

Health Reform—Opportunities and Challenges for Providers

Welcome to The Commonwealth Fund podcast. I'm Martha Hostetter.

In this episode, we talk with three experts about the opportunities –and challenges –the Affordable Care Act presents to providers. Much of the focus on the health care reform law has been on its expansions of coverage—with relatively little attention paid to the provisions that seek to strengthen the delivery system by increasing transparency, encouraging more organized care, and promoting payment reform.

KP: While a significant aspect of the Affordable Care Act is the expansion of coverage to millions of uninsured, there are a number of landmark initiatives and programs that will help chart a path in the right direction, including novel reimbursement mechanisms and a Center on Innovation within Medicare and Medicaid.

That was Kavita Patel, M.D., M.P.H., a primary care physician and managing director for clinical transformation and delivery at the Brookings Institution. Patel was director of policy for the White House's Office of Intergovernmental Affairs and Public Engagement during passage of the health reform law.

The challenge now lies beyond Washington, D.C. and lands squarely within clinical settings, patients, providers, payors, and other stakeholders. This challenge may seem daunting but it is really a tremendous national opportunity to deliver the right care at the right time. *Howard Beckman, M.D., views new payment systems as opportunities for providers to learn how to deliver better care.*

HB: The most perverse incentive that we confront is a volume-based payment system. The movement toward using payment dollars to design care that is more effective and successful is scary but really exciting. There are so many providers that have imagination about how to do things differently; we'll see all sorts of creative solutions to helping patients do what they need to do for themselves and work with their physicians.

As director of Innovative Strategies at the Finger Lakes Health System Agency, based in Rochester, New York, Dr. Beckman worked with community physicians to help identify and eliminate unwarranted variation to achieve higher-value care.

HB: We looked at variation in care of patients with high blood pressure. Higher-cost practitioners used angiotensin receptor blockers and brand-name combination medicines while the lower-cost doctors used ACE inhibitors and diuretics. If you compare their decisions to guidelines for treatments for high blood pressure, it makes as much sense to use one type of drugs as it does to use the other. So as payment systems start focusing more on the total costs of care for a patient population, understanding variation that exists, increasing underuse, and

reducing overuse should increase appropriate care and focus on what's necessary for improving outcomes.

Anne-Marie Audet, M.D., head of The Commonwealth Fund's Health System Quality and Efficiency program, sees great promise in the law's efforts to move health care delivery away from the fee-for-service payment system.

AMA: If you look at a lot of the data we have about innovators, especially those that have been able to show significant impact on the triple aim—impacting the health of a population, impacting the quality of care and services that are provided to that population, and really impacting and lowering the costs of care—most if not are able to do this in a context where they have been able to creatively work with their payers to design new payment systems that allow them the flexibility of designing care models for their population. Which means, usually, capitation, so they're given a fixed amount of dollars and they decide how to use resources to design models of care.

Dr. Patel argues that—for health care providers to be held accountable for their performance--they need more meaningful data to understand how their decisions impact health outcomes as well as the bottom line.

KP: I personally have very little idea what I do every day and how that affects patients' care and outcomes. I get meaningless quarterly reports, with bar charts showing among those of my patients who should be getting mammograms, here's the percentage that do. That means nothing to me in terms of changing my strategy with patients in the room with me. If providers are in private practice, they need to look at how they can negotiate with vendors for IT, with contractors for payment, with private insurers—how to get this information in real time.

Hospitals, too, need to ramp up their information systems to be prepared for payment models based on the value of care provided.

KP: I have yet to meet a hospital CEO that does not talk about quality without talking about their IT system. They are retrofitting their electronic health records, spending millions to focus on measuring quality. There's a very interesting model at Mt. Sinai using RFID, tracking devices that allow patients to be monitored throughout the system. You can see: here's a delay in this patient getting antibiotics. They are supposed to get them within 60 minutes; it took this patient 82 minutes, so what's happening?

The Affordable Care Act also tries to promote higher-value care through "accountable care organizations" in which hospitals and other providers take joint responsibility for the overall care of a group of patients, and receive shared savings from meeting quality and cost goals. But how can providers prepare to work under such radically different circumstances? Kavita Patel:

KP: I would say that ACOs to most providers represent this great idea in theory that they don't fully understand. The most common question I've heard about this is: how do we find a real one? The promise of ACOs is integration of providers across settings—to get them in room and sit down and look at panel of patients—who are the most expensive; who are coming into the ER more than average, then create an ACO around some of those concepts.

Health reform also created the Center for Medicare and Medicaid Innovation, which will fund pilot programs by hospitals and other health care providers to test new payment and system delivery models.

KP: The reason \$10 billion stayed in the Affordable Care act for the Center for Medicare and Medicaid Innovation is to allow flexibility to do things in real-time settings. One concrete example: there's a lot of interest in having CEOs of health systems step forward and say in their intensive care units they will report medical errors in real time; they are willing to do that and be transparent about it as long as the innovation center will help support whatever it is they need to do to monitor and improve, and not necessarily penalize people for coming forward and admitting errors. It's not just giving someone money but actually changing behavior. Hopefully that's how you'll spread from whatever Center for Medicare and Medicaid Innovation funds to the rest of the nation.

What else can providers do to flourish in the era of health care reform? Anne-Marie Audet:

AMA: If really the goal is to have a high performance health system, many other things need to happen. We now have the law, we have regulations, but we know we need to have intrinsic motivation to change. Fundamentally there is a lot that the professions—nursing, physicians, pharmacy, social workers—can do to look at how they are going to work together. They all play key roles in putting together care plans and operationalizing the care we want.

For more analysis of the Affordable Care Act, visit the Fund's Health Reform Resource Center.

