How Risk-Adjusted Global Payment Systems Can Work and How Hospitals Can Participate

Hospital Payment Reform Summit

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Patient Choice Case Study: Example of a True Health Care Market

- Originally implemented in 1997 by MN employer coalition (BHCAG)
- Forced doctors and hospitals to compete by managing cost and improving quality
- Gave consumers incentives and tools to migrate to better performing providers
- Many similarities to proposed ACO model

How This is Different

- **Care systems establish their own price position:**
  - Providers submit bids based on their expected **total cost of care** for like patient populations with the same benefit set
- **Care systems compete for patient volume:**
  - Providers organize into systems of doctors and hospitals, measured on total cost and quality (like proposed ACOs)
- **Consumers seek care based on provider value:**
  - Consumer premium and benefit incentives established to spur choice of better performing providers
- **Fee levels vary based on total cost performance:**
  - Care systems accountable for global cost. Hospital and physician reimbursement rates driven by total cost performance.

Discrete Care Systems Emerge

- Physicians and hospitals organize into care systems
  - Primary care components unique to each organization
  - Included small and large hospital owned, IPA, PHO, multi-spec, single specialty
- Care systems self define their referral and hospital network
- Care systems create their own brand and market position
  - gatekeeper or open-access
  - can focus on specific population or region
  - set their own price, contracted externally for many services
  - providers control care management
- Data analyzed and distributed
  - Patient attributed to care systems
  - Data risk and catastrophic adjusted
  - Provider cost of care analyzed, detailed results shared with providers

