

Healthcare Payment Reform & Provider Reimbursement: A Summary of Strategies for Consideration by the Oregon Health Fund Board

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Healthcare Payment Reform & Provider Reimbursement: A Summary of Strategies for Consideration by the Oregon Health Fund Program

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Contents

Executive Summary	1
Introduction	2
Reimbursement with the current healthcare system	2
Types of payment methods	3
The cost of care	4
Reimbursement and risk	5
Patient/condition differential and reimbursement	7
The future of the healthcare payment system	7
Pay-for-Performance	11
State initiatives in provider reimbursement	18
Conclusion	21

Executive Summary

The Oregon Health Fund Board (OHFB), as established by the Healthy Oregon Act, is commissioned with developing a healthcare reform plan, which will establish an equitable, sustainable system that provides high-quality, efficient care to all Oregonians. Moreover, it calls for increased care coordination through the use of medical homes. A large piece of this reform is devising a payment structure that promotes the goals delineated by the Act as well as those outlined in the Medical Home Model.

The current approach to provider reimbursement is based on a fee-for-service system that promotes patient over-treatment and lacks incentive for providers to more efficiently coordinate a patient's care. Furthermore, it does little to promote quality care improvements. Without reform, this structure will continue to perpetuate the growth of healthcare expenditures without necessarily improving the population's health. However, creation of a system that rewards providers for rendering quality care in an efficient manner has the potential to cap the costs of healthcare while also leading to improved health outcomes.

Many factors such as cost of care, differences in patient populations, and severity of illness must be taken into account when constructing a payment system. It is also imperative to consider the risk that is assumed by both patients and providers dependent upon method of reimbursement. The level of risk that is assumed by the provider can serve as the basis for encouraging more efficient provision of care. Bearing these factors in mind, the OHFB could consider developing a system that:

1. *Rewards providers for health outcomes and improvement in quality of care.*
2. *Adequately compensates providers for care coordination and management services.*
3. *Is transparent to payers and providers.*
4. *Is sustainable.*
5. *Adjusts for risk based on incidence of illness within a given population.*
6. *Builds on the experiences of other reforms at the local, state, and national level as well as the private sector.*

Introduction

Enrolled Senate Bill 329, the Healthy Oregon Act, established the Oregon Health Fund Board (OHFB) in June 2007.¹ OHFB is charged with developing a comprehensive reform plan for the Oregon Health Fund program. The overarching goals of this reform are to provide all Oregonians with timely access to high-quality, efficient healthcare while also containing costs and ensuring sustainability of the system. In attempt to achieve these goals and provide Oregon Health Fund Program participants with effective, efficient, coordinated care, the act also specifies that the program should support the use of medical homes.

A primary care medical home is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family. The guiding principles of a medical home as developed by the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association focus on the use of a personal physician, a physician-directed medical practice, whole-person orientation, coordinated/integrated care, quality and safety, enhanced access, and an appropriate payment structure.²

Restructuring provider³ reimbursement methods in order to create an appropriate and equitable payment system is, and will continue to be, at the forefront of healthcare reform both at the state and national level. The purpose of this paper is to provide background information about provider reimbursement methods to the OHFB. It looks at factors contributing to the costs of care, payment methods traditionally used within the healthcare system, and suggested payment methods that support the principles of the medical home model.

Reimbursement within the current healthcare system

The current healthcare delivery system relies heavily on a fee-for-service (FFS) payment method in which a provider is paid a fee for rendering a specific service. Although seemingly straightforward, this system is built such that medical overutilization and resource inefficiency are rewarded.⁴ Policies which further exacerbate this trend include the undervaluation of preventive services as well as the overvaluation of non-preventive services; non-payment to physicians for services required to provide patient-focused, care coordination; and the provision of incentives for volume of services without regard to quality of care or resource utilization.⁵

¹ Enrolled Senate Bill 329, The Healthy Oregon Act. June 2007.

² Rogers, JC. Strengthen the Core and Stimulate Progress: Assembling Patient-Centered Medical Homes. *Family Medicine*. 2007; 39(7): 465-8.

³ In this context, the term "provider" refers to the organization or individual providing healthcare services. For example, a "provider" could be a hospital, diagnostic testing facility, physician, nurse, etc.

⁴ Schoen C, et al. Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending. The Commonwealth Fund. December 2007.

⁵ American College of Physicians. Reform of the Dysfunctional Healthcare Payment and Delivery System. 2006. Available: http://www.acponline.org/advocacy/where_we_stand/policy/dysfunctional_payment.pdf.

There are concerns that without a radical shift in provider reimbursement methodology, the current system is unsustainable and could lead to the collapse of primary care.⁶

Types of payment methods – There are six methods of provider reimbursement, which have been traditionally utilized within the healthcare system:⁷

- **Fee-for-service:** A provider is paid a fee for rendering a specific service.
- **Per diem:** A provider is paid a set amount per patient for each day that patient is in the provider's care. All services rendered during that day are covered under the set amount.
- **Episode-of-care:** A single provider is paid a set amount for all services rendered (by that provider) during a defined "episode" of care. For example, a provider may be paid a pre-determined amount for a patient undergoing a kidney transplant. This payment would cover the surgery and all services, including follow-up, associated with that "episode." Using this method there would typically be multiple payments for a single episode since more than one provider may treat a patient.
- **Multi-provider bundled episode-of-care:** Multiple providers are jointly paid for all services rendered during an episode of care, as defined above. Using this method there would only be a single payment made by the payer⁸, which would cover the services rendered by all providers.
- **Condition-specific capitation:** One or more providers are paid a pre-determined fee to cover all services rendered for a specific condition. These payments can be either a one-time fee or on going depending on the severity of the illness.
- **Capitation:** One or more providers are paid a regular, pre-determined fee to cover all services rendered for the continuous care of a patient. This fee covers all episodes and all conditions.

Currently, the majority of providers are reimbursed using either a FFS, per diem, or episode-of-care payment with FFS being the most predominantly used. Capitation is still utilized as a method of payment, although not as often as it was in the 1990s during the height of managed care organizations.⁹ Medicare uses both FFS methods and an episode-of-care method called a prospective payment system (PPS).¹⁰ The PPS uses diagnosis-related groups (DRG) to classify services, which can be bundled together into a single payment for an "episode." This method of payment may reduce the risk assumed by providers; however, it is also believed that DRG payment systems are too slow to incorporate new medical technology.¹¹

⁶ Shodell D. Public Health Perspective: Paying for Prevention. Medscape Public Health & Prevention. 2006; 4(2). Available: <http://www.medscape.com/viewarticle/544651>.

