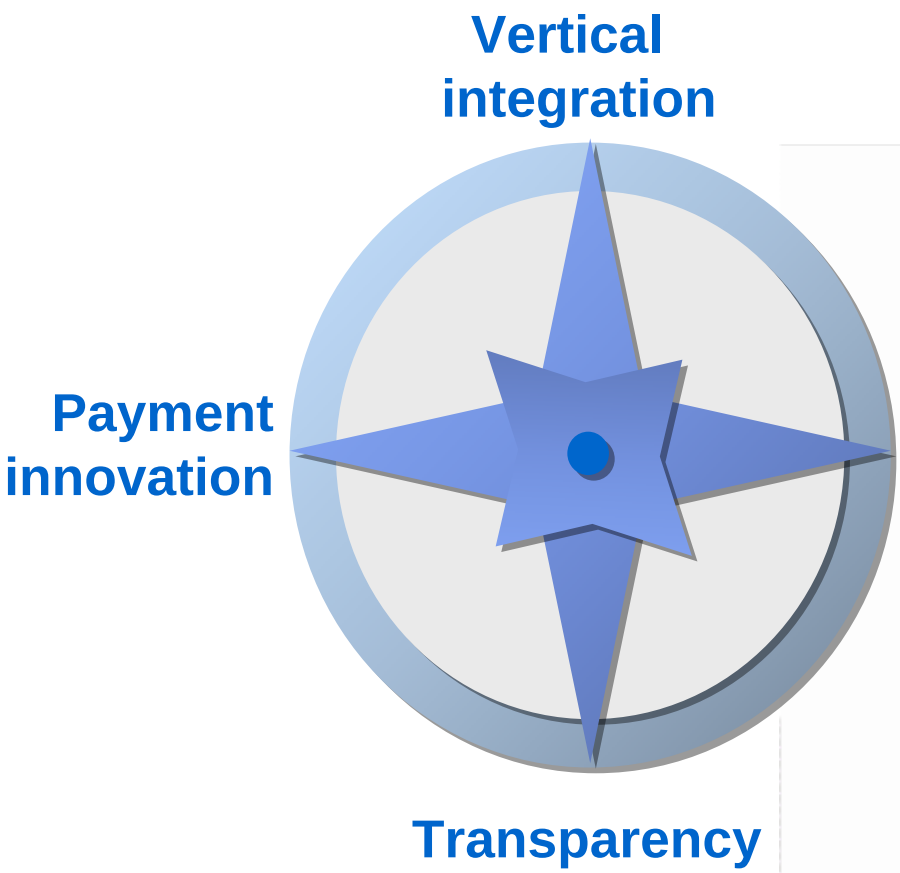
Episode-Based Payment: What's Happening and the Path to Scale

June 17, 2014

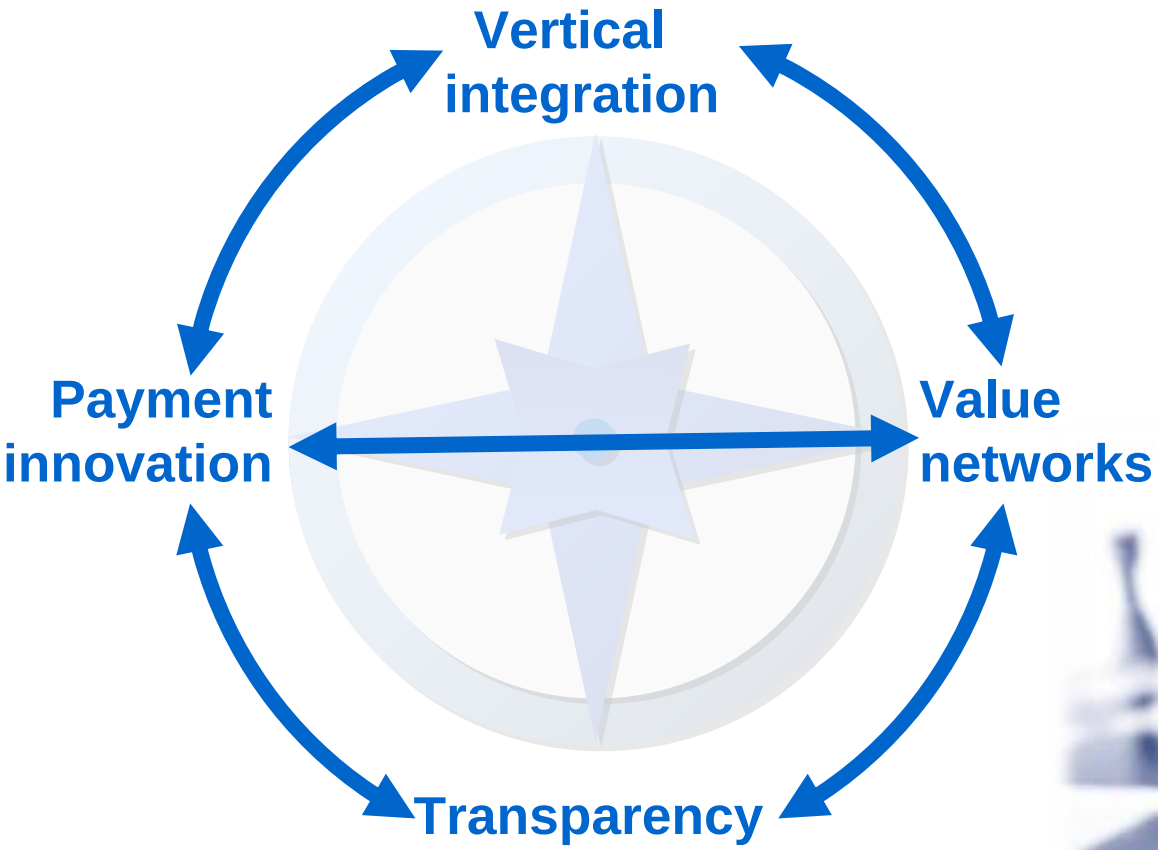
Topics

- **Broader context: the new normal in payment models**
- Where we stand on episode payment approaches and lessons learned
- Q&A: group discussion

