CATALYST FOR PAYMENT REFORM

Alternatives to Traditional Fee-for-Service Models

February 25, 2015

Suzanne Delbanco, Ph.D.
Executive Director

Who We Are and What We Do

Who We Are

Catalyst for Payment Reform (CPR) is an independent, non-profit corporation working on behalf of large employers and public health care purchasers to catalyze improvements in how we pay for health services and to promote higher-value care in the U.S.

- 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.
- FedEx Corporation
- Equity Healthcare
- GE
- Group Insurance Commission, Commonwealth of MA
- The Home Depot
- Maine Bureau of Human Resources
- Marriott International, Inc.
- Mercer
- Michigan Department of Community Health (Medicaid)
- Ohio Medicaid
- Ohio PERS
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Qualcomm Incorporated
- Safeway, Inc.
- 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 & Co

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

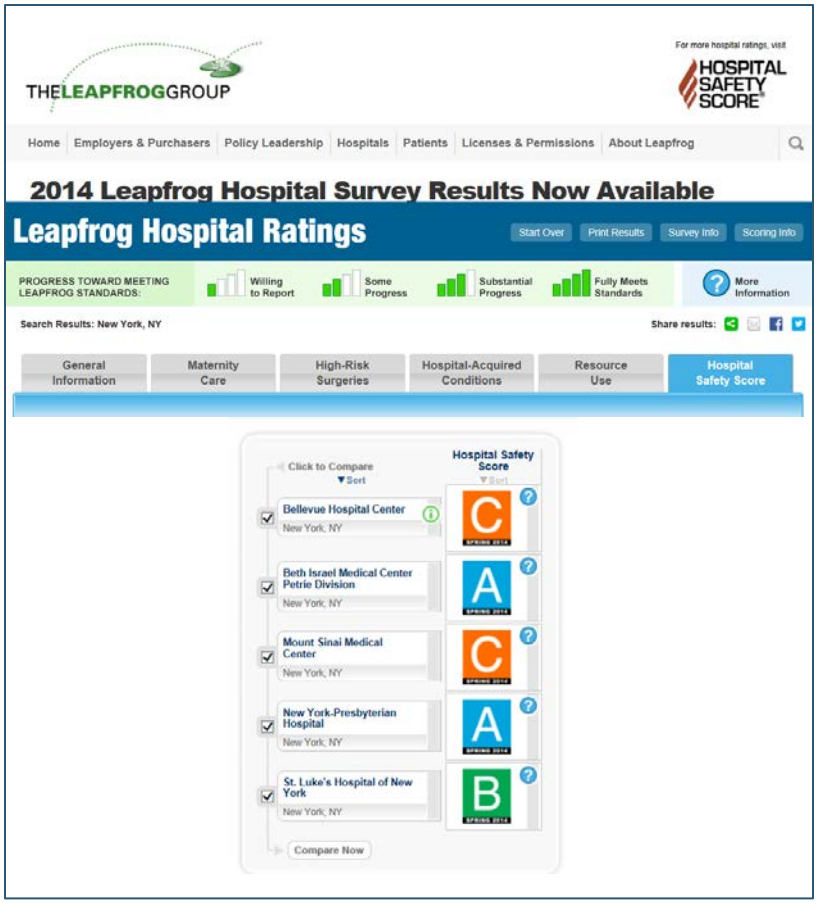
Implement Innovations

- Price transparency
- Reference and value pricing
- Maternity payment reform
- Pilots on high-impact areas
- Enhance provider competition

The Challenges to High Value: Variation in Quality and Safety

Huge quality variation

- To Err is Human, 1999: 44,000-98,000 deaths per year
- McGlynn et al, 2003: Patients only get recommended care 55% of the time



The Challenges to High Value: Variation in Prices and Payments

Prices in the U.S. can vary as much as 700%

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.

