The New Wave of Innovation: How the Health Care System Is Reforming

THE COMMONWEALTH FUND

A Resource for Journalists from The Commonwealth Fund

The Affordable Care Act—also known as national health reform—will transform the U.S. health care system in many ways. Some provisions, such as coverage for young adults, small-business tax credits, and new quality initiatives, are already in place. Other major reforms, including Medicaid expansion and new state health insurance exchanges for individuals and small businesses, will take effect in 2014. Yet even before health reform has been fully implemented, the health system has started—quite literally—to re-form itself. That's partly because of the parts of the law that are already in effect. But many hospitals, physicians, employers, insurers, and states are also anticipating the changes ahead and preparing for them now, and discovering new ways to improve access and quality, and control rising health care costs as they do.

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The result: experimentation—across the health care system. The new emphasis is on primary care, care coordination, and chronic disease management. With this shift in health care delivery comes new ideas for payment models and financial incentives that take a broader view of health management than the traditional fee-for-service structure. The aim is to allocate more resources to up-front preventive and primary care, as well as care coordination, reducing the need for costly acute and emergency care services down the road.

This report shines a light on emerging innovations, providing examples from different sectors across the country, to inform journalists and others of the different ways in which the system is reforming itself. It may also provide ideas for journalists who are interested in exploring the early effects of health reform and the implications for the future.

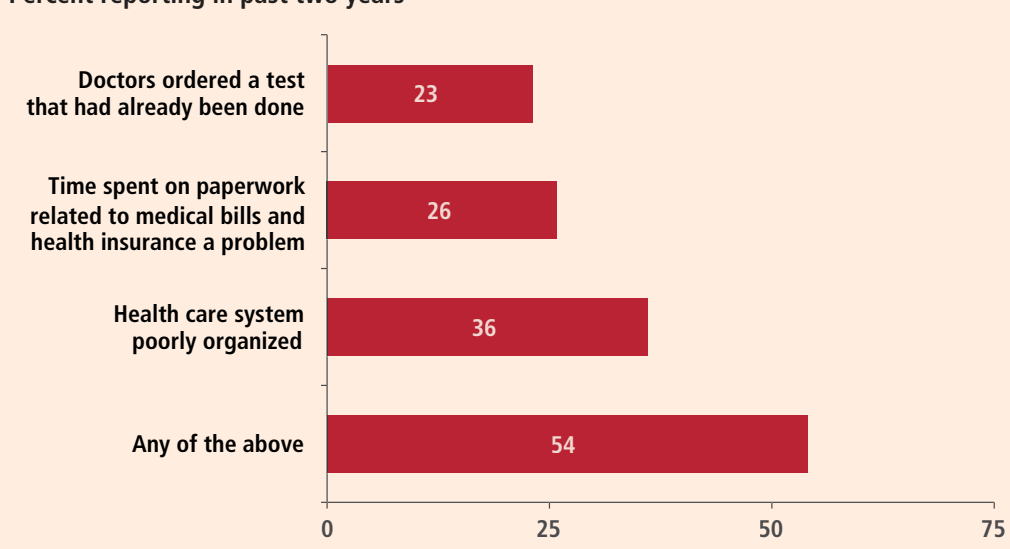
What Are Some of These Innovations?

Some of the most common innovations fall into these categories:

- **Accountable care organizations (ACOs).** Under health reform, ACOs are networks of physicians, hospitals, and other health professionals that coordinate patient care and share in any savings they generate for the government by keeping Medicare patients healthy. These new networks would be led by primary care physicians and would share the risk for cost overages. Although few ACOs are up and running now, a number of providers and payers are preparing to participate in ACOs in the future.
- **Medical homes.** A medical home is a health care setting, such as a primary care practice, that serves as the central base for all a patient's health care needs. Medical homes provide patients with timely, well-organized, and coordinated care, and easier access to specialty care and other providers when needed. The emergence of medical homes reflects the new emphasis on primary care and care coordination.

