

# **Health Care Payment Reform:**

## **A Background Report for the Incentives and Outcomes Committee of the Oregon Health Policy Board**

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**Oregon for Oregon Health Policy and Research**

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## **A Background Report for the Incentives and Outcomes Committee of the Oregon Health Policy Board**

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<sup>1</sup> Oregon Health Authority. [http://www.oregon.gov/OHA/about\\_us.shtml](http://www.oregon.gov/OHA/about_us.shtml)

## **Executive Summary**

The Oregon Health Policy Board and the Oregon Health Authority were created in 2009 by the Oregon Legislature. Among the tasks of the health policy board is developing a statewide approach to measure the quality and efficiency of health care as well as strategies, such as payment reform, to contain the growth of health care costs and promote the delivery of high quality care in an efficient delivery system. The work of the Health Policy Board and Health Authority are guided by the “triple aim” goals<sup>1</sup>:

1. Improve the lifelong health of all Oregonians,
2. Increase the quality, reliability, and availability of care for all Oregonians, and
3. Lower or contain the cost of care so it is affordable to everyone.

## Introduction

Enacted HB 2009 created the Oregon Health Policy Board and the Oregon Health Authority (OHA).<sup>2</sup> The legislature tasked the new policy board with developing a statewide approach to measure the quality and efficiency of health care as well as strategies to contain the growth of health care costs and promote the delivery of high quality care in an efficient delivery system.

The 2008 report of the Oregon Health Fund Board (HFB) identified a number of strategies and approaches that could be used to achieve the above objectives including the development of robust statewide data on the quality and cost of health care, formation of an Oregon Quality Institute, promotion of new delivery models and organizational structures such as integrated health homes and accountable care districts and development of new payment methods that utilize cost and quality data to inform payment for health care services.<sup>3,4</sup>

A number of activities that will support the above strategies are actively underway within the Oregon Health Authority. Work to date includes the following:

- Ongoing development of an all payer all claims database by the Office for Oregon Health Policy and Research (OHPR)
- Completed Standards and Measures for Patient Centered Primary Care Homes by OHPR<sup>5</sup>
- Development of a list of Value Based Services and Value-Based Benefit Design by the Health Services Commission (HSC)

The Oregon Health Policy Board established the Health Incentives and Outcomes Committee and its Subcommittees on Quality and Efficiency and Payment Reform to develop detailed recommendations and coordinated strategies for quality and efficiency measurement and payment reform.

The purpose of this paper is to provide background information to the Health Incentives and Outcomes Committee and its subcommittees. It looks at factors contributing to the costs of care, traditional payment methods and potential new models, new developments in health care payment since the Health Fund Board's 2008 report, payment reform initiatives in recently passed Federal health care reform legislation and suggested principles to guide a new approach to payment for health care services.

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<sup>2</sup> Enacted House Bill 2009. June 2009.

<sup>3</sup> Oregon Health Fund Board. Final Report. December 2008.

<sup>4</sup> Delivery Systems Committee Recommendations to the Oregon Health Fund Board. May 2008.

<sup>5</sup> Standards and Measures for Patient Centered Primary Care Homes. OHPR. February 2010.

## Rationale for Development of New Payment Models

The current delivery system relies heavily on a fee for service (FFS) method of payment for health care services. Fee for service payment has been widely recognized to reward overutilization and resource inefficiency.<sup>6</sup> Additionally, current fee for service payment policies create a variety of adverse incentives including: the undervaluation of preventive services, the overvaluation of procedural services, the absence of a payment mechanism to support coordination and integration of care, and the relative absence of incentives to improve the quality and efficiency of care.<sup>7</sup>

In its final report, the Oregon Health Fund Board noted sharply rising health care costs and relatively poor quality of health care in Oregon and questioned the sustainability of the current system.<sup>3</sup> The HFB identified payment reform as a key strategy to correct the adverse incentives created by fee for service payment and achieve the “triple aim” goals of health reform:

1. Improve the lifelong health of all Oregonians,
2. Increase the quality, reliability, and availability of care for all Oregonians, and
3. Lower or contain the cost of care so it is affordable to everyone.

Since the writing of the HFB report, a number of states and the Federal government have developed frameworks for payment reform. Some of these efforts call for transition to a completely new method of payment while others take incremental steps improve current payment methods. Many groups, including the Delivery Systems committee of the HFB, have proposed principles for reforming payment for health care services, these principles are contained in Appendix A.

## Overview of Payment Methods and Strategies

**Primary Payment Methods** – Several methods of health care payment are currently in widespread use or have been proposed as the basis for payment reform. The three most commonly cited methods are variations of fee for service (the dominant method in our current delivery system), episode-based payments and global payments. These three methods are described below, along with a fourth approach of creating blended payment models that seek to combine the strengths of each method.

- **Fee For Service:** A provider is paid a fee for rendering a specific service. Proposed modifications to traditional fee for service include re-valuing fees for specific services (such as prevention, primary care and “cognitive” services), establishing a uniform fee schedule across all payers and paying certain providers “enhanced” fees based on a variety of criteria.
- **Episode-Based or Bundled Payments:** a provider or group of providers are paid a set amount for a “bundle” of services rendered during a defined “episode” of care. The most

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<sup>6</sup> Schoen C, et al. Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending. The Commonwealth Fund. December 2007.

<sup>7</sup> American College of Physicians. Reform of the Dysfunctional Healthcare Payment and Delivery System. 2006. [www.acponline.org/advocacy/where\\_we\\_stand/policy/dysfunctional\\_payment.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/dysfunctional_payment.pdf).

prominent example of episode-based payment is Medicare diagnosis related group (DRG) payments to hospitals.<sup>8</sup> Newer concepts regarding episode-based payment include the idea of bundling payments across multiple providers (e.g. hospitals and outpatient physicians), risk-adjusting bundled payments based on medical complexity (evidence-informed case rates) or considering fixed time periods as “episodes” in the treatment of individuals with chronic diseases.<sup>9,10</sup>

- **Global Payments/Capitation:** one or more providers are paid a prospective fee to cover all services rendered for the continuous care of a patient for a specific period of time. Global payments can either cover all medical costs and conditions or pertain only to specific types of services (e.g. primary care). Capitation is still used as a method of payment, although not as often as it was in the 1990s during the height of managed care organizations.
- **Blended Payments:** blended payment models utilize a combination of the above methods. For example, some proposals for payment reform in primary care call for blended payments consisting of fee-for-service, prospective payments for care management and pay for performance based on quality.<sup>11</sup>

