MEETINGS ON VALUE IN HEALTHCARE

July 27, 2009

To: President Barack Obama
Secretary Kathleen Sebelius
Director Nancy Ann DeParle
Senator Charles Grassley
Senator Tom Harkin
Congressman Leonard Boswell
Congressman Bruce Braley
Congressman Steve King
Congressman Tom Latham
Congressman Dave Loebsack

CC: Iowa Governor Chet Culver
Iowa Department of Human Services
Iowa Department of Public Health
Iowa Department of Inspections and Appeals
Iowa State Legislative Leadership

Health care reform is once again at the top of the public agenda. In Iowa, and across the nation, policymakers are attempting to reconcile three important goals: control unsustainable cost growth, improve results for consumers, and provide timely and appropriate health care access to all Americans. These expectations are producing a complex, and increasingly contentious, debate.

At this point, the need for a definitive framework to evaluate health care reform has become critical. In our view:

- Costs should not exceed benefits;
- Efficiency should not be advanced ahead of effectiveness or equity;
- Cost controls should not adversely impact patient quality and access;
- Expansion of access and quality improvements should not occur without cost control.

We believe that the primary focus for all policymakers should be improving the value in health care.

Iowa can make a valuable contribution to the health care reform debate because our state is nationally recognized for delivering high value health care. Consequently, with support from the Iowa College of Public Health, the Iowa Healthcare Collaborative, and The Concord Coalition, we convened a diverse blend of Iowa health care providers, purchasers, payers, patient advocates, and policy analysts for several meetings this year to examine the issues around health reform and to discuss how to ensure value in health reform.[1]

Attached to this letter are a set of value-based principles, derived from the advice and input of the individuals who participated, and offered to facilitate policymakers' understanding of how focusing on value can improve the system. They are based on examples of success of the high-value care provided in Iowa which, we believe, can be replicated in regions and states across the nation.

[1] Please see the Iowa Committee for Value in Healthcare Participation Roster (attached). Participants of the Iowa Committee for Value in Healthcare joined together to discuss health reform because of the importance they attach to achieving value-based health care reform, given their experiences creating a valuable health care system in Iowa. The "Principles for Value-Based Health Care Reform" offered here reflect and summarize the ideas expressed in our Committee meetings but do not necessarily reflect the views of each individual participant or the organizations with which they are affiliated.

We do not claim to have found all of the answers to the complex challenges we face. We are convinced, however, that policymakers, interest groups, and health care stakeholders must commit to working together — and sacrificing together — to achieve an improved system.

We seek your support in this effort to have value be a primary focus for health system reform. Unless quality is improved and cost reduced, we believe expansion of coverage to all will only make a broken system worse. Our principles are outlined on the following pages. In September, we will produce a report that illuminates these guidelines with anecdotes and additional data about the "Iowa experience." Our work is not intended to be as definitive as it is descriptive. We trust you will find it useful.

Sincerely,

Christopher G. Atchison
College of Public Health
University of Iowa

Thomas C. Evans, MD
President
Iowa Healthcare Collaborative

Sara Imhof, PhD
The Concord Coalition
Midwest Regional Director

MEETINGS ON VALUE IN HEALTHCARE

Participation Roster

The Iowa College of Public Health, the Iowa Healthcare Collaborative, and The Concord Coalition convened two public meetings at which participants discussed with national and local experts ideas for national health reform, with a focus on fiscal challenges associated with the system and the importance of increasing the value of dollars spent in the health system. Participants met for a third meeting to summarize key concepts from the first two meetings and to obtain advice and input from participants for the drafting of the "Principles for Values-Based Health Care Reform" document.

April 2, 2009: Health Care Financing and Reform

Karin Peterson -- Pella Corporation
John Aschenbrenner -- Principal Financial
Chris Atchison – UI College of Public Health
John Brooks – UI College of Pharmacy
Lisa Charnitz – SPHR, Iowa State SHRM Council
Stacey Cyphert – UI Health Care
Bery Engebretsen – Primary Health Care, Inc.
Tom Evans – Iowa Healthcare Collaborative
Eugene Gessow – Iowa Department of Human Services
Sara Imhof – The Concord Coalition
Brian Kaskie – UI College of Public Health
Mike Kitchell – Iowa Medical Society and McFarland Clinic PC
Bruce Koeppl – AARP-Iowa
Eric Kohlsdorf – Iowa Association of Health Underwriters and Prisma LLC
Tom Newton – Iowa Department of Public Health
Kirk Norris – Iowa Hospital Association
Ronald R. Reed – Mercy Hospital Iowa City
Peter Roberts – Wellmark
Elliott Smith – Iowa Business Council
Karon Perlowski – Child and Family Policy Center