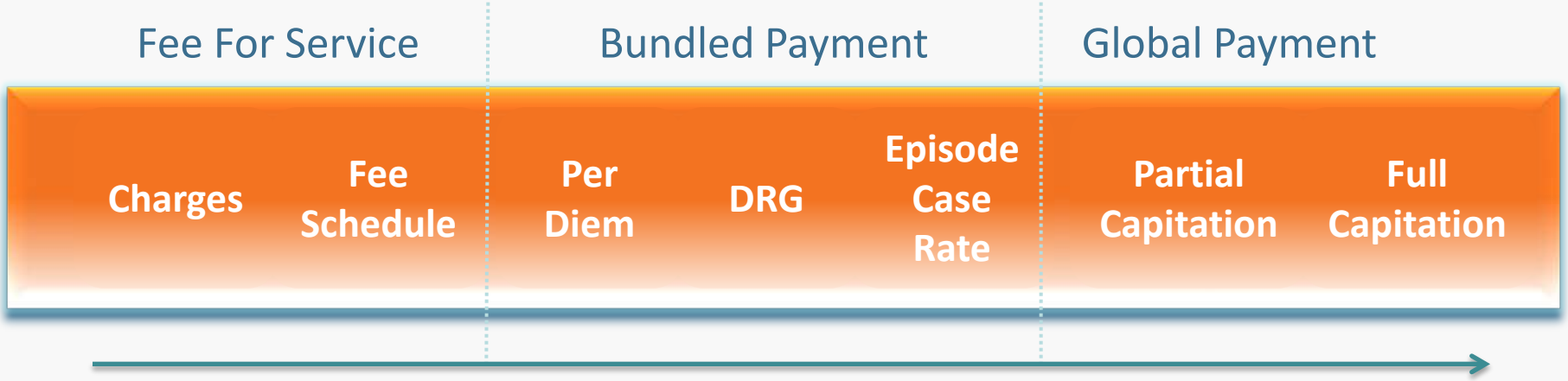
**Source: Mathematica Policy Research*

Time to Reform Payment & Delivery

- Today's approach to payment allows for poor value; tweaks and reforms may help to improve quality and reduce costs
- Health reform included several "Game Changers" and a focus on specific models –is there 'Irrational exuberance?'
- We still know very little about what works – but we know there is no one-size-fits-all model
- Most of the time our payments are fee-for service and we pay regardless of quality or outcomes – and there are aspects of care they we don't pay for at all though we should
- Must we start from scratch or can we build on what we have?

Payment Model Evolution

BASE PAYMENT MODELS



PERFORMANCE-BASED PAYMENT OR PAYMENT DESIGNED TO CUT WASTE

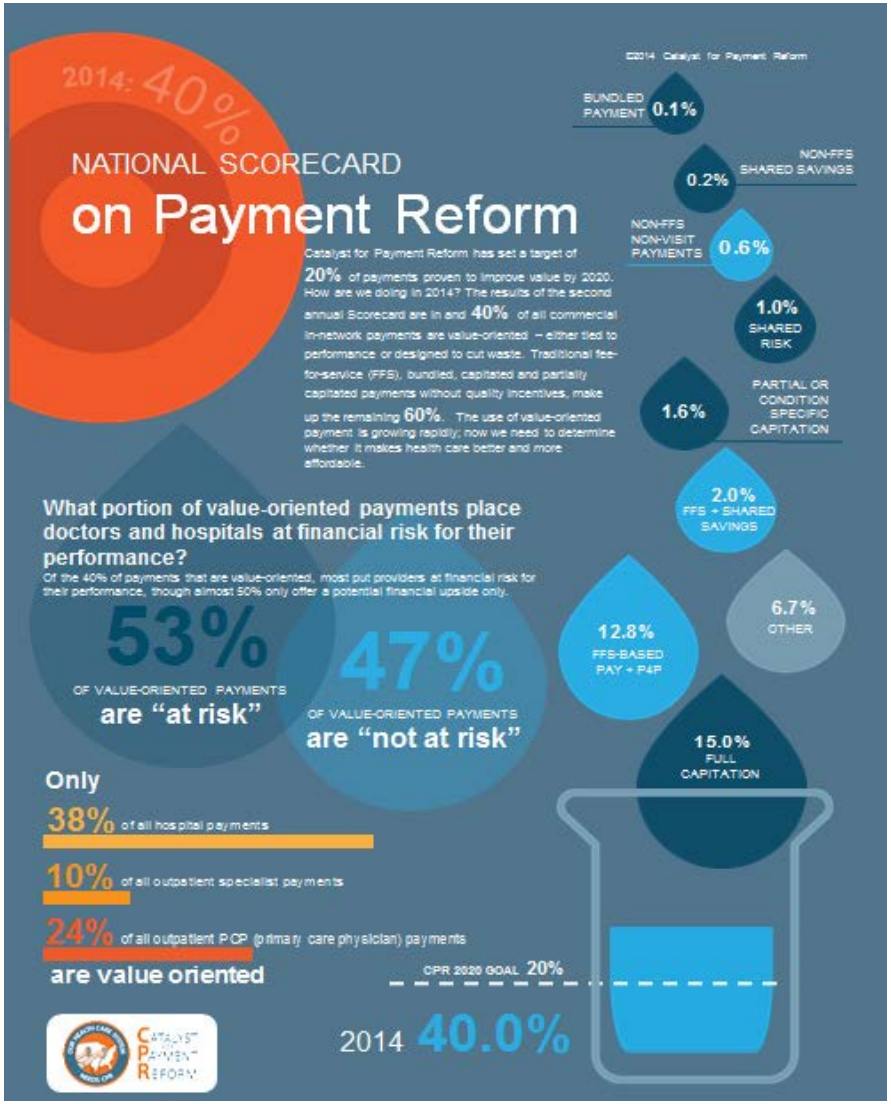
(financial upside & downside depends on quality, efficiency, cost, etc.)

