MASSACHUSETTS
HEALTH POLICY COMMISSION

Provider Price Variation Stakeholder Discussion Series

May 19, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **HPC Staff Presentation: Direct limits on price variation**
- Presentation by Dr. Joshua Sharfstein, Former Secretary of Maryland Department of Health and Mental Hygiene and Current Professor and Associate Dean of the Johns Hopkins University Bloomberg School of Public Health
- Stakeholder Discussion
- Next steps

Recap: Key findings from HPC examination of provider price variation

- Provider prices vary extensively for the same sets of services.
- Provider price variation has not diminished over time.
- Market leverage continues to be a significant driver of higher prices; higher hospital prices are not generally associated with higher quality or other value-based factors that provide benefit to the Commonwealth.
- While some variation in prices may be warranted to support activities that provide value to the Commonwealth (e.g. physician training), unwarranted variation in prices combined with the large share of volume at higher-priced providers results in increased health care spending and creates inequities in the distribution of health care resources.
- Other states have also found unwarranted variation in provider prices; however, in one state that limits hospital price variation to value-based factors, hospital prices for specific services vary less than in Massachusetts.
- Unwarranted price variation is unlikely to diminish over time absent policy action to address the issue.

Source: Health Policy Commission 2015 Cost Trends Report: on Provider Price Variation

Recap: Provider price variation stakeholder discussions

Following the 2015 Cost Trends Report on Provider Price Variation, the HPC has provided additional research and analyses and convened stakeholders to present and discuss specific policy options to reduce unwarranted price variation, including:

March Policies to enhance healthcare market transparency and encourage consumers to use high-value providers for their care;

April Transitioning away from use of historic spending for setting global budgets; and

Today Options to directly limit price variation

A more sustainable and value-based health care system

Direct limits on price variation: Overview

- Policies that directly limit price variation are potentially a more **direct**, **faster** and **more targeted approach** to addressing unwarranted price variation
- There are both different direct limit policy options to consider, e.g.:
  - Rate "banding," or prohibiting prices from varying from average by more than a given amount;
  - Creating differential growth rates where lower-priced or more efficient providers are allowed greater increases in prices and/or global budgets than higher-priced or less efficient providers;
  - Limiting price variation (FFS or global budgets) to value-based factors that provide benefit to the Commonwealth;
  - And other options, including those used in payment systems (e.g. Maryland, Medicare)
- …and different ways to implement those policies, e.g.:
  - Implementation over time versus at one point in time
  - Implementation of one versus a combination of multiple policies
  - Differing degrees of government oversight, e.g. full rate-setting versus retaining private negotiations within certain guardrails

Considerations and challenges for direct limit policies

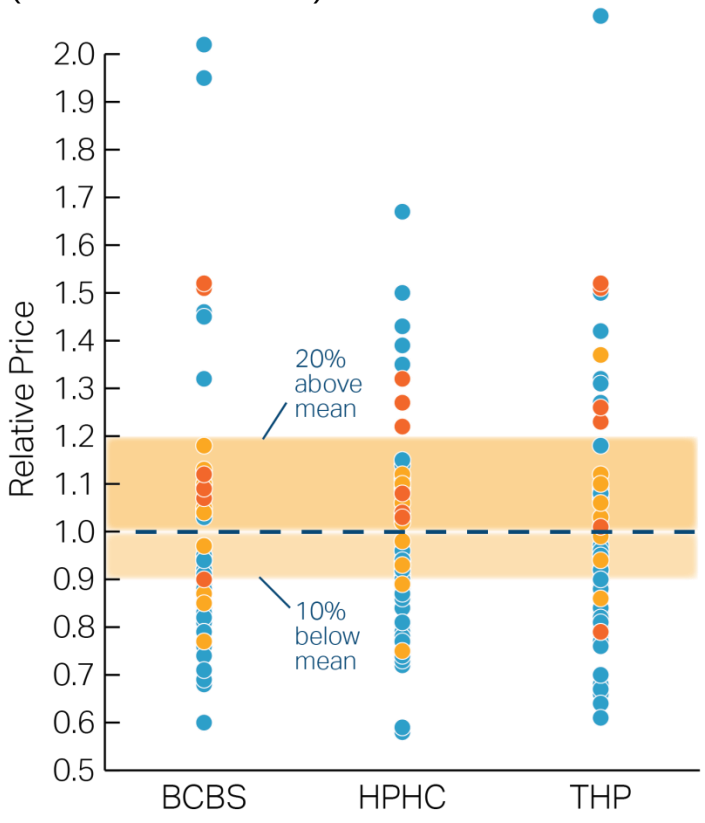
- Different policies and implementation options will differ in the extent to which they can achieve certain outcomes, e.g.:
  - Controlling total health care spending over time, in addition to price variation
  - Creating a more value-driven health care marketplace
  - Promoting the financial health of low-cost providers
  - Complementing demand-side and supply-side incentives, including by applying to both fee-for-service rates and global budgets
  - Aligning incentives across the provider market, including for lower-priced providers
  - Applying across health care market, e.g. to hospitals, primary care and specialist physicians, insurance markets

- …and the challenges they may create:
  - Resources necessary for greater government oversight
  - Technical complexity of defining appropriate target levels of variation, timing for rate convergence, and/or adjustment levels for appropriate variation
  - Potential for unintended consequences for providers, payers, and/or consumers

Direct limit policy options: Rate banding

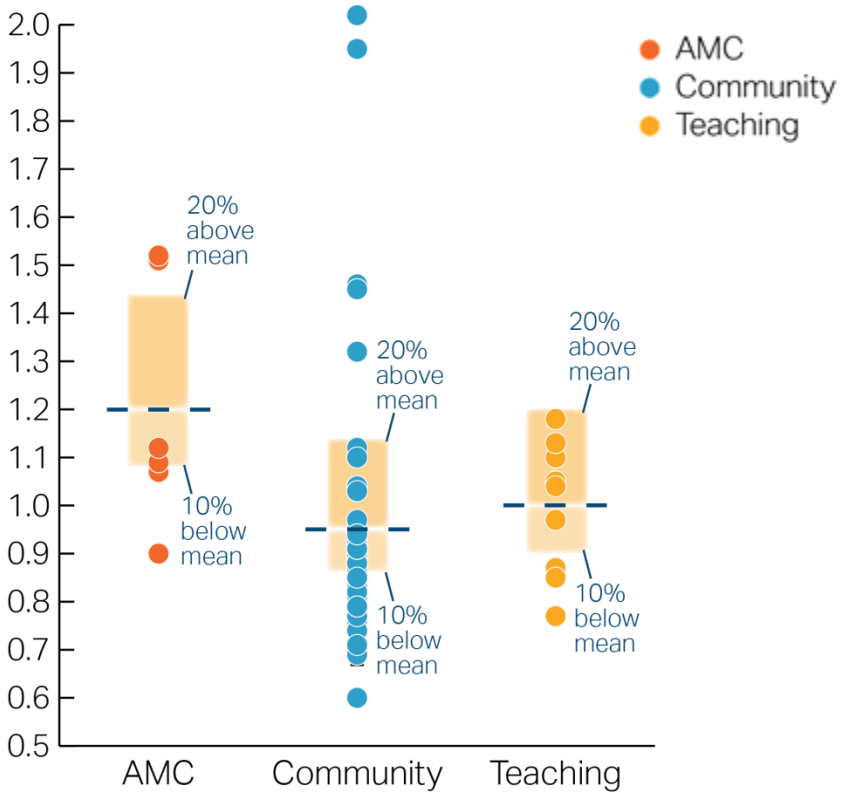
Example of Rate Banding: All Hospitals

(2014 Relative Prices)



