

ISSUE BRIEF

State Health Reform Series:
Strengthening State/National Partnerships to
Support Delivery System Reform

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ENGELBERG CENTER for Health Care Reform
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Overview

Health care in the United States today is marked by a growing concern about the gap between the care that Americans actually receive and the quality and efficiency of care that should be possible. Across the country, the consistency with which high-quality, evidence-based health care is provided is remarkably uneven. The challenge of care coordination in an increasingly complex and fragmented delivery system is widely acknowledged. And rising health care costs and other state and federal fiscal challenges threaten not only the feasibility of greatly reducing the number of people without insurance, but also the affordability of health insurance for those who already have coverage. Given these challenges, public and private stakeholders at the state and national level have a strong, shared interest in improving the delivery of health care in order to improve quality and lower overall cost growth.

A forum on October 8, 2008 – hosted by the Engelberg Center at the Brookings Institution and the National Academy for State Health Policy (NASHP) – will convene state and national leaders committed to the development and implementation of multi-stakeholder delivery system reforms at the state level. Panelists will highlight and critically examine the barriers to broader state-level reforms that could be mitigated to some extent by stronger national partnerships with the federal government, national payers, and large employers operating in more than one state.

This background paper briefly summarizes efforts underway in several states that will be represented at the forum. While these are not the only states engaged in innovative efforts to improve the delivery of care, many of the challenges they face and opportunities they seek are representative of the experiences of other states.

Colorado

In early 2008, Colorado Governor Bill Ritter introduced the Building Blocks to Health Care Reform which seeks to expand access to care, especially for children, and address quality improvement and cost containment. It follows the recommendations of the Blue Ribbon Commission for Health Care Reform, which was created to study and establish health care reform models for expanding coverage and to decrease health care costs for Colorado residents. Several components of Colorado's Building Blocks to Health Care Reform are highlighted below.

Coverage Expansion with Medical Home

As part of the health reform package, children and pregnant women earning 225 percent of the Federal Poverty Level (FPL) will be eligible for coverage in the Child Health Plan Plus (CHP+) starting in March 2009, up from 205 percent of FPL. In addition, the State is increasing reimbursement rates for primary and preventive health care and dental care and, in accordance with a legislative mandate issued in May 2007, is providing all children in Medicaid and CHP+ with a primary care medical home. The goal of these efforts is to expand access, reduce health care costs, and improve quality by

improving coordination of care and preventing unnecessary emergency room utilization. As of September 2008, approximately 15,000 children have been enrolled in medical homes. The State is currently looking to expand this effort to adult pilot populations.

The Center for Improving Value in Health Care

The Building Blocks to Health Care Reform also called for the establishment of a multi-stakeholder center to identify and pursue strategies for quality improvement and cost containment. Since January 2007, the Center for Improving Value in Health Care has convened groups of consumers, business leaders, health care providers, and representatives from insurance companies and state agencies to develop value-based payment and purchasing strategies for the State. The Center has drafted the following recommendations that will be delivered to the Governor in December 2008:

- Develop a common framework for payment and system reform across multiple public and private payers;
- Coordinate payment policies regarding adverse health events;
- Implement payment policies to promote medical homes (i.e., standard definitions, outcome measures, and payments);
- Coordinate financial incentives for consumers related to chronic disease and wellness; and
- Leverage purchasing power across public and private sectors to drive health system improvements.

Colorado Regional Health Information Organization

Colorado is also investing in health information technology (IT) through the Colorado Regional Health Information Organization (CORHIO), a broad-based group of public and private stakeholders committed to improving the health care of Coloradoans through the development of a statewide health information network. The CORHIO is working to develop a statewide electronic health information exchange between four large health care entities in the State: Denver Health, University Hospital, Children's Hospital, and Kaiser Health Plan. The exchange, which is scheduled to go live November 2008, is expected to help drive quality improvement and cost containment in Colorado.

North Carolina

Two major health reform efforts underway in North Carolina are designed to improve the coordination of care, improve quality, and control costs: Community Care North Carolina (CCNC) and The Governor's Quality Initiative (GQI).

