How Payment Reforms Can Help Achieve a High Performance Health System

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Strategies for a High Performance Health System

- **Insurance market reforms that make affordable coverage available to all;**
- **Payment reforms that align incentives for high value and effective cost control;**
- **Delivery system reforms that ensure the provision of accessible, evidence-based, patient-centered, coordinated, and accountable care;**
- **Investment in public reporting, evidence-based medicine, and infrastructure improvements that enable the delivery of the best care possible to patients in a culture of innovation and improvement; and**
- **Leadership and collaboration among all stakeholders to set and achieve national goals.**

Source: The Commonwealth Fund Commission on a High Performance Health System, *Focusing on Success: Reaffirming the Vision of a High Performance Health System*, (New York: The Commonwealth Fund, forthcoming).

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Payment and Delivery System Reforms that Contribute to High Performance Health System

- **Payment:**
  - **Blended payment; bundled payment; global payment**
  - **Primary care/specialty care imbalance**
  - **Value-based purchasing**
- **Delivery System:**
  - **Accountable care organizations (ACOs)**
  - **Medical homes**
- **Tools, infrastructure support:**
  - **Enhanced care coordination/chronic disease management**
  - **Health information technology**
  - **Beacon communities; health information exchanges**
- **Combination strategy in innovator communities**

Source: The Commonwealth Fund, *The New Wave of Innovation: How the Health Care System Is Reforming*, (New York: Columbia Journalism Review, November 2011).

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Timeline for Payment and System Innovation

2010	2011	2012	2013	2014	2015
Productivity Improvement	10% Medicare Primary Care Increase	Medicare Shared Savings (ACOs)	National Medicare Payment Bundling Pilot	Independent Payment Advisory Board (IPAB)	Value-based Purchasing for Physicians
Patient Centered Outcomes Research	Innovation Center (CMMI)	Pioneer ACOs	Medicaid Primary Care up to Medicare Levels		Reduce Payment for Hospital Acquired Infections
	All-Payer Demos and Health Innovation Zones	Bundled Payment for Care Improvement Initiative			
	Physician Group Practice Transition Demonstration	Value-based Purchasing for Hospitals			
		Improve Physician Feedback			
		Reduce Payment for Preventable Readmissions			

Source: S. Guterman, K. Davis, K. Stremikis, and H. Drake, "Innovation in Medicare And Medicaid Will Be Central To Health Reform's Success," *Health Affairs* 29, no. 6 (June 2010).

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New Innovation Center Initiatives

- **Advance Payment Model**
  - **Tests whether advancing a portion of future shared savings for physician-based and rural providers in the Medicare Shared Savings Program will increase their participation and more quickly improve care for Medicare beneficiaries**
- **Innovation Advisors Program**
  - **Seeks to broadly help individuals refine, apply, and sustain managerial and technical skills necessary to drive delivery reform for the benefit of Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries**
- **Comprehensive Primary Care initiative**
  - **CMS-led, multi-payer approach to give primary care practices more support and enable better care coordination in communities across America**
- **Bundled Payments for Care Improvement**
  - **Seeks to improve patient care through payment innovation that fosters improved coordination and quality through a patient-centered approach**
- **Pioneer ACO Model**
  - **Allows provider groups already experienced in coordinating care for patients across care settings to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program**

Source: Center for Medicare and Medicaid Innovation, http://innovations.cms.gov/.

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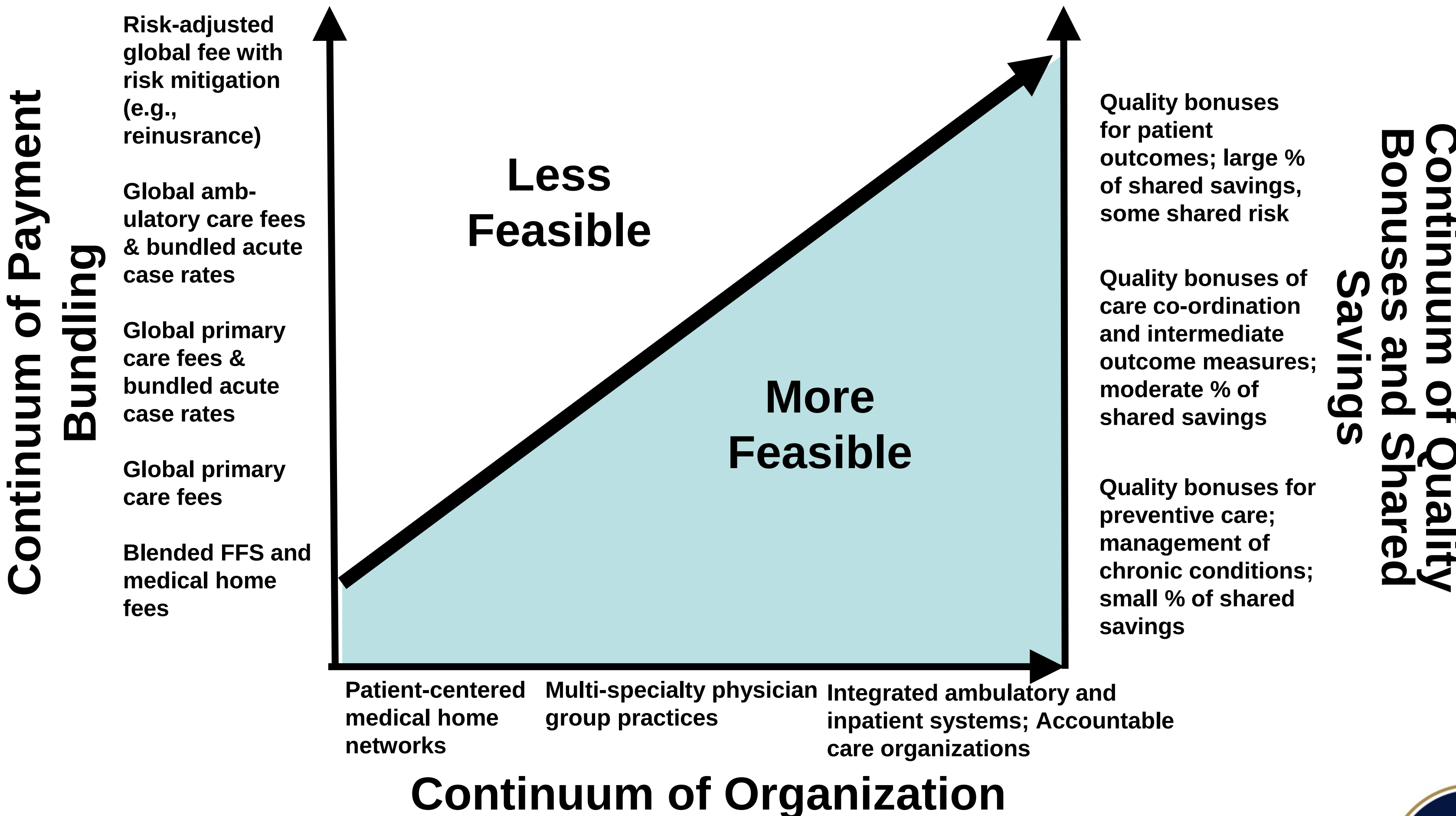
Promising Models of Payment and Care Delivery



Source: A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance*, (New York: The Commonwealth Fund, August 2008).

