Denver-Area Market Assessment Report

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Denver Market Assessment for Payment Reform
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Introduction

Colorado is one of the more progressive states when it comes to innovative approaches to paying health care providers, with over half of all medical spend flowing through value-oriented care arrangements. However, the state ranks 6th out of the 25 states studied in the [RAND hospital pricing study], with commercial payers paying rates that average 276% higher than Medicare's. In the Denver Metro Area, the problem is particularly acute, with significant variation in pricing of common procedures, including non-emergent procedures. The average variance is 837% between the lowest price and highest price. For example, a shoulder MRI in Denver could cost anywhere between $450 and $4,999.00 – a variance of 1111%.[1] For outpatient services, Denver-area hospitals relative prices ranged from 119-698% of Medicare for outpatient services, and 139-394% relative to Medicare for inpatient services. Given health care costs have outpaced inflation and wage increases, it's no surprise that many Denver residents struggle to afford health insurance premiums and health care bills, despite the city's booming economy and tight labor market.

Catalyst for Payment Reform (CPR) is an independent non-profit organization 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. In 2019, CPR partnered with the Colorado Business Group on Health (CBGH) to conduct an extensive assessment of the local dynamics that drive the Denver Metro Area's health care market. The goal was to identify optimal strategies for improving quality, affordability and transparency for Denver employer-purchasers – principally through payment reform as a means of aligning the incentives of those who use and pay for health care with those who deliver it. There are other aspects of the health care system that also have a significant impact on cost and quality, such as pharmaceutical drug pricing, and warrant examination; however, such issues are outside the scope of this report.

CPR developed its Market Assessment Tool (MAT) to provide employers and other health care purchasers with a structured process for assessing the characteristics and local dynamics of a specific market to determine which payment reform strategies to implement. While many variables affect which payment reform options might be best suited to a particular market, experts agree that providers, health care purchasers (e.g. employers), and health plans (i.e. payers or carriers) have the greatest impact and, depending on local dynamics, can each take on a *market shaping* or *non-market shaping* role. Through primary and secondary research with stakeholder groups, the CPR MAT tool identifies where the locus of *market-shaping* power resides in any given market: with providers, with purchasers or with health plans or some combination, creating 8 distinct market types. Each market type has a corresponding set of

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[1] Healthcare BlueBook, Price Variance Report, 2017.

reform initiatives that have the greatest prospects of effectiveness and feasibility, according to the input of more than 35 reform experts across the country. Local market conditions have implications for which payment reform options may work best and which may produce unintended negative consequences. The MAT can also help create a shared, data-driven understanding of the market and the best options for payment reform among the various stakeholders that ultimately will need to work together to implement change.

This report has four sections: Section 1 describes the landscape of the Colorado health care market in detail – with a specific focus on Denver. Section 2 covers an in-depth analysis of the three stakeholder groups who most shape payment reform opportunities in a given market, using insights and perspectives from primary interviews. Section 3 & 4 use these insights and information to classify Denver among the 8 market types and create a Denver-specific list of reform opportunities based on market dynamics, public-private partnership opportunities, and legislative constraints.

Summary of Findings on the Denver Market and Recommendations Regarding Payment Reform

In Denver, health care providers appear to have a market-shaping role. While larger health plans are implementing limited reforms and employer-purchasers are quickly becoming more activated, most stakeholders agreed that providers are exerting more influence. The Denver market seems to be at a tipping point where many laws and regulations, the support of the current governor, and the activism of local business groups are creating space for purchasers to exert increasing market power. Considering these dynamics is critical in determining next steps for improving the value (price and quality) of health care for the commercially-insured Denver population through payment reform or other means.

Considering both the current efforts to reform provider payment and the characteristics that define the market, CPR recommends the following next steps on the part of CBGH and its employer members to move payment reform forward in Denver[2]:

- Continue building on purchaser momentum, particularly in concert with the statewide purchaser cooperative initiative. Rationale: Increasing collective purchasing power will prove essential if employers are to change the trajectory of health care costs and improve the consistency of outcomes.
- Implement benefit designs to encourage consumers seek higher value care.* Rationale: Influencing employee demand – particularly in terms of providing incentives to seek high-value care from more affordable providers – is essential to controlling premiums.
- Align with Medicaid in two-sided risk arrangements and the Polis-Primavera "Roadmap to Affordability." Rationale: Aligning the commercial sector, through the statewide cooperative with Medicaid could leverage both parties' influence, while sending consistent signals to providers on priority quality measures.

[2] CPR has notated with asterisks the recommendations that substantively align with the recommendations put forth by the Commission on Affordable Health Care in 2017.

- Implement value-oriented programs such as two-sided risk arrangements that hold providers accountable to quality and cost targets.* Rationale: To create meaningful improvement incentives, providers need to have a business case to reduce unnecessary care while achieving high-quality standard for services provided.
- Expand on earlier success in enhancing transparency on health care quality and prices.* Rationale: Employers can't fix health care or function as better purchasers without actionable data.
- Promote the benchmarking of pricing relative to Medicare as a means for allowing employers to determine whether the health care prices they are paying are reasonable. * Rationale: Medicare payments, adjusted for several factors, provide an empirically based method for benchmarking prices.

Methodology

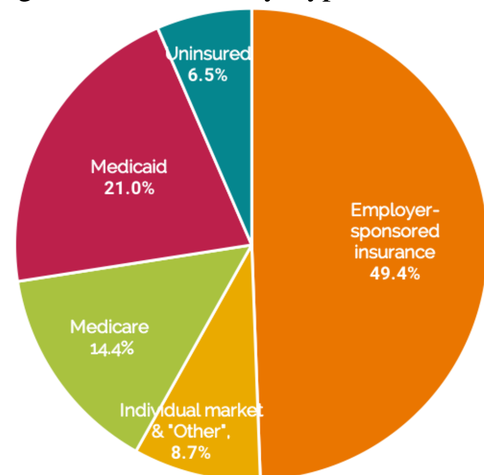
CPR undertook a three-pronged process to collect data in its assessment of the Denver market. First, CBGH invited various representatives of the Denver health care market to share their views in a stakeholder-specific online survey about the dynamics in the market and opportunities for payment reform. Twenty-two representatives out of the 36 invited (61%) responded to the online survey. Second, CPR conducted semi-structured follow-up interviews with 11 key informants. Survey respondents and interviewees represented large health care systems, professional medical associations, physicians, large payers, large purchasers, legal/regulatory bodies, as well as employee benefits consultants. Third, CPR gathered publicly-available structural data about providers/provider systems, health plans and purchasers in the Denver market as well as the local mix of insurance coverage. With information from these various sources, CPR then classified the Denver market according to a proprietary categorizing system developed by CPR with the input of over 35 leading payment experts.

