



Leader Perspectives

on the impact and future of payment reform in Colorado

A report to accompany the

**2018 COLORADO SCORECARDS ON
PAYMENT REFORM 2.0**

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Compiled and prepared by:

Catalyst for Payment Reform

Andréa Caballero, MPA

Alejandra Vargas-Johnson

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Introduction to Scorecard on Payment Reform 2.0



As health care spending continues to grow for both public and private purchasers, many stakeholders nationwide see payment reform as an important strategy for improving the quality and affordability of health care. State leaders know that a strong economy depends on an efficient health care system that delivers value to employers and other health care purchasers and the people for whom they buy health care. To this end, both the public and private sectors are working to make fundamental changes to how they pay for health care and expand these changes over time.

Catalyst for Payment Reform (CPR) is a national, independent non-profit working to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace. The pioneer in tracking payment reform since 2013, CPR is piloting an expanded Scorecard on Payment Reform, known as Scorecard 2.0, with the purpose of evaluating whether payment reform is delivering on its promise to improve the value of health care.

Like CPR's previous [national](#) and [state-level](#) Scorecards on Payment Reform, Scorecard 2.0 continues to measure how much payment reform there is and of what type. Building on this base, 2.0 also includes 12 additional metrics to help shed light on whether payment reform correlates with improved health care quality and affordability across the health care system. Furthermore, CPR interviewed health care leaders to obtain qualitative information about payment reform and its impact in Colorado. Through the quantitative and qualitative analyses, CPR aims to understand the progress toward CPR's goal that by 2020 at least 20 percent of payments to clinicians and hospitals are made through payment methods *proven* to improve the quality and affordability of health care. CPR also aims to arm Colorado stakeholders with baseline data on which they can make informed strategic decisions.

With grant funding from the Laura and John Arnold Foundation and the Robert Wood Johnson Foundation, CPR piloted the Scorecard 2.0 methodology at the state-level in Colorado, New Jersey, and Virginia, with the help of local organizations in each state. In Colorado, the Center for Improving Value in Health Care (CIVHC) served as the local sponsor of the effort.

The long-term goal of this project is to improve the health and health care of all Americans through helping purchasers in both the private and public sectors track progress with payment reform, as well as high-level indicators of its impact on the cost and quality of health care. Many stakeholders are betting that payment reform is an essential building block to enhancing value in health care, and this project will help ensure that such programs are helping achieve the goals of better and more affordable care on a macro-level.

While it continues to be important to evaluate each payment reform program individually, there is also much to be gained from a higher level, aggregate analysis and contextual review. The health care system is incredibly adaptive and success with one payment reform program may not be scalable or may have negative ramifications elsewhere as health care providers seek to maintain their revenue. While Scorecard 2.0 is not able to identify direct causal relationships, it does explore the relationship between alternative payment methods taking root and concurrent changes in health care quality and cost. It is critical to determine at the system level whether this flurry of activity to reform how we pay health care providers is leading to the intended outcomes.

Interview Methodology

This paper summarizes the perspectives CPR captured through semi-structured interviews with 17 health care leaders across and within five stakeholder groups: employers, public purchasers and consumers (3), health plans (2), state government health leaders (2), health care providers/systems (3), and academic researchers/non-profit leaders working toward health care improvement (7).

The local sponsor identified health care leaders across the stakeholder groups to ensure CPR could capture important perspectives and invited prospective interviewees to participate. To preserve the integrity of the insights and the confidentiality of the participants, CPR elected to not identify any individuals or organizations who contributed to the report and instead attribute the themes and insights in this report to stakeholder groups. CPR thanks all participants for their candor, expertise, and time.

CPR conducted the semi-structured interviews by phone over the course of three months (December 2017 - February 2018), with the exception of one interview that CPR conducted in June 2018; most interviews took approximately one hour. CPR provided each interviewee with an interview guide describing the project, the methodology, and questions in advance. CPR's program director, Andréa Caballero, and project and research manager, Alejandra Vargas-Johnson, led and facilitated the interviews with each participant.