- **Bundled payment.** Driven by Medicare, insurers and government payers are becoming increasingly interested in paying not for discrete health care services, but for the overall management of patient health. Under a bundled payment system, a single reimbursement covering an entire hospital stay or episode of care replaces separate payments to hospitals and doctors involved in different aspects of a patient's care.
- **Enhanced care coordination / chronic disease management.** Our current health care system is frequently fragmented and uncoordinated. For example, a patient with high blood pressure, diabetes, and heart disease probably has multiple doctors, but if those doctors don't communicate effectively with each other, the resulting care may be ineffective, and may even be unsafe. New delivery models are being developed to improve disease management and care coordination across the spectrum of needs.
- **Health information technology.** Spurred by substantial financial incentives, providers are accelerating their adoption of electronic health record (EHR) and clinical support systems. The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) provides $34 billion in financial incentives for Medicare providers who make "meaningful use" of EHR systems to improve patient care.
- **Value-based purchasing.** Value-based purchasing is increasingly employed by large purchasers of health benefits, including employers and government, to reduce inappropriate care and steer consumers to those who provide the best care most efficiently. The model uses public reporting of quality and cost information, payment reforms and informed consumer choice to highlight and reward high-performing providers or organizations. Value-based benefit design builds consumer incentives into insurance plans or premium contributions to get consumers to make decisions that have a positive impact on health outcomes. Such incentives can relate to use of specific medical services or medications, adoption of healthy lifestyles, or selection of providers.

Potential Waste and Inefficiency: More Than Half of Adults Experience Wasteful and Poorly Organized Care



Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2011.

Providers Are Innovating

Some of the most exciting innovations are happening among physicians and hospitals across the U.S., making health care providers from small practice groups to large health systems excellent sources for compelling stories.

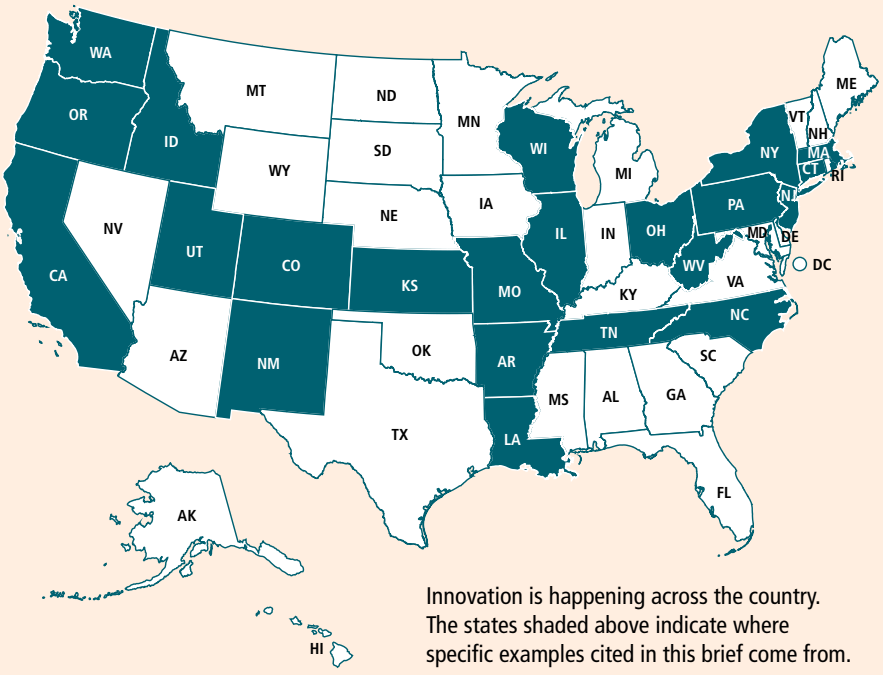
Gathering Momentum for ACOs

ACOs have attracted a great deal of attention, but the story is evolving quickly and in different ways in different communities. Most providers are in the exploratory stage. Here are a few examples of what's happening.

Group Health Cooperative in Seattle, Washington, is leading two new accountable care pilot projects designed to reward providers based on patient outcomes rather than the number of health care services they provide. The pilots, which should be up and running by January 2012, will include at least one integrated health care delivery system and one network of community health care providers.

Five health systems in eastern Wisconsin have created a network that enables partners to respond like a regional ACO while retaining autonomy in their individual markets. The five systems are: Agnesian Healthcare, Fond du Lac; Aspirus, Wausau; Bellin Health, Green Bay; Columbia St. Marys, Milwaukee; and Froedtert Health, Milwaukee. Together they have formed a company called Accountable Care Solutions, LLC, to serve as a clinically integrated contracting entity for the regional network. **Read more here**.