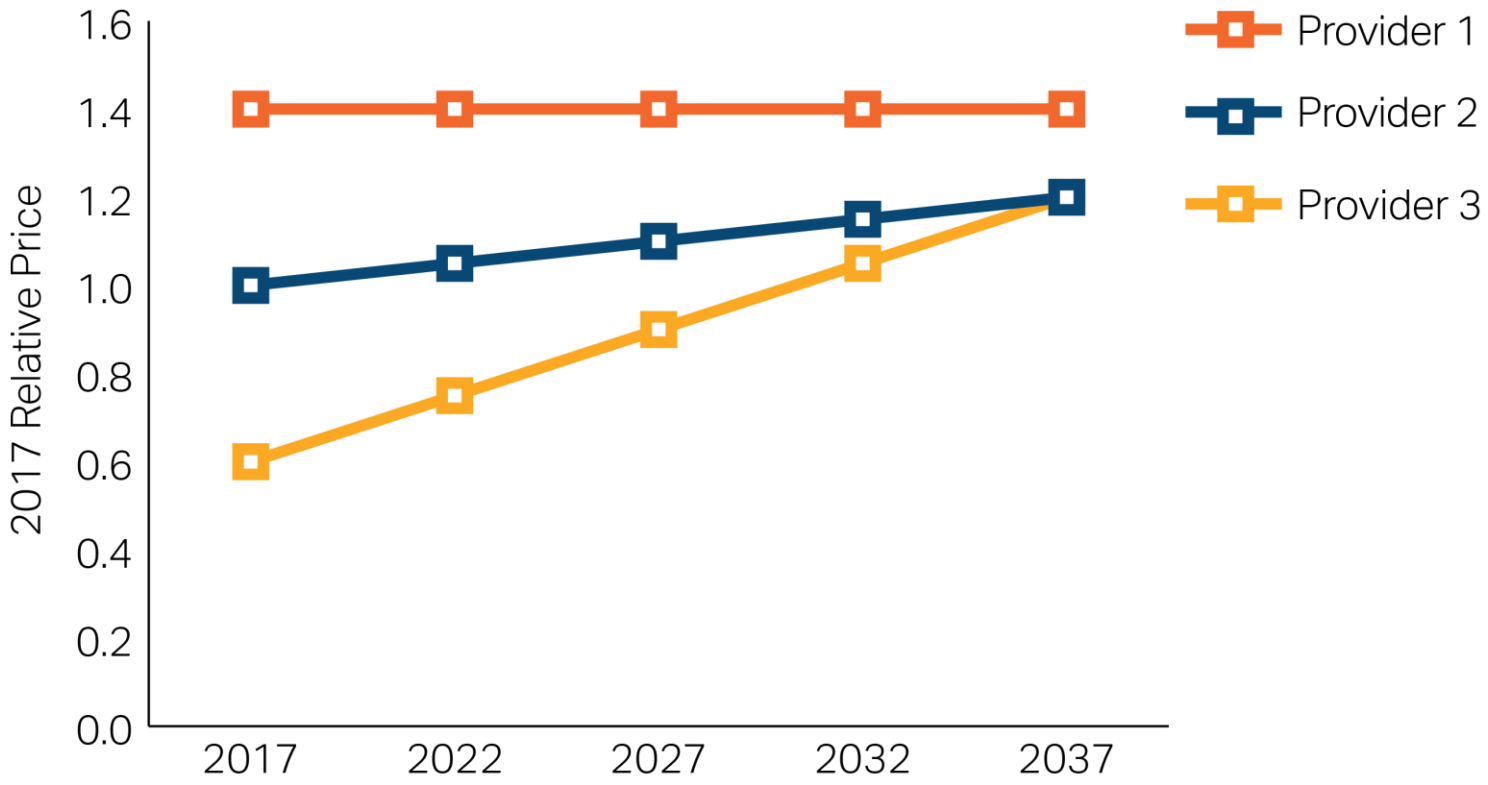
Example of Rate Banding: By Cohort

(2014 BCBS Relative Prices)



Direct limit policy options: Differential growth rates

Example of Differential Price Growth: No Growth for Highest-Priced Provider



Convergence may take time. As noted in the Cost Trends Report on Provider Price Variation, due to the extent of the price variation in the market for the same sets of services, it would take **19 years** for some hospitals to reach the prices of the 75th percentile in 2013, even if they received 3.6% annual price increases.

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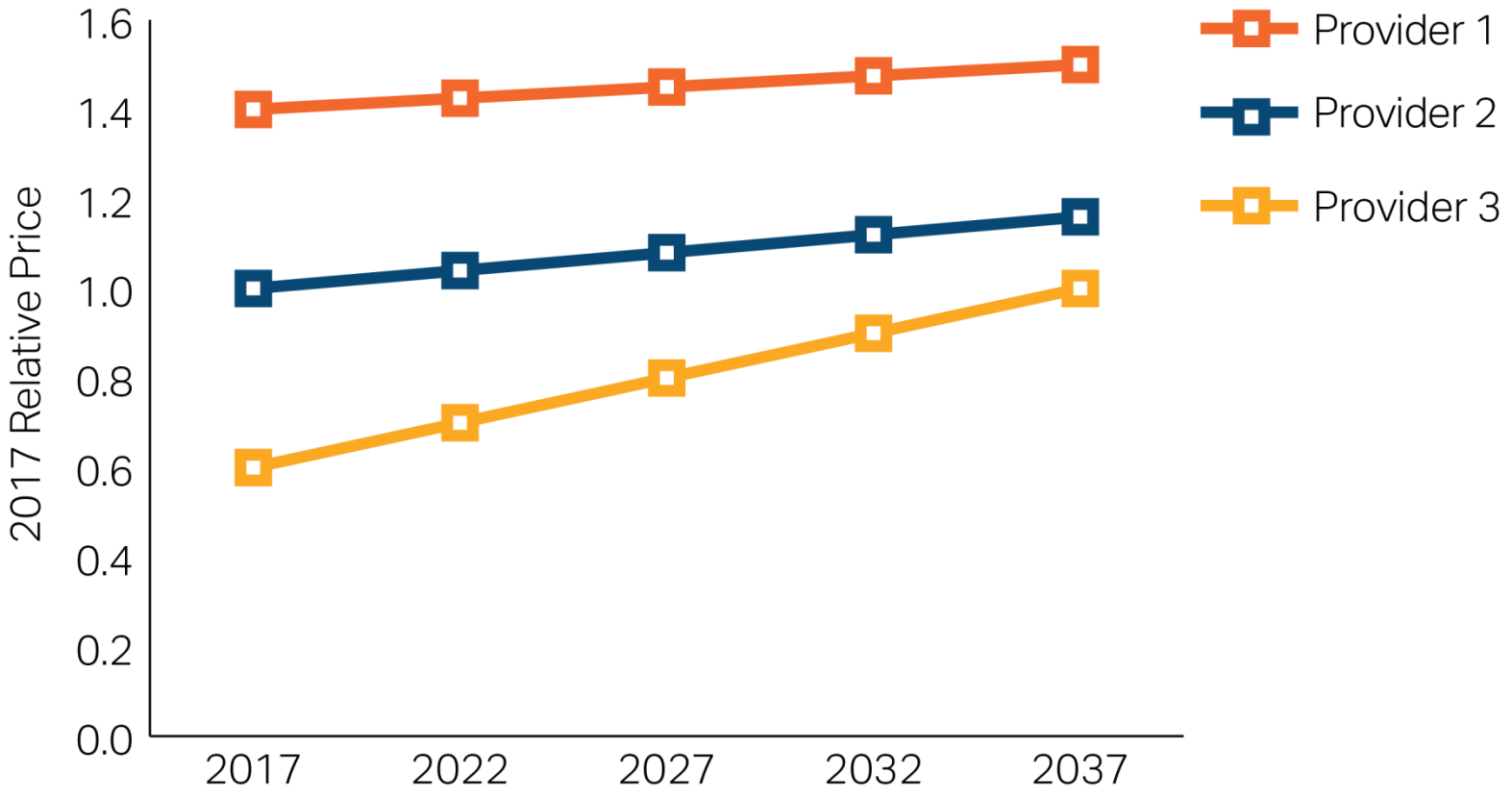
Direct limit policy options: Differential growth rates

Example of Differential Price Growth: Slow Growth for Highest-Priced Provider



Limiting variation to acceptable factors; examples of "acceptable factors" from other payment systems

