Building onto a Strong Foundation: Strategies for Taking Health Care Purchasing to the Next Level

Suzanne F. Delbanco, Ph.D.
Executive Director

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WHAT IS CPR?

About CPR

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An independent non-profit corporation **working to catalyze employers, public purchasers and others** to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

- 32BJ Health Fund
- Aircraft Gear Corporation
- Aon
- Arizona Health Care Cost Containment System (Medicaid)
- CalPERS
- Compassion International
- Covered California
- Equity Healthcare LLC
- General Motors
- Group Insurance Commission, MA
- Hilmar Cheese Company, Inc.
- The Home Depot
- Independent Colleges and Universities Benefits Association
- Mercer
- Miami University (Ohio)
- Ohio Medicaid
- OhioPERS
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Purdue University
- Qualcomm Incorporated
- San Francisco Health Service System
- Self-Insured Schools of California
- South Carolina Health & Human Services (Medicaid)
- State of Tennessee
- TennCare (Medicaid)
- UNITE HERE HEALTH
- Walmart Inc.
- Washington State Health Care Authority
- Willis Towers Watson

CPR's Goals

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Each year there will be a **meaningful increase** in the portion of payments flowing through methods proven to improve value.

Health care purchasers will be more **educated and activated** on the use of high-value health care purchasing strategies.

Through greater visibility and effective policies, the **health care marketplace will be more competitive**, cost conscious (or cost constrained) and responsive to the needs of those who use and pay for health care.

Tackling the Tough Challenges for Purchasers Since 2010

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Payment Reform

Price Transparency

Provider Consolidation

Data Access

EDUCATION

- Webinars and virtual summits
- Online education courses
- State of the marketplace reports

TOOLS & SUPPORT

- Toolkits
- Case studies
- Program evaluation
- Product evaluation
- Market assessment

COORDINATION

- Shared Agenda
- Health Plan User Groups
- Purchaser collaboratives
- Curbside consulting

RESEARCH & ANALYSIS

- Amicus curiae briefs
- Scorecards on Payment Reform
- State report cards
- White papers

Employer-Purchasers Have a Track Record of Reforming Health Care

Some achievements from the last two decades:

- **Standard measurement**
- **Public reporting**
- **Payment tied to performance**
- **Price Transparency**
- **Multi-payer databases**
- **Fighting anti-competitive behavior by providers**

Lehigh Valley Business Coalition on Healthcare Has a Track Record Too

Photo Credit: Yura Timoshenko

A unicorn among coalitions:

- **Group purchasing is a rarity**
- **Discounts on administrative fees**
- **Partnering with providers**
- **A tried and true, long-lasting model**

However, the Health Care Marketplace Isn't Functioning Well

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- Imbalances of power between supply side and buy side – insufficient competition
- Shopping is too complex for most end users
- Prices continue to outpace inflation
- Price and quality uncorrelated

Employer-Purchasers Need to Step Up

Photo credit: Renate Vanaga

Many Purchasers Have Delegated Too Much to TPAs/Carriers

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- Many TPAs and carriers who have provider networks are conflicted. Who is their customer - the purchaser or the provider? They may not share the purchaser's priorities.
- The contracts these TPAs and carriers have with providers may prohibit them from offering purchasers high value strategies
- There may be better opportunities for purchasers through direct relationships with health care providers

Photo credit: Agni B.

Beyond Managing Health Plans…What Else Could You be Advancing?

Delivery Reforms

- **Advanced Primary Care** - onsite or near-site clinics and telehealth
- **Appropriate Site of Service** - delivering care in appropriate but less expensive settings
- **Health Equity** - it's time to measure, innovate and improve
- **Palliative Care** - care for patients with serious illness improves quality and saves money

Payment Reform – payment models that support delivery reform and share financial risk with providers

Benefit Design - incentives for consumers to seek beneficial care and avoid low value care that also reinforce care delivery reforms

Transparency

- **Data Stewardship** – take complete ownership of your data to plan and evaluate
- **Standardized Reporting by Health Plans** – demand the equivalent of the nutrition label for payment and delivery reforms

Health Policy Reforms - where the marketplace fails, policy can help

DELIVERY REFORMS

Advanced Primary Care

Advanced Primary Care

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"Advanced primary care" means:

- Patient is at the center of care
- Better access
- Onsite clinics, near-site clinics, telehealth
  - Alternative, added, potentially less expensive sites of care
- More control over adherence to guidelines
- Care coordination and informed referrals to providers in the community

Source: Mercer and NAWHC Worksite Health Centers 2021 Survey Report.

