

# Paying for Better Care

*A Consumer Advocate's  
Reference Guide to  
Payment Reform*

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*Paying for Better Care: A Consumer Advocate's Reference Guide to Payment Reform* is the fifth in a series of Community Catalyst publications on consumer-friendly options to improve quality and contain costs within the health care delivery system. Other papers in the series are as follows:

- **More for Our Health Care Dollar: Improving Quality to Cut Costs** (October 2008)
- **Getting What We Pay For: Reducing Wasteful Medical Spending** (December 2008)
- **Saving Money by Improving Medicaid** (January 2009)
- **Special Delivery: How Coordinated Care Programs Can Improve Quality and Save Costs** (May 2009)

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## About Community Catalyst

**Community Catalyst** is a national nonprofit advocacy organization dedicated to making quality, affordable health care accessible to everyone. Since 1997, Community Catalyst has worked to build consumer and community leadership to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

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# Executive Summary

America's a-la-carte method of paying for health care needs to be changed to reach the twin goals of improving care and slowing growth in spending. Policymakers are increasingly focusing on new payment options as a way to fix the disjointed system that leaves too many without insurance and even more with poorly coordinated, inappropriate and expensive care.

The most commonly discussed alternatives fall into these categories:

- Paying preset fees for bundles of services, such as all the care for a hip replacement operation (e.g. episode-based payments)
- Paying preset rates for some or all services provided to individual patients (e.g., the global payment model)
- Simultaneously using other payment strategies to achieve joint cost and quality goals (e.g., pay-for-performance, provider tiering, evidence-based purchasing, shared savings)

Understanding these options is key to determining which is the best alternative to our current fee-for-service system of paying for each individual dose of care.

Because delivery systems vary so widely across the country, no single model will work everywhere. In many states, effectively adopting new payment methods will require changing how the care is delivered. Furthermore, many payment reform models have yet to be broadly implemented or tested. Given these two factors, all payment reform proposals should be evaluated to ensure that they promote the following goals:

- Improved health outcomes
- Increased reliance on primary care
- Improved care coordination
- Greater provider accountability to patients and communities
- Patient-centered care that adjusts for unique needs and circumstances
- Increased education and empowerment for patients and their families
- Greater transparency on how providers are paid and the quality of care they offer

Finally, consumer advocates have a unique role to play in ensuring that the voices of patients and their families – particularly those with complex health care needs – are represented in discussions about payment reform. Actions for advocates include:

- Placing cost and quality on the reform agenda
- Talking with policymakers and the public about existing programs that incorporate new ways of paying for care while improving value for consumers
- Communicating the need and opportunity for delivery system change and payment reform in terms that matter to the public

## Background: Changing the Status Quo

Health care is too expensive in the United States. In 2008, Americans spent an average of nearly \$8,000 per person on medical services<sup>1</sup> – the highest spending per person in the world.<sup>2</sup> Rising health care costs claim ever larger portions of states' budgets and are a central factor in the national health reform discussions now taking place. If nothing changes, we will be spending one out of every five dollars in the U.S. on health care by 2018.<sup>3</sup>

In spite of this, the U.S. health care system does not deliver value for many people. Millions are uninsured, millions more skip needed services or prescriptions because of the cost, medical errors are common and many people are simply not healthy. In international comparisons, the U.S. health care system typically ranks poorly on measures such as the frequency of medical errors and the number of deaths potentially preventable with timely and appropriate medical care.<sup>4</sup>

Lately, the conversation in Washington has revolved around reforming the U.S. health care system so that it offers quality, affordable health care for all. However, political and economic realities dictate that the coverage and quality goals of national reform will not be possible without also bringing costs under control.<sup>5</sup> This dynamic has surfaced in bills from each of the Congressional committees with jurisdiction over national health care reform where proposals to significantly increase access to coverage have been tempered by the price tags associated with certain expansions or paired with delivery system reforms to offset costs. This suggests that it is possible to simultaneously slow the growth of health care spending and improve patients' experiences and outcomes in large part by changing how we pay for health care, and how those payments motivate provider behavior.

This brief offers a primer on payment reform, designed to help consumer advocates evaluate different models. It begins by discussing the way the United States' most prevalent payment method – “fee-for-service” – has contributed to escalating costs by rewarding providers who order high numbers of complex services while underpaying for high-value, lower-cost services such as primary and preventive care, evaluation and care coordination. The brief then describes several payment reform models currently being offered as alternatives and discusses the incentives they create. It concludes by recommending principles consumer advocates can use to evaluate proposed payment models and suggests roles they should play in crafting payment methods that reward providers for quality, effective, consumer-friendly care.

