Little Hoover Commission
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Background

Health care costs are rising at unsupportable rates (now over 15% of the gross domestic product), making it increasingly difficult for employers and their employees to afford health insurance. As we deal with greater numbers of uninsured and underinsured, there is a growing burden on our public health insurance programs and health systems—with direct impact on the State budget.

Medi-Cal is the nation's largest Medicaid program, serving 6.5 million low-income and disabled enrollees and is the second largest in terms of dollars spent ($34 billion). It is the source of health coverage for one in six Californians under age 65 and one in four of our state's children.[1]

Low-income seniors and adults with disabilities account for a quarter of Medi-Cal enrollees, but nearly two-thirds of its expenditures (about $19.2 billion). For example, on average, a disabled enrollee with chronic conditions costs five to seven times more than a non-disabled enrollee. Higher costs may be appropriate, but are these enrollees getting the appropriate care for these higher costs? We don't really know.

We do know from national studies, however, that patients with chronic conditions have about a 50/50 chance of receiving recommended (evidence-based) care[2], such as regular blood sugar testing for diabetics. The rates of recommended care may be even lower in Medicaid populations. Limited data from Medi-Cal managed health care plans do show lower rates of childhood immunization when compared to commercial health plans.[3]

Why Does Data Matter?

You can't manage what you don't measure. Data, or health information, is a primary window into understanding the quality of care we are paying for and receiving. "Quality" in this context is defined by the Institute of Medicine as: *The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.* Poor quality can be described in three ways:

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[1] California HealthCare Foundation: Medi-Cal Facts and Figures, 2006. Medstat analysis of Medi-Cal MIS/DSS data updated through October 2005. Fee-for-service payments and eligibles only. Long-term care (LTC) includes nursing facilities, home and community-based waiver service and intermediate care facilities.

[2] E. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine* (June 26, 2003): 2635–2645

[3] Health Families 2005 Health Plan Quality Measurement Report—12/20/06

- Misuse—When diagnoses are missed or delayed, or mistakes with medications and treatments (medical error)
- Underuse—When patients do not receive important preventive care, diagnostic test, or necessary treatments
- Overuse—When patients receive surgeries, drugs, test or treatments that are unnecessary, risky, and costly.

A primary source of health data is billing information (usually claims or administrative data). Its collection and use are designed for payment, not for improving quality or health. In spite of its limitations, employers, commercial health plans, and now Medicare, have been actively using claims data to better identify potential under- and overuse—and in some cases, misuse of care services. Claims data generally contain patient identifiers, basic demographic information (e.g., age, gender), medical diagnosis code, and a code for the specific service rendered.   For example, underuse of appropriate services can be "measured" by the lack of a claim for mammography services for a woman over the age of 50. Similarly, overuse can be detected by the number of services, such as repeated steroid joint injections, that exceed the recommended spacing of treatment. Claims data are also being used to identify: patients who might benefit from better oversight of their care (i.e., disease management), programmatic alternatives for cost savings (e.g., substituting generic for brand-name drugs), and fraud and abuse.

In the commercial world, it is an industry standard for health plans to use data to assess and drive improvements in health care delivery and cost savings. In addition, financial incentives (in the forms of capitation and pay-for-performance) rely on the availability and use of timely claims data. This is the case for pay-for-performance activities in California. The current program led by the Integrated Healthcare Association includes seven health plans, over 8 million enrollees and uses standardized performance measures based on administrative data. Realizing the limits of this information, the program has moved forward with the adoption of uniform data standards for pharmacy and laboratory information to better assess health care quality.

Underlying the State's role as payer of health services is the belief that access to and payment for health services contribute to the health and well-being of the population. But do we really know that the services being provided and purchased with State dollars are actually benefiting the patients that receive them? As stated earlier, patients (both in the private and public sectors) with known chronic conditions are only receiving appropriate (evidence-based) care about half of the time.

