



## American Hospital Association®

### **Ensuring a Healthier Tomorrow**

*Actions to Strengthen Our Health Care System and  
Our Nation's Finances*

#### **Executive Summary**

##### THE PROBLEM:

The current growth rate for health care spending is a central area of focus for policymakers. The growth in Medicare and Medicaid spending is contributing to the nation's debt and deficit. Today, Medicare costs about \$560 billion annually. And the Congressional Budget Office (CBO) projects spending will almost double over the next decade, totaling more than \$1 trillion by 2022. If health care spending is not slowed, the effects will be profound and affect everyone – health care providers, the government, insurers and employers, and individuals.

In times of fiscal crisis, the federal government repeatedly turns to cutting Medicare and Medicaid spending, almost exclusively through reducing provider payment. **But ratcheting provider payments will not put us on a sustainable path for the future; we need real targeted reforms, not blunt cuts to provider payment.**

##### THE SOLUTION:

As policymakers grapple to rein in Medicare and Medicaid spending, they should focus on the following two interconnected strategies that will improve the health care system, ensure the short- and long-term financial viability of these programs, and tackle the federal debt and deficit:

- **Promote and reward accountability.** We need to re-structure the system in a way that promotes and rewards accountability – to patients, their families and their communities—and ensures that all stakeholders are responsible and answerable for the quality, appropriateness and efficiency of health care provided.
- **Use limited health care dollars wisely.** We need to focus on using limited health care dollars more wisely—in ways that eliminate inefficiency and improve quality of care for patients.

This paper identifies a number of **recommended changes** necessary to achieve each strategy. Perhaps more importantly, it lays out an **action plan and priority checklist** for providers, the government, insurers and employers, and individuals. Everyone bears some responsibility and everyone must contribute to the solution.

## **STRATEGY 1: PROMOTE AND REWARD ACCOUNTABILITY**

1. ***Accelerate Payment and Delivery System Reforms.*** Payment systems need to move away from fee-for-service toward integrated and innovative delivery models, such as medical homes, bundled payments and accountable care organizations (ACOs).
2. ***Eliminate Preventable Infections and Complications.*** Healthcare-associated infections and complications are among the leading causes of death and result in unnecessary health care costs. We must eradicate them.
3. ***Engage Individuals in their Health and Health Care.*** Unhealthy behavior, such as smoking, poor diet and sedentary lifestyles, accounts for up to 40 percent of premature deaths in the U.S. Involving patients in their health and health care is critical to improving wellness and health outcomes.
4. ***Better Manage Advanced Illness.*** We need to ensure that severely ill patients and their families are empowered to make health care decisions and have access to a comprehensive set of health care and social services.
5. ***Advance the Use of Health Information Technology and Electronic Health Records (EHRs).*** EHRs hold the promise of providing clinicians and patients with real-time access to medical information, which can improve medical decision-making, quality and patient safety. We need to standardize these technologies and achieve interoperability.
6. ***Promote Transparency of Quality and Pricing Information.*** Patients and clinicians need useful, reliable information about the quality and price of health services so they can make informed health care decisions.

## **STRATEGY 2: USE LIMITED HEALTH CARE DOLLARS WISELY**

1. ***Eliminate Non-value Added Treatments.*** There is ample evidence that more care does not necessarily mean better care. It is estimated that a significant amount of health care spending does not result in improved outcomes.
2. ***Revamp Care for Vulnerable Populations.*** According to the Kaiser Family Foundation, historically, about half of all health care spending was used to treat just five percent of the population. Better coordinating care for our most complex, vulnerable patients—low-income children, dual eligibles, racial and ethnic minorities, and high utilizers of health care—will help bend the cost curve.
3. ***Promote Population Health.*** According to the Centers for Disease Control and Prevention, chronic diseases, such as obesity, diabetes and heart disease, are the leading cause of death and disability and account for 75 percent of the nation’s health care spending. We need to sharpen our focus on better managing the health of a community.
4. ***Modernize Federal Health Programs.*** Updating Medicare and the Federal Employee Health Benefit Program to reflect changes in demographics, life expectancy and service delivery could save an estimated \$2 trillion over the next decade.

5. *Simplify Administrative and Regulatory Processes.* Reducing the administrative complexity of health care could save \$40 billion annually. Providers need to spend more time on patients, not paperwork.
6. *Reform the Medical Liability System.* CBO and other deficit reduction committees have found that medical liability reform could save \$17 billion to \$62 billion over 10 years, depending on the policies implemented.

Implementing these 12 recommendations would make our health care system more effective and efficient. This list is not exhaustive, but it is a starting point of initiatives and activities stakeholders can take together. There are many things providers need to do, but we cannot do it alone. We need others to do their part—in many cases to help us, and in others to move aside so that we can forge ahead.

#### CONCLUSION:

Real improvements in health and health care—as opposed to arbitrary cuts to provider payment—have the ability to put our country on a more sustainable fiscal path. But slowing health care spending is only one part of the solution to our nation’s fiscal crisis. And, hospitals are just one component of the health care system. **Together, we need to create solutions that allow individuals to access the care they need, when and where they need it, and have it delivered in the safest, most cost-effective manner.** By focusing our efforts and taking responsibility for that which we can control, together we can ensure a healthier tomorrow.



