Improving Healthcare Quality and Controlling Costs: Options for State Policymakers and Regional Leaders

On August 2, 2013, the Institute of Politics convened a meeting of approximately 100 elected officials, foundation and community leaders, and business and healthcare executives and advocates to discuss state-level policy reforms that could lead to greater value in our healthcare system. This, the first of three programs in a series on cost-effective healthcare, offered an overview of policy options in the following five areas:

- Transparency on Price and Quality
- Payment Reform
- Value-Based Benefit Design
- Regulation of Prices
- Quality Improvement

In his opening remarks, State Representative Dan Frankel stated that one goal of reform is to ensure that people have access to healthcare at a price that doesn't drive them into bankruptcy. However, this access cannot come at the cost of bankruptcy for the government either. Frankel then noted that when more dollars have to be spent on healthcare, there is less to spend on other government priorities, such as infrastructure or public education.

Additionally, he questioned the value Americans receive for the dollars spent. Other countries achieve better health outcomes at a much lower cost. In many ways, this is a result of the way medical care is provided and paid for in the U.S.: doctors are often paid for doing more rather than for doing better. Frankel urged elected officials to take action now, as the problem is only growing worse.

The keynote speaker, Harold Miller, president and CEO of the Center for Healthcare Quality and Payment Reform, provided an overview of the options for achieving higher quality, more affordable healthcare. Healthcare is the biggest driver of federal spending, as opposed to discretionary spending, on which most of the discussion in Congress is focused. When Congress has to choose between cutting services to seniors and cutting fees to physicians, physicians often lose out. Cost shifting to the private sector makes businesses less competitive, and businesses are now shifting their healthcare costs to employees.

But it is not the federal government on which Miller believes we should focus. It is at the local level where we have the greatest opportunity for reducing costs: through prevention, managing chronic conditions, and better management of people who enter and leave hospitals. Miller noted that between 5 and 17 percent of hospitalizations are preventable. Given that there is a 10-fold variation across the country in how much physicians are paid for particular operations, there are many opportunities to do better at a lower cost.

Miller noted that the Pittsburgh region has the 8th highest Medicare spending among 40 regions nationwide, and that people in Pittsburgh tend to visit the ER more frequently for care than people in other regions. The region is lower than average in the amount of commercial spending on healthcare, and lower than average in the number of people visiting physicians. For inpatient procedures, the region has lower than average payments but higher than average admissions.

Miller next outlined several options for payment reform, described as follows:

- Bundled payment
- Warranted payment
- Condition-based payment

Miller referenced Geisinger Health Systems' warranted payment system, but he noted that it doesn't take a large health system to implement this type of reform, which began with a single surgeon. He added that warranted healthcare is not an outcome guaranty, and that prices for warranted care, as would be expected, are slightly higher. A crucial element of these payment systems is shared, trusted data for pricing.

Miller then addressed hospital budgets, noting that margins are really where the focus should be. Reducing patients doesn't significantly decrease total costs at a hospital because of the large portion of fixed costs; however, he noted that a one percent change in hospital volume has a 25 percent impact on the margin. He then demonstrated a payment system that would allow fewer readmissions, would lower costs, and would also allow hospitals to increase their margin.

Moving on to specialty practices, Miller noted that opportunities and solutions for payment reform varied by specialty, but he noted that both payment method and price needed to be adjusted. He noted that Maryland sets all-payer rates; all payers pay the same, including Medicare. Miller also explained large-payer dictation and small payer negotiation, noting that rates depend on the size of the payers and the providers.

Next, Miller examined provider competition. He noted that there are significant barriers to addressing competition, which include:

1) Payers can't figure out what the quality of services and the costs actually are
2) Limited data suggests a lot of price variation in Pittsburgh
3) Lower cost hospitals often have higher quality ratings, which can be confusing for consumers

One solution is to give consumers a plan that reimburses them only for the lowest cost high quality option. Another solution is to increase competition in the market; more consolidated hospitals generally lead to higher prices. Miller provided a list of anticompetitive actions by providers, including being the only one to offer a particular desired service, and refusing to

contract with a tiered health plan, and stressed the need for hospitals to compete based on their relative efficiency.

In order to achieve successful reform, Miller noted that all stakeholders need to change and that many components of reform will need to be coordinated to do this. How can the state help? Miller then reiterated the initial categories of policy options and noted that these options would form the basis for the later discussion.

