



CALIFORNIA  
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# Health Care Payment in Transition: A California Perspective

*Prepared for*

CALIFORNIA HEALTHCARE FOUNDATION

*by*

Shelley Oberlin, MBA, MHA, MS Physiology  
Senior Manager

Scott Tackett, MHA, MPH  
Manager

Philip Macdonald, PhD  
Senior Manager

Stacey Stanton, BS Biomedical Engineering  
Analyst

KURT SALMON

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### **About the Authors**

**Kurt Salmon** is a global management consultancy. In health care, it provides management advisory services in facility planning, operations, strategy, finance, and information technology to nonprofit hospital systems, community hospitals, academic medical centers, children's hospitals, and physician group practices. For more information, visit [www.kurtsalmon.org](http://www.kurtsalmon.org).

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### **About the Foundation**

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at [www.chcf.org](http://www.chcf.org).

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# I. Executive Summary

*Many believe that the entrenched quality and cost challenges of the US health care system are largely due to how health care services are paid.*

THE UNITED STATES SPENDS MORE PER CAPITA AND A higher percentage of its gross domestic product (GDP) on health care than any other country. Yet other developed countries outperform the US on measures of quality, efficiency, and access. Many believe that the entrenched quality and cost challenges of the US health care system are largely due to how health care services are paid. In the US, current payment models do not provide incentives that reward value (improved quality and services at a lower cost); instead, they provide incentives for higher volumes, often leading to overutilization of services and high costs. To actualize a health care system that not only decreases spending, but better aligns costs with outcomes, there is an urgent need for payment reform. As California has historically introduced innovative payment models that promote greater efficiency and lower costs, many are interested in how the California market will respond and transition to emerging payment approaches.

This report presents the findings of a review conducted to better understand current payment models and those likely to emerge in California and the rest of the nation. Interviews were conducted and multiple meetings held with an Advisory Group comprised of known health care leaders in California and other areas of the country. Using information gathered from these interviews and meetings, this report: (1) provides an overview of and historical context for the current payment landscape in California, (2) highlights new payment models under consideration or that appear to be the most likely to advance in California (and perhaps nationwide) over the coming years, (3) discusses dominant themes regarding California's evolution towards future payment models, and (4) discusses implications and strategies key stakeholders (providers, patients, purchasers, and policymakers) should consider during a new payment method transition period. This report is meant to be a primer on payment models in California, providing basic information for a wide set of interested parties across the care continuum ranging from board members to administrators to policymakers.

## Key Findings

The Advisory Group identified seven of the most common current payment models in California, and nine emerging payment models that have already been implemented, are undergoing experimentation, or are likely to advance in California. The nine emerging models were further grouped by similar characteristics into three payment approaches: (1) value-based payment modifiers (e.g., pay-for-performance programs), (2) payment adjustments (e.g., payment reductions for cases involving readmissions or hospital-acquired conditions), and (3) funds flow arrangements (e.g., global or bundled payments).

Through discussions with the Advisory Group around the differences between the emerging payment models and approaches, and the likelihood of key stakeholders' abilities to implement them, three major themes regarding payment reform in California surfaced and are discussed in detail in this report. These include:

1. The transition to future payment models will be evolutionary, not revolutionary.
2. Any future payment system will remain pluralistic; there is no "one-size-fits-all" approach.
3. Large employers and purchasers of health care are likely to have a dominant role in driving payment reform.

Finally, the report identifies and discusses a number of considerations and strategies that stakeholders should take into account as they transition to future payment models. These include: (1) greater collaboration, (2) service line consolidation, (3) robust analytics around a common patient identifier, (4) incentives that align value and effectiveness, and (5) impact of the cost of doing business.

While all of these considerations are interconnected, they will likely vary for each stakeholder. By taking a proactive approach to payment reform, stakeholders will be more likely to successfully develop a transitional payment strategy that is closely aligned with their vision, goals, culture, and capabilities.

## II. Introduction

*This report provides stakeholders, especially in California, information about the historical context of payment systems, analysis of emerging models, and insight on how the landscape is most likely to evolve.*

TODAY'S HEALTH CARE PAYMENT SYSTEM IS IN TRANSITION, both in California and nationwide. Spurred by market and economic factors — and now by imminent health reform mandates — new payment approaches are emerging while traditional ones still exist. During this transitional period, there are many decisions to be made by health care stakeholders including providers, public and private payers, purchasers, and policymakers. The actions that are taken in the short term to change and improve the payment system are likely to have long-lasting effects. California, which has often taken the lead in modeling innovations in health care delivery and payment, will be carefully observed in its choice of options moving forward.

This report provides stakeholders, especially in California, information about the historical context of payment systems, analysis of emerging models, and insight on how the landscape is most likely to evolve. It also discusses implications and strategies that stakeholders should consider during a transition period. Throughout the report, emphasis is given to clarifying details of existing and evolving payment systems, simplifying technicalities, and reducing confusion, in order to create a common understanding of the subject matter for those who are not involved in the payment system on a daily basis.

The information contained within this report was generated from both primary and secondary research. Primary research included individual interviews and three group meetings with the members of an Advisory Group made up of a broad array of California health care leaders (see Appendix B for Advisory Group members). Secondary research consisted of a detailed review of publicly available sources. In addition, a case study was developed to illustrate the differences between the current payment system and one emerging payment model — in this instance, a bundled payment model. The case study is presented in Appendix A.

The urgency of health system reform, and payment reform in particular, is demonstrated in statistics from a variety of sources. Health care spending in the US is among the highest in the world. In 2009, expenditures reached \$2.5 trillion and accounted for 17.6% of the GDP.<sup>1</sup> At the same time, the US continued to underperform on

quality, access, efficiency, equity, and overall health status of the population compared to other developed countries.<sup>2</sup> Among other states, California has a mixed record. It spent \$167 billion on health care in 2009 and, compared to other states, ranked favorably on some common health indicators including mortality rates, smoking, and obesity. Still, it ranked 22nd in avoidable hospital use and costs.<sup>3,4</sup>

Health care cost and quality problems have received considerable attention from the public and private sectors in the last decade. In the 2000s, organizations such as The Leapfrog Group (a coalition of large employers) formed to improve and influence quality and affordability in health care.<sup>5</sup> Payers began to offer financial incentives through pay-for-performance programs to influence quality and costs for their members.<sup>6</sup> In 2007, the Institute for Healthcare Improvement launched the Triple Aim initiative to help organizations improve care quality and population health while lowering costs; some 50 organizations in eight countries now take part in that initiative.<sup>7</sup> Most notably, in March 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law, instituting changes in the health care delivery model focused on improving access and quality of care while lowering costs.<sup>8</sup> Although many of these and related initiatives emphasize improved clinical effectiveness, outcomes, and value demonstration, most agree that the cost and quality conundrum cannot be resolved without changes in how we pay for health care.

### III. Current Payment System

THE US HEALTH CARE PAYMENT SYSTEM includes an overwhelming array of coverage options and payment methodologies. Depending on a person's age, income level, employment status, and medical condition, coverage may be provided by Medicare Parts A, B, C, and D; Medicaid (Medi-Cal in California); the Veterans Health Administration; TRICARE; the Children's Health Insurance Plan; the Federal Employees Health Benefits programs; private insurance companies; self-insured employers; other state-based plans such as CalPERS and Healthy Families; and, for those without coverage, self pay.

Payment methodologies for each type of coverage vary. Providers can receive payments from purchasers of care ranging from fee-for-service (FFS, a separate payment for each service) to capitation (typically a flat rate per member per month). They also receive payments from patients with varying levels of copays, deductibles, and co-insurance. To add further to the complexity, payments are distributed separately to multiple providers. The result is an elaborate, disjointed payment system that is continuously changing, making it almost impossible for patients and providers to understand.

To reduce the complexity of the payment system and provide more value for every health care dollar, health policy discussions have focused a great deal of attention on finding equitable and appropriate payment methods. There are also several initiatives and demonstration projects that test new payment methodologies. These include the Centers for Medicare and Medicaid Services (CMS) Bundled Payment Initiative and the Integrated Healthcare Association (IHA) Bundled Episode Payment and Gainsharing Demonstration project. In California,

large purchasers of health care such as CalPERS and Safeway are proactively altering the current payment system through the use of reference pricing, an approach that uses benefit plan design to limit employer exposure to highly variable prices.

For these and other new payment approaches to be effective, the new models must overcome the challenges with the existing payment methods, provide incentives that reward value, and be politically acceptable and practical to implement. For perspective, it is useful to consider the evolution of payment methods in the nation and in California, most notably from the middle of the twentieth century and forward — a period that saw increases in coverage for Americans and increasingly higher expenditures.

#### Historical Context

Figure 1 shows a timeline of developments in the health care payment system within California and nationally since the early 1900s.<sup>9</sup> (See page 7.)

Public and private health insurance concepts had several introductions throughout the twentieth century. Between 1940 and 1960, growth in private insurance was driven largely by federal policy allowing employer contributions to employee health plans to be tax-exempt. Recognizing a gap in health coverage for the elderly, disabled, and indigent populations, federal and state governments established Medicare and Medicaid (Medi-Cal in California) in the mid-1960s.

These early insurance plans by private and public sources were mostly indemnity-based (fee-for-service). Coverage was wide and mostly unrestricted; payment to providers was paid on charges. In



to help slow private sector expenses. The lower-cost payment structures of HMOs increased the popularity of managed care programs across the US in the late 1970s and 1980s. During the mid-1980s, Medicare also tried to control costs by implementing a diagnosis-related group (DRG) payment system which established a set payment for an acute hospital inpatient stay based on diagnosis. Subsequent public payment schedules were put in place for other delivery settings such as nursing homes, long term care hospitals, and ambulatory care settings.

While several of these payment methods were helpful in controlling costs, there was concern that restrictions on coverage options and utilization came at the expense of providing appropriate care. In the late 1980s and early 1990s, attempts were made to better align delivery with payment systems. A significant development was the creation of preferred provider organization (PPO) insurance plans as an alternative to HMOs. These plans, while allowing more choice, provided incentives for the consumer to control their costs via copayment formulas. For example, copayments would be higher if care was provided out of a plan's established network.

In an attempt to adopt private sector payment innovation, Medicare in the late 1990s and early 2000s initiated several managed care programs, with the current program called Medicare Advantage. Medicare Advantage allows private health plans to coordinate care received by beneficiaries while reducing costs through prevention measures and limits on utilization of services.