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### **Ensuring a Healthier Tomorrow**

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Our Nation's Finances*

#### THE PROBLEM:

**The current growth rate for health care spending is a central area of focus for policymakers.** A number of factors contribute to the rise in spending, including changing demographics and the aging of the baby boom generation, the growth in chronic illness, advances in medical technologies, and system inefficiencies. Achieving a sustainable level of health care spending requires reducing both the cost of individual services and the use of total services.

**Our nation has both a debt and deficit problem.** At the end of 2010, the Congressional Budget Office (CBO) projected, absent changes in law, that debt held by the public would rise from \$5.8 trillion in 2008 (about 40 percent of gross domestic product, or GDP) to more than \$16 trillion in 2020 (or 70 percent of GDP). This will drive up interest rates, reduce investment and harm future economic growth. According to CBO, while the deficit has been shrinking over the past few years, at the end of fiscal year 2012 the national deficit was \$1.1 trillion – the fourth-largest deficit since World War II. Spending continues to outpace revenue.

**Future growth in Medicare and Medicaid represents a serious challenge.** Today, Medicare covers more than 48 million people. Baby boomers are now reaching the eligible age of 65 at the rate of 10,000 a day. The program currently costs about \$560 billion annually, and over the next decade, CBO projects Medicare costs will almost double— totaling more than \$1 trillion by 2022. In 2008, the Medicare Trust Fund began to pay out more in benefits than it received in revenue; the fund is projected to become insolvent in 2024. The 2012 Medicare Trustees Report projects that the ratio of workers-to-beneficiaries will decline from four workers per beneficiary in 1965 (the start of the Medicare program) to slightly less than three workers per beneficiary in 2011, to two workers per beneficiary in 2040. And, the Urban Institute reports that the average couple will receive \$387,000 in Medicare benefits but only pay \$122,000 in Medicare taxes over their lifetime. These major demographic shifts and trends create a significant burden for future generations.

The total number of Medicaid recipients is over 62 million. According to the Centers for Medicare & Medicaid Services (CMS), between 1990 and 2010, national Medicaid spending increased from \$72 billion to more than \$400 billion annually. Federal spending alone increased from \$40 billion to an estimated \$271 billion during this timeframe. Much of this growth has

been due to increased enrollment, caused by the recent recessions and an increase in the disabled population. But this trend is projected to continue with the implementation of the *Patient Protection and Affordable Care Act (ACA)*.

**While the increase in health care spending has recently slowed, costs are still projected to rise at an unsustainable rate.** Families, employers and government are struggling with rising costs. Chronic illnesses—such as obesity, diabetes and heart disease—are draining the health of Americans young and old. Shortages of physicians, nurses and other caregivers are projected to grow even worse in 2014 when health coverage will be expanded to 32 million individuals. While health care quality, safety and efficiency are improving, care must be better integrated and coordinated.

THE SOLUTION:

**The AHA’s vision is a society of healthy communities where all individuals reach their highest potential for health.** Health coverage is critical to fulfilling this vision. The ACA expanded access to health care coverage, enacted significant insurance reforms and put in place opportunities to reform the delivery system. To help expand health care coverage to millions, the hospital field will undergo changes that will stretch Medicare and Medicaid dollars further.

**Additional provider payment reductions will not put us on a sustainable path for the future.** Numerous studies have found—and the flawed physician sustainable growth rate confirms—that reducing provider payment rates does not result in reducing Medicare spending on services.

Policymakers need to call upon all stakeholders to make changes that will:

- **Promote and reward accountability.** We need to re-structure the system in a way that promotes and rewards accountability—to patients, their families and their communities—and ensures that all stakeholders are responsible and answerable for the quality, appropriateness and efficiency of health care provided.
- **Use limited health care dollars wisely.** We need to focus on using limited health care dollars more wisely—in ways that eliminate waste and improve quality of care for patients.

Focusing on these two interconnected strategies will improve the health care system, ensure the short- and long-term financial viability of these programs, and tackle the federal debt and deficit.

This paper identifies six **priority recommendations** to achieving each strategy. Each recommendation has a list of **suggested actions** that providers, the government, insurers and employers, and individuals can take to strengthen our health care system and our nation’s finances. The task is a large one, and it will not be achieved overnight. But we cannot solve our problems in isolation. We must come together to ensure a healthier tomorrow.

# STRATEGY 1

## Promote and Reward Accountability

Providers, the government, insurers and employers, and individuals must become more accountable and work together to improve care and create a health care system where the patient is at the center of all health care decisions. Jointly, our focus must:

### 1. Accelerate Payment and Delivery System Reforms

New delivery models hold the promise to improve care, but they require new payment approaches that align incentives among physicians, nurses and other caregivers across the continuum. The AHA supports the implementation of a multi-stage, coordinated plan to adopt payment models that encourage and support delivery reform. Providers are at different levels of readiness to adopt new care models and payment approaches; it follows that such a plan would need to plot a path of evolution and allow providers to enter and move along the path based on their readiness. For example, payment approaches should support accepting accountability for care coordination and larger units of services, such as medical homes; combining hospital, physician and/or post-acute services reimbursement into one bundled payment; or forming accountable care organizations (ACOs). But for such innovations to occur and thrive, a number of legal and regulatory barriers that stand in the way of allowing hospitals, doctors and other providers to work together must be overcome. At the end of 2009, the AHA Board of Trustees approved a white paper on payment reform; for more, visit:

<http://www.aha.org/content/00-10/09-11-payment-reform-report-board-action.pdf>.

