health action council

PROVIDER INCENTIVES
INSIGHT BRIEF

REDUCING COSTS AND IMPROVING OVERALL HEALTH

PROVIDER INCENTIVE STRATEGIES CAN REDUCE COSTS AND IMPROVE OVERALL HEALTH

EMPLOYERS ARE AMPING UP THE USE OF VALUE-BASED CARE MODELS TO REDUCE HEALTHCARE SPENDING AND IMPROVE OVERALL POPULATION HEALTH.

Although there is no one-size-fits-all approach, Health Action Council has identified some of the most popular provider incentive models and is providing you with a brief overview, strengths and weaknesses, and questions you should ask your brokers, consultants and plan administrators.

TOPICS COVERED

FEE SCHEDULE
A complete listing of fees that are used to pay providers for services

CAPITATION
Understanding fixed payments for a defined set of services

INCREMENTAL PAYMENT MODELS
Models to spend more sensibly on healthcare services

SHARED SAVINGS AND SHARED RISK

PAY-FOR-PERFORMANCE (P4P)

BUNDLED PAYMENTS FOR EPISODIC CARE
Payments made over a course of a defined period of care

DIAGNOSIS RELATED GROUPS (DRGS)
Methods to classify and categorize inpatient case mix into clear paths of care

GLOBAL BUDGETS
A fixed amount of funding for a specific period of time for a specialized population

GLOBAL CAPITATION
Payments made to an integrated care organization that distributes accordingly

REFERENCED BASED PRICING
A system where insurer selects a price it is willing to pay for a health care service

FEE SCHEDULE

A complete listing of fees developed by CMS that is used to pay doctors or other providers/suppliers for services

GOAL | ENCOURAGE PROVIDER ACTIVITY FOR GENERAL AND SPECIFIC SERVICES

STRENGTHS

- More control over payments
- Predictable payments
- Use cost-sharing to impact appropriate utilization of services
- Encourage desired provider behavior by paying for services
- Solid patient care data to determine provider performance
- Flexible

WEAKNESSES

- Encourage overprovision of services
- No way of tracking if service was appropriate or well performed
- Creates a fragmented system
- No incentive to coordinate care
- Limits services not included on the fee schedule
- Limited data on efficiency and effectiveness of services

QUESTIONS TO ASK REGARDING THIS TOPIC ON THE NEXT PAGE

FEE SCHEDULE

A complete listing of fees developed by CMS that is used to pay doctors or other providers/suppliers for services

QUESTIONS TO ASK

- Are you supplementing your fee schedules with other incentives to improve the quality of care being delivered to patients?
- Do you include any value-based payments in your fee schedules?
- Where have you seen the best outcomes?
- What benefit designs work well with fee schedules?
- How do you work with providers to mitigate the risk and ensure they do not over provide or duplicate services?
- How do you compare satisfaction with providers?
- Do your fee schedules reward providers for patient evaluation and management activities related to a patient's care path?
- Are there cost-mitigation strategies being used to address of 'upcoding' or fraud?
- Do you engage providers when creating a fee schedules?

CAPITATION

A prospective unit of payment per patient per month/year in which a payer makes a fixed payment for a defined set of services, regardless of the number of services provided

GOAL

PLACES DECISION-MAKING POWER IN THE HANDS OF THE HEALTHCARE PROFESSIONALS BY PERMITTING PROVIDERS TO DECIDE THE OPTIMAL MIX OF PRODUCTS AND SERVICES TO MEET EACH PATIENT'S INDIVIDUALIZED NEEDS

STRENGTHS

- Predictable costs
- Easy to administer
- Incentivizes providers to limit unneeded services
- Provider flexibility
- Use of non-traditional communication and care delivery

WEAKNESSES

- Can restrict patients' choice of care
- If a contract does not adjust for health risk status, physicians could turn away sicker patients
- Very limited ability to track clinicians' activities or performance
- Sometimes providers will take on too many patients, creating waitlists
- Limited ability to promote or encourage activities or services
- Restricted to certain managed care organizations, except for self-funded employers who can contract with providers

