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A LESS VISIBLE PATH

A PRIMER FOR CARE, PAYMENT AND QUALITY HEALTH INITIATIVES

By Greger Vigen

Various forces across the health care industry and the Patient Protection and Affordable Care Act (ACA) are driving major changes within the health care industry. Much of the public discussion has focused on the current programs arising from the ACA, such as exchanges, Medicaid expansion, and the related tax impacts. However, much is happening behind the scenes, particularly with topics covered in Title III of the ACA. This article provides a brief overview of the many programs and initiatives that have been somewhat less visible. Deeper background material is available through various references, which you can find listed at the end of this article.

As actuaries working under health care reform, we need to understand:

- The impact on current results (added administrative costs and, possibly, lower trends).
- Available public material lets us become better educated relatively quickly.
- Some new initiatives have the potential for major performance improvements.
- Performance on specific quality initiatives has often been strong; performance on cost initiatives, generally, has been very uneven.
- As a result our professional expertise is essential to improving financial performance within the broader goals.

These new programs and initiatives impact millions of people in the public sector under Medicare and Medicaid.

GOAL—THE "THREE-PART AIM"

Let's start with a broad statement of goals: a "Three-Part Aim" has been extensively presented by the government and, nationally, by many thought leaders in the health care industry. The goals of this effort, also known as the Triple Aim, are:

1. better care for individuals,
2. better health for populations, and
3. lower growth in expenditures.

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In short, the Triple Aim can be summarized by "Care/Health/Cost." There are major opportunities for improvement; in some parts of the country, there is already strong performance, but in many areas there is not. Consequently, there are huge opportunities to spread the successful underlying initiatives to the rest of the country.

The third part of this goal, the cost element, is driving major actions to move to a pay-for-value health system and to align payment programs across various buyers.

SUMMARY OF MAJOR ACTIONS

To support the Triple Aim, actions are happening at multiple levels.

The health reform statute, the ACA, creates extensive changes in direction for both Medicare and Medicaid. Some changes are mandatory; others are voluntary. For example, the readmissions reduction program is mandatory. On the other hand, many providers are voluntarily participating in new federal initiatives such as accountable care organizations (ACOs), which are optional.

The ACA also gives authority to the Centers for Medicare and Medicaid Services (CMS) to test and to expand successful pilot programs into broader initiatives.

Many Medicaid changes are being proposed and implemented at the state level, including major waivers, quality initiatives, patient-centered medical homes (PCMHs), bundled payments and primary care physician payment reform.

However, it is crucial to understand this is not merely about a legislative initiative. There are strong business issues driving the transformation of the health industry. Budgets are tight across all sectors. The combination of financial pressures and extensive new capabilities creates transformation and the potential for substantial improvements. Public sector actions are reinforcing private sector actions and effecting change within the industry. As a key example, the provider community (such as hospitals and primary care physicians) is actively and voluntarily driving these initiatives—often across all lines of business (Medicare, Medicaid and commercial).

This health industry transformation is outlined in my *Health Watch* article for May 2013.[1]

These new developments offer challenges and, also, a wealth of opportunities.

FEDERAL AND STATE PROGRAMS

This article focuses primarily on common elements across both Medicare and Medicaid. However, the populations, payment systems, health system and regulatory requirements for both programs are very different. References at the end of the article provide more detail on various populations.

FEDERAL PROGRAMS THROUGH CMS

CMS is the federal agency responsible for administering Medicare, Medicaid and other insurance programs. CMS—and its new Center for Medicare and Medicaid Innovation (CMMI)—has been very active.

One major part of the ACA is the move to "value-based-payment," such as readmission reduction and the effort to reduce hospital-acquired infections. These programs have been very visible in the industry. Early reported results have indicated that the change in payment methods under the ACA has improved quality and reduced readmissions and other adverse events.

OTHER MAJOR NEW FEDERAL PROGRAMS

- ACOs (including both the Pioneer and Shared Savings ACOs)[2]
- Bundled payment[3]
- Comprehensive Primary Care (CPC) initiative[4]
- State demonstrations to integrate care for dual-eligible individuals (beneficiaries with both Medicare and Medicaid)[5]
- Physician Quality Reporting System (PQRS)

- Web-based comparative tools such as Hospital Compare
- Innovation grants

These programs have had high participation. For example, more than 4 million beneficiaries will be receiving care from several hundred providers participating in Medicare shared savings initiatives through ACOs.

In addition to the direct links, a summary of these and other programs is available in the Society of Actuaries (SOA) report "Measurement and Performance—Health Care Quality and Efficiency: Resources for Health Care Professionals (Third Edition)" (Section 5.1.2) and related Inventory.

STATE PROGRAMS

Fiscal problems, plus powerful new technology, Web capabilities and increasing focus on health care costs are driving major action. However, the state programs are very diverse, with differences depending on sponsor and purpose. Some are working through waivers, some through Managed Medicaid, and others are running new dual demonstration projects. Some of these programs are of long-standing tenure and, often, have substantial public information available on their websites.

