Puget Sound Health Alliance

Cost/Price Transparency
All Alliance Meeting
March 8, 2013

Alliance Mission and Vision

Mission:

To build a strong alliance among patients, providers, purchaser, health plans and others to promote health and improve quality and affordability by reducing overuse, underuse and misuse of health care services.

Vision:

By 2017, physicians, other providers and hospitals in the region achieve top 10% performance in the nation in the delivery of quality, evidence-based care and in the reduction of unwarranted variation, resulting in a significant reduction in medical cost trend.

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Strategic Goals to Achieve the Vision

1. **Reduce cost/price of health care services**
   - Develop and implement the capability to measure cost of care
   - Total cost of care; episodes of care; Potentially Avoidable Complications
   - Cost of drugs (generics, specialty drugs)
2. **Reduce overuse of health care services**
   - Avoidable use of ER
   - 30-day hospital readmissions
   - Ambulatory-sensitive hospitalizations
   - Unwarranted variation in Resource use/Intensity of care
   - Non-evidence based testing and services (Choosing Wisely)
   - Elective, preference-sensitive procedures
3. **Reduce underuse of effective health care**
   - Management of chronic disease for adults in primary care setting
   - Prevention screening
   - Patient experience/consumer engagement

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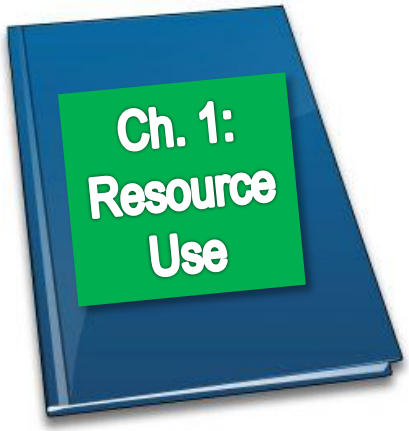
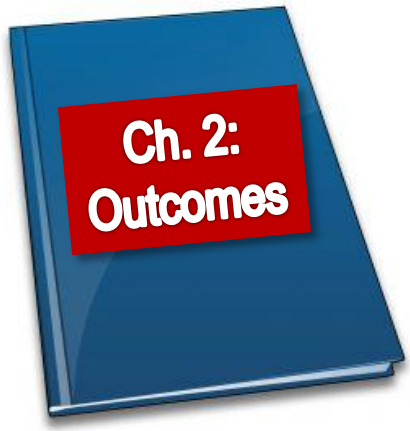
Common Hospitalizations Report Release Sequence

Released as "chapters" to purchasers and providers

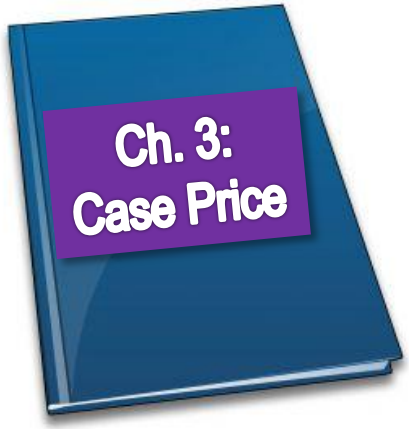
First Resource Use, then Outcomes, and finally Total Case Price



April 2012
Commercial Patients
Service Intensity and Consistency
…by delivery system



January 2013
Medicare Patients
Mortality and Patient Safety rates
…by delivery system



Spring 2013
Commercial Patients
Inpatient Case Price Variation
…by delivery system

Price Transparency

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The Alliance has a two-pronged approach.

Aggregated allowed amounts for distinct hospitalizations

TRACK A

Price variation for 20 common hospitalizations

A one-time, ad-hoc study with data from 6 health plans and 8 self-insured purchasers.

A first step, to show results and confirm interest in measuring/reporting price variation.

