

"It's important to realize that, as with checkups, mortality is not the only outcome that matters," Aaron Carroll, MD, MS, vice chair for health policy and outcomes research in the Indiana University School of Medicine's pediatrics department, wrote recently in the JAMA Forum about the screening review (<http://bit.ly/1Arjz33>). "Trying to improve quality of life or reduce morbidity are also important outcomes."

Out of the Clinic and Into the Community

Although the physician-patient encounter should be the centerpiece for the delivery of preventive services, Shenson said, "clinicians are focused on their patient panels and do not feel that their role is a public health role. We need to bridge that gap."

The best way to do that? "Getting out to where people are in their daily life," said Kathryn Kietzman, PhD, MSW, a University of California, Los Angeles, research scientist who directs the ongoing Community Health Innovations in Prevention for Seniors (CHIPS) project, funded by the CDC. "If somebody's already thinking about prevention by going into the pharmacy to get a flu shot, that's a great opportunity to tap into the mindset of that individual." For

example, besides administering a flu shot, the pharmacist could ask whether the customer has been screened for colorectal cancer, Kietzman noted.

A program in San Francisco did just that, according to a recent CHIPS report (*Policy Brief UCLA Cent Health Policy Res.* 2014;[PB2014-6]:1-8). The program sought to promote colorectal cancer screening among people recruited at flu immunization clinics in select pharmacies. It compared providing home screening kits with only providing education about colorectal cancer screening and found that the former was more effective in raising screening rates (Potter MB et al. *J Am Pharm Assoc.* 2010;50[2]:181-187).

Another of the many programs described in the CHIPS report is one that enlists black women who've had breast and cervical cancer to bear witness at their churches about the importance of screening and refers women to low-cost mammography and cervical cancer screening (Erwin DO et al. *Cancer Control.* 2003;10[5 suppl]:13-21). Launched in rural Arkansas more than 20 years ago, the Witness Project is now a national nonprofit with 18 active sites, said co-founder Deborah Erwin, PhD, director of the office of cancer health disparities research at the Roswell Park Cancer Institute.

A third program mentioned in the CHIPS report is Vote and Vax, one of the biggest projects of Sickness Prevention Achieved Through Regional Collaboration (SPARC), a Connecticut-based nonprofit agency working on expanding the population-wide use of preventive care (<http://bit.ly/17yGdj1>).

Vote and Vax, funded by the CDC, partnered with local pharmacies around the country to administer flu vaccine, for a fee. Some of the vaccination clinics were adjacent to the polls, while others were in nearby pharmacies.

Because it falls in November, Election Day is the perfect time to immunize people against the flu, Shenson noted. Besides 2012, Vote and Vax also operated during elections in multiple states in 2004, 2006, 2008, and 2010, taking 2014 off to analyze the data it had collected, Shenson said.

"We are definitely hoping to be active in 2016," he said. "We're now ramping up our search for funding."

Shenson sees no reason to stop at flu shots. Vote and Vax also could offer pneumococcal vaccination and the opportunity for voters to make appointments for screening tests.

"I'm not diminishing the role of the doctor-patient connection within the clinician's office," Shenson said. But he said, "we will not protect everyone as best we can if we rely exclusively on that model." ■

The JAMA Forum

Payment Reform Is About to Become a Reality

David M. Cutler, PhD

The US Department of Health and Human Services (HHS) continues to take major steps toward transforming the payment system for Medicare. After hinting about a new payment reform plan in September (<http://bit.ly/17cQ2mz>), HHS Secretary Sylvia Mathews Burwell put out more specifics in late January.

Secretary Burwell's proposal calls for 30% of Medicare payments to be based on non-fee-for-service models by the end of 2016, and 50% to be so by the end of 2018 (<http://bit.ly/15LuMEh>). By comparison, such payments did not exist in 2011 and account for about 20% of Medicare payments today. In addition, the Secretary intends to have 85% of Medicare fee-for-service pay-

ments tied to quality or value in some fashion by the end of 2016.

Make no mistake: this is major news. Medicare is the largest health care purchaser in the country, so these changes matter a lot. In addition, many private insurers that have been hesitant about payment reform are likely to follow Medicare's lead. Payment reform is about to become a reality.

Cautious Reactions

Secretary Burwell did not announce specifics about new payment models. This lack of specificity may explain the cautious reaction of professional societies to the news. The president of the American Medical Association, Robert M. Wah, MD, stated



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(<http://bit.ly/1vRfERJ>), "We look forward to hearing more details behind the percentages HHS put forward as well as their plans to reach these percentage targets." The executive vice president of the American Hospital Association, Rick J. Pollack, MPA, said in a statement (<http://bit.ly/1yPcYyw>), "We look forward to learning more from HHS on how these new goals will be phased in. At the same time, we encourage the Administration to fully evaluate and improve on the delivery system reforms currently in place.... Moreover, we need to phase in changes in a thoughtful manner that is tailored to the specific needs of individual communities."