#### *Actions by Providers:*

- ✓ Actively participate in one or more new care models to develop the competencies for accountable care, such as better coordinating care and assuming greater accountability for the quality and efficiency of services.
- ✓ Participate in national and/or local delivery and payment reform demonstration projects.
- ✓ Develop partnerships with other provider or community organization to enhance care coordination.
- ✓ Explore and simplify a single patient assessment instrument across care settings to ensure appropriate transitions in care.

#### *Actions by the Government:*

- ✓ Implement a sufficient range of federal and state delivery and payment innovations to enable participation by all types of providers.
- ✓ Ensure continued funding for the Center for Medicare and Medicaid Innovation.
- ✓ Provide timely, meaningful data to providers so they can engage more easily in alternative delivery models.

- ✓ Aggressively evaluate and then expand delivery models that are successful in reducing expenditures while enhancing quality.
- ✓ Establish financial incentives for providers and patients to participate in models that move away from fee-for-service reimbursement and reward value.
- ✓ Remove barriers to clinical integration to allow doctors, hospitals and others to work together in teams or networks, especially those related to antitrust, the patient referral (“Stark”) law, civil monetary penalties, anti-kickback, and the Internal Revenue Service.
- ✓ Permit, encourage and simplify broad-scale hospital-physician “gain sharing.”
- ✓ Expand competitive bidding under the fee-for-service system to include medical devices and equipment.
- ✓ Align the Federal Employees Health Benefits Program (FEHBP) with Medicare to require plans to use alternative payment methods, such as ACO arrangements or value-based purchasing.

***Actions by Insurers and Employers:***

- ✓ Collaborate with providers to expand the number and type of available delivery and payment reform options.
- ✓ Offer financial incentives to providers and enrollees to participate in new models of care.
- ✓ Re-design payment methods to recognize time spent by physicians and others in coordinating patient care, especially

following a hospital or skilled nursing facility stay.

***Actions by Individuals:***

- ✓ Actively seek out and participate in multidisciplinary care arrangements, such as ACOs and medical homes.

**2. Eliminate Preventable Infections and Complications**

For many years, providers have worked diligently to improve the safety and quality of the care they provide. Through the AHA's *Hospitals in Pursuit of Excellence* (HPOE) initiative ([www.hpoe.org](http://www.hpoe.org)), hospitals are sharing field-tested practices, tools, education and other resources to support efforts to meet the Institute of Medicine's six aims: care that is safe, timely, effective, efficient, equitable and patient-centered. HPOE was created to help accelerate performance improvement and support delivery system transformation.

Hospitals have made impressive strides in reducing infections and preventing complications in care. According to the Centers for Disease Control and Prevention (CDC), over the past decade, hospitals have reduced the rate of central-line associated blood stream infections (CLABSI) by 58 percent, saving \$1.8 billion in excess health care costs. More than 1,100 hospitals from 44 states, the District of Columbia and Puerto Rico were enrolled in a national effort called *On the CUSP: Stop BSI* which was led by the AHA's Health Research & Educational Trust (HRET) affiliate and supported by the Agency for Healthcare Research and Quality (AHRQ). Nearly 1,000 hospitals are participating in a national effort to reduce catheter-associated urinary tract infections (CAUTIs) led by HRET, supported by AHRQ. Also, through its Hospital Engagement Network contract with the federal government, the AHA, in partnership with 31 state hospital associations, has engaged nearly 1,600 hospitals in efforts to reduce infections, adverse drug events, injuries and preventable hospital readmissions.

***Actions by Providers:***

- ✓ Actively participate in national efforts to achieve reductions in CLABSIs, CAUTIs, adverse drug events and preventable hospital readmissions.
- ✓ Eliminate preventable mortality in hospitals as reflected by a reduction of the publicly reported all-cause, 30-day mortality rates for acute myocardial infarction, heart failure and pneumonia to 12.1 percent in 2013, to 11.7 percent in 2014, and to 11.2 percent in 2015.
- ✓ Report to a Patient Safety Organization to better track, understand and prevent errors.
- ✓ Contribute at least one best practice to the AHA's HPOE portfolio of resources to accelerate performance improvement.

***Actions by the Government:***

- ✓ Expand national governmental efforts like CMS's Partnership for Patients to support quality and safety improvement.
- ✓ Align value-based purchasing initiatives across all providers to ensure they are working toward the same goals.
- ✓ Limit provider payment penalties related to readmissions, infections and complications only to those that are truly preventable.
- ✓ Adopt meaningful measures related to care coordination, patient outcomes and efficiency across the care continuum.
- ✓ Develop quality measures that use data from all payers.
- ✓ Coordinate resources with respect to measure development and reporting.

***Actions by Insurers and Employers:***

- ✓ Provide data, information, tools and technologies to providers to identify opportunities to reduce infections and readmissions.
- ✓ Encourage device companies to produce and utilize software-controlled monitoring systems to help reduce medical errors and avoidable injuries.
- ✓ Offer financial incentives to eliminate CLABSI as well as other healthcare-acquired infections and complications.
- ✓ Design safety checklists (such as Blue Surgical Safety Checklist<sup>SM</sup>) and encourage providers to adopt them.

- ✓ Develop materials and programs to help members and employees understand medication management to prevent unnecessary readmissions.

