

States Tackle Health Care



As Congress debates, states keep the ball rolling toward an efficient, affordable health care system.

BY JULIA C. MARTINEZ

Learn more about the future of health care reform at the NCSL Legislative Summit, Aug. 6-9, in Boston. Learn more at www.ncsl.org/summit2017.

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Marietta Wright was 80 years old when she began a long, painful journey through the health care system. Two days before an operation to treat what doctors thought might be a spinal compression fracture, an MRI showed her spine was “riddled with cancer.” Instead of canceling the surgery, as her family expected, doctors performed the operation, which only weakened Marietta, physically and mentally.

“They did a surgery for something that didn’t exist,” her daughter Barbara Wright says. “It compromised the limited resources she needed to fight the cancer.” Then, as Marietta began cancer treatments, she was given an inappropriate dose of antidepressants, which “tipped off a mental health collapse,” Wright says. “It was too big a dose for an 80-year-old weighing 100 pounds.”

Other setbacks followed. Marietta was admitted to a cancer center in North Carolina, then to a nursing home. Her subsequent death, three years after the surgery, was attributed to metastatic breast cancer.

With all the cutting-edge technologies, high-tech equipment, luxurious hospitals suites and doctor specialists, it is tempting to think Americans’ health care must be the best in the world. But, as the Wrights discovered, when it comes to caring for patients, all too often it is uncoordinated, too costly, wasteful and even dangerous.

Health care spending, including Medicaid, Medicare, children’s health insurance and the Affordable Care Act, comprises the largest share of the federal budget and accounts for nearly a third of the average state’s budget. Per-person health care spending in the U.S. is nearly twice that of other developed nations. Yet, life expectancy in America is shorter than in dozens of other countries, and rates of infant mortality and diabetes are higher. High costs place a heavy burden on federal and state gov-

ernments, employers and consumers.

Although one can find examples of high-quality care all across the country, numerous reports, including a 2010 inspector general’s report on Medicare patients, say too many Americans do not get the health care they need. Barbara Wright described her mother’s experience before entering the cancer center as a “nightmare.” Besides unnecessary surgery and excess medication, mammogram results were lost for several weeks. Communication among providers and between the providers and her family was “mass chaos.” When her mother needed help from the mental health system, which operates independently of the physical care system, navigating the system was like landing in a foreign country without knowing the culture or the language.

Major Health Care Cost Drivers

- Fragmented, uncoordinated care
- High use of expensive medicine
- Fee-for-service payments
- High physician, facility and drug costs
- Lack of incentives for patients to consider costs
- High administrative expenses
- Unhealthy behaviors
- Expensive end-of-life care
- Provider consolidation and market share
- High use of expensive medicine

Source: State Health Care Cost Commission, Miller Center, University of Virginia, 2014

"We still have a payment system that primarily pays for quantity and we need to match that up with quality and outcomes."

—REPRESENTATIVE JAMES A. DUNNIGAN, UTAH

The family's experience highlights some of the shortcomings of a health care system in which "unnecessary services, excessive administrative costs, fraud and other problems" amount to \$750 billion annually, or 30 percent of total health care spending, according to a 2012 report by the Institute of Medicine.

The fee-for-service payment system contributes to fragmented care, driving costs up and quality down. Providers get paid for services rendered—whether it's an exam, lab test or a surgery—but not necessarily for producing results. "Fee-for-service is simply the wrong model to pay for primary care," Dr. Rushika Fernandopulle, a practicing physician, wrote in an August 2015 Health Affairs article. "It is toxic to good care and to physician and team culture, so we

should simply stop using it."

With all the unknowns about future national health care legislation, states need to lead the way in identifying ways to improve the health system, addressing the practices that raise costs but do little to improve people's health, says Utah Representative James A. Dunnigan (R), co-chair of the state's Health Reform Task Force.

"It's very urgent. ... We still have a payment system that primarily pays for quantity and we need to match that up with quality and outcomes," he says.

That's a lot to tackle. Here are five things states are doing with promising results.



