

Cost Transparency from the Ground Up
Findings from the Regional Total Cost of Care Pilot
Executive Summary

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Why Total Cost of Care?

The burden of healthcare costs affects people and organizations differently but the impact is widespread and increasingly challenging to government, employers, communities and families. Consumers may be paying higher deductibles, experiencing limited coverage or trying to find services in narrow networks. Public institutions may shift their revenue to pay for healthcare and research shows that a decade of US wage growth has been consumed by healthcare inflation. The question at the root of these issues: is healthcare today as efficient and effective as possible? And if not—how do we improve?

“It is simply past time to address the growing chasm between rising healthcare costs and the quality outcomes and health we should expect for what we spend,” says Elizabeth Mitchell, President and CEO of the Network for Regional Healthcare Improvement (NRHI). “But we still don’t have the basic information needed to understand or address healthcare spending. In order to ascertain the effectiveness of the current healthcare system, we need more transparent information around costs and their drivers. Once we know that, people, providers and purchasers can begin to make truly informed decisions that enable better care and lower cost,” says Mitchell.

This urgent challenge is what prompted NRHI to secure grant funding from the Robert Wood Johnson Foundation (RWJF) to tackle barriers to creating and using cost information. We leveraged the national network of Regional Health Improvement Collaboratives (RHICs) who’ve been working with all of their regional healthcare stakeholders to take on these challenges—from data, to measurement, reporting and use.

RHICs are uniquely positioned to both generate needed information and develop coordinated, multi-stakeholder solutions for healthcare cost and quality problems. Many have rich claims and/or clinical data resources

to inform their work, measurement expertise, and strong stakeholder relationships to put the information to use. A RHIC does not deliver or pay for healthcare; it provides a neutral forum with trusted data to enable the community to plan, facilitate and coordinate successful transformation of its healthcare system.

The Total Cost of Care Pilot

Nearly 18 months ago, five member RHICs came together through the leadership of NRHI and with generous support from RWJF to measure and report Total Cost of Care and Relative Resource Use in their respective regions. Knowing both the need for reliable transparent cost information and the burden of misaligned measurement, we sought to standardize measurement to provide trusted information and to enable meaningful comparisons across regions. “Working on a project of this scale with four other regions provides valuable insights for how to produce valid information and to use it to improve healthcare quality and reduce costs,” said Meredith Roberts Tomasi, Program Director at Oregon Health Care Quality Corporation, one of the five participating collaboratives. “It allows us to learn together to accelerate progress and overcome barriers.”

To be eligible to join the project, each participating RHIC had access to multi-payer commercial claims data, had a robust provider directory to enable attribution and had all the necessary fields—including allowed amounts—to match data and verify results. Two participants had well developed programs underway at the beginning of the pilot including the Maine Health Management Coalition who also served as a technical advisor for the pilot. One participant, Minnesota Community Measurement, had developed a distributed model in which individual health plans ran data and shared aggregated results for analysis and reporting. Without this data access and skilled analysts—to check data

quality, run the measures and verify results—the project would not have been possible. With RHIC leadership and the project coordination to work together for national impact, we have only scratched the surface of the potential of this regional approach to transparency and improvement. Like the transformative contribution of the Dartmouth Atlas showing regional variation on Medicare spending 30 years ago, commercial cost variation attributed to practices can change the way we understand—and seek to improve—care and spending.

But we know from experience that measurement is not enough. Measurement and actionable reporting must be linked to effective engagement and use of data for improvement. NRHI member RHICs are leading cost transparency efforts to inform their communities, assist providers seeking to be accountable for cost and to enable payment reform, and working through barriers together at the community level— where implementation happens.¹

The five partnering RHICs in the Total Cost of Care Pilot are: Center for Improving Value in Health Care (CIVHC-Colorado); Maine Health Management Coalition (MHMC); Midwest Health Initiative (MHI-St. Louis, MO) Minnesota Community Measurement (MNCM); and Oregon Health Care Quality Corporation (Q Corp).

Total Cost of Care Pilot Partners

Regional Health Improvement Collaboratives (RHICs)

- Center for Improving Value in Healthcare
- Maine Health Management Coalition
- Midwest Health Initiative
- Minnesota Community Measurement
- Oregon Health Care Quality Corporation

Technical & Funding Support

- Technical Advisors**
- HealthPartners
 - Maine Health Management Coalition
- Support**
- Robert Wood Johnson Foundation

Project Goals

1. Measure and report Total Cost of Care and Resource Use in a standardized way across five regions;
2. Create a process for benchmarking multi-payer commercial healthcare costs;

1. Miller H, Mitchell E, Hasselman D. Payment Reform Series No. 1. Moving from Quality to Value: Measuring and controlling the Cost of Care. Network for Regional Healthcare Improvement, Center for Healthcare Quality and Payment Reform, & Robert Wood Johnson Foundation. Jan 27, 2015.

