Petition Title: New CON Methodology Related to Ambulatory Surgical Operating Rooms Based on Pilot Demonstrations, Disclosure, and Consumer Choice

Petitioner:

Affordable Health Care Facilities, LLC
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Request: The request is to (i) revise the composition and authority of the SHCC and (ii) establish parameters for more CON's to be issued where increased price competition would be beneficial to consumers to increase quality, access, and value of health care services. The results and core principles of this petition are to:

1. Lower cost of facility services;
2. Develop managed competition;
3. Increase disclosure and transparency of all facility costs for consumers (patients);
4. Increase (a) choice; (b) safety/quality; (c) access; and (d) value of facility services for consumers;
5. Protect the fragile rural health care delivery system;
6. Support increased levels of operational efficiency in facilities that can be documented and measured; and
7. Encourage innovation in health service delivery.

Adverse Effects: Excessive costs for facility services for consumers will continue to result in the market place without implementation of this petition's premises/objectives. Hospital providers will encounter increased competition based on the QAV Basic Principles or be managed under a "public service utility" type of approach.

Duplication: The proposed methodology allows competition where excessive pricing for facility services exists.

QAV: The petition is based on the SMFP's QAV Basic Principles.

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Medical Facilities
Planning Section

It is the request of AHCF that hospital representatives and board members, as well as physician practice representatives, whose organizations possess CONs and who serve on the SHCC, maintain fiduciary conflicts of interest in regard to this petition and should not be permitted to vote on this petition.

It is important to note that very few participants in the health care system maintain true incentives to lower costs as described in the table below:

	Participants	Incentive to Reduce Health Care Costs
1	Insurance industry	No. Insurance payers and representatives are generally compensated as a percentage of medical expenses on a "mark-up basis." One of the greatest health industry misunderstandings is the belief that insurance payers and commissioned agents and consultants are truly motivated to reduce health care costs. As health costs rise, insurance participants gain increased revenues and earnings.
2	Hospitals	No primarily. Limited Yes. Increased charges generally result in increased revenues and earnings, especially for outpatient services with private payers as this petition describes. Hospitals have an incentive to reduce inpatient health care costs when paid on a prospective payment basis.
3	Physicians	No primarily. Limited Yes. Physicians are generally paid on a fee-for-service basis. Yet, many physicians continue to be concerned about the continuing burden of health care costs on their patients. As the leading care givers to patients with nurses, many, but not all, physicians tend to feel a responsibility to reduce health care costs while increasing access and safety/quality of health care services for patients.
4	Other health care providers	No. Most other health care providers are paid on a fee for service basis.
5	Pharmaceutical companies	No. Pharmaceutical companies are paid for each prescription ordered and purchased. There is an incentive to increase price and utilization of prescription drug use by consumers. However, it can be argued that prescription drugs used efficaciously can reduce hospitalization and other health care expenses.
6	Medical/DME suppliers	No. Suppliers are paid on a fee-for-service basis.
8	Consumers (Patients)	Yes with caveats. Consumers are often screened from the direct purchase costs of health care services, and if they are medially ill, there is limited incentive to seek less costly treatments. Medically ill patients seek to get well, often regardless of the cost to their health plan payer.
9	Government	Yes. Unequivocally the answer is "yes" unless lobbyists and conflicts of interests prevent elected representatives from voting on legislation that lowers health care costs.

Petition
State Health Coordinating Council ("SHCC")

Reformation of SHCC Composition and Expansion of Regulation of Health Care Facilities In the State of North Carolina

Proposed By:
Affordable Health Care Facilities, LLC
March 3, 2010

Preamble and Background

Affordable Health Care Facilities, LLC ("AHCF") has presented petitions to the SHCC in prior years. For the most part, the SHCC and the DHSR have chosen to ignore key tenets of the petitions, including:

1. increased transparency of health service pricing; and

2. Increased competition for licensed health care facilities.

It is AHCF's contention that the SHCC is primarily composed of individuals who (i) maintain conflicts of interest in holding their own CON's or representing organizations that hold CON's and (ii) do not have the political will to recommend substantive change to how the development of medical facilities in North Carolina are managed from an affordability perspective. Our nation cannot afford the health care delivery system as it is currently configured. The recent debate on health care reform has confirmed this contention. The trajectory of our national debt related to health care expenditures is unaffordable for nation and future generations of Americans.

On January 29, 2010 Attorney General Martha Coakley of Massachusetts released a preliminary report, Investigation of Health Care Cost Trends and Cost Drivers (attached herein as **Appendix A**). As we know, Massachusetts is a leading state working toward universal health insurance coverage for its citizens. However, Massachusetts is falling short of this universal goal from an affordability perspective. Attorney General Coakley is seeking to address this problem. The Boston Globe describes the preliminary report in a January 29 lead article:

> Coakley's staff found that payments were most closely tied to market leverage, with the largest hospitals and physician groups, those with brand-name recognition, and those that are geographically isolated able to demand the most money. "Everybody knows that there is dysfunction in the system, and nobody is happy with it," Coakley said in an interview yesterday. "These rising costs are unsustainable. If we don't do something about it, the only thing we'll be able to afford is health care. No one will have money for food or housing."

The Certificate of Need ("CON") statutes were developed first and foremost to secure affordable health services:

Article 9.

Certificate of Need.

§ 131E-175. Findings of fact.
The General Assembly of North Carolina makes the following findings:

(1) That the financing of health care, particularly the reimbursement of health services rendered by health service facilities, limits the effect of free market competition and government regulation is therefore necessary to control costs, utilization, and distribution of new health service facilities and the bed complements of these health service facilities.

(2) That the increasing cost of health care services offered through health service facilities threatens the health and welfare of the citizens of this State in that citizens need assurance of economical and readily available health care.

(3) That, if left to the market place to allocate health service facilities and health care services, geographical maldistribution of these facilities and services would occur and, further, less than equal access to all population groups, especially those that have traditionally been medically underserved, would result.

It is AHCF's contention that CON regulation and the resulting SMFP have failed to adequately contain health care costs in North Carolina so as to result in affordable and accessible health insurance for our citizens, including large populations such as state employees.

Recommendation

AHCF recommends the following steps be taken to address rising health care costs in North Carolina:

1. The SHCC should be reconstituted in the following manner:

   a) The SHCC should be composed of members solely representing business and industry who (i) have no ties to health care providers through board membership or other association and (ii) are freely able to confirm that they possess no conflicts of interest.

   b) An advisory board to the newly constituted SHCC should be maintained that is composed of health care providers that represent all major components of the health care delivery system and can deliver important insight to the newly constituted membership of the SHCC.

2. The SHCC should recommend to the Governor and the North Carolina General Assembly that:

a) All health care facility service pricing (charges and reimbursement by payer) should be fully disclosed to consumers prior to the delivery of care in a transparent manner.

b) The newly constituted SHCC should be given increased regulatory authority to establish maximum charges by health care provider in much the form of a "public service utility" model.

c) In highly populated geographic areas where there is (i) confirmed consolidation of health care providers through integrated delivery systems ("IDS's") or otherwise and/or (ii) confirmed reimbursement to providers by private payers that is considered to be excessive by a "reasonable person" in relation to underlying costs or generally resulting in excessive financial returns, new applicant facilities should be given the opportunity to apply for CON's to increase competition for purposes of quality, access, and value.

AHCF fully recognizes that the above recommendations are beyond the purview of the SHCC and the DHSR in terms of authority to implement. The recommendations will require legislation enacted by the Governor and the NCGA. However, the SHCC and the DHSR can be bold in their leadership and fully consider these recommendations in a forthright manner and involve citizens and other interested parties to participate in the review of the effectiveness of the SMFP to maintain quality, access, and value of health services in North Carolina for our citizens through a more transparent approach than used to date.

Compelling Evidence

If Attorney General Cooper and his office undertook the same study of health care service pricing and reimbursement that Attorney General Coakley did in Massachusetts, AHCF believes that the same conclusions would be reached as to price being the key driver of rising health care costs. Compelling evidence can be found with most all health care facility-based services in North Carolina. With increasing employment of physicians by hospitals and larger health systems throughout the state, market leverage is only increasing so that payers, such as BCBSNC, have limited capability to negotiate reasonable reimbursement with hospitals and larger health systems.

CON protection has in effect provided medical facilities in North Carolina with monopolistic and oligopolistic market protection and leverage. This

market protection is only increasing with further horizontal and vertical integration by hospitals and health systems. The market leverage is best exemplified by the fact that most all hospitals/health systems negotiate only a discount off of billed charges for all outpatient services (e.g surgery, diagnostic testing, home health, DME) from BCBSNC. Most all physicians and their physician practices on the other hand all have fixed reimbursement generally established as a multiple percentage of Medicare. Hospitals should be held to fixed pricing like physicians. The financial weight of discount off of billed charges for outpatient services reimbursement falls mostly on non-Medicare patient populations.

Please review the November 2009 EOB from BCBSNC in **Appendix B** for a very common radiology service and established technology, a CT scan (pelvis and abdomen), performed at a non-profit, relatively urban community hospital:

Table I – CT Scan Reimbursement by BCBSNC (Hospital and Physician)

Facility Fee	Charge Amount	Contract Discount	Allowed Amount	Medicare Allowable
CT Abdomen (CPT 74170)	$3,111.78	$1,717.70	$1,394.08	$311.49
CT Pelvis (CPT 72193)	$2,628.77	$1,451.01	$1,177.76	$241.76
Facility Services	$515.60	$284.61	$230.99	N/A
Total Facility Fees	$6,256.15	$3,453.32	$2,802.83	$553.25

Physician Fee	Charge Amount	Contract Discount	Allowed Amount	Medicare Allowable
CT Abdomen (CPT 74170)	$212.00	$74.52	$137.48	$69.21
CT Pelvis (CPT 72193)	$187.00	$72.90	$114.10	$57.53

Facility Fee	Charge MCare Ratio	Allowable MCare Ratio	Effective Discount
CT Abdomen (CPT 74170)	999.00%	447.55%	55.20%
CT Pelvis (CPT 72193)	1087.35%	487.16%	55.20%
Facility Services	N/A	N/A	55.20%
Total Facility Fees	1130.80%	506.61%	55.20%

Physician Fee	Charge MCare Ratio	Allowable MCare Ratio
CT Abdomen (CPT 74170)	306.31%	198.64%
CT Pelvis (CPT 72193)	325.05%	198.33%

The hospital charge to Medicare allowable ratio for the facility fees was over 1,000%, nothing short of outrageous. The ultimate BCBSNC discount was 55.20% for the facility portion, which confirms a flat discount off of charge approach for reimbursement. The physician reimbursement is approximately 198% of Medicare, which is within the acceptable range.

