

# THE MORNING CONSULT

*Edited by*

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## *Recommended Washington Read:*

### [The Budget & Economic Outlook: An August Update](#)

From Congressional Budget Office by Douglas W. Elmendorf (et al)

CBO estimates that outlays for Medicare (excluding receipts from premiums) will total \$555 billion (3.5 percent of GDP) in 2012, about the same, in nominal terms, that it estimates for 2011. Between 2013 and 2021, outlays are projected to grow at an average annual rate of 6.3 percent, reaching \$966 billion (4.1 percent of GDP) in 2021. Spending will be pushed up over the decade by increases in the number of beneficiaries and in health care costs per beneficiary (in nominal terms). At the same time, growth in spending will be restrained by reductions in updates to payment rates that were included in the 2010 health care legislation and by the program's sustainable growth rate mechanism, which, under current law, is projected to reduce payments to physicians by about 30 percent in 2012 and by additional amounts thereafter.

CBO projects that federal outlays for Medicaid will decrease by 5.5 percent in 2012, mostly because the enhanced matching rates under ARRA and the lower enhanced rates provided by subsequent legislation have expired and because anticipated economic growth will lead to slow growth in enrollment. Over the rest of the decade, however, Medicaid outlays are projected to rise at an average annual rate of 9.0 percent because of demographic changes and a sharp increase in enrollment beginning in 2014 stemming from the 2010 health care legislation, which also increased the average federal share of the program's costs. (CBO estimates that the legislation will boost Medicaid enrollment by about 17 million people by 2021.) Federal spending on Medicaid is projected to reach \$561 billion (2.4 percent of GDP) in 2021, compared with \$259 billion (1.7 percent of GDP) in 2012. Beginning in 2014, subsidies for health insurance will become available for individuals and families who meet income and other eligibility criteria. In total, outlays for those subsidies, for establishing and operating exchanges to facilitate the purchase of health insurance, and for running related programs will increase from \$1 billion in 2012 to \$96 billion in 2021, CBO estimates.

## *Recommended Business Strategy Read:*

### [How to Solve the Cost Crisis in Health Care](#)

From Harvard Business Review by Robert S. Kaplan and Michael E. Porter

Robert Kaplan ([Balanced Scorecard](#)) and Michael Porter ([5 Competitive Forces that Shape Strategy](#)) have

teamed up in a must-read piece for healthcare executives and policymakers alike. Kaplan and Porter address the disturbing state of how the healthcare system attempts to measure costs. They put it bluntly, “There is an almost complete lack of understanding of how much it costs to deliver patient care, much less how those costs compare with the outcomes achieved. Instead of focusing on the costs of treating individual patients with specific medical conditions over their full cycle of care, providers aggregate and analyze costs at the specialty or service department level. Cutting payor reimbursement does reduce the bill paid by insurers and lowers providers’ revenues, but it does nothing to reduce the actual costs of delivering care. Providers share in this confusion. They often allocate their costs to procedures, departments, and services based not on the actual resources used to deliver care but on how much they are reimbursed. But reimbursement itself is based on arbitrary and inaccurate assumptions about the intensity of care. (Be sure to listen to the [HBR interview with Kaplan](#))”

I can personally attest to the woeful state of provider accounting systems from having advised hospital CFOs. Currently non-profit hospitals are exempt from following “Generally Accepted Accounting Principles (GAAP). Consequently, provider financial reports should be viewed as at best educated guesses, and more often as creative financial engineering. The lack of accurate financial reporting undermines academic/government research as well as the potential for payment innovation (ex: bundled payment) and improved care coordination (ex: accountable care organizations). I agree whole heartedly with Kaplan and Porter that if we are to truly solve the cost crisis in healthcare, we must start by facilitating improved cost measurement throughout the healthcare system.

