



HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

HEALTHCARE PAYMENT REFORM

A CALL TO ACTION

In June 2008, the Healthcare Financial Management Association published *Healthcare Payment Reform: From Principles to Action*. This report urged development of new payment systems built on the principles of quality, alignment of incentives, fairness and sustainability, simplicity, and societal benefit. Policymakers and payers are incorporating these concepts into new payment approaches with the intent of removing barriers to, and creating incentives for, higher value health care. Now it's time for providers to take action.



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CONTENTS

Executive Summary	1
1. Pressure for Change	2
2. Seeds of Change	4
3. Provider Positioning	5
4. Key Competencies	7
5. Key Enablers	13
6. Concluding Thoughts and Agenda for Action	15
Appendix: Healthcare Reform Demonstration Projects	16

Healthcare Payment Reform: A Call to Action

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EXECUTIVE SUMMARY

Signs of payment reform are everywhere—in pay-for-performance programs, demonstration projects, and a flurry of legislative activity in Congress. All signs point to changes in payment streams that will provide the incentives for diverse providers to collaborate to reduce costs and improve quality. For providers, the challenge is to transform their structures and operations to enhance the value of their services in keeping with those incentives.

Lacking specifics about federal legislation and with relatively small amounts of revenue currently tied to quality measures, providers are taking measured steps to position themselves for reform, according to HFMA research. Some organizations have structures in place to formally integrate hospitals and other providers, but are waiting to operationalize those structures until the details of reform become clear. Given the expense and complexity of creating these integration structures, some organizations are waiting for more specifics about payment reform before investing the necessary time and capital. However, most experts can agree that several changes are very likely:

- Shifts away from fragmented, volume-based payments to more unified (bundled or global) types of payments that are episode or population based
- Transitions away from the “medical care” model to a broader-based “healthcare” model, which includes more incentives and payment for prevention and primary care
- Pursuit of comprehensive care processes that require enhanced IT connectivity and more integrated and complex costing methodologies

Federal payment reform appears poised to emerge, and once it does, providers may need to change quickly. To succeed under payment reform, providers can begin today to build their competencies in three key areas:

Integration. The ultimate success of payment reform will depend heavily on collaboration among stakeholders across the care continuum, especially between hospitals and physicians. While all stakeholders are making efforts to improve the quality of their own processes, transformation will require hospitals, physicians, and other providers from across the care continuum to work together to bring the needed change.

Risk Management. Payment reform may shift portions or all of the financial risks among industry stakeholders, making the ability to manage these risks essential for success under payment reform. The two most important changes for providers will involve the financial risk of managing a population’s health and the technical risk associated with adapting to systems based on quality and efficiency.

Pricing. Establishing an accurate price in relationship to cost has been hard enough under traditional fee-for-service payment. Under payment reform, providers will need to set prices for brand new bundles of services at levels that allow them to recoup costs (both direct and indirect), include some measure of the risk involved in providing the service, and incorporate a margin that allows the provider to make necessary capital reinvestments and fund programs central to the mission of the organization.

To develop these competencies, provider organizations will need to be able to access accurate cost information, base decisions on real-time clinical and financial information, understand their competitive markets and the populations they cover, and educate and empower their entire organizations about seizing the opportunities of change.

1. PRESSURE FOR CHANGE

Change is coming to the U.S. healthcare system. Problems in healthcare delivery, payment, and coverage are too large to ignore. The momentum for major healthcare reform is building, as government, employers, the public, and providers express concerns about the current system's challenges in relation to costs, national economic growth and development, global economic competitiveness, access and quality of health services, and healthcare infrastructure.

GOVERNMENT PERSPECTIVE

Government pays for about 48 percent of all healthcare costs in the United States today. With costs rising rapidly, healthcare payments are becoming an increasingly unsustainable burden at both the federal and state levels. The latest Medicare Trustee report projects that the Medicare Health Insurance Trust Fund will be exhausted by 2017. For the fund to remain financially viable in the long term, either payroll taxes that fund this portion of the Medicare program would have to more than double or an immediate 53 percent reduction in Medicare spending would have to occur. Neither of these actions appears to be achievable practically or politically.

Another important concern for the government is providing affordable coverage for the 46 million who lack healthcare insurance. Uninsured individuals are less likely to have access to the sound primary and preventive care necessary for maintaining good health. This lack of access ultimately raises the cost of caring for the uninsured, and these costs spread throughout the healthcare economy as a hidden burden on every public and private stakeholder.

The Obama administration and congressional leadership have vowed to act swiftly to implement healthcare reform that will extend coverage to the uninsured, improve quality levels, and reduce costs. The president's first budget

proposal included provisions to extend coverage to the uninsured, with \$630 billion in funding for the expansion coming through transfers from existing healthcare programs. The Senate Finance Committee and Health, Education, Labor and Pensions Committee have held multiple listening sessions and vowed to mark up legislation in June 2009.

State-level government also is taking action. Led by Massachusetts, dozens of states are implementing programs to expand coverage, create medical homes, and/or bundle payments. These initiatives provide valuable evidence about which ideas hold the most potential for achieving positive and meaningful reform.

EMPLOYER PERSPECTIVE

After a decade of seeing healthcare inflation near double digits, U.S. employers and workers are spending significantly more on health care than are major economic powers in Europe and emerging nations in other parts of the world. For every dollar spent on health care by U.S. companies, corporations in the G-5 countries of France, Germany, Italy, Spain, and the United Kingdom spend \$0.63, and BIC (Brazilian, Indian, and Chinese) companies spend only \$0.15.¹

This healthcare cost burden is eroding the economic performance of U.S. companies in the global marketplace. U.S. automakers, for example, have been at a competitive disadvantage because healthcare coverage of their workers adds \$1,525 to the price of every one of their cars.

In response to these cost burdens, employers are changing the way they provide coverage for their employees. Many are seeking insurance products that give beneficiaries more financial incentives for pursuing healthy lifestyles and choosing the right services and healthcare providers to support these efforts.

HFMA'S PAYMENT REFORM PROJECT

The Healthcare Financial Management Association recognizes that changing the current healthcare payment system is key to achieving the nation's overall health goals of wellness, high-quality care, access to care and other societal benefit, and financial stability. In September 2007, HFMA held a retreat titled Building a Better Payment System to get input from a cross section of payment system stakeholders and identify principles that should guide changes to the current system. Arising from that retreat was the paper *Healthcare Payment Reform: From Principles to Action*. The paper identified the guiding principles of quality, alignment of incentives, fairness/sustainability, simplification, and societal benefit. The paper further identified a number of payment techniques that could support the principles and included feedback

from industry stakeholder groups about how these techniques might be received in the industry.

In September 2008, HFMA brought together a group of healthcare executives to examine the actions that providers would need to take to support various approaches to payment reform and followed up that retreat with research to see how leading provider organizations are preparing for reform.

The result is this paper, *Healthcare Payment Reform: A Call to Action*, which shows the key competencies that provider organizations will need to succeed under payment reform that is emerging from the federal government and throughout the country.