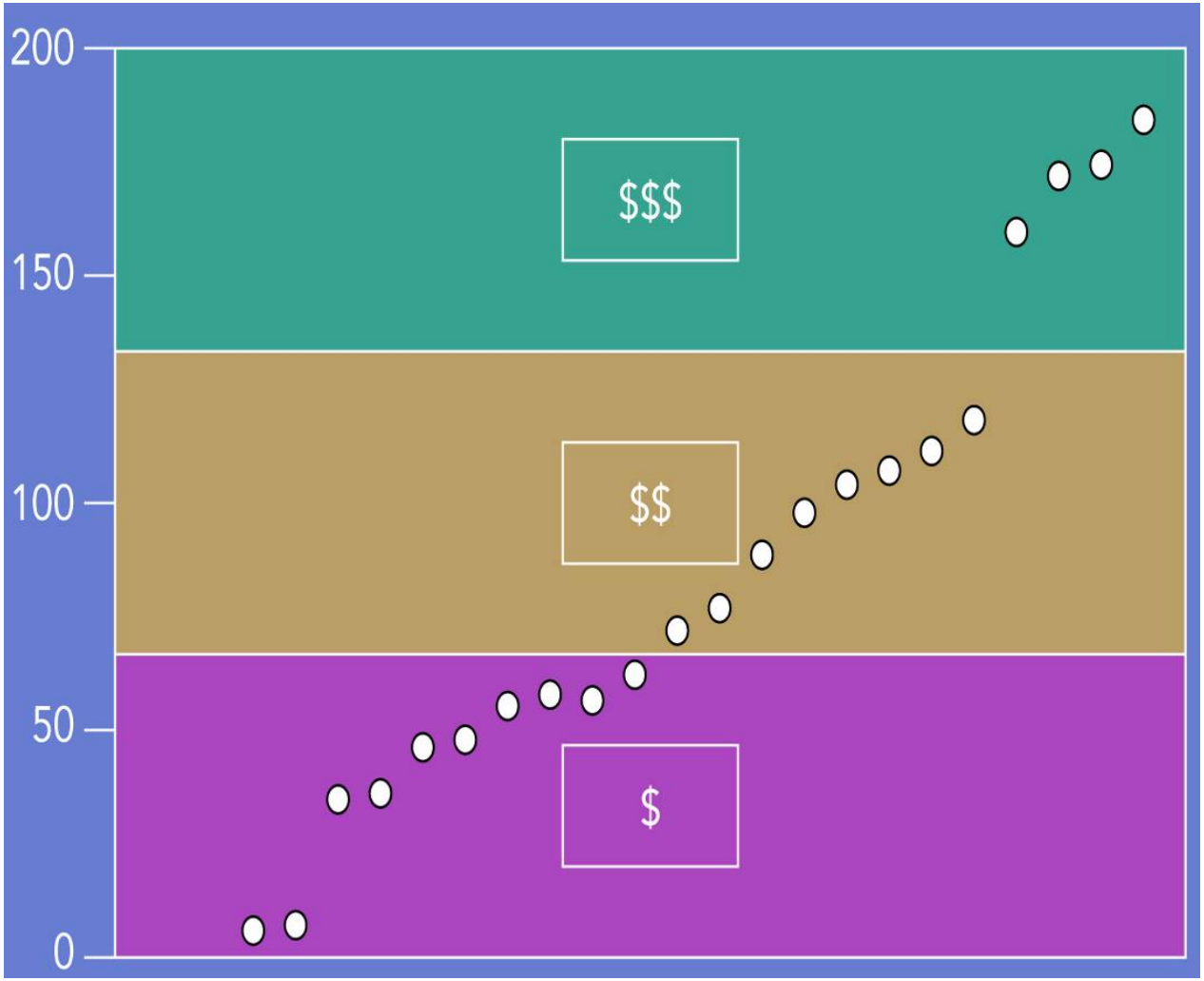
Providers Establish a Total Cost Target

- Patient Choice distributes easy to use bid model
- Bid model pre-set with care system past resource use
- Care systems input contracted or desired fee levels
- Providers can add other withhold amounts to cover non-paid services, such as care management fees
- Bid model combines provider submitted prices with historic resource use to calculate expected total cost of care
- Total cost of care risk adjusted for illness burden of care system population compared to overall population
- Result is pmpm Claim Target

Care Systems are Compared to Each Other on Cost and Quality

- Care system Claim Targets are adjusted for care system performance on quality measures
- Adjusted Claim Targets are arrayed against each other
- Similar Claim Targets are placed into bands
- Quality and capabilities information collected and displayed
- Information provided to consumers
- Consumers choose care systems based on their own values

Quality Adjusted Total Cost of Care Comparison Example



Each circle is a Care System-includes physician and hospital

Providers within band are presented at equal cost to consumer

Access to high cost providers requires more premium or more cost sharing for consumers

Three bands is arbitrary and done for administrative simplification purposes. More would be better.

Cost Differences Combined With Other Consumer Information

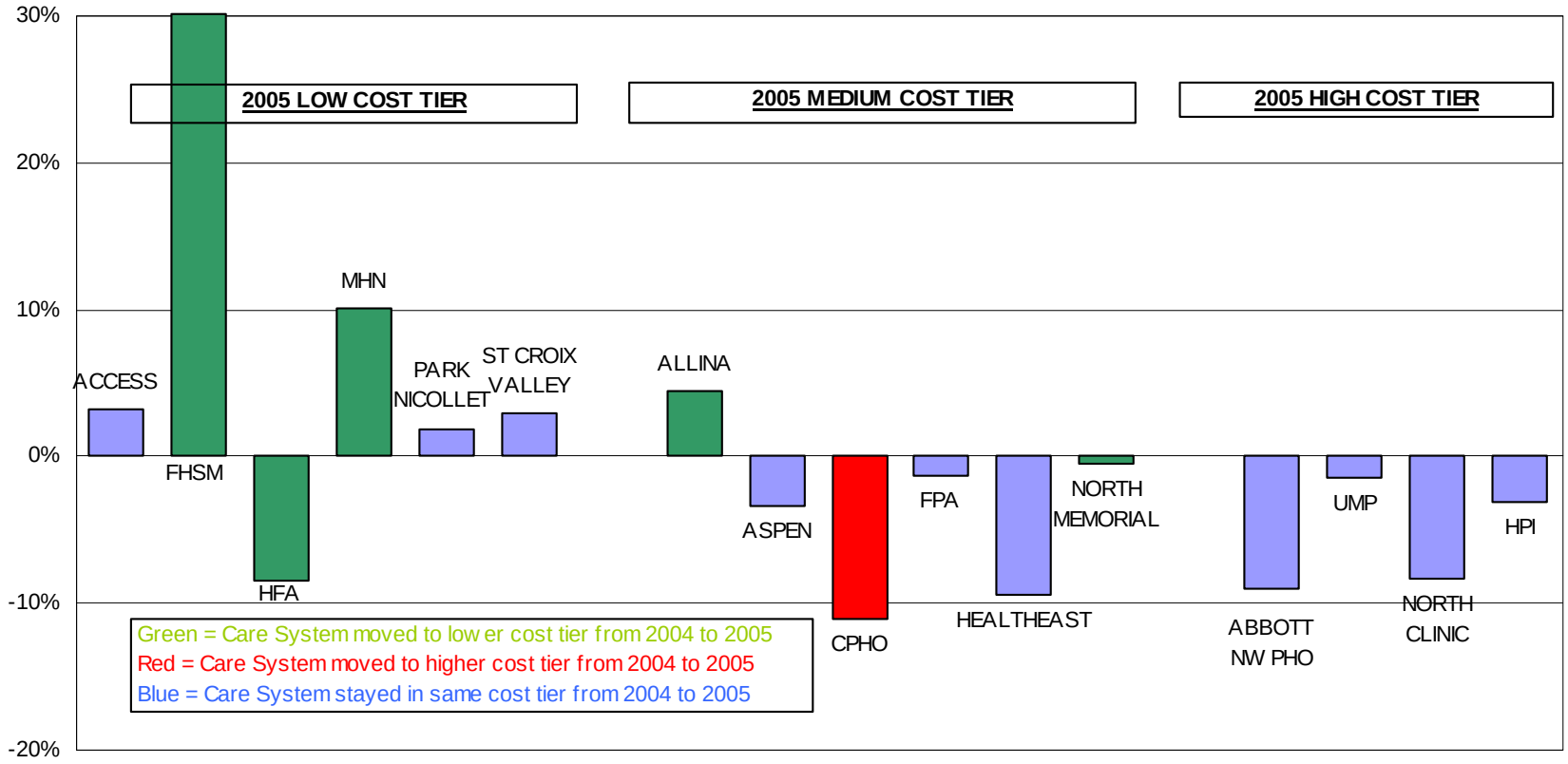
Consumers Choose Providers Based on Value

