Health Reform In 2013: What's Happening, What's Not

By Susan Dentzer
Editor-in-Chief, *Health Affairs*
Presentation to the
Population Health & Care Coordination Colloquium
March 13, 2013

This presentation at a glance

- Major changes afoot in health care ecosystem – the reinvention and renewal
- Galvanized by – but will extend far beyond – Affordable Care Act, which now moves forward
- Triple Aim focus; rapid cycle transformation schedule
- Payment and delivery system reforms; care integration; innovations
- Unfinished business: population health
- Some conclusions

Obama Signs Affordable Care Act into Law, White House, March 23, 2010

- The bill "enshrines the core principle that everybody should have some basic security when it comes to their health care."
- Nearly three years later, having survived legal challenges that went to the Supreme Court and the 2012 elections, implementation is moving forward

Simplified Structure of Affordable Care Act

- Coverage expansion to projected 30 million more Americans -- “stretching our security blankets”
- Roughly 15 million to be able to buy private health insurance coverage through state exchanges with assistance of federal subsidies
- Roughly 15 million to obtain coverage through expanded Medicaid program
- Individual and employer mandates
- Insurance market reforms to broaden and stabilize private coverage, including ban on preexisting condition restrictions

Simplified Structure of Affordable Care Act

- Essential health benefits
- E.g., coverage of many preventive services at no cost-sharing
- Maternity coverage for all women in all plans and coverage without cost-sharing for women's preventive health services, including contraceptives.
- Mental health services have to be provided at parity, which extends to Medicaid

Health Insurance Exchanges: Arrangements As Of March 2013

- 18 states to run state-based exchanges (includes DC)
- 7 states to run “partnership” exchanges with federal government
- 26 states will have the federal government operate an exchange in their state

Medicaid Expansion

- 25 states support (includes DC; also Florida [?])
- 16 Oppose – nominally includes Texas
- 10 Weighing Options
- Many natural experiments ahead!

Simplified Structure of Health Reform

- Move away from classic fee-for-service payment
- Pay health care providers in new ways to spur delivery system reform, enhance patient care, get rid of waste and slow the growth of health spending -- e.g., ESRD bundled payment
- Accountable Care Organizations -- now including some disease-specific initiatives such as the Comprehensive ESRD Care Initiative moving forward under CMMI
- Patient Centered Medical Homes
- Various pilot and demonstration projects, some new, some building on experiments tried in previous administrations

Simplified Structure of Health Reform

- Financing (taxes, slower Medicare spending and fees) to pay for above

- Health Promotion and Prevention initiatives, including $18.75 billion Prevention and Public Health Fund for FY 2010-2022, since reduced to $12.5 billion to offset SGR cuts

- Now $1 billion from FY 2013-2017, $1.25 billion in 2020 and 2021, and $2 billion in 2022

- Other, including workforce and capacity development

The Triple Aim

- Better health
- Better health care
- Lower cost
- Core principle now at heart of major U.S. payment and delivery system reform efforts

Donald Berwick, MD
Former Administrator
Centers for Medicare and Medicaid Services

Better Health

…We'll come back to that!

Better health care

"Crossing the Quality Chasm: A New Health System for the 21st Century"*

- US health care not sufficiently

  - Safe
  - Effective
  - Patient Centered
  - Timely
  - Efficient
  - Equitable

*Source: Institute of Medicine, 2001

"Amenable mortality:" US falling further behind Europe

- Amenable mortality = deaths that should not occur in the presence of timely and effective health care
- Comparison of amenable mortality in the United States compared to those in France, Germany, and the United Kingdom between 1999 and 2007.
- Overall, amenable mortality rates among men from 1999-2007 fell by only 18.5 percent in the United States compared to 36.9 percent in the United Kingdom.
- Among women, the rates fell by 17.5 percent and 31.9 percent, respectively.
- US deaths from circulatory conditions—mainly, cerebrovascular disease and hypertension – were the main reason.
- Source: Nolte et al, *Health Affairs*, September 2012

Lower Costs

“Health care costs are the pounding headache to which all of us in medicine will awaken each day for the rest of our lives.”

--Thomas Lee, CEO, Partners Healthcare

Waste in Health Care: The Savings Opportunity

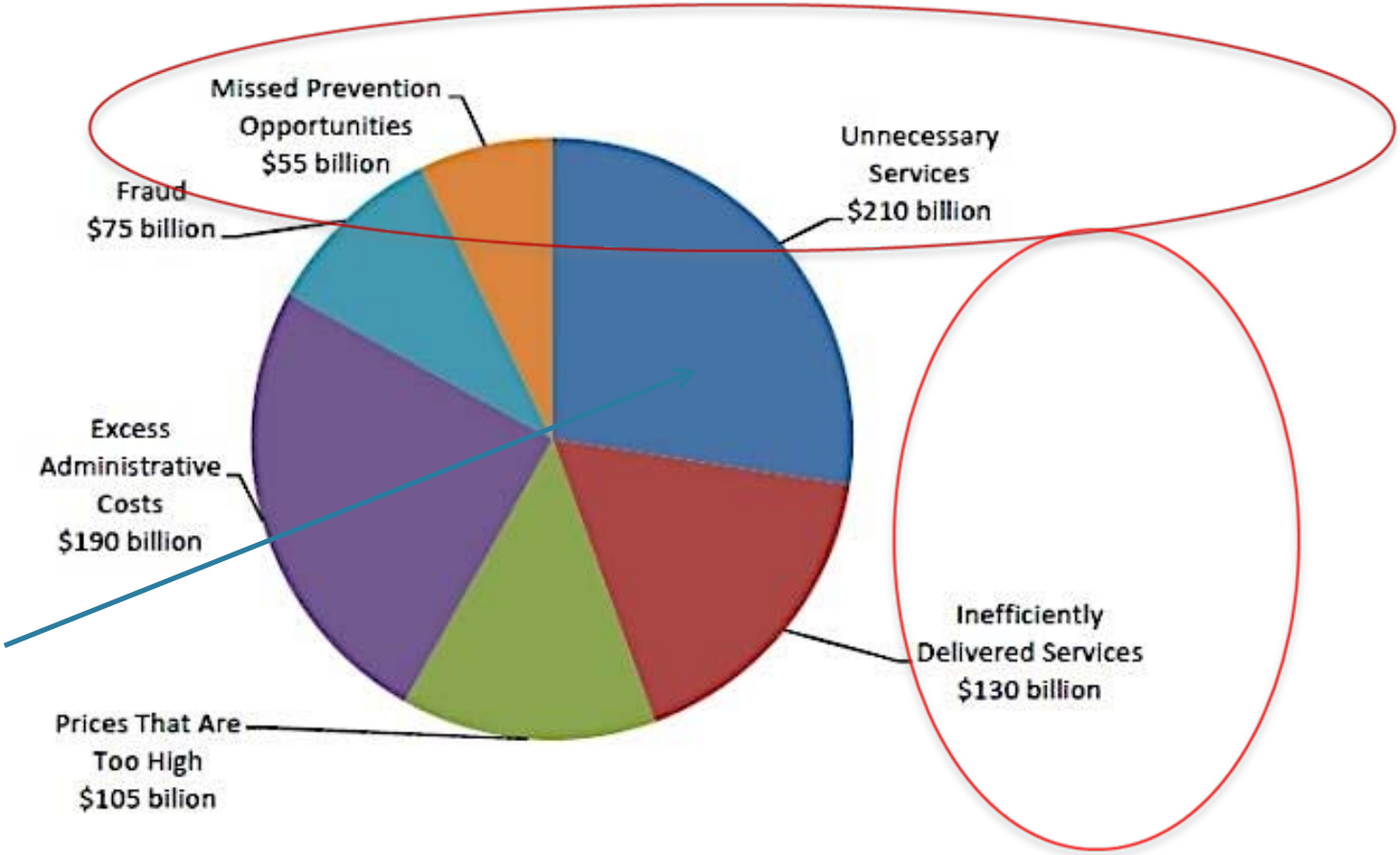
- Six categories of waste estimated to equal 21% to 34% of all US health spending (estimated $558 billion to $910 billion annually)
- Overtreatment – subjecting patients to care that can't possibly help them, and may be harmful
- Failures of care coordination – what happens when patients fall through the cracks, e.g., unnecessary hospital readmissions
- Failures in execution of care processes – e.g., not doing things known to be effective, such as infection control
- Administrative failures – when payers have inefficient or misguided rules
- Pricing failures: when prices are far above what would be seen in well-functioning markets – e.g., CT and MRI costs in US
- Fraud and abuse

Source: Donald M. Berwick and Andrew D. Hackbarth, "Reducing Waste in Health Care Spending," , *Journal of the American Medical Association*, April 11, 2012.

