quality-based health care purchasing for state
policymakers

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Summary

American health care costs are growing at unsustainable levels, consuming over 17% of the national economy. At some point in 2010, government's share of that growing bill is expected to pass 50%. There is ample evidence that more spending does not improve the quality of health care. In areas of the United States with higher health spending, fewer patients receive recommended levels of care and patient satisfaction is lower. A consensus is building among payers, consumers, providers and policymakers that the way we pay for health care is a large part of the problem. Currently providers are paid based on volume and the intensity of care; there is little financial return for preventing health problems. Providers are also paid regardless of the quality of care delivered, leaving no incentive to invest in quality improvement.

There is growing interest in radically reforming the health care payment system to reward quality and efficiency, or value, rather than volume. Quality based purchasing is a reorganization of incentives to promote better health outcomes, improved health status, lower costs of care, improved patient safety, and better patient satisfaction. As the nation's largest purchaser of health care, Medicare has embraced quality-based purchasing, conducting and testing over twenty pilot programs.

As substantial purchasers of health care, state government budgets are increasingly strained by escalating health costs and lagging quality. One in five Americans is covered by a state-run Medicaid program; state employee plans are very large coverage pools providing comprehensive coverage paying generous rates. States have other unique and important roles in the health care system – states license and train providers, regulate insurers, sponsor public health programs, collect and analyze health data, and have led the nation in health system innovation. States have a trusted role in educating the public and convening disparate stakeholders to collaborate on shared goals.

States have several options to implement quality-based purchasing. Improved transparency, including provider and health plan report cards, give consumers the tools they need to drive the market toward higher quality. At least 25 states no longer pay for “never events,” serious, avoidable medical errors. States have embraced pay-for-performance programs, awarding bonuses to health care providers who reach quality standards. States have begun steering consumers toward higher quality, more effective care by reducing cost sharing for accessing

care through preferred providers. States have also begun to provide consumers with incentives to identify and reduce health risks, such as quitting smoking and complying with prenatal care. Some states are sharing the savings realized through payment reforms with the providers who helped generate the savings, providing another value incentive. States are experimenting with bundled payments, flat rates to cover a defined clinical episode of care. Others are considering global payments to providers to cover all costs associated with each consumer's health needs. To ensure fairness, payments are risk-adjusted, providing more resources for patients with more needs. To counter incentives to reduce the quality of care, global payments are linked to quality bonus systems such as pay-for-performance. States have embraced other initiatives that support quality based purchasing such as patient-centered medical homes and formation of Accountable Care Organizations.

Current state laws and regulations may hold barriers to implementation of quality-based purchasing. Some of those barriers include anti-trust provisions, state regulation of insurance risk, ownership, privacy and security standards of health quality data and analysis, non-discrimination provisions, and interactions with federal law. States pursuing quality based purchasing reforms are advised to clarify state law to be supportive while recognizing the state's responsibility to protect the public.

Some important lessons have emerged from states that are pursuing quality based payment reform. It is critical to get all stakeholders to collaborate on a strategy through a fair and open process, to take the time necessary, start small and with the strongest partners, to coordinate across payers, be very clear on goals, emphasize patient education, engage the power of transparency and disclosure, invest in data and analysis, and plan for transitions. To guide states embarking on payment reform the Council of State Governments/Eastern Regional Conference Health Policy Committee has assembled a set of guiding principles for state quality based purchasing. The principles include the importance of aligning and fairly balancing the interests of patients, providers and payers, building the system to improve quality and foster innovation, rewarding efficiency to reduce the long term growth of health care costs, sharing savings among all stakeholders, promoting patient-centered care, and ensuring transparency.

Value Over Volume

Quality-Based Health Care Purchasing for State Policymakers

US health care costs are escalating at unsustainable levels across all payers, while a consensus is growing that we are not getting what we pay for. Consumers, providers, and payers are universally calling for reform. Many blame fragmented systems of care and counterproductive incentives for rising health care costs and disappointing quality levels. The current fee-for-service dominated system does not link payment to quality, but rather reward volume and intensity of care over efficiency. Many payers, including private employers, insurers, federal and state governments, are moving toward new systems of paying for health care that reward value.

The Problem

Health care consumes more than 17% of the American economy and, without system reform, is predicted to grow to over 19% by 2019. Sometime in 2010 it is predicted that government's share of health care payments will pass 50% -- government will be paying more than half of all medical bills. Over 80% of Americans believe that the health care system needs fundamental change. Residents of the Northeast are most likely to believe that the health system must be completely rebuilt.¹

As substantial consumers of health care services, state budgets are being squeezed by accelerating health costs, displacing other critical expenditures. Council of State Governments/Eastern Regional Conference (CSG/ERC) states spend \$80 billion each year just on Medicaid², a program that grew nationally by 23% in 2009.³

CSG/ERC states are among the most expensive for health care, growing on average 12% faster than the rest of the country⁴. However the care received is generally only rated "average".

Each year, a larger share of spending at all levels of government goes to health care, which has led to tax increases, cuts in other programs, and higher budget deficits.

