PATIENT CHOICE HEALTH CARE PAYMENT MODEL CASE STUDY

Pay For Performance Summit

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OUR GOAL: CREATE A REAL HEALTH CARE MARKET

- Force providers to compete by managing cost and improving quality
- Give consumers incentives and tools to migrate to better performing providers
- Do this without requiring a miracle

HOW IS THIS DIFFERENT?

- **DISCRETE CARE SYSTEMS--**Providers organize into systems, measured on cost and quality
- **PROVIDERS BID--**Providers submit bids based on their expected total cost of care for like patient populations with the same benefit set
- **TRANSPARENT INFORMATION ON CARE SYSTEM COST AND QUALITY**
- **CONSUMERS CHOOSE ON VALUE--**Consumer premium and benefit incentives established to spur choice of better performing providers
- **VARIABLE FFS PAYMENT**—Care systems accountable for global cost. Reimbursement rates driven by total cost performance (aka virtual capitation/"capitation in drag")

DISCRETE CARE SYSTEMS

- Providers organize into care systems
  - Primary care components unique to each organization
  - Included small and large IPA, PHO, multi-spec, single specialty
- Providers self define their referral and hospital network
- Providers 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 decisions
- Data analyzed and distributed
  - Patient attributed to care systems
  - Data risk and catastrophic adjusted
  - Provider cost of care analyzed, detailed results shared with providers

