CATALYST FOR PAYMENT REFORM

Healthcare Payment Reform & Future State? What's Working Today? What Does the Future Hold?

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December 9, 2013

Goals for This Presentation

- To understand where we are with payment reform today, the challenges to payment reform, and the vast market variations that require unique solutions

- To highlight what employers are trying with payment reform and benefit and network design strategies, and how it is working and how strategies will likely evolve

Today's Agenda

- **Background and Context**
  - Who is CPR
  - How do we define payment reform
  - Progress to date, on a national level
  - Challenges to payment reform
  - No "one-size-fits-all" solution—market type matters!
- **What's Out There Today**
  - Payment Reform Typology, examples, and results
  - Benefit and network designs that support payment reform
- **Bringing it All Together—Lessons Learned**

Who We Are

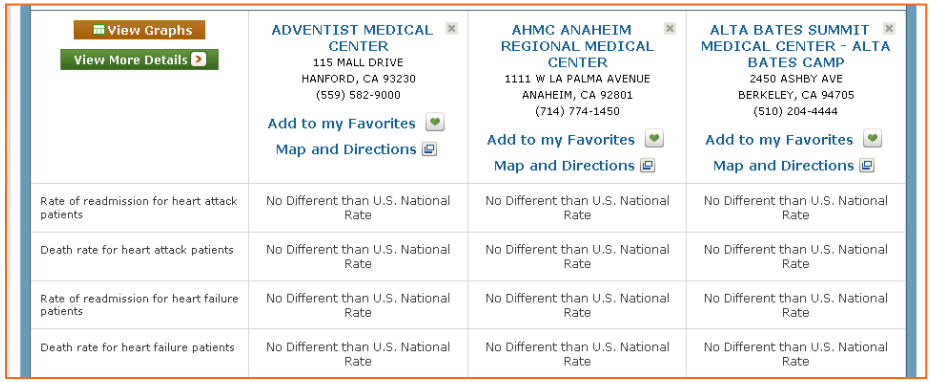
Catalyst for Payment Reform (CPR) is an independent, non-profit corporation working on behalf of large employers and public health care purchasers to catalyze improvements in how we pay for health services and to promote higher-value care in the U.S.

- 3M
- Aircraft Gear Corp.
- Aon Hewitt
- Arizona Health Care Cost Containment System (Medicaid)
- AT&T
- Bloomin' Brands
- The Boeing Company
- CalPERS
- Capital One
- Carlson
- Comcast
- Delhaize America
- Dow Chemical Company
- eBay, Inc.
- Equity Healthcare
- GE
- Group Insurance Commission, Commonwealth of MA
- The Home Depot
- Ingersoll Rand
- IBM
- Marriott International, Inc.
- Ohio Medicaid
- Ohio PERS
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Safeway, Inc.
- South Carolina Health & Human Services (Medicaid)
- TennCare (Medicaid)
- Verizon Communications, Inc.
- The Walt Disney Company
- Wal-Mart Stores, Inc.
- Wells Fargo & Company

The Challenges to Better Value: Insufficient Quality Measures

Huge quality variation

- Quality Measures would be different if set by purchasers: measures on areas of performance where improvement could lead to the greatest reduction in harm, with the greatest variation on quality and price, areas of greatest cost
- Instead we have measures that are easy to collect and show little variation across providers and meaningless to consumers
- But we know enough to know there are massive failures



View Graphs / View More Details	ADVENTIST MEDICAL CENTER 115 MALL DRIVE HANFORD, CA 93230 (559) 582-9000 Add to my Favorites Map and Directions	AHMC ANAHEIM REGIONAL MEDICAL CENTER 1111 W LA PALMA AVENUE ANAHEIM, CA 92801 (714) 774-1450 Add to my Favorites Map and Directions	ALTA BATES SUMMIT MEDICAL CENTER - ALTA BATES CAMP 2450 ASHBY AVE BERKELEY, CA 94705 (510) 204-4444 Add to my Favorites Map and Directions
Rate of readmission for heart attack patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for heart attack patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Rate of readmission for heart failure patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Death rate for heart failure patients	No Different than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate

The Challenges to Better Value: Unwarranted Payment Variation

Huge payment variation (amounts)

Table 6: Observed Prices for Selected High-Volume Maternity DRGs by Severity of Illness, 2009

