TRANSFORMING HEALTHCARE: RECOMMENDATIONS FOR PAYMENT REFORM

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INTRODUCTION

The Center for Health Transformation extended an invitation to its members to participate in a work group to develop tripartisan solutions to what we felt was a key driver in creating a system that delivers better health at lower cost.

Nearly forty of our members, representing very diverse stakeholders in the healthcare system accepted that offer, an offer to invest their time, energy and creativity to create real change, change that might have a profound impact on their organizations.

We convened the work group for our first meeting held in Washington, DC. We engaged Rita Numerof, PhD, CEO of Numerof & Associates, Inc. to work with Julie Eckstein, VP Center for Health Transformation (CHT) to lead this ambitious body of work.

The initial meeting set the stage for the work with opening comments from Former U.S. Speaker of the U.S. House of Representatives Newt Gingrich, founder of CHT, who gave the call to action. He shared his experience that very often in the legislative process, elected officials have heard the problems loud and clear from constituents or interest groups, but they have not been offered, nor created themselves, the solutions for those problems. It is this vacuum that the work group must fill; this absence of a solution or set of solutions that must be developed. The group accepted that challenge.

After being presented with a vision of a new reality that represented an "ideal world," albeit without total agreement, the group spent time discussing that vision and the barriers that exist to prevent it from becoming reality. The outcome of those very rich, thoughtful and somewhat intense conversations and debates fell into six themes for the work ahead. Those themes laid the ground work for a set of six strategies that later emerged.

At the second formal gathering of the group, Former U.S. Senate Majority Leader Tom Daschle opened the meeting by sharing his view of the current reality and his vision of what reform could accomplish and needed to accomplish. His remarks and the ensuing dialogue were refreshingly similar to the comments from Speaker Gingrich. There seemed to be amazing agreement on the challenges and areas in which the solutions would be found. We must note that each participant may not agree with each of the recommendations in this document. That is to be expected with such a complex challenge.

Next steps for the group were to take the strategies identified and drill down to potential tactics, specific steps to help reach our goals and cross the bridges that would otherwise be barriers to the needed transformation. During that meeting and subsequent small group meetings, calls and emails, a robust set of recommendations emerged. After numerous edits, the document we present here is the first step in our goal to realign the incentives to reach a more rational system.

Americans deserve and demand a system that provides them better health, better care, better outcomes and better transparency, with much less expense, less waste, less bureaucracy and less complexity. As Senator Daschle so simply and accurately stated, “we must pay for value, not volume.”

The Center for Health Transformation is very grateful to everyone who participated in this effort. Knowing this is not the end but rather the beginning of what is needed to create a better payment system, we look forward to continued work together to achieve better health at lower cost for all Americans.

I: BACKGROUND AND CONTEXT

As our national debate over healthcare reform continues to rage, even after the passage of "The Patient Protection and Affordable Care Act" there are some things most people agree upon. Most Americans agree that our goal should be better overall health and better care outcomes at lower costs. Nor is there much disagreement that the way we pay for healthcare currently doesn't provide the right incentives or financial framework to support progress toward these goals. The current system of payment seldom rewards physicians and hospitals for improving quality or lowering costs. Instead it often unintentionally encourages the maximum use of resources and fails to reinforce prevention and wellness. Across both the public and private sectors there is growing recognition that *this is an unsustainable business model.* Something has got to change.

Understanding Healthcare Reform as Business Model Change

Healthcare is not the first industry to face the need for a fundamentally different business model. All industries go through periods of such transition as a result of changes in their regulatory environment, competition, technology, or needs of the consumer. These times of transition are very difficult. They force *all* stakeholders to rethink their business models and challenge fundamental assumptions about their markets, who their customers are, what products and services they should offer, and how they should bring them to market.

This transfusion of fresh thinking requires an *external analysis* of customers … in this case healthcare consumers … to identify *truly unmet needs*. Such analysis must go well beyond studying the potential demand for services *as they are defined today*. For example, hospitals must go beyond simply studying the demographics of the population in the geographic area they serve and projecting demand accordingly. The real unmet need that's ignored in this approach is the fact that most people don't want to go to a hospital. Yet if hospitals focus on keeping people healthy and keeping them out of the hospital, under our current payment model, they risk putting themselves out of business.

Underlying the development of a new business model is the need to identify a better value proposition. The healthcare industry has historically been focused on a *clinical* value proposition without consideration of associated costs.

Health outcomes in the hospital setting, for the most part, have only been measured in terms of gross mortality and morbidity rates associated with given procedures. The industry has experienced a surge of innovation, providing more and better treatment options – but at increasingly higher costs. Missing in the current fee-for-service payment method – which assigns an economic value procedure-by-procedure – is any analysis of *total economic and clinical value* over a continuum of care. This is the essence of trying to achieve better outcomes at lower cost – the objective of healthcare reform. We must move from volume to value.

Once unmet needs and new economic and clinical value propositions are identified they must be operationalized. Creating a new business model requires developing new *infrastructure* – defining new mandates for core functions, developing new capabilities and supporting processes. This is enormously hard work and, not surprisingly, it often meets with great resistance. Reform efforts usually recognize this potential resistance and appropriately work to include all stakeholders in business model redesign. Stakeholders, predictably and to some extent justifiably, come to the table to protect their current interests first. Change is fine, as long as it happens to someone else!

Effective new business model implementation will require an integrated approach that surfaces and resolves sources of resistance as well as unintended consequences. Every segment of the industry - - from pharma, to device and diagnostics manufacturers, to payers, providers, employers and consumers - - will need to come to terms with the fundamental changes that will be required - - or we face the real possibility of destroying what works in the industry.

The Central Role of Payment Reform

There is general agreement that the healthcare financing mechanisms in place today *do not align* with the goals of disease prevention, improved health outcomes, and reduced costs.[1,2,5,7,8,12,16,17,23,26,29,30,31,33,46,52] Changing these mechanisms starts with different and better answers to four key questions:

1. Who pays?
2. How does the payment exchange occur?
3. What gets paid for?
4. And, at the end of the day, is it worth it? (Are we getting value for what's delivered?)

The changes necessary to better answer these questions must be made systemically. They must affect all stakeholders, including payers, providers, manufacturers, employers, government, and consumers. Each must make changes in an orchestrated, coordinated, and integrated manner, or the changes won't be effective.

Whenever change is introduced, there are *always* unanticipated and unintended consequences. Uncoordinated "islands" or "siloed" approaches to change increase the likelihood of such unintended consequences. As change is introduced in one area, there are ripple effects as the change begins to impact other areas. There are two examples that clearly illustrate this point, and they are central to understanding the healthcare challenges we're facing today.

Unintended Consequences – The Hospital Example

Paying for volume, not results

Hospitals today are paid on a production basis reflecting what they 'do' to people. There is no incentive to keep people out of the hospital. They are only paid when people are admitted to the hospital. Increasing volume is good in this business model. The more patients and the more procedures, the more money they make. Misaligned incentives have put hospitals in the *sickness* business, not the prevention or wellness business. As one hospital CFO said, "I'm not investing one dime in wellness … it doesn't pay the bills. And I don't think it ever will!"

Coming from an acute care, sickness business model, it's hard for many hospital administrators to conceive of anything else. Success for hospitals has meant more procedures. Since someone else was paying - - a third party insurer or employer in most cases - - increasing costs didn't really

matter - - until recently. As a nation we are getting exactly what we pay for, exactly what the system is designed to do and exactly what we can no longer afford in terms of health outcomes and cost. The design is flawed.

The real impact of CMS on quality of care and costs

It's ironic that the first time the healthcare delivery industry took costs seriously was when CMS (Center for Medicare and Medicaid Services, which administers both programs) introduced DRGs (diagnosis related group pricing) as an alternative to the traditional retrospective method of UCR (usual and customary rates) payment. This was a well intended attempt to impose cost controls in a situation CMS recognized wasn't sustainable.

Hospitals were incented to improve their "efficiency," since any difference between their actual costs and their DRG reimbursement was "profit" – or "loss". Few anticipated that the way in which they would choose to lower costs would result in many of the serious quality issues and increased costs we face today. Hospitals began focusing on increasing demand and capacity to handle more procedures to offset lower revenues per procedure. As a result, many hospital executives estimate that 30-40% of the care delivered today isn't clinically necessary. And these estimates are from people managing some of our nation's best institutions.

CMS' introduction of DRGs as a means to control costs was based on an assumption that hospitals would *ensure quality* as part of any change. Unfortunately that hasn't proven to be the case. As noted in he cover story of the September 2009 issue of "Consumer Reports"[40], many hospitals aren't as safe or as sanitary as they should be - - something insiders have known for years. In a side-by-side survey of nurses and patients two very different perspectives emerged:

- 28% of nurses saw problems with hospital cleanliness while only 4% of patients saw problems
- 38% of nurses said that care wasn't coordinated properly compared to 13% of patients
- 26% of nurses said that hospital staff sometimes did not wash their hands while only 5% of patients had this observation

In their efforts to cut costs, many hospitals partially dismantled the infrastructure they needed to ensure quality. They slashed the ranks of first line and middle management, seriously compromising their capability to build, monitor and correct quality processes. As a result, an *unintended consequence* of CMS' effort to control costs is that consumers now face a significant risk of getting sicker in a hospital rather than better.

This unintended consequence of the DRG approach to cost control has more recently led to yet another band-aid. CMS has informed the industry that it will no longer pay for so called "never events" – preventable errors, medical problems that they created or should have avoided, such as hospital acquired infections, medication errors, or falls.

The premise is that if hospitals are responsible for paying for their errors they'll make sure that errors are prevented. What's now being discussed and is reflected in the current law is the idea of refusing to pay for 30-day readmissions for the same diagnosis. The intent is to force better discharge planning and coordination with community services, which was once the hallmark of many healthcare delivery organizations under "usual and customary rates," but not cost effective under DRGs.

Lost in this series of CMS band-aids is the fact that healthcare payment is mired in minutiae that in and of itself is contributing to the cost problem. The implementation of DRGs was a cost-accounting approach that has actually spawned a whole new industry to help providers figure it out in order to get paid. Care providers are spending a considerable amount of resources coding their interventions for maximum reimbursement; time that could be spent with patients. In addition to introducing a complexity that has increased administrative costs, this payment method has also completely disconnected payment from outcomes; care provided and outcomes achieved is what the money is meant to buy. A sub-industry devoted to maximizing reimbursement per case has also been spawned as providers learn to upcode in an effort to maintain revenue.

The unanticipated consequences of DRGs illustrate what can happen when changes are introduced as isolated actions rather than as a series of integrated steps across stakeholders. Instead of controlling costs, this change in payment has triggered additional administrative costs, a deluge of unnecessary care, and an erosion of quality of care – all unintended consequences that have significantly added to the costs of healthcare rather than reduce them.

Unintended Consequences – The Primary Care Example

Consider the circumstances of an independent primary care doctor who shared his story. He is an internist who is extraordinarily proud of his ability to help his patients manage their chronic disease – asthma, diabetes, various cardiac problems, etc. The more complicated the case, the more he gets to serve as "medical detective"! His patients appreciate him because of his thoroughness, and because he so effectively diagnoses and helps them manage their conditions, in contrast to their

usual physician experience. As a result, they maximize their quality of life, avoiding complications, unnecessary hospital visits, and multitudes of specialists.