**Adjunct Payment Methods** – A number of payment reform proposals call for the use of adjunct payment strategies in addition to one or more of the major payment methods. Adjunct payment methods create incentives for providers to provide certain types of care, improve the quality of care or increase the efficiency of care. Two major approaches to adjunct payments are gain sharing and pay for performance:

- **Gain Sharing/Shared Savings:** the cost of care over a specific period of time is measured against the predicted cost of care. At the end of the period a portion of “savings” below the projected cost of care are paid to the provider. Certain gain sharing arrangements withhold a portion of payment to cover possible losses or cost overruns. Several federal laws could potentially restrict gain sharing arrangements, including federal antikickback statues and the Stark laws. However, based on the results of a successful CMS demonstration using gain sharing, the Medicare Payment Advisory Commission (MedPAC) recommended that “Congress should grant the authority to allow gain sharing arrangements between physicians and hospitals and to regulate those arrangements to protect the quality of care and minimize financial incentives that could affect physician referrals.”<sup>12</sup>
- **Pay for Performance:** pay for performance (P4P) has been used to refer to a wide variety of arrangements in which providers are given a financial incentive for achieving specific care

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<sup>8</sup> Centers for Medicare and Medicaid Services. Prospective Payment Systems – General Information. Available: <http://www.cms.hhs.gov/PropMedicareFeeSvcPmtGen/>.

<sup>9</sup> de Brantes F, Camillus JA. Evidence-Informed Case Rates: A New Health Care Payment Model. The Commonwealth Fund. April 2007.

<sup>10</sup> Berenson R. Payment Options to Support Medical Homes: Theory and Practice. Presentation during National Academy for State Health Policy (NASHP) Webinar on Medical Home Payment Models. March 2, 2010. [www.nashp.org](http://www.nashp.org)

<sup>11</sup> Spann S. Report on Financing the New Model of Family Medicine. *Annals of Family Medicine*. 2004(2(Suppl 3));S1-S21.

<sup>12</sup> Wilensky GR, Wolter N, Fischer MM. Gain Sharing: A Good Concept Getting a Bad Name? *Health Affairs*, web exclusive. 2007; 26(1): w58-w67.

outcomes, most commonly improved quality of care. Quality can be outcome-based and measured in terms of benchmarking or process-based and measured in terms of improvement.<sup>13</sup> The most common form of P4P financial incentive is the bonus payment, however a wide variety of incentive structures have been used. Examples of different types of incentive models are shown in Table 1. While table 1 highlights P4P incentives for ambulatory care, similar approaches have been used for specialty and hospital care.

- Pay for Performance:** pay for performance (P4P) has been used to refer to a wide variety of arrangements in which providers are given a financial incentive for achieving specific care outcomes, most commonly improved quality of care. Quality can be outcome-based and measured in terms of benchmarking or process-based and measured in terms of improvement.<sup>13</sup> The most common form of P4P financial incentive is the bonus payment, however a wide variety of incentive structures have been used. Examples of different types of incentive models are shown in Table 1. While table 1 highlights P4P incentives for ambulatory care, similar approaches have been used for specialty and hospital care.

**Table 1. Examples of Pay For Performance Financial Incentives<sup>13</sup>**

<i>Financial Reward</i>	<i>Example</i>

<sup>13</sup> Llanos K, Rothstein J, Dyer MB, et. al. Pay for performance in Medicaid: A Guide for States. Center for Healthcare Strategies, Inc. March 2007.

**Pay for  
Participation**

Providers are paid for reporting quality data or time spent at quality improvement meetings.

**Pay for Process**

A primary care provider (PCP) receives an automatic payment of \$10 every time one of the PCP's age-appropriate, female, adult patients receives a biannual mammogram.

**Bonus for achievement of a benchmark**

A PCP receives a bonus payment if 80 percent or more of age-appropriate, female, adult patients received a mammogram in the past two years. The PCP receives a larger payment if more than 90 percent did so.

**Bonus based on comparative ranking**

A PCP receives a bonus payment if ranked in the top 50 percent of PCPs for delivery of mammograms to age-appropriate, female, adult patients in the past two years. A larger payment is received if ranked in the top 25 percent of PCPs.

<p><b>Bonus for demonstration of improvement</b></p>	<p>A PCP receives a bonus payment if the PCP demonstrates improvement in the percent of age-appropriate, female, adult patients receiving a mammogram in the past two years. (PCPs with rates over a benchmark also receive the bonus)</p>
<p><b>Performance-based fee schedule</b></p>	<p>A PCP is paid 105 percent of the usual fee schedule if strong performance on</p>

	several performance metrics distinguishes the PCP from other PCPs.
<b>Compensation at-risk</b>	A PCP forfeits a fee schedule increase unless the PCP achieves the statewide mean on several identified performance metrics.

While payers have implemented a wide variety of P4P programs, there is considerable debate about the impact of pay for performance models on overall cost and quality.<sup>14</sup> Proponents point to research demonstrating that hospitals can gain up to 15% in additional revenue from the successful implementation of P4P programs without assuming significant financial risk.<sup>13</sup>

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<sup>14</sup> Rosenthal MB, Dudley RA. Pay-for-performance. Will the latest Payment Trend Improve Care? JAMA. 2007;297(7):740-743.

financial risk.<sup>13</sup> However, payers often consider the dilemma of how to fund P4P bonus payments. Some private payers, such as BCBS of Michigan, make use of the bonus payment without an explicit source of funding.<sup>13</sup> Alternatively, the national CMS demonstration project funded P4P payments by reducing the yearly total base payments for all participating hospitals by an amount equal to the total projected bonus payments.<sup>6</sup> States have used additional methods of funding bonus payments including budgeting specific pools of dollars, funding “challenge pools” where unearned bonus monies or unearned withheld capitation payments are paid out to those who excel, reallocating monies collected as penalties, linking rate increases to physicians meeting certain standards, and withholding a portion of an organization’s capitation payment and paying it back later contingent upon performance.<sup>13</sup>

### **Considerations in Selecting a Payment Method**

The primary goal of payment reform is using financial incentives to advance the triple aim goals by influencing provider behavior and thereby impacting the quality and/or cost of care. Different methods of payments have particular strengths and create different incentives for providers that must be considered when selecting a method of payment. In addition to considering the basic payment method, adjunct payment methods and the overall level of payments, policymakers should also consider the ability of different payment methods to control health care costs, the potential adverse incentives created by the transfer of financial risk to providers, the strengths of payment methods by condition type and the ability of payment methods to appropriately value health care services.<sup>15</sup>

