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The Options for Payment Reform in U.S. Health Care

By UWE E. REINHARDT

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Over the years, both experience and empirical research have taught policy makers around the globe that how money enters the health system – and how much enters – has a powerful influence over the shape and modus operandi of health care delivery.

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It is therefore not surprising that "payment reform" has become the new battle cry in the United States, as the nation seeks better control over the annual increases in health spending per capita.

So, what choices do policy makers have in payment reform?

It is useful to go back to basics. Any payment system for health care has several dimensions:

1. The "base" upon which prices are defined and paid.
2. The level of the payment per unit of the chosen base.
3. The administrative and economic process by which that price level is determined.

The chart below focuses on the first and third of these dimensions. The columns describe the main bases in the menu; the rows describe the methods by which price levels are determined. The second dimension — that is, the "right" level of payment — is highly debated. From society's perspective, economists would define that level as the minimum that must be paid to elicit from the providers of health care the supply of health care goods and services that society wishes to have and is willing to pay for.

By far the most prevalent payment base around the world has been and continues to be the piece-rate method base as fee for services, or F.F.S.

A major advantage asserted for F.F.S. is that it rewards providers of health care in direct proportion to the number and type of services they render — what is called

"productivity." A second advantage is that by its very nature F.F.S. forces the providers of care to describe in detail what services they have delivered to patients. It lays bare what goes on, or at least what is reported to go on, in the provider's practice.

A major disadvantage of F.F.S. is the strong financial incentives it creates to prescribe for and deliver to patients more health care than may be clinically warranted by best-practice standards.

Furthermore, if the profit margin implicit in the level of a fee for a service and the cost of producing the underlying service varies significantly across services — as in practice it generally does — then these profit margins may distort the mix of services going into medical treatments away from best clinical practice.

Finally, the F.F.S. system enables the much-deplored fragmentation of health care suspected of yielding substandard overall quality of medical treatments and excessive costs.

Bundled payments per episode of illness, the next payment base in the chart, are thought to mitigate the disadvantages ascribed to F.F.S.

The idea here is that expert clinicians use evidence-based, best clinical practices to compose the bundle of distinct goods and services that should go into the treatment of a given medical condition. There should then be one single payment made — the so-called bundled payment — for the entire package of these goods and services. There would, of course, have to be an organization at the receiving end of the payment capable of coordinating the entire treatment and distributing the bundled payment among the various participants in the treatment.

The theory driving bundled payments is that, given the payment, the various providers of health care involved in the treatment of a given medical condition — e.g., a hip replacement or a coronary artery bypass graft — will naturally be driven to seek the most cost-effective treatment package.

By "cost effective" is meant the total cost incurred to achieve a given clinical outcome from a treatment — for example, a change in life expectancy or in "quality-adjusted life years," known as QALYs (pronounced KWAH-lees). The QALY is a metric based on life expectancy, with each year adjusted by a multiplier ranging from 0, for death, to 1, for perfect health, for the health status experienced in that year (as I discuss in Pages 519-25 of this paper).

An added advantage attributed to bundled payments is that they automatically force our health care delivery system to change from its current fragmented organization toward clinically integrated health care, generally thought to yield health care of superior quality (and often lower costs).

To health-policy analysts and the policy makers they advise, and many clinicians as well, the concept of bundled payments has enormous intuitive appeal. Not surprisingly, then, bundled payments have become the latest nouvelle vague in this arena.

On the way from concept to implementation, however, bundled payments have to run, first, the gantlet of health care providers, not all of whom gain in the switch to bundled payments from F.F.S., and, second, the gantlet of political partisanship. (Because bundled payments are so enthusiastically endorsed now and yet face these serious obstacles, I shall return to them in the future.)

Capitation is the third base upon which payment to providers of care can be made. This concept is particularly suited to nonepisodic, chronic care.

Under capitation, an organization — for example, a large, multispecialty medical group or a staff-model health maintenance organization such as Kaiser Permanente in California — willing to coordinate all care an individual may need during an entire year against a prepaid flat capitation receives a payment that is adjusted for the expected, actuarial risk of the patient.

Subsequent to receipt of that payment, the paid organization is expected to assume financial risk for the care actually needed by the covered individual. In extraordinary circumstances that could not have been actuarially foreseen, there may have to be ex-post risk-adjustment payment.

Annual salaries for health personnel, including physicians, and predetermined budgets for institutions are the final base upon which payment can be made for health care.

Budgets for institutions, including nursing homes and hospitals, have been widely used around the world, but less so in the United States.

Health personnel other than physicians have traditionally been salaried everywhere. Hospital-based physicians are salaried in many countries and increasingly in the United States, where physicians have switched from self-employment to being employees of hospitals, academic health centers, clinics or large group practices.

Salaried physicians almost always receive their payments from an institution (e.g., hospitals or a clinic) that acts as an intermediary between insurance carriers and patients, on the one hand, and physicians on the other. These institutions may be paid by any of the other payment bases in the chart, and frequently by F.F.S.

When physicians are in the employ of hospitals, the hospitals have far more control of the costs they incur over the signature of physicians ordering hospital services than hospitals have under the traditional American system, in which self-employed physicians have affiliations with hospitals that they can view as rent-free workshops

In that system, the order entry of self-employed physicians attending their hospitalized patients causes the hospital to incur costs over which they have little or no control, while the physicians initiating these costs have typically not been held formally accountable for them. From a managerial perspective, it is an awkward arrangement (see "Hospital Economics 101").

While F.F.S. payment is generally thought to result in overuse and misuse of health care services, bundled payments, capitation, budgets or physician salaries carry with them the risk that clinically desirable services are withheld from patients for financial reasons or simply because exertion is not rewarded.

Therefore, these methods must be accompanied by some means to protect patients from these untoward effects through constant monitoring of the care rendered.

During the 1990s, for example, California experimented widely with capitation — alas, with mixed results. As the California HealthCare Foundation has noted, capitation methods must be accompanied by constant monitoring of the care rendered, to protect patients from these untoward effects. Actually, the same is true for all payment methods, including F.F.S.

Indeed, anyone who thinks for a moment about the problem of paying the providers of health care will quickly come to the disheartening conclusion that there is no ideal method of injecting money into the health care system. Each approach has strengths and weaknesses that must be traded off against one another in settling on a payment option.

In my next post, I shall examine the alternative methods of determining the level of payment per unit of whatever base for payment is chosen. Here, too, the choice of method is not obvious. Each method has strengths and weaknesses.

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The End of Health Insurance Companies

By EZEKIEL J. EMANUEL and JEFFREY B. LIEBMAN

Ezekiel J. Emanuel on health policy and other topics.

Tags:

health care reform, Health insurance, Medicine and Health

Here's a bold prediction for the new year. By 2020, the American health insurance industry will be extinct. Insurance companies will be replaced by accountable care organizations — groups of doctors, hospitals and other health care providers who come together to provide the full range of medical care for patients.

Already, most insurance companies barely function as insurers. Most non-elderly Americans — or 60 percent of Americans with employer-provided health insurance — work for companies that are self-insured. In these cases it is the employer, not the insurance company, that assumes most of the risk of paying for the medical care of employees and their families. All that insurance companies do is process billing claims.

For individuals and small businesses, health insurance companies usually do provide insurance; they take a premium and assume financial responsibility for paying the bills. But the amount of risk sharing that is accomplished is limited because the insurers charge premiums that vary, depending on the health of an individual or a group of employees, and use their data and market power to identify healthy people to cover and unhealthy people to exclude from coverage. (The health care law's total ban on exclusions for pre-existing conditions will begin in 2014.)

A new system is on its way, one that will make insurance companies unnecessary.

Many health insurance companies also impose barriers — like requiring prior authorization for tests and treatments and denying payment for covered services, which forces patients to appeal — to discourage patients from using the medical services for which they are insured and to attempt to avoid paying for those services. While these barriers can reduce waste by preventing unnecessary care, they can also discourage patients from receiving care they need, as well as impose administrative burdens on doctors and patients.

But thanks to the accountable care organizations provided for by the health care reform act, a new system is on its way, one that will make insurance companies unnecessary. Accountable care organizations will increase coordination of patient's care and shift the focus of medicine away from treating sickness and toward keeping people healthy.

Because most physicians and hospitals today are paid on a fee-for-service basis, medical care is organized around treating a specific episode of illness rather than the whole patient. This system encourages overtreatment and leads to mistakes and miscommunication when patients are sent between their primary care doctors, specialists and hospitals. Indeed, under today's payment system, investments in providing better care are doubly penalized. If a hospital hires a nurse to follow up with patients after they are discharged in order to reduce readmissions — for example, to help patients with diabetes improve blood sugar control — it must pay for the nurse, which is typically not reimbursed by insurance companies or Medicare, and it loses revenue by preventing the readmission.

In contrast, accountable care organizations will typically be paid a fixed amount per patient, along with bonuses for achieving quality targets. The organizations will make money by keeping their patients healthy and out of the hospital and by avoiding unnecessary tests, drugs and procedures. Thus, they will actually have a financial incentive to hire that nurse for follow-ups.

In addition to providing better and more efficient care, A.C.O.'s will also make health insurers superfluous. Because they will each be responsible for a large group of patients (typically more than 15,000), they will pool the risk of patients who have higher-than-average costs with those with lower costs. And with the end of fee-for-service payments, insurance companies will no longer be needed to handle complicated billing and claims processing, nor will they need to be paid a fee for doing so. Payments can flow directly from an employer, Medicare or Medicaid to the accountable care organizations. A.C.O.'s will require enhanced information systems to track patients and figure out how to deliver more effective care, but this analytic capacity will be directed at improving health outcomes, not at imposing barriers to those seeking treatment.

A.C.O.'s are not simply a return to the health maintenance organizations of the 1990s. Although in both models patients are members of a provider network with a specific group of doctors and hospitals, and both are paid primarily per member rather than per procedure or test, there are big differences between them. H.M.O.'s were often large national corporations far removed from their members. In contrast, A.C.O.'s will consist of local health care providers working as a team to take care of patients who are likely to be members for years at a time. H.M.O.'s often cut costs not by keeping people healthy but by denying patients services and by forcing doctors and hospitals to take lower payments. In the 1990s, we lacked the information technology and proven models of

integrated care delivery that we have now. These advances will allow A.C.O.'s to simultaneously improve health outcomes and reduce costs.

A final bonus of A.C.O.'s is that they will lead to a better form of competition in health care markets. Today, consumers have to choose among insurance plans with a bewildering array of copayments, deductibles and annual out of pocket maximums — choices that few of us are any good at making. In the A.C.O. model, consumers will choose a primary care physician and the team of doctors and hospitals that are in the same group. Choosing a doctor and provider group is a responsibility that consumers want to have and are likely to be much better at.

A few health insurers see this asteroid coming. Wellpoint, for example, bought the clinic operator CareMore for $800 million last summer to make the transition into the A.C.O. business. Others, like the Optum unit of UnitedHealth Group, are developing data analysis services to provide to future A.C.O.'s. If they don't want to go the way of the dinosaurs, insurance companies will have to find a new business to be in, one that is useful in the new world of coordinated care.

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ONE YEAR OF INNOVATION

[Taking Action to Improve Care and Reduce Costs]



DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicare & Medicaid INNOVATION

OVER THE PAST SEVERAL YEARS, there is one point on which policy makers, health care providers and patients have come to agree: if we want an improved and sustainable health care system, **we need to transform how we deliver and pay for health care**.



Through the Affordable Care Act, the U.S. Department of Health and Human Services (HHS) has been helping providers improve how they deliver health care services, through hospital value-based purchasing, realigned and increased primary care payments, and greater coverage for preventive care. The Center for Medicare and Medicaid Innovation (the Innovation Center), is an important new resource for health care providers dedicated to improving how our health care system works. Its mission is to move quickly to identify, test, and spread delivery and payment models to help providers improve care while cutting costs.

In the year since opening its doors, the Innovation Center's work is well underway. It has introduced 16 initiatives (see Table at end of report) involving over 50,000 health care providers that will touch the lives of Medicare and Medicaid beneficiaries in all 50 states and will continue to expand its partnerships and reach in the years to come. These initial efforts are focused on improving patient safety, promoting care that is coordinated across health care settings, investing in primary care transformation, creating new bundled payments for care episodes, and meeting the complex needs of those dually eligible for Medicare and Medicaid.

THE CASE FOR INNOVATION

The American health care system is, in many respects, the envy of the world. The United States is the global leader in developing new ways to prevent, diagnose, manage, and cure illness. Our academic institutions offer the finest education and training available. Our talented physicians, nurses, and clinicians work hard each day to deliver the highest quality care. Many of our hospitals are internationally known and admired. Yet despite having the world's best doctors and nurses, most advanced medical technology, and finest hospitals, Americans continue to live sicker and die sooner than citizens of many other nations.

Our health care system is full of barriers, roadblocks, and red-tape—ranging from the way we pay for health care services to a lack of usable, reliable information for patients and clinicians alike—that often keep health care professionals from practicing medicine in a collegial, evidence-based, and patient-centered manner. Many doctors, nurses, and other providers have had great ideas, good intentions, and determined efforts, but have been thwarted by disincentives and other obstacles to innovation. The result is a health care system that is often disjointed, inefficient, and costly.

Yet we know improvement is possible. Dedicated clinicians and innovative entrepreneurs around the country have found ways to work with other providers and payers in their local communities to break down barriers and redesign care for the benefit of their patients, themselves, and their communities. For example, large employers and unions are working together to improve the health of their workers by investing in comprehensive primary care, which is decreasing the overall cost of healthcare.

Similarly, some health systems have demonstrated that by keeping people healthy in the first place, providing a coordinated care experience, and striving to get care right every time, they can achieve better outcomes and lower costs for their patients. From their efforts, we know what can and should be done. The current and crucial health care challenge is to bring the best of these approaches to every community in the country.

Through specific transformative programs in the Affordable Care Act and programs launched by the Innovation Center, HHS and Centers for Medicare and Medicaid Services (CMS) are working hard to support physicians, nurses, hospital systems, and others who have accepted the challenge to develop a new, sustainable health care system. It will be a system where providers work with engaged patients and are rewarded for keeping people well, not simply for delivering more services.

AN INNOVATIVE "MENU" OF OPTIONS FOR PARTNERSHIP

We know there is growing consensus that we must move from a volume-based and fragmented health care system to one more based on achieving value for patients and providers through better care, better health, and lower cost. Our strategy is to partner with the patients, providers, and other payers to test new payment and care models that support providers in transitioning to that new system.

To implement that strategy over the past year, the Innovation Center actively sought input from a broad array of stakeholders to identify some of the most promising ways to improve care and lower costs. The Innovation Center met with hundreds of outside innovators, held ten regional meetings with over 4,000 attendees, and received nearly 500 significant proposals for improving health care payment and delivery through the "Innovation Portal" on its website.

Incorporating this rich feedback, the Innovation Center launched an initial menu of initiatives that engage different types of providers and payers at varying levels of experience with care coordination. Each initiative holds the promise of reducing health care costs, improving quality, and improving health. All of these models are tests to help identify which care and payment models deliver greater value for our health system and then to rapidly spread what works.

Some of the new initiatives launched by the Innovation Center this year are described below, and a broader list of initiatives are described in the table at the end of this report:

Improving Patient Safety in Hospitals—The Partnership for Patients. Through the Partnership for Patients initiative, the Innovation Center is working with hospitals, physicians, nurses, other clinicians, consumer groups, and employers to reduce hospital-acquired conditions and preventable hospital readmissions. The program is a public-private partnership with over 7,100 organizations participating as of January 2012—including more than 3,200 hospitals. By joining the Partnership, these organizations have pledged to meet the Partnership's two goals—to reduce preventable harm in hospitals by 40 percent and readmissions to hospitals within 30 days of discharge by 20 percent in the next three years.

The Partnership is investing up to $500 million in public-private engagement networks that will help hospitals adopt proven strategies to reduce hospital-acquired conditions in their own facilities and systems. The Partnership's second component, the Community-based Transitions Program, is a $500 million initiative to reward hospitals, physicians, and others who partner together to keep patients out of the hospital after discharge. Taken together, the Partnership has the potential to save 60,000 lives, reduce millions of preventable injuries and complications in patient care and, by meeting its goals, save our health care system as much as $50 billion over 10 years, according to the CMS Office of the Actuary.

Encouraging Care Coordination—Pioneer Accountable Care Organizations (ACOs) and Advance Payment Models. Today's system of paying on a per-service basis often discourages—and even financially penalizes—health care providers for working together to coordinate care and keeping patients healthy and out of the hospital or a nursing home. The Pioneer ACO Model tests the rapid transition to a new payment model where experienced organizations are paid according to their ability to improve the health of their patient population, rather than for each specific service they provide. Starting on January 1, 2012, 32 organizations are participating in the Pioneer ACO Model to test what can be achieved through highly coordinated care for more than 850,000 Medicare fee-for-service beneficiaries. Participating organizations must create similar arrangements with other private sector payers so that more patients have access to this highly coordinated care. According to the independent CMS Office of the Actuary, this model is projected to save Medicare up to $1.1 billion over five years.

A closely related initiative, the Advanced Payment ACO Model, will test whether pre-paying a portion of future shared savings will allow more physician-based and rural ACOs to participate in the Medicare Shared Savings Program, to improve care for beneficiaries and generate greater Medicare savings more quickly. In the Shared Savings Program, groups of providers come together

"The Partnership for Patients is going to give us the ability, for the first time, to unlock the energy that's already there. We know when we look at some of the hospitals that we work with, that people are doing great stuff around really saving lives, around making patients lives better. So, for instance, one hospital in our membership, Stony Brook, has cut mortality from sepsis, from severe infections, by half. That's great news. But now the question is, how do we spread that, how do we make sure that that's not just exception, that everybody's doing that and everybody knows how to do that and has sort of the basic tools to make it happen? That's what the Partnership can really accelerate, can really create a breakthrough around."

DR. BRUCE SIEGEL
President and CEO, National Association of Public Hospitals and Health Systems

"The Pioneer ACO program provides an important opportunity for physicians who are ready to participate in an ACO now, while other groups can begin the process of forming a Medicare ACO in CMS' program throughout 2012."

PETER W. CARMEL, MD.
President, American Medical Association

"This (Pioneer ACO announcement) is a large step forward for Medicare, and for the entire health care delivery system."

DR. DON CRANE
President, California Association of Physician Groups

as accountable care organizations to improve care coordination for Medicare beneficiaries and can share in savings they generate for Medicare if they meet certain quality improvement metrics. The Innovation Center is still accepting applications for Advanced Payment ACOs, which will start in April and July of this year in concert with the first two enrollment periods for the Shared Savings Program.

Matching Payment to the Patient Experience—Bundled Payments for Care Improvement. Patients experience care in episodes, often visiting multiple doctors' offices, hospitals, and laboratories as they seek treatment and recovery. But today's system of paying separately for each service often leads to disjointed care, poor outcomes, and a confusing and frustrating experience for many patients. The Bundled Payments for Care Improvement initiative builds on episode-based payment models pioneered in the private sector by redesigning payment to match the patient experience. It offers providers four patient-centered episode of care models to choose from, allowing providers the flexibility to choose the conditions they believe make sense to bundle, decide how best to work together to deliver high-quality, coordinated episodes-of-care, and determine participating providers' share of payment. Health care organizations will give Medicare a discount off the current cost of care for the episodes covered under the initiative, thereby ensuring Medicare Trust Fund savings.