Where Is Innovation Happening?



Innovation is happening across the country. The states shaded above indicate where specific examples cited in this brief come from.

Building Medical Homes

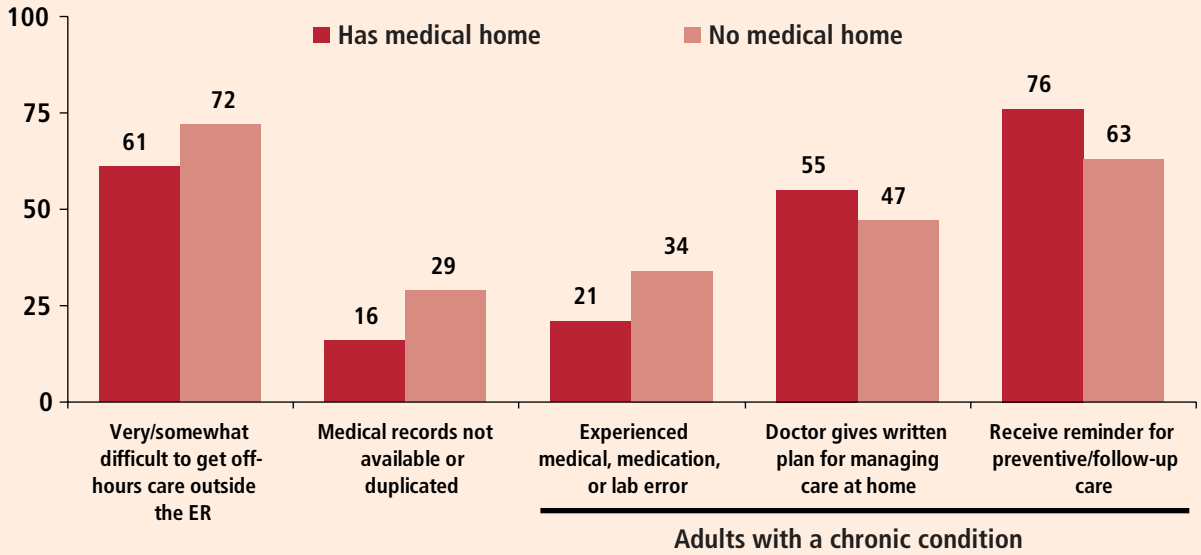
Increasingly, primary clinics and practices are moving to establish patient-centered medical homes.

Community Care of North Carolina is a private-sector initiative that comprises 15 community-based networks of primary care providers with about 3,500 primary care physicians who provide medical homes for 1 million patients enrolled in Medicaid and the Children's Health Insurance Program. By improving care coordination, Community Care is credited with saving the state millions of dollars since its founding in 1998. Now a group of employers – including drug maker GlaxoSmithKline, pharmacy chain Kerr Drug, analytics firm SAS, the state, and Blue Cross and Blue Shield of America – has announced that their employees will be able to enroll voluntarily in Community Care. **Read more** here.

Sponsored by The Commonwealth Fund in collaboration with eight cofunders, **The Safety Net Medical Home Initiative** is a five-year demonstration project designed to help 65 community health centers in five states transform into patient-centered medical homes. Health centers in Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania—each of which partnered with 10 to 15 safety-net clinics in their state—are receiving technical assistance, training, and ongoing support in to improve care delivery, including better coordinating care, enhancing access to care, improving doctor–patient interactions, and implementing quality improvements. **Read more** here.

Impact of Medical Homes on Quality of Care

Percent of adults reporting



Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care. Errors include medical mistake, wrong medication/dose, or lab/diagnostic errors.
Source: 2007 Commonwealth Fund International Health Policy Survey. Data collection: Harris Interactive, Inc.

New Approaches to Care Management and Coordination

Following are just a few examples of ideas providers across the nation are exploring to improve care management and coordination. This type of activity is particularly common among integrated delivery systems, networks of hospitals and physician practices that provide care across a continuum of services to a defined population in partnership with a payer (such as an insurer).