-- *The Economic Case for Health Care Reform; Update 12/14/09, Executive Office of the President, Council of Economic Advisers*

State	Health care spending per person rank among states ⁵	Quality rating ⁶
Connecticut	5	average
Delaware	6	average
Maine	2	average
Massachusetts	1	strong
New Hampshire	22	strong
New Jersey	12	average
New York	3	average
Pennsylvania	10	average
Rhode Island	7	strong
Vermont	8	average

There is strong evidence that paying more does not guarantee better quality care. Studies of high spending regions of the United States find increased use of hospitals and intensive care units, more specialists, more tests, and more minor procedures. However those high spending areas are also associated with lower quality of care including fewer patients receiving condition-appropriate care.⁷ Contrary to expectations, higher spending is correlated with worse patient satisfaction.⁸ To a large extent, health care spending is driven by the supply of health care services rather than patients' need for care.⁹ Americans on average only get 55% of recommended care¹⁰ and only 39% are confident that they can get safe, effective care when needed. One in three Americans report getting unnecessary care or duplicate tests.¹¹ Over 19% of Medicare patients in CSG/ERC states discharged from a hospital are readmitted within 30 days, on average.¹²

State	Avoidable diabetes admissions, per 100,000 adults ¹³	Pediatric asthma admissions, per 100,000 ¹⁴
Connecticut	6.0	149
Delaware	7.8	126
Maine	5.0	57
Massachusetts	28.7	156
New Hampshire	38.1	254
New Jersey	11.1	144
New York	3.8	50

State policymakers have important and unique roles in the health system. States are often the largest payer of health care coverage, through Medicaid and state employee benefits. State and local governments spend billions of dollars on uncompensated care for uninsured residents.¹⁵ Providers and insurers are licensed and regulated by state governments. States are large producers and consumers of health care quality and financial data. States take responsibility for regulating, operating and funding critical public health functions. State higher educational institutions have a primary role in educating health care providers. States have taken a lead role in promoting health system innovation including expanding coverage, promoting primary care, care management and patient-centered medical homes. States also have a powerful convening role in leading other stakeholders to participate in larger system reform providing anti-trust liability protection.

This paper is part of a project for the CSG/ERC Health Policy Committee exploring quality-based purchasing concepts, research, current initiatives, and to consider the role of state health policymakers in health care system payment reform. We have developed a set of guiding principles and policy options for state and provincial policymakers to consider in performing their critical roles in the health care system.

Current incentives

Many blame the current fee-for-service payment system for skyrocketing health costs. The existing system rewards volume and intensity over efficiency and quality, driving up costs without improving value. The vast majority of health care providers are paid for each service

they provide, and generally only for services provided in person on a face-to-face, individualized basis. This system made sense when most health care could only be delivered in person but does not recognize the benefits of recent innovations such as secure email, care coordination, and group visits. Providers are not paid to assist patients by phone when appropriate and have incentives to bring patients in for unnecessary follow up visits. Providers are also paid higher rates for more intense interventions, discouraging “watchful waiting” of conditions when that might be the most appropriate choice. Incentives favor duplication of services; 32% of Americans report that in the last two years a doctor ordered a test that had already been done and/or recommended unnecessary treatment or care with little health benefit.¹⁶

Fee-for-service payments encourage overuse of services and reward increased intensity of care. Every condition prevented means less business to a provider. In fact, providers who improve efficiency, coordinate care, reduce duplications, and invest in prevention can find that their funding is reduced.¹⁷

Current payment systems also make no distinction between high and low value care. Providers at the top and bottom of the quality scale are paid the same rate for each treatment. Payments are negotiated based on volume and system capacity, rarely on the quality of care. Consumers generally pay the same out-of-pocket costs to access care from the highest and lowest performing providers. In most cases they have little information to distinguish the performance record of providers even if they wanted to use that information in their health care decisions.

In fact, our current payment system creates differing incentives between providers. Physicians and hospitals may compete for the most lucrative patients and procedures. Primary care providers have greater incentives to provide more care to some patients, but refer others needing more time or attention to specialists. Providers who accept high risk or noncompliant patients are at a disadvantage in fee-for-service as they are paid the same for each patient, regardless of the intensity of care needed.

Incentives in the current fee-for-service payment system are not aligned with improving quality and value. Fee-for-service encourages:

- More services
- Face-to-face, individualized services
- Less coordination
- Incentives to duplicate treatments
- Incentives to increase high profit services
- Incentives to avoid difficult patients and/or shift them to specialty providers
- Few incentives to prevent or manage disease
- Stifles innovation
- Has no link to quality or performance
- Includes no incentives to invest in patient safety

Quality based purchasing

A consensus is emerging among payers, providers and consumers that our payment system needs reform that promotes and rewards value over volume. Quality based purchasing refers to “organized attempts by purchasers to ensure and improve the quality of health programs when negotiating costs with providers and insurers.”¹⁸ Quality based purchasing focuses economic incentives on better outcomes including improved health status, lower costs of care, improved patient safety, and better patient satisfaction. Quality based purchasing removes incentives to increase the volume and intensity of services unless it is warranted. Quality based purchasing gives providers flexibility to customize care for each patient and to explore innovations that improve outcomes. Quality based purchasing aligns provider, payer and consumer incentives to reward quality and efficiency, and it reduces fragmentation and conflicting incentives in the system.¹⁹

Consumers support quality based purchasing. 95% of Americans feel it is important to have information about the quality of care provided by different doctors and hospitals. 88% feel it is important that they have information about their costs of care before they access services.²⁰

Federal quality-based purchasing initiatives: Medicare

Without system reform, the Medicare program is projected to run out of money in 2017.²¹ As the largest payer of health care bills in the nation, Medicare has embraced value-based purchasing to reduce costs, serving as an agent of change for the entire American health care system.²²

