



ITUP

INSURE THE UNINSURED
PROJECT

Improving the Value of Health Care

Cost-Containment Federal Reform

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Improving the Value of Health Care: Cost-Containment Federal Reform

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Background

Billions of California dollars are spent on unnecessary treatments/services, excessive administrative costs, overpriced services, and ineffective and sometimes even harmful care. Research has shown that as much as 30 percent of care may be unnecessary.¹ The US has by far the most expensive health care system in the world, with poor outcomes that do not correlate with the level of expenditures.² While there are islands of excellence, the health system too often does not function as a system, but rather as autonomous and disparate units, and it is the disconnected nature of the American health system that accounts for a portion of its high costs and poor quality outcomes.³

The cost of health insurance is the product of health care services prices and utilization with the cost of administration added in. The American health system is characterized by high prices and low utilization, further burdened with a high cost of administration. Our utilization, however, is very high on some technically advanced, high cost diagnostic procedures. US administrative costs are high due in part to the multi-payor system we have and the low penetration of compatible health information technology (HIT); some would add for-profit medicine to the list.

Cost containment and quality enhancement are vital parts of federal reform efforts and are intricately linked and coordinated with the other aspects of reform, such as insurance reforms and coverage expansion. To be effective, cost containment and quality improvements will have to be implemented at the local provider level, although state/federal governments and health plans have significant roles to play. Reform must be able to produce tangible cost reductions and quality improvements for patients, taxpayers, employers and employees, rather than just cost shifts from one payor to the next.

California has historically been more successful than other states in containing costs because of its high HMO enrollment/utilization and its early success in adopting competitive market approaches. California led the nation in the early adoption and spread of HMOs; and in 1983 the state again led the nation in adopting competitive market reforms, such as selective contracting and the development of PPOs. The old uncontrolled fee-for-service indemnity insurance products have largely disappeared; yet prices and premiums, which were initially slowed by reform, have soared, and California's comparative cost advantage has eroded.⁴

By the mid 90s, rising prices and premiums were under control, due to a range of approaches that loosely fell under the umbrella of managed competition. At the same time, some health plans began to overreach, resulting in consumer and provider backlash regarding rampant and unjustified claims denials, excessively rigid gate-keeping and poor customer service and responsiveness. This resulted in the state's managed care reforms of the mid to late 90's that eliminated some particularly egregious abuses through stronger state regulation. Capitation (a

¹ Levine RA. Fiscal responsibility and health care reform. *NEJM* 2009;361:e16.

² Johnson T. Healthcare costs and US competitiveness. Council on Foreign Relations. Accessed on 5/3/10 [http://www.cfr.org/publication/13325/]

³ *ibid.*

⁴ Baumgarten A. California Health Care Market Report 2006 for the California HealthCare Foundation. Accessed on 5/3/10 [http://www.chcf.org/publications/2007/03/california-health-care-market-report]

flat rate form of provider payment) is typically blamed by many HMO critics for these abuses, as it creates incentives for reduced care; however, it also relieves providers of the need to earn their incomes by billing for every possible service and allows them to focus instead on care that truly improves patient's health outcomes.

Since the mid 90s, premiums and prices have resumed their untenable spiral that puts the nation's budget in near permanent and ever-growing deficit,⁵ and may impair the nation's global competitiveness due to burdens on employers. The increases certainly have driven too many employers to drop coverage, too many health plans to reduce their schedules of covered benefits and too many individuals to drop/reduce their private coverage due to premiums that far exceed the growth in wages. The fee-for-service reimbursement system (a piecework form of provider payments) is typically blamed by many commentators for the rise in health spending as it tends to reward increased quantities of billable and costly services as opposed to improved patient outcomes; however fee-for-service reimbursement does assure that providers are more fairly compensated for the extensive work required for the most complex and hard-to-treat cases.

Congress has passed and the President has signed legislation that requires all individuals to have coverage through an individual mandate, and also seeks to slow the rise in health spending. If the cost containment and quality enhancement measures that were enacted fail to slow health spending, it is a near certainty that far tougher measures will follow from future Congresses.

The Congressional Budget Office (CBO) has projected that the health reform package will bend the cost curve for both Medicare and private insurance. In Medicare, this means slowing the growth in costs by 2% annually, e.g. from 6% to 4%; for private insurance, the rate of growth will be slowed by 1%, e.g. from 6% to 5%. The Cadillac benefits tax is the most important feature in slowing the rise in private insurance spending. MedPac with teeth, competitive bidding for Medicare Advantage and the negotiated payment reforms with the hospital and drug industries are the most significant in CBO scoring of public program cost reductions. It is likely that the "soft" cost containment reforms, such as HIT, comparative effectiveness, transparency, the Exchange, data and enhanced competition, care coordination, prevention and wellness could have enduring changes in slowing spending growth. Payment and delivery system reforms are prevalent throughout the legislation, and while their direction is sound, the changes are seen as multi-pronged and modest. There are ample opportunities for state policy makers and the state's plans/providers to implement them in a truly effective fashion appropriate to California. We will first discuss the "hard" cost savings and then the "soft" reforms, which we believe will be critical in transforming the payment and delivery system.

