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# Chapter 8: State Efforts Improve Quality, Contain Costs and Improve Health

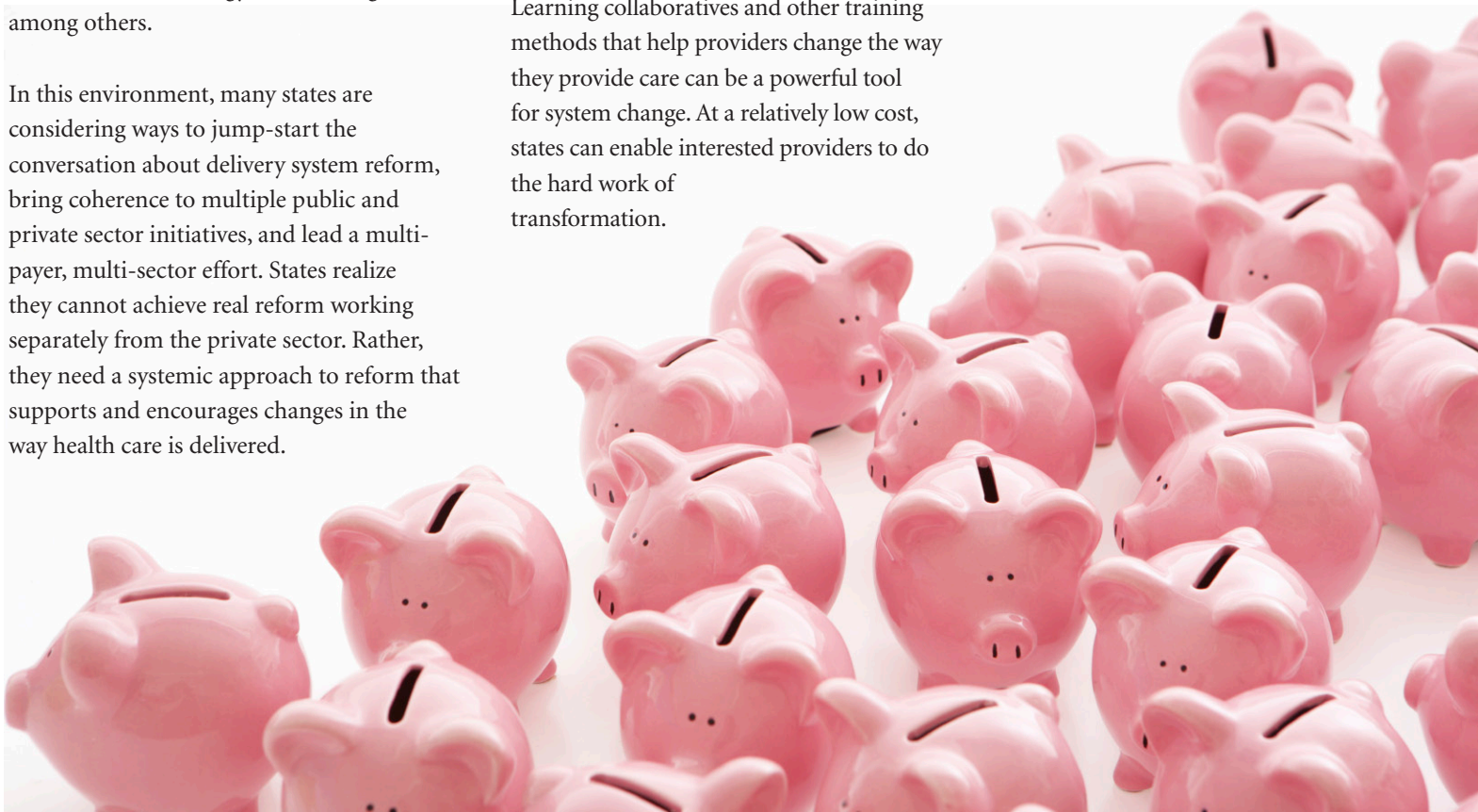
Health care costs continue to escalate in both the public and private sectors. In addition, more information is available showing that much of the health care system is not delivering high quality care in an efficient manner. Finally, there is growing recognition that not only should improved population health be a goal in and of itself, but can lead to a moderation in the overall health cost increase trend. As such, states are undertaking a set of strategies to redesign the delivery system, reform related payment structures, and improve the health of their populations. These efforts include patient-centered medical homes (PCMHs), accountable care organizations (ACOs), payment reform, increased transparency and reporting requirements, population health initiatives, and the adoption of health information technology and exchange, among others.