HFMA will continue to help its members and others involved in healthcare finance to succeed given the nation's efforts to build a sustainable and effective health system.

PUBLIC PERSPECTIVE

About one in three individuals responding to a Kaiser national survey report that their family has had problems paying medical bills, and almost one in five report such problems stem from medical bills amounting to more than \$1,000. Healthcare costs are not only pocketbook issues; they affect wellness and well-being. Nearly half of those surveyed reported someone in their family has skipped medications or postponed or cut back on medical care due to the cost of care.²

It's no wonder then that half of the public believes the healthcare system needs fundamental change and 20 percent believe the system should be completely overhauled.³ Second to the Iraq war, health care was considered by voters during the last general election to be the most important problem for the federal government to address.⁴

PROVIDER PERSPECTIVE

The 2008-09 economic decline is threatening the financial stability of the nation's hospitals. Fifty-four percent of hospitals responding to an HFMA survey conducted in April 2009 reported a negative margin, 73 percent reported a decrease in days cash on hand, 43 percent reported a decline in patient revenue, and 78 percent reported a decline in nonoperating revenue.⁵

Hospitals, which already provide nearly \$30 billion in uncompensated care per year, are seeing more uninsured and underinsured patients. Sixty-one percent of hospitals surveyed in January 2009 reported that rising charity care expenses are hurting their financial performance, while 63 percent reported that rising bad debt is hurting their financial performance.⁶

Although government, employers, the public, and healthcare providers may not see eye to eye on the most desirable approaches to reform, their joint concerns have created a powerful momentum that is already bringing about change.

2. SEEDS OF CHANGE

Seeds of payment system change already are planted and growing, and the emerging shape is being strongly influenced by federal reform efforts as well as experiences gleaned from various pilot projects.

Significant changes are occurring at the national level. In February 2009, Congress passed legislation to expand the SCHIP healthcare program for children. The legislation provides \$33 billion in funding that will support government-subsidized insurance for 4 million children from low-income households and reduce the number of uninsured children by half over the next four and a half years.

The American Recovery and Reinvestment Act (often called the stimulus package) includes \$147.7 billion in healthcare spending. Most of that amount (\$111.3 billion) is intended to assure health insurance coverage through Medicaid and extended COBRA benefits. But \$19 billion is allocated for healthcare IT intended to improve quality and reduce costs by streamlining communication among physicians, hospitals, and patients. Another \$1.1 billion is for comparative effectiveness research that seeks cost savings by identifying the best treatments that can be delivered at the lowest price.

Although the scope and structures of long-term healthcare reform efforts are still taking shape, policy options are beginning to surface. President Obama's proposed budget for FY10 includes a major expansion in healthcare coverage funded by a shift of \$630 billion from other healthcare programs, including provider payments and Medicare Advantage plans. Major savings are expected to come from bundling hospital and post acute care payments (\$17 billion) as well as by reducing payments to hospitals with high readmission rates or low quality scores (\$20 billion).

Other reform actions are taking place on a smaller scale, through demonstration projects sponsored by health plans, government agencies, insurance companies, universities, and even private companies. These projects are designed to determine the specific mechanisms that might promote efficiency and quality. (See the appendix for a list of these projects.) Most of the projects focus on improved management of high-volume, high-cost (often chronic) conditions,

including diabetes, cancer, cardiac conditions, asthma, or hypertension. Also common are projects in such specialty areas as pediatrics, orthopedics, and obstetrics/gynecology. Many of the projects are studying the impact of enhanced preventive care on healthcare costs and how to create financial incentives to reward prevention.

Typically, these projects measure treatment effectiveness using established standards for quality and efficiency, such as evidence-based protocols promulgated by specialty societies or standards of organizations such as the National Quality Forum and the National Committee for Quality Assurance. In most cases, meeting established goals triggers incentives in the form of bonuses, additional payments for services, or increased percentages for fees. Some projects withhold a portion of payment until goals are met or improvement is noted. Some have no financial incentive but offer educational inducements. Still others pass the incentive to patients in the form of reduced copayments or deductibles.

Payments for favorable outcomes are made in time frames from immediate to years distant. Most frequently, the payments are made within six months of compliance or are reviewed annually. Reviews at periodic intervals allow the project sponsor to evaluate provider success and adjust payments or determine payment. A few of these projects make a one-time payment at the start of the endeavor, and still fewer do not pay until three to five years after the initiation of the study.

Several common threads of these projects are highly suggestive for the shape of forthcoming payment reform. In most of the projects, financial incentives are linked to:

- Clinical outcomes or processes that have been demonstrated to influence outcomes
- Outcomes associated with a condition or episode of care, rather than a specific treatment or procedure
- Avoidance of more intensive care through prevention

For providers, the message of these projects is unmistakable: In the near future, financial success will require collaboration among various care providers and settings, with financial benefit shifting from higher acuity care to maintaining health.

3. PROVIDER POSITIONING

Signs of payment reform are everywhere in pay-for-performance programs, demonstration projects, and a flurry of activity in Congress. All signs point to changes in payment streams that will provide the incentives for hospitals and other care providers to collaborate in ways to reduce costs and improve quality. It will be up to providers to transform their structures and operations to enhance the value of their services in keeping with those incentives. As discussed, a multitude of payment reform pilots are currently operating throughout the country. All of these pilots were designed to achieve specific goals and to inform policymakers about which components of payment structures produce the desired outcome.

Lacking specifics about federal legislation and with relatively small amounts of revenue currently tied to quality measures, providers are positioning themselves for reform in measured steps. Some have structures in place to formally integrate hospitals and other providers but are waiting to operationalize those structures once the details of reform become clear. Given the expense and complexity of creating these integration structures, some organizations are waiting for more specifics about payment reform before investing the necessary time and capital.

To capture how providers are positioning themselves on the cusp of federal reform legislation, HFMA interviewed healthcare provider organizations that have participated in payment reform demonstration projects and that are otherwise on the forefront of reform. Interviewees were an industrywide sample of executives from 25 hospitals and health systems across the country. The interviews—conducted in the spring of 2009 with the assistance of Wrightwood Partners—gathered information on providers' readiness for reform, actual payment reform efforts under way in their local markets, and the steps being taken to prepare for reform.

The interviews sought to determine whether the organizations were experiencing significant financial incentives for change and whether they had made or were planning to make changes in the following areas:

- *Budgeting.* Are providers budgeting for anticipated changes in inpatient or outpatient volumes, coverage, and payment rates?
- *Organizational structure.* What organizational structures have providers put into place to deal with the altered incentives of payment reform?
- *Personnel and equipment.* Are hospitals making investments in existing or new categories of personnel or equipment?

- *Integration.* Are hospitals entering into formal business relationships with physicians and other providers to align their interests and coordinate their ability to enhance quality and lower costs?

