Report of the Work Group on Health Care Cost and Quality
Approved by the CMS Board of Directors November 16, 2018

Background: The board of directors approved and appointed a special Work Group on Health Care Costs and Quality at its July 13, 2018, meeting. The work group's goal is to guide CMS efforts to influence reductions in the cost of care, while ensuring quality. The group met on October 30 and submits the following report and recommendations.

The board will be voting on three recommendations from the work group:

1. Priority areas to partner with the Denver-metro Chamber of Commerce (DMCC) and other business stakeholders on efforts to reduce costs and increase quality;
2. Out-of-network: Legislative specifications; and
3. DOI Network Adequacy Waiver Rules: An alternative to ensure adequate networks for patients

Issue area background is detailed below along with the recommendations upon which the board will be voting.

Why the board is taking action on these recommendations
Evidence continues to mount that Colorado has reached the tipping point on rising health care costs. Frustration within the business community has galvanized action by the Denver-metro Chamber of Commerce to convene a multi-stakeholder group to devise a set of recommendations to decrease costs that the business community can champion in the coming years via voluntary efforts, regulation and legislation. These recommendations will soon be finalized, and action will turn from development to implementation as the business community seeks out partners to operationalize these ideas. Stories about out of network billing continues to drive shocking media headlines. To date CMS and others have been unsuccessful in efforts to negotiate a legislative solution that ends unfair practices by a few OON providers, gets the patient out of the middle when they are inadvertently treated by an OON provider, and recognizes the plight of most physicians that have no negotiating power against take-it-or-leave-it contracts with health plans. Legislators on both sides of the aisle have declared that they will finalize a solution in 2019. On October 30 the Division of Insurance (DOI) issued a rule that would allow health insurance carriers to apply to DOI for a waiver from a single geographic network adequacy requirement for a specific network and service area if certain conditions are met. In September the CMS board discussed potential implications of a draft of the now officially proposed rule and directed that the issue be brought back in November after further work.

Issues overview
1. **DMCC priorities for partnership** – Throughout the past year the DMCC has worked with a multi-stakeholder group to address the factors driving up the cost of health care in Colorado and to develop recommendations to impact these factors. DMCC members are skeptical that the industry could reform itself in a way that would positively impact the cost of care and the DMCC board is holding a special

meeting on November 26 to finalize the recommendations created by the stakeholder group that included CMS. Recommendations fall into five categories including data, transparency, education and outreach, payment reform, and access/workforce.

During their review of the latest recommendations, the CMS Work Group on Health Care Costs & Quality emphasized that as DMCC work unfolds, it will be critical for CMS and physicians to focus on areas where they have expertise and the ability to affect outcomes. Physicians can have a meaningful impact, and collaboration will be key because the profession cannot make necessary changes alone.

The board voted to approve the following three recommendations.

1. **The work group recommends that the CMS board of directors target the following priority issues found in the DMCC report as a way to partner with the business community:**
   - Data
     - Pursue the creation of a set of uniform quality measures for use across payers
     - Leverage existing resources like the all-payer claims database and seek the creation of repositories and other analytic tools and offerings for CMS members to help inform their practice and efforts to control costs and maximize quality.
     - Monitor accuracy of attribution
   - Payment reform
     - Value-based benefit design and standardization of benefit designs
     - Bundled payment – Learn from and scale existing public and private pilots
     - Elimination of waste and duplication, and reduction of administrative burden
   - Education and outreach
     - Engage and educate physicians
     - Utilize existing and innovative physician and employer efforts to plug directly into employee/consumer education and outreach initiatives

2. Out of network proposal – CMS has been working on OON solutions for the past five years. The work group was charged with devising a workable alternative for 2019. The proposal addresses situations when a patient inadvertently receives care at an in-network facility by an OON provider. The proposal calls for the plan to pay the OON provider for that care based upon a minimum benefit standard (MBS) that would range from 200% of the average contracted rate for that service and the 80th percentile of charges. Plans would alert OON provider about patient cost sharing amount (based on in-network rate benefit conditions) and provider would bill patient. If the provider accepts the initial payment, then the process ends. If provider declines initial payment, then good faith negotiations would be required. Should negotiations fail then the process would move to arbitration where the parties split the costs and a paper process (aka baseball arbitration) would be used where each party provides their best offer to minimize expense and maximize efficiency. The

arbiter would consider a number of criteria including the MBS. Results would be binding.

- **The work group recommends that the CMS board of directors:**
  - Recognize that the OON proposal is on the right track and should be used in the 2019 legislative session;
  - Continue to flesh out details of the proposal, including the minimum benefit standard and other criteria to be used in the arbitration process; and
  - Include a repeal or sunset clause to require a thorough evaluation of the OON problem and the effectiveness of this solution.

3. **DOI network adequacy waiver rule** – CMS should not support any effort to weaken network adequacy standards, but rather work to preserve and strengthen networks. Proposed regulations that chip away at network adequacy standards are best met with an alternative. That alternative should depend on a private sector solution to the greatest extent possible. Even though physicians are not impacted by the current proposed rule, they may well be a focus in the near future and being proactive now will better serve the profession later. The rule offers the profession an opportunity to address network adequacy and other payer issues that remain some of the highest priorities of CMS members.

The proposal is only applicable in situations when health plan-provider negotiations conclude without success and *either* the health plan is not able to gain product compliance with network adequacy standards based upon the criteria in the DOI waiver rule *or* a physician has not achieved in-network status and contends that the plan therefore has in inadequate network of providers based upon certain criteria. Either the health plan or the provider could request private arbitration to help the parties achieve contract, in-network terms. If the parties agree to private arbitration, then the outcome would be final for a single contract year and result in the health plan network adequacy compliance. If the parties do not agree to private arbitration, then either party may file a request for intervention and settlement through a public process.

- **The work group recommends that the CMS board of directors:**
  - Recognize that current strawman proposal is a start that requires further refinement and analysis.
  - Continue work to devise an alternative to the DOI network adequacy waiver rule.