Today, even with various payment methods put in place by the public and private sectors, health care expenditures as a percent of GDP are still increasing. The current payment system includes multiple reimbursement methods, many with misaligned incentives that do not reward providers for improving performance or managing costs. With the passage

of health reform legislation in 2010, the health care industry is once again tasked with transforming the payment system to stem the growth of health care costs while enhancing quality and access.

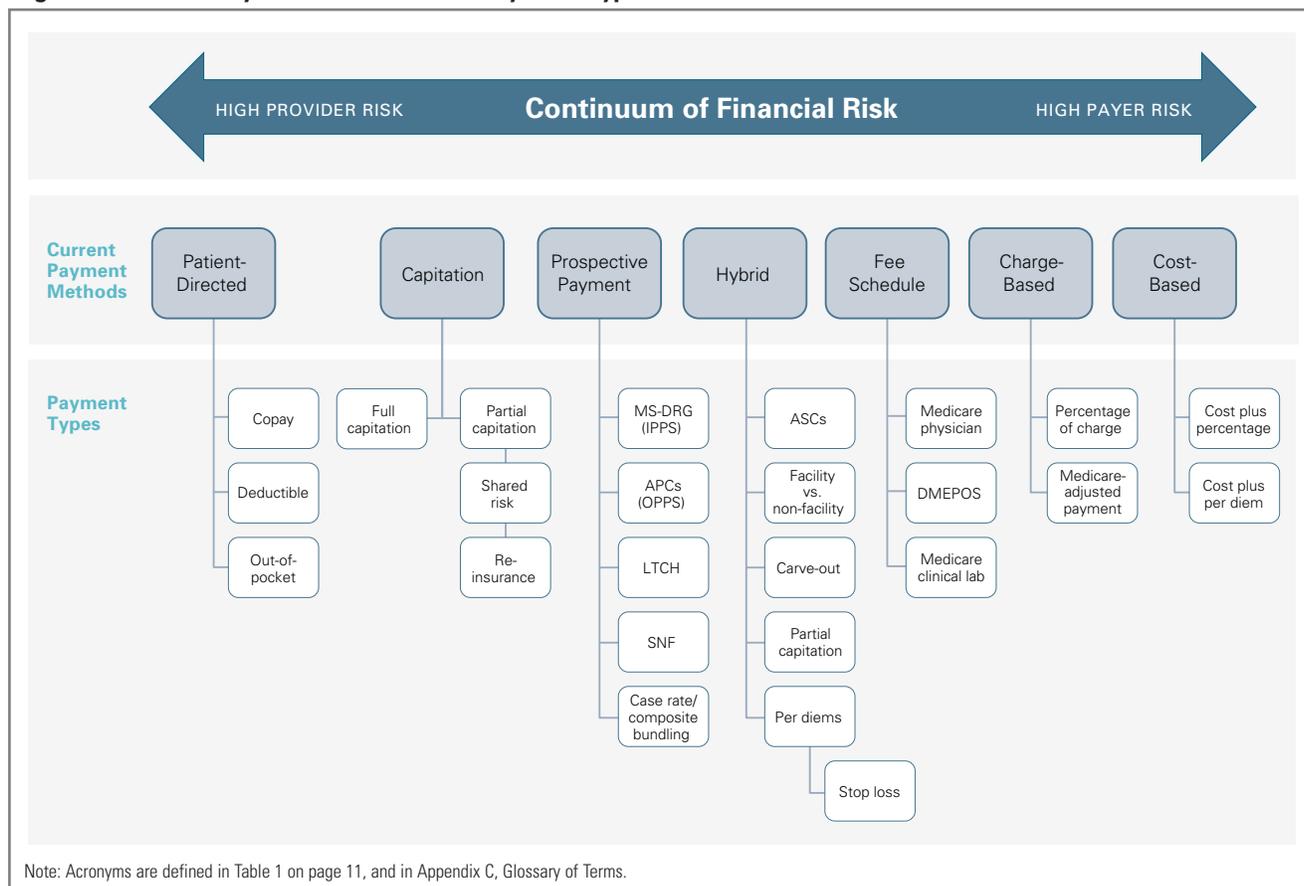
## Current Payment Methods

To better appreciate the payment reform models now under consideration, it is important to understand first the basic elements and challenges of current payment methods. While there are a variety of methods to pay for medical services, this report focuses on the seven most common current methods:

1. Patient-directed
2. Capitation
3. Prospective payment
4. Hybrid (resulting from a blend of multiple payment methods)
5. Fee-schedule
6. Charge-based, and
7. Cost-based.

Each payment method has multiple payment types with varying degrees of individual payment percentages and financial risk for all parties involved. Typically, parties are defined as follows: the patient (first party), the provider of care (second party), and the payer (third party). Figure 2 illustrates the seven current payment methods, their common payment types, and where they are positioned on the continuum of financial risk. (See page 9.) A description of each payment type can be found in Appendix C, Glossary of Terms. Details around the mechanics of the payment types and formulas have been well documented elsewhere and are not part of this report.<sup>12</sup>

**Figure 2. Current Payment Methods and Payment Types**



It should be noted providers (hospitals and physicians) are often paid through multiple payment methods with payment types and formulas varying by payer. For instance, a hospital may receive payments from 40 different payers which could be generated from 100 separate contracts. For CMS payments, further adjustments are made to factor in differences in wages, patient acuity, geography, teaching-related costs (such as graduate medical education and indirect medical education), and uncompensated care (as with disproportionate share hospitals), to name a few. For an illustration of the current payment system for traditional Medicare, please see the case study in Appendix A documenting a 90-day episode of care for a patient with congestive heart failure (CHF).

Also of note, the continuum of financial risk is illustrated in the broadest sense. First, the terms “providers” and “payers” are used generally, recognizing there are multiple payers, including private, commercial, and government payers. Similarly, providers can include hospitals (including for-profit and nonprofit hospitals, county-organized health systems, academic medical centers, etc.), skilled nursing facilities (SNFs), long term care (LTC) facilities, home health agencies, physicians (including independent physicians, primary care physicians, physician groups, independent practice associations (IPAs), foundations, multispecialty groups, single-specialty groups, etc.), and other health professionals such as nurse practitioners.

Specific payers and providers might be positioned differently in terms of financial risk.

In addition, the continuum reflects differences in financial risk between providers and payers. For cost-based or charge-based contracts, risk is placed on the payer because there are few utilization or cost controls. On the other hand, for capitated contracts the provider is at financial risk, not the payer. Access, quality, and costs are constants for providers to consider while managing a pre-determined fee to manage insured lives for a set period of time.

The differences among the payment methods, including their positions on the continuum of financial risk, can be characterized by units of payment, time orientation, and other elements of financial risk.<sup>13</sup> These are discussed further below.

### Units of Payment

There are two main units of payment: fee-for-service and capitation. Fee-for-service is analogous to paying a-la-carte for each medical service, while capitation is like a one-time cover charge for unlimited access to a buffet of medical services within a given length of time. Most capitated contracts are based on a flat rate per member per month (PMPM) and are often adjusted for age, sex, and geographic location (urban versus rural).<sup>14</sup>

The difference between the two units of payment often spurs debate and criticism around appropriate treatment protocols and utilization of services. When utilizing FFS, physicians and other health professionals have financial incentives to perform more billable services for their patients, leading some observers to believe these providers over-utilize health care resources (such as by ordering unnecessary tests and procedures) and/or don't spend enough time with patients (such as by trying to see more patients per day to increase billable charges). In addition, FFS payment does not provide

incentives for care coordination or case management. In this environment, health care providers are not responsible for, nor are they necessarily aware of, the services provided by other providers such as primary care physicians, specialists, hospitalists, labs, or imaging providers.

In contrast, capitation gives provider organizations a financial incentive to limit health care utilization and/or prevent high-cost procedures. Physicians in this setting are often viewed as being less productive than FFS providers, and in some cases, are thought to limit the scope of services they provide or under-treat patients.<sup>15</sup> In a capitated environment, hospitals, physicians, and other caregivers often try to set a minimum patient enrollment (covered lives) to ensure the volumes necessary to remain financially sustainable.

### Time Orientation

Time orientation refers to whether the payment method determines the total billed amount for services before (prospective) or after (retrospective) the services are provided. Prospective payment methods are predetermined based on average resource use, and factor in estimated treatment time, disease or condition, plus some adjustments for local market dynamics. Since these are averages, there is uncertainty whether a payment will cover the cost of an individual episode of care. As such, prospective payment methodologies generally protect payers from financial risk, shifting the responsibility of managing resource consumption and costs to the providers.

Retrospective payments have the opposite effect. Based on a FFS unit of payment, they support greater choice of service for both the patient and provider, but include limited incentives to control costs. This tendency drove Congress in 1983 to mandate the creation of a prospective payment system for Medicare beneficiaries.<sup>16</sup>

## Patient Health Risk and Provider Performance Risk

Additional elements of financial risk include patient health risk and provider performance risk. Patient health risk can lead to insurer or provider losses when patients are sicker and require more medical services than average patients. Provider performance risk reflects whether or not the provider is efficient in delivering care. If the provider is inefficient, this usually results in higher costs. Who is liable for

the costs varies by payment model. In recent years, providers and payers have tried to spread financial risk among the various parties through the use of hybrid payment methods.

Table 1 describes the seven most common payment methods currently used in California, including typical providers that use these methods, units of payment, time orientation, and where each method stands regarding exposure to patient health risk and provider efficiency.

**Table 1. Overview of Seven Current Payment Methods**

	TYPICALLY USED TO PAY FOR:	UNIT OF PAYMENT	TIME ORIENTATION	FINANCIAL RISK DUE TO:	
				PATIENT HEALTH	PROVIDER PERFORMANCE
<b>Cost-Based</b>					
Payers agree to pay a percentage of reported costs incurred in providing care (i.e. Medicare pays critical access hospitals at 101% of self-reported reasonable costs).	Inpatient care delivered in critical access hospitals, Federally Qualified Health Centers, or other providers practicing in rural and socioeconomically challenged geographies.	Fee-for-service (payment per episode of care).	Retrospective: Costs are settled after they are incurred.	Payers bear risk of patient health as sicker patients need more services, and each service will need to be paid for.	Payers bear risk of provider performance as they agree to pay providers a percentage of their self-reported costs. This means that low-performing providers who are inefficient and incur higher costs still get their costs reimbursed within the episode of care.
<b>Charge-Based</b>					
Payers reimburse providers based on a percentage of billed charges.	Universal, widely used method that includes technical and professional fees for acute inpatient and outpatient services, skilled nursing facilities, and procedures, and durable medical equipment.	Fee-for-service (payment per each service rendered).	Retrospective: Provider bills accordingly after services are rendered.	Same as cost-based; payers bear risk of patient health as sicker patients need more services, and each service will need to be paid for.	Payers bear risk. Low-performing providers who incur higher costs can charge higher prices to cover costs. Providers can also perform more services, and although some may be unnecessary, they will be paid for by the payer.

