Introduction: Determining
Medical Pricing Reasonableness

- Why do we need to reference prices?
- How can we do so using evidence and reason?
- When we do, what do we see in Colorado?
- What have other employers/states done?
- What can you/we do in Colorado?
- Conclusions and Panel Discussion
- Intent: Fix problems, not blame.

Colorado Business Group on Health
Working Together to Improve Health Care Value

June 14th, 2018

HEALTHCARE PRICE VARIANCE REPORT

MARKET | DENVER

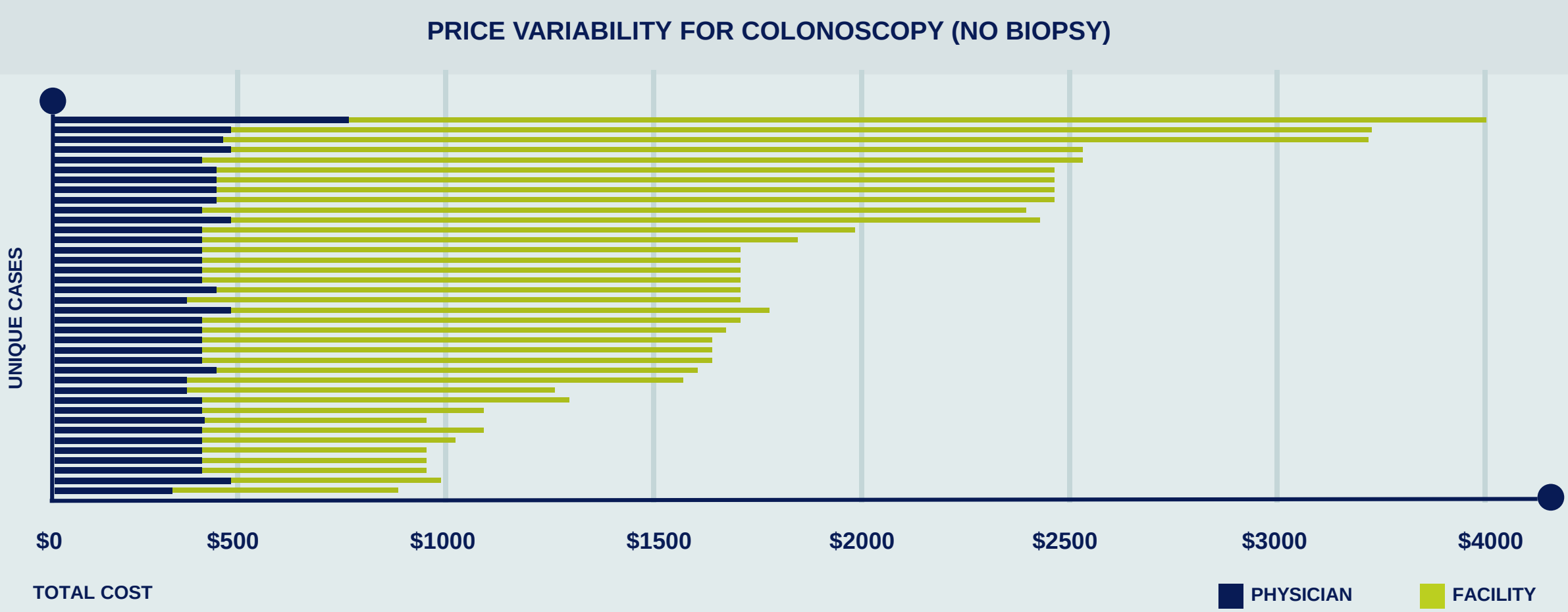
Procedure	Low Price	High Price	Variance
Abdominal Ultrasound	$115	$1,029	895%
Carpal Tunnel Surgery	$1,634	$5,806	355%
Chest CT (no contrast)	$248	$2,492	1005%
Cholecystectomy (laparoscopic)	$6,368	$19,530	307%
Colonoscopy (screening)	$1,296	$4,052	313%
Ear Tube Placement (Tympanostomy)	$1,737	$12,765	735%
Hysteroscopy (with biopsy)	$3,705	$9,316	251%
Knee Arthroscopy	$2,796	$23,462	839%
Shoulder MRI (no contrast)	$450	$4,999	1111%
Sleep Study	$899	$4,341	483%
	Average Variance		**837%**

EQUIVALENT VARIANCE IN A GALLON OF GAS	$2.20	$18.41	837%

What gas would cost per gallon with the same price variance

** All healthcare procedure costs are derived from claims amounts after network discounts were applied*

It's not the *physician*, it's the *facility*…



Healthcare Bluebook™

Premises
of Today's Discussion

- We don't have a "broken system." We do have a **dysfunctional market.**

- **Functional markets** bring reciprocal, discernable value to sellers and buyers – which relies upon/requires ***transparency*** and a means of *assessing proportionality of value (e.g, "reasonableness*.")

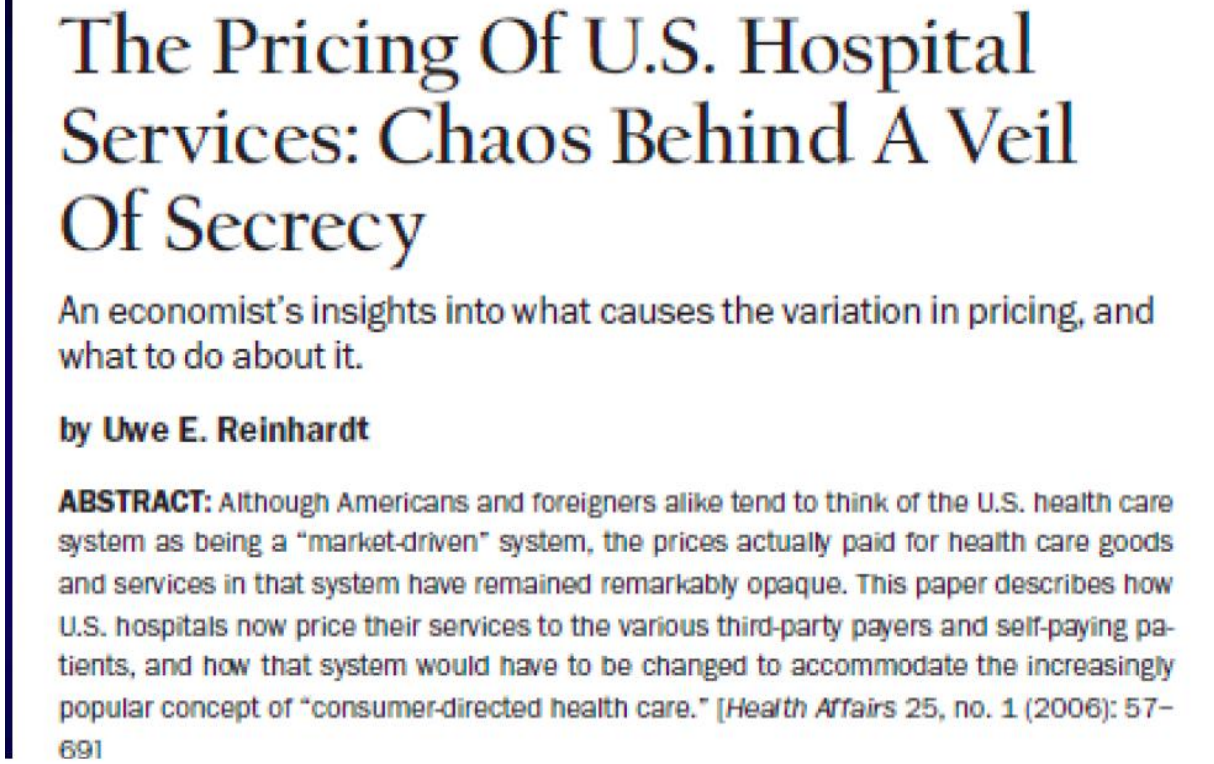
- Three current market ***practices that CRIPPLE*** any meaningful effort to actually "purchase" care based on **value**:
  1. The current ***basis of pricing*** (e.g., discounts from charges)
  2. ***Pricing and quality opacity*** (and lack of common measures)
  3. ***Unbundled billing*** by multiple providers for a single episode

Definitely not for the "faint of heart!"

A Renowned Economist's Take on Pricing…

"Frankly, I would much rather be asked to make the case for the Virgin Birth than to argue that private markets in the US price health care efficiently and on the basis of value to the patient - not to even mention 'humanely.'"

Uwe Reinhardt



The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy

An economist's insights into what causes the variation in pricing, and what to do about it.

by Uwe E. Reinhardt

ABSTRACT: Although Americans and foreigners alike tend to think of the U.S. health care system as being a "market-driven" system, the prices actually paid for health care goods and services in that system have remained remarkably opaque. This paper describes how U.S. hospitals now price their services to the various third-party payers and self-paying patients, and how that system would have to be changed to accommodate the increasingly popular concept of "consumer-directed health care." [*Health Affairs* 25, no. 1 (2006): 57–691

"Fools rush in?"

Purposes of Today's Discussion

1. Provide an empirically sound method to employers who wish to ***assess the reasonableness*** of the prices they and their employees pay for health services.
   - Provide a reference point for employer use in negotiating contracts and providing value based benefit designs.
   - Share (blinded) data on how prices across Colorado vary from that reference point based on the ***Colorado All Payer Claims Database***
2. Share with you two examples of leadership:
   - What the ***State of Montana*** has done and what's happened
   - What ***Indiana employers*** are doing
3. Discuss what employers might do in ***Colorado***

Guest Speakers and Panelists

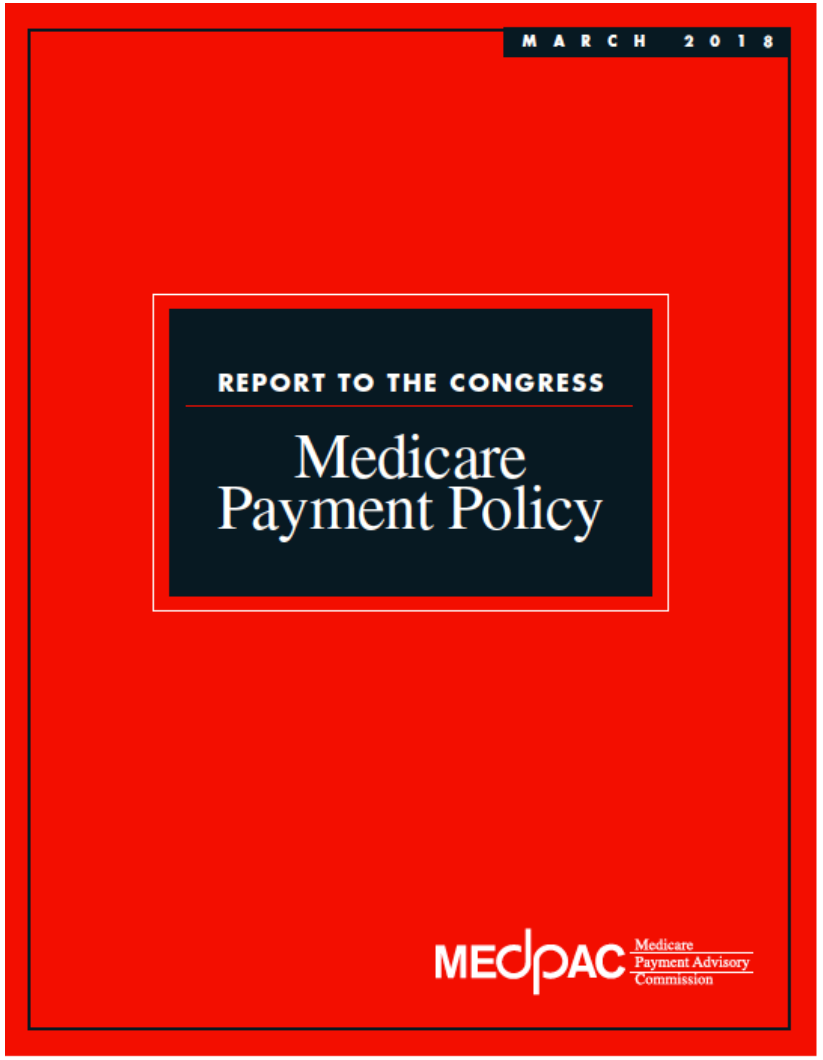
- **Donna Lynne**, Lt. Governor, State of Colorado
- **Kim Bimestefer,** Executive Director, HCPF
- **Joann Ginal**, State Representative; Chair, House Insurance Committee
- **Janet Pogar**, Regional VP, Anthem BCBS of Colorado
- **Ana English**, President & CEO, Center for Improving Value in Health Care
- **Gloria Sachdev**, PharmD, FASHP, President & CEO, Employers' Forum of Indiana
- **Marilyn Bartlett**, Benefits Administrator, State of Montana

Determining Medical Pricing Reasonableness:

Using Medicare payment as a benchmark/reference point.

Colorado Business Group on Health
Working Together to Improve Health Care Value

Robert Smith
Executive Director
June 14th, 2018



About MedPAC
(Medicare Payment Advisory Commission)

- Independent US federal body established by the Balanced Budget Act of 1997.
- Composition: 17 members with expertise in health care financing and delivery.
- Primary roles:
  - To advise Congress on issues affecting Medicare payment, particularly it effects…
  - Beneficiaries' **access to care** and the **quality of care** received.
- MedPAC produces reports to Congress with recommendations to improve Medicare access, quality, cost and ***payment adequacy***.