Despite the organizations' participation in payment reform projects, the research found that only a small percentage of their revenue currently is tied to quality. Hospital and health system executives interviewed for this project indicated that only about 2 percent of annual revenue is currently at risk because of quality, efficiency, or other measures, and 0.5 percent is at risk because of the health status of the population they serve. However, half of the interviewees noted that insurers in their markets are incentivizing consumers to use high-quality or highly efficient providers, and one-third reported that payers are assembling tiered networks of providers based on measures of quality or efficiency. Given this payer focus on quality and efficiency, it is not surprising that two-thirds of the hospitals in the survey are receiving information from insurers about their performance on quality and efficiency measures as well as how they compare with peer benchmarks.

BUDGETING

One of the most daunting tasks for healthcare providers today is forecasting and budgeting for the full impact of payment reform. Uncertainty about the course and effect of reform efforts is reflected in the range of responses to survey questions about the assumptions that healthcare providers are building into their short-term strategic plans. While interviewees overall anticipate a modest increase in inpatient volume over the next one to three years (+1 percent on average), expectations vary widely: from a -2.5 percent decline in volume for one institution to a +6 percent inpatient growth rate for another.

Some of the larger positive inpatient growth estimates seem to be related to anticipated changes in market share within the organizations' service areas. However, the hospital system that is projecting a -2.5 percent decrease in inpatient volume expects that payment reform will profoundly affect the demand pattern for inpatient services by reducing the number of admissions and raising the acuity levels of the patients who are admitted.

Hospital budgeting and forecasting assumptions for outpatient services fluctuate as widely as they do for inpatient services, with estimates ranging from -2.5 percent to +6 percent and an average of +1.54 percent. Projections of the degree to which government rates and commercial

pricing is likely to change are exhibiting the same wide variation. Nevertheless, interviewees tended to identify local market dynamics, such as competition, rather than payment reform, as significant drivers of utilization and rate forecasting, at least in the short term.

ORGANIZATIONAL STRUCTURE

Although some providers interviewed for this project had structures in place—such as a hospital-physician organization (PHO)—to facilitate a tight integration among providers across the care continuum, they either had not operationalized these structures or had made few changes in organizational structure or service lines in their organizations in anticipation of payment reform. Such lack of structural change likely arises from the complexity of the changes necessary to adapt to a new payment system and the early stage of payment reform activity. With only 2 percent of revenue currently at risk and little in the way of new forms of bundled payments, providers have no incentive to change the structures and service lines that have been developed over many years to fit the vagaries of existing fee-for-service payment schemes. With margins stressed and capital scarce, the financial risks are too high for providers to invest in a new department or service that may not meet the needs of future reform. However, this wait-and-see strategy means that providers will have to be sufficiently agile to adapt their organizations when new payment streams are implemented.

Most providers interviewed for this project are still manually merging quality, clinical, and financial data to assess clinical efficiency and quality—an approach that will be unwieldy as payment reform moves forward, not only because payers will be implementing new sets of measures but also because providers will need to rely on clean and timely datasets to review patterns of performance and identify potential focus areas for improvement.

Interviewees indicated that the CFO is most frequently the person responsible for the processes that merge clinical and financial data and continues to have primary responsibility for the analysis and approval of payment contracts. In the future, the management of new payment processes may demand multidisciplinary teams that require a closer relationship among financial and clinical departments.

PERSONNEL AND EQUIPMENT

Many interviewees reported investing in revenue cycle management, particularly related to health information and coding, to respond to changing demands on their organizations. These investments are consistent with the current payer focus on the collection of data on quality measures.

Many aspects of payment reform are driving investment in IT, not only hardware and software, but also staffing. The emphasis on quality improvement and efficiency will make investment in clinical information systems imperative. And analysis of the data produced by these systems is becoming more critical. One of the larger systems interviewed for this project is making a multi-million dollar investment in IT personnel to enhance a data-mining capability that will be vital for its quality improvement efforts. Another large and geographically dispersed healthcare system noted that its investment in IT is essential for integrating and gaining the cooperation of physicians in efforts to enhance quality and lower costs.

INTEGRATION

The hospital executives interviewed for this project have taken steps to engage physicians, and some are creating the structures and processes for a significant degree of hospital-physician integration. However, while other HFMA surveys identified physician integration as a key strategy, thus far, many hospitals have focused only on physician alignment. (The difference between the two strategies is that integration—which involves changes in care practices to produce better coordination and overall outcomes—requires a closer relationship among providers than does alignment—which involves contractual relationships, limited employment of needed specialties, joint ventures, and similar relationships.) To achieve full integration, the larger healthcare systems are using—or intend to use—existing hospital-physician structures, whether they involve a PHO, a faculty practice plan, or physician-run facilities. These systems focus on improved coordination of care processes. A small number of providers interviewed are stepping up efforts to employ physicians with an eye toward gaining greater physician involvement in quality improvement. However, none of these providers is yet including gainsharing or language on sharing of future payments in employment contracts with physicians.

The issue of hospital-physician alignment is coming to the forefront of the healthcare payment reform debate because neither hospitals nor physicians alone will be able to improve processes across the continuum of care and enhance the efficiency of healthcare system performance. Incentives for hospitals and physicians clearly will need to be aligned.

Yet two significant barriers must first be overcome to achieve both integration of care delivery and alignment of incentives. First, state and federal legal restrictions to alignment must be addressed. Corporate practice of medicine, Stark rules, and so forth put up barriers to effective alignment and integration. Second, incentives need to be

aligned in such a way so as not to create a serious financial burden for providers. As those interviewed stressed, the creation of a formal hospital-physician structure or the large-scale employment of physicians is a costly proposition. Many providers involved in this project believe that the investment in and ongoing loss from these structures is too great and that, therefore, full-sale integration will be challenging for a significant portion of hospitals and physicians.

LESSONS FROM THE SURVEY

The HFMA survey highlights several key actions that hospitals are taking to improve the quality and efficiency of their organizations in preparation for payment reform. First, hospital executives appear to understand that alignment of incentives among providers across the care continuum will be essential to improve quality and lower cost. They are taking steps to begin integrating with physicians through organizational structures such as PHOs and employment of physicians. Second, respondents indicated that they are investing in IT as well as coding and data-mining staff with

their mind on the mantra “you can’t manage what you can’t measure.” Having accurate, real-time data will be essential in managing the process changes needed to reform health care. Finally, providers are accepting that long-term budget projections may not capture potential changes in the market. Only a handful of those surveyed were changing their budget projections in the latter years of a three-to-five-year budget horizon to account for what is likely to be a turbulent utilization picture. That turbulence may be caused by overlapping factors such as economic recovery, the focus on reducing readmissions, the expansion of “never events,” implementation of medical homes, and provider consolidation. Although charting the course of utilization change is difficult, the rate of change likely will be different toward the end of a five-year budget period from what it is during the first year.

Without being able to know exactly where payment reform will go, what can providers do to prepare themselves? The next sections of this report discuss in detail some of the key focus areas suggested by this survey’s findings and the course of reform to date.

4. KEY COMPETENCIES

When federal reform emerges, changes will need to come quickly. Billions of dollars of costs will have to be removed from the healthcare system within the next decade, and providers will be at the forefront of accomplishing that goal. Despite little in the way of a specific roadmap indicating the path of payment reform, providers need to be proactive.

