



HEALTH CEOs *for*
HEALTH REFORM
A BETTER HEALTH SYSTEM FOR ALL

**REALIGNING U.S. HEALTH CARE INCENTIVES
TO BETTER SERVE PATIENTS AND TAXPAYERS**

June 12, 2009

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Introduction

Health reform must make quality health care and health insurance affordable and accessible to all. In order to achieve the goal of quality, affordable coverage for all, we support:

- Health insurance exchanges or new marketplaces to help consumers compare and choose the health plan that is right for them
- Reforms that end insurance discrimination based on age, sex, and health status, including: guaranteed issue, community rating, and a ban on pre-existing condition exclusions
- Subsidies financed through broadly shared responsibility to ensure coverage is affordable
- A requirement that individuals obtain coverage, once such coverage is accessible and affordable

Yet meaningful health care reform that delivers on the promises of coverage for all, increased quality, and lower costs must also make our health delivery system sustainable for families, employers, providers, and governments. In addition, we must be mindful that our most vulnerable Americans, like the chronically mentally ill and the homeless, have unique needs that must be considered. 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. Further, too much time and too many resources are expended meeting regulatory and reporting guidelines, rather than focusing on patient care and outcomes. 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.

Make no mistake: a more sustainable, value-based health system is eminently feasible. We have to look no further than our backyards to prove it.

The U.S. Senate Finance Committee recently identified some important first steps, including:

- Investing in infrastructure, including: health information technology (HIT), comparative effectiveness research and dissemination, and workforce planning and development
- Linking payment to value, not volume, for all providers in the Medicare program
- Aligning incentives across multiple providers to give efficient, high-quality care both medical and business value¹

We fully support these initiatives. Yet, we want to be clear: policymakers can and must be bolder. We must realign current incentives to create new payment structures that reward high-quality, patient-centered, efficient care, while discouraging the fragmented and low-value care that drives health care cost growth today. Furthermore, we must improve the way we deliver care by moving toward more integrated, coordinated delivery models. Specific reforms that use Medicare (and to the extent possible Medicaid) as a catalyst to move us away from our current fee-for-service, pay-for-volume payment structure can and will bring us closer to the health system our citizens expect and deserve. Make no mistake: a more sustainable, value-based health system is eminently feasible. We have to look no further than our own backyards to prove it is possible.

Over the next 10 years, we can reduce system-wide cost growth by far more than many think, enough to save \$500 to \$600 billion in the Medicare program alone. This level of cost growth reduction can be achieved while simultaneously improving the quality and patient-centeredness of care. Over time, this money could help fund coverage expansions, improvements to Medicare and Medicaid benefits and payment rates, and deficit reduction. We describe reforms that will make these savings possible in the remainder of this paper.

Recent Reasons for Increased Confidence

In addition to our personal experience, three recent documents buttress our belief that we can reach further toward quality improvement and cost reduction.

Stakeholder commitment to reduce health care costs.

On May 11, 2009, several leading industry trade associations, including America’s Health Insurance Plans (AHIP), American Hospital Association (AHA), Advanced Medical Technology Association (AdvaMed), American Medical Association (AMA), and Pharmaceutical and Research Manufacturers of America (PhRMA), pledged to reduce health care cost growth significantly over time. While the pathways for getting there were not specified, their statement suggests widespread agreement that substantial savings within our health system are achievable. Further, the letter signals broad awareness that the status quo is unsustainable for everyone: patients, stakeholders, and governments alike. This statement has increased the likelihood of successful health reform this year.

Economic assessment of potential savings as a result of health system incentives. Also on May 11, 2009, David Cutler² released a paper estimating that a combination of information and practice incentives could save the federal government almost \$600 billion within 10 years. Cutler concludes that if we can change the outdated way in which we provide and pay for health care, we will see significant savings—making health reform far more affordable.

