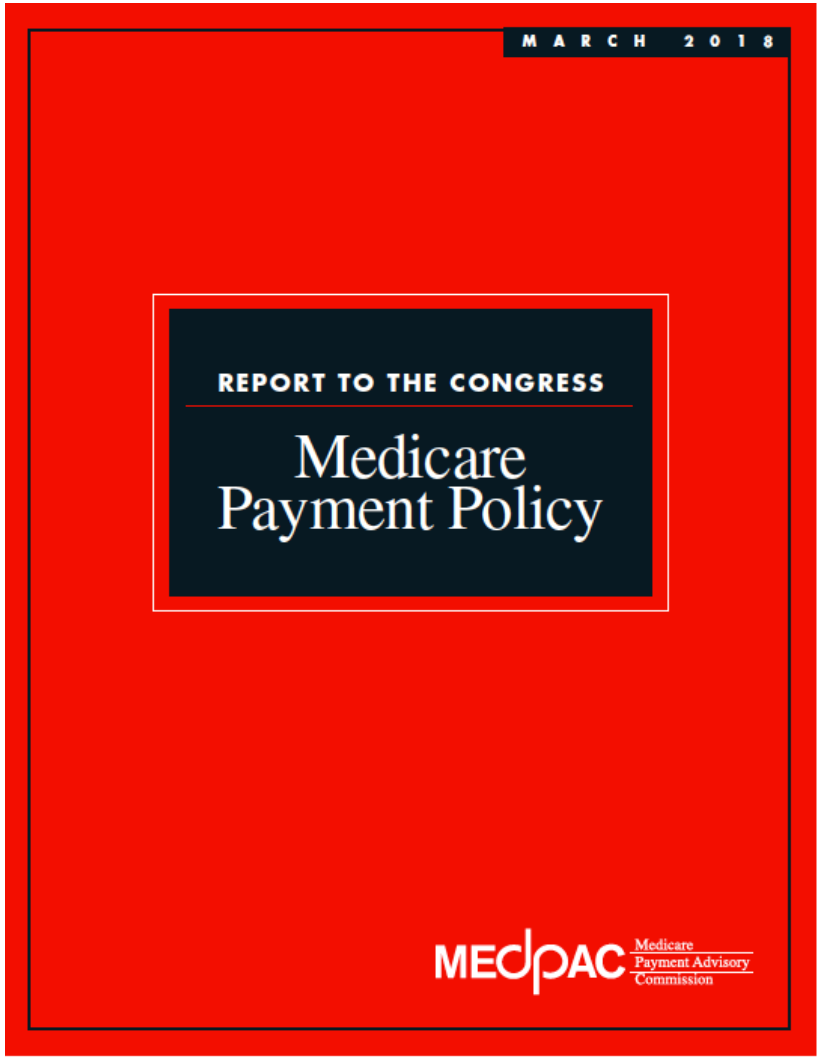
Determining Medical Pricing Reasonableness:

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.

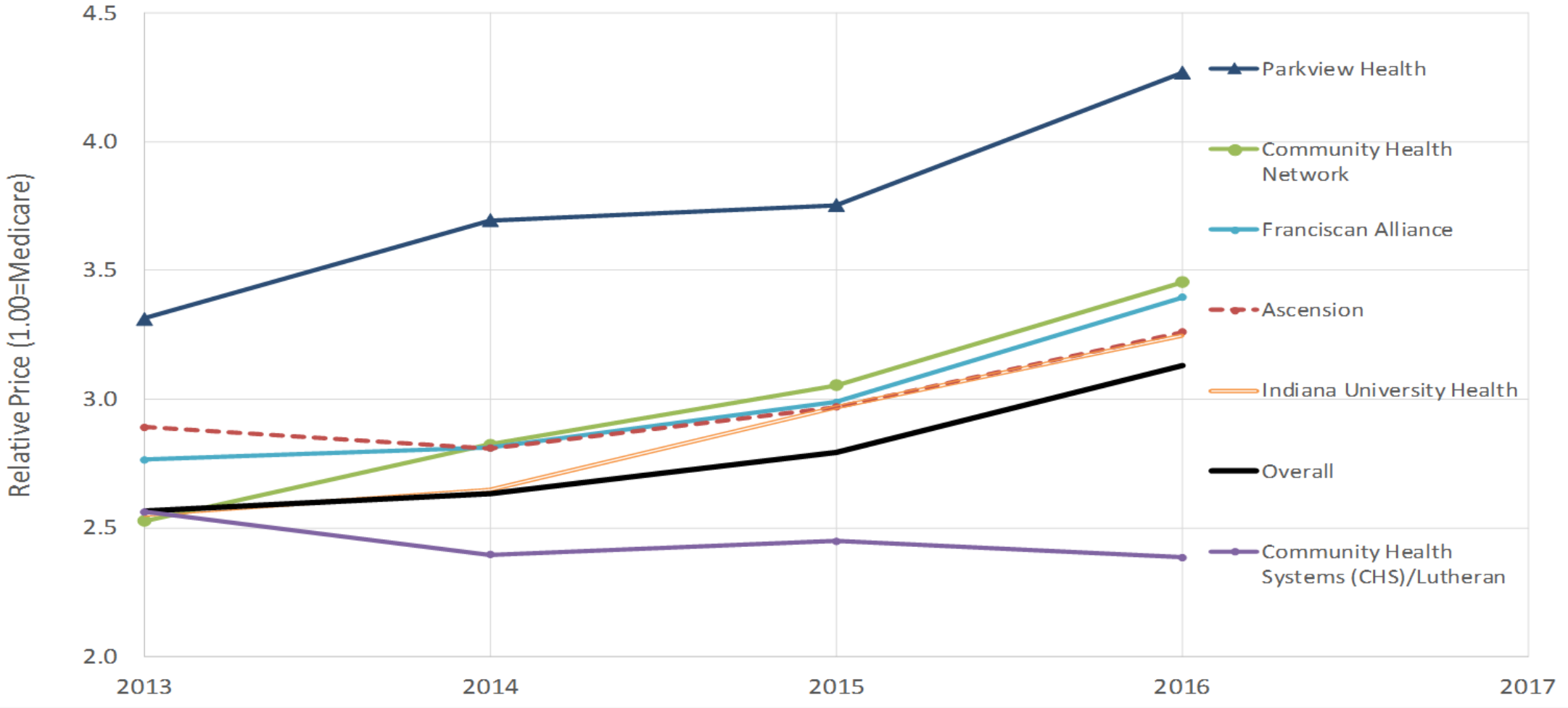
There's a contradiction at the core of our thinking. We want the best care when we or our loved ones get sick. It's a moral issue. There should be no limits on treatment. But the resulting uncontrolled health spending harms the country. It undermines other priorities — higher wages (more labor income 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?