Colorado Medical Society

"Advocating excellence in the profession of medicine"

September 14, 2015

Bill Lindsay
Colorado Commission on Affordable Health Care
Denver, CO 80203

Dear Mr. Lindsay:

On behalf of the Colorado Medical Society and the over 7,500 physician members across the state, I want to thank you for your work and the opportunity to provide feedback to the Commission on Affordable Health Care. Colorado Medical Society actively supported the passage of SB14-187 that created the commission and we look forward to continuing our collaboration with you and others to help ensure that Coloradans consistently get the highest quality, most cost effective care. We respectfully offer the following comments in response to your questions.

What are the fundamental cost drivers and why?

1. Administrative waste and complexity – The size and scope of administrative waste within the health care system is well documented, and its impact on physician practices and the patients they serve is often profound. Administrative waste affects the approach to care delivery and patient engagement by focusing more energy on compliance rather than good care. In addition, it also helps to drive corollary concerns with defensive medicine that cause many unnecessary tests and resulting harms to patients. These systems and requirements in turn frequently bog down the care, healing and wellness processes – making them more complex, costly and needlessly redundant, especially for patients.
2. Misaligned payment and incentive systems – Engineering the health system to produce more value is still a work in progress and the paradigm shift from fee-for-service to pay-for-value has proven to be challenging for many physician practices, especially given the disparate approaches currently used by public and private payers. It is problematic to run multiple payment schemes simultaneously within the same organization, as the incentives around volume and efficiency are polar opposites. Importantly, focusing solely on payment incentives ignores the professional drive within physicians to provide the best care possible for their patients as Cassel argues, and it may not sufficiently leverage patient and community health relationships and resources.
3. Fragmented care delivery and miscommunication – The seemingly ever-growing, technical sophistication and complexity of care has improved the health of countless people, and it has also failed to contain costs and improve quality on many fronts. Missed opportunities to ensure care quality, cost effectiveness and patient engagement occur more often than they should for a host of reasons that arguably center upon barriers that prevent care teams from being informed, empowered and encouraged to work together with patients. Fragmentation and miscommunication at systems, management and leadership levels drive costs and decrease the quality and safety of care.

What are the barriers to reducing costs?

The following list of barriers is interconnected and must be considered together as action in one area likely affects outcomes in others.

1. Administrative and regulatory burdens – Administrative burdens that are focused more on the business of medicine and regulation versus patient centered care are burning out physicians and

sapping time and talent away from much needed change initiatives. These burdens make for a harried care environment that negatively impacts physicians, their empathy for patients, the care experience and decisions about necessary and unnecessary care.

2. Lack of interoperable information systems that provide timely, clinically relevant and actionable cost and quality information to patients and their families, community health leaders, and clinicians at the bedside are key barriers to delivering the right care at the right place, every time. Proprietary approaches, unfocused and non-standardized measures and methods, and a growing emphasis exclusively on lowering costs without a similarly enduring commitment to quality improvement are sources of profound, daily frustration by physicians and patients.
3. Lack of multi-payer payment and delivery system reforms drive up administrative complexity and wasteful workflows, while driving down physician professional satisfaction. We recognize that there is no one right way to enhance health care value, but concerted action to align reforms are desperately needed so that clinicians can focus on honing their practice and strengthening their relationships with patients, rather than contorting their efforts to meet disparate demands.
4. Increasingly uncompetitive marketplace – Recent news of more mega-mergers between health insurance company giants have the potential to exacerbate access to care problems further, narrow choice and the ability of physicians to obtain fair contracts. Research just released highlights the chilling effect on market forces that these mergers will have in Colorado, specifically cutting competition in half in Colorado Springs, Greeley and Grand Junction.
5. Reticence to change and adopt best practice – It is important to recognize the power of the status quo and the resistance to change it engenders by all stakeholders, including physicians, and society as a whole. Encouraging more honest, open and data-driven conversations like those being sponsored by the Commission on Affordable Health Care are key to overcoming this barrier. In addition, the science of medicine is continually changing and steps to analyze, adopt and spread best practice frequently are taken either too slowly or are purposefully hobbled, as has happened lately with many comparative effectiveness research efforts. Concerted effort is needed to ensure that all stakeholders actually know what works and what doesn't. Surmounting these barriers to improving the science of medicine must not come at the expense of the art of medicine and the primacy of the physician/patient relationship. Staying focused on patient needs is critical. Therefore necessary variation in care must be respected.
6. Lack of meaningful patient engagement – We see patients every day that are confused, scared and sick. While some advances are being made, the fact is that all too often the care process is just too complex, costly and hurried for patients, which drives missed opportunities to truly connect with them and serve their wishes. This is especially important when it comes to end of life care. Similarly, patients as individuals and as communities must be active stewards of their health and health care by embracing prevention and wellness strategies in order to reduce their risk of developing chronic disease. Often these relatively simple behavioral changes can do far more than any prescription a physician can write. Patients simply must be a part of the solution. Greater patient engagement via shared decision-making and evidence based benefit design will help patients partner with their physicians in advancing the Triple Aim.

