Towards a Shared Vision Of Payment Reform

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Executive Summary

During the past several years a reform movement that seeks to confer accountability for the costs and outcomes of health care on organized groups of providers has been underway. Two key concepts are integral to this movement: (1) global payment, and (2) the accountable care organization (ACO). Global payment refers to reimbursement based on a set budget or target spending for a population. Global capitation is one form of global payment in which the payer pays a fixed amount per capita to cover all health care services needed by the population for a period of time. At the other extreme, a shared savings arrangement based on a global spending target confers only "upside" risk on providers. In practice, a continuum of possibilities exists with stop-loss, risk corridors, and risk sharing arrangements carving out portions of financial risk to be borne by providers and health plans. An ACO is loosely defined as any provider entity with the capabilities to manage both the financial risk associated with global payment and the health care needs of the population.

The 2010 Affordable Care Act, signed by the President on March 23, 2010, introduced a series of policy changes in Medicare that may promote global payment and ACOs. Framed by federal policy reforms that promise a gradual shift away from reliance on fee for service by Medicare, a debate about how far and how quickly parallel changes in payment and organization should proceed in Massachusetts is taking place. In many respects, the state is on the leading edge of both payment reforms that confer accountability for populations to providers and new models of care that are patient-centered and integrated. At the same time, we face unique challenges to diffusing global payment and transformative changes in care delivery due to market structure and the importance of academic medical centers to the state. While commercial insurers have already begun working with large provider systems on new contracting models, the state government, in its capacity as both purchaser and regulator is contemplating policies to support and shape both the risk sharing contracts and the provider arrangements that are viewed as essential to managing care both more effectively and efficiently.

While most physicians recognize the need for reform, the pace of change and the lack of evidence to support best practices in payment and delivery reforms has been cause for concern in this sector. In particular, little is known about what kinds of organizations can serve most effectively as ACOs or how payers should optimally structure risk-sharing arrangements. In the interest of promoting effective and sustainable policies that will help maintain affordable, high-quality quality care in Massachusetts, the Massachusetts Medical Society convened a symposium to educate and engage physicians on payment reform and accountable care organizations (ACOs) in October 2010. This report summarizes both the presentations and discussion from the conference, "Toward a Shared Vision of Payment Reform."

Presenters highlighted both the potential benefits and risks of ACOs and payment reform for the Commonwealth. While there were many common themes among the various participants no single model of ACO structure or payment incentive design was held up as a model. Indeed, there was a general acknowledgment that no evidence-based treatment for the problems of fragmentation, waste, and poor quality yet exists. Clear requirements for the process by which reform should proceed were identified directly or indirectly throughout the day, however. In particular, the design and implementation of reform must be: (1) transparent (to providers and patients), (2) flexible, (3) locally tailored with respectful engagement of physicians, (4) undertaken through pilots with evaluation and dissemination of best practices, (5) accompanied by timely data sharing from payers to providers and throughout referral networks, and (6) supported by resources adequate for providers and payers to make the transition to new models.

It has become almost a cliché to preface discussions of health care reform with the

observation that the rate of growth of health care spending in the U.S. is unsustainable, as the sector consumes an ever-larger share of the gross domestic product. The reality, however, is that the need to slow the growth of health care spending is more urgent than ever. The costs of failure to do so include destabilization of national and state efforts to achieve universal health insurance coverage, increasingly painful tradeoffs with other public spending priorities such as education, welfare programs, and infrastructure, and suppressed growth in cash wages.

Controlling health care spending will require difficult choices. As an overarching matter, in any cost control effort policy makers and private decision makers need to ensure that the value of health care spending (i.e. health benefits at a given level of cost) is preserved or improved to the extent possible. This principle animates current efforts by physicians and health care policy experts to seek cost saving opportunities from better coordination and integration of care and the elimination of low-value practice patterns. Such approaches to improving the value and reducing the cost of health care require systematic reengineering of the delivery system and investments in both human capital and infrastructure. Provider entities that would form the basis of this reengineered delivery system have been dubbed “Accountable Care Organizations” (ACOs). A variety of visions have been put forward about the appropriate scope, capabilities, and roles for ACOs.

