Welcome!
All Alliance Meeting

March 11, 2019

WASHINGTON HEALTH ALLIANCE

Leading health system improvement

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Today

- Washington Health Alliance
  - New Members
  - Recent achievements
  - 2018 eValue8 results
  - New pricing results



Guest Speaker: Christopher Koller
President, Millbank Memorial Fund

"How Employers and Individuals Can Make Health Care More Affordable"

Welcome to our newest Alliance members!





























Highlights: A Few of Our Recent Achievements

- "First, Do No Harm" report using the Milliman MedInsight Health Waste Calculator, released December 2018
- Seattle Business Magazine Awards
  - The Everett Clinic
  - Kaiser Permanente Medical Group
  - Swedish Medical Group
  - UW Medicine – Valley Medical Group
  - Virginia Mason Medical Group
- Alliance Advice and Testimony to the U.S. Senate Health, Education, Labor and Pensions Committee

2018 eValue8™ Results
Health Plan Performance

Results are embargoed until the Alliance releases its public report later this month.

What is eValue8™?

A national, standardized health plan evaluation created by business coalitions and employers like Marriott and General Motors to measure and evaluate health plan performance

Why the Alliance (and it's purchasers) sponsor eValue8:

- Articulates purchaser expectations
- Facilitates purchasers' value-based selection of health plans by supplying the "Quality Factor" in the value equation
- Provides benchmarks for local and national comparisons - between plans, and over time
- Identifies and promotes opportunities for quality improvement
- Drives collaboration between purchasers and health plans
- Results used to educate employees on health plan quality

eValue8 Purchaser Sponsors

Association of Washington Cities	Port of Seattle
The Bill & Melinda Gates Foundation	Puget Sound Energy
The Boeing Company	Seattle Chamber of Commerce
Carpenters Trust of Western Washington	SEIU 775 Benefits Trust
City of Seattle	Sound Health and Wellness Trust
Davis Wright Tremaine LLP	Starbucks Coffee Company
King County	Washington Health Benefit Exchange
Pacific Health Coalition	Washington State HCA
Point B	Washington Teamsters Welfare Trust

Health Plan Participation in eValue8 - 2018

In 2018, six health plans* responded to the purchasers' invitation and responded to the eValue8 RFI:

- Aetna PPO
- Cigna PPO
- Kaiser Permanente Washington HMO
- Kaiser Permanente Washington PPO
- Regence Blue Shield PPO
- UnitedHealthcare PPO

*Premera Blue Cross was invited but declined to participate in eValue8.

eValue8 2018 – Participating Health Plans Cover over 2 million Live in Washington State

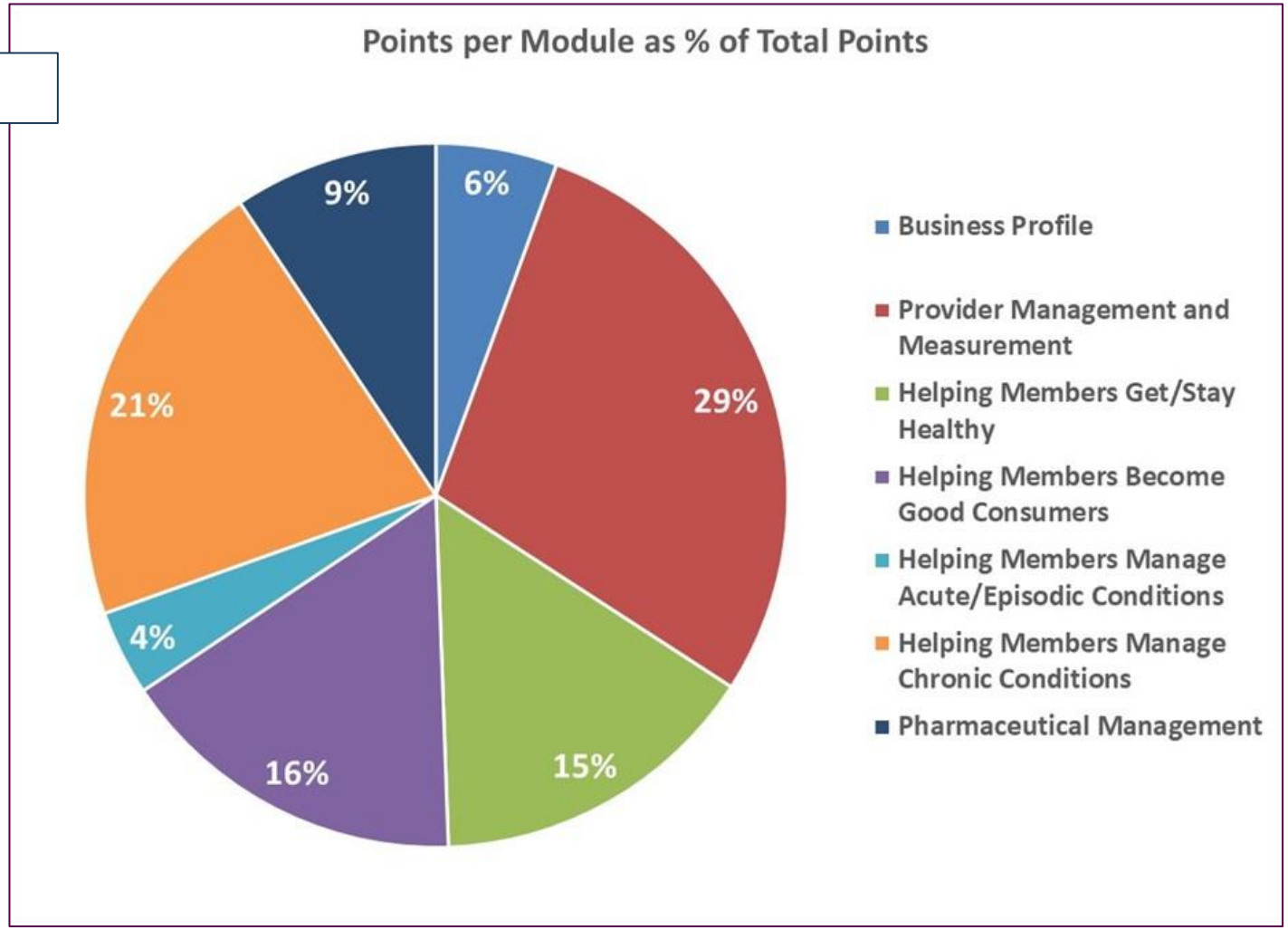
Health Plan	Commercial Lives in this market	Lives as % of Total Plan Nationwide (Commercially-insured)
Aetna	392,696	1.9%
Cigna	193,261	1.4%
KP-WA HMO	350,235	3.6%
KP-WA PPO	154,385	1.6%
Regence Blue Shield	703,112	42.5%
UnitedHealthcare	261,743	1.0%

High Level Summary: Focus Areas in eValue8

- **Provider (Physician and Hospital) Management, Support and Measurement**
  - Support for engaging patients
  - Support for care management, identification of gaps in care
  - Scope of measurement for transparency and rewards
  - Effective use of contracting to drive innovation and improved performance among providers
- **Member Support and Engagement -- "Helping Members . . ."**
  - Alignment of plan design with desired outcome (value-based benefit design)
  - Member screening, identification of gaps in care
  - Price and quality transparency
  - Robustness of tools: shared decision-making and provider choice
- **Performance Results**
  - CAHPS and HEDIS (Diabetes, Heart, Behavioral Health, Cancer screening, Tobacco Use, Obesity, Overuse/appropriate utilization)
  - Accreditation

Overview of eValue8 2018 – Seven Modules

Total Points = 484.5



Member Support ("Helping Members") Total = 56%

Summary of Current Health Plan Accreditation

Plan	NCQA	URAC
Aetna	Accredited (Dec 2019) Physician Quality MBHO	Pharmacy Benefit Mgt Specialty Pharmacy
Cigna	Accredited (Sept 2020) Physician & Hospital Quality MBHO	Pharmacy Benefit Mgt Specialty Pharmacy Case Management
Kaiser Permanente Washington HMO	Commendable (June 2019)	Pharmacy Benefit Mgt
Kaiser Permanente Washington PPO	Accredited (June 2019)	Pharmacy Benefit Mgt
Regence Blue Shield	Commendable (Sept 2019)	Pharmacy Benefit Mgt Specialty Pharmacy
UnitedHealthcare	Accredited (Nov 2021) Physician Quality MBHO Case Management	Pharmacy Benefit Mgt Specialty Pharmacy

Summary of HEDIS Results, 2018 eValue8

# of HEDIS Measures (58 measures total):

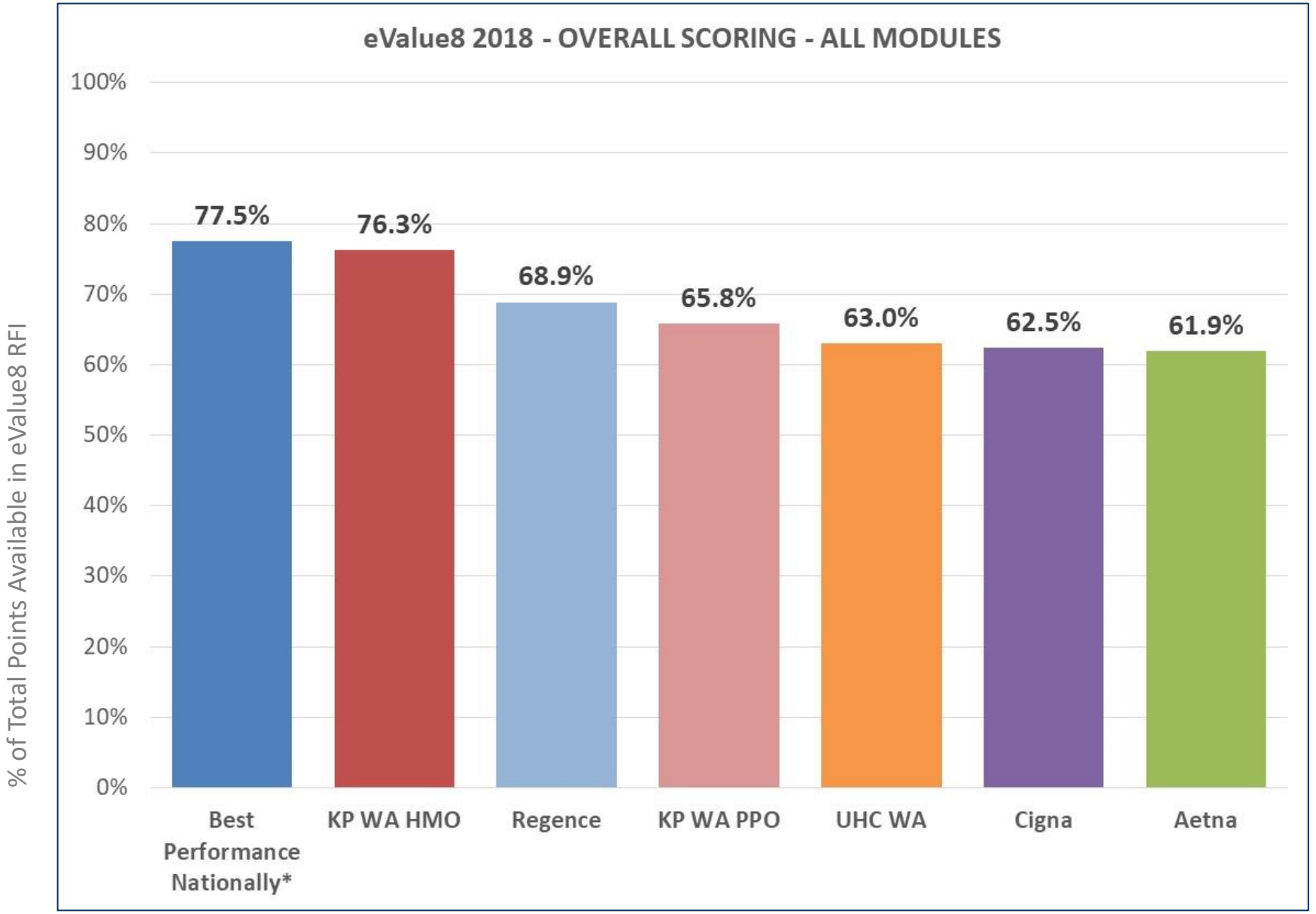
Health Plan	Very Good	Good		Needs Significant Improvement	
	Above the 90th Percentile*	Between the 75th and 90th Percentiles	Between the 50th and 75th Percentiles	Between the 25th and 50th Percentiles	Below the 25th Percentile
Aetna	3	12	13	21	9
CIGNA	2	12	13	21	10
KP-WA HMO	16	15	16	7	4
KP-WA PPO	6	13	15	20	4
Regence	1	12	20	24	1
UHC	1	9	26	19	3

Overall CAHPS Scores – Patient Experience

Health Plan	Overall Rating of All Health Care (% of 9+10)	Overall Rating of Health Plan (% of 9+10)
Aetna	Below 25th	Below 25th
CIGNA	Between 25th and 50th	Below 25th
KP-WA HMO	Below 25th	Between 25th and 50th
KP-WA PPO	Below 25th	Below 25th
Regence	Between 50th and 75th	Between 50th and 75th
UnitedHealthcare	Below 25th	Below 25th

- *Scores shown as percentiles, as compared to national performance of commercial insurers, NCQA Quality Compass (e.g., "Below 25th" means below the national 25th percentile.)*
- *% of 9+10 refers to the percentage of patients that award the plan a top score on a scale of 0-10.*

eValue8 2018 Overall Results



Top Ranked Plan in Washington, by Module

Module	Top Ranked Plan	% of Total RFI Points
1 – Achievement of health plan accreditation (commendable or higher)	Regence Blue Shield PPO	63.3%
2 – Physician and hospital measurement and management to drive value	Kaiser Permanente WA HMO	87.2%
3 – Helping members get and stay healthy (prevention, tobacco, obesity)	Kaiser Permanente WA HMO	65.0%
4 – Helping members become good consumers (treatment option support, shared decision-making, quality and price transparency)	Cigna PPO	81.6%
5 – Helping members manage acute conditions (OB)	Kaiser Permanente WA HMO	77.2%
6 – Helping members manage chronic conditions (diabetes, CAD, BH)	Kaiser Permanente WA HMO	89.2%
7 – Pharmaceutical management	Cigna PPO	83.4%