Price Transparency – Track A

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Goals:

- Measure and report (to Alliance members) variation between delivery systems in commercial prices for high volume hospitalizations.
- Use results to complement other Alliance inpatient reporting on differences between delivery systems in (1) service intensity and (2) quality
- Demonstrate capability to report on costs through a voluntary effort

Methods:

- For selected high volume hospitalizations, health plans add up their contracted prices for all facility and professional services in each inpatient case
- Data sent to Milliman to develop blended, multi-payer average case price for (1) each type of hospitalization (APR-DRG), (2) the community overall, and (3) each delivery system
- Alliance will array and report results by delivery system, merging hospital and professional prices.
  - Reports will not show dollar amounts but use index for variation.
  - Different report formats for purchasers and providers

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Total Case Price variation: reports for purchasers

Separate report for each kind of hospitalization, severity adjusted

1. Delivery system's case prices compared against regional quartiles
2. Each delivery system's average case price shown as a relative index
3. Magnitude of regional price variation is quantified

PURCHASERS' REPORT (EMPLOYERS, UNION TRUSTS, and HEALTH PLANS) *SAMPLE*

Cesarean Delivery, minor severity

	Overall Case Distribution	Percent of Delivery System Cases Priced within Regional Quartiles				
	Region Quartiles (EXPECTED)	Alder Sytem (OBSERVED)	Birch Sytem (OBSERVED)	Cedar Sytem (OBSERVED)	Dogwood Sytem (OBSERVED)	Elm Sytem (OBSERVED)
Highest Price Level	**25%**	5%	20%	25%	20%	45%
Higher	**25%**	15%	20%	25%	40%	35%
Lower	**25%**	30%	40%	25%	20%	15%
Lowest	**25%**	50%	20%	25%	20%	5%
	100%	100%	100%	100%	100%	100%
Average Case Price Index	**1.00**	0.65	0.92	1.00	1.94	3.10
Magnitude of Regional Price Variation	**6.1x**	(95th percentile case price / 5th percentile case price)				

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Total Case Price variation: reports for providers