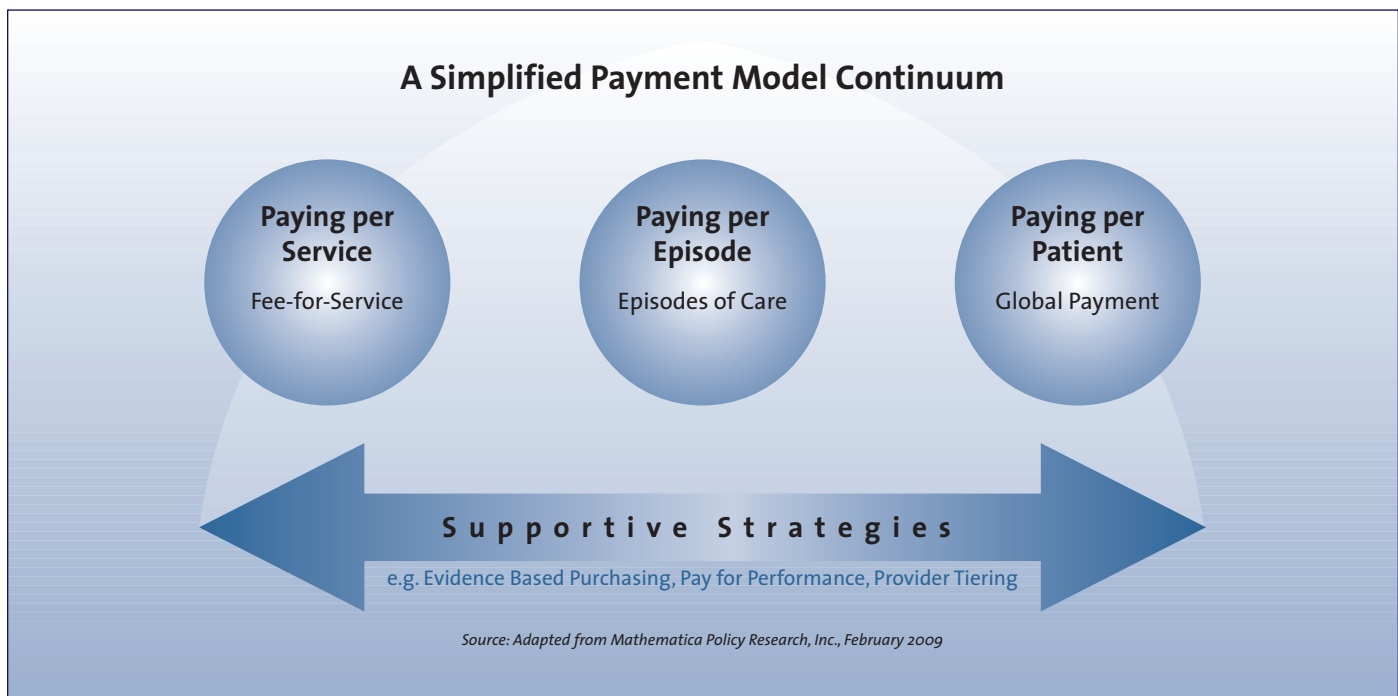
## Payment Models: Weighing Incentives, Understanding Risks

Envision a system that pays not for individual services, without limit, but for patients – for keeping them healthy or getting them well. Such a payment system would include financial incentives for doctors to keep patients' well-being at the center of their decisions and would reward quality, not quantity. Changing how we pay for health care would allow us to focus efforts on improving quality by better coordinating care, enhancing primary care, and reducing unnecessary hospitalizations and nursing home stays, among other benefits. And we could also realize major savings: one estimate is that adopting payment reforms similar to those outlined could save the nation \$1 trillion in health care spending through 2020.<sup>6</sup> Some of these savings could be captured and redirected to help pay for coverage expansions.

The challenge, of course, is to identify, evaluate, and promote the adoption of payment reforms that promote higher quality at lower cost, ideally within the context of changes to the delivery system that support the new payment model.



