



The National Health
Leadership Council

The Road to Health Care Delivery Reform: Payment Reform and Accountable Care Organizations



San Francisco, CA
March 2-4, 2011



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May 2011

The National Health Leadership Council (NHLC) of the National Business Coalition on Health (NBCH) brings together leaders from business, health coalitions, provider organizations, health plans, and other stakeholders to discuss issues at the cutting edge of financing, organization, access, and quality. Recent meetings have explored patient-centered medical homes, consumer-centered care and consumer-directed health benefit models, evidence-based benefit design, physician performance measurement and payment reform, the link between employee health and productivity, strategies for engaging the C-suite in promoting employee health and productivity, and building healthier communities.

In March 2011, the NHLC met in San Francisco, CA, to discuss another timely, critical topic—the need for payment reform, particularly as such reform relates to accountable care organizations (ACOs). Co-hosted by the Pacific Business Group on Health (PBGH), the meeting focused on payment reform as a principal lever—along with benefit redesign and consumer engagement—for improving the healthcare system. Theoretical discussions about meaningful payment reform have gone on for years, but getting true reform done in the real world has proven difficult. Individual purchasers in particular have faced difficulties in effectuating meaningful change. With the advent of healthcare reform and ACOs, purchaser coalitions have an opportunity to work with the Centers for Medicare & Medicaid Services (CMS) and other partners to enact meaningful payment reform. Success will require industry, suppliers, and government to come together to develop effective messages so that consumers understand the importance for reform and the need to make important, thoughtful decisions when choosing providers and treatments. As David Lansky, President and Chief Executive Officer (CEO) of PBGH noted, “the moment is now, and the purchaser’s voice is desperately needed.”

To promote such reform, the NHLC meeting consisted of two days of rich conversation among representatives of key stakeholder groups. The meeting served as an opportunity to discuss critical issues and divergent opinions, with the goal of building consensus. It included the following elements:

- An overview of the key challenges related to payment reform
- A review of strategies and tools for implementing payment reform
- A panel discussion where various stakeholders responded to the need for payment reform
- Purchaser case studies on payment reform
- A review of purchaser principles related to ACOs
- A panel of providers offering their perspective on ACOs
- An update on the new CMS Center for Medicare and Medicaid Innovation*

This report summarizes the presentations and discussions from the meeting. Our hope is that it will help in promoting efforts to transform health care community by community.

Sincerely,

A handwritten signature in black ink that reads "Andrew Webber". The signature is written in a cursive, flowing style.

Andrew Webber, President and Chief Executive Officer, NBCH

*Peter V. Lee, Director of Delivery System Reform in the Office of Health Reform at the U.S. Department of Health & Human Services (DHHS), provided an update on the Center for Medicare and Medicaid Innovation, a new organization created by the Patient Protection and Affordable Care Act. Because he presented information still being reviewed within DHHS and the Obama administration, a summary of his remarks does not appear in this paper.

Overview

The National Health Leadership Council (NHLC) of the National Business Coalition on Health (NBCH) is a vehicle for high-level discussions of issues important to coalition members and all major parties in health care, including purchasers, providers, insurers, suppliers, and consumers. The expectation is that NHLC meetings will produce statements of agreement among the stakeholders that will promote the advancement of a more value-based health care system. The goal is to encourage community-based changes founded on market principles.

In March 2011, NHLC met for two days in San Francisco, CA, to discuss the critical issue of payment reform, particularly as it relates to accountable care organizations (ACOs). The first day included an overview of the challenges related to payment reform, strategies and tools for implementing such reform, discussion of payment reform among representatives of various stakeholder groups (e.g., providers, consumer organizations), and case studies of purchaser efforts to promote payment reform. Day two included a review of purchaser principles related to ACOs and a panel of providers offering their perspective on ACOs. Day two also included an update on the new Center for Medicare and Medicaid Innovation within the U.S. Department of Health and Human Services (DHHS).^{*} This report summarizes and synthesizes the key points from the presentations and discussion; it is organized into the following sections:

- **The Challenge of Payment Reform**
Arnold Milstein, MD, Medical Director, PBGH
- **Strategies and Tools for Implementation of Payment Reform**
Harold Miller, President and CEO, Network for Regional Healthcare Improvement; Suzanne Delbanco, PhD, Executive Director, Catalyst for Payment Reform
- **Multi-Stakeholder Response to Payment Reform**
Jamie Robinson, Kaiser Permanente Professor of Health Economics, Director, Berkeley Center for Health Technology, University of California, Berkeley (moderator); Andrea Walsh, Executive Vice President and Chief Marketing Officer, HealthPartners; Jennifer Eames Huff, Deputy Director, Consumer-Purchaser Disclosure Project; Bruce Spurlock, MD, Executive Director, Clinical Acceleration of the BEACON Collaborative
- **Purchaser Case Studies in Payment Reform**
Bill Kramer, Executive Director of National Health Policy, PBGH; Catherine Dodd, PhD, RN, Director, San Francisco Health Service System; Leslie Johnstone, Health Services Coalition, Las Vegas; Gary Rost, Savannah Business Group on Health
- **Purchaser Principles on ACOs**
David Lansky, President and CEO, PBGH
- **Provider Perspectives on Accountable Care Organizations**
Jay Crosson, MD, Senior Fellow, The Kaiser Permanente Institute for Health Policy; Paul Swenson, Executive Vice President, John Muir Health; Stuart Levine, MD, Corporate Medical Director, HealthCare Partners

^{*}Peter V. Lee, Director of Delivery System Reform in the Office of Health Reform at DHHS, provided the update on the Center for Medicare and Medicaid Innovation, a new organization created by the Patient Protection and Affordable Care Act. Because he presented information still being reviewed within DHHS and the Obama administration, a summary of his remarks does not appear in this paper.

Clinical Service Innovation to Meet the Challenge of Health Reform

Arnold Milstein, MD, Professor of Medicine & Medical Director of the Pacific Business Group on Health

The Need for Rapid Innovation

The 2010 health reform law substantially remedied the problem of the uninsured. Americans now need rapid innovation in health care delivery models to better align health care spending growth with GDP growth. Purchaser coalitions can play a critical role in pushing for such innovation, beginning with payment reform. Just as the airline industry eliminated the need for “navigators” in the cockpit in response to demands for safe, affordable travel, the healthcare industry needs to innovate more quickly to meet demand for lower-cost, high-quality care. Failure to spark such innovation will carry severe consequences. The healthcare sector continues to grow more rapidly than overall gross domestic product (GDP) in the U.S., a phenomenon that Warren Buffett describes as a “societal tapeworm.”

Such growth rate differences pose little damage if they occur for only brief periods of time—in fact, allocating a higher proportion of the nation’s wealth to health care may be desirable as nations prosper. The problem, however, comes when such increases continue on a sustained basis, as they have in the U.S. for the past 50 years. As a higher proportion of the income goes to health care, more Americans lack the means to pay for other essential goods and services, including housing, food, and child care. Something has to give, so they either forego these things or healthcare services.

Absent cost-lowering innovations, the remedy is higher taxes on the wealthy. In the current political climate, the ability to impose higher taxes on upper-income individuals appears quite limited. The only solution, therefore, is to make care more affordable, which depends on purchasers motivating the healthcare industry to rid itself of the equivalent of the cockpit navigator—care that adds no value or care delivered inefficiently. Without faster productivity gains via innovation in health service delivery

methods, worse care for non-wealthy citizens or suppression of valuable but cost-additive biomedical innovations will inevitably follow.

Such politically unpopular choices can be avoided if the rate of clinical productivity gains reach or exceed an additional 2.5 percentage points per year. Such increases could end the longstanding trend of health care consuming an ever greater share of the nation’s income and prevent social divisiveness. Other service and manufacturing industries have boosted annual productivity growth through effective use of information technology (IT) and modern performance management tools, such as LEAN. The combination of IT with tools like LEAN has boosted annual productivity gains in other U.S. service sectors to between 2 and 6 percent. This level of improvement in health care will occur only if the industry is sufficiently motivated to innovate in service delivery. Purchasers need to assure that payers deliver such motivation. The goal should be to create a U.S. health industry that produces better and leaner services every year.

Such value gains can be achieved in health care. For example, an internist in Downey, California became fed up with the worst of managed care practices, such as delaying patient access to specialists and lowering primary care payment. He borrowed money to form Caremore Medical Group and a Medicare Advantage insurance plan. By taking on global capitation and caring better for the sickest patients, he improved quality while reducing annual per-capita spending by roughly 15 percent. He achieved these results through a relentless daily focus on care improvement—hypothesizing, testing, and refining ideas for improvement, and then adopting those that worked and abandoning those that did not. His work is further described in “American Medical Home Runs” (see <http://content.healthaffairs.org/content/28/5/1317.full?ijkey=XcSSzfxg.6uc&keytype=ref&siteid=healthaff> for more information).

Getting from Here to There

Accelerating such innovation throughout the entire healthcare supply chain—attaining the healthcare equivalent of “Moore’s Law”—will require four phases:

- **Value comparisons:** Providing comparisons of the relative value offered by hospitals, physicians, organized health care systems, and

treatment options.

- **Value sensitivity:** Redesigning benefit plans and provider payment so that patients' share of costs and provider payments are based on service value, not service volume. For example, tiered provider networks have significant potential to reduce costs. It remains to be seen whether the excise tax included in the Patient Protection and Affordable Care Act (PPACA) will be enough to encourage purchasers to require plans to implement value-tiered networks. Doing so will be critical, as history suggests that industries do not innovate more quickly unless they face a "do-or-die" situation. In other words, providers will be unlikely to innovate faster unless doing so becomes a requirement for their economic survival. For many providers, being excluded or adversely tiered in an insurer network qualifies as a do-or-die situation.
- **Clinical reengineering:** Faster uptake and discovery of "better, faster, leaner" care methods through adoption of delivery innovations.
- **Faster value improvement:** Society gains as clinical reengineering spurs large annual gains in the affordability and quality of care.

Achieving the healthcare equivalent of Moore's Law will not be easy for the healthcare industry. To date, purchasers have not created the type of "burning platform" necessary to induce provider organizations to innovate at a more rapid pace. In addition, IT-enabled clinical improvement skills remain weak, and the industry is just learning to manage performance effectively. Payers hold the key to changing this situation. By collectively focusing on value—including payment reform, tiered networks, and reference-pricing for high-end surgeries—purchasers can stimulate innovation in health care. Keys to success include the following:

- **Harmonizing public and private payers:** Payers in both the public and private sector need to come together to promote higher-value care delivery innovation. Their impact will be much greater if private employers and

insurers use the same clinical performance measures and gain-sharing formulas as CMS. If such an approach proves impossible due to provider resistance, payers must make the "hard choice" to use narrow or tiered provider networks and reference pricing.

- **Making improvement simple:** Under the leadership of Don Berwick, the Institute for Healthcare Improvement (IHI) realized that the health industry is not yet ready for complex process re-engineering. As a result, IHI tends to focus on encouraging a few major changes in a handful of high-priority areas. IHI also adopted Dr. Stephen Shortell's concept of "twinning," where doctors and hospital leaders from weak-performing organizations visit organizations that have been successful in improving quality and reducing costs, such as Virginia Mason Medical Center and Intermountain Healthcare. Leaders of these organizations have been willing to share their programs with others. However, much more needs to be done to share best practices. Creating something similar to an agricultural extension service may be required to help spread successful clinical innovations more quickly.
- **Encouraging "singles" rather than home runs:** Purchasers need to do more to aid and abet the adoption of "disruptive innovations" in health care. For example, purchasers can encourage use of nurse-led clinics in retail stores for minor acute illnesses and preventive services. Less expensive staff can also perform simple, repetitive tasks as well as doctors or nurses.

The Pivotal Role of Employer Coalitions

The U.S. has the potential to eliminate up to one third of current healthcare spending with no reduction in health or patient experience. While such savings may never fully materialize, roughly \$1 trillion in annual health spending could safely be eliminated over the next 10-15 years, boosting other important sectors of society, such as education, child care, and infrastructure.

“The time is now; this is your moment. CMS is willing to harmonize with you in motivating high-value innovations in care delivery. National economic growth and societal cohesiveness depend on private sector use of value-based provider networks and provider payment methods. No one knows how to harmonize the voice of influential purchasers better than you. Do you have the will?”— Arnold Milstein, MD, MPH, calling on purchaser coalitions to become a more effective national catalyst for faster productivity gains in health care delivery.

Purchaser coalitions are critical to achieving such savings. A harmonized purchaser voice can create the “burning platform” for providers to boost productivity gain. Some large multi-employer plans and coalitions, such as the Culinary Health Fund and Health Services Coalition (HSC) in Las Vegas, are already playing this role. They have narrowed physician networks based on value and invited hospital systems from outside the area to bid on services amenable to travel. These actions send a clear signal to Las Vegas providers to improve value. Las Vegas providers have responded to this message, by supporting innovations such as the “Doctor-tomorrow” program, which reduces emergency department (ED) visits through an evening appointment line that guarantees a primary care visit by 10 a.m. the morning after the call. Purchasers need to be willing to adopt narrow networks, reference pricing, and revamped provider payment methods such as shared-savings programs with providers. Shared-savings arrangements may initially need to be more generous to providers who do not have experience or confidence in their ability to reduce costs. Over time, the formulas can be re-evaluated, and purchasers can begin to use more narrow networks that exclude providers that do not improve value over time. Employees generally accept narrowed or tiered networks if they enable substantial lower out-of-pocket spending and/or premiums.

Arnold Milstein, MD, MPH, serves as Medical Director of PBGH (the largest regional healthcare improvement coalition in the country) and as Professor of Medicine at Stanford University, where he also directs the Stanford Clinical Excellence Research Center, a collaboration of the Schools of Medicine, Engineering, and Business to design and test new health care delivery models that both lower per-capita spending and improve clinical outcomes. He also guides employer-sponsored, clinically-based innovation development for Mercer Health and Benefits and chairs the Steering Committee that directs the largest U.S. physician pay-for-performance program, operated by the Integrated Healthcare Association. Previously, he co-founded the Leapfrog Group and Consumer-Purchaser Disclosure Project, and served as a Congressionally-appointed Medicare Payment Advisory Commission (MedPAC) Commissioner. He has also chaired the Institute of Medicine’s planning committee that examined the best methods to lower per capita health care spending and improve clinical outcomes. Dr. Milstein received his Bachelor of Arts in economics from Harvard University, his Medical Degree from Tufts University, and his Masters in Public Health (MPH) from the University of California at Berkeley.