APR-DRG and severity	Minimum price	Median price	Average price	Maximum price	Difference between maximum and minimum price	Ratio of maximum to minimum price
Cesarean delivery (540)						
Severity 1	$3,244	$7,598	$7,859	$15,915	$12,671	4.9
Severity 2	$2,828	$8,718	$9,338	$20,424	$17,596	7.2
Severity 3	$3,621	$11,389	$13,266	$26,018	$22,397	7.2
Severity 4	$9,600	$17,134	$19,156	$30,660	$21,059	3.2
Vaginal delivery (560)						
Severity 1	$1,810	$4,990	$5,225	$11,066	$9,256	6.1
Severity 2	$2,182	$5,692	$5,884	$12,177	$9,995	5.6
Severity 3	$2,812	$6,450	$7,656	$20,446	$17,634	7.3

Source: Mathematica Policy Research analysis of private insured and self-insured fee-for-service claims for Massachusetts residents.

Note: Payments include patient cost-sharing in fee-for-service coverage. Payments made under managed care contracts are not included.

Huge payment variation (methods)

- See CPR's Scorecards…

The Challenges to Better Value: Lack of Transparency

In our current health care environment, there are some longstanding barriers to payment reform, including:

- **A lack of price and quality transparency**

  - It is difficult to pay providers based on value, not volume, where there insufficient information about provider quality
  - Lack of price information often means consumers can't play a role in shopping for value

Time to Reform Payment

There is momentum behind transforming payment to providers and incentives for consumers. . .

- Health Reform Included Several "Game Changers" - Some Will Take Time And They Will Be Disruptive
- Focus On Specific Models – But Is There Some 'Irrational Exuberance' At Work?
- We Still Know Very Little About What Works
- Our Current System Will Be Around For A While - And We Shouldn't Ignore It

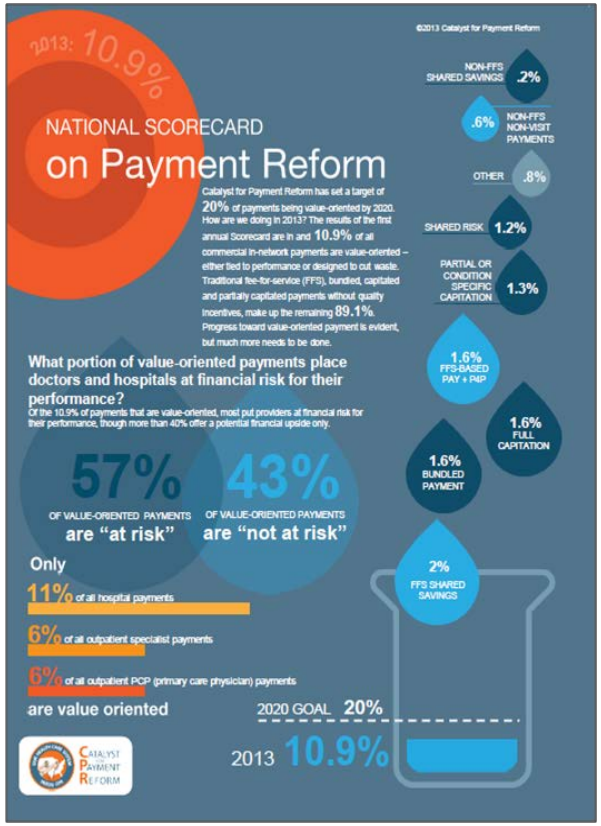
What is Payment Reform

CPR defines payment reform as follows:

- Payment that reflects provider performance, especially the quality and safety of care that providers deliver;
- Payment methods that are designed to spur efficiency and reduce unnecessary spending;
- If a payment method only addresses efficiency, it is not considered value-oriented; it must include a quality component.

