COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

REFORMING PROVIDER PAYMENT: ESSENTIAL BUILDING BLOCK FOR HEALTH REFORM

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ABSTRACT: Changing how the nation pays for health care is critical to improve value, achieve better quality, and slow cost growth. This report examines in greater detail key payment reform recommendations made by the Commonwealth Fund Commission on a High Performance Health System in its report, *The Path to a High Performance U.S. Health System.* The authors explore bundling payments to cover care over a specified period, revising fees to increase compensation for primary care, and offering providers financial incentives to serve as patient-centered medical homes. These strategies seek to encourage more collaboration among providers, accountability for patient outcomes, and efficient use of resources than exist in our current fragmented system of care. On a foundation of universal health insurance coverage and new systems to promote better decision-making and improve population health, these payment reforms could slow the growth of health spending by $1 trillion through 2020, compared with current projections.

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EXECUTIVE SUMMARY

In its report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, the Commonwealth Fund Commission on a High Performance Health System recommended an integrated set of reforms for changing the way the nation pays for health care, in order to reward high-quality care and prudent stewardship of resources and to encourage reorganization of the health care delivery system. This report describes the Commission's payment reform recommendations in greater detail. It illustrates how the reforms might be applied and what their impact would be if implemented on a foundation of universal health coverage combined with system reforms that provide information for better decision-making and improve population health.

The Commission-recommended payment reforms seek to improve value by providing incentives and support for a more accessible, effective, and efficient health delivery system. The reforms would:

- Strengthen and reinforce primary care by revising the Medicare fee schedule to enhance payment for primary care services and to ensure annual increases that keep pace with the cost of efficient practice;
- Institute new ways of paying for primary care to encourage adoption of the medical home model and promote more accessible, coordinated, patient-centered care, with a focus on health and disease prevention;
- Promote more effective, efficient, and integrated health care delivery by adopting more bundled payment approaches to paying for care over a period of time or for the duration of an illness, with rewards for quality, outcomes, and efficiency; and
- Correct price signals in health care markets to better align payments with value.

To estimate the potential effects of these payment reforms, Commission staff developed and modeled specific policies that followed the recommendations. The analysis of these policies examines their impact on total spending compared with projected trends and also on spending by households, employers, and federal and state and local governments. The results indicate that, by increasing emphasis on primary care, improving coordination, and eliminating unnecessary and duplicative services, these

payment reforms could slow growth in total health care spending by a cumulative $1 trillion through 2020, compared with baseline projections (Exhibit ES-1). This figure represents about one-third of the overall system savings of $3 trillion projected for the Commission's integrated set of recommendations. The additional savings result from a reduction in insurance administrative costs, investment in a sounder information infrastructure for the health system (e.g., health information technology and comparative effectiveness), and measures to improve public health.

Exhibit ES-1. Net Impact of Path Recommendations on National Health Expenditures Compared with Current Projection, 2010–2020 (in billions)

	Total NHE	Private Employers	State & Local Governments	Households	Federal Budget
Total Payment Reforms	–$1,010	–$170	–$10	–$82	–$749
Enhanced payment for primary care	–$71	–$28	–$2	–$11	–$30
Encouraged adoption of Medical Home model	–$175	–$25	–$13	–$36	–$101
Bundled payment for acute care episodes	–$301	–$75	–$4	–$11	–$211
Correcting price signals					
• High-cost area updates	–$223	–$64	–$3	–$29	–$127
• Prescription drugs	–$76	+$22	+$12	+$5	–$115
• Medicare Advantage	–$165	$0	$0	$0	–$165

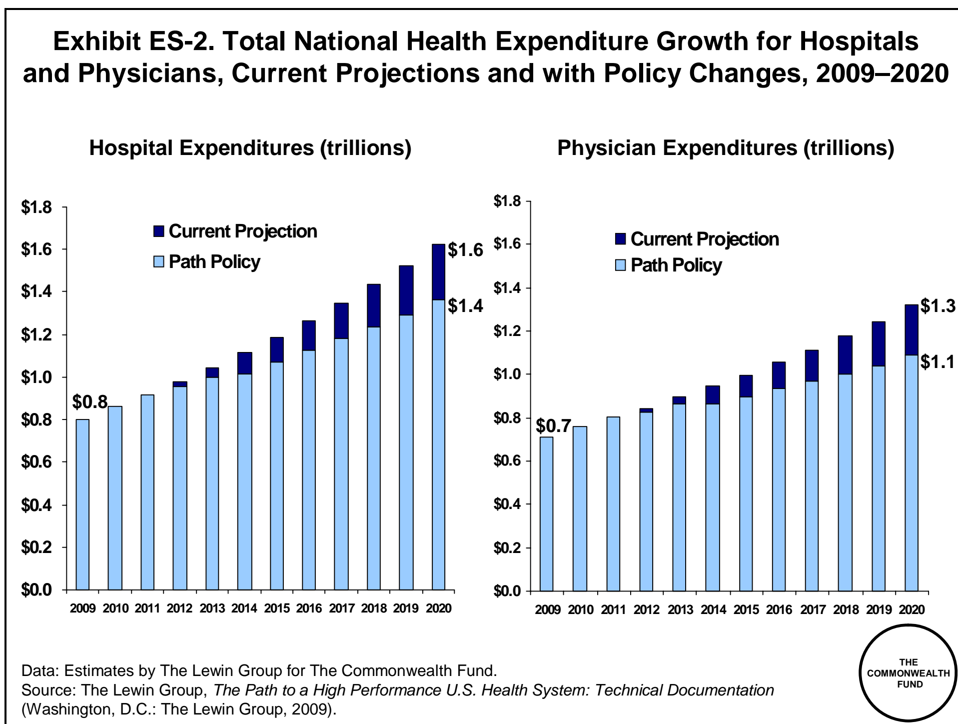
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Lewin Group, *The Path to a High Performance U.S. Health System: Technical Documentation* (Washington, D.C.: The Lewin Group, 2009).

The $1 trillion savings from payment reforms would accrue to all payers, including the federal government ($749 billion), employers ($170 billion), households ($82 billion), and state and local governments ($10 billion). These estimates rest on the assumption that insurance would be available to all and that payment reforms would apply to Medicare, Medicaid, and a new public health insurance plan to be offered as an option along with private insurance choices through a national health insurance exchange. The estimates assume that some private payers will voluntarily adopt the payment reforms; if most or all private payers adopted the reforms, there would be additional savings to employers and households.

The effects of the payment reforms depend upon their being pursued simultaneously with coverage and system reforms. Covering all or nearly all of the uninsured would eliminate the need for implicit cross-subsidies from private insurers to

meet the costs of their care. To align incentives and promote equity, Medicaid payment would be raised to Medicare levels. Coverage of the uninsured and improvements in Medicaid payment would improve the fiscal stability of safety-net providers. Offering a public health insurance plan that would adopt the recommended payment reforms—and encouraging private payers to follow suit—would strengthen the emphasis on efficiency and value. Investing in better information systems would further enhance the effectiveness of payment reforms and enable delivery system change and innovation.

These payment reforms offer significant opportunities for health care providers to benefit from improving care and making prudent use of resources. The new payment methods reward value rather than volume. Although provider revenues would grow more slowly over the next decade, they would continue to grow (Exhibit ES-2). Projected national health expenditures under the integrated set of *Path* report recommendations would increase to $4.6 trillion in 2020—up 73 percent from the $2.6 trillion estimated for 2009. Although that is lower than the $5.2 trillion projected for 2020 in the absence of reform, spending on hospitals and physicians would continue to increase. Furthermore, if providers respond positively by increasing the efficiency of the services they deliver and cut out waste and duplication, ample opportunities exist for growth in their net revenues and margins.



While embarking on payment reform may be daunting for stakeholders, given the large investment they have in the current system, new and innovative strategies are needed to align incentives to encourage and reward more effective and efficient care—improving the performance of the health system for those it is intended to serve, while making the system more sustainable for all those who provide, receive, and pay for care.

REFORMING PROVIDER PAYMENT: ESSENTIAL BUILDING BLOCK FOR HEALTH REFORM

Introduction

Our health care delivery system is fragmented. Even when individual services meet high standards of clinical quality, there is often poor coordination of care across providers, services, and settings, as well as poor communication among providers, patients, and their families. The focus is on high-cost, intensive medical interventions rather than high-value primary care. Most importantly, there is often a vacuum of accountability for the total care of patients, the outcomes they achieve, and the efficiency with which resources are used.

The way the nation pays for care fuels this fragmentation. The current fee-for-service payment that typifies our health system emphasizes the provision of health services by individual providers rather than health care coordinated across providers to address the patient's needs. It undervalues primary care and preventive care while offering strong incentives to provide complex services, even when there may be better, simpler, and lower-cost ways to treat the patient. Our payment system rewards volume and does not recognize value, and fails to compensate care coordination or the infrastructure necessary to support more coordinated care.

The Commonwealth Fund Commission on a High Performance Health System (the Commission) has issued a series of recommendations meant to put the U.S. health system on a path toward a high-performing system that will provide affordable care for all, emphasize high-quality care and better outcomes, and slow growth in costs.[1] A key part of this set of recommendations is changing the way we pay health care providers.

