Payment Reform as a Critical Imperative for Achieving Value and What Employers Can Do About It

Suzanne Delbanco
Executive Director, Catalyst for Payment Reform
May 13, 2015

Agenda

Introduction
- Who We Are
- Employer Perspective

The Need for Reform
- Perverse Incentives
- Quality & Price Inefficiencies

Alternative Payment Models
- Payment Models
- National Results
- Setting Goals

Taking Action (What Employers Can Do)

Who We Are

- A **critical mass of voices** all asking for the same thing at the same time
- **A light shining** on the urgency of payment reform

- 3M
- Aircraft Gear Corp.
- Aon Hewitt
- Arizona Health Care Cost Containment System (Medicaid)
- AT&T
- Bloomin' Brands
- The Boeing Company
- CalPERS
- Carlson
- Comcast
- Delhaize America
- Dow Chemical Company
- eBay Inc.
- Equity Healthcare
- FedEx Corporation
- GE
- Group Insurance Commission, Commonwealth of MA
- The Home Depot
- Maine Bureau of Human Resources
- Marriott International, Inc.
- Mercer
- Michigan Department of Community Health (Michigan Medicaid)
- Ohio Medicaid
- Ohio PERS
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Qualcomm Incorporated
- South Carolina Health & Human Services (Medicaid)
- TennCare (Medicaid)
- Towers Watson
- Verizon Communications, Inc.
- Wal-Mart Stores, Inc.
- The Walt Disney Company
- Wells Fargo & Company
- Woodruff Sawyer & Company

Shared Agenda

Payments designed to cut waste or reflect performance

Leverage purchasers and create alignment

- Health plan sourcing, contracting, management and user groups
- Alignment with public sector

Implement Innovations

- Payment reform
- Pairings for payment reform with benefit and network design
- Price transparency
- Enhance provider competition

Employers Have a Significant Role

Other than Medicare, private and public employers are the biggest consumers of health care;

56 percent of Americans get their health insurance coverage through their employers

Theoretically, they have significant leverage to shape the market

Employers Are Eager for Payment Reform…

Employers embrace emerging payment approaches to improve quality and affordability of care

Companies increasingly expect their health plans to adopt payment methodologies that hold providers accountable for the cost of an episode of care, replacing discounted fee-for-service. In fact, 18% of best-performing companies plan to adopt these approaches in 2015.

"Employers strongly believe we need to reform health care payment to make our health care spending go further…"

--Steve Morgenstern, North America Health and Welfare Plans Leader Dow Chemical Company

Source: Towers Watson

CATALYST FOR PAYMENT REFORM

The Need for Reform

Perverse Incentives: FFS

Historically, physicians have been paid on a **fee for service-basis**, this means,

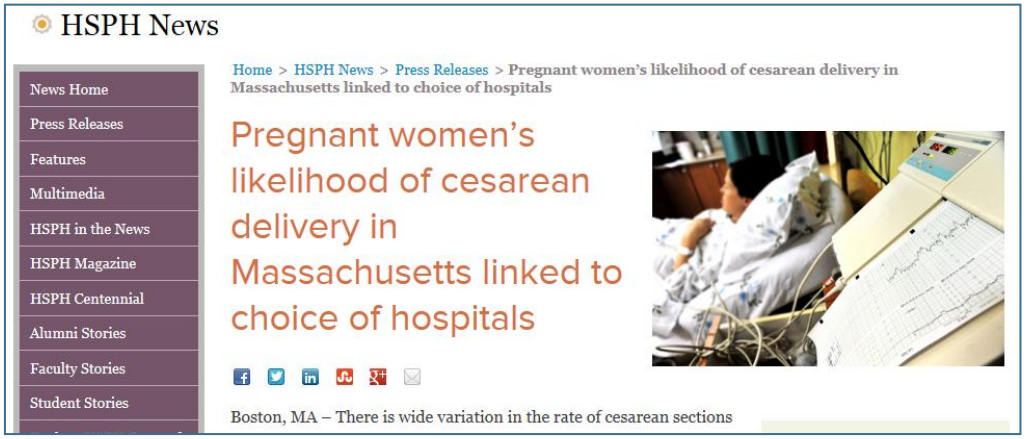
- We pay for care regardless of quality and outcomes;
- We pay for every test and procedure regardless of necessity; and,
- There are aspects of care – i.e. care coordination – that do not get paid for under this model