## **General**

### **1) Portman May Be Pivotal to 'Super Committee' Success**

**From Kaiser Health News by Kirk Victor**

Freshman senators typically are seen but not heard, but it didn’t take long for Republican Rob Portman of Ohio to shatter that mold. When the Senate's "Gang of Six" Democrats and Republicans tried to hammer out a deficit-reduction plan earlier this year, they repeatedly turned to Portman for advice on fiscal issues. Then, as the battle over raising the debt ceiling reached the boiling point earlier this month, Senate Minority Leader Mitch McConnell, R-Ky., leaned heavily on Portman for technical and political advice in negotiating with President Obama and Democratic leaders.

During his career in the House from 1993 to 2005, Portman authored or co-authored over a dozen bills that became law, including legislation to reform the Internal Revenue Service and curb unfunded federal mandates. A number of times he collaborated with Democrats to pass legislation. In 2005 he left Congress to join President George W. Bush’s administration, first as U.S. Trade Representative and then as director of the Office of Management & Budget, where he honed his expertise on spending and tax issues. Even as skeptics dismiss the Super Committee as a prescription for more gridlock, Portman is seen by many seasoned observers — Republicans and Democrats alike — as a pivotal figure in helping bridge the partisan divide and facilitate the chance for a deal. Former Sen. Alan Simpson of Wyoming, the Republican co-chairman of President Obama’s bipartisan fiscal commission, told The Fiscal Times that Portman “could easily be a catalyst” to getting a deal. “He is the best there is — he has the trust of both Democrats and Republicans. He’s very authentic and knows the game since he has been there with budget issues,” Simpson added.

## **2) Forecast Clouds Debt-Cut Outlook** from Wall Street Journal by Damian Paleta

The congressional panel charged with finding ways to reduce the deficit by at least \$1.2 trillion over the next 10 years received daunting news Wednesday when the Congressional Budget Office projected stubbornly high unemployment will accompany large deficits for much of the decade. "A great deal of the pain of this economic downturn still lies ahead of us," CBO Director Douglas Elmendorf said. The nonpartisan arm of Congress projected the unemployment rate, now 9.1%, will decline to a still-high 8.5% by the end of next year and will remain above 8% until 2014. Full employment won't arrive until 2017, it said.

The challenge of reducing the deficit while spurring job growth is a key point of division between the two parties. Many Democrats are arguing for more spending to stimulate the economy; many Republicans are arguing for spending cuts and regulatory relief to the same end. In its mid-year review of the federal budget, CBO projected the deficit for the fiscal year that ends Sept. 30 would be \$1.3 trillion, or 8.5% of gross domestic product. That's down from its January forecast of \$1.48 trillion, reflecting spending cuts forced by Congress and higher than previously projected individual income tax payments. For fiscal 2012, CBO projected the deficit will narrow to \$973 billion, or 6.2% of GDP

## **3) Stocks Rise, Yen Weakens Before Fed; Apple Drops, Greek Yields at Record**

From Wall Street Journal By Stephen Kirkland and Shiyin Chen

Stocks rose, the yen weakened and gold dropped on speculation the Federal Reserve may act to support the economy. Nasdaq-100 Index futures fell after Apple Inc. Chief Executive Officer Steve Jobs resigned, while Greece's 10-year bond yield climbed to a record.

The Stoxx Europe 600 Index added 0.5 percent at 8:21 a.m. in New York and Standard & Poor's 500 Index futures advanced 0.3 percent. Nasdaq contracts slipped 0.2 percent as Apple sank 1.9 percent in pre-market trading. The yen depreciated against 15 of its 16 major peers, and gold sank 1.8 percent, bringing its slide in three days to 8.7 percent. Greece's 10-year yield rose to 18.52 percent.

The gain in S&P 500 futures indicated the gauge will extend a three-day, 4.8 percent rally. Apple, the world's most valuable technology company, makes up 3.2 percent of the S&P 500, 9.3 percent of the Nasdaq Composite Index and 15 percent of the Nasdaq-100. Jobs, who has been combating a rare form of cancer, will be succeeded by Chief Operating Officer Tim Cook, while he becomes chairman. U.S. initial claims for jobless benefits probably fell by 3,000 to 405,000 last week, a Bloomberg survey of economists showed before today's Labor Department report. Data tomorrow may indicate the world's biggest economy grew 1.1 percent in the second quarter, down from a previous estimate of 1.3 percent, according to the median of 80 forecasts in a separate survey. Investors are awaiting a speech by Fed Chairman Ben S. Bernanke in Jackson Hole, Wyoming, tomorrow for any indications of whether the central bank will embark on further stimulus.

