

Accountable Care – The Overarching Vehicle for Rehabilitating Health Care – A New Hampshire Perspective

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Introduction

New Hampshire, like the rest of the Nation, has struggled to identify an effective solution to the health care crisis. New Hampshire citizens are faced with increasing costs, uncertain quality of care, and limited healthcare access for some. Solutions to these issues have been proposed in the areas of expanding health insurance coverage, increasing incentives for promoting high quality care, expanding technology to improve quality and efficiency of health care delivery, and many others. Most prominently, transforming how health care gets *paid for* has been seen as a promising approach, known generally as payment reform. One proposed way to reform the payment system is through the implementation of Accountable Care Organization (ACO) models.

NH Citizens Health Initiative's long-term goal is to create and sustain a public dialogue that will measurably improve the "systems" that finance and provide health care in New Hampshire in order to accomplish two fundamental objectives:

- Assure a healthy population
- Create an effective system of care

This brief introduces the concepts of payment reform and focuses on how ACOs can be used to achieve the goal of reforming the payment system. More specifically, New Hampshire's proposed pilot for ACOs will also be described.

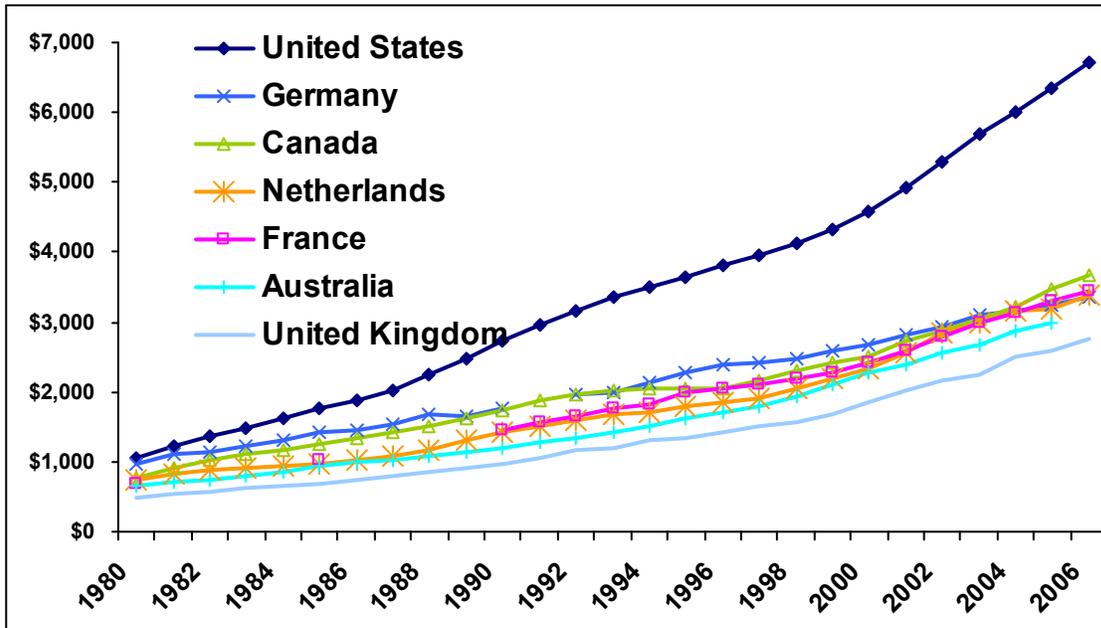
Health Care Spending in NH

New Hampshire has some of the highest medical costs in the nation. The state's favorable socioeconomic demographics—a well-educated, relatively wealthy population with high rates of health insurance coverage—would hypothetically translate into better health outcomes and lower costs. Instead, NH has:

- Significant variation in prices of individual services, as well as for a market basket of services across providers of health care ¹
- Health spending that amounts to more than 18% of GSP and is expected to reach 22% by 2017 ²
- An average family health insurance premium that is one of the highest average family premium in the United States. In 2006, NH's \$12,686 premium far exceeded the national average of \$11,381. ³
- Personal annual per capita health care spending of \$6,456 in 2007, with a projection of reaching \$11,043 by 2017 ⁴

New Hampshire's concerns about health care spending mirror those of the nation as a whole. The United States is twice as costly, yet ranks last in terms of quality, when compared to other industrialized nations.