	TYPICALLY USED TO PAY FOR:	UNIT OF PAYMENT	TIME ORIENTATION	FINANCIAL RISK DUE TO:	
				PATIENT HEALTH	PROVIDER PERFORMANCE
<b>Fee Schedule Payment System</b>					
Payers predetermine a fixed price for specific services including professional fees and other resources such as supplies.	Physician outpatient services and some inpatient hospital services such as labs.	Fee-for-service (payment per each service rendered).	Prospective: Payments are based on a predetermined fee schedule.	Same as cost-based; payers bear risk of patient health as sicker patients need more services, and each service will need to be paid for.	Payers bear less risk than cost- and charge-based models as they pay a fixed price for each service, even if the provider delivers the service inefficiently. Providers have an incentive to perform more services, and although some may be unnecessary, they will be paid by the payer.
<b>Hybrid</b>					
Payments are determined using both fixed and variable reimbursement methods simultaneously (e.g., a payer uses both a fee schedule and a prospective payment system to determine the fee for the services delivered).	Implemented as a methodology for CMS to reimburse ambulatory surgical centers or other procedural services.	Fee-for-service (payment per episode of care).	Prospective/retrospective.	Similar to that of the prospective payment system (below).	Performance risk is variable depending on which piece of the payment is fixed and which piece is variable. For example, sometimes the technical fees (hospital fees) are per diem, while the professional fees are fee schedules.
<b>Prospective Payment System (PPS)</b>					
Each medical service or inpatient episode is assigned a predetermined relative weight based on variables that affect cost, such as diagnosis, severity, expected resource utilization, and geographic variation.	<p>Inpatient hospital services centered around an acute care episode.</p> <p>Typically set by CMS with private payers negotiating a fixed payment rate per unit of weight.</p> <p>CMS uses separate payment systems based on care setting:</p> <ol style="list-style-type: none"> <li>1. Inpatient (IPPS)</li> <li>2. Outpatient (OPPS)</li> <li>3. Skilled nursing facilities (RUGs: resource utilization groups)</li> <li>4. Long term care (PPS)</li> </ol>	Fee-for-service (payment per episode of care).	Prospective: Payments are based on a predetermined payment rates.	Risk is mitigated on the payer side because the severity of the patient's illness can be categorized under this system. However, the payer will still be at risk if the health of the patient warrants multiple, distinct episodes. Provider risk partially offset by patient severity of illness index.	Providers get a fixed payment per episode so they have an incentive to be efficient in the delivery of care for each episode.

	TYPICALLY USED TO PAY FOR:	UNIT OF PAYMENT	TIME ORIENTATION	FINANCIAL RISK DUE TO:	
				PATIENT HEALTH	PROVIDER PERFORMANCE
<b>Capitation</b>					
Providers are paid a flat rate per capita for a set period of time, independent of service utilization.	All providers (typically primary care and OB providers), inpatient and outpatient.	Capitation (typically a per-member per-month (PMPM) fee for the purchase of agreed medical services).	Prospective: Payments are made as a lump sum at the beginning or end of the month.	Provider bears risk for patient's overall health. Provider is paid a fixed fee over a specified time period regardless of amount of medical services utilized. Payers bear no risk for patient health unless it is a partial capitation agreement.	Providers are at risk for their own efficiency.
<b>Patient-Directed</b>					
The patient pays a portion or all of the medical bill out-of-pocket.	Each inpatient and outpatient encounter.	Exists in FFS and capitation in the form of copays or coinsurance, or when patient does not have any insurance and must pay the entire medical bill out of his/her own pocket.	Retrospective: The bill increases as the patient incurs new services.  Prospective: The beneficiary typically knows the amount of copays and deductibles in advance.	Patient bears risk for his/her own health. The more medical services a patient needs, the more he/she will pay out-of-pocket.	Providers are generally more at risk for direct patient payments as they are responsible for collection. This is often captured as bad debt or charity care on physician and hospital financial statements, and while the risk is higher for providers than payers, this is typically a smaller dollar amount compared to the potential loss of a contract from one of the other six payment methods.

## IV. Emerging Payment Models

SIMILAR TO THE LARGE NUMBER OF CURRENT payment methods, there are several emerging payment models that either have been implemented, are undergoing experimentation, or are proposed for consideration.<sup>17,18</sup> Since payment methods from California can be considered the historical basis for many of today’s coverage and payment models

nationwide, many stakeholders are watching carefully to see how California will respond to payment reform.

The Advisory Group identified nine payment models that are already in progress or most likely to advance in California. Table 2 lists the nine emerging payment models, including a description of each.<sup>19</sup>

**Table 2. Nine Emerging Payment Models Advancing or Likely to Advance in California**

<b>Global payment</b>	A single payment is made for all services rendered. Like capitation, it uses a per-member per-month rate, but includes a performance and risk payment adjustment. Groups of providers are now able to be rewarded for improved quality and efficiency, and due to improved data analysis, payers can adjust the payment to better align it with severity of the patient population being treated. <sup>20</sup>
<b>Shared savings and risk for a population</b>	Providers are able to share in the cost savings achieved for managing the care of a population over a specific period of time, provided they meet quality and cost benchmarks. Participation in CMS’s shared savings model can be through the development of an accountable care organization (ACO) beginning in 2012. <sup>21</sup> See Glossary of Terms in Appendix C for the definition of an ACO.
<b>Bundled payments</b>	A single payment is made to cover all costs associated with an episode of care for a particular condition. While the payment may cover multiple providers in various care settings, the difference from global payment and shared savings is that the payment is for a specific condition or procedure rather than total care delivered over a specified time period.
<b>Hospital/physician gainsharing</b>	Hospitals and physicians are able to share the cost savings achieved through collaborative efforts resulting in improved quality and efficiency. Gainsharing is not profit-sharing. It is a team-based approach to improve performance through the involvement of others. If performance targets are met, providers share the financial gain.
<b>Payment adjustment for readmission</b>	Payment rates are adjusted (typically reduced as a penalty) for high rates of readmission and potentially avoidable readmissions.
<b>Payment adjustment for hospital-acquired conditions</b>	Payment rates are adjusted (typically reduced or eliminated as a penalty) for hospitals with high rates of hospital-acquired conditions (HACs). CMS includes 10 categories of HACs such as falls and trauma, manifestations of poor glycemic control, and surgical-site infections after select surgeries. HACs and never events overlap, but not all HACs are never events. <sup>22</sup>
<b>Payment adjustment for never events</b>	No payment is received for never events or outcomes that are unambiguous, preventable, and serious. CMS currently recognizes 28 diseases or conditions as never events, including surgery on wrong body part, foreign object left in patient after surgery, and death/disability associated with use of contaminated drugs. <sup>23</sup>
<b>Pay-for-performance</b>	Hospital and physicians receive differential payments (rewards or penalties) for meeting or missing performance benchmarks.
<b>Other value-based payments</b>	Providers are financially rewarded for behavioral changes that lead to greater value. Two examples include shared decisionmaking and care coordination (see Glossary of Terms in Appendix C).

While each payment model listed above is distinct, many share common characteristics around their methodologies, overarching goals, and incentives for change. Given these similarities, the nine payment models were further categorized according to three broad payment approaches: value-based payment modifiers, payment adjustments, and funds flow arrangements (payments requiring changes to the flow of funds between organizations). Each of these broad approaches is discussed in more detail below. Table 3 summarizes the similarities and differences in the payment models based on their payment approach.

## Value-Based Payment Modifiers

Value-based payment modifiers typically target physicians, physician groups, and hospitals, and offer a financial bonus for improving performance. There is minimal risk to providers as modifications are primarily associated with positive financial rewards. The presumption is that as performance improves, the cost of care will either decrease or better align with the delivery of care and associated outcomes. This payment approach is not necessarily new to the industry as physician performance profiling (PPP) and pay-for-performance (P4P) programs have been in practice for several years.

**Table 3. Categorization of Nine Payment Models by Payment Approach**

	VALUE-BASED PAYMENT MODIFIERS	PAYMENT ADJUSTMENTS	FUNDS FLOW ARRANGEMENTS
<b>Emerging payment model</b>	<ul style="list-style-type: none"> <li>• Pay-for-performance (P4P)</li> <li>• Shared decisionmaking/ care coordination</li> </ul>	<ul style="list-style-type: none"> <li>• Avoidable hospital readmissions</li> <li>• Hospital-acquired conditions</li> <li>• Never events</li> </ul>	<ul style="list-style-type: none"> <li>• Global payments</li> <li>• Shared savings and risk</li> <li>• Bundled payments</li> <li>• Hospital/physician gainsharing</li> </ul>
<b>Methodology</b>	<ul style="list-style-type: none"> <li>• Performance-based incentive payment on top of existing payment models</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in pay or no pay</li> <li>• Decline in avoidable hospital readmission may result in bonus pay</li> </ul>	<ul style="list-style-type: none"> <li>• Typically, a single payment to one provider organization (a convener) that is responsible for distributing the funds to all other providers along the care continuum</li> </ul>
<b>Overarching goal</b>	<ul style="list-style-type: none"> <li>• Primary: Improved quality and efficiency</li> <li>• Secondary: Cost containment</li> </ul>	<ul style="list-style-type: none"> <li>• Primary: Improved safety and quality</li> <li>• Secondary: Cost containment due to reductions for avoidable care</li> </ul>	<ul style="list-style-type: none"> <li>• Primary: Cost containment by offsetting incentives of FFS</li> <li>• Secondary: Coordinated, high-quality care</li> </ul>
<b>Impetus for change (incentive or penalty)</b>	<ul style="list-style-type: none"> <li>• Incremental income (incentive)</li> </ul>	<ul style="list-style-type: none"> <li>• Payment reductions (penalty)</li> <li>• Potential bonus payment for reducing avoidable readmissions (incentive)</li> </ul>	<ul style="list-style-type: none"> <li>• Combination: Financial loss if actual cost of care exceeds set amount (penalty); financial gain if actual cost is less than the set amount (incentive)</li> </ul>
<b>Envisioned changes in behavior of the delivery system</b>	<ul style="list-style-type: none"> <li>• Improvements in performance measures</li> <li>• Greater collaboration and coordination among key decisionmakers</li> </ul>	<ul style="list-style-type: none"> <li>• Greater collaboration and coordination among key decisionmakers</li> <li>• Standardization of processes</li> <li>• Greater transparency and reporting</li> </ul>	<ul style="list-style-type: none"> <li>• Greater accountability among providers for quality, outcomes, and cost of care for a population</li> <li>• Greater coordination of care for an episode and across the continuum</li> </ul>

Recognizing the need to accelerate incentives for cost containment, organizations such as the Integrated Healthcare Association (IHA) are modifying their existing P4P programs to focus on value — directly aligning quality with costs and rewarding for greater physician accountability.<sup>24</sup> Other value-based payment approaches include shared decisionmaking and care coordination. Both of these models use decision tools and processes to reward physicians and caregivers for collaborating with patients and other providers in identifying the best course of treatment.<sup>25</sup>

Overall, value-based payment modifiers require no major structural changes to the current payment system and are often considered easier to implement compared to payment adjustments and funds flow arrangements.

