



National Health Reform and Delivery System Change: How Can New Jersey Use New Reforms to Move the State Health Care Agenda?

Many of the reforms contained within the *Patient Protection and Affordable Care Act* (PPACA) are aimed at reducing health care costs and improving quality without rationing care, cutting benefits or reducing eligibility. Starting with the populations that suffer from the most difficult health conditions and have the most medical expenses makes sense. If designed and implemented properly, these reforms hold the potential to transform not only their lives, but also to serve as models for other populations. However, this promise cannot be realized without the informed and meaningful participation of patients, families and their advocates.

The problem: our fragmented system

There is widespread acknowledgement that our current health care system is fragmented, failing to consistently deliver high quality care, particularly to certain vulnerable people, such as: those with multiple chronic conditions, the frail elderly, people who are dually eligible for Medicare and Medicaid, and members of a racial or ethnic minority. These populations tend to see more physicians, have more office visits and take more medications. Too often, there is no one to coordinate this care. This failure to coordinate leads to poor care, such as:

- Duplicative tests or procedures
- Medication errors
- Avoidable hospital admissions
- Preventable hospital readmissions
- Unnecessary nursing home placements

This fragmentation comes at a cost. Overall, health care costs represent 16 percent of our Gross Domestic Product. In 2009, we spent \$2.9 trillion on health care. The cost of health care services provided to vulnerable populations is disproportionate to their numbers. For instance, 96 percent of Medicare dollars and 80 percent of Medicaid dollars are spent on patients with multiple chronic conditions. And, Medicaid and Medicare spend four times as much for the nearly nine million dually eligible beneficiaries than for non-duals. This disproportionate spending is in part because these populations have more complex health care needs. But preventable hospitalizations, complications and unnecessary nursing home admissions contribute significantly to these high costs. Improving the health delivery system for these vulnerable people will improve the quality of their lives, while also saving money.

New opportunities emerging from national health care reform

Noted Harvard surgeon and author Atul Gawande said it best in his December 2009 *New Yorker* article “Testing, Testing,” where he responded to claims that there was no master plan for improving quality and reducing costs in the then-pending national reform bills. Drawing from what’s worked in agriculture, he said that “[t]o figure out how to transform medical communities, with all their diversity and complexity, is going to involve trial and error. And this will require pilot programs – a lot of them.”

Indeed, the PPACA is filled with just these types of reforms aimed at testing what works. By its very nature, it acknowledges the differences among health delivery systems. While there are too many reforms to cover, this brief aims to discuss some those that hold the most promising for states to improve the health of vulnerable populations.

Center for Medicare and Medicaid Innovation¹

The PPACA creates this new center within the Centers for Medicare & Medicaid Services (CMS) and charges it with testing innovative ways of delivering and paying for health care provided to Medicare and Medicaid beneficiaries. The goal of these new models is to reduce program costs while preserving or enhancing the quality of care. While the Center has discretion to choose the models it will test, Congress requires it to give preference to those models that also improve the coordination, quality and efficiency of health care services. The Center will provide funds to states and other organizations to test these models of providing better care.

The Center can choose models to test. The new law suggests eighteen options, including:

- Patient-centered medical homes
- Geriatric assessments and comprehensive care plans
- Health information technology (HIT)-enabled provider networks
- Medication therapy management services
- Community-based health teams
- Patient decision-support tools
- State management of Medicare and Medicaid funds for dually eligible beneficiaries

In choosing which models to test, the Center can consider important factors such as whether the model puts patients, family members and other caregivers at the center of the care team; uses electronic health records; and provides for a close relationship between care coordinators, other providers and community-based organizations.

Because the PPACA does not provide many details about how and where these demonstration and pilot programs will

operate, advocates have an ideal opportunity to influence the design of the programs and to work with their state to position itself to apply to be a demonstration site.

