PROVIDER PRICE VARIATION & THE COST OF HEALTHCARE IN RHODE ISLAND

Presentation to the Massachusetts Special Commission on Provider Price Variation

January 31, 2017

Dr. Kathleen C. Hittner, Health Insurance Commissioner

Agenda

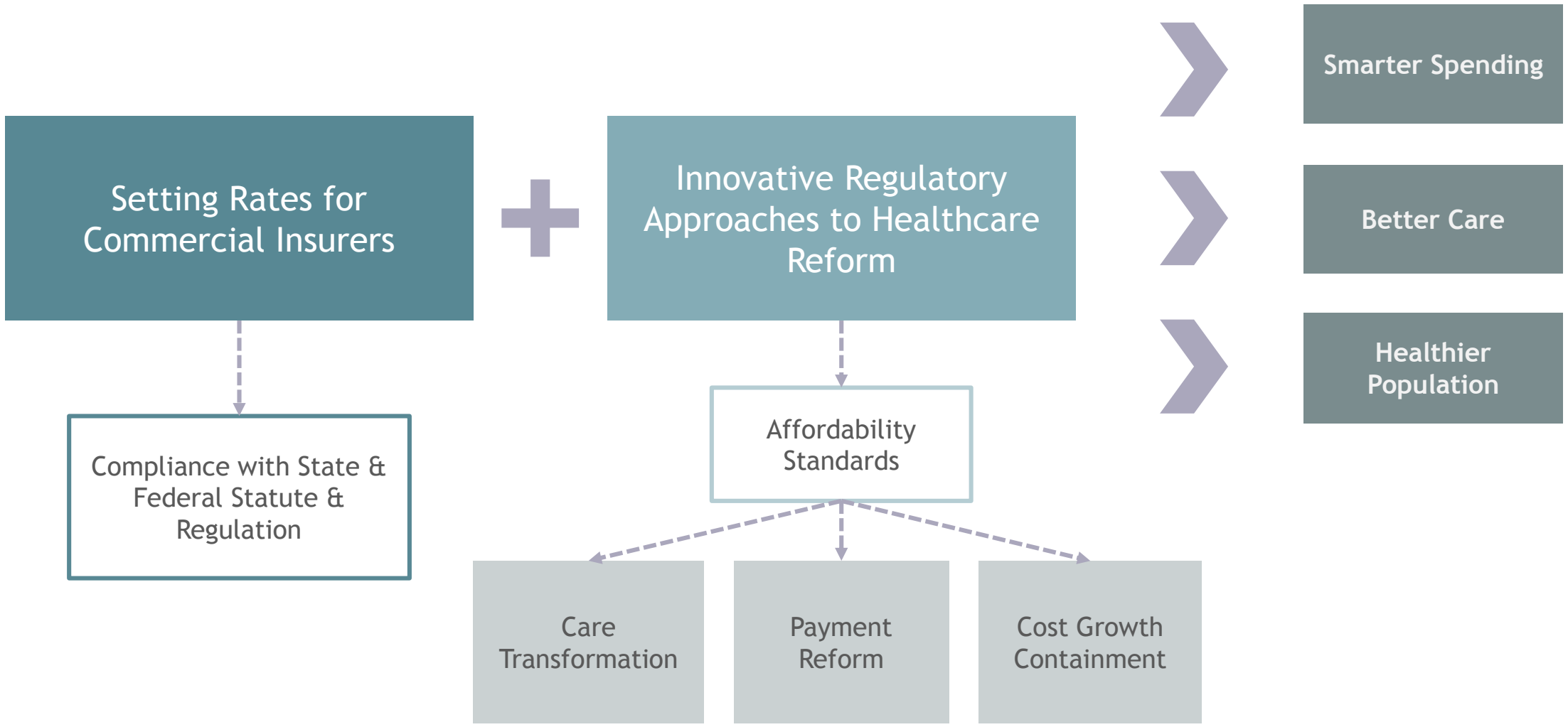
- Background on OHIC
  - OHIC Theory of Action
- Why OHIC Cares About Price Variation
- OHIC Efforts to Curb Spending Growth
  - Price Transparency
  - Innovative Regulation