⁵ Romer CD. Health Care Reform And The Budget Deficit. Center for American Progress. 2009. Accessed on 5/3/10 [http://www.whitehouse.gov/files/documents/HealthCareDeficit.pdf]

California's Landscape

Most of California's private employer market are enrolled in HMOs, and most of the private individual market in PPOs.⁶ Employer plan enrollment, however, is shifting towards PPOs. In our state PPO, premiums are well above the national average, while HMO premiums are slightly below. With the exception of Kaiser, California's HMO plans are average to below average in national quality rankings.⁷ The delegated model (characterized by extensive delegation from the HMO to the Independent Practice Association or IPA) that has helped contain costs is eroding due in part to the policies of several large national health plans, and this may impair efforts to slow spending trends.⁸ Hospital consolidation has spread quite rapidly and is also impairing the effectiveness of California's competitive model.⁹

The state of California is unique in that it has high Medicare and low Medi-Cal per capita spending.¹⁰ California has well above average Medicare enrollment in Medicare Advantage Plans. More than half of Medi-Cal enrollment is in HMOs; however, nearly 80% of the program's expenditures are not in HMOs, but rather in fee-for-service and in the program's administrative costs.

Medi-Cal reimbursements to most doctors and hospitals are well below cost and significantly below other payors. This is not the case for most community clinics and public hospitals for which Medi-Cal pays at cost and is a far better payor than their other major patient population – the uninsured. Commercial reimbursement is on average 20% above provider costs and for that reason highly valued by private practitioners. Medicare reimbursements are roughly at cost, but in a fee-for-service system that has weak controls on utilization.

In anticipation of reform, plans and providers may be increasing their prices in an unwarranted fashion. This will require state and federal oversight, which is provided in the federal reform. California has historically not been a state that regulates the rates and premiums that its plans and hospitals charge the general public, except in its state administered Medi-Cal program.¹¹

Additional measures will need to be adopted to further improve quality and efficiency of care in California. There is fairly widespread recognition among many in the plan and provider community that medical price inflation must be slowed, administrative costs reduced and volume/mix of over-priced services contained in order to reduce spending. However, these changes will impact the bottom lines of plans and providers, and previous efforts to adopt cost containment measures have had mixed results in California's legislative mix-master. While most proposals that included cost containment and quality enhancement were defeated in the

⁶ Baumgarten A. California Health Care Market Report 2006 for the California HealthCare Foundation. Accessed on 5/3/10 [<http://www.chcf.org/publications/2007/03/california-health-care-market-report>]

⁷ http://www.opa.ca.gov/report_card/

⁸ Shifting Ground: Erosion Of The Delegated Model In California. December 2009. CHCF. (complete cite)

⁹ Ibid.

¹⁰ California Health Care Almanac: Medicare Facts and Figures. January 2010. CHCF. Accessed on 5/3/2010 [<http://www.chcf.org/publications/2010/01/medicare-facts-and-figures>]

¹¹ The new federal reform authorizes interim funding for state regulators and federal regulatory authority as well. In the Commonwealth of Massachusetts the Department of Justice has begun to examine the anticompetitive pricing practices of the state's largest and best known hospital system. Congressional oversight hearings are also focused on these pricing practices in the pharmaceutical and health plan industries.

legislature and/or vetoed by the Governor in past years, there have been some important successes.

The Fate of Recent CA legislation

Hospital-acquired infections (HAI) and methicillin-resistant *Staphylococcus aureus* (MRSA) epidemics have needlessly contributed to extended hospital stays, increased bills, poorer health outcomes and sometimes death. The Center for Disease Control (CDC) estimates that two million patients contract HAI per year, with almost 100,000 deaths annually. SB 158 (Florez) and SB 1058 (Alquist) address HAI with patient safety plans, improved hygiene programs, infection control and surveillance, better regulatory oversight and public disclosure; both bills were passed and signed in 2008.

Transparency in costs, billing and quality theoretically will result in improved accountability, quality and cost efficiency. AB 2967 (Lieber), SB 1300 (Corbett), AB 1296 (Torricco) and AB 2146 (Feuer) would respectively address cost/quality data reporting by providers and insurers; sharing of cost and quality information by plans; providing claims data and contract payment amounts for hospital services for CalPERS members; and ban billing for “never events”. Each bill was defeated in Committee.

Section 1115 of the Social Security Act authorizes “experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute;” it is another avenue for cost containment/value enhancement. The flexible nature of the §1115 waiver can allow for an expanded use of managed care (or at least better coordinated care) for Medi-Cal populations. These could stabilize expenditure growth, possibly save money for the state and improve care for beneficiaries of the program, if well designed and executed. California is seeking such a waiver that could increase managed care enrollment among high cost populations currently in fee-for-service and could also better coordinate care for persons with Medicare and Medicaid coverage. .

ABX1 1 (Núñez), which was rejected by the Senate Health Committee in 2007, proposed community makeover grants, coverage of prevention, bulk purchasing of prescription drugs, robust transparency provisions with a new Health Care Cost and Quality Transparency Commission, and a cap on health plan administrative costs with at least 85% of premiums spent on care (medical loss ratios). The passage of HR 3590 and its implementation at the state/county level renews the possibility that these measures to improve affordable health care and increase its quality and accessibility can be implemented in California. The passage of state implementation bills may facilitate rapid implementation of the federal reform measures.

We divided the remainder of this paper into the following topics:

HARD SAVINGS

CHANGED INCENTIVES

Providers

Plans

Individuals

PAYMENT REFORMS

SYSTEMS EVOLUTION

DATA AND TRANSPARENCY

1. Hard Savings

The Cadillac Tax

Beginning January 1, 2018, HR 3590 levies a 40% tax on insurance companies or plan administrators for any health coverage plan above a specified threshold (\$10,200 for single coverage and \$27,500 for family coverage, not including stand alone dental and vision coverage). The tax is applied to the amount over the threshold and will not apply to plans purchased on the individual market unless that coverage qualifies for the deduction for self-employed individuals. The thresholds are adjusted upward by \$1,650 for individuals and \$3,450 for families for retired individuals ≥ 55 years of age and for plans that cover employees engaged in high-risk professions.

