Psychiatric Reimbursement Reform in New York State: Lessons in Implementing Change

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With deinstitutionalization, states increasingly rely on general hospitals for acute inpatient psychiatric care as the shrinking supply of their public mental hospital beds is converted for intermediate and long-term care. Restructuring the inpatient mental health sector and assuring connections to a range of community care programs and social services pose formidable challenges to public authorities and general hospitals, as they simultaneously address cost control, patient access, and quality of care (Hogan 1992; Mechanic and Surles 1992). Developing the needed inpatient and outpatient service capacity on a widespread basis that extends beyond demonstration programs, especially for those with serious and persistent mental illness, and assuring a continuum of care and coordination among diverse programs have been difficult objectives (Dill and Rochefort 1989; Kiesler and Sibulkin 1987). These challenges are compounded significantly in the complex environments of large cities with their multiplicity of public, nonprofit, and private providers, innumerable funding streams, and large disadvantaged patient populations whose social and economic resources are limited. It is apparent that making deinstitutionalization more than an empty promise will require consolidating compatible and

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mutually reinforcing strategies (Mechanic 1991). Reimbursement policy is a key element in any approach.

In this article, we examine the failure of an innovative and ambitious effort in New York State to modify patterns of psychiatric care by restructuring reimbursement for hospitals and outpatient providers. The goals of this initiative were, for the most part, consistent with a shared view among mental health professionals and hospital psychiatric staff regarding needed changes in the care of persons with severe and persistent mental illness. Yet, despite initial enthusiasm and considerable goodwill among the hospitals and professionals involved, the impact of these reimbursement changes was small.

As health care reform proceeds, there will be increasing efforts to structure incentives for cost-effective and high-quality practice through financing and regulatory structures. Designers of public policy either explicitly or implicitly base their work on behavioral assumptions of how policy initiatives affect decision makers at varying organizational and practice levels. These theories, however, often fail to capture the true complexity of the organizational systems to which they are directed, the various motives of the persons whose behavior they are trying to change, and the different stages of the implementation process (Pressman and Wildavsky 1979). Here we relate a cautionary tale of the numerous ways in which a seemingly sensible and intuitively appealing set of interventions lost focus and force in the context of a complex health care environment that reflected the competing pressures on hospitals and mental health professionals.

The Context

In 1989, the New York State Office of Mental Health (OMH), in cooperation with the state's Department of Health and an advisory group representing the hospital industry and the psychiatric community, implemented a multifaceted strategy for reimbursing mental health services. This regulation, the Consolidated Inpatient and Outpatient Psychiatric Rate Methodology (CIOPRM), changed the mental health reimbursement system to meet four major objectives:

1. Expand access to acute inpatient care in general hospitals, especially for persons with serious and persistent mental illness, while limiting the addition of expensive new psychiatric beds.

2. Encourage more appropriate lengths of stay by reducing long stays and extending very short ones.
3. Facilitate continuity of inpatient and outpatient care and timely linkage of patients to outpatient services.
4. Increase the intensity of outpatient care directed especially to persons with severe, persistent illness and reduce inpatient recidivism.

Each element of the reimbursement regulation was designed to address significant problems in the New York State mental health system. Unlike Medicare's prospective payment system, CIOPRM was not intended to contain costs initially, although a successful outcome was expected to facilitate the continuing reduction of costly state hospital beds. Under the payment system, OMH anticipated modest annual increases in revenues going to general hospitals and outpatient programs.

The first implementation phase of the payment system began in October 1989 for 27 of the state's approximately 100 acute-care hospitals with inpatient psychiatric units. The remaining 75 percent of the hospitals would join the system over the next three years. The second phase of implementation was delayed, but another 25 hospitals entered the reimbursement system in July 1991. No further hospitals entered the system, although all hospitals with a psychiatric outpatient department could benefit from rate premiums for outpatient care given to specified groups of the Medicaid population. Currently, the reimbursement system is being revised in light of these and other analyses of its impact.

Background to New York State's Psychiatric Reimbursement Reform

Beginning in 1986, New York State's OMH, together with members of the state's hospital and mental health constituencies, initiated the Alternative Reimbursement Methodologies (ARMs) project to design a patient classification and payment scheme that could be implemented for Medicaid, Blue Cross, and other non-Medicare payers. An alternative payment system for inpatient psychiatric care was needed once the state's Department of Health converted from hospital-specific per diem rates for all disorders to case payments that excluded psychiatry.

In the early years of the ARMs project, OMH sought to develop a workable classification system for reimbursing inpatient stays. In one of the largest funded research projects for modeling alternatives to psy-

chiatric DRGs, OMH collected detailed clinical, functional, and sociodemographic data on 2,226 patients and on varied measures of resource consumption in 70 hospitals throughout the state (New York State Office of Mental Health 1987). Developing a meaningful and administratively feasible patient classification system produced results no better than those observed in other studies of alternative psychiatric patient categories (Horgan and Jencks 1987). The eight ARMs groups that were constructed performed only marginally better than the psychiatric DRGs, by explaining only 12.5 percent of the variation in length of stay. Strong objections to these early clinical groups by the hospital industry and psychiatric community delayed development of a new classification and reimbursement system.

During the second stage of this project's development, the scope of the payment system's goals was broadened to address not only case mix, but also critical issues in discharge planning, linkage with aftercare, and readmissions while de-emphasizing the empirical basis of the patient classification system. As beds in state institutions were being rapidly reduced, OMH had to ensure access to general hospitals and community programs. OMH also wanted to differentiate its efforts from the major cost containment focus of the state's Department of Health. After several revisions and accommodations to meet the objections of psychiatrists and the hospitals, CIOPRM became operational on October 1, 1989, and the first rate adjustments occurred in July 1990.

Description of the Payment System

CIOPRM is a hospital-specific reimbursement system for acute-care, general hospitals whose inpatient psychiatric units are exempt from the Medicare prospective payment system and for licensed outpatient programs. On the inpatient side, CIOPRM applies to non-Medicare psychiatric patients, including those whose psychiatric care is paid by Medicaid, Blue Cross, and all other non-Medicare payers. The outpatient financing component provides enhanced rate premiums to Medicaid assistance payments.

Hospital per diem rates were to be adjusted every six months to achieve (ideally) a closer association between hospital performance and incentive payments, and hospitals were to receive timely reports on their performance under CIOPRM. Calculated on the basis of individual hos-

pital costs rather than peer groups or industrywide patterns, the rates were compared with a base year (1988) and adjusted for severity of illness proxies, level of care, readmissions within 30 days of discharge, and linkage to outpatient care.

