PROMOTING VALUE-BASED HEALTHCARE: A PATH FORWARD

by Representative Suzanne Harrison

(09/14/21)

STAKEHOLDERS

- Patients
- Healthcare clinicians
- Healthcare systems
- Third-party payers
- Regulators

BASIC CONCEPTS

- **Increasing the use of value-based healthcare requires a willingness and ability to:**
  - identify, deliver, receive, and pay for care with the greatest comparative value (best outcomes per cost), including preventive care that reduces downstream costs.

- **Comparative value of a service may be increased by:**
  - reducing its overuse, reducing its underuse, and otherwise improving its use; or
  - reducing cost.

- **Value-based healthcare is more likely to occur if:**
  - patients, clinicians, and payers are able to identify highest-value care;
  - clinicians are allowed to capture an adequate portion of the savings in total healthcare costs realized because of their investments made to improve health outcomes for patients (investments in data gathering and analytics, improved care protocols, etc.); or
  - payment systems otherwise promote the use of highest-value care (traditional fee-for-service payment systems have paid for all medically necessary care, regardless of comparative value).

LEGISLATIVE INITIATIVES IN UTAH

- **Identification and Elimination of Medical Waste**

  2020 H.B. 195, Identifying Wasteful Health Care Spending, *(Harrison)* required the Utah Department of Health to analyze Utah's all-payers health insurance claims database and identify use of non-evidenced-based healthcare. The legislation also charged the department with identifying nonaligned quality measures clinicians are required to report and reviewing scientific literature and soliciting input on the use of duplicative procedures. Before November 1, 2021, and every year thereafter, the department will report its findings and recommendations for improvement to the Health and Human Services Interim Committee.

- **Value-Based Payment**
  - PEHP

    2019 S.C.R. 4, Concurrent Resolution Directing Creation of a Request for Payment Pilot Program, *(Millner)* directed PEHP to issue a request for proposals for healthcare services using a value-based payment methodology and report on outcomes to the Legislature at the end of an initial three-year contract term. See 8/22/19 report by PEHP.

- Medicaid

  2011 S.B. 180, Medicaid Reform, *(Liljenquist)* directed the Utah Department of Health to develop and implement, with approval of the federal government, a plan to replace the Medicaid fee-for-service payment model with risk-based payment that rewards healthcare providers for delivering the most appropriate services at the lowest cost and in ways that maintain or improve patient health status.

- **Medicaid Expansion**

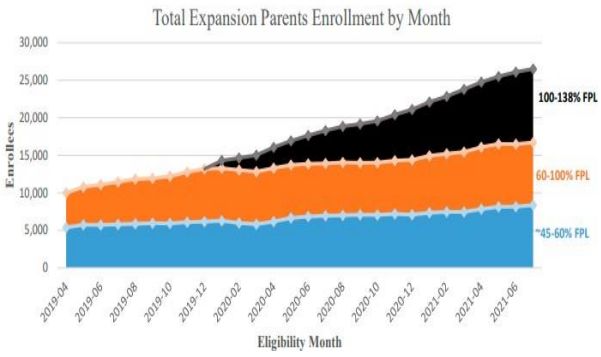
  2016 H.B. 437, Health Care Revisions *(Dunnigan)*, the 2018 voter initiative Proposition 3, Utah Decides Healthcare Act of 2018, and 2019, S.B. 96 Medicaid Expansion Adjustments *(Christensen)* expanded Medicaid eligibility. The impacts on enrollment and spending are documented here. Summaries of studies analyzing the impacts of expansion on individuals and state budgets and economies generally are available here, here, and here.

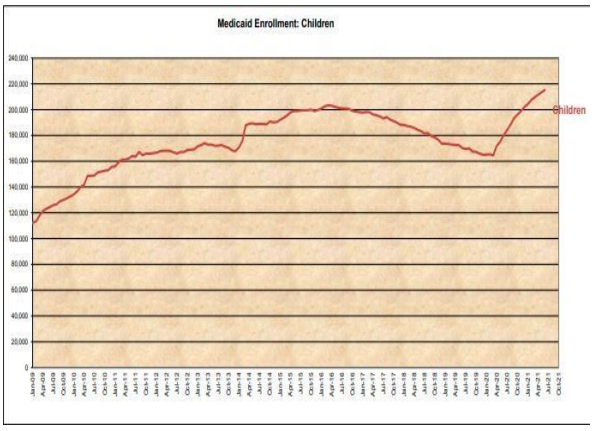
  Utah's full Medicaid expansion began on January 1, 2020. There are already noticeable positive effects from that policy change.

  1) Medicaid expansion is **helping address the issue of Utah's rising uninsured rate**, as more low-income Utahns gain coverage. Currently, there are over 98,000 Utahns enrolled in Medicaid expansion, many of whom would otherwise be uninsured during an unprecedented health and economic crisis.