The intent of this tax is to reduce the amount of over-insurance and unnecessary care, and create strong incentives to slow the rising cost of health care. The beneficiary of the plan is not taxed, but rather the burden lies on the insurer or plan administrator. Also known as the “Cadillac tax”, this will create strong incentives for plans to slow the rate of growth in health plan premiums, while raising up to \$20 billion in revenue¹² that can be used to fund health care reform. While many unions and employers opposed this aspect of the reform, many health economists believe the “tax free” nature of employer health benefits is highly inflationary and extremely regressive and believe this is one of the most important elements to save costs.

MedPAC “With Teeth”

One of the most potentially powerful changes is informally referred to as “MedPAC with teeth.” MedPAC, or the Medicare Payment Advisory Committee, is an independent agency that advises Congress on issues related to Medicare. MedPAC has researched and made recommendations to Congress on a variety of issues ranging from reimbursements for private Medicare plans/providers to access/quality of care. MedPAC has historically only been able to make recommendations with no guarantee of implementation. MedPAC with teeth would allow for these recommendations to come to quick fruition.

HR 3590 establishes the Independent Payment Advisory Board (IPAB) to, in consultation with MedPAC and MACPAC, construct annual reports with recommendations on ways to reduce Medicare’s spending growth rate.¹³ When per capita spending growth is above the target CPI plus 1%, IPAB’s annual report must be submitted to Congress. The Secretary must then implement the recommendations unless Congress enacts related legislation that achieves the same cost reductions in lieu of the IPAB recommendations.

Possible Lessons for California

California policy makers have for years sought some form of fail-safe trigger to assure reforms actually save costs; the spending reduction targets of the Cadillac tax and MedPac with teeth could be applied at the state level as well to stem rising health program expenditures. For example, the Exchange, CalPERS, Medi-Cal and Healthy Families could each pursue a

¹² The CBO projects \$12 billion in revenue in 2018, the first year the tax will be imposed and \$20 billion in 2019.

¹³ Recommendations may not restrict benefits or change Medicare eligibility criteria, such as rationing care or raising Medicare premiums or cost sharing.

contracting strategy with plans that gives them incentives and disincentives if they succeed or fail to meet a comparable agreed on growth rate.

Medical Device Manufacturers, Insurers and Pharmaceuticals – Excise Tax/Fees

Federal health reform legislation will bring an estimated 30 million Americans into the insurance market. More people receiving care means more business, higher incomes and greater profits for medical device manufacturers and suppliers. HR 3590 as amended imposes a 2.3% tax on the sales price of the medical devices, excluding consumer goods like contact lenses, eye glasses, or other related products.

The CBO projects this will raise \$107 billion in revenue nationally from 2010-2019 (\$14 billion in 2018). The excise taxes/fees apply as well to manufacturers and importers of brand name drugs and some health insurance providers.

Productivity Adjustments, Negotiated Discounts and Rate Freezes

Medicare fee schedules and reimbursement rates are adjusted annually based on the growth in input costs, such as labor, salaries, and the costs of equipment/supplies. Congress, the Administration and the affected stakeholders negotiated a range of productivity adjustments, one time freezes and drug manufacturer discounts to slow the rise in Medicare spending. The CBO project an annual federal budget savings of \$46 billion in 2018.

DSH Payments

Medicare and Medicaid DSH pay for hospital care to the uninsured in those hospitals most impacted. As health reform means fewer and fewer Americans go uninsured, the federal legislation decreases DSH payments by \$10 billion nationally in 2018. As a state's uninsured population is decreased by 45%, DSH payments will be reduced by up to 50% of that state's allotment in FY2012. As a state that spends more than 99.9% of DSH funding, California's DSH funding will reduce by 25% when the trigger point is reached and could approach 50% if and as the uninsured population approaches zero. California's Medi-Cal program pays over \$1 billion to public hospitals and over \$500 million to private hospitals in DSH and DSH look-alike funds.

California needs to redirect its residual DSH funds to the hospitals most impacted by the residual uninsured and make a strong argument for redistribution of federal DSH funds among states based on their shares of the residually uninsured.

Competitive Bidding for Medicare Advantage

Medicare Advantage, also known as Part C, refers to private health plans that provide Medicare services. The private plans are paid on average 14% more than it costs the Medicare program to pay providers directly for these services. The introduction of phased-in competitive bidding is projected to save Medicare nearly \$20 billion annually in 2018.

Tanning Services

Federal reform levies a 10 per cent tax on indoor tanning services using an electronic product with one or more UV lamps effective on or after July 1, 2010. The individual receiving the services shall pay the tax. Tanning salons have been cited as being the 'next generation cigarette'.

California should consider fees on those substances contributing to poor health status and increased public spending.

2. Changed Incentives

Federal reform sought to change health system incentives in a variety of ways: 1) to encourage providers to improve quality (health outcomes), 2) to encourage plans to manage costs and improve the quality of care, rather than denying and rescinding coverage to those who get sick and need it the most and 3) to encourage individuals to improve their own health status through wellness, prevention and behavioral changes.

Provider incentives

Pay-for-Performance

HR 3590 legislates a series of payment reforms including incentives for providers and purchasers to move towards a more responsive health care system. Pay-for-performance (P4P) is an example proposed to contain health care costs while improving quality. P4P works by rewarding health care providers (e.g., physicians, hospitals, medical groups) for reaching or improving upon measures of quality and efficiency. They are given bonus payments if health outcomes are improved without increasing costs, or inversely, cut costs without diminishing health outcomes. For those who do not improve or meet certain standards, penalties may be imposed. In essence, payments are redistributed from low to high quality providers.

P4P can include educating and potentially rewarding the public to choose higher quality or more cost-effective care. This may include tiered payments or reference pricing so that patients pay the cost differential between high and low cost providers, and treatments of equal efficacy.