BEST CARE AT LOWER COST

The Path to Continuously Learning Health Care in America

Institute of Medicine Study Released September 2012



Targets of Opportunity For Savings

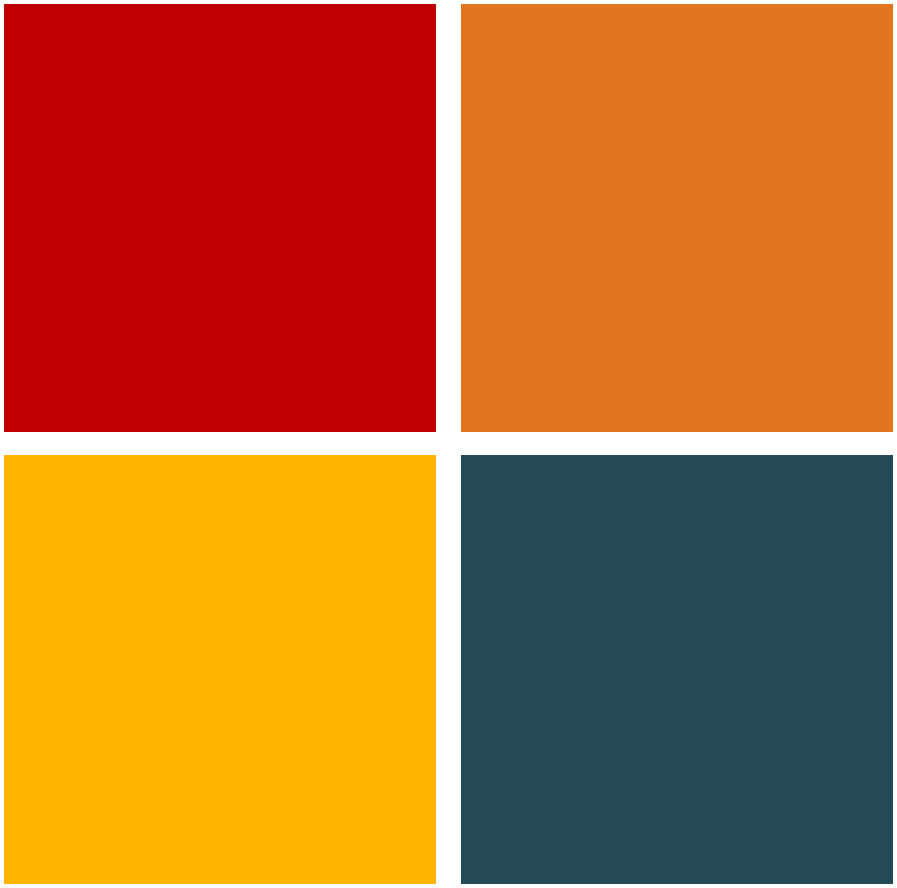
Wide Variations in Cesarean Delivery Rates

- Study by Kathy Kozhimannil of University of Minnesota and coauthors, forthcoming, March 2013 *Health Affairs*
- 2009 data, 593 US hospitals
- Cesarean rates varied tenfold across hospitals, from 7.1 percent to 69.9 percent
- For women with lower-risk pregnancies, 15-fold variation, from 2.4 percent to 36.5 percent
- Lower risk derived by following ACOG recommendations and excluding ICD-9 codes

Wide Variations in Cesarean Delivery Rates

- C-section delivery = 30% higher costs to private insurers versus vaginal delivery ($12,739 versus $9,048 in 2010)
- Although often performed to improve neonatal outcomes and mitigate risk, is also associated with greater risk of asphyxia, respiratory distress, other pulmonary disorders infants, and greater chance of infection, injury, blood clots and need for emergency hysterectomy in mother
- Medicaid pays for nearly ½ of all births
- Authors recommend better maternity care coordination, more data collection and measurement, tying Medicaid to quality improvement, and enhancing patient-centered decision making through public reporting

Reinvention and Realignment

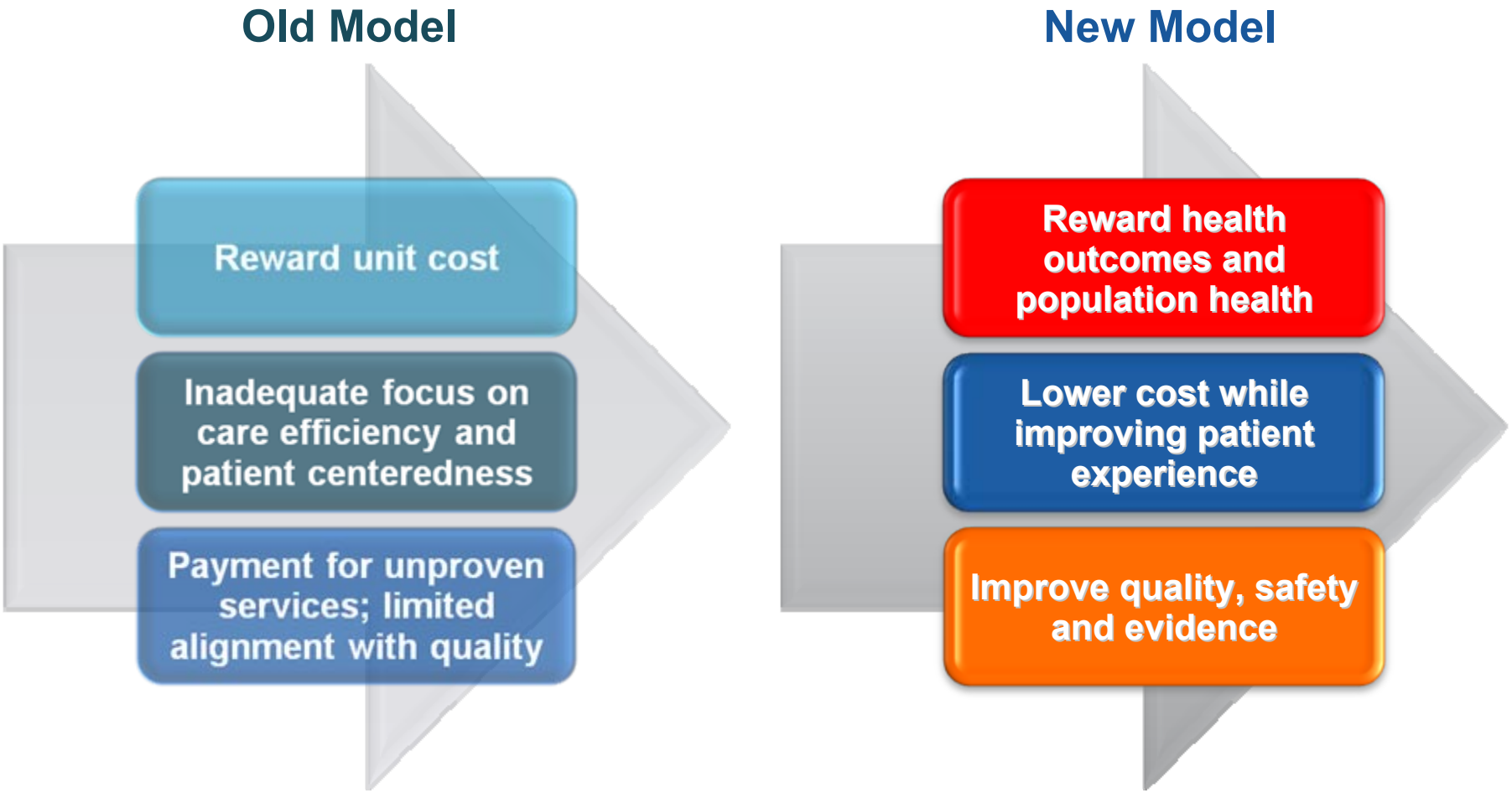


Payment and Delivery System Transformation

The core problem of fee-for-service medicine…

…volume ahead of value.