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Accountable Care Organizations

Key Elements of Success for Accountable Care Organizations

1. Strong Primary Care Foundation
2. Accountability for Quality of Care, Patient Care Experiences, Population Outcomes, and Total Costs
3. Informed and Engaged Patients
4. Multi-Payer Alignment
5. Calculation of Shared Savings and Payment of ACOs
6. Innovative Payment Methods and Organizational Models
7. Balanced Physician Compensation Incentives
8. Timely Monitoring and Support
9. Criteria for Entry and Continued Participation
10. Mission

Source: S. Guterman, S.C Schoenbaum, K. Davis, et al. *High Performance Accountable Care: Building on Success and Learning from Experience* (New York: The Commonwealth Fund Commission on a High Performance Health System, forthcoming).

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Recent ACO Developments

	Medicare Shared Savings Program in ACA	Pioneer ACO Model through CMMI	Physician Group Practice Transition Demonstration
Shared Savings Payments	Share on first dollar for one- and two-sided risk tracks once minimum savings threshold achieved; $1.3 billion to ACOs, $470 million back to Medicare	1 percent minimum savings threshold	Minimum savings threshold calculated using a sliding scale based on the number of assigned beneficiaries
Patient Assignment	Preliminary prospective assignment with final reconciliation after each performance year	Retrospective or prospective; 15,000 patient minimum except in rural areas	Retrospective based on services by PCPs; 8,383 to 44,609 patients in original PGP demo base year
Provider Participation	Groups specified by ACA plus CAHs, FQHCs, and Rural Health Clinics	Primary care physicians, non-physician clinicians, certain specialists all eligible; FQHCs and CAHs eligible	10 large, multi-specialty groups that participated in previous 5-year Physician Group Practice demo
Contract Period	Applications due in early 2012, first agreements start 04/01/2012 and 07/01/2012	Three periods: CY2012, 2013, 2014	CY2011, 2012
Governing Board	75 percent of the board must be representatives of participating provider groups	More lenient	More lenient
Multi-Payer Alignment	More lenient	50 percent of ACO revenue must come from outcomes-based contracts, including contracts with private payers	More lenient

Notes: ACA – Affordable Care Act; ACO – Accountable Care Organization; CAH – Critical Access Hospital; CMMI – Center for Medicare and Medicaid Innovation; FQHC – Federally Qualified Health Center; PGP – Physician Group Practice.
Source: M. Zezza and S. Guterman, *Accountable Care Organization Final Regulations Give Health Care Providers More Flexibility*, (New York: The Commonwealth Fund, October 2011); M. Zezza, *The Pioneer Accountable Care Organization Model: An Alternative to the Medicare Shared Savings Program*, (New York: The Commonwealth Fund, forthcoming 2011).

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Proposed Rule vs. Final Rule for ACOs in Medicare Shared Savings Program

	Proposed Rule	Final Rule
Shared Savings Payments	One- and two-sided risk models; mandatory transition to two-sided risk; 2-3.9 percent minimum savings threshold	One- and two-sided risk models; no mandatory transition to two-sided risk; share on first dollar once minimum savings achieved
Patient Assignment	Retrospective based on utilization of primary care services	Preliminary prospective assignment with final reconciliation after each performance year
Provider Participation	Limited to primary care physicians; FQHCs and CAHs must partner with eligible providers	Groups specified by ACA and proposal rule; FQHCs and Rural Health Clinics also eligible to form and participate in ACO
Quality Measures	65 measures in 5 domains; pay for reporting in first year, pay for performance in subsequent years	33 measures in 4 domains; pay for reporting in first year, pay for reporting and performance in subsequent years
Electronic Health Record Use	50% of PCPs must be meaningful users by start of second performance year	No longer a condition of participation but used as a quality measure
Start Date	Three years with uniform annual start date; based on calendar years	Applications due in early 2012, first agreements start 04/01/2012 and 07/01/2012

Source: Berwick DM. Making Good on ACOs' Promise — The Final Rule for the Medicare Shared Savings Program. *N Engl J Med* 2011 10/20; 2011/10.

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Brookings-Dartmouth ACO Pilot Site Program: HealthCare Partners

- **Large medical group and independent practice association (IPA) in Los Angeles, California**
- **Developing an ACO with Anthem to provide care coordination for 50,000 Anthem preferred provider organization (PPO) members**
- **ACO is physician-owned and governed, and will include 1,000 primary care physicians and 1,700 specialists**
- **Success factors**
  – **Stable leadership**
  – **Consistent emphasis on prevention and health promotion**
  – **Integrated health information technology (HIT) infrastructure**
  – **Use of effective care coordination and care management**
  – **Extensive experience taking on full risk capitation**
  – **Solid payer-provider relationship (including active involvement in a joint implementation committee)**

Source: A. D. Van Citters, B. K. Larson, S. M. Shortell, E. C. Nelson, and E. S. Fisher, Toward Accountable Care: A Report on Four Organizations' Efforts to Reduce Costs, Improve Quality, and Improve Care for Patients and Populations, (New York: The Commonwealth Fund, forthcoming).

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Brookings-Dartmouth ACO Pilot Site Program: Monarch HealthCare

- **Large independent practice association (IPA) located in the Southern, Northern, and Coastal regions of Orange County, California**
- **Developing an ACO with Anthem to provide care coordination and care navigation support for 25,000 Anthem PPO members in Orange County**
- **ACO is physician-owned and governed, and will include approximately 500 of its 850 primary care physicians**
- **Success factors**
  - **Strong executive leadership**
  - **Trust and transparency in partnerships**
  - **Extensive experience taking on full risk capitation**
  - **Solid payer-provider relationship (including active involvement in a joint implementation committee)**

Source: A. D. Van Citters, B. K. Larson, S. M. Shortell, E. C. Nelson, and E. S. Fisher, Toward Accountable Care: A Report on Four Organizations' Efforts to Reduce Costs, Improve Quality, and Improve Care for Patients and Populations, (New York: The Commonwealth Fund, forthcoming).

