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### Informational Hearing: Improving Performance and Aligning Incentives in Commercial Health Insurance and Medi-Cal February 27, 2019 - 1:30 PM Room 4203

**Purpose:** The Senate Health Committee will examine strategies across purchasers and programs that have the objective of improving the care delivered to people with chronic conditions. The Committee will focus on aligning incentives to reward excellence in patient health outcomes, meeting the needs of patients across socioeconomic, age, and insurance status, and bringing projects with high quality outcomes to scale statewide.

**Background:** Chronic conditions are the leading cause of death and disability in the U.S., and the biggest contributor to health care costs. However, there is wide variation in their incidence, with major differences depending on age, income, race and ethnicity, and insurance status. According to a report from the California Health Care Foundation (CHCF), about 40% of California adults reported having at least one of the following five chronic conditions: asthma, diabetes, heart disease, high blood pressure, and serious psychological distress. Seventy-one percent of adults on Medicare and 44% of adults on Medi-Cal or other public insurance had at least one chronic condition. Adults with public insurance are more likely to have one or more chronic condition compared to those on private coverage or the uninsured. They are also more likely to face additional socioeconomic challenges that further complicate caring for those conditions. Moreover, where patients reside impacts how they receive care, the cost of that care and even their likely health outcomes as a result of care. A number of entities in California have been working towards improving care and aligning incentives in both the commercial and public insurance markets.

**The Health Care Cost and Quality Atlas (Atlas):** The Atlas is a multi-payer atlas by geographic region, developed by the Integrated Healthcare Association (IHA) with support from CHCF and the California Health and Human Services Agency. The Atlas includes data from commercial insurance, Medicare, and Medi-Cal on more than 30 standardized measures of health care quality, cost, patient cost sharing and utilization. The Atlas is intended to help purchasers, health plans, and policymakers target performance improvement initiatives. Ten health plans participate in the Atlas: Aetna, Anthem Blue Cross, Blue Shield of California, Cigna, Health Net, Kaiser Permanente, SCAN Health Plan, Sharp Health Plan, UnitedHealthCare, and Western Health Advantage. These plans provide commercial Health Maintenance Organizations (HMO),

Preferred Provider Organization (PPO), and/or Medicare Advantage data for 29 million Californians or 75% of the 2015 population. The Centers for Medicare & Medicaid Services (CMS) provides Medicare fee-for-service (FFS) data for the Atlas, and Medi-Cal managed care and FFS results are provided by the California Department of Health Care Services (DHCS).

In 2015, clinical quality varied across the state's 19 geographic regions by an average of 25 percentage points and costs ranged from 22% below to 29% above the statewide average. Northern California continued to show the strongest performance on clinical quality for commercially insured members but at relatively high cost; Southern California performed solidly on quality at much lower cost; and Central California showed weaker performance on quality with mixed cost performance. Like the commercial market, there is wide variation in care in the Medicare program, where clinical quality is better for cancer screening, asthma and diabetes care in Northern California compared to Southern California, and Southern California is better than Central California. Medi-Cal does not exhibit wide variation across Northern, Central and Southern California. However, there is variation across the 19 regions with an average of 22 percentage point difference between the best and worst performing regions. For example, these differences mean if care for all commercially insured Californians were provided at the same quality as top-performing regions, nearly 205,000 more people would have been screened for colorectal cancer and 31,000 more women would have been screened for breast cancer in 2015. If care for all commercially insured Californians were provided at the same cost as observed in San Diego—a relatively high-quality, low-cost region—overall cost of care would decrease by an estimated \$2.6 billion annually, or about 5% of the \$55 billion total cost of care for the commercially insured. Through the Atlas, IHA found the greatest PPO quality improvement was seen on blood sugar control for people with diabetes but compared to HMOs, PPOs were still markedly worse (50% poorly controlled for PPO enrollees compared to 35% poorly controlled for HMOs). In 2019, IHA will update the Atlas with 2017 data.

In addition to the Atlas, IHA has several Align-Measure-Perform (AMP) programs to create benchmarks and performance assessment for medical groups, independent practice associations, accountable care organizations (ACOs), HMOs, Medicare Advantage, and Medi-Cal managed care plans.