Medicare's IPPS: Inpatient Prospective **Payment System**

- Based on 335 Diagnostic Related Groups or DRG's
- Each split into 2 or 3 based on resource use
- Result: 752 severity adjusted "MS-DRGs"
- A series of adjustments the applied to separate operating and capital base payment rates
  - New technology
  - Teaching
  - Bad debt
  - etc

Figure 1 Acute inpatient prospective payment system for fiscal year 2018

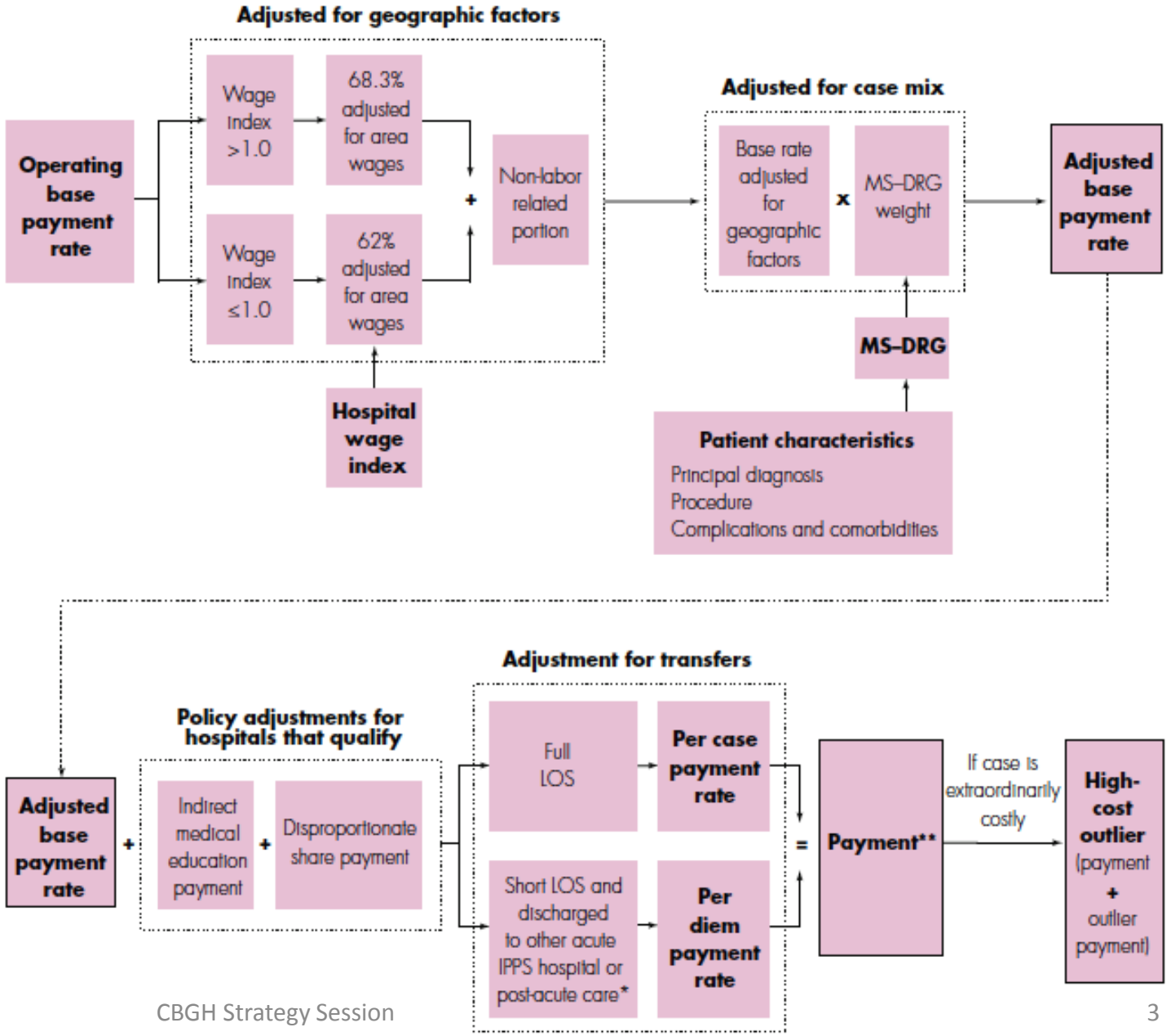
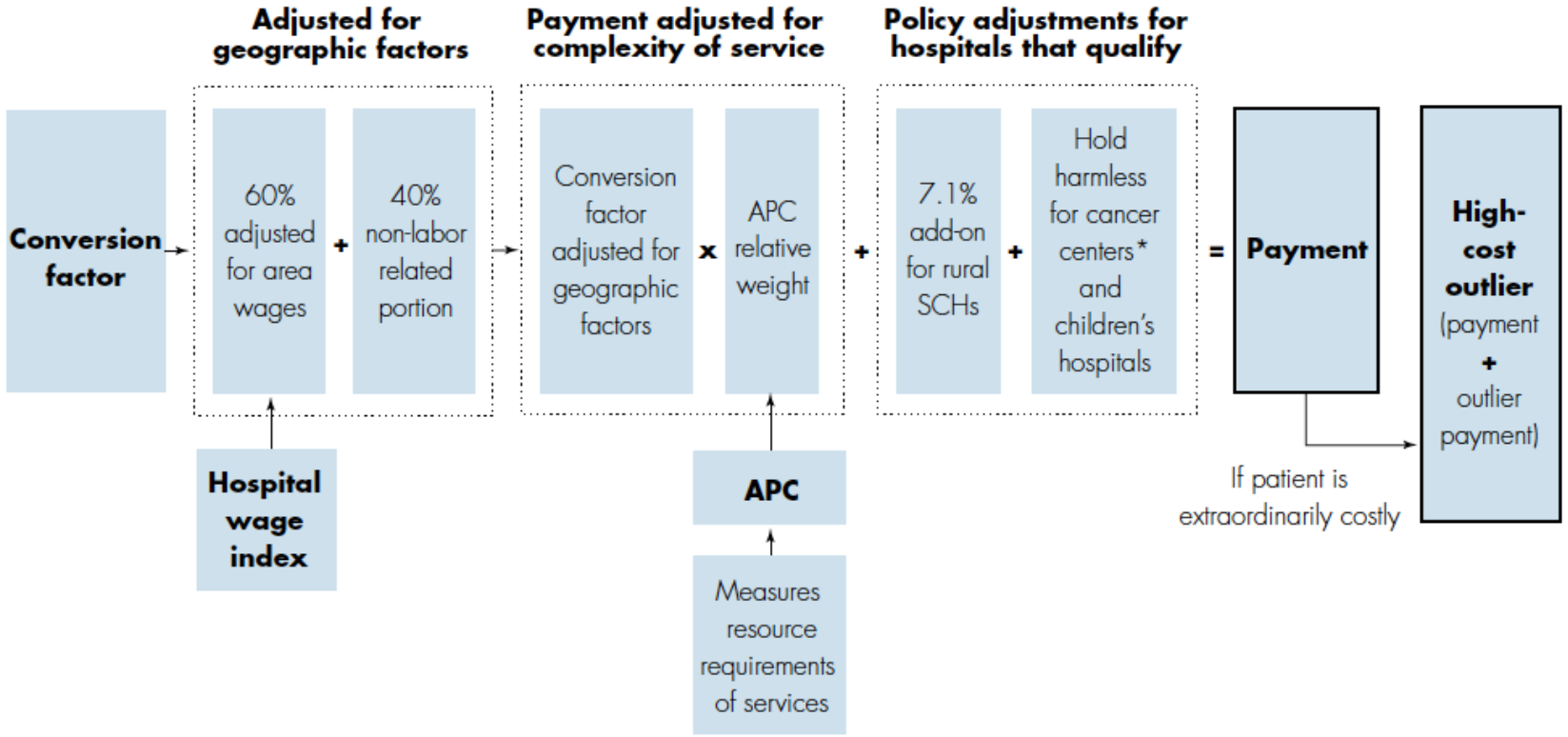


Figure 1 Hospital outpatient services prospective payment system



Note: APC (ambulatory payment classification), SCH (sole community hospital). The APC is the service classification system for the outpatient prospective payment system. *Medicare adjusts outpatient prospective payment system payment rates for 11 cancer centers so that the payment-to-cost ratio (PCR) for each cancer center is equal to the average PCR for all hospitals.

Medicare **OutPatient Payments**

About “Relatively Efficient” hospitals

Hospitals were identified as relatively efficient if they met four ***risk-adjusted*** criteria in each year from 2013 to 2015:

- Mortality rates were among the best 2/3^{rds} of all hospitals.
- Readmission rates were among the best 2/3^{rds} of all hospitals.
- Standardized costs per discharge were among the best 2/3^{rds} of all hospitals.
- Mortality or standardized costs per discharge were among the best one-third of all hospitals.

MedPAC's March 2018 Report:

Assessment of hospital payment adequacy

- **Adequacy Indicators Include:** Beneficiary access to care, changes in the quality of care, hospitals' access to capital, and the relationship of Medicare's payments to hospitals' costs for both *average and relatively efficient hospitals* (for Medicare patients).

- **Adequacy Conclusions:**
  - Payment rates 8% higher than ***variable costs*** associated with M'care patients.
  - In 2016, hospital's aggregate Medicare margin was -9.6 percent.
    - - 11.0% for non-profit hospitals
    - - 2.4 for profit hospitals
  - **Overall margins were approximately zero for *relatively efficient providers*.**

Other Relevant Observations

- Hospitals' all-payer operating ***margins reached a record high*** in 2015; slightly lower in 2016 but still near 30 year high.
  - All-payer margins remain strong "***because the growth of private-payer rates continues to rise faster than costs.***"
  - "Hospitals with strong profits on non-Medicare services and investments are under ***relatively little pressure to constrain their costs***."

  Note: In 2014, MedPAC report that the Medicare rate was 50% higher than payments to OCED countries' hospitals.

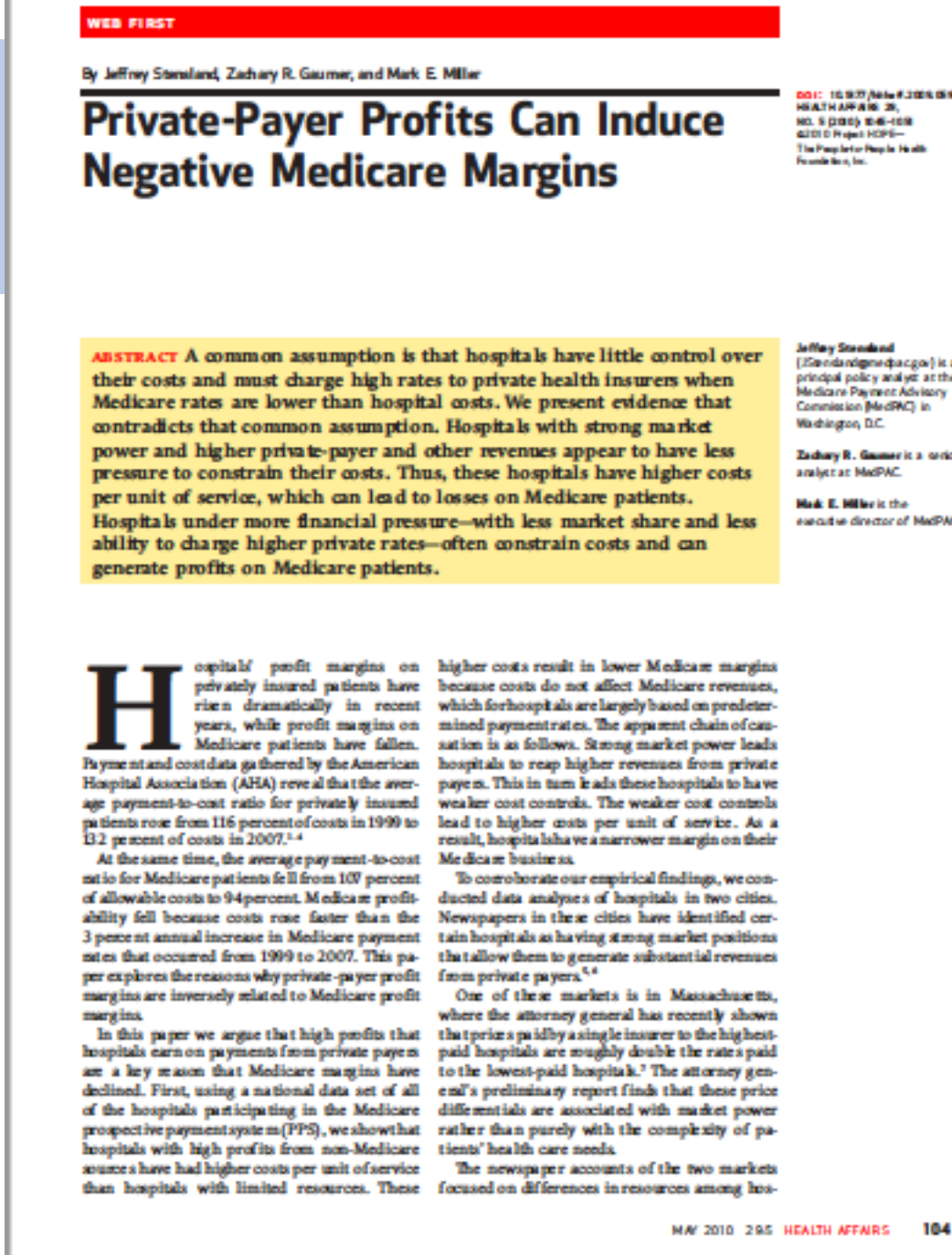
- "When providers receive high payment rates from insurers, they face no particular need to keep their costs low, and so, all other things being equal, ***Medicare margins are low because [hospital] costs are high.***"

Why are so many hospitals Losing Money on M'care?"

"Strong market power leads hospitals to reap higher revenues from private payers. This in turn leads these hospitals to have weaker cost controls. The weaker cost controls lead to higher costs per unit of service. As a result, hospitals have a narrower margin on their Medicare business."

Jeffrey Stensland

Principal Policy Analyst MedPAC)



WEB FIRST

By Jeffrey Stensland, Zachary R. Gaumer, and Mark E. Miller

Private-Payer Profits Can Induce Negative Medicare Margins

ABSTRACT A common assumption is that hospitals have little control over their costs and must charge high rates to private health insurers when Medicare rates are lower than hospital costs. We present evidence that contradicts that common assumption. Hospitals with strong market power and higher private-payer and other revenues appear to have less pressure to constrain their costs. Thus, these hospitals have higher costs per unit of service, which can lead to losses on Medicare patients. Hospitals under more financial pressure—with less market share and less ability to charge higher private rates—often constrain costs and can generate profits on Medicare patients.

Jeffrey Stensland [JStensland@medpac.gov] is a principal policy analyst at the Medicare Payment Advisory Commission (MedPAC) in Washington, D.C.

Zachary R. Gaumer is a senior analyst at MedPAC.

Mark E. Miller is the executive director of MedPAC.

Hospitals' profit margins on privately insured patients have risen dramatically in recent years, while profit margins on Medicare patients have fallen. Payment and cost data gathered by the American Hospital Association (AHA) reveal that the average payment-to-cost ratio for privately insured patients rose from 116 percent of costs in 1999 to 132 percent of costs in 2007.[1-4]

At the same time, the average payment-to-cost ratio for Medicare patients fell from 107 percent of allowable costs to 94 percent. Medicare profitability fell because costs rose faster than the 3 percent annual increase in Medicare payment rates that occurred from 1999 to 2007. This paper explores the reasons why private-payer profit margins are inversely related to Medicare profit margins.

In this paper we argue that high profits that hospitals earn on payments from private payers are a key reason that Medicare margins have declined. First, using a national data set of all of the hospitals participating in the Medicare prospective payment system (PPS), we show that hospitals with high profits from non-Medicare sources have had higher costs per unit of service than hospitals with limited resources. These higher costs result in lower Medicare margins because costs do not affect Medicare revenues, which for hospitals are largely based on predetermined payment rates. The apparent chain of causation is as follows. Strong market power leads hospitals to reap higher revenues from private payers. This in turn leads these hospitals to have weaker cost controls. The weaker cost controls lead to higher costs per unit of service. As a result, hospitals have a narrower margin on their Medicare business.

To corroborate our empirical findings, we conducted data analyses of hospitals in two cities. Newspapers in these cities have identified certain hospitals as having strong market positions that allow them to generate substantial revenues from private payers.[5,6]

One of these markets is in Massachusetts, where the attorney general has recently shown that prices paid by a single insurer to the highest-paid hospitals are roughly double the rates paid to the lowest-paid hospitals.[7] The attorney general's preliminary report finds that these price differentials are associated with market power rather than purely with the complexity of patients' health care needs.

The newspaper accounts of the two markets focused on differences in resources among hos-

Observations – Cont'd.

- OP payments rose because of volume increases, price increases, and ***the continued shift of services from lower cost physician offices to higher cost hospital outpatient settings*.**

- **Hospital consolidation** contributed to commercial spending growth from 2010 to 2015 of **3.2 percent annually**.

- **Meanwhile (back at the family ranch), from 2006 to 2016**
  - Household incomes increased **22%**
  - Average premium for family coverage increased **58%** (2.6 x incomes)

So, for your consideration…

- Medicare rates, although adjusted for hospital-specific variables (eg., indigent care load) are not, *per se*, being recommended for commercial payers. We would suggest, however…

- Medicare payment provides a tangible, ***empirically-based point of reference*** at which an "efficient" hospital, with adequate volumes, can break-even, which then begs the question…..