### **Payment Adjustments**

Payment adjustments are similar to value-based payment modifiers in that they require minimal structural changes to current payment methods. They differ in that they are designed to penalize rather than reward provider performance. The payment adjustment often reduces or eliminates pay, which shifts the financial risk from payers to providers for avoidable outcomes. In some cases, a financial incentive is available for decreasing unnecessary readmissions. The primary goal of these payment models is to reduce medical errors and associated costs, resulting in a safer, higher quality care environment.

Over the last decade, many physicians and hospitals have begun incorporating tools and processes such as evidence-based care guidelines, standardized care processes, and standardized facility designs to improve patient safety. However, the list of hospital-acquired conditions, never events (particularly egregious medical errors such as

wrong-site surgery that should never occur), and readmissions continues to grow; many contend that not all of these are preventable. The result is widespread concern that a flat denial of payment for such events may not be the best method to encourage collaboration and foster a culture focused on value.<sup>26</sup>

### **Funds Flow Arrangements**

In funds flow arrangements, there is typically one entity that receives the payment. This entity bears financial risk and acts as a facilitator (or “convener”) for all providers involved in the episode of care, serving to remove the administrative burden from the payer. The convener is responsible for distributing funds to entities providing services across the care continuum. Across the US, many believe the convener will likely be a hospital, health system, or integrated delivery network, as these organizations often have the most resources (e.g., human capital, robust information technology systems, and finance departments) and the greatest access to capital.

Funds flow arrangements are the most complex payment approach, but are likely to achieve the most effective overall outcomes. These arrangements provide incentives for greater collaboration and care coordination among providers with the primary goal of minimizing unnecessary costs.

For most payment models under this arrangement, providers (hospital, physicians, or other caregivers) must agree to manage the care of a patient (or a patient population) across the care continuum (preventative, outpatient, inpatient acute, and post-acute care). Accountability may be for all medical services over a period of time (as with global payments and shared savings and risk arrangements), or for a single episode of care (as with bundled payment arrangements). (For an example of a bundled payment arrangement, see the case study in Appendix A.) These three payment models — global

payments, shared savings and risk, and bundled payments — are likely to involve multiple providers across multiple organizations, thus requiring a greater degree of collaboration compared to another funds flow arrangement, hospital/physician gainsharing, which may involve just a single hospital or health system and independent physicians or physician groups. In some instances, providers are awarded a bonus for meeting a cost target and improving quality and efficiency.<sup>27</sup>

In California, large independent physician associations (IPAs) are aligning directly with payers to assume the accountability of care for a population.<sup>28</sup> In this environment, an alternative arrangement could develop where IPAs assume the role of the convener. The challenge is that physicians and hospitals are independent organizations, and under California's corporate practice of medicine statutes they must maintain that separation; therefore, they must collaborate effectively in order to deliver high-quality, cost-effective care.

## V. California's Course to the Future: Major Themes

THE PRESSING NEED TO CONTROL HEALTH care costs — particularly in the wake of the ACA — is a powerful incentive for change in the health care payment system. While the emerging payment models discussed in this report do not solve all problems with the current payment system, most agree they are a step in the right direction. Currently, nothing precludes health care service providers from adopting any of the emerging payment models or approaches, either solely or in combination, to uniquely position or advance their organizations.

However, for a new payment model to be successful, stakeholders (hospitals, physicians and other caregivers, patients, and payers) must build trusting relationships and incorporate multiple alignment models that promote greater collaboration and care coordination. All who wish to participate must commit to identifying and implementing evidence-based guidelines, finding and addressing the sources of excess cost (e.g., unnecessary or redundant testing, avoidable readmissions, medical errors, lack of coordinated care, etc.), and maintaining or improving quality of care.<sup>29</sup> It remains to be seen how health care providers in California will manage these challenges in adopting new payment models.

California is often thought to have a unique health care environment compared to other states. There are several factors contributing to this, including, but not limited to: a higher presence of managed care (HMO penetration of 42% in 2010, compared to 22% in the US); more physicians in medical groups or IPAs; and a ban on corporate practice of medicine which prevents hospitals from employing physicians.<sup>30,31</sup> This environment has resulted in more than 20 years of experimentation

with various partnership and alignment models, and in some cases, is credited with promoting greater efficiency in the delivery of care. In 2009, for example, the ratio of patient days per 1,000 population for Medicare FFS beneficiaries was 1,834 nationally and 1,592 in California. This ratio was even lower for California Medicare Advantage patients, at 1,203 days per 1,000 population.<sup>32</sup> While quality data is inconclusive, a 2002 meta-analysis of 79 studies from 1997 to 2001 showed that quality of care was roughly comparable between HMO and FFS plans.<sup>33</sup>

With these factors as a foundation, the Advisory Group discussed the likelihood that stakeholders in California will be able to make a successful transition to new payment models. Three major themes emerged from this discussion on California's trajectory to payment reform:

1. The transition to future payment models will be evolutionary, not revolutionary.
2. Any future payment system will remain pluralistic; there is no "one-size-fits-all" approach.
3. Large employers and purchasers of health care services are likely to have a more dominant role in driving payment reform.

These themes are discussed in more detail below.

### **New Models Will Evolve Incrementally**

Transforming the health care payment system will take significant time and planning. New payment models will need first to overcome challenges embedded in the current payment system including

lack of aligned incentives, administrative burdens with multiple contracts, and lack of transparency around the costs of care. In addition, emerging payment models must align with the goals outlined in the ACA: decreased spending, increased coverage, improved quality of care, and a healthier population. To achieve these goals, hospitals, physicians, and other health care professionals will need to be accountable for the care they provide and to collaborate with other providers and organizations. To improve the likelihood of positive changes in provider behavior, emerging payment models must offer financial and non-financial incentives for all providers to improve the delivery system.

Given the hurdles that payment reform must overcome, it will likely occur over both the short and long term. In the short term, the focus will be on understanding how to transition today's payment models to ones that emphasize performance and value. In the long term, payment models should promote greater collaboration and care coordination across the continuum of care. Ideally, this continuum spans wellness and prevention, primary and specialty ambulatory care, acute/tertiary care, SNF/nursing home care, and end-of-life care.

### **Future Payment Systems Will Be Pluralistic**

While standardization should help mitigate some of the challenges of the current payment system, variations in payment methods will likely remain. This is due, in part, to the competing interests of multiple stakeholders. For example, patients want choice at a low cost; employers want to remain profitable with lower premiums, while also offering competitive benefits to employees; insurers want lower prices and risk while securing a profit; physicians and other health care professionals want compensation that reflects their value; and hospitals

must remain financially viable to serve as a resource to the communities they serve. In addition, there are significant regional and local market variations that must be considered (e.g., urban vs. rural locations, health systems vs. independent hospitals, large physician groups vs. independent physicians).

Some national and California-specific examples of the variety of payment models currently emerging are included in Table 4 on page 20.

### **Large Purchasers Will Drive Reform**

Employer-sponsored coverage is the leading source of health care coverage in the US and California. As salaries, wages, and benefits are among the largest expenses for most employers, fluctuations in overall health care costs directly impact their ability to generate positive margins. From 2002 to 2010, premiums in California increased by approximately 134%, resulting in 28% of firms reducing benefits or increasing cost sharing among their employees.<sup>34</sup> While the rate of employer health care costs are projected to slow to 1997 levels in 2012, many companies expect an increase in health benefit costs ranging from 5.4% to 7%.<sup>35</sup>

With premium growth rates higher than inflation and wage earnings, many employers are not able to absorb the costs and are faced with discontinuing coverage or incorporating other cost-cutting measures such as increasing employee cost sharing, or shifting towards consumer-directed health plans (CDHPs). Large purchasers, including government and large employers, will likely be the drivers of reform since they have the resources and the market leverage to stimulate the development of more effective payment systems.

Historically, employers faced consumer backlash in the 1990s when the market shifted towards a managed care environment. Two decades later, as costs continue to rise, many employers and

**Table 4. Emerging Payment Models in the United States and California**

UNITED STATES	CALIFORNIA
<ul style="list-style-type: none"><li>• ACA requires CMS to establish a shared-savings program to facilitate coordination and cooperation among providers to improve the quality of care and reduce unnecessary costs for FFS Medicare beneficiaries.<sup>36</sup></li><li>• In August 2011, CMS introduced four different bundled/episode-based payment models focused on acute and post-acute care.<sup>37</sup></li><li>• Cigna (a commercial insurer) is offering patient-centered collaborative accountable care initiatives that reward physicians for results rather than volume.<sup>38</sup></li></ul>	<ul style="list-style-type: none"><li>• The Integrated Healthcare Association (IHA), an organization that aligns key stakeholders to improve health care services, is implementing a Bundled Episode Payment and Gainsharing Demonstration to test the feasibility of bundled payments. IHA plans to expand the episodes, which originally focused on total hip and knee replacements, to 10 acute conditions and procedures.<sup>39</sup></li><li>• IHA is also well known for its Pay for Performance (P4P) program that was initiated in 2002. The success of the program, which measures performance on the dimensions of clinical quality, coordinated diabetes care, patient experience, IT-enabled systems, and appropriate resource use, has laid the foundation for transitioning to a value-based incentive program, which will reward for high-quality and efficient resource use.<sup>40</sup></li><li>• Insurers are showing a growing interest in expanding into other elements of health care delivery. For example, in 2011 UnitedHealth Group's Optum business initiated a purchase for the operations of a southern California physician group, Monarch HealthCare. The goal was to better align patients, providers, and payers in a more transparent process that focuses on increased quality and affordability of care.</li><li>• By 2015, Blue Shield of California hopes to have 20 ACOs throughout California focused on controlling costs while optimizing patient care. Three ACOs have already been developed. The ACO with California Public Employees' Retirement System (CalPERS), Catholic Healthcare West, and Hill Physicians has already achieved \$15.5 million in savings in 2010. Two separate ACOs with the San Francisco Health Service System have already committed to achieving savings of \$10 to \$15 million per year.<sup>41,42</sup></li><li>• With a target date of July 2012, the state will shift from a cost-based, per-diem payment rate to a PPS DRG payment system for FFS Medi-Cal beneficiaries. The goal is to change the payment method to one that promotes improved utilization of inpatient resources.<sup>43</sup></li></ul>

purchasers of health care are adopting a more proactive approach by developing strategies and tools to help manage costs, with some focused on quality. For example, the University of California (UC) aligned with Health Net to develop the Health

Net Blue & Gold HMO network in an effort to lower costs. Also, as mentioned previously, CalPERS and Safeway are both utilizing reference pricing (described in Reference Pricing) to drive down the cost of some medical procedures.