Provider leadership that encourages realigned incentives. A recent article in the *New Yorker* authored by Atul Gawande, M.D.³ makes clear that many of our system’s current incentives reward the delivery of low-value, high-cost health care.⁴ Our health system’s incentives should be redesigned to reward quality, patient-centeredness, and efficient practice because delaying reform risks deteriorating performance in additional communities. The article further illustrates that incentives should not directly or indirectly encourage the overuse of or unnecessary capital investment in specific service lines. Physician and hospital arrangements should be designed for the purposes of care coordination and integration, instead of financial gain from distorted relative prices and temporary profit opportunities that do not add to patient health. The essay also makes clear that providers must take a leadership role in both exposing and fixing the system’s flaws. Two recent examples of this are noteworthy:

- The American College of Cardiology promulgating “appropriate use criteria” for

many expensive tests and invasive procedures⁵

- The American Boards of Internal Medicine developing a new physician “charter” that elevates stewardship of scarce resources to be coequal with a physician’s responsibility to individual patients and society⁶

Health CEOs for Health Reform Vision

With proper investments in electronic infrastructure, best practice information, and payment incentives, the U.S. health care system can deliver high-quality, efficient, patient-centered care to all within the next decade. Transforming our delivery system is good public policy and smart fiscal planning.

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.

Improving health care quality is consistent with reducing health care costs, which is essential to fund coverage expansion and make Medicare and Medicaid more sustainable for generations to come. To reach these goals, we must develop, pursue, and implement strategies to achieve greater value for the American health care dollar. 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. Likewise, patients must be encouraged to make healthier choices through changes to their incentives. This will require exemplary and even courageous provider leadership and significant cultural change.

Our system should deliver the right care, at the right time, at the right place, with the right outcome. Therefore, payment policy should be refocused to reward quality in each of its four dimensions:

- Clinical quality of care
- Patient satisfaction
- Better health
- Efficient resource use

In addition, payment policy must be adjusted to stop rewarding providers for inefficient, low-quality care.

Clinicians must make decisions based on their own knowledge, experience, and learning. Yet, they also have an ethical obligation to continually seek and act upon current best practice information. As part of the same bargain, provider organizations, payer consortia, and governments have a responsibility to make this information transparent and easily accessible to patients and providers alike.

Thus far, unfounded myths driven by misguided rhetoric have constrained policy advances in this direction. The consequences of inaction are too high to ignore the facts:

We can identify overuse, underuse, and misuse and implement best practice processes. More care does not always make patients healthier. In addition, disparities in care across racial and ethnic populations persist. Many people do not get the care they need. Decades of research work has shown that certain types of therapies, tests, procedures and hospitalizations do not improve health.⁷ More importantly, documented examples illustrate the ability of high-quality care processes to reduce overuse, improve quality, and reduce costs.⁸ While simply being a low-cost area or provider does not guarantee the most efficient, highest quality care, several systems and communities have demonstrated the ability to deliver outstanding outcomes with fewer resources than are expended elsewhere.

Comparative effectiveness research, best practice information, and decision support tools will enhance the doctor-patient relationship. Giving patients and providers more information about treatments and procedures and developing best practice standards will help providers give patients the highest quality care. Each patient is different. One course of treatment will never be right for everyone. However, good, personalized information inserted at appropriate points in processes of care can turbo-charge patient-centeredness along with quality and efficiency gains.⁹

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Specific Proposals

Immediate First Steps

Large-scale payment reforms will need to be implemented over time. In the near-term, it is essential that the Medicare program (and to the extent possible Medicaid) convey the seriousness with which it will approach payment reforms. Medicare must articulate clearly its long-term goals to allow providers to prepare for future payment incentives. Therefore, reform legislation should empower Medicare to announce the following:

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 payment and toward outcome-driven bundled payments that encourage provider accountability through full and partial risk contracts within 10 years.

Providers will be held accountable to reasonable cost and quality standards at a specified date. Today's Medicare fee-for-service payment structure reimburses providers for delivering services regardless of quality or appropriateness. As a result, costs and utilization vary across providers and regions far more than can be explained by underlying cost of living factors and patient acuity. More efficient, value-based incentives will lead to higher-quality, lower-cost care. However, if voluntary efforts prove inadequate to slow the rate of health care cost growth within five years, Medicare should hold higher-cost providers accountable to the cost, quality, and utilization standards reached by their more efficient peers. While we do not expect this policy to be necessary, it is essential that Medicare convey it will take concrete action if costs continue to grow at unsustainable rates.

