Advancing High-Value State Health Reform

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Potential of the U.S. Health Care System

- Increased access to affordable coverage options
- Personalized, coordinated and innovative care leading to improved health
- Effective, evidence-based treatments
- Payments for providers and insurance benefits for consumers based on high-value care

Greater use of improved cost and quality measures
Declining Death Rates from Heart Disease in the United States, 1950 – 2000

Age-adjusted heart disease deaths per 1,000 people

Declining Infant Mortality, 1950 – 2000

Declining Death Rates from Cancer in the United States, 1999 – 2003

Rate per 100,000

186
190
194
198
202
1999 2000 2001 2002 2003

Source: Centers for Disease Control and Prevention, National Center for Health Statistics.
The Value of Medical Treatment

Benefit/Cost Ratio

<table>
<thead>
<tr>
<th>Condition</th>
<th>Ratio</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular disease</td>
<td>4</td>
<td>(1950-1990)</td>
</tr>
<tr>
<td>Low birthweight infants</td>
<td>5</td>
<td>(1950-1990)</td>
</tr>
<tr>
<td>Depression</td>
<td>7</td>
<td>(1991-1996)</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>7</td>
<td>(1984-1998)</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>1</td>
<td>(1985-1996)</td>
</tr>
</tbody>
</table>


i.e., the estimated benefits of heart attack treatment (i.e., longer and higher quality of life) are approximately 7 times greater than related medical costs.
Steep Costs of Health Care Progress

Projected Spending on Health Care as a Percentage of GDP, 2007 – 2082

Source: Congressional Budget Office, “The Long-Term Outlook for Health Care Spending” (November 2007).
Regional Variations in Per Capita Medicare Spending, 2005

Note: unit of analysis is hospital referral region.

Source: Congressional Budget Office, "Geographic Variation in Health Care Spending" (February 2008).
What Explains Regional Variation in Spending?

- Commonly used medical services are provided much more frequently in the “high-use regions”
  - Hospitalizations and inpatient days
  - Intensive Care Unit or Critical Care Unit days
  - Visits (evaluation and management services)
  - Specialist referrals
  - Imaging
  - Diagnostic tests

Source: Peter Orszag, Congressional Budget Office, “Health Care: Capturing the Opportunity in the Nation's Core Fiscal Challenge” (presentation at Princeton University, March 12, 2008).
Higher Medical Spending Does Not Translate to Higher Quality Care

The Relationship between Medicare Spending and Quality of Care, by State (2004)

Note: The composite measure of quality of care, based on the Medicare beneficiaries in the FFS program who were hospitalized in 2004, conveys the percentage who received recommended care for myocardial infarction, heart failure or pneumonia.

Source: Congressional Budget Office, “Geographic Variation in Health Care Spending” (February 2008); Data: Centers for Medicare and Medicaid Services, Agency for Healthcare Research and Quality.
Variation in Health Care Quality Across States

Source: Commonwealth Fund, “Aiming Higher: Results from a State Scorecard on Health System Performance” (June 13, 2007).
Big Gaps in Evidence

- The evidence base for known effective and safe care—especially medical practices—is limited.
  - Only a relatively small fraction of all services are supported by strong evidence.
  - Because many medical interventions have not been rigorously evaluated, it is difficult to enact evidence-based coverage and payment policies.
  - Evidence on medical practices and the benefits and risks of treatments in particular patients, not just average effects of specific treatments, is challenging.

## Even Effective Evidence-Based Treatments are Often Underutilized

### Percentage of Medicare Beneficiaries Ages 65+ Using Preventive Services, 1995-1999

<table>
<thead>
<tr>
<th></th>
<th>1995</th>
<th>1997</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal—ever</td>
<td>38%</td>
<td>46%</td>
<td>55%</td>
</tr>
<tr>
<td>Influenza—within previous year</td>
<td>60%</td>
<td>66%</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Screening services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical cancer—pap smear within previous 3 years</td>
<td>70%</td>
<td>71%</td>
<td>72%</td>
</tr>
<tr>
<td>Breast cancer—mammogram within previous 2 years</td>
<td>66%</td>
<td>72%</td>
<td>75%</td>
</tr>
</tbody>
</table>