OHIC's Legislative Charge

"View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access"

R.I. Gen. Laws § 42-14.5-2

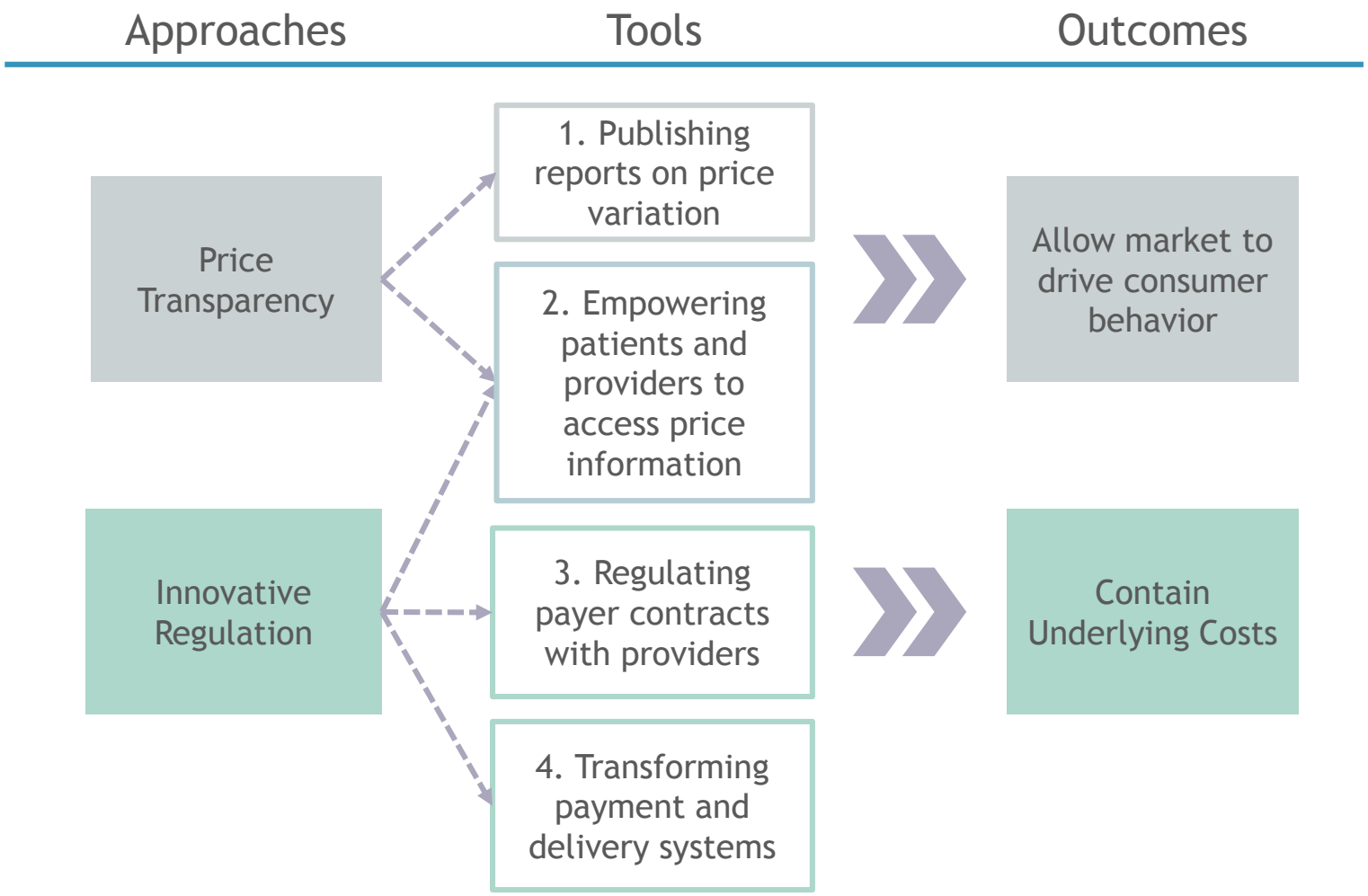
OHIC Theory of Action



Why does OHIC care about Price Variation?