There are many ways to achieve this goal. For example, after a specified period of time¹⁰ Medicare could reduce annual update factors for providers with higher-than-median costs to generate the 10-year savings targets Congress sets in reform legislation. Furthermore, all payment levels will be dependent on compliance with standards related to quality of care, patient outcomes and satisfaction, and patient-centeredness.

The purpose of this policy is not to punish providers, but rather to guarantee that Medicare will succeed in slowing the rate of cost growth. It is reasonable to expect all providers to reach target levels of efficiency if they are given access to the tools necessary to deliver high-quality, efficient care. We describe some essential tools in detail below.

Develop and transition toward bundled payment models. Medicare should begin a concerted and focused effort to develop and implement payment bundles to enable a widespread transition from fee-for-service payment. Separate payment for 8,000 CPT codes and 745 DRGs without regard to quality makes our system inefficient and provider-centered.¹¹ Ultimately, linking provider payment to quality and patient outcomes within an episode or continuum of care delivery and allowing clinicians to share in the potential savings (and financial risk) will encourage care coordination, increase quality and efficiency, and refocus health care on the patient. Specifically, bundled payments could:

- Help reduce hospital readmissions by aligning the interests of clinicians and hospitals
- Improve the coordination of care for the chronically ill by encouraging communication between members of a patient’s care team
- Rationalize pricing distortions that discourage time-intensive but high-value services delivered by primary care clinicians

The development of bundles should be an interim step to accountable payments and should not unduly add to administrative complexity.

In the short-run, we understand that not all providers are ready to accept risk for the costs of patient care, nor are they prepared to coordinate extensively across sites of care. Therefore, we must address these realities by developing bundled payment structures that allow clinicians to assume responsibility and bear risk for some, but not all, of the costs of a specific patient’s care.

We recommend the Centers for Medicare and Medicaid Services work with high-quality, integrated health systems to identify and develop specific bundles of payment in specific settings. These bundles can be used to set “efficient” payment rates for groups of services that should be delivered to

specific types of patients. It may be necessary to adjust the bundled unit and payment rate for use outside the integrated delivery system context, but today’s highest performing health systems are great places to begin to identify high-quality processes of care. All bundled payments will be:

- Adjusted for patient acuity
- Representative of local input prices and availability of resources
- Contingent on patient outcomes and quality of care delivered

This initial effort to produce credible payment bundles should include additional key dimensions that will generate immediate and considerable value to patient safety, quality, and resource use. For example:

- Standard order sets for Computerized Physician Order Entry (CPOE) applications within hospitals and health systems
- Intensive Care Unit and surgical checklists, like those discussed by Peter Pronovost and Atul Gawande
- Required participation in disease registries¹²

Specific Payment Models

When best practice bundles become operational, providers should earn bonuses by meeting increased quality standards and reducing costs sooner or by more than expected. Targets will be moved toward efficient levels over time. We should not create shared savings arrangements without first setting clear cost and quality targets.

Bundled payments should be considered in three dimensions:

- How much care is bundled?
- How much financial risk and reward is accepted by the provider versus the payer?
- How fast can financial risk and responsibility be transferred from payer to provider?

Implementing Bundled Payments

Eventually, all clinicians will have strong incentives to move toward more integrated models of care that allow them to accept full responsibility and reward for high-quality patient care and patient outcomes. In

the meantime, the size of the bundled unit will vary by provider willingness and capacity to coordinate care. Some examples include:

1. Comprehensive services with shared risk. Some integrated systems and provider groups are ready to transition to accountable payments, but are unwilling to accept full responsibility initially. These providers could accept some, but not all, risk on the fully-accountable amount. We recommend that savings-based bonuses and the percentage of cost overruns borne by the health system vary based on the system's costs relative to the median per capita cost nationwide. This will allow Medicare (and private payers who wish to follow) to maintain strong incentives for lower-cost and higher-quality systems to keep improving, even as it sets reasonable benchmarks for less-efficient and lower-quality providers. At the outset, patients with chronic conditions (and eventually everyone) should be given a financial incentive to use accountable organizations as their "medical home."¹³