Context: health care value creation strategies



Context: health care value creation strategies



AS OBSERVED OVER THE PAST 3 YEARS

Beliefs about payment innovation

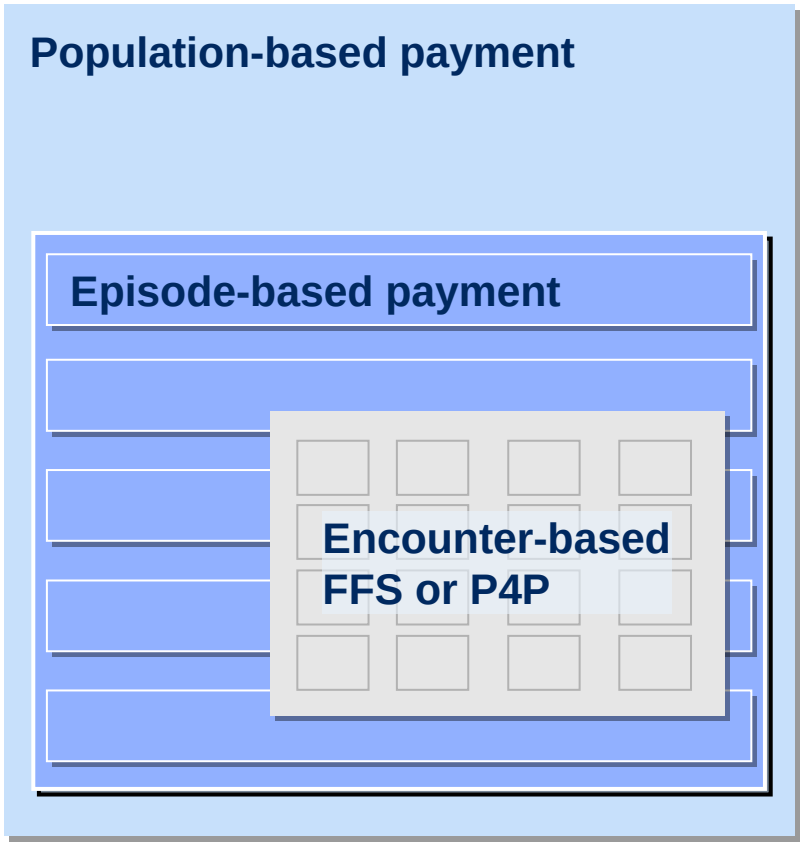
Old School

- Payment innovation has the potential to disrupt sources of competitive advantage
- Payment innovation must be multi-payer to change behavior
- Doctors treat all patients alike; payment/clinical innovation lifts all boats
- Payment innovation can (not) be a differentiator

New School

- Payment innovation can either disrupt or stabilize competitive advantage
- Multi-payer alignment is not necessary to capture low-hanging fruit, though may be necessary for business model transformation
- Doctors don't discriminate in medical decisions; however, providers can and do differentiate clinical operations by payer
- Early adopters have opportunity to shape key design decisions to their advantage; long-term, key differentiators will be superior insights and engagement

End-state for value-based payment (at least in our lifetime)



Most applicable to improvements in

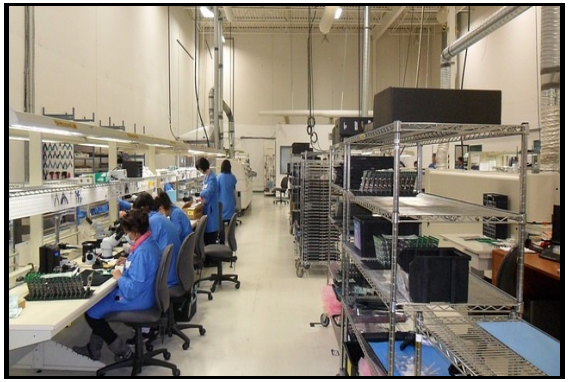
- Chronic medical care (e.g, diabetes)
- Shared decision making
- Referrals for elective acute care

- Acute procedural episodes (e.g., joints)
- Acute medical episodes (e.g. CHF, AMI)
- Behavioral health episodes (e.g., ADHD)

- Discrete services correlated with favorable outcomes or lower cost

Are we approaching a tipping point in adoption?

Pay-for-performance



Many payers placing **3-5%** of hospital payments at risk for quality

5% bump to specialists and **10%** bump to PCPs

Episode-based payment

500 hospitals in Medicare Bundled Payment Initiative

AR, OH, TN on path to **statewide, multi-payer** adoption of **50-75** episodes

Population-based payment

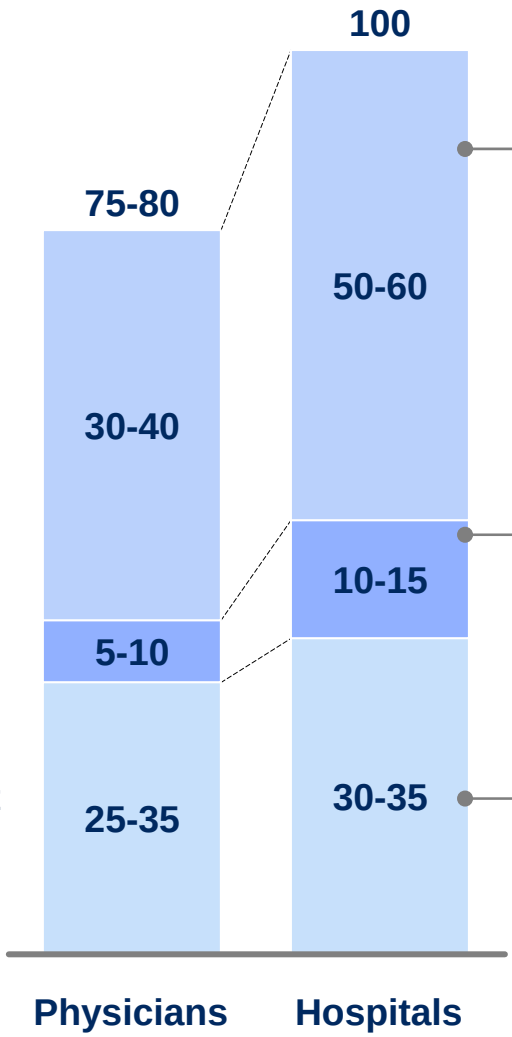
Both regional and national payers with goals to achieve 50-80% adoption over the coming 1-3 years

More than a dozen Governors have made public commitments to drive multi-payer transition to population-based payment

Are we approaching a tipping point in adoption?

ESTIMATES

Percent of providers participating in value-based payment



Encounter-based P4P (only)

Episode-based payment (with or w/o P4P)

Population-based payment (with or w/o other models)

Select examples

- Bridges to Excellence (Aetna, others)
- BCBS of Michigan PGIP
- Medicare QIP
- Medicare Readmission Penalties

- Medicare BPCI
- Arkansas multi-payer initiative
- Horizon BCBS of New Jersey
- United HealthCare chemotherapy bundle

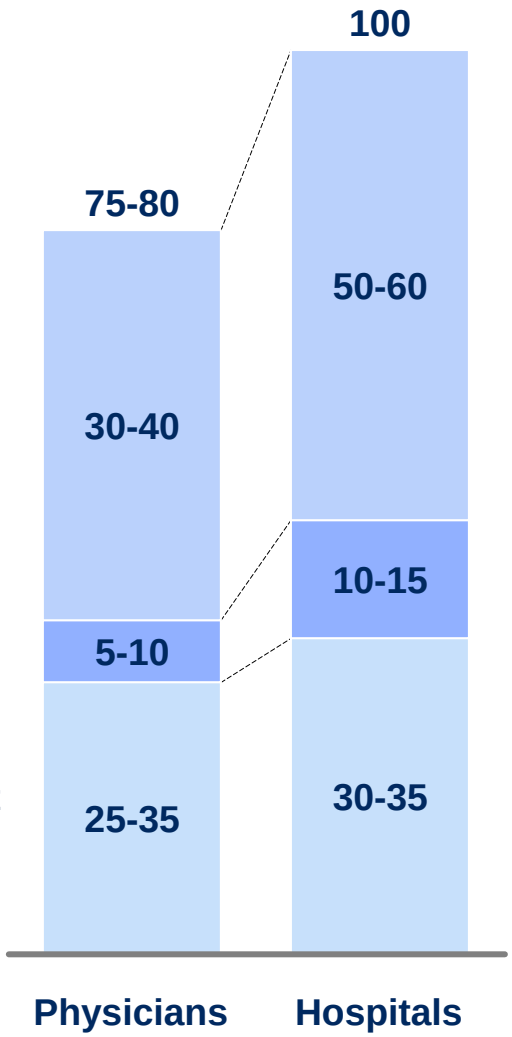
- Pioneer ACO and MSSP
- Commercial ACOs (e.g. WellPoint EPHC)
- Medicaid ACOs (e.g., CO, IA, OR, VT)
- Comprehensive Primary Care initiative

SOURCE: CMS, MedScape, Availity, Health Affairs, Catalyst for Payment Reform, McKinsey client experience

Are we approaching a tipping point in adoption?

