

# STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS  
OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

The National Academy for State Health Policy (NASHP) convened a roundtable of state and national health policy leaders in October 2009 to discuss opportunities for states and the federal government to develop congruent policies to promote patient safety. This brief summarizes recommendations that emerged from that meeting. Participants identified four criteria to use in selecting issues for state-federal coordination: (1) degree of readiness for change, (2) symbolic value and potential to send broad messages about priorities, (3) potential to avoid harm from non-aligned policies, and (4) potential for cost savings. Considering these criteria, participants recommended three topics as especially worthy of future dialogue: reducing healthcare-associated infections (HAIs), decreasing preventable hospital readmissions, and avoiding hospitalizations for ambulatory care-sensitive (ACS) conditions.

NATIONAL ACADEMY  
for STATE HEALTH POLICY

# Briefing

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## Opportunities and Recommendations for State-Federal Coordination to Improve Health System Performance: A Focus on Patient Safety

BY JASON BUXBAUM

The federal government and the states—as regulators, purchasers, and providers of health care—have various levers available to improve health care quality. When federal and state policies are designed to use these levers in a coordinated manner, the influence of both levels of government on the quality of care is enhanced. To explore potential topics where congruent policies may be developed and to consider ways to foster collaborative policy development going forward, the National Academy for State Health Policy (NASHP) convened a meeting of high-level state and national leaders in October 2009.

Participants at that meeting identified four criteria to use in selecting issues for future dialogue around state-federal coordination: (1) degree of readiness for change, (2) symbolic value and potential to send broad messages about priorities, (3) potential to avoid harm from non-aligned policies, and (4) potential for cost savings. Considering these criteria, participants recommended three topics as especially worthy of future dialogue: reducing healthcare-associated infections (HAIs), reducing preventable hospital readmissions,

and reducing hospitalizations for ambulatory care-sensitive (ACS) conditions. Participants suggested using meetings and focused learning collaboratives to foster state-federal coordination around these topics.

Meeting participants identified the following recommendations to maximize the efficacy of efforts to improve state-federal policy alignment:

- **Be patient-centered.** Recognize the centrality of patients and families at all times, act in their interests, consider their preferences, and include them in discussions.
- **Cultivate a sense of urgency.** Build momentum by highlighting connections across issue areas, such as the need to improve value and quality of care in order to avoid higher costs associated with increased access to care.
- **Set reasonable goals.** Recognize that precise policy alignment may not be essential or even desirable, as long as policies do not conflict.
- **Avoid duplicative efforts.** When possible, partner and collaborate with allied agencies and organizations.
- **Be inclusive.** Include stakeholders, such as providers and private payers, in discussions.
- **Engage providers and provider organizations.** Consider providing support to organizations willing to experiment and innovate to enhance important public goals.
- **Consider potential undesirable consequences** of policy change, and take action to reduce the likelihood of occurrence.
- **Avoid holding back leading states;** set floors rather than ceilings when possible. Variation can be worthwhile.
- **Benchmark against evidence and nationally recognized standards,** as they frequently provide valuable guidance and offer credibility.

## INTRODUCTION

In 1999, the Institute of Medicine’s (IOM) report *To Err is Human* estimated that as many as 98,000 deaths per year occur in the United States due to preventable medical errors.<sup>1</sup> Ten years later, Consumer Union’s Safe Patient Project has “give[n] the country a failing grade on progress,” deplor-

ing what it has described as continued “needless death” and a failure to meet goals laid out in the IOM report.<sup>2</sup> A recent *Health Affairs* article notes “unmistakable progress,” but concludes that the nation’s “overall grade for progress in patient safety” ought to be a B-.<sup>3</sup>