⁷ Miller HD. Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. The Commonwealth Fund. September 2007.

⁸ In this context, the term "payer" refers to the organization, such as an employer or health insurance plan, or individual purchasing healthcare services.

⁹ Ibid.

¹⁰ Centers for Medicare and Medicaid Services. Prospective Payment Systems – General Information. Available: <http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/>.

¹¹ Nichols LM, O'Malley AS. Hospital Payment Systems: Will Payers Like the Future Better Than The Past? Health Affairs. 2006; 25(1): 81-93.

The Medicare FFS rates are determined by relative value units (RVU) using the resource-based relative value scale (RBRVS). Each piece of providing a service, including physician work, practice expense, and professional liability insurance, is translated into a RVU. Physician reimbursement is calculated by totaling the RVUs for all services rendered. Adjustments are made for geographical location.¹²

The Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) have recently endorsed expansion of Medicare's partially bundled PPS for certain services. There are nine key elements that were considered in the design of Medicare's bundled PPS¹³:

- A specific scope of services included in a bundled rate that has a defined unit of payment;
- Case-mix adjustments¹⁴ that reflect the variation of resources for individual patients;
- Geographic adjustments that reflect variation in costs by geographic region;
- Adjustments based on facility characteristics such as size;
- Design or implementation issues unique to a particular service such as separation or consolidation of rates for multiple facilities;
- Operational, administrative, and systems issues dependent upon the magnitude of change required to adopt a bundled PPS;
- Requisite provider education;
- Establishment of initial payment rates and a process for payment rate updates;
- Encouragement of providers to more efficiently render service.

The last element, encouraging providers to render services more efficiently, has raised the concern that some providers may actually limit services that are medically needed. However, among Medicare beneficiaries, a relationship between higher expenditures/higher utilization of services and higher quality of care/better health outcomes has never been established.¹⁵

The cost of care – There are several variables that contribute to the overall cost of a patient's care (Figure 1). Inevitably, if any of these variables increase, the overall cost of care increases. In regard to the actual payment for a patient's care, these variables embed themselves within one of six "cost types": primary care physician services, specialist physician services, diagnostic services, drugs and medical devices, short-term non-physician services and facilities, and long-term non-physician services and facilities.¹⁶ The framework under which a payment system is

¹² American Medical Association. The Resource-Based Relative Value Scale. Available: <http://www.ama-assn.org/ama/pub/category/16391.html>.

¹³ Leavitt MO. A Design for a Bundled End Stage Renal Disease Prospective Payment System. US Department of Health and Human Services. 2008. Available: <http://www.cms.hhs.gov/ESRDGeneralInformation/downloads/ESRDReportToCongress.pdf>.

¹⁴ Case-mix adjusting is the process of grouping patients according to expenditure and resource utilization.

¹⁵ Schoen C, op. cit.

¹⁶ Miller HD, op. cit.

designed depends on whether these costs are paid for separately or whether one fee covers multiple services in a bundle as described in the previous section.

Figure 1. Variables Contributing to the Cost of Care

$\frac{\text{Cost}}{\text{Patient}}$	=	$\frac{\text{Cost}}{\text{Process}}$	×	$\frac{\text{No. of processes}}{\text{Service}}$	×	$\frac{\text{No. of services}}{\text{Episode of care}}$	×	$\frac{\text{No. of episodes of care}}{\text{Condition}}$	×	$\frac{\text{No. of conditions}}{\text{Patient}}$
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Source: Miller HD. Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. The Commonwealth Fund. September 2007.

When constructing a payment system, it is important to note that not all costs are necessarily incurred during the same timeframe. One typically considers the cost of care to be those charges that are incurred at the time of service. This portion of the overall cost of care is referred to as short-run direct costs. However, one must also consider short-run indirect costs, the cost of lost productivity during recovery; long-run direct costs, future provider expenditures that are attributed to current care (or lack thereof); and long-run indirect costs, the cost of lost productivity in the future as a result of current care (or lack thereof). The total cost can be tabulated as the sum of each of these¹⁷:

$$\begin{aligned} \text{Total cost} = & \text{Short-run direct costs} + \\ & \text{Short-run indirect costs} + \\ & \text{Present value}^{18} \text{ of long-run direct costs} + \\ & \text{Present value of long-run indirect costs} \end{aligned}$$

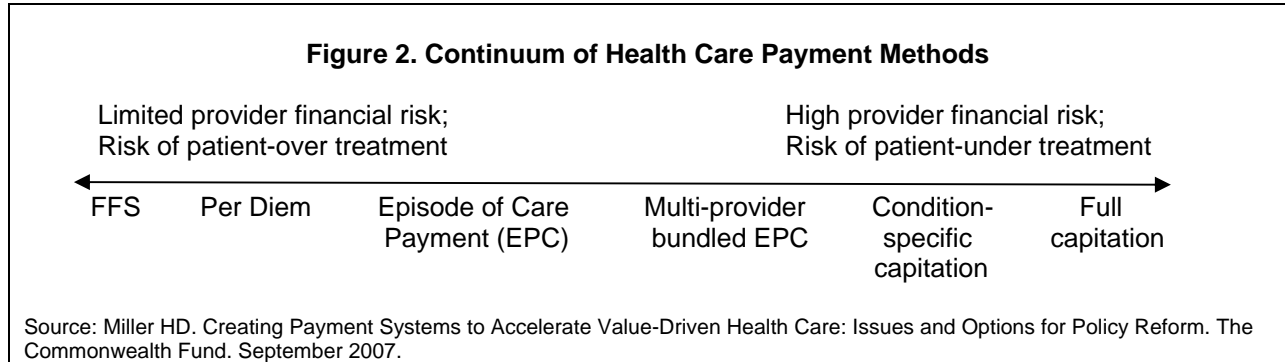
For example, a provider overlooks giving a patient a pneumonia vaccine during an exam. As a result, the patient contracts pneumonia at some point in the future. The total cost of care that can be associated with the initial exam visit is the cost for services provided at the visit plus the cost of all services relating to the measles treatment plus the cost of lost productivity (i.e. time off of work, etc.) during the patient’s recovery from measles. Under a FFS system, total expenditures will be greater for the payer since he is responsible for reimbursing the long-run direct costs. In this instance, the long-run direct cost is the cost of service for measles treatment. However, in a system that uses capitation for reimbursement, the provider assumes responsibility for the total care of the patient, which would include treatment for measles. This care would be provided without any additional reimbursement by the payer. The value of considering long-run costs becomes increasingly apparent when tabulating the cost of care for preventive services. The long-run costs associated with a lack of available preventive services outweigh the short-run direct costs of providing many of those services.