The US has already experimented with P4P, but research has been limited in quantity, duration, and rigor. HR 3590 will implement a series of programs and pilots to improve quality through payment incentives. Certain Medicare providers will participate in a P4P pilot to better understand the impact of value-based purchasing on health care costs and patient outcomes. Starting no later than January 1, 2016, psychiatric, long term care, rehabilitation, and PPS-exempt¹⁴ cancer hospitals and hospice programs will participate in the pilot, which will be budget neutral (total spending cannot be greater than estimated spending absent the pilot). After January 1, 2018, the Secretary of Health and Human Services may expand the pilot in length or scope if it has shown potential for reducing costs without sacrificing the quality of care and/or improving quality without increasing costs.

Medicare's broader programs and pilots link payments with quality outcomes. Starting October 1, 2013, yearly incentive payments will be made to hospitals for meeting performance standards or levels of performance improvement in a given year. Certain hospitals must participate, and those meeting all the criteria may only be exempt if they implement similar programs. Hospitals

¹⁴ Medicare's PPS (prospective payment system) pays hospitals a predetermined, flat rate per admission based on the DRG (diagnosis-related group) for the Medicare inpatient. PPS-exempt hospitals are not paid this way, because PPS is considered a poor indicator of more extensive resource use.

that are not able to participate will have the opportunity to test innovative methods of measuring and rewarding quality under a separate three-year waiver demonstration.

Skilled nursing facilities, home health agencies and ambulatory surgical centers will participate in value-purchasing programs as well. These programs are to be designed by October 1, 2011 with payment adjustments according to how well these facilities meet performance standards on quality and efficiency. As of 2015, some physicians and physician groups under Medicare will be paid for reporting data on and improving upon quality, cost and systems-based care; unsatisfactory compliance will result in penalties.

California Implementation of P4P Quality Incentives

California is in a strong position from which to assimilate new reforms into practice. The state already has P4P experience through the Integrated Healthcare Association (IHA), a multi-stakeholder organization promoting quality improvement and accountability in health care through performance measurement and public reporting (currently through the Office of the Patient Advocate).¹⁵ As the country's largest P4P effort, IHA started this program in 2001 to streamline P4P initiatives and measures for better aggregate comparison with a sub-focus on adopting HIT. IHA ranks physicians for eight major health plans, collecting data and reporting results for about 35,000 physicians and 235 physician groups caring for 10.5 million beneficiaries.¹⁶ This program has had limited success, with physicians focusing not on true outcomes but improving measures or results that provide a substantial return on investment for stakeholders, and consumers showing little interest in using the rankings.¹⁷ Despite its weaknesses, this program has given California nearly a decade of first-hand experience from which to learn and adapt to new federal reforms and take advantage of funding offered to innovators ready to implement effective programs. The new federal reforms also push for measures showing movement towards systems-based care, an additional layer of change not traditionally linked to California's payment incentives for P4P.

More than 240 California hospitals voluntarily participate in a value-based purchasing program that publicly reports performance measures through calhospitalcompare.org. Depending on the level of overlap between these programs and federal reforms, California hospitals may be quite ready to take on performance improvement initiatives or apply for exemptions based on having similar programs in place. Other providers, such as skilled nursing facilities and home health agencies would be well served by learning from others' experiences—particularly as they participate in more integrated systems of care.

Increasing Innovation Incentives and Opportunities

A new Center for Medicare and Medicaid Innovation (CMI) within the Center for Medicare and Medicaid Services (CMS) will test new incentives and patient care models, including broad payment/practice reforms and activities to address care disparities, starting no later than January

¹⁵ <http://www.ihah.org>

¹⁶ Data is now shared as four-star health plan and medical group ratings. The Blue Ribbon Recognition initiative plans to publicly release data on *individual* physicians' performance as of June 1, 2010 using quality data from the California Physician Performance Initiative.

¹⁷ <http://www.ahrq.gov/about/annualmtg08/090908slides/Williams.html>

1, 2011. Funding will pay for the design, implementation, and evaluation of models through 2019, including reforms like patient-centered medical homes for high-cost patients, salary-based reimbursement for primary care providers, physician payments for adhering to best practices, and electronic patient monitoring (i.e., tracking vital signs remotely).

CMS will give states grants to implement three-year Medicaid waivers (starting January 1, 2011) that incentivize beneficiaries to adopt healthy behaviors and meet targets for reduced health risks or improved health outcomes (e.g., lower cholesterol). Children will benefit from funding allocated to review and test innovative medical therapies for pediatric use. Grants for up to five years will incentivize states to strengthen patient safety, reduce medical errors and develop alternatives to tort litigation. Additional incentives will help immunize more adults through a grant-funded demonstration.

Plan incentives

Insurance Plan Incentives – Creating a New Competitive Market for Plans

HR 3590 seeks to improve the quality of patient care by wholly changing insurance industry incentives and practices in the private individual market. The design of the reforms will transform the individual market. The reform aims to stop the plans' practice of medical underwriting in the individual and small group markets by denying, excluding, out-pricing and rescinding coverage for those with serious medical conditions; instead, they must guarantee issue and guarantee renew all their policies to all current and prospective customers. It also forecloses other common health plan practices of annual and lifetime limits, exclusion of or high copays for preventive care, pre-natal care or maternity benefits; all plans must cover a basic minimum set of services of at least 60% of expected medical costs. This should focus plans on seriously controlling costs, rather than simply reducing benefits and avoiding coverage of those with high medical costs.