Separate report for each kind of hospitalization, severity adjusted

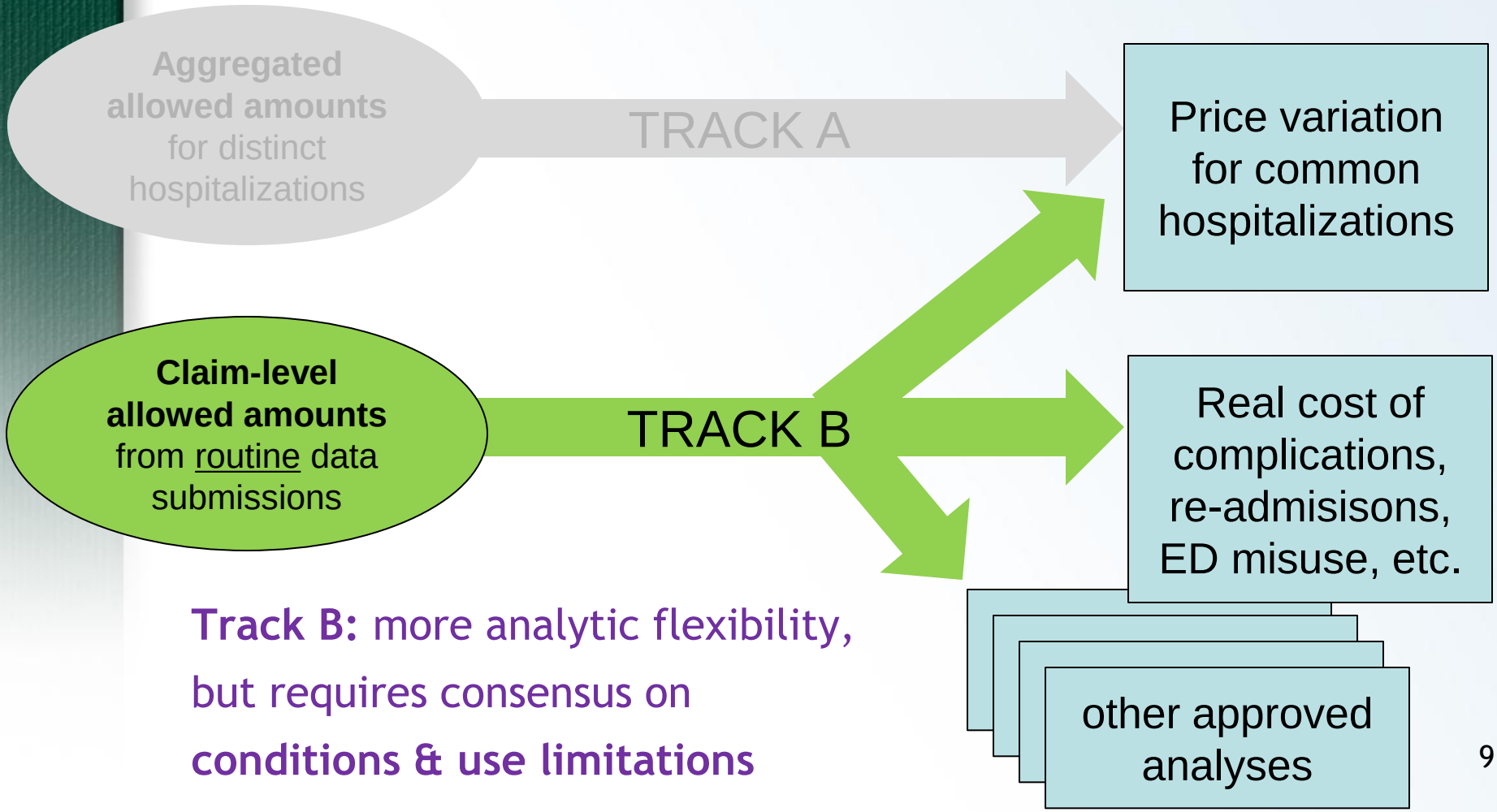
1. Recipient's case prices compared against regional quartiles
2. Magnitude of regional price variation is quantified
3. No relative index; no other delivery systems shown

PROVIDER'S REPORT *SAMPLE*

Cesarean Delivery, minor severity

	Overall Case Distribution	Percent of Delivery System Cases Priced within Regional Quartiles				
	Region Quartiles (EXPECTED)	Delivery System 1 (OBSERVED)	**Birch Sytem** (OBSERVED)	Delivery System 3 (OBSERVED)	Delivery System 4 (OBSERVED)	Delivery System 5 (OBSERVED)
Highest Price Level	**25%**		20%			
Higher	**25%**		20%			
Lower	**25%**		40%			
Lowest	**25%**		20%			
	100%	0%	100%	0%	0%	0%
Magnitude of Regional Price Variation	**6.1x**	(95th percentile case price / 5th percentile case price)				

The Alliance has a two-pronged approach.



Track B: more analytic flexibility, but requires consensus on **conditions & use limitations**

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Alliance's Price/Cost Transparency Task Force

Background

- The health plans, whose provider agreements govern pricing terms, cited confidentiality clauses in those agreements as the major legal impediment to providing allowed amount information to the Alliance
- Advice from a variety of stakeholders was to try to find a solution outside of the legislative process
- Alliance Board instructed staff to convene key stakeholder representatives to find areas of mutual interest for a voluntary solution.
- Task Force made recommendations, which Alliance Board approved January 29.

Alliance's Price/Cost Transparency Task Force

Objectives

- Agree upon stakeholders' collective goals for price transparency and Track B;
- Develop a clear understanding of each stakeholder's interests related to the routine sharing of price data for measurement and reporting;
- Set forth a framework of methods and restrictions to guide the Alliance's further development of a detailed plan and;
- Agree upon uses of the data that reflect the interests of stakeholders balanced with the Alliance's goal of increased price/cost transparency.

