nrhi
Network for Regional Healthcare Improvement

Getting to Affordability

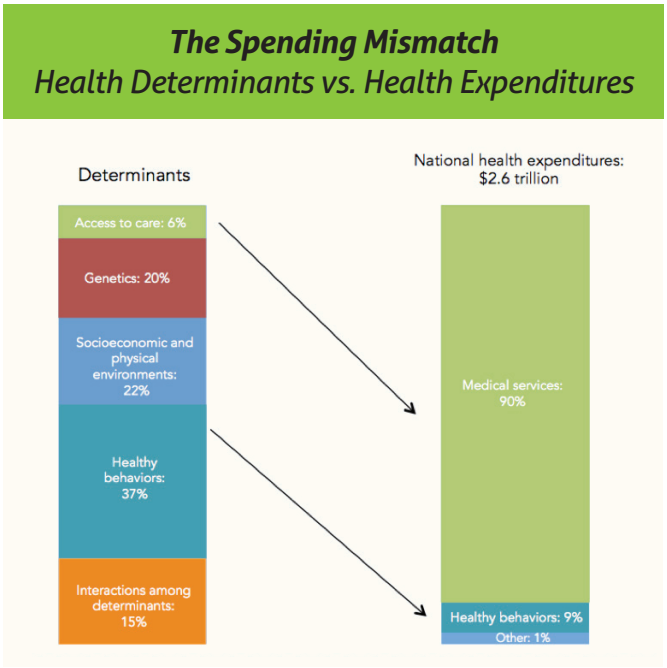
The National Affordability Summit

September 2017

At the recent National Affordability Summit, healthcare and business leaders from around the nation challenged each other to dramatically reduce American healthcare spending. A path forward quickly emerged.

- Payment models must continue evolving to support more effective care, reduce avoidable harm to patients, and decelerate price escalation.
- Swift and meaningful reductions in total cost will require bold leadership, broad collaboration, and good data.
- Over the long-term, health spending must rebalance to spend less on the provision of medical services and more on building economic, social, and environmental frameworks that promote well-being.

The day-long summit, which was held in Washington, D.C., brought together health policy experts, physicians, employers, and regional healthcare leaders from around the country. The event was convened by the Network for Regional Healthcare Improvement (NRHI), with support from the Robert Wood Johnson Foundation.



Healthy People / Healthy Economy: An Initiative to Make Massachusetts the National Leader in Health and Wellness. 2015. Data from HEHI 2013. JOINING FORCES: Adding Public Health Value to Healthcare Reform. Boston, MA: Commonwealth of Massachusetts. http://www.mass.gov/eohhs/docs/dph/com-health/prev-wellness-advisory-board/2017/170308-pwtf-annual-report.pdf Accessed November 9, 2017

> ***"Healthcare happens in communities. We are bringing those communities to Washington, D.C. to have a national conversation to address the drivers of the healthcare affordability crisis—unnecessary care, high prices, entrenched interests, and misaligned payment models."***
>
> **Elizabeth Mitchell** *President and CEO of NRHI*

Though the pace of healthcare spending slowed during the years immediately following passage of the Affordable Care Act, the gains were short lived. By 2014, increases in health spending once again outpaced growth in gross domestic product (GDP). Today, approximately one in every six dollars flowing through the American economy is spent on healthcare. In 1960, it was one in twenty.[1]

Across our nation and its communities, healthcare spending crowds out investments in infrastructure, education, and public health. Ironically, healthcare spending constricts investments in what we know cultivates American health and wealth.[2, 3]

[1] Centers for Medicare and Medicaid Services. (2014, May 05). *National Health Expenditure Data.* Retrieved October 25, 2017, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html

[2] Orszag, P. R. (2017, October 25). *How Healthcare Can Save or Sink America.* Retrieved October 25, 2017, from https://www.foreignaffairs.com/articles/united-states/2011-06-17/how-health-care-can-save-or-sink-america

[3] https://www.forbes.com/sites/chrisconover/2013/02/12/bullets-vs-band-aids-is-health-spending-crowding-out-defense/2/#5ea518f144a9

"Our ability to create great care at a lower cost ripples through almost everything that matters to our country and to our country's ability to make a difference in the world."