Geisinger Health System, an integrated delivery system in central-northeastern Pennsylvania, has significantly reduced rates of inpatient admission and readmission through intensive care management and coordination of patients with complex, chronic conditions. Geisinger's ProvenHealth Navigator program makes primary care practices responsible for patients 24 hours a day, seven days a week, regardless of where they are. A new payment model awards more dollars to primary care providers up front and to the practices themselves, and an incentive program provides additional compensation based on quality and efficiency.

Presbyterian Healthcare Services, an integrated delivery system in Albuquerque, New Mexico, has reduced costs by offering certain patients who arrive at the emergency department with acute care needs the option of being treated in their homes rather than the hospital. Patients must meet specific criteria in order to participate in the Hospital at Home program, which provides patients with the medications and equipment they need to be treated at home, as well as a nurse case manager. Clinical outcomes for the program were equal to or better than outcomes for hospitalized patients, and the program had lower average length of stay and lower cost per episode than did hospital care. Patient satisfaction was as high as 94 percent. **Read more** here.

Investing in Health IT

From small physician practices to large hospitals, health care providers are joining the Information Age at a more rapid clip. Here are some examples.

Jen Brull, a family physician in rural Kansas, was one of the very first physicians in the country to be certified as a "meaningful user" of an EHR system. In 2007, Brull and her colleagues purchased an EHR system for $90,000, based on its price and ability to integrate billing and medical records. The new system has enabled the practice to focus on process improvement. It has dramatically improved staff productivity and enabled the practice to add two additional providers without increasing support staff. The system has also helped her boost rates of certain preventive services, such as screening for colorectal cancer. Brull said that with increased productivity and concurrent cost savings related to EHR use, her annual income has increased by 40 percent. **Read more** here.

In New York State, the **Greater Rochester Independent Practice Association** implemented electronic medication prescribing – also called e-prescribing – with outpatient clinics associated with the Rochester General Health System, which includes a 528-bed hospital. Within the first year of implementation, patient complaints regarding medication renewals fell 50 percent and prescription-related phone calls dropped by 80 percent. Numbers of prescription errors fell significantly. **Read more** here.

How Are Employers Responding?

Employers have long combated rising health care costs, primarily by engaging in various types of "value purchasing" initiatives that typically focus on quality improvement, cost efficiency, and provider accountability. Some employers are exploring other types of activities as well, enhancing their workplace wellness programs, for example, and attempting to involve workers more actively in their own health.

Value-Based Benefit Design

Nowhere do employers have a better opportunity to address both overuse and underuse of health care than when designing their health benefit programs. The following examples show that when employers embrace value-based benefit design, they can get significant results.

Gulfstream Aerospace Corp., a Savannah, Georgia-based business jet aircraft manufacturer with more than 8,000 employees, dropped its copay for flu shots and generic drugs for certain chronic disease to zero. Overall, pharmaceutical costs dropped significantly as the effort yielded a 98.4 percent generic substitution rate.

Pitney Bowes, a Stamford, Connecticut-based manufacturer of mailing and shipping software and hardware with 36,000 employees worldwide, established a three-tier pharmacy benefit designed to steer employees toward generics and high-value medications for diabetes, asthma, and hypertension. Not only did net pharmacy costs decline, but among diabetics, emergency room visits declined 35 percent and overall medical costs decreased 6 percent.

Employer-Led Initiatives

Some employers, typically working through regional coalitions with hospitals and physicians, are pursuing initiatives to maximize health care quality and cost-effectiveness. Chronic diseases are a common focus, as the following example shows.

The Employer Data Project, a Findlay, Ohio-based collaborative of local employers, physicians, and a hospital system, set out to reduce variations in the quality and costs of care for chronic conditions such as hypertension and diabetes. Physicians were encouraged to follow standardized treatment protocols. In addition, the hospital system redesigned its care practices for diabetic patients. The focus on hypertension led to a 25.5 percent reduction in combined costs of physician visits and hospital care. Diabetes care improved as well. **Read more here.**

Paying for Prevention

Does prevention really pay? Starting in 2014, employers will have broad latitude to find out. That's when the federal cap on wellness program incentive payments rises from 20 percent to up to 50 percent of the cost of an employee's health premiums. Following is a case in point.