- The price of healthcare services is a significant factor in the level and growth of healthcare expenditures, which impacts premiums.
- Variation in prices paid by different payers translates into a differential cost burden borne by different healthcare purchasers.
- There is no apparent link between payment rates and quality of care.
- State efforts to curb excessive healthcare spending growth should focus on price variation, among other factors, including price inflation rates, unnecessary utilization of services, etc.
- OHIC's efforts to curb health expenditure growth encompass several mechanisms that drive our delivery system toward value-based, efficient, and high-quality care.

OHIC Efforts to Curb Spending Growth



1. Publishing Reports on Price Variation

Variation in Payment for Hospital Care in Rhode Island: A 2012 Study

- In 2012, OHIC and EOHHS commissioned a study on hospital payment variation
- The study used a dataset of 2010 inpatient and outpatient claims from public and private payers in RI, spanning 11 general hospitals and 2 psychiatric hospitals.
- Payments were casemix adjusted to allow for apples-to-apples comparison

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Variation in Payment for Hospital Care in Rhode Island: Key Findings

- Considerable variation in payments for similar services
- Commercial plans paid the most
- Medicaid FFS ranked relatively high as a payer

Table 3.1.1

Examples of Variation in Payment for Specific Services

	Medicare FFS	Medicare Mgd Care	Medicaid FFS	Medicaid Mgd Care	Commercial Plans		
Service	**Overall**	**Overall**	**Overall**	**Overall**	**Overall**	**Lowest-Paid Hospital**	**Highest-Paid Hospital**
Inpatient Care							
Pneumonia, severity 3 (APR-DRG 139-3)	$8,518	$9,217	$10,374	$11,401	$12,566	N/A	N/A
COPD, severity 2 (APR-DRG 140-2)	$6,496	$6,761	$5,615	$9,163	$12,627	N/A	N/A
Knee joint replacement, severity 1 (APR-DRG 302)	$15,147	$13,667	N/A	N/A	$22,405	$22,911	$26,758
Vaginal delivery, severity 1 (APR-DRG 560-1)	N/A	N/A	$3,386	$3,716	$7,043	$5,413	$7,663
Outpatient Care							
Colonoscopy, including related services	N/A	$745	N/A	$954	$1,440	$802	$2,343
Evaluation of chest pain (note 1)	N/A	$888	$813	$508	$918	$480	$2,035
Typical ER evaluation (note 2)	$231	$365	$206	$188	$638	$482	$1,214
Typical advanced imaging service (note 2)	$398	$413	$321	$395	$486	$376	$808

Notes:

1) Evaluation of chest pain refers to the total payment for a patient seen in the ER for evaluation of chest pain, including related services. Patients who were admitted to inpatient care or who underwent cardiac catheterization were excluded from this definition. See Appendix Section B.6.4.
2) "Typical" ER evaluation and advanced imaging services refer to a weighted average index of procedure codes, e.g., 99281-99285 for ER evaluation. These figures refer to the specific procedure codes only; related services are excluded. See Appendix Section B.6.5.
3) Data are shown only for services where the hospital performed at least 50 services for a specific payer in 2010. Other cells are shown as N/A.
4) Examples shown are for purposes of illustration. Overall analysis of variation in cost and payment was done using all stays and visits, typically using APR-DRGs for casemix adjustment of inpatient care and EAPGs for service mix adjustment of outpatient care.
5) Detailed Medicare FFS data for outpatient claims were not available, so the cells for colonoscopy and evaluation of chest pain are shown as N/A. Medicare FFS payment figures for the ER evaluation and advanced imaging service indexes were calculated using APC fees applicable in Rhode Island.

