

**PAYMENT REFORM: ONLY A MEANS TO AN END
REPORT OF THE TASK FORCE ON PAYMENT REFORM**

**Approved by Board of Trustees
American Hospital Association
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Introduction

Throughout discussions under the *Health for Life: Better Health, Better Health Care* initiative, a clear sense of direction emerged in support of meaningful health care reform that expands coverage, improves the quality of care and care coordination, promotes wellness and preventive care, rewards effective and efficient care, promotes innovation, and decreases cost. For the most part, meeting these objectives requires systemic change to how health care is delivered in the United States, which in turn requires fundamental restructuring of the incentives created by current payment systems. Anything less than systemic change may alter the health care system around the edges but will not be adequate to achieve true and meaningful reform. As has been the case for decades and as discussed in multiple health care reform debates, achieving greater clinical integration in care delivery is the key to achieving many of these goals. Also important is the role of individuals in exercising personal responsibility in how they care for themselves and how they utilize services, but that and other issues are not part of the charge to this task force.

President Obama has called on Congress to reform America's health care system this year, and reform is unfolding in Washington. Several of the proposals for payment reform that are under debate as a part of broader reforms have been discussed individually by AHA's members in governing council, regional policy board, and Board of Trustee meetings over the last few years, primarily in the context of changing Medicare payment. Such changes include the bundling of services, value-based purchasing, reducing payment for readmissions, medical home models, and accountable care organizations (ACOs). In each case, those proposals received mixed responses from members—they had the potential to positively change incentives in the health care field but were often weighed down by design elements that would be harmful or missing key enabling elements.

In the current debate, those organizations and areas of the country that have achieved a meaningful degree of clinical integration are those that have consistently been held up as role models for the efficient delivery of high quality services. At the same time, there has been a lack of understanding among most public policy makers regarding the changes needed to enable and encourage clinical integration in a variety of settings. Those changes range from legal and regulatory barriers, to the high front-end investment costs (both time and money) associated with building the infrastructure for clinical integration—chiefly information technology and clinical systems reengineering.

It also has become clear that the hospital field must reach some conclusions about which provider payment reforms it can support and advocate for and under what conditions. Otherwise, what is likely to emerge is a mix of approaches that does not yield aligned incentives for

providers or that frustrates rather than encourages efforts to improve health care delivery. Payment reform must be viewed as a means to an end of delivery reform, not simply as a way to artificially reduce payer costs.

To stimulate that discussion, in late April 2009 the AHA Board of Trustees appointed a Task Force on Payment Reform to develop a framework for provider payment reform and evaluate the range of proposals being debated within public policy circles, in the hope of developing an approach that could be supported by the hospital field. The task force is comprised of health system and hospital leaders from every region, including several physicians, a trustee, and a state hospital association executive. Task force members also were drawn from a range of settings, from critical access hospitals to acute and post-acute care hospitals to large health care systems. The committee's membership is listed in the attachment to this report.

The Role of Payment Reform under Broader Health Care Reform

Health care reform involves a myriad of changes designed to accomplish several goals. In developing the framework of *Health for Life: Better Health Care, Better Health* in consultation with a variety of stakeholders, the goals for health care reform were depicted in the following graphic.

National Framework for Change



In focusing the work of this task force on payment reform, its discussions and the following recommendations were developed in the context of the broader health care reform effort and our complete national framework for change, but were limited to the role of provider payment reform. For example, the task force recognized that the incentives for individuals to adopt healthy lifestyles would come primarily from coverage and benefit designs, as well as the availability of preventive services and better coordination of care among health care providers. The role of provider payment reform is to change the provider incentives created by payment methods to encourage greater coordination of care across settings, to achieve the best possible outcomes at the most efficient cost, and to do it in a way that helps individuals navigate the health care system.

Consequently, the task force's report does not discuss all elements of the broad issue of health care reform, but is designed to support overall reform by ensuring that its provider payment recommendations complement and affirm the broader health reform objectives. Of necessity, its discussions focused on creating the right incentives for providers to change how they deliver care so that the system supports high quality, better coordinated care that is efficient and affordable. Similarly, the task force's report does not attempt to outline changes in payment for all types of providers at every stage—it is more focused on our experience and expertise, our commitment to our communities, and how the hospital and health system field can best contribute to the broader goals of health care reform.

Analytic Framework for Payment Reform

In examining specific approaches to payment reform, the task force first developed an analytic framework laying out the criteria that should be used to evaluate any given approach. That process involved reviewing the entire National Framework for Change under the *Health for Life* initiative and the results of various work groups. In laying out the analytic framework for payment reform, the task force cautioned that given the interconnectedness of payment and delivery reform, it is critical for these changes to be an evolutionary process, not a revolutionary process.

The task force also cautioned that America's hospitals are very diverse.