The adjustments for severity of illness included case-mix weights assigned to four broadly defined patient categories (child, nonpsychotic, persistent, and acute). The highest weights were applied to children and persistent cases (1.04), and the lower case weights were given to discharges with acute (.99) and nonpsychotic diagnoses (.96). The level-of-care adjustment put into practice the block payment strategy or variable per diem payments suggested several years ago by Frank and Lave (1986) to reduce systematic risk to hospitals for treating high-resource-use psychiatric patients and to make the most disabled less vulnerable to the undersupply of mental health care. Using this strategy, different per diem weights were given to four discrete blocks of days during the hospital episode; breakpoints between blocks were established for each of the four case-mix categories. The per diem weights are highest during the first 10 to 14 days of the hospital stay, and then they decline until the 60th day to encourage hospitals to consider carefully the need for extending the admission after the initial intensive care period. After the 60th hospital day, the base rate is restored to protect against inappropriate discharges of patients who remained psychotic or did not have adequate housing. The higher per diem weights during the first two weeks also were used to encourage hospitals to extend very short stays for more appropriate treatment.

The payment system established an episode of illness as the unit of reimbursement. Merged into a discrete hospital stay was any readmission occurring within 30 days of a discharge. Because the readmission and previous stay were treated as a single episode in assigning a patient category and level of care, readmissions resulted in lower per diem rates to the hospitals.

The final adjustment to the per diem rate was based on a $65 "bridging fee," which was a bonus to hospitals for developing a discharge plan and for ensuring that a Medicaid client received outpatient services within 10 days of discharge. The patient had to keep the appointment with the outpatient provider for the hospital to receive the bonus. To receive this discharge case management adjustment, the hospitals were expected to facilitate successful linkage and to reduce readmissions through timely and appropriate care by outpatient providers.

Two additional features gave hospitals revenue protection during the implementation period. The inpatient rates were calculated to be revenue neutral so that hospitals maintaining their historical pattern of practice were entitled to the same reimbursement they would receive under the prior psychiatric rate structure, whereas hospitals improving their performance received incentive markups. Hospitals were "held harmless," although revenue losses could occur if additional staff were added to carry out the goals of CIOPRM without generating additional revenues to pay for their salaries. Essentially, hospitals participated during the implementation period with limited or no financial risk. Relief from the Department of Health's volume adjustment also allowed hospitals to avoid the financial risks associated with an increase in total patient days beyond that allowed by the state's Department of Health. Caring for more disabled patients and extending very short lengths of stay would increase patient days, resulting in a penalty for hospitals under the prior rate structure's volume adjustment. These revenue-protective features were not in the original OMH design, but were negotiated by the hospital and psychiatric representatives who participated in the development of the payment system.

The outpatient adjustments included a 40 percent rate premium to the Medicaid assistance payment for each unit of service provided by licensed facilities to Medicaid clients during the first 30 days after discharge; an additional 20 percent premium applied to services during the second to twelfth month after discharge for Medicaid clients classified as persistently mentally ill and for some other special categories. This outpatient component was intended to encourage early postdischarge services and continuing outpatient care for the most disabled mentally ill.

Research Approach

To study the implementation of this reform of the psychiatric payment system, we used several research strategies. Econometric analyses on statewide hospital discharge abstract data derived from the Statewide Planning and Research Cooperative System (SPARCS) files examined the impact of the new regulation on key hospital performance indicators, including length of stay, readmissions, and case mix. Medicaid claims data were analyzed to learn how the reimbursement reform affected the linkage of discharged patients to the outpatient care system. Multivariate

models were used to address how specific characteristics of participating hospitals were related to changes in performance. Careful attention was given to the selection bias inherent in choosing participating hospitals in a nonrandom manner from a pool of volunteers. Two-stage estimating procedures controlled for the substantial prereform differences among hospitals and the simultaneity or anticipated hospital performance bias that otherwise could have incorrectly attributed hospital performance changes to the new payment system. In evaluating the experiences of hospitals, we refer to several relevant groups: the participating, volunteering, and nonvolunteering hospitals. Variations among these hospital groups are also compared: participating versus nonparticipating hospitals; volunteering versus nonvolunteering hospitals; and participating versus nonparticipating, volunteering hospitals.

More qualitatively oriented studies were conducted to learn about the attitudes and efforts of hospital staffs to implement the payment system. One-hour telephone interviews were conducted with two to four key staff in administration, finance or reimbursement, and psychiatry and related clinical and social services at each of 68 hospitals that participated, volunteered, or did not volunteer under the new payment system. Some of the staff interviewed were architects of the reform, others were primarily responsible for introducing the intervention at their hospitals, and still others functioned under its implementation. A total of 208 completed telephone interviews were conducted during the first year of implementation. A structured interview schedule contained both open-ended and closed response questions. Cooperation from the hospital staffs was extremely good, and the refusal rate was very low (6 percent). On-site follow-up interviews were conducted during the fourth year of implementation at a subsample of 10 hospitals that gained the most and the least financially under the payment system. These interviews were also done with hospital administrators, financial officers, psychiatrists, nurses, and social workers.

Added to these endeavors were several smaller studies. We examined the reliability of the Medicaid claims data for tracking patients linked to outpatient programs; we measured the steps taken in discharge planning and referral and their impact on linkage; and we contacted mental health advocates and informed observers of the New York mental health system and community in order to learn whether they were aware of the initiative having any adverse effects on mentally ill clients.

We will integrate our findings to define lessons for implementing re-

imbursement reform in a state mental health system. We focus especially on the policy challenges faced by state administrators and by those providers the regulation was designed to influence. We believe the specific lessons learned through this initiative have value for other states as they implement new reimbursement policies to encourage improved treatment of the mentally ill in community settings.

