How Payment Reforms Can Help Bend the Cost Curve

Karen Davis
President, The Commonwealth Fund
Fifth Annual National Pay for Performance Summit
San Francisco, California
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kd@cmwf.org
www.commonwealthfund.org

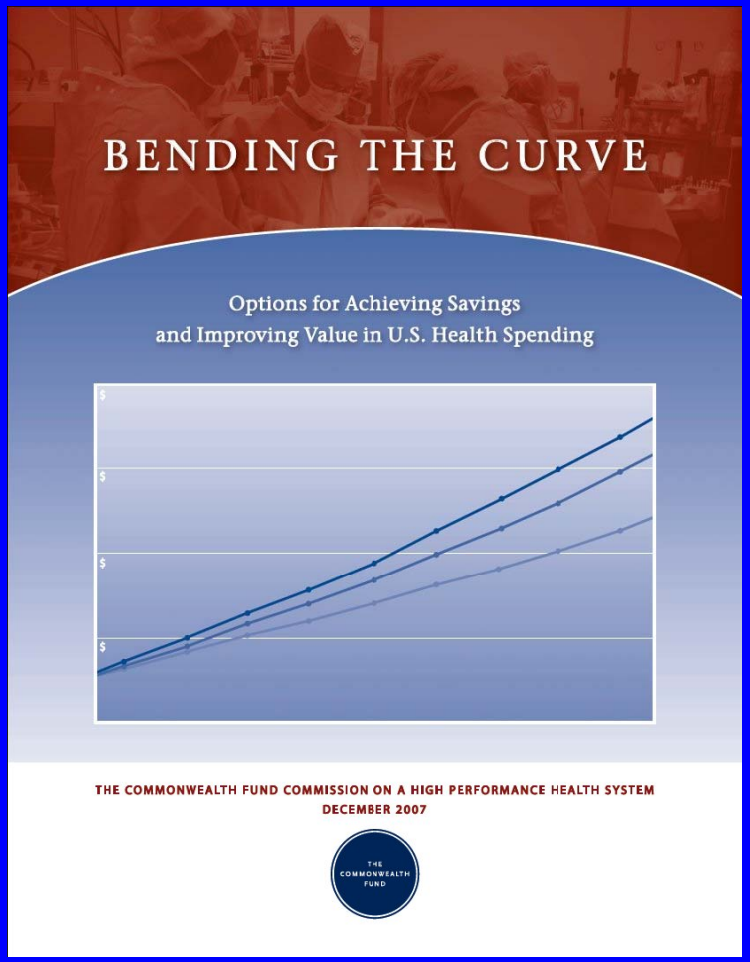
Five Key Strategies for High Performance

1. **Extending affordable health insurance to all**
2. **Organizing the delivery system to ensure accessible, coordinated, patient-centered care**
3. **Aligning financial incentives to enhance value and achieve savings**
4. **Meeting and raising benchmarks for high-quality, efficient care**
5. **Ensuring accountable national leadership and public/private collaboration**

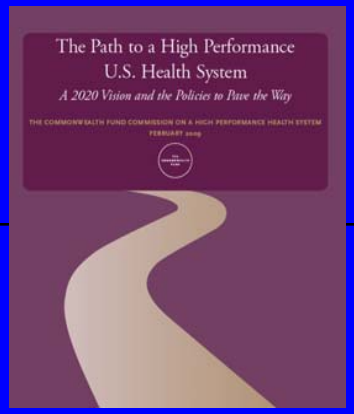
Source: Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007

Options to Achieve Savings

- Producing and Using Better Information
- Promoting Health and Disease Prevention
- Aligning Incentives with Quality and Efficiency
- Correcting Price Signals in the Health Care Market



Source: ***Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*****, Commonwealth Fund, December 2007.**

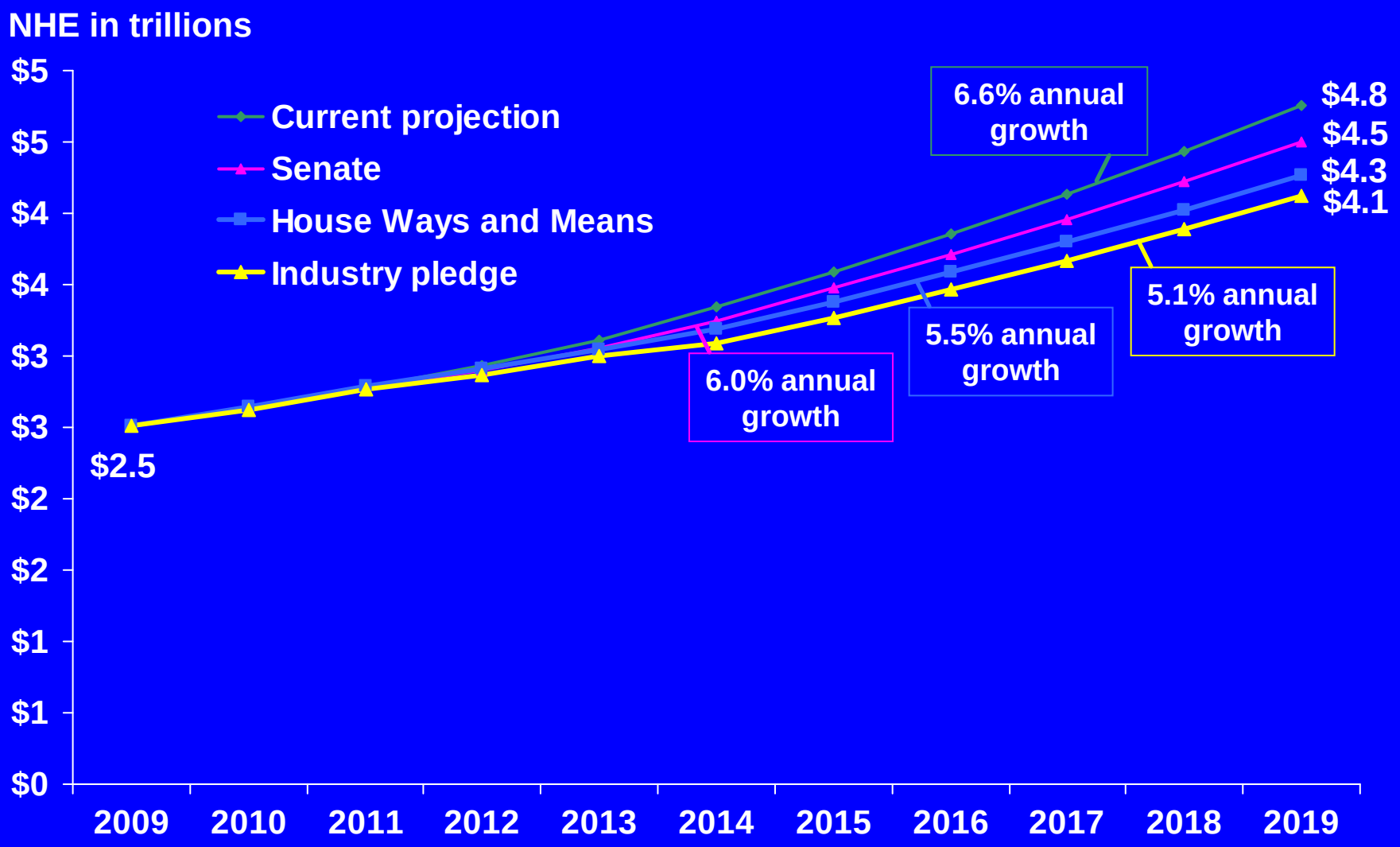


Net Impact of Commonwealth Fund Path Recommendations National Health Expenditures Compared with Current Projection, 2010–2020 (in billions)