- They range from small critical access hospitals in America's frontier and rural areas to mid-size suburban hospitals to large teaching hospitals in America's biggest cities to health care systems serving major cities, regions, or multistate areas. They also differ in their focus; from full-service acute to acute hospitals focused on special populations such as children's hospitals to post-acute hospitals focused on rehabilitation or long-term care. And they differ in terms of whether they are part of a larger health care system or operate on an independent, stand-alone basis.
- They serve communities that also are very diverse, especially with regard to the demographics of the people who live in those communities and the availability of health care providers and resources. For example, hospitals in inner-city areas often serve populations that are poor; uninsured or covered by government programs, such as Medicaid; and who often have limited access to sub-specialty physicians and other providers such as home health agencies. Populations that suffer from socioeconomic and health disparities are generally more expensive for hospitals to treat because they require additional services and more support to overcome the conditions under which they live.
- They vary significantly in their level of clinical integration; their relationships among hospitals, physicians, post-acute, and other providers in the community; and their ability to coordinate with each other. At this time, relatively few hospitals are organized to clinically integrate all of these services and many are not prepared to attempt this level of integration.

Thus, hospitals are in very different positions with respect to their current capabilities, how quickly they will be able to implement payment or delivery reforms, and the number of barriers they face in implementing these reforms. Consequently, long-term success will require the development of a path for hospitals to move along a continuum of payment and delivery reform,

as well as the tools and funding to move through that evolution. It will also require evolution in how the quality and efficiency of care are measured, so that the evaluation of providers' progress matches the different points along that path.

Furthermore, while many of the payment reforms that are being discussed have known and proven strategies for effective implementation, others do not. In some cases, the reforms may have been tested for only a particular type of community or provider, without any sense of whether the reform will need to be modified for other communities. Where the strategies have been tested, providers will need assistance in implementing them, drawing on the experience of others. Where the strategies are not well tested or proven, demonstrations, pilots, and further research will be necessary before the strategies are broadly implemented. In all cases, broad scale implementation will require monitoring to identify and quickly resolve unintended consequences.

The analytic framework developed by the task force is intended to apply to payment approaches by all payers and includes the following criteria or principles:

1. ***The key goals of health care reform that must be reflected in payment approaches and supported by aligned incentives include:***
 - ***Care should be patient-centered and focused on wellness, including primary and secondary prevention. Incentives under coverage and benefit designs for individuals to be responsible about healthy behaviors and use of services need to be supported by adequate funding of provider efforts to help educate individuals on wellness and prevention, appropriate use of services, and self-management of chronic conditions.***
 - ***Care should be quality focused, reflect available scientific evidence and best practices, and promote continuous improvements in the standards of care.***
 - ***Care should be cost effective and provided at the right time, in the right setting, and in a manner that achieves the best outcome at the least cost.***
 - ***Care should be guided by collaboration and coordination among the various health care providers and the patient and family or others involved in caring for the patient, and by the patient's end-of-life wishes where applicable. In other words, care should be as clinically coordinated as is possible given local conditions.***
 - ***Care must be supported by adequate funding for health professions education, including the training of physicians and other health care providers in sufficient numbers to care for everyone and to provide effective education of patients and their families.***
2. ***Payment approaches should establish accountabilities for all providers—physicians, hospitals, and others—for the decisions they make regarding the quality and outcomes of the care provided, the coordination of care across different settings, and the efficiency with which that care is delivered.***

3. *Payment approaches must be scalable and capable of being applied to different markets, different types of institutions, and different patient populations. In some cases, that may mean multiple approaches rather than a single approach that is not suitable for universal application, as long as the approaches provide incentives to achieve clinical integration and all providers are held to comparable quality and efficiency standards.*
4. *Payment approaches must be transparent in several respects:*
 - *The basis for and calculation of payment to providers should be open to scrutiny, including any data bases used (i.e., no black boxes).*
 - *The basis for making coverage decisions regarding patient care should be open to scrutiny and clear to patients and their caregivers.*
5. *Payment approaches must create a sustainable financial model for efficient health care providers, support their community benefit initiatives, and avoid chronic underfunding. Specifically, a sufficient operating margin should be attainable to enable the capitalization of needed equipment, information technology, and facility renovation or replacement. It must recognize the cost of caring for communities that have experienced disparities in care, such as language services, transportation, and physician shortages. It must also recognize the cost of standby emergency and trauma services by full-service hospitals, including the increasing demand by physicians to be paid for emergency on-call coverage.*
6. *Payment approaches must recognize the significant costs of creating and maintaining the infrastructure required to enable and support clinical integration and coordination of care activities by hospitals, physicians, and other providers. Those costs include information technology, additional clinical personnel to facilitate coordination among providers, reengineering of clinical systems, and staff training in new systems.*
7. *Payment approaches must, in fact, be capable of reducing the rate of growth in health care expenditures (for payers and providers alike) based on proven techniques but also recognize that demand for services will increase as the population ages and shifts in location as greater proportions of the population are covered. Payment incentives should encourage cost-effective resource use where appropriate.*

To achieve the goals of reform and enable appropriate provider responses to incentives, health care reform must include upfront changes to several federal and state laws and regulations that are underpinnings for the transition to a more efficient and higher quality delivery system. Areas where change or modernization is needed are:

- *The federal laws and regulations affecting hospital-physician relationships, including the Ethics in Patient Referrals Law (better known as the Stark Law), the Antikickback law, the Civil Money Penalties (CMP) Law, the Antitrust law, and Internal Revenue Service (IRS) private inurement rules—these laws present significant barriers to clinical integration.*
- *Federal laws and regulations in a variety of areas regarding the inability to recommend sources of post-acute care to patients based on care coordination relationships or bundling contracts, emergency standby and on call requirements under EMTALA, limitations on the*

ability to move patients to more appropriate levels of care (again, EMTALA), artificial separation and limitation of services by post-acute providers that impede relationships across settings (such as the SNF three-day prior hospitalization rule, the long-term acute care hospital “25 percent rule,” and the inpatient rehabilitation facility “60 percent rule”).