Implementation of CIOPRM

In designing the multiyear phase-in of the payment system, OMH administrators used a two-tiered nonrandom selection process that resulted in three sharply different groups of hospitals (table 1). For phase 1, the first year of implementation, OMH asked for hospital volunteers, and 27 were selected from among the 52 hospitals that volunteered. In choosing the initial hospitals, OMH administrators wanted those that would be most likely to respond favorably to the financial incentives. Good performance outcomes in the first group of participating hospitals, it was reasoned, would encourage successive groups of hospitals to volunteer and support the payment system's goals and, equally important, focus the policy spotlight on the reform's potential. Table 1 shows that the hospitals participating in phase 1, however, were not representative of the total population of eligible hospitals. They had the lowest mean length of stay for non-Medicare psychiatric patients (18.7 days) in the base year (1988) compared with the volunteering hospitals (19.0 days) and the total population of hospitals (20.1 days). Heartening to OMH staff were the prior successes of phase 1 hospitals in limiting their length of stay increases between 1986 and 1988 despite caring for both a higher proportion of the indigent mentally ill (61.9 percent) and more of those defined as persistently mentally ill (36.4 percent). Although all three groups of hospitals showed increases in their average length of stay during this 1986–88 period, participating hospitals had only a .5 percent increase, compared with 1.8 percent for volunteers and 1.5 percent for all hospitals.

Unknown at the time of selecting these participating hospitals was an unanticipated 8.6 percent increase in their length of stay between 1988 and the first three quarters of 1989 just before the new rates went into effect, compared with lower increases in nonparticipating hospitals. This selection process resulted in a group of participating hospitals that were less able to benefit from the financial incentives; additionally, the selec-

TABLE 1
Descriptive Characteristics of New York State's General Hospitals with Psychiatric Units and Volunteering and Participating Hospitals in CIOPRM

Variable	General hospitals with psychiatric units[a]	Hospitals that volunteered	Hospitals selected to participate
Number of hospitals[b]	100	52	27
Rural	11.0% (11)	9.6% (5)	11.1% (3)
Urban	89.0 (89)	90.4 (47)	88.9 (24)
Teaching status[c]			
Med school affiliated	12.2 (12)	19.2 (10)	22.2 (6)
Teaching	25.2 (25)	21.2 (11)	29.6 (8)
Public	12.2 (12)	11.5 (6)	14.8 (4)
Nonteaching, nonpublic	50.0 (49)	48.1 (25)	33.3 (9)
Region			
Central	12.0 (12)	9.6 (5)	14.8 (4)
Long Island	19.0 (19)	11.5 (6)	18.5 (5)
Hudson	19.0 (19)	28.9 (15)	18.5 (5)
New York City	38.0 (38)	36.5 (19)	33.3 (9)
Western	12.0 (12)	13.5 (7)	14.8 (4)
Total hospital beds (x)[d]	439	462	501
Psychiatric beds ($\bar{x}$)	53	55	68
Indigent psychiatric patients	54.8%	58.3%	61.9%
Non-Medicare persistently mentally ill	32.6%	34.6%	36.4%
Occupancy rate	83.9%	84.0%	83.4%
Readmissions[e]	6.02%	6.37%	6.53%
Length of stay, non-Medicare psychiatric patients ($\bar{x}$)	20.1	19.0	18.7
Change in length of stay, 1986–88	1.5%	1.8%	.5%
Change in length of stay, 1988–89[f]	2.8%	5.0%	8.6%
Percent change in hospital net income, 1988–89 (median)[g]	−20.0%	−20.0%	54.0%

[a] Included are acute-care general hospitals with inpatient psychiatric units in New York State. Two of these hospitals were not exempt from the Medicare prospective payment system and were consequently not eligible for CIOPRM.
[b] Numbers of hospitals are in parentheses. Numbers do not always total 100 because of missing data.
[c] Five public hospitals in New York State are classified as medical-school-affiliated hospitals, not as public hospitals, for reimbursement purposes. The Bureau of Health Economics defines teaching hospitals based on specific residency and program characteristics.
[d] 1988 data (base year for the methodology) are used for total hospital beds, psychiatric beds, indigent, and non-Medicare psychiatric patients.
[e] Readmissions represent those patients readmitted within 30 days of a previous discharge for the same hospital and within hospital transfers occurring after the first level-of-care stage for a patient's case-mix category.
[f] Length-of-stay data for 1989 include the January to September period only (prior to the implementation of CIOPRM in October 1989).
[g] Data calculated by the Division of Health Care Financing, New York State Department of Health.

tion factors made it more difficult to evaluate how well the payment system was working. Had the initial hospitals been selected in a less biased fashion, such as by a random sample of volunteering hospitals, OMH could have monitored the effects more easily. Instead, the almost two-day increase in average length-of-stay among the selected participating hospitals after the base year made it especially difficult for them to benefit financially from the length-of-stay incentives and vastly complicated the evaluation of the impact of the reimbursement system.

Impact on Hospital Performance and the Organization of Psychiatric Care

Our analyses of the medical discharge abstract data showed that by December 1991 the payment system had little impact on hospital performance and rarely in the direction anticipated by OMH administrators. Using two-stage multivariate regression models, which controlled for selection effects, only readmissions within 30 days of discharge declined slightly by 1.8 percent across the 27 participating hospitals, compared with the readmission rate predicted for them had CIOPRM not been in effect.

A major goal of CIOPRM was to reduce overall lengths of stay and thereby increase bed capacity to care for more acute episodes among the serious and persistent mentally ill. A comparison of the performance of the participating hospitals with their behavior had the new reimbursement system not been in effect showed that the impact of CIOPRM resulted in an initial decline in length of stay nine months after implementation (Wilcox-Gök et al. 1991). However, this decline was not sustained. By the end of two years' experience under CIOPRM, overall length of stay had increased in participating hospitals by 1.8 percent while total discharges declined by 2.7 percent. Participating hospitals continued to serve almost twice as many persistent patients as the non-participating hospitals, but, as their occupancy declined, length of stay was extended. Furthermore, hospitals were not penalized owing to CIOPRM's provision of relief from the volume adjustment.

The linkage of Medicaid patients to specialized mental health care services was analyzed with Medicaid claims files. Logistic regression analyses that controlled for patient and hospital characteristics and selection effects showed that the average statewide linkage rate to specialty mental

health care within 10 days of discharge increased under CIOPRM by 8.7 percent. As shown by the large regional variations, the impact of CIOPRM on linkage was not uniform statewide. Regional increases in linkage ranged from 13 percent in the western region to less than 1 percent in the Hudson Valley area. Those regions with the highest base linkage rates showed the least change attributable to CIOPRM. The payment system also had a selective impact in significantly improving the probability of linkage at teaching and nonpublic hospitals, hospitals located in rural areas, smaller hospitals, and those with lower percentages of persistent cases. CIOPRM did not improve the probability of linkage for a particular diagnostic group of patients, but older patients were more likely to be linked to aftercare within 10 days of discharge under the payment system.

