



Improving Healthcare Value: Proven Ideas States Can Deploy Now

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@LynnQuincy @HealthValueHub

Altarum

A 450-employee, nonprofit health services research organization that creates and implements solutions to advance health among vulnerable and publicly insured populations.



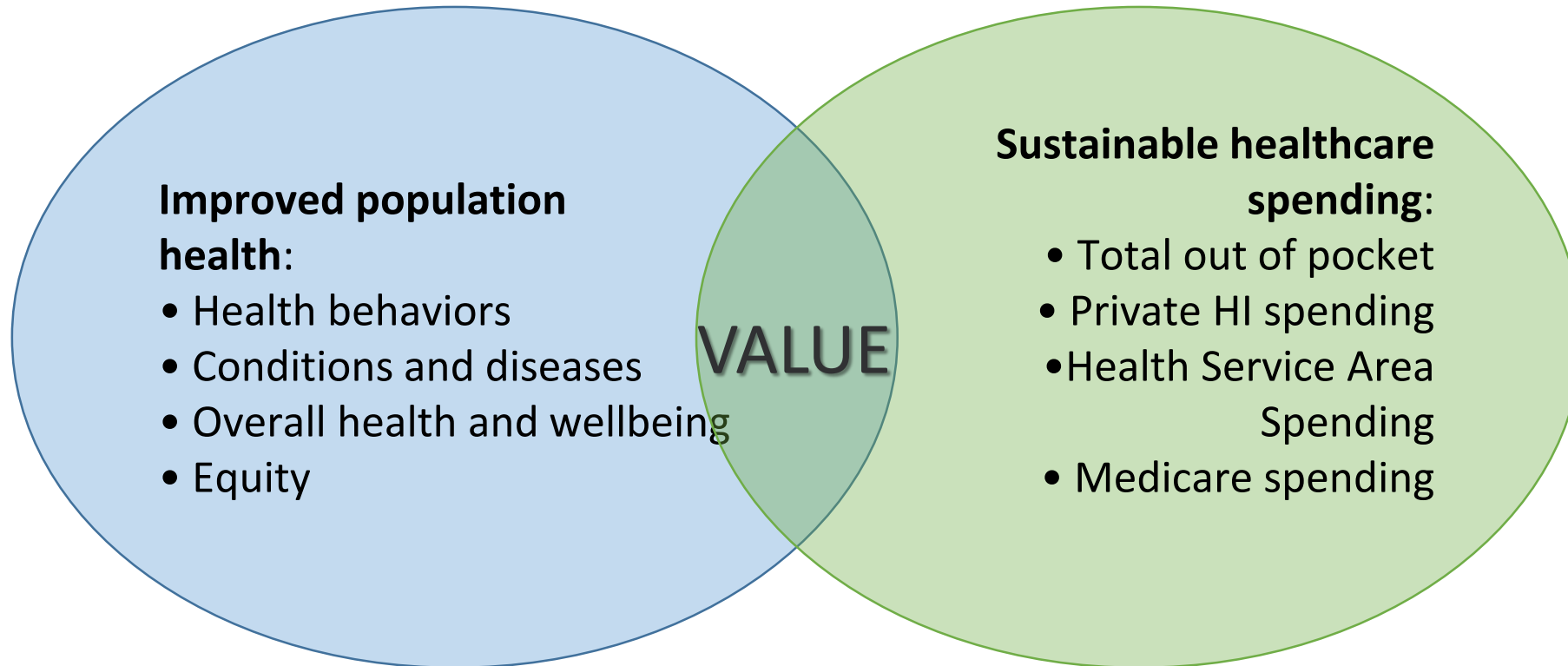
What is the Healthcare Value Hub?



With support from the Robert Wood Johnson Foundation:

- We provide FREE resources to help advocates and others work on healthcare value issues.
- The Healthcare Value Hub reviews evidence to identify the policies and practices that work best.
- We support and connect consumer advocates across the U.S., providing comprehensive fact-based information to help them advocate for change, and connect them to researchers and other resources.

Key HPIO Dashboard Concepts:



What is healthcare value?



A health system that
allocates resources fairly and wisely, and
delivers care that is
equitable, effective, affordable and patient-centered.

