

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

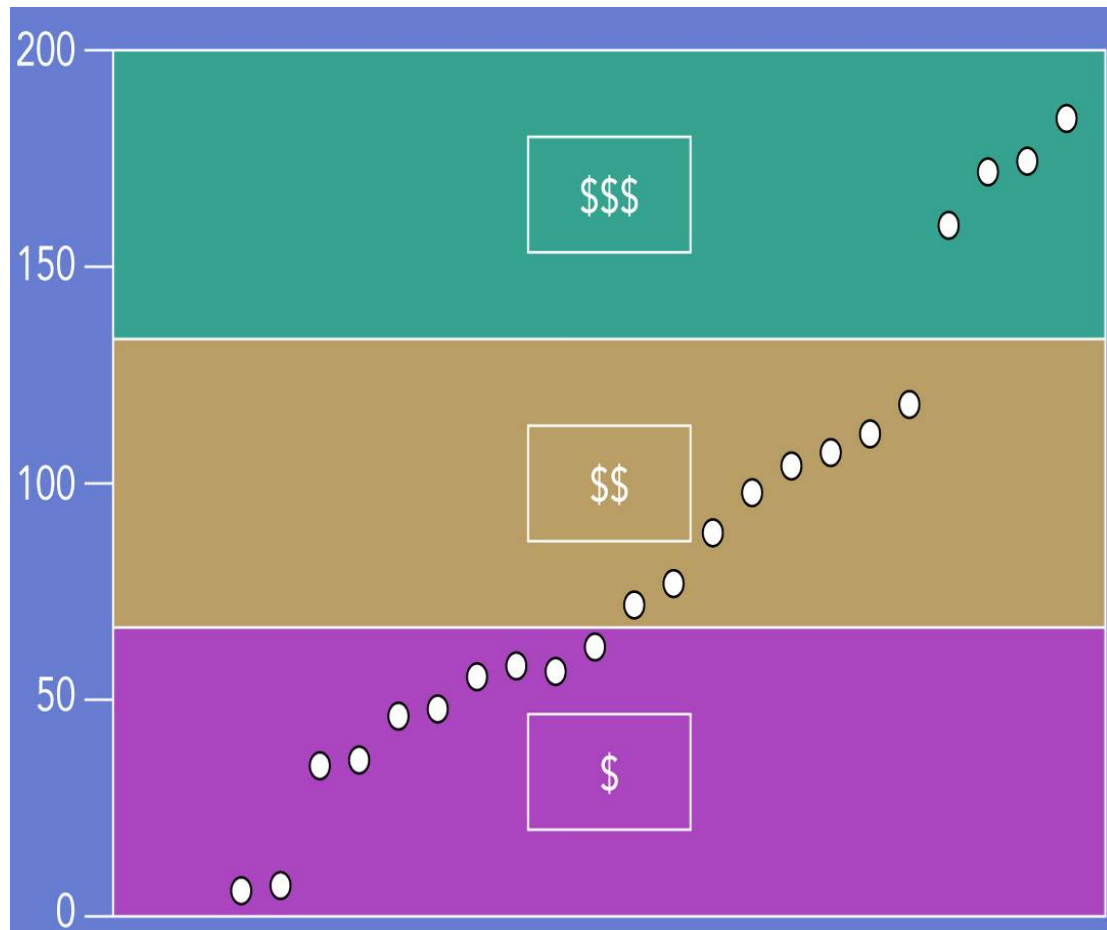
PROVIDERS BID

- 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



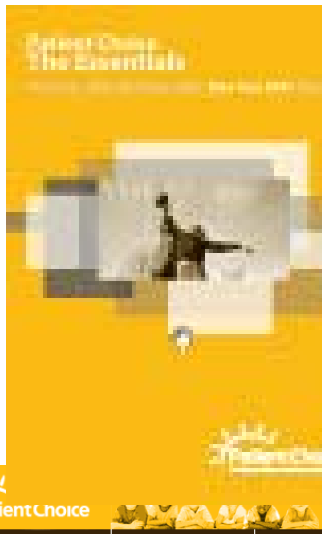
Each circle is a Care System

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



Patient Choice Comparison Guide

A Consumer's Guide to Care System Quality, Cost and Service

Plan Year 2005 Plan Year 2005 Plan Year 2005 Plan Year 2005

Patient Choice
A Higher Way to Purchase Health Care

- About Us
- Provider Directory
- Consumers Coalitions Program Participants
- Employers Coalitions Plan Buyers
- Brokers Agents Consultants
- Physicians Hospitals
- Health Care Professionals
- Insurers
- Third Party Administrators

Home	Contact Us	Provider Directory	Site Map
Summary	Patients/yr	Mortality	Complications
Length of Stay	Cost	Other Evals	More

Report on Appendectomy

Minneapolis, MN. 40 miles
Data Source: Patients over 65

This report compares hospitals within 40 miles of Minneapolis, MN for Appendectomy, and is based on your selections and rankings. This is just one of several sources you should consult to select a hospital; always consult your physician about what decision is right for you. [Click here for more information.](#)

Name	Rank	Index	Patients/yr	Mortality	Complications	LOS	Cost
North Memorial Medical Center	1st	1.67	2nd	1st	2nd	1st	1st
Methodist Hospital	2nd	2.33	1st	5th	1st	2nd	2nd
Abbott-Northwestern Hospital Inc	3rd	2.67	3rd	1st	4th	4th	3rd
HealthEast St John's Hospital	4th	3.00	5th	1st	3rd	3rd	5th
Fairview Southdale Hospital	5th	3.33	4th	1st	5th	5th	4th

[New Search](#) | [Change Hospitals](#) | [Change Rankings](#)

Print report
Email report

Hospital Patient Safety

A 1999 report by the Institute of Medicine (IOM) found that up to 98,000 Americans die every year from preventable medical errors made in hospitals. Today, medical errors in the intensive care of The Leapfrog Group are made of more than 100 specific and precise regulations that provide health care benefits to more than 24 million individuals.