He takes the time to ask questions and diagnose the root cause(s) behind his patient's symptoms, utilizing expensive diagnostic tests only when necessary. He uses visits to educate his patients, guiding them to better manage their health to avoid preventable healthcare interventions if their condition progresses. He coordinates care among needed specialists to whom he refers his patients … when he's determined he really needs their consultation.

Discouraging the type of care that results in better outcomes

Unfortunately, this primary care physician is penalized in our current payment system, yet his behavior is exactly what's needed to lower costs and improve outcomes! His time to educate patients isn't reimbursed. Or, if he codes for an extended visit to recoup his legitimate time spent, his claim is much more likely to be noted by an insurer as an outlier … either rejecting the claim outright or resulting in delayed payment. Unfortunately, his behavior is not typical of primary care today. It is a much easier path for the primary care doctor to pass his patient on to a specialist, reducing his liability, and in the process increasing costs to the system.

Once again, approaching the work of primary care physicians on a piece work basis has resulted in the unintended consequences of both increased costs and reduced quality. To sustain a viable income, primary care physicians have focused on maximizing the number of patients they see rather than spending the amount of time necessary to guide their patients and orchestrate their necessary care. As a result, more expensive specialists are utilized unnecessarily. Care is fragmented and uncoordinated between doctors, increasing the likelihood of errors and the redundant use of expensive tests.

Creating a critical shortage of the "right" kind of doctors

Beyond the negative cost and quality impacts of the way we're paying primary care physicians is an even larger problem. Just as we're realizing the critical importance of primary care to achieve improved outcomes at lower costs, we're facing a severe shortage of primary care physicians. Why does this shortage exist, and why is it currently projected to get more severe? Quite simply, the answer is financial. There is little incentive today for graduating medical students to choose careers in primary care. Since primary care doctors are the lowest paid of all physicians, graduating medical students with thousands of dollars of school loans are

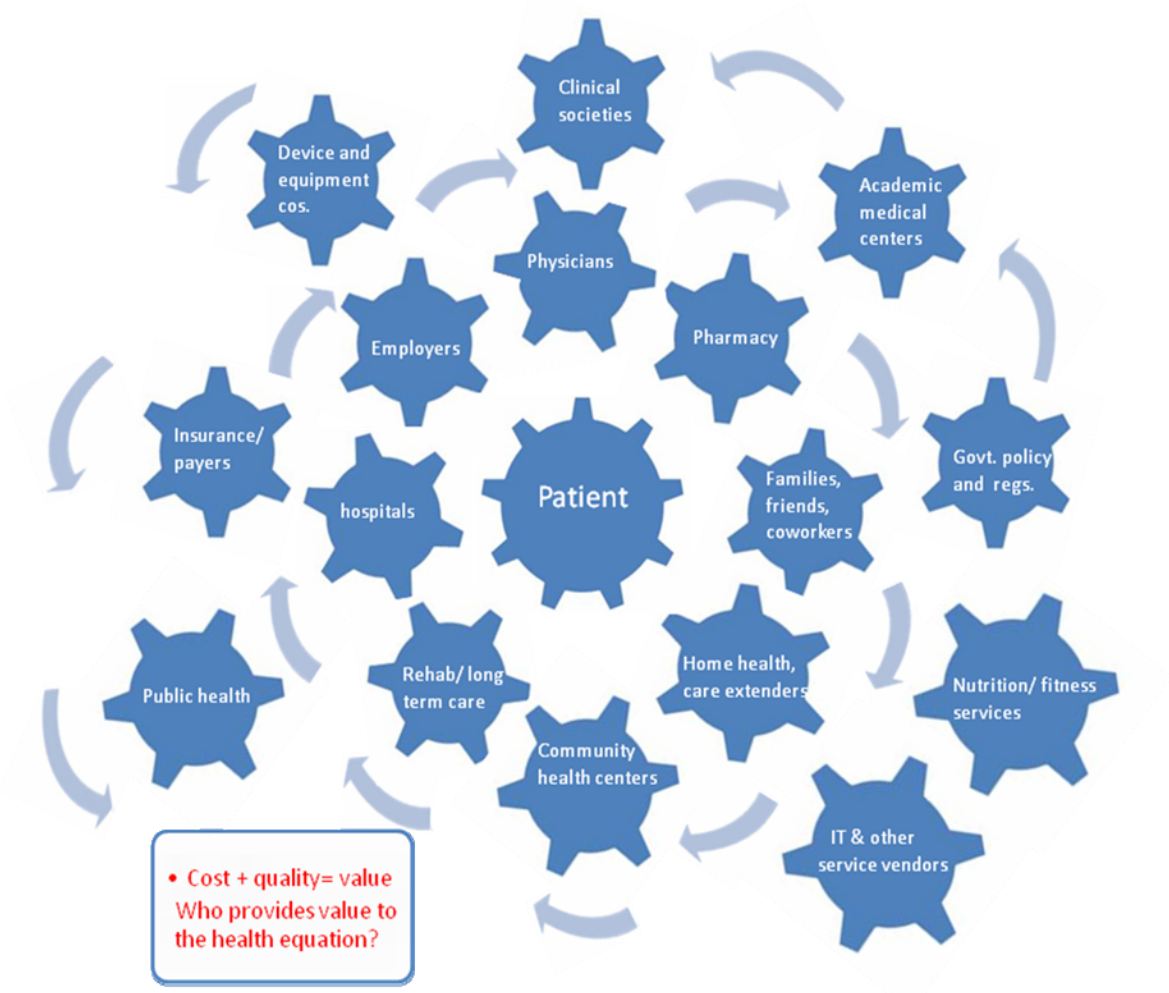
choosing primary care with much lower frequency. Only an astounding 2% of internal medicine residency graduates choose to stay in general internal medicine.[34] The rest opt for the more lucrative subspecialties in which they are paid to do procedures such as cardiac catheterization and endoscopies. Medicare and insurance companies pay much more for procedures than the intellectual capability of primary care physicians to diagnose, provide and coordinate care … which can often obviate the need for expensive procedures!

As noted by the Center for Payment Reform, "payments should create market incentives that foster an adequate supply of clinicians to meet the needs of an aging population and to ensure that all patients have access to high quality and affordable healthcare services. Particular specialties for which there have been market failures include: comprehensive primary care, including geriatrics; other generalist physicians, such as general surgeons; and mental health providers. Creating market incentives will require that we more highly value primary care functions related to evaluation, counseling and coordination relative to the value of procedural, diagnostic, and interventional care."[11,12,15]

Healthcare is BIGGER Business

The hospital and primary care physician compensation examples just described illustrate the failure of uncoordinated, isolated efforts to make improvements and the unintended negative consequences they bring. Any realistic effort to create an improved business model for healthcare must comprehensively address the extraordinarily complex array of multiple stakeholders involved with the consumer's needs - the central focus, as illustrated in Figure 1.0 below.

Figure 1.0 – Healthcare Stakeholder Clusters



Successful business model change must anticipate and plan for the fact that each of these stakeholders has an agenda, and a vested interest in maximizing it. In such a market environment, incentives must be aligned. Creating a new business model to improve care and reduce costs must be approached systemically, integrating changes across and within the parts so that the intended solutions work together. However, there may be winners and losers.

Considering our current national economic stress and the level healthcare costs have reached -- estimated at approximately one sixth of GNP (Gross National Product) -- it's understandable that many want to look for someone to blame. Certainly it is politically expedient to single out private healthcare insurers or drug and medical device manufacturers as primary causes of our cost problem. Looking for a scapegoat (and forcing change only in that area) is the wrong answer, and would just repeat the isolated, band-aid approach to fixing the system that we've taken in the past.

Everyone's part of the problem … and must be part of the solution

How did we get into this mess? *Every one of these stakeholders plays a role in the current dysfunction, including the consumer.* But each is playing the role our current payment structures have incentivized.

- Manufacturers have focused on clinical value or equivalence as required for regulatory approval, and otherwise largely ignored economic value in their innovation of new drugs, medical devices, and tests. In every other industry new technology has resulted in *more benefit at lower cost*. In healthcare this has not been the case, as payments have not been tied to evidence of economic and clinical value.

- Providers have assumed a production mentality that has resulted in over utilization, uncoordinated care and deteriorating quality. In the absence of payment tied to quality and cost management, the healthcare delivery industry has, to a large extent, failed to change how it provides care in order to improve.

- Consumers' unhealthy lifestyles and poor choices have led to high rates of preventable disease. Yet, the consequences are born by all of us in higher rates to reflect the higher level of services required. In addition, consumers are demanding drugs and procedures whether their physician says they need them or not. Over time, employer-based healthcare insurance, detaching the consumer from directly paying the bill, has eroded any expectation or capability of consumers to make cost-benefit decisions on their own behalf, displacing this with a sense of entitlement for any service they desire. Direct-to-consumer advertising by drug and device manufacturers has taken great advantage of this lack of accountability, encouraging patients in droves to "talk to their doctor" about any real or imagined ailment for which there is a product.

- It would be fair to include physicians in the list, for largely failing to take the time and exert the effort to educate the patients who request drugs based on direct-to-consumer advertising about the pros and cons of the product, and to genuinely evaluate the need and applicability to the specific patient, rather than take the easy way out and write a scrip.

- And in their interests to control costs, payers (especially the government) have devised a payment system that lacks any alignment either with better care or reduced costs. Worse, they have created a new administrative cost burden with a cost-

accounting approach to payment that has spawned a new industry just to deal with the minutiae of detail – totally disconnected from any outcomes healthcare is supposed to achieve.

CMS has chosen to underpay providers by 15-20% relative to market rates and the actual cost of care delivery as its way of managing costs. Because of its massive market power, providers have no choice but to accept this compensation, which naturally leaves them feeling abused. Mandated by law, CMS also has established the business practice of paying promptly and without adequate review the claims received, which, combined with a Byzantine pricing scheme serves as an invitation to game the system through up-coding, which has become too frequent. In some cases this has led to outright fraud.

Private payers have taken the opposite tact. They scrutinize claims, challenging, denying, and down-coding payments. When combined with excessive payment delays, this again leaves providers feeling victimized, setting the stage for rationalization of any tactic they take that allows them to redress the financial limits forced on them.
As a result, the U.S. is paying more than any other country for healthcare, while national epidemics such as diabetes and obesity rage out of control. All stakeholders are contributing to this situation, and all will need to be part of the solution.

The Perversion of the Concept of "Insurance"

Too often in our debate about healthcare reform the distinction is not made clear between saying that Americans have *no healthcare* vs. saying they have *no health insurance*. We have reached a point where the method of financing healthcare has become synonymous with the care itself. In his article for The Atlantic, David Goldhill[28] describes how the concept of "insurance" has become perverted, and the significant impact this has had on healthcare costs.

The need for insurance is obvious. It protects us from catastrophic financial hits. This is why we buy car insurance, home insurance, life insurance, and personal liability insurance. Certainly there is a parallel need for health insurance, considering that we one day may require urgent, extensive care which would cost far more than the average person could expect to finance.