QUESTIONS TO ASK REGARDING THIS TOPIC ON THE NEXT PAGE

CAPITATION

A prospective unit of payment per patient per month/year in which a payer makes a fixed payment for a defined set of services, regardless of the number of services provided

QUESTIONS TO ASK

- How do you compare customer satisfaction with providers?
- How are you supplementing your capitation models with other provider incentives, or shared risk models? Is to improve the quality of care?
- What benefit designs work well with capitation arrangements?
- Are there efforts to limit referrals to providers outside of the capitation payment models? Do you penalize them in any way?
- What other payment models are you using to complement the capitation model?
- Do you have examples of value-based arrangements that have worked/not worked?

SHARED SAVINGS AND SHARED RISKS

Spending reductions that include some form of quality measurement. One-sided or upside models (shared savings): there is no performance risk to providers for higher costs or not achieving quality performance goals. Two-sided or upside-downside models (shared savings AND shared risk) Provider accepts some accountability for costs that greatly exceed the goals.

GOAL | **SPEND MORE SENSIBLY ON HEALTHCARE SERVICES**

STRENGTHS

- More control over payments
- Predictable payments
- Use cost-sharing to impact appropriate utilization of services
- Encourage desired provider behavior by paying for services
- Solid patient care data to determine provider performance
- Flexible

WEAKNESSES

- Encourage overprovision of services
- No way of tracking if service was appropriate or well performed
- Creates a fragmented system
- No incentive to coordinate care
- Limits services not included on the fee schedule
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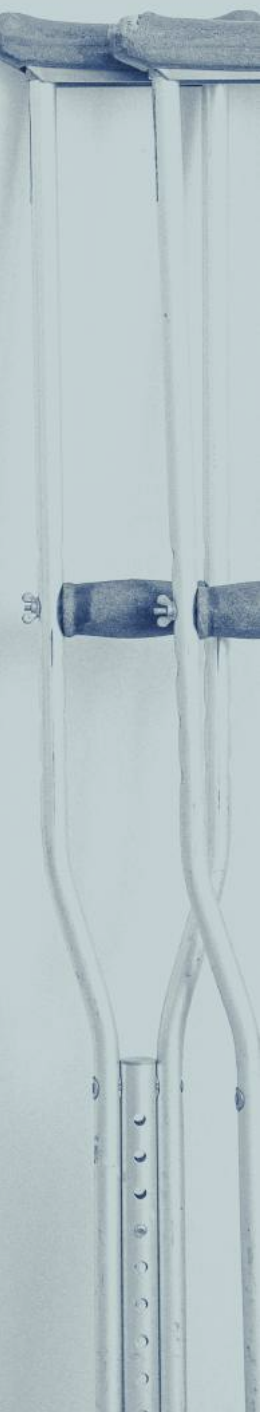
QUESTIONS TO ASK REGARDING THIS TOPIC ON THE NEXT PAGE

SHARED SAVINGS AND SHARED RISKS

Spending reductions that include some form of quality measurement. One-sided or upside models (shared savings): there is no performance risk to providers for higher costs or not achieving quality performance goals. Two-sided or upside-downside models (shared savings AND shared risk): Provider accepts some accountability for costs that greatly exceed the goals.

QUESTIONS TO ASK



- How do you determine shared savings metrics and track results?
- How do you ensure physicians are not stinting services?
- How do you measure patient quality of care?
- What metrics have been incorporated into shared savings to measure organizational performance with regards to population health?
- How are you ensuring that primary and secondary preventive services are being offered in support of population health?

SHARED SAVINGS AND SHARED RISKS

Spending reductions that include some form of quality measurement. One-sided or upside models (shared savings): there is no performance risk to providers for higher costs or not achieving quality performance goals. Two-sided or upside-downside models (shared savings AND shared risk): Provider accepts some accountability for costs that greatly exceed the goals.

QUESTIONS TO ASK

- Are appropriate referral metrics offered to encourage physicians under the shared savings plan to refer patients to high-quality physicians outside of the plan if it meets patients' needs better?