	Clinical Complexity	Geography	Teaching	Patient/ Payer mix	High-Cost Outliers	Other
Medicare (IPPS)	Yes (DRG weight)	Yes (wage index)	Yes (direct and indirect)	Yes (DSH adjustment)	Yes	Payments for certain rural or low-volume hospitals; bad debts, etc.
MassHealth (inpatient)	Yes (DRG weight)	Yes (wage index)	No	Yes (e.g., DSH adjustment)	Yes	Pass-throughs (e.g., organ acquisition); readmission adjustments; Critical Access Hospitals
Maryland (inpatient & outpatient)	Yes	Yes (wage index)	Yes (direct and indirect)	Yes (Uncompen-sated care and DSH-type adjustment)	Yes	Certain highly specialized services excluded, special readmission rules
OECD generally (*DRG-based, inpatient)	Yes	Yes	Yes	--	Yes	E.g., research, innovation, high-cost services

DRG: Diagnostic-Related Group; DSH: Disproportionate Share Hospital; IPPS: Inpatient Prospective Payment System; OECD: Organization for Economic Cooperation and Development. *OECD member countries with health insurance systems tend to use DRG-based payments for hospital services (countries with tax-funded national health systems predominantly use global budgets). The OECD information represented on this slide is generalized; the specific factors, methodologies, and details of implementation vary by country.

Limiting variation to acceptable factors; examples of adjustment amounts for acceptable factors from Medicare

- While the range of variation permitted for these factors varies, for many factors the range of adjustments in Medicare is relatively narrow. For others, only a few providers qualify for the additional payment.
- Medicare payment ranges for acute inpatient hospitals (FY 2016):
  - **Geography:** Current wage index differentiation* in MA is narrow (**3%**)
  - **Teaching status** (based on ratio of residents per bed): maximum adjustment in MA was a **40% increase** to operational DRG rates
    (30 hospitals; median 14% increase; 10th to 90th percentile range 1% to 36%)
  - **Disproportionate share of low-income patients**** (DSH): maximum adjustment in MA was **11% increase** to operational DRG rates
    (47 hospitals; median 3% increase; 10th to 90th percentile range 1% to 7%)
  - Few hospitals qualify for **additional rate adjustments** (e.g. based on rural status)

*Differences in payment due to geographic variation were narrowed (with lower end raised) in 2011 by the reclassification of the rural Nantucket Cottage Hospital from a critical access hospital to a hospital paid under the regular inpatient hospital payment system.

** A hospital's low-income share is the sum of the proportion of its Medicare inpatient days provided to patients eligible for Supplemental Security Income benefits and the proportion of its total acute inpatient days furnished to Medicaid patients. In addition, under PPACA, hospitals will receive a share of a fixed pool of dollars representing the "uncompensated care pool." (MedPAC Payment Basics, IPPS 2016)

Source: HPC analysis of CMS FY 2016 IPPS final rule and correction notice impact public use file.

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Limiting variation to acceptable factors; examples of adjustment amounts for acceptable factors from Medicare

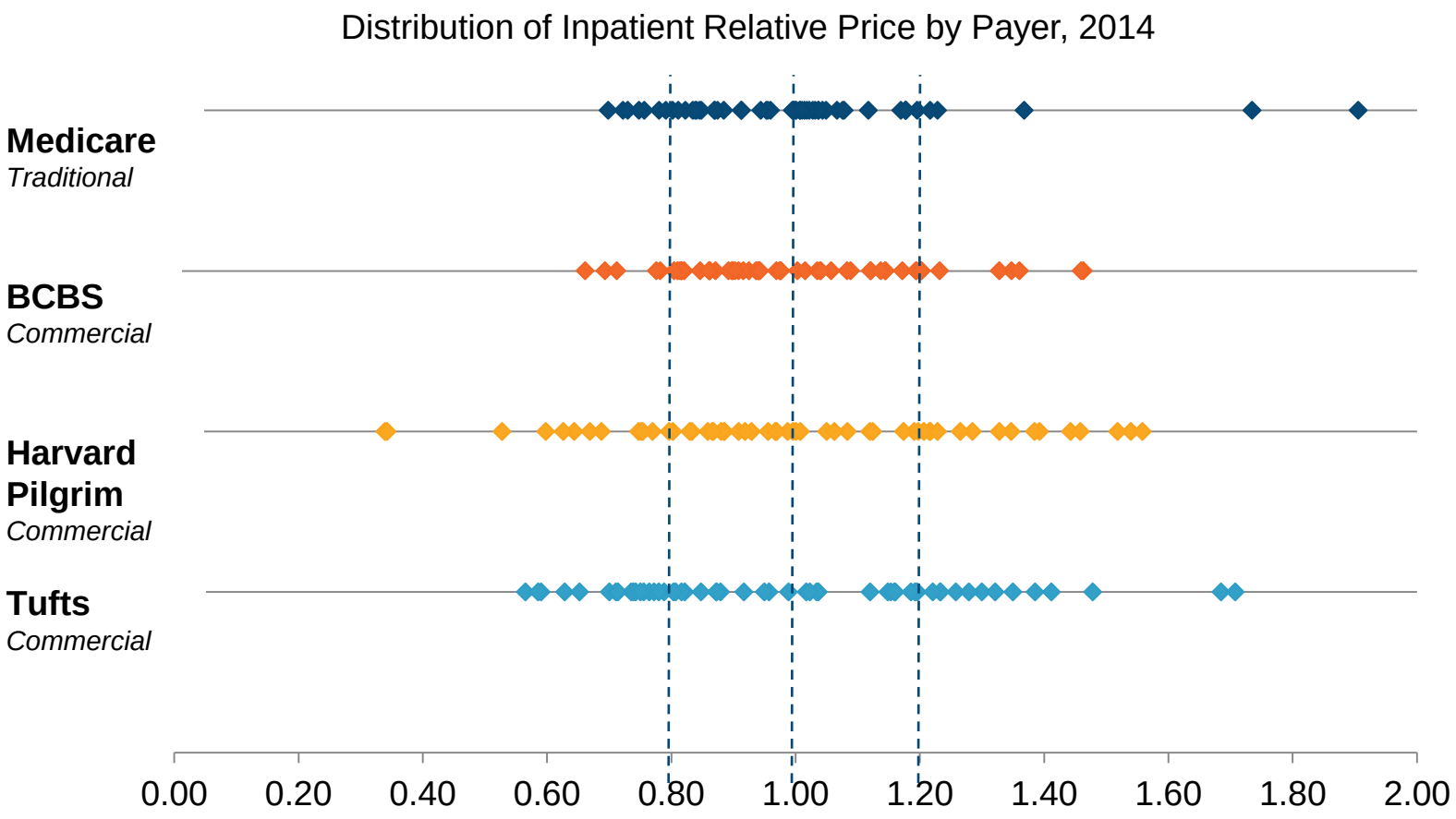
- Medicare payment ranges for physician services (CY 2016):
  - In Massachusetts, Medicare only pays differently for "**practice expenses**" (e.g. office space, administrative staff) for two different regions, paying only **9 percent more** for practice expenses in Metro Boston compared with the rest of the Commonwealth.
  - For example, for a 15 minute evaluation & management visit*, Medicare pays $79 in metro Boston vs. $75 in the rest of the Commonwealth in 2016.
  - In comparison, in 2013, BCBS paid $139 at the 90th percentile and $66 at the 10th percentile for a 15 minute evaluation & management visit.

*CPT code 99213

Source: HPC analysis of CMS 2016 physician fee schedule, and Massachusetts All-Payer Claims Database, 2013.

