



# DELIVERY SYSTEM REFORM

*Action Steps and Pay-for-Value Approaches*

A joint perspective from:



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## Introduction

This paper outlines a vision and action steps for reforming the health care delivery system in the United States. We propose changes, including payment reforms, that will promote greater organization in the delivery system and through that organization, improve the value of health care services provided. We define value as a function of quality and cost over time, and keep the patient's needs at the center of proposed changes. As three leading health care organizations – Intermountain Healthcare, Kaiser Permanente and Mayo Clinic – we have come together to put forth a set of principles and characteristics that we believe *all* health care organizations should strive to achieve, including:

- Care Coordination and Teamwork
- Choice
- Shared Decision Making
- Shared Responsibility
- Promotion of Primary Care
- Patient-Centered Use of Information Technology
- Evidence-Based Care

We also identify key components that will require consideration in reforming current payment mechanisms:

- Pay for Value
- Transparency
- Science of Health Care Delivery
- Innovation
- Professional Liability Reform

Health care delivery in the United States is facing a crisis, in part because the “cottage industry” approach to medicine has not produced the quality and efficiency results we want and need. Alternatives to the predominantly fragmented system exist already in the form of large integrated systems and multi-specialty group practices. By learning from those organizations that are already performing at the highest levels and through development of thoughtful policy changes, we can better organize the health care delivery system to achieve value for patients and purchasers.<sup>1</sup>

## Background

In its landmark *Crossing the Quality Chasm Report*, the Institute of Medicine (IOM) advised that “the current care systems cannot do the job. Trying harder will not work. Changing systems of care will.”<sup>2</sup>

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<sup>1</sup> While outside the scope of this paper, we recognize that the health care needs of children are unique and must be considered separately from the health care needs of adults. This paper primarily focuses on adults, but we encourage further development and reporting of evidence-based measures for children and pilot medical home programs in Medicaid which covers 27% of all children, pays for approximately 50% of all care provided at children's hospitals and pays for the birth of approximately 40% of all babies.

<sup>2</sup> Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, DC: National Academy Press, 2001.

## Background

*(continued)*

The IOM report envisions a delivery system capable of meeting six challenges:

- Redesign care processes to incorporate evidence-based care processes that improve effectiveness and reliability of delivery
- Make effective use of information technologies to make clinical information readily accessible to patients and all members of the care team
- Manage the growing knowledge base and ensure that all health care workers have the skills they need
- Continually advance the effectiveness of teams
- Coordinate care across patient conditions, services and settings over time
- Use performance and outcomes measurement for continuous quality improvement and accountability

Group practices exist across the country that are already bringing about the Institute of Medicine's vision of an ideal health care system – one that is safe, effective, patient-centered, timely, efficient and equitable. Group practices that incorporate the elements of an ideal delivery system can demonstrate how beneficial an accountable coordinated system is to the quality of care for patients and to the practice of medicine.

The following proposal outlines concepts and principles to move the country from a fragmented delivery system with ineffective incentives for quality and efficiency of services to a highly functioning, organized delivery system with the patient at the center. The changes we propose will contribute to improvement in value for health care services, with value defined as quality divided by cost over time, and with quality including outcomes, safety, and service. For the sake of brevity, we provide only summary thoughts on selected topics, noting where further detail could follow in subsequent papers.

## Program Overview

A critical goal of health care reform is to create value for patients, which would result in both better quality and lower cost over time. To achieve this goal we must focus effort in the following areas:

### **I. Create an integrated, patient-centered health care delivery system that generates value.**

Patients should have access to a health care system in which health professionals share information, learn from each other, and hold themselves and one another accountable in order to generate the best medical outcome at the most reasonable cost for each patient.

## Program Overview *(continued)*

### II. Establish payment mechanisms to financially reward providers that deliver value.

Health care professionals must provide and be rewarded for giving patients high-value health care – a quality outcome, a safe environment, and a satisfied patient at a reasonable cost over time. We believe that competition based on value is the best way to improve quality and decrease costs. Also, payment must be reasonably predictable over time to allow for appropriate investments in care systems. Possible approaches to payment reform include care-coordination payments, episode-based payments and prospective population-based payments.