The federal Centers for Medicare and Medicaid Services (CMS) is currently conducting and testing over twenty value-based purchasing programs and pilots in Medicare.²³ October 1,

2008 Medicare stopped payments to hospitals for “never events” – rare medical errors that should never happen to a patient.²⁴ Never events include conditions such as surgery on the wrong body part or wrong patient, bed sores, infections and other hospital-acquired conditions that could have been prevented.²⁵ Based on a study showing that 20% of Medicare patients discharged from hospitals are re-admitted within thirty days and 34% within ninety days²⁶, Medicare is considering payment limits for preventable readmissions.²⁷

Early results from three Medicare quality-based purchasing demonstration programs show considerable promise in reducing costs and improving quality. In 2003, Medicare began the Hospital Quality Incentive Demonstration, in collaboration with Premier, Inc., a national hospital quality measurement consortium. Top performing hospitals received over \$36.5 million in incentives for improvements on thirty evidence-based quality measures for heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. The project involved 225 hospitals, including thirty in CSG/ERC states. Over four years, participating hospitals raised overall quality by 17 percentage points on average. Because of its success, CMS has extended the demonstration to new measures and new payment models.²⁸

Two Medicare physician quality-based purchasing demonstrations have also demonstrated significant successes. All ten large physician groups participating in the Physician Group Practice Demonstration program met benchmark performance goals on at least 28 of the 32 targeted measures of care quality. Over three years, the physician groups averaged quality scores increases of 10% on diabetes measures, 11% on congestive heart failure measures, and 10% on cancer screening measures. Five practices will receive a total of \$25.3 million as a share of Medicare’s \$32.3 million in savings from the program. A similar demonstration for small and solo physician practices reaching clinical performance standards generated \$7.5 million in shared savings to over 560 practices. The average payment per practice was \$14,000 with some reaching as high as \$62,500.²⁹

This summer Medicare announced creation of three new value-based purchasing initiatives, one for nursing homes, including 79 homes in New York, and two allowing physicians to share in savings from improved quality of care, including Beth Israel Medical Center in New York City.³⁰

Quality-based purchasing in national health care reform proposals

Quality-based purchasing is a prominent feature in both the House and Senate health care reform bills devoting 190 pages between both bills to initiatives. The House bill, HR-3962, the Affordable Health Care for America Act, includes two fast-tracked studies of geographic variation in health spending and asking for quality-based purchasing recommendations for Medicare, plans to bundle Medicare payments for follow up care after hospital discharge, and

quality adjustments to Medicare rate setting. The Senate bill, HR-3590, the Patient Protection and Affordable Care Act, implements a “value” modifier to Medicare physician payments, a program to tie hospital payments to quality performance, payment adjustments for hospital-acquired conditions, includes significant funding to develop and collect quality measurements, provides quality reporting in six categories for long term care institutions, creates bundling and shared savings programs, and creates an Interagency Working Group on Health Care Quality. Both bills include extensions of the current successful pilots.³¹

National reform proposals also expand the federal government’s comparative effectiveness research efforts, which will be critical to building effective quality-based purchasing systems. The American Recovery and Reinvestment Act of 2009, the federal stimulus bill, passed in April 2009 included \$1.1 billion in funding for comparative effectiveness research split between three federal agencies.³² The funds are to support research to fill the very large gaps in understanding of which health care treatments and strategies are the most effective in improving health. The research will evaluate the costs, risks and potential of treatments for specific populations of patients. Without this information, our health system has tended to embrace each new, more expensive treatment, without good information on its effectiveness.³³ This information will be critical in developing payments systems that reward value by identifying the most effective treatments. Purchasers pursuing value, including states, will have a growing body of research to draw on in designing system incentives.

State opportunities for quality-based purchasing

Quality-based purchasing could have significant benefits for states in a variety of roles.

- States have a primary role in operating **Medicaid** programs. Medicaid consumes 21% of state budgets on average surpassing all other state programs; a proportion that is likely to grow³⁴. Medicaid now covers one in five Americans, and is one of the largest health care purchasing groups in states.³⁵

State	Medicaid as % of state budget, FY 2009	% increase in Medicaid spending, FY 2008 to 2009 ³⁶	% of state residents covered by Medicaid ³⁷
Connecticut	18.7%	9.5%	15%
Delaware	12.3	8.7	22
Maine	30.4	17.7	23
Massachusetts	19.1	5.3	19
New Hampshire	27.0	5.3	11
New Jersey	20.0	3.6	11
New York	26.7	4.5	27
Pennsylvania	29.8	5.4	17
Rhode Island	23.3	-3.9	19
Vermont	20.4	8.5	26

- **State employee plans** are also very large purchasers of health care services. State employee benefits are usually comprehensive, state employee populations are generally stable, and reimbursements to providers and health plans tend to be generous. Forty two states self-insure their state employee plans, including eight CSG/ERC states, with the state bearing financial risk for rising costs.³⁸
- States have a critical role in **regulating** insurers, licensing providers, protecting consumers, and restraining costs for all payers.³⁹
- States are large funders and sponsors of **public health programs**. State tobacco control, healthy living, environmental health and other wellness programs benefit all members of the population, reducing costs across payers. States invest significant funding in these programs, but the benefits are shared by all payers. These important quality initiatives must be integrated into payment mechanisms to ensure incentives are aligned across providers and not working at cross purposes.
- States have a strong role in **training health care providers**. Most health care professionals are educated at public colleges and universities.⁴⁰ It is critical that providers are trained in the new quality-based environment and are engaged in making it succeed.