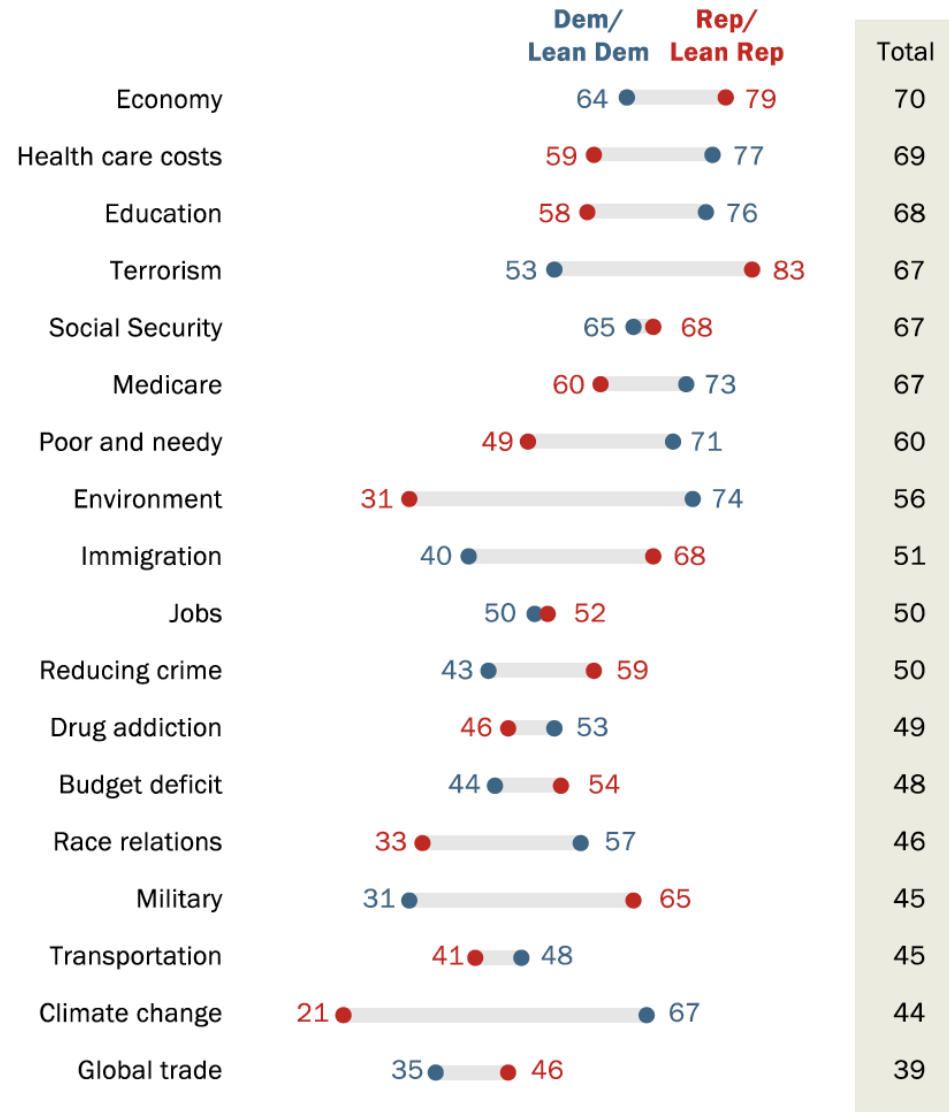
Coverage and Healthcare Value are Intertwined



- Coverage is the top factor in improving access to care, coordination of care and quality outcomes.
- Better healthcare value is essential to sustaining coverage gains.
- Reforms designed to produce better healthcare value (provider payment reform, etc.) rely on a population with coverage.

Partisans far apart on the importance of many issues, including the environment and strengthening military