Revitalizing Primary Care—The Comprehensive Primary Care Initiative and The Federally Qualified Health Center Advanced Primary Care Practice Demonstration. Communities with high-performing health systems share a common trait: a strong primary care backbone. Through various investments such as free Medicare Wellness visits and enhanced reimbursement for primary care as a result of the Affordable Care Act among other initiatives, CMS has made the commitment to strengthen the primary care system. However, general practitioners still often struggle to find time to spend with each patient due to the increasing demand from patients and lagging supply of primary care practitioners. The Innovation Center has launched multiple initiatives to strengthen primary care by supporting clinicians willing to comprehensively manage and coordinate the care of their patients, particularly those with serious or chronic diseases with the goal of reinvigorating the primary care system.

The Comprehensive Primary Care Initiative is a collaboration between public and private payers and primary care practices to support patient-centered primary care in communities across the country. Primary care practices will receive new, public, and private funding for primary care functions not currently supported by fee-for-service (FFS) payments, including an opportunity to share net savings generated through this program. In return, participating practices will agree to give patients 24-hour access to care, create personalized care plans for their patients, and coordinate with other providers to ensure patients are getting healthy and staying well.

The Federally Qualified Health Center Advanced Primary Care Practice Demonstration tests whether advanced primary care practice at community health centers can improve care and patients' health, and reduce costs. In October 2011, 500 community health centers in 44 States were selected to receive approximately $42 million over three years to reorganize as Patient Centered Medical Homes and improve the coordination and quality of care they give to people with Medicare and other patients.

"The Medicare Bundled Payment for Care Improvement Initiative has the potential to speed up bundled payment implementation by testing various models and giving providers a great deal of flexibility to design a model that works for them."

MARK ZEZZA, STUART GUTERMAN, AND JENNIE SMITH
The Commonwealth Fund, January 2012

The Comprehensive Primary Care initiative "offers enormous potential to promote the kind of personalized and coordinated care that patients seek and that physicians want to deliver. The program will provide primary care physicians with the support needed to work hand-in-hand with patients toward a shared goal of ensuring high-quality care while making the most efficient use of health care resources."

DR. STEVEN WEINBERGER
Chief Executive Officer, The American College of Physicians

New Models of Care and Payment to Support Medicare-Medicaid Enrollees. The Innovation Center is committed to working with other purchasers of health care—both private and public—to ensure care is improving across patient populations. Working with the CMS Medicare-Medicaid Coordination Office, the Innovation Center is empowering States to test new payment and service delivery models that will help improve quality of care, and reduce the costs of care, for the nearly nine million people enrolled in both the Medicare and Medicaid programs. While these Medicare-Medicaid enrollees represent a small percentage of the nearly 100 million people enrolled in the two programs, their care is complex and costly: they account for 21 percent of Medicare beneficiaries but 36 percent of Medicare spending, and 15 percent of Medicaid recipients but 39 percent of Medicaid cost. To date, 15 States have been awarded design contracts of up to $1 million to develop new ways to meet the needs of this complex population. Additionally, the Innovation Center and the Coordination Office have offered States the opportunity to move beyond the design phase and test new models of payment and care coordination in their States. Thirty-eight States and the District of Columbia have expressed interest in working with CMS.

Engaging Local Innovators—Health Care Innovation Challenge. The Innovation Center recognizes that many of the best ideas will come from physicians, other health care providers, and innovative thinkers in communities across the country. Announced in November 2011, the Health Care Innovation Challenge will award up to $1 billion in grants to applicants who put into practice the most compelling new ideas for rapidly delivering better health, improved care and lower costs to people enrolled in Medicare, Medicaid and CHIP, particularly those with the highest health care needs. The initiative is also looking for new models of workforce development and deployment to support the transition toward high-value care. Awards will range from $1 million to $30 million for a three-year period. Providers, payers, local government, public-private partnerships and multi-payer collaboratives may apply.

Supporting Individuals to Help Transform Health Care—Innovation Advisors Program. Crucial to the efforts of transforming the health care system is supporting individuals who can test and refine new models to drive delivery system reform. The Innovation Center seeks to deepen the capacity for transformation by creating a network of experts in improving the delivery system for Medicare, Medicaid, and CHIP beneficiaries. The Innovation Advisors will:

Utilize their knowledge and skills in their home organizations or communities in pursuit of the three-part aim of improving health, improving care, and lowering costs through continuous improvement;

- Work with other local organizations or groups in driving delivery system reform;
- Develop new ideas or innovations for possible testing of diffusion by the Innovation Center; and
- Build durable skill in system improvement throughout their area or region.

In December 2011, the CMS Innovation Center selected 73 individuals out of 920 applications through a competitive process to participate in the initiative. The first group of Innovation Advisors is starting their six-month intensive orientation and applied research period in January 2012.

LOOKING FORWARD

The Innovation Center is not only testing new models of care delivery and payment, it is also changing the way CMS partners with providers and conducts demonstration projects. Learning from previous CMS projects and feedback from the health care community, the Innovation Center is committed to providing participants more timely and useful data necessary to improve and coordinate care, rapid-cycle evaluations on their performance, and a new array of opportunities to learn from each other as they innovate. The Innovation Center is also piloting new ways to spread lessons learned, so that success is not just a report—but tangible to providers and patients across the country. That's why every Innovation Center initiative includes a "diffusion" element that matches participating organizations with experts in the field and peer organizations to discuss successes and learn from mistakes. Providers will have tools and resources available to them and will be expected to help diffuse best practices, lessons learned, and improved care strategies so that innovation is not limited to a demonstration site or only one particular community.

INNOVATION CENTER INITIATIVES

[2010 – 2011]

INITIATIVE	APPLICATION DEADLINE	INITIATIVE START DATE	LENGTH	PARTICIPANTS/ LOCATIONS	TOTAL FUNDING	NUMBER OF BENEFICIARIES AFFECTED
PRIMARY CARE TRANSFORMATION						
Comprehensive Primary Care Initiative Demonstration Public-private partnership to enhance primary care services, including 24-hour access, care plans, and care coordination	1/17/2012	2012	4 years	Plan for payers and states in 5–7 markets; 75 practices per market	$322 million	315,000 Medicare 15,750 Medicaid
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration Care coordination payments to FQHCs in support of team-led care, improved access, and enhanced primary care services	9/16/2011	11/1/2011	3 years ending on 10/31/14	500 FQHCs in 44 states	$49.7 million	202,000 Medicare
Multi-payer Advanced Primary Care Practice Demonstration State-led, multi-payer collaborations to help primary care practices transform into medical homes	8/17/2010	Phased-in starting 07/01/2011	3 years	NC, ME, MI, MN, NY, PA, RI, VT	$283 million*	332,000 Medicare
Independence at Home Home-based care for patients with multiple chronic conditions	2/16/2012	Summer 2012	3 years	Up to 50 practices with at least 200 high need beneficiaries.	$15 million*	10,000 Medicare
BUNDLED PAYMENTS FOR CARE IMPROVEMENT						
Bundled Payment for Care Improvement Initiative Episodic payments around inpatient hospitalizations to incentivize care redesign	Model 1: 11/18/2011; Models 2-4: 4/30/2012	2012	3 years	To be determined	$118 million	Not available

INITIATIVE	APPLICATION DEADLINE	INITIATIVE START DATE	LENGTH	PARTICIPANTS/ LOCATIONS	TOTAL FUNDING	NUMBER OF BENEFICIARIES AFFECTED
ACCOUNTABLE CARE ORGANIZATIONS						
Pioneer Accountable Care Organization Model Initiative Experienced provider organizations taking on financial risk for improving quality and lowering costs for all of their Medicare patients	8/19/2011	January 2012	3 years (with optional 2-year extension)	32 ACOs—see link for full list of orgs	$77 million	860,000 Medicare
Accelerated Development Learning Sessions Public opportunities to learn from leading experts about successful ACO development	Not applicable	June 2011	3 sessions completed	Open to leadership from developing or existing ACOs	$1.5 million	Not applicable
Advanced Payment Accountable Care Organization Model Initiative Prepayment of expected shared savings to support ACO infrastructure and care coordination	2/1/2012 for 4/1/2012 start date; 3/30/2012 for 7/1/2012 start date	4/1/2012 or 7/1/2012	Payments end June 2014	Physician-based and rural ACOs in the Shared Savings Program	$175 million	650,000 Medicare[+]
Physician Group Practice Transition Demonstration A precursor to the Medicare Shared Savings Program; rewards physician groups for efficient care and high quality	Not applicable (open only to participants in original PGP demo)	1/1/2011	Up to 3 years	10 group practices started the demo; 3 moved to the Pioneer ACO model	$500,000* in administration costs	87,700 Medicare
MEDICARE-MEDICAID ENROLLEES						
State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees Assistance to help states engage stakeholders in redesigning care for Medicare-Medicaid enrollees	2/1/2011	April/ May 2011	18 months (with extension option)	CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, WI	$15 million	Not applicable
Financial Alignment Model Demonstrations Opportunity for States to implement new care and payment systems to better coordinate care for Medicare-Medicaid enrollees	Spring 2012	January 2013	3 years	38 States and DC have submitted letters of intent	To be determined	2 million Medicare-Medicaid enrollees

[+] **Note:** The budget for the Advance Payment Model was based on an estimated 650,000 Medicare beneficiaries. These beneficiaries would be assigned to Shared Savings Program ACOs.

INITIATIVE	APPLICATION DEADLINE	INITIATIVE START DATE	LENGTH	PARTICIPANTS/ LOCATIONS	TOTAL FUNDING	NUMBER OF BENEFICIARIES AFFECTED
CAPACITY TO SPREAD INNOVATION						
The Partnership for Patients National campaign targeting a 40% reduction in hospital-acquired conditions and a 20% reduction in 30-day readmissions	Ongoing	4/12/2011	Ongoing	26 Hospital Engagement Networks supporting over 3,200 hospitals in all 50 states	$500 million	Not applicable
Innovation Advisors Program Training health care providers from around the country in achieving the three-part aim	11/15/2011	January 2012	Ongoing	73 Advisors selected and started January 2012 with up to 127 more in the next cycle	$5.9 million	Not applicable
Health Care Innovation Challenge A broad appeal for innovations with a focus on developing the workforce for new care models	1/27/2012	3/30/2012	3 years	To be determined	$1 billion	Not available
OTHER						
Medicaid Emergency Psychiatric Demonstration Expanding access to inpatient psychiatric services for Medicaid beneficiaries	10/14/2011	Spring 2012	3 years	Unspecified number of states	$75 million*	Not yet available
Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) Program Collaborating with States to test the effectiveness of preventive services in Medicaid	5/2/2011	Sites awarded 09/13/2011	5 years	WI, MN, NY, NV, NH, MT, HI, TX, CA, CT	$100 million*	Not available

* Program developed and implemented by the Innovation Center, but funding based on other statutory authorities.

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Center for Medicare and Medicaid Innovation aims to cut health-care costs

By N.C. Aizenman, Published: January 26

The Obama administration touts it as a key solution to the nation's runaway health-care spending: a new national center set up by the 2010 health-care law to test and implement groundbreaking ways to cut costs while improving patient care.

On Thursday, a little more than 14 months after the center opened, officials will release a report summarizing its progress: 16 recent initiatives, funded with more than $1.7 billion in federal money, that will involve more than 50,000 providers over the next five years.

The Center for Medicare and Medicaid Innovation is technically limited to experimenting with payment incentives and methods of delivering care within Medicare and Medicaid, as well as the Children's Health Insurance Program (CHIP). But its director, Richard Gilfillan, said he will work with providers who also see a large share of private patients, to ensure that the models tested are effective for those populations as well.

The sheer number of seniors covered by Medicare and low-income Americans covered by Medicaid suggests that any changes embraced by the doctors and hospitals that serve those patients could soon be adopted system-wide.

"The reality is that over the years, the private sector has by and large followed Medicare's lead in payment systems," Gilfillan said. "Medicare has been the most innovative payer if you look back over

the last 30 years."

With $10 billion in total funding to spend through the end of 2019, Gilfillan said he anticipates rolling out additional initiatives soon. They could include ideas that emerge at an "innovation summit" the center will hold in Washington on Thursday with about 1,500 representatives from the health-care and health technology fields.

The initiatives — the longest of which has been running for a few months — could take 15 to 18 months to produce results, he said. If an approach is found to either reduce spending without lowering the quality of care, or to improve the quality of care without increasing costs, Health and Human Services Secretary Kathleen Sebelius will have new authority to implement it nationwide.

Some health-care experts question how many of these experiments will result in significant savings.

They point to a study released by the Congressional Budget Office last week that found that savings were produced in only one of 10 major Medicare demonstration projects tried by administrations since 1967 — all of them similar to initiatives the innovation center has begun.

"It would be wrong to assume we shouldn't do these new projects just because the last ones didn't succeed," said Robert Laszewski, a health-care consultant with clients across the industry. "If Thomas Edison had stopped the first time he failed, we wouldn't have the light bulb."

Still, he said, it is worth focusing on the key feature of the one experiment that did succeed: It penalized providers that did not produce savings.

"What we've learned is that you can't rely on people to do the right thing just because you've provided them with more information," he said. "You've got to change the way they're paid so that there is a downside to not doing the right thing. … You can't have all carrot with no stick."

The center's current list of initiatives is a mixed bag in that regard.

Several are focused on incentives — for instance, offering extra compensation to primary-care providers to coordinate patients' treatment and prevent them from developing costly illnesses.

Another initiative will spend $77 million to test whether doctors and hospitals can save money by forming "accountable care organizations" that receive a set amount for each patient and then coordinate care. It offers pioneering ACOs a choice: They can keep a large amount of any savings they produce, but take a hit if their costs exceed government targets. Or they can choose to be insulated from that financial risk in exchange for a smaller share of any savings.

Among the most ambitious experiments is the "Partnership for Patients," which will provide more than 7,100 organizations — including more than 3,200 hospitals — $500 million to help them reduce hospital-acquired conditions.

In exchange, participating providers have pledged to reduce preventable harm in hospitals by 40 percent, and to cut readmissions to hospitals within a month of discharge by 20 percent over the next three years. The partnership initiative itself will not penalize them if they fail. Providers will, however, have an incentive to succeed because of a separate provision of the health-care law: Beginning this fall, Medicare will dock the pay of hospitals with a high percentage of preventable readmissions.

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The Center for Medicare and Medicaid Innovation: Activity on Many Fronts

Timely Analysis of Immediate Health Policy Issues
February 2012

Robert A. Berenson and Nicole Cafarella

One of the few health policy issues that receives bipartisan support is the need to dramatically alter the way providers are paid, shifting from "paying for volume" to "paying for value." New payment approaches and new organizations capable of accepting value-based payments are seen by some as transformative innovations that can alter the trajectory of health care spending while improving quality of care. The Patient Protection and Affordable Care Act of 2010 (ACA) has equipped the Centers for Medicare & Medicaid Services (CMS) with a range of cost-cutting and quality-enhancing tools, the most significant of which might be the Center for Medicare and Medicaid Innovation (Innovation Center).

The Innovation Center is pursuing a groundbreaking portfolio of payment and delivery reform initiatives that will attempt to fundamentally change the way we deliver and pay for care in the future. The ACA appropriates $10 billion for Innovation Center activities initiated between and including fiscal years 2011 to 2019, and then appropriates an additional $10 billion for each of the following decades (without an end date).[1] Congress appropriates rather than authorizes the Innovation Center's funding to ensure that it does not have to return to Congress each year or even each decade for additional funding. Although $10 billion per decade represents a major spending commitment, it is still less than 0.1 percent of Medicare and Medicaid spending through the end of this decade—far less than most organizations commit to research and development.[2]

There seems to be broad agreement in the policy community on the objectives the Innovation Center was established to achieve. A 2011 Commonwealth Fund/*Modern Healthcare* survey of health care opinion leaders found that 83 percent of respondents thought the Innovation Center was an important initiative—support that is about 20 percentage points higher than for the Patient-Centered Outcomes Research Institute and the Independent Payment Advisory Board.[3]

Nevertheless, a contrary view is skeptical about the role of government, as centralized in the Innovation Center, in promoting and adopting true innovation. Advocates of market-based solutions to cost and quality problems argue that innovation springs from competitive forces—from the ground up—and cannot be determined and spread from a government agency, however worthy its intentions. And, perhaps reacting to claims by White House officials that the Innovation Center would be a source of job creation,[4] three members of the Senate Finance Committee recently publicly voiced concerns in letters to both the Government Accountability Office (GAO) and the Department of Health and Human Services' (HHS) Secretary Sebelius. Senators Orrin Hatch, Mike Enzi, and Tom Coburn asked the GAO to review the Innovation Center's activities and funding decisions, its fiscal impact on Medicare and Medicaid, and the degree of redundancy in CMS due to the Innovation Center's existence.[5]

While required to carry out initiatives specified in the ACA, the Innovation Center also has placed emphasis on promoting change from the ground up, in an attempt to be responsive to new ideas. In November 2011, it announced an Innovation Challenge to award between $1 million and $30 million in grants (totaling $1 billion) to any applicant who proposes to implement compelling new ideas to deliver better care to people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). In various ways, the Innovation Center has also made a commitment to actively seek collaboration with other payers of health care services, including states and private insurance companies, to find common innovations in payment and care delivery. Since its inception, the Innovation Center has announced over a dozen major initiatives, ranging from a program that helps individuals build the skills needed to innovate from the ground up to a demonstration that invites public and private payer collaboration in developing a medical home approach to a set of initiatives that complement Medicare's existing

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accountable care organization (ACO) program.

Given all of this activity, some now express concern that the Innovation Center may be doing too much too soon, providing overwhelming numbers of program options without an articulated vision or clear road map of the direction it wants the health delivery system to take.[6] According to this viewpoint, the rapid succession of requests for proposals (RFPs) with tight time deadlines seems geared more to large, well-financed organizations than to the majority of providers who may need longer to generate innovative approaches. Yet, conversations with Innovation Center leadership make clear that they are proceeding with "a sense of urgency" to address the Triple Aim to (1) improve the individual experience of care, (2) improve the health of populations, and (3) reduce per capita costs of care for populations.[7]

The goal of this paper is to provide a status report on the Center for Medicare and Medicaid Innovation. The paper first defines the goals Congress envisioned for the Innovation Center and the new tools it was given, emphasizing how the enhanced authority compares with CMS' traditional demonstration programs. Next, the paper outlines the Innovation Center's organization and staffing, how it sets priorities and decides on funding, and its approach to altering traditional approaches to testing innovative ideas, while also seeking a much more collaborative interaction with providers, other payers, and the public. The paper concludes with a description of the major activities to date, along with a table listing the projects that the Innovation Center has initiated so far (see Table 1).

Most of the information in this paper was found in publicly available sources. We supplemented that review by interviewing senior leadership within the Innovation Center. We have also drawn on observations by some providers and delivery system reform experts who have interacted with the Innovation Center, to understand the perspective of those on the outside. To facilitate frank discussion, we promised that we would not attribute comments to specific individuals.

Why Was the Innovation Center Created?

Congress established the Innovation Center in the ACA primarily to test new payment and delivery models. The law specifically charges the Innovation Center with identifying, developing, assessing, supporting, and spreading new models that might reduce expenditures under Medicare, Medicaid, or CHIP while improving or maintaining care quality. The statute also suggests that the Innovation Center make multipayer initiatives one of its priorities.[8]

The ACA directs the Innovation Center to give preference to models that enhance coordination, quality, and efficiency of care provided to Medicare and Medicaid beneficiaries, as well as those dually eligible for the two programs. Congress further suggests that the Innovation Center give preference to models that address "a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures." The law suggests but does not require that it explore 18 priorities, called models, for delivery reform**.** [9] It is important to note that the ACA also enables the Secretary of HHS to waive certain provisions of existing law that otherwise would prevent CMS from testing models with alternative provider payment systems and/or coverage policies.[10]

How Does the Innovation Center's Authority Compare to CMS' Traditional Demonstration Authority?