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 National Scorecard Benchmark Metric 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

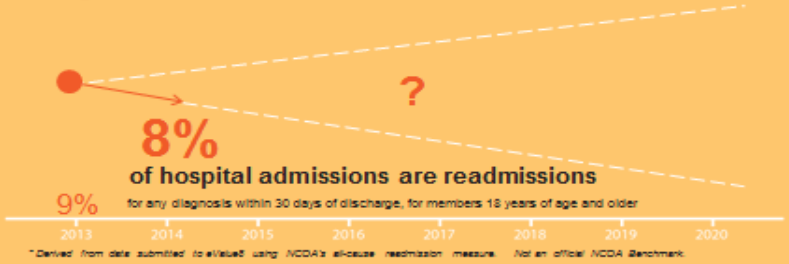
74% of **physician choice tools** have integrated cost calculators

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*

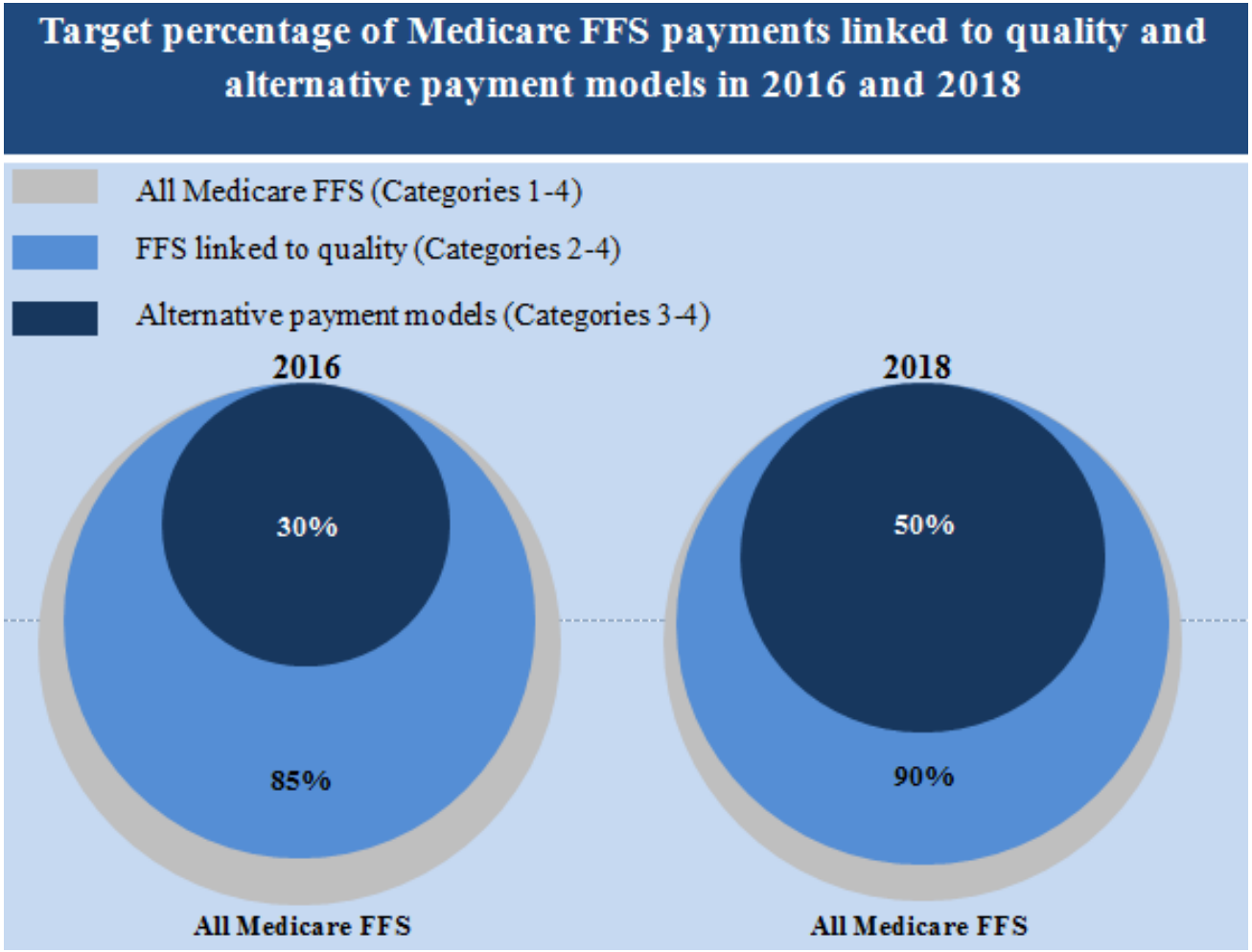


Non-FFS Payments and Quality

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

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