***Actions by Individuals:***

- ✓ Use publicly available information on quality, infections and complications to choose doctors and hospitals with lower rates.
- ✓ Ensure your doctors, nurses and care team – as well as family members and visitors – wash their hands frequently to prevent the spread of infection.
- ✓ Get recommended vaccinations.

**3. Engage Individuals in their Health and Health Care**

Given that unhealthy behavior, such as smoking, poor diet and sedentary lifestyles, accounts for as much as 40 percent of premature deaths in the U.S., a great opportunity to improve health and decrease costs lies in spurring patients, families and communities to take responsibility for their own health and health care. Strategies to engage patients must be identified and adopted. The AHA’s Committee on Research is examining this issue in depth and plans to release a report in early 2013. The committee is focusing on strategies for hospitals to become more “activist” in their orientation and move “upstream” to intervene earlier in disease states in order to improve outcomes and reduce health care costs. Together, we must find ways to help improve individual behaviors and develop a culture that supports patient and family engagement.

***Actions by Providers:***

- ✓ Place individuals, their family caregivers and their advocates at the center of all care planning decisions.
- ✓ Involve patients and families in multidisciplinary rounds.
- ✓ Establish patient and family advisory councils, and involve patients/families in hospital planning, program development and quality improvement efforts.
- ✓ Reduce health care disparities by increasing diversity in hospital staffing, leadership and governance.
- ✓ Provide easy-to-read, customized educational materials and instructions.
- ✓ Encourage shared decision-making.
- ✓ Use “teach-back” methods to ensure patient/family understanding.
- ✓ Explore the use of e-mail, social media, video conferencing and other technologies to better connect patients, families and caregivers.

***Actions by the Government:***

- ✓ Offer incentives to Medicare and Medicaid enrollees to engage in their care planning and self-management of chronic conditions.
- ✓ Support use of telehealth and e-visits.
- ✓ Provide a national Web-based repository for patient education materials in multiple languages that can be used by providers.
- ✓ Lead a multi-stakeholder effort to promote the development of advanced care directives.

***Actions by Insurers and Employers:***

- ✓ Provide patient education materials, guides and aids to members and employees.
- ✓ Explore use of web tools, social media and other technologies to provide health information to members and employees.
- ✓ Support use of telehealth, e-visits and home health care.
- ✓ Provide workplace wellness programs for employees.

- ✓ Vary health insurance cost-sharing based on enrollee/employee participation in maintaining or improving his/her health.
- ✓ Assist members and employees with their health literacy so they can better understand health information and use that information to make good decisions.

***Actions by Individuals:***

- ✓ Seek health information and knowledge.
- ✓ Communicate your wishes to your family and your care team often.
- ✓ Ask questions to make informed choices about your care.
- ✓ Fill and take medications as prescribed.
- ✓ Schedule and attend follow-up visits.
- ✓ Comply with treatment plans and protocols.
- ✓ Know who on the care team to contact if you have questions or need additional assistance.

**4. Better Manage Advanced Illness**

All individuals need to engage in advance care planning early and throughout their life cycle so their wishes about end-of-life care are understood and honored. These are difficult, emotional conversations, but they are critical if we want to better honor patients' wishes and remove barriers to expanding access to palliative care. When individuals and families are informed of their choices, they often prefer to spend their last days at home with hospice rather than in hospital intensive care units. Individuals and families must be encouraged to address these difficult decisions so that appropriate, compassionate care can be provided at the right time, in the right setting.

The AHA's Committee on Performance Improvement has spent 2012 focusing on effectively integrating advanced illness management into the care continuum. Hospitals that develop and integrate advanced illness management strategies can increase quality, improve patient satisfaction and remove inefficiencies in the health care system. Its first report, *Advanced Illness Management Strategies*, is available at: <http://www.aha.org/about/org/aim-strategies.shtml>. A second report, *Engaging the Community and a Ready, Willing and Able Workforce*, will be available at the end of 2012.

***Actions by Providers:***

- ✓ Expand access to advanced illness management services, by integrating palliative care and hospice service into the care continuum.
- ✓ Educate physicians, nurses and other caregivers to provide advanced illness management services.
- ✓ Make a discussion of advanced illness care part of the "Welcome to Medicare" physical examination.
- ✓ Use Physician Orders for Life-Sustaining Treatment (POLST) order sets to identify the medical treatment patients want toward the end of their lives.
- ✓ Ensure POLST order sets travel with patients during transitions in care, especially

between skilled nursing facilities and hospitals.

- ✓ Increase awareness of the benefits of advanced illness management services in the community.

***Actions by the Government:***

- ✓ Increase public awareness of the benefits of advanced illness management.
- ✓ Reimburse providers for discussing a patient's goals/wishes.
- ✓ Require all Medicare and adult Medicaid patients to have an advance directive.

***Actions by Insurers and Employers:***

- ✓ Expand coverage and reimbursement of hospice and palliative care.

- ✓ Reimburse providers for discussing a patient's goals/wishes.
- ✓ Encourage enrollees to have an advance directive.

***Actions by Individuals:***

- ✓ Understand the benefits of advanced illness management.
- ✓ Discuss your goals/wishes with your family, primary care physician and other caregivers early and throughout your life.
- ✓ Complete an advanced directive before advanced illness occurs.

