



Healthcare that Works: Answering President Obama's Challenge of Finding What Works

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Healthcare that Works Outline

The Center for Health Transformation is developing an approach to improve healthcare quality, lower costs, and ultimately insure every American - and there are hundreds of breakthrough practices and solutions that are proven to do just that. If we rebuilt government policies to maximize the rate of migration to these practices and solutions, we would be dramatically healthier and would also save an incredible amount of money. The key components are:

1. Creating a healthcare system that works, in which the federal government and other healthcare stakeholders consistently migrate to best practices. We must ensure that *health* is the driving focus of the health reform debate. The best way to accomplish this is to surface what is actually working today to save lives and save money and then designing public policy to encourage their widespread adoption. Best practices should drive policy—not the other way around. The Center for Health Transformation has compiled a robust collection of best practices that: 1) Improve health and wellness through prevention and personal responsibility; 2) Improve quality, administration and the delivery of care; 3) Lower costs; and/or 4) Expand access to care. For example, according to the *Dartmouth Health Atlas*, the definitive authority on healthcare quality and variation, if the 6,000 hospitals in the country provided care at the Intermountain or Mayo standard, Medicare alone would save 30 percent of total spending every year – with better health outcomes. We need to make best practice minimum practice.

2. Building a nationwide electronic system in two phases by the end of President Obama's administration. To do anything to transform health—from paying for outcomes to comparative effectiveness to avoiding medical errors—health IT is absolutely essential. No other industry is as antiquated as healthcare. EHRs and other technologies are the only tools that simultaneously reduce costs while improving care. We can first make information more accessible through the Web and then electronically connect all stakeholders with interoperable IT.

3. Dramatically reducing healthcare fraud and changing the budget act so the savings can serve as a major pay-for for health information technology and covering the uninsured. Outright fraud – criminal activity – accounts for as much as 10% of all healthcare spending. That is more than \$200 billion every year. Medicare alone could account for as much as \$40 billion a year. This level of theft and crime can be detected, eliminated, and then prevented with the right kind of electronic resources. As it stands now, it is simply impossible to keep up with fraud in a paper-based system. An electronic system would free tens of billions of dollars to be spent on investing the kind of modern system that will transform healthcare.

4. Implementing science and investment-based budgeting with generation-long scoring. The U.S. government must be able to distinguish cost from investment, and the 1974 Budget Act must be amended to reflect this. Former NIH director Dr. Elias Zerhouni noted in recent testimony before the U.S. House and Senate that \$10 billion invested in basic research on HIV/AIDS between 1985 and 1995 saved the United States \$1.4 trillion in healthcare expenditures – a return on investment of 140 to one. However, according to current scoring models, the \$1.4 trillion saved would not be taken into account, as the \$10 billion would be viewed purely as cost. As it stands, the current budget mechanism is so inadequate and destructive that scoring models must be replaced.

Driving the Adoption of Best Practices through Smart Policy and Purchasing *CHT Leads: David Merritt and Alissa Momberg*

All too often we get stuck talking about dollars and cents. While financing is obviously important, healthcare at its core boils down to life and death. We must ensure that *health* is the driving focus of the health reform debate.

The best way to accomplish this is to surface what is actually working today to save lives and save money and then designing public policy to encourage their widespread adoption. Best practices should drive policy—not the other way around.

The Center for Health Transformation has compiled a robust collection of best practices that: 1) Improve health and wellness through prevention and personal responsibility; 2) Improve quality, administration, and the delivery of care; 3) Lower costs; and/or 4) Expand access to care. These examples are based on documented results; are replicable so that others can achieve similar success; and have champions who are willing to testify before congress and teach others how to implement the programs.

The following policy proposals can help others adopt best practices that improve health and quality, lower costs, and expand access?

