Facts Are Stubborn Things; Statistics Are Pliable
How RAND Corporation Is Endangering Our High-Value Healthcare Systems by Oversimplifying the Complexities of How the System Works

By Nathan Kaufman

Steve Jobs stated that consultants are not useful because they rarely get more than a two-dimensional understanding of a business. That is, they can measure the business and develop models of the business. Still, without being deeply involved in operating a company over many years, they cannot possibly have an accurate understanding of how that business works.[i]

RAND Corporation's Round 3 Research, "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans," is a classic example of Steve Job's concern, i.e., a little knowledge is dangerous. The renowned management consultant, Peter Drucker, considered hospitals to be the most complex human organization ever devised.[ii] By oversimplifying the complexities of the healthcare industry, RAND is encouraging the commoditization and possible demise of high-value health systems. The broad generalizations presented in the *Implications Section*[iii] of the report show a lack of depth of knowledge. For example:

1. **RAND states: "Addressing prices paid by employer-sponsored and other private insurance plans represents a tangible way to reduce health spending."** This statement has little basis. In Maryland, where an independent rate-setting commission sets prices for hospitals, insurance premiums continue to rise at the same rate as the rest of the country and there is no evidence that any cost savings has been passed on to the consumer.[iv]

   Recent research shows that costs are lower in markets with well-organized vertically integrated provider networks.[1] Conversely, markets that were less aligned vertically tended to have higher costs with no correlation to hospital prices.[v]

2. **RAND states: "If a sufficient number of employers within a market aggressively design benefits with provider prices in mind, providers may respond by lowering prices."** Health systems, with community input included in the financial assistance and rate setting process, base their commercial rates on the health care delivery needs of their institutions and the populations they serve. Health systems have had extensive experience responding to aggressive pricing negotiations with payers, and they either a) come to a satisfactory conclusion; b) go out of network; or c) accept discounted prices out of desperation, which often results in closing services and laying off personnel, including physicians. And some have had to sell their facility to a larger system or close the hospital. This is especially true for smaller hospitals and those in rural markets.

It appears that RAND has designed their study to ignore the deeper complexities of healthcare delivery; let me correct the record.

[1] Vertically integrated provider networks are health systems that include providers at different levels across the supply chain. For example, health systems that include both hospitals and physician practices are said to be vertically integrated.

“Been there done that” using far more sophisticated techniques.

RAND is not calling for anything new. Their strategies and recommendations have been around for decades. In the ’80s health insurance companies promoted narrow network HMOs as a cost saving strategy for employers. Health plans have worked aggressively on behalf of themselves and self-funded employers to, as RAND put it, "design benefits with provider prices in mind...."

For example, many health plans in North Carolina introduced lower-cost tiered and narrow-network products since 2013. None of these products received significant adoption from employers or employees because they preferred choice over the confusion and limited savings that these restricted networks offered. It appears that some NC plans have abandoned this limited-choice-cheap-care network strategy based on discounts from hospitals for what they believe is a shared savings value-oriented approach that promotes care coordination and quality.

Most self-funded employers are advised by a health plan or other sophisticated third-party administrator. These advisors have comprehensive information on the local provider community. That is, unlike RAND, which has a single ratio cobbled together from an unscientific sample, these advisors have data on rates for every provider for every service. Also, the major plans have analyzed the market and designated the highest quality providers for different service lines using their proprietary algorithms, e.g., Blue Cross Blue Shield’s Blue Distinction, Cigna's Centers of Excellence, etc. *Using the over-simplified, composite RAND data, and unsophisticated/unrepresentative surrogate measures of ‘quality’ will be a step backward for most employers.*

RAND commoditized hospital quality and the role of the physician staff, focusing entirely on their single Medicare ratio as the basis for hospital selection, which will lead to poor choices.

When selecting a health system, deep consideration must be given to many factors, including:

a) the physicians on staff, their unique training and experience, and the competency of the clinical team that supports them;
b) the ability of the medical community to coordinate care;
c) the geographic footprint of the health system to provide convenient access;
d) the assurance that every patient gets the prompt state-of-the-art care in the appropriate site of service;
e) the sophistication and range of services available;
f) the financial stability of the organization; and
g) adherence to best-practice protocols and standards, etc.

And as is standard practice by all payers, quality is always assessed by industry-standard benchmarks for each service line.

Sophisticated buyers of healthcare understand that price should not be the primary consideration when selecting a provider network. Payers and large employers such as Walmart, Lowes, and McKesson are designating health systems as Centers of Excellence who they believe provide superior quality and outcomes for specific service lines e.g., cancer, spine, cardiac surgery, etc.[vi] Walmart did not choose its "Centers of Excellence" based on a relative percent of Medicare ratio or oversimplified quality metrics, e.g., CMS stars. Walmart analyzed a series of industry-recognized quality metrics and performed an extensive evaluation of the health system and their doctors to ensure that evidence-based guidelines are

routinely followed in the office and hospital. Unlike RAND, Walmart was not looking for the cheapest care defined by a Medicare ratio. Walmart wants to make sure that every associate gets the right diagnosis and treatment plan every time[vii] (which cannot be determined by or inferred from CMS stars nor Leapfrog grades.) Walmart decided that price was the least important criteria in the selection process. In the case of spine surgery, it is reported that Walmart pays their Centers of Excellence 7.5% more than their "Non-Centers of Excellence."

