

FOSTERING STATE POLICY TO SUPPORT
INTEGRATED DELIVERY SYSTEMS:
SUMMARY OF A DISCUSSION AMONG
STATE POLICYMAKERS AND DELIVERY
SYSTEM LEADERS

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- **Christopher Koller***, Rhode Island Health Insurance Commissioner
- **Carolyn Lawson**, Chief Information Officer for the Oregon Health Authority
- **Scott Leitz***, Assistant Commissioner of Health Care, Minnesota Department of Human Services
- **MaryAnne Lindeblad***, Assistant Secretary for the Washington Aging and Disability Services Administration
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EXECUTIVE SUMMARY

In 2011, NASHP brought state officials and representatives of leading integrated delivery systems together to discuss key health policy strategies that can foster integrated delivery system development and sustainability in line with state health policy goals. This report summarizes the day's discussions and is intended to help state policymakers understand the potential of integrated delivery systems, identify policy levers for fostering their development, and overcome barriers to success. Each topic addressed during the meeting is introduced with an overview of issues and challenges. Session presentations and discussions are synthesized to offer lessons from current practices in leading integrated delivery systems and state integration initiatives. Summaries of themes and actionable tips as identified by meeting participants are offered for consideration.

Integrated delivery systems are characterized by care delivery and payment methodologies that are aligned to foster highly effective and coordinated care that leads to improved quality and efficiency of health care services. The degree of delivery system integration can be understood in terms of location along a continuum. At one end are single physicians, small group practices and individual hospitals operating independently and coordinating care informally in a fee-for-service environment. At the other end of the continuum is the fully integrated delivery system with an insurance component that employs multispecialty providers and hospitals, such as Kaiser Permanente or Group Health Cooperative. States, and markets within states, will fall at different points along the continuum and may be able to improve quality and lower costs by moving toward greater integration, regardless of the starting point.

As they convened, meeting participants expressed the hope that states and providers working together to structure delivery system innovations can help turn the tide toward achieving the triple aim of improving the experience of health care, improving health status, and containing costs through more integrated, less costly and higher quality care. Based upon their experiences as state and delivery system leaders, participants offered guidance, and emphasized several points they consider to be critical for navigating the path to effective integration of service delivery.

- **Recognize true integration versus aggregation.** States should recognize and demand true integration and not confuse aggregation (e.g., independent provider practices becoming part of a hospital system) with integration. True integration requires synergistic relationships and approaches to meet core dimensions of integrated care.
- **Define a shared vision for increasing statewide delivery system integration.** A shared understanding among stakeholders that greater integration is critical to achieving the goals of improved quality and efficiency sets the stage for coordinated government policy and program decisions. Across branches of government and state agencies, a shared vision will influence efforts to structure aligned incentives and supports that move providers and the health care marketplace toward more integrated health care.
- **Payment reform strategies are a critical priority.** Partnerships are important, but ultimately, economic incentives will reign; states must focus on using their leverage to promote re-alignment of payment strategies to foster integration across payers in the state's health care environment.
- **Remember that “community culture eats strategy for lunch.”** State policymakers must recognize tools and strategies to foster the degree of culture change required among all sectors—clinicians, patients, and organizations—to achieve delivery system integration.

- **Keep focused on value for the consumer.** Achieving the goals for high quality, cost-effective care through integrated care systems requires new levels of consumer engagement. Ultimately, consumers will realize the benefits from improved care processes and should be involved in designing more coordinated, high value services. States need to consider how to meaningfully involve consumers as part of strategies to advance integrated care.

Regardless of the starting point, achieving successful integration requires strategies and tools in key areas: restructuring payment, ensuring data and information technology supports, and utilizing innovative provider networks and services.

REALIZING PAYMENT REFORM

Payment structures play a critical role in fostering—or hindering—delivery system integration. The prevailing disaggregated fee-for-service environment, even with performance bonuses based on quality, outcomes, or efficiency, is a barrier to provider collaboration and coordination. Fee-for-service systems tend to favor specialty over primary care and contain incentives for higher volume and intensity of health services. Pursuing more integrated delivery of services requires transitioning to payment structures that encourage more cohesion within and between groups of physicians, as well as more efficient and effective care. Shifting incentives in this way requires integrated delivery systems to be able to accept degrees of financial risk linked to achieving high quality, cost-effective care processes and health outcomes. States must be able to effectively structure incentives and payment models, then monitor and reward performance.

Several guidelines emerged from the 2011 meeting:

- **Simplify and minimize the administrative and regulatory cost burden.** Providers will need to be encouraged to participate in integration and accountable care initiatives; as a result, states must weigh very carefully the cost of participation on providers.
- **Create capacity for innovation.** States should seek to maintain avenues for innovation as they design payment reforms and pursue contracting strategies.
- **Adopt a consistent approach and direction over time.** States are more likely to experience success with integration if they pursue a consistent approach to engaging payers and providers. Key issues raised by participants in the meeting—including adequate risk adjustment, gradual phase-ins of payment reform to minimize provider backlash, and rewards for innovative models such as patient-centered medical homes that strengthen the patient-provider relationship—would all benefit from a consistent, strategic approach by state government.
- **Align all payers around payment and value.** Both public and private payers must adopt consistent and coherent strategies for using payment to reward value in health care delivery and ensure that the costs of efficient providers are covered.

INFORMATION AND INFORMATION SYSTEMS

The transition to payment structures involving degrees of financial risk tied to high-value outcomes will require an ability to collect large amounts of information. Accurate data collection, quality measurement, and reporting are essential components of integrated systems. Moreover, coordination of care across providers requires timely access to accurate clinical information. The success of integrated care models requires that these information technology (IT) supports are in place to optimize health care processes and outcomes and to support monitoring and payment. Strategies states can pursue as they shape their IT agendas include:

- **Collaborate with private payers to assist providers in electronic health record adoption and financing.** A united effort between public and private payers is crucial to encourage the adoption of electronic health records (EHRs).
- **Promulgate standards for data storage and exchange.** Coherence in national standards for exchange, as well as in state-level decisions about privacy and security standards for data transmission, is necessary to facilitate wider information sharing.
- **Demand quality outcomes.** Measuring and rewarding quality outcomes will force providers to deliver quality over time through integrated systems. Such a quality focus, along with reimbursement methods that incent physicians, hospitals, and payers to work together for quality outcomes, will require IT systems that support timely data sharing and analytics. The demand for information will help drive targeted EHR adoption and data sharing across providers through health information exchange networks.
- **Define success before beginning.** Any large-scale data projects in the state should be accompanied by concrete performance measures. State policymakers should be prepared to evaluate actual outcomes against assumptions and expectations, revisiting the state's data strategy as needed.

INNOVATIVE NETWORK PROVIDERS AND SERVICES

Advancing along the continuum of integration requires moving beyond care delivered in traditional hospital or physician practice settings to incorporate a wider array of provider networks, care settings, and processes of care. This broader approach aligns with an emerging paradigm for health care delivery at the heart of increasingly popular care models, such as patient-centered medical homes, health homes, and accountable care organizations. Re-engineering health care this way to improve quality, services, and efficiencies challenges providers to adapt to new practice dynamics and a culture of interdisciplinary and intra and inter-organizational relationships. There are several guidelines states should consider as they build new partnerships and engage new providers.

- **Have reasonable expectations and support potential new partners in moving towards integration.** There will be a learning curve for all participants as greater integration is achieved. States must find a balance between fostering the growth and maturation of new partnerships and responding (e.g., through contract vehicles) to the need to move quickly to begin integrating providers' services.
- **Move toward integration of funding streams so they serve the consumer.** Medicaid carve-outs for services such as mental health treatment reinforce the fragmentation of health care and inhibit the integration and coordination of services.
- **Work with providers to protect them from unacceptable risk.** States will need to consider ways to shelter integrated delivery systems from some of the financial risks associated with behavioral health and long-term care supports to remove an important barrier to engaging providers beyond just medical practitioners in integrated networks.

The time is ripe for states to partner with delivery system leaders and other stakeholders to address deficiencies in the health care system caused by unnecessary fragmentation and duplication. Integrated delivery systems offer the prospect of high-quality care and a better patient experience at a lower cost.

Private and public sector integrated delivery systems across the country have success stories to tell, and states should begin a dialogue with these systems as a springboard to statewide integration efforts. By wielding the policy levers available to them and incorporating lessons from successful systems, states can begin to build high-value, integrated systems that meet the triple aim of better patient care, better population health, and reduced costs.

INTRODUCTION

State policymakers have long sought to improve the provision of health care services. Recent evidence has shown integrated delivery systems can improve the quality of care and contain costs. Many factors about these provider systems contribute to efficient delivery of high-quality care: physician groups with organizational cohesion, sufficient size and scale to support needed infrastructure, and strong affiliations within the larger health system have been shown to generally produce higher quality care more efficiently than independent practice associations.¹ Integrated systems tend to score well on preventive quality measures and are more likely to use electronic health records than other systems.

To foster and use integrated delivery systems effectively, state policymakers need to better understand how they work and how to move their health systems toward greater integration. To this end, on October 3, 2011 the National Academy for State Health Policy (NASHP) convened a one-day meeting, “Integrated Delivery Systems: Fostering State Policy to Support Delivery System Transformation,” in conjunction with the 24th Annual NASHP State Health Policy Conference held in Kansas City, Missouri.

This meeting brought together state officials and representatives of leading integrated delivery systems to discuss policy strategies that can foster integrated delivery system development and sustainability in line with state health policy goals. By pairing a delivery system leader with a state leader across key topic areas, the agenda fostered a unique dialogue and public-private shared learning opportunity. The meeting offered state policymakers and other stakeholders the opportunity to ‘look under the hood’ to better understand how integrated delivery systems work, steps some leading states are taking to increase integration, and potential application of that information to their own state.

