



How States Can Improve the Health Care System

Four Steps for Health Care Reform

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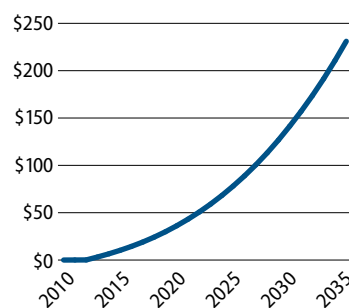
State and local governments currently spend about \$300 billion annually on health care, and health care accounts for nearly one-third of state budgets. This high level of medical spending, combined with the increased need for services and reduced revenues driven by an economic recession, creates enormous financial difficulties for states, as their experience with budget shortfalls over the past few years illustrates. States have an urgent need to modernize the medical care system to improve the quality of care while simultaneously lowering its cost.

Fortunately, state governments are in a good position to do so. The Patient Protection and Affordable Care Act of 2010, when combined with the HITECH provisions of the American Recovery and Reinvestment Act of 2009, gives states the tools they need to modernize the health care system. They will have access to information on health care cost and quality, and can change payment information to reward low-cost, high-quality care more favorably. Applying these tools could lower the growth rate of medical spending by 1.5 percentage points per year, saving state governments \$35 billion annually by the end of this decade and \$140 billion annually by the end of the next decade.

To materially improve health care, states need to approach health care the way that successful businesses approach struggling divisions. They need to understand the root causes of failure, and make the changes necessary to improve the situation. Fortunately, there is ample precedent for this. Industries from manufacturing to retail trade to business services have used a common process to become more efficient, which states can follow as well. This process is characterized by a few simple features:

Health reform saves money

Projected savings to state budgets from health care reform, in billions of dollars



Knowing more. High-performance businesses invest in information technology. They know what tasks need to be taken, who should perform them, and how to do them most efficiently. Wal-Mart pioneered this strategy in retail trade as Toyota did in automobiles, and it has spread to other parts of manufacturing, online sales, and even professional services. In health care, by contrast, there is little information available on the quality of different providers, the value of different types of care, and the steps involved in providing care efficiently.

Rewarding good work. In all successful businesses, the economic case supports doing the right thing. Employees are rewarded for adding value, not doing too much—witness banks gambling with taxpayer money—or too little—salaries with no performance incentives. Health care has traditionally rewarded providing more intensive care, but not coordinating care or making sure the care provided is appropriate. Operating on a patient with a heart attack is reimbursed highly, but helping people avoid a heart attack is not. The result is inadequate prevention and excessive costs when care is needed.

Employee and customer empowerment. The most successful firms are not hierarchical; rather, decision-making is decentralized to employees, individually or in groups. Because employees are given the right information and the right economic incentives, they can make good decisions for the firm as a whole. This is not the case in health care. Doctors and nurses have great latitude in how they care for individual patients, but have little say in how the hospital overall operates or how the unit they work in is structured. Patient expertise is considered, but not very extensively.

For health care to become more efficient, it must change in each of these areas. The required changes will not be easy, but they are possible. Indeed, recent legislation makes these changes even more feasible. There are four steps that state governments can take to promote these changes:

Steps to promote health care savings

1. Tackle administrative costs	Lead an effort with insurers, providers, and state government to reduce administrative costs by 50 percent over five years
2. Push the information revolution	Set up all-payer databases to measure quality and demand quality improvements; encourage providers to invest in IT for federal stimulus money
3. Lead payment reform	Work with Medicaid/SCHIP, private insurers, and Medicare to design payment systems that bundle care and reward good performance
4. Be open to new organizational forms	Remove barriers to coordination and entry into health care

Step 1: Tackle administrative costs

Our health care system spends about \$250 or \$300 billion annually on administrative expenses. Money that insurers spend on selecting good and bad risks is one obvious element of this cost, but this is just the tip of the iceberg. Provider groups spend millions of dollars and employ hundreds of people in billing operations. Duke University hospital, for example, has 900 hospital beds and 1,300 billing clerks. The bulk of these people are paid to ensure that forms are correctly documented and to resubmit bills that are rejected in the first round. Insurers employ equal numbers of people to determine if claims are appropriate and fully documented.

Insurers and providers together pledged in the recent health reform debate to eliminate this type of waste. The steps involved in doing so are not complex. They include streamlining the credentialing process for physicians, coordinating the information provided to different insurers and state agencies, moving to electronic payment systems, establishing online insurance interchanges, and adopting real-time claims adjudication processes.

