NEJM Catalyst

September 2017

The New Marketplace of Health Care: Impacts and Incentives of Payment Reform

A collection of original content from NEJM Catalyst

NEJM GROUP

NEJM Catalyst

September 2017

Dear Colleague,

When will pay-for-performance take hold as a true business model for health care? Most providers welcome the shift away from fee-for-service reimbursements, which they widely recognize as producing perverse incentives for procedural volume. But the changeover has been slow in coming—far slower than many expected, despite specific mention of value-based payment in the Affordable Care Act.

Payment reform and the lack thereof underlie many of the moves in recent years made by provider organizations, payers, regulators, pharmaceutical firms, and even patients. The enclosed collection of original content from NEJM Catalyst shows how these various segments seek to understand the changing marketplace and chart a sustainable path forward. Read about the strategy map of an integrated health system, Intermountain Healthcare, as it prepares for the inevitability of value-based care; how an independent orthopedic physician group saw an opportunity with bundled payments; and how academic health systems, which may be may be at a structural disadvantage under alternative payment models, nonetheless can position themselves for the future. Read federal regulators' account of the painstaking progress toward payment reform and of the lessons to date from episode-based payments; an informed take on how to trigger the tipping point in payment reform; and a conversation among health care economists, including Leemore Dafny, PhD, professor at Harvard Business School and NEJM Catalyst's Theme Leader for New Marketplace content, on who will win and lose under alternative payment models. Hear a call to let efficient providers prosper and another to bring Big Pharma into value-based payment calculations, read how physician payment is changing under MACRA, and study an NEJM Catalyst Insights Report on how physicians and hospitals choose to cut costs.

Through daily digital publication, monthly Insights Reports, and quarterly live-streamed events, NEJM Catalyst offers original content, expert dialogue, and insightful analysis. We invite you to join NEJM Catalyst and stay informed on how the new marketplace of health care is changing.

The Editors,
NEJM Catalyst

781.893.3800 | CATALYST@NEJM.ORG
860 WINTER STREET, WALTHAM, MA 02451-1413 USA | catalyst.nejm.org

NEJM Catalyst

September 2017

The New Marketplace of Health Care: Impacts and Incentives of Payment Reform

Turning Value-Based Health Care into a Real Business Model

Article · October 24, 2016

Thomas H. Lee, MD, MSc & Laura S. Kaiser, FACHE, MBA, MHA

Press Ganey Associates, Inc.
Intermountain Healthcare

The shift from volume-based to value-based health care is inevitable. Although that trend is happening slowly in some communities, payers are increasingly basing reimbursements on the quality of care provided, not just the number and type of procedures. But because most providers' business models still depend on fee-for-service revenues, reducing volume (and increasing value) cuts into short-term profits. How, then, are innovative providers redesigning care so that, despite financial pain in the short term, they achieve long-range success?

Let's start with four examples from the front lines of care and then step back to see what deeper strategic advantages all of them have in common.

At Intermountain Medical Group clinics, mental health care is integrated with primary care as a default practice, first piloted 15 years ago. All primary care patients undergo mental and behavioral health screening, and they get appropriate follow-up with counselors, often at the same location. The clinicians collaborate in the same way for all patients, whether or not Intermountain's health plan is the insurer. As a result, patients are receiving coordinated behavioral care, and their outcomes are improving. Costs per member are now $22 higher up front but are also $115 lower overall annually, because of reductions in ER visits and other care. In the current fee-for-service environment, Intermountain obtains those long-term savings for the minority of patients for whom it is the payer, but other payers reap the rewards for most patients.

At Mayo Clinic, surgeons who perform lumpectomies or partial mastectomies for breast cancer work *during* the operation with the Frozen Section Pathology Lab to determine whether all the cancer has been removed. Such microscopic analysis of frozen-tissue samples can take 24 hours or more at some hospitals, but Mayo achieves it in, say, 20 minutes while

the surgery is in process. Yes, 20 minutes is valuable extra time in an operating room while the surgeon and staff wait for pathology findings. But Mayo doesn't do it just to get results to a patient 23 hours sooner. The main benefit is the on-the-spot chance to extend the surgical excision, if needed, to remove all evidence of cancer. That approach eliminates the need for repeat lumpectomy in about 96% of patients. In a study of five years of lumpectomy data, the 30-day reoperation rate was 3.6% at Mayo in Rochester, Minnesota, compared with 13.2% nationally. The result: Mayo's costs for surgery are higher in the short term, and it earns less revenue from follow-up operations. But it reduces overall medical costs, and the patient gets peace of mind more quickly.

> *We see a compelling business case for acting now to achieve value-based care without worrying about when the market will make the shift."*

The American College of Radiology (ACR), in 1993, developed clinical practice guidelines for radiologic services. Some of the task force leaders came from Boston's Brigham and Women's Hospital, which subsequently introduced its own internal radiology prior-authorization program — for all patients, regardless of payer. The hospital's computerized order-entry system now compares imaging requests with the patient's medical record, allowing physicians to check for prior imaging and to see whether the new request jibes with current ACR guidelines. The system improves patient safety and outcomes, but it slows down and irritates physicians who are trying to order a test. Revenue has also taken a hit as so-called "low-value" tests have declined (for instance, CT chest scans for pulmonary embolism fell by 20%). In addition, patients whose images were imported from other hospitals had a 17% lower rate of new diagnostic imaging, compared with patients whose prior images could not be obtained. The result: more-appropriate use of radiology tests for all patients, but crankier physicians and forgone revenue. Insurance companies were the major financial beneficiaries for almost all patients.

And Intermountain Healthcare initiated a care-process model for febrile infants in 2008, including guidelines for the use of physical exams, lab tests, antibiotics, and discharge criteria. As a consequence, more infants with urinary tract infections or viral illnesses were identified and appropriately treated, and fewer infants at low risk for serious bacterial infections received antibiotics unnecessarily. Infant outcomes improved, hospital stays shortened with no increase in readmissions, and overall costs declined. Intermountain made a major investment even though one of the results was lower patient revenue.

Acts of Strategy

In all four examples above, the organizations' short-term financial hits were real and painful. Nevertheless, we don't consider these efforts to be acts of charity but acts of strategy. What specific strategic elements do they share?

> *The organizations that have been shifting their strategies toward value-based care generally share certain advantages: financial stability, positive relationships with physicians, advanced information systems, and (often) affiliation with a health plan."*

First, in each example, the provider organization used process improvements to boost quality of care for patients: better outcomes, an enhanced care experience, lower anxiety, less wasted time, and fewer health risks. When the results became clear, each effort also fostered pride and teamwork, thereby reducing employee turnover.

Second, the organizations decided that improving value was more important than short-term fee-for-service profit. They made investments — and often disrupted the habits of their staff — because they recognized that a business plan based on value was the right kind for their patients.

Third, they decided not to game the system by targeting only patients in contracts that would yield financial rewards. Instead, they understood that care redesign had to be of value for *all* patients, or it wouldn't happen reliably for *any*. They traded losses in some contracts for potential defection of some patients to other providers, greater professional pride, and a forward-looking strategy.

In short, we see a compelling business case for acting now to achieve value-based care without worrying about when the market will make the shift. Provider organizations that are leading the way cite the following reasons for their strategies:

1. *Sustainability.* Innovative providers aim to compete for and attract more customers with lower prices and higher-quality care and services. As value-based payments gradually replace the fee-for-service model, providers that have not adapted will be left behind.
2. *Experience in managing risk.* Providers who pursue value-based care as a strategy gain expertise in managing the risk of caring for a population under a prepaid budget. This includes recognizing and managing the full continuum of care, focusing on both prevention and intervention, and using evidence-based care practices to ensure appropriate utilization. Organizations that start sooner will be better positioned for success.

3. *Relationship building.* Learning to collaborate with stakeholder groups takes time. Health systems are seeking closer alignment with physicians and other staff (whether or not they employ them) who can help to achieve higher value in an evolving marketplace. Relationships also must be cultivated with social service agencies, government, and other provider organizations to address the complex medical and social needs of underserved populations, which often incur the highest costs.

4. *Lack of alternatives.* A business that delivers health care that patients don't need is pursuing a poor strategy. Providing relatively affordable, high-quality care is much less likely to fail as a strategy, not just with respect to the bottom line but also in terms of how an organization fulfills its mission. Persisting with an outdated model ultimately may lead to unacceptably high financial and public-relations costs, as payers shift their business to higher-value competitors whose approaches to care are perceived as more responsible and sustainable.

How to Emulate the Leaders

The organizations that have been shifting their strategies toward value-based care generally share certain advantages: financial stability, positive relationships with physicians, advanced information systems, and (often) affiliation with a health plan. Nevertheless, several providers that lack those advantages are making progress. The investment required is as much in leadership as in dollars.

For one, the push toward building relationships with stakeholder groups internally and in the broader community is largely one of will. The innovations of the pioneers are more replicable than you may think. For instance, to maintain high quality of care and reduce rehospitalizations for patients who are discharged to skilled nursing facilities (SNFs), Intermountain now requires that the SNFs have a minimum Medicare Star Rating of 3 (out of 5) and participate in both Medicare and Medicaid. Intermountain seeks a direct dialogue with the preferred-quality SNFs about how to improve care for patients with special or complex needs, such as those who require ventilators or have behavioral health issues.

Organizations can also begin to pay more attention to the changing marketplace and, using those observations, take concrete preliminary steps to change the way they provide care. For instance, many health systems have instituted telehealth services whereby patients can have an e-visit consultation with a doctor or an advanced practice clinician, any time of day or night, via an easy-to-use Skype-like interface. Telehealth's long-term effects on spending and quality have yet to be documented, but early results are promising. Health systems would do well to explore a variety of opportunities to deliver effective care in ways that acknowledge the changing consumer landscape.

The leading providers are taking an "all in" innovative approach as they do the hard work of developing new organizational competencies and nurturing cultural change from within. Their new high-value models will give them a clear advantage over institutions that fail to act strategically now.

Thomas H. Lee, MD, MSc
Press Ganey Associates

Dr. Lee is the Chief Medical Officer for Press Ganey Associates, Inc., a member of the Editorial Board of The New England Journal of Medicine, and the NEJM Catalyst Leadership Board Founder. Learn more about Thomas H. Lee...

Laura S. Kaiser, FACHE, MBA, MHA
President and Chief Executive Officer, SSM Health, St. Louis

Creating Physician-Owned Bundled Payments

Case Study · October 24, 2016

Daniel B. Murrey, MD, MPP

OrthoCarolina, North Carolina

At OrthoCarolina, a multi-site independent orthopedic physician group in the Charlotte area, we lowered cost by 10-30% and dramatically improved outcomes for hip and knee replacement surgery. We did this by creating a standardized coordinated care program and pairing it with commercial bundled payment contracts in which the surgeons took primary financial risk.

KEY TAKEAWAYS

1. Bundled payments can improve clinical outcomes, reduce variation in care pathways, and substantially lower the cost of joint replacement surgery.
2. Consensus-driven pathways, patient and family empowerment, and care navigation are key elements of success..
3. Private practice physicians can effectively manage performance-based episode-of-care risk.
4. It is possible to scale such a program and reproduce similar results at multiple sites.