Representative
James A. Dunnigan
Utah

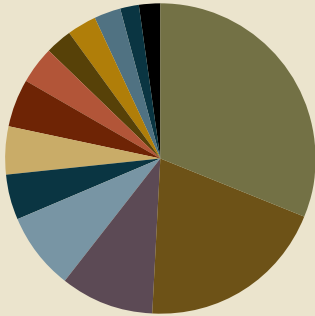
Improving Health Care Quality

- Prevent overuse, underuse and misuse of health care services and ensure patient safety.
- Identify what works in health care—and what doesn't—to drive improvement.
- Hold health insurance plans and health care providers accountable for providing high-quality care.
- Measure and address disparities in how care is delivered and in health outcomes.
- Help consumers make informed choices about their care.

Source: Agency for Healthcare Research and Quality

Where the Money Goes

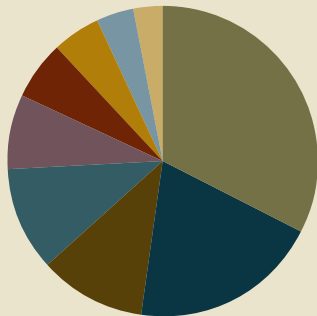
Spending by Type of Service or Product



- 32% Hospital Care**
- 20% Physician and Clinical Services**
- 10% Prescription Drugs**
- 8% Government Administration Net Cost of Health Insurance**
- 5% Other Health, Residential, and Personal Care Services**
- 5% Nursing Care/Retirement Facilities**
- 5% Investment (Research and Equipment)**
- 4% Dental Services**
- 3% Home Health Care**
- 3% Other Professional Services**
- 3% Public Health Activities**
- 2% Durable Medical Equipment**
- 2% Other Non-durable Medical Products**

Where the Money Comes From

Spending by Major Source of Funds



- 33% Private Health Insurance**
- 20% Medicare**
- 11% Medicaid – Federal**
- 11% Out-of-Pocket**
- 8% Other Third Parties**
- 6% Medicaid – State and Local**
- 5% Investments**
- 4% VA, DOD, CHIP**
- 3% Public Health Activities**

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, based on 2015 data

1. Focus on patient-centered care.

Had Marietta Wright’s doctors used a comprehensive, team-based approach to caring for her, each of her providers would have had her health records and would have coordinated safe, quality treatment designed for her needs while communicating with her, the family and each other. Such patient-focused care could have saved her and her family much pain and suffering.

Arkansas was one of the first states to use a patient-centered medical home model of care for Medicaid patients. This approach involves a primary care clinician who coordinates safe, high quality care among all a patient’s providers, specific to the needs and preferences of patients and their families.

This voluntary program for physicians has been in operation for a little more than three years. About 80 percent of the state’s Medicaid beneficiaries were covered last year, with promising results. According to the Arkansas Department of Human Services, the initiative has reduced hospitalizations by 16.5 percent, and emergency room visits by 5.6 percent, per 1,000 beneficiaries. Patient-centered medical homes have also slowed the rate of cost increases more than other providers.

Oregon also provides team care for its Medicaid population through a network of providers known as coordinated care organizations. They work in local communities and focus on prevention, helping people manage chronic conditions such as diabetes, supporting patients newly discharged from hospitals and screening children for mental health risk. This approach helped to reduce spending on unnecessary emergency room visits by 19 percent between 2011 and 2013.

Oregon’s Patient-Centered Primary Care Home program saved an estimated \$240 million over its first year, according to an evaluation report by Portland State University.

Although state Medicaid programs have widely adopted patient-centered care models, Medicare, which was Marietta’s insurer, has been slower to embrace coordinated care by primary care physicians.