ESTIMATES

Percent of providers participating in value-based payment



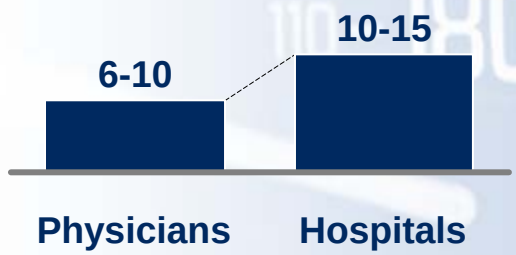
Encounter-based P4P (only)

Episode-based payment (with or w/o P4P)

Population-based payment (with or w/o other models)

Percent of payments that are value-based

60% of providers expect value-based payment to become the dominant payment model



SOURCE: CMS, MedScape, Availity, Health Affairs, Catalyst for Payment Reform, McKinsey client experience

Topics

- Broader context: the new normal in payment models
- **Where we stand on episode payment approaches and lessons learned**
- Q&A: group discussion

Three themes/ reflections from our work in multiple markets

- **We are seeing four general approaches to episode-based payment across markets**
- **Episode based-payment is working where the right conditions are in place**
- **Four dimensions of uncertainty will shape which models prevail and the path to scale**

Three themes/ reflections from our work in multiple markets

We are seeing four general approaches to episode-based payment across markets

Episode based-payment is working where the right conditions are in place

Four dimensions of uncertainty will shape which models prevail and the path to scale

We are seeing four approaches to episode adoption across markets

State-led/ statewide

- Strong policy impetus; Medicaid as lead
- Significant multi-payor involvement (multiple MCOs, Commercial)
- Typical: mandatory model, fixed thresholds for performance rewards

Payor-led, voluntary for providers

- Payor developed program/ framework
- Providers choose to voluntarily participate
- Incentives typically based on shared savings and/ or network benefits

BPCI

Provider-led

- Providers initiate (e.g., competitive adv.)
- May establish rewards with payors or relationships with providers/ ACOs
- Service lines with attractive economics (e.g., orthopedics, cardiac)

Range of health systems

Employer-led

- Employers initiate episode performance framework
- Sometimes involve strong network incentives (”centers of excellence”)
- May be prospective payment model

Example: state-led, statewide episodes

Arkansas

- Statewide (Medicaid + commercial payors)
- Mandatory provider participation
- 13 episodes launched, others about to launch (range of procedural, acute medical, and BH)
- > 1,000 providers with gain/ risk sharing

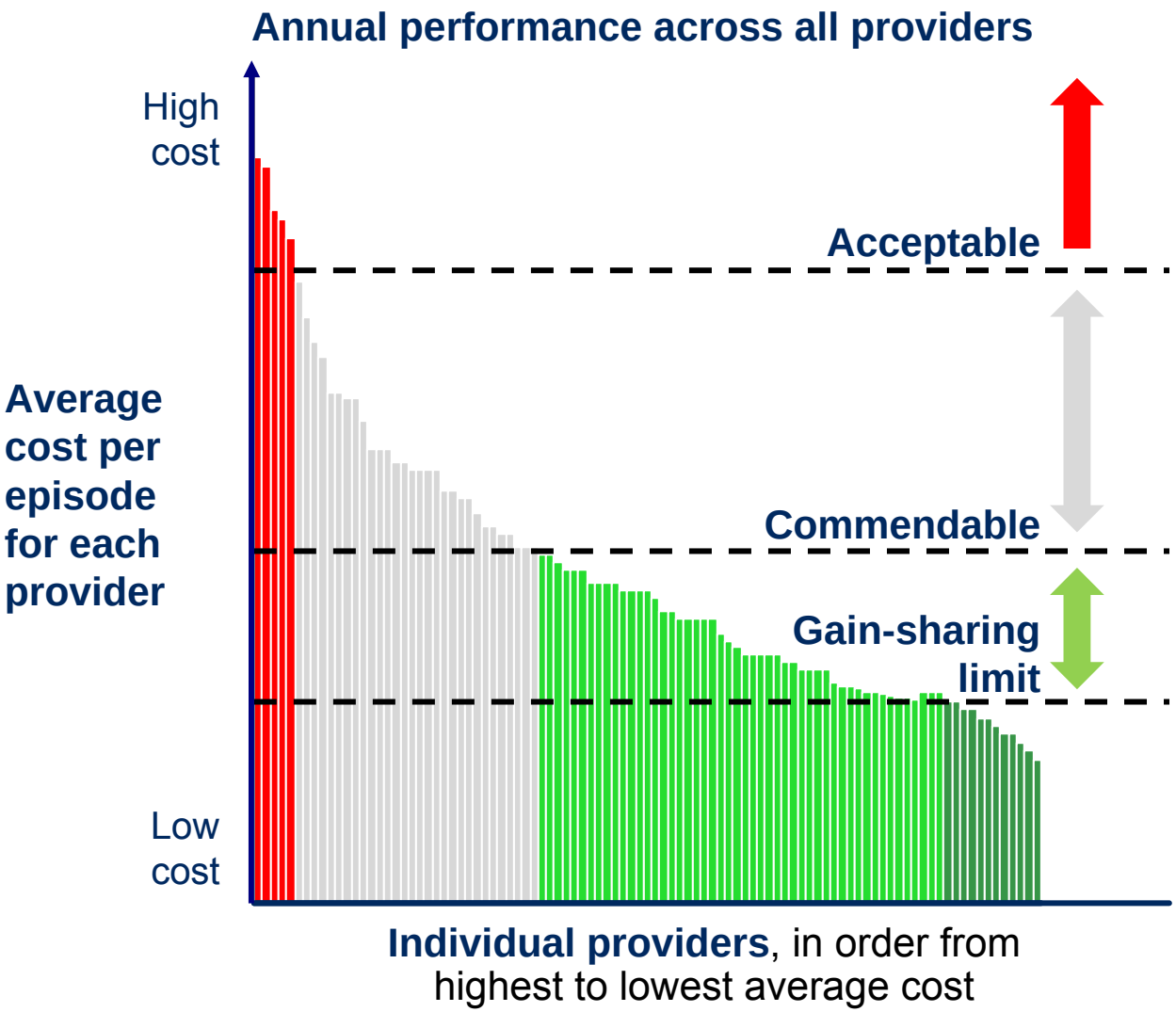
Tennessee

- Statewide (Medicaid MCOs + state employees)
- Mandatory provider participation
- 3 episodes launched: joints, obstetrics, Asthma; COPD to launch shortly
- Initial reports produced and launched