% who say ____ should be a top priority for Trump and Congress this year

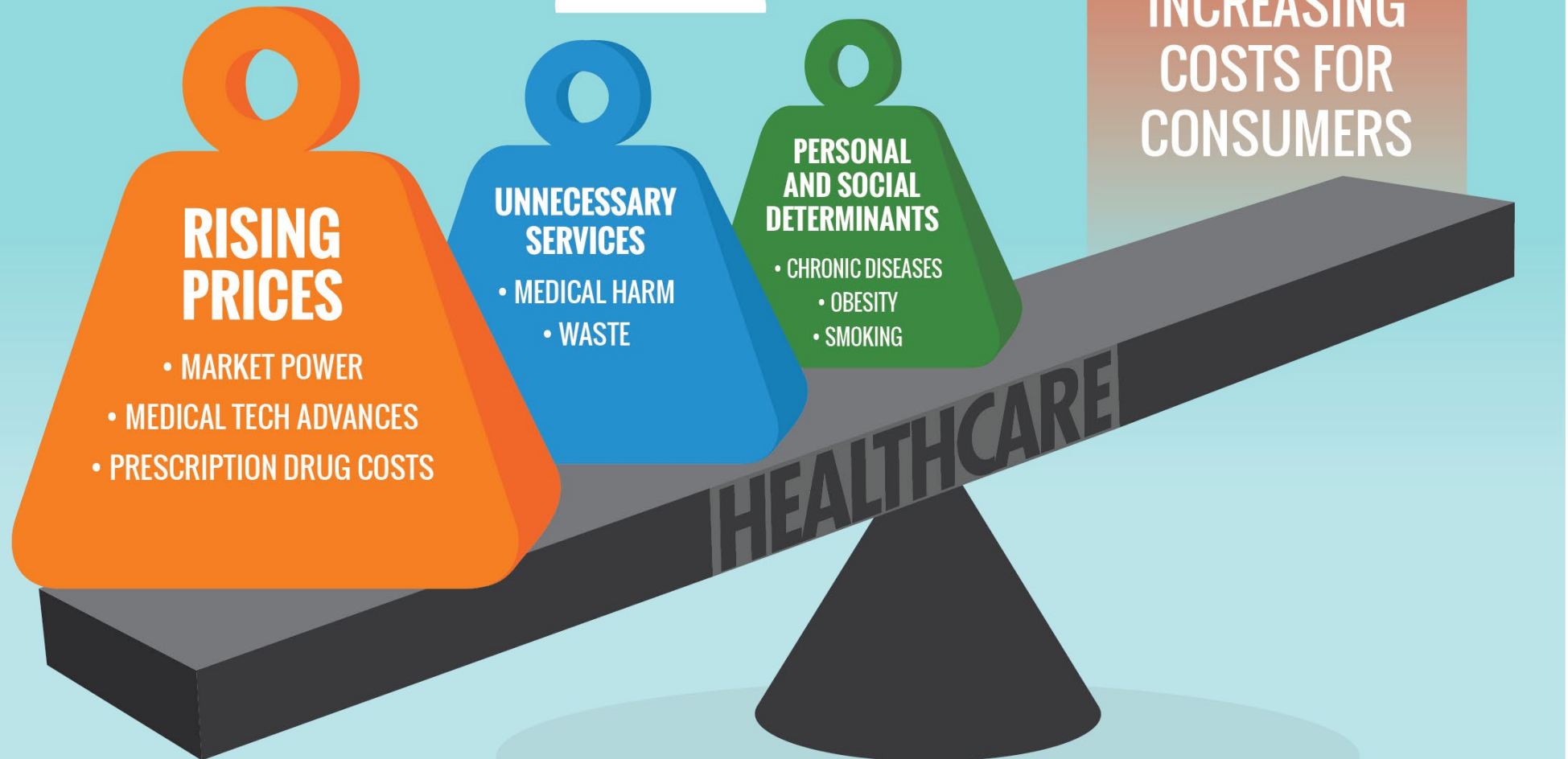


See also: KFF Health Tracking Poll (November 2018) and Gallup (November 2, 2018)

Source: Survey of U.S. adults conducted Jan. 9-14, 2019.

WHAT DRIVES HEALTHCARE SPENDING?

COST DRIVERS

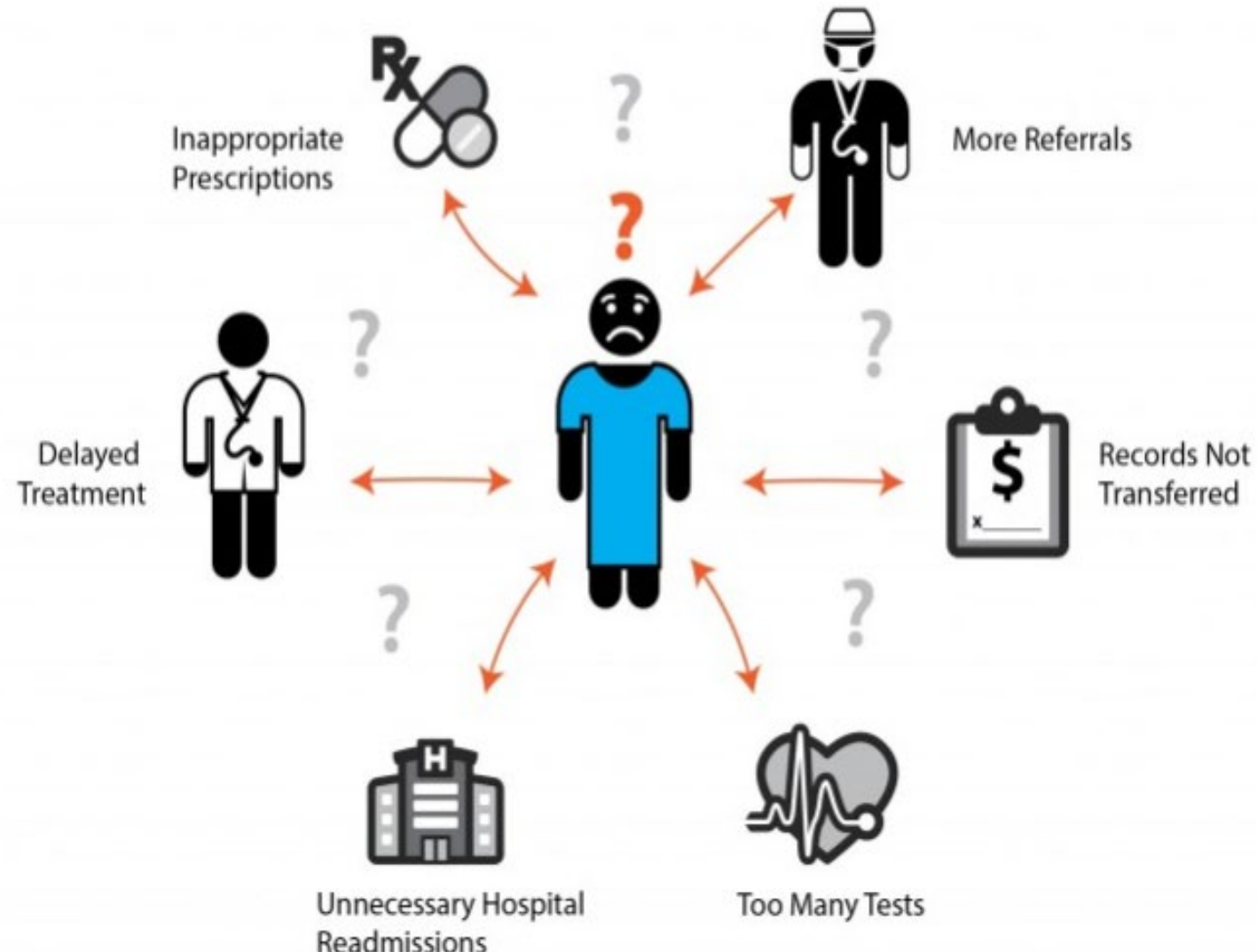


Learn more at

HEALTHCAREVALUEHUB.org/Cost-Drivers

Too Many Patients Have to Manage Their Own Care

Uncoordinated Care Results in Worse Outcomes, Higher Costs & Patient Frustration



How DO we transform our health system to be: accessible, affordable, patient-centric and to deliver uniformly high quality to all?



Because more than one problem detracts from value, we must deploy an array of reforms.

Our evidence base is quite good with respect the solutions to address specific types of harm.