The Commission's report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, (*Path* report), recommends an integrated set of insurance, payment, and system reforms. The insurance reforms in the *Path* report include a new national insurance exchange that would offer a choice of private plans and a new public health insurance plan for the under-65 population. Payment reforms would apply to Medicare, Medicaid, and the new public health insurance plan offered through the national health insurance exchange to all employers as well as to individuals. Private insurers would be free to adopt these payment reforms as well, or to develop additional innovations. System reforms would include a health information system and comparative

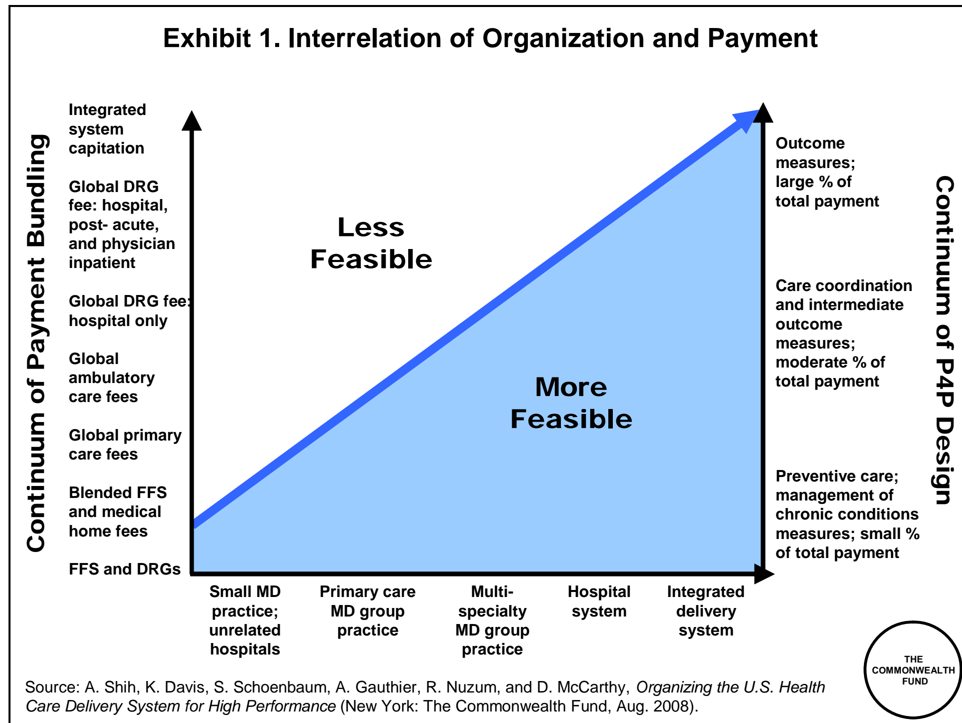
effectiveness mechanism that provide the means for better decision-making by providers, payers, and patients, as well as measures to improve population health.

This policy report describes the Commission's payment reform recommendations in more detail and indicates how their implementation would move health care away from the current fee-for-service mechanism to payment methods that encourage patient-centered primary care and enable providers to organize in ways that produce more appropriate, integrated, and efficient care. A set of specific policies developed by the Commission staff is described to illustrate how its payment reform recommendations might be carried out, with estimates of their potential impact on national health expenditures.

1. A Framework for Payment Reform

Payment for health care and the organization of the delivery system that provides that care are closely interrelated. Payment methods incorporate incentives that influence the organization of care and use of resources. As payment methods change, those who provide care will innovate in response to new incentives. Just as providers have responded to the incentives embedded in the current fee-for-service mechanism by steadily increasing the volume and intensity of services in a fragmented health care delivery system, other incentives can encourage providers to work together, either in formal organizations or in virtual systems of care, in ways that will enable them to take broader responsibility for the patients they treat and the resources they use—and benefit from doing so. As organizational arrangements evolve, payment methods can be adjusted to encourage and reward increasing levels of accountability, with continuous improvement over time.

A framework for using payment to stimulate more organized care with increased accountability is presented below (Exhibit 1). The aim is to generate more patient-centered, coordinated, high-value care, over the course of an illness or over time. To accomplish that aim, more bundled payments and more sophisticated forms of pay-for-performance can be given to providers in more organized arrangements (which are more capable of taking on and successfully responding to the new incentives) and used to encourage, enable, and reward more favorable outcomes of care.[2] The challenge for any system of incentives is to design them so they are effective in eliciting a desired behavior. In this case, the array of possible payment approaches should be available to individual providers and small provider organizations, as well as to larger, more integrated systems, as incentives to provide more accessible, coordinated care, rather than fragmented care. Patients must be comfortable getting their care from providers in the organizational arrangements that result and be able to realize the benefits from doing so.



Source: A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, Aug. 2008).

The Commission's *Path* report recommends changing the way we pay for health care to reward high quality and prudent stewardship of resources and to encourage more organized health care delivery. The recommendations include the following payment reforms:

- Strengthen and reinforce primary care by revising the Medicare fee schedule to enhance payment for primary care services and ensure annual increases that keep pace with the cost of efficient practice;
- Institute new methods of paying for primary care that encourage adoption of the medical home model and promote more accessible, coordinated, patient-centered care, with a focus on health and disease prevention;
- Promote more effective, efficient, and integrated health care delivery by adopting more bundled payment approaches to paying for care over a period of time or for the duration of an illness, with rewards for quality, outcomes, and efficiency; and
- Correct price signals in health care markets to better align payments with value.

These policies, examples of which are described and modeled below, move the emphasis away from the current fee-for-service system toward a series of reforms meant to spur the reorganization and reorientation of the health care delivery system, so that it becomes focused on effective, efficient, and patient-centered care. This report provides

illustrative details developed by the Commission staff on how the Commission's broad policies might be applied in practice.

2. Payment Reform in the Context of Comprehensive Health Reform

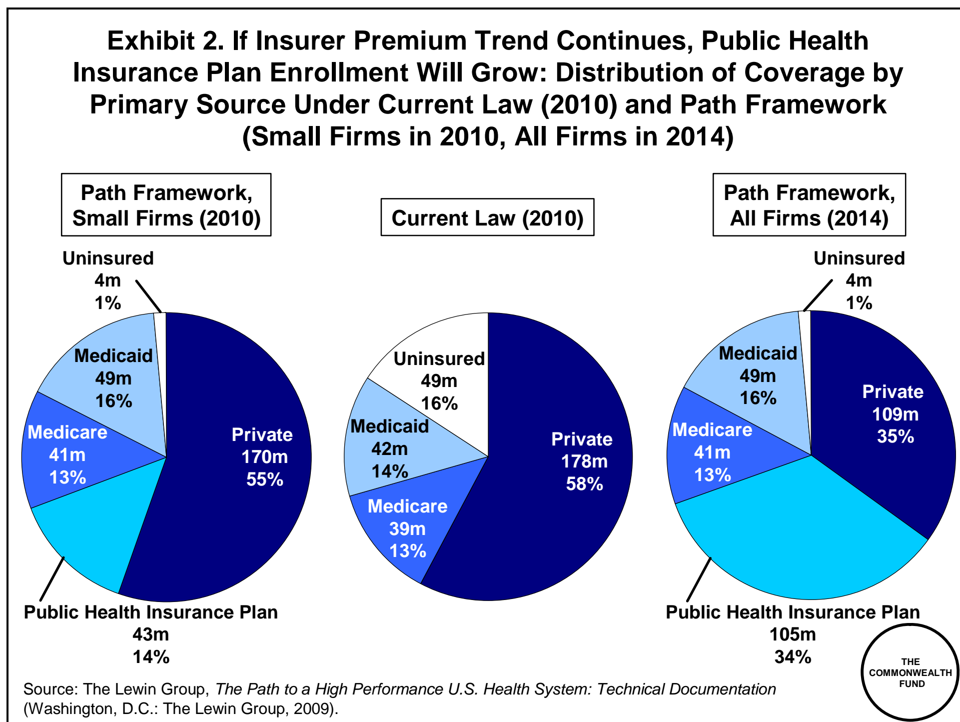
The goals of the *Path* payment reforms are to create incentives for health care providers to be accountable for the total care of patients, including their health outcomes and the prudent use of resources in providing care; to improve coordination of care; and to slow the growth of national health spending.[3]

These goals are envisioned as part of a comprehensive health reform package which would ensure affordable insurance for all, give providers the means to reach benchmark levels of quality and efficiency, and put in place public health measures and patient incentives that will promote health and prevent disease.[4] Each component of this package is important in achieving a high-performing health system and reinforces the effectiveness of the other components. For example, the establishment of a national health insurance exchange with associated insurance market reforms, as recommended by the Commission, provides a mechanism not only for improving access to affordable coverage and care but also for focusing and encouraging competition among payers on the basis of quality and efficiency. The availability of coverage (and the associated payment) for all patients would substantially reduce the justification for the large surpluses exacted by hospitals and physicians from private insurers to offset uncompensated care. More coherent pricing and payment methods would make it easier to compare performance and enhance competition among providers in matters of quality, outcomes, and cost. The availability of a public health insurance plan in addition to private insurance plans through an insurance exchange will provide not only the opportunity to apply the revised payment methods to a broader population but also a mechanism for encouraging all insurers—public and private—to align their payments with the value produced for the patient.