The National Scorecard: Tracking Our Progress to Date

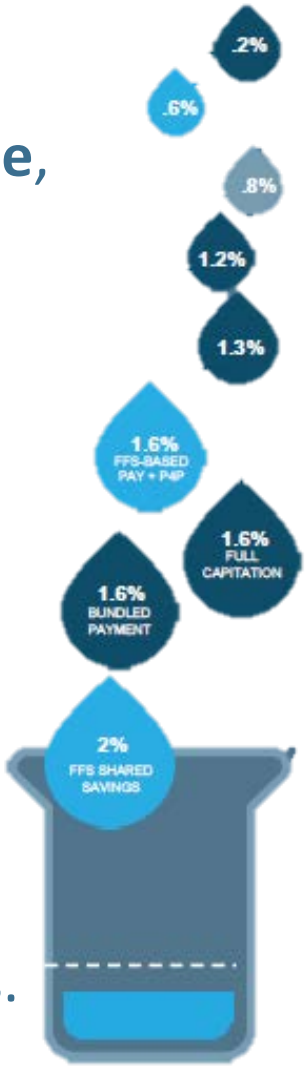
- In 2010, CPR and its members set a goal: by 2020, 20 percent of commercial payments would tied to models proven to enhance value.
- In March of 2013 CPR released the first National Scorecard on Payment Reform to track our nation's progress: we are currently at 11 percent
- By 2017, Medicare will put 10 percent of its reimbursement to providers at risk based on their performance—alignment between the public and private sector is key.



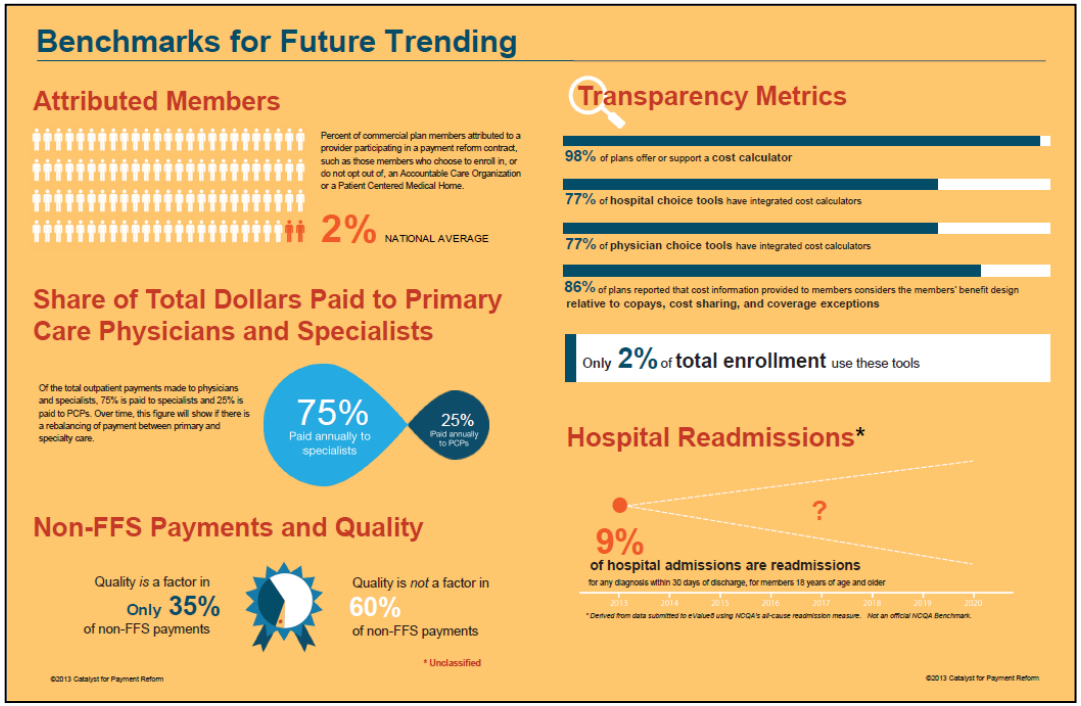
The National Scorecard: Tracking Our Progress to Date

The Scorecard found that:

- **Almost 90 percent of payments remain in fee-for-service**, or in bundled or capitated payments without quality incentives;
- **Only about 11 percent of payments today are value-oriented**;
- Within that 11 percent:
  - 43 percent of payments offer providers a potential upside to support higher quality care;
  - 57 percent of payments put providers at financial risk if they do not meet certain quality and cost goals.