***Controlling Health Care Costs*** – Increases in health care costs are driven by a variety of factors impacting either utilization (greater need for services in the population, inefficient care, changing standards of care, oversupply of services, etc.) or prices. The causes for cost increases (and payment strategies to address cost increases) may be very different depending on the type and location of service. Some authors recommend considering payment strategies for six distinct “cost types:” primary care physician services, specialist physician services, diagnostic services, drugs and medical devices, short-term non-physician services and facilities, and long-term non-physician services and facilities.<sup>15</sup>

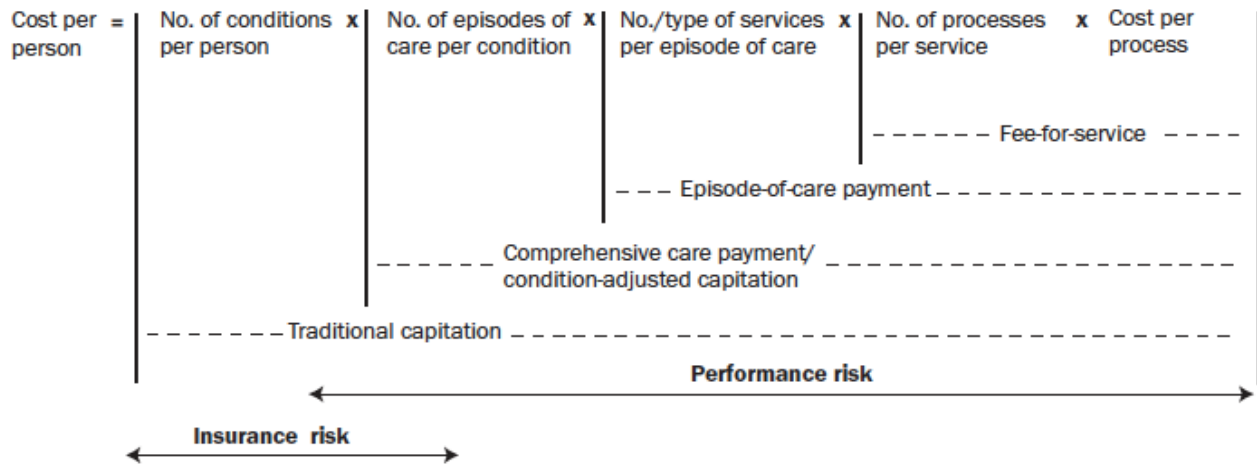
Figure 1 depicts the ability of major payment strategies to influence factors contributing to the overall cost and utilization of health care. Provider behavior is assumed to have little impact on costs driven by the underlying prevalence of disease in the population or “insurance risk.” Conversely, costs driven by “performance risk” are presumed to be factors where the behavior or “performance” of health care providers could be optimized to achieve better outcomes. For example, for a change in health care payments should have little impact on the number of patients with diabetes or cancer (# of conditions per person), but it should be able to encourage optimal management of those conditions to prevent unnecessary hospitalizations (# episodes of care per condition) and improve the efficiency of ongoing care in both acute and ambulatory settings (# of services per episode and # of processes per service).

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<sup>15</sup> Miller HD. Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. The Commonwealth Fund. September 2007.



**Figure 1: Impact of Different Payment Methods on Drivers of Per-Capita Costs<sup>16</sup>**



Several key questions should be considered when evaluating the impact of a particular payment method on the overall cost of care.

*What is the relationship between the level (amount) of payment and the actual cost of care?*

Most fee for service payments are based on the Medicare process for setting FFS rates using relative value units (RVU) and the resource-based relative value scale (RBRVS).<sup>17</sup> This system is, in theory, designed to set prices for health care services in a way that covers providers’ overhead costs and provides a profit based on the work they perform. Under episode-based and global payment systems, prospective payments are typically calculated based on the actual cost of care in past time periods and some form of risk adjustment. Each of these payment methods can distort the relationship between the level of payment and the actual cost of delivering care, creating the potential for excessive profits or losses for providers. In the case of FFS, providers can negotiate higher rates for their services, depending on their market power. In addition, there is considerable debate about whether the RVU system sets appropriate payments for the amount of “work” required to deliver certain services.<sup>18</sup> Because episode-based and global payments are based on historical costs, these methods also sometimes fail to set payment levels appropriately. For example, there have been criticisms that the DRG system within Medicare is too slow to incorporate the cost of new medical technology or adapt to changing standards of care, and may penalize providers that have been historically efficient in delivering care.<sup>19</sup>

<sup>16</sup> Miller HD. From Volume to Value: Better Ways to Pay for Health Care. Health Affairs. September/October 2009;28(5):1418-1428.

<sup>17</sup> American Medical Association. The Resource-Based Relative Value Scale. Available: <http://www.ama-assn.org/ama/pub/category/16391.html>.

<sup>18</sup> Ginsburg PB, Berenson RA. Revising Medicare’s Physician Fee Schedule – Much Activity, Little Change. NEJM. 2007;356(12):1201-1203.

<sup>19</sup> Nichols LM, O’Malley AS. Hospital Payment Systems: Will Payers Like the Future Better Than The Past? Health Affairs. 2006; 25(1): 81-93.

*Does the payment method promote or require bundling of cost types?*

Fee for service payments typically treat all cost types as independent expenses and thus individual fees are paid for each cost type and service. Depending on the structure of episode-based and global payment models, cost types can either be treated independently (as in the case of hospital DRG payments or monthly payments to a pharmacy benefit manager) or bundled together, such that a single payment covers multiple or even all cost types for a particular patient or condition. While fee for service requires little organization or coordination between health care providers, administration of prospective bundled payments is more complex. Bundling payments across cost types may require the formation of new organizational structures to appropriately divide payments among providers. Based on early experience with prospective bundled payments in Medicare, the Government Accountability Office (GAO) and MedPAC have endorsed expansion of Medicare’s partially bundled payments. Other experts have also cited the development of bundled payments as an approach likely to result in significant cost savings.<sup>20</sup> Medicare’s bundled payment program incorporates several key elements:<sup>21</sup>

- A specific scope or “basket” of services that has a defined unit of payment;
- Case-mix adjustments<sup>22</sup> that reflect differences in resource requirements based on patient condition;
- Geographic adjustments that reflect variation in costs by geographic region;
- Adjustments based on provider/facility characteristics;
- Contracting with organizations with the operational, administrative, and systems capacity to adopt bundled payment;
- Provider education;
- Establishment of initial payment rates and a process for payment rate updates;
- Encouragement of providers to more efficiently render service.