Top ranked plan nationally as of 1/29/19, subject to change

Common Areas of Opportunity

While each health plan differentiates itself with strong programs and results in select areas, the following represent areas of opportunity for *most or all* health plans:

Patient/Member Experience

- Support from plans to effectively understand/ use benefits and get needed care
- Provider quality and price transparency
- Treatment option support and shared decision-making
- Support for telehealth, web-based applications
- Ensure members held harmless from surprise billing

Using health plan leverage to drive higher value

- Increase use of value-based payments to providers (including shared risk)
- Robust and transparent measurement of value (quality, efficiency, patient experience and total cost of care)
- Use results in feedback to providers; drive higher referrals to higher value providers
- Close management of specialty medications

Common Areas of Opportunity

While each health plan differentiates itself with strong programs and results in select areas, the following represent areas of opportunity for *most or all* health plans:

Improve Quality and Outreach

- Cancer screening rates for adults
- Immunization rates and well care for kids
- Evidence-based care for chronic illness (diabetes, CAD)
- ID members with depression, substance use, obesity and/or tobacco use and broaden interventions
- Improve access and network adequacy for behavioral health

Reduce potentially avoidable care and overuse

- C-sections
- Hospital readmissions
- Inappropriate use of ER
- Known overused procedures, e.g., cardiac catheterization, back surgery, hysterectomy

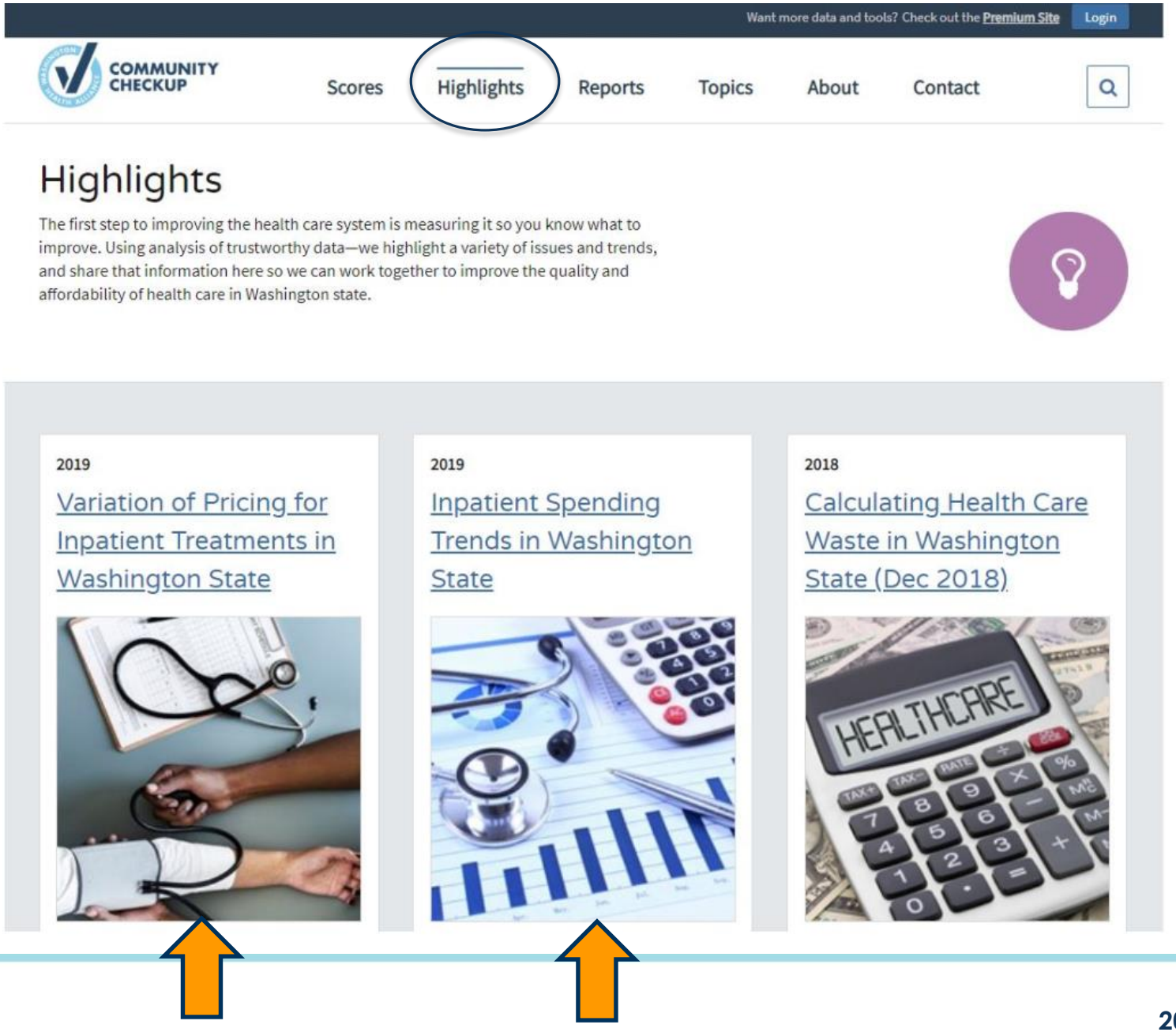
Two new reports featuring price data

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Where to find these reports

www.wacommunitycheckup.org/highlights



Report #1
Price variation for inpatient treatments

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Price variation for inpatient treatments

- **Multi-payor commercial case prices**
  - Price is the total of privately negotiated fees incurred during each hospital stay
  - Hospital, physician fees combined
  - Minor severity (few/no clinical complications)
- **Three kinds of price variation**

  (1) Statewide (2) between hospitals (3) within-hospital

Depicting price variation by treatment

Admitting hospital, sorted by median price, with lower* and higher* prices defining the horizontal range

Hospital	Low	Median	High	$0	$25,000	$50,000
SWEDISH MEDICAL CENTER	$17,703	$36,136	$51,603		$36,136	
VIRGINIA MASON MEDICAL CENTER	$18,150	$34,903	$52,562		$34,903	
VALLEY MEDICAL CENTER	$17,780	$32,775	$34,978		$32,775	
OVERLAKE HOSPITAL MEDICAL CENTER	$16,040	$31,599	$41,282		$31,599	

*Each price range represents the “middle 90%” of cases (5% most and least expensive cases have been removed)

Price variation: some use cases

Employers:



upon seeing market price ranges for planned treatments

Providers: How competitive are we when [illegible] and physician fees?

Price variation findings

Statewide results for 171 distinct inpatient treatments

- **Seven** treatments account for **50%** of studied spending
  - Among these, higher prices are 2.8 to 3.8 times greater than lower prices statewide
  - Example: certain **spine fusion** treatments ranged from **$30,000-$118,000**, a 3.8 fold difference
- **Between-hospital** median prices show a similar degree of variation
- **Within-hospital** case price variation can exceed statewide readings

WA prices for highest-spend treatments

Treatment (minor severity) Hospital & physician fees	LOWER	MEDIAN	HIGHER
1. Vaginal delivery	$6,451	**$11,060**	$18,947
2. Knee replacement	$15,910	**$30,759**	$51,749
3. Hip replacement	$16,405	**$31,988**	$50,631
4. Cesarean delivery	$9,576	**$16,459**	$28,285
5. Spine fusion - dorsal/lumbar	$30,897	**$60,620**	$118,375
6. Normal newborn	$1,336	**$2,495**	$4,789
7. Spine fusion - cervical	$19,370	**$37,634**	$68,747

Report #2
Inpatient spending trend analysis

WASHINGTON HEALTH ALLIANCE

Leading health system improvement

Inpatient spending trend analysis

A **demonstration** and an **invitation**

- This inaugural report serves to demonstrate a technique for isolating and quantifying distinct spending drivers, using statewide data
- The Alliance invites discussions with employers wishing to conduct this analysis on their data

Spending trend: employer use case

Scenario:

Board of directors wants to know why inpatient costs rose last year. They want specifics:

"Is it our growth? Usage of healthcare? Complexity of treatments delivered? Price per unit of service?"

Directors want both big picture and treatment-specific explanations.

Not just hospital fees, but professional fees, too.

Four drivers of spending change

Two VOLUME-related drivers (e.g., the number of cases)

1. Membership

- Insuring more people drives spending up

2. Service Frequency

- Seeking care more often drives spending up

Two PRICE-related drivers (e.g., the price per case)

3. Service Intensity:

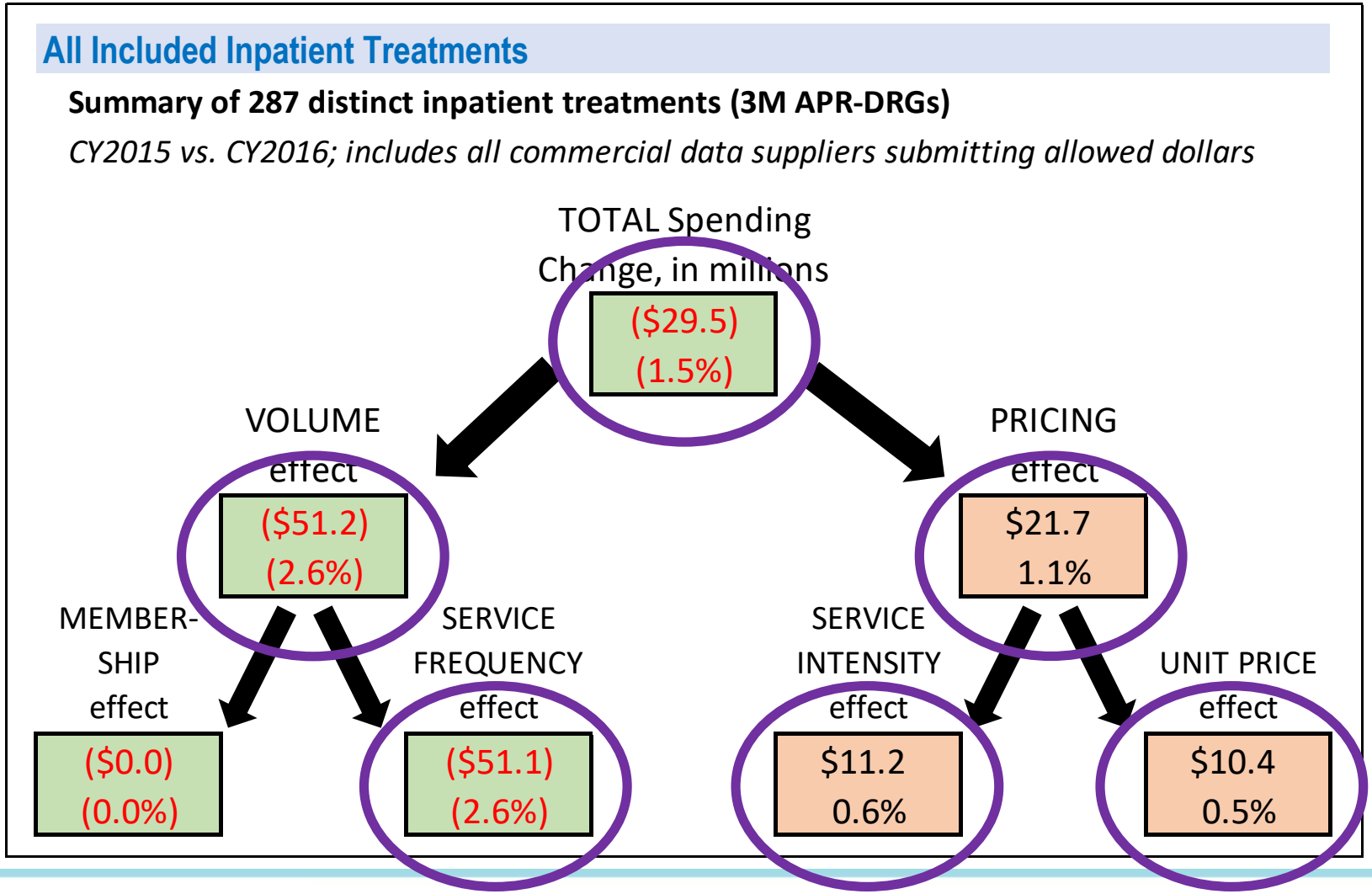
- More units of service to deliver care drives spending up (e.g., longer hospital stays, more technology, etc.)

4. Unit Price:

- Paying more for each unit of resource drives spending up

Big picture findings

Note: patterns/results will differ for individual employers!



Drilldown findings: 24% of inpatient spend is here

Commercial Inpatient Spending Trend Analysis 2015-2016 ($ thousands)

Top 5 Treatments based on 2016 Spending

3M APR-DRG description	2016 Spending (sorted)	2015 Spending	Change (%)	What accounts for the change in spending? VOLUME-related: changes in Member-ship	VOLUME-related: changes in Service Frequency	PRICING-related: changes in Treatment Intensity	PRICING-related: changes in Unit Price	Total Change in Spending
Vaginal Delivery	**$123,439**	$126,615	(2.5%)	($212)	($3,858)	($1,264)	$2,158	($3,175)
Knee Joint Replacement	**$107,983**	$112,580	(4.1%)	$26	($1,154)	($3,957)	$489	($4,596)
Hip Joint Replacement	**$84,341**	$83,821	0.6%	$20	$1,019	($2,301)	$1,782	$520
Cesarean Delivery	**$80,377**	$86,972	(8%)	($145)	($7,559)	($218)	$1,327	($6,595)
Dorsal & Lumbar Fusion	**$77,881**	$77,293	0.8%	$18	($2,454)	$2,054	$970	$587
	$474,021	**$487,281**	**(2.7%)**	**($293)**	**($14,006)**	**($5,686)**	**$6,726**	**($13,260)**
				(0.1%)	(2.9%)	(1.2%)	1.4%	

Combined spending **decline** masks Unit Price **increases**

What's next?

We are engaging with our stakeholders and committees to determine the Alliance's next areas of price reporting.

We have lots of ideas and welcome your thoughts and suggestions.

Making Health Care More Affordable for Individuals and Employers

Washington Health Alliance
March 11, 2019
Christopher F. Koller



About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly,* a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

Agenda

- The Goal
- Principles
- How does Washington stack up?
- Implications
- Best Practices from Other States
- Where from here?