Strategies and Tools for Implementation of Payment Reform

10 Strategies for Advancing Payment Reform

Harold Miller, Executive Director, Center for Healthcare Quality and Payment Reform

A variety of strategies can be used to advance payment reform, as outlined below. (For more information on these and other payment and delivery reform strategies, see www.PaymentReform.org.)

Focus on Improvements in Care Instead of “Risk” and Organizational Structure

To date, most discussions of ACOs and payment reform have not explained how the cost of health care can be reduced in a way that benefits patients, causing patients to fear that payment reform will lead to rationing. To overcome such fears, physicians and hospitals should focus on how they will reduce costs by improving the quality of care. Three major strategies exist: (1) keeping patients well so they don't need healthcare services at all; (2) helping patients manage chronic diseases to reduce costly ED visits and hospitalizations; and (3) reducing infections, complications, and readmissions associated with hospital care.

Define Payment Reforms That Support Care Changes

Payment reform is needed because the current payment system rewards poor outcomes and higher costs. However, many current discussions about payment reform are disconnected from strategies for improving care. Instead of focusing so heavily on how much “risk” providers can accept and suggesting that providers need financial incentives to deliver high-quality care, the emphasis should be on giving providers the ability and flexibility to improve outcomes and reduce costs in a financially feasible manner. Desired changes in care should

drive the nature of payment reform, not the other way around. For example, episode-of-care payments can facilitate better coordination of care between hospitals and physicians during a hospitalization and eliminate current penalties for reducing infections and complications. Comprehensive care payments (also known as “global” payments) can provide the resources and flexibility to allow physicians to help patients with chronic disease avoid hospitalization in the first place.

Focus on Physicians, Not Hospitals or Health Plans

Physicians will be primarily responsible for doing the things that will keep patients healthy and out of the hospital. By contrast, hospitals will see lower revenues as a result of keeping patients healthy and out of the hospital, making it difficult for them to take a lead role in improving care and revamping payment systems.

Contrary to conventional wisdom, physicians need not be part of large systems to have success with payment reform. In fact, the earliest documented example of episode-based pricing came not from a large integrated system, but from a single physician who offered a fixed total price for surgical services for shoulder and knee problems, effectively giving a warranty for any subsequent services needed for a two-year period, including repeat visits, imaging, hospitalizations, and surgery. The program ended up providing the surgeon with 80 percent more in payments and the hospital 13 percent more in payments than they would have otherwise received. At the same time, the health insurer saved 40 percent. The key to this success came from reducing unnecessary auxiliary services (e.g., radiography, physical therapy), complications, readmissions, and length of stay.

To be successful, purchasers need to work with physicians to identify opportunities to reduce costs and support them in making the necessary changes in care through revamped payment structures and benefit designs. Physicians will generally react positively to the idea of payment reform if it is designed in a way that will improve patient care and that does not hold physicians accountable for things they cannot control. For example, a recent payment reform summit in Colorado drew 100 physicians from

across the state who identified dozens of cost-savings opportunities, along with the payment and delivery system changes needed to realize these savings. These physicians, from a wide range of specialties, expressed overwhelming support for episode-of-care and global payments, and welcomed training on how to redesign care processes, monitor performance, and manage payment systems.

To be sure, small, independent physicians will need assistance in managing revamped payment systems. While hospitals can serve as one mechanism for providing such support, other mechanisms also exist, such as independent practice associations (IPAs) which can create the critical mass of physicians needed to successfully manage global payment structures.

Facilitate Creation of Purchaser-Provider Partnerships

A neutral facilitator can bring purchasers and providers together to redesign payment and benefit structures to support low-cost, high-quality care. This convener can also provide data and technical assistance to support the effort. In Maine, for example, the Maine Health Management Coalition (a multi-stakeholder collaborative led by purchasers) is working to facilitate the transition to global payments and ACOs, including engaging employees in these initiatives. State government agencies, non-profit collaboratives, purchasing coalitions, and other organizations may also be able to play this role. To date, purchaser coalitions have not been active enough in this area.

Start with Win-Win-Win Opportunities

Many opportunities exist to provide better care for patients, equal or better margins for providers, and lower costs for purchasers/payers. The key to finding such opportunities lies in accessing and analyzing claims and clinical data, not just to produce traditional quality measures, but also to help physicians and hospitals identify win-win-win opportunities. The data used for such analyses must be trusted by both sides of the purchasing arrangement--providers and purchasers--so having the data collected and maintained by a neutral community organization can be essential to success.

Purchasers need to recognize, however, that the cost

of “warrantied” care may be higher than traditional unit costs. Some purchasers react negatively to this, feeling they should not pay more for high-quality care than they are paying today. But in every other industry, customers expect that “warrantied” products will cost more on a unit-price basis than products not offering a warranty. However, the value of the warrantied product can only be seen by calculating the total current cost of the product, including repairs and replacement. For example, the true price of a \$10,000 hospital procedure that carries a five percent risk of a \$20,000 infection is \$11,000 (the original \$10,000 price plus five percent of \$20,000). Most purchasers do not have the data to understand this true cost. With access to such data, purchasers would realize that if the same procedure had a warranty against infections, it would cost more than \$10,000 but less than \$11,000, thus saving them money while simultaneously rewarding the provider financially for improving quality. For example, suppose the provider set the initial price for the warrantied procedure at \$11,000. This price gives the provider an incentive to reduce the infection rate—if it drops to four percent, the average cost falls to \$10,800, thus allowing providers to initially earn an additional \$200 per procedure. If consumers also have an incentive to seek better-value care, the provider may drop the price to \$10,800 in hopes of attracting more volume. When that occurs, both consumers and purchasers save money. This process repeats itself as the provider continues to re-engineer care to reduce the infection rate. In the end, a win-win-win situation occurs, with quality improving, costs falling, and providers becoming more profitable.

Create Effective Transitional Payment Models

Providers cannot move overnight to global or episode payments after having worked for decades under fee-for-service (FFS). Consequently, transitional models are needed. Although medical home payment models that give primary care practices an upfront payment to cover the cost of investing in care managers help the practices transition, many payers do not like the idea of paying more upfront with no guarantee of improved outcomes. The “Shared Savings” model goes too far in the other direction, since it provides no upfront resources or flexibility to allow providers

to change the way they deliver care. Consequently, a better transitional approach is to provide upfront money, but also require achievement of specific targets for reducing costly, avoidable services such as ED visits, imaging tests, etc., and pay bonuses or penalties based on success in meeting those targets. This approach, which creates a virtuous cycle of improvement, is being implemented this year in Washington State with primary care doctors who wanted a flexible model to allow them to redesign care.

To illustrate how an upfront payment better motivates providers to redesign care processes, consider a situation where a health plan provides a small primary care practice with upfront funding to cover the costs of a nurse practitioner (NP) who provides care management to a group of high-risk patients, tied to a commitment by the practice to use the NP to significantly reduce non-urgent ED visits and an agreement by the health plan to share any net savings with the practice. This arrangement results in net savings to the plan while allowing the primary care practice to increase physician salaries. Without the upfront payment, however, the practice would have to pay the NP salary, meaning that the doctors would lose money in the first year. Even under a shared savings model, any bonus would not be paid until the second year, and might not be enough to cover the initial losses incurred by the practice even after several years.

In addition to the method of payment, purchasers and payers need to think about the length of contracts. Longer-term (rather than annual) contracts provide the predictability providers need to recoup large initial investments. Too many pay-for-performance (P4P) systems operate on an annual basis, with providers never being sure what comes next. To address this issue, some plans now routinely use multi-year contracts. For example, under its Alternative Quality Contract, Blue Cross Blue Shield of Massachusetts has signed five-year contracts with providers that build in increases at a fixed (low) rate tied to overall inflation. Many other plans now routinely use three- or five-year contracts to provide this transitional period to providers.

Create Multiple, Appropriately Sized ACOs

To ensure competition, markets should have multiple “right-sized” ACOs, rather than one large ACO. Within a given market, such ACOs might be created by multiple physician-driven IPAs or Physician-Hospital Organizations that compete with each other on quality and cost. Tools to support the creation of right-sized ACOs include the following:

- Physician education, engagement, and training.
- Transitional payment reforms to enable physician practices to build capabilities.
- Removal of legal barriers to collective action by IPAs. Currently, hospitals with employed physicians can negotiate with private payers as a unit, but IPAs cannot without proving that they are “clinically integrated” or accept significant risk.
- Create incentives for patients to use lower cost, high-quality providers; copayment and coinsurance differentials and high deductibles do not do this effectively today.

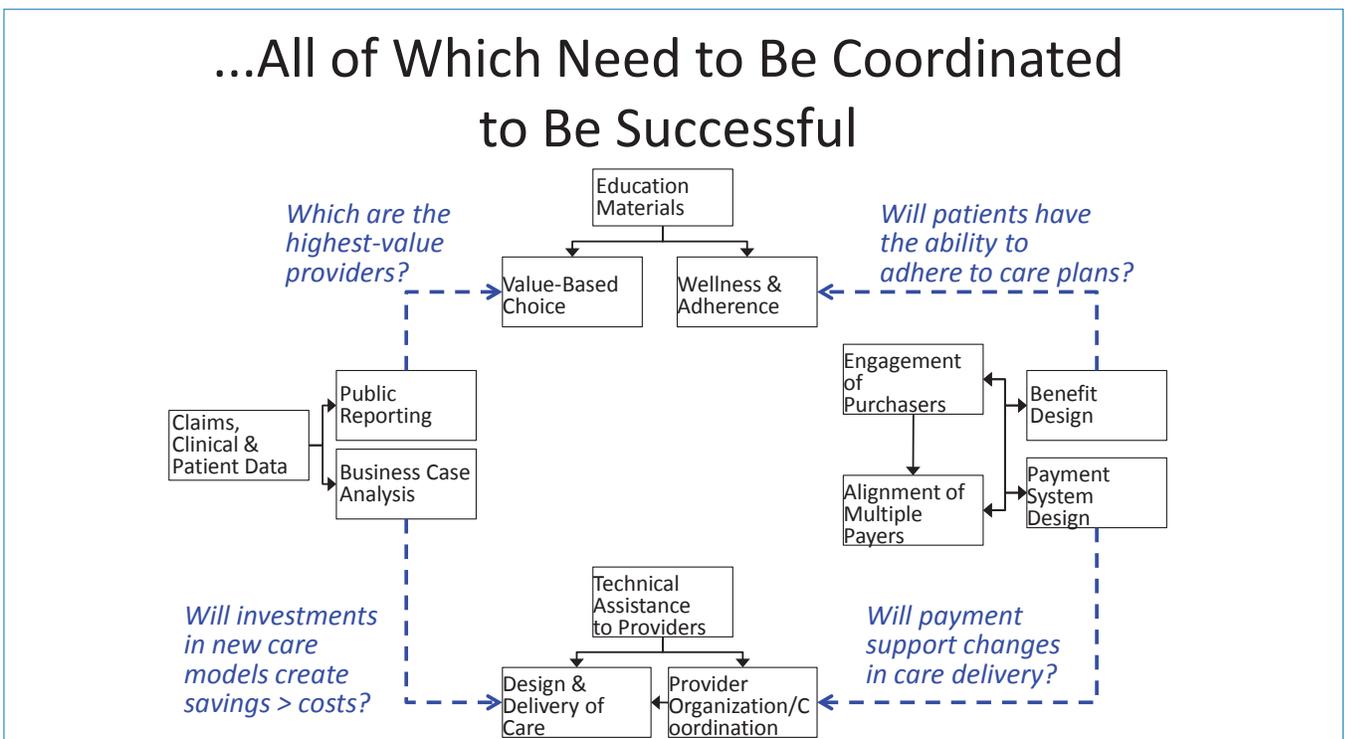
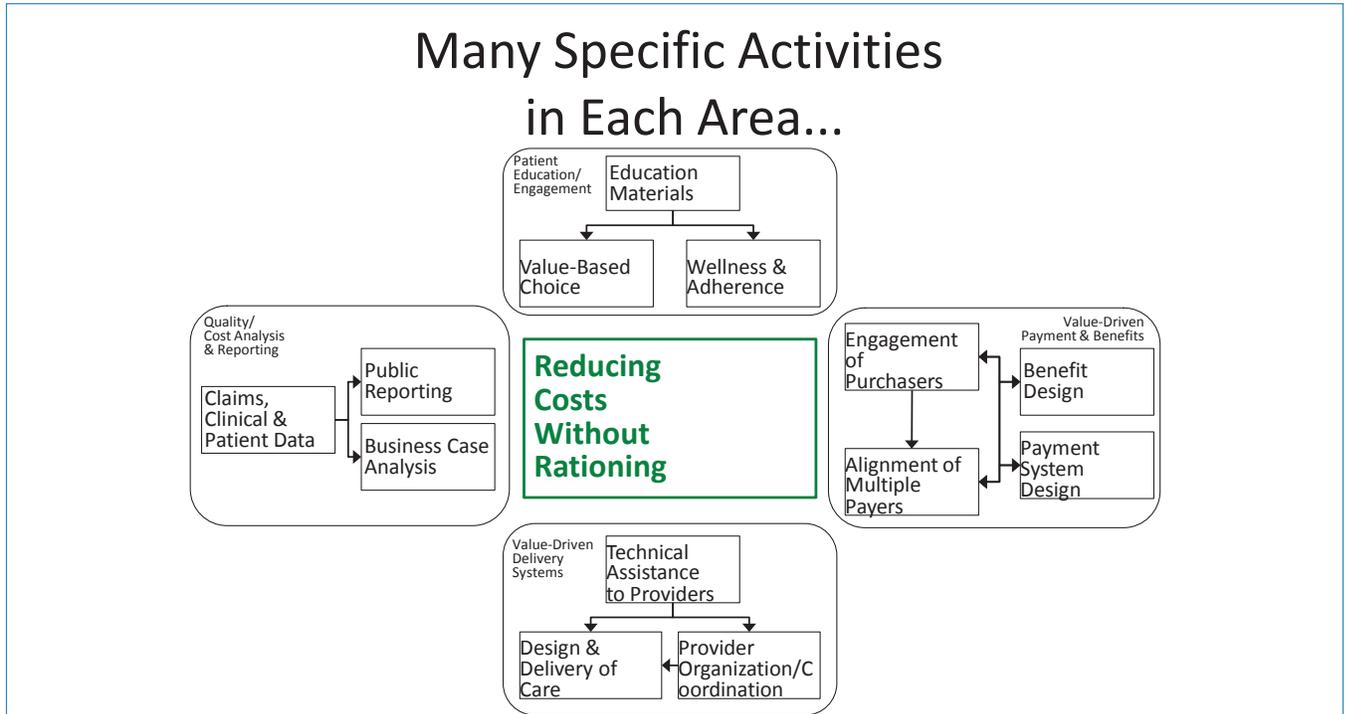
Enact Benefit Changes to Complement Payment Reforms

Payment reform alone will not be effective without concomitant changes in employee benefit structures that encourage individuals to improve their health, enable them to afford their prescribed medications, and incentivize them to choose high-value providers and services. For example, benefit packages should coordinate pharmacy and medical benefits. A single-minded focus on reducing pharmacy costs (e.g., through high deductibles, high copayments for brand names when no generic alternative exists, and doughnut holes that create gaps in coverage) can cause patients to skip taking their medications, leading to higher spending on hospitalizations. In fact, the principal treatment for most chronic diseases involves regular use of maintenance medication(s). To avoid employee resistance, purchasers need to explain to employees why these benefit changes make sense and will ultimately benefit them.

