# *Issues in Missouri Health Care 2009*

## Buying Value: Improving the Quality of Missourians' Health Care

## Acknowledgement

This is one in a series of issue papers on critical health care issues facing Missouri and the nation prepared by Health Management Associates, Inc., a national health care policy research and consulting firm and made possible by funding from the Missouri Foundation for Health and the Healthcare Foundation of Greater Kansas City. The papers are intended to provide nonpartisan expert analysis in an accessible format that will contribute to the public dialogue on the state of health care in Missouri. Questions should be directed to Thomas McAuliffe, Policy Analyst, Missouri Foundation for Health, 314.345.5574, tmcauliffe@mffh.org.

## Issue Statement

Missouri spends $31 billion on health care each year, or $5,444 per person, [1] slightly higher than the U.S. average of $5,283. Higher expenditures do not equate with better outcomes, however. Missouri ranks in the bottom third of states on key indicators of quality and health outcomes.[2] The residents of Missouri could get better value for their health care dollars with improvements in the quality of care and patient safety. State health policy plays a vital role in making this happen.

## Background

Quality care is providing the right care at the right time in the right place. Far too often, patient care fails to meet this standard. Poor quality generally takes the form of overuse, underuse, misuse or some combination. Some ineffective services are vastly overused, while other types of care that could prevent illness are seriously underused. Medical errors occur in all parts of the health care system, from prescribing contradictory medications to operating on the wrong limb. One-third of health care that is delivered in the U.S. is estimated to be of questionable value; nearly half of all Americans do not receive recommended preventive or primary care (45%)[3]; and about 98,000 deaths a year are attributed to preventable medical errors.[4]

## Opportunities to Improve Quality of Care in Missouri

Missouri ranks 33rd among the 50 states in quality of care, according to The Commonwealth Fund, a national health care foundation.[5] Just 38 percent of adults age 50 or older received recommended screening and preventive care in Missouri. Among adults with diabetes, 43 percent received recommended preventive care. Children fare better, with 79 percent of children ages 19 to 35 months getting all recommended immunizations. In 2003, there were nearly 28,000 preventable hospitalizations and

---

[1] Kaiser State Health Facts. www.statehealthfacts.org. Accessed September 17, 2008. Expenditure data include all privately and publicly funded personal health services. Health insurance administration, research, and construction are excluded.

[2] Cantor, J.C. et al. June 2007. *Aiming Higher: Results from a State Scorecard on Health System Performance*, The Commonwealth Fund. http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551. Accessed September 17, 2008

[3] McGlynn, E.A., et al. 2003. The quality of health care delivered to adults in the United States. *The New England Journal of Medicine*, 348(26): 2635-2645.

[4] Institute of Medicine. *To Err is Human: Building a Safer Health System.* National Academies of Science Press, Washington, D.C., 1999.

[5] Cantor, et al. 2007.

readmissions among Missouri's elderly. On the positive side, Missouri does better than average on the quality of care delivered to patients in the hospital.

*Greater use of preventive care***.** Improving the quality of care can improve health care outcomes and reduce health care spending. The Commonwealth Fund estimated the benefits to Missouri residents if the state's performance on nationally recognized quality indicators matched that of the highest ranked states in the country:

- 198,267 more adults (ages 50 and older) would receive recommended preventive care, such as colon cancer screenings, mammograms, pap smears, and flu shots at appropriate ages.
- 72,815 more adults (ages 18 and older) with diabetes would receive three recommended services (eye exam, foot exam, and hemoglobin A1c test) to help prevent or delay disease complications.
- 15,666 more children (ages 19-35 months) would be up-to-date on all recommended doses of five key vaccines.

*Reduction in avoidable hospitalizations***.** Improving the quality of health care services in Missouri has the potential to reduce hospital admissions by tens of thousands each year, lowering costs by hundreds of millions of dollars. Improving the state's quality care to levels similar to that of the highest ranked states could lead each year to:

- 23,842 fewer preventable hospitalizations for ambulatory care sensitive conditions among Medicare beneficiaries (age 65 and older) at a savings of $108 million.
- 4,103 fewer hospital readmissions among Medicare beneficiaries (age 65 and older) at a savings of $43 million.
- 4,096 fewer long-stay nursing home residents hospitalized at a savings of $35 million.

