View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by IssueLab

June 2010

Issue Brief

COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

Developing Innovative Payment Approaches: Finding the Path to High Performance

Stuart Guterman and Heather Drake
The Commonwealth Fund

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this study, please contact:

Stuart Guterman
Assistant Vice President
Payment System Reform
The Commonwealth Fund
sxg@cmwf.org

To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts.

Commonwealth Fund pub. 1401
Vol. 87

ABSTRACT: The Center for Medicare and Medicaid Innovation, created by the new health reform law, has a mandate to develop innovative payment models to improve health care delivery. To achieve higher quality and slower cost growth, the new center should be prepared to try a variety of approaches that will encourage and reward more integrated care across the health care continuum and work with other public programs and private payers and purchasers to provide consistent incentives for providers and patients. This paper addresses several issues related to facilitating the process of identifying, developing, implementing, and monitoring new initiatives, while recognizing the need to maintain the fiscal integrity of the Medicare program and to focus on new initiatives that show promise to improve quality and control costs.

★ ★ ★ ★ ★

OVERVIEW

During his first presidential campaign, Franklin Roosevelt said: "The country needs, and unless I mistake its temper, the country demands, bold, persistent, experimentation. It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all, try something."[1] With health care spending putting increasing pressure on households, employers, and government budgets, it is more important than ever to try new ideas that have a reasonable prospect of slowing cost growth, improving quality, and increasing value.

The Patient Protection and Affordable Care Act of 2010 establishes new payment initiatives to offer incentives for better and more efficient health care.[2] The success of those initiatives, however, will depend on the ability to identify and carry out needed changes in the way health care is delivered and paid for and the flexibility to tailor innovations to the circumstances in which they are applied.

This issue brief discusses how the development, implementation, and evaluation of new approaches to paying for care can be improved, and how those

improvements can help achieve the broader goals of health reform. We focus largely on Medicare, but also consider the potential for enhancing the impact of Medicare payment innovations through multipayer collaborations involving other public programs, such as Medicaid and the Children's Health Insurance Program (CHIP), as well as private insurers and purchasers of care.

THE NEED FOR PAYMENT AND DELIVERY SYSTEM REFORM

The U.S. health care delivery system is fragmented. Even when the individual health care services provided to a patient meet high standards of clinical quality, the coordination of care, which may be delivered by multiple providers in multiple settings, often is lacking. Inadequate communication among providers, and between providers and patients and their families, is also common. There is a vacuum of accountability for the total care of patients, the outcomes of their treatment, and the efficiency with which medical resources are used.

The way the nation pays for care fuels this fragmentation and fosters this lack of accountability. Fee-for-service payment, which predominates throughout the health system, emphasizes the provision of health services by individual providers, rather than care that is coordinated across providers to address the patient's needs. Under this system, providers are offered strong incentives to deliver complex services and procedures, even when there may be better, simpler, and lower-cost ways to treat the patient. Volume, rather than value, is rewarded, while efforts to coordinate care are not—moreover, no support is provided for the infrastructure required to make such efforts successful. Consequently, fee-for-service payment complicates efforts to promote accountability in the health care system, with no clear lines of responsibility for the overall quality, outcomes, or costs of patient care.

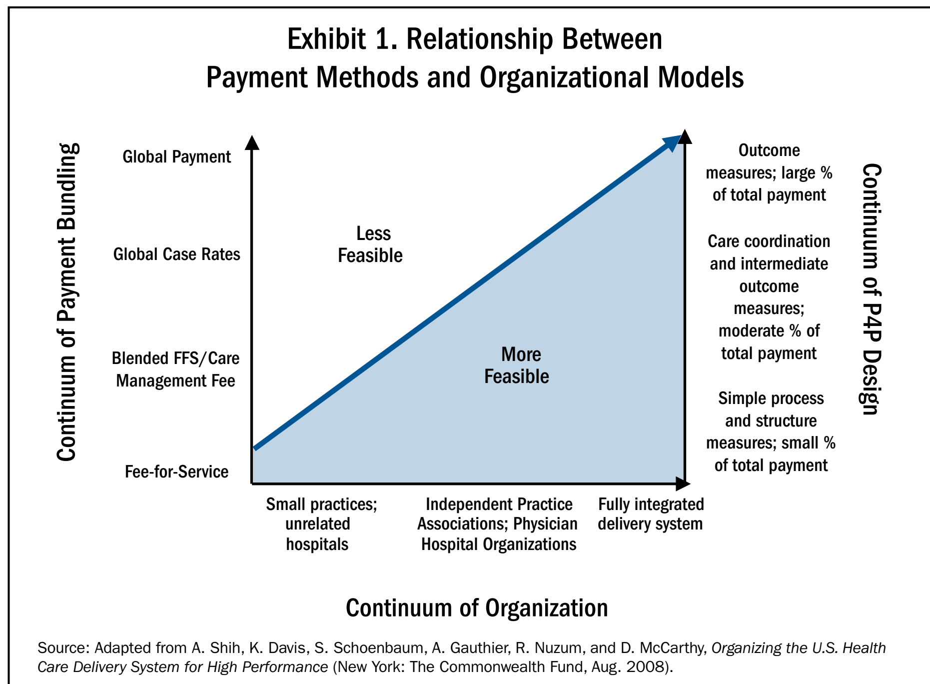
If the objectives of health reform—improved access, higher quality, and slower cost growth—are to be achieved, the health care delivery system must be reformed to provide coordinated, appropriate, and effective care, with accountability for patient outcomes and population health, and more diligent stewardship of the nation's health care resources. But changing the way health care is organized and delivered requires a change in the way it is paid for—with alternative approaches that would better align financial incentives with system goals, and enable and encourage providers to consider their patients' needs in a broader context, collaborate to provide the care that they need, and take mutual responsibility for patient outcomes and cost.