Reimbursement and risk – Each type of provider reimbursement method carries its own set of risks. Those risks are assumed either by the payer, the provider, or both. Generally speaking, as

¹⁷ Ibid.

¹⁸ The present value of a long-run cost takes into account future price inflation for a service.

you move down the payment type list from FFS to capitation, the risk shifts from payer to provider (Figure 2).



FFS systems, as mentioned previously, tend to provide financial incentives for providers to over-treat the patient. Here, the payer must assume the full risk of care. He can pay, or choose not to pay, for as many services as the provider is willing to render. Episode-of-care payments put slightly more risk on the provider since it is unknown at the beginning of the “episode” exactly what services may be needed. Condition-specific capitation creates incentives for the provider to limit the number of “episodes” of care per condition.¹⁹ Full capitation creates incentives for providers to prevent illness in the patient and to treat any illness in an efficient manner. However, this also puts providers at risk if they treat populations that are sicker than average. Essentially, payment methods that include any kind of bundling or capitation create a financial risk for providers, which may cause them to under-treat their patients. Payment methods that individualize services and their associated payments (i.e. FFS) create a risk of providers over-treating their patients.²⁰ Table 1 presents each reimbursement method with the trigger for payment and associated risks. Here, episode-of-care and multi-provider bundled episode of care payment are combined into the category of “case rate” and condition-specific capitation and full capitation are combined into simply “capitation.”

Table 1. Unit of Payment and Financial Risk in Medicare

Unit of payment	Trigger for payment	Selection risk	Utilization risk
FFS	Delivery of service	Almost none; sicker patients lead to greater volume or more intense service mix, or both	Providers try to have their cost (intensity per unit) below other providers’ costs
Case rate	Onset of treatment for diagnosed patient	Average severity within the definition of a qualified case	Providers must control the volume and intensity of each case
Capitation	Enrollment or assignment to panel	Areawide incidence rates, plus average severity, for all types of conditions	Providers must control the volume and intensity of each member

Source: Wallack SS, Tompkins CP. Realigning Incentives in Fee-For-Service Medicare. Health Affairs. 2003; 22(4): 59-70.

¹⁹ Miller HD, op. cit.

²⁰ Ibid.

Patient/Condition differential and reimbursement – Within a given payment system, it may be necessary to include a few different kinds of reimbursement methods based on patient or condition type. Four distinct categories of condition type should be considered when defining a payment system²¹:

- **Major Acute Episodes:** A patient typically requires several, often expensive, services within a short period of time (i.e. heart attack, stroke, major trauma, etc.).
- **Chronic Conditions:** This includes care associated with the chronic condition but not care associated with exacerbation of the condition that may lead to more serious treatment. For example, regular check-ups and medication for an asthma patient would be included in this category. However, a hospitalization resulting from failure to properly use an inhaler for the asthma would not be included.
- **Minor Acute Episodes:** A patient may have a self-limiting condition or a condition not requiring treatment. This category also includes conditions that could lead to more serious illness if left untreated (i.e. minor wounds, minor respiratory illness, etc.).
- **Preventive Care:** This includes services that are provided to prevent both chronic conditions and acute episodes (i.e. immunizations, counseling, etc.).

Our broken payment system – As eluded to previously, there are several problems that our current healthcare reimbursement system facilitates. First and foremost, our payment system does not encourage providers to consider the appropriateness of the services they render. FFS systems often reward providers for rendering unnecessary or low-value services while also offering disincentive to focus on preventive or palliative care. Essentially, providers are not adequately compensated for spending time with a patient whether it is to explore patient history, symptoms of illness, or chronic disease prevention. They are, however, overcompensated for ordering additional diagnostic tests, treatments, medications, and so on. Re-aligning the priorities of our healthcare system with provider incentives to include quality and efficiency in health services would result in a higher level of illness prevention, more accurate diagnoses/prognoses of conditions, more appropriate care, avoidance of adverse events, and improvements in follow-up to care.²²

The future of the healthcare payment system

“Absolute simplicity is impossible, but relative simplicity – reducing the number of prices to negotiate – is imaginable.”²³

In order to promote a value-based, patient-centered healthcare system, provider reimbursement models should^{24,25,26,27}:

²¹ Ibid.

²² Ibid.

²³ Nichols, op. cit.

²⁴ Miller HD, op. cit.

²⁵ Patient Centered Primary Care Collaborative. A New Physician Payment System to Support Higher Quality, Lower Cost Care Through a Patient-Centered Medical Home. May 2007. Available: <http://www.pcpc.net/content/physician-payment-reform>.

- Encourage providers to deliver care in a high-quality, efficient manner;
- Ensure the accurate valuation of provider services including care coordination and management work that is conducted outside of face-to-face patient visits;
- Support and encourage investment in health information technologies that will lead to improvements in efficiency and quality;
- Support coordination of care among multiple providers;
- Provide accountability and transparency.
- Not encourage or reward over-treatment or medically unnecessary procedures;
- Not encourage or reward under-treatment or exclusion of high-risk patients;
- Not reward provider errors or adverse events;
- Not encourage cost-shifting.

Although there is a high level of consensus on the attributes that a revised payment model should hold, there has not been widespread adoption of such systems. When constructing a payment system, categories that must be addressed include the basic payment method, possible bundling of services, payment levels, and performance standards²⁸. The following section describes payment system proposals that promote the efficient provision of high-quality care. The section entitled ‘Pay-for-Performance’ explores several options for provider rewards programs that could be combined with provider reimbursement mechanisms.

Uniform provider payment methods and rates – This payment system would require all payers to adopt payment rates and methods similar to those of Medicare. All rates would be publicly available and updated periodically to reflect annual fluctuation in productivity and per-unit costs. It is estimated that implementation of this system would result in national, system-wide savings of \$23.1 billion over 5 years²⁹. Although there is great potential for savings, implementation of this payment system would possibly result in a reduction in income for some providers. It would most likely effect providers who typically do not see many Medicaid patients and/or those who currently have high reimbursement rates. In order to avoid legal complications surrounding anti-trust laws, legal advice should be sought before establishing uniform payment levels across all payers and providers.

Prometheus Payment Model – The Prometheus payment model is based on evidence-informed case rates (ECR): single, risk-adjusted, prospective payments shared between multiple providers, both in inpatient and outpatient settings, to care for a patient with a particular diagnosis³⁰. The payment would be based on the total amount of resources required to provide care for an entire episode. In addition, a portion of the payment would be withheld and re-distributed based on provider performance. The foundation of this model is to separate technical risk from

²⁶ American College of Physicians, op. cit.