Ohio

- Statewide (Medicaid FFS + MCOs)
- Mandatory provider participation
- 6 episodes launched: joints, obstetrics, COPD, Asthma, acute PCI, non-acute PCI

State-led models: common elements of the payment model



- Mandatory provider participation
- Retrospective model
- Absolute rewards (thresholds), upside/ downside model
- An accountable "quarterback" (hospital or specialist) designated for each episode
- Quality standards for receiving payouts
- Risk adjustments, exclusions, outliers, other adjustments

Reasons (today) for multiple models

	Why you would choose	Challenges to consider
State-led/ statewide	▪ Best enables multi-payor/ full system transformation	▪ Need preconditions in place (sufficient alignment of stakeholders)
Payor-led, voluntary	▪ Leading payor adopting value-based payment as strategic lever	▪ Need sufficient share to be meaningful to providers ▪ Likely engages subset of providers
Provider-led	▪ Provider ready to invest (or already high performing) and views as source of competitive advantage	▪ Need attractive economics – likely to apply to certain service lines or require network benefits
Employer-led	▪ Influential/ high volume providers ready to move, but payors not sufficiently aligned	▪ Difficult to get critical mass and needed claims data ▪ May require significant network incentives (e.g., “centers of excellence” approach)

Three themes/ reflections from our work in multiple markets

We are seeing four general approaches to episode-based payment across markets

Episode based-payment is working where the right conditions are in place

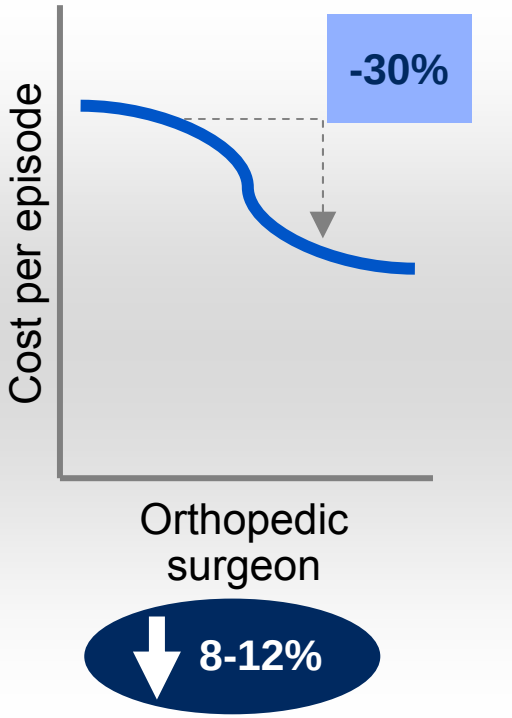
Four dimensions of uncertainty will shape which models prevail and the path to scale

