Multi-stakeholder Approach to Addressing Total Cost of Care

May 11, 2018
Mission

We are an independent, neutral nonprofit dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information.

In 2017, Q Corp merged with HealthInsight, a larger nonprofit organization serving Oregon, Utah, New Mexico and Nevada. In 2018, HealthInsight merged with Qualis Health.
“...[For] the first time in history, health care has surpassed manufacturing and retail, the most significant job engines of the 20th century, to become the largest source of jobs in the U.S.”

-- Derek Thompson, Jan. 9, 2018, The Atlantic

We have an unsustainable problem. Harder choices are coming.

Between 2006–2016 premiums rose 77%

Healthcare costs will consume half of household income by 2021


We ALL created this problem. We ALL need to be part of the solution.

Consumers  Payers  Providers  Purchasers  Policymakers
Regional Health Improvement Collaborative (RHIC)

Patient Engagement

Data Collaborative Products
- Compare Your Care (public website)
- Practice Reporting Portal
- Statewide Reports

Patient and Family Advisory Council
Development and expansion of self-management programs

Training and Assistance in Performance Improvement

Providers

Performance Measurement and Transparency

Payment and Delivery System Reform

Consumers

Quality Improvement Organization
Hospital Improvement Innovation Network

Payers

Payment reform projects
Medicare Quality Payment Program technical assistance
CPC+ Payer Group facilitation

Purchasers
The initiative was piloted by NRHI and RHICs in five regions. Their success led to the expansion to fourteen additional regions over the course of the project.
Data Collaborative

- Fuller picture than any one data source
- Comparisons – between health plans, medical groups, practices and providers
- Follows patients over time, across payers

Aggregated claims data
2017 Claims Data Summary

82% Fully Insured Commercial population

25% Self Insured Commercial population

100% Medicaid population

89% Medicare FFS and Medicare Advantage
Data Collaborative Members

Collaborative Members Provide: Data, Funding, Governance
Other Funders

Robert Wood Johnson Foundation

Department of Health & Human Services, USA

Harvard University

Image sources: https://www.rwjf.org/
https://www.harvard.edu/about-harvard/harvard-glance/history
https://www.hhs.gov/web/services-and-resources/icon-and-widget-library/index.html
Oregon’s program is led by stakeholders

- Board voted for cost transparency project: 2013
- RWJF grant funding for two projects: 2013–2018
- Created Cost of Care Steering Committee in July 2014
- Laid out road map:
  - Private reporting to primary care clinics x2
  - Private reporting to participating payers
  - Public reporting
- Healthy tension created by variety of perspectives and priorities
Cost of Care Steering Committee Members

Tim Bucy
Manager, Managed Care Contracting
US Oncology

Scott Conroy
Administrator
Hillsboro Cardiology

Susan Clack, MD
President, Pacific Medical Group
President, Portland IPA

Bill Dwyer
Director, Analysis & Reporting
Moda Health

Paige Frederick, RN
Quality Assurance Coordinator
The Portland Clinic

Robert Gluckman, MD, FACP
Chief Medical Officer
Providence Health Plan

Kerry Gonzales
Executive Director
Oregon Academy of Family Physicians

Stephen Hale, MD
Hospitalist, Program Director
Samaritan Pacific Communities

Doug Koekkoek, MD
Chief Executive Officer, Providence Medical Group & Clinical Services—Oregon
Providence Health & Services

Sandra Lewis, MD, FACC
Cardiologist
The Oregon Clinic

Steve Mann, DO
President
High Lakes Health Care

Jennifer Matson
Business Development Manager
Biotronik

Barry Newman, MD, MBA
Medical Director of Pediatric Surgery
Providence Children's Health

Jesse Ellis O’Brien, MSW
Healthcare Advocate
OSPIRG

Traci Rieckmann
Chief Operating Officer
GreenField Health

Ruth Rowland
Program Coordinator
OHSU Center for Health Systems Effectiveness

Deborah Rumsey
Executive Director
Children’s Health Alliance

John Santa, MD, MPH
Director of Dissemination for OpenNotes
Beth Israel Deaconess Medical Center

Amit Shah, MD
Chief Medical Officer
CareOregon

Divya Sharma, MD
Internist, Mosaic Medical
Medical Director, Central Oregon IPA

Bob Sumner, MBA
Engagement Manager
Provider Partnership Innovations
Cambia Health Solutions

Michael Whitbeck
Administrator
Northwest Primary Care
HealthPartners Total Cost of Care Overview

- Based on the NQF-endorsed patented algorithm of HealthPartners, Inc.
- In use for over 12 years and adopted nationally. Over 264 licensees in 40 states.