The debate about ACOs – what they are, what we want them to be – overlaps considerably with a broader discussion about the need to reform provider payment as a necessary element of cost control. It is widely believed that payment in health care relies too heavily on fee for service and this emphasis encourages over use of high-cost services, fragmented, and wasteful care. Reform of this system would entail payment related to larger “baskets” of care, including global payment (i.e., a budget or spending target that ties incentives to total costs for a population), and payment related to outcomes or value of care. These payment approaches in turn require that there be providers that could both manage financial risk and implement clinical systems to improve patient care and control costs. In other words, payment reform as currently envisioned requires some variety of ACOs to step forward or be built from the ground up.

Payment reform would also require major changes in health plan operations. If providers are to contract on the basis of population costs at a minimum they need information from payers about health care utilization and costs of care outside of their direct control (e.g., emergency room visits, hospitalizations, care delivered to their patients by other physicians).

State and federal policy makers have already proposed and implemented provider payment reforms that move towards broader accountability for costs and value. The Patient Protection and Affordable Care Act of 2010 takes a formidable step in this direction by creating a new program within Medicare to contract with ACOs (minimally defined) and share savings that accrue from ACO activities. The Massachusetts Health Care Quality and Cost Council Committee on the Status of Payment Reform Legislation has been holding a series of public meetings since September 2010 to outline next steps for health care reform and to draft an outline of legislation to implement comprehensive payment reform, with a clear focus on facilitating the development of ACOs.

While many details about ACOs and the payment reforms designed to promote this form of health care delivery remain unclear, almost surely the proposals will call for a significant departure from the status quo. Not surprisingly then, physicians among other professional and institutional providers, have concerns about both the pace and direction of these policies and want to participate meaningfully in the debate. To this end, with funding from the Commonwealth Fund, the Massachusetts Medical Society (MMS) convened a conference in October 2010 to examine both the premise of current payment reform efforts and a range of issues that arise in the design and implementation of these policies. This report summarizes the content of this

conference and the major themes that emerged both from speakers and audience participants.

What do we need to know for reform to succeed?

With the goal of both educating its members about developments in payment reform and giving them a voice in the debate, the MMS invited national and local speakers to share a variety of perspectives on both the payment and delivery system aspects of reform. The questions around which the various presentations and discussion opportunities were intended to revolve were the following: What will ACOs look like: size, structure, minimum requirements? How do we make the case for providers (physicians and hospitals, others) to want to form ACOs? What should the payment model(s) be? How can we protect against/mitigate adverse effects? Such unintended effects include the potential for both patient harm – through risk selection, for example – and harm to the delivery system, by for example eliminating cross-subsidies that sustain essential, but money-losing services. What is the role of government? In particular, how should the Commonwealth proceed? How do we effectively transition from the current system to the ideal of accountable care? This last question about the "glide path" to reform was picked up by many conference participants. In his opening remarks, Stuart Guterman from the Commonwealth Fund put it best: "We know where we are, where we want to get to, but very little about how we get from here to there."

Dr. Guterman laid out the agenda for the conference by first noting the familiar litany of problems with the health care system: fragmented care, lack of accountability, variable quality, and high and rapidly-growing costs. He drew the audience's attention to the essential complementarity between policy solutions involving greater "bundling" (i.e., more prospective and less fee for service payment) and pay for performance and organizational structures in the delivery system. Payment reforms that transfer substantially greater accountability to providers for costs and outcomes are only feasible where there is sufficient organizational capacity to manage risk, quality, and the continuum of care. The challenge for policy is to make parallel progress on payment approaches and infrastructure, organizational change in the delivery system. He ended on a note of optimism, citing the seeds of reform embedded in the recent federal legislation and the projected impact these changes will have on spending growth.

Lessons from entities that embody ACO-like features

The first panel of the conference drew on the experience of two provider organizations that are viewed as national models of accountable care: Geisinger Health System (Geisinger) and Sutter Health. Both organizations accept global payment for at least a portion of the patients they care for and oversee a diverse network of physician practices and hospitals.

Geisinger is an integrated delivery system with a related HMO, an employed medical group, and a large network of contracted physicians and hospitals in rural Pennsylvania. Sutter Health is a network of physician groups and hospitals in Northern California. Panelists described successes and challenges they had encountered in their efforts to deliver better, lower cost care. These examples highlight the kinds of capabilities and programs ACOs will need to have or develop to be effective.