- 1. Value-based healthcare.** Create a cost and comparative effectiveness initiative that certifies public and private evidence-based practices. Government health programs should then reward organizations that adopt these best practices through higher reimbursements.
- 2. New payment models.** Develop a policy roadmap to replace current physician reimbursement models, including the Resource-Based Relative Value Scale (RBRVS) and the Sustainable Growth Rate, with a model rewards the use of best practices, chronic care management tools, information technology and emphasizes patient wellness. The delivery reform proposal released in November 2008 by Kaiser, Intermountain Healthcare and the Mayo Clinic provide a range of options that would be vast improvements over the status quo, including bundled or episode-based payments, accountable care organizations and chronic care coordination payments.
- 3. Liability protection.** Extend federal liability protection to providers who follow established clinical guidelines or use certified best practices.
- 4. Transparency.** Release price and quality information from all government health programs—Medicare, Medicaid, Veterans Affairs, and FEHBP—for all providers, suppliers and health insurers that do business with the federal government so that taxpayers can see which organizations provide the best and most efficient care.
- 5. Physician practice.** Improve and then expand nationwide the CMS Group Practice Demonstration.
- 6. Medical home.** Expand provider eligibility for the CMS medical home demonstration.
- 7. Hospital quality.** Expand nationwide the CMS Hospital Quality Incentive Program.

8. Provider reporting. Improve and expand the Physician Quality Reporting Incentive (PQRI) to enroll more eligible physicians.

9. Reward health and wellness. Give private health plans, including those that participate in Medicare and Medicaid, more latitude to design insurance products to encourage, incentivize and reward individual healthy behaviors.

10. Medical error reporting. Provide limited liability protection and incentives to publicly report and publish data on medical errors.

Creating an Electronic Health System *CHT Leads: David Merritt and Alissa Momberg*

The most important component of health-based health reform is the widespread adoption of health information technology. To do anything to transform health—from paying for outcomes to comparative effectiveness to avoiding medical errors—health IT is absolutely essential.

No other industry is as antiquated as healthcare. According to a study in the *New England Journal of Medicine*, a scant [4% of physicians](#) use the most sophisticated and modern tools, like electronic health records, in the course of treating patients. EHRs and other technologies are the only tools that simultaneously reduce costs while improving care.

President Obama should be applauded for making the modernization of healthcare one of his highest priorities. He recently pledged, “We will make the immediate investments necessary to ensure that within five years, all of America’s medical records are computerized.”

Now comes the hard part: succeeding. The following steps can be taken to help reach this goal:

- 1. Health IT adoption.** Invest in physician adoption of information technologies by financially incentivizing its purchase and use. Models could include bonus payments, expanding the CMS Electronic Health Record Demonstration and higher Medicare reimbursement rates, such as the model for encouraging the adoption of electronic prescribing in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Electronic health records and other technologies purchased using federal dollars must be certified by the Certification Commission for Healthcare Information Technology (CCHIT).
- 2. Interoperability data standards.** Expedite the development, completion and promulgation of key interoperability data standards. Aggressive deadlines should be set for their completion. Value/use cases and subsequent data standards should be prioritized anew.
- 3. Do not refight battles of the past.** Build upon current industry governance, such as CCHIT, Health Information Technology Standards Panel (HITSP), and the National eHealth Collaborative (formerly AHIC). No new parallel organizations should be created to address the problems these entities are tackling.
- 4. Personal health information.** Make patient-protected Medicare data available to beneficiaries, and their providers if patients so choose, via smart-card technology and web portals. Making Medicare claims data available at the point of care will help coordinate care, improve patient safety, and lower costs, particularly for medication management.
- 5. CMS personal health records.** Expand the CMS Personal Health Record pilot to a broader demonstration project and then nationwide. CMS should make claims information accessible through any personal health record that a beneficiary chooses, if the technology is certified by CCHIT.
- 6. Homeland security.** Fund a joint project between HHS and DHS to explore the use of existing federal IT infrastructures, such as the Veterans Administration, Tricare and HHS, with non-governmental networks, such as Internet2 and SureScripts-RxHub, to create a nationwide notification network for extreme disasters. This project should build upon the CDC’s Public

Health Information Network by including organizations and individual healthcare providers beyond public health.

7. Open-source technology. Promote the use of open-source technologies and collaborations in RFIs or RFPs for taxpayer-funded health infrastructure initiatives. Any developed software created using federal funds should be “owned” by the public and contributed back to open source communities on commercially reasonable terms in accordance with Open Source Initiative approved licenses.

8. Coordination. Coordinate the implementation of ICD-10 diagnosis/procedure codes and HIPAA 5010 transaction codes with the National eHealth Collaborative, HITSP, and other entities. Modernizing this information is crucial to gathering more precise data for reporting and comparative effectiveness, but their implementation must be orderly, organized, and coordinated among all parties, both public and private.

