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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

List of Attendees and Interviewees

We are extremely grateful to the experts who took the time to attend our convening in person or graciously agreed to speak with us by phone. Most also provided resources and reviewed this report. Any errors remain the responsibility of the Healthcare Value Hub.

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factors that drive variations in price, utilization and quality are unique to each state, states may be best positioned to understand the specific "hot spots" that need attention in their local healthcare markets.

Currently, states vary in what they view as their responsibility when it comes to healthcare system efficiency and differ philosophically on the role of government vis-a-vis residents. While some services are uniformly viewed as state responsibilities—like public safety and education—there is much wider variation in views about public responsibility to provide access to affordable care and promote the wise use of health resources.

While all states have well-defined roles for certain segments of their health system, such as Medicaid, state employee coverage, healthcare delivered within the justice system, public health and safety-net coverage, relatively few states take a comprehensive, systematic approach to ensure that all consumers get value for the healthcare money they spend.[3] For example, most states fail to collect timely and reliable data to identify local healthcare cost drivers, poor quality providers, whether or not interventions designed to improve healthcare value are working as intended, and many lack HHS waiver authority to implement broad multi-payer approaches.[4]

But participants agreed that *all* states are under financial pressure to prioritize and promote health system efficiency to manage their budgets and attract employers, who are well aware of the impact of health costs on their bottom lines. Further, surveys have found that citizens are looking to government to address healthcare access, pricing, quality and transparency problems that individuals have no power to control and markets will not address.[5]

Areas for State Accountability

The participants suggested ways in which states can become better stewards of healthcare, noting that states already oversee many aspects of healthcare. As one participant said: "States have a ton of tools they can use. They are purchasers, regulators, taxers, conveners, employers, and collectors and disseminators of information." They have oversight for Medicaid, state employee coverage, healthcare delivered within the justice system, public health and safety net coverage.

Of these, **Medicaid** merited special attention by the group. The share of state budgets devoted to Medicaid varies among states but is universally substantial.[6] Moreover, the program has a tremendous impact on the health of residents, particularly children.[7] Many states have taken a systematic approach to improving outcomes under this program.[8]

Other state roles discussed by participants included:

Establishing a comprehensive, integrated state plan. The sectors of a state's healthcare system are interdependent, and progress in one area may lead providers to make up lost revenues in another area. For example, efforts to limit per admission hospital charges have been shown to increase the volume of admissions.[9] To ensure that efforts to control costs do not result in quality or access problems, states must **establish goals** and **data systems** that look comprehensively at healthcare spending and quality.

Collecting reliable and actionable data is essential to evaluating a state's unique healthcare market, health system performance and progress towards goals.[10] Establishing a multi-payer claims database enables policymakers to make sound policy decisions and track the effectiveness of interventions.

Insurance rate review has historically been used by states with a variety of approaches and to widely different levels of public accountability. Noting that insurance rates are something consumers care deeply about, participants discussed new authority to enhance the factors that regulators examine, funding to increase regulator capacity, and review processes which include input from the public and consumer advocates. A robust review process can serve as a public "check in" to see if the state's fully insured products are conforming to the state's overall healthcare value plan. Among other states, California, Rhode Island and North Dakota have recently used the rate review process to reduce rates for consumers.[11]

States are uniquely positioned to oversee the **wise use of resources and proper investment in "upstream" health approaches**. For reasons discussed below, few states look at the "big picture" when thinking about wise health spending. However, proper funding on upstream interventions have been shown to reduce healthcare costs. For example, since half of births in some states are financed through Medicaid, states could benefit from investments in initiatives to prevent low birthweight babies.[12] There is a tight connection between the weight of babies at birth and how they develop later in life into productive workers. One participant pointed out that increased funding for mental health services can lead to fewer crimes and lower prison populations. Another example is low birth weight of babies, since half of births in some states are financed through Medicaid.