Figure 1



While this brief discusses each of the payment models, it is first useful to understand that they exist, by and large, on a continuum (see Figure 1). Fee-for-service (FFS), the most common payment model today, lies at one end. Providers reimbursed through this method are paid a pre-established fee for individual services. On the opposite end, providers are paid a pre-established rate per patient for a specified period of time, regardless of the number or cost of services the patient receives. This model is known as global payment. Other approaches and variations – for example, bundling payments to providers by paying a fixed rate for certain services provided during an episode of illness – lie between these two poles. Other reforms discussed in this brief – evidence-based purchasing, pay-for performance (P4P) incentives, provider tiering, shared savings – are not payment models *per se*. They are strategies that states and other purchasers of health care services can use in addition to an underlying payment model to further limit the overuse of unnecessary services, reward providers for positive health outcomes, and encourage providers to coordinate patient care.

#### ***Paying Per Service: The Status Quo***

Today, most health care is purchased on a FFS basis. Providers are paid piecemeal according to a set fee schedule for each individual service, a practice that gives providers great latitude in terms of the services they order. In general, payers – the state or federal government, insurance plan, or consumer – bear all of the financial risk for health care provided.

In the absence of safeguards, FFS rewards providers for the volume and intensity of services they order.<sup>7</sup> Providers have little financial incentive to limit either the number or the complexity of services they give; in fact, the incentive is just the opposite. In practice, FFS arrangements tend to undervalue primary care and patient supports – care coordination, home visits, and 24/7 access – and lack incentives to practice medicine in ways that have been shown to deliver quality and value.<sup>8</sup> FFS contributes to a health care system with fragmented and costly late-stage services rather than preventive, consumer-centered care based on best practice, efficiency, and quality outcomes.

### ***Paying Per Episode***

One alternative model bundles payments together, paying one fixed fee in advance for all the services a patient receives over the course of an “episode” of care, rather than paying each provider separately for every service.<sup>9</sup> An “episode” might be defined as a discrete diagnosis, a single acute illness requiring hospitalization, or care for a particular chronic illness over a predetermined period of time. For example, physicians and hospitals participating in an episode-based system might divide a flat fee for a routine hip replacement surgery. The payment might cover all services – hospital, physicians, prescription drugs, medical devices – the patient receives over a certain length of time in connection with the surgery, from preadmission to rehabilitation at home. Under this payment model, a provider’s financial responsibility is triggered only when a patient becomes ill and requires treatment. At that point, the provider is financially responsible for all costs of care associated with the treatment.<sup>10</sup>

Paying per episode may be an appealing policy for several reasons. First, it can serve as a step towards more patient-centered reforms by encouraging providers to coordinate care within an episode (Figure 2, page 9). It encourages the use of more preventive or care management services, such as transition planning, home visits or social service supports. And, unlike FFS, capped episode-based payments place providers on the hook for some of the financial risk that accompanies treatment decisions, creating incentives to treat patients effectively (for example, by reducing avoidable hospital readmissions) and curbing incentives to over treat.

On the other hand, there are potentially negative incentives to episode-based payment reform as well. Providers could try to boost payments by claiming multiple episodes, or might offer too few services within an episode, reducing the quality of care a patient receives. It’s worth noting that both the Obama administration and Senate Finance Committee proposals to reduce hospital admissions tackle this problem by combining episode-based payment policies with a penalty for hospitals that have higher-than-average readmission rates or by failing to pay hospitals that have avoidable readmissions.<sup>11</sup> Critics of episode-based payment also claim that the approach does nothing to encourage care coordination beyond the episode of care, keeping the delivery system fragmented.<sup>12</sup> And there is a risk that providers could be motivated to cherry-pick healthier patients for procedures in order to minimize risk and maximize revenue.

### ***Global Budget Model***

The global budget model is a variation of episode-based payment. Payers cap the total amount that they will pay a participating facility or practice to cover multiple episodes of care for multiple patients over a period of time, regardless of an unanticipated increase (or decrease) in the need for services or in the case of public programs, a surge in enrollment.<sup>14</sup> The objective of a global budget is to limit costs. The best known use of a global budget is in government-structured payment systems, such as the way Canada pays hospitals. In the United States, one recent example of the global budget model is the five-year block grant Rhode Island received to care for its entire Medicaid population.<sup>15</sup>

One benefit of the global budget approach is that it introduces predictability into government and other payer budgets, particularly when it is coupled with the regulation of provider payments, as in Medicare or Medicaid. As with episode-based payments, though, a