## Vision

### An Integrated Delivery System that Centers on the Patient

*Create an integrated delivery system in which health professionals share information, learn from each other and hold themselves and one another accountable in order to generate the best health outcome at the most reasonable cost for each patient.*

To realize this vision, major stakeholders should commit to the principle of centering care around the needs of the individual patient. Physicians have an enormous impact on the performance of the entire delivery system, and only when they accept broad accountability for the total care of patients will we see the magnitude of change needed in this country. Pro-active leadership from the health care profession is a critical element in effectively reshaping the delivery of care in the United States. Below are key components that we, as physician group leaders, believe would help the United States create a patient-centered, integrated, health care delivery system:

#### Care Coordination and Teamwork

As medical science continues to become more subspecialized, there is an increasing need for truly coordinated health care. Care coordination is especially important since more people are developing multiple chronic diseases such as diabetes, heart failure and depression. Unfortunately, far too many patients do not have their care appropriately coordinated. The Commonwealth Fund reports that Medicare patients with four or more chronic diseases see an average of fourteen physicians annually, leading to medical costs equal to two-thirds of the federal program's total spending. "There's growing recognition that Medicare and its payment system, which were designed around acute care, need to encourage and reward care coordination," the report notes.<sup>3</sup> Without integrated care, there is increased risk of contradictory treatments and increased expense.

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<sup>3</sup> *Quality Matters*: June Update from The Commonwealth Fund, June 2005.

## **Vision** *(continued)*

Physicians must coordinate care in functional health care teams – preferably within multi-specialty medical groups – across conditions, care sites and over time. While the traditional fee-for-service system emphasizes physicians as independent decision makers, integrated delivery systems rely on teams (often led by physicians, but including nurses, pharmacists, and other health care and administrative professionals) to work together with patients to provide care. Evidence tells us that a highly functional health care team provides a superior care experience for patients, and increases the morale and satisfaction of physicians, nurses and other health care professionals. Research on patient care teams suggests that teams with greater cohesiveness are associated with better clinical outcome measures, lower total cost and higher patient satisfaction.<sup>4</sup>

At the same time, medical education must change if delivery system reform will be achieved. Physicians must be taught new knowledge and skills to be effective in 21st century medicine. Medical schools should teach physicians how to work effectively on teams, how to coordinate care, and how to apply systems thinking and re-engineering to health care delivery. In addition, physicians will need to shift their focus from disease treatment to incorporate disease prevention, care management and health promotion.

### **Choice**

As the central figure in the health care delivery system, the patient must be fully informed when making decisions. The principle of personal choice needs to be reflected in any reform proposal.

### **Shared Decision-Making**

To truly transform our delivery system into one centered on the patient, we need to develop better tools and approaches to help consumers make decisions about their care. Patients should be afforded opportunity for meaningful input into health care decisions that affect them, and the health care decision-making process should be nimble enough to accommodate the various levels of involvement that different patients may choose. When consumers have accurate information about treatment options and alternatives, they make decisions that are more aligned with their own values and preferences. And those decisions often result in better outcomes.

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<sup>4</sup> K. Grumbach and T. Bodenheimer, *Can Health Care Teams Improve Primary Care Practice?* JAMA, March 10, 2004: Vol. 291, No. 10, 1246-1251.

## **Vision** *(continued)*

Without this kind of information, most patients rely on their doctors, whose recommendations may be rooted in practice patterns that reinforce the “more is better” mindset that permeates our health care system. The Foundation for Informed Medical Decision Making points out that for 70 percent of people who have a heart bypass operation, the result would have been the same if they had chosen medication alone. Many of those patients were probably unaware that they had more than one treatment option, and might have chosen differently.

### **Shared Responsibility**

Providers should be given incentives to focus on keeping patients healthy and providing value. Indeed, a major goal of reform should be to change to a payment system based on value rather than the volume of services provided. The traditional fee-for-service (FFS) system rewards the provision of more services and more procedures, whether clinically appropriate or not. We must shift to a system that rewards value, not volume. Patients, like providers, must be involved clinically as well as financially. Patients must take personal responsibility for their health – including making healthy lifestyle choices, following treatment regimens, and accepting fair financial responsibility for their health care and lifestyle choices when some options are clearly more efficient than others. Patients must have the information they need to make informed choices. Value-based benefit design may assist in this effort.