The Innovation Center is in many ways an extension of and improvement on CMS' existing authority to conduct demonstrations in Medicare, Medicaid, and CHIP. CMS' authority to conduct Medicare demonstrations is most commonly based on Section 402 of the Social Security Amendments of 1967 (as amended by Section 222(b) of the 1972 Social Security Amendments). CMS' "Section 1115 Medicaid demonstration" authority, the most common source of authority for Medicaid demonstrations, dates back to 1962, when Section 1115 of the Social Security Act was enacted. Section 1115 also is the basis for CMS' authority to conduct demonstrations under CHIP, though that program was created much later as part of the Balanced Budget Act (BBA) of 1997.[11]

Over time, Medicare and Medicaid demonstrations have taken on different roles within each program. CMS uses Medicare demonstrations as a tool to (1) test the effectiveness of delivery, payment, and benefit innovations on a small population of beneficiaries or a specific geographic area over a short time period, and (2) gain operational experience applicable to future demonstrations or programmatic changes.[12]

Medicaid demonstrations are used commonly to waive provisions of statute that limit the range of

programmatic changes available to states and provide matching federal funds for services and/or populations that otherwise would not be eligible for federal reimbursement. Many states have used Medicaid demonstrations to redesign significant portions of their programs, to the point, in the analysis of a Medicaid policy expert, that "in many states, the demonstrations have become the Medicaid programs."[13]

The Innovation Center's authority to conduct demonstrations marks an important departure from CMS' traditional demonstration authority. The ACA gives the Innovation Center a reliable stream of funding—appropriated rather than simply authorized by Congress—and the Secretary of HHS new authority over the demonstration approval process, the scope of models to be tested, and the decision to scale up successful models to the national level.

The Office of Management and Budget (OMB) actively participates in the development and final review of Innovation Center initiatives, but models tested, evaluated, or expanded under Innovation Center authority are exempt from OMB review and approval of information collections under the Paperwork Reduction Act and of CMS' budget neutrality analysis.[14]

However, to ensure spending discipline in the demonstration process, the Secretary is required to terminate or alter a demonstration unless the Secretary finds that the demonstration is (1) improving quality while maintaining or decreasing cost levels, or (2) reducing costs while maintaining or improving quality. The CMS chief actuary must also certify the Secretary's findings regarding demonstration spending levels. The law, however, is silent on the length of time needed to make this determination—giving the Secretary flexibility on ending a demonstration.[15]

ACA also gives the Secretary the authority to scale up nationally successful demonstrations without first obtaining congressional approval. To broaden a model, the Secretary must determine that such action "would not deny or limit [beneficiary] coverage or provision of benefits" to beneficiaries, in addition to passing the quality and spending requirements, mentioned above, for continuing a demonstration. The CMS chief actuary also must independently verify that model reduced trust fund expenditures before the Secretary can authorize scaling up the model.[16]

Medicare Demonstration Authority

Under CMS' traditional Medicare demonstration authority, demonstrations can be initiated through an act of Congress or action on the part of the Secretary. Medicare demonstrations initiated by CMS under this authority generally have tested delivery, payment, and/or benefit changes. These demonstrations cannot proceed if they lower the quality of care that beneficiaries receive, expand program eligibility, or waive beneficiaries' freedom to choose their providers.[17]

Congress can mandate that CMS implement a new Medicare demonstration project through legislation or the annual appropriations process, or Congress can extend existing demonstrations beyond their planned date of completion. In the past, Congress mandated few Medicare demonstrations. Over time, Congress has become more active in this area. As of April 2010, Congress had mandated 17 of the 31 active or upcoming Medicare demonstrations in CMS' active portfolio.[18] Despite the increase in congressionally mandated demonstrations, funding levels in the 2000s for research, demonstrations, and evaluations have varied considerably—ranging from $138 million in 2001 to only $31 million in 2008.[19]

Medicaid Demonstration Authority

Under Section 1115 demonstration authority, the Secretary is permitted to waive certain provisions of Medicaid statute relating to the design and operation of state programs. For example, the Secretary can waive provisions that cover Medicaid eligibility criteria, the range of offered services, and the delivery and payment system approach used in a state. The state also becomes eligible for federal matching funds to cover the new services or population.[20]

Since Section 1115 demonstrations must be budget neutral, the cost of any proposed program expansions must be offset by savings to the program in other areas. In the past, states have generated savings to offset new costs by implementing managed care capitated payments (the most common method); redirecting Medicaid payments made to hospitals that serve a disproportionate share of Medicaid and/or uninsured patients; and limiting offered benefits to or increasing cost sharing for existing Medicaid patient populations. OMB also allows states to count program expansions already permitted under federal law but not adopted by the state as savings for the purpose of calculating a demonstration's budget neutrality.[21]

In 1993, the Clinton administration signaled that it would begin to use Section 1115 authority as a tool for achieving statewide health reform—

OMB Authority to Review Budget Neutrality

To pass OMB review, a demonstration's total spending cannot exceed anticipated spending levels under existing law and must generate savings to offset the agency's operational costs.[1]

When the Health Care Financing Administration[2] (HCFA) was created in 1977, it had almost unlimited power over the demonstration process. Tension between OMB and HCFA began to mount immediately over both the agency's decisions to authorize certain demonstrations and the size of the Medicare budget devoted to research and demonstrations (as much as 20 percent of Medicare's budget from the late 1970s to the early 1980s).[3]

During the fiscal 1983 budget process, OMB assumed greater control over the demonstration process through an agreement brokered between then-OMB Director David Stockman and then-HHS Secretary Richard Schweiker, giving OMB clearance authority over demonstrations and creating the budget neutrality requirement.[4]

Over the years, some have raised concerns about the narrowness of OMB's budget neutrality review. The budget neutrality determination may not recognize savings generated after the demonstration period has ended—as is often the case with primary and secondary prevention interventions—or even savings to another government program. The budget neutrality requirement also may limit CMS' ability to test ideas with unproven potential to reduce or maintain spending levels while improving quality, or ideas that could give CMS important operational experience that could be applied subsequently in demonstrations and program administration.[5]

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[1] Medicare Payment Advisory Commission. "Report to the Congress: Aligning Incentives in Medicare," 2010.
[2] HCFA was renamed CMS in 2001.
[3] Dobson A, Moran D and Young G. "The role of federal waivers in the health policy process." *Health Affairs*, 11(4): 72-94 2010; Shirk C. "Shaping Public Programs through Medicare, Medicaid, and SCHIP Waivers: The Fundamentals." Washington, DC: National Health Policy Forum, 2003.
[4] Dobson et al, "The role of federal waivers in the health policy process"; Shirk, "Shaping Public Programs through Medicare, Medicaid, and SCHIP Waivers."
[5] Cassidy M. "The Fundamentals of Medicare Demonstrations." National Health Policy Forum, 63, 2008; Greenwald L. "Converting Successful Medicare Demonstrations into National Programs." In *Pay for Performance in Health Care: Methods and Approaches*, Cromwell J, Trisolini M, Pope G, et al. (eds). Research Triangle Park, NC: RTI Press, 2011; Medicare Payment Advisory Commission, "Report to the Congress."

significantly expanding the scope of Medicaid demonstrations. By 2003, 16 statewide health reform demonstrations were operating under Section 1115 authority.[22]

Successes in the Traditional Medicare Demonstration Program

Among the permanent programs that have been developed out of Medicare demonstrations are the hospice benefit, the Program of All-Inclusive Care for the Elderly, and competitive bidding for durable medical equipment. In addition, several broader initiatives have been developed as demonstrations, including the inpatient prospective payment system (IPPS) to replace cost-plus reimbursement to hospitals, the Medicare risk program (now known as Medicare Advantage), and other prospective payment systems.[23] The IPPS is still used today in the Medicare program, and this payment approach has been adopted by other U.S. payers and at least 12 European countries.[24]

Sometimes even a negative result can be useful. Success can be found in conducting a sound demonstration that adequately tests a proposed approach and provides evidence as to whether the approach works or not. CMS' experience with disease management demonstrations is a case in point. During the 1990s, employers and private health insurers began to use a form of disease management in which a nurse, usually based in a call center, periodically telephones patients with particular chronic conditions to provide education to support patient self-management and to monitor the patient's condition. The goal was to facilitate early intervention to head off clinical deterioration that might result in a hospitalization. The intervention did not directly involve patients' physicians, yet took advantage of the health plan's relationship with its subscribers. The approach was considered a useful tool for delivering evidence-based care to those with chronic illnesses and widely adopted by private health insurers, yet never subjected to a rigorous evaluation to demonstrate its impact on patient well-being and health spending.[25]

The CMS-sponsored demonstration, the Medicare Health Support (MHS) pilot program, was the first large study of this common form of disease management; it failed to reduce spending and was terminated. However, participants point to a number of problems with the operational implementation of the MHS program that suggest the need for so-called "rapid cycle" implementation, which has been

adopted as a core approach for the Innovation Center, as discussed later.[26] Whatever the operational lessons for conducting improved demonstrations, however, CMS ended funding of some of the pilot sites early because failure to engage complex Medicare patients in the disease management approach contributed to a reconsideration of this approach among private insurers as well as public payers, leading to a renewed effort to include patients' physicians directly in the care management endeavor.

Between 1999 and 2008, the Medicare program conducted seven disease management or care coordination demonstrations that included 300,000 beneficiaries across 35 programs in 22 states, including the MHS pilot program.[27] As of January 2009, only three of the 20 programs with final evaluations showed evidence of quality improvement while being close to budget neutrality (minus fees), and early findings of the remaining 15 programs suggested that only four would be able to pay for their fees.[28] Lessons learned from this experience show that three types of interventions can reduce hospitalizations among Medicare beneficiaries who have multiple chronic conditions—transitional care, self-management education, and coordinated care.[29] So even "failed" demonstrations provide lessons that can be used to focus on promising approaches for improving care delivery.

Addressing Problems in the Demonstration Process

Despite these complete or partial successes, operational and political challenges have routinely constrained the scope and reach of Medicare demonstrations.[30] A major challenge has been overcoming political influence and non-evidence-based policymaking. For example, the Medicare Participating Heart Bypass Center Demonstration, which operated from 1991 to 1996, tested an approach that used bundled payments for hospital and physician services for coronary artery bypass graft surgery. The subsequent evaluation showed that the approach cut costs by 10 percent, reduced inpatient mortality rates, and improved patient satisfaction with nursing care, length of stay, and the amount of paperwork.[31] CMS attempted to build on this success by implementing the Centers for Excellence Demonstration, which would have expanded the approach to other cardiac procedures and to hip and knee replacements, but political pressure from hospitals and physicians prevented CMS from following through with these efforts.[32]

In many cases the problem can be traced to the length of the demonstration process. A demonstration that lasts one year can take three times that long to complete—one year for research and design, one year for operation, and one year for evaluation.[33] Completion of longer demonstrations can take twice as long as their actual operation. An often cited example, the five-year Physician Group Practice (PGP) Demonstration, took more than 10 years to complete—from enactment of the congressional mandate to conduct of the demonstration in 2000 to CMS' announcement of the five-year results in 2011. The Medicare Coordinated Care Demonstration process took even longer; it was authorized in the BBA of 1997 and completed 14 years later.[34]

The Innovation Center's new authority is designed to shorten the demonstration process. At the front end, ACA exempts demonstrations initiated under the Innovation Center's authority from OMB's cumbersome and lengthy budget neutrality and Paperwork Reduction Act review. The Secretary grants the Innovation Center authority to conduct rapid cycle evaluation (explained below) on top of its formal demonstration evaluation—enabling the Innovation Center to produce usable findings for policymakers, providers, and other stakeholders more quickly. And finally, the Secretary's new authority to scale up successful demonstration nationally or program-wide without new statutory authority will help to speed the pace at which policymakers act on a demonstration's results.

Another set of problems with the demonstration process stems from the perceived rigidity of CMS' formal evaluation process when used to test all innovations. Some proposed innovations lend themselves more readily to traditional randomized trial methods and may fill important evidence gaps,[35] such as the MHS pilot. However, under this formal evaluation approach, CMS is unable to obtain feedback from participants about needed alterations to the intervention, generate early assessments of impact, and then make midcourse corrections while the demonstration is operating.

Participants in the failed MHS pilot observed that evaluation methods other than controlled trials better facilitate "rapid learning" and are more appropriate for models of care not well-suited to randomization.[36] Indeed, some types of complex social experiments, such as new models for providing chronic care management, are not conducted in laboratories but rather in a changing environment. This makes it difficult to maintain

control over important aspects of such trials, and attempts to do so can be counterproductive.[37]

A particular challenge is whether all possible innovations are best tested in a demonstration. For example, it is not surprising that the PGP Demonstration did not cause providers to alter the way they deliver care to achieve significant reductions in Medicare spending. After all, the current fee-for-service payment system penalizes providers for doing what was asked in this demonstration: namely, to reduce the volume of services they deliver through better care coordination and to pay greater attention to evidence of what actually benefits patients. Given the initial three-year limit on CMS' commitment to the payment approach used in this demonstration (a typical time commitment for demonstrations), it might have been foolhardy for participants to overhaul their business model, including reducing their revenues from hospital admissions, for a temporary opportunity being offered by only one payer, even one as important as Medicare.[38] Yet, many of the operational lessons learned from the PGP Demonstration now permit CMS to proceed with the Shared Savings Program and the Pioneer ACO demonstrations, as discussed below.

In short, these examples point to the fact that different kinds of innovation require different approaches to testing and evaluation. Some can undergo classic randomization in a formal trial, as CMS has long done. However, other innovations need to be tested with more flexible approaches, using rapid cycle evaluation approaches, and still others may need to be fostered without formal demonstrations at all because of the nature of the change being promoted.

The examples also point to the need for a multipayer approach to test new models in order to magnify the power of new incentives, reduce administrative burden on providers, and help address unwarranted and contradictory variation in payment methods and rates across payers.[39]

About the Innovation Center

How Is the Innovation Center Staffed and Organized?

Former CMS Administrator Donald Berwick, MD, named Richard Gilfillan, MD, acting director of the Innovation Center in September 2010. With his 20-year experience as head of the Institute for Healthcare Improvement, Berwick was actively involved with forming the Innovation Center and helping formulate its strategic direction. With his departure, Dr. Gilfillan now reports directly to CMS' acting administrator, Marilyn Tavenner, whom President Obama recently nominated to become permanent administrator.[40] A search is still in progress for a permanent director for the Innovation Center.

The Innovation Center's leadership initially arranged the organization to reflect its research priorities, focusing on three primary areas: models that improve care in individual episodes, models that cover populations across time and settings, and models that aim to improve community or population health. The Innovation Center has created corresponding research and model development groups: the Patient Care Models Group, directed by Director Valinda Rutledge; the Seamless Care Models Group, directed by Director Richard Baron, MD; and the Community Improvement Models Group, directed by Acting Director James Hester, PhD.[41]

The Innovation Center has also formed a Learning and Diffusion Group, led by Joseph McCannon, which will provide technical assistance, introduce ideas, and spread successful ones; a Stakeholder Engagement Group, led by Mandy Cohen, MD, which generates awareness about the Innovation Center and communicates its activities to the public and stakeholders; a Program and Policy Group, led by Thomas Reilly, PhD, which focuses on vetting ideas the organization receives; and a Rapid Cycle Evaluation Group, led by William Shrank, MD.[42]

The Innovation Center's leadership has also created a Portfolio Management Committee—comprised of the Innovation Center's directors, Dr. Gilfillan, and other senior staff—recognizing that the lines across the research groups do not always accommodate particular initiatives. Innovation Center staff members present potential opportunities to the Portfolio Management Committee, which in turn identifies the most promising ideas for further development. This arrangement helps to balance workloads and increases collaboration among the directors and their groups.

Since the Innovation Center's creation in 2010, an immediate task was hiring staff. To expedite the hiring process, the Office of Personnel Management granted the Innovation Center direct hiring authority until March 2011—enabling the organization to hire 80 staff members in its first five months of existence. Six months later, the Innovation Center had doubled in size to 160 staff, due in part to the organization's absorption of the Office of Research, Development, and Information's (ORDI) evaluation and demonstration groups.

What Is Rapid Cycle Evaluation?

The typical CMS evaluation generally has involved independent evaluation by contracted researchers using several basic elements:

- Careful definition of the target population and how it is to be assessed to judge success.
- One or more comparison or control groups to serve as a benchmark for what would have happened without the intervention.
- Metrics defining the outcomes of interest and how they change over time, often requiring new forms of data collection or unique data files.
- Long time frames designed to distinguish immediate effects from more stable, longer term effects.[1]

The evaluation designs seek to distinguish true effects of an innovation from those that can be explained by other factors, including secular trends, changes in patient mix, or other changes in the environment for those being evaluated.[2] As discussed earlier, this approach does not work well to evaluate many possible innovations. To address an inflexible evaluation process, the Innovation Center has emphasized an approach that will enable the organization to make "rapid cycle" changes during a demonstration's implementation phase.

The Innovation Center's Federal Register notice, which lays out the organization's basic functions and delegated authorities, specifies that the Innovation Center perform "rapid cycle evaluation of innovation and demonstration activities to determine effectiveness and feasibility for broader dissemination, scale, and sustainability."[3] Rapid cycle evaluation offers a way for the Innovation Center to capture real-time data on and incorporate early insights into demonstrations as they unfold, learning from failure and success along the way.[4]

However, although formal evaluations will still be conducted, those evaluations must deal with imperfect controls, incomplete data,[5] and even changing interventions, all leading to a probability of "messy" evaluations, in the words of a member of the Innovation Center leadership. In its commitment to rapid learning, the challenge for the Innovation Center will be to maintain the appropriate balance between scientific rigor and practical need to adapt to actual conditions being experienced by the demonstration participants.

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[1] Gold M, Helms D and Guterman S. "Identifying, Monitoring, and Assessing Promising Innovations: Using Evaluation to Support Rapid-Cycle Change." *The Commonwealth Fund*, 1512(12), 2011.
[2] ibid.
[3] *Federal Register*. "Department of Health and Human Services: Centers for Medicare and Medicaid Services: Statement of Organization, Functions, and Delegations of Authority," 2010.
[4] Gold et al, "Identifying, Monitoring, and Assessing Promising Innovations."
[5] Guterman S and Drake H. "Developing Innovative Payment Approaches: Finding the Path to High Performance." *The Commonwealth Fund*, 1401(87), 2010.

ORDI's demonstration group, renamed the Medicare Demonstrations Program Group under the Innovation Center and led by Linda Magno, focuses on demonstrations that predate the Innovation Center or that are congressionally mandated. ORDI had administered most of CMS' demonstrations for the past decade under the agency's traditional authority.

CMS' internal reorganization centralizes management of almost all Medicare and Medicaid demonstrations under one entity, the Innovation Center. With the addition of ORDI's demonstrations and evaluations components, the Innovation Center has gained career staff who have long-term experience in the demonstration and evaluation process and thus are well positioned to inform the Innovation Center's decisions going forward. About half of the Innovation Center's staff consists of individuals with government experience. The Innovation Center's leadership objective has been to pair directors who are new to government with experienced CMS deputy directors.