To thrive under payment reform, providers can begin today to build their competencies in three key areas:

- Integration
- Risk management
- Pricing

Building these competencies will require a number of key enablers:

- Costing
- Real-time information
- Market intelligence
- Agility

The following section of this report explains these key competencies, while Section 5 provides more detail about the key enablers.

PRIORITIZATION OF PAYMENT REFORM COMPETENCIES AND ENABLERS			
Enablers	Competencies		
	Integration	Risk Management	Pricing
Costing	Low	High	High
Real-time information	Medium	High	Medium
Market intelligence	High	Medium	High
Agility	Medium	High	Medium

INTEGRATION

Although individual efforts toward quality improvement are important for successful healthcare reform, the heavy lifting of clinical process transformation will require hospitals, physicians, and other providers from across the care continuum to work together. Unfortunately, experience has shown that successful hospital-physician integration is difficult to achieve. The 1990s saw a significant trend toward developing large integrated systems through the mergers of hospitals and the acquisition of physician practices. In many cases these new ventures were not financially successful, and a wave of divestitures of physician practices followed. Often cited as reasons for these “break-ups” were contracting structures that did not provide the proper incentives for achieving clearly stated goals and significant cultural differences between hospitals and physicians.

In recent years the industry has begun to see an evolution in hospital-physician relationships as the voluntary medical staff model has moved to competition over both inpatient and outpatient services, hospitals have experienced difficulties filling key physician roles, and employment of physicians has increased. Although some reason for optimism can be found in the changing environment, most experts anticipate that fully effective cooperation and collaboration will be every bit as difficult to achieve in the near term as it was in the first wave of consolidation in the 1990s.

Success under a payment system that rewards coordination and quality of care requires tight integration among providers and settings across the continuum of care. Those organizations that can develop and maintain strong relationships with physicians will be best positioned for such a future. Also, when hospitals and physicians are tightly integrated through employment or a jointly governed entity, alignment of economic incentives is easier to achieve since it is an intra-organization issue, rather than the even more complex dance of frequently competitive self-interests that is seen with separate entities. The investment needs and loss of revenue experienced by one party may be offset by added revenue accruing to one of the other stakeholders.

That said, experience shows hospital-physician integration is difficult and expensive—a special challenge in the current economic environment. It is unlikely that all hospitals and physicians (and other providers) will be able to participate in fully integrated systems, due to geographic location, size and scope, market conditions, and current physician relationships.

Hospitals and physicians (and other providers) can use a number of different approaches to engage with one another. The tightness of the integration can be judged by the degree to which the arrangement:

- Provides common incentives for quality improvement and cost reduction
- Mitigates the impact of revenue redistribution
- Fosters the flow of information, goods, and services among stakeholders

INTEGRATION APPROACHES AND DEGREE OF INTEGRATION ACCORDING TO KEY FACTORS			
Integration Approaches	Integration Factors		
	Aligns incentives	Mitigates revenue redistribution	Fosters information flow
Part-time compensation	Low	N/A	Low
Gainsharing	Medium	N/A	Low
IT sharing	Low	N/A	Medium-High
Structural integration	Medium-High	Medium-High	Medium-High
Employment	High	High	Medium-High
Accountable care organization/full integration	High	High	High

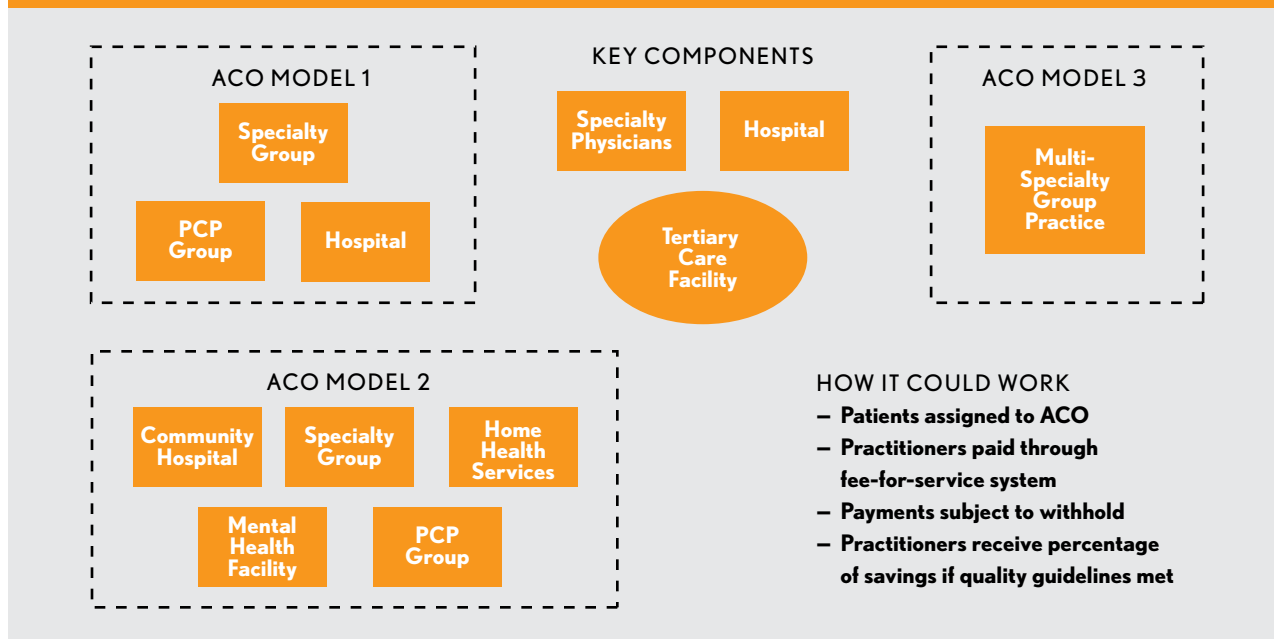
Part-Time Compensation

Arrangements such as medical directorships, departmental chairmanships, and management contracts encourage the physicians in these roles to play a larger role in assisting hospitals with the development and implementation of quality improvement programs. However, they do little to integrate with the wider medical staff and non-staff physicians and offer no opportunity to mitigate the revenue redistribution that is likely to occur under payment reform.

Gainsharing

Gainsharing is another integration tool that holds promise for enhancing quality and efficiency and that can be used outside of the framework of a tightly integrated organizational structure between a hospital and physicians. To date, gainsharing has been fairly narrowly defined by governmental regulatory agencies to include only the savings generated by choosing one medical device over another. The Centers for Medicare & Medicaid Services (CMS) is operating a limited demonstration project to test concepts that would apply gainsharing principles to cover savings from quality improvement efforts between hospitals and physicians. If this form of gainsharing is ultimately permitted, it could become an important tool to align the financial interests of hospitals and physicians to enhance quality and efficiency. In addition, if the effects of revenue redistribution could be included in the calculation of savings, gainsharing could neutralize some of the detrimental effects likely to come

MODELS OF ACCOUNTABLE CARE ORGANIZATIONS



Source: Adapted from Brookings Institution Issue Brief, Accountable Care Organizations, March 2009.

with alignment. (Gainsharing does not require a tightly integrated structure, so the sharing of goods and services would have to be accomplished through another means.) Also, gainsharing concepts should be relatively inexpensive to implement. The most difficult part would be anticipating and defining the savings equation and arriving at contractual agreements with the stakeholders.