  2) Medicaid expansion created a **new pathway for more parents to get access to health insurance**. When parents are insured, their children are more likely to be insured as well. Utah has had a worrisome and persistently high rate of uninsured children, many of whom are eligible for some type of coverage. Medicaid expansion is helping to curb that trend and since the policy was implemented, more children have gained access to Medicaid and CHIP.

  Context: The Families First Coronavirus Response Act (FFCRA) provided states more money in response to the COVID-19 crisis and its impact on unemployment and uninsurance. This boosted Medicaid match-rate (FMAP) came with a Maintenance of Effort (MOE) provision requiring states to maintain continuous coverage during the public health emergency. This MOE rule has helped Utah families maintain health insurance coverage without the typical "churning" on and off the program that happens without continuous eligibility.

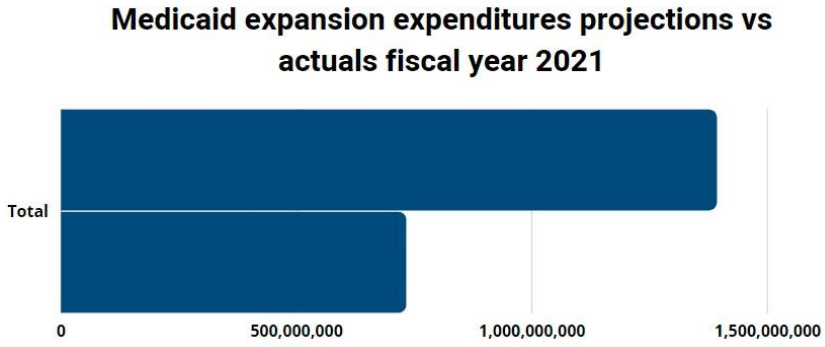




3) Utah's full Medicaid expansion was implemented just in time to provide a **crucial safety net during the biggest health coverage loss in US history**. The federal government opened an additional enrollment period for the healthcare.gov individual marketplace from February to August 2021, which allowed almost 40,000 Utahns to purchase commercial insurance. That open enrollment period combined with Medicaid expansion and continuous eligibility helped mitigate long-term coverage loss.

In the wake of record enrollment, the Medicaid expansion budget remains in excellent shape.

Fund Name	Rev Source	Prior Year Balance	Rev $	Expense	Ending Balance
2019 expansion fund	gifts, grants, donations, approp, taxes, savings, interest	6,092,151	94,434,769	37,796,139	62,730,781
2020 expansion fund	gifts, grants, donations, approp, taxes, savings, interest	62,730,781	125,754,448	79,168,062	109,317,167



The budget continues to outperform during the pandemic and expenditures have been significantly below what was expected, though economic recession caused abnormally, temporarily, high enrollment in the program.

Reminders: There is an additional Medicaid expansion savings account, the Medicaid Budget Stabilization Restricted Account, which had $74.5 million in it at the close of FY 2021. The legislature has chosen not to draw funds from this account.

The Medicaid expansion budget surplus was originally intended to be used on health programs, but that was rescinded when Proposition 3 was replaced with SB96.

- **Cost Transparency**
  - 2019 H.B. 178 Transparency Website Amendments, *(Daw)* required the state auditor to create a tool to present healthcare price information to consumers in a clear and accurate manner and report each year to the Health and Human Services Interim Committee on options for improving access to price data. The information presented by the auditor is from the state's all-payers health insurance claims database.

- **Coverage for Preventive Services**
  - If enacted, 2021 H.B. 194, Diabetes Prevention Program, *(Harrison)*, which passed the House and was recommended by a Senate committee, would have appropriated $500,000 to the state's Medicaid program to fund participation by enrollees in the National Diabetes Prevention Program.

- **Promoting Value-Based Plan Design**
  - Insulin
    2020 H.B. 207, Insulin Access Amendments, *(Thurston)* established enrollee cost sharing caps for insulin covered by certain health benefit plans. The Legislation also directed PEHP to create a program that allows Utahns to purchase insulin at discounted prices.

  - Epinephrine
    2021 H.B. 206, Epinephrine Auto-injector Access Amendments, *(Harrison)* expanded the PEHP discount program to include epinephrine auto-injectors.