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Participants noted that there's a role for the states' **Attorneys General** to address issues such as market consolidation, consumer protections, price gouging and oversight of community benefits by nonprofit hospitals.

Finally, the group discussed the important role states can play as **conveners** to bring together providers, insurers, employers and other stakeholders to develop coordinated action to improve quality and reduce costs.[13]

Barriers to State Accountability

As one participant said "self interest dictates that states should be doing this" yet this is rarely the case. Participants identified several barriers preventing states from acting as stewards of healthcare.

Limited Resources and Competing Priorities: State governments are constrained by the need to annually balance their budget, have limited ability to raise revenue and, in most states, limited personnel resources.[14] As one participant said: "States divide their world into two categories: things they *have to do*—like balancing the budget and getting reelected—and things they *want to do*. Unless they see stewardship as something they HAVE to do, they are unlikely to focus on it."

Participants brainstormed on how to make healthcare affordability a *have-to-do* issue. For example, creating

a "business case" for how states more easily balance budgets over the long term by addressing healthcare affordability and rallying persistent voter and employer demand for scrutiny. Some in the group also suggested engaging leaders, such as the insurance commissioner, to take a more aggressive role in addressing healthcare affordability. While participants commended the few states that have created agencies tasked with comprehensively addressing spending and affordability,[15] the group generally agreed that most states would be unwilling to dedicate funding to these activities. As a result, increasing state accountability would ideally require minimal new state resources.

Voter Perception: The cost of healthcare is a top consumer concern, but many consumers feel that unaffordable healthcare is an intractable problem without a solution. One participant likened it to the inability to control the weather. However, consumers should be made aware of the state's ability to make positive impacts on the healthcare system. As an analogy, a participant noted that states can require consumer protections to mitigate the dangers associated with uncontrollable events or accidents, such as building codes for regions that are prone to tornados, flooding or earthquakes or requiring drivers to buy liability insurance in order to get a license.

Multiple Purchasers and Payers: Highly segmented healthcare markets provide very different levels of opportunity for multi-payer initiatives to address healthcare value. For example, states regulate commercial health insurance, but most regulation only applies to individual and small group insurance. Most large groups are self-insured and largely exempt from regulation under ERISA. Some states have been able to develop multi-payer initiatives that include self-insured plans, state employee plans, Medicaid and even Medicare, but it can be difficult to bring all payers together to coordinate on common goals or evaluate or make recommendations to address local efficiency problems.[16] Although a couple of states exercise authority over provider payment across payers,[17] most lack the statutory authority and expertise essential to undertaking that task.[18]

With respect to Medicare, participants identified the RVS Update Committee (RUC) as a major obstacle to achieving better healthcare value. The committee, coordinated by the American Medical Association, provides CMS with recommendations regarding the value of physician services under the Medicare physician fee schedule. However, this group has historically been criticized for recommending high reimbursement rates, especially for new technologies and specialty providers. Participants believed experts responsible for establishing the fee schedule should be less financially invested in the outcome.

Center for Medicare & Medicaid Innovation (CMMI): Participants raised the concern that if funding for CMMI were to be repealed—and with it the focus on multi-payer initiatives and fee-for-service alternatives—innovation in the healthcare industry would stall. Through State Innovation Model grants, CMMI provides critical funding to design and implement strategies for health system transformation.[19]

Graduate Medical Education (GME)*:* Some participants noted that federally determined GME funding levels may under-invest in patient-centered care by establishing too few slots for primary care and geriatrics, and failing to emphasize the role of socio-economic factors and team-based care.[20]

Provider and Insurer Consolidation: Growing provider and insurer consolidation often results in higher prices for consumers and may make it more difficult to accomplish practice transformation. Participants also noted that large corporations are able to finance large lobbying campaigns to oppose government actions. States should take a more active role in evaluating whether mergers (both horizontal and vertical) have tangible long-term benefits for consumers.