In this environment, many states are considering ways to jump-start the conversation about delivery system reform, bring coherence to multiple public and private sector initiatives, and lead a multi-payer, multi-sector effort. States realize they cannot achieve real reform working separately from the private sector. Rather, they need a systemic approach to reform that supports and encourages changes in the way health care is delivered.

There are several different roles that states can play in these efforts. They include:

- *Identifying Priorities:* Leadership from the governor's office, cabinet secretaries, or state legislature can send a strong signal to stakeholders about which issues are going to be areas of focus for the state.
- *Influence and Purchasing Power*: State agencies can bring powerful support to priority issues, lending staff and expertise. Their purchasing power can also be leveraged to bring strength and momentum to state-led initiatives.
- *Convening Stakeholders*: The state can bring different parties together, particularly for all-payer initiatives, and coordinate efforts.
- *Coordinating Learning Collaboratives*: Learning collaboratives and other training methods that help providers change the way they provide care can be a powerful tool for system change. At a relatively low cost, states can enable interested providers to do the hard work of transformation.
- *Integrating Different Initiatives*: Many states have a variety of public and private delivery system reform efforts underway at the same time. The state can serve a vital role in bringing these initiatives together, and coordinating their activities to reduce inefficiencies and administrative costs for both providers and plans.

The Patient Protection and Affordable Care Act (ACA) includes funding for many of the delivery system changes states were already contemplating. It also promotes increased data collection and a move to allow the Medicare program to be more innovative in its payment models (in some cases, Medicare will be able to participate



in state-led initiatives). The ACA creates a landscape where states can take the lead in implementation, designing initiatives that best account for their environments, while the federal government will provide support, financial incentives, and some regulation of these efforts.

## STATE QUALITY IMPROVEMENT INSTITUTE

For the last several years, many states have been faced with budget difficulties due to the recession, and have been forced to look closely at their health care delivery system to find potential savings. Some of these states have made a commitment to increasing the quality of care delivered, with more coordination across delivery sites, in an effort to drive down costs, especially among the population suffering from chronic diseases. These individuals stand to benefit considerably from more coordinated care, which also can decrease the costs borne by the state.

Throughout 2009 and 2010, a number of states worked together to learn about, design, and implement systemic changes under the auspices of the State Quality Improvement Institute (SQII), a technical assistance partnership between The Commonwealth Fund and AcademyHealth. Eight states—Colorado, Kansas, Massachusetts, Minnesota, Ohio, Oregon, Vermont, and Washington—from a variety of geographic locations and with different levels of previous experience with system change participated.

Participating states developed, refined, and began implementing action plans around specific improvement strategies. The action plan process allowed states the opportunity to bring various stakeholders together and have candid discussions about a strategic vision for the state. States identified priority issues, and engaged stakeholders from various communities (e.g., providers, payers, patients) to establish a plan to address those issues.

In general, states changed their focus from more granular reforms to broader delivery system redesign efforts. This shift reflects the notion that in order to have a meaningful impact on costs and quality, the reforms pursued and put in place need to move beyond small-scale process measures and take a more holistic look at the delivery system, leveraging existing efficiencies, and using state leadership to identify and pursue strategies for meaningful, systemic reform. Important strategies under way in the eight participating states include implementation of medical homes and care coordination initiatives; adoption of population health programs to reduce chronic disease risk in the community; enhanced chronic disease management to improve outcomes and avoid costly hospitalization and avoidable re-hospitalization; and use of data for performance improvement, public reporting, and program evaluation.

## PATIENT-CENTERED MEDICAL HOMES

All states participating in the SQII, in addition to a number of other states, have identified patient-centered medical homes (PCMHs) as one potential delivery system reform that can result in better coordinated, more efficient care. More than 30 states have engaged in efforts to implement programs to advance medical homes in Medicaid/CHIP programs, and states working across payers on these initiatives include Colorado, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia.

In 2008, the American Academy of Family Physicians (AAFP) defined a PCMH as a practice that "integrates patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of the preventive, acute, and chronic needs of patients using the best available evidence and appropriate technology."[1] While many states use this definition in their PCMH initiatives, some states, such as Maryland,[2] Minnesota,[3,4] New Mexico,[5] and Ohio[6] have moved beyond the AAFP definition to include other providers of primary care, including physicians assistants or nurse practitioners, as possible leaders of PCMHs.