This report from the 2011 meeting summarizes the day’s discussions and is intended to help state policymakers understand the potential of integrated delivery systems, identify policy levers for fostering their development, and overcome barriers to success. It explores key facets of delivery system integration from the perspective of state policy makers and delivery system leaders, and provides findings and recommendations that emerged from discussion among the participants. These are organized around the four major agenda themes—understanding the continuum of delivery system integration, the role of information systems, the need for payment reform, and the challenges to engaging nontraditional service providers in integrated networks. Each section includes:

- An overview of the issues, challenges, and perspectives around the issue;
- Lessons from current practices in leading integrated delivery systems and state integration initiatives, featuring speakers that participated in the 2011 meeting;
- A summary of themes and actionable tips for states to pursue as they move forward with delivery system integration.

I. THE PATH TO INTEGRATED HEALTH CARE AND DELIVERY SYSTEM CHANGE

As states pursue health care reform, integrated delivery systems have much to offer. They impact the overall quality and efficiency of health care by creating a new culture of care by teams of cooperating practitioners, implementing and making effective use of information systems, establishing improved evidence-based standards of practice, improving “hand-offs” of patients between providers, and measuring and rewarding quality outcomes. Studies show that in more highly integrated groups, scores on HEDIS (Healthcare Effectiveness Data and Information Set) preventative measures were better and the groups were more likely to have electronic medical records (EMRs). More highly integrated groups were also more likely to engage in quality improvement programs, offer smoking cessation, use care management processes, and use reminder systems for preventative services than more independent practices.²

UNDERSTANDING INTEGRATION - POINTS ALONG A CONTINUUM

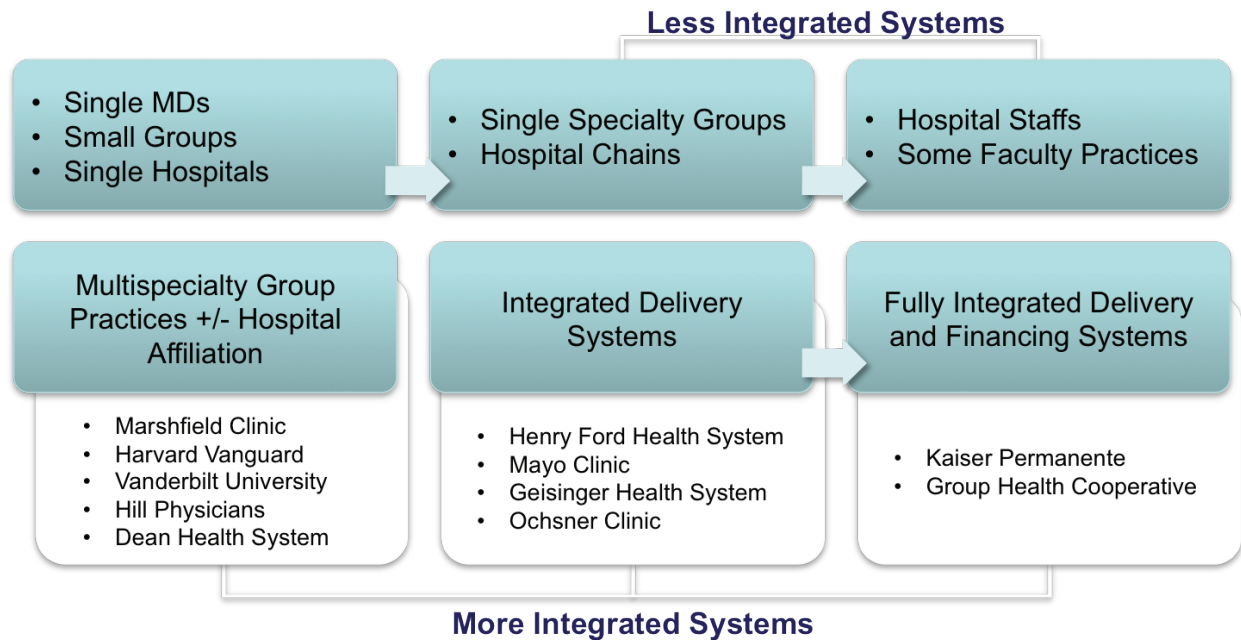
Integrated delivery systems are characterized by health care delivery and payment methods that are aligned to foster highly effective and coordinated care, leading to improved quality and efficiency. One feature of integrated delivery systems entails a shift away from the traditional fee-for-service payment system to other payment methods; integrated delivery systems are characterized by providers being willing and able to link some aspects of their payment and revenue streams to how well they manage care for their patient populations.

A fully “integrated delivery system” has been described as follows:

“Integrated delivery systems”...are built on the core of a large, multispecialty medical group practice, often with links to hospitals, labs, pharmacies, and other facilities and often with a sizable amount of revenue based on per capita prepayment.... The systems themselves would have the following characteristics: processes to ensure the provision of appropriate, evidence-based care; the full spectrum of care coordination; use of comprehensive, shared patient records; and the ability to improve efficiency on a large scale.³

Fully integrated systems at this scale, however, are more the exception than the rule. The degree of delivery system integration can be understood in terms of location along a continuum (see Figure 1). At one end are single physicians, small group practices and individual hospitals operating independently and coordinating care informally in a fee-for-service environment. At the other end is the fully integrated delivery system with an insurance component that employs multispecialty providers and hospitals, such as Kaiser Permanente or Group Health Cooperative.

In between are delivery system models such as the “medical home” and accountable care organizations (ACOs). A patient-centered medical home (PCMH) generally involves highly coordinated primary care processes with care teams and care coordination designed to support the needs of particular patient populations (e.g., the chronically ill, children). ACOs offer a full range of highly coordinated primary, acute and other health care services, supported by payment incentives for quality, appropriateness and efficiency. Both of these innovative models represent forms and degrees of integration that may or may not be part of even larger integrated health care systems. In this report, “integrated delivery systems” will be used to refer to models across the continuum, unless noted otherwise.

FIGURE 1: CONTINUUM OF DELIVERY SYSTEM ORGANIZATION IN THE UNITED STATES

FOSTERING INTEGRATION - FINDING THE RIGHT PLACE ON THE CONTINUUM

As state policymakers take steps to identify goals and feasible options for changing their health care delivery systems, it is important to understand that a framework for achieving integration encourages movement along the continuum.

States, and markets within states, will fall at different points along the continuum and may be able to improve quality and lower costs by moving to greater integration, regardless of the starting point. As discussed in Section II, payment is the most frequently used tool to promote integration. However, payment methods must fit the characteristics and readiness of providers to respond to and manage these incentives, given their current levels of organizational integration.

Providers and markets are at different places in terms of the level of financial risk and accountability for quality and cost outcomes they are organized and equipped to accept. They will have differing abilities to manage advanced payment methods. As discussed further in the upcoming section, states may be best served by considering delivery system reform in terms of multiple steps that incorporate two pathways: changes in payment structures and changes in the delivery system.

TWO EXPERIENCES - STATE AND HEALTH SYSTEM EFFORTS TO ADVANCE INTEGRATION

The on-the-ground experiences of providers and health care systems in changing long established patterns of medical practice provide important lessons to inform states' strategies for fostering delivery system integration.

Rhode Island: Lessons from "Pre-Integration" Work

In 2004, Rhode Island created the first state agency in the nation dedicated solely to health insurance oversight, the Office of the Health Insurance Commissioner. Christopher Koller, serving as Rhode Island's Health Insurance Commissioner, offered a state's perspective on the promise of integrated delivery

systems for meeting long-standing state health policy goals to deliver better population health outcomes at lower costs. In his remarks launching the meeting, Mr. Koller offered a compelling look at steps by Rhode Island to reform its health care system. He detailed how the state is poised to build on existing “pre-integration” work to develop more robust infrastructure supports for integrated delivery systems, including health information exchange and advanced primary care models.

Recognizing that accountability for care delivery and health outcomes for distinct populations is a hallmark of integrated delivery systems, Mr. Koller suggested that when choosing their strategies, states should leverage strategies targeting the key populations for which the state is responsible (see Table 1).

Table 1: Advancing Integration - Thinking Systematically about Populations in States

Population	Public Agency	Medical/Health Care Needs
Entire State	Health Department	Prevention Safety Disparities reduction
Low Income and Disabled	Medicaid	Cost effective medical care Adequate provider choice Attention to special needs Cultural competency
Commercially Insured	Insurance Department	(through insurers) Lower rates of premium increase Consumer protections
Public Employees	Administration	Lower rates of premium increase Adequate provider choice Workforce productivity Wellness and prevention

States seeking to realize the promise of integrated delivery systems need to develop solutions targeted to specific populations. For example, Medicaid agencies may choose to contract with specialized managed care organizations (MCOs) that are designed to serve a segment of the Medicaid population. By limiting the provider networks associated with MCOs, Medicaid agencies can ensure the participation only of providers who can devote attention to the special needs of beneficiaries by exploring patient-centered medical home models and reducing the state’s dependence on institutional care. Medicaid can contract with integrated delivery systems that meet Culturally and Linguistically Appropriate standards, which can help states offer culturally competent care. Similarly, leveraging the purchasing power of Medicaid and state employee health plans to encourage systems of accountable care can help prompt providers to strive to improve health care safety and reduce disparities.

According to Mr. Koller, Rhode Island already has a number of building blocks in place that will facilitate delivery system integration in the state. A robust and growing statewide health information exchange—

known as “currentcare”—is spearheading Rhode Island’s strategy for encouraging sharing of electronic health information. Efforts to encourage provider adoption of electronic health record systems (EHRs) and information sharing between various providers and their EHR systems is part of the state’s overall strategy to develop patient-centered medical homes and put information to work for population-based care. Rhode Island has a Program of All Inclusive Care for the Elderly (PACE) that is creating financial incentives to support the development of integrated care systems. The Rhode Island PACE combines Medicare and Medicaid monies to target individuals eligible under both programs (“dual eligibles” or “duals”) who are often at high risk for nursing home admission. PACE premiums have facilitated the growing integration of services for duals by fostering business relationships and primary and specialty care contracts between nursing homes and home health agencies serving as PACE providers.