**5. Advance Health Information Technology and Electronic Health Records (EHRs)**

Adoption of health information technology (IT), if done right, can improve health care quality and efficiency. However, policymakers have been impatient to see its benefits and have moved to regulate ahead of field experience and capacity in some areas. Policymakers should focus on ensuring that existing incentive programs result in widespread adoption and use of EHRs by all providers, regardless of size and location, and not in widespread penalties. Additionally, all stakeholders need to promote and invest in health information exchanges. Rational support will ensure the country realizes the full potential of IT, from standardizing orders and notes, to ensuring that needed information follows the patient, to facilitating quality improvement goals.

***Actions by Providers:***

- ✓ Adopt and use EHRs by 2015.
- ✓ Implement standards that support interoperability.
- ✓ Help reduce health care disparities by increasing the consistent collection and use of race, ethnicity and language preference data.
- ✓ Report quality measures through EHRs when sufficient infrastructure exists.
- ✓ Share best practices in how health IT can support care transformation.
- ✓ Adopt and promote telemedicine to extend access to care in small, rural and underserved communities.

***Actions by the Government:***

- ✓ Invest in field testing and necessary infrastructure to allow for accurate and feasible reporting of quality measures through EHRs.
- ✓ Establish unique patient identifiers to link individuals to their health records.
- ✓ Create a realistic national plan for adoption of interoperability standards that allow providers to share health information that includes systematic support for standards adoption.
- ✓ Invest in health information exchanges.

- ✓ Ensure privacy regulations are coordinated across programs.
- ✓ Create data-sharing mechanisms between the Medicare and Medicaid programs, health plans, providers and others.

***Actions by Insurers and Employers:***

- ✓ Use unique patient identifiers to link individuals to their health records.
- ✓ Use interoperability standards that allow providers to share health information.
- ✓ Enable electronic exchange of eligibility, claims, and other administrative information among payers and providers.
- ✓ Develop systems that integrate clinical and administrative functions, such as billing, prior authorization and payment.
- ✓ Provide monthly electronic "explanation of benefits" statements to consumers.
- ✓ Ensure privacy regulations are coordinated across programs.

***Actions by Individuals:***

- ✓ Create a personal health record to maintain a summary of one's medical and health history.
- ✓ Use other automated tools to better manage one's health.

## **6. Promote Transparency of Quality and Pricing Information**

Individuals deserve access to information about the quality and price of their health care. Hospitals are committed to sharing information so that individuals can make informed decisions about their care. As a founding partner of the Hospital Quality Alliance, the AHA has spent nearly a decade working with other stakeholders to identify good, reliable measures that could be used to report publicly on hospital care. Currently, hospitals are reporting on more than 160 measures for the Medicare program alone. Reporting on quality measures is often linked to hospital payment, through programs such as value based purchasing, meaningful use of EHRs, readmission penalties and healthcare-acquired conditions. Hospitals also are reporting measures for state Medicaid programs, for accreditation organizations such as The Joint Commission, for employer groups such as The Leapfrog Group, and for other private insurers such as Blue Cross Blue Shield. Hospitals are committed to fulfilling reporting requirements, yet are struggling to comply with multiple and often unaligned requirements. We need a rational approach for developing meaningful measures that can satisfy the interests of providers, individuals and other stakeholders so that the information gathered is used in a meaningful manner. Additionally, information about prices, in particular, may result in individuals being more discriminating in purchasing and using health care services, if the information made available is useful.

### ***Actions by Providers:***

- ✓ Participate in state efforts to make consistent and meaningful quality and pricing information available to patients.
- ✓ Work with health plans to make real-time information available to patients on their expected coverage and out-of-pocket costs for specific services on a pre-service basis.
- ✓ Examine the hospital charge structure and mechanisms to avoid public confusion about the difference between charges, payment levels and patient out-of-pocket costs for specific health care services.

### ***Actions by the Government:***

- ✓ Require that information about insured enrollees' expected out-of-pocket costs is available to them through their insurance company or public program.
- ✓ Require all key stakeholders—hospitals, physicians, payers, pharmaceutical and medical device companies, vendors and other—to participate in the development of meaningful and understandable information on the quality and pricing of their services to help aid patient decision-making.
- ✓ Ensure that the data reported are meaningful to individuals and not overly burdensome for stakeholders to report.

- ✓ Provide pricing comparisons for all plans in state (or federal) health insurance exchange(s).
- ✓ Provide incentives, such as discounts, for those individuals who choose high-value plans or providers.

### ***Actions by Insurers and Employers:***

- ✓ Support health care coverage transparency by making premium, coverage, and cost-sharing information readily available to individuals using consistent language and formats.
- ✓ Provide out-of-pocket cost estimates to enrollees.
- ✓ Provide ready access to information on coverage of specific needed services and abide by prior authorizations.

### ***Actions by Individuals:***

- ✓ Better understand quality and pricing information so you can make informed health care decisions.
- ✓ Consider “shopping” for routine health care services based on price and quality.

## STRATEGY 2

### Use Limited Health Care Dollars Wisely

While increased accountability of providers, government, payers and individuals will reduce costs, as a nation we are faced with limited resources. We must create a balanced strategy to allocate limited funding and resources appropriately by ensuring that every action, transaction, test and procedure positively affects the health of the patient. Jointly, our focus must:

#### 1. Eliminate Non-value Added Treatments

There is ample evidence that more care does not necessarily mean better care. It is estimated that a significant amount of health care spending does not result in improved outcomes. Recently, a number of physician organizations collaborated to identify commonly used, but often unnecessary, services, tests, and procedures in an initiative called “Choosing Wisely.” Examples include excessive use of antibiotics, unnecessary imaging tests, and use of surgery when watchful waiting would be better. This type of collaboration should be expanded, measured and shared as a way to educate physicians, patients and their families. Additionally, service delivery and payment reforms, such as medical homes, ACOs, bundled payments and value-based purchasing, hold promise for eliminating inefficient and unnecessary care.

