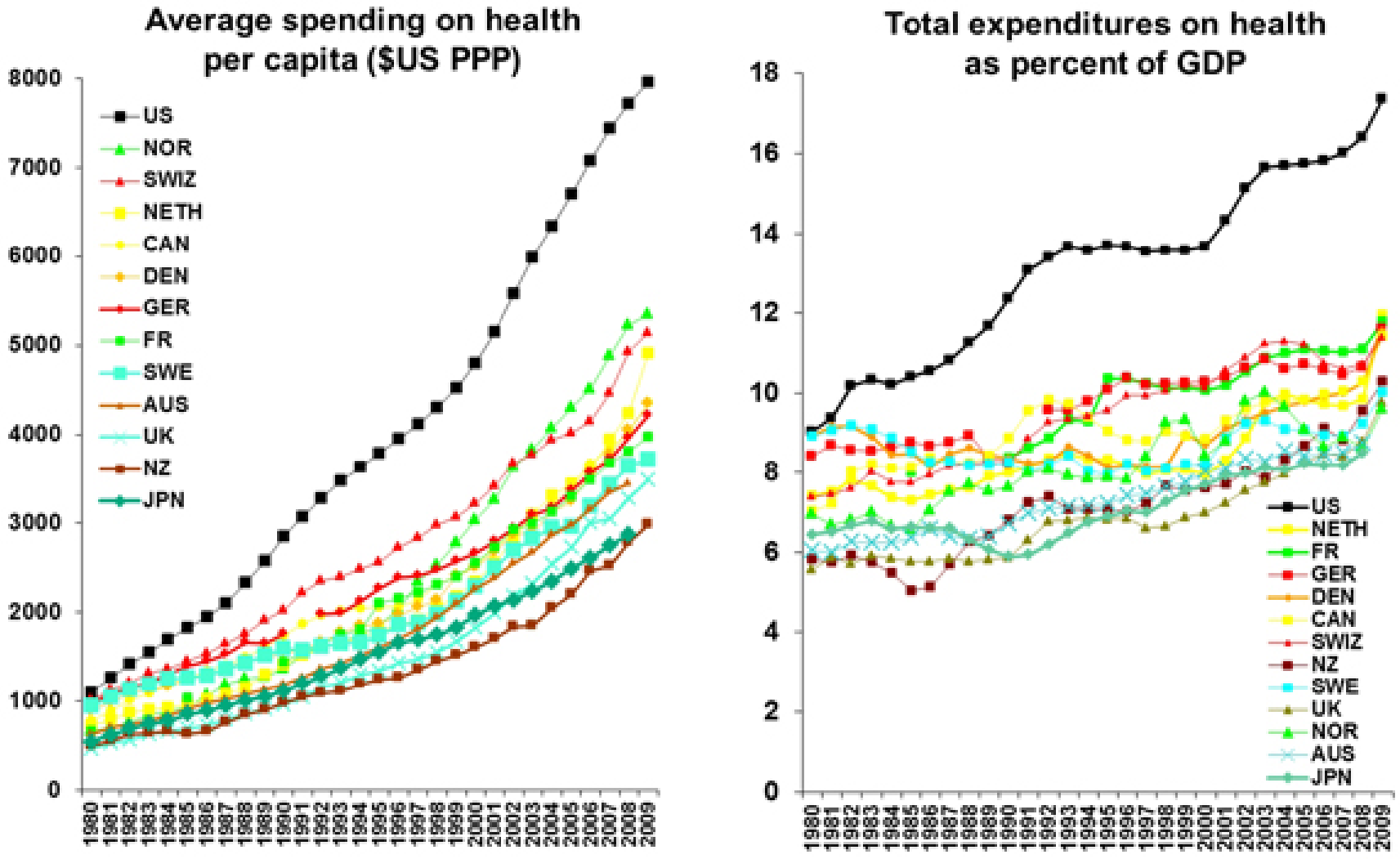
ACA Care Delivery Reforms: Prospects for Progress

Jim Reschovsky, Ph.D.
Senior Fellow
Center for Studying Health System Change

What are the problems?

- High health care costs
- Cost growth unsustainable
- Care quality often lacking
- Rising chronic condition prevalence

International Comparison of Spending on Health, 1980–2009



Note: PPP = Purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned.
Source: OECD Health Data 2011 (Nov. 2011).

THE COMMONWEALTH FUND

Aging Baby Boomer Generation Compels Need to Control Costs

LA FOLLETTE HOME UW HOME UW DIRECTORY MY UW

ROBERT M.
LA FOLLETTE SCHOOL OF PUBLIC AFFAIRS
UNIVERSITY OF WISCONSIN-MADISON

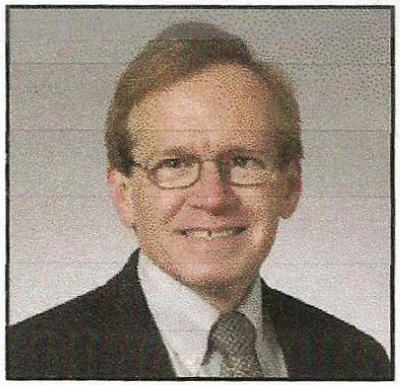
La Follette School News

Reschovsky to retire, plans to live off of younger generations after years of meager UW salaries

Andrew Reschovsky has spent his career exploring how tax policies affect individuals and the various ways in which state and local governments are financed.

Although the government finance expert is retiring from the University of Wisconsin – Madison, his research schedule remains full, with further exploration of the fiscal health of central cities in the United States and plans for a conference and journal issue on school finance.