- Does the added administrative costs to implement these arrangements increase insurance costs? By how much?

- What benefit designs have employers used to support shared savings programs by incentivizing employees to utilize providers that are actively working to improve quality processes and outcomes? What has worked well?

- What cost sharing measures have employers used to support P4P programs? What has worked well, and what hasn't?

- How are you currently incorporating shared shavings and shared risk programs with your P4P agreement models?

PAY-FOR-PERFORMANCE (P4P)

A payer compensates physicians according to an evaluation of physician performance, typically as a potential bonus on top of the physician's fee-for-service compensation

GOAL | IMPROVING SPECIFIC QUALITY METRICS IDENTIFIED BY THE PAYER

STRENGTHS

- Shifts payment towards quality of care
- Gives payers the flexibility to emphasize aspects of performance and quality they want to focus on
- Increased transparency on payments to providers
- Gives consumers data to help them make informed choices
- Can increase provider attention on factors related to customer satisfaction
- Supports a quality health care improvement framework
- Easy to implement in conjunction with other programs and models
- Gives payers a simple way to improve provider value
- Increased focus on P4P models is expanding measure sets and approaches to achieving greater measurement accuracy

WEAKNESSES

- Higher administrative requirements and costs
- Poor measures and data collection processes could lead to bad judgements on providers' overall quality and value
- Heavy focus on clinical measures, which doesn't always equate to improved health outcomes
- It might not be fair to providers with more challenging patient populations due to socioeconomic factors or unmeasured case-mix differences
- Some risk that clinicians might adjust their activities to perform better on P4P measures than other routine care

QUESTIONS TO ASK REGARDING THIS TOPIC ON THE NEXT PAGE

PAY-FOR-PERFORMANCE (P4P)

A payer compensates physicians according to an evaluation of physician performance, typically as a potential bonus on top of the physician's fee-for-service compensation

QUESTIONS TO ASK

- How are you incorporating P4P into traditional payment models?
- What metrics are you using to design your P4P model?
- Do you use evidence-based metrics to improve clinical outcomes, or are they more experimental in nature?
- What specific process measures are being used to track progress and efficiency?
- What outcome measures are being used to benchmark and track quality outcomes?
- Is a combination of P4P and publicly reported data being used to determine performance measures?
- Are you familiar with any employers that have engaged their employees to use providers actively working on quality improvement efforts? What has worked well and what hasn't? Have you seen cost-sharing measures implemented with P4P programs? Any outcomes?
- What is the main goal of your P4P programs? Is it to influence patient choice of providers? Is it to achieve greater provider accountability? To improve health outcomes? To reduce cost and improve outcomes for high impact and high- cost procedures?

BUNDLED PAYMENTS FOR EPISODIC CARE

Prospective payments made for all care a patient receives over the course of a defined clinical episode and period of management.

GOAL | **PROMOTES BETTER CARE COORDINATION AMONG CLINICIANS, HOSPITALS AND OTHER PROVIDERS.**

STRENGTHS

- Procedure-based bundled episodes internalize the incentive for efficiency
- Providers are coordinating to improve patient outcomes and reduce costs
- Hospitals are likely to develop close relationships with physicians and post-acute-care facilities who are willing to cooperate, follow care guidelines, and achieve quality and cost targets
- Improved continuity of care for patients when everyone works together
- Bundled episodes ease clinicians and organizations into more broad payment reform that are more consistent with existing strategies
- The approach requires providers to cooperate but not to integrate, it can reduce risk for provider consolidation that could raise prices

WEAKNESSES

- It might result in unneeded procedures
- If no risk adjustment mechanism, incentives to skimp on care or avoid sicker patients exists
- Referrals can be limited by hospital, reducing a patient's choice of provider
- The risk of higher administrative costs to adjudicate claims
- Ensuring the services are paid on time and once can be difficult
- Few procedures are amenable to a bundled episode approach
- Hospitals and physicians in non-competitive markets may be able to increase volumes and prices for other services to make up for the losses
- Providers may not be willing to assume the risk for fear of large losses

QUESTIONS TO ASK REGARDING THIS TOPIC ON THE NEXT PAGE

BUNDLED PAYMENTS FOR EPISODIC CARE

A payer compensates physicians according to an evaluation of physician performance, typically as a potential bonus on top of the physician's fee-for-service compensation

QUESTIONS TO ASK

- What quality measures have you implemented to measure outcomes for a bundled payment arrangement?