- ***So the question will be: What percent of Medicare payment do you, as a buyer, find reasonable and fair? What will you do?***

To quote John Oliver…

”And now, this….”

If the first rule of medicine is *“Do no harm*,” then we would be wise to consider this:

Financial harm IS harm.

Colorado Business Group on Health

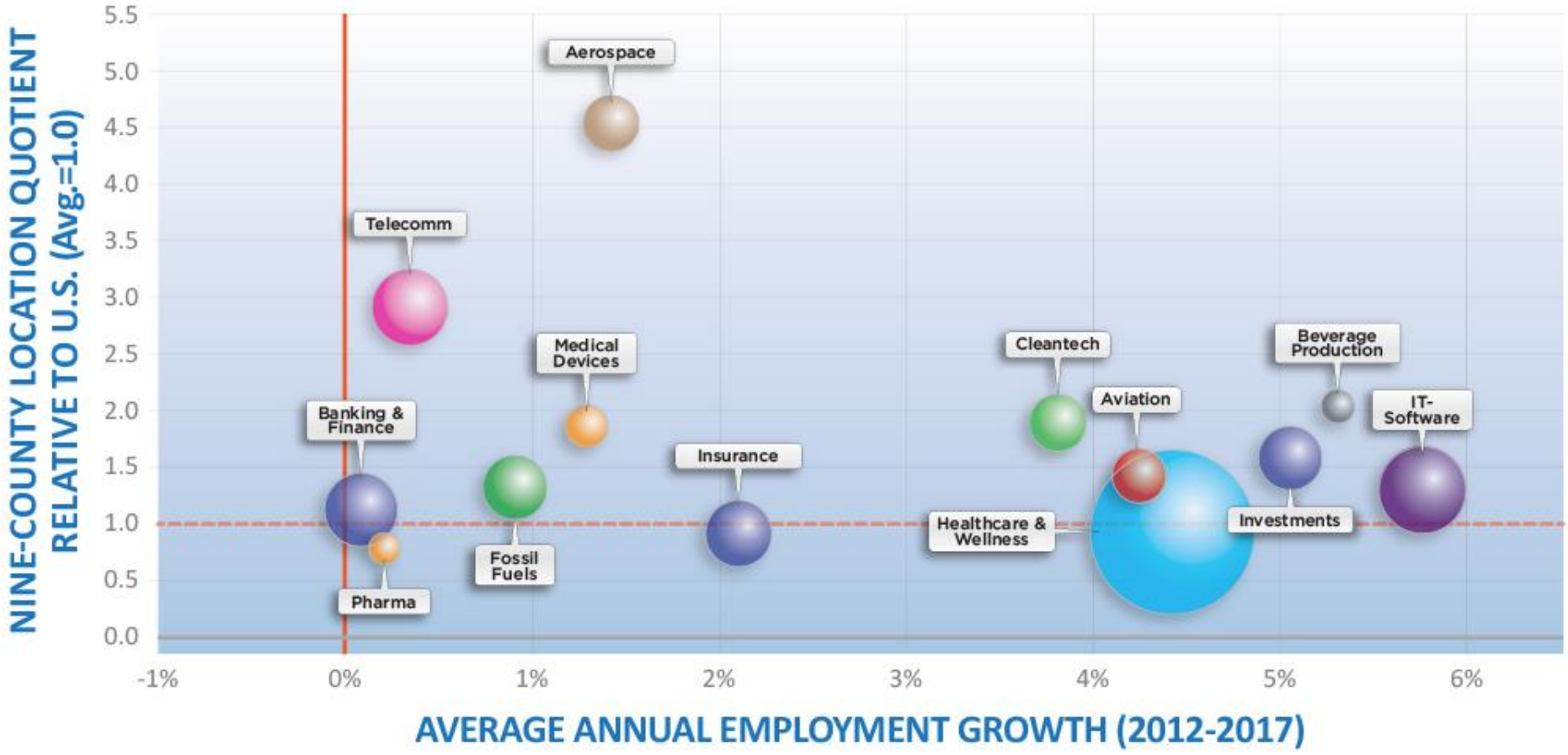
June 14, 2018

Kim Bimestefer

Executive Director

Department of Health Care Policy & Financing

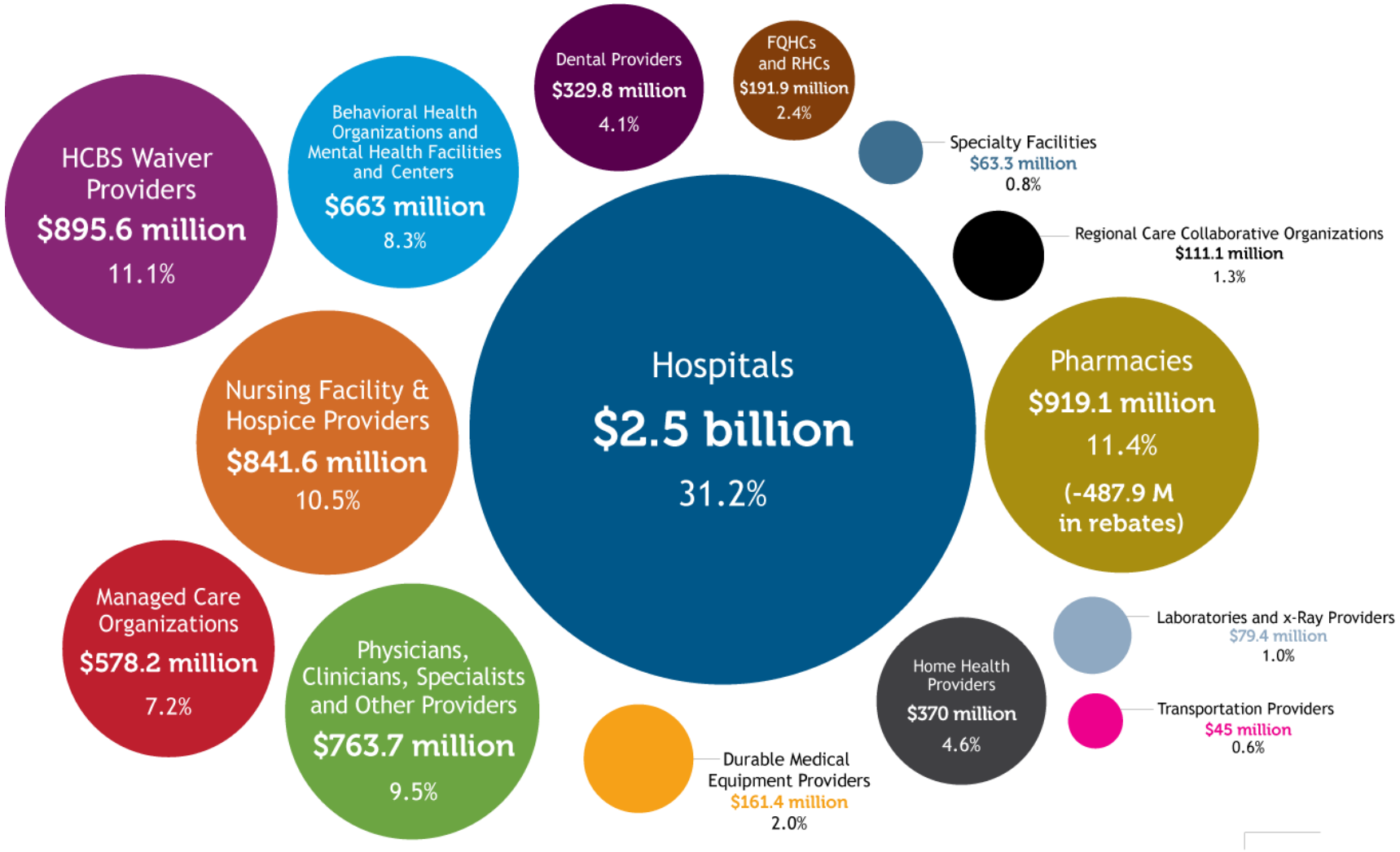
Goal: Impact the Healthcare Sphere Together



Source: Metro Denver Economic Development Corp.

Goal: Shrink the blue sphere via innovation, efficiencies to aid employers/consumers
Goal: Grow the blue sphere via innovation, care & intellectual property exportation

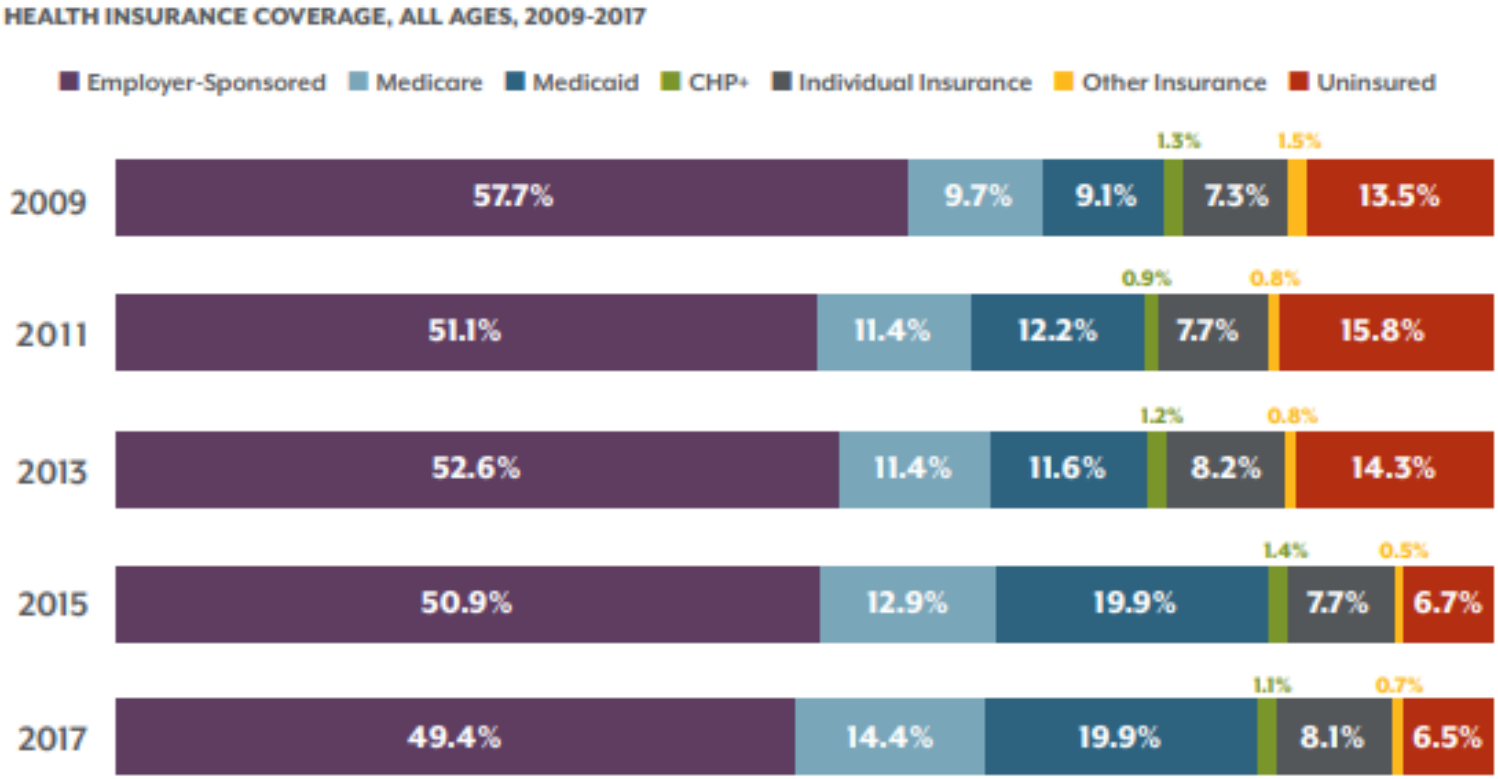
Where do Medicaid $$ Go…and Yours?



Hospitals: 40/30/10 impact

Calendar Year 2016 Data

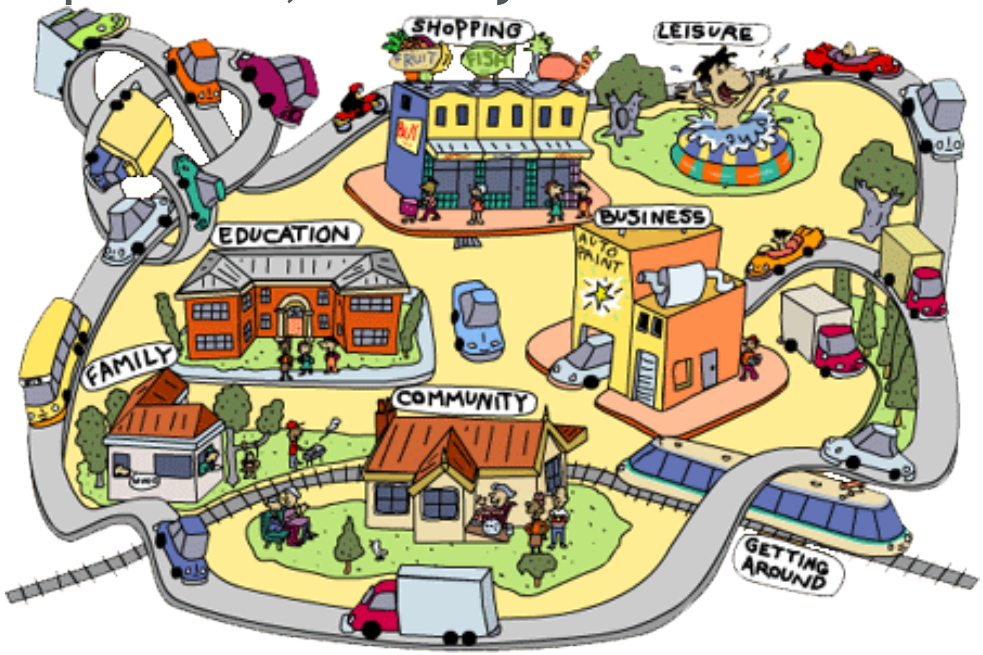
Recognize the Changing Payer Mix Impact on Hospital Income



Source: Colorado Health Institute, Colorado Health Access Survey, September 2017, Pg. 8

How Do APMs Drive Hospitals to Meet the Needs of the Community?

- American Lifestyle Chronic Disease
  - But what about prevention? (Diet/Weight, Tobacco Use)
- Socioeconomic
- Mental Health: Addiction, Depression, Anxiety
- Shifting Demographics



Shifting Demographics – Impact on Community Needs & Hospital Revenue

- 1% of the population accounts for 30% of the nation's health care expenditures.[1] Nearly half of those are seniors.