The Challenge

The cost of hip and knee replacement in our large local health systems was high enough that local employers began incentivizing patients to choose narrow networks for surgery outside the state. The large local systems were not ready to enter into risk-bearing contracts or to lower their prices until a larger tipping point in the market was reached. Given that orthopedics is the specialty in which much new payment model experimentation is occurring, we knew that our practice would feel the impact of this pricing pressure long before our hospitals did. In addition, the rise of high deductible plans was causing patients to be more price sensitive and demand lower cost options from us as their surgeons.

The Goal

We sought to provide a competitively priced, high-quality local option for joint replacement, with predictably positive outcomes, while reducing the cost to patients and their employers.

The Execution

Creating a Quality Data Platform

No one wants low-cost, low-quality joint replacement, so we first needed a way to validate that results would be as good as, or better than, our current outcomes. We invested in technology that would allow us to collect patient-reported outcome measures (PROMs) electronically from patients, both pre- and post-op, at regular intervals. Our Quality Improvement (QI) Committee determined which measures to collect, and the QI staff coordinated collection of hospital-based data in addition to the patient-reported data from our new practice platform.

Reducing Variation through Consensus Protocols

All 26 surgeons who do a significant number of total joint replacements in our practice were invited to participate in a consensus process to create an evidence-based common care pathway and order set for knee and hip replacement. The group, working within our physician practice governance, was charged with eliminating anything that didn't add value to the patient's outcome or experience.

The process produced a much simpler care pathway for patients, eliminating many commonly used items that could not be proven to add value (continuous passive motion machines and urinary catheters, for example). At the conclusion, surgeons who desired to care for bundled payment patients were required to stipulate that they would use the consensus protocol and order set unless a specific clinical condition required deviation.

98%
patient satisfaction

Negotiating the Contracts

Without a willing hospital partner at the outset, we needed assistance to obtain cost data. We contracted with a consulting firm to determine the typical cost of joint replacement. We then compared it to the Explanation of Benefits from our employees who had joint replacements in each local system. The comparison revealed a significant opportunity for cost savings.

First one payer (Blue Cross and Blue Shield of North Carolina), and then a large regional employer, agreed to negotiate a rate for the entire 90-day prospective bundle directly with us, including stop-loss protections and exclusions to limit us to performance risk rather than actuarial risk.

"We would be responsible for negotiating a facility fee with the hospitals and a professional fee with physicians . . . physical therapists, and any other providers. We would function as the third-party administrator (TPA), responsible for payment to all participants."

We would be responsible for negotiating a facility fee with the hospitals and a professional fee with physicians (including anesthesiologists and radiologists), physical therapists, and any other providers. We would function as the third-party administrator (TPA), responsible for payment to all participants. Patients operated on in a facility where we had an agreement would be paid under the bundle; patients operated on elsewhere (or excluded for certain co-morbidities) would remain fee for service.

A 123-bed suburban community hospital, attracted by the ability to retain patients locally or even gain market share, agreed to participate contingent upon surgeon participation in cost reduction efforts within the service line. After achieving significant success at that institution (see metrics below), we created a new management company that replicated the program at three additional facilities.

Creating the Care Coordination Program

Based on the clinical pathway, we produced a Joint Journal for bundled patients and their families that explained every step, from initial visit to the end of their care episode. This engaged the family and patient, reduced any anxiety or uncertainty about the procedure or the process, and assured them that everything the surgeons agreed should happen actually did. Patients were assigned a navigator to accompany them through all phases of care, to be a first responder to direct quick resolution of any problems, and to ensure timely completion of all outcome measures.

Our business services, accounts payable, and value-based services teams collaborated to create the third-party administrator (TPA) function. Patients — who knew that they would be paying a single price for care within the 90-day episode — were given an OrthoCarolina Bundled Payment "insurance card" to use instead of their regular insurance card for any care during the bundled period, thus limiting inappropriate claim submission.

Partnering with the Hospital

Our four hospital partners to date each designated a team that includes nursing, quality, and administrative departments. This team collaborates with our Coordinated Care team to ensure all who interact with the patient or family are fully trained in the care pathways and expectations so that all care and communications are consistent. Weekly "huddles" ensure that issues are dealt with quickly and patient care processes are regularly updated and improved. Because the clinical process changes applied to all OrthoCarolina patients at that facility, the hospitals enjoyed the "halo effect" of savings and synergies for nonbundled patients.

Timeline

Approximately four years from initial research to our first broad commercial contract.

Metrics

Of the first 200 patients who underwent hip or knee replacement surgery in our commercial bundled payment program in four hospitals, we had 0% readmissions, 0% reoperations, 0.5% deep vein thrombosis, 100% discharged to home, 100% pain controlled. Length of stay dropped from 2.4 days to 1.5 days (compared to our prior patients in the same hospitals). Patient satisfaction, using our own survey, was 98%.

"Of the first 200 patients who underwent hip or knee replacement surgery in our commercial bundled payment program in four hospitals, we had 0% readmissions, 0% reoperations, 0.5% deep vein thrombosis, 100% discharged to home, 100% pain controlled."

PROMs, including VR-12 for quality of life and short-form HOOS for hips and KOOS for knees (measuring pain and physical function), all showed substantial improvement compared to pre-op. These improvements were comparable or better than their historical comparison groups. Because we used metrics of the National Orthopedic and Spine Alliance, we were able to compare our PROM results to NOSA's four other major joint replacement centers and found them to be statistically similar.

Payers report that their cost per patient has been 10-30% lower than before. The broad range may reflect differences in payments to facilities previously used by the payers.

In total, we've now negotiated shared savings contracts with two commercial payers, and prospective bundled payment contracts with 6 commercial payers or employers, in addition to participating in the CMS BPCI in 15 episode groups.

Where to Start

Seek a commitment to quality improvement first through systems-based change, and then use incentive-based contracts to drive individual behavior change. Reduce variation in care through consensus-building, collect meaningful outcome metrics, and create a governance process to review them collectively in a nonjudgmental learning environment.

Disclosure: Daniel B. Murrey is a shareholder in OrthoCarolina.

Daniel B. Murrey, MD, MPP
Orthopedic spine surgeon and since 2008, CEO of OrthoCarolina, one of the largest orthopedic practices in the U.S. with over 150 physicians and 1,400 employees in western North Carolina; also CEO of Transformant Healthcare Solutions, the management company that grew out of the OrthoCarolina experience with value-based care

One Path to Value-Based Care for Academic Health Systems

Article · September 12, 2016

Sachin Jain, MD, MBA, Michael M.E. Johns, MD & Jonathan S. Lewin, MD

CareMore Health System
Emory Healthcare

Academic medical centers (AMCs), perhaps more than any other health care organizations, are feeling the tension between fee-for-service and value-based care. Given their three-part mission (teaching, research, and patient care) and their role as tertiary referral centers for complex patients, AMCs may be at a structural disadvantage under alternative payment models. Nevertheless, many AMCs are affiliated with integrated delivery networks that have large primary-care and multispecialty-group practice footprints — networks that may thrive under value-based payment.

As many AMCs experiment with alternative payment models that have an underlying fee-for-service architecture, Georgia-based Emory Healthcare decided in August 2014 to move toward population-based payment by partnering with Anthem-owned CareMore Health System, a network-model health maintenance organization that operates Medicare Advantage plans and delivery sites across several states. The goal: Leverage Medicare Advantage's unique payment mechanisms to help Emory Healthcare edge closer to value-based care delivery.

> *Unlike fee-for-service Medicare, Medicare Advantage afforded the opportunity to experiment with a single delivery model and then engage multiple payers in the greater Atlanta market."*

Under the partnership, called Emory Healthcare Network Advantage, Emory assumes full responsibility for the care of Atlanta-area seniors who are enrolled in several Medicare Advantage plans. CareMore works with Emory to redesign clinical and care-coordination services for this population — specifically, to develop Emory Coordinated Care Centers, train and integrate "extensivist physicians" (who care for patients with multiple complex conditions), and adopt innovative technologies — modeled on CareMore's efforts in southern

California. Reimbursement is structured as a population-based, sub-capitation model: Medicare Advantage plan operators make a risk-adjusted, per-member, per-month payment to Emory Healthcare for beneficiaries who are enrolled in the Emory Healthcare Network Advantage shared-savings program.

Cataloguing the Advantages

Emory chose to leverage Medicare Advantage's payment features for several reasons:

Financial flexibility. Most alternative payment models are incremental by design. With some exceptions, Medicare and commercial payers continue to pay physicians on a fee-for-service basis, with year-end bonuses (or penalties) for performance on cost and quality targets. Although these structures shield physicians from the full financial risk of capitation, they also limit the capacity for innovation. Despite the promise of downstream savings, substantial up-front investments in care-management capabilities and digital infrastructure are required. Population-based payments in Medicare Advantage afford greater financial resources (given the 100% shared risk) and more freedom (related to prepayment) to invest in new clinical capabilities and experiment with new strategies, such as building care centers and hiring extensivist physicians.

A focus on high-risk patients. Emory Healthcare Network Advantage was designed to focus specifically on older adults who have, or are at risk for, chronic conditions such as diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). Medicare Advantage is well suited as a delivery and payment model for older high-risk patients, given the ability of special-needs plans (SNPs) to provide high-risk elders with benefits and clinical services specifically tailored to their clinical conditions (e.g., CHF, COPD). Both prepayment and 100% shared risk also allow a provider to invest in comprehensive clinical services and coordinate inpatient and outpatient care for the most vulnerable patients, such as the care that Emory Coordinated Care Centers provide. Finally, risk-adjustment methodology for Medicare Advantage payments does not penalize providers for focusing on high-risk, high-cost patients.

Alignment across payers. Unlike fee-for-service Medicare, Medicare Advantage afforded the opportunity to experiment with a single delivery model and then engage multiple payers in the greater Atlanta market. Although CareMore has experience operating Medicare Advantage plans, Emory deliberately decided not to offer its services through its own health plan and, instead, created a payer-agnostic delivery system in the Atlanta area. Emory Healthcare Network Advantage is now being offered to Medicare Advantage enrollees by the three largest commercial payers in the region — Humana,

8.9%

hospital readmission rate for patients enrolled in shared-savings plan and seen by an extensivist physician

Cigna Healthspring, and Blue Cross Blue Shield — and, likely, by another two insurers soon. These relationships are expected to streamline efforts to develop alternative-payment contracts for traditional commercial populations that these health plans serve. Specifically, the organizations are developing shared expectations about payment reform and making preliminary agreements regarding quality-measure benchmarks. Reflecting these benefits, Emory Healthcare has already signed an alternative-payment contract with Blue Cross Blue Shield.

Future positioning. As experiences with alternative payment models evolve, the most progressive approaches will move away from fee-for-service and toward population-based payment. Within Medicare, for example, current regulations suggest that population-based and capitated payments will become commonplace among Pioneer and Next Generation ACOs in three to five years. As this transition occurs, risk-adjustment and reimbursement structures will more closely resemble Medicare Advantage's structures than those of contemporary ACOs.

Tallying the Early Results

As of March 1, 2016, we have enrolled 13,511 patients under shared-savings contracts with Humana, Cigna Healthspring, and Blue Cross Blue Shield. Although Medicare Advantage currently represents only 14% of Emory's total business, we will gradually move more patients into managed Medicare products and expand the Medicare Advantage component. Medicare currently represents about 40% of our payer mix, and the Medicare Advantage share is growing.