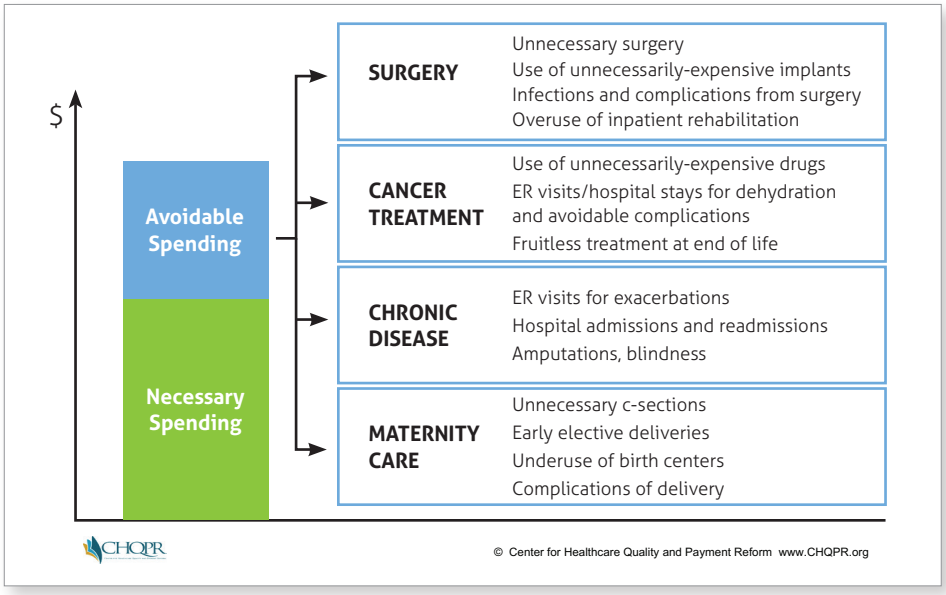
Arnold Milstein, MD *Director of the Clinical Excellence Research Center at Stanford University*

NRHI works with national thought-leaders and with those who provide, pay for, and use healthcare in regions from Massachusetts to Hawaii. Its members and their partners are the "HealthDoers" addressing these problems through shared action in each of their communities. Many NRHI members serve as data stewards for their states and regions, aggregating and sharing claims and/or clinical data or data reflecting experience of care. NRHI members also are leaders in quality improvement, population health management, and practice transformation. In guiding innovative transparency and payment reform efforts, they see firsthand what works and what needs to happen next.

We Are Hurting Patients

In 2010, the Institute of Medicine (IOM) found that 30% of healthcare spending was wasted, often on unnecessary and potentially harmful care. IOM workshops that followed advised reducing medical errors, unnecessary procedures, systemic inefficiencies, and administrative waste.[4] Redirecting unnecessary spending toward care that improves health and outcomes is foundational to payment system reforms included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Questions, however, remain about whether those programs and pay-for-performance efforts in the private sector send strong enough signals or give physicians sufficient pathways to innovate and reap the rewards.

Avoidable Spending
Occurs in All Aspects of Healthcare



Slide from:
Harold Miller, Center for Healthcare Quality and Payment Reform

[4] Institute of Medicine (US) Roundtable on Evidence-Based Medicine; Yong PL, Saunders RS, Olsen LA, editors. *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary.* Washington (DC): National Academies Press (US); 2010. Appendix A, Workshop Discussion Background Paper. Available from: https://www.ncbi.nlm.nih.gov/books/NBK53915/

"There are lots of things we are doing in healthcare that cost lots and lots of money that are not good for the patients. With the right kind of payment system, we can reduce avoidable spending, increase spending on services patients need, and keep high-quality healthcare providers financially viable —a win-win-win approach."

Harold Miller
President and CEO of the Center for Healthcare Quality and Payment Reform

To pursue high-value care payment models we will need well-designed incentives to drive efficient use of services, said Harold Miller, President and CEO of the Center for Healthcare Quality and Payment Reform. He sees opportunities to reduce unnecessary surgeries, lower administrative costs, connect patients to higher-value cancer treatment, improve maternity care, and better manage chronic disease. Barriers to these changes include no or low payments for many of the highest-value services, lost revenue when low-value services go away, and continued high fixed costs.

