Comments for the Colorado Commission on Affordable Health Care[1]

September 18, 2015

1. **What do you think are the fundamental cost drivers and why?**

As a fundamental principle, the Colorado Hospital Association (CHA) believes the Colorado Commission on Affordable Health Care (Commission) should focus on the broad body of evidence-based research that addresses the question of what drives health care costs and why.[2] This evidence identifies several key factors, including (but not limited to):

- **Underlying health of the population:** Growing incidence of obesity and chronic disease, aging of the U.S. population, and lifestyle choices contribute to increasing health care costs;[3]
- **Payment systems that incentivize volume over value:** It is broadly recognized that the fee-for-service (FFS) payment system creates an environment in which there is little incentive to manage costs, leading to growth in per-unit cost as well as increased utilization;[4]
- **Administrative cost and inefficiency:** The complex systems of billing and reimbursement are costly, but they ensure patients get care and providers receive payment for the care they provide;[5]
- **Structure and supply of the healthcare workforce**: Insufficient data and analysis, maldistribution of health care workers, ineffective workflows, and unnecessary restrictions on scope of practice lead to inefficient use of highly-trained – and often costly – health care professionals;[6]
- **Advances in medical technology and research:** Although new developments in technological or pharmacological treatment of illness can lead to better patient outcomes, the research and development to develop these treatments can have high price tags and significant lag time prior to widespread and effective adoption.[7]

Much of the published evidence identifies best practices or promising strategies for reducing costs or mitigating the rate of cost growth, and this information should form the basis for the Commission's analysis and recommendations. An important tension to recognize in evaluating potential solutions is the interplay between the three "legs" of the Triple Aim – reduced cost, improved health outcomes, and improved patient experience of care – and the fact that for any particular health care cost driver, an investment may result in increased cost but have the benefit of achieving the other two objectives of the Triple Aim. In some cases, this creates positive results in a cost-benefit analysis despite the front-end cost increase.

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

CHA and its member hospitals are committed to the Triple Aim. In pursuit of Triple Aim goals, CHA facilitates statewide quality improvement initiatives with the aims of improving care, reducing harm, and thereby lowering health care costs. By disseminating clinical evidence and strategies for best practices, CHA assists hospitals in embedding strategies for patient safety in daily clinical practice and creating administrative support for organizational cultures that encourage safety and clinical excellence. Three initiatives that best exemplify this work are Project RED, the Hospital Engagement Network (HEN), and Antimicrobial Stewardship.

Project RED

In 2012 and 2013, CHA facilitated a quality improvement collaborative with 19 Colorado hospitals to implement the Project RED intervention with select target populations. Project RED (Re-Engineered Discharge) is a training program sponsored by the Agency for Healthcare Research and Quality (AHRQ) to re-engineer discharge processes and improve patient outcomes. In this effort, CHA provided hospitals with education on best practices and created a network for shared learning. Each hospital tracked its all-cause and same-cause readmission rate and the percentage of compliance with eleven action steps deemed to be best practice.

The Project RED interventions were implemented in Colorado with nearly 7,700 patients, resulting in a 30% relative reduction in the all-cause readmission rates and a 43% relative reduction in same-cause readmission rates. In just two years, CHA estimated that this project saved $2.6 million by averting 311 all-cause readmissions over seven quarters of intervention. National studies on Project RED indicate similarly positive results, including 30 percent lower readmission rates and a savings of $431 per patient.[8]

Hospital Engagement Network (HEN)

From 2012-2014, 36 Colorado hospitals participated in a quality improvement project led by CHA as part of a nationwide initiative created by the Centers for Medicare & Medicaid Services (CMS) called the Partnerships for Patients (PfP). The campaign aimed to reduce patient harm by 40 percent and avoidable readmissions by 20 percent at U.S. hospitals by using Hospital Engagement Networks to facilitate education, training and improvement activities in eleven core focus areas.

As a result of this project, Colorado hospitals and health systems prevented 2,800 patient harms for an estimated cost savings of $14.8 million. The improvements made by Colorado hospitals participating in CHA's HEN means patients treated in those facilities are less likely to develop an infection from surgery, be injured in a fall, experience a medication error or have to return to the hospital for additional care within 30 days. CHA HEN hospitals prevented the following patient harms:

- 1,250 readmissions
- 447 adverse drug events
- 176 early-elective deliveries and 71 adverse obstetrical events
- 25 incidents of post-operative pulmonary embolisms or deep vein thrombosis (blood clots)
- 14 central line-associated bloodstream infections
- 15 catheter-associated urinary tract infections
- 67 surgical site infections

- 3 pressure ulcers
- 732 falls (79 with injury)

Antimicrobial Stewardship

In March 2015, CHA initiated a project to improve the utilization of antibiotics for treatment of common infections. Through this new two-year program, conducted in partnership with the Centers for Disease Control and Prevention (CDC) Get Smart for Healthcare Campaign, CHA will help hospitals and health systems improve programs for accurately diagnosing urinary tract infections (UTIs) and for proper prescribing of antimicrobials for UTIs and for skin and soft tissue infections.