HPIO: 9 strategies that work to improve health value

Create opportunities for all Ohio children to thrive

- 1. Home visiting**
- 2. Quality early childhood education and child care subsidies**
- 3. Lead screening and abatement**

Invest upstream in employment, housing and transportation

- 4. Earned income tax credit**
- 5. Safe, accessible and affordable housing**
- 6. Public transportation**

Build and sustain a high-quality addiction prevention, treatment and recovery system

- 7. Tobacco prevention and cessation**
- 8. K-12 drug prevention and social-emotional learning**
- 9. Behavioral health workforce**





1. State Accountability for Healthcare Value



State Accountability for Healthcare



CONVENING REPORT | MARCH 2017

State Accountability for Healthcare: A Report from a Convening of Healthcare Experts

This report summarizes the discussion of a small, diverse group of health policy experts who gathered in Washington, D.C., on Feb. 2, 2017, to address the topic of how to further state efforts to increase system efficiency, rein in high healthcare prices and waste, improve quality and become accountable to the public for making progress towards these goals.

All states are concerned about their direct healthcare budgetary responsibilities (e.g., Medicaid, prison system, state employees and retiree health benefits) but not all states recognize or embrace a role that addresses the larger health delivery system. Even states who have embraced this larger responsibility feel they do not have the resources to successfully take on a larger role.

Meeting participants discussed the definition of state accountability, the “business case” for broad accountability, examples of best practices from around the country, barriers confronting states and next steps for promoting the concept.

What is State Accountability in Healthcare?

In an influential 2000 report, the World Health Organization (WHO) noted that “the ultimate responsibility for the overall performance of a country’s health system must always lie with government.”¹ Using the term “stewardship,” the WHO noted that accountability “not only influences the other functions, it makes possible the attainment of each health system goal: improving health, responding to the legitimate expectations of the population, and fairness of contribution.”

While the WHO report focused on stewardship at the national level, the focus of this small group meeting was on the role of states, although all meeting participants acknowledged that the best results would come from true state/federal partnership.

Reflecting on the WHO’s understanding of healthcare accountability of government (stewardship) and the views of the participants this meeting, the following definition was developed:

State accountability for healthcare is assuming responsibility for a fair, efficient healthcare delivery system on behalf of all state residents. Being fully accountable to their residents means establishing broad strategic goals for healthcare affordability, spending and outcomes, providing transparent oversight, collecting and using data to track progress towards goals and coordination with non-governmental stakeholders to establish and achieve the goals.

Why Do We Need State Accountability for Healthcare?

Affording healthcare is a top financial concern for consumers in the U.S.² Premiums continue to increase faster than wages, and consumers are fearful that they will not be able to pay their out-of-pocket expenses should they get sick. Consumers are also concerned about their ability to maintain health insurance coverage.

States and local governments also feel the pressure of rising health costs. The costs of Medicaid, public employee coverage, public health and other aspects of healthcare are straining budgets and crowding out spending on other necessary state functions, such as education, infrastructure improvement and public safety.

States play a critical role in how the health markets function. As primary evidence, participants noted the great variation in health outcomes, spending levels and other health system characteristics. Given the mix of

Assuming responsibility for a fair, efficient healthcare delivery system on behalf of *all* state residents.

Why Make States Accountable?



- States are close to the unique, local market conditions that give rise to high prices, waste and “entrepreneurial spirit.”
- Inter-connectedness of the health system means a comprehensive view needed.
- The only stakeholder with the incentive to broadly consider the entire health system, from social determinants to provider workforce.
- When health system works well, helps all payers – relief for state budgets.
- Consumers, employers and even providers want states to play this role

Oversight Entity Examples



- ▲ Ohio: Office of Health Transformation (*for a time*)
- ▲ Colorado: Office of Saving People Money in Healthcare
- ▲ Connecticut/Vermont: Office of the Healthcare Advocate

