HJR 20 SUBCOMMITTEE REPORT TO CFHHS INTERIM COMMITTEE
Meeting February 16, 2018
Prepared by Rep. Kathy Kelker, Subcommittee Presiding Officer

Introduction
The subcommittee is nearing the end of its work and beginning to coalesce around recommendations. Throughout its work so far, the subcommittee keeps coming back to a discussion of the three parts of the health care triangle—the provider, the payer, and the patient. There has been much discussion about the responsibilities for providing and using health care cost information. In this session, the subcommittee took a hard look at what consumers (patients) want and need to know and what tools are currently available to assist patients in making comparisons and wise health care choices.

Consumer Needs in Price Transparency
The subcommittee heard from a panel of five participants (Peg Hasner, Divisional Vice President of Medicaid Operations—Blue Cross Blue Shield; Gary Lusin, physical therapist; Barbara Schneeman, Vice President-Communications and Public Affairs, Riverstone Health; Stacey Anderson, Communications and Public Affairs Manager, Montana Primary Care Association; Ward VanWichen, CEO, Phillips County Hospital) about what they thought consumers want to know in terms of transparency in pricing. Here are some of their suggestions:
- Information that is up to date and stays consistent (e.g., comparing apples to apples)
- Transparency for hospitals, providers, and insurers (all the players)
- Disclosure of business relationships between providers and services such as MRI, labs, and imaging
- Disclosure of referral patterns
- Transparency concerning commissions physicians may receive on particular tests that they request for patients
- Frank discussion about what tests are "really" necessary, what they cost, and what they will add to the person's care
- In non-emergency situations, a practice of waiting for initial test results before ordering additional testing
- Explanation of differences between cost, charges, and paid amounts
- Knowing up front if insurance companies will pay for a specific procedure, test, or surgery
- Knowing in advance all of the costs for which consumers may be billed (e.g., hospital, physicians, consultants, specialists, auxiliary services, anesthesia)
- No surprise medical bills due to involuntary (not patient-driven) use of out-of-network providers

Health Care Literacy
The subcommittee read two research articles, one by Judith Hibbard and Ellen Peters and another by Judith Hibbard. These articles focused in more depth on the kind of information that is most likely to be used by health care consumers. According to these authors, making informed choices and navigating a complex health care system requires that consumers have easily accessible,

accurate, and timely information and that they actually use the information. The research evidence demonstrates that having an abundance of information does not always translate into its being used to inform choices. Understanding health information (health literacy) is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services, including the nature of the treatment and its cost. Being a patient is a job that no one wants and almost no one is prepared for. Health care has its own jargon, insurance policies are full of dense prose and limiting clauses, and medical bills have codes that are not meaningful to the average person. In the end, being health care literate is dependent on the abilities of the individual and the communication skills of health care providers and insurers.

One of the panelists provided the subcommittee with a health literacy infographic with the following data:
- More than one in two adults can't use a Body Mass Index graph to find their healthy weight, understand a vaccination chart, or read a prescription label.
- Only 60% of US adults can read above a 6th grade level.
- 33% of U.S. adults track health indicators or symptoms like blood pressure, blood sugar, headaches, or sleep patterns. Of those who track health indicators, 46% say that this activity has changed their overall approach to maintaining their health, 40% of trackers say it has led them to ask their doctor new questions, and 34% say it has affected a decision about how to treat an illness or condition.
- Marketers who are selling health products or treatments use digital methods to reach consumers: online videos, webinars, blogs, and video chats.
- One in two US adults has a smart phone yet only 25% of providers use a smart phone for interacting with patients. Only 20% use a tablet for educating patients.
- Individuals with low health literacy have an average annual health care cost of $13,000 compared to only $3,000 for those with high literacy levels.
- Eighty-one percent of patients age 60 and older at a public hospital could not read or understand basic materials.
- Seventy-seven million U.S. adults would have difficulty with common health tasks such as following directions on a prescription drug label.
- Emergency room patients with inadequate health literacy are twice as likely to be hospitalized as those with adequate literacy, even after adjusting for self-reported health, health insurance, and socioeconomic characteristics.
- The cost of providing health literacy information and tools is $238 billion annually.