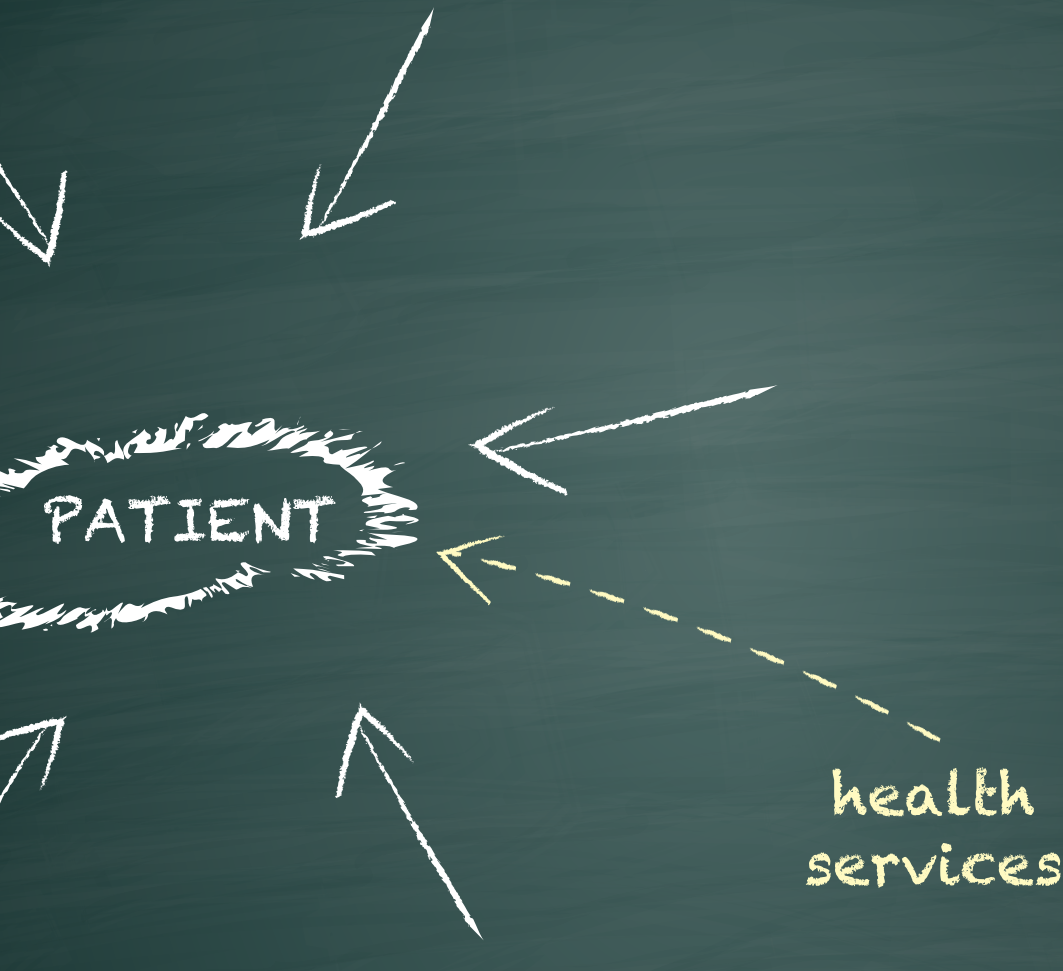
2. Integrate health services.

Running separate primary and behavioral health care systems is costly and inefficient, with economic and social consequences, says Dr. Benjamin Miller, director of the Eugene S. Farley Jr. Health Policy Center at the University of Colorado School of Medicine.

Mental health issues drive a dramatic portion of Medicaid spending. Physically ill patients who also have mental health or substance use issues, or both, incur health care costs that are 40 percent higher than those for patients receiving only physical care, Miller says.

Their diagnoses take longer and treatment is more complicated, with poorer results. Many are left to “churn in the system.” He says they often lose their jobs, end up homeless or in prison, or commit suicide.

Miller cited a 2002 study in the American Journal of Psychiatry that found “on average, 45 percent of suicide victims had contact with primary care providers within one month of suicide.” He noted that the report continues to be cited by leading health journals as suicide rates increase



and underscores the need for better integration of primary care with behavioral health care services.

Despite a large body of evidence that shows integrating physical and behavioral health services would save states money while helping patients heal, uniting the systems has been difficult. It's challenging to integrate care for long-term behavioral health patients, and tough finding the time and resources to train primary care doctors to recognize and treat mental health problems. But a few states are succeeding.

Missouri pioneered the Healthcare Homes program to integrate care for Medicaid beneficiaries with chronic medical conditions and severe mental illness. Based in community mental health centers, staff coordinate care and disease management for the "whole person." Case managers ensure patients have access to community supports, transportation and primary care.

The program won a Gold Achievement Award from the American Psychiatric Association in 2015 for improved health for patients. It also resulted in significant Medicaid savings—\$31 million after its first year, largely due to reductions in hospitalizations and emergency room visits.