The argument that hospitals have greater expenses due to uncompensated care than physicians does not "hold water" under rigorous analysis. First, hospitals receive disproportionate share payments from the federal government to account for uncompensated care. Please refer to **Appendix C** for disproportionate share payments made to North Carolina hospitals for Fiscal Year 2009. The purpose of these payments is to partially reimburse hospitals for uncompensated care provided. Second, physicians provide professional services as uncompensated care but receive no federal subsidies under the disproportionate share program.

It also can be argued that BCBSNC and other private payers have limited employers to maintain complete provider networks without disruption. Perhaps more importantly, private payers earn more revenues as health care expenses increase as most off of their administrative and risk fees are calculated as a "cost-plus" mark-up of paid/allowable health care expenses.

As the aforementioned radiology facility bill was further negotiated with the hospital, an argument was made by the hospital to the following effect in a "sanitized" quotation of this discussion:

> We subscribe to a comparative pricing service (PMMC) out of Charlotte. PMMC uploads Medicare data into a reporting system. We ran a comparative charge report with these two CPT's comparing [this hospital] to a Market Average which included the following hospitals [list of 8 in the region]. The time frame was calendar 2008 (the most current that they had available). The variance in our charges for these procedures compared to the market was about $229.

This statement almost proves that hospitals in North Carolina compare pricing with each other and "shadow price." Without more management of pricing that is more closely related to underlying costs, the citizens of North Carolina, private payers, and state government will continue to pay outrageous reimbursement for health services from medical facilities, particularly the larger ones with more market leverage. The question that we must ask is what is fair reimbursement for a hospital in North Carolina or any other state?

Below in **Table II: Sample Hospital Financial Performance**, I have prepared an algebraic model for proposed hospital UCR reimbursement without

geographic, medical education, and other adjustments as a modeling exercise for UCR reimbursement.

- Assumptions/Explanation:

1. Total operations costs are equal to $100 for all health services at a sample hospital.

2. Target total reimbursement is equal to 105 or 5% above operations cost. A 5% percent earnings margin from operations is fair for a not-for-profit hospital.

3. The patient payer mix is 42% Medicare; 2% TriCare; 6% Medicaid; 6% FEHP and SEHP (government employee health plans); 31% Commercial; 3% Private Pay; and 10% Charity Care.

4. The cost to reimbursement ratio column assumes that Medicare reimbursement is 75% of cost ($100). Medicaid reimbursement is set at 80% of Medicare or 60%. FEHP/SEHP reimbursement is set at 60% above Medicare or 120%.[1] Private Pay reimbursement is set at 30% Or 40% of Medicare. Charity Care has no reimbursement or 0%.

The Commercial Payer "Cost to Reimbursement Ratio" is set (backed into) at the level that results in target reimbursement being equal to $105. In the table below, this Commercial reimbursement is calculated to be 194.50% of cost or 259.33% of Medicare.

Table II: Sample Hospital Financial Performance

	Payer Mix	Cost to Reimb. Ratio	Weighted Average	% of Medicare
Medicare	42.00%	75.00%	$31.50	100.00%
TriCare	2.00%	75.00%	$1.50	100.00%
Medicaid	6.00%	60.00%	$3.60	80.00%
FEHP and SEHP	6.00%	120.00%	$7.20	160.00%
Commercial	31.00%	194.50%	$60.30	259.33%
Private Pay	3.00%	30.00%	$0.90	40.00%
Charity Care	10.00%	0.00%	$0.00	0.00%
	100.00%		$105.00	
Target Reimbursement			$105.00	

[1] The GAO and CBO may have more accurate estimates as to what percentage of actual cost is covered by government sponsored health plans. If Medicare covers more than 75% of cost, then less cost shifting to private commercial payers would be required.

This computation is approximately 50% of what BCBSNC agreed to reimburse the hospital for the CT-Scans (506.61% of Medicare) in November 2009 as shown in **Table I.**

Lastly, recent research as shown in **Appendix D** has shown that ASC's offer lower cost and higher quality alternatives for consumers. The single specialty pilot demonstration for ASC's approved by the SHCC in 2009 does little to provide needed competition at the price and quality level for hospitals. We need more price competition for hospitals with ASC's.

Conclusion

If we as a state and as a nation wish to make health care affordable and universally available to all citizens, then we must make it affordable. CON legislation has failed to manage health care costs in an adequate model given evidence presented in this petition and references. Therefore, AHCF recommends a more heavy handed approach to regulating facilities and their pricing, especially given increasing market concentration and leverage resulting from expanding IDS's (e.g. vertical and horizontal integration, including physician employment). This management should begin with a reformation of the SHCC and its membership due to conflicts of interest.

A more palliative alternative may be to more fully open competition among health care facilities where excessive reimbursement can be documented as AHCF has proposed in prior petitions. If the SHCC cannot overcome its member conflicts of interests and does not have the political will to pursue such managed competition, then we as consumers are left with little other recourse than to recommend increased price regulation under a "public service utility" model.

Appendix A

Investigation of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 118G, § 6½(b)

Preliminary Report

January 29, 2010

OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY
ONE ASHBURTON PLACE o BOSTON, MA 02108

OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY

Investigation of Health Care Cost Trends and Cost Drivers
Pursuant to G.L. c. 118G, § 6½(b)

PRELIMINARY REPORT
January 29, 2010

I. OVERVIEW

The Office of the Attorney General (AGO) releases this preliminary report based on its ongoing investigation of health care cost trends and cost drivers pursuant to the authority granted to the Attorney General by Section 24 of Chapter 305 of the Acts of 2008, *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care.* In accordance with the statutory mandate, the focus of our investigation and this preliminary report is squarely on factors that contribute to cost growth within the Commonwealth's health care system. This preliminary report identifies factors driving up health insurance premiums in Massachusetts to help policymakers in this state develop measures to control costs without sacrificing quality or access. It reflects current realities of the Massachusetts health care market to inform policymakers focused on cost containment. This report does not address health care reform efforts in other states or at the national level. This preliminary report provides a broad analysis of the Massachusetts health care marketplace and does not make any conclusions about specific health care providers or insurers.

Although our investigation is ongoing, our preliminary analysis indicates that current contracting practices by health insurance companies and health care providers have resulted in significant differences in compensation rates among hospitals and physicians that do not appear to be based on the complexity or quality of the care provided. These market dynamics and distortions should be considered by the Legislature and administration policymakers pursuing health care cost containment strategies.

Health care costs are increasing much faster than the growth in the economy, gross domestic production (GDP), and wages. Such increases, if unchecked, threaten the financial stability of individuals and businesses, and the future viability of our gains in health care access. Massachusetts is a national leader in health care. In the Commonwealth, we benefit from highly ranked health plans and hospitals, and we also have strong market reforms protecting access to health care that are a national model. As a result of Chapter 58, Massachusetts has expanded coverage to 97% of the population through the shared responsibility of individuals and employers. These landmark gains in access, however, are jeopardized by unsustainable increases in health care costs in Massachusetts.

To advance the discussion of cost containment and to help foster value-based system redesign, the Attorney General used the civil investigative demand authority the Legislature granted in Chapter 305 to scrutinize the Massachusetts health care market. The AGO analyzed information and documents produced by five health insurance companies representing more than 70% of the Massachusetts market, and fifteen health care providers from various regions of the state and representing diverse hospitals and physician groups including community, teaching,

and disproportionate share medical centers.[1] We focused our investigation on contracting practices and contract prices (i.e., the prices negotiated between health insurance companies and hospitals and physicians for hospital inpatient and outpatient care, and professional services) for commercial health insurance for the period 2004 through 2008. While our investigation continues and our analysis is not final, our preliminary review has revealed serious system-wide failings in the commercial health care marketplace which, if unaddressed, imperil access to affordable, quality health care. In brief, our investigation has shown:

A. Prices paid by health insurance companies to hospitals and physician groups vary significantly within the same geographic area and amongst providers offering similar levels of service.

B. Price variations are not correlated to (1) quality of care, (2) the sickness or complexity of the population being served, (3) the extent to which a provider is responsible for caring for a large portion of patients on Medicare or Medicaid, or (4) whether a provider is an academic teaching or research facility. Moreover, (5) price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.

C. Price variations are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers.

D. Variation in total medical expenses on a per member per month basis is not correlated to the methodology used to pay for health care, with total medical expenses sometimes higher for globally paid providers than for providers paid on a fee-for-service basis.

E. Price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts.

F. The commercial health care marketplace has been distorted by contracting practices that reinforce and perpetuate disparities in pricing.

The Attorney General expects to complete this analysis and present detailed findings through the G.L. c. 118G, § 6½ health care cost containment hearings before the Division of Health Care Finance and Policy (DHCFP), scheduled to begin on March 16, 2010. The Attorney General plans to focus attention on the preliminary findings outlined in this report during the DHCFP hearings.[2]

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[1] The Division of Health Care Finance and Policy (DHCFP) defines "teaching hospitals" according to the Medicare Payment Advisory Commission's (MedPAC) definition of a major teaching hospital: At least 25 fulltime equivalent medical school residents per one hundred inpatient beds. DHCFP defines "disproportionate share hospitals" (DSHs) as those hospitals with a large percentage (63% or more) of patient charges attributed to Medicare, Medicaid, other government payers, and free care.

[2] This cost containment investigation is the latest of several AGO initiatives to control health care costs and to protect consumers and small businesses. The Attorney General's efforts have included: (1) Medicaid fraud enforcement actions that yielded record recoveries for Massachusetts, (2) civil actions against drug companies and

Pursuant to the requirements of the statute, this preliminary report does not disclose any confidential information produced in response to our civil investigative demands. Instead, we present de-identified information at this time for illustrative purposes.