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Variation in Payment for Hospital Care in Rhode Island: Key Findings

Chart 4.2.3
Commercial Payment Compared with Total Cost
Cost includes medical education

	So Co	St. J	Lndmrk	Rog Will	Wstrly	Kent	Nwprt	Mirm	Mem	RIH	W&I
Cost incl med ed	0.80	0.81	0.81	0.82	0.82	0.92	0.94	0.95	1.03	1.05	1.40
Payment	1.08	0.96	1.10	0.96	1.08	1.19	1.11	1.14	1.06	1.28	1.85

Payment and cost figures are relative to statewide averages. Hospital-specific figures are for the commercial population specifically. The difference between payment and cost reflects differences in the relative positons of the hospitals; it is not a profit margin. See Appendix Section A.4.2.

- Commercial plans tended to pay more to Lifespan and Care New England than to other hospitals
- Considerable variation in costliness across hospitals
- Higher cost hospitals tended to be paid more

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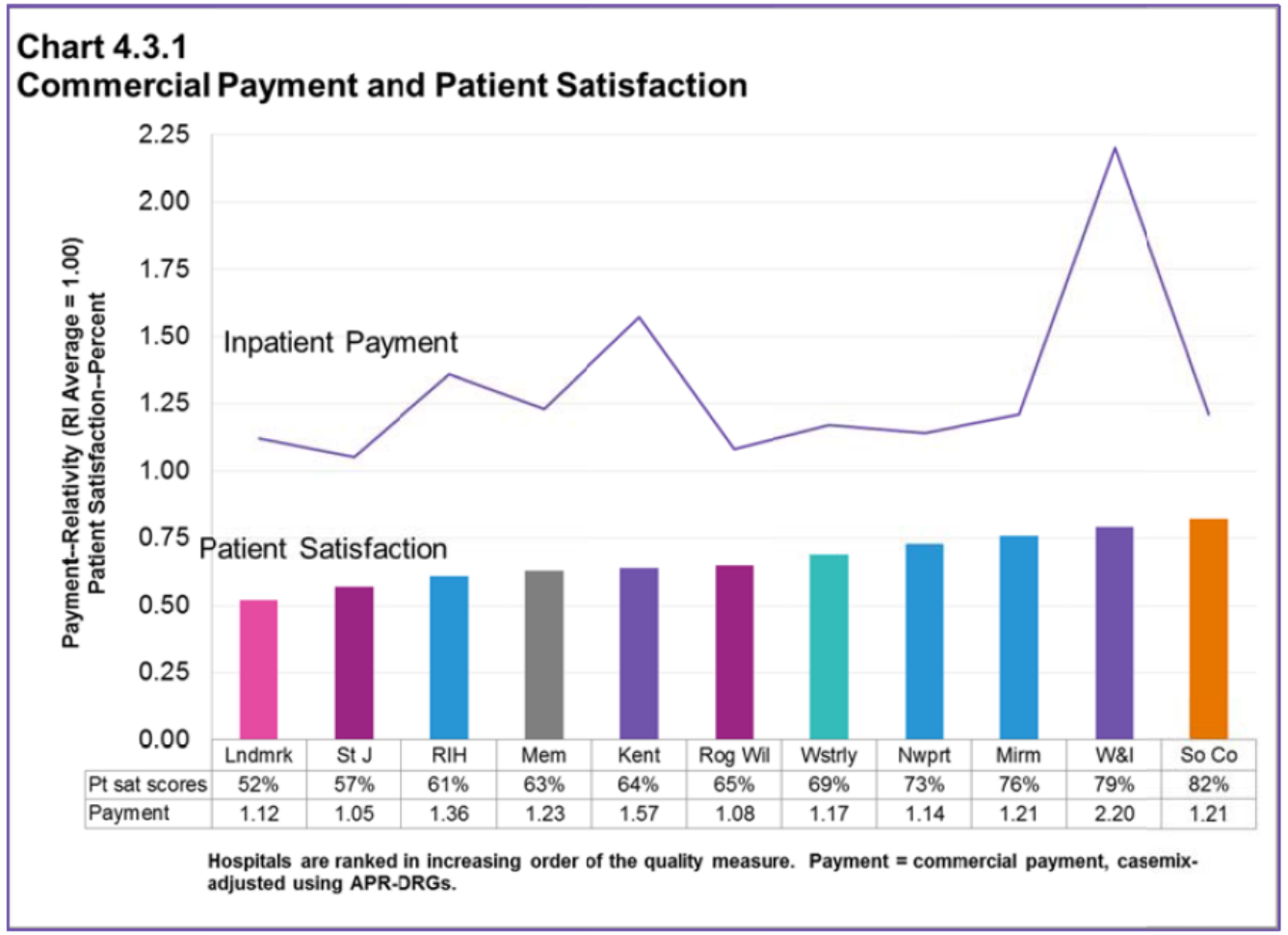
Variation in Payment for Hospital Care in Rhode Island: Key Findings

