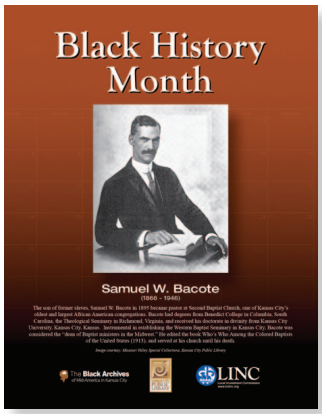
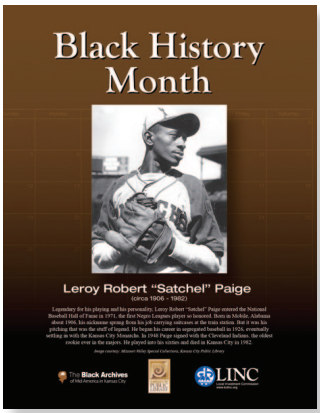
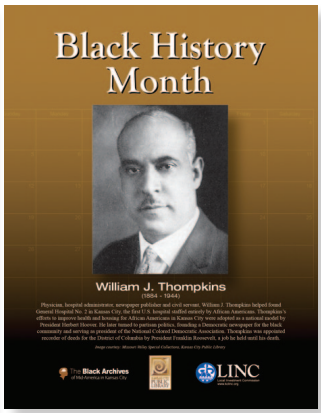
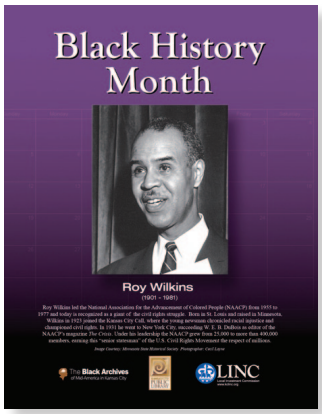
LINC Commission Meeting

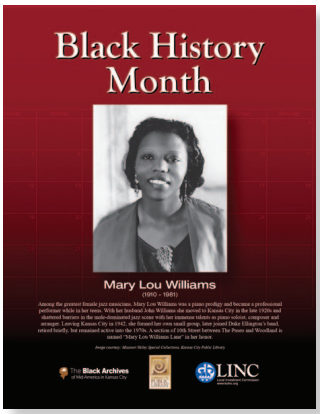
January 23, 2012

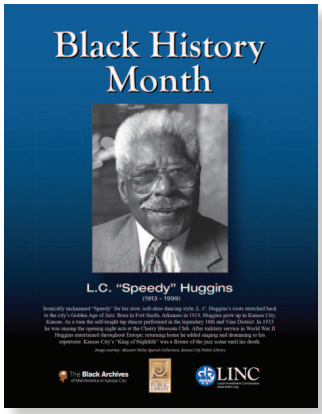


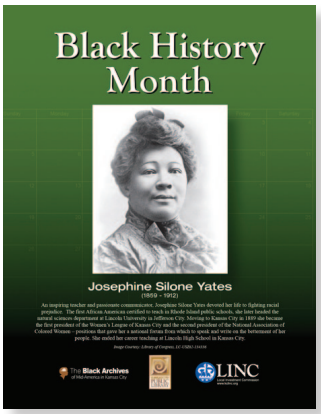












Black History Month 2012

Kansas City Leaders

The **Local Investment Commission (LINC)** produced this set of educational posters in partnership with the **Kansas City Public Library** and the **Black Archives of Mid-America**, with contributions from the **Kansas City Star**. The poster set celebrates and supports Black History Month from a local perspective. Learn more at kclinc.org/blackhistory

The **Black Archives** of Mid-America in Kansas City

KANSAS CITY PUBLIC LIBRARY

LINC
Local Investment Commission
www.kclinc.org

Local Investment Commission (LINC) Vision

Our Shared Vision

A caring community that builds on its strengths to provide meaningful opportunities for children, families and individuals to achieve self-sufficiency, attain their highest potential, and contribute to the public good.

Our Mission

To provide leadership and influence to engage the Kansas City Community in creating the best service delivery system to support and strengthen children, families and individuals, holding that system accountable, and changing public attitudes towards the system.

Our Guiding Principles

1. COMPREHENSIVENESS: Provide ready access to a full array of effective services.
2. PREVENTION: Emphasize "front-end" services that enhance development and prevent problems, rather than "back-end" crisis intervention.
3. OUTCOMES: Measure system performance by improved outcomes for children and families, not simply by the number and kind of services delivered.
4. INTENSITY: Offering services to the needed degree and in the appropriate time.
5. PARTICIPANT INVOLVEMENT: Use the needs, concerns, and opinions of individuals who use the service delivery system to drive improvements in the operation of the system.
6. NEIGHBORHOODS: Decentralize services to the places where people live, wherever appropriate, and utilize services to strengthen neighborhood capacity.
7. FLEXIBILITY AND RESPONSIVENESS: Create a delivery system, including programs and reimbursement mechanisms, that are sufficiently flexible and adaptable to respond to the full spectrum of child, family and individual needs.
8. COLLABORATION: Connect public, private and community resources to create an integrated service delivery system.
9. STRONG FAMILIES: Work to strengthen families, especially the capacity of parents to support and nurture the development of their children.
10. RESPECT AND DIGNITY: Treat families, and the staff who work with them, in a respectful and dignified manner.
11. INTERDEPENDENCE/MUTUAL RESPONSIBILITY: Balance the need for individuals to be accountable and responsible with the obligation of community to enhance the welfare of all citizens.
12. CULTURAL COMPETENCY: Demonstrate the belief that diversity in the historical, cultural, religious and spiritual values of different groups is a source of great strength.
13. CREATIVITY: Encourage and allow participants and staff to think and act innovatively, to take risks, and to learn from their experiences and mistakes.
14. COMPASSION: Display an unconditional regard and a caring, non-judgmental attitude toward, participants that recognizes their strengths and empowers them to meet their own needs.
15. HONESTY: Encourage and allow honesty among all people in the system.

Monday, Jan. 23rd, 2012 | 4 – 6 pm
Kauffman Foundation
4801 Rockhill Rd.
Kansas City, Mo. 64110

Agenda

I. **Welcome and Announcements**

II. **Approvals**
   a. **November minutes (motion)**

III. **Superintendent's Reports**

IV. **Health Care – Payment Reform**
   a. **Harold D. Miller – webinar**

V. **LINC President's Report**

VI. **Finance Committee**
   a. **Quarterly Report**

VII. **Other**

VIII. **Adjournment**

THE LOCAL INVESTMENT COMMISSION – NOV. 21, 2011

The Local Investment Commission met at the Kauffman Foundation, 4801 Rockhill Rd., Kansas City, Mo. Chairman **Landon Rowland** presided. Commissioners attending were:

Sharon Cheers
Jack Craft
Herb Freeman
SuEllen Fried
Tom Gerke
Rob Givens
Anita Gorman
Bart Hakan
Adele Hall
Rosemary Lowe
Sandy Mayer (for Mike Sanders)
Mary Kay McPhee
David Rock
David Ross
Bailus Tate

Superintendents' Report

- **John Tramel** (Community Development Specialist, Independence School District) reported on high participation in parent-teacher conferences and on construction plans for two new elementary schools.
- **Bob Bartman** (Superintendent, Center School District) reported on high participation in Battle of the Brain and on family mobility and homelessness.
- **Todd White** (Superintendent, North Kansas City School District) reported the district population continues to grow and the school board was recognized by the Mo. School Board Association.
- **Mark Enderle** (Superintendent, Fort Osage School District) reported on the negative effects of transiency on academic performance.
- **Ray Wilson** (School Board Member, Kansas City (Mo.) School District) reported he is meeting with parents concerning the results of the pending deaccreditation of the district.

A discussion of graduation reporting requirements followed.