Advanced Primary Care

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Onsite and Near-Site Clinics

- Nearly 1/3 of employers ≥ 5,000 employees offer a primary care clinic to their employees.
- Prevalence varies by industry
- Smaller employers ≤ 5,000 employees are more likely to share a clinic with other local employers than large employers who offer clinics
- Over half of clinics require **no co-payment**

Source: Mercer and NAWHC Worksite Health Centers 2021 Survey Report./

Advanced Primary Care

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Intersection with the health care marketplace

- 40% of users select the onsite or near-site clinic as their primary care provider (but 60% do not)
  - This can lead to **continuity of care issues** with external primary care providers and specialists
  - However, 65% of these clinics refer only to **in-network providers** and 12% use a custom provider list based on **cost and quality**

- Opportunities for **payment reform** – provider may be salaried and be eligible for quality bonuses

- There are many vendors to partner with for these services if the local health care system isn't cutting it

Source: Mercer and NAWHC Worksite Health Centers 2021 Survey Report.

Advanced Primary Care

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Telehealth

- Telehealth can be **part of advanced primary care** or available to employers through **direct contract**, contracted health plans or local providers
- **Use has risen dramatically** since before the pandemic, but has tapered off from its height
- **Payment parity laws** helped support providers during the pandemic, but **have made telehealth more expensive**

Appropriate Site of Service

Appropriate Sites of Care Can Improve Access and Reduce Costs

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Patients can often receive the care they need in lower-acuity settings such as:

- Worksite and near-site clinics
- Telehealth
- Urgent care centers
- Retail clinics
- Outpatient clinics or ambulatory surgery centers
- Home infusion therapy
- Birth centers

Convenience, potential cost savings to plan member and employer, enhanced provider competition

Payment Models and Benefit Designs Can Provide Support

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Savings come from a less expensive payment to a less expensive provider….

or

From site neutral payments – paying the same amount regardless of the setting, creating a disincentive for health systems to use higher acuity settings than needed

Benefit designs can support site of service programs by **incentivizing plan members to seek care from alternative, less expensive sites of care**.

Health Equity

Demand that Health Plans Measure Disparities & Enhance Equity

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Employer-purchasers should ensure that health plans demonstrate efforts to improve health equity and reduce racial disparities in care outcomes

- Select quality metrics that reveal disparities between racial and ethnic groups
- Support providers in making improvements
- Reward providers for improved outcomes and reductions in disparities among racial and ethnic populations

Regardless of one's circumstances, race, gender, where one lives or other socioeconomic factors, **every individual** deserves the best possible, personalized, cost-effective care delivered in the right setting at the right time

Palliative Care

What is Palliative Care?

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Specialized care that focuses on providing **relief from the symptoms and stress of a serious illness**—whatever the diagnosis.

Appropriate at any age, at any stage of a serious illness, and should be **provided along with curative treatment**, including for patients who are aggressively seeking a cure.

May sometimes be called "**care for the seriously ill**," "**supportive care**," "**compassionate care**," "**advanced illness management**," and "**personalized care**."

The Value Inherent in Palliative Care

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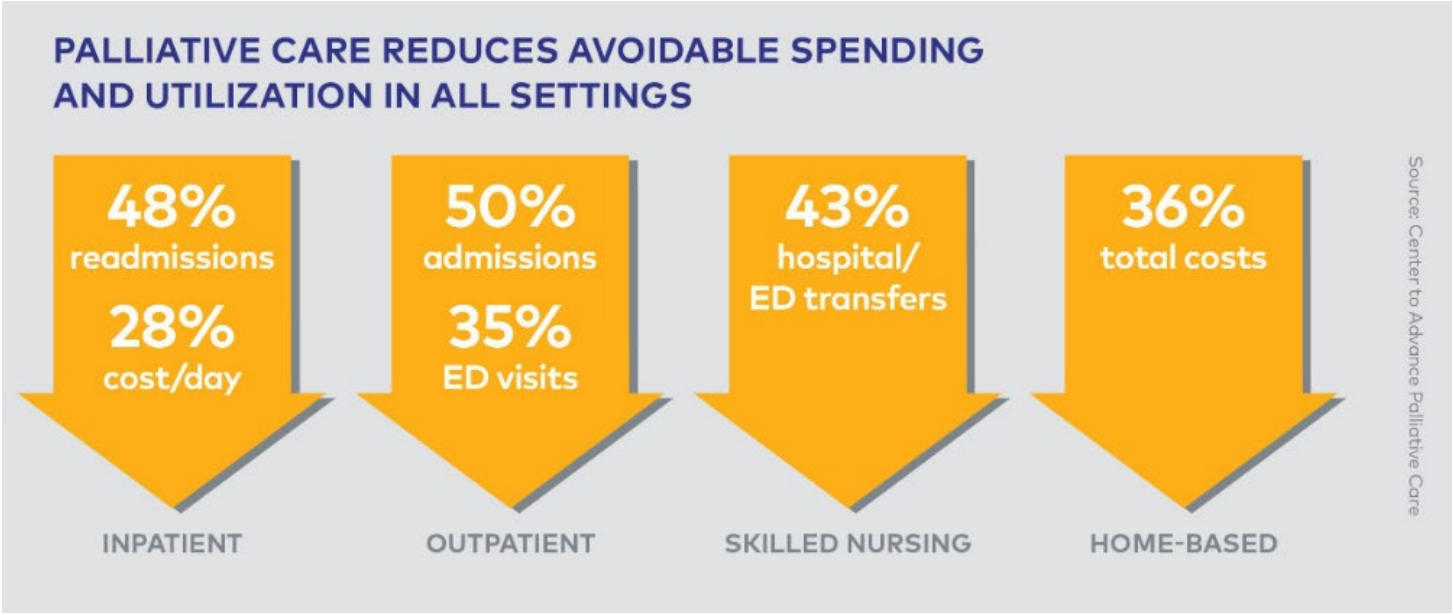
Through palliative care, purchasers can make a direct and significant improvement on the quality of life of employees living with serious illness and their caregivers, while also potentially saving money.