Working with medical groups throughout the country to offer patient safety improvements in hospitals, The Leapfrog Group has identified four areas for hospitals that it recommends hospitals should focus on. They include Computer-Prescribe Use Order Entry, Evidence-Based Hospital Referral, Intensive Care Unit Physician Staffing and National Quality Forum Safe Practices.

Program and show information and beginning to implement programs and are highlighted below.

- Intensive Care Unit
- Medical Staff
- Physician Staffing
- Computer-Prescribe Use Order Entry
- National Quality Forum Safe Practices

Internet Capabilities

There is growing interest among individuals to utilize the Internet as a tool for connecting with their health care providers. You can use the information below to find the Care Systems that offer services through the Internet.

Care Systems Cost Group 1	Appointments Scheduling	Billing, Invoicing, Reports, etc.	Prescription Refills	Lab Result Reporting	Reminders	Physician Staffing
Access Quality Care Systems	●	●	●	●	●	●
Centimark Health Systems	●	●	●	●	●	●

Customer Service Capabilities

Many Care Systems have developed innovative programs and services enhancements to better meet your needs. This information will help you learn about some of the programs and capabilities Care Systems have in place to probably affect your care experience.

Care Systems Cost Group 1	Forming & Invoicing Apps	Same Day Non-Urgent Appts	24 Hour Health Advice Line	Electronic Medical Record	Electronic Prescribing	Health Educ. Programs
Access Quality Care Systems	●	●	●	●	●	●
Centimark Health Systems	●	●	●	●	●	●

Patient Satisfaction and Access

This information shows what individuals think about key aspects of service and their overall care experience with Care Systems. How does the overall satisfaction individuals have with services compare to their children?

