

HJR 20 SUBCOMMITTEE REPORT TO CFHHS INTERIM COMMITTEE

Meeting January 17, 2018

Prepared by Rep. Kathy Kelker, HJR 20 Subcommittee Presiding Officer

Remaining Meeting Topics and Schedule

The January 17th Meeting of the HJR 20 Subcommittee replaced the canceled meeting originally scheduled for November 16th. Only one more meeting was scheduled (March 21st) before the subcommittee would present its findings and recommendations on May 14th. Senator Caferro suggested that the subcommittee consider having an additional meeting so that there would be more time to prepare recommendations. Prior to the January 17th meeting, Sue O'Connell polled the subcommittee members concerning possible dates for an additional meeting. The poll showed that Friday, February 16, was the date when most of the subcommittee members could attend.

With the additional meeting, the remainder of the work for the subcommittee will include the following:

February 16

Panel: What do consumers want and need to know?

Demonstrations: Transparency Tools from Montana Hospital Association and Blue Cross Blue Shield

Presentation: Montana Health Information Exchange

The Health Information Exchange of Montana is a unified electronic health record that consolidates patient data from different treatment settings into a single source. The HIEM encompasses six hospitals and 25 clinics, including the Northwest Healthcare system, covering 45,000 square miles in Montana.

Study: Review of medical bill formats

March 21

Panels: What are other states doing to provide health care transparency?

What role should Montana play in health care transparency?

Presentation: Montana's System for Handling Medical Malpractice Cases

Committee Discussion of Findings and Recommendations

Topic Terminology

For the January 17th meeting, there were two Topic Terminology papers, one for Reimbursement and Pricing and another for Model Cost Reduction Programs. In the reimbursement/pricing glossary, Rep. Kelker suggested that the last sentence should be crossed out in the definition of *Cost-to-Charge Ratio*. Cost-to-Charge Ratio is the ratio of a hospital's costs for a service to what they charge for the service. This term is usually applied to Medicare. CMS allows hospitals to charge more than the actual cost of service in order to account for their overhead costs. Rep. Kelker also took a few minutes to highlight or clarify eight definitions in the cost reduction programs glossary: high-cost patients, medical guidelines, medical home, patient pricing

education, population health, reference-based pricing, transparency in health care pricing, and value-based pricing.

Discussion of Pre-Meeting Reading Materials

Josh Poulette, Fiscal Analyst, led a discussion of the reading materials for this meeting.

1. **Feldstein, Chapter 2—How Much Should We Spend on Medical Care?** The United States spends more on medical care than does any other country—17.2 percent of its gross domestic product (2013). Feldstein suggested that American consumers of health care are “sovereign” in that they get to make choices in health care without being concerned about cost. Those who have insurance rely on their insurers or the government to fund the care they want. Feldstein says: *Naturally, the public would like to pay lower insurance premiums and out-of-pocket costs and still have unlimited access to health care and to the latest medical technology. As in other sectors of the economy, however, choices must be made.*
2. **A Way Forward for Bipartisan Health Reform?** This study of health care policy goals shows that state legislators who are Republicans are interested in reducing individual costs and costs for payers while Democrats focus on improving health, increasing access, and reducing disparities in health outcomes. Both parties, however, agree on the need to reduce costs and educate consumers.
3. **Singapore Healthcare.** p. 1—*Singapore teaches us that patients must understand that health services cost money and that they should pay a portion of those costs. It teaches us that hospital and doctor incentives must encourage them to provide the best service at the best price. Government can create a framework of rules that does that. And it does not have to be a cold-hearted solution. The framework must also assure that people have the ability to pay, and it must provide a safety net for those who also assure that people have the ability to pay, and it must provide a safety net for those who cannot. Lastly, all health costs and outcomes should be transparent to the patient and the payer.*
4. **Montana Health Care Innovation Plan.** The Governor’s Council on Health Care Innovation and Reform studied the following topics as areas that may reduce medical costs and provide better outcomes:
 - Montana Health Care Innovation Plan
 - Population Health
 - Behavioral Health and Chronic Disease
 - American Indian Health Status
 - Delivery Systems
 - ECHO-Enhanced Collaborative Care
 - Community Resource Teams
 - Medicaid Health Homes
 - Value-Based Payment
 - Collaborative Care
 - Community Resource Team Model
 - Health IT
 - Health Information Exchange

Presentation: Introduction to Reimbursement and Pricing. Steve Loveless, Chief Executive Officer of St. Vincent Healthcare and Regional Manager of SCL Health (Holy Rosary, St. James, and St. Vincent Healthcare), introduced the subject of health care pricing and reimbursement by explaining that American health care is in the middle of significant shift in focus from a segmented group of services to coordinated care. This move is occurring for two major reasons: 1) coordinated care produces better outcomes for patients, and 2) coordinated care is more efficient and therefore potentially less expensive.