Federal Office for Coordinated Health Care²

The PPACA creates this office within CMS to promote better care for beneficiaries who are dually eligible for Medicare and Medicaid. The purpose of the Office is to better integrate benefits from the two programs and improve the coordination between the federal government and states to ensure that dually eligible beneficiaries get full access to benefits and services. The specific goals of the Office include:

- Providing dually eligible beneficiaries full access to the benefits to which they are entitled
- Simplifying processes for accessing services
- Improving the quality of acute and long-term care services
- Increasing dually eligible beneficiaries' understanding of and satisfaction with coverage
- Eliminating regulatory conflicts between Medicare and Medicaid rules
- Improving care continuity and ensure safe and effective care transitions
- Eliminating cost-shifting between Medicare and Medicaid and among related health care providers

If properly staffed and coordinated with the Center for Medicare and Medicaid Innovation, the Office could dramatically improve the health of dually eligible beneficiaries and lower the costs associated with their care.

Medical home state option

The new law allows states the option of providing “health homes” – a regular source of coordinated primary care – for Medicaid beneficiaries with chronic conditions.³ Under this provision, a state can, as part of a state plan amendment, provide additional payments to a designated provider, team of health care professionals operating with a provider, or health team to treat eligible beneficiaries with chronic conditions. Health home services are defined as:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings
- Patient and family support, including authorized representatives
- Referral to community and social support services, if relevant

- Use of health information technology to link services, as feasible and appropriate

In exchange, designated providers receiving payment for these services must provide regular reports to the state on a set of applicable quality measures. The New Jersey Legislature is currently considering a bill that would create a primary care medical home demonstration project. Should that bill pass, New Jersey could explore taking this state option, and advocates could weigh in on the development of quality measures that are most relevant to vulnerable populations.

Accountable care organizations (ACOs)

The new law creates a general ACO pilot program in Medicare⁴ and a pediatric ACO demonstration project in Medicaid,⁵ in which groups of providers who work together to improve the quality of care they deliver to beneficiaries will be permitted to keep half the savings they achieve over a three-year period. Participating ACOs must promote evidence-based medicine and patient engagement, report on quality and cost measures and coordinate care. They must also demonstrate that they meet patient-centeredness criteria, such as the use of patient and caregiver assessments or the use of individualized health plans. The criteria by which a group of providers will be judged in order to qualify as an ACO will be determined by regulation issued by the Department of Health and Human Services, which will also determine the measures to be used to assess the quality of care provided by the ACO. There is already interest in New Jersey in creating an ACO demonstration project to serve urban, underserved communities. Creating a state project may position New Jersey to take advantage of the federal pilot funding.

Home and community-based services (HCBS)

The new law offers incentives to states that provide HCBS to individuals instead of placing them in nursing homes.⁶ Specifically, the law increases Federal Medical Assistance Percentage (FMAP) payments to States that decrease the percentage of spending while increasing spending on HCBS. The law also removes barriers to providing HCBS by giving states the option to provide more types of HCBS through a state plan amendment to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment.⁷ This provision could provide new options to a state like New Jersey, where over 50 percent of elderly Medicaid long-term care beneficiaries are still in nursing homes.

New payment models in Medicaid

The law creates a pilot program to allow states to test bundling payments.⁸ This program would permit states to pay providers a fixed fee for all the services a Medicaid beneficiary receives over the course of an “episode” of care, rather than paying for each service. An episode might be defined by HHS as a discrete diagnosis, a single acute illness requiring hospitalization or care for a particular chronic condition.

The law also creates a demonstration program to test global payment.⁹ Under this program, five states will be permitted to adjust payments made to an eligible safety-net hospital system or network from a fee-for-service payment structure to a global capitated payment model. While the law does not establish the exact framework of the model, global payment generally means that states will pay providers an upfront, fixed payment per patient for a certain time period to coordinate and order the full array of services the patient may require.

If New Jersey decides to pursue these types of programs, it is essential to ensure that the payment incentives are both transparent and tied to important quality measures.

