State Leadership for Health Care Reform

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Figure A-1.
Revenues and Primary Spending, by Category, Under CBO’s Long-Term Budget Scenarios Through 2080

(Percentage of gross domestic product)

Extended-Baseline Scenario

- Total Primary Spending
- Revenues
- Other Noninterest Spending
- Medicare, Medicaid, CHIP, and Exchange Subsidies
- Social Security

Alternative Fiscal Scenario

- Total Primary Spending
- Revenues
- Other Noninterest Spending
- Medicare, Medicaid, CHIP, and Exchange Subsidies
- Social Security

Source: Congressional Budget Office.
Notes: Primary spending refers to all spending other than interest payments on federal debt.

The extended-baseline scenario adheres closely to current law, following CBO’s 10-year baseline budget projections through 2020 (with adjustments for the recently enacted health care legislation) and then extending the baseline concept for the rest of the long-term projection period. The alternative fiscal scenario incorporates several changes to current law that are widely expected to occur or that would modify some provisions that might be difficult to sustain for a long period. (For details, see Table 1-1 on page 3.)

CHIP = Children’s Health Insurance Program.
Key Issues for State Leadership

• Lower Cost Growth and Better Health Care Quality: “Bending the Curve”

• Reforming Performance Measurement

• Reforming Health Care Payments

• Reforming Health Care Benefits and Benefit Choice
Bending the Curve

Full-text available at: http://www.brookings.edu/health

Full-text version includes:

- Additional context
- Specific sub-recommendations
- Breakdown of legislative vs. regulatory actions
Achieving Real Health Care Reform

- Expanding insurance coverage and squeezing prices won’t do it
- State leadership needed

- Support what we want: Better quality, lower costs
- Requires much more accountability and support for better care, lower costs – system wide
- Four key elements
  - Measurement and Evidence
  - Payment
  - Benefits
  - Insurance Choice
Measure Performance to Enable Better Choices

- Convene/Lead to Provide Measures of Quality and Cost That Matters to Patients and Providers
  - Right Measures, Especially Outcomes of Care and Total Costs
  - Consistent Methods with Valid Results

- Two Strategies for Bringing Data Together
  - All-Payer Claims Databases
  - Distributed-Data Collaborations
Distributed data use to support improvement, payment reform, and consumer engagement

Data Exchange for Care Coordination and Quality Improvement

- Consumers
- Health Plans
- Pharmacies
- Lab
- Hospitals
- Registries
- Physicians

Identifiable Patient-Care Data Remains Behind Firewalls

Summary results (denominator/numerator) are consistently calculated and transmitted

Data Use: Consumer Engagement/Choice

Date Use: Payment & Benefit Reform
Reform Payments Based on Value

• Measurement of Quality and Cost Provides Foundation for Payments Based on Value: Accountable Care
• “Shared Savings”
• Examples of Accountable Care
  – Medicare Physician Group Practice Demonstration
  – Medicare Regional Demonstrations: Sustaining Health Insurance Exchanges
    • Community Care of North Carolina
    • Indiana Regional Health Insurance Exchange
  – Brookings-Dartmouth Accountable Care Organization (ACO) pilots
  – Premier ACO Network
  – Private Health Insurer ACOs
  – Upcoming Medicare and Medicaid ACOs
Little formal ACO activity two years ago

Public Sector

= Medicare Physician Group Practice Demo; Medicare Health Care Quality Demon
Now ACO implementation is accelerating across the U.S. {Not exhaustive}

**Private Sector**
- ⭐ = Brookings-Dartmouth
- ⭐ = Premier
- ☆ = CIGNA
- ✽ = AQC (9 organizations in MA)
- ✷ = Other private-sector ACOs

**Public Sector**
- ★ = Beacon Communities
- 🔘 = PGP, MHCQ

{Not exhaustive}
Wide variety of possible models for ACO implementation

<table>
<thead>
<tr>
<th>Integrated Delivery System</th>
<th>Multispecialty Group Practice</th>
<th>Physician-Hospital Organization</th>
<th>Independent Practice Association</th>
<th>Regional Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more hospitals &amp; large group of employed physicians</td>
<td>Strong physician leadership</td>
<td>Joint venture between one or more hospitals &amp; physician group</td>
<td>Small physician practices working together as a corporation, partnership, professional corporation or foundation</td>
<td>Independent or small providers</td>
</tr>
<tr>
<td>Insurance plans (some cases)</td>
<td>Contract with multiple health plans</td>
<td>Vary from focusing contracting with payers to functioning like multi specialty group practices</td>
<td>Often contract with health plans in managed care setting</td>
<td>Leadership may come from providers, medical foundations, non-profit entities or state government</td>
</tr>
<tr>
<td>Aligned financial incentives, advanced health IT, EHRs, &amp; well-coordinated team-based care</td>
<td>Developed mechanisms for coordinated care (sometimes arranged through another partner)</td>
<td>Many require strong management focused on clinical integration &amp; care management</td>
<td>Individual practices typically serve non-HMO clients on a standalone basis</td>
<td>Sometimes in conjunction with health information exchanges or public reporting</td>
</tr>
</tbody>
</table>
Advancing payment models to support improved performance