## States Have Influential Role to Play in Advancing Quality Improvement

States have considerable influence over health care quality through their roles as purchasers of health services, as regulators of providers, and as supporters of innovation. They can use these levers to improve quality and patient safety, and safeguard the public.

Key strategies states are pursuing to improve quality include:

- Leveraging the purchasing power of the Medicaid and state employee health programs and other state agency purchasers.

- Engaging providers and consumers by collecting and publicly reporting data on medical errors and adverse events.
- Promoting adoption of Health Information Technology (HIT) and Health Information Exchange (HIE) so that providers and consumers have safe, reliable systems underlying their decision-making.

# Policy Options

## Leverage Purchasing Power for Quality

State government is responsible for 25 percent of all health spending in Missouri.[6] As a major purchaser of health care—for state employees, Medicaid beneficiaries, wards of the state and residents that receive public health services—Missouri has the purchasing power to demand high quality from providers. The state pays for poor quality care when it is the result of overuse, under use, or misuse of health care services.[7] Missouri can use its purchasing leverage to improve quality and patient safety by rewarding high quality, safe performance and encouraging correction of poor performance.

## Standardize Performance Measures Used for Purchasing High Quality Care

States are leveraging their purchasing power for quality in a variety of ways. Medicaid, state employee health programs and other state agencies that purchase health services are:

- Building quality and safety standards into their contracts with health plans and providers that include requirements for reporting on quality and safety measures.
- Using standard contracting language, performance measures, reporting requirements, and incentives, i.e., Pay-for-Performance (P4P), for quality to create more value per state health care dollar and create greater efficiencies for providers.
- Issuing joint requests for proposals (RFPs) for health services, which may include managed care, behavioral health, prescription drug benefit management, quality and patient safety data collection and reporting.

[6] Kaiser State Health Facts.

[7] Hess, C. et al. 2008. *State Health Policies Aimed at Promoting Excellent Systems: A Report on States' Roles in Health Systems Performance*, National Academy for State Health Policy. www.nashp.org/Files/shapes_report.pdf. Accessed September 15, 2008.

- Forming multi-payer purchasing coalitions with private purchasers to make measurement, reporting and incentive programs uniform for providers and to establish common benchmarks for improvements in quality and safety.

## Align Quality Improvement and Health Outcomes Goals across State Agencies

A state's leverage to drive quality improvements and efficiencies in the health care system is enhanced when an agency has a contract or grant requirement specifically designed to support the goals of another state agency or program. For example, a Medicaid program could require health plans to work with local public health departments on strategies to improve immunization rates. Sister agencies can also share data and the costs of data collection and reporting related to mutual health care goals such as improving immunization and lead screening rates.

## Reward High Quality Where Medicaid is the Largest Purchaser: Nursing Homes

As the largest purchasers of nursing home care services in their states, Medicaid programs have considerable purchasing power to promote improvements in quality of care provided by their state's skilled nursing facilities. Missouri spends $2.5 billion annually on nursing home care.[8] On average state Medicaid programs pay 46 percent of the total bill.[9] Georgia, Iowa, Minnesota, Ohio, and Oklahoma have used their purchasing power to implement nursing home quality improvement pay-for-performance initiatives. The initiatives typically include financial incentives that target improvements in resident outcomes (using the Minimum Data Set); staffing-level measures; certification survey deficiencies; and resident/family quality of life surveys.

## Potential Strategies for Missouri to Leverage Purchasing Power for Quality Improvement:

- Examine other states' multi-purchaser P4P initiatives to gain insights that could be valuable for Missouri. These include the states of: Kansas, Maine, Minnesota, and Washington.

---

[8] www.statehealthfacts.org. Accessed September 17, 2008.

[9] Ellen O'Brien. 2005. *Medicaid's coverage of nursing home costs: Asset shelter for the wealthy or essential safety net*? http://ltc.georgetown.edu/pdfs/nursinghomecosts.pdf.
Accessed September 18, 2008.