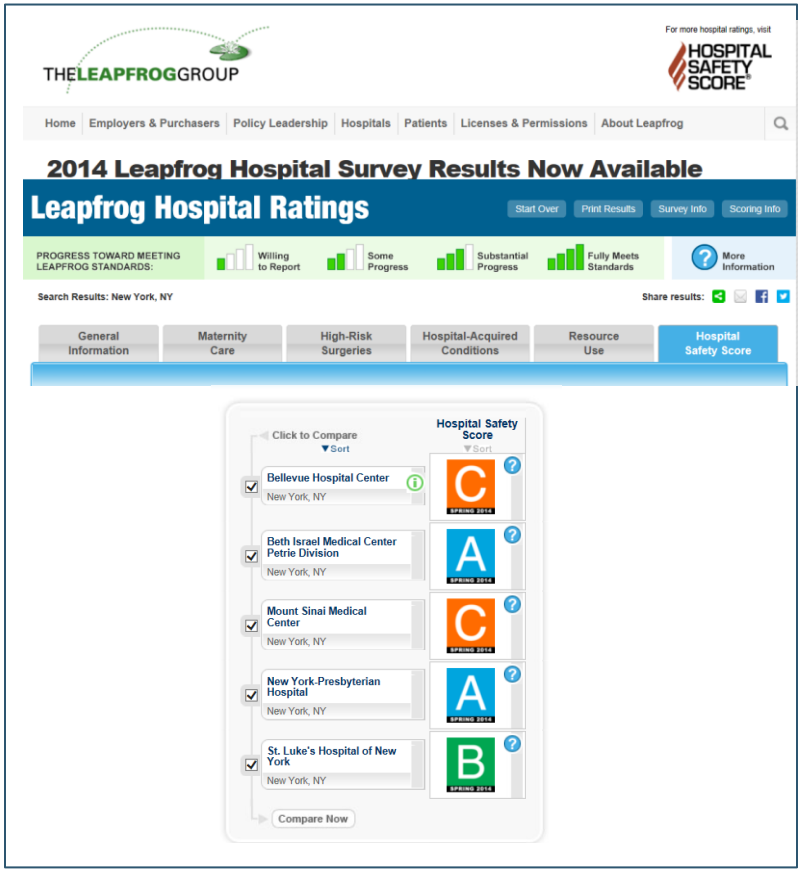
Quality Inefficiencies

Patients only get **recommended care 55%** of the time

44,000-98,000 deaths per year

Without appropriate benchmarks, it is almost impossible to pay providers based on value…





Price Inefficiencies

Prices for services are not standardized

The cost of a **lipid panel blood test**, in California can vary from as much as **$10** to **$10,169**[1]

And prices in the U.S. can vary as much as **700%**

**Source: Mathematica Policy Research*

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.

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; and,
>
> Is not considered value-oriented payment, if a payment method only addresses efficiency; it must include a quality component;

CATALYST FOR PAYMENT REFORM

Alternative Payment Models

Provider Payment Models

BASE PAYMENT

Fee For Service | Bundled Payment | Global Payment

Charges	Fee Schedule	Per Diem	DRG	Episode Case Rate	Partial Capitation	Full Capitation

Increasing Accountability, Risk, Provider Collaboration, Resistance, and Complexity

PERFORMANCE-BASED PAYMENT OR PAYMENT DESIGNED TO CUT WASTE
(financial upside & downside depends on quality, efficiency, cost, etc.)

Alternative Payment Models

1) Pay-for-Performance/Bonus Payments for Quality and Efficiency
   - Provides incentives (typically financial) to providers to achieve improved performance by increasing quality of care and/or reducing costs;

2) Shared Savings Model
   - Provides an incentive for providers or provider entities to reduce unnecessary spending for a defined patient population, by offering a percentage of any realized net savings.

3) Shared Risk Model
   - Provides an incentive for providers or provider entities to reduce unnecessary spending for a defined patient population, in which providers accept some financial liability for not meeting specified financial or quality targets;

**Pay-for-Performance, Shared Savings, and Shared Risk Models may have a base payment other than FFS, though they are most commonly seen with a FFS-base

Alternative Payment Models

4) Bundled Payment Model

- Provides a single payment to providers or health care facilities 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/ condition as well as costs associated with preventable complications

5) Capitation with Quality

- Provides a fixed dollar payment to providers for the care that patients may receive in a given time period with payment adjustments based on performance and patient risk. This method includes a quality of care component with pay-for-performance

6) Non-Visit Payments

- This involves giving providers incentives such as payment for care coordination or Health Information Technology

