



Patient Protection and Affordable Care Act (PPACA) Opportunities: Delivery System and Financing of Health Care

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States Have Key Advantages in Implementing Delivery System Reform

- Leadership:
 - Convening and Coordinating
 - Provide anti-trust protection
 - States can exempt providers and insurers who come together to discuss payment reform
- Proximity:
 - Due to the local nature of health care delivery, states are closer to the action in the process of system redesign
- Flexibility to implement system redesign:
 - States have in-depth knowledge of local landscapes and the ability to foster relationships with local stakeholders critical to successful system change.

States Have Key Advantages in Implementing Delivery System Reform

- Ability to coordinate policy levers:
 - States can use the purchasing power of Medicaid and public employee programs, regulate health plans, and capitalize on relationships with federal officials to move delivery system reform forward
- Develop and support shared infrastructure:
 - States can help set up HIEs, assist providers in making technology improvements, invest in pilot projects, and develop data-sharing tools.

Federal Government Has a Role in Delivery System Reform

- Federal health reform legislation includes many features that would strengthen state efforts
- Federal government can ensure Medicare is a partner in state delivery system reform efforts
- Changes to ERISA can encourage self insured plans to participate in multi-payer initiatives.



PPACA: What 2014 Will Look Like

- Medicaid/CHIP
 - New Medicaid coverage up to 138% FPL (MAGI)
 - Childless adults receive 90-100% federal match
 - Maintenance of Effort
 - Adults, ends 1/14
 - Children, through 2019—but no CHIP allocations after FY 15
- The exchange
 - Run by the state or HHS
 - Offers plans to small groups and individuals
 - Tax credits and other subsidies for non-Medicaid eligibles without access to employer-sponsored coverage (ESI) up to 400% FPL
- Shared responsibility
 - Individual mandate
 - Possible penalties for companies with > 50 workers not offering ESI
 - Increased Medicare payroll taxes for households with incomes above \$250,000 (\$200,000 for single tax filers)
- Insurance reforms

State Reform Opportunities and Initiatives

- Delivery System Redesign/Care Coordination
 - Payment Reform
 - Medical Homes
 - Accountable Care Organizations
 - Care Transitions/Preventable Readmissions
- Population Health, Prevention and Wellness
- Transparency/All-Payer Claims Databases
- Consumer Engagement
- Comparative Effectiveness
- Health Information Technology and Exchange



Delivery System Redesign/Care Coordination:

Payment Reform

Medical Homes

Accountable Care Organizations

Care Transitions/Preventable

Readmissions



Why Reform Payment?

- Perhaps nothing more heavily influences how the provider system is organized and how care is delivered than the fee-for-service (FFS) payment system. FFS...
 - provides a financial incentive to increase the number of services they produce.
 - leads to underuse of services with low financial margins, including preventive care and behavioral health services
 - leads to underuse of high value services for which there is no fee, e.g., PCP phone consult with specialist
 - results in poor coordination of care across providers, including transition management

Principles of Payment

- Health care payment models pay providers for different levels of service aggregation
 - from individual services (FFS) to large aggregations of services (capitation)
- As payments are made for increasingly larger aggregations of services, the amount of financial risk borne by the provider increases and decreases for the payer



A Limited Range of Primary Payment Models

- Fee-for-service
- Bundled or Episode-Based Payment
- Shared savings
- Capitation



Fee-for-Service

- “Piece work” payment system financially rewards providers for doing more, and for doing more of whatever yields the highest margin – inherently inflationary
- Supports patient access to and use of services
- The provider bears little financial risk; the payer bears a great deal of financial risk
- The predominant payment system in the U.S.

Bundled or Episode-Based Payment (1)

- Two applications:
 - payment for services by all involved providers around a procedure –may include services that precede and/or follow the procedure (e.g., OB)
 - payment for all services delivered over a period of time (e.g., a year) for patients with a specific condition (e.g., diabetes)
- Limited use to date, e.g., earlier CMS demo, three Prometheus Payment pilots started in 2009

Bundled or Episode-Based Payment (2)

- Payments for procedures will, in theory, create more efficient and effective procedures, but not necessarily fewer procedures, specifically for “gray area” procedures
- Payments for conditions should address the “volume incentive,” but need to deal with co-morbidities and there are many conditions
- Needs to be balanced with access and quality incentives to address risk of under-treatment
- Provider bears more risk and payer less than with FFS

Shared Savings (1)

- Payer and provider agree upon a budget of risk-adjusted expected expenditures for a population
- Should actual spending fall below expected spending, savings are distributed between payer, provider, and sometimes, purchaser
- Needs to be balanced with access and quality incentives to address risk of under-treatment
- Provider has no more risk than with FFS, but has a financial incentive to achieve upside gain

Shared Savings (2)

- In limited use in the U.S.
 - Recommended by Fisher for ACOs
 - Recommended by the CBO for Medicare
 - Recommended by Massachusetts Payment Commission as a transition strategy

- Challenges
 - Setting (and agreeing upon) the budget target
 - Sustaining the model over time as initial savings are realized – provider fear of one-time savings reward
 - Desire for gain motivates less than fear of loss
 - Some health plans report that shared savings does not result in transformative change by providers.

Capitation

- Payer and provider agree upon a budget of risk-adjusted expected expenditures for a population
- Provider has the strongest financial budget management incentive of the four models
- Needs to be balanced with access and quality incentives to address risk of under-treatment
- Provider bears significant financial risk, and the payer much less than with FFS
- Requires provider risk mitigation for “insurance risk”
- Discarded in many regions of the country, persists in select markets (e.g., CA) where larger providers have organized to manage in response
- Many believe it to be the best payment model, despite past missteps.

Experience with Capitation

- Lessons learned from California:
 - Capitation can be employed on a large scale
 - Providers need formal organizational arrangements and certain administrative capacity
 - Payment should balance budget incentives with quality and access incentives to prevent under-treatment
 - Regulation and oversight are necessary to ensure provider solvency and patient protections.

Source: Hammelman E. et. al. “Reforming Physician Payments: Lessons from California”, California HealthCare Foundation, September 2009.

Secondary Models

- Secondary models are those that can be used in conjunction with any of the primary models, but are not themselves payment models:
 - Pay-for-Performance
 - Traditionally used with FFS, but can be integrated into any of the four primary models
 - Medical Home
 - Typically comprised of supplemental payments to cover the costs of historically uncompensated primary care services
 - Currently used with multiple primary payment models and with P4P

Two Major Areas of Health Policy Innovation

→ Medical Home

- Primary care practice transformation
- New payment models that increase primary care practice resources

→ Accountable Care Organization

- Organized networks of providers
- Accountability for budget, access and quality



Care Coordination/Care Management

- A recent survey of state Medicaid directors shows two types of programs were prominent in 2009:
 - Disease or care management programs
 - Care coordination/medical homes initiatives
- There has been a renewed focus on medical homes in recent years with more clearly defined standards for those claiming to be a medical home.
- Growing body of research points to a number of important factors in successful medical home demonstrations
- A key realization from research is that no one insurer has a sufficient percentage of a primary care provider's patient base to significantly affect the PCP. Thus the impact of single payer medical home demonstrations is limited.



Multi-Payer Medical Home Initiatives (1)

- Multi-payer medical home projects bring major insurers in a state together to implement changes in the interaction between primary care providers and patients.
- Typically, these changes have meant investing more money into primary care, with the additional funds being tied to various performance measures.
- Payers must decide how much reimbursement should be tied to structure and process (use of EMRs) or outcome measures (reduce ER visits).



Multi-Payer Medical Home Initiatives (2)

- Funding of extra medical home services was initially achieved by increasing funding to the system, as opposed to using savings from elsewhere in the system.
- The economic downturn has forced states to find more creative ways to fund medical home initiatives, including:
 - Requiring insurers to find cost neutral ways to increase primary care funding without raising premiums (as is done in Rhode Island)
 - Shared savings models
 - And other strategies that reward physicians for savings achieved.