### **Promotion of Primary Care**

Patient access to high-quality, primary care is essential for a well-functioning health care delivery system. While a personal relationship with a physician is a critical component of primary care delivery, creating teams of clinicians who support a physician can further improve an organization’s approach to providing primary care. Research suggests that improving access to primary care and reducing reliance on specialty care may improve the efficiency and quality of health care delivery.<sup>5</sup> This is particularly important, given that effective primary care is not rewarded by today’s most common payment mechanisms (and decreasing numbers of new physicians select training in these critical areas).

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<sup>5</sup> Medicare Payment Advisory Commission, *Report to the Congress: Reforming the Delivery System*, June 2008, 23.

**Vision** *(continued)***Patient-Centered Use of Information Technology**

Individual medical records, medication lists, the latest disease-specific information/studies and up-to-date information on applicable clinical trials must be available for providers and patients at the touch of a button. With appropriate patient confidentiality safeguards, electronic medical records should allow all types of providers over vast geographic spans to collaborate and coordinate care for patients. Reforms must promote the development of effective clinical information systems and the skills to use them.

As the field of personalized medicine moves from research to practice, the patient's unique genetic profile may also be a factor in determining a patient's predisposition to a disease and the interventions that would best manage a patient's disease. Within a decade, each of us may carry our entire genetic sequence on a molecular "identity card" so that clinicians can target our treatments to individuals. The availability of such personalized information will have implications for privacy and security, and specific guidelines will need to be developed to ensure consumer safeguards around underwriting and guaranteed issue are addressed.<sup>6</sup>

**Evidence-Based Care**

Having health information technology and the means to exchange information will do us little good if we do not foster and support better information about the effectiveness of care, including the relative benefits, risks, and costs of treatments and services. We need a robust federal commitment to comparative effectiveness research so that health professionals can ensure each individual patient gets the care that is right for them. Reforms must also ensure that patient information can be used not only to optimize care for one specific patient, but also to improve care for all patients through, for example, the development of clinical care guidelines and disease management protocols. This requires the use of patient information and appropriate access to patient records, with privacy safeguards as currently required under HIPAA rules.

**Payment Reform**

*Health care providers must work together to create value – a quality outcome, a safe environment and a satisfied patient, at a reasonable cost over time – and payers must establish payment mechanisms that financially reward providers who deliver value.*

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<sup>6</sup> The field of individualized medicine is a rapidly developing field and will be an integral part of delivering high value care in the future. This paper touches on the ideas in a summary fashion. Further detail could be provided in subsequent discussions and papers.

## Payment Reform

*(continued)*

The financial incentives that exist today do just the opposite. Physicians are rewarded for taking actions – doing procedures, prescribing drugs, performing tests – regardless of whether the best evidence calls for such action. We must move away from the traditional FFS system, which rewards volume rather than value because each provider has an economic interest in providing more services for the patient rather than coordinating with other providers to determine how and what mix of care is ideal.

To reform the current payment system, payers must commit to the principle of rewarding value. Below are key components to enable the rewarding of value:

### **Pay for Value**

Provider payment systems should be based upon value rather than upon completing processes or performing discrete services. Health organizations would then be motivated to constantly and thoroughly study processes that lead to better outcomes, rather than being paid to follow today's process lists or to encourage marginal procedures. Organizations that provide greater value should be rewarded. Appendix A describes eight possible payment approaches (which are not mutually exclusive) that could be used to move in this direction.

### **Transparency**

Transparency drives quality improvement. Publishing valid resource use, quality outcomes and cost-per-episode information is critical if consumers are to make informed choices within a market-based system. Effective measurement approaches will provide insight into how to improve care delivery processes. Current measurement initiatives contain a variety of approaches for provider reporting and level of aggregation, including the individual provider, treatment team, practice site, facility and medical group levels. The choice of aggregation level across this continuum impacts the utility and validity of the reporting for purchaser decision-making as well as the usefulness of the reporting in driving performance improvement.<sup>7</sup> Consistent and well-developed reporting requirements and measurement approaches across the industry will make it easier for patients to understand the information and will reduce the reporting burden currently faced by providers.

