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Using Medicare Payment Policy To Transform The Health System: A Framework For Improving Performance

Medicare could help slow its cost growth, improve the value obtained for the dollars it spends, and serve as a model for broader health system change.

by Stuart Guterman, Karen Davis, Stephen Schoenbaum, and Anthony Shih

ABSTRACT: As the largest payer for health services in the United States, Medicare has the potential to use its payment policies to stimulate change in the organization of care to improve quality and mitigate cost growth. This paper proposes a framework in which Medicare would offer an array of new bundled payment options for physician group practices, hospitals, and delivery systems, with incentives to encourage greater integration in the organization of health care delivery and the provision of more coordinated care to beneficiaries. These changes could also serve as a model for other payers to improve quality and efficiency throughout the health system. [*Health Affairs* 28, no. 2 (2009): w238–w250 (published online 27 January 2009; 10.1377/hlthaff.28.2.w238)]

THE HIGH COST OF HEALTH CARE IN THE UNITED STATES—which exceeded 16 percent of gross domestic product (GDP) in 2007 and is rising rapidly—places increasing financial stress on businesses and their workforces and puts future generations of retirees at risk as it erodes retirement savings. High premiums and out-of-pocket health care costs, in fact, are the American public's number-one health care concern.¹ With health care spending projected to claim an increasing proportion of available resources, governments, businesses, and individuals will be forced to make difficult budget choices.

Although advances in medical science and health care technology have yielded

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gains in the quality of life and healthy life expectancy, there is broad evidence of excess costs, inefficient and poorly coordinated care, and variable quality.² More-costly care does not necessarily translate into higher-quality care, and our health system is not providing optimal value to its principal customers: patients, payers, and society at large.

Medicare is the largest single payer for health services in the United States; it accounted for 19 percent of national health expenditures in 2006.³ Medicare spending has grown steadily since the program's inception, putting increasing pressure on the federal budget and making it an important component of the health care problem.⁴ But Medicare, as the largest payer, can and must also play an important role in any solution to that problem.

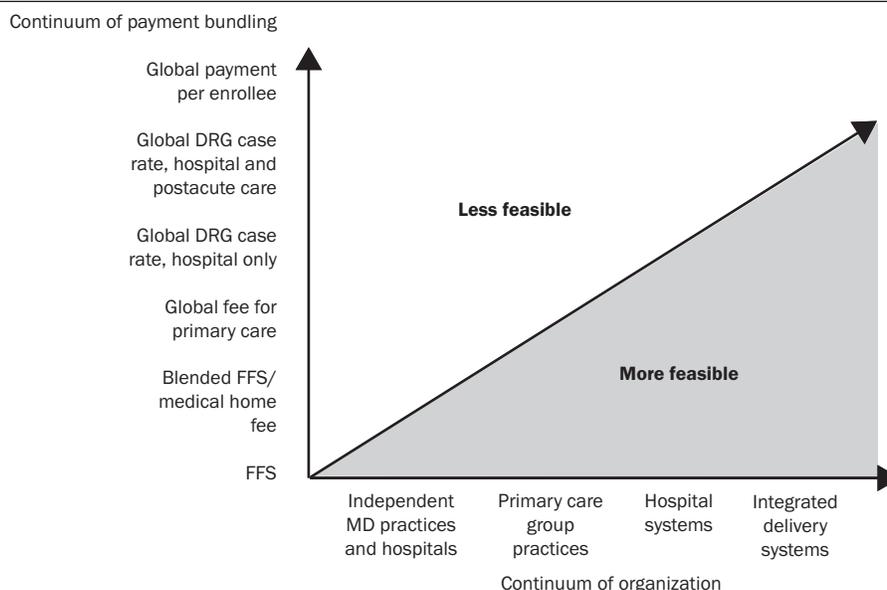
In this paper we propose a new framework for Medicare provider payment reform that could help slow Medicare's cost growth, improve the value obtained for the dollars it spends, and serve as a model for broader health system change. The goals of this payment reform are to (1) create incentives that empower health care providers to take broader accountability for the care and outcomes of their patients and enable them to benefit from doing so; (2) improve care coordination and reduce fragmentation of the delivery system; (3) slow the growth in Medicare outlays; and (4) serve as a model for private payers to increase the value obtained for health care spending.