- *Example:* Minnesota seeks to realize savings to the public by insisting on stringent quality and safety standards in state health contracts. Standards and payment incentives across state agencies, including Medicaid and the state employee health plan must be aligned to meet benchmarks of improved patient safety and quality of care by 2010.

- Study feasibility of requiring state health programs, particularly MO HealthNet and state employee health benefit plans to issue RFPs with uniform requirements regarding the collection and reporting of quality (and patient safety) measures.
  - *Example:* The Maine state employee plan participates in an ad hoc group that includes five large purchasers from both the public and private sector. This group has agreed to a set of purchasing principles and RFP language related to patient safety and quality performance.
- Align goals and requirements of MO HealthNet and other health-related service agencies with state public health priorities.
  - *Example*: The Washington Medicaid program jointly supports the state's Department of Health's Child Profile health promotional materials and immunization registry.
- Convene a stakeholders' group to research the cost, benefits and feasibility of implementing a state P4P initiative that targets skilled nursing homes in Missouri.
  - *Example:* Virginia is actively designing a comprehensive Medicaid nursing home P4P program that could be a model for Missouri.[10]

## Engage Consumers and Providers by Collecting and Publicly Reporting Data on Medical Errors and Adverse Events

Nearly ten years ago the Institute of Medicine (IOM) published its landmark report *To Err is Human: Building a Safer Health System.* The 1999 report revealed that medical errors were the fourth leading cause of death in the United States.[11] Since then, the federal government's response has taken three primary paths:

- Funding systems of measuring and reporting medical errors.
- Increasing consumer awareness and involvement in their own safety.
- Denying Medicare payment for certain medical errors, called "never events."

[10] Medicaid Nursing Home Pay for Performance Working Group Recommendations. http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingMats/Quality/DRAFT-QualityReportSection.doc. Accessed April 9, 2008.

[11] Institute of Medicine.

A variety of private organizations[12] also began to address professional training, process improvement, and safety standards.

## States' Progress to Reduce Medical Errors and Adverse Events

States have undertaken a variety of strategies to protect the public's health and safety. These include launching patient safety reporting systems, creating patient safety centers, making patient safety part of facility licensure requirements, joining purchaser groups devoted to patient safety, and providing patient safety educational materials to consumers and providers.[13] Some states also choose to publicly release data to improve accountability by informing consumers and payers about the quality of health care facilities.

## Data Collection Mandates For Providers And Public Reporting

The IOM called on every state government to create a mandatory reporting system to collect information about adverse events that result in death or serious harm. As of February 2008, 37 states and the District of Columbia have implemented legislation or regulations that require hospitals and/or other facilities to report to a state agency on medical errors or adverse events, or require reporting of judgments or settlements related to physician malpractice.[14] Eight states have a legislative mandate to publicly report data on measures of patient safety. The purpose of public reporting is to stimulate providers to focus on improving care processes to reduce errors that may cause bad health outcomes.

## Not Paying For Poor Quality

The National Quality Forum reached consensus on 28 "never events"—occurrences that should never happen in a hospital and can be prevented.[15] At least four states have passed legislation denying Medicaid payment to hospitals for never events. Hospital associations in three states are recommending to their members that they voluntarily not bill for never events.[16]

---

[12] For example, the National Quality Forum, The National Committee on Quality Assurance, the Institute for Health Care Improvement, and the Hospital Research and Education Trust.

[13] National Academy for State Health Policy. 2008. *States' Roles in Addressing Patient Safety*. www.nashp.org. Accessed September 15, 2008.

[14] Kaiser State Health Facts.

[15] National Quality Forum. www.qualityforum.org. Accessed September 22, 2008.

[16] National Conference of State Legislatures e-newsletter, Volume 29, Issue 519, July 7, 2008. Accessed September 15, 2008.