The major barrier to improvement in these areas has been the lack of coordination. Without coordination, there is no rationale for insurers to harmonize their systems or for providers to implement necessary upgrades. State governments are ideally designed to provide this coordination. They work regularly with large insurers, hospital and physician organizations, and individual providers. Further, they can ensure that Medicaid changes are synchronized with private sector changes. Thus, action at the state level is natural.

To start, state governments should set a very firm goal: providers and insurers should commit to reducing administrative costs by 50 percent over the next five years. The state can then convene insurers and providers to meet this goal. The specific steps required to meet this will vary by state, depending on the existing degree of automation, administrative integration, and electronic investment. But the steps will include at least some harmonization of insurance submission requirements and adoption of electronic interchange.

Step 2: Push the information revolution

No industry has ever become more productive without knowing what it was doing. Gathering and analyzing health care information is an essential precondition to cost savings. States can facilitate the collection and use of this information in sev-

eral ways. First, states can collect medical claims data from all insurers to analyze what is done and how well it is done. States have always had access to Medicaid data. Private insurance data are generally available as well, since insurance claims are now kept electronically. Medicare data have traditionally been more difficult to obtain, but a provision of the Patient Protection and Affordable Care Act allows the Department of Health and Human Services to release Medicare data for quality analysis. States should apply for access under this provision.

States can put together quality information on different providers with these data. For common conditions such as heart disease, cancer, and strokes, states can evaluate which providers have better outcomes or lower costs than others. States can do several things with this information. They can start by feeding it to consumers, insurers, and providers, which will allow them to make better-informed care decisions. Further, providers that are high-cost and low-quality can be asked for improvement plans—what steps is the institution taking to get better, and how will they be monitored? With a small number of providers, states can monitor implementation of quality improvement programs. States like New York, Pennsylvania, New Jersey, and others have taken the lead in this area, publishing reports on cost and quality data for both hospitals and surgeons. Subsequent reports have shown that transparency has contributed to mortality declines greater than 20 percent for cardiac valve surgeries as well as reductions in infection rates. Other state models include the Wisconsin Collaborative for Healthcare and Quality, the Maine Health Management Coalition, and the Iowa Healthcare Collaborative.

Ultimately, states and others will want information from electronic medical records. As a result of the HITECH Act enacted as part of the American Recovery and Reinvestment Act in 2009, providers can receive federal payments for investing in health IT. States can facilitate data gathering by encouraging providers to invest in qualifying IT and providing technical help allowing them to do so. The technical help will typically consist of supporting local interchange systems and facilitating bulk purchasing of electronic equipment. The goal for states should be a common, interoperable health record across the state as a whole by the end of this decade. New York's Office of Health Information Technology and Transformation, which aims to coordinate health information technology programs and policies across public and private providers in the state, may serve as a useful example for states looking to implement such reforms.

Step 3: Lead payment reform

Payment reform is critically important to cost reduction. As long as payment is oriented toward the volume of care and not its value, opportunities for cost savings will never be fully realized.

The progression of care for a typical sick person highlights the need for payment system reform. People generally start healthy, and then develop chronic conditions as they age. If successfully managed, the person will continue in that state. Often, though, the disease progresses to an acute episode, requiring immediate and follow-up care.

A variety of providers are associated with chronic, acute, and post-acute treatment, including primary care physicians, specialists, hospitals, nursing homes, laboratories, pharmaceutical companies, and medical equipment providers. Generally, these providers are paid on a piece-rate basis. Physician payments are separate from hospital payments, even if the medical service occurs on an inpatient basis. Primary care physicians are not incentivized for reducing emergency department visits, even if reducing such visits would save the system money overall. There are many ways that the payment system can be improved. The options include:

Bundled payments, where a single provider accepts reimbursement for the care of a patient as a whole. The bundled payment might be for an acute episode, for care of a particular chronic disease, or for care for the patient as a whole. For example, in 2008 Minnesota passed legislation that would develop “basket of care” payments, which bundle all provider payments related to a full diagnostic or treatment procedure given to a patient. The state is working to establish at least seven basket payments for conditions such as asthma care for children, diabetes care, total knee replacement, and obstetric care.

Performance-based payment, where providers are paid based on specific metrics such as limiting emergency department utilization or ensuring adherence to evidence-based guidelines.

States can play a significant role in payment reform efforts. States already operate the Medicaid and SCHIP programs, which account for about 15 percent of acute care payments and will increase in importance as a result of reform. In addition, state employees’ health insurance programs are among the largest purchasers of medical care in most states. Further, states will soon be operating insurance exchanges, where there is additional purchasing leverage.