Panel: Health Care Reimbursement and Pricing. The subcommittee heard from a distinguished group of experts about how reimbursement and pricing affect cost to the payers and patients.

- Kirk Bodlovic, Regional Chief Financial Officer, Providence Health & Services
- Jesse Laslovich, Vice President of Network Development, St. James Healthcare, Butte
- John Church, Health Care Consultant, Fresno (via telephone)
- Mary Dalton, Former State Medicaid Director

PANEL QUESTIONS

1. What is your payer mix—self-pay, commercial insurance, Blue Cross/Blue Shield, CHAMPUS, Indian Public Health, Worker’s Compensation, Medicaid, and Medicare?

The hospital representatives indicated that the percentage of patients paying through government programs (Medicaid, Medicare) is growing and becoming a larger percentage of the payer mix (40% to 60%). They also noted that high-deductible insurance policies (catastrophic plans) are becoming more common because of their lower premiums.

2. Which reimbursements cover the actual cost of services? The payments from private insurance come closest to paying the actual cost of service plus overhead.

3. How are reimbursement rates set? Government reimbursements are set by allocations from Congress and state legislatures and administered by the Centers for Medicare and Medicaid Services. Reimbursement from private insurance companies are determined by contracts between the providers and the companies. These contracts vary from company to company.

4. How do contracts between insurers and health care providers affect reimbursements to providers? Cost of insurance premiums? The health insurers bargain with the providers with the goal of gaining an array of high-quality services at a reasonable price. Insurance premiums go up because of increases in pharmaceutical costs, new treatments and technology, and inflation in the cost of supplies and labor.

5. How do government reimbursement rates affect private insurer rates? Because the reimbursements from government programs cover only part of the actual cost, health care providers must charge more to private-pay patients in order to cover all of their costs.

6. How are prices set? What is included in a price? The following are considerations in setting health care prices:

- What is the payer source?
- What is the plan within the payer source?
- Is there co-insurance?
- What is the deductible/is it met?
- Is the patient in or out of network?
- Is the provider employed or independent?
- Is the provider in or out of network?
- What are the patient health problems?
- What are the provider preferences for this procedure or treatment?
- Is what was anticipated in the intervention what actually occurred? Did something else need to be done?
- What is involved in the patient's recovery?

7. Why do patients pay different prices for the same health care services? Patients pay different prices depending on whether they have private or government insurance or are self-pay. Mary Dalton, the former Montana Medicaid director, was able to provide historical information about how Medicaid has changed over time, starting first with people with disabilities, adding pregnant women and children, and finally including low income able-bodied adults who do not have employer-based insurance or any other source of insurance.

Panel: Model Cost Reduction Programs

- Pam Palagi, Vice President of Finance, St. James Healthcare, Butte
- Dr. Monica Berner, President, Blue Cross Blue Shield of Montana
- Scott Malloy, Senior Program Officer, Montana Healthcare Foundation
- Todd Lovshin, Vice President/Montana Regional Director, PacificSource Health Plans

PANEL QUESTIONS

1. What are some of the most cost-effective clinical delivery models? Where are they being implemented in Montana? American health care is in the midst of a dramatic shift away from fee-for-service to payment based on outcome and coordination of care. In the older model, physicians and other health care providers were paid for each service they provided. This process led to physicians doing more tests and procedures than were necessary to treat the patient. In the new model, providers are paid for coordinating care and being efficient in providing high-quality services that lead to better outcomes and fewer complications for patients. The addition of behavioral health to the array of services at the primary care level is showing benefits in patient compliance with treatment plans and more referrals for treatment of addictions or mental illnesses. Below is a sample of new processes being implemented throughout Montana:

- Integration of behavioral health with physical health
- Bundled payment
- Coordinated care
- Evidence-based medicine

- Patient-Centered Medical Home
- Population health
- Referenced-based pricing
- Use of mid-level professionals and medical assistants (EMTs, CNAs)
- Tele-medicine
- Value-based pricing
- Wellness services

2. Health care delivered by specialists is more expensive. Are there ways to reduce cost by utilizing primary care physicians more effectively?

Many health problems can be treated effectively at the level of primary care. Primary care physicians can assist patients with accessing specialists only when they are needed.

3. Does having health care networks—providers, critical access hospitals, major hospitals—have potential for reducing costs to consumers? Having networks among various levels of health care can be an efficient model because most of the care can be provided at the lowest level by primary care physicians and mid-level professionals. Having more advanced levels in networks allows patients to get specialized care from physicians who have the records from the lower level professionals. In this way, duplication of tests and procedures can be avoided.