The Goal



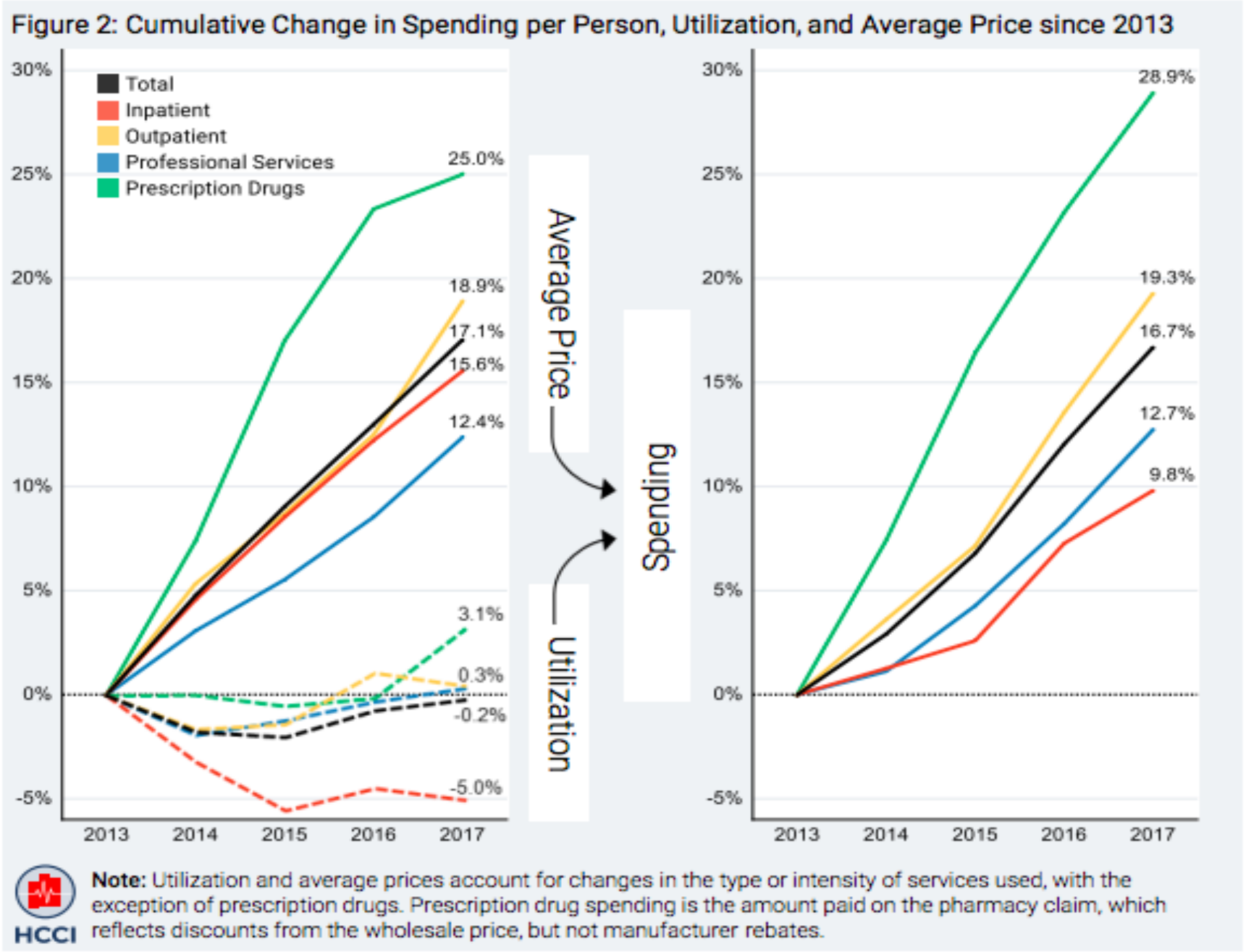
Lower Rates of trend in spending for health insurance for employers and employees

Principles
(Systemic problems demand systemic solutions)

1. Focus on underlying costs - no cost shifting.
2. Focus on per capita costs:
   - Price * utilization

   (total costs = # of people * per capita cost)

3. We are more expensive than other countries because of higher provider prices and administrative costs - not higher utilization. Price is also driving trend rates.



For Commercial Insurance – Price increases swamp small utilization decreases

"2018 Health Care Cost and Utilization Report" Health Care Cost Institute. January 2019

Milbank Memorial Fund

Compared to other countries we make the wrong kinds of doctors (and pay them too much)

EXHIBIT 3

Health care workforce in selected Organization for Economic Cooperation and Development (OECD) countries, 2000 and 2015

	United States	OECD median	OECD minimum	OECD maximum
NURSES				
Average salary of hospital nurses, US $PPP, 2015	72,980	53,226	17,445 (Latvia)	94,183 (Luxembourg)
Practicing nurses per 1,000 population				
2000	10.2	8.1	2.2 (Mexico)	13.3 (Iceland)
2015	7.9	9.9	2.0 (UK)	18.0 (Switzerland)
Nursing graduates per 100,000 population, 2015	63.1	46.0	12.0 (Mexico)	109.0 (Korea)
PHYSICIANS				
Practicing MDs per 1,000 population				
2000	2.3	2.8	1.3 (Korea)	3.9 (Austria)
2015	2.6	3.2	2.2 (Korea)	5.1 (Austria)
Medical graduates per 100,000 population, 2015	7.5	12.1	0.0 (Luxembourg)	23.7 (Ireland)
MD visits per capita, 2015	6.5	6.5	2.7 (Luxembourg)	16.0 (Japan)
Generalist MDs as percent of total MDs, 2015	11.9%	27.9%	11.9% (US)	59.0% (France)

SOURCE Authors' analysis of data from OECD Health Statistics (see note 4 in text; data extracted January 2018). **NOTES** Some figures are estimates or have breaks or differences in methodology. In the US, hospital nurses and practicing nurses refer to professionally active nurses only. All OECD country comparisons are in appendix exhibit 3 (see note 5 in text). PPP is purchasing power parity.

More Principles
(Systemic problems demand systemic solutions)

4. Provider price determination in the US makes no sense.
5. The market will not work for health care services.
6. Follow the money: seek public and private payer alignment.
7. Policy efforts - Build on existing strengths; don’t chase the bright shiny object.

Implications

- Alternate Payment Mechanisms, Value Based Insurance Designs and Low Value Service Identification are necessary but not sufficient for the goal:
  - Positive effects on utilization
  - Limited effects on provider price and supply – especially in consolidated markets
- Commercial Insurance Pricing is the black box:
  - Half the money in the system
  - Costs rise to level of revenues available: Works well for providers with market power
- No quick solutions.

How Does The Evergreen State Stack Up?



What is Missing from This Picture?

Washington State: An Emerging Healthcare Ecosystem

Employers
- Select providers based on value
- Pay with bundled contracts
- Utilize value based benefit design
- Extend mental health coverage
- Build culture of health & wellness at workplace

Employers:

BOEING

Washington State Health Care Authority

TEAMSTERS WELFARE TRUST

Alliances
- Promote accepted outcome standards
- Conduct external outcome measurement evaluation & reporting
- Develop bundled payment models
- Convene all stakeholders

Health Plans

PREMERA BLUE CROSS

Alliance Organizations:

DR. ROBERT BREE COLLABORATIVE

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES



Heal
- Support and req measurement fr
- Standardize bun contracts with m
- Enable competit processing and I

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Washington Is in a Strong Position

	Personal Health Care Spending			Average Annual Change, 2010-2014		
	Medicare	Medicaid	PHI	Medicare	Medicaid	PHI
United States	$ 10,986	$ 6,815	$ 4,551	1.2%	0.0%	3.3%
Alaska	$ 9,288	$ 12,001	$ 5,958	1.5%	1.2%	3.5%
California	$ 11,833	$ 5,368	$ 4,735	1.5%	3.5%	4.6%
Hawaii	$ 8,592	$ 6,087	$ 4,222	2.2%	2.2%	3.0%
Nevada	$ 10,796	$ 5,484	$ 3,417	2.1%	-1.5%	-3.6%
Oregon	$ 8,942	$ 7,185	$ 4,232	1.6%	-1.3%	0.8%
Washington	$ 8,997	$ 5,851	$ 4,328	1.3%	-0.2%	1.4%

Source: Cuckler et al. Health Spending By State 1991-2014: Measuring Per Capital Spending By Payers and Programs,Health Affairs, June 2017

Avoidable Hospital Use

source: 2018 Commonwealth Fund State Score Card

Measure	WA State Rank	Improving relative to other states over time?
Hospital Admission for Pediatric Asthma, per 1k	3	Improved
Potentially Avoidable ED Visits, Ages 18-64, per 1k employer-insured enrollees	9	NA
Potentially Avoidable ED Visits, Age 65 and older, per 1k Medicare beneficiaries	9	Worsened
Ambulatory Care-Sensitive Conditions Admissions, Ages 18-64, per 1k employer-insured enrollees	2	NA
Ambulatory Care-Sensitive Conditions Admissions, Ages 65-74, per 1k Medicare beneficiaries	2	No Change
Ambulatory Care-Sensitive Conditions Admissions, Age 75+, per 1k Medicare beneficiaries	2	No Change
30 Day Hospital Readmission, Ages 18-64, per 1k employer-insured enrollees	5	NA
30 Day Hospital Readmission, Age 65 and older, per 1k Medicare beneficiaries	5	No Change
Short-stay Nursing Home Residents with a 30-day Readmission to the Hospital	12	No Change
Long-stay Nursing Home Residents with a 30-day Readmission to the Hospital	7	No Change
Home Health Patients with a Hospital Admission	6	No Change
Adults ages 18-50 with Low Back Pain who had an Imaging Study at Diagnosis	5	NA
Total employer-sponsored insurance spending per enrollee	22	No Change
Total Medicare (Parts A&B) reimbursements per enrollee	8	No Change

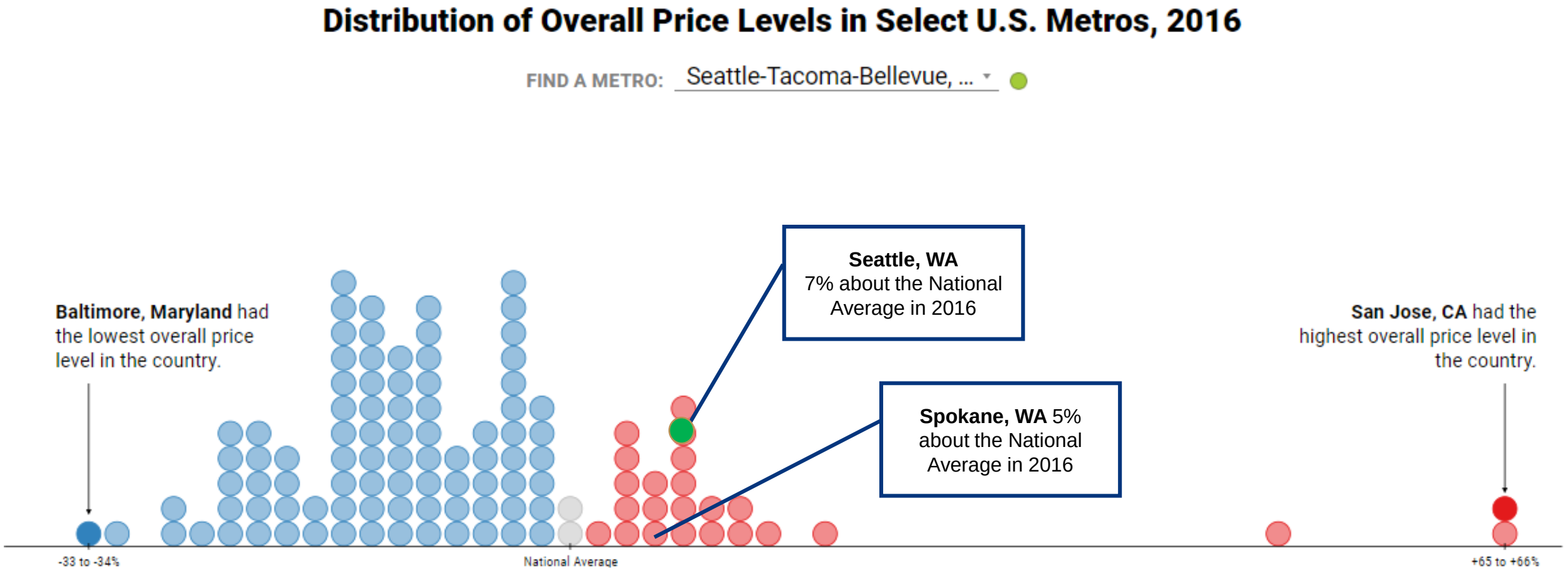
Total Commercial Costs: Why is Maryland so Cheap??