²⁷ Rogers JC, op. cit.

²⁸ Miller HD, op. cit.

²⁹ Schoen C, op. cit.

³⁰ de Brantes F, Camillus JA. Evidence-Informed Case Rates: A New Health Care Payment Model. The Commonwealth Fund. April 2007.

probability risk for the provider. Each provider would be held accountable for technical risk through the utilization of payment-linked performance standards but shielded from the probability risk by risk-adjusting the payments.

Although ECRs, also called episode-of-care payments, are gaining popularity, there may be barriers to implementation for some providers. Without a more integrated delivery system, it may be difficult to identify the entity to which the ECR should be paid if more than one provider is involved with the patient's care. Furthermore, identifying the exact onset of an episode for which an ECR may apply could prove to be challenging for some patients and/or conditions.

Primary Care Case Management programs – Physician practices that are certified as medical homes could receive a per-member per-month (PMPM) fee in addition to current FFS rates. The PMPM would cover enhanced primary care services such as care coordination and chronic disease management. Quality and efficiency based incentives could also be used in conjunction with this model. Expansion of programs such as these has the potential to achieve a national, system-wide savings of \$193.5 billion over 10 years with \$4.1 billion in savings seen at the state level.³¹ A shortage of primary care physicians may serve as a barrier to implementation.

Virtual Bundling Payment Program – MedPAC recently presented an option for payment reform that aims to slow the growth of Medicare expenditures. It calls for implementation of a bundled payment system for all services associated with a hospitalization. In this instance, the term “hospitalization” includes the hospital stay plus 30 days following discharge.

The recommendations regarding bundled payments that were proposed by the commission are as follows³²:

1. Congress should require CMS to confidentially report provider resource use around hospitalizations. After two years, Congress should implement a virtual binding bundling system that would reduce payment to hospitals and inpatient physicians with relatively high resource use for defined conditions. This payment penalty would be used to finance bonus payments to providers with relatively low resource use.
2. Congress should require CMS to create a voluntary pilot program to explore issues related to actual bundled payments for services around a hospitalization.

A virtual bundling system would retain the current fee-for-service (FFS) system but payment to both hospitals and inpatient physician services would be adjusted based upon the amount of services rendered to a patient during a hospitalization. The fee would also be subject to a withhold. High and low benchmark spending levels would be determined prior to implementation. Providers with average or relatively low overall expenditures would be eligible to get the withhold back; however, those with relatively high expenditures would not be reimbursed for the withhold. All Medicare providers would be required to participate in this program.

³¹ Schoen C, op. cit.

³² Medicare Payment Advisory Commission. Public Meeting. March 5, 2008. Available <http://www.medpac.gov/transcripts/03050306Medpac%20final.pdf>.

The first draft recommendation was proposed with the rationale that providers might not be aware of the total amount of resources that can be associated with a patient's hospitalization. However, once provided with this information, they may find ways to alter their practice, which could result in more efficient resource coordination. It creates an incentive for both hospitals and physicians to be accountable for spending across a patient's episode. Additionally, this concept could be combined with a pay-for-performance program to hold providers accountable for quality.

The second draft recommendation addresses the issue that not all providers may be prepared to implement an actual bundled payment system. Participation in the 'actual bundled payment' pilot program would be completely voluntary. As opposed to the virtual bundling system, an actual bundling payment system would replace the current FFS system with an episode-of-care payment structure.

Gain sharing – In this context, gain sharing is referred to as the ability for physicians to share savings that result from the efficient use of services and reductions in medical errors. This concept raises the concern that these arrangements could potentially have negative impacts on quality of care. Accordingly, there are several federal restrictions on gain sharing arrangements including federal antikickback statutes and the Stark Laws. However, following a successful CMS demonstration using gain sharing as a means to reduce spending for cardiovascular care, the Office of the Inspector General issued several advisory opinions allowing gain sharing arrangement for specific services at selected hospitals. Furthermore, MedPAC recommended in 2005 that “Congress should grant the authority to allow gain sharing arrangements between physicians and hospitals and to regulate those arrangements to protect the quality of care and minimize financial incentives that could affect physician referrals.”³³ Currently, the only way to pursue gain sharing as a method of reimbursement is to participate in a federally sponsored demonstration project.

Primary Care Comprehensive Payment – The current system of encounter-based payments would be replaced with a risk/needs adjusted payment made to primary care providers for comprehensive care of patients. The monthly payment would be sufficient to cover all expenses including salaries that are associated with a physician's group practice (Table 2). It has been suggested that a proportion of such a payment be performance or outcomes based and paid as a bonus for achieving predetermined goals.³⁴ Under this model, charges from hospitals or specialists would not be covered by the payment and would remain the responsibility of the payer.

³³ Wilensky GR, Wolter N, Fischer MM. Gain Sharing: A Good Concept Getting a Bad Name? Health Affairs, web exclusive. 2007; 26(1): w58-w67.

³⁴ Goroll AH, Berenson RA, Schoenbaum SC, et. al. Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care. Journal of General Internal Medicine. 2007; 22(3): 410 – 415.

Table 2: Sample allocation formula for comprehensive payment system*

Formula for comprehensive payment for adult primary care

- 25% - Physician reimbursement: PCP reimbursement (all care) before bonus and fringe
- 60% - Staff, fringe, rent, office expense (assumes hiring of multidisciplinary office team charged with timely delivery of personalized comprehensive care)
 - Nurse Practitioner: 17%
 - Nurse: 15%
 - 0.5 FTE Nutritionist: 6%
 - 0.5 FTE Social worker: 6%
 - Receptionist: 10%
 - Medical assistant: 8%
 - Rent: 7%
 - Office expenses: 8%
 - Insurance: 8%
 - Physician fringe: 12.5-15%
- 10% - Information technology/patient safety/quality monitoring
 - Purchase/lease/setup of electronic health record and quality monitoring system: 35%
 - Data manager: 65%
- 5% - Performance bonus for meeting established goals

*Example assumes an avg. comprehensive payment of \$500/yr/pt, an average panel size of 2,000 patients/full time primary care physician and team, 30% fringe benefit, and gross revenue of \$1M/full time primary care physician and team.
Source: Adapted from Goroll AH, Berenson RA, Schoenbaum SC, et. al. Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care. *Journal of General Internal Medicine*. 2007; 22(3): 410 – 415.