9. Administrative simplification. Migrate all providers to electronic processes for administration, including eligibility verification, claims status inquiry, claims remittance, and electronic payment. CMS must lead by making a real investment in its own electronic processes, followed by rewarding and then requiring their use for all government health programs.

10. Innovation. Invest in promising state and local health information exchanges that are replicable and self-sustaining.

Paying for Quality Care by Reducing Fraud *CHT Leads: Jim Frogue and Liz Noelcke*

Without spending any new money, we can build a modernized healthcare system simply by catching and preventing healthcare fraud. Outright fraud—criminal activity—accounts for as much as 10% of all healthcare spending. That is more than \$200 billion every year. For the federal government, in Medicare alone, it could account for as much as \$40 billion every year. This fraud not only strips resources needed for the sick, but also drives up the cost of healthcare for everyone.

This waste and abuse comes from the hands of dishonest providers and patients who use various schemes to cost taxpayers money. Some examples of common schemes:

- Billing for services, procedures, or equipment never provided, also called “false claims”
- Billing for more expensive products or procedures than actually provided, a scheme called “upcoding”
- Performing medically unnecessary procedures solely for billing purposes, a dangerous technique that can put patients’ lives at risk, called “rent-a-patient”
- Accepting kickback dollars for patient referrals or prescriptions, or, from the patient end, for use of their medical ID numbers used in billing

Medical costs are on the rise. The Congressional Budget Office (CBO) projects that Medicare costs alone will double over the next ten years, in part due to the rising number of “baby boomers” who will soon access the system. Fraud and waste cannot continue unchecked. It puts honest doctors in financial jeopardy, patients in danger of limited access to care or receiving unneeded procedures, and American taxpayers’ dollars at risk.

This level of theft and crime can be detected, eliminated and then prevented with the right kind of electronic resources. As it stands now, it is simply impossible to keep up with fraud in a paper-based system. An electronic system would free tens of billions of dollars to be spent on investing the kind of modern system that will transform healthcare—better health, lower costs.

Specific action items to detect, prevent, and eliminate healthcare fraud and abuse include:

- 1. Posting all Medicare and Medicaid claims data online for public access as close to real time as possible.** Currently, the financial accounting and health outcomes of Medicaid are incredibly opaque. Posting *patient-protected, de-identified* claims would reveal billing and practice patterns for all participating providers in both programs, laying bare for all Americans, particularly academic institutions and researchers, the extreme outliers who are likely engaged in fraudulent behavior. Excellent studies such as the Dartmouth Health Atlas show the helpful and even lifesaving information can come from public data. Additionally, transparency would drive quality improvements by shining a spotlight on best practices and providers. For instance, what percentage of poor women over 50 in Medicaid are getting mammograms? (Only 17% in one state.) What percentage of children are getting well child check ups? (Typically less than 50%.)
- 2. Stop using Social Security numbers as each senior’s Medicare Beneficiary Identifier.** The Federal Trade Commission tells Americans, “Protect your Social Security Number – do not carry it in your wallet or write it on checks.” But on the back of every Medicare card, which includes seniors’ Social Security number it says, “Carry this card with

you when you are away from home.” Having this vital information so prominent makes fraud and identity theft much easier for criminals.

- 3. Fully fund the HHS Office of the Inspector General.** Current temporary funding streams under the Medicaid Integrity Program end at the conclusion of FY 2010 so staff reductions via attrition are already underway. HHS must be given the means necessary to be impactful in combating fraud and abuse.
- 4. Follow MedPAC’s recommendation and move Medicare to a program where there is risk adjustment and payment for sticking with best practices and professionally recognized standards of care.** This incentivizes identification of overpayment and recovery.
- 5. Expand the Money Follows the Person (MFP) Rebalancing Demonstration.** This program provides support for elderly and disabled persons under Medicaid who wish to live at home rather than institutions. This program removes the emphasis for long-term care away from nursing homes and to home and community-based services.
- 6. Focus survey and certification of healthcare facilities on poor performers and explore whether separate quality improvement organizations are needed or if those functions could be performed by the state survey agencies.**
- 7. Require enhanced coordination of benefits and third party liability identification.** California could find huge savings in overall Medicaid costs by simply being more accurate with identifying patients’ primary source of insurance. A sizable minority is actually already covered by private insurance, though Medicaid is footing the bill. One insurer recently analyzed Medi-Cal claims coming through its company and found \$250 million in claims to Medicaid when other insurance had been *volunteered* by both the patient and the provider. This is a 1 percent savings, just on volunteered information. Further attention would undoubtedly yield even greater abuse.
- 8. Require enhanced use of electronic remittances/electronic fund transfers for accuracy to and from providers.** Not only does this save on paper postage, but it increases accuracy and timeliness of payments.
- 9. Aggressively utilize predictive modeling for payments.** These technologies catch outlier billing practices before payments are even made. This moves Medicaid way from the “pay and chase” model that criminals loves.
- 10. Require biometric identification for Medicaid patients to access provider treatment.** Texas is currently expanding a pilot program that gives Medicaid recipients a plastic card, encoded with eligibility and identity information required by providers. Beneficiaries scan the card and his/her fingerprint at the doctor’s office. The system compares readers and verifies the person’s identity in seconds. This “smart card” reduces costs, particularly the reduction in mailing paper cards, and protects client information.
- 11. Educate providers on Medicare and Medicaid billing procedures, especially when changes occur.**