"When a person is having mental health

issues and a primary care provider observes it, there needs to be an identified pathway to treatment for the individual," says Iowa Representative David Heaton (R), chair of the House Health and Human Services Appropriations Subcommittee.

Iowa is building that pathway with an integrated system for adults and is now designing one for children as well. Legislation required the state Health Department to collaborate with Iowa Medicaid and child health specialty clinics to coordinate activities of the "1st Five" initiative. It supports health providers in detecting social-emotional and developmental delays in children from birth to age 5. It also coordinates referrals, interventions and follow-up care. But it hasn't been easy, Heaton says. Uniting the two systems has been a struggle and continues to face many challenges, including training primary care physicians to deal with patients who have mental illness.

"I know a lot of primary care doctors try to do the best they can," he says, "but as far as a systemic approach, my state at least has a long way to go."



Representative
David Heaton
Iowa

Super-Utilizers, Super Price Tag

Patients with several complex health needs comprise just 5 percent of the nation's health care cases, but they account for approximately 50 percent of the costs. Sometimes known as "super-utilizers," many have chronic health conditions, including mental health issues.

Improving and coordinating their care and meeting their nonmedical needs can save states money.

The following strategies, according to The Commonwealth Fund, can improve care and reduce costs for these high-needs patients:

- Classify patients by common needs.
- Invest in coordinating care.
- Shift care from institutions to the community.
- Integrate medical, behavioral and social services.
- Give providers flexibility in allocating resources.

New Jersey's "hot-spotting" initiative, under the Camden Coalition of Healthcare Providers, tracks super-utilizers, who tend to frequent hospital emergency rooms for their health care needs.

Coalition partners help connect these patients to outpatient resources that can coordinate their care and offer support services.

The project reported a 50 percent drop in avoidable hospitalizations among the patients it has helped.

3. Improve patients' safety.

"Failure to improve the health care system will result in needless mortality and morbidity," warned The Commonwealth Fund Commission on a High Performance Health System in 2006. Others have issued similar warnings, yet medical errors still kill way too many people.

In the summer of 2002, John "Alex" James collapsed while running and died three days later at the age of 19. After a previous collapse a month earlier, Alex had undergone tests and was given a clean bill of health.

His father, Dr. John T. James, former chief toxicologist for NASA, told a U.S. Senate subcommittee in 2014 that "at least three catastrophic errors were made by his doctors." One was that the doctors "knew he should not return to running, wrote this

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in his medical record, but never warned him not to run; Alex's only discharge instructions were not to drive for 24 hours."

The year Alex died, the Institute of Medicine attributed some 98,000 deaths in U.S. hospitals and clinics to medical errors. Last year, that number was up to more than 250,000 lives lost, according to Johns Hopkins University School of Medicine researchers.

"It boils down to people dying from the care that they receive rather than the disease for which they are seeking care," says Johns Hopkins surgeon Dr. Martin Makary, who led a 2016 patient-safety study.

The Centers for Disease Control and Prevention's chief of mortality statistics, Bob Anderson, says medical mistakes are likely the intervening cause of many deaths, and stresses the importance of educating doctors about the value of reporting errors on death certificates. Errors are "very much underreported," he says. "This

is a public health issue, and they need to report it for the sake of public health."

Given states' authority to license phy-

sicians and oversee death certificates, Anderson says state legislatures are strategically positioned to motivate doctors to report medical errors and complications.

Some states have passed laws requiring doctors or hospitals to notify families of "unanticipated outcomes." Others have passed "I'm sorry" laws that permit providers to extend apologies to next-of-kin for "adverse events" without facing legal action. Still, reporting remains sporadic. "Patient safety needs to be at the fore-front of our health care," says Senator Marc Pacheco (D) of Massachusetts.

"We've come a long way, but we still have a long way to go to ensure the implementation of best practices across our health care system," he says. Massachusetts is one of 36 states with an "apology law," but Pacheco is working with consumers, physicians, insurers and state regulators to go further to improve patient safety.