	Total NHE	Private Employers	State & Local Governments	House-holds	Federal Budget
Total Payment Reforms	–$1,010	–$170	–$10	–$82	–$749
Enhanced payment for primary care	–$71	–$28	–$2	–$11	–$30
Encourage adoption of Medical Home model	–$175	–$25	–$13	–$36	–$101
Bundled payment for acute care episodes	–$301	–$75	–$4	–$11	–$211
Correcting price signals					
• High-cost area updates	–$223	–$64	–$3	–$29	–$127
• Prescription drugs	–$76	+$22	+$12	+$5	–$115
• Medicare Advantage	–$165	$0	$0	$0	–$165

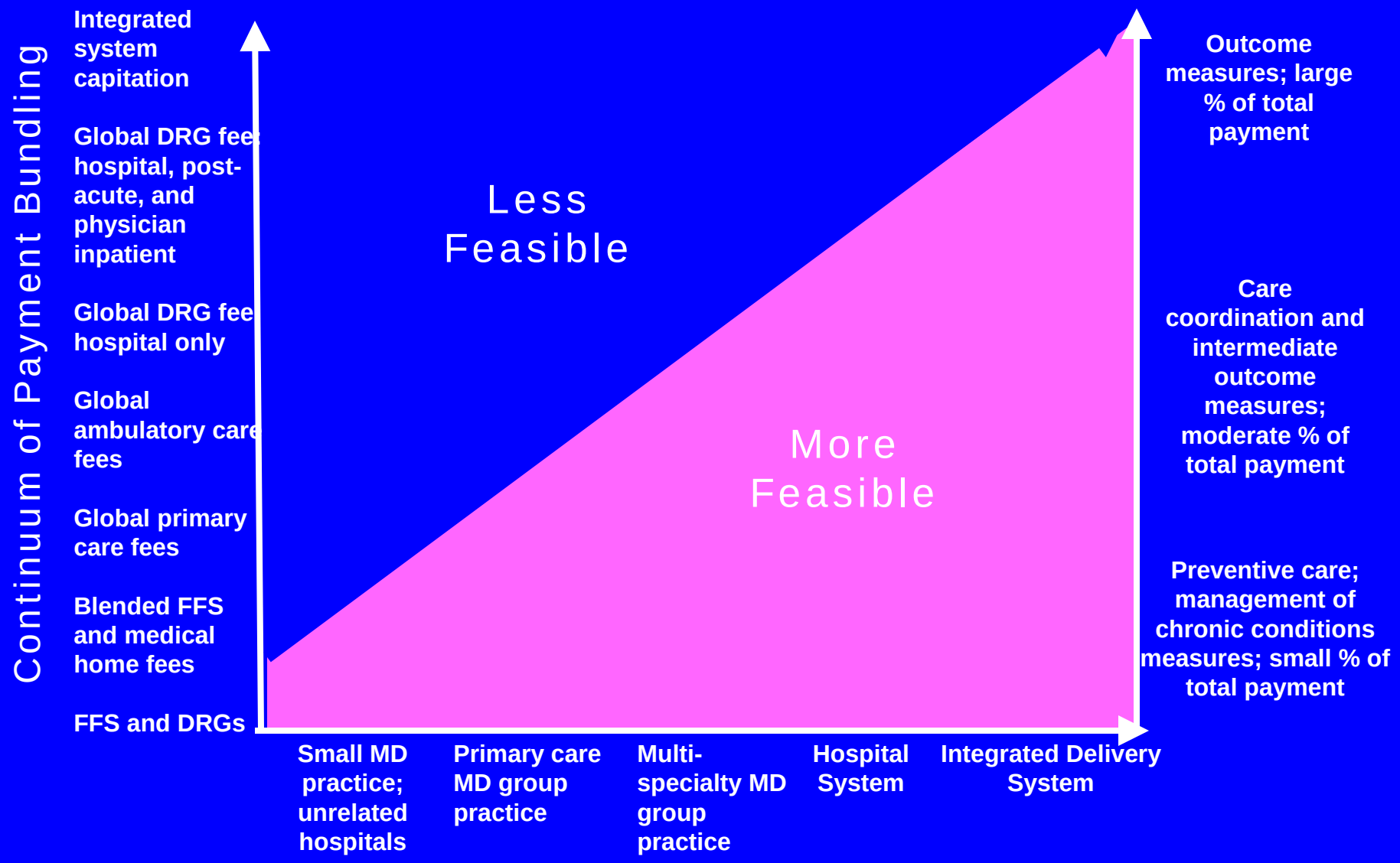
Source: S. Guterman, K. Davis, C. Schoen, and K. Stremikis, Reforming Provider Payment: Essential Building Block for Health Reform, The Commonwealth Fund, March 2009

Total National Health Expenditures (NHE), 2009–2019
Current Projection and Alternative Scenarios



Data: Authors' estimates.

Organization and Payment Are Interrelated: Need Incentives for Organized Care



Source: A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance*, The Commonwealth Fund, August 2008

Payment Reform Innovations: What is Promising?

- Rewarding performance based on quality and/or cost
- Patient-centered medical homes
- Aligning hospital and inpatient physician incentives – gain-sharing
- Acute care episode payment
- Episode-based payment
- Accountable care organizations with shared savings
- Global payment – risk-adjusted full or partial capitation with quality bonuses
  - Group employed model
  - Integrated delivery systems
  - Nonprofit community health plans

Rewarding Performance

Integrated Healthcare Association (IHA)

California statewide leadership group that promotes quality improvement, accountability, and affordability of health care. Principal projects include:

- IHA P4P Program in California (2003 to present)
  - Largest non-governmental physician incentive program in the U.S. with over $315 million paid to date
  - 235 physician organizations representing 35,000 physicians providing care for 10.5 million members
  - 7 CA health plans participate in incentive payments and public reporting – Aetna, Blue Cross, Blue Shield, CIGNA, Health Net, PacifiCare, and Western Health Advantage. Kaiser Permanente participates in public reporting only.
  - Data is collected, aggregated, and analyzed by NCQA
  - Includes measurement and reward of efficiency and resource use
  - P4P program is evolving into performance-based contracting
- Value Assessment and Purchasing of Medical Devices
  - Project designed to improve data transparency and payment methods for high-value medical devices, including orthopedic and cardiac implants
- Healthcare Affordability: Bundled Episode of Care pilot
  - Demonstrates the feasibility of private-sector episode payments in the context of complex CA healthcare delivery system.
  - Initially includes episode payments for total knee replacement and CABG