Rowland introduced Jackson County Executive **Mike Sanders**, who gave a presentation on the Smart Moves regional transit vision. Smart Moves would engage local municipalities in a venture to enhance the area transit system by building on unused rail corridors. The initiative is seeking to engage the public on planning. More information is at www.kcsmartmoves.org.

LINC Treasurer **David Ross** presented the first quarter LINC financial report.

Rob Givens introduced a presentation of the LINC FY 2010-2011 financial audit. Shared materials included the financial audit report and management. **Abe Cole** of auditors BKD reported LINC management has responded appropriately to address the material weakness found by the audit. The material weakness was regarding allocation of employee hours.

A motion to receive the audit was passed unanimously.

LINC staff **Brent Schondelmeyer** reported on the LINC chess program. LINC site staff recently took part in the LINC Chess Academy, a multi-week training to equip staff with the knowledge needed to teach chess. Three Trails site coordinator Paul Lichtenauer reported the academy was a good experience and will be beneficial to students. Information about upcoming chess

tournaments is at www.kclinc.org/chess.

LINC staff **Steve Winburn** gave a presentation on LINC's efforts to provide resources, advice and support to youth ages 14-21 making the transition to adulthood. Winburn introduced two representatives of the Missouri Children's Division (Jackson County): new regional director **Tanya Keys** and Independent Living specialist **Karen Candie**. Winburn also introduced two youth participants, **Vernae Watson** and **Karyia Edmonds**, who were featured in a video that was shown. Discussion followed.

LINC staff **Robin Gierer** reported he and **David Renz** of the Midwest Center for Nonprofit Leadership have been facilitating meetings of the Missouri Foster Care Task Force. A task force report is due Dec. 1.

The meeting was adjourned.

CENTER FOR
HEALTHCARE
QUALITY &
PAYMENT REFORM

How to Create Accountable Care Organizations

Harold D. Miller

www.CHQPR.org

EXECUTIVE SUMMARY

HOW TO CREATE ACCOUNTABLE CARE ORGANIZATIONS

What Would Accountable Care Organizations Be Accountable For, and What Would They Do Differently?

- The goal of Accountable Care Organizations should be to reduce, or at least control the growth of, healthcare costs while maintaining or improving the quality of care patients receive (in terms of both clinical quality and patient experience and satisfaction). There are many opportunities that exist for improving quality and reducing healthcare costs without the need to ration care. These include improved prevention and early diagnosis, reductions in unnecessary testing and referrals, reductions in preventable emergency room visits and hospitalizations, reductions in infections and adverse events in hospitals, reductions in preventable readmissions, and use of lower-cost treatments, settings, and providers. (See pages 3-5 for more detail.)
- Although Accountable Care Organizations should accept greater accountability for reducing costs, they should not be expected to take on insurance risk, i.e., the risk associated with whether the patients who come to them are sick or well (unless they choose to do so). Insurance plans should continue to manage insurance risk, and Accountable Care Organizations should manage performance risk, i.e., the ability to successfully treat an illness in a cost-effective way. (See page 5 for more detail.)
- Accountable Care Organizations should not be expected to take responsibility immediately for all possible opportunities for cost reduction. They can be accountable for total costs and make significant impacts on those costs just by pursuing a subset of the many opportunities for cost reduction. (See page 6 for more detail.)

What Kinds of Organizations Can Serve as Accountable Care Organizations?

- To the maximum extent possible, an organization's ability to serve as an Accountable Care Organization should be determined by its success in improving outcomes – controlling costs, improving quality, and providing a good experience for patients – not on its organizational structure or even the specific care processes it uses. In the short run, since outcomes can only be known after the fact, some structural and process criteria are needed to define which organizations have the greatest probability of success. (See page 7 for more detail.)
- The core of an Accountable Care Organization is effective primary care. Although the majority of healthcare expenditures and increases in expenditures are associated with specialty and hospital care, some of the most important mechanisms for reducing and slowing the growth in specialty and hospital expenditures are prevention, early diagnosis, chronic disease management, and other tools which are delivered through primary care practices. (See pages 7-8 for more detail.)
- In order for primary care practices to become an Accountable Care Organization, they will need to have at least eight things:
    1) Complete and timely information about patients and the services they are receiving;
    2) Technology and skills for population management and coordination of care;
    3) Adequate resources for patient education and self-management support;
    4) A culture of teamwork among the staff of the practice;
    5) Coordinated relationships with specialists and other providers;
    6) The ability to measure and report on the quality of care;
    7) Infrastructure and skills for management of financial risk;
    8) A commitment by the organization's leadership to improving value as a top priority, and a system of operational accountability to drive improved performance.

    (See pages 8-10 for more detail.)
- Efforts to help primary care practices become more effective, such as the tools of Patient-Centered Medical Homes, the Chronic Care Model, etc., are helpful, but not sufficient. In order to create a successful Accountable Care Organization, primary care practices must add the capability to manage both cost and quality outcomes. Moreover, not all of the standards in current Medical Home accreditation programs may be necessary to success as an Accountable Care Organization. (See page 10 for more detail.)

- Small primary care practices that work together through organizational mechanisms such as an Independent Practice Association (IPA) have a better ability to form an Accountable Care Organization if the number of participating physicians and their organizational structure gives them:
  1) The ability to manage and coordinate patient care;
  2) The ability to manage financial risk associated with the costs of patient care; and
  3) The ability to measure cost and quality in a statistically valid way.

  (See pages 10-12 for more detail.)
- It is undesirable to require or encourage all physicians in a geographic area to form a single Accountable Care Organization. Participation should be voluntary – based on a commitment to success. There are advantages to having multiple Accountable Care Organizations in a region, but also some additional challenges, and the best approach will vary from region to region. (See pages 12 and 17 for more detail.)
- Specialists will continue to play an important role in patient care, but their roles relative to primary care will need to be rationalized and better coordinated, and the volume of referrals to specialists will need to decrease in most regions. Although an Accountable Care Organization will need to have effective working relationships with specialists, specialists do not necessarily need to be part of the Accountable Care Organization itself. (See pages 13-14 for more detail.)
- It can be very advantageous to have a hospital included in an Accountable Care Organization if the hospital is committed to the goals of reducing total costs and improving quality. However, Accountable Care Organizations should not be *required* to include a hospital, since the interests of hospitals and physicians may be in conflict in the early stages of development of Accountable Care Organizations. (See pages 14-16 for more detail.)
- Integrated Delivery Systems could serve as an ideal model for Accountable Care Organizations if they have true clinical integration and a commitment by their leadership to fulfill the vision of an Accountable Care Organization. (See page 16 for more detail.)
- Since providers in different parts of the country differ dramatically in terms of size, clinical and corporate integration, and skills in managing costs, there is no single definition of "Accountable Care Organization" that will work everywhere. Four different levels of Accountable Care Organizations (ACOs) should be considered:

  Level 1 ACO: Primary care practices functioning together through an IPA or other organizational mechanism and focusing on prevention and improvement of care for ambulatory care-sensitive conditions.

  Level 2 ACO: Primary care practices and frequently-used specialties, working together through an IPA or multi-specialty group practice, and focusing on prevention and improvement of care for ambulatory care-sensitive conditions and common specialty procedures.

  Level 3 ACO: Primary care practices, specialists, and hospitals, working together through an integrated delivery system or other organizational mechanism, and focusing on all or most opportunities for cost reduction and quality improvement.

  Level 4 ACO: Healthcare providers, public health agencies, and social service organizations working jointly to improve outcomes for a very broad patient population, including homeless individuals and the uninsured.

  (See pages 18-19 for more detail.)

What Payment Reforms Are Needed to Support Accountable Care Organizations?