KEY STATE STRATEGIES TO BETTER HEALTHCARE VALUE



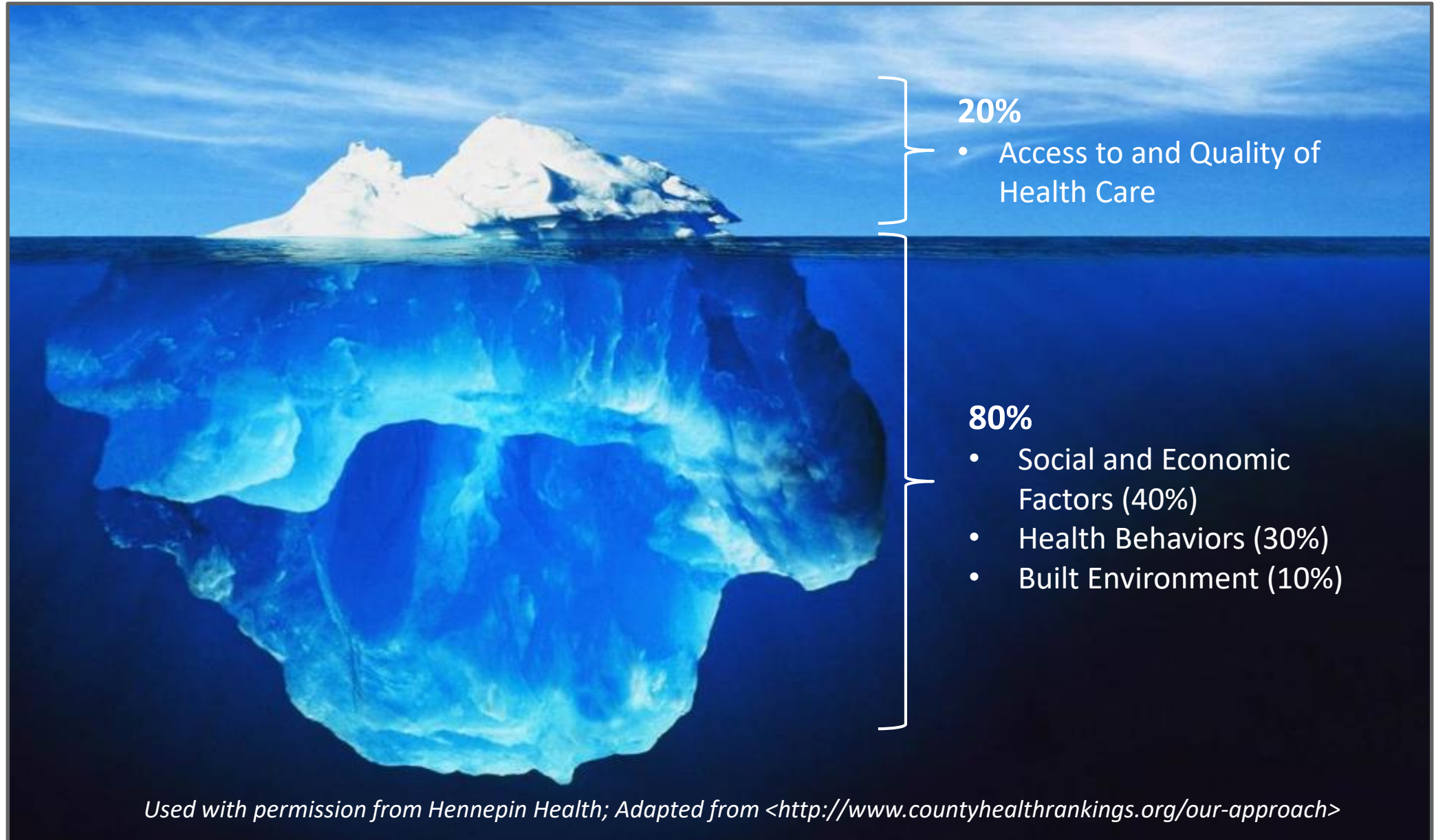
States have responsibility for fair, efficient health systems. For details:

HEALTHCAREVALUEHUB.org/state-accountability

➤ **2. Address Social Determinants of Health**



Modifiable factors influencing health outcomes



Used with permission from Hennepin Health; Adapted from <<http://www.countyhealthrankings.org/our-approach>>

SOCIAL DETERMINANTS OF HEALTH



Economic Instability

Unhealthy Food Options

Lack of Transportation Options

Quality of Education

Substandard Housing

Public Safety

Inadequate Parks/Playgrounds

The conditions where you live, work and play impact your health outcomes.

Addressing Personal and Social Determinants of Health





- Assess community needs and capacity to address needs
- Improve data collection to track disparities and support targeted interventions
- Place-based, Accountable Health Structures, plus variations
 - Environmental nudges
 - Social-medical models of care
- Address financing silos

Social-Medical Care Teams



- Strong evidence with respect to outcomes and possible savings when addressing complex patients



RESEARCH BRIEF NO. 17 | FEBRUARY 2017

Addressing the Unmet Medical and Social Needs of Complex Patients

As providers, policymakers and advocates navigate myriad approaches to addressing high healthcare costs and uneven quality in America, special attention to meeting the needs of complex patients is warranted. The care these patients receive is often fragmented and not tailored to address their unique social and medical needs.

Innovative models have been adopted around the country that employ new care approaches to address unmet social and medical needs. These approaches can result in lower healthcare costs, improved quality and may reduce disparities. Realizing these benefits can be challenging—program directors must surmount financing silos, adopt new data systems and tailor the right model to the right population. Nonetheless, these models deserve a careful look.

Who are Complex Patients?

Complex patients account for a large portion of healthcare spending in the U.S. The costliest one percent of patients account for 20 percent of healthcare spending and the costliest five percent account for 50 percent.¹

Excellent work by the Commonwealth Fund² and others reveals that complex patients are a very diverse group, including:

- people who have major complex chronic conditions;
- the nonelderly disabled;
- frail seniors; and
- children who have complex special healthcare needs.

This patient group lacks a precise taxonomy. Complex patients are also referred to as super utilizers and high-cost, high-need patients.

The Agency for Healthcare Research and Quality defines complexity as the “magnitude of mismatch between a patient’s needs and the services available to him/her in the healthcare system and community.”³ The Centers for Medicare & Medicaid Services defines these patients as those with “complex, unaddressed health issues and a history of frequent encounters with healthcare providers.”⁴ Research done by The Commonwealth Fund defines complex patients as those with three or more chronic conditions and a functional limitation.⁵

What’s critically important for realizing the gains from the social-medical care models described below is to understand the diversity within these patients and to tailor the model to meet their needs. For example:






SUMMARY

Complex patients have multiple chronic conditions and often struggle to manage them. They may have functional limitations, or a combination of vulnerabilities including social disadvantages such as homelessness, low income, behavioral health issues, or being a racial and ethnic minority.






Because this is a very high-cost population that often experiences unmet social needs and care coordination failures, there is tremendous opportunity to improve the lives of these patients and possibly reduce net social and health spending. Models of care that are data driven, tailored to patient needs and integrate care from healthcare and social service providers are extremely promising and deserve the sustained attention of policymakers and advocates. Implementing the models of care described in this paper could mean great progress in lowering cost, improving quality of care and reducing disparities.

