IMPLEMENTING HEALTH REFORM

Innovation Center to Focus on Pilot Projects

Next year, the federal government will launch the Center for Medicare and Medicaid Innovation, a new department to oversee the portfolio of payment pilot projects called for under the Affordable Care Act. As part of its charge, the innovation center will develop and evaluate pilot projects for new and old payment ideas that include accountable care organizations, patient-centered medical homes, bundled payments, and capitated payments.

Officials at the new center, one of the Centers for Medicare and Medicaid Services (CMS), will have the authority to extend or expand projects that show the potential to improve quality or cut costs.

Stuart Guterman, who studies payment policies for the Commonwealth Fund, explains the potential and the challenges for officials leading the new innovation center.

BY STUART GUTERMAN

RHEUMATOLOGY NEWS: Why did lawmakers create this innovation center as part of the Affordable Care Act? Is it necessary?

Mr. Guterman: I think it is necessary. I think, in fact, it may turn out to be one of the most important provisions in the law. It focuses the attention of the CMS, which runs the two biggest health programs in the country, on the notion of innovation. It emphasizes the idea that we need to try new approaches to both payment and delivery of health care to get off the path that we're on, which is leading to ever-growing health care costs and increasing pressure on the health care system.

We already spend 50% more than any other country in the world on health care. Everybody points to the amount of waste in the system. But it's harder to identify ways of actually getting rid of it and making the health care system work better for people. That's what this innovation center was intended to do – to focus the attention of the federal government on that issue and to bring in the other parts of the health care sector to collaborate on better ways of providing care and better ways of paying for care.

RHEUMATOLOGY NEWS: Some of the concepts—such as medical homes and capitated payments—have been tested before. What makes this effort different?

Mr. Guterman: Capitation was tried in the 1990s, but the world was a different place then. In the 1990s, we didn't have the kinds of measures of health system performance that we have now.

Also, the notion of capitating payments so that you provided a strong incentive to reduce costs got separated from the notion of providing care in an effective, efficient way. So we started out with a managed care movement that was focused on providing coordinated care for patients and we ended up with a movement that was focused primarily on reducing the costs, sometimes in arbitrary ways.

Today, I think we have the tools to avoid going off that track. We may not get all of the way to capitation, but there are bundled payments and other strategies that get us away from the current fee-for-service system.

In terms of the medical home, models are being tested by various private payers, Medicare is developing a demonstration project, and Medicaid is testing several models. But those efforts are fragmented, just like the rest of our health care delivery and financing systems. If we conduct these pilots individually, they are much less effective than if they can be coordinated and focused, using the same kinds of measures.

RHEUMATOLOGY NEWS: What are the keys to making the innovation center successful?

Mr. Guterman: We need to bring together all of the health care system's stakeholders. We are currently projected to spend between $30 trillion and $35 trillion on health care over the next 10 years. The issue is not what to cut, it's how to use some reasonable amount of money to buy the kind of health care we think our system should produce. That requires the involvement of everyone—providers, patients, and public and private payers.

RHEUMATOLOGY NEWS: What challenges will officials at the innovation center face in rapidly testing new payment concepts?

Mr. Guterman: It's easy to say that everyone ought to be involved, but right now people tend to look at change as something that threatens them. We need to overcome that. We also need to have patience. A lot of these projects will take time to develop and implement, and to adjust as they go along. But Congress and the American public also need to have patience and realize these strategies will take a while to unfold.

RHEUMATOLOGY NEWS: Is the innovation center's work likely to have a significant impact on lowering costs?

Mr. Guterman: Yes, though it's hard to predict just how much. You've got a system now that pays for more care, more complicated care, and more invasive care, but not more appropriate and efficient care. So you've got to figure that if you change the focus from more to better and from more invasive to more appropriate, that you can make some difference in lowering costs. ■

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IOM Finds Progress, Pitfalls in Women's Health Research

Committee recommends initiatives for high-risk populations, creation of communication task force.

BY NASEEM S. MILLER

FROM A PRESS BRIEFING HELD BY THE INSTITUTE OF MEDICINE

WASHINGTON – Over the past 2 decades, women's mortality from cardiovascular disease and breast and cervical cancer has declined, thanks to research focused on women's health; however, little progress has been made in addressing debilitating conditions such as autoimmune diseases, addiction, lung cancer, and dementia, according to an Institute of Medicine committee.

"We are pleased with how much progress has been made, but there are some caveats," Nancy E. Adler, Ph.D., chair of the IOM Committee on Women's Health Research and director of the Center for Health and Community at the University of California, San Francisco, said at a press briefing held to release the report.

Based on the report, "Women's Health Research: Progress, Pitfalls, and Promise," the committee recommended:

► Undertaking initiatives to increase research in high-risk populations of women.

► Ensuring adequate participation of women in research and analysis of data by sex.

► Creation of a task force to communicate health messages about research results to women and prevent them from receiving conflicting messages from various venues.

Communication is one area in which office-based physicians can play an important role, translating research into their practices, said committee member Alina Salganicoff, Ph.D., vice president and director of women's health policy at the Kaiser Family Foundation. "Their recommendations hold a lot of weight" with their patients, she said.

The report comes 20 years after the creation of the Office of Research on Women's Health Research at the National Institutes of Health and 25 years after a Public Health Service task force concluded that excluding women from medical research had compromised women's health care.

Before those landmark events, women were not included in research studies as often as men were because of concerns about fetal exposure to potentially harmful substances, the "flux" of hormones, and the assumption that research findings in men would translate to women, according to the report.

The committee found that requiring researchers to enroll women in clinical trials had resulted in advances, yet the benefit of increased participation by women has not yet reached its full potential because researchers usually don't separate the results by sex.

Committee members could not pinpoint why progress was made in some conditions and not others, according to the report, which offered possible explanations such as the extent of attention from government agencies, interest from researchers, understanding of the condition, and political and social barriers.

In addition to major progress in cardiovascular diseases and breast and cervical cancers, the report noted that some progress had been made in reducing the burden of conditions such as depression, HIV/AIDS, and osteoporosis in women.

However, there has been little progress research having an impact on conditions such as unintended pregnancy, maternal morbidity and mortality, autoimmune diseases, addiction, lung cancer, gynecologic cancers other than cervical cancer, and Alzheimer's disease, according to the report.

"Knowledge about differences in manifestation of diseases is crucial for further studies to identify the underlying biology of disease in women vs. men and to develop appropriate prevention, diagnosis, and treatment strategies for women," wrote the committee members. ■