- Payment systems need to be changed significantly to support Accountable Care Organizations (ACOs). Payment reforms should achieve five goals:
  1) Provide the ACO with the flexibility to deliver the right services to patients in the right way at the right time;
  2) Enable the ACO to remain profitable if it keeps people healthier or reduces unnecessary services;
  3) Pay the ACO more for high-quality care than for low-quality care, and encourage patients to use higher-quality ACOs;
  4) Pay the ACO adequately, but not excessively, to cover the costs of the services it provides for all of its patients; and
  5) Avoid penalizing the ACO for caring for sicker patients (unless the sickness was caused by the ACO itself).

  (See pages 20-21 for more detail.)
- Offering arbitrarily defined "shared savings" to an ACO is not sufficient to encourage the formation of ACOs and to enable ACOs to truly transform the way they deliver care. To be effective, shared savings would need to be based on net savings (including unreimbursed costs of changes in care delivery) and combined with other payment changes. (See pages 22-23 for more detail.)

- A properly-structured Comprehensive Care Payment (or global payment) system can achieve all of the goals of payment reform, as long as it is structured so as to avoid the problems of traditional capitation payment systems. (See pages 24-25 for more detail.)
- Episode-of-Care Payment can serve as both a transitional payment reform and as an important long-run component of an overall payment system. (See pages 26-27 for more detail.)
- Hybrid payment models (e.g., partial comprehensive care payments with bonuses and penalties based on savings and quality) can also be used as a transitional payment reform. (See page 27 for more detail.)
- In addition to implementing new payment *methods*, effective mechanisms for setting appropriate payment *levels* will also be needed. The appropriate mechanisms will vary from region to region and provider to provider, depending on the structure of local healthcare markets. (See page 28 for more detail.)

What Should Communities Do to Encourage and Support the Development of Accountable Care Organizations?

- Comparable changes in payment systems should be made by all payers, but as a minimum, changes need to be made by the payers that provide health insurance coverage for a majority of an Accountable Care Organization's patients so that the ACO has the resources and ability to change the way it cares for all patients. Medicare needs to have the flexibility to change its payment systems to match the changes local payers make. (See pages 29-30 for more detail.)
- The outcomes and measures of success for Accountable Care Organizations should be defined by the community they serve, rather than by individual payers. States, Regional Health Improvement Collaboratives, large payers, and consortiums of payers can play a key role in building consensus among payers and providers on what the standards for success should be and on the appropriate transitional paths. (See pages 30-31 for more detail.)
- It is critical to build support among consumers and patients for changes in care delivery and payment, and to have consumers actively engaged in achieving the desired outcomes, rather than trying to hold Accountable Care Organizations solely accountable for improving quality and reducing costs without adequate patient support and involvement. (See pages 31-32 for more detail.)
- Other changes in laws and policy would be helpful in encouraging and supporting Accountable Care Organizations, such as malpractice reform, changes in accreditation processes, and modifications to anti-trust laws and gain-sharing laws. (See pages 32-33 for more detail.)

How Can the Transition to Accountable Care Organizations Be Facilitated?

- It is unreasonable to expect healthcare providers in most parts of the country to successfully accept full accountability for costs and quality quickly or in a single step. Transitional approaches will be needed. (See page 34 for more detail.)
- Support should be made available to willing providers to help them get started, including coaching and technical assistance, information on their current costs and quality, shared services for improved care management, financial resources to support changes in care, and financial modeling to help in taking on financial risk. (See pages 34-35 for more detail.)
- A multi-year process for transitioning to full accountability should be used, such as focusing initially on subgroups of patients and subsets of costs. Measures of success should be based on absolute standards of performance, relative performance compared to other providers, and improvement relative to a provider's own baseline. (See pages 35-36 for more detail.)
- Special attention should be given to underserved communities and consumers to ensure they participate in and benefit from improved care delivery. (See page 37 for more detail.)
- Payment changes should also transition over time in ways that support the transitional changes in care processes. Since initial payments will be based on the fee-for-service system, reforms to the current fee-for-service system, particularly its support for primary care, should be a high priority. (See pages 38-40 for more detail.)
- Medicare should encourage and participate in regionally defined Accountable Care Organization initiatives by waiving Medicare requirements and changing payment rules to match what other major payers in the region, including commercial payers and Medicaid, are doing. (See pages 38-39 for more detail).

HAROLD D. MILLER

Harold D. Miller is the Executive Director of the Center for Healthcare Quality and Payment Reform and the President and CEO of the Network for Regional Healthcare Improvement. Miller has been working at both the regional and national levels on initiatives to improve the quality of healthcare services and to change the fundamental structure of healthcare payment systems in order to support improved value. Miller also serves as Adjunct Professor of Public Policy and Management at Carnegie Mellon University's Heinz School of Public Policy and Management, where he was Associate Dean from 1987-1992.

Miller organized the Network for Regional Healthcare Improvement's national Summits on Healthcare Payment Reform in 2007 and 2008. His report *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform* which was prepared for the 2007 Summit was published by the Commonwealth Fund in September, 2007,and his summary of the recommendations from the 2008 Payment Reform Summit, *From Volume to Value: Transforming Healthcare Payment and Delivery Systems to Improve Quality and Reduce Costs*, was published in November 2008 by NRHI and the Robert Wood Johnson Foundation. His paper "From Volume to Value: Better Ways to Pay for Healthcare" appeared in the September 2009 issue of *Health Affairs*. He also authored the Center for Healthcare Quality and Payment Reform's report *How to Create Accountable Care Organizations*, the Massachusetts Hospital Association's report *Creating Accountable Care Organizations in Massachusetts*, and the American Medical Association's report *Pathways for Physician Success Under Healthcare Payment and Delivery Reforms*.

Miller's work with the Pittsburgh Regional Health Initiative (PRHI) demonstrating the significant financial penalties that hospitals can face if they reduce hospital-acquired infections was featured in *Modern Healthcare* magazine in December, 2007. He designed and is currently leading a multi-year PRHI initiative to reduce preventable hospital admissions and readmissions through improved care for chronic disease patients. In 2007 and early 2008, he served as the Facilitator for the Minnesota Health Care Transformation Task Force, which prepared the recommendations that led to passage of Minnesota's path-breaking healthcare reform legislation in May, 2008. He is currently working with regional health improvement collaboratives in several states to design and implement payment and delivery system reforms.

From Volume To Value: Better Ways To Pay For Health Care

Providers would be better able to reduce costs and improve quality under episode-of-care and comprehensive care payment systems.

by Harold D. Miller

ABSTRACT: Payment systems for health care today are based on rewarding volume, not value for the money spent. Two proposed methods of payment, "episode-of-care payment" and "comprehensive care payment" (condition-adjusted capitation), could facilitate higher quality and lower cost by avoiding the problems of both fee-for-service payment and traditional capitation. The most appropriate payment systems for different types of patient conditions and some methods of addressing design and implementation issues are discussed. Although the new payment systems are desirable, many providers are not organized to accept or use them, so transitional approaches such as "virtual bundling," described in this paper, will be needed. [Health Aff (Millwood). 2009;28(5):1418–28; 10.1377/hlthaff.28.5.1418]

SERIOUS PROBLEMS EXIST WITH THE QUALITY and cost of health care today. One major cause of these problems is that current payment systems encourage volume-driven care, rather than value-driven care. Physicians, hospitals, and other providers gain increased revenues and profits by delivering more services to more people, fueling inflation in health care costs without any corresponding improvement in outcomes. Moreover, current payment systems often penalize providers financially for keeping people healthy, reducing errors and complications, and avoiding unnecessary care.[1] Fortunately, alternative payment systems exist that encourage both higher quality and lower costs by giving providers greater responsibility for the factors driving health care costs.