IT Sharing

IT connectivity is critical to any integration effort, particularly the use of clinical IT tools to facilitate quality improvement and cost-reduction efforts across provider types and settings. In some cases, sharing of IT across settings can be done without the framework of structural integration. In October 2006, the federal government published a safe harbor to the Stark regulations that allowed hospitals for the first time to donate IT to physicians to support the development and use of electronic medical records. However, IT sharing by itself does little to soften the impact of revenue redistribution or enable the flow of non-technology goods and services among the parties. IT sharing is also costly. A 2006 meta-analysis by the Agency for Healthcare Research and Quality titled "Costs and Benefits of Health Information Technology" concluded that the physical components and software needed to install an electronic health record system in an integrated delivery network with a 250-bed hospital and 16 clinics would cost \$19 million. Whether IT sharing is done outside of or within an integrated organizational structure, costs of this

magnitude may make IT integration outside the reach of a significant portion of the healthcare industry.

Structural Integration

If carefully constructed, organizational structures such as PHOs, medical staff organizations (MSOs), and independent practice associations (IPAs) all can support alignment and revenue redistribution goals. They also can provide the platform to support shared staff and resources that can be very efficient in improving quality and efficiency of clinical processes. However, these structures are relatively expensive to create. So while a formal organizational structure may be a very promising mechanism for hospital-physician integration, not all providers can afford to execute these strategies.

Employment

Full physician employment models should provide tight alignment of incentives and strong mitigation of revenue redistribution. The main difficulty is the subsidy loss that hospitals incur when they employ physicians; the loss has been estimated as an average of \$70,000 per physician per year. Lessons learned from hospitals that were actively engaged in employing physicians and acquiring physician practices in the 1990s may optimize contracting to minimize such losses.

Accountable Care Organizations/Full Integration

Accountable Care Organizations (ACOs) have been discussed extensively by academics and policy experts. Much of the detail on the structure of these organizations has dealt with

CHANGING PAYMENT INCENTIVES

Current payment systems and policy have little to encourage and support successful hospital-physician integration. The prevailing systems pay each party separately and on a volume basis that encourages competition rather than cooperation. Further, while there has been a movement toward pay for performance to provide economic incentives for providers to invest their resources in quality improvement, these incentives generally remain small. Although providers have continued to engage in efforts to improve quality in spite of the lack of economic support, for sweeping transformations in care delivery to occur, these economic incentives must be explicitly recognized and changed.

Bundled payment is the most frequently discussed vehicle for changing economic incentives to foster cooperation among the caregivers involved in an episode of care. The actual features of bundled payment schemes vary. In general, they involve a single payment to multiple caregivers who provide care to a patient. The amount of this payment is dependent on caregivers' abilities to follow efficiency- and quality-driving protocols.

The degree of collaboration induced by bundled payment structures will depend on the specific payment design features. For example, the payment scheme utilized in the Medicare Acute Care Episode (ACE) Demonstration project provides more incentives for hospital-physician collaboration than the current fee-for-service system. However, it involves somewhat challenging negotiations between hospitals and physicians as well as the usual exercise of relative market power among the parties. In the ACE project, which is just getting under way, the hospital receives a bundled payment for an episode of care, and the hospital is expected to have an integrated relationship with physicians or to make payment arrangements with physicians who participate in the episode of care.

Another approach to aligning economic incentives comes from PROMETHEUS Payment, Inc., a not-for-profit

corporation whose mission is to promulgate a payment system that will improve quality, lower administrative burden, enhance transparency, and support a patient-centric and consumer-driven environment. The PROMETHEUS Payment® model bases a portion of the payment bundle on the achievement of certain goals across the entire episode of care. Unlike many other models, however, it ties the economic interests of providers together. Thus, it may be more effective than other models in achieving the desired cooperation between hospitals and physicians.

That said, whether this tie is enough to foster the level of collaboration necessary for achieving clinical process transformation remains to be seen. The answer likely resides in the difficult calculus of overlapping economic and noneconomic incentives for improving value in health care. Noneconomic incentives have been the impetus for much of the improvement in clinical quality to date. Providers have improved processes because it is the right thing to do. The PROMETHEUS Payment model begins to get at providing the economic incentives for alignment and transformation.

Also, it is important to note the PROMETHEUS Payment model deals primarily with the "top line" of the economic picture and all providers involved will be facing an economic impact at the margin level, not at the top line. They will be considering the positive impact on revenue from the incentive payments, but they will also be looking at the investments they will have to make to earn this incentive payment and the gain or loss in margin from utilization impacts stemming from the process change. Every provider, whether a hospital, primary care physician, or specialist, will have a different set of values feeding into these variables; for economic incentives to align, all stakeholders need to achieve a similar result. If the results are not similar in direction and relative magnitude, then the economic incentives will not be aligned and lasting collaboration could be jeopardized.

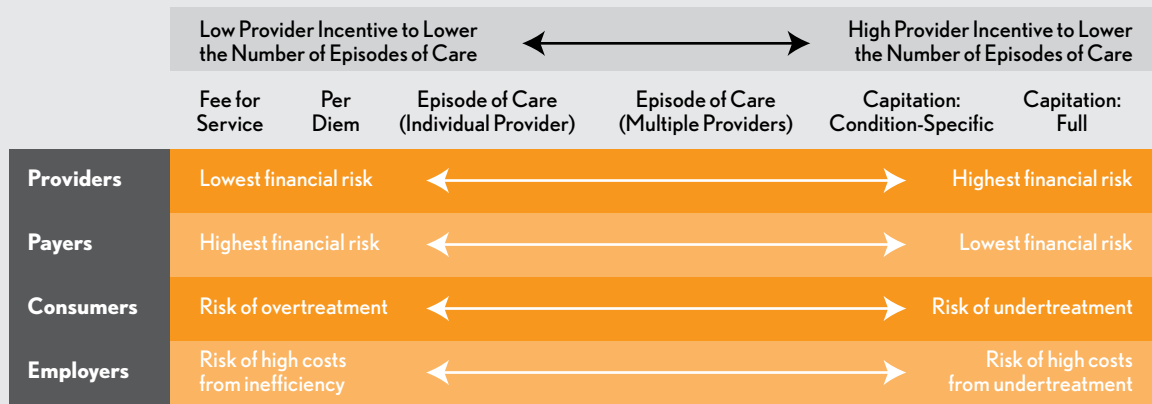
defining them in terms of assignment of patients to the ACO. The Senate Finance Committee's proposed options for delivery system reform recommend that an ACO should:

- Agree to a minimum two-year participation
- Have a formal legal structure that would allow the organization to receive/distribute bonuses to participating providers
- Include the primary care providers of at least 5,000 Medicare beneficiaries
- Provide CMS with a list of the primary care and specialist physicians participating in the organization
- Have contracts in place with a core group of specialist physicians
- Have a management and leadership structure in place that allows for joint decision making (e.g., for capital purchases)

- Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care

PHOs or fully integrated healthcare systems with employed physicians would have the legal structure necessary to receive/distribute bonuses and would have the management structure to support joint decision making. However, the ACO model of hospital-physician integration is too complex and expensive for a significant portion of the healthcare market to adopt. Hospitals will need to assess the range of options to link their incentives and activities with those of physicians and other care providers, and they will need to be ready to take significant steps toward integration if they are to succeed under the types of payment models likely to emerge from healthcare reform.