**Covered California:** Covered California is California's health benefit exchange where individuals and small businesses can purchase Affordable Care Act (ACA) compliant health insurance. Through Covered California, individuals who qualify can get Advanced Premium Tax Credits funded by the federal government and for some with lower incomes, additional cost sharing reductions. There are 11 participating plans serving over 1.4 million Californians who purchase insurance through Covered California. Individuals who purchase health insurance outside of California also benefit from Covered California's selective contracting, standardized benefit designs, and premium rate negotiations because Qualified Health Plans (QHPs) must also offer those same products at the same premium prices outside of Covered California.

In the QHP contracts, Covered California sets forth specific requirements related to improving quality, lowering costs, promoting better health and reducing health care disparities, both for the Covered California enrolled population and more broadly in the health care system. Covered California's focus has been on prices, benefits, networks, quality, and other factors that assure

those with coverage through Covered California get the right care at the right time, and that, when aligned with actions of other payers and purchasers, promote delivery system reforms to improve health care for all Californians.

Beginning with the 2014 plan year, Covered California set forth standards and strategy for quality improvement and delivery system reform in a Model Contract that was updated in 2017. Many of these standards and strategies are outlined in "Attachment 7" of the contract. One standard requires QHPs to report initiatives undertaken to improve the routine exchange of timely information, which could include notifying primary care clinicians when one of their patients is admitted to a hospital. Another requirement on QHPs is developing systems to collect clinical data as a supplement to the annual Healthcare Effectiveness Data and Information Set (HEDIS) process developed by the National Committee for Quality Assurance (NCQA), such as diabetes test lab results and blood pressure readings. QHPs must track quality measures on diabetes, hypertension, asthma and depression by racial or ethnic group or both, including for the health plan or insurer's full book of business, excluding Medicare.

Attachment 7 requires QHPs to agree to actively promote the development and use of care models that focus on access, care coordination, and early identification of at-risk enrollees and consideration of total cost of care, including ensuring that all enrollees have a primary care clinician. These models should include patient-centered medical home (PCMH), integrated healthcare models (a system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary providers) or ACOs. QHPs are required to report annually for the percent of enrollees obtaining primary care in a patient centered medical home based on national benchmarks. QHPs are also required to implement value-based reimbursement methodologies to providers within networks contracted to serve Covered California. Value-based reimbursement methodologies must include payments to hospitals and physicians that are linked to quality metrics, performance, costs and value measures and must include the health plans or insurers entire book of business with the provider.

At a recent board meeting, Covered California reported on the progress of adoption of payment reforms among larger network plans with market power, blended case rates for maternity, value based contracting with hospitals, ACO/Integrated Health Care (IHM) models, and 99% of enrollees have a primary care provider. There is evidence of significant investment in supporting providers in advanced primary care practice transformation, and less progress with primary care payment reform and PCMH recognition. There is significant growth in enrollment in ACO/IHM models for network QHPs, and advances in standardization of measuring ACO performance that will permit comparing ACO models. In the three years of baseline data for chronic conditions and depression, QHP issuers show steady improvement for a subset of important measures including blood sugar levels, diabetes medication adherence, and colorectal cancer screening.

Covered California is in the process of revising and improving their quality improvement and delivery system reform standards and requirements for the 2021 plan year.

As ACA marketplaces continue to mature and evolve in response to federal and state policy changes, one of the indicators of an exchange's success involves the average health status of

enrollees who participate. An exchange that attracts a disproportionate number of enrollees with poor health status may be at risk. The ACA established three programs to manage risk and stabilize the new market. Two of the three programs (reinsurance and risk corridors) were temporary programs available in the first three years of implementation of the ACA (from 2014 through 2016) to encourage health insurance companies to participate and offer reasonable premium rates without knowing the health status of the newly insured population. Both programs provided individual market plans with high cost populations payments to offset those higher costs. A reinsurance program assesses all health insurance issuers and self-insured plans to fund payments to individual market plans inside and outside of an exchange. The risk corridor program is funded from QHPs with lower than expected claims and payments are made to QHPs with higher than expected claims.