In the past, it was often difficult to track state-by-state programs. However, this is now much easier to do. The National Academy for State Health Policy (NASHP) and the Medicaid and Children's Health Insurance Program (CHIP) Learning Collaboratives (MAC Collaboratives) have websites with extensive summaries of state-level programs. There are also more than a dozen programs summarized in the SOA measurement report (Section 5.1.3) and related SOA Inventory.

At one level, the wide variations in pilot program approaches by state make understanding and comparisons difficult. However, these multiple pilot programs will, eventually, offer insights into which actions work to improve performance.

THE DUAL CHALLENGES—ALTERNATIVE SOLUTIONS

Many initiatives are underway; each major type of initiative has a specific purpose. For example, PCMHs focus on the potential for enhanced primary care to improve patient outcomes. The financial incentives for the primary care physician are increased and aligned with his or her new responsibilities.

Underlying the many initiatives and pilot programs are dual challenges: (1) a fragmented U.S. health system; and (2) a payment system focused on production while not being accountable for results. Three fundamental questions and principles underlie most initiatives.

Who should act?	A more responsible **health system** is needed. An entity (provider-based organization or individual provider) should be identified to accept financial and quality responsibility for patients.
How should providers be paid?	Modernize the **payment system** and align financial incentives for quality and efficiency. Also, offer incentives to reduce waste.
How should system and payment be linked?	Most initiatives offer an improved payment structure to providers in exchange for additional responsibility. These payments fund improvements in quality and financial results.

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EXAMPLES OF "WHO"

For example, an ACO (hospital and/or physician group) is an organization that accepts accountability for quality and efficiency in their communities. As another example, PCMHs often focus on primary care and pediatric physicians.

These examples build on the various high-performance networks already available for certain individuals in a few parts of the country (for example, the networks behind some Medicare Advantage programs).

EXAMPLES OF "HOW TO PAY"

New payment ideas often include explicit payments for quality—typically based on formal, generally accepted metrics. For example, the CMS ACO program has chosen 33 major metrics for its final standards—half of the number originally proposed.

Other financial arrangements range from small per-member payments to payments that can be tied to the total cost of care, such as shared savings programs or total capitation. Other options include bundled payments, capitation/salaried, global payments, pay for performance, or primary care payment reform.

In addition, there are mandatory programs such as the CMS initiatives on readmissions or hospital-acquired complications, and "never events." Often, multiple programs are used in combination.

SUMMARY

In conclusion, we are seeing extraordinary times in the health industry. These new developments create challenges for everyone but also create a wealth of opportunities for you and your organizations. Individuals with financial and risk management expertise are essential to creating an improved and financially sustainable health care system for ourselves, our friends, and our communities.

REFERENCES

SOA References:

Society of Actuaries Medicaid Listserv (also currently have ongoing conference calls)—the "Health Medicaid" listserv is near the bottom of the page

http://www.soa.org/News-and-Publications/Listservs/list-public-listservs.aspx

Measurement and Performance—Health Care Quality and Efficiency: Resources for Health Care Professionals (Third Edition)

Sections 5.1.2 and 5.1.3 are focused on social programs.