However, health insurance has become different from other types of insurance. For the most part, we are using health insurance to pay for

almost all expenses, not just the catastrophic expenses. We expect it to cover regular check-ups or an antibiotic prescription for a standard sinus infection. If other insurance worked the same way we would expect our auto insurance to pay for oil changes, or our homeowners insurance to pay the plumber to unclog a toilet. If this were actually the case, our auto and home insurance would cost much more than they do today.

How did we get to this point? It started during World War II when employers began offering benefits such as health insurance to attract and keep employees. Then in 1954 Congress passed a law making employer contributions to these health plans tax-deductible … without making the health benefits taxable to employees. This innocuous tax benefit not only encouraged the spread of catastrophic insurance, but also unintentionally encouraged the use of healthcare insurance for all expenses. The snowball continued to gain momentum when Medicare and Medicaid adopted the comprehensive insurance model as the basis for their payments. As a result, today we all believe we need comprehensive health insurance for all care, and that even routine care is too expensive for us to handle on our own. This is quite ironic given the consensus on the importance of healthcare. If so valuable, shouldn't we be willing to pay something for it rather that the current frequent entitlement mentality where I should get it "free?"

The Perversion of IT

In the last administration, health information technology (HIT) began to get attention long overdue. The current Obama Administration hails an investment in HIT, specifically Electronic Medical Records (EMRs), as one of the keystones of healthcare reform. As Todd Park and Peter Basch noted in their May 2009 article for the Center for American Progress,[41] the effectiveness of this IT utilization will ultimately depend on its alignment with a different payment model.

The healthcare industry has already invested significantly in IT. The irony is that much of the use of IT has been focused on getting paid, not on delivering better outcomes. *This represents another unintended cost consequence of CMS' implementation of DRGs* … and a lost opportunity to date of utilizing such technology to achieve better outcomes.

As has been well documented, the current payment system pays for the delivery of services performed, not for the quality of healthcare outcomes achieved. It is a payment system that unintentionally punishes providers for achieving efficiencies such as the elimination of avoidable hospital readmissions and unnecessary care. Not surprisingly, hospitals generally

haven't pressured the companies that provide health IT solutions for products that support significant improvements in care quality and value. Instead, they've wanted IT solutions to help pick codes for billing purposes and document care for malpractice purposes … not often enough for clinical decision support, care path management, and quality performance reporting.

George Halvorson also noted the misuse of IT in a commentary article. "It's sad, ironic, and a bit frustrating that an information-dependent, high-tech profession is relying for the most essential, actionable, context-setting clinical data on scraps of paper that are too often inaccessible and illegible and are always completely inert."[29] He went on in his article to note the thus far missed opportunities to utilize IT to better disseminate the flow of new medical knowledge, to better coordinate care, and to capture and track outcomes in support of evidence-based medicine.

Virtually every other industry invests in and utilizes technology to compete by providing better products for lower cost. Due to how we pay for healthcare, however, the industry has a perverted use of IT. It historically has under invested in IT because there has been no incentive or drive to improve efficiency or outcomes, leaving the government to mandate and finance the investment. Industry's primary use of IT has been to manage the administrative nightmare of getting paid, with little discernable impact on improved outcomes or lower cost … the objectives we have now set for healthcare reform.

This critical IT investment program now underway will fail if it embraces technology adoption for the sake of adoption alone. If this new IT investment is wedded to a strong commitment to provider payment reform and implemented as an accelerator of healthcare delivery innovation, then the investment can help transform U.S. healthcare as we know it.

Creating a Competitive, Functioning Market

Many voices in our current national debate are advising against too much government intervention and the preservation of a natural market.[2,5,7,14,26,30,33,38,44,45,46,52] While this is directionally the right approach, it implies that a functioning market has been at work in the past. Nothing could be farther from the truth!

There is little accountability in the current system

A critical requirement for a functioning market is accountability for the cost consequences of decisions, in this case the treatment decisions between a physician and a patient. Across stakeholders, this accountability is actually very difficult to find, and more the exception than the rule. As we have described, providers and consumers are driving unnecessary utilization that represents unnecessary costs. Quality is slipping but providers expect to be compensated for fixing problems they've created. And private insurers have followed CMS' lead in lock step to create a payment system that encourages over utilization rather than quality and cost control.

As our hospital and primary care physician examples illustrated, when we remove accountability for the consequences of our actions we realize unintended negative consequences. The implementation of DRGs in essence removed any organizational or individual responsibility for cost *and* quality decisions. The doctors who make the decisions generally do not have any stake in the cost to treat their patients – and often have a positive stake in more procedures. This has stimulated a tendency to test more, treat more, and to consume more health services … with little if any incentive to save costs. Not surprisingly, costs have gone up without any necessary improvement in health outcomes.

The consumers who have had employer-based healthcare coverage also do not have any accountability for costs. They have no real line of sight to how increasing healthcare costs have negatively impacted their salary, so they don't even know that they should be participating in an informed way to make decisions that balance cost vs. outcomes. As a result, they have no meaningful incentive to save cost.

A fundamental economic premise has been ignored in our creation of a payment system that has no accountability. *Demand curves always go up as the cost of the product to the consumer goes down; as cost approaches zero, demand approaches infinity - - or at least system capacity - - which drives cost (to payers) up.* Any solution to payment reform will have to build in this currently lacking accountability across stakeholders if the corrective pressures of a natural, competitive market are to be unleashed.

There is little information available on which to base responsible care decisions

If there were incentives for consumers to manage costs, including modifying their own health behaviors, they would demand much better information than the mortality and morbidity outcome data that is still the

most readily available data. Imagine if the auto repair industry competed for customers on such a "mortality and morbidity" value proposition. Repair garages would run commercials advertising that "your car is less likely to never run again if you come to our garage," or "come see us because we're less likely to remove your engine when you come in for a simple oil change!"

As noted by the Health Quality Alliance steering committee,

> "the problem is we do not always know which providers are doing a good job and which are not. It is hard to tell the good from the bad or determine the best value. Unlike most well-functioning markets, there is a lack of consistent information about our fragmented healthcare system that can be used to improve outcomes for patients while keeping costs down. What is needed now is a nationally consistent, technologically sound, and efficient approach to make performance information widely available. You cannot improve what you do not measure. This is why measuring and reporting on performance in healthcare is a vital step in fixing our fragmented healthcare system."[44]

We can more easily 'pull a switch' and mandate performance measures for routine, predictable procedures. We will have to be more cautious and flexible with complex situations, where diagnosis is difficult and disagreements on courses of care can be expected. There is danger in formulaic approaches to all care needs, but this should not preclude establishing standards for more routine, predictable care.

The U.S. healthcare market today – a collection of disengaged stakeholders?

Another critical requirement of a free market is an industry's ability to self-monitor and correct. To this point the healthcare delivery industry has demonstrated an inability to do this. When hospitals should have invested in information technology in order to improve efficiency and effectiveness they didn't do it. Now the industry is playing catch-up with a government mandate to implement electronic medical records.

Providers, who interestingly have to deal with market forces on the expense side (costs of salaries, supplies, equipment, etc.) are forced to live with government set rates for much of the revenue side of their business. Can you think of another industry that experiences such a market imbalance? Providers have historically just passed increasing costs on to payers rather than embed a culture focused on continuous efficiency improvement -- until payers pushed back. The pushback wasn't a collaborative effort to determine new approaches to care that were more

effective and efficient. It was just the dictate of an arbitrary discounted price like any buyer with muscle pushes on its suppliers.

Consumers – encouraged by their employers and insurers long ago – now have a warped sense of entitlement, viewing healthcare insurance as free unlimited care rather than protection against catastrophic financial costs. The solution to payment reform must make the necessary information available and align incentives for all stakeholders to self-monitor, make decisions and act accordingly.

There Is Already Enough Money In The System

Part of our national debate on healthcare reform is whether or not we can afford it. In fact, it is possible to ensure coverage for all without increasing cost, without increasing taxes, without creating increased debt and without introducing yet another government solution.

Based on a report from UnitedHealth Group's new Center for Health Reform and Modernization, "the federal government could save $540 billion in healthcare costs over the next 10 years *if existing, proven programs* and techniques that have improved healthcare quality and slowed the growth of medical spending *are applied more broadly*."[52,53]

A broader look at the entire industry promises an even richer savings potential if common errors and unnecessary services can be reduced. With the proper incentives, we can easily find $500 billion annually that we are unnecessarily spending. For starters:

- According to AHRQ medication errors cost $5.6 million per hospital annually. Across 5000 hospitals that represents *$28 billion* of annual unnecessary cost. (In a recent AHA News article, one hospital was praised for reducing medication errors from 20% to 8%, without acknowledging that more work must be done to further reduce errors to zero.)[50]

- A project to reduce length-of-stay (LOS) at one hospital conservatively estimated an annual cost of $75 million for unnecessary LOS. Considering there are over 5700 hospitals in the U.S.,[4] *better care coordination* and corresponding *reduction in LOS* can easily produce *$380 billion* in annual savings. This must be done, however, without an unintended consequence of readmissions for the same diagnosis, thus increasing overall costs.

- Leading hospital executives estimate 30-40% of the care they are providing is *clinically unnecessary*. Considering over $650 billion of

care is annually provided by hospitals,[4] eliminating 15% of that care (vs. 30-40%) represents an annual savings of *$100 billion.*

- Our CHT book *Stop Paying the Crooks* along with many other experts and media estimate the cost of fraud in our government systems of Medicaid and Medicare in the range of $80-120 billion each year. 48

As we've illustrated, there is at least $500 billion per year that can be redeployed. And this is before we deal with the abuse and fraud in the system. The problem isn't that we're not spending enough, it's that we're not spending it appropriately.

There Is a Solution, and it's Closer Than Some Think

In the process of creating the real change we all desire from healthcare reform, we need to be *really clear* about *what* we're changing and *why* … and what the impacts are likely to be, both intended and unintended. If we introduce change, but we don't address the underlying causes of inefficiency, duplication, and error, we won't solve the problem!

This will require a yet-to-be-developed, integrated strategy and corresponding set of solutions that rest on an understanding of the drivers of our current problems. This integrated strategy must effectively align and implement change across all stakeholders. Isolated band-aids haven't fixed anything, and have actually exacerbated the problem. Successful reform will require a planned and coordinated creation of a fundamentally new business model for healthcare … that aligns the financing mechanisms of the industry with the goals of prevention, improved quality, and reduced costs.

There is an important role for government in this new business model creation, but it is not legislating the new model. We need to change legislation to enable more healthcare insurance competition, a point that was accomplished with the March 2010 law (Patient Protection and Affordable Care Act). With incentives for everyone to have insurance – as we require of car owners – and financial help for those who truly cannot afford it, insurance companies can design and offer solutions to meet the myriad of needs within the construct of a truly American solution. We have enough money in the current system to cover Americans without insurance. Government doesn't need to raise more money with new taxes or more debt.

Finally, we need to make certain that consumers are at the center of our new business model. They need to have real economic and clinical value and meaningful outcome information in order to make good cost/benefit choices. Consumers should not have to be dependent on their employers for insurance if we eliminate barriers in healthcare insurance and create a truly competitive market space.

II. VISION FOR THE FUTURE

CHT Principles – Requirements for a Payment Reform Solution

PRINCIPLES OF PAYMENT REFORM IN A 21ST CENTURY INTELLIGENT HEALTH SYSTEM

By Nancy Desmond, CEO Center for Health Transformation

If our health system is to sustain the challenges of the 21st century, we will increasingly be faced with the reality that we cannot simply make reforms to the system we have today. The answer is not, as some have suggested, to expand the current government bureaucracy, in which individuals have limited power, innovation is slow and fraud abounds.