- Consumer premiums or benefits are based on which band their chosen care system is in
- Quality and customer service information shared with consumers
- Patients choose providers based on their values
- Patients seek care through their chosen providers
- Consumers can change care system at any time with notice. For admin reasons most employers limited change to equal or downward cost group and held premium constant

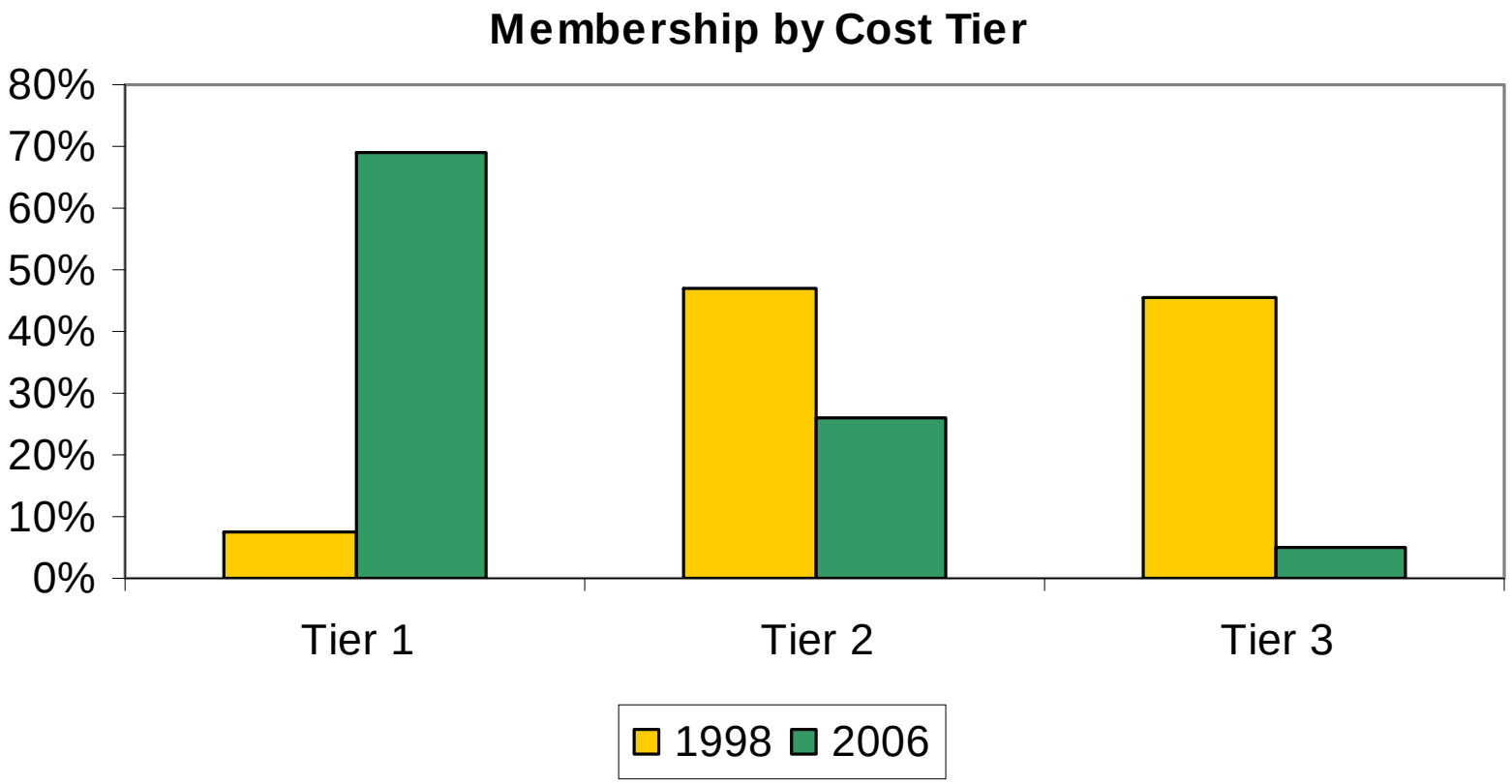
Better Performing Providers Attract More Patients