Episode-based payment is working

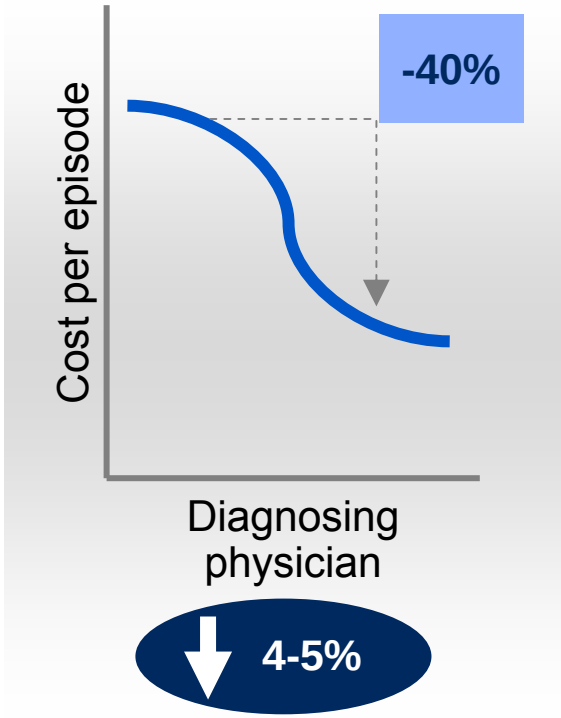
75%ile to 25%ile Year 1 impact

Provider variation in cost per episode

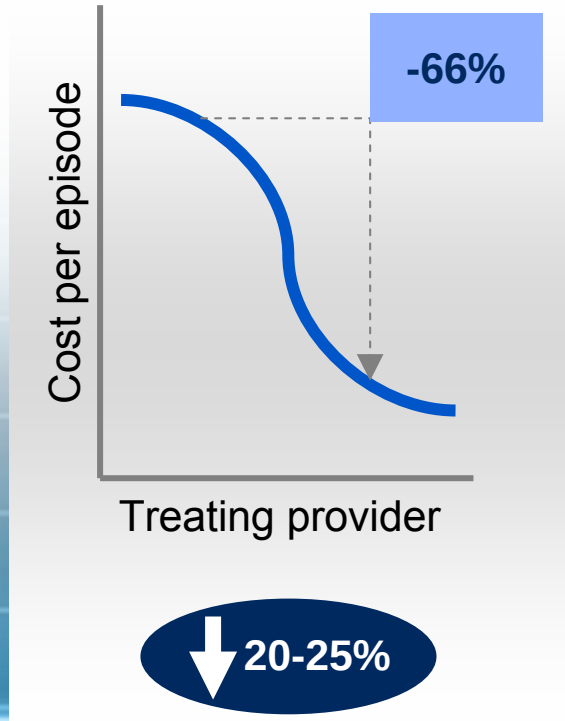
Joint replacement



Upper respiratory infection



ADHD

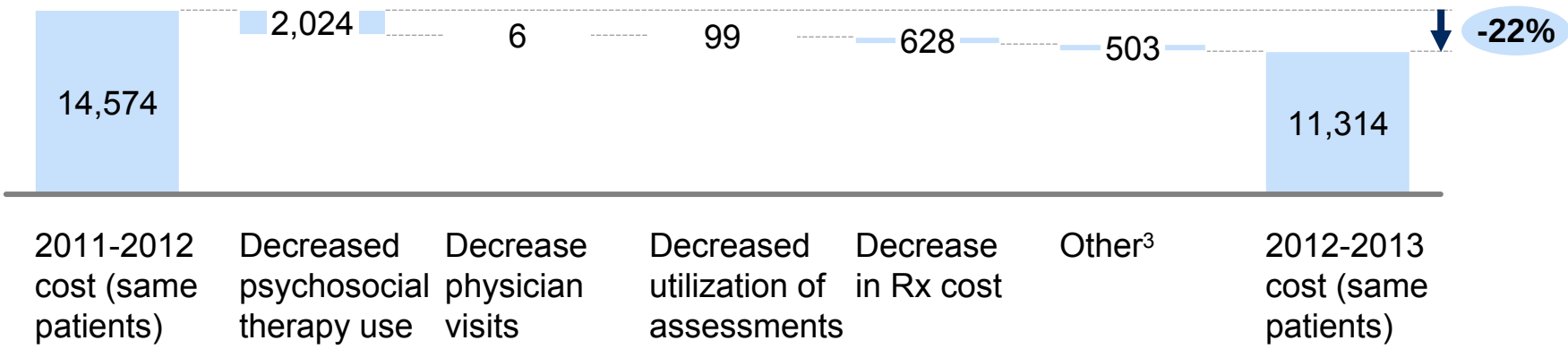


SOURCE: McKinsey client experience

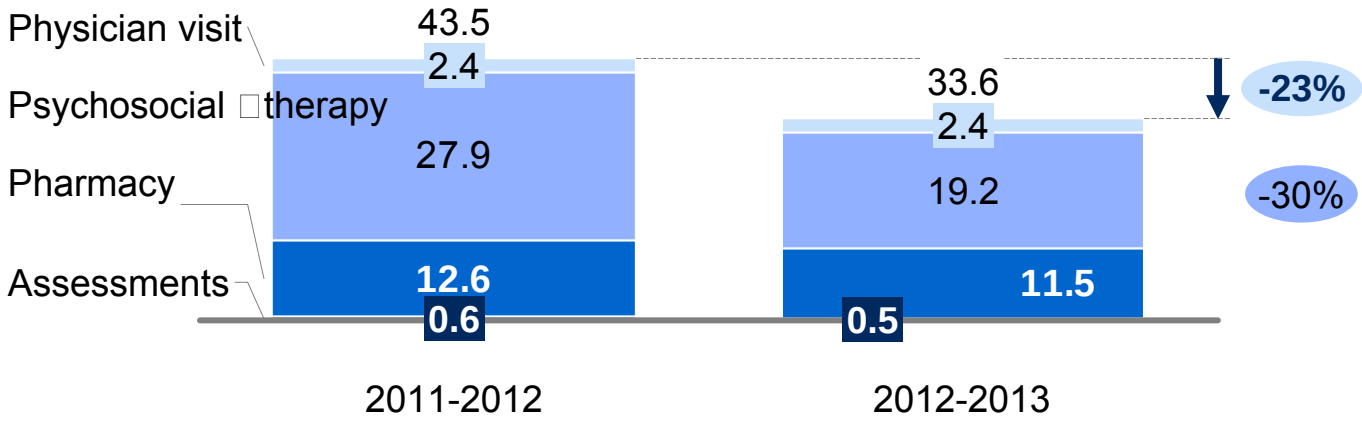
ADHD example: 22% decrease in same-patient average cost, driven by greater guideline-concordant care

Comparison of average episode costs (same patients)

Thousand dollars

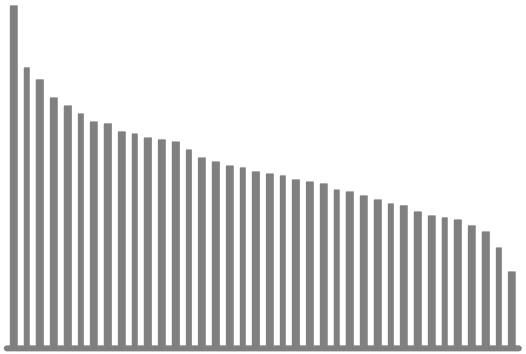
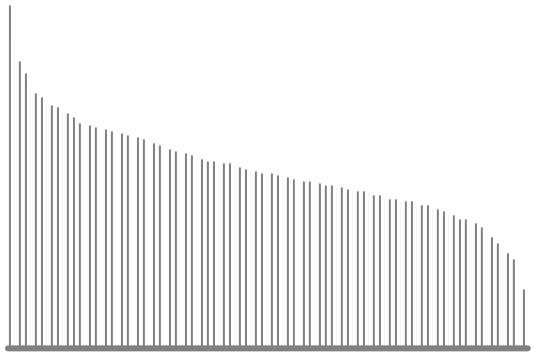
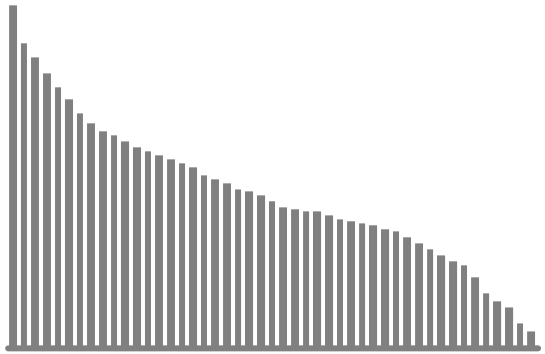


Average number of claims per client by claim type



Source: Arkansas Payment Improvement Initiative

Sources of value captured

	Cholecystectomy Gallbladder removal plus 90 days **U.S. State A**	**Pregnancy/delivery** Prenatal care thru 2 mo. post birth **U.S. State B**	**Acute asthma exacerbation** Hospital visit + 1 mo. post discharge **U.S. State C**
Sources of value	▪ % of cases done in inpatient setting varies from 0% to 20% ▪ >400% variation in hospital length of stay	▪ >500% variation in imaging and diagnostic costs ▪ C-section rate varies from 20% to 70%	▪ Rate of admission from the ER varies from 0% to 100%, even after risk adjustment ▪ >400% variation in rate of repeat visit to ER or hospital (within 30 days of discharge)
Dist. in average cost per episode, by provider			

Each bar represents the average total cost per episode for 3-5 providers with similar costs (performing surgeons for a cholecystectomy, delivering providers for a birth, and facilities for an acute asthma exacerbation). Total costs include all relevant professional, facility, and other inpatient and outpatient claims. Patients with meaningful co-morbidities or risk factors are excluded or risk-adjusted. Outlier (high cost) episodes were also removed.

Some highlights and lessons learned

- Power of data and reporting to enable provider behavior change
- Power of multi-payer alignment (consistency) and “inevitability”
- It’s possible to design and launch episodes rapidly (nine months)
- Multiple and significant sources of value to capture
- Importance and influence of specialists
- Necessity of “localization”

Three themes/ reflections from our work in multiple markets

We are seeing four general approaches to episode-based payment across markets

Episode based-payment is working where the right conditions are in place

Four dimensions of uncertainty will shape which models prevail and the path to scale