To use resources more wisely, we have to know what works best. Yet often patients, providers and others don't have the best information to make informed health care decisions. That requires investment in comparative effectiveness research to develop and use evidence-based medicine. Comparative effectiveness research is an important mechanism for improving quality, decreasing unjustified variation in care, and reducing health care costs. And, when it includes the cost of innovations, it can increase the value of every dollar spent.

#### ***Actions by Providers:***

- ✓ Eliminate overuse, underuse and misuse of treatments and services.
- ✓ Ensure patients, physicians and others are knowledgeable about best practices.
- ✓ Collaborate with others in the provider community to implement evidence-based recommendations in the “Choosing Wisely” campaign and/or develop similar hospital field recommendations.
- ✓ Make comparative effectiveness research available to patients, families, clinicians and others so they have the best information to make decisions.
- ✓ Increase the use of generic drugs.

#### ***Actions by the Government:***

- ✓ Provide payment incentives for reducing preventable readmissions, infections and complications.
- ✓ Reward providers who follow recommended best practices.

- ✓ Allow inclusion of cost-effectiveness data in comparative effectiveness research.
- ✓ Limit the exception to the prohibition on self-referral for in-office ancillaries.
- ✓ Provide funding for pilot programs to develop new processes for care.
- ✓ Allow providers to clinically integrate so they may reduce inefficient care.

#### ***Actions by Insurers and Employers:***

- ✓ Require vendors and manufacturers to provide cost data.
- ✓ Require prior-authorization of certain advanced imaging tests and procedures by providers who have a history of overuse.
- ✓ Utilize cost-effectiveness findings in payment and coverage decisions.

#### ***Actions by Individuals:***

- ✓ Seek data on best practices to understand which drugs, devices and treatments may be most effective.

- ✓ Exercise restraint in demanding services your physician says are marginally or not effective.

## 2. Revamp Care for Vulnerable Populations

According to the Kaiser Family Foundation, historically, about half of all health care spending was used to treat just 5 percent of the population. Better coordinating care for our most complex, vulnerable patients—low-income children, dual eligibles, racial and ethnic minorities, and high health care utilizers—will lead to lower costs. Medicaid and the Children’s Health Insurance Program (CHIP) provide health insurance coverage to one-third of all children. Among children, the top 10 percent of enrollees account for 72 percent of total Medicaid/CHIP spending on children. At the same time, 30 percent of children enrolled in Medicaid/CHIP receive little or no care—in some cases despite having special health care needs or chronic conditions. To change the long-term trajectory of health care spending in America, we must focus on improving health care for our children, with a special focus on childhood obesity and high risk births.

In addition, there are more than 9 million dual eligibles enrolled in both Medicare and Medicaid. These individuals tend to be among the sickest and poorest individuals, and yet they must navigate both government programs to access necessary services. Care for this population is often fragmented, lacking management and coordination at the program level. Improving care coordination alone would result in better outcomes at lower cost. AHA’s 2011 report *Caring for Vulnerable Populations* (<http://www.aha.org/research/cor/caring/index.shtml>) highlights nine best practice recommendations for hospitals to implement to improve care for this challenging patient population.

### ***Actions by Providers:***

- ✓ Adopt person-centered care practices by placing individuals, their family caregivers, and their advocates, including non-traditional, community-based caregivers, at the center of all care planning decisions.
- ✓ Institute multidisciplinary care teams to coordinate health care and support services with primary care practitioners at the core.
- ✓ Adopt an effective care plan based on an initial comprehensive patient assessment, and periodic reassessments, to reflect evolving patient needs.
- ✓ Reduce health care disparities by increasing cultural competency training of the health care workforce.
- ✓ Collaborate with state and community programs to conduct outreach to high-risk pregnant women.
- in a timely manner to support care coordination.
- ✓ Develop and apply valid, reliable and meaningful measures of care coordination and quality outcomes specific to vulnerable populations.
- ✓ Assume under Medicare the full financial responsibility and coverage of Medicare premiums and cost sharing for the dually eligible to treat Medicare beneficiaries equally and to reduce administrative complexity.
- ✓ Promote and support Medicare and Medicaid financing mechanisms, payment arrangements and administrative and regulatory functions to encourage and support care coordination.
- ✓ Encourage and financially support care coordination across the full continuum of care.

### ***Actions by Government:***

- ✓ Create data-sharing mechanisms among the Medicare and Medicaid programs, health plans, providers and other government programs to collect, analyze and report data
- ✓ Change both Medicare and Medicaid to overcome care and coverage coordination issues and conflicting administrative requirements and financial incentives to

increase administrative efficiency in caring for the dually eligible.

- ✓ Retain essential support services that are not covered by Medicare and some Medicaid programs, such as dental and vision services and transportation to appointments, if they are shown to reduce long-term costs.
- ✓ Monitor high prescribers and users of prescription drugs in the Medicaid program.
- ✓ Require manufacturers of brand-name drugs to pay the federal government a rebate on drugs purchased by enrollees in the low-income subsidy program for the Medicare Part D benefit.