Instead we have to migrate toward a 21st Century Intelligent Health System that will save lives and saves money for every American.

It is critical that payment reform be based on the vision and principles of such a system.

The Vision

In a 21st Century Intelligent Health System, the individual is the center of knowledge, decision-making and responsibility for their own health. Knowledge of health and knowledge of finances are available in the most accurate, least expensive and most convenient manner possible.

In a 21st Century Intelligent Health System, individuals have accurate, timely, personalized knowledge about their health and treatment options, including information about cost and quality. They have the assurance that their treatment is based on the most up-to-date evidence-based medicine, and there is a focus on preventive care and early intervention.

The system encourages and rewards wise healthcare purchasing decisions and offers more choices of higher quality at lower cost.

By creating a 21st Century Intelligent Health System, we can transform the current problem of inadequate health outcomes – combined with steadily rising costs – into two great 21st century opportunities:

1. An Intelligent Health System will improve health outcomes, improve the quality of life, lead to longer lives at lower cost and save individuals, companies and governments billions of dollars.
2. An Intelligent Health System will be the greatest single 21st century source of high-paying jobs and foreign exchange earnings as people across the world discover they want the quality of life, the level of health, and the effectiveness of health care which the American Intelligent Health System will make possible.

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Vision Principles

As we move from today's 20th century system to our new vision of a 21st Century Intelligent Health System, the following from-to principles must guide the transition and serve as a template as we set policies, including policies regarding payment reform:

Current System	21st Century System
Provider-centered	Individual-centered
Price-driven	Value-driven
45 million uninsured Americans	100% coverage
Hidden price and quality information	Transparent price and quality information
Knowledge-disconnected	Knowledge-intense
Slow diffusion of innovation	Rapid diffusion of innovation
Disease-focused	Prevention and health-focused
Paper-based	Electronically-based
Third party controlled market *(patient – provider – payor)*	Binary mediated market *(individual – provider)*
Limited choice	Increased choice
Predatory trial lawyer litigation system	New system of health justice
Quantity and price measured	Quality of care and quality of life
Process-focused & administered	Metrics-led & outcomes focused
Bureaucratic Management	Collaborative leadership
Punishment-driven	Incentives-pulled
Overall cost increases	Overall cost decreases

The 21st Century Model

A 21st Century Intelligent Health System – and the principles of that system – can be distilled into three essential component areas:

Component One: Centered on the Individual

Putting individuals at the center of the system requires that they be given the incentives, the information, and the power to make wise choices.

However, the 20th century system we inherited is one in which individuals seldom have information about cost or quality,
have no financial incentives for wise consumption, and generally have decisions made for them rather than choosing for themselves. Starting with the decision in 1943 to go to a third-party system, we've turned healthcare into a rental car. The problem is, almost no one washes a rental car.

Right to Know - Allowing individuals to choose will work only if we also provide them with the information needed to make informed choices. Yet the current healthcare system is absurdly secretive. When it comes to healthcare, Americans typically have no way of comparing the cost and the quality of the various health services, products, or providers they are considering. This situation is tantamount to asking someone to shop for a car when the dealer hides the prices, rolls back the odometers, and does not disclose that his lot is filled with a fleet of rental cars.

Personal Responsibility -In a 21st Century Intelligent Health System individuals have certain rights, including the right to know cost and quality information and the right to be assured that their providers are practicing the best standards of care. But they also have responsibilities.

First, individuals are expected to be informed and to use that information to make wise decisions. Second, individuals are expected to engage in (and encourage their children or family to engage in) healthy behaviors, related to both nutrition and exercise, that are proven to prevent illnesses and complications. If they develop a chronic illness, they are expected to learn and follow best standards of care to avoid costly complications. Third, individuals are expected to help pay for their care. Everyone should be incentivized to participate in the insurance system. Those whose incomes are too low should receive vouchers or tax credits to help them buy insurance. Those who oppose the concept of insurance should be required to post a bond to cover costs. Allowing individuals to pass their health costs on to others reinforces the attitude that it's not their problem and adds to the irresponsible, unhealthy behaviors that are bankrupting the current system.

Personalized Health System

The 21st century individual-centered system will be a personalized system of health, resulting in dramatically better health for everyone. Imagine a future where tests will allow us to know exactly what combination of medicines will protect us from the specific diseases or conditions to which we are most susceptible, based on our genetics. Consider a world where we know that health and treatment regimens are designed specifically for each individual.

We are already seeing glimmers of how the future of medicine is likely to change as we move toward a more personalized system. Not long ago, the newspapers ran a story about a drug that scientists learned, in reviewing years of data, had a stunning impact on preventing heart attacks in African American males. This was not the original purpose of the drug. Moreover, the drug had no such impact on white males.

In a 21st century, IT-rich, intelligent system, we will be able to recognize these patterns much more quickly and to share them more widely in order to prevent illnesses, thereby saving lives and money.

Component Two: Information Technology and Quality

The personalized system of health we just described cannot be possible without a system that is IT-rich. The system must allow easy but secure sharing, analysis, and usage of information about health and health history and about the cost, quality, and outcomes of treatments we are considering.

The difference between health and healthcare and other sectors of society when it comes to information technology is dramatic. And it has had a dramatic impact on the lives—and deaths—of the American people.

Paper Kills

Paper kills. It is that simple. Instead of saving lives, our current paper system is often taking them. With as many as 98,000 Americans still dying as a result of medical errors every year, ridding the system of paper-based records and quickly adopting health information technology will save lives and money.

Each day that we refuse to move from a paper-based to an electronic system, people are dying needlessly. This is not just conjecture— health information technology's tremendous potential to saves lives and money is real and is happening in some of the most forward looking practices and transformational institutions in our country.

Component Three: Health, not Healthcare: Prevention, Early Detection, Self-Management, and Best Practices

The need to transform the current system from an acute care–focused system to one of prevention and early detection is evident.

Heart disease, the leading cause of death for both men and women in the United States, accounted for nearly 700,000 deaths in 2002. In 2005, heart disease was projected to cost $393 billion. It is the leading cause of death for American Indians, Alaska Natives, blacks, Hispanics, and whites. More than 300,000 people have bypass surgery in the United States each year.

Yet heart disease and its complications can often be prevented. Among people with heart disease, studies have shown that lowering cholesterol and high blood pressure can reduce the risk of dying of heart disease, having a non-fatal heart attack, and needing heart bypass surgery or angioplasty. For people without heart disease, studies have shown that lowering high blood cholesterol and high blood pressure can reduce the risk of developing heart disease in the first place.

A system focused on prevention rather than on acute care would provide the incentives and policies to support lifestyle changes needed to control cholesterol and blood pressure. A culture of physical activity and healthy diet choices would replace the current epidemic of inactivity and "fast food."

However, our current system, by providing reimbursement for volume of care rather than outcomes, discourages the type of care that prevents disease, complications and acute episodes.

The same mindset is evident when it comes to the willingness of the system to pay for technologies and discoveries to keep us healthy. Using diabetes as an example, the current system's tendency is to pay for dialysis and amputations but to refuse to pay for the education, the tools or often the medications that can prevent these costly and tragic consequences. A system that takes advantage of 21st century opportunities will be able to provide us with a whole new range of technologies, tools and screening mechanisms that will allow us to stay healthier, avoid or delay many illnesses and manage illnesses we develop.

Two Futures

If CHT Senior Advisor Dr. Andy von Eschenbach (who previously headed the National Cancer Institute and then the FDA), is right, we may be able to eliminate cancer as a cause of death in the next ten years. But even if we find the breakthroughs that would allow us to do this, if our current 20th century system of delivery has not been transformed, it is likely that our own doctor might not adopt the necessary life-saving treatment for seventeen years. In those seventeen years how many people will have died needlessly? How many wives or husbands, sisters or brothers, children or grandchildren?

It is a potential scenario that gives us a startling glimpse into two futures: one in which we cling to the status quo and another in which we save countless lives and millions of dollars by creating a 21st Century Intelligent Health System.

The opportunities exist, the choices are clear, the time for choosing is now. The choice we make is not just important, it is a matter of life and death –

not only for us but for our children, our children's children, and Americans everywhere.

Creating the Future: A Look Ahead to 2020

Preface

We are currently engaged in a national debate on how best to transform American healthcare, with the dual objectives of achieving better health at lower cost. It is generally recognized that incentive misalignment with these objectives is one of the key contributing factors to the uncoordinated care, quality gaps, redundancy, and inefficiency everyone would like to eliminate. In other words, care providers are typically paid for the activity they perform (i.e. fee for service) rather than for the health outcomes that result from their services.

The Center for Health Transformation convened a payment reform work group consisting of representatives of all key stakeholders in this issue. The mission was to develop a model of healthcare payment that properly aligns incentives with better health and lower costs. The goal was to develop a workable plan to recommend to policy makers in government and the private sector. This plan was to include strategies to optimize efficiency, provide the highest quality care possible, increase access, and emphasize preventative, primary, and wellness care.

In order to develop this plan, the payment reform work group wanted to establish a clear vision of what reform is intended to achieve. Using this vision as a base the group could then identify gaps with our present state, barriers to getting to the vision, and the strategies and tactics that would be required to remove barriers in order to realize the vision.

This approach to developing a plan for payment reform incorporated the *key requirements for successfully implementing complex change**, proven across industries:

- There must be dissatisfaction with the status quo (already established in our healthcare reform environment)
- There must be a clear vision of the future state (the vision articulated below which the payment reform work group established as a base on which to develop its recommendations and plan)
- There must be a clear process for action and participation (the plan presented in this white paper)

Following is the Vision used by the work group to develop its plan and recommendations for payment reform.

The Vision

It's the year 2020. It's hard to believe that just a decade ago there was intensive debate about healthcare in the U.S. Today we have more options than were available before, we spend less on healthcare delivery and we seem to be generally healthier as a nation. Costs have come down dramatically in some sectors of the industry. Dynamic new businesses have sprung up to meet emerging needs. Traditional businesses have evolved with core components repurposed. Financing mechanisms have changed, and while not perfect, there is better alignment between cost and quality. There is more coordination of care, more personal accountability for health outcomes, more choice and competition, fewer restrictions, and generally less intervention and fewer procedures.

Of course, there have been some business 'casualties' across the entire industry as those organizations which held onto old models found themselves unable to adapt and therefore unable to compete in a new marketplace.

Medical tourism is dramatically improving the economy, as the U.S. has once more become the destination for elective procedures and continues to be the focus for complex care. Innovations here have been taken to other parts of the globe as researchers in the U.S. continue to work collaboratively with their O.U.S. counterparts to find ways to improve health outcomes. New investments in Research & Development have had big payoff -- as medical interventions have replaced surgery, and in some cases minimally invasive surgical procedures have replaced chronic medical treatment. As importantly, non-Western approaches to treatment have gained popularity and acceptance as the evidence base for outcomes is increasingly demonstrated.