Bridges to Excellence

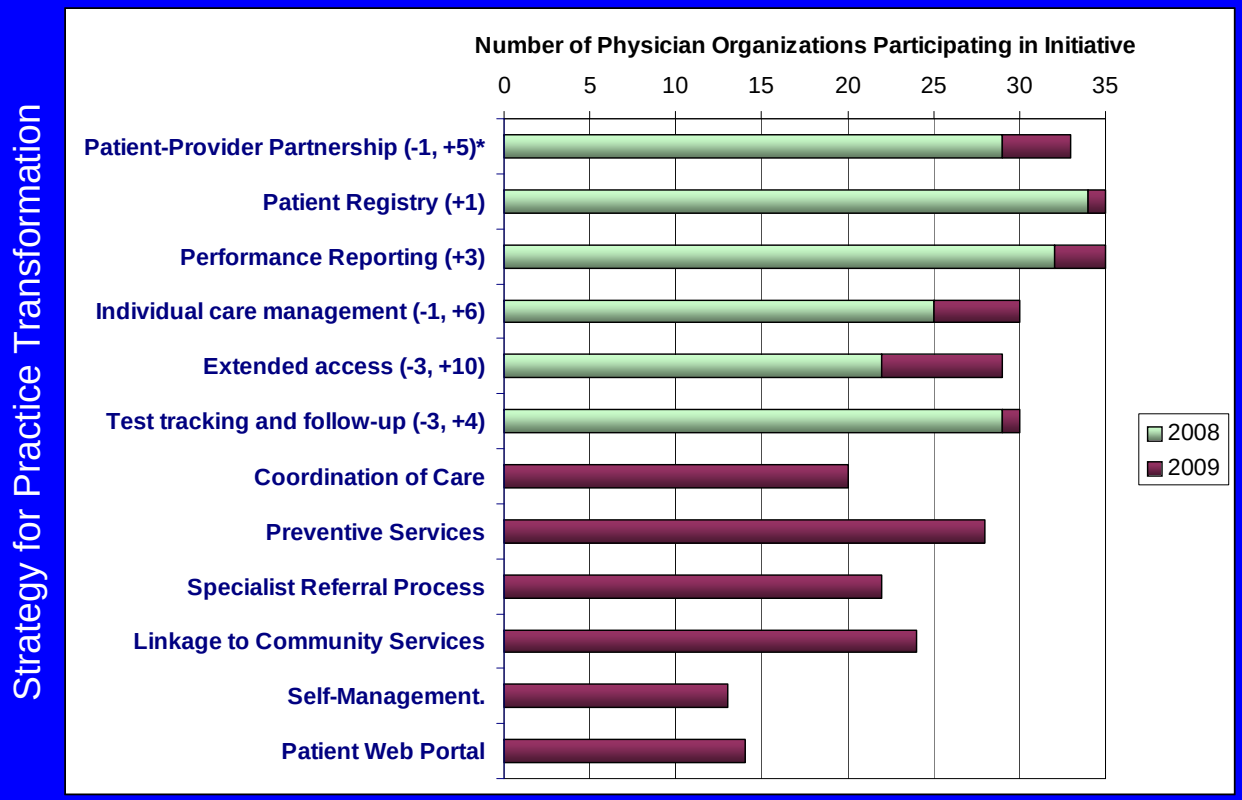
- Began in 2003
- Offers bonus payments to:
  - Physicians in: ME, CT, NJ, MA, MD, DC, NY, PA, OH, VA, KY, NC, GA, AL, IL, AR, MN, TX, CO, UT, AZ, CA, and WA;
  - Who treat patients employed by participating employers or enrolled in member plans for high performance; and
  - Deliver high performance care across 12 dimensions
- Approximately 14,000 physicians and 3,000 practices have been rewarded $12.4 million in bonuses from 2003-2009

ICSI Institute for Clinical Systems Improvement

- Founded 1991, by HealthPartners Medical Group, Mayo Clinic, and Park Nicollet Health Services in MN and WI
- Includes 56 medical groups sponsored by 6 health plans
- Baskets of Care
  - MN DOH has defined 7 "baskets of care" to help consumers compare services and rewards providers for high quality, low cost services over an episode of care
- Health Care Home
  - Health Care Home Steering Committee – representatives from provider groups, payers, purchasers, patients, academia, and gov't agencies
    - Adopted the principles of a PCMH endorsed by AAFP, AAP, ACP, and AOA
    - Focusing on developing care delivery models, financial and measurement models, and engaging stakeholders to increase transparency
    - Addressing technical and cultural changes of having a PCMH, determining connectivity between PCMHs and specialty groups, and determining patient expectations
  - State Health Care Reform
    - ISCI was awarded a contract to recommend health care system and patient outcomes to be considered in evaluation of health care homes for Minnesota's health care home rule which took effect in January 2010
- Palliative Care
  - Will address delivery redesign, payment methodologies, and elements of patient/family-centered care

Michigan BCBS Physician Group Incentive Program

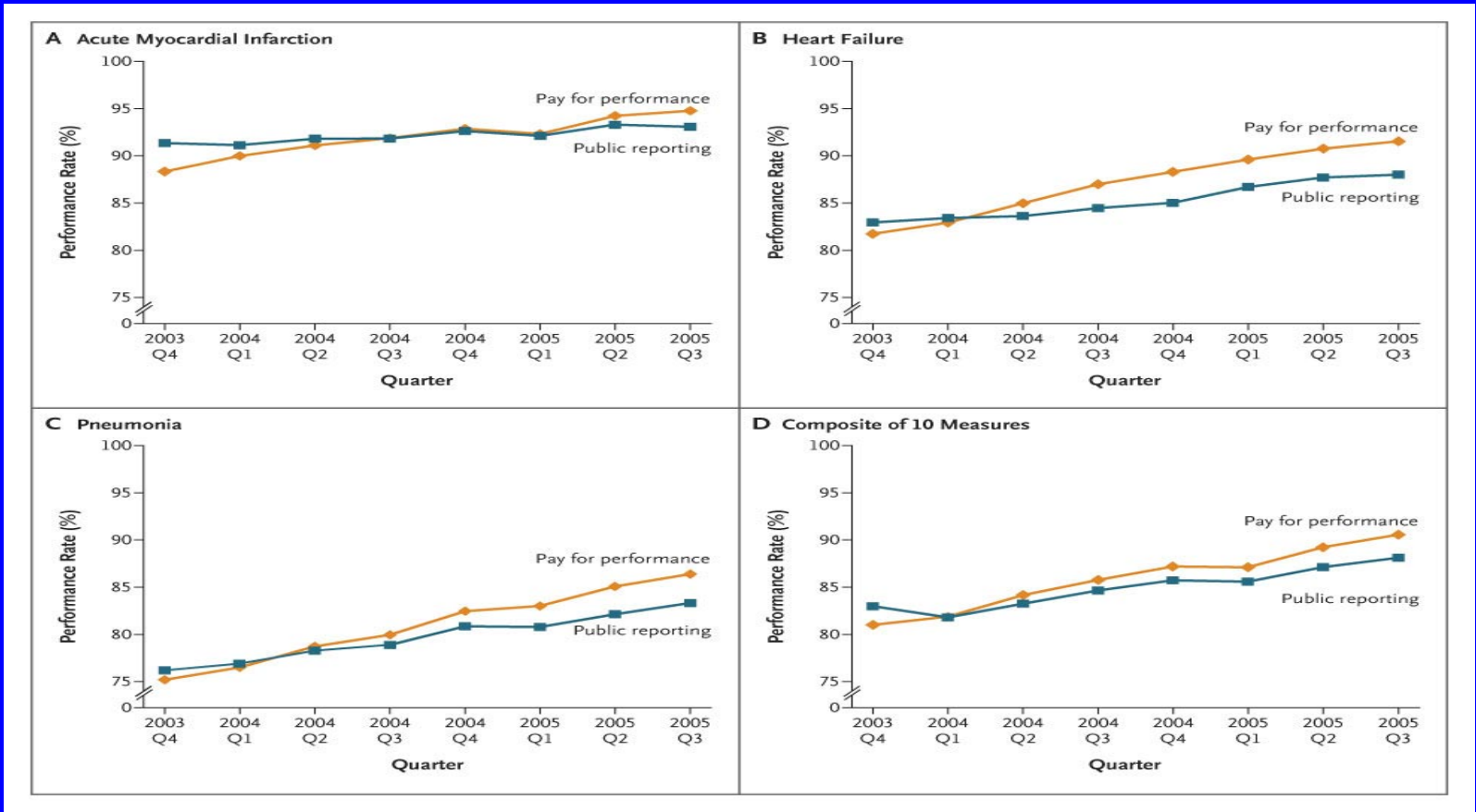
- Designed in 2005 by BCBS-MI to reward high quality, cost-effective care with proactive management of patient populations
- As of 2010 includes: 8,148 physicians in 38 groups, covering 1.8 million people with an incentive pool over $64 million as of 2009
- Principles:
  - Population based
  - Rewards performance and improvement of physician organizations
  - Allows for customization and collaboration rather than “one size fits all”
  - Voluntary