**Bundled Payment and Capitation operate with base payments that do not rely on fee-for-service

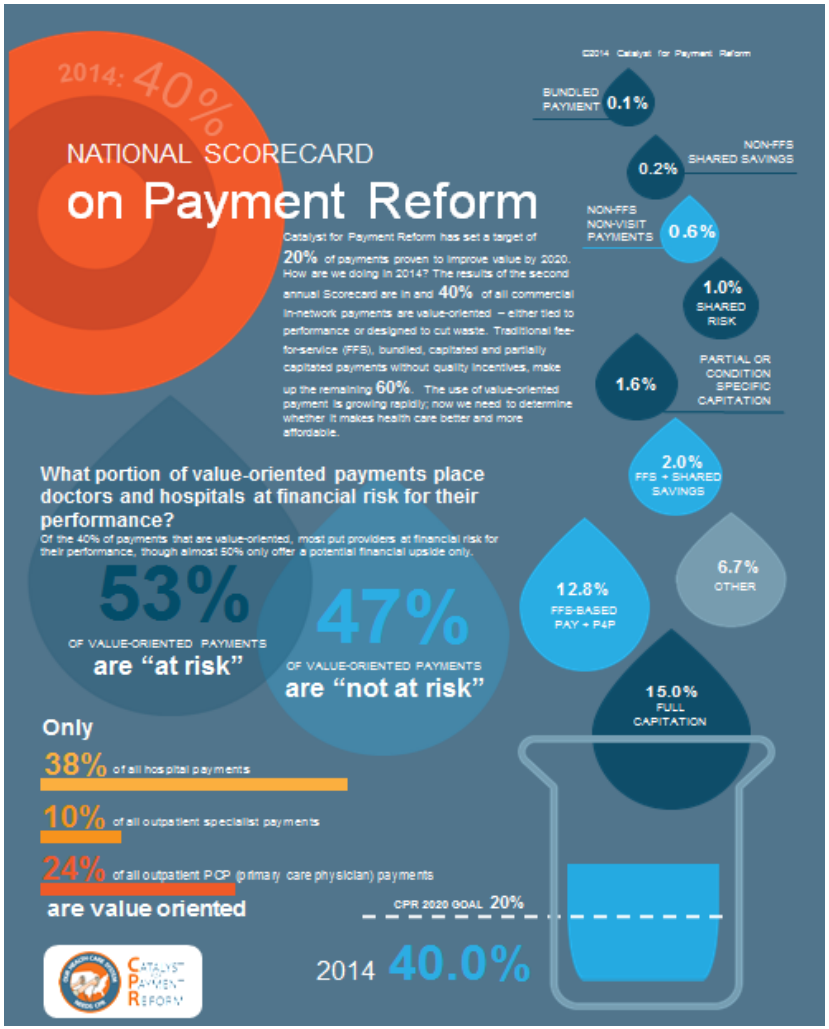
Upside, Downside, Two-Sided Risk

Type	Examples
Upside only for providers	Physicians •Primary Care Medical Home/payment for care coordination or payments for other non-visit functions •Payment for shared decision making •Payment for nontraditional visits (e.g. e-visits) •Hospital-physician gainsharing •Pay for Performance •Shared savings Hospitals •Pay for Performance •Shared savings
Downside only for providers	•Hospital penalties (e.g. readmissions, Hospital Acquired Conditions, never events, warranties, Length of Stay)
Two-sided risk (both upside and downside)	•Bundled payment •Global payment/capitation •Shared-risk in Accountable Care Organization environment

Most payment reforms built on a fee-for-service chassis

2014 National Scorecard Results

- 40% of commercial in-network payments are value-oriented; 29% jump from 2013 when it was 11%
- 53% of the value-oriented payment is considered “at-risk”
- 38% of payment to hospitals is value-oriented
- 10% of outpatient specialist and 24% of PCP payment is value-oriented
- Respondents may be larger than average health plans in the U.S. and include HMOs
- Scorecard results not statistically reliable, possibly biased upward as survey is voluntary and self-reported



2014 Scorecard Benchmark Results

Benchmarks for Future Trending

Attributed Members

Percent of commercial plan members attributed to a provider participating in a payment reform contract, such as those members who choose to enroll in, or do not opt out of, an Accountable Care Organization, Patient Centered Medical Home or other delivery models in which patients are attributed to a provider.

15% NATIONAL AVERAGE

Transparency Metrics

97% of plans offer or support a **cost calculator**

63% of **hospital choice tools** have integrated cost calculators

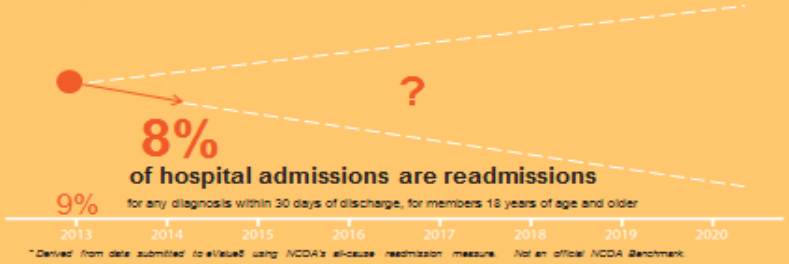
74% of **physician choice tools** have integrated cost calculators

82% of plans reported that cost information provided to members considers the members' benefit design **relative to copays, cost sharing, and coverage exceptions**

Share of Total Dollars Paid to Primary Care Physicians and Specialists

Of the total outpatient payments made to primary care physicians and specialists, 71% is paid to specialists and 29% is paid to PCPs. Over time, this figure will show if there is a rebalancing of payment between primary and specialty care.