Absence of Data Systems to Support Accountability: Reliable and actionable data is essential to understanding a state's unique healthcare market. Many states have, or are in the process of creating, all-payer or multi-payer claims databases (APCDs). However, it is far less common that these datasets are used to take a robust, comprehensive look at state spending and utilization to inform a strategic plan. Participants believed that APCDs and other data systems should be promoted. Participants noted new challenges related the Gobeille

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vs. Liberty Mutual decision which established that self-funded employer participation in APCDs is voluntary.[21] Databases lacking wide participation are less useful for conducting analyses.[22]

Next Steps to Better Accountability

Participants spoke at great length about the appropriate next steps to encourage states to become accountable stewards of healthcare. Three broad steps were identified: defining the problem, generating public support and creating a pathway for action.

Defining the Problem

Healthcare in the U.S. is notoriously inefficient, complex and expensive. That is why healthcare costs are a top financial concern for consumers and governments at all levels. Using this research brief as a starting point, a broad group of stakeholders needs to carefully define the problem, the reasons for why state action needed to increase health system efficiency and decrease the consumer harm caused by poorly functioning markets.

Gaining Public Support

The participants identified several tools that could help motivate policymakers to commit to a specific plan of action.

One expert suggested focusing on **educating legislators** on what actions we want them to take, the results of the action, and the proponents and opponents of the proposed action. Many participants focused on the importance of leveraging patient stories that resonate with media, policymakers and voters. For example, stories of consumers who faced exorbitant surprise medical bills have helped motivate protective legislation in many states. These consumer stories should be tied to specific goals that reflect a comprehensive understanding of the state's healthcare delivery system.

Finding the right messaging will be important in encouraging the adoption of state accountability. Besides the primary audience of the state legislators, the messaging must also resonate with consumers.

Effective messaging can **convince consumers** that healthcare affordability is a solvable problem and lead to a unified call to action to pressure elected officials to act. The participants recommended focusing messaging around jobs and wages. For example, by describing increasing healthcare premiums as leading to lower paychecks—"wage theft," or as a cause for layoffs or decreasing the number of available of jobs. Another messaging opportunity centers on the confusion and angst consumers feel when interacting with the health system. Participants liked using the term "shopping blind" to describe consumer experiences while trying to navigate the healthcare system. Messaging should also anticipate the opposition, potentially originating from powerful stakeholders in the healthcare community.

In a similar vein, participants recommended getting buy-in from a **diverse coalition of local stakeholders**. Participants suggested local Chambers of Commerce and other business coalitions, regional health improvement collaboratives, law enforcement, state public health and public policy institutes, large employers and employer groups, disease and trade associations among others. This coalition could also serve as trusted messengers for the public.

Creating a Pathway for Action

In addition to pressure from voters, participants agreed that the business case must be made to convince states—liberal and conservative—that accountability results in better efficiency and more healthcare value. More efficient spending can ease pressure on a state's budget, make the state more attractive to employers and alleviate voters' concerns.

Drilling down on the need to establish the business case, the group discussed:

- Establishing the "cost" of poor health by tying current state spending on education, prisons, retirement/pensions explicitly to healthcare spending efficiency. For example, taxpayers pay for the healthcare provided to prison inmates and the treatment of opioid abuse. Tackling the opioid epidemic can reduce the prison population and lead people to live healthier lives. Likewise, if the healthcare costs of retired state workers increases because preventative care was not provided the amount the state has less to spend on other programs. A participant suggested a way to communicate this point to state policymakers is to review the economic impact of poor vs strong healthcare value policies.
- Working with state budgetary officials to see if broader health costs and savings—including future costs and savings—can be accounted for more clearly.
- Leveraging existing APCDs to calculate the economic competitiveness of the state compared to other states.

By framing accountability as helping states meet their economic obligations or as gaining competitiveness, and in the context of existing resources and capacities, states may be more likely to take action to become stewards of healthcare.