Source: M. Casmer and Linda Mackensen, BCBS-MI. “Large-scale PCMH Program Launch within BCBS-MI Value Partnerships PGIP.” 10/6/09.

HQID Medicare-Premier Hospital Demonstration Improves Quality

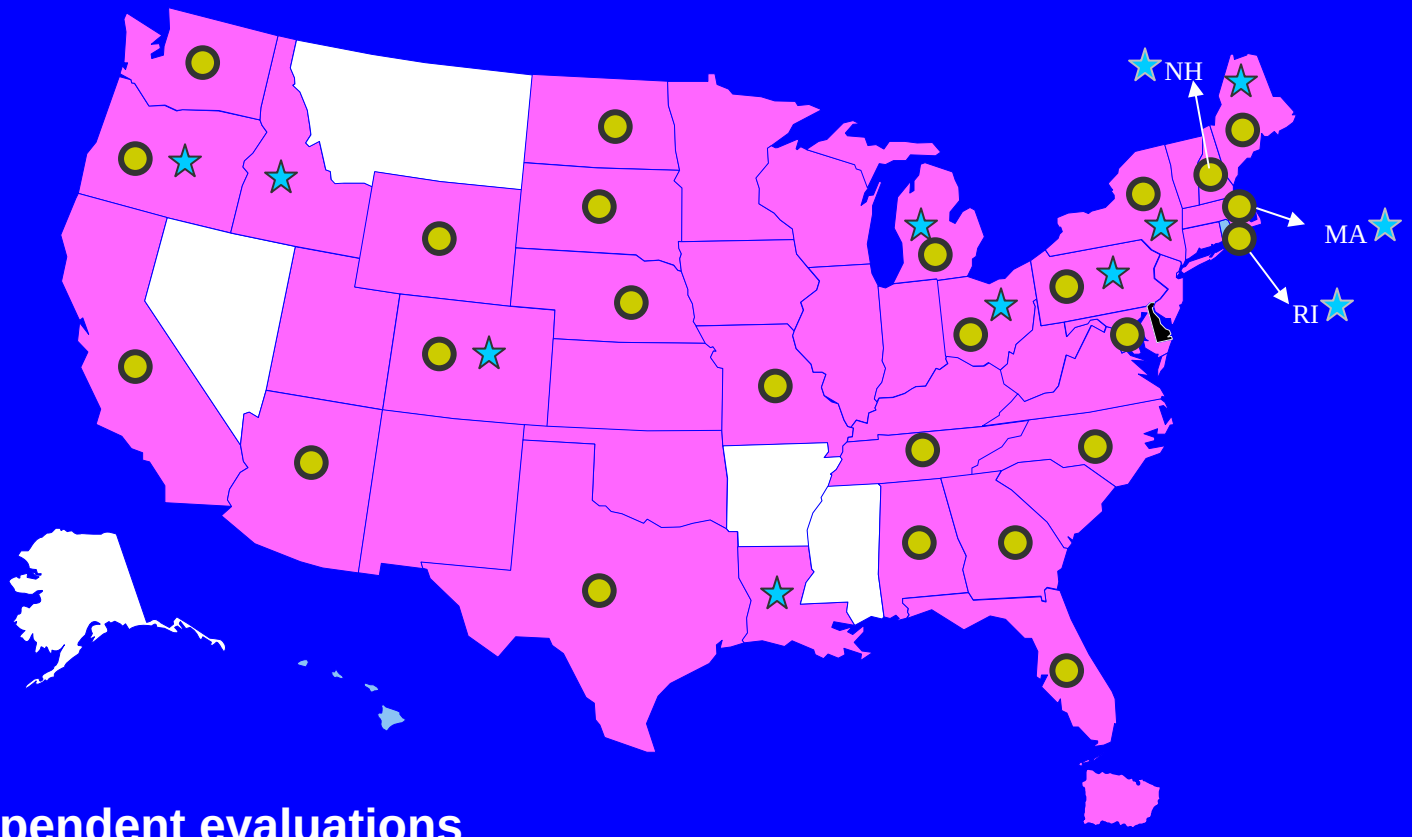
For hospitals participating in the Premier healthcare alliance, Centers for Medicare and Medicaid Services (CMS) Hospital Quality Incentive Demonstration (HQID) pay-for-performance project, the median composite quality scores (CQS), a combination of clinical quality measures and outcome measures, improved significantly between the inception of the program in October 1, 2003 through June 30, 2007 (15 quarters) in all five clinical focus areas:



Source: P.K. Lindenauer, et al. Public Reporting and Pay for Performance in Hospital Quality Improvement , NEJM 356:486-496

Patient-Centered Medical Homes

2009 Overview of Medical Home Pilot Activity, Evaluations, and Planning Discussions



- **Independent evaluations**
- **Multi-Payer pilot discussions/activity**
- **Identified pilot activity**
- **No identified pilot activity – 6 States**

Source: Patient Centered Primary Care Collaborative, 2009

Group Health Cooperative

Changes in the Physician Practice:

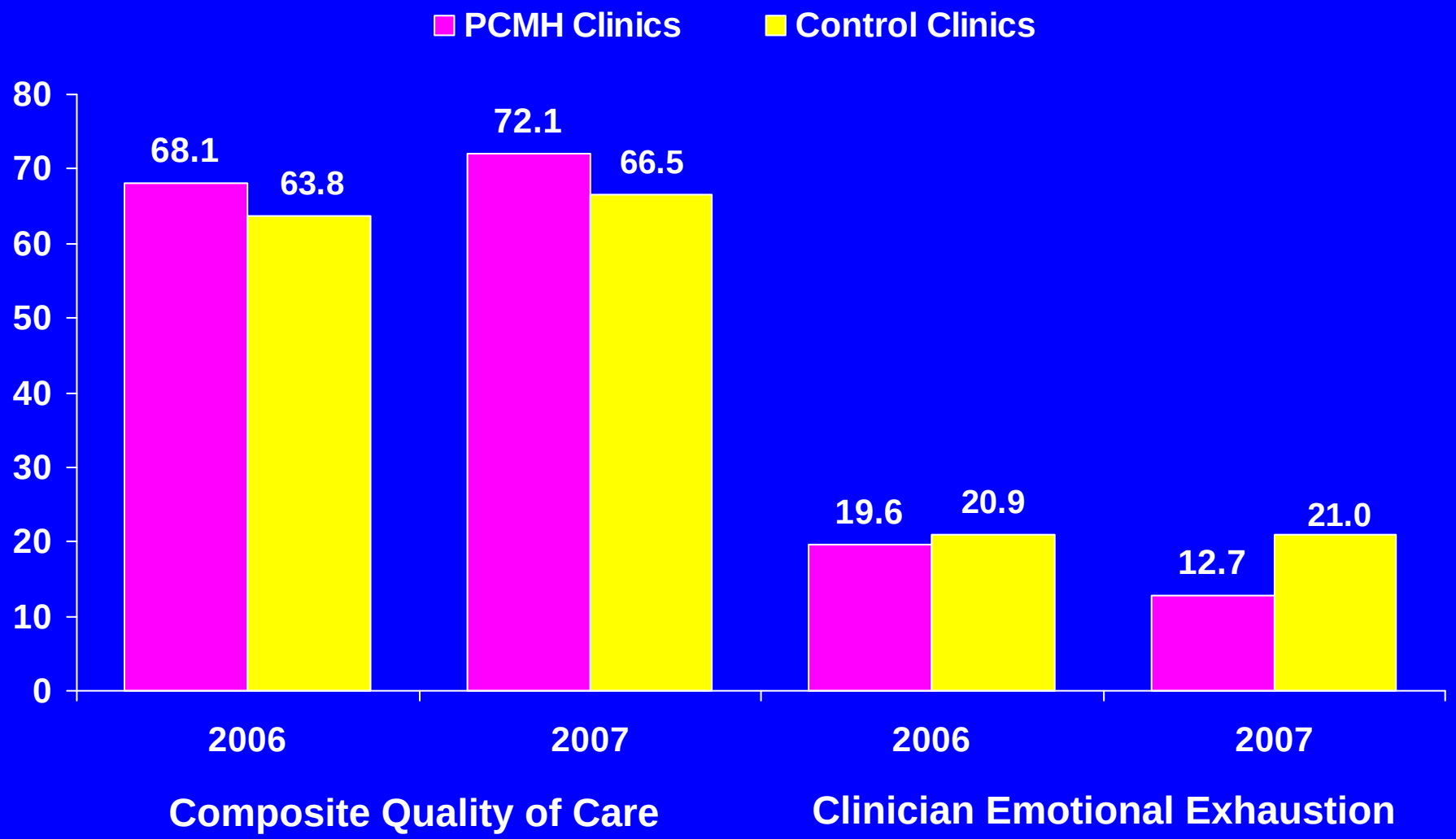
- **Reduced panel size: 2,300 to 1,800**
- **Increased appointment length: 20 minutes to 30 minuets**
- **Increased planned telephone and email virtual visits**
- **Allocated time for staff to perform outreach, coordination, and other activities**
- **Team-based care: Daily care team huddles, pairing MD and medical assistants, visit planning**
- **Chronic disease medication outreach; EMR reminders and alerts**
- **Real-time specialist consulting via EMR**
- **Emergency visit and inpatient follow-up**

Results

- **29 percent reduction in inappropriate emergency care**
- **11 percent reduction in preventable hospitalizations**
- **Significant improvements in patient experience**
- **Significant improvements in physician satisfaction (e.g., lower burn-out rates)**
- **Significant improvement in quality of care (e.g., better control of cholesterol levels among CHD patients)**
- **Despite investment at primary care sites, costs recouped within 12 months**

Source: Reid RJ, Fishman PA, Yu O, Ross TR, Tufano JT, Soman MP, Larson EB. Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. Am J Manag Care. 2009 Sep 1;15(9):e71-87.

Group Health Cooperative: Comparison of Clinical Quality and Staff Burnout at the Patient-Centered Medical Home Site and Comparison Clinics, 2006 to 2007



Notes: Mean difference in composite clinical quality changes from 2006 to 2007 between clinics significant at $p<0.01$; difference in mean emotional exhaustion in 2007 between clinics significant at $p<0.01$.

Source: R.J. Reid, P.A. Fishman, O. Yu, et al., "Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation," *The American Journal of Managed Care* 2009, 15(9):e71-e87.

Geisinger Health System: Personal Health Navigator Program

Changes at the Physician Practice:

- **Nurse embedded in practice to facilitate care coordination**
- **24/7 patient access to primary and specialty care**
- **Internet-based lab results and trending over time, clinical reminders, self-scheduling, secure e-mail, prescription refills.**
- **Provided detailed monthly performance reports on quality and efficiency results.**

Enhanced Payment:

- **Payments of $1,800 per physician per month to recognize the expanded scope of practice**
- **Monthly transformation stipends of $5,000 per thousand Medicare members to help finance additional staff, support extended hours, and implement other changes**
- **Additional incentive pool, conditional upon performance**

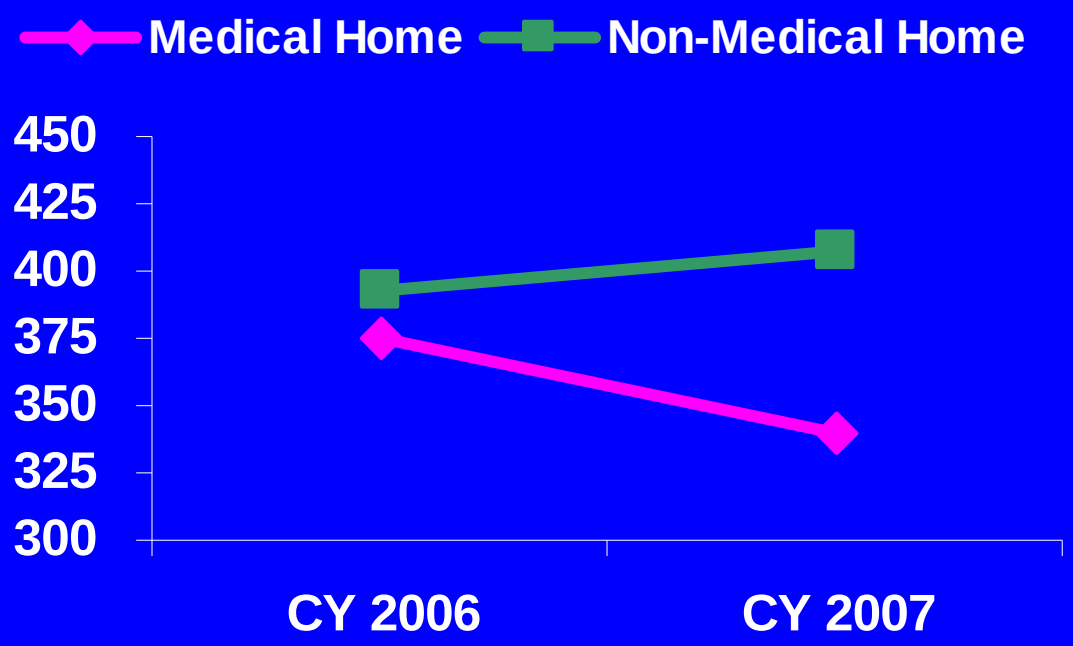
Results:

- **20 percent reduction in all-cause hospital admissions**
- **7 percent total medical cost savings ($3.7 million) between intervention and control practices**
- **Significant improvements in preventive care and chronic disease management in PCMH sites**