One notable change shown in our descriptive statistics was the decline (up to five days) in the median number of days to a first outpatient appointment among groups of participating and nonparticipating hospitals throughout the state. Thus, although the linkage rate did not change appreciably, appointment time was reduced.

We anticipated modest hospital responses during the early implementation period, particularly in light of the "hold harmless" provision, but, by the fourth year, the performance data on the hospitals continued to show only limited changes in the patterns of service for persons with serious mental illness. Some prior work refers to the fourth year after implementation as very early for measuring program effects (Beyer and Trice 1978), and other research on state regulation shows that, although few effects may be observed in early phases, a significant impact is demonstrated after longer periods of time (Altman and Ostby 1991; Biles, Schramm, and Atkinson 1980). In contrast, some studies find preregulation and preprogram changes (the "sentinel effect") when organizations anticipate and implement desired services before effective implementation dates (Gortmaker et al. 1987; Russell 1989).

Table 2 shows the initial reactions of hospital staff to CIOPRM's logic and the intent to respond to its principles and goals during the first year of implementation. Although from 81 to 85 percent of the staff at both participating and volunteering hospitals agreed that "CIOPRM was a rational approach to paying for psychiatric care," and two-thirds agreed with the logic about case mix and targeted groups, this endorsement did not translate into high expectations that the financial incentives would induce changes in psychiatric services.

TABLE 2
Hospital Professionals' Attitudes about the Logic of CIOPRM and Its Financial Incentives[a]

Attitudes	Percentage agreement		
	Participating hospitals	Volunteering hospitals[b]	Nonvolunteering hospitals
1. [CIOPRM] is a rational approach to paying for psychiatric care.	81	85	62*
2. [CIOPRM] is geared to those psychiatric patients most in need of care.	77	61	63
3. The patient case weights are clinically relevant.	68	61	63
4. The financial incentives are strong enough to prompt changes in psychiatric care.	53	64	43

[a] N = 208.
[b] These hospitals volunteered, but were not selected, to participate in CIOPRM.
* χ^2, $p < .01$

More direct questions to hospital staff about their responses to the payment system (table 3) showed even fewer making efforts consistent with the financial incentives. Not surprisingly, more agreement was found about reducing length of stay, yet fewer clinicians than other respondents indicated that this was likely to occur. As clinicians comprised the group exerting the most direct control over how long patients remain in the hospital, their opinions were most likely to affect the outcome. Lengthening very short stays and targeting children and persistent cases were not well-endorsed strategies. At most, only 18 percent of clinicians at participating hospitals reported efforts to lengthen very short stays.

Table 4 shows eight types of organizational responses to the new payment system that were measured across hospitals. The bulk of organizational responses occurred in planning and monitoring activities. Informational and planning meetings took place within all hospitals during the first year. Participating hospitals conducted some early informal "boundary-spanning" activities with other hospitals and with community and regional outpatient providers. An average of two to three planning meetings within the hospital and with outside providers took place

TABLE 3
Hospital Professionals' Reported Responses to CIOPRM's Goals[a]

Attitudes	Percentage agreement[b]					
	Participating hospitals		Volunteering hospitals[c]		Nonvolunteering hospitals	
	Clinicians	Adm/Finance	Clinicians	Adm/Finance	Clinicians	Adm/Finance
1. As a result of [CIOPRM], are you trying to reduce your hospital's overall length of stay for psychiatric patients?	36	51	58	67	26	43
2. As a result of [CIOPRM], are you trying to lengthen *very* short lengths of stay for some psychiatric patients?	18*	9	0	8	4	2
3. Has your hospital targeted treatment to one or more specific subgroups of the mentally ill, such as children or the more severe and persistently mentally ill, since the October 1989 implementation of [CIOPRM]?	14		24		10	

[a] N = 208.
[b] The wording for the first two items was slightly different for the two groups of clinicians and administrators and financial officers. Their results are presented separately.
[c] These hospitals volunteered, but were not selected to participate in CIOPRM.
* χ^2, $p < .01$ for differences among clinicians across the three groups of hospitals.

TABLE 4
Reported Organizational Responses to CIOPRM across Hospital Groups

Organizational responses[b]	Range of scale	Volunteering hospitals[a] (n = 41)		Nonvolunteering hospitals (n = 27)		Participating hospitals (n = 27)		Nonparticipating hospitals (n = 41)		Nonparticipating volunteering hospitals (n = 14)	
		$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD
1. Planning activities, interhospital/agency contacts	1–6	2.66	1.46	2.15	1.81	2.74	1.23	2.27	1.82	2.50	1.87
2. Monitoring activities	1–10	6.12	3.00	5.48	3.31	6.63*	2.62	5.37	3.34	5.14	3.53
3. Hospital policies	1–4	1.44**	1.14	.78	.97	1.41	1.22	1.02	1.04	1.50	1.02
4. Inpatient psychiatric services, retraining	1–4	.93**	1.13	.37	.69	.96*	1.22	.54	.81	.86	.95

5. Outpatient psychiatric services, retraining	1–9	.76	1.30	.48	1.48	.81	1.39	.54	1.36	.64	1.15
6. Inpatient psychiatric services, program changes	1–4	1.15	1.01	1.52	1.25	1.19	1.08	1.37	1.16	1.07	.92
7. Outpatient psychiatric services, program changes	1–9	1.90	1.71	1.59	1.55	1.85	1.51	1.73	1.75	2.00	2.11
8. Administrative services, retraining and program changes[c]	1–12	.76	1.07	.85	1.90	.81	1.21	.78	1.59	.64	.74

[a] Respondents' reports of changes are compared across hospital groups: volunteering versus nonvolunteering, participating versus nonparticipating, and participating versus nonparticipating but volunteering hospitals.
[b] All of the measures of organizational responses were based on multi-item scales constructed from questions asked the key professional informants at each hospital. The maximum score on each item (1,0) given by any of the respondents interviewed at a hospital was used in each scale. Scores were not summed across respondents at a hospital.
[c] Separate scales were also constructed for retraining and program changes in administrative services. No significant differences existed across any of the hospital groups for these separate organizational responses.
* Significant difference between participating and nonparticipating hospitals based on t-test, $p < .10$.
** Significant difference between volunteering and nonvolunteering hospitals based on t-test, $p < .01$.

for all hospital groups during the first year of implementation, but no significant differences in general communication about the new reimbursement reform emerged across hospital groups.