Rhode Island’s Office of the Health Insurance Commissioner is also using the state’s insurance premium rate review process to drive delivery system reform. Starting in 2010, as a condition for receiving approval of rate increases, health insurers must meet a set of conditions, including:

- increasing the portion of medical spending going to primary care;
- supporting and expanding Rhode Island’s all-payer patient-centered medical home initiative;
- supporting electronic health record adoption incentives; and
- pursuing hospital payment reform by incorporating six contract elements, including utilization of efficiency-based units of payment other than fee-for-service and inclusion of contract terms promoting improved clinical communication between the hospital and other providers.

Mr. Koller emphasized that other states can use these policy levers to begin pushing delivery systems in the state along the continuum of integration. However, he also identified a number of barriers that states must address in their efforts to begin that movement.

- **The provider status quo.** Providers in the state may resist efforts to foster integrated delivery systems, either due to provider cultures that prize autonomy or to comfort and familiarity with current payment structures.
- **The patient status quo.** Patients have become used to measuring quality in terms of choice and ignoring the costs of the current care delivery paradigm.
- **Misaligned incentives.** Common payment systems across payers will be key for integrating delivery systems.
- **Budget pressures.** Immediate budget pressures lead to demands for short-term savings, making it difficult to take the long-term perspective required for recognizing the benefits of integrated delivery.

Rhode Island’s experience indicates that states can overcome these barriers and move their delivery systems in the direction of greater integration. Rhode Island did so through strong public and private leadership, appropriate statutory authority for state regulators and willingness to leverage federal funding opportunities (e.g., federal rate review funding), common rules among payers, and public reporting of performance.

Kaiser Permanente - Keys to Effective Delivery System Integration

Dr. Amy Compton-Phillips, the associate executive director for quality at Kaiser Permanente, joined NASHP at the 2011 meeting to provide the perspective of a leading integrated delivery system. Dr.

Compton-Phillips stressed that effective integrated care is more than the sum of individual components of health care, and that the stakes are high for developing truly integrated health systems: uncoordinated care can be harmful—even fatal—for patients, even if every individual provider does nothing wrong.

The success factors that have made Kaiser Permanente the country's largest non-profit health system illustrate many of what Dr. Compton-Phillips stressed are the key principles of delivery system integration.

- **A clear, agreed-upon mission.** Kaiser Permanente's stated mission is to improve the health of members and the communities served. This mission drives the delivery system's focus on total health and primary care, as keeping members healthy helps the system to avoid paying for greater disease burdens in the future. As a result, Kaiser Permanente has developed a culture that rewards primary care and wellness, as well as health outcomes.
- **Visionary leadership.** Physician leadership is a key component of Kaiser's success and delivery system integration more generally, as Dr. Compton-Phillips suggested that clinicians will look first to other clinicians for leadership. Kaiser Permanente has developed a culture in which physicians lead integration efforts and proactively reach out to doctors in the community. The organization engages in in-depth development work—in areas such as communication, business development, and systems thinking—to teach doctors to be leaders.
- **Aligned structures and incentives.** Kaiser Permanente invests in incentives for quality, service, affordability, and safety. Teamwork and coordination between clinicians is a key feature of Kaiser's system, facilitated in part by the organization's investment in health information technology. Kaiser has built information technology platforms that allow the exchange of information needed to provide effective, high-quality care. In addition, Kaiser makes use of clinical guidelines—using measurement to hold clinicians accountable—to ensure that patients get the care that clinical evidence suggests they should.

Dr. Compton-Phillips pointed out there are many roads to accountability, ranging from structures such as the Alternative Quality Contract launched by Blue Cross Blue Shield of Massachusetts in 2009, to public health expenditures aimed at reducing smoking and obesity.⁴ She suggested that a key advantage of integrated delivery systems is their ability to offer patient-centered care and their ability to emphasize preventive care, which will result in improved outcomes in the long run. For instance, Kaiser Permanente has a system for notification and outreach to women who are due for a mammogram, as well as procedures for providing patients who experience a heart event everything from emotional support to medication to prevent a recurrence within 24 hours of discharge from the hospital. As a result of these efforts, all of Kaiser Permanente's regional systems are ranked by the National Committee for Quality Assurance at or near the 90th percentile for breast cancer screenings nationally. Disaggregated fee-for-service environments are not able to offer that level of synergistic patient-centered care, nor are they likely to produce the cost savings associated with the aggressive provision of preventive care.

MOVING FORWARD - ADVICE TO AVOID PITFALLS, FOSTER APPROPRIATE INTEGRATED HEALTH CARE MODELS AND STRATEGIES

While states are beginning to move toward integrated systems in incremental ways, Dr. Compton-Phillips and Mr. Koller agreed on several ingredients for success that states should be mindful of as they move forward.

Recognize true integration versus aggregation. In response to Mr. Koller and Dr. Compton-Phillips' remarks and continuing over the course of the meeting, state policymakers and integrated delivery

system leaders alike emphasized the notion that states must recognize and demand true integration and not confuse aggregation (e.g., independent provider practices becoming part of a hospital system) with integration. True integration requires that care processes and workflows, information supports, and quality strategies are linked across providers. Mere consolidation of providers is not enough to achieve the principles of integration identified by Dr. Compton-Phillips or to provide the systematic approach to addressing population-centric care needs envisioned by Mr. Koller. Rather, synergistic relationships must be developed between providers to meet individual care needs, ease care transitions, and enable a whole-person perspective.

Define the vision for advancing delivery system integration in the state. A shared vision across branches of government and state agencies is necessary for aligning the incentives and supports required by providers and the health care marketplace to achieve more integration. A shared understanding among stakeholders that improved integration is essential to achieving the goals of improved quality and greater efficiency sets the stage for coordinated government policy and program decisions. For example, state approaches to facilitating health information exchange should line up with care coordination projects (e.g., patient-centered medical home initiatives), and state payment reform strategies should conform to state plans for engaging novel care and service providers.

Align payment with the state’s vision. Partnerships are important, but ultimately, economic incentives will reign; states must focus on aligning payment strategies across payers in the state. State policymakers can begin the process internally, as states themselves control a huge stream of health dollars that can be leveraged to pay for quality instead of quantity, particularly in states that have consolidated their health purchasing strategies under a single health care authority.

Remember that “community culture eats strategy for lunch.” Institutional and cultural considerations within the health care environment can impact the degree and pace of movement toward integration. Clinicians, patients, and organizations will all need to accept a degree of cultural change to embrace delivery system integration, and this evolution will take time.

Keep focused on value for the consumer. Both speakers emphasized the importance of also engaging consumers and families in conceptualizing delivery system redesign, and in validating the benefits of system changes. Inherent to integrated care models is the need for consumers, as patients, to shift their level of participation and degree of empowerment in health care processes. Therefore, it is important for states to address consumer engagement as part of strategies for achieving greater integration.

Together these insights outline the path to successful delivery system reform. Ultimately, states and providers working together to structure positive delivery system innovations can help turn the tide toward achieving the triple aim—improving the experience of health care, improving health status, and containing costs—through more integrated, less costly, higher quality care.

II. THE ELEPHANT IN THE ROOM: REALIZING PAYMENT REFORM

A capstone feature of emerging integrated delivery system models is movement toward structured financial incentives that are performance- and outcome-based and related to budget targets for health care spending. As states pursue policy strategies to move away from fee-for-service payment, it is important to understand the influence of payment methods on provider behaviors, relevant marketplace dynamics and the range of feasible state policy strategies.

PAYMENT MODELS – IMPROVING EFFICIENCY AND QUALITY

There is significant evidence that more integrated systems use resources more efficiently. Rather than rewarding volume and intensity of services, more integrated health systems allow for payment incentives that foster primary and preventive care and avoid unnecessary services. One meta-analysis showed that costs were about 25 percent lower in prepaid group practices than in other types of practices.⁵

To varying degrees, restructured payment models facilitate greater integration by encouraging coordination and discouraging fragmented care delivery associated with traditional fee-for-service payment. These payment models lie along the following continuum.⁶

- **Fee-for-service payments with performance bonuses based on quality, outcomes, or efficiency.** This approach bears the closest resemblance to the currently predominant payment approach. The use of performance bonuses is intended to counter the incentives for volume inherent in fee-for-service payment and encourage provider collaboration to meet performance targets. However, critics suggest that the value of these rewards in the U.S. may be too low to succeed in meeting these goals.
- **Episode-based payment (“bundling”)** Bundling mitigates some of the volume-based incentives of fee-for-service payment by paying for a specified set of services provided during a given period, encouraging providers to offer the bundle in the most efficient way possible. Though bundling may be thought of as an interim step between fee-for-service payment and capitation—encouraging greater integration by requiring providers to work together to manage a patient or condition efficiently—developing definitions of bundles and allocating bundles across providers can be challenging.
- **Global comprehensive care payment (“capitation”)** Capitation replaces fee-for-service payment with a fixed payment for all health care provided to each patient for a fixed period of time, discouraging the silos that form under fee-for-service reimbursement. Provider organizations can accept financial risk for being able to deliver services for a specified payment amount—capitated payments—along a continuum of services, from professional, primary care services to specialty or inpatient care services. Organizations typically are positioned to be able to take on additional risk as they become more integrated, and therefore able to predict greater levels of efficiency and quality in how services can be provided.

STRUCTURING PAYMENT INCENTIVES IN INTEGRATED DELIVERY SYSTEMS

Payment to providers within integrated systems can take many forms, dependent in part on the size and nature of the provider organization. Figure 2 illustrates the relationship between provider organization type and appropriate forms of payment. More integrated organizations are more likely to be able to support electronic health records, support care coordination in complex situations, and establish practice

procedures that will reduce errors and improve coordination. Such an organization can structure individual provider incentives and rewards based on organizational targets for quality and efficiency. For example, a physician on salary with a hospital-physician group has no personal incentive or disincentive with respect to the volume or efficiency of care, but is more inclined than a solo practitioner to adopt procedures that are encouraged or required by the organization. As a result, the incentives that payers provide to these systems will to some extent drive the behavior of their physician and allied staff.