- Do you incorporate shared decision-making, patient reported outcomes and clinical appropriateness measures?

- Have you done anything to combine like conditions under one budget payment model? Do you think that it encouraged physicians to treat the whole person, rather than just treating them through various episodes?

- Do you have policies in place to discourage providers making questionable diagnosis in order to trigger an episodic payment?

- How do you monitor providers to ensure they are not limiting needed care for their patients?

- Do you measure the clinical appropriateness of specific bundles?

- What evidence-based approaches are you using, and what have you learned?

BUNDLED PAYMENTS FOR EPISODIC CARE

A payer compensates physicians according to an evaluation of physician performance, typically as a potential bonus on top of the physician's fee-for-service compensation

QUESTIONS TO ASK

- What benefit designs work well with this payment structure? Any outcomes or results you can share?
- What other reimbursement models are being used to complement bundled payment models?
- What work have you done to incorporate reference-based pricing approaches?
- What evidence-based guidelines and quality standards are being used?
- For preferred or high-quality physicians, have you worked to complement their narrow or tiered networks with bundled payment models?
- Have you worked to incorporate DRGs into bundled payments to improve hospital discharge planning and better continuum of patient care ?
- How are you using bundled payments to complement capitation with primary- care physicians under an at-risk contract? What about population-based payment models such as ACO's?
- What factors are critical to the success of bundled payments for episodic care?

DIAGNOSIS RELATED GROUPS (DRGS)

A payment method used by both CMS and private insurance carriers to classify and categorize inpatient case mix into clear paths of care with "flat rate discharges"

GOAL | REDUCE COSTS ASSOCIATED WITH AN INPATIENT STAY, UNNECESSARY HOSPITAL SERVICES AND LENGTHS OF STAY.

STRENGTHS

- Hospitals have an incentive to reduce costs per stay
- Payers can achieve savings with reduced hospital stays and services.
- Improve care pathways to reduce lengths of stays and focus on the appropriateness of the stay
- New approaches to promoting quality and cost containment can be included

WEAKNESSES

- Hospitals retain an incentive to increase the number of unnecessary hospitalizations
- Changes coding practices of diagnosis and procedures ("DRG creep"')
- Heavy administrative burdens and increased reporting
- Surgical procedures can be favored over medical management.
- Unless the payment design doesn't permit a new payment for readmission within a specific time period, hospitals may be inclined to discharge patients prematurely
- Patient transfers to other hospitals or post-acute care facilities generate overpayments from artificially low length of stays

QUESTIONS TO ASK REGARDING THIS TOPIC ON THE NEXT PAGE

DIAGNOSIS RELATED GROUPS (DRGS)

A payment method used by both CMS and private insurance carriers to classify and categorize inpatient case mix into clear paths of care with “flat rate discharges.”

QUESTIONS TO ASK

- Have you modified DRG weights to incentivize desired high-value behavior and decisions? Such as penalizing providers performing a procedure associated with patterns of inappropriate care?

- Do you currently incorporate normative standards of care for efficiently produced evidence-based care into DRG weights to promote greater efficiency and enhance quality and cost of care? What benefit designs work well with DRG arrangements? Any positive outcomes?