CPR Tools Support Development of a Palliative Care Strategy

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Move your health plans and provider networks to action by leveraging the following tools in your sourcing and contracting process.

- Request for Information (RFI): Access to Comprehensive and High-Quality Serious Illness Care
- Evaluation Guidance and Model Responses
- Model Health Plan Contract Language
- Health Plan Conversation Guide

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PAYMENT REFORM

We Haven't Yet Gotten Payment Reform Right

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Payment reform: a range of health care payment models that use payment to promote or leverage greater value for patients, purchasers, payers, and providers.

Spectrum of Health Care Provider Payment Methods

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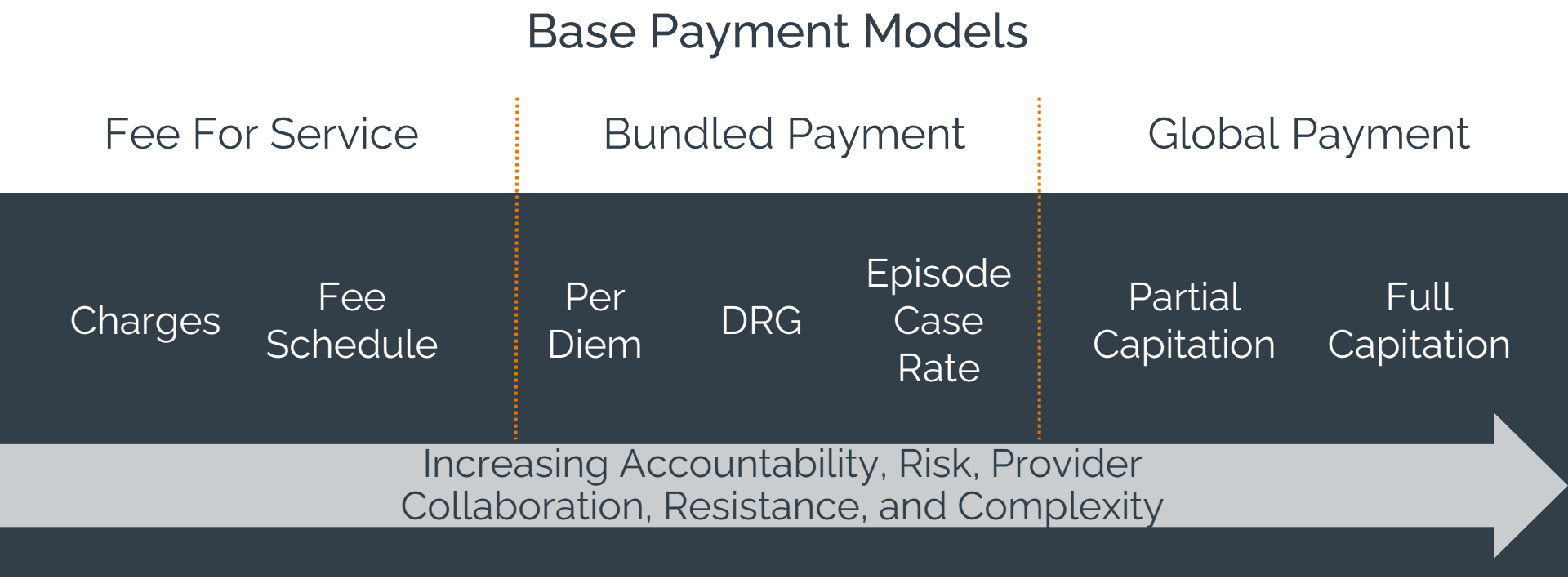

+

Performance-Based Payment or Payment Designed to Cut Waste
(financial upside & downside depends on quality, efficiency, cost, etc.)

Same Payment Methods Means the Same Provider Behavior

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If we want providers to change how they deliver care, we can't keep paying the same way and expecting them to improve...

- When we pay a la carte for each service – we get providers to deliver more services
- If we want better outcomes at lower costs, we need to pay accordingly.