Pay-for-Performance

Pay-for-performance (P4P) is a method of reimbursing providers based on the achievement of pre-determined measures of quality. Quality can be outcome-based and measured in terms of benchmarking, or quality can be process-based and measured in terms of improvement.³⁵ Implementation of P4P programs can help to counteract some aspects of our current payment system that do not promote quality improvement.³⁶ There is a growing interest in these programs due to variation in quality across providers, difficulty within the current payment system to reward high-quality, cost-effective care, and the lack of incentive within the current system to encourage providing services with long-term health or cost savings payoff.³⁷ It has also been cited that consumer choice alone does not provide sufficient incentive for providers to improve their quality of care.³⁸ Moreover, it has not been shown that consumers consistently use available information on quality to aid in their healthcare decision-making.

P4P programs can include non-financial as well as financial incentives. Non-financial incentives include but are not limited to performance profiling and referral, public recognition, and technical assistance. Since this report is aimed at provider reimbursement, this section will focus more on financial P4P incentives

³⁵ Llanos K, Rothstein J, Dyer MB, et. al. Pay-for-Performance in Medicaid: A Guide for States. Center for Healthcare Strategies, Inc. March 2007.

³⁶ Schoen C, op. cit.

³⁷ Nichols LM, op. cit.

³⁸ Rosenthal MB, Fernandopulle R, Song HR, et. al. Paying For Quality: Providers' Incentives For Quality Improvement. *Health Affairs*. 2004; 23(2): 127-141.

The most common form of P4P financial incentive is the bonus payment. Bonus payments are monetary sums paid to providers in addition to the usual fee associated with a service if the provider reaches certain quality goals. There are various types of bonus payments as well as a few additional methods of financial incentives used in P4P systems (Table 3).

Table 3. Examples of Financial Incentives Models	
Financial Reward	Example
Pay-for-participation	The primary care provider (PCP) is reimbursed for time spent at quality improvement workgroup meetings focused on women's health or time spent attending meetings to review performance profiling information and developing quality improvement action plans.
Pay-for-process	The PCP receives an automatic payment of \$10 every time one of the PCP's age-appropriate, female, adult patients receives a biannual mammogram.
Quality grant	The PCP may apply for a grant to implement a patient registry system to facilitate tracking of patients in need of a routine mammogram.
Bonus for achievement of a predetermined threshold	The PCP receives a bonus payment if 80 percent or more of age-appropriate, female, adult patients received a mammogram in the past two years.
Tiered bonus for achievement of predetermined thresholds	The PCP receives a bonus payment if 80 percent or more of age-appropriate, female, adult patients received a mammogram in the past two years. The PCP receives a larger payment if more than 90 percent did so.
Tiered bonus based on comparative ranking	The PCP receives a bonus payment if ranked in the top 50 percent of PCPs for delivery of mammograms to age-appropriate, female, adult patients in the past two years. A larger payment is received if ranked in the top 25 percent of PCPs.
Bonus for demonstration of improvement	The PCP receives a bonus payment if the PCP demonstrates a statistically significant increase in the percent of age-appropriate, female, adult patients receiving a mammogram in the past two years. PCPs with rates over 90 percent also receive the bonus since further improvement above 90 percent might be extremely difficult to achieve.
Performance-based fee schedule	The PCP is paid 105 percent of the usual fee schedule if strong performance on several performance metrics distinguishes the PCP from other PCPs.
Compensation at-risk	The PCP forfeits a fee schedule increase unless the PCP achieves the statewide mean on several identified performance metrics.

Source: Llanos K, Rothstein J, Dyer MB, et. al. Pay-for-Performance in Medicaid: A Guide for States. Center for Healthcare Strategies, Inc. March 2007.

It has been shown that hospitals can gain up to 15% in additional revenue from the successful implementation of P4P programs, and it has not been demonstrated that these programs put hospitals at a large financial risk.³⁹ This may, however, be dependent upon how the program is

³⁹ Ibid.

designed. Generally speaking, public P4P initiatives tend to be budget neutral while programs in the commercial sector are not. For example, some private payers, such as BCBS of Michigan, make use of the bonus payment without an explicit source of funding such as a withhold.⁴⁰ Whereas, the national CMS demonstration project funded payment by reducing the yearly total base payments for all hospitals in the PPS by an amount equal to the total projected bonus payments.⁴¹ States have used additional methods of funding bonus payments including budgeting specific pools of dollars; funding “challenge pools” where unearned bonus monies or unearned withheld capitation payments are paid out to those who excel; reallocating monies collected as penalties; linking rate increases to physicians meeting certain standards; and withholding a portion of an organization’s capitation payment and paying it back later contingent upon performance.⁴²

The private sector has more experience with P4P programs; however, several pilot projects have taken place at the state level for both Medicaid and Medicare. Preliminary data for a national Medicare P4P demonstration has recently been published. The following section describes selected national, state, and commercial P4P efforts.

CMS/Premier Hospital Quality Incentive Demonstration – The Centers for Medicaid and Medicare Services/Premier Hospital Quality Incentive Demonstration (HQID) project is a collaborative P4P effort consisting of over 250 hospitals around the United States.⁴³ The explicit goal of this project is to determine if “economic incentives are effective at improving the quality of inpatient care.”⁴⁴ Between October 2003 and June 2007, hospitals were measured on their attainment of composite quality scores (CQS) for several clinical conditions.^{45,46} Bonus payments were paid to each hospital based on one of three types of performance⁴⁷:

- Top performance: Relative to other hospital performance, hospitals that attained or exceeded the 90th percentile CQS for a given clinical area received a 2% bonus on Medicare payments for discharges in that clinical area.
- Absolute performance: Hospitals that attained or exceeded an absolute level of performance in any clinical area independent of other hospital performance received a 1% bonus on Medicare payments for discharges in that clinical area. The absolute level of performance was defined as the 75th percentile among all hospitals during the two years prior to payment.

⁴⁰ Ibid.

⁴¹ Schoen C, op. cit.

⁴² Llanos K, op. cit.

⁴³ Premier, Inc. Hospital quality improving, cost, mortality rate trends declining for participants in Medicare Pay-for-Performance Project. January 31, 2008. Available: <http://www.premierinc.com/about/news/08-jan/performance-pays-2.jsp>.

⁴⁴ Lindenaer PK, et al. Public reporting and Pay for Performance in Hospital Quality Improvement. *New England Journal of Medicine*. 2007; 365(5): 486-491.

⁴⁵ Premier, Inc., op. cit.

⁴⁶ Schoen C., op. cit.

⁴⁷ Ibid.

- Performance improvement: Hospitals that show an improvement in any clinical area as determined by a ratio of the payment year's CQS to the previous two years CQS received a 1% bonus on Medicare payments for discharges in that clinical area.