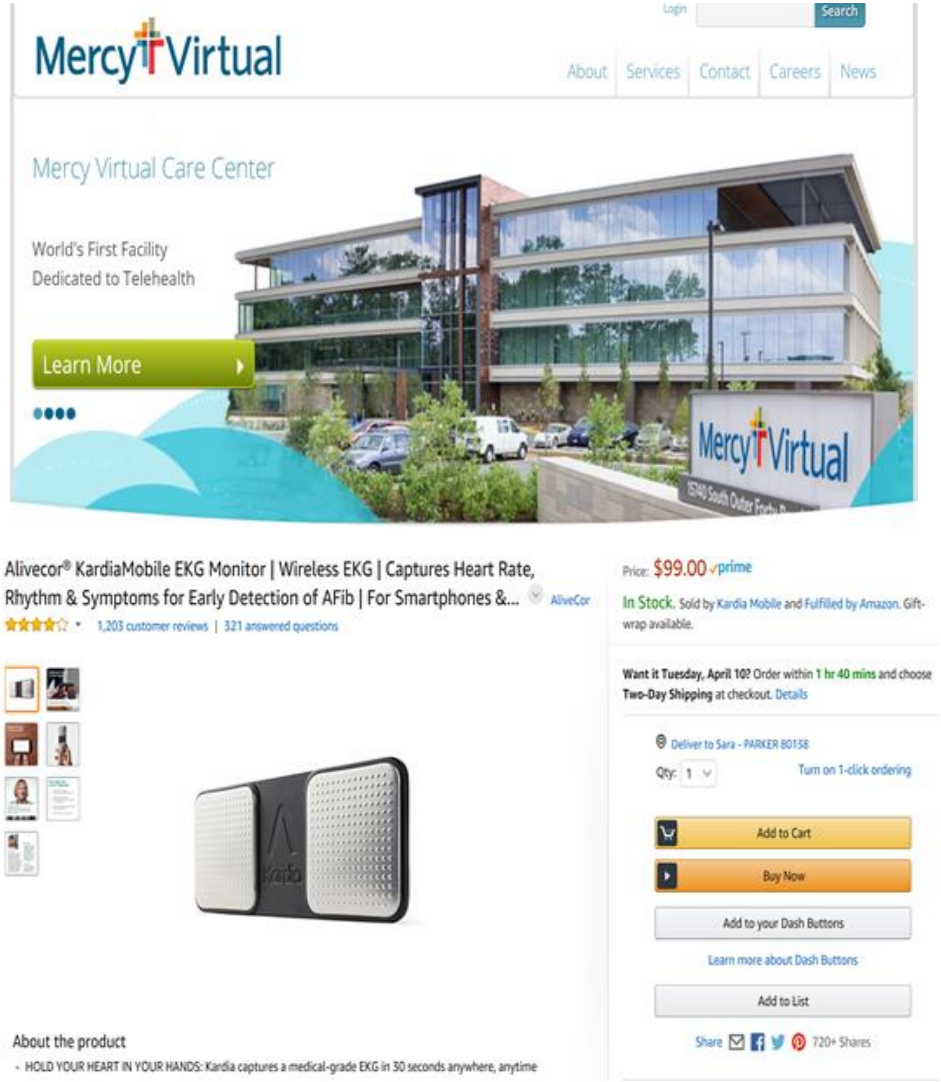
- Seniors - 43% population growth in Colorado between 2010-2017 compared to 14% non-senior growth and projected 57%+ growth between now and 2030.[2]

Sources: [1] The Health Care Financing Administration (HCFA), which oversees Medicare spending, Agency Analysis trends 1993, 1975, 1980, 1985, and 1988. [2] State demographer office, as per the 2018 Denver Chamber industry report

How do APMs drive tomorrow's innovation efficiencies?

Hospital Pricing evolution needs to drive efficiency innovations

- $54M hospital without beds
- Nationally recognized center for developing and delivering telehealth
- How do we maximize the next generation of Tele-Health?
- Or coverage policy…
- Or Rx efficiencies...



How do APMs drive efficiencies in the Delivery System?

- Standalone ED/ER
  - vs. extended hour primary care or MHSA
  - Dual track, EMTALA
- Arms race/excess capacity vs. COE partnerships
- Independent docs vs. hospital owned
  - Clinical pathway – efficiency vs. system referral
- Acquisition of ASC and billing practices
- Prescribing patterns and delivery site…

Collaborating on Hospital Transformation Program (HTP)

Today's Hospital Quality Incentive Program (HQIP)

- Payment for Providing Services that Improve Health Care Outcomes
  - 7% (statute) of Prior Year Hospital Supplemental Payments: $90+ million

Tomorrow's HTP Ideas under Consideration

- Supplemental payments (provider fee) tied to value (Waiver due 10/2018)
  - Efficiency: Shared End of Life education tools and & document repository; shared prescribing efficacy tools; shared MHSA highest user management tools
  - Collaboration btw hospitals and Medicaid's care management arms (RAEs)
  - Improved maternity outcomes and opioid management
  - Transparency - submission of required financial information
  - Interventions that reduce avoidable costs (incl. Prometheus)
  - Appropriate care, appropriate settings, appropriate price
  - Evolution to global budgets in rural communities

3-5+ Year Roadmap to Control Costs to the Benefit of Employers, Consumers and Other Payers

- Creates a framework to control State healthcare costs
  - Responds to the voice of consumers, employers
  - Maximizes– Payer Collaborative, SIM, CPC+, CMMI
  - Framed by healthcare experts; refined by stakeholders
  - Inclusive process

- Monitors and aligns with Denver Chamber, CBGH and other employer focused work where possible

Stakeholder Collaboration

Employers & Associations
Unions & Advocates
Governor's Health Cabinet
Carriers / Payers
Regional Accountable Entities
Providers & Associations
Legislators
CIVHC, COHRIO & CO Health Institute
Others, Including You

Questions?

Contact:
Kim.Bimestefer@state.co.us
303-866-4167

CIVHC

CENTER FOR IMPROVING
VALUE IN HEALTH CARE

CBGH Employer Meeting

6.14.18

Ana English
President and CEO

About CIVHC

Who We Are

Our Mission:

We strive to empower individuals, communities, and organizations through collaborative support services and health care information to advance the Triple Aim.

About CIVHC

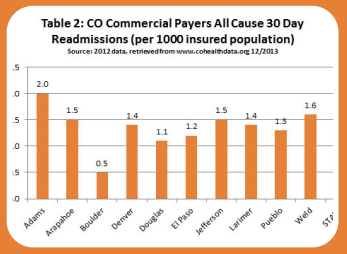
Who We Serve

Change Agents:

Individuals, communities or organizations working to lower costs, improve care, and make Colorado healthier.

About CIVHC

Focus Areas



Data Transparency

- Colorado All Payer Claims Database Administrator
- Provide public and custom data to advance the Triple Aim

Health Care Reimbursement

- Support new ways to pay for care that lower costs and improve outcomes through data, analytics, education and convening

Care Delivery

- Manage Healthy Transitions Colorado, a care transitions collaborative
- Work with organizations to expand access to Palliative Care

Colorado Inpatient/Outpatient Potential Cost Savings Analysis

- Median payments analyzed (actual payments to providers by patients and health insurance payers)
- Top 12 Inpatient, top 10 Outpatient claims by volume and price
- Analyzed 2012-2016 claims submitted by 33 Colorado commercial health insurance payers to the CO APCD (64% of all commercially insured lives)
- Outpatient payments were compared to the last published Medicare fee schedule, and Inpatient payments were compared to the median payment amounts of Medicare Fee-for-Service claims in the CO APCD.
- Percent Medicare rates reflect the percentage commercial payments differ from Medicare.

Services Analyzed

Inpatient

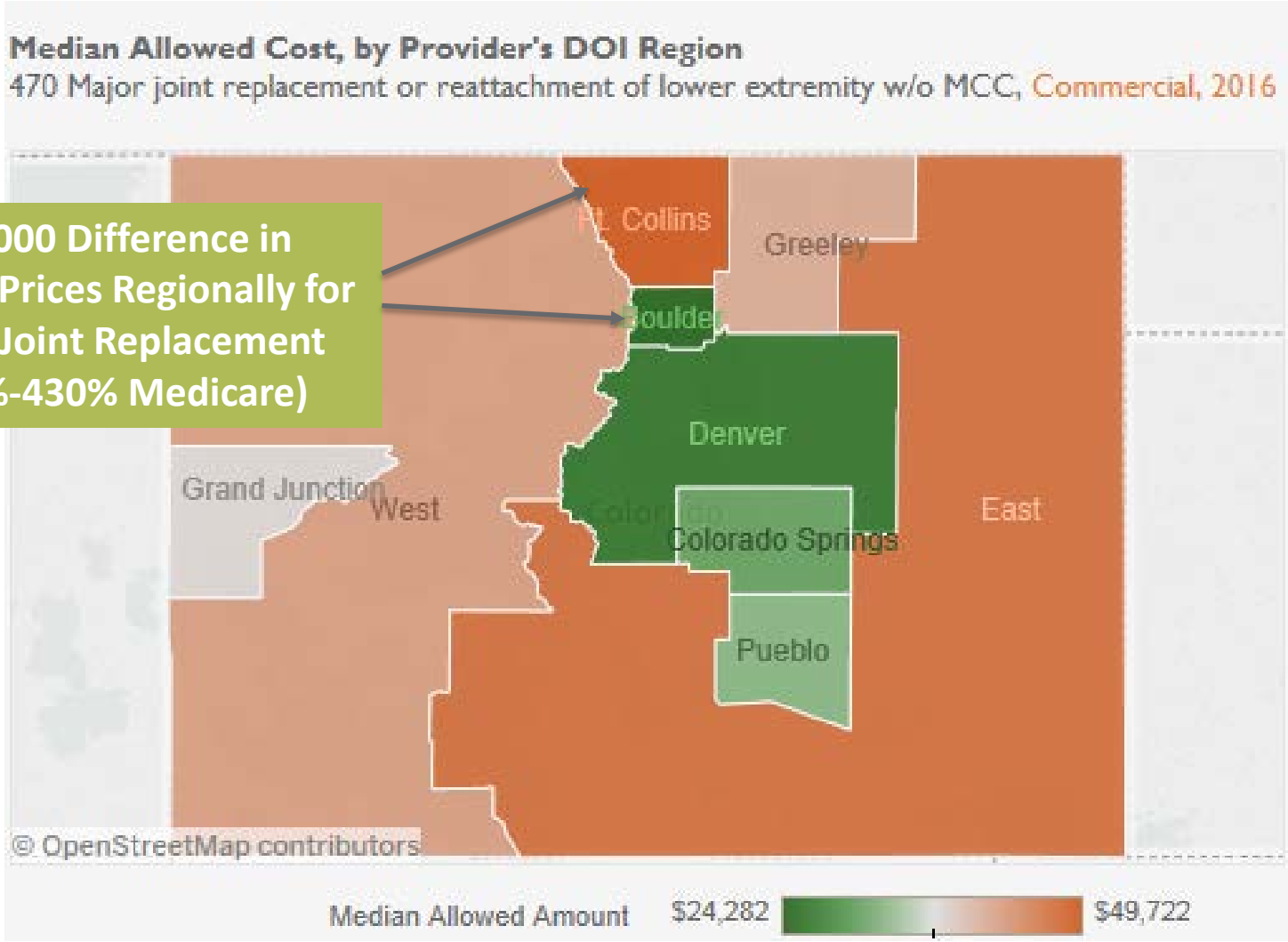
- Bronchitis & Asthma, DRG 203
- Cesarean Section, DRG 766
- Cesarean Section, w complicating conditions, DRG 765
- Esophagitis, Gastroenteritis, and Digestive Disorders, DRG 392
- Heart Failure & Shock, DRG 293
- Heart Failure & Shock, w complicating conditions, DRG 292
- Major Joint Replacement/Reattachment, Lower Extremity, DRG 470
- Newborn, DRG 795
- Spinal Fusion, non-cervical, DRG 460
- Stroke (Transient Ischemia Attack), DRG 069
- Vaginal Delivery, DRG 775
- Vaginal Delivery w complicating conditions, DRG 774

Outpatient

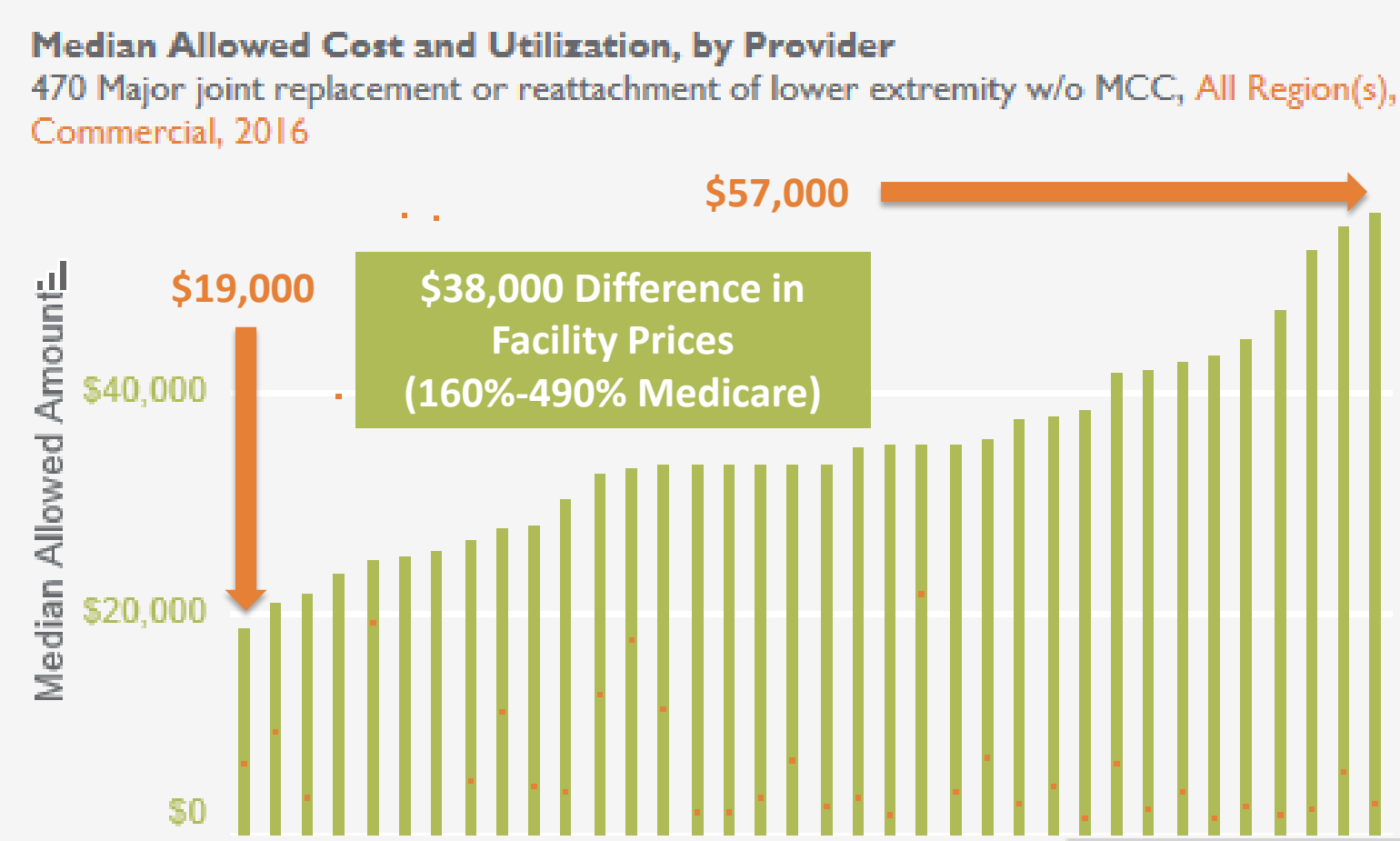
- Cataract Surgery with Lens, CPT 66984
- Chemo Infusion (1 hr), CPT 96413
- Colonoscopy w Biopsy, CPT 45380
- Colonoscopy w Lesion Removal, CPT 45385
- Dialysis evaluation, CPT 90945
- Knee Arthroscopy/Surgery, CPT 29881
- Major Joint, Bursa Drain, Injection, CPT 20610
- Ultrasound Therapy, CPT 97035
- Upper GI Endoscopy with Biopsy, Single/Multiple, CPT 43239
- Laparoscopy Appendectomy, CPT 44970

Service-Level Results: Variation Significant Across Regions for Specific Services

$26,000 Difference in Median Prices Regionally for Major Joint Replacement (210%-430% Medicare)



Service-Level Results: Variation Significant Across Providers for Specific Services



Statewide Results: Percent of Medicare Fee Schedule Comparison/Trend, Commercial Payers

Service Type	2012 Avg % Medicare*	2016 Avg % Medicare*	Percentage Point Increase 2012-2016
Inpatient Services (Top 12 By Volume/Price)	**250%** (Range 210%-300%**)	**290%** (Range 260%-330%**)	↑ **40**
Outpatient Services (Top 10 By Volume/Price)	**440%** (Range 210%-1,160%**)	**520%** (Range 250%-1,150%**)	↑ **80**

* Average % Medicare reflects an average of the individual service category averages analyzed for IP and OP.
** Range reflects lowest average % Medicare rate and highest average % Medicare rate across the individual services analyzed.