- *Medical liability system reforms to ensure that patients harmed are appropriately compensated, while at the same time eliminating the high cost of defensive medicine and protecting physicians and providers who follow clinical guidelines.*
- *State reevaluation or federal preemption of state corporate practice of medicine laws.*
- *Reexamination by states of the best use of non-physician care practitioners to meet the needs of all patients.*

Evaluation of Payment Reform Approaches

Using the analytic framework, nine approaches to payment reform were evaluated. The task force also had the benefit of a compendium of payment reform approaches developed by Avalere Health, a Washington, D.C.-based consulting firm. The nine approaches were not considered mutually exclusive but were considered as a *menu* of payment reform elements that could be incorporated in a comprehensive approach. The nine included:

- Accountable Care Organizations (ACO)
- Medical Home Model
- Comprehensive Episode Bundled Payment
- Acute Care Bundled Payment
- Pay-for-Performance—Assessed on Patient Outcomes
- Pay-for-Performance—Assessed on Clinical Processes
- Pay-for-Reporting
- Capitation
- Selective Contracting

In evaluating these nine approaches, the task force folded capitation into the ACO approach, but emphasized a shared risk approach through capitation, global budgeting (a la Massachusetts’ new program), or some other approach that may emerge from demonstrations. The task force believed that pursuing a full-risk capitated model was already available by forming a health maintenance organization (HMO) or similar insurance product, whether in the private sector or, for example, through the Medicare Advantage (MA) program. It also discarded the selective contracting approach as one that did not support clinically integrated care. Finally, it viewed pay-for-reporting as a current approach rapidly headed to pay-for-performance. Consequently, the task force narrowed down the above list to six promising approaches:

- Accountable Care Organizations
- Medical Home Model
- Comprehensive Episode Bundled Payment
- Acute Care Bundled Payment
- Pay-for-Performance—Assessed on Patient Outcomes
- Pay-for-Performance—Assessed on Clinical Processes

These six options were then examined in more detail, including:

- The factors necessary for these approaches to be implemented successfully.
- Where and how these approaches would best fit on an evolutionary path that uses the incentives created by payment methods to achieve desired changes in health care delivery.

Task Force Recommendation

The task force believes that traditional fee-for-service payment does not provide the right incentives and is not viable in the long term. Consequently, it believes that payment methods should migrate away from fee-for-service toward larger bundles of services and health care providers should help shape the direction of that migration.

The task force's recommendation (the italicized material that follows) focuses on the Medicare program initially, recognizing that where Medicare goes, many other payers follow. It also recognizes that Medicare is the major current program that can be affected by federal public policy changes, which is AHA's primary advocacy arena. It is important to note, however, that hospitals, physicians, and other providers need to operate under consistent and aligned incentives. To the extent that different payment approaches with different incentives are in place for different segments of a provider's patient population, the likelihood of progress in delivery reform will be diminished or delayed. Consequently, the task force urges the adoption of compatible approaches by other payers as well.

Similarly, reforming payment to break down the silos in which all providers currently operate needs to occur across the spectrum of provider types, including hospitals, physicians, post-acute and rehabilitation hospitals, skilled nursing facilities, home health agencies, and hospices. True delivery reform will require that all health care providers operate under aligned incentives that encourage coordination of care across settings, high quality, and efficiency.

Recommendation: AHA should support adoption of a payment reform approach that advances the goals of health care reform and meets the criteria described in the analytic framework above (the italicized material beginning on page 4) and provides for an evolutionary path that synchronizes several key changes to the current payment and delivery system. AHA should focus its advocacy efforts, at least initially, on changing how Medicare pays providers. Where alternative approaches at the state level, especially those involving multiple payers, are consistent with the framework, federal programs should be flexible enough to participate in those state programs. Such participation supports innovation and expands our understanding of which new payment methods work best and under what conditions. With respect to the Medicare program, changes should include:

- ***Increasing the size of the unit of service for payment (from diagnosis-related groups (DRGs) to episodes of care to partial-risk capitation where feasible) to establish greater provider accountability for quality, utilization, and efficiency;***
- ***Aligning the unit of service and incentives for providers, especially hospitals and physicians, to encourage effective working relationships;***

- *Increasing the degree of clinical integration and care coordination capability among health care providers to improve the quality of care, the efficient delivery of care, and the ability to manage larger units of service;*
- *Changing how the quality and efficiency of care is measured to match providers' progress at different points along the path of payment and delivery reform; and*
- *Developing and implementing tools (including the removal of legal and regulatory barriers to the development of appropriate incentives in relationships between hospitals, physicians, and other providers) to help providers move through that evolution. The types of barriers that need to be addressed are summarized in the following chart and described in more detail in separate AHA documents.*