II. OFFICE OF THE ATTORNEY GENERAL INVESTIGATION

A. Statutory Authority

The Legislature, through Section 24 of Chapter 305 of the Acts of 2008, *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care*, directed DHCFP to hold annual public hearings "concerning health care provider and private and public health care payer costs and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates." The statute authorizes the Attorney General to intervene in these hearings and, with specific authority to compel the production of information from payers and providers, to conduct an investigation into the factors that contribute to health care cost growth and the relationship between provider costs and payer premium rates.[3]

B. Goals of AGO Investigation

To fulfill her responsibility under the statute, the Attorney General directed her Health Care Division to conduct an extensive investigation into how health care is paid for in the Commonwealth, focusing in particular on commercial health plan payments to health care providers. Through our investigation, we sought to understand how commercial health insurance companies (sometimes referred to as "insurers," "health plans," or "payers") and health care providers (e.g., hospitals, physician groups) contract, how insurers measure and evaluate the quality of providers, and how insurers and providers negotiate payment rates. In particular, we sought to determine whether the contracting process ultimately supports or impedes the delivery of quality health care at an affordable price.

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insurance companies that returned millions to the Commonwealth and its agencies, (3) antitrust review that monitored potentially anticompetitive market conduct, (4) community benefits guidelines that promoted non-profit hospital and health plan activity to serve their communities and provide free or low-cost services, and (5) non-profit/public charities oversight that expanded review of executive compensation at major health care providers and insurers.

[3] G.L. c. 118G, §6½(b) provides:

> The attorney general may review and analyze any information submitted to the division under section 6 and 6A. The attorney general may require that any provider or payer produce documents and testimony under oath related to health care costs and cost trends or documents that the attorney general deems necessary to evaluate factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates. The attorney general shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose such information or documents to any person without the consent of the provider or payer that produced the information or documents except in a public hearing under this section, a rate hearing before the division of insurance, or in a case brought by the attorney general, if the attorney general believes that such disclosure will promote the health care cost containment goals of the commonwealth and that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Such confidential information and documents shall not be public records and shall be exempt from disclosure under section 10 of chapter 66.

C. Information Gathered and Reviewed

The AGO issued civil investigative demands (CIDs) pursuant to § 6½(b) to five major Massachusetts health plans as well as to fifteen providers representing a geographical cross-section of academic medical centers, community and disproportionate share hospitals, physician organizations, and an ancillary service provider. The information we gathered pursuant to the CIDs includes contract documents, financial and operational strategy documents, as well as detailed cost and quality data discussed in this report.

In addition, we conducted more than three dozen interviews and meetings with providers, payers, health care experts, consumer advocates, and other key stakeholders. To assist with the investigation, the AGO engaged consultants with extensive experience in the Massachusetts health care market, including an actuary and experts in the areas of health care quality measurement and evaluation, and payer-provider contracting.

In preparing our analysis, we focused on documents and information reflecting how Massachusetts health plans and providers think about cost and quality and, in particular, how they compare payment rates and evaluate quality performance. Our goal was not to independently assess whether a provider is "good quality" or "poor quality" (and we make no such judgments in this report), but to determine how the market participants themselves approach these questions, so that we could assess the current functioning of the health care marketplace and, specifically, whether payers and providers are engaged in "value-based" contract negotiations that pay providers based on the quality and complexity of the services being delivered.

1. Health Care Pricing and Cost Data

We obtained and analyzed detailed information from health plans and providers regarding: (a) price – the rate at which health plans reimburse providers for each health care service, (b) total medical expenses – the per member per month medical spending attributed to each member's primary care physician or physician group, and (c) unit cost – the cost to a health care provider to deliver particular health care services.

a. Price

Price is the contractually negotiated amount (or reimbursement rate) that an insurer agrees to pay a particular hospital or health care provider for health care services. This is the "price tag" that a given insurer has agreed it will pay each time one of its members incurs a covered expense.

We obtained detailed information from the major health plans on comparative pricing for the Massachusetts hospitals and affiliated physician organizations in each plan's network. While the comparison of individual service or procedure pricing may be useful for consumer comparison as provided by the Health Care Quality and Cost Council's website

http://www.mass.gov/myhealthcareoptions, analysis of the entire payment rate structure more accurately reflects the way health plans and providers negotiate and set prices.

Typically, major health plans and hospitals negotiate prices for inpatient health care services using a base case rate. The base case rate represents a severity-neutral price that is then adjusted by a set of standard "weights" that reflect the complexity of each case and may be further modified if the case becomes atypical or an "outlier." Additional prices are negotiated for a limited set of other inpatient services such as very high-cost or experimental procedures. For hospital outpatient services, health plans have set standard fee schedules for the universe of outpatient services (e.g., standard fees are set for radiology, laboratory work, observation, behavioral health, etc.). The plans and hospitals negotiate a specific multiplier to each of these standard fees; for example, a provider with a 1.2 multiplier for radiology services would be paid 120% of the standard fee schedule rate for covered radiology services. Similarly, physicians and plans typically negotiate a multiplier to be applied to each plan's standard fee schedule for professional services.[4]

In response to our CIDs, health plans provided detailed information regarding the variation in prices and payment rates in their networks. Two major health plans provided information on the variation in payments made to each hospital and physician group in their network, as compared to the network-wide average, with no additional calculation required on our part. These plans calculated a "payment relativity factor" for hospitals taking into account volume, product mix, service mix, and other factors particular to a hospital's payment history. Both plans case mix adjusted their hospital inpatient payments for the acuity of the patients served at that hospital, in order to compare hospital rates on an "apples-to-apples" basis that strives to account for differences in the sickness of the population served and the complexity of the services provided. The information provided allowed us to measure the variations in hospital and physician payment rates in each health plan's network.

Another major health plan provided us with detailed hospital inpatient and outpatient price information, rather than payment rate information. Unlike payment rate information, this price information was not adjusted for volume, product mix, service mix, or other factors particular to a provider's payment history. With this price information, we were able to calculate the relative price paid to each hospital for the same comprehensive market basket of services by weighting each hospital's inpatient and outpatient price information to the health plan's network-wide average mix of all inpatient and outpatient services. Since this approach controls for differentiating factors such as volume, product mix, service mix (complexity), and case mix (acuity), we were able to compare the pure "price" that insurers negotiate with different hospitals for all hospital inpatient and outpatient services.

b. Total Medical Expenses

In addition to price and payment rate information, health plans track the total medical expenses (TME) incurred for each health plan member back to that member's primary care provider and/or physician group. TME is expressed as a per member per month dollar figure

[4] Our analysis accounts for variations in units of payment, such as payments based on per diems or a percent of charges, where possible based on data received.

based on allowed claims. TME accounts for *all* of the medical expenses associated with a member regardless of where those expenses are incurred (i.e., it includes physician visits as well as all hospital, laboratory, imaging, and other services, wherever those services occur). As such, TME reflects both the volume of services used by each member (utilization), as well as the price paid for each service (unit price).

Two health plans provided us with data comparing the TME of different provider systems in their respective networks based on claims data for more than one million Massachusetts members.[5] As is industry practice, the health plans adjusted their TME data with standardized health status scores to account for the demographics and sickness of the populations cared for by each provider system. This enables an apples-to-apples comparison of relative spending per patient, and ensures that systems caring for a sicker population will not inaccurately appear as higher spending solely for that reason.

c. Unit Cost

In addition to price, payment rate, and total medical expense information, we obtained detailed information from a number of hospitals regarding their internal costs for inpatient services as tracked through their own cost-accounting systems. Hospitals typically track their inpatient costs by 500 or so diagnostic related groups (DRGs), and break out the costs associated with each admission or discharge by the direct costs (such as the labor, equipment, and materials used directly in the patient's medical care), and indirect costs (such as any teaching or research that the hospital engages in as part of its mission, or the salaries of its management staff that are not attributable to any one admission or discharge). We are continuing to analyze this detailed internal cost information. We also obtained some providers' internal analyses that compare certain hospital costs on a case mix adjusted discharge basis.

2. Quality Data

We reviewed numerous quality metrics that assess the performance of hospitals and physician groups. First, we obtained data collected by health plans using their own aggregate measures of quality for both physicians and hospitals. While we found that each health plan takes a unique approach to evaluating provider quality, the major plans generally select quality measures from national government and non-profit organizations that are well-vetted and widely accepted, including: Centers for Medicare and Medicaid Services (CMS); Agency for Healthcare Research & Quality (AHRQ); National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS); Massachusetts Health Quality Partners (MHQP); and the Leapfrog Group. Second, we examined publicly reported quality metrics and results for Massachusetts hospitals and physicians, including CMS measures of patient experience and hospital performance.

[5] While TME can only be calculated for HMO and point of service (POS) members, whose expenses can be attributed to a particular primary care physician, the large numbers of patients insured under HMO and POS products in Massachusetts means that TME is a useful metric for comparing the varying levels of expenses incurred by different provider systems per patient.

Through our investigation, we have learned that different health plans and providers view different quality measures more or less favorably for a variety of reasons. We do not reach any conclusions regarding the accuracy, statistical significance, or appropriateness of the quality measures we reviewed. Rather, our focus is to identify the quality measures that health plans use and to then determine whether those measures influence contract negotiations such that prices paid to health care providers correlate positively with quality as measured by those health plans (i.e., are health plans paying more to providers who provide higher quality care as measured by the health plans themselves).

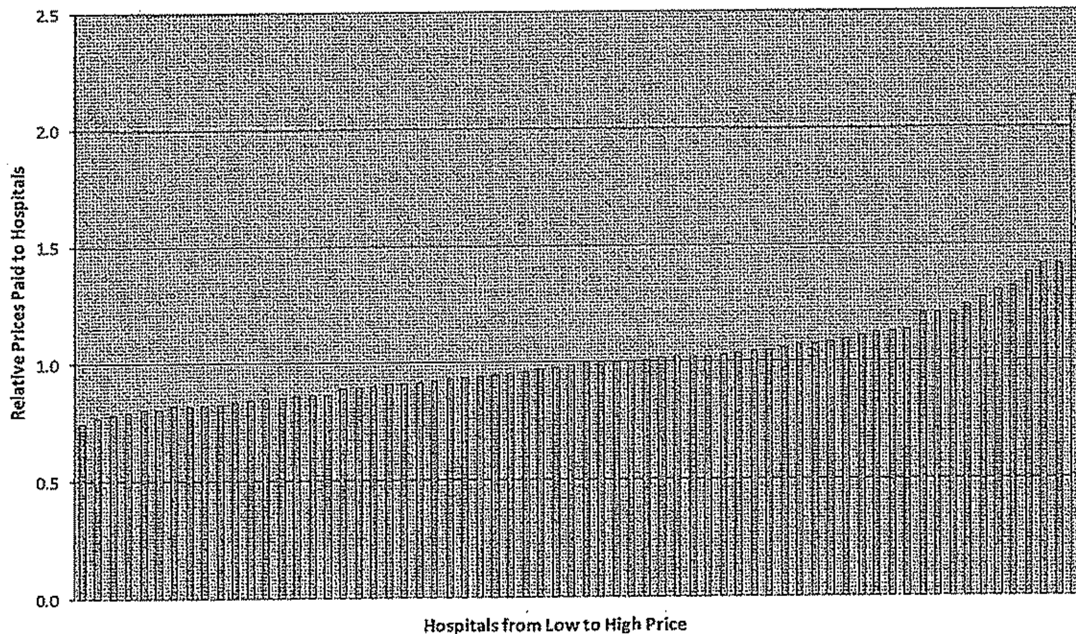
III. PRELIMINARY FINDINGS

A. Prices paid by health insurance companies to hospitals and physician groups vary significantly within the same geographic area and amongst providers offering similar levels of service.