Ochsner Health System, a Louisiana-based nonprofit with eight hospitals, 35 clinics, and about, 7,100 benefits-eligible employees, expanded its workplace wellness and prevention program with Health Miles, which rewards employees for increasing their physical activity and meeting goals for key health measurements, such as body mass index and blood pressure. Based on their results, employees could earn a $500 reduction on their annual premium costs, or $3,000 for those with family coverage. During the program's first year, more than 80 percent of employees participated, and nearly 90 percent either improved or maintained their body mass index. Employee-only medical claims fell by more than $3 million. **Read more here.**

Promoting Patient Engagement

Patients who are not actively engaged in their own health care can undermine their health by missing doctors' appointments, failing to refill prescriptions, not exercising or eating right, or refusing the support of disease management programs. Some employers are encouraging patients to become partners in their own health rather than passive recipients of care.

The Illinois-based **Council 31 of the American Federation of State, County, and Municipal Employees (AFSCME)** encouraged its 400 employees, retirees, and dependents to sign a formal, written health care contract that included an annual health risk assessment, participation in comprehensive care management programs, ongoing relationships with primary care doctors, regular biometric screenings, and online health lessons. Employees who chose to participate paid substantially less for health care than those who did not participate. AFSCME's overall average monthly medical costs have gone down by about 10 percent, and the overall health of the participant population is improving, as reflected in measures of smoking, hypertension, and cholesterol. **Read more** here.

What Are Insurers Doing to Innovate?

Health reform presents an opportunity for insurers to expand market share – and profitability – with the expansion of coverage to an estimated 30 million newly eligible individuals through Medicaid and the insurance exchanges. Some insurers are moving quickly to embrace the new opportunities. CIGNA, for example, just launched a national ad campaign geared toward the individual health insurance market.

Meanwhile, insurers are also forming ACOs, exploring new payment methods, working to improve care coordination and disease management, establishing medical homes, and enhancing primary care.

Accountable Care Organizations

Activity in this area is certain to increase, not only because of health reform, but also because the ACO model explicitly addresses care coordination and disease management, two priorities for insurers. In California, Oakland-based Kaiser Permanente's integrated structure – the staff-model HMO has an exclusive relationship with its medical groups and, in most regions, its own hospitals – has been critical to its success as an ACO. Most insurers, however, need to develop new relationships with contracting medical groups to form ACOs.

CIGNA, a national insurer based in Bloomfield, Connecticut, has launched a collaborative accountable care initiative – CIGNA's version of an ACO – in Memphis, Tennessee. Partnering with CIGNA is Health Choice, a physician–hospital organization affiliated with Methodist Le Bonheur Healthcare, a Memphis-based health care system. The program focuses on 17,000 members who will receive care from among 29 doctors at seven practices charged with monitoring and coordinating all aspects of patient care, with special emphasis on managing chronic conditions such as diabetes and heart disease. CIGNA will pay physicians as usual for the medical services they provide, but it has also created a "pay for performance" structure that rewards physicians who meet targets for improving quality and lowering medical costs.

In Southern California, leading provider groups and insurer Anthem Blue Cross are participating in an **ACO pilot project** designed to encourage physicians, hospitals, and insurance companies to work together to coordinate care, improve quality, and reduce costs. **HealthCare Partners,** a Torrance, California-based medical group and independent practice association (IPA), and **Monarch HealthCare,** an Irvine, California-based medical group IPA, are the provider groups participating in the project led by the Engelberg Center for Health Care Reform at Brookings and the Dartmouth Institute for Health Policy and Clinical Practice. **Read more** here.

