The Road to Affordable Healthcare: Where do we go from here in Washington State?
Wednesday, October 31, 2018
Sea-Tac Conference Center

Agenda

8:00 am  Continental Breakfast and Networking
8:30 am  Welcome and Introductions
Overview of National Movement to Address Affordability and Total Cost of Care
- Nancy A. Giunto, Executive Director, Washington Health Alliance
- Sue Birch, Administrator, WA Health Care Authority
8:50 am  Healthcare Stole the American Dream – Here’s How We Take It Back
- Dave Chase, Co-founder of the Health Rosetta and Author of “The CEO’s Guide to Restoring the American Dream: How to Deliver World Class Healthcare to Your Employees at Half the Cost”
9:40 am  Break
10:00 am  Tackling Waste and Reducing Harm in Health Care
- Linda Brady, ACO Portfolio Manager, The Boeing Company
- Susie Dade, Deputy Director, Washington Health Alliance
10:40 am  First, Do No (Financial) Harm: The Impact of Expensive Healthcare on Patients and Families
- Eliot Fishman, Ph.D., Senior Director of Health Policy, Families USA
11:25 am  Overview of the Afternoon
11:30 am  Lunch (Box Lunches Provided)
12:20 pm  Action Steps to Drive Affordability: Employer’s Perspective
- Michael Cochran, Sr. Manager, Global Benefits, The Bill & Melinda Gates Foundation
- Ron Crawford, Vice President, Benefits, Starbucks
- Sonja Kellen, Director of Global Health & Wellness, Microsoft
- Mich‘l Needham, Chief Policy Officer, WA State Health Care Authority
1:20 pm  **Action Steps to Drive Affordability: Payers’ Perspective**
- Drew Oliveira, MD, Executive Medical Director, Regence WA/ Cambia Health Solutions
- Joe Smith, Vice President, Marketing Sales and Business Development, Kaiser Permanente Washington
- Staici West, Director of Provider Network Management and Solutions, Premera Blue Cross

2:10 pm  **Action Steps to Drive Affordability: Providers’ Perspective**
- Robert Mecklenburg, MD, Medical Director, Center for Health Care Solutions at Virginia Mason
- Peter Rutherford, MD, Chief Executive Officer, Confluence Health
- Sara Rutherford, Quality Program Manager, Eastside Health Network
- Mika N. Sinanan, MD, PhD, Medical Director of Contracting and Value-Based Care, UW Medicine

3:10 pm  Break

3:30 pm  **Strength in Numbers: Collaborate and Align Strategies to Accelerate Affordability Initiatives in Washington**
- Niall Brennan, President and Executive Director, Health Care Cost Institute (HCCI)

4:25 pm  **Closing Remarks**
- Nancy A. Giunto, Executive Director, Washington Health Alliance

4:30 pm  Adjourn

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A BIG thanks to the following organizations who joined the Washington Health Alliance to sponsor today’s event.

10X Health
Arthur J. Gallagher & Co.
Association of Washington Cities
Confluence Health
Eastside Health Network
Kaiser Permanente Washington

Network for Regional Healthcare Improvement
Robert Wood Johnson Foundation
The Everett Clinic
Virginia Mason
Washington Health Benefits Exchange
Washington Health Care Authority
The Road to Affordable Health Care: Where do we go from here in Washington state?
October 31, 2018

As part of the registration process for this conference, registrants were asked to answer the question “What are the three most important action steps needed to address health care affordability?”

The responses generally fell under one of ten main themes, listed below and not in order of priority. Not surprisingly, these recommended action steps have been part of the affordability discussion for some time, yet they lack specificity. So the next question is, what do we have to do individually and collectively to put these action steps into effect?

The road to health care affordability is complex, with many moving parts. There are competing motivations and there’s big money involved. But these suggestions from today’s participants – including the additional suggestion of “genuine reflection and real honesty in acknowledging what each of us must do to impact change” – provide a solid starting place for a discussion on improving the value of health care in our state.