Example: Lead Remediation for a Single Year Birth Cohort (U.S.)





Lead Service Line Replacement would:

-  Remove 272,000 lead service lines
-  Protect 350,000 children
-  Cut blood lead levels (BLLs) by 33.6%
-  Generate \$2.7 billion in future benefits
-  Return up to \$1.33 per dollar invested

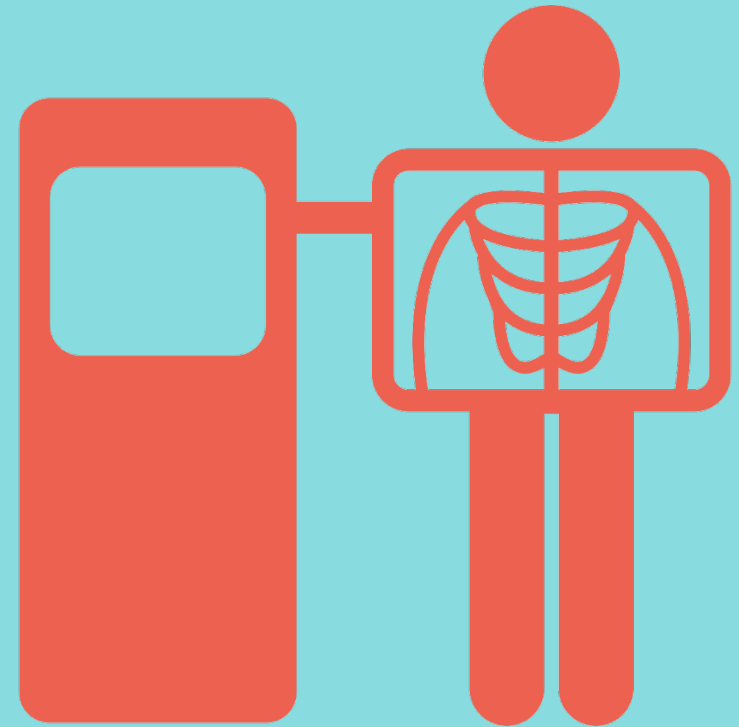
Lead Paint Hazard Control would:

-  Remove 244,000 lead paint hazards
-  Protect 311,000 children
-  Cut blood lead levels by 40.0%
-  Generate \$3.5 billion in future benefits
-  Return up to \$1.39 per dollar invested

Lead-safe Renovation & Repair Standards would:

-  Protect 211,000 children
-  Prevent BLL increases of 1.08 $\mu\text{g}/\text{dL}$
-  Generate \$4.5 billion in future benefits
-  Return up to \$3.10 per dollar invested

➤ 3. Get Utilization Right



LOW-VALUE CARE

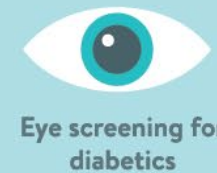
.VS

HIGH-VALUE CARE

EXAMPLES



EXAMPLES



Spending wasted on low-value care is estimated to be more than \$340 billion each year.

Providing more high-value care could avoid costly care later, saving more than \$55 billion each year.



For details on the strategies, go to:

HEALTHCAREVALUEHUB.org/low-vs-high-value-care

GETTING UTILIZATION RIGHT: STRATEGIES



Provider
Payment
Reform

**GET
INCENTIVES
RIGHT**



Non-Financial
Provider
Incentives

**ALSO
POWERFUL**



Patient Shared
Decision-Making
should be the

**STANDARD
OF CARE**



Insurance
Benefit Design
but

**KEEP IT
SIMPLE**

➤ 4. Address High Unit Prices



When provider and/or product competition exists:



- Peer comparisons
- Price Transparency
- Reference pricing



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EASY EXPLAINER | NO. 14 | NOVEMBER 2018



Strategies to Address High Unit Prices: A Primer for States

Year-over year increases in the price of healthcare services are the predominant reason for our high growth in annual health spending, particularly in the commercial sector and for inpatient hospital services and prescription drugs. Policymakers need to consider a wide range of the health system issues, like addressing social determinants of health and encouraging adherence to treatment guidelines, but failure to address excess healthcare prices and price growth will ultimately undermine their efforts to create a patient-centered, high-value healthcare system.

States are an important stakeholder when it comes to identifying high healthcare prices and, through their role as regulators and payers, are well positioned to address them. This brief explores state options for controlling healthcare costs and notes that policy options vary in effectiveness depending on the presence (or absence) of competition between providers, prescription drug companies and device manufacturers.

When are Prices Excessive?

When U.S. healthcare prices are compared to those in other countries or when healthcare price growth is compared to the growth of non-healthcare commodities, there is general agreement that prices seem excessive. But there is no universal consensus on the point at which healthcare prices become excessive. Early efforts to quantify excessive prices stem from the Institute of Medicine's identification of "pricing failures" as a category of waste. Pricing failures occur when the price of a

product or service exceeds "the cost of production plus a reasonable profit." Using this definition, researchers estimated that excess prices added \$84-\$178 billion to healthcare spending in 2011.

Commercial sector prices are often compared to Medicare prices in order to gauge reasonableness. For example, efforts around the country to address surprise medical bills often include a suggested amount that providers should be paid for a particular service, typically based on a multiple of what Medicare pays. Although Medicare's payment systems are replete with critics, the program does make an effort to establish prices using the cost of production plus a reasonable profit.