Here's a couple of examples. Consider efforts to reduce admissions and scale back use of profitable outpatient services like imaging and testing. The changes might benefit patients and communities, but hospitals see dramatic drops in revenue and slight change on the expense side. Lowering rates of cesarean sections can pose challenges for obstetricians. Under the most challenging maternity reimbursement models, physicians receive a lower payment for a vaginal birth even if it was the right care and took more time.

Most believe that healthcare providers will only deliver high-value care if the payment system provides adequate payments for services that will keep patients healthy and holds providers accountable for aspects of quality and cost that they can control.

A recognition of the potential harm and waste of unnecessary care led the ABIM Foundation to create the Choosing Wisely® campaign, which includes participation among many NRHI members. Choosing Wisely promotes conversations between physicians and patients about utilizing the most appropriate tests and treatments. A 2015 study based on Choosing Wisely recommendations and published in the Journal of General Internal Medicine found that nearly two million Medicare beneficiaries received unnecessary imaging for low back pain, some of which included exposure to radiation. Unnecessary tests before surgery, low-value preventive screenings, and unwarranted prescriptions for anti-psychotics and opioids were other examples of low-value, potentially dangerous, care received.

"Fee-for-service economics are not incentive neutral. Bad things happen. We are hurting patients when we use fee-for-service economics. It's not just wasteful. It actually hurts people."

Frederick Isasi
Executive Director of Families USA

Miller pointed out that the typical approaches used by health plans to reduce healthcare spending were cutting physician fees and shifting costs to patients, and these had failed to slow the growth in health insurance premiums. He said the fastest growing components of healthcare spending in recent years were hospitals and insurance administration, not physician payments or drugs. Of the $240 billion increase in private health insurance spending from 2009 to 2015, half had gone to hospitals and another 12% had gone to insurance administration and profits. He noted that private health plans were spending as much on insurance administration and profits as they were spending on drugs.

According to Miller, pay-for-performance programs had been used for many years and had failed to have any impact on cost or quality. National statistics show that only two-thirds of patients with diabetes and with hypertension, for example, have their conditions under control. What pay-for-performance programs have done is significantly increased administrative costs. A 2016 Health Affairs article estimated physicians spent $15.4 billion to report quality measures.[5]

> ***"It's costing everybody a lot of money and it's not saving a lot of money," Miller said of pay-for-performance initiatives. "It has been studied to death and yet it isn't dead."***
>
> **Harold Miller**
> *President and CEO of the Center for Healthcare Quality and Payment Reform*

Miller said that current ACO initiatives were also unlikely to have significant impacts on costs because "shared savings" payment models do not actually change the fee-for-service payment system or remove the barriers to delivering higher-value care. He said that instead of reducing spending, Medicare has actually spent more on ACOs every year than it would have spent without them, and ACO initiatives are accelerating the consolidation of providers and resulting in higher prices for private purchasers.

It is time to move beyond simplistic pay-for-performance and shared savings programs and start designing and implementing alternative payment models that solved the problems with fee-for-service payment without creating new problems for patients and providers recommended Miller. He gave examples of an oncologist, an orthopedic surgeon, an emergency physician, and a gastroenterologist who had dramatically reduced spending and improved patient outcomes when they were given the resources and flexibility they needed to deliver care differently.

For example, a gastroenterologist, Lawrence Kosinski, MD, a managing partner of Illinois Gastroenterology Group found patients with Crohn's disease were needing frequent hospitalizations and having too many resulting complications despite being on high-priced biologic medications. He developed Project Sonar, an app to track patients conditions. Once a month, patients answer a few questions about their symptoms, medications, and general health. The app helps Kosinski and his team keep better track of patients' health and follow-up with those that need help before they need to be hospitalized. So far, Kosinski's approach has allowed patients to spend less and feel better. And, his medical group is earning more. Now the Centers for Medicare and Medicaid Services (CMS) is deciding whether to roll the app out to Medicare patients nationwide.[6]

Too Many Sacred Cows

For decades, hospitals have served as economic engines and sentimental centers of their communities. In many communities, hospitals are among the largest employers and where residents welcome newborns, experience healing, and say last goodbyes. These roles buy favor and esteem, making it difficult for community leaders to act in any way perceived to be "anti-hospital."