Commercial insurers in Massachusetts pay health care providers at significantly different levels. As shown below, the disparity between the highest and lowest paid provider can exceed 200% (i.e., the highest paid provider can be paid at more than twice the rate of the lowest paid provider). We found wide disparities in both price and payment rates.

1. Variation in Hospital Prices

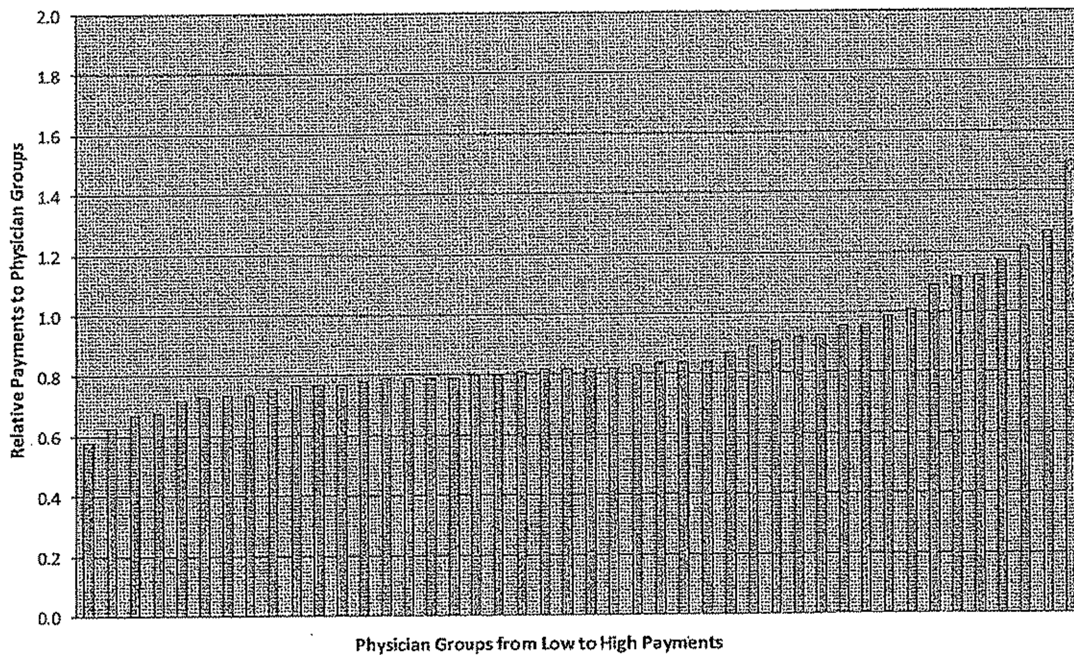
The following graph shows the variation in "pure price" paid by one major insurer to Massachusetts hospitals for the same market basket of services.



The prices paid to hospitals in this insurer's network vary by about 190% from the lowest to the *second* highest paid hospital.[6]

2. Variation in Physician Group Prices

This next graph shows the significant variation in rates paid by one major insurer to physician groups in Massachusetts with the highest paid group receiving a rate that is more than two times the rate of the lowest paid group.



The comparative price information and comparative payment information show the same results: Insurers are paying hospitals and physician groups in their networks widely varying prices.

[6] Prices vary by about 280% from the lowest to the very highest paid hospital, which is a community hospital with negotiated prices that appear to be significantly higher than all other hospitals.

B. **Price variations are <u>not</u> correlated to (1) quality of care, (2) the sickness or complexity of the population being served, (3) the extent to which a provider is responsible for caring for a large portion of patients on Medicare or Medicaid, or (4) whether a provider is an academic teaching or research facility. Moreover, (5) price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.**

1. **Wide disparities in price are not explained by differences in quality of care**

Wide variations in price are unexplained by differences in quality of care delivered as measured by the insurers themselves. We compared price and quality data using dozens of graphs and statistical calculations to determine whether there is a correlation between price paid and quality measured. These graphs include comparisons of physician and hospital prices and payment rates to insurers' own overall quality and mortality scores for those providers, as well as to publicly available CMS process and patient experience scores for those providers.

Our preliminary results indicate that there is no correlation between price and quality, and certainly not the positive correlation between price and quality we would hope to see in a rational, value-based health care market. During our investigation, we interviewed numerous providers and insurers who confirm that there is no correlation between price paid to providers and the quality of the providers' services.

Insurers track price, payment rates, and TME. They also measure the quality performance of providers in their networks. Yet they do not pay providers based on their quality performance, and are aware that providers they measure as high quality are often paid at a lower level than providers they measure as poor quality.[7]

2. **Wide disparities in prices and total medical expenses are not explained by the sickness or complexity of the population being served**

a. **Hospitals**

We have found that the prices paid to hospitals do not correlate to the acuity or complexity of the cases handled by the hospital as measured by the hospital case mix index (CMI), which is calculated for each hospital in Massachusetts by the Division of Health Care Finance and Policy and publicly available on the Executive Office of Health and Human Services' website.[8] A CMI of 1.0 is average and hospitals with a higher CMI (above 1.0) serve a

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[7] Our analysis suggests that the pay-for-performance (P4P) programs implemented by all major insurers have proven inadequate to align payment with quality outcomes. First, the amount at risk in typical P4P programs is limited. Evidence shows that the amount of payment at risk in typical P4P programs is never more than 10% of a provider's total reimbursement, with one major insurer's programs ranging from 1-5% to total revenue. The vast majority of reimbursement is therefore unrelated to quality performance. Second, since P4P measures, targets, and payouts are negotiated between insurers and providers, market leverage (see Section C below) factors into the design of these programs.

[8] See http://www.mass.gov/?pageID=eohhs2terminal&L=6&L0=Home&L1=Researcher&L2=Physical+Health+and+Treatment&L3=Health+Care+Delivery+System&L4=DHCFP+Data+Resources&L5=Hospital+Summary+Utilization+Data&sid=Eeohhs2&b=terminalcontent&f=dhcfp_researcher_hsudf_hsudf_08&csid=Eeohhs2

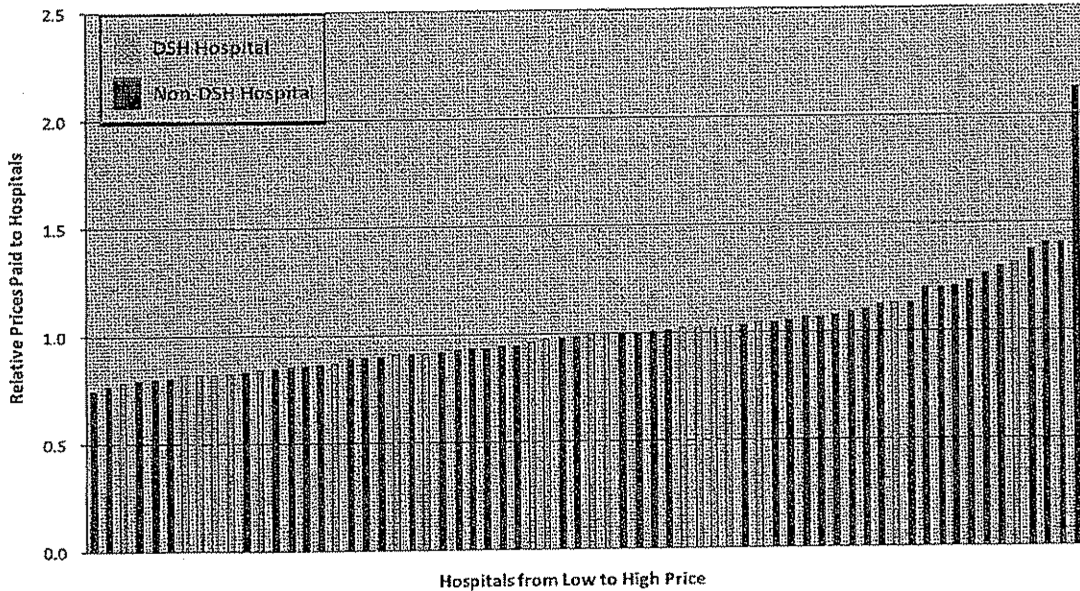
more complex or sicker population on average. The CMI for hospitals do not correlate to the price difference paid to those hospitals. As one example, on a list of 65 Massachusetts hospitals sorted from highest to lowest paid by a major health plan, some of the highest paid hospitals have some of the lowest CMIs, whereas a major tertiary medical center with one of the highest CMIs was paid less than dozens of other hospitals with lower CMIs.

b. Provider Groups

We also found that the total medical expenses (TME) associated with each provider group do not correlate to the acuity or complexity of the populations served as measured by the health status score provided to us by health plans. Plans use health status scores to adjust TME data to reflect differences in the acuity of the populations served by particular provider groups. We examined whether high-spending providers – those who have a higher TME per patient than their peers, whether due to higher prices, higher utilization, or a combination thereof – tend to care for sicker (i.e., higher acuity) populations. We found no correlation between the per member amount paid to providers and the acuity of the populations that the providers serve. Providers caring for populations that are relatively healthy (i.e., health status score of less than 1.0) are sometimes high spenders and sometimes low spenders. It appears the higher expenses of some provider groups cannot reliably be explained by the fact that these groups care for sicker populations.

3. Wide disparities in prices are not explained by the extent to which a provider is responsible for caring for a large portion of patients on Medicare or Medicaid

Insurers generally pay lower prices to disproportionate share hospitals (DSHs), which have a large percentage (e.g., 63% or more) of patient charges attributed to Medicare, Medicaid, other government payers, and free care. The graph below shows a major health plan's relative payment rates to 67 Massachusetts hospitals with hospitals identified by DHCFP as DSH (shown in blue) generally on the lower end of the payment rate spectrum. Information from three health plans shows that on average the plans pay non-DSH hospitals rates that are 10 to 25% higher than those paid to DSH hospitals.