Factors Driving Health Care Costs

Total per capita health care costs are driven by five principal factors: the prevalence of health conditions in the population (for example, how many people have heart disease); the number of "episodes of care" they require per condition (for example, how many heart attacks a person with heart disease has); the number and types of health care services a person receives in each episode (for example, when

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DOI 10.1377/hlthaff.28.5.1418

be adjusted for severity; for example, a provider would be paid more for caring for a heart attack patient with major artery blockage than one with minimal blockage.

The advantages of episode-of-care payment include the flexibility for providers to decide which services should be provided within the episode (rather than being restricted by the services specifically authorized under fee-for-service) and the incentive it creates to eliminate any unnecessary services within the episode. Moreover, if the services of multiple providers are covered by the same episode-of-care payment (which is called "bundling" payments), there is also an incentive for those providers to coordinate their services.

■ **Traditional capitation.** As is apparent from Exhibit 1, episode-of-care payment does not create any constraint on the number of episodes of care. For some types of episodes, this is not really a problem (for example, there is little variation in the rate of surgery for hip fractures across the country,[3] and it is unlikely that obstetricians will convince more women to become pregnant, no matter how lucrative a labor and delivery episode is), but for others it is a problem (people can get heart surgery when they do not need it,[4] and many chronic disease patients are hospitalized frequently for preventable exacerbations of their disease).[5]

"Capitation" models of payment are designed to control the number of episodes of care as well as the cost of individual episodes. The basic concept is for a provider (or a group of providers, working in a coordinated fashion) to receive a single payment to cover all of the services their patients need during a specific period of time, regardless of how many or few episodes of care the patients experience.

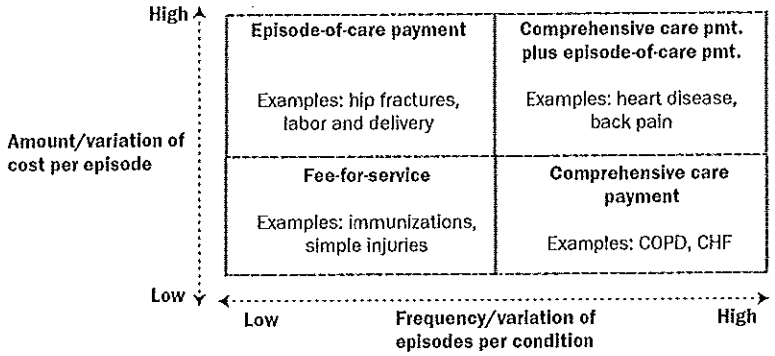
A key problem with most capitation systems is that the amount of the payment is the same regardless of how sick or how well a provider's patients are. This gives the provider a strong and undesirable incentive to avoid patients who have multiple or expensive-to-treat conditions, and it puts providers at risk of financial difficulty or bankruptcy if they take on large numbers of such patients.

■ **Comprehensive care payment.** Fortunately, as Exhibit 1 shows, there is a middle ground between episode-of-care payment (which does not control the number of episodes) and traditional capitation (which puts the provider at risk for how sick patients are). This approach can be called "comprehensive care payment" or "condition-adjusted capitation."[6]

Under this model, a provider or group of providers would receive a single payment to cover all of the services their patients need during a specific period of time (such as a year). However, this payment would be adjusted based on the health of the patients and other characteristics that affect the level of services needed (for example, whether they have language barriers or not). A provider would receive a higher payment if he or she has more patients with severe rather than mild heart disease, but the payment would not depend on what kinds of treatment patients receive.[7] As a result, a provider gets paid more for taking care of sicker patients but not for providing more services to the same patients.

Comprehensive care payment gives providers responsibility for performance

EXHIBIT 3
How Different Payment Systems Solve Different Cost/Quality Problems



SOURCE: Author's analysis.
NOTES: COPD is chronic obstructive pulmonary disease. CHF is congestive heart failure.

tory care–sensitive conditions are hospitalized varies greatly across the country.[10] (Some have proposed that a year of chronic disease care should be defined as an episode; in effect, this approach is an application of the comprehensive care payment model to patients with a particular condition.)[11]

A combination of both payment systems may be needed for patients with conditions where both the cost of individual episodes and the frequency of episodes are believed to be too high. For example, the *Dartmouth Atlas of Health Care* project has found wide variations in the frequency of cardiac surgery and other types of procedures across the country, with no evidence that patients achieve better outcomes in areas with higher frequencies.[12] Moreover, the cost of heart surgeries varies greatly from hospital to hospital, even after case severity and outcomes are adjusted for.[13] To address these situations, a physician practice or health system could receive a comprehensive care payment to manage patients with the underlying condition, and then, out of the comprehensive payment, an episode-of-care payment could be made to a hospital if it is determined that a particular patient needs surgery or other treatment.

A final category includes conditions where the problem is not overuse or misuse, but underuse of services (for example, low rates of immunization); for these, fee-for-service may continue to be the most appropriate payment system.

Using multiple payment methods for different types of conditions and patients is not unusual; for example, surgeons and obstetricians are typically paid on a case-rate basis, whereas other physicians are paid fees for individual services. The goal should be to pay for the care of each condition or combination of conditions in the right way, not necessarily the same way for all conditions.

payment is set too low, providers may be forced either to underprovide care or to suffer financially. If the amount is set too high, the pressure to improve efficiency will be less, and unnecessary services may be provided.

There are three basic approaches to determining payment levels, any of which could be applied to either episode-of-care or comprehensive care payments.

Regulation/price setting by the payer. The federal government uses this approach to establish the rates paid by Medicare to providers under its various payment systems. In Maryland, the Health Services Cost Review Commission sets mandatory all-payer rates for hospitals.[17]

Negotiation between payer and provider. This is the method typically used by commercial health plans to determine how much they will pay providers. The outcome, however, depends on the relative size and level of consolidation of payers and providers in a particular regional market.

Price setting by the provider; competition for patients based on value. Although this model is used in most other economic sectors, it is used rarely in health care, other than for services where consumers pay all or most of the cost of the service (such as for cosmetic or laser eye surgery).

It would likely be easier to use the third option (market competition) under episode-of-care and comprehensive care payment structures than under fee-for-service. Under FFS, even if consumers know the price of individual services, they do not know how many services will be used by different providers to treat them, so they cannot easily compare the relative value of different providers. In contrast, a single price for an entire episode of care or for an entire year of care would make such comparisons much easier.[18]

In addition, however, changes in the cost-sharing requirements for consumers will also be needed to facilitate price competition. Whereas most insurance benefit structures require consumers to pay at most a portion of the "first dollar" that the provider charges for each individual service (through a copayment, coinsurance, or deductible), episode-of-care and comprehensive care payments would facilitate a benefit design in which consumers were charged the "last dollar"—that is, the difference in total prices between higher-cost and lower-cost providers.

■ **Assuring quality of care for patients.** A concern about episode-of-care and comprehensive care payments is that they may encourage providers to skimp on care, particularly preventive services with longer-term outcomes. (Even fee-for-service payment is not immune to this problem, as evidenced by the widespread concerns about quality of care and the proliferation of P4P programs.)

The first level of protection for patients is the use of a good condition adjustment system to ensure that sicker patients can receive more services. A growing number of these systems are available.[19] Beyond this, patients can be protected through techniques such as the following: (1) making outlier payments for patients requiring unusually high amounts of care; (2) including rewards or penalties for providers based on the outcomes of their care; (3) requiring that essential

Under the Patient Choice model, "care systems" (groups of providers, including both hospitals and physicians) bid on the condition-adjusted (total) cost of caring for a population of patients. The care systems are divided into cost/quality tiers based on their relative bids. Consumers select a care system, and they pay the difference in the bid price if they select a care system in a higher cost tier.