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[5] Casalino, Lawrence P. (2016 March), *US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures.* Health Affairs, VOL. 35, NO. 3 : Physicians, Prescription drugs, ACOS & more.

[6] J. Duncan Moore, J. (2017, August 10). *This made-in-Chicago health app soon may go national.* Retrieved from Crain's Chicago Business: http://www.chicagobusiness.com/article/20170810/ISSUE01/170819997/this-made-in-chicago-health-app-soon-may-go-national

So, when a health plan proposes a narrow network bound to drive savings, an employer may be hesitant. An executive of the employer might sit on the hospital board or have a personal experience of a good outcome. Or, the employer may fear any restriction in access, even to low-value care, will prevent them from attracting talent. These factors limit willingness to make needed changes to infrastructure and spending.

> ***"There are too many sacred cows. There are too many entrenched interests. Hospitals employ too many people in any urban area."***
>
> **Niall Brennan**
> *President and Executive Director of the Health Care Cost Institute*

Cornerstone Health Care, a multi-specialty physician group in High Point, North Carolina, worked for years on adopting new methods to reduce over utilization and lower costs. While the practice won national recognition for innovation, many in High Point lacked enthusiasm for the efforts. Thanks to better care and a closer eye toward appropriate utilization and cost savings from less expensive facilities, fewer Cornerstone patients sought hospital services. Feeling threatened, hospitals began offering Cornerstone physicians handsome salaries if they left the practice and came on staff. Nearly a third decided to make the move. Employers became concerned that struggling or shuttered hospitals would make the region less attractive to employees. Eventually, Cornerstone was bought by an area hospital system.[7]

> ***"As we emptied the hospitals in our area, we were seen as a threat, not only by hospitals but by employers. They were concerned the hospital would shut down."***
>
> **Grace Terrell, MD**
> *an internist, who led Cornerstone Health Care for more than 15 years before joining Envision Genomics*

It's Still the Prices, Stupid

While reductions in unnecessary services reflect improved care quality and reduce exposure to potential harm, they do not equal lower overall cost. An average U.S. hospital stay costs $18,000, nearly three times the average of other Organization for Economic Co-operation and Development (OECD) countries. Similarly, an MRI costs $130 in Spain, $215 in Australia and $1,119 in the United States, according to the International Federation of Health Plans 2015 Comparative Price Report. A cardiac catheterization costs, on average, $181 in Switzerland versus more than $5,000 in the United States, the report found. Unlike the United States, many OECD countries regulate prices and some even set mandatory budgets telling hospitals and other providers how much they can spend. International health policy experts find under these regulations, quality does not suffer and physician supply remains sufficient.

> ***"Price is two-thirds of the reason we spend more in this nation than any other nation. We need to start characterizing this as price gouging. We need a new ethic for healthcare financial management. We need to get rid of personal, institutionalized, legitimatized greed."***
>
> **George Isham, MD**
> *Senior Advisor at HealthPartners, Inc.*

[7] Ableson, R. (2016, 12 23). A Health Care Experiment on Life Support. *The New York Times* , p. BU1.

Multiple academic studies suggest that the formation of integrated delivery systems with the capital wherewithal and information technology infrastructure to effectively participate in the most advanced payment models also result in vertical integrations that reduce market competition and pressure primary care providers to refer within their large, relatively pricey systems. Not surprisingly, with strong market power and captive customers, higher prices result. CMS warns increases in total healthcare spending over the next decade will be driven by increases in price.

Data from academic research and consumer healthcare transparency websites clearly demonstrate wide variations in price depending on the site of service even within a market. Aparna Higgins, then a Senior Vice President at America's Health Insurance Plans (AHIP), analyzed 2008 to 2013 claims data for seven services based on total payments. She and her colleagues looked across clinical categories but focused on areas where differences in payment were unlikely to result from differences in clinical quality or patient characteristics. Across all services, prices at hospital outpatient departments were statistically significantly higher than payments to physician offices, ranging in 2013 from 21% more for an office visit to 258% more for chest radiography. Over the study period, increases in prices and a shift of services to hospitals resulted in a 44% increase in total spending between 2008-2013. Higgins said the results reminded her of the well-known 2004 paper by Princeton healthcare economics professor Uwe Reinhardt, PhD, and colleagues, *"It's the Prices, Stupid."*

> ***"We should have called the paper, 'It's Still the Prices, Stupid.' If we don't address pricing we are never going to get costs under control. And, it's not just drug pricing. It's all pricing."***
>
> **Aparna Higgins**
> *Visiting Scholar at the Heller School for Social Policy and Management at Brandeis University*

In a strong response to high-priced, hospital-based imaging services, Anthem recently announced it would no longer pay for MRIs or CT scans delivered at hospitals in nine states this year and five additional states next year. The policy will be waived if a review finds it was medically necessary to perform the scans at a hospital.