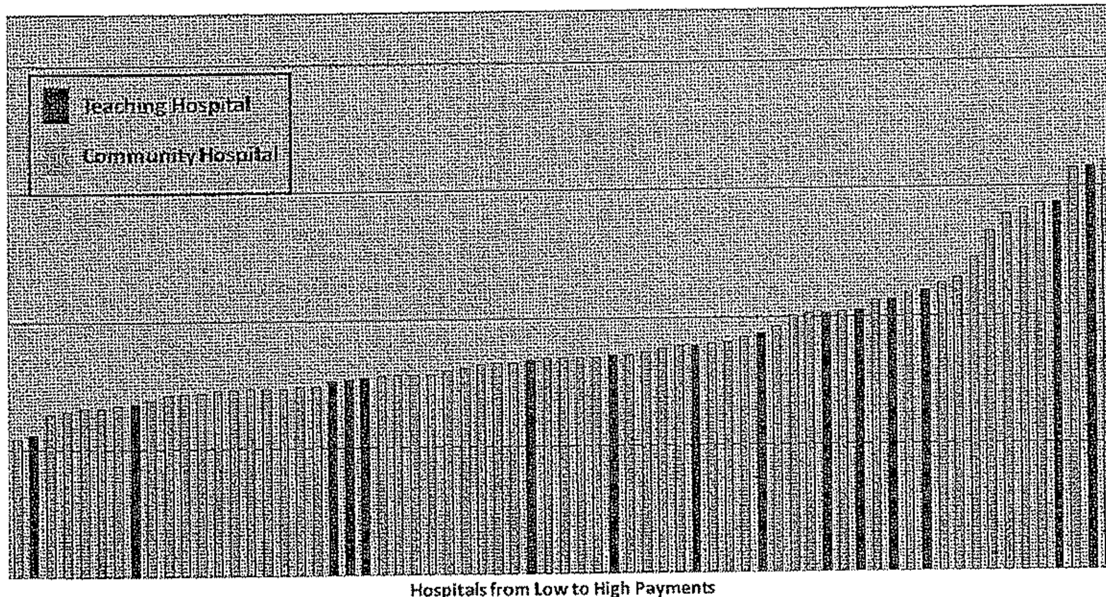
4. **Wide disparities in prices are not explained by whether a provider is an academic teaching or research facility**

Insurers do not consistently pay higher prices to hospitals that provide academic teaching and research services. As shown in the graph below, which illustrates a major health plan's relative payment rates to 67 Massachusetts hospitals, those hospitals identified by DHCFP as teaching hospitals (shown in red) are paid at widely varying levels.

While some teaching hospitals command above-average rates, others are paid significantly less than dozens of community hospitals that are not academic teaching or research

facilities. In fact, of the 10 best paid hospitals by this health plan, only two are teaching centers.

Variation by Teaching Status in A Major Health Plan's Hospital Payments (2008)



5. Wide disparities in prices are not explained by differences in hospital costs of delivering similar services at similar facilities

Disparities in hospital prices are not adequately explained by differences in hospital unit costs. Unit costs are the costs incurred by the hospital for the delivery of services, including direct and indirect expenses such as labor costs, supplies, overhead, costs associated with medical education and capital expenditures. It appears that higher price and payment rates are reflected in higher cost structures, but are not *caused* by them. Information we have reviewed indicates wide variations in hospital cost information that appear to track the amount those providers are paid rather than the acuity, complexity, or quality of the health care services provided. Although our review is ongoing, it appears that hospitals manage costs, including capital expenditures, to budgets based on their anticipated revenue from payment rates. Over time, hospitals receiving greater revenue from higher payment rates expend more on direct and indirect costs and capital investment while hospitals receiving less revenue struggle to manage their cost structure to make ends meet.

The variation in hospital internal costs among academic medical centers and community hospitals alike is not adequately explained by the services provided by the hospitals or by the acuity or complexity of populations being served. In fact, one provider's own analyses using publicly available DHCFP 403 Cost Report data show widely varying internal costs, viewed on a cost per discharge basis, among hospitals that the provider viewed as competitors. For example, an analysis comparing severity adjusted inpatient costs for select academic medical centers reveals that the highest cost hospital, at $8,000 per case mix adjusted discharge (CMAD), is

100% higher in cost than the lowest cost hospital at $4,000 per CMAD. Similarly, in a community hospital peer group, the highest cost hospital was 58% higher than the lowest cost hospital at $6,050 and $3,800 per case mix adjusted discharge, respectively. Since in each case the data is case mix adjusted, the difference cannot be explained by the hospital caring for sicker patients or offering more complex services. This raises the important question of why it costs more for certain hospitals to provide similar types of services to similar populations at similar levels of quality that are provided by other hospitals at a lower cost.

One telling measure of a provider's fiscal health and ability to deliver state of the art clinical services is its ability to maintain or expand its capital asset base. A provider's capacity to capitalize has a direct impact on the ability to improve its facilities, invest in new equipment, recruit physicians, and attract patient volume, all of which in turn increase revenue.

A review of selected hospital capital ratios over the past five years suggests that, while ratios can vary year to year, more highly paid providers are able to fund depreciation consistently at or above industry standard (optimally 130% or more). These hospitals are able to build new buildings, purchase new equipment and technology, and add to their cost structure. In contrast, hospitals with lower payment rates are unable to put comparable resources toward building maintenance or equipment acquisition, and in turn are disadvantaged in their endeavors to gain leverage, attract more patients, and preserve market share and revenue. This results in a loss of volume to better capitalized, more expensive hospitals.

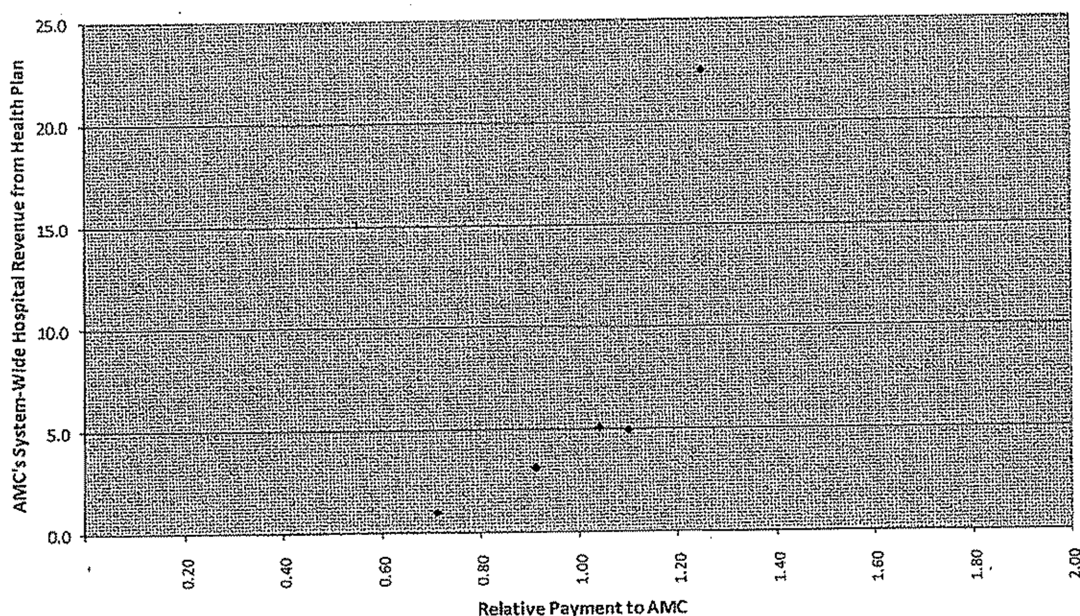
C. Price variations <u>are correlated</u> to market leverage – the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers.

Our investigation shows that there is a strong correlation between the price insurers pay to providers and providers' market leverage. We define "leverage" as a measure of the ability to influence the other side during negotiations. Both providers and insurers can bring leverage into contract negotiations. While our preliminary investigation of market leverage has focused on providers, we anticipate refining our analysis by incorporating consideration of insurer leverage. For providers, the source of leverage varies from provider to provider. Typically, leverage results from variables such as: size, geographic location, "brand name," and/or niche or specialty service lines offered. Providers use leverage strategically to obtain higher payment rates and more favorable contract provisions. While we are continuing to explore all of these factors as well as others, our preliminary investigation has focused primarily on the size of health care providers.

Large health care provider organizations have a great deal of leverage in negotiations because insurers must maintain stable, broad provider networks. Insurers have explained to us that the failure to contract with a large provider organization would cause serious network disruption, not only because a large percentage of their members would be forced to seek care elsewhere, but because employers and others are less interested in purchasing products that do not contain the largest providers.

Two ways to illustrate the size of a health care provider include measuring the total revenue paid by an insurer to hospitals within one provider system, and counting the total number of HMO/POS member lives covered by an insurer within one provider system. Both figures create a proxy for the size of the provider system within a given insurer's network, and therefore the amount of disruption that the insurer would face if the provider were not in its network.

The following graph shows that hospitals with greater leverage, as measured by system-wide hospital revenue, are generally paid at a higher rate compared to similar hospitals with less leverage.



The x-axis shows the variation in payment rates to select academic medical centers. The y-axis shows the total revenue received by all hospitals in a given system. While some hospitals contract with insurers by themselves, others contract jointly with hospitals and/or physicians in a "multi-provider network." Showing the total revenue for *all* hospitals within a contracting system is a better proxy of a member hospital's leverage since that hospital contracts as a multi-provider system rather than as a single hospital. Note that the y-axis shows total revenue for the hospitals in a system, and does not include revenue for the physician groups in the same system.