OVERVIEW OF STAKEHOLDER RISK BY PAYMENT TYPE



Risks for stakeholders by payment type will largely depend on the incentive for providers to be efficient in the treatment process and lower the number of episodes of care.

Source: *Healthcare Payment Reform: From Principles to Action*, Healthcare Financial Management Association, 2008.

RISK MANAGEMENT

Provider organizations are exposed to a variety of financial risks embedded within the payment system for patient care.⁷ Payment reform may shift portions or all of these risks among industry stakeholders, making the ability to manage these risks essential for success under payment reform. The two most important changes for providers will involve the high financial risk of managing a population's health and taking on the technical risk associated with adapting to systems based on quality and efficiency.

Population Health Risk

Providers encounter population health risk (often described as insurance risk) when they take responsibility for the treatment and care of a defined population of patients, usually in exchange for some financial reward or penalty. Providers may assume population health risk in the form of a periodic fixed amount to cover the cost of care, such as a monthly per member per month capitation arrangement, or a retrospective distribution of withholds or incentive payments for achieving population health targets.

Assuming a population's health risk can pose numerous challenges for providers. Because hospitals and physicians have been paid for patient care on a predominantly fee-for-service basis, they have had little incentive to build the capabilities that are needed to understand and price the risks inherent in covering a given patient population. Providers have not been driven to develop the tools and skill sets that are required to effectively manage the healthcare needs of a patient population, which are very different from those needed to meet the acute care needs of individual patients. It has frequently been observed that the key to the success of operating under a capitated payment system

involves the enrollees whom "you don't see more than the ones who utilize services." Providers therefore must extend their reach well beyond the walls of their offices or hospitals and encourage enrollees to access the primary and preventive care services that will help mitigate future need for more costly acute care. Providers in the 1990s were not able to develop the kinds of integrated delivery systems that would promote wellness and coordinate care across the continuum. As a result, almost all providers that chose to manage population risk at the time by entering into capitated payment agreements quickly exited.

Quality Risk

Quality risk is the risk that errors, poor quality of care, or poor outcomes will result in the provision of services that will not be paid for or will result in a penalty. While quality has always been of the utmost importance to healthcare providers, it has only recently been factored into payment for patient care, thereby creating specific payment risk. Many payers are currently adjusting payments based on quality at the patient level. In the near future it is anticipated that they will make similar adjustments at the facility level.

Patient-level adjustments in payment are typically termed "never events," which are defined by the National Quality Forum as "errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a healthcare facility."⁸

CMS links payment with patient-level quality by refusing to pay for "never events" that were not present on admission. If one of these never events is acquired during a patient's hospital stay, CMS will not pay the higher rate that is paid for treating a complication.⁹

Pay for performance is a facility-level adjustment in payment that is based on a hospital's ability to meet or exceed a predefined quality benchmark. Although many pay-for-performance programs are being tested in the marketplace, few are having a major fiscal impact or incorporate strong incentives for clinical process improvement. (Most of these pay-for-performance programs are withholding a portion of the payment and retrospectively reaching a settlement on the amount that will be paid based on aggregate performance against quality metrics.)

Medicare is laying the groundwork for performance-based payment by requiring healthcare facilities to submit quality data electronically in order to receive the full market-basket update. This step ensures that providers will be developing infrastructure and benchmarks that will be needed under pay for performance. In addition to this "pay for reporting" process, CMS also has run several demonstration projects that examine the impact of incentive payment tied to quality performance. The most notable example of these demonstration projects is the Hospital Quality Initiative that CMS is conducting in partnership with Premier, Inc. To date this demonstration project has distributed \$24.5 million to hospitals based on their performance in treating heart attack, heart failure, and pneumonia and in performing coronary artery bypass grafts and hip and knee replacements.

Efficiency Risk

Efficiency risk is related to a facility's ability to provide care in a cost-effective manner at an acceptable level of quality. Successfully managing this risk requires reasonably accurate cost data and control over most of the inputs to care. Providers encounter efficiency risk when payment systems pay a fixed amount based on fee for service (DRG payments) or a unit of time (per-diem payments).

While quality and efficiency risk are solely under the control of healthcare providers, most fee-for-service payment systems have transferred some degree of this risk to insurance companies. Providers therefore have had little incentive to coordinate or align their actions in order to improve the overall value of services by simultaneously decreasing cost and improving quality. A key goal of payment reform is to rectify the misalignment of incentives by holding providers fully responsible for efficiency risk.

The experience managing risk under capitation in the 1990s yields some lessons for organizations that will manage risk under today's evolving payment systems. Organizations that managed population-health risk successfully under capitation did the following:

- *Accepted capitated contracts only for well-defined populations.*

By accepting population risk for a defined group, providers

increased the accuracy of cost estimates and therefore were able to negotiate payments that were more likely to cover costs and provide a profit margin.

- *Became highly integrated.* Integration at this level was achieved by investments designed to stringently control costs and manage quality. Specifically, these investments created a "three-legged stool" that improved financial reporting systems, developed clinical care tools, and empowered front-line staff.¹⁰

PRICING

Establishing an accurate price in relationship to cost has been hard enough under traditional fee-for-service payment. Under payment reform, it will be even harder.

Providers will need to establish prices and negotiate payments at levels that allow them to recoup costs (both direct and indirect), include some measure of the risk involved in providing the service, and incorporate a margin that allows the provider to make necessary capital reinvestments and fund programs central to the mission of the organization.

Providers face several basic challenges in pricing that payment reform will only exacerbate. One challenge is that the intensity and volume of services and hence the costs associated with a procedure or condition may vary markedly depending on physician practice patterns. Another challenge is that hospital cost-accounting systems typically are not able to accurately cost the subcomponents of services or allocate indirect costs. And costing processes at physician practices and other smaller provider organizations are often rudimentary. As a result, providers have to rely on a cost-allocation process that leads to wide variations between the actual and derived cost of a procedure or service. Also, integration of care processes requires integration of costing processes. Most providers have done limited work on these costing systems. Finally, as variations in quality outcomes increasingly affect payment, providers will need to determine how prices should incorporate that factor into contract analysis and pricing.