Part 1: Detailed Findings on the Denver Market

A. General Economic Indicators

The Denver Metropolitan area, in Colorado's Front Range of the Rocky Mountains, is made up of seven contiguous counties (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson) with a

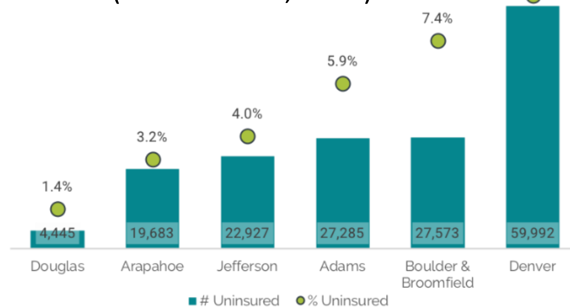
Figure 1. Insurance by Type, Colorado



Source: 2017 Colorado Health Access Survey

combined population of 3.14 million.[3] The city and county of Denver, Colorado's state capitol, is the most populous within the Metro area, with more than 700,000 residents.[4] Since Colorado expanded Medicaid coverage in 2014, the rate of residents in in Colorado without health insurance has been in the single digits – only 6.5% were uninsured in 2017, with even smaller proportions uninsured at the county level in the Denver region.[5]

Figure 2. Uninsured Rate, Denver Area by County (Total = 3.0M, 5.3%)



Source: 2017 Colorado Health Access Survey

Colorado, and Denver in particular, has a very healthy economy, with an unemployment rate of under 4% since 2015 and a job growth rate of 2% or higher since 2012. In just 2018, Colorado added 49,300 nonfarm jobs.[6] In July 2018, the Denver Post ran a story headlined "Colorado employers stretched thin by a tight labor market," sharing examples of employers in both the private and public sectors struggling to fill labor shortages.[7] Another sign of a strong local economy is a median household income in the Denver metro area of $76,643, which is 25% higher than the national figure and 10% higher than in Colorado statewide.[8]

Although several national Fortune 500 companies have headquarters or campuses in Denver, health systems remain the largest private-sector employers in Colorado.[9,10]

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[3] The official Denver-Aurora Metropolitan Statistical Area (MSA) does not include Boulder county, which brings the combined MSA population to 2.88 million in 2017. https://censusreporter.org/profiles/31000US19740-denver-aurora-lakewood-co-metro-area/

[4] http://www.metrodenver.org/do-business/demographics/

[5] 2017 Colorado Health Access Survey, Courtesy of the Colorado Health Institute, www.ColoradoHealthInstitute.org, 303 E. 17th Avenue, Suite 930, Denver, CO 80203. Accessed June 26, 2019.

[6] https://www.denverpost.com/2019/03/11/colorado-january-2019-unemployment-rate/

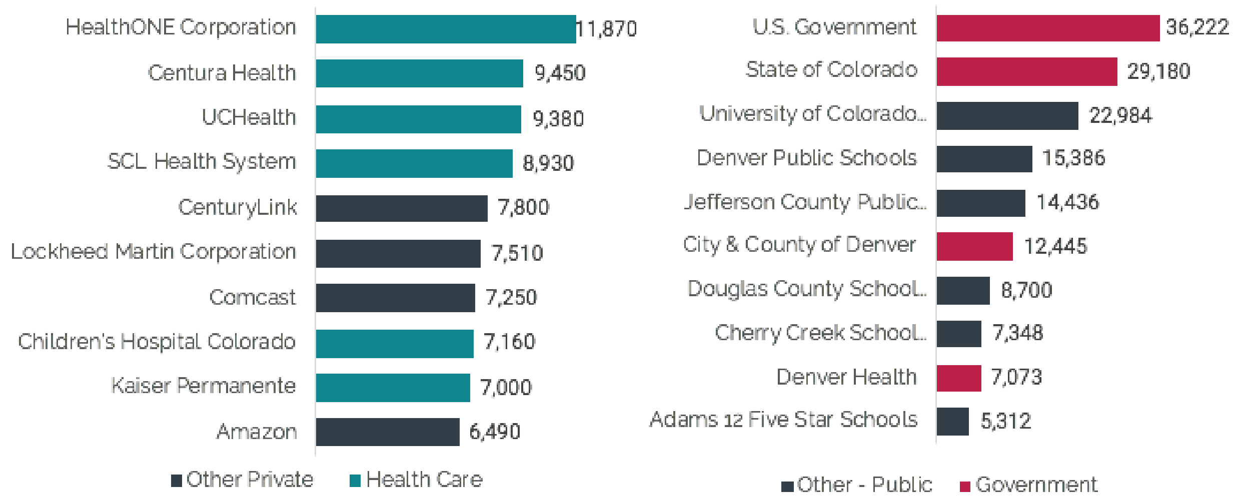
[7] Svaldi, A., Seaman, J., and Rubino, J. "Colorado employers stretched thin by a tight labor market," The Denver Post, July 22, 2018. https://www.denverpost.com/2018/07/22/colorado-labor-markets-stretching-employers/

[8] https://censusreporter.org/profiles/31000US19740-denver-aurora-lakewood-co-metro-area/

[9] Top Public and Private Sector Employers; Revised June 2019. http://www.metrodenver.org/resources/data-central/

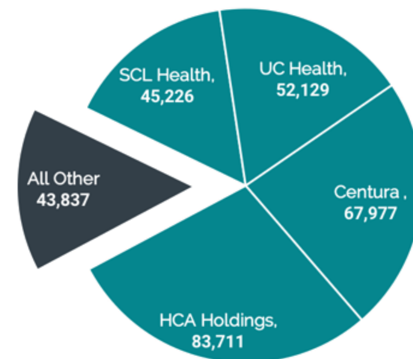
[10] Denver Book of Lists, Denver-Area Private Sector Employers.