3. Identify the best ways to share cost information with key stakeholders in local communities to identify drivers of and reduce healthcare costs; and
4. Conduct focused work with physicians to help them use cost information to adopt practices that will reduce costs and improve care. Encourage them to serve as leaders in their communities.

Pilot Approach

The pilot tested three key questions:

1. Can this measurement technically be done in a valid and reliable way?
2. Can the approach be standardized for alignment and comparison?
3. Can the information be effectively used to improve care?

The technical process of measuring and reporting Total Cost of Care is difficult. Many issues of attribution, risk adjustment, and data quality remain unresolved for valid national standardization using a local implementation model. However, the pilot did demonstrate that similar measurement can be implemented locally. By licensing a shared risk adjuster, testing the impact of different attribution models, and assessing various differences in available data, we learned a great deal about what standardization requires, and what trade-offs may not be warranted for actionable results.

Even though the technical work alone is challenging, solving the technical issues is a necessary first step toward changing stakeholder behavior to achieve more affordable healthcare. By sharing results directly with stakeholders in the community we learned early lessons about what support is needed to effectively use the data for improvement. It is essential that the data are complete and accurate and the calculation and analyses valid and reliable. However you can't push a button, produce a report, and assume it will change stakeholder behavior to reduce the

cost of healthcare. Direct engagement of all stakeholders in a completely transparent process is critically necessary to ensure the reports have the intended impact.

Measurement is an imperfect science and while the bar for perfection has often limited progress, at a minimum it needs to be valid and measure what is intended. We know that we can produce meaningful, valid results that can inform improvement despite some unresolved questions. Given the sensitivity of some of the issues identified, local collaboration by engaging users is essential to transparently address any limitations. Significant progress was demonstrated in each for the five regions. This progress was possible due to the established multi-stakeholder engagement, forums and relationships which are foundational to all RHICs. Although each region's organization and structure differs, they play a common role as a neutral, trusted community convener. RHICs are committed to a transparent and inclusive measurement and reporting process, engaging and supporting stakeholders early and often along the journey, and helping them put data to use—whether it is a provider seeking to improve care or a purchaser seeking to change incentives.

What is the Total Cost of Care?

In January, 2012, the National Quality Forum (NQF) finalized the organization's first-ever endorsement of a population based measurement approach to total cost. To support this, the measure developers, HealthPartners of Minnesota, shared comprehensive documentation about this measure set developed from almost two decades of implementation experience. This background and their results can be found on their public website, www.healthpartners.com/public/tcoc and provide valuable insights into the measure set, its reliability, and its effective use. Having earned NQF's endorsement, this measure set provided the starting point for the five partnering RHICs striving to achieve the optimal level of standardization to generate comparable information and compare cost across the five regions.

It is also important to note what the total cost measure set is not – it is not a method to provide individual pricing for episodes or procedures. It does not tell an individual consumer what they will pay out of pocket. It does not necessarily tell a provider the cost of an individual treatment. It does tell a community how practices or clinics compare on the healthcare costs for attributed panels of patients. It is also a measure of accountability to know whether costs are actually increasing or coming down. “We all talk about squeezing the healthcare balloon—savings in one area pop up as increased spending in another. Total cost of care is the whole balloon. If you know total spending you can get your arms around the cost problem and in turn, make meaningful improvements around containment,” says Mitchell.

HealthPartners’ Total Cost of Care and Resource Use (TCOC) framework addresses one of the most fundamental problems related to population health: rising health care costs. TCOC is designed to support affordability initiatives, to identify instances of overuse and inefficiency, and to highlight cost-saving opportunities. It is a full-population, person-centered measurement tool that accounts for 100% of the care provided to a patient.²

In January 2015, Health & Human Services Secretary Sylvia Burwell announced measurable goals and a timeline to move Medicare and the healthcare system itself toward value-based care—i.e., paying providers based on the overall quality of care rather than the episodic quantity of care delivered. Secretary Burwell noted that “Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a healthcare system that delivers better care, spends healthcare dollars more wisely, and results in healthier people.”³ Moving from volume to value, whether in the public or private sector, requires transparent information about quality, outcomes and the Total Cost of Care. “As we move to value based payment, we are potentially re-allocating trillions of dollars. We must have transparent performance information to not only enable improvement, but to know we are paying for the right things,” noted David Lansky, PhD, President of the Pacific