Support Regional Health Improvement Collaboratives

Payment reform alone will not be enough. In fact, many specific activities need to be coordinated in multiple areas, with all stakeholders being engaged, as depicted in the charts below.

This coordination needs to occur at a community level. Regional Health Improvement Collaboratives represent an ideal mechanism for achieving this type of coordination. These regional non-profit entities bring purchasers, physicians, hospitals, health plans, and consumers together to promote payment and delivery system reform by supporting public reporting,



patient education, purchaser engagement and alignment, and technical assistance for providers. A large, growing network of these organizations exists throughout the country, as illustrated in the chart below:

Get Payment and Delivery Reform Started

Rather than waiting for Medicare to drive change, communities can get started themselves, by bringing

relevant stakeholders together to discuss the issues and options and come to an agreement on how to proceed. Such “payment reform summits” have been used in many communities to ensure that the stakeholders develop a strategy that works for them and that they actively support. As part of this effort, it will be critical for purchasers to give providers the data that will allow them to figure out how to implement payment reforms.

Leading Regional Health Improvement Collaboratives

- Albuquerque Coalition for Healthcare Quality
- Aligning Forces for Quality – South Central PA
- Alliance for Health
- Better Health Greater Cleveland
- California Cooperative Healthcare Reporting Initiative
- California Quality Collaborative
- Finger Lakes Health Systems Agency
- Greater Detroit Area Health Council
- Health Improvement Collaborative of Greater Cincinnati
- Healthy Memphis Common Table
- Institute for Clinical Systems Improvement
- Integrated Healthcare Association
- Iowa Healthcare Collaborative
- Kansas City Quality Improvement Consortium
- Louisiana Health Care Quality Forum
- Maine Health Management Coalition
- Massachusetts Health Quality Partners
- Midwest Health Initiative
- Minnesota Community Measurement
- Minnesota Healthcare Value Exchange
- Nevada Partnership for Value-Driven Healthcare (HealthInsight)
- New York Quality Alliance
- Oregon Health Care Quality Corporation
- P2 Collaborative of Western New York
- Pittsburgh Regional Health Initiative
- Puget Sound Health Alliance
- Quality Counts (Maine)
- Quality Quest for Health of Illinois
- Utah Partnership for Value-Driven Healthcare (HealthInsight)
- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Healthcare Value Exchange



Harold D. Miller serves as Executive Director of the Center for Healthcare Quality and Payment Reform and as President and CEO of the Network for Regional Healthcare Improvement. In these roles, Mr. Miller works at both the regional and national levels to improve the quality of healthcare services and to change the fundamental structure of healthcare payment systems to support improved value. Mr. Miller also serves as Adjunct Professor of Public Policy and Management at Carnegie Mellon University’s Heinz School of Public Policy and Management, where he served as Associate Dean from 1987 to 1992. Mr. Miller has authored numerous reports on the role of innovative payment systems in promoting delivery system reform. In addition, his work with the Pittsburgh Regional Health Initiative (PRHI) demonstrated the significant financial penalties that hospitals can face if they reduce hospital-acquired infections. He also designed and is currently leading a multi-year PRHI initiative to reduce preventable hospital admissions and readmissions through improved care for patients with chronic disease. In 2007 and early 2008, he served as the facilitator for the Minnesota Health Care Transformation Task Force, which prepared recommendations that led to passage of Minnesota’s path-breaking healthcare reform legislation in May, 2008. He is currently working with Regional Health Improvement Collaboratives in several states to design and implement payment and delivery system reforms.

A Strategy for Purchasers to Drive Value Through Payment Reform

Suzanne Delbanco, PhD, Executive Director,
Catalyst for Payment Reform

Purchasers often lack the resources and knowledge to push effectively for payment reform on their own. To address this issue, several large employers created an independent organization-- Catalyst for Payment Reform or CPR—to work with providers, health plans, consumers, and labor groups to improve quality and reduce costs by identifying and coordinating workable solutions to improve how health care is paid for in the U.S. The goal is to work to create awareness of the problem, a national framework for payment reform, tools to catalyze change in the marketplace, and to align public and private-sector strategies. While purchasers may be removed from the patient-provider interaction, they have the leverage necessary to make reforms to payment. Seeking both short-term “wins” in payment reform as well as longer-term bold strategies, CPR will base its work on a set of payment reform principles it developed with a wide range of health care stakeholders. These principles suggest that health care payment should:

- Promote health by rewarding the delivery of high-quality, cost-effective, affordable, patient-centered care that reduces disparities.
- Encourage and reward patient-centered care that coordinates services across providers and settings while tailoring services to individual patient needs, values, and preferences.
- Encourage alignment between the public and private sectors to promote improvement and innovation in areas deemed to be national priorities, and to minimize the impact of payment decisions made in one sector on the other.
- Balance the perspectives of consumers, purchasers, payers, physicians, and other providers in making decisions about payment, which should be guided by what best serves the patient and society.

- Foster ways to reduce expenditures on administrative processes such as claims payment and adjudication.
- Balance the need for urgency against the need for realistic goals and timelines that take into account the need to change complex systems and geographic and other variations.

To date, a relatively small group of employer purchasers have been involved in shaping the effort, including Boeing, CalPERS, Delta Airlines, Dow, Equity Healthcare, General Electric, Intel, Verizon, Wal-Mart, Xerox, and the Group Insurance Commission in Massachusetts. PBGH houses and serves as a core leader of CPR, and several PBGH members actively participate. Efforts to recruit a much larger group of employers will commence in the spring of 2011.

Payment Reform Toolkit

To encourage coordinated action across healthcare purchasers, CPR is developing a payment reform toolkit to provide a strategic framework and accompanying resources to support purchasers and other stakeholders in taking calculated, coordinated actions to reform payment. Key elements of the toolkit include the following:

- **Payment framework:** This framework helps purchasers and other users understand the range of payment models (e.g., FFS, bundled payments, global payments, enhanced payments based on value). It also emphasizes that movement across the payment spectrum (e.g., from FFS to global payments) does not guarantee greater value, and that more value can be extracted out of each approach. In some situations, improving the current payment method might work better than moving to a new one.
- **Action briefs:** These short briefs, to be released in the spring of 2011, outline the value proposition for stakeholders, potential steps to implement payment reforms, and strategies for addressing potential unintended consequences. Topics include fee-for-service, bundled, and global payments; ACOs and medical homes; and strategies for ensuring competition in the marketplace.

- **Market assessment tool:** Also to be released in the spring of 2011, this tool will assist purchasers and payers in identifying opportunities for payment reform based on market conditions, delivery system organization, and other factors. Because a “one-size-fits-all” approach will not work, the tool helps purchasers create a comprehensive inventory of market characteristics that can have an impact on delivery and payment reforms. The tool will also help users examine regulatory issues, market power, current and past payment reform activities, and the readiness of various stakeholders to participate in reforms. CPR plans to conduct assessments in three markets in 2011.
- **Sourcing tools:** These standardized modules for health plan requests for information (RFIs) and contract language support a “coordinated buy” with respect to payment methodologies. The standardized questions, which are synched with the NBCH eValue8 tool, will evolve with the CPR agenda over time. Current questions ask for the proportion of payments tied to performance and/or designed to align incentives to reduce unnecessary costs. Future questions will cover short-term payment reforms, ACOs, and the Partnership for Patients. The model health plan contract language will cover similar areas.
- **National Scorecard on Payment Reform:** This high-level scorecard will monitor progress in implementing payment reform and the impact of such reforms on the quality and cost of care.

A Shared Agenda Going Forward

Going forward, CPR leaders will work with key stakeholders to achieve both short-term and long-term payment reforms. At the start, the focus will be on incremental reforms to FFS and other existing payment structures. Participating employers will discuss and prioritize opportunities, with CPR supporting implementation of those deemed a high priority. The primary implementation tools include the aforementioned RFP questions/contract language

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and direct dialogue with health plans. Longer term, the focus will be on going beyond FFS and creating specifications for future payment systems, including setting target goals for the percent of payments tied to performance, identifying top opportunities for bundled payments, and assisting with rapid evaluation and sharing of lessons learned related to ACOs and other new delivery models. Over the long term, CPR will also focus on developing solutions to address the potential negative impact of excessive market power among some health care providers. CPR will align with DHHS in supporting hospital payment reform and will work with private purchasers to adapt these reforms and with health plans to implement them. Finally, CPR will continue to “shine a light” on the urgency for payment reform. To that end, CPR commissioned the Center for Studying Health System Change to study variations in payment rates to hospitals and physicians; this study concluded that market power drives costs. CPR also supports development of a National Scorecard on Payment to measure progress

and impact, and will continue to engage in focused advocacy efforts to inform policy and align private and public sector activities.

Bending the cost curve represents a long-term challenge; any successful effort must include payment reform. Rather than latching on to the latest “fad,” effective implementation requires optimizing FFS payment systems in the short term, while at the same time testing, refining, and implementing new, more effective models on a broad scale in a timely manner. To succeed, private purchasers and payers must have a significant role and work together to reform the system. More information on CPR can be found at www.catalyzepaymentreform.org.

Multi-Stakeholder Response to Payment Reform

Representatives of various key stakeholders provided their perspectives on payment reform.

The Case for Benefit Design and Payment Reform in Tandem

James Robinson, Leonard D. Schaeffer Professor of Health Economics and Director, Berkeley Center for Health Technology, University of California at Berkeley

In various P4P and other payment-related projects, both provider and health plan leaders note the importance of the consumer role, particularly the need to combine payment reform with benefit redesign to create incentives for consumers to make better choices. Without the marrying of these two, the impact of payment reform will be limited. At present, consumers do not understand the costs of care and have no incentive to pay attention to the relative costs/value of hospitals and physicians. Consequently, providers rightfully become concerned that they will not attract incremental patients as a reward for doing the work necessary to take on bundled or global payments. For their part, health plan leaders worry that, in the absence of flexible benefit designs that shift part of the cost to consumers, providers will raise prices even when paid on a bundled basis.

Benefit redesign and payment reform need to work

together to focus on three distinct levels of choice faced by consumers:

- **Choice of treatment:** Bundled payments and other payment reform models do nothing to ensure the patient makes a good decision as to the type of treatment to pursue (if any). Getting at this issue—i.e., the appropriateness of care—requires incentives for consumers to engage in shared decision making.
- **Choice of provider:** Once a patient decides on a treatment, he or she must choose where to have it done. Reference pricing schemes that pay a fixed amount but then require the consumer to pay the costs above this amount can be very effective in encouraging wise choices. Copayment differentials can also be effective. CalPERS and its carrier Anthem use this approach with certain surgical procedures—for example, paying up

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to \$30,000 for a hip replacement in a market where such procedures cost anywhere from \$15,000 to \$115,000. Anthem has found that several brand-name hospitals perform the procedure with excellent outcomes for under \$30,000, but some others do not.

- **Choice of product:** Consumers generally are not in a good position to evaluate the type of product—for example, which implant or stent is used during a surgical procedure. Hence benefit design does not really address this issue. Some health plans use formularies, but these generally do not work well either. Episode-based or bundled payments, however, do create an incentive for providers to choose cost-effective products.

Lessons from an Integrated Delivery and Financing System

Andrea Walsh, Executive Vice President and Chief Marketing Officer, HealthPartners

HealthPartners is an integrated delivery and financing system in Minnesota with approximately one million members (excluding 300,000 getting only dental coverage). HealthPartners has a 700-physician multispecialty practice, more than 50 ambulatory care sites, and several hospitals, making it the largest consumer-governed, nonprofit health care organization in the nation. Roughly a third of members receive care from HealthPartners' own delivery system, with providers paid on a total cost-of-care payment system. The remaining two thirds receive care from providers under contract with HealthPartners. The contracted provider network overlaps considerably with that of other health plans, as few plans in the region compete by differentiating networks. Rather, they compete in part by partnering with providers to help them produce better clinical outcomes and manage cost trends. To that end, most contracted partners have also signed total-cost-of-care agreements with HealthPartners. These agreements also include quality and patient satisfaction metrics. This "triple-aim" focus encourages providers to work on care process and delivery system redesign. These agreements will evolve over time into long-term contractual partnerships that leverage expertise on how to focus and redesign care for better

population health, patient experience, and trend/cost management. Such redesign can be quite difficult, since it requires a change in physician culture and work focus to create patient-centric models.

At present, HealthPartners is focused on creating a team culture that uses the electronic medical record (EMR) to standardize practice while still personalizing care to the patient. Rather than providing individualized care each time, providers take standard, proven processes and apply them as appropriate based on the patient's unique needs and circumstances. Along with payment reform, HealthPartners is also trying to embed health plan capabilities within its owned and contracted delivery systems. Many providers do not currently have the data and analytical capabilities to understand what is going on with their patient population. Without access to claims-based analysis, they find it difficult to take a population-based perspective and to focus on ongoing management of disease.