The way organizations are paid and the way in which they pay their physicians are related. Robinson and colleagues found that medical groups and independent practice associations in markets with high managed care penetration are significantly less likely to pay individual physicians using fee-for-service than are organizations in markets with lower managed care penetration.⁷ In a different study, Robinson found that medical groups facing external pay-for-performance incentives are more likely to pay their primary care physicians and specialists based on quality and satisfaction than are groups not subject to pay-for-performance.⁸ Further, medical groups under capitation payment are more likely to pay member physicians on salary and less likely to pay based on productivity than groups paid fee-for-service by insurers.

In the systems most advanced on the continuum of integration, where—as with Kaiser Permanente and Group Health—the provider is also the insurer of most patients, the incentive is greatest for efficiency as well as quality. Here, if hospital revenue is lost because an emergency room admission is avoided, the entire integrated system gains as a result of the plan not having to pay those costs. On the other hand, if a large hospital/multispecialty integrated system is internally integrated, but is paid by multiple payers on a fee-for-service basis, the organization will still be driven by the need to maintain a certain volume of revenue generating procedures and hospital stays. These systems may still be in a position to function effectively as integrated systems if they have the necessary infrastructure supports for providers, including electronic health records, evidence-based practice protocols, preventive care, and other quality initiatives. They also are likely in a better position to move away from fee-for-service and toward accepting more risk.

It is worth noting, however, that even within an integrated system with salaried or partnered physicians, implementing procedures to encourage evidence-based practices or greater efficiency may be difficult for management working with personnel accustomed to independent practice.

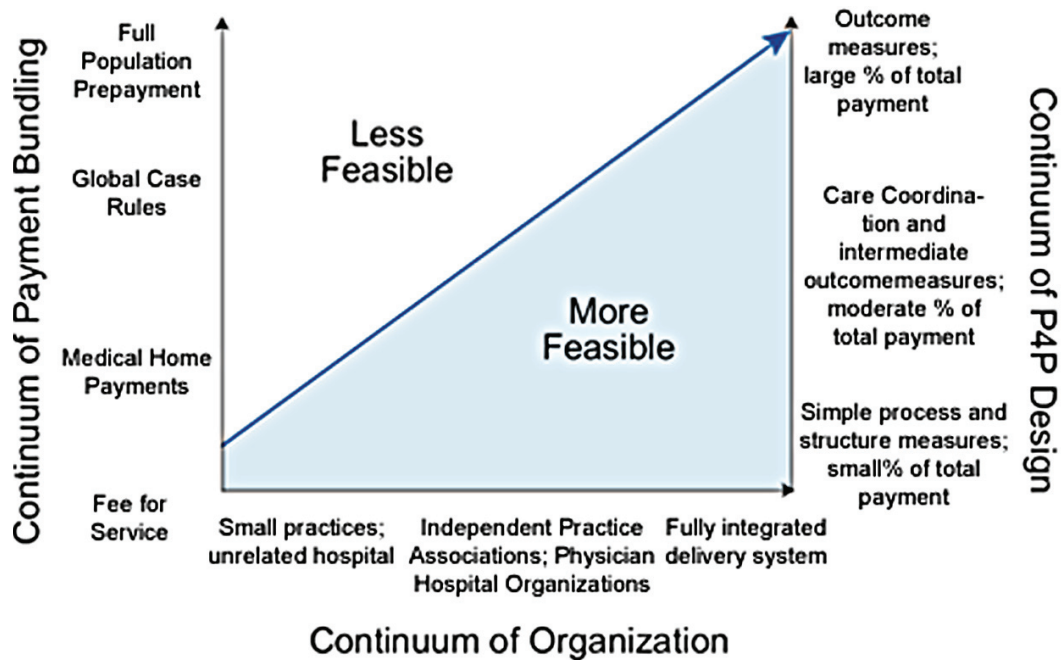
STATES AND MARKET-BASED PAYMENT REFORM EFFORTS

As they pursue greater quality and efficiency, both public and private payers are building payment reforms into their provider contracting strategies in an effort to encourage greater clinical integration. Health providers are at various places with respect to their level of clinical integration. However, in most states, health care marketplaces remain largely dominated by independent physician practices, hospitals, and hospital/physician groups and are reliant on fee-for-service payment systems.

There is a significant difference between the managed care efforts of the 1990s and the current strategies involving capitated payment. In the 1990s, although payment to health plans was capitated, the health plans continued to pay providers primarily on a fee-for-service basis and attempted to control costs with mechanisms such as prior authorization and utilization review. As a result, the volume incentive for physicians, hospitals and other health care providers remained essentially the same. By contrast, today, with the advent of technology that allows better measurement of results, payment reform efforts are striving to align payment with provider incentives for quality and efficiency.

As states select strategies to foster greater integration, they must consider the capacity of the providers in terms of infrastructure, ability to bear risk, and, more generally, their point on the integration continuum.

Figure 2: The Relationship of Payment and Integration



A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, "Organizing the U.S. Health Care Delivery System for High Performance," The Commonwealth Fund, August 2008.

States have various opportunities, including under the Affordable Care Act (ACA) and otherwise, to encourage greater integration of care through payment reform.

- **Contract with accountable care organizations.** States with large, relatively integrated provider groups could pursue ACO-style contracts for Medicaid or for state employee health benefits, similar to the ACO structures being pursued under the ACA's Medicare Shared Savings Program. In these contracts, a lead provider organization is responsible for quality and cost of inpatient and outpatient care by linking payment to quality improvement and cost savings.⁹
- **Establish bundled payments for specific conditions and episodes of care.** As payers, states may also establish bundled payments per episode of care. A bundled payment for an episode of care requires all providers involved in that care to coordinate to reduce avoidable complications or risk financial loss. For example, under Geisinger Health System's ProvenCare program, payment is bundled for non-emergency coronary artery bypass graft procedures, such that the provider organization is responsible for all care – including hospital readmissions – for 90 days following the procedure. The Centers for Medicare & Medicaid Services (CMS) are authorized under section 2704 of the ACA to establish demonstrations in up to eight states to evaluate the use of bundled payments for integrated care delivery. This opportunity may be useful for states with strong hospital physician groups with the infrastructure to coordinate care and with data to estimate the integrated cost.
- **Incentivize reductions in preventable hospital readmissions.** State systems not prepared for either ACOs or bundled payments for episodes of care could also encourage better integration by

improving transitions from the hospital to another provider or the community. Maine legislators, for example, sought initially to require that a diagnosis-related group payment to a hospital (itself a form of bundled payment) also include care for ten days after the patient leaves the hospital to encourage hospitals to better coordinate care upon discharge. Concerned about risk to the hospitals and to better align with Medicare, the law reduced the period to 72 hours.¹⁰

- **Encourage primary care integration via medical homes.** Finally, significant efforts are underway in many states to establish advanced patient-centered medical homes (PCMHs) in Medicaid and, for eight states under a demonstration, in cooperation with Medicare. The heart of the PCMH is well coordinated, integrated care. Typically in Medicaid medical home efforts, primary care providers are paid on a fee-for-service basis, and additional funds are provided for care coordination and primary care practice transformation. These additional funds are paid on a per-member per-month basis, and can be structured to improve quality or pay for specific staff to provide care coordination.¹¹ Aiding these medical home efforts are evolving plans under section 2703 of the ACA under which state Medicaid programs may receive enhanced federal funding over eight quarters for health homes for people with two or more chronic conditions or with serious and persistent mental illness.¹²

There are undoubtedly other creative ways that states, through payment reforms both large and small, are advancing health systems along the path toward greater clinical integration. This is a historic time in which states, the federal government, providers and payers are engaged in critically important experiments to adjust payment incentives to achieve more cost effective and higher quality health care.

As states chart the course toward better-integrated health care, experience shows that planners must start by considering the capacity and status of providers, payers and the marketplace to respond to different payment methods and degrees of clinical integration. The variability of how health systems are structured influences the degree to which they are practically integrated and capable of entering into arrangements to accept risk-based payment structures. Lessons from capitated managed care plans in the 1990s demonstrated that moving to full financial risk (fully capitated payments or global risk) without the capacity to measure and demonstrate levels of quality across providers does not necessarily improve care or result in effective and sustainable cost containment. The right infrastructure, standards of practice, and incentives for high quality clinically integrated care must be aligned with the particular characteristics of a financially competitive market and its independent providers. States and providers must assess the degree to which risk can or should be shifted to providers and health care systems and the extent to which systems must be integrated in order to accept financial risk.

TWO PERSPECTIVES AND LEVELS OF EXPERIENCE WITH PAYMENT REFORM

Following are two perspectives—one from an innovative state and another from a leading integrated delivery system—on keys to moving along the continuum of payment reform.

The Billings Clinic Experience

The Billings Clinic is a community-governed and physician-led organization based in Billings, Montana that entered the ranks of integrated delivery systems in 1993 with the merger and integration of a multi-specialty group practice and a community hospital. Since this merger, clinical quality and service have been at the core of the clinic's mission, vision, and strategy. The organization has made substantial investments in clinical quality infrastructure, including information technology.

Dr. Douglas Carr, the Medical Director for Education and Systems Initiatives at the Billings Clinic, joined NASHP for the 2011 meeting to discuss payment reform from the perspective of an integrated delivery system that has participated in payment reform demonstrations. Dr. Carr identified a number of the current shortcomings of payment structures, including wide variations in costs and care delivery, and the tendency for providers to deliver care in silos.

He described the Billings Clinic's participation in CMS's Physician Group Practice (PGP) demonstration, a precursor to the current Medicare Shared Savings Program. While this demonstration was a federal initiative to test payment reforms in Medicare, its use of shared savings and payment incentives for performance and care coordination is similar to strategies states are currently planning in Medicaid programs. Dr. Carr reported that clinical interventions undertaken at Billings as part of the PGP demonstration were applied to all patients, regardless of payer and that clinical outcomes of the PGP demonstration were positive. Billings was compelled to increase its focus on population and chronic disease management and, as a result, was able to reduce indicators for heart failure across the board. However, despite these quality gains, Billings was unable to recoup any net savings under the timeframe and structure of the program, with the savings being less than the reduction in revenue and the business costs of implementation.