We also know that there is no correlation between health care expenditures and health outcomes—in fact, many years of data analysis (of Medicare information) shows that there is actually an *inverse* correlation—that is, higher expenditures are often associated with worse outcomes.[4] In particular, being in higher intensity care situations (such as a hospital or intensive care unit) can be detrimental to one's health. Hospitalization can be the source of infections and complications. Medical errors in hospitals are estimated to account for 44,000 to 98,000[5] deaths per year in the US.

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[4] Fisher ES et al. The implications of regional variations in Medicare spending. Part 2: Health outcomes and satisfaction with care. *Annals of Internal Medicine* 138(4):288–298.
[5] Institute of Medicine, Crossing the Quality Chasm, 2000

If we go back to the assumption that our public dollars should be used to protect and improve the health of our population, especially those of lower income, then there is a responsibility to know not only how many we are serving and how much is spent, but what is received with those expenditures. The larger "vision" is that the State must and should protect its citizens and be a responsible payer. In order to fulfill this role, it must have and exercise the ability to monitor the quality of services it purchases. This appropriate fiscal responsibility extends beyond fraud and abuse detection. A recent report has already concluded that current State data systems are ill-equipped to address even this limited scope, and recommended improvements in fraud and abuse detection would also improve the ability to improve quality of care in the Medi-Cal program.[6]

To know if quality care is being provided, we need data, and ideally, data already in an electronic (rather than paper-based) format. The current method for most quality data collection includes very time-consuming and expensive reviews of hand-written charts. Beginning in January, 2006, the Centers for Medicaid and Medicare Services launched its first initiative to collect electronic quality data from physicians, data which includes three key measures on diabetes care and is using nationally standardized measures. So, the precedent for requesting and receiving such data now goes beyond private payers and is being set by the federal government as well.

The systematic use of existing data helps us understand what care we are paying for and patients are receiving. The next and more important step is to understand whether patients are doing better as a result of these investments (e.g., Is blood pressure well-controlled? Is kidney function maintained or failing?). The federal government has made commitments to promote the adoption of health information technology and our current Governor has committed to make California a part of this movement. In the next ten years, the plan is for electronic health records to be ubiquitous and able to provide the electronic data to better measure and improve care quality. Until that time arrives, **the State has opportunities now to use existing electronic health information, namely claims, pharmacy and laboratory information.**

Barriers to data analysis

Medi-Cal's current data collection system is based on individual claim transactions, without a way of consistently linking claims to a single beneficiary. For example, pharmacy claims are consistently analyzed by the State to assess opportunities for better pricing and rebates based on drug sales volumes. These same claims, if linked to beneficiaries, could also provide important medication history information, could detect whether a patient is receiving medications which may be toxic if combined.

Data systems in the commercial sector can consistently link individual claims to beneficiaries, and even more importantly can identify the care they receive for specific conditions. Diabetes is one of our most common, growing and costly chronic conditions in California. Medi-Cal should, for example, be able to count the number of its beneficiaries who have diabetes and review the care received. It could identify whether a given patient has received an eye exam over the past

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[6]State of California Attorney General's Medi-Cal Task Force Report, December 2006.

year, whether they have had blood tests to assess their glucose control, etc. Most importantly, **Medi-Cal should be able to determine and assure that the care diabetics receive meets national guidelines for regular glucose tests and interventions to prevent diabetes-related blindness, kidney failure, and heart disease.**

For those of us who work with data and data systems, we know that all electronic information is not alike. In order to use and analyze data, it must be accurate, consistent, and uniform. In other words, clear and detailed specification and standards must be used. Unfortunately, health care is one industry where such data standards are the least well-developed and deployed. This environment is changing as the Office of the National Coordinator for Health Information Technology has been empowering (and funding) organizations to expand and certify these health data standards.[7]