Total Cost = Resource Use \times Price

- **Overall cost effectiveness of managing patient health**
- Measures the frequency and intensity of services used
- Affected by fee schedules, referral patterns and place of service

- Costs are adjusted to account for differences in age, gender and illness burden.
- Designed to highlight cost-saving opportunities and to identify potential instances of overuse or inefficiency in health care delivery.
Methodology is trusted and program is spreading: National Benchmarking

Average cost of healthcare for comparable populations

States could potentially save over $1 billion. Imagine if all the participating states could match the lowest cost state, several billion dollars would be available for other parts of the economy.

This work is based on the patented algorithm of HealthPartners, Inc. (Bloomington, MN) and is used with their permission.
Methodology is trusted and program is spreading: Benchmark key findings

• Healthcare costs are complicated! (who knew?)
• It’s not just price.
• It’s not just care patterns and delivery systems.
• It’s not just waste in the system.
• It’s different from state to state (and sometimes within a state).

*The size of the bars represents the impact of price and resource use on the total cost. As seen in the above graphic, price and resource use played different roles in the variation of total cost by state.*
Price Continues to Lead in Oregon

**Total Cost of Care by Service Category**
*Commercial Population 2015*  
*Combined Attributed and Unattributed*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Colorado</th>
<th>Maryland</th>
<th>Minnesota</th>
<th>Oregon</th>
<th>Utah</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Cost</strong></td>
<td>17%</td>
<td>-16%</td>
<td>7%</td>
<td>0%</td>
<td>-4%</td>
</tr>
<tr>
<td><strong>Resource Use</strong></td>
<td>11%</td>
<td>-3%</td>
<td>5%</td>
<td>-8%</td>
<td>-3%</td>
</tr>
<tr>
<td><strong>Price</strong></td>
<td>6%</td>
<td>-13%</td>
<td>1%</td>
<td>9%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

**Note:** This is the midpoint of the ranges created from the sensitivity analysis and represents the percent above or below the risk adjusted average across all regions.  
*View the full range of results in Table 1 on page 17*

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**Price**

<table>
<thead>
<tr>
<th>Measure</th>
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<th>Maryland</th>
<th>Minnesota</th>
<th>Oregon</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td>6%</td>
<td>-13%</td>
<td>1%</td>
<td>9%</td>
<td>-1%</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>16%</td>
<td>-12%</td>
<td>-1%</td>
<td>16%</td>
<td>-14%</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>4%</td>
<td>-13%</td>
<td>-5%</td>
<td>11%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Professional</strong></td>
<td>2%</td>
<td>-20%</td>
<td>10%</td>
<td>15%</td>
<td>-5%</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>0%</td>
<td>1%</td>
<td>-2%</td>
<td>-2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Note:** This is the midpoint of the ranges created from the sensitivity analysis and represents the percent above or below the risk adjusted average across all regions.  
*View the entire Table 2 on page 19*
Cost Drivers: Why are Oregon’s Prices Higher?

<table>
<thead>
<tr>
<th>Factors Affecting Commercial Unit Price:</th>
<th>Factors Affecting Utilization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider market power</td>
<td>Health status (morbidity)</td>
</tr>
<tr>
<td>Health Plan market power</td>
<td>Physician practice patterns</td>
</tr>
<tr>
<td>Cost-shifting</td>
<td>Patient cost-sharing level</td>
</tr>
<tr>
<td>Regional cost of living</td>
<td>State mandates</td>
</tr>
<tr>
<td>Location of service</td>
<td>Providers in network</td>
</tr>
</tbody>
</table>

- In states with lower utilization rates the price of services is often increased.
- Provider and health plan negotiation can play a role. Limited competition can lead to higher prices.
Overall Medicare margin continued to trend downward after holding relatively steady between 2009 and 2014.