The Innovation Center's leadership has recognized the need to attract personnel with extensive experience in the private sector, other CMS units, other public payers, and academia; the Innovation Center's commitment to ground-up innovation is partly based on already-tested approaches in use outside of government programs and in collaboration with other public and private payers. Likewise, the Innovation Center has made a point of recruiting seasoned CMS employees for leadership positions—individuals who, like their counterparts in the private sector and academia, are foregoing opportunities for higher pay and employment outside of the government. The Innovation Center has adopted a strategy of both hiring

full-time employees and assigning temporary staff (who might later become full-time employees) through the Intergovernment Personnel Act Mobility Program. Given the difficulty CMS sometimes has had in the past in attracting staff with specialized private sector and academic expertise,[43] partly because of inability to offer competitive salaries, the Innovation Center has been notably successful at attracting experienced experts willing to work at a General Schedule (GS) 15 salary—in the $125,000 to $155,000 range[44]—in order to be part of this new endeavor.

Recently recruited staff include Nancy Nielson, MD, an internist and former president of the American Medical Association; Richard Baron, MD, an internist with experience as the chief medical officer of a not-for-profit Medicaid health maintenance organization and the chair of the American Board of Internal Medicine Board of Directors; James Hester, PhD, the former director of Vermont's Health Care Reform Commission; William Shrank, MD, a Harvard professor of medicine and pharmacoeconomics; Joseph McCannon, former senior vice president at the Institute for Healthcare Improvement, who oversaw the 100,000 Lives Campaign for the Institute; Valinda Rutledge, former CEO of Caramont Hospital in North Carolina; Thomas Reilly, PhD, a researcher with over 20 years of CMS experience; and Mandy Cohen, MD, an internist and former executive director of Doctors for America.

How Does the Innovation Center Prioritize Projects?

The Innovation Center's leadership sees its role as twofold: (1) complementing existing efforts in the private sector, among states, in Congress, and at CMS itself to innovate; and (2) delving into new ideas. Most of the Innovation Center's efforts to date have focused on the former—implementing congressionally mandated demonstrations or ideas that Congress or policy experts have already conceived (e.g., bundled payments or accountable care organizations)—and have drawn criticism for being too rigid and prescriptive. More recently, the Innovation Center has begun to seek new ideas from innovators across the country and promote bottom-up innovation through its Innovation Challenge.

Using ACA's list of suggested models of care as a guide, the Innovation Center's leadership has developed a list of priorities—called the Portfolio Criteria—that the organization is using to build its demonstration portfolio. The Innovation Center does not expect that prospective models will be able to satisfy all elements of the Portfolio Criteria, but rather seeks to develop a model portfolio that mirrors those priority areas.

In addition to the Triple Aim of better health care, better health, and reduced costs, the Portfolio Criteria include having "the greatest potential impact on Medicare, Medicaid, and CHIP beneficiaries, and the ability to improve how care is delivered nationally," balancing short-term and long-term initiatives, and examining health conditions that have the greatest potential for improving care while reducing costs. A full list of the Portfolio Criteria is available on the Innovation Center's website.[45]

The Innovation Center is focusing on testing models that fit into its priority areas and that it determines are worth exploring. In most cases, the Innovation Center does not work one-on-one to fund innovators who present interesting proposals, but rather decides whether the idea can be converted into a model that would then be put into an RFP and funded on a competitive basis.

The Innovation Center has not yet promulgated a strategic plan that lays out a vision for the kind of health care delivery system toward which it is working, the health care delivery reforms that would get us there, and a road map for proceeding, as called for by some.[46] Absent a concrete strategic plan, the Innovation Center has developed a detailed list of priorities in which selected models must fit, a process for identifying and selecting proposals to test, and a competitive process by which interested parties can apply to participate in an initiative. The Innovation Center has not yet articulated how these priorities or specific initiatives fit into a larger plan for revolutionizing the delivery system. As noted earlier, some observers find this to be a serious omission.

Once an idea has been approved by the Portfolio Management Committee and approved within the administration, the Innovation Center generates an RFP for interested providers and/or payers. All parties interested in participating in an Innovation Center initiative must go through the competitive application process. Some have criticized the Innovation Center for exchanging transparency and flexibility for speed and competitiveness in its approach—particularly since the process generally does not accept applications on a rolling basis throughout the life of an initiative. Once the Innovation Center turns down an application for one of its initiatives, the opportunity to participate may be gone forever; rejected applicants have no opportunity to re-apply.

The Health Care Innovation Challenge offers an additional mechanism for a wide array of stakeholders to propose ideas to the Innovation Center. The Healthcare Innovation Challenge will award grants to applicants who can rapidly implement the most compelling new ideas to deliver better health, improved care, and lower costs to people enrolled in Medicare, Medicaid, and CHIP, particularly those with the highest health care needs.

The Innovation Center considered establishing a Federal Advisory Committee Act (FACA) – compliant committee – an advisory body that could potentially include agency officials, issue experts, and members of the public and professional societies—to help guide Innovation Center priorities and to provide broad-based support for the direction the Innovation Center takes,[47] perhaps modeled after the two successful FACA committees implemented to make recommendations to the National Coordinator for Health Information Technology.[48] Ultimately, the Innovation Center's leadership decided that the requirements of managing a FACA committee were potentially too burdensome, while the attendant delays to get such a committee up-and-running ran counter to the urgency CMS leadership felt to get started. Instead, the Innovation Center asserts it is attempting to achieve similar objectives without a formal Advisory Committee by emphasizing transparency of its project solicitation process and through ongoing dialogue with the public, facilitated by the Stakeholder Engagement Group. For example, the Innovation Center sponsored a Care Innovations Summit on January 26, 2012, in collaboration with the Office of the National Coordinator for Health Information Technology, the West Wireless Health Institute, and *Health Affairs*.

How Can External Innovators Interact with the Innovation Center?

The Innovation Center is continually soliciting ideas related to ways to build the organization itself and new payment and delivery models for it to test. Members of the public can submit ideas on both topics through a web portal located on the Innovation Center's website or through letters to the Innovation Center. The Innovation Center is set up to accept innovative payment and delivery reform ideas, feedback, and suggestions from the public, but not detailed proposals.

The Innovation Center currently does not have the capacity to respond to submitted comments or release them (or summaries) for public consumption. Innovation Center staff use submitted comments to inform internal discussions about building the organization's capacity and identifying potential models to test. Innovators who submit model ideas that the Innovation Center ultimately decides to test will have the opportunity to respond to the Innovation Center's RFP on specific topics, but will not be afforded preferential treatment.

What Initiatives Has the Innovation Center Started So Far?

The Innovation Center is responsible for a range of demonstrations that fall under either CMS' traditional demonstration authority or the Innovation Center's new authority as laid out in ACA. The Innovation Center has inherited most of CMS' existing demonstrations, which operate under the agency's traditional authority, through its absorption of the demonstration group within ORDI. New initiatives that are congressionally mandated also operate under traditional demonstration authority and are administered by the Innovation Center. The Innovation Center administers new demonstrations unrelated to congressional mandates under its new authority.

Since its founding, the Innovation Center has announced 13 new initiatives. This ambitious schedule highlights a new predicament for the Innovation Center's prospective applicants. In most cases, to participate in a demonstration, they have to relinquish the option of participating in potentially more desirable demonstrations in the future; an entity's participation in multiple demonstrations could potentially confound its evaluation. The Innovation Center's policy is to address this problem on a case-by-case basis, and where possible it does allow overlapping participation among its initiatives. In some instances, however, the Innovation Center has not allowed cross-participation. For example, Minnesota's statewide participation in the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration has precluded public and private payers in the state from applying to participate in the Comprehensive Primary Care initiative, which may offer a preferred approach for some.

So far, the Innovation Center has announced or begun to implement demonstrations that address primary care redesign (which includes medical home initiatives like the Comprehensive Primary Care initiative), bundled payments, ACOs, dual-eligible beneficiaries, and the health care system's capacity for spreading innovative ideas. In some instances, the Innovation Center is

implementing congressionally mandated demonstrations; the MAPCP Demonstration is one example. For the projects initiated under the Innovation Center's authority, it is trying to generate top-down and bottom-up innovation: taking a more prescriptive approach with initiatives like the Pioneer ACO Model initiative; creating a pathway for homegrown solutions to issues identified by the Innovation Center, as is the case with the Health Care Innovation Challenge; and allowing the CMS Medicare-Medicaid Coordination Office to take the lead on initiatives targeting dual-eligible beneficiaries.

The appendix describes many of the Innovation Center's initiatives. For a complete list, see Table 1.

Conclusion

In its first year of operation, the Innovation Center has a long list of accomplishments: attracting experienced personnel; developing processes for prioritizing and developing projects and for soliciting applicants for those projects; bolstering CMS thinking on several policy fronts, including ACOs; and committing to incorporating rapid cycle evaluation as a more flexible approach to determining success and promoting change. Concerned about the urgency to achieve delivery system change to achieve the Triple Aim, the Innovation Center is firing on all cylinders.

Yet, some policy and health delivery observers express concern that the Innovation Center's speed and approach are leaving behind potential innovators that have not been ready to respond to the quick pace of RFPs. They seek a more deliberative process that permits establishment of a consensus vision—and plan—for achieving a reformed health care delivery system. Exactly how such a consensus would be achieved remains unclear, given divergent views of how "paying for value" can best be achieved.

Table 1. The Innovation Center's Initiatives					
Initiative	**Application Deadline**	**Initiative Start Date**	**Length**	**Participants**	**Source of Authority**
Primary Care Redesign					
Comprehensive Primary Care Initiative Demonstration	1/17/2012	Unspecified	4 years	Payers and states in 5-7 markets*; 75 practices per market*	Section 3021 of ACA
Federally Qualified Health Center Advanced Primary Care Practice Demonstration	9/16/2011	11/1/2011	3 years - ends on 10/31/14	500 FQHCs (see link for details)	Section 3021 of ACA
Multi-payer Advanced Primary Care Practice Demonstration	8/17/2010	Phased-in starting 07/01/2011	3 years	NC, ME, MI, MN, NY, PA, RI, VT	Section 402 of the Social Security Amendments of 1967 (as amended)
Bundled Payments					
Bundled Payment for Care Improvement Initiative	Model 1: 11/18/2011; Models 2-4: 3/15/2012	Unspecified	3 years (with 2-year extension option)	Unspecified number of provider organizations*	Section 3021 of ACA
Accountable Care Organizations					
Accelerated Development Learning Sessions	N/A	2011	1 year (4 sessions)	Open to any organization	Section 3021 of ACA
Advanced Payment Accountable Care Organization Model Initiative	2/1/2012 for 4/1/2012 start date; 3/30/2012 for 7/1/2012 start date	4/1/2011 or 7/1/2012 (4 years)	4 years	Physician-based and rural ACOs in the Shared Savings Program*	Section 3021 of ACA
PGP Transition Demonstration	N/A	1/1/2011	2 years	The 10 practices from the original PGP Demonstration	Section 1866A(a)(1) of the Social Security Act
Pioneer Accountable Care Organization Model Initiative	8/19/2011	3rd or 4th quarter of 2011	3 years (with 2-year extension option)	32 organizations (see link for details)	Section 3021 of ACA
Dual-eligible Beneficiaries					
Demonstration to Improve Care Quality for Nursing Facility Residents	Fall 2011	Unspecified	Unspecified	Unspecified number of independent organizations (to serve up to 150 nursing facilities)*	Section 3021 of ACA
State Demonstrations to Integrate Care for Dual-Eligible Beneficiaries	2/1/2011	April/May 2011	18 months (with extension option)	CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, WI	Section 3021 of ACA

Dual-eligible Beneficiaries (cont.)					
Financial Alignment Model Demonstrations	Unspecified	2012	3 years	Unspecified number of states*	Section 3021 of ACA
Capacity to Spread Innovation					
The Partnership for Patients	Ongoing	4/12/2011	Ongoing	Over 6,400 partners (no cap)	N/A
Community-based Care Transition Program (part of the Partnership for Patients)	Applications accepted on a rolling basis starting 4/12/2011	1/1/2011	5 years	Site selection phased-in starting November 2011 with 7 sites elected	Section 3026 of ACA
Innovation Advisors Program	11/15/2011	12/1/2011	Ongoing (each cycle is 6 months)	73 individuals in the first cycle (see link for details); up to 200 individuals in the second cycle*	Section 3021 of ACA
Health Care Innovation Challenge	1/27/2012	3/30/2012	3 years	Unspecified number of public and private organizations*	Section 3021 of ACA
Miscellaneous					
Medicaid Emergency Psychiatric Demonstration	10/14/2011	1/01/2012 target date	3 years	Unspecified number of states*	Section 2707 of ACA
Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) Program	5/2/2011	Sites awarded 9/13/2011	5 years	WI, MN, NY, NV, NH, MT, HI, TX, CA, CT	Section 4108 of ACA
Independence at Home Demonstration	2/6/2012 (practices applying as consortiums have an additional 90 days)	2012	3 years	Up to 50 practices*	Section 3024 of ACA
**Participants not selected yet*					

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Appendix

The Innovation Center has announced or begun to implement demonstrations that address primary care redesign, bundled payments, ACOs, dual-eligible beneficiaries, and the health care system's capacity for spreading innovative ideas. Below is a description of many of the Innovation Center's initiatives. For a complete list, please see Table 1.

Primary Care Redesign

The Innovation Center is testing various models of primary care redesign. One of those models is what is called the advanced primary care practice (APC), also known as the patient-centered medical home (PCMH). The APC is defined as "a physician-based or nurse practitioner-led medical practice that provides continuous, comprehensive, coordinated, and patient-centered medical care."[49]

The Innovation Center has inherited a new medical home initiative that Secretary Sebelius announced in 2009: the Multi-payer Advanced Primary Care Practice Demonstration. This project allows the Medicare program to join Medicaid and private payer advanced primary care initiatives (also referred to as medical homes) in eight states, but the RFP specifically targeted states with partnerships with private payers, not the private payers themselves.

The Innovation Center also is implementing a medical home initiative mandated in the ACA that targets Federally Qualified Health Centers (FQHCs). The FQHC Advanced Primary Care Practice (APCP) Demonstration will test the effectiveness of the PCMH model in the FQHC setting. To be eligible to participate, FQHCs must provide primary care services and serve at least 200 Medicare beneficiaries (including some duals). Participating FQHCs will receive a small monthly management fee for each Medicare patient in their practice. The fee is intended to cover care coordination and other services typically delivered by PCMHs.

In September 2011, the Innovation Center announced a medical home demonstration initiated by the Innovation Center called the Comprehensive Primary Care initiative. This initiative is similar to MAPCP but targets private payers as applicants instead of states, provides a higher per member/per month reimbursement fee for care coordination services, and extends for an additional year. CMS would like to collaborate with state and commercial health insurance plans in five to seven markets across the United States. CMS will pay primary care practices a monthly fee for coordinating care furnished to their Medicare patients plus the usual program fees. The additional fee will help practices lend greater support to patients with serious or chronic conditions, provide patients with access to care 24 hours a day, provide preventive care, work more closely with patients and their families, and coordinate with other physicians. Primary care practices will be chosen to participate in the initiative once CMS has identified the markets in which the demonstration will operate. Participation in the Comprehensive Primary Care initiative by state and commercial plans and providers is voluntary, but states (or, in the case of larger states where participation is not statewide, markets) participating in MAPCP are precluded from applying to the Comprehensive Primary Care initiative.

Bundled Payments

The Innovation Center is testing several variations on the bundled payment model. Under a bundled payment approach, separate payments, for example, to a hospital and physicians for services provided during an inpatient hospitalization, are combined into a single payment, with the goal of providing common financial incentives for the various providers to decrease fragmented care and improve efficiency.

The Bundled Payments for Care Improvement initiative[50] will test four approaches to bundling the care delivered around a hospitalization. Three of the four models would test retrospectively setting a bundled payment amount and would allow participating[51] providers to share in the savings generated from delivering the care at a lower cost but would incorporate different combinations of providers. One model would test bundling payments for the acute hospital stay only, a second for the acute hospital stay and the associated post-acute care, and a third for post-acute care only. The latter two models

would also include physicians' services, related readmissions, and other services such as clinical laboratory services. The fourth model would test prospectively setting a bundled payment amount for services delivered by the hospital, physicians, and other medical practitioners. Applicants have some flexibility to select the conditions that will be tested through this initiative.

Accountable Care Organizations

One of the Innovation Center's highest profile priorities is testing the ACO concept. The Innovation Center defines an ACO as a group of providers of services and supplies "that have established a mechanism for shared governance and work together to coordinate care for Medicare fee-for-service beneficiaries. ACOs enter into an agreement with CMS to be accountable for the quality, cost, and overall care of traditional fee-for-service Medicare beneficiaries who may be aligned with it."[52] The Innovation Center has announced several ACO-related initiatives over the past year based on CMS' experience with the PGP Demonstration.

In January 2011, the Innovation Center extended the PGP Demonstration (renamed the PGP Transition Demonstration) for two additional years with some adjustments. All of the practices that participated in the initial five-year demonstration have agreed to participate.

For those organizations ready to take on more risk than the Medicare Shared Savings Program allows, the Innovation Center will test a more aggressive approach through the Pioneer ACO Model initiative. In the first two years of the initiative, ACOs will operate under a shared savings and shared loss approach. After two years, ACOs that have generated savings will be eligible to shift to a population-based payment arrangement, akin to partial capitation. Organizations can participate in the Medicare Shared Savings Program or the Pioneer ACO Model initiative, but not both.

The Innovation Center also has decided to provide start-up funding for qualifying organizations accepted into the Medicare Shared Savings Program. The Advanced Payment ACO Model will give eligible ACOs a portion of their share of the savings in advance of actually generating those savings, to make the infrastructure and staffing investments needed to succeed as an ACO.

Dual-eligible Beneficiaries

A growing body of research shows that dual-eligible beneficiaries have substantially higher medical spending than other populations on average yet are less likely to receive coordinated care. Duals represent 16 percent of Medicare beneficiaries yet are responsible for 25 percent of Medicare spending. Even more striking, duals comprise 18 percent of Medicaid beneficiaries and 46 percent of Medicaid spending.[53]

Since care for duals is reimbursed through two completely separate funding streams, neither program takes responsibility for coordinating the care delivered to these beneficiaries. Each program uses coverage rules to avoid costs. Medicare generally provides restorative and recuperative care, while Medicaid often pays for care that maintains or prevents further decline in health. At times, classifying services as restorative or maintaining the status quo can be ambiguous. For example, Medicaid, which covers the long-term care of nursing home residents, has a financial incentive to hospitalize those beneficiaries; Medicare covers their hospitalization and the first 100 days of nursing home care following a hospital stay.[54]

To address this unique set of challenges, ACA established the Medicare-Medicaid Coordination Office, which focuses on coordinating dual-eligible beneficiaries' care, improving access to high-quality care, and making the system more cost-effective. This office is taking the lead on the design, implementation, and evaluation of new state-based payment and delivery system reform demonstrations, but the initiatives are being implemented through the Innovation Center's authority and funding.[55] Although the initial emphasis has been on state-based demonstrations, whether states or the federal government should hold primary responsibility for the care—and consequently cost containment—for duals remains controversial.[56]

The Innovation Center launched its first initiative targeting duals in April 2011. For the State Demonstrations to Integrate Care for Dual Eligible Individuals, CMS is working with 15 states to develop person-centered approaches to care coordination for duals. Each participating state will receive up to $1 million to develop its approach and produce a specific proposal.

