# Determining the Value of Hospital Services: The Colorado Experience

*”Management is doing things right.*
*Leadership is doing the right things.”*

*Peter Drucker*

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

## Employers Forum of Indiana

**Robert Smith, MBA**
**CBGH Executive Director**
**July 31st, 2019**

# Topics/Discussion

- Why healthcare may be THE socio-economic issue or our time.
- The Centrality of the Problem of Hospital Value
- Colorado Activity
  - 2019 Colorado Hospital Value Report
  - Legislative Activity
  - Summit County
  - Implementing a Statewide Purchasing Alliance
- A question for employers

# About CBGH

An employer-led, multi-purchaser 501c3 committed to ***value-based health care*** through collaboration on:

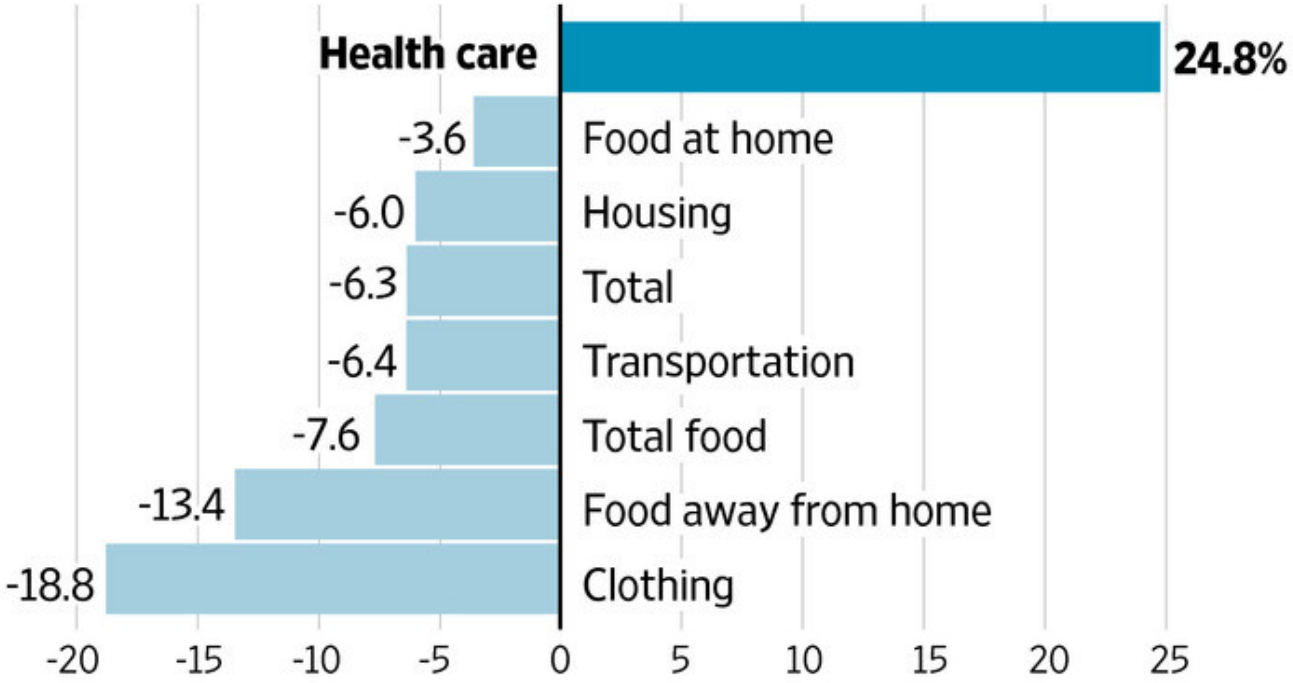
- Quality and price transparency.
- Reference-based contracting/pricing.
- Alternative payment methods (e.g., *pay for value vs pay for volume*).
- Common provider performance measures.
- Benefit designs that incentivize consumer engagement and use of high value services.

CBGH works with national and regional health leaders and employer coalitions.

## A Bigger Bite

Middle-class families' spending on health care has increased 25% since 2007. Other basic needs, such as clothing and food, have decreased.

**Percent change in middle-income households' spending on basic needs** (2007 to 2014)




Sources: Brookings Institution analysis of Consumer Expenditure Survey, Labor Department

THE WALL STREET JOURNAL.

Nationally…

*"Twenty years of wage stagnation on the middle class has been 95% caused by exploding healthcare costs.."*

- Wall Street Journal

In Colorado…

*"Family incomes rose 21% between 2000 and 2016, but family out-of-pocket health care costs rose 70 percent."*

- Bell Policy Center

# Edging Out Salary Growth & Economic Development

Opinions

## Where did our raises go? To health care.


Personal finances, budgeting, living paycheck to paycheck. (Mark Jensen/Istock)

By **Robert J. Samuelson**
Columnist
September 2

It's wages vs. health benefits. On this Labor Day, just about everything seems to be going right for typical American workers, with the glaring and puzzling exception of wage stagnation. The unemployment rate is 3.9 percent, near its lowest since 2000. The number of new jobs exceeds the peak in 2008 by about 11 million. Then there's wage stagnation.

Corrected for inflation, wages are up a scant 2 percent since January 2015, according to the Bureau of Labor Statistics. The gain is roughly one-half of 1 percent annually. Little wonder that many workers feel they're not getting ahead. They aren't.