Here are some of our notable results:

- Having a single operating model for all Medicare patients, rather than unique models for each Medicare Advantage payer and for traditional Medicare, has simplified processes for our primary- and specialty-care physicians.
- Emory Healthcare's primary-care capacity has increased because our PCP practices have fewer administrative responsibilities, making more time available for patients' acute visits to PCPs.
- For our shared-savings contract with Humana, signed in October 2015, our Emory-specific Medicare Star rating has risen from 3.18 to 3.54.
- Our hospital readmission rate for patients who are enrolled in the shared-savings plan and have been seen by an extensivist physician is 8.9%.

Facing the Challenges

Despite the strategic and operational advantages, using Medicare Advantage to edge close to value-based care poses challenges.

> *Population-based payments in Medicare Advantage afford greater financial resources and more freedom to invest in new clinical capabilities and experiment with new strategies."*

Member enrollment and communication. Many commercial and Medicare ACOs attribute patients to physician organizations and health systems on the basis of historical claims data, but members must proactively enroll in Medicare Advantage plans. The practice of engaging potential members and communicating the benefits of clinical program offerings is unfamiliar to most health systems, especially AMCs. Given that the Emory Healthcare Network Advantage program is offered across several payers, Emory has been able to draw on each payer's sales and marketing expertise. Even health systems engaged with only a single Medicare Advantage payer partners will be able to leverage this expertise.

Physician discomfort and organizational tensions. Bypassing modified fee-for-service comes with growing pains, as most physicians are still more comfortable with the fee-for-service system. Furthermore, the CareMore model's focus on team-based primary care and extensivist physicians for managing high-risk older patients may not align completely with the structure of, or strategies for, clinical service delivery at other health care systems. For example, the use of care centers and extensivist physicians reduced the frequency of patient visits to specialists at Emory. This very real challenge during the implementation of Emory Healthcare Network Advantage required — and continues to require — frequent, consistent messaging from senior leaders to lay out the vision and communicate benefits in terms that matter to doctors (e.g., improved patient outcomes). We are making real progress and expect to make more.

***

To be sure, Medicare Advantage is not the only payment model AMCs and other delivery systems can draw on to move toward value-based care. Nevertheless, it may be attractive to physician organizations and health systems that wish to expand their capacity for risk-based contracting, as we at Emory Healthcare Network Advantage have done.

We gratefully acknowledge the contributions of Leeba Lessin, Brian Powers, Sangita Vatave, and Anthony Nguyen.

Disclosure: Michael Johns was the Interim Executive Vice President for Health Affairs at Emory University from September 2015 – January 2016. The views expressed in this article are those of the authors and not necessarily the views or policies of their respective affiliated institutions.

Sachin H. Jain, MD, MBA

CareMore Health System

Sachin H. Jain, MD, MBA is President and Chief Executive Officer at CareMore Health System, an innovative health plan & care delivery system with $1.2B revenue & over 100,000 members in eight states. Learn more about Sachin H. Jain...

Michael M.E. Johns, MD

Emeritus President, Chief Executive Officer, and Chairman of the Board, Emory Healthcare

Jonathan S. Lewin, MD

President, Chief Executive Officer, and Chairman of the Board, Emory Healthcare

Progress and Path Forward on Delivery System Reform

Article · February 5, 2017

Sandra L. Fryhofer, AB, Meena Seshamani, MD, PhD, Karen B. DeSalvo, MD, MPH, MSc & Patrick H. Conway, MD, MSc

U.S. Department of Health and Human Services

Nearly 2 years ago, U.S. Department of Health and Human Services (HHS) Secretary Sylvia M. Burwell outlined a three-part vision to move health care to a more coordinated, person-centered system grounded in value-based payment. The HHS delivery system reform effort aimed to 1) realign incentives to pay for better patient outcomes and higher value, 2) advance care models that emphasize coordination and prevention, and 3) leverage health care data, including electronic health records and information on cost and quality of care, to improve patient care.

Since that time, the public and private sectors have made marked progress on this vision, setting and achieving goals for payment reform and establishing momentum for delivery system reform. The basic goals of delivery system reform — to promote quality and value in our health care system — remain at the core of bipartisan efforts in health care, and it is therefore essential that such efforts continue.

Realigning Incentives to Pay for Better Care

In January 2015, HHS announced new goals for moving Medicare away from paying for quantity of services and instead paying for quality, patient-centered care through alternative payment models: 1) 85% of all Medicare fee-for-service payment would be tied to quality or value by the end of 2016, and 90% by the end of 2018; and 2) 30% of Medicare payments would be tied to quality or value through alternative payment models by the end of 2016, and 50% by the end of 2018.

The Secretary also called for the entire health system to set similar goals. To that end, HHS launched the Health Care Payment Learning and Action Network, a public-private partnership focused on alternative payment model adoption. Today, more than 6,500 individuals — from leading providers, businesses, states, payers, and consumer groups — have signed on, including over 130 organizations that set their own individual goals.

> *"The basic goals of delivery system reform — to promote quality and value in our health care system — remain at the core of bipartisan efforts in health care, and it is therefore essential that such efforts continue."*

Created by the Affordable Care Act to test new payment and service delivery models, the Center for Medicare and Medicaid Innovation (Innovation Center) has piloted over 20 new payment models since 2010. Through accountable care organizations, medical homes, and bundled payments, HHS met the ambitious 2016 Medicare payment goals 11 months ahead of schedule, with 30% of Medicare payments in alternative payment models and 85% tied to quality or value as of January 1, 2016. Preliminary estimates from the Learning and Action Network indicate commercial payers and states are not far behind, with 25% of health care spending in alternative payment models as of January 2016.

These percentages are likely to grow as models are scaled. Models can be expanded more permanently in Medicare, through rulemaking, if they are found to meet one of three scenarios: better quality, lower cost (best scenario); better quality, same cost; or same quality, lower cost. Two models have satisfied the criteria for expansion so far: the Pioneer Accountable Care Organization and the Diabetes Prevention Program. These programs have demonstrated that they can improve patient outcomes and reduce costs to Medicare, making it imperative that they continue.

Importantly, there is bipartisan support in Congress for institutionalizing payment reform. In April 2015, Congress passed legislation modernizing how Medicare pays physicians and clinicians by creating two paths rewarding value: 1) in the Merit-Based Incentive Payment System (MIPS), clinicians are rewarded for high performance in four areas: quality, resource use, advancing care information, and clinical improvement activities; 2) in advanced alternative payment models, clinicians can be exempted from the MIPS program and instead receive a 5% lump sum bonus. The first rule for this program was finalized in October 2016 as part of the MACRA final rule (passed with bipartisan support) and received praise from Congress and health care stakeholders.

Advancing New Care Models That Support Coordination and Prevention

Equally important to payment reform are new innovations in care delivery. Partnership for Patients, a public-private partnership started in 2010, created a platform for hospitals to share best practices for patient care and safety. From 2010 to 2015, incidents of patient harm such as infections, falls, and traumas in hospitals fell 21% nationally, resulting in an estimated 3.1 million fewer hospital-acquired conditions and infections, 125,000 fewer patients dying in hospitals, and nearly $28 billion in cost savings. The Transforming Clinical Practice Initiative builds on this success, awarding $680 million to health care transformation networks to invest in peer-to-peer, evidence-based support and enabling over 140,000 clinicians to improve how they care for patients.

> *Over time, this empirical, learning approach will yield results for patients and providers, leading to a smarter, more effective health system in which they can thrive."*

The Centers for Medicare & Medicaid Services (CMS) has prioritized several primary care and prevention payment models that hold promise for advancing value-based care in the future. Earlier this year, CMS announced the Multi-Payer Advanced Primary Care medical home model, which could reach 20 regions across the nation, including more than 20,000 clinicians and 25 million patients. In March 2016, a Diabetes Prevention Program (DPP) model run by the YMCA became the first preventive service model to meet CMS' criteria for expansion in Medicare. By providing weekly counseling sessions on weight control and diabetes prevention, DPP reduced bodyweight by 5% and saved an estimated $2,650 per enrollee. The expanded model is set to begin in 2018 and aims to make services available for all Medicare beneficiaries, an important step toward achieving the goals of better care with smarter spending.

Leveraging Health Care Data to Improve Care

Progress in digitizing the health care experience of Americans is a fundamental enabler for improved care at lower cost. The HHS Office of the National Coordinator for Health IT (ONC) has focused on achieving widespread electronic health record (EHR) adoption and interoperability. By 2015, 96% of hospitals and 74% of physicians were using certified EHRs, and 82% of hospitals were able to exchange clinical data with outside providers, marking continued year-over-year progress. Last spring, major health information technology vendors — including Epic, Cerner, and other leaders, and altogether representing 90% of the hospital EHR market and health systems in 46 states — committed to supporting consumer access to their data, avoiding blocking of health information, and moving off of proprietary and onto federally recognized, national standards so that technologies can share health data securely and seamlessly. And the recent bipartisan 21st Century Cures legislation further provides ONC with the authority to require interoperability.

Finally, the federal government is increasing access to cost and quality of care information. Medicare Compare websites enable patients and caregivers to compare physicians, hospitals, nursing homes, home health agencies, dialysis facilities, and health and drug plans. HHS and AARP recently announced awardees from a challenge to encourage health care organizations, designers, and technology companies to design a medical bill that is easier for patients to understand.

The Path Forward for Delivery System Reform

Much of the work to date has been based on empiricism: developing models, learning what works, and scaling successes. Not all models will work; some will require improvement and iteration. Participants will enter and exit. Over time, however, this empirical, learning approach will yield results for patients and providers, leading to a smarter, more effective health system in which they can thrive. It is essential for this empiric approach to continue to meet the nonpartisan goals of better care, smarter spending, and healthier people.

The views expressed in this article are those of the authors and do not necessarily represent the views or policies of the U.S. Department of Health and Human Services or Centers for Medicare and Medicaid Services.

Patrick H. Conway, MD, MSc
Centers for Medicare and Medicaid Services

Patrick Conway, MD, MSc, is the CMS Acting Principal Deputy Administrator and Deputy Administrator for Innovation and Quality & CMS Chief Medical Officer. As the CMS Acting Principal Deputy Administrator and CMS Chief Medical Officer, Dr. Conway is responsible for overseeing the programs that serve the millions of Americans that access health care services through Medicare, Medicaid, CHIP and the Marketplace. Learn more about Patrick H. Conway...

Sandra L. Fryhofer, AB
Director, Delivery System Reform, U.S. Department of Health and Human Services

Meena Seshamani, MD, PhD
Director, Clinical Performance Improvement, MedStar Health; former Director, Office of Health Reform, U.S. Department of Health and Human Services

Karen B. DeSalvo, MD, MPH, MSc
Acting Assistant Secretary for Health, U.S. Department of Health and Human Services

CMMI on Leveraging Lessons in Episode-Based Payments

Blog Post · November 17, 2016

Hongmai Pham, MD, MPH, Christina Ritter, PhD, Matthew J. Press, MD, MSc, Amy Bassano, MA & Patrick H. Conway, MD, MSc

Care delivery transformation is no longer a start-up enterprise. The United States is six years into health care's evolution under the Affordable Care Act, and on the eve of the Quality Payment Program for Medicare, which may be a good time to pause and consider how best to leverage what we've learned to date.