Upon completion of the interviews, CPR analyzed the responses and identified key themes. The remainder of this report reflects this analysis using the same sequence of questions as in the interviews and compares and contrasts CPR's interview findings with quantitative data from the Scorecards.

Comments on the Quantitative Findings

This report is accompanied by two quantitative scorecards: one on Colorado's commercial market and one on Colorado's Medicaid market, both of which showcase how much and what types of payment reform occurred in the Colorado in 2016. Detailed information on the quantitative findings and methodology is available at www.catalyze.org.

Payment Methods – Commercial

The most prevalent value-oriented payment method in the commercial market in Colorado in 2016 was shared savings. Thirty-four percent (34%) of health care dollars¹ flowed through shared savings arrangements that year.² The second most prominent value-oriented payment method in the commercial market in 2016 was pay-for-performance (P4P)³ at 18.1% of dollars paid. Dollars flowing through full capitation, also known as global payment,⁴ made up 7.3% of total dollars; shared risk dollars accounted for 4.4% of total dollars.⁵

¹ From responding health plans.

² Shared savings is defined as arrangements between health plans and providers where there is an upside-only financial incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings. "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared savings programs can be based on a FFS payment system. Shared savings can be applied to some or all of the services that are expected to be used by a patient population and will vary based on provider performance.

³ P4P provides incentives (typically financial) to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of fee-for-service payment. The financial incentive payment that is given for achieving certain performance levels is sometimes also referred to as a bonus payment.

⁴ Full capitation is defined as a fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year.

⁵ Shared risk refers to arrangements in which providers accept some financial liability for not meeting specified financial targets. It may also include arrangements in which providers accept some financial liability for not meeting specified quality targets. Examples include: loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; withholds that are retained and adjustments to fee schedules.

The least prevalent value-oriented payment methods in the commercial market at that time were partial or condition-specific capitation⁶ (0.2%) and bundled payments⁷ (0.6%).

Payment Methods – Medicaid

In 2016, the two most prevalent value-oriented payment methods in Colorado's Medicaid market were pay-for-performance and payments for non-visit functions,⁸ with 16.4% percent of health care dollars flowing through each of these. The next most prominent payment method in the Medicaid market was partial or condition-specific capitation at 12.1%. The remaining dollars flowing through payment reform methods in Colorado's 2016 Medicaid market were in bundled payment (9.5%).⁹

Macro-Indicators

The quality and affordability metrics in the two Colorado Scorecards on Payment Reform 2.0 highlight strong points as well opportunities for improvement. Notably, 76% of children ages 1.5 – 3 years old, state-wide, received all recommended immunizations, whereas the national average across all states in 2016 was 71% for children in this age range. Another strong point is Colorado's cesarean section rate for first time mothers delivering one baby in the vertex position, a population referred to as NTSV, which surpassed the Leapfrog Group's target of 23.9% for both commercially-insured (22.5%) and women covered by Medicaid (18%). However, there appears to be room for improvement for caring for patients with diabetes: in the commercial sector, more than a third of patients with diabetes covered by Colorado health plans either experienced poor blood sugar control or didn't have at least one annual Hemoglobin A1c test conducted, and in the Medicaid market fewer than 80% of patients with diabetes received at least one annual HbA1c test, whereas the national average for Medicaid plans was 87% in 2016. Colorado had a better than average rate of patients who, after being discharged from acute care hospitals, reported that they were given information about what to do during their recovery at home, as well as a better than average rate of adults reporting their health-related quality of life in positive terms like "good," "very good," or "excellent." Colorado beat the national average for the percent of adults not accessing care due to cost concerns by one percentage point.¹⁰ While Colorado may be performing average or well in these metrics, there is still room to improve. Stakeholders hoping to excel in these areas may look to payment reform as a potential tool to drive better results if implemented successfully.