1. **Replace fee-for-service payment with payment for value.**
   - Tie provider payment to specific expectations related to quality (process and outcome) and patient experience
   - Manage total cost of care (in addition to unit pricing)
   - Make sure “accountable care” products offer true high value (and not just a cheaper price for a narrower network)
   - Share savings – there’s not a lot of incentive for one player to reduce cost in their part of the ecosystem if the savings accrue to someone else
   - Make sure that reduced medical cost trend translates to lower premiums and consumer cost share

2. **Address the wide variation in pricing of health care services** that appears to be related more to market consolidation/contracting leverage than the underlying cost of care.
   - Drill down on what’s driving high prices – the irony of value-based payment models is that they appear to drive market consolidation which, left unchecked, leads to higher prices
   - Demand accountability for fair pricing
   - Limit or eliminate “hospital facility” pricing
   - Ensure much greater price transparency for both purchasers and patients
   - Eliminate surprise billing and balance billing
3. **Reduce pharmaceutical drug prices** overall and effectively manage step therapy, site-of-care and the appropriate use of specialty drugs and biologics.

4. **Ensure that care is delivered with the least amount of intensity possible** to achieve a positive outcome (site of care, care team members).
   - Take immediate steps to rectify the shortage of primary care and behavioral health providers over the longer term
   - Promote conservative care that is based on evidence and standardized care pathways
   - Take specific and targeted steps to reduce over-diagnosis, over-treatment and duplication

   - Build out integrated clinical information systems and/or health information exchange to inform decision-making at the point of care

6. **Strive to ensure the effective integration of physical and behavioral health.**

7. **Elevate the issue of social determinants** and their overall impact on health and well-being.
   - Finance moving “health care upstream” to avoid and/or minimize the effects of chronic disease over time
   - Ensure fairness and equitable access to needed services

8. **Empower consumers** with improved health literacy, greater use of shared decision-making and objective, credible information that is available BEFORE care decisions are made.
   - Don’t overplay the consumer role: high out-of-pocket expenses combined with low health literacy and overuse is harming individuals and families

9. **Align purchaser action** to send clear market signals and reduce administrative complexity
   - Coordinate buyers’ performance expectations for quality, experience and price to send clear market signals
   - Standardize health plan design to reduce variation and administrative complexity

10. **Reduce administrative cost and complexity** that doesn’t add value.
    - Health insurers
    - Health care provider organizations
**Background:**

- Cambia Grove is a health care innovation hub focused on bridging the gap between entrepreneurs and the traditional health care sectors to drive system-wide transformation.
- One of Cambia Grove’s core goals is to break down barriers to innovation in response to the needs of the health care changemaker community.
- The current health care payment & incentive structure presents a barrier to innovation for the community, and was therefore selected as a focus area.
- **Underlying assumption:** If payment is made for value, the health care delivery system will be further incentivized to “pull” innovation from the changemaker community to improve overall quality and affordability for the people we serve.

**Approach:**

- To understand the challenges and opportunities associated with payment reform & identify areas where the community could catalyze solutions, Cambia Grove completed interviews with >30 stakeholders representing the traditional health care system and the entrepreneur community.
- Detailed feedback was distilled down to common themes, specific challenges and community initiatives - - all stakeholder interviews were conducted in confidence to enable candid discussion and open dialogue; feedback has been anonymized and summarized.