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Price/Cost Transparency Task Force

	Member	Organization	Stakeholder Group
1.	Steve Hill, Chair	Washington State	Purchaser
2.	Mark Adams, MD	Franciscan Health System	Provider
3.	Christopher Blanton	CIGNA	Health Plan
4.	Scott Bond	WA State Hospital Association	Provider
5.	Tom Curry	WA State Medical Association	Provider
6.	Joseph Gifford, MD	Providence Health System	Provider
7.	David Grossman, MD	Group Health Cooperative	Health Plan/Provider
8.	David Hansen	UnitedHealthcare	Health Plan
9.	Beth Johnson	Regence Blue Shield	Health Plan
10.	Gary Kaplan, MD	Virginia Mason	Provider
11.	Mary Anne Lindeblad	WA State Health Care Authority	Purchaser
12.	Greg Marchand	The Boeing Company	Purchaser
13.	Peter McGough, MD	UW Neighborhood Clinics	Provider
14.	Gary McLaughlin	Overlake Hospital Medical Center	Provider
15.	Larry McNutt	Carpenters Trust	Purchaser
16.	Jim Messina	Premera Blue Cross	Health Plan
17.	Steve Mullen	Washington Business Roundtable	Purchaser
18.	Tom Richards	Alaska Air	Purchaser
19.	Ron Sims		Consumer
20.	John Wagner	Aetna	Health Plan
21.	Caroline Whalen	King County	Purchaser

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Track B: Goals

Use allowed amounts from data suppliers in routine semi-annual claims submissions to:

- Develop credible, comprehensive reporting on provider performance incorporating both cost and quality data that reflects a blended, multi-payer perspective *in order to bring to scale delivery system changes and payment reform*
- Use price information together with quality
- Incorporate price to begin measuring and rewarding value, not to display unit prices
- Advance employer adoption of value-based benefit designs and linkage of members to high performing care systems
- Measure reductions over time in unwarranted cost variation
- Improve speed-to-market for Alliance projects, while reducing expenses and administrative burden for staff and payers.

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Stakeholder Interests: Purchasers

1. Understand cost/quality variation across the entire system (all payers) to:
   - Leverage purchasers' combined efforts with the same information for a robust view of provider performance
   - Constrain cost shift and reward high value delivery systems
2. An independent source of information on cost variation that employees will trust and to help mobilize the community
3. Robust, community-wide information to inform the development of new payment system approaches
4. Keep healthcare local by learning & recognizing where excellent value is delivered
5. Enable provider systems to identify and adopt preferred practices and innovate

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Stakeholder Interests: Providers and Delivery Systems

1. A single, common multi-payer data source to enliven opportunities to mobilize the provider community, triggering culture change
2. Information that drives more efficient and effective care, not just reward low-cost providers
3. Focus on the total cost of care AND quality and appropriateness; adjust for population differences
4. Inform the development of new payment system approaches

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Stakeholder Interests: Health Plans

1. Preserve confidentiality of plan-provider contracted unit pricing
2. Avoid unintended consequences of duplicating plan cost calculators, showing disparate information that confuses plans' payment reform efforts, or raising provider prices
3. Data must be secure and restricted to uses agreed-upon by data suppliers
4. Motivate purchasers to adopt value-based (steerage) programs offered by payers
5. Enable a credible, comprehensive view of provider performance not possible with single payer data
6. Increase administrative efficiency in performance measurement
7. Raise public awareness of variation in the quality and cost of care

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Stakeholder Interests: The Alliance

1. Support Alliance Board-directed efforts to identify opportunities for savings and inform collective strategies, especially value-based purchasing
2. Enable analysis of price/cost variation among providers in this market based on aggregated multi-payer data;
3. Continue voluntary, collaborative approach if possible but disrupt culture that rewards volume and opacity
4. Enable a faster, more streamlined, less expensive process for measuring/reporting on price/cost;
5. Avoid duplicating health plan-provided consumer-focused cost calculators