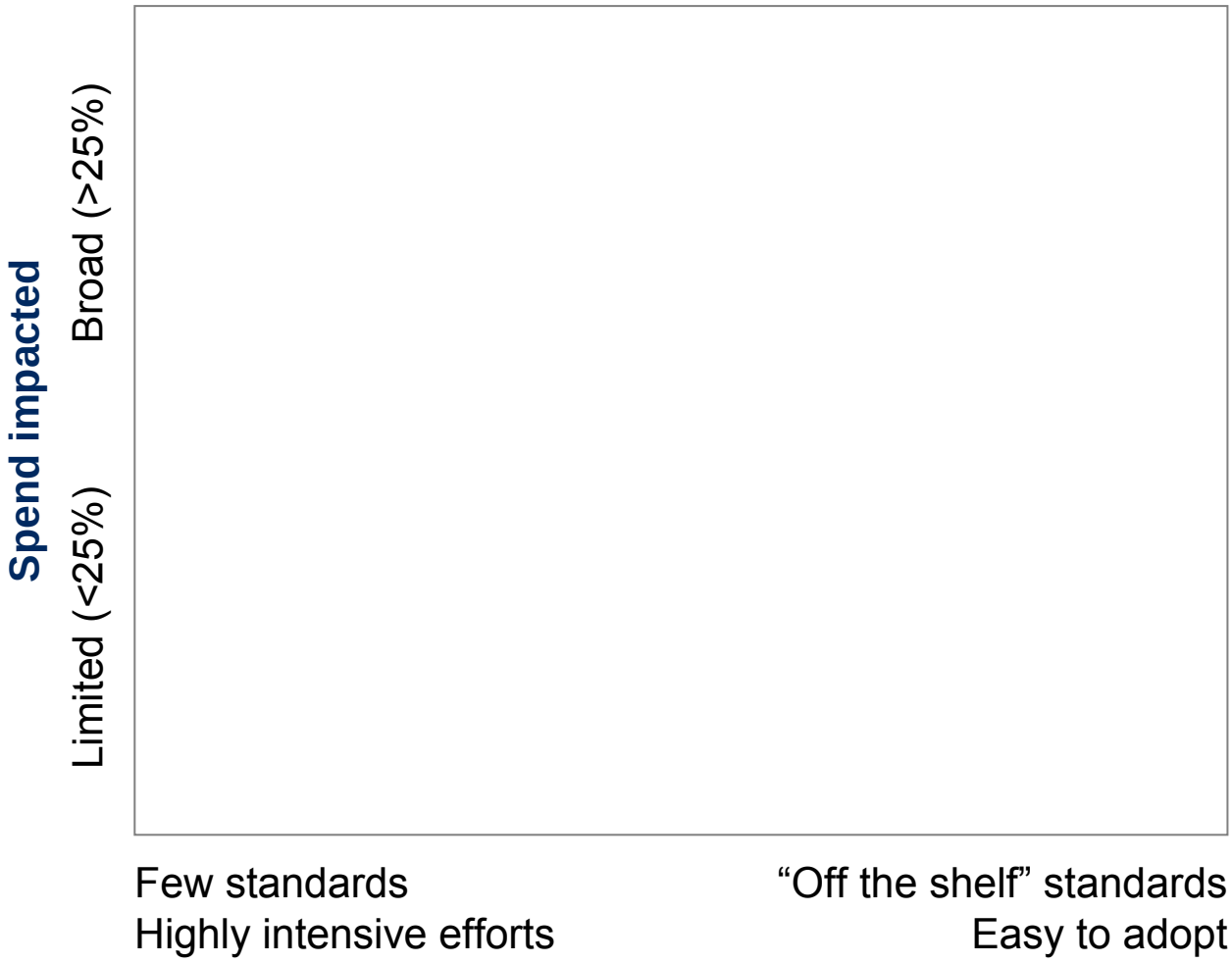
Looking forward: which approaches will prevail, and what will the path to scale look like over the next 3-5 years?

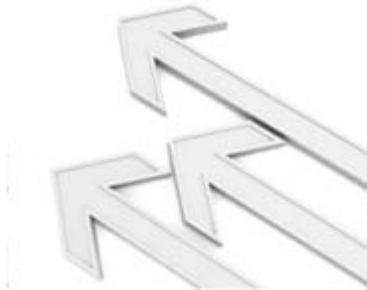
Today

- 1-10% of spend impacted
- Often 24-36 months for implementation/ launch
- Dozens of customized/ disparate efforts
- Private payors developing distinct approaches and competitive strategies
- Providers opportunistically looking for sources of advantage

Looking forward: which approaches will prevail, and what will the path to scale look like over the next 3-5 years?

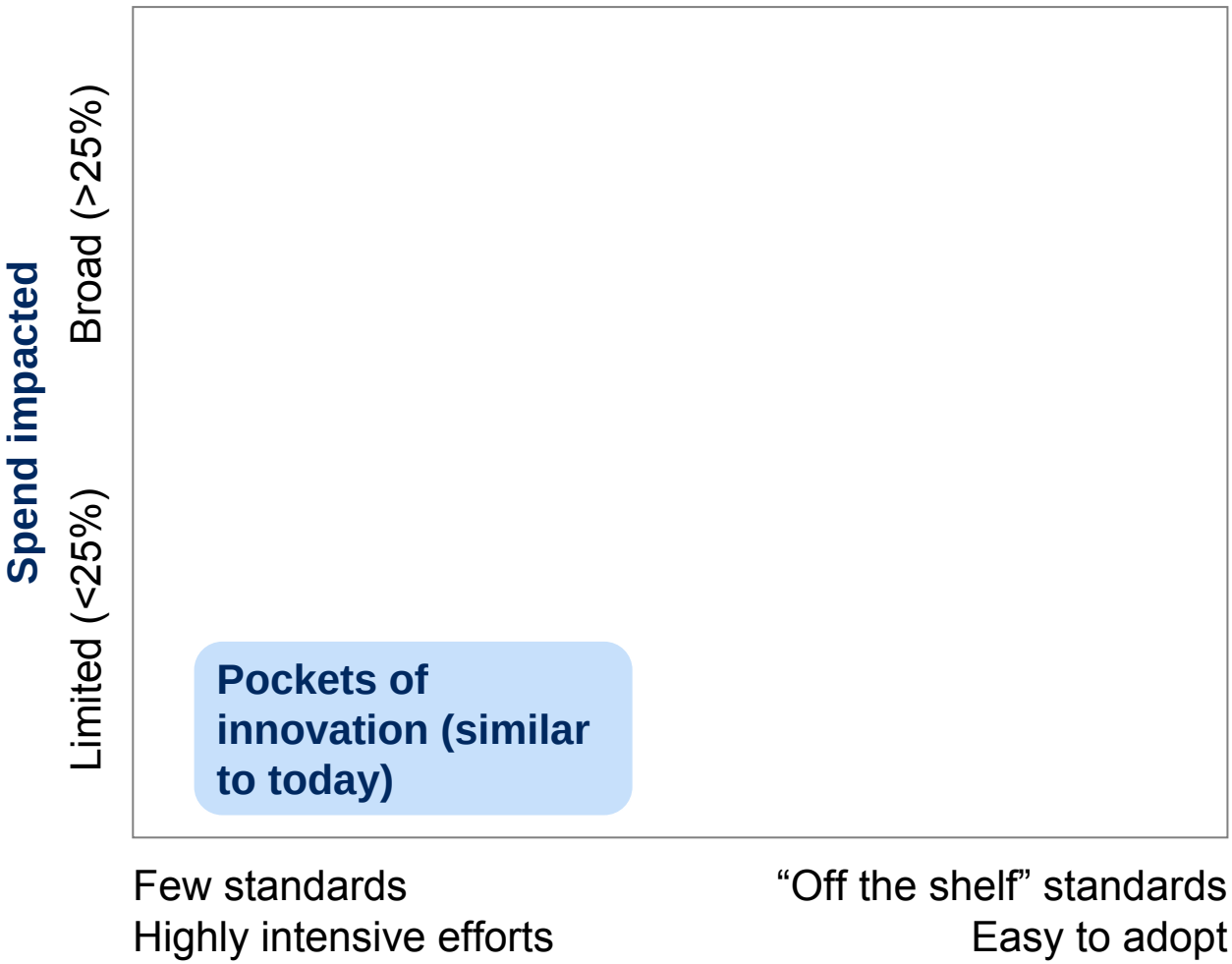
Potential scenarios over next 3-5 years





Looking forward: which approaches will prevail, and what will the path to scale look like over the next 3-5 years?