- States, including agencies and elected officials, serve as **trusted sources information** in health care including data collection and analysis, emergency preparedness, health care planning, and consumer protection. Reforming the health care system is difficult. Quality based purchasing faces strong cultural and political challenges. States can provide the public with assurances that the transformation and investment are worth the effort.
- States have historically served as laboratories of **health care innovations**.⁴¹ States have taken the lead in developing health information exchanges, supporting transformation in health care delivery, and expanding coverage. CSG/ERC states such as Maine, Massachusetts and Vermont have led the nation in covering the uninsured, not waiting for national reform. States have the flexibility and the history of innovation to embrace quality-based purchasing and make it work.
- States have a long history of serving a disinterested **convening role** across stakeholder groups bridging across interests. States can provide payers with protection from anti-trust concerns⁴² and states carry the authority and influence to ensure that all actors participate.

State policy options for linking health care payments to quality

There is a continuum of overlapping options available to payers and policymakers seeking to implement quality-based purchasing. Many are already common practice; others have not been widely adopted to date. The options vary in the expense and difficulty of implementation and in the evidence of effectiveness in improving quality and restraining costs.

Transparency

Consumers who want to compare treatment options based on cost and quality have few sources of information. Some states collect and analyze quality and cost data on health care services and publish report cards. More than half of all states are publicly reporting quality and/or patient safety data⁴³ and 37 states have mandatory inpatient hospital reporting systems.⁴⁴ However, recent research has called into question the effectiveness of report cards in improving the quality of care.⁴⁵

The Pennsylvania Health Care Cost Containment Council has been collecting and analyzing patient safety and quality data for state residents since 1986. The Council was created by the state to help reduce skyrocketing health care costs by providing consumers with comparative information about the most effective health care options available and giving providers comparative information creating opportunities to improve care. The Council has published hundreds of reports covering topics including cardiac surgery, insurance mandates, hospital-acquired infections and comparing the quality of Pennsylvania’s HMOs, all available to the public, at www.phc4.org.

Never events

Payers can choose to limit or eliminate payment for low quality care. It is estimated that 42% of the costs of hospital infections are preventable and preventable infections are responsible for 7.7% of hospital readmissions.⁴⁶ In September 2008 Medicare stopped paying for a list of eight “never events,” or serious, reportable adverse events that could have reasonably been avoided with the use of evidence-based guidelines. The original list of conditions included foreign objects left in the body after surgery, incompatible blood transfusions, and pressure ulcers. Medicare’s list of conditions for non-payment has grown to 28⁴⁷; at least a dozen states and several private payers have followed, limiting payments for serious, avoidable hospital complications.⁴⁸ At least 25 states require licensed health care facilities to report serious medical errors.⁴⁹

Pay for Performance

Unlike nonpayment for never events, which utilizes only disincentives, Pay for Performance (P4P) relies on incentives to improve the quality and value of care. The concept rests on providing bonuses for higher quality, more efficient health care, giving providers and health plans resources to invest in value. In 2006, twenty eight state Medicaid agencies were operating P4P programs; by next year, it is expected that there will be 82 programs in 43 states.⁵⁰ State performance targets include well-child visits, cervical cancer screening rates, immunization rates, and HbA1c testing for patients with diabetes. Financial rewards include paying primary care providers each time one of their patients receives a screen, performance-

based fee increases, bonus payments for reaching a performance threshold, or bonuses based on improvement. States have also implemented P4P programs with non-financial incentives including public recognition, technical assistance, and reduced administrative burdens such as less frequent quality auditing.⁵¹

Maine’s Medicaid program has included bonus payments to higher performing physicians since 1998. Pediatricians, family practitioners, internists and OB/GYN physicians participating in MaineCare, a primary care case management program, are compared quarterly to their peers based on their performance on measures including access to care, preventive screenings, and emergency room use. Providers in the top 80% of performers share about \$3 million each year; payments are based on individual performance measures and specialty. The mechanism to distribute payments was developed by the state in collaboration with providers. Providers reportedly pay close attention to their performance reports. The desire to improve their ranking on the publicly shared report is often a greater motivator than the bonus payments.⁵²

While pay-for-performance programs are widespread across state Medicaid programs and private plans, evidence of their impact on quality is mixed. Some studies have found evidence of sustained and growing benefits⁵³ while others find that quality improvements in the P4P programs are no better than outside them.⁵⁴ A recent study found that while targets are being measured and rewarded, performance improves. But those improvements are short-term; when targets are reached, improvement slows. More importantly, even the short term effect does not generalize across the system; the quality of care declined for conditions not linked to incentives and continuity of care was reduced.⁵⁵

Provider support of pay for performance incentives has been lukewarm. A 2008 survey of primary care physicians found that 41% believe that pay-for-performance is a good idea but believe that data standards are lacking and 38% believe it is a poor idea because performance is too hard to quantify. Only 7% felt that it is a good idea whose time has come.⁵⁶

In response to the research,⁵⁷ payers are modifying pay for performance programs to improve effectiveness. Pennsylvania is using incentives to reduce health disparities in diabetes care and Oklahoma is using pay for performance to strengthen their primary care infrastructure.⁵⁸