To ensure that messaging about the business case for state accountability is effective, participants suggested holding a focus group of five to ten members of Congress or state legislators. The focus group would seek to learn how to convince legislators that tackling rising healthcare costs and poor population health is imperative to their budget or their re-election. While owning up to how difficult it is to address inefficient health spending, we also need to learn how to convince state legislators they have the capacity and capability to make a difference. As one participant put it: "Be prepared to address their questions. What action do you want me to take and what will be the result? Who will hate me if I advance it? Who will support me?

Because states often compare themselves to their geographic neighbors, participants suggested **developing comparison products** so states can see how they perform compared to other states. Participants, however, were somewhat divided as to whether state report cards would be particularly useful. After all, there are already a large number of "report cards" in use today. The best move may be to consolidate existing scorecards and add an affordability component to better account for how health spending impacts the consumer. The need for a trusted, unbiased source for this information was raised by several participants. Several recommended the need to emphasize goals and endpoints and may not need to prescribe how states achieve them.

State accountability of healthcare should be embraced as a way to spur efficient use of state financial resources, bring better value and affordability to residents and create healthier communities.

Workgroup participants also recognized the importance of **timing in the political process**. One strategy would be to provide model legislation, fact sheets or other supporting products to allies and stakeholder groups, and wait for the right time, or right state champion, to take action. One of the greatest challenges is to determine how to get the accountability commitment to transcend different administrations.

Finally, the workgroup also identified the need to **find state champions** who will promote state accountability for healthcare. A well regarded state insurance commissioner, governor or staffer, state legislator, respected consumer advocate, academic thought leader, or individuals that participated in CMMI projects could be helpful champions.

Always a Role for Federal Government

Participants agreed that federal government engagement is critical to promoting a fair, high quality and efficient healthcare delivery system. As we've seen across myriad federal programs that provide grants to states, these initiatives can be crucial to building sustainable capacity in states. Moreover, Medicare demonstrations and provider payment reforms have been influential spurring changes

in healthcare delivery among other payers, including private market payers. The federal government can also generate critical evidence, sponsor program evaluations and fund data collection that helps inform state policy.

The Reforming States Group, a bipartisan group of state health leaders coordinated by the Milbank Memorial Fund, highlighted four key policy concepts of federal-state partnership: support state efforts for broad reforms of healthcare payment and delivery; support state efforts to address causes and improve management of chronic illness; support state use of date to inform policy; and strengthen the state-federal partnership on health to assure greatest impact from federal investments. [23]

Perhaps the most important federal function is to provide strong guardrails that protect consumers and a federal fall back to ensure that states have critical, minimum safeguards with respect to access to coverage, market rules and other key components of how consumers get and use healthcare and health coverage.

Conclusion

This diverse group of experts agreed that states should act as stewards by establishing broad strategic goals, collecting and using data to evaluate progress in achieving the goals and providing transparent results to the public. Participants noted that state accountability for healthcare is a way to spur efficient use of state financial resources, bring better value and affordability to residents and create healthier communities.

Adopting an accountability role is one important avenue for addressing a top consumer concern, the rising cost of healthcare. Success managing rising healthcare costs would also provide states extra flexibility in their budgets.

More work is needed to address the barriers states currently face in adopting an accountability role for healthcare value. This work will require diverse stakeholder coalitions, committed champions in the states and resources to generate state buy in, such as a "playbook" of successful interventions and guidance on how to develop a state-specific business case.

Some states have already taken aggressive steps to become accountable for their local health systems that have provided proof-of-concepts on this issue,[24] while the concept of accountability will be new to many other states. But participants agreed that it is in states' best interest to make their health systems more efficient—both for their budget bottom line and to lower costs for citizens.

The participants agreed to continue to work together to encourage and better support states to become better stewards of healthcare.