Care Systems Cost Group 1	Access & Continuity	Physician Interest/Introduction	Hospitalization of Care	Physician Year	Overall Satisfaction Adult Care	Overall Satisfaction Children Care
Access Quality Care Systems	●	●	●	●	●	●

Clinical Performance

This information shows the results of our program to evaluate Care Systems' health outcomes and care processes for diabetes, coronary artery disease and preventive care, as well as service and satisfaction levels. Care Systems that choose to participate were screened in three categories, resulting in corresponding quality credits. These categories include:

- Clinical Performance Level - measures Care Systems on self-reported topics such as laboratory results and completeness of care compared to best practices.
- Care Process - refers to the Care System's infrastructure that allows them to identify and manage their patient's needs.
- Patient Experience - refers to patient reported satisfaction with their care under each condition.

Care Systems Cost Group 1	Diabetes Care			Preventive Care			Coronary Artery Disease			Overall Satisfaction Adult Care	Overall Satisfaction Children Care
	Clinical Care	Patient Referral	Physician Experience	Clinical Care	Patient Referral	Physician Experience	Clinical Care	Patient Referral	Physician Experience		
Access Quality Care Systems	●	●	●	●	●	●	●	●	●	●	●
Centimark Health Systems	●	●	●	●	●	●	●	●	●	●	●

● Highest Level Credit Awarded ● Mid-Level Credit Awarded ● Credit Awarded ● No 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

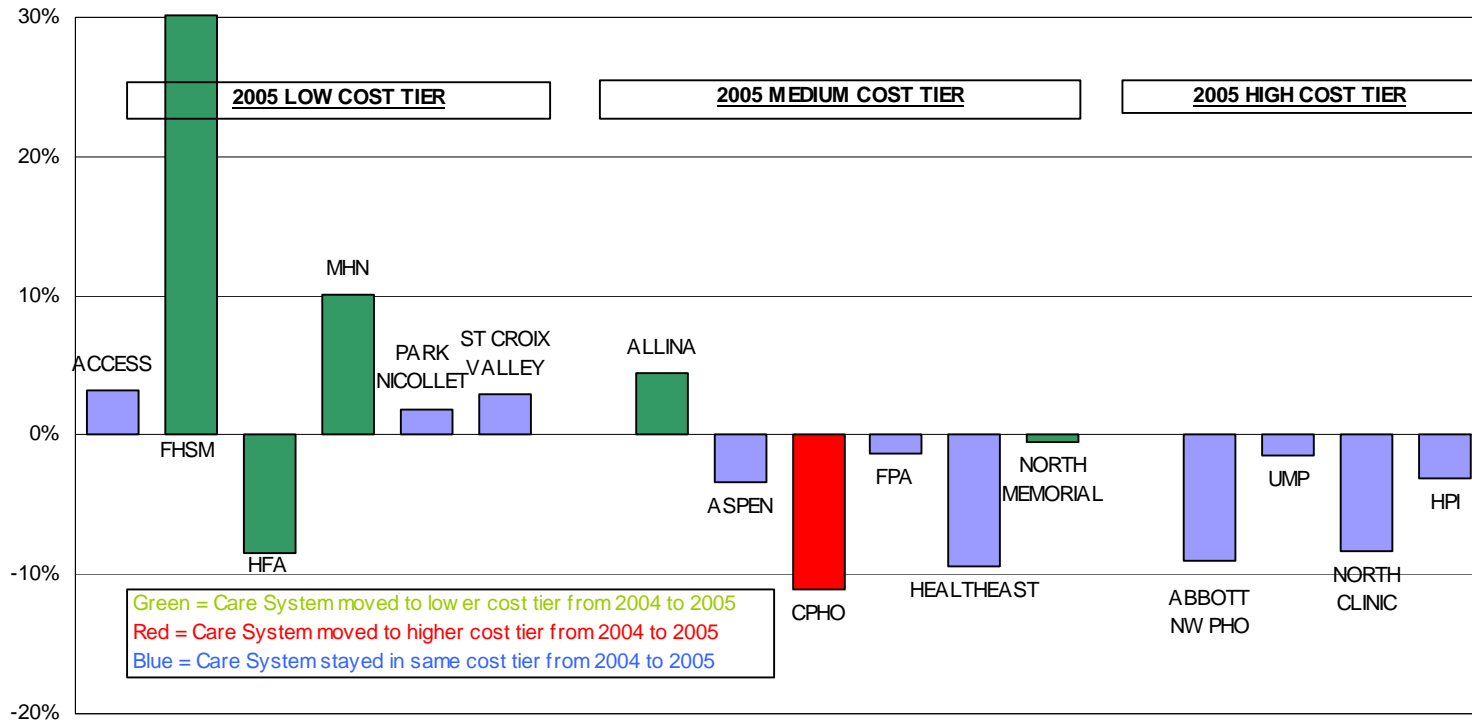
- Consumer premiums or benefits are based on which band their chosen care system is in
- Quality and customer service information shared with consumers
- Patients choose providers based on their values
- Patients seek care through their chosen providers
- Consumers can change care system at any time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