## Lack of Physician Adherence to Recommended Care

### Adherence to Quality Indicators, Overall and According to Type of Care and Function

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. of Indicators</th>
<th>No. of Participants Eligible</th>
<th>Total No. of Times Indicator Eligibility Was Met</th>
<th>Percentage of Recommended Care Received (95% C.I.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall care</td>
<td>439</td>
<td>6,712</td>
<td>98,649</td>
<td>54.9 (54.3-55.5)</td>
</tr>
<tr>
<td>Type of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive</td>
<td>38</td>
<td>6,711</td>
<td>55,268</td>
<td>54.9 (54.2-55.6)</td>
</tr>
<tr>
<td>Acute</td>
<td>153</td>
<td>2,318</td>
<td>19,815</td>
<td>53.5 (52.0-55.0)</td>
</tr>
<tr>
<td>Chronic</td>
<td>248</td>
<td>3,387</td>
<td>23,566</td>
<td>56.1 (55.0-57.3)</td>
</tr>
<tr>
<td>Function</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening</td>
<td>41</td>
<td>6,711</td>
<td>39,486</td>
<td>52.2 (51.3-53.2)</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>178</td>
<td>6,217</td>
<td>29,679</td>
<td>55.7 (54.5-56.8)</td>
</tr>
<tr>
<td>Treatment</td>
<td>173</td>
<td>6,707</td>
<td>23,019</td>
<td>57.5 (56.5-58.4)</td>
</tr>
<tr>
<td>Follow-up</td>
<td>47</td>
<td>2,413</td>
<td>6,465</td>
<td>58.5 (56.6-60.4)</td>
</tr>
</tbody>
</table>

Poor Patient Adherence to Recommended Care

- Patients do not always follow their physicians’ recommendations.
  - In general, patients adhere to medication regimens about 50% of the time.
  - Long-term, successful adherence to physicians’ instructions to lose weight or stop smoking stands at 10%.

- Potential factors driving poor adherence, especially to medications, include:
  - Patients’ lack of belief in benefits of the treatment
  - Patients’ lack of insight into the illness
  - Poor patient-provider communication
  - Treatment complexity
  - Treatment costs
  - Potential side effects (medications)
  - Patients’ psychological or cognitive problems
  - Missed appointments

Health Declines and System Fragmentation Make Coordinating Care a Challenge

Problems include:

- Coordination among providers
  - Between primary care physicians and specialists
  - Between primary care physicians and emergency departments
  - Between physicians and sources of diagnostic data
  - Between hospital-based physicians and primary care physicians

- Coordination between providers and patients and their families
  - Between physicians and patients and their families
  - Between hospitals and patients and their families

Summary of Health-System Challenges

- Innovative treatments have improved health, but the system is costly. Meanwhile, the prevalence of chronic disease is increasing.

- Spending varies substantially across the United States and is not correlated to quality.

- Many treatments are not supported by evidence, but even evidence-based care is underutilized because payments and insurance benefits are not focused on supporting what does work.

- Our fragmented health-care system is poorly equipped to coordinate care, especially for those with complicated problems.
Toward High-Value Health Reform

Delivery System Reform
- Quality and cost measures
- Payment reform
- Care coordination
- Effective use of IT

Insurance Market Reform
- Purchasing groups/connectors
- Subsidies for low income and high risk populations
- Insurance rating reform

Leading to...
Higher-value health care and improved outcomes

Individual Assistance
- Health benefits that allow consumers to make better choices and save money
- Incentives and personalized support for informed decision-making

Financing Reform
- Addressing the tax treatment of ESI and Medicare subsidies
- Greater state flexibility to use existing Medicaid funds
PROBLEM: Disjointed quality measurement efforts and payer incentives

STATE REFORM APPROACHES: Better measures and a coordinated approach to adoption and testing

- Better measures
  - Processes
  - Outcomes
  - Satisfaction
  - Cost

- Coordinated approach to adoption and testing
  - Adopting common cost and quality measures
  - Regional multi-payer collaboration
Value-Based Provider Incentives

**PROBLEM:** Payment methods and other provider incentives are not aligned with the delivery of high-quality, cost-effective care

**STATE REFORM APPROACHES:** Payment reform (e.g., pay-for-performance, medical homes, shared savings)

- **Pay-for-Performance**
  - Over half of Medicaid programs use some form of P4P.¹
  - If all current plans to start new programs are realized within the next four years, nearly 85 percent of states will be operating Medicaid pay-for-performance programs.¹

- **From P4P to Shared Savings and Shared Value**
  - Some states are considering or developing efforts to move beyond incremental P4P approaches to revamp payment methods using shared savings and other payment approaches to align incentives for high-quality, cost-effective, and patient-centered care.