SOURCES :

pewinternet.org, Journal of General Internal Medicine, health.gov, cdc.gov, nlm.nih.gov, healthexperienceproject.com

From her research, Hibbard suggests that there are techniques that help consumers to understand and use complex data in decisionmaking. Some data presentation approaches that help consumers understand and use information include: reducing the burden of information processing; interpreting the meaning of the data for the user; and highlighting best options. Below is a chart that demonstrates how data concerning knee replacement surgery can be sorted to help a consumer make choices.

HOSPITAL	IMPROVED FUNCTIONING	PREVENTION OF COMPLICATIONS	AVERAGE COSTS	HIGH VALUE (High Quality and Low Cost)
Evergreen Hospital	Average	Below	$32,685	
Lakeview Hospital	Better	Better	$23,815	✓
Woodland Hospital	Below	Below	$44,686	
Sierra Vista Hospital	Better	Better	$25,652	✓
Parkdale Hospital	Average	Average	$38,789	

Transparency Tools

Driven by the growth of high deductibles and price transparency initiatives, patients are being encouraged to compare prices before seeking care. Across the United States, more than 60 publicly accessible websites hosted by state agencies, insurers, hospitals, and hospital associations are now available. However, despite the prevalence of health care price tools and their potential for savings, research is showing few consumers actually use these tools. Factors that deter consumers from using the comparison information include:

- Too much information; information is hard to sort
- Insurance or payer information needs to be connected to medical pricing information
- Once a consumer meets his/her deductible, there is little interest in cost
- Price is not the only concern; consumers want to choose their providers and are interested in quality of outcomes
- Consumers are loyal to their current providers and don't want to switch
- Consumers value provider quality over the amount of out-of-pocket costs
- When consumers have serious illnesses, they are more interested in their prognoses than in the cost of care.

Source: Patients' Views on Price Shopping and Price Transparency by Hannah L. Semigran, Rebecca Gourevitch, Anna D. Sinaiko, David Cowling, and Ateev Mehrotra. June 2017. www.ajmc.com

At the February 16th meeting, the subcommittee had the opportunity to view the features of two sophisticated electronic tools, one from the Montana Hospital Association and the other from Blue Cross Blue Shield.

Montana Hospital Association--https://mtha.org/mt-informed-patient/
Roberta Yager, MHA Director of Information Services, presented Informed Patient, a website that has been around for several years and was recently updated. This website includes information about pricing in hospitals (also nursing homes and hospice) and quality of outcomes. The staff at MHA also answer questions from the public about how to interpret or use the tool.

Blue Cross Blue Shield
John Doran, Divisional Vice President of External Affairs for Blue Cross Blue Shield of Montana used his own family's portal on the BCBS website. This site is meant for use by customers of BCBS who have health care insurance plans. The website provides abundant information, but it is "sorted" so the data is easier to use. For example, one feature allows the consumer to search an 80-mile radius from home. The database shows what providers are available in that area and what the cost would be to the consumer for a particular treatment or procedure. The tool also provides information about patient satisfaction with a provider's services. When an inquiry is made, the first provider listed is the one with the lowest cost and the highest quality ratings.

Health Information Exchange (HIE)
Research shows that consumers do like to use tools to check their previous insurance claims history and deductible status and to plan ahead for costs of an upcoming visit or procedure. One opportunity that Montana has for collecting and disseminating high-quality information of this kind is the Health Information Exchange (HIE). Carol Jones, Director of Financial IT at the Billings Clinic, and Dr. Jonathan Griffin, President-Elect of the Montana Medical Association, shared with the subcommittee their enthusiasm for an IT project that could be Montana's answer to providing health care pricing and outcomes data.

In order for Montana to adjust to new clinical models that reward for outcomes and not just volume, consumers, payers, and providers need the ability to collect and analyze data in a meaningful way. As new care and payment models evolve, establishing such a platform could open doors to more innovative ways of delivering and coordinating care and paying for services. A collaboratively developed health information exchange has the potential to create improvements within systems of care and assist in targeting limited resources to those most in need.