Can you list up to three things that you are doing to address cost that are unique?

1. Working to reduce low-value care – Colorado Medical Society was the first state medical society in the nation to endorse the *Choosing Wisely* campaign by the American Board of Internal Medicine Foundation. We have subsequently launched *Choosing Wisely Colorado* as a way to reduce low value care and in the process strengthen patient-physician relationships. In addition, a statewide physician education campaign on end of life and palliative care utilizing the *Respecting Choices* model will soon begin. Kaiser Permanente Colorado, and likely others, have successfully utilized this approach.
2. Actively educating Colorado physicians on ways to improve the quality, safety and cost effectiveness of care including focusing on:

- Payment reform and the core competencies and capabilities physicians must have to excel within new care models, like patient-centered medical homes and systems of care that integrate care with specialists (including mental and behavioral health), as conceptualized in patient-centered medical neighborhoods;
- Transforming Medicaid into a high performance delivery system through the Accountable Care Collaborative. We have and continue to work closely with the state and other partners as Regional Care Collaborative Organizations have operationalized this work. More recently we helped to identify ways to enhance access to specialty care through the use of e-referrals and other telehealth modalities; and
- Actively participating and supporting the Colorado State Innovation Model and associated work to integrate mental and behavioral health care with primary care.

3. Physician leadership development – CMS has prioritized efforts to contain health care costs and created a new, multi-specialty task force of physicians from across the state tasked with reviewing and developing evidence-based proposals to reduce costs and improve quality. In addition, CMS has developed and now graduated 72 physicians from our Advanced Physician Leadership Program. The program directly tackles the well-documented need for more physician leaders. More programming is in the works with the intent to grow Colorado physician leadership capacity to help drive much needed transformations across the health and health care systems.

Is there any supporting data that demonstrates a reduction in cost?

1. Reducing low-value care –Research done for the *Choosing Wisely* campaign underscores the pervasive nature of low value care, finding that 72 percent of physicians say the average medical doctor prescribes an unnecessary test or procedure at least once a week. The research also details the fact that physicians are uniquely positioned to impact those care decisions with patients. The Institute of Medicine (IOM) has also found that of the 30% of waste in health care, $210 billion is spent on unnecessary services each year.
2. Importance of primary care – Strong evidence exists documenting the importance of a strong foundation of primary care. Similarly, evidence continues to mount about the beneficial impact of high performance primary care models, like patient-centered medical homes (PCMH), and the important role they are playing in reshaping care delivery. In addition, the most recent data from the Colorado Accountable Care Collaborative show a net savings of $31 million for Medicaid thanks to PCMH-focused efforts to redesign delivery and payment models.

Where do you see waste in the system?

Administrative complexity consumes far too much time from physicians and other providers – time that could be better spent on direct patient care. Research by the IOM shows that $190 billion each year is wasted on excessive administrative costs. Other research shows that physicians spend about 43 minutes a day interacting with health plans about payment, dealing with formularies, and obtaining authorizations for procedures. The mean estimated cost in 2009 dollars of interacting with all payers in the United States is $88,855 per physician and $40.8 billion annually for office-based physicians. Other projections show that Colorado could save $80 million annually if a standardized set of health care claim edits and payment rules to process medical claims were implemented. More concerted effort on administrative simplification is necessary.

Waste also comes from inadequate technology systems, including electronic health records (EHR). While much has been invested in efforts to drive meaningful use of EHRs, the story thus far for most physicians is not one of increased efficiency. A recent study just found that:

- 42 percent of physicians think that their EHR system's ability to improve efficiency was difficult or very difficult;

- 72 percent thought their EHR system's ability to decrease workload was difficult or very difficult, and
- 43 percent said they had yet to overcome the productivity challenges related to their EHR system.