### Reference Pricing

Reference pricing is similar to a bundled payment. Essentially, purchasers identify a reference price as a maximum, reasonable price for a particular procedure. Beneficiaries can choose from a variety of providers to perform the procedure, but if the actual cost is higher than the reference price, then the beneficiary is responsible for covering the difference. For example, CalPERS found that it was paying between \$15,000 and \$100,000 for hip and knee replacements. After assessing the costs for several hospitals, CalPERS chose 46 hospitals that were able to perform hip and knee replacements for \$30,000 or less, establishing the reference price. CalPERS then established a value purchasing benefit design program in collaboration with Anthem Blue Cross that allows beneficiaries to assess the costs of joint replacement procedures for a number of hospitals in California.<sup>44</sup> Beneficiaries still have a choice, with the understanding that they are responsible for covering costs in excess of \$30,000.<sup>45</sup> Similarly, Safeway set a reference price of \$1,500 for a routine colonoscopy. The company also offers a transparency tool for employees to research the costs of specific

facilities. If Safeway employees choose a higher-cost provider, they are responsible for paying the difference between what the provider charges and the reference price.<sup>46</sup>

Many employers are experimenting with ways to manage or decrease health care expenditures, but it is difficult for any one employer to have sufficient leverage to reshape the approach to health care payment in the marketplace. Organizations such as the Pacific Business Group on Health (PBGH) and, more recently, Catalyst for Payment Reform (CPR) are beginning to help.<sup>47</sup> Both of these organizations are assisting employers and other purchasers in not only understanding health care costs and utilization, but also how to transition to a payment system focused on value. By forming partnerships, purchasers are able to develop tools for more informed decisionmaking, signal to providers when costs are unreasonable, and create opportunities for insurers, providers, and patients to collaborate.

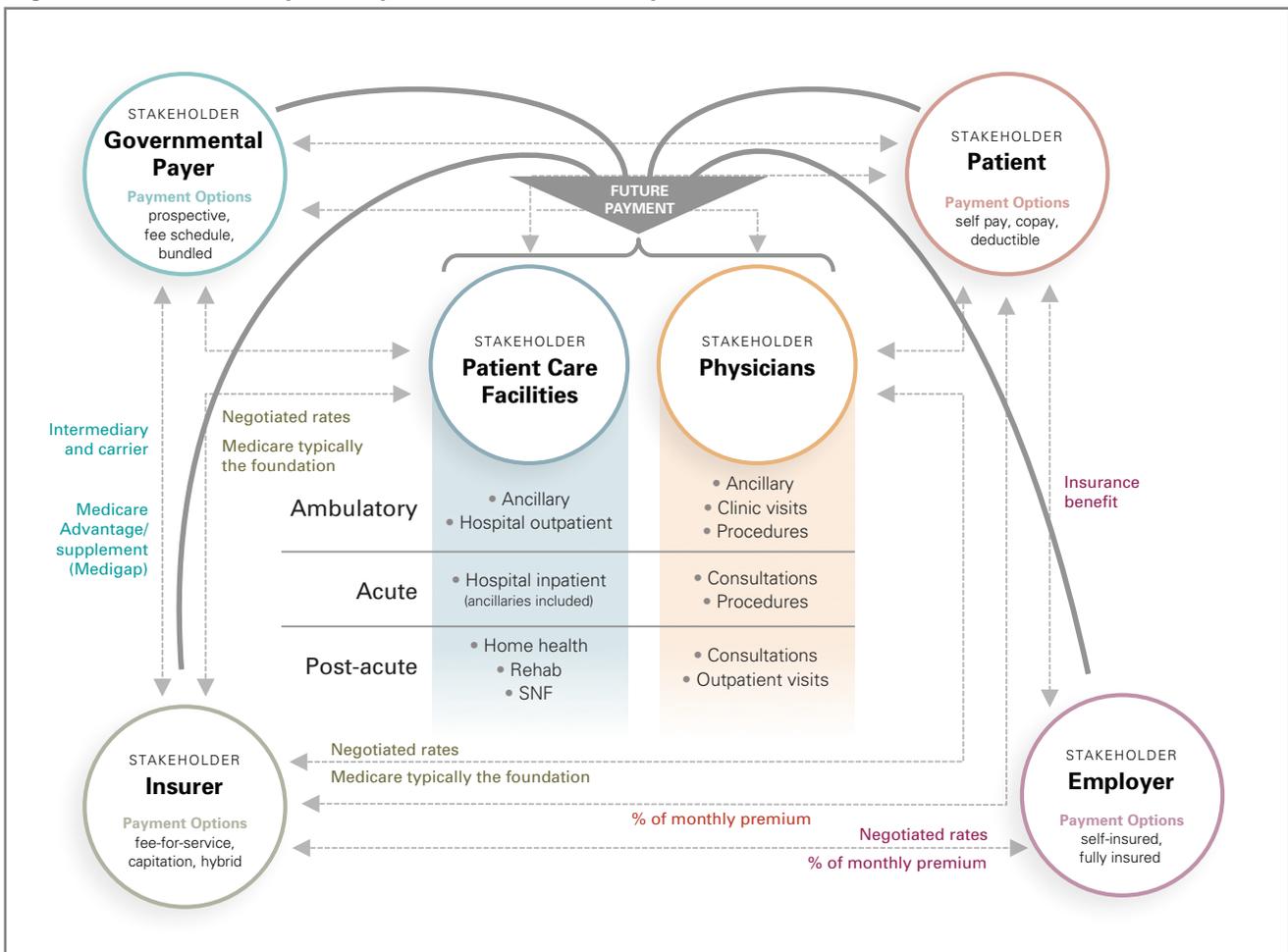
## VI. Transitional Implications and Strategies

AS DISCUSSED ABOVE, MULTIPLE stakeholders are involved in both the delivery and payment of health care services. Figure 3 illustrates the various stakeholders, including their interactions in the current payment environment (dotted lines) and their interactions as emerging payment approaches are advanced (solid lines). The future payment system will likely be a blend of current and emerging models, suggesting minimal changes to how stakeholders interact today. For illustrative

purposes, Figure 3 assumes a funds flow type of arrangement (e.g., global payment or bundled payment) for future payments that may result in one payment to all care continuum providers.

As each stakeholder is unique — relative to culture, leadership team, strategic goals, partnerships with other stakeholders, human resources and IT capabilities, and financial strength — the implications of transitioning to payment approaches will vary. However, there are five overarching

**Figure 3. Stakeholder Payment System Interactions Today and in the Future**



implications stakeholders should consider as they make the transition: (1) greater collaboration, (2), service line consolidation (housing specific services such as oncology or cardiac care in a centralized location), (3) robust analytics, (4) aligned incentives for value and effectiveness, and (5) impact on the cost of doing business. Details on each consideration and subsequent strategies follow.

### Greater Collaboration

Trying to improve the quality, safety, and efficiency of health care requires a higher level of clinical integration than exists today, and may necessitate new care delivery models involving multiple specialties across care settings (outpatient, inpatient, and post-acute). Decisions cannot be made independently if the desired outcome is greater care coordination and accountability.

Strategies for fostering greater collaboration include:

- **Develop a stronger network.** Whether the stakeholder is a hospital, health system, independent physician, or physician group, all will need to develop or expand their existing networks to strengthen relationships with other care continuum providers. In addition, as the focus of care transitions from a patient to a population, the network should also include community members, purchasers, and policymakers. Potential vehicles to enable the creation of a stronger and more formal network include ACOs, regional health improvement collaboratives (RHICs), IPAs, foundations, and organizations such as the Pacific Business Group on Health and Catalyst for Payment Reform that directly align with employers and purchasers of health care.
- **Establish new governance or leadership models to lead collaborative efforts.** Organizations — particularly independent hospitals and physicians, and those that lack strong physician/hospital partnerships — need visible leadership teams to help navigate and guide all stakeholders through the transition. This will be most critical for those pursuing a funds flow payment approach (including global payment, shared savings and risk, and bundled payment arrangements). First, hospitals, physicians, and payers must define and agree to the population(s) being cared for. Second, the new leadership team will need to define specific targets for improved quality and lower costs, and be able to negotiate these metrics when contracting with payers. Finally, as physicians are able to have privileges at several hospitals, the hospital(s) and physicians involved in the collaborative effort will need to clearly outline criteria for other health professionals to participate in a new payment environment.
- **Identify champions for change (especially physicians).** Transitioning from individual decisionmaking to a collaborative teamwork environment will not be easy or always well-received. Identifying champions, particularly in the physician community, will be critical to gain buy-in.
- **Focus on the patient and quick wins.** Changing from a culture of competition to collaboration among hospitals, physicians, and payers will require more than just a physician champion. These entities will need to identify ways to quickly generate demonstrable successes to keep the momentum going. For example, hospitals and physicians could begin with co-developing evidence-based guidelines around specific care processes before moving to tougher decisions

involving contract negotiations, funds flow arrangements, risk-sharing, etc.