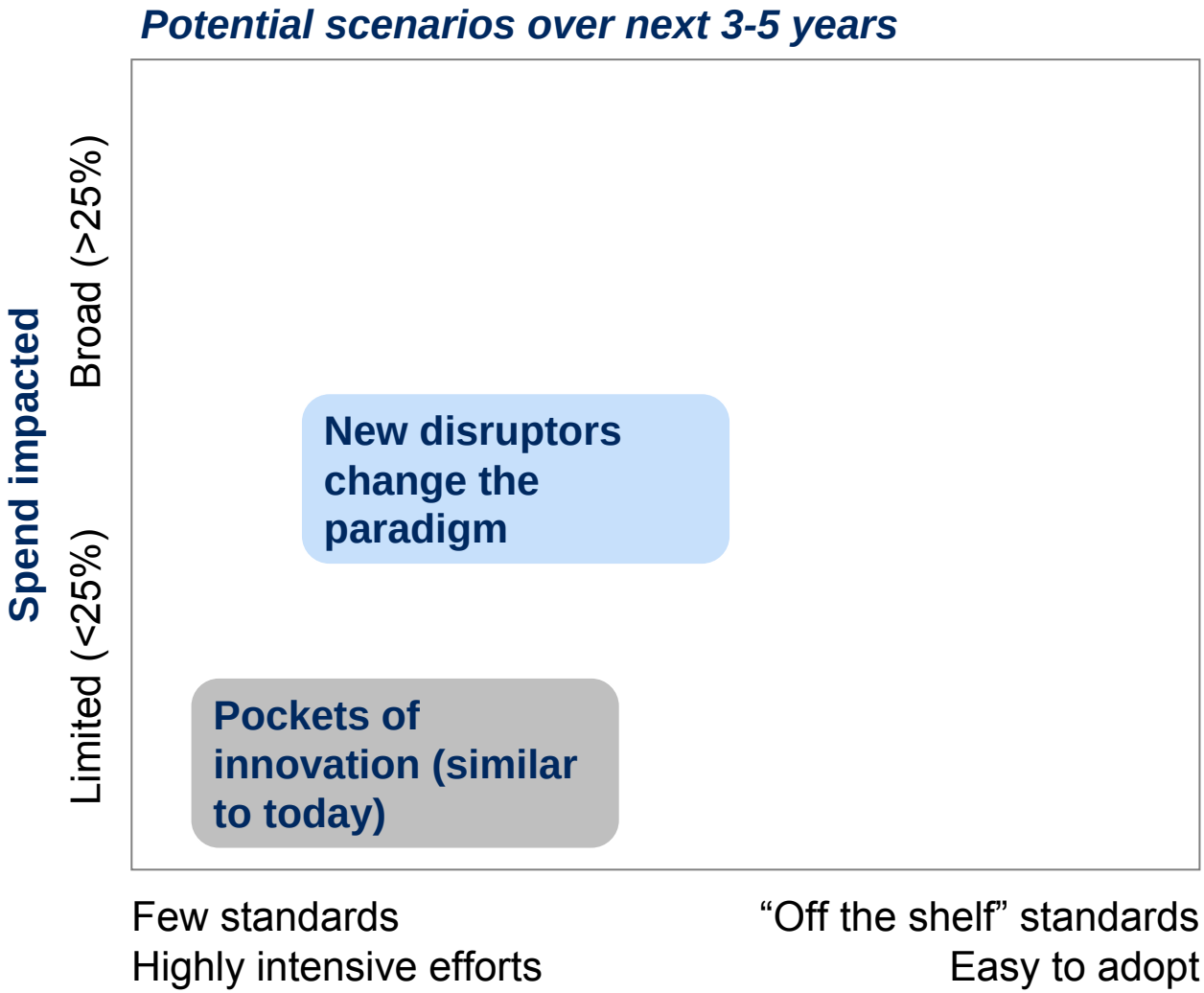
Potential scenarios over next 3-5 years



Pockets of innovation (similar to today)

- Multiple models prevail, pockets of innovation
- However, few truly at scale efforts
- Disparate and highly intensive, customized efforts prevail

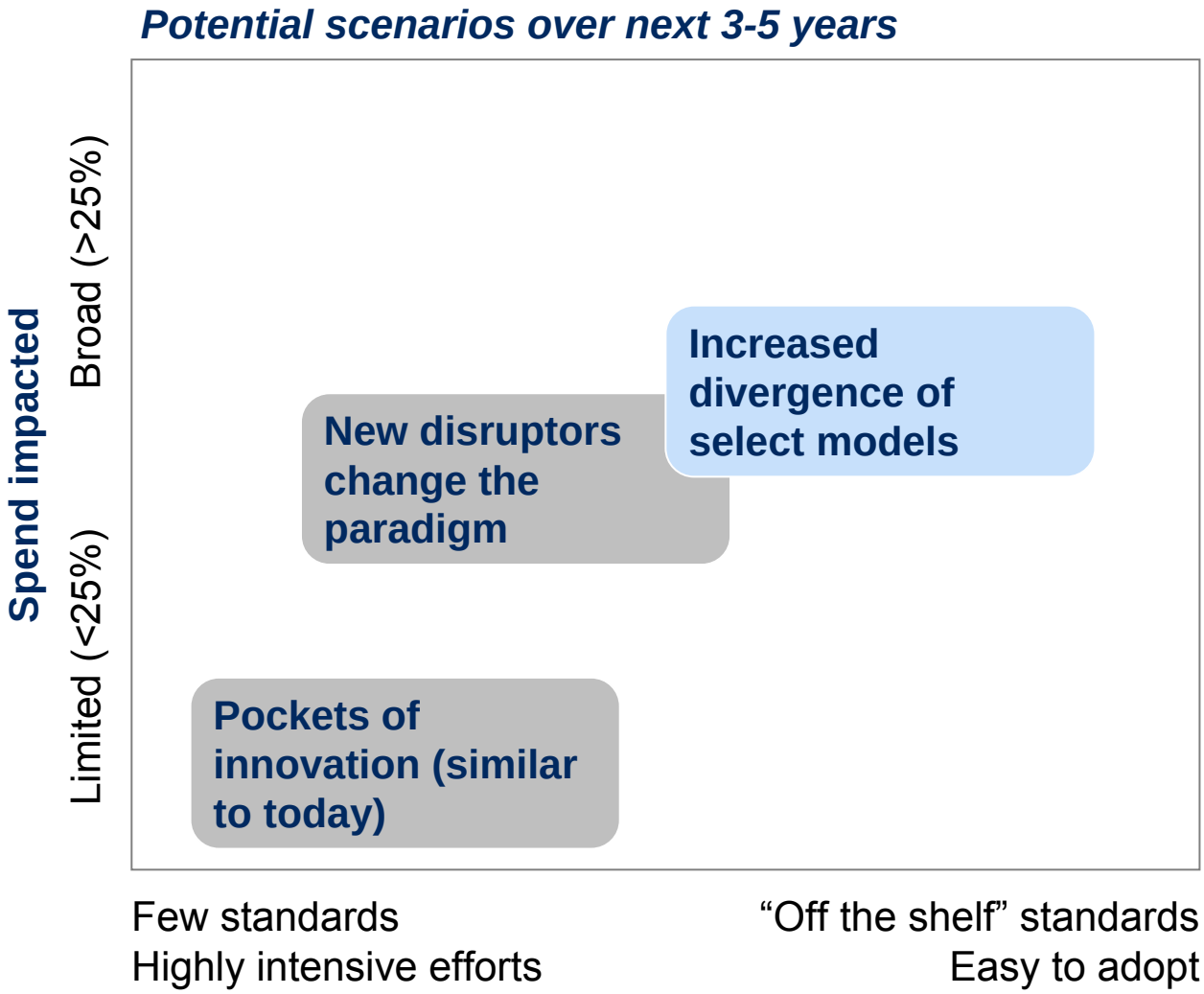
Looking forward: which approaches will prevail, and what will the path to scale look like over the next 3-5 years?