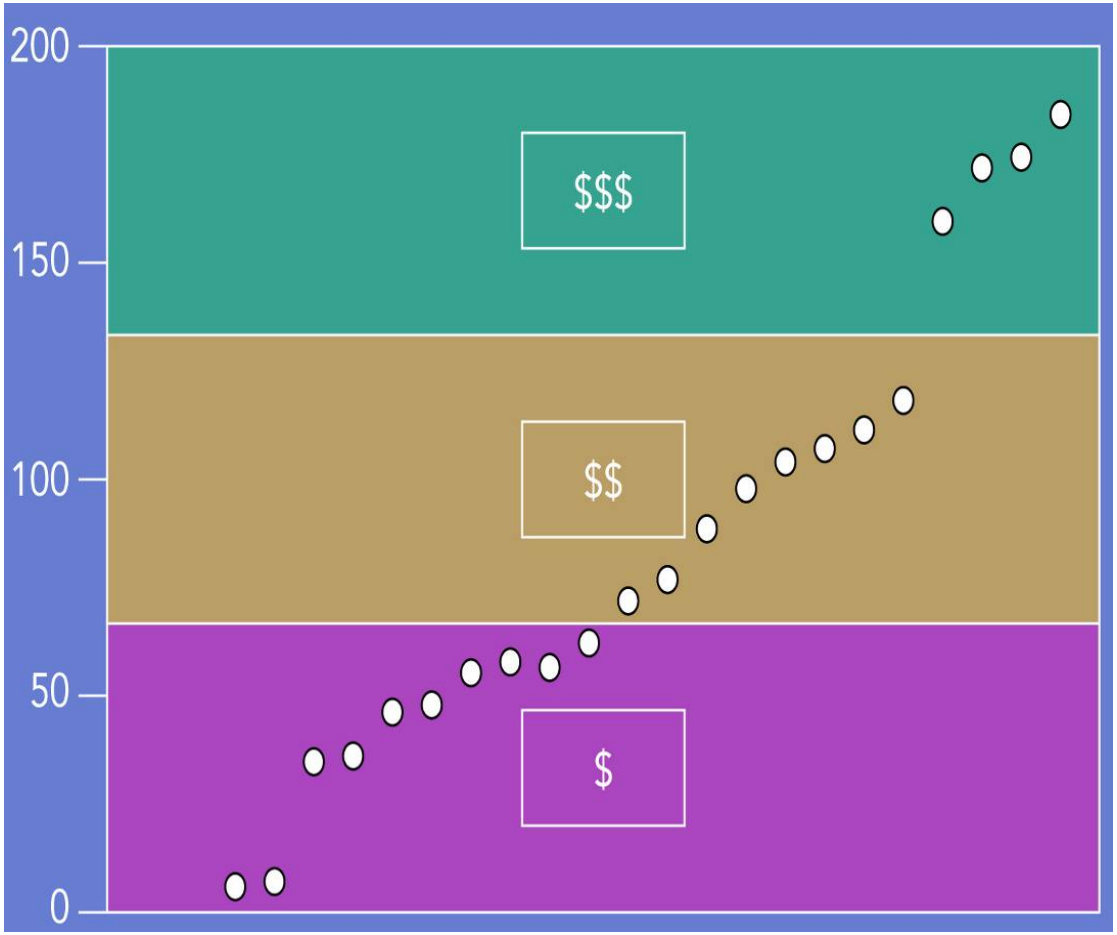
PROVIDERS BID

- Patient Choice distributes easy to use bid model
- Bid model pre-set with care system specific historic resource use for attributed patients
- Care systems input desired prices into bid model
- Providers can add other withhold amounts to cover non-paid services, such as care management
- Bid model combines provider submitted prices with historic resource use to calculate 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

TRANSPARENT INFORMATION 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 adjusted Claim Targets are placed into bands
- Quality and capabilities information collected and displayed
- Information provided to consumers