Reducing avoidable hospital infections and readmissions

The PPACA includes provisions aimed at reducing the number of hospital-acquired infections. Under the law, hospitals will be required to report on these events and those with high rates of hospital-acquired infections will see reduced Medicare payments.¹⁰ Similarly, hospitals will be required to report on avoidable readmissions related to certain conditions and will have reductions in their Medicare payments for excess readmissions.¹¹ Hospital-specific readmission rates will be publicly available on the CMS Hospital Compare website. The information provided through these two reforms could nicely enhance the information already available on New Jersey Hospital Care Compare, the Hospital Association-sponsored website that compares New Jersey hospitals in measures including heart failure, pneumonia and postoperative surgical infection rates.

Quality measurement

The new law includes many provisions aimed at improving the quality of health care by accurately measuring the areas most important to patients and their families. For instance, the law requires the Secretary of HHS to develop a national strategy for improving health care quality with a focus on improving patient health outcomes and functional status, coordination of care, equity of care and reduction of health disparities, and patient experience.¹² It also requires the development and endorsement of quality measures in the areas determined to be priority areas.¹³

How can New Jersey advocates take advantage of these new reforms?

Consumer advocates in New Jersey can have an essential role in shaping the implementation of delivery and payment reforms contained in the PPACA. Providers and insurers are already heavily engaged in these discussions. A powerful consumer voice will be needed to counter these interests at the federal regulatory level – where much of the framework will be established – and at the state level, where public and private stakeholders will decide how to implement these provisions, or whether they should implement them at all. Because those with complex health care needs – people with chronic illnesses or disabilities, seniors and people eligible for both Medicaid and Medicare – are most affected by changes in the way care is organized and paid for, it is

particularly important that their interests are meaningfully represented at both the state and federal levels. A starting place is to ensure that any new delivery or payment system meets a set of core principles, including:

- **Patient and families at the center of care:** New delivery or payment systems must be oriented to the patient's individualized needs, circumstances and preferences. They should work with the patients and families to develop individualized plans of care that starts with an initial assessment of the patient's needs, environment and goals, and continues with regular reassessments as needed to adjust the original plan. Care should be delivered in a culturally and linguistically appropriate manner.
- **Increased reliance on primary care:** Delivery systems serving vulnerable populations should be anchored in primary and preventive care, which promote better quality and lower costs. Every patient should have ready access to a primary care provider who is held accountable through payment incentives for gauging the patient's needs and organizing and coordinating care across the full spectrum of services.
- **Improved coordination of care:** Providers must have a set of supports that allow them to better coordinate their patients' total health care, including behavioral health, as well as connect them to the community-based supports they need. These supports might include employing people to help patients navigate the system, ensure they understand hospital discharge instructions and assist them with referrals to specialists or community services. Another important factor in the coordination of patient care is information technology that allows data-sharing and communication among providers.
- **Improved health outcomes:** Any new delivery model should measurably improve the quality and safety of care, especially as patients transition between settings, such as from hospital to home. Payment incentives should be tied to real improvements, such as reduction in the need for nursing home services, an increase in the ability to live independently, and a reduction in preventable hospital readmissions.
- **Accountability and Transparency:** Delivery and payment systems should be completely clear to all patients, providers and payers. In particular, patients should have access to information about how providers are paid, how quality is measured and what incentives may be affecting the type and amount of care they receive. They should also be able to review any evaluations of care

provided under the system. This type of transparency – backed by the ability of regulators to impose penalties – will not only benefit patients but will help prevent providers from gaming the system in order to receive higher payments, ration care or treat only healthier patients.

- **Patient and family education and empowerment:** New payment and delivery models should encourage a partnership between providers, patients and their families to develop, implement and adjust a care management plan. In addition, new models should use tools to help patients participate in making treatment decisions and should support programs that educate patients and their families about their conditions, what to watch for, and how to manage them. Finally, these systems should require providers to actively seek patient and caregiver assessments of their care and make improvements based on those assessments.

With these principles in mind, advocates can begin developing campaigns to shape how provisions of the PPACA become reality.

