

DON'T WAIT FOR
WASHINGTON



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HOW STATES CAN REFORM
HEALTH CARE TODAY

EDITED BY
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Paragon Health Institute

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Printed in the United States of America.

ISBN: 979-8-9850916-2-5 (Paperback)

ISBN: 979-8-9850916-1-8 (PDF)

ISBN: 979-8-9850916-0-1 (epub)

21 22 23 24 25 10 9 8 7 6 5 4 3 2 1



Implement Transparency

Release Data to Improve Decision-Making

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KEY TAKEAWAYS

- There is a significant amount of waste in the U.S. health care system, some of which is driven by inappropriate or unnecessary health care services. Receiving inappropriate or unnecessary services can harm patients and lead to worse health outcomes.
- More than 70 million Americans are enrolled in the Medicaid program, so Medicaid contains a wealth of information about the services received by patients. States should utilize Medicaid data and make it publicly available to help inform patients and providers about the delivery of health care services.
- Providing information about physician practice patterns could improve patient outcomes by reducing provision of unnecessary and inappropriate care and increasing patient selection of clinicians that deliver higher-quality care.
- Appropriateness measures should target areas where there is evidence of significant waste or clinical harm. One potential target area is low-risk Cesarean section. Of U.S. births categorized as “low-risk,” 25.6 percent were delivered by Cesarean section—a surgical delivery typically reserved for high-risk births. Reduction of low-risk Cesarean sections could improve maternal health outcomes and reduce birthing costs.

PROBLEM

Medicaid recipients often receive low-quality care and have worse health outcomes than the general U.S. population.¹⁻³ State Medicaid programs can improve beneficiary health by reducing inappropriate or unnecessary care.

In a 2017 survey, physicians estimated that 21 percent of medical care delivered is unnecessary.⁴ According to some estimates, waste in the U.S. health care system costs between \$760 billion and \$935 billion, nearly one-quarter of total health spending. Overtreatment alone was estimated to account for \$76 billion to \$102 billion of that wasteful spending.⁵ Applied to Medicaid, these estimates suggest that roughly one-quarter of the program's spending, which reached \$613 billion in 2019, is spent on unnecessary care and one-tenth is spent on overtreatment.

Appropriateness of Health Care Services

Appropriateness measures, developed with the input of clinical experts practicing in the area under consideration, can be used to evaluate individual physician practices and drive improvements in care. Unlike traditional quality measures, many of which assess single instances of care (i.e., wrong-side surgery), appropriateness criteria are adaptable and longitudinal, meaning they can quickly change as consensus recommendations evolve and can assess a physician over a long period of time. A 2018 Department of Health and Human Services (HHS) report observed problems with existing quality measures: "In the past, the government has often failed to establish sensible metrics, creating significant reporting burdens for providers and metrics that are not informative for patients or industry and can easily be gamed when reimbursement is tied to them."⁶

Two U.S. Government Accountability Office (GAO) reports, in 2016 and 2019, called for improvements in the government Quality Measurement Enterprise (QME), noting that many metrics promulgated by government programs do not drive hoped-for improvements in health outcomes.^{7, 8} The peer-reviewed literature has echoed the need for improved quality metrics, documenting the shortcomings of many existing metrics: questionable validity, failure to account for the most up-to-date evidence, and implementation costs that can exceed purported benefits.⁹⁻¹¹

Appropriateness measures should be clinically actionable for individual physicians, should prioritize patient outcomes, and should target practice

areas where there is evidence of significant waste or clinical harm.¹² The Improving Wisely project, discussed in detail here, uses physician-specific metrics to advance the delivery of high-value care.¹³ These metrics, developed by provider consensus, aim to reduce clinical waste. Examples of measures include number of biopsies per screening colonoscopy; percentage of elective hysterectomies performed with a laparoscopic approach; number of stages per case in Mohs surgeries; incidence of polypharmacy in the elderly; dosage and duration of opioids prescribed after common medical procedures; and the rate of early peripheral revascularization for claudication.^{14–16} The following case study describes how waste can be decreased and care quality improved by applying the Improving Wisely methodology to a clinical practice area known for having suboptimal outcomes for Medicaid recipients.