Two Measures...Per Capita

Total Cost of Care

- Medical Costs
- Pharmacy Costs
- Includes price and service utilization
- Identifies market-specific variation

Total Resource Use

- Resource use across
 - inpatient
 - outpatient
 - professional
 - pharmacy
- Uses “standard pricing”

2. Source: <https://www.healthpartners.com/public/tcoc/>

3. HHS News Release: <http://www.hhs.gov/news/press/2015pres/01/20150126a.html> Release Date: Jan 26, 2015.

Business Group on Health and Board Chair of the Center for Healthcare Transparency (CHT). Information about CHT can be found at <http://www.nrhi.org/work/multi-region-innovation-pilots/center-healthcare-transparency/>.

Regional Collaboratives are in the unique position to effectively utilize multi-payer regional data to generate cost and quality measures on a comparable basis within their communities and across regions. The data sets are developed and provider directories maintained so that comparisons can be made within geographic regions of care, to the level of the physician practice or, in some cases, physician. Of the nation's 12 Qualified Entities, 10 are Regional Health Improvement Collaboratives in the NRHI network which, going forward, could also enable comparisons with public data for a true understanding of total cost. As cost drivers are identified and effectively communicated, targeted market-specific strategies can then be developed with community stakeholders to alleviate the impact of these drivers. Although the impacts will vary by region, community, and practices nationwide, consistent measurement and comparability will enable evaluation, accountability and accelerated progress.

Total Cost of Care

Represents all healthcare costs of patients attributed to a primary care provider.

Population, person-centered measurement approach using regional multi-payer data.

Adjustment for patient illness burden allows for meaningful comparisons across practices.

Separate out cost from relative resource use for identification of variation and potential overuse.

Physician Engagement

Physician leadership and engagement is essential to addressing healthcare costs. Physicians are the most trusted source of information and control or influence most utilization decisions. As accountability for cost and health outcomes grows, physicians are best positioned to responsibly manage costs aligned with patient values. But without actionable data it is unreasonable to expect physicians to change current practices. With trusted and usable information, physicians can be leaders of total cost reduction and care improvement.

In August 2014, NRHI held a focused two-day conference—the National Physician Leadership Seminar—at Stanford University. Together with Dr. Arnold Milstein and the Center for Clinical Excellence Research Center at Stanford University, NRHI brought together physicians from each of the five regions in a forum to provide feedback on comparative healthcare cost reports and their usefulness in identifying cost variations and interventions. Alongside colleagues from across the country, physicians learned about national movements and research underway; the technical aspects of measuring and reporting total cost of care and resource use; why inducing change is so hard, and what approaches give them the best chances to be successful. The group also participated in case study discussions to learn strategies for improving quality while reducing healthcare costs. Physicians left the seminar with commitment to drive improvement and knowledge that practice transformation is possible when given actionable information. They acknowledged feeling better equipped to lead change both nationally and in their own communities, backed by a new peer network of support. “Hopefully this will help me understand more of the data analysis that we can give them [physicians, administrators and other caregivers] to improve their understanding for more support [to change],” said Rajiv Patel, MD, Vice President of Medical Affairs/CMO, DePaul Health Center, St Louis, MO.

A regional version of this Physician Leadership seminar is being offered in Minnesota in June 2015 to further physicians’ leadership, understanding and engagement in using Total Cost of Care information. We expect this to be a positive step toward meaningful change at the local level.

Tamaan Osbourne-Roberts, MD, President of the Colorado Medical Society, said “physicians...are the ‘most natural and best partners’ to lead the transparency movement because no one else is as closely aligned with patients’ needs.’ Physicians are now being asked...to not only be responsible for delivering high quality healthcare, but they’re being asked how we should be delivering high quality healthcare at the most appropriate cost possible,” Dr. Osbourne-Roberts told *MedPage Today*. Having meaningful comparative data within a region—at the practice

level—will actually give physicians the information they need to play a key role in cost reduction and practice transformation. The partnership among the RHICs will provide the foundational structure through which best practices are shared, successes are recognized, and lessons learned are fruitful.