Multi-Payer Medical Home Initiatives (3)

- In the past, a major hurdle to multi-payer medical home initiatives was the lack of participation of Medicare (VT, PA experience)
- In September 2009, it was announced Medicare would be freed to participate in state based medical home projects
- It remains to be seen how flexible Medicare will be in its implementation
- Other hurdles to multi-payer medical home initiatives include ERISA and gaining access to Medicare and public health data



What is the Medical Home Model?

- Origins: use of a central medical record to support children with special health care needs (AAP, 1967)
- Currently: transformation of primary care to a more efficient and effective model of health care delivery
 - “**Joint Principles**” (2007): developed by the ACP, AAP, AAFP and AOA in response to a request by large national employers
 - **NCQA**: recognition program for the “Patient-Centered Medical Home” (PCMH)

Why the Medical Home?

- Primary care-oriented health systems generate lower cost, higher quality, fewer disparities (Starfield).
- The Chronic Care Model – the chassis for much of the NCQA standards – has been heavily evaluated and found to improve quality. There have been fewer evaluations of cost and utilization impact, but most findings have been positive (Wagner, RAND).
- Primary care supply is declining nationwide and shortages will extend without change.
 - 2% of graduating medical students pursuing Internal Medicine intend to become primary care providers (*JAMA*, 2008)
- Increasing evidence from medical home pilots of effectiveness in improving quality, reducing costs and ER & IP utilization, and/or improving clinician satisfaction.

Eight Distinguishing Characteristics

- Personal physician (clinician)
- Team-based care
- Proactive planned visits instead of reactive, episodic care
- Tracking patients and their needed care using special software (patient registry)
- Support for self-management of chronic conditions (e.g., asthma, diabetes, heart disease)
- Patient involvement in decision making
- Coordinated care across all settings
- Enhanced access (e.g., secure e-mail)



Current U.S. Medical Home Initiatives

- Current initiatives take many different forms, with variation in:
 - Practice transformation emphasis
 - Payment design
 - Sponsorship
 - Involvement
- Tremendous learning underway
- Medical Home design issues
 - Practice Redesign
 - Consumer Engagement Beyond Primary Care Setting
 - Incentive Alignment
 - Evaluation
- *Risk*: moving on to the next new thing (e.g., the ACO) before perfecting the medical home



State Medical Home Initiatives

- Over 30 states have engaged in efforts to implement programs to advance Medical Homes in Medicaid/CHIP
- States working across payers on Medical Homes Programs include CO, LA, MA, MD, MN, NH, NY, PA, RI, VT, WA, and WV
- Three leading initiatives – all state-sponsored: PA, RI and VT
 - All dealt with anti-trust concerns by having the state take “state action” and play a leadership and facilitative role
 - Legislation necessary only in VT for an intransigent payer, but can be helpful in defining the role of the state



Relationship between Medical Homes and Accountable Care Organizations

- Even the best conceived medical home face barriers outside its control, for example:
 - No incentives are provided to compel other providers (hospitals and specialists) to cooperate with primary care providers
 - There is no way for primary care providers to share in the savings they may generate
- Medical home initiatives can bring together all payers but do not bring all providers.
- ACOs were developed to address these shortcomings
- ACOs are differentiated from similar financing arrangements in that they incorporate more quality measures and oversight by payers.

What is an ACO? (1)

- In fact, there is little agreement
- Some see it as a virtual organization with providers assigned based on claims history
- Others emphasize that they are real organizations, typically identified as integrated delivery systems, with or without a hospital as part of it



What is an ACO? (2)

- An “ACO” is a network of providers who come together to assume clinical and financial responsibility for the care of a defined patient population.
- An ACO must have a foundation of primary care practices, ideally functioning as medical homes.
- There are differing views on what other providers should/should not be part of an ACO.
- Most believe that some form of coordinated provider entity is necessary to receive global payment and thereby move away from the deleterious effects of fee-for-service payment.

ACOs Will Look Very Different, But a Few Characteristics are Essential

- Ability to provide and manage, with patients, the continuum of care across different institutional settings, at the very least, ambulatory and inpatient care
- Capacity to prospectively set budgets and allocate resources
- Sufficient size to support comprehensive, valid, and reliable performance measurement



Potential Real ACO Organizations

- Shortell and Casalino identified 5 types of current organizations that could be, in whole or in part, an ACO
 - Independent Practice Association
 - Multispecialty Group Practice
 - Hospital Medical Staff Organization
 - Physician-Hospital Organization
 - Organized or Integrated Delivery System
- Contracted network of any combination of providers
- Trading off what is ideal and what makes sense

Is ACO Just a New Term for PSO (Provider Sponsored Organization)?

- In BBA 1997, PSOs were created to permit Medicare to engage in financial risk contracting directly with providers
- They built it and no one came – actually 3 in 10 years.



What is New?

- Greater flexibility in organizational models
- New payment models, no longer full capitation – e.g., FFS with shared savings based on total spending and partial capitation
- Improved risk adjustment
- Availability of performance measures
- Prospect of ratcheting down on FFS rates
- Alternatives to a beneficiary hard lock-in



How Would an ACO Work for Purchasers and Commercial Plans?

- Well-founded concern about Medicare-“sanctioned” ACOs developing and using market power in negotiations to drive prices higher
- Concern is they might reduce costs due to decreased utilization of services resulting from better coordinated care but not provide the savings to purchasers in reduced premiums



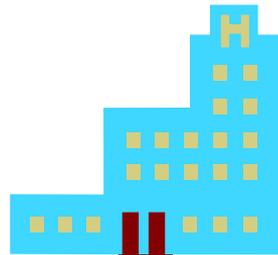
What Providers Comprise an ACO? It Varies

Accountable Care Organization

Primary Care



Hospital



Some Specialists



Other Possible Components:

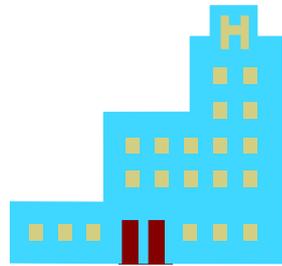
Home Health

Mental Health

Rehab Facilities



How are Patients Assigned to the ACO?



Providers sign agreement to participate with ACO

(PCPs must be exclusive to one ACO; Specialists can be part of multiple ACOs)



Patients are assigned to their PCP based on the majority of their outpatient E&M visits



Three Components of ACO Infrastructure



- Local Accountability for Cost, Quality, and Capacity



- Shared Savings



- Performance Measurement



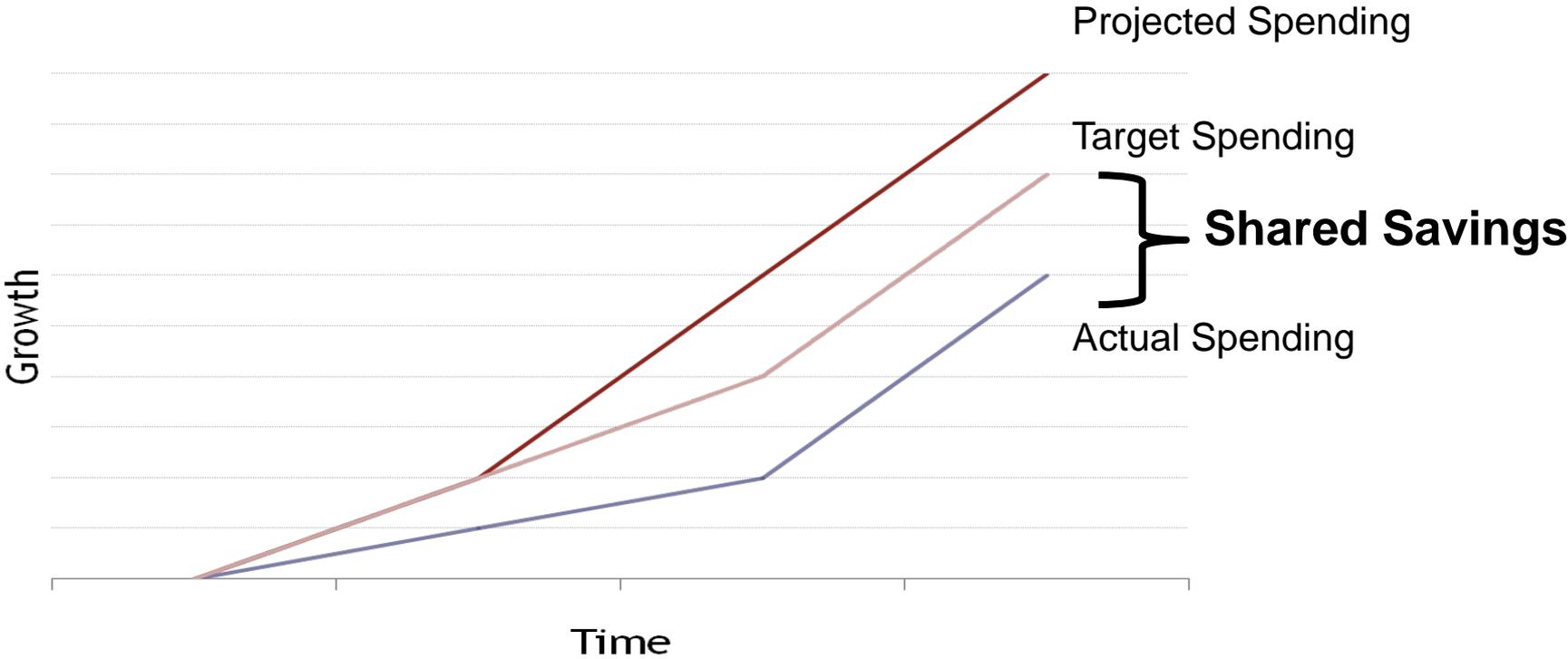
Health Care is Practiced in Local Markets