The risk adjustment program is the third market stabilization program and is still in effect. Risk adjustment is intended to protect against adverse selection (only people who need care seek it out) and risk selection (when health insurers avoid people with costly conditions) in the individual and small group markets, inside and outside of the exchanges by spreading financial risk across the markets. Plans with lower risk scores make payments to plans with higher risk scores. A May 2017 report by Covered California that uses the year-specific risk scores from 2016 and 2017 shows that 2017 enrollment was slightly healthier, with fewer chronic conditions compared to 2016. Another finding is that for both 2016 and 2017 enrollment cohorts, mean risk scores increased as plan actuarial value increased, meaning that consumers are selecting a plan that provides financial coverage for their expected health care needs. The report also finds that healthy new enrollees in Covered California contribute to the stability of this marketplace.

For the 2017 risk adjustment year, CMS indicated the permanent risk adjustment program is working as intended. In the 2017 benefit year there was a shift in healthier enrollees from richer benefit plans to those with less coverage in the individual market and to a lesser extent in the small group risk pool. With respect to California-specific 2017 benefit year transfers, Anthem, Blue Shield of California, and Cigna were receivers of risk adjustment transfers in the individual risk pool and Kaiser, Molina, Centene, and other regional and local plans were identified as payers of risk adjustment transfers.

There has been litigation around CMS' use of the statewide average premium in the risk adjustment transfer formula for the 2014-2018 benefit years, which has not yet been resolved. Additionally, CMS has recently proposed changes to several risk adjustment requirements to which Covered California has submitted comments, including that near-term improvements should be made to ensure that risk adjustment data validation is performed more accurately and that the methodology reflect 2019 enrollment data to account for the impact of the elimination of the individual mandate penalty. Covered California also suggests long-term improvements to the risk adjustment process to assure improved accuracy, and minimize health plan uncertainty, and Covered California encourages federal Health and Human Services to convene a workgroup to discuss improvements.

**California Public Employees' Retirement System (CalPERS):** CalPERS is the nation's largest public pension fund, serving more than 1.9 million members. It is also the largest public

employer purchaser of health benefits in California and the second largest employer purchaser in the nation after the federal government. CalPERS spent \$9.2 billion in 2018 to purchase health benefits for 1.5 million members and their families. CalPERS contracts with seven HMOs; two Exclusive Provider Organization (EPOs) and three self-funded PPOs. There are also three association plans.

In 2017, approximately 41% of members enrolled in a CalPERS health plan had an existing chronic condition and 30% had one or more of the major most prevalent chronic conditions. In 2017, seven of the major chronic conditions, affecting between 0.5 and 10.5% of CalPERS' California population, were:

- Hypertension
- Diabetes
- Depression
- Asthma
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure

In CalPERS' Medicare plans, conditions such as hypertension and diabetes are highly prevalent. The CalPERS population, on average, is older and has a higher prevalence of chronic conditions when compared to other insured populations. According to the two largest carriers by enrollment, which account for roughly two-thirds of CalPERS' population, the prevalence of diabetes, depression, coronary artery disease, heart failure, and asthma are all higher among members enrolled in CalPERS' plans.

CalPERS is engaged in many efforts to ensure quality care for CalPERS members. In June 2016, the board adopted "diabetes prevention" as one of five benefit changes for the 2017 health plan year. The board required all CalPERS contracted health plans to implement diabetes prevention programs that meet the Centers for Disease Control and Prevention "Diabetes Prevention Recognition Program Standards and Operating Procedures," at no additional cost to members. This benefit is designed to reach pre-diabetic plan members to prevent or reduce the onset of Type 2 diabetes.

Beginning in 2019, a new value-based insurance design (VBID) option is available for those enrolled in the PERS Select Basic plan. This plan provides members and their families a lower-cost option and encourage enrollees to be more engaged in their health care. By adjusting co-pays for some services and by introducing the VBID option, CalPERS is offering a lower-cost premium plan with a slightly different cost-sharing structure and lower actuarial value. This lower cost plan aims to improve the health of enrollees by offering economic incentives to encourage the use of preventive health services and high-value coordinated care. Over \$2 million in savings was projected for the first year of the program.