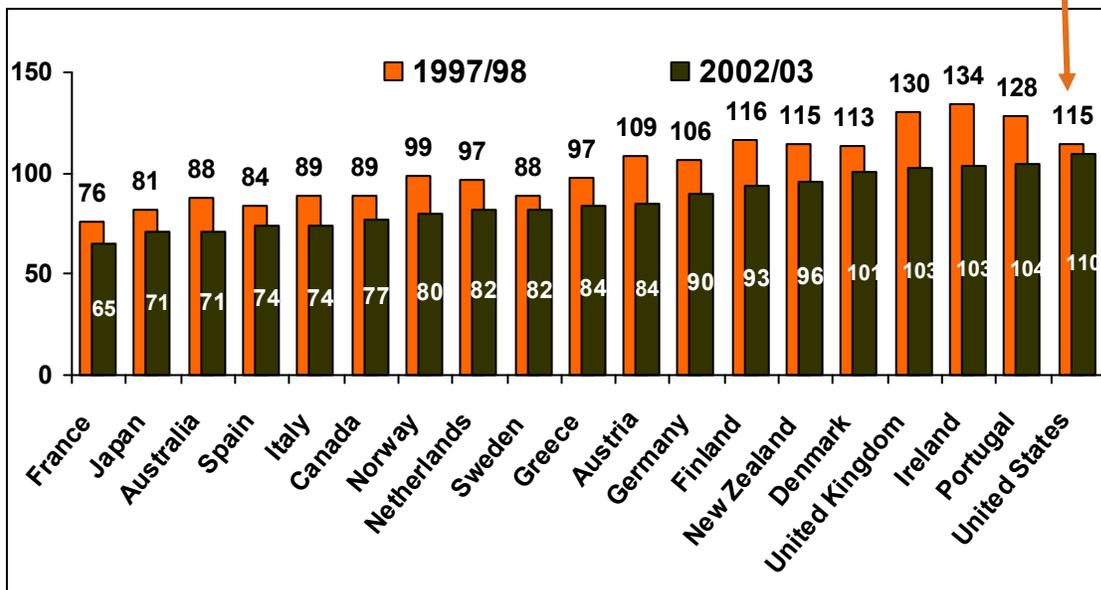
Average spending on health per capita (\$US PPP*)



* PPP = Purchasing Power Parity. Data: OECD Health Data 2008, June 2008 ⁵

Deaths per 100,000 population*

19th out of 19



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections.

Data: E. Nolte and C. M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization mortality files (Nolte and McKee, *Health Affairs* 2008).⁶

A recent study explored the cost implications for the State if New Hampshire were to improve its performance and achieve health care cost levels equivalent to the average of the top 5 “low cost, high quality” states^A. The results indicated that New Hampshire could achieve the following:⁷

- Total Health Care Expenditures as a Percent of Gross State Product (GSP) would be 14.6%, rather than 18.1% of GSP, based on 2008 estimates. This would mean that NH health care expenditures, currently about \$10 billion per year, would decrease by \$2 billion.
- On a per person basis, Total Health Care Expenditures per Person would be reduced by about \$1,000 per person, from \$8,235 to \$6,909, based on 2008 estimates.
- Average premium for health insurance for family coverage would decline from \$12,686 to \$10,954 resulting in savings of about \$1,500 per family, based on 2006 estimates.
- Average premium for health insurance for single coverage would be reduced from \$4,622 to \$3,890, based on 2006 estimates.

In summary, health care spending in New Hampshire, like the rest of the country, is substantial. However, opportunities exist to change the spending patterns and slow, or even, stop the increases that have been standard over the past 10–20 years. One of these opportunities is reforming the payment structure for health care services.

Payment Reform through Accountable Care

One way to modify the structure of the health care system is to fundamentally change the way we pay for health care services. The manner in which we currently pay for health care is exclusively focused on volume (more services), and not on outcomes (whether the service helped or improved the patient’s health). Payment reform is appropriate because current payment methods:

- Fail to appropriately value the complexity of health care that is delivered in the primary care setting;
- Over-value specialty services; emergency room and urgent care use; and specialized testing, such as CT-scans and MRIs;
- Pay for services whether or not they are medically necessary, yet fail to pay for the time needed for important conversations between physicians and patients about fundamentally important topics, such as end of life care, disease prevention, or effectiveness of alternatives to expensive or risky treatments
- Fail to pay for coordination of care across providers, hospitals, testing sites, and outpatient procedures. This lack of coordination can then result in medication errors, duplicate and unnecessary tests, and patient confusion and inconvenience.

Changing what is paid for in health care—and how— has the potential to allow providers to:

- Focus more on outcomes and providing the right care at the right time;

^A The top five states are best in cost and quality, based on overall Z scores. In 2009, the best states were South Dakota, Hawaii, Utah, Colorado, and Virginia.

- Take the time to collaborate with colleagues and other treating providers on treatment plans and alternatives;
- Plan for care in a formalized, long-term way, particularly for those patients with complicated medical conditions, such as those multiple or special conditions or needs;
- Communicate with patients to provide individualized care using methods that make sense for the situation and for the needs of the patient; and
- Focus on being more efficient in delivering services, decreasing waste, improving communication, and streamlining processes; these are steps that have been successfully accomplished in nearly every other industry.