The wide variation in financial outcomes for participants in the demonstration indicates the importance of getting the payment methodology right and has implications for the current push to integrate care using accountable care arrangements. Dr. Carr believes that several important lessons for launching ACOs emerged from the PGP demonstration.

- **Attribution** of patients should be prospective, to make sure that patients are engaged in the model, and at the primary care level where care is managed;
- **National comparison targets** must be chosen carefully; the large number of comparison groups used to estimate savings in the PGP demonstration limited the value of analysis;
- The **threshold** for shared savings needs to be rational and attainable;
- **Risk adjustment** is crucial, as provider risk may increase with adoption of electronic health records and better care coordination because organizations demonstrating quality attract high-risk patients;
- **Quality measures** should focus on high cost, high volume diseases; and
- **Timely data turnaround** is crucial for allowing providers to put information to use for improvement.

Dr. Carr pointed to ACOs with PCMHs at their core as the next stage of payment reform. PCMHs will help emphasize prevention, encourage relationships, and promote shared decision-making. That structure allows for more efficient care delivery—from use of allied health professionals to the incorporation of web-enabled tools—and can result in less variation in utilization. Dr. Carr mentioned Montana Medicaid's ongoing work to develop grassroots momentum for a statewide multi-payer medical home project as a potentially key piece of delivery system reform in Montana.

The Minnesota Approach - Delivery System Integration via Payment Reform

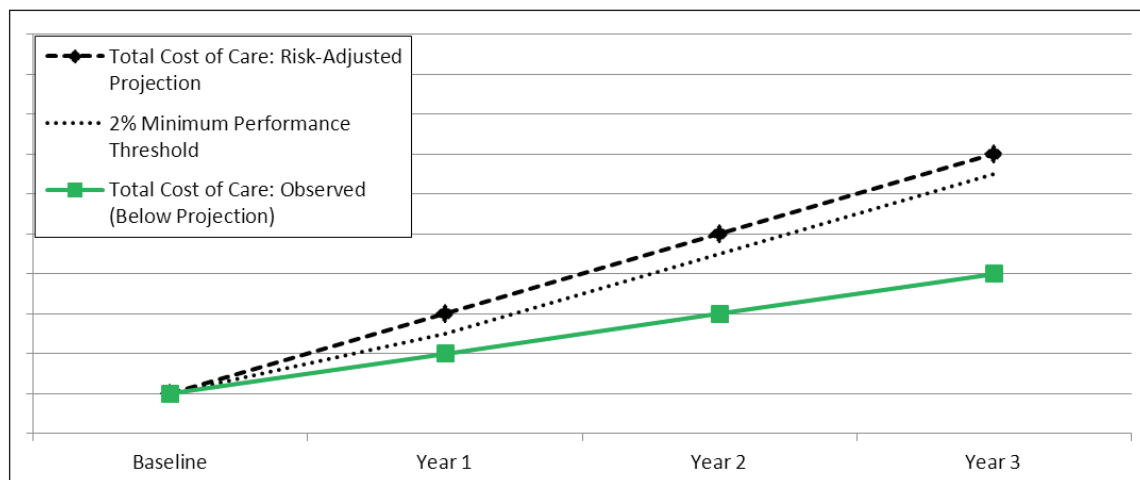
Scott Leitz, the Assistant Commissioner for Health Care in Minnesota's Department of Human Services, offered the perspective of a state that has aggressively pursued payment and delivery system

reforms. Minnesota has enjoyed some distinct advantages, including relatively good population health, low uninsurance rates, a high rate of employer-sponsored coverage, and a history of public-private collaboration. However, the state has faced many of the same problems as other states, including rising uninsurance rates and rapid increases in health care costs. Driven by a desire to combat uneven health care quality, poor value for health spending, a lack of available information, and misaligned payment incentives, Minnesota passed a reform package in 2008 that contained the building blocks for comprehensive delivery system reform. Among other things, these reforms create an all-payer claims database, establish standardized quality measures and move toward a system of paying for “baskets of care” and shifting the financial incentive to providers to coordinate to produce better, less costly outcomes.¹³

Mr. Leitz pointed to the heavy emphasis on quality and performance measurement in Minnesota’s 2008 reforms as a necessary component of payment reform. Minnesota implemented a statewide quality measurement system to unify payers in the state around a standardized set of measurements. The goal of this effort was to develop a meaningful perspective on health outcomes in the state. Minnesota also launched a Provider Peer Grouping initiative designed to facilitate comparison of provider performance on cost and quality measures.

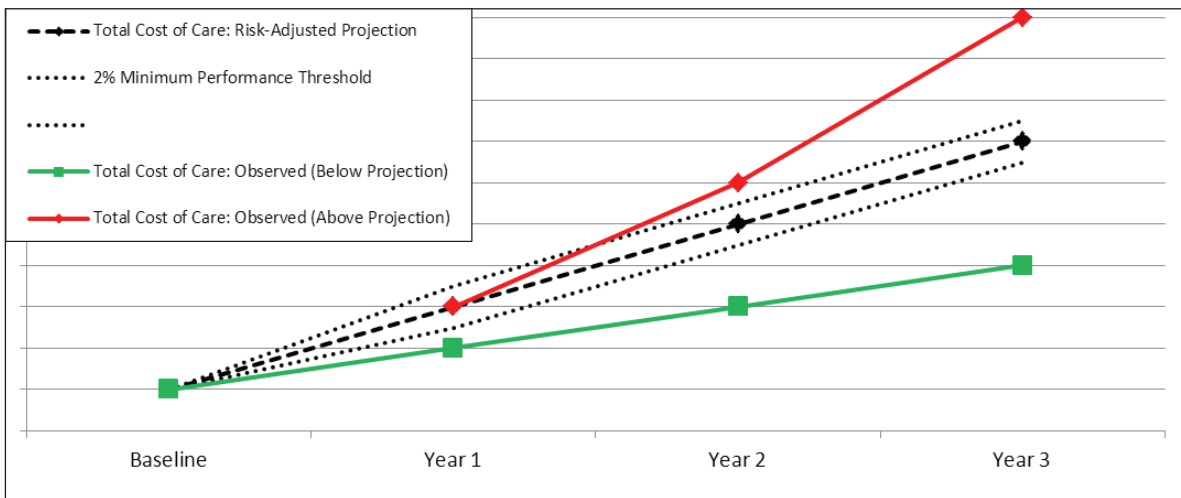
In 2010, Minnesota’s legislature authorized a demonstration for ACO-type models for Medicaid populations. Under the Health Care Delivery Systems Demonstration, the state has proposed two payment models.¹⁴ In the first model, known as the Virtual Health Care Delivery System, primary care providers and multi-specialty provider groups not affiliated with a hospital or integrated system are eligible to participate. Under this model, savings achieved beyond a two percent minimum performance threshold are shared equally between Medicaid and the delivery system.

Proposed Payment Model 1: Minnesota’s Virtual Health Care Delivery System



Under the second model, known as the Integrated Health Care Delivery System (HCDS), integrated delivery systems providing a broad spectrum of outpatient and inpatient care as a common financial and organizational entity may participate. This model incorporates shared risk, building toward a two-way risk sharing model in which a symmetrical “downside” risk for the HCDS is in place by the third year. Savings achieved beyond the two percent minimum threshold are shared between Medicaid and the delivery system, while the delivery system is required to pay back a pre-negotiated portion of spending above the minimum threshold.

Proposed Payment Model 2: Minnesota’s Integrated Health Care Delivery System



MOVING FORWARD – ADVICE FOR ADOPTING NEW PAYMENT STRUCTURES

During the discussion, state and delivery system leaders acknowledged that the structure of the delivery system is shaped by payment strategies, and that movement away from simple fee-for-service arrangements to ones that reward quality and efficiency is necessary for facilitating integration.

A “wish list” emerged for state policymakers to consider as they implement payment reforms to encourage delivery system integration. These suggestions for provider and public payer relationships provide tips for states to consider as they plan changes to existing payment structures.

Simplify and minimize the administrative and regulatory cost burden. Providers will need to be encouraged to participate in integration and accountable care initiatives; as a result, states must weigh very carefully the cost burden of participation on providers. Quality indicators that payment incentives will be based on should be chosen carefully and purposefully.

Create capacity for innovation. Despite the clear need for accountability and a systematic approach, payment and delivery system reforms that are too rigid may end up stifling innovation instead of encouraging it. States should seek avenues for innovation as they design payment reforms and pursue contracting strategies. For instance, Minnesota’s Request for Proposals for the Health Care Delivery Systems Demonstration explicitly leaves room for mutually agreed-upon modifications to proposals and contracts based on additional Department of Human Services research, emerging findings, and feedback from the participating health care delivery systems.

Adopt a consistent approach and direction over time. States are more likely to experience success with integration if they pursue a consistent approach to engaging payers and providers. Providers, payers, and patients will all need to develop trust; consistency by state government is a necessary component of that process. Important issues raised by participants in the meeting—including adequate risk adjustment, gradual phase-ins of payment reform to minimize provider backlash, and rewards for innovative models that strengthen the patient-provider relationship, such as patient-centered medical homes—would all benefit from a consistent, strategic approach by state government. As part of these approaches, it is important for states to promote relationship-driven partnership strategies by instituting payment mechanisms that reward collaboration and coordination between providers.

Align all payers around payment and value. Public payers alone cannot drive the level of reform required for true delivery system integration. Private payers also must adopt consistent and coherent strategies for using

payment to reward value in health care delivery and ensure that the costs of efficient providers are covered. Reform should be a collaborative process that involves payers, providers, and patients.