2003 Economist Ewe Reinhardt et al

# "It's the Prices, Stupid"

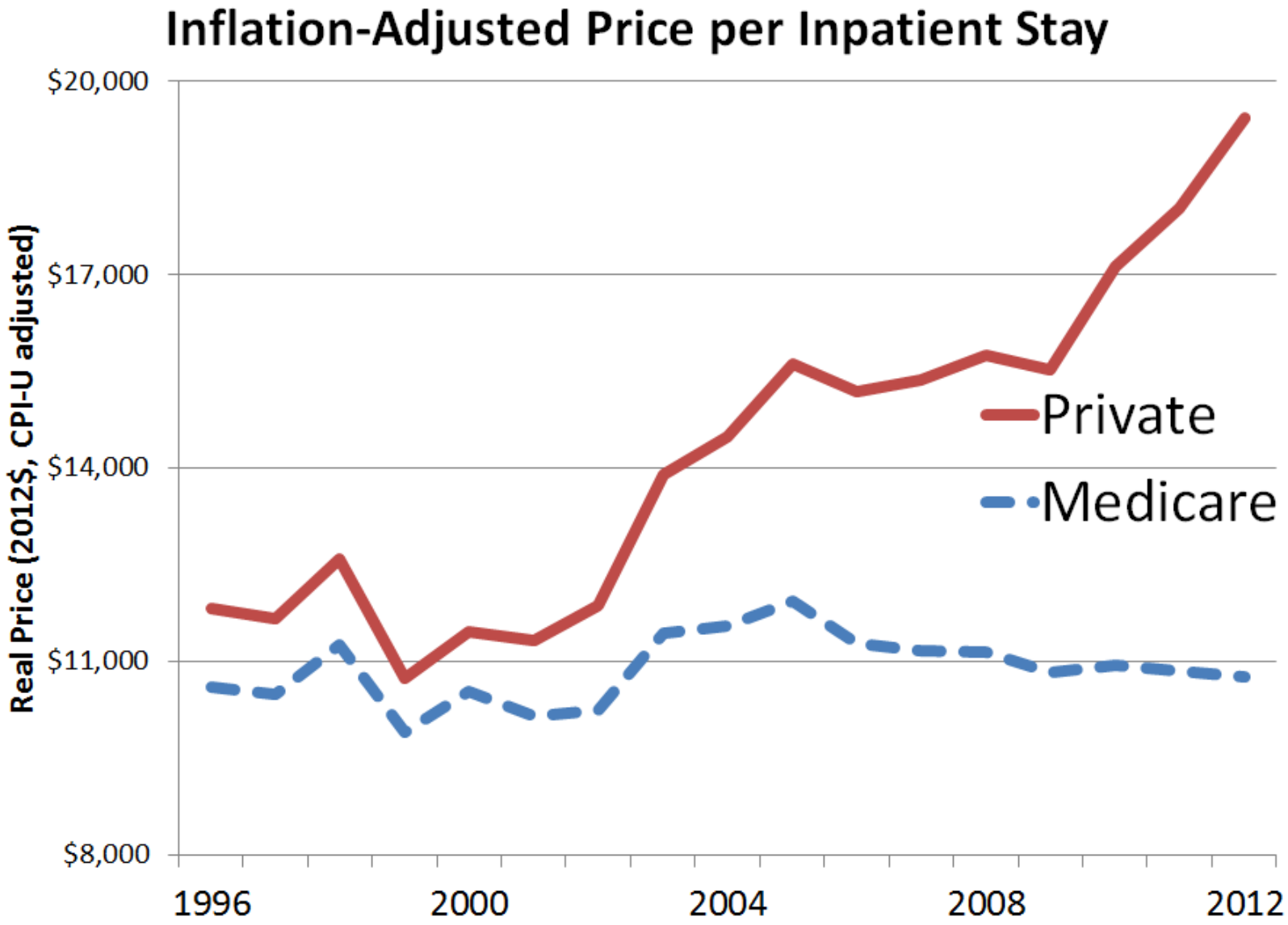
- "Higher health spending but ***lower use of health services*** adds up to much **higher prices** in the United States than in any other OECD country."

2019: Anderson, Hussey, and Petrosyan

# "It's Still the Prices, Stupid"

- Despite policy reforms and despite health systems restructuring…
- **Prices remain the primary reason** why the US spends more on health care than any other country.

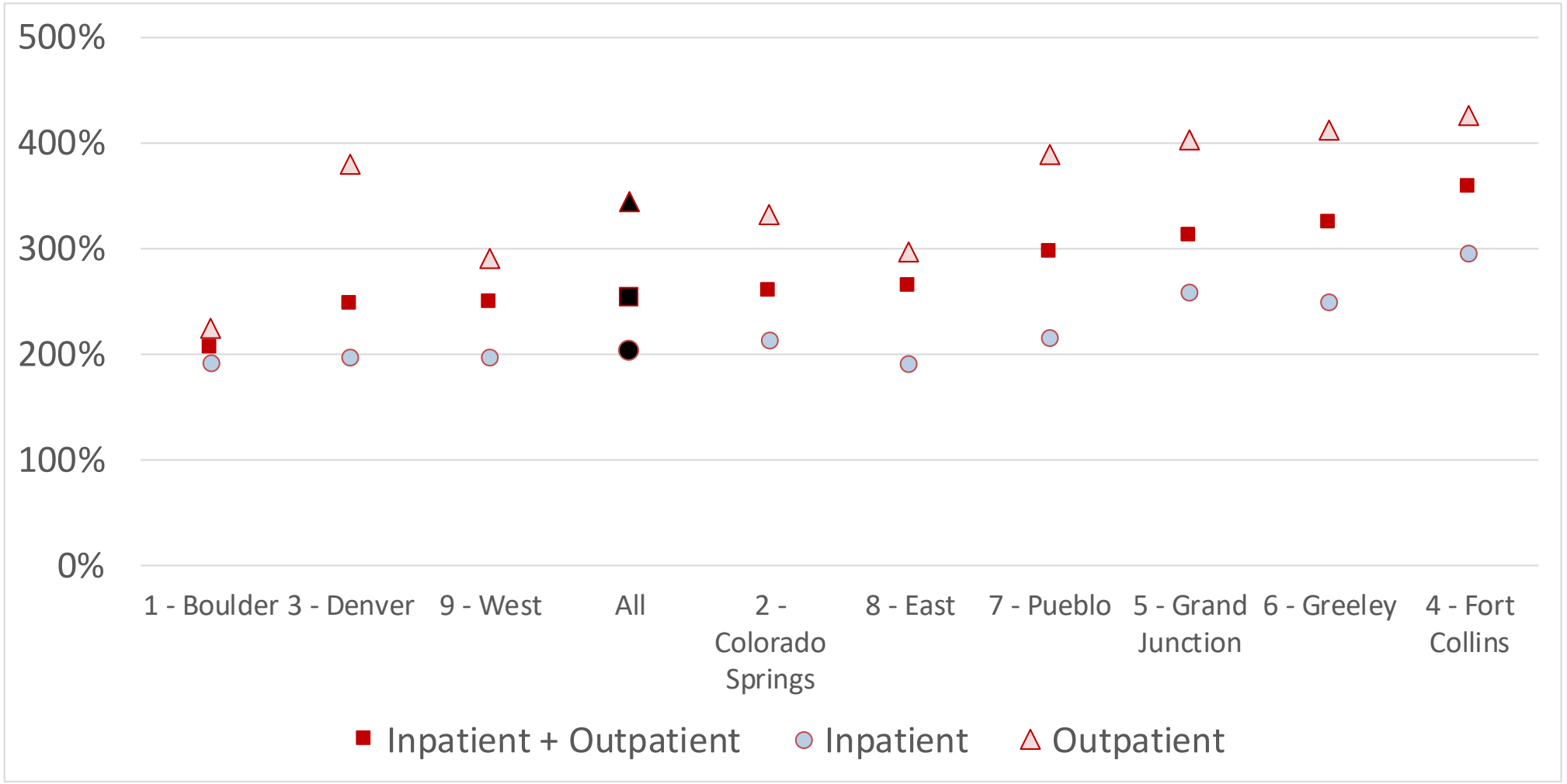
***"Medical costs are the tapeworm of American economic competitiveness."***
Warren Buffett