Both the federal government and states have various levers available to improve the nation’s patient safety grade – public health promotion and consumer education, professional licensure requirements, adverse event reporting systems, support to providers to implement best practices, and purchasing policies are but five such tools. The purchasing lever is particularly significant: Medicaid programs and the Children’s Health Insurance Program (CHIP), administered by the states, provide medical coverage for about 14.1 percent of Americans, while the federal Medicare program covers about 12.4 percent of Americans.<sup>4</sup> With respect to expenditures, Medicaid and Medicare account for approximately 45.5 percent of national hospital care spending.<sup>5</sup> According to *To Err is Human*, these large public purchasers are “well positioned to exert considerable leverage in the marketplace.”<sup>6</sup>

Many public (and private) payment systems currently reimburse for care related to adverse events that harm patients. Patient safety advocates see payment system reform as an opportunity to motivate change at the practice-level and reduce the occurrence of preventable adverse events. To this end, the federal Medicare program and public purchasers in twelve states have implemented nonpayment or reduced payment policies for some types of adverse events.<sup>7</sup>

This congruence of policies across levels of government offers the potential to increase the influence of government on the quality of care. By acting in concert, the federal and state governments can maximize their capacity to drive change at the clinical level through reimbursement policies.

## PROJECT METHODOLOGY

The National Academy for State Health Policy (NASHP) convened a meeting of high-level state and national leaders in October 2009 to discuss opportunities to align state and federal policy to promote patient safety and quality improvement. In attendance were officials from federal agencies, state Medicaid offices, state employee benefits agencies, governor’s health policy offices, and other state agencies, as well as other patient safety and quality improvement experts. NASHP began the meeting with a dialogue around the purpose and mechanics of policies related to reduced

payment for adverse events. A separate issue brief addresses these findings.<sup>8</sup> The conversation then moved to a discussion regarding the role of state-federal dialogue more broadly, and the potential of alignment to enhance health system improvement efforts. The meeting concluded with a brainstorming session regarding other issues that may be appropriate for state-federal coordination going forward.

## THE VALUE OF STATE AND FEDERAL AGENCY COORDINATION

The value of state and federal agency coordination can extend well beyond payment reform to address a variety of system performance issues. State and federal officials can deliver a consistent and effective message across agencies and levels of government to motivate change and overcome inertia. Shared focus and shared emphasis can be of great value.

There are some areas where federal and state governments bring unique resources, and can enhance the success of a health policy in ways that their counterparts may not be able to. The federal government can offer unique assistance to the states in several respects:

**Financial resources to fund projects.** Programs such as the Agency for Healthcare Research and Quality’s (AHRQ) Chartered Value Exchange or the Office of the National Coordinator for Health Information Technology’s (ONC) state health information exchanges provide critical resources that would be unavailable through state funding for states to implement innovative programs.

**Momentum.** National attention can raise the profile of an issue to a greater extent than attention from state officials alone typically can. In the context of reduced payment for adverse events, for instance, Medicare’s announcement of its policy to reduce payment for certain hospital-acquired conditions (HACs) drew a *New York Times* front page headline.<sup>9</sup> State announcements of nonpayment policies have generally not garnered this level of attention.

**Unique research abilities, expertise, and experience.** State agencies may find it easier to “piggyback” on work done by federal officials or financed by federal agencies than to work on their own and develop unique and potentially contradictory policies.<sup>10</sup> In developing a nonpayment policy, for instance, Missouri’s Medicaid program used Medicare’s list of Medicare HACs (and added six additional events that do not

appear on the Medicare list). Additionally, federal agencies maintain large healthcare-related datasets that may be useful as states attempt to benchmark against national rates and track progress over time.<sup>11</sup>

Conversely, states can offer federal agencies unique capabilities:

- **Practical implementation.** Often, state actors are better positioned to build consensus for change among providers, patients, and other stakeholders and offer technical assistance at the practice-level. State experience working with provider groups and familiarity with implementation can turn national aspirations into local realities.
- **Opportunity to test options and derive lessons.** States frequently view themselves as laboratories of innovation exploring solutions to problems, and can offer tested solutions that may be applicable to federal initiatives. While Medicare’s reduced payment policy preceded most of the 12 states’ nonpayment policies, the diversity of state nonpayment lists and event identification techniques offers the possibility to inform federal efforts going forward.
- **Regulation of health care providers and facilities and reporting requirements.** States oversee the licensure of health care facilities and professionals. They can require reporting of certain conditions and events, and can take disciplinary action when warranted. As regulators, many states now require the collection and reporting of certain quality metrics from their hospitals. States use these public reporting requirements to drive accountability and improvement.<sup>12</sup> These efforts have the potential to motivate change by making public what was once inaccessible, and some states have made certain quality improvement indicators a condition of hospital licensure.
- **Ability to provide anti-trust protection for quality improvement data sharing.** Under the state action doctrine, states can convene private payers and others to further quality improvement or another “clearly articulated state policy.”<sup>13</sup> Pennsylvania, for instance, has used this authority in implementing its patient-centered medical home pilot.<sup>14</sup>

## CRITERIA TO GUIDE THE SELECTION OF ISSUES FOR STATE–FEDERAL COORDINATION

During the roundtable, NASHP held a discussion regarding best practices for state-federal dialogue around health systems performance. Although the conversation centered around patient safety issues, it quickly became clear that there is no shortage of potential topics for state-federal dialogue to improve health care quality. Roundtable participants agreed that issue prioritization is essential given resource constraints, and they identified several criteria to consider in prioritizing issues for future dialogue.

- **Degree of readiness for change:** Roundtable participants noted that issues for discussion ought to be sufficiently advanced to have already garnered some enthusiasm and momentum among policymakers and other leaders. At the same time, participants recognized that ideal issues for discussion and dialogue are in early enough stages of development that policies are still malleable. Opportunities to coordinate policy in a particular issue area may be fleeting.
- **Symbolic value and potential to send broad messages about priorities:** CMS’s announcement of Medicare’s HAC reduced payment policy emphasized that the agency is moving towards purchasing health care value and quality, not just a quantity of services. The selection of a particular issue area for state-federal dialogue can send messages about larger priorities, goals, and values.
- **Potential to avoid harm from non-alignment:** In certain issue areas, the absence of state-federal coordination may lead to adverse consequences. In designing their adverse event nonpayment policy, officials with New York’s Medicaid program recognized an undesirable scenario: in the case of a dual eligible, New York’s Medicaid program as the “payer of last resort” might be expected to pay in full for a service not paid in full by Medicare under the Medicare adverse event reduced payment policy. This situation could undercut financial incentives for hospitals to make practice safer while saddling the State with new expenses. New York’s policy averts this possibility by specifying that Medicaid will not pay in these situations. Issues in which coordination is needed to avoid

undermining other efforts are especially worthy of state-federal dialogue.

- **Potential for cost savings:** Researchers have estimated that between \$325 and \$425 billion of care purchased each year in the United States is not evidenced-based or is provided due to practitioner error or inefficiency.<sup>15</sup> Some of this care harms patients, or exposes them to risk of harm without the reasonable likelihood of benefit. Better preventive care could avert the need for between \$25 and \$50 billion of medical spending each year.<sup>16</sup> By paying for only the right care, at the right time, purchasers see the potential for great savings.

Setting priorities for dialogue on the basis of anticipated savings has the benefit of generating enthusiasm and momentum for change among policymakers, especially elected officials. Washington State’s value-based approach to Medicaid coverage determination, whereby the state has refused to pay for certain procedures that are not evidence-based and do not offer a reasonable likelihood of benefit, was cited as an example of this strategy.<sup>17</sup> However, participants cautioned that a dollar-oriented approach alone can promote an adversarial relationship with stakeholders and lead some providers and hospitals to focus on meeting requirements rather than meaningfully changing the way care is delivered. For instance, an aggressively enforced reduced payment policy that tries to derive significant savings while failing to provide support for practice transformation might encourage providers and hospitals simply to overcode present on admission (POA) conditions.<sup>18</sup> This type of gamesmanship does little to improve patient care.