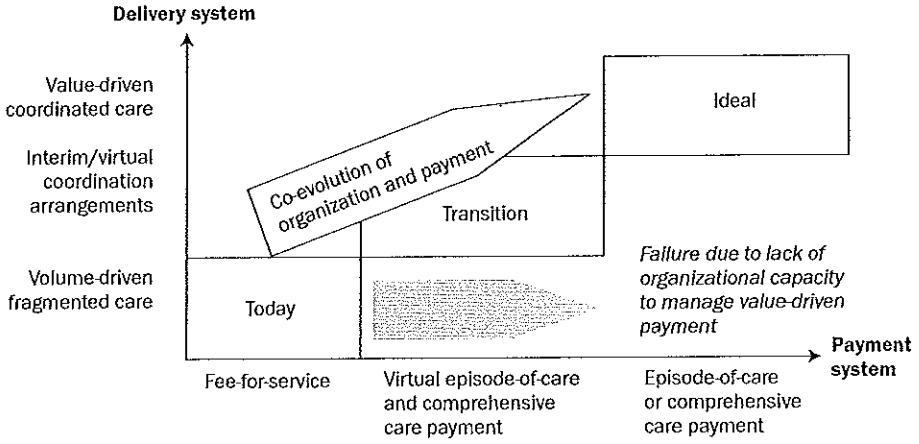
Providers bill based on fee-for-service codes (with the addition of new codes to cover previously unpaid-for services), but the fee levels paid are adjusted to keep total payments within a budget, and each provider is paid directly by the payer. The budget is based on the care system's bid, but it is adjusted upward or downward based on the characteristics of the patients who are actually cared for, so the care system has no incentive to avoid accepting sicker patients.

Analyses indicate that this system has encouraged patients to select more cost-effective providers and has encouraged providers to reduce their costs while maintaining or improving quality to attract more consumers.[27] In 2008 and 2009, several new efforts were initiated to implement versions of comprehensive care payment systems, including the Alternative Quality Contract created by Blue Cross Blue Shield of Massachusetts[28] (which covers all health care costs in a single condition-adjusted payment), the primary care practice payment model being tested by the Massachusetts Coalition for Primary Care Reform (which covers all practice expenses, but not hospitalization and other services, in a single payment),[16] and the PROMETHEUS Payment pilots for patients with chronic disease.

Moving From Volume-Driven To Value-Driven Health Care

Implementing episode-of-care and comprehensive care payment systems could help address the cost and quality crises in health care. However, improving pay-

EXHIBIT 4
Transition In Both The Payment And The Delivery Systems



SOURCE: Author's analysis.

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Department of Social Services

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Missouri to receive up to $2 million to combat child hunger in major metropolitan areas

Expansion of pilot program will help students from low-income families during the summer

Jefferson City, Mo. — Missouri will receive up to $2 million from the USDA to provide access to healthy foods to approximately 10,000 vulnerable children from the St. Louis, Kansas City, Hickman Mills and Center school districts next summer.

“No child should ever go hungry in Missouri; but unfortunately, many children who receive free or reduced-price meals are at risk of malnutrition during the summer,” said Gov. Jay Nixon. “I have long been a strong advocate for these programs to help children in need, and I’m pleased that Missouri is leading the way to help these children in the summer months as well.”

The Missouri project operates as a collaborative between the Department of Social Services; the Department of Elementary and Secondary Education; the Department of Health and Senior Services; the Local Investment Commission (LINC) in Kansas City; Area Resources for Community and Human Services (ARCHS) in St. Louis; and the Kansas City, St. Louis, Hickman Mills and Center school districts.

Missouri’s grant is the second-year expansion of an existing pilot project already implemented in the Kansas City area for which Governor Nixon’s administration competed aggressively against other states. Because of Missouri’s success in the first year of grant implementation, the number of children receiving a food benefit from the grant will quadruple from 2,500 children to 10,000. In addition to providing substantial nutrition benefits during the summer, this $2 million investment—$1 million for St. Louis and $1 million for the Kansas City area—will generate substantial local economic benefits for grocers, farmer’s markets and other food retailers.

As part of the project implementation the USDA will execute an independent evaluation of this project. The evaluation will determine whether the model implemented in Missouri offers an effective method to improve food security among children during the summer. At the conclusion of the evaluation a report will be made available to Congress and the public.

The New York Times

Lines Grow Long for Free School Meals, Thanks to Economy

Steve Hebert for The New York Times

More than 100 students eat a free dinner daily after classes at Ingels Elementary School in Kansas City, Mo. The Hickman Mills C-1 district feared students would otherwise go to bed hungry.

Nov. 29, 2011

By SAM DILLON

Millions of American schoolchildren are receiving free or low-cost meals for the first time as their parents, many once solidly middle class, have lost jobs or homes during the economic crisis, qualifying their families for the decades-old safety-net program.

The number of students receiving subsidized lunches rose to 21 million last school year from 18 million in 2006-7, a 17 percent increase, according to an analysis by The New York Times of data from the Department of Agriculture, which administers the meals program. Eleven states, including Florida, Nevada, New Jersey and Tennessee, had four-year increases of 25 percent or more, huge shifts in a vast program long characterized by incremental growth.

The Agriculture Department has not yet released data for September and October.

“These are very large increases and a direct reflection of the hardships American families are facing,” said Benjamin Senauer, a University of Minnesota economist who studies the meals program, adding that the surge had happened so quickly “that people like myself who do research are struggling to keep up with it.”

In Sylva, N.C., layoffs at lumber and paper mills have driven hundreds of new students into the free lunch program. In Las Vegas, where the collapse of the construction industry has caused

hardship, 15,000 additional students joined the subsidized lunch program this fall. Around Rochester, unemployed engineers and technicians have signed up their children after the downsizing of Kodak and other companies forced them from their jobs. Many of these formerly middle-income parents have pleaded with school officials to keep their enrollment a secret.

Students in families with incomes up to 130 percent of the poverty level — or $29,055 for a family of four — are eligible for free school meals. Children in a four-member household with income up to $41,348 qualify for a subsidized lunch priced at 40 cents.

Among the first to call attention to the increases were Department of Education officials, who use subsidized lunch rates as a poverty indicator in federal testing. This month, in releasing results of the National Assessment of Educational Progress, they noted that the proportion of the nation's fourth graders enrolled in the lunch program had climbed to 52 percent from 49 percent in 2009, crossing a symbolic watershed.

In the Rockdale County Schools in Conyers, Ga., east of Atlanta, the percentage of students receiving subsidized lunches increased to 63 percent this year from 46 percent in 2006.

"We're seeing people who were never eligible before, never had a need," said Peggy Lawrence, director of school nutrition.

One of those is Sheila Dawson, a Wal-Mart saleswoman whose husband lost his job as the manager of a Waffle House last year, reducing their income by $45,000. "We're doing whatever we can to save money," said Ms. Dawson, who has a 15-year-old daughter. "We buy clothes at the thrift store, we see fewer movies and this year my daughter qualifies for reduced-price lunch."

She added, "I feel like: 'Hey, we were paying taxes all these years. This is what they were for.' "

Although the troubled economy is the main factor in the increases, experts said, some growth at the margins has resulted from a new way of qualifying students for the subsidized meals, known as direct certification. In 2004, Congress required the nation's 17,000 school districts to match student enrollment lists against records of local food-stamp agencies, directly enrolling those who receive food stamps for the meals program. The number of districts doing so has been rising — as have the number of school-age children in families eligible for food stamps, to 14 million in 2010-11 from 12 million in 2009-10.

"The concern of those of us involved in the direct certification effort is how to help all these districts deal with the exploding caseload of kids eligible for the meals," said Kevin Conway, a project director at Mathematica Policy Research, a co-author of an October report to Congress on direct certification.

Congress passed the National School Lunch Act in 1946 to support commodity prices after World War II by reducing farm surpluses while providing food to schoolchildren. By 1970, the program was providing 22 million lunches on an average day, about a fifth of them subsidized. Since then, the subsidized portion has grown while paid lunches have declined, but not since 1972 have so many additional children become eligible for free lunches as in fiscal year 2010, 1.3 million. Today it is a $10.8 billion program providing 32 million lunches, 21 million of which are free or at reduced price.