Everyone in the U.S has health insurance. Typically it's attached to the person although there are still some sectors of the economy where employer based healthcare is the preferred option. National access opened up competition. Local providers sprung up, sometimes coordinated with more traditional care delivery organizations who together built comprehensive or "bundled" approaches to disease management, wellness and prevention. Whereas fragmentation and inefficiency characterized healthcare in 2009, coordination and cost effectiveness are reflective of the new approach in the industry. Of course, there are still niche players who are quite successful in their market segments.

What is so remarkable is the creativity that was (and still is) brought to bear on what appeared in 2009 to be intractable problems where some argued that only a single, government payer could fix the ills. Indeed, it has been the creation of true market based solutions with very targeted policy (government) intervention that has enabled the magnitude of change in such a relatively short period of time.

Insurance payment reform enabled interstate access and reduced complicated rules and bureaucratic inefficiency. Restrictions on pre-existing conditions were lifted. Member retention, once a major problem for the industry -- in part due to an over-reliance on employer based benefit coverage, has dramatically increased in recent years. Whereas average member retention was once pegged at 18-24 months, it continues to increase with some carriers reporting averages of 6-8 years and a positive trend line. Portability is characteristic of all insurance since most individuals hold their policies, with a myriad of design options for consumers to choose from -- long term care, full coverage including vitamins and over the counter (OTC) products, basic catastrophic coverage and specialty options, including 10, 20 and 30 year life support.

Pooling and tax incentives have leveled the playing field and made this a reality. True competition has lowered cost and increasingly put consumers in the driver's seat. Employers, where they do provide coverage, have almost entirely moved to defined contribution approaches. Employers get to make the determination of what the contribution will be -- not the insurance provider or the government.

On the delivery side things are very different. Fundamental to change has been a shift in a basic assumption of the industry -- that volume (or at least a certain type of volume based on payer and procedure) is good. In the world of the healthcare continuum -- prevention, early diagnosis, intervention and rehabilitation -- traditional hospitalization volume represents a cost, not revenue! Not wanting to repeat the mistakes of capitation in the 1980s, 2010 innovators committed to short and longer term health outcomes.

This required enormous behavioral change on the part of physicians, social agencies, and consumers. It also required new approaches to metrics and the generation of evidence. Increasingly, healthcare delivery institutions are focused on optimal outcomes -- the right treatment(s) in the right amount, administered in the right way, at the right time, for the right patient. Hospitals are less frenetic for caregivers.

Nurses, frequently focused in 2009 on getting through the shift without hurting anyone, focus on the "bedside" -- on consumer and family

education, on rehab, on care management, coordination and health outcomes.

Hospital acquired infection rates, while never reaching ‘0’ have been dramatically reduced -- approaching ‘0’; medication errors also are down below 1 %. No longer are hospitals generally recognized as unsafe.

Together with the elimination of redundant and unnecessary care, estimated at between 30% and 40% at the best hospitals in 2009, these changes resulted in the savings that enabled innovation and universal coverage without adding cost.

CMS’ refusal to pay for such error based ‘never events’ forced healthcare delivery institutions to dramatically change practice -- or go out of business. Similarly, 30 day readmission payment restrictions drove better coordination within the hospital setting and facilitated discharge planning and coordination with community agencies and post acute care settings. Discharge planning now starts pre-admission except in the case of emergent situations, and even there, it begins at the time of admission. Commercial insurers, not surprisingly, followed CMS’ lead.

On the physician front, frightening trends in primary care have been reversed. With balanced payment increasingly recognizing the enormous contribution and broad system expertise of primary care physicians and a decrease in compensation for narrow “specialty” care, more physicians have been going into primary care medicine as a specialty -- thus reversing the disturbing trend in 2009. Where only 2% opted for primary care medicine in 2009, 20% have selected this specialty area in 2020. Contrary to what was anticipated in 2009, the small business model for independent physicians continues; nurse practitioners have opened offices; and integrated cross-specialty practice models have emerged to offer their customers comprehensive healthcare solutions accessible to local communities.

In the midst of this change some hospitals have repurposed bricks and mortar -- turning low occupancy beds into assisted living, Long Term Care and Long Term Acute Care Hospitals. Still others have created temporary residences for families visiting sick relatives who receive needed treatment and rehabilitation.

It is truly a different world!

III. SPECIFIC **STRATEGY RECOMMENDATIONS**

CHT's Plan Framework – MOST Hierarchy*

In any planning effort there is a tendency to devolve to activity and milestones without sufficient clarity on how the activities link. Under the pressure of time constraints, this tendency is even more likely to occur. When it does, references to "objectives" vs. "strategies", and implementation "tactics" get blurred and confused, leading to an ends/means inversion.

Especially for complex problems such as the payment misalignment we are trying to resolve, a necessary degree of discipline is essential to our success. We want to ensure that objectives, strategies, and tactics are not intermingled throughout the plan development process. Accomplishing this will avoid an ends-means inversion, where there is greater importance placed on implementing a "means to an end" than there is on the "end" itself … which is the ultimate objective. This inversion creates a bias to getting work activity done, as opposed to achieving an outcome and *challenging any work activity* that doesn't help achieve that outcome.

There is a hierarchy which, if done well, helps planning efforts align all work activity with important outcome objectives. We call this the *"MOST"* hierarchy, which consists of:

Mission/Mandate:	The overall purpose of a planning effort
Objective:	An overarching goal or outcome critical to achieving the mission
Strategy:	A broad course of action needed to realize a strategic objective
Tactics:	Specific actions, with associated responsibilities and timelines, necessary to implement a strategy

We have taken our collective work group efforts and summarized them in a payment reform plan consistent with this MOST hierarchy.

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CHT Payment Reform Mission

As noted earlier the Center for Health Transformation convened a work group of representatives of all key stakeholders in this issue. Our mission was to develop a model of healthcare payment that properly aligns incentives with better health and lower costs. This mission includes the development of a workable plan to recommend to policy makers in government and the private sector. Our plan includes core strategies to optimize efficiency, provide the highest quality care possible, increase access, and emphasize prevention, primary, and wellness care … all of which will require innovation.

Overarching Payment Reform Objectives

Before we fix something we need to be clear about what we are fixing and why. Subsequently, our objectives have to address the root cause of the problem we're trying to fix. One root cause issue we have identified is the lack of accountability for the cost consequences of choices made, which has perverted natural market forces. A second root cause issue is the application of piecemeal solutions to what is a complex and interrelated set of market factors.

Any attempt at payment reform must also answer the four critical questions noted earlier:

- Who pays?
- How does the exchange occur?
- What gets paid for?
- Is it worth it?

There are three over-arching objectives that have been implicit in our work, which address root cause issues, and which serve as a basis for answering our four critical questions:

1. Reattach accountability for the cost consequences of all decisions made by all constituents across healthcare … and align incentives accordingly to ensure a competitive market that offers affordable healthcare insurance and that delivers better care at lower cost.

2. Enable accountable decision-making with clear and supportable information about the economic and care outcome value proposition of all products and services being offered.

3. Construct integrated solutions that take all constituents into account, integrating change across components in a manner that changes in one area anticipate and avoid unintended consequences in another area.

Practical – and Integrated Core Strategies to Achieve What We Want

There are six core strategies which we have derived from our work and which we believe, in total, will accomplish our three overarching objectives.

One: Require and pay for predictive care paths and other evidence based medicine.

While some health conditions are clearly too complex and variable to predict, that is not true for all conditions. Healthcare providers such as Geisinger Health System, Gundersen Lutheran Health System, Mayo Clinic, and Sutter Health have already done considerable research establishing predictive care paths. This is an example of evidence-based medicine at work. It is now generally understood that the amount and types of care required for some conditions can be predicted. And therefore, a total cost for treatment can be established – without creating an added administrative cost burden by boring down into step-by-step detail and paying separately for those component parts. [9,18,19,31,32,51] Organizations like EBSCO Publishing have a considerable amount of expertise in identifying what the evidence really is when it comes to published research. NCN through its comprehensive data systems has established the cost of services across providers. Similarly, QMedtrix and its data and algorithms also compares costs across providers to determine appropriate payments. These are examples of private sector innovations and use of IT to determine in tandem quality and cost of care. Together this data can achieve the value equation.

Some of these predictive care paths already exist and are in use. Why reinvent the wheel? Where they exist, CMS and other insurers can require all hospitals to adopt such care paths or local equivalents – and reimburse them for the total cost that has already been established. It's a start that can happen within the next two years, with everyone involved reserving the right to learn from experience. As additional research is completed more predictive care paths can be established, or existing paths can be improved.

These care paths – and the outcomes they achieve – are the true "product" of hospitals and physicians, not each procedural detail. Considering the goals of healthcare reform this implies that – like manufacturers – investments in "R & D" (e.g. new approaches to care delivery) will need to become part of the new business model. As such, these "products" can be audited for quality just as products of pharmaceutical and medical device manufacturers get audited. This addresses one of the biggest disconnects of fee-for-service and capitation* payment methods – *they do nothing to ensure quality of care*. Care paths as a tangible product of evidence-based medicine also promise a better standard of care. Innovations in healthcare delivery should lower cost and improve outcomes, as is true in other industries.

With a fixed total "price" for an evidence-based care path there is no incentive to provide any additional, unnecessary care. A significant administrative efficiency can also be achieved, moving away from the cost-accounting minutia of the current system – which consumes provider time and encourages upcoding abuse.

As "products" there must also be transparency of both the price and the value of the care path products being offered. Responsible buyers need this information if we expect them to be accountable for the cost consequences of their decisions. This is true of CMS, private insurance, or consumer buyers. Transparency of price and value is already evident and established in non-covered healthcare markets such as cosmetic dermatology and corrective vision surgery.

* Capitation is a payment method that pays a fixed fee to serve a patient population. When established in the 1980s, there was no measurement or requirement for quality of care. As such, the incentive was for providers to maximize profit by minimizing the health services they provided.

Two: Change the basis for paying primary care physicians and expand the role for other professionals.

At the same time we are recognizing the importance of primary care in prevention and managing health to avoid more costly care, we are facing a critical shortage of primary care physicians. The reason for this is how we pay these physicians today. Their average compensation is so much less than subspecialists (performing procedures we more richly compensate) that we have eliminated any incentive to practice primary care. This is now widely recognized as one of the most important issues payment reform must address.[3,6,8,19,32,34]

Primary care takes time with a patient … to ask questions and diagnose the root cause behind symptoms, to study diagnostic tests and patient history,

to educate patients and guide them in managing their own health, and to coordinate their care when subspecialists need to be involved. *As such, the important unit of value for primary care physicians is time.*

We can establish a dollar value for an hour of a primary care physician's time, and we can adjust this regionally based on cost of living data. This eliminates the incentive to minimize time with patients in order to see as many patients as possible … which is what these physicians need to do today to sustain an income. This value must also be set at a level that eliminates the disincentive to choose primary care practice. The 5-10% pay increases currently being proposed do not come close to adequately addressing the current compensation disparity between primary care and subspecialty practice.

Insurers, including CMS, can periodically audit physician practices, focusing on outlier time charges. If there is a trend of such outlier practice, without any supporting rationale, insurers can choose to exit such physicians from their networks. In addition, patients can fill out "standard of care" report cards which would verify that the care that should be delivered in fact was delivered … in effect measuring how well a physician used their time with the patient.