Figure 3. Denver Metro Top 10 Private and Public Sector Employers (by Count EE's)



B. Health care market dynamics: Provider Consolidation

Figure 4. Health System Market-share in Denver by 2017 Patient Admissions



Source: Denver Business, Book of Lists, "Denver-Area Hospitals, Ranked by Patient Admissions in 2017," December 2018

Four health systems dominate the Denver market: HCA Holdings; Catholic Health Initiatives (known locally as Centura); UC Health, and SCL Health, with over 85% of hospitals admissions distributed among these four top players.[11] According to the Herfindahl-Hirschman Index (HHI), this indicates a market that is "Moderately Concentrated," – i.e., ***concentrated enough to stifle price competition***. The publicly available draft of the 2019 Cost Shift Analysis report by the Department of Health Care Policy and Financing describes the growth of the seven health systems in Colorado through mergers, acquisitions, and new construction. These seven systems collectively own more than half of all general and critical access hospitals in the state.

Health systems in Colorado have also integrated vertically by acquiring physician groups. This strategy significantly increases their market power while minimizing the ability of health plans to control health costs and improve efficiency, as has been documented in research by

[11] Denver Book of Lists, Denver-Area Hospitals, Ranked by Patient Admissions in 2017, December 28, 2018.

Berenson, Ginsburg, Christianson, and Yee (2012) and other studies.[12] As of July 2015, more than 30% of all physicians in Colorado were employed by hospital-owned practices, up from 20% in 2012.[13] In addition to expanding market share through vertical and horizontal integration, Colorado hospitals – fueled by some of the highest profit margins in the country, as noted by the RAND Corporation – continue to expand their footprints and increase their own expenses through construction projects. Despite an overall occupancy rate of 63% in 2016, capital expenditures for Colorado hospitals are the second highest in the nation, after Alaska.[14] Hospital expansion in Colorado is not regulated through any type of certificate of need (CON) review. CON regulations are intended to ensure hospital growth is sustainable within a region and that there isn't over- or under-capacity. Without dedicated regulatory oversight, and neither shareholders nor taxpayers to whom they have to pass along net income, not only do the majority of Colorado hospitals have no constraints on growth, but they actually have incentives to expand in regions that do not need additional capacity. This is likely one reason why Colorado's tax-exempt hospitals have adjusted *per diem* operating expenses that are 25% higher than tax-exempt hospitals nationally[15] and hold billions of dollars in reserves.[16] while, according to the RAND Employer Price Transparency Study, Colorado hospitals are paid among the highest in the country.

The consolidation of the hospital sector has had a ripple effect on other sectors of the health care delivery system. In response to hospitals purchasing physician practices, the two largest independent physician associations in the Denver Metro area merged in 2015 to create PHPrime, managed by Physician Health Partners.[17] PHPrime serves more than 300,000 patients in Denver. With these figures, it's clear that Denver's providers, whether they be health systems or large physician groups, have garnered significant market power through mergers and acquisitions.

C. High Cost of Care

There is substantial evidence that provider consolidation leads to higher health care prices, and this correlation clearly plays out in the Denver market.[18] In 2018, the RAND corporation launched a national study using all-payer and commercial payer claims data to compare hospital prices relative to Medicare reimbursement rates. The RAND study found that among the 25 markets studied, Colorado hospitals rank 6th with average prices about 269% above

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12 Berenson, R., Ginsburg, P., Christianson, J.B., and Yee, T. "The Growing Power Of Some Providers To Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed," 2012. https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.0920

13 HCPF Cost Shift Analysis.

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

15 https://www.beckershospitalreview.com/finance/average-hospital-expenses-per-inpatient-day-across-50-states.html

16 Financial reserves are necessary for health system sustainability. However, the current level of reserves of tax-exempt health systems in Colorado should be examined for appropriateness relative to their tax-exempt status.

17 https://www.bizjournals.com/denver/news/2015/11/23/merger-creates-largest-group-of-primary-care.html

18 Scheffler, R.M., Arnold, D.R., and Whaley., C.M. "Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices." https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0472

Medicare prices – with inpatient services at 221% and outpatient services at 350% of Medicare prices. Additionally, the study found that Colorado prices grew almost 3 percent between 2015 and 2018, the highest rate of growth among all markets studied. It's worth noting that, in the same time period, one state (Michigan) with relatively low prices saw their hospital prices actually decline, due in part to a large employer forgoing the traditional carrier relationship and contracting directly with a local health system.[19]

The RAND study also found great variability in price and quality among Colorado hospitals. Relative prices for outpatient services in Denver-area hospitals range from 698% of what Medicare pays (North Suburban Medical Center - HCA Health Care in Thornton) to 119% (OrthoColorado Hospital at St. Anthony Medical Campus - Catholic Health Initiatives in Lakewood).[20] It's worth emphasizing that there are high-quality, low-priced hospitals in Colorado, as additional analysis by the Colorado Business Group on Health and the Colorado Consumer Health Initiative pairing the RAND results with Quantros' CareChex hospital quality information clearly shows. About 20% of the more affordable hospitals in Colorado fall into the 75th-100th percentile of hospitals when ranked by the CareChex by Quantros Composite Quality score. About half of the hospitals whose prices range from 200-300% of Medicare also fall into the top quarter of hospitals ranked nationally.[21] Meanwhile, one in five of the most expensive hospitals in Colorado were in the bottom three quartiles of quality, based on the CareChex Overall Hospital Care National Composite Quality Score rating system.

Given these data, it should not be surprising that high health care costs are a significant problem in Denver. The Denver Metro Chamber of Commerce website states that the challenge of high health care costs "impacts employees' ability to sustain themselves and their families and affects business' competitive position in the current market."[22] The Altarum Healthcare Value Hub surveyed adults in the Denver metro region in late 2018-early 2019 and found that over half of adults felt burdened in the prior year by health care costs they believed they could not afford. Additionally, more than 39% of Denver adults struggled to pay their medical bills, incurring credit card debt or using up all or most of their savings.[23]

At the state-level, multiple studies have identified exorbitant health care prices in Colorado. In 2018, the Network for Regional Healthcare Improvement (NRHI) and the Center for Improving Value in Health Care (CIVHC) reported that in 2016, Colorado's total cost of care in the commercial market was 19% higher than the average total cost of care for comparable populations across six states participating in the study. Diving deeper, the high costs in Colorado result from a combination of high prices (13% higher than the average) and higher utilization (5% higher than average). [24] The study found that for the commercial population in

[19] White, C., Whaley, C. "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative," 2019. Santa Monica, CA: RAND Corporation, https://www.rand.org/pubs/research_reports/RR3033.html.

[20] Ibid.