Payment Innovation: Improving Value And Affordability



Performance-based Innovations under CMS – A Sampling

- Medical homes: All-payer national pilot; Medicaid "health homes"
- 25 states have now implemented patient-centered medical homes in Medicaid
- Comprehensive Primary Care Initiative – 500 primary care practices in 7 geographic areas (Arkansas, Colorado, New Jersey, Oregon and Albany/Hudson Valley in New York, Cincinnati-Dayton in Ohio and Kentucky and Greater Tulsa in Oklahoma; average $20 per beneficiary per month care management fees; shared savings
- Federally qualified health centers Advanced Primary Care Practice (patient centered medical home) demonstration – 500 participants expected to achieve patient-centered medical home recognition; receive monthly $6 per-beneficiary management fee

Performance-based Innovations under CMS

- Federally-sponsored State Demonstrations to Integrate Care for Dual Eligibles

- 15 states awarded contracts and 26 states plan to participate

- Goal to better coordinate and integrate (medical, behavioral, long-term institutional, home-and-community based services) care of "dual eligibles" (Medicare + Medicaid); capitated and managed fee-for-service models; core measures to be collected; most projects delayed until later this year or next

Innovations under CMS

- Accountable Care Organizations, including
- Medicare Shared Savings Program (now 237 organizations participating)
- Pioneer program (32 participants)
- "Advance Payment" ACOs (30 participants)
- Total of more than 2.5 million Medicare beneficiaries participating in all Medicare ACO's = 7-8 percent of entire fee-for-service portion of Program
- Medicaid ACO's in Minnesota, Colorado, Oregon and Washington

Comprehensive ESRD Care Model and ESCO's (ESRD Seamless Care Organizations)

- Goal: to test and evaluate new model of payment and care delivery specific to Medicare beneficiaries with ESRD
- Improve health outcomes and reduce per capita Medicare expenditures
- ESCOs must have minimum of 500 beneficiaries "matched" to their organization
- Participating organizations clinically and financially responsible for all care
- Three payment tracks; ESCOs with at least one dialysis facility owned by a large dialysis organization must participate in risk-based payment

ACO Contracts, Private Sector

- Growing number of ACO-like contracts now in private market
- Proliferation of models: Advocate Health System and Blue Cross Blue Shield of Illinois; Inova/Aetna in Northern Virginia, announced June 2012; 10 ACO's formed by Blue Shield of California; Aetna and Memorial Hermann Health System in Texas (January 2013)

Insurers And Provider Combinations: Growing In Number

HIGHMARK. HUMANA. UnitedHealth Group WELLPOINT.

West Penn Allegheny Health System

- $475M contribution to 5-hospital West Penn Allegheny
- "Affiliation" will enable West Penn to move from fee for service to salaries for physicians and offer incentives for quality and efficiency goals

Concentra

- 300 medical centers in 42 states; 240 worksite health-care facilities
- Will provide urgent care, wellness programs, and physical and occupational therapy to 3 million Humana members near a Concentra center

Monarch HealthCare A Medical Group, Inc.

- United's OptumHealth services unit acquires Monarch: 2300 doctors; 30+ urgent care centers; access to 20 hospitals in Orange County
- OptumHealth: previously entered into management agreements of two California groups, AppleCare Medical Group and Memorial HealthCare Independent Practice Association

CareMore It's what we do.™

- Provides Medicare Advantage coverage and coordinated care for 54,000 people in California, Arizona and Nevada
- CareMore's 26 Care Centers are models for integrated health care and include a variety of services including medical evaluations and diabetes care

Performance-based Innovations under CMS

- Physician quality and outcomes incentives to begin in 2015
- Pay for performance – e.g., ESRD
- Community-based care transitions program – 102 organizations now participating; community-based organizations paid an all-inclusive rate per eligible discharge based on cost of care transition services
- One of new CBCT programs just announced: York County (PA) Area Agency on Aging partnering with York Hospital, Gettysburg Hospital, Hanover Hospital, the Adams County Office for Aging, and multiple downstream providers across south central Pennsylvania and northern Maryland to assist high-risk Medicare beneficiaries through the Care Transition Intervention along with integrating broad system changes and ongoing quality improvement initiatives.

Bundled Payments for Care Improvement Initiative (BPCI)

- More than 450 providers now set to participate
- Surge in participation by post-acute care providers
- Participants have “free range” to define and price care bundles for fee-for-service Medicare beneficiaries
- Four models offered: model 1 = all inpatient admissions; models 2 = specific DRG’s; model 3 = post-acute bundle; model 4 = prospective bundle
- Prospective model = hospital gets single lump sum payment from Medicare and then distributes to all providers involved
- Retrospective model = all providers receive FFS payments at standard rates; after episode concludes Medicare calculates whether agreed-upon bundle price was achieved; providers either receive additional payment or repay Medicare

Hospital Value-Based Purchasing In Medicare

- Required by Affordable Care Act Section 3001
- Designed to transform Medicare "from a passive payer for services to a prudent purchaser of services, paying not just for quantity of services but for quality as well at more than 3,500 hospitals nationwide
- Medicare reduced payment to all hospitals by 1 percent; hospitals then "earn back" bonuses (roughly $1 billion)
- Value-based incentive payments began January 2013 for performance period July 2011 through March 2012
- Based on achievement or improvement on a set of 12 clinical and 8 patient experience of care quality measures (from HCAHPS)