CalPERS implemented a risk adjustment program from 2014 to 2018. As a result, CalPERS received more data from its health benefit plan carriers than before 2014, there were more health benefit plan choices available since before its implementation, and it might have been partly

responsible for the very modest premium increases experienced by CalPERS, especially for plan year 2017-2018. However, there were some challenges. Some carriers were better than others in capturing data that reflected membership health (or risk), which led to some “coding bias,” where a carrier’s ability to properly code disproportionately drove the risk score, rather than the health of the plan’s enrollees driving the score. Additionally, there was difficulty in subsequent years of accurately predicting risk scores of new enrollees at the time when premiums were set due to the timing of open enrollment and inter-plan migration as a result of plan competition. Ultimately, CalPERS determined that goals to control cost trends, foster competition, improve diseased management, and improve data and transparency could be accomplished by means other than risk adjustment.

**Pacific Business Group on Health (PBGH):** PBGH is a purchaser-only coalition, representing 60 public and private organizations across the U.S. that collectively spend \$40 billion a year purchasing healthcare services for 10 million people. PBGH offers its members guidance on the use of ACOs that have the potential to deliver high-quality care at reduced costs by improving care coordination and linking provider reimbursement to quality outcomes and utilization results. PBGH does this through the use of a comprehensive ACO toolkit and requirements for ACOs that include transparency, health information technology and administrative infrastructure, and market competition.

Another example of a PBGH project is the California Quality Collaborative (CQC) which was created in 2007 as an agreement between major health plans and California medical groups to coordinate improvement strategies on care for patients with chronic disease. Through PBGH’s efforts, health plans agreed to create standards for all providers and to help the medical community move towards these best practices. It specifically targets key improvement indicators that purchasers have identified as important, such as the IHA pay-for-performance program and CMS’ hospital readmission penalties and chronic care performance. Recent successes of CQC programs include a 15% reduction in the 30-day all-cause readmission rate across 24 hospitals, resulting in savings estimated at \$60 million over three years and significant improvement in ten chronic-care metrics for three million Californians, saving an estimated \$1 million per year.

The programs described above are very brief snapshots of some of the many efforts through the private insurance market that are underway in California to improve care management through collaboration, evidence based practices, and high value care. There are also activities specific to the Medi-Cal population that can help inform policymakers of how best to incentivize quality care for people with chronic conditions.

**Medi-Cal:** Administered by the DHCS, Medi-Cal provides health care services for 13 million low-income Californians, including families with children, seniors, persons with disabilities, foster care youth, pregnant women, and low-income people with specific diseases. In 2018, 10.8 million beneficiaries were enrolled in a Medi-Cal managed care plan (MCPs), which totaled 82% of all enrollees.

**Assessing Performance and Chronic Disease Management:** MCPs report annually on a set of quality measures, known as the External Accountability Set (EAS), to evaluate the quality of care delivered to beneficiaries. DHCS contracts with an external quality review organization

(EQRO) to prepare an annual, independent technical report on beneficiary access to and quality of care, including an evaluation of plan performance in quality measures. In consultation with the EQRO and stakeholders, DHCS selects the EAS measures from standardized measures developed by HEDIS. MCPs are required to meet a minimum performance level (MPL) for certain EAS indicators. When MCPs fail to meet the MPL, which is set at least as well as the lowest 25% of Medicaid plans across the country, DHCS may impose a corrective action plan or financial sanctions, if the problems are severe.

Currently, the EAS indicators for managing chronic conditions include comprehensive diabetes care, controlling high blood pressure, and asthma medication ratio. DHCS also includes EAS measures for preventing chronic conditions, like breast cancer screening, cervical cancer screening, depression screening, and as well as weight and nutrition screening. Not all measures related to chronic conditions are held to an MPL. However, MCPs performing well in certain EAS measures do receive preference in DHCS's auto assignment algorithm for newly enrolled beneficiaries. In other words, under the current quality strategy, DHCS awards MCPs that excel in certain measures by assigning more members to that plan. Only certain EAS measures directly related to managing chronic conditions are counted toward the auto assignment algorithm.