## **Payers**

### **4) Advocates back regulators' call for equal standards among plans** from The Hill by Sam Baker

Consumer advocates on Wednesday echoed state insurance regulators' call for a "level playing field" between

existing healthcare plans and new multistate policies created by healthcare reform. The National Association of Insurance Commissioners [recently told](#) the federal government that multistate plans should still have to comply with state regulations and meet all the requirements of the healthcare law. NAIC's consumer advocates echoed that position Wednesday. Multistate plans will be available in state-based insurance exchanges, and they'll be automatically deemed to meet the standards for sale through an exchange. If they're not actually held to each state's standards, however, consumers might not be able to make a fair comparison among policies.

The NAIC consumer advocates also noted a provision of the healthcare law that requires a level playing field between the national plans and other policies. If the government lets multistate policies off the hook for certain requirements, they said, the same exemption might have to cover all insurers. "Exempting Multi-State plans from any state requirement [covered by the healthcare law] would not only reduce protections for consumers in Multi-State plans, but would eliminate those protections for consumers in all plans," the consumer advocates wrote in a letter to the Office of Personnel Management. "We believe this is not only contrary to Congress's intent, but would also be a dramatic departure from the traditional federal-state framework for regulating insurance, in which federal law sets a floor of consumer protections, but states can continue to provide more robust protections." The Office of Personnel Management is responsible for selecting multistate plans.

#### **5) Survey: Overhaul May Push Employee Benefits Shift** From Associated Press by Tom Murphy

Nearly one of every 10 midsized or big employers expects to stop offering health coverage to workers after insurance exchanges begin operating in 2014 as part of President Barack Obama's health care overhaul, according to a survey by a major benefits consultant. Towers Watson also found in its July survey that another one in five companies are unsure about what they will do after 2014. Another big benefits consultant, Mercer, found in a June survey of large and smaller employers that 8 percent are either "likely" or "very likely" to end health benefits after the exchanges start.

The surveys, which involved more than 1,200 companies, suggest that some businesses feel they will be better off dropping health insurance coverage once the exchanges start, even though they could face fines and tax headaches. The percentage of companies that are already saying they expect to do this surprised some experts, and if they follow through, it could start a trend that chips away at employer-sponsored health coverage, a long-standing pillar of the nation's health system. "If one employer does it, others likely will follow," said Paul Fronstin of the Employee Benefit Research Institute. "You would see this playing out over the course of years, not months." A large majority of employers in both studies said they expect to continue offering benefits after these exchanges start. But former insurance executive Bob Laszewski said he was surprised that as many as 8 or 9 percent of companies already expect to drop coverage a couple of years before the exchanges start. Such a move could lead to more taxes for both companies and employees, since health benefits currently are not taxed, and companies could be fined for dropping coverage. It also would give their employees a steep compensation cut if they don't receive a pay raise, too.

#### **6) CBO expects delay in new healthcare program** from The Hill by Sam Baker

The Obama administration will likely fall a year behind schedule in implementing a controversial piece of healthcare reform, according to the Congressional Budget Office (CBO). The budget update that CBO released Wednesday assumes a one-year delay in the law's new insurance program for long-term care. The program — Community Living Assistance Services and Supports, or CLASS — has faced serious skepticism ever since its inclusion in the healthcare overhaul.

Under the healthcare law, CLASS is slated to begin collecting premiums next year. But CBO said Wednesday that "based on the pace of implementation actions thus far," it doesn't expect the program to start taking in money until 2013. As recently as March, the budget office was still projecting that CLASS premiums would begin rolling in next year. The CLASS program collects premiums for several years before it begins paying out benefits, but stakeholders have still raised questions about whether it will ultimately be able to sustain itself.