In 2016, Commercial Payers paid 290% - 520% Medicare rates (IP/OP), and OP rates have increased nearly 80 percentage points

Reducing CO Statewide Price Variation: IP/OP Annual Potential Savings Scenarios, Commercial Payers, 2016

Service Type	Total Current Spend	Median Price (Potential Savings*)	200% Medicare (Potential Savings**)	150% Medicare (Potential Savings**)
Inpatient Services (Top 12 By Volume/Price)	$284 Million	$36 Million	$86 Million	$136 Million
Outpatient Services (Top 10 By Volume/Price)	$59 Million	$13 Million	$36 Million	$42 Million
Total (IP/OP) (rounded to nearest million)	**$343 Million**	**$49 Million**	**$122 Million**	**$178 Million**

*Median Price Potential Savings reflects potential annual statewide savings if all IP/OP payments analyzed that were above the statewide median were paid at the statewide median price. Assumes prices below statewide median remain the same.

**150% and 200% Medicare Potential Savings reflects potential annual statewide savings if all IP/OP payments analyzed were normalized to either 150% or 200% Medicare payments.

Potential Annual Statewide Cost Savings: $49-$178 Million

$178 Million Annual Savings Could Pay For:

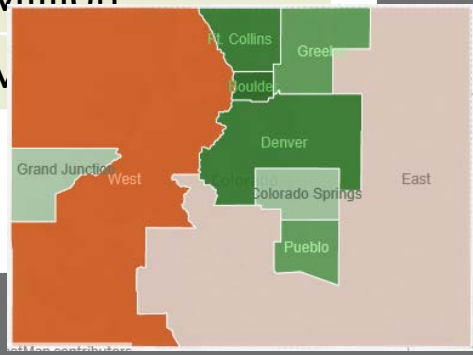
- A 6.4% or $3300 raise for every CO teacher
- Tuition at CU Boulder for 12,000 students
- Affordable housing units for 890 families in need
- 20% of CO's annual road repair budget shortfall

Regional Inpatient Results: Price Comparison, High to Low as % Medicare, 2016

Division of Insurance Region	Median Inpatient Price as % of Medicare	Inpatient Current Spend (Top 12 by Volume/Price)
West	386%	$26.7 Million
East	374%	$4.9 Million
Ft. Collins	354%	$17.8 Million
Grand Junction	347%	$11.6 Million
Greeley	326%	$5.6 Million
Denver	280%	$156.2 Million
Pueblo	278%	$5.8 Million
CO Springs	251%	$21.0 Million
Boulder	242%	$34.7 M

1.6 x Difference

Note: Map included for demonstration of CO Division of Insurance (DOI) Regions only and do not reflect color ranking order per table above.



Regional Cost Savings Analysis, Inpatient: West DOI Region Annual Potential Savings, Commercial Payers, 2016

Service Type	Total West DOI Current Spend	Median Price Potential Savings*	200% Medicare Potential Savings**	150% Medicare Potential Savings**
Inpatient Services (Top 12 By Volume/Price)	$26.7 Million	$8.9 Million	$12.8 Million	$16.3 Million

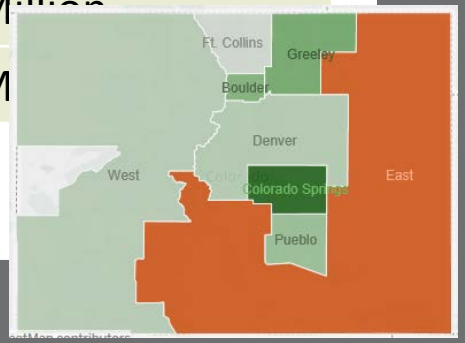
*Median Price Potential Savings reflects potential annual savings for the West DOI region if all Inpatient payments analyzed that were above the statewide median were paid at the statewide median price. Assumes prices below statewide median remain the same.
**150% and 200% Medicare Potential Savings reflects potential annual savings for the West DOI region if all Inpatient payments analyzed were normalized to either 150% or 200% Medicare payments.

Potential Annual Inpatient Cost Savings, West DOI Region: $9-$16 Million

Regional Outpatient Results: Price Comparison, High to Low as % Medicare, 2016

Division of Insurance Region	Median Outpatient Price as % of Medicare	Outpatient Current Spend (Top 12 by Volume/Price)
East	694%	$2.4 Million
West	648%	$6.4 Million
Pueblo	564%	$2.0 Million
Denver	563%	$28.6 Million
Greeley	534%	$1.8 Million
Boulder	495%	$6.8 Million
Ft. Collins	453%	$5.3 Million
Grand Junction	410%	$1.6 M
Colorado Springs	324%	$4.0 M

2.1 x Difference



Note: Map included for demonstration of CO Division of Insurance (DOI) Regions only and do not reflect color ranking order per table above.

Regional Cost Savings Analysis, Outpatient: East DOI Region Annual Potential Savings Scenarios, Commercial Payers, 2016

Service Type	Total East DOI Current Spend	Median Price Potential Savings*	200% Medicare Potential Savings**	150% Medicare Potential Savings**
Outpatient Services (Top 10 By Volume/Price)	$2.4 Million	$990K	$1.7 Million	$1.9 Million

*Median Price Potential Savings reflects potential annual savings for the East DOI region if all Outpatient payments analyzed that were above the statewide median were paid at the statewide median price. Assumes prices below statewide median remain the same.
**150% and 200% Medicare Potential Savings reflects potential annual savings for the East DOI region if all Outpatient payments analyzed were normalized to either 150% or 200% Medicare payments.

Potential Annual Outpatient Cost Savings, East DOI Region: $990K-$1.9 Million

Regional Cost Savings Analysis, IP/OP: Denver DOI Region Annual Potential Savings Scenarios, Commercial Payers, 2016

Service Type	Total Denver DOI Current Spend	Median Price (Potential Savings*)	200% Medicare (Potential Savings**)	150% Medicare (Potential Savings**)
Inpatient Services (Top 12 By Volume/Price)	$156 Million	$16 Million	$45 Million	$72 Million
Outpatient Services (Top 10 By Volume/Price)	$29 Million	$8 Million	$18 Million	$21 Million
Total (IP/OP) (rounded to nearest million)	**$185 Million**	**$24 Million**	**$63 Million**	**$93 Million**

*Median Price Potential Savings reflects potential annual Denver Division of Insurance Region (DOI) savings if all IP/OP payments analyzed that were above the statewide median were paid at the statewide median price. Assumes prices below statewide median remain the same.

**150% and 200% Medicare Potential Savings reflects potential annual Denver Division of Insurance Region (DOI) savings if all IP/OP payments analyzed were normalized to either 150% or 200% Medicare payments.

Potential Annual Denver DOI Savings: $24-$93 Million

Employer Case Study:
Inpatient Annual Potential Savings Scenarios, Commercial Payers, 2016

Service Type	Total Current Spend	Median Price Potential Savings*	200% Medicare Potential Savings**	150% Medicare Potential Savings**	100% Medicare Potential Savings**
Inpatient Services (Top 12 by Volume/Price)	$5.1 Million	$530K	$1.5 Million	$2.4 Million	$3.3 Million

*Median Price Potential Savings reflects potential annual savings for a Colorado Employer if all Inpatient payments analyzed that were above the statewide median were paid at the statewide median price. Assumes prices below statewide median remain the same.
**100%, 150% and 200% Medicare Potential Savings reflects potential annual savings for a Colorado Employer if all Inpatient payments analyzed were normalized to either 100%, 150% or 200% Medicare payments.

Potential Annual Inpatient Savings, Employer Case Study: $530K-$3.3 Million

$45-$275 per person

Questions

Comments

Insights

Contact Info

- Ana English, aenglish@civhc.org
  - President and CEO

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STATE OF MT – RBP INITIATIVE

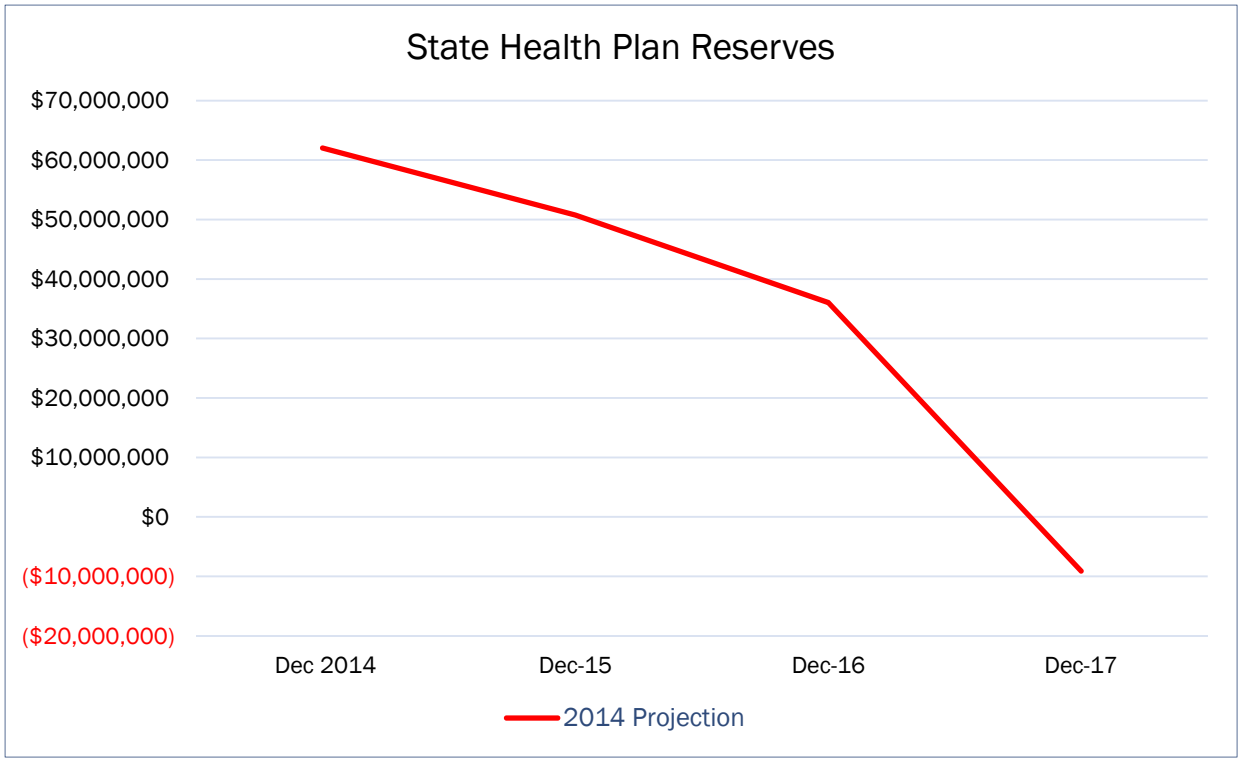
COLORADO BUSINESS GROUP ON HEALTH – JUNE 2018

HCBD
HEALTH CARE
& BENEFITS DIVISION

STATE OF MONTANA EMPLOYEE HEALTH PLAN

- 12,700 Employee Lives; 2,000 Retirees
- 31,000 Total Lives
- Self-Funded Plans for Medical, Dental, RX, Montana Health Centers, Vision
- Largest Self-Funded Plan in Montana