Community Care North Carolina (CCNC)

Health care leaders developed CCNC in 1988 seeking long-term quality improvement and cost containment in the Medicaid program. Today, Medicaid physicians are organized into 14 regional networks that are coordinated and supported by a statewide infrastructure. Each Medicaid patient in CCNC is linked to a primary care medical home, and participating physicians receive a management fee (in addition to the usual Medicaid fee schedule) for providing ongoing, comprehensive primary care and care coordination with other providers and for participating in regional quality improvement efforts. Patients given enhanced primary care case management are identified primarily through claims data (e.g., multiple emergency department visits, high numbers of medication claims, or diagnosis of asthma, diabetes, or congestive heart failure).

CCNC practices offer improved access to care, including 24-hour on-call coverage, and engage in community-based quality improvement initiatives based on the results of statewide audits and other claims-based performance information that includes regional and state benchmarks. Cost and quality results are available to participating practices; networks or practices successful in one area are encouraged to share strategies with other practices. CCNC's local organization allows networks to respond quickly to changing needs and ideas and allows providers to treat patients based on knowledge of the community. The statewide CCNC infrastructure allows for learning across networks and effective roll-out of new pilot programs. The statewide structure also supports standardized data aggregation and information sharing to facilitate ongoing quality improvement efforts.

As of August 2008, CCNC consists of approximately 1,200 primary care practices across North Carolina and manages the care of 750,000 Medicaid patients, accounting for roughly 80 percent of the State Medicaid population or almost 10 percent of the North Carolina population. Efforts are underway to further engage primary care practices that are not currently participating, as well as other medical specialists.

North Carolina is also working with CMS to secure a Medicare 646 demonstration allowing the State to expand CCNC enrollment to the dual eligible population (i.e., those eligible for both Medicaid and Medicare) and, later, patients in traditional Medicare. If approved, this effort will establish a shared savings model agreement with the Federal government in which a portion of any cost savings resulting from better management and coordination of dual-eligible or Medicare-only patients and their conditions would be shared between the Federal government and the State; the State would use its share of savings to facilitate expansion of CCNC and to enhance other quality improvement and cost containment initiatives in North Carolina.

Governor's Quality Initiative

Recent statewide efforts to drive health system performance improvement in North Carolina also include the Governor's Quality Initiative (GQI), introduced in early 2008. The goal of the GQI is to develop a unified set of quality measures for several common chronic conditions (initially diabetes, asthma, congestive heart failure, hypertension, and post-myocardial infarction care) across several public and private payers in the State. The GQI will also provide enhanced practice support for physicians in order to more consistently implement the evidence-based guidelines. The GQI is supported by three major payers – Blue Cross Blue Shield of North Carolina, the State Employees and Retirees Health Plan, and Medicaid. Together, these payers account for up to 75 percent of covered lives in the State. They have agreed to submit claims data to a central data warehouse that will be used to facilitate multi-payer quality and cost assessments and analysis, including the dissemination of provider performance information to participating practices with state and regional benchmarks.

Measures used in the GQI will be based on nationally recognized standards, such as those developed by the National Committee for Quality Assurance (NCQA) and endorsed by the National Quality Forum (NQF) and those which have been widely accepted in the North Carolina provider community. Claims-based quality measures will be computed for all practices with eligible patient populations in the State. To complement claims analysis, chart auditors will visit a sub-set of participating practices to review a random sample of medical records.

Practice-level performance information will be available to individual practices, payers, and quality improvement consultants. Initially, payer-specific averages for the quality measures will be available to specific participating payers, and community and statewide averages for the quality measures will be available to the public.

Payers will not initially use provider performance information to change the provider reimbursement system (e.g., enhanced incentives for quality improvement), but by building on CCNC, GQI creates a platform for future multi-stakeholder payment and other reforms that can further drive quality improvement and cost containment in North Carolina.