Notes

1. *The World Health Report 2000. Health Systems: Improving Performance*, World Health Organization (2000).
2. *Healthcare Costs Top U.S. Families' Financial Concerns*, Gallup (April 27, 2016). *http://www.gallup.com/poll/191126/healthcare-costs-top-families-financial-concerns.aspx*
3. *Measuring Healthcare Value at the State Level: A Call to Action*, Research Brief No. 15, Healthcare Value Hub (December 2016).
4. Ibid.
5. See for example, *Engaging Consumers on Health Care Cost and Value Issues*, Consumers Union (October 2014).
6. *Medicaid's Share of State Budget*, Medicaid and CHIP Payment and Access Commission (MACPAC). Available at: *https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/*
7. *Medicaid Enrolment by Age*, Kaiser Family Foundation (webpage).
8. Van Vleet, Amanda, and Julia Paradise, *The State Innovation Models (SIM) Program: An Overview*, Kaiser Family Foundation (Dec. 9, 2014).
9. Murray, Robert, and Robert Berenson, *Hospital Rate Setting Revisited*, Urban Institute (November 2015).
10. An example provided by one participant is Ohio's Health Value Dashboard. Available at: http://www.healthpolicyohio.org/2017-health-value-dashboard/
11. *Effective Rate Review Programs*, CMS Center for Consumer Information & Insurance Oversight. Available at: *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/rate_review_fact_sheet.html*
12. For example, see: Rosenthal, Jill, *A Labor of Love: State Policies and Partnerships to Lower Infant Mortality*,

National Academy for State Health Policy (Nov. 28, 2016).

13. For case studies of multi-payer initiatives in Arkansas, Minnesota, Oregon and Vermont, see: Stremikis, Kristof, *All Aboard: Engaging Self-Insured Employers in Multi-Payer Reform*, Milbank Memorial Fund (2015).
14. Feder, Judy, et al., "Statewide Payment and Delivery Reform: Do States Have What It Takes," *Journal of Health Politics, Policy and Law* (forthcoming).
15. See, for example, Massachusetts, Minnesota and Vermont case studies in *Measuring Healthcare Value at the State Level: A Call to Action,* Research Brief No. 15, Healthcare Value Hub (December 2016).
16. Musumeci, MaryBeth, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understand Approved by CMS*, Kaiser Family Foundation (Dec. 7, 2015).
17. For example, the work done under SIM, as well as the Maryland and Vermont case studies in *Measuring Healthcare Value at the State Level: A Call to Action,* Research Brief No. 15, Healthcare Value Hub (December 2016); See also, Stremikis (2015).
18. Feder, Judy, et al. (forthcoming).
19. *State Innovation Models Initiative*, Centers for Medicare & Medicaid Innovation (webpage).
20. *Graduate Medical Education That Meets the Nation's Health Needs*, Institute of Medicine (July 2014).
21. The National Academy for State Health Policy, in collaboration with the National Association of Health Data Organizations and the APCD Council announced that they are developing a Common Data Layout (CDL) for the collection of claims data in a single national standard format, which addresses a major concern of the justices. See: *Comments on Department of Labor Notice of Proposed Rulemaking*, NASHP (Sept. 20, 2016).
22. *Necessary Versus Sufficient Claims Data*, Data Brief No. 4, Health Care Cost Institute (July 2016).
23. Koller, Christopher, Thomas Alexander and Susan Birch, "Population Health: A Bipartisan Agenda for the Incoming Administration from State Leaders," *New England Journal of Medicine* (Dec. 15, 2017).
24. See *Measuring Healthcare Value at the State Level: A Call to Action,* Research Brief No. 15, Healthcare Value Hub (December 2016) and the *Health Care Stewardship Case Studies*, Urban Institute for Colorado, Ohio, Oregon, Minnesota, and Vermont. Available at: *http://www.urban.org/policy-centers/health-policy-center/projects/health-care-stewardship-case-studies*

Resources to support state accountability efforts are available at *www.healthcarevaluehub.org/advocate-resources/state-accountability*

Meghan McMonagle, health policy analyst, and Tad Lee, communications manager, authored this report. Thanks to meeting participants for their valuable review and input.

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