Table 1: Total Cost Index and Resource Use Index Commercial Population 2016

	Colorado	Maryland	Minnesota	Oregon	St. Louis, MO	Utah
Indexed Risk Score	*0.90-0.97*	*1.11-1.19*	*0.98-1.01*	*0.96-0.99*	*1.02-1.05*	*0.89-0.92*
Rel. Use Index	1.01-1.09	0.90-0.97	1.05-1.09	0.89-0.91	1.08-1.12	0.94-0.97
Price Index	1.13	0.86	1.04	1.16	0.85	1.01
Total Cost Index	1.15-1.23	0.78-0.83	1.10-1.13	1.03-1.06	0.92-0.95	0.95-0.97

Source: Network for Regional Health Care Improvement

Seattle and Spokane above average for Overall Commercial Provider Payment Levels



Source: Health Care Cost Institute, 2016 data

Milbank Memorial Fund

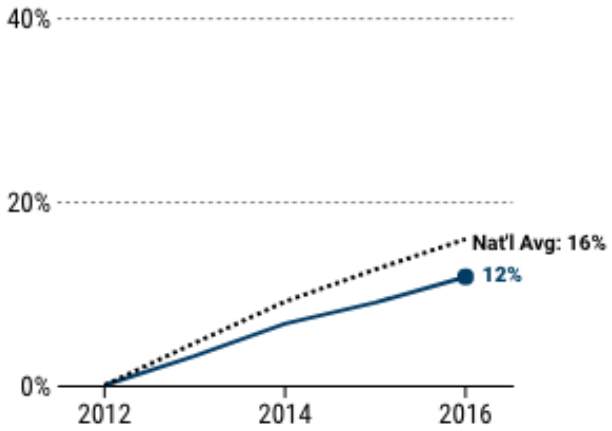
Overall price growth higher in Spokane than Seattle

Seattle-Tacoma-Bellevue, WA

2016 Price level: 7%
above national average



Price growth since 2012: 12%

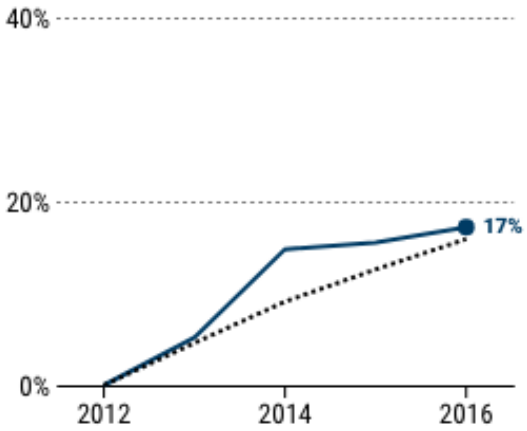


Spokane-Spokane Valley, WA

2016 Price level: 5%
above national average



Price growth since 2012: 17%

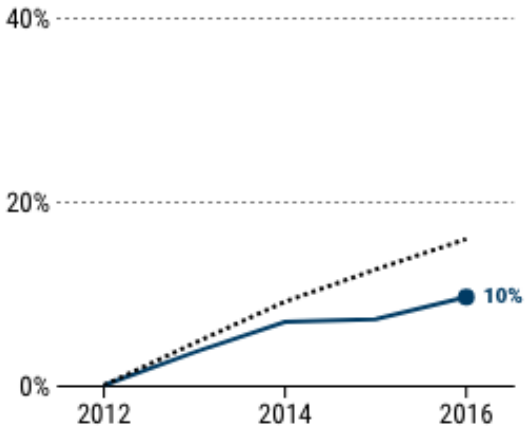


Providence-Warwick, RI-MA

2016 Price level: 20%
below national average



Price growth since 2012: 10%

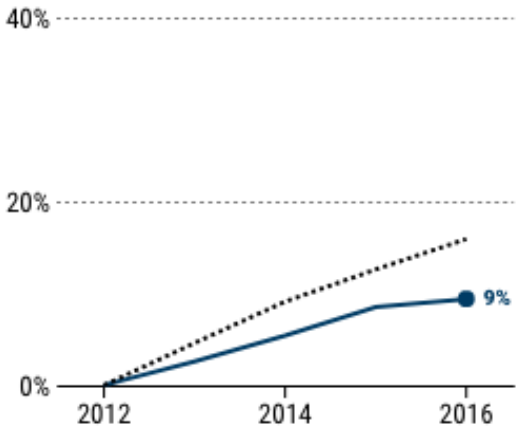


Baltimore-Columbia-Towson, MD

2016 Price level: 33%
below national average



Price growth since 2012: 9%



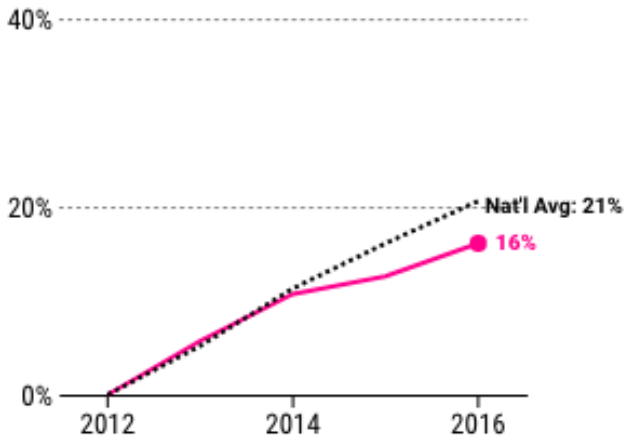
Inpatient Services – More expensive but Seattle rising slower than country

Seattle-Tacoma-Bellevue, WA

2016 Price level: 12%
above *national average*



Price growth since 2012: 16%

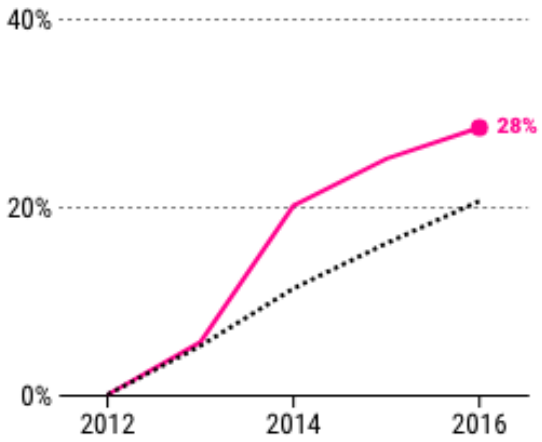


Spokane-Spokane Valley, WA

2016 Price level: 3%
above *national average*



Price growth since 2012: 28%

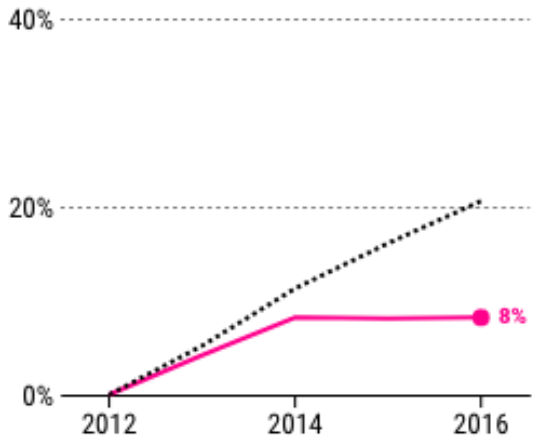


Providence-Warwick, RI-MA

2016 Price level: 20%
below *national average*



Price growth since 2012: 8%

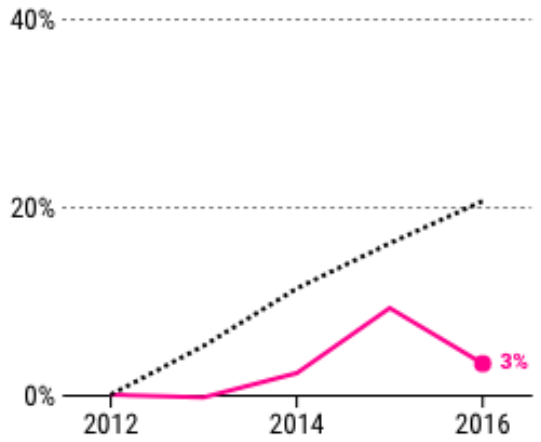


Baltimore-Columbia-Towson, MD

2016 Price level: 32%
below *national average*



Price growth since 2012: 3%



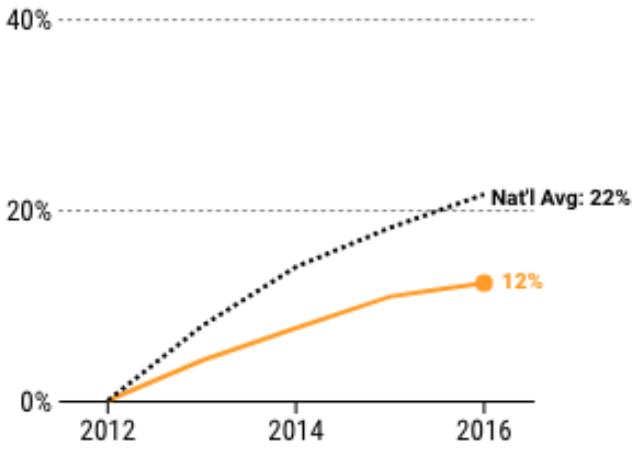
Hospital Outpatient Services: Close to national averages in both markets

Seattle-Tacoma-Bellevue, WA

2016 Price level: 1%
above *national average*



Price growth since 2012: 12%

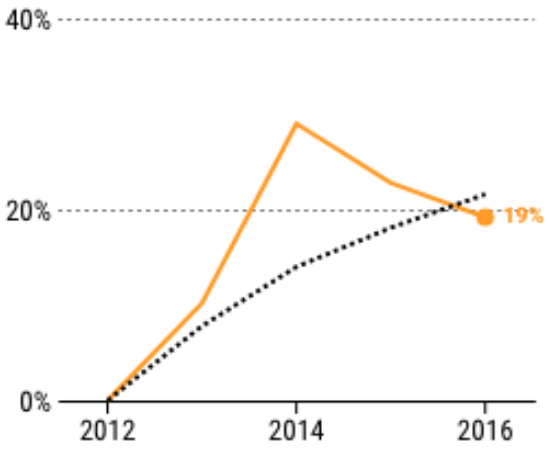


Spokane-Spokane Valley, WA

2016 Price level: 6%
below *national average*



Price growth since 2012: 19%

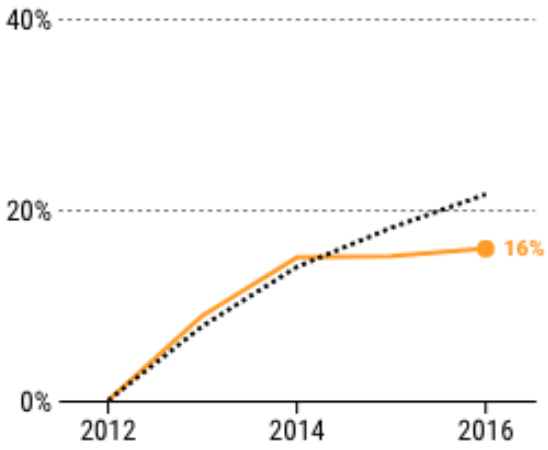


Providence-Warwick, RI-MA

2016 Price level: 25%
below *national average*



Price growth since 2012: 16%

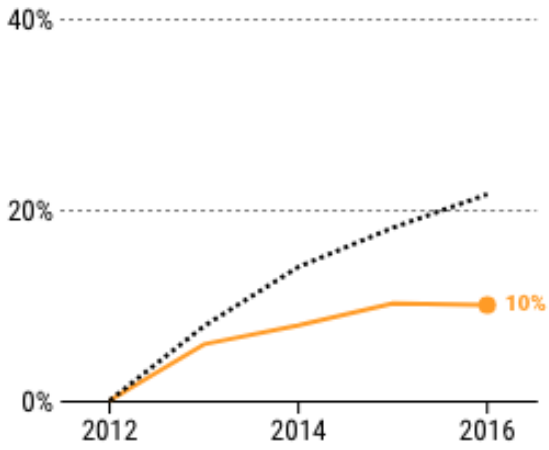


Baltimore-Columbia-Towson, MD

2016 Price level: 58%
below *national average*



Price growth since 2012: 10%



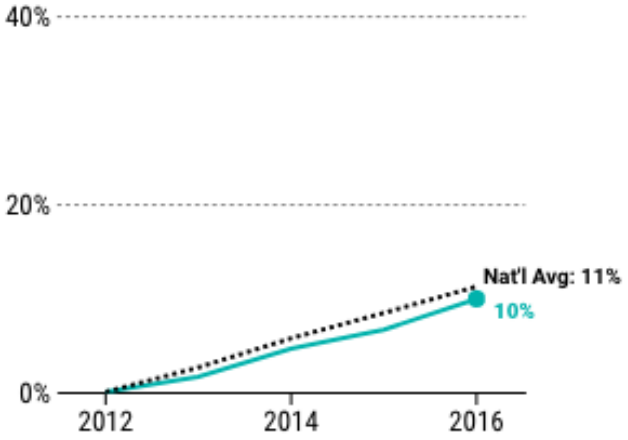
Professional Services: Higher than national averages

Seattle-Tacoma-Bellevue, WA

2016 Price level: 9%
above national average



Price growth since 2012: 10%

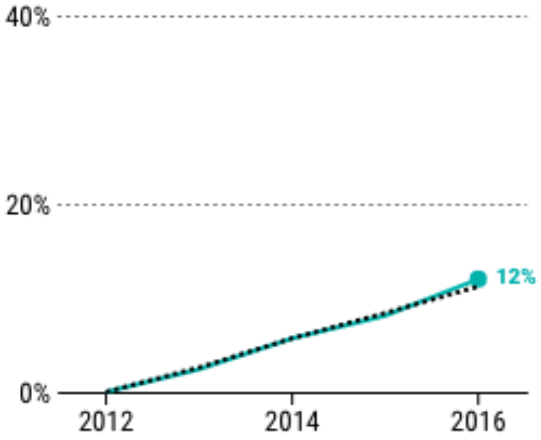


Spokane-Spokane Valley, WA

2016 Price level: 12%
above national average



Price growth since 2012: 12%

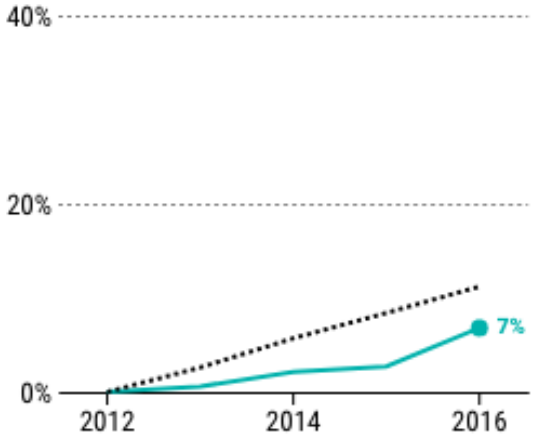


Providence-Warwick, RI-MA

2016 Price level: 17%
below national average



Price growth since 2012: 7%

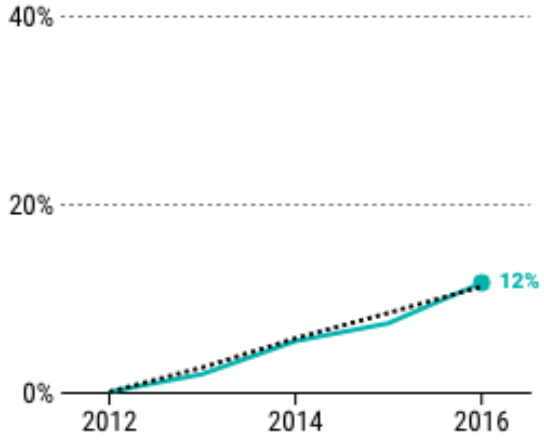


Baltimore-Columbia-Towson, MD

2016 Price level: 15%
below national average



Price growth since 2012: 12%



So you can't be Maryland
Who else is taking on Pricing in the Commercial Market?