According to Miller, under many current health plan benefit designs, there is no incentive for patients who need expensive procedures to choose providers that charge lower prices. He said that patients need to be responsible for the "last dollar" of costs, instead of facing high deductibles and high cost-sharing that discourage the use of preventive care. He also said that current efforts at transparency and reference pricing (in which a health plan, employer, or union defines the maximum price it is willing to pay for a service) are not successful because they only focus on individual services, not the full costs of treating a condition. Choosing a provider that charges a lower price for a procedure but has a higher complication rate could result in higher spending, not less. He said that alternative payment models in which providers are paid a single price for managing a condition or delivering a procedure enable the "apples-to-apples" comparisons that are essential complements to transparency and reference pricing initiatives.

The Value Agenda Needs All-Payer Reinforcement

New programs from the federal government and health plans merge lessons from previous payment reform attempts and propel them forward under new models. Milstein described recent CMS payment reforms as a "tailwind" and a "political gift" to those trying to achieve improvements in value. With these programs in

place, shared savings could approach the 20% threshold, which Milstein believes may finally attract providers' attention. Still, these reforms only apply to Medicare payments. To sustain providers' focus, private payers will need to reinforce government actions and vice versa, Milstein said.

"For the value agenda to make a difference, it needs all-payer reinforcement."

Arnold Milstein, MD
Director of the Clinical Excellence Research Center at Stanford University

To date, employers have been hesitant to offer significant provider bonus payments, restrict access to more narrow networks, or contract with an accountable care organization. With federal programs underway and many regional collaborative projects gaining momentum, now may be the time to convene employers around payment reform, said David Lansky, the President and Chief Executive Officer of the Pacific Business Group on Health (PBGH), a coalition of 60 large employers and healthcare purchasers representing more than 10 million Americans.

Already, many large, national employers, such as The Boeing Company, Wal-Mart Stores, Inc., and Lowe's Companies, Inc. are participating in payment reform initiatives. Frequently, regional business coalitions support the work of leading employers and bring successful innovations to larger scale adoption. Employers' engagement may grow as their health plan partners offer more opportunities to participate.

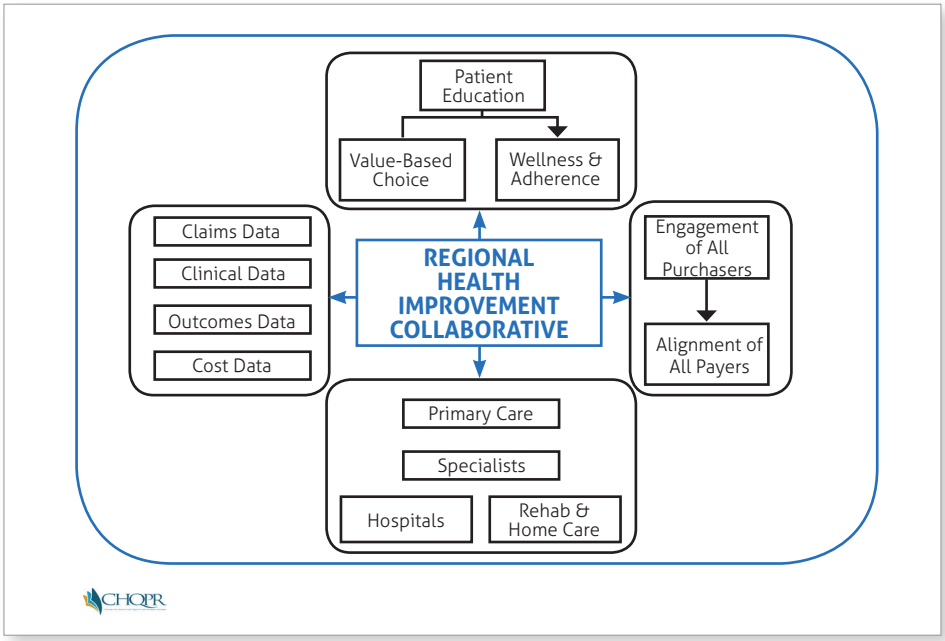
One model may be the Regional Comprehensive Primary Care (CPC) initiatives occurring around the country. CPC initiatives deliver multi-payer, public, and private sector collaboration. They are guided by the federal CMS Innovation Center and implemented through local action. Some of the fourteen CPC+ programs nationally report meaningful progress. With the support of Oklahoma's Health Information Exchange MyHealth Access, an NRHI member, worked with nearly 70 medical practices and more than 30 hospitals in Oklahoma to lower Medicare patients' total cost of care 5% after accounting for care management fees. Hospitalizations and emergency department visits each decreased 7% for these patients. Results were even stronger for Medicare Advantage patients, with total costs decreasing nearly 14%. They saw a nearly 50% decline in imaging costs, a more than 30% decline in outpatient costs and a more than 10% drop in admissions. All of these reductions contributed to the lower total cost, MyHealth Access, reported. This regional experience demonstrates that multi-stakeholder alignment to design better care for patients can mean lower spending and better outcomes.