Source: Selden, T. M., Karaca, Z., Keenan, P., White, C., & Kronick, R. (2015). The Growing Difference Between Public And Private Payment Rates For Inpatient Hospital Care. *Health Affairs, 34(12), 2147-2150. doi:10.1377/hlthaff.2015.0706.*

## What we learned from Rand 2.0…

# Colorado Rating Area Relative Prices - 2017

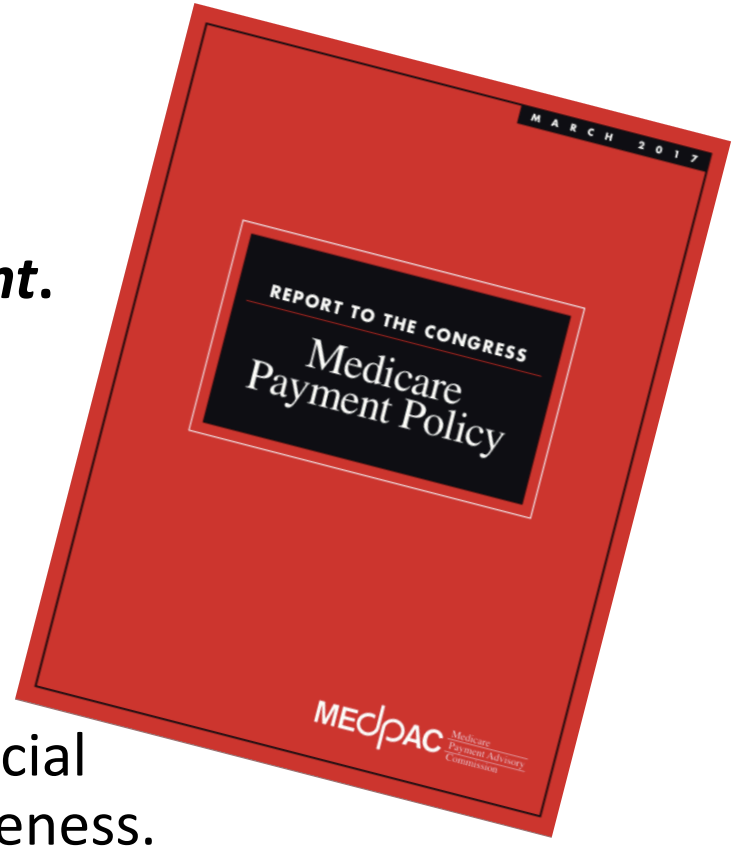


## Why Medicare Payment Provides

# A Reasonable Pricing Frame of Reference

**MedPAC** (Medicare Payment Advisory Committee) advises Congress on hospital ***payment adequacy*** considering both operating and capital expenses.

- Prices and methods are ***empirically based*** and ***transparent*.**
- Medicare prices ***intended to be fair***. Adjusted for…
    - Patient case mix
    - Local costs of living
    - Wage index and labor costs
    - Indigent care load, teaching status, other ”policy” issues
- Medicare allows “***apples-to-apple***s” comparisons of financial performance and a framework for determining reasonableness.



## MedPAC specifically addresses the question…

# "Are hospital payments adequate?" (pp70-89)

- 2017 Medicare margins remained ***negative for most hospitals***.
  - Overall margins were -9% on *fully allocated costs*
  - For-profit hospitals' margins: –2.6%;
  - Tax-exempt hospitals' margins: -11%
    (Differential reflects "lower outpatient costs at for-profit hospitals.")
  - Rural hospitals (exc. CAH) margins: - 8.2%; urban hospital margins: -10%
- **2017 margin for "relatively efficient" hospitals was -2%.** (p. 71)
- All-payer margins remain at historic levels "***because the growth of private payer rates continues to rise faster than costs.***" (p. 81)

BECKER'S
# Hospital CFO Report

**Adjusted In-Patient Expense Per Diem – Jan '19**

| | | ”Non-Profit” Hospitals | ”For-Profit” Hospitals |
|---|---|---|---|
| U.S. Average Hospitals | | $2,488 | $1,889 |
| Indiana Hospitals | | $2,633 | $2,360 |
| Colorado Hospitals | | $3,119 | $2,692 |

## MedPAC March 2019 Report to Congress

“When **nonprofit hospitals** have more resources, they tend to spend those resources because non-profit hospitals do not have shareholders to distribute profits to…..“These expenditures lead to ***higher costs per discharge and lower profits*** on Medicare patients.”

In contrast: “When **for-profit hospitals** have high profits from non-Medicare sources, they tend to retain the additional profits for shareholders ***instead of increasing their cost structure***.”