Rhode Island

A number of health reform efforts are underway in Rhode Island, including initiatives to promote health information technology, drive delivery and payment reform, and expand coverage.

Health Information Technology

Rhode Island has received national attention for its efforts to promote health IT adoption through the RI Quality Institute, a non-profit organization comprised of all major health care stakeholders that serves as the State's designated Regional Health Information Organization (RHIO). This health IT strategy has included efforts to improve the rate of e-prescribing, promote the adoption and use of qualified electronic health records, and develop a health-information exchange based on an AHRQ-funded pilot project.

Smart Purchasing

The State also is promoting the notion of "smart purchasing" through its state and municipal employee purchasing reforms and through its Medicaid "Global Consumer Choice Compact Waiver," application. If approved by CMS, the waiver, which builds on the success of the State's Medicaid managed care program RItE Care, would provide the State with new flexibility in program design in exchange for meeting a ceiling on federal matching funds. Currently, the waiver application is being reviewed by CMS.

Rhode Island Chronic Care Sustainability Initiative (CSI-RI)

In all of these efforts, commercial insurers are critical partners and vehicles. The Office of the Health Insurance Commissioner has revised its rate review process to align the efforts of health insurers with system improvement priorities in the State. To this end, the State has developed a 2-year statewide multi-stakeholder chronic care improvement initiative designed to align quality improvement goals and incentives across Rhode Island's health plans, purchasers, and providers.

This initiative seeks to develop and support a sustainable model of chronic disease care delivery in primary care settings that can improve quality and contain costs. Beginning in January 2008 and continuing through December 2009, the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) will provide enhanced payments to primary care providers for the delivery of high-quality chronic disease care, including the establishment and promotion of medical homes.

Five pilot sites have been selected to implement chronic care improvement strategies for three chronic conditions: coronary artery disease, depression, and diabetes. The State plans to measure the implementation of services in the pilot practices, improvements in clinical care, marginal costs to each health plan for instituting the pilot, and total costs of patient care for patients in the CSI pilot compared to comparable, non-CSI pilot patients.

All major payers in the State – Medicaid, Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and United HealthCare New England, which together represent 67

percent of insured residents – are participating in the initiative. In addition, the CSI-RI includes the State's two largest private sector employers, Care New England and Lifespan, and has the support of major primary care provider organizations. In all, the initiative will impact 25,000 covered lives in the State.

The initiative grew out of increasing interest in the sustainability of primary care, as evidenced by the Governor's initiative in "balanced health care," Medicaid's move to develop primary care infrastructure and reduce costs for chronic disease through its Connect Care Choice Primary Care/Case Management program, and a state health insurance statute that directs health plans toward policies that improve system affordability, accessibility, and quality. Building on a history of multi-stakeholder collaboration and existing practice assistance infrastructure and chronic care improvement collaborations, the State is one of four communities granted funding from the Center for Health Care Strategies' "Regional Quality Improvement Initiative," funded by the Robert Wood Johnson Foundation.

Participating payers have selected a group of practice sites to implement a standard set of clinical services based on the primary care medical home (PCMH) model. Payers have agreed to assess practices using common measures drawn from national measurement sets and to pay according to a consistent methodology across all payers. All pilot sites are focusing on the same three chronic conditions in their care quality improvement efforts and will be paid a monthly \$3 per member per month fee in return for providing enhanced PCMH services in addition to their current fee-for-service (FFS) payments. At this time, payments will not be paid based on clinical performance incentives.

Training for participating practices and care management teams is being provided by the Rhode Island Chronic Care Collaborative. Nurse care managers are located within the practices and provide services to all patients regardless of provider. They are provided with cash payments from the health plans in return for conducting initial patient assessments and risk stratification; maintaining a data registry, monitoring quality measures, and generating reports; gathering and maintaining educational information and educating patients on disease and treatment; and accessing health plan resources for patients.