Just as we defined a predictive care path as a "product," so too is primary care management. Changing the unit of value to time does not remove the requirement for *price and value transparency* of primary physician care. For example, there *will* be primary care physicians who achieve better results over a continuum in helping their patients manage diabetes or obesity. Buyers – consumers or insurers – can only make responsible choices when the price and value is known. Concierge primary care has already established the precedent for a known product (ready access to the physician) and a corresponding price.

Today, a physician is in an insurer's network because they have agreed to accept a lower payment than they would otherwise charge in a free market. The physician then determines how to play the coding game to get more money. We are suffering from the consequences of this payment approach. Our proposal for tomorrow provides for fair, time-based compensation to the physician, and kicks them out of the network if audits and patient "standard of care" report cards indicate they are "working the system."

Appropriate valuing of primary care and rebalancing compensation accordingly is a two-edged sword. Just as we are substantially underpaying for primary care we are correspondingly over compensating surgeons and subspecialists. Our redesign of financing mechanisms must address compensation imbalance *from both directions*. To be direct, this

strategy calls for the relative reduction of subspecialist compensation as primary care compensation would increase.

Over time the natural law of supply and demand will result in more primary care physicians and fewer subspecialists. As we have suggested, removing the income disincentive to choose the practice of primary care will change the ratio of primary care to subspecialists. In addition, the impact of better primary care in avoiding surgery and specialist work – thus reducing demand – will also result in reducing the number of sub specialists.

At the same time we are experiencing the shortage of primary care physicians, we have also not fully utilized the training and expertise of other health professionals including advanced practice nurses, pharmacists and other complementary providers. By maximizing their capabilities within the scope of their license, patients can obtain the care and education they need to optimize their health and well being.

Three: Increase consumer engagement and personal responsibility, reducing the abuse of the system by consumers.

We are currently paying avoidable healthcare costs due to two types of choices by consumers. One is not managing their own health – and the other is not buying insurance even if they are able to afford it.

A number of changes can be made to change these consumer behaviors and dramatically reduce associated costs:

- Provide incentives to encourage everyone to have health insurance or to post a bond to cover their financial risk or exposure. Subsidize those who truly cannot afford it, another point addressed in the new law.
- Remove restrictions on insurance due to pre-existing conditions. Again, everyone must be encouraged to have insurance. There must be consumer accountability for cost/benefit care decisions and personal management of their health.
- Encourage private insurers to provide a range of products/pricing structures that charge higher premiums to those who demonstrate they aren't managing their health (this is a competitive market at work). A FICO-like consumer health score can be established just as a credit score is established. Just as the cost of loans varies based on consumer credit behavior the cost of healthcare insurance can vary based on consumer health behavior.
- Remove requirements to treat the uninsured in ERs, encouraging instead the use of community clinics to treat uninsured.

- λ Encourage community clinics to try new approaches to change the behaviors of people that won't manage their health and lifestyle.

A necessary part of this strategy is the need to accept the reality that some people will always get away with "working" the system. Regardless, significantly reducing the number of abusers of the system represents tremendous cost savings and collectively better health.

Four: Reduce fraud and abuse by providers.

Private insurers on average do a reasonable job of verifying claims, monitoring trends, and taking actions to identify and address fraud. Their for-profit, bottom line orientation drives them to perform this work, a responsibility of any organization buying products or services. This is the point where payment for services, appropriately, actually and satisfactorily rendered should always be determined.

CMS does not currently operate at this same standard. Fraud can be immediately and substantively reduced by CMS adopting private insurers' best practices in this area. This is a prime example of an area where better use of technology can have a huge impact.

Five: Stimulate private insurance competition and provide consumers with greater product options.

There should be more and better healthcare insurance products on the market, more customized to the range of different consumer needs, and with pricing that provides incentives for consumers to manage their own health. These products do not exist today, due to regulations that restrict competition and a prevailing practice by private insurers to just follow CMS.

We need to make certain that consumers are at the center of our new business model. They have to have real economic and clinical value and meaningful outcome information in order to make good cost/benefit choices. And they should not have to be dependent on their employers for insurance if we eliminate barriers in healthcare insurance and create a truly competitive market space.

Payment reform can only be successful if a true market environment is established. If we want competition, consumers have to have choices, and they should not be denied coverage because of pre-existing conditions, yet another point addressed in the new law. In order to provide choices, payers need to look at care continuums over time vs. episodic care. To provide care continuum choices with the right incentives payers have to have long-term relationships with their customers.

Consumers are always best served when there is competition for their business. Government can stimulate this by dismantling the regulations that prohibit private insurers from competing on a national basis. Unencumbered, there is no government insurance option that cannot be matched or exceeded by private insurers.

Having said this, private insurers also must change their business model. They need to move beyond traditional market research and more precisely segment consumer needs. They need to then design more products, better matched to the various needs of consumer subsets. This includes the development of special life situation products, such as the degree of end-of-life care for which consumers want to pay. Establishing direct-to-consumer sales channels can eliminate the free market constraints of employer-based health insurance. Insurers need to price products accordingly, with built-in incentives for consumers to manage their own health. They need to re-educate consumers about healthcare insurance, reestablishing accountability for cost/benefit decisions. Last, they need to provide transparent cost and value information on which consumers can make accountable cost/benefit decisions.

As consumers continue to bear first-hand an increasing burden of their healthcare costs they are acting more and more like customers, demanding value for their money and proof of that value. This natural market pressure needs to be unleashed and private insurers need to respond to it.

Six: Accelerate government's role as "enabler", not "architect", of new industry business models

There is an important role of government in this new business model creation, but it isn't legislating the new model. We need to change legislation to enable more healthcare insurance competition. With more people having insurance, insurance companies can design and offer solutions to meet the myriad of needs within the construct of a truly American solution. For individuals who oppose insurance, a bond can be posted to cover their financial obligations or risks.

As noted by a variety of organizations now working on healthcare reform,[5,7,13,26,46,52] CMS has historically been a mechanism of payer industry change – sometimes with negative consequences. Recognizing this, CMS can serve as a powerful accelerant for *implementing* a better model for valuation of and payment for healthcare services. But CMS should defer to the private sector in a collaborative effort to *design* a better model. The misalignment of our current payment system with our objectives – brought on by CMS' introduction of DRGs – is evidence for limiting CMS' role to a mechanism of change rather than a designer of new models. Design of a

valuation model aligned with better care and lower cost is most likely to come from organizations with experience and capability in being accountable to customers for such results … namely private enterprises.

Finally, government does not need to raise more money for healthcare via new taxes or more debt. There is over $500 billion dollars in *annual* savings ripe for the picking, more than enough to redeploy to helping people buy healthcare insurance or increasing CMS compensation for primary care. Eliminating medication errors, reducing unnecessary length-of-stay across 5700 hospitals, and eliminating just half of unnecessary care accounts for $500 billion. And we are not yet counting any reduction in fraud or abuse.

In the next section we will detail the tactics and timeframes to implement these strategies, defining the bridges to the vision for the future.

IV. BRIDGES TO GET THERE

Core Strategy 1: Require and pay for predictive care paths

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
1. Create a Care Pathing Project (similar to the Human Genome Project) to identify and map the best care paths. Start with the most costly areas of medicine to help address the current cost crisis. Include a cross-section of leadership from academia, practicing medicine, payer community, consumers, etc. A sense of experimentation should be encouraged by the care pathing project, including exploration of incentives and communication (e.g. in-office videos) that affect improved consumer health behaviors.	Leverage what is already in place, utilize stimulus funding for CER as well as foundation funded research that is applicable. Examples already exist such as IHA/Bridges to Excellence, Geisinger, Mayo, etc. Identification of care paths should include the means to audit performance and capture outcome results, recognizing that many complex conditions do not lend themselves to predictive care paths. This approach will reconnect cost and quality. Care pathways should be feasible: λ When there are conditions for which there is consensus and evidence regarding best treatment. λ When there is low variation of care approach, but discretionary spending. Care paths might include integrated systems of care, whether or not those integrated models include an ACO. We need integrated and accountable care but do we need new, special "organizations" to achieve that?	1 – 2 Years	Government (CMS) funded with representation from academia, practicing medicine, Payer community, consumers, etc
2. To stimulate process of developing predictive care paths,		1 – 2	Government (CMS)

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
create an awards program enabling organizations to submit best care paths based on quality, cost effectiveness and patient satisfaction. Winners whose care paths are chosen would share in any cost savings made through Medicare for a defined period of time.		Years	
3. Tort reform limiting or eliminating malpractice when/if providers follow established predictive care paths, unless there are other contributing malpractice factors by the provider at the time (known as "Safe Harbor.")	It will be more difficult to establish predictive care paths for more complex patient conditions, which require more physician judgment and flexibility. Correspondingly, tort reform would be limited to those situations where EBM predictive care paths have been established.	3 – 4 Years	Government
4. Under Medicare or Medicaid, require providers to follow newly defined care paths to receive a set, bundled payment. Private payers will likely follow.	If a care path can be established, a fair fee for the delivery of the care path can also be established. Creating pricing transparency for buyers/consumers can only be accomplished via dramatic simplification of pricing.	3 – 4 Years	Government (CMS)
5. Focus the utilization of the $31 billion funded by ARRA '09 for electronic medical records in two ways: λ Provide a nationally consistent medical knowledge base and guidance regarding predictive care paths that have been proven to be the best EBM and for which CMS and other payers are paying a fixed bundle fee. Utilize technology to guide providers to deliver the best care as determined by outcome evidence. λ Establish a portable personal medical record (on disk or credit card or internet) to be kept by individuals and presented to any care provider they choose. Many exist already so government need not duplicate.	Information technology is an enabler, it is not a solution in and of itself. It can enable and guide the consistent delivery of what is established as the best quality and most efficient care as defined by established predictive care paths. A personal medical record (PMR) and history should be the property of the person. Like a drivers license or insurance card a personal electronic medical record can be issued to every individual. Individuals manage privacy by presenting their record (or a password) to providers they choose – no signing of HIPAA papers every time	1 – 4 Years	Government (Hi-Tech), Providers, Payers

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
	you visit a new office. The provider's computer can provide automatic updates to a FICO system (see tactic 4, strategy 3). The personal record can be designed to present key diagnostic data in a trend analysis format so a new provider can easily note changes in basic health metrics. An individual may choose not to present their PMR, but this may limit who is willing to be their provider or insurer. The market decides.		

Potential Barriers	Resolution/Comments
1. There is likely to be resistance to "cookbook" medicine.	Engage and involve providers in the development of care paths. Enable providers to participate in updating and developing refinements to future care paths through the suggested awards program. Pathways should serve as a base to enhance communication and transparency across providers, patients, and payers as opposed to consisting of a rigid set of procedural guidelines. Special care should be given to avoid care paths being a siloed approach to care. We need to ensure we encourage the integrating of care into sometype of holisitc care rather locking in further siloes. Focus should be on long-term longitudinal care that allows for prevention and true efficiency. We need to be wary of those who would try to game this system by not creating perverse incentives as has occurred with DRG's.
2. There is likely to be resistance from consumers and the legal community to tort reform.	Clearly define liability limits when care paths are followed vs. when provider negligence is truly involved. Part of the requirements of predictive care paths should include the physician explaining to the patient that the prescribed care is the best evidence-based path known today, and what risks are known to exist. This will improve literacy.
3. There will be a significant communication challenge in educating the provider community on care paths and billing and coding changes.	This is where simplicity of design is crucial. Broad communication can be coordinated by payers including utilization of professional associations, major medical groups, etc. Establish an electronic health

	record subgroup to help embed new care paths into electronic systems.
4. Questions will need to be answered regarding how to manage pathways over the course of care as a patient transitions in and out of a hospital.	Once defined, these pathways will serve as a guide for better coordinated care as patients transition to different care providers.
5. Currently there is a relatively thin evidence base for the impact of continuums of care on the overall health spend.	Government can contract with private sector companies like EBSCO, NCN and QMedtrix who specialize in analyzing and creating an evidence base for quality and cost respectively.

