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A Report On Eight Early-Stage State And Regional Projects Testing Value-Based Payment

ABSTRACT To help contain health care spending and improve the quality of care, practitioners and policy makers are trying to move away from fee-for-service toward value-based payment, which links providers' reimbursement to the value, rather than the volume, of services delivered. With funding from the Robert Wood Johnson Foundation, eight grantees across the country are designing and implementing value-based payment reform projects. For example, in Salem, Oregon, the Physicians Choice Foundation is testing "Program Oriented Payments," which include incentives for providers who follow a condition-specific program of care designed to meet goals set jointly by patient and provider. In this article we describe the funding rationale and the specific objectives, strategies, progress, and early stages of implementation of the eight projects. We also share some early lessons and identify prerequisites for success, such as ensuring that providers have broad and timely access to data so they can meet patients' needs in cost-effective ways.

Calls for reform in the way health care providers are paid were made as far back as the 1930s but began in earnest in the early 1970s,[1] after the implementation of Medicare and Medicaid. The implementation of Medicare's hospital inpatient prospective payment system in 1983 led to more such calls.[2]

The Medicare inpatient prospective payment reform was followed in the 1990s by the resource-based relative value scale, Medicare's payment schedule for physicians, which is also used by many other payers.[3,4] Another development in the 1990s was the increase in capitation-based contracting. In this approach, medical groups and networks of hospitals and physicians are paid a set monthly fee for each person served.

On the heels of a backlash against managed care, the past decade has witnessed experiments in pay-for-performance[5,6] and shared savings. In the shared savings approach, health care systems or providers get part of any savings achieved from reducing the cost of care.[7]

We have also seen experiments using bundled payments[8,9] and risk-adjusted global payments, in which providers receive a fixed prepayment that takes into account patients' underlying health status. These global payments reflect the next generation of capitation-based contracting.[10,11]

The hope of policy makers and practitioners is that these refinements will overcome the shortcomings of prior payment reforms.[12] Underlying the call for payment innovation is a desire to pay for "value," rather than volume.[13]

Another crucial insight from recent payment policy research is the need to align payment with delivery system design so they work together to achieve the intended goals.[9,14] One example is the use of a capitation fee for primary care in patient-centered medical homes. These medical homes aim to improve the quality of care by making care more comprehensive and patient centered and by coordinating it with community-based social and health services such as home health.

In this article we highlight eight new payment reform projects, funded by the Robert Wood Johnson Foundation in six states. We describe the foundation's rationale for funding the projects and its methods for soliciting proposals and selecting which of them it would fund.

We then briefly describe the projects' objectives, strategies, progress, and early stages of implementation. We conclude by offering an overview of the projects as a group and presenting some broad preliminary lessons.

Funding Goals And Strategy

The Robert Wood Johnson Foundation has been working to improve the quality and reduce the cost of health care for more than thirty years. Unfortunately, providers are paid in a way that runs counter to these goals because the predominantly fee-for-service system rewards providers for high-volume, rather than high-value, care. The foundation

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recognizes that to achieve and sustain quality improvement and cost reduction, health care payment must be fundamentally transformed.

With this perspective in mind, the foundation has begun to support payment reform. The foundation's signature effort to ameliorate quality of care is its Aligning Forces for Quality program, which emphasizes the development of community alliances for quality improvement, performance measurement, and public reporting. The foundation also supports payment reform through several other initiatives. One such initiative is Payment Reform for High-Value Care, a national program that is the subject of this article.[15]

CALL FOR PROPOSALS In September 2010 the Payment Reform for High-Value Care program issued a call for proposals to conduct innovative payment reform projects to promote high-value health care. Applicants were asked to be as "bold as possible" in their proposed payment reform efforts and to describe explicitly the payers involved and their respective roles. The foundation hoped to expand the number and scope of payment reform activities in the United States; therefore, applicants that had not yet implemented a payment reform but proposed to plan or implement one were eligible to apply.

By requesting boldness in payment reform, the foundation expected that grant applicants would go beyond the initial wave of pay-for-performance programs implemented during the early 2000s and embrace a more fundamental payment innovation based on value. Global payment; bundled payment based on medical episodes; and shared savings, with a mixture of upside gain- and downside risk-sharing, are all examples of such innovations. So are the mixed models combining care redesign and value-based payment, such as accountable care organizations.