- Rhode Island – Commercial Insurer Affordability Standards
- Oregon – Comprehensive Primary Care
- Colorado – Public Reporting of Hospital Costs and All Payer Primary Care Transformation
- Massachusetts – Total Costs of Care Measurement

2003: In response to Physician and Employer Outcry Over Insurer Behavior, RI Legislature Strengthens Health Insurer Oversight



New Charge

- See the system as a whole and direct insurers to policies that promote affordability, accessibility and quality of system

Full Rate Review and Comprehensive Set of Affordability Standards for RI Insurers

1. Invest in Primary Care (Raise Primary Care Spend by One Point a Year for Five years).
   - Not in FFS increases, not add on to overall costs
2. Support Multipayer Efforts.
3. Invest in Health Information Technology.
4. Implement Value Based Payment Model with Caps on Hospital Rate Increases.

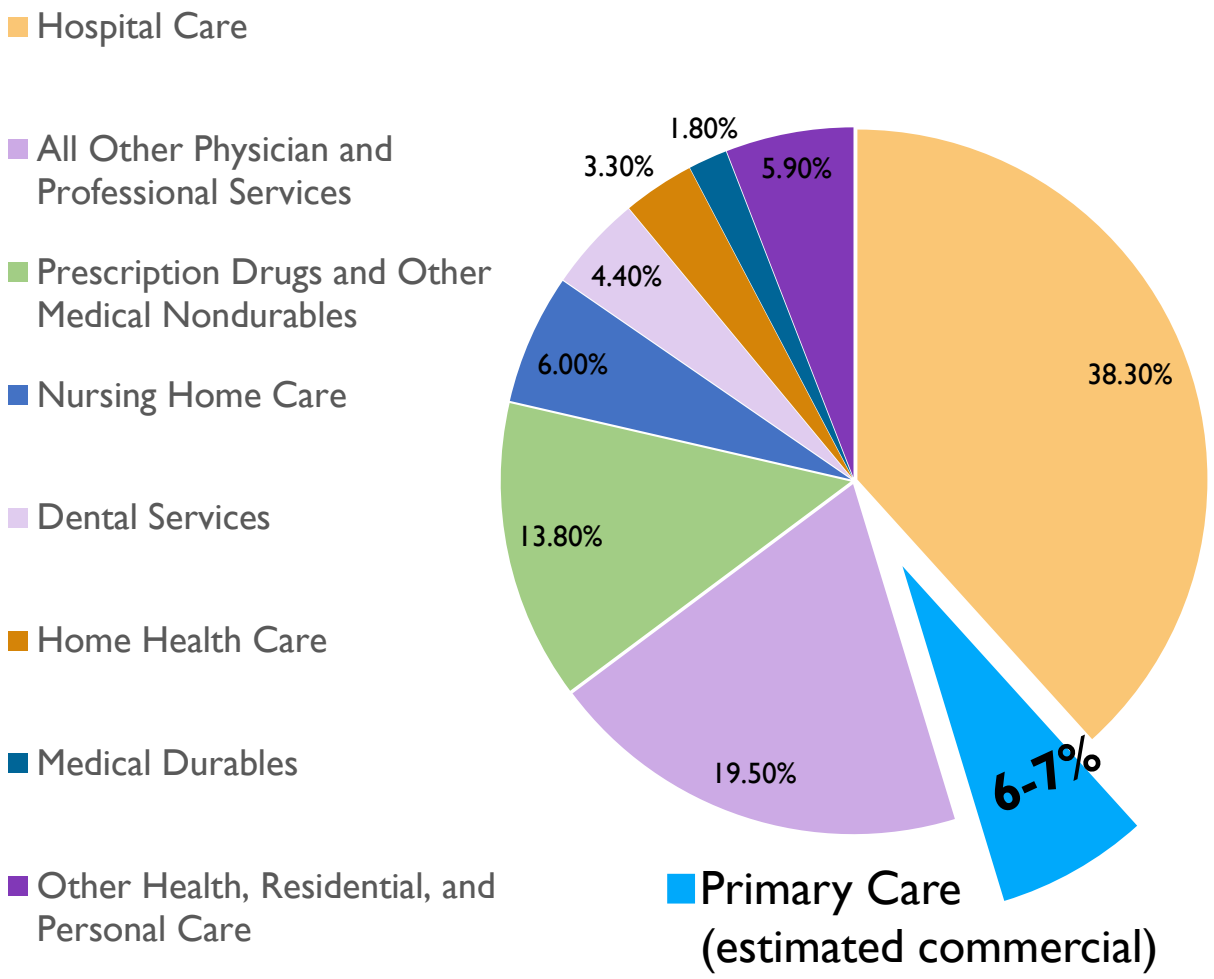
Developed with Advisory Council.

Enforced through rate review process.

Why Primary Care Spend as a Goal?

1. Supported by evidence.
2. Number and implications easily comprehended by public.
3. Non-partisan.
4. ACO/VBP evidence is that primary care governed entities success and acute care-governed ones do not.
5. Communicates misplaced social priorities and builds consensus on societally-oriented goals:
   - "Gateway" policy to more attention to social services investing

Make the Slice Bigger



Source: CMS Actuary. All Payments

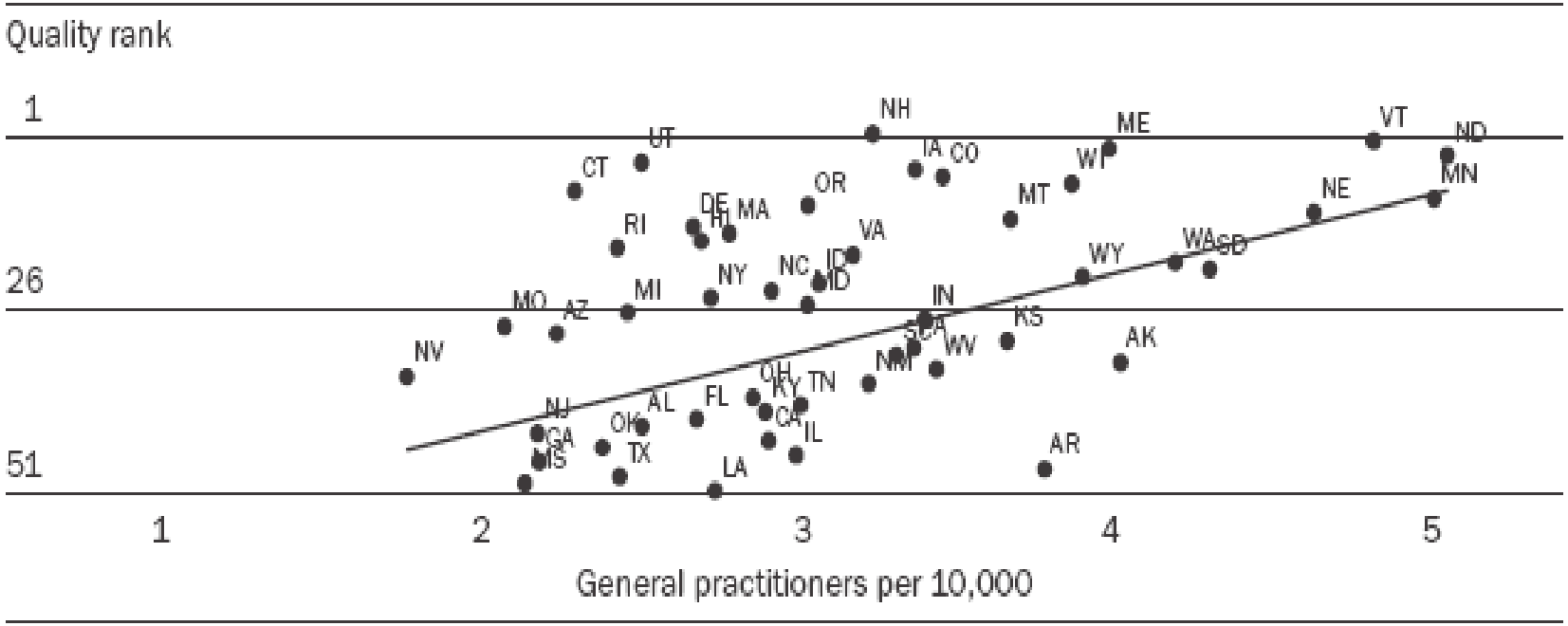
"This evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care. The evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies".

Source: (Starfield Milbank Q. 2005 Sep; 83(3): 457–502.)

What is the Evidence?
Primary Care Associated with Higher Quality…

EXHIBIT 8

Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000



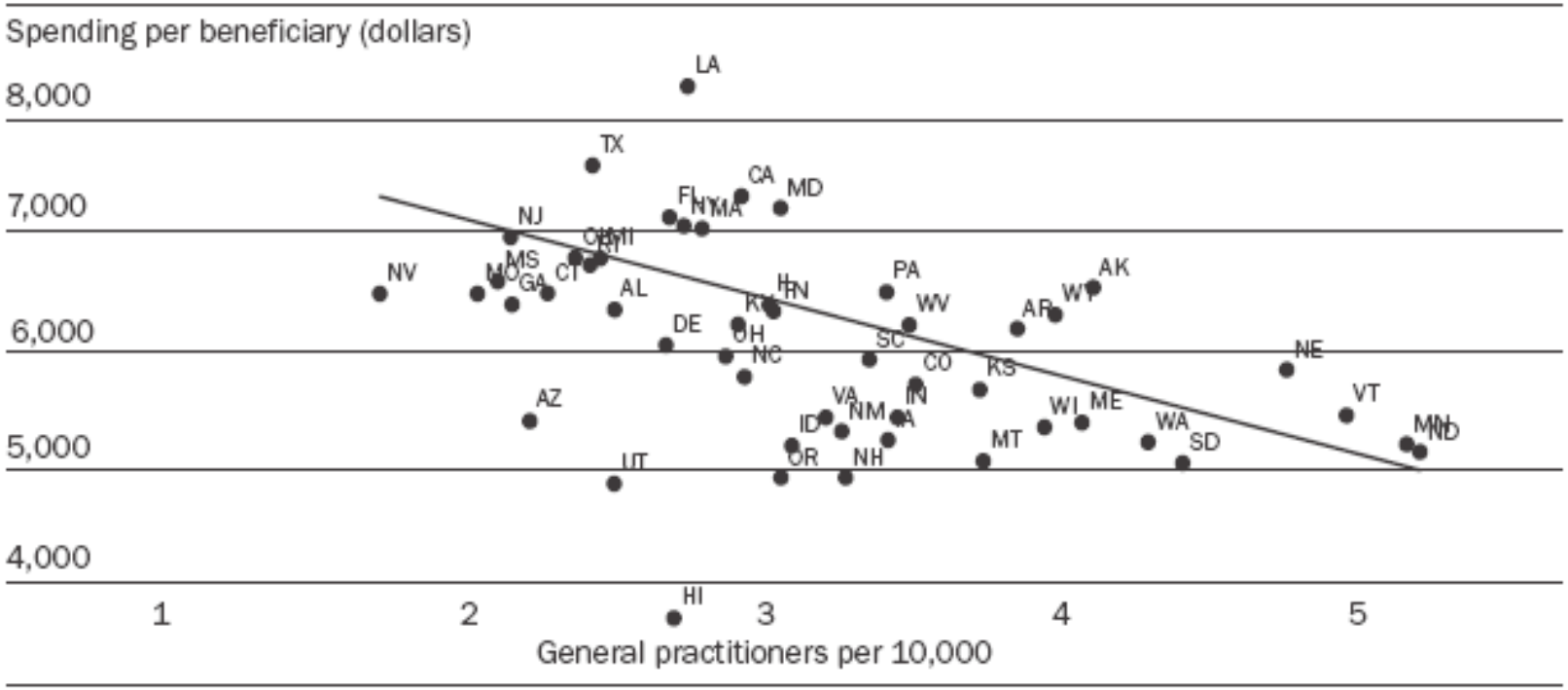
SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004

…And Lower Costs

EXHIBIT 9

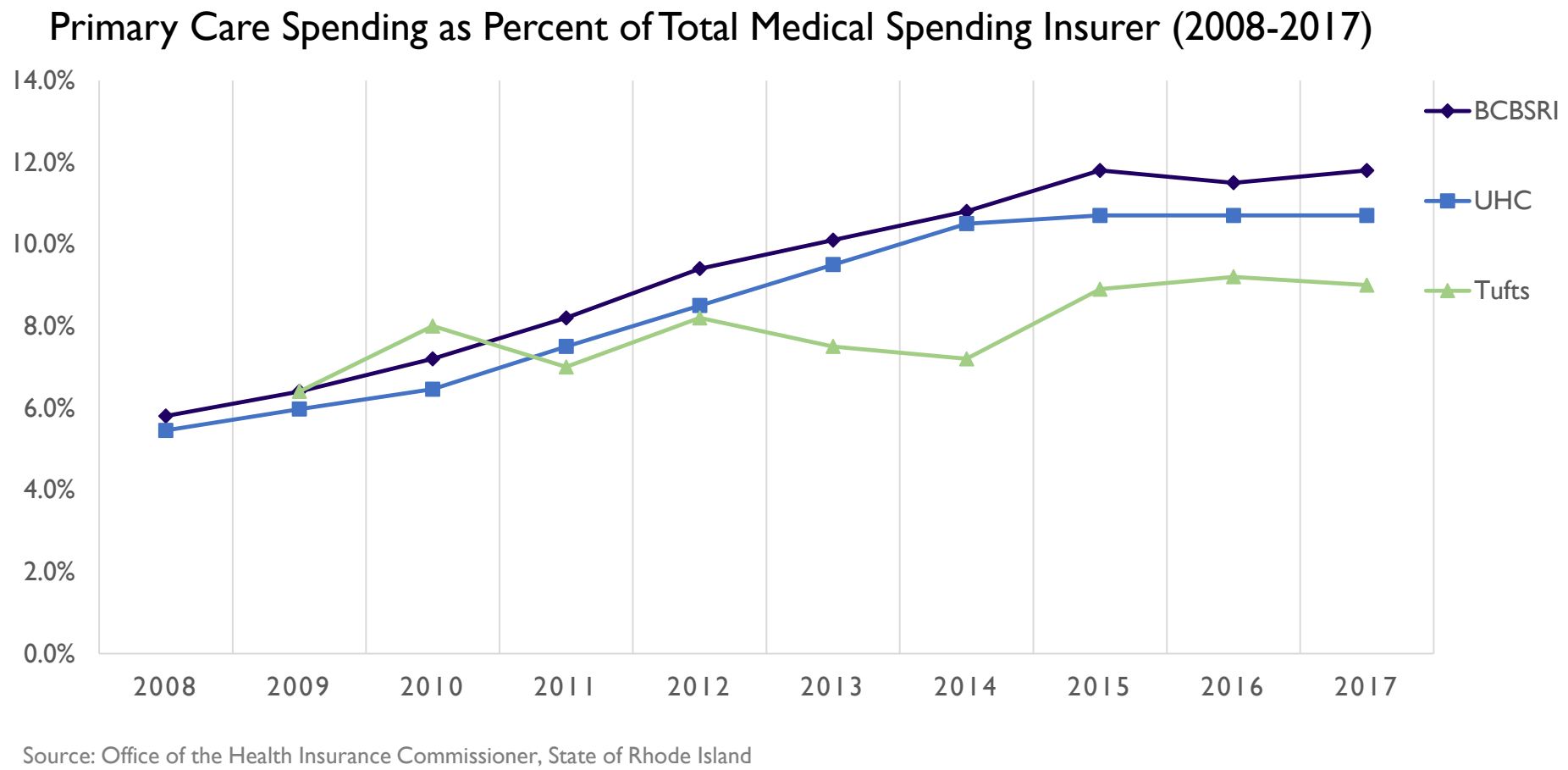
Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004

Making Primary Care a Priority for the State's Health Care System: A little gets you a lot.