- While quality data were limited, no link between quality and payment was found



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Variation in Payment for Hospital Care in Rhode Island: Key Findings

Price variation for hospital services is a problem everywhere, and if payments vary less in Rhode Island, it may be because of our smaller, more tightly regulated provider and insurer markets.

Table 3.5.1

Variation in Inpatient Payment by Private Plans for Specific Inpatient Services

APR-DRG			Median Hospital		Difference from Lowest-paid Hospital to Highest-paid Hospital	
	RI Low Hospital	RI High Hospital	RI	MA	RI	MA
139-3 Pneumonia, severity 3	$9,330	$12,538	$11,967	$12,420	30%	1350%
140-2 COPD, severity 2	$7,207	$21,291	$10,691	$7,455	200%	520%
302-1 Knee joint replacement, Sev 1	$18,041	$26,758	$21,882	$21,241	50%	980%
540-1 Cesarean delivery, Severity 1	$6,334	$12,405	$7,935	$7,598	100%	490%

Notes:

1) The source for the Massachusetts data is Massachusetts Executive Office of Health and Human Services, Division of Healthcare Finance and Policy, *Massachusetts Healthcare Cost Trends: Price Variation in Healthcare Services* (Boston: DHCFP, June 2011), p.9.

2) In 2010, Rhode Island had 11 general hospitals while Massachusetts had 79. Rhode Island figures are for hospitals with at least five stays for each DRG, while the Massachusetts figures are for hospitals with at least 30 stays for each DRG. Rhode Island data are for 2010 while Massachusetts data are for 2009.

2. Empowering Patients and Providers to Access Price Information

Regulation 2, Section 12: Price Disclosure

- OHIC's Price Transparency requirements are written into Regulation with the intention to empower consumers and providers to make cost-effective healthcare decisions within the realm of the insurer's network. The two key requirements are:

Disclosure of Price Information to Providers

Insurers must disclose price information to designated providers (upon request) for the purposes of:

- Making cost-effective referrals
- Engaging in care coordination
- Making treatment decisions

Submission of a Comprehensive Price Transparency Plan

Insurers created comprehensive Price Transparency Plans that include:

- An Implementation Timeline
- Services, products, and supplies subject to price disclosure
- Appropriate limitations on disclosure
- FFS and APM price information

Innovative Regulation: OHIC Affordability Standards

The Affordability Standards were written into regulation in 2010 to influence the affordability of healthcare by focusing on three key strategies:

Care Transformation	Improving the efficiency and quality of care by transforming primary care practices
Payment Reform	Moving from volume to value by increasing the amount of payments that are tied to quality and cost efficiency
Cost Growth Containment	Slowing the rate of rising healthcare costs by limiting the rate increases of hospital based services and ACO total cost of care budgets