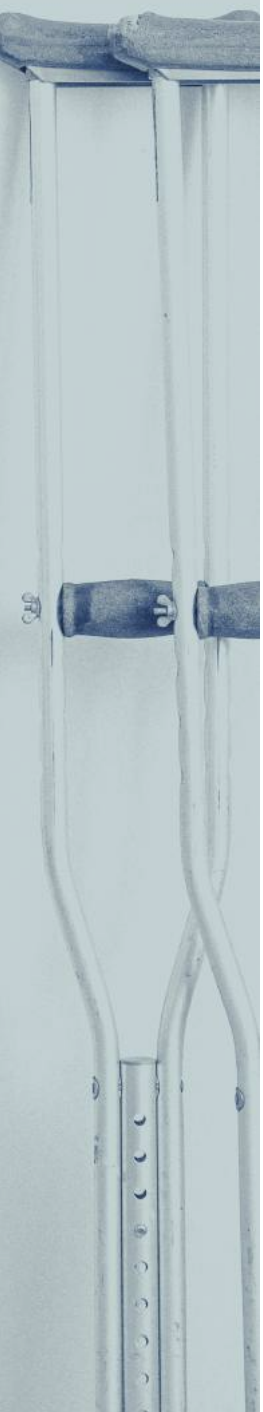
- Do you have strategies to mitigate risks where DRG’s incentivize hospitals to enhance volume of care with increases in the rates of admittance and re-admittance?

- Do you have any option for a transfer policy to keep the number of days spent in the hospital to a minimum? Is there a way to take advantage of observation days? Have you worked with other employers to create quasi-hospital budgets or volume thresholds to place predetermined limits on payments? How have you done this before? Any lessons learned?

DIAGNOSIS RELATED GROUPS (DRGS)

A payment method used by both CMS and private insurance carriers to classify and categorize inpatient case mix into clear paths of care with “flat rate discharges.”

QUESTIONS TO ASK



- Do you have policies in place allowing employers to forgo making a new DRG payment for patients readmitted for the same problem within a “DRG-specific duration” after discharge?

- What strategies do you have to prevent DRG payments diverging substantially from underlying costs of production? Have you worked with employers to recalculate based on DRG weights or monetary conversion factors? Any lessons learned?

- Have you implemented any policies that would help reduce costs and improve value?

- What other reimbursement models are being used to complement DRG’s? Are you incorporating DRGs into bundled episodes of payment?

GLOBAL BUDGETS FOR FACILITIES

A fixed amount of funding for a specific period and population.

GOAL | HOSPITALS SHOULD ENSURE THAT PEOPLE ENJOY REASONABLE ACCESS TO AFFORDABLY PRICED SERVICES.

STRENGTHS

- Improves operating efficiency and reduces the number of cases, outpatient encounters and services per patient
- Provides spending predictability
- Hospitals have greater autonomy and flexibility to improve the production of health care services
- Easy to administer and navigate
- Less risk for fraud
- Price sharing can be included if cash flow is based on units of service per diems

WEAKNESSES

- Limited availability unless you're in an all-payer or single-payer environment
- Doesn't promote hospital competition or reward hospitals for growth in market share unless linked to specific populations
- Without performance incentives, there may be a negative impact on access and quality. Extreme divergence from historical spending may cause real financial hardship for affected hospitals, impacting both quality and access to care

QUESTIONS TO ASK REGARDING THIS TOPIC ON THE NEXT PAGE

GLOBAL BUDGETS FOR FACILITIES

A fixed amount of funding for a certainfixed period for a specific population.

QUESTIONS TO ASK

- How do you track quality in global budget arrangements? Do you combine other quality improvement incentives like P4P to ensure quality?

- Do you implement other policies like: average length of stay; readmissions; patient safety measures; and hospital acquired conditions to maintain specific levels of access and quality?

- What benefit designs work well with a global budget for facilities? Any positive outcomes?

- What cost-sharing models align with global budget arrangements?

- What elements of historical, capitation and normative approaches do you incorporate when you set the global budget?

- Is there a framework in place that ensures volume levels are achieved or adjusted for and quality standards are met?

- What other reimbursement models are being used in conjunction with global budgets? Are you incorporating any population-based payment approaches such as shared savings or shared risk?

GLOBAL CAPITATION TO AN ORGANIZATION: POPULATION HEALTH BASED PAYMENTS

Payments are made to an integrated care organization or a large physician group that distributes payments accordingly.