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¹ Commonwealth Fund, “Pay for Performance in State Medicaid Programs” (April 2008).
### Increasing Treatment Value by Reforming Benefits

**PROBLEM:** Consumer incentives are not aligned with cost-effective, quality care

<table>
<thead>
<tr>
<th>STATE REFORM APPROACH: Value-based consumer incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer access to provider performance information</td>
</tr>
<tr>
<td>Consumer incentives designed to inform consumers’ health care decision making, improve quality, and contain costs</td>
</tr>
<tr>
<td>Lowering out-of-pocket costs based on patient characteristics for specific “high-value” services</td>
</tr>
<tr>
<td>Broader use of tiered benefits, including efforts to steer consumers to low-cost, high-quality providers</td>
</tr>
<tr>
<td>Consumer incentives to participate in targeted care management and other programs</td>
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</tbody>
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Beyond Coverage Expansion: Current State Progress Towards Reform

- States are engaged in efforts to address system-wide quality and cost problems that can limit the feasibility or sustainability of coverage expansions.

- States are considering or adopting innovative solutions to address:
  - Poor care coordination
  - Unexplainable practice pattern variations
  - Inadequate payment provider methods
  - Poorly performing individual and small-group insurance markets
  - Limited adoption of health IT

- State leaders are seeking:
  - More information about reform options
  - Greater evidence about the potential impacts of these options
  - Guidance on introducing reforms as part of broader health reform
States Are Increasingly Taking Multi-Stakeholder Approaches to Reform

- States are recognizing that reform efforts can have greater impact and sustainability when they:
  - Address the health system as a whole
  - Are coordinated across public and private payers
  - Have the support of, and are able to draw expertise from, a broad range of key payers and stakeholders

- Accordingly, new waves of state health reform will combine:
  - Targeted access expansions (e.g., support for small firms providing benefits)
  - Common quality and cost measurement
  - Provider performance transparency initiatives
  - Care coordination activities
  - Population health and chronic disease activities
  - Insurance market reforms
  - Consumer incentive initiatives

...across public and private payers and stakeholders
The Governor’s Quality Initiative (GQI) is a multi-payer quality initiative led by three major public and private payers.

The initiative aims to prevent, manage, and treat chronic disease more effectively by:
- Developing a set of common quality measures for chronic disease care across major payers
- Supporting providers in the adoption of these measures
- Building an aggregated data warehouse to monitor practice patterns and results

The GQI builds on the infrastructure established by Community Care of North Carolina (CCNC).
- The collaborative structure creates opportunities for future integration of payment reforms and consumer incentives to improve chronic disease management and care coordination.
Minnesota has a strong history of purchaser-driven reform initiatives. Efforts include:

- Minnesota Community Measurement: Health plans collaborate to develop uniform quality reporting measures
- Smart Buy Alliance: Public and private health care purchasers share knowledge about pay-for-performance and public reporting

QCare, the state’s most recent effort, aligns quality with payment to providers and benefit design for consumers for all state purchased health care by:

- Setting common performance measures
- Publicly reporting performance online
- Changing the payment system to reward quality
- Maintaining greater overall accountability

Private sector health care purchasers and providers are encouraged to adopt QCare standards through the Smart Buy Alliance.
Vermont, through its Blueprint for Health, has designed a comprehensive and integrated approach to reform that:

- Expands access to affordable and effective health care
- Improves quality through multi-payer incentives
- Reduces the prevalence and burden of chronic conditions

The Blueprint promotes better prevention of chronic disease and improved coordination and treatment of chronic disease care through:

- Multi-payer data aggregation and information exchange to support statewide provider profiling and analysis
- Statewide Regional Health Information Organization (RHIO) to support the sharing of health information within regional networks
- Expanded health information technology grants to accelerate adoption at the community level

Coordinated efforts are supported by the federal government, which is allowing the flexible use of existing federal matching funds.
State Health Reform Initiative Objectives

- Structure provider incentives based on quality and efficiency measures
- Improve coordination across the delivery system
- Encourage provider performance transparency
- Accelerate adoption of health IT
- Empirically estimate the actual or likely impacts of policy options on health system performance
- Identify key considerations for introducing reform options in different market settings
- Provide information to state policy makers and other stakeholders to better position states to enact health reforms that can promote quality improvement and cost-containment
- Identify ways the federal government can assist states in undertaking reform
- Inform national health policy discussions based on state-level innovations

**Identify and analyze a range of innovative state health reform efforts**

- Provide better quantitative evidence on potential impacts of reform proposals at the state level

**Synthesize and disseminate findings to key stakeholders**