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<sup>7</sup> Performance measurement has improved dramatically over the past 20 years, but there is still much progress to be made. Challenges include questions of how to move from process measures to outcomes measures, how to link measurement to provider behavior in such a way as to achieve better outcomes, and how to best share information with patients and purchasers. This paper touches on the ideas in a summary fashion. Further detail could be provided in subsequent discussions and papers.

## Payment Reform

*(continued)*

### **Science of Health Care Delivery**

The health care industry must commit to using system engineering principles to analyze outcomes and processes of care – a key step to improving health care quality, identifying innovative ways to care for patients, and reducing waste and inefficiencies. Medical education needs to stress these concepts in training programs.

### **Innovation**

Value-based competition is a catalyst for innovation. Research and education are primary underpinnings of innovation and should be supported by society as a whole. The inability to regularly translate research findings into practical improvements in patient outcomes and the nascent nature of research on the science of health care delivery are obstacles to improving the quality of care. Identifying and sharing techniques associated with successful translation of research into practice should be built into health services and health delivery research objectives. In addition, research and education funding can be targeted to address specific and high priority areas needed for care improvement and workforce adequacy, particularly in primary care.

### **Professional Liability Reform**

The current liability environment impacts both practice patterns and physician supply, as physicians make both career choices and clinical decisions based on perceived liability risks. Fear of liability may create an unwillingness to discuss or even admit to medical errors. Delivery system reform should address new ways to improve the current environment so that a culture of safety, learning and communication is encouraged.

## Action

### **A Timeline for Accomplishing the Vision**

Realizing a common vision requires action from all parties involved in U.S. health care: providers, payers, patients and the government.

Here's how we propose to get there:

**Action** *(continued)***Year 1****Develop Pilot Concepts and Provider Partnering Models**

- Providers, payers and insurers develop pilot programs for implementing payment models that foster integrated and coordinated care, and reward value. Medicare can play a major role in this phase by building on tested and existing demonstrations. All providers will be on notice that the phase-in of new payment models is beginning, and that the ability to provide integrated and coordinated care through various models (including virtual groups) will be a primary goal of the pilots. Pilots should be established that include incentives for providers to utilize disease registries and electronic medical records for patients with chronic conditions, and include mechanisms for dealing with issues around reporting and data ownership. Further, programs should be developed that reward employers and employees who effectively manage chronic disease.

**Establish Infrastructure**

- Urge Congress to place portions of health care policy development into the purview of a new entity that is protected from undue political pressure.<sup>8</sup> Such an independent entity might be given the charge to:
  - collect information on health care value and suggest ground rules for paying for that value;
  - produce and provide information about the comparative effectiveness of health services;
  - determine quality measurement and safety reporting strategies; and
  - develop, maintain, and disseminate evidence to inform decision making.

The entity must be supported by a dedicated, broad-based financing mechanism with funding from federal and private sources. An independent board of experts should oversee the entity's efforts to ensure objectivity of research and recommendations. Analyses can be used to help the government and private payers encourage value-based benefit designs, payment policies and coverage decisions.

- Implement a plan based on the Government Accountability Office's mandated report on the newly enacted "Physician Feedback" program under which physicians would receive confidential information about the resources used in furnishing care to Medicare beneficiaries on a per episode or per capita basis (or both). This program may focus on physician

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<sup>8</sup> Development of a new entity to play a role in the health care policy arena has been much debated in recent years. Models suggested have included the Federal Reserve, Base Closing Commission, Securities and Exchange Commission, Federal Aviation Administration and others. Suggested functions for such an entity have included administrative simplification, insurance exchange, alternative dispute resolution, benefit packages and others. This paper touches on the ideas in a summary fashion. Further detail could be provided in subsequent discussions and papers.

## Action *(continued)*

specialties that account for a certain percentage of Medicare physician expenditures, on physicians who treat high cost/high volume conditions, on physicians who manage chronic conditions successfully, on physicians who use a high amount of resources compared to other physicians, on physicians practicing in certain geographic areas, or physicians who treat a minimum number of Medicare beneficiaries.