Core Strategy 2: Change the basis for paying primary care physicians

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
1. Change the basis of payment for primary care to a fixed dollar amount per time spent on a patient, regardless of if it is spent with the patient or otherwise managing the care of that patient. Correspondingly, introduce a "patient scorecard." The patient would complete a confidential scorecard and send to their payer. The design of the scorecard would reflect the objective of verifying that the expected "standard of care" was delivered. This is an area where "meaningful use" of HIT can play an important role. Giving the consumer the summary of care they received can allow them to review for potential errors, purposeful or accidental, as an important deterrent to fraud.	The key to cost reduction and transparency is simplicity. Consultants throughout other industries are paid based on a fixed hourly rate with minimal administrative cost or on a defined project basis. This eliminates the incentive to maximize volume of patients at the possible risk of not taking the time to educate patients, coordinate their care with other providers, etc. Establish an hourly rate that eliminates the disincentive to primary care practice. Outliers seeking overpayment can be identified through the use of good data systems.	1 – 2 Years	CMS, Medicaid, Payers
2. Modify the basis of payment for subspecialists to a combination of either a fixed dollar amount per time spent or a fixed bundled rate for a procedure and all corresponding services (e.g. pre-surgery testing, prep, surgery, follow-up). As suggested in tactic one a patient scorecard should be introduced to involve the patient in verification of the delivery of the expected standard of care.	Fairly compensating surgeons for their time, regardless of whether or not they operate, encourages managing care to avoid surgery if possible. In a functioning market the buyer/consumer is best served if they understand the total cost for all services involved in an episode of	1 – 4 Years	CMS, Medicaid, Payers

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
	care. For example, there is a fixed price to receive Lasik® Vision correction which includes testing for suitability, preparation, surgery, and follow-up visits for a year afterwards. Establish reimbursement rates that fairly compensate the subspecialist's additional education and skills, but that do not distort value relative to primary care.		
3. Working through the care pathing project, establish a wellness care path for government and private payers. Include annual incentive payments to primary care providers for patients who do not have a "serious" medical event during the previous year and who receive a high patient satisfaction score. The auto insurance industry does this to reward safe drivers. Rewards for health are even more important.	Another approach could involve improving a patient's FICO scores (see tactic 4 for strategy 3). The approach to primary care path development should include experimentation with different practice methods such as group appointments or electronic consults. Consumer education experimentation is also important to improve consumer literacy in the intelligent use of healthcare resources. This can include different roles of the physician in providing consumer education; development of tools that are simple to access and understand; defining the appropriate level of patient self management of chronic disease; and self management of resources such as electronic care monitoring.	3 – 4 Years	Government, Payers
4. Eliminate primary care provider discrimination, allowing ancillary professionals (physician assistants, nurse practitioners, pharmacists, etc.) to fill some of the primary care gap by providing health education, basic testing and referral up to their scope of licensure.	Compensate these providers on an hourly rate like primary care physicians, reflecting their education and skill level. This provides a lower cost alternative to support healthcare needs as appropriate.	1 – 2 Years	Government, Payers

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
5. Modify primary care education and training to coincide with healthcare transformation such as wellness care paths and medical home model.	Education should help primary care providers develop non-clinical competencies such as communication with patients to help them manage their health.	1 – 4 Years	Med Schools

Potential Barriers	Resolution/Comments
1. There may be some significant pushback from the most highly compensated providers in our healthcare system.	There is ample precedent for CMS setting the price and private payers following. In a functioning market providers are free to find customers with the means or insurance to pay higher prices, if they choose to do so. Price does not necessarily correlate to quality of care. Value is defined by the amount a consumer is willing to pay.
2. Payers may have a concern that creating a wellness tract could drive initial costs up.	There should be an immediate reduction in subspecialist costs as primary care providers focus on managing care vs. maximizing patient value. The avoidance of more expensive procedures through better primary care is an additional savings that can be expected to increase over time.
3. There may be resistance from physicians to the inclusion of ancillary professionals in primary care.	EBM will support the inclusion of ancillary professionals in primary care paths. These professionals are already empowered to practice within the scope of their license. In a functioning market ancillary professionals will be incented to make the case to expand the scope of their licensure if unsatisfied demand for services can be safely met.
4. There is an element of the industry that believes "accountable care organizations" (ACOs) should be left to determine the appropriate mix of primary – subspecialist care, and that such organizations can best coordinate care because they have all services under one roof.	ACOs are not an outcome, they are one of a number of means to an end. The outcome is better care at lower cost. This cannot be accomplished without better coordinating care, or without heading off avoidable major medical needs through better primary care. Care providers do not have to belong to the same organization to coordinate care – they need to be incented to do so. ACOs can become large, complex organizations, and as such are bureaucracies. Bureaucracies always add administrative cost. If we

Potential Barriers	Resolution/Comments
	can accomplish our outcome of better care at lower cost without ACOs – and we can – our system will be more efficient without mandating this unnecessary bureaucracy and administrative expense.
5. Stark bill requirements may prohibit or inhibit the very collaboration we need between physicians to better integrate care for better and more efficient outcomes.	Modifying the Stark law to align with goals of the system is necessary.

Core Strategy 3: Increase consumer engagement and personal responsibility

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
1. Establish a presidential health focus. Have the White House declare a "War on Obesity." Bring together every sector of our economy to contribute ideas how we can reduce our waistlines. Instead of a weekly radio address, conduct a weekly walk on Saturday in every state capitol until we reach a certain weight goal (e.g. 5 million tons) as a nation.	Additional educational efforts can be regularly added, such as early age health education in schools. The First Lady, Michelle Obama has initiated a campaign on obesity and we should find ways to enhance those efforts in our communities without government control or mandates.	1 – 2 Years	White House, Government
2. Provide incentives for all citizens to have health insurance or post a bond. Correspondingly, require private insurers to accept consumers with pre-existing conditions – unless they are so extreme they qualify for government reinsurance (see strategy 5, tactic 3).	Encourage all financially able citizens to avail themselves of an insurance product/plan or post a bond so as to not become an avoidable, unreimbursed cost burden. Provide financial aid to those not able to purchase insurance.	1 – 2 Years	Government
3. Remove taxes- federal, state and local or provide tax credits on HSA (Health Savings Account) eligible plans to encourage greater uptake in those consumer directed plans.	HSA eligible plans create “skin in the game” for consumers when they are managing their own money. This can be a powerful tool to create greater consumer engagement and reduce unnecessary care. Vital components to make this successful are easy	1-2 years	Government

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
	access to transparent cost and quality data along with consumer education regarding health and healthcare decisions.		
4. Create tax credits as an incentive for: those who manage their health well and have no serious preventable illnesses during the year; or those that achieve a health goal such as a % of weight loss as discussed in tactic one. CMS can develop "Health Rewards" innovations to provide incentives for wellness, tobacco cessation, and other good health behaviors.	Borrow from the proven "gain sharing" programs used by corporations to encourage employee behaviors toward increased profits. Tax credits would be funded from the savings realized from more responsible personal health management.	3 – 4 Years	Government, CMS
5. Create a FICO health score and sustaining system. Much like a credit rating, a "FICO – type" healthcare number can be created for each individual. It would take into account age, gender, medical history, medical conditions under active treatment, metrics showing the degree of compliance with prescribed medical treatment (e.g. controlling blood sugar for diabetics), and basic health metrics (e.g. height, weight, BMI, cholesterol lever, smoker). This score would provide a predictor of potential future healthcare service needs. Factors under a patient's control (weight, smoking, etc.) would be usable to determine health insurance premiums. FICO scores could also be used to correct outcome and quality studies dimensioning the "input" variable of patient sample groups with different degrees of risk.	The credit market is an example of a functioning market, the higher the credit rating, the lower the interest rate to borrow money. Premiums for different types of healthcare insurance can function the same way, providing financial incentives to those consumers who responsibly manage their health and thus represent lower risk of expensive care needs.	3 – 4 Years	Government, Payers
6. Establish care path outcome reporting. Require providers to show their health outcomes by established care path on the web and within their facilities. Establish significant penalties if they do not disclose their outcomes.		5 – 6 Years	Government, Providers
7. Eliminate "first dollar" coverage for the typical office visit and pharmaceutical expenses of preventative/wellness primary care. Transition "insurance" back to its natural function as financial asset protection from major medical or catastrophic care needs.	All other naturally functioning service markets hold the consumer responsible for decisions to use the services and to pay for them. This is changing the rules, and will require time to signal intent and allow for all	6 – 8 Years	CMS, Payers

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
	stakeholders to adjust. Those financially dependent on Medicare/Medicaid first dollar care may need to be partially "grand fathered" into this aid. This should not prevent the majority of financially capable Americans from shouldering a natural market responsibility they already capably handle for all other services they consume. Any insurer who wants to provide a plan with first dollar coverage is free to do so.		
8. Expand education and information, tailored to consumers and providing actionable, understandable information.	Currently communication is much too complex, reflecting a design for providers to communicate to payers. Possible tactics include: λ Starting education in elementary schools. λ Providing consumers cost information on their annual healthcare consumption. λ Establishing "Personal Health Records" (PMRs) to shape responsible consumer behavior. λ Providing cost information on the front end of buying decisions. λ Creating a reliable, comparative information market on the Consumer Reports model. λ Empowering consumers on end-of-life issues, making this part of insurance and Medicare enrollment.	1 – 10 Years	Government, Payers, Providers

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
	λ Establishing HIT standards for consistency of consumer information. λ Defining quality, cost and value from a consumer perspective to enable comparison and choice.		
9. Establish patient scorecards enabling consumers to act as a fraud auditor for their own care (see strategy 2, tactics 1 and 2).			

Potential Barriers	Resolution/Comments
1. There may be some political fallout of showing favoritism toward the obesity health issue over others.	Constant communication as part of the "War on Obesity" that obesity is a contributing factor in many major health conditions of importance today, such as diabetes, etc.
2. Consumers may not seek major medical care in fear of losing a tax credit.	Create an either/or scenario, allowing consumers to achieve a tax credit either by avoiding major medical scenario or by meeting a specific goal such as losing weight, etc.
3. Some people are dependent on first dollar coverage.	The government will have to provide the necessary coverage for those people – much as it already does through CMS, Social Security, etc.
4. There may be resistance from consumer groups concerned about discrimination toward those with poor health.	
5. There may be some resistance from providers to public outcome and quality posting.	The real concern of providers is how extremely sick patients can negatively skew their outcome results. As noted in Tactic 3, Strategy 1, care paths will need to begin with less complicated, more predictable conditions. The types of patients that skew outcome results are unlikely to be part of a measured care path.
6. A major challenge may be accurately calculating meaningful metrics that feed the assignment of a medical FICO number.	The credit industry has already established precedent and refined the methodology to create a credit FICO number. Much can be learned from this precedent. Due to considerable research already conducted, we know the value of primary care in preventing more expensive and avoidable care needs. These physicians already

Potential Barriers	Resolution/Comments
	utilize basic health metrics as part of their diagnosis (e.g. weight, blood pressure, blood sugar, cholesterol, etc.). These are known and reliable metrics which can immediately be used as the core factors for a medical FICO number.
7. Regarding consumer engagement it will be critically important for the entire healthcare system to be ready to respond to and accept a more engaged consumer. We cannot empower consumers without empowering information.	