## Service Line Consolidation

As the pressure increases to demonstrate value, not all hospitals or physicians will be successful. Consolidating service lines to bring a range of coordinated and integrated resources to address a common, high-volume clinical challenge such as congestive heart failure or total joint replacement can help to provide excellent care at a reasonable price. Providers that have the resources and efficiencies to demonstrate better quality and service at a lower cost are likely to be at an advantage and increase market share. Those unable to demonstrate value are at risk of not only losing volumes but also becoming financially unsustainable. Potentially negative effects of service line consolidation — particularly by large, integrated systems of providers — include market consolidation which may result in reduced competition and increased prices.<sup>48</sup>

Strategies for managing service line consolidation include:

- **Focus on market strength and efficiency.** Payers, hospitals, and physicians in a particular market should agree to focus on high-volume services or patient conditions that are likely to demonstrate better outcomes at a lower cost. For example, hospitals and physicians may want initially to participate in Medicare demonstration projects, as Medicare beneficiaries are among the highest users of medical services and chronic disease management for conditions such as heart disease, stroke, cancer, diabetes, and chronic respiratory diseases. Alternatively, Harold Miller, in his article, “Transitioning to Accountable Care” offers four criteria to help providers identify these services and conditions: (1) conditions that affect

a large number of patients; (2) services where there is evidence of overutilization or inefficiency involving relatively large amounts of spending; (3) changes in care that have been proven to reduce overutilization or inefficiency, that are relatively simple or low-cost to implement; and (4) services or conditions where there is strong clinical leadership in the community.<sup>49</sup>

- **Pursue small-scale experiments.** Providers that are not tightly aligned with other care continuum providers should experiment with payment changes on a smaller scale. Examples include CalPERS’ “total hips and joints focus,” Safeway’s routine colonoscopies, or IHA’s bundled payment demonstration on knee and hip replacement procedures.
- **Monitor access and value.** As hospitals, physicians, and other health professionals either begin or continue to experiment with new payment approaches, policymakers must continue to track and report on progress to ensure all stakeholders are advancing value — including improvements to the delivery of care and how it is paid for.

## More Robust Analytics around a Common Patient Identifier

The need for health information technology (IT) has been well recognized, but health IT has not been widely implemented because of high costs. In 2009, with funding from the American Recovery and Reinvestment Act and the need to comply with meaningful use requirements, many providers have been investing in IT systems. Typically, large health systems and physician groups have well-established quality improvement, utilization management, and health IT systems; however, several of these systems do not link business data with clinical data. Nor do

they provide data in real time, making it difficult for physicians and other caregivers to understand the overall health of the patient and adjust treatment decisions accordingly. Furthermore, a single patient is likely to have different identification numbers from every organization (such as the physician clinic, hospital, and/or post-acute care setting) that provided treatment. Multiple patient identifiers combined with inconclusive data leads to inefficiency (duplication of tests is just one example) and a lack of care coordination.

Strategic IT considerations for transitioning to new payment approaches include:

- **Continue investment in IT systems and infrastructure.** Real-time communication, interoperability, and results should be emphasized. Health care organizations' analytical platforms should include warehouses for business and clinical data with sophisticated analytic tools. Migrating to a single, integrated IT platform will also help the development and reporting of metrics necessary for greater accountability and transparency. The use of health information exchanges will be critical to ensure communication between providers, patients, purchasers, and payers.
- **Use risk management and adjustment tools.** Managing the risk of a patient population will be a new business for many health care providers including hospitals, physicians, and post-acute care professionals. A risk adjustment tool allows providers to group multiple patients in a clinically meaningful way. The grouping not only allows providers to assess care management and outcomes measures, but also determines the risk of the population for the purpose of adjusting payment rates. The following is a subset of criteria

providers should consider when implementing a risk adjustment model.<sup>50</sup>

- Specificity of the model to the population to which it is being applied.
  - Transparency of the mechanics and results of the model.
  - Access to data of sufficient quality (including clinical utilization and financial information).
  - Software with multiple functions (e.g., facilitates payments to providers and plans and/or streamlines case management trending and assessment).
  - Reliability of the model across settings, over time or with imperfect data (e.g., ability of the model to be replicated for different data sets and populations).
- **Dedicate decision-support personnel to analyze, interpret, and report progress (or lack thereof).** Many believe that part of the reason payment system changes have proceeded so slowly is because there is a lack of understanding around what needs to be changed and/or how these changes should be implemented.

### **Aligned Incentives for Value and Effectiveness**

The current payment system does not reward for value or clinical effectiveness. Strategies for aligning incentives to better promote value and effectiveness include:

- **Create incentives that are superior to the current payment methods for at least a significant number of providers.** For example, without health reform, fiscal realities are likely to drive continued payment cuts for most hospitals and physicians resulting in even greater scrutiny

of individual decisions. In this instance, payment reform is likely to be more attractive than the status quo.

- **Ensure incentives are aligned with changes in the delivery system.** As cost containment measures are put in place, it will be important for hospitals and physicians also to maintain or improve quality and outcomes. Incentives should include financial and non-financial rewards that are motivating to all stakeholders (e.g., physicians, hospitals, payers, purchasers, and patients). For example, payments can be designed explicitly to improve quality by rebalancing payments to encourage physicians to adhere to evidence-based guidelines.
- **Ensure flexibility.** Stakeholders must recognize that the development of aligned incentives will be a continuous process requiring experimentation and modification over time. For example, initial payments using diagnosis-related groups (DRGs) for inpatient acute care were modified to Medicare severity (MS) DRGs to factor in severity of illness. Similar refinements and modifications with any emerging payment system are to be expected.
- **Clearly define value and clinical effectiveness.** As each organization will vary, it will be critical to create a baseline reflecting where hospitals and physicians are currently positioned, outline expectations and goals for the future, and continue to monitor and track progress at reasonable time intervals.

## Impact on Cost of Doing Business

Implementing new payment approaches comes with a cost, regardless of the payment model. There are costs associated with IT implementation, full-time equivalents (FTEs) to serve as dedicated resources to manage change, and, in some instances, discounted payment rates. In addition, administrative burdens are not eliminated, but shift from payers to providers. Whether there is a value-based bonus, a reduction in pay, or a combination of the two, providers are now tasked with determining how to distribute those funds across multiple care continuum entities.

At the same time, transitioning to new systems does not happen instantaneously. Organizations must learn to manage both current payment methods and emerging models during the transition. For some organizations, small changes to the existing payment structure can result in significant implications for their bottom line. For example, many hospitals rely on bonds to build or maintain new infrastructure. Minor changes to one contract can disrupt their revenue stream, which subsequently could lead to lower overall bond ratings. As a result, some hospitals are taking a more conservative approach to payment reform, experimenting with payment models focused on lowering costs or improving value rather than making large-scale changes. As organizations transition to new payment models, they will need to balance their aspirations for payment reform with what they realistically can afford to do.

Strategies for organizations to remain financially sustainable as they transition to new payment models include:

- **Develop a contracting strategy.** Hospitals, physicians, and other health care professionals will need a strategy for managing payment contracts. This should include an understanding of what the contract covers, criteria for who is

able to participate, and benchmark comparisons to assess if the contracts represent market realities. To ensure buy-in among most care continuum providers, the contracting strategy should be developed and revised through a committee or leadership team that includes hospital administrators, clinicians, payers, and in some cases, purchasers.

- **Focus efforts on building strong, trusting relationships among all stakeholders, but particularly between hospitals and physicians.** Trust will be essential to create an equitable risk model. Since hospitals in California are not able to employ physicians (due to corporate practice of medicine statutes), other forms of hospital/physician integration should be considered to demonstrate commitment to the relationship. With the IHA bundled payments demonstration, hospitals and physician organizations that had high levels of trust were able to overcome the political hurdles and initiate the payment pilot more quickly than others.
- **Prioritize the implementation of new payment approaches.** Organizations should begin with models that are easy to implement. For some, the focus may be on value-based payment modifiers or payment adjustments rather than models requiring funds flow arrangements. It is unrealistic to think small hospitals and independent physicians will take on significant financial risk. These organizations should consider aggregating into groups or clusters — either virtually or physically — to help ease the transition.

## VII. Conclusion

THE NEED TO BOTH REDUCE THE COMPLEXITY of the current payment system and demonstrate greater value is driving the health care industry to develop new models and modified approaches to paying for health care services. As California has historically been the birthplace of innovations that promote greater efficiency and lower costs, many are interested in how the California market will respond to the challenges of payment reform.

In evaluating the likely course of California's transition to a new payment system, a number of themes have emerged:

- **New models will evolve incrementally.** In the short term, the focus will be on understanding how to transition today's payment models to those that emphasize performance and value. In the longer term, payment models should enhance value by promoting greater collaboration and care coordination across the continuum of care.
- **Future payment systems will be pluralistic.** While standardization of payment systems should help mitigate some of the challenges of the current payment system, variations in payment methods will likely remain.
- **Large purchasers will drive reform.** With premium growth rates higher than inflation, many employers and governmental purchasers are not able to absorb the costs. Large purchasers, including government and large employers, will likely be the drivers of reform since they have the resources and the market leverage to stimulate the development of more effective payment systems.

Each of the emerging models discussed in this report varies in impact and ease of implementation. Providers will need to consider how transitioning to new payment models will impact their costs of business, and how to balance strategic investments in adopting new payment models with maintaining margins. In some cases, focusing on a proven approach — such as bundling high volume total joint services — may generate the momentum needed to make the transition to all-encompassing payment models (e.g., funds flow arrangements). By taking a proactive approach and creating a transitional payment strategy, organizations have the opportunity to develop a plan that aligns with their vision, goals, culture, and capabilities — and one that is politically acceptable, financially feasible, and complies with changes in the legal and regulatory landscape.

## Appendix A: Fictional Case Study

This fictional case study was created to provide an example of how the current payment system works and to illustrate an emerging payment model. The current payment methods illustrated include prospective payment systems and fee schedule systems for a traditional Medicare fee-for-service beneficiary. A bundled episode payment is used to illustrate the emerging payment model.

Jane Smith is a 68-year-old Medicare beneficiary who was diagnosed with congestive heart failure (CHF) two years ago. She has been routinely monitored by her general cardiologist since her diagnosis.

During her last routine visit, the general cardiologist noticed Ms. Smith's condition was getting worse and referred her to a heart failure specialist. Upon her initial evaluation, the specialist recommended a full work-up including a stress test to better assess her heart's structural and arrhythmia characteristics, including cardiac output. Ms. Smith went to the cardiologist's outpatient facility for these tests, and the test results were delivered to the specialist for interpretation. Her test results showed she would likely need cardiac resynchronization therapy: a treatment involving the implantation of a defibrillator device.

Because the implantation of a defibrillator and follow-up care is typically carried out by an electrophysiology (EP) cardiologist, Ms. Smith was referred to an EP for a consult office visit. Once the EP cardiologist confirmed the need for a defibrillator and reviewed the clinical evidence, potential outcomes, and risks associated with such a procedure with Ms. Smith, she elected to have the procedure.

The implantation was performed in the hospital's cardiac catheterization facility. After the procedure Ms. Smith was admitted to the hospital where her

post-operation recovery could be closely monitored. She stayed at the hospital for two days before being discharged. After discharge, she followed a typical rehabilitation regimen.