Sites are required to self audit at nine and 18 months into the pilot, and Harvard School of Public Health will conduct the final evaluation with support from The Commonwealth Fund. Outcome measures for each chronic condition will be drawn from registries maintained by the nurse managers and not claims data. Specifically, the final evaluation will look for evidence that:

- The organizations providing care adopted components of the patient-centered medical home model;
- The intervention had an impact on patients, including changes in care processes, outcomes, and experiences of care; and
- The intervention was associated with changes in the cost of care, qualitative information on experience of PCMH adoption, and the use nurse care managers.

By changing how providers are paid for services that are known to be effective, the initiative will seek to impact provider behavior, which has typically been strongly influenced by commercial payers' use of Medicare's payment incentives that reward providers for volume and intensity of services. Thus far, the State cites transparency and a focus on non-monetary benefits to providers (e.g., training, information, potential for enhanced efficiency) as factors contributing to broad stakeholder participation.

Vermont

The State of Vermont passed comprehensive health reforms beginning in 2006 that are designed to expand access to coverage, improve the quality and performance of the health care system, and contain costs. The reforms encompass over 60 different initiatives, including the availability of new subsidized coverage options for low-income uninsured individuals, investments in health IT, and the Blueprint for Health, which focuses on new chronic disease prevention and management resources. The Blueprint includes a multi-payer primary care medical home initiative which is currently testing a combination of primary care payment reform, community care coordination teams, and health IT for patient care. As a possible next step in reform, the State is also assessing the feasibility of broader, community-based payment reform options.

Primary Care Medical Home Pilots

Starting in 2008, three Vermont communities will implement the Blueprint patient-centered medical home program. New legislation in 2007 authorized the creation of medical homes that provide enhanced provider incentive payments in return for meeting nationally recognized functional standards for medical homes. Health care delivery and public health prevention efforts are closely integrated in these pilots, and each participating practice has access to local, multidisciplinary care support teams, including prevention specialists, which are shared across practices. In addition, practices are provided with a web-based clinical tracking system for tracking patient health information and producing population-based reports.

Vermont has mandated that Medicaid and the three commercial payers in the State participate in the pilot. Each of these payers has contributed funds to finance the initiative along with state appropriated general funds to test a public-private multi-payer approach to health care reform. Medicare does not participate as an active payer; however, the costs of enhanced payments and other resources devoted to Medicare patients are being born by the State's Blueprint budget in an effort to include a large majority of the patient base to better influence provider behavior.

Feasibility Assessment of Alternative Payment Reforms

Another key component of Vermont health care reform builds on the infrastructure that has been developed for the Blueprint PCMH payment pilots and involves a feasibility assessment of payment reforms based on the Accountable Care Organization (ACO) model. This model and related pilots would be designed to address the shortcomings of existing FFS payment and pay-for-performance initiatives. These limitations include the focus on individual providers as the locus of accountability and the lack of sufficient incentives for all providers in a community to improve population health, support better patient experiences of care, and contain total per capita costs in a coordinated fashion. Such an approach would shift the locus of responsibility for cost effectiveness from individual providers to the network of providers that work together to deliver patient care across multiple settings.

The ACO approach would enable a fundamental shift toward overall accountability for value without requiring fundamental restructuring of provider relationships or current payment systems in the short term. Other advantages include improved technical and practical ability to measure performance through larger sample sizes and the potential to capture performance of all physicians and other clinicians who contribute to the care of a population in various care settings; local organizational accountability for capacity and appropriate utilization; and enhanced ability to make investments in quality improvement through better infrastructure and access to capital.

The Vermont Joint Legislative Commission on Health Care Reform is using the ACO model as an initial framework to identify the broad issues and concerns that will need to be addressed in designing community-wide payment reform pilots. From October 2008 to February 2009, the Commission will convene a wide range of stakeholders to assess the feasibility of and propose a framework for community-wide payment reform pilots in Vermont. Among other things, Vermont's feasibility study will address:

- **Technical issues** around defining performance measures and the populations to which these measures apply; designing payment models; and building the administrative capacity to implement the initiatives; and
- **Political and professional concerns** regarding scope of practice; linking clinical sectors that have traditionally operated in separate silos; the selection of pilot communities; and agreeing on and designating a shared savings model to ensure accountability and aligned incentives.