The reform requires that plans must meet minimum medical loss ratios (MLRs) of 80% for small group and individual coverage and 85% for large group coverage. A plan that fails to meet these requirements must either reduce premiums or improve payouts on their covered benefits to meet these thresholds. The MLRs take effect in January 2011 and apply to plan costs and premiums for the year 2010. The federal MLRs are higher than current state MLRs (70%), and higher than the ratios of some large plans, particularly for their individual insurance products.

The Exchanges will allow individuals and small employers to compare plans on price, quality, customer service, MLRs and rankings of their provider networks. Within the Exchange, refundable tax credits for individuals with incomes up to 400% of the federal poverty level (FPL) are tied to a reference price – the premium for the second lowest priced plan – giving individuals very strong incentives and information to comparison shop based on price, quality and coverage.

Up to \$6 billion in start-up loan funds will be made available for the creation of member-run cooperatives. The co-ops must be non-profit and will offer qualified health plans to its participants. If they are of sufficient size, the tax-exempt arrangements will improve buying power by allowing members to receive services at lower group rates. Co-ops may be able to better provide culturally appropriate, efficient, and customer-oriented services for specific

regions and areas, but their successes in other states are quite localized to the particular plan and participating providers and subscribers.

These design features hold the potential to improve patient outcomes and bend the future cost curve in the individual and small group markets. If they prove successful, they may be the models of future coverage for larger employers as well.¹⁸

Other Tools for the Exchange

HR 3590 requires the Exchange to be a pioneer for slowing premium increases. For instance, the bill outlines standards for health plans participating in the exchange: quality reporting; effective case management; care coordination; chronic disease management; medication and care compliance initiatives, including the use of the medical home model; activities aimed at preventing hospital readmissions, such as patient education and counseling, comprehensive discharge planning, and post-discharge reinforcement by a health care professional; activities to improve patient safety and reduce medical errors using best practices; the use of evidence-based medicine; investment in HIT; and the implementation of wellness and health promotion activities.

California: see ITUP paper on the Exchanges at www.itup.org/reports.

Individual incentives

Within the Exchange, individuals will have strong incentives to purchase wisely as they pay 100% of the incremental difference for more costly plans, extra benefits and broader coverage. Federal reform allows employers to adjust employee premiums by up to 30% for employees who enroll and participate in programs with demonstrated success in improving health status and reducing health risk; this could include smoking cessation, diabetes care management, and weight reduction for those struggling with obesity. This follows the successful Pitney Bowes and Safeway models of “Healthy Incentives”. Federal reform also gives state policy makers the option to adopt comparable programs in state Medicaid programs .

¹⁸ The Wyden-Bennett bill, the Healthy Americans Act, has a comparable design, which many consider a highly promising innovation. After several years of the reform (in 2017) the state Exchange can be opened to larger employers and/or the state have the option to shift coverage for all Californians to this model.

Shifting system incentives

HR 3590 relies on the mantra of getting people the right care at the right time. It discourages both over- and under-utilization that will not improve health outcomes and instead focuses on prevention, primary care and behavioral changes that will improve health outcomes. It seeks to shift the onset of serious morbidity ever and ever later into patients' lives, avoiding decades of costly chronic disease and secondary conditions, costs can be avoided and productivity can be enhanced. The goal of the reform effort is to shift plan, patient and provider incentives towards health and wellness.

3. Payment Reforms

P4P, productivity adjustments, prescription drug rebates and DSH reductions discussed above are some of the payment reforms in the bill, and there are many others. Most of the payment reforms are focused on Medicare; however, California may wish to apply them to its Medi-Cal program so the incentives are consistent for providers. Many of these reforms start as pilots and then are rapidly spread nationally if successful.

Medicare pays hospitals based on a system called DRGs (diagnosis related groupings), which is credited with reducing average lengths of stay (ALOS) nationally. Medicare pays doctors based on their usual and customary charges, with a variety of state and local caps to assure that payments are “reasonable”. Over a decade ago, Congress added sustainable growth rates (SGR), a new concept which capped physician reimbursement based on a formula that included increases in both price and utilization. While this worked well for a few years, physician reimbursement began to bump up against the SGR cap, and Congress has since postponed implementation of the SGR cap. SGR, if implemented today, would reduce Medicare payments to doctors by an estimated 21%, and has now become a political hot potato that will be costly to resolve. The problem with the SGR approach is that the SGR incentives were global in nature, not provider specific, and did not change the underlying incentives for individual practitioners.

Medicare pilots

Bundling

Several pilots are mentioned in the bill, one of which is a national pilot on payment bundling under Medicare. The concept of bundling is to pay for “episodes” of care rather than discrete services and to pay for team services rather than individual providers. This encourages care coordination among several provider types, loosely mimicking the concept of an accountable care organization (ACO), but limited to ten specific conditions.

- Under Medicare, HR 3590 legislates a pilot to test the impact of innovative approaches providing comprehensive, coordinated, and cost-effective care to beneficiaries exposed to environmental health hazards.
- Another pilot allows up to 15 hospice programs to test the impact of providing Medicare patients with both hospice care and all other Medicare benefits on patient care, quality of life, and cost-effectiveness.

- Other Medicare pilots experiment with P4P and value-based purchasing to improve quality and cost measures.
- The Independence at Home Demonstration Program incentivizes physicians, PAs and nurses to direct home-based primary care teams for Medicare beneficiaries, provide 24-7 availability of home visits and use electronic health information systems, remote monitoring, and mobile diagnostic technology.

Reprioritizing Payments

Medicare and Medi-Cal physician payments are based on a relative value system that underpays primary care and the cognitive component of physician services, while overvaluing surgical procedures and hospital-based care. The reform bill acknowledges that primary care is underpaid and increases those rates by 10%, and that certain imaging and unspecified other services are over-paid and reduces those rates. A larger problem is geographic disparities; the reform measure increases rates for rural providers who have historically been undercompensated.¹⁹ This is not offset by reductions to urban and suburban providers who typically are paid more. However, there are provisions to study geographic rate and treatment disparities that typically have advantaged providers located in California's largest urban areas and disadvantaged providers in rural communities.