GOAL | IMPROVE THE EFFICACY AND EFFICIENCY OF CARE DELIVERED BY A PROVIDER ORGANIZATION.

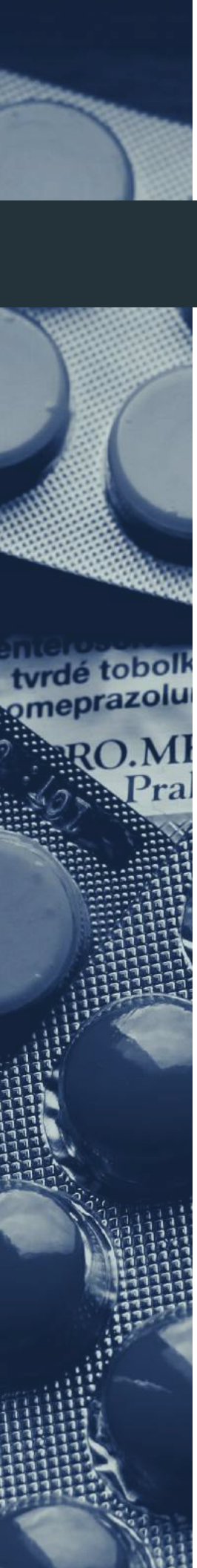
STRENGTHS

- Puts clinicians in charge to determine the best mix of services and professionals most capable of meeting the needs of the target population
- Permits the greatest flexibility in deployment of resources and payment of health professionals and suppliers
- Promotes integration of services across individual systems and offices.
- Provides on-going cash flow and permits recipients to deploy capital and establish reserves for delivery system enhancements
- Easy to administer

WEAKNESSES

- May result in financial losses outside providers' control, which could lead to service reductions and limit access
- Global capitation is not as scalable because many organizations lack the capital and infrastructure, including managerial skills to manage
- The groups capable of accepting global capitation often hold market power and may use it to raise prices
- Subject to 'code creep' where you have more extensive coding of diagnosis and procedures which increase cost
- Limits patients' choice of providers
- Risk undermining the patient-physician relationship
- Administratively complex to administer with significant regulatory oversight

QUESTIONS TO ASK REGARDING THIS TOPIC ON THE NEXT PAGE



GLOBAL CAPITATION TO AN ORGANIZATION: POPULATION HEALTH BASED PAYMENTS

Payments are made to an integrated care organization or a large physician group that distributes payments accordingly.

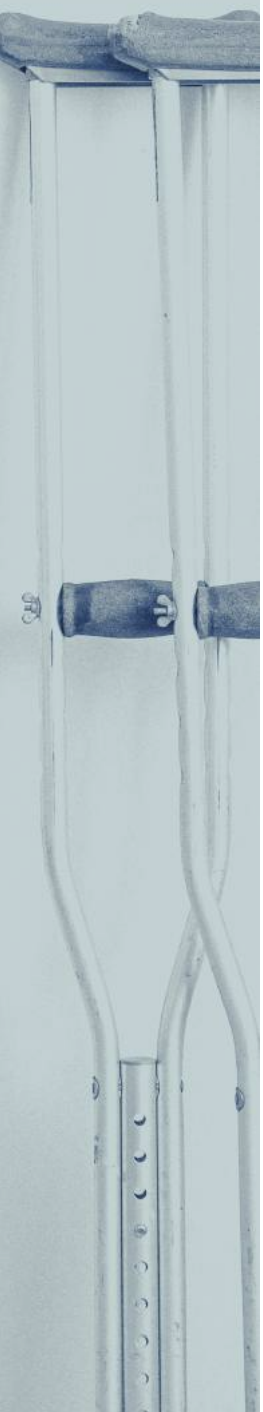
QUESTIONS TO ASK

- What quality or performance measures are being used to track value and improve patient outcomes?
- How do you monitor providers to ensure they're not limiting care and investing in preventive care services?
- What ways do you measure and track care paths to ensure the best continuum of patient care?
- Have you implemented any measures to track referral appropriateness for services outside of the contracted organization, where strong clinical expertise may be needed to ensure high quality outcomes?
- Are you engaging in any cost-sharing or risk sharing agreements related to high-risk treatment pathways?
- Have you incorporated any risk adjustments based on patients' health status to encourage providers to take on all cases regardless of how complex they may be?
- Do you promote the use of integrated care pathways? If so, how are you measuring and tracking risk associated with patient's health status? What data are you collecting? Will that increase administrative costs?