#### ***Actions by Insurers:***

- ✓ Collaborate with providers and other care practitioners to ensure that administrative and financial barriers do not impede care coordination.
- ✓ Embrace new innovations in payment and care delivery.

#### ***Actions by Individuals:***

- ✓ Take an active role in care management and, to the extent possible, assume personal responsibility for your health care.

### **3. Promote Population Health**

We need to accelerate initiatives and identify more effective approaches to health promotion, primary care and disease prevention, and management of chronic disease. As a country, we need to sharpen our focus on better managing the health of a community. Today, nearly half the population suffers from at least one chronic health condition such as obesity, diabetes or asthma. Chronic disease affects not only health and quality of life, but also contributes to the rapid growth in health care utilization and spending, and other societal costs, such as sick time and disability. According to the CDC, chronic disease accounts for about 75 percent of the nation's aggregate health spending. To halt declining health, we must remodel the way primary care services are delivered and compensated and find ways to better manage chronic illness, treat complications early, minimize acute care and move towards population health. Efforts to improve population health can help reduce overall health care spending.

In January 2011, the AHA Board released a call to action for hospitals to be leaders in creating a culture of health. They encouraged hospitals to start by engaging their own employees in health and wellness activities. The report (available at: <http://www.aha.org/research/cor/creating-culture/index.shtml>) highlights current hospital activities, gives examples of promising practices and provides recommendations to the field. In addition, addressing disparities will be vital to performance excellence and improved community health. The U.S. Census Bureau has found that racial and ethnic minorities currently represent one-third of the U.S. population and will become a majority of the population in 2042. While multiple societal factors impact disparities in care, including environmental and other social determinants, the AHA and other national health care organizations have come together to create a national call to action to eliminate health care disparities. Resources, best practices and guides to eliminate disparities are available at [www.equityofcare.org](http://www.equityofcare.org).

#### ***Actions by Providers:***

- ✓ Serve as a role model of health for the community and create a culture of healthy living.
- ✓ Eliminate tobacco-use on the hospital campus.
- ✓ Act as a convener to link the various components of wellness and primary care in

communities to build an integrated, regional approach to health.

- ✓ Engage the community to offer health education, outreach and programs; work with schools, faith-based organizations and other community partners to provide screenings, health education, health literacy and wellness programs.

- ✓ Participate in the Partnership for a Healthier America’s “Healthy Hospital Initiative” to curb childhood obesity within a generation.
- ✓ Eliminate all trans fat from hospital cafeterias; include nutrition labeling on all products and menus.
- ✓ Implement an employee wellness program. Include a variety of program offerings, such as an employee health risk assessment, biometric screening, and health coaching. Provide positive and negative incentives to increase participating and improve outcomes.
- ✓ Review the AHA’s guide on Equity of Care to help address and eliminate disparities of care in your community.

***Actions by the Government:***

- ✓ Modify reimbursement structures to reward primary care.
- ✓ Permit non-physician practitioners (NPPs) to practice to the full extent of their training.
- ✓ Encourage greater personal responsibility around lifestyle behaviors.
- ✓ Ensure a strong public health infrastructure.
- ✓ Reduce barriers toward receiving high-value preventive services.
- ✓ Encourage policy changes that promote a healthier lifestyle (i.e., prohibiting tobacco use in public areas, banning trans-fats in restaurants and eliminating sugary drinks from school cafeterias) at the local level.

***Actions by Insurers and Employers:***

- ✓ Offer insurance products with lower premiums for patients who receive recommended preventive services or who improve their health.
- ✓ Collaborate with providers to identify opportunities and financial rewards to improve or excel in their patients’ health outcomes (i.e., controlled blood sugar).
- ✓ Educate employees on the appropriate use of preventive services and the resources offered by their medical plans.
- ✓ Implement employee workplace wellness programs.
- ✓ Explore ways to reduce access and time barriers to preventive services (such as offering periodic onsite screenings, coaching and flu shots)

***Actions by Individuals:***

- ✓ Adopt healthy behaviors, especially around diet, physical activity, alcohol, tobacco and drug use.
- ✓ Know and monitor your key indicators of health (i.e., blood pressure, glucose, cholesterol, body mass index).
- ✓ Engage in employer-offered wellness activities.
- ✓ See your primary care physician annually. Receive all preventive immunizations, tests and screenings.
- ✓ Learn and practice self-management of chronic conditions.

**4. Modernize Federal Health Programs**

The Medicare program was created nearly 50 years ago; it needs to be modernized to reflect changes in demographics, life expectancy, medical science, and technology, and how services are delivered. Today’s Medicare beneficiaries receive significantly more in benefits than what they paid through taxes during their working years to support the program. The Urban Institute reports that the average couple will receive \$387,000 in Medicare benefits but only pay \$122,000 in Medicare taxes over their lifetime. In addition, the Medicare Trustees Report projects that the ratio of workers-to-beneficiaries will decline from four workers per beneficiary in 1965 (the start of the Medicare program) to slightly less than three workers per beneficiary in 2011, to two workers per beneficiary in 2040. The current contribution structure must be modernized, and take into account beneficiary income levels.