To promote equity as well as coherence among public insurance programs, payment reforms would also increase payment for care of Medicaid beneficiaries to Medicare levels. The combination of extending insurance coverage to everyone (covering the uninsured) plus Medicaid payment reforms would provide new revenues for all clinicians and hospitals that serve these two populations and would eliminate the need for cross-subsidies to offset the costs of uncompensated care. The importance of this opportunity to realign payment policies cannot be overstated. The provisions would generate enhanced revenues in the early years of reform that should assist providers in reorienting their business strategy and organization of care. Incentives embodied in

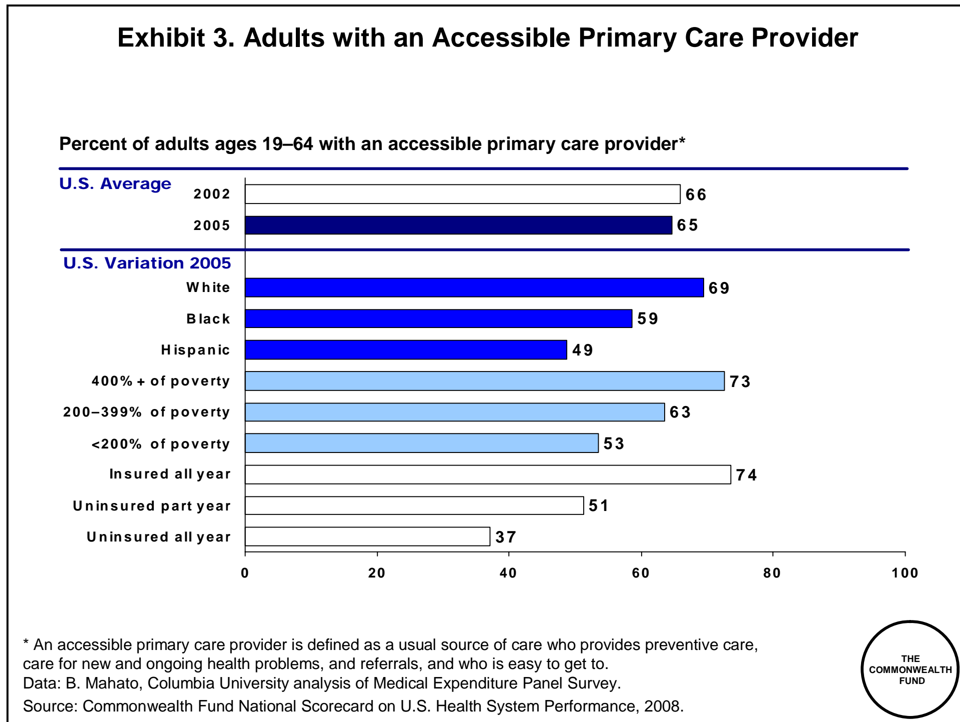
payment reforms would focus attention on care procedures, outcomes, and use of resources to produce a model of patient care that better controls chronic conditions, prevents avoidable emergency room use and hospitalizations, and reduces duplicative services, complications, and medical errors that now arise in a very fragmented delivery system.

Similarly, applying payment reforms not only to Medicare but also to Medicaid and the new public health insurance plan offered through the national health insurance exchange would provide a broad base for dissemination of reforms throughout the health system. Based on estimates of families' and businesses' choices of insurance coverage and assuming that private insurance premium trends continue, approximately 35 percent would be enrolled in private plans and 34 percent in the public health insurance plan by 2014, while about 29 percent would be covered by Medicare and Medicaid. This coverage distribution is based on a timeframe in which the exchange opens in 2010 and employers' access to choices through the insurance exchange is phased in gradually by firm size (Exhibit 2). Moreover, these payment reforms are assumed to spread to private insurance over time.[5] The modeling highlights the potential for reduced growth in costs as payment incentives encourage and support more integrated care for broad population groups. In fact, however, private insurers likely would adopt their own versions of the innovations described here or develop new innovations to enable them to compete in the new financing system, shifting the balance toward a greater market share than is produced by the *Path* model—but the potential for system savings would be the same, if not greater.



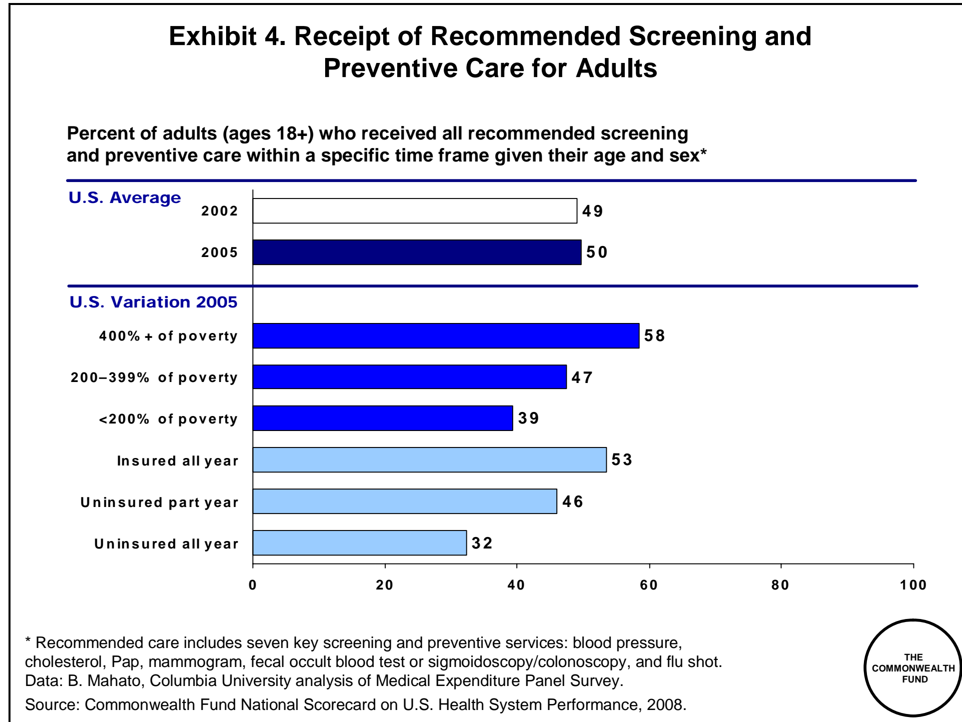
3. Strengthening and Investing in Innovative Primary Care

A high-performing health system would provide everyone with timely access to care, emphasize prevention and chronic care management, organize care around the patient, and coordinate care across settings and over time. Every person needs a regular provider who is accessible, knows the patient's medical history, maintains a complete medical record that is accessible to other providers and to the patient, and works with the patient to ensure that he or she receives all appropriate care in a timely and coordinated fashion that is focused on health needs. Yet, only two-thirds of adults under age 65 report having an accessible primary care provider (Exhibit 3).



A patient-centered medical home ideally would use high-performing clinical information systems, including not only electronic medical records but additional functionalities such as chronic disease registries and clinical decision support tools to ensure that patients receive appropriate preventive as well as acute care and that their chronic conditions are well-managed. Only half of adults are up-to-date with recommended screening and preventive care procedures (Exhibit 4), and only two-fifths of adults with high blood pressure have their condition diagnosed and controlled (Exhibit 5). Studies repeatedly document wide variations in prevention and chronic care outcomes across health plans and geographic areas. The uninsured are significantly less likely than the insured to have their chronic conditions under control, but even among Medicare and privately insured enrollees, control of chronic disease is well below desired levels. As a

result, health spending on Medicare beneficiaries with chronic conditions varies twofold across geographic regions of the United States, with the top 10 percent of spending areas paying twice as much as the lowest 10 percent (Exhibit 6).



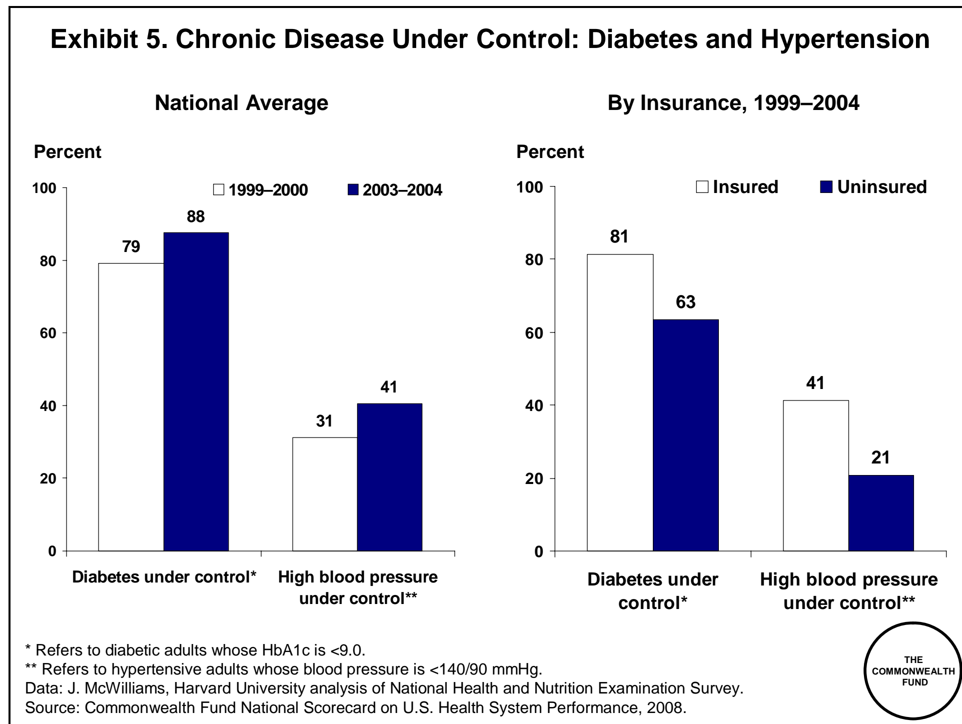


Exhibit 6. Costs of Care for Medicare Beneficiaries with Multiple Chronic Conditions, by Hospital Referral Regions, 2001 and 2005