Medicaid demonstrations

- One of two broad Medicaid demonstrations allows up to eight states to conduct five-year demonstrations testing the use of integrated care (including risk-adjusted, bundled payments) for services before and after hospitalization.
- The second allows up to five states to adjust payments made to their safety net hospital system/network from fee-for-service to a global capitated payment model from FY2010 to FY2012.
- A smaller Medicaid pilot allows up to eight states to conduct a three- to five-year emergency psychiatric care demonstration, where certain facilities will be reimbursed for mental disease services needed to stabilize an emergency psychiatric condition.

California may wish to apply to participate in these demonstrations. Some Bay Area counties may be particularly well suited to test the global capitation model and might want to consider doing so as a region, rather than as individual counties.

4. Delivery System Evolution

The reform legislation seeks to encourage a steady evolution in the delivery system so that it promotes a far better integrated delivery system, focused on prevention and wellness, and is centered on the family doctor rather than the hospital emergency room. The framers of reform sought to encourage the development of innovative new delivery models like Geisinger, Intermountain, Mayo, Cleveland and the Group Health Cooperative that provide higher quality at lower costs. The authority and direction is for the Exchanges and the Center for Innovation to assist these local models in development. California state government needs to comparably assist promising local innovation in surmounting the thicket of regulatory and stakeholder obstacles.

¹⁹ See for example sections 3121 through 3129 of HR 3590.

The test for innovation ought to be whether or not it improves quality, lowers costs and attracts subscribers, and the state needs to allow for local pilots to develop and prove these models.

Prevention

Under HR 3590, public programs and private plans will encourage, not deter the use of preventive health services by eliminating copays and deductibles on those that are proven effective.

Wellness Grants

Community-based transformation grants will help states, local governments and communities more broadly implement, evaluate, and disseminate evidence-based preventive health activities to reduce chronic and secondary disease, as well as reduce health disparities among residents. These activities range from creating healthier schools and worksite wellness programs to highlighting healthy options at restaurants.

Systems of Care – The Workforce

To help ameliorate current and future workforce shortages, incentives will be put in place (for at least five years), for health professionals to relocate to priority service areas and enter into fields with high workforce needs such as primary care, geriatrics, long term care, and chronic care management; other incentives will help train and retain these workers. An additional 10% will be added to primary care payments and to reimbursements for surgeons practicing in workforce shortage areas from January 1, 2011-2016.

Coordination and Wellness - States, Local Governments, Communities and Indian Tribes

Grants will be available to states for a variety of purposes.

- One will be for states or partnerships of states and local government to design, implement and evaluate innovative models of accountable, coordinated and integrated emergency and trauma care.
- Grants will be awarded to state/local health departments and Indian tribes for five-year pilots that provide public health community interventions, screenings, and clinical referrals in order to improve the health of 55-64 year olds.
- One of the broadest grants establishes a three-year demonstration for state-based nonprofit, public-private partnerships in up to 10 states to provide comprehensive health care service to the uninsured at reduced fees. Each state will receive up to \$2 million to establish and carry out the projects, administered through HRSA, and the Secretary will evaluate the feasibility of expanding the project to additional states.
- At the local level, 10 community health centers will be funded to test individualized wellness plans (e.g., nutrition and fitness counseling) for their at-risk patients.

Care Coordination and Quality Improvement – Educating and Developing the Workforce

To develop a workforce able to provide high quality care in a timely manner, efforts to increase the number and skill level of professionals are also included in HR 3590. One grant provides schools with federal matching for developing and implementing curricula for health professionals that focus on quality improvement and patient safety. Additionally, HR 3590 will launch a demonstration to provide low-income individuals with education, training and career advancement opportunities for current and projected occupation shortage areas. To increase

dental care access in underserved areas, HR 3590 offers grants to schools, clinics, and hospitals to establish training programs for alternative dental health care providers (dental hygienists or even primary care physicians). Up to five hospitals under another demonstration will receive payments for training advanced practice nurses between FY2012 -15.

Systems of Care – Long Term Care

The Medicaid (Medi-Cal) program pays for most long term care services. It is typically faulted for being over-weighted towards institutional care as opposed to home and community based alternatives (which are sometimes, but not always less expensive and typically preferred by seniors). HR 3590 rewards states for using home- and community-based care options in place of their commonly more expensive alternatives—nursing homes—through an increase in FMAP.

California already has multiple home and community based care programs of which the largest in funding and utilization is IHSS (In Home Support Services). Its nursing home population has shown remarkably little growth in utilization over the past 20 years. California has model programs, such as On Lok, SCAN and other PACE programs that integrate and coordinate the delivery system for long term care. They are limited in number and geographic location, and as such should be expanded into other areas.

Long Term Care – Quality Improvements

Specific to long term care, grants will support 1) programs to train ombudsmen to better monitor and respond to abuse and neglect, which can increase the quality of care and potentially reduce costs (e.g., preventing pressure ulcers); 2) an independent entity to temporarily monitor select inter- and intra-state chains of skilled nursing facilities for quality of care and compliance with state and federal laws; and 3) facility-based demonstrations lasting up to three years that develop best practices for nursing facilities involved in the “culture change” movement and investing in HIT to improve resident care.

High Cost, Chronically Ill

HR 3590 provides for a 1,000-person demonstration (starting this past January) with incentives for physicians and nurses to direct home-based primary care teams designed to reduce costs and/or improve outcomes for high-cost Medicare beneficiaries. A physician or nurse will lead an “independence-at-home medical practice,” using a variety of professionals to provide home-based care to beneficiaries including remote monitoring and diagnostics, 24-hour availability to assist in self care, and in-home visits.