As Congress and the Administration have debated deficit reduction, several “plans” and proposals have emerged. These have often been the result of bipartisan commissions, such as the National Commission on Fiscal Responsibility and Reform (also known as “Simpson-Bowles”) and the Debt Reduction Task Force (also known as “Rivlin-Domenici”). These various plans

identified a number of potential policy options that would curb federal spending. The AHA supports a number of these options, which could save an estimated \$2 trillion over the next decade.

***Actions by the Government:***

- ✓ Gradually increase the eligibility age for Medicare to age 67 with appropriate opportunities for those close to retirement age to purchase insurance coverage in an exchange.
- ✓ Create a combined annual deductible for Medicare Parts A and B.
- ✓ Add a stop-loss limit to Medicare, as is common with insurance policies in the private sector.
- ✓ Gradually increase the basic Medicare Part B premium from 25 to 35 percent of program cost.
- ✓ Modify supplemental insurance (Medigap) plans to avoid unnecessary utilization.
- ✓ Restrain growth in the cost of the FEHBP by increasing the federal government’s annual contribution based on a measure of inflation linked to the overall economy.
- ✓ Speed up the availability of generic biologics, and prohibit brand-name companies from entering into “pay-for-delay” agreements with generic companies.
- ✓ Use Medicare’s buying power to increase rebates from pharmaceutical companies.

**5. Simplify Administrative and Regulatory Processes**

Providers face duplicative regulations and high compliance burdens, as well as varying claims-processing and record-keeping requirements, imposed by the array of public and private insurance plans. Care can be more affordable if health care professionals spend more time at the bedside and less time on paperwork. Insurers and employers also want to reduce administrative costs. The Center for American Progress estimates that administrative costs consume 14 percent of all health care expenditures, and that at least half of this spending is wasteful. Its analysis found that reducing the administrative complexity of health care could save \$40 billion annually.

Additional cost savings could be achieved through regulatory relief, such as limiting and better coordinating the flood of new and often overlapping auditing programs that are drowning providers with duplicative audits, unmanageable medical record requests and inappropriate payment denials. No one questions the need for auditors to identify fraud or correct billing mistakes; however, the multiplicity of federal, state and private payer programs are resulting in unnecessary costs and burdens. Similarly, the many credentialing and quality improvement initiatives established by regulators, private accreditors and payers have conflicting and overlapping requirements that make care delivery more expensive.

***Actions by Providers:***

- ✓ Utilize standardized credentialing databases and systems.
- ✓ Engage in the Council for Affordable Quality Healthcare’s (CAQH) Committee on Operating Rules for Information Exchange (CORE), the entity designated by the Department of Health and Human Services to develop operating rules to streamline standardized transactions.
- ✓ Become certified as compliant with CORE operating rules.

***Actions by the Government:***

- ✓ Require in contracts with vendors that they become CORE-certified.
- ✓ Streamline and coordinate billing processes, including eligibility inquiries, claim status and remittance information.
- ✓ Adopt common operating rules to standardize provider and health plan communication.
- ✓ Simplify program integrity efforts by synchronizing the roles of auditors.

- ✓ Require auditors to improve their accuracy or face financial penalties.
- ✓ Limit the number of medical records that can be requested at one time or within any month.
- ✓ Apply predictive analytics to focus reviews and identify potential inappropriate use of services.
- ✓ Standardize provider credentialing requirements.
- ✓ Align quality measurement and reporting across all public and private payers.

***Actions by Insurers and Employers:***

- ✓ Overhaul administrative processes to standardize and automate five functions: claims submissions, eligibility, claims status, payment, and remittance.
- ✓ Reduce overly complex, burdensome and inefficient paperwork.
- ✓ Limit time required for provider to complete billing procedures and processes.
- ✓ Standardize network credentialing requirements.

**6. Reform the Medical Liability System**

Hospitals and physicians continue to face skyrocketing costs for professional liability insurance. This is affecting access to care as physicians leave states with high insurance costs or stop providing services that expose them to higher risks of lawsuits. This also often leads clinicians to practice “defensive medicine”—providing extra, often unnecessary, care to minimize the risk of lawsuits. Analysts note that liability reform could save \$17 billion to \$62 billion over the next decade.

***Actions by Providers:***

- ✓ Create a culture of safety where clinicians and others may report errors.
- ✓ Adhere to clinical guidelines and best practices.
- ✓ Minimize the practice of “defensive medicine.”

- ✓ Establish “safe harbor” protections for providers who follow evidence-based clinical practice guidelines.

***Actions by Insurers and Employers:***

- ✓ Adjust providers’ liability insurance premiums based on occurrence of preventable errors.
- ✓ Avoid overly rigid or inappropriate decisions regarding medical necessity.

***Actions by the Government:***

- ✓ Cap non-economic damages.
- ✓ Allow courts to limit lawyers’ contingency fees.
- ✓ Model federal proposals on proven state models of reform.
- ✓ Provide prompt compensation to injured patients based on an agreed-upon payment schedule.

***Actions by Individuals:***

- ✓ Resist filing unjustified malpractice claims.

**Conclusion**

Real improvements in health and health care—as opposed to arbitrary cuts to provider payment—have the ability to put our country on a more sustainable fiscal path. But slowing health care spending is only one part of the solution to our nation’s fiscal crisis. And, hospitals are just one component of the health care system. **Together, we need to create solutions that allow individuals to access the care they need, when and where they need it, and have it delivered in the safest, most cost-effective manner.** By focusing our efforts and taking responsibility for that which we can control, together we can ensure a healthier tomorrow.