Photo credit: Sunrise Photos

Fee For Service Still Prevalent; Links to Quality Less So

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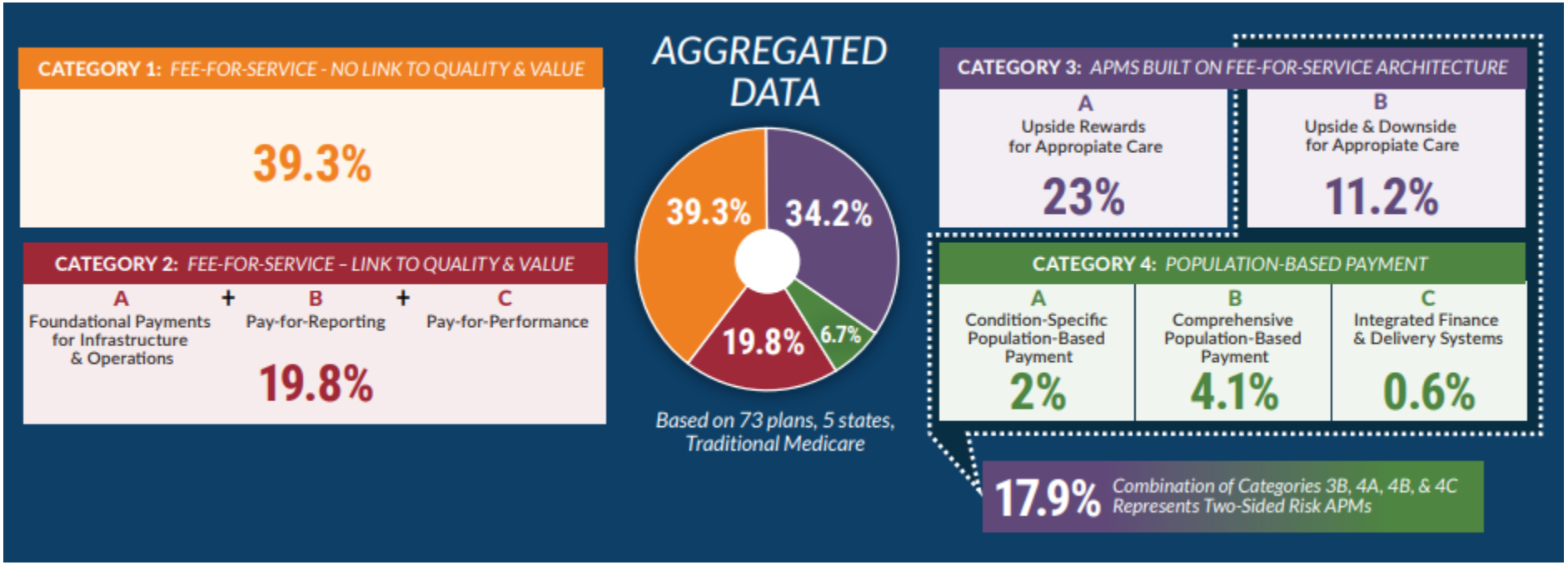
- 93% of payments start with fee for service
- Only 60% of payments are tied to quality
- Of the payments linked to quality, the vast majority offer carrots – no sticks