Number of Medicare Beneficiaries in Network	Percent of Total Beneficiaries	Number of Local Networks	Patient Loyalty to Local Network
Under 5,000	21.7%	3109	63.6%
5,000 -10,000	26.2%	936	70.8%
10,000 –15,000	20.5%	430	72.9%
15,000 +	31.5%	371	75.6%

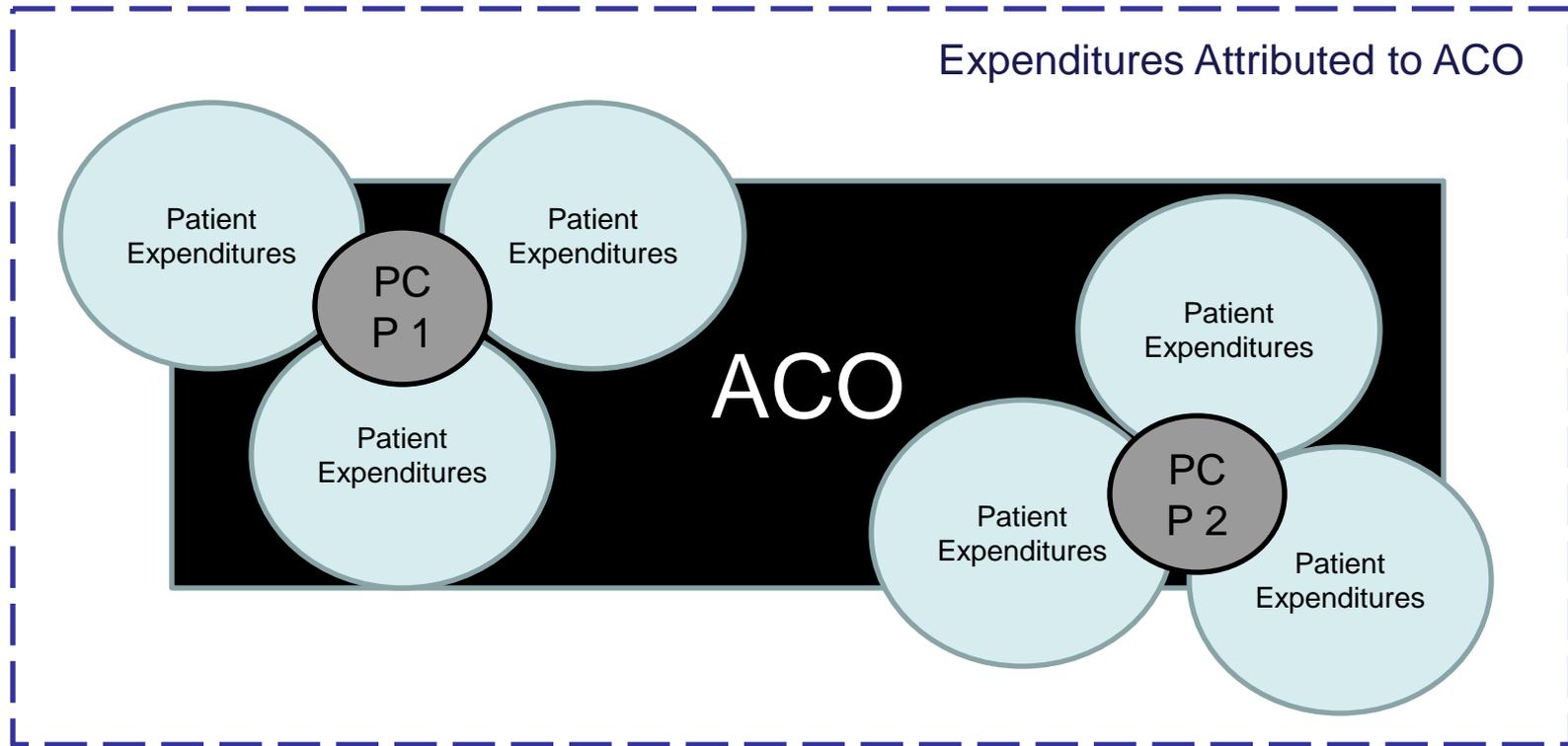
Illustrative purposes only using 2004 physician data on hospital use; ACO proposal involves no requirements for hospital-based affiliations. From Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum and Daniel J. Gottlieb, Creating Accountable Care Organizations: The Extended Hospital Medical Staff, Health Affairs 26(1) 2007:w44-w57.



Calculating Savings Based on Spending Targets



ACO is Responsible for All Patient Expenditures



Multiple Initiatives within the ACO Model

\$800M (Target Expenditures)

- \$525M (Traditional Fee for Service Payments)
 - \$115M (Bundled Payments for Specific Conditions)
 - \$150M (PMPM Payments for Medical Home)
-

\$790M (Total)

\$10M (Available Shared Savings)

(80/20 agreed upon split)



\$8M to the Providers



\$2M to the Payers

ACOs will Look Different across Local Markets

- “Partner payers” will differ by market
 - Some large private payers are cooperative but vary by site
 - Medicaid in some markets
 - Medicare (when ready)
- Negotiation points among stakeholders:
 - Setting expenditure target for ACO
 - Distribution of shared savings (e.g., 80/20, 50/50)
 - Will there be a threshold for savings (e.g., under 2%)
 - Withholds or penalties for spending over target
 - Start-up or interim payments to providers



How Do ACOs Reduce Expenditures?

Through systematic efforts to improve quality and reduce costs across the organization:

- Using appropriate workforce (increased use of NPs; working at top of scope of practice)
- Improved care coordination
- Reduced waste (e.g., duplicate testing)
- Internal process improvement
- Informed patient choices
- Chronic disease management
- Point of care reminders and best-practices
- Actionable, timely data



What Will Make the ACO Successful?

- Local leadership
- Engaged stakeholders, broad participation
 - Payers, purchasers, providers and patients
- Providing the information, tools, support that providers need to make effective changes
- Fair structure for distributing shared savings

It would be nice...

