Alternatives to Traditional Fee-for-Service Models

February 25, 2015
Suzanne Delbanco, Ph.D.
Executive Director
Who We Are and What We Do

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

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

www.catalyzepaymentreform.org

February 25, 2015
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
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**

<table>
<thead>
<tr>
<th>APR-DRG and severity</th>
<th>Minimum price</th>
<th>Median price</th>
<th>Average price</th>
<th>Maximum price</th>
<th>Difference between maximum and minimum price</th>
<th>Ratio of maximum to minimum price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cesarean delivery (540)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity 1</td>
<td>$3,244</td>
<td>$7,598</td>
<td>$7,859</td>
<td>$15,915</td>
<td>$12,671</td>
<td>4.9</td>
</tr>
<tr>
<td>Severity 2</td>
<td>$2,828</td>
<td>$8,718</td>
<td>$9,338</td>
<td>$20,424</td>
<td>$17,596</td>
<td>7.2</td>
</tr>
<tr>
<td>Severity 3</td>
<td>$3,621</td>
<td>$11,389</td>
<td>$13,266</td>
<td>$26,018</td>
<td>$22,397</td>
<td>7.2</td>
</tr>
<tr>
<td>Severity 4</td>
<td>$9,600</td>
<td>$17,134</td>
<td>$19,156</td>
<td>$30,660</td>
<td>$21,059</td>
<td>3.2</td>
</tr>
<tr>
<td>Vaginal delivery (560)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity 1</td>
<td>$1,810</td>
<td>$4,990</td>
<td>$5,225</td>
<td>$11,066</td>
<td>$9,256</td>
<td>6.1</td>
</tr>
<tr>
<td>Severity 2</td>
<td>$2,182</td>
<td>$5,692</td>
<td>$5,884</td>
<td>$12,177</td>
<td>$9,995</td>
<td>5.6</td>
</tr>
<tr>
<td>Severity 3</td>
<td>$2,812</td>
<td>$6,450</td>
<td>$7,656</td>
<td>$20,446</td>
<td>$17,634</td>
<td>7.3</td>
</tr>
</tbody>
</table>

*Source: Mathematica Policy Research*

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.
• 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?
BASE PAYMENT MODELS

Fee For Service | Bundled Payment | Global Payment

- Charges
- Fee Schedule
- Per Diem
- DRG
- Episode Case Rate
- Partial Capitation
- Full Capitation

Increasing Accountability, Risk, Provider Collaboration, Resistance, and Complexity

PERFORMANCE-BASED PAYMENT OR PAYMENT DESIGNED TO CUT WASTE (financial upside & downside depends on quality, efficiency, cost, etc.)
### Upside, Downside, Two-Sided Risk

<table>
<thead>
<tr>
<th>Type</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upside only for providers</strong></td>
<td>Physicians</td>
</tr>
<tr>
<td></td>
<td>• Primary Care Medical Home/payment for care coordination or payments for other non-visit functions</td>
</tr>
<tr>
<td></td>
<td>• Payment for shared decision making</td>
</tr>
<tr>
<td></td>
<td>• Payment for nontraditional visits (e.g. e-visits)</td>
</tr>
<tr>
<td></td>
<td>• Hospital-physician gainsharing</td>
</tr>
<tr>
<td></td>
<td>• Pay for Performance</td>
</tr>
<tr>
<td></td>
<td>• Shared savings</td>
</tr>
<tr>
<td></td>
<td>Hospitals</td>
</tr>
<tr>
<td></td>
<td>• Pay for Performance</td>
</tr>
<tr>
<td></td>
<td>• Shared savings</td>
</tr>
<tr>
<td><strong>Downside only for providers</strong></td>
<td>• Hospital penalties (e.g. readmissions, Hospital Acquired Conditions, never events, warranties, Length of Stay)</td>
</tr>
<tr>
<td><strong>Two-sided risk (both upside and downside)</strong></td>
<td>• Bundled payment</td>
</tr>
<tr>
<td></td>
<td>• Global payment/capitation</td>
</tr>
<tr>
<td></td>
<td>• Shared-risk in Accountable Care Organization environment</td>
</tr>
</tbody>
</table>

Most payment reforms built on a fee-for-service chassis
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
### 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

**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 reallocation of payment between primary and specialty care.

- 71% Paid annually to specialists
- 29% Paid annually to PCPs

**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

**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

### Hospital Readmissions*

- 8% of hospital admissions are readmissions for any diagnosis within 30 days of discharge, for members 18 years of age and older

Goals Set by HHS in 2015

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016:
- 30% All Medicare FFS
- 85% FFS linked to quality (Categories 2-4)
- 15% Alternative payment models (Categories 3-4)

2018:
- 50% All Medicare FFS
- 90% FFS linked to quality (Categories 2-4)
- 10% Alternative payment models (Categories 3-4)

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”…

20% of payments proven to improve value by 2020
Contact

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