During the first phase of implementation, OMH made substantial efforts to introduce CIOPRM to hospital personnel through training sessions, and its financial office promised hospitals timely reports that would allow them to monitor their performance. Our interviews indicated that department administrators who participated in early training sessions understood both the broad goals of the payment system and, to a limited extent, its financial bonuses, as well as how their hospitals might respond to its objectives. OMH did not continue these training sessions as new hospitals came into the system, and there were no formal mechanisms for introducing newly hired hospital personnel to its features. With attrition and turnover, initial understanding of the reimbursement system diminished, and staff at the service level often knew little about CIOPRM. Because of staff reductions and budget cuts at the state level and delays encountered in the approval of rates, OMH could not follow through on issuing timely reports to hospitals on their performance and rate adjustments. At times, hospitals did not receive reports on their performance and subsequent rate adjustments until more than a year later, which did not allow them to adapt in a timely and relevant manner. The types of reports issued that focused on rate calculations were difficult to interpret and thus were not useful to the hospital staffs.

The organizational responses of participating hospitals to the payment system were significantly different from those of nonparticipating hospitals on two measures: (1) monitoring clinical and financial indicators of psychiatric utilization, and (2) retraining hospital staff in inpatient psychiatric services. Participating hospitals refined their technical capabilities for dealing with the new payment system by coding psychiatric diagnoses more accurately and completely and by more closely monitoring indicators of psychiatric service utilization and costs. Especially emphasized in retraining were efforts to plan discharge earlier in the hospital stay, seek placement more assertively, and encourage outpatient staff to meet with inpatients.

These initial, though circumscribed, changes taking place in participating hospitals were related to the information requirements needed to understand, plan, control, and evaluate a new payment system. Staff at participating and volunteering hospitals also reported that the payment system would result in a better knowledge base for their psychiatric pro-

gram planning over the next five years. When hospital staff were interviewed three years later, none had moved beyond these initial planning sessions. Despite the emergence of some innovative ideas about linking patients to aftercare and improving coordination with outpatient providers, few hospitals proceeded to implement new plans. OMH administrators hoped that some horizontal integration of services with outpatient providers would occur as a major strategy to enhance coordination and continuity of care; to the extent that this happened, respondents did not attribute its achievement solely to the payment system's incentives.

Beyond informational and planning meetings, some inpatient staff retraining, interagency contacts, monitoring of psychiatric and financial indicators, and improvements in the coding of diagnoses, no other differences were discerned between participating and nonparticipating hospitals' inpatient and outpatient psychiatric services. Only two other statistically significant findings occurred in the hospitals' organizational responses. Volunteering hospitals were more likely than nonvolunteering ones to have made hospital policy changes such as initiating follow-up of patients attending outpatient services and retraining staff in inpatient psychiatric services.

Given the limited performance and organizational changes attributable to CIOPRM, it is useful to examine the barriers to successful reform. Using the data from our interviews conducted with key professional and administrative hospital staff, we describe the problems confronting both hospital staffs and OMH administrators during this reimbursement initiative. Several specific lessons for mental health reimbursement reform at the state level can be identified.

Lessons for Mental Health Reimbursement Reform

1. *General support and confidence in reimbursement reform do not ensure change at the service level.* The initial support of the new psychiatric reimbursement system was seen as critical to its implementation and ongoing introduction into successive groups of hospitals and their staffs. Once the concessions were made to the hospital and psychiatric communities, the reform was introduced into hospitals with little or no controversy. Support for its logic and goals was relatively high. Hospital staffs and OMH officials expressed confidence that the payment system could work. Yet a warning emerged in the first year, when approxi-

mately 50 percent of the hospital staff interviewed reported that the financial incentives would not be effective tools for changing psychiatric practices and services. This reaction struck at the heart of CIOPRM's design.

Only a few hospital staffs responded to the incentives for lengthening very short stays and targeting children and persistent cases for admission. Although hospitals interested in maximizing their revenues could do so by lengthening these short stays, staff saw responding to this incentive as wasteful and inappropriate. Drug-induced psychoses, for example, were seen as requiring only short hospital stays. Although consultant psychiatrists were involved in the development of the payment system and in defining its goals, it became clear that the clinical staffs at the hospitals did not always share the same views of good clinical practice. As in other clinical areas, there is limited consensus about appropriate norms of inpatient care and length of stay. Shortell, Morrison, and Friedman (1990) also report that organizations make changes that are closely related to their current strategies or "strategic comfort zone." Increasing short lengths of stay may be beyond the strategic comfort zone, thereby disrupting current hospital policies and clinical practices and communicating conflicting signals. Our analyses also showed no relation between hospital occupancy rate and efforts to increase short lengths of stay.

Understandably, CIOPRM was not especially constraining to hospital providers, and, equally important, this payment system provided regulatory relief for psychiatric units in hospitals facing drastic cuts once the Department of Health's case payments were introduced into general hospitals in New York State. Hospital providers might have feared more stringent controls on utilization. CIOPRM involved no obvious risks and offered potential financial gains without costly restructuring of services.

Hospital staffs were not failing to take action because they rejected the goals or the logic of the new payment system. The widespread agreement and consensus among key hospital professionals could have facilitated implementation, but the will to make changes did not emerge in subsequent months after the payment system was introduced. Despite strong endorsement of the reimbursement design, this support did not translate into the clinical and administrative behaviors necessary to achieve its intended goals.

2. Implementation of a complex intervention requires continuing reinforcement. The failure of OMH staff to reinforce initial efforts to acquaint hospital staff with the payment system and the cessation of

OMH training sessions after the first hospital group entered the system were significant because this innovation was a relatively small feature in a large, complex environment where hospital staff face competing demands in administration and service provision. Unlike the Medicare prospective payment system, which affected almost all services in the hospital and received much general attention and discussion, these psychiatric reimbursement changes were relatively invisible to all but the hospital's financial officers and the director of psychiatry; even these staff members only partially understood their hospital's performance under CIOPRM. Introducing such a set of complex changes requires sustaining educational and informational efforts, which did not happen here, and as time went on and the usual staff turnover occurred, familiarity with the reimbursement system and its focus eroded.