RELATIONSHIP BETWEEN PAYMENT AND ORGANIZATION

In developing new payment approaches, it is important to consider the diverse array of organizational models that make up the health care delivery system and the different environments in which those organizations operate. Provider organizations vary widely in size, scope, and degree of integration, and in the extent to which they may be willing or able to assume broader clinical or financial accountability for their patients' care.

Traditional fee-for-service Medicare, like most other payers, makes direct payments only to independently practicing physicians, hospitals, and other individual service providers. Successfully moving away from the perverse incentives provided by the current system and toward alternative payment approaches and organizational models—such as the bundled payment approach and accountable care organization model specified in the new health reform law—requires recognition that health care delivery may be configured differently in different geographic areas. At least at the outset, then, payment and delivery system reforms must include an array of payment approaches that are compatible with providers' current organizational structure. At the same time, the reforms must establish rewards and requirements that both encourage high quality and value and create incentives for those organizations to offer more coordinated care.

A schematic depicting the interaction between payment methods and organizational models is presented in Exhibit 1. Payment approaches can range from the current fee-for-service system to more bundled approaches, including global payment that



covers all the health care provided to each patient during a year. Organizational models can range from small practices and unrelated hospitals to groups of providers in single-specialty or multispecialty practices or fully integrated delivery systems. The more integrated a health care organization is, the more feasible it becomes for that organization to take responsibility for a larger bundle of patient care. The availability of more sophisticated—and more substantial—rewards for organizations that deliver more effective and efficient care can provide an incentive for providers to move toward greater coordination and accountability and away from the fragmented delivery system that patients currently face.

As payment methods and incentives change, those who deliver care will be able to innovate in response to those incentives. The right incentives can encourage providers to work together, either in formal organizations or in less-formal relationships, in ways that enable them to take broader responsibility for the patients they treat and the resources they use—and benefit from doing so. As organizational arrangements evolve, payment methods can be continuously adjusted to encourage and reward ever-increasing levels of accountability. But even over time, different payment approaches and organizational models may be required in different geographic areas and different market conditions to accomplish the goals of health reform.

PAYMENT INITIATIVES TO ALIGN INCENTIVES AND CONTROL COSTS

The need to change how we pay for health care has been recognized for several decades. Initiatives in both the public and private sectors have aimed to change the incentives embedded in fee-for-service payment, and these provide a foundation for broader payment reform:

- The Medicare program has constructed systems for collecting and reporting data on the quality of care offered by hospitals, nursing homes, home health agencies, and dialysis facilities, and a similar system is planned for physicians. The program also has been testing models for rewarding high-quality performance by hospitals and physicians and is beginning to test value-based purchasing models for nursing homes and home health agencies. In addition, Medicare has been testing models for improving coordination of care among different types of providers, as well as several models of broader system redesign.

- Medicaid programs in more than half the states have pay-for-performance systems in place, and many more have plans to adopt such approaches. Several states have implemented payment reform initiatives to improve access and coordination; some are actively supporting delivery system reform, for example, by promoting patient-centered medical homes and accountable care organizations.[3]
- Within the private sector, there are many initiatives aimed at improving quality and efficiency. Private payers are also pursuing alternative approaches to payment and encouraging greater coordination among the various providers responsible for treating different patient populations.

In September 2009, the U.S. Secretary of Health and Human Services (HHS) announced plans to allow Medicare to join Medicaid and private insurers in innovative state-based advanced primary care initiatives. This type of coordination among payers however, is an exception; consequently, the initiatives developed by different payers suffer from the same fragmentation that many of them are intended to reduce. (Additional detail on some of the particularly noteworthy initiatives is provided in the Appendix.)

PAYMENT INNOVATION PROVISIONS IN THE HEALTH REFORM LAW

The health reform law contains several provisions to develop new payment initiatives intended to improve quality and efficiency and curtail costs.[4] The law calls for pilot projects to assess the effectiveness of medical homes, accountable care organizations, bundled payment, pay-for-performance, and several other payment and system innovations in achieving those objectives. The law also would create a Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS) to oversee the development, implementation, and evaluation of pilot projects to improve care and reduce costs, with the authority to extend and/or expand those projects if they are found to be successful.