Reschovsky's work spans several themes, including city finance, intergovernmental fiscal relations, and tax policy. His recent scholarship has appeared in a number of academic journals, including the *National Tax Journal, Regional Science and Urban Economics, Public Finance Review, Education Finance & Policy*



Andrew Reschovsky

Reschovsky helps students sharpen analysis skills

Andrew Reschovsky has trained many La Follette School alumni in the

Why is U.S. health care so inefficient?

- Fee-for-service (FFS) provider payment
  - Rewards volume, not good medicine
- Distorted price signals
  - Influenced by interest group politics
  - Affects physician practice patterns
  - Inadequate payments for primary care, care coord., etc.
- Fragmented delivery and payment systems
- Local market concentration→ high prices
- Poor insurance design re: patient incentives

Consequences of rising health care costs

- Higher taxes
- Lower GDP
- Decreased employment
- Lower wages, standard of living
- Crowding out of other important expenditures (e.g. education)

Historical Context for ACA Strategy

- Managed care revolution
  - Rise of capitation
  - Greater controls on physicians by insurers
  - Restricted provider networks
  - Costs fell in mid 90's!
  - But focus on controlling costs trumped improving care
- And providers and consumers rebelled
- Return to FFS, broad networks (and higher patient cost sharing)

ACA strategy mindful of mistakes of managed care revolution

- Forging a middle path between FFS and capitated payment (partial capitation)
- Nudging the health care system towards larger, more integrated systems that:
  - Are better prepared to take some insurance risk
  - Are better positioned to change systems of care
- Let local providers/systems figure out best approaches

General ACA strategy

- FFS continues, though provider rates squeezed
- New payment mechanisms on top of FFS
  - Rewards for lowering costs, improving quality (penalties if performance slips in some cases)
    - Shared savings/risk arrangements; pay for performance
    - Bundled payment
  - Incentives to integrate providers into systems of care
- Correct FFS price distortions
- Build infrastructure to support structural changes
- (Public insurance initiatives mostly, spur private payers to follow)

The other view of the ACA strategy

Key ~~strands of spaghetti~~ ACA initiatives

Patient-Centered Medical Homes (PCMH)

- Reinvention of primary care
  - More comprehensive, patient centered (more proactive)
  - Greater efforts to coordinate care, engage patients in self care
  - Use HIT for coordination, decision support, physician feedback
  - Work in interdisciplinary teams
  - Improve accessibility (same-day appts., 24/7 coverage)
  - Emphasis on prevention and quality improvement
- Practices paid monthly care mgmt. fee, later shared saving/pay for performance arrangements
- Primary demo in conjunction with private payers, Medicaid agencies

Accountable Care Organizations (ACOs)

- Provider networks (MDs, hosp., etc.) held accountable for cost and quality of care delivered to population of patients
- No restrictions on provider choice (in Medicare)
- Providers paid by FFS, but ACO receives rewards/penalties based on cost and quality performance.
- Provides motivation for coordination/integration

Bundled Payment

- Encourages integration of care across types of providers.
  - Payments at episode of care level
- Triggered by hospitalization for specific conditions
- 4 models being tested:
  1. Hospitalization period only
  2. Hospitalization + post-acute
  3. Post-acute only
  4. Hospitalization period only with capitated payment
- Models 1-3: FFS with shared risk payment arrangements

Initiatives for patients dually eligible for Medicaid & Medicare

- Duals are costly, diverse, have complex needs
  - Fragmented financing, administration & delivery
  - Different classes of duals, with different benefits
- Variety of ACA initiatives; state experimentation
  - 2 main models:
    - Capitated plans (3-way state/fed/health plan contract)
    - Managed FFS models (betw. state & feds) with shared savings arrangements
  - Participation by Medicaid and Medicare managed care plans

Value-based purchasing

- Expansion of public reporting of provider quality
- Development of new quality measures
- Physician Quality and Resource Use Reports
  - Initially comparative data for informational purposes
  - Linked to payment for large groups starting in 2015
    - Known as pay-for-performance
- Value-based payment adjustments for hospitals (e.g. linked to readmission rates).

Payment changes

- Temporary fee increases for primary care physicians, …
- Independent Payment Advisory Board (IPAB)
  - If per capita spending targets not met:
    - IPAB will develop Medicare payment recommendations
    - Recommendations become law if not rejected by Congressional super-majority
  - Can't "ration" care, change benefits, raise taxes, or make changes in patient cost sharing/premiums
  - Aim is to take power away from Congress and special interests.

Investments in technical, workforce, and information infrastructure

- Incentives for electronic medical record adoption (in ARRA, not ACA)
  - Medicare payment penalties for those who don't adopt
- Workforce development (espec. primary care)
- Comparative effectiveness research
  - Establishment of PCORI (Patient Centered Outcomes Research Institute)

Prospects for the future

Glass half empty

- Improving quality does not necessarily lower costs
- Ability to measure quality remains primitive
- Reforms built on top of flawed FFS system:
  - Allows providers to game the system
  - Despite protections, cherry picking of patients possible
- Reforms spurring provider consolidation → more integrated care or higher prices??
- Implementation & system change is tough!!
  - Need to lower expectations for quick results
  - ACA 3-5 year long demos may be too short
  - Beware of low hanging fruit

Glass half full

- Reforms focused on many key payment and delivery system problems
- Mindful of historical missteps (MC revolution)
- Some spaghetti is bound to stick to the wall
- Lots of positive momentum
  - Private sector moving forward with own initiatives
    - Some promising results
  - States actively pursuing reforms
  - Will motivate provider participation, spur syst. change