[21] https://www.quantros.com/Colorado-hospital-value-report

[22] https://denverchamber.org/policy/health-care-policy-work/

[23] Hub-Altarum Data Brief No. 31 - CO Denver Region

[24] NHRI TCOC 2018 Report

2016, Colorado's inpatient prices were 31% higher and outpatient total cost of care was 34% higher than the multi-state average.[25]

D. Payer Dynamics

Like the provider market in Denver, the payer market is concentrated with three payers accounting for over 80% of market share for individual exchange, small group, and large group business.[26] But in contrast to the provider and health system industry, insurance carriers are governed by stricter regulatory oversight. Colorado is a "prior approval" state, where the Department of Insurance has oversight of premium rate increases. Additionally, insurance companies must provide a competitive impact analysis in order to proceed with proposed mergers and acquisitions.[27]

Despite these regulations, there is some evidence of a lack of competitiveness in some of the payer lines of business in Colorado, according the United States Government Accountability Office analysis of Colorado's large group insurance market. The largest issuer in the state for large group insurance, Kaiser Foundation Group, held nearly 50% of market share in 2016.[28] However, in practice, there are signals that the payer market does function competitively as the self-insured employers interviewed in this assessment consistently contract with multiple carriers for their employee plan offerings. Additionally, the profit margins of Colorado payers have been a mixed bag in recent years, with only six out of 11 payers analyzed in the 2017 Colorado Health Market Review posting positive net income margins in 2016. The profitability of one payer's Medicare Advantage business (PacifiCare, a subsidiary of UnitedHealth Group) drove health plan profitably overall in Colorado in 2016, while the Kaiser Foundation Health Plan only managed to break even.[29] These signals, as well as the new trends in direct contracting between employers and providers that disrupt the payer status quo, show that there is some healthy competition among payers in Colorado.

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[25] https://www.civhc.org/2018/11/08/colorados-health-care-costs-continue-to-rise-above-other-states/

[26] United States Government Accountability Office, Report to Congressional Committees Private Health Insurance, March 2019, Accessed March 22, 2019. Retrieved from: https://www.gao.gov/assets/700/697746.pdf

[27] Colorado Revised Statutes Title 10 Insurance § 10-3-803" Acquisition of control of or merger with domestic insurer;" The Source on Healthcare Price and Competition. See Appendix for more information.

[28] United States Government Accountability Office, Report to Congressional Committees Private Health Insurance, March 2019, Accessed March 22, 2019. Retrieved from: https://www.gao.gov/assets/700/697746.pdf

[29] Baumgarten, A. 2017 Colorado Health Market Review, www.AllanBaumgarten.com

E. Momentum from Colorado's Legislative and Executive Branches of Government

Colorado's legislative and executive branches are extremely active in health care reform. In 2017, the Colorado legislature passed the Colorado Healthcare Affordability and Sustainability Enterprise Act that instated the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board to oversee delivery and payment reform programs statewide. Additionally, the current Administration identifies health care affordability as a key issue. After creating the Office of Saving People Money on Healthcare, Governor Jared Polis' Administration published The Polis-Primavera Roadmap To Saving Coloradans Money On Health Care.[30,31] The Roadmap incorporates a number of short- and long-term strategies to improve the efficiency of the health care system in Colorado (see Appendix).

Spotlight on Peak Health Alliance

The Peak Health Alliance in Summit County is a purchasing cooperative chartered in 2019 to address health care costs in a region that has consistently had the costliest health care in the nation. Representing about 6,000 covered lives, including two local governments, the county and at least one private-sector employer, the Peak Alliance negotiated a "very aggressive" reduction in rates directly with the largest health system in the county - Centura Health - as well as other providers, and will work with carriers to administer the new, negotiated rates. This bold solution is an emerging strategy that has the support of the Governor's office, as well as the support of the Colorado Insurance Commissioner, Michael Conway, who is working to implement a similar model statewide.[28,29,30,31]

F. Payment reform in Colorado

The payment reform movement has gained significant traction in Colorado, with 54.4% of dollars in the Medicaid market and 57.1% of dollars in the commercial market between payers and providers flowed through payment reform arrangements that are tied to quality.[36] While adoption in both Medicaid and commercial sectors is greater than the national average (32.2% and 43.5% respectively in 2017), the fact that the Colorado commercial market lags behind Medicaid is striking and highlights both the obstacles faced by the commercial sector, as well as the large role that the public sector is playing in adopting advanced alternative payment models.[37,38]

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30 https://www.colorado.gov/governor/sites/default/files/inline-files/RoadMapDoc-3.pdf

31 Additionally, the Hickenlooper Administration convened the Colorado Commission on Affordable Health Care, which published its final report in 2017. https://www.colorado.gov/cocostcommission

32 https://www.modernhealthcare.com/payment/unique-collective-has-ambitious-plan-lower-healthcare-costs

33 Such an entity exists because of CRS10.16.1001, a unique statute that encourages and supports the formation of purchasing cooperatives.

34 https://coloradosun.com/2019/02/15/peak-health-summit-county-health-care-prices/

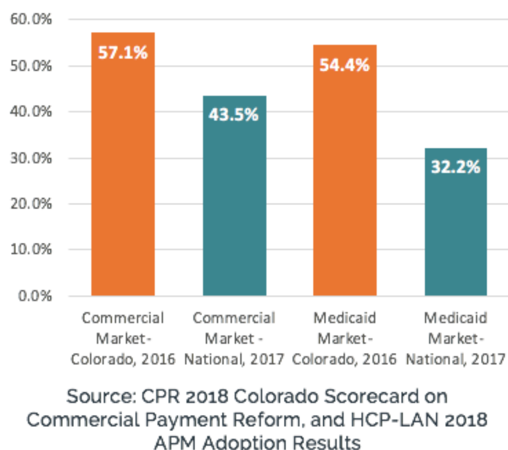
35 https://www.modernhealthcare.com/payment/unique-collective-has-ambitious-plan-lower-healthcare-costs

36 Catalyst for Payment Reform 2018 regional scorecard for CO, conducted in concert with the Center for Improving Value in Healthcare (CIVHC).