      Pilot Project. An alliance of providers in Billings is currently implementing an HIE pilot project. This project includes St. Vincent Healthcare, Billings Clinic, and RiverStone Health. Carol Jones explained the purpose of the pilot project is to share patients' health care information across organizations within the region. The project developed its structure and management activities by utilizing several work groups: an Executive Team, Clinical Work Group, Quality Improvement, Technology, Privacy and Security, Business and Financial, and Project Management. The pilot project then identified three initiatives—a provider portal, implementation of patient-centered medical homes (PCMH), and appropriate care for "super" utilizers.

The provider portal was designed to store patient data from the point of care. Arranging for sharing this information required many legal agreements that took significant amounts of time to develop. The result, however, appears to be worth the effort. The pilot project has been successful in demonstrating that health care providers can effectively and securely share information across agencies and use the collective information about a patient to ensure there is no duplication of effort and better planning for positive outcomes.

Future of HIE. Concurrently with the pilot project, the Montana Medical Association, in collaboration with the Montana Hospital Association, has been leading a statewide group of stakeholders to receive updates and learn from the pilot project and use that information to begin planning a statewide expansion of the information sharing model established in the pilot project. Dr. Griffin explained that the Montana health information exchange effort currently is establishing a foundation of trust with rapidly expanding private-public partnerships. In order to maintain trust and engagement, the health information exchange organization is being set up as a neutral, not-for-profit corporation organized and operated for the sole purpose of serving information needs of participants jointly working together under a clearly designed governance structure. Fair representation and decisionmaking authority will be granted to all key stakeholder groups, including state agencies such as DPHHS and Montana Medicaid in addition to patients, patient advocacy groups, critical access hospitals, tertiary hospitals, physician groups, commercial payers, medical associations and societies, tribal and urban Indian providers, Indian Health Services, the university system, and policymakers. The health information exchange organization will:

- guide the development for mutually agreed upon use of data for clinical and quality improvement;
- create a business and financial model aligned with current regulatory and market demands;
- formulate privacy and security policies and procedures that adhere to current industry standards;
- acquire a technological platform vendor with proven capacity and capability to achieve the uses and objectives established by the governing body; and
- establish the necessary contracting processes, participation agreements, terms and conditions, and other organizational policies and procedures necessary for usual business operations.

The Montana HIE organization will be designed similar to a public utility in that it will be a stand-alone entity housing and maintaining the infrastructure for a public service – managing shared, statewide health information – subject to public control and regulation ranging from community-based groups to state agencies. It will not be owned by any one entity and will be governed by those with the greatest interest in realizing success.

So far, the HIE organizing partners have completed a feasibility study for the HIE. This document will be distributed to the subcommittee in preparation for its next meeting on March 21st. The next step after the feasibility study is a business plan that involves private and public sources of funding. Then the process of expanding the network of shared information will evolve with the addition of new partners until the whole state health system is included.

Sources: PowerPoint presented by Dr. Jonathan Griffin and Montana Health Care Innovation Plan, pp. 92-97.

Price Shopping in Montana

According to Hannah Semigran, et al., in their article *Patients' Views on Price Shopping and Price Transparency*, consumers in their survey expressed frustration with health care costs and had a positive opinion of the idea of price shopping in theory. But there were two barriers to using price shopping: 1) shopping couldn't occur if their health plans did not cover all the providers under consideration; and 2) other factors were more important to the consumers than price. Below is a list of reasons not to shop gleaned from the article and discussions in the subcommittee:

- In rural Montana, there are limited choices of providers available in communities, so there are no options for "shopping."
- Rural consumers have to weigh the cost of traveling to another community and staying there to see if the health care cost savings actually pencils out.
- Sometimes shopping does not yield any benefit because out-of-pocket costs are the same due to the consumer's insurance plan.
- Some services, especially for chronic illnesses, are ongoing and do not lend themselves to shopping.
- Consumers want their care to be coordinated across various providers; case coordination is more important than choosing health care services because of lower cost.
- Surgeries, tests, imaging, and labs as discrete procedures are easier to shop according to price than ongoing treatment for chronic conditions.