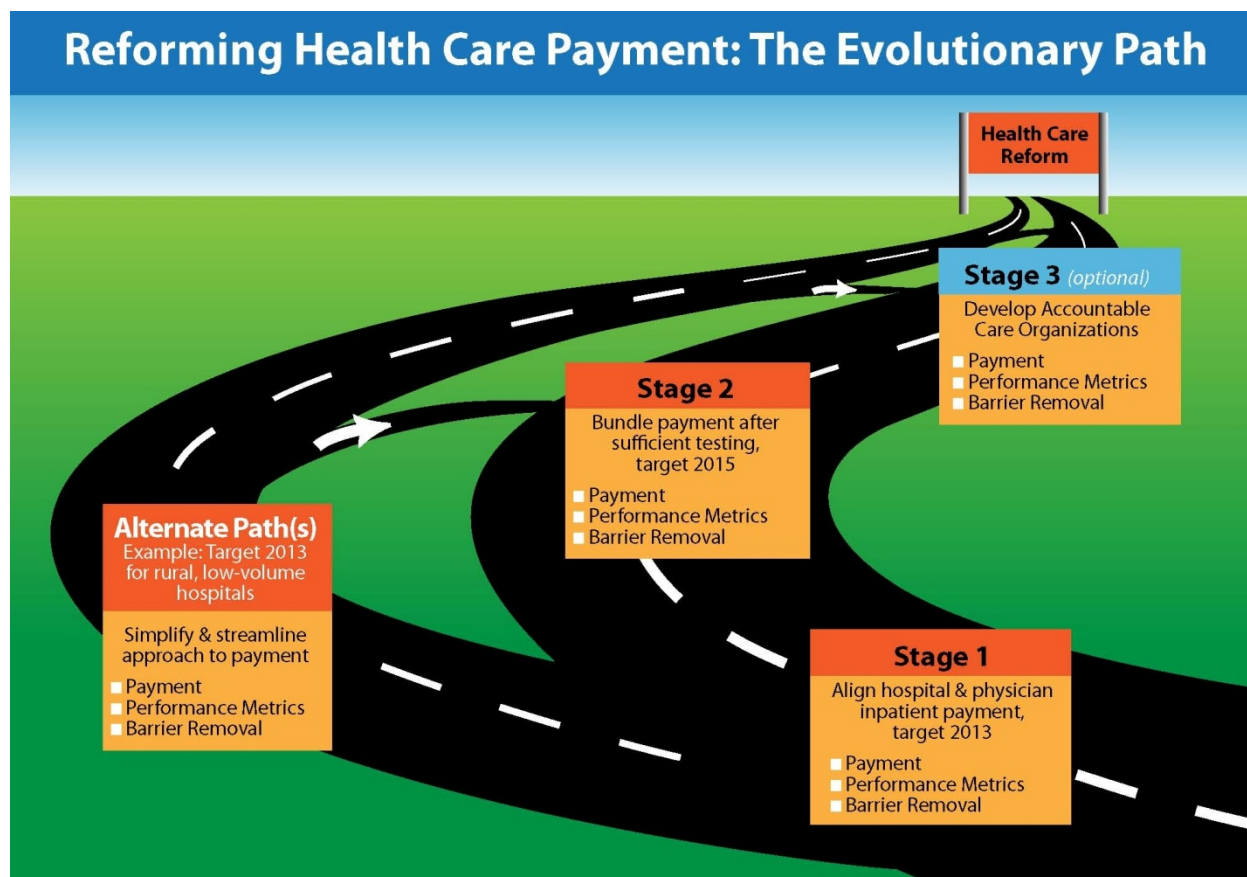
This evolutionary path will require significant upfront investments by providers to build the information technology and clinical infrastructure and relationships needed to achieve the major long-term quality and efficiency goals of delivery system reform. The Medicare program must avoid stripping providers of the means to make these upfront investments and should either contribute toward these investments or refrain from seizing the savings associated with the investments until their cost is recouped by providers.

This approach to payment reform also needs to accommodate those organizations that—for a variety of reasons—will need to take an alternative path or at least linger at intermediate points along the path (e.g., some low-volume rural hospitals and some inner-city safety-net hospitals). Any attempt to move all providers at the same pace will lead to chaos, with some providers being pushed too fast and other providers being held back or penalized for having progressed farther and faster than others. Similarly, the pace of moving through these changes needs to take into account whether the techniques employed have been demonstrated to be successful and, if not, to test the techniques before broad scale implementation. However, all providers should be held accountable for the quality and efficiency of the care they provide no matter which path they follow.

The evolutionary path described below attempts to show how payment reform, coupled with aligned incentives and the removal of barriers to clinical integration, could implement the task force's recommendation under the Medicare program and encourage providers to continue evolving toward the type of organizations that can change the face of health care delivery and support care for everyone. It includes three stages, with intermediate changes within those stages, and side paths for certain types of organizations. Each stage involves three types of changes: payment, performance metrics, and barrier removal. It also calls for mechanisms to allow already integrated organizations to move through the stages more quickly than is possible for other provider organizations either by participating in demonstrations or pilots for an upcoming stage or by skipping ahead to the formation of an ACO as soon as the necessary regulatory framework can be created.