National Scorecard on Payment Reform: Benchmark Metrics



USA TODAY

Slow Progress On Efforts To Pay Docs, Hospitals For 'Value,' Not Volume

HealthAffairs
AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

Payment Reform: A Promising Beginning, But Less Talk And More Action Is Needed

The Washington Post

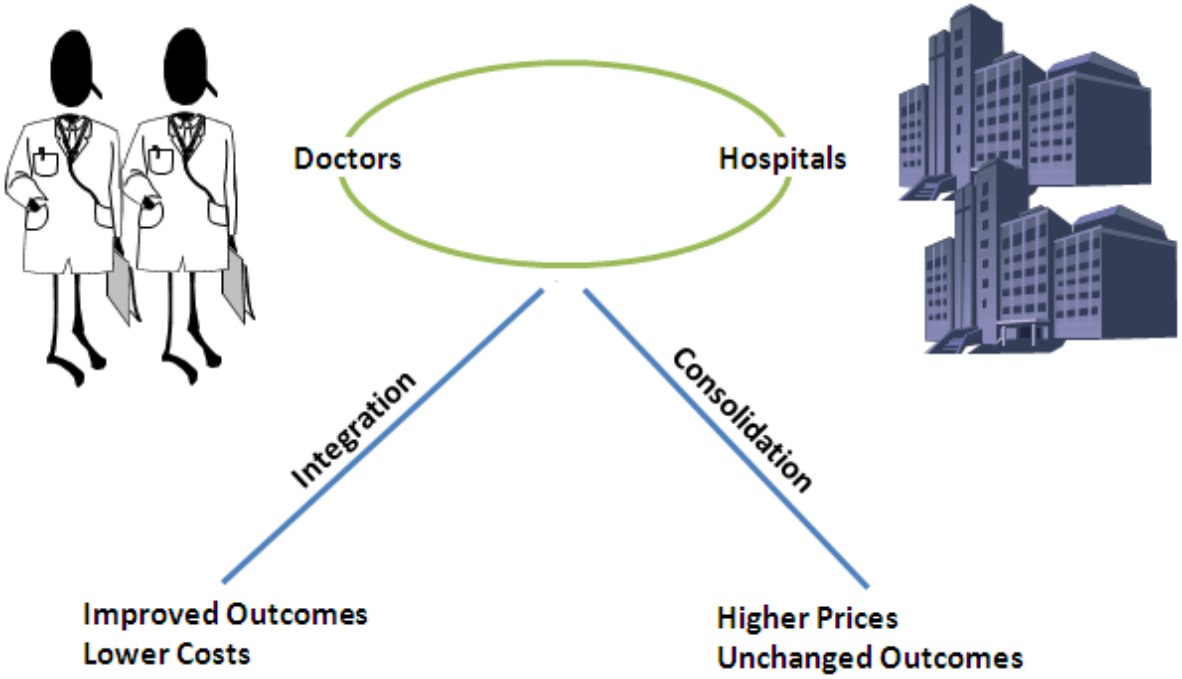
How Fortune 500 companies plan to cut health costs: Act like Medicare

