Health Value and Access Commission in New Mexico

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Chair, Study Group

How this proposal developed

- National reports continue to remind us that while we spend far more taxpayer & personal $$ on health care than all developed nations, outcomes don't always rank high (CF Mirror Mirror 2017).
- NM ranks 31st overall on a range of quality & affordability measures even w highest coverage rates in our history (CF Scorecoard 2018)
- These facts led to the convening by SOI and Rep Armstrong of a study group to look at how – IF we were smart about monitoring our health system components - we can ensure sustainability AND ensure measurable value and improved access.

Study Group

- Convener: John Franchini, Superintendent of Insurance
  Chair: Nandini Pillai Kuehn, Ph.D., MHA

MEMBERS IN ALPHABETIC ORDER	
Charles Alfero	Rep. Deborah Armstrong, J.D.
Paige Duhamel J.D.	R. Philip Eaton, M.D.
Larry Georgopolous Pharm.D.	Harvey Licht
Richard Mason	Lee Reynis M.A., Ph.D.
Michael H. Trujillo M.D.	James Tryon, M.D.

Issues confronting Legislators

- Legislators know that increasing health care payments play havoc with state budgets & appropriations across all state programs
- Legislators have regularly expressed frustrations about not having good analytical health data to help with difficult and competing balancing needs
- Health care costs continue to spiral upwards with no concrete reassurance of improved outcomes

More Challenges for Legislators

- CMS Forecasts big cost increases between 2017-2026
  - H.C. costs to grow an average rate of 5.5% per year, (totaled $5.7 trillion in 2017) & this growth is 1% faster than GDP
  - Aging of population and some changes in ACA will add to cost pressures
- Impact on state budgets
  - As purchaser of health care for ~185,000 state employees
  - As payer w Medicaid for est 800-900K & $5.8 billion in appropriations – huge and unknown impact if block grants introduced
  - Threatens funding for all other state programs
- We cannot control our future if we don't track our expenditures, measures of value & barriers to access

Remember these challenges…?

- Hospitals or clinics in distress ask for additional funding – facing closure without state help leaving communities with no h.c. *No capacity to assess the reasons and ensure long term solutions to access to care*
- 13 mental health clinics closed in the state – legislators do not know what happened to their patients. *Again, no data capacity, there were no assessments*.
- Unreimbursed care dropped to single digits NM, there was no change to prices of services or premiums. *Why?*

Need New Responses to Forecasted Changes

- … “ *our fragmented health system typically limits the ability of any one payer or stakeholder to incentivize the provider practice changes that will lead to lower costs*” (Altarum HC Value HUB, 2017)
  - Who in NM has quality, cost-effective outcomes? Replicate them?
- Moreover, for all future challenges need innovative solutions:
  - Can’t keep raising premiums & enrollee costs, cut provider payments
  - Need new responses to measure/incentivize value outcomes
  - Sustain/retain access: workforce and provider systems
  - Impact of job losses if health care sector retrenches
- Balance the impact on state coffers to fund education, social supports

What stops us now?

- We have no entity with the mandate to access comprehensive data across payers and providers to influence good policy development and/or assess & replicate PGMs with measurable, good outcomes
  - No analytical or storage capacity to collect, accumulate or analyze data and model forecasts, policy options
  - No capacity to research & develop long term solutions (instead of crisis reactions), assess innovative practices
  - No coordination of payment reform such as paying for value in our health system & innovative access strategies
  - No coordination of policy to optimize service coordination of state services

Solutions in Other States

- Study group reviewed other state oversight efforts
  - 5 states have oversight entities – MD, MA, VT, PA, OR
  - 18 states have an All Payer Claims Data Base
  - Other states (CT and CA) are moving in this direction
- States with oversight vary in population size, and budgets
- Not a one-size-fits-all situation: each State Commission reflects its own needs, policies, politics & priorities
- All have access to relevant health care costs, claims data

WIDE VARIATIONS IN OVERSIGHT ROLE

- Maryland Health Services Cost Review Commission
  - Independent state agency with 7 Commissioners apt by Gov
  - Started with CMS waiver orig to manage its own cost control mechanisms, recently renewed for “global cost of care” approach
  - Supported by hosp industry, analyses hosp utilization, costs, outcomes
- Massachusetts Health Policy Commission
  - Independent state agency with 11 Commissioners
  - Set up in resp to having highest per capita costs in country
  - 4 key functions: Research data based reports; expert input into statewide problems, Cost and Mkt review watch dog role, support innovation
  - Set targets for reducing cost growth

Achievements by Other States with Oversight Entities

- Maryland (est 1971): recent comparative study showed MD's average cost of healthcare for comparable populations = 16% below average of 5 other states
- Massachusetts (2013) had the highest per-cap h.c. costs in the US; set up a target for controlling cost-growth and exceeded their 3.6% target with 2.8% growth - estim $5.9 billion lower than without them
- Pennsylvania (1986) tackled double-digit cost growth by focusing on hospitals and succeeded in eliminating waste and poor practices = hospital readm rates, reducing hosp infections, and deaths from CABG
- Vermont's Green Mountain Care Board (2011) consolidated all their state health decision making under one Board, set hosp budgets and CON, and delivery system reform

PROPOSED STRUCTURE FOR NM

- An independent entity with a 9 member Commission reflecting geographic representation & skill sets required to provide unbiased analyses. The Director of Legislative Finance Committee and Superintendent of Insurance will be Commissioners

- Skill sets proposed and subject to conflict of interest provisions (all under development)
  - Executive level finance or management purchaser of health care; Consumer advocacy in health or human services; Small business; Health care management or finance; Health policy or public health expertise; Health care economics

- Advisory Councils –for permanent and one-off expert advisory role
  - Economics, Native American, health care disparities, delivery system council, council of federal policy, state and public entities

Overview of Scope

- Authority to receive de-identified, comprehensive utilization data from providers & claims from all payers (APCD), cost reports : accept existing data reporting requirements
- Identify cost drivers and payment outliers, variations in utilization, payment reform, rural/urban issues; socio economic drivers of health care costs - recommend changes
- Monitor implementation of recommendations for change, assess impact on NM of changes in federal policy
- As is done in other states, authority to levy assessments from providers &/or payers to become self-funding

NM's needs will be met by this Commission

1. Focus on Value – are we spending on the right things, are we getting value for what we spend? How to measure and monitor this across all health sectors; structural issues;
2. Access: quantify access barriers - are there innovative means we can collectively participate in that help mitigate geographic, financial and other barriers? Specialist access?

DATA HAS TO BE THE BEDROCK: MUST DELIVER VALUE

Cooperation and coordination, agreement on priorities, population based & evidence based program develop; consumer focused