Source: Office of the Health Insurance Commissioner, State of Rhode Island

Increasing Primary Care Spend is high leverage:

In RI, primary care spending by commercial insurers increased from $47 million/year to $73/year over this period. Self insured not captured

Hospital Rate Trend Caps and VBP implementation timeline

- Origin – Insurer rate review documented large price increases to hospitals from plans.
- Insurance Commissioner study documented wide variations in average prices paid to hospitals as percent of Medicare.
- Hospitals unwilling to adopt VBP voluntarily.
- Agreed to by plans as a signed condition to annual rate increases. They impose in contracts. Regulator audits contracts.
- Sported by Advisory Council.
- In regulation. Withstood court challenge.

1. What Happened in RI?

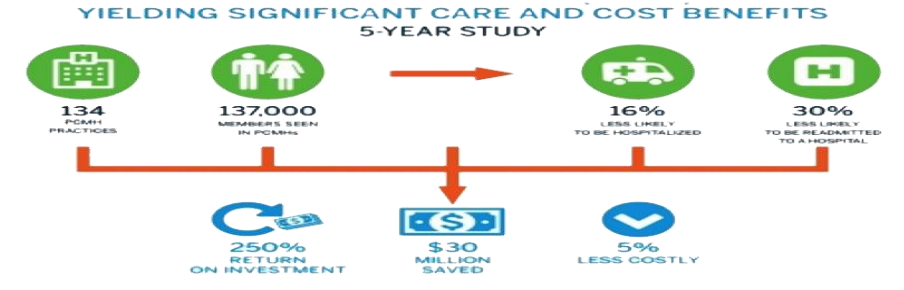
Top Ten Medicare ACO

COASTAL MEDICAL
LEADERS IN HEALTHCARE

Health Information Exchange

current care®

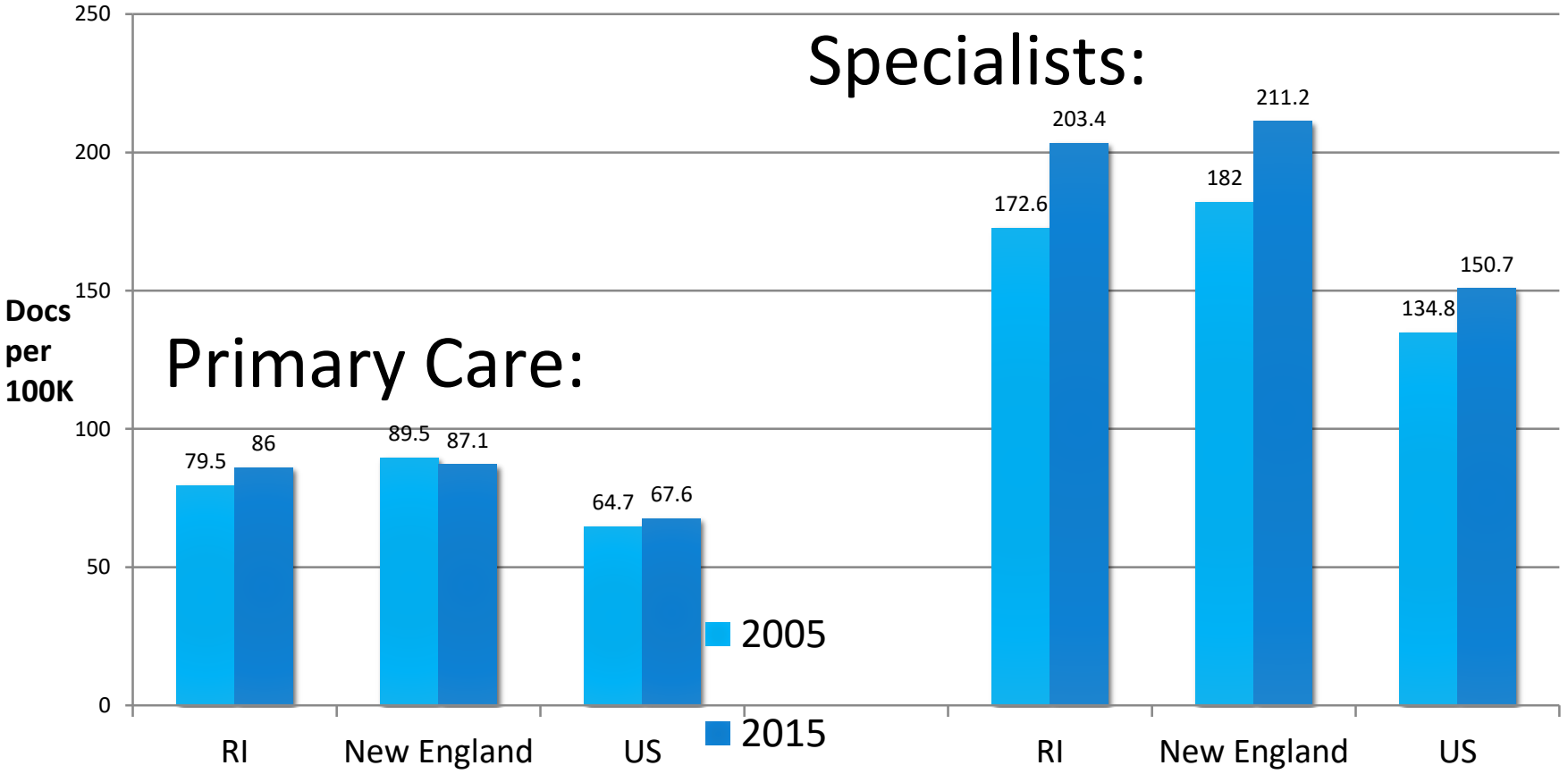
Successful PCMH at Blue Cross



Multi-payer Primary Care Transformation

CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

RI Defied Trends and Increased Primary Care Supply
(No Specialty Flight)



Notes: MDs only; Primary Care: FP, Peds, IM;
Sources: AMA Licensure and Census.Gov

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Have a Delivery System Transformation Plan - Engage Commercial Payers

PRIVATE HEALTH INSURANCE

By Aaron Baum, Zirui Song, Bruce E. Landon, Russell S. Phillips, Asaf Bitton, and Sanjay Basu

Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers

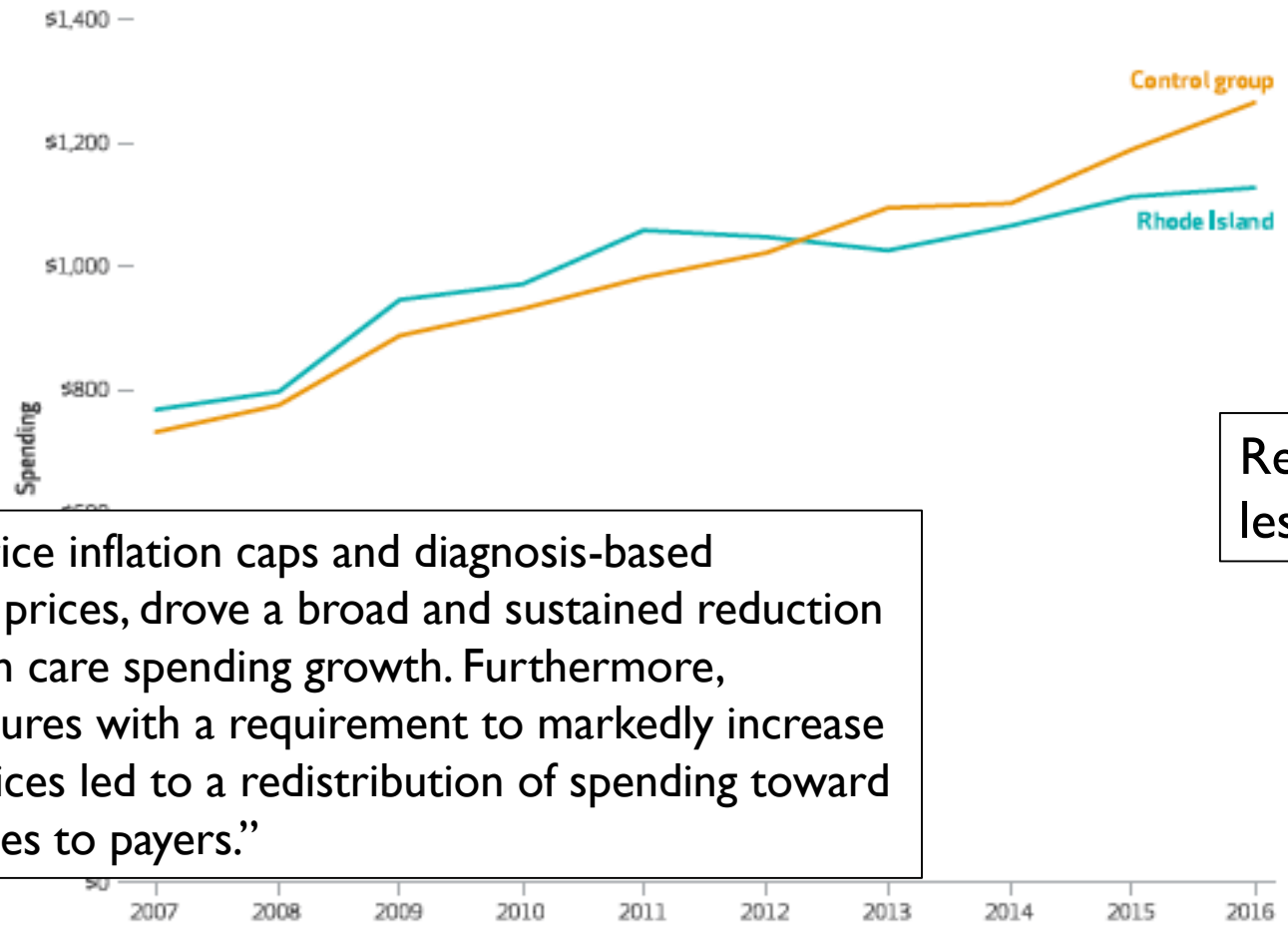
DOI: 10.1377/hlthaff.2018.05164
HEALTH AFFAIRS 38,
NO. 2 (2019): 237–245
©2019 Project HOPE—
The People-to-People Health
Foundation, Inc.

- Study effects of Affordability Standards
- RI Claims vs similar population
- Matched for demographics and enrollment.
- Look at Differences in Differences

Headline: RI Bent the Trend

EXHIBIT 2

Quarterly per enrollee fee-for-service spending in the Rhode Island and control-group cohorts, 2007–16



SOURCE Authors' analysis of data for 2007–16 from the Truven MarketScan Commercial Claims and Encounters database. **NOTES** The cohorts are explained in the notes to exhibit 1. All values were adjusted to a standardized ninety-day quarter. Dollar amounts were inflation adjusted to 2015 dollars. Rhode Island's affordability standards were implemented in 2010.

"Our analysis suggests that price inflation caps and diagnosis-based payments, which led to lower prices, drove a broad and sustained reduction in commercially insured health care spending growth. Furthermore, combining price control measures with a requirement to markedly increase funding to primary care practices led to a redistribution of spending toward primary care without net losses to payers."

Researchers found no lessening of quality.

Source: Baum et al
Health Affairs Feb 2019

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2. Oregon – Comprehensive Primary Care



Source: https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/SB-231-Report-2018-FINAL.PDF

Led by Oregon health Authority

Primary Care Transformation Collaborative

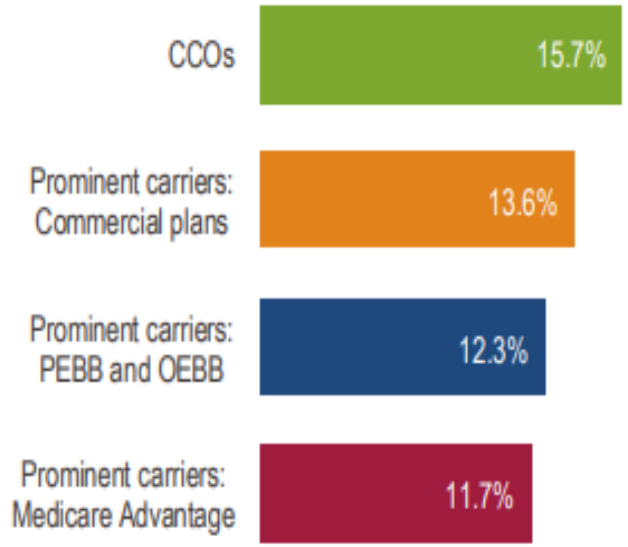
Primary Care Spend Legislation

Multi payer collaborative (Medicare CPC+)

Goal-Baseline and Document Variation by Product Line

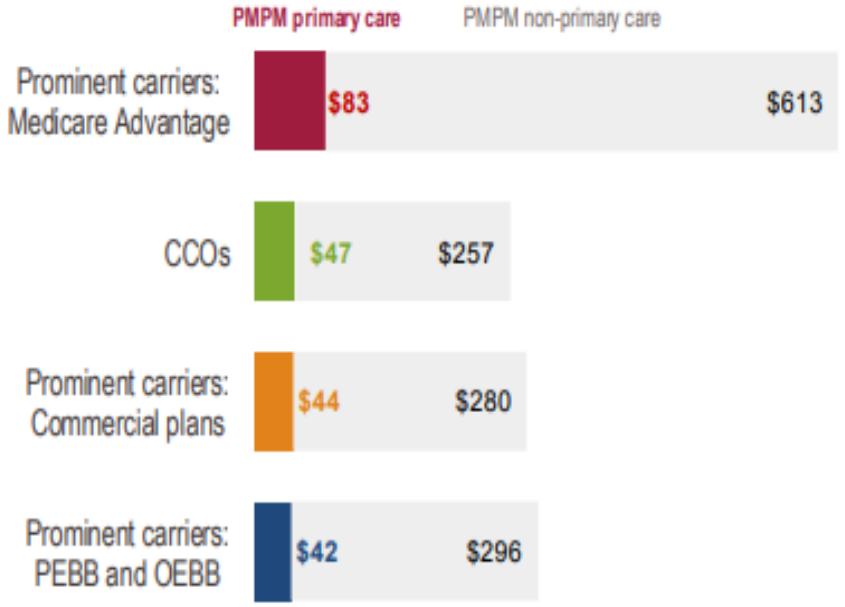
Percentage of total medical spending allocated to primary care

In 2016, CCOs allocated an average of 15.7 percent of total medical spending to primary care. Commercial, Medicare Advantage, and PEBB and OEBB plans allocated an average of 13.6 percent or less of total medical spending to primary care.