Senator
Marc Pacheco
Massachusetts



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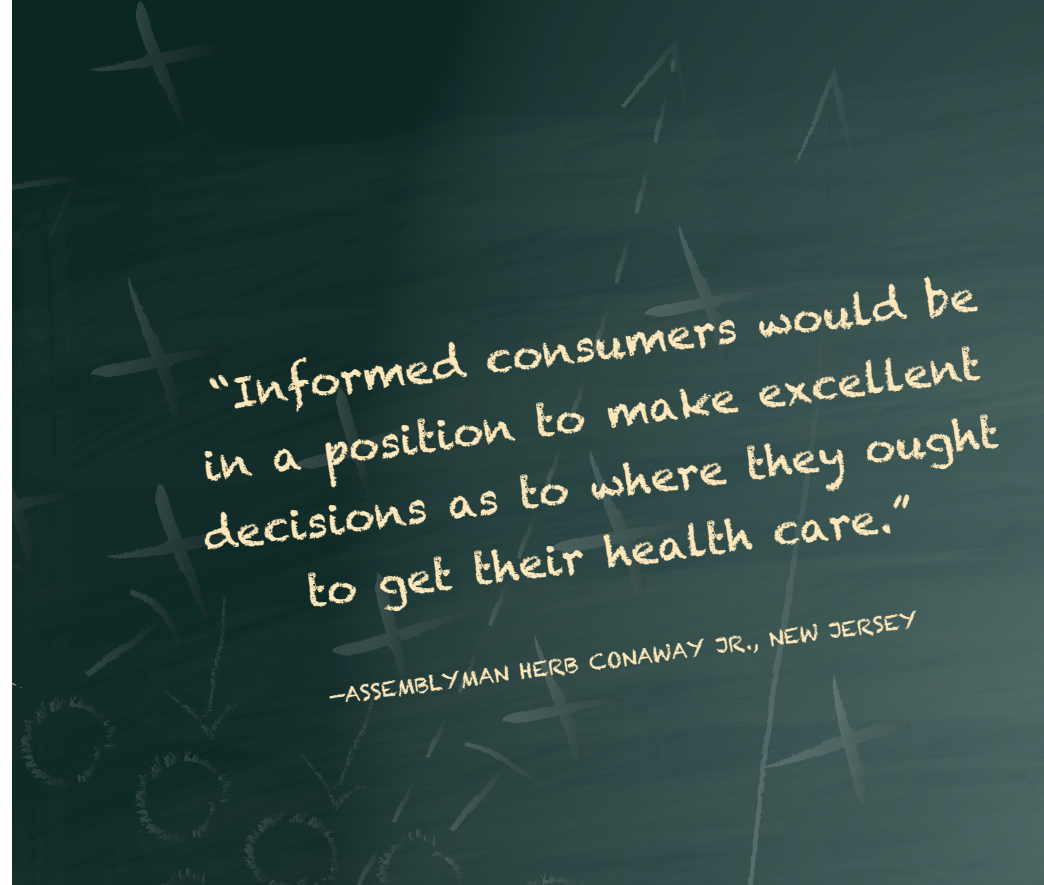
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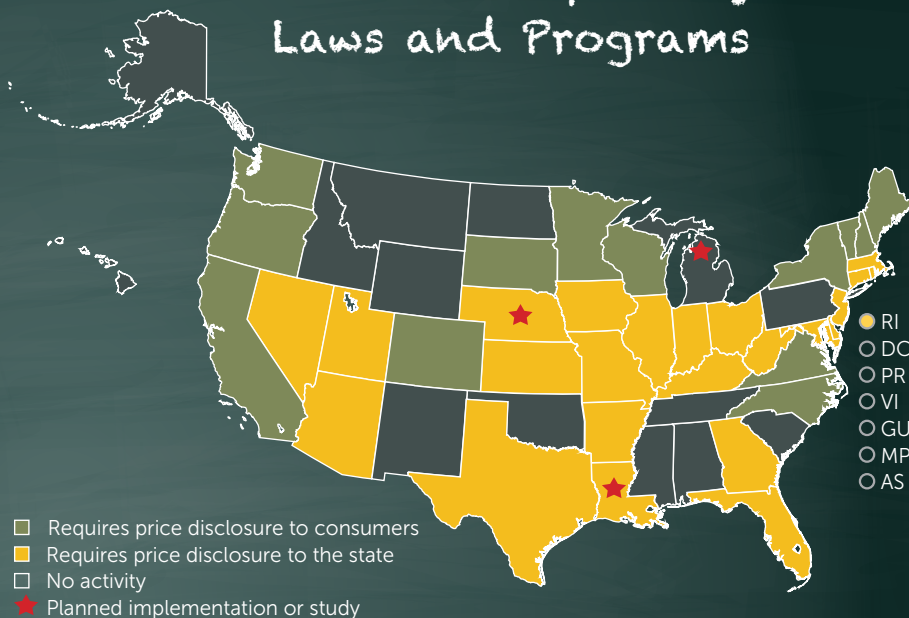