While early iterations of medical homes rewarded providers for achieving various process measures (best exemplified by the NCQA standards),[7] there is a trend among states to move beyond process measures for medical homes and to focus on outcome measures. Often, outcome measures can be linked to overall cost reductions and reductions in preventable hospital and emergency room visits. Minnesota and Oregon both have defined medical homes beyond NCQA standards to focus on outcomes.

*Federal Activities:* The ACA builds on this state-led momentum in important ways: the law creates the Center for Medicare and Medicaid Innovation (CMMI), and offers several important grant opportunities to states in support of more widespread PCMH planning and implementation. CMMI will test different payment and delivery system reforms designed to reduce costs and increase the quality of care. It will have flexibility in the selection of pilot programs, and those pilots will not have to be budget-neutral during the initial phases. Congress has appropriated $10 billion through 2019 to pursue these projects.[8] Patient-centered medical homes have been designated by ACA as an area of innovation in which CMMI should invest.

An additional hurdle faced by state multi-payer pilots has been the lack of participation from Medicare. On September 16, 2009, Secretary Sebelius announced that the Centers for Medicare & Medicaid Services (CMS) will develop a demonstration project that will enable Medicare to participate in state-based "Advanced Primary Care (APC) models," also known as medical homes. On November 16, 2010, the eight states selected to participate in this demonstration project were announced: "Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota will participate in the Multi-Payer Advanced Primary Care Practice Demonstration that will ultimately include up to approximately 1,200 medical homes serving up to one million Medicare beneficiaries."[9]

For the states selected to participate in the demonstration, Medicare will provide an enhanced payment to participating practices for their Medicare patients. In order to quality for the demonstration, the selected states had to have medical home programs underway that:

- Were conducted under state auspices;
- Had promotion of the APC model as its central purpose;
- Included Medicaid and substantial participation by private health plans;
- Had substantial support by primary care providers;
- Included mechanisms for community support of participating practices; and
- Were coordinated with state health promotion and disease prevention efforts.[10]

Additionally, the ACA has several provisions that specifically promote patient-centered medical homes, including the following:

- Section 2703 creates a new Medicaid option to provide certain chronically ill beneficiaries with PCMH services. Such services can include comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and use of HIT. The section authorizes waivers of the statewideness and comparability requirements[11] that normally apply to Medicaid. Beginning in January 2011, HHS is directed to give states up to $25 million in planning grants. During the first eight quarters of a state's implementation of this option, the federal government pays 90 percent of the cost of PCMH services.
- Section 3502 authorizes HHS grants to states to develop community health teams to support the PCMH model. These teams support primary care physician practices who, by themselves, may not be equipped to perform the full set of PCMH functions.
- Section 5405 authorizes $120 million in annual funding, during 2011 and 2012, to establish a system of educating primary care providers about new models of practice, including the patient-centered medical home. This section creates a "Primary Care Extension" program that will operate through state and regional hubs, with local "extension agents."[12]

## TRANSITIONS OF CARE

Within the process of care delivery, transitions of care—when a patient moves out of one care setting and into another—have been identified as a priority by the federal government and states. Well-functioning transitions of care can reduce preventable hospital readmissions, and lead to improved outcomes for patients.

The STate Action on Avoidable Rehospitalizations (STAAR) initiative is an Institute for Healthcare Improvement (IHI) technical assistance offering initially working in three states: Massachusetts, Michigan, and Washington.[13] In 2010, Ohio became the fourth state to participate in the initiative. STAAR engages clinicians and other providers across varied delivery sites (starting with a hospital-based team, individuals from nursing facilities, ambulatory practices, home health agencies, and patients and family caregivers) with the goal of improving quality of care, the patient experience, and reducing avoidable utilization through a multi-stakeholder process to reduce rehospitalizations. The initiative focuses on the following elements for improvement:

- Assessment of post-discharge needs;
- Teaching and learning;
- Communication at discharge; and
- Timely post-acute follow up.[14]

Using the state as the unit of intervention, STAAR's approach is to provide technical assistance to front-line teams of providers working to improve the transition out of the hospital, as well as improving the reception of the patient into the next setting of care. STAAR's focus on this component of the transition separates it from other interventions, which mainly seek to enhance transitional services offered by the hospital.