2. Complete chronic care. Chronic illness is a main driver of health care costs. It accounts for 75 percent of health care costs.¹⁴ The treatment of chronic illness could be improved dramatically through improved care coordination that gets patients to the right place, at the right time, for the right care, with the right outcome. These bundles would assign an annual spending target per chronically-ill patient of a specific type and include higher payment levels for those with more than one condition. Initially, these bundles could focus on the most prevalent and costly chronic conditions, including: diabetes, congestive heart failure, hypertension, and chronic obstructive pulmonary disease (COPD). This unit of payment will reflect the cost for the full amount of care that a chronically-ill patient with particular conditions might need in a given year. This model would require coordination across sites of care. Indeed, this is highly complex, as many patients have multiple chronic conditions. Medical homes could accept responsibility for these patients, as well as integrated delivery systems and provider networks with cooperative agreements that include hospitals.

3. Ambulatory chronic care. This bundle would also target chronically-ill patients, but would only focus on ambulatory services. This model would allow primary care providers to move to bundled payments immediately without sharing much risk or reward

with specialists and hospitals. While this may be viewed as an interim step on the way to bundling all care for the chronically-ill, improving the quality, efficiency, and patient-centeredness of ambulatory care for chronically-ill patients would be a vast improvement from many of today's fee-for-service arrangements. It could also be a way to make bundled payments attractive to primary care providers by increasing income and professional satisfaction.

4. Acute episode. This type of bundle would target high-cost, acute episodes that involve a hospitalization. Bundles for acute, as opposed to chronic, episodes should encompass all aspects of care, including: pre-admission physician visits, hospitalization, post-acute services and physician use, drugs, and ancillary devices. This bundle would be of particular interest to hospitals and specialists. Appropriate targets for this type of bundle could be complex episodes, such as cardiac surgery, transplantation, bariatric surgery, and joint replacement or less-complex episodes like cataract and hernia surgery.

Speed of Assumed Responsibility

The speed at which providers are willing to transition toward bearing full accountability for patient well-being and financial performance should influence shared savings arrangements. For example, providers willing to accept greater shares of the risk within a shorter timeframe should be allowed to capture a greater share of the savings achieved from increased quality and efficiency. In addition, providers would need to participate in patient registries and electronic records systems that can help verify patient well-being and quality of care.

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Other Payment Reforms

Accountable organizations that accept full responsibility for high-quality patient care and efficient performance will be encouraged and favored over time. Considerable evidence and experience suggests that cooperation across traditional provider groups—physicians, hospitals, and post-acute facilities—

results in high-quality, efficient care, especially when shared accountability for collective performance leads to mutual rewards. Therefore, integrated models of care—integrated delivery systems, health plans contracting with integrated or tightly affiliated providers, and disparate provider groups forming accountable care systems or organizations—that hit quality targets will be favored by the Medicare and Medicaid programs in the future.¹⁵

Integrated models of care that hit quality targets will be favored by the Medicare and Medicaid programs in the future.

Further, accountable organizations should be allowed to bid directly to federal and state governments a comprehensive fee (full-risk, accountable rate) for all Medicare beneficiaries who agree to use them as their medical home. Medicare will document quality performance and link payment to quality. This will protect beneficiaries who might worry about provider incentives to stint on efficacious care. Organizations that take full responsibility and hit quality and resource use targets should be allowed to earn more than their bid amount. This will encourage accountable organizations to form and excel.

Delivering high-quality care within accountable payment models will be more profitable than fee-for-service Medicare. Within a few years, Medicare must make clear to providers that continuing with traditional fee-for-service reimbursement will be far less attractive than forming accountable organizations, sharing savings, or accepting full or partial risk. Medicare should announce freezes or negative update factors for 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. Medicare should begin with imaging and endoscopic procedures and expand over time. Similar policy applies currently to mammograms covered under Medicare.