## **Episodes of Care: The Geisinger ProvenCare Experience**

Geisinger Health System is an integrated health organization in central and northeast Pennsylvania. Geisinger began redesigning its payment systems by launching an episode-based care model for patients receiving heart bypass surgery. They calculated the total cost for all of the pre-operative, post-operative and rehabilitation services associated with the surgery and paid providers this price. The program – called “ProvenCare” – was also combined with systems to ensure that doctors were following best clinical practices for the surgery. As a result of implementing this program, there was a 21 percent reduction in all complications from the surgery, a 25 percent reduction in surgical site infections and a 44 percent decrease in hospital readmissions. Geisinger has since expanded this program to other episodes of care such as hip replacement surgery, cataract surgery, obesity surgery, prenatal care for babies and mothers, and heart catheterization.<sup>13</sup>

global budget model does not inherently include incentives that encourage providers to offer high-value care. Because cost is the overarching concern, services might be reduced or slowed to meet budget restrictions, limiting patients' access to care.<sup>16</sup> In government-structured systems, funding a global budget also relies on maintaining political will, leaving consumers vulnerable to cuts or without access to services in times of fiscal distress or economic downturn, when higher numbers of people tend to enroll in state-sponsored programs.<sup>17</sup>

### ***Paying Per Patient***

The global payment model moves beyond episode-based payments by bundling payment at the patient level to effect better coordination of care.<sup>18</sup> As it is currently being discussed, this model anticipates a team-based approach to care by paying providers upfront fixed payments per patient, per month or year, to coordinate and order the full array of services a patient may require. Full global payment would integrate care across traditional primary, specialty and hospital lines and include behavioral, social and non-medical services as necessary to improve the patient's health.<sup>19</sup> As an intermediate step, partial global payment would cover a subset of these services with more predictable costs. In stark contrast to FFS, providers in a global payment model are fully responsible for managing all of the costs associated with their patients' health and care, from well visits and routine preventive services to treatment for acute conditions. Global payment models can also be structured so that providers may share in any savings.

Proponents of the global payment model argue that it motivates providers to give high quality care because they are liable for costs that exceed their fixed payment rates and for failing to meet performance measures related to health outcomes. Critics counter that global payment is simply a recasting of the capitation methods that rose to prominence during the heyday of managed care in the 1990s, and then fell into disrepute because many felt that medical decisions were being made to maximize insurers' revenue, not to improve quality of care.

The evidence favoring one or the other of these views is mixed. Nevertheless, the idea of structuring payment to motivate coordinated, patient-centered care has promise, provided a global payment system includes features that discourage cherry-picking and limiting access to care. These include payment adjustments to reflect factors such as a patient's age, frailty, and severity of illness (methods for these adjustments have improved significantly since the 1990s), close regulatory oversight, and public reporting of quality and other performance measures.

One of the challenges of a global payment model is that it requires significant investment in data systems, restructuring delivery systems, and financial arrangements to shield providers from excessive risk. Since most delivery systems are not currently set up to handle the complexities of integrated, coordinated care, it may be necessary to work towards global payment in incremental steps (see 'Incremental State Approaches to Payment Reform: The Massachusetts Transition to a New Payment Model' on page 11). For example, payment could be "blended" to allow systems to achieve more incremental reforms: that is, payment for a portion of services would be fixed, while additional, "non-fixed" payments – for behavioral health care or prescription drugs, for example – would be given to providers as they become able to meet additional standards or provide additional services.

## **Supportive Strategies**

### ***Pay-for-Performance***

The pay-for-performance (“P4P”) concept can be used in conjunction with other payment models, including fee-for-service or global payment. The goal of P4P is to improve quality of care by giving additional incentives such as enhanced payments, public recognition or referrals to providers who demonstrate a desired improvement in the health of their patients or in how they deliver care.<sup>20</sup> P4P arrangements have rewarded doctors and hospitals for:

- Using a recommended care process or treatment for a particular condition
- Demonstrating that patients have improved health outcomes or express satisfaction with the care they receive
- Meeting cost or quality benchmarks or increasing efficiency within a practice
- Using electronic health records to track patient care and outcomes
- Developing systems to coordinate patients’ care