One commonly cited approach to payment reform would entail bundled payments that expose providers to quality and financial risk by providing one all-inclusive payment for an episode of care and by sharing risks among all providers involved in that episode.¹¹ The definitions of the episodes of care that may be suitable for bundled payment vary. Some common elements include conditions that:

- Are either highly prevalent or incur high costs
- Require coordination among disparate providers
- Need services that are not currently reimbursed
- Have clear boundaries
- Have existing clinical practice guidelines or are amenable to practice guideline development

Given the scope of services that may be covered in an episode of care, providers need to take a new approach to pricing, one that separates the component services of traditional units of payment such as DRGs or APCs, understands the individual costs of these services, and reassembles costs in flexible packages that represent these new bundles.

To price services in this way, clinicians must establish best practices of care for the conditions that meet bundling criteria, and healthcare finance departments need to acquire or develop cost-accounting systems that provide accurate micro-cost data.

At a high level, actions required of providers for pricing under a bundled system would be as follows.

- Estimate how many cases of a given condition are likely to occur during a year based on an analysis of the population covered and statistical averages
- Use the evidence-based protocol for that condition to determine the treatment activities related to the condition
- For each treatment activity, determine:
 - The resources (eg, equipment, facilities, and supplies) needed to perform the treatment activity
 - The practitioner most likely to use these resources
 - The location where the activity most often is delivered
 - The length of time needed to deliver the care¹²

- Use this information to estimate the total cost for an episode of care related to the treatment protocol
- Multiply the cost by the estimated number of patients who will require this treatment pathway over one year
- Add the required margin to the cost and adjusting the result to take competitors' pricing positions into account

Bundled payments will not only require providers to view the cost and quality of services rendered within their own organizations, but also to link the performance of all providers involved in an episode of care in order to align incentives. Providers analyzing the impact of bundled payments on their organizations should therefore have a clear understanding of the utilization patterns of the patients within the episode: Do these patients tend to utilize services within the provider organization or elsewhere? Is there a collaborative framework in place that will facilitate the management of quality and cost across all providers involved in the episode? The answers to these questions will be crucial for providers to establish the risk of sustained financial loss on bundled payments and hence the pricing of the bundle.

5. KEY ENABLERS

Mastering the competencies of integration, risk management, and pricing requires a number of key enabling factors, including costing, real-time information flow, market intelligence, and agility.

COSTING

Successfully managing population health and technical risk requires providers to obtain precise cost data for each of the component procedures that constitutes an episode of care so they can negotiate proper price and payment levels, establish benchmarks for continuous quality improvement initiatives, and identify and eliminate costly variations in clinical care. Results from the Medicare Heart Bypass Demonstration project provide an interesting case in point. Due in part to financial system upgrades made in advance of the demonstration project, three of the four participating

facilities were able to substantially reduce costs by using detailed cost information to convince physicians of the need for cost-effective clinical decision making. Changes in clinical decision making led to reductions in hospital lengths of stay and the use of generic drugs rather than branded medications. Because the remaining facility did not invest in an advanced financial information system, it had considerable difficulty validating costs and, as a result, spurring changes in physician practice patterns.¹³

REAL-TIME INFORMATION FLOW

Many types of clinical care tools also are required to improve quality, reduce cost, and effectively manage population health. Clinical care processes that make use of disease registries, encourage peer review among physicians, and compare results to available quality benchmarks help hospitals establish

optimal practices that minimize clinical variation, reduce costs, and improve quality. Dedicated care coordinators supported by utilization management tools make further gains in quality and performance by ensuring that patients adhere to treatment regimens and receive the right care at the appropriate time. Technology solutions such as electronic health records facilitate the coordination of care by making a patient's medical record readily available across the health system so physicians can compare treatment outcomes when creating evidence-based best practices.¹⁴

Healthcare reform will make it critical for providers to monitor and understand their operations in more detail than ever before. New metrics, such as readmissions rates, never events, quality measures, outcomes, and detailed costs, will have to be collected, analyzed, aggregated, and re-aggregated as bundles change. Understanding and managing the sources of volumes and the cost of those services has never been more critical to the success of a provider organization. Providers also should carefully examine their service offerings to determine whether they remain relevant, are positioned well in the market, and are consistent with strategic goals.

MARKET INTELLIGENCE

It will be essential for providers to understand how they are positioned within their market based on cost, quality, and customer satisfaction data. Further, the health and demographic profile of the market will need to be well understood. Are there opportunities for collaboration or acquisition in the market that could enhance the organization's strategic position? Are competitors likely to consolidate or align themselves with other key stakeholders? Market intelligence also entails understanding the health needs of the population the organization intends to cover—a critical factor in pricing and managing financial and clinical risk.

AGILITY

The changes necessary to succeed under payment reform will require an organizationwide effort, involving everyone from front-line staff to the board. The organization will need

to analyze the potential effects of reform, educate and train staff on reform and what it will mean to the organization, and create a framework for collaboration.

Detailed cost data and well-developed clinical care tools will have little impact if front-line personnel are not empowered to use them. Providing caregivers (including staff and non-staff physicians) with financial and management data allows front-line personnel to identify and eliminate variations in patterns of care. Training in basic financial skills helps healthcare personnel identify issues and interpret their implications on the delivery system's performance. Regular meetings bring multidisciplinary staff together to discuss issues and design improved clinical protocols.¹⁵

Two types of incentives are especially helpful in encouraging improvement in cost and quality:

- Having a service line manager and a designated physician “medical co-leader” for each facility's focus areas who are both held directly accountable for clinical and financial outcomes under their control
- Providing direct financial incentives to staff. Hospital employees receive bonuses if goals are exceeded. To avoid the appearance of any impropriety, shared gains for non-employed physicians are reinvested into the clinical area, and funds are typically used to pay for staff increases, education, equipment, or research.

Many of the changes arising from reform will not be spelled out in the *Federal Register* or other payer notification, but will come through decisions along the care continuum that will ripple through multiple provider settings. Being ready for these changes requires careful analysis of those potential effects. For example, has leadership questioned what efforts to reduce readmissions will do to patient volumes? How long will it take for the organization to recognize the impact from the implementation of medical homes within the market? Providers will need to be extraordinarily sensitive to these shifts, and once these shifts are understood, take action. Having staff that are well educated on the possible course of payment reform, are empowered to take action, and are used to working in a collaborative framework will enhance the agility of the organization.

6. CONCLUDING THOUGHTS AND AGENDA FOR ACTION

Payment reform has the potential to bring sweeping transformations to the way clinical care is delivered and provider organizations are managed. While the exact course of reform is yet to be seen, the outlines are clear. Don't wait. Provider executives must consider the known and possible reform concepts in the context of their organizations' strengths and weaknesses. It is important to resist the urge to hunker down and to wait for additional details to be published. Enhancing the competencies of integration, managing risk, and pricing will help ensure

that an organization will be in a position to succeed financially and to continue to fulfill its patient-care mission in a reform environment. Further developing "enablers" for costing decisions, real-time information flow, market intelligence, and agility will allow providers to adapt to the various iterations of payment reform. Embracing the process of reform will help organizations shape themselves, their market, and the healthcare industry in a way that provides patients with the highest quality care and that will be sustainable for decades to come.