Payment Reform And Health Care Delivery

Payment, organizational structure, and care delivery are closely linked: in paying for individual services by individual providers within the context of individual patient encounters, the fee-for-service (FFS) payment that typifies our health system has fostered fragmented organization and care that often does not meet patients' needs. To change the way health care is organized and delivered, we need to change the way it is paid for—to move from FFS payments to bundled payments, which would enable and encourage providers to consider their patients' needs in a broader context and provide more appropriate, integrated, and efficient care.

The U.S. health care delivery system is diverse, with a wide array of organizational models varying in size, scope, and degree of integration. Providers may vary in the degree to which they are willing and able to assume broader accountability for their patients' health. Traditional FFS Medicare—like most other payers—recognizes only independently practicing physicians, hospitals, and other individual service providers for direct payment. Under the payment reform framework proposed here and illustrated in Exhibit 1, Medicare would recognize provider entities at various levels of organizational integration, offer an array of payment approaches that more appropriately apply to such entities in the context of their current organizational structure, and establish rewards and requirements both to encourage high quality and value and to provide incentives for those organizations to move “up the hill” toward increased integration.

**EXHIBIT 1
Medicare Payment Reform Framework: Organization And Payment Methods**



SOURCE: Authors' analysis.
NOTES: DRG is diagnosis-related group. FFS is fee-for-service.

Defining Provider Organizations For Alternative Payment

The framework set forth in this paper involves defining and recognizing different types of provider entities that would participate in Medicare under alternatives to the current FFS payment system. A number of different formal or informal organizational models could be considered in the context of this framework, but for purposes of illustration, we discuss here one example in each category.

In category 1, groups of physicians and other ambulatory care providers, we discuss primary care physician group practices that can take responsibility for a full range of primary care services and function as medical homes. In category 2, groups of hospitals and other acute and postacute care providers, we discuss hospital systems, defined by their capacity to provide or otherwise take responsibility for not only acute inpatient care but also postacute care and transitional care between the inpatient and other care settings. In category 3, integrated health care systems, we discuss integrated delivery systems (IDSs) that are capable of providing the entire array of Medicare-covered services or have contractual agreements with other providers to enable them to arrange and be responsible for those services.

Exhibit 2 provides examples of certification requirements that might be used for each provider category, corresponding payment approaches, and potential rewards for participating providers and beneficiaries under the proposed framework; the remainder of this paper addresses each of those issues.

**EXHIBIT 2
Alternative Provider Categories And Payment Mechanisms, Requirements, And Rewards**

	Provider category		
	Primary care group practice	Hospital system	Integrated delivery system
Provider certification/ accreditation requirements	Certification Provision of evidence-based care Medical home Electronic practice information system	Accreditation Provision of evidence-based care Electronic hospital information system	Accreditation Provision of evidence-based care Electronic integrated health record and system
Payment choices	Blended FFS/medical home fee Global fee for primary care	Global DRG case rate, hospital only Global DRG case rate, hospital and postacute care	All at left, plus global payment per enrollee
Public reporting and rewards for high performance	2% incentive pool Rewards for percent of patients with up-to-date preventive care; percent of patients with controlled chronic conditions; A-CAHPS rating	4% incentive pool Rewards for lower standardized mortality rates; provision of transitional care; reduced hospital readmissions; one-year survival rate H-CAHPS rating	5% incentive pool Rewards for all measures at left plus HEDIS, CAHPS ratings
Savings rewards (added to pool for high performance or annual payment update)	25% of difference between expected and observed Medicare outlays 35% for primary care global fee	60% of difference between expected and observed episode outlays for hospital only 75% for global case rate including postacute care	90% of difference between expected and observed Medicare outlays
Beneficiary requirements and rewards	Enroll in primary care physician practice or be auto-enrolled 5% reduction in Part B premium, 10% coinsurance for in-practice services	Transitional care after hospitalization covered without cost sharing	Services covered only within IDS or under contract

SOURCE: Authors' analysis.

NOTES: FFS is fee-for-service. DRG is diagnosis-related group. A-CAHPS is ambulatory Consumer Assessment of Healthcare Providers and Systems. H-CAHPS is hospital CAHPS. HEDIS is Healthcare Effectiveness Data and Information System.