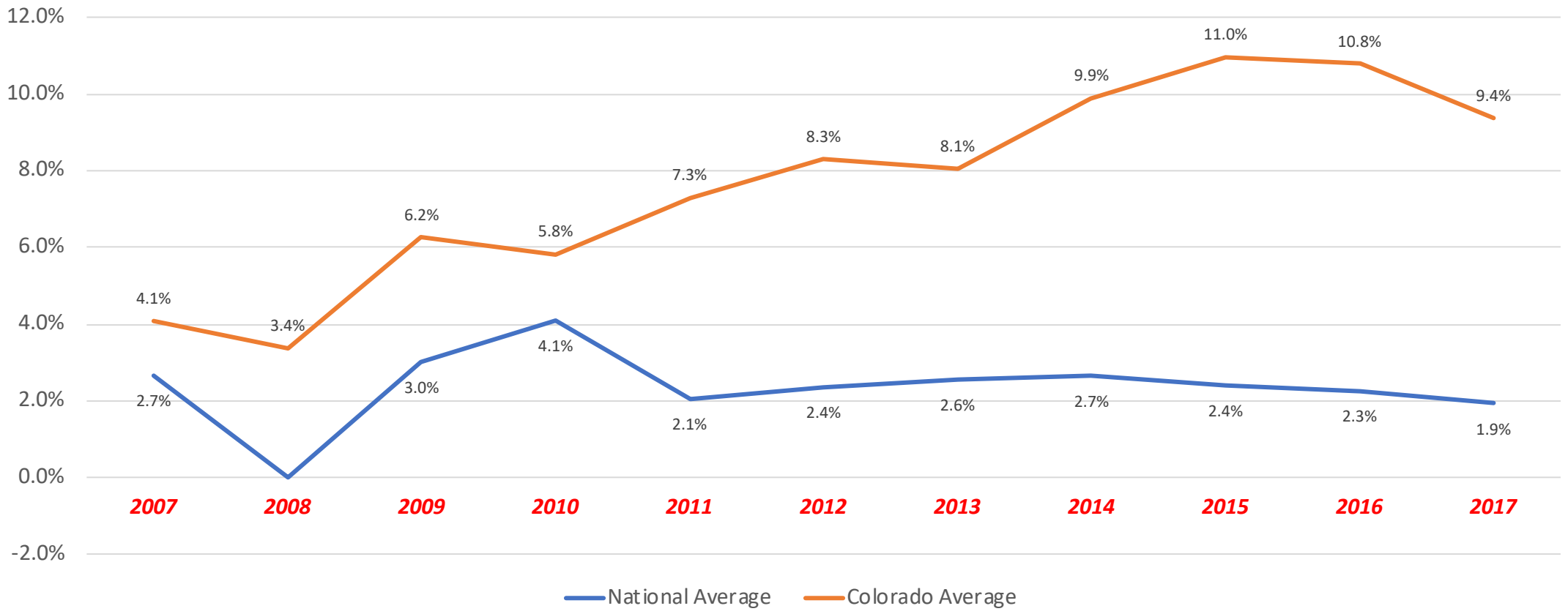
Hospitals in Colorado that are…

# At or above 400% of Medicare (all services)



| Hospital name | Hospital system or, if independent, IPPS/CAH | Relative price for outpatient services | Relative price for inpatient services | Relative price for IP & OP services |
|---|---|---|---|---|
| Colorado Plains Medical Center | LifePoint Health | 782% | 329% | 573% |
| St Anthony Summit Medical Center | CHI | 697% | 336% | 503% |
| North Suburban Medical Center | HCA Healthcare | 698% | 289% | 461% |
| Poudre Valley Hospital | University of Colorado | 575% | 331% | 430% |
| St Anthony Hospital (Lakewood) | CHI | 500% | 394% | 430% |
| Medical Center Of The Rockies | University of Colorado | 483% | 389% | 429% |
| Sterling Regional Medcenter | Banner Health | 546% | 245% | 419% |
| Valley View Hospital Association | Independent (IPPS) | 478% | 301% | 399% |

# Hospital Operating Profit Margins: CO vs US




RAND Corp. Hospital Database http://hospitaldata.rand.org/
File Names: rand_hcris_cy_hosp_a_2018_09_01.csv.zip, rand_hcris_cy_st_a_2018_09_01.csv.zip, rand_hcris_cy_natl_a_2018_09_01.csv.zip

## So why are most hospitals…

# Losing Money on Medicare?”

“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, PhD

Sr. Principal Policy Analyst

Medicare Payment Advisory Committee


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.


Hospital 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.[1,2]

At the same time, the average payment-to-cost ratio for Medicare patients fell from 109 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.[3,4]

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.[3] 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-

# Defining *THE* Dysfunctional Marketplace

- ***INELASTIC DEMAND*** for tertiary/quaternary care and much of pharma
- Completely opaque pricing and performance
- No standard definitions for “product” or “costs of care”
- Conflicted, inflationary economic incentives (across the board):
  - **Health plans:** Earning/share drive off profit where profit is a percent of premium. (Salaries drive off EPS)
  - **Hospitals:** ***Fee for service payment*** is antithetical to practice transformation or continuous quality improvement; ***Discounted FFS*** encourages getting big, not being good.
  - **Physicians & Hospitals**: RBRVS/pricing rewards treating results, not causes.
  - **Employees**: High value and low value services are covered the same
- Fragmented purchasing incentives.