In 2012 there were 900,000 hospital admissions for drug-resistant conditions and the avoidable cost from antibiotic misuse ranges from $27 billion to $42 billion.[9] In addition, the overuse and misuse of antibiotics are key factors contributing to antibiotic resistance and unnecessary health care costs. According to the CDC, numerous studies have shown that implementing an antibiotic stewardship program can not only save lives, but can save significant health care dollars. Inpatient antibiotic stewardship programs have consistently demonstrated annual savings to hospitals and other health care facilities of $200,000 to $400,000. According to a University of Maryland study, implementation of one antibiotic stewardship program saved a total of $17 million over 8 years at one institution.

As part of this program, CHA also seeks to reduce the incidence of health care-associated clostridium difficile (C. difficile) infections. Illness from C. difficile most commonly affects older adults in hospitals or in long-term care facilities and typically occurs after use of antibiotic medications, and it has become increasingly difficult to treat in recent years. In 2011, C. difficile caused almost half a million infections in the United States, and 29,000 people died within 30 days of the initial diagnosis.[10]

3. Where do you see waste in the system?

Waste and inefficiency account for up to 30 percent of U.S. health care spending ($2.9 trillion in 2013), or roughly $870 billion each year, but these factors are notoriously difficult to measure.[11,12] Opportunities for cost savings related to waste include better care coordination, administrative simplification, and reducing fraud and abuse. For example, assisting patients with transitions of care, reducing hospital readmissions, and improving discharge planning could save an estimated $25 billion to $45 billion annually.[13] Reducing administrative complexities faced by providers could save between $107 billion to $389 billion annually if they were made more efficient.[14] Finally, while valuing the cost of intentional fraud and abuse is quite difficult; some estimate the cost to both public and private payers at over $270 billion.[15]

4. What are the principal barriers to transparency?

Transparency of both cost and quality data continues to improve, although at a slower trajectory than is considered appropriate by most stakeholders. CHA has been a long-term, consistent supporter of efforts to improve transparency, both through its support of Colorado's All Payer Claims Database (APCD)[16], the Hospital Price Report,[17] and the Colorado Hospital Report Card.[18] Collectively, these three services enable consumers and policymakers to thoroughly evaluate costs and clinical quality information for common health care services provided in Colorado hospitals. Colorado is among the top-performing states when compared to other states in transparency efforts. In July 2015, Catalyst for Payment Reform gave Colorado a "B" for price transparency, New Hampshire and Maine being the only states to do as well or better, and with 45 states given an "F".[19]

CHA has also taken an active role in supporting the framework described by the Healthcare Financial Management Association (HFMA) report, "Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force."[20] The 23-member task force that developed the report included representation from hospitals, physicians, rural health, consumers, insurance, and government. Released in 2014, the report provides guiding principles and policy considerations for price transparency. To be effective, price transparency must offer clear information that is readily accessible to patients and enables them to make meaningful comparisons among providers. Recommendations for efforts to increase transparency include the estimated price of the service, the patient's estimated out-of-pocket responsibility, information about clinical outcomes and patient satisfaction, and network information. The report also concluded that health plans should serve as the principal source of information for their members. Providers should be the principal source of information for uninsured and out-of-network patients. The report also lists responsibilities for employers and referring clinicians. These recommendations provide a strong foundation to provide relevant information to patients when needed.

Despite these successes, significant barriers to transparency remain. Among the greatest barriers is the challenge of how to simultaneously achieve the following goals for health care price and quality data:

- **Accurate:** Because business consequences are so significant, data about health care prices and quality must be accurate and verifiable.
- **Comprehensive:** Pricing information alone is insufficient to meaningful consumer decision-making; systems should pair price and quality information.[21]
- **Meaningful:** Data should be communicated in such a way that consumers can easily understand its significance and translate it into informed decision-making.
- **Secure:** Data systems for transparency must adequately protect both personal and proprietary information.
- **Timely:** Many reporting systems for price and quality data often run on a significant months- or years-long delay, which can undercut its value for prospective consumer decision-making.
- **Actionable:** Transparency for its own sake may be laudable, but transparency in-and-of-itself will not help to reduce health care costs; available information must translate into actions that impact the market.

All players in the health care system – including providers, payers, consumer advocates, and others – can improve on transparency efforts with the above principles in mind, which will help patients understand pricing and quality differences and enable them to better evaluate their options for care. But research shows that even when information is available, consumers may not use it. For example, Coloradans' self-reported understanding of key health insurance terms is strong: over 85 percent of Coloradans feel confident about understanding "premiums," "deductibles," and "copayments."[22] However, "more than 1.5 million Coloradans do not look into what their health plan covers before getting services; 1.2 million people say they don't check whether a doctor is in their network before receiving care; and 762,000 people don't review the medical statements showing charges and payments."[23] Helping to improve health literacy and encouraging consumers to understand the financial consequences of health care decisions they make is a shared responsibility.