## **Pharma/Biotech/Device**

### **7) Google in Drug Ad Settlement**

from Wall Street Journal by Thomas Catan

In a rare public mea culpa, [Google](#) Inc. agreed to pay \$500 million to avoid Justice Department prosecution on charges that it knowingly accepted illegal advertisements from Canadian online pharmacies for years. With the long-awaited settlement Wednesday, the company said it banned advertising of prescription drugs by Canadian pharmacies in the U.S. "some time ago." However, it said that "it's obvious with hindsight that we shouldn't have allowed these ads on Google in the first place."

The U.S. government said the ads led to illegal imports of prescription drugs and could have put American consumers at risk of taking mislabeled or tainted medicine. The Justice Department said the forfeiture was one of the largest by a company in the U.S. The \$500 million sum represented both the illicit revenue earned by Google from the ads and the money earned by the Canadian pharmacies from their sales to U.S. consumers. "The Department of Justice will continue to hold accountable companies who in their bid for profits violate federal law and put at risk the health and safety of American consumers," said [James Cole](#), deputy attorney general.

### **8) Its Gene Patents Upheld, Myriad Genetics Moves to Protect Its Secrets**

from New York Times by ANDREW POLLACK

Myriad Genetics retained its monopoly on a lucrative genetic test for breast cancer risk when a federal appeals [court recently upheld](#) the company's patents on two human genes — and the validity of gene patents in general. But it is only a matter of time before the company's business faces severe challenges, some experts say, because that \$3,340 test is technologically outmoded, incomplete and too costly.

Myriad sequences the two patented genes, known as BRCA1 and BRCA2, for mutations that raise the risk of a woman getting breast and ovarian cancer. But newer DNA-sequencing techniques are far faster and only a fraction of the cost of the 1990s technology that Myriad uses. Indeed, it will soon be possible to sequence a person's entire genome, all 22,000 or so genes, for less than Myriad charges for just two genes.

## **Health IT**

### **9) Super-sized HIEs rise up nationwide**

from FierceHealthIT by Ken Terry

Even as some health information exchange projects fail, others are rising to take their place, and some are quite

large. The two latest examples are regional HIEs in western Pennsylvania and southern California. The ClinicalConnect exchange in Pennsylvania will include nine of the area's health care systems. Among them are Altoona Regional Health System, Armstrong County Memorial Hospital, Butler Health System, Excelsa Health, Heritage Valley Health System, Jefferson Regional Medical Center, St. Clair Hospital, The Washington Hospital and the University of Pittsburgh Medical Center (UPMC). Starting with a pilot at Heritage Valley, ClinicalConnect will be implemented over the next two years. There are plans to bring in other regional health systems in the near future. One of the neighboring systems is Western Penn Allegheny Health System (WPAHS), which is being sold to Highmark, the largest insurer in the area. Highmark, Western Penn Allegheny, Allscripts, and Accenture are partnered in a program to induce more small practices to adopt electronic health records.

The new HIE in southern California promises to be even bigger than the one in the Keystone State. The Inland Empire Health Information Exchange covers San Bernadino and Riverside Counties, an area nearly as large as Maine with a population of 4.5 million. About 15 hospitals and 2,000 physicians are expected to participate in the HIE, according to *California Healthline*. Yet the Inland Empire exchange is only one of 17 Golden State HIEs that eventually will coalesce into a statewide data exchange. The membership of the Inland Empire Exchange, which will use a subscription-based financial model, is unusually broad. It encompasses not only doctors, hospitals, and community clinics, but also a Medicaid plan--the Inland Empire Health Plan. Between the state's plan to transition Medicaid recipients into managed care and the Medicaid expansion mandated by healthcare reform, the Inland Empire plan expects to have 900,000 members by 2014. It views participation in the HIE as a way to control health costs. What's striking about this approach is that a health insurer sees value in joining and contributing to an HIE. But it may not be unique. If Western Penn Allegheny ends up joining the ClinicalConnect HIE, Highmark will become at least a de facto member of that exchange.