Mount Auburn Cambridge Independent Practice Association

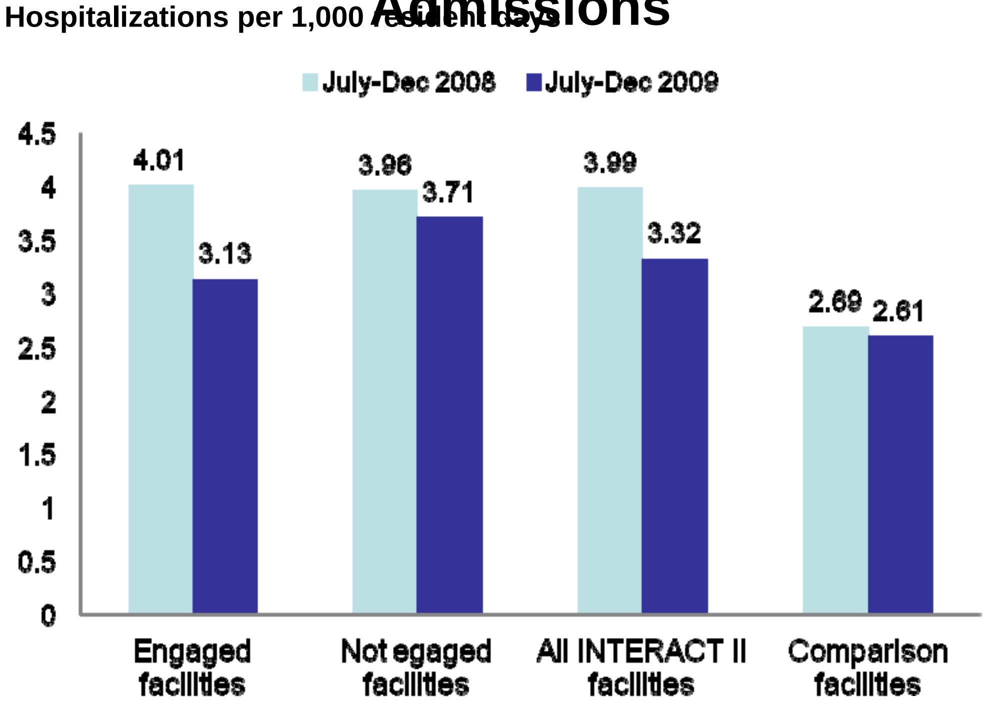
- **Boston-area independent practice association (IPA) forged relationships among physicians and a hospital to share in savings generated by improved quality and lower costs**
- **Participant in Blue Cross/Blue Shield Alternative Quality Contract**
- **High-risk case management program for patients at Mount Auburn Hospital and in the community, discharge planning, pharmacy management, referral management, utilization review, and related information services including performance reporting to physicians on utilization and quality improvement**
- **Participating physicians encouraged to adopt a common electronic health record (EHR) system that interconnects with the hospital's clinical information system to share laboratory and radiology results**
- **Physicians in the IPA have achieved notable results on 12 of 23 measures of ambulatory care quality on which they were rated by the Massachusetts Health Quality Partners (MHQP)**
- **Exceed both state and national benchmarks for the care of diabetic adults, preventive care for children and adults, and appropriate use of imaging tests for lower back pain.**

Source: D. McCarthy, *Quality Matters Case Study: The Mount Auburn Cambridge Independent Practice Association*, (New York: The Commonwealth Fund, July 2010).

INTERACT Collaborative Quality Improvement Project

- Interventions to Reduce Acute Care Transfers (INTERACT) II helps nursing home staff identify, assess, communicate, and document changes in residents' status
- Three strategies:
  - identifying, assessing, and managing conditions to prevent them from becoming severe enough to require hospitalization;
  - managing selected conditions, such as respiratory and urinary tract infections, in the nursing home itself; and,
  - improving advance care planning and developing palliative care plans as an alternative to acute hospitalization for residents at the end of life

INTERACT II Shows Potential to Reduce Hospital Admissions



Source: J. G. Ouslander, G. Lamb, R. Tappen et al., "Interventions to Reduce Hospitalizations from Nursing Homes: Evaluation of the INTERACT II Collaborative Quality Improvement Project," Journal of the American Geriatrics Society, April 2011 59(4):745–53.

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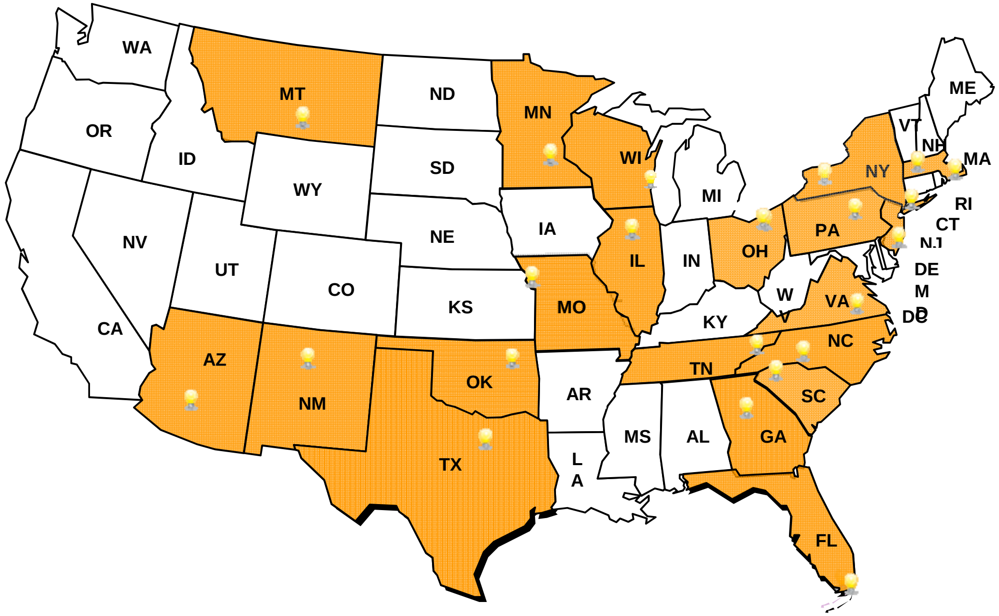
Premier Collaborative Members