Chart of Legal Barriers to Clinical Integration and Proposed Solutions

Law	What is Prohibited?	The Concern Behind the Law	Unintended Consequences	How to Address?
Antitrust (Sherman Act §1)	Joint negotiations by providers unless ancillary to financial or clinical integration; agreements that give health care provider market power	Providers will enter into agreements that either are nothing more than price-fixing, or which give them market power so they can raise prices above competitive levels	Deter providers from entering into pro-competitive, innovative arrangements because they are uncertain about antitrust consequences	Guidance from antitrust enforcers to clarify when arrangements will raise serious issues
Ethics in Patient Referral Act (“Stark Law”)	Referrals of Medicare or Medicaid patients by physicians for certain designated health services to entities with which the physician has a financial relationship (ownership or compensation)	Physicians will have financial incentive to refer patients for unnecessary services or to providers based on financial reward and not the patient’s best interest	Arrangements to improve patient care are banned when payments are tied to achievements in quality and efficiency rather than for hours worked.	Congress should remove compensation arrangements from the definition of “financial relationships” subject to the law. They would continue to be regulated by other laws.
Anti-Kickback Law	Payments to induce patient referrals or ordering goods or services	Physicians will have financial incentive to refer patients for unnecessary services or to providers based on financial reward and not the patient’s best interest	Creates uncertainty and may preclude arrangements where physicians are rewarded for treating patients using evidence-based clinical protocols	Congress should create a safe harbor for clinical integration programs
Civil Monetary Penalty	Payments that directly or indirectly induce physician to reduce or limit services to Medicare or Medicaid patients	Physicians will have incentive to reduce the provision of necessary medical services	As interpreted by the Office of Inspector General (OIG), the law prohibits any incentive that affects a physician’s delivery of care ...even if the result is an improvement in the quality of care.	The CMP law should be changed to make clear it applies only to the reduction or withholding of medically necessary services
IRS Tax-Exempt Laws	Use of charitable assets for the private benefit of any individual or entity	Assets that are intended for the public benefit are used to benefit any private individual, e.g., a physician	Uncertainty about how IRS will view payments to physicians in a clinical integration program is a significant deterrent to the teamwork needed for clinical integration	IRS should issue guidance providing explicit examples of how it would apply the rules to physician payments in clinical integration programs
State Corporate Practice of Medicine	Employment of physicians by corporations	Physician’s professional judgment would be inappropriately constrained by corporate entity	May require cumbersome organizational structures that add unnecessary cost and decrease flexibility to achieve clinical integration	Most states have ended the prohibition or exempted hospitals. Remaining laws should be adapted to allow employment in clinical integration programs.
State Insurance Regulation	Entities taking on role of insurers without adequate capitalization and regulatory supervision	Ensure adequate capital to meet obligations to insured, including payment to providers, and establish consumer protections	Bundled payment or similar approaches with one payment shared among providers may inappropriately be treated as subject to solvency requirements for insurers	State insurance regulation should clearly distinguish between the risk carried by insurers and the noninsurance risk of a shared or partial risk payment arrangement
Medical Liability	Health care that falls below the standard of care and causes patient harm	Provide compensation to injured patients and deter unsafe practices	Liability concerns result in defensive medicine and can impede adoption of evidence-based clinical protocols	Establish administrative compensation system and protection for physicians and providers following clinical guidelines



Stage 1: Align Hospital and Physician Payment for Inpatient Care, Target 2013

Stage 1 should be viewed primarily as a preparatory stage. During this critical first stage, several major changes will need to be set in motion so that they come to fruition by Stage 2. The first step is to align hospital and physician payment around a common unit of service. It may not be necessary to actually bundle the payment initially. This initial step provides an incentive to begin working together more closely, which will require that hospitals and physicians begin developing new relationships (hence the need to remove barriers to clinical integration at the outset). It also will be necessary to begin developing relationships with other providers in the continuum of care, especially post-acute providers.

Part of this process requires that all involved providers gain access to and share data on their performance around utilization and quality for episodes of care. Providers will need these data to better understand their own performance as well as with whom they need to develop working relationships so that they can examine a variety of delivery issues and needed areas of change (e.g., care transitions from one setting to another, readmissions, etc.). The Centers for Medicare & Medicaid Services (CMS) will need to develop the capacity to analyze payment and performance on the basis of an episode of care as well and must commit to sharing that data with providers. It will be a critical period during which the ability to define episodes of care will be developed, and the role of different providers in the “natural” duration of different types of episodes will be assessed. Also critical will be to determine the effect of lack of access to alternative services in some communities on both efficiency and cost for episodes of care.

Payment

- Hospital inpatient: Continue the admission-based payment methods of Medicare-Severity (MS) DRGs for inpatient prospective payment system (PPS) hospitals.
- Physician inpatient: Begin moving physician payment for inpatient-related care to an admission basis so that the unit of service is aligned with the unit of service applied to hospital payment. The ability to determine and establish the cost of physician services related to an admission (and ultimately an episode of care) is an essential stepping stone toward bundled payment, and the alignment of hospital and physician payment incentives will help stimulate better working relationships.
- Other providers: Continue current payment methods.
- Initiate medical home payment approaches for primary care physicians providing those services.
- If not already underway, establish demonstration or pilot projects to test various approaches to bundling and which services should be bundled for particular conditions. These demonstration or pilot programs should specifically include different combinations of providers and focus on such issues as:
 - Eligibility for receipt of the bundled payment;
 - How best to define and classify bundles to ensure that each is condition-specific, defines a real episode of care (not an arbitrary amount of time) and supports patient-centered care (which may or may not be appropriately based on MS-DRGs);
 - How to price bundles, including adjustment factors required for an episode of care, including socioeconomic and other population characteristics;
 - How best to construct a robust outlier payment or other risk-management approach, which is more critical than ever to protect providers from undue risk and patients from adverse selection;
 - How to handle certain services that may have been reimbursed differently from one community to another (such as emergency medical services) and may not have consistently been paid by Medicare or how to handle out-of-network services;
 - Identify conditions that are not suited to bundled payment due to extreme variation in patient needs;
 - Test the extent to which chronic conditions are suited to bundled payment; and
 - How to ensure consistent patient assessment across settings through a common assessment tool to support better care coordination and outcomes measurement.