Because….“A problem well-defined is a problem half-solved.” Chas. Kettering

# Do NOT define the problem as a “broken system.”

Berwick’s First Law of Improvement

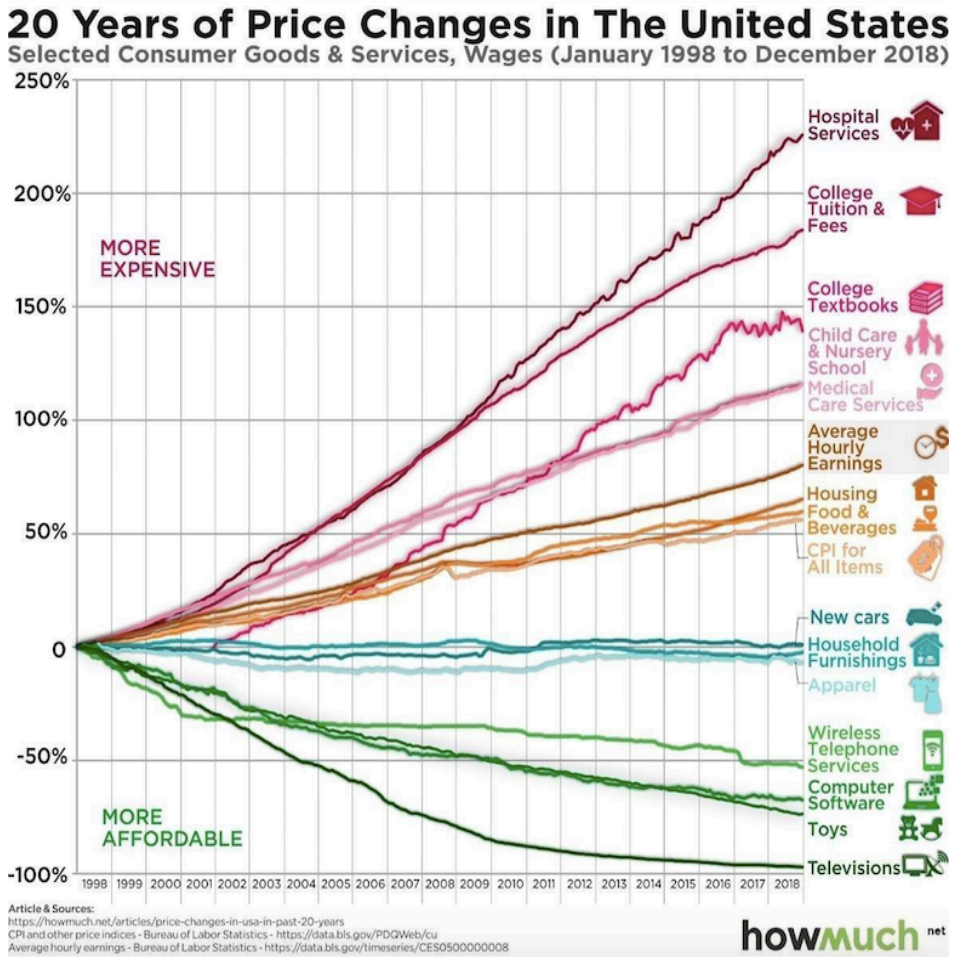
**EVERY SYSTEM IS PERFECTLY DESIGNED TO ACHIEVE EXACTLY THE RESULTS IT GETS.**

A library of studies document that those results are:

- Inconsistent effectiveness
- Consistent inefficiency
- Ever-increasingly expensive

# Does Rand 2.0 raise *even more questions for buyers* than it does the sellers?

1. How have employer **purchasing and benefit design practices contributed** to price inflation > costs or the CPI?
2. What is an employer's **fiduciary responsibility** to change purchasing and benefits practices to…
   - Employees?
   - Tax payers/shareholders?
3. **What could employers, as purchasers, do to change this trajectory? What would be required – beginning TODAY???**



Harvard Business Review

COSTS

# To Control Health Care Costs, U.S. Employers Should Form Purchasing Alliances

by David Blumenthal, Lovisa Gustafsson, and Shawn Bishop

NOVEMBER 02, 2018

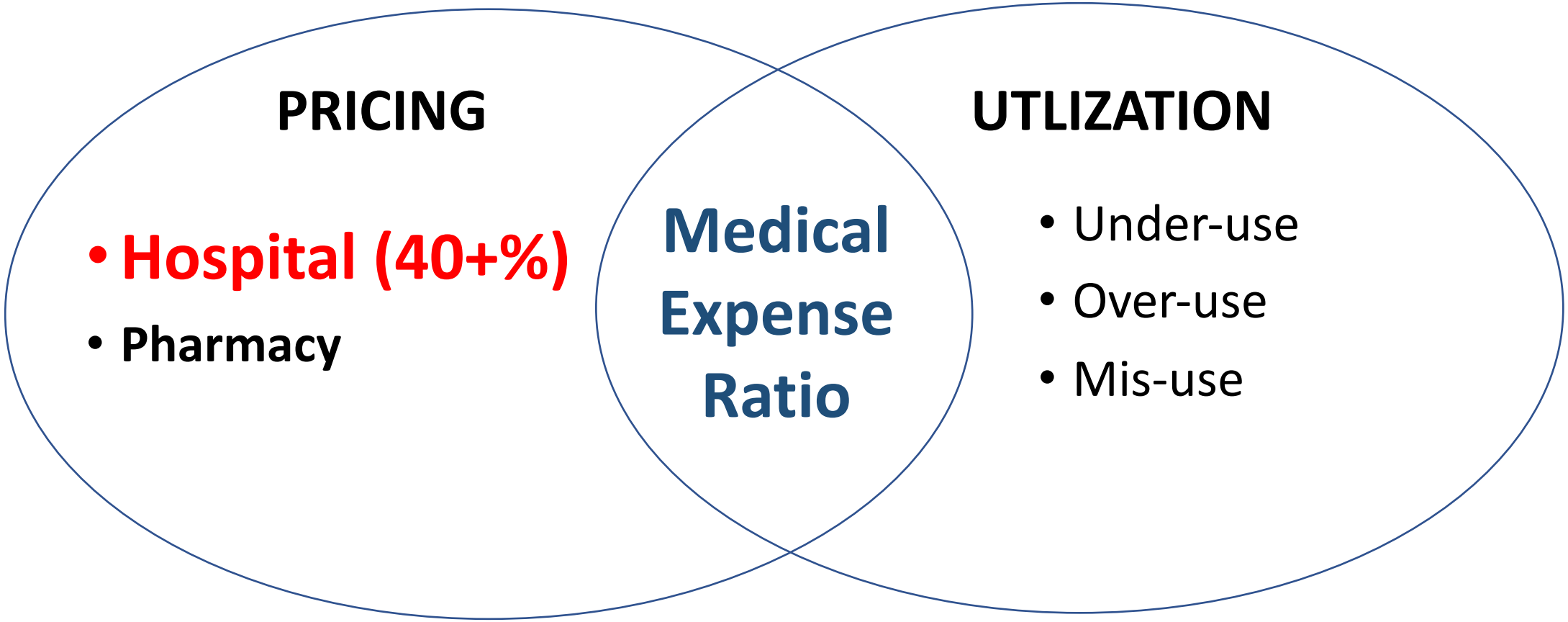
*"To control costs going forward, employers may have to confront the true underlying causes of rising health care expenditures:* ***high prices and health care inefficiencies."***