Limiting variation to acceptable factors; extent of price variation under Medicare's administered pricing

As a result, **Medicare prices do vary**, but the variation is based on certain factors that are defined by that system as acceptable, and prices are similar for most providers

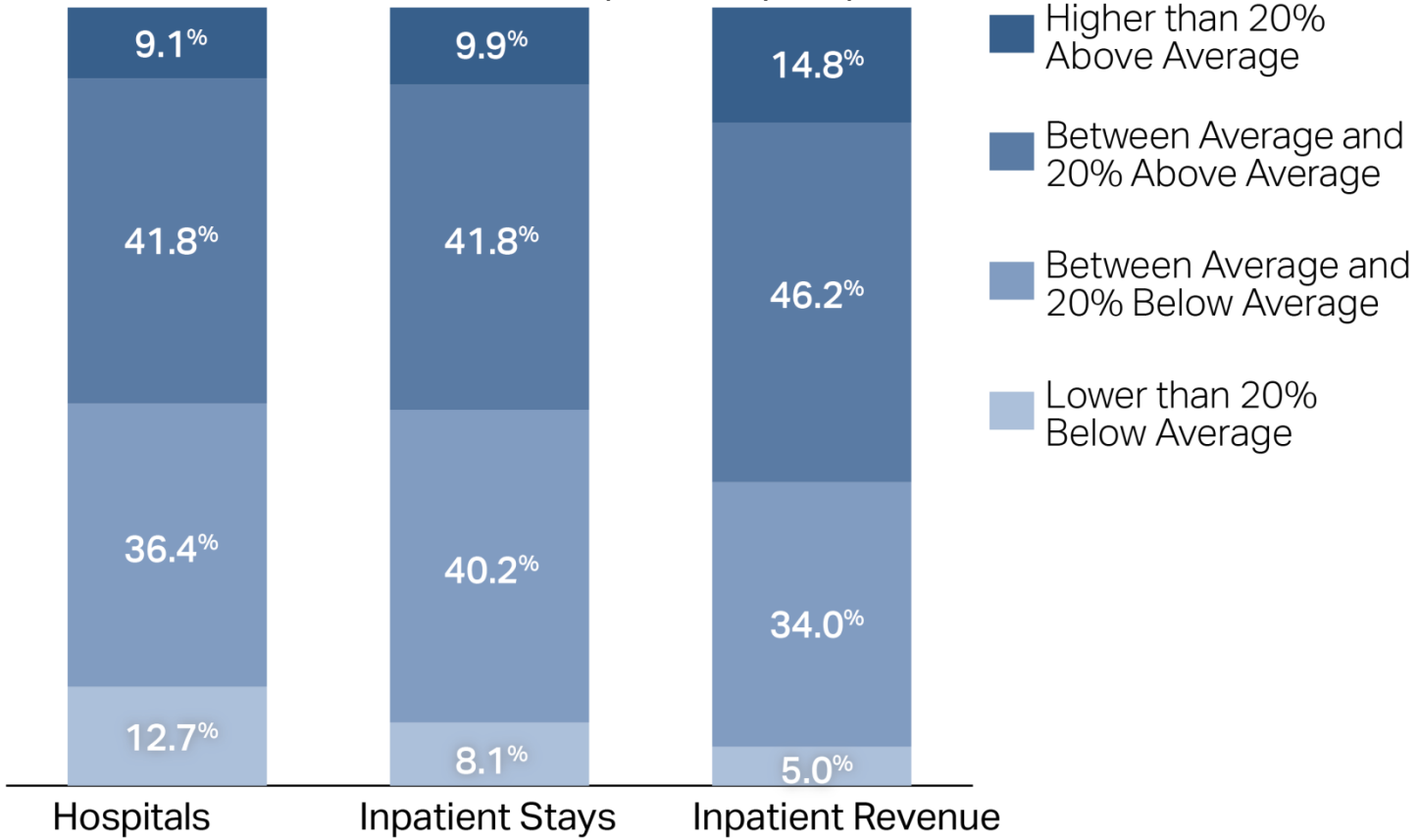


Note: Acute hospitals not paid under Medicare IPPS are excluded to provide more appropriate comparisons.
Source: Analysis performed by CHIA at HPC's request

Limiting variation to acceptable factors; concentration of stays and revenue by Medicare price level

- In Medicare, **more than three-quarters** of providers receive prices that are within 20% of average, and volume and revenue are not concentrated among the highest priced providers.
- The highest priced **50%** of hospitals account for **51.7%** of volume and **61%** of revenue.

Distribution of Hospitals, Inpatient Stays, and Revenue by Inpatient Relative Price: Medicare 2014 (n=55 hospitals)

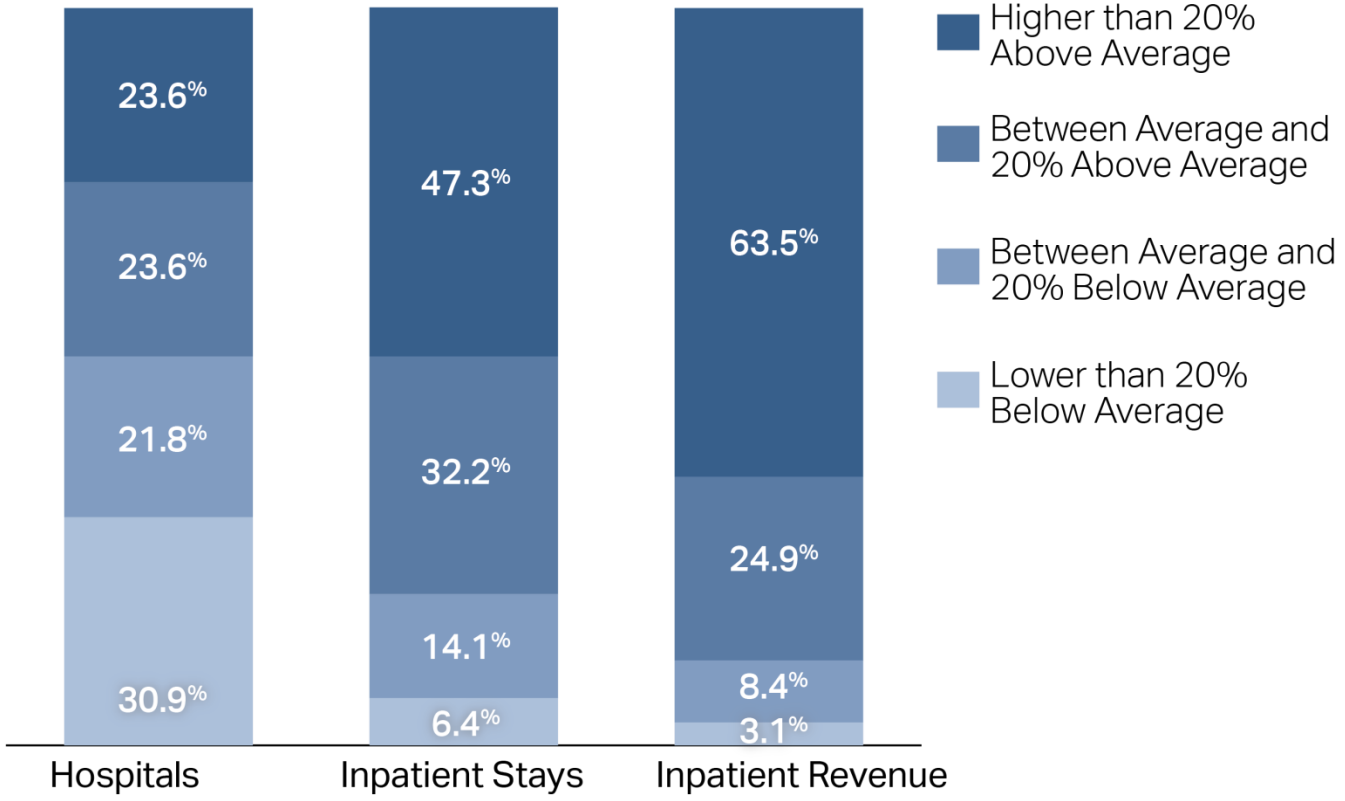


Note: Acute hospitals not paid under Medicare IPPS are excluded to provide more appropriate comparisons.
Source: Based on analysis performed by CHIA at HPC's request

Limiting variation to acceptable factors; concentration of stays and revenue by commercial price level

- In contrast, in the commercial market where prices may vary based on market factors, prices are more variable, and volume and revenue tends to be at the highest priced providers.
- For Tufts Health Plan, **fewer than half** of providers receive prices within 20% of average, and the highest priced **47.2%** of hospitals account for **79.5%** of volume and **88.4%** of revenue.