The Roles Of Incentives And Requirements

It is essential that the bundled payment options be attractive to both providers and their patients; it is equally essential that providers be able to assure Medicare and their patients that they can meet certain requirements. For example, primary care group practices would be required to meet the Patient-Centered Medical Home certification standards of the National Committee for Quality Assurance (NCQA). To qualify for other bundled payment options offered under this framework, each provider organization would need to obtain category-specific certification or accreditation by organizations such as the Joint Commission or NCQA that it meets high quality standards and is capable of providing and assuming clinical and financial responsibility for a specified continuum of care for enrolled beneficiaries. To minimize regulatory burden, current accreditation of hospitals and IDSs should be streamlined where possible and refocused on ensuring that partic-

icipating organizations follow evidence-based guidelines. Participating organizations would also have to satisfy requirements on use of electronic health information systems meeting federal standards. There would be graduated certification requirements reflecting the information necessary for organizations to assume progressively greater accountability for a broader continuum of care.⁵ Reporting of information on clinical quality of care, patient outcomes, patients' experiences with care, and resource use by providers would be essential to assure patients that quality will not be jeopardized by "skimping" and to monitor and reward high performance.

Alternative Payment Approaches

An array of payment methods along the continuum of bundled payment would be offered to provider organizations, explicitly designed to reward quality and prudent use of resources by organizations in each category and to encourage them to move to higher levels of integration to be eligible for greater rewards. Although providers could still receive payment under Medicare's current physician fee schedule and hospital diagnosis-related group (DRG) case-rate payment, there would be new payment approaches, including (1) a global fee for primary care; (2) a global DRG case rate for each hospitalization, including postacute care, subsequent hospital admissions, and emergency department (ED) care for thirty days after the initial discharge; and (3) per enrollee payment for IDs.

Each of these alternative payment methods provides incentives for more coordinated and efficient care. Organizations achieving savings in the use of resources would share with Medicare in those savings—subject to their ability to meet performance standards. The following examples illustrate how such alternative payment options might be designed.

■ **Global fee for primary care.** Under this payment option, physician practices would receive a risk-adjusted per patient global fee per month to cover all primary care services.⁶ This would be in lieu of payment for individual primary care services, and an amount would be included to cover the functions of the patient-centered medical home.⁷

Although this payment approach would put the practice at financial risk for the use of the primary care services it can deliver, it also provides the practice an enormous advantage by increasing its flexibility to manage its resources within the global fee to best provide the care that its patients need. Both the practice and its patients, therefore, would benefit from providing better-coordinated and more-efficient and -effective care. It would eliminate the "tyranny of the visit" that prevails under FFS payment, enabling practices to adopt alternative ways of providing care that currently do not generate revenue—such as e-mail visits, telephone calls, clinical task delegation to nurses or other health professionals, or group patient visits.

The primary care global fee could be based on the expected average payment for

primary care services per Medicare beneficiary, risk-adjusted for those enrolled in the practice and adjusted for geographic differences in the prices of practice inputs. The expectation is that avoidance of hospitalizations that are preventable with good primary care, ED overuse, overprescribing, and unnecessary specialist referrals would generate reduced overall patient care costs relative to what would be anticipated under the traditional system, as well as improving care. Over time, these savings could be shared between Medicare and participating practices in at least two ways: (1) a share of the savings from reduced costs could be added to the pool from which rewards are made to individual participating practices for high performance on quality, patient experience, and coordinated care measures; and (2) the mechanism for updating the primary care global fees for all participating practices could be structured to reflect a share of the total savings from reduced costs as a provider group.

■ **Global DRG case rate for hospitalization (including thirty days post-discharge).** This payment option provides an opportunity for qualified hospital systems to benefit from reducing complications and hospital readmissions. It establishes a global DRG hospital case rate, including expected hospital readmissions, postacute care (inpatient rehabilitation, skilled nursing, and home health), and ED use over a thirty-day period following the initial hospital discharge. This case rate includes acute and subacute care and ED services, but not office-based physician services—including any services provided by other hospitals. These global rates could apply to all hospitalized patients or to patients with a selected set of conditions, such as surgical procedures or chronic illnesses. Hospital systems that qualify for this payment method would have the prospect of greater control of the resources they use to treat their patients, reimbursement that covers a continuum of care over thirty days after admission, and the opportunity to benefit from savings resulting from reduced complications and readmissions.

