Potential Joint Government And Private Sector Initiatives

by Dale H. Yamamoto

Two of the major objectives of the current presidential administration's health reform outline are to reduce health care costs and to improve the quality of health care delivery. This paper provides an outline of three potential initiatives that may be undertaken by the government and the private sector. The first initiative aims at reducing the cost of health care at the provider level. The second initiative provides a means to improve the quality of health care. The third initiative creates a constructive basis for identifying medical best practices to enhance quality. All three initiatives require cooperation amongst many parties to make it successful, but are achievable in the relatively short term (say five years).

These initiatives assume that something similar to a National Health Board described in Tom Daschle's book, *Critical: What We Can Do About the Health-Care Crisis*, is created and would have some input into the organization of the work to be done.

Common Provider Fees

All of the major health plans spend a lot of time contracting with physicians, laboratories and hospitals for their network programs. Ten years ago, there were marked differences in these contracts between the major plans. Today, these differences have narrowed significantly so that many experts consider them a tie in many cases. What has emerged is that the most significant differences exist between the major national carriers and the regional health plans that tend to use rental networks with significantly higher contract rates (lower discounts) with providers.

The first initiative is to create one common contract between all health plans and providers. To accomplish this, a national group will need to provide the ground rules for the new regional contracting groups. The national group will be comprised of a few government personnel, but will be made up mostly of knowledgeable provider contractors from the health plans. The regional contracting groups will be entirely made up of current health plan contractors; they will do the local contracting following guidelines set by the national group.

This initiative will, in the long run, save administrative costs for both health plans and providers. There will be a net reduction in the number of persons responsible for provider contracting within health plans. In fact, health plans will likely only need a handful of people in this area to act as liaisons with the new contracting entity. Many of the current health plan contractors will be employed by the new national or regional groups. Today, physician offices spend an inordinate amount of time on administrative negotiations with health plans on fee payment levels. Under this initiative, providers will deal with one contractor and their fees will be the same for all health plans.

With a universally accepted fee schedule, health plans can also use these fees to pay out-of-network providers. Providers will be able to bill their patients the difference between their customary fee and the network fee. Perhaps a limit could be placed on the amount of this "balance billing."

Next steps for this type of arrangement include pay-for-performance and other quality improvement initiatives that will be easier to implement on a national basis with a common contracting mechanism.

National Data Warehouse

The Holy Grail of health care is defining quality. And, a key to better understanding quality health care delivery is through data. Independently, all health plans are attempting to develop quality metrics, but in many communities of the country they do not have the needed volume of data to calculate statistically significant results. Pooling all data together will allow more robust analysis and hasten the establishment of quality criteria for providers. This type of quality analysis needs to be valuable to both payers and consumers. For payers, quality analysis helps them potentially understand payment mechanisms, quality providers, regional differences and medical management techniques. For consumers, there is a better understanding of practice

and potentially cost differences of providers. So, the primary purpose for creating a national data warehouse will be to develop key quality measures that all parties can agree on; this, in turn, could be communicated to the general population.

Anyone who has attempted to take health care claims data from two or more health plans in order to combine them into one dataset can tell you that it is virtually impossible, especially if the goal is to create a perfect combination of all of the sources. Each health plan has established data parameters that meet its specific needs and has specific coding that it concluded was important to its business. Even for common data fields, the codes are different. The establishment of a national data warehouse will help prescribe uniform data fields and coding.

For confidentiality reasons, this may need to be a governmental operation. Alternatively, it could be a nonprofit group jointly funded by all health plans. The National Health Board will need to be very specific as to the types of studies that this group will be allowed to conduct. Claims data is a critical asset of each health plan and its use will need to be strictly monitored.

Agreements of data sharing will need to be negotiated among the health plans, and limitations of the data need to be recognized. Staffing of the analysis needs to come from the health plans and the medical community—not academia. Researchers will need a strong practical background in order to understand the key drivers of health care costs and quality.

Physician Council

A byproduct of the data warehouse will be reporting of medical procedures. Analysis of data will assist a panel of physicians in identifying "low hanging fruit" of commonly done procedures that have a large variation in cost by community. After identifying a number of these procedures, a better understanding of the reason for the variations will be conducted. For procedures where there are clear best practices that could reduce the variation, targeted communication will be made to the profession.

As medical practice evolves, these best practices need to change to match new technologies so these new guidelines will be constantly reviewed. In addition, new best practices will continuously be added to the guidelines.

In addition, these guidelines should be flexible enough to continue to allow professional judgment of physicians in the treatment of their patients. This flexibility will need to be integrated in the newly developing health information technology systems.

The physician council itself will be made up of practicing physicians and participants will not hold permanent positions. They should serve four- to six-year rotations with a requirement that they were practicing within a recent time period prior to appointment. In order to account for regional differences in practices and to promote physician cooperation, regional councils should also be established. These regional councils would require part-time physician commitments, but again, on a rotation basis. The regional councils will allow a process for local physicians to get counsel and to gain input into the national council.

The creation of the guidelines will better assure good quality health care delivery throughout the country and provide a means to spread new technologies developed in one community to others in a more efficient manner.

Interaction Of Initiatives

The three initiatives described—common provider fees, national data warehouse and physician council—can be carried out independently, but they will work the best if the development is coordinated.

Today, the comparison of health plans is very subjective and difficult to discern even by the best experts in the field. The combination of the three initiatives will help to normalize some of the factors affecting analysis. Many consultants and brokers are placing too heavy an emphasis on the level of discount differences for measuring financial efficiency. Establishing a universal fee schedule eliminates the price discussion in these comparisons. Creating a

national data warehouse will facilitate the ability for actuaries and other analysts to have access to more consistent data from all health plans; this will help them better understand their ability to manage health care utilization. And, the physician council guidelines will help to reduce the volatility in medical practice that is prevalent today so that collected statistics will have greater significance.

Implementing all three initiatives will improve the quality of health care as physicians become more efficient through quicker dispersion of best practices. Health plans will better understand what medical management techniques work best because prices will be more uniform and high frequency procedures are more stable; and beneficiaries will have access to better information about the quality of providers, making them better consumers.

Overall health care costs should stabilize with the contracted pricing process because provider negotiations will be more efficient. Better communicated physician best practices will create more efficient treatments of care and the national data warehouse will assist in creating important metrics to measure costs.

Summary

These three initiatives will create a foundation for true health care reform. The timeframe for fully evolving these measurements will take some time, but five years is a very reasonable expectation to create meaningful metrics. Finally, the creation of the provider council will provide a more efficient means for physicians to communicate best practices for more procedures.

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