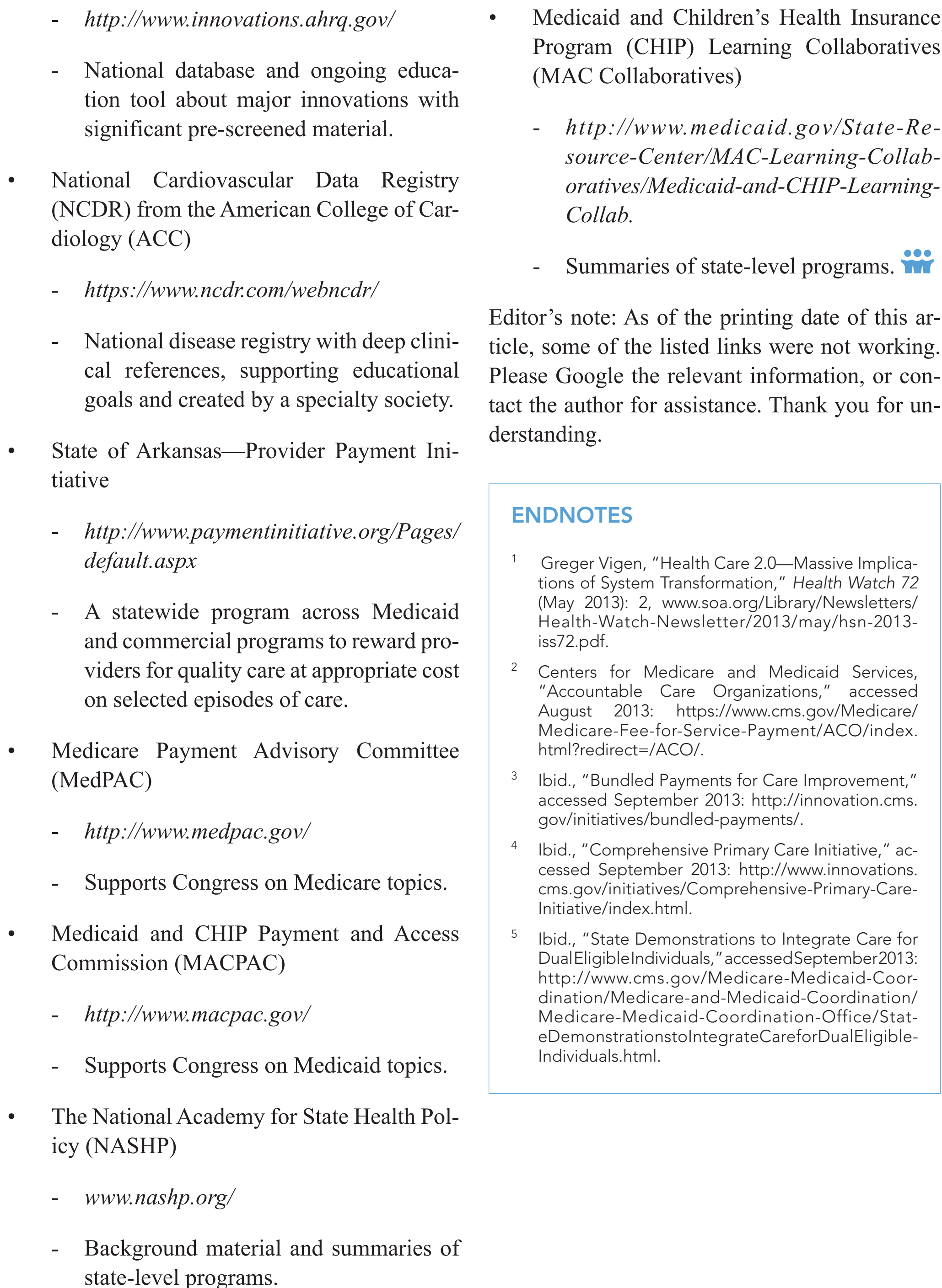
http://www.soa.org/Files/Research/Projects/research-quality-efficiency-report-2010-update.pdf

Measurement and Performance: Inventory (many examples from key websites)

http://www.soa.org/Files/Research/Projects/research-quality-efficiency-inventory-2010-update.pdf

Other References:

- *Health Affairs*
  - *http://www.healthaffairs.org/*
  - Monthly peer-reviewed articles focused on changes in the health system—typically has several articles focused on measurement and performance.
  - *Health Affairs* requires a subscription (it is free to Health Section members).
- Agency for Healthcare Research and Quality's (AHRQ's) Innovations Exchange



- *http://www.innovations.ahrq.gov/*
- National database and ongoing education tool about major innovations with significant pre-screened material.

• National Cardiovascular Data Registry (NCDR) from the American College of Cardiology (ACC)
  - *https://www.ncdr.com/webncdr/*
  - National disease registry with deep clinical references, supporting educational goals and created by a specialty society.

• State of Arkansas—Provider Payment Initiative
  - *http://www.paymentinitiative.org/Pages/default.aspx*
  - A statewide program across Medicaid and commercial programs to reward providers for quality care at appropriate cost on selected episodes of care.

• Medicare Payment Advisory Committee (MedPAC)
  - *http://www.medpac.gov/*
  - Supports Congress on Medicare topics.

• Medicaid and CHIP Payment and Access Commission (MACPAC)
  - *http://www.macpac.gov/*
  - Supports Congress on Medicaid topics.

• The National Academy for State Health Policy (NASHP)
  - *www.nashp.org/*
  - Background material and summaries of state-level programs.

• Medicaid and Children's Health Insurance Program (CHIP) Learning Collaboratives (MAC Collaboratives)
  - *http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Medicaid-and-CHIP-Learning-Collab.*
  - Summaries of state-level programs.

Editor's note: As of the printing date of this article, some of the listed links were not working. Please Google the relevant information, or contact the author for assistance. Thank you for understanding.

ENDNOTES

1. Greger Vigen, "Health Care 2.0—Massive Implications of System Transformation," *Health Watch 72* (May 2013): 2, www.soa.org/Library/Newsletters/Health-Watch-Newsletter/2013/may/hsn-2013-iss72.pdf.
2. Centers for Medicare and Medicaid Services, "Accountable Care Organizations," accessed August 2013: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/.
3. Ibid., "Bundled Payments for Care Improvement," accessed September 2013: http://innovation.cms.gov/initiatives/bundled-payments/.
4. Ibid., "Comprehensive Primary Care Initiative," accessed September 2013: http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html.
5. Ibid., "State Demonstrations to Integrate Care for Dual Eligible Individuals," accessed September 2013: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html.