37 CPR analysis of HCP LAN 2018 APM Measurement Effort (counting Category 2 payments as value-oriented)

38 Bannow, T. "Survey results show risk is in the eye of the beholder," Modern Healthcare. July 13, 2019. https://www.modernhealthcare.com/hospital-systems/survey-results-show-risk-eye-beholder

Figure 5. Value-Oriented Payment Reform Adoption, as Percent of Total Dollars



Source: CPR 2018 Colorado Scorecard on Commercial Payment Reform, and HCP-LAN 2018 APM Adoption Results

Colorado's public sector has multiple initiatives in payment reform. For example, Colorado received a Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) grant, with a goal of providing access to healthcare with value-based payment for 80% of Colorado residents by 2019.[39] Along with the Colorado SIM initiative, Colorado also embarked on a Multi-Payer Collaborative (MPC) in 2012, which attempted to integrate all payers operating in Colorado, including Medicare and Medicaid, to facilitate participation in programs such as Comprehensive Primary Care (CPC), Colorado SIM, and Comprehensive Primary Care Plus (CPC Plus). The MPC effort had limited impact.

Finally, Colorado's Medicaid program, known as Health First Colorado, is extremely active in payment reform. Unlike most states where the Medicaid agency contracts with Managed Care Organizations to provide Medicaid coverage, Health First Colorado is a Managed Fee-For-Service program that works directly with providers to provide coverage to over 1.3 million Coloradans. Colorado Medicaid has recently embarked on a hospital transformation program,[40] and successfully rolled out a statewide Accountable Care Collaborative program that is on the forefront of integrating behavioral health.[41]

Part 2: Stakeholder Analysis

A. Purchasers

To understand the viewpoint of health care purchasers in Colorado, CPR surveyed five employer-purchasers and conducted follow up interviews with three of them. Those surveyed noted they are only somewhat involved in payment reform efforts, but are more robustly involved, in their view, than physicians and health plans. All five employer respondents felt employers are marginally shaping the market through their influence and activities.
The only example of successful employer-initiated payment reform cited was Colorado Public Employee Retiree Association's (PERA) bundled payment program for State retirees, for which the organization worked with a carrier to implement a bundled payment program for hip and knee surgery at four Denver-area hospitals. Covered members who undergo surgery at these hospitals, which were vetted for quality prior to implementation, pay no out-of-pocket costs for the procedure.[42] The five surveyed employers reported that employers have been promoting or using HEDIS and CAHPS metrics with their covered populations, but mostly believe these

[39] SIM Overview slide deck, available at: https://drive.google.com/file/d/0BxUiTIOwSbPUekZBcFJTX0ZwLU0/view
[40] https://www.colorado.gov/pacific/hcpf/colorado-hospital-transformation-program
[41] CPR, Colorado Leader's Perspectives Report, November 2018.
[42] https://www.catalyze.org/product/colorado-perspectives-health-care/

transparency initiatives have been only marginally successful at directing patients to high-quality providers.

Most employers surveyed felt that health plans are minimally ready to implement new forms of payment, and there was consensus that health plans in Denver have shown little interest in implementing payment reform. However, most noted that health plans were accommodating their payment reform requests, though one employer said health plans were resistant.

Employers agreed that the market power in the Denver area lies with providers. For example, employers noted the presence of hospitals with "must-have status," which means insurance products must have these hospitals in the network to be attractive to employers and/or employees. The most frequently cited barriers to payment reform include consolidation among providers, hospital ownership of physician groups, and providers' lack of incentive to reduce prices or provide price transparency.

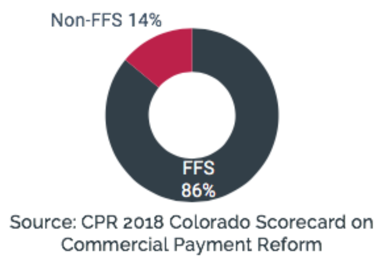
Employers identified purchaser cooperatives, price transparency, and Reference-Based Based Contracting—Medicare as the best opportunities for payment reform in the Denver market. One employer supported legislative reform to spur payment reform forward.

B. Providers

Two physician representatives and three hospital or health system representatives participated in CPR's online survey, and CPR conducted follow up interviews with both physicians and one of the hospital/health system representatives. These respondents recognized the varying involvement from diverse stakeholders in payment reform initiatives, including physicians and medical groups (seen as marginally involved), regulatory bodies (very involved), hospitals, health systems, and the hospital association (moderately involved), and health plans acting on behalf of employers (moderately or very involved). Additionally, the providers see multi-stakeholder coalitions, which include hospitals and health systems as members, as having a strong presence in the work toward payment reform.

The provider representatives noted that there are a few influential physician groups that refuse to participate in payment/delivery system reform, while there are also dominant physician groups that have demonstrated leadership in payment reform. On the hospital side, respondents recognized that some hospitals/health systems typically refuse to participate in payment reform programs.

Figure 6. Use of Fee-For-Service in Value-Oriented Payments in Colorado (2016 data)



Source: CPR 2018 Colorado Scorecard on Commercial Payment Reform

Although Colorado had a strong showing with respect to the percent of spend in value-oriented payment programs in the commercial market in 2016, the majority of this spend was in upside-only, fee-for-service based shared savings arrangements (26.5%) or pay-for-performance (18.1%). Payment reform programs not built on a fee-for-service architecture (i.e. bundled payment, and full or partial capitation) only accounted for 14% of value-oriented payments (Figure 5).[43] The provider representatives surveyed for this project validated CPR's Scorecard findings, responding that most hospitals are involved in per-diem and diagnosis-related group (DRG) based payments, with a significant proportion of contracts including pay for performance and shared savings. Surveyed hospital representatives believed that 11-25% of contracts in Denver include bundled payments. However, as of 2016, CPR's Scorecard on Payment Reform found that bundled payment accounted for less than 1% of commercial payments and less than 10% of Medicaid payments.[44] This disconnect between the responding provider's perception of current bundled payment contracting trends and the limited spend bundled payment spend in 2016 may be explained either by a recent uptick in bundled payment programs or, as one provider representative explained, a lack of benefit designs promoting patient use of bundled payment programs when offered. Providers interviewed for this study cited low use of global payment arrangements in Denver.

According to the providers CPR interviewed, the greatest obstacle to implementing new forms of payment, such as requiring global payment or downside risk, is the technical and analytic infrastructure required to support these contracts. They cited that information technology (IT) infrastructure is not sufficiently in place to support advanced payment models, limiting providers' capacity to handle global payment or downside risk. In some cases, health system respondents reported that they receive analytic and operational support from health plans; however, it's unclear whether this support fosters sufficient confidence among providers in adopting advanced payment models. Provider representatives also identified resistance to change, fear of the unknown and loss of control, and lack of trust among constituents as major barriers to advancing payment reform. Ultimately, physicians and hospitals did not assert an overt resistance to payment reform. Based on their sentiments, however, they are not the stakeholders championing advancement of advanced payment models, nor do they have incentives to be.