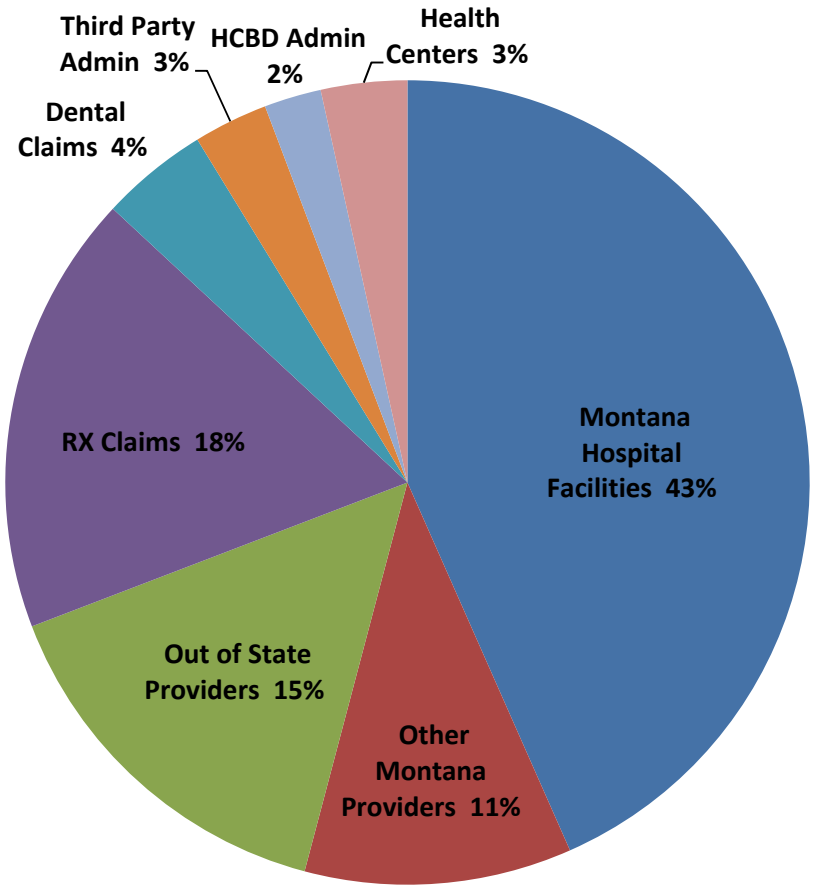
DECEMBER 2014 TURNING POINT



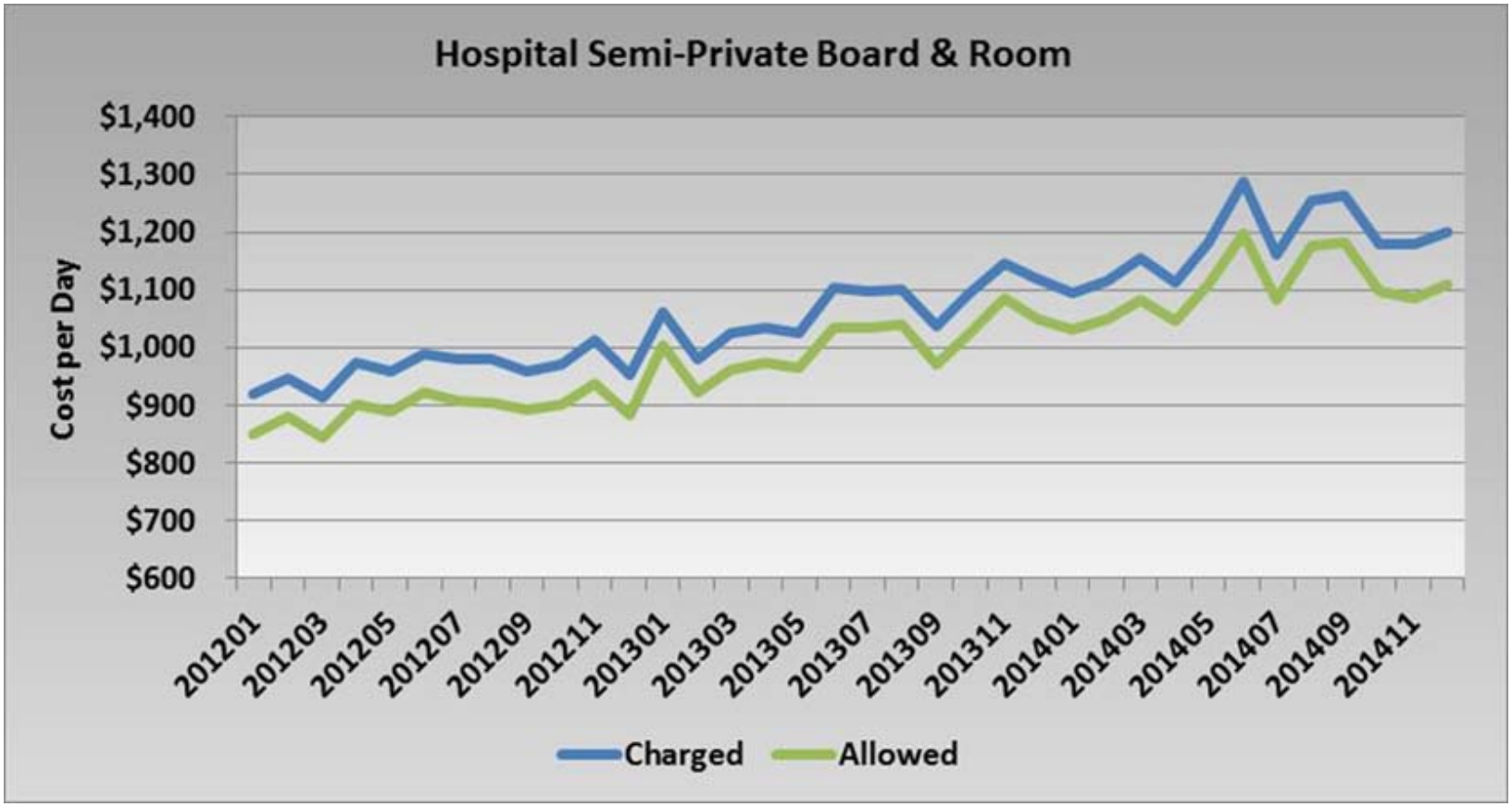
PRESSURES FROM ALL STAKEHOLDERS

- Montana Legislature – Senate Bill 418
- News Media
- Governor's Office
- Vendors and Providers
- Montana Hospitals
- Pharmacy Product through Purchasing Co-Operative
- Plan Members
- Unions
- Our own staff
- Running out of $$$

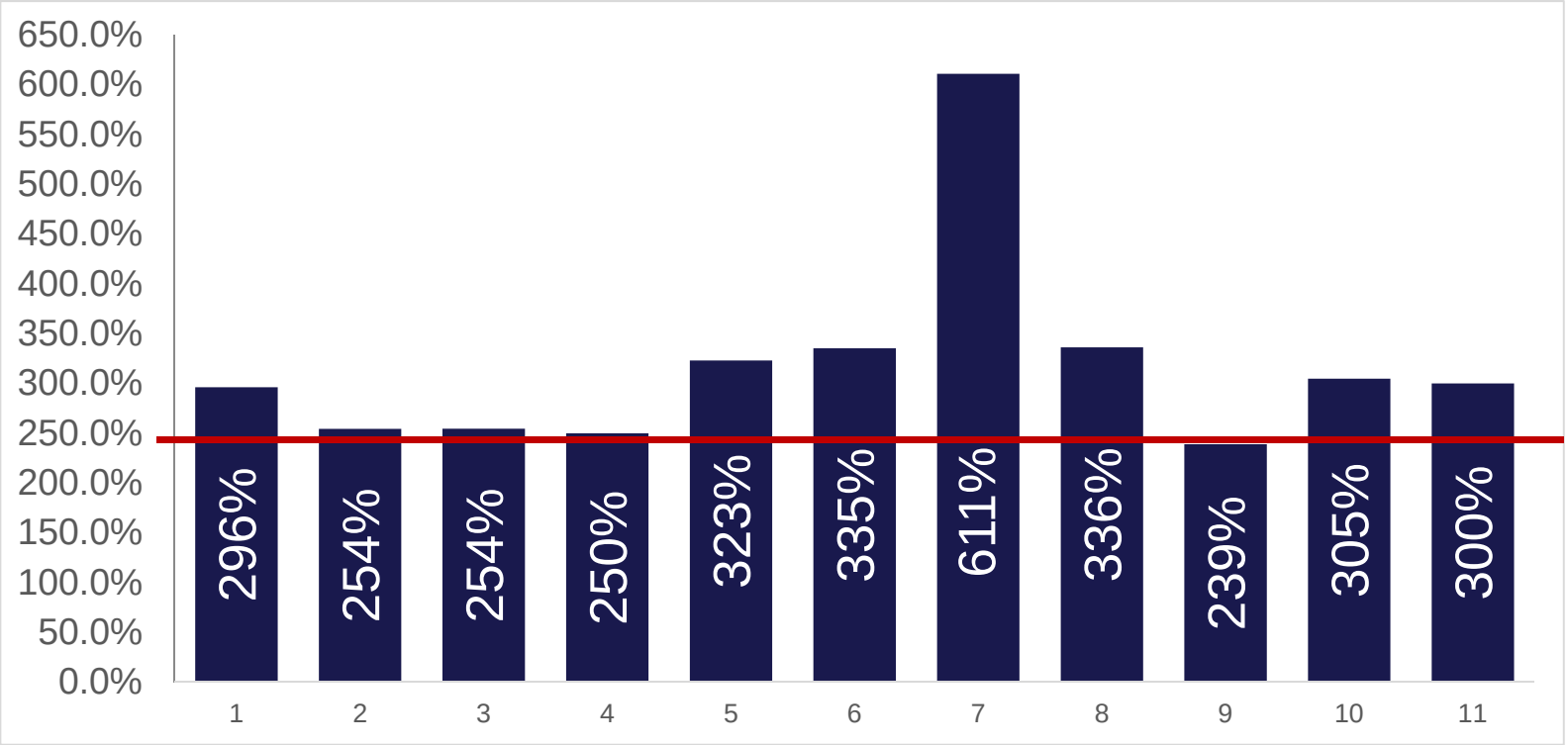
HOW ARE THE PLAN COSTS DISTRIBUTED?



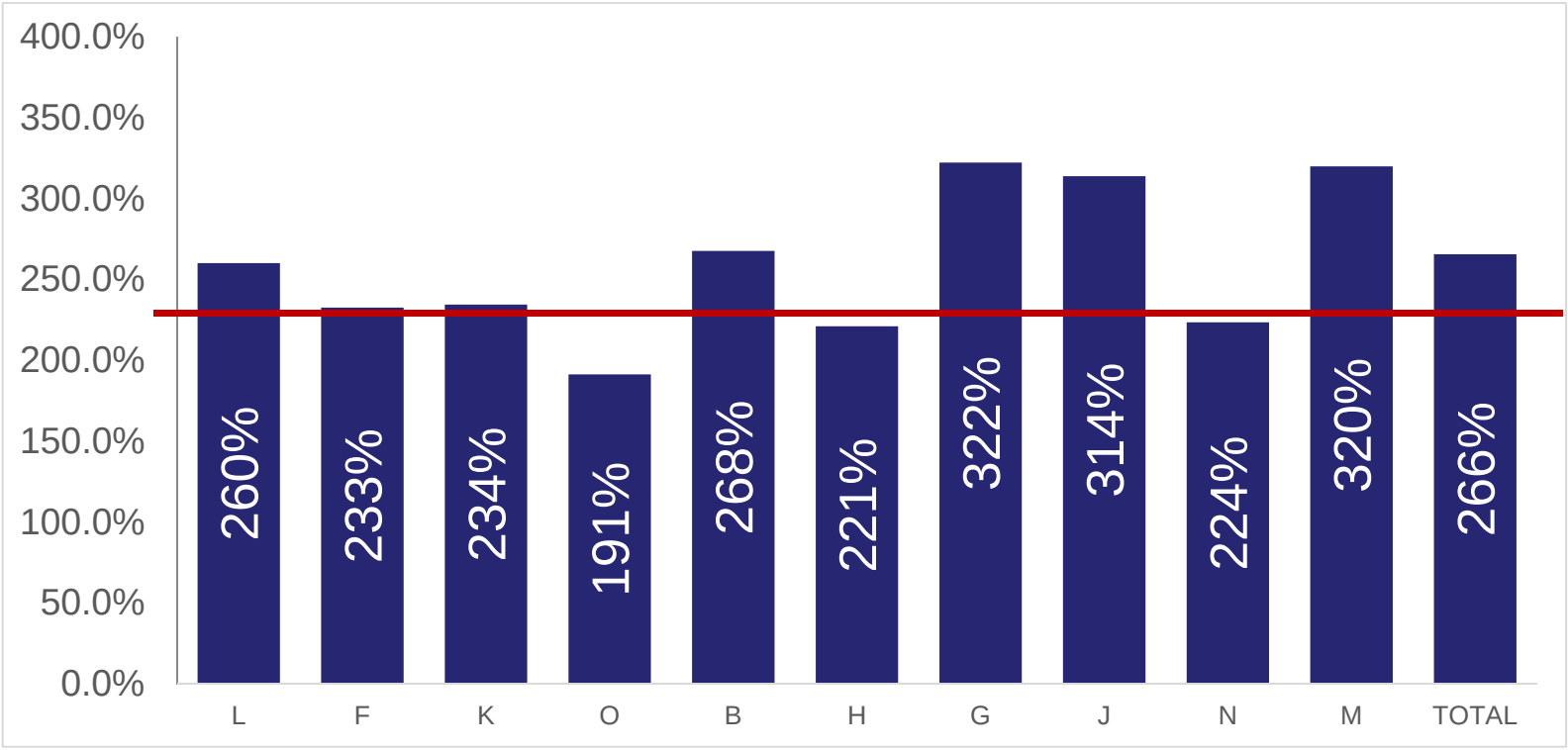
MONTANA HOSPITALS - CHARGE LESS DISCOUNT