Major Payment and Delivery System Initiatives

The health reform law specifies a number of new initiatives to be conducted by Medicare or Medicaid, or both. Some of the major initiatives related to payment and delivery system reform are reviewed below.

Medical home demonstration. Medicare is developing a medical home demonstration in which Medicare beneficiaries with multiple chronic conditions designate a certified physician to provide them with comprehensive and coordinated care for a per-patient care management fee, in addition to the usual fee-for-service payments. Other medical home models to be tested by the new Center for Medicare and Medicaid Innovation include patient-centered medical homes for high-need individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service–based reimbursement and toward comprehensive or salary-based payment.

The reform law also will establish community-based health care teams to support medical homes in small practices; entities eligible to serve this function will include states or state-designated entities and Native American tribes or tribal organizations. It will allow states to enroll Medicaid beneficiaries with chronic conditions into a "health home," in which a team of health professionals provides a comprehensive set of medical services, including care coordination.

Accountable care organizations. The accountable care organization (ACO) is an organizational model based on three key features: local accountability for the effective management of a full continuum of care; shared savings based on historical trends and adjusted for differing patient populations; and performance measurement including outcomes and patient experience.[5] Though these three features are common across ACOs, each organization is potentially different, depending on its mix of patients, configuration of providers, and other factors related to the environment in

which it operates. The ACO model also is compatible with a wide array of payment approaches.

The recently enacted legislation establishes a shared-savings pilot for ACOs, to begin in 2012. Participating providers will receive additional payments for savings relative to a cost benchmark, subject to quality improvement requirements. The HHS secretary will have the authority to extend or expand the use of models found to be successful.

The law also establishes a Medicaid pediatric ACO demonstration project, in which qualified pediatric providers could receive payments as an ACO, subject to certain performance guidelines.

Bundled payment. Bundled payment is an approach in which providers receive a fixed amount to cover a specified set of services—usually related to a particular event, illness, or individual. Providers paid in this way have a strong incentive to manage the resources they use to provide that set of services. Examples of bundled payment in Medicare include: the global surgical fee, a single payment covering all preoperative care and postoperative follow-up care, as well as the surgery itself (including the surgeon's costs, but not the hospital's or other providers' costs); the prospective payment for inpatient hospital services, which covers hospital costs for the duration of a patient's stay (but does not cover physician services provided in the hospital); the home health episode-based payment, which covers all the services provided by home health agencies for a 60-day episode of care; and the Medicare Advantage (private Medicare plan) payment, which applies to all covered care a beneficiary receives in a month.

The new law will establish a Medicaid demonstration project in up to eight states to study the use of bundled payments for hospital and physician services provided during an acute care episode. Each participating state could target the project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the state, with the requirement that the project be as representative as possible of the demographic and geographic composition of the state's Medicaid beneficiaries.

A national voluntary pilot program on payment bundling for acute care episodes, involving hospital, physician, and post-acute care and focusing on selected conditions, will begin by 2013. Providers will be able to share in any Medicare savings, subject to performance on quality improvement measures. Also called for in the new law is a community-based care transitions program to improve care for high-risk Medicare beneficiaries during their move from one care setting to another (e.g., from hospital to home health care).

The legislation also contains a provision for a Medicaid global payment system demonstration project in up to five states. Participating states will adjust their current payment structure for safety-net hospitals from a fee-for-service model to a capitated payment structure, with a single payment covering all services provided to each patient.

Medicare Advantage

Another important issue addressed in health reform is a major revision in how payment for Medicare Advantage plans is determined. Medicare Advantage is the program that gives Medicare beneficiaries the option of enrolling in private plans, rather than traditional fee-for-service Medicare, to receive their coverage.

The new policy establishes different payment benchmarks in each county (phased in from 2012 through 2016). These benchmarks reflect per capita spending in fee-for-service Medicare and the county's level of spending relative to the distribution across all counties in the U.S., with both higher benchmarks and higher rebates (extra payments based on a proportion of the difference between the plan's bid and the applicable county benchmark) for plans that perform well on quality and patient experience metrics.[6] The changes eliminate, over time, most of the extra payments (relative to fee-for-service Medicare) that have characterized the Medicare Advantage program since 2004, and for the first time establish substantial performance-based rewards.[7]

The new payment provisions, along with other provisions enacted in 2009, make Medicare Advantage more promising as a platform for developing new

payment approaches.[8] The new approaches also could lend insight to strategies for coordinating care in fee-for-service Medicare as well.

Center for Medicare and Medicaid Innovation

The Center for Medicare and Medicaid Innovation, which is to be launched in 2011, will test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care furnished to beneficiaries in Medicare or Medicaid, or both. The HHS secretary is given new authority to develop pilot projects that might increase program spending initially, but they would have to be terminated if they are not expected to improve the quality of care or reduce program spending over time (as determined, respectively, by the CMS administrator and chief actuary). The pilots will be formally evaluated, as well, for their impacts on quality and costs, and the secretary will have authority to expand the application of a model if such expansion is expected to improve quality, reduce program spending, or both. Beginning in 2012, the secretary is required to submit to Congress a biannual report on the activities of the new center.