Another approach that tries to gauge the reasonableness of a price is "reference pricing," which attempts to mitigate excessive prices by identifying unwarranted price variation within a geographic area and examining the distribution of prices to determine a reasonable (i.e., "reference") price.

The Role of Concentrated Markets

Competition—or lack thereof—plays a large role in determining how much providers and drug and device manufacturers can charge for their products and services. It also affects the set of solutions available for states to address high and rising unit prices.

Provider consolidation through mergers and acquisitions increases the market power of providers and strengthens their ability to negotiate higher prices in their

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Price Transparency: Truths



- Instrumental to keeping **consumers** safe by allowing them to judge affordability and plan for the expense of needed healthcare services.
- Allows **policymakers/regulators** to address unwarranted price variation.
- Incentivizes high-cost **providers** to align more closely with industry rates (via peer comparisons or reference pricing).

Price Transparency: Myths

does NOT incentivize

- Price transparency ~~incentivizes~~ consumers to compare services and shop for the best price.

does NOT drive

- Consumer-facing price transparency ~~drives~~ value in the market place.



Revealing the Truth about Healthcare Price Transparency

For years, price transparency has been touted as a vital component of a high functioning healthcare system—and with good reason. Price transparency is instrumental to keeping consumers safe by allowing them to judge affordability and plan for the expense of needed healthcare services. It also enables state policymakers to address unwarranted price variation and, in some cases, can incentivize high cost providers to lower their prices to align more closely with industry rates.

Despite its merits, price transparency is also inappropriately credited for its ability to make markets more efficient. Most notably, transparency tools have generally not been successful when it comes to incentivizing consumers to compare services and shop for the best price.

SUMMARY

Price transparency is vital to a high functioning healthcare system in many respects. It keeps consumers safe by allowing them to judge affordability and plan for future healthcare expenses, enables state policymakers to address unwarranted price variation and can incentivize high cost providers to lower their prices. Despite its merits, studies show that price transparency does not make markets more efficient by incentivizing consumers to shop for the best price. This brief discusses the opportunities and limitations of price transparency and explores its uses by stakeholder group.

Increasing the effectiveness of price transparency will require a nuanced understanding of its strengths and limitations with respect to each audience using the information: patients, policymakers, regulators and providers. This brief discusses the opportunities and limitations of price transparency and explores its uses by stakeholder group.

Myth: Price Transparency Drives Smarter Spending by Consumers

A common motif is that making healthcare prices more transparent for consumers will drive value in the marketplace by increasing competition. The argument goes: price transparency will allow consumers to identify providers offering services for the best price, driving business to those that offer the greatest value and incentivizing others to fall in line. Variations on this theme are that combine price transparency with quality data so consumers can find the best value and/or combine transparency with cost sharing to increase consumers' "skin in the game" in order to incentivize shopping by patients.

The hope is that widespread use of this strategy will reduce price variation and decrease healthcare spending. However, there are five reasons to be skeptical of these claims:

- *There is minimal evidence that making prices more transparent for consumers will drive healthcare value.* Retrospective studies find minimal evidence that price transparency alone improves value by incentivizing consumers to shop for the best price.^{1,2} Although experience in other markets suggests that price transparency can drive down prices, the healthcare market has unique characteristics that prevent it from working in the same way. These include variations in quality that make it difficult for consumers to make

When provider and/or product competition DOES NOT exist:



- Global budgets
- Hospital/physician rate setting
- Anti-price gouging legislation
- Antitrust enforcement actions
- Certificate/determination of need