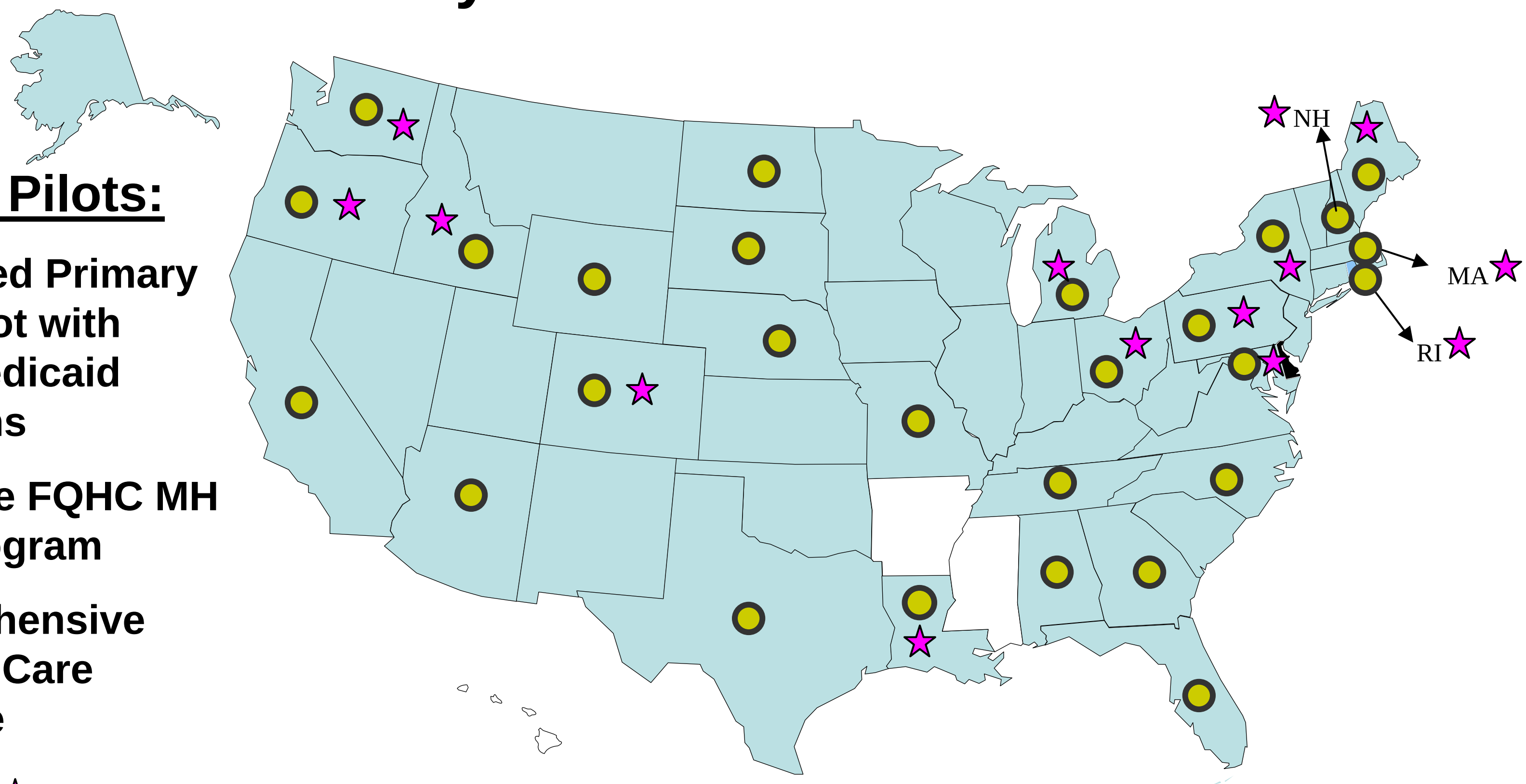


- **AtlantiCare, Egg Harbor Township, N.J.**
- **Aurora Health, Milwaukee, Wisc.**
- **Banner Health System, Phoenix, Ariz.**
- **Baystate Health, Springfield, Mass.**
- **Billings Clinic, Billings, Mont.**
- **Bon Secours St. Francis Health System, Inc., Greenville, S.C.; and Bon Secours Richmond Health System, Richmond, Va. - part of Bon Secours Health System Inc.**
- **CaroMont Health, Gastonia, N.C.**
- **Fairview Health Services, Minneapolis**
- **Geisinger Health System, Danville, Pa.**
- **Hackensack University Medical Center, Hackensack, N.J.**
- **Heartland Health, St. Joseph, Mo.**
- **Methodist Medical Center of Illinois, Peoria, Ill.**
- **Memorial Healthcare System, South Broward, Fla.**
- **Mountain States Health Alliance, Johnson City, Tenn.**
- **North Shore-LIJ Health System, Long Island, N.Y.**
- **Presbyterian Healthcare Services, Albuquerque, N.M.**
- **Rochester General Health System / GRIPA, Rochester, N.Y.**
- **Saint Francis Health System, Tulsa, Okla.**
- **Southcoast Hospitals Group, Fall River, Mass.Summa Health System, Akron, Ohio**
- **Texas Health Resources, Arlington, Texas**
- **University Hospitals, Cleveland, Ohio**
- **WellStar Health System, Atlanta, Ga.**

Source: A. Forster et al., *Learning What it Takes to Form Successful Accountable Care Organizations*, (New York: The Commonwealth Fund, forthcoming 2011).

Medical Homes

Overview of Medical Home Demonstrations, Multi-Payer Activity and Evaluations



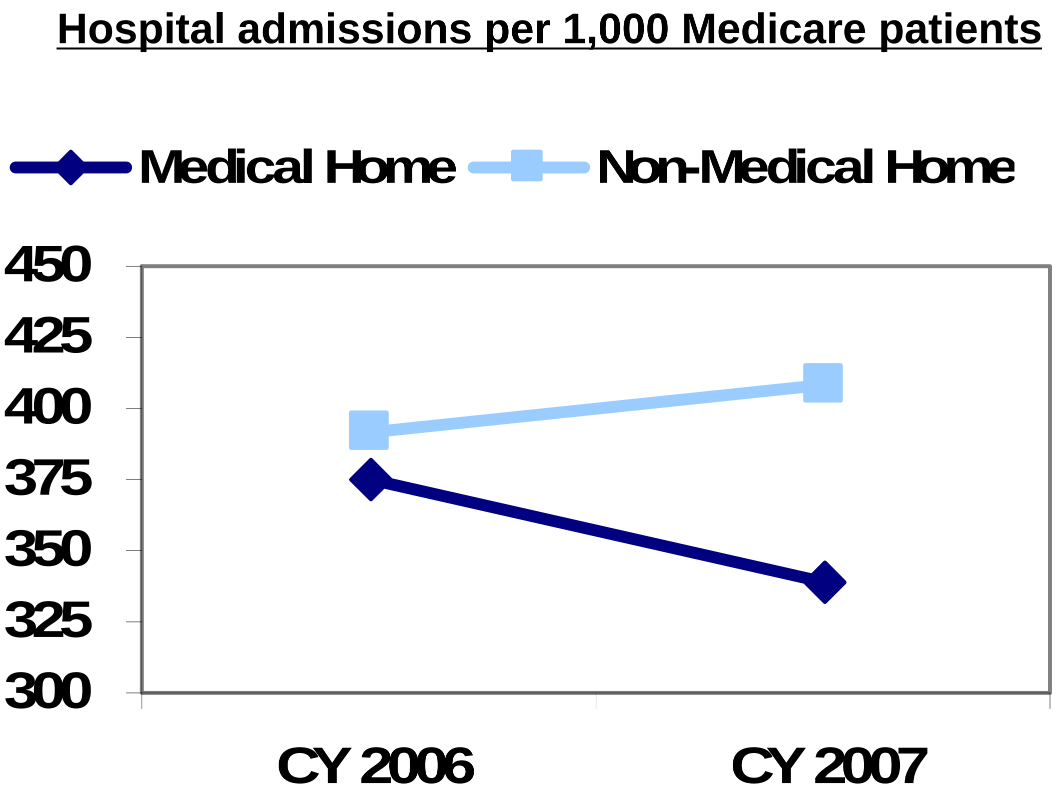
3 Federal Pilots:

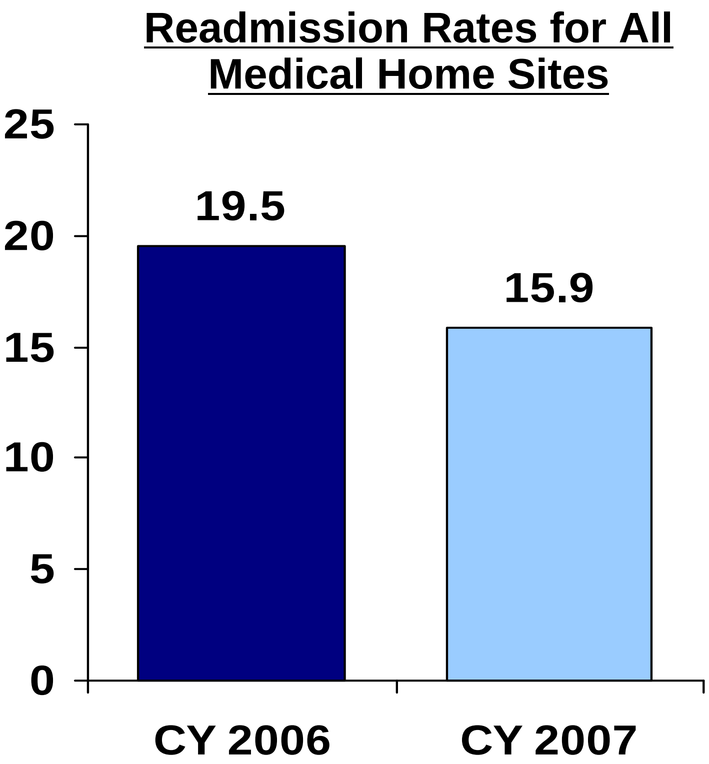
1. **Advanced Primary Care pilot with state Medicaid programs**
2. **Medicare FQHC MH pilot program**
3. **Comprehensive Primary Care initiative**

★ Independent evaluations
● Multi-Payer pilot discussions/activity
■ Identified pilot activity
□ No identified pilot activity – 2 States

Source: Patient Centered Primary Care Collaborative, updated October 2011; Commonwealth Fund analysis of PCMH Evaluations

Geisinger Medical Home Sites and Hospital Admissions/Readmissions

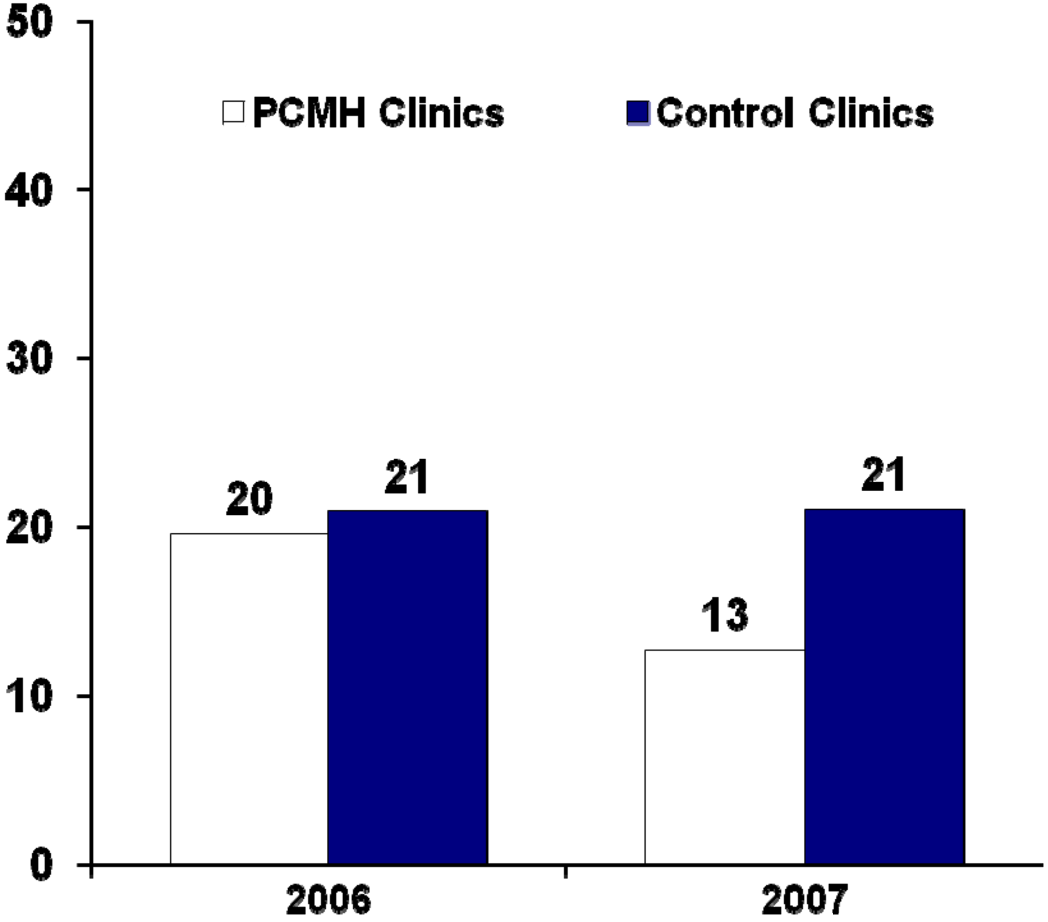




- 20% reduction in hospital admissions
- 18.5% reduction in hospital readmissions
- 7% total medical cost savings

Source: Geisinger Health System, 2008.

Medical Home Improves Clinician/Staff Satisfaction



Clinician Emotional Exhaustion

QUALITY (HEDIS)

•Year 1: Quality improved 2x that of control clinics

•Year 2: Quality improved 20 –30% more than comparison sites in 3 of 4 composites

PATIENT EXPERIENCE

•Year 1: Five percent increase in patient activation/goal setting;

•Year 2: Scores continued to improve at Medical Home; controls were slightly worse

Notes: Mean difference in composite clinical quality changes from 2006 to 2007 between clinics significant at $p<0.01$; difference in mean emotional exhaustion in 2007 between clinics significant at $p<0.01$.

Source: R.J. Reid, P.A. Fishman, O. Yu, et al., "Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation," *The American Journal of Managed Care* 2009, 15(9):e71-e87.