Colorado Medical Society supports interoperable health information technology and information exchange systems that are easy to use and serve as tools to improve care decisions. The fact is that current systems largely don't live up to their promise yet.

Finally, from a practical perspective, one can argue that waste in health care is anything that gets in the way of providing quality care as defined by the IOM. In fact, primary drivers of professional dissatisfaction by physicians come from waste in today's health care system. We partnered with the American Medical Association and the Rand Corporation in a study to identify the factors that influence physicians' professional satisfaction. Findings suggest that monitoring the factors (including cumbersome EHRs) contributing to physician dissatisfaction offers tangible early warning signs of deeper quality problems developing in the health care system. The study also affirmed the common sense notion that focusing on these issues, like addressing quality concerns, tackling problems with EHRs, ensuring fair payment arrangements that align with good patient care, and providing a knowledge base and resources for internal physician practice improvement, can drive physician satisfaction and better system efficiency.

What are the principal barriers to transparency?

Principal barriers to transparency include:

- Lack of agreement on measure identification and use – There is a dizzying array of quality and cost-effectiveness physician performance measures that are used in different ways, at different times, for different reasons. A few years ago CMS conducted an analysis of performance measures across 14 programs from six commercial and public payers. We started with 956 measures and consolidated those down into 699 individual measures across all programs. Of those 699 measures, only 38 aligned with four or more physician performance programs (e.g. PQRS and meaningful use). Other research finds similar results. Each program compels its own set of administrative demands that further saps resources and frequently draws focus away from actual performance improvement. In essence, the noise to signal ratio caused by lack of alignment of measures is just too strong and the result is confusion and lack of use by physicians, patients and policy makers.
- Use of process versus outcomes measures – Claims data-driven process measures often are just flawed proxies for quality and cost effectiveness. Concerted efforts to develop and drive the use of more outcomes measures that use clinical data, often captured through EHRs or registries, must continue given the deep-seated mistrust of billing data by physicians. A balanced measure set approach that utilizes outcomes, claims and patient experience data would provide more meaningful and actionable information.
- Lack of collective will to address this problem – Numerous payers are using their own, frequently proprietary methodologies to meet their individual needs. Without a compelling business case or sufficient political will, it is safe to assume that the use of disparate systems will continue. The promise of transparency of health care data hinges on that data being accurate, timely, meaningful and actionable. New systems of care and alternate payment models are slowly increasing demand. We believe that, while many of these transparency initiatives have not yet demonstrated significant changes in behavior, efforts to align measures are still critically important in order to accelerate more informed decision making and individual and system performance improvement.

What would you change to make things better

We believe that there are both long and short-term steps that can be taken by all stakeholders to help contain the growth of health care costs. We also believe that recommendations must not be considered in isolation of efforts to improve the experience, quality and safety of care as embodied in the CMS supported Triple Aim. CMS has developed and approved a set of policies focused on systems of care that

provide the foundation upon which major changes to the current system can be applied, including:

- Integration, coordination and organization;
- Strong primary care-based system;
- Patient engagement; and
- Promoting payment reform that appropriately aligns compensation with both individual and system performance.

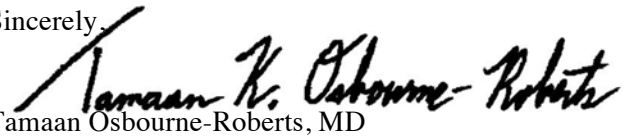
We encourage your careful review of this complementary set of policies.

In the short-term, we support the exploration of ways to create a common performance measurement set for Colorado created by physicians, other providers and community health leaders on the front lines of patient care and public health. As mentioned previously, we cannot move to value-based system unless we know what health care value really is. This framework provides a commonsense, improvement-focused way to get patients, physicians and other health care providers the usable, meaningful and actionable data they need at the point of care. Similar efforts are underway across the nation, but the time for waiting is past. We recommend building upon the momentum of these efforts to pioneer a statutory or regulatory framework that will provide a common method to understand and act upon what is and isn't working to improve quality and reduce costs in Colorado.

Conclusion

Thank you once again for the opportunity to participate and for your thoughtful outreach and collaboration. Colorado Medical Society is committed to supporting the commission and your efforts to ask and answer the hard questions about health care costs and quality in Colorado. We look forward to continuing our work together.

Sincerely,



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