Most payers, including private insurers and state Medicaid programs, already incorporate P4P in some way, but recent studies of P4P programs show mixed success in improving health care delivery and outcomes. Some experts think P4P may be hampered by low payments or by structural problems such as a lack of coordination or inability to share data across care delivery sites.<sup>21</sup> Different payers use different benchmarks, making it more difficult for providers to meet them all simultaneously.<sup>22</sup> Lessons culled from a 2007 study of Massachusetts P4P programs seem to indicate that P4P tends to work better where medium-to-large physician groups are common; where groups are able to share data; and where the focus of the P4P effort is aligned with other quality improvement strategies such as public reporting of quality measures.<sup>23</sup>

### ***Provider tiering***

Provider tiering refers to a strategy increasingly used by health plans to direct their members into physician networks that tend to perform well in terms of cost and quality. Health plans analyze data to determine which physicians are providing the highest quality care, and then designate or “tier” these providers as “high performers.”<sup>24</sup> Choosing a provider from a designated high-performance network will lower a member’s out-of-pocket costs, while choosing a provider from a lower-performance network will increase them. The concept was developed in part to sensitize employees to the true costs of providing health care by requiring employers and employees to share additional financial risk for choosing lower-value, higher-cost providers. Preliminary studies raise questions as to whether tiering influences consumer decisions about providers; whether insurers also secretly tier providers based solely on costs; and whether it has reduced access to services in underserved areas.<sup>25</sup>

### ***Evidence-based purchasing and benefit design***

Evidence-based purchasing and benefit design are coverage strategies that encourage providers to use treatments and services shown by rigorous research to be the most effective. Typically, insurers cover these services more comprehensively and pay more for them. The objective is to prevent misuse or overuse of services that do not provide proven benefit to patients.<sup>26</sup> One current example is the move some states are making to encourage evidence-based prescribing of drugs by sending unbiased experts to educate doctors.<sup>27</sup>

Evidence-based purchasing is not yet widely used in setting payment policies.<sup>28</sup> Impediments include a lack of scientific evidence, particularly evidence specific to



certain populations (e.g. minorities, women, children), lack of patient advocacy for evidence-based medicine, demand for services based on excessive supply or advertising, and a concern that evidence-based medicine will lead to rationing or denial of patient care.

### ***Sharing savings with providers***

Another way to create incentives is to allow providers to share in any savings they create from providing better-quality, more cost-effective care.<sup>29</sup> Payers and providers negotiate a rate for payment. If providers are able to provide care for less than the negotiated cost, the payer shares those savings with the provider. Payments are made after care is provided and can be tied to achieving quality benchmarks or outcome measures.