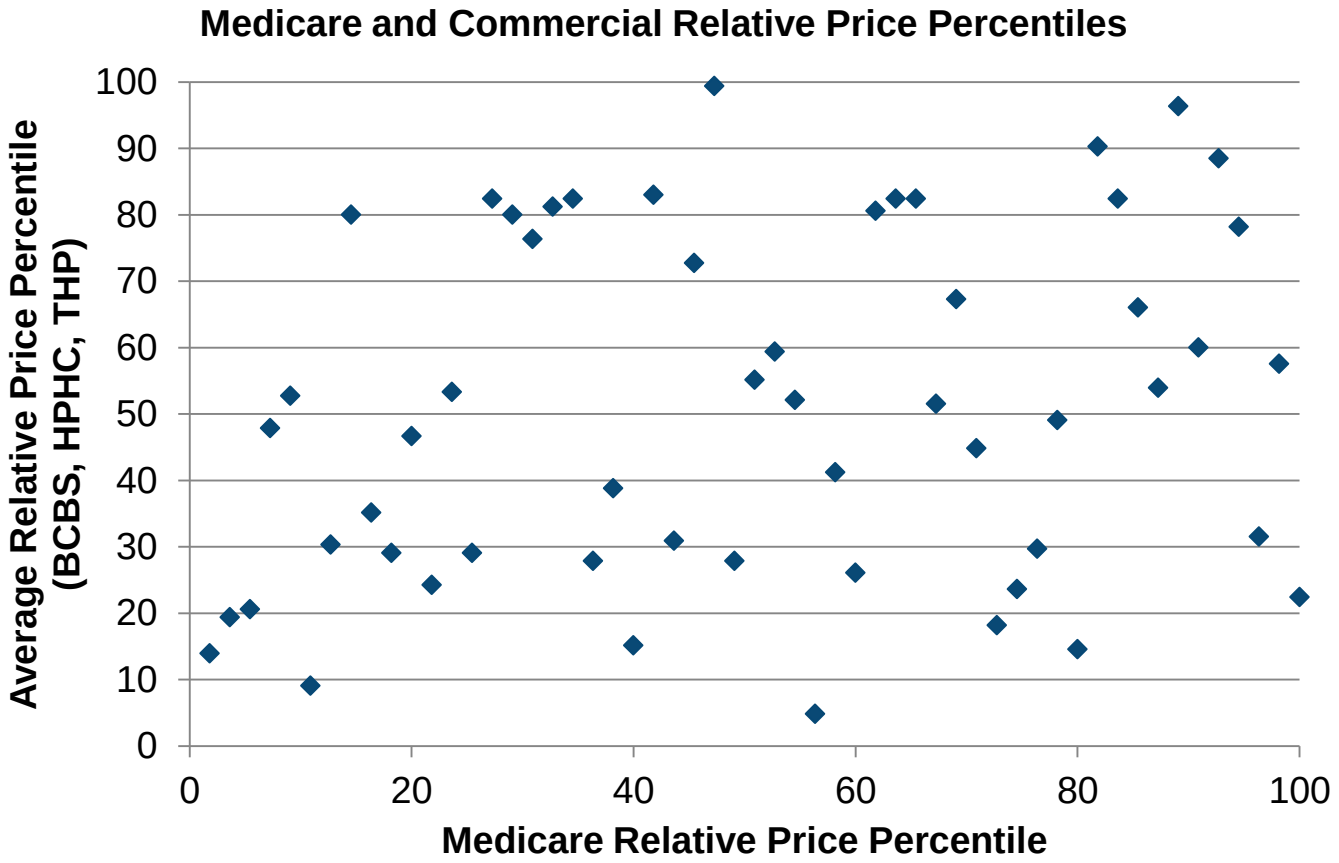
Distribution of Hospitals, Inpatient Stays, and Revenue by Inpatient Relative Price: THP 2014 (n=55 hospitals)



Note: Acute hospitals not paid under Medicare IPPS are excluded to provide more appropriate comparisons.
Source: Based on analysis performed by CHIA at HPC's request

Limiting variation to acceptable factors; Medicare and commercial prices have little correlation

In Medicare, where prices are allowed to vary based on certain acceptable factors, the price levels of different providers also have little relationship with commercial price levels.



Note: Acute hospitals not paid under Medicare IPPS are excluded to provide more appropriate comparisons.
Source: Based on analysis performed by CHIA at HPC's request

Limiting variation to acceptable factors; current Massachusetts market

A quick recap: In Massachusetts, a substantial portion of hospital price variation is associated with market structure, and not with quality

Factors associated with higher commercial prices (Holding all other factors equal)
Less competition
Larger system size (above a certain size)
Corporate affiliations with certain systems
Provision of higher-intensity (tertiary) services
Status as a teaching hospital

Factors associated with lower commercial prices (Holding all other factors equal)
More Medicare patients
More Medicaid patients
Corporate affiliations with certain systems

Factors not generally associated with commercial prices (Holding all other factors equal)
Quality
Mean income in the hospital's service area

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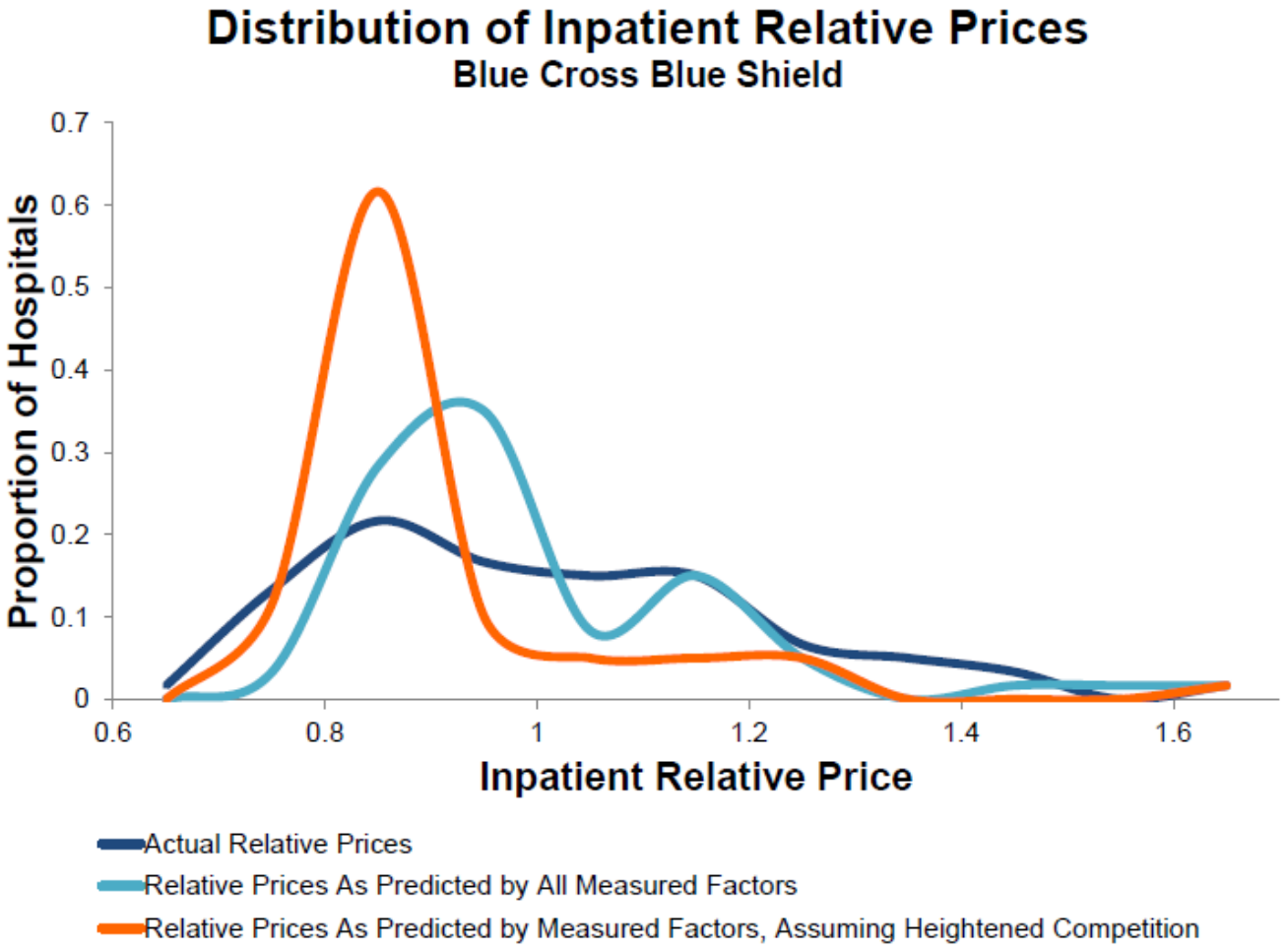
Limiting variation to acceptable factors; holding certain competition factors constant reduces variation