RISK ADJUSTED TOTAL COST AND QUALITY ARRAYED



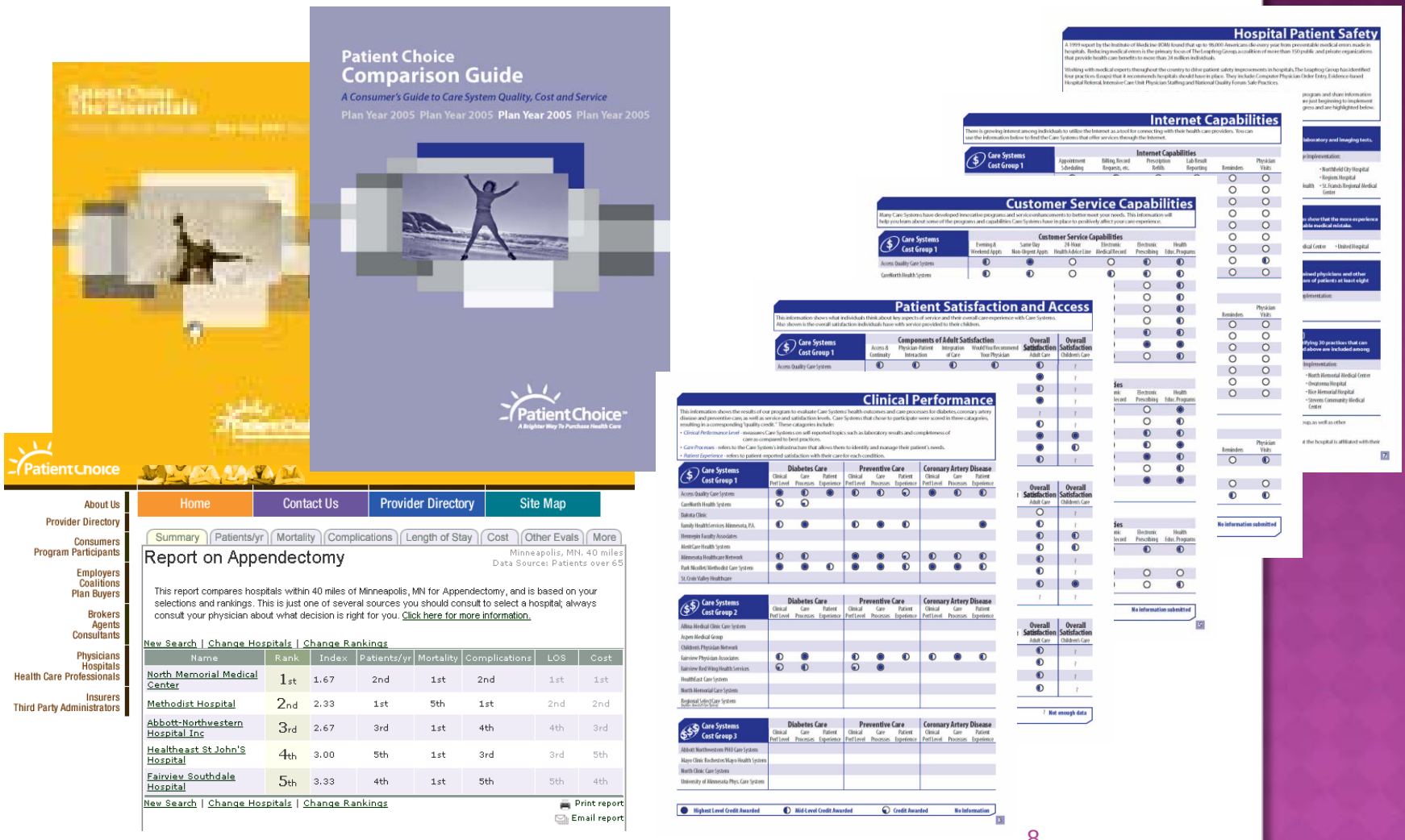
Each circle is a Care System

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.

CONSUMERS SEE COST DIFFERENCES COMBINED WITH CONSUMER INFORMATION



MULTIPLE CATEGORIES OF CONSUMER INFORMATION, NO ROLL UP METRIC

- Condition specific clinical performance
  - Diabetes, Asthma. CAD, Prev.
  - Care management capabilities
  - Outcomes (from MN Comm Measurement)
  - Condition specific patient feedback
- Customer service capabilities
  - Extended hours
  - Same day appointments
  - 24 hour health advice
  - EMR
  - ERx
  - Health Ed
- Patient satisfaction and access
- Internet capabilities
  - Appointments
  - Billing
  - Rx refills
  - Lab results
  - Patient reminders and outreach
  - Web physician visits

CONSUMERS CHOOSE ON VALUE

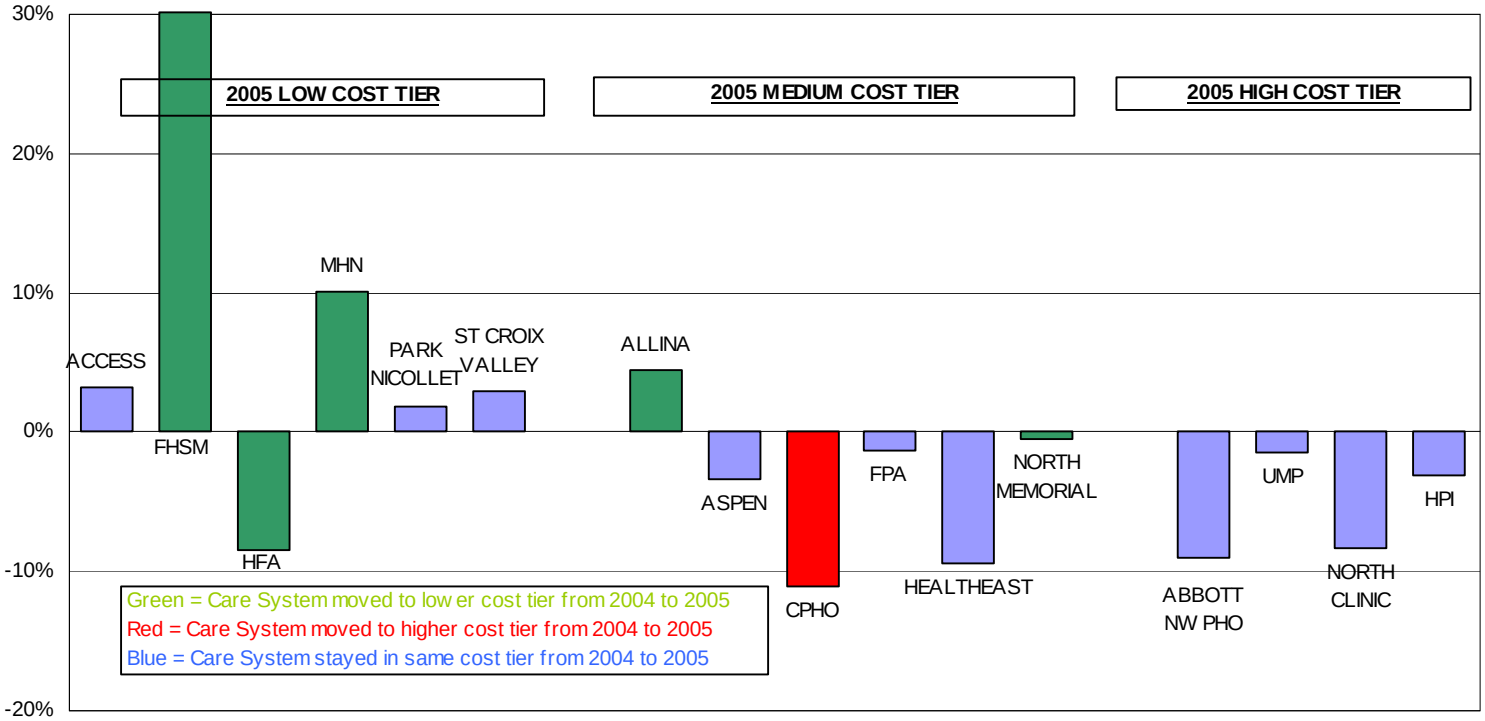
- Consumer premiums or benefits are based on which band their chosen care system is in
- Quality and customer service information shared with consumers
- Patients choose providers based on their values
- Patients seek care through their chosen providers
- Consumers can change care system at any time 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