A primary problem with the current health care delivery and payment structure is a lack of accountability. The current structure divides accountability across a number of organizations (e.g., hospital, primary care, specialist, testing center, insurance carrier, employer), with no one holding primary, or exclusively managing overall, accountability. A model of health care delivery and payment that addresses this fundamental issue is the Accountable Care Organization (ACO). In general, an ACO organizes around capable and committed leaders who draw together the currently disparate parts of the system, to function as a coordinated, cohesive whole, with shared priorities and goals. More specifically:

- An ACO assumes the primary role and responsibility for a population's health care, which includes cost and outcomes.
- ACOs can be structured in a number of ways, with physicians, physician groups, or hospitals functioning as the lead organization.
- ACOs serve a defined geography, but the services (hospital, specialty, long-term care, home care, etc.) for which they are accountable might vary from one ACO to another.
- To be an ACO, an organization must demonstrate proficiency in a number of areas including:⁸
 - Commitment by leadership to improving value as a top priority, and a system of operational accountability to drive performance;
 - Functioning as a team;
 - Coordinating care;
 - Infrastructure and skills for managing financial risk;
 - Maintaining and accessing complete records of services on patients;
 - Offering options for patient self-management; and
 - Ability to measure and report on quality.

An organization's transformation to an ACO requires a fundamental shift in behavior, focus, operations, analytics, policy, and management. This level of transformation cannot be in name only, or there is risk of encountering the same problems that plagued prior reform attempts. The role and responsibility of leadership in defining and committing to a mission and vision of value and outcomes cannot be understated.

NH Citizens Health Initiative Accountable Care Organization Pilot

In an effort to achieve the level of cost and quality performance of the top 5 “low cost, high quality” states, stakeholders from the New Hampshire provider, hospital, insurance carrier, and policy communities have partnered under the NH Citizens Health Initiative (the Initiative) Payment Reform Pillar Project to apply new and proven payment reform strategies. These strategies are intended to mitigate the rate of increase, foster greater accountability, obtain better value for the care that is purchased. This will result in better health for the residents of New Hampshire. The accountability for performance will transition control from a small group of stakeholders to a system of shared responsibility by all involved in the use, management, provision, and payment of health care.

Using ACOs as the framework, the Initiative’s Payment Reform Pillar stakeholders have devised a pilot of reformed health care payment and systems, to be launched with all of the major insurance carriers in New Hampshire (Anthem Blue Cross Blue Shield of NH, CIGNA Health Care, Harvard Pilgrim Health Care, and MVP Health Care) and the NH Medicaid Program.

ACOs will be selected through a competitive application process, for a pilot that will run over a period of five years. For the ACO pilot:

- ACOs will assume responsibility for the full range of care for the population in its region, including care utilization, outcomes and efficiency, and overall management within a budget.
- The ACOs involved in the pilot will participate in a formal Learning Collaborative, where they will be responsible for reporting progress towards explicit pilot goals and improving overall and process-specific performance.
- Pilot leadership will collaborate on developing risk adjustment methodologies and risk-adjusted budgets, as well as defining the manner and methods by which any savings are distributed across the entities within an ACO.
- The pilot will further be responsible for translating its lessons through the Learning Collaborative, as well as through the development and publication of a tool-kit.
- The project will be facilitated through the Initiative, and will be managed by a steering committee comprised of health care system, insurance carrier, State, and professional society representatives.
- Technical support will be provided to the pilot participants to link the pilot health care system to national best performers and to assist in the translation of other lessons from other experts to the local pilot.
- All data about the pilot; including quality, cost, and efficiency outcomes, with benchmarks; will be reported transparently.

The pilot has some clearly defined, and specifically intended, outcomes that include:

- Better health care cost and quality;
- More tightly coordinated care;
- Greater efficiency in health care service delivery;
- More appropriate care – the right care at the right time;
- Lower health care service unit costs;
- Increased transparency;
- Higher levels of customer satisfaction; and
- A health care market that has healthcare goals that are aligned across constituents.

Conclusion

Given the current economic struggles at the national, state, and local levels, health care spending is an issue that must be addressed. One strategy to address the issue is payment reform; that is, transforming how the health care system pays for services. While multiple ideas for payment reform have been proposed (insurance pools, pay for performance, etc.), few also fundamentally change who is accountable for the care of a community. The ACO model seeks to address both payment and accountability (and, thus, quality) simultaneously.

New Hampshire is poised to test payment reform in a concrete way through a combined effort of stakeholders across the health system (hospitals, insurers, state agencies). Organized by the Initiative, NH will develop an ACO pilot to test the potential impact of transforming health system to the ACO model. Inherent in the design of this pilot is sharing of lessons learned and transparency in cost and quality reporting. The pilot should be informative both locally and nationally, and can serve as a model for further ACO efforts in the future.

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The Citizens Health Initiative acknowledges the support of our funders:

- The Endowment for Health
- The NH Charitable Foundation
- The Local Governance Center
- Harvard Pilgrim Health Care
- WellPoint Foundation
- Mary Hitchcock Memorial Hospital
- NH Department of Insurance
- The College of Health and Human Services at UNH.

2010 Issue Brief Citations

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