*Does the payment method consider long-run and indirect costs?*

Fee for service payments pay providers for the cost incurred at the time of service. This portion of the overall cost of care is referred to as short-run direct cost. However, the overall cost of care is also comprised of a variety of other costs: short-run indirect costs (the cost of lost productivity during recovery); long-run direct costs (future health care costs due to current care, or lack thereof); and long-run indirect costs (the cost of lost productivity in the future as a result of current care, or lack thereof). The total cost of care can be tabulated as the sum of short- and long-run direct and indirect costs:<sup>15</sup>

$$\begin{aligned} \text{Total cost} = & \text{Short-run direct costs} + \\ & \text{Short-run indirect costs} + \\ & \text{Present value}^{23} \text{ of long-run direct costs} + \\ & \text{Present value of long-run indirect costs} \end{aligned}$$

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<sup>20</sup> Hussey PS, et al. Controlling US Health Spending – Separating Promising from Unpromising Approaches. *New England Journal of Medicine*. 2009; 361(22):2109-2111.

<sup>21</sup> Leavitt MO. A Design for a Bundled End Stage Renal Disease Prospective Payment System. US Department of Health and Human Services. 2008. Available: <http://www.cms.hhs.gov/ESRDGeneralInformation/downloads/ESRDReportToCongress.pdf>.

<sup>22</sup> Case-mix adjusting is the process of grouping patients according to expenditure and resource utilization.

<sup>23</sup> The present value of a long-run cost takes into account future price inflation for a service.

To better understand indirect and long-run costs, consider an elderly patient who fails to receive a pneumonia vaccination. While not delivering a vaccine would reduce short run direct costs, if that patient contracts pneumonia at some point in the future, the total cost of care will increase due to the long-run direct costs of treatment for pneumonia as well as the long run indirect costs of lost productivity during the pneumonia episode and recovery.

Under a FFS system, providers have an incentive to increase some short-run direct costs but have no incentives to consider indirect or long-run costs. Episodic payments and capitation payments are designed to place providers at risk for managing long-run direct costs to varying degrees, though the time horizon for most episodic and global payments is relatively short (1 year or less). In many cases, the total cost of care is quite difficult to measure, as indirect costs may be non-monetary. For example, a mammogram detecting an early breast cancer will likely increase long-run direct costs due to cancer treatment. However, the total cost of care depends on the economic value placed on long-run indirect costs such as additional years of life and productivity created by the treatment of the cancer.

**Financial Risk** – Different methods of payment transfer greater degrees of risk from the payer to the provider. As shown in Figure 1, episode-based and some global payment methods require providers to assume “performance risk” associated with the efficiency of care delivery and the number of episodes of illness (e.g. hospitalizations in a patient with congestive heart failure) while a true global payment also expects providers to assume “insurance risk” associated with the prevalence or incidence of disease in the population (e.g. new diagnoses of cancer).

Table 2 demonstrates how the transfer of financial risk from payer to provider changes incentives for providers both in terms of patient selection and the rate of delivery of services (utilization). FFS payments transfer little risk to providers and create the greatest incentives to deliver more services. Episode-of-care payments transfer greater risk to providers and create incentives to deliver care efficiently within a particular “episode.” Condition-specific capitation creates incentives for providers to limit the number of “episodes” of care per condition.<sup>15</sup> Full capitation creates incentives for providers to prevent illness (depending on the duration of capitation contracts) and to treat any illness in an efficient manner. However, this also puts providers at risk if they treat populations that are sicker than average.

**Table 2. Impacts of Payment Method on Patient Selection and Utilization<sup>24</sup>**

<b>Payment Method</b>	<b>Trigger for payment</b>	<b>Impact on Patient Selection</b>	<b>Impact on Utilization</b>
FFS	Delivery of service	Almost none; sicker patients lead to greater volume, more intense service mix, or both	Providers try to lower their cost per service and deliver more services
Episode-based	Onset of treatment for diagnosed patient	Providers rewarded for selecting healthier patients within the definition of an episode	Providers must control the volume and intensity of each case
Global Payment	Enrollment or assignment to panel	Providers rewarded for selecting healthier patients for all types of conditions	Providers must control the volume and intensity for each patient

<sup>24</sup> Wallack SS, Tompkins CP. Realigning Incentives in Fee-for-Service Medicare. Health Affairs. 2003;22(4)59-70.

***Patient Condition Type*** – Four distinct categories of condition type should be considered when considering a method of payment:<sup>15</sup>

- **Major Acute Episode:** A patient typically requires several, often expensive, services within a short period of time (i.e. heart attack, stroke, major trauma, etc.).
- **Chronic Condition:** Routine care associated with a chronic condition but not care associated with an acute exacerbation of the condition. For example, regular check-ups and medication for an asthma patient would be included in this category, but a hospitalization resulting from failure of routine care would be a major acute episode.
- **Minor Acute Episode:** Self-limiting conditions or condition requiring minor or no treatment. This category includes conditions that could lead to more serious illness if left untreated (e.g. minor wounds, minor respiratory illness, etc.).
- **Preventive Care:** Services that are provided to prevent both chronic conditions and acute episodes (e.g. immunizations, counseling, etc.).

For each condition type, a specific payment method may have advantages in promoting optimal care. For example, episode-based payments may have advantages in major acute episodes where efficient, coordinated delivery of high intensity services is of primary importance to manage quality and costs. However, fee for service may have advantages for preventive care (assuming payment rates are high enough) where the goal of payment is to maximize appropriate utilization of preventive services and a long time horizon exists between the delivery of a service and anticipated cost savings.

***Value of Services and Performance Standards*** – A final consideration in selecting a payment method is whether the payment for a service reflects the value of the service to an individual or the population in terms of the quantity of health produced per unit cost. None of the three payment methods focus inherently on the health outcomes produced by a particular service when determining the level of payment for that service. FFS systems have been criticized for rewarding providers for rendering unnecessary or “low-value” services while paying poorly for or not at all for “high-value” services such as preventive or palliative care and care coordination. However, episode-based payments and global payments, if based on the historical costs and utilization patterns, may not inherently reduce the overuse of low value services or encourage the use of high value services. Regardless of the payment method, additional incentives or performance standards will likely be needed to create provider accountability for maximizing the delivery of high value care and avoiding the delivery of low value care. P4P adjunct payments are a major strategy to encourage providers to consider the value of services delivered, regardless of the dominant payment method.<sup>6</sup>

## **Payment Reform Proposals and Demonstration Projects**

*“Absolute simplicity is impossible, but relative simplicity – reducing the number of prices to negotiate – is imaginable.”<sup>19</sup>*

A number of proposals and ongoing demonstrations seek to improve on the dominant payment method of fee for service. In order to achieve the triple aim goals, many of these demonstrations seek to achieve the following goals:<sup>6,7,16,25,26</sup>

- Encourage providers to deliver care in a high-quality, efficient manner;
- Ensure the accurate valuation of provider services including care coordination and management work that is conducted outside of face-to-face patient visits;
- Support and encourage investment in health information technologies that will lead to improvements in efficiency and quality;
- Support coordination of care among multiple providers;
- Provide accountability and transparency;
- Not encourage or reward over-treatment or medically unnecessary procedures;
- Not encourage or reward under-treatment or exclusion of high-risk patients;
- Not reward provider errors or adverse events;
- Not encourage cost-shifting.