Figure A1 illustrates Mrs. Smith's total episode of care including the total number of days for the episode, all provider encounters, and the respective codes and charges per encounter for a traditional Medicare fee-for-service beneficiary. (See page 30.)

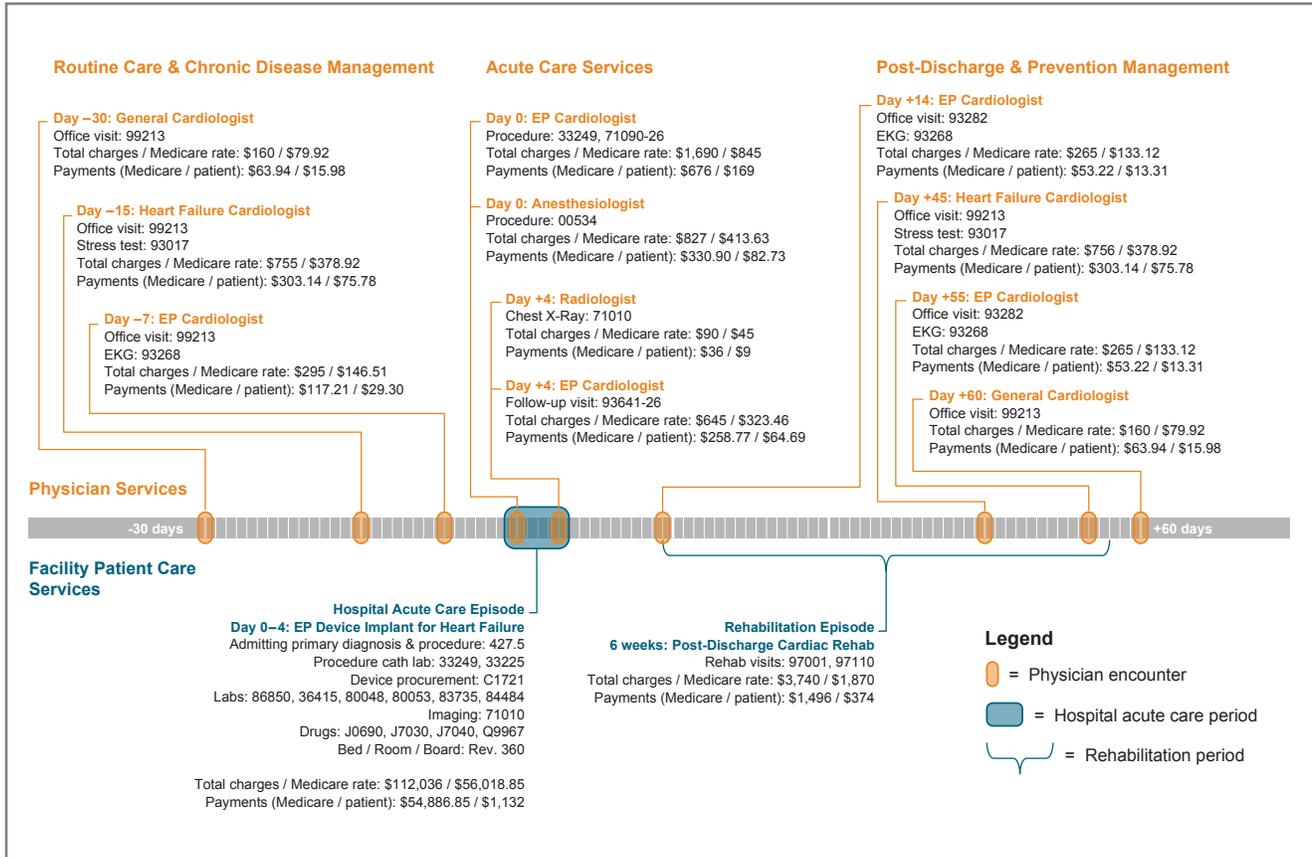
Ms. Smith's total episode of care covered a 90-day period. During those 90 days, she had 11 physician encounters with multiple EKGs, stress tests, and a chest X-ray; one hospital stay that included the defibrillator implant procedure, labs, pharmaceuticals, and monitoring; and 24 rehabilitation encounters.

Based on current CMS payment rates for medical services performed in a metropolitan region of California, Ms. Smith generated \$121,684 in medical service charges. Medicare paid \$59,774 and Ms. Smith paid \$2,071 out-of-pocket, totaling \$61,845. The difference of \$59,839 was written off, as the billed charges reflect a total amount before any contracts, discounts, allowances, or plan adjustments are applied. The total monies from Medicare and Ms. Smith were paid to five separate physicians, one hospital, and one rehab facility.

Table A1 shows a summary of encounters, invoices, and payments by provider. (See page 30.)

In this example, there were three main payment methods used throughout this one episode of care. Payments made to the hospital were based on a prospective payment system under Medicare Part A's inpatient prospective payment system (IPPS). Payments made to the individual physicians such as the general cardiologist, heart failure specialist, and EP cardiologist followed a different fee schedule

**Figure A1. Ms. Smith's 90-day CHF Episode of Care (Current Medicare Payment Method)**



**Table A1. Summary of Ms. Smith's 90-day CHF Episode of Care**

PROVIDER	ENCOUNTERS	CHARGES	MEDICARE PAYMENT	PATIENT PAYMENT	TOTAL PAYMENT	DIFFERENCE BETWEEN PAYMENT AND CHARGES
Physician	11	\$5,908	\$2,259	\$565	\$2,824	-\$3,084
Hospital	1	\$112,036	\$56,019	\$1,132	\$57,151	-\$54,885
Rehab	24	\$3,740	\$1,496	\$374	\$1,870	-\$1,870
<b>TOTAL</b>	<b>36</b>	<b>\$121,684</b>	<b>\$59,774</b>	<b>\$2,071</b>	<b>\$61,845</b>	<b>-\$59,839</b>

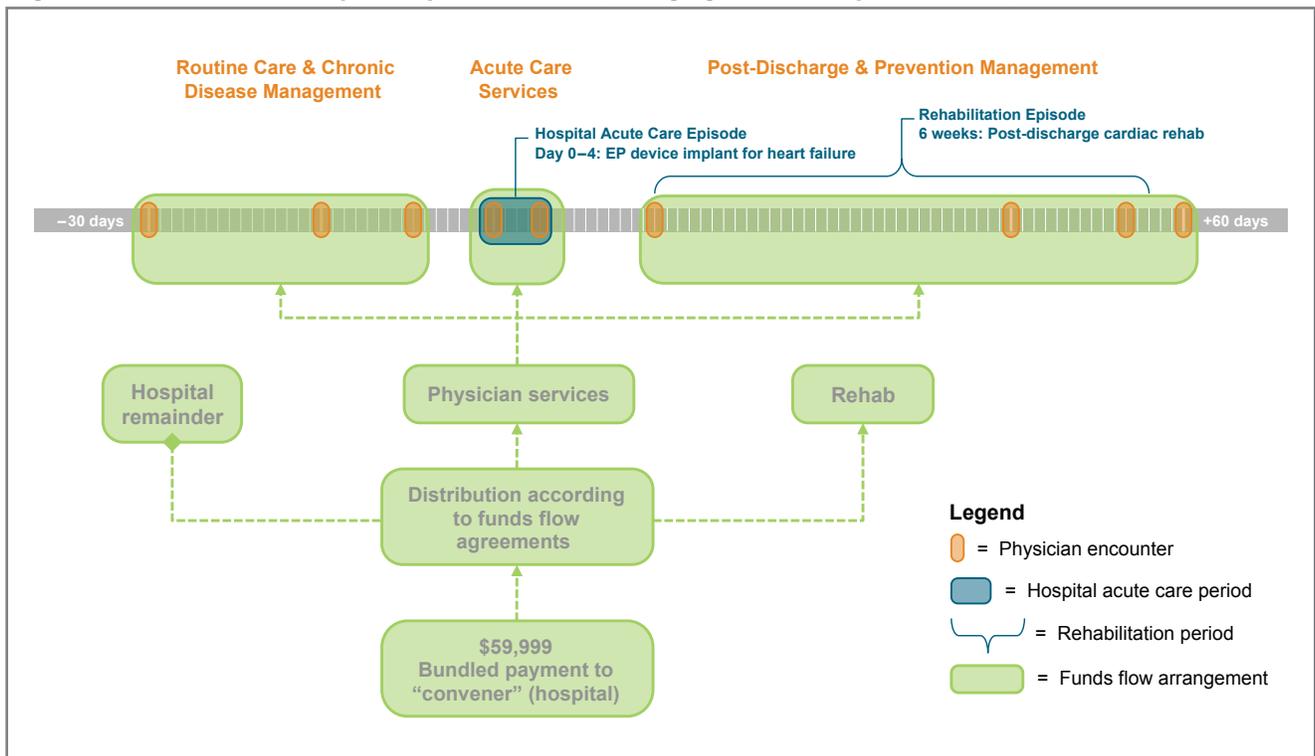
arrangement under Medicare Part B's Medicare Physician Fee Schedule. Payment for the outpatient rehabilitation facility fell under the outpatient prospective payment system (OPPS).

With the passage of ACA, Medicare and other payers are looking to introduce new payment models that will encourage provider groups to collaborate and be more accountable for managing the care of a population. One such payment method is bundled payment. This model allows physicians and hospitals to work together in reducing costs throughout an episode of care, much like the 90-day episode experienced by Ms. Smith. Providers who choose to group together to adopt a bundled payment model will be allowed to retain any cost savings. These

same providers will also have to agree to take an overall discount on their combined services delivered throughout a given episode. In the recent CMS bundled payment initiatives, discount percentages for Medicare FFS beneficiaries can range from 0% to 3% depending on the type of model employed.<sup>51</sup> Adhering to a lower cost target and the potential shared savings provides the incentives for providers to collaborate, coordinate care, reduce unnecessary utilization, and improve efficiency with the overall goal of providing more value for the delivery of medical care.

Figure A2 illustrates a bundled payment arrangement for Ms. Smith's 90-day CHF episode.

**Figure A2. Ms. Smith's 90-day CHF Episode of Care (Emerging Bundled Payment Model)**



Under a bundled payment model, Medicare makes one payment for Ms. Smith's 90-day episode (discounted at 3%) to the hospital. The hospital, in this case, acts as the convener, bringing together all providers that were involved in the episode of care.

