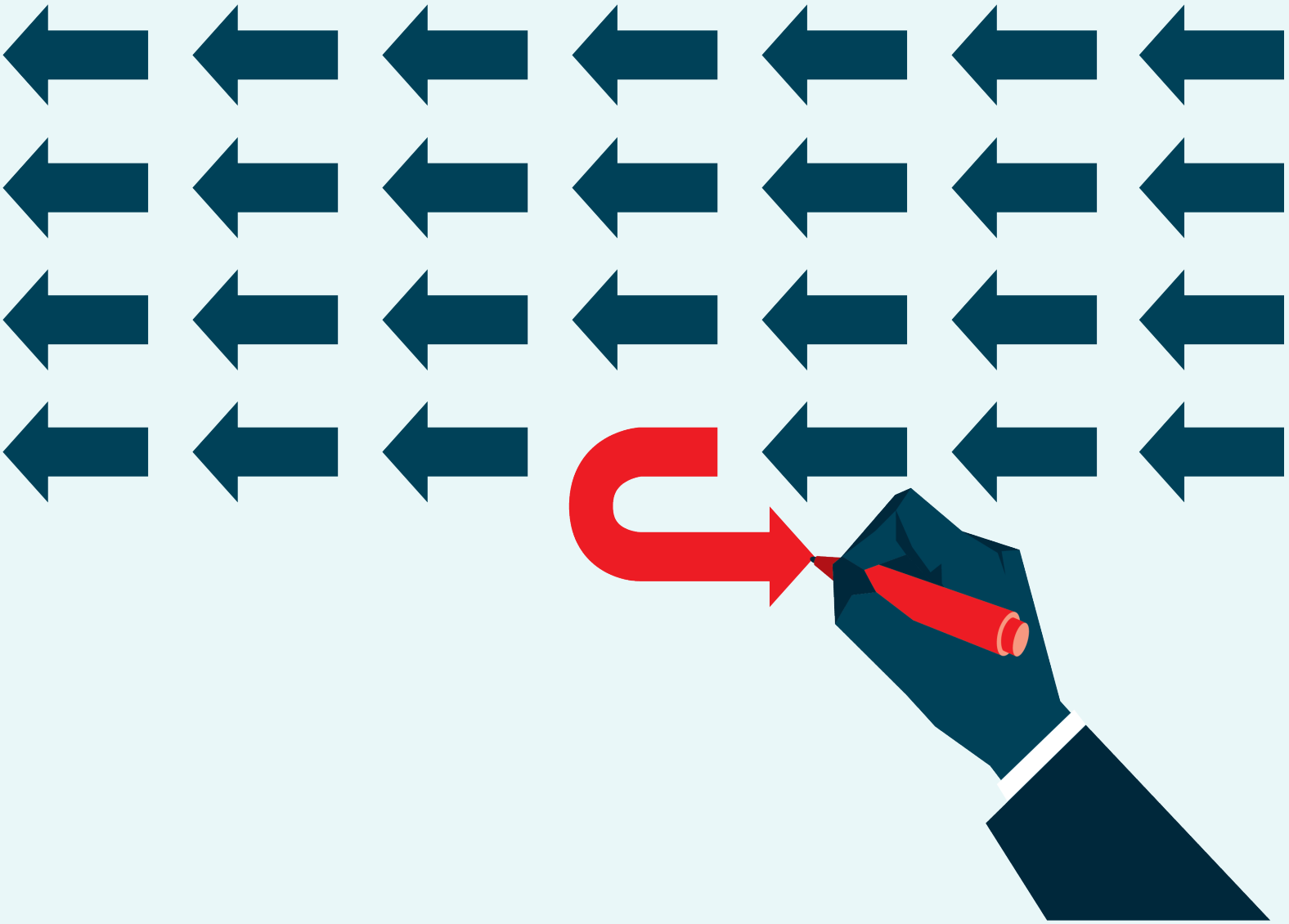
ALTARUM
HEALTHCARE VALUE HUB

Getting to Healthcare Value

Redirecting the Policy Debate Toward Lower Costs and Better Quality



Highlights from a Convening of Consumer Advocates

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Support provided by the Robert Wood Johnson Founation.

This report reflects the discussions and views of participants of the Healthcare Value Hub meeting in New Orleans, Nov. 6-8, 2017.