In Ohio and Northern Kentucky, 13 payers and 562 primary care practices participate in the nation's largest CPC program. As in other regions, the program pays physician practices to aggressively manage and coordinate care as well as engage patients and caregivers. The expectation is for those efforts to pay off through reductions in potentially-avoidable care such as hospitalizations. Hospitalizations fell more than 20% from the fourth quarter of 2013 to the first quarter of 2016. This drop included a nearly 32% decline in hospitalizations for chronic obstructive pulmonary disease. The Health Collaborative, an NRHI member in Cincinnati, performs a dual role for the CPC+ program. It's the convener and learning collaborative under contract with CMS, and the organization designated by the payers to aggregate and report claims data to practices and plans.

However, not all CPC and CPC+ regions report the same levels of success. Nationally, the program marked a 1% increase in Medicare costs after factoring in care management fees. On a positive note, hospitalizations and emergency department visits declined. CMS has said total cost savings would grow as practices continued evolving. Others suggest the programs will only reap true savings when primary care providers are more forcefully incentivized to better manage costs outside of their own walls, such as by referring to lower cost providers or sites of service.

Another strategy may be more coordination across the many community partners contributing to the work. In Oklahoma and Ohio, in addition to serving as data hubs, Regional Health Improvement Collaboratives (RHICs) brought together multiple payers across the region, aligned their work with the federal government, and coordinated with providers to ensure shared goals and information sharing. The collaboration gave participants opportunities to plan together, learn as a cohort, and address barriers with the benefit of all perspectives.

***This is Only Feasible at the* Regional *Level, with a* Facilitator**



Slide from:
Harold Miller, Center for Healthcare Quality and Payment Reform

Starting to Produce Change

As demonstrated by the CPC programs, efforts to improve affordability should include a measure of total cost. Without this umbrella measure, it's not clear whether costs were lowered or simply shifted through higher prices on other services or increased utilization. For nearly four years, RHICs working through NRHI have refined and standardized commercial claims data to measure and report on differences in total cost of care

across and within their communities. With support from the Robert Wood Johnson Foundation, participants have produced standardized, risk-adjusted comparisons of total cost, resource use, and price using the National Quality Forum-endorsed HealthPartners measure set.[8] Deeper dives into the data are providing meaningful information on cost and resource use back to primary care providers who can use it to identify inefficiencies.

In Oregon, NRHI member Oregon Healthcare Quality Corporation, now HealthInsight Oregon, leads a monthly workgroup representing health plans, provider organizations, and consumers that discusses ways to engage peers, payers, and policymakers in review of the data and in conversations about quality and affordability improvement. Using a voluntary, multi-payer data base and their robust provider directory they are producing practice level reporting and contributing to national benchmarks. This actionable output is a comprehensive report on cost and quality trends shared with providers that serves as the basis for deeper dialogue.