- Integrated delivery system
- History of successful innovation, implementation of another reform (HIT, clinical innovations)
- Currently collecting and reporting performance



Current U.S. ACO & Global Payment Activity

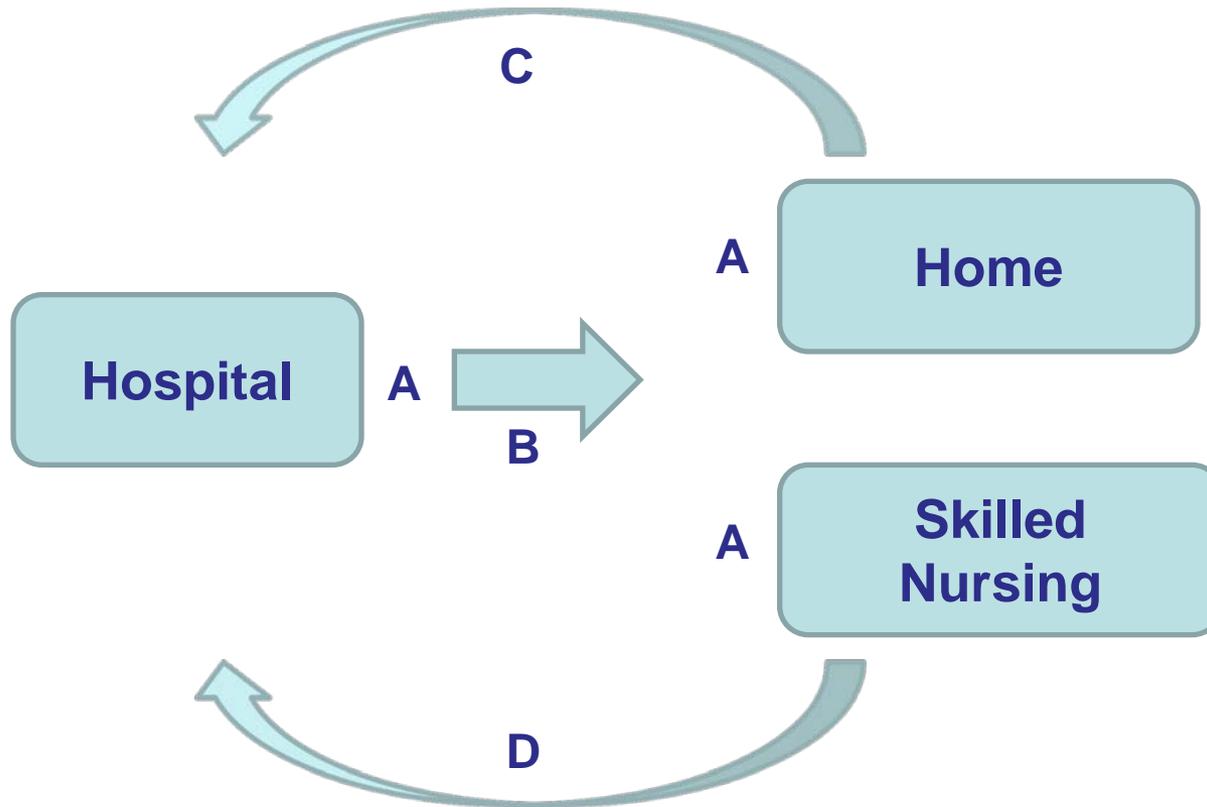
- Three Brookings/Dartmouth ACO Pilots
- Many long-standing capitation contracts between providers and insurers in select regions of the country
 - 20% of all commercial insurer physician payments in MA are capitated
- State efforts to assess or plan efforts to move towards ACOs and global payment in MA, ME, MN and VT
- Medicare/Medicaid pilots in PPACA

Preventable Hospital Readmissions: The STAAR Initiative - Overall Summary

- Rehospitalizations are ***frequent ,costly and many are avoidable***
- Successful pilots, local programs and research studies demonstrate that rehospitalization rates ***can be reduced***
- Individual successes exist ***where financial incentives are aligned***
- Improving transitions state-wide requires ***action beyond the level of the individual provider; systemic barriers*** must be addressed



Many Complementary Approaches



A: Improve transition out of the hospital and **into the next setting of care**

B: Enhanced care by coaches, clinicians in the month(s) following hospitalization

C: Proactive care to avoid ED/hospitalization (including “medical home”)

D: Improve care in Skilled Nursing Facilities to avoid hospitalization

STAAR Initiative

State Action on Avoidable Rehospitalizations

→ ***Improve the transition out of the hospital***

- Cross-continuum teams
- Collaborative learning
- State-based mentoring and quality improvement infrastructure

→ ***Support state-level, multi-stakeholder initiatives to address the systemic barriers***

- State leadership- coordinating, aligning, convening
- State-level data and measurement
- Financial impact of reducing readmissions
- Engaging payers to reduce barriers
- Working across the continuum
- Other leadership, policy, regulatory levers



STAAR State Level Strategy

→ Hospital-level

- Improve the transition out of the hospital for all patients*
- Measure and track 30-day readmission rates*
- Understand the financial implications of reducing rehospitalizations*

→ Community-level

- Engage organizations across continuum to collaborate on improving care, partner with non-clinical community based services, address lack of IT connectivity, clarify who “owns” coordination, engage patient advocates*
- Ensure post-acute providers are able to detect and manage clinical changes, develop common communication and education tools*

→ State-level

- Develop state-level population based rehospitalization data*
- Convene all payer discussions to explore coordinated action*
- Link with efforts to expand coverage, engage patients, improve HIT infrastructure, establish medical homes, contain costs, etc.*
- Establish state strategy, use regulatory levers*



PPACA: Delivery System and Payment Reform Opportunities



New Entities to Improve Quality and Value

- **Center for Medicare and Medicaid Innovation (§ 3021): CMS**
 - Charged with testing innovative payment and service delivery models in Medicare and Medicaid
 - Has broad authority to determine what models will be tested, in what populations, and for how long, with a preference for models that reduce program costs while preserving or enhancing quality
 - Can adopt more broadly without going back to Congress if achieve certain positive outcomes on quality and/or cost
 - Waives current budget neutrality requirement initially, but Secretary is supposed to terminate if either quality is not improved or spending reduced
 - \$10 billion over 10 years (but concern about being “raided” for other purposes in a seriously underfunded agency)
 - Must be established by 2011
- **Interagency Working Group on Health Care Quality (§ 3012)**
 - Coordinate reform efforts in order to avoid duplication
 - Develop streamlined process for reporting and compliance
 - Assess alignment of efforts in the public and private sectors

New Entities to Improve Quality and Value

→ **Center for Quality Improvement and Patient Safety (§ 3501)**

- Located in the Agency for Healthcare Research and Quality (AHRQ)
- Identify, develop, evaluate, disseminate, and provide training in innovative methodologies/strategies for quality improvement practices that represent best practices in health care quality, safety, and value.
- Will provide funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services.
- Build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs

→ **Independent Payment Advisory Board (§ 3403)**

- Must submit proposals to Congress to reduce per capita growth rate in Medicare spending if it exceeds targeted growth rate, beginning in 2014.
- Makes advisory recommendations related to the private sector to reduce cost growth and promote quality.
- Produces a system wide report on cost and quality by 2014 and annually thereafter.

Payment Reform to Improve Quality and Value

→ Physician Payment

- Value-based Purchasing
 - Physician Quality Reporting Initiative (PQRI) (§ 3002)
- Physician Compare Website (§ 10331)
- Value-based Payment Modifier (Medicare) (§ 3007)
- Reassessment of RBRVS (§ 3134)
- Primary Care Payments (§ § 5501, 1202)
- Reports to Physicians on Resource Use (§ 3003)

→ Hospital Payment

- Value-based Purchasing (§ 3001)
- Readmissions (§ 3025)
- Health Care Acquired Infections (§ 3008)

Payment Reform to Improve Quality and Value

→ Health Plans

- HHS must develop reporting requirements for health plans with respect to coverage benefits and provider reimbursement structures (§ 2717). They must:
 - improve outcomes through quality reporting, case management, care coordination, use of medical homes model;
 - implement activities to prevent hospital readmissions through a comprehensive discharge planning program;
 - improve patient safety and reduce errors; and
 - implement wellness and health promotion activities.
- Medicare Advantage (§ 1102)
 - Medicare Advantage (MA) plans will receive bonuses based on their quality

Payment Reform/Care Coordination: State Opportunities

→ Medicaid

- Medical Homes – State Plan Option (§ 2703)
 - Enhanced FMAP of 90% for medical home service costs during the first two years of the program
 - Grants to help develop medical home State Plan amendment
- Community Health Teams for PCMHs – Grants (§ 3502)
- Pediatric ACO (§ 2706)
- Primary Care Extension Program (§ 5405)
- Bundled payment for hospital and physician services - Demo (§ 2704) – Up to 8 states (2012-2016)
- Chronic care prevention activities – Grants (§ 4108)