OUTPATIENT COST COMPARISON

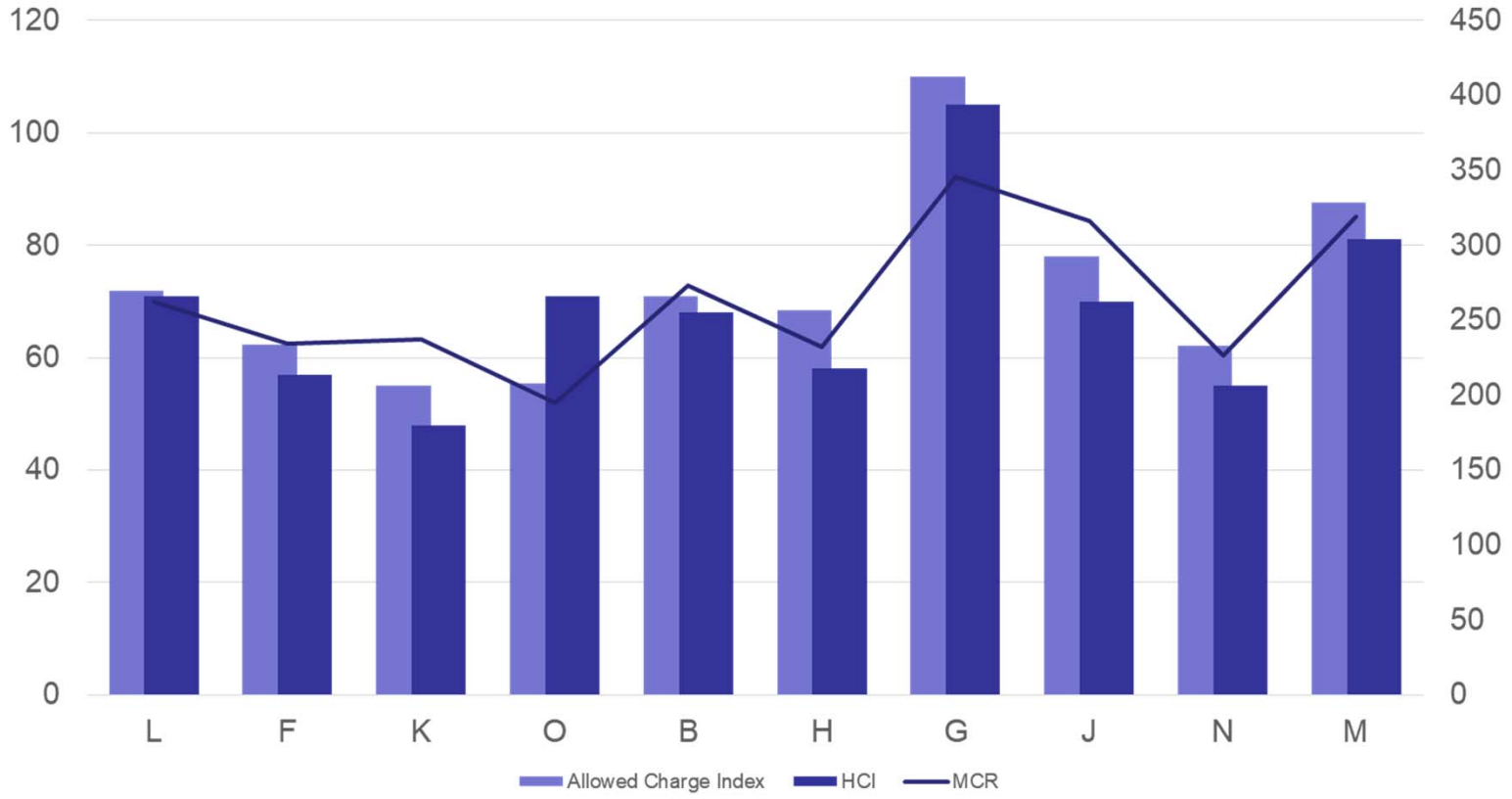


INPATIENT COST COMPARISON

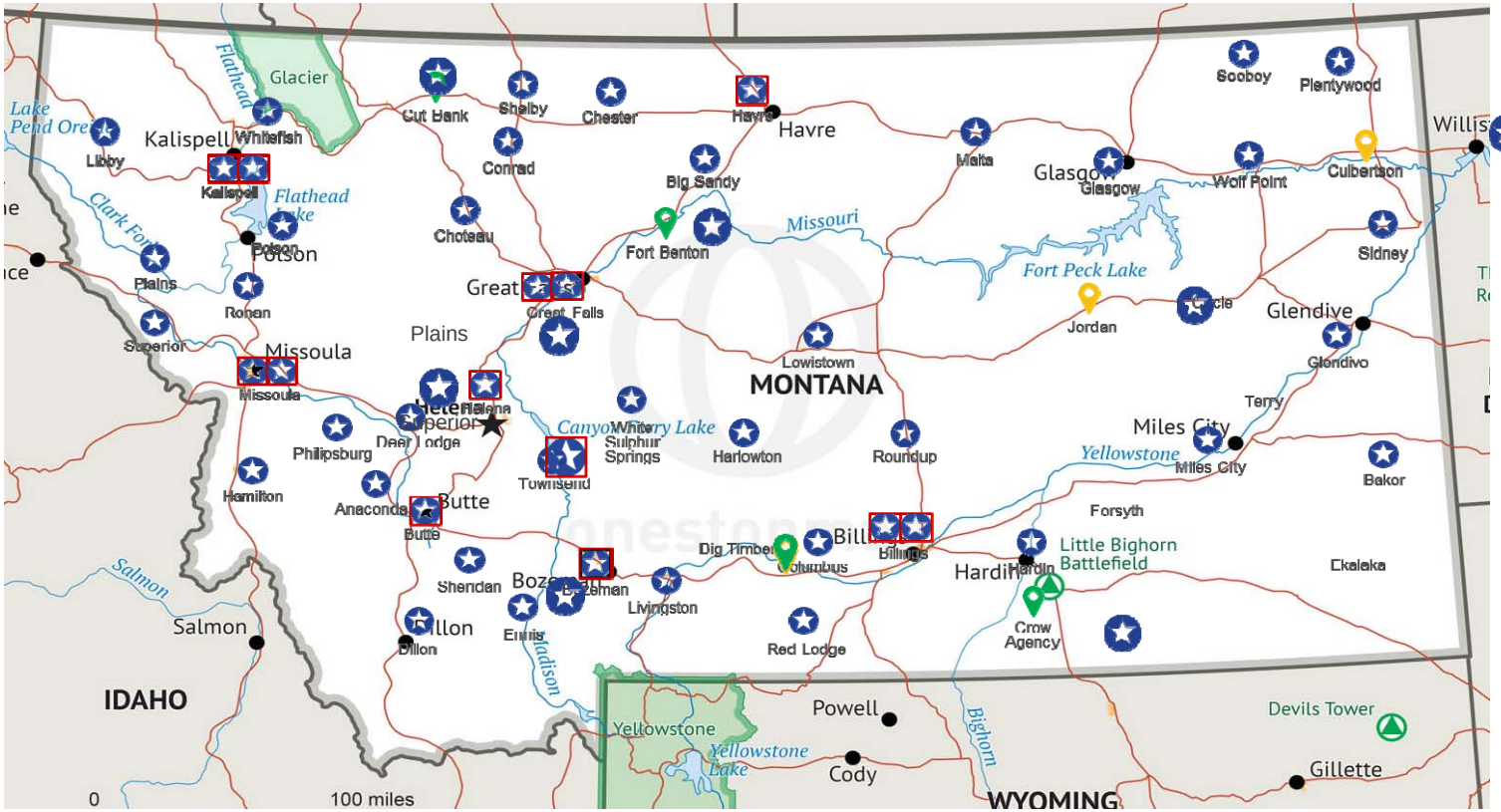


HC BD HEALTH CARE & BENEFITS DIVISION

CLEAVERLY & ASSOCIATES



DISTRIBUTION OF PARTICIPATING PROVIDERS



Signed, PPS

Signed, CAH

Not Signed, CAH

HC BD
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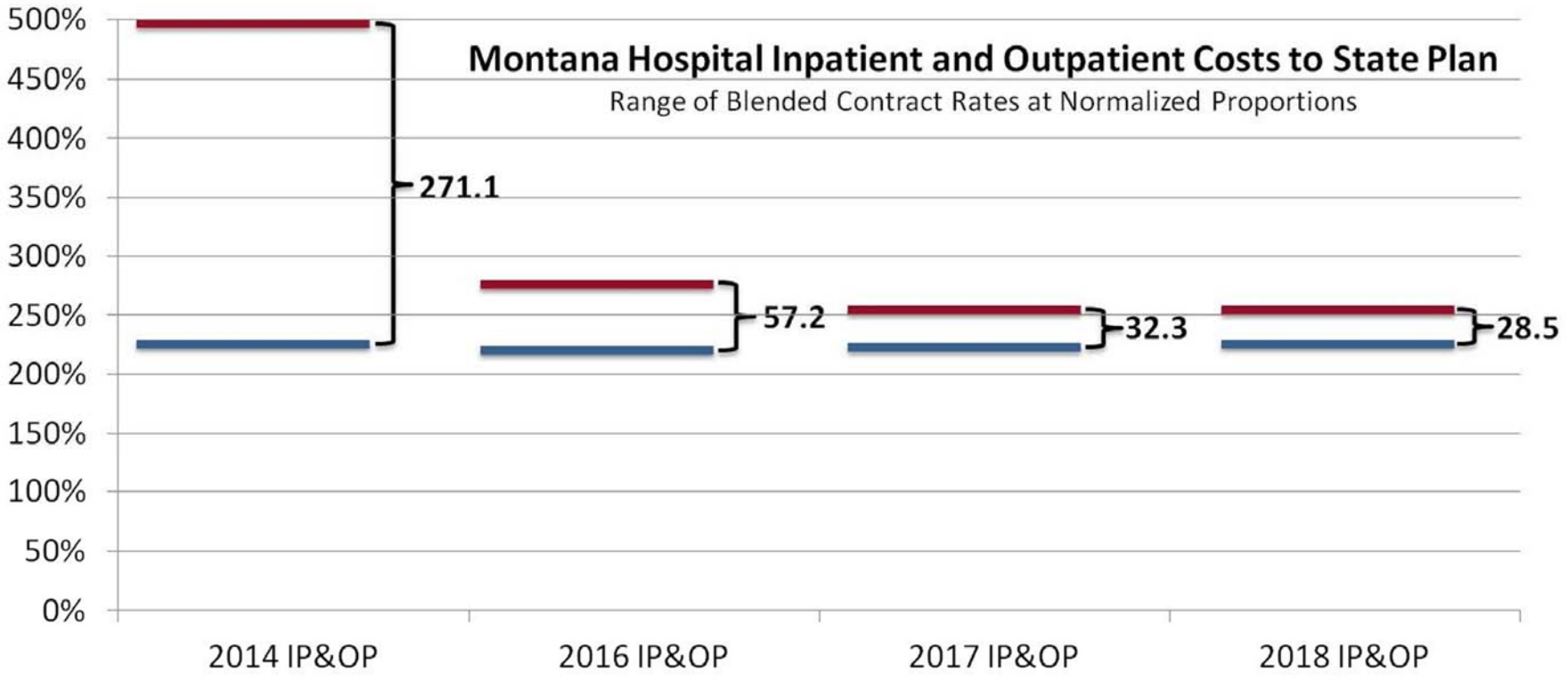
& BENEFITS DIVISION

REFERENCE BASED PRICING



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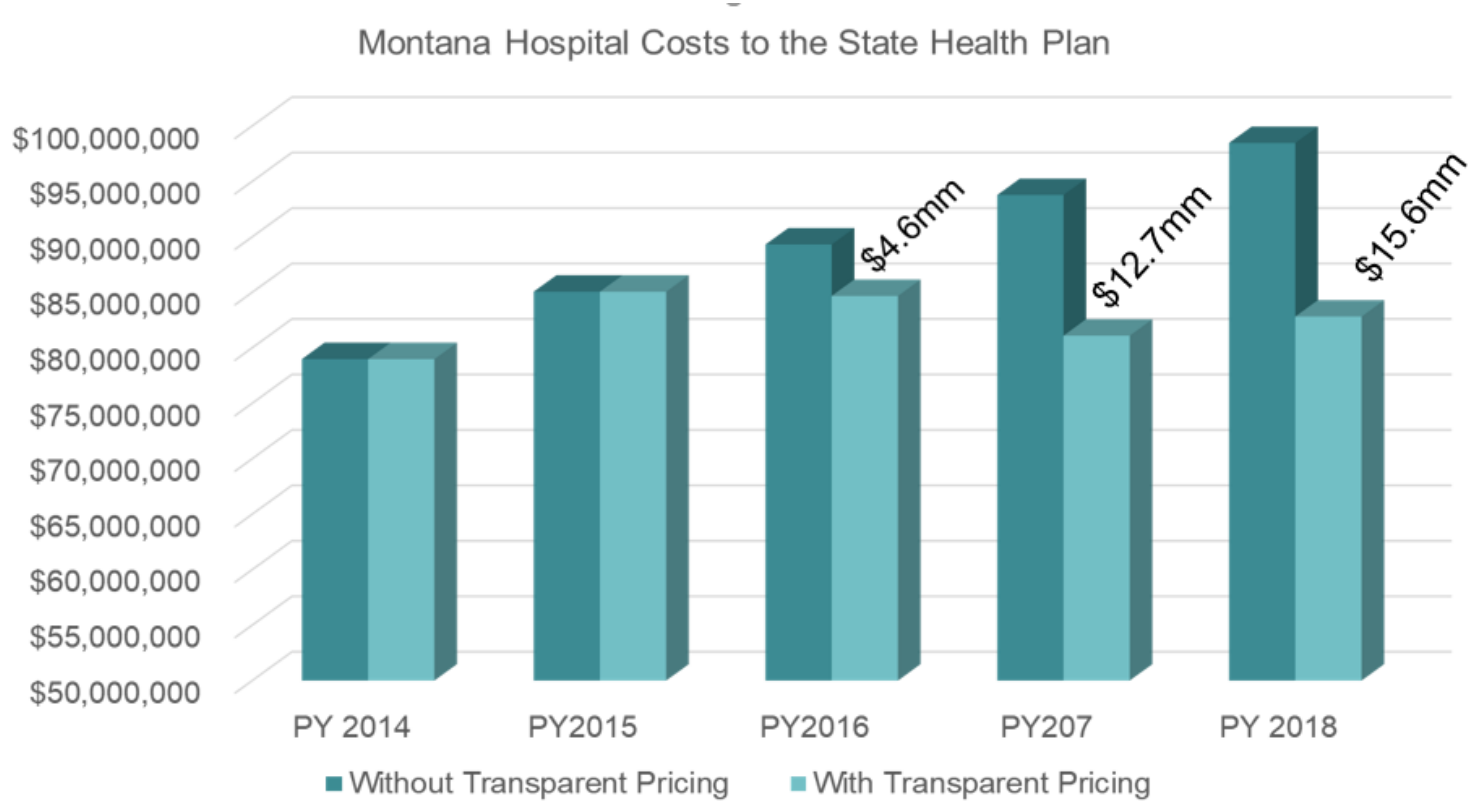
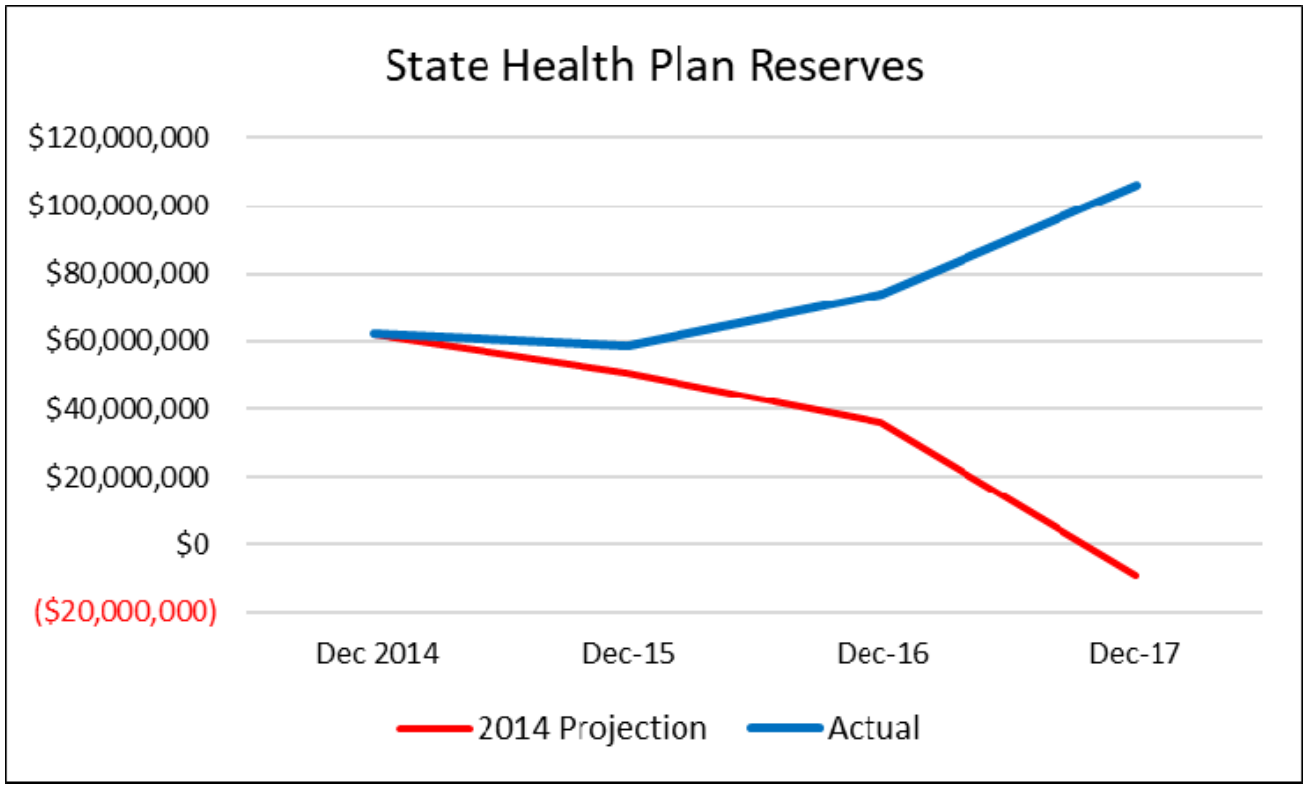
REFERENCE BASED PRICING PROJECTIONS



