Reforming Health Care Delivery

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Focus on Reforming Health Care Delivery in Bipartisan Health Care Reform

- **Information**
  - Health IT
  - Better Evidence

- **Provider Payment**
  - Initial support for coordinated care (e.g., medical homes, community health teams)
  - Initial payments for reporting/performance, bundling
  - Transition to accountability for Results

- **Benefits**
  - More effective competition through insurance market and tax reforms
  - Value-based benefits
Lessons from Research and Practice

• **Key elements of effective payment & delivery system reforms**

  • Foster greater accountability for quality and cost
    » Integrated reforms “build in” expectations of cost containment and quality improvement – not just reducing payment updates

  • Feasible across diverse practice, organizational, and market settings
    » Reforms should be flexible to allow for variation in the strategies that local health systems use to improve care

  • Transition payments from rewarding volume and intensity to increasing value
    » Payments should encourage collaboration and shared responsibility among providers and consistent incentives/measures from payers

• Help consumers make better decisions
  » Increased accountability on the part of providers should be accompanied by improved incentives and information for consumers
# Evolution of Payment Reform

From Incremental Reporting Bonuses to More Comprehensive and Integrated Population-Level Reforms

<table>
<thead>
<tr>
<th>Supporting Better Performance</th>
<th>Paying for Better Performance</th>
<th>Paying for Higher Value</th>
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<tbody>
<tr>
<td>Pay for reporting. Payment for coordination. Case management fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).</td>
<td>Pay for performance. Provider fees tied to one or more objective measures of performance (e.g., guideline-based payment, nonpayment for preventable complications).</td>
<td>Shared savings with quality improvement. Providers share in savings due to better care coordination and disease management.</td>
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<tr>
<td>Partial or full capitation with quality improvement. Systems of care assume responsibility for patients across providers and settings over time.</td>
<td>Episode-based payments. Case payment for a particular procedure or condition(s) based on quality and cost.</td>
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Accountable Care Organizations

- Accountable Care Organizations (ACOs) are multi-stakeholder public/private collaborations for which providers assume responsibility for overall patient care across providers and settings through:
  - Voluntary provider participation, broad payer participation, local accountability, payment incentives, and performance measurement

- ACO configurations vary reflecting the diversity of local health care markets and preferences of participants; however, several characteristics are essential for all ACOs:

  - Can provide or manage a continuum of care as a real or virtually integrated delivery system
  - Are of sufficient size to support comprehensive performance measurement
  - Are capable of prospectively planning budgets and resource needs
Integrating Care through ACOs

ACOs can serve as “integrators” that link fragmented entities of the health care system around accountability for value.

Illustrative ACO

- Specialty Group
- PCP Group
- Hospitals
- Other Providers

Other Providers Operating Outside the ACO

- Home Health Services
- Mental Health Facility
- Other providers

Community Services & Supports (e.g., transportation, translation services)

Wellness Initiatives (e.g., smoking cessation, nutrition)
How Do “Shared Savings” Models Work?

Initial shared savings derived from spending below benchmarks

- ACO Launch
- Projected Spending
- Spending Benchmark
- Actual Spending

Spending

Time
Accountable Care Step by Step

Steps for Initial ACO Implementation

1. Local providers and multiple participating payers agree to pilot ACO reform
2. ACO develops list of participating providers and payers
3. Patients are “assigned” to ACOs (e.g., based on preponderance of E&M codes)
4. Actuarial projections about future spending are based on last 3 years
5. Determine/negotiate spending benchmark and shared savings
6. ACO implements capacity, process, and delivery system improvement strategies (e.g., reducing avoidable hospitalizations, coordinating care, health IT)
7. Progress reports on cost and quality are developed for ACO beneficiaries
8. At year end, total and per capita spending are measured for all patients (regardless of whether they received care from ACO providers)
9. Savings under the benchmark is shared between providers and payers
ACOs and Health Care Reform

• ACOs are designed to reflect key lessons from effective payment and delivery reforms:
  » Supports providers when they take steps to improve care and lower costs
  » Fosters greater accountability for quality and cost across diverse practice, organizational, and market settings.
  » Promotes high-value care over high-intensity care
  » Helps consumers make better health care decisions

• ACOs are fully compatible with other reforms, including:
  » Bundled payments
  » Care coordination reforms
  » Chronic disease management
  » Health IT
Reforms Should Reinforce Public/Private, Multi-Stakeholder Collaboration

• Public/private, multi-stakeholder reform processes can provide greater momentum and support
  » Common quality measures and reporting requirements across payers
  » Integrated performance information from a variety of data sources means more accurate and complete performance measurement
  » Payment and benefit reforms based on these measures can reinforce each other
  » Regional population-based approaches to health and health care

• Does not require changes in antitrust laws – and better evidence on quality and efficiency can promote better antitrust enforcement
Multi-Stakeholder Reform Initiatives

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<tr>
<th>Examples of Existing Regional, Multi-stakeholder Initiatives</th>
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<tr>
<td><strong>Indiana Health Information Exchange</strong></td>
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<td>Multi-payer, community-wide quality improvement through a health information exchange and pay for performance initiative.</td>
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<td><strong>North Carolina Community Care</strong></td>
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<td>Common quality measures across public and private payers; statewide chronic care management, care coordination, and quality improvement program for high-risk populations.</td>
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<td><strong>Vermont Reform Blueprint</strong></td>
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<td>Comprehensive multi-payer reform supported by medical home pilots and alternative payment reforms (e.g., ACOs).</td>
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<td><strong>Taconic Health Information Network and Community (THINC RHIO)</strong></td>
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<td>Multi-payer health information exchange network including pay-for-performance and reporting initiatives and efforts to develop common quality standards and protocols for data exchange.</td>
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<td><strong>New and Emerging Medicare Demos</strong></td>
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<td>For example, forthcoming Medicare Health Quality demos (Section 646 of MMA) support more coordinated care for Medicare/Medicaid beneficiaries by, in part, encouraging consistent quality measurement and payment reform efforts across multiple provider and payer groups.</td>
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New Medicare “Shared Savings” Demos Reflect Multi-Stakeholder Approaches

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<tr>
<th>Features</th>
<th>Demo 1</th>
<th>Demo 2</th>
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<tr>
<td>Key stakeholders</td>
<td>Commercial payers, self-funded employers, Medicaid MCOs, and Medicare, range of providers</td>
<td>Commercial payer, public employees, Medicaid, and Medicare, range of providers</td>
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<td>Baseline Data</td>
<td>Dynamic baseline computed using previous trends and comparison group trends for each cohort of providers</td>
<td>Expected costs calculated annually based on risk adjusted data from control groups</td>
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<td>Controls</td>
<td>Control areas in neighboring metropolitan areas</td>
<td>Control areas are in-state counties</td>
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<tr>
<td>Savings Threshold</td>
<td>Demo receives 80% of savings above threshold compared to control group</td>
<td>Demo receives 80% of savings above threshold in control counties</td>
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<tr>
<td>Quality/Efficiency</td>
<td>50% of payments contingent on QI; will increase to 80% over demonstration period</td>
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