Miller then took questions from attendees. The first question was, "Where do we start – payors, regulators, providers?" Miller said to look for the opportunities in your particular community, acknowledging that first we need good data. A workforce shortage was also cited as a potential complication.

Questions regarding anticompetitive actions let to an explanation of Highmark's narrowed network Community Blue. Miller noted that someone with Community Blue insurance has to pay more to use a UPMC physician or hospital. He also pointed out that very large health systems often can offer specialty services that no one else offers.

Frankel added that the purpose of this program is to help educate policymakers, and although the state can take action to help resolve this issue, the community needs to come to a consensus first about what needs to be done.

Miller then introduced the first panel, comprised of physicians. Dr. Frank Civitarese opened his remarks by explaining the physician support system that is provided at his practice. However, he noted that most of the services provided through this support system are not reimbursable through insurance. Instead, the physicians in the practice got together and funded the support system themselves, because they recognized it to be important in the provision of care. Features include two fulltime RNs that focus on quality and a registered dietician.

Dr. Civitarese mentioned that his practice instituted three major quality of care initiatives, two of which were funded internally.

1) In order to address the readmission rate of the practice's patients, they collaborated with a home care system. Home care workers are embedded in the ER, and they introduce themselves to patients prior to discharge, to help with continuity. Savings on prevented readmissions have been significant.
2) The practice recruited a PharmD student to analyze the records of diabetic patients to determine which of them are taking their medications regularly. Out of the patients who were not, the practice was able to institute appropriate medication in 55 percent of them. After a review of the charts, the other 45 percent were deemed ineligible for those particular medications, and that information was noted on their records.
3) A chronic care initiative funded by Bayer resulted in healthier chronic care patients by the end of the study.

He concluded by noting that there are ways for physicians to improve quality and decrease costs, but these things are labor and time intensive. Any reform should allow for these types of wraparound services to be included in the payment scheme.

Dr. James Costlow of Premier Medical Associates began his remarks by noting that value equals quality over cost. He referenced Highmark's Quality Blue program, noting that out of 1570 participating practices with approximately 4500 physicians, only 197 practices reached the highest level in the program, and only 58 were able to get the highest score. This illustrates that while quality reforms may sound simple in theory, they are often difficult for physicians to carry out under the current system.

He attributes his practice's success in part to their EDGE mission statement, which was developed to ensure no gaps in care. He says that electronic medical records have been helpful in ensuring that all staff has the ability to help every patient. One example Dr. Costlow gave was a cardiologist who noted that a patient he was seeing had not had a recommended colonoscopy. The cardiologist was able to order the test right away. He also noted that diabetic patients in his practice are admitted to the hospital on average 48% less than other diabetics.

Dr. Amelia Paré, president of the Allegheny County Medical Society, offered remarks regarding the future expected growth in healthcare costs. She noted that 80 million Americans would be on Medicare by 2030. She also noted that Pennsylvania has one of the most expensive Medicaid programs in the country, and suggested that the Arkansas plan, where Medicaid dollars could be used to purchase private insurance, was a potential model.

She also stressed the importance of price transparency, stating that the public needed to know the cost of their care. Dr. Paré also noted that only through transparency and understanding would patients come to realize the importance of the necessary reforms.

Some reforms that Dr. Paré recommended included legislation to correct SGR payments, creating incentives for patients to choose lower cost care, and requiring electronic medical record systems to communicate with one another. Right now, EMR systems have no incentive to integrate, and Dr. Paré has gone through four different systems in the short time that she's used them in her office.

During the subsequent question and answer session, a discussion regarding the use of nurse practitioners as a lower cost method of providing primary care ensued. Dr. Costlow responded that nurse practitioners are used in his practices, but often their use is a double-edged sword. They are under a lot more scrutiny than doctors are, and are often more cautious as a result. In addition, physicians have to review the charts of all NP patients.

Another question revolved around tort reform and the practice of defensive medicine. The doctors noted that additional legislation would be welcome. Dr. Costlow related the example of doctors in the ER who are uncomfortable releasing patients complaining of chest pain. Even if

they have few of the risk factors for heart attacks, the doctor could be held liable if something happens to the patient within six months to a year following their visit.