State Innovation Models (SIM)Under ACA

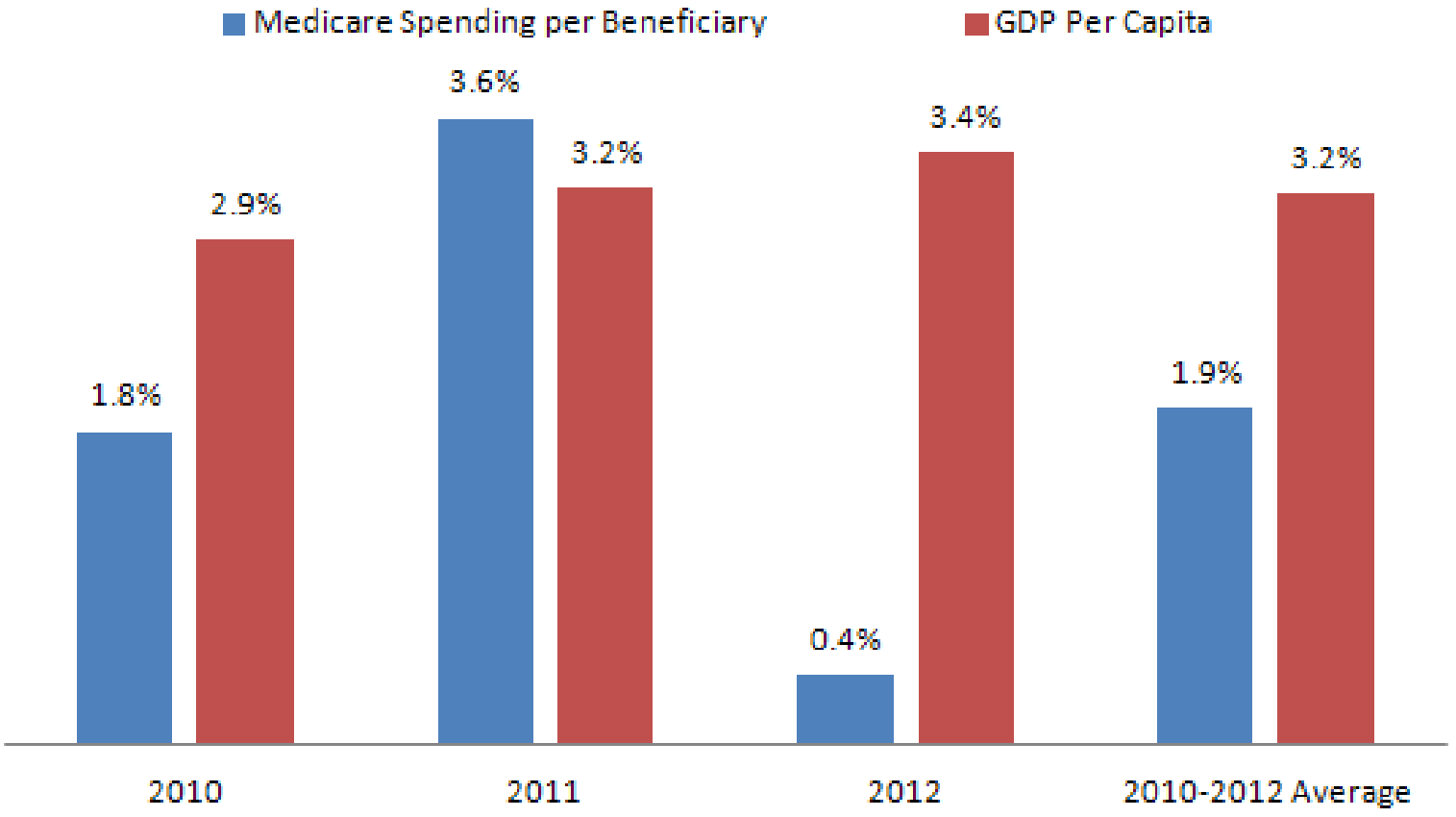
- More than $250 million in Model Testing awards now support six states in implementing their State Health Care Innovation Plans (Arkansas, Maine, Massachusetts, Minnesota, Oregon, Vermont).

- E.g., over the next 42 months, Minnesota will receive up to $45 million to implement and test Minnesota Accountable Health Model – to ensure that every citizen in state has the option to receive team-based, coordinated, patient-centered care that increases and facilitates access to medical care, behavioral health care, long term care, and other services.

- Three states to receive pre-testing assistance to work on a comprehensive State Health Care Innovation Plan; 16 states to receive Model Design funding will produce a State Health Care Innovation Plan.

Early Results of Medicare Cost Saving Pressures?

Expenditures per Medicare beneficiary increased by only 0.4% in fiscal year 2012, substantially below the 3.4% increase in per capita GDP



Better Health

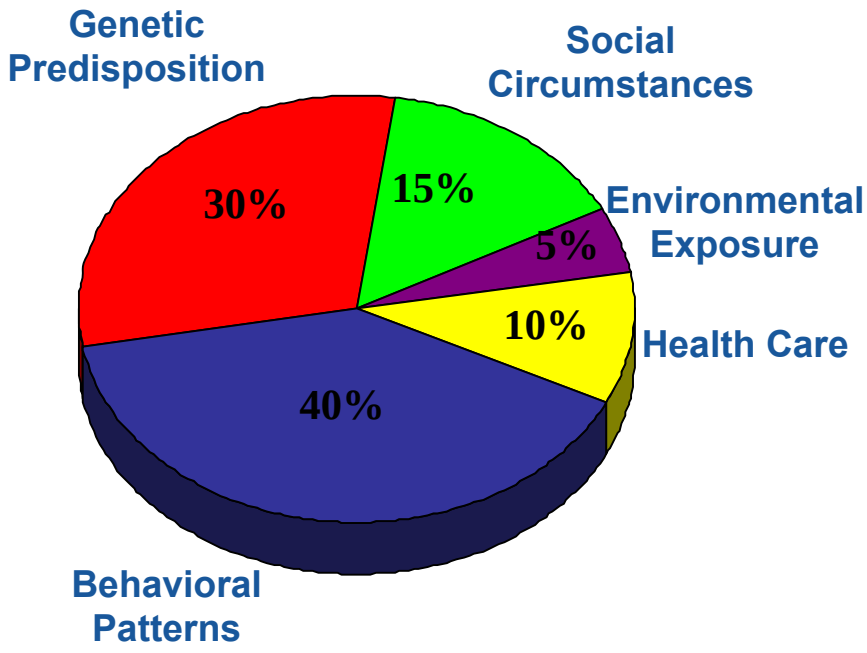
…He’s back!

The State Of US Population Health

Key Drivers of Health Status

Obesity	66% adults obese or overweight
Physical Inactivity	28% inactive
Smoking	23% smokers
Stress	36% high stress
Aging	22% > 55 years old

Contribution to Premature Death



Source: Schroeder S. N Engl J Med 2007;357:1221-1228

Study captures national attention

The New York Times

Washington Edition

Today, clouds and sun, seasonably warm, high 80. Tonight, partly cloudy, low 65. Tomorrow, some sun with late-day thunderstorms high 86. Weather map, Page B8

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FRIDAY, SEPTEMBER 21, 2012

POLITICAL MEMO

Daunting Path Greets Romney Before Debates

He's Hoping to Change Campaign Dynamic

By JEFF ZELENY and JIM RUTENBERG

WASHINGTON — There are seven days until early voting begins in Iowa, less than two weeks until the first debate and 46 days left in the race for Mitt Romney to change the dynamic of a campaign that by many indicators is tilting against him.

That, advisers to President Obama acknowledge, is plenty of time.

But the burden rests to a remarkable degree directly on Mr. Romney and his ability to restore confidence to his campaign, become a more nimble candidate and clearly explain to voters why he would be the better choice to repair the economy and lead the nation in addressing its challenges at home and abroad.

The state-by-state landscape

Mitt Romney spoke to supporters during a campaign event in Sarasota, Fla., on Thursday.

REVERSING TREND, LIFE SPAN SHRINKS FOR SOME WHITES

4-YEAR DROP SINCE 1990

Nation's Least Educated Suffer While Others Are Living Longer

By SABRINA TAVERNISE

For generations of Americans, it was a given that children would live longer than their parents. But there is now mounting evidence that this enduring trend has reversed itself for the country's least-educated whites, an increasingly troubled group

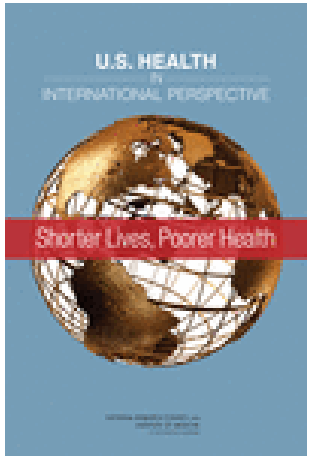
Researchers have long documented that the most educated Americans were making the biggest gains in life expectancy, but now they say mortality data show that life spans for some of the least educated Americans are actually contracting. Four studies

Widening disparities in life expectancy

- S. Jay Olshansky et al, *Health Affairs*, August 2012
- In 2008, US adult men and women with fewer than 12 years of education had life expectancy roughly equal to all American adults in the 1950s – 60 years ago
- Falling life expectancy particularly pronounced for less-educated women
- Mix of factors seems to be at play, including obesity, smoking, stress, prescription drug abuse
- When race and education are combined, disparities are even more striking

