



# HEALTH CEOs *for* HEALTH REFORM

A BETTER HEALTH SYSTEM FOR ALL

## Realigning U.S. Health Care Incentives to Better Serve Patients and Taxpayers

### Our Vision

Health care reform must make quality health care and health insurance affordable and accessible to all. Yet meaningful health care reform must also make our health delivery system sustainable for families, employers, providers, and governments. As health care leaders who operate in our current system, we firmly believe that upwards of 30 percent of the resources spent on health care in the United States are a result of too few efforts to coordinate care and not enough attention to quality. We must achieve higher value for our health care dollar to make affordable coverage and high-quality care available for all, including our most vulnerable, for years to come.

We will not control health care costs until we create clear incentives for providers – the people who deliver care – to focus on quality and efficiency.

The Medicare program must convey the seriousness with which it will approach payment reforms that move away from fee-for-service and toward accountable payments. Medicare must articulate clearly its long-term goals to allow providers to prepare for future payment incentives.

### Medicare Payment Reforms

**Fee-for-service payment is unsustainable.** Medicare will lead a concerted effort to end fee-for-service payments for individual services within five to seven years. Further, Medicare will cooperate and collaborate with private payers to transition the entire delivery system away from fee-for-service payments and toward outcome-driven bundled payments that encourage provider accountability through full and partial risk contracts within 10 years.

**Hold providers accountable to reasonable cost and quality standards at a specified date.** Medicare should hold higher-cost providers accountable to the cost, quality, and utilization standards reached by their more efficient peers. For example, after a specified period of time Medicare could reduce annual update factors for providers with higher-than-median costs. Payments will be dependent on quality of care, patient outcomes and satisfaction, and patient-centeredness.

**Develop and transition toward bundled payment models.** CMS should work with high-quality, integrated health

systems to identify and develop specific bundles of payment. These bundles can be used to set efficient payment rates for groups of services that should be delivered to specific types of patients.

**Implement bundled payment structures.** Providers could receive a bundled payment based on comprehensive services and shared risk, complete or ambulatory care for the chronically ill, or acute episodes. Providers willing to accept greater shares of the risk within a shorter time-frame should be allowed to capture a greater share of the savings.

**Accountable organizations that accept full responsibility for high-quality patient care and efficient performance will be encouraged and favored over time.** Cooperation across traditional provider groups leads to mutual rewards. Therefore, integrated models of care that achieve quality targets will be favored by the Medicare and Medicaid programs in the future.

**Delivering high-quality care within accountable payment models will be more profitable than fee-for-service Medicare.** After a period of time, Medicare should announce freezes or negative update factors for high-cost providers who do not move towards integrated models of care.

**Require providers to meet explicit quality standards as a condition of payment for certain high-cost and/or over-utilized services.** For certain high-cost and/or over-utilized services, Medicare should make payment contingent on compliance with strict quality standards.

**Regionalize high-cost, resource-intensive services under Medicare.** Medicare should identify regional “Centers of Excellence” to deliver the highest-cost, most resource-intensive services. To qualify as a Center of Excellence, a provider should perform a large volume of the targeted procedure with excellent risk-adjusted outcomes, define effective processes of care, and demonstrate efficient resource use.

**Eliminate the Sustainable Growth Rate (SGR) formula for determining physician payments.** Instead of relying on the SGR formula, Medicare should move away from the fee-for-service payment structure by implementing a more value-based payment system.

## Other Payment Reforms

### Provider Tools

- Identify, collect, and disseminate the best information from government and private sources on the science of delivering high-quality health care services.
- Reform medical malpractice laws to protect providers that embrace the best-identified quality and efficiency standards.
- Update existing laws and regulations to enable clinicians to share in the savings from high-quality, efficient care.
- Streamline regulatory oversight to create three regulatory bodies each responsible for one topical area, including quality and safety, financial oversight, and education and training.
- Continue investment in quality infrastructure, including health information technology, decision support tools, and comparative effectiveness research.

### General Medicare Reforms

- Reform Medicare Advantage payments to drive quality and innovation.
- Improve the quality and patient-centeredness of end-of-life care through advanced planning and palliative care.

### Medicaid Reforms

- Create payment incentives for the formation and expansion of the Program of All Inclusive Care for the Elderly (PACE) and Special Needs Plans that deliver high-quality care for dual eligibles.
- Require all Medicaid patients receiving primary care from a 340B provider to use that provider for pharmacy services.
- Encourage states to match the quality and efficiency of the highest performing Medicaid managed care plans by implementing medical home programs, moving more beneficiaries to managed care, developing tight drug formularies, and joining with other states to form regional purchasing pools to buy prescription drugs and medical devices.

### General Reforms

- Develop insurer billing and reporting regulations that will reduce hospital and physician administrative costs.
- Incentivize the transition toward more team-based learning styles and provide loan forgiveness programs and malpractice premium subsidies to those who choose primary care.



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This brief summarizes the June 12, 2009, white paper by Health CEOs for Health Reform entitled: "Realigning U.S. Health Care Incentives to Better Serve Patients and Taxpayers."