5. What would you change to make things better related to costs?

Among the greatest challenges in the U.S. health care cost puzzle is untangling and defining key terms (including cost, price, payment, and reimbursement) and analyzing the relationships between each in order to determine appropriate interventions for the problems at hand. Often, perhaps due to the integral role hospitals and health systems play in the delivery of care, it is assumed that they have significant abilities to unilaterally exercise control over health care costs. However, financing for healthcare is much more complex, and hospitals and health systems may not be able to bear primary responsibility for cutting costs.

As part of the complex financial analysis done by the Colorado Department of Health Care Policy and Financing, a recent report assessed the relationship between what hospitals spend to provide care ("costs") and payments made to hospitals ("payments" or "reimbursements") by all payers, including Medicaid, from 2009 to 2013.[24] The report reveals that, at a population level, Colorado hospitals are paid only a small amount above what it costs for them to deliver care.

As illustrated in the table below, the payment-to-cost ratio shows that reimbursement is highly correlated to costs and is highly consistent across years. From 2009 to 2013, payments to cost were between 1.08 and 1.05, as illustrated below. In 2013, government payers paid between 66 percent of cost (Medicare) to 80 percent of cost (Medicaid), meaning government reimbursements do not fully cover the cost of services their members incur. As a result, expenses associated with government payers go unreimbursed and the difference is reimbursed by private payers. Private payers paid 164 percent of the cost of care received by their members in 2009, but as government reimbursements rose over the five-year period, private insurers paid only 152 percent of the cost of the care received by their members in 2013.

	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
Medicare	0.79	0.74	0.75	0.74	0.66
Medicaid	0.61	0.75	0.79	0.79	0.80
Insurance	1.64	1.58	1.61	1.54	1.52
CICP/Self Pay/ Other	0.55	0.62	0.63	0.67	0.84
Overall	1.08	1.05	1.07	1.07	1.05

This data underscores the inter-related nature of health care financing, as well as the importance of having an all-payer approach to effectively tackle rising health care costs and bend the cost curve.

[1] Comments submitted by the Colorado Hospital Association, the leading voice of the state's hospital community. Representing over 100 hospitals and health systems throughout Colorado, CHA serves as a trusted, credible resource on health issues, hospital data and trends for the media, policymakers and the general public. Though CHA, Colorado's hospitals work together in their shared commitment to improving health care in Colorado.
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[2] An illustrative sample of recent literature reviews on this topic include:

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- Herman, Bob. Nine drivers of high healthcare costs in the U.S. January 2014. Becker's Hospital Review. Available at: http://www.beckershospitalreview.com/finance/9-drivers-of-high-healthcare-costs-in-the-u-s.html
- Bipartisan Policy Center. What is driving U.S. health care spending? September 2012. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401339
- Alliance for Health Reform. Cost drivers in health care. April 2012. Available at: http://www.allhealth.org/publications/Cost_of_health_care/Cost_Drivers_in_Health_Care_109.pdf
- Fodeman and Book. Bending the curve: what really drives health care spending. The Heritage Foundation. February 2010. Available at: http://www.heritage.org/research/reports/2010/02/bending-the-curve-what-really-drives-health-care-spending

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[4] National Commission on Physician Payment Reform. Phasing out fee-for-service payment. New England Journal of Medicine, 368:2029-2032. May 2013.

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[6] Bipartisan Policy Center. What is driving U.S. health care spending? September 2012. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401339

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[11] National Health Expenditure Data, 2013. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html

[12] Institute of Medicine. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. September 2012. Available at: http://iom.nationalacademies.org/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx

[13] Berwick and Hackbarth. Eliminating waste in US health care." Journal of the American Medical Association. September 2012; 307(14):1513-1516.

[14] "Health Policy Brief: Reducing Waste in Health Care," *Health Affairs*, December 13, 2012.

[15] "Eliminating Waste in US Health Care." Berwick, D.M.; Hackbarth, A.D. *Journal of the American Medical Association*, 2012; 307(14):1513-1516.

[16] https://www.comedprice.org/

[17] http://www.cohospitalprices.org/hprices/index.php

[18] http://www.cohospitalquality.org/corda/dashboards/COLORADO_REPORT_CARD_BY_MEASURE/main.dashxml

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[21] Binder, Leah. "Why health-care price transparency isn't enough for consumers." Wall Street Journal. March 26, 2015.
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[23] Colorado Health Institute. A new day in Colorado: Findings from the 2015 Colorado Health Access Survey. September 2015. Available at: http://www.coloradohealthinstitute.org/uploads/downloads/2015_CHAS_for_Web_.pdf
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