Howard Grant, then CMO of Geisinger, (now CEO of Lahey Clinic) offered three takeaways from their experience for successful ACOs: reorganization of health care delivery to make it proactive, a healthy relationship with a health plan/payer to provide timely data and expertise, and deployment of health information technology (HIT) to engage providers and patients. These ACO requirements for success were brought into relief through descriptions of a number of flagship initiatives of Geisinger including ProvenCare acute care episode payment, ProvenCare Navigator (a model akin to the patient-centered medical home) and several high-risk care management programs. All of these efforts, which are

precisely the types of programs ACOs are intended to develop, required sophisticated data analysis, decision support and engagement of physicians in both design and implementation. Dr. Grant further noted that Geisinger's ability to innovate around population health management owed a great deal to their organizational commitment to quality at all levels. As one example, he noted that executives were compensated in part based on the quality performance of the organization.

Because Geisinger is an integrated delivery system with a related HMO, Dr. Grant addressed the question of whether their results could be replicated without legal integration of providers, and separately whether they could have engaged an unrelated payer in their payment experiments. In his view, legal integration of providers is not essential; indeed, he observed that Geisinger's experience suggested that freestanding practices are more nimble and motivated than employed physicians. HIT investment, however, he did believe was critical for population management. Finally, he noted that a true partnership between payers and providers is required to make progress with new models of care and accountability. While this is more likely with a related payer, in theory this could be accomplished with an arm's length relationship.

Michael Van Duren from Sutter Health, a very large and more loosely integrated system in Northern California, focused his message to the audience on their model of physician engagement with quality and efficiency improvement. Sutter has focused on respectful engagement of physicians that leverages their intrinsic motivation, as compared to the carrot and stick model of behavior change, which operates on extrinsic motivation. Dr. Van Duren's message, which has some support in the behavioral psychology literature, was that over-reliance on extrinsic incentives (e.g., pay for performance) risks devaluing and dampening intrinsic motivation. Instead, he described a strategy to mobilize intrinsic motivation through training, feedback, and collaboratively sharing trusted data. While the remainder of his presentation illustrated how Sutter uses data to identify and change low-value practices, Dr. Van Duren noted "It's not the data, it's what we do with it" that matters. Specifically, he described a very localized process whereby small groups of physicians gather in a private, non-judgmental setting to compare practice patterns around types of episodes (e.g., headache), letting the physicians decide what to look at and identify projects to work on with measurable goals.

Dr. Van Duren's description of Sutter's processes suggests several insights for designers of ACOs. First, to the extent that Sutter's experience generalizes and intrinsic motivational approaches are critical, ACOs might be well-positioned to engage physicians in this way because they are provider-sponsored organizations (health insurers likely cannot mobilize sufficient trust do this in most cases). Second, cost control efforts would need to be pretty localized – within a specialty, within a group of physicians that share trust and mutual respect. Important remaining questions include specific issues around how groups within an ACO would be identified or formed and whether physicians would have incentives to join a group and/or share in any savings produced by the group's work.

Experience with Accountable Care in Massachusetts

Closer to home, a number of payers and providers already have experience with risk contracting and organizing systems of care to improve coordination and patient management. Several leading local organizations discussed their experiences and talked about the promise and challenges to spreading accountable care models more broadly.

The largest payer in the Commonwealth, Blue Cross Blue Shield of Massachusetts (BCBS-MA) established a new contracting model with providers in 2008. The Alternative Quality Contract (AQC) is an arrangement whereby a global budget is set for health care. Contracts are signed for a five-year period with annual adjustments to the budget based on the rate of general inflation. Performance incentives related to

quality of care may also be paid, depending upon the organization's ability to meet any of a series of "gates" or thresholds of performance. Roughly 25% of BCBS-MA's HMO enrollees are attached to a primary care physician covered by the AQC. Dana Safran, Senior Vice President for Performance Measurement and Improvement for BCBS-MA, described the plan's efforts to engage providers in partnership around performance measurement, through providing both data and technical resources to practices. Like Sutter, their approach has been to provide the resources but allow physicians and systems participating in the AQC to exercise discretion in identifying low value/high cost practices to work on. According to Dr. Safran, the ongoing flow of information from the plan to practices key to the success of providers under the AQC, who otherwise would have an incomplete picture of patient care.