**Medi-Cal Managed Care Quality Improvement Strategy:** The Medicaid Managed Care and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule) requires DHCS to implement a written quality strategy to assess and improve the quality of health care and services provided by its contracted MCPs. DHCS meets this requirement by conducting an assessment of its managed care plans annually and a comprehensive review every three years.

Under DHCS's annual managed care assessment, MCPs are evaluated in seven focus areas for quality improvement. The focus areas are chosen to reflect DHCS priorities, address large performance gaps, and have interventions readily available to improve the health of significant segments of the Medi-Cal managed care population. Five of the focus areas are directly linked to quality metrics, including two in the management of chronic diseases (diabetes and hypertension). For each of the focus areas that are grounded in quality metrics, DHCS sets a three-year target that is compared to a baseline year, annually evaluating progress toward the target.

As part of the quality improvement strategy, DHCS also requires MCPs to participate in two Performance Improvement Projects (PIPs) annually. In 2015, MCPs selected their first PIP topic, which was one of four DHCS pre-selected topics that align with the priority focus areas, including diabetes and hypertension. Of the 23 full-scope MCPs that participated in the first round of PIPs, eight selected the topic of diabetes care and two selected the topic of controlling high blood pressure. In January 2016, MCPs selected their second PIP topic. Under the guidance of DHCS and the EQRO, MCPs provided information supporting their choice of topic and were encouraged to select an area where they had a demonstrated need for improvement. Many of the MCPs chose another of the four DHCS pre-selected topics that align with the priority focus areas, but others chose topics related to other areas in need of improvement that include chronic disease prevention and management, such as cervical cancer screening or the medication management of people with asthma.

For PIP topics in 2017-18, DHCS required each MCP to participate in a health disparity focused topic and encouraged MCPs to choose a health disparity related to an EAS metric on which the plan is not performing well, when possible. For their second PIP topic, MCPs were required to

follow an algorithm that may have required them to work on controlling high blood pressure or comprehensive diabetes care.

**Investing in Models to Better Care for Chronic Conditions:** While Medi-Cal's quality strategy requires MCPs to improve health outcomes and better manage chronic conditions, these efforts may be hampered by disincentives built into the Med-Cal program as a whole. For instance, according to the California Health Care Foundation, plans may be negatively impacted when they invest in more innovative initiatives that improve outcomes and result in lower costs. This can occur when an MCP seeks to improve care by investing in services that may not be considered traditional Medicaid benefits, like improved care coordination or housing assistance. These interventions may lead to better patient outcomes and a decline in high-cost utilization, like emergency room visits or inpatient hospital use. However, it also causes the cost basis for the plan's future rates to decline, leading plans to receive a lower rate than would it have received without the intervention. Moreover, when MCPs excel in managing chronic conditions, according to current EAS indicators and the quality improvement strategy, the primary mechanism for rewarding this behavior is auto assigning a larger share of new enrollees to the plan.

Despite these challenges, Medi-Cal still has authority and flexibility to align its program incentives toward more efficient, effective, and affordable care and improved health outcomes. For instance, MCPs may develop value-based payment arrangements for providers and contracted entities responsible for delivering the health care services to plan enrollees. Medi-Cal has implemented the Medicaid Health Homes State Plan Option, drawing down federal matching funds to support care coordination for beneficiaries with chronic conditions. In current and previous 1115 Waivers, DHCS has crafted pay-for-performance, global payments arrangements, and care coordination program features aimed at meeting the needs of vulnerable and underserved individuals with chronic conditions. A few of the state-level efforts are detailed below:

- Global Payment Program (GPP): GPP is part of the Medi-Cal 2020 section 1115 waiver. It establishes a statewide pool of funding for the remaining uninsured by combining federal Disproportionate Share Hospital (DSH) and uncompensated care funding. The program seeks to improve the health of the uninsured through care coordination. It encourages public hospital systems to provide greater primary and preventive services and emphasizes the value of coordinated care.
- California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program: PRIME is a five-year, \$3.7 billion federally funded initiative under the Medi-Cal 2020 section 1115 waiver that aims to improve the way care is delivered through California's safety net hospital system by maximizing health care value and moving toward alternative payment models (APMs), such as capitation and other risk-sharing arrangements. PRIME includes three "Domains" that consist of 18 clinical project areas that are tied to a required set of reporting and performance metrics, including complex care management for individuals with chronic conditions. The hospitals' ability to meet the performance metrics determines the amount of PRIME funding they will receive.
- Whole Person Care Pilots (WPC): WPC is a five-year, up to \$1.5 billion federally funded pilot program to test county-based initiatives that coordinate health, behavioral health,