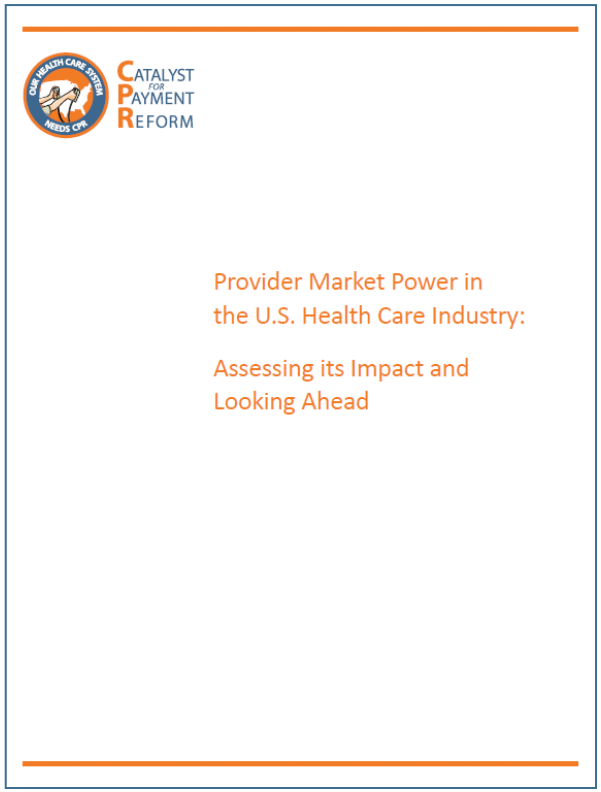
ModernHealthcare.com

Value-based insurance plans gain momentum

The Challenges to Payment Reform: Provider Market Power

Price is the leading driver of health care cost growth today





Consolidation pushes payments 3% higher nationwide

The Challenges to Payment Reform: No "One-Size-Fits-All" Solution

- Every market has different forces at work
- Experts agree that providers, purchasers, and health plans have the greatest impact in the market – CPR's Market Assessment Tool (MAT) can characterize each of these three groups as *market shaping* or *non-market shaping* based on a variety of elements.
- Once the market type and market shapers have been identified, the various payment reform options available become much more clear.

Reform Options for Better Value

Risk and Market Forces	*Payment Reforms & Benefit and Network Designs*
Payment Reform with Upside Risk Only	-Pay-for-Performance/Bonus Payments -Non FFS, Non-Visit Payments -Shared Savings Model
Two-Sided Risk	-Bundled Payment -Condition-Specific Capitation -Partial Capitation -Full Capitation with Quality/Global Payment -Shared-Risk Model (with Shared Savings)
Payment Reform with Downside Risk Only	-Non-payment
Consumer Shift to High Value Care	-Price and Quality Transparency -Reference/Value Pricing -Centers of Excellence -Evidence-Based Plan Design & V-BID -Consumer Directed Health Plans -Tiered and Narrow Networks in Plans -High Cost Case Management
Regulatory Options	-Rate Setting -Health Plan Oversight -Mandatory Public Reporting/Data Submission

Not under discussion today

Payment Reform Strategies

1) Pay-for-Performance/Bonus Payments for Quality/Efficiency

Definition:
A pay-for-performance (P4P) model provides incentives (typically financial) to providers to achieve improved performance by increasing quality of care and/or reducing costs. Incentives are typically paid on top of fee-for-service

Example: Bridges to Excellence (BTE) is a collection of physician recognition programs using national quality measures; participating physicians can earn both peer recognition and additional revenue from participating health plans

Results: Studies show BTE participating physicians provide better care, use resources more efficiently. In the CMS Physician Group Practice Demonstration, participating physician groups improved the clinical management of diabetes and a number had lower Medicare spending growth rates than their local markets.

Pay-for-performance pairs well with value-based insurance design as they both encourage the use of treatments determined to be more effective

Payment Reform Strategies

2) Non FFS, Non-Visit payments

Definition: This payment reform involves giving providers incentives (not tied to FFS), such as a payment for care coordination or HIT adoption.

Example: Payments for the adoption of HIT; payment for care coordination in a patient-centered medical Home (PCMH).

Results: In an early experiment with patient-centered medical homes, Geisinger Health System show a 7-percent net savings, accomplished through a 20-percent reduction in hospital admissions. The Department of Defense at Hill Air Force Base in Utah found its PCMH to improve sugar control for diabetics, saving $300,000/year.

Non FFS, Non-Visit payments pair well with pay for performance bonuses which can incentivize specific improvements in the delivery of care

Payment Reform Strategies

3) Condition-Specific Capitation

Definition: Condition-specific capitation is a fixed dollar payment to providers for the care that patients may receive for a specific condition or set of conditions (e.g. (HIV/AIDS, Cancer care, Diabetes) in a given time period, such as a month or year. Non-specified conditions remain reimbursed under fee-for-service or other payment method.

Example: Medicare Health Support (MHSO) pilot provided monthly management fees for patients with multiple chronic illnesses.

Results: Findings from the first 18 months of the MHSO pilot were analyzed and were not encouraging as none of the eight MHSOs achieved gross savings rates that were statistically different from zero.

Payment Reform Strategies

4) Partial Capitation

Definition: This capitation model involves a fixed dollar payment to providers for specific services (e.g. payments for carve outs for high-cost items such as specific drugs or medical devices, like prosthetics) that patients may receive in a given time period, such as a month or year. Non-specified services remain reimbursed under fee-for-service.

Example: Partial capitation is a growing Method of payment for orthopedic implants, as the cost hip and knee implants has skyrocketed. From 1991 to 2006, the average list price for coated hip implants increased 171 percent. If an implant device is covered under partial capitation, the price is constant every time the procedure is performed.