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APPENDIX

PAYMENT REFORM DEMONSTRATION PROJECTS

Program name	Program sponsor(s)	Program location	Provider segment(s)
Medical Home Demo	CMS	All states	Physicians
Hospital Value Based Purchasing/ HQID Pay for performance	CMS/Premier	All states	Hospitals
Acute Care Episode	CMS	Texas, Oklahoma, New Mexico and Colorado	Hospitals and Physicians
EHR Demo	CMS	12 states	Physicians
PCP Recognition Program	BlueChoice, Inc.	District of Columbia, Maryland, Virginia	Physicians
Quality-In-Sights®: Hospital Incentive Program (Q-HIPSM)	Anthem Health Plans, Inc., Anthem Health Plans of Maine, Inc., Anthem Health Plans of Virginia, Inc., Blue Cross Blue Shield of Georgia, Inc., Blue Cross Blue Shield of Georgia Healthcare Plan of Georgia, Inc., Empire HealthChoice Assurance, Inc. and Empire HealthChoice HMO, Inc.	Connecticut, Georgia, Maine, New Hampshire, New York, Tennessee, Virginia	Hospitals
Anthem Hospital Quality Program	Anthem Blue Cross Blue Shield	Indiana, Kentucky, Missouri, Ohio	Hospitals
QualityBlue Hospital Pay for Performance Program and QualityBlue Physician Pay for Performance Program	Highmark Inc.	Pennsylvania	Hospitals
Hospital Performance Incentive Program	Excellus BlueCross BlueShield	New York	Hospitals
Recognizing Excellence	Blue Cross Blue Shield of Minnesota	Minnesota, North Dakota, South Dakota, Wisconsin	Physicians
Blue Shield of California's Integrated Healthcare Association (IHA) Pay for Performance Incentive Program	Integrated Healthcare Association (IHA), Blue Shield of California	California	Physicians
Blue Shield of California Integrated Healthcare Association (IHA) Pay for Performance Program	Integrated Healthcare Association, Blue Shield of California	California	Physicians
Blue Cross of CA Program	Blue Cross of California	California	Physicians
PPO Pulse	Blue Cross of California–PPO Pulse P4P Program	California	Physicians
Ohio Payment for Quality Program	Anthem Blue Cross Blue Shield of Ohio	Ohio	Physicians
Colorado & Nevada Primary Care PHQ	Anthem Blue Cross and Blue Shield Colorado, Anthem Blue Cross and Blue Shield Nevada	Colorado, Nevada	Physicians
Performance Improvement Rewards Program (PIRP)	Blue Shield of California	California	Physicians
Hospital Performance Incentive Program (HPIP)	Blue Cross Blue Shield of Massachusetts	Massachusetts	Hospitals
Recognizing Physician Excellence	Blue Cross and Blue Shield of Florida	Florida	Physicians
PCP Incentive Program (PCPIP)	Blue Cross Blue Shield of Massachusetts	Massachusetts	Physicians
Group Performance Incentive Program (GPIP)	Blue Cross Blue Shield of Massachusetts	Massachusetts	HMO, PPO and other health plans
UnitedHealth Practice Rewards	UnitedHealthcare	Florida, Illinois, Indiana, Kansas, Ohio, Texas, Wisconsin	Physicians
The Gold Standard	Savannah Business Group on Health	Georgia	Hospitals
Platinum Standard–Physician Performance Measurement	Savannah Business Group on Health	Georgia	Physicians
Duke Prospective Health	Duke University and Health System	North Carolina	Hospitals
Duke University Live For Life Employee Health Promotion	Duke University	North Carolina	Hospitals
Workplace wellness program	American College of Physicians– Center for Practice Innovation	California, Colorado, Delaware, Georgia, Illinois, Maryland, New Jersey, New Mexico, New York, Ohio, Pennsylvania, South Carolina, Texas, Vermont	Physicians

Program name	Program sponsor(s)	Program location	Provider segment(s)
Closing the Gap Program	American College of Physicians, sponsored by educational grants from the AHRQ, Novo Nordisk, Pfizer, and Bristol Myers Squibb	All states	Physicians
ACOVEprime: Improving Geriatric Care	American College of Physicians, RAND/ UCLA, and Atlantic Philanthropies	All states	Physicians
Adult Immunization Quality Improvement program	American College of Physicians and the Centers for Disease Control	All states	Physicians
Physician Incentive Program	Priority Health	Michigan	Physicians
Pay for Performance	Priority Health	Michigan	Physicians
Kansas Medical Home	Kansas Med Home, Kansas Medicaid	Kansas	Physicians
Guaranteed Savings / Financial Performance Measures	Pennsylvania Department of Public Welfare (DPW)	Pennsylvania	Medicaid
Pennsylvania Department of Public Welfare ACCESS Plus Provider P4P Program	Pennsylvania Department of Public Welfare (DPW)	Pennsylvania	Physicians
Ohio Medicaid Managed Care P4P Program	Ohio Medicaid Managed Care, The Ohio Department of Job & Family Services	Ohio	Medicaid HMO participants
Performance-Based Contracting – MCO Pay for Performance Program	PA Department of Public Welfare	Pennsylvania	Medicaid HMO participants
Good Signs to Wellness	Goodwill Industries of Central Indiana, Inc.	Indiana	Payer
Quality Incentive Program	PacificCare/ United	California	Physicians
Medical Home Facilitation	Capital District Physicians' Health Plan	New York	Physicians
MVP Health Care Pay for Performance	MVP Health Care	New York, Vermont	Physicians
Aetna – Bridges to Excellence participation	Georgia: UPS, Xerox, Southern Company, Choice Point Cincinnati and Louisville: UPS North Carolina: GSK, Wachovia D.C. Metro area, Seattle	Physicians	
Provider HEDIS Bonus Program	Health Plan of Michigan	Michigan	Physicians
Supporting Excellence Rewarding Quality	Hudson Health Plan	New York	Physicians
Value Based Formulary	Marriott International	All states	Pharmacy
Bridges to Excellence	Bridges To Excellence	Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Kentucky, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New York, North Carolina, Ohio, Washington	Physicians
Clinical Diabetic Quality Bonus Program	HealthAmerica	Pennsylvania	Physicians
Primary Care Physician Incentive Program	Paramount Health Care	Ohio	Physicians
Physician Quality Summary	Geisinger Health Plan	Pennsylvania	Physicians
MedEntentive Information Therapy Program	MedEntentive, LLC	All states	Physicians
Diabetic Incentive Program	FedEx Express	All states	HMO, PPO, and other health plans
Immunization and Well-Child Incentive Program	Department of Social and Health Services, Health and Recovery Services Administration, Medicaid Managed Care	Washington	HMO and Medicaid
Distinctions (sm)	HealthPartners	Minnesota, North Dakota, South Dakota	Hospitals
Partners in Quality Programs: Partners in Excellence and Partners in Progress	HealthPartners	Minnesota, Wisconsin	Hospitals
HealthPartners Healthy Benefits (sm)	HealthPartners	All states	HMO, PPO, and other health plans

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