New disruptors change the paradigm

- New, broad alignment with payors (e.g., vertical integration, fully capitated risk models a la Chen Med)
- Episodes serve as reporting tool, not individual payment mechanism

Looking forward: which approaches will prevail, and what will the path to scale look like over the next 3-5 years?

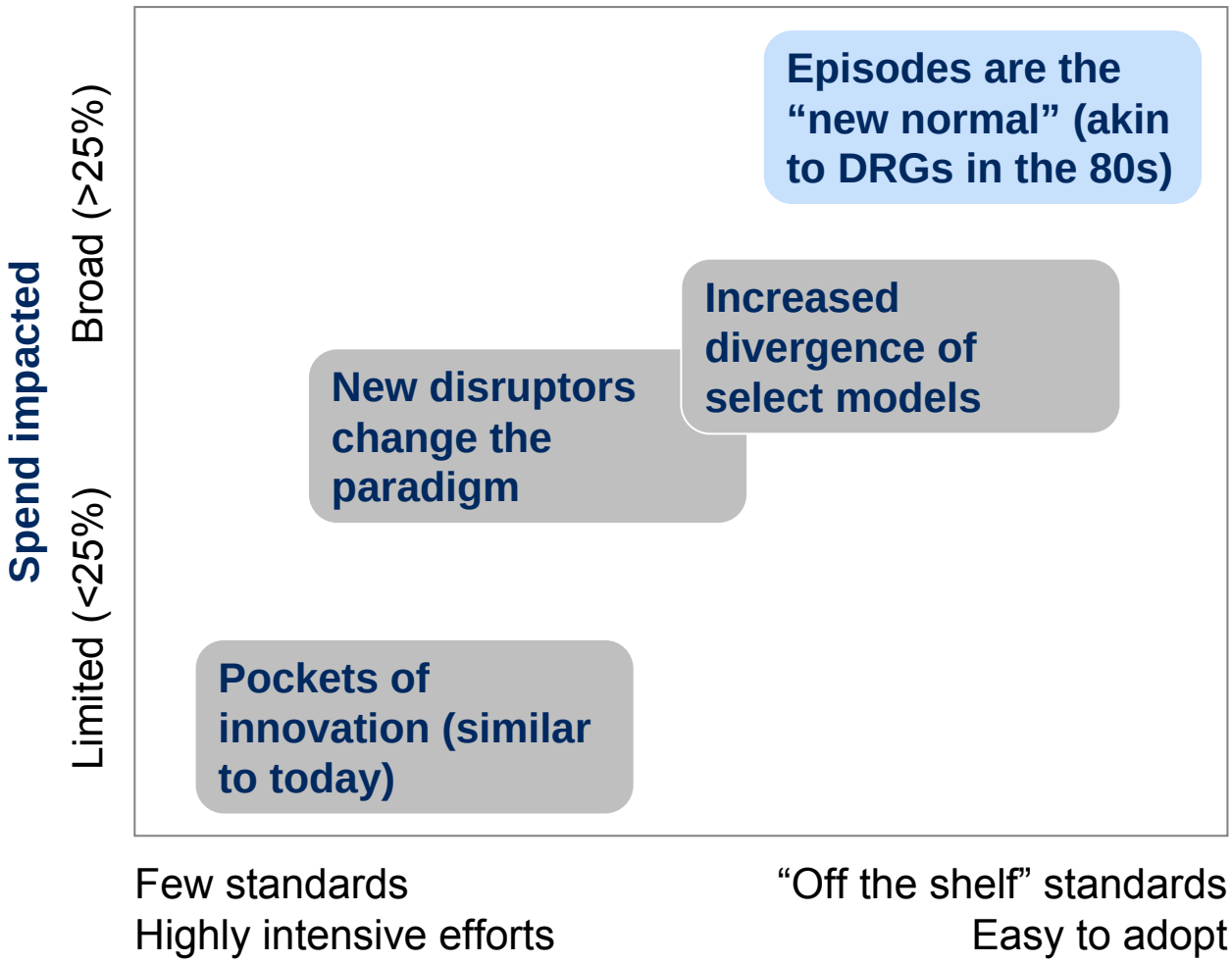


Increased divergence of select models

- Episode champions (payors or providers) forge ahead to adopt episodes at scale
- Certain books of business (e.g., Medicaid, Medicare) converge around standards for episodes
- However, efforts largely disparate, with increasing divergence between payors based on competitive positioning

Looking forward: which approaches will prevail, and what will the path to scale look like over the next 3-5 years?

Potential scenarios over next 3-5 years



Episodes are the "new normal" (akin to DRGs in the 80s)

- Broad adoption as payment model between payors/ providers
- Convergence of models: "off the shelf" standards
- New paradigm (value-based care) across the entire system

Four dimensions of uncertainty that will shape the path to scale

Emergence of standards to reduce "barriers to entry"

- Success (and provider acceptance) of current episode grouping approaches
- Convergence (or not) of current efforts across states and markets

Level of appetite across payors to exercise "levers" of influence

- Degree of State-wide transformation, a la AR, OH, TN
- What Medicare does with BPCI (scale up, alignment with state efforts)
- Whether private payors choose to make this a strategic cornerstone for cost containment and/ or competitive advantage

How aggressively providers lead or respond

- Degree to which certain providers become champions for episode-based payment as a source of advantage
- How hospitals and specialists align (or not)

Level of pressure from purchasers of health care

- Degree to which plan sponsors or individuals press for new strategies aligning payments with value

Questions