Regionalize high-cost, resource-intensive services under Medicare. High-cost, resource-intensive

services, like complicated surgeries and advanced trauma care, are often unavoidable and therefore less responsive to price-based incentives. Precisely because of their “necessary” nature, however, they are often performed by providers without much experience who achieve poor outcomes. Medicare should identify regional “Centers of Excellence” to deliver the highest-cost, most resource-intensive services to help control costs and increase quality of care. 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. The SGR was created to help keep Medicare spending growth in line with growth in the national economy. Yet, the SGR has many flaws. In addition, Congress intervenes consistently to prevent devastating cuts. This has created an unpredictable and unaccountable system for physician payment. Instead of relying on the SGR formula, Medicare should reinforce its intention to move away from the fee-for-service payment structure by implementing a more value-based payment system over time. We can safely eliminate and pay for the SGR by implementing the payment reforms described in this document.

We must give providers the tools they need to reach our goal of high-quality, efficient, and patient-centered care.

Necessary Tools for Provider Success

Many barriers prevent our health system from evolving, including the payment incentives we address above. In addition, we must give providers the tools they need to reach our goal of high-quality, efficient, and patient-centered care. These tools range from high-cost, high-complexity resources such as CPOE to low-cost process redesign techniques. The following reforms should enable most providers to reach our value-based targets.

Identify, collect, and disseminate the best information from government and private sources on the science of delivering high-quality health care services. The

Office of the Secretary should work with a range of existing public and private bodies⁶ to provide technical assistance and help providers reach quality, efficiency, and patient satisfaction performance targets in the Medicare program and throughout the broader health system. The ultimate goal is to align incentives among payers so that providers have clear signals about what will be rewarded by every payer. This service could act somewhat similarly to the Cooperative Extension Service, which helps farmers and other Americans at the county level use research-based knowledge to adapt and thrive in constantly evolving market conditions.

Reform medical malpractice laws to protect providers that adhere to high-quality care standards. Patients should have the right to address medical grievances through the legal process. However, providers who follow best practice and quality standards should be protected from unwarranted legal action. We must shield providers who wholeheartedly embrace the best-identified quality and efficiency standards from legal consequences like having to participate in proceedings without merit. A high-level, federal task force on malpractice reform, appointed and staffed by the Office of the Secretary, should be given one year to propose how to:

- Create and oversee safe harbors for clinicians following best practices
- Recommend changes in federal or state statutes

Enable clinicians to share in the savings from high-quality, efficient care. Existing antitrust laws, anti-kickback statutes, anti-bribing laws, and other laws and regulations often make it difficult for clinicians and hospitals to share in the savings realized when costs and utilization are reduced—sometimes known as “gainsharing.” Narrow exceptions have been granted in special cases today; however, we must develop general and statutory solutions so that clinicians and hospitals can negotiate and share in resource savings when quality and patient care standards are met. A high-level task force, jointly chaired by the Secretary of Health and Human Services (HHS) and Attorney General, should examine and recommend policy and statutory changes that would remove all legal barriers to high-quality, efficient, and coordinated care processes. The task force should also consider tightening self-referral prohibitions and requiring transparent reporting of

vendor-physician and vendor-hospital relationships.

Streamline regulatory oversight. Today, many regulatory bodies, requirements, and audits are duplicative and burdensome for providers. Adhering to these obligations costs providers time and money and does not necessarily move us closer to the safe, high-quality, and efficient health system we seek. Evidence-based regulation must become as large a part of our health care culture as evidence-based medicine. Therefore, a task force should be appointed by the Secretary of HHS to review and streamline existing regulatory bodies. The task force should recommend within one year how to form and operate three specific regulatory bodies, possibly as public-private partnerships. Each would have sole responsibility for one topical area:

- Quality and safety
- Financial oversight
- Education and training

Once consolidated and created, these authorities must ensure compliance with standards, develop new standards continually, and disseminate findings and judgments about specific organizations to the public and all relevant stakeholders, including payers and other providers. In addition, the task force should recommend strategies to standardize medical staff credentialing for hospitals, insurance panels, and others. The current credentialing process is time consuming and outdated. To realize savings immediately, no new regulatory requirements should be implemented until a new regulatory oversight structure is established and functioning.