## *Employer challenges:*

1. Lack of **purchasing power.**
2. Lack of sophistication **as purchasers**.
3. **Fear** of alienation/disruption.

Since “Medical expense ratio” is the product of “unit price” times ”unit use”

# Five levers employers need to pull




# Genesis:

A (heated) luncheon over how pricing should be determined.

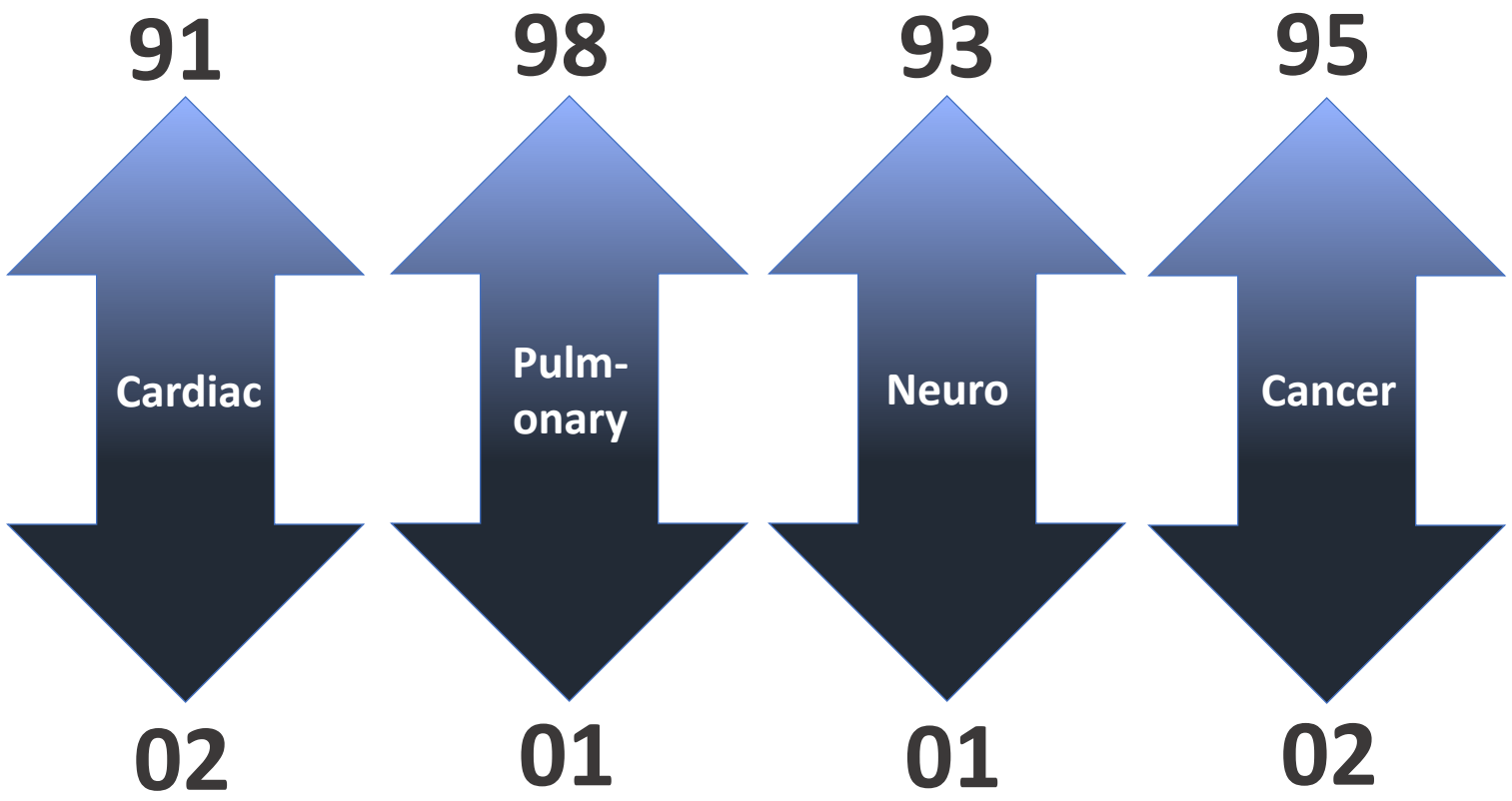
# Co-Publishers:

CBGH
CCHI

# Content:

Pricing: Rand 2.0 (Colorado APCD)
Performance: CareChex Hospital and Health System Ratings

# Using CareChex Hospital Ratings
# Nat'l Percentile Differences – Major Service Lines




**Composite Quality Includes**

- Risk-adjusted mortality
- Risk-adjusted complications
- AHRQ quality measures
- Patient safety
- Patient satisfaction