Amy Boutwell, director of health policy strategy at IHI and the co-principal investigator of the initiative, explains that STAAR's multi-tiered strategy requires working at the hospital, community, and state level. Dr. Boutwell notes that at the hospital level, elements of the STAAR initiative include: improving the transition out of the hospital for all patients, measuring and tracking 30-day readmission rates, and understanding the financial implications of reducing rehospitalizations. At the community-level, STAAR engages organizations across the continuum to collaborate on improving care, partners with non-clinical community-based services, addresses the lack of IT connectivity, clarifies who "owns" coordination, engages patient advocates, and ensures that post-acute providers are able to detect and manage clinical changes. STAAR also develops common communication and education tools. Finally, at the state level, STAAR works to develop population-based rehospitalization data, convene all-payer discussions to explore coordinated action, link with efforts to expand coverage, engage patients, improve HIT infrastructure, establish medical homes, contain costs, and establish a state strategy, using regulatory levers.[15]

While the STAAR initiative is just one example of an on-going care transition program, it provides a strong model for states to consider as they seek to improve transitions of care for patients. States can also learn from the ongoing Medicare demonstration, the Community-Based Care Transition Program,[16] and other leading care transitions programs.[17]

*Federal Activities:* As part of the ACA, Medicare will begin implementing its Community-Based Care Transitions Program in 2011, and the demonstration will run for five years. This program provides "$500 million to collaborative partnerships between hospitals and community-based organizations designed to meet the goal of implementing evidence-based care transitions services for Medicare beneficiaries at high risk for hospital readmission."[18]

## HEALTH INFORMATION TECHNOLOGY AND HEALTH INFORMATION EXCHANGE

A considerable amount of energy and resources are focused on health information technology (HIT) and health information exchange (HIE) at both the state and federal level. The federal Office of the National Coordinator (ONC) has provided numerous opportunities to states through the American Recovery and Reinvestment Act (ARRA), which was signed into law February 17, 2009. The HITECH (Health Information Technology for Economic and Clinical Health) Act within ARRA provides states with substantial funding to support health information technology investment.

Some states, like Massachusetts, already had legislation or strategic plans in place to support the adoption of HIT before the passage of these federal provisions. In 2008, the state passed Chapter 305, a bill to promote "cost containment, transparency and efficiency in the delivery of quality health care, and include a goal to implement electronic health records (EHR) in all provider settings by the end of 2014."[19] This legislation positioned the state to begin the process of creating an organizational structure to support HIT. That structure includes the establishment of Massachusetts eHealth Initiative (MeHI) to coordinate HIT efforts in the commonwealth.

MeHI released its Health Information Technology Strategic Plan in 2010, which outlines Massachusetts' vision, goals, and strategies around HIT; the plan outlines four goals and the six strategies to achieve those goals. Through the use of HIT, Massachusetts hopes to improve access to comprehensive coordinated care, improve the quality and safety of care (using evidence-based decision support applications), slow the growth of spending by taking advantage of the efficiencies created by HIT and its use, and employ health information exchange to undertake population health efforts. Some of the strategies that will be used to achieve these goals include establishing a multi-stakeholder governance structure and a robust privacy framework, implementing interoperable EHRs in all types of clinical settings, developing and implementing a statewide HIE, creating and training a workforce capable of operating in an HIT environment, and monitoring success.[20]

In Oregon, the Health Information Technology Oversight Council (HITOC) was legislatively established in 2009. HITOC is the coordination body for Oregon's public and private efforts to support HIT and HIE statewide. "[HITOC] is charged with developing a statewide strategic plan for electronic health information exchange, coordinating public and private efforts to increase adoption of electronic health records, setting technology standards, ensuring privacy and security controls, and creating a sustainable business plan to support meaningful use of health information technology to lower costs and improve quality of care."[21] There are 11 members of HITOC, all appointed by the governor. Members come from across the state, both from the public and private sector. Additionally, HITOC has created three workgroups—Finance, Legal and Policy, and Technology—that will study these issues in-depth and deliver recommendations to the full Council in September 2011. The council has an active Consumer Advisory Panel, reflecting the state's recognition that, in order to have a successful HIE, the public has to be willing to consent to having their data shared.[22]

Rhode Island is another leading state in implementing a statewide HIE. The state received a $5 million demonstration contract from the Agency for Healthcare Research and Quality to design and implement a statewide HIE, called current*care*. Individuals voluntarily sign up for the program. At that time, their medical information—currently only lab results, although the system will expand to include more information—can be shared across authenticated providers in the state through a secure HIE network. Only providers involved in delivering ongoing care to specific patients can access their medical record, except for the case of emergencies, in which any doctor providing care will be allowed access. Patients can request to see the log of providers who have viewed their information, adding an extra layer of engagement and oversight to the system.[23]