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Highlights

Meeting annually in New Orleans has become a tradition for a core group of advocates dedicated to making our healthcare system work better for consumers, including addressing their top concerns about healthcare affordability and protecting them from unwarranted variation in quality of care.

The meeting represented a coming together after a year of threats to repeal the Affordable Care Act and the related coverage concerns. Addressing these threats was all consuming for advocates and the Hub's meeting in New Orleans represented a respite—allowing them to think proactively about the reforms that would bring addressing costs and quality back into the federal and state policy debates.

AGENDA

Wednesday, November 6

Name that State Game Show and Welcome Dinner

Thursday, November 7

Opening Remarks
David Adler, Robert Wood Johnson Foundation
Jim Lee, Altarum

Looking Back: A Year of ACA Defense, but also State Gains
Anthony Wright, Health Access California (moderator)
All-attendee facilitated discussion

Drug Costs: Recent State Victories and Potential Strategies
Jill Zorn, Universal Health Care Foundation of Connecticut (moderator)
Bobbette Bond, Unite Here Health
Vincent DeMarco, Maryland Health Care for All Coalition
Rebekah Gee, Louisiana Department of Health

Medicaid and Healthcare Value: How Advocates Can Help Set the Agenda
Jim Carnes, Alabama Arise/Arise Citizens' Policy Project (moderator)
Anne Dunkelberg, Center for Public Policy Priorities
Christine Severin, Community Care Cooperative
Judy Solomon, Center on Budget and Policy Priorities

Healthcare Value in Rural Areas: Unique Challenges and Opportunities
David Adler, Robert Wood Johnson Foundation (moderator)
Bruce Goldberg, Oregon Health & Sciences University
Lauren Hughes, Pennsylvania Department of Health

The Call for Single Payer: What is Our Answer?
Michael Miller, Community Catalyst (moderator)
Eagan Kemp, Public Citizen
Robin Lunge, Vermont Green Mountain Care Board
Harold Pollack, University of Chicago

Friday, November 8

State-Based Oversight Entity: A Must-Have to Increase Healthcare Value?
Brian Rosman, Health Care for All Massachusetts (moderator)
Bruce Goldberg, Oregon Health & Sciences University
Robin Lunge, Vermont Green Mountain Care Board

Tapping the Outrage: Leveragine Consumer Concern about Costs to Push fo Policy Changes
Jesse O'Brien, OSPIRG (moderator)

Revisiting Our Commonalities: What Are Our Next Steps?
All-attendee facilitated discussion

Conference Sessions

Looking Back: A Year of ACA Defense, but also State Gains

California advocate Anthony Wright helped kick off the meeting with an all attendee reflection, reprising the role he played at the conclusion of the 2016 meeting to address what was then a just emerged but grave threat to the coverage gains of the Affordable Care Act.

Attendees lamented it had been an exhausting year since the November 2016 New Orleans convening while recognizing some surprising gains around the country including: drug pricing legislation in several states, whole person care pilot programs in California, surprise billing and network adequacy protections in several states all while keeping the protections of the Affordable Care Act mostly intact. Attendees noted that all the debates vastly expanded the number of policymakers who understood their Medicaid program and who benefits from it. There was general agreement that the Affordable Care Act had "won in the court of public opinion."

Drug Costs: Recent State Victories and Potential Strategies

The high cost of prescription drugs is a top consumer concern. Drugs account for nearly 17 percent of personal health spending and drug prices have been increasing at rates well above other medical services and products.[1] States budgets have been impacted by spikes in the prices of new specialty drugs, as well as inexplicable price hikes for existing drugs, and all payers are seeking ways to control costs.

This session was moderated by Jill Zorn of the Universal Health Care Foundation of Connecticut and featured Bobbette Bond of Unite Here Health in Nevada, Vincent DeMarco of Maryland Health Care for All Coalition and Rebekah Gee, Secretary of the Louisiana Department of Health.

The ability of states to take comprehensive action to reduce drug prices is fairly limited but our panelists showcased some innovative approaches.

Secretary Gee began the session by describing Louisiana's experiences dealing with high cost—but lifesaving—hepatitis C medications. The state can only afford to pay for the treatment of patients in cases of significant liver damage. Last year, that meant only 386 of roughly 35,000 Medicaid or uninsured patients with hepatitis C received the new medications.