In response to a question about how smaller practices might adopt these quality and efficiency measures, it was noted that while smaller practices might not be able to do some these things on their own, they can partner with other small groups and work together. Things like informatics can be a challenge. Small groups can also use the services of a larger practice, which could serve as a vendor.

Miller then introduced the second panel, who represented the consumers of healthcare. Chris Whipple, executive director of the Pittsburgh Business Group on Health, spoke first and noted that the group's members understand the value of the dollars they spend on their employees' healthcare. She also said that in the 30 years she's been working on this issue, the problems haven't changed much, but she believes that we're closer to a solution.

Whipple indicated that one major challenge for employers is purchasing insurance without clear information about the services that their employees need or use. She noted that they did a study in 2011 on cost and utilization to determine how different Pittsburgh was from the rest of the country; the study found that Pittsburgh often had lower costs, but those were offset by a substantially higher healthcare utilization rate.

The availability of cost and quality information is a key problem, not just for employers but now for employees with high deductible plans. Employees seeing increased costs need to know what they can expect to pay for different services. She mentioned reference-based pricing, where employers could define what they would reimburse as a percentage of the average cost of a particular service. Then it would be up to the individual to determine which provider to choose and how much they are willing to pay.

She concluded by indicating that credible data that allows for comparison should be a critical component of reform.

Next, Beth Heeb, executive director of the Consumer Health Coalition, noted that one big challenge for consumers is how to find quality providers. She identified Medicare.gov as one source, but there is significant room for improvement on the site. 2014 is supposed to bring additional quality information from the federal government. Some information is available for consumers in terms of hospitals and infection rates, but the information is far from perfect, not available on all procedures, and vulnerable populations have trouble using the system.

Other challenges include getting patients enrolled in insurance programs, and getting them to and from appointments. Also, low income people often float between Medicaid and other insurance programs, or having no insurance at all, which makes continuity of care very difficult. In addition, they also have trouble affording everything else they need to stay well, including medications, transportation, copays, and durable medical equipment. With chronic illness

patients, who have multiple doctors and multiple medications, it can be very confusing, especially when they have no coordinator of their care. Even when they do have caregivers, it is difficult to connect those caregivers with the health system. Inclusion of patients in their own care plans is critical; if they don't feel included, they're not going participate.

With regard to a community campaign, Heeb cautioned against talking about payment models, as consumers begin to worry about rationed care, or that they will be dropped by their doctors. She encouraged physicians and others in the healthcare system to focus on finding a way to pay for transitions and for consumer education, and to offer incentives to consumers to make more cost-effective decisions.

Isabel MacKinney Smith, a care manager at UPMC St. Margaret, offered remarks on patient issues relating to hospital stays, home care, and chronic care management. She noted that patients often have trouble understanding their disease maintenance place, or the proper sequencing of their medications. Other issues include not being able to work medical equipment (like an inhaler), avoiding triggers (like ozone action days), and following particular diets. One tool that can be helpful is having a chronic disease action plan, so that patients know what to do in case of an exacerbation and whether or not they need to seek medical attention.

MacKinney Smith mentioned health literacy as a major component of patient care; she noted that one needs a good baseline level of literacy in order to understand health information. She also mentioned that education that takes place in the hospital is less effective than education that takes place in the home. Often a patient's family support is not available in the hospital, and the patient can be on multiple medications that make remembering instructions very difficult.

Additional challenges for patients include:

- inability to afford copays
- unwillingness or inability to comply with testing regimens
- difficulty in accepting the lifestyle changes that often accompany chronic disease management
- a lack of social and emotional support to maintain prescription use or diet plans
- difference in the goals of the patient vs. goals of the physicians/practitioners with respect to treatment

MacKinney Smith also reported that chronic disease care managers cannot be reimbursed for the services they provided via insurance, but readmission rates have gone down by 45% for patients who have had the benefit of their services. Cost savings from the preventions of these readmissions are significant, even more so when complicated readmissions are prevented. In a Colorado system that implemented a care management team of nurses, social workers, and pharmacists, a savings of $15 million annual was achieved.

MacKinney Smith offered four additional thoughts on cost-effective ways to improve quality, noting that it comes down to doing the right thing to improve the lives of patients.