Two additional factors make now a good time for states to start on payment reform. First, the restrictions on underwriting in the Affordable Care Act will make risk selection increasingly less profitable, and thus focus insurer attention on managing care better. Second, recent legislation gives the federal government the ability to experiment with Medicare payment changes. States pursuing multipayer initiatives have the opportunity to include Medicare as well, as Rhode Island, Vermont, and other states are exploring.

The key for states is to use their authority to leverage systemwide payment reform. Medicaid and private insurers should act first to implement new payment systems. The federal government can then be brought in over time. The new systems will typically involve gainsharing: states agree to share savings from better management with providers that achieve these savings.

The specific nature of the incentive payment will differ across areas of the country. Some areas are extremely hospital-oriented, so that reductions in hospital utilization are the key marker of cost reduction. Other areas have difficulty providing appropriate primary care, so better incentives for primary care management is the most natural payment reform. Some population groups may also be more amenable to management than others. Most states have a large number of very expensive “dual eligibles,” people who are eligible for both Medicare and Medicaid, for whom better management is a high priority. States can work with Medicare to better manage these patients, potentially sharing savings across the two programs.

Step 4: Be open to innovation

A coordinated health care system will look very different from the current one. Physicians will work in teams, not individually; health centers will monitor care, not just treat people when sick; IT will be ubiquitous. The experience of other industries suggests that new organizational systems will be needed to make this change work. Wal-Mart, for example, almost single-handedly changed the way the retail trade industry operated. Toyota, Southwest Airlines, and Amazon.com did the same in automobiles, travel, and online sales. In each case, these firms were entirely new, or had at best a minor place in the industry when they started. Health care needs to be open to this type of innovation.

New firms in health care might appear in several guises. Some might be consolidations of existing firms. For example, under federal regulations due out this fall, providers will have the opportunity to become federally designated accountable

care organizations—organizations that care for a large number of Medicare beneficiaries and accept a single payment to provide all the care for those beneficiaries. State governments can encourage providers to form such organizations as a vehicle to coordinate care throughout the medical system.

Similarly, primary care providers might be encouraged to set up medical home practices to better coordinate the primary care they deliver. A medical home is a combination of physician(s) and ancillary staff that coordinates care across the spectrum of needs; in most models, providers receive additional reimbursement when patients are kept out of acute care settings and maintain their health. In other cases, the innovation might come from outside health care altogether. The private equity firm Cerberus has recently agreed to partner with Caritas Christi in Massachusetts, and Vanguard Health Systems, a subsidiary of the Blackstone Group, is on track to purchase Detroit Medical Center in Michigan. These organizations can bring some of the managerial know-how that has been developed in other industries into health care, where it is sorely lacking.

States can support health care savings by being open to new organizational models. For example, states could facilitate legal and clinical reforms such as changes in clinical practice of medicine rules that would enable new organizations to enter the health care delivery system and allow for alternative business models. Second, states could review scope of practice laws to evaluate potential efficiency gains from empowering nonphysicians in clinical settings. Third, states could provide technical assistance to smaller provider groups seeking to redesign their care delivery systems. For example, states could help draft legal documents for practices seeking to become accountable care organizations or for firms entering into risk-sharing contracts. In all cases, new organizations, like existing ones, should report and be responsible for quality improvement.

Further steps

States that adopt these steps will make significant strides—creating more efficient health care systems and controlling the growth of health care costs. But these steps don't address some of the other important drivers of growing health care costs, such as increased rates of obesity and the related higher prevalence of chronic disease. While new payment strategies will improve care for individuals with chronic illness, long-term savings will also depend on fewer individuals developing multiple chronic conditions in the first place.

States may wish to develop additional strategies to combat these rising trends. Improving the nutritional quality of school lunches and working with local government and private sector partners to maximize federal grant opportunities, such as the Racial and Ethnic Approaches to Community Health for Communities, to target unhealthy behavior through community-based interventions, can help improve health among targeted populations, such as children and minority communities. States may also choose to compete for the new funding opportunities in the Affordable Care Act directed towards promoting individual and community health, as well as preventing the incidence of chronic disease.

Additional options may include other individual and community-based reforms to improve health, such as workplace wellness programs and public education campaigns. States may also consider increasing the price of fattening foods, such as high-sugar and high-fat foods, through targeted taxes. As of January 2009, 33 states already applied a sales tax to sugar-sweetened beverages (e.g., soft drinks) at an average of 5.2 percent. Using these proven strategies, ranging from new financial incentives to investments in community-based health improvements, states can start to turnaround long-term trends in obesity and chronic disease.

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