## PRIORITIES AND RECOMMENDATIONS FOR STATE–FEDERAL COORDINATION

Having identified the principles mentioned above, roundtable participants brainstormed a list of patient safety and quality of care issues that may benefit from state-federal dialogue to promote alignment. There was agreement that even when initial congruence is achieved, there likely will be a need for continued discussion as experience accrues. For example, additional discussions regarding reduced payment for adverse events and conditions would be worth-

while, especially as state and federal payers consider adding additional events and conditions and extending policies beyond the hospital setting. Other topics mentioned ranged from avoiding unnecessary caesarean sections to encouraging appropriate end of life care to promoting centers of excellence (see Table 1).<sup>19</sup>

**TABLE 1: TOPICS SUGGESTED FOR STATE-FEDERAL DIALOGUE TO PROMOTE POLICY ALIGNMENT**

Discouraging medically unnecessary <b>birth inductions and caesarean sections</b>
Improving <b>care transitions</b>
Promoting <b>centers of excellence</b>
Ensuring <b>compatibility of health information exchange systems</b>
Addressing issues specific to <b>dual eligibles</b>
Improving <b>end of life care</b>
Implementing <b>fundamental payment reform</b>
Increasing <b>generic medication usage</b>
Reducing <b>healthcare-associated infections (HAIs)</b>
Reducing unnecessary <b>high tech imaging</b>
Reducing <b>hospitalizations for ambulatory care-sensitive (ACS) conditions</b>
Promoting <b>integrated delivery systems</b>
Promoting the <b>patient-centered medical home</b>
Improving <b>patient safety for children</b>
Reducing <b>preventable hospital readmissions</b>
Reducing the <b>occurrence of pressure ulcers</b>

When asked to prioritize the identified topics, the following three topics were selected:

- **Reducing healthcare-associated infections (HAIs):** The Centers for Disease Control and Prevention (CDC) defines an HAI as an infection that a patient “acquire[s] during the course of receiving treatment for other conditions within a healthcare setting.”<sup>20</sup> HAIs are one of the top ten causes of mortality in the United States, and payers could save billions of dollars by eliminating

them.<sup>21</sup> State-federal dialogue could center on the role of payment strategies in encouraging the adoption of evidence-based practices that have been demonstrated to prevent HAIs, save lives, and save money.

- **Reducing preventable hospital readmissions:** Multiple studies have shown that certain case management methods can reduce hospital readmission rates.<sup>22</sup> A recently published study found hospital utilization within 30 days of discharge was reduced by about 30 percent for patients receiving a package of case management services at a Boston hospital. On average, participants receiving the intervention saved payers about 33 percent relative to a control group.<sup>23</sup> State-federal dialogue could center on the creation of reimbursement systems that reward valuable “in-between care” that keeps people out of the hospital and saves payers money. This could take the form of extra payment to encourage an entity to take ownership of care during the transition process. Dialogue could also further efforts to standardize readmission definitions and reporting.
- **Reducing hospitalizations for ambulatory care-sensitive (ACS) conditions:** AHRQ defines ACS conditions as “conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.”<sup>24</sup> Examples of ACS conditions include diabetes, hypertension, adult asthma, and congestive heart failure. According to a 2003 study, over half of all emergency department (ED) visits nationally are for ACS conditions; this figure rose to 70 percent of ED visits when examining just Medicaid patients.<sup>25</sup> State and federal officials see opportunities for long-term savings and healthier populations by investing in primary care that can avoid these costly hospitalizations. State-federal dialogue can center on developing and aligning payment mechanisms that reward unneeded care that is averted – and not just care that is delivered.

**TOOLS AND MECHANISMS TO SUPPORT STATE-FEDERAL COORDINATION**

Having identified topics for future dialogue, roundtable participants were asked to consider tools and mechanisms to promote state-federal coordination. Participants agreed that two mechanisms deserve particular attention:

- **Meetings and roundtables:** Participants found the high-level roundtable NASHP hosted to be a model

worth replicating. Officials reported that the face-to-face meeting provided a valuable forum for promoting coordination, cooperation, and alignment.