The original call for proposals stated that the Robert Wood Johnson Foundation would fund as many as three grants for up to three years each, with a total amount for each grant of $50,000–$300,000. The foundation received fifty-two brief proposals.

EIGHT PROJECTS SELECTED Ultimately, eight projects in New Hampshire, Massachusetts, Maine, Pennsylvania, Oregon, and Washington were chosen to receive funding. Five of the projects were new, stand-alone programs whose funding began in May 2011. The other three projects were already receiving funding through the foundation's Aligning Forces for Quality program. They began to receive additional funding during 2009–10. Many of the projects focused on reducing hospital readmissions or transforming care for patients with chronic illnesses. Some proposed to develop and implement a payment reform project, while others had already developed a payment reform proposal and planned to use the new foundation funding to implement the proposed reform.

The Robert Wood Johnson Foundation selected five proposals for funding based on the proposals' expected contribution to knowledge about payment reform implementation; evidence of the relevant stakeholders' commitment; and the projects' scope, potential impact, and generalizability. The three projects that were already funded through the Aligning Forces for Quality program added payment reform onto the quality improvement efforts already under way in that program.

Although the foundation had hoped to expand beyond this familiar set of organizations and regions, its ultimate goal was to fund the projects that were boldest and most likely to succeed. The eight currently funded projects from New England, southwestern Pennsylvania, and the Northwest provide a degree of geographic diversity and also present substantial variation in payment reform environments and strategies.

ENCOURAGING EXPERIMENTATION IN PROGRAM DESIGN The Robert Wood Johnson Foundation frequently exerts its funding leverage to strongly encourage particular program design features. For example, in its recent call for proposals on accountable care organization research (closed September 5, 2012), the foundation offered support for case studies of accountable care organizations as they develop in the private sector—including barriers and facilitators to their implementation and their effects on a variety of outcomes.[16] However, in its Payment Reform for High-Value Care program, the foundation explicitly did not impose such direction on potential projects because its goal was simply to support experimentation.

The foundation chose to fund an independent evaluation of these eight payment reform projects to learn, and to help the field learn, from them in a systematic way. It emphasized qualitative evaluation and analysis of implementation because each project was not expected to have achieved its final cost or quality outcomes by the time the foundation's funding ended. The evaluators' initial round of site visits in the fall of 2011 provided preliminary lessons for the field. Complete analyses of interviews will be presented elsewhere. In this article we discuss certain key takeaway points.

The fundamental purpose of the Payment Reform for High-Value Care projects was to improve the value and lower the cost of health care. However, such outcomes, if present, typically are not measurable until more than two years after a project's inception. Nevertheless, many communities and stakeholders want to know how such payment reforms are actually being carried out. For example, which stakeholders were involved in each project? How were the projects designed? What exactly was the approach to payment reform, and which patient population was the focus?

The foundation anticipated that detailed descriptions of each project, as well as an account of the barriers and facilitators each encountered, would be the evaluation's most useful contributions. Therefore, this article highlights some initial lessons and experiences gleaned from the eight projects. The article is not intended to rate the success or failure, degree of progress, or return on investment of individual projects or of the payment reform program as a whole.

Project Summaries

The projects' objectives and payment reform strategies are shown in Exhibit 1. Although the Robert Wood Johnson Foundation funded two projects in Maine, we combined them in the exhibit because they share common leadership and objectives. Thus, the exhibit describes seven projects.

Overall, the projects are quite diverse, and no two of them have the same ob-

EXHIBIT 1

Descriptions Of Projects In The Robert Wood Johnson Foundation's Payment Reform for High-Value Care Program