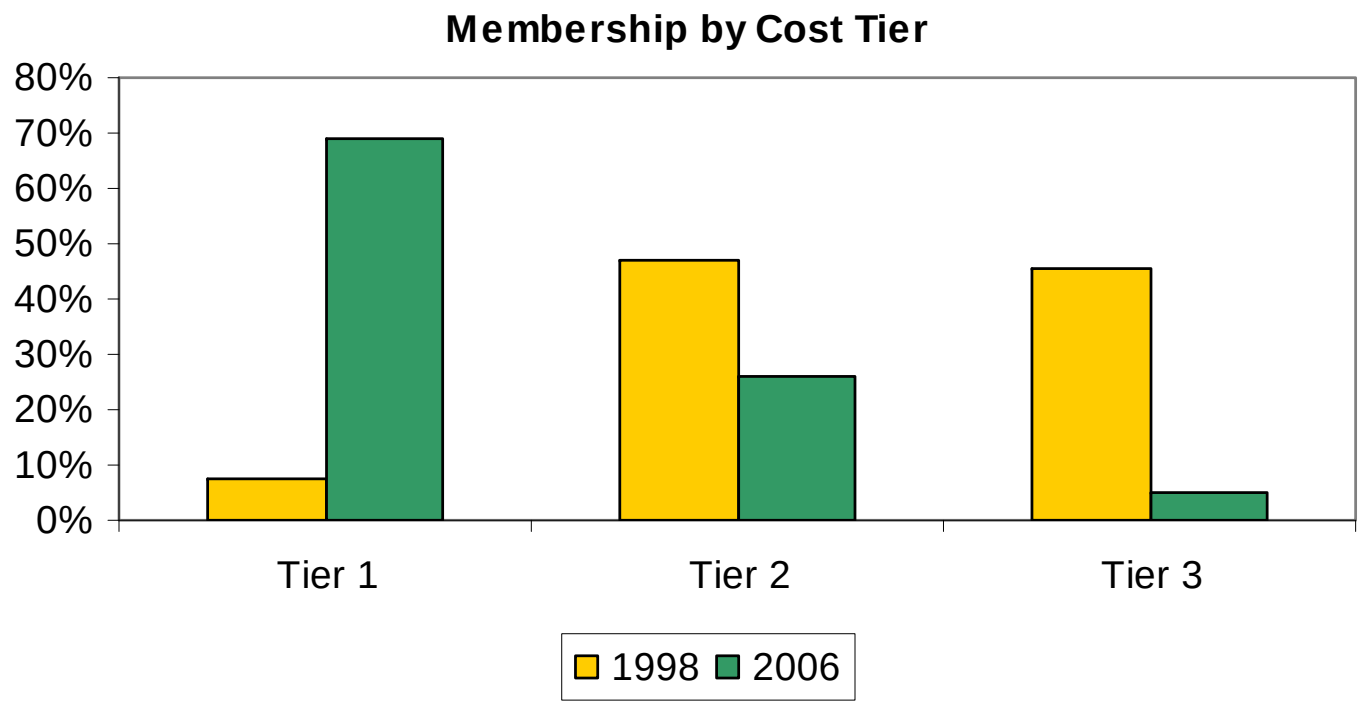
(SMALL INDEPENDENT GROUPS OFTEN PERFORM BEST)