- Establish transparency of appropriate provider quality (patient outcomes, safety and service) measures and cost over a span of time.
- Develop IT interoperability definitions and standards in order to move toward a nationwide interoperable health information technology infrastructure. A truly national health information technology system should be nurtured rather than the regional variation approach that is inherent in Regional Health Information Organizations (RHIOs). The work of the Office of the National Coordinator should be adequately supported by Congress to expedite the work.

### **Promote Primary Care**

- As the Medicare Payment Advisory Commission (MedPAC) has noted, primary care services – which tend to involve cognitive functions such as patient evaluation and management – are presently undervalued and thus risk being underprovided relative to procedurally-based services. Not surprisingly, the number of U.S. medical school graduates entering practice as generalists is declining. The Centers for Medicare and Medicaid (CMS) and private insurers should increase fee schedule payments for primary care services furnished by clinicians focused on delivering primary care. Similarly system-level, all-inclusive payments should reward health systems that have coordinated primary care, which also motivates increased relative primary care payment.

### **Facilitate Payment Stabilization**

- The combination of administrative pricing and lack of volume constraints in payment policies results in inappropriate care. The delivery system needs a mechanism to counteract the incentive for volume growth in the FFS system and reward improved quality. The Sustainable Growth Rate (SGR) system has not been effective at controlling the volume of physician services and is significantly flawed. The SGR does not distinguish between those doctors who provide high quality care to beneficiaries and those who provide unnecessary services. In fact, physicians providing the most efficient

**Action** *(continued)*

care are penalized under Medicare's current payment system while a physician who orders more tests or performs more procedures than are indicated is paid more. Today, we have a system whereby physicians are constantly lobbying Congress to avoid a payment cut, and Congress is struggling to find the money to pay for it. Clearly, broad-based payment reform must be addressed as soon as possible.

**Create one or more additional payment update “pools” as a pilot project to reform the SGR update process.**

- CMS would authorize the creation of one or more physician payment update pools for the purpose of calculating separate annual updates and sharing savings generated through improved coordination of care and appropriate incentives for volume of services provided while maintaining high standards for quality of care.<sup>9</sup> The initial pools would consist of multi-specialty group practices and other organized provider organizations that care for Medicare beneficiaries on a fee-for-service basis. Medical groups could participate after meeting a set of established criteria which could include:
  - a demonstrated ability to use evidence-based medicine and other systematic processes of care;
  - electronic health information capabilities;
  - the use of systematic quality of care improvement techniques;
  - responsible physician compensation practices; and
  - the willingness to be part of a collective, transparent monitoring and improvement process.

Participating practices could receive a separate annual payment update based on the difference between the annual volume of services provided in the “group” payment pools and the volume of services provided in the national physician pool. Creating these separate update rules will foster the growth of more care coordination and integrated care systems.

**Year 2****Develop Multiple Pay-for-Value Pilots**

- Pilots should strive to combine Medicare, other public programs and private insurers in common payment models where possible.
- Providers work with government and private purchasers to develop multiple pay-for-value pilot programs, including but not limited to medical home,

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<sup>9</sup> J. Crosson, “An SGR Reform Proposal: The Impact of a Payment Update Alternative for Multi-Specialty Group Practice Groups,” Health Affairs Blog, February 19, 2008.

## Action *(continued)*

hospital and physician payment bundling for hospitalized patients, chronic care management, multi-specialty group and accountable care organizations options, palliative/advanced illness care, capitation models and shared decision making. (See Appendix A for additional detail about concepts.)

Pilots should start with a few conditions that are the most common (and also most costly) to the system. Expansions will come as warranted.

Pilots should seek to combine payments across time and provider silos. This may require change in the Medicare payment structure that currently separates funding for parts A and B.

## Year 3

### Implement Pilots

- Pilots are launched and open to all providers. An additional Medicare payment update increment is available for those participating in pilots. Medicaid pilots for dual-eligibles and special needs populations could also be explored and rewarded with higher federal-matching funds.

## Year 4-5

### Evaluate and Modify Pilots

- Pilots continue with modifications based on evaluation of the first two years. Beginning in year five, all providers are notified that they will be paid under a new system.