All 50 states have shown increases, according to Agriculture Department data. In Florida, which has 2.6 million public school students, an additional 265,000 students have become eligible for subsidies since 2007, with increases in virtually every district.

“Growth has been across the board,” said Mark Eggers, the Florida Department of Education official who oversees the lunch program.

In Tennessee, the number of students receiving subsidized meals has grown 37 percent since 2007.

“When a factory closes, our school districts see a big increase,” said Sarah White, the state director of school nutrition.

In Las Vegas, with 13.6 percent unemployment, the enrollment of thousands of new students in the subsidized lunch program forced the Clark County district to add an extra shift at the football field-size central kitchen, said Virginia Beck, an assistant director at the school food service.

In Roseville, Minn., an inner-ring St. Paul suburb, the proportion of subsidized lunch students rose to 44 percent this fall from 29 percent in 2006-7, according to Dr. Senauer, the economist. “There’s a lot of hurt in the suburbs,” he said. “It’s the new face of poverty.”

In New York, the Gates Chili school district west of Rochester has lost 700 students since 2007-8, as many families have fled the area after mass layoffs. But over those same four years, the subsidized lunch program has added 125 mouths, many of them belonging to the children of Kodak and Xerox managers and technicians who once assumed they had a lifetime job, said Debbi Beauvais, district supervisor of the meals program.

“Parents signing up children say, ‘I never thought a program like this would apply to me and my kids,’ ” Ms. Beauvais said.

Many large urban school districts have for years been dominated by students poor enough to qualify for subsidized lunches. In Dallas, Newark and Chicago, for instance, about 85 percent of students are eligible, and most schools also offer free breakfasts. Now, some places have added free supper programs, fearing that needy students otherwise will go to bed hungry.

One is the Hickman Mills C-1 district in a threadbare Kansas City, Mo., neighborhood where a Home Depot, a shopping mall and a string of grocery stores have closed.

Ten years ago, 48 percent of its students qualified for subsidized lunches. By 2007, that proportion had increased to 73 percent, said Leah Schmidt, the district’s nutrition director. Last year, when it hit 80 percent, the district started feeding 700 students a third meal, paid for by the state, each afternoon when classes end.

“This is the neediest period I’ve seen in my 20-year career,” Ms. Schmidt said.

Robbie Brown and Kimberley McGee contributed reporting.

Published: November 29, 2011

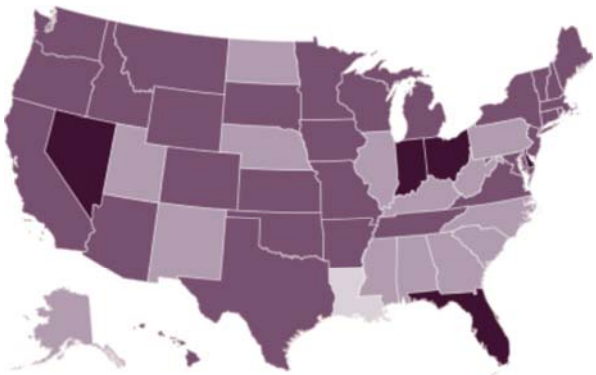
Rates of Increase in Subsidized Lunches

Since 2007, the proportion of fourth graders eligible for free or reduced-price lunches through the federal government's school meals program has increased nationwide to 52 percent, from 46 percent. Related Article »

CHANGE MAP TO SHOW:

Change in percent from 2007 to 2011
Fourth-graders eligible for free or reduced-price lunch

+0 +5 +10



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The New York Times
January 16, 2012

Learning to Be Lean

By REED ABELSON

As one of the many outgrowths of the sweeping federal health care law, health insurers and employers must now pay the cost of screening children for obesity and providing them with appropriate counseling.

With about one in three children in the United States obese or overweight, according to government statistics, the need for such programs is clear. But, experts say, creating them will be challenging. Other than intensive hospital-based programs, few proven models exist for helping children and adolescents achieve and maintain a healthier weight, and researchers do not even fully understand the factors that contributed to the rapid rise in childhood obesity in recent years. “If this were easy, if there were clear outcomes for success, we would be investing in these,” said Dr. Samuel R. Nussbaum, the chief medical officer for WellPoint, one of the nation’s largest health insurers.

While there are many community efforts aimed at getting every child to eat better and exercise more, including Michelle Obama’s “Let’s Move” initiative, there is also growing demand for programs that help children who are already seriously overweight. WellPoint and the UnitedHealth Group, another large insurer, are experimenting with new approaches, and even Weight Watchers says it is working to develop a program for children and teenagers. Drug companies and medical device makers are also testing some products on children.

Adults have a difficult enough time losing weight, and the issues are even more complicated with children and teenagers, experts say. Children are still growing, and the goal of any program may be to help them grow into a healthier weight rather than to actually lose pounds. Experts also say that to be successful, programs need to focus on the family as a whole, changing what everybody eats and how much time they are all active, not sitting in front of a computer screen or television.

UnitedHealth’s pilot program, aimed at these family dynamics, was conducted in partnership with the YMCA of the USA and the YMCA of Greater Providence, R.I. The sessions at the Y, with young children or teenagers talking about their struggles with food and exercise, are intended to be a friendlier, more cost-effective alternative to hospital programs.

Accompanied by a parent, the children meet for 16 hourlong sessions, initially once a week. Led by a coordinator who has been trained at a Y or other community setting, the children and parents learn about what foods they should favor, why children may be overeating and how to balance what they eat with how active they are.

In Rhode Island, parents like Dana Morel said the program was appealing because there were few other options. “There really wasn’t anything like this,” said Ms. Morel, who enrolled her son, Ryan, after hearing about it from her local Y. “That’s why we jumped on this.”

Ryan, now 11, said he was initially reluctant to go to the meetings but was won over by the woman leading the group and the promise of $150 in gift cards if he filled out the paperwork (The use of gift cards was limited to the study.)

Ryan, who weighed 122 pounds, lost 30 of them as he learned to make better choices about what he ate and to recognize that he sometimes ate because he was bored. He learned to limit his portions and substitute turkey burgers for cheeseburgers.

Already active in sports like soccer, the leaner Ryan said he has become a better player. “I’m faster,” he said. “I don’t lose my breath as quickly. I can run.”

The early results of UnitedHealth’s efforts are promising, according to the insurer, which said that 84 percent of the 155 children and teenagers who completed the program had an average 3.5 percent reduction in weight after six months. Parents also lost weight, according to UnitedHealth. The insurer says it is expanding the program, even as it continues to study its longer-term impact.

Raytheon, a military contractor, started offering the sessions to its employees in Massachusetts and Rhode Island as part of a pilot program. “We are always seeking out innovative ways to help our employees and their families live healthy lifestyles,” Keith J. Peden, a Raytheon executive, said in a statement.

UnitedHealth is now working with Texas and Louisiana to offer a similar program this year for children enrolled in Medicaid under the insurer’s Medicaid plans.

“There’s not a lot of programs, especially programs that children are interested in participating in,” said Dr. Rodney Wise, the medical director for Louisiana’s Medicaid program. The state, which suffers from one of the country’s highest rates of obesity, is asking all the health plans serving Medicaid to address the problem.

In another experiment aimed at teenagers obsessed with videogames, UnitedHealth said it was studying whether Microsoft’s Kinect for Xbox 360 could help children become more fit by playing fitness games at home.

Now that insurers and employers must pay for child obesity services, “the market will respond” with more treatment options, said Dr. Deneen Vojta, a pediatrician and UnitedHealth executive. But some of those treatments may not prove effective, she said.