**Initial Results:**

<table>
<thead>
<tr>
<th>ID.</th>
<th>Top Theme Areas</th>
<th>Specific Challenges</th>
<th>Potential Community Initiatives</th>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Alignment on Goals, Methodologies &amp; Measurements</strong></td>
<td>- Need for system-wide alignment on vision, goals and desired outcomes</td>
<td>1. Build on the work of the Bree Collaborative, HCA and Medicare and execute system-wide initiative to establish collectively defined goals, definitions and success metrics</td>
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<td>- Opaque and varied definitions of key terms (e.g. value, affordability and quality)</td>
<td>- Ensure approach addresses challenges with low volume regions</td>
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<td>- Disparate approaches, methodologies and success measures</td>
<td>- Include measures that employers find important (e.g. time loss/return to work, functional improvement, etc.)</td>
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<td>2. Leverage existing data, reports and analyses to outline approaches and most critical action steps</td>
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<td>2.</td>
<td><strong>Employer Mobilization</strong></td>
<td>- Limited push from employer community for advancements in value-based care - - purchasers must see substantial value to disrupt employee benefits or limit choice</td>
<td>3. Build upon employer consortium at the Washington Health Alliance to:</td>
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<td>- Lack of coordinated voice across employer community to 1) identify and advocate for effective paths</td>
<td>- Enhance health care expertise</td>
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<td>- Define employer-specific vision for effective value based approach (see initiative #1) - - include small to large employers, public and private</td>
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<td>forward and 2) leverage purchasing power</td>
<td>- Evaluate best practices from peers (see initiative #6)</td>
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<td>- Leverage purchasing power to demand change (e.g. centers of excellence, bundles, etc.)</td>
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<td>3.</td>
<td>Consumer Engagement</td>
<td>▪ Public perception that the current state is working well and that change would be unwelcome</td>
<td>4. Execute public education/communications strategy to build consensus and momentum around urgent need for change</td>
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<td>▪ Complexity of system places the consumer multiple steps away from the true costs of care, which enables disengagement</td>
<td>5. Support innovations around price transparency and patient engagement</td>
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<td>4.</td>
<td>Bright Spots &amp; Best Practices</td>
<td>▪ Skepticism around the overall effectiveness of value-based care</td>
<td>6. Collect, curate and showcase local and national success stories - - highlight for applicable 5 Points of Health Care™ stakeholder groups (i.e. patients, providers, purchasers, payers and policy-makers) the vision, goals, measures, outcomes and operational challenges/details</td>
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<td>▪ Limited line of sight into results of local efforts</td>
<td>7. Learn from rural payment initiative (may include global budgeting and performance incentives)</td>
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<td>▪ Successes exist nationwide, but are not at the forefront of local discussions</td>
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<td>5.</td>
<td>Systems &amp; Infrastructure</td>
<td>▪ Operational systems and clinical workflows were built around the fee-for-service model, and do not easily support alternative payment models</td>
<td>8. Ensure collectively defined vision provides financing sufficient for necessary change and a clear glide path for operational adjustments (see initiative #1)</td>
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<td>▪ Perception that alternative payment model incentives are 1) not substantial enough to justify the risk/effort, 2) do not reach the individual provider and 3) will not lead to dramatic changes in the quality and/or process of care delivered</td>
<td>9. Support innovations around real-time data sharing and alternative payment processing</td>
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<td>▪ Impact of high unit costs on overall affordability</td>
<td>10. Identify and disseminate best practices for system improvements such as incentives, direct dialogue between purchasers and providers, support for sharing risk, and failures, etc. - - methods that have been effective (see initiative #6)</td>
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Please submit questions and comments to:

Julie Panek Anderson, Assistant Director of Strategic Initiatives, Cambia Grove, julie@cambiagrove.com
Dr. Bob Crittenden, Executive in Residence, Cambia Grove, bob@cambiagrove.com
Health Care Purchasers Need to Hit the “Play” (not the “Pause”) Button on Value-Based Purchasing Strategies

Earlier this year, PricewaterhouseCoopers released their 2018 “Health and Well-being Touchstone Survey Results.” This survey includes data from over 900 participating employers in 37 industries across the U.S (22% from the Northwest). The report provides a view into the current landscape and future outlook for health care benefits and other parts of the “total rewards” equation for employers and other healthcare purchasers.

Here is one of the key takeaways from the report that caught our eye at the Washington Health Alliance, and had us wanting to know more. “While healthcare cost increases continue to outpace general inflation, other factors such as a tight labor market and an influx of cash from tax reform have allowed employers to hit the "pause" button [on value-based purchasing]. This has resulted in a continuation of the status quo rather than the adoption of new, emerging strategies.”

Among all survey respondents, 46% say they are not considering value-based plan design, 60% say they are not considering narrow networks, and 67% say they are not considering direct contracting with providers or ACOs. These numbers drop somewhat for just the large employer segment (5,000+ active employees), who have been a little quicker to implement value-based buying strategies. But still, the numbers are low overall. Broad-network PPOs are still the predominant choice for health plan benefit design. Employee turnover (and recruitment) is a key concern in a competitive labor market; and, compensation relative to market is the number one factor for attracting (and retaining) talent. Health care benefits are much less important for younger employees (age 30-34) but rise to the top two spots for those ages 35 and older (tying with compensation as number one for select age groups).