Overall Impression of Payment Reform Penetration in Colorado

To ground the interviewees in the present, CPR pointed to recent national research showing that 25-50% of payments made to providers includes some type of incentive payment based on quality and efficiency,¹¹ and asked the interviewees whether this range sounded high, low, or about right for Colorado. Matching the Scorecard's quantitative findings, the majority of respondents estimated that Colorado falls on the high end of this range, but that the penetration differed across market segments and type of provider. A state government leader pointed to distinct initiatives driving this activity: "the State Innovation Model (SIM) project has been working on value-based payments with a focus on integrating behavioral health, and in Medicaid the Regional Care Collaborative Organizations (RCCOs) and Behavioral Health

⁶ Partial or condition-specific capitation is defined as fixed dollar payments to providers for specific services (e.g. payments for high-cost items such as specific drugs or medical devices, like prosthetics) or for specific condition (or set of conditions) in a given time period, such as a month or year.

⁷ Bundled payment, also known as "episode-based payment," means a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or to provide a given treatment. Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.

⁸ Non-visit functions include but is not limited to payment for outreach and care coordination/management; after-hour availability; patient communication enhancements, health IT infrastructure and use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments, and/or per-episode fees for specialists.

⁹ All other payment methods were 0.0%.

¹⁰ <https://interactives.commonwealthfund.org/2018/state-scorecard/state/Colorado>

¹¹ http://hcp-lan.org/workproducts/measurement_discussion%20article_2017.pdf

HealthFirst Colorado

"In the mid-90's, Colorado Medicaid invested in the managed care delivery model, but now we are doing what we call a 'direct managed care model.' The Department of Health Care Policy and Financing agency is the managed care agency, and we subcontract with regional entities and hold them accountable to the care they deliver. Our claims data is more timely and detailed than any encounter data that a managed care organization would provide. Some of the regional entities are local groups of providers coming together; they know their communities well. The statewide program is the Accountable Care Collaborative; the regional entities will be known as Regional Accountable Entities (RAE) - part of their payment will be at-risk for behavioral health; the rest will be monthly payments for care coordination, case management and facilitating the medical home network that provides physical health services. The RAE's will pay a subcontracted case management fee to the medical homes in their region." – Colorado Medicaid

pick up speed in Colorado. A state government health leader shared that "there's increasing angst and concerns about the cost of health care. This is a galvanizing focus for many stakeholders. My concern is that the focus is on cost instead of including value and quality of care." A handful of leaders pointed to Medicaid as the driving force behind increasing momentum for payment reform, and a leader from the state Medicaid agency, the Department of Health Care Policy and Financing (HCPF), elaborated on the phase two of Colorado Medicaid's Accountable Care Collaborative program: "The Accountable Care Collaborative is a regional-based model with entities paid case management and care coordination fees. These vendors are held accountable like managed care organizations are held accountable. Phase two is launching in July 2018 and will integrate behavioral health. There will be a huge focus on primary care payments." A health plan leader explained that the level of momentum differed by type of provider, explaining that, "An integrated health care system may have the organizational structure to manage their doctors in a value-based arrangement so, for us, there will be more momentum in those contracts.

Organizations (BHOs), which are turning into Regional Accountable Entities, or RAEs, are pursuing value-oriented payments." A leader representing private purchasers of health care pointed out that Colorado is a "CPC+ state," referring to the Comprehensive Primary Care Plus program characterized as a multi-payer, primary care medical home model. The program launched in 2017 with the participation of 207 practices in the Centennial State,¹² so the quantitative findings, which showcase data from 2016, do not capture the payments made to these providers. A hospital leader clarified that while value-oriented programs may be common, "the incentive part is a very small of percentage of the overall payments" for providers. Health plans indicated it is not feasible to report only the incentive or bonus payments paid through payment reform arrangements; therefore, the Scorecard on Payment Reform methodology asks health plans to report total dollars paid through payment reform contracts, thereby capturing the base payments plus any incentive, shared savings, or shared risk payments. Notably, the Colorado Department of Health Care Policy and Financing, which provided data for the Medicaid Scorecard, did separate out the incentive portion from the total dollars paid to hospitals in 2016. Quality performance Incentive payments made up 7% of total dollars paid to hospitals in 2016, as noted in the Medicaid Scorecard infographic.