The Centers for Medicare & Medicaid Services (CMS) has invested in a diverse range of tests of payment strategies. These strategies are influencing the entire health system, including the private sector, and have had widespread, bipartisan support. Broadly speaking, they fall into three categories: population-based payment (accountable care organizations and primary care medical homes), episode-based payment models (bundled payments), and other models focused on specific types of providers and/or patients. Now is the ideal time for more payers to engage with these efforts.

We believe that the early results from Medicare in the first two categories should encourage payers that have not yet participated in these efforts to begin the hard work of targeting priority areas, designing and implementing those strategies, and engaging their provider partners to achieve success. We also believe early-adopting payers — including Medicare, Medicaid, and commercial plans — now have an important opportunity to evaluate where and how to leverage their early investments and lessons learned, while continuing to refine ideas and test new ones.

Our nation, as well as individual payers and providers, needs robust alternative payment models (APMs) to help us achieve better health, better care, and smarter spending. And payer alignment is vital to care delivery transformation. Committed providers deserve the predictability that comes with knowing that a variety of payers — from public to private —

> *Committed providers deserve the predictability that comes with knowing that a variety of payers — from public to private — are also committed to paying for better value."*

are also committed to paying for better value. This alignment is not only key to the success of early adopters, but it can also give ambivalent or unconvinced providers confidence that they will have the support necessary to succeed under these models.

The Health Care Payment Learning and Action Network (LAN) was created by the Department of Health and Human Services under Secretary Burwell's leadership as a public-private partnership to facilitate alignment across stakeholders, and to help build momentum for the health care system's adoption of effective APMs. This partnership has already proven successful, with the recent announcement that plans and states representing almost 200 million of the nation's covered lives had 23% of their 2015 health care spending flow through APMs. These partners are well on their way to their programs matching the goals the Obama Administration set for the Medicare program of 30% of spending flowing through APMs by the end of 2016; a goal the Administration met 11 months early.

The work of the LAN is even more important now in the era of the Quality Payment Program, which implements the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and promotes participation in APMs.

Achieving Alignment Across Payers

Medicare has already joined with many private payers and Medicaid programs in publishing consensus recommendations on approaches to the design of population-based payments, such as ACO initiatives that build upon the Medicare Shared Savings Program and Pioneer ACO Model, and early private-sector initiatives, including the Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract, all of which have demonstrated early positive results. And we engage with other payers through a variety of mechanisms — not only the LAN, but also through the State Innovation Models Initiative and other models.

> *Truly meaningful payer alignment would touch on both the design and implementation of episode-based payments."*

This payer alignment is also key to the success of episode-based payment models. The highly technical nature of how payers define episodes, set target prices, and select quality metrics can drive how providers might approach their own data analytics, changes to workflows, staffing, and business arrangements. Given this complexity, it is important for the LAN to continue developing consensus recommendations and for other payers to engage with CMS on the design of episode payment models.

Truly meaningful payer alignment would touch on both the design and implementation of episode-based payments. Defining discrete units of accountability like a care episode, details of risk adjustment, episode definitions, and the timing of different payers' data reports can make a real difference in how effectively providers can plan and act. With these considerations in mind, payers should leverage the recent report on early evaluation results of Medicare's bundles on lower extremity joint replacement, as well as the LAN paper on joint replacement episodes.

The growing array of APMs means more opportunities for providers and payers to transform their care delivery and improve quality and value for their patients. Payers should seize every opportunity to minimize mixed signals to providers and to help focus their care improvement efforts. Alignment across new payment strategies like ACOs and PCMHs has begun, and there is opportunity for alignment with episode-based payment to accelerate care delivery transformation across public and private sectors. We look forward to working with health care stakeholders to continue to align on critical aspects of these new APMs, so that — together — we can all achieve better care, better health, and smarter spending at a much faster rate for our entire nation.

Hongmai Pham, MD, MPH
Vice President, Provider Alignment Solutions, Anthem, Inc.; former Chief Innovation Officer, Center for Medicare and Medicaid Innovation

Christina Ritter, PhD
Director, Patient Care Models Group, Innovation Center, Centers for Medicare and Medicaid Services

Matthew J. Press, MD, MSc
Director, Learning and Diffusion Group, Innovation Center, Centers for Medicare and Medicaid Services

Amy Bassano, MA
Innovation Center Deputy Director, Centers for Medicare and Medicaid Services

Patrick H. Conway, MD, MSc
Innovation Center Director, Deputy Administrator for Innovation and Quality & Chief Medical Officer, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

Triggering the Tipping Point in Payment Reform

Blog Post · October 24, 2016

Mark McClellan, MD, PhD & Mark Smith, MD, MBA

Moving from volume to value in health care is a goal that has broad support throughout the health care system and among policymakers, as reflected in many state reforms as well as in bipartisan legislation like the Medicare Access and CHIP Reauthorization Act (MACRA). But as NEJM Catalyst readers know, it's a goal that is much easier to state than achieve, as it requires new expectations and actions by clinicians, payers, purchasers, and consumers. With support from the Department of Health and Human Services, the Health Care Payment Learning & Action Network (LAN) was formed in March 2015 as a public-private initiative to accelerate the adoption of alternative payment models (APMs).

The LAN brings together health plans, private employers, consumer groups, providers, state governments, state Medicaid programs, and other partners to expand the uptake of APMs that reward the provision of better care, improved outcomes, and smarter spending. The LAN is committed to the goals of ensuring 30% of U.S. health care payments are in APMs by the end of 2016 and 50% by 2018.

As its name suggests, the *Learning and Action Network* is just that — involving leading experts from all facets of our nation's health care system, learning and working together to develop and share promising practices. The first activity of the LAN was the development of an APM Framework — a shared approach to both categorizing APMs and providing a mechanism to measure how they are adopted across the country.

APM Framework: A Guide to Payment Reform

The APM Framework establishes a set of common concepts and language, and organizes payment models into a trajectory of categories emphasizing provider accountability for both the quality of patient care and total cost of that care.

Using the APM Framework, the LAN has conducted a new national initiative to collect spending data from leading national and regional health plans for measuring use of APMs across the country."

In categories 3 and 4, the two most comprehensive categories defined in the Framework, the focus is on broad accountability for people's health and outcomes, via clinical episode payment and population-based payment models rather than traditional, fee-for-service payments. By defining and promoting these new approaches, the APM Framework helps nudge the field toward more effective payment models.

Using the Framework, the LAN has conducted a new national initiative to collect spending data from leading national and regional health plans for measuring use of APMs across the country in commercial, Medicaid, and Medicare Advantage market segments. We shared the outcome of this effort at the LAN's fall Summit. We expect the results to help shed light on how markets are evolving, and to provide a foundation for further tracking of payment reform activity.

The Promise of Population-Based Payment Models

Population-based payment (PBP) models provide a means to broaden the current payment system from fee-for-service — which supports the provision of some services but not others — toward a system that gives health care professionals the opportunity to take other, potentially more efficient steps to improve the overall health of a population for which they are responsible. At their core, PBP models offer providers the flexibility to invest resources strategically, treat patients holistically, and deliver coordinated, person-centered care — accompanied by more accountability for improving results.

At their core, PBP models offer providers the flexibility to invest resources strategically, treat patients holistically, and deliver coordinated, person-centered care — accompanied by more accountability for improving results."

The LAN has focused on several priority areas critical to the success of PBP models, which are captured through a set of papers refined by wide public comment: patient attribution, financial benchmarking, performance measurement, and data sharing. We hope that the LAN's recommendations can help the health care community align around PBP models more quickly. By using these widely supported methods for effective PBP implementation, health care organizations and those working with them can move on to steps that improve care and potentially lower costs — for example, by proactively engaging patients and helping patients to work with their doctors to build relationships and manage their own health and wellness.

Supporting Clinical Episode Payment Models

The LAN also supports the acceleration and implementation of Clinical Episode Payment models. LAN recommendations for joint replacement, maternity care, and cardiac care focus on 10 design elements common to episode payment design. These examples span major procedures, time-limited conditions, and chronic diseases. In each case, the LAN's work on clinical episode payments aims to support what is feasible in today's health care system while providing a path forward to more comprehensive reforms in the evolving health care system.

Convening a National Conversation

Where there are opportunities for federal/state/private employers and plans to align around broadly supported elements of payment reform, more traction and momentum is possible. An example of this is the Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive Primary Care Plus (CPC+) model. CMMI selected payers within 14 regions to participate in this initiative to improve the quality of care and care coordination that patients receive. The LAN is supporting this work by facilitating a Primary Care Payer Action Collaborative (PAC), which brings payers together who are participating in multi-payer APMs, such as the CPC+ initiative. These payers will join a participant-driven "national table" where they can address regional and national issues and challenges related to implementing APMs with the goal of developing strategies and solutions. Through this work, the LAN aims to spur collaborative thinking, learning, and sharing on the practical opportunities and challenges involved in implementing effective APMs across multiple payers.

In addition to the PAC, which focuses on payment models for primary care, the LAN is also supporting learning and tools for implementation of maternity episode payments. All health care stakeholders are invited to participate in the LAN and to help shape payment reform.

Mark McClellan, MD, PhD
Director, Duke-Margolis Center for Health Policy, and Robert J. Margolis Professor of Business, Medicine, and Health Policy, Duke University

Mark Smith, MD, MBA
Co-chair of the Guiding Committee, Health Care Payment Learning & Action Network; Visiting Professor, University of California at Berkeley; Clinical Professor of Medicine, University of California at San Francisco

Who Will Succeed with New Payment Models? Part 1

Interview · February 12, 2016

Leemore Dafny, PhD & Michael Chernew, PhD

Kellogg School of Management
Harvard Medical School

Who will win or lose under alternative payment models? Health care economist Michael Chernew, PhD, says good management and the right financial incentives matter more than whether physicians are employed or affiliated.

Chernew, the Leonard D. Schaeffer Professor of Health Care Policy and director of Healthcare Markets and Regulation Lab at Harvard Medical School, sat down with fellow economist Leemore Dafny to discuss his work and insights on alternative payment models. Listen to or read Part 1 of the interview below.

Listen to audio interview.

Leemore Dafny: This is Leemore Dafny for NEJM Catalyst. I am speaking today with Michael Chernew. Professor Chernew is the Leonard D. Schaeffer Professor of Health Care Policy and the Director of the HealthCare Markets and Regulation (HMR) Lab in the Department of Health Care Policy at Harvard Medical School. His research examines several areas related to controlling health care spending growth while maintaining or improving quality of care, and he studied a variety of insurance-driven payments reforms, including value-based insurance design and the alternative quality contract in Massachusetts. Today we'll be focusing on Professor Chernew's work and insights regarding alternative payment models. Welcome.

Michael Chernew: Thanks for having me. It's wonderful to chat with you.

Dafny: My first question for you is that we've known for quite some time that fee-for-service is broken. Why, in particular, is the government doing something about that now?