Price Transparency Comes in Different Forms and They Are Both Important

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CONSUMER HEALTH CARE COST CALCULATORS

- Best provided by plan administrators
- Most credible if cost information is linked with quality info
- Ability to link data to provide custom info for individuals:
  1. Individual consumer's health plan/status of benefits
  2. Plan's contracted provider network, reflecting discounts
  3. Consumer's specific search/query for particular service or procedure
- Useful to help individuals/families make decisions
  - Plan for annual (known) health care expenses
  - Compare cost of care for treating some health conditions
  - Choose providers for specific services and procedures

Price Transparency Comes in Different Forms and They Are Both Important

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ANALYTIC REPORTS FOR BUYERS/SELLERS

- Best provided by neutral, third-party
- Utilize multi-payer, blended information on pricing to understand total market dynamic
- Informs community-wide efforts to reduce unwarranted variation/waste and improve overall value
  - Understand regional "health spend" and primary drivers of cost trend
  - Identify higher value systems for inpatient and outpatient care
  - Identify cost of avoidable care and inform strategies for addressing "waste"
- Useful to help purchasers be effective as change agents
  - Leverage purchasers' combined efforts with same information and robust view of provider performance and market variation
  - Inform benefit design, contracting and payment approaches to reward value
  - Demonstrate value of anchoring members to higher performing care systems in new plan products

Track B: Methods

- Data suppliers would include claim-line allowed amounts in routine, semi-annual data submissions to the Alliance
  - Use of the data would be defined by the master Data Supplier Agreement.
  - Uses would be limited to those approved by the Alliance Board and subject to agreement by data suppliers.
- The Alliance would measure and report to Alliance members a blended, multi-payer view of regional health costs, delineated by geography and/or delivery system
- Detailed reports would be provided to purchasers, providers and health plans. If required, report content will differ for providers/health care delivery systems/plans to maintain compliance with antitrust recommendations.
  - The Alliance would create other report versions utilizing summary-level information that is appropriate for the public.
- The experience of implementing Track A would be incorporated into Track B efforts.

Track B: Restrictions on Use of Data

- Results must preserve the confidentiality of plan-provider contracted unit pricing and preclude inferring plan-specific contracted rates for specific services
- Data must be secure and restricted to uses agreed upon by the Alliance Board of Directors and data suppliers
- The Alliance or its data aggregator will not use the claim-level allowed charge data for:
  - Cost-calculators for consumers
  - Reporting/disclosing negotiated prices for discrete services (i.e., at the claim line level)
  - Commercialization of service price data
- Results must be used in a manner that discourages lower priced providers from leveraging higher prices in contracting.

Recommendation: Project #1

STRUCTURE OF REGIONAL HEALTH COSTS

- Show the total yearly cost per insured person, breaking it down into types of services received
  - Identify specific areas where cost savings can be targeted
  - Achieve a consensus around interventions and strategies
  - Measure progress in making improvements
- Example of similar effort:
  - Maine Health Management Coalition