		Average annual reimbursement					Ratio of percentile groups	
		Average	10th percentile	25th percentile	75th percentile	90th percentile	90th to 10th	75th to 25th
All 3 conditions (Diabetes + CHF + COPD)								
	2001	$31,792	$20,960	$23,973	$37,879	$43,973	2.10	1.58
	2005	$38,004	$25,732	$29,936	$44,216	$53,019	2.06	1.48
Diabetes + CHF								
	2001	$18,461	$12,747	$14,355	$20,592	$27,310	2.14	1.43
	2005	$23,056	$16,144	$18,649	$26,035	$32,199	1.99	1.40
Diabetes + COPD								
	2001	$13,188	$8,872	$10,304	$15,246	$18,024	2.03	1.48
	2005	$15,367	$11,317	$12,665	$17,180	$20,062	1.77	1.36
CHF + COPD								
	2001	$22,415	$15,355	$17,312	$25,023	$32,732	2.13	1.45
	2004	$27,498	$19,787	$22,044	$31,709	$37,450	1.89	1.44

CHF = Congestive heart failure; COPD = Chronic obstructive pulmonary disease.
Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

Improving health outcomes and management of care will require changing the way we pay for primary care. It will also require attracting more physicians and advanced-practice nurses into primary care and practices that meet the standards of patient-centered medical homes. The first set of primary care payment policy changes discussed below would enhance the value of primary care and ensure that payment keeps pace with the cost of practice; the second would encourage and support the adoption of patient-centered medical home approaches to primary care. The results described below correspond to policies that are consistent with Commission's recommendations for valuing and supporting primary care.

a. Enhancing Payment for Primary Care: Revising the Medicare Fee Schedule

This policy would enhance payment for primary care by revising the Medicare fee schedule. It includes two features:

- **Adjusting the Relative Value Weights to Emphasize Primary Care Services.** The Medicare Payment Advisory Commission (MedPAC) recommended in its June 2008 *Report to Congress* that an upward payment adjustment be made for primary care services billed under the Medicare physician fee schedule and furnished by primary care practitioners.[6] The policy option modeled in this report provides a 5 percent increase in 2010 payment levels for evaluation/management services (other than in the hospital inpatient setting) provided by geriatricians,

family practitioners, internists, and pediatricians, as well as nurse practitioners and physician assistants. Payment levels for other services would be decreased by 0.5 percent so that the total amount of Medicare physician payments in 2010 would not change.

- **Applying Differential Updates for Primary Care Services.** To enhance the value of primary care over time and slow the growth of payments for specialized care and procedures, different updates would be applied to the fees for primary care versus other services. Primary care services would be given preferential treatment in the annual update process, while other services that exhibit large increases in volume would be given smaller increases.

MedPAC also recommended, in its March 2006 *Report to Congress*, that Medicare identify overvalued services and refer them to the Relative Value Scale Update Committee for consideration of payment reductions.[7] The MedPAC analysis focused on the fastest-growing procedures; based on that analysis, the modeling includes a requirement that overvalued services (defined as the 100 fastest-growing procedures) be subject to prior authorization in order to be eligible for Medicare payment.

All of these policies would reduce the differentials between payments for primary care and other specialties. They would also slow the growth of spending for technical procedures, expensive diagnostic tests, and specialized care where increasing volume has driven up total spending.

b. Encouraging Development and Spread of Patient-Centered Medical Homes

This policy would include a new per-patient payment, in addition to traditional fee-for-service payments, to support increased access to primary care services, case management for patients with complex conditions, and a team approach to care. Participating practices would be required to furnish evidence of their capacity to provide enhanced patient-centered care, with particular emphasis on their ability to offer accessible, appropriate and coordinated care for persons with chronic conditions and multiple comorbidities. Positive incentives—reduced premiums or cost-sharing—would encourage patients to designate a primary care practice that meets the qualifications of a medical home. The policy has three elements:

- **New Per-Patient Medical Home Payment.** Qualified providers who elect to participate in the medical home program could choose either of two alternative payment options:

- A per-patient per-month medical home fee in addition to all currently covered fee-for-service payments; the fee would vary depending on the severity of the enrolled patient's illness, with an average fee of $8 per patient per month; or
- A risk-adjusted per-patient per-month global fee, to cover all primary care services (not including laboratory, radiology, pharmacy, vaccines, etc.), which would be set at the expected risk-adjusted average payment for primary care services, adjusted for geographic differences in the cost of running a practice.

To qualify for participation in the program and for the medical home payment, primary care providers would have to demonstrate the capacity to serve as a patient-centered medical home. They would need to be qualified in regard to factors such as the ability to:

- Provide enhanced access (24-hour coverage; same/next day appointments);
- Use information technology to improve patient care (e.g., registries and electronic health records with reminders, e-prescribing, and clinical decision support);
- Offer care management and care coordination services; and
- Report measures of quality of care and patient experience (see the section on Incentives for Providers below).

- **Incentives for Patients.** To encourage patients to enroll and designate a primary care practice, Medicare beneficiaries would receive a discount on their Medicare Part B premiums equal to one-third of total savings achieved under the program. Those insured under the new public health insurance plan through the national health insurance exchange would have their deductibles waived and share of primary care costs lowered. Designation of a medical home would be required for Medicaid beneficiaries; the Medicaid provision would build on similar efforts in North Carolina and other states that seek to enhance chronic care management and team-based care with payment and support.[8]

- **Incentives for Providers.** Physicians would also participate in the incentive program, under which savings in total health spending for enrolled groups would be shared by patients, providers, and payers. Participating providers could receive their share of savings as year-end bonuses based on their performance as judged by clinical quality and patient experience. Evaluation measures might include, for

example, the proportion of patients who are up-to-date with recommended preventive services and percentage of patients with chronic conditions that are adequately controlled.

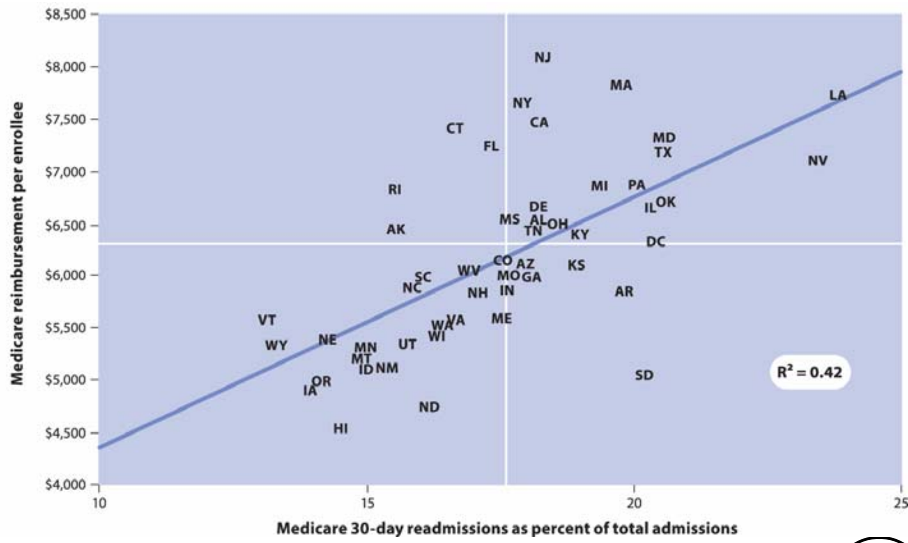
These payment policies would increase the role of primary care, put more emphasis on high-value services, and make primary care a more attractive choice to physicians and other providers entering the health care workforce. In addition to payment reforms, other policies would need to be pursued to encourage an expansion in primary care sufficient to meet the nation's needs.[9]

4. Implementing Bundled Payment for Acute-Care Episodes

New payment methods applied to acute-care episodes (including the hospital stay plus 30 days post-discharge) would encourage hospitals and other providers to collaborate in developing the capacity to provide high quality and efficient care for their patients. Non-emergency hospital admissions that vary widely across geographic areas would be subject to more scrutiny and providers and patients would be educated about the benefits and risks involved and the opportunity for shared decision-making.

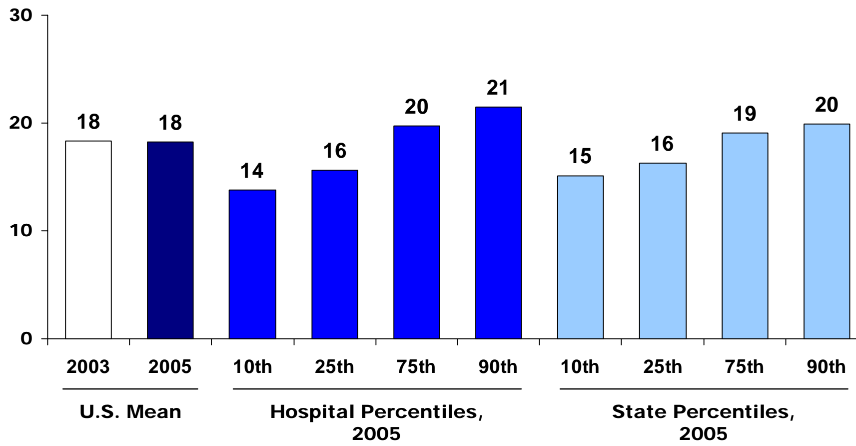
This policy recommendation addresses the wide variation across hospitals and geographic areas in the proportion of patients with hospital readmissions and the amount spent on post-acute care. The Commission's state scorecard, for example, has documented a high correlation between hospital readmissions and total Medicare spending per beneficiary (Exhibit 7).[10] Medicare readmissions within 30 days for 31 selected conditions range from 14 percent for the 10 percent of hospitals with the lowest readmission rates to 21 percent for the 10 percent of hospitals with the highest rates (Exhibit 8). Furthermore, analysis of variations in Medicare spending for one common and costly condition, the coronary artery bypass, found a threefold difference in the amount spent on readmissions between the hospitals in the 25th percentile of Medicare spending and hospitals in the 75th percentile; similarly, there is a threefold variation among these patients in spending for post-acute (rehabilitation, skilled nursing, or home health) care (Exhibit 9).