- **Learning collaboratives:** Meeting participants praised peer-to-peer learning formats, such as the Institute for Healthcare Improvement’s (IHI) Breakthrough Series Collaborative<sup>26</sup> and NASHP’s Assuring Better Child Health and Development (ABCD) initiative, funded by The Commonwealth Fund.<sup>27</sup>

Roundtable participants also found environmental scans that present baseline data helpful in setting the stage for more interactive alignment discussions.

Efforts to institutionalize mechanisms to promote state-federal coordination merit careful consideration. This institutionalization could take many forms:

- Ongoing, regularly scheduled meetings of high-level officials.
- Routinely seeking input from state and federal counterparts, through formal or informal means, when considering, formulating, or revising policies.

## MAXIMIZING THE EFFICACY OF EFFORTS TO IMPROVE STATE–FEDERAL POLICY ALIGNMENT

Asked to identify factors that can promote successful state-federal policy alignment, roundtable participants identified several recommendations.

- **Be patient-centered.** Recognize the centrality of patients and families at all times, act in their interests, and consider their preferences. Include consumer representatives in quality improvement discussions.
- **Cultivate a sense of urgency.** National efforts to expand coverage could expose many more patients to expensive and avoidable adverse events. A national discussion about financing a coverage expansion can thus lend urgency to a discussion about quality improvement.
- **Set reasonable goals,** understanding what dialogue can and cannot accomplish. Participants should set clear goals, but recognize that precise policy alignment may not be essential or even desirable. In those cases, compatibility and the avoidance of conflicting goals and incentives can be worthwhile endeavors.

- **Avoid duplicative efforts.** Partnerships and collaboration with allied agencies and organizations can maximize the efficacy of all parties’ efforts.
- **Be inclusive.** For instance, with respect to reduced payment for adverse events, private payers may be willing to align with public payers, and all involved may find such an arrangement advantageous.
- **Engage providers and provider organizations** during and after high-level meetings of public agency officials. Participants noted that even well-coordinated and well-aligned government efforts have their limits with respect to health system transformation. Agencies may consider providing support to organizations willing to experiment and innovate to enhance important public goals.
- **Consider potential undesirable consequences.** As discussed above, some meeting participants voiced concerns that, for example, reduced payment for adverse event policies could encourage gamesmanship on the part of practitioners (e.g., POA coding changes) rather than true practice change. Anticipating this possibility, participants emphasized the importance of providing support for actual practice transformation; payment reform alone is insufficient.
- **Avoid holding back leading states;** set floors rather than ceilings when possible. For instance, with respect to reduced payment for adverse events, it is preferable to set a minimum standard rather than a single uniform policy that could limit the ability of leading states to innovate. Variation can be worthwhile.
- **Benchmark against evidence and nationally recognized standards.** In the case of reduced payment for adverse events, the National Quality Forum’s list of “Serious Reportable Events” served as a helpful starting point for many payers in crafting policies.<sup>28</sup>

## CONCLUSION

Given the landscape of dispersed authority in health care policymaking, coordination among state and federal officials is especially essential. Going forward, three particularly promising opportunities for state-federal dialogue to promote coordination are: reducing healthcare-associated infections, reducing preventable hospital readmissions, and reducing emergency department visits for ambulatory care-sensitive

conditions. State and federal officials can benefit from further meetings, roundtables, and learning collaboratives. Efforts to opportunities to set a shared agenda for quality improvement efforts, share best practices, and align policies through institutionalize this process merit careful consideration.

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## ENDNOTES

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**NATIONAL ACADEMY**  
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**About the National Academy for State Health Policy:**

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: [www.nashp.org](http://www.nashp.org).

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**Portland, Maine Office:**

10 Free Street, 2<sup>nd</sup> Floor, Portland, ME 04101  
Phone: [207] 874-6524

**Washington, D.C. Office:**

1233 20th Street NW, Suite 303, Washington, D.C. 20036  
Phone: [202] 903-0101