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Continue Investment in Quality Infrastructure. Health information technology (HIT) and best practice information are necessary components of high-quality, 21st Century health care. The American Recovery and Reinvestment Act laid the groundwork for provider incentives to adopt HIT and the execution and dissemination of comparative effectiveness research. In the future, continued attention and perhaps resources will be necessary to ensure HIT is embraced widely and incorporated with appropriate

decision support tools. Similarly, while the funding for comparative effectiveness research included in the American Recovery and Reinvestment Act was a significant first step, a larger investment may be necessary over time. Comparative effectiveness research is a necessary component of a high-value health system. It will help providers stay up-to-date on the latest treatments and technologies, while empowering patients to take a more active role in their own health.

General Medicare Reforms

Non-payment-related changes can also help realign incentives.

Reform Medicare Advantage payments to drive quality and innovation. Currently, Medicare pays more by formula for Medicare Advantage enrollees than it would if they were enrolled in fee-for-service Medicare. Simply changing the Medicare Advantage payment formula, however, risks creating new challenges. Medicare Advantage payments should be reformed to drive quality and innovation. For example, Medicare Advantage plans could bid competitively to determine a new local benchmark payment amount. Actual payments to plans should be adjusted for the risk profile of enrollees and plan performance based on quality and patient satisfaction indicators.

Improve the quality and patient-centeredness of end-of-life care through advanced planning and palliative care. A large percentage of U.S. health care dollars are spent during a patient's last year of life. Often patients receive treatment that is not consistent with their wishes because they did not sign an advanced directive or because they or their family did not fully understand their options. Every Medicare and Medicaid patient entering a nursing home should be required to complete an advanced directive form indicating their requests with regard to hospitalizations, intensive care, and intubation. In addition, every hospital serving Medicare or Medicaid should be encouraged to create palliative care programs when developing care coordination strategies. Palliative care ensures that end-of-life decisions are patient- and family-centered and often result in decreased resource use.¹⁷

Medicaid Reforms

Much of the health reform conversation has focused on Medicare rather than Medicaid. We must be vigilant about also ensuring that our Medicaid programs are delivering the highest-quality and highest-value care. Not only does Medicaid serve our nation's most vulnerable populations, but it is also our largest health insurance program. In addition, virtually all reform proposals include Medicaid expansions.

Create payment incentives for the formation and expansion of Program of All Inclusive Care for the Elderly (PACE) and Special Needs Plans that deliver high-quality care for dual eligibles. PACE and Special Needs Plans organize the care of especially vulnerable beneficiaries in return for an accountable payment. PACE and Special Needs Plans should receive bonus payments above and beyond their competitive bid for hitting quality and resource-use targets. By incentivizing these models of care, we can achieve savings and efficiency for some of the most expensive and complicated beneficiaries.

Require all Medicaid patients receiving primary care from a 340B provider¹⁸ to use that provider for pharmacy services. Under law, pharmaceutical companies are required to provide 340B providers a discount. Therefore, it is less expensive for Medicaid beneficiaries to access pharmaceuticals through 340B providers compared to retail pharmacies. Requiring more Medicaid beneficiaries to obtain prescription drugs through the 340B providers they use for regular care will generate savings.

Encourage states to match the quality and efficiency of the highest performing Medicaid managed care plans. States must continue to have flexibility in administering their Medicaid programs. If states choose not to use managed care strategies, however, they should create incentives and quality targets that can raise the performance of fee-for-service providers. States could consider several reforms to the Medicaid program, including implementation of medical home programs, moving more beneficiaries to managed care, developing tight drug formularies, and joining with other states to form regional purchasing pools to purchase prescription drugs and medical devices. Specifically, state Medicaid programs should identify

providers who are already successful in treating the most vulnerable and ensure they are serving as Medicaid medical homes. The federal government should consider linking Federal Medicaid Assistance Percentages (FMAP) levels to state quality and utilization performance in Medicaid.

General Reforms

Develop insurer billing and reporting regulations that will reduce hospital and physician administrative costs. Over 10 percent of hospital and physician revenue is spent on administrative functions required by the more than 1,000 different insurers in the United States.¹⁹ Some of these protocols are necessary. However, idiosyncratic variations in billing requirements, utilization review, and documentation procedures—combined with variation in patient cost sharing and benefits—all contribute to a high and growing burden on providers. In a system with interoperable electronic records programmed to populate standardized coding forms, health insurance coverage for all, and more standardized benefit packages, we can expect and demand far more uniform communication and administrative requirements. This will yield savings and allow more resources and time to be devoted to patient care.