Institute of Medicine Study, January 2013

- "For many years, Americans have been dying at younger ages than people in almost all other high-income countries."
- 27 countries now outperform the United States on life expectancy at birth.
- "Americans also have a longstanding pattern of poorer health that is strikingly consistent and pervasive over the life course – at birth, during childhood and adolescence, for young and middle-aged adults, and for older adults."
- Source: *US Health in International Perspective: Shorter Lives, Poorer Health.* Institute of Medicine, 2013



Institute of Medicine Study, January 2013

- Deaths that occur before age 50 are responsible for about two-thirds of the difference in life expectancy between males in the United States and peer countries
- Deaths before age 50 explain about one-third of the difference for females

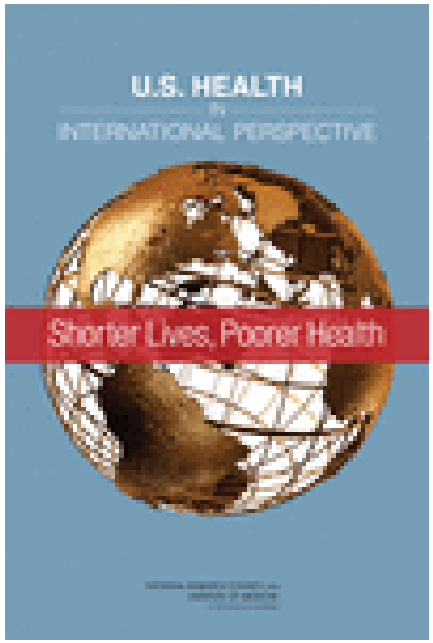
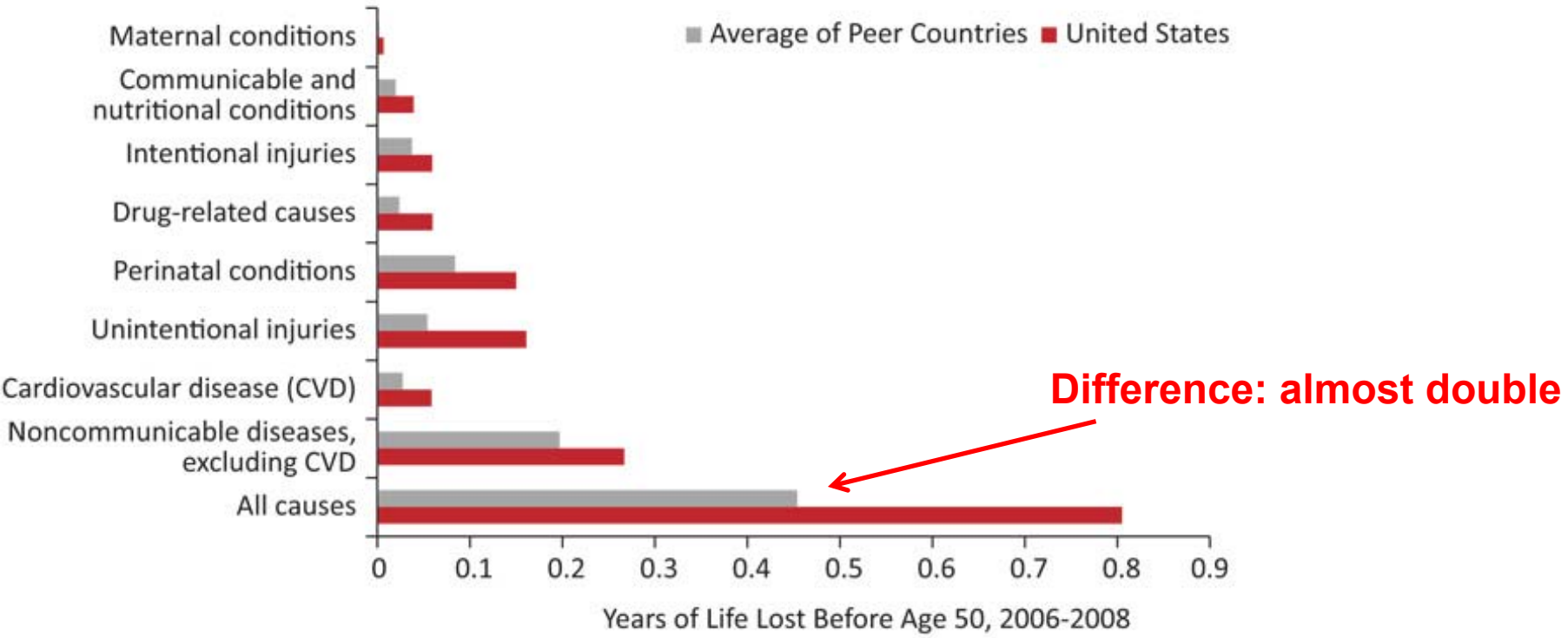


FIGURE: Causes of Death for U.S. Women Before Age 50, Compared with Average of Peer Countries, 2006-2008



Difference: almost double

NOTE: CVD is cardiovascular disease

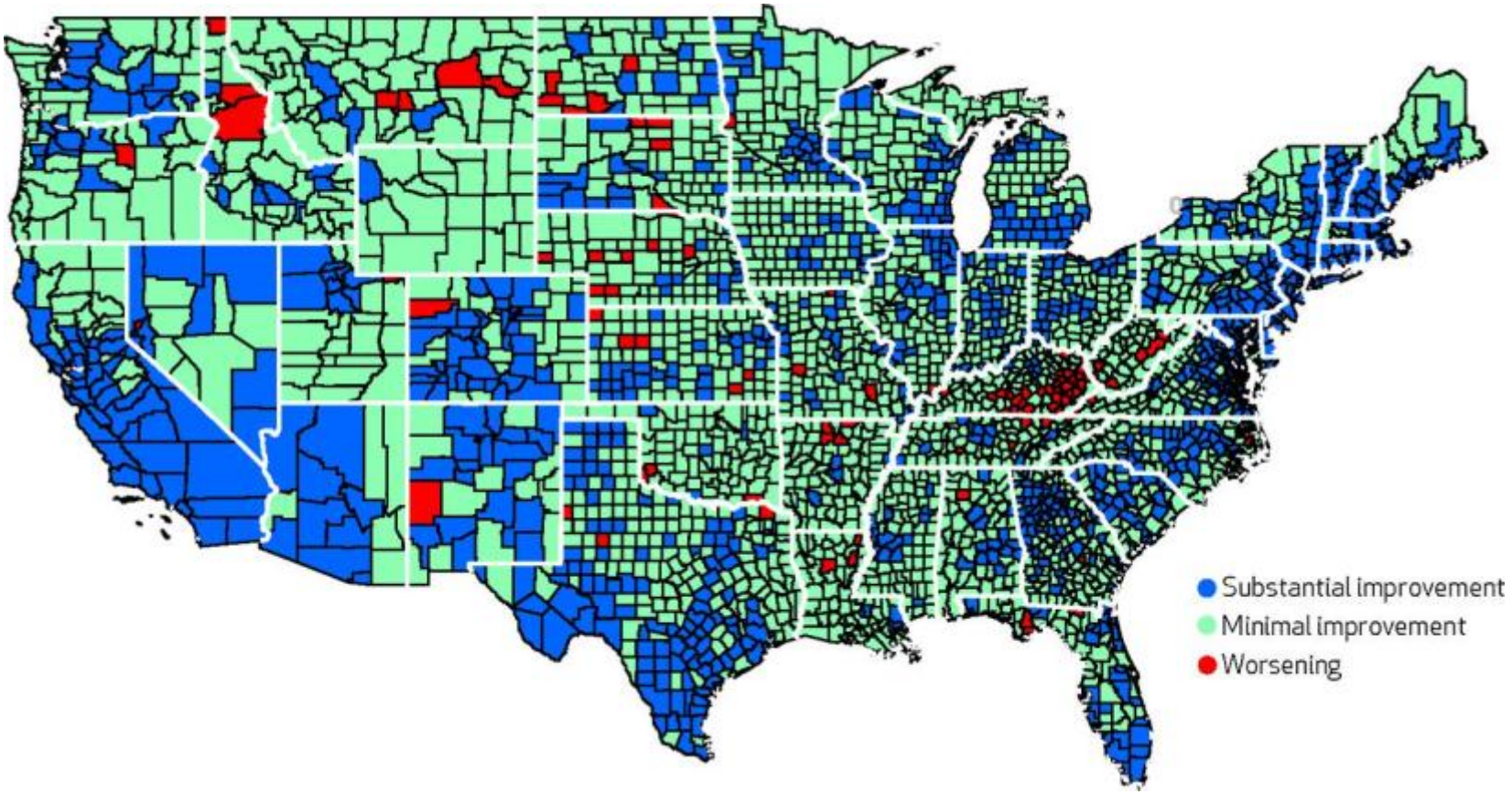
SOURCE: Data from the Human Mortality Database, the World Health Organization Mortality Database, and Statistics Canada, as reported in Ho, J. Y. and S.H. Preston (2011). *International Comparisons of U.S. Mortality.* Data analyses prepared for the National Academy of Sciences/ Institute of Medicine Panel on Understanding Cross-National Health Differences Among High-Income Countries. Population Studies Center, University of Pennsylvania. *U.S. Health in International Perspective: Shorter Lives, Poorer Health*, January 2013