Exhibit 7. Medicare Reimbursement and 30-Day Readmissions by State

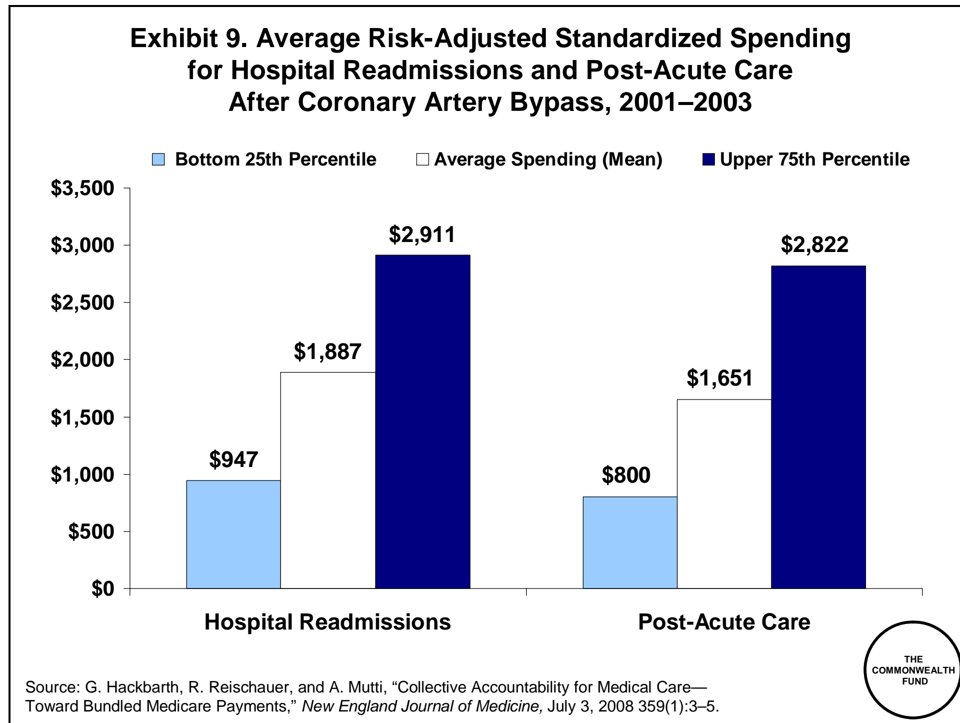


Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

Exhibit 8. Medicare Hospital 30-Day Readmission Rates



* See report Appendix B for list of conditions used in the analysis.
Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.



Offering a bundled acute-care payment (a global fee covering hospitalization and a specified set of services for 30 days following discharge) would give hospitals and other providers an opportunity to share the savings from their efforts to reduce complications of treatment and numbers of readmissions; it would also allow more flexibility in allocating their resources. The size and scope of the bundle would increase over time to allow providers the chance to respond to the growing incentives to work together to offer their patients coordinated, effective, and efficient care. The modeling assumed the policy would evolve in stages:

- **Acute-Care Global Case Rate.** The payment rate received by the admitting hospital would cover the initial stay and any additional hospital admissions that occur within the 30 days. Under this setup, hospitals would have an incentive to perform, or arrange for, follow-up care for patients they discharge to avoid the cost of readmissions. MedPAC estimates that 18 percent of Medicare patients are readmitted within 30 days of a hospital discharge (which cost $12 billion in 2005) and that 75 percent of these readmissions are potentially preventable.[11]

- **Acute-Care Global Case Rate, Including Post-Acute Care.** In addition to hospital care, this bundled payment would cover post-acute care. By including post-acute care, providers in various settings would be encouraged to collaborate to ensure that patients who require a different level of care after discharge can

receive it in a coordinated, effective, and efficient manner. MedPAC's analysis indicates that 40 percent of Medicare hospital patients use some type of post-acute care after discharge and that 20 percent of those patients are discharged to at least one additional post-acute care-setting (such as home health care after discharge from a skilled nursing facility).[12] Hospitals could provide the post-acute-care services directly or contract with post-acute providers for such services, with the option of using Medicare payment rates for those services.

- **Acute-Care Global Case Rate, Including Post-Acute, Physician-Treated-Inpatient, and Emergency Room Care.** By expanding the bundle of services to include physician care provided in the inpatient setting and in the emergency room, physicians would become jointly responsible with the hospital for the coordination, effectiveness, and efficiency of care given the patient. Physicians have primary responsibility not only for the services provided during the hospital stay but also for the choice of the hospital to which the patient is admitted. In addition, the physician has a role to play in determining the setting to which the patient is discharged as well as in providing follow-up care after the discharge, either in post-acute-care facilities or at home. Bringing all the providers under the same payment umbrella would encourage better communication and collaboration between physicians and hospitals.

A number of experts have suggested options for determining which party would receive the bundled payment or how the global case rate could be allocated across providers.[13] Integrated delivery systems, which provide both hospital and physician services, are well-positioned to accept such payments. About 1,000 physician-hospital organizations and the nation's 125 integrated academic medical centers could also adapt quickly to handling payments for acute-care episodes.[14] In addition, physicians in multispecialty group practices should be well-positioned to collaborate with their local hospitals and post-acute-care facilities to enter this type of arrangement: the American Medical Group Association reports that 95,000 physicians, serving 95 million patients, practice within member organizations, some 98 percent of which are multispecialty group practices.[15] Payment could be made to the admitting hospital or to a large physician group practice or to a virtual network of physician practices, with suitable contractual agreements among providers involved in the patient's care, or allocated between hospitals and physicians.

For each bundle described above, the initial payment rates reflect the average cost of hospital care for the period that includes the initial hospitalization and extends for 30 days

post-discharge for patients in each DRG (Diagnosis Related Group, a payment system for Medicare), adjusted for the increased efficiency (reduced readmission rates, post-acute-care use, and in-hospital physician costs) that would be expected from coordination across providers.[16]

In the modeling, payment based on these successively more inclusive bundles is phased in. The policy starts in 2010 with the acute-care global case rate being applied to all hospitals currently under Medicare prospective payment (i.e., short-stay hospitals but excluding critical-access hospitals, which are mostly small and rural, accounting for 27 percent of all short-stay hospitals but only 4 percent of Medicare discharges).[17] The bundle is expanded to include post-acute care in 2013 and inpatient physician care related to acute episodes in 2016. This phase-in would give providers time to prepare for the new system and Medicare time to develop appropriate rates that reflect the cost of efficient provision of various bundles of care. In practice, organizations that could accept more bundled payments could "skip ahead" and commit early to bundling, so long as the payment rates and rewards could be appropriately applied.

The incentives provided by progressively more bundled payments should lead to increasingly efficient resource use, with bonuses available for high performance on measures of clinical quality and patient outcome. Based on the Medicare Hospital Quality Incentive Demonstration, in which more than 250 hospitals competed for bonuses equal to 1 percent or 2 percent of DRG payment rates depending on the quality of experience for patients in each of five acute-care conditions, pay-for-performance can lead to improved levels of care and reduced costs. An early analysis of hospitals participating in this demonstration found overall improvement in the quality of care given and savings derived from shorter lengths of stay, fewer complications, and reduced readmission rates.[18] The anticipated result of an increase in bundled payments would be more efficient and effective care, which in turn should be more satisfying to patients and providers.