PATIENT CHOICE CARE SYSTEM : % CHANGE IN MEMBERS ENROLLED IN BOTH YEARS
2005 OVER 2004

Metro Care Systems, Fully Implemented Employers



Market Migrates to Better Performers



Provider Accountability for Total Cost of Care Using Variable FFS Payment

Providers bill as usual, reimbursed for all services rendered

- Physician payments based on common RBRVS structure
- Established standard hospitals CASE DAY methodology using APDRG specific front end loaded perdiems converted to RVU X Conversion factor
- APC derived structure for outpatient facility
- FFS payments based on fee levels submitted with bid
- Reimbursement for non-traditional services are allowed--Can be billed with FFS claims or through withhold fund

Fee levels adjusted quarterly (or less often)

- Actual risk adjusted provider total cost of care compared to Claim Target
- FUTURE fee levels then adjusted up or down based on performance
  - Performance better than predicted against claim target—fees are increased
  - Performance worse than predicted against claim target—fee decreased

Process is repeated each year

- Providers submit new bid, new Claim Target established
- Providers re-arrayed relative to one another
- Consumers reconsider provider choices

THIS IS NOT THE SAME AS CAPITATION

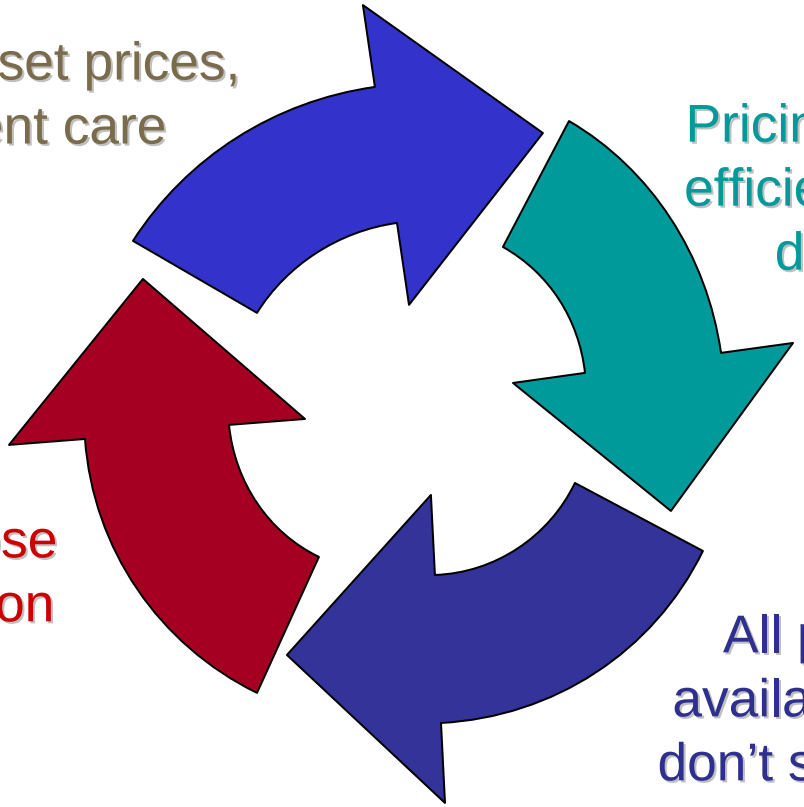
- Every service is reimbursed, risk to providers is market share and future fee level earned
- Providers do not receive a pool of dollars prospectively
- Providers do not distribute dollars, claim payer does
- Providers cannot run out of dollars or pocket excess dollars
- Avoiding sick patients is counterproductive
- Performance evaluations are risk adjusted
- Can be used for self-funded employers and can apply to any benefit style