An additional feature that diluted the potential of the payment system was the complex way in which revenues earned by hospitals were paid. As originally planned, there was to be a direct relation between responding to the incentives and receiving financial bonuses, but earned revenues were simply factored into the overall hospital rates for psychiatry for the next or subsequently delayed payment period. Some hospitals reported receiving lump sum payments for their psychiatric services, but there was no documentation to relate the payments to specific performance. Timely and clearly interpretable performance feedback was not given to those who were to implement the goals, or even to those who were administratively responsible. No direct or immediate reinforcement highlighted responses consistent with OMH goals. There was not even symbolic recognition for those who successfully implemented OMH policy.

3. Frontline staff within and across hospitals and outpatient programs must be involved in implementing practice changes. A rich heritage in the study of complex organizations underscores the power of frontline staff to affect performance and determine the outcome of policies (Etzioni 1961; Mechanic 1962). Policy change is at the mercy of the staff who must perform the activities required to achieve targeted objectives. Most staff below the administrative level in various disciplines were relatively uninformed about the payment system. Planning meetings usually involved heads of departments, not staff at the service level. Staff hired one to two years after the initial start-up date were not familiar with CIOPRM.

Establishing clear communication among levels of a complex orga-

nization can be challenging enough, but the task is even greater when implementation requires interorganizational collaboration. Under the payment system, hospital and outpatient staff were to use innovative strategies to ensure that patients kept their appointments within 10 days of discharge if hospitals were to receive the "bridging fee." Because the types of patients involved commonly fail to keep appointments, special procedures were needed to achieve linkage.

The timely connection of psychiatric patients to outpatient services, a major goal of the payment system, required strong coordination with the outpatient care system and its complex array of services as well as persistent efforts in encouraging patient compliance. The "boundary-spanning" activities necessary to accomplish linkage can be time consuming and do not necessarily assure the desired results. Few hospitals reported that they had the resources to add staff to assist with such activities, and strategies devised by some of the regular staff to remind discharged patients of their first appointment or otherwise to achieve linkage were sporadic and short lived. Although one hospital assigned a staff person to take patients to outpatient services and residences before discharge and to check with each outpatient program after a patient's discharge to see if the patient was compliant, this potentially effective link between the inpatient and outpatient system unraveled when the staff member was transferred to another site.

Programmatic initiatives for frontline staff have to accompany the introduction of financial incentives. Regularized institutional mechanisms and specific procedures lend clarity to the objectives of policies and help communicate expectations to staff. Hospitals rarely reported establishing any specific procedures for meeting the objectives of the payment system. Department heads often spoke knowledgeably about linkage with aftercare, but the steps necessary for implementation were seldom in place. The revenues from the relatively low "bridging fee" were rarely if ever credited to the department of psychiatry's budget, and this incentive was not effective in augmenting efforts of the discharge planning staff except in shortening the wait for appointments.

4. Small penalties as well as rewards are needed to change provider behavior. Participating hospitals were either held harmless, allowing them to invoke the rates they would have received under the prior rate system, or they were able to earn premiums under the new payment system. Thus they did not face any financial risks, nor were they required to change services to comply with the goals of CIOPRM.

Although studies have not examined systematically the outcomes associated with remunerative and negative inducements in health regulation, some stringency is associated with desired system change. In evaluating the initial years of the case-based DRG system in New Jersey, Hsiao et al. (1986) suggested that hospitals responded more to constraints on their revenues. The financial "bite" of the DRGs has been credited with reducing length of stay and lowering the anticipated increase in Medicare expenditures. Successful changes occurring under Ohio's Mental Health Act of 1988 are credited to economic incentives for local mental health boards to participate while holding them at risk for hospital use (Hogan 1992). Recent changes in the financial rules at the state and local levels in the Texas mental health system suggest that the sole use of rewards has not prompted desired changes (Frank and Gaynor 1992). Reasonable and modest fiscal risks may be necessary to bring about fundamental changes and to convince providers of the seriousness of a reform effort in the payment system.

5. Making participation too easy may fail to generate the needed commitment for reform. There were no specific requirements for hospitals to participate. They did not have to submit plans to indicate the steps they would take to achieve the goals of the payment system. A reimbursement reform project of this magnitude requires hospitals as well as outpatient programs to develop plans to achieve certain goals. At the very least, specifying the efforts required to meet guidelines raises awareness about the project. Although OMH expected hospitals to admit more persistent cases, strategic planning to provide inpatient services for a higher volume of disabled mentally ill was not required nor was the specification of strategies to achieve higher linkage rates for patients to outpatient programs expected. Higher expectations associated with an active application process may stimulate some of the coordinated efforts needed to improve services.

The Robert Wood Johnson Foundation Program on Chronic Mental Illness, a service demonstration in nine cities, required its grantees to submit not only the basic application, but also viable strategies for centralizing administrative, fiscal, and clinical responsibilities into a single mental health authority (Aiken, Somers, and Shore 1986). Community-wide efforts had to be mobilized to prepare the grant application and to commit to a long-term plan. Furthermore, the foundation required the endorsement of local and state government executives. This initiative underscored the relevance of involving multiple actors at an early stage

and obtaining their commitment to allocate, reallocate, and integrate services. Although the evaluation has shown that "expectations about the potential for rapid change were exaggerated and unrealistic" (Goldman et al. 1992), modest system revisions were facilitated by the early planning, commitment, and ongoing active involvement of several agencies that served as responsible parties to the demonstration.

6. *Incentives may not be perceived as advantageous by those most responsible for implementation.* The logic underlying the incentives was that the availability of additional revenues would stimulate or support staffing and service changes consistent with the objectives of the payment system. Implicit here is a vague notion that if the unit increases its revenues, the administration might favor them with additional resources. However, although changes had to be made at the psychiatric unit level, hospital operating practices showed that any increased reimbursement flowed to the hospital, not to the unit. Revenues earned under the payment system were never credited or transferred to the department of psychiatry.

Because the unit administrators of psychiatry were not able to access the revenues earned under CIOPRM, much of the force of the intended incentives was eroded. Departments of psychiatry were typically facing deficits in either their inpatient or outpatient services and were required to cut costs. Whereas revenues earned lessened deficits in some instances and could be used occasionally as leverage to forestall staff cuts, or even perhaps to negotiate an added residency slot, the link between added revenues and the service innovations needed to respond successfully to CIOPRM was not achieved. If incentives are to have force, a clear link is necessary between the behaviors that require modification and promised rewards. This link was never clear to those at the unit level whose behavior the payment system was intended to change.