III. INFORMATION AND INFORMATION SYSTEMS: ACHIEVING CRITICAL SUPPORTS FOR DELIVERY SYSTEM INTEGRATION AND OUTCOMES

It is widely acknowledged that fragmented paper health records contribute to the health care system's inefficiencies, quality deficits and high costs. The goal for developing the nation's information technology (IT) infrastructure is to make data available when and where it is needed. Achieving this widespread interoperability of health information requires a major transition from paper to electronic systems—a multi-level challenge of system “re-engineering” that includes:

- the purchase and integration of electronic health record (EHR) systems into provider practices and patterns of care;
- implementation of IT services, applications, and components that facilitate data sharing across organizations and enable sharing between systems/providers/sources of data (referred to as “Health Information Exchange” or “HIE”); and
- data analytics to support decision making by providers, payers, and consumers of health care (such as for self care, clinical health care services, program management and business intelligence).

The success of integrated care models and systems requires that these IT-enabled supports are in place to optimize health care processes and outcomes and to support monitoring and payment for high quality health care services.

INFORMATION TECHNOLOGY SUPPORTS FOR SUCCESSFUL INTEGRATED SYSTEMS

To achieve delivery system and payment reforms, both states and integrated delivery systems must develop new capacities. For both, achieving more coordinated care, greater reliance on quality measurement, and transitioning to global payment structures requires robust information systems that enable accurate and real-time data collection, quality measurement and reporting, and support for financial management—the ability to monitor costs, project quality outcomes and payment—under a variety of payment arrangements.

Electronic health records are one key to better managing patient care, streamlining workflow, and meeting quality improvement and efficiency targets. As part of EHR systems, clinical decision support tools are key in helping prevent errors such as adverse drug interactions and integrating the use of clinical guidelines, reminders, and other information supports such as electronic checklists, order sets, and clinical flow sheets into the routine work flow of patient care.¹⁵

In addition to the investments and change management required by providers to integrate EHRs into their practices, the ability to effectively share patient information across organizational boundaries is critical, especially as new provider affiliations and partnerships develop. As part of new delivery system models and provider relationships across a continuum of coordinated care, IT system interfaces need to be installed with other providers outside of the mainstream health system, including community providers. As state and federal quality reporting requirements continue to evolve in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act and the ACA, providers will need to incorporate these demands into their workflows and ensure their IT systems are nimble enough to accommodate these requirements.¹⁶ Timely data reporting and analysis will be critical responsibilities of providers and states as they pursue the payment changes and quality improvement goals of the current push for delivery system reform.

DEPLOYING NEW IT CAPACITY WITHIN INTEGRATED DELIVERY SYSTEMS

Integrated delivery systems have embraced information technology as a tool for improving care processes by ensuring that caregivers have access to—and make use of—real time clinical information about patients and other clinical decision supports. Examples of how EHRs and information systems are being used in integrated delivery systems include:

- **Measurement for improvement.** Intermountain Healthcare in Utah developed a clinical management information system for measuring adherence to clinical guidelines and for tracking cost and quality outcomes around specific clinical care processes.¹⁷
- **Workflow simplification.** The Geisinger Health System in Pennsylvania uses electronic health records and data infrastructure to streamline physician workflows by eliminating, automating, or delegating many tasks.¹⁸ All relevant clinical information is available at the point of care, and patients' care plan needs are incorporated electronically into physician order sets.
- **Enhancement of clinical care processes.** Trinity Health, a multi-state health system headquartered in Michigan, implemented a system-wide EHR and redesigned key aspects of care delivery.¹⁹ The EHRs were used to reduce variations in care processes and to promote evidence-based practices by incorporating clinical decision support tools. EHR use allowed nursing assessments for pain level, immunization status, fall risks, tissue integrity, sedation level, and priority needs of patients to be embedded into physician workflows.
- **Patient populations and disease tracking through registries.** Regional subsystems within the New York City Health and Hospitals Corporation update disease registries nightly directly from EHRs, allowing physicians to track and understand their patient populations over time.²⁰

STATES' DATA AND IT STRATEGIES FOR DELIVERY SYSTEM REFORMS

States are participating to varying degrees as part of broad and multifaceted federal strategies to drive IT system modernization. Both HITECH and ACA give states options for enhanced funding for clinical, as well as administrative, information systems, including Medicaid management information systems and eligibility and enrollment functions. However, states remain challenged in their efforts to organize, deploy, and adequately finance the full range of IT capacity building efforts required to support both coverage and delivery system reforms.

Nonetheless, states are crafting various strategies to realize greater value from health care expenditures and linking them to data and IT system development. In addition to or as part of Medicaid integrated delivery system strategies, state actions include a variety of quality improvement initiatives, pay for performance pilot programs, and managed care contracting programs incorporating quality measurement and performance incentives. Examples of state initiatives include:

- **Multi-payer claims databases.** Thirteen states have developed all-payer claims databases.²¹ In Maine and New Hampshire, aggregated payment data are published online and de-identified, and research files are made available for qualified uses.
- **Data analytics linked to performance-based contracts.** Colorado is developing a statewide data analytics organization to support care integration. These information supports will enable performance-based contracts with new Medicaid regional collaborative care organizations as part of the agency's Accountable Care Collaborative Program.²²

- **Linking HIT capacity to other pay-for-performance or pay-for-participation programs.** Most state Medicaid programs operate pay-for-performance programs, some of which are explicitly linked to use of health information technology.²³ Alabama increases case management fees for providers who connect to an electronic database offering patient-specific drug, office visit, and laboratory result information.
- **Incentives for EHR adoption and health information exchange.** Every state is participating in the federal Medicaid EHR Incentive Program established by the HITECH Act. Under the program, the state supervises incentive payments to Medicaid providers who adopt and meaningfully use EHRs. Providers must report electronically on select quality measures to meet the definition of meaningful use.²⁴ The HITECH Regional Extension Center program provides supports for providers across states to adopt and integrate EHR systems. Each state also participates in the federal State Health Information Exchange Cooperative Agreement Program under HITECH and receives funds to help implement statewide networks and interfaces for information sharing. By and large, these state efforts are in early stages; IT supports within leading integrated delivery systems are targeting EHR adoption and information sharing among health care partners with business affiliations often using common EHR platforms.

TWO EXPERIENCES - DATA AND IT SYSTEM DEVELOPMENT FOR INTEGRATED SYSTEMS

At the 2011 meeting, a leading integrated delivery system and an innovative state offered insights into their experiences in implementing critical IT supports.

Intermountain Healthcare - Harnessing Data for Quality Improvement

Intermountain Healthcare is a nonprofit integrated health system serving Utah and southeastern Idaho and is recognized for its innovative use of information technology as a driver of improvements in the clinical processes of care. Dr. Christopher Wood, Intermountain's Medical Director for Information Systems, participated in the meeting.

Dr. Wood described how Intermountain has seamlessly integrated information technology tools into a broader strategy for systematically measuring and improving care by developing innovative organizational structures designed to improve key clinical processes. In this context, key processes are:

- High volume processes affecting large numbers of patients;
- High morbidity or high mortality processes with associated high costs;
- Processes in which care is delivered in a definable clinical micro-system;
- Processes characterized by great variability in how care is delivered.

Clinical operations teams bring hospital, physician, and nurse leaders to the same table and ensure they share responsibility for the same care processes. Evidence-based shared protocols of care, developed collaboratively by clinicians and representatives from Intermountain's information systems, administrative, and financial departments, form the basis of clinical processes. These protocols serve as common baselines of care from which clinicians can deviate according to patient needs. Electronic health records are a key to Intermountain's strategy for quality improvement, allowing clinical teams to monitor progress and adherence to evidence-based protocols, and enabling development teams to focus on data driven targets for improving clinical processes.

Dr. Wood shared an illustrative example of the roles that information technology and data play in improving care at Intermountain. One of the highest-volume procedures at Intermountain is delivering healthy babies. While medical literature suggests that the earlier a first time mother is induced for labor, the more likely she is to need a Caesarian-section, individual physicians at Intermountain maintained that they had never had that experience. Intermountain was able to use its information technology and data analytics infrastructure to capture the relevant data and show physicians that Intermountain's own experience validated the medical literature. This ability to provide feedback to physicians made a difference in the way physicians approached deliveries. This knowledge has now been incorporated into Intermountain's workflows: the electronic appointment book for deliveries cannot even be opened without first inputting relevant data about the pregnancy. As a result of these interventions, the length of time Intermountain's nurses spend delivering babies has fallen, Caesarian-sections have dropped, and delivery costs have stayed below expected trends.

This is one of many examples that illustrates that Intermountain's IT focus lies in finding ways for data to help clinicians consistently make better decisions. According to Dr. Wood, Intermountain's experience suggests information technology supports are valuable tools in several important areas.

- **Pay for Performance.** Data is needed to reward performance, as well as identify procedures or care processes for which utilization, costs, or quality are outliers. Using information collected through appropriate IT tools can help drive variable cost out of a health system.
- **Fostering efficiency under bundled payment arrangements.** Financial management under bundled payment arrangements and other payment reforms requires timely data translated into information for providers, enabling them to monitor and adjust the efficiency and effectiveness of their services.
- **Integrating care for patients.** Greater delivery system integration will require the ability to follow Intermountain's lead in analyzing the processes underlying care delivery. This involves measuring quality outcomes, looking for insight on high-volume and high-cost procedures, and working collectively as a care team to re-design processes that result in highly coordinated care with positive outcomes for patients.

Oregon – Lessons Learned During State Delivery System Reforms

Oregon is in the midst of state-level health reforms that pre-date the passage of the ACA in 2010. Carolyn Lawson, Chief Information Officer for the Oregon Health Authority, noted that, among other changes, Oregon recently consolidated the state's health services purchasing power into a single health authority, in part to help drive delivery system reform. In her remarks, Ms. Lawson reflected on the technical challenges of meeting the integration demands of both state and federal health reform as a key concern in Oregon.