To put the cost of these drugs into perspective, Gee worked with researchers at Memorial Sloan Kettering to develop the Louisiana Budget Allocator (www.drugpricinglab.org/louisiana-budget-allocator) to illustrate the enormous cost of hepatitis C drugs and the impact on other state spending priorities. For example, to pay to treat all Medicaid recipients

[1] *Observations on Trends in Prescription Drug Spending*, U.S. Department of Health and Human Services (March 8, 2016).

with hepatitis C at current prices, the state would have to eliminate all K-12 funding and the majority of higher education funding. In an effort to reduce prices so the state could afford to treat more patients, Gee noted that the Louisiana governor has joined with 10 other governors to work together to negotiate with drug companies.

Bobbette Bond, of Unite Here Health, described how Nevada opted to focus on just diabetes drugs. She noted that drugs for diabetes were by far the highest category of drug spending, that three companies control the majority of the 95-year-old insulin market and that the average cost of the drugs tripled between 2002 to 2013 (from $231 to $736 per year, per patient).[2] Bond also pointed to the curious fact that the drug manufacturers have been increasing prices in concert with one another, instead of competing on price.

To address insulin price increases, Unite Here Health joined with other stakeholders to create the Nevada Political Diabetes Coalition to push for better price transparency. The coalition's campaign included patient testimonies, online videos, polling, a diabetes lobby day and a robust ground game to energize voters. The campaign resulted in a diabetes drug transparency law that requires manufacturers to justify price increases and pharmacy benefit managers to report rebate prices for these drugs.

Vinny DeMarco, of the Maryland Health Care for All Coalition, described his state's new drug price gouging law that—for the first time—gives a state attorney general the power to block generic drug manufacturers from raising prices to unreasonable levels. Health Care for All formed a stakeholder coalition, conducted polling and gathered consumer stories and testimonials to help get the law passed. He said his organization and others will come back in 2018 to push for expansion of the price gouging law to include brand name drugs.

DeMarco also discussed the problems Maryland is having with the price of certain drugs, particularly hepatitis C. He said that only 20 percent of state residents with hepatitis C can afford the treatment and that the state Medicaid program, like Louisiana and other states, can only provide the treatment for those in late-stages of the disease. He claimed that if the hepatitis C drug manufacturers lowered their prices so 100 percent of patients could afford the drug—instead of the current 20 percent—the drug companies would still make the same profits.

2. Hua, Xinyang, Natalie Carvalho and Michelle Tew, "Expenditures and Prices of Antihyperglycemic Medications in the United States: 2002-2013," *JAMA* (April 5, 2013).

Medicaid and Healthcare Value: How Advocates Can Help Set the Agenda

Federal reform proposals have placed a bright spot light on Medicaid, highlighting two very different schools of thought: is Medicaid an open-ended entitlement or an innovative program that holds down costs and transforms how health care is delivered? On the positive side, several advocates noted that legislators' understanding of the Medicaid program has greatly increased.

Judy Solomon, of the Center on Budget and Policy Priorities, provided an overview of recent Medicaid policy decisions at the federal level, such as changing the criteria for 1115 waivers—which might make it harder for states to qualify for demonstration projects—and allowing states to implement work requirements, time limits for certain populations and eligibility lockouts. She stressed that the purpose of 1115 waivers is to enable demonstration projects and experiments that promote the aims of Medicaid—to expand access to care. She pointed to several states with waiver programs that seem to have had detrimental impacts on recipients. For example, Michigan implemented a cost-sharing requirement but only 26 percent of people knew that monthly contributions were required. In Iowa, new program incentives have had little to no impact on utilization. She said that we need to quickly evaluate waiver demonstration projects to see what has worked and what has not.

Anne Dunkleberg, of the Center for Public Policy Priorities, described Medicaid reform efforts in Texas, a state that did not expand Medicaid, but in 2011 received an 1115 waiver that yielded dozens of experiments around the state. Indeed, Dunkleberg noted that the state didn't have the evaluation capacity to understand what worked and what didn't. Constraints include the fact the state Medicaid program is based on inadequate fee-for-service payments with strictly limited per capita spending growth and low provider payment levels. Physician and hospital payments have not had annual updates for more than 20 years, she noted.

For Medicaid to improve in Texas, Dunkleberg said that the state needs to align Medicaid budget priorities to support, not undermine, value and outcome-based system transformation.