This payment approach would be expected to produce savings to Medicare as well as financial benefits to participating hospital systems. There is now wide variation in hospital readmission rates and spending for postacute care.⁸ Medicare would save by setting the global case rate at the DRG rate for the initial hospitalization plus an allowance somewhat less than the current average of post-discharge spending for similar patients in the FFS system. Participating hospital systems that could accept responsibility for and manage or influence the key processes involved in the initial hospitalization and transitional and follow-up care would be likely to spend less than the current average and realize financial gains. To induce greater participation over time, Medicare savings could, as described above, be shared between Medicare and providers through performance rewards and higher payment updates.

■ **Global payment per enrollee.** Under this payment method, an IDS including one or more hospitals and multispecialty physician group practices would be paid a fee covering all Part A, Part B, and Part D services, including inpatient and post-

inpatient care, ambulatory care, and prescription drugs, for each patient enrolled in the system. The payment amount would be adjusted for the health risk of enrolled beneficiaries and geographic differences in the prices of practice inputs. Any services provided to enrolled beneficiaries by other providers would be covered only if provided under contract to the IDS. The expectation is that care could be managed by these organizations in a way to yield both higher quality and more prudent use of resources. As in the other options described above, savings would be shared with participating delivery systems through rewards for achieving high performance on quality, patient experience, and care coordination and increased payment updates that reflect the increased efficiency of these systems.

This option could be particularly attractive to IDSs that do not have a Medicare Advantage (MA) product, because of the opportunity to directly receive rewards for high performance and share in the savings they achieve. To the extent that providers would be enticed to form more-integrated organizations, they would be in a better position to provide coordinated care not only through traditional Medicare but also through contracts with MA plans.

Rewards For Provider Performance

Rewards for excellence would be given to providers who perform well and show improvement on relevant sets of performance metrics. The magnitude of these rewards could be set for each type of provider organization to correspond to the level of integration; for example, as a start, 2 percent of outlays could be set aside to establish a reward pool for primary care group practices, 3 percent for hospital systems, and 5 percent for IDSs—providing a graduated incentive to providers to integrate care and assume accountability for a broader continuum of care.

Beneficiary Rewards And Responsibilities

For physician group practices, hospital systems, and IDSs to assume accountability for care of a defined set of patients, it is important that Medicare beneficiaries be encouraged to designate a physician practice as their primary source of care or, failing that, to be auto-enrolled in a practice based on quality and utilization patterns so that they can benefit from more-effective and -efficient care. Historically, beneficiaries have used multiple sources of care.⁹ It will take time to encourage all beneficiaries to establish a relationship with an enduring long-term source of care, but such a designation is important to encourage both enrollment in group practices selecting the new payment choices and greater accountability for care even among physicians who continue to participate independently in the current Medicare payment system.

Lower premiums and reduced deductibles and coinsurance could induce beneficiaries to enroll with more-integrated provider organizations, engage in management of their conditions, and use services within the designated medical practice

or system of care. In exchange for these financial inducements, beneficiaries would be expected to use services within the designated practice or delivery system or on referral to providers for selected services under contract to the practice or delivery system. Beneficiaries enrolling in group practices, hospital systems, and IDs would formally agree to have all relevant clinical information shared with all involved providers. Beneficiaries would benefit not only from financial inducements but also from greater assurance that their care is being coordinated, meeting guidelines, and being monitored in the aggregate for higher quality.

Medicare's Role In Supporting Improved Provider Performance

For physician practices, hospital systems, and IDs to improve their performance on agreed-upon metrics, it is important that Medicare provide timely periodic reports to providers on their own performance and performance compared to relevant benchmarks (for example, the eightieth-percentile benchmark performance threshold for performance payments under the Medicare Hospital Quality Incentive Demonstration). Rewards for high performance on quality, patient experience, and coordination, as well as efficiency, should be made as soon as possible after the period to which they apply, to keep clear their connection to the actions that produced them and strengthen the incentives they are intended to provide.

Although improved health information systems should enable providers to monitor the conditions and progress of their patients, Medicare should make every effort to supplement that information as necessary for organizations to track care outside their own systems and address the underlying causes for avoidable utilization such as nonessential ED visits.