In July 2011, CMS announced that the Innovation Center would be conducting two additional demonstrations targeting duals. One, the Innovation Center is administering a demonstration that would reduce preventable inpatient hospitalizations among long-term nursing facility residents, although the approach may also benefit other nursing facility residents. Organizations separate from nursing facilities would implement evidence-based interventions in nursing facilities with high hospital admission rates and a large share of duals.

Two, the Innovation Center released guidance to states on a new demonstration that would test two financial approaches to aligning Medicare and Medicaid reimbursement for duals' care: a capitated approach and a managed fee-for-service model (meaning fee-for-service that maintains freedom to choose providers but adopts some managed care techniques, such as requiring beneficiaries to obtain authorization from the insurer or payer prior to filling a prescription from the treating physician). Under the capitated approach, a state, CMS, and a managed care plan would sign a three-way contract whereby Medicare and Medicaid would provide to the plan a blended prospective payment to cover the full range of needed care. States and CMS will jointly choose plans through a competitive selection process. Under the managed fee-for-service approach, a state and CMS would agree to make the state eligible for a share of the Medicare savings generated from managed fee-for-service initiatives that are designed to improve quality and lower Medicare and Medicaid costs. States would provide an up-front investment to support care coordination in return for a share of Medicare savings once a specific savings threshold is reached. The states participating in the State Demonstrations to Integrate Care for Dual Eligible Individuals also are encouraged to use these models in their plans.

Capacity for Spreading Innovation

In April 2011, Secretary Sebelius announced the creation of a national public-private partnership called the Partnership for Patients to encourage homegrown improvements in patient safety and care quality across the health care system. The goal of the partnership is to reduce hospital-acquired conditions by 40 percent and 30-day hospital readmissions by 20 percent over the next three years. To help its private sector partners facilitate improvements in patient safety and quality, the Innovation Center has promised to award up to $500 million for initiatives that support the partnership's goals.

CMS is supporting hospitals and other providers participating in the Partnership for Patients by making available an additional $500 million for a Community-based Care Transition Program established in the ACA. This program is designed to help hospitals and community-based organizations improve the care that Medicare beneficiaries at high-risk of readmission receive as they transition from the hospital to other sites of care.

More recently, the Innovation Center has established an initiative to improve the health care system's capacity for developing innovations beyond the patient safety and care transitions targeted in the Partnership for Patients initiative. Specifically, the Innovation Center has created a program designed to broadly help individuals refine, apply, and sustain managerial and technical skills necessary to drive delivery system reform for Medicare, Medicaid, and CHIP beneficiaries, called the Innovation Advisors Program. The objective is to facilitate participants becoming part of a network of experts, who can support the Innovation Center as it tests new models, provide a unique set of skills and knowledge regarding their communities or areas of expertise, collaborate with other local organizations to facilitate change in the delivery system, develop innovative ideas for testing, and develop skills in system improvement in their region.

The Innovation Center is seeking up to 200 individuals with expertise in health care economics, population health, systems analysis, and operations research to apply to the new program. Seventy-three advisors have been selected for the first of two cycles. Participants are expected to spend 10 hours per week working on Center activities during the first six months of their fellowship. Part of that time will be spent on seminars and instruction, and the rest will be spent

developing the improvement project proposed in their application to the program. Participants will remain employees of their home organization but will receive a stipend from the Innovation Center.

As previously noted, the Innovation Center has also issued a challenge to innovators across the country to develop and implement new initiatives that deliver better health, improved care, and lower costs to Medicare, Medicaid, and CHIP beneficiaries, called the Health Care Innovation Challenge. The Innovation Center is specifically targeting initiatives that will expand the health care workforce and improve worker efficiency. Applicants who are selected will receive grants ranging from $1 million to $30 million, depending on their proposals. Prospective applicants could include providers, payers, local governments, public-private partnerships, and multipayer collaboratives. The Innovation Center has set aside $1 billion to fund these grants.

Notes

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Quality Oncology Practice Initiative Certification Program: Overview, Measure Scoring Methodology, and Site Assessment Standards

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Short abstract

More than a decade ago, the Institute of Medicine created the National Cancer Policy Board and identified a need to assess national quality of cancer care, generating a cascade of projects, including ASCO's QOPI.

The concepts of quality assessment, monitoring, improvement, and accountability are becoming mainstream in US medicine. Pressure to demonstrate high-quality care and a commitment to continuous quality improvement are mounting for health care providers. For a time, quality efforts focused on areas outside of cancer care, most notably on primary care, cardiology, and diabetes care. This is likely a reflection of the complexity of cancer care, the limitations of claims data in providing meaningful quality analyses, and the emotional context of cancer rather than of the confidence that all cancer care is appropriate and safe.

Background

More than a decade ago, the Institute of Medicine increased the focus on oncology with the creation of the National Cancer Policy Board. Its final report, *Ensuring Quality Cancer Care*, identified a need to create systems to assess the quality of cancer care nationally.[1] This seminal publication generated a cascade of quality reports, initiatives, and projects in the years afterward, including the ASCO Quality Oncology Practice Initiative (QOPI).

Joseph Simone, MD, chair of the National Cancer Policy Board, put forth the initial concept for QOPI. In 2002, he recruited a small group of medical oncologists to develop and pilot a voluntary program to assess and improve processes of care in oncology practices.[2] QOPI was made available to all ASCO-member medical oncologists and their practices in 2006.

QOPI provides a system for practices to measure processes of care semiannually, using retrospective medical record abstraction methodology. Practice personnel select patients who meet QOPI sampling requirements, starting with the most recent patients seen in practice and proceeding backward in time for up to 6 months to meet the sample size. The number of full-time equivalent medical oncologists or hematologist-oncologists at a practice site determines the QOPI abstraction sample size. The QOPI patient selection methodology and sample size have been previously described.[3] A practice submits a limited data set to the QOPI database using a structured, secure online patient report form, and results are analyzed and reported back to the practice.

The analyzed QOPI quality reports are the primary benefit of QOPI participation. Reports are available within 4 weeks of the close of data collection, so practices can use data received for targeted improvement. For each quality measure, reports detail practice-specific data (and office-specific data, if collected at multiple sites) and comparative aggregate data.

The QOPI measures are organized into a required core set and disease- and domain-specific modules. The core measures are applicable across the majority of medical records abstracted and are required. Disease-specific sets include breast cancer, colorectal cancer, non–small-cell lung cancer, and non-Hodgkin's lymphoma. The domain-specific sets include end-of-life care and symptom/toxicity management. A minimum requirement for practices participating in QOPI is to select and submit data for two modules.

By design, practices participating in QOPI are a self-selected group. Registration for the program remains open year round, resulting in new and returning practices participating in each data submission round. At the time of this writing, more than 640 individual reporting sites in almost 500 practices were registered for the QOPI program.

Volunteer leaders have been encouraged by the ongoing QOPI registration and participation. Voluntary use of practice staff time to participate is considered a testament to oncologists' eagerness to ensure oncologist leadership in defining and measuring quality and embrace improvement in their own practices. Recognizing the commitment on the part of practices involved in QOPI, ASCO has attempted to ensure that QOPI participation and data provide as many benefits as possible (eg, QOPI can be applied to American Board of Internal Medicine Maintenance of Certification and to Continuing Medical Eduction credits).

As the QOPI program has evolved, participants and ASCO members have asked for enhancements in two major areas:

- Provide additional quality improvement opportunities for those who have participated for several years and/or have more sophisticated improvement processes/goals.
- Position QOPI, a trusted and oncologist-led program, as a solution for payers seeking to implement quality programs in oncology.

To begin to address the second point, ASCO initiated the QOPI Health Plan Program, whereby ASCO notifies health plans selected by participating practices of the successful participation of those practices in a QOPI round. The QOPI Health Plan Program is not performance based; rather, it confirms successful participation in completing medical record abstraction, in a format that is useful for health plans. Plans have recognized QOPI participation in a variety of ways, ranging from practice payment to recognition in provider directories.

Although the QOPI Health Plan Program was a successful first step, it neither fully met existing member needs nor prepared for near-future needs. Participants asked to share performance details from QOPI reports with health plans. Oncologists and their practice staff asked for meaningful ways to include details of their QOPI participation in practice marketing materials.

These member requests led to a detailed review of QOPI, needs assessment, and business plan development. The concept of a certification for outpatient hematology-oncology practices—a unique concept to date—was developed. The ASCO Board of Directors approved the development of the QOPI Certification Program in 2008. Beginning with the fall 2009 QOPI abstraction round, all QOPI data reports will include information regarding the QOPI Certification measure scoring requirements. Application for the program will open in January 2010. This article describes the methodology, measures, scoring, and site assessment standards of the QOPI Certification Program. All components of the program were developed by the QOPI Steering Group using a consensus-based process.

QOPI Certification Program Methodology

The QOPI Certification Program provides 3-year certification for outpatient hematology-oncology practices. Certification is accomplished on the basis of practice achievement in two areas:

1. QOPI medical record abstraction measures selected for certification
2. QOPI Certification Site Assessment, conducted on the basis of structural standards

To enter the QOPI Certification Program, a practice must first complete a round of QOPI data abstraction, using the QOPI modules, sampling strategy, and sample size appropriate for certification. The QOPI report provided at the close of data abstraction indicates whether the overall scoring requirements for QOPI Certification were met. If so, the practice may apply for the QOPI Certification Program. The processes to initiate and achieve QOPI Certification are depicted in Figures 1 and 2. A detailed QOPI Certification Program Participation Manual is available to help practices fully understand the certification program expectations, processes, and timeline.



Figure 1.
Process to initiate Quality Oncology Practice Initiative (QOPI) Certification.



Figure 2.
Process of Quality Oncology Practice Initiative (QOPI) Certification. Steps in circles indicate practice actions; steps in squares, QOPI actions or decisions. Orange represents pre-application status; blue, QOPI Certification–pending status; green, (more ...)

Measure Selection, Sampling, and Sample Size for QOPI Certification

Practices seeking QOPI Certification must complete the core measures and each QOPI module that includes a certification measure applicable to the patient population of the practice (Table 1). The standard QOPI sampling methodology and sample size requirements[2,3] apply to QOPI Certification and are

documented in detail in the QOPI Users Manual. Sample size requirements per module vary from 24 to 40 medical records, depending on full-time equivalent oncologists in the practice/site.

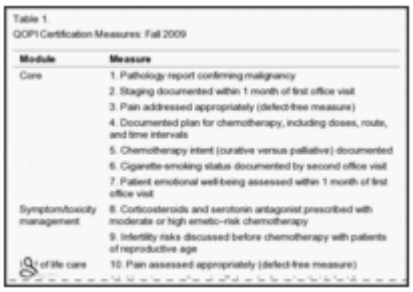


Table 1.
QOPI Certification Measures: Fall 2009

Module	Measure
Core	1. Pathology report confirming malignancy
	2. Staging documented within 1 month of first office visit
	3. Pain addressed appropriately (defect-free measure)
	4. Documented plan for chemotherapy, including doses, route, and time intervals
	5. Chemotherapy intent (curative versus palliative) documented
	6. Cigarette-smoking status documented by second office visit
	7. Patient emotional well-being assessed within 1 month of first office visit
Symptom/toxicity management	8. Corticosteroids and serotonin antagonist prescribed with moderate or high emetic-risk chemotherapy
	9. Infertility risks discussed before chemotherapy with patients of reproductive age
End of life care	10. Pain assessed appropriately (defect-free measure)

Table 1.
QOPI Certification Measures: Fall 2009

A new sampling option has been added for multisite practices for 2009, involving the collection of one sample across the multiple office sites in the practice. To use this method, the practice generates or compiles a list of patient visits at all applicable office sites. To ensure that all practice sites and oncologists have a chance of being represented in the sample abstracted, practice personnel must comply with QOPI methodology to select patients, using that list. The new sampling option addresses the fact that multisite practices will likely seek QOPI Certification for the entire practice (rather than for an individual office site). Full participation in as many as five QOPI modules at every office site may not be feasible for large practices. The second option for multisite practices is the standard QOPI model, which involves a distinct medical record pull at each office site. Practices can select the methodology most feasible and appropriate for their quality improvement goals.

QOPI Site Assessment

The QOPI Certification Program includes a newly developed component: an assessment of the concordance of practices with structural quality standards. Using a structured online questionnaire, practices indicate their degree of compliance with the structural standards and provide requested supportive documentation. The QOPI Site Assessment is conducted on the basis of responses and documentation submitted by the practice, supported by audits. A practice must pass the QOPI Site Assessment to achieve QOPI Certification.

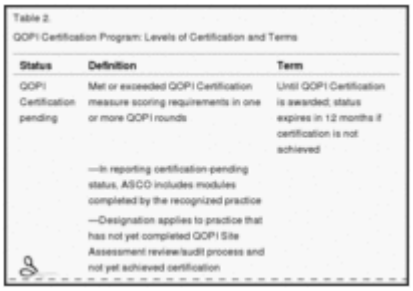
QOPI Certification Audit Activities

All sites applying for QOPI Certification undergo audit reviews. Audits occur as part of the QOPI Certification review process before full QOPI Certification is awarded. To verify medical record abstraction data, all certification applicants are instructed to send de-identified medical record documentation for five records selected by ASCO staff. To verify site assessment data, all certification applicants are instructed to send supportive practice documentation. Finally, all practices that apply for QOPI Certification are at risk for an onsite audit. The onsite audit may include a review of medical record sampling, medical record data submitted, and site assessment data submitted. Audits are intended to confirm results, help ensure the integrity of the program, and add to the improvement and learning opportunity of the QOPI Certification Program process. Practices receive notification of audit findings and, if necessary, are given the opportunity to address shortcomings.

Achieving and Maintaining QOPI Certification

As shown in Figure 2, an interim designation of QOPI Certification pending is awarded to practices that meet QOPI Certification measures scoring requirements, submit a complete certification application, submit a complete site assessment questionnaire and supportive documentation, and submit de-identified medical record documentation requested for audit. A practice can maintain QOPI Certification–pending status for 1 year. During that year, the practice must implement any improvements necessary to achieve QOPI Certification and resubmit information as directed, or certification-pending status is lost.

The complete certification term is 3 years from designation of QOPI Certification–pending status. Practices must participate in at least one round of QOPI medical record abstraction annually and meet certification scoring requirements to maintain QOPI Certification–pending or QOPI Certification status. Details of the QOPI Certification Program designations are outlined in Table 2.


Table 2.
QOPI Certification Program: Levels of Certification and Terms

Status	Definition	Term
QOPI Certification pending	Met or exceeded QOPI Certification measure scoring requirements in one or more QOPI rounds	Until QOPI Certification is awarded; status expires in 12 months if certification is not achieved
	—In reporting certification-pending status, ASCO includes modules completed by the recognized practice	
	—Designation applies to practice that has not yet completed QOPI Site Assessment review/audit process and not yet achieved certification	

Table 2.
QOPI Certification Program: Levels of Certification and Terms

QOPI Certification Measures Selection

Since the inception of QOPI, quality measures have been adopted, developed, and maintained under the leadership of volunteer oncologist committees. The processes used to develop and refine QOPI measures have been described elsewhere.[2–5] At the time of certification program development, the QOPI Steering Group benefited from a library of more than 80 tested QOPI measures and several years of historical data. A full listing of QOPI measures can be found at http://qopi.asco.org.

The QOPI Steering Group implemented an iterative, consensus-building process to identify the measures appropriate for use in the QOPI Certification Program. The major criteria for review included: measures that are evidence based or for which there is strong professional consensus; feasibility demonstrated through QOPI use; an adequate sample size demonstrated through QOPI use; and measure validity/reliability supported by QOPI use, QOPI audits, and/or testing in other settings.

In addition, the QOPI Steering Group sought to develop a diverse measure set. Many of the QOPI measures are reported in a series, with each measure reporting meaningful differences but assessing the same construct. Some QOPI measures are incorporated into combined measures or defect-free measures in analysis. For purposes of selecting measures for the certification program, QOPI Steering Group members chose measures that do not overlap analytically.

Of the 81 reviewed QOPI measures, 24 were ultimately selected for QOPI Certification. Table 1 lists the QOPI Certification Program measures, organized by QOPI module. The specifications for the certification measures were reviewed in light of the use of the measures in the certification setting to ensure that all valid exclusions were captured. The measures selected for the QOPI Certification Program are reviewed and reassessed after each QOPI data collection/reporting round.

QOPI Certification Program Measures Scoring

In developing the scoring requirements for the QOPI Certification Program, QOPI Steering Group members sought an approach that is transparent, fair, rigorous, understandable, and flexible enough to allow diverse medical oncology and hematology-oncology practices to be eligible. The QOPI Steering Group determined that scoring requirements for future QOPI rounds should be determined on the basis of analyses of existing QOPI data. Use of a predetermined performance score provides transparency for participating practices and discourages the perception that practices are competing against one another for certification.

The QOPI Steering Group considered but rejected the notion of setting specific performance goals for each certification measure. In any given QOPI round, the number of medical records abstracted by a practice contributing to a specific measure varies, and on occasions, the number can be low. Individual performance thresholds also increase complexity. Instead, a decision was made to develop a model to combine performance across measures in the practice into an overall practice quality score, similar to test scoring for board certification.

An overall practice quality score approach requires adjustment to increase the contribution of specific measures, especially when those measures do not apply to the majority of medical records abstracted. The QOPI Steering Group modeled several scenarios to increase the contribution of QOPI measures related to adjuvant therapy. Weighting was tested but not implemented because of the relatively arbitrary decisions required to assign weights and the complication of the approach. Ultimately, the steering group chose to set a minimum performance requirement for the adjuvant treatment measures. The adjuvant measures appear with an asterisk in Table 1. Thus, the two components of the QOPI Certification Program Scoring Methodology are:

1. Overall quality score: An overall quality score for each practice calculated by aggregating the practice data for each of the 24 quality measures. If a practice does not have any eligible patients for a specific measure, that measure does not count toward or against the overall quality score of the practice.
   Numerator = number of patients in the practice who pass each indicator, contingent on being eligible for the indicator: $P_{overall} = p_{measure\ 1} + p_{measure\ 2} + \ldots + p_{measure\ 24}$
   Denominator = number of patients in the practice eligible for each indicator: $N_{overall} = n_{measure\ 1} + n_{measure\ 2} + \ldots + n_{measure\ 24}$
   Overall quality score = $P_{overall} / N_{overall}$
2. Adjuvant treatment quality score: A minimum performance of 80% is required on the adjuvant treatment certification measures. All adjuvant treatment measures submitted by the practice are analyzed as an overall adjuvant score, using the same equation described for the overall quality score. Practices that have eligible patients for adjuvant measures are required to submit data for those measures. If a practice does not have any eligible patients for any adjuvant measure, this component of scoring is not implemented.

Overall Quality Score Performance Requirement

When determining the scoring threshold for the overall quality score, the QOPI Steering Group members considered that current QOPI participants are a self-selected group of practices committed to quality improvement. Many have participated in QOPI for several years. The performance of these practices on the QOPI Certification measures is likely higher than that of their peers nationally.

Several rounds of QOPI data were analyzed using the overall quality score to determine the scoring cutoff that would identify the top 85th percentile performers on the certification measures. For the fall 2009 QOPI round, the overall quality score performance requirement is 72.62%.

QOPI Certification Site Assessment

The QOPI Certification Site Assessment is the second component of the QOPI Certification Program, intended to review the concordance of a practice with structural quality standards.