**Data Source:**

- MedPar
- Three-year rolling average

**36 Discrete Service Lines**

QUANTROS

| RAND CORPORATION HOSPITAL PRICING AS A PERCENT OF MEDICARE | | | | QUANTROS CLINICAL QUALITY SCORES (CQS) | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| HOSPITAL NAME | CITY | RELATIVE PRICE FOR OUTPATIENT SERVICES | RELATIVE PRICE FOR INPATIENT SERVICES | OVERALL HOSPITAL CARE NATIONAL COMPOSITE QUALITY SCORE | OVERALL HOSPITAL CARE MORTALITY | OVERALL HOSPITAL CARE COMPLICATIONS | OVERALL HOSPITAL CARE READMISSIONS | HIGHEST PERFORMING CLINICAL CATEGORY | LOWEST PERFORMING CLINICAL CATEGORY |
| Valley View Hospital Association | Glenwood Springs | 478% | 301% | 89.2 ✓+ | 88.8 | 80.6 | 69.2 | Cardiac Care 95.2 | Orthopedic Care 9.9 |
| Community Hospital | Grand Junction | 409% | 302% | 31.1 ✓ | 32.6 | 12.1 | 93.2 | Stroke Care 82.3 | Gastrointestinal Care 3.8 |
| OrthoColorado Hospital at St. Anthony Medical Campus | Lakewood | 119% | 313% | 89.9 ✓+ | 77.2 | 26.1 | 89.2 | Joint Replacement 95.7 | Spinal Fusion 43.0 |
| Colorado Plains Medical Center | Fort Morgan | 782% | 329% | 46.7 ✓ | 78.7 | 65.0 | 23.1 | General Surgery 73.7 | Orthopedic Care 24.9 |
| Poudre Valley Hospital | Fort Collins | 575% | 331% | 99.7 ✓++ | 98.2 | 98.5 | 95.0 | Joint Replacement 99.8 | Chronic Obstructive Pulmonary Disease 25.8 |
| St. Anthony Summit Medical Center | Frisco | 697% | 336% | 78.4 ✓+ | 68.3 | 74.8 | 60.3 | Pulmonary Care 81.6 | Orthopedic Care 50.0 |
| Animas Surgical Hospital, LLC | Durango | 346% | 350% | 76.3 ✓+ | 69.1 | 71.0 | 76.2 | Overall Surgical Care 82.2 | Spinal Surgery 36.5 |
| Medical Center of the Rockies | Loveland | 483% | 389% | 99.0 ✓++ | 95.0 | 98.7 | 96.2 | Cardiac Care 97.8 | Interventional Carotid Care 4.8 |
| Centura Health St. Anthony Hospital | Lakewood | 500% | 394% | 86.4 ✓+ | 96.8 | 65.0 | 98.2 | Trauma Care 99.0 | Heart Failure Treatment 2.5 |

LEGEND: ✓-- ≤ 10th percentile ✓- 11th – 25th percentile ✓ 26th – 74th percentile
✓+ 75th – 89th percentile ✓++ ≥ 90th percentile -- No Data / Not Eligible
(If a Clinical Category case count is less than eleven, no composite quality score will be calculated.)

DATA TIME PERIOD: Q4 2014 – Q3 2017

# Key Conclusions

**You *may* get excellent hospital care in CO:**

- Five out of six: at least 1 top quartile service line
- Over half: at least 1 top decile service line

**But the exact opposite is also true:**

- Five out of six: at least 1 bottom quartile service
- Half: at least 1 bottom decile service

**Quality varies nearly as much within hospitals as it does across hospitals.**

- Of the 50 Colorado hospitals offering a service in the top 25% of hospitals in the country…
- 32 of these same hospitals also offer a service in the bottom 25% of all hospitals in the country.

**No reliable quality/price relationship.**

a

"If you want something new, you must stop doing something old." Peter Drucker

# Establishing New Relationships

## Summit County (Contracting)

- Community based: Initiated by local employers and elected officials
- Pilot for using CRS 10.16.1001
  - Establishes and protects "***Purchasing Coops***" for purpose of increasing "purchasing power."
  - Separates contract ***negotiation*** from contract ***administration.***
  - Allows employers to utilize separate TPAs and even insurer.

## Northern Colorado (Collaborating)

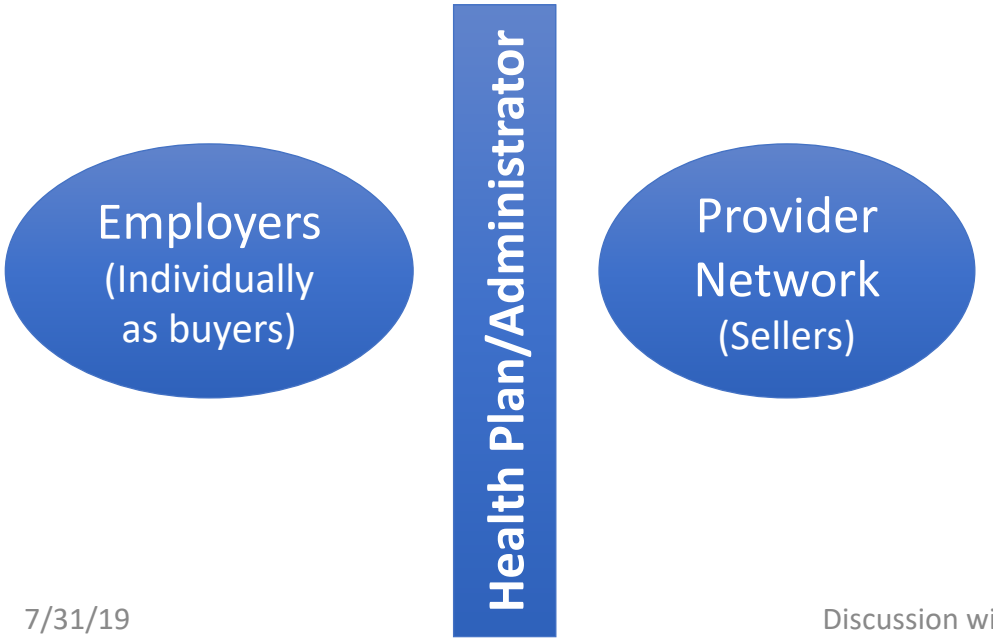
- **Employer-IPA Initiatives** (using APCD)
  - ED Utilization
  - Joints and Spine
  - Over-utilization ("Choose-Wisely")
  - Advanced Directives
- **Possible Employer-Hospital Initiatives?**
  - Over-utilization
  - Advanced directive
  - Pilot episodes of care
  - Direct contracting