Chernew: We've been at it for a long time. In the 1980s, they started with the DRG system for hospital payments. By the 1990s, they were on to physician payments with the RBRVS system, which has given us relative value units. Then in the late '90s — but it really got started in the early 2000s — there was a sustainable growth rate system for physician payments, which was many things, but not sustainable.

"We wanted a payment model that allows providers that practice care efficiently to benefit economically from that behavior, and by doing that we can create an incentive for efficient practice of medicine."

So there's been this evolution of activities regarding payment reform, primarily, frankly, to control health care spending growth. And we hadn't been that successful with these other strategies for a variety of reasons, and so that's why I think there are these new ideas. I think in addition to this desire to have a payment model designed to help control health care spending growth, we wanted a payment model that allows providers that practice care efficiently to benefit economically from that behavior, and by doing that we can create an incentive for efficient practice of medicine.

Dafny: The government (CMS) and payers have been serious for quite some time. They've implemented other approaches that basically have failed in terms of controlling health care costs. What is new and how is it working?

Chernew: Well, there's a number of things that they're trying to do. Let me start with what I would call, broadly speaking, the changes in the way they're trying to bundle payments. They're trying to take the payment model and give a payment that spans providers and spans time. So that would include a population-based payment model like global budgets, for example, and also episode-based payment models.

The population-based payment models set a fixed target of spending for an entire person over typically a year, and the episode payment model looks at a particular type of client care — say, a hip replacement and knee surgery, something like that — and sets a budget for that that spans providers and spans times. You see that, for example, in the Bundled Payments for Care Improvement initiative. Personally, I have some concerns about how broadly applicable episode-based payment models can be, because so much of our spending is among patients with multiple chronic conditions. So it's very hard to divide up that spending to specific episodes and figure out exactly which provider should be accountable. But there's a lot of innovation going on in that space, and we'll see where they actually go. And those types of episode models can actually be well suited to target specific providers. The population models are much broader, but they require large organizations to manage them, and they require those organizations have mechanisms to allocate this broad population-based payment down to the different providers that care for their patients.

Dafny: At some level, as you described it, population-based health has really been what insurers have been doing, which is taking a set amount of funds and managing the care to some degree of enrollees and dispersing those funds. So perhaps you can explain to me why policymakers think that providers will do a different job, and hopefully a better job, of managing population health with the funds.

Chernew: I think, fundamentally, the success of the health care system requires that the people who deliver care, and the organizations that they're affiliated with, practice care efficiently. And the insurers, in accepting this population payment — which we call a premium — when they allocate it to the providers, the incentives that the insurers faced didn't get translated very well to the organizations that were actually delivering care. And the essential idea behind these population-based models is to move that incentive to manage spending for a population away from the insurers that had very weak levers and very weak control over the actual delivery of care down to the organizations that actually are on the ground, interacting with patients. And that, essentially, had been the theory, and of course, as these population-based payment models move forward, many of them currently — and there's increasing aspirations to have more of them — require the providers' systems to bear risks.

Dafny: You've done extensive research on alternative payment models. Can you give me a summary of your understanding of ACOs and how they're working?

"In a population-based payment model for Medicare, if you can control the benchmark ... you can control the rate of growth and spending and essentially hold the providers accountable."

Chernew: The official ACOs are in the Medicare program, and our sense is — it's very early on in the game — they're saving a few percent. That's not nearly as much as advocates would have hoped for, but on the other hand, if you can save a few percent, that's better than not saving a few percent, and they're expanding. Again, somewhat more slowly than advocates would have liked, but more organizations are accepting these types of models. Here in Massachusetts, there was an early ACO-like program — it was called the Alternative Quality Contract implemented by Blue Cross and Shield of Massachusetts — and our estimates were that by four years that program saves roughly 10 percent relative to what otherwise would have been spent. It's really important to understand that spending is not going down. It's just going up more slowly. A lot of those savings in the Alternative Quality Contract was because in the private sector there's very wide variation in prices, and when the providers had the incentive to direct patients to the lower-priced settings and organizations, they did that. And about half of the savings were due to those types of activities.

Dafny: What I'm hearing you say is that the way in which a commercial ACO reduces health care spending, and presumably while achieving or exceeding quality targets, is by redirecting patients to lower-cost sites of care or lower-cost providers. That — at least the lower-priced provider angle of it — is not going to work for Medicare ACOs.

Chernew: Yeah. So that's about half of the savings in the commercial programs we've studied. And it still can work in Medicare to some extent, because there's such different prices for similar services delivered in an office-based or facility-based setting. So there's some amount of price variation, but yes — you're correct. There's a lot less room for that in Medicare ACOs.

So we would expect, long run, the saving opportunities are less. But remember, we're not trying to lower spending; we're trying to change the rate of growth in spending, and historically the rate of growth in spending has been driven largely by volume increases. So in a population-based payment model for Medicare, if you can control the benchmark, which is really the central policy parameter in my view, you can control the rate of growth and spending and essentially hold the providers, as opposed to the insurers, accountable for a rate of spending growth that's more in line with the rate of income growth.

Dafny: Right. So a sustainable rate of spending growth certainly sounds like a worthy target, and actually reducing spending is not something that, I think, is at all likely to happen. So if I'm a provider organization, what kinds of advice would you offer to me as I think about how to succeed in this new set-up?

Chernew: What is essentially happening with all these new models is that they're changing the business models that provider organizations face. And the organizations, to be successful, have to be more sophisticated and think more broadly about populations, because in general, they're accountable for care outside of their walls in a whole variety of ways over time with other providers. So most of these models, the population ones, are centered around primary care physicians. The episode models, less so. They're developed, in some ways, in ways that can work more for specialists. But all of the organizations have to figure out how to find where the value lies and succeed by reducing the amount of care — ideally, reducing the amount of wasteful care in the system, as opposed to increasing the amount of care. You succeed, essentially, by translating reduced waste into profit, which can only be done in these new models.

Dafny: Can you speak to the questions surrounding how providers are organized to achieve this? And here, specifically, I'm referring to whether physicians need to be jointly owned with hospitals. Do they need to jointly own all of the different sites along the continuum of care in order to achieve this? What does your research tell you about whether that's likely to be the route?

> *I think the fundamental issue in terms of accelerating the pace [toward ACOs] is the extent to which you maintain pressure on the fee-for-service system."*

Chernew: In our first analysis, we found that you could succeed under either organizational structure. Essentially, if you're a hospital-based organization, very integrated between hospitals, physicians, and perhaps other providers, post-acute and others, you really do have the ability to coordinate care across the spectrum. The challenge, of course, is as you try and reduce wasteful care, many of the providers of that care are part of the organization, and it really becomes a challenge. So if your strategy is to reduce hospital care, that might be harder to do if the organization is dominated by the hospital. On the other hand, organizations that don't include those other facilities inherently are going to need to refer their patients outside of their control, and they're going to need to manage that better through contracting, referral patterns, and things of that nature. And we're in a period in which we're exploring which of those organizational forms work. Frankly, I don't think there's going to be one answer. My general sense is organizations of both types can be successful. It's just that they have to execute on their strategy well, and understand that in order to succeed, there will be some organization that's going to have to receive less money than it otherwise would have received, but still probably more money than it had in the past.

Dafny: Right, and operate under an entirely different incentive structure than it currently does, which brings me to the next question. We've actually heard and read a lot about ACOs, since even before the Affordable Care Act was passed in March 2010, and it still seems like they are just taking root, and that fee-for-service is a better descriptor of our health care payment system today. What do you think is slowing down the transition, and are there any steps that you think either the government, or state legislators, or providers, or payers, could take to accelerate the pace?

Chernew: Yeah. I think, in fact, these types of models are growing, both in public and the private sector. They might not be growing as fast as one would expect, but the trajectory still seems to be moving upward. I think the fundamental issue in terms of accelerating the pace is the extent to which you maintain pressure on the fee-for-service system, which is currently scheduled to happen — if you look at the new fee schedule that was put in place following the repeal of the sustainable growth rates through a legislation that was called MACRA in the system, [and] related to this MIPS, or the new quality payment model. In that system, the updates for physician payments are 0.5 percent through 2019, and then they drop down to zero. There are quality bonuses that go on top of that.

Ignoring whether we think the quality measures are good or bad, that system is designed to have winners or losers. So the net amount of money going into the physician system, and to some extent the hospital systems with the productivity adjustments in the Affordable Care Act — all of the fees in the fee-for-service system are scheduled to rise very slowly. Much more slowly than we would anticipate inflation being. In order for providers to succeed in that model, they need to be able to convert efficiencies into income, and these new payment models allow them to do that. If we relax these payment models — obviously, put more money into the system one way or another — we will discourage the transition to the alternative payment models. The other thing that's really important is that the rules around the alternative payment models, particularly the federal ones, have been changing periodically. We had the Pioneer program, now we have the Next Generation program. At some point, we'll probably have the next, next generation model, but in any case there are a lot of subtle rules that sometimes make it hard for organizations to succeed — the way the benchmarks are set, the size of the shared savings, a number of other governance rules and a whole bunch of rules. And we're still in a period of experimentation, both in the public and private sector, to figure out exactly what works. I could give examples of private-sector versions of this where these are evolving and moving forward. So it's a combination of push and pull.

Listen to or read Part 2 of this interview.

Leemore Dafny, PhD
Harvard Business School
Leemore Dafny is the MBA Class of 1960 Professor of Business Administration at Harvard Business School.
Learn more about Leemore Dafny...

Michael Chernew, PhD
Leonard D. Schaeffer Professor of Health Care Policy and Director, HealthCare Markets and Regulation Lab, Department of Health Care Policy, Harvard Medical School

Let Efficient Providers Prosper

Blog Post · December 6, 2016

Michael Chernew, PhD & Jonathan Bush, MBA

The American health care system is the most expensive in the world, with little evidence that the higher spending is justified by better outcomes. The current effort to shift from a mostly fee-for-service payment system to one that relies on some combination of population- or episode-based payment represents one strategy to improve health system efficiency. We saw the latest step in the effort with CMS's release of the MACRA rule that favors alternative payment models. But payment transformation will only be successful, and avoid the pitfalls of our current payment system, if the government sets broad fiscal and quality targets but then allows providers the flexibility to innovate — and reap sufficient rewards, if they meet those targets.

The theory behind payment reform is simple and well understood, but it bears repeating. Efficiency, by definition, requires more judicious use of resources. Fee for service, however, discourages greater efficiency in two key ways. First, under the current system, we *use too much* care, in part because wasteful care is profitable. Providers who find ways to avoid wasteful services and use a more efficient mix of services may suffer the penalty of lower incomes. Second, under the current system, we *pay too much* for the care we use. Incentives to avoid high-price service or sites of care or to make referrals to low-price providers are weak at best. The provider who refers a patient to a high-quality, lower-price specialist or hospital captures none of the savings. This not only increases spending in the short run, but it also fosters a market dynamic that leads to ever-rising prices.