Although there is a high level of consensus on the goals payment reform should achieve, there has not been widespread adoption of payment methods successful at achieving these goals. The following paragraphs describes a variety of early payment reform efforts or proposals that seek to address the flaws in the current system.

*Rate Setting* – The wide variation of payment rates across payers and providers is beginning to gain attention.<sup>27,28</sup> Uniform rate setting would require all payers to adopt similar payment rates and methods (including for self-pay patients). All rates would be publicly available and updated periodically to reflect annual fluctuation in productivity and per-unit costs. It is estimated that uniform adoption of Medicare rates would result in national, system-wide savings of \$23.1 billion over 5 years.<sup>6</sup> Although there is great potential for savings, implementation of this payment system would result in a reduction in income for many providers, especially those who have limited their exposure to Medicare and Medicaid or currently have high reimbursement rates.

*Evidence-Informed Case Rates (ECR)* – The Prometheus Payment® model is based on evidence-informed case rates (ECR): single, risk-adjusted, prospective payments shared between multiple providers for an episode of care for a patient with a particular diagnosis (e.g. hospitalization and post-hospital care for a heart attack).<sup>9</sup> In the Prometheus model, a portion of the ECR is withheld and re-distributed based on provider performance. The goal of ECRs is to create provider accountability for performance risk through the utilization of payment-linked

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<sup>25</sup> Patient Centered Primary Care Collaborative. A New Physician Payment System to Support Higher Quality, Lower Cost Care Through a Patient-Centered Medical Home. May 2007. Available: <http://www.pcpcc.net/content/physician-payment-reform>.

<sup>26</sup> Rogers, JC. Strengthen the Core and Stimulate Progress: Assembling Patient-Centered Medical Homes. *Family Medicine*. 2007;39(7):465-468.

<sup>27</sup> Reinhardt UE. A Modest Proposal on Payment Reform. July 24, 2009. Health Affairs Blog. <http://healthaffairs.org/blog/2009/07/24/a-modest-proposal-on-payment-reform/>

<sup>28</sup> Office of Massachusetts Attorney General Martha Coakley. Examination of Health Care Cost Trends and Drivers. March 16, 2010. [www.mass.gov](http://www.mass.gov)

performance standards but shield providers from insurance risk through risk-adjustment of payments. ECRs have a number of limitations, chiefly the need for an integrated delivery system capable of dividing payments among providers and applicability to a relatively small number of condition-specific “episodes.”

*Acute Care Bundled Payments* – In January 2009, CMS announced a demonstration project implementing global bundled payments for certain acute care cardiac and orthopedic conditions.<sup>29</sup> In the demonstration, a bundled payment to demonstration sites will cover all Medicare Part A and Part B services for hospital care and associated care 30 days following discharge. If broadly implemented, bundled payments have been estimated to reduce national health spending from 0.1 to 5%.<sup>20</sup>

*Global Payments for Primary Care* – Some authors have proposed moving to a system of risk adjusted global payments for primary care.<sup>30</sup> Under this approach, a single payment in the range of \$500 per patient per year would cover all expenses including salaries that are associated with a primary care practice. A portion of such a payment could be performance or outcomes based and paid as a bonus for achieving predetermined goals. This payment model would create stability for primary care providers and create a funding stream for care coordination and other primary care services not covered under fee for service. However, unlike total capitation, global payments for primary care would not place primary care providers at financial risk for charges from hospitals or specialists.

*Accountable Care Organizations (ACOs)* – An ACO, as described by Fisher, is a virtual organization composed of local hospitals and the physicians that work within and around them.<sup>31</sup> Other authors have described ACOs as centered around groups of primary care providers but involving hospitals and specialists.<sup>32</sup> Regardless of the organizational structure, ACOs would serve as a locus of accountability for driving efficiency and quality improvement in a community’s health care system. The ACO would make all data pertaining to cost, resource utilization, and performance publicly available. The community would then be able to hold the organization accountable for using its resources in the most efficient and effective manner. ACOs could receive FFS payments, but would also have the capability to receive episode-based or global payments. Some authors have suggested that an ACO would need to have a significant patient population and an adequate network of providers, especially primary care to be effective at managing risk and improving efficiency.<sup>33</sup>

*Blended Payment Models for Primary Care Homes* – A number of states and private sector payers have implemented “medical home” demonstration projects that pay primary care clinics recognized as medical homes a combination of fee for service, prospective care management

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<sup>29</sup> Medicare Acute Care Episode Demonstration. Press Release and Fact Sheet. January 6, 2009. [www1.cms.gov](http://www1.cms.gov)

<sup>30</sup> Goroll AH, Berenson RA, Schoenbaum SC, et. al. Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care. *Journal of General Internal Medicine*. 2007; 22(3): 410 – 415.

<sup>31</sup> Fisher EM, Staiger DO, Bynum JPW, et. al. Creating Accountable Care Organizations: The Extended Hospital Medical Staff. *Health Affairs*, web exclusive. 2007; 26(1): w44-w57.