Some Promising Organizational Models for ACOs

	Advanced primary care networks	Multispecialty physician group practices with hospital affiliation	Integrated ambulatory, inpatient, and postacute care
Criteria for Participation	Primary care: • 24/7 access arrangements • Chronic condition registries: at least basic HIT • Teams • Contract entity	• Primary care foundation • Health information technology links across practices • Hospital able to accept bundled payment for select conditions • Contract entity	• Primary care foundation • Health information technology links across sites including hospital • Legal entity to contract and take financial risk
Payment Mix	• Blended fee-for-service payment and medical home monthly fees • Shared savings	• Medical home monthly fees for primary care • Bundled acute case rates with 30-day warranty for at least two conditions • Shared savings	• Medical home monthly fee for primary care • Bundled acute case rates for multiple conditions • Moving toward risk-adjusted global fees • Reinsurance or other methods to mitigate insurance risk
Tracking Metrics—Targets based on top 10% and starting point for each ACO	• Patient survey • Admissions for ambulatory care–sensitive conditions; 30-day readmission rates; and emergency department use • Chronic care outcomes • Total costs of care for chronically ill, including Rx • Targets for each	• Patient survey • Admissions for ambulatory care–sensitive conditions; 30-day readmission rates; and emergency department use • Chronic care outcomes • Mortality for select acute conditions • Total costs of care, including Rx • Targets for each	• Patient survey • Admissions for ambulatory care–sensitive conditions; 30-day readmission rates; and emergency department use • Chronic care outcomes • Mortality for acute conditions • Total costs of care, including Rx and post-acute care • Targets for each
Criteria to Renew Contract	• High patient ratings • Meet quality targets • Slow cost growth • Reinvest savings in care system	• High patient ratings • Meet quality targets • Slow cost growth • Reinvest savings in care system	• High patient ratings • Meet quality targets • Slow cost growth • Reinvest savings in care system

Source: Commonwealth Fund, "High Performance Accountable Care: Building on Success and Learning from Experience," 2011.

Medical Homes

Insurers see a pay-off in medical homes: Greater up-front investment in primary care and care coordination will reduce the need for more expensive care later. Here are a few examples of how insurers are approaching this growing area of activity.

In New Jersey, **Horizon Healthcare Innovations,** a subsidiary of Horizon Blue Cross Blue Shield has launched what it says is the state's first comprehensive patient-centered medical home program, in collaboration with the New Jersey Academy of Family Physicians. The program involves 63 primary care physicians who treat 24,000 patients. Doctors are paid a set fee for managing the comprehensive care needs of their patients, regardless of how many appointments they make or tests they run. The idea is that doctors will do more to monitor patients – particularly those with chronic health problems – between visits, saving money on acute and emergency care. The insurer says this will result in better quality of care, high patient satisfaction, and lower overall costs.

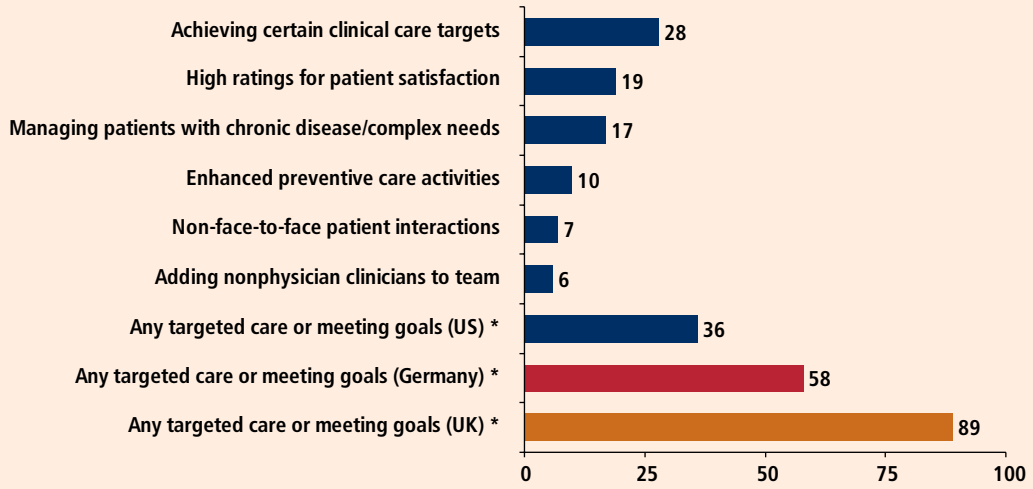
Highmark Inc., a Pittsburgh-based plan that serves 4.8 million people, is working with 13 physician practices throughout western and central Pennsylvania and West Virginia on a pilot medical home program. The program includes 160 physicians in 29 locations caring for 45,000 members. Highmark anticipates that better management and coordination of care will reduce hospital readmissions and emergency room visits. Use of health information technology to support patient care will play an important role, the insurer says. **Read more here.**

Strengthening Primary Care

For many years, primary care has been undervalued, but that's changing. Health reform includes new financial incentives for primary care, and private insurers are also recognizing the need to invest more resources in this area.