Consumer financial incentives for quality

Harnessing the power of markets is another promising strategy employed by payers to improve quality. Generally the costs of care to consumers are the same regardless of quality; patients are charged equal copays for care from high and low performing providers. Giving consumers incentives to select higher quality and more efficient care can increase volume to those providers and serve as an incentive to improve value. Plans can also limit access to only those providers who reach quality thresholds. Tiered drug benefits, charging consumers less for generic or more effective medications, are common in many plan designs. Tiering of health plans, hospitals and provider networks based on cost and quality performance is becoming more common.⁵⁹

Maine's State Employee Health Commission is the largest employer-sponsored plan in the state with 40,000 covered lives. Since 2005, the Commission has employed quality-based purchasing incentives beginning with a program of reduced cost sharing for members with diabetes participating in disease management. In the first year, participants averaged \$1,300 in lower costs compared to a control group. Building on that success, the Commission began a hospital tiering program for members. Patients are given quality comparisons of providers and are charged less to access care from higher tier, or preferred, providers. In the first year, there was a 5% shift in outpatient services from non-preferred to preferred hospitals. Pressure from members led lower performing hospitals to improve, almost doubling the number who met preferred status in less than a year. The program has now moved to a primary care provider tiering system, waiving copays and deductibles for visits to preferred practices. Between 2007 and 2008 there was a 35% increase in the number of practices reaching the highest level of quality.⁶⁰

Value-based insurance design is the next step in this trend. The use of lower consumer cost sharing for appropriate, effective services is meant to drive utilization toward higher value treatments with strong evidence of clinical benefit and away from services with little or no demonstrated value.⁶¹ Reducing or eliminating copays for appropriate use of blood pressure medications is a form of value-based insurance design. Eventually, these choices will be tailored to individual patients. Value-based insurance design is closely linked with comparative effectiveness research; it is critical to base consumer incentives on the best available scientific evidence. Early results are promising; in three prescription programs, reductions in copays correlated with increased compliance in drug regimens.⁶² A recent controlled study found that a value-based insurance plan that reduced patient copayments to encourage high value services was associated with a 10% reduction in patients not taking prescribed medications recommended for diabetes, heart disease and breathing problems. The plan experienced a reduction in more intensive health care services, offsetting the costs of reduced copayments and higher drug utilization.⁶³

Plans have also begun providing consumers with incentives to identify and reduce health risks. Incentives to comply with recommended care, such as prenatal care, and higher premiums for members who refuse health risk assessments are becoming more common. Incentives to either participate in or achieve smoking cessation or weight loss are on the rise in health plan designs. While these incentives hold great promise to improve the overall health of Americans, there is concern that they could be discriminatory based on socioeconomic and genetics and may exacerbate racial and ethnic health disparities. It is critical that these incentives be carefully designed and that consumers have access to the tools needed to achieve health gains. For example, to penalize smokers without comprehensive coverage for smoking cessation would be counterproductive.⁶⁴

Payment structure overhaul

Variations on the current fee-for-service reimbursement system of payment have been gaining momentum. The concept is to give providers and plans an incentive to reduce costs with flexibility to achieve those savings. Shared savings, bundled payments, episode of care payments, and global payments are variations on this theme. Payment reform proposals are combined with significant quality incentives, such as pay for performance, to remove any provider incentives to deny appropriate care or disincentives to invest in quality.

Shared savings or gain sharing, the least constrictive of the new options, allows physicians and provider networks to share in the savings they help generate by reducing ineffective care, enhancing high value care, and coordinating care particularly for medically complex cases. A drawback to this concept is that incentives are paid well after the initial provider investment

in reducing costs and improving performance; providers will not know what their level of payment is until long after the patient receives treatment.

Alabama’s Medicaid primary care case management program, Patient 1st, began sharing savings with providers in 2007. The program targets use of generic medications, emergency room use, and office visits. Savings are shared equally with practices through a point system that recognizes costs and performance for each provider’s panel compared to expected costs and quality measures. The shared savings payments are in addition to monthly care management fees.⁶⁵

Episode-based or bundled payments provide a single reimbursement to providers for each clinically defined episode of care, for example coronary bypass surgery. Providers receive an all-encompassing fee that covers the full range of services associated with each clinical episode including inpatient and post-acute care following discharge.⁶⁶ Bundling and episode-based payments are often compared to Medicare’s system of hospital payments – Medicare severity diagnosis-related group (MS-DRG). Medicare pays hospitals at discharge only for the services provided in the hospital for that clinical episode based on diagnosis. Bundling or episode-based payments would cover inpatient care as does Medicare, but also include pre and post-acute care the patient receives including home health care and rehabilitation. The advantages to this concept are that hospitals would be more involved in coordinating care with post-discharge providers and would have an incentive to ensure that post-acute care is effective.⁶⁷ A drawback is that it gives providers no incentive to avoid the clinical episode by providing patients with preventive care, for example medications and lifestyle counseling to prevent and manage coronary artery disease eliminating the need for surgery. An evaluation of a Medicare demonstration project in the 1990s of bundled payments for coronary artery bypass graft surgery resulted in savings averaging 10% while reducing patient mortality by 8% per year.⁶⁸ It is estimated that bundling payments could provide up to 5.4% savings in health care spending between 2010 and 2019, more than hospital rate regulation, health information technology, or disease management.⁶⁹