Is Payment Reform Gaining Momentum in Colorado?

The overwhelming majority of interviewees believed that payment reform will continue to

¹² <https://innovation.cms.gov/Files/reports/CPC+2017-Summary.pdf>

Meanwhile, independent doctors who are not part of a physician group do not have the structure to do value-based contracts, so we are going to scale back our value-oriented contracts in order to meet them where they are at."

CPR followed up by asking the leaders to identify which payment methods might be picking up the most momentum. Leaders identified shared savings and pay-for-performance, the two payment models that had the most dollars in 2016, as picking up the most momentum, followed by bundled payment. The CMS Medicare Shared Savings Program (MSSP) represents the most common explanation for why shared savings may pick up momentum. A leader from an integrated health system gave additional context for the momentum for these payment methods: "Bundled payment will be more dominant in the commercial space; shared savings and pay-for-performance go together and are only growing. It's important to note that ideas are great but time and financial investment are necessary to operationalize the ideas. There's a lag time before ideas can be well implemented."

Leaders from a large public purchaser shared their experience with bundled payment: "There was a health care commission that recommended to the state to pursue bundled payment, so we asked for quality scores from different providers and negotiated a bundled payment through our contracted health plan. It's a hip/knee program that includes surgery, anesthesiologist, and the hospital. It doesn't include physical therapy because [our benefits offering] already has a great physical therapy program and [we] didn't want to force patients to have to come back to the Denver area for physical therapy." An employer leader gave additional insights into the large purchaser's bundled payment program, saying, "they had to really push the health plan to do the bundled payments, but in the end, the plan implemented bundled payment arrangements with four hospitals. What's great is that when [their members] use one of those hospitals, the procedure is 100% covered." The low rate of bundled payment in the commercial sector (0.6%) reinforces the operational difficulties health plans may have in implementing such arrangements.

Finally, one leader from state government took a different approach when responding to the question of momentum for payment reform, stressing that "I hope there is a focus on evaluating these different models instead of just mandating [them] without proof of concept."

Will Payment Reform Improve Health Care Quality in Colorado?

This section of the interview sought to understand if payment reform could enable Colorado to improve the quality of its health care and how. Given that there are myriad ways to define and measure health care quality, CPR asked participants to apply their own definition of quality when responding to the question of whether payment reform can improve health care quality in Colorado. Multiple respondents raised the importance of "whether or not care is clinically-indicated," as well as the importance of patient-centered metrics. For example, a health care policy organization emphasized that "quality of care needs to take into account the patient perspectives. What do patients care about when it comes to quality?" The vast majority of stakeholders felt optimistic that payment reform can improve the quality of health care in the short term (12-18 months), including one provider leader who said: "providers respond when they get paid to report quality measures, it's about aligning payment with the quality



"Quality of care needs to take into account the patient perspectives. What do patients care about when it comes to quality?"

– Health policy leader

goals." A health care researcher who felt that payment reform would not improve quality of care in the short term acknowledged that, "yes payment reform will improve measured quality because payments will be tied to those specific quality measures, but I'm less certain that these efforts will improve quality in the patient-experience dimension because I don't think quality measures are highly correlated with the type of quality patients would perceive or prefer." When explaining their "yes" answer, a provider leader offered perspective to contextualize payment reform along with other levers working simultaneously: "Payment reform ensures physicians are engaged in the right activities and incentivized the right way, but they need the data and best practices to actually improve quality."

When asked which payment methods have the most potential to improve quality, a state government leader stated: "Bundled payment because it spans the continuum of care, including care outside the hospital, and care coordination." Another leader from a non-profit health care improvement organization offered the following strategy: "Changes to the physician fee schedule can drive primary care utilization, thereby promoting a whole field of medicine that has been shown to improve quality." A health care researcher suggested that risk-based models, like capitation and shared risk, were effective at driving quality because, through these methods, "providers become aware that there is a limited pool of money to spend and are motivated to use that money in the way that is most beneficial to meet quality targets."