3. Regulating payer contracts with providers

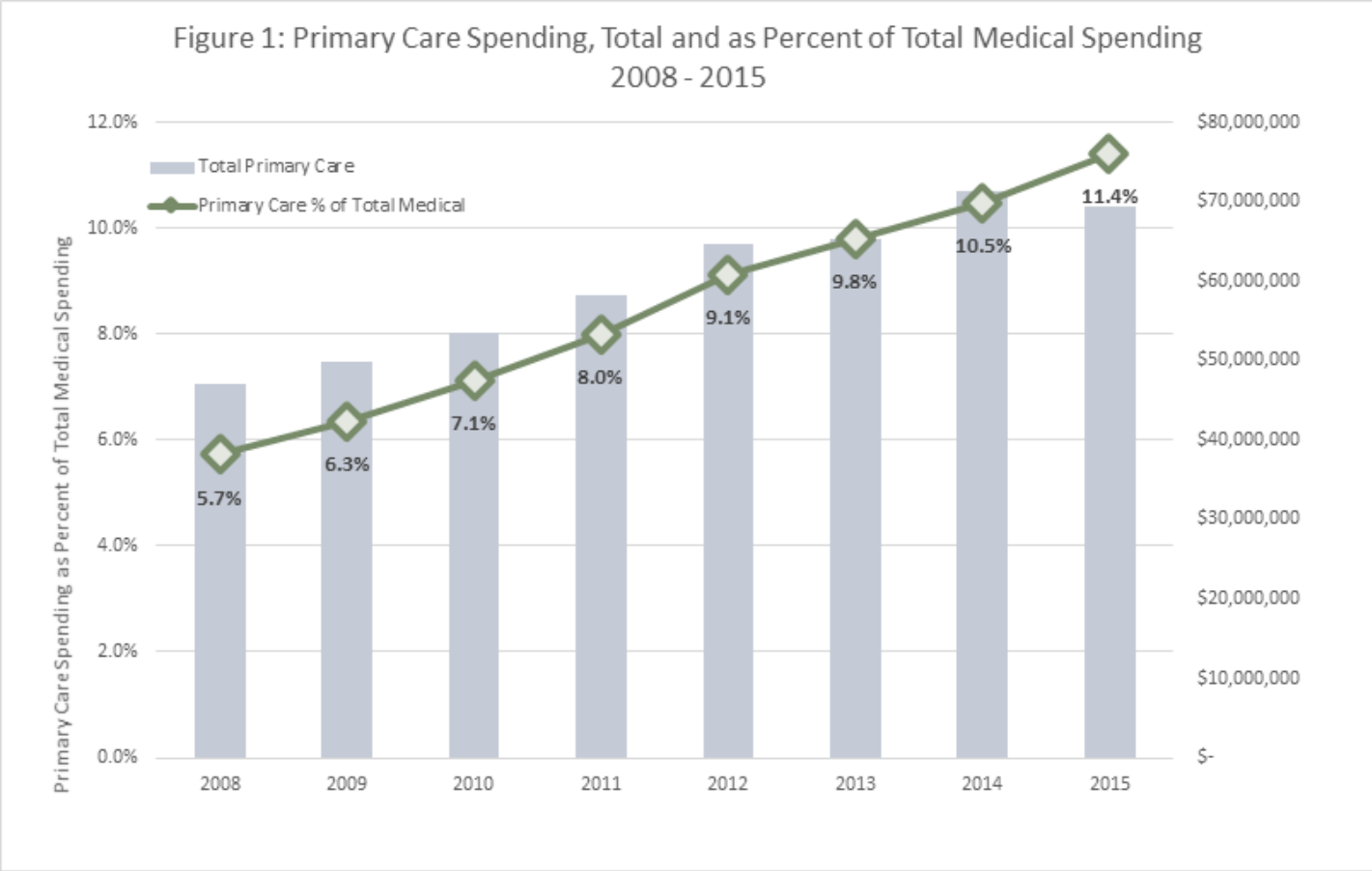
Containing Medical Cost Growth

- Recognizing that health insurance rate increases are driven not only by fee-for-service payment structures, but also by systemic medical expense trends, the Affordability Standards include requirements that limit the annual rate increase of medical services.