Andrea Walsh serves as Executive Vice President and Chief Marketing Officer at HealthPartners, where she is responsible for health plan and care delivery marketing and product development, sales, government relations, and public affairs, and has operational accountability for customer service, worksite health, and the Central Minnesota Clinics. She has been with HealthPartners since 1994 in a variety of roles. She began her career practicing law and served as the Assistant Commissioner of Health at the Minnesota Department of Health in the early 1990s. While there, she served as a leader in the development of MinnesotaCare, Minnesota's health care access reform initiative. Ms. Walsh serves on several boards, including the Minnesota Chamber of Commerce, Minnesota Science Museum, and the Minneapolis Downtown Council. In 1999, she was recognized by the Health Care Forum as an "International Emerging Leader in Health Care", and in 2005 as a "Woman to Watch" by the Minnesota Business Journal.

Lessons from Learning Collaboratives

Bruce Spurlock, MD, President and CEO of Convergence Health Consulting, Inc.; Executive Director, Clinical Acceleration of the BEACON Collaborative

The BEACON Collaborative—a 40-hospital voluntary learning collaborative in the Bay Area of Northern California—serves as a neutral convener, bringing participants together to engage in constructive dialogue and working with providers on clinical improvement and cost reduction. The approach has worked, even in the absence of public reporting (which the collaborative agreed not to do) and incentives. Through internal reporting, sharing of ideas, and peer-to-peer learning, more than half of participating hospitals have eliminated hospital-acquired infections. Mortality rates from sepsis—the number-one cause of death in hospitals—have declined by 30 percent in participating hospitals. The collaborative’s activities have stimulated improvements that save an estimated 400 to 500 lives each quarter, with improvement in participating hospitals going at a faster pace than in the rest of the nation (which has also experienced reductions in infections). Payment reform has not been a part of this success, although it could potentially accelerate the pace of improvement going forward.

A similar approach has been used with a group of 100 hospitals in Florida focused on reducing readmissions. This effort, launched 2.5 years ago, involved an initial flurry of activity that resulted in significant improvement. However, the effort was stymied by payment issues, as leaders of participating hospitals began to realize that the drop-off in admissions significantly affected their bottom line, with one 7-hospital system estimating it would lose \$20 million if it eliminated readmissions in its top 10 diagnosis-related groups (DRGs). Current payment systems do not provide enough of an incentive to make it financially realistic to keep the effort going. At present, collaborative leaders are trying to figure out how to set up a gain-sharing arrangement that creates a “win-win-win” scenario. For example, if the hospital system received half of the savings generated (with the rest going to health plans or purchasers), it could at least breakeven on its efforts.

Finally, a third collaborative effort involves a multi-stakeholder coalition in California known as the Chart Initiative (www.calhospitalcompare.org). This program seeks to publicly report meaningful performance data to drive selection of hospital providers. The effort has faced several challenges, and it is not yet clear if the idea of comparing and benchmarking hospital performance will have any impact on consumer behavior.

Bruce Spurlock, MD, serves as President and CEO of Convergence Health Consulting, Inc., a boutique management consulting firm that works with physicians and health care executives to create state-of-the-art, results-oriented clinical management programs. Dr. Spurlock also serves as Executive Director and Chair of the CHART Board, a collaboration of hospitals, purchasers, health plans, and consumer groups that produces voluntary, standardized hospital performance reports in California. He also leads large, multi-participant quality collaboratives in California, Washington, and Florida designed to accelerate the implementation of evidence-based clinical practices in large regions. Currently, he serves as an Adjunct Associate Professor at Stanford University. Prior to developing his national consulting practice, Dr. Spurlock served as Executive Vice President for the California Healthcare Association, practiced internal medicine with The Permanente Medical Group, Inc., and served as Assistant Clinical Professor for the University of California at Davis and on the California Medical Association’s Board of Trustees. In 1997, he was appointed by California Governor Wilson to the Managed Health Care Improvement Task Force. Dr. Spurlock received his Doctor of Medicine degree from the University of California at Davis and completed his internal medicine residency, chief residency, and general medicine fellowship at Kaiser Foundation Hospital in Santa Clara, California.

Lessons from a Consumer-Purchaser Collaborative Project

Jennifer Eames Huff, Director, Consumer-Purchaser Disclosure Project

Funded by the Robert Wood Johnson Foundation and co-led by PBGH and the National Partnership for Women & Families, the Consumer-Purchaser Disclosure Project (CPDP) brings consumer organizations, labor groups, and purchasers together to advocate on issues that will improve the quality and affordability of health care. The project's focus has evolved over time, with an initial emphasis on getting good performance measures used for public reporting purposes and a more recent focus on payment reform as a way to rein in costs. The project brings consumers and purchasers together in hopes of giving them a louder voice in the debate on national policy, with the message that reform is not moving fast enough. Having this voice also lets the federal government know that key stakeholder groups support forward movement to address quality and cost issues. In addition to working at the national level, sometimes the project becomes involved in regional issues that could have national implications. For example, CPDP organized New York purchasers and consumers and met with the state attorney general to share principles to guide how health plans measure and report physician performance. These principles were incorporated into agreements the attorney general made with the plans. CPDP also rolled out a national model known as the Patient Charter for Physician Performance Measurement, Reporting, and Tiering Programs. Work on the CPDP has made it clear that payment reform is not an end, but rather a means to an end. The ultimate goal is delivery system reform that results in higher-quality, lower-cost care. Part of this reform effort must be focused on public health initiatives designed to change unhealthy behaviors, including smoking and poor diet. In addition, the new healthcare reform law has created increased concerns about continued cost-shifting to the private sector. For that reason, public public-private partnerships must be a part of the solution, including alignment of incentives and a focus on common issues that can benefit the system as a whole.

Jennifer Eames Huff serves as Director for the Consumer-Purchaser Disclosure Project at PBGH. She brings over 15 years of experience in healthcare performance measurement to the project. Prior to joining PBGH, Ms. Huff was a Health Economist at Genentech, where she contributed to the development and commercialization of products by overseeing patient-reported outcomes and providing economic assessments. Before that, she served as a Program Officer at the California HealthCare Foundation (CHCF), where she managed a portfolio of projects related to patient safety, health disparities, and the public reporting of provider performance. Prior to joining CHCF, she served as Director of Client Service at the Picker Institute, where she helped clients measure patients' experience with care and use the information for improvement, public reporting, and financial rewards. Ms. Huff has also held quality management positions at health systems in New England, and has a Bachelor of Arts degree from Wellesley College and an MPH in health policy and management from University of California at Berkeley.

Key Insights from Multi-Stakeholder Discussion

Following the overview from each stakeholder, panelists and attendees engaged in a multi-stakeholder discussion on how best to work collaboratively to promote payment reform and broader improvements in the cost and quality of health care. Key insights include the following:

- **Strategies for engaging providers:** Providers can either be forced or encouraged to accept payment reform. Selective contracting can be a way to force them, although limits may exist on the ability of purchasers to use this strategy, particularly in specialties without an excess supply of physicians. Consumers still value choice, something that may be lacking in a narrow network, especially in markets where providers have consolidated. A

better approach, therefore, may be to entice providers into accepting payment reform by offering an upside. Potential considerations include the following:

- **Opportunity to get off of “hamster wheel”:** With the threat of new regulations and further cuts in Medicare reimbursement, providers may be very receptive to accepting total-cost-of-care payments. Many physicians are tired of working harder and getting paid less, and want to get off of the “hamster wheel” created by FFS payments. In Minnesota, HealthPartners has been transparent in sharing clinical performance data, which has been key to getting providers on board and ending “fights” about data. Most providers have embraced payment reform due to this combination of transparency and a desire to end their current “misery” in FFS.
- **Enticing to primary care, less so to specialists and hospitals:** Primary care physicians likely will embrace payment reform as a way to raise their incomes. However, specialists and hospitals might not be so receptive, as they continue to make more money by doing more procedures. Faced with the threat of lower income, they may well boost their volume by providing more inappropriate care. Since specialists have a big influence in Congress and state legislatures, the ability to promote payment reform may be somewhat limited. Similarly, hospitals will be the big loser from payment reform, with significant declines in inpatient utilization likely to occur. However, closing hospitals can be very difficult politically.
- **Need for win-win-win scenarios:** As noted earlier, new payment systems need to create benefits for all key

stakeholders--plans, purchasers, and providers. Since these revamped systems generally create savings in one or more parts of the system (often due to efforts by another part of the system), the key is to create systems that give every stakeholder a “fair share” of those savings.

- **Need for benefit redesign:** As noted earlier, payment reform needs to go hand-in-hand with benefit redesign that creates incentives for consumers to make better (higher-value) choices. Some consumers, however, may resist the idea of having to pay more to access certain providers, especially low-income consumers. If providers can reap meaningful increases in patient volume by redesigning care processes, they will be more likely to accept the accompanying payment reforms. Consumers, moreover, will likely be willing to travel if they have a financial incentive to do so and they understand that the distant hospital offers better-quality care. If not, they will simply assume that the higher-cost hospital provides better care, since consumers generally view price as a proxy for quality when buying other goods and services. Sometimes the mere threat of changing benefit design so as to encourage consumers to travel for care can be enough to get local providers to improve their performance, particularly in small markets.
- **“Re-valuing” primary care:** Primary care clinicians need to play a central role in redesigning care delivery, yet the current payment system does not value them highly, particularly in Medicare. Revamping how Medicare and other payers value primary care could help to address this issue. Such changes can be difficult to make, however, as they typically require cuts in payments to specialists and

hospitals, which (as noted) tend to have significant political clout.

- **Start small:** Providers will become more engaged in care redesign once they see a small project reap some dividends. For example, a group of Florida health plans and hospitals have created a website that helps them better coordinate care management activities after discharge. As part of this effort, they share information on patients discharged to skilled nursing facilities. In the past, health plan care managers did not have adequate information on these patients, resulting in suboptimal care management. Now they have the right information, resulting in better care. This small project will lay the groundwork for plans and hospitals to work together on tougher issues, such as payment reform, in the future.

- **Strategies to encourage upfront investment in care redesign:** As noted earlier, shared savings models may not adequately recognize the significant upfront investment that providers must make to redesign care. Consequently, promises of undefined benefits a year or more later may not seem real enough or be large enough to encourage such investment. To address this issue, some combination of upfront payment may be needed, with a link to additional back-end payments based on actual improvement. Key considerations in setting up such systems include the following:
- **No discussion of upfront payments to hospitals:** While physicians may require an upfront payment to encourage care redesign, hospitals likely do not, and such payments have generally not been a part of negotiations. The key with hospitals is to structure the back-end incentive in such a manner that it more than compensates for the negative financial impact of lower utilization, such as reduced readmissions. Purchasers and health plans stand to reap

tremendous benefits from such reductions. But they will not occur without shared-savings models that give hospitals a true financial incentive to redesign care delivery.

- **Supporting medical home development:** HealthPartners is considering ways to support primary care doctors in creating medical homes, although organizational leaders prefer providing some upfront seed/grant money to a per-member-per-month fee. Providers have shown some receptivity to the notion, although some would prefer a new FFS-based payment. HealthPartners, however, would prefer to end the pattern of FFS payments. In fact, the plan has been holding the line on FFS increases, instead reallocating dollars into shared-savings pools that get paid out based on trends in total care costs. Providers receive increases (paid out of the pool) only if they meet pre-determined targets.
- **Setting the appropriate bar:** Any shared-savings program and accompanying criteria should not set the bar too low. For example, the ACO program coming out of Medicare should not allow existing organizations to qualify and hence reap financial rewards simply by providing care in the same manner they do today. (Many providers claim to already be an ACO.) Rather, shared savings must be based on true improvements in care delivery. With the bar set appropriately, some upfront payment to encourage investment in care redesign may be acceptable for small provider organizations. Alternatively, these organizations could be given access to low-interest loans with flexible repayment terms.
- **Need for culture change:** Culture change remains the biggest challenge to effective transformation. As the book *Switch* notes, driving change requires both a technical and an emotional component. The leaders of most healthcare organizations spend time on the technical piece, which tends to be easy. However, changing the emotional piece represents the bigger challenge. Until providers buy in emotionally, change will not occur. Payment reform represents one piece

of driving this cultural change, but progress remains slow. Education, regulations, tort reform, and organizational change also play a part, and payment reform must fit into these changes as well. Providers generally recognize the need for cultural change, but need assistance in making it happen.

- **Need for public health initiatives:** Health care plays a limited role in improving health status. Behavior change plays a much bigger role in addressing chronic illness, obesity, and other problems driving up healthcare costs. To be effective, payment reforms will have to create meaningful incentives for providers to look outside their four walls to address these issues. Providers can play an important role—for example, former Arkansas Governor Mike Huckabee credits his primary care doctor for starting him on a journey of behavior change and for being a partner in his successful effort to lose weight and improve health status. Part of this role included telling him in no uncertain terms that he only had about 10 years to live if he did not change his behaviors. As part of any public health initiative, providers and consumers need access to community-based resources that help in promoting better health and population health management. HealthPartners is currently testing a model where members complete a 15-minute online health assessment before their first clinic visit. The assessment covers health-related behaviors, including smoking, drinking, physical activity, and nutrition. Embedding this assessment into routine care delivery has proven more difficult than initially imagined. To facilitate the process, HealthPartners created a home within the medical record for the assessment results, which has helped providers remember to raise and discuss these issues with patients during visits.
- **Need for immediate cost control:** While public health initiatives are undoubtedly important, they will not suddenly make the system more affordable. In fact, they likely will not pay dividends for many years. In the meantime, health care remains too expensive,

with many individuals simply unable to afford it. Unhealthy behaviors, medical malpractice systems, and other commonly blamed factors are not in fact the root causes of this problem. Rather, the system too often provides unnecessary care at a high unit cost, and too often fails to provide needed services to those with chronic conditions. Consequently, any long-term public health initiatives must be accompanied by short-term efforts to revamp an inefficient, expensive system that produces subpar outcomes.

Case Studies: Examples of Coalition Efforts to Promote Payment Reform

Representatives of four coalitions described their efforts to promote payment reform within their local communities.