"We had to change our whole infrastructure to adapt to pay-for-performance, and time is required to change practice patterns."

– Provider leader



Given the mix of strategies and definitions of quality, it's not surprising that there was no clear consensus as to whether the quality of care will improve in the next three years Colorado. One leader predicted that "only when payers are holding their providers accountable to the same measures, then we can see quality improve." It should be noted, however, that some leaders pointed to the alignment of quality measures between the Medicaid ACC program and the CPC+ initiative as a positive step in the right direction. But as described by a provider leader, there is still more work to be done, especially in the commercial sector: "We have 8 different ACO contracts, and each one has different set of quality metrics. When we put them all into an Excel spreadsheet, there were more than 500 different quality metrics. The lack of standardization makes us all crazy." Similarly, a leader from a non-profit health care improvement organization took the idea of

quality measures farther, adding the role of consumers to the equation: "If the providers have skin in the game, meaning they are at financial risk, then they'll pay attention to quality and try to improve it. Especially if performance is reported publicly, and purchasers pay attention to that information and vote with their feet and go to high-quality practices, then yes, quality could measurably improve." A common explanation for thinking "no, quality will not measurably improve" rested on the timeframe. For example, a provider leader shared that "we had to change our whole infrastructure to adapt to pay-for-performance, and time is required to change practice patterns. Three years is not enough time."

Will Payment Reform Improve Health Care Affordability in Colorado?

Allowing interviewees to define the “affordability” of health care in their own terms, CPR inquired whether leaders believed payment reform could improve affordability in Colorado. The leaders approached the affordability discussion through different angles, including out of pocket costs for the consumer, total cost of care for populations, lowering the administration fees paid in addition to health care services, and lowering prices of the services themselves. The vast majority of leaders did in fact believe that payment reform has the potential to improve affordability. A leader representing a public purchaser shared these

Colorado's All Payer Claims Database

The Colorado All Payer Claims Database collects claims data from commercial payers, Medicare and Medicaid that includes paid amounts and other key indicators of cost, quality, utilization and condition prevalence. In 2019, the APCD will begin collecting current and 3-years of historic information on Alternative Payment Models. APM information in the APCD will help Colorado track progress in payment reform and identify successful models.

thoughts: “When payment reform is done well, it helps avoid unnecessary care and steer[s] patients to the right site of care. Bundled payment helps purchasers negotiate a more affordable price.” The interplay between utilization of care and price of care showed up in the response of a health care researcher who said: “It’s going to be hard to bend cost and utilization curves in 12-18 months even with these payment models. A reduction in use of unnecessary services has the potential to address some overspending but that is not necessarily the same thing as improving affordability. While some payment models provide incentives for preventive care, it’s not clear if the increase of preventive care would lead to reduction in acute care utilization in the 12-18-month timeframe.” The question could be answered in the future, because as a leader from a health-related non-profit stated, “The beauty of having an All Payer Claims Database (APCD) is we can determine with only a 6-month lag where total cost of care and utilization stand.”

The ability to improve affordability by tackling administrative overhead in the health care system arose multiple times during the interviews. A public purchaser leader shared that “overhead is a key component to measuring a provider’s value. By looking at the financials of federally qualified health centers and analyzing the non-medical overhead of these health centers, what we found was astonishing. Some of them had 25% overhead and others with 60% overhead. Meanwhile, on the hospital side, the for-profit hospital has very low overhead costs, and, in comparison, the non-profit hospitals have 50% higher overhead.” A provider leader applauded the medical-loss ratio (MLR) minimum established by the Affordable Care Act as a “necessary external force toward the path to affordability” and a leader from a non-profit health care improvement organization referred to administrative overhead as “the giant elephant in the room.” The topic made local headlines in an October 2018 article from the Denver Post.¹³