	Hospital Contracting Requirements	ACO Contracting Requirements
Annual Rates for:	Inpatient and outpatient services	Total cost of care for services
Affordability Standards Requirement:	Average rate increases shall not exceed the CPI-Urban percentage increase plus 1%	Increase in the total cost of care shall not exceed the CPI-Urban plus 3.0% in 2016, plus 2.5% in 2017, plus 2.0% in 2018, and plus 1.5% in 2019.

4. Transforming Payment and Delivery Systems

Increasing Investments in Primary Care



The Affordability Standards ensure the financial support of primary care

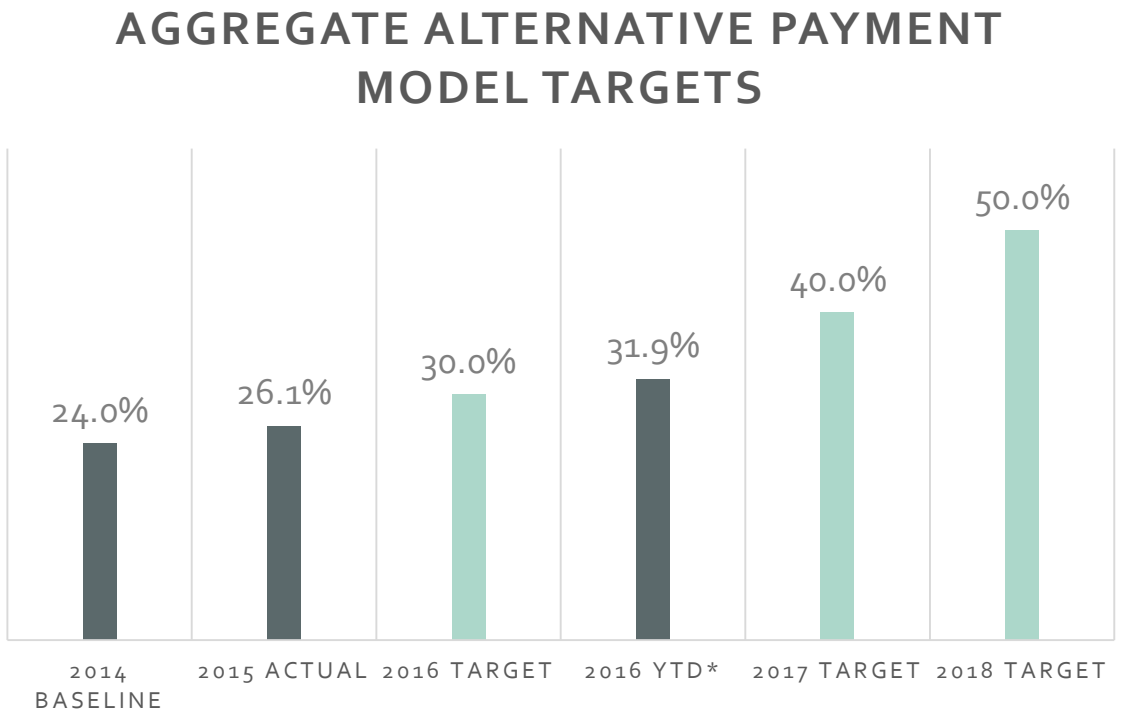
- Between 2010 and 2014, insurers were required to increase primary care spending by 1 percentage point (of total medical spend) each year
- Now, primary care expenses must comprise at least 10.7% of total medical spend
- Investments in primary care reinforce ongoing care transformation work

4. Transforming Payment and Delivery Systems

Reforming Payment Models

The Affordability Standards call for significant reductions in the use of fee-for-service payment as a payment methodology by commercial insurers

- **Target:** 50% of an insurer's annual commercial insured medical spend will be in the form of APM payments by 2018
- OHIC's Alternative Payment Methodology (APM) Committee establishes annual targets for commercial insurers



*2016 YTD figures include data up to the end of May 2016

THANK YOU

Any Questions?