In 2008, ASCO and the Oncology Nursing Society (ONS) partnered to develop the standards for safe chemotherapy administration.[6] The development of these standards has been described in detail in *Journal of Clinical Oncology*. Briefly, a workshop of multiple stakeholders was convened to draft initial standards appropriate for all adult outpatient cancer chemotherapy. A consensus-building process followed, including public comment. The result was the development of 31 standards.

ASCO leaders envisioned that the ASCO/ONS safety standards would be appropriate to become the majority of the QOPI Certification site standards. When reviewing the full set of standards, those that met the following criteria were prioritized for inclusion in the QOPI Certification Program at launch: standards appropriate to implement in oncology practice with short turnaround time (because of the limited time between publication of the ASCO/ONS safety standards and assessment through the QOPI Certification Program); standards that apply broadly to practices that would seek QOPI Certification; standards most crucial for patient safety; and standards that do not duplicate QOPI medical record measures.

The 17 standards selected for QOPI Certification include standards related to staff training, chemotherapy planning documentation, patient education and consent, chemotherapy orders, drug preparation, chemotherapy administration, and monitoring and assessment. A complete list of the standards can be found at www.jop.ascopubs.org and http://qopi.asco.org/certification. The remainder of the ASCO/ONS standards will be reevaluated for inclusion at later dates, as will other structural measures. Practices are required to comply with all of the QOPI Site Assessment structural standards to achieve QOPI Certification.

Discussion

The QOPI Certification Program has the potential to engage oncology practices in enhanced performance assessment and improvement. Participation should stimulate practice discussion and encourage review of practice processes, systems, and documentation. Importantly, the QOPI Certification Program will provide demonstrable evidence of high-quality practice performance in a way not supported by QOPI to date. Certification is not mandatory, and the QOPI program will continue as a free member benefit. Oncologists and their practices can choose the approach that best meets their quality improvement needs, marketing goals, and environment.

Like any highly visible new program, it is likely that the QOPI Certification Program will have supporters and detractors among the ASCO membership and broader cancer community. Some may be opposed to the notion of external judgment of practice quality or disagree with the measures, standards, or scoring. Those who feel that the train has left the station on external assessment might see the QOPI Certification Program as service for ASCO members. There may be disagreement regarding who should define quality in cancer care and determine oncology standards. Finally, some may object to the charge associated with the QOPI Certification Program, intended to help cover some program costs.

Health plans engaged in the QOPI Health Plan Program have provided commentary and feedback on the QOPI Certification Program. Many have noted that performance-based programs will be developed by health plans or others outside the profession, if the profession does not do so. For the QOPI Certification Program to gain traction with health plans, it is crucial that the program include rigorous and transparent standards. Certainly, the existence of the QOPI Certification Program will allow ASCO to advocate for members in a concrete way, discouraging development and implementation of other quality programs, which may require significant practice staff time to generate results that are not considered trustworthy or meaningful for quality. The QOPI Steering Group and ASCO leadership are committed to an ongoing evolution of the QOPI Certification Program and will invite member feedback. An important goal of the program is to help all practices improve cancer care quality and safety. Thus, performance targets are expected to change over time.

The overall quality score calculation and scoring requirement will be revisited after each round of data collection and adjusted as needed on the basis of results. The modeling of historical data used to generate the QOPI Certification scoring requirements has many benefits, but it also has limitations. It is known that practices will select modules and sample differently if they are seeking to apply for the certification program. Some of the variation in measure-level numerators and denominators may decrease. It is possible that concordance will increase as oncologists and abstractors hone in on the importance of these measures and are especially careful about locating relevant data in medical records. On the other hand, changes to specifications for some of the certification measures to be implemented in the fall 2009 QOPI round may push concordance down slightly. Careful review and additional analysis after the fall 2009 round will be important and may determine changes to be implemented in 2010 rounds.

QOPI has evolved rapidly over its 7-year history. It was initially conceived as a tool to allow practices to assess the quality of care provided to their patients by measuring concordance with a limited set of process measures. As the number of participating practices has increased, and experience with measures has grown, QOPI has become a useful benchmark for practices, allowing comparisons with peers and possibly improving performance.[4] More recently, collaborative networks have been created to enable sharing of best practices, using QOPI to track performance.[7] The QOPI Certification Program is the next step in a continuum of changes to QOPI that is intended to additionally improve patient care and respond to a rapidly changing workplace.

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The authors indicated no potential conflicts of interest.

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Time to Focus on Inpatient Safety: Revision of the American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards

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See related article in *J Oncol Pract* 8:2-6, 2012

In 2009, the American Society of Clinical Oncology (ASCO) and the Oncology Nursing Society (ONS) jointly published a comprehensive set of chemotherapy safety standards.[1] The project was the end result of a highly structured multistakeholder process and the sole focus was on outpatient chemotherapy administration in the facilities in which most adult cancer chemotherapy is administered.[2,3] In 2011, ASCO and ONS convened a workgroup to revise the standards. The revised standards are published in the January 2012 issue of *Journal of Oncology Practice* (*JOP*).[4] In addition to clarifying language, the workgroup voted unanimously to extend the standards to encompass the inpatient setting. Inpatient chemotherapy administration, especially in the community setting, is believed to pose a silent but growing threat to patient safety.

Most patients with cancer prefer to be managed as outpatients, and ambulatory management of cancer is more cost-effective than inpatient management.[5-8] Indeed, some insurers now require justification to admit a patient to the hospital solely to receive chemotherapy.[9] The trend, then, of shifting adult medical oncology care from the hospital to the outpatient setting reflects patient-centered, cost-effective care. It has occurred gradually during the last decades of modern cancer chemotherapy, accompanied by shifts in care from academic centers to the community, where it is estimated that at least 80% of adult cancer care is provided.[2,3] The change reflects at least three major advances. First, medical oncologists have become skilled in the management of highly toxic agents. Predictable toxicities of chemotherapeutic agents have been defined and risk factors have been identified, allowing for the prevention or amelioration of most serious adverse effects. Pretreatment assessment of renal function in conjunction with aggressive hydration, for example, has allowed cisplatin to be routinely administered in the outpatient setting.[10,11] Second, the availability of highly active antiemetics and better-tolerated chemotherapeutic agents has additionally reduced the need for inpatient administration. Third, technologic advances that enable the safe delivery of continuous chemotherapy infusions in the home permit the ambulatory administration of complex regimens that previously required supervision in an inpatient setting.[5,6]

Community oncology practices have also become adept at managing the consequences of cancer and cancer treatment on an ambulatory basis. They have developed comprehensive care systems that rely on highly experienced nursing and pharmacy staff. Certification requirements for nursing and pharmacy staff along with the availability of supportive services that include nutritionists and social workers complement these practices. Patients who experience venous thromboembolic events, for example, are routinely managed with low molecular weight heparin as outpatients. Patients with low-risk chemotherapy-induced fever and neutropenia are managed with close observation and oral antibiotics. Patients who experience treatment-related GI toxicity are managed with ambulatory or home fluid resuscitation, and those with hypercalcemia receive potent parenteral bisphosphonates.[12-15] Each of these patient groups are now routinely spared the risks and inconvenience of hospitalization.

The consequence of these advances in the ambulatory care of patients with cancer is the disintegration of trained, cohesive chemotherapy teams in many hospitals; this problem is compounded by flaws in the transfer of data between outpatient and inpatient systems.[3,16] The advances made in ambulatory practices (electronic chemotherapy order entry, for example) are inconsistently reflected in the inpatient setting. Fundamental changes in hospital staffing have occurred, with fewer dedicated nurses and pharmacists who are skilled in chemotherapy protocols and more hospitalists providing inpatient cancer care. Because of declining inpatient censuses and declining revenue, many hospitals have had to eliminate dedicated inpatient oncology units.[3] This scenario may create a perfect storm in which very ill hospitalized patients are exposed to high-risk procedures (chemotherapy) that are provided by staff with diminishing expertise and without the needed infrastructure.

Academic and comprehensive cancer centers have been somewhat insulated from the changes that have affected community practices. Because these centers rely on referral of rare or refractory cancers, and because such cases often require more intensive management, they have been less affected by the shift of chemotherapy administration to the outpatient setting. However, with the increasing ability to

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manage highly complex therapies on an outpatient basis, academic and comprehensive cancer centers are not immune from concerns related to reduced use of inpatient chemotherapy services.[17-21]

Patients who are managed in the ambulatory setting have also benefitted from the availability of tools that are designed to make their care as safe as possible. The Quality Oncology Practice Initiative, available as a free service for ASCO members, allows practices to measure the care that is provided to their patients and to compare themselves against national benchmarks.[22,23] A Quality Oncology Practice Initiative Certification Program has been in place since January 2010; 92 practices achieved certification as of September 2011.[24] Certification is a rigorous process that requires practices to demonstrate that they reliably deliver high-quality cancer care in a safe environment. These tools, which provide standards for documentation, assessment, treatment, and monitoring, must now be implemented for inpatient cancer care.

The January issue of *JOP* contains the first revision of the ASCO/ONS Chemotherapy Administration Safety Standards (http://jop.ascopubs.org/content/8/1/2.full). Each standard has been modified to be applicable to the inpatient setting. The ASCO/ONS workgroup recognizes that implementation of the standards in hospitals will pose challenges. Community medical oncologists often admit patients to multiple institutions and have variable direct influence over the processes that lead to the delivery of care. Most US hospitals are accredited by the Joint Commission and many are certified by the American College of Surgery Commission on Cancer. To date, these bodies have not focused attention on the safety of patients who are receiving chemotherapy. The modified ASCO/ONS Chemotherapy Administration Safety Standards serve as a call-to-action to these organizations. We encourage medical oncologists to bring the standards to the attention of medical and administrative leaders in their hospitals and to offer their expertise to assist in their implementation. ASCO, ONS, and other organizations must also take the lead to develop quality metrics that are focused on the unique aspects of inpatient medical oncology care.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

The author(s) indicated no potential conflicts of interest.

AUTHOR CONTRIBUTIONS

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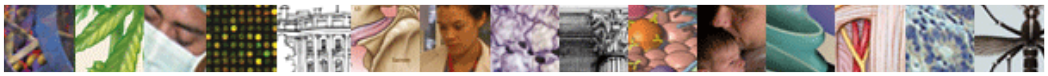
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The NEW ENGLAND JOURNAL of MEDICINE



Perspective

What We Talk about When We Talk about Health Care Costs

Peter J. Neumann, Sc.D.

N Engl J Med 2012; 366:585-586 | February 16, 2012

Comments open through February 22, 2012

Article

> Physicians have a responsibility to practice effective and efficient health care and to use health care resources responsibly. Parsimonious care that utilizes the most efficient means to effectively diagnose a condition and treat a patient respects the need to use resources wisely and to help ensure that resources are equitably available.
>
> — *American College of Physicians Ethics Manual: Sixth Edition,* 2012[1]

New ethics guidelines from the American College of Physicians (ACP) calling for physicians to practice "parsimonious care" have reignited a debate about the role and responsibility of physicians in addressing the country's problems with health care costs.[1] The ACP argues that the guidelines will help physicians to consider more carefully the tests and treatments they order and prescribe for patients and to think on a higher level about the well-being of the community at large.[2] Others have balked at the term "parsimonious," viewing it as implying that care should be withheld and that society should be stingy about how resources are allocated for health care.[2]

The debate reflects the larger struggle in the United States over how to deal with — and talk about — health care costs. U.S. political leaders are generally at pains to assure Americans that proposed health care reforms will not reduce their benefits nor curtail their choices. Health care costs are a major problem, they admit, but the way out of our dilemma is to deliver more efficient, more effective, and safer care and to reduce waste.[3]

There is a sturdy logic to these arguments, beyond their obvious political advantages. Research has revealed nonadherence to clinical guidelines, variations in practice patterns, preventable errors, and unnecessary hospitalizations. There is an overwhelming case for being smarter about how we finance and deliver care.

The problem is that no one in charge seems willing to acknowledge that getting a handle on cost growth will also involve uncomfortable trade-offs. We cannot as a society provide patients with unlimited access and unlimited choice. Providing better-quality care, though it is vital, won't change that reality.

The language of the Affordable Care Act highlights the dilemma. The law states, for example, that the newly created Independent Payment Advisory Board, established to recommend spending reductions for Medicare, cannot change benefits, shift costs to patients, or ration care. The law created a Patient-Centered Outcomes Research Institute (PCORI) to conduct comparative-effectiveness research but specifies that the secretary of health and human services cannot use it as the sole basis for denying coverage for items or services. The Affordable Care Act forbids the PCORI and the Department of Health and Human Services from using cost-effectiveness thresholds.

The inclusion of "patient-centered" in the name of the PCORI underscores the issue. On the one hand, the focus on patients has clear benefits, apart from its inspired branding. As PCORI Executive Director Joseph Selby recently observed, "The notion that patients could be at the center of a research enterprise is pretty different from the way research has rolled out over the past century."[4] The idea is to concentrate on outcomes that patients view as important. The PCORI website lists questions of consequence to patients (e.g., "What can I do to improve the outcomes that are most important to me?") and stresses that

individual patients value different outcomes differently. The PCORI has also embraced “stakeholder engagement,” which, like patient-centeredness, acknowledges the importance of giving a voice to affected parties and ensuring that clinical studies answer relevant questions.

However, changing the conversation to emphasize patients and stakeholders also has unhelpful consequences that few are willing to acknowledge. Focusing on patients' own preferences to the exclusion of considerations of societal resources will only compound our cost problems. Engaging stakeholders is undoubtedly important, but one person's stakeholder is another person's interest group. Moreover, the only stakeholders seemingly not at the table are future taxpayers (our children and grandchildren).

The resulting conversation allows little space for cost concerns. It ignores resource constraints and has an unreal, wishful quality to it, as though skydivers could defy gravity by cleverly talking their way around it. Rarely is there any mention that we will have to face hard choices and in some cases make do with less: patients with fewer services, more cost sharing, and restricted alternatives and physicians and hospitals with less revenue.

Even the move toward accountable care organizations (ACOs), for all its promise, will not eliminate the need to confront trade-offs. With their focus on integrating systems, rewarding performance, coordinating care, and reducing spending growth, ACOs should bring much-needed change. However, they will also decentralize choices, not remove them. Indeed, because they will put providers at financial risk and tie together payments for a continuum of care, ACOs may represent the ideal model for delivering parsimonious care, though that terminology is rarely employed.

The challenge is how to have a more honest conversation. A candid discussion could set expectations, inform policy debates, and help the country prioritize uses for resources within and outside the health care sector. There seems to be little evidence, however, that such a conversation will take place, at least in the public sphere. There is no political advantage in talking realistically about our problems. The election-year rhetoric will continue to emphasize prevention, quality, and health information technology. On the campaign trail, the speechifying will be about fraud and abuse, the evils of rationing, and the need to improve our way to sustainability.

That is why the new ACP guidelines are so valuable. Their focus on responsibility, their direct acknowledgment of the need to consider constraints, their recognition that less care may be better care, and their call for individual physicians to use resources wisely are rare and welcome. The ACP should be applauded for its engagement of costs. Is “parsimonious” the right word? Perhaps there are better ones, but “frugal,” “prudent,” “thrifty,” “cost-conscious,” and others would also raise objections. Whatever we call this necessary quality, the conversation could use a dose of reality. Calling it parsimonious is a reasonable start.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Center for the Evaluation of Value and Risk in Health, Institute for Clinical Research and Health Policy Studies, Tufts Medical Center, and the Tufts University School of Medicine — both in Boston.

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Comments (5)

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Chris Kantor | Other | Disclosure: None
February 20, 2012

At what cost?

When the body, mind and soul of the employee is unhealthy, there is a cost to the employer and to everyone involved.

Health literacy on what is meaningful first needs to be established before the cost cutting conversations begin.

Data by Profession and Location

JAMES RICKERT, MD | Physician | Disclosure: None
BLOOMINGTON IN
February 20, 2012

Cost effective patient centered care can be delivered by ACOs while maintaining high patient satisfaction rates.

DAVID RIVERA, MD | Physician | Disclosure: None
LOMBARD IL
February 18, 2012

Cutting our annual health care expenditures depends on doing less and/or paying less. Who gives in first? Hospitals? Patients? Physicians? Pharmaceutical companies? Technology and device companies? Insurance companies? I'll work for less money in exchange for getting the plaintiffs' attorneys off my back, better working conditions and being able to talk to my recalcitrant patients like Judge Judy instead of Marcus Welby.

As an obstetrician, I often do more than I think is necessary. I don't give a damn about any "quality metrics" and "chronic disease guidelines" because my patients don't care. If there is a bad outcome and the patient's perception is that I didn't do everything possible, I'm likely to be sued. Witness the recent furor over the USPSTF breast cancer screening guidelines.

Customer service is the patients' proxy for quality and competence. Americans believe "more" care is "better" care, a perception freely exploited by hospitals and drug companies. If you really want to change health care, patients need to be part of a public debate on how everyone contributes to health care costs, instead of being seen as hapless victims.

ilaboo lener | Other | Disclosure: None
February 16, 2012

I go to pharmacy to get new medication--it costs me $40.00 for 30 tablets. Person next to me on Medicaid pays nothing for hers. I need not tell you what my wife's cataract post surgery medications cost. The entire waiting room was full of patients on Medicaid and this system has the nerve to tell me to open my wallet while others don't. Some one is hallucinating. The American people right now I doubt has any idea whatsoever what changes are going to impact on their costs. The people on Medicaid are the only one who won in this scenario . I am a retired Physician Assistant with 30 years of experience throughout the country.

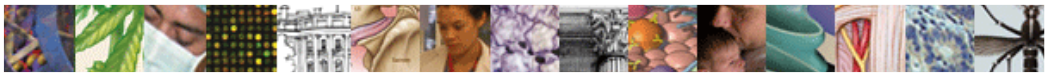
STEPHEN KARDOS, DO CEO | Physician | Disclosure: None
RUMSON NJ

February 16, 2012

Choosing more socially acceptable terms to describe economic models to reduce health expense perpetuate a rogue wave in America's thought that an economic solution is the way to reform health care. For those of us who examine the relationship between Value, Cost, and quality in health, the use of quality metrics, not economic metrics, are required to bend the trend and reduce the medical expense burden patients and doctors suffer from. Examination of many population studies from private and public sponsors of health care highlight poor compliance to basic preventive health and chronic disease guidelines from the American Cancer Society, the American Diabetes Association, The American Heart Association, and the American Academy of Pediatrics. The following equation Quality = Outcome/Cost should guide America's discussion on health reform. Outcome is defined by compliance to preventive guidelines for preventive health and chronic disease management. Patients, their care givers, and health plan sponsors must be made aware individually and collectively about what the actual quality of care rendered and received is. Parsimonious health will do nothing to insure quality and lower cost of care.

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The NEW ENGLAND JOURNAL of MEDICINE



Perspective

Keeping Score under a Global Payment System

Bruce E. Landon, M.D., M.B.A.

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Comments open through February 8, 2012

Article

It is widely acknowledged that continued growth in health care spending is threatening the viability of the U.S. health care system. Although there are no clear comprehensive solutions to this problem, most observers see payment reform as the next best hope for reining in out-of-control costs. Our current fee-for-service payment system provides incentives to physicians to increase the delivery of services, which results in excessive utilization. Moreover, neither individual physicians nor the patients receiving the services bear the brunt of these utilization decisions. Rather, they're reflected in ever-rising health insurance premiums or tax-financed government expenditures shared by all. Many observers are therefore calling for fundamental redesign of the ways in which physicians and hospitals are compensated for the care they provide. Most options call for bundling payments to physicians; specific approaches range from prospective payments for discrete episodes of care (e.g., coronary-artery bypass surgery) to global payment or risk-based models of care.