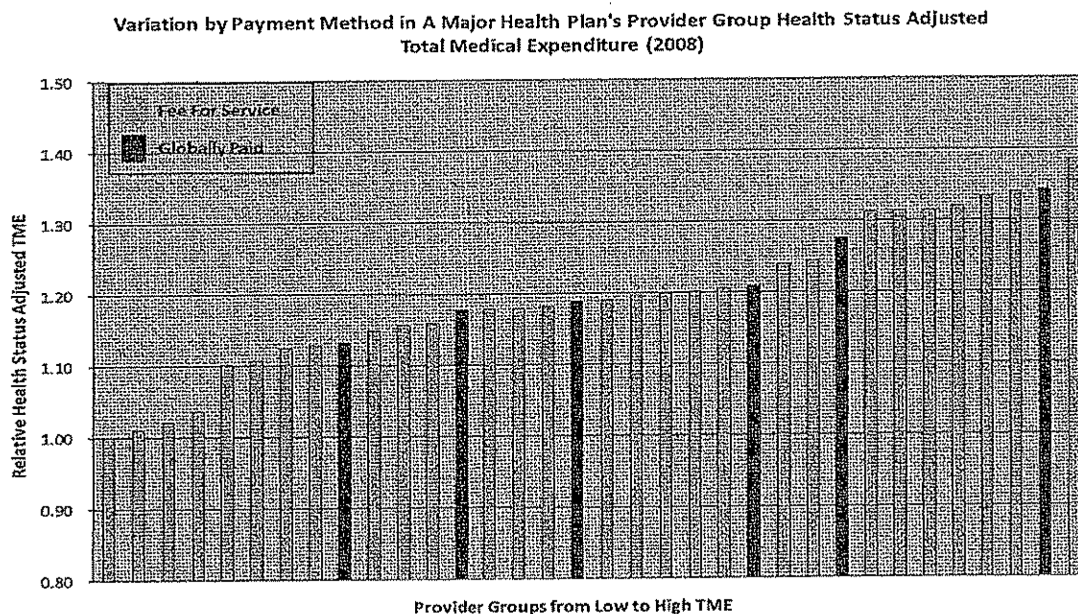
While the above graph focuses on size as a source of leverage, our investigation confirms that size is not the only factor that predicts leverage. Specifically, certain hospitals are able to negotiate higher rates because of their geographic location, subjective consumer "brand" perceptions, and/or specialty service lines. For example, insurers must include geographically isolated hospitals in their networks in order to provide hospital services to their members in that geographic location. Because there is no alternative hospital, a geographically isolated hospital

is not forced to compete for network inclusion and can garner a higher price.

While our investigation continues, it is clear that prices paid for health care services reflect market leverage. Although this report does not purport to explain all reasons for provider price disparities, our investigation shows that those disparities are not adequately explained by quality of care, patient severity, or the status of a hospital as a teaching or disproportionate share hospital.

D. Variation in total medical expenses on a per member per month basis is not correlated to the methodology used to pay for health care, with total medical expenses sometimes higher for globally paid providers than for providers paid on a fee-for-service basis.

Our investigation did not uncover any relationship between payment methodology and the total medical expenses associated with a given provider group. This graph illustrates the per member per month TME of major provider groups with those groups paid on a global budget shown in red.



Contrary to what one might expect in a risk-based contract, some globally paid provider groups are among the highest cost providers in the state.[9] The lack of correlation between payment methodology (i.e., fee for service or global risk contracts) and TME has serious implications for payment reform initiatives. Payment reform, such as the global payment methodology recommended by the Special Commission on the Health Care Payment System, may result in system benefits such as better integration of care. But, a shift to global payments

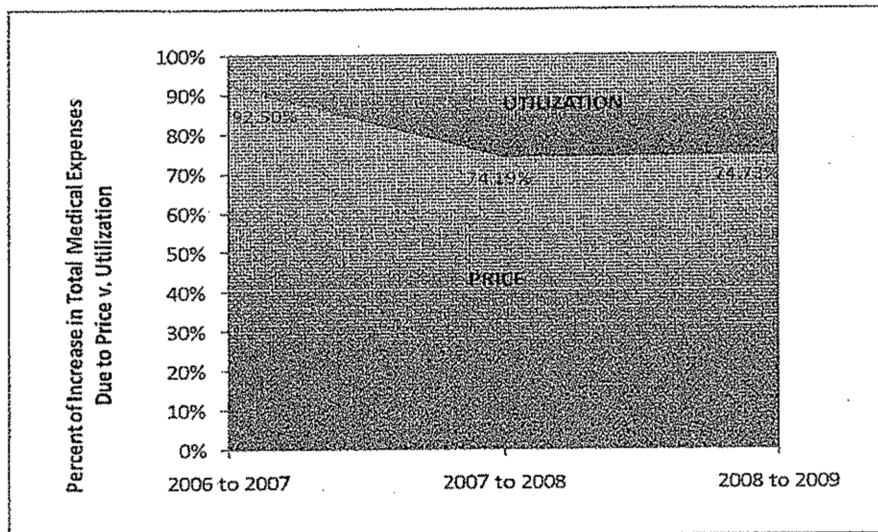
[9] Note that all globally paid providers are reimbursed for some portion of their services on a FFS basis, most notably the care they render to patients insured through PPO products.

may not control costs, and may result in unintended consequences if it fails to address the dynamics and distortions of the current marketplace.

E. Price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts.

Data from two large health plans show that price increases are responsible for roughly three quarters of the total health care cost increases in the commercial health care marketplace over the past three to four years. As shown in the graph below, for one major payer for the 2006 to 2009 period, price increases – not increases in utilization – accounted for on average 80% of the growth in total medical expenses, with price increases accounting for more than 90% of cost growth from 2006 to 2007.[10]

A Major Health Plan's Cost Drivers From 2006-2009: Price as a Driver of Total Medical Expenses



NOTES
(1) Cost drivers are expressed as a percent of unadjusted Allowed Medical Claims trend.
(2) The 2006-2008 data reflects 6 month re-forecasted analysis; the 2009 data is based on an initial projection.

The Massachusetts Association of Health Plans concurs that approximately 75% of total health care cost increases are attributable to price rather than utilization.[11] This conclusion is also consistent with the trends found in the report commissioned by the Division of Insurance, *Trends in Health Claims for Fully Insured, Health Maintenance Organizations in Massachusetts, 2002-2006* (by Oliver Wyman, September, 2008).

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[10] Health plans track the growth of allowed medical claims (calculated on an unadjusted basis or adjusted for change in member cost-sharing). From this, they can determine the percent increase that is attributable to price increases as compared to other factors, which include utilization, site substitution (changes in where care is received, e.g., from a community hospital to an academic medical center), changes in product mix or benefit design, and demographics.

[11] Testimony at Division of Insurance Special Session on Small Business, Docket No. G2009-07, November 4, 2009.

The fact that price is such a significant cost driver in Massachusetts has direct implications for statewide cost containment efforts and policy development. While addressing the utilization component of the cost growth problem is essential, any successful reform initiative must take into account the significant role of unit price in driving costs. Bending the cost curve will require tackling the growth in price and the market dynamics that perpetuate price inflation and lead to irrational price disparities.

F. The commercial health care marketplace has been distorted by contracting practices that reinforce and perpetuate disparities in pricing.[12]

In our review of tens of thousands of contract documents from insurers and providers, we have identified a number of contracting practices in effect during the 2004-2008 period that reflect and perpetuate the market dynamics and pricing disparities described in this report. While these provisions vary by contract and may or may not still be in effect, they do exemplify a contracting dynamic that obscures transparency, perpetuates market leverage, and prioritizes competitive position (parity) over consumer value.

1. Payment Parity Agreements

Payment parity agreements are agreements in which a provider organization agrees not to charge an insurance company more than the price that it charges that insurance company's competitors. Our review has shown that parity agreements are pervasive in the industry, and have been used, at some time and in some form, whether in contractual provisions enforceable with a third-party audit or less formal understandings, by several major health plans in Massachusetts.

While insurance companies seek payment parity to remain competitive and gain market share, such agreements may lock in payment levels and prevent innovation and competition based on pricing. Parity clauses may decrease competition among providers by reducing their incentive to offer lower prices to insurers. Likewise, parity clauses may reduce insurers' incentive to bargain with providers, since rival insurance companies with parity provisions would obtain any price savings. Parity clauses may also deter entry to the marketplace since any discount would have to be passed on to insurers already in the market.

Parity agreements can be used by insurers to guarantee that they will not be competitively disadvantaged by giving rate increases to providers. For example, if Insurer A agrees to give a provider a rate increase – presumably resulting in a corresponding increase in Insurer A's premium rates – Insurer A wants to make sure that the provider will require its competitors to pay the same rate increase, so that all premiums will rise together and Insurer A will not be at a

[12] Through our investigation of how health plans and providers contract and negotiate payment rates, we have also indentified numerous administrative inefficiencies that contribute to overall health care costs. There is a startling amount of variation that can only contribute to administrative expenses for both health plans and providers. The tremendous variation in methods (or units) of payment creates unwarranted administrative complexity. While most major health plans pay on a base DRG basis, one major health plan pays per diem rates. Some providers are paid on a percent of charges basis, while others are paid on a fee schedule with inflators and still others are paid on a percent of premium basis. Likewise, there is no standardization in quality measures. Each plan uses and requires reporting on different quality metrics, especially for the specific measures and targets selected for P4P programs.

competitive disadvantage. Therefore, these agreements may have the net effect of allowing insurers to increase payment to providers without concern that they will be at a competitive disadvantage to other insurers.

2. Product Participation Provisions

Product participation clauses are used to dictate the terms under which a provider may (or must) participate in an insurer's new product offerings. We have found a significant number of these provisions, such as "anti-steering," "guaranteed inclusion," and "product participation parity" clauses, which inhibit the innovation in product design that could lead to better value for consumers.[13]

For example, providers with market leverage are able to obtain contractual provisions that prohibit or inhibit insurers from creating limited network products and/or tiered products that might steer patients away from them. Even clauses that guarantee participation in a limited network so long as the provider meets certain criteria may inhibit the creation of limited network products. Product participation parity provisions may discourage insurers from seeking to create innovative new products if they believe that their competitors will automatically be able to market the very same product. They may likewise discourage providers from participating in new products if the provider would be willing to participate with one insurer, but not with all insurers.

3. Supplemental Payments

We have found a widespread practice of major insurers making supplemental payments to providers, which are payments in addition to contracted or scheduled rate payments. These payments, which do not include pay-for-performance quality or utilization bonuses, include lump sum cash payments, signing bonuses, infrastructure payments, as well as bad debt or government payer shortfall payments.

As is the case with payment rates, it appears that market leverage dictates the amount and type of supplemental payments paid to providers. Although the total amount of supplemental payments has declined overall since 2004, certain providers – notably those with the strongest market leverage – continue to receive substantial amounts of money through supplemental payments.