Michael van Duren, MD, MBA, Vice President of Clinical Transformation at the Sutter Medical Network at Sutter Health in Sacramento, Calif., spoke with *MedPage Today* about attempts to influence physician behavior change. He recounted gathering groups of physicians and showing them some of their own records. In one instance, he showed a group of urgent care doctors the average price for ancillary services for abdominal pain. In another group, he showed clinicians how many CT scans they had ordered. In both cases, the next time the clinicians returned to meet together, the high-end outliers had reduced their orders. “You don’t have to pay them extra, you don’t have to shame them, you don’t have to publicize this or put it in the newspaper, all you have to do is say, ‘Hey, you’re different from your peers,’ and they want to do the right thing,” Dr. van Duren said.

With consistent parameters by which to measure Total Cost of Care, the NRHI team and TCoC pilot RHICs are looking ahead toward implementation. The group is developing a framework upon which Total Cost data can and will be shared with physicians and other caregivers. “Our approach to Total Cost of Care is both a top down and bottom up strategy,” says Mitchell. “We know that the best way to affect meaningful practice transformation is to educate, communicate, collaborate and support at all levels. The benefit NRHI and its regional collaboratives bring to this work is the experience and proven success in trusted, well-designed, and exceedingly thorough data sets and implementation plans to help support substantive practice change and cost containment.”

Conclusions & Results

The Total Cost of Care Pilot has achieved important successes and identified difficult unresolved questions. The work has demonstrated

the value of RHICs working together to understand total cost of care measurement. Under the effective leadership and project management of NRHI, the five RHICs have learned together through shared experience. In many cases underlying data issues have been resolved through more centralized quality review of data, development of technical specifications and analysis to assure data integrity and completeness, and shared learning and strategies to solve complex issues. The inaugural National Physician Leadership Seminar, a one and a half day event held at Stanford University in August 2014, yielded a cadre of passionate physician leaders who understand the value and utility of cost measurement and reporting and are mobilizing in their communities and together nationally. The overall lessons learned benefit the local communities and will inform national policy. Lessons learned shine light on remaining barriers to measurement, cost transparency and next steps for payment reform, delivery system redesign and practice transformation. Below are summarized results:

GOAL 1: Attributed Practice Level Reporting

Achieved: Each region produced and distributed attributed practice level reports in their respective communities. Starting points ranged from those with newly acquired cost data sets to two rounds of comprehensive cost reports. The reporting varied across communities based on readiness and ranged from informational, blinded community comparisons to public website practice level reporting. A common risk adjuster was tested but not implemented by all RHICs for community level reporting. It is important to emphasize that none of the regions who publically report cost data did so in the absence of quality information. In regions where the information directly or indirectly could impact provider payment or influence patient choice of providers, the measurement reliability was increased with additional methods, a responsibility not taken lightly by any of the pilot participants. At the top of the following page is a portion of a sample practice level report.

Q Corp Total Cost of Care Report Overview

Clinic scores are risk adjusted to account for variations in illness burden.

Clinic Risk Score

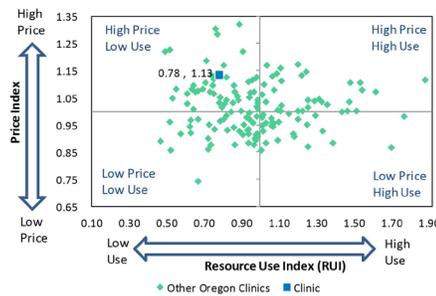


Overall Summary by Service Category

	Clinic		OR Average		TCI	= RUI x	Price Index
	Raw PMPM	Adj PMPM	PMPM				
Professional	\$203.02	\$183.18	\$167.12	1.10	0.99	1.11	
Outpatient Facility	\$69.00	\$62.25	\$115.53	0.54	0.60	0.90	
Inpatient Facility	\$71.08	\$64.13	\$72.21	0.89	0.78	1.13	
Pharmacy	\$73.92	\$66.70	\$69.20	0.96	0.98	0.98	
Overall	\$417.03	\$376.26	\$424.06	0.89	0.85	1.05	

Inpatient Price vs. Resource Use Comparison by Clinic

Clinic comparisons on Resource Use and Price.



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This work is based on the patented algorithm of HealthPartners, Inc. (Bloomington, MN)

GOAL 2: Benchmarking

Achieved: A benchmarking approach across five regions was developed and tested.