Global prospective payments became prevalent during the heyday of managed care in the 1990s. Such so-called capitation payments were common in many markets, whereas in others physician organizations were actively preparing themselves for a coming tide of capitation that never materialized. In a fast-growing economy, both patients and physicians bridled at the restrictions of choice and access associated with such payment arrangements, and capitation quickly fell out of favor. In addition, the information systems and infrastructure necessary to successfully manage risk under global payments were underdeveloped during that period. After a lull of more than a decade, however, global payment is again seen as the potential savior of the health care system.

Among the most important anticipated experiments in global payments are accountable care organizations (ACOs), which were included as part of the Affordable Care Act and are also being developed under the auspices of the Center for Medicare and Medicaid Innovation. ACOs represent a hybrid of our fee-for-service system and true capitation. The ACO regulations, proposed by the Obama administration last March and finalized in October, call for two models of shared savings. In the first model, health care organizations would be eligible to share in savings but would bear no risk for losses for the first 2 years. Under this program, ACOs would be eligible for approximately 50% of the savings accrued by the Medicare program after they surpassed a fixed savings threshold. In the second model, there is both upside and downside risk sharing for participating health care organizations from the start. Because these organizations are taking on risk for losses, they would also be eligible for a larger percentage of shared savings. This latter version of ACOs most closely approximates true capitation. These proposed ACOs are similar to arrangements already present in the commercial sector, such as the Alternative Quality Contract rolled out by Blue Cross Blue Shield of Massachusetts in 2009.[1,2]

Conceptually, global payment represents an important opportunity for changing the perverse incentives inherent in our current fee-for-service system. To be successful, however, ACOs must pass these incentives along to their member physicians, who continue to be responsible for most utilization decisions. Although organizations can implement various managerial strategies to influence physicians' decision making (e.g., radiology decision support and prior authorization), ACOs are unlikely to reduce the rate of increase in health care spending without some essential changes in the behavior of member physicians — and therein lies the rub. The fundamental questions become how ACOs will choose to divide their global budgets and how their physicians and

other service providers will be reimbursed. Thus, this system for determining who has earned what portion of payments — keeping score — is likely to be crucially important to the success of these new models of care.

Under ACOs and many commercial global payment products, providers will continue to receive traditional fee-for-service payments, and hospitals will receive their usual contracted payments, through either the diagnosis-related-group (DRG) system or per diem payments. All spending for each patient that is attributed to the ACO will then be tracked and compared with the calculated budget retrospectively at the end of the performance year in order to calculate savings or losses. Thus, standard fee-for-service payments remain the de facto method for keeping score, which works against the very design of the program. The inequities of the fee-for-service system, which reward proceduralists and specialists at the expense of cognitive specialties and primary care, remain embedded in the payment system. Although organizations can receive surplus payments, additional revenue from any surpluses will not flow into organizations until at least 18 months after the program begins.

As global payment systems are currently designed, primary care physicians stand to be among the big winners. However, to earn rewards, they will also have to shoulder the largest burden of the work needed to succeed under risk-sharing arrangements.[3] In a well-functioning health care system, primary care physicians are the point of access, are responsible for care coordination and management, have perspective on the whole patient, and have the ability to manage the care of a patient population. Moreover, most quality incentives being incorporated into the payment systems for ACOs and other new global payment contracts also fall under the purview of primary care. To accomplish the care-management and quality goals, however, primary care physicians will need substantially more resources — for hiring care managers and other personnel to pursue population health management, for coordinating and managing care, and for implementing processes to ensure adherence with quality measures.

Although many ACOs will direct future surpluses to primary care, infrastructure payments to facilitate the development of the care-management functions noted above have not been built into the design of the ACO program or many new versions of capitation. Since most of these organizations will continue to rely on fee-for-service payments for the purpose of keeping score, making funds available to invest in this infrastructure would require a transfer of funds from specialists or hospitals to primary care, and it may be difficult for organizations to unilaterally alter the flow of funds to accomplish these aims. Moreover, although organizations may face strong incentives to control costs, specialist physicians who continue to be paid through the fee-for-service system and hospitals, which continue to receive DRG-based payments, face no such inherent incentives — and in fact will continue to benefit from practicing in much the same way as they do now.

Over time, if global payments become the norm, there is likely to be a resurgence of subcapitation and budgets for particular specialties, and systems will be designed to provide similar incentives to specialists while also enhancing funding for primary care. In addition, ACOs and their aligned hospitals must share incentives to control hospital costs. This transition, however, is likely to be painful and prolonged under the current design of the programs. Certainly, adjustments to the fee schedule that limit specialist pay and divert funds to primary care will be helpful, but even more helpful would be up-front payments that organizations can use to invest in their care-management and primary care infrastructure to facilitate this transition without taking funds from specialists or hospitals, at least until they achieve surpluses that ensure the continuation of this funding stream. Tightly managed multispecialty or primary care groups without strong alignment with a hospital may be well positioned to manage this transition.

The health care system is placing tremendous hope in changing incentives to control the ever-increasing costs of care. Hybrid approaches such as ACOs that incorporate global incentives but continue to keep score using fee-for-service payments will face serious challenges as they attempt to place increasing burdens on the already-stressed primary care system without providing additional resources for achieving the aims of global payments — slowed growth in costs and higher-quality care.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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Comments (3)

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Great Neck NY
February 02, 2012

In an ACO world, balancing the need to reduce access with the perception of 'adding value' at each encounter will be a challenge that the average consumer of healthcare in this country will soon recognize as the ruse that it is, only with more paperwork.

Doctors, in fear of further devaluation, are fleeing into hospital contracts in droves. Hospitals, where almost all healthcare inflation originates, will now be our managing partners in helping control cost. Guess where the biggest savings opportunity exists?

Data by Profession and Location

If this trend continues, America will devolve into a single payer system with mediocre doctors at the mercy of hospital oligopolies treating melancholy patients.

Rather, make sure that every citizen has health insurance and let them seek differentiated doctors who provide transparent care well, simply administered where the value is palpable. The best doctors don't need disincentives to keep patients out of hospitals, good doctoring does that naturally.

JONATHON ROSS, MD | Physician - Health Law/Ethics/Public Policy | Disclosure: None
OTTAWA HILLS OH
February 01, 2012

Do we really believe that another layer of administration like an ACO is going to save money? Administrative costs are the problem not the solution. We need simplicity. We need public accountability and transparency of our finances.

This could be easily accomplished in a national health program using an improved and expanded Medicare for all. We could follow all the money since it would all be in one pool. We could see exactly where it goes and why. The administrative simplicity of a single payer like Medicare would save enough money (the estimates exceed $400 billion annually) to cover everyone with comprehensive benefits and with very low or no co-payments. The Taiwanese are the most recent country to prove this can be done successfully with better outcomes and greater satisfaction of patients.

What holds us back? Sadly, it's fear, greed, distrust and selfishness in my opinion. I for one am tired of HMO's, MCO's, PPO's, PHO's, and now ACO's. I say NO MO. It is time for improved expanded Medicare for all under a public and enforceable budget. The public gets cost control, comprehensive universal coverage and better outcomes. We can go back to practicing medicine.

JONATHAN SCHWARTZ, MD | Physician | Disclosure: None
TUCSON AZ
February 01, 2012

so many intelligent people have worked on this problem and not one has considered free market solutions. The once free market in medicine has been consistently warped by wave after wave of Statist utopian 'final solutions' yet we are told that costs keep skyrocketing. The ACO's are another example of a recycled Statist solution of the same type that has gotten us into this mess. Is there no intelligent person with power who understands the true organic and creative power of the free market in solving all the problems of mankind or are we doomed to the same centralized failed systems characteristic of much of the 20th Century?? The ACO like all Statists solutions will fail and lead to further out of control costs and a further deterioration of quality. What is the definition of insanity??

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PAGE 1 |

By Michael E. Chernew, Robert E. Mechanic, Bruce E. Landon, and Dana Gelb Safran

Private-Payer Innovation In Massachusetts: The 'Alternative Quality Contract'

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HEALTH AFFAIRS 30,
NO. 1 (2011): 51–61
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The People-to-People Health
Foundation, Inc.

ABSTRACT In January 2009 Blue Cross Blue Shield of Massachusetts launched a new payment arrangement called the Alternative Quality Contract. The contract stipulates a modified global payment (fixed payments for the care of a patient during a specified time period) arrangement. The model differs from past models of fixed payments or capitation because it explicitly connects payments to achieving quality goals and defines the rate of increase for each contract group's budget over a five-year period, unlike typical annual contracts. All groups participating in the Alternative Quality Contract earned significant quality bonuses in the first year. This arrangement exemplifies the type of experimentation encouraged by the Affordable Care Act. We describe this unique contract and show how it surmounts hurdles previously encountered with other global-payment models.

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Dana Gelb Safran is senior vice president for performance measurement and improvement at Blue Cross Blue Shield of Massachusetts, in Boston.

In January 2009 Blue Cross Blue Shield of Massachusetts launched a new provider payment system called the Alternative Quality Contract that exemplifies the type of experimentation with novel payment models that the Affordable Care Act encourages. The Alternative Quality Contract is a modified global payment model in which annual payments to medical groups are linked to a per member per month budget. The model was designed to improve quality and outcomes while greatly slowing health care spending growth. Although the Alternative Quality Contract has similarities to capitation models of the 1990s, which paid fixed amounts per member per month, it was designed specifically to address the most important limitations of prior capitation programs.

Historically, one concern about global-payment contracts has been the transfer of financial risk to providers. That is, in the event that a provider's patients needed more care or consumed more resources than allocated in the budgets, the provider would be responsible for some or all of the shortfall. Evidence of the economic incentives created by these risk contracts, mostly based on prior studies of capitation, indicates that capitated providers practice a more conservative style of care, reducing the use of resources.[1–5] Despite the reduction in resources associated with these early capitation models, most available evidence finds no adverse effects on the quality of patient care or health outcomes.[6–10] Nonetheless, many provider organizations suffered significant financial losses under capitation.[11]

As a result, there is considerable resistance to payment models that put provider groups at financial risk for medical spending. In addition, concerns persist about the potential for global payments to diminish the quality of care. Capitation contracts of the 1990s had virtually no formal quality incentives, largely because of the lack of experience with quality measurement at the time.

For these reasons, as well as because of the consumer backlash against managed care restrictions on patients seeking care,[12] the prevalence of capitation contracts declined after the mid-1990s. The percentage of physicians refus-

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by MARK GORMAN

ing to participate in capitation contracts rose from 36.2 percent in 1998 to 60.7 percent in 2008.[13]

Since the decline of capitation, however, the need to control spending growth has become even more critical, particularly given anticipated coverage expansions under health care reform. Moreover, new attention has been focused on the role that fee-for-service incentives have played in our nation's unrelenting health care spending growth.

In this environment, there have been prominent efforts to reform payment policies. Newer models of global payment have attracted attention, including shared savings models, as envisioned for accountable care organizations (ACOs). Under shared savings, a per person spending target would be set by Medicare; physicians and hospitals would share the savings with the government if they could reduce aggregate Medicare spending to a level below the target. Stronger payment models, such as the Alternative Quality Contract, require providers to share some or all of the risk if spending exceeds the target.

As with capitation, these new payment models reduce the incentives for overusing services common in fee-for-service reimbursement systems. Moreover, in such systems it is difficult for health insurers, employers, and other purchasers to control spending because price reductions are frequently offset by increases in the volume of services provided. Global payment allows these purchasers to control price and quantity simultaneously, and thus achieve predictability and control over aggregate spending and, potentially, spending growth.

Structure Of The Alternative Quality Contract

Provider organizations in an Alternative Quality Contract agree to accept accountability for managing care within a specified annual budget and have an opportunity to earn significant financial rewards for meeting clinical performance targets. Participating provider organizations may be large multispecialty groups, independent practice associations that represent many smaller physician practices, or physician-hospital organizations—that is, joint ventures between one or more hospitals and physician groups.

Eligibility for the Alternative Quality Contract requires that a group include primary care physicians who collectively care for at least 5,000 members of Blue Cross health maintenance organizations (HMOs) or point-of-service (POS) plans. The Alternative Quality Contract lasts for five years, compared with typical provider contracts of one to three years. Provider groups supported this longer window to have more-predictable payment levels and time to develop the necessary capacity to manage the new payment model.

Thus, three major features define the Alternative Quality Contract: a global budget with annual spending growth limits, incentive payments to improve quality, and technical support for participating groups.

Global Budgets With Negotiated Annual Spending Limits

Alternative Quality Contract groups agree to accept a global budget to cover all health care services delivered to Blue Cross HMO and POS patients, whether or not the care is provided by that provider group's physicians and hospitals.[14] Blue Cross negotiates a base year's budget with each participating provider group. The starting point for the negotiation is the past year's medical spending for Blue Cross HMO and POS patients who are on the panel, or patient roster, of the group's primary care physicians.

Blue Cross does not seek to reduce a group's initial budget below its current spending levels. Rather, it focuses on controlling future growth rates. This helps ensure that there are adequate resources to provide the level of care delivered in the past and that no group will be forced to reduce quality as a result of initial budget reductions.

After initial budgets are set, Blue Cross uses trend allowances to manage health care spending growth over the five-year contract period. Setting these annual budget growth rates is a critical aspect of the negotiation.

In general, Blue Cross negotiates explicit annual rates of change in the budget. In the early years, the updates generally reflect the HMO network's projected average increase in spending. Over the five-year period, the budget increases are reduced by about half.

Groups with high baseline budgets are generally given lower budget increases relative to those with lower baseline budgets. Although the baseline budgets tend to incorporate existing payment rate differences that were influenced by each group's market power, the budget trajectories are intended to reduce the disparities. Provider groups with more leverage could theoretically negotiate for higher annual growth rates, but Blue Cross has been successful so far at negotiating contracts that narrow payment differences over time.

The Alternative Quality Contract incorporates several means of mitigating financial risk. First,

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by MARK GORMAN

The use of absolute performance thresholds encourages groups to continuously improve.

each group's budget is adjusted annually for changes in patients' health status (measured concurrently) using the Diagnostic Cost Groups (DxCG) risk-adjustment model.[15] In the absence of ongoing risk adjustment for budgets, provider groups could easily lose money if they encountered high adverse patient selection—that is, a higher-than-typical proportion of sicker patients.

Second, groups can choose to participate in the Alternative Quality Contract on a risk-sharing basis rather than a full-risk arrangement. Currently, the risk borne by groups ranges from 50 percent to 100 percent. Groups that accept 100 percent risk for being both over or under budget retain all surpluses earned relative to their budget and are financially responsible for all deficits. Groups assuming less than 100 percent risk share both surpluses and deficits with Blue Cross.

Third, all groups are required to have reinsurance—a separate insurance policy that protects them in the event of high-cost cases, in which a patient's medical spending exceeds a specific threshold, such as $100,000. The policy value generally covers 70–90 percent of the cost above the threshold. Groups can purchase reinsurance coverage from Blue Cross or another reinsurer.

Fourth, the Alternative Quality Contract includes a "unit cost corridor," which increases (or decreases) the global budget if Blue Cross negotiates higher (or lower) fees with providers than originally projected.[16]

Finally, some groups were concerned about being locked into a five-year rate agreement even if unforeseen events greatly increased their costs. Therefore, in some cases an overall cost-trend corridor, based on the experiences of all Blue Cross HMO patients, allows Alternative Quality Contract group budgets to be increased to protect groups against significant trends that affect all HMO business.[17]

Quality Incentive Payments

Prior versions of capitation were criticized for creating financial incentives for medical groups to withhold necessary care in order to save money. Blue Cross has attempted to address this criticism by creating quality incentive payments of up to 10 percent of the total per member per month payments. The incentive payments are determined based on quality measures drawn from nationally accepted sets of measures.

Groups can earn bonuses of up to 5 percent based on their performance on thirty-two care measures for ambulatory or office-based services (Exhibit 1) and up to another 5 percent for their performance on thirty-two measures of hospital care (Exhibit 2). The incentive payments are not incorporated into the budgets but must be earned each year. The potential for up to 10 percent additional earnings annually represents an important source of revenue for these groups, and the bonus may be used as each group deems appropriate (for instance, investing in system improvements or rewarding clinicians, staff, and managers).

The quality bonus system is based on absolute rather than relative performance. It is the same for all groups and constant for the entire contract period. Ultimately, the bonus depends on an overall quality score that is created by aggregating quality scores from each measure.

Specifically, for each measure, there is a range of performance targets ("gates") enumerated in Exhibit 1. The highest target (gate 5) is set at an empirically derived score that available evidence suggests can be achieved by an optimally performing physician group or hospital. Gate 1 is set at about the network median for each measure. For each measure a "gate score" is computed linearly based on where the group scores relative to the gate 1 and gate 5 thresholds. For example, if a group's performance is halfway between gates 1 and 5, the group gets a 3 for that measure. If it is 75 percent of the way from gate 1 to gate 5, the score for that measure is a 4. The gate scores for each measure are then summed.

Outcome measures, such as controlling blood pressure, are given triple weight compared to process measures, such as breast cancer screening, and also compared to patient experience measures, such as the quality of communication. The annual quality payment is based on the aggregated score. The relationship between the bonus and aggregate score is S-shaped. Thus, a one-unit increase in aggregate score generates a bigger increase in the bonus for groups around the middle of the performance range relative to at the top or bottom. The use of absolute performance scores (as opposed to scores relative to other groups) encourages groups to continu-

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EXHIBIT 1

Alternative Quality Contract Ambulatory Quality Measures, Blue Cross Blue Shield Of Massachusetts, 2009

Measure	Gate 1	Gate 5	Weight
PROCESS			
Depression			
Acute-phase Rx	65.3	80.0	1.0
Continuation-phase Rx	49.6	70.0	1.0
Diabetes			
HbA1c testing (2 times)	69.9	83.2	1.0
Eye exams	58.0	72.0	1.0
Nephropathy screening	79.7	91.4	1.0
Cholesterol management			
Diabetes LDL-C screening	85.3	93.8	1.0
Cardiovascular LDL-C screening	85.3	93.8	1.0
Preventive screening/treatment			
Breast cancer screening	77.1	90.0	1.0
Cervical cancer screening	83.5	92.4	1.0
Colorectal cancer screening	65.2	83.3	1.0
Chlamydia screening			
Ages 16–20	45.9	63.7	0.5
Ages 21–24	50.1	67.3	0.5
Adult respiratory testing/treatment			
Acute bronchitis[a]	—	—	1.0
Medication adherence			
Digoxin monitoring	83.9	91.6	1.0
Pediatric testing/treatment			
Upper respiratory infection	90.6	97.7	1.0
Pharyngitis	83.1	99.6	1.0
Pediatric well-care visits			
<15 months	91.8	99.3	1.0
3–6 years	85.5	99.2	1.0
Adolescent well-care visits	60.0	87.7	1.0
OUTCOMES			
Diabetes			
HbA1c poor control	45.0	4.7	3.0
LDL-C control (<100 mg)	33.4	75.6	3.0
Blood pressure control (130/80)	30.9	47.3	3.0
Hypertension			
Controlling high blood pressure	71.6	82.5	3.0
Cardiovascular disease			
LDL-C control (<100 mg)	33.4	75.6	3.0
PATIENT EXPERIENCE			
Patient experience (c/G CAHPS/ACES)—adult			
Communication quality	91.0	98.0	1.0
Knowledge of patients	80.0	95.0	1.0
Integration of care	80.0	96.0	1.0
Access to care	79.0	96.0	1.0
Patient experience (c/G CAHPS/ACES)—pediatric	95.0	97.0	1.0
Communication quality	95.0	97.0	1.0
Knowledge of patients	89.0	93.0	1.0
Integration of care	85.0	91.0	1.0
Access to care	70.0	90.0	1.0

SOURCE Data from Blue Cross Blue Shield of Massachusetts. **NOTES** Gates are performance targets, with 5 being the highest and 1 being the network median for each measure. HbA1c is glycated hemoglobin. LDL-C is low-density lipoprotein cholesterol. C/G CAHPS/ACES is Clinician and Group Consumer Assessment of Healthcare Providers and Systems/Ambulatory Care Experiences Survey. [a]This measure was reported in 2010 but was not included in the incentive payments. Thus, no performance targets (gates) were defined.

ously improve and to share best practices with one another.