Christina Severin, of Community Care Cooperative, noted that Massachusetts Medicaid's 1115 waiver authorized a $1.8 billion investment over five years to transition more than 900,000 MassHealth recipients to accountable care organizations (ACOs). The ACOs take on all the health risk and must

include a range of providers: community health centers, primary care, behavioral health, long-term services and supports, community partners and community service agencies.

Severin described the Community Care Cooperative as a new ACO, organized to take responsibility for managing the cost and quality of healthcare for approximately 123,000 members in 15 federally qualified health centers. She described their goals to transform primary care through direct financial investment, technical support and investments in community-based efforts to alleviate social impediments, like poverty, to health and wellness.

Healthcare Value in Rural Areas: Unique Challenges and Opportunities

Rural areas differ from urban areas in many ways. Compared to more populated areas, people living in rural areas are generally older, poorer and sicker. Rural areas also generally struggle to attract and retain physicians, causing many rural areas to have a shortage of clinicians which leads to access problems for consumers. To make things even more complicated, rural areas are not all alike—they differ significantly among themselves.

Compared to more populated areas, less is known about the cost and quality of care provided in rural areas. Moreover, some policy interventions used in urban areas may be largely ineffective in rural settings.

This panel focused on the unique challenges in rural areas, what strategies work best and the innovative things being done in some states to increase healthcare value.[3] The session, moderated by David Adler of the Robert Wood Johnson Foundation, featured panelists Bruce Goldberg of Oregon Health & Science University and Lauren Hughes of the Pennsylvania Department of Health.

Bruce Goldberg began his presentation by stressing that the urban-rural divide is a myth—that the health status of rural populations mimic problems seen in urban areas. According to Goldber, the real divide is between rural and suburban areas. He then described rural areas as having more uninsured and publicly insured populations. There is also less competition and fewer consumer choices in the insurance and provider markets, workforce shortages, distance and transportation issues and relatively poor health literacy.

Goldberg described some of the national and state policy responses that have helped, to

3. *Improving Healthcare Value in Rural America*, Research Brief No. 19, Healthcare Value Hub (October 2017).

some extent, including: funding to retain rural hospitals that get cost-based reimbursement; loan repayments, tax credits and/or stipends to recruit and retain rural providers; investments in telehealth and broadband access; and changes in provider scope of practice laws.

He described opportunities for improvement, including regional cooperation by strategically reallocating resources and looking at rural communities as a system, not just a bunch of small towns. He also suggested doing more to understand provider quality in rural areas and a focus on social determinants of health.

Goldberg described the Eastern Oregon Coordinated Care Organization's efforts to increase regional coordination and resource allocation. The program serves 12 counties in an area the size of New York state, but with a population of less than 200,000. The program includes transformation grants, technology investments patient-centered primary care home investment, and community capacity building, including hiring community health workers. Results include reduced emergency department visits, better care coordination and better coordination across agencies. The savings realized by the program have funded its expansion.

Lauren Hughes, of the Pennsylvania Department of Health, noted that in addition to vital medical services, rural hospitals provide value to their communities in other ways. People in rural communities have a long-standing relationship with their local hospital

and providers. They are personal and familiar to community members and likely one of the major employers.

However, Hughes said that rural hospitals lack financial stability and funding unpredictability has caused many to close down or be in jeopardy of closing. Quoting from a *Huffington Post* article describing rural hospital closures, she said: "If you want to kill a small community, close the hospital."[4]

Hughes described a global budget model the state is developing with the goals of preserving access to healthcare services in rural communities, shoring up the finances of rural hospitals and allowing them to invest in improving population health. She said the Pennsylvania global budget model will provide predictable, fixed annual revenue to participating rural hospitals. It will also incentivize providers to develop transformation plans to reduce avoidable service use, improve operational efficiency and increase appropriate outpatient and inpatient volume to increase revenue streams.

4. "A Hospital Crisis is Killing Rural Communities. This State is 'Ground Zero,'" *Huffington Post* (Sept. 27, 2017).

The Call for Single Payer: What is Our Answer?

The continued high and rising cost of healthcare has led to increased discussion among policymakers and healthcare advocates about the potential benefits and feasibility of a single-payer system in the U.S.

Serving as the panel's moderator, Michael Miller of Community Catalyst framed the discussion around the fact that the U.S. spends more than any other country but still has too many uninsured people and is administratively inefficient. Furthermore, outcomes are too uneven and costs are too high. These facts are causing a resurgent call for single payer, even in a challenging political environment.