Hospital Readmissions*



*Derived from data submitted to eValue8 using NCQA's all-cause readmission measure. Not an official NCQA Benchmark.

Non-FFS Payments and Quality

Quality *is* a factor in **97%** of non-FFS payments

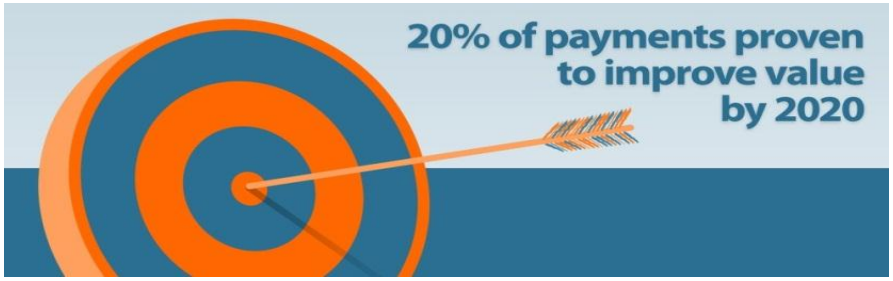
Quality is *not* a factor in **3%** of non-FFS payments

©2014 Catalyst for Payment Reform

Value-Oriented Payment Reform

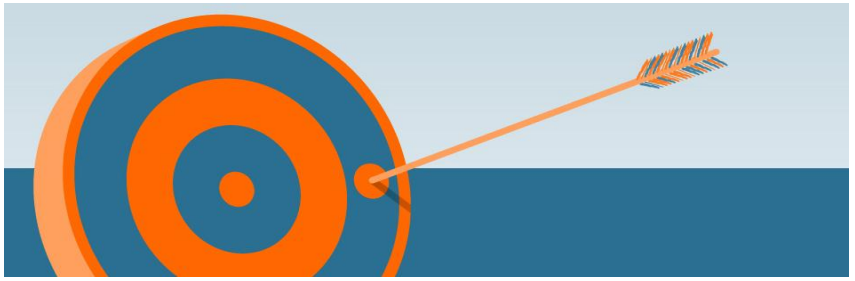
Are we going to hit our target but miss the bull's-eye?

CURRENT



- We are measuring use of "value-oriented payment" methods;
- What happens if we get to 60, 70, or 80 percent by 2020 but value has not improved?

FUTURE



- We need to build an evidence base of what works in what context;
- We need to get to a preponderance of payment flowing through methods proven to produce "***value***";
- We need to engage in collaboration between multiple players

CATALYST FOR PAYMENT REFORM

Taking Action: What Employers Can Do

Employers Taking Action

Educate Yourself

Let your voice be heard; join other purchasers in sending consistent signals about the need for payment reform to improve the quality and cost of care by using CPR's tools