Such demonstrations or pilots will provide a sound basis for implementing bundling and also provide an opportunity for more integrated delivery organizations to proceed with bundled payment by joining a demonstration or pilot. Most importantly, they will improve the ability to identify and resolve unintended consequences before broad scale implementation.

Performance Metrics

- For hospitals, the current pay-for-reporting measures with Hospital Quality Alliance-approved expansions should be continued initially. New measures should be harmonized

with physician-level measures so that providers begin to be evaluated on the same performance measures. Over time, the pay-for-reporting program should be converted to a pay-for-performance program, such as a budget-neutral value-based purchasing program with limited funds at risk—no more than 2 percent of payments.

- Publicly report condition-specific, risk-adjusted readmission rates for unplanned, related admissions.
- Develop reporting to all providers regarding efficiency measures (i.e., resource use) on an episode of care basis, including all service providers within the episode. Initially, the reporting could be done confidentially to give providers a period of time to evaluate the data and resolve any data collection, reporting, and adjustment issues before making it available publicly.

Barrier Removal

- Implement the federal and state legal reforms outlined in the chart on page 10 to remove major barriers to clinical integration.
- Identify and eliminate specific federal regulatory barriers to clinical integration and bundled payment, such as regulations that prohibit or limit the ability to recommend sources of post-acute care to patients based on care coordination relationships or bundling contracts, emergency standby and on call requirements as well as limitations on the ability to move patients to more appropriate levels of care under EMTALA, artificial separation and limitation of services by post-acute providers that impede relationships across settings (such as the skilled nursing facility three-day prior hospitalization rule, the long-term acute care hospital “25 percent rule,” and the inpatient rehabilitation facility “60 percent rule.”)
- Provide low-rate loans to support information systems and other infrastructure development needed for clinical integration.

Side Roads: Alternative Approaches for Certain Hospitals, Target 2013

There are some types of hospitals that will not be able to make bundled payments work appropriately due to their operating environments. The obvious case is rural low-volume hospitals that account for a disproportionately small share of the nation’s Medicare expenditures on hospital care. Rural hospitals with less than 2,000 annual Medicare inpatient discharges constitute about 40 percent of acute-care, general hospitals but only about nine percent of Medicare’s hospital expenditures. Their small number of admissions makes the current MS-DRG-payment unmanageable, as they are not able to rely on higher-than-average cost patients “averaging out” with lower-than-average cost patients. The larger unit of service involved in a bundled payment could exacerbate that problem. In most cases, and especially for the 1,300 critical access hospitals, expecting them to create elaborate delivery models is not always realistic, and they often approach issues such as care coordination and clinical integration differently than their larger counterparts. A simpler, more streamlined approach to payment and to developing greater capacity to deliver coordinated patient care may make more sense.

The movement to bundled payment also may pose insurmountable risks for inner-city safety-net hospitals but for very different reasons. While the demonstration projects called for in Stage 1 should attempt to develop adjustment factors reflecting differences in patient populations and socioeconomic conditions in specific hospital service areas, it may never be possible to adequately adjust for those factors in the case of inner-city safety-net hospitals. Here, it is not low volume that is at issue—it is that these hospitals’ patients often have inadequate or no housing, basic services may not be available in the community (such as home care or physician sub-specialty services), and patients may lack transportation to obtain necessary services, speak many different languages or not be literate, or lack the funds or family assistance to self manage chronic conditions.

Side paths for these rural low-volume and inner-city safety-net hospitals may be critically important to their objective of providing access to services for their communities but are unlikely to look the same. Their challenges are different, and they will need different side paths available to them. At the same time, those hospitals may find that at a later point they have achieved some level of clinical integration and the ability to adjust payments for their particular circumstances has improved. If so, they should have the option of joining the main path described above and move toward bundled services and/or partial-risk capitation.

However, side paths should be kept to a minimum and they should be held to comparable quality and efficiency standards similar to those required of providers on the main path. The purpose of side paths would be to accommodate significantly different operating environments or patient populations, not to provide a “pass” on the demands of delivery reform or to provide a competitive advantage over other facilities in the area.