Although national benchmarks have not been created, participants were able to test ways to compare results across markets and draw important conclusions. Ultimately participants did not feel confident that true benchmarks could be created at this time. Putting the submitted data side by side showed that despite the significant work invested by each region in standardizing everything from data collection and risk adjustment to final aggregation, given the stakes, we did not believe we were in a position to state with confidence that the submission for each region reflects the same information as other regions, nor that the submission for each region accurately reflects the market. Several factors limited the ability to create these benchmarks including: how regions treat substance abuse claims—and different state-level restrictions on use of this data; mixed representation of self-insured and fully funded commercial health plans; market sensitivity about submission and use of cost data; costs for capitated services and incentive payments; and

coding characteristics of providers. Each of these issues, as well as the influence of variable attribution methods, potential cost shifting between public and private payer mix, and relative cost of living in each region warrants further exploration and work to achieve reliable benchmarking—an important goal.

GOAL 3: Engagement

Achieved: Each Regional Collaborative shared reports with community stakeholders. Each region recognized that reporting cost is a sensitive issue and although many had previously reported quality, cost reporting required a new level of engagement with all key stakeholders in their community. This pilot was not the first step to engage local stakeholders' interest and input about reporting. Many RHICs had been preparing their members and communities for many years and some had started implementation. Through sharing how, why and when engagement was implemented in each region, all RHICs learned and benefited from best practices, and possibly more importantly what didn't work.

Although the organizational and community stakeholder forums differed in each region, some of the common approaches that yielded successful engagement included:

- Allowing for provider validation of results in advance of public disclosure;
- Giving physician groups that are the subject of the reporting a meaningful role in the process to build buy-in along the way;
- Listening to concerns and meeting individually or in groups to fully understand and work together toward resolution;

Ray Kleeman, Board Member for the Midwest Health Initiative and Vice President of Human Resources for Monsanto

"I don't expect the results to be perfect—this is complex information. But, what I have seen is if you persevere through the barriers, a certain momentum develops—we get closer to where we want to be. What this pilot does is establish the meaningful and necessary framework to have the right discussions around affordability. Everyone needs to partner and work together towards this consistent framework so we can tackle this challenge that is crippling the U.S. economy. Everyone needs to have information on healthcare costs and resource use to catalyze these conversations. And I am proud to say that this pilot—initiated by the five Collaboratives and led by NRHI—is the foundation for doing this," remarks Ray.

- Engaging, educating and setting expectations with stakeholders early and often;
- Leveraging prior experience and trust with community measurement and reporting; and
- Always presenting healthcare cost information alongside quality information when publicly reporting.

Goal 4: Physician Leadership

Achieved: Participating physicians were supported to lead change both locally and nationally with a reporting framework, strategy and practical approaches to affect change.

As demonstrated during the National Physician Leadership Seminar, physicians are willing partners in addressing overall cost of care. What is needed is comprehensive, comparative information that is actionable and allows them to identify causes of practice variation. Patients expect providers to be responsible stewards of resources. The real challenge is that providers don't have this information most of the time. With information, support, skills and tools they are ready to answer the call toward more affordable healthcare for their patients.

"Many physicians don't understand how their own practice patterns differ from their peers and the impact on the cost of care. Accountability for cost when they don't know this information themselves is an unreasonable expectation," says Mitchell. "But when you give providers this information and support them to use it, it is immensely powerful. If you give physicians data they can trust, they want to use it to affect change. We are now poised to do just that."

Recommendations

Although much was learned over the course of this 18-month pilot, we do not have all of the answers. More detailed efforts exploring year to year variation, impact of risk adjustment on results and inclusion of public payer data are needed and planned. The following are recommendations

to further inform all stakeholders and enable meaningful delivery system and payment reform. This work will continue to address rising healthcare costs and improve quality outcomes and health.

- 1. Continue to drive** toward standardized and comprehensive reporting of Total Cost of Care and expand the work to include Medicare and Medicaid data to enable measurement of the full population. This will enable providers to know, manage and ultimately reduce overall healthcare spending, and will give public and private purchasers the needed information to change payments for population health.
- 2. Engage** more regions in standardized reporting of Total Cost of Care enabling widespread use as a foundational measure for payment reform and community engagement.
- 3. Improve access** to all payer claims data, including amounts paid to providers and by consumers. Standardized collection of complete data will enable more efficient processes and robust data sets and a more comprehensive reporting of Total Cost of Care and comparisons across regions.
- 4. Continue to engage and support** providers to interpret and use reports to reduce variation in cost and utilization and overall healthcare costs in their region.
- 5. Engage purchasers** of healthcare to use standardized Total Cost of Care reporting to manage healthcare costs through reformed payment and value based benefit design.

NRHI and the five participating RHICs are committed to implementing these recommendations and continuing to lead their communities in reporting and use of Total Cost of Care measurement toward healthcare affordability.