Medi-Medis

Some patients have both Medicaid and Medicare coverage and are known as the Medi-Medis. Medicaid and Medicare have markedly different features and dual-eligible individuals face difficulty accessing coordinated services due to this silo-ed and discontinuous structure. Reform now offers the opportunity to provide integrated and coordinated care to these patients through the establishment of a Federal Coordinated Health Care Office, with a focus on regulatory/access simplification and customer satisfaction. This is consistent with the direction of California’s proposed §1115 waiver.

Accountable Care Organizations -- Moving Towards a Better-Integrated Delivery System

Part of restructuring the health care system involves integrating and coordinating teams of providers across a variety of settings to improve outcomes and lower costs -- accountable care organizations (ACOs). ACOs are teams of providers that manage and coordinate care for patients across different care settings to improve outcomes and share the savings. Ideally, they would budget resources globally and aggregate performance data.²⁰ HR 3590 includes incentives to encourage the creation of Medicare and Medicaid ACOs, including a five-year Medicaid pediatric ACO demonstration project starting January 1, 2012. If the ACO meets established performance guidelines and savings, the members receive a portion of these savings as an incentive for successful collaboration.

P4P rewards an individual physician or hospital for meeting certain measures of quality or cost; under the ACO concept, a broader health care team is rewarded for these measures. The founding theory is that health depends not on individual physicians or hospitals, but instead on the efforts of a team of providers. From the in-home support services worker who assists an individual with daily living to the primary care physician who monitors a patient's chronic disease, the care of a patient takes many hands and shares many dollars. An ACO works to weave these units together within a broader network, making it easier for the various providers to share in resource planning and use, and the savings are accrued through greater care coordination.

HR 3590's Medicare Shared Savings Program will serve as a testing ground for using ACOs in Medicare and, with success, a model for other public and private sectors' networks outside Medicare. This program will primarily link physicians in group practice with hospitals in order to create ACOs that serve at least 5,000 patients, share a governance/legal structure, and can distribute shared savings. These ACOs will be accountable for their populations for at least three years, using evidence-based medicine to deliver high quality, efficient, patient-centered care to Medicare beneficiaries. Provided that they do not purposefully avoid high-needs beneficiaries, ACOs that perform well will get a portion of the system savings.

The other ACO mentioned in HR 3590 is the five-year Pediatric ACO Demonstration Project, beginning January 1, 2012. This will allow pediatric medical providers in participating states to become ACOs and receive incentive payments for the system savings achieved through higher quality care.

All performance data will be publicly available via the Medicare Hospital Compare website, a Physician Compare website, or through other media as needed. Using such data, a pilot started before 2019 will test the impacts of financial incentives for those Medicare beneficiaries who choose higher quality care.

²⁰ Berenson, R.A. and K.J. Devers. (2009). Can Accountable Care Organizations Improve The Value Of Health Care By Solving The Cost And Quality Quandaries? Retrieved April 12, 2010 from <http://www.rwjf.org/files/research/acobrieffinal.pdf>.

One of the main difficulties with implementing ACO and P4P initiatives is determining the appropriate incentive(s) to promote higher quality care and ensuring that the performance measures chosen are valid, risk-adjusted indicators of higher quality care.²¹ A standard range of best practices can be created to flexibly measure improved health outcomes. Efforts to improve quality will benefit greatly from a better coordinated system that can be jointly accountable to improve patient care and share the savings that result.

Administrative simplification within ACOs

Under the Medicare Shared Savings Program (an ACO pilot starting by January 1, 2012), incentives will be used to promote the use of e-prescriptions, electronic health records and similar HIT.

State efforts

Recent studies indicate that large multi specialty group practices are achieving better results at lower costs than individual and small group practices.²² California's large multi specialty group practices have been limited to the Los Angeles and Bay Area metropolitan regions, but quite successful there. Providers must become ready and willing to actively participate in implementing this aspect of federal reforms. California may also wish to emphasize ACOs in its Medi-Cal, Healthy Families and other publicly financed programs.

5. Data and Transparency

The increased transparency that HR 3590 will bring both to the government and private sector has the potential to improve quality, accountability and informed consumer decision-making. The successful and seamless sharing of data across the Exchange, health plans, points of service, and other public and private entities is imperative for improving the value of our health care system. We need to know price, costs and quality to not only improve patient outcomes but also to bend the cost curve. To give some concrete examples, what doctor would not want to know how colleagues are achieving better results with a different treatment regimen? What patient facing serious and costly surgery does not want to know which hospitals and doctors have the best results at the most affordable price? What health plan or provider network does not want to have the data to show that it is treating the sickest patients and demonstrably achieving the best outcomes?

The timely disclosure of standardized, accessible and understandable information is beneficial at all levels, and serves the common goal of providing better outcomes at a lower cost. With the exponential growth in medical innovation and often expensive technology and the exponential

²¹ Comparable and risk adjusted data are critical to this undertaking. Because Medicare covers all seniors and does so on a continuous basis, this data is more readily available for the Medicare population than it is for those under age 65 who typically cycle through a multiplicity of programs and plans. Electronic health records may ease and resolve the data challenges.

²² See Weeks et al, Higher Health Care Quality and Bigger Savings Found at Large Multispecialty Medical Groups Health Affairs, 29,no.5 (May 2010). The authors are hopeful but cautious. Ginsburg et al point that the delegated model despite its success is declining in California due in part to the disinterest of the large national health plans. See Shifting Ground: Erosion of the Delegated Model in California, California Health Care Almanac (December 2009) at www.chcf.org/publications/2009/12/issues-and-trends-from-a-sixregion-study-of-california

growth of IT that has only been sparingly applied to health care. HIT will truly be the glue of 21st century health care.