Cost and Quality Outcomes: Medicaid-Sponsored Interventions

Colorado Medicaid and SCHIP

- Cost:
  - Median annual costs $215 less for children in PCMH practices due to reductions in ER visits and hospitalizations
  - Median annual costs $1,129 less for children with chronic diseases in a PCMH practice
- **Quality:**
  - **72% of children in the PCMH practices have had well-child visits, compared with 27% of controls.**

Community Care of North Carolina

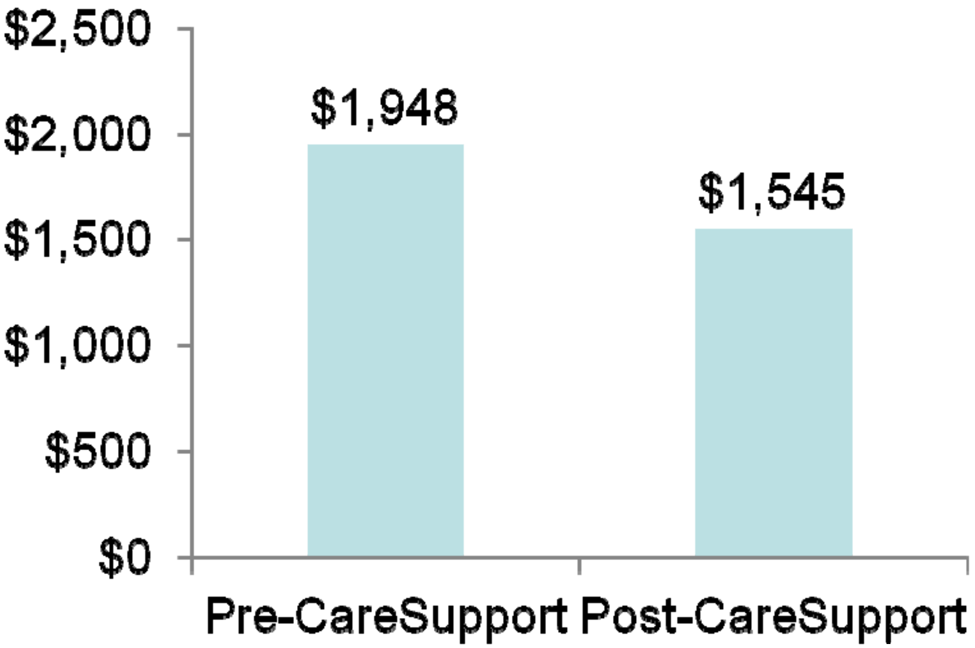
- **Cost**
  - 40 percent decrease in hospitalizations for asthma
  - 16 percent decrease in ER use
  - Total savings to the Medicaid and SCHIP programs: $535 million
- **Quality**
  - **93% of asthmatics received appropriate maintenance medications**
  - **Diabetes quality measures improved by 15%.**

Source: Grumbach, Kevin and Paul Grundy. “Outcomes of Implementing Patient-Centered Medical Home Interventions A Review of Evidence from Prospective Evaluation Studies in the United States” Patient Centered Primary Care Collaborative. 16, November 2010.

CareOregon: Transforming the Role of a Medicaid Health Plan from Payer to Partner

- **Patient-centered medical home initiative in safety-net clinics**
- **Multidisciplinary case management program for members at high risk of poor health outcomes**
- **Emphasize the use of learning communities through which independent providers can acquire, share, and practice techniques to achieve the Triple Aim**
- **By partnering with health care providers to create and pursue a common vision for improving primary care delivery, CareOregon is transforming its role from payer to integrator of care on behalf of its members**

PMPM Cost for Members Enrolled in CareSupport



Source: S. Klein and D. McCarthy, *CareOregon: Transforming the Role of a Medicaid Health Plan from Payer to Partner*, (New York: The Commonwealth Fund, July 2010).

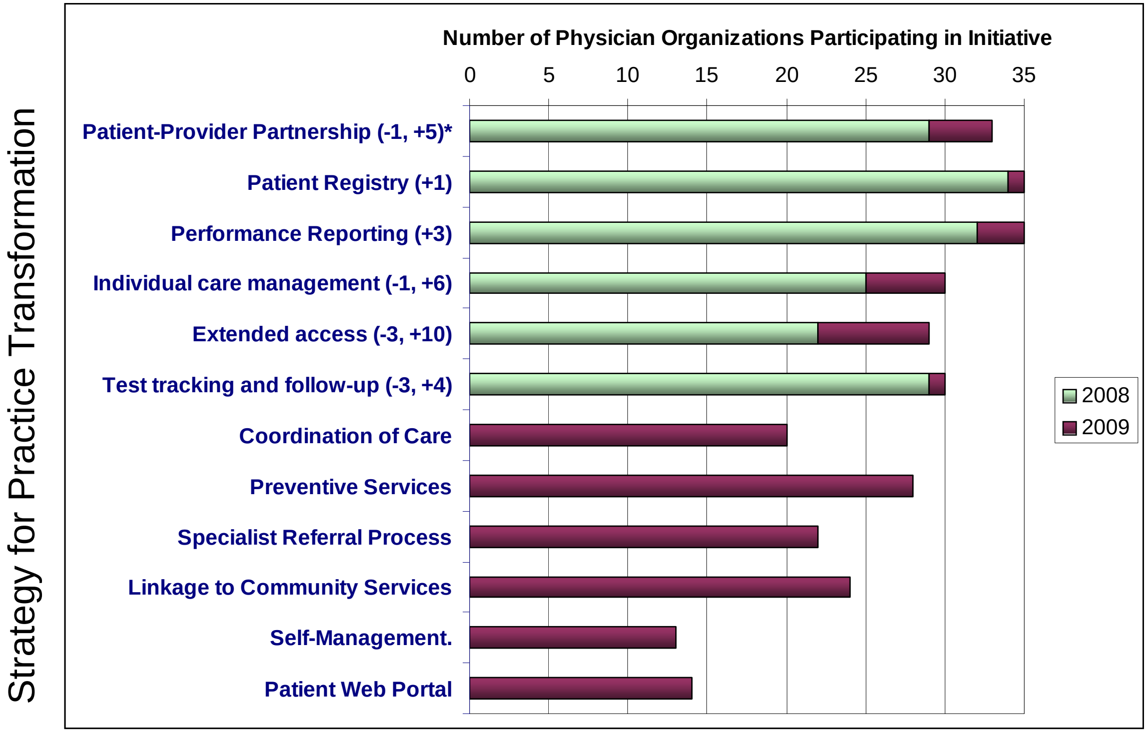
Vermont Blueprint for Health

- A foundation of medical homes and community health teams that can support coordinated care and linkages with a broad range of services
- Multi Insurer Payment Reform that supports a foundation of medical homes and community health teams
- A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry
- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact

Value-Based Purchasing

Michigan BCBS Physician Group Incentive Program

- **Designed in 2005 by BCBS-MI to reward high quality, cost-effective care with proactive management of patient populations**
- **As of 2010 includes: 8,148 physicians in 38 groups, covering 1.8 million people with an incentive pool over $64 million as of 2009**
- **Principles:**
  - **Population based**
  - **Rewards performance and improvement of physician organizations**
  - **Allows for customization and collaboration rather than "one size fits all"**
  - **Voluntary**