Source: https://hcp-lan.org/workproducts/APM_Infographic_2021.pdf

Payment Reform Needs "Reform" to Improve Quality & Affordability

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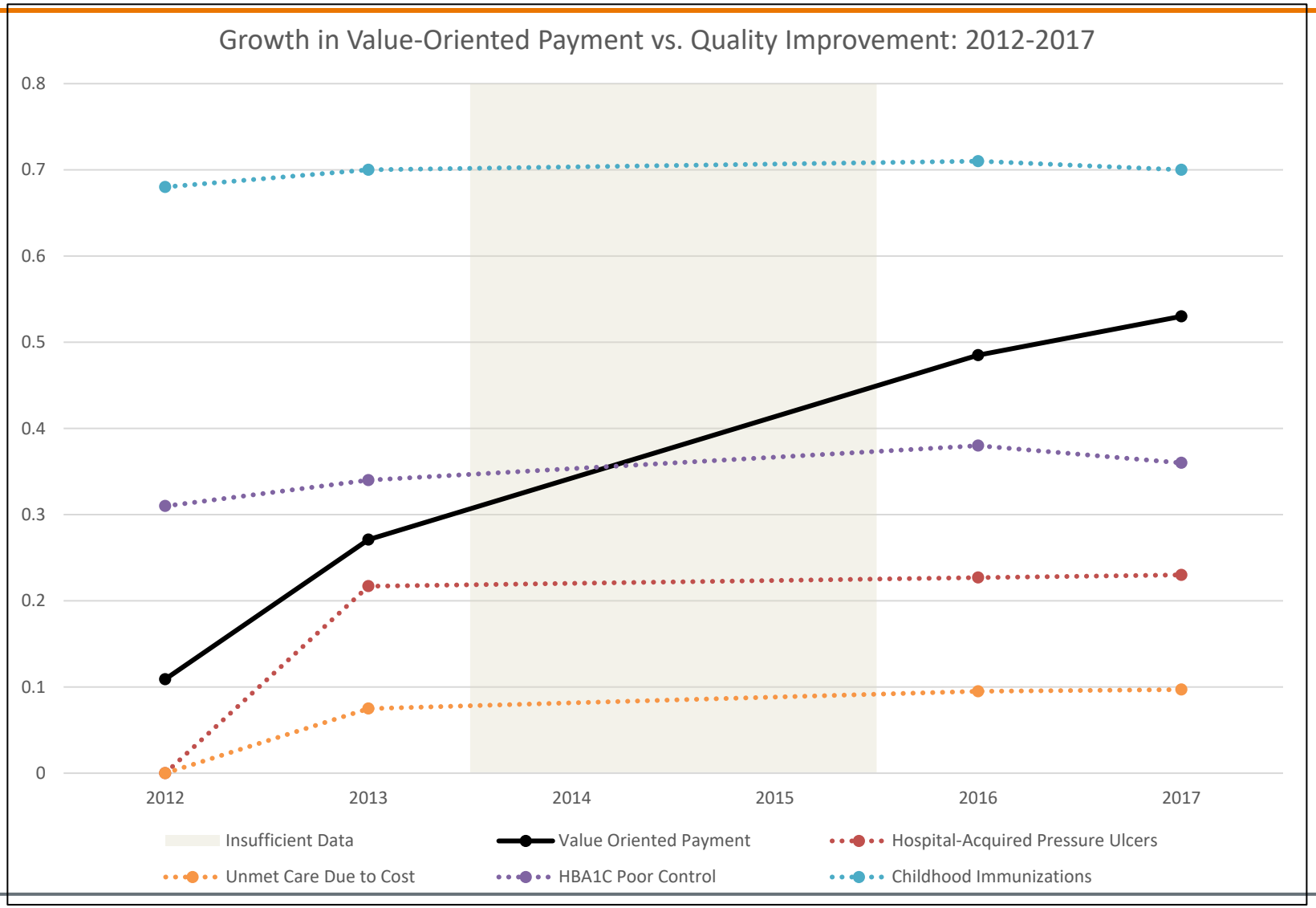

Examples of Different Payment Methods Improving Value

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RESEARCH ARTICLE | CONSIDERING HEALTH SPENDING

HEALTH AFFAIRS > VOL. 40, NO. 3: NURSING HOMES, COVID-19 & MORE

CONSIDERING HEALTH SPENDING

An Employer-Provider Direct Payment Program Is Associated With Lower Episode Costs

Christopher M. Whaley, Christoph Dankert, Michael Richards, and Dena Bravata

Carrum Health bundles services into episodes, providers bill as a team, payment includes accountability to improve outcomes, pays providers immediately

- Independent study by RAND of 8 employers' experience
- Episode prices for spinal fusion, joint replacement and weight loss surgery declined by an average of $4,229, a 10.7% relative reduction.
- Patient cost-sharing payments decreased by $498 per episode (a 27.7% relative decrease)
- Fewer readmissions: about 80% less than national average

Focus on Fewer and More Potent Payment Models

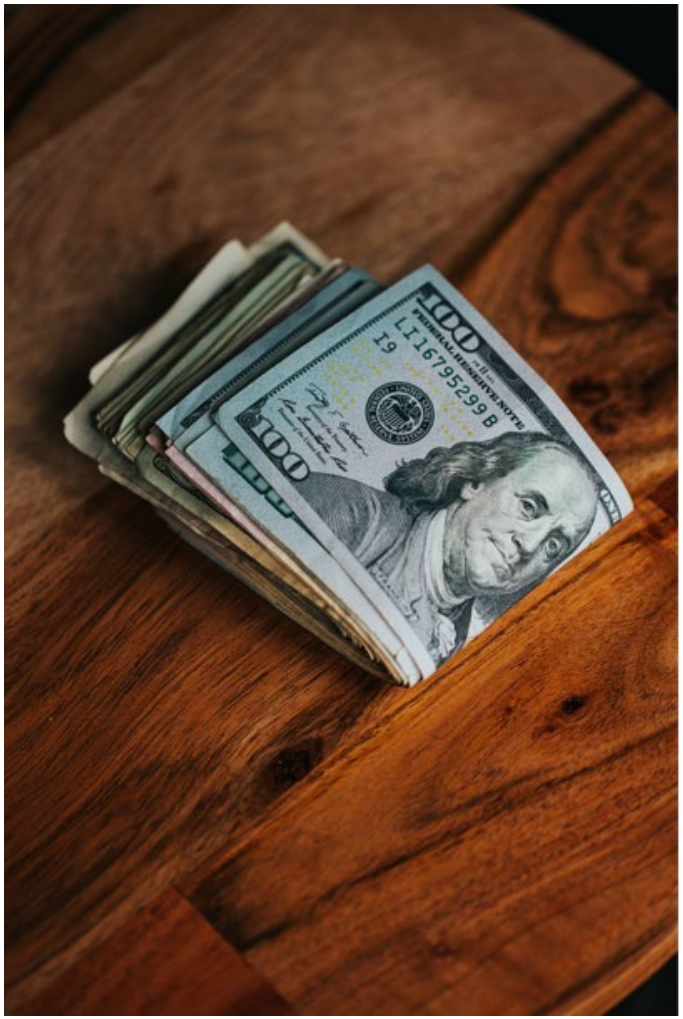

Photo credit: Nathan Dumlau

- Bundled payment beyond procedures to condition-based episodes of care with primary care providers and specialists
- Episode-based payment within accountable care models
- Accountable care and total cost of care models…moving along the glide path to sharing financial risk with health care providers
- Global payment