Medical Billing

Clay Fosjord, Director of Patent Financial Services at Billings Clinic, presented to the subcommittee a PowerPoint that clearly outlined the medical billing cycle. He explained that medical bills are often mysterious to patients who receive them. The reimbursement documentation used by the health care industry is different from that used by other businesses. The whole billing system is based on codes (ICD-10) that are attached to condition(s) the patient had addressed by the provider. There also are CPT (Current Procedural Terminology) codes used on medical claims to identify each service/procedure billed, and HCPCS Codes that Medicare uses instead of CPT Codes. The value of having these codes is making the billing process consistent among the multiple parties involved in the billing process (providers, insurers). These codes are familiar to health care providers and billings clerks but are a totally different language for consumers.

Mr. Fosjord was asked two questions that he answered in the following ways:

- Why are there sometimes long delays before a consumer receives a bill?
  - More information is needed to process the claim and the claim is sent back to the provider.
  - The claim is denied by the insurer as not payable under the consumer's plan.
  - The claim is held back by the payer for internal review.
  - Additional documents are requested from the provider (e.g., medical records).

- Additional information is needed by the payer from the patient (e.g., other insurance coverage, accident report).

- Why do billed amounts vary for the same procedure?
  - Overall health of the patient
  - Other comorbid conditions (e.g., obesity, diabetes)
  - The speed with which the patient recovers
  - Whether or not the patient's pain is under control
  - Other problems were discovered as a result of the procedure

Mr. Fosjord showed examples of four different bill amounts for a knee replacement. The charges varied significantly based on the health conditions of the patients.

Surprise Medical Bills
Surprise medical bill is a term commonly used to describe charges arising when an insured individual inadvertently receives care from an out-of-network provider. This situation could arise in an emergency when the patient has no ability to select the emergency room, treating physicians, or ambulance providers. Surprise medical bills might also arise when a patient receives planned care from an in-network provider (often, a hospital or ambulatory care facility), but other treating providers are brought in to participate in the patient's care who are not in the same network. These can include anesthesiologists, radiologists, pathologists, surgical assistants, and others. In these non-emergency situations, too, the in-network provider or facility generally arranges for the other treating providers, not the patient.

For insured patients, the surprise medical bill can involve two components. The first component reflects the difference in patient cost-sharing between in-network and out-of-network providers. For example, in a managed care plan that provides coverage in- and out-of-network (sometimes called a PPO plan), a patient might owe 20% of allowed charges for in-network services and 40% of allowed charges for out-of-network services. A second component of surprise medical bills is due to "balance billing." Typically, health plans negotiate fee schedules, or allowed charges, with network providers that reflect a discount from providers' full charges. Network contracts also typically prohibit providers from billing patients the difference between the allowed charge and the full charge. Because out-of-network providers have no such contractual obligation, however, patients can be liable for the balance bill in addition to any cost-sharing that might otherwise apply.

Source: https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/

In the subcommittee's discussion of billing, concerns came up that Montana does not have a law specific to "surprise" medical bills due to nonvoluntary use of out-of-network providers. The consumer panel and a member of the public touched on this topic and agreed that consumers want transparency or advanced warning if an out-of-network provider was going to be used.

Key Points to Share With Interim Committee

CONSUMER NEEDS
- Transparency tools that meet standards for excellence
- Montana has transparency tools from a variety of sources (e.g., hospitals, MHA, insurers)
- Requirements for proper credentialing of physicians in insurance healthcare networks
- Standards for creating insurance healthcare networks
- Standards for Preferred Provider Organization (PPO), especially procedure-based PPO's
- Need simplicity in healthcare information and cost information
- Consumers want more than a transparency tool; they want care coordination
- Having the raw information is not enough; consumers benefit from personal explanations from their physicians, insurance agents, or health navigators; consumers appreciate being engaged directly
- There is a difference between what consumers want and what providers think they need. For example, the patient may want to tackle the most annoying health problem first instead of trying to "fix" every health problem at once.

HEALTH INFORMATION EXCHANGE
- What incentives might there be to continue HIE development?
- Joining the HIE network might be too expensive for rural hospitals and providers. Could there be a sliding scale?
- Could a consumer portal be added?
- The collection of information about patients' and their treatments could easily be related to value-based performance on the part of the providers.
- There is a need for the Subcommittee to know more about the cost of expanding HIE. How could the cost be mitigated? How could the network be sustained?

BILLING
- Remedy for surprise bills
- Code definitions that consumers can understand

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