The Cesarean Section Case Study

Three conditions related to pregnancy and childbirth (liveborn, complications during childbirth, and previous C-section) are extremely common in the Medicaid program.^{17,18} New analysis from the National Vital Statistics Reports (NVSR) found that in 2019 Medicaid paid for 42.1 percent of all births in the United States,¹⁹ including 65.1 percent of deliveries among black women and 29.4 percent of deliveries among white women.²⁰ Cesarean sections (C-sections) were performed in 31.7 percent of *all* U.S. births and were performed in 25.6 percent of U.S. births categorized as “low-risk.”²¹ Low-risk C-sections are surgical deliveries performed for a woman’s first baby, after she has been pregnant for at least 37 weeks, when she is carrying only a single baby, and where the baby would come out headfirst if delivered vaginally.²² C-section rates vary by race, with 35.9 percent of black women delivering by C-section versus 30.7 percent of white women, and with 30.0 percent of black women undergoing low-risk C-sections versus 24.7 percent of white women.²³

Women who undergo C-sections are at higher risk for postnatal infections and blood clots than women who deliver vaginally, although the incidence of these complications is rare overall.²⁴ Nearly 90 percent of subsequent deliveries by women who have undergone a previous C-section will *also* be by C-section.²⁵ Data suggest that by decreasing the number of low-risk C-sections they perform, physicians can reduce birthing costs and significantly improve maternal health outcomes. It has long been a public health goal to

reduce the number of low-risk C-sections performed, both to improve care quality and to reduce racial disparities in maternal health outcomes.

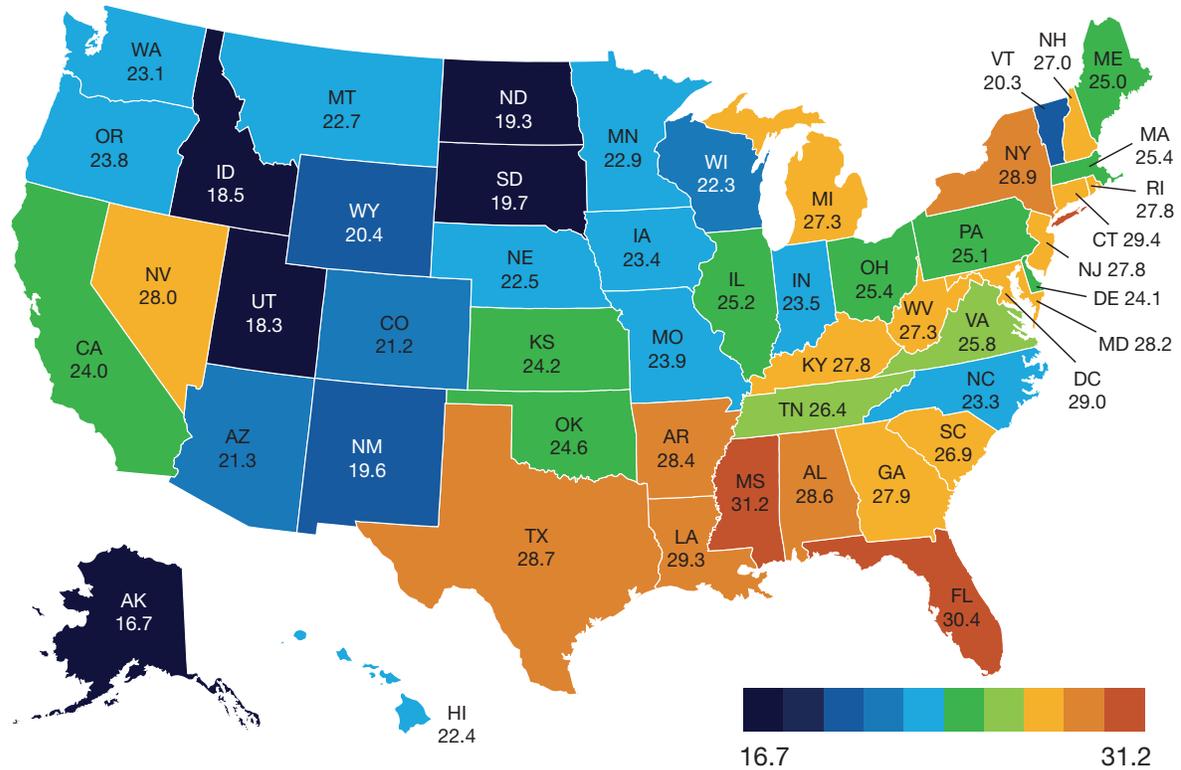
In July 2015, the National Association of Medicaid Directors and the Association of Maternal and Child Health Programs released an issue brief titled “Low-Risk, Primary Cesarean Births in Medicaid.” The brief identified excess use of low-risk, primary C-section as an opportunity for quality improvement and value delivery. The brief further described multiple pathways to reform, including “transparency and reporting on low-risk C-section rates; education efforts for providers and consumers on the risks of non-medically indicated C-sections; and payment mechanisms that target the overuse of C-sections for low-risk, first-time mothers.”²⁶