The legislation provides $5 million for design, implementation, and evaluation in fiscal year 2010 and $10 billion for pilots initiated from 2011 through 2019, with further funding available after that initial period. In addition, $25 million is available specifically for designing, implementing, and evaluating the models to be assessed.

SUCCESSFULLY IMPLEMENTING PAYMENT INNOVATION

In creating the Center for Medicare and Medicaid Innovation, the legislation provides a mechanism to develop alternatives to the fee-for-service system and its adverse incentives. The pilot projects initiated by the center are intended to help improve effectiveness and efficiency within the health system while encouraging and supporting a focus on patients' needs.

Focus, Organization, and Management of the Center

Although the Center for Medicare and Medicaid Innovation offers the potential to develop needed payment reforms, several issues need to be considered related to its role and how that role is to be carried out. How these issues are addressed will be critical to the center's success. Following are some suggestions for federal policymakers as they delineate the center's scope and structure and determine how its initiatives are to be selected and developed.

Payment innovation pilots should not be limited to Medicare but should also include Medicaid and other public programs as well as the private sector. One of the key shortcomings of our health system is the fragmented nature in which health care is provided. With few notable exceptions—the Advanced Primary Care Initiative recently announced by the HHS secretary being one—Medicare demonstrations and pilot projects very rarely involve collaboration with Medicaid, the Children's Health Insurance Program (CHIP), or payers in the private sector.[9] There are great potential benefits to be gained from such collaboration in broad payment reform initiatives. Nine of 10 respondents (89%) to a recent Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders survey favored collaboration in multipayer initiatives of this type.[10]

Collaborative efforts across the public and private sectors to develop innovative approaches to payment and health care delivery could have several beneficial effects. Such multipayer initiatives could:

- magnify the power of any new incentives by sending consistent signals about what is valued across different payers;
- reduce administrative burden for health care providers responding to new payment approaches; and
- provide a way to address unwarranted variation in payment methods and rates—that is, those not reflective of differences in the costliness of patients treated—among different payers.[11]

Such an effort across the public and private sectors may also help accomplish important goals of health care reform—to enhance quality, to expand use of evidence-based medicine, and to improve care coordination, while making health care more affordable—and to quickly promote and disseminate new payment models consistent with these goals.

Both 'top-down' and 'ground-up' approaches should be considered. Medicare traditionally has played the lead role in developing and implementing new payment policies, but as described above (and in more detail in the Appendix), there are many new initiatives under way in other public programs and the private sector. CMS should be prepared to take the lead in developing new approaches to paying for health care, but it should be open to initiatives developed and led by states or private sector entities. CMS should actively encourage states to propose waivers for multi-payer payment reform.

An array of payment models, gain-sharing and risk-sharing arrangements, and reward systems should be included among the pilots developed and implemented, and the process should allow for flexibility in modifying those models as experience is gained. The new legislation specifies a number of new models and payment approaches that the Center for Medicare and Medicaid Innovation might try as pilot programs:

- The accountable care organization, described above, is an organizational model that exists in a variety of forms and should be compatible with a variety of payment approaches. Among the approaches that could be tried initially is fee-for-service payment with shared savings, similar to Medicare's ongoing Physician Group Practice (PGP) demonstration, in which participating practices are paid on a fee-for-service basis but with a bonus for holding total Medicare payment below an established growth rate target. The ACO model also can be compatible with a partial capitation approach, in which payments are based on a blend of fee-for-service rates and a global per-patient amount.
- The patient-centered medical home is another organizational model with several potential forms, and similarly should be compatible with alternative payment approaches. One common payment approach is a combination of fee-for-service payment with a per-patient fee for providing medical home services—the method planned for the Medicare demonstration under development. Another approach is to make a global payment for primary care to the medical home provider, which would be receiving a direct reward for managing patients efficiently.
- The health reform law also specifies several bundled payment approaches, under which a single payment is made for a specified set of services, such as for all hospital and post-acute care. There are several ways of defining the services included in the bundle and the applicable payment amount; the key is to provide a group of providers with the incentive to assume joint responsibility for the clinical and financial outcomes of their patients' care.
- For integrated delivery systems—those now in operation and those that will develop over time in response to new incentives—global per-patient payment might be most appropriate. This approach, applied to a system that is organized to assume responsibility for all of the care needed by its patients, can provide more flexibility in determining the appropriate amount and mix of care, because the provider is not focused on generating a fee for each service performed. Various strategies for mitigating or sharing risks (as discussed below) may encourage more systems to participate.
- Making private plans available to Medicare beneficiaries originally was seen as an opportunity not only to expand beneficiary choice but also to allow the program to benefit from the potential for greater efficiency that private plans

were thought to offer. With extra payments and the resulting distortion of incentives under the program largely eliminated by the new legislation, Medicare Advantage—Medicare's private plan option—may once again provide a platform for developing new models of coordinated care and allow the program to benefit from the best features of both traditional Medicare and private coordinated care plans.