12. Ensure that providers and suppliers meet government standards, and enforce removal from the system of those who do not. This is particularly a problem in Medicare, as fraudulent durable medical equipment suppliers claimed more than \$1.0 billion in improper payments in just over a year. In addition, it should be ensured that doctors who lose Medicare/Medicaid billing privileges in one particular state must be unable to bill in another.

13. Emulate best practices in billing and anti-fraud efforts from the credit card industry. Fraud programs are most effective when they are composed of measures for prevention, detection and mitigation, which requires a number of efforts in each phase of the point of interaction and the payment lifecycle: from Participant participation (e.g. account opening) through authentication and authorization for a transaction to application of back office analysis and customer service.

The necessary component in the Network is a regulatory body (for purposes of this document, this body is called “Healthcare Network Authority” or HNA). For and between all Participants in the Network, the HNA’s mandate would be to administer regulations, define standards, settle financial accounts, arbitrate discrepancies and assess fines and penalties within the legislative framework that places the importance of the Healthcare System above any Participant or groups of Participants.

- a. **Standards** - The Network must be compatible based on open (i.e., non-proprietary) data format, content standards and definitions for Participants. Compatibility must be enforced (e.g. through financial incentives and penalties).
- b. **Know Your Customer (and Vendor/Supplier)** - Network participation for all Participants is only allowed after initial vetting to ensure proper credentials, soundness and capabilities exist. Ongoing participation is re-assessed both in “real time” and ad-hoc. (For example, a provider’s billing volume and/or billing type does not materially exceed established norms for the provider on a daily, weekly or monthly basis.)
- c. **Decentralized Financial Liabilities** - Liabilities are “pushed” down to the lowest level of Participant in the system. In the event the instigator is not financially solvent or can not be located, the next higher level above the instigator is liable.
 - In the case of a provider that as a result of exceeding real-time monitoring thresholds causes an alert to the Network, there would be a specific action plan invoked by the Network (e.g. withhold payments until an investigation concludes which may conclude fraud with financial and/or criminal implications). If the provider could not fulfill the penalties, the entity that allowed the provider to participate in the Network would be held responsible. (In the credit card industry, the provider would be akin to a merchant whose participation is allowed by a financial institution. If the merchant is found to be fraudulent in some way and can not fulfill the penalties assessed, the financial institution is held responsible.)
 - In the case of a patient, the next level up may be the employer or perhaps plan administrator or payer.
 - In the case of a secondary Participant, the primary Participant who engaged with the supplier or vendor would be held responsible.
- d. **Authenticate and Authorize** - Beginning with each point of interaction (or point of service), through to ‘check out’ and ongoing, all Participants in the process must be uniquely identified and authenticated and provisioning of services must be authorized in real time. The intent would be to monitor activity real time and create an electronic

audit trail for transaction traceability and potential payment revocability. Real time monitoring allows for the use of fairly simplistic algorithms to full neural networks and could be invoked by specific transaction parameters (i.e. suspected fraud Participant, location, type of service, etc. or a combinations of these). Though this process is envisioned to be real time (such as in the case of the credit card environment, sub second), allowances must be made, however, in life threatening or disaster situations.