Put your hand on the steering wheel in major challenge areas

Assess your key markets for opportunity

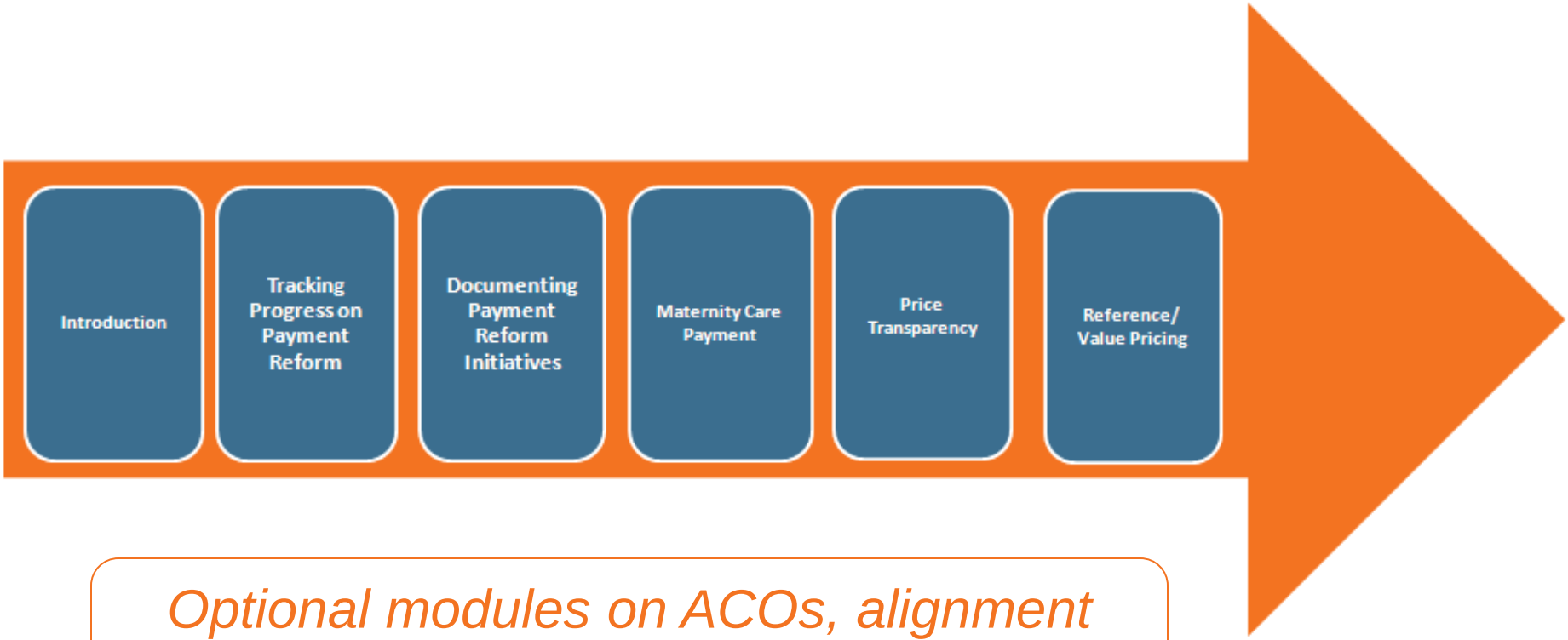
Educate Yourself

Learn the Basics about Payment Reform and Health Care Costs:

- ✓ Action Briefs on various payment reform topics
- ✓ Research reports, e.g. The Cost of Having a Baby, Provider Market Power in the U.S., Variation in Hospital and Physician Payment Rates, etc.
- ✓ Report Card on State Price Transparency Laws

Let Your Voice Be Heard: Health Plan Sourcing

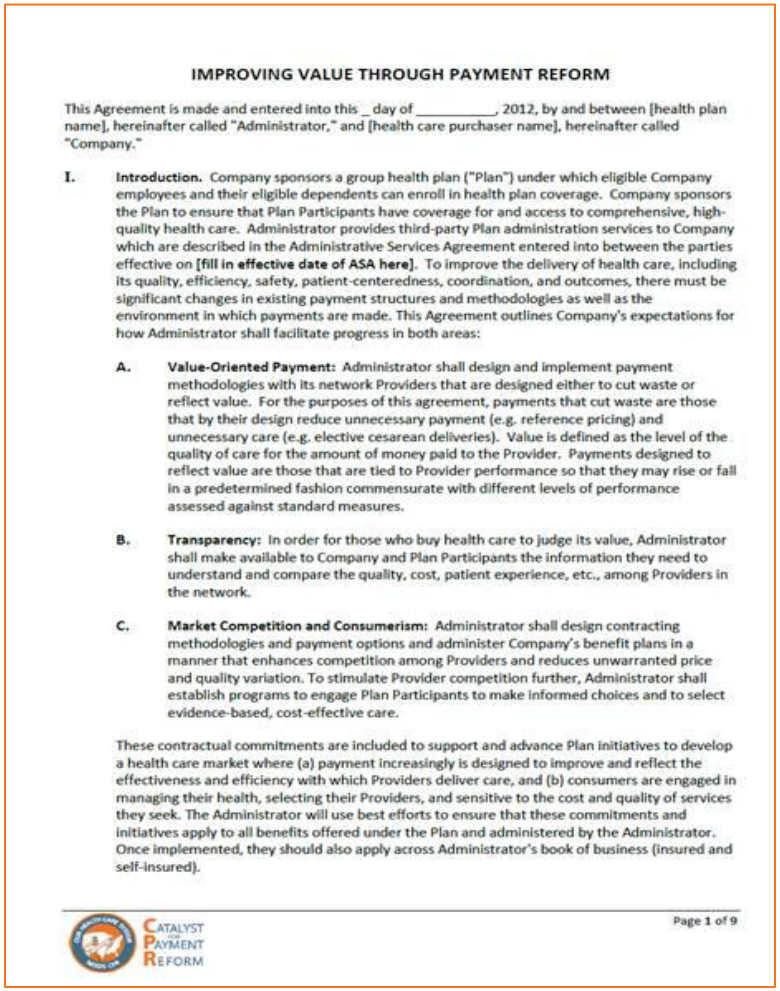
CPR's Health Plan Request for Information (RFI) Questions



Optional modules on ACOs, alignment with Medicare, and future strategies

Let Your Voice be Heard: Health Plan Contracting

CPR's Model Health Plan Contract Language



IMPROVING VALUE THROUGH PAYMENT REFORM

This Agreement is made and entered into this _ day of _____, 2012, by and between [health plan name], hereinafter called "Administrator," and [health care purchaser name], hereinafter called "Company."

