Although health policy experts disagree on many issues, they largely agree on the short-comings of fee-for-service payment. The inefficiency of a payment method that rewards increases in service volume, regardless of health benefit, has become practically indefensible. But replacing discrete payments for each service with bundled payment for a set of services does not simply promote efficiency; it also potentially promotes skimping on care or avoidance of costly patients.

The Center for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services recently announced a large-scale demonstration of bundled payments for hospital and post-acute care services, and President Barack Obama’s 2014 budget proposes to move forward with that approach. Lest we sacrifice quality and access in the pursuit of efficiency, it is worth considering whether a payment approach in which savings and risk are shared — a hybrid of a fee-for-service system and one providing rewards for spending reductions — will achieve a better balance of cost, quality, and access than a system of single bundled payments, at least until our capacity to measure patients’ care needs and outcomes is sufficiently robust.

The Medicare program already has considerable experience not only with capitation payments to health plans for the full range of Medicare services but also with bundled payments for sets of services: inpatient hospital services are bundled into “stays,” skilled-nursing-facility (SNF) services are bundled into “days,” and home-health-agency (HHA) services are bundled into “episodes.” That bundles’ powerful rewards for reducing costs create an efficiency–selection trade-off — simultaneously rewarding desirable and undesirable behavior — is old news. But even new news (regarding Medicare Advantage plans) documenting that technical payment refinements can reduce the rewards provided for avoiding costly patients or costly care also shows that behavior favoring service to low-cost patients over high-cost patients persists.

Experience with current prospective payments raises particular concerns about selection and skimping in post-acute care. The tip-off to the risk involved in offering powerful incentives for these providers to keep costs low is the presence of extremely high and varied profits, in a service area devoid of standards for high-quality care. In 2010, SNFs and HHAs earned profits of 19%, on average, and the top quarter earned in excess of 27%.

In theory, these high and widely varying profits might reflect variations in efficiency. But two factors other than relative efficiency probably explain these margins. First is that classification of patients into payment categories for rate-setting purposes is not sufficiently precise to eliminate variation in expected costs among the patients within a category — so providers serving patients whose care needs are lower than average for the category are overpaid, and those whose patients have above-average care needs are underpaid. Second is the long history of patient selection in nursing homes and recent evidence that the HHAs with the highest profit margins provide fewer visits, despite serving patients with greater measured care needs.

Given the weakness of patient classification and quality norms, policymakers would do well to heed previous advice that, in these circumstances, a hybrid approach better balances efficiency and appropriate care.
Influenza A (H7N9) and the Importance of Digital Epidemiology

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On March 31, 2013, Chinese health officials notified the World Health Organization of three cases of human infection with novel influenza A (H7N9). Since then, 132 people have been infected, 37 of them fatally (see figure, Panel A). To date, there is no evidence of ongoing transmission of the virus. Since the first cases were reported, increased surveillance and testing have been implemented, which facilitated early detection. Digital epidemiology tools can play a crucial role in this process by allowing real-time tracking and analysis of infection data.

Digital epidemiology involves the use of digital data to monitor and analyze disease outbreaks. This approach can help public health officials quickly identify and respond to emerging threats, such as the spread of novel influenza strains. By leveraging data from various sources, including electronic health records, social media, and mobile devices, digital epidemiology can provide early warnings and support targeted interventions.

In the case of H7N9, digital epidemiology can help in several ways:

1. **Early Detection:** Digital data can alert health authorities to unusual patterns of disease activity, allowing for prompt investigation and containment measures.
2. **Surveillance Enhancement:** By integrating multiple data streams, digital epidemiology can provide a more comprehensive view of disease spread than traditional methods.
3. **Risk Stratification:** Digital tools can help identify high-risk populations or areas, enabling targeted public health interventions.
4. **Resource Allocation:** Digital data can inform the allocation of resources to areas with the greatest need, optimizing response efforts.

As we continue to face new and emerging threats, digital epidemiology becomes an indispensable tool for public health. By harnessing the power of data, we can achieve more rapid response times, improved disease tracking, and better resource allocation, ultimately leading to improved public health outcomes.

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