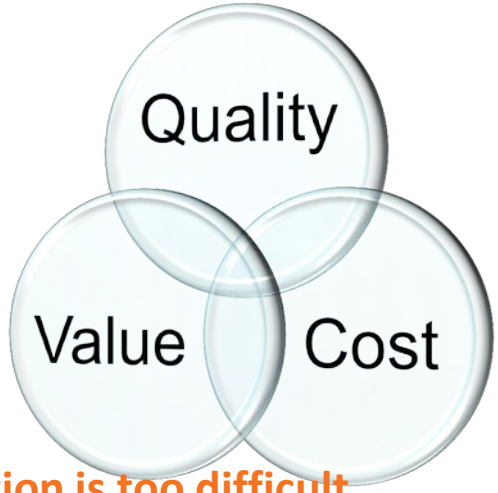
Payment Reform Strategies

5) Full Capitation with Quality and/or Global Payment

Definition: Full capitation with quality is considered to be a fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year, with payment adjustments based on measured performance and patient risk. Hence, this method includes quality of care components with pay-for-performance (P4P). Full capitation plus P4P is considered full capitation with quality.

Example: Minnesota Senior Health Options provides a capitated payment for seniors eligible both for Medicare and Medicaid. There is a value-based component to the payment.

Results: enhanced access to care, reduced preventable hospital and nursing home admissions, and generated high levels of satisfaction among beneficiaries and participating providers



Total Cost of Care contracts provide a work around when capitation is too difficult

Payment Reform Strategies

6) Bundled Payment

Definition: Bundled payment, also known as "episode-based payment," means a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or to provide a given treatment.
Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.

Example: Geisinger's ProvenCare Model; among others, offers bundled payment for CABG surgery

Results: Data have shown improved health outcomes, lower re-admission rates; up to -6% off total spending (Rand study for Massachusetts)

Bundled payment pairs well with disease management, medical homes & reference pricing

Payment Reform Strategies

7) Shared Savings Model

Definition: This arrangement provides an incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g. upside risk only). "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared savings programs can be based on a FFS payment system.

Example: Boeing, CalPERS, and PG&E use the Intensive Outpatient Care Model (care coordination for complex patients) with shared savings for providers and employers.

Results: Boeing's preliminary experience with the model showed improved health outcomes, and savings of 20 percent.

Shared savings are also the starting place for most ACO or ACO-like arrangements

Payment Reform Strategies

8) Shared Risk

Definition: This model refers to arrangements in which providers accept some financial liability for not meeting specified financial or quality targets; examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; withholds that are retained and adjustments to fee schedules. Shared-risk programs that include shared-savings are included in the shared-risk category (e.g. includes both upside and downside risk). Shared-risk programs can be based on a FFS payment system.

Example: CalPERS Global ACO with Blue Shield of CA, Hill Physicians, and Dignity

Results: Reduced admissions, readmissions and length of stay; $20 million in savings in 2010. Savings of $400 per member per year.

Payment Reform Strategies

9) Policies of Non-Payment to Providers

Definition: Policies of non-payment to providers arise when there is substantial medical evidence stating that a particular service or practice is harmful to the patient and/or does not contribute to the care process in any meaningful way. Payment policies are then crafted that no longer allow providers to be reimbursed for rendering such services in the given circumstances.

Example: South Carolina Medicaid and SC Blue Cross Blue Shield teamed up to stop paying for early elective deliveries

Results: Reduced elective inductions, NICU stays, saved Medicaid at least $6 million in Q1 2013.

The Post and Courier

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Study highlights success of S.C. Birth Outcomes Initiative

Lauren Sausser

Posted: Friday, November 8, 2013 9:00 p.m.

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A statewide group of health care leaders, called the Birth Outcomes Initiative, reduce the number of early elective infant deliveries in South Carolina since 2 a new report published Thursday.

The reason is simple. The two largest insurers in the state — BlueCross BlueS Carolina and the Medicaid agency — stopped paying for them. In January, ho in South Carolina were no longer reimbursed for inducing delivery before 39

Policies to eliminate avoidable complications pair well with disease management or medical homes

Payment Reform Strategies

9) Policies of Non-Payment to Providers, continued

Example: Medicare non-payment for hospital readmissions for certain conditions (heart attacks, pneumonia and heart failure)

Results: Readmissions dropped from 19% to 17.8% from 2011 to 2012. More than 2,200 hospitals faced some penalty in the first year. The penalties amounted to about $125,000 per hospital on average and $280 million total.