While these are just a few of the states that have developed HIT and HIE infrastructures, all states are in the process of undertaking such work, and the federal government has awarded funding to the states to support these efforts. In February and March 2010, ONC announced funding to all 50 states, the District of Columbia, and eligible territories through the State HIE Cooperative Agreement Program. Some states elected for the funding to be awarded to a state-designated entity, as opposed to a state agency. This program is designed to support states as they develop the capacity necessary to exchange information within their state and across states.[24]

The application process required states to identify a state HIT coordinator, who will have a leadership role in the design and development of HIE in their state. Participating states will also be expected to use their authority and resources to:

- Develop and implement up-to-date privacy and security requirements for HIE within and across state borders;
- Develop state-level directories and technical services to enable interoperability within and across states;
- Coordinate with Medicaid and state public health programs to enable information exchange and support monitoring of provider participation in HIE;
- Remove barriers that may hinder effective HIE, particularly those related to interoperability across laboratories, hospitals, clinician offices, health plans and other health information exchange partners;
- Ensure an effective model for HIE governance and accountability is in place; and
- Convene health care stakeholders to build trust in and support for a statewide approach to HIE.[25]

States then developed and submitted strategic plans about the design, implementation, and evaluation of their HIEs to the ONC. ONC will work closely with the states over the coming years, offering "program direction and technical assistance to help recipients in advancing HIE across all providers, as well as in enhancing the effectiveness and relevance of the state HIE initiatives to local and national health improvement goals."[26]

For example, New York's eHealth Collaborative (NYeHC) works with the New York Department of Health to develop common policies, standards, and technical approaches for the state's HIT efforts. As of December 2010, New York has 12 regional health information organizations (RHIOs) across the state; the state has announced plans to link together these existing regional exchanges with some new infrastructure, creating the country's largest HIE. "The proposal was submitted to the Office of the National Coordinator for Health Information Technology (IT). It presented an outline for the use of $129 million in state and federal funds in building and implementing a statewide HIE network that could potentially serve hundreds of hospitals, thousands of providers and more than 20 million patients a year."[27]

HIEs are highly dependent upon the availability of patients' medical records in electronic form. In order to support the expansion of EHRs, Medicaid and Medicare providers are eligible for financial incentives to support their adoption and meaningful use. The incentives can be as high as $44,000 (through Medicare) and $63,750 (through Medicaid) per clinician. In order to qualify for these enhanced payments, clinicians must use EHRs to improve the quality of the care they deliver as evaluated by both process and outcome measures. They must incorporate the meaningful use elements at rates set by the federal government in order to qualify for the incentive payments, and will have to report data about their quality of care, which will eventually be available to the public.[28]

On July 13, 2010, ONC released its final regulations defining the meaningful use of electronic health records (EHRs). The meaningful use elements were classified into core objectives and additional tasks. This delineation was made in response to comments from stakeholders that the requirements in the initial rule were too difficult for providers to meet within the timeline provided. Core objectives are basic tasks and functions of an EHR that allow for its use to support improvements in the delivery of care.

"As a start, these include the tasks essential to creating any medical record:

- Entry of basic data including patients' vital signs and demographics, active medications and allergies, up-to-date problem lists of current and active diagnoses, and smoking status;
- Using clinical decision support software and tools designed to improve the safety, quality, and efficiency of care through better decision making by clinicians and avoidance of preventable errors;
- Using EHRs to enter clinical orders and medication prescriptions; and
- Providing patients with electronic versions of their health information."[29]

Beyond these core objectives are the additional tasks created by the final rule. Providers will choose five tasks from the list of 10 that they then will implement in 2011 – 2012. The hope is that this flexibility in implementation and "meaningful use" requirements will allow more providers to meet the requirements of the final rule within the required timeline.

## VALUE MEASUREMENT AND TRANSPARENCY

For a many years, various states have been collecting data to measure health plan and provider (primarily hospital and nursing home) performance and disseminating that information to the public. The primary focus has been twofold: to educate consumers and employers in order to help them be more savvy purchasers and users of health care, and to encourage internal quality improvement on the part of health plans and providers. Increasingly, states are concentrating on transparency and reporting of health care cost and quality information as part of their delivery system reform efforts, including a focus on the use of all-payer claims databases (APCDs) to support broad data collection and analysis (**see the box titled "All-Payer Claims Databases"**). While the following information about several states comprises only a small number of examples of activities that states have underway, they illustrate how measurement is critical for quality improvement efforts.