Early results may be misleading, agreed Karen Miller-Kovach, the chief scientific officer of Weight Watchers International.

Weight Watchers, which runs a weight-loss program for adults that involves group meetings as well as a Web-based program, had to abandon one approach after discovering children were regaining their weight after a year, with some even gaining more than they might have had they not participated.

Weight Watchers has not given up, however. Departing from the early program, it is now trying to develop ways of engaging the whole family to eat better. The new efforts focus less on counting “points” for foods.

Children, especially teenagers, can rebel under an overly strict regime, said Ms. Miller-Kovach, and programs need to focus on making smaller, sustainable changes in their lifestyle.

Many of the most established treatment programs for childhood obesity are based at hospitals or academic medical centers, and experts say they may not be well suited to a child who is overweight but has not yet developed a serious medical condition like diabetes and is not an appropriate candidate for bariatric surgery. Parents are also often reluctant to take their child to a hospital for treatment.

"There's a big gap" between what is available for children and what is needed, said Gary D. Foster, the director of the Center for Obesity Research and Education at Temple University in Philadelphia, who serves as a consultant to UnitedHealth on its program.

WellPoint is trying a different approach, working through pediatricians. Because many pediatricians lack the background to help children who are overweight and have nowhere to refer them, WellPoint provided training to 100 doctors and linked them with dietitians in Virginia. The health plan pays for four visits to the doctor and four visits to the dietitian, whose sessions are aimed at improving the diet of the entire family.

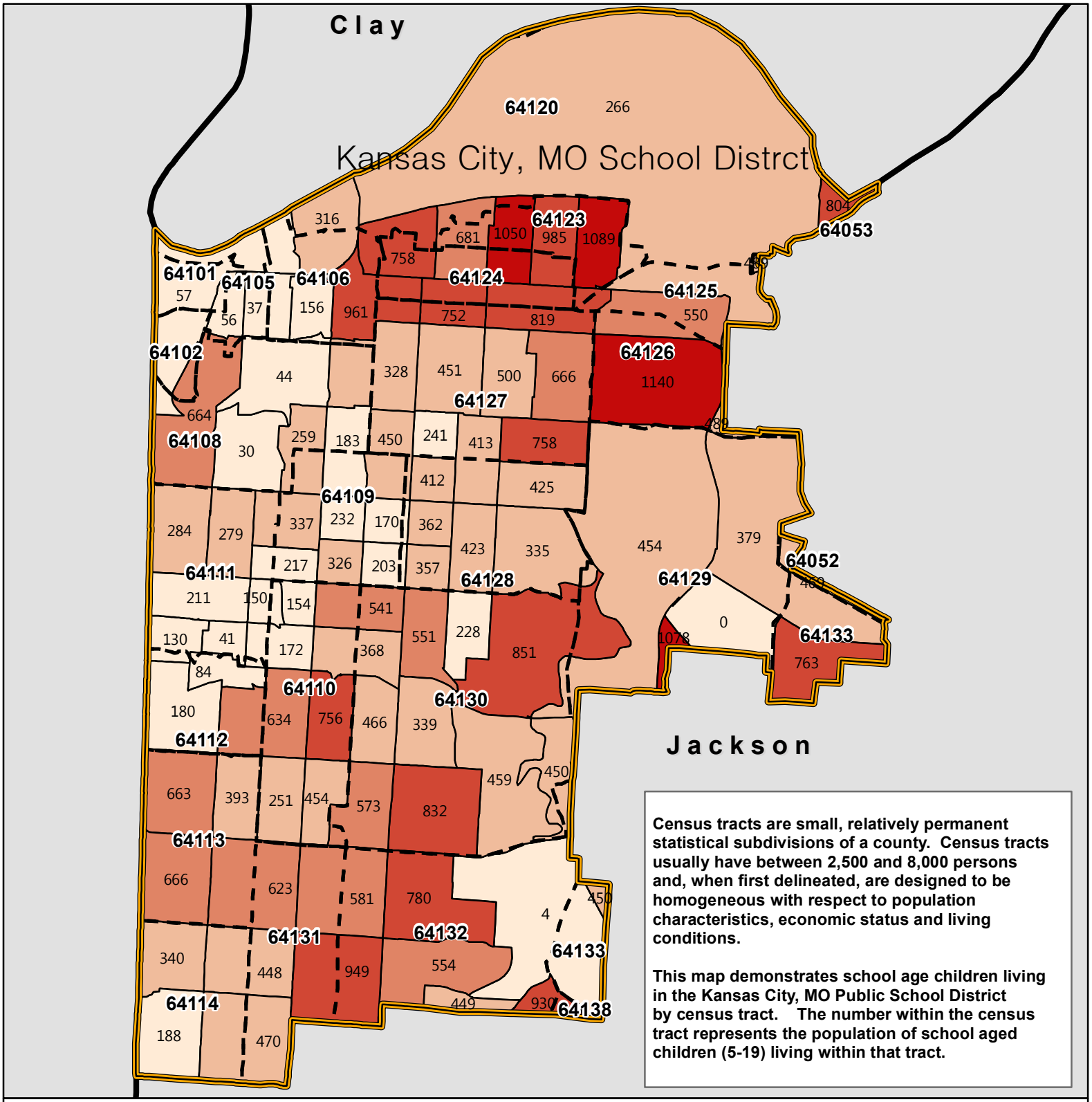
WellPoint is already planning to expand its efforts to customers in California and Wisconsin this year as soon as it is able to identify dietitians who can work with the pediatricians.

Experts say it is critical to take the long-term view. "What we're learning about treating childhood obesity is that there is no magic bullet in dropping weight in kids," said Dr. Colleen Kraft, a pediatrician in Roanoke, Va., who worked with WellPoint there.

Success may be achieved when an overweight child does not become an obese adult. "It's going to be a generation return on investment," she said.

This article has been revised to reflect the following correction:

School Age (5-19) Youth Living within the Boundary of the Kansas City Public School District



Census tracts are small, relatively permanent statistical subdivisions of a county. Census tracts usually have between 2,500 and 8,000 persons and, when first delineated, are designed to be homogeneous with respect to population characteristics, economic status and living conditions.

This map demonstrates school age children living in the Kansas City, MO Public School District by census tract. The number within the census tract represents the population of school aged children (5-19) living within that tract.

LINC
Local Investment Commission

School Age Population

- More than 1,000
- 750 to 1,000
- 500 to 750
- 250 to 500
- Less than 250

Zip Code Boundary

Kansas City Public School District Boundary

N

0 0.5 1 2 Miles

Map Produced by Local Investment Commission

Data Source: 2010 U.S. Census

KansasCity.com
THE KANSAS CITY STAR.

Wednesday, Jan 18, 2012

Nixon proposes $106 million cut from Missouri higher ed

By JASON HANCOCK
The Kansas City Star

Missouri Gov. Jay Nixon rolled out a budget Tuesday night that would cut higher education funding by more than $100 million while increasing state aid for K-12 education.

In his fourth State of the State address, and his final one before he stands for re-election, Nixon laid out an agenda that cuts $508 million from the state's budget, including reducing the state payroll by 816 jobs — to the lowest level in 15 years.

All this, he said, would help balance the state's finances without increasing taxes.

"Other states have not shown that fiscal discipline," Nixon said. "More than 30 states have raised taxes, including Kansas and Illinois. But we have not. Because we know that Missouri families can't afford a tax increase. Period."

Although higher education takes a hit, Nixon proposes increasing funding for K-12 schools by $5 million. However, the total amount is still nearly $500 million less than what is called for by the state's school funding formula.

"I haven't met one parent or one teacher in Missouri who thinks we should balance our budget by taking money from their kids' classroom," Nixon said.

Nixon also called on lawmakers to pass a charter school accountability bill that holds all schools "to high standards of academic achievement and financial integrity."