Dr. Gene Lindsey, President and CEO of Atrius Health (Atrius) was the next presenter, offering insights from the perspective of a large physician organization with a comparative advantage in managing health care under a budget. Atrius, a non-profit alliance of physicians in Massachusetts, is a party to the AQC and has long experience with risk contracting. More than 25% of the approximately 700,000 patients cared for by Atrius are reimbursed under risk contracting arrangements.

Atrius physicians share an electronic medical record (EMR), which Dr. Lindsey viewed as central to their ability to manage patients and control costs. Despite its usefulness, Atrius found that its medical record had become cumbersome over time, as a result of serial custom projects. Simplification of its EMR (through returning to the standard version of EPIC) was one outcome of a strategic planning process that identified both infrastructure and workflow changes that were needed for Atrius to effectively manage populations. An overarching component of the reform efforts recently implemented by Atrius has been to use LEAN management principles to make more effective use of resources. In addition, Atrius has been focused on improving the job design of physicians both to improve professional satisfaction (particularly critical in light of workforce shortages) and efficiency. Team-based care in the model of the advanced medical home and shared medical appointments are specific examples of changes implemented by Atrius that alter both the content and the roles of non-physician professionals in the delivery of health care.

Dr. Lindsey emphasized that Atrius' strengths derived not only from its infrastructure and ability to use data and information for care management, but from its organizational culture, which rests on strong physician leadership, peer-to-peer feedback, and a collaborative approach to quality improvement. In noting this philosophy, Dr. Lindsey concurred with previous speakers on the need to engage physicians based on professionalism rather than extrinsic incentives. Looking ahead, Atrius aspires to be a successful ACO, without a single hospital partner but in collaboration with hospitals and other providers in the market. Consistent with this aspiration, Dr. Lindsey also noted that Atrius would continue its work to integrate its clinical operations and improve care delivery using LEAN principles.

The Mount Auburn Cambridge Independent Practice Association, a provider with a similarly long history of risk contracting in Massachusetts, presents an interesting contrast to Atrius. MACIPA is made up of private practice physicians with a strong hospital partner (Mt. Auburn Hospital). Dr. Barbara Spivak, president of MACIPA, reflected first on keys to their success managing risk contracts. First, she noted that both the hospital and IPA believed that managed care was better care and were committed to working together with mutual respect. Dr. Spivak emphasized that the focus needed to be on quality, rather than cost, but that efficiencies would follow from improved quality. In her experience, changes in practice would follow from sharing data and information with physicians, with financial incentives playing a secondary role.

MACIPA's 25 years of experience with developing an infrastructure and organization to manage risk contracts is instructive about the challenges newly emerging ACOs will face. First, Dr. Spivak noted that implementing a common EMR across a network of small, private practices would be difficult and expensive. Second, culture change is difficult for physicians, particularly change that affects professional roles and responsibilities such as team-based care models. Moreover, patients may be reluctant to accept some of these changes, particularly if they alter the physician-patient interaction. All of these changes take time – MACIPA's programs have evolved over 25 years. ACOs, Dr. Spivak warned, will not appear overnight.

A Model for Statewide Delivery System Reform: Vermont

Vermont, like Massachusetts, has made health care policy a central component of state policy in recent years. Contemporaneously with Massachusetts' ambitious coverage expansion, Vermont set two major objectives for its own statewide reform: cover the uninsured and make it sustainable. In contrast to Massachusetts, Vermont policy makers decided to work on sustainability in parallel with a less ambitious coverage initiative.

The affordability reforms Vermont elected to test were a combination of payment and structural changes, beginning with a model of patient-centered primary care. James Hester, Ph.D., director of the Vermont Health Care Reform Commission, noted that while payment reform is necessary it was not sufficient to transform care delivery. A major component of Vermont's "Blueprint for Health" is comprised by the notion of "Systemness." According to Hester, systemness was Vermont's way of thinking about the need to create ACOs. Systemness requires: service integration, financial integration, governance, shared information, and process improvement capabilities.

In the first phase of its delivery system reforms (focused on primary care) Vermont adapted a patient-centered model that would work for small rural practices. In particular, they created networks of providers with teams that care for about 25,000 patients, with the specifics of staffing determined locally. The second phase of this reform will bring in specialists and hospitals under ACOs and is intended to allow these provider groups to retain some of the "savings" (revenue loss) from improved care management to reengineer what they do to better meet the needs of the community.