1. Effective post-discharge services include involving the community in promoting health and preventing disease.
2. With Medicare, the homebound requirement prevents access to home care for the non-homebound population.
3. Critical to care is patient access to support from their primary care physician or physician's office following the diagnosis of a chronic disease for the implementation of a chronic disease action plan.
4. Sub-acute centers for the management of chronic diseases such as asthma and diabetes help to avoid trips to the emergency room.

In the subsequent open discussion, Chris Whipple took the opportunity to explain the Pittsburgh Business Group on Health's diabetes program. She noted that the program waived copays for diabetes medications and assembled a team of "coach" pharmacists to meet with patients. Anecdotally, the program was keeping people healthy and out of the hospital. However, Whipple noted several barriers to the program, including:

1) The growth in high deductible health plans. Convincing people to remain with the program until their deductibles were met is a challenge.
2) Expansion is blocked by the STARS rating system; pharmacy resources are overly committed to meeting those goals set by that system.

She noted that employers have paid millions of dollars for wellness programs but have not seen results; it would be helpful for them to see outcomes from those programs.

A healthcare consumer in the audience reported that providing accurate value information to patients, specifically information about outcomes, would help to drive healthcare costs down. She also spoke about the physical barriers that prevent people with disabilities from accessing primary care, noting that many exam tables and even doorways were not suited for people in wheelchairs and cited a statistic that people with disabilities use primary care at less than half the rate of others.

Representative Frankel noted that transparency continues to be an issue and noted that the reauthorization of PHC4 represents an opportunity to broaden the scope of the agency. If so, two questions that need to be addressed are:

- What information should be mandated?
- How should it be funded?

The opportunity costs of spending on healthcare, referenced by Frankel at the beginning of the program, were echoed by another member of the audience, who referenced an Institute of

Medicine report indicating that the United States spends twice as much on healthcare as other developed countries but has poorer outcomes.

Other issued that emerged from the open discussion included:

- The importance of promoting health: health advocacy in the community needs to be strengthened in order for reforms at the state level to be effective
- The role of pharmacists as a provider of care, and the need for them to be treated as such by insurers
- The challenges of people with multiple diagnoses (mental/physical health) and the need to provide care for the children of those people
- Reforms should find a way to incentivize cultural competency and address health disparities; this should be done system-wide, not just with providers
- The role of nurse practitioners and physician assistants in our future healthcare system
- The role of patient-centered medical homes as a pathway for integrating disciplines and establishing roles for various specialty physicians and other non-doctor providers. This drew comments from legislators who noted that they are accustomed to a general lack of agreement between the various specialties about scope of practice. H. Miller noted that in comparison with other states, PA's scope of practice laws are restrictive, and that this issue is related to payment for services. There is also a need for patient education on the roles of various practitioners.
- How to meet the future workforce needs of an aging population; while there are economic incentives for businesses in areas of need, there are none for primary care physicians
- Concerns about the closure of state health clinics and the extra burden it will place on free clinics, as well as the projections on the number of Pennsylvanians who will choose not to purchase insurance under ACA

While few attendees responded to Miller's request for specific recommendations for state policy action, one audience member representing an insurer offered the following options for consideration:

- Establish higher quality metrics that are aligned
- Be clear about what data should be transparent
- Create payment policy pilots to compare different options and identify best practices
- Establish regulations relating to provider and payer competition
- Enact additional tort reform legislation
- Expand Medicaid
- Determine a better way of integrating health and social welfare policies at the state level

Another suggestion was to model payment reform after Medicaid and/or other state systems. Also, there was a suggestion to look at best practices related to transparency nationwide, and establish a task force to determine what would work best in Pennsylvania.

Dr. Paré recommended that the state address electronic medical records; currently, the systems are unable to talk to one another, and the providers of these services are not very reliable.

Another suggestion relating to transparency was to create a hospital discharge database that would make it easier to access clinical data.

Candi Castleberry-Singleton closed the morning's program with a recommendation that the best practices that are ongoing in the local offices of the practitioners on the panel need to become models for statewide reform. She noted that, while people came to the program for different reasons, all were there because they care about providing high quality care. In her role as chief inclusion officer at UPMC, the issue of cultural competency is very important to her, as it relates to providing care for the most vulnerable populations in our society. She referenced the work of the Regional Health Literacy Coalition in addressing this issue. By working together, we are showing our commitment to continuing this conversation.