In a pilot program, the **national insurer Aetna,** based in Hartford, Connecticut, placed nurse case managers in 36 primary care practices to work alongside providers in their offices to help manage patients' conditions. So far, the program has involved about 20,000 patients, all members of Aetna's Medicare Advantage plan, and has resulted in improved care processes, some improvements in care outcomes, and reduced numbers of hospitalizations. **Read more** here.

U.S. Primary Care Doctors' Reports of Financial Incentives Targeted on Quality of Care



* Can receive financial incentives for any of six: achieve clinical care targets, high patient satisfaction ratings, managing patients with chronic disease/complex needs, enhanced preventive care (includes counseling or group visits), adding nonphysician clinicians to practice and non–face-to-face interactions with patients.
Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

What Are States Doing?

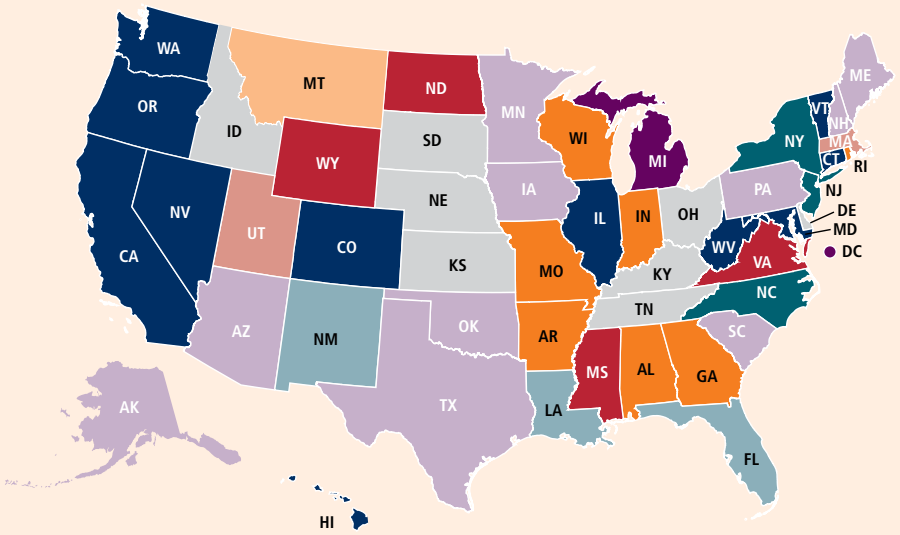
Health reform expanded the to-do list for states, which are engaged in efforts to set up new insurance exchanges, scrutinize their insurance regulations, and promote medical homes and ACOs.

Insurance Exchanges

Most states are focusing on issues pertaining to the new publicly subsidized health insurance exchanges. By mid-August 2011, 13 states had approved legislation authorizing the exchanges. Two others, Massachusetts and Utah, already had exchanges. Twenty-six states have won federal grants to help build their exchanges. The ACA gives states substantial leeway on how to structure the exchanges.

Utah's exchange is built on a market model that allows the private market to compete under limited oversight and regulation. It is basically a web portal through which small businesses can make a defined contribution toward health insurance, and their employees can compare and select health plans from a range of options. Employees pay the difference between the employer's contribution and the premium. **Read more** here.

Status of State Legislation to Establish Exchanges, as of October 2011



- State exchange in existence prior to passage of ACA
- Legislation signed into law post passage of ACA
- Legislation signed: intent to establish an exchange, creation of study panel or appropriation
- Legislation passed one or both houses
- Legislation pending in one or both houses
- Pending legislation failed
- Governors pursuing non-legislative options
- Governors working with HHS on options
- Governor veto or decision not to establish exchange
- No legislation/bills introduced

Source: National Conference of State Legislatures, Federal Health Reform: State Legislative Tracking Database. http://www.ncsl.org/default.aspx?TabId=22122; Politico.com; Commonwealth Fund Analysis.

Accountable Care Organizations

Legislation related to ACOs has been introduced in 25 states, but only 10 have enacted laws. Florida and Utah, for example, have moved to incorporate ACOs into Medicaid. In other states:

Oregon this year **approved legislation that will move nearly 1 million Medicaid enrollees**, teachers, and government employers into so-called "coordinated care organizations," similar to ACOs. The idea is to realign financial incentives under a global budget to restructure care delivery and hold providers accountable for both outcomes and costs. **Read more** here.