Vermont now has several years of experience organizing delivery system and payment reform. Dr. Hester distilled what he viewed to be the key lessons from their experience. First, such transformative changes require pilots with ongoing evaluation to support rapid-cycle improvement. While some aspects of care delivery and payment models can be designed based on evidence (e.g., the Chronic Care Model, a core element of most patient-centered medical home pilots, has been demonstrated to improve quality and patient experience), too little is known about how to combine these elements and implement reform in the most effective manner to warrant full-scale policy changes. Second, there can be no single solution; building in local flexibility is essential. Provider capacity and population preferences should be considered among other factors that should drive local solutions.

The Legal Landscape

Federal and state health care reimbursement policies are pushing providers towards alignment and integration (both horizontal and vertical) but other policies constrain or prohibit alignment and integration. In particular, antitrust rules and enforcement directly impinge on the ability of providers to form alliances for contracting purposes. Various fraud and abuse provisions that relate to Medicare also have implications for permissible models of shared accountability. Sara Rosenbaum, Harold and Jane Hirsh Professor of Health Law and Policy and Chair of the Department of Health Policy at the George Washington School of Public Health and Health Services, a leading authority on health care law, described the applicable legal frameworks,

the challenges they pose, and previewed possible reforms.

Antitrust

Antitrust policy as applied to integrated health care organizations in based on the rule of reason (i.e., each case is judged individually). Organizations that: (1) take substantial financial risk for managing care, are not too large, and demonstrate value, or (2) have essentially no market power and demonstrate clinical integration (substantial ongoing activities to improve the quality of care) without taking risk will survive antitrust scrutiny.

According to Prof. Rosenbaum, given the urgent demand for delivery system reforms to address fragmented, increasingly unaffordable care, a liberal interpretation of the rule of reason is needed to allow larger organizations to form, at least to test whether they can deliver greater value. Antitrust policy at the federal level should be informed by and aligned with the policies of Health and Human Services including promotion of "meaningful use" of information technology, formation of accountable care organizations, and patient-centered care. States also play a role in antitrust enforcement. In this capacity, some states are contemplating a statute that would sanction ACOs, regulate them and shelter them from antitrust liability.

Fraud and abuse

In addition to antitrust policy, federal laws designed to prevent fraud and abuse in the Medicare program may thwart efforts to share accountability, particularly among legally independent providers. The sharing of savings among unrelated providers is currently hindered by legal provisions designed to protect the quality of patient care from being compromised by financial motivations.

The central provisions that prohibit certain kinds of payments between providers are the Civil Monetary Penalty Act, the Stark Act and the Anti-Kickback Statute. While these statutes effectively ban many forms of payment or shared savings between unrelated providers, the enforcement agencies have some scope for permitting exceptions. Currently there are some safe harbors for ACO-like activities that would violate the Civil Monetary Penalty Act, Stark, and the Anti-Kickback Statute. Moreover, the Affordable Care Act of 2010 permits Health and Human Services to develop additional safe harbors. Progress in this direction may be particularly important to allow hospitals and physicians to collaborate effectively around readmissions and other quality or efficiency problems that cross boundaries between institutional and community care settings.

What Role for the State Government in Payment/Delivery System Reform?

An underlying current of the conference was the need to delineate the role in reform for the state government in its dual capacity as purchaser and regulator. Arguably, market forces have already made significant inroads into reshaping health care contracting in Massachusetts along the lines of the ACO model. Given the progress to date of Atrius, MACIPA, BCBS-MA and others like them, how can state policy most effectively sustain and improve the ability of the delivery system to deliver effective and affordable patient care? Judy Ann Bigby, the Massachusetts Secretary of Health and Human Services articulated the timeline and high-level policy goals for this process.

The Massachusetts Special Commission on the Health Care Payment System was established by Chapter 305 of the Acts of 2008. The Commission was charged with proposing a common payment methodology and recommending steps whereby the state could promote the implementation of this payment approach across the delivery system. In July 2009, the Commission issued its broad recommendations, which identified global payment (also known as capitation) with appropriate adjustments to promote quality (including but not limited to pay for performance and risk adjustment) as the goal towards which the state should be working. The Commission's report recognized that numerous policy and infrastructure changes would be necessary

to accomplish this vision with the collaboration of providers, payers and the Commonwealth.