The report goes on to say that “with the continued changes in the healthcare economy – consolidations, new entrants, emerging technology, new partnerships/mergers – employers who seize this moment will leapfrog their competitors by offering more cost efficient programs that optimize spend while engaging employees/dependents.”

We wanted to informally test this idea with some health care purchasers in Washington state: are they really “hitting the pause button” on value-based purchasing and, if so, why? For many (but not all), the answer seems to be a tentative “yes.” Here’s what we learned in conversation with public and private purchasers in Washington about some of the reasons why:

- Purchasers are watching and they are not convinced that the value-based products currently being offered are consistently meeting the delivery system performance standards that purchasers think should be the hallmark of so-called accountable care or value-based products. They perceive there to be more talk than action – more smoke than fire. Unreliable performance against standards makes it hard for them to “sell” a narrower network to their covered population. AND, they want to know that performance standards set a high bar for quality, access and patient experience, not just lower cost.

- Value-based product designs developed by health plans keep changing. Purchasers start to get interested in a specific product and then it changes or disappears altogether – and purchasers aren’t sure why. Lack of insight into what is driving product design causes purchasers to feel wary.
Purchasers report that, generally, some health plans seem to be back-peddling on value-based product designs. Purchasers aren’t sure what the plans’ hesitancy is about, but acknowledge that they have been cautious about leaping into the deep end of the value-based strategy pool. Maybe plans have backed off on the “sell” because they haven’t found a receptive audience.

When purchasers compare notes about what they are being told about value-based product design, it is not always the same, leading to confusion and an urge to wait and watch.

Some purchasers know that they have a large number of high utilizers with significant health conditions. They worry that narrower networks will not offer the broad net of providers needed to reliably provide high-quality, effective care to meet the specific needs of their covered population.

Some purchasers are viewing their role differently. For some, instead of trying to change what they perceive to be a significantly broken system, they are prioritizing the use of advocates/navigators to help their covered population effectively get and use what they need from the system that exists. While others take a more consumer-oriented approach, with stronger interest in vehicles that give individuals more choice along with more financial responsibility for their choices (for example, private exchanges with standardized plan elements, set subsidies and competition on price).

All of these seem to be reasonable concerns and potentially worthy of hitting the pause button. But – and it’s a big BUT – this is really short-term thinking and purchasers will pay the price for it – they are paying the price for it.

Market concentration of hospital systems and physician practices is leading to higher health care costs and higher insurance premiums for patients. Inexplicable price variation across provider organizations, coupled with high facility fees and opaque billing practices are leaving patients with big surprise bills and purchasers with a medical cost trend that exceeds inflation.

The problem of waste in health care won’t go away on its own. Estimated at 20% to 30% of total health care spending, waste is a huge part of the total cost of care equation. The health care industry obviously has to play the lead role in reducing waste, but self-policing will not be sufficient. Obviously, it hasn’t been sufficient. Health care purchasers’ use of value-based buying strategies, with clear performance standards (including appropriateness), can shape different incentives that motivate reduction of waste and the physical, emotional and financial harms that patients experience.

And, the current economy won’t last forever – a number of nationally-known pundits are already predicting the next significant economic downturn.

**Bottom line:** Health care purchasers who wait to adopt value-based strategies will almost certainly find themselves far behind in the struggle to manage their health care costs and provide high value to their employees.

To get and stay ahead, the Washington Health Alliance strongly encourages health care purchasers – both public and private – to take their finger off the pause button and continue on the path of value-based purchasing. The massive health care industry will not change significantly without concerted external pressure. We need the collective voice and buying power of Washington’s health care purchasers to drive the health care market in our state to be among the top ten nationally for quality, patient experience and total cost of care.
Providing high-quality care to patients includes eliminating unnecessary tests, treatments and procedures.

A recent study in Washington state1, reveals that at least 100,000 patients received unnecessary pre-op testing during a one-year period, at an estimated cost of over $92 million—a very conservative estimate.

Routine preoperative lab studies, pulmonary function tests, X-rays and EKGs on healthy patients before low-risk procedures are not recommended because they are unlikely to provide useful, actionable information.