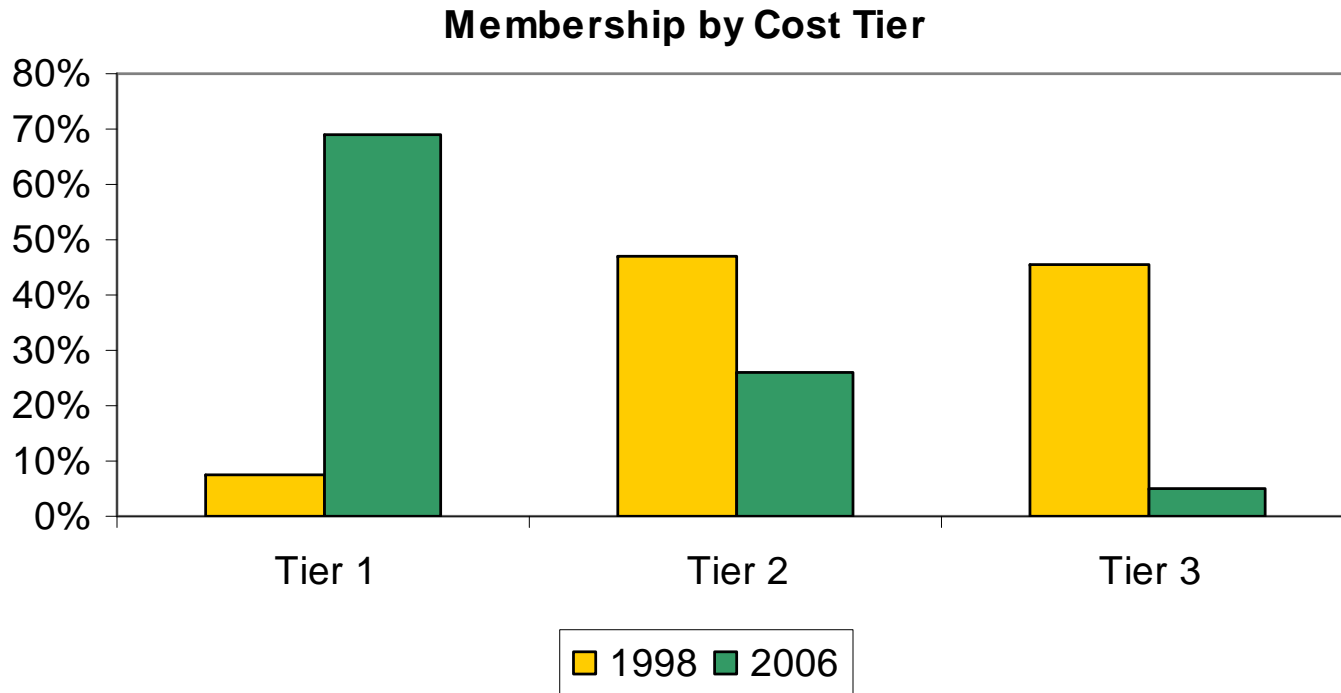
(SMALL INDEPENDENT GROUPS OFTEN PERFORM BEST)

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