Despite this initiative from leading organizations, the previously referenced NVSR data showed that overall low-risk C-section rates did not change, accounting for 25.7 percent of births in 2016 and 25.6 percent of births in 2019.²⁷ As demonstrated in Figure 8.1, there is substantial state-level variation in low-risk C-section rates, with the South having the highest rate, followed by the Northeast.²⁸

PROPOSAL

There is bipartisan support for increasing health care transparency, with respect to both prices and quality. This transparency is necessary for Americans to make better health care decisions. Part of this information includes an understanding of physician practice patterns, why practice patterns matter for care quality, and how physicians compare to each other. Since Medicaid pays for health care services for tens of millions of Americans, the program has a wealth of information that can help the decision-making of both physicians and patients. States should first permit Medicaid data to be analyzed for these purposes and make such data publicly available. Second, for certain procedures or services where physician consensus about appropriate practice patterns is clear, states should make the practice pattern information (e.g., physician C-section rates for low-risk pregnancies) available both to physicians and to the public. Note that these clinical appropriateness measures should be viewed as a complement to traditional quality metrics.

In this example, a clinical consensus would determine the maximum percentage of low-risk C-sections that an individual physician should perform. Accessible publication of individual physician low-risk C-section rates would empower women with Medicaid coverage to choose providers with low-risk



Source: Centers for Disease Control and Prevention, National Center for Health Statistics/National Vital Statistics System Birth Date, 2018. https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13_tables-508.pdf

Figure 8.1 Rate of low-risk Cesarean deliveries per 100 deliveries by state, 2018.

Note: These rates are based on NTSV cesarean deliveries, which occur among women who are pregnant for the first time, are at a minimum 37 weeks of gestational age, giving birth to a single baby (no twins or multiples) that is in the vertex position (positioned in the uterus with the head down). The measure used to generate these rates differs from the measure used to calculate the 31.9 percent overall cesarean estimate, which includes all births.

Source: Graphic adapted from U.S. Department of Health and Human Services, “Healthy Women, Healthy Pregnancies, Healthy Futures: ACTION PLAN TO IMPROVE MATERNAL HEALTH IN AMERICA,” December 2020, https://aspe.hhs.gov/sites/default/files/private/aspe-files/264076/healthy-women-healthy-pregnancies-healthy-future-action-plan_0.pdf, p. 62.

C-section rates in the clinically appropriate range and encourage physicians to evaluate their practice patterns relative to the clinical consensus of their peers.