She focused on the importance of coordination and clear communication between policy leaders and IT professionals in state government and emphasized repeatedly that policy should drive IT decisions, saying that too often structural forces in states encourage the reverse. To overcome the disconnect that often exists between IT professionals and health policymakers, Ms. Lawson offered observations from the ongoing experience in Oregon:

- **Structure Policy-IT communication and collaboration.** A dialogue between state policy leaders and IT personnel is essential to establish information systems that can meet the policy needs of the state. The technical professionals need not be decision-makers about directions in health policy, but they do need a seat at the table so they can listen and understand which tools the state will need. State leaders need to confer with IT personnel to identify data needs and determine how to make data available to answer policy questions.

- **Create a data strategy.** Think about where the data required to meet the state's policy goals is located and determine the most effective ways to link the data together (e.g., in a single location or in multiple locations that can be queried using a single tool). Oregon has large amounts of data available in formats—Portable Document Formats (PDFs)—that cannot be co-mingled with other data. This is not conducive to achieving the state's health policy objectives.
- **Apply technology.** An inventory and gap analysis of existing IT assets will help the state avoid redundant and underused tools. State leaders should create a technology plan and an implementation plan based on the results of the state's IT gap analysis. Ms. Lawson reminded policymakers not to settle for what the available technology offers but instead to ask for the right IT tools to meet the state's policy goals.

In addition to this strategy, Ms. Lawson discussed the importance of building the human capital within state government to manage information technology tools. Oregon is creating an enterprise architecture team and training its staff to a skill-level equivalent to IT consultants. By developing the skills in-house to manage the state's health information technology infrastructure, Oregon will avoid some of the frustrations of the state procurement process for outside vendor support.

MOVING FORWARD - LEVERAGING IT CAPACITY TO SUPPORT INTEGRATION

Despite their many successes, states have struggled with the limitations of their data. The inability of older generation siloed and largely paper-based information systems to provide robust and timely information has created barriers for agency programs. Most significantly, it has limited the nature and degree of leverage exerted by states in their roles as regulators and payers under Medicaid, insurance and other human services programs. States also face challenges in developing IT system capacity as they seek to juggle various priorities: the harmonization of state and federal IT supported information strategies; the integration of delivery system reform objectives into the state's IT development plan; demands that compete with the prioritization of capacity development for integrated delivery systems; and timing issues around state readiness and federal IT and delivery system reform timelines. Overcoming these challenges to advance along the continuum of integration will require a concerted strategy of leveraging existing and emerging IT capacity in cooperation with a range of stakeholders in the state.

Dr. Wood and Ms. Lawson offered several pieces of advice for states to consider as they advance delivery system integration strategies.

Assist providers in electronic health record adoption and financing. In addition to building the infrastructure needed to facilitate the exchange of health information across and between states, state governments will need to make sure providers are positioned to take advantage of that infrastructure. A united effort between public and private payers to encourage the adoption of electronic health records is crucial, as many of the functions required for greater delivery system integration require the existence of sufficient IT supports. The federal incentives available through Medicare and Medicaid may not be enough for all providers. Additional financial assistance may be necessary to help small providers adopt and use electronic health records.

Promulgate standards for data storage and exchange. Intermountain is collaborating with four other integrated delivery systems in a Care Connectivity Consortium to take interoperable health information exchange to the next level by sharing information between widely separated health systems.²⁵ Coherence in national standards for exchange, as well as in state-level decisions about privacy and security standards for data transmission, is necessary to facilitate wider information sharing.

Demand quality outcomes. Dr. Wood indicated that focusing on measuring and rewarding quality outcomes will force providers to deliver quality over time through integrated systems. Such a quality focus will require IT supports and help drive targeted EHR adoption and IT system strategies. Similarly, developing reimbursement methods that incent physicians, hospitals, and payers to work together for quality outcomes will require IT systems that support timely data sharing and analytics.

Define success before you begin. Any large-scale data projects in the state should be accompanied by concrete performance measures. State policymakers should be prepared to evaluate actual outcomes against assumptions and expectations, revisiting the state's data strategy as necessary. States should be careful to set the expectation among players in delivery system reform such that the incorporation of health information technology tools will be a continuous, iterative process. The work states are doing is too important to not get the most out of their technology.

IV. BEYOND THE USUAL SUSPECTS IN INTEGRATED CARE NETWORKS: INNOVATIVE NETWORK PROVIDERS AND SERVICES

Two hallmarks of integrated care models are the innovative use of the health care workforce and creative approaches to delivering services. Advancing along the continuum of integration requires moving beyond care delivered in traditional hospital or physician practice settings to incorporate a wider array of provider networks, care settings, and processes of care. This broader approach aligns with an emerging paradigm that is at the heart of increasingly popular care models, such as patient-centered medical homes, health homes, and ACOs. Re-engineering health care along these lines to improve quality, services, and efficiencies challenges providers to adapt to new practice dynamics and a culture of interdisciplinary and intra and inter-organizational relationships. States, as they pursue value-based health care coverage and delivery system reforms—especially to serve the expanded populations who will be eligible for coverage under the ACA—must seek the right strategies for establishing provider network adequacy standards. They must balance the need for appropriate minimum standards with ensuring opportunities for provider flexibility as integrated care models continue to evolve.

INTEGRATED CARE AND A NEW PARADIGM FOR DELIVERING SERVICES

Emerging integrated health care models involve coordinating acute, chronic, preventive, and end of life care, as well as community and social supports for the patient. These enhanced forms of primary care seek to address diverse medical and non-medical patient needs and recognize that providers beyond just primary care physicians are essential. For example, a CMS letter describing the new Section 2703 Medicaid State Option to Provide Health Homes for Enrollees with Chronic Conditions reviewed the provider infrastructure necessary for a health home.²⁶ In addition to a designated primary care provider, health home provider arrangements could consist of:

- A **team of health care professionals**, consisting of physicians and other professionals that may include a nurse care coordinator, nutritionist, social worker, behavioral health professional, and others; or
- An interdisciplinary **health team** which may include medical specialists, nurses, pharmacists, nutritionists, dietitians, social workers, behavioral health providers, doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants.

PROMISING PRACTICES IN INTEGRATED DELIVERY SYSTEMS

Promising models of care are developing that include providers working in teams, innovative care processes and settings such as group visits and use of nurse practitioners and providers such as health educators, behavioral health practitioners, and other community-based workers. For instance, Kaiser Permanente's Collaborative Cardiac Care Service is a multidisciplinary approach to caring for patients with coronary artery disease. Teams involving physicians, nurses, and clinical pharmacists work collaboratively with patients to coordinate cardiac risk reduction strategies.²⁷

Furthermore, spurred by Medicaid managed care strategies and other reform efforts, health care delivery systems have been moving to expand their provider networks to serve targeted patient populations. Examples highlighted in a recent U.S. Government Accountability Office examination of integrated delivery systems include:²⁸

- **School-Based Health Centers** Some integrated delivery systems run School-Based Health Centers that provide primary care to underserved children, regardless of ability to pay.

- **Federally Qualified Health Centers (FQHCs)** These include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers. Some integrated delivery systems operate FQHCs directly, while others collaborate with FQHCs (e.g., by providing specialty care to patients who receive primary care in the FQHC).
- **Mobile Health Units** Integrated delivery systems can use mobile health units to offer acute and chronic care to underserved populations, including homeless or rural patients.
- **Telehealth** Remote interaction between patients and primary care physicians or specialists enables some integrated delivery systems to expand the reach of their networks to rural areas.

STATES STRATEGIES TO FOSTER USE OF INNOVATIVE PROVIDER NETWORKS

Through contracting strategies as part of Medicaid, state employee benefits, and health insurance exchanges, as well as through broader health delivery reform efforts, states are in a position to influence the development and sustainability of new provider relationships that are key to innovative, cost-effective integrated care models. Opportunities include:

- Encouraging the expansion of integrated care networks to include community based providers already engaged in trusting relationships and providing effective services to patient populations;
- Developing contracting requirements and payment methods that foster the sustainability of expanded provider networks and services;
- Fostering agreement for new core competencies for both states and providers that address goals for reducing health disparities, enhancing cultural competency, etc;
- Breaking down walls for IT-supported data-sharing (for example, on mental health history) and expanding efforts to digitize health records across diverse care settings and services (e.g., standardized data elements and quality measures for care coordination); and,
- Supporting ongoing change management efforts to foster new partnerships among providers and adoption of new team-based practice patterns.

As pressure for state health care reforms continues to build, and considering the context and timeline for Affordable Care Act implementation, many states are moving toward integrated health care and addressing provider network participation. California received approval for a Section 1115 Demonstration Waiver that will expand the use of medical homes to improve care coordination for Medicaid beneficiaries.²⁹ Safety net providers, including public hospitals, private community hospitals, physicians, and community health centers, will be contracted to serve as medical homes. In addition, a Delivery System Investment Pool will be created to support public hospital systems and strengthen the safety net delivery system.

The State of Utah has submitted the Utah Medicaid Payment and Service Delivery Reform 1115 Waiver Request, which would replace the current Utah Medicaid managed care model with the Utah Medicaid ACO model.³⁰ The medical home model would be built into Utah's ACO delivery model. These examples of states making innovative uses of providers and care settings to expand access and improve coordination will only become more numerous as the provisions of health reform emphasizing integrated health care delivery are fully implemented.

CONSIDERATIONS FOR SAFETY NET PROVIDERS AND PATIENTS

Integrating care for patients who rely on the safety net currently presents challenges for providers and states alike. Fragmentation among safety net providers and a sparse history of partnering with peers

inhibits care coordination for patients with multiple providers. Despite recent investments by Federally Qualified Health Centers in redesigning care processes and implementing electronic health records, a lack of investment in health information technology in many safety net facilities still hinders care coordination and prevents the generation of accurate cost and quality data. A challenge for safety net health clinics is developing new business partnerships, accountabilities and data sharing capacities for measuring quality in new ways. Perhaps even more fundamental, the unique needs and characteristics of the population served by the safety net make implementing financially sustainable models of integrated, patient-centered care challenging, especially as states consider new delivery systems that include public and private providers.³¹

States pursuing integrated care face challenges in creating reasonable and achievable expectations for health plans and providers regarding safety net collaboration. Integrating care for complex populations who have psychosocial needs in addition to traditional medical needs may require health plans to engage in services outside of their traditional roles or core competencies, generating new measurement and oversight demands for states.