Holding certain competitive factors constant at levels that indicate increased competition among hospitals results in reduced price variation (orange line).



Note: See *2015 Cost Trends Report on Provider Price Variation: Technical Appendix* for detailed information on regression variables.

Other direct limit policy options: Examples from other states

Rhode Island

- Office of the Health Insurance Commissioner (OHIC) conducts annual insurance rate review. The standards for the review include Affordability Standards.
- The Affordability Standards include Hospital Contracting Conditions:
  - The average annual percent increase in inpatient and outpatient price may not exceed the increase in the national Consumer Price Index for Urban Consumers, plus 1%.
  - All hospital contracts must have a quality incentive program, and at least 50% of annual price increases must be earned through quality performance.

West Virginia

- Health Care Authority (HCA) sets maximum hospital charges for commercial payers.
- Hospitals and commercial payers negotiate prices within a corridor with a floor of the hospital's costs and a ceiling of the HCA-set charge limit.

Maryland

- All-payer rate-setting system

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Other direct limit policy options: Maryland's approach to hospital pricing before 2014

- Maryland's pricing system was built on unit prices for individual services. Prices were set based on historical hospital costs plus a mark-up, and adjusted where costs were excessive relative to peers, after accounting for the same factors noted below.
- Utilization of individual services was constrained by per-case charge limits, case-mix-adjusted using APR-DRGs (inpatient) and ambulatory patient groups (outpatient). For most of the period from 1977 to 2014, an additional volume adjustment was applied to prices for volume exceeding defined levels.
- Unit prices and per-case limits were adjusted annually for inflation and to adequately account for input cost increases, new technology, and productivity improvement.
- There was also an annual screening for the reasonableness of hospital charge-per-case. Hospitals were compared to peers (based on AMC status, geography, and size) with adjustments made to hospital charges for:
  - Uncompensated care
  - Direct Medical Education, Nurse Medical Education, and trauma
  - Indirect Medical Education
  - Disproportionate share of low income and elderly patients
  - Case Mix
  - Labor market adjustment
  - Capital costs (partially recognized)
- After those adjustments, hospitals found to have excessive charges* reduced them over time through lower unit prices.

*As of 2007, hospitals with charges more than 3% over the peer group average after adjustments were considered to have excessive costs. MARYLAND HOSPITAL ASS'N, ACHIEVEMENT, ACCESS, AND ACCOUNTABILITY: MARYLAND'S ALL-PAYOR HOSPITAL PAYMENT SYSTEM (2007)

Other direct limit policy options: Maryland's approach to hospital pricing before 2014

- This system yielded financial stability across the hospital sector and a narrower distribution of earnings at the individual hospital level.
  - The span between the tenth and ninetieth percentiles of total (all-payer) margins, for example, was 8.2 percent in Maryland, compared to 21.1 percent nationally in 2003.*
  - Maryland has also had the highest proportion of hospitals rated "investment grade" of any state.**
- From 2010 to 2015, the state's flagship AMC, Johns Hopkins Hospital, has consistently had operating margins above 3%. Other metrics further indicate a consistently strong financial position.***
- Maryland's new global revenue system was designed to build on the previous system to encourage hospitals to care for a patient population while reducing potentially avoidable utilization.

*_Robert Murray,_ Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience, Health Affairs (2009) citing a MedPAC analysis of 2003 Medicare Hospital Cost Reports.
**_Id. citing_ Moody's Investor Services; 2006. Maryland had 72 percent of its hospitals rated "investment grade" (33 of 46 nonprofit hospitals) compared with 19 percent rated "investment grade" nationally (560 of 2,919 nonprofit hospitals).
***HPC analysis of audited financial statements

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- Stakeholder Discussion
- Next steps

Global Budgeting: Good for What Ails MA?

Presentation to the Massachusetts Health Policy Commission

Joshua M. Sharfstein, M.D.

May 19, 2016

A CENTURY OF SAVING LIVES
MILLIONS AT A TIME

JOHNS HOPKINS
BLOOMBERG SCHOOL
OF PUBLIC HEALTH

Starting Questions

- How do we create a system that supports a healthier population, appropriately rewards high-quality and efficient providers, and also reduces health care spending over time?
- How do we ensure that different parts of the health care system are included (e.g. physicians, specialty providers, and populations beyond those in the small group and/or fully-insured markets)?
- How can we accomplish a significant change in the health care payment system while supporting opportunities for health care providers to innovate and make decisions that affect their future?

Plan

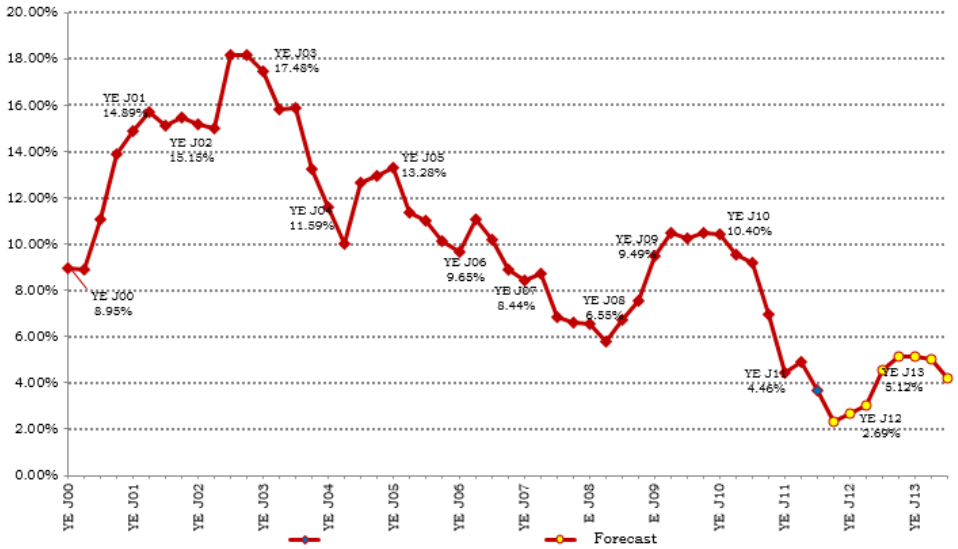
- Background on Maryland's all-payer rate setting system
- Explanation of Maryland's new model for global budgets for hospitals
- Maryland and Price Variation
- Answers to 3 Questions

The MARYLAND HEALTH SERVICES COST REVIEW COMMISSION

- Since the late 1970s, the Maryland's quasi-public Health Services Cost Review Commission sets inpatient and outpatient hospital rates for all public and private payers.
- Rates set based on factors that include case mix, reasonable hospital costs, wage variations, graduate medical education, quality incentives, level of uncompensated care.
- Essentially, each hospital gets its own rate card and all payers pay off the rate card.
- In the last 35 years, Maryland's rate-setting system:
  - Eliminated cost-shifting among payers
  - Allocated cost of uncompensated care and medical education among all payers
  - Allowed usage of creative of incentives to improve quality and outcomes