5. Correcting Price Signals

Bundled payments encourage providers to redesign care processes to improve transitional care and make more efficient use of costly resources, especially hospital, post-acute, and specialist care. Rewards for high performance reinforce the bundling incentives and emphasize increased quality and responsiveness in health care delivery. Additional policies that correct prices that are out of line with efficient care or what would be expected in competitive markets would enhance the effectiveness of those changes by reducing the distortion of prices and the incentives that high prices convey.

a. High-Cost-Area Payment Updates

Medicare spending per enrollee varies considerably across geographic areas. In Miami, Fla., Medicare spending per enrollee was $14,359 in 2005, while in Rapid City, S.D., it was $5,281.[19] Analysis indicates that variations in practice patterns rather than health status and local area costs drive this wide variation.[20] Moreover, lower-cost areas often have quality and outcomes that are at least as good as or better than in high-cost areas. To encourage more prudent use of resources in high-cost areas, payment updates for all providers each year would be based on total Medicare spending per beneficiary in each area relative to the national median, adjusted appropriately for costs outside the hospitals' control. The payment update in each area would be adjusted to reflect the percentage difference between Medicare spending per beneficiary in the region and the national median, with the full updates being applied for providers in low-cost areas (those with costs below 105 percent of the median), no updates for providers in areas with very high costs (those with costs at least 125 percent of the median), and reduced updates (according to a sliding scale) for other areas with high costs (between 105 percent and 125 percent of the median). The update adjustments would be recalculated each year, based on the most recent data on Medicare spending per beneficiary, so that areas that improve their costs relative to the national median can improve their payment updates over time.

b. Prescription Drugs

In addition, a set of policies would be implemented to reduce prices paid for certain prescription drugs under Medicare. This policy involves three specific mechanisms drawn from a proposal by R. G. Frank and J. P. Newhouse.[21] The first, based on the fact that Medicare plans currently pay higher rates for drugs used by dual-eligible beneficiaries than Medicaid pays for the same drugs, is a requirement that Medicare drug plans pay no more than the Medicaid rate for prescription drugs for dual-eligibles. The second mechanism, in recognition of the fact that manufacturers of therapeutically unique drugs effectively have a monopoly, is that the Secretary of Health and Human Services be authorized to set the price for therapeutically unique drugs, using prices paid by other countries to identify a target range. The third calls for the Secretary to establish a purchasing collaborative of all public payers and allow large employers and multi-employer purchasing groups to participate on a voluntary basis.

c. Medicare Advantage

The current mechanism for setting payment rates for private plans under Medicare Advantage (MA) overpays the plans and fails to establish incentives for cost-efficient care. In 2008, Medicare paid the private plans an estimated $8.5 billion more than their

enrollees would have been expected to cost the program under traditional Medicare.[22] In addition to inflating Medicare spending, these extra payments diminish the incentive for MA plans to operate efficiently.[23] To correct price signals and encourage more efficient care, this policy recommendation would modify the current Medicare payment mechanism by setting the benchmark rates for each county, rates that are used in determining payments to MA plans equal to the county's projected per capita spending under traditional Medicare.[24]

6. Alternative Models of Health Care Delivery

The ultimate form of bundled payment is full capitation, and a number of integrated delivery systems have insurance products that generate premium income for nearly all or a substantial portion of their revenue. Integrated delivery systems committed to a mission of providing top quality care to enrolled members while making prudent use of resources can be successful in the context of the payment reforms described here. To the extent that these integrated systems can provide care more efficiently than the traditional health care delivery system, they can generate surpluses which can be used for innovation, adopting information systems, and providing services that improve enrollees' health even if the services are not typically covered by traditional private insurance.[25] Alternative models of care, which may vary in their size and makeup and the formality of the arrangements among the participating providers, may also produce results that would be rewarded in the new payment environment.

Under the *Path* proposal advanced by the Commission, such insurance products would be available on a regional basis through the national health insurance exchange, thus expanding their market substantially beyond what now prevails. (Currently, many employers—especially small businesses—do not offer such plans to their employees because of the administrative difficulty of multiple plan offerings.) Further, overall insurance enrollment would increase as more than 40 million uninsured become newly covered, and enrollment in integrated delivery systems, in particular, would expand as more individuals are given a choice of plans through the insurance exchange.

7. Payment Reform: Implications for National Health Expenditures

The set of payment reform policies described above align the way we pay for care, and the prices we pay, with the value we obtain for care. Based on modeling estimates, these policies have the potential to slow the growth of health care spending by an estimated $1 trillion through 2020 relative to baseline projections (Exhibit 10). Many of the potential savings are shared with providers to help finance the care redesign process and the development of infrastructure required to improve quality of care and patient outcomes.

The enhanced payment for primary care is expected to save $71 billion over the 2010-to-2020 period, the medical home payment to save $175 billion; and the bundled payment for acute-care episodes $301 billion. The differential update in high-cost areas would save $223 billion, while the prescription drug policies would save $76 billion. Leveling the playing field between Medicare Advantage plans and traditional Medicare would generate $165 billion in savings. The net benefits of all these savings would be realized by the federal government, employers, households, and state and local governments. The federal budget savings of $749 billion would be the largest share of the total, mainly because most of the payment policy reforms apply immediately to Medicare, Medicaid, and the public health insurance plan available through the national exchange to the under-65 population.

Exhibit 10. Net Impact of Path Recommendations on National Health Expenditures Compared with Current Projection, 2010–2020 (in billions)

	Total NHE	Private Employers	State & Local Governments	Households	Federal Budget
Total Payment Reforms	**–$1,010**	**–$170**	**–$10**	**–$82**	**–$749**
Enhanced payment for primary care	–$71	–$28	–$2	–$11	–$30
Encouraged adoption of Medical Home model	–$175	–$25	–$13	–$36	–$101
Bundled payment for acute care episodes	–$301	–$75	–$4	–$11	–$211
Correcting price signals					
• High-cost area updates	–$223	–$64	–$3	–$29	–$127
• Prescription drugs	–$76	+$22	+$12	+$5	–$115
• Medicare Advantage	–$165	$0	$0	$0	–$165

Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Lewin Group, *The Path to a High Performance U.S. Health System: Technical Documentation* (Washington, D.C.: The Lewin Group, 2009).

The potential impact of these policies could accelerate over time, with increased emphasis on services that provide value and the reorganization of the health care delivery system around the patient to achieve more effective and efficient care. Broad adoption among private insurers of these (or equally effective) policies would augment their impact.

The coverage, payment, and system policies recommended by the Commission would enhance one another’s effectiveness. For example, the expansion of health insurance coverage increases the population to whom payment reforms are applicable, and covering the uninsured and improving Medicaid payment levels would largely

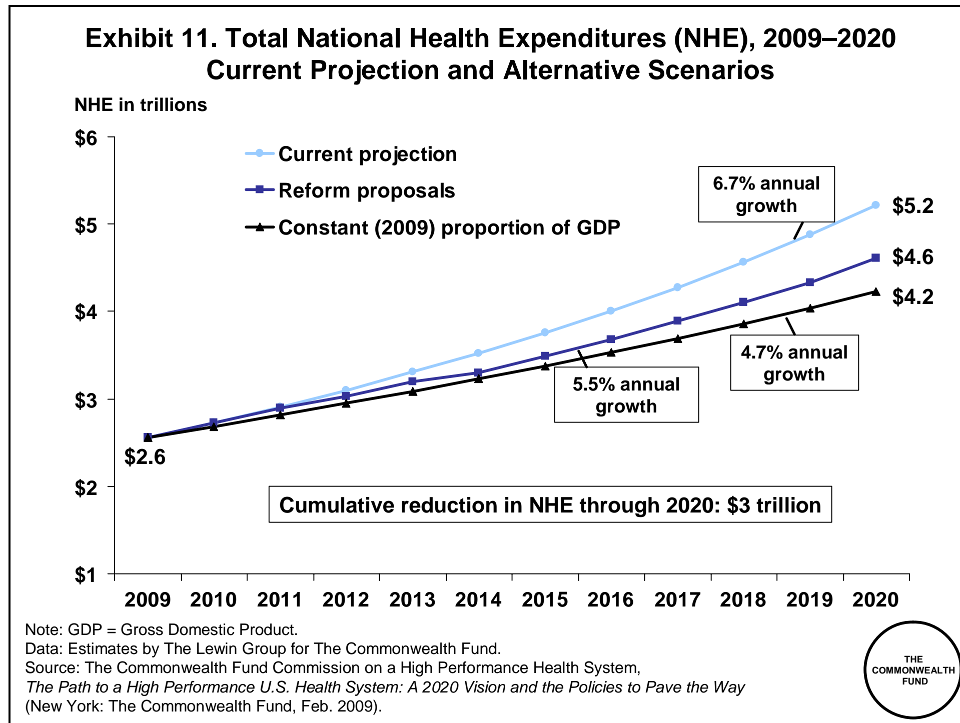
eliminate the need for the implicit cross-subsidies currently extracted from private insurers. Such cross-subsidies are currently justified by the need to cover care of the uninsured and make up Medicaid payment shortfalls, but are inefficient for that purpose—because they tend not to go to the hospitals that treat uninsured and Medicaid patients—and, by masking the relationships between payments and resources used to provide care, make it more difficult to control costs.

Other system reforms, such as investing in higher-quality information and improved information systems, would enhance the effectiveness of payment reforms and enable delivery system change. Paying for value requires knowledge about outcomes—health, patient experiences, and costs of care. Investments in a health information technology infrastructure, along with development and deployment of policies to use that technology, will make it easier to obtain the knowledge that is needed. Additionally, a mechanism for producing information about comparative effectiveness—particularly in combination with improved health information technology—would enable better decision-making on the part of providers, patients, and payers, further enhancing the ability of the health care delivery system to meet patients' needs.

Perhaps the most important impact of the payment reforms described here, however, is that they provide incentives that can lead to a more responsive, effective, and efficient health care delivery system. That would not only increase value for the amount of money we spend on health care but also help produce better care, more satisfaction, and improved outcomes for all. Payment reforms combined with coverage reforms would benefit the insured as well as uninsured—and would secure a more sustainable health system for future generations.