#### 10) [VA social media policy outlines interaction, patient privacy protection practices](#)

from **FierceHealthIT** by **Ken Terry**

The U.S. Department of Veterans Affairs (VA) has formalized its burgeoning social media empire by announcing a policy on how VA employees should use these online platforms. According to a press release, the policy "allows the Department and its employees to leverage emerging platforms that enhance communication, stakeholder outreach, and information exchange." The new policy explains how employees may apply to create a social media site, describes the proper modes of interaction with veterans, and provides guidance on how to protect the privacy of patient data. Among other things, VA employees are prohibited from using social media to contact individual veterans online. On the other hand, the policy encourages veterans to use social media to seek information from the VA. "Veterans should have consistent and convenient access to reliable VA information real time using social media--whether on a smartphone or a computer," Secretary of Veterans Affairs Eric Shinseki said in the press release. "They also should be able to communicate directly with appropriate VA employees electronically."

VA has been using social media sites since 2009. It now has over 100 Facebook pages, more than 50 Twitter feeds, two blogs, a YouTube channel, and a Flickr page. VA's Facebook pages have 293,000 users, and its Twitter feeds have 53,000 followers. By the end of the year, the Department expects to have an active Facebook page and Twitter feed for all 152 VA Medical Centers. In addition, VA has posted more than 300 videos on YouTube and more than 9,000 photos on Flickr, which together have been viewed more than 1.1 million times. The policy is designed to ensure that VA employees use social media in appropriate and legal ways. Besides addressing the public purposes of social media, it also describes how VA staff may use these online tools to "streamline processes and foster productivity improvements...Web-based collaboration tools enable widely dispersed facilities and VA staffs to more effectively collaborate and share information to achieve greater productivity, efficiency, and innovation."

To learn more:

- read the VA [press release](#)

- see the [policy statement](#) (.pdf)

## **Opinions and Editorials**

### **Wall Street Journal**

#### **11) [What Austerity?](#)**

**From Wall Street Journal by Editorial Board**

Give President Obama and the two Pelosi Congresses credit for this much: They said they would spend our way out of recession, and they sure gave it the old Beltway try. The problem is that we got the spending without the promised economic growth.

This is the real cause of our current deficit and debt woes. As a share of the economy, spending will once again come in at nearly 23.8%, up from 20.7% as recently as 2008. Defense spending is expected to increase by only \$14 billion to \$703 billion in 2011, despite the surge in Afghanistan. The bigger increases are in Medicare, Medicaid, and the usual panoply of entitlements and other payments to individuals.

All of this means the deficit will roll in at nearly \$1.3 trillion, or 8.5% of GDP this year. That's down a mere \$10 billion from fiscal 2010, and we suppose taxpayers should be grateful for small fiscal favors.

The reason for this small deficit dip is that total tax revenues will climb in fiscal 2011 by about \$150 billion. Individual income tax receipts will increase this year by about 21%, or \$190 billion, though tax rates have stayed the same. Even with this good news, revenues will still come in at only 15.3% of GDP, which is far below the modern historical average of more than 18%.

Revenues would have been about \$115 billion higher without the temporary payroll tax cut pressed by President Obama. But that tax cut hasn't provided any economic lift, and overall growth simply isn't fast enough to get revenues back to normal. Merely returning to an average economic expansion would reduce the deficit by 3% of GDP a year, or hundreds of billions of dollars.

Looking forward, CBO forecasts a sunnier fiscal picture, but it is based on assumptions that will never come true. The deficit is projected to fall to \$973 billion in fiscal 2012, then fall again to \$510 billion in 2013, and to a mere \$265 billion in 2014.

But this assumes that federal spending will grow by only \$12 billion in 2012, a level of spending control that even Ronald Reagan never achieved. President Obama wants much more spending next year and so does the Senate. Oh, and Medicare payments to doctors will fall by nearly 30% starting in 2012. Congress has been promising this cut in payments since 1997, but it never happens and would hurt medical care if it did.

### **LA Times**

#### **12) [California needs to be able to regulate health insurance premiums](#)**

**from LA Times by Editorial Board**

A bill to let the state block excessive health insurance premiums is running into trouble in the Senate, where critics complain about its cost, its impact on large groups and the power it could give regulators with an ax to grind. Some of those arguments are specious; some of them are worth considering. But in any event, lawmakers shouldn't lose sight of the basic problem the bill would address: the inability of regulators to do anything but complain about unreasonable increases in premiums.