<sup>32</sup> Miller HA. How to Create Accountable Care Organizations. Center for Healthcare Quality and Payment Reform. September 2009. [www.chqpr.org](http://www.chqpr.org)

<sup>33</sup> Fisher ES, McClellan MB, Bertko JB, et al. Fostering Accountable Health Care: Moving Forward in Medicare. *Health Affairs*. 2009;28(2):w219-w231.

payments (either in a single annual sum or monthly payments based on either the number of providers or the number of patients in the clinic panel) and performance bonuses based on quality or other process measures. Early results from various pilots suggest that while this model may result in increased primary care costs, it can produce improvements in quality measures, higher provider and patient satisfaction, reduced utilization of the hospital and emergency room and reductions in the total cost of care.<sup>34,35,36,37</sup>

*Pay for Performance Models* – Both public and private payers have developed a wide variety of experience with pay for performance models. While there is some uncertainty about the overall effectiveness of some P4P approaches, it seems clear that this strategy will be a component of any payment reform. A few key P4P demonstrations are highlighted below:

- *CMS /Premier Hospital Quality Incentive Demonstration* – The Centers for Medicaid and Medicare Services/Premier Hospital Quality Incentive Demonstration (HQID) project is a collaborative P4P effort consisting of over 250 hospitals around the United States.<sup>38</sup> The explicit goal of this project is to determine if “economic incentives are effective at improving the quality of inpatient care.”<sup>39</sup> Between October 2003 and June 2007, hospitals were measured on their attainment of composite quality scores (CQS) for several clinical conditions. Bonus payments were paid to each hospital based excellent or improving performance. Bonuses were offset by reductions in payments to low performing hospitals. The hospitals participating in the P4P program as well as the control hospitals that did not implement a P4P system showed improvement in each of the measured areas of quality. However, hospitals with the P4P program showed significantly greater improvement when compared to the control hospitals in 7 out of 10 individual measures. On average, the median hospital cost per patient in the P4P hospitals declined by over \$1,000 during the span of the demonstration, and the median mortality rate decreased by 1.87%.<sup>6</sup>
- *SoonerCare Choice* – *SoonerCare Choice* is a primary care case management (PCCM) program in Oklahoma that provides health care for low-income, Medicaid-eligible, pregnant women; children; and the SSI-eligible population. Its P4P program provides bonus payments, averaging approximately \$2,800 per provider, to physicians for completing early periodic screening, diagnostic, and treatment requirements for children (EPSDT). Since program implementation in 1997, the state has seen its EPSDT rates improve by over 20%. The state funds its program by designating \$1 million per year for bonus payments.<sup>13</sup>

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<sup>34</sup> Reid RJ, Fishman PA, Yu O, et al. Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation. *The American Journal of Managed Care*. 2009;15(9):e71-e87.

<sup>35</sup> Paulus RA, Davis K, Steele GD. Continuous Innovation in Health Care: Implications of the Geisinger Experience. *Health Affairs*. 2008;27(5):1235-1245.

<sup>36</sup> Gabbay R. The Pennsylvania Multi-Payer Statewide Medical Home Model. Presentation at the National Medical Home Summit, March 2, 2010. [www.medicalhomesummit.com/agenda/day2.html](http://www.medicalhomesummit.com/agenda/day2.html)

<sup>37</sup> Ward RE/ The Michigan BCBS-Provider Partnership. Presentation at the National Medical Home Summit, March 2, 2010. [www.medicalhomesummit.com/agenda/day2.html](http://www.medicalhomesummit.com/agenda/day2.html)

<sup>38</sup> Premier, Inc. Hospital quality improving, cost, mortality rate trends declining for participants in Medicare Pay for performance Project. January 31, 2008. Available: <http://www.premierinc.com/about/news/08-jan/performance-pays-2.jsp>

<sup>39</sup> Lindenauer PK, et al. Public reporting and Pay for Performance in Hospital Quality Improvement. *New England Journal of Medicine*. 2007; 365(5): 486-491.

- Excellus/Rochester Individual Practice Association – The Excellus/Rochester Individual Practice Association (RIPA) Rewarding Results Initiative is a collaboration between a health plan, Excellus, and a physician group, RIPA. Excellus provides shared savings programs that give financial contributions to the RIPA Value of Care plan, a P4P program. RIPA contributes approximately 10% of its total capitation from Excellus to the P4P program. The average return for a RIPA primary care provider ranges between \$4,000 and \$12,000 dollars. The Excellus/RIPA program was the first rewarding results initiative, a national grant-awarding program to help purchasers and health plans align incentives for high quality health care, to realize a positive return on investment (Table 3).<sup>13</sup>

**Table 3. Excellus/RIPA Return On Investment Calculations – Diabetes and Coronary Artery Disease**

	2003	2004
<b>Expenses:</b>	\$1.15 million	\$1.15 million
<b>Savings on trend:</b>	\$1.90 million	\$5.80 million

ROI:	1.6:1	5.0:1
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- Integrated Healthcare Association* – The Integrated Healthcare Association (IHA) P4P project is a collaborative that includes 7 California health plans, 225 physician organizations, and over 35,000 physicians. The participating health plans have developed a uniform performance measure set that covers clinical quality, patient satisfaction, and investment in information technology. Since its implementation, the health plans have seen a 40% increase in patient visits and reduced hospitalizations. Furthermore, between 2003 and 2005, the mean medical group performance for breast cancer screening increased by 4%, cervical cancer screening increased by 6.9%, and HbA1c screening for diabetics increased 7.6%.<sup>13</sup>

- *Bridges To Excellence* – Bridges to Excellence (BTE) is an employer-driven P4P program that recognizes providers delivering high quality cost-effective care for 11 different chronic conditions.<sup>40</sup> BTE has been implemented in a variety of states. BTE has a suggested reward structure (Table 4); however, it is up to the individual health plan to determine the actual reward amounts.

**Table 4. Bridges to Excellence Suggested Provider Reward Structure**

Level of PRO Recognition (per patient per year)	Level I	Level II	Level III
Physician Office Link	\$15	\$30	\$50

<sup>40</sup> Bridges to Excellence. BTE Reward Administration Guidelines. 2007. Available: [http://www.bridgestoexcellence.org/Documents/BTE%20Reward%20Administration%20Toolkit\\_122707.pdf](http://www.bridgestoexcellence.org/Documents/BTE%20Reward%20Administration%20Toolkit_122707.pdf).