In making these goals concrete, HHS might proceed in several ways.

One path is to create incentives that spur more providers to join accountable care organizations (ACOs). More than 400 organizations currently participate in one of Medicare's 2 ACO programs (<http://go.cms.gov/1DoDlu1>), and even more participate in similar private programs. The outcomes of the federal ACO program have been mixed. Cost and quality targets have been met, but a number of providers have left the program. Far more success has been achieved in some of the private models. For example, the Alternative Quality Contract run by Blue Cross Blue Shield of Massachusetts realized cost savings (<http://bit.ly/1AxWjql>) of nearly 10% by its fourth year of operation, while at the same time improving quality.

Second, HHS could more aggressively push bundled payments for episodes of acute care. A relatively small share of conditions account for a large share of Medicare spending (50% of spending is accounted for by the top 17 conditions) (<http://bit.ly/1DjX9rd>). This includes common forms of cardiovascular disease and musculoskeletal impairments. There are bundled payment models already developed for patients with many of these conditions, including those receiving coronary bypass surgery (<http://1.usa.gov/1BiekJ3>), patients with common cancers (<http://bit.ly/1zjTV0l>), and those undergoing elective joint replacements (<http://bit.ly/1vRh7qY>). Such payment systems generally group together preoperative care, the acute-phase treatment, and postacute care such as rehabilitation and nursing home use. The Congressional Budget Office has found significant savings associated with bundled payments in the Medicare program (<http://1.usa.gov/1L566nB>), and there are savings in private

sector programs (<http://bit.ly/1A10xaR>) as well. The Center for Medicare and Medicaid Innovation already has a Bundled Payment for Care Improvement demonstration program (<http://1.usa.gov/1le2DbC>). One straightforward reform would be to extend the programs there into a mandatory, nationwide program.

Third, HHS can tie more of its fee-for-service payments to quality indicators. Some of the quality programs enacted to date have been very successful. For example, the readmission rate in the Medicare population has declined by 8% in the 2 years since the readmission penalty was implemented. Similarly, hospital-acquired infections are down by as much as 50% in the past few years, at least partly because of nonpayment by Medicare and private insurers. Most of these value-based payments are on the hospital side. An obvious extension would be to make quality a condition for physician reimbursement as well.

Hard Work Needed

Although cost savings from payment reform are possible, they are not automatic. Indeed, achieving cost savings requires hard work from physicians, nurses, and other care providers. Consider the example of a bundled payment for an episode of care, such as for joint replacement. Under such a system, hospitals and physicians can save money by standardizing order sets, using such standardization to bargain for lower costs from suppliers, preventing infections or unnecessary readmissions, and discharging patients to less-intensive settings (if warranted).

Clearly, hospitals and clinicians will need sophisticated information systems to take maximum advantage of these opportunities. Equally important are personal interactions. Surgeons need to work carefully with nurses and discharge planners to ensure a smooth flow of patients throughout the care experience. And finally, such innovation may require changes in how physicians are compensated. If health systems are no longer paid on the basis of the volume of services provided, these groups will not be able to sustain pure volume-based compensation models for physicians.

A fascinating recent study in *Healthcare* (<http://bit.ly/1sMqhmS>) examined how 10 leading health systems (as defined by reputation) paid their staff physicians. Five organizations paid a salary without produc-

tivity adjustment; 5 more had a salary payment with modest productivity adjustment (generally less than 10% of total compensation) defined by quality, service, patient volume, and teamwork. In all of these cases, the lack of strong fee-for-service incentives allowed these other organizational goals to be more prominent.

The difficult internal work of adjusting to a changing world may partly explain why programs such as the Medicare Pioneer ACO program has realized large savings (<http://1.usa.gov/17Kjf9q>) in some settings (5.8% for the 3 highest savers), but more modest savings overall (1.6% on average). It may take time for institutions to learn how to adapt.

The recent HHS announcement anticipates some of these problems. At the same time Secretary Burwell announced the payment reforms, she also announced an \$800 million Transforming Clinical Practice Initiative to provide "hands-on support to 150 000 physicians and other clinicians for developing the skills and tools needed to improve care delivery and transition to alternative payment models." How will this program work? Will it be enough? No one knows the full answer to these questions.

I believe the capacity for system improvement is there (<http://amzn.to/1FVjmtN>), and thus I am optimistic about what this payment change portends. But we are about to get a real-world trial to find out for sure. ■

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