I. **Introduction.** Company sponsors a group health plan ("Plan") under which eligible Company employees and their eligible dependents can enroll in health plan coverage. Company sponsors the Plan to ensure that Plan Participants have coverage for and access to comprehensive, high-quality health care. Administrator provides third-party Plan administration services to Company which are described in the Administrative Services Agreement entered into between the parties effective on **[fill in effective date of ASA here]**. To improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes, there must be significant changes in existing payment structures and methodologies as well as the environment in which payments are made. This Agreement outlines Company's expectations for how Administrator shall facilitate progress in both areas:

A. **Value-Oriented Payment:** Administrator shall design and implement payment methodologies with its network Providers that are designed either to cut waste or reflect value. For the purposes of this agreement, payments that cut waste are those that by their design reduce unnecessary payment (e.g. reference pricing) and unnecessary care (e.g. elective cesarean deliveries). Value is defined as the level of the quality of care for the amount of money paid to the Provider. Payments designed to reflect value are those that are tied to Provider performance so that they may rise or fall in a predetermined fashion commensurate with different levels of performance assessed against standard measures.

B. **Transparency:** In order for those who buy health care to judge its value, Administrator shall make available to Company and Plan Participants the information they need to understand and compare the quality, cost, patient experience, etc., among Providers in the network.

C. **Market Competition and Consumerism:** Administrator shall design contracting methodologies and payment options and administer Company's benefit plans in a manner that enhances competition among Providers and reduces unwarranted price and quality variation. To stimulate Provider competition further, Administrator shall establish programs to engage Plan Participants to make informed choices and to select evidence-based, cost-effective care.

These contractual commitments are included to support and advance Plan initiatives to develop a health care market where (a) payment increasingly is designed to improve and reflect the effectiveness and efficiency with which Providers deliver care, and (b) consumers are engaged in managing their health, selecting their Providers, and sensitive to the cost and quality of services they seek. The Administrator will use best efforts to ensure that these commitments and initiatives apply to all benefits offered under the Plan and administered by the Administrator. Once implemented, they should also apply across Administrator's book of business (insured and self-insured).

Page 1 of 9

- Outlines purchaser expectations creating accountability
- Sets short and long term expectations
- For use during renewals or as addendum
- Focuses on:
  - Value-oriented payment
  - Transparency
  - Market competition and consumerism
  - Alignment with Medicare
  - Oversight of ACOs
  - Evaluating Results

Let Your Voice be Heard: Health Plan Management

Health Plan User Groups

2013 CPR Health Plan User Group Quarterly Progress Report

Purpose of the Health Plan User Group Quarterly Progress Report

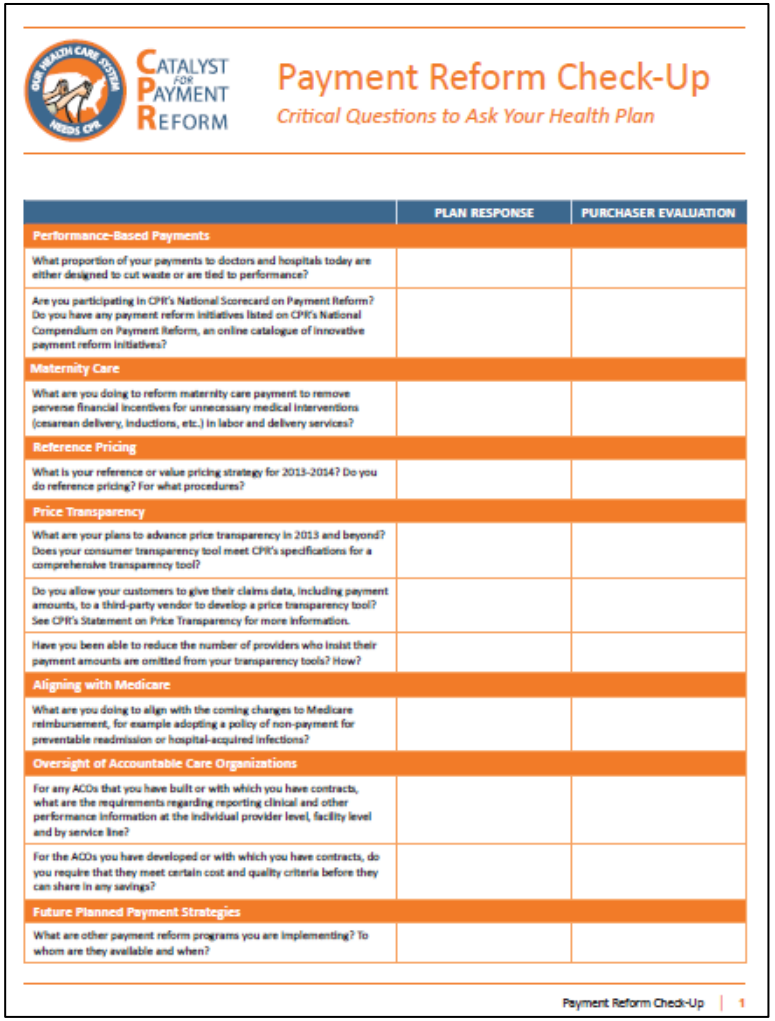
The purpose of this Quarterly Progress Report is to facilitate a robust conversation between purchasers and health plans during CPR's scheduled Quarterly Health Plan User Group meetings. The Progress Report puts forth a standardized and strategic set of metrics to help assess a health plan's progression toward payment reform and will provide a structure for the quarterly discussions and ensure that CPR purchaser expectations are clear and tracked through carefully-selected metrics. Please note any changes from 2012's Progress Report are denoted in red.