Shared savings when quality improves
- Benchmark based on per-capita spending for assigned patients
- If actual spending lower than target AND quality measures improve, providers receive additional payments

Going further with transitions to “two-sided risk” and partial capitation
- Two-Sided Risk: Increased incentive for providers to decrease costs as they are at risk for losses if spending exceeds targets
- Partial Capitation: Mix of FFS and prospective fixed payment; while potentially greater upside, if ACO exceeds budgets, more risk means greater financial downside
Measuring and rewarding performance

Core measures

- **Measures**: Easily calculable through administrative data or existing patient survey systems
- **Health IT**: Implementable without fully functioning and integrated EHRs (e.g. internal web portals, patient registries)

Interim clinical process measures

- **Measures**: Require clinical data on evidence-based processes of care that are less accessible in a standardized format by many health care organizations
- **Health IT**: Expanded health IT capabilities from investments in electronic data systems and better access to clinical data

Advanced measures

- **Measures**: Advanced, patient-reported measures that include functional outcomes and health risk assessment
- **Health IT**: Advanced health IT capabilities that likely include an integrated and fully-functioning EHR system

Increasingly Sophisticated Measures Over Time
<table>
<thead>
<tr>
<th>Sample Domains</th>
<th>Sample Measures</th>
<th>Proposed MMSP</th>
<th>B-D Core Set</th>
<th>B-D Interim Clinical Process</th>
<th>B-D Pilot Site</th>
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<tbody>
<tr>
<td>Patient/Care Giver Exp.</td>
<td>Clinician/Group CAHPS - Patients’ Rating of Doctor</td>
<td>X</td>
<td>X</td>
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<tr>
<td></td>
<td>Clinician/Group CAHPS – Care Coordination</td>
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<td>Care Coordination</td>
<td>Risk-Standardized, All Condition Readmission</td>
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<td></td>
<td>Care Transition Measure</td>
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<td>Patient Safety</td>
<td>Health Care Acquired Conditions Composite</td>
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<td></td>
<td>Annual Monitoring for Patients on Persistent Medications</td>
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<tr>
<td>Preventative Health</td>
<td>Colorectal Cancer Screening</td>
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<td></td>
<td>Mammography Screening</td>
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<td>At-Risk Populations</td>
<td>Diabetes Composite (All or Nothing Scoring)</td>
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<td></td>
<td>Hypertension (HTN): Blood Pressure Control</td>
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<td>Cost of Care</td>
<td>Resource Use and Costs Associated with a Patient’s Care Over a 1-Yr Period</td>
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<td></td>
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<tr>
<td>Functional Outcomes/Health Risk</td>
<td>Health Risk Assessment</td>
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<tr>
<td></td>
<td>Mental Health (SF-36 or CHQ)</td>
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{Not Exhaustive}
Core Competencies for Accountable Care

1. **Governance and leadership** focused on the resources and project management required to implement new models of care

2. **Health IT** that supports measurement for both improvement and accountability – starting with simple systems for tracking patients and progressing to electronic health records

3. **Care coordination** – especially for the frail elderly or for those with multiple chronic conditions – across clinicians and sites of care

4. **Care improvement programs** that allow teams comprised of nurses, pharmacists and other health professionals to maintain health and prevent costly complications of chronic diseases and major procedures
Lessons learned from ACO implementation

Develop a process

• Use data to inform a move towards value and identify a payer-partner to initiate discussions
• Develop an implementation plan that identifies opportunities to improve care delivery and population management
• Launch initiatives that reinforce payment changes (PCMHs, episode-based payments)
• Implement reforms with a long-term contract to ensure success

Secure ongoing commitments

• Commit to ongoing adjustments to the ACO contract – from both payers and providers
• Harmonize the assets of both payers and providers
• Receive commitments from the payer for: timely data, management of insurance risk, and possibly sharing of performance risk

Distinguish risk from uncertainty

• Develop realistic estimates of ACO start-up costs
• Review past data to understand organizational performance
• Align on clear and realistic expectations for both quality and costs
ACOs are synergistic with other reforms
Synergy in payment reform

**Value-based payment reform**

**Aligned Performance Measures**
- Quality (Including Impact on Outcomes, Population Health)
- Cost/Efficiency Impacts

**Aligned Reform Priorities and Support**
- Timely data for patient care
- Supportive health plan, specialty providers, hospitals

**Aligned Payment Reforms**
- HIT Meaningful Use
- Payments for Reporting/
- Medical Homes
- Episode Payments
- Accountable Care
- Others

**Sufficient Scale**
- Sufficient capital to provide time, effort, and technical support for real delivery change (payers, providers-including physicians, equity)
- Strategy for using and augmenting Federal payments
- Systemwide leadership: regional collaborations; business groups; states; Federal government?
Multi-payer efforts critical to successful ACO formation

Successful ACOs will need support from CMS, private payers, and states
Indiana State/Multipayer Health Care Quality Demo

With the Quality Health First Program as its foundation, Indiana’s Medicare Health Care Quality Demonstration Program is a community-wide quality measurement and P4P program with a shared savings component that uses information on adherence to treatment guidelines and practice efficiency to distribute savings that are achieved through better care management.