Use of supplemental payments contributes to the lack of transparency in payment rates. Because supplemental payments are not "loaded" into unit prices and can obscure price outliers, it makes it difficult for regulators, market entities, or others to make valid comparisons of provider rates, and further complicates the ability of providers to contract for value-based,

[13] "Anti-steering" provisions prohibit insurers, in whole or in part, from creating products that might steer patients away from certain providers. "Guaranteed inclusion" provisions guarantee the participation of certain providers in certain products – for example, an insurer's limited network product – so long as the provider meets certain criteria. "Product participation parity" provisions require a provider to participate in an insurer's product if that provider agrees to participate in a similar product offered by a competing insurer.

market appropriate prices. The indefinite and flexible nature of supplemental payments also raises questions regarding how such payments affect insurers' margins from year to year.

4. Growth Caps

Growth caps are contractual provisions that limit provider growth. These clauses, which we found in contracts of a limited number of provider organizations with high physician payment rates, set a limit or "cap" on the number of newly added physicians who can be paid at the higher rate. The caps, which can be expressed as numbers of physicians or a percentage of the total or net number of physicians, target either overall physician growth or growth in specific areas, such as growth of specialty services or acquisition of practices over a certain size.

While growth caps can be seen as a reasonable attempt by insurers to save costs by limiting the growth of their most highly-paid provider groups, given the market dynamics and price disparities we have documented, we are concerned that growth caps may have the deleterious effect of freezing disparities in the market place. In practice, the growth caps can prevent smaller physician organizations from meaningfully competing with the largest provider organizations.

IV. CONCLUSION AND RECOMMENDATIONS

Our preliminary findings show that the current system of health care payment is not value-based – that is, wide disparities in payment levels are not explained by differences in quality or complexity of the health care services provided. These findings have powerful implications for ongoing policy discussions about ways to contain health care costs, reform payment methodologies, and control health insurance premiums without sacrificing quality or access in Massachusetts. The Office of the Attorney General looks forward to completing its investigation and to presenting a fuller exposition of its findings through the DHCFP cost containment hearings.

Although our investigation continues, it is clear that prices paid for health care services reflect market leverage. As a greater portion of the commercial health care dollar shifts, for reasons other than quality or complexity, to those systems with higher payment rates and leverage, costs to the overall system will increase and hospitals with lower payment rates and leverage will continue to be disadvantaged. If left unchecked, there is a risk that these systemic disparities will, over time, create a provider marketplace dominated by very expensive "haves" as the lower and more moderately priced "have nots" are forced to close or consolidate with higher paid systems.

The present health care marketplace does not allow employers and consumers to make value-based purchasing decisions. Our findings show the system lacks transparency in both price and quality information, which is critical for employers and consumers to be prudent purchasers.

These market dynamics and distortions must be addressed in any successful cost containment strategy. Payment reform, such as the global payment methodology recommended by the Special Commission on the Health Care Payment System, may result in system benefits

such as better integration of care. But, a shift to global payments may not control costs, and may result in unintended consequences if it fails to address the dynamics and distortions of the current marketplace.

The Office of the Attorney General is committed to working with the Legislature, the Patrick administration, health plans and providers, the business community, and consumer groups to develop cost containment strategies that promote value-based purchasing and ensure consumer access to high quality, affordable health care. We stand ready to assist the Legislature, the Administration, and other policymakers as the Commonwealth develops cost containment solutions. Based on our work to date, we make the following recommendations to advance the goal of providing universal access to affordable, quality health care services in Massachusetts:

1. Prompt consideration of legislative and administrative action to discourage or prohibit insurer/provider contract provisions that perpetuate market disparities and inhibit product innovation;

2. Increasing transparency and standardization in both health care payment and health care quality to promote market effectiveness and value-based purchasing by employers and consumers, including:

    - Tracking and publishing TME (total medical expenses) for all providers;

    - Promoting uniform quality measurement and reporting; and

    - Promoting standardization of units of payment and other administrative processes;

3. Consideration of steps to improve market function, including:

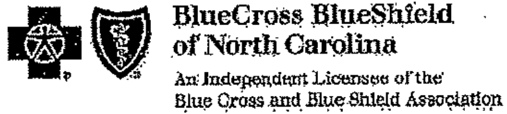
    - Adopting payment reform measures that account for and do not exacerbate existing market dynamics and distortions;

    - Developing legislative or regulatory proposals to mitigate health care market dysfunction and rate disparities. These proposals would be designed to promote convergence of provider rates where there are no differences in quality or other value-based factors;

4. Engaging all participants in the development of a value-based health care market by promoting creation of insurance products and decision-making tools that allow and encourage employers and consumers to make prudent health care decisions.

Working together, policymakers, health plans, providers, employers, and consumers will be able to deliver the health care quality and value that the people of Massachusetts deserve.

Appendix B



BlueCross BlueShield of North Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

Subscriber's Name: [redacted]

ID Number: [redacted]
(Please refer to this number if you have a question)

Date: December 05, 2009

If you have any questions, please call Customer Service at 1-888-206-4697, Monday - Friday, 8:00 a.m. - 6:00 p.m.

Patient's Name [redacted] (dependent) — **ID Number:** [redacted] — BLUE ADVANTAGE

Service Provider / Claim ID / Date of Service/ Type of Service	Amount of Bill	Amount You Do Not Owe	Amount Paid By BCBSNC	Amount Provider May Bill You	Explanation of Your Balance
[redacted] Claim ID [redacted] 11-24-2009 RADIOLOGY	212.00	74.52		137.48	137.48 Applied to benefit period deductible amount.
[redacted] Claim [redacted] 11-24-2009 RADIOLOGY	187.00	72.90		114.10	114.10 Applied to benefit period deductible amount.
CLAIM TOTAL:	**399.00**	**147.42**		**251.58**	

Please save this form for your tax records.	Your balance may not reflect any prior payments made by you or another insurance company.
$467.30 Applied to Deductible Benefit Period 01/01/2009	

Si tiene preguntes y desea hablar con un representante de servicio en espanol, por favor llame a Servicio al Cliente al 1-877-258-3334, Lunes-Viernes, 8:00 am - 6:00 pm

BlueCross BlueShield of North Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

Date: December 10, 2009

Subscriber's Name: [redacted]

ID Number: [redacted]
(Please refer to this number if you have a question)

If you have any questions, please call Customer Service at 1-888-206-4697, Monday - Friday, 8:00 a.m. - 6:00 p.m.

Patient's Name: [redacted] (dependent) | **ID Number:** [redacted] | BLUE ADVANTAGE

Service Provider Claim ID Date of Service/ Type of Service	Amount of Bill	Amount You Do Not Owe	Amount Paid By BCBSNC	Amount Provider May Bill You	Explanation of Your Balance
[redacted] Claim ID [redacted] 11-24-2009 FACILITY SVCS	2,628.77	1,451.08		1,177.69	1,177.69 Applied to benefit period deductible amount.
[redacted] Claim ID [redacted] 11-24-2009 FACILITY SVCS	3,111.78	1,717.70	431.26	962.82	855.01 Applied to benefit period deductible amount. 107.81 Coinsurance.
[redacted] Claim ID [redacted] 11-24-2009 FACILITY SVCS	515.60	284.61	184.79	46.20	46.20 Coinsurance.
CLAIM TOTAL:	**6,256.15**	**3,453.39**	**616.05**	**2,186.71**	

Please save this form for your tax records.	Your balance may not reflect any prior payments made by you or another insurance company.
$2,500.00 Applied to Deductible Benefit Period 01/01/2009	$154.01 Applied to In Network Coinsurance Benefit Period 01/01/2009

Si tiene preguntas y desea hablar con un representante de servicio en espanol, por favor llame a Servicio al Cliente al 1-877-258-3334, Lunes-Viernes, 8:00 am - 6:00 pm

Appendix C

North Carolina Division of Medical Assistance
Total DSH and Enhanced Payments by Hospital
FFY 2009

		Oct. 2008 - Sept. 2009				
		Teaching Hospital DSH/	DSH Payments			
Provider Number	Provider Name	Enhanced	UCC DSH	HMO	Enhanced Payments	Total Payments
Teaching Public						
3400028	Cape Fear Valley Medical Center	3,489,814	1,515,179	-	22,094,174	27,099,166
3400040	Pitt County Memorial Hospital	5,442,990	2,291,343	-	-	7,734,333
3400113	Carolinas Med Center	9,949,129	5,290,645	-	56,624,072	71,863,846
3400141	New Hanover Regional Med Center	5,341,458	2,338,660	-	17,925,792	25,605,910
Subtotal - Teaching Public		24,223,391	11,435,826	-	96,644,037	132,303,254
Teaching Private						
3400002	Mission Hospitals Inc.	3,810,413	-	-	21,684,632	25,495,045
3400014	Forsyth Memorial Hospital	2,820,174	-	18,417	12,877,733	15,716,324
3400030	Duke University Hospital	8,155,346	-	-	25,491,945	33,647,291
3400047	The NC Baptist Hospital	4,441,848	-	-	32,646,760	37,088,608
3400069	WakeMed	6,212,132	-	-	19,290,630	25,502,762
3400091	The Moses H Cone Hospital	4,776,430	-	45,957	16,967,019	21,789,406
Subtotal - Teaching Private		30,216,343	-	64,374	128,958,718	159,239,435
Public						
3400001	CMC Northeast Medical Center	-	929,023	-	9,794,422	10,723,445
3400003	Northern Hospital Of Surry	-	281,093	-	1,194,435	1,475,528
3400017	Margaret R Pardee Memorial Hospital	-	630,308	-	3,135,935	3,766,243
3400021	Cleveland Regional Med Center	-	533,456	-	4,126,796	4,660,251
3400024	Sampson Regional Medical Center	-	179,314	-	1,519,101	1,698,415
3400027	Lenoir Memorial Hospital	-	362,603	-	4,015,895	4,378,497
3400032	Gaston Memorial Hospital	-	1,247,608	28,166	10,847,265	12,123,038
3400037	Kings Mountain Hospital Inc	-	207,782	-	1,250,379	1,458,160
3400038	Beaufort County Hospital	-	344,453	-	2,259,954	2,604,406
3400042	Onslow Memorial Hospital	-	467,274	-	4,182,322	4,649,595
3400051	Watauga Medical Center	-	301,518	-	1,944,307	2,245,824
3400055	Valdese General Hospital	-	-	-	941,140	941,140
3400064	Wilkes Regional Medical Center	-	262,966	-	1,362,904	1,625,870
3400068	Columbus Regional Healthcare Sys	-	211,600	-	1,982,973	2,194,573
3400071	Betsy Johnson Regional Hospital	-	427,810	-	4,577,424	5,005,234
3400084	Anson County Memorial Hospital	-	-	-	331,549	331,549
3400090	Johnston Memorial Hospital	-	455,254	-	4,211,869	4,667,123
3400098	Mercy Hospital Inc.	-	765,936	-	4,373,444	5,139,380
3400099	Roanoke Chowan Hospital	-	179,470	-	2,666,032	2,845,502
3400107	Heritage Hospital	-	228,645	-	2,994,810	3,223,455
3400109	Albemarle Hospital	-	314,084	-	3,140,209	3,454,293
3400120	Duplin General Hospital Inc	-	147,927	-	1,405,051	1,552,978
3400121	J Arthur Dosher Mem Hospital	-	86,072	-	221,597	307,669
3400127	Granville Hospital	-	65,030	-	911,510	976,540
3400130	Union Regional Medical Center	-	565,400	-	4,135,718	4,701,118
3400131	Craven Regional Medical Center	-	660,766	-	4,675,466	5,336,232
3400142	Carteret General Hospital	-	229,751	-	2,405,744	2,635,495
3400143	Catawba Valley Medical Center	-	544,974	-	5,363,735	5,908,709
3400145	Lincoln Medical Center	-	301,546	-	2,259,567	2,561,113
3400147	Nash General Hospital	-	506,168	-	8,407,406	8,913,574
3400166	Carolinas Medical Center-University	-	636,900	-	3,136,289	3,773,189
3400184	Haywood Regional Medical Center	-	227,671	-	1,686,044	1,913,715
3403026	Charlotte Institute Of Rehabilitation	-	82,449	-	3,098,299	3,180,748
Subtotal - Public			12,384,843	28,166	108,559,583	120,972,591