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



VARIABLE FEE FOR SERVICE PAYMENT

Providers bill as usual, reimbursed for services rendered

- 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 is compared to Claim Target
- FUTURE fee levels are 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
- 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 with any benefit style

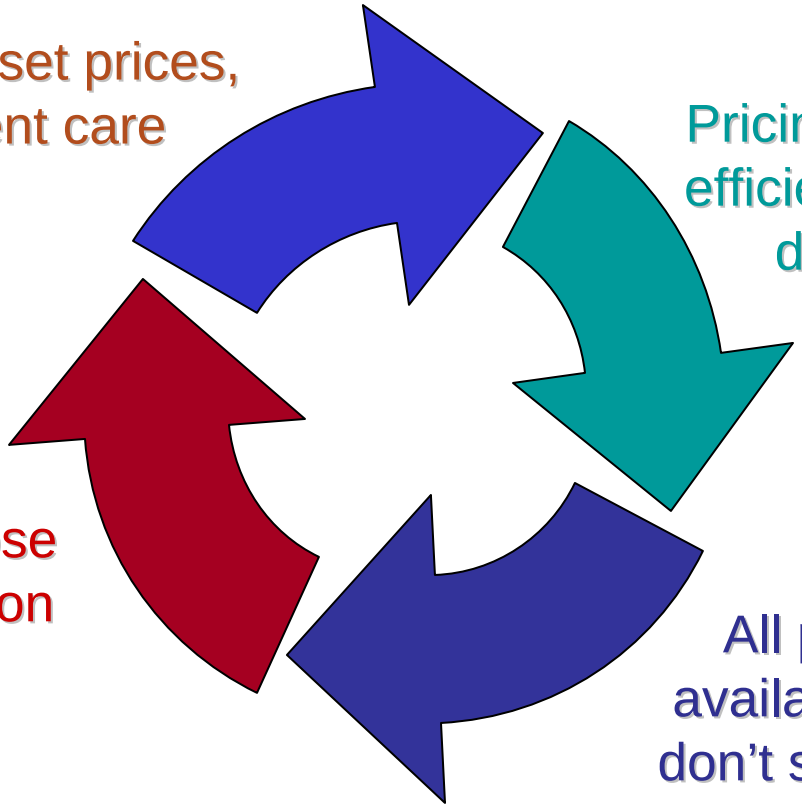
PAYMENT MODEL INCENTIVE COMPARISON

	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
PROVIDER ORGANIZATION	Consolidate to increase negotiating power	"Right size" to optimize efficiency	Consolidate to increase negotiating power

SUMMARY

Provider groups set prices, manage patient care

Pricing, risk adjusted efficiency and quality drives cost to consumer



Consumers choose providers based on their values

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

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

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

A FEW OF THE BARRIERS WE OVERCAME

- 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
- Unknown existence or influence of the mythic “health care consumer”

BARRIERS WE DIDN'T SOLVE

- Critical mass of patients 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

- Employers reluctant to hold their employees accountable for their choices, still paternalistic
- 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

COULD THIS BE DONE ELSEWHERE?

- National employers looking for all-at-once national solutions
  - This requires local attention and provider interaction, can't be dropped wholesale on entire country
- Easiest to implement in markets with some degree of physician organization, v. solo or very small practices
- 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