Republican lawmakers were quick to dismiss Nixon's plan to cut $106 million from higher education, a total that would be a 12.5 percent reduction from the 2012 budget. Senate Appropriations Chairman Kurt Schaefer, a Republican from Columbia, said the cuts were unacceptable. Universities have seen their budgets cut for three straight years.

"At some point, we're going to have to accept responsibility for funding our public universities," he said.

Nixon said the state's universities and colleges will have to change their business models.

"I am calling on all our colleges and universities to continue to look for more ways to cut overhead and administrative costs and run smarter, more efficient operations," Nixon said.

House Minority Leader Mike Talboy, a Democrat from Kansas City, worried that university administrators might have already done all they can.

"I don't know how much more efficient they can get," he said.

The state's projected 2013 budget was expected to face a $500 million shortfall thanks to an end to federal stimulus funds and a reduction in the rate the federal government pays for Medicaid. To help fill that budget gap, Nixon's plan relies on $191 million in Medicaid savings, mostly obtained through

efficiencies without changes to eligibility or covered services, and from $52 million in increased revenue from a tax amnesty plan that twice failed to clear the legislature last year.

Senate President Pro Tem Rob Mayer, a Republican from Dexter, said the governor's overall budget, despite Nixon's claims, is not balanced because it relies on ideas like tax amnesty, which have proved difficult to reach consensus on in recent years.

"From just looking at the budget figures he's giving us, we're more than $100 million short, which is not acceptable," Mayer said.

Nixon's budget plan also calls for state employees to receive a 2 percent raise, starting Jan. 1, 2013. Schaefer called the idea of giving state workers a raise — their first since 2009 — a "reasonable" idea, if they can find a way to cover the $23.6 million price tag.

Nixon also called for the legislature to take up his "Missouri Works" program, an idea he has rolled out in recent weeks that he says could spur more jobs among auto parts suppliers, increase international exports, and offer job-training subsidies for companies that hire military veterans.

The plan also calls for $4 million in funding for the Missouri Science and Innovation Reinvestment Act, known as MOSIRA. That would fund incentives for science- and technology-based companies.

Linda Luebbering, Nixon's budget director, said that of the 816 projected job cuts in the governor's budget, the bulk would be accomplished by attrition. Of those, more than 600 come from the Department of Transportation. The next biggest chunk comes from the Department of Social Services.

Luebbering insisted that despite the reduction in workforce, there will be no impact on state services.

Amy Blouin, executive director of The Missouri Budget Project — an organization that analyzes financial issues with an emphasis on their effect on the poor — slammed the governor's proposal for relying on cuts alone to deal with a budget shortfall. Instead, he should be willing to increase state revenues to deal with budget problems.

"While the governor mentions the need for job creation, these cuts will make it harder for students to get the quality education they need to compete in the global economy and for Missouri to attract jobs to our state," she said.

Talboy echoed Blouin's concerns, saying he would have liked to have seen some revenue increase measures, especially collecting Internet sales taxes.

"Unfortunately, I'm in the minority on that," he said.

Throughout his speech, Nixon struck an upbeat tone, pledging to work with lawmakers from both parties to "move Missouri toward brighter days ahead."

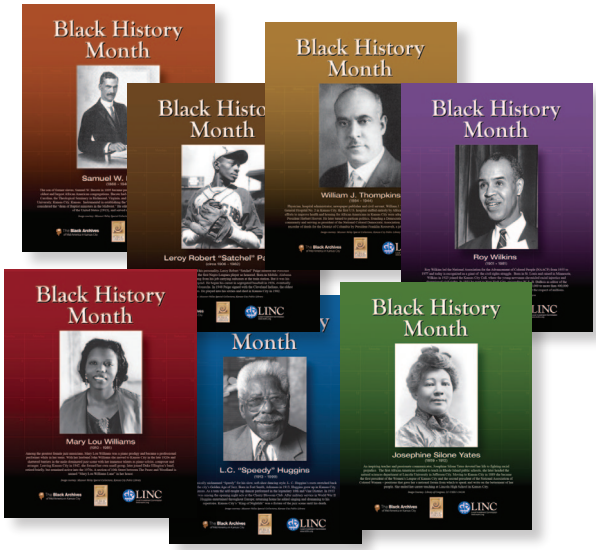
"Whether you're from the big city, or a small town. Whether you make your living on the farm, or in a lab. Whether you're a Democrat, a Republican, an Independent — or none of the above. We're all Missourians first," he said. "And here in Missouri, we're not defined by our differences. We're defined by our shared values."

To reach Jason Hancock, call 573-634-3565 or email jhancock@kcstar.com.

Celebrate Black History Month

You can download the complete Black History Month series of local and national leaders at

kclinc.org/blackhistory



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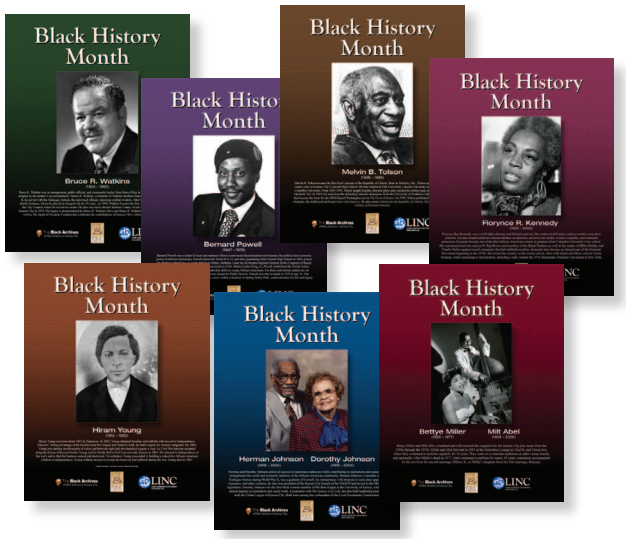

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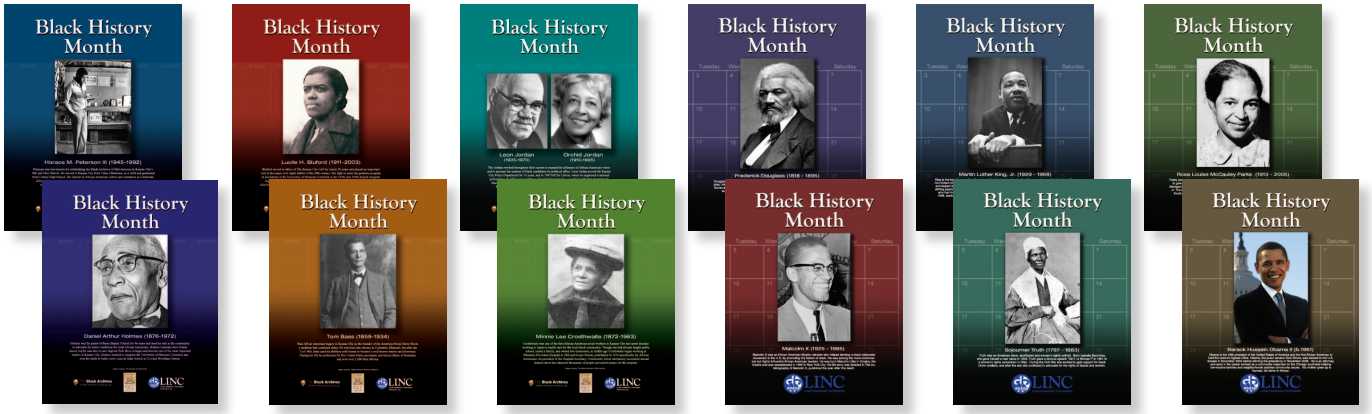

2010

The **Black Archives** of Mid-America in Kansas City

KANSAS CITY PUBLIC LIBRARY

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