Diabetes Care Link (in POL regions / in non-POL regions)	\$80 / \$100	\$160 / \$200	N/A
Cardiac Care Link (in POL regions / in non-POL regions)	\$80 / \$100	\$160 / \$200	N/A
Spine Care Link	N/A	\$50	N/A

- Concerns and Limitations of P4P programs* – While there is general consensus that P4P programs are an effective strategy for improving the quality of care, there are several potential pitfalls that must be considered when implementing P4P. First, P4P programs have typically been limited to particular payers, and thus can be cumbersome to clinics. Encouraging payers to use the same quality measures would unify the system and simplify

payers to use the same quality measures would unify the system and simplify the reporting process for providers. Second, P4P programs have tended to focus on individual providers and not performance across the health care system. Measurement systems that focus on individual providers rather than the larger system risk reinforcing the fragmentation and lack of coordination already inherent within our health care system.<sup>41,42</sup> Third, it has also not been overwhelmingly documented that improvement in selected quality measures leads to better clinical outcomes, and there is some concern that P4P incentives could encourage providers to focus on the tasks that are explicitly rewarded to the detriment of those that are not.<sup>42</sup> Fourth, there is great uncertainty regarding the optimal size of P4P payments to both compensate for the collection of data and motivate change in the way providers care for patients.<sup>41</sup> Fifth, using an absolute level of performance as opposed to performance improvement to measure quality may unintentionally penalize providers that have fewer resources and poorer baseline performance.<sup>19</sup> And lastly, if physicians are not convinced that appropriate risk adjustment is being performed, they may avoid treating sick or challenging patients in order to achieve high quality scores and earn P4P bonuses.<sup>41</sup>

## **Recent State Approaches to Payment Reform**

*Massachusetts* – In 2008, the Massachusetts legislature created a special commission to develop a statewide strategy for comprehensive payment reform. The committee underwent an extensive review of payment methods and considered a number of strategies, with extensive input from a wide variety of stakeholders. The report of the committee was released in June 2009, and contained a strong recommendation that the state transition to a system of global payments over the next five years. The commission recommended that a reformed payment system would contain the following features:<sup>43</sup>

- The development of Accountable Care Organizations (ACOs);
- Patient-centered care and a strong focus on primary care;
- Patient choice with payments to ACOs following the enrollee’s choice of a PCP;
- Use of pay for performance (P4P) incentives to ensure appropriate access to care, and to encourage quality improvement, evidence-based care, and coordination of care among providers and across sites of care;
- Participation by both private and public payers to ensure alignment of financial incentives for providers treating patients covered by different payers;
- Sharing of financial risk between ACOs and carriers;
- Strong and consistent risk adjustment;
- Cost and quality transparency; and
- Widespread adoption of the medical home model.

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<sup>41</sup> Fisher ES. Paying for Performance – Risks and Recommendations. *New England Journal of Medicine*. 2006; 355(8): 1845-1847.

<sup>42</sup> Rosenthal MB, Fernandopulle R, Song HR, et al. Paying for Quality: Providers’ Incentives for Quality Improvement. *Health Affairs*. 2004;23(2):127-141.

<sup>43</sup> Recommendations of the Massachusetts Special Commission on the Health Care Payment System. July 2009.

**Minnesota** – The Minnesota legislature passed major health reform legislation in 2008. The legislation called for payment reform proposals across a number of areas:<sup>44</sup>

- *Pay for Performance* – building on its statewide quality reporting data, the state has developed a proposed methodology for quality incentive payments for ambulatory providers and hospitals, to be implemented starting in July 2010 in the Minnesota DHS and the Minnesota State Employees Group Insurance Program (SEGIP) populations.
- *Health Care Home Payments* – the state has developed a process to certify clinics as health care homes as well as a payment methodology that will allow providers to bill for periodic “care coordination” payments based on a patient’s medical complexity. Prospective payments for care coordination would be in addition to regular fee for service payments and are scheduled to be implemented in the DHS and SEGIP populations in July of 2010.
- *Provider Peer Grouping* – the state has developed a methodology for public comparison of peer-groups of providers on quality and cost and is developing incentives to encourage enrollees to choose high quality low cost providers. Incentives are anticipated to be implemented in January of 2011.
- *Bundled Payments* – the state is developing “baskets of care” and bundled payments for asthma, diabetes, low back pain, obstetric care, total knee replacements and preventive care for adults and children.

**Colorado** – In 2008, the Colorado Blue Ribbon Commission for Health Care Reform recommended that Colorado restructure its health care system to provide a medical home for all its citizens.<sup>45</sup> It recommended paying providers for care coordination and case management, while also paying providers based on their use of care guidelines, quality performance measures, and the use of health information technology. Moreover, it called for increasing Medicaid provider reimbursement to at least 75% of the Medicare reimbursement rates. The Commission formulated its final recommendations based on the analysis of five health care reform proposals submitted by various agencies, including one from the Commission itself. Each plan had varying suggestions for setting provider rates both within the Medicaid and CHIP programs and for private insurers. The savings projected in the Solutions for a Healthy Colorado plan are achieved primarily achieved by mandatory reductions in hospital payments for the privately insured.

**Vermont** – The Vermont Blueprint for Health implemented primary-care focused health care reform starting in 2007.<sup>46</sup> The Blueprint for Health reforms center around the development of Patient Centered Medical Homes supported by Community Health Teams (CHT). Payments are both through direct funding of CHTs and a blended payment to medical home clinics. In addition, the state Health Care Reform Commission has proposed development of accountable care organizations to promote greater accountability and efficiency within the health care system.

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<sup>44</sup> Minnesota’s Vision for a Better State of Health: Quality Cost and Payment Reform. Accessed April 2010. <http://www.health.state.mn.us/healthreform/payment/index.html>

<sup>45</sup> Blue Ribbon Commission for Health Care Reform. Final Report to the Colorado General Assembly. January 31, 2008.

<sup>46</sup> Vermont Blueprint for Health 2009 Annual Report. January 2010. <http://healthvermont.gov/blueprint.aspx>

The development of ACOs is currently being evaluated and would complement the work the state has already completed under its Blueprint for Health.<sup>47</sup>

### **Payment Reforms in Federal Health Care Legislation**

While recently passed Federal health care legislation does not contain a comprehensive approach to payment reform, a number of provisions will impact payment for health care services and new opportunities for federal grants and payment reform demonstration projects will complement state reforms. Key payment reform provisions included in the Federal legislation include the following:<sup>48</sup>

- *Increases in Payment for Primary Care and General Surgery* (starting in 2011) – 10% increase in certain codes for Medicare payments for primary care providers and general surgeons (in shortage areas) and an increase in Medicaid payments for primary care to Medicare levels for certain codes billed by primary care providers.
- *Medicaid Medical Home Payments* (2011 or later) – 90/10 federal match for clinics participating in state pilots focused on Medicaid recipients with 1 or more chronic conditions. 90/10 match to start in 2011 and continue for 2 years from the date of CMS approval of an amendment to the state’s Medicaid plan.
- *Other Opportunities for Pilot Projects and Demonstrations* (2011 or later) – creation of a variety of competitive federal grants for states seeking to test payment reform models in Medicaid or Medicare populations, including:
  - Development of Pediatric Accountable Care Organizations
  - Development of community health teams to support medical homes
  - Development of home care models (Medicare)
  - Development of Accountable Care Organizations (Medicare)
  - Development of bundled payment models for certain conditions

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<sup>47</sup> Vermont Health Care Reform Commission. Vermont Pilot of Community Based Payment Reform: Accountable Care Organization. March 7, 2008.