Unlike employer-purchasers, the providers engaged in this assessment see health plans as having the power in the market. They also find that health plans are not fully prepared to implement payment reform programs. Providers acknowledged that employers have a large

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[43] Catalyst for Payment Reform, 2018 Colorado Scorecard on Commercial Payment Reform, Available at: https://www.catalyze.org/product/colorado-commercial-payment-reform/

[44] Ibid.

role to play in implementing payment reform, and that previous payment reform attempts struggled because the lack of appropriate benefit designs created a risk of patients going out of network and failed to drive business to the health systems willing to accept new forms of payment. Providers voiced resistance to a "Reference-Based Based Contracting—Medicare" (RBC-M) approach like that being implemented by the Montana State Health Care and Benefits initiative.

C. Payers/Health Plans

To gain the payer perspective, CPR surveyed six payer representatives and conducted follow up interviews with two representatives. The health plan representatives noted that health plans are involved in payment reform on behalf of their self-funded customers, a perspective echoed by CPR's analysis of payment reform penetration in the state.[45] Health plans described themselves as only somewhat engaged in multi-stakeholder coalitions.

Health plan representatives identified fee-for-service as still the predominant method of payment to providers and were unsure whether hospitals can handle new forms of payment. Health plans cited that payment for non-visit functions or supplemental payments to primary care providers is more widespread – in fact, it accounted for 10% of spending in Medicaid line of business in 2016.[46] Payers cited transparency on health care costs and quality as an important way to encourage members to seek high-value care.

Despite the concerns of other stakeholders, payers identified significant strengths in their own ability to roll out payment reform. Payers say they have experience giving technical support to providers and are confident they can customize payment for the Denver market. Health plans noted there are statutory and regulatory barriers that put limitations on downside risk in self-funded business, specifically when a provider accepts risk for a defined population when there are some services that this provider doesn't offer.[47] That said, experts also agree that there are ways to circumvent this regulatory restriction.

There was a lack of consensus among payer representatives as to where the balance of power lies in Denver's health care market. While none of the payers saw themselves as market-shaping, they disagreed as to whether the more powerful stakeholders were employers or providers. The health plan respondents identified the lack of provider ability to implement payment reform, the need for collaboration, and the need for locally developed solutions as the

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[45] Catalyst for Payment Reform, Colorado Leader Perspectives on Payment Reform Impact, November 2018. Available at: https://www.catalyze.org/product/colorado-perspectives-health-care/

[46] Catalyst for Payment Reform, 2018 Colorado Scorecard on Medicaid Payment Reform, Available at: https://www.catalyze.org/product/colorado-medicaid-payment-reform/

[47] Specific statutory references are C.R.S 10.3.903 related to transacting insurance business in Colorado and 10.3.903.5 related to jurisdiction over providers of health care benefits. The DOI has applied these sections to say that if a health care provider is taking risk for services or care they cannot provide (e.g., multiple transplants, dialysis, burn treatment), the provider is offering insurance without a license, and the DOI can therefore require the provider to be regulated as an insurer or to limit the risk the provider takes.

biggest barriers to reform. The biggest opportunities for payment reform, in their view, lie in pursuing alignment across payers, including Medicaid, for payment to support integrated primary care, and engaging employers in payment reform programs.

Part 3: Market Types and Payment Reform Options

Based on the combination of the online stakeholder survey and interview findings, as well as structural data about the market, CPR identified each of these three groups (providers, health plans, and purchasers) as *market shaping* or *non-market shaping*. The interplay of who has power in the market -- who's calling the shots – may make all of the difference in what payment reform options are available or the best options for starters. The possibilities for payment reform are only as limited as our imaginations, but there is a fairly discrete list that is most often discussed today. Most changes to payment fall into one of three categories: upside only for providers; downside only for providers; and two-sided risk (both upside and downside for providers).

The right and left side of the schematic below separates markets into those in which providers are shaping the market (left) and those in which providers are not market-shaping (right). The top and bottom of the schematic divide markets into those in which purchasers are shaping the market (top) and those in which purchasers are not (bottom). Then within those two purchaser categories, there is the added dimension of the role of the health plan in shaping the market, which further distinguishes the four main quadrants into eight separate market types.

Figure 7. Catalyst for Payment Reform, Market Archetypes

Purchasers		Providers: Market-Shaping	Providers: Not Market-Shaping
Market-Shaping	HP +	Purchasers, providers and health plans are market-shaping (1)	Purchasers and health plans are market-shaping, providers are not (2)
	HP –	Purchasers and providers are market-shaping, health plans are not (3)	Purchasers are market-shaping, providers and health plans are not (4)
Not Market-Shaping	HP +	Providers and health plans are market-shaping, purchasers are not (5)	Health plans are market-shaping, purchasers and providers are not (6)
	HP –	Providers are market-shaping, purchasers and health plans are not (7)	Purchasers, providers and health plans are not market-shaping (8)

More than 35 leading payment reform implementation, academic, and research experts in the country provided input to CPR on which payment reform types are best suited to the eight different market types. However, each market is unique and there are micro markets within larger markets that deserve analysis. CPR will continue to build the knowledge base for such recommendations over time based on further expert input and, most importantly, iterative experience. Furthermore, the characteristics of markets are not static and can change over time. As a result, appropriate recommendations for a specific market are also likely to evolve.

Part 4: Denver Market Type and Payment Reform Recommendations

Based on CPR's market-type identification system, CPR considers Denver **a market type 5**, in which providers and payers are market-shaping and purchasers are not (yet) market-shaping, with the caveat that there is significant regulatory payer oversight that both constrains their market power and harnesses it toward high-value programs. Additionally, due to the current legislative and regulatory environment, as well as growing frustration at the variable value of the health care services they procure, purchasers appear to be stepping into a market-shaping role.

Based on expert analysis, the payment reform models that best suit this type of market include **upside only payment reforms** and efforts to **shift consumers to high-value, low-priced providers**. Payment reform programs with downside or two-sided risk arrangements are more viable when purchasers and health plans have enough leverage with providers to implement such programs. Given that purchasers are on the cusp of harnessing a market-shaping role, and the fact that upside only payment reform is abundant in the market (100% of Medicaid's payments to hospitals are in pay-for-performance; and over 44% of dollars in the commercial market are paid through shared savings and pay-for-performance arrangements), two-sided risk arrangements appear to be viable in Denver, especially if purchasers and payers creatively employ the leverage they hold to the fullest extent.