In articulating the Commonwealth's approach to reform, Dr. Bigby noted: "First of all it is very clear that we need a balance between regulating conditions of change and promoting innovation and flexibility and that is a very common theme." Throughout her presentation, Dr. Bigby returned to the theme of pluralistic approaches to reform: "We believe ACOs should be very diverse." Similarly, Dr. Bigby underscored the need for a continuum of payment options to be available to payers and providers, including fee for service, where appropriate.

Dr. Bigby summarized the Commission's findings and noted that they include a role for the state in establishing an oversight board to guide and monitor implementation. In this oversight role, the state will balance the need to promote innovation through flexibility against the need to protect consumers and providers, particularly in the safety net context. Some responsibilities of the oversight board will include establishing minimum requirements of ACOs, rules for risk sharing arrangements and data reporting requirements that will permit identification of both best practices and problems. The Board would also tackle issues such as the payments for teaching, safety-net subsidies, and services that should be carved out of global budgets.

Beyond regulatory oversight, the Commonwealth can also facilitate reform through its role as a payer. Just recently, Dr. Bigby noted, the Commonwealth received approval from the Centers for Medicare and Medicaid Services to use Medicaid dollars to fund transitional payments to providers under a yet to be determined payment reform plan for Medicaid (MassHealth). In the future, Health and Human Services might apply for a Medicare waiver to allow Medicare beneficiaries to be included in specific ACO or medical home pilot projects. Finally, the Commonwealth may identify complementary policies such as antitrust or fraud and abuse law safe harbors that are needed to facilitate reform.

How do we get there from here?

To a large extent presenters at the "Toward a Shared Vision of Payment Reform" conference offered up enticing examples of the benefits that ACOs and global payment might engender in a reformed health care system. But they also highlighted the challenges and caveats that must be recognized in generalizing their experience to the delivery system as a whole. Moreover, it was clear that even among market leaders in managing care under global payment, there was still work to be done in such diverse areas as physician engagement, effective deployment of information technology, capture of data from third party sources (e.g., health plans), and support for patient self-management.

One recurrent theme of the day was the need for flexibility and a multiplicity of both payment and organizational solutions. Locally tailored models of payment and delivery will be required not only to address underlying differences among communities but also to provide an opportunity to engage physicians and other providers as partners in developing local reform solutions. This latter point picks up on the second major theme of the day: new methods of respectfully engaging physicians and other providers in the work of cost control and quality improvement are needed. It will be critical to approach both the design and implementation of reform with a process that is transparent and encourages trust. If audience reactions are any indication, payers and policy makers have work to do to overcome the current failure of trust and skepticism about the goals and means of payment reform.

There are important roles in supporting reform for: government, primary care physicians, specialists, hospitals, employers, payers, and patients. Both state and federal policy makers and regulators have much to do to promote ACOs and also permit them sufficient flexibility to operate effectively (e.g., antitrust) while protecting patients and providers. Providers across the continuum of care are being asked to transform the way they deliver care and to eliminate waste. Employers and payers need to change the

way they provide health benefits to support provider reform – through benefit design and "service bureau" activities such as routine reporting of utilization data to providers.

The patient's role in making payment reform successful is perhaps most critical but least well defined. One speaker noted the "…essential aspect of longitudinal patient involvement" for cost control and quality improvement. ACOs, however, have been sold to policy makers in part based on no patient lock-in (i.e., no gatekeeping) despite the ACO being financially rewarded based on total cost. Dr. Van Duren embraced this challenge, stating: "In the new world, ACOs shouldn't count on patient lock-ins but instead should try to win patient loyalty by delivering better patient experience."

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In summary, what emerged from the daylong conference was an acknowledgement of both the opportunities and risks of payment reform in the Commonwealth. As yet, there is no evidence-based treatment for the problems of fragmentation, waste, and poor quality that ACOs and global payment are being proposed to address. In this circumstance, the process by which reform proceeds is critically important to its success. In particular, the design and implementation of reform must be: (1) transparent (to providers and patients), (2) flexible, (3) locally tailored with respectful engagement of physicians, (4) undertaken through pilots with evaluation and dissemination of best practices, (5) accompanied by timely data sharing from payers to providers and throughout referral networks, and (6) supported by resources adequate for providers and payers to make the transition to new models. Finally, all presenters and discussants at the conference agreed that a truly collaborative effort among payers, providers, and government would be needed to identify and implement effective reform.

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