4. Chronic care is the costliest type of health care. What measures can be taken to reduce these costs while maintaining quality? Patients with chronic disorders like diabetes, asthma, and heart trouble can benefit from regular contact with medical providers, but those encounters do not always have to be with a physician. Costs can be reduced if the patient is assisted with compliance with a health plan that is monitored by lower level health care providers.

5. How does coordination of care reduce the costs for consumers? Coordination of care is more efficient because several health care providers share information and determine what care is needed. This process gives the patient comprehensive treatment without having separate providers repeating tests or procedures.

6. Can health care providers become more efficient in utilizing staff, equipment and processes and reduce costs to consumers? Yes, in the model of coordinated care, health care providers are becoming much more careful about suggesting expensive testing (MRI, PET scan) unless those tests are actually needed to diagnose or treat the patient.

7. How do new medical technology and drugs increase the prices of health care? New technology (robotic surgery, more effective scans) is extremely expensive when purchased. Health care providers have to add these costs to pricing as overhead. Drug prices are difficult to control because prices are set by manufacturers and wholesalers. Private insurers and government insurers negotiate for formularies with lower prices, but costs are still higher in the United States than in other advanced countries.

8. What roles does advertising of new drugs and medical technologies play in increasing health care costs? New medications are heavily advertised by American media. Generally, new drugs are much more expensive than existing medicines. Consumers sometimes demand to have

the new drugs when that choice might not be the best for their health. A few states have banned or curtailed advertising of medications.

9. What effect do administrative costs for processing insurance claims have on the price of health care? Are there ways to reduce processing costs? About 20% of the cost of health care in the United States can be attributed to the processing of medical bills. Every health care provider has to have staff whose job it is to determine how patients' insurance will cover treatments, procedures, and medications. In countries where there is a single payer, all pricing is the same and regulated by the government, so there isn't nearly as much money spent on sending out bills and collecting payments.

10. What is the relationship between prices for health care and quality of health care? Several studies have shown that higher cost does not necessarily produce better outcomes. In fact, sometimes the lowest-cost provider has the best outcomes.

The implementation of coordinated care instead of fee-for-service presents a need for consumers of health care to set aside myths when making health choices. These myths include: more treatment is always better, more expensive treatment is always best, amenities matter more than good care, there is no free choice, there is no such thing as a fixed medical price, and there is no standardization for medical billing.

Key Points to Share with Interim Committee

- Health care consumers can mean patients and payers
- Transparency tools exist in Montana, but they may not include all the information that patients need; it may be wise to invest in information and tools to help people make optimal choices for themselves and the system as a whole
- Evidence in favor of transparency tools is not there yet; alternatives to educate patients exist
- Transparency in cost of care should be comprehensive, including travel, rehabilitation
- Data about health outcomes needs to be transparent
- As the overall health care model is changing, patients need to be incentivized to make choices based on cost and quality of outcomes
- Health care providers need to be rewarded for good outcomes and coordinated care
- Promising health care management models exist and are evolving in Montana
- The state employee health plan is focused on cost containment and quality of care; chronic care management is important in bringing down costs and achieving better outcomes
- In Montana, there is already lots of collaboration between payers and providers
- The public would like to pay **lower insurance premiums** and **out-of-pocket costs** and still have **unlimited access to health care and to the latest medical technology**. But choices must be made.
- Need to listen to the consumer (patient) voice
- Health systems will vary at the local level; communities should do local assessments to determine what works in their areas

- Managing the care of “high-utilizers” can lower overall costs; Comprehensive Primary Care Plus (CPC+) is being used by Billings Clinic to manage behavior of high utilizers; for example, there is no co-payment for going to express care, the lowest level of care.
- At the local level, make use of a variety of providers, including home health care, EMTs, visiting nurses as well as primary care physicians
- Patients are more likely to comply with treatment plans if there is a strong relationship between the health care provider and patient
- Any transparency proposal should include all health plans, from employer-based to self-funded plans and multiple employer welfare arrangements
- The state should avoid putting licensing or other restrictions on people who can provide the appropriate care at the appropriate level
- There may be a need for tools to help people understand their health care choices and treatment

What can the Legislature do?

- Require a state plan for health care transparency in pricing
- Also provide transparency in medical costs; DPHHS could take the lead on this with the government programs the Department oversees.
- Premium dollars should be made available to community care organizations
- Encourage transparency at the primary care level; physicians should provide information about the cost of prescription options; more information = better outcomes

Is the medical community taking on more social responsibility?

- Many state human service programs impact health (and vice versus)
- Many innovations can occur outside of mandates
- Medical bills should include a broad set of actors instead of separate bills from each participant
- It is important at the state level to collect data and sort out and share relevant data to allow cross-comparisons; the Montana Health Information Exchange may serve this purpose

Before the next meeting, the subcommittee will receive examples of state laws dealing with transparency in health care pricing.