Regardless of the organizational models or payment approaches that are implemented, certain features can enhance the appropriateness of the incentives that providers face. The availability of *payments for high quality, desirable outcomes, coordination, and patient satisfaction* can focus attention on those aspects of care. *Shared savings* might be used to provide a direct incentive for efficiency; linking the distribution of shared savings to measures of quality improvement can help safeguard quality while encouraging efficiency (an approach being used in the PGP demonstration mentioned above and described in more detail in the Appendix). Both the types and sizes of the incentives provided in the new pilot projects will be important, not only for incorporating appropriate incentives but also for making voluntary participation in the pilots desirable to prospective providers.

Bundled payments and global payments involve some financial risk for providers who, although they may be willing and able to take clinical responsibility for their patients, often are not in a position to manage the corresponding financial risk. Since the objective of the new pilot projects should be primarily to encourage the former, approaches to mitigate financial risk may serve both to maximize the effectiveness and fairness of the payment incentives and make pilots more attractive to prospective participants. *Reinsurance* can be used to limit the losses that a provider might have to bear in treating a few exceptionally expensive patients—the outlier policy in Medicare's inpatient hospital prospective payment system is an example of an internally financed reinsurance mechanism. Alternatively, providers could be allowed to acquire private reinsurance. *Risk corridors,* in which payment is partially adjusted to reflect unusually high or low costs, also could be used to defray some of the risk that providers might face.

A key requirement is the establishment of an explicit set of objectives for payment reform and a system for monitoring and evaluating each pilot's performance relative to those objectives. Each pilot should be adapted to the environment in which it is being implemented, and only those that are successful should be permitted to continue. Also needed is a system of incentives that encourage other potential participants to develop their own models to suit their particular circumstances—provided these models show real promise of achieving the specified objectives.

There should be flexibility in determining the size of the pilots implemented by the Center for Medicare and Medicaid Innovation. Provider participation should be maximized, subject to the objectives of the individual pilot and the potential ability of providers to achieve those objectives. The objective of the center should be to put in place payment and delivery models that can be successful in the environments in which they operate. It is crucial that these pilot projects be viewed not as an attempt to determine a definitive model that can be universally applied to improve health care and control costs, but as part of a process to determine a range of models that can help achieve the goals described above in a way that is suited to each local health care system. Pilot projects should be large enough to have a significant impact in the areas in which they are implemented. But allowing some small initiatives may facilitate the testing and development of new approaches before they can be taken to scale as well as the application of innovative models in smaller areas.

The likely result of this approach is not a vastly different model for each geographic area, but rather a set of local variants on a small number of basic models that have been shown to work. These variants will have different combinations of attributes based on what fits the needs of the local population, different

configurations of providers and payers, and other local characteristics that affect what works best in each setting.

Pilot projects should be continued as long as they are found to be effective in meeting their goals, and additional participants should be allowed to participate subject to their ability to establish that they have a reasonable likelihood of meeting the goals of the program. Systems should be put in place to provide evidence on the impact of each initiative in a timely manner. Flexibility should be a recurring theme in the operation of the center. The appropriate time frame will depend on the specifics of each pilot project, such as its objectives, the approach proposed for achieving them, and the characteristics of the area in which it will be conducted.

In any case, provision should be made for continuous monitoring of the project's performance, with an eye toward coordination of health care, patient satisfaction, and improved effectiveness and efficiency, as well as dissemination of information about new approaches and shared learning across delivery sites. As long as a project appears to be successful along those dimensions and is meeting the other objectives set out by the agency and the other participants, there is a case for continuation. Monitoring and evaluation also should focus on aspects of the model that may be most useful for application to other pilots in other areas.

One of the most difficult aspects of monitoring these projects will be having data available on a timely basis. Sufficient effort and resources should be devoted to ensuring that the information necessary for implementing, operating, and making adjustments to the pilot—as well as information needed for decisions on whether and how the project should be continued or expanded—is produced and accessible by those who need it. Striking an appropriate balance between the resources devoted to design and implementation and those devoted to information and analysis will require careful thought.

Resources should be made available to establish an infrastructure to support the success of pilot projects in accomplishing the goals of health reform. Delivery system reform will likely require more than putting in place appropriate incentives. It will also require having shared resources available at the community level, including health information exchanges to support clinical decision-making and facilitate coordinated care; 24-hour, seven-day availability of needed after-hours care, so patients can obtain the care they need when they need it; and chronic care nurses to monitor patients and help them manage their conditions, so they can stay out of the emergency room or the hospital. These resources will enable providers to furnish patients with valuable services in a coordinated manner, and will increase the probability of success while increasing systemwide efficiency and effectiveness.

The results of the payment innovation pilots should be considered in the deliberations of any formal entity charged with cost reduction. The new legislation calls for establishment of the Independent Payment Advisory Board, which will be responsible for achieving reductions in the growth of Medicare spending under certain circumstances.[12] The Medicare Payment Advisory Commission (MedPAC) will continue to analyze access to care, quality of care, and other issues affecting Medicare and will continue to advise Congress on payments to health plans participating in Medicare Advantage and providers participating in Medicare fee-for-service. In addition, the Children's Health Insurance Program Reauthorization Act of 2009 established the Medicaid and CHIP Payment and Access Commission (MACPAC) to review Medicaid and CHIP access and payment policies and to advise Congress on issues affecting the two programs. The activities and resources of these various entities should be coordinated so that they enhance, rather than interfere with, each other's functions.