NATIONAL RESEARCH COUNCIL AND INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Rising Female Mortality

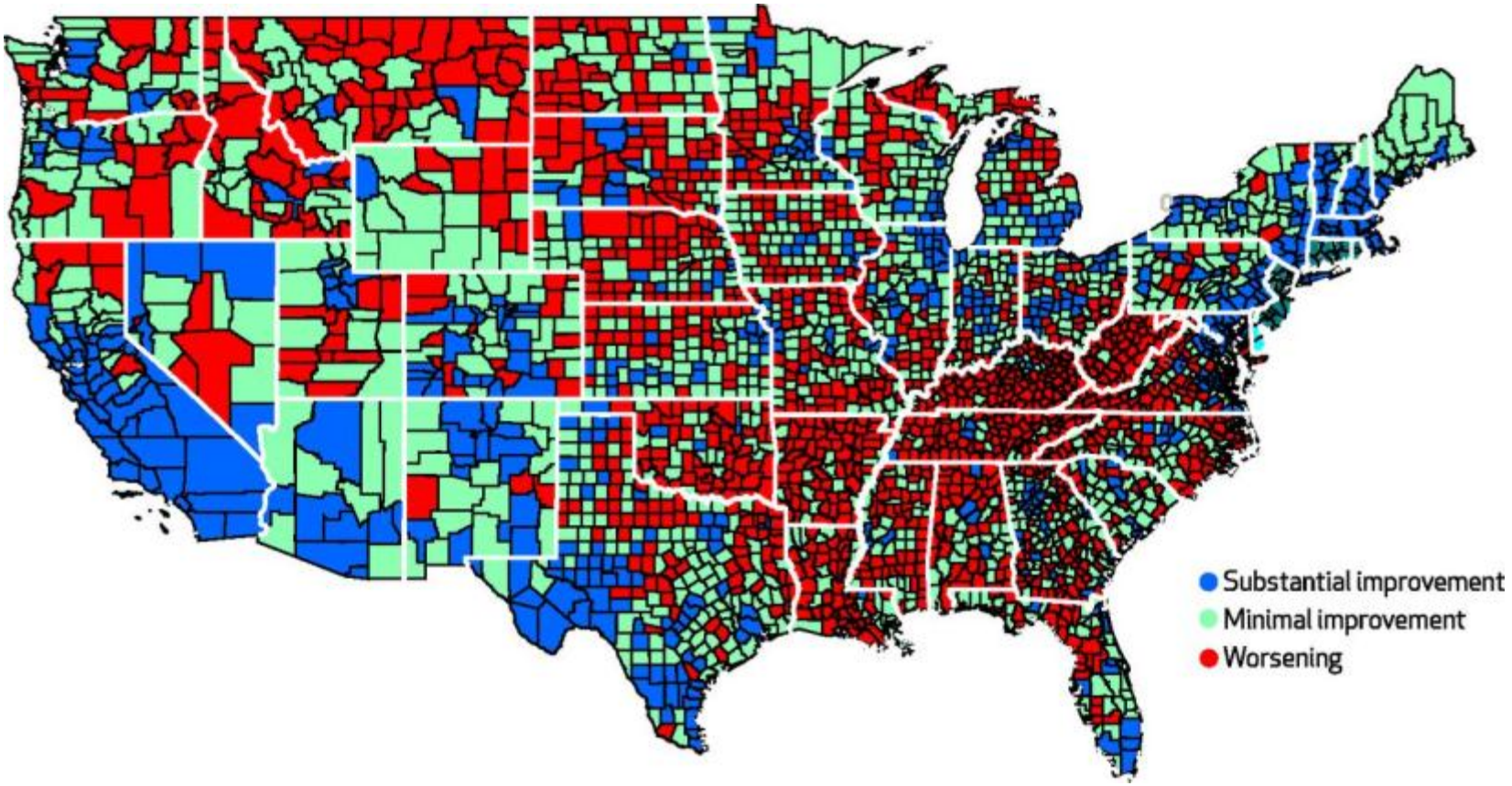
- Study examined trends in male and female mortality rates from 1992–96 to 2002–06 in 3,140 US counties.
- Female mortality rates increased in 42.8 percent of counties, while male mortality rates increased in only 3.4 percent.
- Several factors, including higher education levels, not being in the South or West, and low smoking rates, were associated with lower mortality rates.
- Source: DA Kindig, ER Cheng,"Even As Mortality Fell In Most US Counties, Female Mortality Nonetheless Rose In 42.8 Percent Of Counties From 1992 To 2006." *Health Affairs*, March 2013

Change In Male Mortality Rates From 1992–96 To 2002–06 In US Counties.



Kindig D A , and Cheng E R Health Aff 2013;32:451-458

Change In Female Mortality Rates From 1992–96 To 2002–06 In US Counties.



Kindig D A , and Cheng E R Health Aff 2013;32:451-458

HealthAffairs

Rising Female Mortality

- Medical care variables, such as proportions of primary care providers, were not associated with lower rates.
- Findings suggest that “improving health outcomes across the United States will require increased public and private investment in the social and environmental determinants of health—beyond an exclusive focus on access to care or individual health behavior.”

- Source: DA Kindig, ER Cheng,”Even As Mortality Fell In Most US Counties, Female Mortality Nonetheless Rose In 42.8 Percent Of Counties From 1992 To 2006.” *Health Affairs*, March 2013

America's Health Deficit: It Starts With Our Kids

- For decades, the United States has experienced the highest infant mortality rate of high-income countries
- US also ranks poorly on other birth outcomes, such as low birth weight.
- American children are less likely to live to age 5 than children in other high-income countries.
- Deaths from motor vehicle crashes, nontransportation-related injuries, and violence occur at much higher rates in the United States than in other countries and are a leading cause of death in children, adolescents, and young adults

Worse Infant Mortality

US reports fetal deaths beginning at 350 grams versus higher weights in other countries