Per-member per-month (PMPM) primary care spending

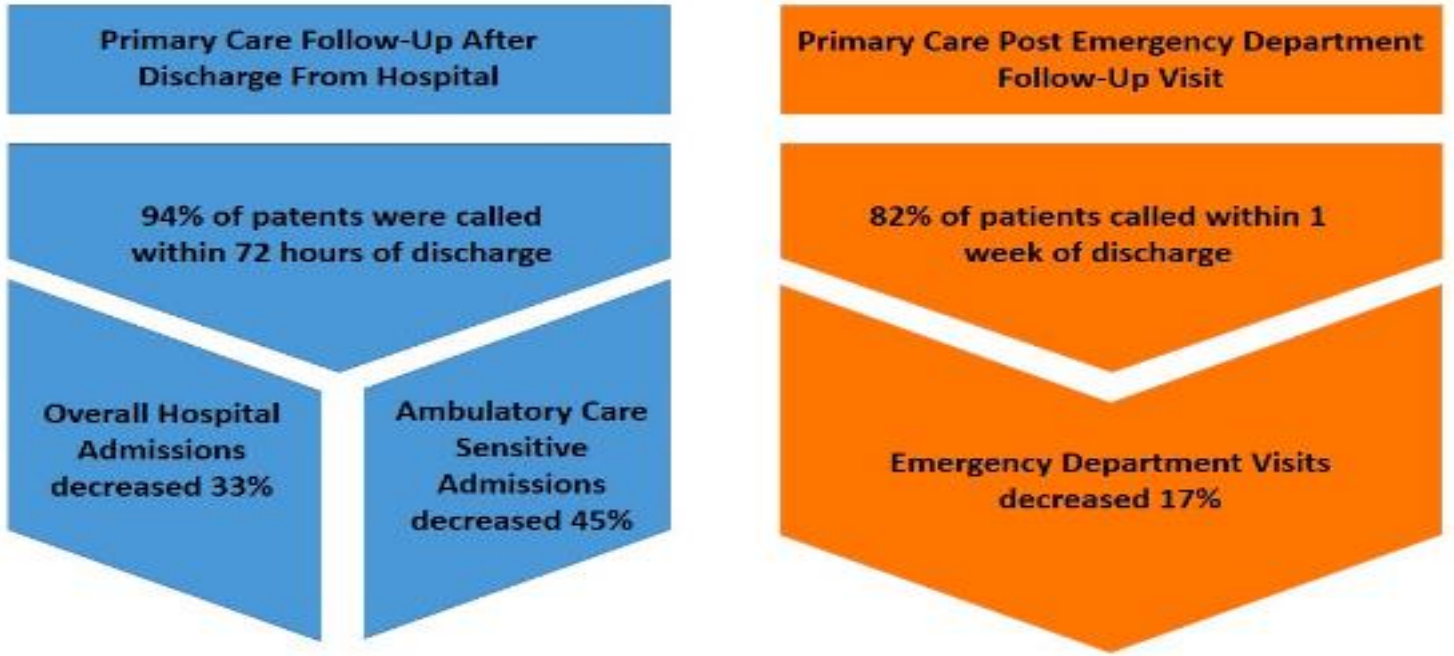
In 2016, PMPM primary care spending ranged from $42 for PEBB and OEBB plans to $83 for Medicare Advantage plans on average. Non-primary care spending ranged from $257 PMPM for CCOs to $613 PMPM for Medicare Advantage plans on average.



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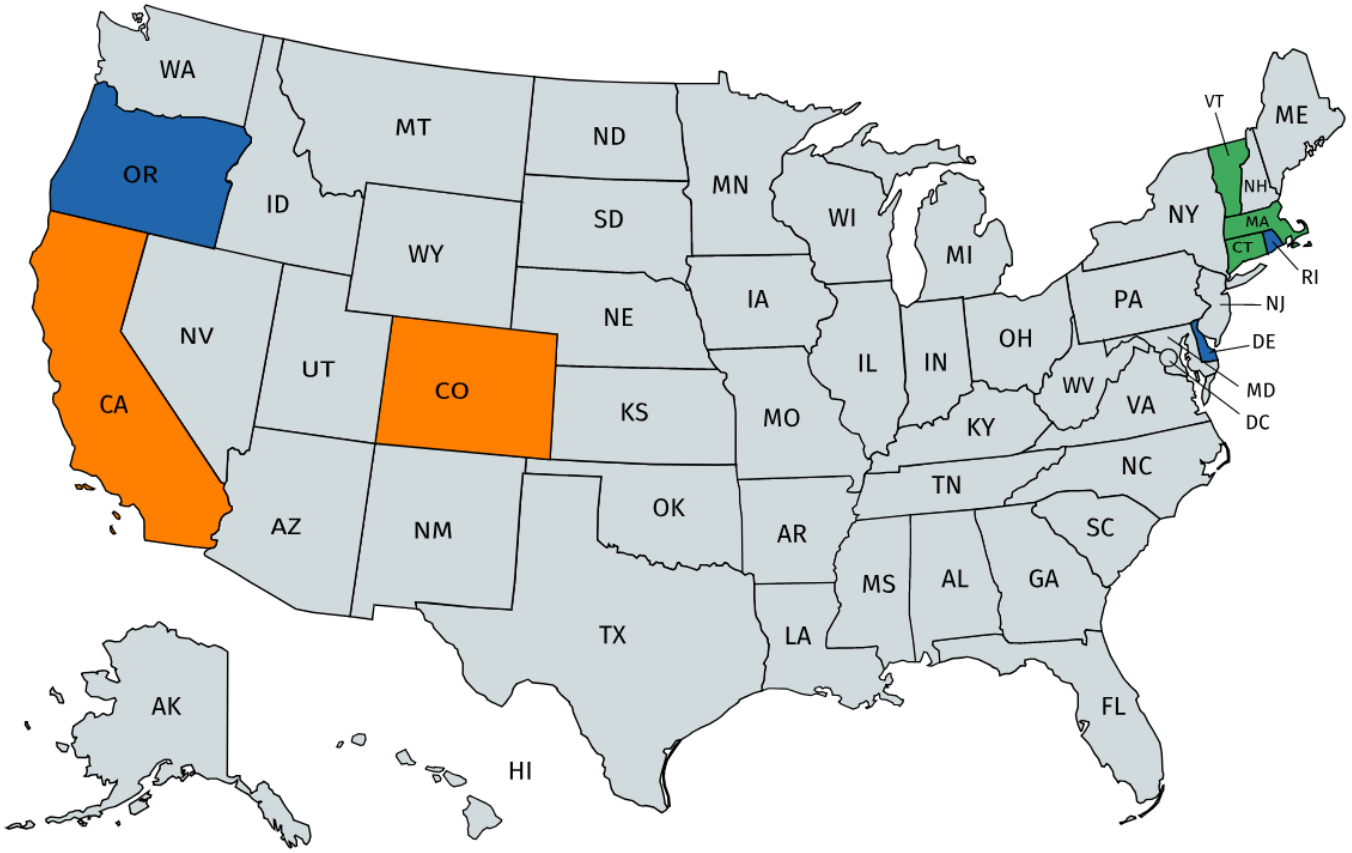
All Payer Primary Care Can Get You A Lot

Figure 1: OHIO/KENTUCKY CPC INITIATIVE ALL-PAYER RESULTS (Comparing 2013 with 2016) – Connecting the impact of staff actions in the outpatient setting with inpatient hospitalization and emergency department visit rates



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Primary Care Spend Idea is spreading –



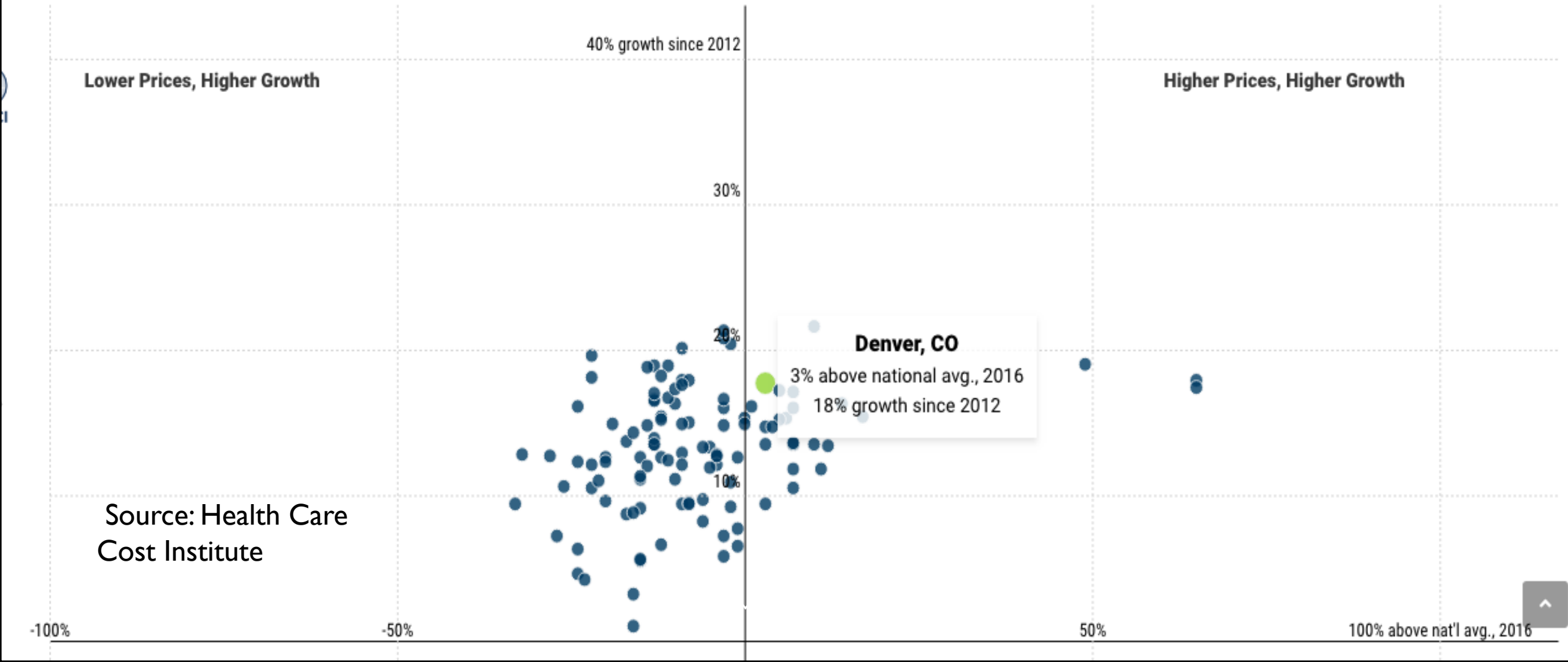
- Statutory or Regulatory Action
- Proposed Legislation
- State-wide Measure of Primary Care Spend

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3. Colorado: Analysis of Hospital Costs

- Medicaid expansion in CO financed with hospital provider tax - proceeds shared with hospitals to make up for alleged Medicaid underpayment “cost shift”.
- Department of Health Care Financing and Policy (HCPF) has access to hospital cost reports and Medicaid Spending.
- Concern about Hospital Costs and Expansion- especially in smaller markets.

Denver Provider Prices appear to be Growing Faster than National Average



Source: Health Care Cost Institute

Tackling Alleged "Cost Shift"

- January 2019 – first in a series of reports by Colorado HCPF analyzing hospital costs and payments.
- Summary by Colorado Institute:

> **Key Takeaways**
>
> - Advocates for Medicaid expansion promoted the idea that hospitals charge extra to patients with private insurance to make up for underpayments from the uninsured and public programs.
> - A new report from Colorado's Medicaid agency calls into question this theory of the "cost shift."
> - Leading economists have debunked the cost shift, saying instead that hospital prices depend on market dynamics and competition.