Insurers should not impose differential administrative burdens on providers. The Secretary of HHS should charge a task force chaired by the Director of the Office of Health Information Technology with developing concrete recommendations about how best to standardize and automate information flow to minimize the burden on providers and maximize financial integrity. This task force should also include insurer, provider, and patient representatives. The task force should consider requiring payers to adopt Medicare billing processes or current Council for Affordable Quality Healthcare (CAQH) standards.

In the meantime, new ICD10 codes should not be implemented. As we move toward more integrated and coordinated care delivery, it would be unwise to devote additional resources to billing protocols focused entirely on fee-for-service payment.

Health education initiatives to improve the potential for coordinating high-quality care. Health education and training of all professionals should focus on

the knowledge and skill set which will be required to succeed in our new American health system. The next generation of health care providers should have the skills to work in a team-based environment and effectively utilize best practice processes and health information technology. We should mandate accountability for graduate medical education (GME) funding in order to reshape incentives for teaching hospitals and academic medical centers to develop GME programs focused on the greatest needs of our population, including primary care.

In addition, loan forgiveness programs and malpractice premium subsidies should be offered to those who choose primary care. The greatest support should be given to those willing to serve underserved communities. Specifically, we should provide incentives for and remove statutory barriers to the establishment and expansion of training venues in non-hospital primary care settings, including rural and underserved areas.

Conclusion

We face tremendous challenges in reforming our health system. Yet, we also live in a time where technology, clinical management expertise, and a fiscal sense of urgency are converging to create a tremendous opportunity. All Americans should have quality, affordably health coverage. In return, individuals should approach their own health with an increased sense of responsibility. Our nation is also in need, however, of vast improvements to its incentive structures and culture of health delivery.

As health care leaders, it is our duty and responsibility to ensure that the promise of quality, affordable coverage comes with a guarantee that care will be affordable, accessible, coordinated, and safe. We have no choice but to embark upon health reform, because our current path is woefully unsustainable.

We know change is not easy. We also know that delay does not make change easier. Our nation can make the changes we need. But we must approach these problems with a uniquely American solution beginning now.

Endnotes

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15. Lawrence P. Casalino, “Balancing Incentives: Value-Based Purchasing in Traditional Medicare,” in *Making Medicare Sustainable*, Nichols and Berenson, eds., (New America Foundation: Washington, DC): 2009. Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis, and Jonathan S. Skinner, “Fostering Accountable Health Care: Moving Forward In Medicare,” *Health Affairs* 28, no. 2 (March/April 2009): w219-w231. From Nichols and Berenson eds.
16. The Office of Health Information Technology, the Agency for Health Care Research and Quality (AHRQ), the Senate Finance Committee’s proposed Chronic Care Management Innovation Center (CMIC), exemplary state Quality Improvement Organizations (QIOs), the Institute of Medicine (IOM), the Health Information Technology Extension Program, the Health Information Technology Research Center, the Health Information Technology Regional Extension Centers, and private organizations including: the National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), the American Boards of Internal Medicine, the exemplary research institutions involved in the Clinical and Translational Science Awards (CTSAs), select specialty societies, and high-performing health systems.
17. Sean Morrison, et al, “Cost Savings Associated with US Hospital Palliative Care Consultation Programs,” *Archives of Internal Medicine* 168, no. 16 (September 2008): 1783-1790.
18. Safety net provider that contracts with state and local governments to provide for the care of the un- and underinsured. For example, public hospital, community health center, family planning clinics.
19. John Holahan and Linda Blumberg, “Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?” *Urban Institute Health Policy Center*, October 2008.

Health CEOs for Health Reform (HC4HR) is a diverse coalition of health care leaders who share a unique willingness to transform their business models to create a more sustainable health system. There is no fee for HC4HR membership. Members are united by their shared desire to construct bold, innovative pathways to a high-quality, efficient delivery system.

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