Source: Report to the Congress: Medicare Payment Policy. (March 2018). [Figure 3-6 Overall Medicare margin continued to trend downward after holding relatively steady between 2009 and 2014]. Retrieved from http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch3_sec.pdf?sfvrsn=0
Potential Issues Resulting in Cost Shift

• Does payer mix for employed physicians differ from private practice physicians? Primary care provider (PCP) vs. specialty

• Previous data on cost shift shows that hospital efficiency improves in lower cost Medicare areas. The declining Medicare margins and growth of negative margin services adds strain to Commercial pricing. Sponsorship of primary care access for public payers may also add price pressure for hospitals.
Total Cost of Care Model Limitations

Maintaining comparability between regions creates limitations

• Analysis based on commercially insured only
• Relies on available data: is not a representative sample
  — Data submission is voluntary in Oregon; does not include all self-insured
• Not adjusted for cost of living
• Regional variations not accounted for (e.g., coding practices)
  — Sensitivity analysis found that regional variations in risk scoring did not change order ranking of any state
• Does not capture capitated or pay-for-performance payments
• May exclude substance abuse, behavioral health, some pharmacy claims
Clinic Comparison Reports - Commercial

Separate Adult and Pediatric reports
Commercial health plan patients

Data from 7 health plans | 421,000+ covered lives

Cost, quality and utilization are compared to Oregon average

Delivered to 176 practices with 600+ attributed patients

Two rounds of reports have been sent with plans for annual delivery going forward. 2016 in production now
Clinic Comparison Report Package

- Quality, Cost and Utilization at the clinic level
- Commercial clinic reports sent to 79 medical groups: 143 adult and 44 pediatric reports
- Reports include drilldowns into:
  - Demographics
  - Professional services
  - Inpatient services
  - Outpatient services
  - Pharmacy
  - ED and Imaging
How are Clinic Comparison Reports being used?

Clinics, medical groups and affiliated organizations are finding value:

• Aggregated (multi-payer) data gives a broader view of their patient population
• Encouraging other health plans to participate
• Validating or challenging assumptions

Clinics are using the reports to:

• Approach their oncology group to recommend patients use lower cost imaging services
• Use their EHR system to drill down on a pharmacy class where costs are high
• Validate practice changes
Variation in Cost vs. Quality

- Considerable variation among clinics and between regions across Oregon
- Rural clinics show higher cost and lower quality, on average
- We are working to better understand cost drivers and what providers can do to influence them
Lessons Learned

• Cost measurement is difficult
• Transparency is the beginning of conversations – you don’t know what you don’t know
• Establishing trust in the data is key to making changes
• Data can validate for clinics that what they are doing is working or that a change is needed
## Priorities for Total Cost of Care (TCOC)

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Actions and Outcomes</th>
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</table>
| Expanding beyond commercial population             | • Identified CCO partners to help us understand the feasibility of producing TCOC reports using Medicaid claims data  
• Expanding to Medicare FFS in 2018               |
| Benchmark reports for 2016                         | • Continuing to participate in NRHI Benchmark reports, allows for increased exposure and potential funding opportunities |
| Public reporting                                    | • HealthInsight Oregon will work closely with its Cost of Care Steering Committee to ensure public cost reporting is actionable and consumer-friendly  
• Public release of combined 2015 and 2016 data in summer 2018 |
| Develop tools to help stakeholders address costs   | • Received a development grant from NRHI to explore referral patterns                |
Top 10 Opportunities

1. More analysis is needed – this is just the start
2. More open and transparent data
3. Supporting innovation – using TCOC to track improvements
4. Inform policy-level change – identify key questions that can be answered with this data
5. Create tools for providers to make informed decisions
6. Use data to examine role of *price discrimination* between market segments

7. Increase visibility into cost data – incorporate meaningful cost information into reporting portal and public reporting

8. Move beyond primary care – create similar reports for specialists

9. Energize employers and purchasers to take action on health care costs

10. Neutral convener role is key – must continue to maintain trust in the data and partners
The Major Drivers of Affordability

- Health
- Price
- Waste

Solving one issue in isolation does not achieve the goal
Addressing the drivers of affordability has systemic benefits, in addition to the positive economic impact.