The Commission will also consider other credible models to achieve community-wide payment reform that may emerge during the feasibility study process. The ultimate goal is to achieve greater value in the health care system statewide by improving the health of the population and containing costs.

Forum on Strengthening State/National Partnerships to Support Delivery System Reform

The success of new and emerging state reform initiatives may depend on developing coordinated, multi-payer strategies to improve quality and contain costs. According to health care leaders developing these reforms, the effectiveness of state health reforms could be improved with more active participation by Medicare and Medicaid as major payers. To be sure, Federal stakeholders emphasize the importance of containing cost growth and increasingly advocate efforts to promote greater value in health care delivery. However, the Federal government's ability to support state programs through demonstrations, data sharing, and increased funding requires strong evidence that these initiatives actually work.

The appendix outlines examples of the challenges and opportunities for progress on health care delivery system reform through stronger state/federal partnerships.

Similarly, state-level delivery system reform efforts can be strengthened with greater participation by large employers and national health plans. However, disparate state-level reform efforts require these national stakeholders to balance different activities taking place in different states, each with distinct goals, participation requirements, and competitive considerations.

This Forum will identify opportunities to strengthen state/national partnerships that can help support the shared goal of improving quality and lowering costs in our health care system. The Engelberg Center for Health Care Reform at Brookings will release a report following the event outlining the results from the Forum, including ideas and recommendations by participants representing state and federal government, providers, health plans, consumers, and a wide range of other stakeholders.

Illustrative Perspectives on the Waiver/Demo Process and Potential Opportunities to Strengthen the State/Federal Partnership

State Perspectives (illustrative)	Federal Perspectives (illustrative)	Examples of Possible Opportunities
<p>There is currently no mechanism outside of the waiver/demonstration process for Medicare to participate actively as a major payer in local and regional pilots.</p> <p>This process can be lengthy and fraught with uncertainty; the process often requires many years of planning which is often not aligned with timelines for state-initiated efforts.</p> <p>States have limited prospective knowledge of what conditions CMS will accept in demonstration negotiations, including whether and how CMS approval of a State's demonstration proposal may affect the Federal government's willingness to approve similar terms and conditions in other state proposals.</p> <p>Terms of approval, including specific shared savings models (e.g., savings thresholds and formulas) may be difficult to achieve to ensure continued participation and overall success.</p> <p>Once approved, waivers/demonstrations may not permit the level of flexibility needed to make changes.</p>	<p>Not all demonstrations have achieved meaningful savings, which has created a strong rationale for the Federal government to be risk averse.</p> <p>CMS is constrained by budget rules that require savings (defined as achieving budget neutrality or better) and regulations surrounding Federal financial participation (FFP).</p> <p>Health care reform is complex, and states vary along many dimensions; prospectively establishing standardized and "pre-approved" waiver protocols may be technically, organizationally, and politically infeasible.</p> <p>There are many technical challenges that must be carefully addressed to ensure the effectiveness of waivers/demonstrations, such as research designs and evaluation methods that can provide reasonable statistical reliability that reforms actually lower costs, improve outcomes, or both.</p>	<p>Development of non-binding templates conveying greater prospective guidance for states regarding key technical and organizational priorities for CMS's participation in state-level multi-payer demonstrations could reduce uncertainty and provide useful information that could accelerate state/federal negotiations without limiting CMS's discretion.</p> <p>CMS could expand its efforts to contribute streams of Medicare claims data to other multi-payer data systems, which could help to establish better baselines, identify target populations, set goals for improving population outcomes, improve appropriate risk-adjustment methods, monitor health status and gaps in care, and assess and reward results.</p> <p>State and Federal leaders could support the development of a new collaborative workshop series for state leaders to address common technical and organizational problems that states face in the waiver/demo process (e.g., best practices for constructing better baseline/controls, appropriate statistical methods to improve the confidence that reforms achieve results, etc.).</p>