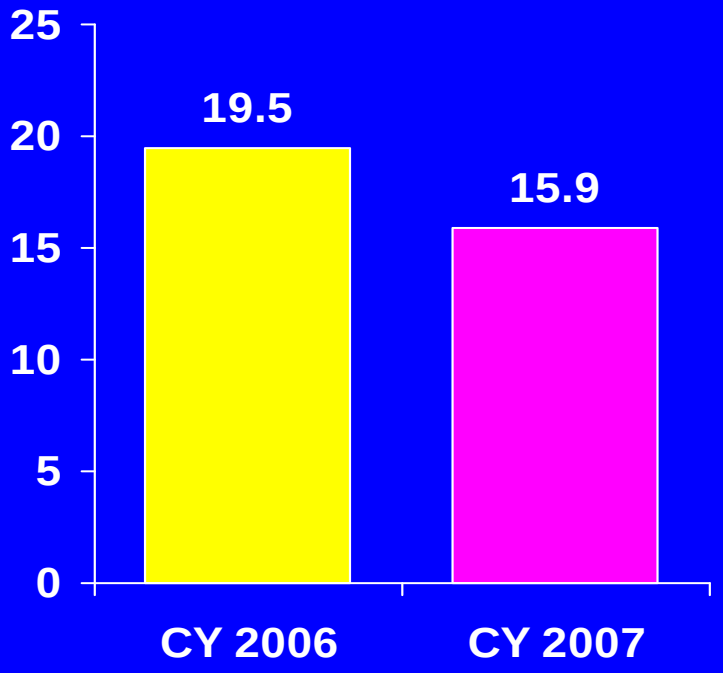
R. A. Paulus, K. Davis, and G.D. Steele, Continuous Innovation In Health Care: Implications Of The Geisinger Experience, Health Affairs, September/October 2008; 27(5): 1235-1245.

Geisinger Medical Home Sites and Hospital Admissions/ Readmissions

Hospital admissions per 1,000 Medicare patients



Readmission rates for all Medical Home Sites



- **20% reduction in hospital admissions**
- **18.5% reduction in hospital readmissions**
- **7% total medical cost savings**

Source: Geisinger Health System, 2008.

Consistent Results from Medical Home Demonstrations Across the Country

HealthPartners "BestCare" medical home Model (Minnesota):

- Proactive chronic disease management through phone, computer and face-to-face coaching
- Increased patient access to care though online scheduling, email consults, availability of test results and post-visit coaching
  - 39 percent decrease in emergency room visits
  - 24 percent decrease in hospital admissions
  - Overall costs in the PCMH practices decreased from 100 percent of network average in 2004 to 92 percent of the state average in 2008

Genesee Health Plan PCMH Model (Medicaid plan in Flint, Michigan):

- Hired "Health Navigators" to work with primary care clinicians to support patients to adopt healthy behaviors, improve preventive and chronic disease care and provide links to community resources
  - 137 percent increase in mammography screening rates
  - 36 percent reduction in smoking
  - 50 percent decrease in ER visits and 15 percent fewer inpatient hospitalizations

Community Care of North Carolina:

- Linked Medicaid and SCHIP beneficiaries to a primary care medical home
- Provided technical assistance to practices to improve chronic care services
- Directly hired nurses to collaborate with practices in case management of high risk patients
  - 40 percent decrease in hospitalizations for asthma
  - 16 percent reduction in ER visit rate of high-risk patients
  - Total savings approximately $135 million per year to Medicaid and SCHIP programs

K. Grumbach, T. Bodenheimer, P.Grundy. The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies, August 2009. Available at: http://www.pcpcc.net/files/Grumbach_et-al_Evidence-of-Quality_%20101609_0.pdf

Commonwealth Fund National Initiative: Transforming Safety Net Clinics Into Patient-Centered Medical Homes

Objective:

- **National demonstration to transform safety net clinics into patient-centered medical homes (PCMH)**
- **To achieve benchmark performance in quality, patient experience and efficiency in safety net primary care practices**

Supporting 65 clinics in 5 regions:

- **Colorado, Idaho, Massachusetts, Oregon and Pennsylvania**
- **Initiative led by Jonathan Sugarman, MD, MPH, President and CEO, Qualis Health and Ed Wagner, MD, MacColl Institute for Healthcare Innovation**
- **Clinics started June/July 2009**
- **Implementation and technical assistance, 2009-2012**

Evaluation led by Marshall Chin, MD, MPH, of the University of Chicago

Funding: Commitment of $8.7 million over five years (including evaluation)

Eight co-funding partners

Medicare Medical Home Demonstration

- Medical home pilots embedded in both Senate and House legislation; authorization for Secretary to spread broadly if improve quality and/or lower cost
- "Medicare Medical Home Demonstration" (§420 of Tax Relief and Health Care Act 2006)
  - Enhanced monthly care management fee to 2,000 qualified primary care physicians in 8 states.
  - Physicians qualify based on (modified) NCQA medical home program. Fees range from $40.14 to $51.70 per member per month
  - Savings are anticipated from reduced resource utilization and fewer hospital readmissions
- "Advanced Primary Care: Medicare Joining Multi-Payer State Demonstrations" (Secretary Sebelius announced 9/16/09)
  - Testing all-payer demonstration with one payment approach
  - Both Medicaid and commercial payer involvement required
  - State multi-payer initiative must be "established"
- "Federally Qualified Health Center Advanced Primary Care Practice Demonstration" (President Obama announced 12/09)
  - Enhanced payment to FQHCs that qualify as medical homes
  - Payment to cover Medicare beneficiaries at FHQCs

Pennsylvania Chronic Care Initiative: Four Different Payment Models

Region	Southeast	Southwest	Northeast	Northwest
Start date	May 2008	May 2009	Oct 2009	Sept 2009
Practices	• 32 intervention practices • Adult and pediatric	• 23 intervention practices • Adult only	• 37 intervention practices • Adult only	• 16 intervention practices
Payment model Details	• $20K per-practice infrastructure payment • $3 "virtual" PMPM at NCQA PPC-PCMH level 3, less at lower levels • Continue preexisting P4P	• $20K per-practice infrastructure payment • $1.50 "virtual" PMPM for participation in year 1 • Additional $1.50 PMPM for NCQA PPC-PCMH level "1 plus" in month 18 • Additional $1 PMPM for NCQA PPC-PCMH level 3 in month 25	• $3K per-physician per year practice support payments • $3K per-physician per practice per year • Shared savings (41-50%), amount contingent on practice requirements	• $12K per year per practice grant • No additional payments from private payers • No PMPM
Technical Assistance	On-site support	On-site support	On-site support	On-site support
Number of Payers	6	4	3	1

Oklahoma Revamping Medicaid Program on Medical Home Model: SoonerCare Choice

- Providers must qualify as "medical homes" based on modified NCQA criteria
- CMS granted waiver to create community care networks that offer care coordination and HIT support (4 networks to be piloted in 2010)
- State provides practices with quality performance reports on key measures (e.g., ED use, preventive care screening)
- Medicaid provides on-site coaches to help with process and quality improvement
- 1,200 participating PCPs; 400,000 members enrolled
- Enhanced payment has 3 components: monthly care coordination payment, visit-based fee-for-service and P4P
  - Care coordination fee varies ($3.03 to $8.69 PMPM) based on level of medical home recognition and type of patient (child v. adult)
  - Bonuses reward improved efficiency and quality (reduced ED use, increased cervical cancer screening rates)
  - Additional FFS reimbursement for after-hours care and behavioral health screening
  - As of 2009, 93 percent of participating practices were receiving an incentive payment, with 708 providers receiving $1.5 million