As an example, here is how a side path might be constructed for rural, low-volume hospitals:

Payment

- Develop a new payment method that is applicable to rural low-volume providers. All other special payment methods applied to rural hospitals, such as the critical access hospital, sole community hospital, Medicare-dependent hospital, and rural referral center programs would be eliminated. (Not affected would be other requirements, such as the altered mix of required services for critical access hospitals.) The new payment method would provide reimbursement at 100 percent of cost for inpatient, outpatient, and swing-bed services, with extra bonuses of up to two percent if performance metrics are met (see below). For example, this means that critical access hospitals currently paid 101 percent of reasonable costs would have to earn any payment above 100 percent of cost by meeting quality and efficiency standards but would have the opportunity to earn up to 102 percent of costs.
- Allow combined billing for hospital and hospital-based physicians on a single bill to simplify billing for hospital services and reduce confusion for patients.
- Provide payment for transitional care (provided within 90 days of hospital discharge) to hospitals and/or physicians for discharged patients if follow-up care is initiated within 15 days following discharge.

Performance Metrics

- Voluntary reporting of Hospital Quality Alliance-approved measures would continue. Over time, the current pay-for-reporting program would be converted to a pay-for-performance

program, such as a value-based purchasing program. These hospitals would be able to earn a bonus of up to 1 percent of payments based on their performance.

- By the start of Stage 2 (targeted to 2015), if these hospitals meet the quality requirements of the pay-for-performance program, they would be able to earn up to an additional 1 percent bonus related to their risk-adjusted rates of unplanned, related readmissions.

Barrier Removal

- Same as for Stage 1.
- Provide low-rate loans to support information systems development and other needed capital improvements/replacement.

Stage 2: Bundled Payment, Target 2015

During this second stage, bundling would be adopted if the demonstration projects and pilots under Stage 1 have provided a sufficient basis for implementation. Implementation should begin with a select group of types of inpatient admissions that are well-defined and do not have highly variable courses. Then, bundling should be gradually increased to most types of admissions with individualized definitions of an “episode” so that the care bundled makes sense for each type of admission. (There may be some types of admissions or conditions that are not suitable for bundling and, ultimately, there may be episodes of care that do not involve inpatient hospital care but are nonetheless appropriately bundled.) Payment for the bundle should go to the provider organization able to organize relationships with the needed range of providers, to assume the financial risk for delivering the bundle, with the ability to support the information systems needed to meet reporting requirements for performance metrics, and with the internal payment apparatus to distribute payment among the providers engaged in delivering the bundled services. Such provider organizations could include multispecialty physician group practices, hospitals, health care systems, etc. The ultimate endpoint is comprehensive bundling for all the services related to an episode of care so that providers assume greater accountability for quality of care, care coordination, and efficient use of services.

Payment

- When testing provides a sufficient basis for proceeding (target 2015), bundled payment should start with inpatient hospital and physician services for select high-volume admissions that are especially amenable to bundling, such as those that have predictable follow-up treatment types and durations and limited post-acute care requirements. Initially, the bundle would include preadmission testing, all services provided during the admission, and hospital and physician services provided during the immediate short post-discharge period (condition-specific but perhaps no more than 7 days), including readmissions. The bundling payment system should include a robust outlier policy to protect both providers and patients.
- Each year the number of conditions paid for under a bundled payment would be expanded. The services included and the length of the episode of care would vary depending on the condition to be bundled. Related post-acute services should be part of the bundle, where appropriate to the condition.

Performance Metrics

- Pay-for-performance programs should incorporate quality measures that assess hospitals, physicians, and other providers' performance at delivering care over the course of an episode of care.
- The hospital pay-for-performance program may remain in place where it is appropriate to evaluate hospitals individually for the care they provide to inpatients. The number of measures and conditions included in the pay-for-performance program may be expanded.
- As appropriate, physician and post-acute provider pay-for-performance programs should begin and be aligned with the other providers engaged in delivering care during an episode of care.

Barrier Removal

- Barriers to clinical integration should have been removed during Stage 1, but it will be important to carefully monitor all of the changes under the payment system, barrier removal, and changing performance metrics to watch for and address any unintended consequences or barriers.

Stage 3: Accountable Care Organizations (optional level)

ACOs are groups of providers organized under a legal structure that enables them to accept responsibility for delivering a defined set of benefits to a defined population for a year. They can be led by physician group practices, hospitals, integrated health systems, and other provider organizations, but must be able to deliver the services required by the payment arrangement and demonstrate their ability to assume and manage financial risk, including the availability of sufficient reserve funds.

The development of ACOs is a step that should be optional for health care providers and made available as quickly as the approach can be implemented. It may, however, require a pilot initially to develop the appropriate level of standards, the payment approach, and the appropriate quality and efficiency metrics. Taking responsibility for a defined population for a year requires even greater risk-taking than bundled payment—something that may not be possible for many providers. Under Medicare currently, the only means available for an integrated delivery system to take responsibility for a defined population is as a HMO or provider-sponsored organization health plan under the MA program. That requires the assumption of full-risk capitation and the acquisition of an insurance or HMO license.

This new option would enable ACOs that are not or may never be ready for full risk to take responsibility for a defined population on a partial or shared risk basis, so that the providers are responsible for the technical risk of providing care and getting ahead of health care problems through prevention, better care coordination, etc., but are not expected to manage the full insurance risk of whether and what portion of their enrolled population becomes ill or injured. For shared-risk ACO approaches, the Medicare Payment Advisory Commission has recommended a minimum size enrolled population of 5,000 Medicare beneficiaries. Full-risk capitation programs require even greater numbers to make the law of averages work, even with health status and other risk adjusters.