Geisinger Health System, a large Pennsylvania network of hospitals and providers, is paid a risk-based flat rate or bundled payment for a growing number of conditions. The rate covers whatever is needed for each episode of care including pre-operative evaluations and work up, hospital and professional fees, routine discharge care and management of any complications arising within 90 days of surgery. Associated innovations to reduce costs and improve quality made possible by the flat rate pricing included enhanced patient education and creating clinical benchmarks for care integrated into electronic health records. Eighteen months after implementing the new pricing and quality program for coronary artery bypass grafts, average length of stay dropped from 6.2 to 5.7 days, 30-day readmissions dropped by 44%, and complications dropped by 21%.⁷⁰

Because of Geisinger's ability to lower health benefit costs, one Pennsylvania community's Board of Education was able to give teachers a \$7,000 raise.⁷¹

Global payments, another payment reform option, compensate providers for all the care needed by a patient over a period of time, such as a year, including hospital, physician, ancillary and prescription treatments. Provider rates do not change if a patient is admitted to the hospital. Global payments are based on estimates of prior cost experience and future risk for each patient's conditions. Patient socioeconomic information can also be included in setting global payment rates. Global payment systems give providers financial incentives to keep patients healthy and provide the most efficient care possible. Providers also have an incentive to coordinate care to reduce duplications and improve quality. It is estimated that 20% of commercial health care payments in Massachusetts are currently made in a global payment system.⁷²

Concerns have been raised that global payments are a return to older forms of capitation that have largely been abandoned because they gave providers a financial incentive to inappropriately limit care. Architects of these new plans emphasize that with appropriate protections, many of which were not available ten or fifteen years ago, those problems can be avoided. The protections focus on risk adjustment and quality incentives. Risk adjustment methodologies modify rates to reflect patients' medical conditions and the likelihood of illness

and future health costs. Unpredictable illness or health costs, such as an automobile accident, are not included in the global payment and are covered by an insurer. Risk adjustment removes incentives for providers to “cherry pick”, to preferentially enroll healthy patients and avoid those with higher health care needs. Proponents of global payments have included significant subsidies for quality, such as pay for performance, in the system’s design.

Supportive trends

Change in the culture of health care systems is critical to effective payment reform. If organizations, and the ways that providers work do not change, payment reform will not be successful.⁷³ Payment reform initiatives will be more successful building on delivery system reforms such as patient-centered medical homes, the development of accountable care organizations, widespread adoption of health information technology and exchange, comparative effectiveness research, and thoughtful health care workforce development.

Patient-Centered Medical Homes

In a recent survey, almost three out of four Americans reported difficulty accessing care from their doctor. Half report poor coordination of care; especially among those who see more than one doctor. One in three Americans reports getting unnecessary care or duplicate tests. Ninety one percent believe it is important to have one place or doctor responsible for their primary care and coordinating care.⁷⁴ Patient-centered medical homes are a new trend in delivering health care built around coordinating care and putting patients at the center of the system. Both bills currently being debated in Congress rely heavily on patient-centered medical homes for reforms.⁷⁵

Patient-centered medical homes are not buildings or hospitals, but a different way of practicing medicine. Patient-centered medical homes offer coordinated, comprehensive primary health care that is accessible, continuous, compassionate, culturally appropriate, and patient-centered. Coordination of care can reduce duplicate tests and prevent errors in conflicting treatment when patients have several doctors. Care is personalized for each patient and delivered by a team of professionals who put the patient and their needs at the center of care. The team may include a doctor, nurse, physician assistant, medical assistant, health educator and other professionals. Patient-centered medical homes can make primary care practice more appealing to graduating primary care physicians who are predicted to be in short supply as the US population ages.⁷⁶ Proponents argue that patient-centered medical homes can reduce health care spending, improve health status, support disease management and prevention, improve the quality of care, reduce medical errors, and reduce racial and ethnic health disparities.⁷⁷

States are recognizing the potential of the patient-centered medical home model. Eight states have defined the patient-centered medical home concept in law or regulation and seven states are developing processes and criteria to recognize patient-centered medical homes.⁷⁸ Patient-centered medical home pilots and programs are operating across the country including New York, Connecticut, Maine, New Hampshire, Pennsylvania, Rhode Island, Vermont, and Massachusetts.⁷⁹ In 2005 Ontario implemented the first wave of Family Health Teams, similar to patient-centered medical homes, to reduce emergency room use and expand access to preventive care.⁸⁰ There are now 150 Family Health Teams across the province in areas of need, with 50 more in planning.⁸¹

Preliminary research on the effectiveness of patient-centered medical homes is promising, but also offers caution and guidance for success including patience, flexibility and support.⁸² Researchers have found that implementing the patient-centered medical home model requires a fundamental transformation of medical practice, which can be difficult even for willing practices. It should be considered an on-going developmental process rather than a destination.⁸³

Vermont's Community Health Care Teams integrate the patient-centered medical home model with health care financing, public health, prevention, clinical services and information technology. The project is unique in combining patient-centered medical homes focusing on individual care with larger public health services. Community Care Teams in three counties provide medical practices with direct services, care coordination, population management and quality improvement support. Teams include a nurse care coordinator, social workers, behavioral health and substance abuse specialists, dieticians, community health workers, and public health prevention specialists. Teams are housed at local Department of Health District Offices. The teams collect data on community health needs including hospital discharges, behavioral risk factors, tobacco use, and highway safety data.⁸⁴

