WASHINGTON HEALTH ALLIANCE
Leading health system improvement

Committee meeting notes

Committee Name: **Health Economics Committee**

Recent Meeting Date(s): **November 10, 2022**

Achievements/Decisions:

- Members heard about a recent in-depth introduction of the Area Deprivation Index for the Board, as well as possible applications suggested by the Quality Improvement Committee.
- The committee learned that a subgroup of the QIC identified three generic prescribing measures for so-called topped-out status.
- At the request of the Board, members were asked to describe concrete use cases that would be possible if total cost results were detailed with utilization and unit price information.
- To understand better how similar or different perspectives might be, committee members spoke to what is entailed in the concept of healthcare value.

Issues/Risks/Concerns:

Developments in using the Area Deprivation Index (ADI) in Alliance projects

- Total Cost of Care statistics and Health Waste Calculator results will be stratified by ADI decile in 2023, with the total cost effort happening first.

Topped-out measures

- Preliminary ADI-stratified results for the three generic prescribing measures show no evidence of pocket of underperformance, clearing the way to finalizing their topped-out status.

Committee guidance on use cases dependent on spending driver transparency

- See paraphrased responses in Section A below.

What does Healthcare Value mean to you?

- See paraphrased responses in Section B below.

Upcoming Activities:

- HEC input on use cases based on disclosure of utilization and unit price data will be transmitted to the Board.
- At their December meeting, the QIC will also take up this use case question.

~ ~

A. Paraphrased responses: Committee guidance on use cases dependent on spending driver transparency

Employer:

Need to get deeper than pointing to rich benefits and high spending levels. It is important to know if use or price is driving spending prior to employers defining benefits offered to members.

Consultant:

Use the Milliman GlobalRVUS in the Alliance database to derive prices that are adjusted for case mix (also called RVU-weighted utilization). This is not the same as "utilization per thousand" statistics. RVU-weighted utilization is superior in a PPO market, where utilization/1,000 doesn't work because members are not empaneled to provider organizations. Instead, case mix adjusted utilization can be done, e.g., for hospital outpatient services, emergency room, etc.

A more thoughtful way to examine services and costs is using Milliman's Care Management Groupings. An example would be to show skilled nursing along with adjacent services like home health.

Providers:

Break commercial performance into PPO and HMO segments. Examine payer competition, benefit design, and alignment of contractual incentives. Risk adjustment is very important.

Effect changes by working with the largest employers. An economic slowdown might create more space for this kind of work. Engage brokers.

Focus on appropriateness of utilization. Could office-administered drugs be delivered at home? Broadly speaking, focused cost control measures will shift, not reduce, expenditures – toward other sites of service and provider types. Think about the ACO perspective: skilled-nursing facility spending might be down, but reduced staffing is a factor. Look to improve partnerships among provider entities. Link interventions to the concept of healthy return to work.

Consumers should be able to see prices. What the employer sees is aggregated price; they should be able to see constituent price detail and understand who is supplying the specific service(s). Data like this should go to providers and purchasers alike.

Health Plans:

Knowing utilization and price is the starting point for discussions. For example, for a category like office-administered drugs, is the mix of drugs a driver of differences in price? For outpatient services, what role do facility fees play in spending?

With hospitals buying private practices, ask: Is care being delivered in the right settings, e.g., offices vs. hospital outpatient departments? Other services are MRIs and procedures, e.g., ASCs vs. hospital outpatient departments. Work with the source of referrals to improve proper service site selection. Also applies to referrals that involve high facility fee costs. Similarly, ER use should be studied in concert with urgent care utilization, including changes over time.

Keep in mind that labor shortages are a defining characteristic of this current time. For example, labor constraints at SNFs lengthen inpatient hospital stays.

There might be promise in examining site of service as a spending driver. Although it is important to take total cost apart to look for insights, much is due to differences between health systems and this makes clear action hard. It is difficult to respond to the Board on this in an orderly way.

It is useful to view spending both through the total cost lens and also the episode of care lens. The traditional perspective of service lines (e.g., endocrinology, primary care, dermatology) is too siloed.

B. Paraphrased responses: What does healthcare value mean to you?

Broker:

It is cost and quality, but as income declines, a commercially-insured person gets less healthcare; income is a constraint on seeking services needed given their prices.

Consumer:

Need better sense of value at a macroscopic level. Show WA healthcare spending as a percentage of state GDP and improving clinical outcomes. Like report cards published by The Commonwealth Fund (see https://2020scorecard.commonwealthfund.org/state/washington). Over time, are we really making a difference in Washington state?

Academic Medical Center:

Access plays an important role for those with disabilities, low income. The time cost of obtaining care raises the question of whether it is worth seeking out.

Health Plan:

Because of price variability, the value relationship is easily disrupted. When price information is made available, only some will try using it.

A different approach is to start with aspects of healthcare that frustrate and disappoint. Examples are the complexity of insurance, affordability, and administrative burdens placed on patients and their families when navigating the system.

Health System:

Align spending to get the most value possible, attending to waste, access, and clinical effectiveness. However, the industry is not aligned regarding goals and incentives.