Encouraging Provider Participation

Under the approach proposed here, physician group practices, hospital systems, and IDs would receive positive incentives for participation, including more-favorable payment updates and individual financial rewards for high performance on specified metrics. Providers would have more flexibility to provide services that benefit their patients—some of which are not included under the current payment system. In addition, financial incentives for beneficiaries to enroll with participating physician group practices and delivery systems should increase the market shares of those organizations, a particular benefit for early adopters.

With improved coordination of care and the elimination of unnecessary and duplicative services, spending growth should slow relative to current projections; however, although the trajectory of Medicare spending should be lower under the proposed approach than under the current system, Medicare outlays would still be expected to increase over time in absolute terms, as the demand for care is fueled by the aging of the baby boomers and the increased capacity of the health sys-

tem to provide beneficial services.¹⁰ Organizational providers receiving bundled payments should still see increases in overall revenue from demand growth, as well as the potential for rewards for high performance and their share of the savings from the reduction of unnecessary or low-value services.

The traditional FFS payment system, however, continues to provide strong incentives for fragmented care and overuse. Explicit disincentives for nonparticipation could help transform the delivery system more rapidly. In particular, strong consideration should be given to applying lower updates to FFS payment rates; also, the current overpayment of MA plans should be eliminated, to avoid continued distortion of the incentives that Medicare provides.¹¹

Discussion And Policy Implications

Medicare has much to gain from rewarding providers who are willing and able to be accountable for a broader continuum of care and encouraging more providers to become so. Bundled payment increases the predictability of Medicare outlays. Also, the new payment system creates pressure on traditional providers to operate in more-organized systems of care and obtain the assistance needed to reach desirable levels of performance.

Early evidence on the potential of models of care that emphasize primary care is promising. The patient-centered medical home pilot test at Geisinger Health System reduced hospitalization by 20 percent and overall cost trends by 7 percent in its first year.¹² The North Carolina Community Care model of medical homes achieved \$231 million in savings in 2005–2006.¹³

Shared-savings payment models also provide the promise of slowing the growth in Medicare outlays over time. The multispecialty group practices participating in Medicare's Physician Group Practice Demonstration have pursued a variety of strategies to reduce overuse, avoidable hospitalizations, and readmissions, resulting in Medicare savings and improved quality.¹⁴ The Medicare Payment Advisory Commission (MedPAC) has estimated that 75 percent of all hospital readmissions are potentially preventable and that these preventable readmissions account for \$12 billion in spending a year.¹⁵ Although not all of these readmissions can be eliminated, many of them could be.

A major question is whether providers will choose to participate. There is no guarantee, of course, that the new payment system would attract substantial "takers" in the provider community. However, some of the attractive features of the approach discussed above should encourage their participation. A number of entities could participate from the beginning.¹⁶ The trick is in designing payment incentives so that additional providers find it attractive to become qualified for the alternative payment mechanisms.

Participation would likely start small and grow slowly for a time. However, this could be an advantage, giving Medicare an opportunity to calibrate payment rates as experience is gained. Medicare might even benefit from limiting the number of

“The impact of the new Medicare payment methods will be greater if they are adopted by private insurers and Medicaid.”

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 organizations permitted to enroll in the program during the start-up years. When ready, Medicare could accelerate progress by instituting more disincentives to providers who remain with current payment methods.

A risk to the program is that the new system could lead to overpayments or higher outlays than under current payment methods. Providers who already excel at care coordination and controlling costs could be expected to be among the first adopters. Medicare could reduce the risk of overpayment by tracking baseline data on the continuum of care for the different payment methods for participating organizations during the start-up period and adjusting payment rates to avoid initial large windfall gains for provider organizations.

Another risk is that provider organizations would shift care to nonbundled services—for example, primary care physician practices might increase specialist referrals; similarly, hospital systems might increase admissions for relatively simple and low-cost cases. Such behavior might be financially advantageous to the individual provider organization, even if it undercuts the overall savings available to be shared. Practice patterns should be monitored, and peer pressure might be brought to bear on providers with unusually high volumes of referrals or inappropriate admissions, through a system of peer site visits and “structured dialogue,” as occurs in the German hospital quality benchmarking system.¹⁷ In addition, good performance on these dimensions could be included in the system of rewards for high performance. Providers persisting in abusing the system could be penalized by withholding rewards or be dropped from participation.