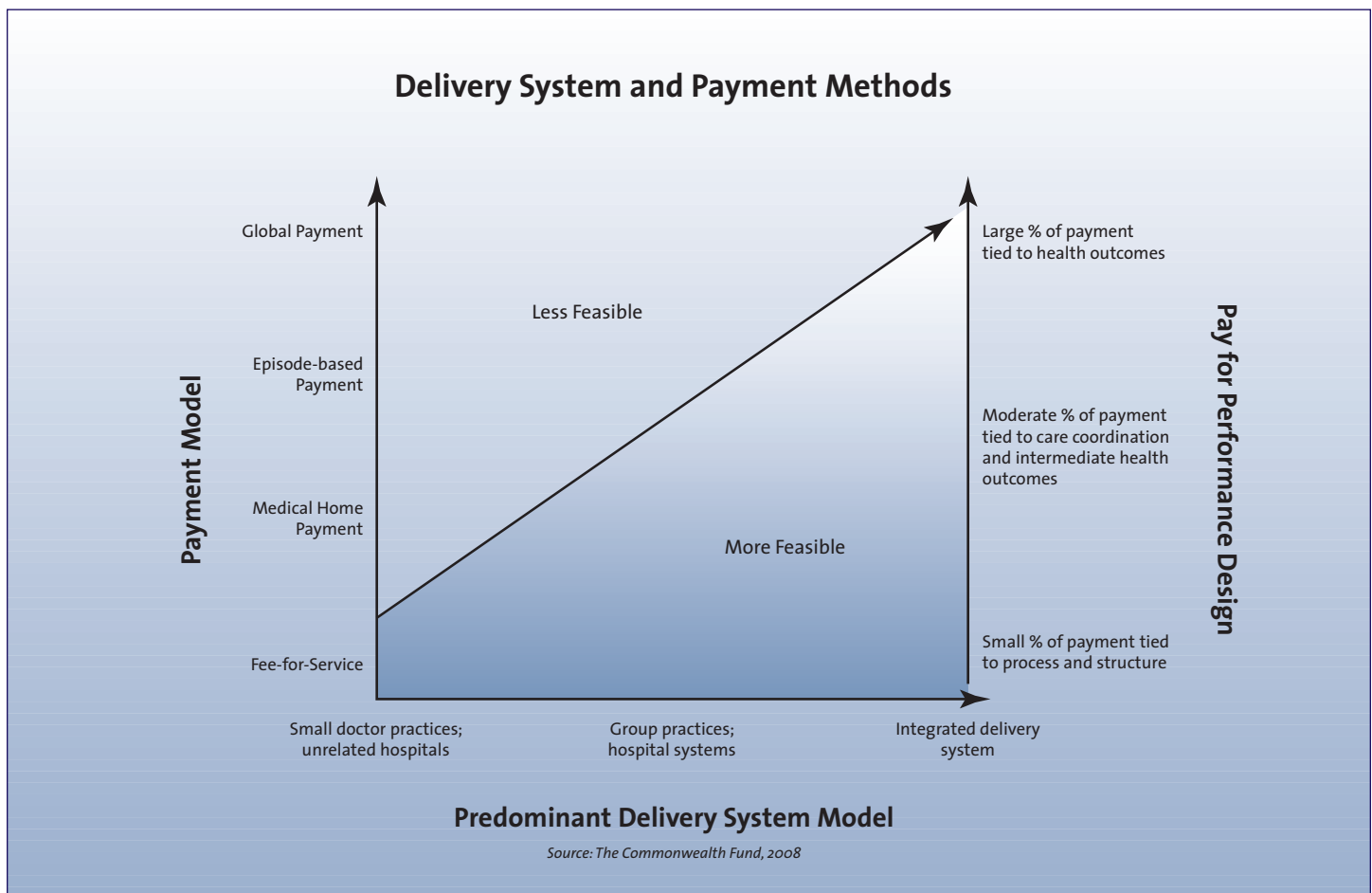
## **Evaluating Payment Reform Proposals**

Each of the models described in this brief has pros and cons. Many have not been broadly implemented or fully tested and thus require consideration of several issues. First, changes in the way health care is paid for will likely require a companion change in the way health care is delivered. Because most of our health care system is organized to pay providers based on FFS model, any move away from that model would need to be accompanied by structural changes to the ways providers interact, coordinate care across settings, and share information. This, in turn, would translate into a difference in how patients receive care. Moving away from a strict FFS model requires making some investment in reforming delivery systems and reaching out to providers, consumers, and payers. Without agreement from these key groups, delivery system reform – and, consequently, payment reform – is unlikely to succeed.

Second, payment models involve tradeoffs. For example, the same model that gives providers the most discretion in ordering services (for example, FFS) has also been singled out as a root cause of the overuse of expensive procedures and technology.<sup>30</sup> Conversely, other models that cap payments to providers as a means of refocusing resources on preventive medicine and care coordination may create incentives to limit care or “cherry pick” patients least likely to require expensive care. It is important to recognize the negative incentives each payment model creates, minimize those incentives from the outset to the greatest extent possible, and create regulatory or monitoring approaches as a secondary strategy to counteract them.

Third, because delivery systems vary so widely across the country, there is no single model that will work everywhere. For example, a state with many small practices and very little managed care will not likely be able to move quickly to a global payment model. On the other hand, a state with advanced, integrated systems of care can easily transition to a variety of payment bundling models. Similarly, delivery systems in rural areas of the country which rely on a limited number of small community hospitals and a low concentration of doctors will likely require a different approach from those in urban areas that host large academic hospitals and a number of doctors in many specialties. Figure 2 (see page 9) illustrates the interplay between the type of delivery system and the payment model.

Figure 2



To best serve patients, a payment system should promote the following goals:

***Improved health outcomes***

Any payment system should include incentives to measurably improve the quality and safety of care, especially as patients transition between settings, such as from hospital to home. Measures of improved health outcomes might include a reduction in the need for nursing home services, an increase in the ability to live independently and a reduction in preventable hospital readmissions.