BENEFIT DESIGN

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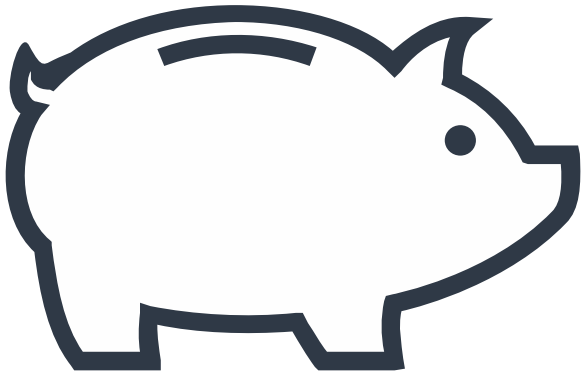
Unmet Care Due to Cost



Percent of adults with commercial coverage who went without care due to cost

'13	'16	'17
7.5%	9.5%	9.7%

(Lower is Better)

Analysis by Catalyst for Payment Reform 2019, BRFSS data (CDC) 2013-2017

More High-Value Care, Less Low-Value Care

Alternative to "Blunt" Consumer Cost Sharing: Value-Based Insurance Design (V-BID)

- Sets consumer cost-sharing on clinical benefit – not price
- Little or no out-of-pocket cost for high value care; high cost share for low value care
- Successfully implemented by hundreds of public and private payers

Source: Mark Fendrick, MD, V-BID Center, U. Michigan

High-Value Benefit Designs are Taking Off, But Not Yet Prevalent

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High-value benefit designs encourage consumers to seek the right services.

22% of employers reduce out of pocket costs for high value services

10% increase costs for services that are overused

*2020 Willis Towers Watson Health Care Delivery Survey

Innovative Benefit Designs Can Work: Centers of Excellence Case Study

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Walmart's Centers of Excellence program

- Walmart identified providers with a track record of delivering high-value spinal care, pursuing multiple partners across geographies for direct contracting.

A voluntary program requires a benefit design with substantial financial incentives

- Covers 100% of the patient's costs for the evaluation, surgery, and travel.
- Surgeries at non-COE providers are out-of-network and subject to 50% co-insurance.
- Those with HDHPs and HSAs must meet their deductible prior to full coverage.

Leveraging bundled payment

- Two separate pre-negotiated prospective bundled payments (evaluation and surgical)
- No additional financial incentives or payments for providers, with exceptions for outliers.

Results

- Evaluations found surgery medically inappropriate in around 50% of the cases.
- Fewer than 2% of associates told by COEs that they did not need surgery returned home and received surgery anyway.

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TRANSPARENCY

Data Stewardship

Bold Strategies Require Transparency and Data

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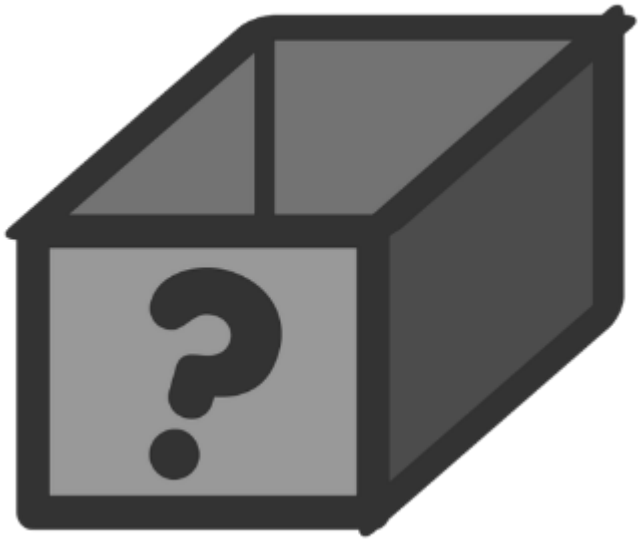
A Purchaser's Bill of Rights: Tenets of Data Stewardship

1. **Data Ownership & Access:** Self-insured purchasers **own their claims and clinical data** and have the right to **access and share data** with business associates.

2. **Data Use:** Self-insured purchasers retain the right to **use data to fulfill Plan Fiduciary obligations**.

3. **Data Timeliness & Accuracy:** Purchasers expect to receive **complete and accurate data delivered on time**, and at a pre-determined frequency.