Ambulatory quality measures almost exclusively reflect the performance of the group's primary care practices, creating strong incentives for groups to invest in primary care. The primary care incentives of the Alternative Quality Contract are notably different from traditional fee-

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EXHIBIT 2

Alternative Quality Contract Hospital Quality Measures, Blue Cross Blue Shield Of Massachusetts, 2009

Measure	Gate 1	Gate 5	Weight
PROCESS			
Acute myocardial infarction			
ACE inhibitor/ARB for LVSD	89.1	98.9	1.0
Aspirin at arrival	98.3		1.0
Aspirin at discharge	98.2		1.0
Beta-blocker at arrival[a]	96.9		1.0
Beta-blocker at discharge	98.5		1.0
Smoking cessation	93.1	99.9	1.0
Heart failure			
ACE inhibitor for LVSD	87.3	98.9	1.0
LVS function evaluation	95.1	100.0	1.0
Discharge instructions	71.4	98.5	1.0
Smoking cessation	88.3	99.6	1.0
Pneumonia			
Flu vaccine	77.8	98.6	1.0
Antibiotics within 6 hours	95.6	99.8	1.0
Oxygen assessment	100.0		1.0
Smoking cessation	86.7	99.8	1.0
Antibiotic selection	87.4	95.4	1
Blood culture	91.0	98.0	1.0
Surgical infection			
Antibiotic received	86.5	98.9	1.0
Received appropriate preventative antibiotic(s)	94.1	99.4	1.0
Antibiotic discontinued	77.9	96.2	1.0
OUTCOMES			
In-hospital mortality, overall	2.15	0.88	1.0
Wound infection	0.30	0.09	1.0
Select infections due to medical care	0.18	0.02	1.0
AMI after major surgery	1.57	0.10	1.0
Pneumonia after major surgery	1.57	0.60	1.0
Postoperative PE/DVT	0.93	0.22	1.0
Birth trauma, injury to neonate	0.20	0.01	1.0
Obstetrics trauma, vaginal without instrument	3.54	1.54	1.0
PATIENT EXPERIENCE			
Communication with nurses	72.6	81.2	1.0
Communication with doctors	78.1	85.5	1.0
Responsiveness of staff	58.4	76.4	1.0
Discharge information	77.7	90.4	1.0

SOURCE Data from Blue Cross Blue Shield of Massachusetts. **NOTES** Gates are performance targets with 5 being the highest and 1 being the network median for each measure. ACE is angiotensin-converting enzyme. ARB is angiotensin-receptor blocker. LVSD is left ventricular systolic dysfunction. AMI is acute myocardial infarction. PE is pulmonary embolism. DVT is deep venous thrombosis. [a]Because the performance on this measure is so high, a single gate value is used. Providers meeting this threshold were rewarded as if they met gate 5.

for-service incentives, which motivate providers to use highly specialized services and which often leave primary care practices as just the gateway to specialty care revenue.

The potential quality bonus is much higher than typical pay-for-performance programs because it is a percentage of total per member per month payments rather than just physician fees. For example, primary care physician payments currently make up about 10 percent of total network medical spending. If a group allocates the entire ambulatory quality bonus (up to 5 percent of total per member per month spending) to primary care physicians, these bonuses could increase primary care physician payments considerably.[18]

Technical Support For Participating Groups

One of the biggest challenges that physician groups face in managing population health is incomplete data. US medical groups generally lack data on care delivered outside of their group, and they may not be informed in a timely manner, or at all, when their patients are admit-

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ted to a hospital.

Blue Cross has developed a data-reporting system that supports medical groups' ability to implement timely medical management. The support includes a series of regular data and performance reports, consultative support, and organized sessions where the groups meet jointly and share best practices. The reports allow groups to monitor their performance on the quality bonus measures as well as current performance relative to their budgets. This informs their efforts to address clinical waste and to manage referrals more effectively.

Blue Cross's reporting emphasizes unexplained practice pattern variations that are both clinically and financially important. Reports include both condition-specific variations in treatment provided in a given medical or surgical specialty and potentially avoidable use of hospital resources. The analyses of condition-specific practice pattern variations demonstrate how physicians within a given specialty—for example, cardiology—differ from their peers in their use of particular technologies, treatments, or diagnostic tests for patients with the same underlying clinical status.

The methodology, drawn from the work reported by Robert Greene and colleagues,[19] has been used to demonstrate unexplained variations in practice patterns such as treatment for conditions like knee, back, and hip pain; use of brand-name medications rather than generics; use of cardiac catheterization and coronary artery bypass graft procedures; use of advanced imaging; nonurgent emergency department care; and treatment of gastroesophageal reflux disease.

Using a similar approach, Blue Cross provides participating groups with data on three categories of potentially avoidable hospital use: admissions that could have been avoided by appropriate outpatient care for conditions like asthma and diabetes; readmissions within thirty days of a hospital discharge; and nonurgent emergency department use.

Operation Of The Alternative Quality Contract

PROVIDER PERSPECTIVE Throughout the contract year, groups are paid on a fee-for-service basis, as they were before the Alternative Quality Contract. All Blue Cross payments for medical services, whether delivered by providers inside an Alternative Quality Contract group or by unaffiliated providers, are debited against the group's budget. Fee-for-service rates paid by Blue Cross differ widely across individual hospitals and physician groups, creating strong incentives for groups to direct referrals to low-cost providers. At year's end, Blue Cross conducts a final reconciliation with each group, paying the group its surplus or recouping any deficit relative to the budget.

The Alternative Quality Contract does not lock patients into any provider network.

ENROLLEE PERSPECTIVE At present, the Alternative Quality Contract applies only to HMO and POS plan enrollees. Because enrollees in such plans are required to designate a primary care physician, attribution of patients to primary care physicians and to the provider's budget is relatively straightforward.

Blue Cross members are not formally notified when they select a primary care physician who is part of an Alternative Quality Contract group. This is consistent with general industry practice of not notifying patients when physician incentives change. The fact that their primary care physician is part of this contract may be invisible to the member, whose benefits remain identical to those of other HMO and POS enrollees. Like any other Blue Cross HMO or POS enrollee, members with physicians in the Alternative Quality Contract may seek care from any network provider if they obtain a referral from their primary care physician prior to receiving specialty care.

Enrollee cost-sharing requirements are not affected by the Alternative Quality Contract or by whether or not the provider a patient sees is part of an Alternative Quality Contract group. Thus, enrollees do not have financial disincentives to see providers outside of the relevant group. The absence of such financial disincentives has the potential to create conflict between patients and primary care physicians, who may want to limit referrals outside their own network. As with any HMO or POS member, enrollees who are dissatisfied with their primary care physician—based on difficulty in obtaining a referral or for any other reason—have the option of changing physicians. Thus, the Alternative Quality Contract does not lock patients into any provider network, but neither does it allow unrestricted patient choice.

In fact, a considerable amount of care delivered to Alternative Quality Contract patients—

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EXHIBIT 3

Groups Enrolled In The Blue Cross Blue Shield Of Massachusetts Alternative Quality Contract Through 2009

Group name	Description	No. of primary care physicians	No. of specialists	Typical physician group size[a]	No. of hospitals	Prior BCBSMA risk contract
Atrius Health	Multispecialty group	400	444	Large	0	Yes
Caritas Christi Network Services	PHO	276	843	Small	6	No
Hamden County IPA	IPA	72	0	Small	0	No
Lowell General PHO	PHO	80	200	Small	1	No
Mt. Auburn Cambridge IPA	IPA with aligned hospital	112	399	Small	1	Yes
New England Quality Care Alliance[b]	Hospital-owned IPA	369	982	Mixed	0	For some providers
Signature Healthcare	Integrated system	50	109	Large	1	No
South Shore PHO[c]	PHO	98	281	Small	1	No

SOURCE Data from Blue Cross Blue Shield of Massachusetts (BCBSMA). **NOTES** PHO is physician-hospital organization. IPA is independent practice association. [a]"Small" means that the majority of physicians practice in groups of five or fewer. "Large" means that the majority of physicians practice in groups of twenty-one or more. [b]Organization works with Tufts Medical Center. [c]The number of physicians was estimated by Blue Cross. Other groups reported numbers of physicians.

generally about one-third, according to Blue Cross data—is delivered by other primary care providers, specialists, or hospitals outside the patients' Alternative Quality Contract groups. However, Blue Cross reports no change in the rate of patients who switch to a new primary care physician.

Medical Groups' Participation In The Alternative Quality Contract

As of the end of 2009, eight provider groups had joined the Alternative Quality Contract; four more have since joined. The groups are diverse in terms of size, geography, organizational form, and prior experience with risk contracting (Exhibit 3).

The Alternative Quality Contract groups include one independent multispecialty group practice, several independent practice associations that contract on behalf of multiple smaller physician groups, and several physician-hospital organizations. Three of the groups, and some of the practices that composed a fourth group, contracted with Blue Cross on a risk-sharing basis prior to signing the Alternative Quality Contract in 2009. The rest of the groups were previously paid on a fee-for-service basis.

It is noteworthy that although all Alternative Quality Contract physicians are part of some organizational structure that contracts on their behalf, about 12 percent of participating physicians are in one- or two-physician practices. For these physicians, the independent practice association or other organizational structure provides an important basis for contracting and administrative functions as well as for performance improvement initiatives. In contrast, physicians practicing in very small practices but without any larger organizational affiliation—about 16 percent of Blue Cross's network—would probably need to join an existing organization or form a new organization in order to manage successfully under this type of contract.

The smallest Alternative Quality Contract group has seventy-two physicians, and the largest group has well over 1,300. Five of the groups include hospitals. Three are independent physician organizations without a hospital.

In some of the groups, the majority of physicians are employed physicians—meaning that they are directly employed by the hospital or large physician group—and in others, most of the physicians are independent practitioners. In 2009 the Alternative Quality Contract covered about 1,600 primary care physicians, representing just over one-quarter of the primary care physicians in the Blue Cross HMO and POS network, who care for about one-third of Blue Cross's HMO and POS plan members.

Importantly, several of the largest provider networks initially chose not to participate in the Alternative Quality Contract, including the physician networks affiliated with Partners Healthcare, Beth Israel Deaconess, UMass Memorial Healthcare, and the Lahey Clinic. Their concerns included their ability to manage risk and the overall generosity of payment. Yet despite these concerns, Blue Cross's discussions with these groups are ongoing, and, in fact, Beth Israel Deaconess has recently signed an Alternative Quality Contract that begins January 2011.

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The initial Alternative Quality Contract groups represent a wide range of baseline cost and quality performance compared with the network average. These groups ranked between fourth-highest and thirty-seventh-highest out of thirty-nine groups for 2008 total medical expenses, according to data that Blue Cross reported to the Massachusetts attorney general's office.[20] Similarly, their 2008 quality scores ranged from the high end to the low end of network performance.

Discussion

Blue Cross's primary motivation for the Alternative Quality Contract was to reduce the growth in medical spending and improve quality and outcomes. Several features of this contract program differentiate it from past capitation models, including the five-year contract period and quality bonuses.

AIMS OF THE CONTRACT PERIOD The five-year contract period achieves two important aims. First, under prior versions of capitation with shorter contract periods, groups that successfully controlled use or services were often "punished" by having to adhere to a lower global budget in subsequent years. Under the longer-term Alternative Quality Contract, groups will have longer to reap the benefit of successful efforts to control use. Second, because the growth rates for the global budgets are specified in the contract, premium increases for purchasers of health insurance become more predictable.

The effect of the Alternative Quality Contract on spending depends on the negotiated global budgets relative to spending that would have occurred otherwise. Although it was Blue Cross's intention that the Alternative Quality Contract's declining budget increases would yield cumulatively large savings even after accounting for anticipated quality bonuses, this result is uncertain because the trend throughout the Blue Cross network cannot be predicted with accuracy over the five-year contract period. Moreover, it is plausible that spending in the Alternative Quality Contract could be higher during the initial contract period than in the rest of the network because some initial budgets were set at relatively generous rates to attract early adopters.

Over longer periods, the Alternative Quality Contract can reduce spending growth by influencing delivery system structures and processes. If contracted groups invest in new infrastructure such as more health information technology, reorient practice culture to place a greater emphasis on primary care, and develop more-efficient care models during the five years of their first contract, they could be poised to operate profitably under future budget growth rates that track the growth of the rest of the economy.

In the first year of the Alternative Quality Contract, all groups met their budget targets and, in fact, achieved savings.

Many policy makers believe that a larger ratio of global payment arrangements relative to other payment reforms will be needed to drive large-scale reorganization of delivery systems. It is likely that successful Alternative Quality Contract groups will want to enter into global budget contracts with other payers, thereby generating broader system effects. Whether this slows spending growth over a much longer time period will depend on whether these efficiencies affect the rate at which groups adopt and use new medical technology and how rates are set after five years.

CHALLENGES TO THE SYSTEM There are several challenges facing the Alternative Quality Contract system. One will be attracting more large physician groups on terms that are consistent with the goals of the contract. A second will be finding ways to effectively engage groups that now have limited infrastructure for managing risk contracts.

Another important problem to consider is the fact that patients' financial incentives are generally not well aligned with the goal of careful use of health care resources that is central to Alternative Quality Contracts. This could create conflicts as groups aim to keep patient referrals within their core provider networks. Blue Cross and contracted groups are working to address these issues but might not succeed in doing so.

Past global payment models have failed because physicians were unable to manage risk.[11] In the first year of the Alternative Quality Contract, Blue Cross reports that all groups met their budget targets and, in fact, achieved savings. Subsequent analyses will evaluate changes that may have generated these savings and will monitor groups' success against budget targets during the five-year contract. All groups are also reported to have earned significant quality bonuses in the first year.

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Some form of provider accountability for resource use seems essential to reining in spending growth.

Even if the Alternative Quality Contract is successful for Blue Cross, other payers might not find it easy to replicate the model. Because Blue Cross is the largest insurer in Massachusetts, its market share may be sufficient to induce meaningful changes in a provider organization's clinical and financial operations. Furthermore, a substantial proportion of the plan's business is in HMO and POS products, which allow provider organizations greater control over patient referrals. Finally, Blue Cross has long-standing relationships with provider organizations in the state. In contrast, large national health plans may have relatively limited market share in any given local area and relatively limited relationships with most local providers.

Public payers such as Medicare may be able to surmount the problem of provider market power and even compel providers—or give them strong incentives—to participate in global payment systems. Yet public payers (and private payers with less local knowledge) may find it more difficult to tailor their model to different organizations and to support those organizations with data. It is likely that Blue Cross's success will reflect its ability to work with providers who face unique situations and to change certain details of the model as needed, based on deep knowledge of the market and providers. Public and many private payers are likely to find such flexibility more difficult.

Nevertheless, the Alternative Quality Contract represents one possible vision for paying accountable care organizations. Alternative Quality Contract groups are responsible for delivering care for a defined patient population within an agreed-upon budget, with financial rewards for meeting quality thresholds. The primary care orientation is consistent with medical home models. But the Alternative Quality Contract does not require participating groups to exhibit any particular structure, nor does it require that groups invest additional funds in primary care payment and infrastructure.

DIFFERENCES FROM MEDICARE SHARED SAVINGS MODEL The Alternative Quality Contract differs from the shared savings model proposed for paying Medicare accountable care organizations under the Affordable Care Act in a number of important ways. First, the Alternative Quality Contract groups bear significant financial risk for failure to meet budget targets. Medicare ACOs may not bear significant financial risk if they fail to meet budget targets.[21]

Second, Blue Cross members can be in the Alternative Quality Contract only if they are enrolled in an HMO or POS plan in which they must select a primary care provider. There is no such requirement for Medicare fee-for-service beneficiaries. There are many advantages to having beneficiaries select their own primary care physician. It allows primary care physicians and affiliated medical groups to know ahead of time which patients they are responsible for.

In contrast, although the proposed method of assigning Medicare beneficiaries to accountable care organizations is consistent with the program's emphasis on freedom of choice, it continues a fundamental disconnect between beneficiary responsibilities and the goals of care systems.

Third, the Alternative Quality Contract is based on negotiated payment rates and budgets. Groups are paid differing amounts based on historical differences in care patterns, severity of patients' medical conditions, and negotiated rates.

Blue Cross's decision to set baseline budgets in accordance with each group's current spending levels was considered necessary to attract voluntary participation. Nevertheless, provider market power has become a major concern of both employers and health insurers. Conceivably, Blue Cross or other insurers could have difficulty negotiating annual budget growth rates below prevailing medical trends, if providers retain sufficient market power to dictate rates.

In contrast, the budget targets of Medicare ACOs will probably be based on administered prices that vary much less than Blue Cross's negotiated rates. Spending growth will therefore depend on congressional decisions about Medicare spending.

CONCLUSION The Alternative Quality Contract represents a global payment model intended to control spending growth and improve quality and outcomes. The same goals are behind policy makers' efforts to encourage growth of accountable care organizations.

Models like the Alternative Quality Contract create stronger financial incentives for improving the value of care. By requiring that members have a primary care physician, they also give medical groups more ability to engage patients

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and coordinate care.

Barriers to success of the Alternative Quality Contract remain. Yet simply clinging to, or modestly rearranging, the fee-for-service payment systems of the past is not a viable option for long-term sustainability. Some form of provider accountability for resource use seems essential to reining in annual health care spending growth rates that continually outpace income growth rates. Pairing accountability for spending with accountability for quality, as the Alternative Quality Contract does, seems an important foundation or design principle for the reforms that will be tested in the years ahead. ■

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Michael E. Chernew is a professor of health care policy at Harvard Medical School.

Michael Chernew, Robert Mechanic, Bruce Landon, and Dana Gelb Safran introduce *Health Affairs* readers this month to the Alternative Quality Contract, a new payment model for providers initiated by Blue Cross Blue Shield of Massachusetts. All four authors view payment reform as fundamental to controlling cost growth in health care, and they believe that the Alternative Quality Contract could influence similar initiatives across the country.

The authors came together under the auspices of Blue Cross Blue Shield. Safran, who is the health insurer's senior vice president for performance measurement and improvement, sought a top-flight evaluation of the program. The result was what she describes as this "trifecta" in health services research, bringing together Chernew's expertise with global payments, Landon's work in quality measurements, and Mechanic's research in the leadership and culture of health care organizations.

Lead author Chernew is a professor of health care policy in the Department of Health Care Policy at Harvard Medical School and also serves as the director of Harvard's program for value-based insurance design. Chernew received his doctorate in economics from Stanford University and is a member of the Institute of Medicine.



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