Potential Cost Savings from Key Initiatives

Cost Reduction Initiative	Reduction in Total Annual Spending	
	Short Term	Medium Term
Reduce Admissions and Readmissions for Chronic Illness	**0.6%**	**3.2%**
Increased Payments for Medical Homes ($3 PMPM)	-0.8%	-0.8%
15% Reduction in Chronic Disease Admissions with 50% Rebate to Hospital for Fixed Cost	1.3%	
30% Reduction in Chronic Disease Admissions with 25% Rebate to Hospital for Fixed Cost		3.9%
Reduce Variation in Utilization for Outpatient Services	**0.9%**	**2.0%**
Reduce Utilization of Top 10 Outpatient Services to Median County PMPM	0.9%	0.9%
Reduce Utilization of 50% of Other Outpatient Services to Median County PMPM		1.1%
Reduce Variation in Price for Outpatient Services	**2.0%**	**6.5%**
Reduce Price of the Top 10 Outpatient Services to Median	4.0%	13.0%
Reduce Prices for Inpatient Care	**1.0%**	**4.4%**
Reducing Average Price for Case Mix Adjusted Price per Admission	1.0%	4.4%
Reduce Variation in Treatment for Preference Sensitive Conditions	**0.4%**	**0.6%**
25% Increase in Fee for Vaginal Delivery	-0.1%	-0.1%
Reducing C-Section Rate from 33% to 25%; 50% Rebate to Hospital, Then 25%	0.4%	0.6%
Reduce Administrative Costs	**1.0%**	**2.0%**
Reduce administrative costs	1.0%	2.0%
Improve Wellness and Community Health	**0.0%**	**4.8%**
Reduce Risk Factors by 2%		4.8%
Total Annual Savings	**5.8%**	**23.4%**
Reduction in Projected Savings Due to Compounded Effects	**1.5%**	**5.9%**
Total	**4.4%**	**17.6%**