Harold Pollock of the University of Chicago kicked things off with a discussion of the political realities and dilemmas faced by both political parties and the "broken" politics in the U.S. He also said that universal coverage is the important, basic principle being discussed and that single payer is one path to universal coverage, but not the only one.

He noted that countries that have universal coverage took many paths to develop their systems. Compared to the U.S. system they are all cheaper, simpler, subsidize low-income people and heavily regulate providers and insurers. But they deal with many of the same problems we face: overuse of services and painful political and social challenges.

Pollock noted that introducing single-payer system means difficult challenges, including a large tax increase and millions of winners and losers as providers and other stakeholders become more regulated—"a serious squeeze on the entire supply-side of the medical care economy."

In the future, Pollock predicted that we're likely to see "strange bedfellows" as Medicaid gathers more bipartisan support than market-based approaches and more "public option" proposals, such as enabling people to buy into Medicaid plans and expanding Medicare to those aged 55 and older.

Eagan Kemp, of Public Citizen, began by describing the different mindset regarding healthcare between the U.S. and Canada. While living in Canada, Kemp remembers being sick but reluctant to go the doctor because of the cost. His Canadian friends thought it strange that someone would forego care when it was needed. He compared that to a family member in the U.S. who developed late-stage stomach cancer because she didn't go to the doctor

because she was concerned she couldn't afford the care she needed.

He described current congressional bills for Medicare for All and public polling that show an increasing trend towards single payer (52% in favor). He said that this trend is the result of 30 million people remaining uninsured and continued consumer frustration with the high cost of healthcare. He called for advocacy and grassroots efforts to educate people on what a single-payer system would mean for them, and more research on the pragmatic steps that could transition us to single payer.

"Polling shows that people are willing to pay more taxes for things that they value."
- Harold Pollock, University of Chicago

Robin Lunge, of Vermont's Green Mountain Care Board, described Vermont's recent effort enact a single-payer system in the state. Despite Vermont's 20 years of progressive health reform efforts, the Universal Publicly Financed Coverage proposal failed when cost estimates were more than anticipated and the economy was growing more slowly than assumed. Financing the system was a major hurdle: a new 11.5 percent payroll tax on businesses and an income-based individual tax increase (0%-9.5%). Although the taxes would have replaced premium costs already being paid by residents, it was not an easy concept to explain.

Vermont subsequently considered a series of smaller but still leading-edge approaches.

Lunge describe a new All-Payer ACO Model proposal that moves from volume-based fee-for-service to a value-based, pre-paid model for ACOs. The model requires alignment across Medicare, Medicaid and participating commercial payers with target annual growth capped at 3.5 percent and a reduction in Medicare growth of 0.1-0.2 percent below national growth. The model has three main goals: improving access to primary care, reducing deaths from suicide and drug overdose, and reducing prevalence and morbidity of chronic disease.

When asked what the most important lesson is for single-payer advocacy, Lunge said that transition planning cannot happen too early. "It's hard to plan for a transition until you know where you want to go. Also, do not underestimate how much people fear change." Pollock responded that we need to understand that health systems are complicated and we need to have an honest discussion to develop incremental changes that are realistic but speak to people's expectations. "Good policy with bad politics will become bad policy," said Pollock.

State-Based Oversight Entity: A Must-Have to Increase Healthcare Value?

Making meaningful progress towards better healthcare value benefits greatly from the existence of an overarching entity with the role of taking a comprehensive and systematic view of the state's system. However, only a few states have a centralized oversight agency charged with that responsibility, namely better arming them to reduce costs, increase quality and innovate for better healthcare value. In most states, responsibility for healthcare is spread out among many different state agencies. State oversight entities can provide leadership and coordination to implement system reforms that can lead to better value for the state and for its residents.

Brian Rosman of Health Care for All Massachusetts moderated the panel and described the spectrum of things that oversight entities can do: from collecting, reporting and analyzing cost and quality data; making recommendations to the state government; and, in a small number of cases, use statutory power to enact changes. He said that "authority is really a misnomer. It's really leadership."