Objectives	Payment reform strategies
NEW HAMPSHIRE	
Reduce cost	Retrospective patient attribution[a]
Improve quality	Reduced year-to-year swings in costs
	Cohort budget target[b] comparing ACO and non-ACO cost growth
	Two-sided risk- and gain-sharing arrangement depending on quality of care
	Adjusted shared savings based on quality performance
MASSACHUSETTS	
Shift the treatment mix for patients with low-risk prostate cancer toward higher-value services	Value-based payment
	Rewards to physicians for using lower-cost treatments that are as effective as higher-cost treatments
Generate overall savings	
MAINE	
Contain costs	Value-based payment
Increase data transparency	Risk-adjusted, annual per capita spending for selected services
Reduce unwarranted variation in use of health services across geographic areas	For supply-sensitive care,[c] global payments to providers and high copayments for patients
	For preference-sensitive care,[d] incentives for shared decision making
Achieve accountability for quality of care and health outcomes	For effective and safe care, reduced cost sharing for evidence-based care
SOUTHWESTERN PENNSYLVANIA	
Reduce costs	Combining savings from reduced hospital readmissions with FFS payments for value-added primary care services[e] and P4P payments to hospitals and physicians
Develop a sustainable, replicable economic model	
PORTLAND, OREGON	
Reduce health care costs	Per member per month nurse care management fee
Improve quality of care and patient satisfaction	50/50 sharing of projectwide savings between payer and provider organizations at the end of two years
SALEM, OREGON	
Improve the quality and efficiency of health care	Financial incentives for a virtual provider team to have a minimum percentage of patients achieve all clinical targets for a specific condition
WASHINGTON STATE	
Improve primary care and reduce avoidable hospitalization and unnecessary ED visits	Per member per month incentives in patient-centered medical homes to improve clinical care practices
Ultimately produce cost savings	50/50 sharing of cost savings between medical groups and health plans if the medical group meets clinical quality metrics
	Financial risk of repaying part of the supplemental payments[f] if medical group fails to meet targets for use reductions

SOURCE Authors' analysis of key-informant interviews and project-related documents. **NOTES** ACO is accountable care organization. FFS is fee-for-service. P4P is pay-for-performance. ED is emergency department. [a]Patients are "attributed" to the clinic where they received the majority of their care in the previous year. [b]The spending target for the ACO's patient population is based on the spending of a comparable population not participating in the ACO. [c]Care for conditions for which the supply of a specific resource has a major influence on the use of the resources. [d]Care for conditions for which legitimate treatment options exist; decisions about this care should thus reflect patients' personal values and preferences. [e]Services that are complementary to a core service offering. [f]Prospective payments made in addition to the base payments for care management and other care not covered by the base payments.

jectives, payment strategies, and anticipated health care delivery reforms. See the online Appendix for more detailed project descriptions, information on project barriers and facilitators, and a summary of emerging themes across projects.[17] Brief summaries of each project and its original programmatic goals follow.

NEW HAMPSHIRE The New Hampshire project is augmenting a five-year, statewide accountable care organization pilot under the facilitation of the NH Citizens Health Initiative.[18]

MASSACHUSETTS The Massachusetts project, which was facilitated by the Institute for Clinical and Economic Review at Massachusetts General Hospital, initially was testing payment reforms for the treatment of low-risk prostate cancer to determine the effectiveness of the concept "equal pay for equal outcomes." The original project has ended, and a new group of stakeholders is using comparative effectiveness research to improve value in health care decisions.[19]

MAINE The projects in Maine are focused on payment reforms for supply-sensitive and preference-sensitive services and the development of accountable care organizations.[20,21] Supply-sensitive conditions are those in which the supply of a specific resource, such as magnetic resonance imaging technology, has a major influence on health care use patterns—in this example, the rate of magnetic resonance imaging tests. Preference-sensitive conditions are those for which legitimate treatment options exist, and thus a decision about which treatment to use should reflect the patient's personal values and pref-

erences. For example, one patient with knee pain might prefer knee replacement surgery, while another might favor physical therapy.

The Maine Health Management Coalition Foundation is managing both projects.

PENNSYLVANIA In southwest Pennsylvania, the Pittsburgh Regional Health Initiative is leading and convening a project focused on small practices. The project is developing an accountable care network composed of one anchor community hospital and a subset of its affiliated primary care practices.[22]

OREGON There are two projects in this state. In Portland the Oregon Health Care Quality Corporation is facilitating a project that seeks to implement a number of primary care delivery system reforms—such as nurse care management and same-day access—through a coordinated, communitywide approach. The reforms are based on direction by the Oregon Health Leadership Council and mandates from the Oregon legislature.[23]

In Salem the Physicians Choice Foundation is directing a project that seeks to implement primary care reform through a model known as Program Oriented Payment.[24] Under this model, payments are made to providers who follow a condition-specific program of care designed to meet goals set jointly by the patient and his or her provider. For example, providers receive incentive payments only after a predetermined minimum percentage of patients has reached the clinical target or targets for the specific condition.