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Provider Number	Provider Name	Oct. 2008 - Sept. 2009: Teaching Hospital DSH/ Enhanced	DSH Payments: UCC DSH	DSH Payments: HMO	Enhanced Payments	Total Payments
Private						
3400004	High Point Memorial Hospital	-	-	33,508	6,466,298	6,499,806
3400008	Scotland Memorial Hospital Inc	-	-	-	2,183,907	2,183,907
3400010	Wayne Memorial Hospital Inc	-	-	-	5,119,105	5,119,105
3400011	Spruce Pine Hospital	-	-	-	653,325	653,325
3400012	Angel Medical Center Inc	-	-	-	460,494	460,494
3400013	Rutherford Hospital Inc	-	-	-	2,110,515	2,110,515
3400015	Rowan Regional Medical Center	-	-	45,191	3,709,765	3,754,955
3400016	Harris Regional Hospital, Inc	-	-	-	1,277,846	1,277,846
3400020	Central Carolina Hospital	-	-	-	2,614,347	2,614,347
3400023	Park Ridge Hospital	-	-	-	1,474,996	1,474,996
3400035	Firsthealth Richmond Memorial Hospital	-	-	-	2,009,897	2,009,897
3400036	Franklin Regional Mem Hospital	-	-	-	1,001,100	1,001,100
3400039	Iredell Memorial Hospital Inc	-	-	-	1,930,369	1,930,369
3400041	Caldwell Memorial Hospital Inc	-	-	-	1,338,178	1,338,178
3400049	North Carolina Specialty Hospital	-	-	-	135,757	135,757
3400050	Southeastern Regional Medical Center	-	-	-	7,890,819	7,890,819
3400053	Presbyterian Hospital	-	-	37,469	13,650,206	13,687,675
3400060	Morehead Memorial Hospital	-	-	-	752,317	752,317
3400070	Alamance Regional Medical Center	-	-	-	3,695,805	3,695,805
3400073	Duke Health Raleigh Hospital	-	-	-	1,332,548	1,332,548
3400075	Grace Hospital Inc	-	-	-	1,994,222	1,994,222
3400085	Thomasville Medical Center	-	-	4,066	1,509,100	1,513,166
3400087	The Mcdowell Hospital, Inc	-	-	-	464,185	464,185
3400096	Lexington Memorial Hospital Inc	-	-	-	2,044,366	2,044,366
3400097	Hugh Chatham Memorial Hosp Inc	-	-	-	876,326	876,326
3400106	Sandhills Regional Medical Center	-	-	-	650,995	650,995
3400114	Rex Hospital	-	-	-	2,972,095	2,972,095
3400115	Firsthealth Moore Regional Hospital	-	-	-	5,671,284	5,671,284
3400116	Frye Regional Medical Center	-	-	-	5,086,776	5,086,776
3400119	Stanley Regional Medical Center	-	-	76,502	1,531,176	1,607,678
3400123	Randolph Hospital	-	-	-	1,726,370	1,726,370
3400126	Wilson Medical Center	-	-	-	3,032,546	3,032,546
3400129	Lake Norman Regional Medical	-	-	-	794,327	794,327
3400132	Maria Parham Medical Center	-	-	-	2,193,810	2,193,810
3400133	Martin General Hospital	-	-	-	749,945	749,945
3400144	Davis Regional Medical Center	-	-	1,064	1,144,543	1,145,607
3400148	Medical Park Hospital Inc.	-	-	-	269,706	269,706
3400151	Halifax Regional Medical Center	-	-	-	2,112,347	2,112,347
3400153	Presbyterian Orthopaedic	-	-	-	420,110	420,110
3400155	Durham Regional Hospital	-	-	-	4,355,399	4,355,399
3400158	Brunswick Community Hospital	-	-	-	1,284,051	1,284,051
3400159	Person Memorial Hospital	-	-	-	568,264	568,264
3400160	Murphy Medical Center Inc	-	-	-	588,649	588,649
3400171	Presbyterian Hospital Matthews	-	-	-	1,493,673	1,493,673
3400173	WakeMed For Western Wake Medical	-	-	-	1,659,533	1,659,533
3400183	Presbyterian Hospital Huntersville	-	-	-	884,565	884,565
Subtotal - Private			-	197,800	105,885,946	106,083,746

North Carolina Division of Medical Assistance
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		Oct. 2008 - Sept. 2009				
		Teaching Hospital DSH/	DSH Payments			
Provider Number	Provider Name	Enhanced	UCC DSH	HMO	Enhanced Payments	Total Payments
Public CAH						
3401304	Bertie Memorial Hospital	-	48,857	-	-	48,857
3401315	Bladen County Hospital	-	54,275	-	-	54,275
3401307	Pender Memorial Hospital	-	95,250	-	-	95,250
3401318	Chowan Hospital	-	105,387	-	-	105,387
3401324	The Outer Banks Hospital	-	195,717	-	-	195,717
Subtotal - Public CAH			499,486	-	-	499,486
Private CAH						
3401302	Our Community Hospital Inc		-	-	-	-
3401303	Firsthealth Montgomery Memorial Hospital		-	-	-	-
3401305	Swain County Hospital, Inc		-	-	-	-
3401308	Hoots Memorial Hospital		-	-	-	-
3401310	Pungo District Hospital		-	-	-	-
3401311	Chatham Hospital		-	-	-	-
3401313	Davie County Hospital		-	-	-	-
3401314	Washington County Hospital		-	-	-	-
3401316	Highlands Cashiers Hospital		-	-	-	-
3401317	Stokes-Reynolds Memorial Hospital		-	-	-	-
3401319	Transylvania Community Hospital		-	-	-	-
3401320	Alleghany County Memorial Hospital		-	-	-	-
3401321	Blowing Rock Hospital		-	-	-	-
3401322	St Lukes Hospital		-	-	-	-
3401323	Charles A. Cannon Jr. Memorial Hospital		-	-	-	-
3401325	Ashe Memorial Hospital Inc		-	-	-	-
Subtotal - Private CAH		-	-	-	-	-
State Owned Hospitals						
3400061	UNC Hospital		42,092,262	-	-	42,092,262
3404001	Central Regional Hospital		67,841,486	-	-	67,841,486
3404003	Cherry Hospital		8,725,542	-	-	8,725,542
3404004	R.J. Blackley ADATC		79,056	-	-	79,056
3404023	Julian F. Keith ADATC		9,120,170	-	-	9,120,170
3404024	Walter B. Jones ADATC		10,104,894	-	-	10,104,894
3404025	Broughton Hospital		53,815,320	-	-	53,815,320
Subtotal - State Owned Hospitals		-	##########	-	-	191,778,730
						-
Total		54,439,734	##########	290,340	440,048,284	710,877,242

Appendix D

Ambulatory Surgical Centers May Exceed Performance of Hospitals for Certain Procedures

Measuring five quality-base performance areas, an ambulatory surgical center out performed a standard hospital-based surgical center in otolaryngic surgeries, according to new research in the December 2009 issue of *Otolaryngology – Head and Neck Surgery*.

The cross-sectional study analyzed a total of 486 cases at a pediatric ambulatory surgical center (ASC) and a hospital-based facility (HBF). The cases comprised the four most common pediatric surgical procedures at the ASC compared to the HBF: ventilation tube insertion, dental rehabilitation, adenotonsillectomy, and ventilation tube insertion/adenoidectomy. Only outpatient procedures were included.

The authors designed a series of quality performance measures based on the Institute of Medicine's multidimensional definition of quality. The study aimed to develop a better understanding of how an ASC might be a viable high-quality, low-cost organizational structure. The quality measures included safety, patient-centeredness, timeliness, efficiency, and equitability.

Seventy-seven percent of ASC cases finished within the scheduled time compared to 38 percent at the HBF, a difference of about 30 percent. Total charges were 12 percent to 23 percent less at the ASC as well. However, patient satisfaction was similar between facilities (ASC, n=64; HBF, n=35). For the studied sample size, the ASC had no unexpected safety events, compared to nine events at the HBF.

The authors pointed out that as the healthcare industry responds to public demand for higher quality with scarce resources, innovative delivery models that provide high-quality, low-cost care are increasingly needed. ASCs have been described as such a model by taking advantage of economies of scale and low-cost organizational structures. The authors further note that although previous studies have shown the benefits of ASCs in one quality measure or another, this study is the first to explore multiple dimensions of quality in one surgical area to give a more complete picture.

The authors wrote "Intense competition, increasing quality standards and scarce resources have led many institutions to shift toward 'service-line' strategies, allowing facilities to concentrate on what they do best. It makes sense, at least, for institutions to determine what types of organizational structure provide the best patient care." The results of this study suggest that government programs supporting ASCs may be a wise use of resources and that investment in ASCs is a way academic health centers can remain financially competitive. ■
American Academy of Otolaryngology — Head and Neck Surgery