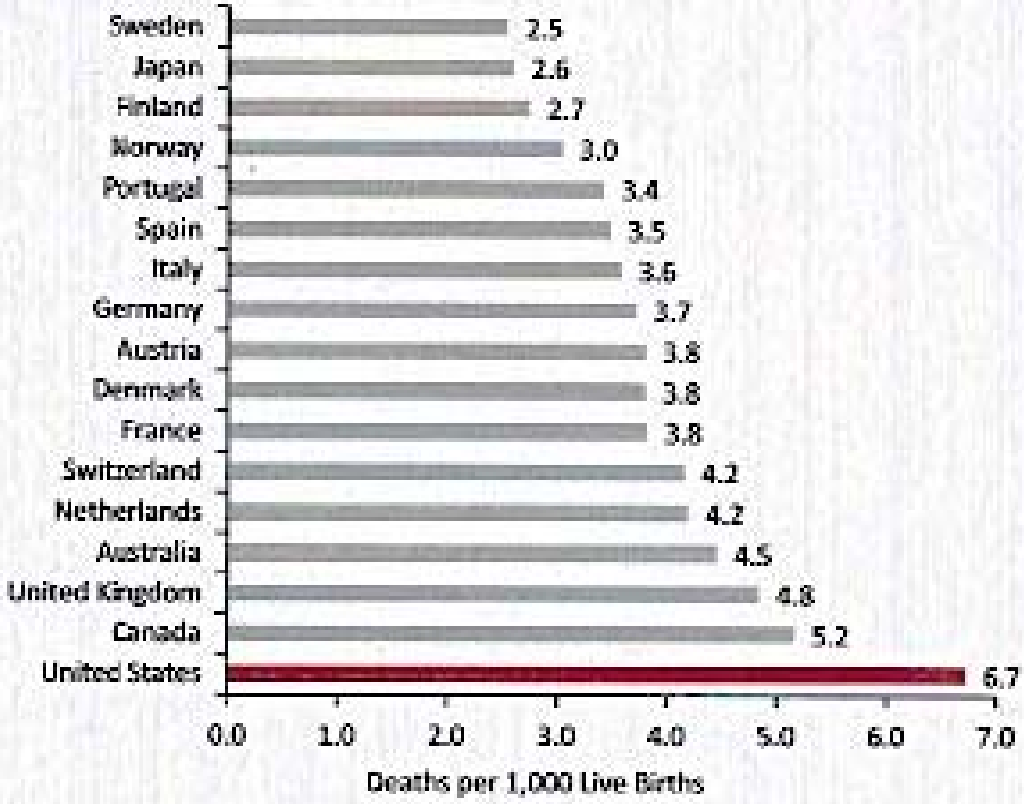
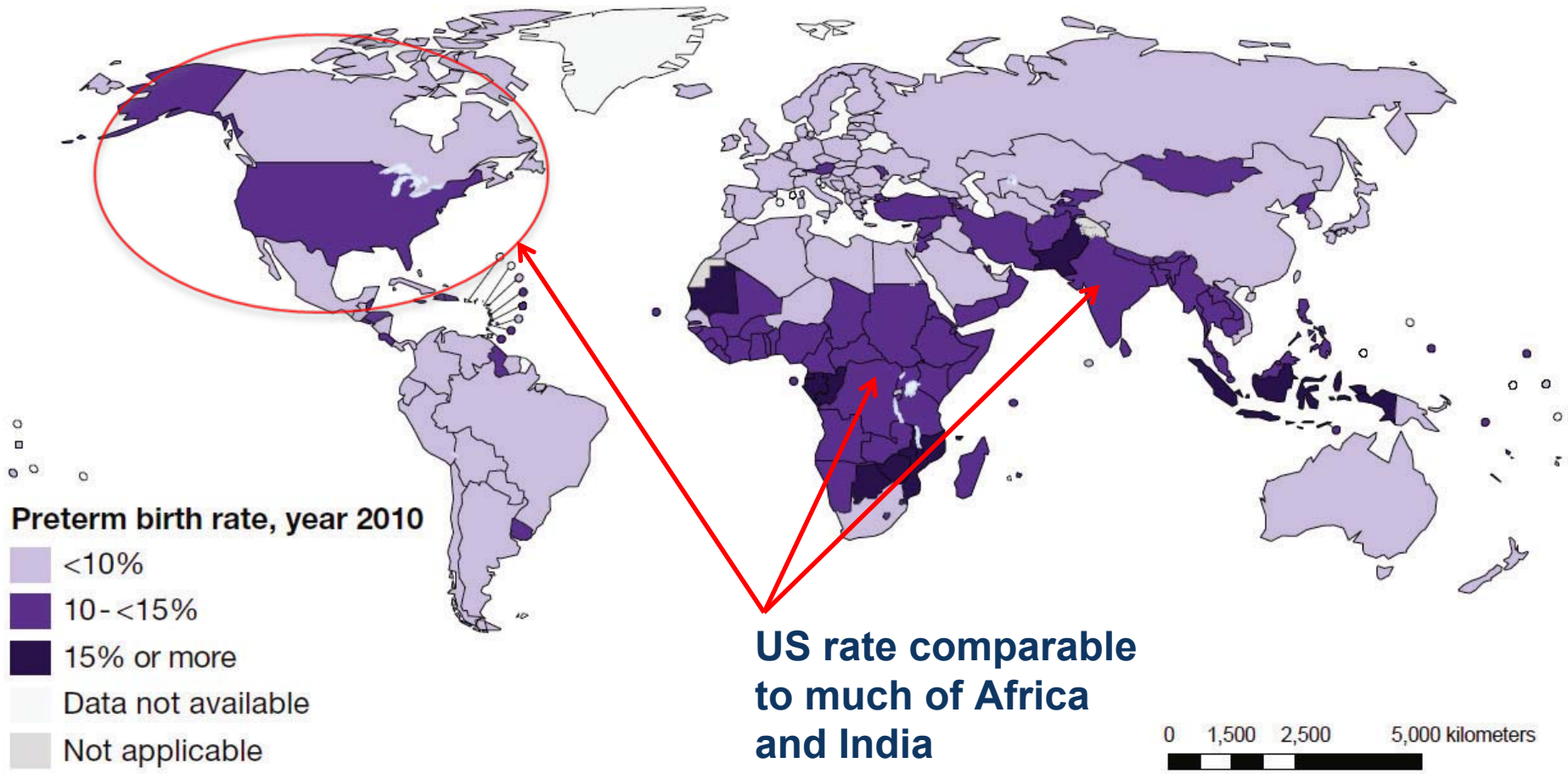


FIGURE 2-1 Infant mortality rates in 17 peer countries, 2005-2009.
NOTE: Rates averaged over 2005-2009.
SOURCE: Data from OECD (2012c).