8. Payment Reform: Implications for Providers

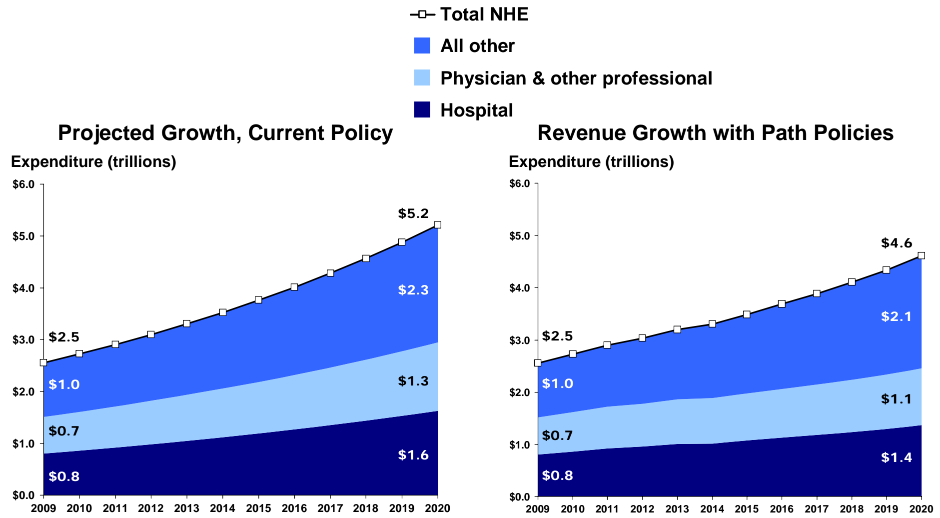
With increased emphasis on primary care, improved coordination, and the elimination of unnecessary and duplicative services, spending growth would slow relative to current projections. However, although provider revenues would grow more slowly over the next decade, they would continue to grow. Indeed, national health expenditures under the Commission's Path reforms are projected to increase from $2.6 trillion in 2009 to $4.6 trillion in 2020, which would be 73 percent higher than current spending but lower than the $5.2 trillion projected for 2020 in the absence of reform (Exhibit 11). Furthermore, if providers respond positively by increasing the efficiency of the services they deliver and cut waste and duplication, then net revenues per provider could grow substantially.



The comprehensive set of reforms proposed by the Commission—including health insurance coverage for all, along with their recommended payment and system reforms—could “bend the curve” in national health spending from the currently projected annual expenditure growth of 6.7 percent over the 2010-to-2020 period to 5.5 percent. This would produce a significant drop-off in health spending—from the projected 20.8 percent of the Gross Domestic Product (GDP) in 2020 to 18.4 percent—albeit still higher than the estimated 16.9 percent of GDP in 2009. Even with the cumulative savings of $3 trillion nationwide by 2020, national health spending will total $39 trillion, cumulatively, from now through the end of the next decade. Coverage of the uninsured will stimulate demand for health care services, as will the growth in, and aging of, the population, leading to an expanding market for health services.

Provider revenues are estimated to increase steadily over the period from 2010 to 2020, with hospital revenues growing from $800 billion in 2009 to $1.4 trillion in 2020 (compared with $1.6 trillion projected if no health reforms are enacted), and physician revenues would rise from $700 billion in 2009 to $1.1 trillion in 2020 (compared with $1.3 trillion projected under current policies) (Exhibit 12). Provider revenues would grow in the early years as providers experience enhanced revenues from coverage of the uninsured and increases in Medicaid payment rates. In the later years, as payment policies spread and take hold, the growth in provider revenues will slow relative to that projected under current policies (Exhibit 13).

Exhibit 12. Total National Health Expenditure (NHE) Growth by Provider Group, Current Projections and with Policy Changes, 2009–2020



Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

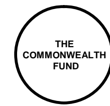
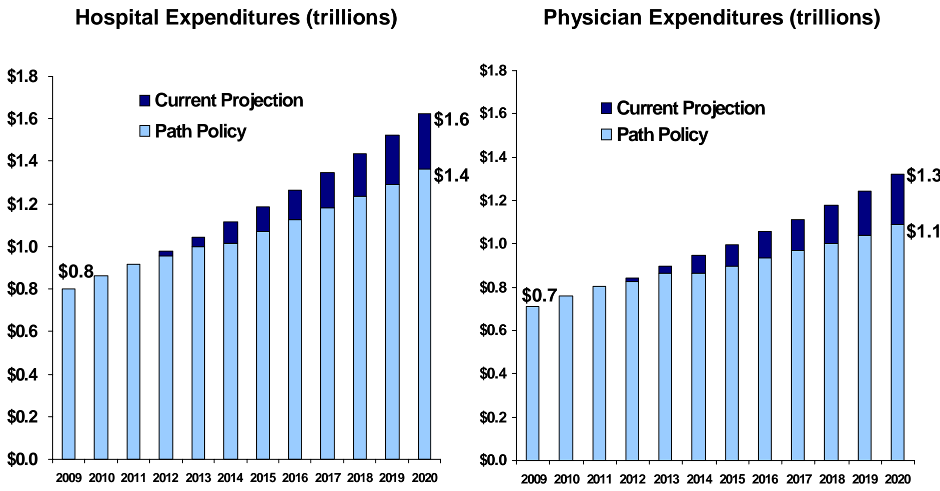
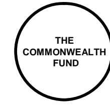


Exhibit 13. Total National Health Expenditure Growth for Hospitals and Physicians, Current Projections and with Policy Changes, 2009–2020

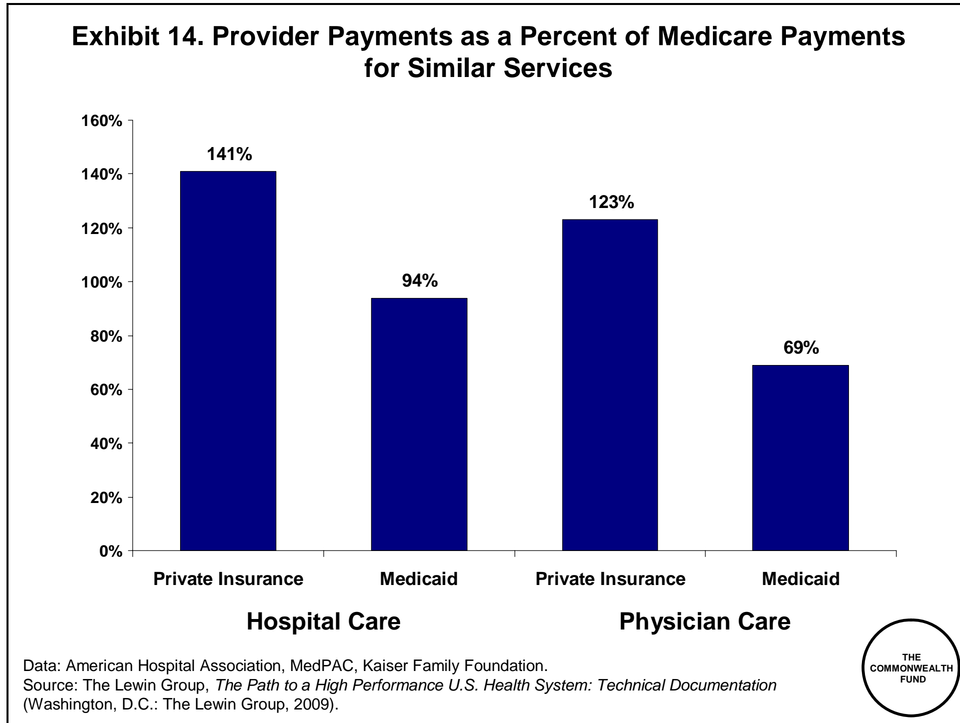


Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Lewin Group, *The Path to a High Performance U.S. Health System: Technical Documentation* (Washington, D.C.: The Lewin Group, 2009).

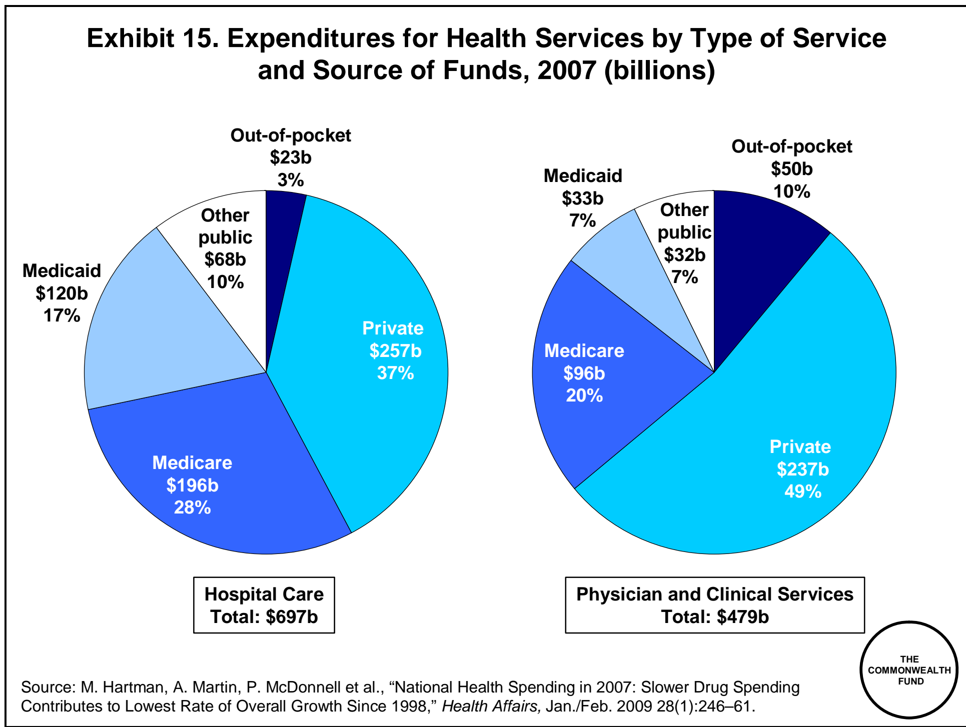


9. Payment Reform: Implications for Public and Private Payers

The different prices paid by different payers could generally be expected to narrow under the payment reforms described above. Currently, private insurers pay 141 percent of what Medicare pays hospitals and 123 percent of what Medicare pays physicians (Exhibit 14).