Payment Reform/Care Coordination: State Opportunities

→ Dual Eligibles

- Establishes a Federal Coordinated Health Care Office within CMS to improve coordination between the Medicare and Medicaid programs on behalf of dual eligibles (§ 2602)
- Authorizes Medicaid waivers for coordinating care for dual-eligible beneficiaries for up to five years (§ 2601)
- By the end of December 2012, all of the more than 300 Medicare Advantage Special Needs plans now specializing in serving dual beneficiaries must have contracts with state Medicaid agencies (§ 3205)
- Care Transitions & Independence at Home – Demo for high-risk Medicare beneficiaries (§ § 3026, 3024)

Payment Reform/Care Coordination: State Opportunities

- Medicare Delivery System & Payment Reforms
 - By January 2013, payments reduced for acute care hospitals with high readmission rates; post-acute care providers starting in 2015 (§ 3025)
 - Pilot programs designed to create ACOs and medical homes (§ § 3021, 3022)
 - Bundled payment for hospital and physician services - Demo (§ 3023)
 - Five year demo (starting as early as 1/2011) to support transitional care for beneficiaries admitted to hospitals for up to three months after discharge to prevent unnecessary readmissions (§ 3026)
 - Medicare Advantage plans are also eligible for care coordination bonuses (§ 3201(n))
 - Gainsharing – Extension of demo (§ 3027)



Payment Reform/Care Coordination: State Opportunities

- Care Coordination Benefits in Other Public Health Insurance Plans
 - Plans offered through exchanges (1/2014) must cover chronic disease management (§ 1302)
 - Basic Health Plans (optional - for low-income individuals not eligible for Medicaid) are expected to negotiate contracts with health plans that include care coordination and care management (§ 1331).
- Global Capitation – 5-state pilot for safety-net hospital systems (§ 2705)

Payment Reform/Care Coordination: Challenges (1)

- Federal government will likely retain discretion to choose which states or provider sites are allowed to participate in any pilots
- Federal participation in a state initiative could depend on whether/to what extent it generates savings for the Medicare trust funds and the federal government overall.
- Emphasis on primary care physicians raises a number of concerns:
 - Will enough primary care physicians be available to participate?
 - Would specialists be allowed to qualify as PCMHs if the patient prefers it and the practice meets all other requirements?
- How will federal and state governments share in the costs to develop PCMHs (TA to help practices transform care delivery, HIT, extra staffing, and any incentive payments)

Payment Reform/Care Coordination: Challenges (2)

- Major health plans' willingness of health plans to collaborate with state government in adopting common standards for disease management and coordinated care
- Ability of providers to take advantage of HIT that will help them adopt such standards in their everyday practice
- Commitment of consumers to take responsibility for their health



Payment Reform/Care Coordination: Lessons Learned

- Target high-risk populations to achieve maximum cost savings and health care outcomes
- Customize services to meet needs of different populations—those with single conditions vs those with multiple conditions or severe chronic illness
- Develop complementary policies to enhance program effectiveness (e.g., provider payment reforms, benefit design changes, and HIT to measure performance and share information across providers in a timely fashion)
- Support and empower consumers and family caregivers to manage chronic health conditions
- Improve transitions between health care settings



Population Health, Prevention and Wellness



Prevention and Wellness Initiatives (1)

- The most cost effective way to reduce health care costs is to prevent illness
- Public health officials have argued against false distinctions between population health and health care
- At the same time, there has been growing criticism of federal and states' siloed approach to public health programs
- New funding in ARRA seeks to address these problems by supporting competitive grants to communities to target physical activity, nutrition, tobacco use, and obesity prevention.



Prevention and Wellness Initiatives (2)

- Some states have already put these ideas into practice:
 - Minnesota announced grants to 39 communities to target obesity and tobacco use
 - Vermont's Blueprint pilot programs link public health and health reform by embedding community health teams in community-based primary care practices.
- Tobacco cessation programs have informed efforts for system wide approach to prevention

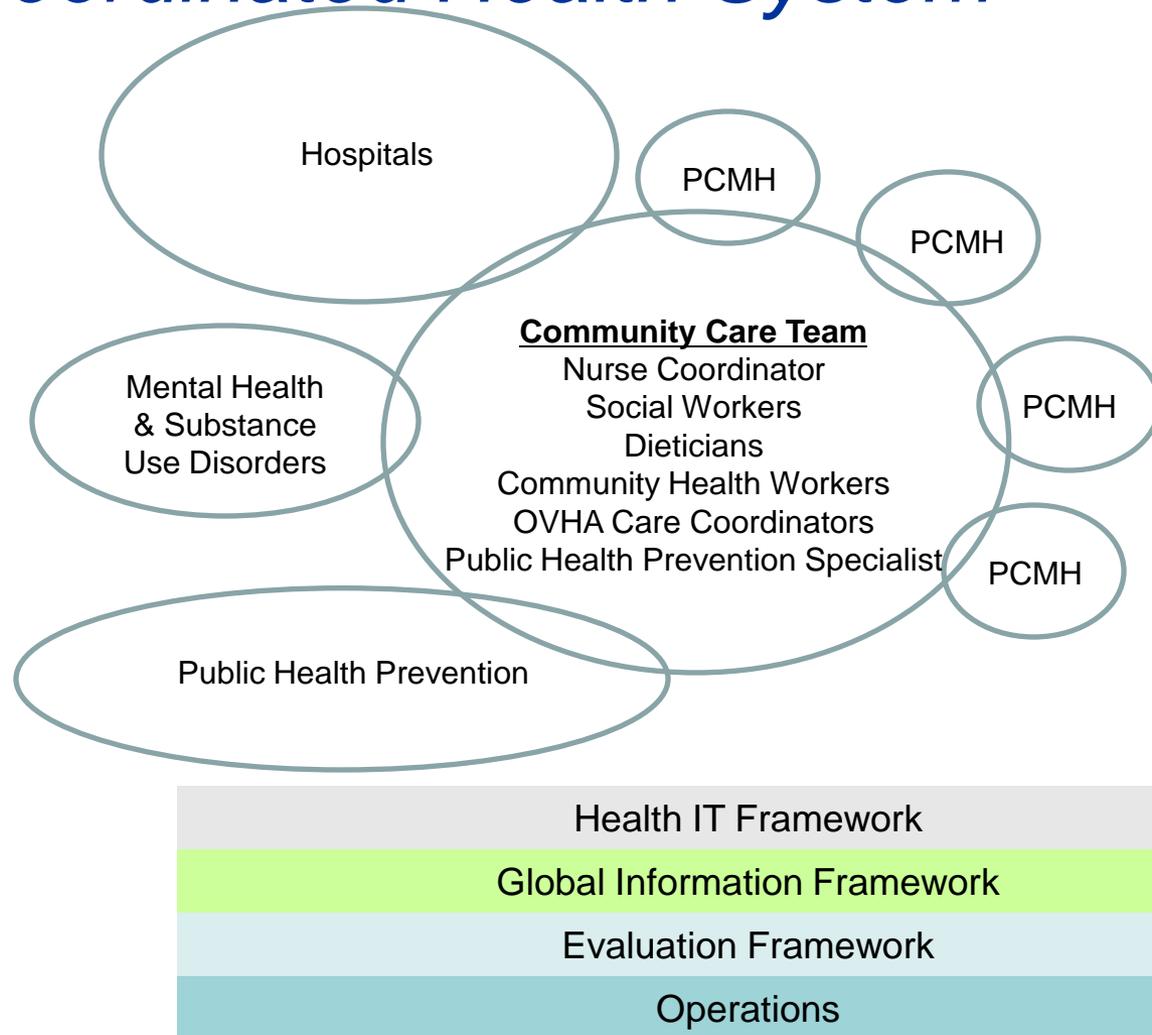
Initial Legislation for Statewide Health Improvement Program (SHIP)

- Due to rising health care costs and rates of chronic disease, legislation **passed in 2007 called for creation of plan** to fund and implement comprehensive **statewide health improvement**
- Developed in consultation with local health advisory committee and MDH Executive Office
- Addresses **risk factors** for preventable deaths, decreased quality of life and financial costs from chronic diseases in four settings:
 - **Community**
 - **Worksites**
 - **Schools**
 - **Health care**
- Based on **Steps to a HealthierMN**