***Increased reliance on primary care***

A payment system should support a delivery system anchored in primary and preventive care, which promotes better quality and lower costs.<sup>31</sup> Every patient should have ready access to a primary care provider who is paid and held accountable for gauging the patient's needs and organizing and coordinating care across the full spectrum of services. The goal is to deliver the right care, in the right setting, at the right time, and to engage patients and their caregivers in developing their care plans and managing their health. This type of care requires a significant investment in building and training a primary care workforce, both professional and paraprofessional. And it requires a system that adequately pays for high-quality primary care.

### ***Improved coordination of care***

Improving the quality of care also requires paying for certain formal clinical and organizational features that allow providers to better coordinate their patients' medical care, as well as connect them to the behavioral and community-based supports they need.<sup>32</sup> These supports might include employing people to help patients navigate the system, ensure they understand hospital discharge instructions and assist them with referrals to specialists or community services. Another important factor in the coordination of patient care is information technology that allows data-sharing and communication among providers.

### ***Accountability***

Better payment systems offer incentives to providers for giving their patients access to the right care, in the right place and at the right time. In addition to the performance measures related to health outcomes and coordination of care, it is essential that payment systems build in measures of patients' and caregivers' experience of care. And, to provide an additional measure of accountability, regulators should have authority to impose financial penalties on providers that game the system by taking only healthy patients or withholding treatment from sicker patients

### ***Patient-centered payment***

Payment should be based on what is needed to get or keep a person healthy, not on how many services a physician orders without regard to their effectiveness. To correct for the additional risk providers take on in caring for patients with complex needs in a system like this, there must be a rigorous method to adjust payments for differences in factors such as a patient's age, frailty, and severity of illness. Proper adjustment for these factors makes possible higher payments for patients with complex problems but not for overuse of unnecessary services.

### ***Patient and family education and empowerment***

Payment methods should encourage providers and plans to provide care that is oriented to a patient's needs and circumstances. It should account for the entire continuum of their needs, including mental health, primary care, acute care, chronic care, community-based care and self care. The system should incorporate into payment rates the time providers take to work with patients and their families to develop, implement and adjust a care management plan. In addition, a payment system should encourage patients and their families to learn more about their conditions, what to watch for, and how to manage them. For instance, a payment system might allow for extra payments to delivery systems that offer innovative programs such as the Stanford University Chronic Disease Self-Management Program that effectively teaches patients how to take control of their lives and cope with a chronic illness, thereby helping to lower the costs of their medical care.<sup>33</sup> Finally, a payment system might also offer incentives for plans and providers that actively seek patient and caregiver assessments of their care and make improvements based on those assessments.

### ***Transparency***

Any payment system should be completely clear to all patients, providers and payers. In particular, patients should have access to information about how providers are paid, how quality is measured and what incentives may be affecting the type and amount of care they receive. They should also be able to review any evaluations of care provided under the system. This type of transparency will not only benefit patients but will generally prevent providers from gaming the system in order to receive higher payments, ration care or treat only healthier patients.

## Consumer Advocate Roles

Consumer advocates have an essential role to play in state and national debates over payment reform. The debate is typically dominated by others, primarily providers, insurance companies, businesses, hospitals and government. Only consumer advocates bring the unique perspective of patients and family caregivers, however. Because those with complex health care needs – people with chronic illnesses or disabilities, seniors and people eligible for both Medicaid and Medicare – are most affected by changes in the way that care is organized and paid for, it is particularly important that their interests be represented.

### *Place cost/quality on the reform agenda*

Consumer advocacy organizations focused on expanding health care coverage must give some attention to payment reform. Any plan for access expansion will need to address improving quality, and reducing costs as well to help make increased coverage sustainable. Accomplishing these goals will require new payment systems that motivate changes in provider and patient behavior.

For example, after the landmark universal health care coverage law was enacted in Massachusetts, Health Care for All (HCFA), the leading statewide consumer health advocacy organization, quickly pivoted to focus on issues of quality and cost as a means to pay for the coverage reforms. Among the measures the group promoted was the creation of a payment reform commission to examine and propose new payment systems. With input from meetings HCFA convened between consumer advocates and commission representatives, the commission ultimately recommended a statewide move toward a global payment system to replace the predominantly FFS system.