The measure, [AB 52](#) by Assemblyman [Mike Feuer](#) (D-Los Angeles), would give the Department of Insurance the same authority to modify or reject proposed increases in health insurance premiums as it has in automobile and homeowner's insurance. Similar power would be granted to the Department of Managed Health Care over the rates charged by HMOs.

Regulators already review rate increases for individual and small-group health coverage before they take effect — the Legislature mandated that [last year](#). But a review alone isn't much help for consumers who, starting in 2014, will be compelled by federal law to buy coverage regardless of the price. They will be the insurers' captive market. And unless they're part of an unusually large or attentive group, consumers won't have the clout or the information needed to bargain effectively with insurers to hold down rates.

## **Health Affairs**

### **13) [Risk-Shifting In Health Care And Its Implications: Part One](#) from Health Affairs by Troyen Brennan and Thomas Lee**

**“We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten.” – Bill Gates**

But major change over the longer term is highly likely, and not just because of Bill Gates' observation that a decade is a long time. The impact of regulatory changes in health care can be enormous as they are allowed to play out; witness [the unanticipated but tectonic effects](#) of the Employee Retirement and Income Security Act (ERISA) of 1973 on health care.

We believe that the most striking changes will occur in the locus of risk for poor health. For the past 40 years, much of that has been held by the insurers, employer and the government acting as insurer. Every sign today is that risk will begin to move to consumers, and to providers, the latter in the form of what is today called an accountable care organization. Health reform appears to be speeding the migration of risk.

Some will have doubts about this shift of risk. Calls for change in U.S. health care based on lack of access, uncontrolled costs, and poor quality have been [heard for the last forty years](#). Some savvy and experienced health care leaders are no doubt certain that the reform winds blowing today will soon die out, and the sturdy system of private insurance and fee for service will prevail. Those who managed through the mid-1990's episode of health reform may feel well justified to take a “sit tight” approach.

### **14) [Medicare's Looming Risk Transfer](#)**

## From Health Affairs Blog by Jaan Sidorov

Suppose, despite my good health and lifelong habit of avoiding doctors, I wanted to give you \$1000 today in exchange for your agreement to cover the future cost for all my unplanned medical expenses in the next year? Your decision would be an exercise in classic “risk transfer,” in which parties simultaneously *monetize* (\$1000) and *transfer* (agree to assume) *risk*. It’s also a gamble. I’m betting that the likelihood of an expensive illness, while low, could exceed \$1000, while you are betting that my good health will continue and that you’ll get to keep most of that \$1000.

Once risk is monetized, it also becomes possible to transfer fractions of it to other third parties. For example, if you accepted my offer, you could make a deal with another party to accept \$100 in exchange for the lower risk of an unexpected diagnosis of cancer. You could give \$150 to another party in exchange for “capping” your exposure to \$2500 of medical expenses. You could also transfer some risk back to me in the form of deductibles (I pay the first \$50 worth of doctor bills), co-insurance (20 percent of any bills) or limits (costs that exceed a certain threshold), all in exchange for a price lower than the original \$1000.

Medicare is also a form of monetizing and transferring risk. My payroll taxes are transferring much of the risk of my health care costs, once I am older or if I become disabled, to the U.S. government. And, as this risk is also monetized, it’s also just as possible for Uncle Sam to transfer that risk – and some or all of the premium dollars that accompany it – to third parties or back to me.

Enter the Republican and Democratic battle over Medicare’s “unsustainable” costs, the debate over “the role of government” and the wrangling over “entitlement reform.” While it may appear that each political party is offering starkly different policy approaches, closer examination reveals that both are ultimately proposing the same solution: *transfer substantial portions of Medicare’s monetized risk from the government to one or more third parties.*

They only differ on where that risk should go.