Help set the rules of the road: Implementing the delivery and payment reform provisions of the new law will first require a set of regulations laying out the design of these programs. For example, to ensure accountable care organizations are truly accountable based on the above principles, consumer advocates must weigh in on the approval criteria for ACOs and medical homes and the standards they must meet to receive bonus payments. Similarly, consumer advocates should insist on regulations that tie increased payment for the shift to home and community-based services to measurable outcomes, such as decreased hospital and nursing home admissions. New Jersey advocates can take an active role in commenting on proposed regulations and in partnering with other state and national organizations that are especially focused on particular delivery and payment reform provisions.

Fight for a seat at the table: The national health reform law creates many new opportunities for consumers and advocates to be at the center of efforts to improve delivery and payment systems. However, more needs to be done. For instance, consumer advocates should push for the creation of advisory committees for both the Center for Medicare and Medicaid Innovation and the Federal Coordinated Health Care Office. Advocates should also get involved with external organizations that will strongly influence new standards. For example, the National Quality Forum and the National Committee for Quality Assurance will be charged with creating standards for many new models, including the patient-centered medical home. It is important for the consumer perspective to be represented in each of these organizations. New Jersey advocates must also make sure they are adequately represented in state and local delivery system reform efforts. New local or regional initiatives should have consumer advisory councils – from the beginning – that give meaningful input into design, implementation and evaluation of these new delivery initiatives.

Talk to policymakers: With nearly every state in budget crises, states are actively looking for new ways to control health care costs, particularly for their Medicaid populations. It's essential that advocates take part in these discussions. Advocates should talk with state policymakers to assess what programs are of interest in their state, and they should ensure that consumers and advocates are part of any decision-making process. Many of the initiatives already being discussed in New Jersey -- particularly the primary care medical home and ACO demonstration programs -- may fit perfectly within some of the pilot programs that will emerge from the Center for Medicare and Medicaid Innovation. In addition, as noted above, the medical home state option or the state plan amendment to offer more HCBS may provide vehicles for some of the reforms ideas emerging from various corners of the state.

Build a public education campaign: Talking about delivery and payment reform is complicated. But talking about the need for reform isn't. Nearly everyone has a story about how the system has failed them or their loved ones. These individuals can provide powerful stories that offer moral and practical grounding for a campaign, and they can be trained to become advocates. It's also important for advocates to highlight models that work. There are a variety of programs throughout the country that are improving patients' quality of care at a lower cost. Advocates will strengthen their campaigns if they can bring valuable information from the community level to state and federal policymakers. Building alliances with a broad range of stakeholders -- providers, insurers, mission-driven plans, business groups -- will also strengthen advocates' position and improve the chances of achieving policy change that will benefit vulnerable populations.

Partner up: Providers, insurers, employers and other stakeholders have large amounts of money and power at risk in deliberations about delivery system reform. It will require an organized and powerful consumer voice to influence the implementation of the delivery and payment reforms on behalf of patients. State advocates should join together to pool knowledge and resources in order to be an effective presence. The aging, disability, family caregiver, labor, disease-specific, mental health, poverty and faith-based communities all have a stake in improving the health delivery system and can be active members of a coalition focused on state-based reforms. On the national level, the Campaign for Better Care¹⁴ is working to influence the implementation of delivery and payment reforms, particularly as they impact vulnerable older adults. Joining this Campaign will offer New Jersey advocates information and opportunities to become more involved in building support for delivery and payment reforms that will improve the quality of care for vulnerable populations while also reducing the costs associated with that care.

¹ *Patient Protection and Affordable Care Act (PPACA) sec. 3021*

² *PPACA sec. 2602*

³ *PPACA sec. 2703*

⁴ *PPACA sec. 1899*

⁵ *PPACA sec. 2706*

⁶ PPACA sec. 10202

⁷ PPACA sec. 2402

⁸ PPACA sec. 3023

⁹ PPACA sec. 2705

¹⁰ PPACA sec. 3008

¹¹ PPACA sec. 3025

¹² PPACA sec. 3011

¹³ PPACA sec. 3013

¹⁴ http://www.nationalpartnership.org/site/PageServer?pagename=cbc_index