> *Our greatest concern should be low-cost, high-quality production of health (not health care) over the long term."*

With efficiency gains as the ultimate goal, if payment reform is to work, then physicians and hospitals must have flexibility and incentives to combine services in a way that produces better outcomes with fewer resources. This might involve new technologies such as telemedicine or e-visits. It might involve group visits instead of individual visits, wise use of non–health care services, or expansion of prevention to reduce

expensive disease complications. It might involve changes in the mix of labor used (nurses instead of physicians, primary instead of specialty care), low-cost drugs instead of comparable high-cost drugs, or drug interventions instead of surgery. The fundamental principle of efficiency producing innovation is one of substitution and wise use of technology (including information technology) to improve care.

Streamline Rules and Reward Efficiency

As the federal government takes on the work of designing alternative payment models, basic market principles can provide key lessons. First, in our quest to improve quality measurement, we should minimize the degree to which such measurement puts a tax on providers and prevents innovation in care delivery. To the extent possible, policy makers should focus on outcome measurement, as opposed to process and structural measures. Where possible, they should specify what outcomes they want to achieve rather than dictating how they should be produced.

Our existing system likely errs on the side of too much data collection burden and too many micro-measures. We place too many structural requirements for ACO governance and reporting. Overly complex quality measures and ACO oversight rules may distract providers from real quality improvements, driving them to game the system rather than find ways to deliver better, more efficient care.

"A similarly virtuous dynamic could be achieved in health care by allowing producers to keep all of the savings generated by their efficiency gains in the short run, while over time allowing a slower increase in the population- or episode-based price or lowering those prices if providers have systematically reaped a windfall."

Second, we must allow providers to capture efficiency gains. In other markets, more efficient producers keep all of the savings — unless they choose to lower prices to capture more market share, or competition from other efficient producers pushes prices down. Consumers benefit from this dynamic. A similarly virtuous dynamic could be achieved in health care by allowing producers to keep *all* of the savings generated by their efficiency gains in the short run, while over time allowing a slower increase in the population- or episode-based price or lowering those prices if providers have systematically reaped a windfall.

Fundamentally, if society does not share the savings, there will be no savings to share. Our greatest concern should be low-cost, high-quality production of health (not health care) over the long term. We should strive to pull the savings out of the health care sector over time. If providers do not have strong incentives to disrupt the system, we may extract short-term savings, but we'll lose the opportunity to put health care on a high-quality, fiscally sustainable trajectory over the longer term.

Finally, the government's desire to create payment models that could suit all providers creates confusion and possibly gaming opportunities among providers. We have the MIPS system created under MACRA, a number of ACO models, and an ever growing number of episode-based models. Outside all of this sits the Medicare Advantage model. Far too much provider time and energy is spent sorting out which payment model to follow and how best to work the system rather than pursuing solutions to create better health care. Reducing the number and complexity of options and signaling the basic strategy for moving forward would go a long way to support effective system transformation.

If our society can seize this moment to unleash the power of innovators to create better models, which allow them to profit from removing waste and finding new efficiencies, we can put ourselves on the path to a satisfying and sustainable health care system.

Disclosure: Dr. Chernew holds equity in V-BID Health and sits on advisory boards for the Commonwealth Fund, the National Institute for Health Care Management, and Archway Health.

Michael Chernew, PhD
Leonard D. Schaeffer Professor of Health Care Policy and Director, HealthCare Markets and Regulation Lab, Department of Health Care Policy, Harvard Medical School

Jonathan Bush, MBA
President and CEO, athenahealth, Inc.

The Big Tent of Value-Based Care Has Room for Big Pharma

Article · September 14, 2016

Thomas H. Lee, MD, MSc & Laura S. Kaiser, FACHE, MBA, MHA

Intermountain Healthcare
Press Ganey Associates, Inc.

At Intermountain Healthcare and other integrated health systems, prescription medications represent the fastest-growing expense category — rising by about 13% per year. Contrast that with increases in salaries and other types of expenses, which (along with revenue gains) are in the low single digits.

During the past 35 years, the percentage of national health expenditures on prescription drugs has increased from 4.7% to 9.8%, whereas the portion spent on hospital care has decreased from 39.4% to 32.1%. In some respects, that shift is good news: medications are improving health and prolonging lives, and the decline in hospital spending (as a percentage of overall health care spending) reflects successes in coordinating care and keeping patients healthier. But rising spending on prescription drugs also raises a fundamental question:

> As payers and providers work together to improve value, will pharmaceutical companies join that effort, or will they act as vendors that merely maximize short-term profits for shareholders?

Pharma Knows It Holds a Stake

Payers and providers are realizing that the overall value of care will not improve unless they collaborate. Take Intermountain's practice of embedding mental health professionals in its primary care practices: per member per year, the approach costs $22 up front but saves $115 in emergency department (ED) visits and other expenses down the road. Intermountain's insurance company sees the savings for only a minority of patients, but focusing on overall value across all patients reveals the wisdom of the investment.

> *Achieving value-based care is difficult when some stakeholders operate outside the tent. Providers, payers, and patients are waiting with open arms for drug companies to come inside."*

Integrated and non-integrated health systems that involve all stakeholders in improving value will fare better in the long run. Greater attention is focusing on Pharma as one of those stakeholders. So far in 2016, at least 14 U.S. state legislatures have considered bills to address the rising cost of prescription drugs and to increase transparency on how pharmaceutical companies price their products. If market forces cannot control costs, regulation will step in, as the pharmaceutical industry is aware. A recent article in *Pharmaceutical Executive* magazine notes, "Making outcomes-based arrangements simple and workable for payers will be critical to mitigate additional price regulation and access restrictions that are being proposed by public and private payers, politicians, and other stakeholders." And in January 2016, Eli Lilly and Anthem made a joint announcement about legislative and regulatory options for promoting value-based contracting arrangements.

How to Integrate Pharma in Value-Based Care

Achieving value-based care will clearly be a joint effort. We briefly propose four ideas for fully engaging pharmaceutical companies in that endeavor:

1. *Rebates based on a drug's effectiveness.* A manufacturer could contractually agree that when a patient does not respond to therapy as expected (from results in pivotal clinical trials), the company will rebate the cost of the therapy. For example, in 2004, Novartis contracted with Intermountain's Health Plan (now called SelectHealth) for such an initiative involving its valsartan (Diovan) blood pressure–lowering products. If a patient did not reach the target blood pressure set by his or her physician while taking the drug as directed, the patient was reimbursed for the copays or the cost of the medication. The initiative also provided adherence-enhancing initiatives (e.g., education kit, medication tracker, pill box, monitor, pedometer). This approach worked well for well-defined therapeutic endpoints while lowering the cost to payers (and patients) for poor outcomes. But it demanded resources for managing the rebated and refunded copays, collecting data and tracking outcomes, and overseeing complex data-sharing arrangements. This approach was also challenging in patients with multiple comorbidities taking several medications, as therapeutic success or failure wasn't always clear. And in some cases, it was tough to ensure that patients were taking medication as directed.

2. *A capitated or fixed rate per patient.* A manufacturer could contract with a payer for such a rate for each of its medications — or for any of its medications within a therapeutic category. With that rate as one data point, patients and their physicians could decide on the appropriateness and feasibility of treatment. Advantages include more-predictable expenses (for the payer) and copays (for the patient); challenges include how to pinpoint the best contracted price.

3. *Collaboration with health systems in bringing drugs to market.* The average time from discovery to drug approval is about 12 years, at an average estimated cost of $2.1 billion. Integrated health systems, such as Intermountain, have the ability to aid in bringing new medications to market more quickly and economically. As drug therapy becomes more individualized, real-world data must augment evidence from randomized controlled trials. Intermountain can offer access to data from large numbers of patients, and widespread use of its electronic health record can facilitate data collection and analysis for regulatory decisions (e.g., about additional indications and populations).

4. *Joint analysis, with providers, of prescribing practices.* This analysis, using national practice guidelines and care-process models as benchmarks, would help to track prescribing behavior, medication adherence, and related patient outcomes. Although medication adherence increases treatment costs, total-care costs usually decrease (thanks to fewer ED visits and hospitalizations). Drug makers could become more of a partner in formulary-management efforts that focus on long-term quality and costs.

These four proposals are not the only ways to involve Pharma in value-based care. Each health system will have to consider these and other possibilities — and then tailor them to its own needs and populations. But the overarching goal is perhaps best captured by an excerpt from a 1950 speech at the Medical College of Virginia, by George W. Merck. Then president and chairman of Merck & Co., he said, "We try to never forget that medicine is for the people. It is not for the profits." All stakeholders in health care would do well to follow that sage advice from a pharmaceutical company executive. Achieving value-based care is difficult when some stakeholders operate outside the tent. Providers, payers, and patients are waiting with open arms for drug companies to come inside.

Thomas H. Lee, MD, MSc
Press Ganey Associates

Dr. Lee is the Chief Medical Officer for Press Ganey Associates, Inc., a member of the Editorial Board of The New England Journal of Medicine, and the NEJM Catalyst Leadership Board Founder. Learn more about Thomas H. Lee...

Laura S. Kaiser, FACHE, MBA, MHA
President and Chief Executive Officer, SSM Health, St. Louis

The MACRA Final Rule: Five Crucial Questions Asked and Answered

Article · November 30, 2016

Ron Shinkman

Health Care Editor and Journalist

"How many of you feel comfortable with the MACRA [rules] that were finally approved?"

Tim Kuruvilla, Co-founder of Viewics, a California health care data analytics firm, posed this question in late October to a group of about 500 people in a hotel ballroom steps from Capitol Hill. Most of the crowd comprised health care executives, physicians, attorneys, and consultants. Most possessed decades of professional experience.

Not a single hand was raised.

Aside from the wildly improbable presidential campaign that just wrapped up, no other element in the health care sector has created as much unease this year as the upcoming implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Many believe this replacement to the Sustainable Growth Rate formula will not only alter in many ways how physicians are paid by the Medicare program, but also how they will be institutionally organized to practice medicine.

"I would argue that for doctors, it will be much bigger than Obamacare," says Michael Ivy, MD, Chief Medical Officer for Connecticut's Bridgeport Hospital, part of the Yale-New Haven Health system. Yet he acknowledges that "we barely know anything about it."

As MACRA likely begins taking hold in the coming months, what should the nation's clinicians expect?

Will MACRA's Fate Change Due to Donald Trump's Election?

Republicans have railed against the Patient Protection and Affordable Care Act (ACA) for the past half-dozen years, and now with control of the White House and both houses of Congress, they could move to repeal the reform law entirely. But generally, MACRA is expected to survive, no matter what happens to the rest of the ACA.

> *Don't forget that MACRA may be the only piece of major bipartisan legislation passed over the past eight years.*

"Don't forget that MACRA may be the only piece of major bipartisan legislation passed over the past eight years. Because of . . . overwhelming bipartisan support in both the House and Senate, we can expect MACRA to continue to be implemented as it was designed in the recent final rule," says Farzad Mostashari, MD, the former National Coordinator for Health Information Technology. He's now Founder and CEO of Aledade, a Maryland-based company that helps physician groups operate accountable care organizations.

Ivy concurs. The law "has the political backing of both parties, so it's positioned well in that sense. No one [said], 'I will repeal MACRA if we win the election,'" he notes. "To my ears, that means we're going to have to figure out if it works."

But Jim Lott, former longtime Executive Vice President of the Hospital Association of Southern California who teaches health care policy at California State University, Long Beach, is less sanguine.