Bonuses averaged \$71,960 per year; however, these payments were partially offset by financial penalties incurred by hospitals with low performance. At the culmination of the demonstration, those hospitals in the lowest two deciles for a given clinical area were penalized 1 – 2% of their Medicare payments for discharges in that clinical area.⁴⁸

The hospitals participating in the P4P program as well as the control hospitals that did not implement a P4P system showed improvement in each of the measured areas of quality. However, hospitals with the P4P program showed significantly greater improvement when compared to the control hospitals in 7 out of 10 individual measures.⁴⁹ On average, the median hospital cost per patient in the P4P hospitals declined by over \$1,000 during the span of the demonstration, and the median mortality rate decreased by 1.87%.⁵⁰

It is estimated that an expansion of this project to all acute care hospitals that are paid under the Medicare PPS would result in an estimated net savings of \$34.0 billion over 10 years. The impact to state and local governments would be a savings of \$0.8 billion over 10 years.⁵¹ The estimated savings is predominately due to an expected decrease in readmissions for Medicare beneficiaries. It should be noted that these estimates are only based on P4P programs for inpatient services. If the program was expanded to all providers and all services, additional savings could be achieved.

SoonerCare Choice – SoonerCare Choice is a PCCM in Oklahoma that provides health care for low-income, Medicaid-eligible, pregnant women; children; and the SSI-eligible population. Its P4P program provides bonus payments, averaging approximately \$2,800 per provider, to physicians for completing early periodic screening, diagnostic, and treatment requirements for children. Since program implementation in 1997, the state has seen its EPSDT rates improve by over 20%. The state funds its program by designating \$1 million per year for bonus payments.⁵²

Access Plus – Access Plus is an enhanced primary care case management (PCCM) program in Pennsylvania that is based on a medical-home model of complex case management for children and adults. The state contracts with case management vendors for several different chronic conditions. In addition to providing incentive for achieving improvement in clinical outcomes, the P4P program embedded in this system is structured to provide incentive for physician offices to actively collaborate with the case management vendor. (Table 4).

⁴⁸ Lindenauer PK, op. cit.

⁴⁹ Ibid.

⁵⁰ Premier, Inc., op. cit.

⁵¹ Schoen C., op. cit.

⁵² Llanos K, op. cit.

Table 4. Sample P4P Payment Opportunities in Access Plus Program

Metric eligible for payment	Amount	Practice is paid for:	Eligibility
Supports ACCESS Plus program as outlined in the pay for performance program enrollment form including completing the physician survey and communicating support of the program to ACCESS Plus patients	\$200	activities outlined in the pay for performance program "Initial Participation Enrollment Form"	PCPs, dentists, OB/GYNs
Provider (or member of practice staff) completes smoking cessation counselor registration with Department of Health	\$200	provider/practice registration as a smoking cessation counselor, one time payment	PCPs
Completes and returns Chronic Care Assessment Tool (CCAT) for high risk asthma, CAD, CHF, COPD and diabetes patients	\$40	each form completed for eligible patients, as requested, up to twice a year/patient	PCP
Contacts and encourages participation of ACCESS Plus patients listed on mailed "patient roster/action items" document	\$40	each patient contacted, as requested, on mailed "patient roster/action items" document	PCPs
ACCESS Plus disease management program patient enrollment support	\$30	complete demographic information received for each patient, as requested in mailed "patient roster/action items"	PCP
Electronic submission of a Chronic Care Assessment Tool (CCAT)	\$2	each unduplicated eligible patient for whom an electronic CCAT is submitted per year	PCP

Source: PA Access Plus. Pay For Performance Summary of Payment Opportunities. Available: http://www.accessplus.org/downloads/P4P/P4P_SummaryPaymentOpportunities.pdf

Excellus/Rochester Individual Practice Association – The Excellus/Rochester Individual Practice Association (RIPA) Rewarding Results Initiative is a collaboration between a health plan, Excellus, and a physician group, RIPA. Excellus provides shared savings programs that give financial contributions to the RIPA Value of Care plan, a P4P program. RIPA contributes approximately 10% of its total capitation from Excellus to the P4P program. Value of Care then redistributes these funds to RIPA physicians based on performance and shared savings. The average return for a RIPA primary care provider ranges between \$4,000 and \$12,000 dollars. The Excellus/RIPA program was the first rewarding results initiative, a national grant-awarding program to help purchasers and health plans align incentives for high quality healthcare, to realize a positive return on investment (Table 5).⁵³

⁵³ Ibid.

Table 5. Excellus/RIPA Return On Investment Calculations – Diabetes and Coronary Artery Disease

	2003	2004
Expenses:	\$1.15 million	\$1.15 million
Savings on trend:	\$1.90 million	\$5.80 million
ROI:	1.6:1	5.0:1

Source: Llanos K, Rothstein J, Dyer MB, et. al. Pay-for-Performance in Medicaid: A Guide for States. Center for Healthcare Strategies, Inc. March 2007.

Integrated Healthcare Association – The Integrated Healthcare Association (IHA) P4P project is a collaborative that includes 7 California health plans, 225 physician organizations, and over 35,000 physicians. The participating health plans have developed a uniform performance measure set that covers clinical quality, patient satisfaction, and investment in information technology. Since its implementation, the health plans have seen a 40% increase in patient visits and reduced hospitalizations. Furthermore, between 2003 and 2005, the mean medical group performance for breast cancer screening increased by 4%, cervical cancer screening increased by 6.9%, and HbA1c screening for diabetics increased 7.6%.⁵⁴

Bridges To Excellence – Bridges to Excellence (BTE) is an employer-driven P4P program that is targeted toward providers in program eligible specialties that include primary care, endocrinology, cardiology, neurology, orthopedics, and neurosurgery. It is composed of 4 sub-programs⁵⁵:

- **Physician Office Link:** Rewards physician office sites based on implementation of specific processes intended to reduce errors and increase quality.
- **Diabetes Care Link:** Rewards providers based on 3-year performance in diabetes care.
- **Cardiac Care Link:** Rewards providers based on 3-year performance in cardiac care.
- **Spine Care Link:** Rewards providers based on 3-year performance in spine care.

BTE bonuses are paid directly to physicians, not to the group or practice that achieves the recognition. BTE has a suggested reward structure (Table 6); however, it is up to the individual health plan administering the program to determine the actual reward amounts.⁵⁶ In January 2008, BTE launched its medical home program whereby physicians can receive a bonus in addition to other program incentive payments if they can demonstrate that they have adopted systems of care that are consistent with the medical home model.⁵⁷

⁵⁴ Ibid.

