Leadership Council of Aging Organizations

ISSUE BRIEF
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BUILDING ON HEALTH DELIVERY SYSTEM REFORMS:
POTENTIAL FOR MEDICARE SAVINGS, BUT MUST BE DESIGNED WITH BENEFICIARIES IN MIND

BACKGROUND:

One of the main goals of the Affordable Care Act (ACA) is to implement new health delivery reforms that would bend the health care cost curve. According to ACA architects, realigning the delivery system to drive out inefficiencies in the health care system will reduce costs and improve quality of care. The ACA, therefore, established five priority areas for delivery system reform: (1) payment reform; (2) primary and preventive care; (3) measuring and reporting quality; (4) administrative simplification; and (5) health information technology.[1]

There is tremendous potential for improved care and cost savings from these priority areas of health care delivery system reform. Innovation in these areas can drive "virtuous cycles" of improvement in care, efficiency in delivery, transparency in information, and reduction in cost. Various studies that have looked at the collective potential for health care savings from such strategies have arrived at annual savings as high as $700 billion to $1 trillion.[2] Reforms, however, must take into account the special considerations of the beneficiary population if they are to deliver on promised efficiencies and cost savings while not sacrificing needed care or positive outcomes.

Payment Reform*:* Most health reimbursement is currently based on volume of services provided. The ACA introduces payment reforms for individual physicians and for larger, organized health care systems, ranging from bundled payments to payment adjustments for hospital-acquired conditions.[3] Empirical evidence shows that payment structures such as these improve care delivery, costs, and quality.[4]

Primary and Prevention Care*:* The ACA includes a number of reforms that realign incentives toward prevention and reinforces the role of primary care providers. These provisions include: the Community Transformation Grant program (§4201), the Community-Based care Transitions program (§3026) and a program to fund community health teams to support the development of primary care practices into medical homes (§3502). In addition, the Center for Medicare and Medicaid Innovation (CMMI) (§3021) is administering the Comprehensive Primary Care Initiative, a program to strengthen primary care practices and help primary care doctors deliver better-coordinated care.[5] Under this initiative, the Centers for Medicare and Medicaid Services (CMS) is working with public and private payers to offer a bonus payment or monthly care management fee to participating primary care doctors who coordinate care for their Medicare patients. When targeted effectively at high-risk patients and preventable, high-cost events, such efforts can reduce total health care costs.[6]

Quality Care*:* Data shows that the health system has significant opportunities for quality improvement in areas such as chronic disease management, prevention, safety, efficiency, and patient experience.[7] The ACA includes incentives for high-performing physicians and hospitals, and quality measurement and improvement are key components to ACA payment and

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[1] A Report from Senator Sheldon Whitehouse for the U.S. Senate Committee on Health, Education, Labor & Pensions (HELP), *Health Care Delivery System Reform and The Patient Protection & Affordable Care Act* (March 2012), p.6. http://www.whitehouse.senate.gov/imo/media/doc/Health%20Care%20Delivery%20System%20Reform%20and%20The%20Affordable%20Care%20Act%20FINAL2.pdf

[2] See, Institute of Medicine. (2011, February 24). The healthcare imperative: Lowering costs and improving outcomes – Workshop series summary. Washington, DC: National Academies Press; Simon, C., Wolcott, J., & Hogan, P. (2009, October 26). Can we reduce health care spending? Searching for low-hanging fruit in the garden of health system reform.

[3] See Patient Protection and Affordable Care Act (Pub. L. 111-148) §§ 2702, 2704, 2705, 2706, 2707, 3001, 3006, 3008, 3021, 3022, 3023, 3025, and 3403. (2010).

[4] *See*, Senate HELP Committee Report, p. 6.

[5] *See*, Senate HELP Committee Report, p.8.

[6] Reid, R., Coleman, K., Johnson, E., Fishman, P., Hsu, C., Soman, M., Larson, E. (2010). The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. *Health Affairs, 29*(5), 835 – 843.

[7] Institute of Medicine. *Crossing the quality chasm: A new healthy system for the twenty-first century* (2001)

care coordination reforms.[8] To improve consistency and address gaps in quality measurement, the ACA includes provisions to identify, update, and expand health quality measures; to publicly report these efforts; and to develop strategic plans for health care quality.

Administrative Simplification*:* Easing the administrative burden on health care providers, particularly the back and forth between providers and Medicare contractors, can reduce costs and improve efficiency in the health care system. The ACA promotes uniform electronic communication between providers and contractors for the purposes of patient eligibility verification, claims status inquiries and payment, and referral authorization requests, among other functions.[9]

Health IT*:* Health information technology (IT) will radically transform the health care industry, and is the essential, underlying framework for health care delivery system reform. The ACA's payment reforms, pilot projects, and other delivery system reforms are built with the expectation of having IT-enabled providers. In particular, the shift to new models of care, like Accountable Care Organizations (ACOs), will rely heavily on having providers "online" to transfer information and patient records, and report quality measures.[10] Health IT will enable health providers to update vital information in real time; access the best practices, treatment information and strategies; and keep patients better informed and engaged.

OUR POSITION:

Payment Reform: LCAO supports efforts to promote efficiencies and decrease waste, fraud and abuse within provider reimbursement. Yet, too deep cuts could cause access issues and provide disincentives from providers participating in federal health care programs like Medicare and Medicaid. **Any proposed payment reforms should not limit patients' access to necessary health care services.**

Primary and Preventive Care: LCAO supports efforts to extending primary care services and providing preventive care services with no copayment requirements to Medicare beneficiaries. Still, **more outreach and education needs to be conducted to inform Medicare beneficiaries of these benefits and encourage their utilization. In addition, such concentration on primary care cannot and should not diminish access to specialty or post-acute care** services that provide care to millions of Medicare beneficiaries.

Quality Care*:* LCAO supports adoption of quality metrics and comparable measurement tools to allow Medicare beneficiaries to make decisions based on quality of care**. Such tools, however, must be user-friendly and accessible to Medicare beneficiaries, some of whom do not have computer capabilities or the ability to go online. The development of quality metrics and standards must also be improved, particularly for vulnerable populations such as those with multiple chronic conditions or functional impairments.**

Administrative Simplification: LCAO supports provisions in the ACA to create administrative simplification for health providers. **Adequate safeguards must be taken, however, to ensure simplification does not make it easier for bad actors to participate and defraud the program.** Providers, however, can't use administrative simplification as an excuse to rollback important and necessary regulations that protect the consumer. **As rules are simplified, therefore, it's important to maintain these important consumer protections.**

Health IT: Technology has the potential to lower costs and increase efficiencies. Yet, **health information and senior personal data needs to be protected and shielded** from hackers, scammers and identity thieves. There needs to be proper safeguards in place to ensure Health IT security and **meaningful procedures need to be developed if such security is breached** and personal health information or other data is compromised.

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[8] *See*, Senate HELP Committee Report, p.8.
[9] *See*, Patient Protection and Affordable Care Act (Pub. L. 111-148) §§ 1104, 1413, and 6105. (2010).
[10] *See*, Senate HELP Committee Report p. 9.