Health Services Coalition (Las Vegas, NV)

Leslie Johnstone, Executive Director, Health Services Coalition

Background

Formed in 1998, Health Services Coalition (HSC) has 22 member organizations that collectively cover 260,000 lives (down from 320,000 in recent years due to the poor economy). Members include companies involved in the gaming industry (e.g., MGM Resorts, Caesars Entertainment, Boyd), union trusts (e.g., culinary, firefighters, Teamsters), and other organizations. The coalition focuses primarily on hospital contracting and legislative advocacy. Hospital contracts cover 13 hospitals in 5 systems, with 3-year agreements set concurrently with each hospital or system. The contracting process has always been contentious and politically charged.

The health status of Nevada residents remains below that of many other states. Nevada ranks 47th in overall health status, driven by low rankings on access, prevention, treatment, and equity, and middle-of-the-pack rankings on avoidable hospital use/costs and healthy lifestyles. Various metrics of hospital care in Southern Nevada demonstrate ample

room for improvement with respect to patient safety and readmission rates. A local newspaper recently ran a five-part series entitled Do No Harm that exposed many problems related to hospital care, including infections and safety issues. (See www.lasvegassun.com/hospital-care/ for more information.)

Revamping Hospital Contracting

To prepare for the latest round of contracting (the most recent three-year contracts expired at the end of 2010), HSC held forums with hospitals and physicians beginning in early 2010. As part of these meetings, HSC brought in a variety of speakers to discuss key issues, including the need for quality improvement and cost control. In April, HSC issued a formal RFP for hospital services, something that had not been done previously in this market. The goal was to open up communications between the coalition and providers. To that end, HSC contracted with two physicians to serve as medical directors—a local doctor to help with relationship-building and a national physician with knowledge of innovative activities elsewhere in the nation. HSC also launched a formal campaign to improve care, known as the “Better” campaign (www.BetterCareNow.org).

The April 2010 RFP did not ask for rate quotes. Rather, it focused on soliciting creative approaches to align payers, physicians, and hospitals. HSC hoped that hospitals would respond with some combination of bundled payments, centers of excellence, and performance-based rates or rate increases. In reality, they responded with little other than a commitment to do a few pilot projects and to provide performance data already being publicly reported. In response, HSC began to push for hospitals to accept “case” rates for services, much like Medicare DRGs. The smaller hospitals (a county facility and one independent hospital) accepted the notion of case rates, while the larger systems indicated they were not ready for such an approach today, but would keep discussing the issue and move toward more case rates over time. HSC also proposed development of a quality incentive that would provide a flat dollar amount to hospitals for reporting performance on quality measures, and create a pool (equivalent to 3 percent of all hospital spending) to be awarded based on performance improvement. The proposal did not get much of a response from hospitals at first, as hospital leaders did

not understand how serious HSC leaders were about this issue. During the subsequent negotiations, HSC modified the quality improvement proposal, ultimately proposing a three-pronged approach that linked rate increases to quality reporting and improvement:

- Negotiated core rate increases with each system.
- Half of the core increase tied to participating in a community-wide collaborative and maintaining current quality on specific measures, and the remaining half tied to meeting or exceeding specific outcome-based quality goals.
- “Stretch” goals if hospitals meet other, harder-to-achieve targets for improvement.

As part of the community-wide collaborative, HSC worked with hospitals to build consensus around specific priorities and encourage use of shared decision-making systems in determining necessary treatment. To date, this effort has received a lukewarm response, and it is not yet clear if such a collaborative process will occur. During these discussions, hospitals indicated a desire to be evaluated based on their own improvement over time, rather than as compared to their peers. Targeted, outcome-based performance measures cover the following areas:

- Infection control
- Surgical safety
- Cardiac care
- Cancer care
- Neonatal care
- Ventilator-associated pneumonia
- Patient satisfaction
- Computerized physician order entry

HSC is negotiating stretch goals with each system or hospital that will focus on more difficult-to-achieve improvements, including reducing readmissions and creating additional registries.

Hospital Response

Overall, the response to HSC has varied across hospitals. As noted, the county hospital and independent hospital have agreed to the case-rate methodology and to most of the quality incentive structure. In fact, these organizations have already indicated a willingness to share performance data and be judged on it. The three larger systems remain reluctant, expressing fears about the public release of data (even though HSC pledged not to release the information). They also appear reluctant to put their rate increases (which in the past happened automatically) at risk based on performance.

One system leader initially rejected the notion of being paid to improve quality, noting that such improvement was the hospital's responsibility. After HSC decided to exclude that system (leaving hospitals out of its network for the first time), the leader quickly changed his position and agreed to negotiate a deal that includes quality-based incentives.

At the end of the day, the agreements reached ended up being less robust than HSC leaders would have wanted. Nonetheless, all hospitals and systems have agreed to report quality performance to HSC and to have some portion of their rate increases tied to improvement. They have also agreed to move toward case rates and not be paid for "never events." This initial round of negotiations has set a solid foundation for future negotiations, and represents a "baby step" that nonetheless feels like a big leap for this market. The next set of negotiations should be easier, as HSC leaders will not have to convince the hospitals they are serious about improving quality and controlling costs.

Savannah Business Group on Health

Gary Rost, Director, Savannah Business Group on Health

The Savannah Business Group on Health has 29 members and represents 50,000 covered lives, or roughly 22 percent of the commercial population in the area. Hence, the coalition has enough market share to get the attention of providers in the area. The coalition's three-pronged mission is to contain costs, improve quality, and improve community health. To those ends, it has been contracting

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directly with providers through its own preferred provider organization since 1986. The coalition began incorporating quality performance measures into its contracts in 1998.

Value-based purchasing (VBP), value-based benefit design, P4P, ACOs, and other initiatives are not new to the healthcare industry. In fact, Savannah Business Group on Health has been engaged in VBP since the 1980s. Employers remain financially at risk for the health of their employees, but operate in a patchwork, fragmented system. As providers have consolidated to gain market power, employers have tried to come together to address the problems in the system. Much of what employers have tried to do has become the law under PPACA. As this reform legislation gets implemented, the Medicare and Medicaid systems—which cover 45 percent of all lives and represent 80 to 90 percent of inpatient revenues for some hospitals—have clear agendas for the next 20 years. Physicians and hospitals will clearly be at risk, responsible for making improvements in

areas where they have historically performed poorly, including readmissions, hospital-acquired infections, and never events. As providers prepare for these changes, employers need to make sure that their goals do not get compromised. For example, hospitals and physicians that form ACOs will be managing things that have historically been outside of their core competencies, such as data analysis and mining, patient education, and disease management. The risk, therefore, is that ACOs will not truly re-engineer care, but rather use the familiar strategy of cost-shifting by making up for low Medicare and Medicaid payments by raising prices on private employers.

To guard against this problem, the Savannah Business Group on Health is working with providers to create ACOs that can effectively serve Medicare and Medicaid beneficiaries and employees. Providers need coalition expertise and resources to set up ACOs able to truly be accountable for managing the health status of a population. To that end, the coalition recently launched a medical home pilot. Primary care doctors have expressed strong support, while pediatricians have been less receptive, feeling they already operate as a medical home. Specialists, however, feel very threatened, with four major groups having called on the coalition to abandon the effort. The coalition views such resistance as a good sign (since specialists should feel threatened by a well-functioning medical home and ACO), and has no plans to abandon the project. The pilot incorporates a PMPM payment for a care coordinator within the medical home. Also as part of the project, a local medical school will begin requiring all students to go through a medical home rotation. Other medical schools are working with pediatricians to adopt a similar model that will allow residents to rotate through a pediatric medical home. These primary care medical homes represent a first step toward becoming a full-fledged ACO focused on patients. The fear, however, is that hospitals and health systems may take over the process, as these organizations have the resources to create the infrastructure required for an ACO. A hospital- or system-run ACO, however, may not be aggressive enough in reducing inpatient and specialist utilization. Another concern comes from physician groups that have begun to incorporate the term “medical home” into their names. Such changes (without accompanying changes in care delivery processes and

Since 2001, Gary Rost has served as Executive Director of the Savannah Business Group (SBG) on Healthcare Cost Management Inc. and its subsidiaries: SBG Preferred Health Resources and Savannah Health Alliance. In this role, he provides leadership and operational oversight of the coalition’s value-based purchasing initiatives, including design and implementation of value-based benefits, contracting, and population health activities. Mr. Rost also serves on numerous national, regional, and local boards, committees, and groups. Prior to joining SBG, Mr. Rost spent 20 years in the US Army.

systems) will do little to improve health care while also confusing consumers.

San Francisco Health Service System

Catherine Dodd, PhD, RN, Director, San Francisco Health Service System

San Francisco has provided health coverage for employees since 1937. Cost increases have been a norm since that time--during the first 10 years, costs rose by roughly 70 percent. In 1949, the system began contracting with a small, independent practice association led by a physician who later founded Kaiser Permanente. Since that time, a portion of city employees have been cared for by Kaiser. Today, the San Francisco Health Service System provides coverage to 109,000 employees, retirees, and dependents of the City and County of San Francisco, the school district, and the community college. The County Charter mandates that employees have a “choice of physician.” At present, approximately 45 percent of covered lives receive care in Kaiser, another 45 percent receive care in a non-staff-model HMO, and 10 percent enroll in a self-insured plan (guaranteeing coverage for retirees who live out of the service area and current employees who want a “choice of physician”).

In 2009, The San Francisco Health Service System hired a new director (Ms. Dodd) just as the annual rate negotiating process began for plan year 2010-2011. As huge organizations, Kaiser and Blue Shield

“It’s time to make lemonade out of lemons. We’re out of time for transition, and this time we have to be successful.”—Catherine Dodd, PhD, RN

both had a lot of leverage in the negotiations. Blue Shield began by proposing an 18-percent increase for active members and a 38.5-percent increase for retirees at a time when the city faced a nearly \$600 million budget deficit.

To address these issues, Ms. Dodd began pressing for changes to the benefit design for employees, such as increased copayments for office visits and brand name and non-formulary drugs. She took this step in spite of being directed by the board (made up of political appointees and plan beneficiaries) not to make such changes. In Ms. Dodd’s view, such changes had to be made to rein in costs. She also made changes to retiree benefits, requiring retirees in San Mateo County to enroll in the Blue Shield Medicare Advantage plan (a rule that had been part of San Francisco Health Service System eligibility since 1975) that saved the system \$2.7 million. Through repeated negotiations, Ms. Dodd also got Blue Shield to accept a much lower aggregate increase of 8.7 percent.

The organization has just completed an RFP for the non-staff-model HMO product. The system faces tremendous pressure to rein in costs, including the possibility of a second public vote in the November election to limit the amount of taxpayer dollars that can be spent on health care. In preparation for the RFP process, Ms. Dodd searched the literature on patient-centered medical homes and ACOs, and included in the RFP a desire to create an ACO to improve the quality and coordination of care (and in doing so, to lower costs). She also included a strong employee wellness component to focus plans on keeping people healthy, along with performance guarantees related to HEDIS and other measures. She requested a multi-year contract to reduce cost uncertainty. In response, two HMOs came back with a multi-year contract with rate increases capped at 11 and 15 percent, respectively. Blue Shield proposed no increase for one year and agreed to create an ACO, focus on wellness, and offer better smoking cessation benefits. On March 1, 2011, the system board voted to approve a revised benefits package and to work with Blue Shield to create two ACOs with local providers. The overall aggregate rate increase

came in at 3.1 percent, lower than any other major employer in Northern California. With the new ACOs, Ms. Dodd hopes to have the purchaser as part of the governance and to require implementation of patient satisfaction measures at the provider group level and to evaluate the impact of the ACOs on utilization, pharmacy costs, and other metrics. (The system has collected five years of data on various metrics.) The ACOs have committed to generating \$15 million in savings, equivalent to four percent of overall payments to Blue Shield.

Despite this progress, the San Francisco Health Service System still faces reform-related requirements

Catherine Dodd, PhD, RN, FAAN, serves as director of the San Francisco Health Service System. Before taking on this role, she held a variety of leadership positions also in the area of health and public policy, including Chief of Staff for a member of the San Francisco County Board of Supervisors, Director of Government Relations for the California affiliate of the American Nurses Association, Director of Government Affairs and Community Relations for Kaiser Permanente Northern California, District Director for House Democratic Leader Congresswoman Nancy Pelosi, Regional Director for the United States Department of Health and Human Services, and Deputy Chief of Staff for Health and Human services under San Francisco Mayor Gavin Newsom. She has previously served on the San Francisco Health Commission and currently serves as a member of several boards of directors, including the National Committee to Preserve Social Security and Medicare, the Breast Cancer Fund, the Glide Foundation, and the Zen Hospice Project. Dr. Dodd is an alumnus of the University of California School of Nursing, receiving a Baccalaureate degree in 1979, a Master of Science degree in 1983, and a PhD in Sociology in 2007.

that will begin in 2014 and will culminate with a 40-percent tax on benefits costing more than \$10,500 for individuals and \$27,000 for families in 2018. The system also must respond to voters who consistently feel that too much public money is being spent on health care. Going forward, meeting these demands will require unprecedented cooperation, collaboration, and compromise, something that has not occurred frequently in the past. Another big challenge will lie in getting unions to participate in finding savings and incentivizing well being. Most union members currently pay nothing for the individual member, and dependents are subsidized at 75 percent of the lowest plan cost. Employees have not received a salary increase in six years and have taken cuts and furloughs the last two years. Last year they absorbed 500 layoffs, with more likely to come this year due to a \$320 million budget shortfall that will increase as state funding cuts are finalized.

Oregon Health Leadership Council

Bill Kramer, Executive Director for National Health Policy, PBGH

Background

Commissioned by the business community in the summer of 2008, the Oregon Health Leadership Council (OHLC) includes 8 major hospitals/health systems, 8 major medical groups, 12 local and national health plans, hospital and medical group associations, and the state director of the Oregon Health Authority, which oversees Medicaid, public health, and the public employee benefit plan. The council's goal is to keep health care costs and premium increases closer to the level of overall inflation. To that end, the council focuses on areas that need critical mass to get results and where the group can be accountable for implementation. The council has created 4 work groups with over 200 individuals working on value-based benefits, evidence-based best practice, administration simplification, and reimbursement and payment reform.