The Portland Clinic, a multi-site primary care group, noticed its patients with cancer had higher than expected costs. Portland Clinic physicians began a conversation by sharing the data with a local oncology group. They found the oncologists were using hospitals for imaging and outpatient surgeries instead of freestanding facilities—increasing costs without any improvement in the quality of care. Patients that called in the evening were being directed to the emergency department, sometimes without good reason. The utility of the data continues to grow as groups learn new ways to identify costs and change practices. Now the conversation has moved to identifying high-value oncology medications.

> ***"The beauty of this project is that it is starting to produce change."***
>
> **Mylia Christensen**
> *Executive Director of*
> *HealthInsight Oregon*

This example illustrates that instead of using a "top-down" approach to payment reform, where Medicare and health plans develop payment models that providers have to try and use, it is time for a bottom-up approach, in which physicians and other providers identify opportunities to improve care and reduce spending and design the type of payments that would enable them to successfully pursue those opportunities. RHICs are a key mechanism for providing the data and neutral facilitation that providers, purchasers, and patients need to reach consensus on and implement win-win-win solutions.

We're All in This Together

There is a growing recognition by clinicians, economists and policymakers that reductions in healthcare spending cannot occur with siloed approaches by any single force, including the wave of a federal policy wand. Rather, lower cost, higher quality care will require collaborative, regional action coordinated across states and supported by a framework of national policies. RHICs, working together under the national umbrella of NRHI, serve as meaningful facilitators of this regional work and as effective advocates and testing grounds for national policy. Mitchell emphasizes, "Leveraging years of trusted relationships with local stakeholders, our NRHI members galvanize the approach that we're all in this together through convening

[8] Network for Regional Healthcare Improvement. (2016, October 31). *From Claims to Clarity: Deriving Actionable Healthcare Cost Benchmarks from Aggregated Commercial Claims Data.* Retrieved October 25, 2017, from http://www.nrhi.org/uploads/g2a-benchmark-report-final-web.pdf

the necessary players, determining shared priorities, and working through competing interests to develop mutually agreeable strategies to tackle the affordability crisis in each of their communities." Describing RHICs and their local partners as "change agents," Milstein said they have stepped into an important role that cannot be filled by government.

> ***"What a difference it can make when public and private influencers and power players in a community coalesce on an issue. When that issue is as vigorously rewarding as healthcare value, coalescence creates ripples that favorably impact almost everything we care about in our society."***
>
> **Arnold Milstein, MD**
> *Director of the Clinical Excellence Research Center at Stanford University*

What We Heard:

- Healthcare spending crowds out investments in infrastructure, education and public health, which we know cultivate American health and wealth.
- Achieving affordable care will require payment structures to evolve to support more effective care, reduce avoidable harm to patients, and decelerate price escalation.
- Around the nation, there are real-life examples proving that with the right kind of payment system, we can reduce the avoidable spending, increase spending on services patients need, and keep high-quality healthcare providers financially viable—a win-win-win approach.
- Lower cost, higher quality care will require collaborative, regional action coordinated across states and supported by a framework of national policies. Regional Health Improvement Collaboratives, working together under the national umbrella of NRHI, serve as meaningful facilitators of this regional work and as effective advocates and testing grounds for national policy.

Become Involved: You can find more information and join the affordability conversation in the Getting to Affordability online community. On the community, you can connect with fellow HealthDoers across the country who are striving towards affordability in their communities. You can also access resources and learning modules that focus on everything from engaging stakeholders on affordability, to the technical total cost of care measure. Join today at: https://g2a.healthdoers.org/home or contact gettingtoaffordability@nrhi.org.

Acknowledgments

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The views expressed here do not necessarily reflect the views of the Foundation.

Network for Regional Healthcare Improvement (NRHI)

ABOUT THE NETWORK FOR REGIONAL HEALTHCARE IMPROVEMENT (NRHI)

The Network for Regional Healthcare Improvement (NRHI) is a national membership organization of more than thirty regional health improvement collaboratives (RHICs) across the United States. These multi-stakeholder organizations are working in their regions and collaborating across regions to transform the healthcare delivery system to one that provides better care at lower cost. For more information about NRHI, visit www.nrhi.org.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

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