Robin Lunge said that Vermont's Green Mountain Care Board was created as an independent agency with an overarching mission to reduce the rate of healthcare cost growth while maintaining a high-quality, accessible healthcare system. This is done through regulation (insurance rate review, hospital budgets, certificate of need, oversight of ACOs, etc.), innovation (payment reform, delivery reform) and evaluation (data collection and analysis, payment reform pilots, state innovation grants). She said the creation of the board consolidated regulation in one public entity and enabled the increased use of analytical data.

Bruce Goldberg of the Oregon Health & Sciences University described the development and achievements of the Oregon Health Authority (OHA). He said the goals of the OHA are to provide a single point of accountability for the state; to leverage purchasing for the state and use that purchasing power to drive value and reform; to establish evidence-based guidelines for efficient care delivery; to consolidate data collection, analysis and technical support; and to be a platform for multi-payer initiatives. The OHA is overseen by the Oregon Health Policy Board, which has the authority to submit legislation, establish statewide quality measures and cost-containment mechanisms.

Established in 2008, the OHA began with the creation of Medicaid coordinated care organizations (CCOs) with global budgets and quality standards tied to finances. The global budgets are flexible and allow for investments in social determinants of health, like housing and mental health. He said that every CCO in the state is spending within its global budget and is meeting the target of reducing Medicaid per capita spending by 2 percent. The CCOs are also making progress on measures of quality, utilization and costs, and towards the goal of shifting resources to primary care.

Goldberg described some of the lessons learned from the first few years of the OHA. He said a common vision and leadership are key—leadership (legislative and executive) that is committed to the goals and deliverables of the reforms. Goldberg also noted the need to engage key stakeholders, including provider and insurance leaders, consumers and the federal government. He said that payment reform is critical—you can't expect new ways of doing business with old methods of payment—and that multi-payer initiatives can greatly accelerate change in delivery systems.

Tapping the Outrage: Leveraging Consumer Concern about Costs to Push for Policy Changes

The high cost of healthcare is a top financial concern for Americans. Roughly half of the U.S. population goes without needed care due to concerns about potential costs while many others have trouble paying their medical bills. But as healthcare advocates, how do we tap into this concern and anger about costs to mobilize consumers to push for reform?

Jesse O'Brien of OSPIRG moderated this panel, which included audience polling and discussion. O'Brien began by describing his organization's experience with canvassing Oregon residents on the issue of insurance rate review. He said they chose rate review because it is a difficult issue for consumers to understand, but if explained in a clear way represents a compelling story that people can relate to and get excited about.

To prepare for the canvassing, OSPIRG tested several messaging approaches including "saves money for consumers" versus "cutting waste from the healthcare system." The language about waste worked much better with consumers, O'Brien surmised, because waste felt like a societal issue and saving money doesn't necessarily impact the person being canvassed. He used this example to stress the importance of testing the messaging used in polling and canvasing. His other key takeaway points were to keep any language and message simple, to cut through politics as much as possible and that trust in the messenger is extremely important. Challenges that O'Brien noted include a lack of consumer faith that government will step in to solve the healthcare problems and not believing the current state of affairs can be changed.

Next Steps?

Revisiting Our Commonalities: What Are Our Next Steps?

The conference ended with an all attendee-facilitated discussion on what steps can be taken over the next year to increase healthcare value for consumers.

In the face of myriad threats to consumers' healthcare access and affordability protections, advocates emphasized several themes:

- We have to be affirmative and evidence-based in our defense but ALSO provide an alternative vision.
- We will be left behind if we don't proactively bring addressing cost and quality into that vision.
- We need a narrative and messaging to convey how proposed changes benefit consumers.
- We have to break through the wall of "why should I care?"
- We may be able to harness interest in single payer—as one advocate noted, "they came for single payer, they stayed for other stuff."

But unanswered questions remain:

- Can we coalesce around some national themes that also work at the state or even county level?
- Do we engage policymakers or consumers first?

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Launched in March 2015, the Healthcare Value Hub supports and connects consumer advocates across the U.S., providing plain language, comprehensive, evidence-based information to help them advocate for change.

The Hub offers both online and hands-on support, with a staff dedicated to monitoring, translating and disseminating evidence about cost drivers and strategies to address those drivers. We also connect advocates, researchers and policymakers together by sponsoring events and networking opportunities around health care cost and value issues.

Getting help is just a simple phone call or email away. You can also sign up for our monthly *Research Roundup*, attend our monthly webinars and follow us @HealthValueHub.

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