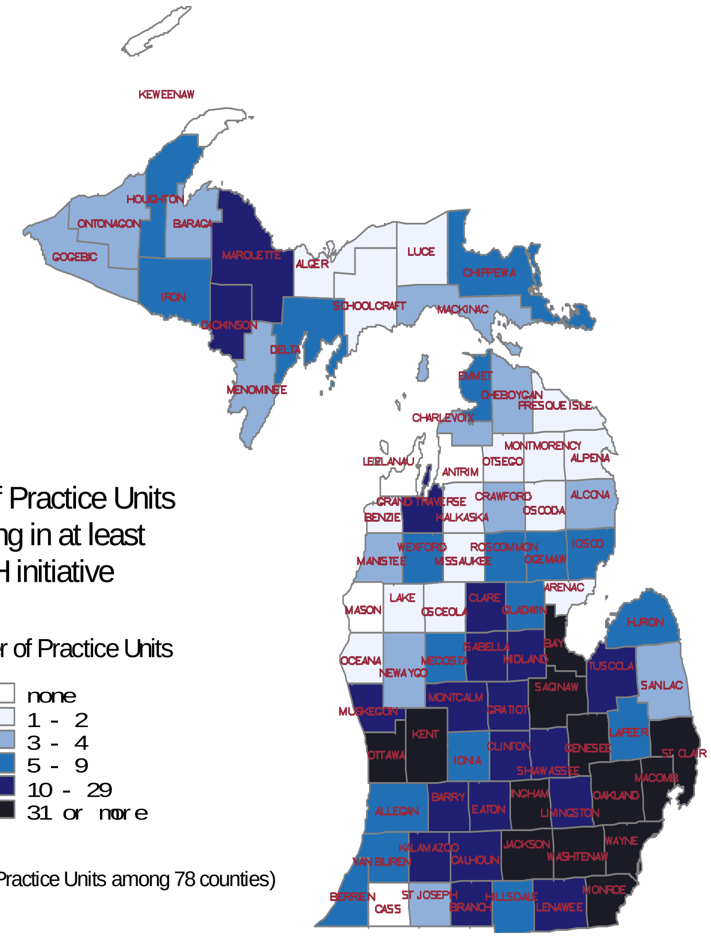


Source: M. Casmer and Linda Mackensen, BCBS-MI. "Large-scale PCMH Program Launch within BCBS-MI Value Partnerships PGIP." 10/6/09.

Michigan BCBS Physician Group Incentive Program

CY 2009, Risk-Adjusted	Designated PCMHs vs. Other Practices
Inpatient Admissions for Ambulatory-Care Sensitive Conditions	-16.7%
Re-Admissions within 30 Days	-6.3%
ER Visits	-4.5%
Standard Cost of Outpatient Care (PMPM)	0.5%
Standard Cost of High Tech Imaging (PMPM)	-7.2%
Standard Cost of Low Tech Imaging (PMPM)	-7.3%
Self-Referral Rate for Low Tech Imaging	-51.5%

Number of Practice Units participating in at least one PCMH initiative



Number of Practice Units

- none
- 1 - 2
- 3 - 4
- 5 - 9
- 10 - 29
- 31 or more

(Total of 2190 Practice Units among 78 counties)

Source: C. Lemak et al., *From Partisanship to Partnership: Evaluating the Physician Group Incentive Program (PGIP)*, (New York: The Commonwealth Fund, forthcoming 2011).

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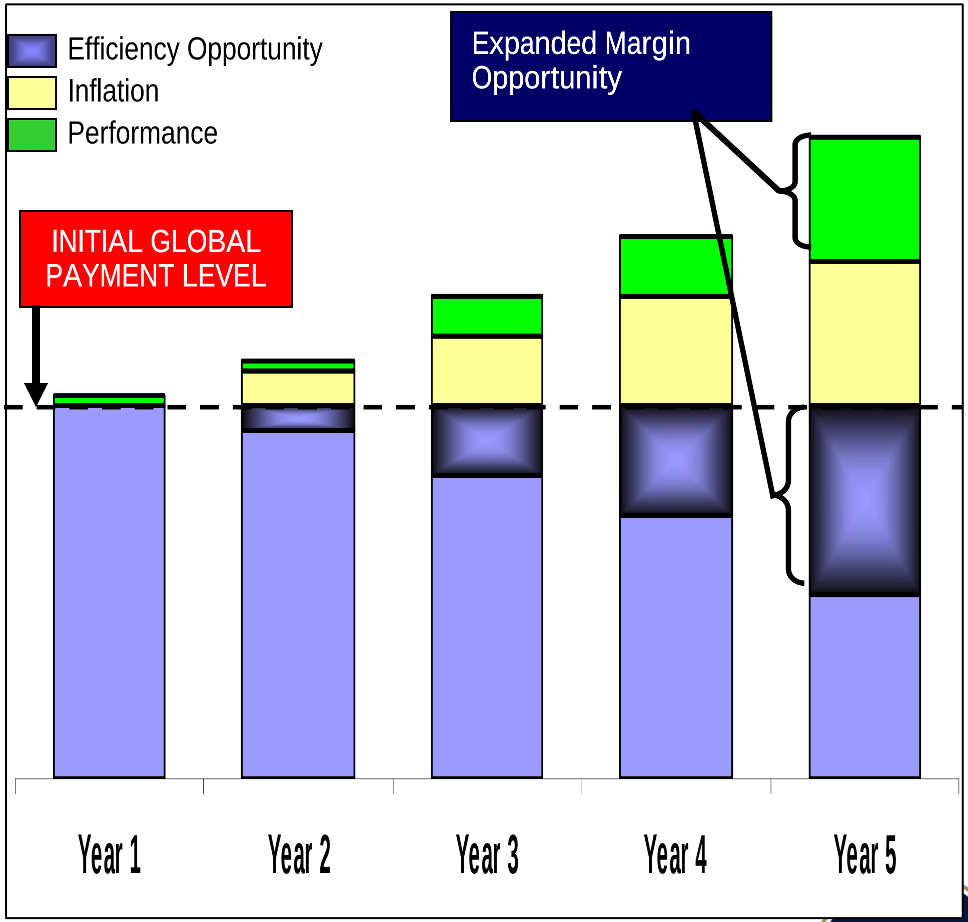
Blue Cross/Blue Shield Alternative Quality Contract