Nearly half of the leaders interviewed identified capitation as the payment method with the most potential to improve affordability. A health plan leader gave this perspective: “Capitated contracts with hospitals would improve affordability because hospitals need to stop nickel-and-diming the health plans for things like Tylenol and with exorbitant facility rates.” A state government leader drew on experience with the capitation model to illustrate their selection of the payment arrangement as having potential to improve affordability: “Phase one of the Medicaid ACC program has a capitated behavioral health model, and while it has maintained cost and developed a state-wide services infrastructure, it hasn’t been able to fund the patient-centered innovations that capitation is supposed to be able to fund.” A researcher explained that, “while capitation and bundled payments have the potential to bend the affordability curve, the critical

¹³ <https://www.denverpost.com/2018/10/04/colorado-health-care-costs-escalate/>

factor will be market dynamics due to provider consolidation." A health plan leader went further: "Colorado is a high-cost market due to the consolidation. As a carrier, I don't have the clout to drive down prices in the face of consolidation, so employer groups have a role to play in helping set the price in a market."

Only about half of the leaders thought that payment reform would improve affordability in the next 3 years, but all agreed that affordability deserved continued attention. A state government leader expressed the fact that "consumers just can't afford to pay what the carriers are asking of them," and an integrated health system leader wondered whether "the savings actually trickle down through lower premiums to the consumer?" A public purchaser stated that, "three years is too short of a horizon. Perhaps in 5 years affordability can increase. We've been talking about affordability since the 1970's, and we will probably be having the same conversation in 5 years." One leader pointed to something new and still evolving in the health care marketplace as a way to improve affordability: "Price transparency is what's really needed.

The local business group on health brought in someone from Indiana where they benchmarked all the hospitals against the Medicare fee schedule, and by identifying those hospitals that are 400% of the fee schedule, consumer can say, 'okay, let's not go there.' So, then it's behavior bringing down the fee schedules." More information on the Indiana example can be found in the 2017 publication "Hospital Prices in Indiana: Findings from an Employer-Led Transparency Initiative" by Chapin White of RAND Corporation.¹⁴

The Role of Network and Benefit Design

With ongoing pressure to lower health care costs and spending, the use of network and benefit design to steer patients toward certain providers is gaining traction nationwide. According to the Henry J. Kaiser Family Foundation's 2018 Employer Health Benefits Survey, employers of all sizes are offering a high-performance or tiered network, and five percent of all large firms said that they offered a narrow network product.¹⁵ The popularity of tiered networks, along with their more limited counterpart - narrow networks - are an economic signal that purchasers and payers are using to bring down health care costs for the purchaser and consumer.¹⁶ For this reason, CPR, along with its multi-stakeholder advisory committee for Scorecard 2.0, decided to measure the prevalence of limited network¹⁷ products in Colorado's commercial market. For the purposes of the Scorecard, CPR did not consider tiered networks, in which consumers typically have access to a health plan's broadest network but face different levels of cost-sharing for providers in different tiers, to be the same as limited networks (though it does consider Health Maintenance Organizations - HMOs - to be limited). In 2016, all four plans providing data for the Colorado



¹⁴ White, Chapin, Hospital Prices in Indiana: Findings from an Employer-Led Transparency Initiative, Santa Monica, Calif.: RAND Corporation, RR-2106-RWJ, 2017. As of October 23, 2018: https://www.rand.org/pubs/research_reports/RR2106.html

¹⁵ <https://www.kff.org/report-section/2018-employer-health-benefits-survey-summary-of-findings/>

¹⁶ <https://www.healthaffairs.org/doi/10.1377/hblog20180208.408967/full/>

¹⁷ CPR defines a limited network as a network of contracted providers that has fewer providers (hospitals, specialists and/or PCPs than the health plan's broadest network.

commercial Scorecard offered a limited network product, and 9% of their patient members are enrolled in these products.