Benefit and Network Design Strategies that Complement Payment Reform

- ✓ **Price and Quality Transparency**
- ✓ **Reference Pricing**
- ✓ **Centers of Excellence**
- ✓ **VBID**
- ✓ **Consumer-Directed Health Care**
- ✓ **Tiered and Narrow Networks**
- ✓ **Case management for high cost beneficiaries**

Like hand and glove

Price and Quality Transparency

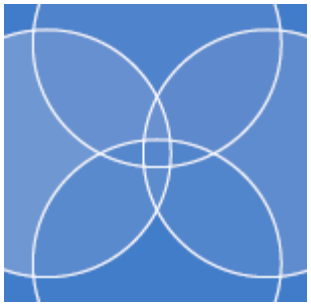
Example: GE developed a treatment cost calculator with Thomson Reuters leveraging existing GE claim experience and that of other employers that addresses out of pocket costs, provider-specific comparisons, reminders, "know and save" opportunities like ER alternatives.

GE HEALTH CHOICE Treatment Cost Calculator

imagination at work

Results: Utilization is strong. Opportunities for savings in every market – as much as 30%+.

Thomson Reuters analysis:
An employer with 20,000 enrollees and a trend of 6.1% could potentially save $715,000 in the first year and $6.8 million by the third year.



73% of employers provide, or plan to provide, price and quality transparency tools, through their health plans or independent vendors, between now and 2016.

Transparency is a building block for reference pricing and pay-for-performance

Reference Pricing

Example: Safeway uses *consumer directed health plans (CDHP*), which gives consumers "skin in the game," plus *reference pricing*, encouraging them to shop for care at a reasonable price, plus quality and transparency tools to facilitate shopping. Together, these benefit strategies help ensure Safeway (through its health plans) is predominately *paying providers for quality care at reasonable prices.*

SAFEWAY

Application of reference pricing to colonoscopies and other services has held per capita health care costs nearly flat

Growing in Popularity Among Purchasers Nationally: 5% in 2013; 15% in 2014*

****NBGH/Towers Watson***

CalPERS

Over $3 million in savings in first year of hip/knee replacement reference pricing program; some high-priced providers renegotiated

Reference pricing necessitates transparency; pairs well with bundled payment and COEs

Reference Pricing and Bundled Payment

Example: CalPERS relies on a *reference pricing strategy*, with a reference price of $30,000 for hip/knee replacement surgery. Members who seek care at a higher price provider pay the difference above the reference price.

Long term, such a strategy would pair well with *bundled payment for providers*, covering the full cost of care for such a surgery plus any related care; e.g. Hoag Orthopedic Institute has a bundled payment program with Aetna for knee replacement surgery.

Centers of Excellence – Direct Contracting

Example: Walmart employees who need heart surgery can travel to one of six *Centers of Excellence*, where the procedure is covered 100 percent. Should they choose a different option (not guaranteed to offer quality care) they will pay more out of pocket. In turn, the providers at these Centers pledge to provide *high quality care (at a negotiated rate).*

25% of surveyed employers contract, or *plan to* Contract directly with physicians, hospitals, accountable care organizations or patient-centered medical homes between now and 2016.

Kroger experienced a savings of roughly 25%, or $10,000, over what orthopedic surgeries would cost at other facilities, even factoring in the cost of travel

COEs pair well with bundled payment and reference pricing as well as other value-based insurance designs

Direct Contract with ACO-Narrow Network

Example: Intel has a direct contract with Presbyterian Health System (PHS) for an ACO-like arrangement. Employees who select this option must use a *narrow network* of PHS providers, who are paid directly by Intel to manage their care and care costs, in an arrangement with *shared risk and shared savings.*

Intel projected it could save $8-10 million through 2017 with Presbyterian as better care improves population health, though costs are initially expected to rise

Value-Based Insurance Design

Example: Purdue Farms, Inc. developed "Best Health" which combined VBID with a narrow network and a health improvement program. To guide plan participants away from low-value or harmful interventions, Perdue Farms differentiates cost sharing for services valued at different levels.

Results: BestHealth participants had 30 percent fewer of the low-value interventions (done per one thousand) as compared to those in other plan offerings. Total costs were lower as a result.