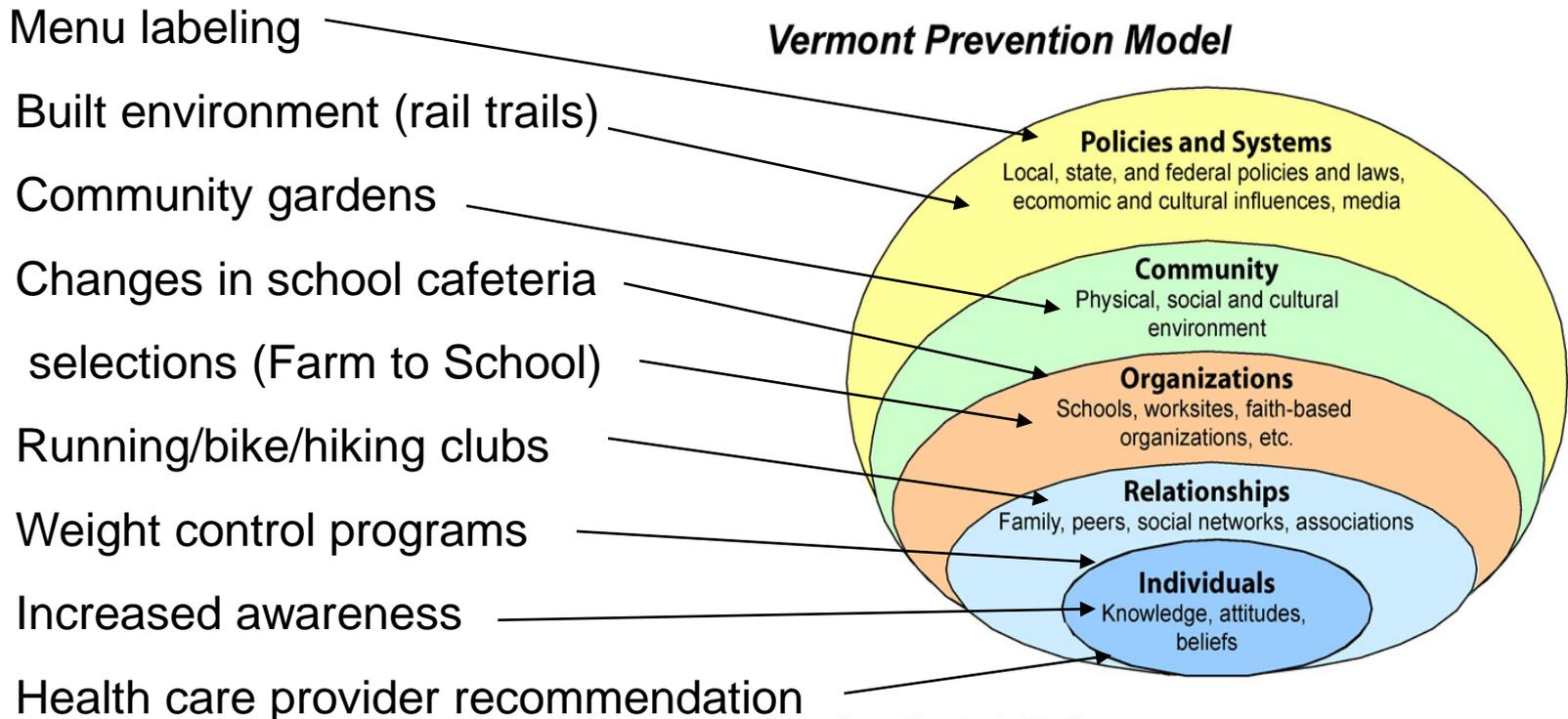


Blueprint Integrated Pilots

Coordinated Health System



Vermont: Prevention Strategies for Obesity



Source: Vermont Department of Health



PPACA:

Promoting Population Health & Wellness

→ **Implement a National Wellness Plan**

- The Secretary shall develop and support a broad effort to promote population health and wellness by March 2011.

→ **Prevention Fund**

- Appropriations rise from \$500M in FY10 to \$2B in FY15+
- Usable to advance national strategy for prevention and health promotion

→ **Benefit Designs to Promote Wellness**

- Coverage for preventive services and incentives for wellness are fostered in Medicare, Medicaid and for private coverage.

→ **Encourage Employer Wellness Programs**

- Employers' efforts to promote wellness are fostered through multiple vehicles.

Population Health, Prevention and Wellness: State Opportunities

- Preventive Services Measures (Medicaid/CHIP)
 - Chronic Disease Incentive Payment Program (§ 4108)
 - Grants (\$100m) for incentives to join programs that reduce obesity, tobacco, blood pressure, diabetes, etc.
 - Elimination of exclusion of coverage of drugs that promote smoking cessation, including FDA-approved OTC (§ 2502)
 - Medical Homes for Enrollees with Chronic Conditions; Planning Grants (§ 2703)
 - Enhanced FMAP for eliminating cost-sharing reqs for clinical preventive services and adult vaccination (§ 4106)
 - Coverage of Tobacco Cessation Services for Pregnant Women - Effective October 2010 (§ 4107)
 - Extension of CHIP Childhood Obesity Demo (§ 4306)



Population Health, Prevention and Wellness: State Opportunities

- Preventive Services Measures (cont) – CDC
 - *Community Transformation Grants* - program to promote evidence-based community preventive health activities intended to reduce chronic disease rates, and address health disparities (§ 4201)
 - *Healthy Aging, Living Well Public Health Grant Program* - grants for pilots to provide public health community interventions, referrals, and screenings for heart disease, stroke, and diabetes for individuals between ages 55 and 64 (§ 4202)

Population Health, Prevention and Wellness: State Opportunities

- Preventive Services Measures (cont) – CDC
 - *Immunization Coverage Improvement Program* - demo grants to improve immunization coverage for children, adolescents, and adults (§ 4204)
 - *Epidemiology Laboratory Capacity Grants* - grants to develop an information exchange and improve surveillance and response to infectious diseases (§ 4304)
 - *State Authority to Purchase Recommended Vaccines for Adults Program* - states may obtain adult vaccines through manufacturers at price negotiated by HHS (§ 4204)



Population Health, Prevention and Wellness: State Opportunities

→ Preventive Services Measures (Other)

- Prevention and Public Health Fund (§ 4002)
- Primary Care Extension Program (§ 5405)
- School-Based Health Centers (§ 4101)
 - Grants to provide comprehensive preventive/primary care services
- Personal Responsibility Education Grant Program (§ 2953)
 - Educate adolescents about abstinence/contraception
- Wellness Program Demonstration (§ 2705)
 - 10-state health promotion program in Individual Market
 - Allows 30% premium reduction
- Health Plan Coverage of Preventive Health Services - no cost sharing for preventive services - Beginning 9.23.2010 (§ 2713)
- Essential Health Benefits Package in Exchange (§ 1302)
 - Preventive services will not be subject to deductibles



Population Health, Prevention and Wellness: State Opportunities

→ Public Health Workforce

- Loan Repayment Program for Public Health Professionals (§ 5204)
- Health Care Workforce Development - Planning and Implementation grants (§ 5102)
- Public Health Training for Mid-Career Professionals (§ 5206)
- Promote Community Health Workforce – CDC will award grants to states to use community health workers to promote positive health behaviors and outcomes in medically underserved communities (§ 5313)
- State and Regional Ctrs for Health Workforce Analysis (§ 5103)
- Fellowship Training in Public Health - Activities to address documented workforce shortages in state and local health departments in the areas of applied public health epidemiology, public health laboratory science, and informatics and may expand the Epidemic Intelligence Service (§ 5314)



Transparency/All-Payer Claims Databases



Transparency & All-Payer Claims Databases

- Consumers, payers, and providers have poor information on cost and quality of care.
- Many states have undertaken projects to compare quality of different providers, especially hospitals
- Another way states have sought to meet transparency goals is by establishing all-payer claims databases



What Are APCDs?