7. *Organizational incentives must be strong enough to sustain the range of activities necessary for implementation.* Cook and colleagues (1983) assume a hierarchical ordering of hospital responses to regulation across three levels of an organization (institutional, managerial, and technical) based on the "costliness" of making changes. Costliness includes not only implementation costs, but also the efforts needed to preserve professional autonomy and reduce uncertainty and unnecessary dependence on the regulatory environment. Limited responses occur where more staff effort and resources are required.

Hospitals rarely addressed the more difficult organizational changes necessary for increasing their use of outpatient services, such as restructuring outpatient services, changing staff responsibilities, or developing strategies for addressing the most noncompliant patients. The departments of psychiatry gave little attention to strengthening links to their own outpatient services to take advantage of outpatient premiums by keeping patients in the "hospital family." Although linkage with specialty mental health outpatient services did not improve substantially, those who were linked made contact with outpatient services more quickly, suggesting that units focused on patients who were most compliant or were already in an outpatient network. Only minor changes in hospital routines were required for the planning meetings, monitoring activities, and reduction in appointment time for the most compliant patients. These responses suggest a policy of incrementalism in which change is largely a function of previous routines that require only marginal adjustments to ongoing practices.

8. The larger policy environment and its changing status must be monitored in any reform effort. Although the mental health authority in New York State developed the payment system for reimbursing hospitals for inpatient psychiatric care, the state's Department of Health retains statutory authority for setting all hospital inpatient rates. Nonparticipating hospitals have also been paid under the prevailing rate system set by the Department of Health. This diffusion of responsibility over financing of mental health and mental-health-related services increases the risk of contradictory actions by these different state agencies. Monitoring of the general health policy context thus becomes critical. Drawing the boundary of the mental health system too narrowly neglects the important external influences that affect mental health services and their provision.

Shortly after the initial implementation of CIOPRM, the Department of Health created new case-mix weights for psychiatry that diverged from OMH's priority groupings. Moreover, rate changes under the payment system were frequently overshadowed by the prospective rates set by the Department of Health. Because the Department of Health's shift to prospective rate setting for all general hospitals in 1989 resulted in large modifications in hospital rates, the smaller adjustments attributed to the new psychiatric payment system appeared inconsequential. In an effort to offset decreases in general revenue funds allotted to mental health ser-

vices while taking advantage of opportunities in the Medicaid program expansion, OMH restructured reimbursement to outpatient programs through a Medicaid clinic option with its Comprehensive Outpatient Psychiatric Programs (COPS) regulation, which was implemented midway into the payment reform. COPS had higher outpatient rates for most programs, far surpassing the Medicaid premiums that could be earned under CIOPRM, while also eliminating deficit funding for charity and uncompensated care.

The payment system also was introduced during a period of considerable economic stress for the hospital sector, buffeted as it was by an economic recession, growing numbers of uninsured persons, and increasing cost pressures. In the context of all these difficulties, the incentives of CIOPRM, which might have seemed weak even under the best of circumstances, were overshadowed by other influences. Budget cuts for the OMH also resulted in reallocation of staff, decreased morale, and reduced attentiveness to following through on the regulatory activities for CIOPRM in a timely fashion.

9. *Weaknesses and flaws in regulatory design will be exploited.* Institutions are not passive in the face of regulatory change. They are highly adaptive to their own needs, and they will exploit any weaknesses in the regulatory system that contribute to their stability and survival.

When the payment system was designed and first introduced, there was a crisis in access to psychiatric beds, and one of the goals of CIOPRM was to increase capacity without adding new beds. It was believed that some hospitals in responding to the payment system would have to increase their patient days and discharges, and thus OMH administrators allowed a waiver to the Department of Health's volume adjustment that penalized hospitals financially for exceeding volume expectations. Some astute hospital reimbursement staff and financial officers recognized that their hospitals could avoid substantial penalties and gain financially by participating in the new payment system *solely* to benefit from this waiver. Some hospitals whose length of stay was increasing volunteered to participate to win financially under this volume adjustment waiver. Some New York City public hospitals were not volunteered by their parent corporation despite the fact that their ongoing behavior was consistent with the payment system's goals. Other hospitals in the corporation were volunteered and participated, despite behavior that was inconsistent with CIOPRM, because they could earn more under the waiver for the volume adjustment. With the volume adjustment in place, hospitals

could increase the length of stay when occupancy fell without losing revenues. The general recognition of such loopholes undermined the integrity of the payment system at the same time that hospitals benefiting from revenue gains supported CIOPRM, but for reasons unrelated to its goals.

When examining the payments made to hospitals under the payment system, only an average of 18 percent of the money paid in rate adjustments in January 1991 could be attributed to "performance" adjustments. The remaining revenues came from adjustments unrelated to the payment system's goals. The amount attributed to performance increased to 34 percent of total payments by January 1992, but the payments still reflected the contradictory incentives in CIOPRM. This design characteristic illustrates the problems that can emerge with a broad reform effort. The paradoxical impact of the volume adjustment waiver compromised the change process as more hospitals came to understand how most of the financial gains were achieved.

10. Inpatient care should be part of a balanced system focused on community care. Hospital clinicians and administrators often complained that they could not meet OMH objectives because they had little control over patient flow into the hospital or over the community context into which patients were discharged. Participating hospitals were already accepting involuntary patients as a condition of participation, and many of the hospitals already had a substantial caseload of persistent cases. Medicaid patients were typically admitted through the emergency room, giving clinicians little control over case mix. Similarly, readmissions were difficult to control with a highly disabled client population when aftercare services, support systems, and housing were inadequate.

The sense of powerlessness often expressed reflects the chaos that prevails when the hospital is not part of an integrated system of care with a clear focus of responsibility for the longitudinal care of patients. Hospital care must be more closely linked with outpatient and rehabilitative services, and the total pattern of care must be meaningfully managed to avoid unnecessary admissions and to ensure that patients are properly connected to the community services they need. Coordinated strategies with community agencies could add to continuity of care, avoid wasteful and unnecessary admissions, and ensure access to a hospital bed for the most disabled when inpatient care is required. Appropriate linkage is a core challenge for both inpatient and outpatient clinicians.

Considerable research and experience suggest that persons with severe

and persistent mental illness benefit from continuous case-management systems like the Program for Assertive Community Treatment (PACT) model developed in Dane County, Wisconsin, and replicated widely (Stein and Test 1985). Incentives are necessary to stimulate development of such systems, which have the fiscal and clinical responsibility to oversee care wherever it may occur. The programs must be adapted to the clinical and political environments in which they function while still focusing responsibility and authority. As the state moves to Medicaid managed care systems, there may be opportunities and incentives to develop the types of programs needed.