WASHINGTON Seattle's Puget Sound Health Alliance and the Washington State Health Care Authority are overseeing a project that provides up-front per member per month payments to support primary care transformation.[25] Providers also face some financial risk if they do not meet performance targets.

Reform Background Varies By State

One reason for the diversity among the projects is that both their contexts and the forces driving reforms vary greatly across the states. For example, Oregon's projects have been heavily influenced by the state legislature's authorization of global payment and coordinated care organizations to provide health care to people with public health insurance, such as Medicaid. In contrast, the New Hampshire and Maine projects emerged from strong public-private partnerships that in turn had evolved from patient-centered medical home pilots and an interest in fashioning regional accountable care organizations.

Some commonalities in context do exist across the separate projects. For example, in many projects a history of collaboration among payers, providers, medical groups, and others—often fostered by an organization that is a trusted "neutral convener"—has helped build consensus.

All-payer databases assemble a statewide repository of health insurance claims information from all public and private health care payers; they are designed to provide information for efforts to contain costs and improve quality. New Hampshire, Maine, and Oregon have developed such all-payer databases. In so doing, the states promote a community-level perspective among project stakeholders, which in turn facilitates quality improvement and cost reduction.

The structures and processes of care delivery have also influenced the projects. The presence or absence of large health care organizations in a state and in local markets has shaped individual projects' payment reforms and strategies. The early work of the Pittsburgh Regional Health Initiative on reducing hospital readmissions demonstrates that work on care redesign frequently preceded payment innovation in the projects.

Controlling Costs And Improving Quality

In general, the projects have two common objectives—controlling costs and improving quality—which in combination enhance health care value. Nonetheless, the projects approach these objectives in widely different ways. For example, in Washington State the focus is on reducing avoidable hospitalizations and unnecessary emergency department visits. In contrast, both Oregon projects target patients who are high risk, high cost, or both. In other projects the goal is to shift the mix of services toward value-based care.

The projects are implementing different delivery system and payment reforms to change the cost and quality of care. The projects in Maine, New Hampshire, and Pennsylvania are implementing forms of accountable care organizations. Those in Pennsylvania and Portland, Oregon, are deploying nurse care managers, while the one in Washington State is relying on an organizational reform—the implementation of patient-centered medical homes—to achieve its objectives. For selected chronic conditions, the strategy of the project in Salem, Oregon, is to link providers' payments to their success in meeting evidence-based quality targets.

The diversity in delivery reforms is matched by the diversity in payment strategies. The New Hampshire and Maine projects are aligning their accountable care organization reforms with global budgets, although the details of their payment strategies are still being developed. The projects in Pennsylvania; Portland, Oregon; and Washington State are using some form of per member per month capitation payment. Some of the projects—in New Hampshire; Portland, Oregon; and Washington State—have schemes for sharing risks and gains, which encourages hospitals and physicians to collaborate in improving quality and efficiency so that they can share cost savings as a reward.

The health care market in Salem, Oregon, is dominated by small, independent practices, with few integrated delivery systems. Consequently, the project there has designed a pay-for-performance, fee-for-service approach that motivates "virtual teams" of providers—who are treating the same patient but are actually in different practices—to manage the quality and cost of care efficiently and effectively for the patient over time. Ultimately, payments to a virtual team are based on meeting specific quality targets.

Value-based payment to providers and innovative patient cost-sharing models are being implemented in the Maine projects. The Massachusetts project is unique in focusing its payment reform effort on "paying equally for what works equally well" in treating low-risk prostate cancer. For example, had the project continued, payment for brachytherapy

(a form of radiotherapy in which a radiation source is placed in or near the area to be treated) would be equal to that for intensity-modulated radiation therapy (using multiple small radiation beams to conform precisely to a tumor's shape), which traditionally has been priced as much as four times higher than the former treatment. The strategy is to lower cost and improve value.

There is still insufficient evidence to predict which combinations of health care delivery and payment reforms described above will be most effective in practice. We expect, though, that the joint effects of payment and delivery system reforms will be greatest when the two types of reforms are closely integrated.