Particular attention should be paid to the coordination of new initiatives intended to improve quality and efficiency with the policies recommended by the Independent Payment Advisory Board, so that the

potential impacts of the pilot projects conducted by the Center for Medicare and Medicaid Innovation are considered in the context of developing the board's recommendations for reducing Medicare spending growth.

Many more questions will need to be addressed in establishing the Center for Medicare and Medicaid Innovation; after all, the center itself is a pilot project to determine whether the federal government can successfully provide the leadership needed to accomplish the goals of health reform.[13]

Making Pilots and Demonstrations More Effective

While the types of pilot projects described above are essential for developing rapid, large-scale innovations in the payment, organization, and delivery of health care, the role of demonstrations will continue. Over time, the process of developing and testing more specific innovations that lend themselves more readily to the traditional randomized-trial method of testing will continue to be needed—and the Medicare demonstrations program has served that need well.

Among the innovations that have been developed as Medicare demonstrations are the hospice benefit, the Program of All-Inclusive Care for the Elderly (PACE), Social Health Maintenance Organizations, and competitive bidding for durable medical equipment. In addition, several important broader policy initiatives have been developed as Medicare demonstrations, including the inpatient hospital prospective payment system based on diagnosis-related groups (DRGs) and the risk program (now known as Medicare Advantage). Moreover, several initiatives that are viewed as promising models for health system reform—including the Physician Group Practice Demonstration, Hospital Quality Incentive Demonstration, and Health Care Quality Demonstration—were and are being conducted as demonstrations.

Hurdles Facing the Demonstrations Program

Several hurdles have kept the demonstrations process from being as productive at it might otherwise be, and these have the potential to affect the work of the Center for Medicare and Medicaid Innovation as well. Although there are legitimate reasons why some of these hurdles were put in place—and those reasons cannot be ignored and must be dealt with—policymakers need to reexamine them if the center is to improve Medicare and Medicaid payment policies and strengthen those programs so that they serve as examples for the rest of the health care sector.

The health reform legislation addresses some of these obstacles—most important, the commitment of new resources to develop and implement new pilot projects and the authority to extend and expand pilots if they are found to be successful—but some others still must be addressed. The following discussion, which focuses on the current Medicare demonstration program but is of some relevance to Medicaid and the private sector as well, describes these hurdles and offers suggestions for lowering them. We also explore how to strike a better balance between protecting the integrity of the Medicare program and its trust funds and allowing for appropriate and necessary changes in program operations.

Transparency. Since the number of potential initiatives far exceeds the resources that could reasonably be available for development, implementation, monitoring, and evaluation, the identification and selection of the types of initiatives to pursue is the first important set of decisions that must be made.[14] (The level of resources made available for these functions is a separate concern discussed later.)

Making the demonstration process more transparent—particularly if it is to be expanded and accelerated—would help safeguard its integrity and allow for better and more timely decision-making. This would involve both establishing an explicit set of criteria for identifying and selecting new initiatives for development and allowing more open discussion of the policy changes of interest and their potential impacts.

In addition, publicly reporting information on planned and upcoming initiatives, as well as findings from ongoing projects, in an electronic newsletter or journal distributed by CMS or posted on its Web site would provide policymakers and other interested parties with a more accessible way to review project and site choices and their implications. Alternatively, or perhaps in addition, such information could be included in the annual reports produced by MedPAC.

Multipayer initiatives. The new law calls for Medicare to engage in multipayer initiatives, with recent actions by the HHS secretary indicating the Obama administration's interest in such initiatives. But the federal government's establishment of such pilots, and its participation in them, should be a high priority for the Center for Medicare and Medicaid Innovation.

Approval process. One major problem in testing new, potentially productive ideas is the long and burdensome process for identifying and selecting the models to be tried and getting approval to proceed with an approach that may be untested or controversial. Developing and implementing a demonstration or pilot involves a lot of technical detail. It also involves achieving agreement among various parties both inside and outside the government—by nature a painstaking process, since the allocation of millions or even billions of dollars of public resources is at stake.