Goals Set by HHS in 2015

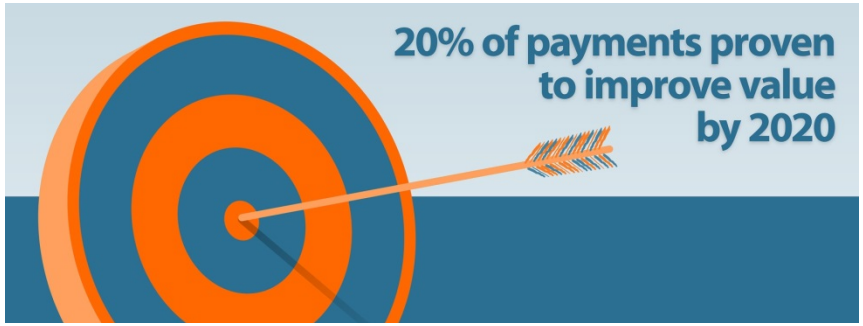


Source: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

How to Define Success

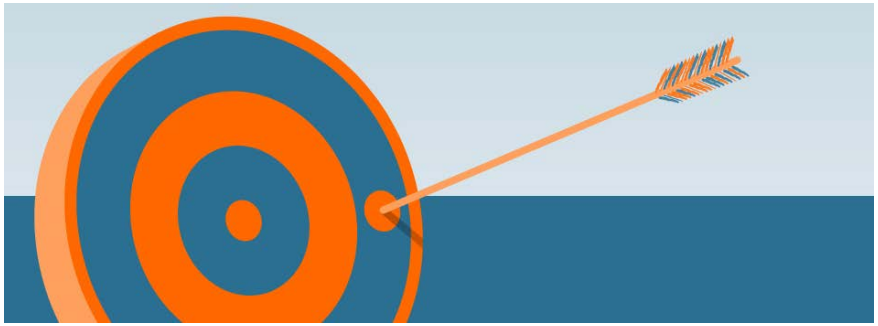
Are we going to hit our target but miss the bull's-eye?

CURRENT



- We are measuring use of "value-oriented payment" methods.
- What happens if we get to 60%, 70%, or 80% by 2020 but value hasn't 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*"…

Contact

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