CPR's recommendations for the best opportunities for advancing payment reform in the Denver market in the near term are as follows:

A. Continue Building on Purchaser Momentum

A critical mass of purchasers is needed to drive payment reform forward. This will be a challenge given the fact that six out of the 10 largest private employers in Colorado are actually health systems. However, emerging trends in regulatory activity and public awareness are colliding to create the right conditions for purchasers to play a constructive role in payment reform, including how payment reform programs are evaluated. The Colorado Business Group on Health provide a foundation and organizational structure for coordinating purchaser action and creating a shared agenda for payment reform.

B. Benefit Design/Consumer Shift

In order to create market conditions for providers to deliver high-value services, purchasers can adopt direct-to-consumer financial incentives to encourage patients to seek care from high-value health care providers. Providers view these strategies as necessary to facilitate the success of value-oriented programs. Similarly, research shows that providing cost and quality information is not enough to ensure that patients will choose the highest value provider on their own; it is advisable that a patient's health insurance benefit design steers them to the best

option through price sharing differentials or other financial incentives. One strategy is the use of ***tiered networks***, in which consumers have lower co-payments if they choose providers that are designated as high-quality and lower cost. Another strategy is ***reference pricing***, which establishes a standard or reference price for a drug, procedure, service or bundle of services, and generally requires health plan members to pay the difference between the allowed amount and the reference price. Both of these strategies require sufficient information and data to compare and stratify providers by cost and quality. Purchasers can rely on multi-payer databases – such as the Colorado All-Payer Claims Database, the RAND study, the Colorado Business Group on Health's contract with CareChex (for quality measures), or alternatively leverage pre-packaged designation programs from health plans. Individual employer purchasers can implement these approaches at their own initiative, which may be an advantage over other strategies that require agreement by a greater number of purchaser parties in the market.

Given the strong desire among purchasers and consumers to improve the affordability of health care, benefit managers can make the case for employees and plan members to use identified providers to reduce costs without sacrificing quality. However, given the tight labor market, employer-purchasers are wary of implementing limited benefits policies that can cause disruption and abrasion within the provider network. With this in mind, the consumer shift strategy should be offered alongside traditional choices to employees with a thoughtful communications strategy.

If necessary, stakeholders can develop public-facing campaigns to build awareness in Denver about the wide variation in prices among hospitals.

Finally, congruent with the recommendations outlined by the Commission on Affordable Health Care, Denver employers have an opportunity to pursue Value-Based Insurance Design (VBID). The Internal Revenue Service recently expanded the list of preventive care services available pre-deductible for patients with high-deductible health plans that qualify for Health Savings Accounts.[48] The policy change removes financial barriers to medical care that helps maintain health status for individuals with chronic conditions, which is at the heart of VBID benefit design strategies. Employers have an opportunity to work with their health plans or TPAs to use benefit design, such as differential cost-sharing, to encourage use of high-value services while discouraging the use of low-value services.

C. Two-Sided Risk/Aligning with Medicaid

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) in coordination with Colorado's Department of Health Care Policy and Financing (HCPF) has rolled out a five-year reform effort -- the Hospital Transformation Program (HTP) -- to expand and accelerate

[48] https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions

hospital value-based payment programs. The programs' many priorities include a focus on preventing avoidable hospital utilization by ensuring the right care in the right setting.

There is both an advantage and an opportunity for private purchasers of health care to piggy back on the work that hospitals and Medicaid, through the authority from the Centers for Medicare and Medicare Services to be granted through the development of a State Plan Amendment (SPA) and a Medicaid 115 Waiver, will undertake through the HTP. The HTP plans to establish a *delivery system reform incentive payment* (DSRIP) program, which will create payment reform arrangements that will be codified by the end of 2019.[49] Private purchasers and their health plan and provider partners have the opportunity to participate in this process and replicate areas of success, creating alignment with the public sector in future payment reform arrangements.

Furthermore, the Colorado Hospital Association identified reducing "unwarranted care variation and unnecessary care" and "reducing emergency department visits for non-emergency medical conditions" as the best ways to reduce health care costs statewide.[50] These recommendations provide an entry point for dialogue with hospitals on how payment reform can lead to reductions in unnecessary care. Additionally, the recently enacted HB 19-1233 *Investments In Primary Care To Reduce Health Costs* law will increase use of primary care, providing health plans and providers with the business case to invest in chronic care management and more effective engagement with patients.

Due to providers' market leverage in Denver, purchasers and their payer partners will need to be creative to entice providers to enter into two-sided risk arrangements. Benefit design will play a key role.[51] Another opportunity to encourage providers to accept two-sided risk is to reduce their administrative burden in return for them taking on additional accountability. One example of the reduction of administrative burden is for health plans to remove or greatly reduce requirements for prior authorization.[52] Multi-payer alignment on performance measurement and care redesign could further reduce provider burden.

D. Building Value-Based Programs (Centers of Excellence, bundles) on Top of a Reference-Based Contracting- Medicare Foundation (Also Known as RBC-M or Medicare-Plus Contracting)

The Montana State Employee Health Plan successfully implemented a Reference-Based Contracting- Medicare (RBC-M) program using the Medicare Physician Fee Schedule as the reference point. The state health plan has seen impressive results. Since implementation, the plan has been able to avoid rate increases and even generate savings to help the state balance

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[49] Hospital Transformation Program, Program Status and Overview. Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) July 29, 2019.
https://www.colorado.gov/pacific/sites/default/files/2019%20July%20HTP%20Status%20and%20Overview.pdf
[50] https://cha.com/wp-content/uploads/2019/01/Health-Care-and-Hospital-Costs-Report-FINAL.pdf
[51] https://catalyst.nejm.org/payment-delivery-system-reform-phase/
[52] https://www.managedcaremag.com/archives/2018/3/conversation-mai-pham-md-payment-innovation-anthem-downside-risk-will-be-rewarded

its general funds. North Carolina State Employee Health Plan also attempted to implement a state-wide reference-based contracting- Medicare program but was unable to get sign on from major health system operating in the state. While 28,000 providers in North Carolina did agree to the contracts offered by the state treasurer's Clear Pricing Project, the purchasing power of the state employee health plan was not enough to contend with the lobbying efforts and impasses put forward by the health systems.[53, 54]