<sup>48</sup> Patient Protection and Affordable Care Act and Education Reconciliation Act. March 2010. US Congress.

## **Conclusion**

The current structure of payment for health care services, based primarily on a fee for service model, is not sustainable and does not support the triple aim goals of the Oregon Health Policy Board and Oregon Health Authority. Thus, the primary method of payment for health care must migrate towards one that rewards providers for quality, efficiency and improving health outcomes.

Although many examples of payment reform have been tested in various settings, much remains to be learned about the best payment method and health care delivery system to support the triple aim goals. New payment structures must take into consideration the cost of care, differences in patient populations and the severity of illness as well as the setting in which care is delivered and the incentives needed to promote optimal care.

The Incentives and Outcomes Committee of the Health Policy Board has been tasked with developing policy proposals for health care payment reform in Oregon. This task involves both short term steps to build on existing work (such as the development of a payment model to support Patient Centered Primary Care Homes) and an overall long term framework to support broader payment reform across the health care system. While payment reform will clearly not fix all of the problems in Oregon's health care system, it is a significant and necessary step forward.

## **Appendix A: Sample Principles and Goals to Guide Payment Reform Discussions**

### ***Oregon’s “Triple Aim” for Transforming the Health System (The Oregon Health Authority)<sup>1</sup>:***

1. Improve the lifelong health of all Oregonians,
2. Increase the quality, reliability, and availability of care for all Oregonians, and
3. Lower or contain the cost of care so it is affordable to everyone.

**Potential Goals and Design Principles for Payment Reform (The Oregon Health Fund Board's Delivery System Committee)<sup>4</sup>:**

*Payment Reform Goals (based on the triple aim):*

1. Improve population health and patient experience with care:
  - Reward providers for good health outcomes.
  - Improve coordination and management of care, especially for people with chronic disease and reward providers who care for patients with complex care needs and/or multiple chronic conditions.
  - Strengthen primary care and support delivery system redesign centered around the integrated health home model.
  - Encourage providers to care for all patients, regardless of health status.
  - Encourage patient choices that improve adherence to recommended care processes, improve outcomes and reduce the costs of care.
  
2. Incentivize providers to be more accountable for delivering high-quality, efficient care:
  - Enable and encourage providers to deliver high-quality, efficient, patient-centered care that is based on best available evidence and aligned with guidelines endorsed by the Quality Institute.
  - Incentivize providers to be responsible for quality and costs within their control.
  - Incentivize behavior that leads to improved population health, as well as better quality and more efficient care.
  
3. Control Costs
  - Identify areas of excess spending for fiscal opportunities to redeploy funds in areas where evidence demonstrates positive effects on population health.
  - Reduce overall health care spending.
  - Increase competition based on quality, efficiency, patient-centeredness and value of care provided.
  - Reward providers who innovate in finding ways to deliver health care that result in higher quality and lower cost care.
  - Move toward a system that encourages providers to reduce per capita spending through better coordination.
  - Align standards and methods of payments across the delivery system to minimize the administrative costs for providers in complying with multiple payment system requirements.

*Payment Reform Design Principles:*

- Develop a mechanism to increase the public transparency of prices for health care services.
- Reduce administrative burden.
- Include providers in the design process in order to develop an effective design.
- Place higher value on primary care, case management and other cognitive services.
- Fairly reimburse providers for delivering services, for which they are currently not compensated, that increase quality and improve patient experience, including but not limited to:

- Telephone and email communication;
  - Pharmacist medication management;
  - Behavioral health counseling;
  - Palliative care services; and
  - Conversations with patients about their goals of care and advance directive and POLST (for patients with advanced chronic disease) preferences.
- Develop a staged plan to allow for differences in provider and plan capacity to move to new payment models. The system should be continuously updated with the goals of developing a system that rewards providers who meet specific quality and efficiency targets, take responsibility for managing and coordinating patient care and follow evidence-based guidelines.
  - Adjust payment for risk based on incidence of illness in a given population.
  - Ensure a majority of providers and payers participate in payment reform so the system is efficient and cost-effective.
  - Evaluate the effect of new payment strategies on total health care spending and the goals of improved quality, efficiency and care coordination.

*Payment Reform Principles (Massachusetts Special Commission on Health Care Payment)<sup>43</sup>:*

1. As currently implemented, fee-for-service payment rewards service volume rather than outcomes and efficiency, and therefore other models should be considered.
2. Health care payments should cover the cost of efficiently provided care, support investments in system infrastructure, and ensure timely access to high quality, patient-centered care. Additional payment should reward and promote the delivery of coordinated, patient-centered, high quality health care that aligns with evidence-based guidelines where available, and produces superior outcomes and improved health status. Performance measurement should rely on reliable information and utilize uniform, nationally accepted quality measures.
3. Provider payment systems should balance payments for cognitive, preventive, behavioral, chronic and interventional care; support the development and maintenance of an adequate supply of primary care practitioners; and respond to the cross-subsidization occurring within provider organizations as a result of the current lack of balance in payment levels by service.
4. Differences in health care payments should reflect measurable differences in value (cost and quality). Payments should be adjusted for clinical risk and socio-economic status wherever technically possible, and should promote greater equity of payments across payers and providers, to the extent that this is financially feasible.
  - a. Differences in health care payments should be transparent, including across different payers.
  - b. Costs associated with desired investments in teaching and research should be paid outside of base payments, and should require provider accountability for how such payments are spent.
  - c. Costs associated with desired investment in special “stand by” capacity should be accounted for in the payment system.
5. The health care payment system should be structured in such a way as to minimize provider, payer and patient administrative costs that do not add value.
6. Payment reform must consider how:
  - a. Some payment methods may require certain organization of the service delivery system,
  - b. Health benefit designs either support or limit payment reform.
7. Health care per capita costs and cost growth should be reduced, and providers, payers, private and public purchasers and patients should all share in the savings arising from payment reform.
8. The health care payment system should be transparent so that patients, providers and purchasers understand how providers are paid, and what incentives the payment system creates for providers.
9. It will be necessary to consider the diversity of populations, geography and providers across the Commonwealth when designing payment reform to ensure high quality, patient-centered care to all populations and geographic regions in the Commonwealth.
10. Implementation should be phased over time with:
  - a. Clear and attainable deadlines;
  - b. Planned evaluation for intended and unintended consequences; and
  - c. Mid-course corrections.