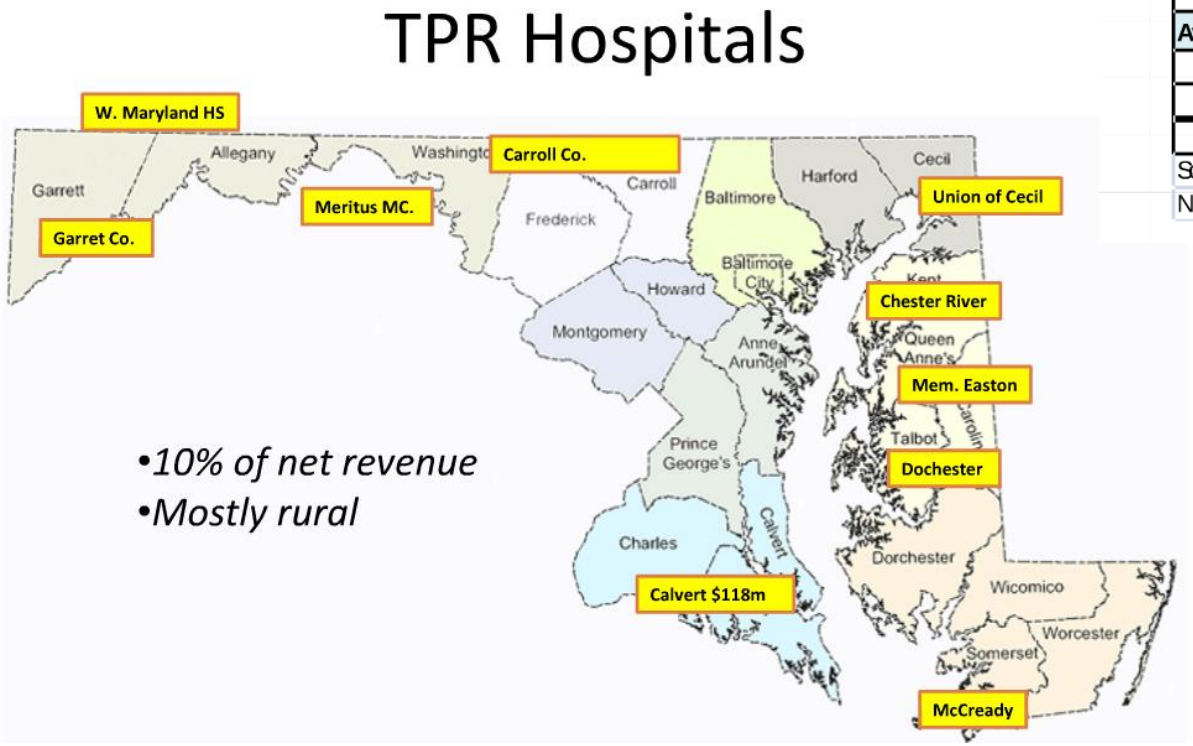
Conditions for Medicare Participation

- All-payer system
- Rate of growth of prices slower than national rate of growth of prices in Medicare program



A Pilot: Total Patient Revenue, Meaning a Global Budget Across All Payers

Strong Incentive for Clinical Transformation



TPR versus non-TPR Hospitals: Before and After TPR Implementation in 2011		
	TPR	**Non-TPR**
Inpatient Admissions		
FY2010	91,672	668,319
FY2013	75,478	608,166
% Change	**-17.7%**	**-9.0%**
Same Hospital Readmissions		
FY2010	9,530	64,842
FY2012	7,729	58,269
% Change	**-18.9%**	**-10.1%**
Avoidable Admissions (PQI90)		
CY2010	11,551	65,517
CY2012	9,593	57,148
% Change	**-17.0%**	**-12.8%**
Source: HSCRC, May 2013.		
Note: FY2013 is based on 6 month data and annualized.		

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ECONOMIC SCENE

Lessons in Maryland for Costs at Hospitals

J.M. Eddins Jr. for The New York Times

Dawn Snyder, a registered nurse, runs a heart failure clinic at Western Maryland Health System.

By EDUARDO PORTER
Published: August 27, 2013

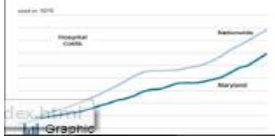
CUMBERLAND, Md. — This hardscrabble city at the base of the Appalachians makes for an unlikely hotbed of health care innovation.

Economic Scene

Eduardo Porter writes the Economic Scene column for the Wednesday Business section.

Author Bio »
Past Columns »

Multimedia



Graphic

Yet Western Maryland Health Systems, the major hospital serving this poor and isolated region, is carrying out an experiment that could leave a more profound imprint on the delivery of health care than President Obama's reforms.

Over the last three years, the hospital has taken its services outside its walls. It has opened a diabetes clinic, a wound center and a behavioral health clinic. It has hired people to follow up with older, sicker patients once they are discharged. It has added primary care practices in some neighborhoods.

The goal, seemingly so simple, has so far proved elusive

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TWITTER
GOOGLE+
SAVE
E-MAIL
SHARE
PRINT
SINGLE PAGE
REPRINTS

Concept: Move All Hospitals to Global Budgets

- Former Hospital Payment Model:
  - Volume Driven

Units/Cases

× **Rate Per Unit or Case (Updated for Trend and Value)**

↓

Hospital Revenue

- Unknown at the beginning of year
- More units creates more revenue

- New Hospital Payment Model:
  - Population Driven

Revenue Base Year

× **Updates for Trend, Population, Value**

↓

Allowed Revenue for Target Year

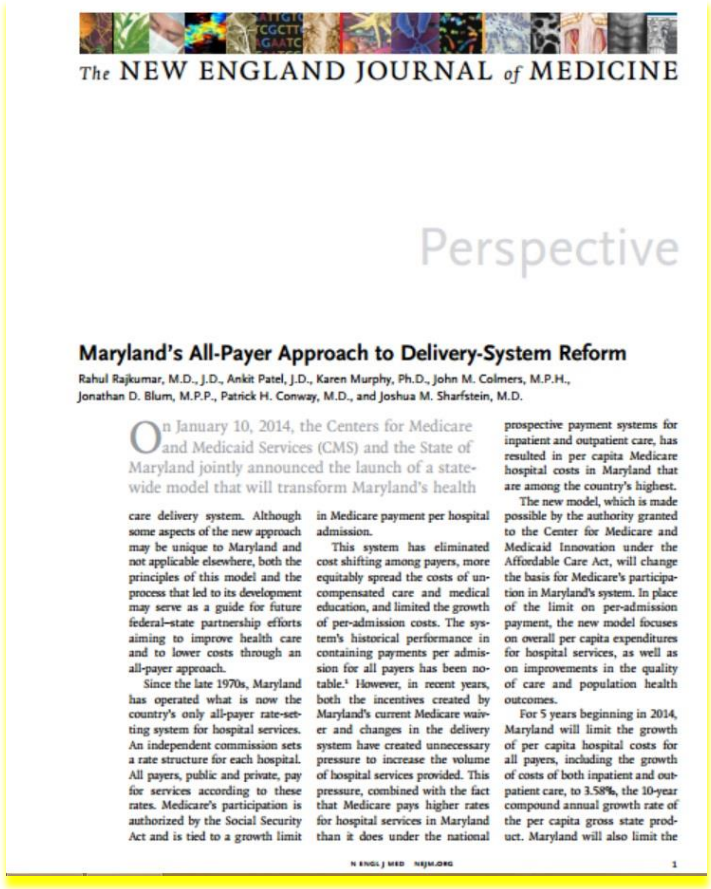
- Known at the beginning of year
- More units does not create more revenue

Source: HSCRC

January 1, 2014: A New Model for Hospital Payment in Maryland

- Transition away from fee-for-service hospital payment over 5 years
- Global budget cap for all payers tied to Gross State Product per capita (3.59% annual growth rate)
- Guaranteed savings to Medicare ($330 million over 5 years)
- Strong requirements for quality and patient experience improvements

Maryland's Hospital Model



The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Maryland's All-Payer Approach to Delivery-System Reform

Rahul Rajkumar, M.D., J.D., Ankit Patel, J.D., Karen Murphy, Ph.D., John M. Colmers, M.P.H., Jonathan D. Blum, M.P.P., Patrick H. Conway, M.D., and Joshua M. Sharfstein, M.D.