## All-Payer Claims Databases (APCDs)

While there is a wide range of ongoing efforts in states focusing on ways to increase transparency, an APCD is a data-collection tool that is increasingly gaining interest among state policymakers and has considerable potential to inform the health care delivery process.

The National Association of Health Data Organizations (NAHDO) and the APCD Council (formerly the Regional All Payer Healthcare Information Council) have defined APCDs as "databases, created by state mandate, that typically include data derived from medical, eligibility, provider, pharmacy, and/or dental files from private and public payers."[30] The information available through APCDs is valuable to an array of stakeholders, including policymakers, consumers, employers, providers, health plans/payers, and researchers.

*Policymakers* (Medicaid, public health agency, insurance department, etc.)

- Helps health care policymakers identify communities that provide cost-effective care and learn from their successes.
- Allows for targeted population health initiatives.
- Allows for assessment of health care disparities and for targeted interventions.
- Informs the design and evaluation of payment reform models, including medical homes and accountable care organizations.

*Consumers*

- Provides access to information, helping consumers and their health care providers make informed decisions about the cost and quality of care.

*Employers*

- Helps businesses know where they stand when compared with their peers, with respect to the cost and covered services of their health insurance policies, and to work with plans to improve the available options.

*Providers*

- Supports provider efforts to design targeted quality improvement initiatives.
- Enables providers to compare their own performance with those of their peers.

*Health Plans/Payers*

- Helps identify utilization patterns and determination of rates.
- Assists with benefit design and planning.

*Researchers* (public policy, academic, etc.)

- Fills the void of information from the most common setting of care (primary care) and for the majority of the population (those with commercial insurance).[31]

Eleven states had existing APCDs as of November 2010 (Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Tennessee, Utah, Vermont, Washington, and Wisconsin).[32] Two (Colorado and Oregon) are in the implementation stage, and a number of others have expressed a strong interest in the concept. One state, Rhode Island, has legislation enacted but no funding.[33]

There are several different governance structures states have used when creating APCDs. In Maine, an independent executive agency, the Maine Health Data Organization, was established to oversee and run the state's APCD. New Hampshire is an example of a state with shared authority between the Department of Health and Human Services and the Department of Insurance. In other states, like Massachusetts and Tennessee, the APCD resides in an existing government agency that is related to the state's hospital reporting process. Vermont houses its APCD in its Department of Banking, Insurance, Securities, and Health Care Administration—the agency that has oversight of carriers in the state.[34]

*Colorado:* Colorado has established the Center for Improving Value in Health Care (CIVHC) after recognizing the need for system-wide reforms to its health care system. It focuses on enhancing the consumer experience of the health care system, improving quality, containing costs, and improving overall population health. One of the specific goals recommended by its Data and Transparency Advisory Group is to "increase transparency and accountability in Colorado's health care system by making comparative cost, quality and safety data for all providers, health plans and medical facilities available to consumers and businesses statewide."[35]

CIVHC has been leading that state's efforts to develop an all-payer claims database which will allow the Center to meet one of its legislative charges to "… collect, aggregate, distribute, and publicly report performance data on quality, health outcomes, health disparities, cost, utilization, and pricing in a manner accessible for consumers, public and private purchasers, providers, and policymakers."[36]

*Massachusetts:* In its *Massachusetts Health Care Cost Trends 2010 Final Report*, the Division of Health Care Finance and Policy (DHCFP) presented both immediate and long-term strategies to address health care cost growth in that state. The long-term framework included five approaches:

- Oversight and direction provided by an independent public entity;
- Payment reform involving all payers;
- Support for health care delivery system redesign and system-wide adoption of health information technology;
- Transparency of cost and quality information; and
- Investment in evidence-based public health and wellness initiatives.[37]

In addition to efforts to implement an all-payer claims database, other examples of work in Massachusetts related to data transparency and performance measurement include the publication of a quarterly report presenting an overview of that state's health care landscape using information collected from providers, health plans, and government agencies and through individual and employer surveys as well as three new reports about preventable/avoidable emergency department use, potentially preventable hospitalizations, and primary care supply and access in Massachusetts.[38]

David Morales, Commissioner of DHCFP, notes that the Division's two key objectives this year are to "continue to produce reputable, transparent, high-quality work that demystifies the [Massachusetts] health care delivery system and informs discussions about health care costs and quality at all levels, and publish the Division's information in a manner that is easily accessible, readable, and understandable to a broader audience."[39]