Accountable Care Organizations

Too often health care decisions that benefit one provider or payer financially disadvantage another, encouraging decisions based on narrow economic interests rather than savings to the overall system or the needs of patients. The need to align incentives to promote quality and efficiency are behind the concept of Accountable Care Organizations (ACOs).⁸⁵ Proposed in 2006⁸⁶ ACOs are integrated networks of local providers across the care continuum, including hospitals, physicians and affiliated providers that are paid based on their ability to provide quality care and restrain costs. ACOs share in the savings they generate as a network by coordinating care, reducing overuse or misuse of care, eliminating wasteful duplication of services, providing wellness programs, and patient support. ACOs shift the emphasis from payment for utilization to payment for health outcomes.⁸⁷ ACOs can be fully integrated health systems, such as the Cleveland and Mayo Clinics, or geographically diverse networks of providers connected through contractual relationships, such as Geisinger Health System in Pennsylvania. The core of the ACO concept is that the parts work as a coordinated entity in the shared goals of improving both the quality and efficiency of care. The Congressional Budget Office estimates that creation of ACOs could save Medicare \$5.3 billion in the next ten years even after returning significant savings back to the provider network.⁸⁸ Medicare savings are estimated at \$300 to 400 per patient per year.⁸⁹

ACOs differ from managed care plans in several ways – ACOs do not have to be at financial risk as HMOs are, but can share in the savings resulting from their efforts. Accountability rests with providers and their treatment decisions rather than insurance companies. ACOs also allow for flexible structures in different regions⁹⁰.

While past efforts to align incentives across health care stakeholders have not been successful, there is optimism that ACOs may be more successful. The health care market has evolved significantly since managed care reforms of the 1990's with providers more willing to enter into contractual alliances with other providers and institutions. Much has also been learned about how to measure and reward the quality of health care delivered. Payers are investing in effective use of information technology that will facilitate care coordination and efficiency.⁹¹

State legislative and regulatory barriers

Much of health care is financed and regulated at the state level. States have traditionally held responsibility for oversight of insurance. In 1945, Congress recognized state regulation of insurance with the McCarran-Ferguson Act, and has redefined and reaffirmed that principle since. Efforts to supplant state insurance regulation with federal oversight have been repeatedly rejected.⁹² State laws vary concerning insurance risk and which products require regulation.⁹³ Many quality-based purchasing arrangements could be considered insurance

products for purposes of state insurance regulation. Arrangements that transfer risk, even partial risk, to providers such as bundled payments, global capitation and ACOs could be problematic. Proponents of these arrangements argue that insurers, self-insured employers and government payers should retain responsibility for “insurance risk” – costs due to whether patients become ill – and provider organizations such as ACOs should assume “performance risk” – based on providing quality care that is cost-effective once a patient has a condition requiring care.⁹⁴ Another open question is whether providers who accept risk, even performance risk, should be required to keep adequate capital reserves to cover that risk.

State and federal anti-trust legislation and regulation may create another barrier to quality-based purchasing. Multi-payer collaborations are critical to ensure that provider incentives are aligned and payers collaborate to reward quality and efficiency of care. However, competition in many states health insurance markets has eroded, leading to higher costs.⁹⁵ Consolidation of providers into integrated care systems such as ACOs could create local monopolies, increasing the costs of care.⁹⁶ States can act as a neutral convener to avoid anti-trust violations and monitor market conditions to preserve competition.⁹⁷

Other concerns include ownership and guarding privacy and security of personal health information and data used to evaluate quality and define payments. Non-discrimination protections in state laws and constitutions could limit value-based insurance design, for example prohibiting the exemption of only some patients from cost sharing due to diagnosis or health history. Interactions between state and federal law, especially in the event that federal reform passes, create more uncertainty. Even if state law is silent on these issues, the ambiguity and resulting litigation could inhibit and delay participation in quality-based purchasing. States that wish to foster health reform would be advised to clarify state law.

Lessons Learned

In interviews some important lessons emerged from stakeholders, including states, pursuing quality-based payment reforms.⁹⁸

- *Collaborate first.* Payment reform is complex and can be threatening, especially to many stakeholders who are financially stretched. Reform must be based on a consensus-building process. There are honest disagreements about what constitutes “quality of care” and how to measure it. These must be acknowledged and addressed in a process that all stakeholders find fair. Collaboration serves to educate all stakeholders about other perspectives and the need for reform, as well as developing robust solutions that are more likely to be successful. The process can be as important as the resulting policies.
- *Go slowly.* Payment reform is a moving target. It is critical to evaluate pilots often and adjust policies as needed to ensure success. Incremental approaches ensure that

members' choices are not severely restricted and allow market forces to drive quality improvement.