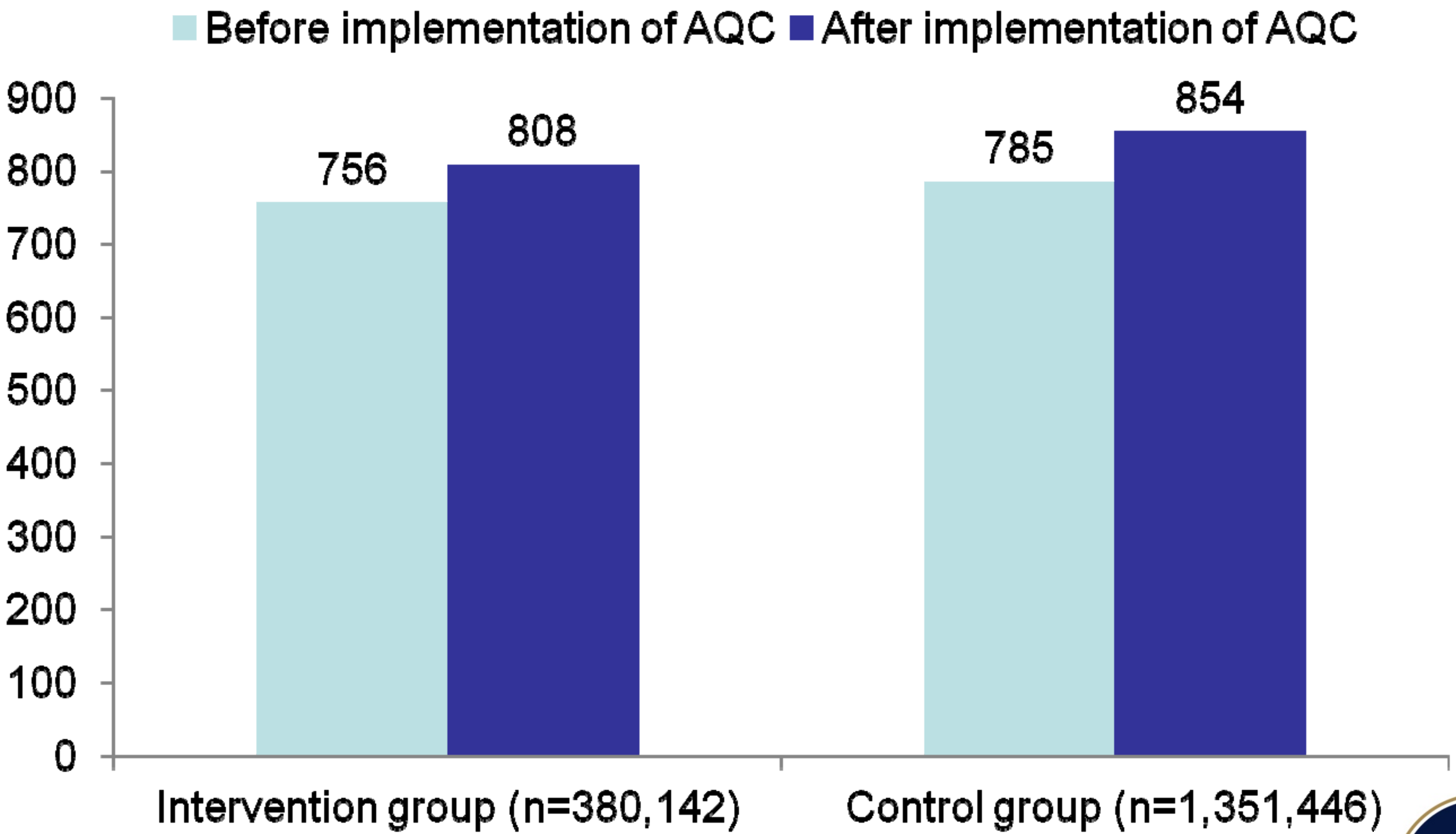
- **<u>Unique contract model</u>:**
- **Physicians & hospital contracted together as a "system" – accountable for cost & quality across full care continuum**
- **Long-term (5-years)**
- **<u>Controls cost growth</u>**
- **Global payment for care across the continuum**
- **Annual inflation tied to CPI**
- **Incentive to eliminate clinically wasteful care ("overuse")**
- **<u>Improved quality, safety and outcomes</u>**
- **Robust performance measure set creates accountability for quality, safety and outcomes across continuum**
- **Substantial financial incentives for high performance (up to 10% upside)**



Source: M. E. Chernew, R. E. Mechanic, B. E. Landon, and D G. Safran, "Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract,'" *Health Affairs*, Jan. 2011 30(1):51–61.

Alternative Quality Contract Associated with Smaller Spending Increase

Average total quarterly spending per enrollee, in dollars



Source: Z. Song, D. G. Safran, B. E. Landon et al., "Health Care Spending and Quality in Year 1 of the Alternative Quality Contract," *New England Journal of Medicine*, published online July 13, 2011.

Medical Group Responses to Global Payment: Early Lessons from the "Alternative Quality Contract" in Massachusetts

- **Strategies for Success**
  - **Change referral patterns to less expensive sites of care and provide routine care within the group's core hospital and physician network**
  - **Identify patients in need of preventive or chronic care management services and ensure these patients received recommended care**
  - **New, multidisciplinary approach to coordinating services for complex patients**
  - **Utilize data on quality of care and invest in infrastructure to produce physician-level data on spending and service use**
- **Medical Group Performance**
  - **Groups new to global payment risk contracts achieved a rate of growth in health care spending 6.3 percent less than the average of groups that did not participate in the contract. The rate of growth for more experienced groups was 1.9 percent less than the average rate of growth for nonparticipating groups.**
  - **Groups that participated in the AQC saw a 2.6 percentage point increase in enrollees who met quality thresholds for chronic care management and a 0.7 percent increase in pediatric quality. However, AQC groups did not realize improvements in adult preventive care.**
  - **Participating medical groups received quality bonuses from 3 to 6 percent of their global budgets.**

R. E. Mechanic, P. Santos, B. E. Landon, and M. E. Chernew, "Medical Group Responses to Global Payment: Early Lessons from the 'Alternative Quality Contract' in Massachusetts," *Health Affairs*, Sept. 2011 30(9):1734–42.

What’s Next? Implementation and the Path Ahead

Strategic Implementation of Reforms

- **Payment models are complementary -**
  - ACOs – Accountability of all services for an entire population, which helps ensure no cost-shifting and overall policy goals of better health and lower total costs are being met
  - Bundled Payments – Accountability for select services and conditions, which helps ensure important gaps in care are addressed and specialists are included in efforts to better coordinate care
  - **Leveraging other payment initiatives (medical home, meaningful use, P4P payments, etc) can help finance start-up costs and maximize returns on clinical transformation efforts**
- **Need to experiment with different approaches**
  - Not sure what works best
  - Vary with local market characteristics and provider experience with care management
- **Early evidence shows that most successful innovators are those with multiple initiatives**

Culture Change

- **Early and critical step for accepting accountability**
- **Requires evolution in relationship between providers, payers and patients**
  - ***Providers and payers*** must move beyond adversarial negotiations around payment rates toward collaborations for more efficient care. Not only about payment reform, but also data analytics and benefit redesign to support higher-value care.
  - ***Providers and other providers*** need to become better at working with each other to coordinate care – includes engaging in best practice sessions, sharing expert opinions and synthesizing patient-centered outcomes research to develop practice-changing innovations.
  - ***Providers and patients*** also need to work better together. Requires time to equip patients, and their care support team, with the information needed to feel confident about making efficient and effective health care decisions.
- **ACO movement is a great signal that the cultural change is happening**
- Will not be easy, there will be failures as well as success
- Need strong commitment and vision

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A New Era in Health Care Delivery: How Payers and Providers Can Help

- The U.S. has passed historic legislation that will help usher in a new era in American health care
- Will make major strides toward achievement of goals of affordable coverage for all while slowing cost growth
- However, realizing the potential is not assured
  - Oversight and system of tracking health system performance will be needed
  - Effective implementation is a big hurdle
  - Stakeholders need to work together toward success of reform
  - Learning rapidly as innovation is tested and experience is gained and applying that knowledge to spread successful innovation are essential
- Providers and payers to come together and help make it work
  - Active participation in innovative payment pilots

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Thank You!

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