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) and the State of Maryland jointly announced the launch of a statewide model that will transform Maryland's health care delivery system. Although some aspects of the new approach may be unique to Maryland and not applicable elsewhere, both the principles of this model and the process that led to its development may serve as a guide for future federal–state partnership efforts aiming to improve health care and to lower costs through an all-payer approach.

Since the late 1970s, Maryland has operated what is now the country's only all-payer rate-setting system for hospital services. An independent commission sets a rate structure for each hospital. All payers, public and private, pay for services according to these rates. Medicare's participation is authorized by the Social Security Act and is tied to a growth limit in Medicare payment per hospital admission.

This system has eliminated cost shifting among payers, more equitably spread the costs of uncompensated care and medical education, and limited the growth of per-admission costs. The system's historical performance in containing payments per admission for all payers has been notable.[1] However, in recent years, both the incentives created by Maryland's current Medicare waiver and changes in the delivery system have created unnecessary pressure to increase the volume of hospital services provided. This pressure, combined with the fact that Medicare pays higher rates for hospital services in Maryland than it does under the national prospective payment systems for inpatient and outpatient care, has resulted in per capita Medicare hospital costs in Maryland that are among the country's highest.

The new model, which is made possible by the authority granted to the Center for Medicare and Medicaid Innovation under the Affordable Care Act, will change the basis for Medicare's participation in Maryland's system. In place of the limit on per-admission payment, the new model focuses on overall per capita expenditures for hospital services, as well as on improvements in the quality of care and population health outcomes.

For 5 years beginning in 2014, Maryland will limit the growth of per capita hospital costs for all payers, including the growth of costs of both inpatient and outpatient care, to 3.58%, the 10-year compound annual growth rate of the per capita gross state product. Maryland will also limit the

"The boldest proposal in the United States in the last half century to grab the problem of cost growth by the horns."

– Professor Uwe Reinhardt, Princeton University

Maryland's original goal was to move, by the end of year 5, 80% of all hospital payment for state residents to global budgets.

By the end of the first six months, Maryland achieved 95%.

Approach to Moving to a More Patient-Centered System

Improving Patient-Centered Care

- Chronic Care & Care for Patients with High Needs
- Collaboration & Coordination Across Providers/Others
- Utilization of Patient-Centered Measures

Reducing Avoidable Utilization

- Maryland's Hospital Acquired Conditions
- PQIs: Prevention Quality Indicators
- Readmissions and Rehospitalizations

Ensuring Consumer Protections

- Global Budget Contracts
- Market Shift, Transfers, Transplants/Other
- Data Analytics: Detailed Monthly Reports on Volumes

Examples

School Health Program

At Meritus Health, we believe that all children are entitled to quality healthcare services and that good health helps support academic achievement. The Meritus Health School Health program serves the 22,000 students of Washington County Public School system in 27 elementary schools, eight middle schools and eight high schools. On average, our healthcare providers see 500 to 700 students each month in school health rooms.

Sinai Hospital and HealthCare Access Maryland Pioneer a New Program to Link Emergency Department Patients with Needed Services

Baltimore, MD – Sinai Hospital of Baltimore and HealthCare Access Maryland are piloting a groundbreaking program developed to proactively help patients, who frequently use the hospital's Emergency Department for non-urgent and chronic health conditions, better manage their own care, lead healthier lives, and in turn, save precious health-related resources.

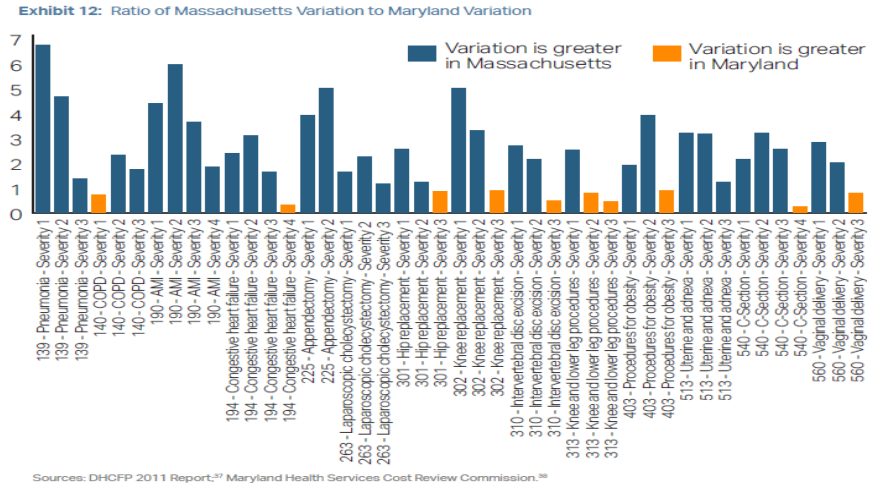
CRISP

Maryland Performance in Year 1 (CY 2014)

Performance Measures	Targets	CY 2014 Results
Hospital Revenue to Global or Population-based	≥ 80% by Year 5	> 95% in Year 1
All-Payer Revenue Growth	≤ 3.58% per capita	1.47% per capita
Medicare Savings in Hospital Expenditures	≥ $330m over 5 years	$116 in Year 1
Medicare Savings in Total Cost of Care	Lower than the national average	1.5% lower than national average
All-Payer Quality Improvement Reductions in Hospital Acquired Conditions	30% reduction over 5 years	26% reduction in Year I
Readmissions Reductions for Medicare	≤ National average over 5 years	.2% gap decrease vs national

Maryland & Price Variation

1. Rate setting meant rates varied but not because of market leverage
2. Naturally, less variation than elsewhere (good)



Source: MA Health Policy Commission

3. Price variation less relevant under global budgets where focus is aggregate spending

How do we create a system that supports a healthier population, appropriately rewards high-quality and efficient providers, and also reduces health care spending over time?

- Answer: Everyone in healthcare system should have aligned incentives for these goals.
- Key concepts:
  - Quality vs. outcome
  - Without hospital engagement, little chance of success
  - All-payer aligns incentives

How do we ensure that different parts of the healthcare system are included?

- Need actionable data for patient care and planning
- Provide opportunities to all for engagement
- Consider integration where possible: ACOs, etc.
- But may not be possible, in which case focus on aligning incentives.
- Even with global budgeting at hospital level in Maryland, planning involves all stakeholders

How can we accomplish a significant change in the health care payment system while supporting opportunities for health care providers to innovate and make decisions that affect their future?

- These two concepts may be linked
- Flexibility is important
- Global budgeting has advantage of being a framework that supports bottom-up implementation
- More thorough vertical integration can also accomplish this goal, but may be more disruptive
- Essential to have vision and then pursue it

Conclusions

- Price variation is an intermediate factor, not an end in itself.
- Reducing price variation in fee-for-service context doesn't necessarily control expenditures or improve outcomes
- Global budgeting and other major payment reforms that incentivize prevention are worth a look.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- HPC Staff Presentation: Direct limits on price variation
- Presentation by Dr. Joshua Sharfstein, Former Secretary of Maryland Department of Health and Mental Hygiene and Current Professor and Associate Dean of the Johns Hopkins University Bloomberg School of Public Health
- **Stakeholder Discussion**
- Next steps

Example questions for discussion

1. How do we create a system that supports a healthier population, appropriately rewards high-quality and efficient providers, and also reduces health care spending over time?

2. How do we ensure that different parts of the health care system are included (e.g. physicians, specialty providers, and populations beyond those in the small group and/or fully-insured markets)?

3. How can we accomplish a significant change in the health care payment system while supporting opportunities for health care providers to innovate and make decisions that affect their future?

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Contact Information

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