- Databases, generally created by state legislation, that typically include data derived from medical, eligibility, provider, pharmacy, and/or dental files from private and public payers:
 - Insurance carriers/TPAs/PBMs
 - Public payers (Medicaid, Medicare)

Why APCDs?

- Deficiencies in current data collection efforts:
 - Medicare: Complete picture of care, but limited population
 - Medicaid: Complete picture of care, but limited population
 - Hospital inpatient/outpatient data: Complete picture of hospital-based care only
 - MEPS (and other surveys): Picture of office-based care, but not population-based (and not robust for states)

Uses of APCDs

- More than just ensuring price transparency; can answer research/policy questions
 - Determine utilization patterns and rates
 - Identify gaps in needed disease prevention and health promotion services
 - Evaluate access to care
 - Assist with benefit design and planning
 - Analyze statewide and local health care expenditures by provider, employer, geography, etc.
 - Establish clinical guideline measurements related to quality, safety, and continuity of care

Something for Everyone

- Policymakers (Medicaid, public health, insurance dept, etc.)
 - Helps health care policy makers to identify communities that provide cost-effective care and learn from their successes.
 - Allows for targeted population health initiatives.
 - Assessment of health care disparities and target interventions.
- Consumers
 - Provides access to information, helping consumers and their health care providers make informed decisions about the cost, quality of care and effectiveness of treatments.

Something for Everyone (cont'd)

→ Providers

- Supports provider efforts to design targeted quality improvement initiatives
- Enables providers to compare their own performance with those of their peers

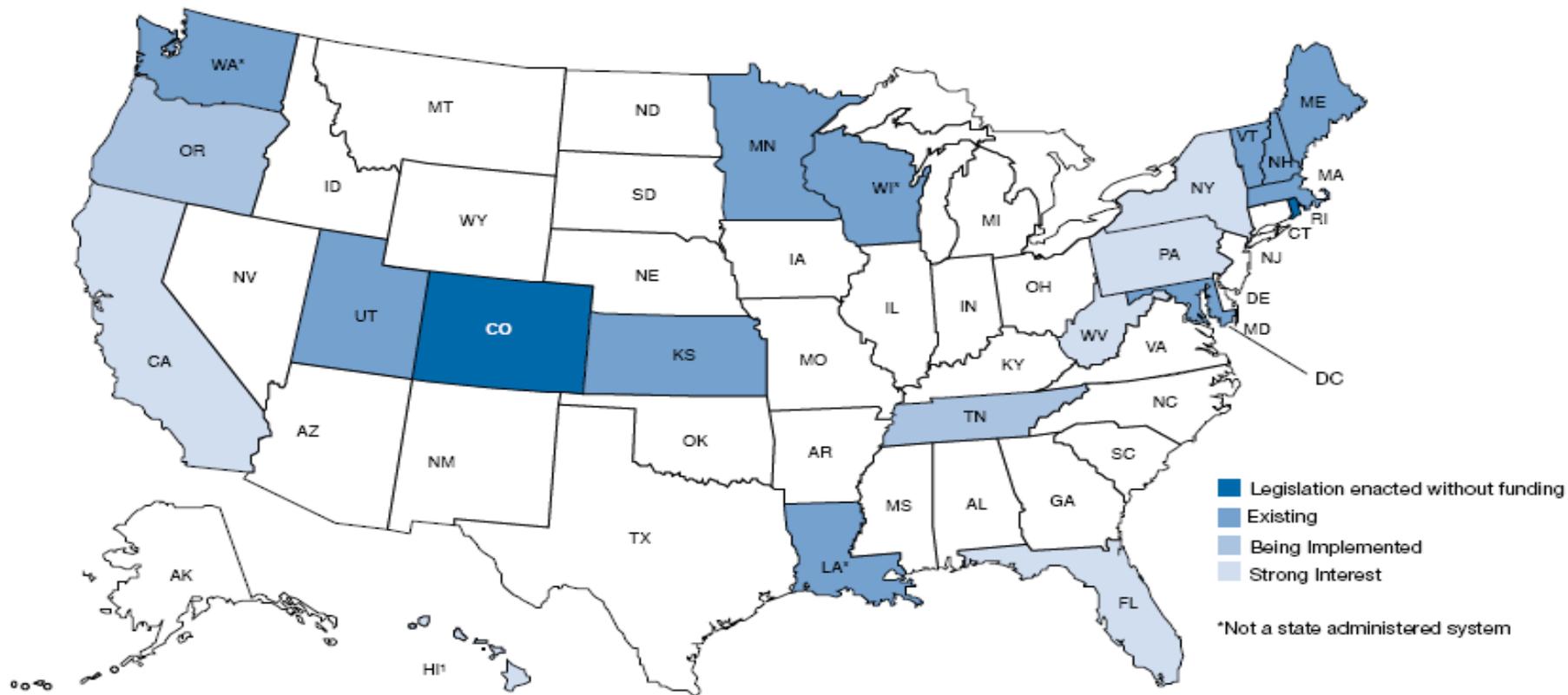
→ Health Plans/Payers

- Determines utilization patterns and rates
- Assists with benefit design and planning

→ Researchers (public policy, academic, etc.)

- Fills the void of information from the most common setting of care (primary care) and for the majority of the population (those with commercial insurance).

Status of State Government Administered All Payer / All Provider Claims Databases as of May 2010



APCD Data Sources

State	Medicaid	Medicare	Commercial	Uninsured
MA	No	No	Yes	No
ME	Yes	Yes	Yes	Partial
NH	Yes, But Not Integrated	No	Yes	No
MN	Yes	Planned	Yes	No
UT	Yes	No	Yes	No
VT	Planned	Planned	Yes	No



APCD Data Files

State	Eligibility	Provider	Medical	Pharmacy	Dental
MA	Yes	Planned	Yes	Yes	No
ME	Yes	Yes	Yes	Yes	Yes
NH	Yes	Yes	Yes	Yes	In process
MN	Yes	Planned	Yes	Yes	No
UT	Yes	Yes	Yes	Yes	In process
VT	Yes	Planned	Yes	Yes	No



APCD Data Submitters

State	Carriers	TPAs	PBMs	Dental
MA	30	1	0	Planned
ME	53	45	0	18
NH	18	14	2	Planned
MN	20	20	0	N/A
UT	12	2	2	N/A
VT	36	16	2	N/A



Typically Included Information

- Encrypted social security
- Type of product (HMO, POS, Indemnity, etc.)
- Type of contract (single person, family, etc.)
- Patient demographics (date of birth, gender, residence, relationship to subscriber)
- Diagnosis codes (including E-codes)
- Procedure codes (ICD, CPT, HCPC, CDT)
- NDC code / generic indicator
- Revenue codes
- Service dates
- Service provider (name, tax id, payer id, specialty code, city, state, zip code)
- Prescribing physician
- Plan payments
- Member payment responsibility (co-pay, coinsurance, deductible)
- Date paid
- Type of bill
- Facility type

Typically Excluded Information

- Services provided to uninsured (few exceptions)
- Denied claims
- Workers' compensation claims
- Premium information
- Capitation fees
- Administrative fees
- Back end settlement amounts
- Referrals
- Test results from lab work, imaging, etc.
- Provider affiliation with group practice
- Provider networks



Governance and Funding

- Generally, legislation establishes authority for an APCD
- Responsibility for Collection and Oversight Varies
 - Where hospital reporting currently occurs (MA)
 - Insurance agency – oversight of carriers (VT)
 - Shared between Health and Insurance (NH)
 - Independent exec agency (ME Health Data Org)
- Broad stakeholder input
- Funding – stable source of ongoing funding
 - General Funds or Fees from Providers/Insurers

PPACA: Public Reporting to Promote Transparency

- **Broad Plan for Public Reporting (§ 3015)**
 - Requires a clear federal plan to make performance information widely available.
- **Hospitals and Ambulatory Surgery Centers (§ § 3001, 3008, 3025)**
 - Expands Hospital Compare; includes information on the VBP program; report on health care acquired admissions, hospital readmissions, and hospital charge data.
- **Physicians**
 - Requires development of Physician Compare website by January 2011 (§ 10331).
 - Annually, physician ownership or investments in hospitals and manufacturers (by September 2013) will be published (§ § 6001, 6002).
- **Nursing Homes, Skilled Nursing Facilities, LTC Facilities**
 - New information will be added to Nursing Home Compare by March 2011 (§ 6103).
 - Nursing home ownership by March 2012 (§ 6101).
- **Health plans - Must provide much data (§ 2717)**
- **Release of Medicare Data**
 - Medicare data will be released to support better transparency of provider performance with full protections of patient privacy as early as January 2012 (§ 10332).