## Year 5+

### New Payment Models

- Some Medicare payments will remain in a FFS model, while most will be made under new payment models. Providers may be paid under more than one model for different types of services and patients. Private insurers are free to use the same or similar payment models as well.

**Appendix A****Pay-for-Value Approaches**

Pay-for-value approaches will not work well without the existence of organizations that have the capacity to make them work. Conversely, delivery system reform is likely to be quite slow without the clear likelihood of new payment modalities to make the difficult transition to integration worthwhile.

Payment reform will require testing of a variety of methods, all leading toward delivery system integration, which reward quality and efficiency. Better physician-hospital integration at the clinical, financial and governance levels is a key component of each of the approaches suggested below. The suggested approaches will also require legal and regulatory “safe harbors” from Federal Trade Commission, Stark self-referral rules, and Medicare anti-kickback regulations, and other current obstacles, while maintaining prohibitions against anti-consumer behavior.<sup>10</sup>

It is important to note, also, that if delivery system consolidation is not multi-disciplinary, it could simply lead to increased market power for providers versus payers, as has happened with some single specialty groups. We need instead to ensure that physician aggregation is in support of the patient’s best interests and benefits the entire system of care.

**Shared Savings**

For high-cost patients (such as patients hospitalized for diabetic-related complications), determine the annual cost per patient for each separate provider system. The payer would share this information with each provider system and offer to share savings in total cost per patient with each provider system that can deliver such savings while maintaining or improving patient outcomes.

**Chronic Condition(s) Coordination Payments**

Under this approach, patients with one or more chronic conditions would choose a “medical home” (place with resources and infrastructure to organize and coordinate care over time) for their care management, preventive care and minor care associated with those chronic conditions. The medical home would receive a periodic, prospectively-defined “care management payment” to cover those services. Acute patient care episodes would be paid separately under regular insurance coverage rules.

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<sup>10</sup> Creating opportunities for organizations to work together in a more integrated fashion must be done with careful consideration to maintain the core intent and accomplishments of the fraud and abuse regulations already in place. This paper touches on this idea in a summary fashion. Further detail could be provided in subsequent discussions and papers.

**Appendix A***(continued)*

From a cost effectiveness standpoint and with real life experience at Geisinger Health System, it might be wise to start with patients who have been hospitalized for a condition related to one or more of the chronic diseases.<sup>11</sup>

**Varied Provider Payment Updates**

This approach would expand the concept used by the CMS-Premier Hospital Quality Demonstration Project. For the hospital-based episodes of care (hospitalized patients account for the majority of healthcare expense), use risk-adjusted patient outcome measures (mortality, safety, patient satisfaction) and cost over a span of time (such as the Dartmouth Atlas cost in the last six months of life) to determine which care systems are delivering the best value. Providers delivering the best value would receive a larger payment update.

**Full Capitation**

Some large, integrated providers can accept full capitation for a defined benefit set for an enrolled population. This is an excellent way to encourage provider efficiency. Shared-risk agreements can be created for groups of various sizes, including smaller groups. It will be important, and possible, to develop capitation approaches that take into consideration the lessons learned from the failures of capitation in the 1990's.<sup>12</sup>

**Shared Decision-Making**

Under this approach, all patient candidates with selected conditions that include preference-based elective surgery and other treatment choices (for example, spinal fusion, PSAs, etc.) would be offered an approved decision aid based on their disease/condition and its treatment options. Medical centers would be compensated for offering the independent educational program. It may be appropriate to create incentives for payers to offer these programs and for patients to complete them.

**Accountable Care Organizations**

Under this approach, a group of physicians (and possibly a hospital) could be responsible for quality and overall annual Medicare spending for their patients. Different payment models could be tested. For example, physicians would be paid FFS rates, less a withhold, and then receive bonuses for meeting resources use and quality targets over the course of a year.

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<sup>11</sup> R.A. Paulus, K. Davis, and G.D. Steele, "Continuous Innovation in Health Care: Implications of the Geisinger Experience," *Health Affairs*, Vol. 27, No. 5, 1235-1245.

<sup>12</sup> This paper touches on the ideas related to risk sharing and capitation in a summary fashion. Further detail could be provided in subsequent discussions and papers.