- **Participants**: coalition of physician practices, hospitals, employers, private and public payers, and public health officials.
- **Shared Savings Model**
  - Maximum payment to IHIE will be the lesser of three amounts: 80% of net savings; 50% of gross savings; or 5% of the expenditure target.
  - Must meet 1.5% savings threshold.
  - Shared savings capped at 5% of total expenditures.
- **Spending Benchmarks**: Baseline expenditure targets for physician panels calculated on a per beneficiary per month basis 12 months before demo start.
- **Quality/ Efficiency**: Percent of available savings contingent on performance increases with each year from 50% in year 1 to 80% in year 5.
Vermont’s ACO pilot builds upon its medical home pilots to include local specialists and community hospitals and provide a mechanism by which the financial benefits of the medical home could be captured and reinvested back into the community for infrastructure and quality improvement initiatives.

• **Range of ACO designs**, from simple shared savings for 2 sites to partial capitation for a PHO with experience managing financial risk

• **Multi-Payer design** (Medicaid and the 3 main commercial carriers), to align incentives and achieve stable expenditure projections and performance measurement

• **IT Infrastructure**: EHR adoption, supplemented by Web-based clinical tracking and registry tools (DocSite), with data flows to a centralized database through the statewide HIE (Vermont Information Technology Leaders, Inc), to provide timely and reliable information for care coordination and population-based provider feedback reports on key measures.
in Rural Areas

• North Carolina
  • NC Community Care Network includes 14 private, nonprofit health networks initially developed to support primary care through IT and other care improvement initiatives
  • Expanding into larger-scale, multipayer delivery reforms
    • Multipayer ACO payment incentives based on shared savings
    • Medicaid, state, private, and Medicare (Section 646 demonstration) participation
    • New multipayer pilot focusing on next steps in improving access and quality in 10 rural counties
    • 2010 legislation for performance measures, shared-savings payments, and delivery reforms by 2012

• Colorado
  • Colorado Accountable Care Collaborative (ACC) established by 2009 legislation
  • ACC framework supporting infrastructure for coordinating health information exchange, medical homes, and further payment reforms
    • Medical home for children in Medicaid, CHIP now being coordinated with regional ACO initiatives
    • Statewide data/analytic support plus 7 regional care coordination organizations
Key challenges for successful ACO implementation

### Challenges

1. **Aligning multi-payer ACOs with other reform initiatives**
2. **Catalyzing real leadership from providers & payers**
3. **Reducing start-up costs**

### Potential solutions

- Develop a common set of performance measures with a pathway for more sophistication over time
- Create harmony between other payment and delivery system reforms
- Commit sufficient leadership support within organization and trust toward shared goals between payers and providers
- Develop common frameworks and contract templates to reduce costs and uncertainty
- Promote transparency to accelerate learning

### Accountable Health Care

ACOs: Coordinated networks of providers with shared responsibility to provide the highest value care to their patients
ACO Learning Network: moving ACO implementation forward through peer-learning

2009-2010 ACO Learning Network

- >60 provider & payer organizations
- Focused on defining core ACO concepts
- Included webinars, ACO materials, and conference discounts

2010-2011 ACO Learning Network

- >135 organizations from across the health care spectrum
- Share lessons learned from ongoing examples of ACO implementation
- In-depth analysis of emerging Federal and State regulation

Implementation-focused webinar series
Member-Driven Conferences
ACO Newsletter
Web-based resources
Reform Coverage and Benefits for Greater Value

• Medicare Part D “Exchange” Experience
  – Broad range of benefit design and coverage options allowed, subject to minimum standards for “actuarial equivalence”
  – Comparative cost and quality information available
  – Fixed subsidies based on income and health status: strong incentives for beneficiaries to choose lower-cost plans that met their needs
  – Steps to address adverse selection: subsidies; risk adjustment; some reinsurance and risk corridors
  – 45% lower costs than projected
  – Beneficiaries chose “tiered” benefits that enabled much more savings based on their drug choices, not traditional Medicare insurance design

• Implications for Health Care Reform
  – Benefit design reforms to support wellness, better adherence and healthier behaviors
  – More comprehensive and more personalized application of benefit tiers: beneficiaries share in savings or get other benefits
Promote Competition in Insurance Choice to Drive Innovative Care and Savings

• Broad flexibility and competition in benefit design
• Support for confident choices: meaningful information, straightforward process to choose, assistance
• Steps to mitigate adverse selection (especially if no effective mandate)
  – Limited enrollment periods
  – Autoenrollment
  – Late enrollment penalty
  – Limited “buy up”
  – Risk-adjusted payments
• Provide strong incentives to choose less costly plan
  – Example: fixed subsidy (based on income, health status, etc.) that doesn’t depend on the cost of the plan chosen, so beneficiary keeps any savings from less costly choice
• Use Federal financial support in system design