## Incremental State Approaches to Payment Reform: The Massachusetts Transition to a New Payment Model

To guarantee provider and consumer buy-in, advocates for payment reform must articulate both visionary and realistic principles. While it may be ideal to move immediately out of a FFS model, it may not be feasible to do so. For example, Massachusetts' Special Commission on the Health Care Payment System recently concluded a six-month process aimed at developing ways to restructure the payment system to reward "efficient and effective patient-centered care" while reducing variations in cost and quality. Because the Massachusetts payment system predominantly operates on a FFS basis, the commission recommended a five-year transition to a global payment model. The commission also recommended creation of an oversight board to guide implementation, including setting criteria for "accountable care organizations" (ACOs) that would receive the global payments. ACOs, which are health care delivery systems made up of doctors, hospitals and specialty providers, would integrate and coordinate care for their patients and share in the financial risk of caring for them. The board would also set milestones for the transition, monitor progress and make mid-course corrections as needed.<sup>34</sup>

### *Talk to policymakers and the public about programs that are working*

There are a variety of programs throughout the country that are improving patients' quality of care at a lower cost. Most of these efforts include new and innovative methods of paying for care. By understanding these programs and the payment incentives they use, advocates will strengthen their knowledge and can bring valuable information from the community level to state and federal policymakers. To start the process, advocates should learn from their constituents about the programs and providers that are effective locally. It would also be valuable to partner with senior, disability, family caregiver and chronic disease organizations to strengthen their knowledge and, ultimately, their position in the payment reform debates.

Using this information, advocates can build stronger alliances with the organizations that operate the innovative programs to improve the chances of achieving payment reform that serves patients' and caregivers' interests. In Oregon and Ohio, for example, consumer health advocates engaged state-based health plans serving Medicare beneficiaries who are dually eligible for Medicaid in conversations about how to improve the delivery of care to their members. These relationships will help advocates influence payment reform debates.

In states with few, if any, payment innovations underway, advocates may consider building on existing systems of care. For instance, community health centers, which currently serve as essential components of many states' health care safety net, have founded a number of innovative health plans across the country and may serve as models for payment reform. For

example, the Association of Community Affiliated Plans (ACAP) membership includes plans with strong ties to community health centers.

### ***Communicate the need and opportunity***

Talking about delivery system change and the payment reform needed to support it is complicated. But public opinion research on system change<sup>35</sup> offers some guidance:

- People think about system changes in personal terms and consider how change will affect their relationships with their doctors and the quality of their care
- Voters say health care is good if they have a choice of doctors and plans, and if they can afford their health care
- People believe any changes to the system should help doctors provide the best care to patients and simplify the system for all

Advocates should convey to the public that changing the way care is delivered and paid for will:

- Help your doctor more effectively care for you
- Slow growth in costs to make health care affordable and sustainable
- Allow for affordable access for all<sup>36</sup>

Advocates can also identify people who are benefiting from payment models like those described or who are suffering from a lack of coordination or poor health outcomes and could benefit from a payment system that uses the principles articulated. These individuals can provide powerful stories that offer moral and practical grounding for a payment reform campaign; they can also be trained to become advocates.

## Conclusion

We can improve the quality of health care and slow the growth in its cost by changing the way we pay for care. Payment models that focus on patients rather than treatments, if thoughtfully and carefully implemented, can shift incentives to reward efficient, effective care, rather than the number of procedures. Variations of such systems already operate across the country and can serve as models for broader statewide or national payment reform. Consumer advocates can help ensure that payment reform benefits patients by understanding the strengths and weaknesses of different options, and insisting that patient-centered principles guide reform.

# Endnotes

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- <sup>7</sup> See, e.g., Whelan and Feder at 6.
- <sup>8</sup> See Whelan and Feder at 9. See also Bodenheimer, T. (2006, August 31). Primary care: Will it survive? *New England Journal of Medicine*, 355(9):861-864.
- <sup>9</sup> See Whelan and Feder at 16.
- <sup>10</sup> See Episode-based payment: Summary, at 2-3. Mathematica Policy Research, Inc. Retrieved July 28, 2009 from [http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/2009\\_02\\_24\\_Episode-based\\_Payment-C1.pdf](http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/2009_02_24_Episode-based_Payment-C1.pdf).
- <sup>11</sup> Whelan and Feder at 20.
- <sup>12</sup> See Whelan and Feder at 18-19.
- <sup>13</sup> See Steele, G. (2009, April 21). Reforming the healthcare delivery system. Testimony of the President and Chief Executive Officer of Geisinger Health System before the U.S. Senate Finance Committee. Retrieved July 28, 2009 from <http://finance.senate.gov/hearings/testimony/2009test/042109gstest.pdf>.
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<sup>23</sup> Ibid.

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