TWO APPROACHES – EXPANDING ALTERNATIVE SERVICES AND PROVIDERS

Speakers from Washington state and Kaiser Permanente shared lessons learned from their experiences engaging safety net providers and providers who fall outside of a strictly medical model.

Kaiser Permanente - Strategies for Engaging the Safety Net

Dr. Susan Fleischman, Vice President of Medicaid, CHIP, and Charitable Care for the Kaiser Foundation Health Plan, Inc., offered Kaiser Permanente's perspective on expanding provider networks. Dr. Fleischman emphasized that developing alternative community-based provider networks is challenging even for experienced integrated delivery systems. New service providers from a range of areas beyond physical health must be incorporated into delivery networks if whole-person care is to be delivered in integrated systems. Other service delivery areas that must be considered include:

- Mental Health
- Dental
- Community Health
- Long-term Care
- Case/Care Management
- Public Health
- Chemical Dependency
- Home Care
- Other Social Services

Though Kaiser Permanente has been highly successful at integrating delivery of physical health services, that integration is achieved mostly using Kaiser Permanente's own delivery system, not via a network of diverse providers. Dr. Fleischman explained that as the scope of integration expands, the challenges—ranging from financial to operational to cultural—expand as well. Engaging a broader array of providers requires more than a contract. It requires tactical integration, such as the alignment of clinical guidelines and the sharing of data via mechanisms like electronic health record interfaces, and it requires cultural integration, in which diverse providers develop bonds of trust and learn to work as part of a larger team.

Kaiser Permanente has invested a large amount of time and resources in the safety net. It sponsors a safety net scholarship program that trains clinical quality leaders by connecting them with Institute for Healthcare Improvement learning opportunities. Kaiser Permanente builds trust—the hardest part of integration for all participants—by placing Kaiser Permanente nurses and physicians in community clinics. The organization has partnered with the National Association of Community Health Centers to develop patient-centered medical homes in the safety net. Kaiser Permanente's ALL (Aspirin, Lisinopril and Lipid-Lowering Medication) and PHASE (Preventing Heart Attacks and Strokes Everyday) programs to reduce

cardiovascular risk among diabetics have been implemented in community clinics and public hospitals. Each of these initiatives is designed to strengthen new high-quality partners in the safety net.

Lessons from Washington State - Health Plans and Nontraditional Providers

MaryAnne Lindeblad, the Assistant Secretary of Washington state's Aging and Disability Services Administration, offered insights from her state's experience fostering networks and care for diverse populations. Like other states, Washington offers a range of services to its Medicaid population: mental health, care for developmental disabilities, long-term care services and supports, and substance abuse treatment. Despite Washington's fondness for pilot programs, demonstration projects to integrate care in the state have struggled: services in Washington are fragmented, with a majority of the Medicaid population in a fee-for-service environment despite a growing number of individuals receiving Medicaid managed care.

Ms. Lindeblad emphasized that medical and social service needs are interrelated, and both are necessary to achieve good health outcomes. Building on Mr. Koller's earlier point about the importance of considering the needs of various populations in the state, Ms. Lindeblad explained that Washington believes delivery system integration is a key to achieving its strategy of getting the right care to patients at the right time, in the right place, and at the right price. Given Washington's experience in attempting to work with payers to integrate the delivery of services beyond just medical, Ms. Lindeblad offered several suggestions for what states will need from health plans and delivery systems if they are to succeed.

Clear vision and commitment. Health plans will need to develop expertise in serving individuals with complex needs, and work quickly to implement improvements to service when deficiencies are discovered. States looking to integrate multiple services for Medicaid beneficiaries will need to be very specific in contracts with health plans to ensure that goals and expectations are clear. At the same time, however, plans should have some flexibility to look at different ways to address the needs of the highest cost and highest need patients, as well as to make credentialing of and payment to providers easier.

Access and equity. States must ensure that health plans maintain an adequate provider network, particularly since some of the providers being brought into the network may have little experience with Medicaid health plans or populations. States should also consider reducing or eliminating waitlists for services and increasing home- and community-based care. Some health plans in Washington have realized the importance of hiring peers and other people from the community to help meet the needs of clients.

Balance of medical and social models. Ms. Lindeblad cautioned that states and health plans should be careful not to "over-medicalize" the social model of care. Health plans should be encouraged to recognize the value of wraparound services and build relationships with housing and safety net provider networks. A philosophy of self-management and participant direction allows health plans to meet people where they are and allows individuals to develop confidence in the value of the care they are receiving.

Recognition of diversity. Health plans will need to anticipate needs for translation, interpretation and support for clients and providers. In Washington's Medicaid population, more than 60 languages are spoken; some health plans in the state contract with organizations with experience dealing with minority populations.

MOVING FORWARD - GUIDANCE TO FORGE NEW PARTNERSHIPS

Expanding care networks to include new provider groups is a major challenge to states as they move along the continuum of integration. Several tips for states emerged from the meeting:

Have reasonable expectations and support potential new partners in moving towards integration.

States will need to remember that providers and health plans do not have experience integrating some of the services they will be asked to provide. There will be a learning curve for all participants as greater levels of integration are achieved. Meeting participants stressed that states must find a balance between fostering the growth and maturation of new partnerships and responding (e.g., through contract vehicles) to the need to move quickly to begin integrating providers' services.

Move toward integration of funding streams so they serve the member. The theme that payment influences the shape of service delivery emerged again during this session of the meeting. Participants emphasized that Medicaid carve-outs for services such as mental health treatment reinforce the fragmentation of health care and inhibit integration and coordination. If integrated delivery networks are to expand to include providers of behavioral health, long-term care, social and other services, the funding streams that support these providers will also need to be integrated.

Work with providers to protect them from unacceptable risk. States will need to consider ways to shelter integrated delivery systems from some of the financial risks associated with taking on additional services, particularly long-term care. Meeting participants repeatedly emphasized the importance of considering behavioral health and long-term care supports when planning for delivery system integration. However, these services can have significant financial risks that may deter providers and integrated delivery systems from expanding to incorporate them. States can play a role in mitigating some of these risks to remove an important barrier to engaging providers beyond just medical practitioners in integrated networks.

CONCLUSION

The U.S. health care system is in the midst of a major transformation as policymakers seek to reform the delivery of health care to reduce wasteful spending, encourage the provision of high-value services, and reduce the fragmentation that compromises care quality. Major initiatives aimed at reforming payment structures, promoting the retention and sharing of information, and forging links between disparate care settings and providers are all aimed at enabling a reorganization of care delivery.

NASHP's 2011 meeting provided a distinct opportunity for dialogue and shared learning among delivery system and state policy leaders. The findings summarized in this report point to a set of invaluable lessons learned by early leaders—both states and health care systems—about the promise of integrated health care and how to move toward these types of systems.

MOVING FORWARD - KEY THEMES

An overriding message from meeting participants is that true delivery system integration—not simply aggregation of disparate providers—needs to be the focus for states as a central goal for structuring system changes during the move to health homes and accountable care organizations. States, particularly in their roles as purchasers and regulators, have significant leverage over delivery systems. They can seek to produce the alignments needed to integrate providers, as well as bring private sector participants together to solve problems. It is inevitable that achieving major gains in value and efficiency through more integrated systems of care requires disruption as providers alter their patterns of care and payers change reimbursement patterns. States are uniquely positioned to consider and seek to balance the level of discomfort that all players in the health system can tolerate in driving toward change.

As states seek to make progress on these multiple fronts, it will be important to keep in mind several themes from the meeting.

Start where you are. Delivery system integration is not a goal states should feel pressured to achieve in a single leap or bound: states may need to start small, even though they want to think big. States can begin fostering integrated delivery systems now, regardless of the degree to which systems in the state are already integrated. States should look to areas where they have a great deal of authority and financial leverage over a defined population to begin pursuing integrated delivery; integration efforts do not initially need to comprise the state's entire delivery system. Regardless of where state delivery systems lie on the continuum of integration, they can partner with stakeholders to work toward greater integration one step at a time.

Remember that integration is not a single task. Integration consists of interrelated efforts to reform payment systems, develop the necessary information technology supports to enable data-driven policy and practice, and build partnerships and linkages between an array of service providers that extends beyond medical practitioners. A focus on culture will be essential for states as they build integrated delivery systems, since culture often trumps policy strategy. Cultural factors can present barriers to payment reform, effective integration of IT into clinical workflows, and relationship-building between disparate groups of service providers. This is an area where states have the benefit of understanding local culture and are best able to adapt successful approaches to state-specific conditions.

Leave room for innovation. States will need to foster a diversity of approaches, but recognize and cultivate the common elements of success: organizations with a well-defined mission, strong leadership, appropriate use of information, a culture of sharing and willingness to exchange information among all parties involved. While standardized care elements are an essential component of integrated care delivery,

organizational structures and models of care may vary; interventions must be specific to a state or region's health system context. In encouraging innovation and multiple approaches to integration, states should be prepared for failures.

Consider all populations. Throughout the meeting, attendees expressed great interest in including populations that require behavioral health and long-term care services in the planning for delivery system integration. Incorporating these kinds of needs may be challenging and will require new partnerships between providers. Regardless of whether a state intends to incorporate those needs in the initial push for integration, the state should consider how to reach out to those populations in the future.

The time is ripe for states to partner with delivery system leaders and other stakeholders to address the deficiencies in the health care system caused by unnecessary fragmentation and duplication. Integrated delivery systems offer the prospect of high-quality care and a better patient experience at a lower cost. Private and public sector integrated delivery systems across the country have success stories to tell, and states should begin a dialogue with these systems as a springboard to statewide integration efforts. By wielding the policy levers available to them and incorporating the lessons learning from successful systems, states can begin to build high-value, integrated systems that meet the triple aim of better patient care, better population health, and reduced costs.

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