"It will probably be easier for Trump to get rid of MACRA given the way it has been received by the doctors, in that they wholly disapprove of it," says Lott, who adds he recently met with a physician who plans to keep his Medicare population under the thresholds required to participate in MACRA.

What Changed Between the Proposed Rule and Final Rule?

The Centers for Medicare & Medicaid Services (CMS) made significant changes to MACRA's final rules, providing what acting Administrator Andy Slavitt says is more flexibility.

The final rule embraces transitional payment methodologies, and by building in additional models, allows physicians to continue to provide their patients with quality care while mitigating potential financial risk."

"Compared with the proposed rule, the final rule embraces transitional payment methodologies, and by building in additional models, allows physicians to continue to provide their patients with quality care while mitigating potential financial risk," says James S. Gessner, MD, President of the Massachusetts Medical Society (MMS) in a statement. "It also alleviates the administrative burden for participating physicians by reducing the number of reporting requirements and utilizes 2017 as a transition period." (MMS owns NEJM Group, publisher of *NEJM Catalyst* and the *New England Journal of Medicine*.)

One of the biggest changes is that the participation threshold for physicians was lifted from a minimum $10,000 in Medicare revenue to $30,000 (or fewer than 100 Medicare patients). According to The Advisory Board, a consulting firm in Washington, D.C., that change handed MACRA exemptions to 124,000 clinicians, and cut the number required to participate in MACRA or experience reimbursement cuts from 836,000 to 712,000 — a reduction of 15%. Altogether, some 384,000 active clinicians won't be participating in MACRA due to low volumes of Medicare patients.

CMS also eased the quality reporting restrictions during the first year. It introduced a "pick your pace" option for the first year of implementation in 2017. That essentially allows doctors or practices to submit data on only a single practice measure or improvement activity and not experience a reimbursement cut. (Practices still have the option of submitting a minimum of 90 days of continuous data to qualify for incentive payments.)

Altogether, some 384,000 active clinicians won't be participating in MACRA due to low volumes of Medicare patients."

"We know there are challenges under the new system, but the recent announcement of the 'pick your pace' reporting options indicates not only that the CMS is responsive to the AMA's advocacy on behalf of physicians, but that it is working to give physicians a fair chance to be successful in the new payment framework," says American Medical Association President Andrew Gurman, MD, in a statement.

CMS also relaxed regulations for advanced alternative payment models (APMs) and allowed another pathway, a Medicare Shared Savings Program (MSSP) Track 1 Plus, which is open to current participants in the MSSP Track 1 Plus. CMS estimates these changes could bump up APM participation from around 5% of practices to 20% or slightly more, but many observers have expressed skepticism such numbers would be met.

"The final rule is very different from what we thought it was going to be," Ivy says. "I thought they were going to be tougher, but it looks like it's going to be okay in the first year. That was certainly not what the preliminary rule suggested."

How Are Physician Practices Preparing for MACRA?

For the most part, physician groups are still familiarizing themselves with what is required under MACRA.

> *The recent announcement of the 'pick your pace' reporting options indicates that CMS ... is working to give physicians a fair chance to be successful in the new payment framework."*

"A vast majority have no idea what is in it at this point. Their first idea is, 'Where can I find shelter from the storm?'" says Lisa Bielamowicz, MD, The Advisory Board's Chief Medical Officer. That reaction applies primarily to physicians who have not yet begun exploring options for merging or seeking employment with a larger group or hospital, she says. She has performed a couple dozen onsite meetings with physicians and medical groups to get them up to speed.

Louis Goodman, CEO of the Texas Medical Association (TMA), one of the most active state lobbies regarding the development of MACRA rules, says his organization has developed a five-step checklist on how to prepare. It includes learning about MACRA through sources on the TMA website and others; evaluating how well one's practice has performed in Medicare's current quality programs; weighing the list of clinical practice improvement activities; and perhaps most importantly, contacting an electronic health records vendor. The TMA site also offers an interactive calculator to determine if participation in MACRA is worthwhile. The American Medical Association (AMA) site offers similar tools.

What Might Be Unintended Consequences of MACRA?

The biggest unintended consequence may be the merging of smaller practices with larger ones, or their acquisition by hospitals and health care systems. Both trends have become pronounced in recent years, but the consensus is this will accelerate.

"There will be plenty of people who will want to join bigger groups, but [those groups] will be selective, particularly if they're a dominant force in the area," Ivy says.

Valinda Rutledge, a consultant with Sg2, a consulting firm in Skokie, Illinois, is also concerned about mergers, but notes that physician groups could seek less formal affiliations with hospitals in order to obtain crucial services, such as inputting data.

Mostashari fears that consolidation could lead to many areas being dominated by larger medical groups, perhaps even ones fully integrated with hospitals. "Payment reform is not going to work without competition," he says. "If a provider is that dominant vertically and horizontally, they cannot do anything. They just demand rent from everyone else."

> *A vast majority have no idea what is in [MACRA] at this point. Their first idea is, 'Where can I find shelter from the storm?'"*

Another possible unintended consequence is that fewer physicians may choose to participate in MACRA than envisioned, and instead retire, particularly those in their late 50s or early 60s. "We are starting to see doctors who have four or five years left in their careers retiring earlier, particularly those who don't want to be employed by large systems," Goodman says. "They say this is the only answer."

One of Goodman's biggest concerns is that there may be too much pressure on rural practices to comply with all MACRA measures, even though they may not have the resources to do so. Another concern: Too much pressure regarding proper data reporting through EHR vendors. Angie Ybarra, TMA's Director of Clinical Advocacy, recalls a member practice that should have received a bonus under the Physician Quality Reporting System (PQRS, which has been combined into MACRA). The EHR vendor submitted the data, which CMS accepted. However, the agency did not mention that there were errors in the data. The client didn't find out until months later that instead of receiving an expected bonus, it was subjected to a negative technical error — a roughly $100,000 shift in revenue. Ibarra says similar outcomes occurred with several other practices in Texas that used the same vendor.

How Is MACRA Positioned for Success?

"We believe that the final rule has the potential to meet its goal of maintaining high standards of value-based patient care while transitioning health care providers to a new payment framework if they choose," says Massachusetts Medical Society's Gessner. "We're working hard with CMS to educate independent physicians and small practices so that they can transition to the new payment system as seamlessly as their larger, well-resourced counterparts."

Rutledge, who is concerned about the impact on smaller and rural practices, notes that CMS has set aside $100 million to provide technical assistance to those practices. That the agency has provided more flexibility on the final rules — and is gathering comments on them as well — suggests to her more changes are coming.

"They see this as an evolutionary process," she says. "They are putting it out in front and will be making modifications as they go along. We have to anticipate it evolving."

Mostashari concurs with this view: “CMS’ response to bipartisan and private-sector calls for more to be done to support independent primary care practices is an encouraging sign of opportunities ahead.”

Ron Shinkman
Los Angeles–based health care editor and journalist specializing in economics and public policy

New Marketplace Survey: Physicians and Hospitals Differ on How to Reduce Costs

Insights Report · March 3, 2016

Leemore Dafny, PhD & Thomas H. Lee, MD, MSc

Harvard Business School
Press Ganey Associates, Inc.

Data from the first survey of NEJM Catalyst opinion leaders are in, and — no surprise — they show that physicians and hospital/system leaders have different ideas on the best ways to reduce health care spending.

The survey queried health care executives, clinician leaders, and clinicians on where they saw marketplace opportunities for improving quality and efficiency — and what they were actually doing. Respondents were asked about:

- Top initiatives to improve efficiency and quality
- Percent of patient care revenue involving risk sharing with payors
- Percent of patient care revenue dependent on quality benchmarks or improvement
- Actions to control spending on high-priced drugs
- How to cut 5% of costs without a harmful impact on patients

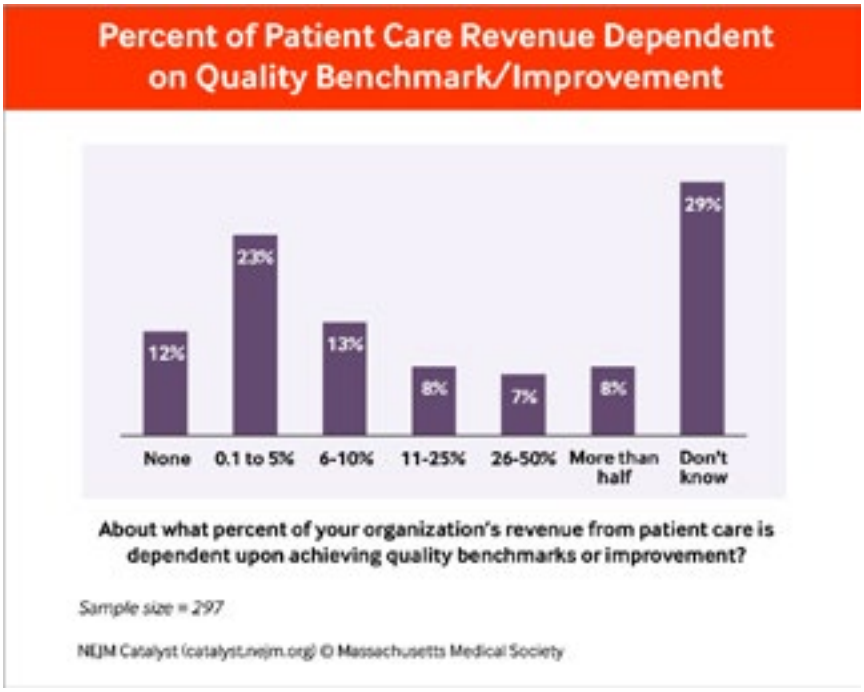
This initial survey also gives a first look at the respondents to NEJM Catalyst Insights Surveys. Our 297 respondents represent leaders across a range of sectors, with a heavy bent toward providers and hospital-affiliated experts in particular. This first set of data from the NEJM Catalyst Insights Council shows the Council is both sizeable and occupies leadership roles in a broad range of provider organizations.

METHODOLOGY AND RESPONDENTS

- In December 2015 and January 2016, an online survey was sent to the NEJM Catalyst Insights Council, which includes U.S. health care executives, clinician leaders, and clinicians at organizations directly involved in health care delivery. A total of 297 completed surveys are included in the analysis. The bounds for a 95 percent confidence interval around any reported result with N=297 are +/-5.7%.
- Respondents are fairly evenly split among executives (27%), clinician leaders (32%), and clinicians (41%). Most of the respondents described their organizations as hospitals (36%) or health systems (19%). These hospitals were predominantly mid-sized (36% had 200-499 beds) or larger (53% had more 500 or more beds).
- Only 11% indicated that their major affiliation was with a physician organization. Those physician organizations tended to be big — 73% had 100 or more physicians.
- Most of the organizations (72%) were non-profit. Every region of the country was well represented.

When asked what percent of their organization's revenue from patient care involved risk sharing with payors, only 6% said more than half. Overall, respondents indicated that risk-sharing was simply not an emphasis — 20% said none of their patient care revenue was tied to risk, 19% said 0.1 to 5%, and 32% said they did not know.

Incentives for improving quality were only slightly more prominent. Most respondents (64%) said they had either less than 5% of revenue tied to achieving quality goals, or did not know the percentage of revenue.