- *Start small and with the strongest partners.* Beginning with the stakeholders most committed to reforming payment systems and most willing to put in the effort to work out problems will improve chances for success. Provide strong supports and safe harbors for first adopters.
- *Coordinate across payers.* It is critical to standardize measures, reporting systems, and incentives across payers; providers facing multiple, sometimes conflicting incentives from different payers will not be able to respond productively. States can help bring disparate, even competing interests to the table to reduce fragmentation and conflicting signals.
- *Ensure a fair and open process.* Policy development must be open and accessible to succeed. All stakeholders must be engaged from the beginning using common language and measurements.
- *Be very clear on goals.* It is critical that the goals of the project, focused on outcomes, are well-understood, using common language, from the beginning. Progress must be measured regularly against those goals.
- *Patient education is critical.* Too often consumers and the public are left out of complex health system reforms. The public often receives conflicting information about health care quality. States serve as trusted sources of unbiased information. If patients do not understand the potential benefits of system reform, and the risks of doing nothing, a voter backlash could undermine reforms, as happened to managed care in the 1990's.
- *Plan for transitions.* Transformations do not happen suddenly. The current health care system is not working, but each interest involved is strong. Care must be taken to protect important but fragile sectors during the transition to quality-based purchasing.
- *Don't underestimate the power of transparency and disclosure.* Several sources interviewed for this report noted that disclosure, even without financial consequences, can be a very strong motivator. Physicians given information on their quality performance compared to colleagues were motivated to make significant changes in their practices.
- *Invest in data and analysis.* Measuring and defining value requires clear information from trusted sources. Confidence in the fairness and integrity of risk adjustment, performance measurement and rate setting is critical. Research is critical to test the impact of strategies, intended and unintended, identify barriers and solutions, and track provider and consumer experiences with reform. There must be a commitment by policymakers to share and act on lessons learned.
- *Be brave.* All sources emphasized that payment reform is not easy, but the results are worth the work.

Guiding Principles

States have a strong interest in successful payment reform, but unlike most payers, states have other unique responsibilities in the health care system including regulating insurers and providers, protect patient safety, stewarding scarce tax dollars and ensuring the long term capacity of the health care system.

A series of guiding principles for states entering into quality-based payment reforms have emerged from the research, the history of health care reforms and lessons from on-going reforms. These principles were adopted by the CSG/ERC Quality-Based Purchasing Advisory Committee on March 16, 2010.

Payment reform must:

- 1. Align and fairly balance the interests of patients, taxpayers, providers and payers.*
States are in the best position to fairly balance interests; they are closer to the patient level than the federal government, have a long history of overseeing health care, and fund a large and growing share of the health care system.
- 2. Improve quality and foster innovation.*
Incentives should be easy to access and meaningful to providers and patients. Administrative burdens to access incentives reduce their effectiveness.
- 3. Reward efficiency, reducing the long term growth of health care costs.*
Performance measures should be prioritized on the basis of clinical evidence to encourage the use of best practices and discourage high-cost or high-volume services with little clinical value. Whenever possible, outcome measures should be emphasized, such as preventable hospitalizations and ambulatory care sensitive conditions that could have been prevented with adequate primary care. Measures should avoid rewarding care that is already routine practice or has only minimal impact on health status.
- 4. Share resulting savings among all stakeholders, including state budgets.*
While states will have to contribute and invest in payment reform initiatives along with other payers and providers, the benefits must also be shared, especially with high performing providers to ensure that gains are sustainable. As the largest payer of health care services, Medicare must participate, both contribute and share in savings from payment reform.
- 5. Promote patient-centered care.*

Payment reform must ensure that patients get the “right care at the right time from the right provider,” respecting their values and preferences. Payment reform must be designed to protect vulnerable consumers who rely heavily on the health care system.

6. *Transparency is paramount.*

Payment reform policies must be developed in a public process with input from all stakeholders. Payment processes and standards must be simple to understand and administer.

CSG/ERC Quality-Based Purchasing Committee

Name	Position	State/Province
Paula Roy	Director, Health Care Commission	Delaware
Lisa Miller	Representative	Maine
Jim Campbell	Representative	Maine
Craig Hall	MA Developmental Disabilities Commission	Massachusetts
Kemp Hannon	Senator	New York
Laurie Harding	Representative	New Hampshire
Toni Harp	Senator	Connecticut
Jim Hester	Director, Health Care Reform Commission	Vermont
Kevin Lembo	State Health Care Advocate	Connecticut
Robin Lunge	Legislative Staff	Vermont
Richard Moore	Senator	Massachusetts
Shafiq Qaadri	MP	Quebec
Usie Richards	Senator	US Virgin Islands
Trish Riley	Director, Health Policy and Finance	Maine
Jeff Shaw	Legislative staff	Connecticut

Interviews

Date	Who	Title	Org
6/24/09	Cathy Schoen, MS	Senior Vice President	Commonwealth Fund
6/9/09	Frank Johnson	Executive Director	Employee Health & Benefits, Maine
6/4/09	Francois de Brantes, MS, MBA	CEO	Bridges to Excellence
4/14/09	Michael Critelli	CEO, retired	Pitney Bowes
	Melinda K. Abrams, MS	Assistant Vice President	Commonwealth Fund
6/25/09	Stuart Guterman	Assistant Vice President	Commonwealth Fund
6/30/09	Jennifer Baron	Senior Researcher	Institute for Strategy & Competitiveness Harvard Business School
6/25/09	Cal Ludeman	Commissioner of Human Services	State of Minnesota
6/29/09	Judy Ann Bigby	Secretary, Executive Office of Health and Human Services	State of Massachusetts
7/1/09	Tom Valuck, MD, JD	Medical Officer and Senior Advisor	Center for Medicare Management, CMS
7/6/09	Kim Davis-Allen, Paige Clark	Director, Program Manager, Transformation	Alabama Medicaid

Initiatives Division

7/17/09

John Young

Acting Director, CMS
Division of
Quality, Evaluation
and Health
Outcomes

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