and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems and have poor outcomes. The Medi-Cal 2020 Section 1115 waiver also authorized the creation of WPC pilots. The program allows each county initiative to identify the specific characteristics of their target population. Many programs include individuals with repeated incidents of avoidable emergency use and individuals with two or more chronic conditions. Each pilot designs and implement specific strategies, which may include increasing care coordination for the most vulnerable beneficiaries, ongoing case management for patients, setting and achieving target quality and administrative improvements, and improving the health outcomes for their WPC population.

- Health Homes Program (HHP): HHP is an ongoing initiative to develop a network of providers that will integrate and coordinate primary, acute, and behavioral health services for the highest risk Medi-Cal enrollees. The program is designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. Enhanced federal matching funds of 90% are available for first two years the HHP, with the 10% non-federal share funded by The California Endowment. After the two years, the federal match will be reduced to 50%. The ACA established a new optional Medicaid state plan benefit covering health home services for beneficiaries with chronic conditions. AB 361 (Mitchell, Chapter 642, Statutes of 2013) authorized DHCS to submit a State Plan Amendment to establish the HHP. DHCS launched implementation of HHP on July 1, 2018. MCP may have health homes models that are not necessarily part of the HHP.
- Proposition 56 – Value-Based Payment Program (Proposed): The Governor’s Proposed 2019-20 Budget includes a proposal to implement a Value-Based Payment Program (VBM). VBM strategies incentivize health care providers to improve their performance on predetermined measures or meet targets that focus on quality and efficiency of care. DHCS proposes to create a set of VBP programs that managed care plan will be required to participate in through directed payment programs approved by CMS. DHCS will develop specific measures and targets to determine the amount of the incentive payments. This incentive program is targeted at providers that meet specific achievements on certain metrics.

### **Policy Considerations**

Purchasers in the private insurance market and programs in Medi-Cal are moving toward better value and improving care for patients with chronic conditions. Policy proposals to scale up or incentivize programs with high quality outcomes should account for the following considerations:

- Demographic and Socioeconomic Differences: Chronic diseases vary in their incidences with respect to age, income, race and ethnicity, and insurance status. For example, caring for an older patient with chronic diseases may differ than caring for a younger patient. Standardizing metrics for evaluation may prevent necessary analysis, like performance in pediatric care. Moreover, patients in private insurance may have different socioeconomic challenges than patients in Medi-Cal. Medi-Cal strategies and programs include specific goals directed at reaching underserved populations, like patients with multiple chronic conditions or individuals with unstable housing. Successful programs for private

insurance patients may not necessarily be appropriate for patients in Medi-Cal and vice versa. Therefore, efforts to support or incentivize programs should take into consideration these population differences and their respective needs, when appropriate.

- Accounting for Patient Experiences: HEDIS and clinical measures tell only a portion of the story in terms of what the patient may be experiencing in care and health outcomes. Patient experiences may reveal how well providers are meeting their needs, which is why many health plan quality evaluations conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Health plans certified by the National Committee for Quality Assurance (NCQA) are required to conduct annual CAHPS surveys. In Medi-Cal managed care, CAHPS surveys are conducted once every three years and only in two languages, English and Spanish. Policies to incentivize better care for patients with chronic conditions may wish to evaluate how best to account for patient experience of care.
- Staff and Data Infrastructure: Improving clinical care and chronic disease management requires investment in data infrastructure, staff and services. Real-time, comparative data reporting with patient demographic information are critical for making population-health driven improvements. Financial incentives may have limited impact without data helping to inform where incentives should go and compare outcomes. Additional staff and resources may be required to identify gaps in care and perform patient outreach, especially for patients with multiple chronic conditions. Finally, data and care coordination should be appropriately shared and aligned. A proliferation of care coordination programs can be unproductive if a patient is receiving multiple or conflicting care plans.