Instructions

1. The health plan contact for the Quarterly CPR Health Plan User Group meetings will coordinate responses to the elements of the Progress Report and provide the final response to CPR one week in advance of the scheduled quarterly Health Plan User Group conference calls.
2. Please insert quantitative results as instructed and narrative explanations as appropriate.
3. If there are questions regarding the intent, purpose or content of this report, please direct them to Shaudi Bazzaz, CPR's Program Manager at sbazzaz@catalyzepaymentreform.org.

2013 Goals				Level of Completeness			
Section A: Price Transparency	Make available to Company and to all Plan Participants all book of business rates for any given service or bundle of services paid to any provider or network of providers. Plans must: • Fully disclose prices to facilitate cost comparisons of Providers by Company and Plan Participants. • Assure tool meets core functionality and content specifications	1a. Price Transparency tools that meet CPR's Comprehensive Specifications for the Evaluation of Price Transparency Tools are available to all Plan Participants. 1b. Please indicate the proportion of plan spend represented by the services included in your plan's transparency tool.	**Fully Met:** Meets all "core" and "expanded" specifications in the Scope and Accuracy sections of the CPR Specifications. **Partially Met:** Meets the "core" specifications but only some or none of the "expanded" specifications in the Scope and Accuracy sections of the CPR Specifications. **Not Met:** Does not meet either the "core" or "expanded" specifications in the Scope and Accuracy sections of the CPR Specifications.	Q1	Q2	Q3	Q4

- User Groups with Aetna, Anthem, Blue Shield of CA, Cigna, United Healthcare
- Tracking progress quarterly: value-oriented payment, reference and value pricing, maternity care payment, price transparency



CATALYST FOR PAYMENT REFORM

Payment Reform Check-Up

Critical Questions to Ask Your Health Plan

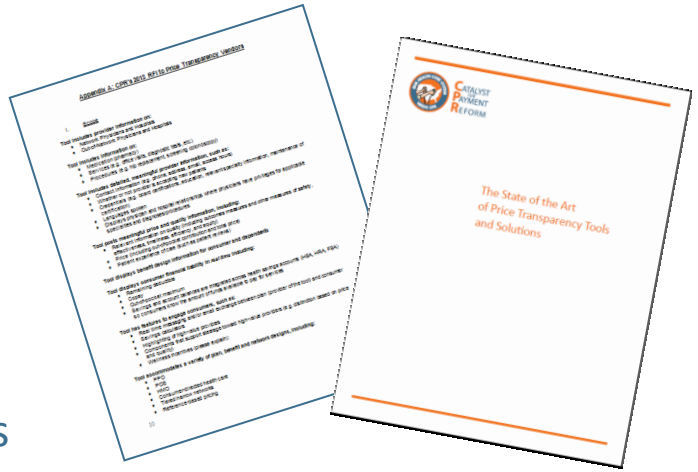
	PLAN RESPONSE	PURCHASER EVALUATION
Performance-Based Payments		
What proportion of your payments to doctors and hospitals today are either designed to cut waste or are tied to performance?		
Are you participating in CPR's National Scorecard on Payment Reform? Do you have any payment reform initiatives listed on CPR's National Compendium on Payment Reform, an online catalogue of innovative payment reform initiatives?		
Maternity Care		
What are you doing to reform maternity care payment to remove perverse financial incentives for unnecessary medical interventions (cesarean delivery, inductions, etc.) in labor and delivery services?		
Reference Pricing		
What is your reference or value pricing strategy for 2013-2014? Do you do reference pricing? For what procedures?		
Price Transparency		
What are your plans to advance price transparency in 2013 and beyond? Does your consumer transparency tool meet CPR's specifications for a comprehensive transparency tool?		
Do you allow your customers to give their claims data, including payment amounts, to a third-party vendor to develop a price transparency tool? See CPR's Statement on Price Transparency for more information.		
Have you been able to reduce the number of providers who insist their payment amounts are omitted from your transparency tools? How?		
Aligning with Medicare		
What are you doing to align with the coming changes to Medicare reimbursement, for example adopting a policy of non-payment for preventable readmission or hospital-acquired infections?		
Oversight of Accountable Care Organizations		
For any ACOs that you have built or with which you have contracts, what are the requirements regarding reporting clinical and other performance information at the individual provider level, facility level and by service line?		
For the ACOs you have developed or with which you have contracts, do you require that they meet certain cost and quality criteria before they can share in any savings?		
Future Planned Payment Strategies		
What are other payment reform programs you are implementing? To whom are they available and when?		