In short, many respondents had some financial incentives for improving quality or efficiency, but, in general, the percentage of revenue that was dependent on either type of performance was small.

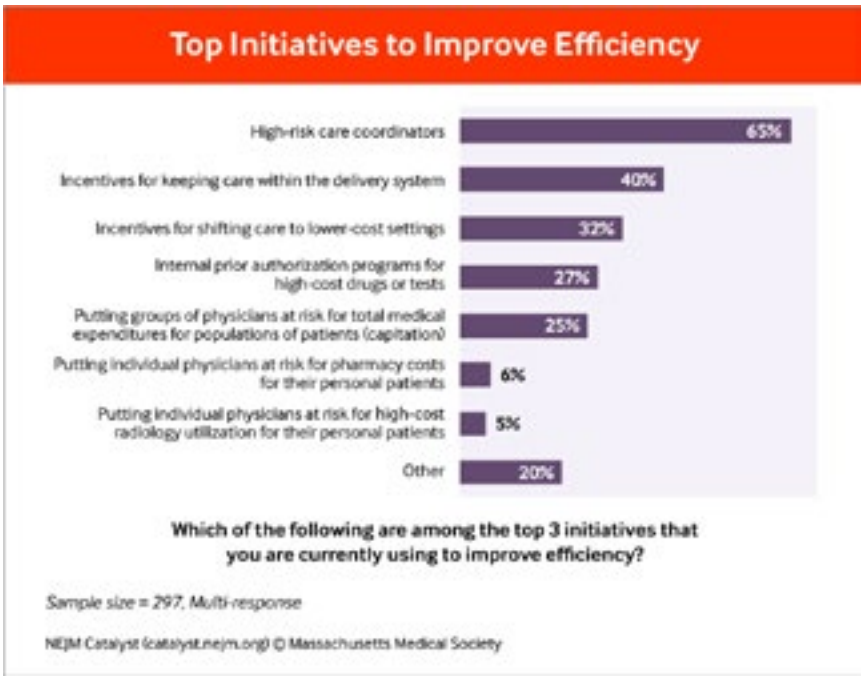
Initiatives to Improve Efficiency

The respondents describe a wide range of initiatives aimed at improving efficiency at their organizations, with the most frequently cited (65 percent) being high risk care coordinators. The second most frequently cited response was use of incentives to keep care within the organization (40 percent). This approach does not necessarily improve efficiency; that depends on whether internal providers have lower costs and prices than the alternatives, or are able to practice more efficiently as a result of a common affiliation among the various providers caring for a patient.

Provider organizations tend to deal with pressure for efficiency by adding systems (i.e., care coordinators) and trying to increase their market share of care that is delivered. Changing how care is actually delivered is a less attractive option."

In fact, the desire to maintain or grow revenue — rather than to improve efficiency — may motivate programs to keep care inside an organization. The share of respondents reporting their employers are shifting care to lower cost settings or developing internal prior authorization program for high-cost drugs or tests was noticeably lower (32 percent and 27 percent, respectively).

In short, the picture painted by these data is that, at this point, provider organizations tend to deal with pressure for efficiency by adding systems (i.e., care coordinators) and trying to increase their market share of care that is delivered. Changing how care is actually delivered is a less attractive option.



Breaking out responses by different categories of respondents reveals that respondents from physician organizations have a different idea of what constitutes "low hanging fruit" than those from hospitals or delivery systems. Most of the physician organizations (52%) indicated that they were using incentives to shift care to lower cost settings, versus only 33% of hospital and 26% of health system respondents. These three groups were nearly identical in their use of high risk care coordinators (70%, 70%, and 68%, respectively). These data suggest that hospitals, health systems, and physician organizations faced similar pressures for efficiency, but were responding differently.

> *The data from this first NEJM Catalyst Insights Council survey paint a picture of a health care system in which there are still only small proportions of revenue at risk based upon efficiency or quality."*

On the other hand, the health systems were more inclined to put groups of physicians at risk for total medical expenditures for populations of patients (capitation) than either hospital or physician organization respondents (42% vs 21% and 21%, respectively). One possibility is that health systems can put groups of physicians at risk, while hospitals and physician groups lack either the skills or infrastructure to implement risk-sharing, or the interest in doing so.

Other findings in segmenting the data include:

- Larger organizations (by patient revenue) were more likely to use high risk care coordinators and have incentives for keeping care within system.
- Capitation was most common in the North East (38%) and North West (32%), and least common in the South (0-9%), perhaps reflecting greater penetration of for-profit entities in the South.

Initiatives to Improve Quality

The respondents viewed high risk care coordinators as one of their most important responses to improve quality as well as efficiency. Many of them reported having chronic disease teams and financial incentives at the individual physician level for improving quality, with variance reporting at an individual clinician level. Same-day visits as a standard were not uncommon — 26% of respondents indicated that their organizations were offering them.

> *Different parts of the health care system respond to different incentives, and leaders probably need to tailor thinking about competition and pressure for improvement for different settings."*

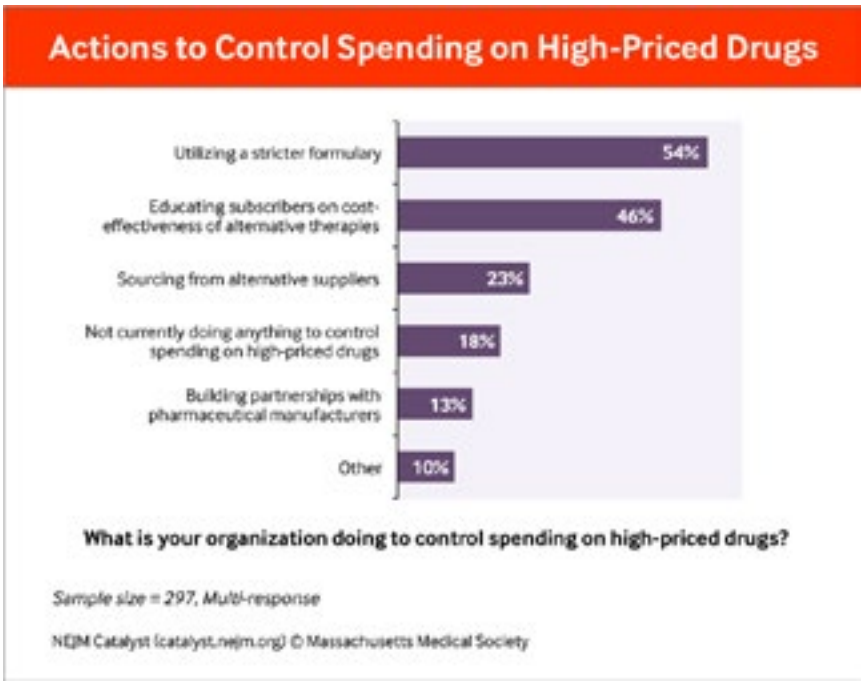
When these data were analyzed by the type of organization of the respondents, the differences were more subtle than for efficiency measures. Health systems and physician organization respondents were more likely to have financial incentives at the individual physician level for quality (both 39%) than hospitals (32%). Hospitals and health systems were more likely to have teams organized around chronic diseases (38% and 30%) than physician organizations (15%).

Same-day access for appointments was apparently easier to implement in smaller organizations. More than one-third of the respondents from organizations with patient revenue below $500 million per year indicated that they were offering such appointments, versus only 13% of those with revenue more than $5 billion. There were no major indications that bigger organizations offered more initiatives to improve quality.

Actions to Control Spending on High-Priced Drugs

Just over half of the organizations indicated that they were using a formulary to try to control spending on high-cost drugs, complemented by educational efforts. Respondents from hospitals were more likely to have stricter formularies compared with health systems or physician organizations (65% vs 53% and 39%, respectively). These differences presumably reflect both the ability of hospitals to address drug selection, as well as the urgency to do so because much of drug spending is a cost center. Health systems may be less effective at imposing tight formularies both because patients have a greater impact on outpatient drug selection, and because they may not directly bear much risk for outpatient drug spending. Finally, few physician organizations appear to have the incentive and/or ability to address drug spending directly.

Most organizations' respondents reported having an in-house team developing that formulary (74%).



Conclusion

The data from this first NEJM Catalyst Insights Council survey paint a picture of a health care system in which there are still only small proportions of revenue at risk based upon efficiency or quality. Organizations are taking some steps to improve both, but they naturally emphasize the initiatives that are most urgent and least painful to execute.

We did not see evidence that "bigger is better" — i.e., that bigger organizations were more likely to do more to improve quality and efficiency. In fact, some data indicate that initiatives (e.g., same day appointments) might be more difficult to implement in bigger and more complex organizations.

A final reaction: different parts of the health care system respond to different incentives, and leaders probably need to tailor thinking about competition and pressure for improvement for different settings.

Beyond that final reaction, one more — we need more data. We'll be coming back to the Insights Council in that search.

VERBATIM COMMENTS FROM SURVEY RESPONDENTS

If you had to cut 5% of costs without harmful impact on patients, what would you do first?

"Eliminate unnecessary screening tests."

"Decrease expensive drugs."

"Address senior leadership incentives so they align with the goals for the organization, i.e., Make them held accountable for across the board goals. For example, have CFO accountable for quality goals and CMO accountable for some financial goals. By doing so, they would be forced to work more collaboratively and hopefully would share data leading to mutual and aligned improvement."

"Destroy morale of the clinic."

"Eliminate positions."

"Analyze where current costs go and assess where we are related to benchmarks. We are already in top 5% for high-quality/low-cost ACO so this would be a difficult exercise."

"Bundled payments for elective surgery."

(CONTINUED ON NEXT PAGE)

VERBATIM COMMENTS FROM SURVEY RESPONDENTS (CONTINUED)

"Currently at rock bottom. Only choices now impact on salaries and benefits such as health insurance, work schedule, etc."

"I would employ the use of non-traditional patient interactions. Instead of having follow-ups for well controlled disease, I would use RN visits to ensure that all is going to plan, and only if there were concerns then they would go on to MD/DO staff."

"That would be impossible."

Leemore Dafny, PhD

Harvard Business School

Leemore Dafny is the MBA Class of 1960 Professor of Business Administration at Harvard Business School. Learn more about Leemore Dafny...

Thomas H. Lee, MD, MSc

Press Ganey Associates

Dr. Lee is the Chief Medical Officer for Press Ganey Associates, Inc., a member of the Editorial Board of The New England Journal of Medicine, and the NEJM Catalyst Leadership Board Founder. Learn more about Thomas H. Lee...

NEJM CATALYST — LEADING THE TRANSFORMATION OF HEALTH CARE DELIVERY

Discover practical ideas and solutions from thought leaders and experts

Developed by NEJM Group, NEJM Catalyst presents actionable solutions and case studies from experts and advisors to meet the most critical challenges affecting health care delivery today. Learn valuable insights from thought leaders who are currently executing successful strategies in their organizations and enhance the value of health care delivery in your organization.

Explore NEJM Catalyst to discover practical ideas and spark innovation in your organization.

- Learn from original content from thought leaders
- Watch live web events and video talks
- Join the Insights Council and share your perspective
- Sign up for our weekly e-newsletter to stay informed

Be a part of the dialogue at
catalyst.nejm.org/join

NEJM Catalyst