THE New York Times **BUSINESS** WEDNESDAY JANUARY 28, 2015

Industry Group to Back Results-Focused Care

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Dr. Richard J. Gilfillan, chief of Trinity Health and a former Medicare official, began the Health Care Transformation Task Force.

By REED ABELSON

A coalition of some of the nation's largest health-care systems and insurers vowed on Wednesday to change the way hospitals and doctors are paid — placing less emphasis on the sheer amount of care being delivered and more on improving quality and lowering costs.

Now, providers are paid through traditional fee-for-volume contracts, meaning the more care they provide, the more money they receive. It is a system, many argue, that contributes to the high cost of medical care, by encouraging hospitals and doctors to perform tests and procedures regardless of the value to a patient.

The coalition said it was committed to finding a way to change the financial incentives, moving the bulk of payments to so-called value-based arrangements by 2020, in which cost and quality would be part of the equation. Many health-care systems and insurers are already experimenting with such arrangements.

The announcement comes on the heels of a similar vow by Health and Human Services Secretary Sylvia M. Burwell on Monday. She said half of all traditional Medicare payments would be based on quality of care or value by 2018.

But the coalition members acknowledged that changing the financial structure of the $3 trillion healthcare industry is a monumental task that involves carefully assessing costs and defining quality. The private coalition includes, among others, Partners Health-Care, the powerful Boston health system that oversees Brigham and Women's and Massachusetts

General hospitals; Ascension, the nation's largest Catholic and nonprofit health system; Aetna, a national for-profit insurer; and Health Care Service Corporation, which operates five state Blue Cross plans.

While largely rhetorical, the commitments by Medicare and the private sector group reflect a fundamental shift in thinking. "We're very much aligned and share a common goal here," said Fran S. Soistman, an executive vice president for Aetna, who said the federal government's announcement "bodes well" for the overall effort.

Paying for better outcomes, not sheer volume of procedures.

The coalition, called the Health Care Transformation Task Force, was proposed by Dr. Richard J. Gilfillan, a former Medicare official and the chief executive of Trinity Health, a Catholic system that operates in 21 states. It hopes to help find some kind of consensus on payment models so doctors and hospitals do not have to negotiate multiple arrangements with Medicare and each private insurer.

"It's really easy to agree on the big-picture stuff, but it gets more complicated when you get into the details," said Dr. Timothy G. Ferris, who is leading the effort at Partners.

"It's not as if we have a cookbook," said David Lansky, the chief executive for the Pacific Business Group on Health, an employer group that is part of the task force.

Changing the payment structure was last tried in the 1990s with the creation of health-maintenance organizations, or HMOs. But those efforts largely failed because of an overemphasis on cost and rules that were seen by doctors and patients as too restrictive.

Several coalition members said, however, that they had learned from those earlier mistakes. Blue Cross Blue Shield of Massachusetts, for example, says it now pays doctors and hospitals more whenever its quality targets are met. Aetna cites its partnership with Inova Health, a health system in Northern Virginia, that it said led to sharply lower hospital stays and readmissions. The insurer estimates that 28 per cent of its claims are now paid under the new arrangements.

And the efforts are not limited to the coalition. UnitedHealth Group, which operates one of the nation's largest health insurers, said this month that it planned to increase the amount it paid under value-based reimbursements by 20 per cent during 2015.

Many health systems are already experimenting with accountable care organizations, in which providers are responsible for the overall cost and quality of care for a group of patients. Others are looking at bundled payments that, for example, include the cost of care for an entire medical episode like heart bypass surgery or a knee replacement, rather than piecemeal payments for tests and procedures related to the episode.

Much of what sets the new models apart is the coordination of care outside a specific setting like a hospital or doctor's office. Advocate Health Care, a coalition member, said it could reach the payment goal as soon as this year.

A patient like Larry Matthias, a 58-year-old with diabetes, heart disease, and Parkinson's, relies on an Advocate case manager to call him every month to check on how he's doing and help him get the right care from his array of specialists. "She's been very instrumental in pointing me in the right direction," said Mr. Matthias, from Waukegan, Ill., who described her as "a kind of glue" because she saw him as a whole patient. She often urges him to call his doctor or go in for an office visit.

At Trinity Health, nurses are trying to help patients who come into the emergency room because they are unable to find care elsewhere. Dr. Gilfillan recalled that one patient was showing up frequently because he had chronic kidney failure and was not getting dialysis. When one of the system's nurses found an outpatient clinic where he could go regularly, he no longer needed to come to the hospital.

Health systems and insurers are also asking nurses in doctors' offices to work with the medical staff in a hospital to make sure patients understand what medicines to take when they go home and to follow up with their doctor.

"It's a long time coming," acknowledged Dr. Stephen Ondra, the chief medical officer for Health Care Service. But he says he thinks that insurers and health systems will have to change. The current model is not sustainable, he said, and the country will eventually move to new, different payment models.