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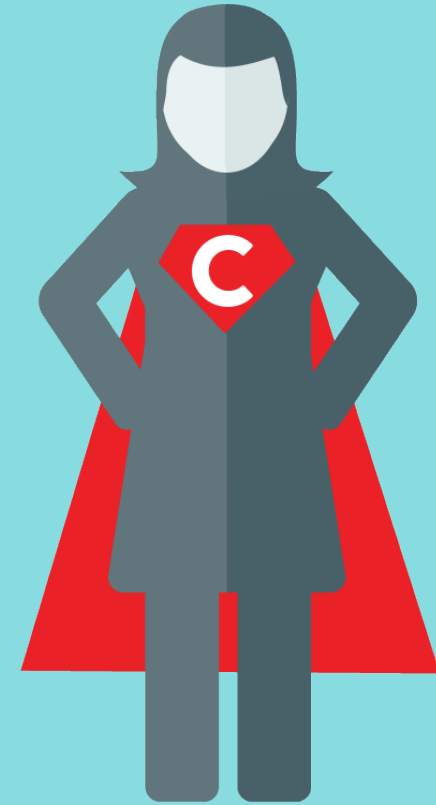
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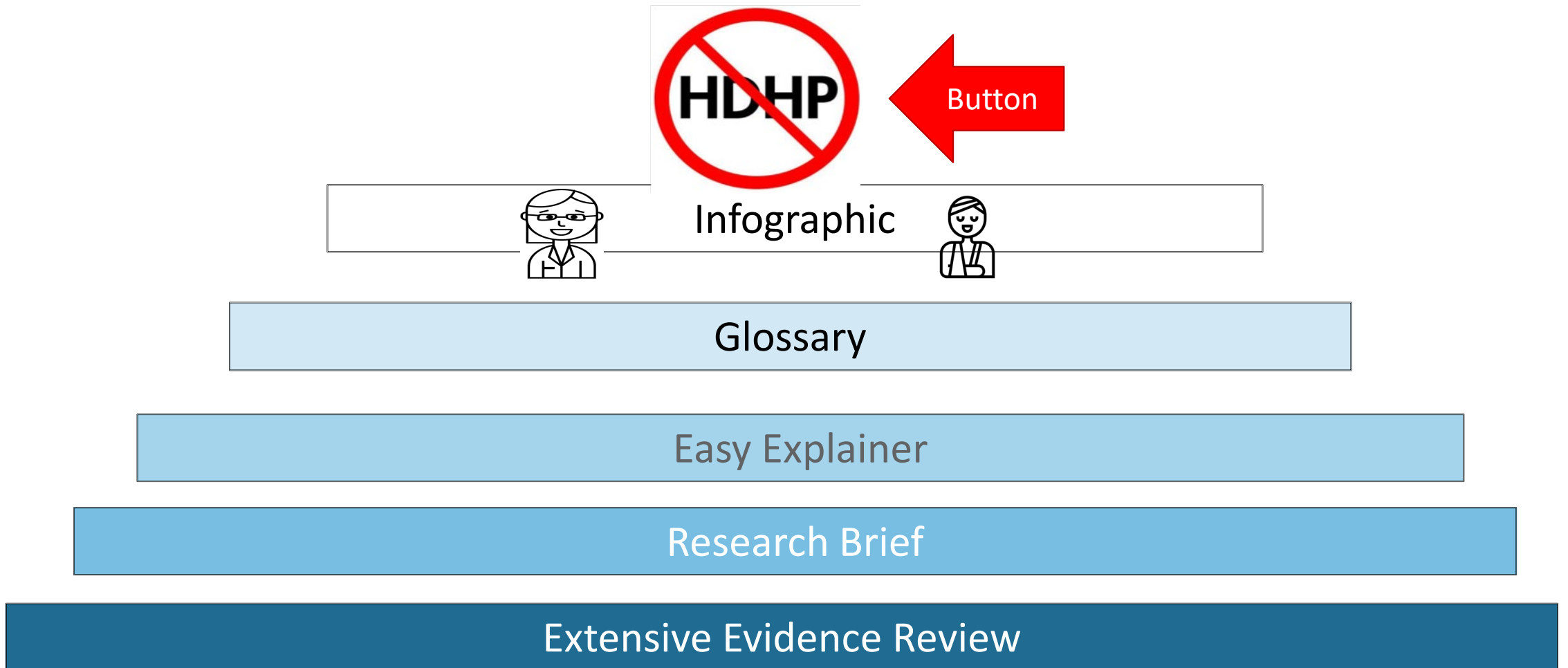
➤ 5. Lift Up
Consumer
Voices



The Hub is here to
help



A layered approach to our free resources

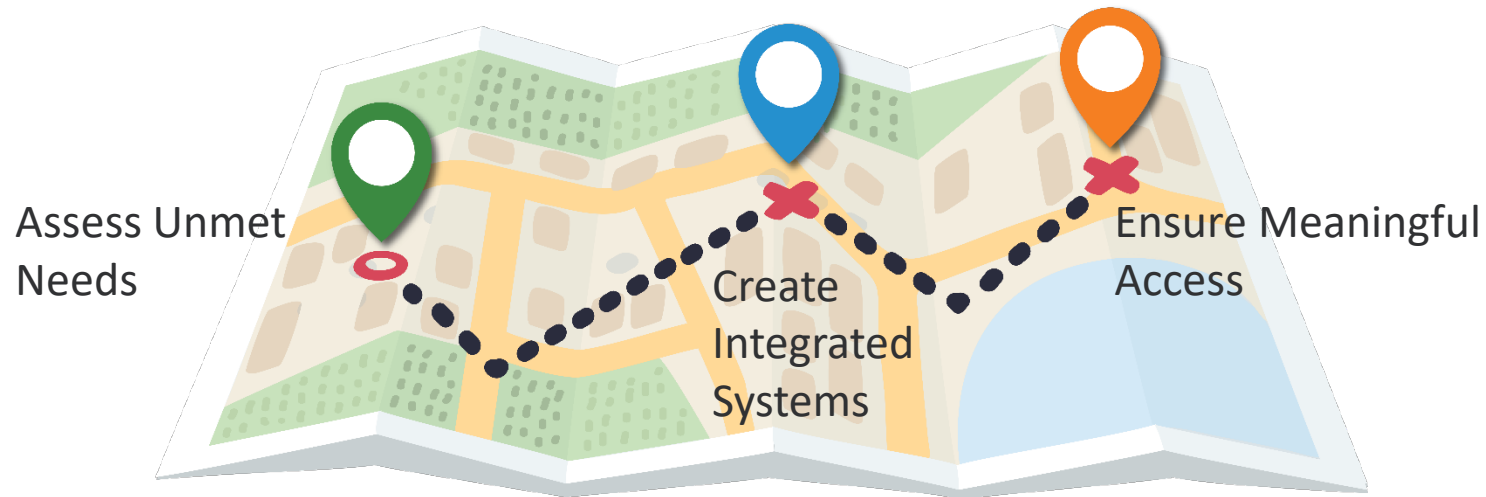


Our Policy Roadmap and Toolkit



Proven policies to ensure that the healthcare system works seamlessly with public health, social sectors and community members to:

1. address the goals and needs of the people it serves and
2. advance health equity.



Your Questions?



Contact Lynn at Lynn.Quincy@Altarum.org or any member of the Hub team with follow-up questions.



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Join our next webinar:

Consumer-centric Scoring of Healthcare Price and Quality

Transparency Tools

Friday, April 19, 2019, 2:00-3:00 p.m. ET

HealthcareValueHub.org/events