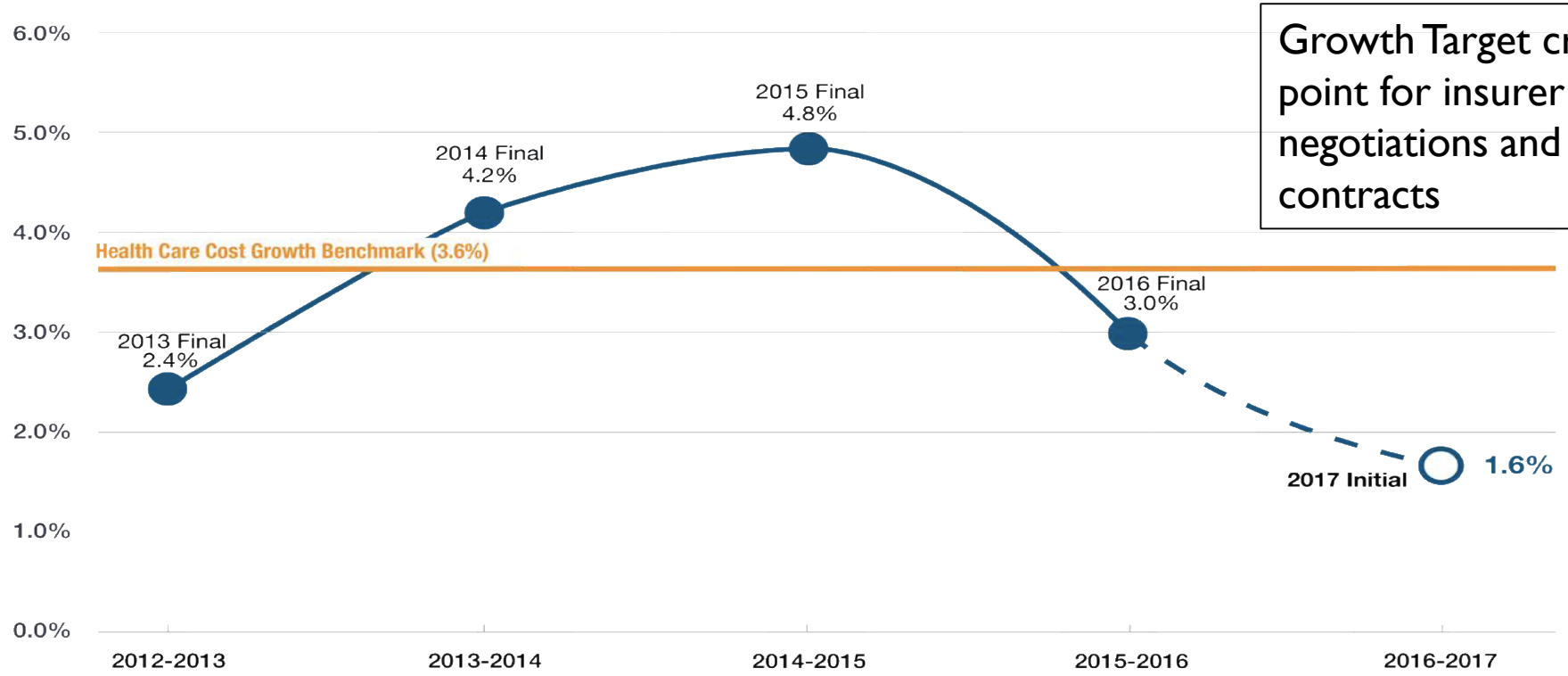
Colorado also building Primary Care Capacity

1. Long standing multi payer primary care transformation collaborative, including Medicare's Comprehensive Primary Care Initiative, supported by State Innovation Model funds.
2. Proposed legislation on primary care spend.

4. Massachusetts - Targeting Growth of per capita costs: lower rates of growth = more money for other uses.

1. Implemented RomneyCare in 2006 - before Obama Care.
2. 2009: Highest rates of per capita spend in country (excluding DC and AK).
3. Legislature creates Health Policy Commission to focus on trends in per capita total costs of care relative to state GDP (growth target).
4. Data plus analysis plus local luminaries: “Name and Shame”.
5. Also advises on hospital consolidations.

Early Results in Mass. – beating the trend.



Growth Target creates a reference point for insurer rate review, provider negotiations and Medicaid MCO contracts

Source: Mass Health Policy Commission

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Others Following Mass. Example

1. Delaware – Governor Executive Order. Measurement assigned to Economic Development Authority.
2. RI – Voluntary Compact of Insurers, Providers and State to tie cost growth to rate of economic growth.
3. OR – pending legislation.
4. Minnesota – reporting.

Rhode Island Health Care Cost Trends Steering Committee

Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island

We, the undersigned members of the Rhode Island Health Care Cost Trends Steering Committee (Steering Committee), convened by the Governor, Rhode Island Executive Office of Health and Human Services (EOHHS), and the Office of the Health Insurance Commissioner (OHIC) to develop an annual health care cost growth target for Rhode Island, have developed a set of recommendations (attached) which we believe will help Rhode Island reduce the growth in health care costs and state health care spending.[1]

Specifically, we agree upon and support the following cost growth target and methodology, and commit to taking all reasonable and necessary steps to annually keep health care cost growth below the target at the organizational level (as applicable to our organization) and state level, while maintaining (or improving) quality and access:

- The cost growth target shall be the value of Rhode Island's Potential Gross State Product (PGSP). PGSP is the total value of the goods produced and services provided in a state at a constant inflation rate and is 3.2%.[2]

- The target's duration is four years, i.e., 2019 through 2022, with the stable value of 3.2% maintained throughout. We commit to revisit the methodology of the cost growth target during 2022 and advise the State on whether to keep the existing target or establish a new target for 2023 and beyond.

Signatories: Providers, Insurers, Employers, Consumer Groups and State

http://www.ohic.ri.gov/documents/cost%20trends%20project/Compact-to-Reduce-the-Growth-in-Health-Care-Costs-and-State-Health-Care-Spending-in-RI.pdf

Big Lessons for WA

1. Focus on commercial insurance “black box”.
2. Raise awareness of price issue.
3. Government role – prioritize, convene, measure.
4. More market oversight if not outright price regulation.
5. The incremental health care dollar is better with employer, employee or primary care than in hospital or specialty care.
6. Multi stakeholder alliance like WHA can amplify voice of “the other 80% of the economy”, give political cover for government and consistency as government administrations transition.

Opportunities for WA – 1. Align Insurer Oversight

- Existing overlapping authority of HCA, Exchange and Departments of Insurance creates opportunities for policy friction and slippage.
- Same with multiple multipayer claims data sources in state.

  - Addressing these takes leadership.
  - Primary care might be a good safe place to start.

Opportunities for WA -
2. Routine Measurement of Price and Total Costs of Care

Target – raise awareness of system issues. Set policy agenda. Improve.

Aligned between HCA, WHA and Insurance Commissioner:

1. Total Costs of Care (MA, RI, DE).
2. Average commercial rates by Hospital and Service Type (RI, MA, CO).
3. Analysis of Commercial Insurer Rate Submissions (RI).

WHA reports on spending trend and pricing are step in right direction.

Opportunities for WA -
3. Set Targets for Total Costs of Care Growth and Track Progress

State Commission – Massachusetts

Government Function – Delaware

Public Compact – Rhode Island

Regardless - Fund the Measurement

Opportunities for WA - 4. Promote Primary Care Capacity Building

Ideas:

- Stronger comprehensive primary care is investment to reduce unnecessary care. (WHA priority).
- Redistribute marginal dollar from acute and inpatient care.
- Create an alternate base of health care discussion to usual dominant providers Alternative path for primary care docs to provider consolidation. Ultimately – change supply mix.

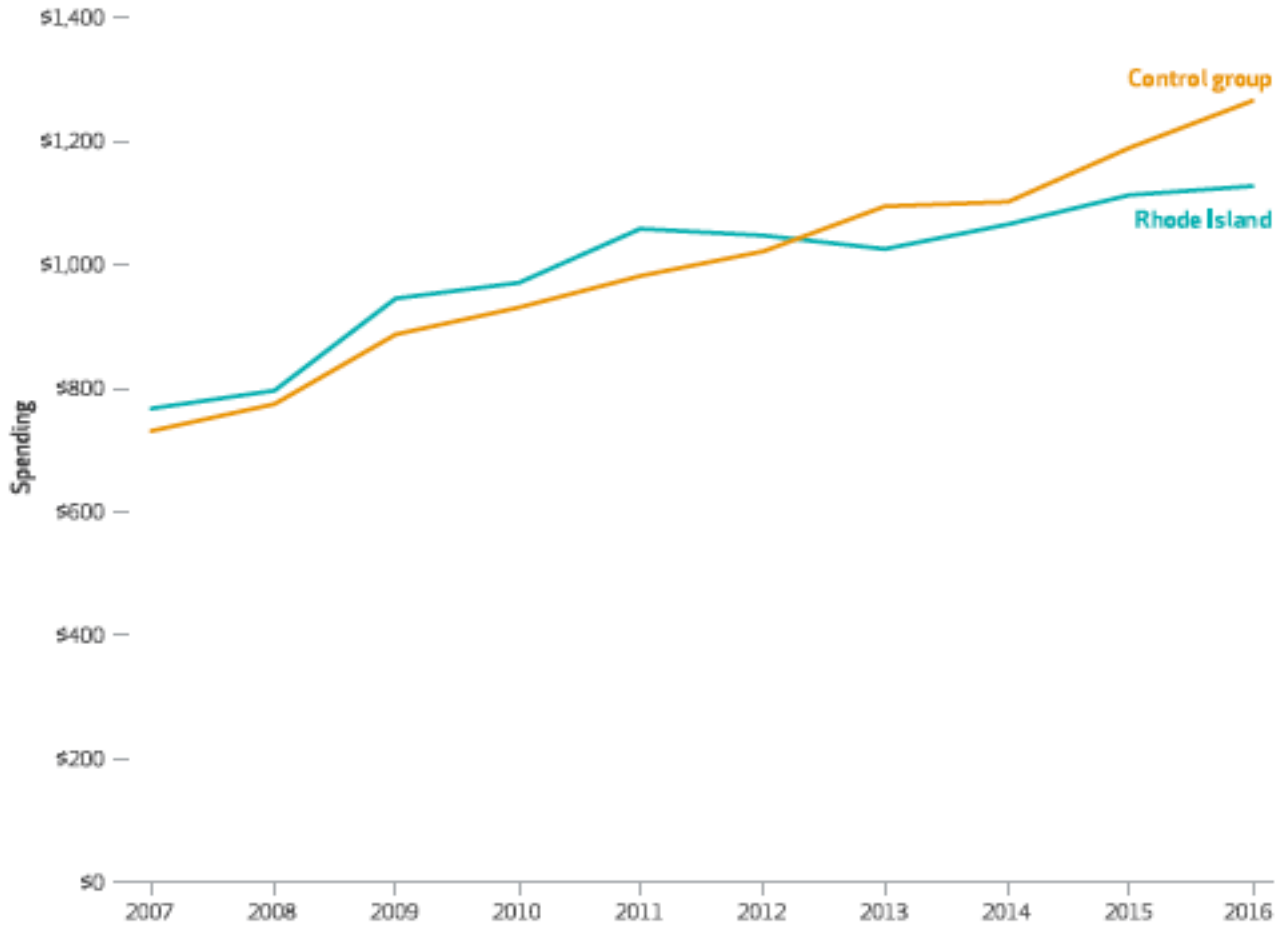
Activities:

1. HCA and WHA aligned reporting on current levels of primary spend (legislation for future).
2. Upcoming Comprehensive Primary Care Initiative solicitation.
3. Payer standards in HCA and WHA member contracts with insurers.

Remember - Systematic Change is possible

EXHIBIT 2

Quarterly per enrollee fee-for-service spending in the Rhode Island and control-group cohorts, 2007–16

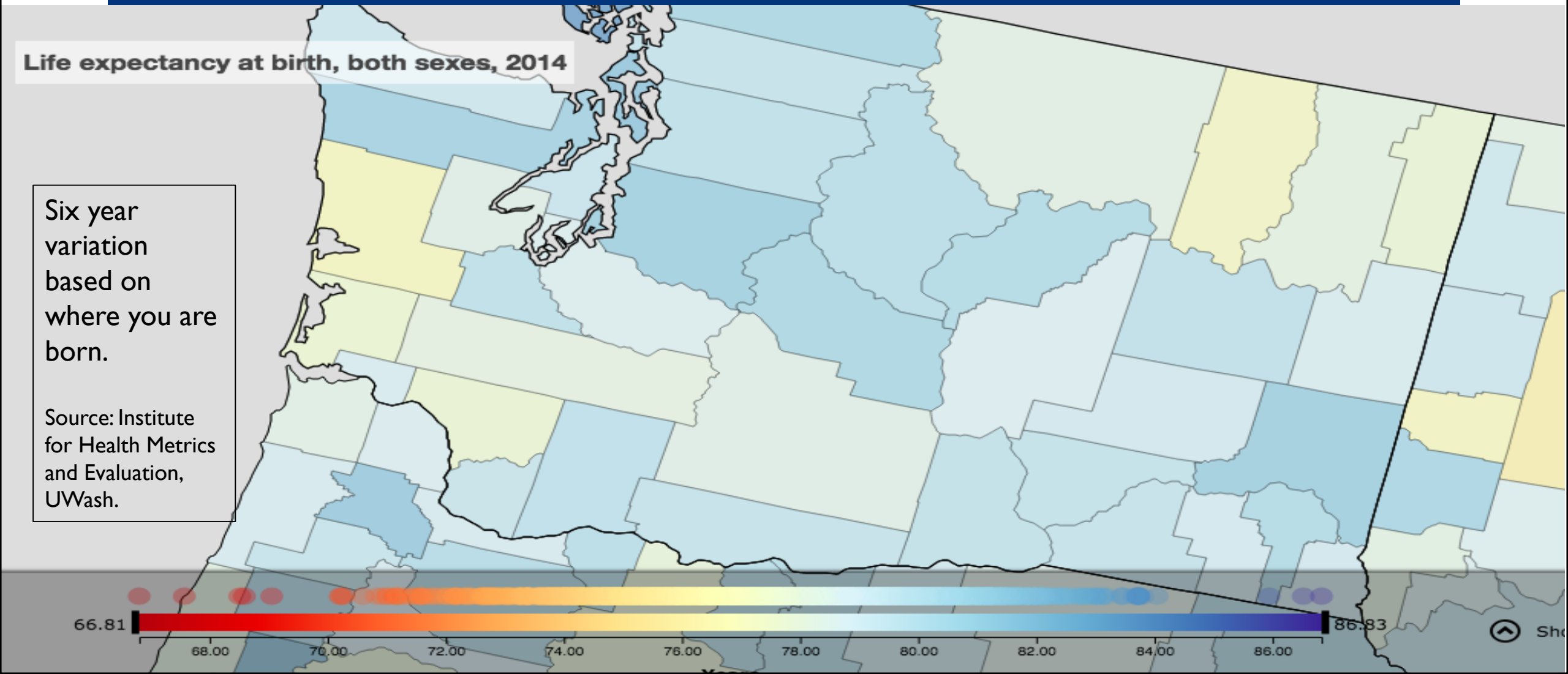


SOURCE Authors' analysis of data for 2007–16 from the Truven MarketScan Commercial Claims and Encounters database. **NOTES** The cohorts are explained in the notes to exhibit 1. All values were adjusted to a standardized ninety-day quarter. Dollar amounts were inflation adjusted to 2015 dollars. Rhode Island's affordability standards were implemented in 2010.

Source: Baum et al
Health Affairs Feb 2019

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Why The Goal Matters: Less Money in Healthcare Means More Money for Health…



Six year variation based on where you are born.

Source: Institute for Health Metrics and Evaluation, UWash.