Drilling down to understand limited networks in the Colorado context, CPR heard the following perspectives. An employer shared that “people don't like [limited networks]. We had one for several years with one health plan that was priced well below other options, but we never got very much enrollment in this product. People don't want to change providers and don't want to be limited.” Meanwhile, a state government leader noted that, “All of the individual and most of the small-group market is in the EPO model - exclusive provider organization model - which is an HMO look-a-like.” A provider explained that, “[limited networks] are a controversial topic. Hopefully, the providers who are selected have good quality and cost thresholds. In our rural areas, we don't have enough providers to cover consumers, so health plans can't set up limited networks. The main question is, who regulates the price and quality and network adequacy of a limited network?” Indeed, a few leaders raised the issue of network adequacy. A state government leader shared: “I've heard that behavioral health networks [within limited networks] are not being updated regularly, and the networks don't have enough providers who are actually accepting patients. If behavioral health is not a priority for the health plans, then that is a huge problem.”

That said, an integrated health system leader made a call to action for the missing piece of the equation: benefit design standardization, saying, “narrow networks can achieve better quality and lower costs. The major piece of this that everybody misses is the benefit design at the health plan level. We've surveyed all of our physicians and looked at the networks, and [we found that] benefits vary by employer. There's no standardization. For example, some employees in a narrow network still get out-of-network benefits to visit a chiropractor. Sometimes there's a higher co-payment at the urgent care center than the emergency room, so benefit design leads people to use the emergency room. Focusing on and standardizing benefit design is key.”

“Sometimes there's a higher co-payment at the urgent care center than the emergency room, so benefit design leads people to use the emergency room. Focusing on and standardizing benefit design is key.” – Integrated health system leader



Conclusion

The unique dynamics of Colorado's health care market will continue to shape the future of payment reform efforts. Reflecting at the end of the interviews, leaders offered their different perspectives, though many had more questions than answers to contribute. For example, a leader in the state government said, “I don't have a solution, but from a state perspective looking at health care costs, I ask, what are the tools that we need to put out there, whether it's from the division of insurance or a non-governmental agency? There are lots of actors in the industry; money is a motivator. Everyone needs to be held accountable in a different way. There's not just one bad actor. Because of the medical-loss ratio constraints on the insurance companies, I don't think they are blameless, they make more when hospitals charge more because they tack on 15% on top. How do we hold insurance companies accountable to getting the best deal? Who is the appropriate entity to report on these things?”

The theme of consolidation in the marketplace arose often in the closing remarks. Another leader from state government noted that “we’re dealing with much larger economic entities than we have in the past, due to consolidation. The hospital systems contract on a state-wide basis for upwards of 15 facilities. Many of those facilities are the sole facility in a town, and this creates a lot of friction.” Other leaders referenced how recent mergers among health plans operating in the state will also make an impact on market dynamics.¹⁸ An integrated health system leader offered the following as a potential strategy: “Direct to employer contracting holds enormous potential and creates an environment with flexibility and creativity without intermediaries dictating.” In terms of understanding how Colorado compares to other states cost-wise, a leader from a non-profit health care policy organization commended the Network for Regional Health Care Improvement’s Total Cost of Care project for advancing the discussion on affordability through an innovative, multi-state approach.

Across the board, leaders shared their commitment to keep the ball rolling on the path towards a more efficient and patient-centered health care marketplace. A large employer emphasized that “we are all in to do anything we can to improve the state of health care.” With a 2016 baseline of the utilization of the various provider payment methods and the perspectives of a diverse set of leaders in hand, Colorado will continue its journey to create a strategic path forward to control health care spending and improve the quality of care for all Coloradans.

Getting to Affordability: Regional Total Cost of Care

The Network for Regional Healthcare Improvement (NRHI), funded by the Robert Wood Johnson Foundation, is leading a multi-regional innovation initiative focused on the production, sharing and use of information about the total cost of care. Through this project, CIVHC, along with 4 other regional health improvement collaboratives worked to standardize the reporting of health care costs and use the resulting information to create awareness and compel forward progress.

Source: http://www.nrhi.org/uploads/g2a_onepager_r17.pdf

¹⁸ <https://www.denverpost.com/2017/03/02/rocky-mountain-health-plans-unitedhealthcare-merger-finalized/>