⁵⁵ Bridges to Excellence. BTE Reward Administration Guidelines. 2007. Available: http://www.bridgestoexcellence.org/Documents/BTE%20Reward%20Administration%20Toolkit_122707.pdf.

⁵⁶ Ibid.

⁵⁷ Bridges to Excellence. Bridges to Excellence Launches Medical Home Program. Available: <http://www.bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=119>.

Several states have already, or are in the process of, implementing P4P initiatives as part of a larger statewide healthcare reform package. These programs are discussed in further detail in the ‘State Initiatives in Provider Reimbursement’ section of this paper.

Table 6. BTE Suggested Provider Reward Structure

Level of PRO Recognition (per patient per year)	Level I	Level II	Level III
Physician Office Link	\$15	\$30	\$50
Diabetes Care Link (in POL regions / in non-POL regions)	\$80 / \$100	\$160 / \$200	N/A
Cardiac Care Link (in POL regions / in non-POL regions)	\$80 / \$100	\$160 / \$200	N/A
Spine Care Link	N/A	\$50	N/A

Source: Bridges to Excellence. BTE Reward Administration Guidelines. 2007. Available: http://www.bridgestoexcellence.org/Documents/BTE%20Reward%20Administration%20Toolkit_122707.pdf.

Concerns and Limitations of P4P programs – There are several limitations that must be addressed when considering P4P implementation. Quality outcomes measures must be further defined and unified across a number of initiatives in order to provide validity to their use as well as simplifying reporting strategies.⁵⁸ Encouraging insurers to use the same quality measures would unify the system and simplify the reporting process for providers. Measurement systems that focus on individual providers rather than the larger system risk reinforcing the fragmentation and lack of coordination already inherent within our healthcare system.^{59,60} There is a need for experimental system-wide P4P payment systems that include both hospitals and physicians.

It has also not been overwhelmingly documented that improvement in selected quality measures leads to better clinical outcomes. However, given that many P4P programs are process-oriented and encourage increased utilization of preventive procedures, these data may not be available for many years post-implementation. An additional area of uncertainty lies in the bonus payment itself. In many cases it is unknown whether the potential bonuses will be sufficient to compensate for the collection of data or to motivate change in the way providers care for patients.⁶¹

P4P programs also run the risk of becoming a significant burden for smaller hospitals. Small and/or rural hospitals may require different sets of quality measures in order for system-wide P4P programs to be equitable.⁶² Also, if providers must attend to a number of tasks with a limited amount of resources, they may focus on the tasks that are explicitly rewarded to the detriment of those that are not.⁶³

⁵⁸ Nichols LM, op. cit.

⁵⁹ Fisher ES. Paying for Performance – Risks and Recommendations. *New England Journal of Medicine*. 2006; 355(8): 1845-1847.

⁶⁰ Rosenthal MB, op. cit.

⁶¹ Fisher ES, op. cit.

⁶² Nichols LM, op. cit.

⁶³ Rosenthal MB, op. cit.

Academic centers and teaching hospitals may be at a disadvantage since physicians at these institutions spend time teaching medical students and residents.⁶⁴ Depending on how the quality measures are defined, time spent teaching could falsely give the appearance that such institutions are less efficient. P4P initiatives must also avoid penalizing hospitals in locations where there may only be one service provider. Using an absolute level of performance as opposed to performance improvement to measure quality may unintentionally penalize hospitals that have fewer resources and poorer performance at baseline.⁶⁵ Lastly, if physicians are not convinced that appropriate risk adjustment is being performed, they may avoid treating sick or challenging patients in order to achieve high quality scores.⁶⁶ It should be noted, however, that the Institute of Medicine has recognized all of these limitations, but still recommends moving forward with implementation of P4P programs as a strategy for improving the quality of care.⁶⁷

State initiatives in provider reimbursement

Minnesota – The Minnesota Health Care Transformation Task Force has created a payment reform strategy that would separate healthcare facilities and payment associated with each into three levels. Level 1 explicitly ties payment to quality of care outcome measures. Level 2 establishes care management payments to providers who have demonstrated that they have the necessary infrastructure to provide coordinated patient care and act as a medical home. It has not been determined if the providers in level 1 and 2 will receive payment based on FFS or an episode-of-care system, however, the recommendations call for payers and providers to establish “baskets” of care. Reimbursement based on baskets of services would move the system away from FFS and towards an episode-of-care structure. Level 3 creates a system wherein the providers are accountable for the total cost of care through a capitation payment structure. Providers in level 3 will submit bids to insurance plans for the total cost of care for a standard benefit set for a given population. The provider will then be responsible for providing all care for that population, as outlined in the benefit set, for the price negotiated with the insurance plan.

Payment in all levels will also be tied to quality outcomes, and payment for levels 2 and 3 will be risk-adjusted. Additionally, it is recommended that payment levels for primary care, care management, and other cognitive services be increased relative to other services in a cost-neutral manner. It is expected that all health care providers will be participating in the level 3 payment structure by 2012 at which time the state will have realized \$4393 million in savings due to this piece of reform.⁶⁸

In addition to the task force reform, the Minnesota Department of Human Services (DHS), acting as a large purchaser, has endeavored in several healthcare reform strategies including P4P. Q-Care is a statewide program that implements quality of care standards and defines a payment structure to reward quality of care as opposed to quantity of services. DHS requires that the

⁶⁴ Nichols LM, op. cit.

⁶⁵ Ibid.

⁶⁶ Fisher ES, op. cit.

⁶⁷ Ibid.

⁶⁸ Health Care Transformation Task Force. Recommendations Submitted To: Governor Tim Pawlenty and the Minnesota State Legislature. January 2008.