Learning from an Established Approach to Improve Appropriate Health Care Delivery

In 2015, the Centers for Medicare and Medicaid Services (CMS) made National Physician Identifier (NPI) numbers available to researchers analyzing

CMS claims data.²⁹ The CMS said that its goal was to “benefit health care consumers through a greater understanding of what the data says.”³⁰ Researchers at Johns Hopkins University began to analyze physician-level data and noted some irregular practice patterns.³¹ While some practice variation could be explained by differences in patient populations, the practice patterns of some physicians were clearly outside the range of reasonably appropriate care.

The Improving Wisely project, initially funded by the Robert Wood Johnson Foundation and led by Johns Hopkins University professor and surgeon Dr. Marty Makary, works with clinical experts and specialty societies to develop consensus definitions of “outlier” practice patterns for episodes of clinical care. As part of the consensus-building process, clinical experts in a specialty establish boundaries for acceptable medical practice variation. While variation in medical practice should be embraced, as it allows for learning and innovation, there are limits to what is considered acceptable variation.³² Outside this range, a physician could be considered an outlier, perhaps in need of information and education. Once standard practice thresholds are set via clinical consensus, the Improving Wisely project then reaches out to outlier doctors to let them know of their status compared to their peers, a process called “peer-benchmarking.”

This approach was used by the American College of Mohs Surgeons (ACMS), a society of skin surgeons, which came to a consensus on the acceptable average number of cuts per case a skin surgeon should make to resect a skin cancer. The ACMS identified outlier surgeons—those making too many cuts—and notified them of their outlier status.³³ In a nonrandomized controlled trial of U.S. Mohs surgeons, 83 percent of outlier surgeons who were notified of their status reduced the average number of cuts they made per case.³⁴ Similar interventions to reduce postprocedure opioid prescribing and polypharmacy in the Medicare population are being assessed by the Improving Wisely research team.

Applications for State Medicaid Programs

State Medicaid programs can utilize the Improving Wisely project’s approach to provide patients with information they need in advance of receiving care and to provide physicians with data that could improve their practice. For clinical care areas where significant waste or clinical harm have been identified, such as low-risk C-sections, states should utilize appropriateness measures and

move beyond confidential data sharing with individual physicians to public reporting to help patients make the best possible decisions.

Data Access

The CMS's Transformed Medicaid Statistical Information System (T-MSIS)³⁵ provides data sufficient to allow states to calculate physician practice patterns. Provider identifiers are available in T-MSIS, allowing states to distinguish providers in claims data and to link Medicaid data with other data sources.

Meaningful Metrics

For appropriateness metrics to be meaningful, they should be reliably measured by claims data and supported by the applicable clinical community. Peer-to-peer physician comparison methods, with metrics developed by the physicians with expertise in that area, will have the most support and thus the most impact.

State Medicaid programs can secure actionable appropriateness measures by using established state or federal metrics or contracting with companies that have developed or can develop such measures. One such company, Global Appropriateness Measures, is a consortium of organizations using appropriateness measures in big data to identify global areas of waste and overtreatment.³⁶ Some of the Global Appropriateness Measures participating organizations, such as Accolade (a personal health and benefits solutions company) or Cedar Gate (a value-based care platform), are incorporating appropriateness measures into their business models in order to reduce unnecessary care.^{37,38} Regardless of the development method, metrics chosen by states should be able to delineate the boundaries of standard practice to allow identification of outlier physician practice patterns. Conceptually, the appropriateness measures would be similar across states.