RESERVE POSITION NOW



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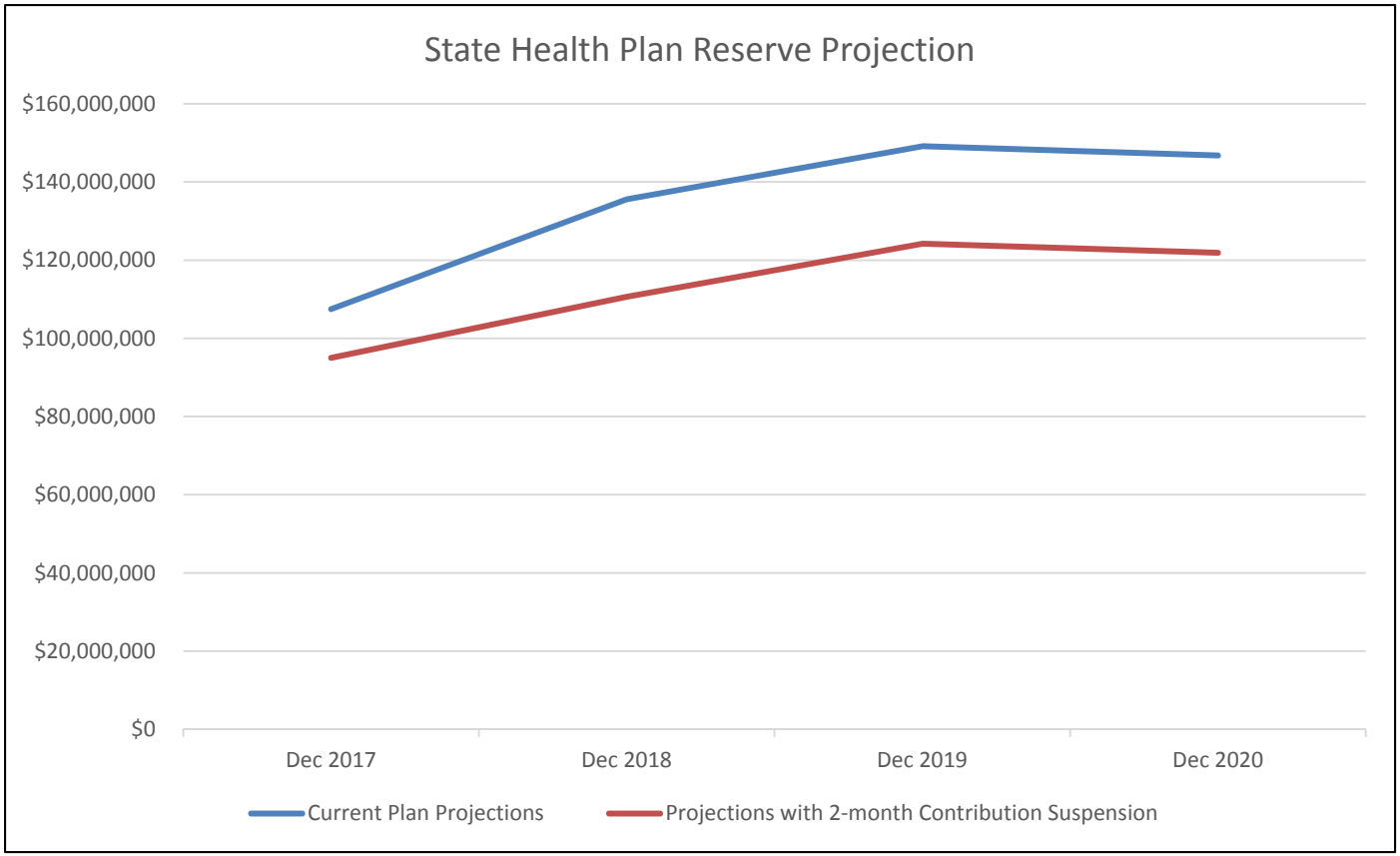
ADDITIONAL EFFORTS

- Transparent Pharmacy Benefit Manager
- Changed TPA
- Benefit Plan Modifications
- Appeals Process Implementation
- On-Site Health Clinics
- 23% Staff Reduction in Benefits Team
- Eliminated Duplicate Programs
- Renegotiated Vendor Fees – 18% to 24% reduction
- Medication Therapy Management Program (Montana Independent Pharmacists and University of MT Pharmacy School

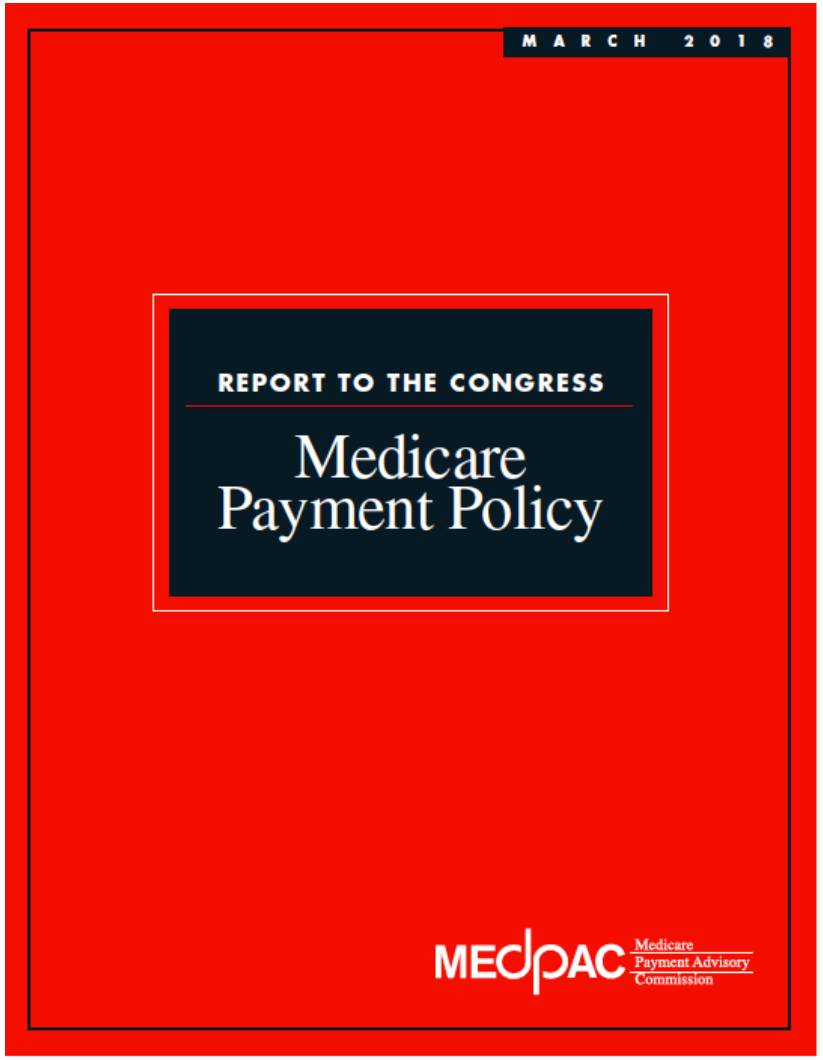
PROJECTIONS



THANK YOU FOR YOUR TIME!

Determining Medical Pricing Reasonableness:

Conclusions & Recommendations



Colorado Business Group on Health
Working Together to Improve Health Care Value

Robert Smith
Executive Director
June 14th, 2018

Conclusions

and Implications for Private Purchasers

1. Meaningfully addressing pricing will require direct employer involvement.

2. Current payment methodologies are significantly flawed:
   - ***Payments as a percent of cost*** originally conceived of to promote expansion.
   - ***Discounted charges*** simply encourages price inflation and consolidation.
   - ***Case rates/DRGs*** directionally sound but should be expanded into "episodes of care" with component pricing referenced to Medicare.

3. Alternative ***methods for using Medicare payment levels*** (perhaps in tandem with market surveys) as a point of reference include:
   - Negotiating payment levels (regardless of payment methodology)
   - Reference-pricing (at the procedure level)

BTW: In the news since last we met…

15 of Colorado's 48 hospitals (31%) are being penalized by CMS for hospital acquired complications.

(Nationally, the rate is 25%.)

NEWS > HEALTH

Flies in operating rooms. A bone fragment on a surgical tool. Colorado hospitals under scrutiny for lapses

Colorado ranks No. 8 on list of states with hospitals facing fines from federal officials over infections

Kathryn Scott, The Denver Post

A surgery at Porter Adventist Hospital in 2015. The Colorado Department of Public Health and Environment recently found problems with how the hospital was cleaning its instruments after surgeries.

By CHRISTOPHER N. OSHER | cosher@denverpost.com | The Denver Post

The Washington Post

Opinions

There's a genuine solution to our health-care problem

By Robert J. Samuelson Columnist April 29 at 7:51 PM

No doubt about it: Health care is a vexing political problem.

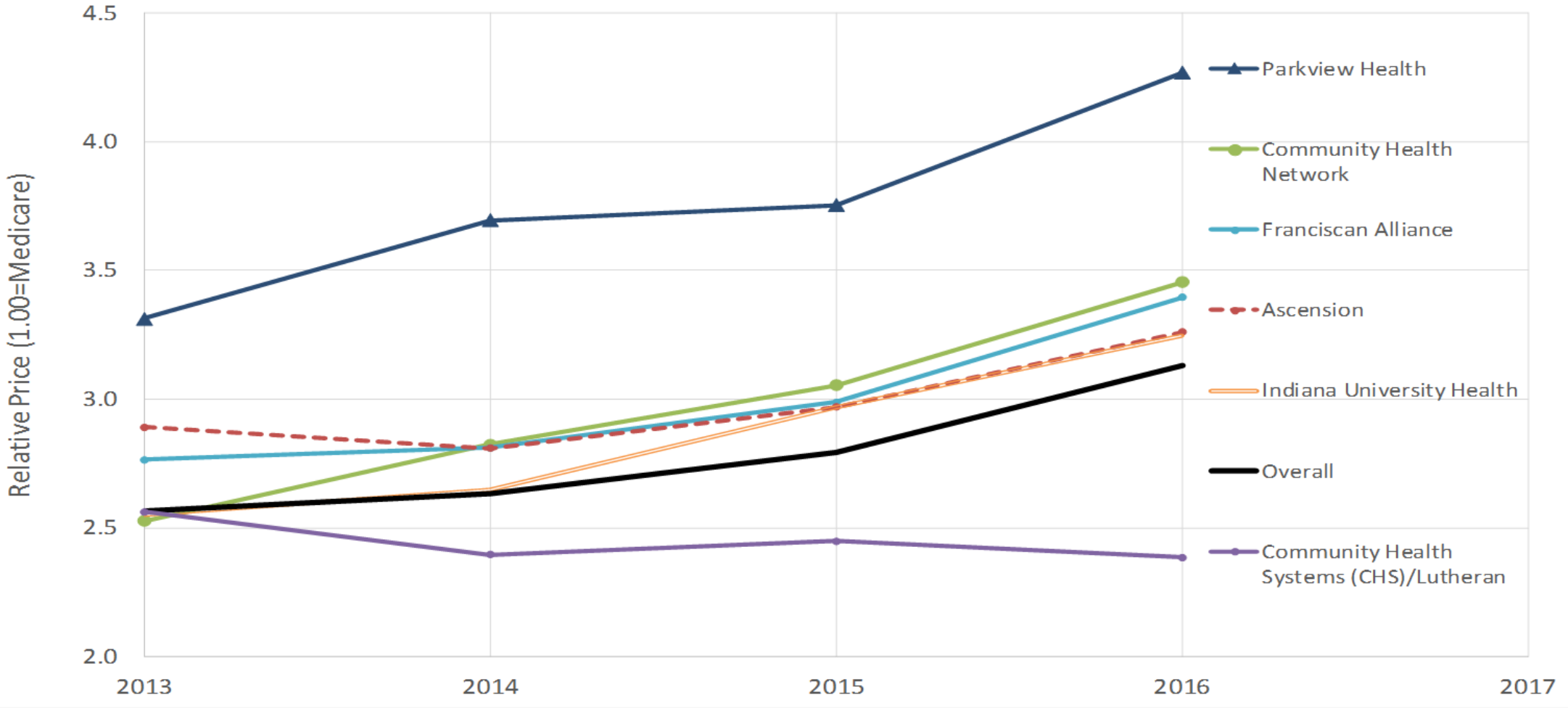
There's a contradiction at the core of our thinking. We want the best care when we or our loved ones get sick. It's a moral issue. There should be no limits on treatment. But the resulting uncontrolled health spending harms the country. It undermines other priorities — higher wages (more labor income gets channeled into health-insurance premiums) and competent government (defense and other programs may be underfunded).

By and large, Americans ignore the contradiction. Presidents and Congresses have wrestled with it for decades without subduing it. The stakes are huge. Collectively, major federal health programs now constitute the budget's largest spending item, more than $1 trillion in 2017, or 26 percent of outlays. In 1990, the comparable figures were $137 billion and 11 percent of outlays. Meanwhile, insurance premiums — often paid by employers — have jumped, as have deductibles.

What can be done?

”We need to slow medical spending and relax the pressure on wages and other government programs. ***The recognition of the huge gap between Medicare and private reimbursement rates creates the opportunity to do that***. We should take it.”

What's Happening in Indiana



What's Happening in Indiana

Post Study Employer Discussions

Employers Take Control: Move away from discounted-charge contracts!!

- Direct negotiations
- Center of Excellence
- On-Site Clinics

Benefits: Move patient volume away from high-priced providers

- Tiered networks
- Reference-based benefits
- Narrow networks

Plan Accountability: Set performance targets for relative prices, with incentives for employers if plan overshoots

Provider Payment: Move toward novel provider contracts

- Percent of Medicare
- ACOs/shared savings with downside risk

Value: Must consider QUALITY in addition to price!

Effective July 1, 2016 in Montana…
Statewide Referenced, Transparent Pricing:

- **Transparent pricing referenced to Medicare designed to…**
  - Control health care costs for citizens and for the State's self-funded plan.
  - Create more transparency, quality, and cost fairness.
- ***State pays a percent of Medicare rates because…***
  - Medicare provides a standard measurement (across all services)
  - It adjusts for differences in hospital locations, size, and the type of patients
  - The process/method is publicly available and transparent.
- **All 10 of largest hospitals; 41 of 48 smaller hospitals are Participate.**
  - For "Non-par" hospitals, State sets a maximum payment
  - Beneficiaries liable for being balance billed.

Because both employer and enrollee function as "Purchasers:"

Recommendations for Value-Based Care

Employers function as…

Wholesale Purchasers

- Contracting/arranging for a network of health care services (thereby establishing incentives)
- Subsidizing premiums and determining benefit designs

Enrollees function as…

Retail Purchasers

- Selecting providers and utilizing services at "point of sale"
- Paying for health services through deductibles and/or copays

Accordingly, value-based health care must address *both purchasing and benefit designs*.

Three Elements of a Multi-Year
Value-Base Purchasing Plan

1. ***Price***. Rather than *negotiating "down"* from hospital charge masters with no apparent ceiling, ***negotiate "up"*** from an empirically based reference point.

2. ***Quality***.
   - Adopt common, multi-payer measure set to determine centers of excellence.
   - Cross-reference pricing to measures as a "***percentile" of the market.***

3. ***Alternative Payment Methods***.
   - ***Care Appropriateness***. Payments should encourage the provision of primary care and discourage overutilization of low-value services.
   - ***Financial Risk***. Put providers at risk for ***the effectiveness and efficiency of their services***, not for the ***acuity of the patients or risk of the population.***

Creating a Glidepath to
Value-Based Benefit Designs

Incentives. Encourage the *use of high value services* such as…

- ***Primary care*** for preventative, routine, and chronic care – particularly providers recognized as "patient centered medical homes."
- ***Low-price providers*** for routine services (in the absence of demonstrably better quality).
- ***Centers of Excellence*** for inpatient care.

Disincentives. Discourage use of low value services such as…

- High-priced sites of care
- Over-used services (e.g., the "Choose Wisely" procedures)
- Free-standing Emergency Departments for non-emergent care

Questions for our panelists:

Based on Today's Presentation…

1. What role could Medicare+ pricing could play in creating a more value-based market in Colorado? (e.g., Instead of negotiating DOWN from charge masters, should we be negotiating UP from Medicare?)

2. What do you see as the barriers? The enablers?

3. If not Medicare+ pricing, would there be a better way to enable purchasers to know how reasonable are the prices they're paying?