Hospital-Inpatient Physician Gain-Sharing

Medicare Gainsharing Demonstrations

- Tests arrangements between hospitals and physicians designed to improve quality and efficiency of inpatient care
- Hospitals are allowed to provide physicians with gainsharing payments representing savings from collaborative efforts to improve quality and efficiency
- Hospital Gainsharing
  - Began October 2008 with two demonstration sites:
    - Beth Israel Medical Center, NYC
    - Charleston Area Medical Center, West Virginia
  - Evaluation considers short term improvements in quality and efficiency during inpatient stay and immediately following discharge
- Physician Hospital Collaboration Demonstration
  - Began July 2009 with a consortium of 12 hospitals in New Jersey
  - Evaluation considers quality and costs in immediate post-discharge period and beyond

Acute Care Episodes

ProvenCare® for Acute Episodic Care (the "Warranty")

Created in 2006 by Geisinger Health System

Uses bundled payments with a fixed rate covering preadmission, inpatient, and follow-up care and a patient compact to encourage patient engagement

Covers: Coronary artery bypass surgery, hip replacement, cataract surgery, angioplasty, perinatal care, bariatrics, low back pain, kidney disease

Providers complete a list of best practices before surgery and insurers pay a flat fee for the procedure and readmissions within 90 days

Since 2009:

- Readmission rates lowered by 44%
- Hospital net revenues increased by 7.8%

Medicare Acute Care Episode Demonstration

- Medicare will make a global payment covering hospital and physician services for inpatient stays involving a specific cardiovascular or orthopedic procedure
  - Payment is based on competitive bids submitted during the application process
- CMS will share up to 50% of program savings with beneficiaries to offset cost-sharing obligations
- 5 sites in 4 states:
  - Oklahoma Heart Hospital, LLC – Oklahoma City, OK
  - Hillcrest Medical Center – Tulsa, OK
  - Baptist Health System – San Antonio, TX
  - Exempla Saint Joseph Hospital – Denver, CO
  - Lovelace Health System – Albuquerque, NM

Commonwealth Fund National Initiative: STAAR (State Action on Avoidable Rehospitalizations)

- Partnership between the Institute for Healthcare Improvement, and the Commonwealth Fund
- Goal: To develop and demonstrate a large-scale model for reducing avoidable rehospitalizations; Objective: Reduce rehospitalizations by 20-30% between 2009-2013
- Participating States and Organizations: Massachusetts (12 partner organizations), Michigan (17 partners), and Washington (14 partners)
- Tactics:
  - System redesign - transitions; * Key leverage interventions:
    - Early assessment of discharge needs
    - Effective teaching and facilitate learning
    - Conduct real time patient and family-centered handoff communication
    - Ensure post-hospital care follow-up
  - Measurement, reporting and tracking of readmissions rates
  - Payment and regulatory reform - incentives

Contact: Anne-Marie Audet, M.D., Vice President, Quality Improvement and Efficiency, Commonwealth Fund ama@cmwf.org.

Episode Payment

PROMETHEUS Payment

- Developed in 2006
- Pilot Sites:
  - Utah; Philadelphia, PA; New York; Minnesota; Rockford, IL; Grand Rapids, MI
- Uses an Evidence-Informed Case Rate (ECR)
  - Global payment for an entire episode of care for a particular group, including payers, providers, and patients
  - Severity adjusted based on patient and provider characteristics and demographic factors, with a stop-loss for any variation in ECR and to insulate the provider

Accountable Care Organizations

Physician Group Practice Demonstration

- A 5-year project began in April 2005
- Provides incentives to large multi-specialty group practices who improve care coordination for Medicare fee-for-service beneficiaries
- Each practice shares in Medicare savings resulting from increased coordination and efficiency
- Over the first 3 years all groups met benchmark performances of at least 28 of 32 measures
  - Bonuses are based on the difference between total Medicare spending for patients assigned to the practice and a target amount
- In year 3, 5 of the 10 sites received bonuses totaling $25.3 million in their share of $32.3 million in Medicare savings

Accountable Care Organizations

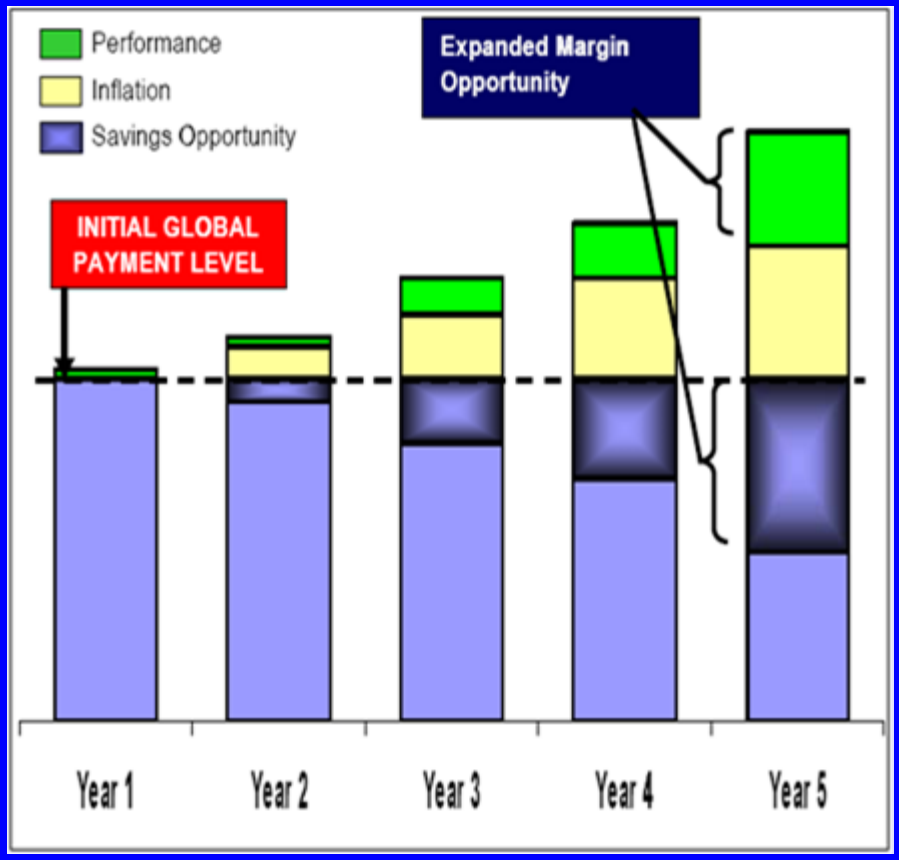
- Designed by Brookings Institution and Dartmouth
- Embedded in both Senate and House legislation
  - Establish provider organizations to manage continuum of care
  - Performance measures to improve care and lower cost
  - Payment reform with spending levels and shared savings
- Three pilots to begin in January 2010:
  - Carilion Clinic, VA – 900 providers and 60,000 Medicare patients
  - Norton Healthcare, KY – 400 providers and 30,000 Medicare patients
  - Tucson Medical Center, AZ – 80 providers and 10,000 Medicare patients

Source: E. Fisher, “Accountable Care Organizations: Why? How? Where Are We Now?” Presentation at 2010 Bipartisan Congressional Retreat, January 15-17, 2010