52% of employers surveyed said they use, or plan to use value-based benefit designs, or provide different levels of coverage based on cost or quality, or evidence-based practice, between now and 2016.

Consumer Directed Health Plans

Example: Safeway offers a CDHP/HRA combination, with coverage of preventive services and a nurse advice line.

Results: Safeway has been able to hold health care spending relatively flat, in part due to consumer directed health care. Safeway's all-inclusive health care costs per capita did not change from 2005-2011. Over the same period, national health care costs have increased more than 60 percent.

Today, 66% of companies have an Account Based Health Plan (ABHP) in place and another 13% expect to add one by 2014.

Such a strategy pairs well with price and quality transparency

Narrow Network

Example: Walmart and Home Depot recently partnered with Imagine Health to offer Illinois-based employees the chance to enroll in a *narrow network* of high-value providers.

Results: Imagine Health reports that its narrow network offering brings in over $1.2 million in savings for every 1,000 employees

According to the Towers Watson survey, 31% of employers have or plan to use differential cost sharing to encourage employees to use high-performing networks, by 2014.

Such a strategy could be well paired with *pay-for-performance* for these high-performing providers.

Case Management for High-Cost Employees Plus HRA

Example: Johnson & Johnson uses a *case management for high cost employees* strategy and a *consumer directed health care* strategy, giving employees money in their HRA for seeking the right care. For example, employees can earn $500 for enrolling in their maternity program (which helps with care management).

Such strategies would pair well with *bundled payment* for maternity care, which would incentivize providers to offer the right care to expectant mothers.

Case Management for Medically-Complex Patients

Example: Boeing uses the Intensive Outpatient Care Model (IOCP), which relies on *intensive case management for medically-complex patients*, and has *shared savings for providers and employers*.

Results: In Boeing pilot, functional status, intermediate outcomes scores, depression, patients' experience of care, and employees' absenteeism improved compared to baseline. Unit price-standardized per capita spending dropped by an estimated 20 percent, primarily due to lower spending for ER visits and hospitalizations. CalPERS, PG&E and others now replicating.

Pairing the model with *Value Based Benefit Design (VBID)* could reduce co-pays on medications needed to treat chronic-illness and improve medication adherence.

Employers Keeping Trend More at Bay Favor the Following…

Figure 25. New provider strategies are favored by best performers

	Best performers		Low performers	
	2013	2014*	2013	2014*
Increase or decrease vendor payments based on specific performance targets	36%	44%	20%	30%
Differentiate cost sharing for use of high-performance networks	13%	31%	12%	25%
Use value-based benefit designs (e.g., different levels of coverage based on value or cost of services)	11%	33%	12%	32%
Offer incentives (or penalties) to providers to improve quality, efficiency and health outcomes of plan participants (i.e., performance-based payments)	22%	47%	5%	28%
Engage a third party to secure improved pricing for medical services	18%	24%	19%	30%
Offer incentives (or penalties) to providers for coordinating care and using emerging technologies or evidence-based treatments	16%	38%	4%	21%
Adopt new payment methodologies that hold providers accountable for cost of episode of care, replacing fee for service	16%	38%	2%	13%
Use reference-based pricing in medical plan (e.g., limited level of coverage for a procedure)	9%	27%	5%	21%
Contract directly with physicians, hospitals and/or ACOs	13%	31%	7%	13%

*Includes companies indicating "planned for 2014"

2013 18th Annual Towers Watson/NBGH Employer Survey on Purchasing Value in Health Care

Bringing it All Together

- Your market matters! You need to understand the forces at work
- Payment reform approaches have success (when the right model is matched to the market), but evidence is very limited
- Many interesting hybrid models are evolving, including across payment, benefit and network designs
- We need to continue to collect data and measure results so we know what works!...Regional Scorecards on Payment Reform (e.g. NY, CA) can help tell us what models are spreading

Bringing it All Together

- CPR has a variety of tools to help you understand your market and the payment reform model that is right for you.

- Action Briefs
- Market Assessment Tool
- Insights on Price Transparency Tools
- Report Card on Price Transparency Laws
- Case studies on what works: e.g. South Carolina Medicaid's nonpayment policy
- Scorecards on Payment Reform
- National Compendium on Payment Reform

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