High-Value, Patient-Centered Care Model: Medical Home Initiative

In early 2009, OHLC decided to advance a payment reform initiative focused on medical homes. To that

end, the council reviewed the successful model used by Boeing, and it launched a project with the goal of reducing costs and increasing quality, satisfaction, and productivity within 12 months of implementation. OHLC hired Renaissance Health in September 2009 to help with development of a medical home focused on high-risk adults (the top 10 percent in terms of costs). The initiative involves multiple payers that will pay for a defined model of care with aligned incentives. The overall goal is to achieve Triple AIM "Plus"—i.e., an expanded version of IHI's Triple Aim. Specifically, the goals are to do the following:

- Improve population health
- Enhance the patient experience and provider team
- Increase patient self-efficacy, motivation, and productivity
- Improve the provider experience
- Reduce the per capita cost of care

The effort has been aligned with parallel work at the state level developing standards for complex/chronic care. The initiative has been structured as a two-year demonstration project, with the hope that it serves as a first step to more comprehensive redesign of the delivery system. Common care model components include the following:

- **Access:** To facilitate access, the model includes a dedicated care manager for each patient, 24/7 access to urgent care, access to the care team via email and phone, and help in accessing non-physician services and integrating them with the primary care physician.
- **Care delivery:** The model relies on rules-based care planning and management, with integrated care coordination that recognizes social and behavioral health needs.
- **Information:** The model includes EMRs and registries, with quarterly feedback to the team and a general movement towards broad data transparency.
- **Coordination:** The model includes management of care transitions (e.g.,

after ED or hospital discharge), a medical neighborhood of specialists with service agreements, and various caregiver and social support systems.

- **Intensive care management:** The model incorporates motivational interviewing and readiness assessments, team-based pre-visit planning, systematic medication review, team huddles, group visits, advance directives, and end-of-life care programs.
- **Staffing:** Registered nurses (RNs) serve as the team lead with support for the entire care team, with each RN covering 200 enrolled patients.

The initiative will use a consistent payment approach and methodology across all payers. The methodology includes an upfront PMPM to pay for the RN care coordinator. Rates have been negotiated by each health plan with each participating medical group so as to avoid antitrust issues. The model uses standard FFS to pay for medical care, along with 50/50 shared savings between the medical groups and payers based on demonstrated savings, with payouts at the end of the demonstration period. Groups will not qualify for the shared savings payout if they do not meet minimum performance on various quality metrics. Participating health plans will use the same basic contract, thus preventing providers from having to deal with multiple contractual requirements (although payment rates will be negotiated separately).

This model does not represent a standard medical home. Rather, it combines payment reform with a carefully designed care delivery model, using a consistent approach across multiple providers and payers. The program enjoys broad participation from both the public and private sector (including state employees and the Medicaid program). Implementation planning began in early 2010, when eight health plans and the state expressed an interest in this approach. These plans identified 25 medical groups across the state that could potentially deliver on the model. OHLC issued an RFP, with staff interviewing representatives of each group, ultimately choosing 14 to participate after a rigorous evaluation process. (A 15th group met all qualifications except for volume.) Ultimately, five of the health plans

(representing all large plans except for Kaiser) and the state (including employees and Medicaid) chose to move forward with the 14 medical groups. Participating groups represent a mix of system-based and standalone entities, including both multispecialty and primary care groups from throughout the state.

In July 2010, each participating plan began negotiating with the medical groups, with a target of 30 days to reach an agreement. During that time, plans began identifying patients to invite into the demonstration program. In September, the medical groups hired 23 RNs to serve as care managers; these RNs attended four days of training in October. Patients began enrolling in October, and as of March 2011, 4,100 patients have voluntarily enrolled. Nurses have begun doing intake visits and developing care plans, and patients seem to have engaged in the program. OHLC is working with Q-Corp to develop quarterly performance reports for the medical groups, with the first scheduled to be released in April 2011. After the release, nurses will meet with the medical groups to review their performance and identify opportunities for improvement.

Lessons Learned

Lessons learned from the medical home pilot project include the following:

- Success depends in large part on strong physician leadership, having the right culture, and being ready for change.
- Exchanging accurate data between health plans and medical groups can be challenging.
- Better attribution models are needed to link patients to medical groups.
- Infrastructure needs to be developed to bill and process capitated payments.
- Success depends on open communication between stakeholders and within organizations, the ability to provide actionable data, and transparency.
- The program represents a good opportunity to increase dialogue between plans, purchasers, and medical groups.

Bill Kramer serves as Executive Director for National Health Policy for PBGH. In this role, he leads the organization's work in Washington, DC, to ensure that health care reform is implemented in ways that improve quality and reduce costs. Mr. Kramer also serves as Project Director for the Consumer-Purchaser Disclosure Project. Prior to taking on his current roles, he led his own consulting practice, working to promote health reform in Oregon by providing policy analysis and guidance to the Oregon Business Council and strategic and technical assistance to the state government. At the national level, Mr. Kramer has worked with a number of organizations, including the Small Business Majority, on the design and implementation of health insurance exchanges. Prior to developing his consulting practice, Mr. Kramer served as a senior executive with Kaiser Permanente for over 20 years, most recently as Chief Financial Officer for Kaiser Permanente's Northwest Region. Prior to his career at Kaiser, Mr. Kramer served as Chief of Budget and Program Analysis Services for the Washington State Department of Social and Health Services.

A key element in the success of the program has been the ongoing leadership and support from the business community. In the summer of 2008 (before the presidential election and passage of health reform), the Oregon business community sent a clear message to the major health plans, hospital systems, and physician community that something had to be done to address runaway costs that threatened the state's economy. Without action, they feared that the government might step in and make matters worse. To their credit, health system and health plan leaders responded favorably and agreed to launch a series of projects to improve care (the medical home initiative being one of these). But this success could not have been achieved without initial and ongoing pressure from the business community.

To build on this effort, next steps on this project will include further work on the processes to support the new care model, including collaborative sharing of best practices and continued measurement and communication of results.

Accountable for What? Purchaser Expectations for ACOs

David Lansky, President and CEO, PBGH

The ACO movement has created a lot of energy and enjoys significant momentum due to provisions in PPACA related to the Medicare Shared Savings Program, to be launched in 2012. PBGH leaders have spent significant time thinking about the implications of ACOs for member organizations. In the meantime, many provider organizations in California have already declared themselves to be ACOs and want to begin getting paid accordingly. PBGH supports the emergence of ACOs, but also wants to clearly communicate what purchasers expect from this new model for delivering and paying for care.

Background

PBGH members include large purchasers in the public and private sector. The organization's mission is to improve the quality and availability of health care while moderating costs. Its vision statement (recently revised) calls for a health care system transparent about quality, costs, and outcomes, where consumers are motivated to seek the right care at the right price, and providers are incentivized to offer better quality, more affordable care. ACOs have the potential to help achieve PBGH's vision by supporting four key strategies:

- **Engaging consumers:** ACOs need to support consumers by providing information and offering incentives to help them choose the right care at the right price. To truly engage consumers, ACOs should provide information on performance at the individual practitioner or group level, rather than at the level of the overall entity (as many large systems do today).
- **Paying for value:** ACOs need to reward providers for quality and efficiency. To gauge whether they do, PBGH wants to understand how ACOs measure quality and pay their individual providers.
- **Redesigning care delivery:** ACOs need to demonstrate a commitment to supporting

providers in achieving improved outcomes at a better price through fundamental reengineering of selected care processes.

- **Advancing value-based policy:** ACOs need to demonstrate that they can implement programs that improve care and reduce costs in response to health reform legislation, policies, and regulations.

David Lansky, PhD, serves as President and CEO of PBGH, directing its efforts to improve the affordability and availability of high quality health care. A nationally-recognized expert in accountability, quality measurement, and health IT, Dr. Lansky has served as a board member or advisor to numerous health care programs, including the National Quality Forum, National Priorities Partnership, the Joint Commission, the National Patient Safety Foundation, the Leapfrog Group, the Medicare Beneficiary Education Advisory Panel, and the American Health Information Community. He also serves as the purchaser representative on the federal HIT Policy Committee, acting both as a member of its Meaningful Use Workgroup and as chair of its Quality Measures and Information Exchange Workgroups. He is also co-chair of Cal eConnect, California's state-designated entity for governance of health information exchange. Previously, he served as Senior Director of the Health Program at the Markle Foundation. Prior to that, he was the founding President of the Foundation for Accountability (FACCT), a public-private venture developing quality measures and web-based tools to help consumers and purchasers assess the value of health care services and providers. Before establishing FACCT, Dr. Lansky served as a senior policy analyst for the Jackson Hole Group and led the Center for Outcomes Research and Education at Oregon-based Providence Health System. The author of more than 30 peer-reviewed papers on outcomes research and quality measurement, he received his doctorate degree from the University of California at Berkeley.

Purchasers should care about ACOs because they have the potential to advance the “triple aim”—better quality, more affordable care, and better population health—by redesigning care delivery, promoting provider accountability, and accelerating payment reform through public sector and private payer alignment.

What Purchasers Want from ACOs

PBGH has developed seven principles that lay out what purchasers want from ACOs; purchasers will be able to use these principles as a “term sheet” during negotiations with a would-be ACO. Specifically, ACOs must:

- **Promote transparency:** PBGH wants a commitment from the ACO to engage in collaborative measurement and reporting and to support making information available to consumers, including internal performance that will expose variations in care and information on how such variations are being managed. PBGH also wants information on financial arrangements with providers, including what portion of overall payment is linked to performance.
- **Focus on outcomes:** ACOs should support the use of robust metrics to improve clinical outcomes, functional status, appropriateness of care, patient experiences, care coordination, care transitions, and costs, including efficiency and resource utilization.
- **Be patient-centered:** ACOs must be able to deliver coordinated patient education and preventive care support; include the patient (and caregivers) in the care process; support shared decision-making, self-care, self-management, and risk reduction; and provide patients access to their health information.
- **Pay providers for quality, not quantity:** ACOs need to structure payments to reward quality, not quantity; align private and public sector approaches; use risk-adjusted, episode payment or bundling methodologies; not pay internally for “never events,” errors, or inappropriate use; offer incentives to reward physicians and other health professionals

based on performance; and participate in shared risk and/or gain-sharing arrangements, subject to financial qualifications.

- **Explicitly address affordability and contain costs:** ACOs need to set explicit targets for overall costs and be held accountable for reaching those targets. Targets should be aggressive, such as holding increases to one percentage point above consumer inflation. ACOs must use sound fiscal policies and financial management practices to oversee risk-based contracts.
- **Support a competitive marketplace:** ACOs should refrain from contractual non-disclosure provisions that preclude the following: community-level quality and efficiency measurement; consumer access to performance information; comparative performance reporting; and contractual prohibitions on provider differentiation by payers.
- **Demonstrate meaningful use of health IT:** ACOs should use IT to support better decision making (e.g., through computerized decision support); promote clinical integration; manage care processes (e.g., through electronic ordering and communication of results); share and exchange information among providers and with the patient; federate with the National Health Information Network structure; and set rigorous adoption expectations as a requirement for practitioner entry.

No single model exists for an ACO to meet these requirements. The organizations will feel different depending on whether an integrated system or virtual network creates the ACO. Accountable care already exists in the marketplace, as demonstrated by the Boeing Intensive Outpatient Care Program, which focuses on improving care coordination for the highest risk members. Under this model, each site created a new ambulatory intensivist practice staffed by specially identified physicians, an RN health coach, and other support staff. Sites implement shared care plans and programs to enhance access to care, with a focus on proactive care management. Participating sites receive a PMPM payment to cover provision of non-traditional

services. Participating members have their copayments for the initial intake visit waived. This model is now being expanded nationally.

Purchaser Considerations

Purchasers will face different issues depending on marketplace conditions and whether an ACO is being developed for a specific or broad population. Nonetheless, general considerations include the following:

- **Structuring ACO to manage financial risk:** Options include direct contracting, shared risk and gain-sharing between purchaser and providers, or a plan-based exclusive provider organization with limited gain-sharing.
- **Regulatory issues:** Purchasers need to monitor ACOs, including the potential for market consolidation, which could undue short-term savings by enhancing the negotiating leverage of providers over time. In addition, state-level regulations for risk-bearing entities may limit design flexibility.
- **Benefit design:** Benefit offerings need to support consumer participation in ACOs, taking advantage of reference pricing, high-performance provider networks, and other vehicles to encourage consumers to make better choices.

Moving Forward

In 2011, PBGH members will push forward with ACOs through a variety of strategies, including the following:

- Implementing reference pricing benefit strategies--in combination with transparent information on relative cost and quality--that improve consumer decision-making.
- Supporting health plan-bundled payment strategies. For example, PBGH is working with the Integrated Healthcare Association on bundled payment programs in several specialties.
- Supporting ACO purchaser expectations.
- Offering high-performance network options that feature ACO-designated groups and that

differentiate contribution strategies.

- Participating in the Ambulatory Intensive Care Unit Pilot Project.

Provider Perspectives on Accountable Care Organizations

Moderated by Emma Hoo of PBGH, this panel included representatives of three provider organizations offering their perspectives on ACOs.

ACOs: Will “It” Work . . . This Time?