Global Payment

Massachusetts BCBS Alternative Quality Contract

- Created in January 2009 by BCBS of Massachusetts
- Aims to improve quality of care and efficiency
- As of May 2009, included 7 delivery organizations encompassing 1037 PCPs (19% of BCBSMA network) caring for 265,000 HMO members and a similar number of PPOs
- Uses a 5-year contract that sets a baseline reimbursement to providers at a global capitated rate
  - Designed so inflation-adjusted spending will not rise unless quality improves
  - Coupled with incentives to improve quality based on performance measures
- Creates accountability for financial and quality outcomes across providers and settings decreasing fragmentation

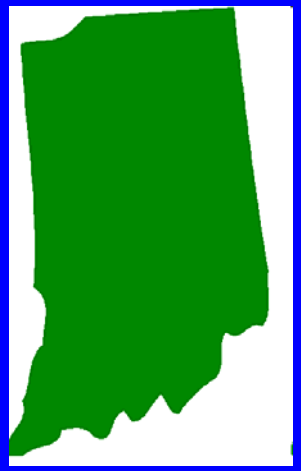


Source: Blue Cross Blue Shield of Massachusetts. Alternative Quality Contract. http://www.qualityaffordability.com/solutions/alternative-quality-contract.html

Multi-Payer Innovations

Medicare Health Care Quality Demonstration Program

- Mandated under Section 646 of MMA, gives CMS broad flexibility to test payment systems to improve care and efficiency
- Indiana Health Information Exchange
  - Regional, multi-payer, and pay-for-performance
  - Will provide evidence for effectiveness of P4P, health IT, and multi-payer initiatives
- North Carolina Community Care Networks
  - Combines physician directed care management and information technology to support care coordination and evidence-based practice with a regional P4P program
  - Tests changes in organization, delivery, and financing of care to improve quality and efficiency



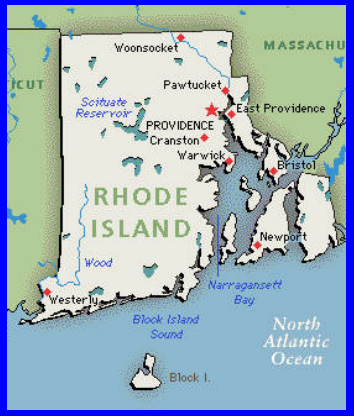
Vermont Blueprint for Health

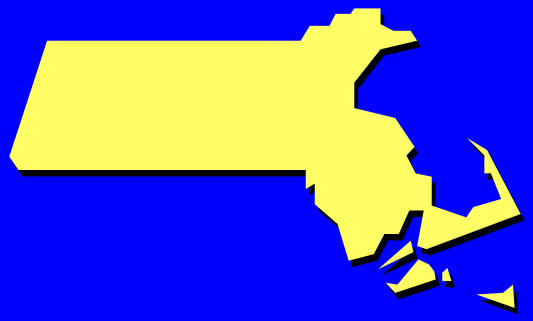
- Payment reform for primary care
  - Patient Centered Medical Home model
  - Sliding care management fee linked to 10 NCQA PCMH criteria
- New community health team funded by payers
- All payer participation
  - Mandated participation by three commercial payers and Medicaid
  - State paying for Medicare patients
- Community based prevention plan and evidence based interventions
- Strong IT support: DocSite clinical tracking tool, EMR interfaces, and health information exchange
- Timeline: Cover 10% of VT population in three communities by 12/09

Source: J. Hester, “Development of a Vermont ACO Pilot: A Community Health System to Achieve the Triple Aims,” Presentation to the IHI Triple Aims Meeting, October 1, 2009.

Rhode Island Chronic Care Sustainability Initiative

- Multi-payer PCMH initiative to bring together purchasers and health plans to target chronic conditions
- Aims to align quality improvement and financial incentives to improve care and enhance primary care
- Implemented at 5 sites with collaboration among medical groups, physician specialty societies and health plans and purchasers
- 29 providers; 28,000 patients
- Each practice receives $3 PMPM to cover costs
- Revenue to practices ranges from $125,000 to $300,000 per year, dependent on practice size





MassHealth

- Massachusetts Medicaid program has been authorized to implement a pilot program for global payments to hospitals or hospital systems to move away from fee-for-service
- The pilot will potentially include a defined set of providers with a large number of Medicaid patients participating in a global fee initiative with a commercial payer and a Medicaid managed care organization

"Innovation Opportunities"

System Reform Provisions of National Health Reform Proposals, 2009

	House of Representatives 11/07/09	Senate 12/24/09
Exchange Standards and Plans	✓	✓
Innovative Payment Pilots; Accountable Care Organizations	✓	✓
Productivity Improvements	✓	✓
Prevention and Wellness	✓	✓
Comparative Effectiveness	✓	✓
Quality Improvement	✓	✓
Primary Care	✓	✓
Independent Payment Advisory Board		✓

Source: K. Davis, S. Guterman, S. R. Collins et al., Starting on the Path to a High Performance Health System: Analysis of Health System Reform Provisions of Reform Bills in the House of Representatives and Senate, The Commonwealth Fund, Updated January 2010.

Future Direction for Payment Reform

- Continued private, state, and federal testing of patient-centered medical homes
- Increased movement toward bundling hospital and post-acute care; incentives to reduce hospital readmissions; hospital-inpatient physician aligned incentives
- Growth of organizations taking greater accountability for patient outcomes and prudent stewardship of resources
  - Accountable care organizations with shared savings
  - Global payment with rewards for quality
  - Group employed models
  - Integrated delivery systems
- Creation of CMS Payment Innovations Center
- Independent Payment Advisory Board
  - Recommendations for Medicare
  - Voluntary recommendations for private payers

Supporting Developments

- Continued investment in research to improve performance, identify and share best practices
- Health information technology; regional extension centers
- Comparative effectiveness research
- Greater transparency and better multi-payer data on comparative performance
- Investment in primary care workforce and improved payment for primary care
- Continued progress in performance metrics and measurement
- Technical assistance to independent practices to improve quality, redesign care processes, collaborative efforts

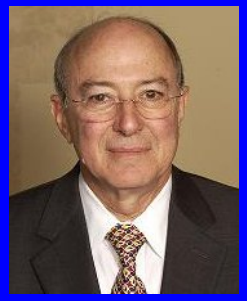
Harmonization of Private and Public Provider Payment

- Long-term will need to bring private and public provider payment closer together in methods and levels
  - Amplify the power of effective incentive approaches by sending the same signals about what is valued across different payers
  - Simplify administrative complexity and reduce burden associated with existing payment methods and minimize administrative burden for providers faced with responding to these new, innovative methods
  - Reduce the likelihood of payment distortions across payers and/or regions
- Important steps in this direction include fostering multi-payer payment innovations under Medicare and state auspices
- Creating better information data systems on payment rates and quality performance across payers and providers

www.whynotthebest.org

- WhyNotTheBest.org – a new Commonwealth Fund web site for tracking performance & facilitating performance improvement
- Enables users to compare their performance with peers, over time, and against a range of benchmarks (currently hospital data)
- Offers case studies of high-performing organizations and improvement tools

Thank You!



Stephen C. Schoenbaum, M.D., Executive Vice President and Executive Director, Commission on a High Performance Health System, scs@cmwf.org

Melinda Abrams, Assistant Vice President, mka@cmwf.org

Cathy Schoen, Senior Vice President for Research and Evaluation, cs@cmwf.org

Heather Drake, Program Associate hd@cmwf.org

Stu Guterman, Assistant Vice President, sxg@cmwf.org

Kristof Stremikis, Senior Research Associate, ks@cmwf.org

For more information, please visit:

www.commonwealthfund.org