Core Strategy 4: Reduce fraud and abuse by providers

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
1. Require standardized and simplified reporting of charges to patients (along the lines of the food labels we have today).		1 – 6 Years	Government
2. Establish a fraud and abuse task force from the private payer community to help develop recommended fraud and abuse systems for adoption by CMS. Consistent definitions of rules, billing terms, and documentation requirements – along with dramatic simplification – are essential to reducing intended and unintended abuse of Medicare.	It will be important to define and distinguish intentional fraud vs. honest mistakes, and to clearly define transparency in terms of "cost, charges, and collections". When it comes to Medicare no one can possibly know all of the rules. This has created an adversarial situation/climate that promotes genuine errors, "fudging" of coding to covertly address inequities, and outright fraud.	1 – 2 Years	Government, Payers
3. Convert CMS from a "pay and chase" process to one that detects questionable claims and delays payment until such claims are verified.	Leverage processes of private payers to detect and prevent fraud.	1 – 2 Years	Government (CMS) Payers

4. Eliminate the use of RBRVS (see strategy 6, tactic 1).			

Potential Barriers	Resolution
1. This may have considerable IT impact in the provider and payer communities.	Establish standardized reporting requirements in years 1-2. Provide a 4-year window for payers and providers to adopt.

Core Strategy 5: Stimulate private insurance competition

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
1. Allow insurers to cross state lines. Eliminate state-defined barriers to competition.	Create one market vs. the 40-50 different markets that currently exist.	1 – 2 Years	Government
2. Provide incentives to encourage health insurance coverage and guarantee access to health insurance by all (see strategy 3, tactic 2).		1 – 2 Years	Government
3. Establish a government "reinsurance" program for the sickest individuals who represent such a high cost risk that no affordable insurance can be designed for them by insurers operating in a competitive, natural market.	The equity part of providing healthcare to "all" is simply not doable without some form of reinsurance to cover provider cost in taking care of sick patients. The fundamental flaw with current private insurance is that its entire business model is to avoid taking care of sick people. If the government subsidized high risk care, the financial downside to insuring care for sick people would still be far less. In fact, providing care to the sick might even be profitable for insurers if they bring efficiencies to the table in caring for the sick. This would be very different from the current model where profit is derived by avoiding customers	1 – 2 Years	Government

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
	who are sick. Incentivizing everyone to purchase insurance and insurers to accept all pre-existing conditions places an impossible burden on insurers to serve the small percentage of the sickest individuals. No reasonable plan and affordable premium can be designed for these individuals. A functioning market can be created to serve *most* of us if the government reinsures the few for which no insurance product can work in a business or economic sense.		
4. Develop alternative insurance plans/products to meet the emerging needs of specific consumers, one example would be end-of-life care plans.	Provide products that enable consumers to make decisions regarding the standard of care they want and for which they can be financially responsible. This will require: λ Standardization of terminology, making it easy to understand products. λ Development of consumer direct distribution channels, similar to online travel purchasing sites. λ Transparency of comparable value equations, allowing consumers to make decisions based on good cost and quality information. λ Flexible product design with incentives for self management. A lack of end of life planning often	1 – 10 Years	Private insurers, CMS

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
	results in uncertainty around patient wishes and unnecessary provision of futile care. This is just one example of specialized consumer needs.		
5. Transition to an emphasis on direct-to-consumer insurance offerings, moving away from employer-based plans.	Long-term health requires a long-term investment in treatments for hypertension, obesity and diabetes as well as strong incentives around behavior. Providers will only make their end of the necessary investments if they can reap an economic return for providing that health. Current employer–based, year–to–year term insurance simply is an absolute mismatch in duration for effective health maintenance. Long–term portable insurance is necessary. For many employees, lack of portable insurance makes them "insurance serfs" bound to an employer fiefdom not by lack of property rights around land but by lack of property rights around healthcare. Employers can be eliminated as an unnecessary "middle man" cost, and they limit the choices individual consumers would have in a competitive, natural functioning market. This transition would also address the problem of short term member retention, allowing insurers to design products and incentives to retain customers and realize the benefits of long term, coordinated care (e.g. prevention, wellness, etc.)	1 – 10 Years	Employers, Payers

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
6. Encourage not-for-profit health insurance programs. The plans adopting this model would agree to a regulated percentage of profit margin and a broader disclosure of dispensation of funds to providers and the public. Providers would share in any excess revenue generated above the regulated profit margin at the end of the year, or suffer in the form of reduced margin if the plan does not manage costs well.		3 – 4 Years	Government, Payers

Potential Barriers	Resolution
1. Information infrastructure and quality of data.	A portable, personal health record (PHR) built on a standard design would be an enabler of better product development and innovation.

Core Strategy 6: Accelerate government's role as "enabler", not "architect", of new industry business models

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
1. Eliminate the use of RBRVS (Resource - Based Relative Value System). Dramatically simplify the basis for payment, eliminating most of the current administrative cost. As recommended in strategy two, change the basis for paying physicians to either an hourly rate or a bundled fee for all services associated with an episode of care or predictive care path. Reimburse hospitals with a single bundled payment for a day in a bed, with a limited range of standard of care options and conveniences (e.g. private, luxury room).	RBRVS is extraordinarily complex and is not an enabler of better care. Its complexity promotes error and uncertainty. Payers have an incentive to withhold payment or pay a lesser amount if there is any question about complex coding accuracy and documentation. A literal 'army' of administrative staff on both the provider and payer sides work to deny claims, challenge denials, manage	1 – 4 Years	CMS, Payers

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
	appeals and arbitrate disputes. It is a system designed for failure, creates excessive rework, and adds no value to patient care. Nor is it flexible to emerging new care options. When hospitals were originally created wards of beds were utilized to cost-effectively care for patients, many of which were poor. This resource management approach is still sufficient in most case situations today (e.g. MASH units), unless there is a need to isolate the patient (e.g. infectious disease). This should be the basic standard of care anyone is *entitled* to receive. Semi-private, private, or luxury suite bed options are *conveniences*, and as such are options for consumers if they want and can pay for them. There is a difference between what is needed to provide care and the range of features consumers can purchase, much as they do when they select hotels. Obviously we again need to look at evidence that can guide an appropriate balance between care guidelines and cost of room design, etc. in the realm of the environment needed to achieve the desired health outcomes. (public health and infection issues)		
2. Develop a cost, quality, and satisfaction scorecard. Reward plans that successfully do all three by allowing them to share in Medicare and Medicaid cost savings (e.g., if they reduce YOY costs by 4%, they keep half of		1 – 2 Years	CMS, Payers

Tactic/Description	Rationale/Comments	Time Frame	Responsibility
what they save). Require payers to provide their scorecard to the public.			
3. Create additional global/bundled fee pilot programs.		1 – 2 Years	CMS, Payers, Providers
4. Create a system for assessing and documenting preferences for end–of–life care across a disease trajectory, not "one shot".	Establish "advanced illness management" as a component of CMS.	1 – 2 Years	Private sector with Government, CMS
5. Design programs and incentives to engage consumers in the management of their own health.		4 – 6 Years	Government, CMS
6. Drop the tax-free status of employer paid health insurance.	Utilize the new tax revenues to fund the government's reinsurance function. This will enable private payers and providers to compete based on the quality and value of their products and services rather than on their ability to select the healthiest customers.	1 – 2 Years	Government
7. Remove taxes- federal, state and local on HSA (Health Savings Account) eligible plans to encourage greater uptake to those consumer directed plans.	See strategy 3, tactic 3		
8. Make a government commitment to upgrade information systems similar to the private sector, with the same penalties.		1 – 2 Years	Government
9. Unify government's voice and direction across federal, state, local and regional levels.	Ensure an integrated, coordinated transformation of healthcare.	1 – 10 Years	Government

Potential Barriers	Resolution/Comments

Potential Barriers	Resolution/Comments
1. It will be difficult to develop scorecard criteria that are seen as fair by all players.	Form a task force with broad level representation to develop the criteria.
2. There may be resistance to a regulated profit margin for non-profits.	Establish broad level criteria and seek advice from the payer community on the viability of building a business model that includes a regulated profit margin and redistribution of dollars to providers above that limit.

CONCLUSION

American medicine has spent 44 years outside the discipline of a market economy. Increasingly all of the factors of production (hospitals, physicians, capital equipment, nurses, ancillary staff, etc.) are far out of kilter. Market prices in some part of healthcare (for example with high deductibles) are essential to getting to rational use of resources. Any new program should encourage market pricing … and the resulting information such pricing provides on what to spend and where to spend. The current world where Medicare engages in thousands of line–item price fixes by individual CPT code - with private insurers forced to follow close behind - drives allocation of health resources further and further away from efficiency.

Market prices would depoliticize the process of paying for healthcare. Now each group spends lots of time lobbying for why their reimbursement codes need to be paid more. This energy could be far better spent competing for consumers based on better value propositions.

The six strategies in this document represent a path for integrated change across key industry stakeholders in order to align how we pay for health care with our economic and health outcome objectives.

Americans deserve and demand a system that provides them better health, better care, better outcomes and better transparency, with much less expense, less waste, less bureaucracy, and less complexity. As Former Senate Majority Leader Daschle so simply and accurately stated, “we must pay for value, not volume.”

The Center for Health Transformation is very grateful to everyone who participated in this effort. Knowing this is not the end but rather the beginning of what is needed to create a better payment system, we look forward to continued work together to achieve better health at lower cost for all Americans.

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Center for Health Transformation
Better health, lower cost

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APPENDIX B: Participants

We are extremely grateful for the participation and contributions of each organization listed below. It is important to note that their inclusion in this list does not indicate their endorsement of any or all of the components of this document. Their participation contributed to much richer conversation and the formulation of a more creative and comprehensive set of recommendations. This was critical in the work on such a complex issue. Many thanks to all.

Alegent Health
American Medical Group Association
Centene
Georgia Hospital Association
Gundersen Lutheran
L-3 Enterprise IT Solutions
NextGen Healthcare Information Systems
Pharmaceutical Care Management Assoc.
Roche Diagnostics
SSM Healthcare
TSYS
VSP Vision Care
Worldwide Policy

AHIP
BlueCross BlueShield Association
Cerner
GetWellNetwork
Healthways
Numerof & Associates, Inc.
Novo Nordisk
Piedmont Healthcare
Sanford Health
Sutter Health
United Health Group
WellStar Health System

American Hospital Association
Cancer Treatment Centers of America
GE Healthcare
GlaxoSmithKline
Herae, LLC
NCN
OptumHealth Care Solutions
QMedtrix
Siemens
Synovus
VitalSpring Technologies
WorldDoc