The RAND Study used the much-maligned CMS star system and the hospitals' Leapfrog grade as surrogate measures of quality.

CMS plans to revise the star system methodology in 2021 because it is generally recognized as flawed and invalid. The ratings use a hodgepodge of measures that were never intended to create a single, representative score of hospital quality, and often do not reflect the aspects of care most relevant to patients. The ratings also do not adequately account for the differences in clinical and social risk factors that can affect hospital performance. During the recent public comment period, CMS received over 800 comments, many expressing concern that ratings were imprecise and provided without proper context to make apples-to-apples comparisons.[viii] While the Leapfrog score provides useful information about patient safety processes, it gives no information about physician competency, outcomes, volumes of most procedures performed, care coordination, etc.

One would assume that if there was a correlation between the CMS star system, the Leapfrog grades, and quality that most of the **US News** [ix] Top 20 Hospitals (including Mayo Clinic, Cleveland Clinic, UCLA, Cedars-Sinai and Barnes-Jewish) would have received an 'A' rating from Leapfrog and 5-stars from CMS. This is not the case. Only 12 of the "Top 20" (60%) received an 'A' rating from Leapfrog;[x] only 2 (10%) of the "Top 20" hospitals received 5-stars from CMS; and 9 (45%) received 3-stars.[xi]

RAND clearly does not understand the complexities driving healthcare costs.

As of 2015, 10% of the commercial population generated 67% of all commercial claim costs. [xii] These were individuals with severe medical conditions requiring specialized coordinated care. The data shows that hospital costs for these high spenders remained relatively flat over the previous years.[xiii] The primary driver of cost growth in this population is prescription drug spending, from which the payers receive huge rebates. Care appropriateness, early intervention, physician selection, care coordination, and proper diagnosis and treatment are the primary drivers of cost savings for these patients, NOT reducing hospital prices. But it appears that RAND is unaware of these critical facts.

No one wins a race to the bottom except the insurance companies.

Health systems have learned that once you compete primarily by lowering prices the system becomes a commodity, which forces the organization to start a never-ending cycle of layoffs and service cuts as the payers demand incremental fee reductions every few years. In the long run, the only winner in a race to the bottom is the health plan that rarely passes most of the savings from these reduced hospital rates back to the employers and employees (except as required by law.) Instead, these rate concessions are used to enhance corporate profits.

RAND's findings do not correlate with other peer-reviewed studies or available data.

1. In the peer-reviewed article "Differences between Public and Private Hospital Payment Rates Narrowed, 2012-2016;" the authors, using a much larger database and a more sophisticated methodology, found that in 2016, reimbursement from private insurers represented 150% of Medicare for inpatients and 180% for outpatients. Far different from RAND's findings.[xiv]
2. RAND calculates the compounded annual rate of increase in hospital prices to be 5.1% while both JP Morgan and Altarum report commercial rates increasing at approximately 2.5% per year during the same period.[xv] [xvi]

Who says a percentage of Medicare based on a composite price is the gold standard for evaluating a health system?

RAND argues that from the employer's perspective, the cost-shift explanation is largely *abstract*. They state, "As purchasers of health care services, the more concrete question for employers is whether it is reasonable and necessary for employers to be paying prices that are nearly 2.5 times as much as Medicare rates, especially when there are hospitals with *similar quality scores* that have lower prices... Medicare sets hospital rates to *approximate hospital operating costs*." [xvii]

Currently, almost 53% of the hospitals in the country are either at-risk or high-risk of financial distress. If a local hospital's high-risk financial condition resulted from low commercial rates, i.e., a low RAND Medicare Ratio, that was negotiated out of desperation and resulted in layoffs and service cuts, does RAND then recommend that other health systems in the area emulate this contracting strategy so that they, too, can become financially distressed?

According to Moody's in 2018, Medicare represented 46.8% of the median share of gross revenue for hospitals. Medicaid and Self-pay, which generally reimburse worse than Medicare, was 14.8% and 5.4%, respectively.[xviii] Per MedPAC, the average Medicare margin in 2018 for hospitals, *before physician employment costs,* was -9.3%.[xix] Also, health systems are facing:

a) growing insured bad debt (insured patients not paying their ever-increasing deductibles or denied claims),
b) excessive denials from payers (the average denial rate for ACA plan in-network claims is 18%,[xx]) and
c) a potential shift from commercially insured to other coverage sources that pay hospitals less due to COVID-related unemployment.[xxi]

In addition, MedPAC falsely assumes that the 0 to 1% increase per year that they have provided physicians over the past decades in the Medicare Physician Fee Schedule has been acceptable.[xxii] This inadequate payment update from Medicare has led hospitals to employ physicians at considerable cost at the doctors' requests to retain a sufficient supply of physicians to meet the needs of their institution and the community. Medicare does not cover this new cost.