Discussion and Conclusion

New York State's new payment system for reimbursing psychiatric care beyond the state hospital system was comprehensive, embracing both inpatient and most outpatient services. It was based on episodes of care, not discrete hospitals stays, and it took account of previous work on psychiatric DRGs and simulation studies (e.g., incorporating case mix but not the imperfect adjustors of DRGs). Under CIOPRM modest financial rewards were used without strong penalties because the mental health system shows a greater supply response to financial incentives than does the general medical care system (McGuire, Mosakowski, and Radigan 1989). CIOPRM also had significant support in the hospital and professional communities. Like any new policy design, however, the ultimate realization of this reform relied on more than its internal components and on many influences extending beyond the control of OMH administrators (Rochefort 1991).

Because health regulation is generally viewed with suspicion and introduced with resistance from provider constituencies, the substantially positive initial acceptance of the psychiatric payment system eased its introduction while creating unrealistic expectations. OMH was seen as addressing some of the current priorities and not simply using the payment system as a "technical fix." Administrators and clinicians had achieved stability in their psychiatric rates after facing a 25 percent reduction once hospitalwide per diems were discontinued by the Department of Health in 1988. Provider representatives also assisted in the design and gained compromises on the burdensome and constraining features. OMH gave hospitals revenue neutrality during the implementation period, allowing

them at least four years to adjust to the new incentives. However, as Beyer and Trice (1978) point out, "even optimistic and enthusiastic acceptance of an innovation at first introduction fails to ensure implementation of organizational change" (p. 79).

The modest revenue gains directly attributable to the incentives for changing practice patterns and the limited organizational changes that were undertaken revealed the circumscribed nature of participating hospitals' responses to the payment system. Some distinct modifications were made at several hospitals in the early implementation period, but more far-reaching actions were necessary for the effects to be meaningful. It appears that the perceived promise of the payment system by both state administrators and hospital staffs was considerably greater than their ongoing efforts to implement its goals.

The early organizational responses reported were consistent with the activities required to introduce an innovation, but then further efforts at implementation ceased. Communicating information about CIOPRM and discussing its incentives with the institutions affected represented positive steps. OMH facilitated some of the informational meetings, but it did not maintain an informational and advisory mechanism. Mechanisms should be established for the review of a payment system's operation and for adjustments that are needed throughout implementation for the benefit of the regulated and regulators. The Prospective Payment Assessment Commission (ProPAC), which was created to advise Congress and the Secretary of Health and Human Services about the implementation of the prospective payment system, serves as a good example of how independent and expert recommendations can be made to revise a major reform effort (Smith 1992).

The features of the payment system itself limited some of the desired changes. CIOPRM had no real financial force, the revenues earned were paid indirectly, and no major changes in hospital routines were needed to participate or even benefit from the financial features. Hospitals were not compelled to change their service patterns, nor did the incentives convince managers that enough revenues could be generated for them to take aggressive action. Participating hospitals saw revenue gains under the payment system largely through the unanticipated impact of the volume adjustment.

One feature of the payment system that was devised as a constraint on clinical practice, the reduced per diem rate to 85 percent of the standard rate during the latter part of the hospital stay, may not have been a

strong incentive because it still probably amounted to more than the marginal cost of care; thus, its influence in reducing length of stay was minimal. In designing the system, no serious assessment was made of the marginal costs to the hospital of caring for patients with longer lengths of stay.

The small number of responses to the payment system by hospital administrators suggests the difficulty of introducing a regulation focused solely on psychiatric rates. When considering the full range of hospital services, the scope of this regulation for psychiatric care is narrow. Generally, psychiatric discharges from New York State's acute-care, general hospitals represent only 3.2 percent of total discharges, or 8.9 percent of patient days, so clear administrative interest during any implementation of a payment system has to be strong to assure the system's success. To the extent that psychiatry instituted program changes under the system, the costs would be borne by psychiatry, but any financial gains might accrue only to the overall hospital budget.

The appeal of this psychiatric reimbursement system was its broad focus on addressing several of the mental health system's greatest problems of inpatient and outpatient access, especially for the Medicaid population and for persons with persistent and disabling mental illnesses. As deinstitutionalization proceeds, a broad approach is needed to substitute for and enlarge the care formerly provided in state institutions by expanding capacity in general hospitals and community programs. The innovations required, however, have to take place in a relatively small clinical area in the overall hospital structure and in hospitals increasingly faced with severe budget cuts, constraints on Medicare hospital payments, increasing numbers of uninsured patients, staffing reductions, and a finite availability of appropriate outpatient services. At state levels, budget crises often limit the availability of additional funds, so that strategies have to be devised to redirect existing sources of revenues. One has to wonder if and how financial incentives can work in a substantial way in such a complex and fragile hospital environment where so many competing issues weigh on the very "institutional survival" of hospitals (Seay and Vladeck 1988).

The experience with CIOPRM has deepened the thinking of state administrators about the difficulties in implementing psychiatric reimbursement reform. The state's OMH is now revising the financial incentives to retain the monies allocated for this initiative. Investing the same dollars targeted for the reform differently, for example, by directly mod-

ifying outpatient care or by establishing more formal ties between the inpatient and outpatient contexts, might have a greater impact on patterns of service utilization. OMH also wants to maximize federal/state cost sharing through the Medicaid program, whereas the state's Medicaid authority tries to contain costs.

The history of financing in the mental health sector illustrates how sensitive service arrangements and locus of care are to the flow of funds (Grob 1991). Because the funds in question come through reimbursement and depend on other state and federal budgets that the state mental health commissioner does not control directly, OMH has a strong incentive to maintain some hold on the payment system. Uncertainties in the external environment, such as federal health policy reform and the state Department of Health's changes in rate setting, also complicate revision of the payment system.

No reimbursement reform can stand by itself. Coordinated strategies are required by multiple state agencies and the regional and local programs providing funds, as is direct assistance in locating suitable residential placements and in developing appropriate community psychosocial rehabilitation opportunities. Whatever reimbursement design is agreed upon, it must provide clear and forceful signals that take account of the real barriers to implementation and ensure that the incentives and rewards are recognized by those who must take the actions needed to translate goals into reality.

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