Early Lessons From The Field

Full implementation of the Affordable Care Act will probably continue to accelerate payment and delivery system reforms. Although several payment models might achieve the act's goals, reforms will be more effective when payment is aligned with substantive changes in delivery system design and improvements in care processes.[11,14,26]

In this section we examine early lessons from the formative and "midterm" experiences of the eight projects described above, in the hope of adding insights to policy and practice in the rapidly evolving health care environment.

Value-based payment reform requires not only time and resources but also a culture change: Private health plans, providers, and purchasers, including self-insured employers; employee benefit trusts, which hold the assets of some employee benefit plans; and public programs must cooperate on an unprecedented scale. The role of employers and consumer groups in this cultural innovation is particularly critical, yet so far it is underdeveloped. For example, keeping employers' senior executive leadership actively engaged in catalyzing payment reform is a continuing challenge, and organized consumer advocacy for payment reform is generally lacking.

GAPS IN PAYMENT REFORM PROCESSES In discussions of health care payment reform, the voices of the patient and the purchaser are often notably absent. Seldom is a patient or consumer advisory council explicitly included, for instance. Future initiatives would benefit from a clear articulation of the role of organized purchasers and patient groups in designing and reinforcing payment reform. Oversight by and input from these groups on health benefit design, as well as provider pricing transparency, are examples of missing components in the Robert Wood Johnson Foundation payment reform projects reviewed here.

Another dimension largely absent from the early stages of these projects is attention focused on the level of provider payment. In the projects reviewed here, multistakeholder payment reform generally has emphasized changes in the unit and method of payment, such as fee-for-service versus episode-based payment, rather than in the amount of payment. A balanced consideration of both these attributes of payment will be important in advancing payment reform efforts. The following two factors probably account for the greater stress on payment unit: legitimate reservations that collective action on payment levels could raise antitrust concerns, and the fact that virtually all of these projects were initially focused on building an organizational care delivery platform prior to designing innovations in methods of payment.

DELIVERY SYSTEM REDESIGN AND PAYMENT REFORM Delivery system redesign—particularly in the form of patient-centered medical homes and accountable care organizations—is not a precondition for value-based payment reform. However, the preliminary evidence from the projects in five of the six states reviewed above—Maine, New Hampshire, Oregon, Pennsylvania, and Washington—suggests that such redesign markedly facilitates the creation of patient-centered bundled payment and global payment models. It is unclear whether payment and delivery system reforms are more effective when they are mandated through "top-down" legislative or other mechanisms or when they emerge from "bottom-up" grassroots efforts to transform local systems.

What factors might influence the alignment of payment and delivery system reforms? Environmental conditions set the stage for the design, implementation, and alignment of each project.

For example, the projects in Oregon and Washington have shown how state legislation can galvanize regional and state payment reform initiatives. The payment reform projects in Oregon were designed to align with state reforms and build on some overlapping foundational work needed to create coordinated care organizations and global health budgets. Washington's project is the second of two initiatives authorized by that state's legislature to promote the growth of patient-centered medical homes.

Federal regulations are another factor influencing the alignment of payment and delivery system reforms. The Centers for Medicare and Medicaid Services' rules and funding for accountable care organizations and shared-savings payment models have supported several accountable care organization pilots in Maine and New Hampshire. Payment reform is also shaped by earlier efforts at organizational change in care delivery. Patient-centered medical homes and accountable care organizations, in particular, represent potentially strong delivery system platforms for value-based payment.

The presence or absence of integrated delivery systems and prior experience with capitation contracting played a fundamental role in shaping the initial conditions for payment reform in local markets. The predominance of gainsharing, shared-savings, and pay-for-performance models among the projects reviewed in this article reflects a slow recovery from the managed care backlash of a decade ago. So does stakeholders' reluctance to move toward two-sided risk-sharing arrangements, in which accountable care organizations share in excess Medicare costs as well as in any savings. Similarly, as described earlier, the predominance of small practices and the absence of large systems in Salem, Oregon, resulted in a unique pay-for-performance model based on virtual care teams.