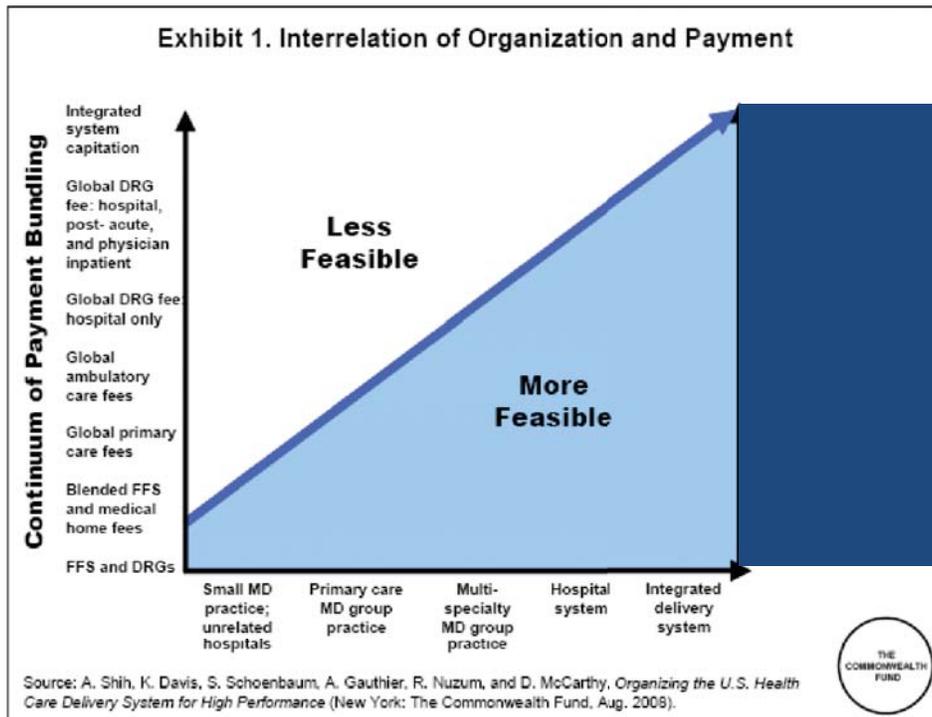
Jay Crosson, MD, Senior Fellow, Kaiser Permanente Institute for Health Policy

The concept of an ACO seems quite similar to ideas that have come and gone over time, including HMOs and prepaid group practices. As shown in the chart

below, the goal of an ACO is to revamp payment systems to “bundled” models that reward providers for managing overall health (rather than just acute episodes), with the goal of creating a more integrated system. Most of the country, however, still resides in the lower left corner of the chart, with the goal of moving “northeast” to more responsible, accountable delivery systems paid through more advanced payment models that promote population health. ACOs represent one way of facilitating this movement.

In a report to Congress in June 2009, MedPAC defined ACOs as “a set of physicians and hospitals accepting joint responsibility for the quality and cost of care received by the ACO’s panel of patients.” In reality, however, many organizations already refer to themselves as an “ACO.” Focus groups, however, suggest that the term has no resonance with ordinary people and barely any with the health policy

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community. Due to this lack of resonance, the public and the media may reject ACOs as soon as vocal opposition arises, just as they did with HMOs.

Current ACO Activity

Some people equate the term “ACO” only with the shared-savings section of PPACA. However, three different ACO “fields of play” actually exist, as outlined below:

- **Medicare Shared Savings Program:** This program, effective January 1, 2012, has been based on the Medicare Group Practice Demonstration Project. Under it, ACOs can be paid for both Part A and B services through FFS, plus qualify for shared savings based on performance against a benchmark. (MedPAC recommended a different payment/incentive model, believing the existing incentive would be inadequate. It remains to be seen if the model will be changed when the draft rules come out.) To participate, organizations must have a “formal legal structure” and make a 3-year commitment. Under the program, participants will enjoy some regulatory relief.
- **The Medicare/Medicaid Innovation Center:** Opened in 2011, this center will create an environment for broader experiments on delivery system reform. The center has broad authority to promote innovation in delivery system structure and payment methods. These experiments need not be budget neutral in the short term. In addition, the Secretary of DHHS can extend the scope and length of projects, and can waive legal barriers to physician-hospital integration. In essence, the Secretary can change the entire Medicare payment process without going to Congress for approval (although it remains unclear if legislators understand this fact and how Congress might respond if the administration uses this authority). The Center has \$10 billion that can be allocated over a 10-year period.
- **Current ACO activity in the commercial sector:** Numerous ACO-related activities are underway across the country, including work sponsored by the Brookings Engelberg Center, the National Committee for Quality Assurance

(which has released draft standards), the “Alternative Quality Contracts” program in Massachusetts, Premier’s “Accountable Care Implementation Collaborative,” and many others.

Key ACO Design Elements

Key questions related to ACO design include the following:

- **How will the population served be established?**
The issue of attribution remains critical—that is, how does one know if a particular patient is the responsibility of the ACO? The Medicare

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Group Practice Demonstration Project uses retrospective, claims-based attribution based on plurality of care. While this approach may make the technical aspects of attribution easy, medical directors do not feel it is viable. On the other hand, forcing patients to “lock in” to a particular provider organization also has problems. A middle ground may exist, such as a “soft” lock-in consisting of an informal, non-binding agreement or a “bilateral pledge of allegiance” to work collaboratively, with the patient retaining the legal right to go elsewhere if desired.

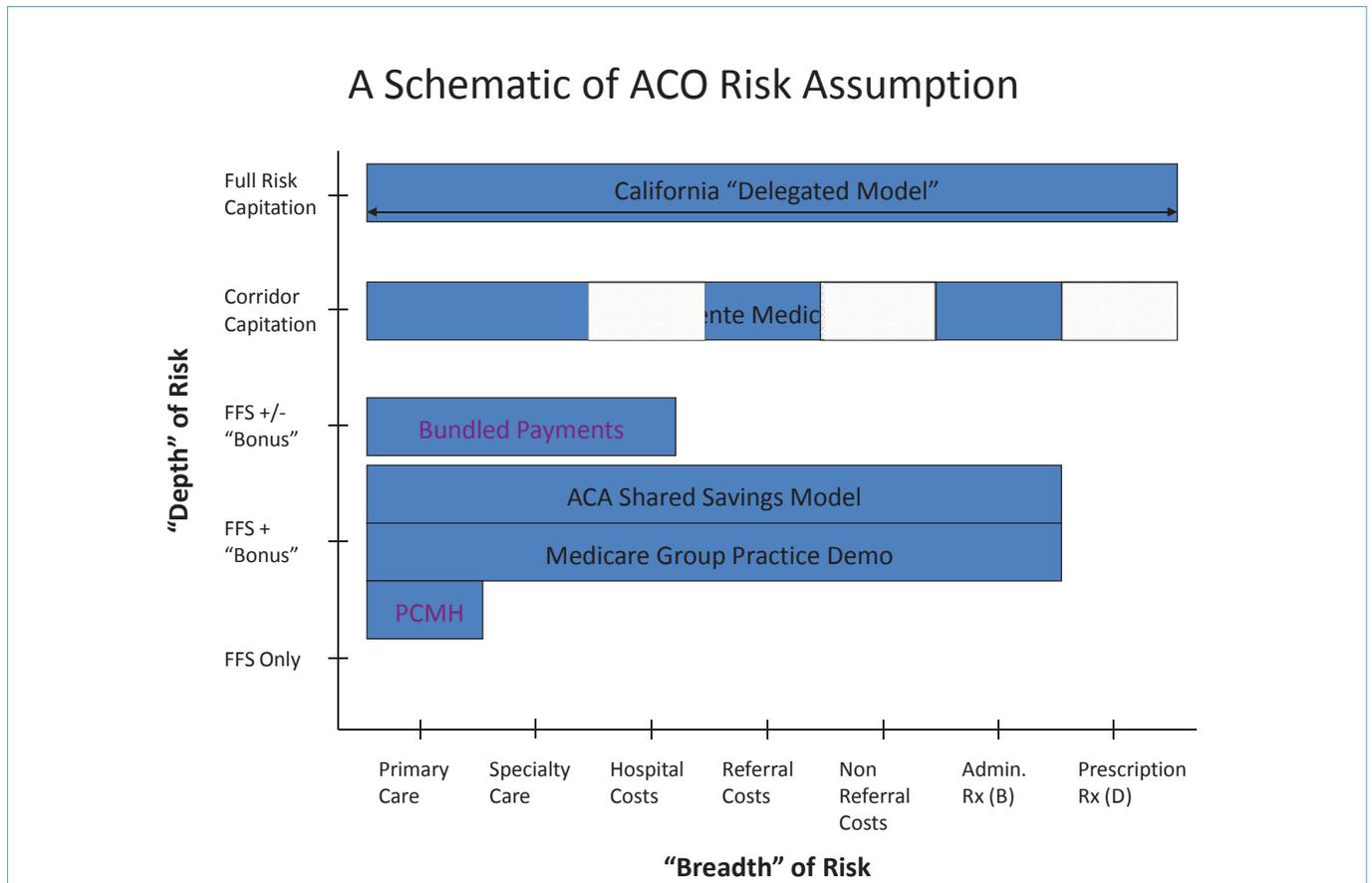
- **What payment/incentive designs are most likely to be successful?**

FFS plus a small bonus will not likely be enough. Rather, as shown in the chart below, different systems will be required depending on the desired “breadth” (e.g., covered services) and “depth” (e.g., type of payment). Some contracts may cover only primary care, while others will cover

some or all of the following: specialty care, hospital services, ED care, and the provision of pharmaceuticals (both administered and prescribed medications). Payment structures can range from traditional FFS to full-risk capitation. Different arrangements will lie on different parts of this spectrum. For example, patient-centered medical homes and bundled payments represent a relatively modest amount of risk on both scales.

- **Is there a role for health plans?**

Some plan leaders believe in the ACO model and see it as a way to partner with providers. Others continue to observe with interest to determine if a business model exists to provide administrative services to ACOs, just as plans presently do with self-funded employers. Yet another group views ACOs negatively, primarily as a transfer of power from plans to providers. It seems unlikely that the ACO idea will succeed without support from plans and other payers.



- **Who will lead—physicians or hospitals?** Time will tell whether physicians can effectively lead ACOs, and/or whether long-term effectiveness requires more of a partnership between physicians and hospitals. ACOs will likely require dramatic changes in how hospitals get paid, and may require changes in provider organization governance models.

Barriers Related to ACOs and Integration

Key barriers related to ACO formation and effective integration include the following:

- Adequate knowledge and skills to succeed, which proved to be the downfall of many failed experiments in the 1990s.
- The inadequacy of current payment incentives to cover upfront costs.
- Concerns about antitrust and referral laws and regulations. Tension exists between provider demands to relax these regulations and employer concerns about the potential for excessive provider market power. The ACO movement could be halted if constructive solutions cannot be found to this problem.
- Cultural and governance issues related to physicians and hospitals.
- Public and media perceptions of ACOs, which could end up being “castigated” like HMOs. The industry needs to be proactive in this area by explaining the benefits of ACOs to the public, thus preventing opponents from framing the debate and casting the concept in a negative light. A new, more patient-friendly term could help with this effort.

Going Forward

ACOs need to succeed. If they do not, no one really knows what might come next. Given the tremendous cost pressures facing the nation, political pressures will be enormous to cut government payments to delivery systems across the board, which will only create more pressure to cost-shift to private purchasers. To avoid this negative scenario,

purchasers need to support the ACO movement and work hard to overcome any barriers to its success.

Health Care Reform Meets the American Provider

Paul Swenson, Executive Vice President, John Muir Health

John Muir Health, an integrated delivery system, operates three hospitals with 750 total beds, 1,000 physicians (150 of whom are part of a medical foundation, with the rest being in independent practice), and 6,000 employees. The system performs well on most quality measures and remains in a financially strong position. In fact, risk-adjusted data suggest that patients have a 40 percent lower mortality rate at a John Muir Hospital than in the average California hospital. However, John Muir remains a relatively expensive place to get care, and needs to continue integrating its diverse constituencies.

Changing Healthcare Landscape

John Muir recently held a physician leadership retreat that highlighted major changes in the healthcare landscape, including those related to legislation, regulations, and the marketplace. Physicians concluded that those who continue to practice medicine in the same way will be worse off a decade from now, and that significant change in technology, revenue models, influence models, and care processes will inevitably occur. Physicians and health systems will adapt, creating winners and losers. As Ian Morrison, a healthcare futurist, has noted, “people often overestimate the impact of phenomena in the near term, but underestimate the impact over the long run.” The same will likely occur in health care as it relates to reform legislation and to ACOs. That said, some change has already begun, with Kaiser, HealthCare Partners, and other organizations already operating as ACOs (a task that remains a work-in-progress at John Muir, as it does in most organizations around the country).

Five Inescapable Trends

Healthcare reform will lead to five inescapable trends that have already begun, as outlined below:

- **Value equals “in or out”:** Transparency will become a major factor for consumers and employers as information about cost and quality improves and incentives to use such information become more common. For example, the Blue Distinction Centers provide consumers with incentives to use high-quality providers for hip and knee replacements, while CalPERS recently removed certain high-cost facilities from its network. The University of California has created a Blue and Gold plan for employees that sets up tiers, with employees paying more to use certain hospitals.
- **Value equals “more or less”:** Payments will increasingly be based on outcomes and use of best practices rather than pure activity. Examples include a recent shift of a statewide P4P plan to a greater focus on efficiency, Medicare’s “meaningful use” incentives related to information technology, the CMS Star Rating System, and CMS non-payment for never events.
- **FFS will shift to bundling:** Providers will increasingly be paid a lump sum for a condition, care episode, or population. However, it remains unclear what entity will receive these payments and how money will be divided. Examples of this approach include Blue Shield’s program with Hill Physicians and Catholic Healthcare West to keep costs flat for CalPERS beneficiaries in Sacramento in 2010, Medicare demonstration projects for cardiac care and joint replacement, and the Medicare ACO program.
- **Hospital squeeze equals physician squeeze:** At present, hospital and physician success frequently go hand in hand. Under healthcare reform, hospitals and health systems will be affected more quickly than doctors, with Medicare payments being reduced based on quality and as a general way of reducing budget deficits. In addition, health plans have become more aggressive in channeling patients to certain hospitals and in contracting with fewer hospitals. Finally, payer mix changes will also affect hospitals. Ultimately,

all of these changes will affect physicians as well.

- **Sharing and/or owning the sandbox:** Health care will increasingly become a team activity, with level of integration and size being key factors. This evolution creates many issues related to compensation, control, timing, and standards. Absent a team orientation, some providers will still do well while others will not be included. Ultimately, however, those with strong teams will win out over strong individuals.

Ensuring Success Going Forward: The 2020 Vision

John Muir’s leaders have been working on the organization’s vision for 2020. While John Muir has been quite successful under the old model, now is the time to begin using financial resources accrued from that model to develop a new one, including aligning with independent physicians. However, many doctors in the latter stages of their careers see little reason to change before they retire, making it difficult to create such alignment. The key issue relates to the speed at which the transformation needs to occur. John Muir currently has 465 different software systems that need to be integrated, with an additional challenge of 38 EMRs being used by its independent physicians. Everyone wants access to relevant data, but achieving such integration can be quite difficult.