Embarking on such a program requires significant purchaser leverage, which Montana had through their state employee purchasing power, but North Carolina came up short. Because the State of Colorado purchases coverage separately for state employees and state retirees, to implement this type of approach, the two entities may need to collaborate to enhance their collective purchasing power, in addition to other private and public employer-purchasers. Banding together to harness market power is a viable solution that purchasers can pursue to harness the market power that currently resides with providers, and, to a lesser extent, payers.[55]

Colorado purchasers have the unique opportunity to create a state-wide purchaser cooperative to gain this leverage, expanding on Summit County's creation of a health care purchasing cooperative. As reported by the Colorado Sun, the Peak Health Alliance successfully negotiated discounted rates with providers enough to reduce premiums by 20%, thereby saving families who currently pay $2,000 in premiums per month approximately $400 a month.[56] There is support from the Department of Insurance to expand use of this strategy statewide, and the Colorado Business Group on Health has updated its by-laws to become a purchaser cooperative. Unlike Summit County, which only has one local hospital, the Denver region has many hospitals. This will increase the complexity of negotiating arrangements between a purchasing cooperative and the hospitals, especially if not all hospitals agree to the network provisions sought by the cooperative. However, HB 1174, Out-of-network Health Care Services, passed in 2019, will regulate and therefore contain costs for patients in the case that some providers become out of network through such a strategy.

E. Expand in Areas of Success: Transparency

Colorado stakeholders have taken impressive strides to promote transparency into health care costs -- though more work remains. While Colorado received a "C" grade on price transparency and an "F" grade on quality transparency in the [2017 Price Transparency & Physician Quality Report Card](), since then, the Colorado legislature passed new legislation to continue improving in this area. For example, new legislation requires all freestanding outpatient facilities to bill using their own unique national provider identifier; this will help to shed light on the price and

[53] March 2019 webinar hosted by the National Academy for State Health Policy.
[54] https://www.healthcaredive.com/news/north-carolina-folds-to-provider-pressure-with-insurance-plan-shifting-away/560649/
[55] https://hbr.org/2018/11/to-control-health-care-costs-u-s-employers-should-form-purchasing-alliances
[56] https://coloradosun.com/2019/06/04/peak-health-summit-county-lower-health-care-costs/

quality of freestanding outpatient facilities owned by larger health systems.[57] The state's All Payer Claims Database (APCD) is an extensive resource designed to put actionable data in the hands of stakeholders. Backed by the Colorado legislature, the APCD has support to increase the prevalence of claims data from self-funded employers and boost its ability to deliver actionable information.[58] Engaging patients with user-friendly, accessible and timely information on provider cost, quality, and medical decision-support tools is a challenging but vital area for employers to support, as it goes hand in hand with the benefit design recommendations outlined previously. Concrete actions that employers can take toward this effort begin with submitting their data as self-funded health care purchasers to the APCD.[59]

Conclusion

CPR is pleased to present this assessment of the current Denver market to CBGH in support of their work to help employers and other stakeholders take steps to create a more efficient and effective health care market. In 2018, the Peterson Center on Healthcare made a grant to CPR to support the adoption of performance-based health care purchasing strategies by employers to improve outcomes for workforces and reduce the cost of care. Given CBGH's potential to steward payment reform strategies in the market, CPR is confident that this assessment and the recommendations put forth can advance the pressing goal of increasing the affordability and improving the quality of health care in the Denver area.

Appendices

1. New and/or Current State Laws Relevant to Market Power

HB 1174: Out-of-network Health Care Services	2019	link
Colo. Rev. Stat. § 10-16-121. Required contract provisions in contracts between carriers and providers-definitions: Health Care Coverage Act – Colorado	1999 Amended: 2017	link
Colo. Rev. Stat. § 25.5-5-414. Telemedicine Legislative Intent: Colorado Medical Assistance Act – Colorado	2006 Amended: 2018	link
HB19-1233 Investments In Primary Care To Reduce Health Costs	2019	link
HB 1282 – Colorado Health Care Provider Unique Identification Per Site Or Service	2018	link
Colo. Rev. Stat. § 25-3-119 – Colorado- Regarding Free Standing Emergency Department	2018	link
Colo. Rev. Stat. § 10-3-803. Acquisition of control of or merger with domestic insurer – definitions: Insurance Holding Company Systems – Colorado.	2014	link

[57] NHRI TCOC 2018 Report.
[58] https://www.civhc.org/get-data/co-apcd-overview/data-submission/self-insured-employers/
[59] https://www.civhc.org/get-data/co-apcd-overview/data-submission/self-insured-employers/

Colo. Rev. Stat. § 10-3-803.5. Acquisitions involving insurers not otherwise covered-definitions: Insurance Holding Company Systems – Colorado	2017	link

2. Polis-Primavera Roadmap to Saving Coloradans Money on Health Care
   - Short term:
     - Increase hospital price transparency, through House Bill 19-1001 which mandates that hospitals contribute data to an annual, statewide Hospital Expenditure Report**.**
     - Establish a reinsurance pool to reduce premiums for people who buy their own insurance, following the leads of states like Oregon and Maryland[60]
     - Drive down the cost of health insurance by supporting a purchasing alliance in Summit County and testing innovative negotiation strategies with the state employee health plan
     - Lower hospital prices through innovative payment models, tools, community engagement to make care more efficient
     - Bolster consumer protections like prohibitions on surprise, out of network costs
     - Lower the cost of prescription drugs by importing prescription medication from Canada
   - Mid to long term:
     - Launch a state-backed health insurance option to increase competition, reduce the number of uninsured, and give consumers more choices and freedom in the health care marketplace
     - Reward primary and preventive care to expand access to behavioral and physical health care and promote cost-effective early identification and treatment
     - Expand the health care workforce so patients have access to the health care providers they need
     - Reform the behavioral health system by launching a statewide strategic action plan to expand access to mental health and substance use disorder treatment
     - Increase access to healthy food, and support the implementation of the Blueprint to End Hunger
     - Improve vaccination rates by sharing evidence with Coloradans so they can make the right choice for their families
     - Support innovative health care delivery and reform models like the Colorado State Innovation Model, Peak Health Alliance in Summit County, and Mesa County Model and implement the statewide strategic plan for health information technology

[60] https://nashp.org/state-reinsurance-programs-lower-premiums-and-stabilize-markets-oregon-and-maryland-show-how/