To create a more effective, efficient marketplace

# We need to change traditional relationships

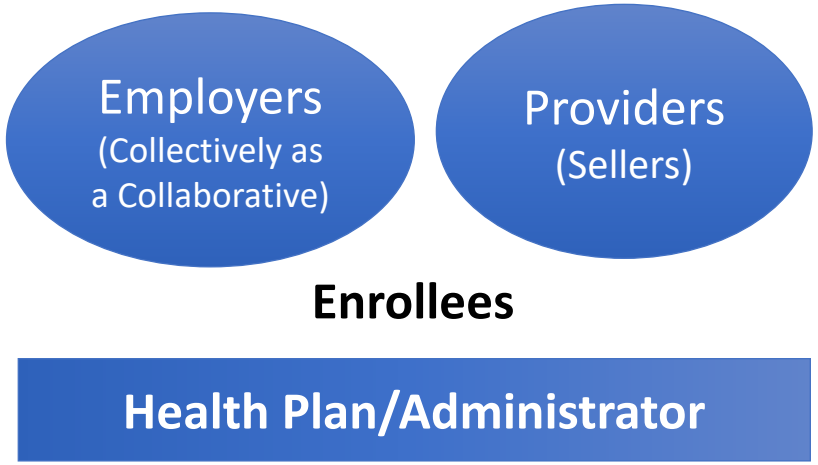
## Surrogate Purchasing

- Health plan functions as “third party”or intermediary; contracts held by health plan.
- No direct interaction between buyers and sellers; all strategies filtered through surrogate purchaser.




## Group Purchasing

- Employers (buyer) negotiate prices, goals; monitor outcome.
- Employers have input into/negotiate pricing terms and payment methods.




## Colorado County's Unique [Employer] Co-Op Could Spread Statewide

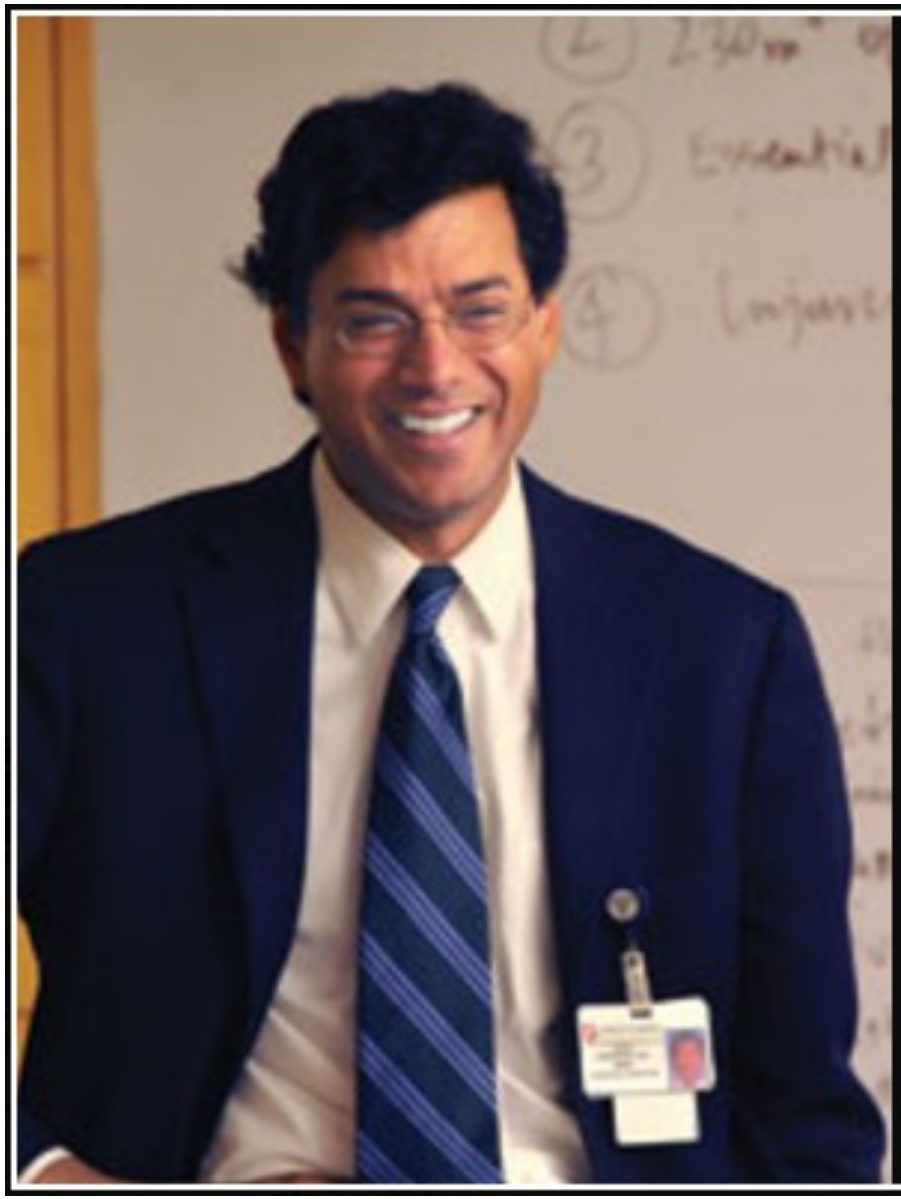
May 28, 2019

"Colorado Democratic Gov. Jared Polis has signed legislation that clears the way for a new county-based health insurance cooperative to leverage the purchasing power of residents enrolled in the large group, small group and individual markets to directly negotiate payment rates with providers."

Colorado's Confluence of

# Enabling Efforts & Factors

- Two years of **CBGH efforts** aimed at
  - Unreserved collaboration
  - Building legislative support and relationships with various state departments
  - Promoting Medicare payment as a benchmark
  - Promoting APCD and the Rand Report
  - Quantifying consolidation & market trends
- **Legislation** enabling group purchasing
- Creative, proactive **Insurance Commissioner**
- **A Governor** who..
  - Ran on health care reform and affordability
  - Personally supports CBGH as the entity to convene employers Statewide



Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try.

— Atul Gawande —

AZ QUOTES