John Muir’s vision for 2020 serves as a framework for prioritization of investments in programs and services, drives decision-making among entities and constituencies, and identifies critical strategic initiatives for the next several years. The vision assumes that the percentage of at-risk payments will rise from five percent today to 70 percent by 2020; that quality, patient experience, and cost data will become readily available and transparent; and that many decisions will be made at the point of enrollment, not the point of care. All key stakeholders generally bought into this vision of what health care will look like in 2020. They also generally agreed on what John Muir Health needed to look like to continue its current success, and what the gap between now and then looked like. More specifically, consensus emerged that John Muir needed to build the

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Success will require investment in computerized physician order entry, evidence-based care guidelines, health information exchanges, EMRs that meet meaningful use criteria, ACOs, primary care, patient portals, medical homes, and various other technologies and processes.

How Purchasers Can Help

Healthcare reform will undoubtedly expand coverage, although its impact on access to care remains unclear. It should help to boost quality and improve transparency and decision-making, but healthcare services will still be expensive. Most importantly, it will serve as a catalyst for change in the purchaser and provider community. For their part, purchasers can help stimulate positive changes by doing the following:

- Partnering with health plans, consultants and key providers.
- Focusing on systemic and not overly customized solutions, since providers cannot handle multiple programs with different requirements.
- Educating and creating incentives for employees and their families to make better healthcare decisions.

following:

- A powerful ambulatory care delivery system.
- Quality infrastructure that can deliver top 10 percent performance across the continuum of care.
- Competitive total costs of care.
- A sustainable physician recruitment and retention strategy, including for primary care, specialists, and physician extenders.
- A compelling, consistent brand position and patient experience emphasizing why consumers should choose John Muir over key competitors such as Kaiser and Sutter.
- A business structure capable of managing significant risk.

The Evolution of Managed Care as the Foundation for Health Reform: ACOs as Care Integrators and Coordinators for All Patients

Stuart H Levine, MD, MHA, Corporate/ Regional Medical Director, HealthCare Partners

Background, Vision, and Mission

HealthCare Partners Medical Group provides care to 685,000 patients in two California counties, Nevada and Florida, including 173,000 Medicare Advantage patients, 511,000 commercially insured individuals, and 25,000 dual eligibles (i.e., those eligible for both Medicare and Medicaid). Just under half (45 percent) of physicians are employed, while 55 percent of

doctors are under contract in a wraparound IPA. One of the first ACOs in the nation, the organization takes full capitated risk, with both staff and IPA physicians organized into pods with financial incentives to reduce ED visits and admissions. The savings generated allows the group to pay physicians roughly 140 percent of Medicare fees and also fund the infrastructure and financial incentives needed to provide high-quality, low-cost care on a consistent basis.

HealthCare Partners vision is to “be the role model for integrated and coordinated care, leading the transformation of the national healthcare delivery system to assure quality, access, and affordable care for all.” To that end, its daily mission is to “partner with patients to live life to the fullest by providing outstanding healthcare and supporting physicians to excel in the healing arts.” HealthCare Partners views any hospitalization as a failure of the healthcare system. (Roughly 40 percent of all deaths occur in the hospital. By contrast, at HealthCare Partners, less than 20 percent of patient deaths occur in the hospital, and the organization’s goal is to bring this figure down below 10 percent.)

Living Up to the Mission

Living up to this ambitious vision and mission requires great execution, with sophisticated IT and other systems to ensure that hand-offs go smoothly and that patients do not fall through the cracks. But success requires more than IT. Rather, it requires a true connection with the patient. To that end, the organization strives to let patients know that they have a voice and that their doctors have not lost the art of caring or being advocates. The goal is to make services and care so good that FFS and other patients used to having a choice of provider no longer want that choice.

Success also requires good care processes, which cost money. While virtually all organizations are investing in EMRs and other IT systems, many end up computerizing bad care processes. At HealthCare Partners, however, care processes are being continually studied and redesigned as necessary to ensure the right processes are in place that center on the patient. While maintaining the sanctity of the physician-patient relationship, HealthCare Partners has invested in new payment systems and infrastructure that allow doctors to get out of the “see something,

do something, get paid” mindset of FFS medicine. The medical group pays an upfront PMPM fee to cover infrastructure, plus generous FFS payments that allow doctors to spend time with patients. For example, HealthCare Partners pays for physicians to provide advance care planning every year to patients and their families. HealthCare Partners has also invested in patient-centered IT systems that allow use of technology in patients’ homes and enable a portal that puts patients’ relevant medical data at physicians’ fingertips, even if those physicians don’t have access to the EMR.

HealthCare Partners accepts “all-willing” primary care providers, as long as they meet NCQA and IMQ quality standards in order to not disenfranchise patients from their PCP. To make the system work, the organization has built systems to support physicians in identifying and proactively managing at-risk patients, with different programs available (e.g., primary care, complex care/disease management, comprehensive care and post-discharge clinics, home care, end-stage renal disease medical home, palliative care) depending on level of risk. This risk stratification process is outlined in the chart above.

While not yet functioning at maximum capability, HealthCare Partners’ risk stratification process has helped to reduce hospital admissions by 85 percent in high-risk patients. This success has been the result of multiple programs aimed at getting at-risk patients the care they need to keep them out of the hospital, and providing lower-risk patients with the support they need to self-manage and stay healthy. Examples of various programs include the following:

- **Team-based home care:** Teams of physicians, nurse practitioners, care managers, and social workers provide care to the riskiest patients (top 2 to 3 percent) in their homes. Each team takes responsibility for 200 frail patients in need of patient- and family-centered home care, providing them with a comprehensive assessment (e.g., of living conditions, social and financial needs, medications, and medical and behavioral health), advance care planning, and palliative care. The substantial upfront cost for this program more than pays for itself by reducing admissions and improving quality. In fact, the program has significantly reduced

Stratifying Patients into the Appropriate Program

Hospice/Palliative Care

Home Care Program

Provides in-home medical and palliative care management .
Physicians, Nurse Practitioners, Care Management, Social Workers Chronically frail Patients
Physical, mental, social, financial limitations in accessing outpatient care

Comprehensive Care and Post Discharge Clinics

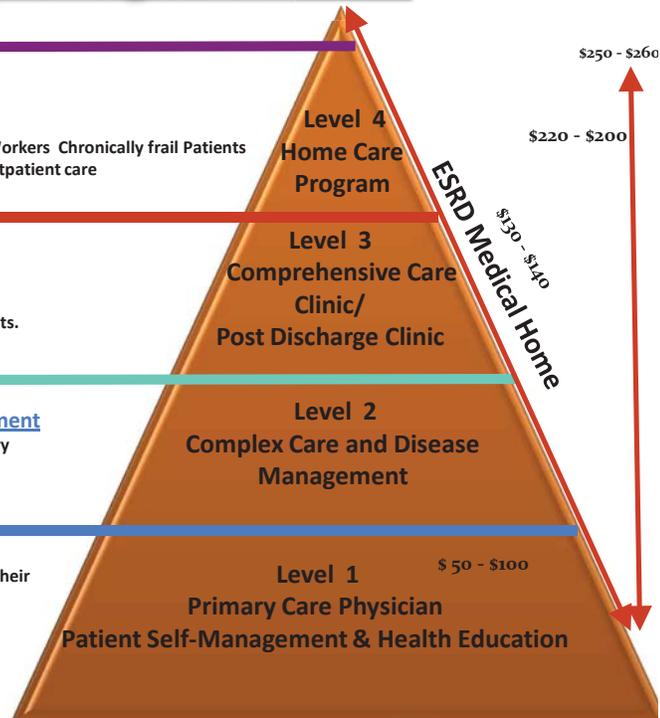
Intensive one-on-one Physician /Patient care
Case management for the highest risk, most complex Patients.
When stable, Patient is upgraded to Level 2.

Complex Care Management / Disease Management

Provide long-term enhanced care oversight. Multidisciplinary team approach for complex, high acuity Patients;
Diabetes, COPD, CHF, CKD, Depression, Dementia

Primary Care Physician

Motivate, educate and engage Patients to get involved in their care and self-management with their PCP and Care Team.



both inpatient admissions and Emergency Room (ER) visits for the 967 patients enrolled.

- **Comprehensive care centers:** This program--originally designed for seniors but now being transitioned to the commercial population--provides services to stabilize patients, facilitate smooth care transitions, and supply ongoing chronic care management, including medication reconciliation, disease/care plan education, behavioral health assessments, post-hospitalization care, and advance care planning. The commercial version will incorporate a greater focus on mental/behavioral health. This program has led to dramatic (90 percent or more) reductions in ED and inpatient admissions for the 426 patients served.
- **End-stage renal disease (ESRD) medical home:** HealthCare Partners sends a nurse practitioner to the dialysis center to provide primary care services, including mental health evaluations. Most ESRD patients spend so much time at

the dialysis center each week that they do not want to make a separate visit for primary care. This program allows them to avoid the need for such visits, while also providing them with critical support and human interaction during what might otherwise be stressful and lonely dialysis sessions. It has led to significant reductions in ED visits and inpatient admissions.

- **Integrated collaborative care, behavioral health:** Patients do not like "carve-outs" for mental health, but instead want to receive mental health services in the primary care setting. HealthCare Partners co-locates social workers in primary care clinics (including IPAs). These behavioral health specialists focus on patients with depression, anxiety, dementia, and chemical dependencies. Most primary care clinics would not have the resources to invest in a social worker on their own.
- **Advance care planning and palliative care:** This program focuses on improving healthcare

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providers' competency in end-of-life management and on helping patients develop an end-of-life care plan based on their values, a realistic assessment of treatment options, and their clinical condition (e.g., prognosis, quality of life).

Through these and other programs, HealthCare Partners has worked to educate its patients that hospitalization should no longer be viewed as a "benefit" to be demanded. Rather, by aligning patients, families, and physicians, all stakeholders now strive to avoid hospitalizations. To achieve this transition and put these programs into place, HealthCare Partners has re-engineered medical management infrastructure and care processes through a formal innovation process. Innovation teams engaging in this process include

representation from corporate and regional operations and local clinical and care management staff. The overall process encourages a culture of innovation built on experimentation and failures, which ultimately lead to success.

The process relies on a set of patient-centered medical home principles for high-risk patients, as outlined below:

- Recognize that the whole is greater than the sum of the parts.
- Design programs for the most frail, chronically ill patients with the highest admission rates, and then adapt them for use with other patients.
- Design programs for IPA patients first, and then adapt them for group/staff-model patients because it is more complex to manage high risk patients with contracted physicians whose behavior you do not directly control. If successful in an IPA clinical innovation, the application of this innovation to an HCP group site where we control staff and processes, this innovation will be guaranteed to be even more successful.
- Use statistical/clinical risk stratification to identify patients and match them with needed programs.
- Measure clinical results and return on investment from programs over time.
- Use continual process testing and improvement of programs and constant re-engineering.
- Conduct regional experiments, using one region as a "research and development shop" for the entire organization.
- Use cross-regional fertilization and sharing of best practices to achieve optimal results.

The culture of innovation has been created through leadership that emphasizes the strict adherence to the following:

- Respect and credibility for innovation leaders. These leaders represent "jacks-of-all trades"

who have some expertise and are passionate, individualistic, motivated, and creative. These problem solvers also bring “out-of-the-box” views of the world to their work.

- Do not accept the status quo.
- Motivate and reward change, energy, and passion.
- Use non-hierarchical decision-making throughout the organization, giving everyone the responsibility to innovate and the right and authority to be wrong.
- Value collaboration from all levels.
- Reward and learn from failure, which fosters creativity, tension, and collective memory.
- Stage chaotic change and thrive in uncertainty.
- Celebrate the human spirit.
- Mind the organization so that the “right hand” knows and trusts the “left hand” without supervision.

These principles and the culture of innovation have allowed the organization to reduce inpatient days per 1,000 among Medicare Advantage beneficiaries to 600, well below the California average for Medicare Advantage (982) and Medicare FFS (1,660), and less than one third of the nationwide Medicare FFS average of 1,900 days per 1,000 (with some states averaging over 2,500 days).

Key Features for Success

Key features that drive HealthCare Partners’ success include the following:

- Allow for physician “ownership” of the patient.
- Use team-based care and teamwork to support the physician and patient to enhance outcomes.
- Motivate and incentivize physicians and the healthcare team.
- Provide the right care at the right time in the right place, every time.

- Remember that the best quality care is the most-cost-effective care.
- Educate patients on their disease, care plan, and how, where, and when to access care.
- Provide quick access to care.
- Use risk stratification to identify at-risk patients prior to catastrophic need.
- Recognize that technology and clinical intervention is needed to improve care.
- Provide life planning and quality care planning, with documented decisions.
- Provider a comprehensive clinical and social assessment, along with medication reconciliation.
- Make sure that IT makes all relevant care information available.
- Invest in infrastructure to care for the highest-risk patients (top 20 to 30% of patients in the highest intensity high risk programs).
- Constantly communicate, as there can never be too much communication.
- Commit to the patient and their quality of life.
- Integrate best practices from around the country.

How ACOs Complete the Picture

ACOs help to complete the picture of what organizations need to do by ending the traditional “vendor” relationship between hospitals and physicians through creation of a risk arrangement that affects all parties, including patients and employers. ACOs highlight the need for hospitals, providers throughout the care continuum, and patients to work collaboratively to ensure appropriate, high-quality, efficient, and cost-effective care. Large medical groups, especially those who participate in managed care, will be in a good position to lead ACOs that focus on improving population health and preventive care so as to reduce inpatient utilization over the long term.

To be successful, providers need to revisit investment

decisions and ensure that such investments strengthen medical management infrastructure, connectivity, and data sharing/communication along the continuum of care to truly coordinate all care, regardless of payer source. Success also requires consideration of investment in outpatient/outreach and access points (e.g., home care, high-risk clinics, hospitalists, physician incentives, hospital partnerships, satellite clinics, electronic visits, alternatives to the ED) to accommodate the increased demand for access to care. Physicians, particularly primary care doctors, must prepare themselves for an increase in newly insured patients who will seek care from a coordinated care team. Finally, patients must be actively engaged to take responsibility for their health, while physicians and hospitals must adopt a population health perspective.

HealthCare Partners leadership believes that ACOs can be a vehicle to achieve this type of success. The organization has been selected as one of five national sites for a Dartmouth-Brookings ACO pilot with Anthem Blue Cross. The organization is also engaged in several ACO pilots with other organizations in the local community.

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