Benefits of Reducing Unnecessary Pre-op Testing

For patients:

- Reduces unnecessary time spent at a lab or clinic.
- Reduces patient’s financial burden.
- Reduces waiting for test results and anxiety from false-positive results.
- Reduces unnecessary delay before procedure.

For physicians:

- Provides evidence-based care to patients and avoids unnecessary care.
- Reduces time spent reviewing, documenting and explaining test results that add no value and won’t impact a decision regarding procedure.
- Reduces risk exposure from not carefully documenting follow-up on all pre-op tests.

Choosing Wisely® Recommendations

“Don’t obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal.”

—American Society of Anesthesiologists

“Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.”

—American Academy of Family Physicians

There are a variety of reasons why unnecessary pre-op tests are ordered, such as:

- Broadly ordering the same pre-op tests for all patients/procedures—based on habit without thoughtful reflection—regardless of a patient’s health or a procedure’s risk.
- A desire to be “thorough” and/or concern that an incomplete pre-op form may delay the procedure for the patient.
- Discomfort with uncertainty and concern about malpractice.
- A mistaken belief that all insurers require pre-op testing.

Pre-op Testing Prior to Low-Risk Procedures for Low-Risk Patients

**Physical Status of Patient Undergoing Low-Risk* Procedure**
(determined based on history and evaluation)

<table>
<thead>
<tr>
<th>Pre-op Test</th>
<th>LOWER RISK PATIENTS</th>
<th>HIGHER RISK PATIENTS</th>
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<tbody>
<tr>
<td><strong>ASA I</strong></td>
<td>A normal healthy patient</td>
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<tr>
<td><strong>ASA II</strong></td>
<td>A patient with mild stable systemic disease</td>
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<tr>
<td><strong>ASA III-V</strong></td>
<td>A patient with severe systemic disease or a patient who is not expected to survive without the operation</td>
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**DO NOT ROUTINELY ORDER**

- Chest X-ray
- Coagulation studies
- Complete metabolic panel
- EKG or echocardiography
- Full blood count test
- Pulmonary function test
- Urinalysis

**DO NOT ROUTINELY ORDER (unless urologic procedure)**

**DO NOT ROUTINELY ORDER**

**CONSIDER ORDERING PER GUIDELINES**

*Examples of Low-Risk Procedures:* Arthroscopy and orthopedic procedures that only require local anesthesia; cataract, corneal replacement and other ophthalmologic procedures; cystoscopy and other minor urologic procedures; dental restorations and extractions; endoscopy; hernia repair; minor laparoscopic procedures; superficial plastic surgery.

**Recommended Actions**

**Physicians, Hospitals and Other Health Care Organizations**

- Educate physicians and team members (e.g. RN, MA) involved in pre-op testing decision-making.
- Delete prompts for pre-op testing in electronic health record (EHR) order sets designed for low-risk patients undergoing low-risk procedures.
- Use evaluation checklists to optimize surgical outcomes (e.g. nutrition, glycemic control, medication management and smoking cessation).
- In hand-off communication to the surgeon or anesthesiologist after your pre-op evaluation, add this or similar language: "This patient has been evaluated and does not require any pre-operative lab studies, chest X-ray, EKG or pulmonary function test prior to the procedure."
- Provide prompt and clear peer-to-peer feedback when unnecessary pre-op testing occurs, make this a topic of departmental and inter-departmental quality improvement discussions, including gathering patient data to inform discussions.
- Measure current rate of pre-op testing on low-risk patients prior to a low-risk procedure and track improvement.

**Payers**

- Review medical policies and prior-authorization requirements to ensure they clearly do not require routine testing prior to low-risk procedures on low-risk patients.
- Utilize health plan data and analytics to measure and monitor use of pre-op testing on low-risk patients prior to low-risk procedures.
- Provide feedback on pre-op testing on low-risk patients prior to low-risk procedures to physicians and health care organizations.

For more information and resources, visit: wsma.org/Choosing-Wisely
What are the most important action steps needed to address health care affordability?

Instructions

How to Vote: Below are the 10 themes that emerged from the question asked at registration. Please select the ONE you feel is most important by checking the box next to the number.

1. Replace fee-for-service payment with payment for value.
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