While it appears as through a bundled payment is simpler compared to the current payment system, this is not necessarily the case for all stakeholders. For Medicare (the payer) there are several advantages: (1) decreased spending by 3% (a net decrease of \$1,855), (2) reduced administrative burden by decreasing the total number of payments from 13 to 1, and (3) by shifting the accountability to the providers, Medicare also shifts the financial risk of managing the patient's care to the providers. Conversely, the hospital, serving as the convener, not only is the bearer of financial risk, but is also responsible for the care being delivered without having the authority to mandate how that care will be delivered.

### **Payment Methodology Variables**

For illustrative purposes, the current payment methods in this example were kept relatively simple. In reality there are many more elements factored into the payment methodology. These elements include, but are not limited to: the level of charity care; teaching status; whether the physician owns any equipment at the facility or hospital; employment of the provider (although not applicable to California given the corporate practice of medicine laws); and other contingencies that could affect how overall payment is calculated and distributed among the caregivers. Variables such as these could warrant technical fees for equipment as well as other types of payments.

In addition, the case study subject is a patient insured by one payer: Medicare. Most providers (hospitals, physicians, post-acute care facilities, skilled nursing facilities, etc.) receive payments from multiple payers for one patient in one single case with each payer employing multiple payment methods with varying formula adjustments. Given the complexity that already exists with one payer, having several payers simultaneously creates significant complexity with accompanying administrative burdens for organizations. In 2008, administrative costs (e.g., procedures for filing claims, resetting prices, complying with federal and state regulations, and marketing) were estimated to be 7% of health expenditures in the US, which is roughly translated to be about \$161 billion.<sup>52</sup>

## Appendix B: Advisory Group Participants and Interviewees *(listed alphabetically)*

### Advisory Group Participants

Richard Culbertson, MHA, MDiv, PhD

Professor, Tulane University

Former Chairman, Aurora Health

Suzanne F. Delbanco, PhD

Executive Director

Catalyst for Payment Reform

Emily Dolan

Policy Analyst

Integrated Healthcare Association

Emma Hoo

Director of Value Based Purchasing

Pacific Business Group on Health

Karen Jones

VP, Finance

Cottage Health System

Benjamin Katz

VP, Network Management Northern California

CIGNA HealthCare of California

David V. Kraus, JD, MPH

Chief Contracting Officer

University of California, San Diego

David O'Neill, JD, MPH

Senior Program Officer

California HealthCare Foundation

Carrie Owen Plietz, MHA and FACHE

Chief Executive Officer

Sutter Medical Center, Sacramento

Maribeth Shannon, MS

Program Director

California HealthCare Foundation

Wells Shoemaker, MD

Medical Director

California Association of Physician Groups

Deborah E. Stebbins

Chief Executive Officer

City of Alameda Health Care District

Betsy L. Thompson, MD, DrPH

Chief Medical Officer

Center for Medicare & Medicaid Services, Region IX

Tom Williams, DrPH, MBA

Executive Director

Integrated Healthcare Association

Murray Ross, PhD

VP, Kaiser Foundation Health Plan

Director, Kaiser Permanente Institute for Health Policy

Larry Wilson, MBA

Former SVP for Finance and Strategy

Kaiser Permanente

### Interviewees

Suzanne F. Delbanco, PhD

Executive Director

Catalyst for Payment Reform

Weslie Kary

Program Director

Integrated Healthcare Association

David V. Kraus, JD, MPH

Chief Contracting Officer

University of California, San Diego

Richard Soohoo

Chief Financial Officer

Sutter Medical Center, Sacramento

Wells Shoemaker, MD

Medical Director

California Association of Physician Groups

Tom Williams, DrPH, MBA

Executive Director

Integrated Healthcare Association

Note: While all Advisory Group participants helped inform the direction and content included in this report, not all agreed with all findings.

## Appendix C: Glossary of Terms

PAYMENT TYPE	DEFINITION
Accountable care organizations (ACOs)	Voluntary groups of physicians, hospitals, and other health care providers that are willing to assume responsibility for the care of a clearly defined population of Medicare beneficiaries attributed to them on the basis of patients' use of primary care services. If an ACO succeeds in both delivering high-quality care or improving care and reducing the cost of that care below what would otherwise have been expected, it will share in the savings it achieves for Medicare. <sup>53</sup>
Ambulatory payment classification (APC)	The method used by CMS (and others) to implement prospective payment for ambulatory procedures. Different ambulatory procedures are clustered into groups for purposes of payment. Payments may also be weighted to account for resource consumption and geography.
Ambulatory surgical center (ASC)	Outpatient surgery may be performed at a hospital, physician's office, or ambulatory surgery center (ASC). Under the hybrid payment method, payments combine Medicare outpatient prospective payment system and Medicare physician fee schedule for procedures performed at an ASC.
Carve-outs	Services pre-selected to be reimbursed using a different payment system than the default negotiated system.
Case rate/composite bundling	Providers (or a group of providers) agree to receive one fixed and predetermined payment amount for all services provided within an episode of care (could include, for example, inpatient services, associated post-acute care and rehab, and durable medical equipment). Under composite bundling, the provider(s) may not bill for each service provided within an episode individually.
Copayment (copay)	A fixed fee that subscribers to a medical plan must pay for their use of specific medical services covered by the plan.
Cost plus per diem	"Per diem" represents each day that a given patient is provided access to a prescribed therapy. Cost plus per diem reimbursement is intended to compensate for costs plus a fair return (the excess of revenues over expenses needed to ensure continued access to the prescribed therapy).
Cost plus percentage	Payment method where a provider is reimbursed for all allowable expenses plus an additional amount for profit; the profit premium is usually calculated as a percentage of those expenses.
Deductible	Dollar amount set by insurer that the beneficiary is responsible for paying before the insurer covers any medical costs. Usually, the beneficiary has a yearly deductible to meet before costs are covered.
Disproportionate share hospital (DSH)	As defined by the US Department of Health and Human Services, DSH adjustment payments provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients; eligible hospitals are referred to as DSH hospitals. States receive an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients that are not paid by other payers, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other health insurance. This annual allotment is calculated by law and includes provisions to ensure that the DSH payments to individual DSH hospitals are not higher than these actual uncompensated costs. <sup>54</sup>

PAYMENT TYPE	DEFINITION
Durable medical equipment prosthetics, orthotics, and supply fee schedule (DMEPOS)	DMEPOS uses Healthcare Common Procedure Coding System (HCPCS) to classify medical equipment. This system accounts for different types of durable medical equipment as well as the condition (new or used) and payment method (purchase or rental).
Full capitation	A monthly arrangement where a third-party payer pays a contracted provider a predetermined amount based on the number of members covered by the payer. All financial risk is placed on the provider who will receive the same monthly payment regardless of the amount of services provided that month.
Long term care hospital (LTCH) prospective payment system	Under Medicare, acute care hospitals with an average length of stay of more than 25 days are considered long term care hospitals. Such hospitals are paid by Medicare on a prospective payment system using LTC-DRGs (long term care DRGs).
Medicare-adjusted payment	Payment adjustments employed by Medicare to account for uncontrollable cost variations associated with providing care (i.e. geography, case mix, etc.).
Medicare clinical laboratory fee schedule (CLFS)	A fee schedule adopted by Medicare to reimburse clinical laboratories for rendered services.
Medicare physician fee schedule (MPFS)	Implemented by Medicare in 1992, it uses current procedural terminology (CPT) codes as its classification system and defines payment rates using the Medicare resource-based relative value scale, which accounts for work experience, practice expense, and malpractice costs.
Medicare severity diagnosis-related groups (MS-DRG)	System adopted by Medicare to categorize and prospectively price inpatient episodes of care based on patient diagnosis and severity. Pricing is set based on the cost to treat an average case with the given diagnosis. MS-DRGs are used for inpatient prospective payment systems.
Out-of-pocket	Any portion of a bill a patient is responsible for after insurance. Usually includes copay and deductible. Could be the entire bill if patient is uninsured.
Partial capitation	Unlike full capitation which is a fixed monthly payment to cover the provision of all medical services, partial capitation covers specified services under a capitated model (fixed monthly fee) while non-specified services remain reimbursed under fee-for-service.
Per diems	A daily payment rate for costs incurred on a daily basis.
Percent of charge	A retrospective payment system in which payers contract with health care providers (i.e. hospitals, physicians) to reimburse a percentage of the billed charges for treatment.
Premium	Payment made by a beneficiary to insurance company to cover costs associated with his/her care. Premiums are calculated by the insurance company to account for risk associated with treating the beneficiary.
Prospective payment system (PPS)	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).

PAYMENT TYPE	DEFINITION
<b>Provider-based (facility) vs. free-standing (non-facility) physician practices</b>	Medicare reimburses different payment rates depending on whether services were provided in a provider-based or free-standing setting. Under a provider-based setting the hospital usually provides the resources, while the physician (contracted or not) provides the care. In a free-standing setting, usually a physician or physician group owns a practice that has no affiliation with a hospital.
<b>Re-insurance</b>	The transfer of part of the insurance risk to another insurer or insurers. Self-funded plans generally buy specific and/or aggregate stop-loss coverage to cover losses in excess of certain limits (also known as excess loss coverage).
<b>Shared risk</b>	Apportionment of chance of incurring financial loss by insurers, managed care organizations, and health care providers.
<b>Skilled nursing facility (SNF)</b>	Developed in 1997 and implemented in 1998 to replace the cost-based system. The payments are based on a per-diem rate and adjusted for case mix and geographic location.
<b>Stop loss</b>	Insurance policy purchased by self-insured or managed care payers to limit cost exposure. Some policies reimburse against individual cases that incur expenses beyond a certain dollar amount, while others insure against cost overruns from paying claims on behalf of all beneficiaries.

Sources: Primary sources include the CMS website ([www.cms.gov](http://www.cms.gov)), TheFreeDictionary's Medical dictionary ([www.medical-dictionary.thefreedictionary.com](http://www.medical-dictionary.thefreedictionary.com)), and the National Association of Health Underwriters Glossary of Terms ([www.nahu.org](http://www.nahu.org)). Other sources include: Anne Casto and Elizabeth Layman, *Principles of Healthcare Reimbursement*, American Health Information Management Association, 2006; Duane Abbey, *HealthCare Payment Systems: An Introduction*, Productivity Press, 2009; and Joanne Waters and L. Blount, *Mastering the Reimbursement Process* (4th Ed.), American Medical Association, 2007.

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**CALIFORNIA  
HEALTHCARE  
FOUNDATION**

1438 Webster Street, Suite 400  
Oakland, CA 94612  
tel: 510.238.1040  
fax: 510.238.1388  
[www.chcf.org](http://www.chcf.org)