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

**Average Variance** 837%

**EQUIVALENT VARIANCE IN A GALLON OF GAS**

<table>
<thead>
<tr>
<th>Low Price</th>
<th>High Price</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2.20</td>
<td>$18.41</td>
<td>837%</td>
</tr>
</tbody>
</table>

*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*…

**PRICE VARIABILITY FOR COLONOSCOPY (NO BIOPSY)**

<table>
<thead>
<tr>
<th>UNIQUE CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
</tr>
<tr>
<td>$500</td>
</tr>
<tr>
<td>$1000</td>
</tr>
<tr>
<td>$1500</td>
</tr>
<tr>
<td>$2000</td>
</tr>
<tr>
<td>$2500</td>
</tr>
<tr>
<td>$3000</td>
</tr>
<tr>
<td>$4000</td>
</tr>
</tbody>
</table>

TOTAL COST

- PHYSICIAN
- FACILITY
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
"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
“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.

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 its 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 Hospital outpatient services prospective payment system

Medicare OutPatient Payments

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.
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\textsuperscript{rd}s of all hospitals.

• Readmission rates were among the best 2/3\textsuperscript{rd}s of all hospitals.

• Standardized costs per discharge were among the best 2/3\textsuperscript{rd}s 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.”
"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}
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

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
$2.5 billion
31.2%

HCBS Waiver Providers
$895.6 million
11.1%

Nursing Facility & Hospice Providers
$841.6 million
10.5%

Physicians, Clinicians, Specialists and Other Providers
$763.7 million
9.5%

Durable Medical Equipment Providers
$161.4 million
2.0%

Dental Providers
$329.8 million
4.1%

FQHCs and RHCs
$191.9 million
2.4%

Regional Care Collaborative Organizations
$111.1 million
1.3%

Laboratories and x-Ray Providers
$78.4 million
1.0%

Transportation Providers
$45 million
0.6%

Specialty Facilities
$63.3 million
0.8%

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
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.
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

Median Allowed Cost and Utilization, by Provider
470 Major joint replacement or reattachment of lower extremity w/o MCC, All Region(s), Commercial, 2016

$19,000

$57,000

$38,000 Difference in Facility Prices (160%-490% Medicare)
## Statewide Results: Percent of Medicare Fee Schedule Comparison/Trend, Commercial Payers

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

* 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

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

*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

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

**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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Total West DOI Current Spend</th>
<th>Median Price Potential Savings*</th>
<th>200% Medicare Potential Savings**</th>
<th>150% Medicare Potential Savings**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Services</td>
<td>$26.7 Million</td>
<td>$8.9 Million</td>
<td>$12.8 Million</td>
<td>$16.3 Million</td>
</tr>
</tbody>
</table>

*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

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

**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

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

*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

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

*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
• Ana English, aenglish@civhc.org
  – President and CEO

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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

State Health Plan Reserves

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<thead>
<tr>
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<th>Dec 2014</th>
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2014 Projection
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 Hospital Facilities 43%

Out of State Providers 15%

Other Montana Providers 11%

RX Claims 18%

Dental Claims 4%

Third Party Admin 3%

HCBD Admin 2%

Health Centers 3%
MONTANA HOSPITALS - CHARGE LESS DISCOUNT
OUTPATIENT COST COMPARISON
INPATIENT COST COMPARISON

- L: 260%
- F: 233%
- K: 234%
- O: 191%
- B: 268%
- H: 221%
- G: 322%
- J: 314%
- N: 224%
- M: 320%
- TOTAL: 266%
REFERENCE BASED PRICING

Montana Hospital Inpatient and Outpatient Costs to State Plan
Range of Blended Contract Rates at Normalized Proportions

2014 IP&OP
2016 IP&OP
2017 IP&OP
2018 IP&OP

0%
50%
100%
150%
200%
250%
300%
350%
400%
450%
500%

271.1
57.2
32.3
28.5
REFERENCE BASED PRICING PROJECTIONS

Montana Hospital Costs to the State Health Plan

- PY 2014
- PY 2015
- PY 2016:
  - Without Transparent Pricing
  - With Transparent Pricing
  - $4.6nm

- PY 2017:
  - Without Transparent Pricing
  - With Transparent Pricing
  - $12.1nm

- PY 2018:
  - Without Transparent Pricing
  - With Transparent Pricing
  - $15.6nm

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HCBD
HEALTH CARE
& BENEFITS DIVISION
RESERVE POSITION NOW

State Health Plan Reserves

- 2014 Projection
- Actual

Dec 2014 | Dec-15 | Dec-16 | Dec-17

$120,000,000 | $100,000,000 | $80,000,000 | $60,000,000 | $40,000,000 | $20,000,000 | $0

($20,000,000)
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

State Health Plan Reserve Projection

- Current Plan Projections
- Projections with 2-month Contribution Suspension
THANK YOU FOR YOUR TIME!
Determining Medical Pricing Reasonableness:
Conclusions & Recommendations

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%.)
"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."

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’s Happening in Indiana
## What’s Happening in Indiana

### Post Study Employer Discussions

<table>
<thead>
<tr>
<th>Employers Take Control: Move away from discounted-charge contracts!!</th>
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<td>Direct negotiations</td>
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### 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?