FOCUS AREAS FOR THE FUTURE

- **Investment in Primary Care**
  - Increase utilization of primary care by increasing the number of primary care providers
    - Primary care is the essential foundation of a successful, sustainable healthcare system. Primary care helps prevent illness and death and is associated with a more equitable distribution of health in populations. A study found that patients who identified primary care physicians as their usual sources of care had lower five-year mortality rates than patients identifying a specialist physician as their usual source of care. (Mostashari F, Sanghavi D, McClellan M. Health Reform and Physician-Led Accountable Care: The Paradox of Primary Care Physician Leadership. JAMA. 2014; 311(18):1855–1856. doi:10.1001/jama.2014.4086)

    - Primary care treatment can not only improve the health of patients, but it is also a highly effective use of healthcare dollars. It is estimated that almost 40 percent of emergency department visits and roughly 10 percent to 17 percent of inpatient hospitalization costs are preventable. (Mostashari F, Sanghavi D, McClellan M., 2014).

    - Utah is ranked 49th out of 50th for primary care providers per 100,000 people. We have 187.5 per 100,000, well below the national average of 241.9 per 100,000. (America's Health Rankings, America's Health Rankings, 2021, p. 149)

    - Although there is some work being done to increase primary care, such as 2020 H.B. 87, Health Care Workforce Financial Assistance Program Amendments, *(Ward)*, which created options for providers entering the field, there are other political levers we can incorporate to facilitate a shift. Ongoing data about how many of our healthcare dollars are going toward primary care is a useful

measurement tool for a baseline and for comparison as we dive into this work in the state.

- ❖ Looking forward, we should be considering investment in building out the primary care infrastructure, and particularly boosting our primary care providers. (Investing in Primary Care: A State-Level Analysis. (2019). Milbank Memorial Fund. Retrieved August 30, 2021)

- ❖ State leaders around the country have a growing interest in using their legislative and regulatory authority to measure and report on primary care spending and, in some cases, to set targets for increasing investment in primary care over the coming years within their jurisdictions. Investing in Primary Care provides a high-level description of such efforts in 10 states, seven of which initiated their efforts in 2019. This focus on primary care spend and primary care investment suggests policymakers have some momentum to shift the U.S. delivery system back to its primary care foundation, so that it can better address diverse patient needs across different age and sociodemographic groups.

- ❖ Investing in Primary Care also examines states' primary care spending patterns, including spending across payer types, and considers the implications of these results for select patient outcomes.

- ➢ Encourage the use of innovative models that result in less spending while improving care
  - ❖ Innovative providers like ChenMed have demonstrated how to reduce healthcare spending with "high-touch" primary care models. "ChenMed's approach has resulted in 50% fewer hospital admissions compared with a standard primary-care practice, 28% lower per-member costs, and significantly higher use of evidence-based medications...." ("Primary-care companies cut costs through preventive models," Modern Healthcare, 10/20/18, accessed 09/14/21 at https://www.modernhealthcare.com/article/20181020/NEWS/181019908/primary-care-companies-cut-costs-through-preventive-models.)

  - ❖ Other innovative models, including direct primary care, are being explored. Fiacare is an example of a virtual direct primary care model.

- **Improve Utah's Medicaid program**
  - ➢ Simplify the Medicaid application and the enrollment process to remove administrative red tape.

  - ➢ Leverage the timing of the agency consolidation to evaluate the eligibility process and make improvements.

  - ➢ Address remaining coverage gaps through continuous eligibility, coverage for all kids, and solutions for pregnancy and post-partum.

  - ➢ Implement continuous eligibility to prevent the upcoming cliff at the end of the public health emergency, add permanent continuous coverage solutions.

- **Identification and Use of High-Value Care**
  - Continue to promote identification and use of highest-value care by analyzing the all-payers health insurance claims database and using the results to inform clinicians, patients, and third-party payers.
    - Waste Elimination
      - Continue to discuss and make all parties aware of the Department of Health's analysis of the database using Milliman's waste calculator (see 2020 H.B. 195, Identifying Wasteful Health Care Spending)
      - Respond to the department's findings and recommendations, due November 1, 2021.
    - Price Transparency
      - Continue work on the state auditor's consumer-facing price transparency website, which is based on the database (Utah Code Section 67-3-11).
      - Consider New York, which created a campaign to let the public know that its price transparency website exists and to encourage people in cost sharing plans to utilize it as a decision making tool for major health interventions and outpatient services.
      - Consider additional proposals that may impact pricing of medical products and services.

- **Addressing Coverage and benefits**
  - Continue considering proposals that promote expansion of affordable, value-based insurance coverage by Medicaid, PEHP, and the commercial market.

- **Addressing Costs**
  - Consider options to reduce costs by strengthening the purchasing position of employers and insurers for pharmaceuticals and other medical goods and services (see reports to the Health Reform Task Force by Johns Hopkins University in 2019 here, here, here, and here).

- **Rewarding Providers for Improved Outcomes**
  - Determine what role the state might play in encouraging healthcare professionals to organize themselves under risk-based payment systems that allow them to capture savings attributable to their investments in improving health outcomes for patients, including investments in prevention activities.