Transparency: State Opportunities

- Make information usable to consumers
 - Put in one place
 - Present in easy-to-understand format. Very challenging. Very important.
- Take advantage of federal work in defining measures of quality and efficiency
 - Specific measures
 - Strategies to tackle hard methodological issues (like risk-adjusting outcome data)
- Add to Medicare performance data information about other payors
 - Direct state-controlled coverage
 - Public employee plans
 - Medicaid and CHIP
 - Exchange plans – state can exclude qualified plans
 - Other plans - Mandate for private insurance?
- Multi-payor strategies

Comparative Effectiveness



PPACA: Comparative Effectiveness

→ **Independent Governance**

- Patient-Centered Outcomes Research Institute - new independent entity to support and oversee comparative effectiveness research (§ 6301)
- Funding starts in 2010 (\$1.26B over 10 years)

→ **No Restrictions on Use of Results**

- The purpose of comparative effectiveness research is for findings to be used by clinicians, patients and others
- Institute may not mandate guidelines, coverage, etc.

→ **Effective Conflict of Interest Provisions**

- Protections are in place and need to ensure that self-interested individuals and entities do not overly influence the CE research agenda and related processes

Comparative Effectiveness: State Opportunities

→ Pay for the lowest-cost, clinically equivalent service
How?

- Apply results by having plan pay for least costly, equally effective service
- Opportunity for provider to make exceptions, with appeals process
- If consumer wants something more expensive, pays the difference

Who?

- Public employee coverage
 - Permission for private insurers
 - Medicaid and subsidies in exchange? Unclear. Little or no ability to pay extra. Maybe need other incentives for consumer or provider.
- HIT decision support, recording reasons for exceptions

Consumer Engagement



Consumer Engagement

- Major areas of consumer engagement
 - Transparency/Choice based on value
 - Patient decision-making in medical services
 - Self-management of chronic conditions
 - Lifestyle and wellness activities
 - Involvement in reform activities



Consumer Engagement

- States can develop programs that encourage consumers to make cost-effective choices, often without a gatekeeper type system
- State programs to engage consumers to seek better health care and effectively manage health conditions include:
 - Value based provider tiering
 - Higher cost sharing for brand name drugs in Medicare and public employee plans
 - Web sites that compare providers and estimate the costs of specific services
 - Providing comparative effectiveness data

Consumer Engagement: Federal and State Opportunities

→ Federal components

- More reporting on patient experiences with care
- Health plans participating in exchanges must develop quality improvement plans including patient-centered education (§ 1311(g))
- Grants to develop standards for patient decision aids and disseminate best practices (§ 3506)
- Consumer advisory council to advise Independent Payment Advisory Board on the impact of payment policies (§ 3403)

→ State opportunities

- Grants to fund state ombudsman offices and consumer assistance programs (§ 2793)
- Patient Navigators in exchanges (§ 1311(i))

Health Information Technology/ Health Information Exchange



Health Information Technology/Exchange (1)

- The adoption of HIT/HIE holds great promise for cost savings
- The American Recovery and Reinvestment Act provides a dramatic boost to HIT/HIE adoption efforts:
 - Creates the Office of the National Coordinator of Health IT (ONC)
 - Provides bonus payments to providers who adopt EMRs and meeting standards for “meaningful use.”
- Additionally, nearly \$1.2 is being provided to HHS to :
 - Support planning and implementation by states to organize and maintain HIEs
 - Support HIT Regional Extension Centers that will offer assistance to providers seeking to utilize HIT and comply with meaningful use standards.

Health Information Technology/Exchange (2)

- States can undertake a number activities to respond to ARRA's HIT provisions, including:
 - Prepare a state roadmap for HIE adoption
 - Engage stakeholders
 - Establish a state leadership office
 - Medicaid agencies establish meaningful use standards
 - Public health agency prepare to integrate population health data into HIE
 - Create a loan program for interested providers
 - Implementing privacy strategies and reforms



PPACA: Health Information Technology/Exchange

- **Builds on the HITECH incentives**
 - The existing law provides incentives for the adoption of “meaningful use” of health information technologies is maintained.
- **Promotes Telehealth (§ 3022, § 6407)**
 - Encourages the use of telehealth in a couple provisions.
- **Supports Administrative Efficiency (§ 1104)**
 - Important provisions support reducing burden on providers and saving resources by standardizing claims, utilization and credentialing processes.

Final Thoughts



Conclusions

- Little success so far in addressing underlying cost of health care but a new focus on chronic care management/preventive care holds potential
- The trend in states is to address access, systems improvement, cost containment simultaneously—concern about long-term sustainability of coverage programs and improved population health
- Reflected in federal law as well.
- Concerns about rising costs are an impetus for reform, but cost cutting is likely to raise opposition from various stakeholders.
 - Health care costs = Health care income!
- Need to build the case for systems reform
 - Work with stakeholders in health system

Conclusions

- Systems reform sounds good in theory – hard to know what to do in practice
- Little concrete evidence on what works
- Huge value to experimentation
 - Only way to learn which elements actually work
 - But only valuable if follow up with careful evaluation
- DON'T want to mandate systems reforms before we know what actually works

Conclusions

- PPACA's basic philosophy on cost and quality: let 1,000 flowers bloom
- Administration open to new ideas
- Rare window of opportunity for active states



SCI Resources

(and from where slides were adapted)

- State Coverage Initiatives Website: www.statecoverage.org
- State Coverage Initiatives Annual Meeting for State Officials (8/10) www.statecoverage.org/node/2356
 - Stan Dorn (Urban Institute): Overview: Roadmap to Implementation
 - Jon Gruber (MIT): Key Drivers of Cost Growth
 - Bob Berenson (Urban Institute): Delivery and Payment System Reforms Contained in Federal Reform
 - Amy Boutwell (IHI): Care Coordination and Care Transitions
- *State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals*, SCI Publication (7/10) www.statecoverage.org/node/2447
- *All-Payer Claims Databases: An Overview for State Policymakers*, SCI Publication (5/10) www.statecoverage.org/node/2380
- Patrick Miller: “Overview of All-Payer Claims Databases” SCI/NAHDO All-Payer Claims Databases Conference (10/09) www.statecoverage.org/node/2058



SQII Resources

(and from where slides were adapted)

- State Quality Improvement Institute Website:
www.academyhealth.org/Programs/ProgramsDetail.cfm?ItemNumber=3148&navItemNumber=2502
- Stan Dorn: “Federal Health Care Reform: Opportunities for States,” SQII Webinar (6/10)
www.academyhealth.org/Programs/content.cfm?ItemNumber=5303&navItemNumber=2504#HealthReform#Presentation
- Michael Bailit: “New Methods for Care Delivery and Payment,” SQII Technical Assistance Meeting for OH (11/09)
www.academyhealth.org/files/SQII/Bailit2.pdf
- John Bertko: “Delivery System Reform: Accountable Care Organization Overview” SQII Technical Assistance Meeting for MA, MN, and VT (10/09) <http://ah.cms-plus.com/files/SQII/Bertko1.pdf>



Other Resources

(and from where slides were adapted)

- Michael Bailit: “Payment 101,” NASHP Preconference, (10/09)
www.nashp.org/sites/default/files/conf_2009/Balit.pdf
- National Governors Association: “State Roles in Delivery System Reform” (6/10)
www.nga.org/Files/pdf/1007DELIVERYSYSTEMREFORM.PDF
- Consumer-Purchaser Disclosure Project: “Changing Delivery & Changing Care: Summary of the Delivery and Payment Reform Elements of the Patient Protection and Affordable Care Act of 2010,” (4/10)
www.healthcaredisclosure.org/docs/files/Disclosure_PPACA_SummaryDeliveryPaymentReform04-05-10.pdf



THANK YOU!

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