In the meantime, California health plans and provider groups, spurred by pay-for-performance, have moved forward with the development and use of standards for the exchange of pharmacy and laboratory data.[8] Some of the primary lessons learned from this work are: the need to constantly monitor/assure that data is compliant with the standard (which can be done with simple software tools); that a system to update standards should be in place; and payers are the drivers of standards adoption. Specifically, one of the more effective means of promoting adoption is for payers to contractually require the use of specific data standards for reporting and/or billing. **The State as regulator could also have a key role in promoting and assuring adoption and compliance.**

Another key issue is the accuracy of information contained in current data flows. At present, Medi-Cal data is used almost exclusively for billing/payment purposes. The same patient, for example, could be given incorrect diagnoses, which would be more easily detected if those diagnoses were all linked back to the right patient (an error example might be a woman with a diagnosis code for pregnancy who also has a code for hysterectomy—uterus removed). Experience from health plans has shown that the simple act of feeding back information to physicians, can quickly improve the accuracy of coding. Similarly, more sophisticated data systems could provide physicians with a list of their female patients over the age of 50 who have not had a mammogram. In other words, if the data fed back to the physician is clinically useful, and can be used to improve care, then the data accuracy improves over time**.**

The timeliness of the delivery of data, however, is very important for its usefulness and credibility. Data reports which have more than a year delay (as is the current norm in Medi-Cal) are not useful, while data available with a quarter's delay (more the norm in commercial plans) can still be limiting. The more automated the system, and more standardized the data, the more rapidly it can be used effectively.

California's Medi-Cal program currently has its own data formats for billing and reporting purposes, one used by the fee-for-service program and a second one for managed care plans.

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[7] Via the Health Information Technology Standards Panel (HITSP) and the Certification Commission for Health Information Technology (CCHIT).

[8] CALINX and ELINCS standards, see www.calinxstandards.org, www.elincs.org

Neither is fully aligned with existing national standards and the latter is also not consistent with standards used by commercial health plans as dictated by the federal Health Insurance Portability and Accountability Act (HIPAA) of 2003.

The changes and costs required to upgrade these systems are far from minimal, but they are necessary to ensure that the billions of dollars in Medi-Cal services are maintaining or improving health. They would require important up-front investments to bring current data systems into the 21st century, strong technical oversight and leadership. These types of resources are clearly available in California, but may not be plentiful within State government. The systems required are proven and are in use throughout health care. Even an investment of $500 million in a new data system would amount to less that 1.5% of the $34 billion paid in Medi-Cal services alone last year.

State Strategies

Simply shining a light on the data can make improvements happen, and simple measures are powerful. The implementation of data systems and the systematic use of data have helped transform the Veteran's Health Administration Health Care System from what was arguably one of the worst quality health care systems to now one of the best, with higher quality outcomes compared to for Medicare beneficiaries in private care.[9] One of the first things measured was rates of flu shots. Physicians were appalled at the low rates and began to improve them before the VA put any specific improvement programs in place.

A key step towards transforming health care in California is clarifying that the State is making the health of its citizens a priority, and that it is paying attention. **The State must be use the information it collects to know what it is paying for and use that information to drive decisions and payment.** Some precedents have been set within Medi-Cal managed care, such as the use of quality measures to "reward" higher performing health plans with auto-assigned enrollees. The paradigm is not new, but has not been wholly embraced or consistently implemented where opportunities exist.

In the current environment and "buzz" about health reform here in Sacramento, the primary focus has been on gaining or improving access to health insurance. This is an important first step, but it assumes that insurance will provide access to something of value that will improve individual health. **We currently do a poor job in assuring that public insurance programs improve the health of current beneficiaries, especially those who are disabled and/or have chronic conditions—arguably the most vulnerable.**

The key question should be with these health reform activities, are we trying to improve people's health, or give them a "pass" to provide them access to poor health services? In order to answer that question, we should be using and analyzing the data at hand to understand and improve the provision of health services (both in the public and private sectors). We need assure that health reform activities move toward achieving the goals of better health for Californians, rather than do harm to those we are trying to help.

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[9] Jha, et al, New England Journal of Medicine 2003, 348:22: 2218-2227.