*Minnesota:* For several years, Minnesota has been using data collection and reporting to support a variety of legislatively required activities including public reporting of a standardized set of quality measures for hospitals and physician clinics, payment for care coordination, developing the definitions of a variety of "baskets of care," consumer engagement strategies, and the creation of a provider peer grouping system.[40]

Minnesota is using its all-payer claims database to support its provider peer grouping initiative.[41] The state's goal is to have the information it obtains through this peer grouping program incent providers to improve their quality, for health insurance companies to create products that reward consumers for choosing providers that deliver high quality care at a low cost, and to allow consumers public access to the information, so they can choose high quality, low cost providers. Minnesota is providing information on total care as well as for care related to specific conditions (pneumonia, diabetes, asthma, coronary artery disease, total knee replacement, and heart failure). Using quality measures, utilization of health services data and pricing information are collected and analyzed. The state reviews the data, and initially releases it to provider practices, allowing them to review their data and grouping for accuracy. Practices will have the opportunity to appeal to the state, if they feel that the data are inaccurate. After this confidential review period, the information will become publicly available. Total care reports will be shared with providers in the summer of 2011, and will be public by the end of 2011. Condition-specific care reports will be shared with providers in the fall of 2011, and will also be publicly available by the end of 2011.[42]

*Ohio:* The Ohio Health Care Coverage and Quality Council was created initially by former Governor Ted Strickland through an executive order and subsequently was established legislatively in July 2009.[43] Its charge is to improve the coverage, cost, and quality of Ohio's health insurance and health care system. To accomplish those goals, it set up four task forces focused on payment reform; medical homes; consumer engagement, and health information technology. (Note: The Council added an additional task force on health benefit exchanges following the enactment of the ACA.) All of the consequent activities that underpin the delivery and payment system reforms envisioned by the Council are supported by performance measurement and the increased use of data. For example, at its recent Payment Reform Summit, participants agreed that "…payment reform should be accompanied by greater transparency and public reporting of data."[44] In addition, the Multi-Payer Enhanced Primary Care Work Group developed recommendations for the evaluation metrics to be used for measuring improved quality of care and for strategies to most appropriately engage consumers in their medical homes.[45]

*Federal Activities:* The ACA includes several provisions that will support additional efforts to increase transparency. The federal law has the potential to increase the amount of information publicly available that can be leveraged by states to improve quality and reform their delivery systems:

- *Performance measures for both providers and plans.* Sections 3013 through 3015 of the ACA direct HHS to establish performance measures of quality and efficiency for plans and providers, to collect such data, and to make them publicly available.
- *Physicians.* Sections 3002, 10327, 10331, and 10332 of the ACA strengthen the current system for evaluating quality and efficiency of physician performance under Medicare, giving physicians increased financial incentives to participate in that system, and making information available to consumers on a "Physician Compare" website operated by HHS. Information from other payers can be incorporated into this system, which HHS is authorized to extend to other providers.
- *Hospitals.* Section 3001 establishes a pay-for-performance system for Medicare hospitals, through which quality and efficiency are rewarded with higher payment levels and the public learns about hospital performance on HHS's "Hospital Compare" website. Section 3025 adds to this website information about the rate at which patients served by particular hospitals are re-hospitalized soon after discharge. In addition, the new Public Health Service Act §2718(e), added by ACA Section 10101(f), requires hospitals to inform the public about their standard charges, as defined by HHS.
- *Health Plans.* ACA Sections 2713(e)(3) (added by Section 10104), 2715A (added by Section 10101), 2717, and 2718 require health plans (including self-insured group plans) to provide a broad range

of public information. These provisions require disclosure, in plain language, of claims payment policies, enrollment and disenrollment statistics, claim denial rates, rating practices, in-network and out-of-network cost-sharing, medical loss ratios, and initiatives to reform health care delivery through care coordination, management of chronic illness, prevention, and other measures that improve health outcomes. Section 2715 requires health plans to describe covered benefits and out-of-pocket costs using an easily understood, readily-compared format developed by HHS.