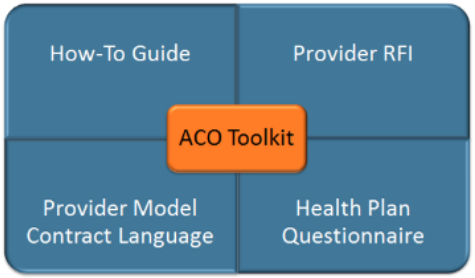
Payment Reform Check-Up | 1

Put Your Hands on the Steering Wheel

Price Transparency Tools for Employees

- "State of the Art" Report
  - A public report examining the features of products today and outlining the features every product should have
- Price Transparency Product RFP
  - An RFP you can use to source transparency tools and solutions





How-To Guide on ACOs

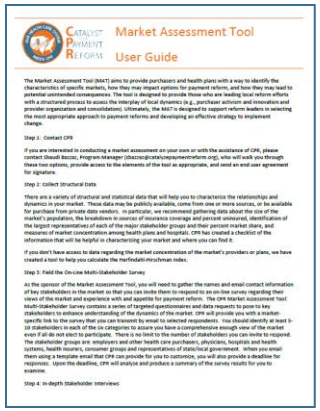
How-to Guides for Working with Plans and Providers:

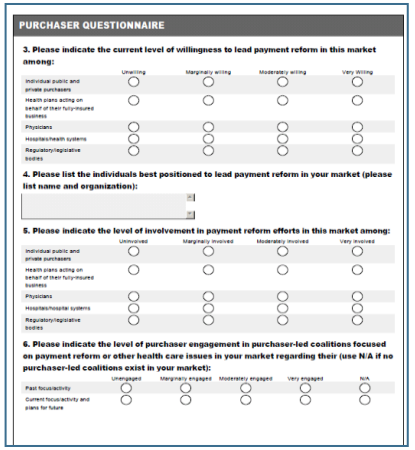
- Early Elective Deliveries
- Model Hip/Knee Program
- ACOs

Assess Your Key Markets

CPR's Market Assessment Tool provides a structured process to assess local dynamics and identify most appropriate payment reform options

- Comprehensive inventory of market characteristics
  - Purchaser activation, provider interest/organization, payer readiness, consumer perspective, competition, regulatory/ legal
- 5 Assessments to Date: Columbus, Grand Rapids, Long Beach, Memphis, Twin Cities
- Developed through rigorous analysis and national/regional expert input


Market Assessment Tool
User Guide

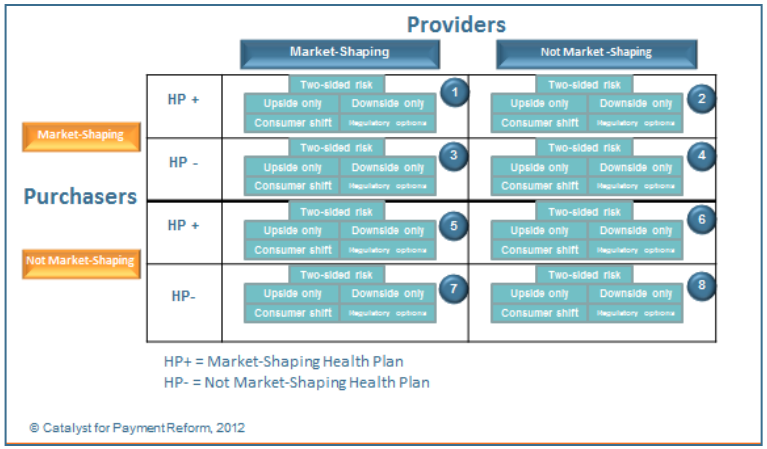

PURCHASER QUESTIONNAIRE

3. Please indicate the current level of willingness to lead payment reform in this market among:

4. Please list the individuals best positioned to lead payment reform in your market (please list name and organization):

5. Please indicate the level of involvement in payment reform efforts in this market among:

6. Please indicate the level of purchaser engagement in purchaser-led coalitions focused on payment reform or other health care issues in your market regarding their (use N/A if no purchaser-led coalitions exist in your market):



CPR Member Innovations

Payment Reforms

- Bundled payment for hip and knees
- Shared savings
- Withholds on capitation payments for quality

Health Care Delivery Reforms

- ACOs (including direct contracting)
- Medical homes

Benefit and Network Design Changes

- Onsite clinic access to price information for referrals
- COEs - spine, hip/knees, cancer, etc.
- Reference pricing - colonoscopies, physical therapy, labs
- Specialty pharmacy - tiering, site of service
- Narrow networks

Unprecedented Innovation

Questions?

Contact information:
www.catalyzepaymentreform.org

Suzanne Delbanco, Ph.D., Executive Director
sdelbanco@catalyzepaymentreform.org
510-435-2364