## Events, Reports, and Research Congressional Budget Office (CBO)

### 15) [The Budget & Economic Outlook: An August Update](#)

From Congressional Budget Office by Douglas W. Elmendorf (et al)

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## **Harvard Business Review (HBR)**

### **16) [How to Solve the Cost Crisis in Health Care](#)**

**From Harvard Business Review by Robert S. Kaplan and Michael E. Porter**

U.S. health care costs currently exceed 17% of GDP and continue to rise. Other countries spend less of their GDP on health care but have the same increasing trend. Explanations are not hard to find. The aging of populations and the development of new treatments are behind some of the increase. Perverse incentives also contribute: Third-party payors (insurance companies and governments) reimburse for procedures performed rather than outcomes achieved, and patients bear little responsibility for the cost of the health care services they demand.

But few acknowledge a more fundamental source of escalating costs: the system by which those costs are measured. To put it bluntly, there is an almost complete lack of understanding of how much it costs to deliver patient care, much less how those costs compare with the outcomes achieved. Instead of focusing on the costs of treating individual patients with specific medical conditions over their full cycle of care, providers aggregate and analyze costs at the specialty or service department level.

Making matters worse, participants in the health care system do not even agree on what they mean by costs. When politicians and policy makers talk about cost reduction and “bending the cost curve,” they are typically referring to how much the government or insurers pay to providers—not to the costs incurred by providers to deliver health care services. Cutting payor reimbursement does reduce the bill paid by insurers and lowers providers' revenues, but it does nothing to reduce the actual costs of delivering care. Providers share in this confusion. They often allocate their costs to procedures, departments, and services based not on the actual resources used to deliver care but on how much they are reimbursed. But reimbursement itself is based on arbitrary and inaccurate assumptions about the intensity of care.

## **New England Journal**

### **17) Opportunities and Challenges for Episode-Based Payment from New England Journal of Medicine by Robert E. Mechanic (et al.)**

Paying providers for episodes of care is one of several leading payment-reform options.<sup>1</sup> Whereas private payers have experience with such approaches as pay for performance and capitation, very few have implemented episode-based payment because of its complexity. They must assign responsibility for performance for episodes in which patients are treated by multiple caregivers in multiple settings. For example, in Medicare, 57% of episodes related to hip fractures involve four or more distinct care settings, requiring a level of joint accountability for results that's very difficult to establish.<sup>2</sup> Episode payment systems must also designate which services count toward particular episodes for patients with multiple health conditions. Among Medicare beneficiaries with acute myocardial infarction, for example, 63% also have hypertension and 54% have congestive heart failure.<sup>2</sup> In addition, payers and providers must divide bundled payments among multiple caregivers, which is particularly difficult to do outside integrated delivery systems. Similarly, such systems should include financial incentives for quality to ensure that providers do not skimp on necessary services within episodes.

Although episode-based payment creates strong incentives for discouraging unneeded services within episodes of care, it does not discourage unnecessary episodes. In fact, by aligning the financial interests of physicians and hospitals, such payment methods could boost the number of episodes of care delivered, unless payers also establish mechanisms to ensure that care is appropriate.

Nevertheless, there's ample reason to push forward. First, an episode-based approach allows provider organizations to ease into payment reform. Whereas systems such as global capitation require an organization-wide mobilization that many are unprepared for, episode-based payment lets providers test the waters with a few services and expand into new types of episodes if initial efforts are successful. Second, episode-based payments can be developed around clinical guidelines and used to engage clinicians in quality improvement.<sup>3</sup> Geisinger Health System's experience creating evidence-based care processes in conjunction with episode-based payment for cardiac surgery is a notable prototype.<sup>4</sup> Finally, episode-based payment creates incentives to improve clinical integration for specialty service lines, in contrast with the emphasis on primary care typical of capitation or shared-savings programs. Therefore, this approach is especially relevant for institutions such as academic medical centers that treat many referral patients with whom they lack a primary care relationship.

But if the use of episode-based payment is to be expanded, critical barriers must be addressed. These include the lack of standard methods for constructing “episodes,” the need for reliable software to automate bundled payment, and the limited number of provider groups prepared to accept risk and manage clinical care. Immediate investments are needed to develop administratively feasible, economically sustainable, scalable programs.

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