**Appendix A***(continued)*

Options might include creating virtual accountable care organizations based on physician-hospital referral relationships. Such an approach would create incentives for physicians and hospitals to work together to provide better value care.

**Palliative/Advanced Illness Care**

Pilot programs could test the use of specific palliative care approaches in conjunction with all other appropriate forms of medical treatment (as distinct from hospice). The palliative care approach has been proven to decrease length of hospital and intensive care unit stays and ease patient transitions between care settings.<sup>13</sup> This results in higher patient and family satisfaction and hospital quality care standards.

Pilots could also reward groups that achieve better quality and lower end-of-life costs through their integration and coordination of care. Rewards should be based on outcomes – patient centered and comprehensive end-of-life care as measured retrospectively over the last year of life.

**Episode-Based Payments for Hospitalized Patients**

This approach would provide a single bundled payment to hospitals and physicians managing the care for patients with major acute episodes. One lump payment for both hospital and physician services is different from the present Medicare DRG payment that only covers the hospital service. The new approach is intended to encourage the two groups (hospital and treating physicians) to effectively integrate patient care.

The idea of “episode-based payments for hospitalized patients” is to concentrate efforts where the dollars are and not get bogged down trying to change payment approaches for all medical services. This is especially pertinent since 10-15% of patients will account for 80% of total costs. “The secret is not, however, to re-jigger 10,000 prices in 3,000 counties so that we get them ‘right’ once and for all (or until medical knowledge or technology or input prices change again). The secret is to pay for what we want ... while bundling ever-larger sets of services into one payment, which frees clinicians and providers to find the most efficient way to deliver health.”<sup>14</sup>

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<sup>13</sup> R.S. Morrison, et.al. “Cost Savings Associated With US Hospital Palliative Care Consultation Programs,” *Arch Intern Med/ Vol 168 (No. 16)*, Sep 8, 2008.

<sup>14</sup> L. Nichols, Director, Health Policy Program, New America Foundation, before the Committee on the Budget, U.S. Senate, June 26, 2007.

### Intermountain Healthcare

Intermountain Healthcare is an integrated system of nonprofit hospitals, clinics and related services based in Salt Lake City, Utah. Intermountain's team includes more than 30,000 employees, providing care in 6 million patient visits every year at 21 hospitals and more than 130 clinics. SelectHealth, a nonprofit insurance company, is also owned by Intermountain and provides benefits for close to 500,000 people.

As a community-based, nonprofit system, Intermountain provides medically necessary care to residents of our region regardless of ability to pay. A pioneer in the use of information technology, Intermountain has used electronic medical records since the 1970s to implement best practices and clinical protocols – resulting in higher quality care that costs less. Medicare spending could be reduced by a third, with improved quality, if the nation provided care the way it's provided by Intermountain Healthcare, according to research from Dartmouth Medical School. For more information, please visit [www.intermountainhealthcare.org](http://www.intermountainhealthcare.org).

### Kaiser Permanente

Kaiser Permanente is America's leading integrated health plan. Founded in 1945, the program is headquartered in Oakland, Calif. Kaiser Permanente serves 8.7 million members in nine states and the District of Columbia. Today it encompasses Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals and their subsidiaries, and the Permanente Medical Groups. Nationwide, Kaiser Permanente includes approximately 164,000 technical, administrative and clerical employees and caregivers, and 14,000 physicians representing all specialties. The organization's Labor Management Partnership is the largest such health care partnership in the United States. It governs how more than 130,000 workers, managers, physicians and dentists work together to make Kaiser Permanente the best place to receive care, and the best place to work. For more Kaiser Permanente news, visit the Kaiser Permanente News Center at: <http://xnnet.kp.org/newscenter>.

### Mayo Clinic

Mayo Clinic is the first and largest integrated, not-for-profit group practice in the world. Doctors from every medical specialty work together to care for patients, joined by common systems and a philosophy of "the needs of the patient come first." More than 3,300 physicians, scientists and researchers and 46,000 allied health staff work at Mayo Clinic, which has sites in Rochester, Minn., Jacksonville, Fla., and Scottsdale/Phoenix, Ariz. Collectively, the three locations treat more than half a million people each year. For more information, please visit [www.mayoclinic.org](http://www.mayoclinic.org).

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