Plans in both the individual and group markets will need to be more transparent on claims, payment policies, and program spending to improve health (e.g., care coordination, chronic disease management, etc.). Individual/small group and large group plans that do not dedicate 80% and 85% of revenue, respectively, to direct patient care must begin to provide a rebate to enrollees by 2011; this data on medical as opposed to administrative costs needs to be collected and disclosed to regulators and the public in a comparable way for all plans. There will be risk adjustment among plans participating in the Exchange, individual and small group markets so that plans with the best networks and outcomes for the sickest patients will be adequately compensated. This too will require comprehensive data, disclosure and careful refinement so that the most cost effective plans are not cross-subsidizing the most inefficient ones. Risk adjustment must be carefully targeted at adverse selection and cherry picking, rather than deterring improved plan cost efficiencies; this cannot be done without sound data. Hospitals must list their standard charges for their services so that patients facing out-of-pocket costs can make informed decisions. Hopefully this will also drive some hospitals to price their services in a more sensible and comprehensible fashion. To simplify administration for the public, providers and plans, uniform standards and rules for electronic transactions between plans and providers will be adopted. HIT will also be used to enroll individuals in federal and state HHS programs (including Medicaid, SCHIP or Exchange plans). HIT will need to become widely used and interoperable among providers and plans. States may request federal funds for HIT investments.

On the consumer's end, grants will be available for states' efforts to help the public navigate the insurance system and make smarter coverage choices. Grants will also be available to develop Internet portals, which allow consumers and small businesses to review and compare insurance options. The state Exchange will help consumers navigate the market and obtain more affordable coverage.

Plans' premium increases during the interim leading up to the Exchange will be subject to state review and approval, and federal funds and technical assistance will be available. This too will require standard, comparable and defensible data. Federal and state monitoring of plan's premium increases is likely to increase after 2014 if premium increases do not abate.

To combat fraud and abuse, the reconciliation bill complements HR 3590 with provisions including Medicare prepayment medical review, a 90-day period of oversight for initial claims of durable medical equipment suppliers, and additional funding for the Health Care Fraud and Abuse Control Fund over the next decade.

California Implementation

California's opportunities depend on the willingness of state policy makers and stakeholders to work with the current federal administration to test innovative models that promise to contain costs and/or improve quality of care. The state has the opportunity to draw down funds from the American Recovery and Reinvestment Act for development of HIT infrastructure. Renewal and growth of the state's §1115 waiver could give California funds to configure a collaborative

safety net infrastructure which will be necessary for safety net providers and plans to participate effectively in the coverage expansions provided for in HR 3590. The assurance of plan and provider choice and timely access to a system of integrated care for a previously uninsured populations will require local safety nets to evolve quite dramatically in a short time frame. San Francisco, San Mateo and other Bay Area communities have already begun.

The state should build upon promising public-private IT developments in the state, such as the unprecedented integration of EHRs between Kaiser and the VA in San Diego County.²³ The California Health Information Exchange, with Cal eConnect's recently designated oversight, could act as the backbone of statewide data sharing and even be incorporated into the Exchange as a preferred/mandated component for plans and provider networks in the new market.

Specific to HR 3590, the state should consider the variety of demonstrations from which the state may draw down funding and change its system towards one that would most benefit its residents. For instance, California may wish to be one of the states chosen to conduct a Medicaid demonstration that tests integrated care around hospitalization or a global capitated payment system for an integrated safety net. These initiatives may complement activities already in progress through the current waiver and those proposed under the waiver's renewal such as efforts to coordinate care around a medical home or to better integrate mental health care needs into total patient care. The federal demonstrations and pilots, grants and flexibility, coverage expansions and insurance reforms represent unparalleled opportunities for California to improve its health care system.

²³ <http://www.signonsandiego.com/news/2010/jan/06/a-medical-breakthrough-va-kaiser-to-share-records/>

ITUP Summary: California Options to Improve Quality and Efficiency under HR 3590

- The state Exchange, CalPERS, Medi-Cal and Healthy Families should pursue contracting strategies that give plans and institutional providers incentives and disincentives based on the success/failure in meeting an agreed target growth rate.
- State legislators may want to consider stronger regulations and review of provider/plan rate increases in anticipation of full implementation
- California needs to redirect its DSH funds to those hospitals most impacted by the residual uninsured, and seek redistribution of federal DSH funds among states based on their respective shares of the residually uninsured.
- California should apply fees to those substances contributing to poor health status and high health spending.
- California should expand its pay-for-performance programs to more hospitals, doctors and institutional providers, improve data collection, risk adjustments and incentives so that quality can be increased.
- California should begin planning the structure of the Exchange as soon as possible, as a strong and selective purchaser with excellent, readily accessible information to consumers and small employers on price and quality.
- California should identify and promote promising co-op opportunities, particularly in communities with high prices and little competition.
- California should switch Medi-Cal reimbursement methodologies to more closely parallel new Medicare policies so that providers have consistent incentives to improve quality and be more cost-effective.
- California should focus on streamlining care for the Medi-Medi population, through both the new waiver and reform's provisions
- California should seek to pilot test Medicaid demonstration projects for integrated care and global budgets.
- California should identify target communities and strategies, and seek funding for community transformation grants, and wellness grants for small employers, community health centers, near seniors and the uninsured.
- California should integrate and coordinate its long term care services by creating additional programs like On Lok and SCAN.
- California should emphasize ACOs in its Medi-Cal, Healthy Families and other publicly financed programs.
- California needs to secure widespread adoption of interoperable electronic health records and create payment incentives/disincentives for providers.