May 28, 2009: Value in Health Care: Lessons Learned in Iowa

William Applegate -- Des Moines University
John Aschenbrenner, Principal Financial
Chris Atchison – UI College of Public Health
Greg Boattenhamer – Iowa Hospital Association
John Brooks – UI College of Pharmacy
Anthony Carroll – AARP- Iowa
Stacey Cyphert – UI Health Care
Bery Engebretsen – Primary Health Care, Inc.
Tom Evans – Iowa Healthcare Collaborative
Carrie Fitzgerald – Child and Family Policy Center
Sara Imhof – The Concord Coalition
Brian Kaskie – UI College of Public Health
Mike Kitchell – Iowa Medical Society and McFarland Clinic PC
Eric Kohlsdorf – Iowa Association of Health Underwriters and Prisma LLC
Dan Kueter – UnitedHealth Illinois and Iowa
Bill Leaver – Iowa Health System
Karin Peterson—Pella Corporation
Ronald R. Reed – Mercy Hospital Iowa City
Elliott Smith – Iowa Business Council

July 10, 2009: Principles derived from the "Iowa Experiences" to Guide National Reform

William Applegate -- Des Moines University
Chris Atchison – UI College of Public Health
John Brooks – UI College of Pharmacy
Anthony Carroll – AARP- Iowa
Lisa Charnitz – SPHR, Iowa State SHRM Council
Bery Engebretsen – Primary Health Care, Inc.
Tom Evans – Iowa Healthcare Collaborative
Carrie Fitzgerald – Child and Family Policy Center
Dawn Gentsch –Iowa Public Health Association
Sara Imhof – The Concord Coalition
Brian Kaskie – UI College of Public Health
Mike Kitchell – Iowa Medical Society and McFarland Clinic PC
Eric Kohlsdorf – Iowa Association of Health Underwriters and Prisma LLC
Rick Miller –Wellmark
Tom Newton—Iowa Department of Public Health
Karin Peterson—Pella Corporation
Ronald R. Reed – Mercy Hospital Iowa City
Elliott Smith – Iowa Business Council
Shannon Strickler –Iowa Hospital Association
Jennifer Vermeer –Iowa Medicaid Enterprise

IOWA COMMITTEE FOR VALUE IN HEALTHCARE

Principles for Value-Based Health Care Reform

In their daily transactions, people seek to maximize value. We strive to purchase goods and services that offer the greatest benefit. The people who provide goods and services attempt to contain costs while offering high quality to the greatest number of consumers. The goal for health reform should be no different. Value in health care means higher quality care at lower cost. Ample evidence exists that improving value is possible, but not without a transformation in provider practices, purchaser coverage agreements, and patient expectations with a commitment by all to reduce costs for long-term system sustainability. As basic as this sounds, many incentives in today's health care system thwart efforts to reach this goal. For example, fee-for-service provider payments, third-party coverage for consumers and unlimited budgets for public programs all contribute to inefficiencies in the demand and supply of health care. As a result, our nation spends roughly two-times more per capita on health care than other developed nations without producing better results. A system that spends too much and achieves too little is a system that does not produce good value.

So far, the health reform debate has focused largely on increasing access to quality, affordable, health care for all Americans – a goal that the Committee supports. However, simply expanding access to the current system would exacerbate its problems. Costs would rise and quality might not improve. That is why our primary recommendation is that any effort to change the health care system be explicitly linked with value. Based on the Iowa experience, reform efforts should specifically embrace the following principles:

Principle #1: Fiscal sustainability

The Committee for Value in Healthcare feels strongly that rapid health care cost growth makes our current health care system fiscally unsustainable. We cannot pretend that resources are unlimited or that sure and swift savings will come from investments in comparative effectiveness research, health care technology and prevention programs. These are all promising strategies that should be included in any health care reform legislation, but they come with significant up-front costs that must be paid for. Moreover, their potential to significantly reduce long-term costs is uncertain. We therefore support the pay-as-you-go (PAYGO) approach to financing health care reforms over the first 10 years, and we further urge that mechanisms be put in place to monitor expectations of long-term savings. This could be done by giving the Medicare Payment Advisory Council (MedPAC) additional powers to implement its recommendations or by creating a new entity within the executive branch.