Draft

Maine Health

Possible Project No. 2

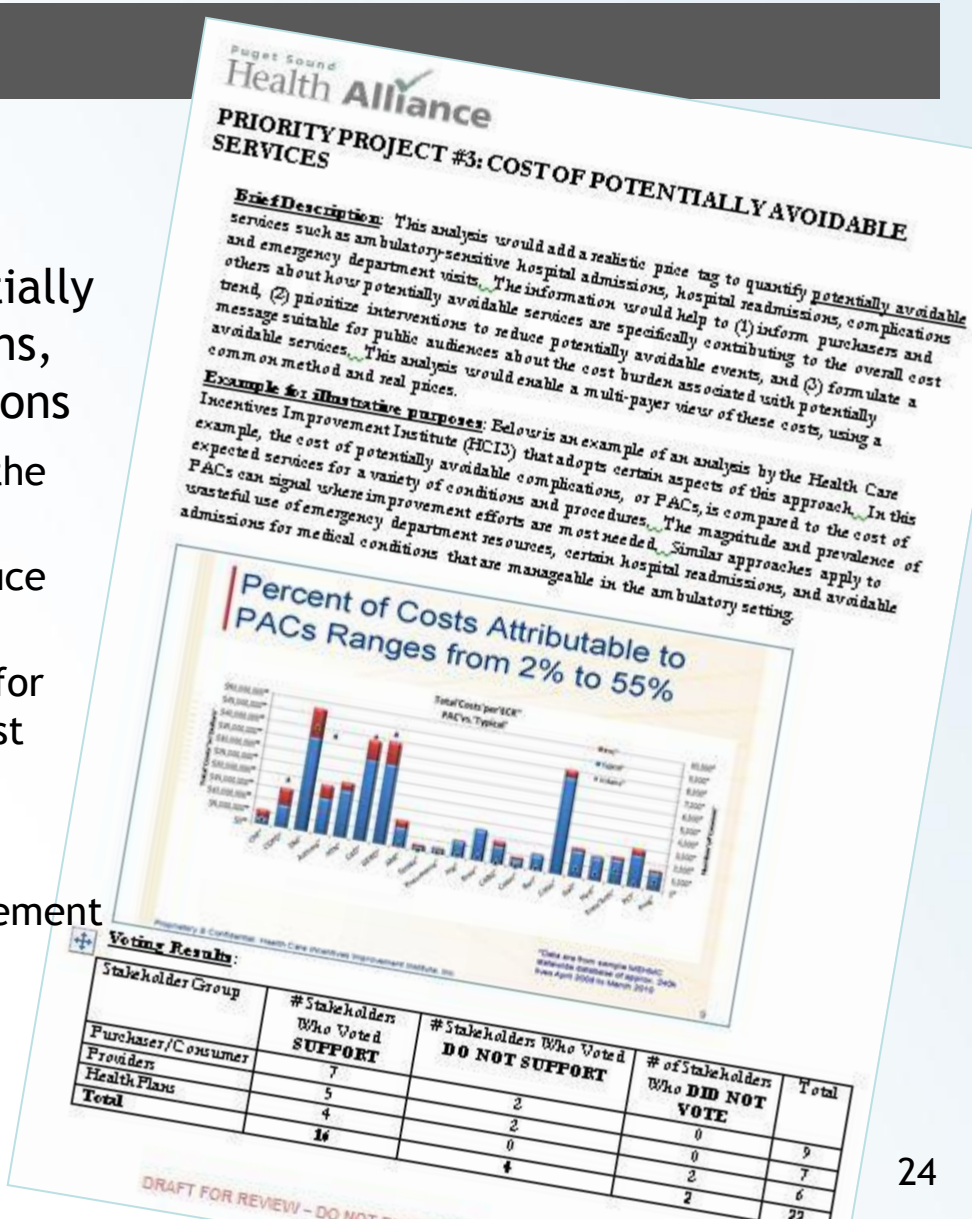
IDENTIFYING HIGH VALUE SYSTEMS

- Use price information along with pre-existing resource use and clinical outcomes data to help purchasers begin to identify:
  - Delivery systems with higher performance patterns for certain kinds of care that include hospitalizations
  - Medical groups that excel at managing the chronically ill patients over time in outpatient settings
- Example of similar effort:
  - Walmart's center of excellence designation program

Recommendation: Project #3

COST OF POTENTIALLY AVOIDABLE SERVICES

- Add realistic prices to potentially avoidable ED visits, admissions, readmissions, and complications
  - Measure their contribution to the overall cost trend
  - Prioritize interventions to reduce potentially avoidable events
  - Formulate a message suitable for public audiences about this cost burden
- Example of similar effort:
  - Health Care Incentives Improvement Institute



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PRIORITY PROJECT #3: COST OF POTENTIALLY AVOIDABLE SERVICES

Brief Description: This analysis would add a realistic price tag to quantify potentially avoidable services such as ambulatory-sensitive hospital admissions, hospital readmissions, complications and emergency department visits. The information would help to (1) inform purchasers and others about how potentially avoidable services are specifically contributing to the overall cost trend, (2) prioritize interventions to reduce potentially avoidable events, and (3) formulate a message suitable for public audiences about the cost burden associated with potentially avoidable services. This analysis would enable a multi-payer view of these costs, using a common method and real prices.

Example for illustrative purposes: Below is an example of an analysis by the Health Care Incentives Improvement Institute (HCI3) that adopts certain aspects of this approach. In this example, the cost of potentially avoidable complications, or PACs, is compared to the cost of expected services for a variety of conditions and procedures. The magnitude and prevalence of PACs can signal where improvement efforts are most needed. Similar approaches apply to wasteful use of emergency department resources, certain hospital readmissions, and avoidable admissions for medical conditions that are manageable in the ambulatory setting.

Voting Results:

Stakeholder Group	# Stakeholders Who Voted SUPPORT	# Stakeholders Who Voted DO NOT SUPPORT	# of Stakeholders Who DID NOT VOTE	Total
Purchaser/Consumer	7	2	0	9
Providers	5	2	0	7
Health Plans	4	0	2	6
Total	16	4	2	22

DRAFT FOR REVIEW – DO NOT

Track B: Planned Timeline

January 29, 2013: Alliance Board approved Task Force recommendations for a conceptual, high-level plan.