Prevalence of Pre-Term Births, 2010



Source: Blencowe, H., et al, Lancet, 379 (9,832), 2, 162-2

Low Birth Weight Compared To Other Countries

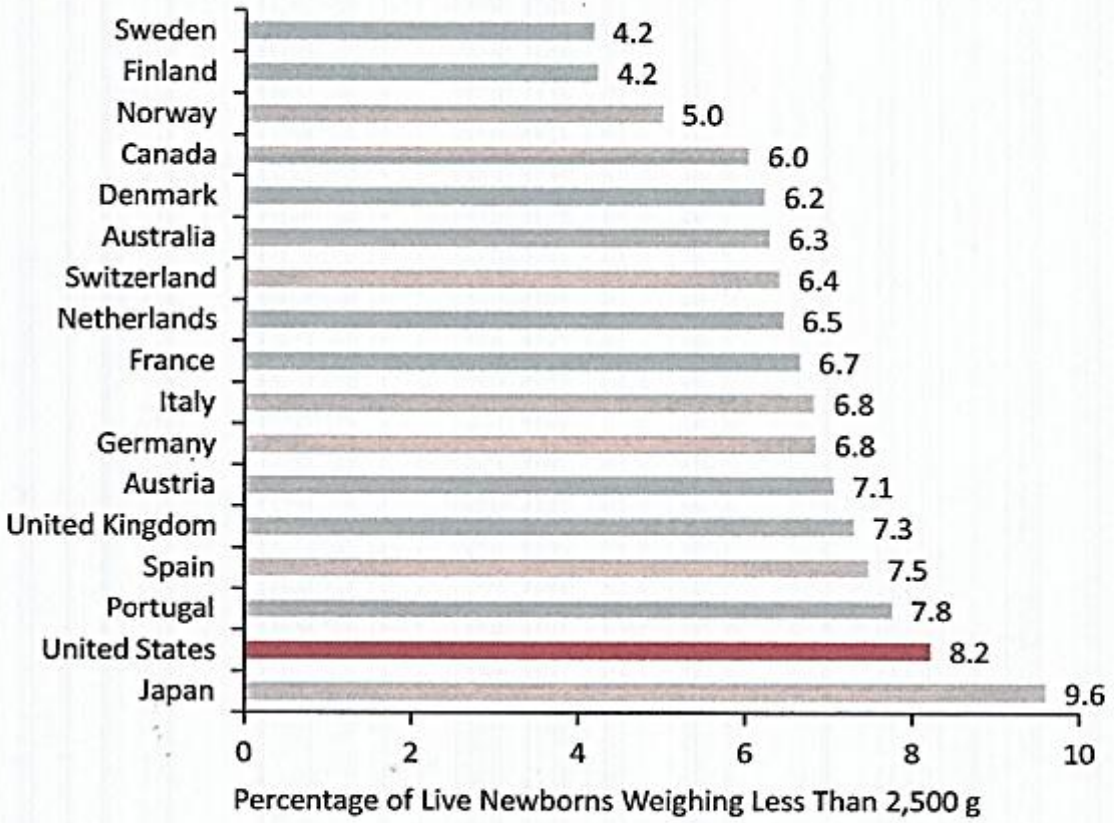


FIGURE 2-2 Low birth weight in 17 peer countries, 2005-2009.
NOTE: Values (if present) averaged over 2005-2009.
SOURCE: Data from OECD (2012l), OECD.StatExtracts: Health Status (database).

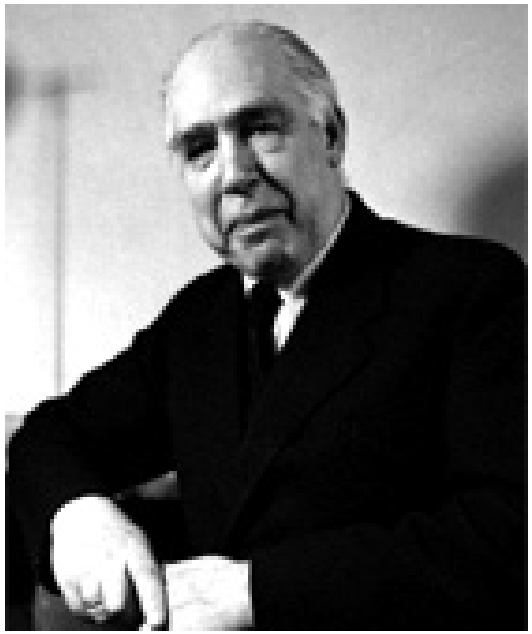
Impact of Sequestration

- Medicare cuts limited to 2 percent
- Medicaid held harmless
- Title X (Public Health Service Act) Family Planning could be cut by $15 million in FY 2013 on top of $23 million in cuts over past two years
- Would limit access to family-planning services and cut back on clinic and staff hours
- One-quarter of all poor women who obtain contraceptive services in US do so at a Title X-supported center
- Estimated 600,000-775,000 low-income women and children at nutritional risk could lose WIC benefits (Special Supplemental Nutrition Program for Women, Infants, And Children) -- $340 million funding cut
- Sources: Center on Budget and Policy Priorities; Center for American Progress

At Risk?

- Prevention and Public Health Fund originally to be $18.75 billion for FY 2010-2022, since reduced to $12.5 billion to offset SGR cuts
- Now $1 billion from FY 2013-2017, $1.25 billion in 2020 and 2021, and $2 billion in 2022
- What will be left after a “Grand Bargain”?

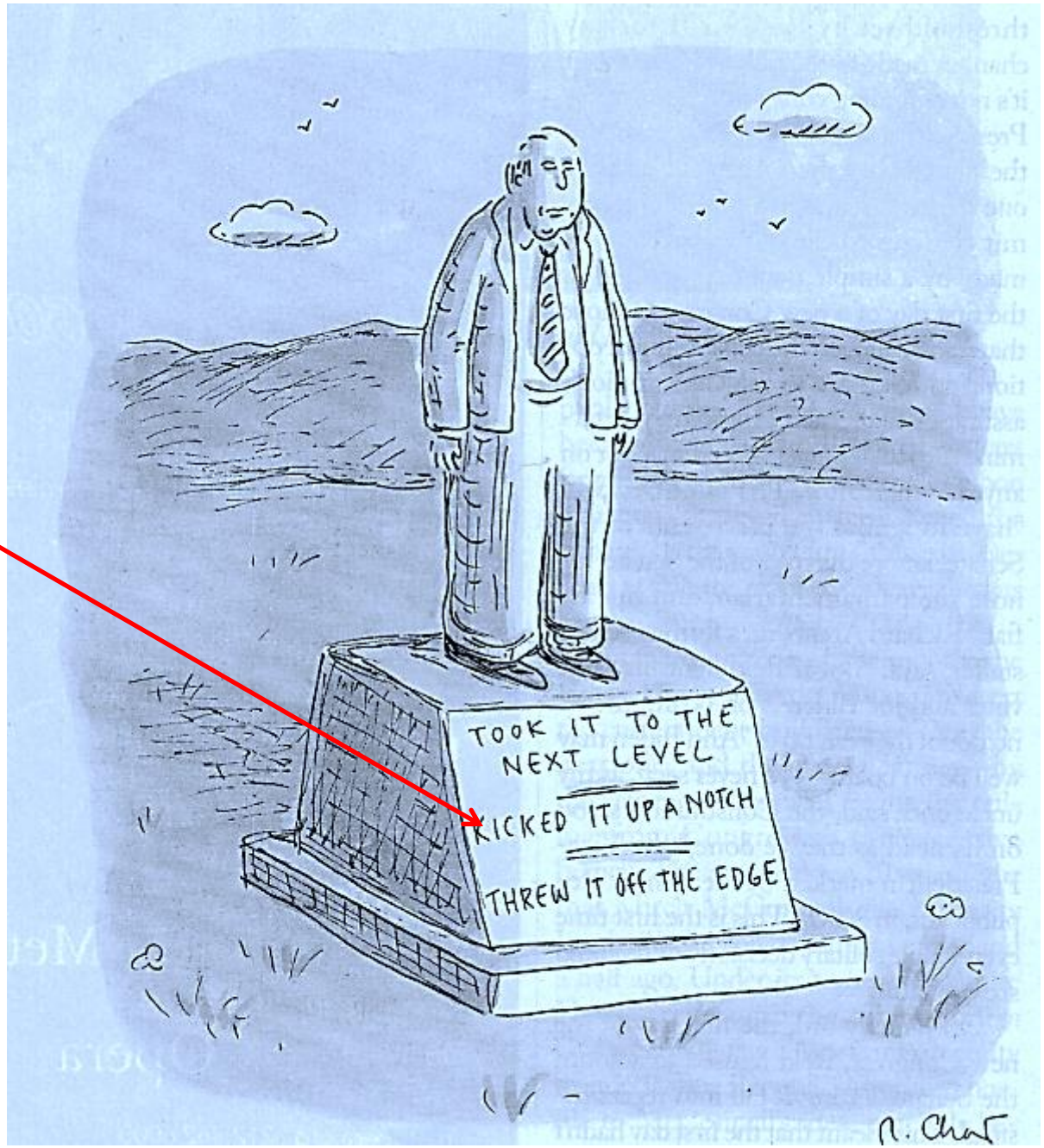
Key Concerns



“Prediction is very difficult, especially about the future.”

-- Danish physicist and Nobel Prize Winner Niels Bohr

Can We Afford To Leave It At This?



The Final Verdict on National Health Reform?

“Somebody has to do something, and it’s just incredibly pathetic that it has to be us.”

--the late Jerry Garcia of the Grateful Dead

The End