Commercial Claims Data are Valuable; Not Everyone Wants to Share



- "I can provide you these data, but not this piece with it."
- "These data are proprietary now that we've _____ it."
- "We can't share this with ___ because they are a competitor of ours."
- "That DUA does not cover your request for those data. We'll need another one."
- "It will take us _ months to program those data to go to ____."
- "We'll look into why you only received _% of the data and why it's inconsistent"

CPR Offers Free Tools to Help Purchasers Reclaim Data

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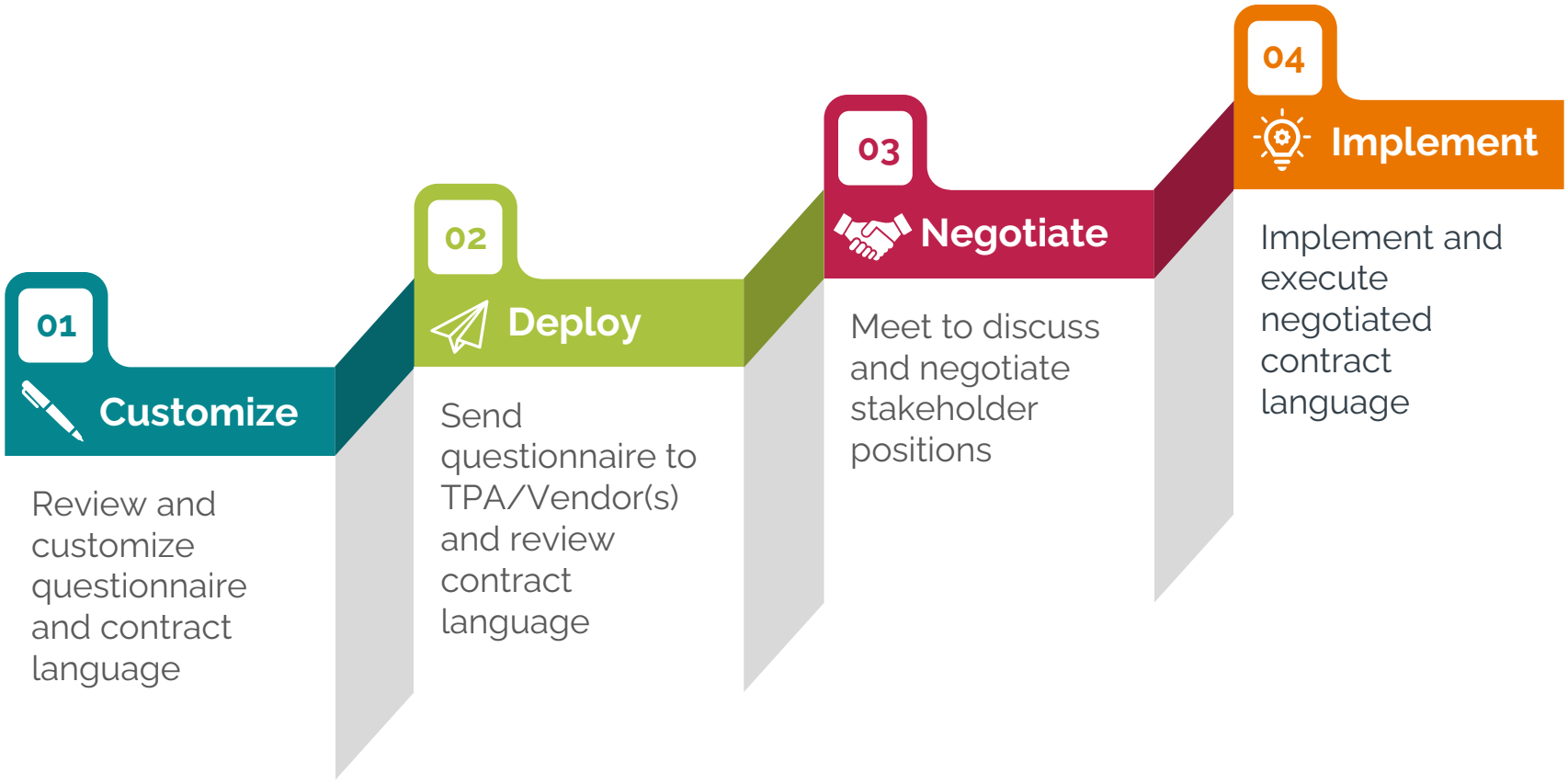
ROAD MAP FOR 2023



Standardized Reporting by Health Plans

What Happens When Reporting on Reforms is not Standardized?

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Pop Quiz:
How can it be that every single payment reform program knocks it out of the park?