Clearly RAND is giving the nation's employers the wrong perspective:

1. RAND talks about "similar quality scores," but only someone with no real-world experience in the delivery of quality healthcare at the bedside would consider the CMS star system and Leapfrog grades to be representative measures of a health system's quality.
2. Medicare does not come close to approximating hospital operating costs. Only a consultant with a two-dimensional knowledge of the healthcare industry, *who has never run a healthcare*

system, would think it possible for most healthcare systems even approach breakeven at today's Medicare rates (which differ significantly by state). And who does RAND expect to cover the ever-increasing unfunded costs generated by Medicaid, self-pay patients, and the insured-bad-debt?

3. The employers better NOT consider the cost shift to be *abstract*, as RAND suggests. If they do, they will experience a severe shortage of physicians and reduced access to quality healthcare. Given the grossly underfunded reimbursement for 67% of the hospitals' government-funded and indigent patients, using Medicare rates as a benchmark for commercial rates may not be sufficient to create an adequate supply of accessible high-quality healthcare in their community.

The RAND Report commoditized quality and care delivery; ignored the importance of physicians in the care delivery process; and assumed that a reduction in services, physicians, and facilities would not be the most likely response to their irrational pricing demands. As a fellow consultant, I was hoping that RAND would produce work that would disprove Steve Job's theory that consultants have a two-dimensional understanding of an industry that leads to misinformation and unrealistic recommendations. Unfortunately, RAND not only confirmed Mr. Job's premise, they reinforced it. Thanks RAND.

Mr. Kaufman has served as a paid consultant for a number of provider clients. The American Hospital Association reimbursed him for his time preparing these comments.

[i] https://www.youtube.com/watch?v=rp6_3UQLi2Y

[ii] *Editorial*, by Stephen J. O'Connor, PhD, FACHE, March-April 2012, Journal of Healthcare Management, Vol 57, Issue 2, p 7.

[iii] Nationwide Evaluation of Health Care Prices Paid by Private Health Plans, Findings from Round 3 of an Employer-Led Transparency Initiative, by Christopher M. Whatley, et al, viii-*Implications,* Copyright 2020 Rand Corporation Research Report.

[iv] https://www.vox.com/policy-and-politics/2020/1/22/21055118/maryland-helath-care-global-hospital-budget

[v] What is Driving Total Cost of Care? By James H. Landman, PhD, JD, et al, pp 3 and 12-17.

[vi] https://hbr.org/cover-story/2019/03/how-employers-are-fixing-health-care

[vii] https://www.beckershospitalreview.com/strategy/walmart-has-no-shelf-space-for-hospitals-shoddy-healthcare

[viii] CMS Plans 2021 'Update' for Hospital Quality Star Ratings, By John Commins, August 19, 2019, Health Leaders Analysis

[ix] https://www.usnews.com/info/blogs/press-room/articles/2020-07-28/us-news-releases-2020-21-best-hospitals-rankings-and-special-hospital-heroes-series-during-historic-year-for-health-care p 4-5.

[x] https://www.hospitalsafetygrade.org

[xi] AHD.com.

[xii] Top Spenders Among the Commercially-Insured: Increased Spending Concentration and Consistent Turnover from 2013 to 2015, February 2018, HCCI Health Care Cost Institute, p 1.

[xiii] Iibid, p 5.

[xiv] Difference Between Public and Private Hospital Payment Rates Narrowed 2012-16, Data Watch, By Thomas M. Selden, 2020 Project Hope, Health Affairs 39, No. 1: 94-99, Exhibit 4.

[xv] Reimbursement Trends, Gary P. Taylor, May 24, 2018, J.P.Morgan, p 20.

[xvi] Health Sector Economic Indicators, July 19, 2019, Altarum Center for Value in HealthCare, p 2.
[xvii] The US Healthcare Provider Economic Model Is in Critical Condition, Part 1, Sept 17, 2020, ECG Management Consultants.
[xviii] Medians – Revenue growth rate inches ahead of expenses as margins hold steady, Sector Profile September 3, 2019, Moody's Investor Service, p 8.
[xix] Report to Congress, 2020, CMS, p 89.
[xx] Https://www.kff.org/privae-insrache/issue-brief/Claims-Denials-and-Appeals-in-ACA-Marketplace-Plans/ p 1.
[xxi] COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State, April 3, 2020, Health Management Associates.
[xxii] Mandated Report on Clinician Payment in Medicare MedPac 2019, p 118.