Nonetheless, efforts must be made to simplify the approval process. Increasing transparency and establishing clear lines of accountability would reduce the need for a lengthy approval process designed to protect against inappropriate proposals that seek only to advance the interests of specific institutions or geographic areas. To the extent that the process is used for that purpose, it is neither very productive—in that it holds up potentially beneficial projects—nor very effective in protecting against undue influence. Another improvement would be to vest sufficient authority in the HHS secretary or the CMS administrator to make the decisions—including negative decisions—but hold her or him publicly accountable for those decisions. Moreover, those who propose initiatives to be tested could be held more accountable for their proposed projects to discourage spurious proposals with narrow, and sometimes self-serving, objectives—such as by posting a listing of each project and its sponsors.[15]

Evaluation. Another hindrance to improving policy is the constraints imposed by the methodology currently available for evaluating their impact. Demonstrations and pilots generally are carefully designed and intended to adhere as much as possible to strict methodological criteria in a carefully controlled environment. These types of social experiments, however, are not conducted in laboratories, but in a world in which the policy environment is constantly changing; hence, the ability to maintain strict control over all aspects of such trials is limited, and attempts to do so can be counterproductive. Consequently, although formal evaluations are conducted in most cases, those evaluations must deal with imperfect controls and incomplete data.

Further complicating attempts to adhere to formal evaluation designs is the fact that, rather than being fixed in stone, payment models should continue to evolve as experience is gained with them—and that evolution may take different forms in each area to which a given model is applied. Moreover, in many cases, some of the major objectives of the policy change being tested are difficult to measure, either because they are qualitative in nature or because there is an absence of good baseline data with which to determine whether the policy in question has had the hoped-for effect. New approaches to evaluating the results of demonstrations and pilots and identifying their implications for developing potential payment reforms would be useful in maintaining the appropriate balance between scientific rigor and policy usefulness.

The timeliness of evaluations is also a chronic issue. Careful evaluation requires accurate and complete data, but the process of collecting, cleaning, and analyzing those data is not only inherently time-consuming but frequently either cannot begin until the initiative is over or must start before the full effects of the trial have occurred. This can result in failure to act on potentially useful policy initiatives at the opportune moment or premature enactment of incompletely

informed policy decisions. Officials should either monitor initiatives continuously or develop preliminary "bellwether measures" to help indicate directions not only for the development of new policies but also for changes in the trial itself. In any case, these issues call for a reexamination of the methodological tools and data systems at our disposal so that we can appropriately use the available information.

Translating pilots into policy. The demonstration program would benefit from a more explicit process for translating what we learn from these trials into new policy. While the health reform law gives the HHS secretary the authority to continue or expand a trial, making the process more transparent would allow for more open discussion of policy changes and their potential impacts. The requirement that the secretary submit a biannual report to Congress is one way of providing a regular vehicle for reporting findings from Center for Medicare and Medicaid Innovation initiatives. Periodic congressional hearings on potential improvements, involving testimony from the HHS or CMS and MedPAC, also would help make the endpoint of the process more visible.

Resource availability. The preceding discussion emphasizes the importance of maintaining the integrity of the process of identifying, developing, testing, evaluating, and implementing promising innovations in Medicare—and potentially throughout the health care system. Equally important, however, is having the resources necessary to carry out such a process and make needed investments in the program and in the health system. Unfortunately, it is increasingly difficult to find those resources in the budget environment in which Medicare operates. As Medicare provides access to care for the rapidly growing number of older Americans, and as Medicare benefits make up an ever-increasing share of both national health expenditures and the federal budget, the resources available for administration consistently shrink as a proportion of the program's size.

There is bipartisan agreement that CMS is underfunded to carry out its day-to-day functions properly, and that, given the record federal budget deficit, it is difficult to find the resources to remedy that situation.[16] Even within that context, the research budget out of which CMS funds demonstration activities is deteriorating, falling from 6.2 percent of the agency's program management budget in 2001 to 1.4 percent in 2008.[17] Both the level of funding and its decline are alarming, particularly in light of the likely increase in the program's role in implementing systemwide health reform. If more new initiatives are to be developed and implemented—and if these are to be both larger in scope and more timely—sufficient resources should be provided to carry them out. Failure to do so puts at risk the ability to identify and successfully implement new initiatives.

Among the functions that would require sufficient resources are: supplying timely data to support pilot sites and to support CMS in implementing and monitoring the pilots, and developing any rewards and bonuses involved; devoting sufficient staff to develop, implement, monitor, and oversee the pilots; and providing adequate contracting funds to carry out the evaluations that will determine whether the pilots are to be continued or expanded and how they can be used as examples for other approaches in other areas.

The new law earmarks funds for the operation of the Center for Medicare and Medicaid Innovation and for the administration, design, and implementation of the pilots, but lawmakers should give consideration to both the appropriate amount and the appropriate allocation of funds for all the center's activities.

CONCLUSIONS

In a recent piece for the *New Yorker*, the physician and journalist Atul Gawande wrote:

> At this point, we can't afford any illusions: the system won't fix itself, and there's no piece of legislation that will have all the answers, either. The task will require dedicated and talented people in government agencies and in communities who recognize that the country's future depends on their sidestepping the ideological battles, encouraging local change, and following the results. But if we're willing to accept an arduous, messy, and continuous process we can come to grips with a problem even of this immensity. We've done it before.[18]

The new health reform law provides a platform on which to build the kinds of innovations that have the potential to bend the health care cost curve. In the end, however, the success or failure of health reform will be determined by whether the innovations that are developed succeed in controlling costs and making health reform sustainable. That success, in turn, will depend to a great extent on how the Center for Medicare and Medicaid Innovation is operated and managed, and how the issues described here are addressed.