4. Keep prices as transparent as possible.

Improving patient care gets complicated by a lack of transparency, says New



Health Cost Transparency State Laws and Programs



Source: NCSL, March 1, 2017 in italic like usual.

catch problems before they become worse.

Wisconsin Representative Dale Kooyenga (R) says that with “health care costs going up, up and up,” legislatures ought to play a leadership role in highlighting issues of health and well-being and encouraging conversations at various levels of the public and private sectors that could lead to healthier communities with less spending.



Representative Dale Kooyenga Wisconsin

Kooyenga, a military intelligence officer in the Army Reserves and a veteran of the Iraq War, says reports from the U.S. Department of Defense and retired military leaders tying the shrinking pool of recruits to an increase in obesity are troubling. But there is “definitely an opportunity for public policy here, such as discouraging junk food and high-calorie beverages in schools,” he says.

“Intervention efforts need to start early with educators teaching students about healthy eating and daily physical activity,” Kooyenga says. “And businesses need to promote healthy behaviors as a workplace issue.”

Oregon Senator Elizabeth Steiner Hayward (D), a family physician, says one of the ways to strengthen well-being and prevention efforts is for legislatures to redefine primary care to include non-traditional care, such as family nutrition counseling, and to encourage insurance companies to pay.



Senator Elizabeth Steiner Hayward Oregon

“Exercise as medicine makes a lot of sense,” says Steiner Hayward, who has prescribed exercise for some of her patients. “Nutrition as medicine makes a lot of sense, and it’s way the heck cheaper because it addresses multiple issues simultaneously.”

“If we could really revamp our system and promote the things that actually promote health and prevent illness,” Steiner Hayward says, we would save “a lot of money that we could be using to build healthier communities.”

Jersey Assemblyman Herb Conaway Jr. (D), a physician and lawyer. Public information about the relative competence of doctors, clinics and hospitals has been virtually impossible to obtain historically. Hospital ratings are hard to interpret and often misleading.



Assemblyman Herb Conaway Jr. New Jersey

“Transparency needs to be increased, and I am talking about across the board, for physicians, hospitals and insurance companies,” Conaway says. He believes consumers armed with information about the price and quality of services offered by doctors, hospitals and diagnostic centers can save themselves money and spur healthy competition that will lead to improvements.

Efforts to improve transparency are underway in over half the states, and the issue remains a topic of interest in state legislatures.

New Jersey’s “hospital price compare” website allows health care consumers to compare information about various services and charges at the state’s acute care hospitals. California, Florida, Maryland and Oregon are among states with similar websites.

Texas consumers can request a cost estimate from health care facilities, physicians or their insurance plan before

receiving care, which must be provided within 10 business days. Health carriers must also disclose the estimated financial responsibility for the patient. These procedures also help protect consumers from “surprise” medical bills, which happens when a patient unexpectedly receives care from a provider outside an insurance plan’s network, such as a hospital’s anesthesiologist.

At least 18 states sponsor databases that collect health insurance claims information from payers, including cost, use and quality information. These All Payer Claims Databases help states analyze charges, payments, clinical diagnosis codes and patient demographics.

5. Emphasize prevention over treatment.

Our system tends to treat diseases rather than prevent them. A small proportion of national health spending goes to prevention. Yet evidence abounds that a healthy weight, physical activity, good nutrition and not smoking play critical roles in reducing risk factors for chronic diseases such as heart disease and diabetes. Preventive services such as immunizations and screenings help keep people well and

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