Principle #2: Innovation through Collaboration

The Committee feels strongly that the future of health care will require a new level of innovation that can be best achieved by high-levels of formal and informal collaborations among all health care stakeholders. Iowa's health care system is shaped by relatively lower reimbursement rates and tight physician supply and has required providers to continuously employ innovative practices to stay in business and provide Iowans the care they need and deserve. Key to these innovations is a sharing and collaboration among providers, patients, payers and purchasers with a focus on execution for value within fiscal and workforce constraints. The degree of collaboration and communication between and within Iowa's hospitals and physicians is both remarkable and notable, and has resulted in the reduction of redundant and inappropriate care and high-quality patient outcomes and safety. The Committee believes similar environments emphasizing provider partnerships and innovation can be replicated in lower-quality, higher-cost regions across the nation if all stakeholders receive the proper incentives and are held accountable for creating such an environment through shared savings and related mechanisms.

Principle #3: Primary Care Transformation

The Committee feels strongly that elevating the role and use of primary care—and the ability to more effectively coordinate with acute-care specialty services and long-term or community-based care—is essential for the transformation of our health care system. Health care providers and state governments have struck proactive poses relating to the need to transform primary care. This transformation emphasizes the notion that the health care system should provide comprehensive well-care and health management for a population and applying more intensive service use for those with corresponding levels of clinical need. It facilitates partnerships between patients and the health care system in a way that a person's total care and health can be optimized. Further, it emphasizes a commitment to ensuring that a viable workforce of appropriate providers (medical, nursing and ancillary) exists to meet the needs of all Americans today and well into the future. This is done in a way that provides appropriate care and considers cost-effectiveness at the patient level. Iowa's policy landscape has emphasized this role for primary care for some time, as demonstrated through public health agency's focus on disease prevention and health promotion, the establishment of the Iowa Safety Net Collaborative, and through private collaborative initiatives emphasizing the adoption and integration of patient-centered medical home concepts into everyday physician practice (e.g., the TransforMed model of care).

Principle #4: Societal Commitment to Prevention and Wellness

The Committee feels strongly that prevention and wellness must be included in governmental and business policy reform and third-party coverage arrangements. Similar to the successful story of Safeway, Inc. undertaking aggressive corporate wellness initiatives, Iowa businesses have also achieved success with health promotion and disease prevention. By redesigning its benefit plan in a way that provides incentives to employees to engage in preventative care and reduce risky health behaviors, one large company reduced its health insurance costs and at the same time improved employee satisfaction and clinical outcomes. While the extent to which prevention and wellness reduce health care costs as realized by the federal government may not be significant, more immediate and tangible returns-on-investment may be observed by American businesses. To that end, the Committee believes encouraging healthy behavior can increase value in our health care system and is important at individual and societal levels, and all levels in between.

Principle # 5: Engaged and Responsible Health Care Consumers

The Committee feels strongly that health reform initiatives should encourage and set expectations for a more active role for the health care consumer. Iowa stakeholders understand that for consumers to assume greater responsibility they must have appropriate access to targeted information about costs, risks, benefits and outcomes of interventions, they must be actively involved in the decision-making process with their providers to select interventions of most value, and they must participate in financing their health care. Individuals should be encouraged to engage in health promotion to stay healthy and if sick to adhere to treatment plans to best manage their disease. Iowa's public and private health sectors are committed to creating such a culture of consumer engagement, focused on health literacy. Specifically, the Iowa Medicaid program reaches out to children and their families early in life to provide them both the needed coverage and the skills for health literacy and healthy behaviors over their lifetime. While achieving increasing patient satisfaction and controlled costs, Iowans have also demonstrated a very high level of individual responsibility for their own coverage decisions, as demonstrated by Iowa's position as one of the top states nationally in the purchase of individual health insurance.

While not unique to Iowa, the Committee also supports as essential to health reform legislation the following:

- **Payment reform driven by quality and efficiencies**
  We believe payment reform is essential for the long-term health of the health care system. Providers who find ways to provide the highest quality care for the lowest amount of resources should be rewarded. Incentives should be directed toward increasing the use of evidence-based

protocols, primary care and prevention, and engaged consumer participation in intervention decisions. Examples we would support include a bundling of payments to providers for episodes of care and the use of some form of accountable care organizational scheme to align payments with results.

- **The creation of a technology-based infrastructure for improved outcomes and system efficiencies**
  This year's stimulus bill has designated approximately $30 billion for the adoption and implementation of a meaningful use of Health Information Technology. The Committee feels meaningful use of HIT includes provisions for interoperability and connectivity for all users. Further, the infrastructure must be based on a set of standards including common population and quality outcomes measures to maximize its potential for assisting in the creation and dispersion of comparative effectiveness research—upon which all providers, payers, and consumers can be held accountable to—and for reducing operating costs while continuously evaluating the system for future improvements.