Similarly, Arkansas is exploring how to **switch its Medicaid program from a fee-for-service model** to paying partnerships of local providers for episodes of cares. As part of that effort, the state is looking at bundled payment for certain areas of Medicaid care, including pregnancy and newborn care, attention-deficit disorder, type 2 diabetes, back pain, cardiovascular disease, upper respiratory infections, developmental disabilities, long-term care, and prevention. **Read more** here.

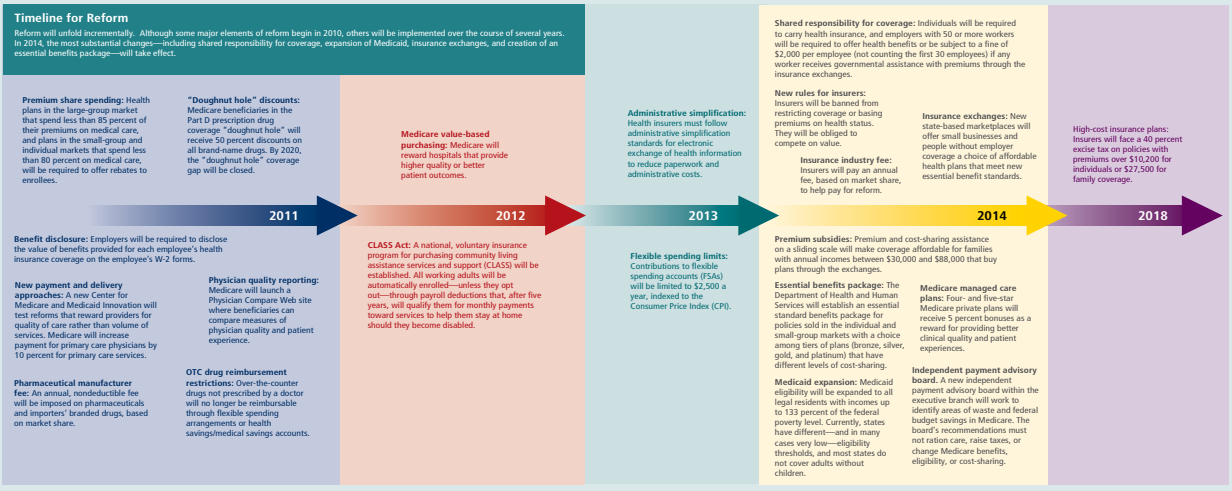
Medical Homes

The National Academy for State Health Policy has identified 41 states that are actively advancing the medical home model for Medicaid. Many are still in early exploration and planning.

Connecticut is one state that already has a **medical home pilot program for state employees and retirees.** The number of physician practices officially considered medical homes has grown dramatically this year, aided by the designation of the state's largest group of primary care practices, **ProHealth Physicians,** as a medical home. Currently, the state is developing plans to encourage health care providers to serve as medical homes for Medicaid patients. **Read more** here.

Missouri is pioneering **integrated mental and medical health homes based in community mental health centers** to provide care coordination and disease management for persons with both mental illness and chronic medical conditions. Missouri's Medicaid program plans to apply for the enhanced federal match under the Affordable Care Act health home provision to expand the breadth and depth of the program. **Read more** here.

For more information, visit The Commonwealth Fund's Health Reform Resource Center at www.commonwealthfund.org.



Looking Ahead

The wave of health care innovation is far from over. In fact, it has just begun. Many initiatives are still in planning stages, while others are only beginning to generate lessons learned that will inform future activities. In addition, many details concerning the implementation of health reform at the federal and state levels have yet to be determined. These and other developments will greatly influence the shape of future innovation.

Resources

Alliance for Health Reform, www.allhealth.org

Center for Studying Health System Change, www.healthsystemchange.org

Kaiser Family Foundation, www.kff.org

National Academy for State Health Policy, www.nashp.org

National Business Coalition on Health, www.nbch.org

National Committee for Quality Assurance, www.ncqa.org

National Health Policy Forum, www.nhpf.org

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