One potential barrier to provider participation is the assumption of risk for large losses—resulting from either catastrophic medical events or the need for extensive services that are included in the bundled fee but provided outside of the provider organization (for example, out-of-network subspecialty care). To help protect against this risk, Medicare should offer a reinsurance mechanism to organizations taking a global fee for ambulatory care, global DRG case rates, or a global payment per enrollee. A variety of mechanisms are possible at both the organization and individual case levels, such as risk corridors, stop-loss insurance, and outlier payments.

The need for these reinsurance mechanisms is greater the broader the scope of services covered by the payment rate, and they are likely to be particularly important for IDs. Such organizations were reluctant to participate as provider-sponsored organizations under Medicare+Choice in the late 1990s, but the availability of reinsurance to ameliorate the risk they face, as well as bonuses for high performance, may increase the desirability of bundled payment options.¹⁸

Another possible barrier to participation is the need to implement new systems

to meet the requirements for participation and accreditation/certification—such as better implementation of evidence-based guidelines and rapid performance reporting. Participating organizations will need electronic information systems, but fewer than half of medical groups with twenty or more physicians have such systems in place now.¹⁹ Nonetheless, new systems and the ability to meet requirements are necessary to provide safeguards on quality and address patients' and the public's concerns over the incentives for underuse that derailed the managed care movement in the 1990s. This issue can be addressed in two ways. Medicare could provide practices with technical support in choosing and implementing such systems; indeed, it is already providing such support to some extent through its Doctors Office Quality Information Technology (DOQ-IT) project and several other initiatives.²⁰ In addition, Medicare ultimately may need to place similar requirements on nonparticipating providers, and the extent to which it is responsive to providers' input on opportunities for streamlining current regulatory burdens will affect the rate of participation among provider organizations.

The impact of the new payment approaches will be greater if, as happened with the Medicare physician fee schedule, Medicare's payment methods are adopted by private insurers and Medicaid/State Children's Health Insurance Programs. By establishing a totally transparent payment system, Medicare could further encourage change throughout the health care system.

Finally, there is a genuine concern that creating larger provider organizations might also increase their market clout with commercial insurers, leading to higher bundled prices. Although Medicare as a major purchaser is likely to be able to set fees at a rate that achieves savings with adequate provider participation, smaller purchasers might not be. It could be necessary to enact policies that counter this monopoly power, such as (in the extreme case) legislation that makes defined monopoly provider organizations "public utilities" responsible for an areawide budget. In such cases, Medicare and commercial payers would shift to paying full capitation based on risk-adjusted and geographic cost-adjusted per capita spending.

THE PAYMENT FRAMEWORK PROPOSED HERE shows promise of meeting all of the goals for Medicare payment reform that we set out above. It would (1) create incentives that empower health care providers to take broader accountability for the care and outcomes of their patients and enable them to benefit from doing so; (2) improve care coordination and reduce fragmentation in the delivery system; (3) slow the growth in Medicare outlays; and (4) serve as a model for private payers to increase the value obtained for health care spending.

To date, efforts to increase value have centered on developing appropriate measures of quality and efficiency; collecting data on provider performance according to those measures; establishing mechanisms for reporting those data so that payers, users, and providers can use them to make appropriate decisions and indicate, facilitate, and implement required improvements; and determining and opera-

tionalizing the criteria and methodology for financial incentives at the margin to achieve high performance. The next phase should be aligning the financial incentives not only at the margin but built into the underlying payment mechanism to encourage and reward accountability and performance—in particular, higher quality and more-coordinated and -efficient care. A flexible approach to calibrating payment rates and performance incentives, as well as disincentives for non-participation, will need to be followed, learning as experience is gained, with rapid turnaround of programmatic information and monitoring of utilization and savings.

We face great peril if our health system continues on its current course of high cost and suboptimal performance, especially as other countries surpass us in improving mortality and other indicators of high-quality care. In our very large and mostly privately owned and operated health care delivery system, changing payment incentives is one of the few tools available for inducing higher performance. The framework presented here shows how Medicare, using payment incentives, could lead the nation to higher health system performance and yield great benefits for individuals, providers, and society as a whole.

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