DATA NEEDS Accessible and high-quality data are necessary for payment reform but remain elusive. Accurate and easily accessible data on the use, cost, and quality of health services are essential to the design and implementation of new payment models. More generally, lags in incurred but not reported claims

also hinder care management. Those same lags as well as gaps in health information systems' interoperability make it hard to attribute patients accurately to their managing physician and provider organization. Accurate attribution of patients is critical to bundled and global payment contracts.

Data sharing among payers, providers, and purchasers is another core requirement in the transition from fee-for-service to value-based and person-centered payment. Health plans often view data as proprietary and a source of competitive advantage; thus, cooperation among plans on data sharing is frequently limited. However, the rise of multipayer and all-payer claims databases linked to electronic health record data has the potential to break such logjams in payer-provider cooperation.

Similarly, the acceptance of a unique "master identifier" for each registered patient would ensure that vital information about that person could be shared among different stakeholders. For example, Maine has operated a multipayer claims database for twelve years, enabling uniform and comprehensive reporting of performance to pilot stakeholders. A web-based portal allows participating physicians to access the data electronically from any site. The database also has varying levels of encryption and displays different views and levels of aggregation for employers and providers.

MEETING THE DEMAND FOR EVIDENCE

Generally, the push for stakeholder buy-in has resulted in incremental, opportunistic reforms—such as reducing emergency department costs and reducing readmissions—that are generally not contentious and have low financial risk. However, they might not have sufficient strength to cause substantial changes in the cost or quality of care. Put differently, sometimes in multistakeholder arrangements there is a tendency to settle for a least common denominator to satisfy diverse interests.

In this era of health reform, the demand for evidence—both quantitative and qualitative—about the design, alignment, implementation, and outcomes of payment reform initiatives is likely to increase in the next several years. Some reforms observed in this evaluation were based on specific evidence.

For example, Portland, Oregon, supported nurse case managers with per member per month payments based on favorable, short-term, return-on-investment results for a similar project previously conducted by Boeing for employees living with complex chronic conditions. The project focuses enhanced care management resources on a subset of high-use patients identified by health plans or nominated by medical groups. Key components include nurse care management, patients' same-day access to providers, 24/7 telephone support, a designated care team for each patient, and the involvement of a care neighborhood—that is, a local environment that supports coordinated and patient-centered care.

When evidence is lacking, economic and organizational systems theory may suggest what effects should be expected.[12] Health services researchers have an important role to play in providing timely reports and "users' guides," written in plain language, to ensure that would-be innovators build on tested theory and empirical evidence. Doing so will also help innovators avoid inadvertently reinventing the wheel. In the long run, work is needed to design and test aligned payment and delivery system models that are powerful enough to foster the system reforms and health outcomes envisioned by the Affordable Care Act.

Conclusion

In an effort to support initiatives to control health care spending, improve the quality of care, and pay for high-value care, the Robert Wood Johnson Foundation funded eight payment reform projects in different regions of the country. These projects have similar objectives but different payment reform strategies. Collectively, they offer valuable insights for both policy makers and practitioners.

The delivery system model has a large impact on payment reform, and patient-centered medical homes and accountable care organizations are strong vehicles for value-based payment. Access to accurate and timely data is necessary but remains difficult to achieve. Ultimately, cooperation among plans, providers, and purchasers is required to make the complete transition from the volume-based, fee-for-service model to value-based payment.

With scarce literature available on the design, implementation, and challenges of payment reform initiatives, the completion of all eight projects may offer additional important lessons for others working in the field. Furthermore, these insights may identify specific policy changes needed to advance value-based payment in the United States. ■

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In this month's *Health Affairs*, Douglas Conrad and coauthors report on eight early-stage projects funded by the Robert Wood Johnson Foundation to test value-based payment reforms. The projects—located in Maine, Massachusetts, New Hampshire, Pennsylvania, Oregon, and Washington—emerged from the foundation's Payment Reform for High-Value Care program. The authors provide some early lessons, such as the need for accessible and high-quality data, so that providers truly understand in real time what is happening with their patients and can take steps to ensure that they are receiving optimal and cost-effective care.

Conrad holds a number of positions at the University of Washington, including professor of health services and dental public health sciences and director of the Center for Health Management Research. He is also an affiliate investigator in the Center for Health Studies at the Group Health Cooperative and was recently appointed by the governor to the Washington State Health Benefits Exchange Board.

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