**+ HEALTH**

*Healthier populations:*
- use fewer resources
- increase productivity
- enhance communities

**- WASTE**

*Unnecessary clinical procedures:*
- increase clinical harm
- cause emotional distress
- incur financial harm

*Administrative burden:*
- increases cost
- is burning out providers

**- PRICE**

*High prices:*
- don’t correlate with quality
- incentivize waste
- misallocate resources
What would it take to fix all this?

- Transparency
- Data & Information
- Changing Incentives
- Community Engagement
- Alignment Across Sectors
- New Payment Models
- Informed Consumers

Who could do all this?
There is hope.

In Oregon we are coming together to untangle complexities and find a path to affordability.
The Path to Affordable Healthcare

We have a problem. We all created the situation. It will take all of us working together to solve it.

The way we receive healthcare in the United States is broken, and as a result Americans are less healthy while paying more.

Regional Health Improvement Collaboratives

Affordability
The drivers of affordability are: Health, Waste and Price.
Solving one issue in isolation does not achieve the goal.

What does it take to address the problem?
- Transparency
- Data & Information
- Aligning Incentives
- Community Engagement
- Collaboration Across Sectors
- New Payment Models
- Informed Consumers

Who could do all this?

Regional Focus Neutral Conveners Non-Profit

Providers
Payers
Consumers
Purchasers

Patient Education & Engagement
Value-driven Payment Systems & Benefit Design
Quality/Cost Analysis & Reporting
Technical Assistance for Delivery System Quality Improvement
“Rational common interests and rational individual interests are in conflict. Our failure as a nation to pursue the Triple Aim meets the criteria for what Garrett Harden called a ‘tragedy of the commons.’ As in all tragedies of the commons, the great task in policy is not to claim that stakeholders are acting irrationally, but rather to change what is rational for them to do.”

-- Don Berwick, Health Affairs May/June 2008
## Contact Us

<table>
<thead>
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<th>Michael Whitbeck</th>
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Organizational Background
Data Collaborative Outputs

Public Reporting

• Supports transparency on key metrics; quality and utilization - cost coming soon
• Audiences: Information for consumers; motivates health care providers to improve, informs all stakeholders
• One way practices meet PCPCH Standard 2.B – Public Reporting

Private Reporting

• Practices and providers – identified patient information shared with providers
• Data Supplier/Health Plans – reports on clinics and plans shared with data suppliers
• Contracts/Custom Reports – P4P, IPA, network evaluation, Cover Oregon measure development, CCO metric validation

Published Analyses and Special Projects

• Transparency and affordability reports for stakeholders
• Total Cost of Care
• Statewide snapshots
# Unique Strengths

## Data Quality
- Data goes through extensive quality review by experienced staff and vendor through various projects, which enhances its quality.
- Data is available at the patient level and attributed to providers, clinics, medical groups and payers who can identify data quality issues; practices specifically review data before public reporting to identify issues and improve data quality.

## Qualified Entity
- Status awarded by CMS, allows Q Corp to receive, analyze and report Medicare FFS data.
- Q Corp was first qualified entity in the nation to publicly report.
- Specific requirements and specifications on what we can do with the data.
- Receive data semi-annually.

## Practice and Provider-level Attribution
- Largest aggregated claims data set in Oregon that delivers multi-payer quality, utilization and cost measures directly to providers across the state.
- Provider directory has over 80% of primary care providers in Oregon and attribution methodology assigns patients to providers and matches providers to physical location.
- Providers can access measures and patient-level detail by measure, provider and clinic.
- Expanding to include specialty providers.
Report Quality Performance to Providers

Quarterly reporting on clinic and provider performance on over 50 quality and utilization measures.