Payment Model Incentive Comparison

	CAPITATION	PATIENT CHOICE	FEE FOR SERVICE
CONSUMER OUT OF POCKET COST	Same regardless of provider choice	Less cost for using better performing providers	Can't tell provider cost in advance
PROVIDER CONTROL OF TOTAL COST	Manage resource use and price for services in capitation	Manage resource use and prices across care spectrum	Maximize fee levels and services
DESIRABLE PATIENTS	Avoid sick patients	Attract sick patients	Attract sick patients
PROVIDER CARE MANAGEMENT	Organize to optimize resources, manage care	Organize to optimize resources, manage care	Organize for negotiating power
PHYSICIAN AND HOSPITAL ORGANIZATIONS	Consolidate to increase negotiating power	"Right size" to optimize efficiency	Consolidate to increase negotiating power

Patient Choice Program Summary

Provider groups set prices, manage patient care



Pricing, risk adjusted efficiency and quality drives cost to consumer

All providers are available, employers don't subsidize higher cost providers

Consumers choose providers based on their values

Response to consumer demand for value spurs providers to improve quality and manage total costs, leading to reduced cost trends

How This Impacts Hospitals

- All types (MD led and Hospital led) of care systems compete
- Higher hospital prices and utilization drive claim targets higher, reducing fee levels and/or ability to compete

  --bigger and more comprehensive not necessarily better

  --profit centers become cost centers
- Physician—hospital collaboration on patient management improves performance
- Hospital reimbursement levels raised and lowered based on overall care system performance—aligns incentives with physicians
- Hospital costs and quality transparent to care systems and consumers

Key Accomplishments

- Got providers to organize themselves into (mostly) discrete systems
- Got providers to be accountable to global budgets (without bloodshed)
- Got providers to feel accountable to their patients v. health plan executives
- Allowed employees to continue to access higher cost systems but at a price
- Enabled cost conscious employees to lower their costs

Some Important Barriers Were Overcome

- Capitation was a dirty word and not legal for self funded employers (but we liked the incentives)
- Inflexible billing and claim systems
- Hodgepodge of provider structures and sizes
- Could work with any style of benefits
- Unknown existence or influence of the mythic "health care consumer"

Barriers We Didn't Overcome

- Schizophrenic provider incentives—critical mass needed to drive substantive change
- Reluctance of employers to hold employees accountable for their choices
- Reluctance of employers to do anything different in a single market
- Resistance to change at every level

Lessons Learned

- Change is really hard, but possible!
- Providers can be accurately differentiated
- Lower prices don't necessarily mean lower cost
- Consumers will respond to financial and quality variation
- Can build on FFS using existing claim system to drive appropriate resource use
- Smaller provider entities can participate if not subject to insurance risk

Lessons Learned

- Data integrity crucial to process and buy-in
- Requires strong administrative capabilities
- Creates winners and losers, losers will undermine
- Need critical mass to drive provider investments, but can create savings just by leveraging variation
- Harder to explain and sell than standard products
- Employers reluctant to hold their employees accountable for their choices, still paternalistic

Implications for Hospitals

- Accountability for total cost of care creates need to manage population resource use
- Consolidation to demand higher prices makes hospitals *less* competitive
- Acquisition of physicians doesn't necessarily increase ability to compete unless costs come down and quality comes up
- Redundant, high margin capacity is counterproductive
- Increased utilization drives reimbursement level DOWN

CAN This Be Replicated?

- National employers looking for all-at-once national solutions
  - This requires local attention and provider interaction, can't be dropped wholesale on entire country
- Many similarities to ACO model proposed by Dartmouth and Brookings
- Can be modified for smaller, less organized markets, set up more like Patient Choice Insights
- Can bridge and combine with more granular approaches to reimbursement, eg episode payments such as Prometheus
- Plans can (and should) create similar products
- May work best in a future individual, rather than group, market
- Market conditions creating renewed interest in this type of solution, eg proposed legislation in Minnesota