Notes

1. F. D. Roosevelt, Address at Oglethorpe University, May 22, 1932 reprinted in F. D. Roosevelt, *The Public Papers and Addresses of Franklin D. Roosevelt, Volume One, The Genesis of the New Deal* (New York: Random House, 1938):639.
2. The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010.
3. N. Kaye and M. Takach, Building Medical Homes in State Medicaid and CHIP Programs (Portland, Maine: National Academy for State Health Policy, June 2009).
4. S. R. Collins, K. Davis, R. Nuzum, S. D. Rustgi, S. Mika, and J. L. Nicholson, *The Comprehensive Congressional Health Reform Bills of 2009: A Look at Health Insurance, Delivery System, and Financing Provisions* (New York: The Commonwealth Fund, Oct. 2009; updated Dec. 18, 2009). The discussion below refers to the bills passed by the House of Representatives on Nov. 7, 2009, and the Senate on Dec. 24, 2009.
5. M. McClellan, "Reforming Provider Payment: Moving Toward Accountability for Quality and Value," Senate Finance Committee, Roundtable on Health Care Reform, April 21, 2009.
6. See B. Biles and G. Arnold, *Medicare Advantage Payment Provisions: Health Care and Education Affordability Reconciliation Act of 2010 H.R. 4872* (Washington, D.C.: George Washington University, March 2010).
7. See B. Biles, J. Pozen, and S. Guterman, *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to $11.4 Billion in 2009* (New York: The Commonwealth Fund, May 2009).
8. The Medicare Improvements for Patients and Providers Act of 2009 revised some of the provisions of the Medicare Advantage program, including placing tighter restrictions on private fee-for-service plans to restrict their ability to operate without requirements to establish provider networks or submit reports on the quality of care.
9. See Department of Health and Human Services, "Secretary Sebelius Announces Medicare to Join State-Based Healthcare Delivery System Reform Initiatives," press release, Sept. 16, 2009, accessed Nov. 3, 2009, http://www.hhs.gov/news/press/2009pres/09/20090916a.html.
10. K. Stremikis, S. Guterman, and K. Davis, *Health Care Opinion Leaders' Views on Medicare Reform* (New York: The Commonwealth Fund, Nov. 2009).
11. P. V. Lee, R. A. Berenson, and J. Tooker, "Payment Reform—The Need to Harmonize Approaches in Medicare and the Private Sector," *New England Journal of Medicine,* Jan. 7, 2010 362(1):3–5.
12. Medicare spending growth targets are set in the legislation, with the board responsible for achieving specified reductions in any year in which projected spending exceeds those targets.
13. Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, Nov. 2007).
14. Another factor that limits the number of demonstration projects that may be conducted at any given time is the desire to avoid overlap in the areas involved in different projects, lest their impact cannot be definitively attributed to the initiative being tested.
15. See, for example, the Legislative Transparency and Accountability Act of 2006, the Federal Funding Accountability and Transparency Act of 2006, and the Lobbying Accountability and Transparency Act of 2006; "OMB to Post All Earmarks on Website," *The Hill*, March 8, 2007, accessed Nov. 3, 2009, http://thehill.com/homenews/administration/4389-omb-to-post-all-earmarks-on-website?tmpl=component&print=1&layout=default&page.
16. Discussion by G. R. Wilensky and B. C. Vladeck, former administrators of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services), at National Health Policy Forum on Great Expectation: Managing the Centers for Medicare and Medicaid Services, May 1, 2009; and J. K. Iglehart, "Doing More with Less: A Conversation with Kerry Weems," *Health Affairs* Web Exclusive, June 18, 2009:w688–w696.

[17] A. Cassidy, *The Fundamentals of Medicare Demonstrations* (Washington, D.C.: National Health Policy Forum, Background Paper No. 63, July 22, 2008).

[18] A. Gawande, “Testing, Testing,” *The New Yorker,* Dec. 14, 2009.

About the Authors

Stuart Guterman, M.A., is an assistant vice president at The Commonwealth Fund, where he directs the program on Payment System Reform. Previously, he was director of the Office of Research, Development, and Information at the Centers for Medicare and Medicaid Services; senior analyst at the Congressional Budget Office; principal research associate in the Health Policy Center at the Urban Institute; deputy director of the Medicare Payment Advisory Commission (and its predecessor, the Prospective Payment Assessment Commission); and chief of institutional studies in the Health Care Financing Administration's Office of Research.

Heather Drake is a program assistant at The Commonwealth Fund, where she works on issues related to Medicare and health system performance. Previously, she was an analyst assistant for the public opinion polling firm Peter Hart Research Associates and a research assistant for Hezel Associates, working with clients from the education field. Ms. Drake graduated magna cum laude from the Maxwell School at Syracuse University, earning a B.A. in political science. She is currently pursuing a master's degree in public health at George Washington University.

Editorial support was provided by Christopher Hollander.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff, or of The Commonwealth Fund Commission on a High Performance Health System or its members.