GLOBAL CAPITATION TO AN ORGANIZATION: POPULATION HEALTH BASED PAYMENTS

Payments are made to an integrated care organization or a large physician group that distributes payments accordingly.

QUESTIONS TO ASK



- How is capitation paid to the provider?
- What methodology do you use to determine the capitation rates for an organization? Do you adjust these rates to reflect risk or health of a population?
- What benefit designs work well with this type of global capitation? Have you seen any good outcomes?
- Have you seen success with value-based benefit designs?
- What types of cost-sharing models have worked well with these payment models? Have you seen success with high-deductible health plans or coinsurance?
- What other payment models are being used to complement this global capitation method? Have you incorporated any P4P agreements with this model?
- Have you used DRG payment models to encourage physicians to reduce the number of days patients spend in the hospital?
- What factors are critical to the success of the global capitation model?

REFERENCED BASED PRICING

A system where insurer selects a price it is willing to pay for a healthcare service. Enrollees who obtain care from a provider with a price at or below the reference price pay only the normally required cost sharing (e.g., deductibles, coinsurance).

GOAL DECREASE SPENDING ON EMPLOYEE BENEFITS BY PROVIDING CONSUMERS THE INCENTIVE TO SEEK CARE AT LOWER COST PROVIDERS AND PRESSURE ON PROVIDERS TO LOWER THEIR PRICES.

STRENGTHS

- Cost transparency
- Manages year over year trends
- Can encourage providers to lower-costs
- Controls costs for specialty services
- Encourages consumers to select lower cost providers
- Reduce costs

WEAKNESSES

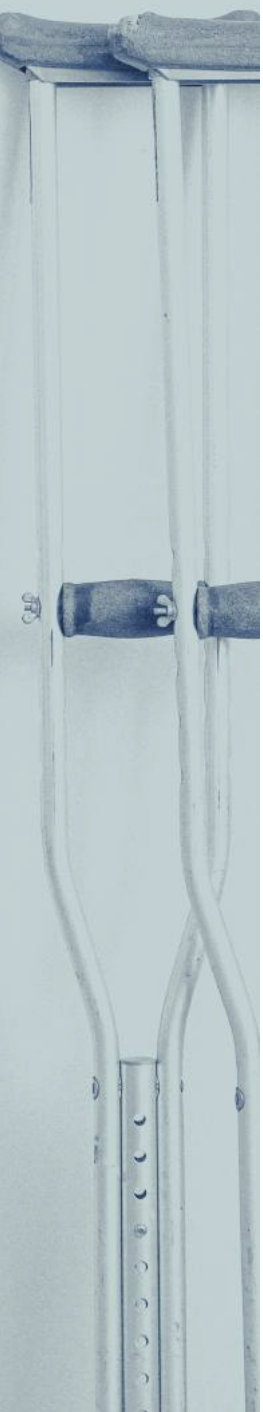
- Can shift costs to consumers
- The focus remains on cost per service not quality of care
- Language in provider contracts can prohibit insurers from steering patients to lower cost providers
- Potential balance billing for patients with Medicare plus models because there are no provider contracts
- High level of consumer education is needed
- May add incentive for provider to increase services to earn more revenue
- Lack of savings opportunities for preventive services and complete chronic care
- May be difficult to administer
- Can restrict patient's choice of care

QUESTIONS TO ASK REGARDING THIS TOPIC ON THE NEXT PAGE

REFERENCED BASED PRICING

A system where insurer selects a price it is willing to pay for a healthcare service. Enrollees who obtain care from a provider with a price at or below the reference price pay only the normally required cost sharing (e.g., deductibles, coinsurance).