## Missouri's Progress in Reducing Medical Errors and Adverse Events

Missouri's approach to patient safety has been mostly private and voluntary. The Missouri Hospital Association (MHA), the Missouri State Medical Association (MSMA) and Primaris established the Missouri Center for Patient Safety (MoCPS) in response to recommendations from the Governor's Commission for Patient Safety in 2004. The primary goal of MoCPS is to serve as a central resource of patient safety information for providers, physicians, consumers and others by:

- Creating and maintaining a voluntary, confidential reporting system that is consistent with national patient safety organization criteria.
- Establishing a focus for improvement activities.
- Identifying best practices for sharing.[17]

## Reporting Hospital-Acquired Infections

The "Missouri Nosocomial Infection Reporting Act of 2004" was passed to decrease the incidence of infections within healthcare facilities in Missouri. It requires hospitals and ambulatory surgical centers to report specific healthcare-associated infections to the Missouri Department of Health and Senior Services (DHSS).[18] The Department will release an annual public report based on the information, which may, but is not required to, identify individual health care providers.

## Reporting Hospital Adverse Events

The Missouri Health Transformation Act of 2008 requires hospitals to report to MoCPS each serious reportable event in health care as defined by the National Quality Forum. MoCPS is required to publish an annual report to the public on reportable incidents. By 2010, hospitals are not allowed to charge for or bill any entity for all services related to the reportable incident.

---

[17] Missouri Center for Patient Safety. http://www.mocps.org/about/. Accessed September 19, 2008.

[18] Missouri Department of Health and Human Services. http://www.dhss.mo.gov/HAI/index.html?target=law.html. Accessed September 19, 2008.

## Potential Strategies for Missouri to Improve the Safety and Quality of Patient Care

Building on its efforts to date the State should consider:

- Moving from voluntary to mandatory reporting so that providers and payers can gain a better understanding of quality and safety problems in the system.
- Requiring that errors of a certain type of frequency trigger corrective action plans; and provide DHHS with resources to oversee the appropriateness and effectiveness of corrective actions.
- Providing DHHS adequate resources to evaluate trends in reporting and outcomes including changes in utilization, readmission rates, and costs over time.

## Support Health Information Technology and Exchange

Electronic health information systems have the capacity to improve the delivery and coordination of care, reduce medical errors, and provide a mechanism for tracking and assessing performance. The federal government, private sector and many states are active—although not always well-coordinated—in advancing new information systems and technologies in the health field.

### States' Involvement in Supporting Health Information Exchange (HIE) and Health Information Technology (HIT)

Most states have public health information systems that integrate data from multiple sources. Immunization and vital statistics data are most common. Other data systems may include newborn screenings, laboratory, hospital discharge or hospital emergency services, and cancer registry. States can leverage financing of HIE and HIT through[19]:

- Demonstration or pilot initiatives.
- Encouraging or requiring use of health information exchange and technology in their purchasing roles.
- Accounting for HIT-related costs in their payment policies.

Twenty states are facilitating electronic health information exchange through participation in Regional Health Information Organizations (RHIOs). Others are

[19] Hess, C et al. 2008.

developing and revising the legal structure through laws and regulations. The most significant challenge for all state efforts is the creation of a sustainable business model.[20]

## Progress in Missouri to Support HIT and HIE

The Missouri Health Information Technology Task Force report of 2006 provided a comprehensive assessment of the opportunities, challenges and status of HIT and HIE in Missouri, along with numerous recommendations.[21] The Missouri Health Improvement Act of 2007 established a Healthcare Technology Fund. This year, MO HealthNet renewed its contract with a HIT vendor to implement electronic health records and e-prescribing for participating Medicaid providers.

## Potential Strategies for Missouri to Improve the Safety and Quality of Patient Care

- Create a public-private HIE organization to set priorities for following through on the recommendations outlined in the 2006 HIT Task Force report.
- Coordinate the HIT and HIE investments within the state (e.g., Healthcare Technology Fund, MO HealthNet, and private sector) through this new entity.

[20] e-Health Initiative. 2008 HIE Survey. http://www.ehealthinitiative.org/HIESurvey/2008KeyFindings.mspx. Accessed September 18, 2008.

[21] *Missouri Health Information Task Force Final Report*. September 2006. http://www.dhss.mo.gov/HealthInfoTaskForce/Report.pdf. Accessed September 18, 2008.