- e. **Carrots & Sticks** - The HNA would use reimbursement rates, pricing, penalties and/or payment terms to incent Participant behavior for not only compliance but to continually enhance and enrich the Network to identify and tackle new forms of fraud, waste, abuse and administrative cost.
- f. **Self-Policing but Enforced** - The HNA would be the option of last resort to resolve disputes between Participants.

The Federal Science and Technology Investment Budget Act *CHT Leads: Robert Egge and Katie Varney*

As we were studying Alzheimer's disease through the Alzheimer's Study Group¹, we realized both the magnitude of this disease, and that a breakthrough that simply postponed the average age of onset of the disease by 5 years would save the Federal government \$600 billion per year by 2050.²

This estimate is in line with past experiences. NIH director Dr. Elias Zerhouni has noted in recent testimony before both the U.S. House and Senate that \$10 billion invested in basic research on HIV/AIDS between 1985 and 1995 saved \$1.4 trillion in healthcare expenditures; a return on investment of 140 to one.³

The more we have talked with experts in the field, the clearer it has become that there are more opportunities to help human beings and more scientists potentially capable of doing good work than the current obsolete and destructive budget process permits. These opportunities encompass leading diseases like cancer, diabetes, and Parkinson's, but also other fields such as energy, environmental science, and education.

As Fred Smith said in 2005, "The biggest problem with government in the modern world is it can never distinguish cost from investment. You could never build UPS or FedEx within the government because all the required investments would be regarded as costs. You'd be driven by the budget process to cut them out every year, and you'd always wonder why nothing ever improved."

The answer to this dilemma is to bring wholesale change to federal budgeting. Specific changes include:

1. **Amending the 1974 Budget Act to provide for a multi-year science and technology based investment budget scored over a generation of return.** The opportunities for scientific breakthrough in health, the environment, energy, national security, and economic development, are so massive and the current budget mechanism is so inadequate and destructive that scoring models must be replaced.
2. **Restore the National Institutes of Health budget, and triple-again the budget of the National Science Foundation.** One of the great bipartisan achievements of the last decade was to double the budget of the National Institutes of Health. However, flat funding and biomedical inflation have already effectively erased this accomplishment. Further, the budget of the NSF – as well as the wellspring of many advances not just in health but also in national security, energy independence, and environmental technologies – should be tripled. There is no more sensible way to stimulate the economy than by investing in a foundation of science and technology that will unlock health breakthroughs and contribute to a strong, globally competitive economy.
3. **Direct the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine to develop joint recommendations for this new**

¹ The Alzheimer's Study Group is a taskforce of national leaders charged with creating an Alzheimer's National Strategic Plan to overcome the mounting Alzheimer's crisis. Co-chaired by Newt Gingrich, former Speaker of the House and Founder of the Center for Health Transformation, and former Senator Bob Kerrey, the ASG will assess the adequacy of the country's current efforts to combat Alzheimer's and recommend strategies to accelerate progress toward defeating this terrible disease. More information is available at www.alzstudygroup.org/.

² Lewin Group (2004). "Saving Lives, Saving Money: Dividends for Americans Investing in Alzheimer's Research." Retrieved from: www.alz.org/national/documents/report_savinglivessavingmoney.pdf.

³ Retrieved from: <http://olpa.od.nih.gov/hearings/109/session2/testimonies/nihbudget.asp>.

multi-year budget. Their recommendations should include an estimated level of return measured over a generation of investment and progress with a professional assessment of the ability of the science community to absorb additional resources in a productive manner; and benefits to the American people, the American economy, and for science and technology.

4. **Require the development of this proposal to be done online in a transparent manner for continuing opportunities for citizens to promote scientists, engineers, entrepreneurs, and citizens at large to offer commentary and to file dissent.**
5. **Ensure that this multi-year investment budget should be scored separately from the current expenditures budget and should be passed by the budget committees based on initial submissions by the science committees and should have the effect of appropriations as passed.**
6. **Modernize the federal scoring covenants as outlined by OMB in *CIRCULAR NO. A-11, PART 8*.** These scoring principles, which bind all federal scorekeepers, will cripple many efforts by President-elect Obama to invest for future returns. For instance, Section 14 states, “No increase in receipts or decrease in direct spending will be scored as a result of provisions of a law that provides direct spending for administrative or program management activities.” That means if savings are recouped by investing in the technologies to detect and prevent healthcare fraud, for instance, they will not be scored as savings. Federal investments in health IT that lead to administrative savings will also be seen as cost drivers—not cost savers.