QUESTIONS TO ASK



- How do you compare customer satisfaction with providers?
- Are you supplementing your providers with other incentives to improve the quality of care?
- What factors were used in selecting the "shoppable services"? Were factors like geography; comparable provider cost for services in the market; ability of consumers to easily choose; and dominant providers in the area considered?
- How is consumer education supported so it's easy for them to identify and access low-cost providers?
- What tools do you use to communicate price transparency with consumers and providers?
- How often, and how do you keep track of provider-cost comparisons?
- How do you monitor provider treatment patterns to ensure utilization and/or upcoding are not occurring?
- Are there penalties for providers who don't lower costs? What happens if the provider does not accept the payment as reimbursement in full for the service?

PROVIDER INCENTIVES COMPARISON TOOL

Health Action Council has identified some of the most popular provider incentive models. Below is a one-page dashboard that easily shows the way each of these serves a different goal

STRENGTHS

	FEE SCHEDULE	CAPITATION	SHARED SAVINGS AND SHARED RISK	PAY FOR PERFORMANCE (P4P)	BUNDLED PAYMENT FOR EPISODIC CARE	GLOBAL BUDGETS FOR FACILITIES	GLOBAL CAPITATION TO AN ORGANIZATION: POPULATION HEALTH BASED PAYMENTS	DIAGNOSIS RELATED GROUPS	REFERENCE BASED PAYMENTS
More control over payments	✓		✓						✓
Predictable costs and payments	✓	✓	✓			✓			✓
Impact appropriate utilization of services	✓	✓	✓		✓	✓	✓	✓	✓
Positive provider behavior change	✓		✓		✓		✓	✓	
More data and efforts to measure and improve provider performance	✓		✓	✓	✓		✓	✓	
Flexible	✓	✓	✓	✓		✓	✓		
Easy to administer		✓				✓	✓		
Use of non-traditional communication and care delivery		✓							
Increase transparency on provider payments and increase value				✓	✓		✓	✓	✓
Give consumers data to help them make informed choices				✓					✓
Less risk for fraud						✓			

WEAKNESSES

	FEE SCHEDULE	CAPITATION	SHARED SAVINGS AND SHARED RISK	PAY FOR PERFORMANCE (P4P)	BUNDLED PAYMENT FOR EPISODIC CARE	GLOBAL BUDGETS FOR FACILITIES	GLOBAL CAPITATION TO AN ORGANIZATION: POPULATION HEALTH BASED PAYMENTS	DIAGNOSIS RELATED GROUPS	REFERENCE BASED PAYMENTS
Encourage over provision of services	✓		✓				✓	✓	
No way of tracking if service was appropriate	✓	✓	✓	✓	✓			✓	
Creates fragmented system	✓		✓						
Lack of preventative or coordinated care	✓		✓	✓				✓	✓
Limits services and access to providers	✓	✓	✓		✓		✓		✓
Limited data on quality or effectiveness of services		✓	✓	✓		✓			✓
Physicians could turn away sicker patients		✓			✓				
Waitlists		✓							
Restricted to managed care organizations		✓							
Limited ability to promote or encourage activities or services		✓			✓	✓			✓
Higher administrative requirements and costs				✓	✓		✓	✓	✓
Providers may not be willing to assume the risk					✓		✓		
Could cause financial hardship for providers						✓	✓		
Can shift costs to consumers									✓

health action council
Enhancing Business. Enlightening Lives. Enriching Communities.

Health Action Council is a not-for-profit 501(c)(6) organization representing mid and large-size employers that works to improve human and economic health through thought leadership, innovative services, and collaboration. It provides value to its members by facilitating projects that improve the quality and moderate the cost of healthcare purchased by its members for their employees, dependents, and retirees.

Health Action Council also collaborates with key stakeholders health plans, physicians, hospitals and the pharmaceutical industry to improve the quality and efficiency of healthcare in the community.

LET'S KEEP THE CONVERSATION GOING

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