~~A. Every payment reform program is a miracle!~~

~~B. Program administrators are pulling the wool over our eyes~~

C. Without a standardized methodology for program evaluation, administrators can cherry-pick favorable results

CPR Created Reform Evaluation Frameworks or "REFS"

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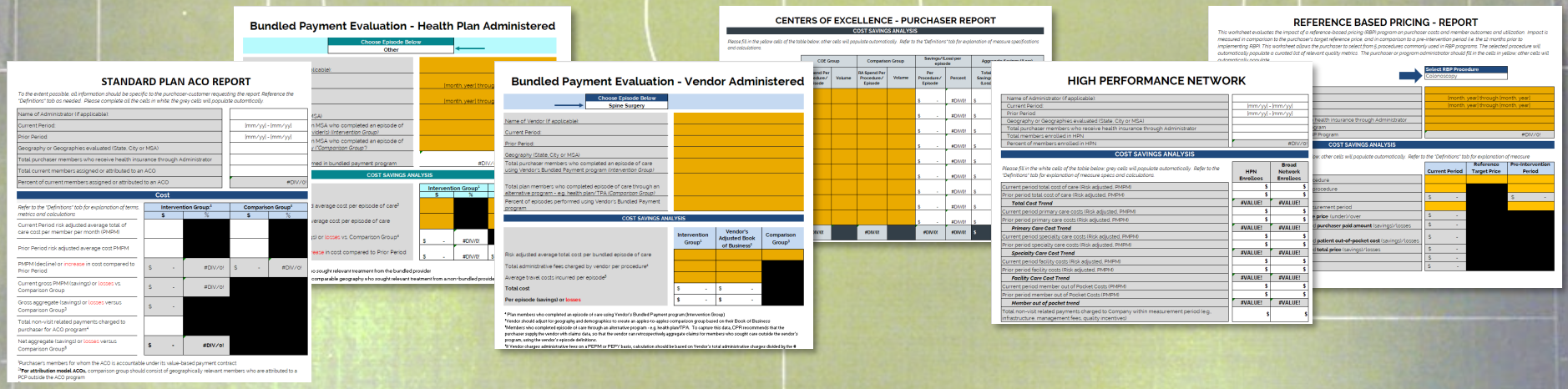
STANDARD PLAN ACO REPORT (SPAR) | **BUNDLED PAYMENT (Health plan)** | **BUNDLED PAYMENT (Vendor)** | **CENTERS OF EXCELLENCE** | **HIGH PERFORMANCE NETWORK** | **REFERENCE BASED PRICING**



REFS provide a standardized template to compare cost, quality, utilization and experiential outcomes, using relevant metrics and an appropriately identified comparison group

Standard Plan ACO Report

- Provides purchasers with a **standard, easy way to identify the value** of their health plans' ACO arrangements.
- Meaningful and comprehensive cost, quality and utilization metrics help purchasers **assess whether care is improving, staying the same, or getting worse**.

Standard Plan ACO Report

ACO Facts: Purchaser

To the extent possible, all information should be ***specific to the purchaser-customer*** *requesting the report. Reference the "Definitions" tab as needed.*

Name of Administrator:		
Current Period:	[month, year] *through* [month, year]	
Administrator		#
Total current members assigned or attributed to an ACO		#
Percent of current members assigned or attributed to an ACO		#VALUE!

Cost	Prior Period	Current Period
Total per member per month spend for non-attributed/non-assigned members (specify if includes/excludes Rx)	$	$
Total per member per month spend for attributed/assigned members (specify if includes/excludes Rx)	$	$
Total cost of care (health care spend of ACOs)	$	$
Total savings produced or overspending (gross gains or losses)	(+/-)	(+/-)
Total gains or losses shared with ACOs	(+/-)	(+/-)
Total per member per month savings or losses generated from participating in the ACO	#VALUE!	#VALUE!
Total non-visit related payments charged to Company (e.g., infrastructure, management fees, quality incentives)	$	$

Inspired by the Nutrition Label

HEALTH POLICY REFORMS

How do we Further Level the Playing Field?

Photo credit: Markus Spiske

Key policies could help level the playing field for employer-purchasers, enhance competition on the right things (e.g. quality) and contain prices.

Some examples include:

- Massachusetts ban on anti-tiering/steering provisions in provider contracts as well as "most favored nation" clauses
- Rhode Island caps on increases in the prices health plans pay providers

Four-Course Policy Menu – Robust Eaters Select ≥One from Each Course

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Ban/Punish Bad Behavior	Prevent (further) Erosion of Competition	Regulate Costs and Prices	Build Oversight Infrastructure
Ban anticompetitive contracting practice, such as: • Anti-tiering/steering • "All or nothing" • Gag Clauses • Exclusive Contracting • Non-Compete Clauses	• Horizontal and vertical merger notification • Horizontal and vertical merger approval • Public option	• Cap OON prices at Medicare multiple • Health plan rate notification • Caps on State EE Health Plan prices • Cap provider prices and/or price increases • Cap insurance premium rates and/or rate increases • Global budgets	• All Payer Claims Database + staffing and resources to administer • Independent Health Care Cost Commission + staffing and resources

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THANK YOU

Suzanne Delbanco, Ph.D.
Executive Director
sdelbanco@catalyze.org