- *Medical Reimbursement Data Centers.* New Public Health Service Act Section 2794(c)(1)(C) and Section 2794(d), added by ACA Section 10101(i), provide for the establishment of Medical Reimbursement Data Centers. Such Centers can be funded from the ACA's $250 million appropriation slated for building state capacity to analyze insurance premiums. These new data centers are either academic or nonprofit institutions that collect, analyze, and report information about local payment rates, including information to help consumers understand the amounts that health care providers charge for particular services.[46]

## PUBLIC HEALTH

Many states are considering what the role of public health will be in a transformed health system. Likewise, particularly in light of health reform efforts, there is an acknowledgement that the public health system should leverage the ACA to effectively and strategically partner with the health care system to improve access to quality, affordable, and integrated care while also promoting chronic disease prevention and improving the population's health. The challenges presented by an unhealthy population with staggering levels of preventable chronic diseases such as diabetes and heart disease are prompting states to reconsider how public health systems should be structured to help individuals adopt healthier lifestyles. There is also a greater emphasis on encouraging policymakers to implement policies based on the best available evidence.

Colorado and Washington are examples of two states that are working toward transforming their public health efforts, approaching them from a more systemic perspective. The state of Washington has recently undertaken a new initiative—*The Agenda for Change*—focused on reshaping the governmental public health system in the state. The agenda has three primary pillars:

- Assure that the most effective and important elements of prevention, early detection, and swift responses are incorporated into the state's communicable disease capacity.
- Encourage policy and system efforts to foster communities and environments that promote healthy starts and ongoing wellness.
- Effectively and strategically partner with the health care system.

The *Agenda* is the state's strategic road map, showing how various agencies within the Department of Health unify and connect to local, state, and federal partners, as well as to private sector partners. The key elements guiding the new way in which the department conducts business include retraining the public health workforce, modifying and modernizing business practices, and developing long-term strategies for predictable and appropriate levels of financing. [47]

Colorado is one of four states across the country testing a chronic disease prevention integration model under a demonstration project through the Centers for Disease Control and Prevention (CDC). One of the most significant strategies that the state has pursued under this project is moving away from "categorical" approaches (e.g., tobacco; HIV). The Department of Health and Environment is structuring its Prevention Services Division around functions rather than disease categories to allow the flexibility to respond to emerging public health issues that cross categorical program boundaries. A new branch has been established to develop and implement policy and environmental change related to tobacco use and obesity. Additionally, a new Health Systems Unit was also developed to respond to ACA and the need to identify the public health role in the new environment of health reform. This unit is taking a comprehensive approach to health outcomes and incorporating similar practices that are used by private sector plans.[48]

*Federal Activities:* The ACA contains a wide array of provisions related to public health promotion, and many grant opportunities for states.[49] States will need to think strategically about applying for such grants, and closely monitor the dates associated with each opportunity, in order to ensure that they are well-positioned to apply for the available funding. Some of these opportunities include:

- *Medicaid Chronic Disease Incentive Payment Program*—HHS will award grants to states to test approaches that may encourage behavior modification for healthy lifestyles among Medicaid enrollees and to determine scalable solutions. HHS will develop program criteria and will conduct an education/outreach campaign to promote states' awareness of the grant program. $100 million has been appropriated for a five-year period beginning January 1, 2011 (ACA Section 4108).
- *Community Transformation Grants*—A program designed to promote evidence-based community preventive health activities is intended to reduce chronic disease rates and address health disparities (ACA Section 4201).
- *Healthy Aging, Living Well Public Health Grant Program*—Grants for pilot programs to provide public health

community interventions, referrals, and screenings for heart disease, stroke, and diabetes for individuals between ages 55 and 64 (ACA Section 4202).

## CONCLUSION

The ACA includes many provisions to encourage local and regional experimentation and improvement in care delivery. Ultimately, these incentives will only be effective if state and local leaders are able to bring together multiple stakeholders in the health care market to promote positive change. This will require enormous effort. Not only do multiple groups need to be convinced of the need for change, but they must be convinced to move in a similar direction. Much greater coordination among the vast array of existing quality programs will be essential in addition to coming together around new ideas.

States are uniquely well-positioned to lead delivery system reform work. This report outlines several reasons for this, including the unique ability of state officials to take the lead and set priorities, a state's ability to get the attention of and convene stakeholders, its significant regulatory power and anti-trust exemption, and its substantial purchasing power as a buyer of health services. Many states have not taken on this mantel of leadership, letting the market guide the direction of the health care system. But with the new tools in the ACA and the growing sense of urgency caused by continued cost increases, a growing number of states will make use of their considerable power to influence to help achieve delivery system reform. Indeed—as this report shows—many states have done just that.

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