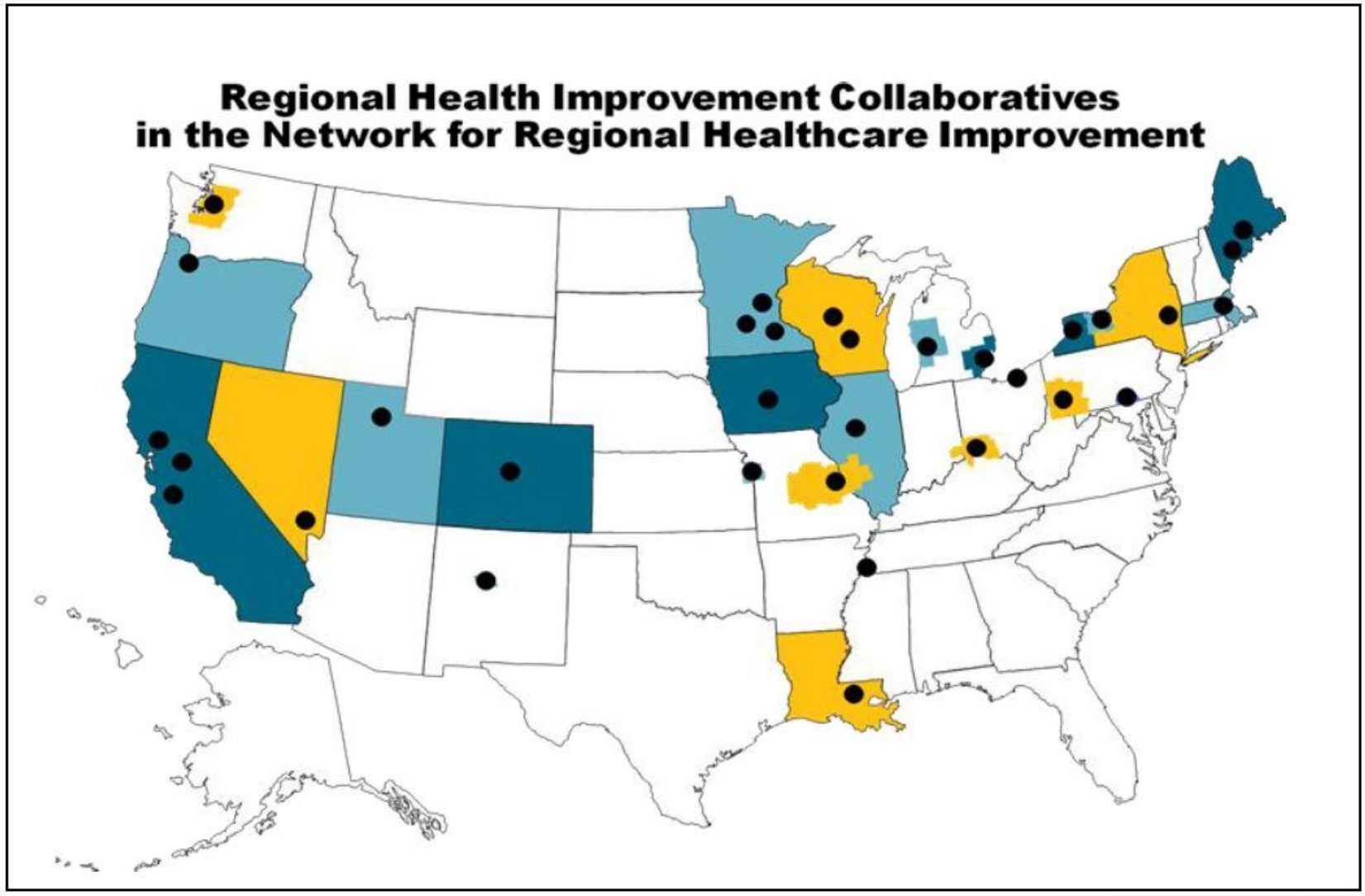
- The Board delegated development of a detailed plan for approved data uses to the Health Economics Committee.

May 2013: The Health Economics Committee will complete a detailed plan for analytics and reporting and present its recommendations to the Alliance Board.

July 2013: Data suppliers agree to a plan for data submission, including a specific timeline.

October 2013: Claim-level allowed amounts are included in routine data submissions.

TBD 2014: First reports will be shared with stakeholders.


Regional Health Improvement Collaboratives
in the Network for Regional Healthcare Improvement