Displaying Data

Many states publish hospital or health plan performance in specific quality metrics. Continuing the case study on low-risk C-sections, the Louisiana Medicaid program offers a strong example of transparency through provision of health-plan-level statistics on Cesarean rates for low-risk, first-birth women (see Figure 8.2).³⁹

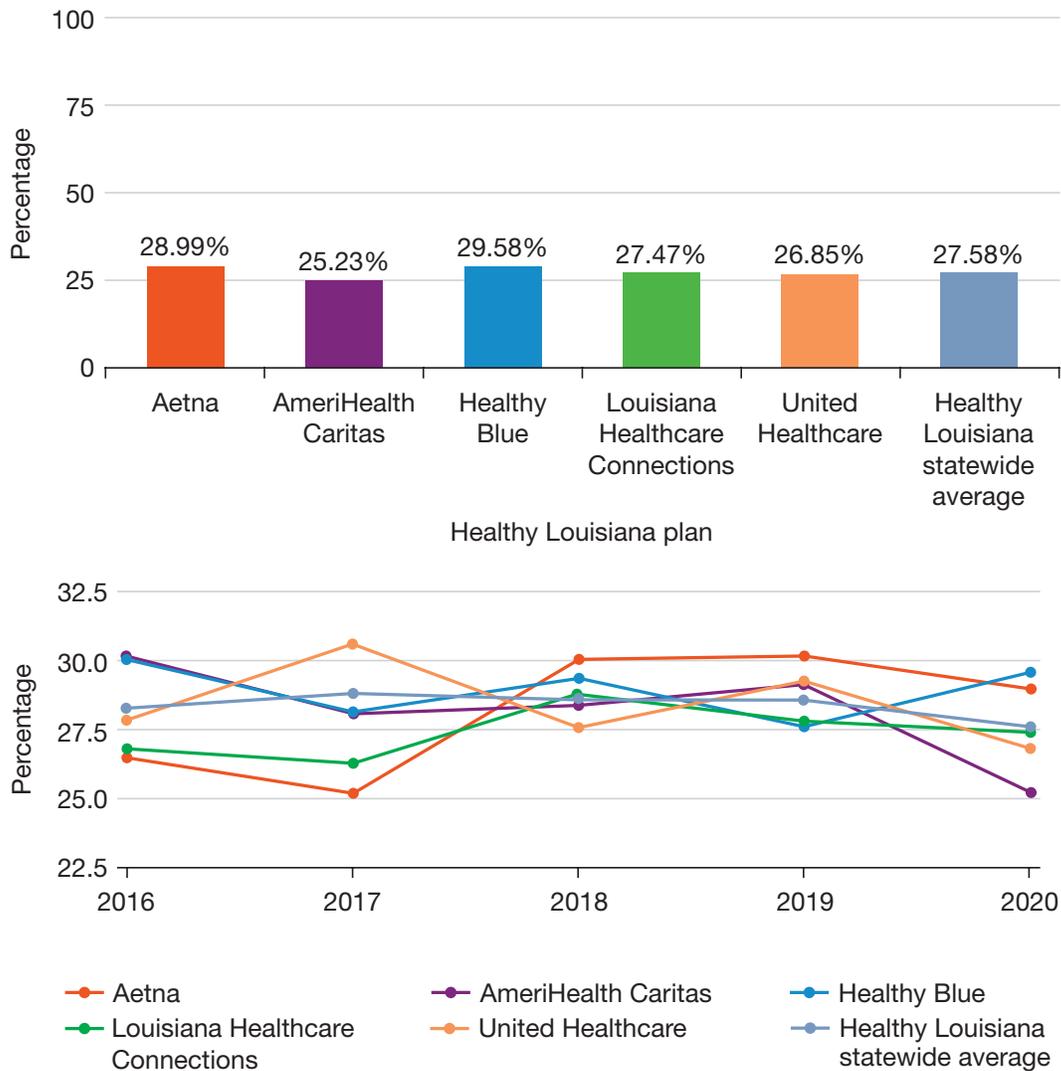


Figure 8.2 Cesarean rates for low-risk, first-birth women, 2016–2020 (top) and 2020 (bottom).

Note: These are inverse (incentive-based) measures.

Source: Louisiana Department of Health, “Medicaid Managed Care Quality Dashboard,” <https://qualitydashboard.ldh.la.gov/>.