Payment

- Payment to ACOs should be on an annual basis for a defined population for a defined set of services, risk adjusted to reflect health status and demographics. Payment could be based on partial-risk capitation under a variety of risk-sharing methods. Such methods might include the use of risk corridors or the development of a reinsurance mechanism through the Medicare trust fund. Payment also could be on the basis of a global budget payment, such as that under discussion in Massachusetts.
- Services covered by the payment must be defined and should be capable of being provided primarily by providers in the ACO.

Performance Metrics

- The quality metrics applied under this approach should be similar to those applied to MA plans.
- Efficiency metrics would need to be consistent with the approach to risk-sharing adopted and the range of services included in the contract.

Barrier Removal

- Develop a regulatory structure that establishes standards regarding adequate experience and ability to accept responsibility for delivering care to a defined population; and the capacity to accept, manage, and fund partial risk assumption but does not require that ACOs become licensed as full-risk health insurance plans that require separate corporate structures and the greater financial reserves required for full risk. The requirements for full-risk health insurance plans can get in the way of integrated delivery systems taking responsibility for delivering care to a defined population.

Conclusion

Reforming the organization and delivery of health care services in the United States is central to the goals of providing high quality care efficiently and affordably to everyone. Payment reform is central to reshaping and realigning the incentives that drive how care is organized and delivered. Sorting out the current fragmented delivery system and misaligned incentives will take a great deal of work and time to achieve, but it is the only way to ultimately reach our long-term goals. It requires a step-by-step process, testing and proving techniques along the way, and the flexibility to accommodate different variations for different operating environments and to make mid-course corrections when what should work simply does not work. More than ever, this period will require a firm commitment to enabling and encouraging innovation.

The recommendations above should be viewed as a “work in progress” that will evolve as issues arise and are resolved to avoid unintended consequences. For the AHA, next steps will require a multi-faceted approach:

Advocacy

- Continued advocacy to remove barriers to clinical integration.
- Advocacy for initiation of the right kinds and mix of demonstration or pilot projects to test and evaluate new forms of payment and performance metrics before they are put into broad scale use. If enacted as part of the health reform bill, the new Innovation Center should be a

primary focus, providing input on broad directions, as well as specific suggestions on implementation issues that need to be resolved and potential fixes that need to be tested.

Further Work

- Examine in more depth (perhaps through workgroups) the elements of how to implement this approach, including such areas as:
 - How to construct a potential side path for inner-city, safety-net providers.
 - How to integrate behavioral health services with acute and chronic medical care services.
 - What standards should apply to ACOs to ensure that they have the infrastructure to provide needed care and they are capable of accepting and managing the risk associated with responsibility for a defined population.
 - How to construct an episode of care approach to payment, including the myriad of implementation issues described above.
 - How to develop and effectively deploy the health professions workforce needed to provide this type of care to everyone in the country, including the most appropriate means of funding health professions education.

Field Education and Peer Leadership

- Provide maximum opportunities for members to learn from each other in developing the organizational cultures and relationships with physicians and other providers to support more coordinated care across settings and to make the best use of resources for better health and better health care.

Change is not easy, but the task force believes that America's hospitals are ready to do so because the consequences of failing to do so are too high.

**American Hospital Association
Task Force on Payment Reform**

Chairman

Leo Brideau
President and CEO
Columbia St. Mary's Health System
Milwaukee, WI

Kevin Conlin
President and CEO
Via Christi Health
Wichita, KS

Members

Mark Adams, M.D.
Chief of Surgery
Harrison Medical Center
Bremerton, WA

Scott Duke
CEO
Glendive Medical Center
Glendive, MT

Nancy Howell Agee
Executive Vice President and COO
Carilion Clinic
Roanoke, VA

Jon Foster
President and CEO
St. David's HealthCare System
Austin, TX

William Atkinson
President and CEO
WakeMed
Raleigh, NC

Jay Grinney
President and CEO
HealthSouth Corporation
Birmingham, AL

David Barrett, M.D.
CEO
Lahey Clinic Hospital
Burlington, MA

Daniel Gross
Executive Vice President
Sharp Healthcare
San Diego, CA

William (Bud) Barrow, II
President and CEO
Our Lady of Lourdes Regional Medical
Center
Lafayette, LA

James Hinton
President and CEO
Presbyterian Healthcare Services
Albuquerque, NM

Penny Brooke, JD, MS, RN
Trustee
Intermountain Health Care, Inc.
Salt Lake City, UT

David Lopez, FACHE
President and CEO
Harris County Hospitals District
Houston, TX

Diane Cecchetti, RN
President and CEO
MultiCare Health System
Tacoma, WA

Kirk Norris
President and CEO
Iowa Hospital Association
Des Moines, IA

Edward Prunchunas
Senior Vice President and CFO
Cedars-Sinai Medical Center
Los Angeles, CA

Steven Safyer, M.D.
President and CEO
Montefiore Medical Center
Bronx, NY

Jim Skogsbergh
President and CEO
Advocate Health Care
Oak Brook, IL

David Tilton
President and CEO
AtlantiCare
Atlantic City, NJ

Staff

Linda Fishman
Senior Vice President, Public Policy
Analysis and Development

Ellen Pryga
Director, Policy

Beth Feldpush
Senior Associate Director, Policy

Joanna Hiatt
Senior Associate Director, Policy