MCOs with which they contract adopt and implement quality guidelines as recommended by Q-Care.⁶⁹

The Minnesota DHS and the Minnesota State Employees Group Insurance Program (SEGIP) have implemented the P4P program Bridges to Excellence (BTE). This is the same program that was discussed previously in the P4P section of this report. Currently, the program is only assessing diabetic care management. However, SEGIP estimated that for every dollar it has spent on provider rewards and program administration, it has achieved \$5.60 in savings.⁷⁰

Lastly, the Minnesota DHS is seeking to create medical homes for all patients covered by public health care programs. Within each medical home, primary care providers will receive a care coordination payment of \$50 per member per month to coordinate the care of chronically ill patients within the DHS FFS program. Over time, this payment will be adjusted to reflect the complexity of the patient's illness and healthcare needs. A P4P program will also be incorporated into this system.⁷¹

Colorado – The Colorado Blue Ribbon Commission for Health Care Reform recently recommended to the Colorado state legislature that Colorado restructure its healthcare system to provide a medical home for all its citizens. It recommended reimbursing providers for care coordination and case management, while also paying providers based on their use of care guidelines, quality performance measures, and the use of health information technology. Moreover, it called for increasing Medicaid provider reimbursement to at least 75% of the Medicare reimbursement rates.⁷² It should be noted that most of the state healthcare reform plans reviewed, in addition to those mentioned here, include raising Medicaid rates to more closely reflect those paid by Medicare.⁷³

The Commission formulated its final recommendations based on the analysis of five healthcare reform proposals submitted by various agencies, including one from the Commission itself. Each plan had varying suggestions for provider reimbursement reform (Table 7). The savings demonstrated by the Solutions for a Healthy Colorado plan are achieved primarily by a large mandatory reduction in hospital payments for the privately insured. This mandate is not included in the other proposals.

⁶⁹ Minnesota Department of Human Services, Employee Relations, Health, and Commerce. Health Care Payment System Reform in Minnesota. December 14, 2007.

⁷⁰ Ibid.

⁷¹ Ibid.

⁷² Blue Ribbon Commission for Health Care Reform. Final Report to the Colorado General Assembly. January 31, 2008.

⁷³ Trinity M, Martinez-Vidal E, Friedenzohn I, et. al. State of the States. Academy Health. January 2008.

Table 7: Summary of Colorado Provider Reimbursement Proposals

Proposal	Key Features	Change in state spending* (billions)
Better Health Care for CO	1. Medicaid and CHP+ service providers paid at current Medicaid and CHP+ payment levels. 2. Payment rates for private insurance would be 130% of Medicare payment levels.	\$65.0
Solutions for a Healthy CO	1. Increase payment rates for Medicaid to Medicare payment levels 2. Private sector payment levels would vary between 125 and 150% of Medicare payment levels based on a P4P program.	(\$558.0)
A Plan for Covering All Coloradans	1. Increase payment rates for Medicaid to Medicare payment levels 2. Payment for private insurance would be based on current private sector rates.	\$412.0
CO Health Services Program	1. Single-payer program 2. Provider payment levels set to the average level of reimbursement across all payers for health care services.	\$0.0
The Commission Proposal	1. Increases Medicaid payment levels to 75% of Medicare payment levels. 2. Private sector payment levels based on current private sector rates.	\$137.0

*Changes in statewide health spending with regard to provider reimbursement based on reductions in uncompensated care, provider reimbursement levels, and changes in cost-shift.
Source: Blue Ribbon Commission for Health Care Reform. Final Report to the Colorado General Assembly. January 31, 2008.

Vermont – The Vermont Health Care Reform Commission recently proposed implementation of an accountable care organization (ACO) pilot program. This complements the work the state has already completed under its Blueprint for Health, which is based around the medical home model. An ACO, as described by Fisher, is a virtual organization composed of local hospitals and the physicians that work within and around them.⁷⁴ Fisher proposes using these organizations as the locus of accountability for a community’s healthcare system. The ACO would make all data pertaining to cost, resource utilization, and performance publicly available. The community would then be responsible for holding the organization accountable for using its resources in the most efficient and effective manner. This model focuses on the efficiency of the system as a whole as opposed to individual providers. It is thought that this approach may begin to unify the fragmented healthcare system.

⁷⁴ Fisher EM, Staiger DO, Bynum JPW, et. al. Creating Accountable Care Organizations: The Extended Hospital Medical Staff. Health Affairs, web exclusive. 2007; 26(1): w44-w57.

Provider reimbursement for the proposed pilot would be paid on a FFS basis using current provider rates; a common fee schedule would not be established. The ACO as a whole would have the opportunity for additional payment if the total actual expenses of the ACO's patient population were less than the predetermined global budget. This budget would be an actuarially based per member per month 'capitation' multiplied by the number of patients within the ACO. If the ACO retained the additional payment, it would have the freedom to choose how it allocated its savings between providers and structural improvements.⁷⁵

Conclusion

The current structure of provider reimbursement, based primarily on a FFS system, does not reward providers for rendering high-quality, efficient care and, often times, provides incentive to over-treat patients. This approach does not produce better health outcomes nor is it sustainable. The primary method of provider reimbursement must migrate towards one that rewards providers for quality and efficiency.

Although many examples of reimbursement reform provided in this paper were aimed at inpatient hospital settings, these same methods could be utilized for primary care or other outpatient venues. In all settings, the payment structure must account for factors contributing to the cost of care, differences in patient populations, and the severity of illness. The framework under which a payment system is devised also determines the amount of risk that will be assumed by both the payer and the provider.

The OHFB has been commissioned with developing a comprehensive healthcare reform plan that supports the use of medical homes as a primary means of care coordination. A large piece of this task is to create a method of provider reimbursement that promotes the goals of the Healthy Oregon Act and the guiding principles of the Medical Home Model. In doing so, the board could consider developing a system that:

1. ***Rewards providers for health outcomes and improvement in quality of care.*** This most likely would involve implementation of a P4P program. The incentives could be linked to either outcome or process measures.
2. ***Adequately compensates providers for care coordination and management services.*** These services are not always covered under a FFS system. Adequate reimbursement of such services could lead to a system with a greater focus on prevention, and ultimately, a healthier population.
3. ***Is transparent to payers and providers.*** Payers should be given information that is sufficient to tell exactly what services are provided for a given cost. At the same time, providers should know what services they are responsible for rendering.

⁷⁵ Vermont Health Care Reform Commission. Vermont Pilot of Community Based Payment Reform: Accountable Care Organization. March 7, 2008.

4. ***Is sustainable.*** Reimbursement levels could be set in a manner that is sustainable for the system. An evaluation mechanism could be established to review payment levels and ensure that providers are being adequately reimbursed for their services while also keeping costs affordable to the payer.
5. ***Adjusts for risk based on incidence of illness in a given population.*** In order to develop a system that is equitable, reimbursement could be provided in a manner that does not penalize providers that care for patients who are sicker than the average citizen. On the same note, the system should not be established to allow providers or insurance carriers to select healthier or wealthier patrons.
6. ***Builds on the experiences of other reforms at the local, state, and national level as well as the private sector.*** Oregon can learn from the experiences and data produced by other initiatives that address many of the same goals as the Healthy Oregon Act. Building partnerships with these collaboratives could advance healthcare reform as a whole and position the Oregon Health Fund Program for success.