While this data may be useful to patients choosing a health plan or hospital, it is not actionable for Medicaid patients seeking to avoid unnecessary C-sections, nor does it allow physicians to benchmark their practice against those of their peers. However, by displaying similar data broken out by individual *physician*, patients can use the data to inform their choice of doctor, and doctors can use the data to benchmark themselves against their peers.

Next Steps

Medicaid claims data can reveal variations in physician practice and can be used to specify, in conjunction with expert consensus, acceptable bounds of practice variation. States should utilize a scaled approach of notification and public reporting. This approach recognizes that most practicing physicians intend to provide high-quality care and will strive to improve their practices when made aware of opportunities to do so. This approach also allows rapid adaptation to changing clinical environments and practice recommendations while still assessing practice patterns over time through the use of retrospective claims data.

On the flip side, the approach can be used to reward clinicians who consistently deliver the standard of care in priority clinical areas. Prior authorization requirements could be relaxed for clinicians who practice appropriate care. While the details of implementation would be negotiated between physicians and managed care organizations, the provision of rewards can be used to promote high-quality care.

The approach should be applied to any high-expenditure Medicaid practice area with identified components of low-value care. For example, there appears to be an overuse of stainless-steel crowns in baby teeth in children enrolled in Medicaid.⁴⁰ The rates and clinical circumstances under which dentists are performing this procedure should be evaluated, and appropriateness measures should be developed and deployed.

OVERCOMING OPPOSITION

A top concern of policymakers is how physicians will respond. This is of special concern for state Medicaid directors, who are loath to offend physicians when there are existing shortages of physicians accepting Medicaid patients. Fortunately, the Improving Wisely approach has received strong support from key clinical leaders. Dr. Jack Resneck, the president-elect of the American Medical Association, coauthored an article supporting the provision of accurate, actionable performance data to Mohs surgeons.^{41,42} In the commentary, Dr. Resneck and his coauthor, Dr. Marta VanBeek, recommended benchmark metrics that target areas of significant waste or harm, saying, “The quality and cost measurement enterprise must be reimaged so that it exclusively targets significant problems that patients and physicians care about while mitigating data collection and reporting burdens that discourage

physicians who are motivated by quality improvement but frustrated by past measures.” This proscription from Drs. Resneck and VanBeek should guide policymakers working to improve quality, particularly those policymakers responsible for managing state Medicaid programs.

The public display of physician outcome data is not new. The Society of Thoracic Surgeons launched a public reporting initiative in 2010 that allowed participating surgeons to voluntarily release their clinical outcomes.⁴³ Other initiatives that deployed behavioral interventions and physician report cards have led to desirable behavior change.^{44, 45} Policymakers may have concerns about how appropriateness measures fit into the existing quality measurement framework, and they may have concerns about the costs of data analysis and publication. State Medicaid directors should view appropriateness measures as a complement to current quality metrics. Because they are abstracted from existing claims data, there will be no attendant reporting burden leveled on physicians. The costs of data analysis and display will be contingent on a state’s existing technical resources but should be small compared with the potential savings from reduced waste and increased quality.

Policymakers may also be concerned that this intervention represents government overreach into the practice of medicine. This concern is unfounded, as the government role in this context simply consists of utilizing appropriateness measures and releasing data. The public display of physician practice patterns is aimed at creating a better-informed patient and provider population. By providing transparency into physician practice patterns and utilizing clinically actionable appropriateness measures, Medicaid programs can reduce waste and empower patients and physicians in a way that results in improved quality of care, particularly for the most vulnerable.

ABOUT THE AUTHOR

Heidi Overton, MD, is the director of the Center for a Healthy America at the America First Policy Institute. Overton recently served as a White House fellow in 2019–2020 in both the Office of American Innovation and the Domestic Policy Council. She is currently a PhD candidate in Clinical Investigation at the Johns Hopkins University Bloomberg School of Public Health and is completing her medical training in preventive medicine. Previously, Overton was a general surgery resident at the Johns Hopkins University School of Medicine, and a physician advocate for price and quality transparency in health care through Restoring Medicine. During medical

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