Medicaid rates are lower than Medicare, averaging 94 percent of Medicare rates for hospitals and 69 percent of Medicare rates for physicians. Medicare payments represent 28 percent of hospital revenues and Medicaid 17 percent, while private insurance payments represent 37 percent (Exhibit 15). By contrast, private insurance payments make up about half of physicians' revenue while Medicare accounts for 20 percent and Medicaid for 7 percent.



If payment for Medicaid patients and the uninsured were brought up to Medicare rates, the pressure on providers to exact a surplus from private insurers—and the rationale for doing so—would decrease substantially. If a mechanism is put in place to allow or encourage the reduction or elimination of this surplus—as would occur with a public health insurance plan available through the national health insurance exchange—there would be savings for all privately insured persons and the employers who provide and pay for such coverage. The savings over time would accrue to businesses as well as families in the form of slower growth in premiums and out-of-pocket costs.

The new public health insurance plan offered through the insurance exchange would incorporate the reformed provider payment methods and rates described above. The reaction of private insurers to competition from the new public health insurance plan with reformed provider payment is hard to predict. Private insurers could choose to use payment methods and rates similar to those implemented by the public sector—and the modeling assumes that some will choose to do so based on historical patterns of adoption of Medicare's payment policies. Or, they may compete by developing their own approaches, using tools that are uniquely available to private plans—for example, creating networks of high-performing providers, with lower hospitalization or readmission rates and better patient outcomes.

Integrated delivery systems that also provide insurance offerings through the insurance exchange may achieve savings through appropriate incentives to physicians,

altering the mix of primary care and specialist physicians, redesigning procedures for patient care, improving management of chronic conditions, and making care delivery more efficient—for example, through greater use of telephone visits, e-mail, or group visits. Whatever the organizational model, efficient practices and care systems would benefit from more bundled payment methods because such methods support productive use of resources. Hospitals, physicians, and other health care practitioners—especially those who redesign systems to deliver care more efficiently and reduce wasteful or ineffective care—should see greater increases in net revenue.

10. Conclusions

Implementing the payment reform changes described above, and the other types of changes necessary to put the U.S. health system on the path to high performance, will be difficult. The payment reforms involve a restructuring of the incentives that would reward efficient care (better quality and lower costs) and penalize waste or poor care. The current system, if unchanged, will produce a projected $42 trillion in health spending by the end of the next decade, absorbing an increasing share of national resources. Slowing the rate of growth and changing the way health services are paid for, is therefore a daunting task, and will seem threatening to many stakeholders. The alternative, however, is untenable; we must transform our inequitable, inefficient, and inflationary payment methods. The strategies outlined above would help right many of the existing imbalances while simultaneously improving quality of care and containing costs. It will take cooperation between the Congress and the President and all the other participants in the health system to begin work on payment reform within Medicare and the larger health care system.

On issues of cost, quality, and coverage, a transformed payment system is the key to a transformed health system. As the discussion about reforming health care gathers steam, it is important to proceed with a comprehensive approach to system reform, one in which issues of access, quality, and cost are considered concurrently. The objective of payment reform should be to change the incentives facing providers and improve health care delivery rather than merely cut payment rates and take 'easy savings' without changing the underlying distortions that have led us down the wrong path. No matter what path reform takes, though, leadership and collaboration among business, government, insurers, providers, and patients are essential. By assessing the likely impact of proposed policies, and offering policy reform ideas, this report seeks to inform and support health care leaders and policy officials who are committed to improving the quality and cost performance of the U.S. health system and the value we get in return for our large national investment.

NOTES

[1] Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

[2] Exhibit 1 is based on concepts presented in A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund Commission on a High Performance Health System, Aug. 2008).

[3] For a more detailed discussion of a framework for moving from fee-for-service to increasingly bundled payments, see S. Guterman, K. Davis, S. C. Schoenbaum, and A. Shih, "Using Medicare Payment Policy to Transform the Health System: A Framework for Improving Performance," *Health Affairs* Web Exclusive (Jan. 27, 2009):w238–w250.

[4] Shih, Davis, Schoenbaum et al., *Organizing the Delivery System,* 2008.

[5] Lewin used the history of the spread of Medicare innovation with DRG and RBRVS to inform the modeling estimates.

[6] Medicare Payment Advisory Commission, *Report to the Congress: Reforming the Delivery System* (Washington, D.C.: MedPAC, June 2008).

[7] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2006).

[8] D. R. Rittenhouse, L. P. Casalino, R. R. Gillies et al., "Measuring the Medical Home Infrastructure in Large Medical Groups," *Health Affairs,* Sept./Oct. 2008 27(5):1246–58.

[9] Commonwealth Fund Commission, *Path to High Performance,* 2009.

[10] J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund Commission on a High Performance Health System, June 2007).

[11] Medicare Payment Advisory Commission, *Payment Policy for Inpatient Readmissions* (Washington, D.C.: MedPAC, 2007).

[12] Medicare Payment Advisory Commission, *Healthcare Spending and the Medicare Program: A Data Book* (Washington D.C.: MedPAC, June 2008):121.

[13] G. R. Wilensky, "Reforming Medicare's Physician Payment System," *New England Journal of Medicine,* Feb. 12, 2009 360(7):653–55; E. S. Fisher, M. B. McClellan, J. Bertko et al., "Fostering Accountable Health Care: Moving Forward in Medicare," *Health Affairs* Web Exclusive (Jan. 27, 2009):w219–w231; Guterman, Davis, Schoenbaum et al., "Using Medicare Payment Policy," 2009; and F. de Brantes and J. A. Camillus, *Evidence-Informed Case Rates: A New Health Care Payment Model* (New York: The Commonwealth Fund, April 2007).

[14] R. E. Mechanic and S. H. Altman, "Payment Reform Options: Episode Payment Is a Good Place to Start," *Health Affairs* Web Exclusive (Jan. 27, 2009):w262–w271.

[15] American Medical Group Association Press Release, "AMGA Reports Significant Growth in 2008," available at http://www.amga.org/AboutAMGA/News/article_news.asp?k=292. Accessed Feb. 20, 2009.

[16] The initial payment rates consist of 100 percent of the mean historical cost for the initial admission, 85 percent of the mean historical cost for readmissions, 90 percent of the mean historical cost for post-acute care, and 95 percent of the mean historical cost for inpatient physician care.

[17] MedPAC, *Healthcare Spending,*2008:73.

[18] P. K. Lindenauer, D. Remus, S. Roman et al., "Public Reporting and Pay for Performance in Hospital Quality Improvement," *New England Journal of Medicine,* Feb. 1, 2007 356(5):486–96.

[19] Data from the Dartmouth Atlas of Health Care Web site, http://www.dartmouthatlas.org/data/download/2005_reimb_table_hrr.xls. Accessed Dec. 5, 2008.

[20] D. Elmendorf, *Options for Controlling the Cost and Increasing the Efficiency of Health Care*, Congressional Budget Office Testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, March 10, 2009.

[21] R. G. Frank and J. P. Newhouse, *Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Pricing*, Discussion Paper 2007–03 (Washington, D.C.: Brookings Institution, Apr. 2007), available at http://www3.brookings.edu/views/papers/200704frank_newhouse.pdf. Accessed May 11, 2007.

[22] B. Biles, E. Adrion, and S. Guterman, *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans in 2008* (New York: The Commonwealth Fund, Sept. 2008).

[23] M. E. Miller, *The Medicare Advantage Program and MedPAC Recommendations,* testimony before the Committee on the Budget, U.S. House of Representatives, June 28, 2007.

[24] As under current policy, if a plan's bid is below the benchmark, it would receive a payment equal to its bid plus a rebate of 75 percent of the difference between its bid and the benchmark, with the requirement that it use the rebate to provide additional benefits or reductions in premiums or cost-sharing. Also as under current policy, if the plan's bid is above the benchmark, beneficiaries wishing to enroll in the plan would have to pay an additional premium equal to the difference between the plan's bid and the benchmark.

[25] R. A. Paulus, K. Davis, and G. D. Steele, "Continuous Innovation in Health Care: Implications of the Geisinger Experience," *Health Affairs,* Sept./Oct. 2008 27(5):1235–45.

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"Using Medicare Payment Policy to Transform the Health System: A Framework for Improving Performance," S. Guterman, K. Davis, S. C. Schoenbaum, and A. Shih, *Health Affairs* Web Exclusive (Jan. 27, 2009):w238–w250.

The Time Has Come for Comprehensive Health Reform. Commonwealth Fund Commission on a High Performance Health System, Nov. 2008.

"Continuous Innovation in Health Care: Implications of the Geisinger Experience," R. A. Paulus, K. Davis, and G. D. Steele, *Health Affairs,* Sept./Oct. 2008 27(5):1235–45.

"Measuring the Medical Home Infrastructure in Large Medical Groups," D. R. Rittenhouse, L. P. Casalino, R. R. Gillies et al., *Health Affairs,* Sept./Oct. 2008 27(5):1246–58.

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