

PATIENT CHOICE HEALTH CARE PAYMENT MODEL CASE STUDY

Pay For Performance Summit

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OUR GOALS

- ⦿ Force providers to manage cost and improve quality
- ⦿ Give consumers incentives and tools to migrate to better performing providers
- ⦿ Do this without requiring a miracle

A FEW OF THE BARRIERS TO CHANGE 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 COULDN'T SOLVE ON OUR OWN, AT THAT TIME

- ⦿ 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

HOW DID IT WORK?

- Created tiered network with unique payment strategy
 - BHCAG sponsored initially
 - Providers invited to organize and bid
 - Providers submitted bids based on their expected total cost of care for like patient populations with the same benefit set
 - Consumer premium and benefit incentives established to spur choice of better performing providers
 - Used variable FFS payment model—reimbursement rates driven by performance on total cost of care (aka virtual capitation, or “capitation in drag”)

A DIFFERENT PROVIDER ROLE

- Solicited bids from actual and provider organized “clinics without walls”
 - 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 define their market niche
 - can be small or large
 - gatekeeper or open-access
 - can focus on specific population
 - set their own price, contracted externally for many services
 - providers control care decisions
- Providers create their own brand and market position

BID AND PAYMENT PROCESS

I. PROVIDERS FORM CARE SYSTEMS

- Providers define their own network
- PCPs part of only one system, some overlap in hospitals and specialists.
- Minimum standards were established, but essentially all providers joined
- Original product, providers defined and contracted their own network. Newer product, INSIGHTS, contracts separately for specialists and hospitals

II. DATA ANALYSIS AND DISTRIBUTION

- Patients attributed to provider groups
- Data risk and catastrophic adjusted
- Provider cost of care performance analyzed, results shared with providers

III. PROVIDERS SUBMIT BID: $\text{Claim Target} = \text{Unit prices} \times \text{Utilization}$

- Patient Choice distributes easy to use bid model
- Providers submit pmpm bids derived by combining future prices with historical resource use
- Providers also allowed to establish “withhold” fund for management or other expenses included in total bid

BID AND PAYMENT PROCESS, CONT'D

IV. BID DETERMINES:

- Total cost benchmark for comparing providers to each other
- Total cost target for evaluation of actual costs to expected costs
- Future reimbursement level based on standard reimbursement structure
- Does not constitute a capitation rate

V. BID RESULTS COMBINED WITH QUALITY INFORMATION USED TO TIER NETWORK

VI. CONSUMERS CHOOSE PROVIDERS AND SEEK CARE

- Product offerings include premium or benefit incentives to choose better performing providers
- Products offerings include cost differences and quality and service info
- 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

BID AND PAYMENT PROCESS, CONT'D

VII. PROVIDERS ARE REIMBURSED FOR SERVICES RENDERED

- Providers paid FFS for services rendered based on fee levels that were submitted with the bid
- Reimbursement for non-traditional services such as care management fees, web and phone consults, and group visits can be allowed and are included in the total cost calculations
- Or, non-traditional services can be performed and funded through withhold or overall higher fees also in total cost calculations

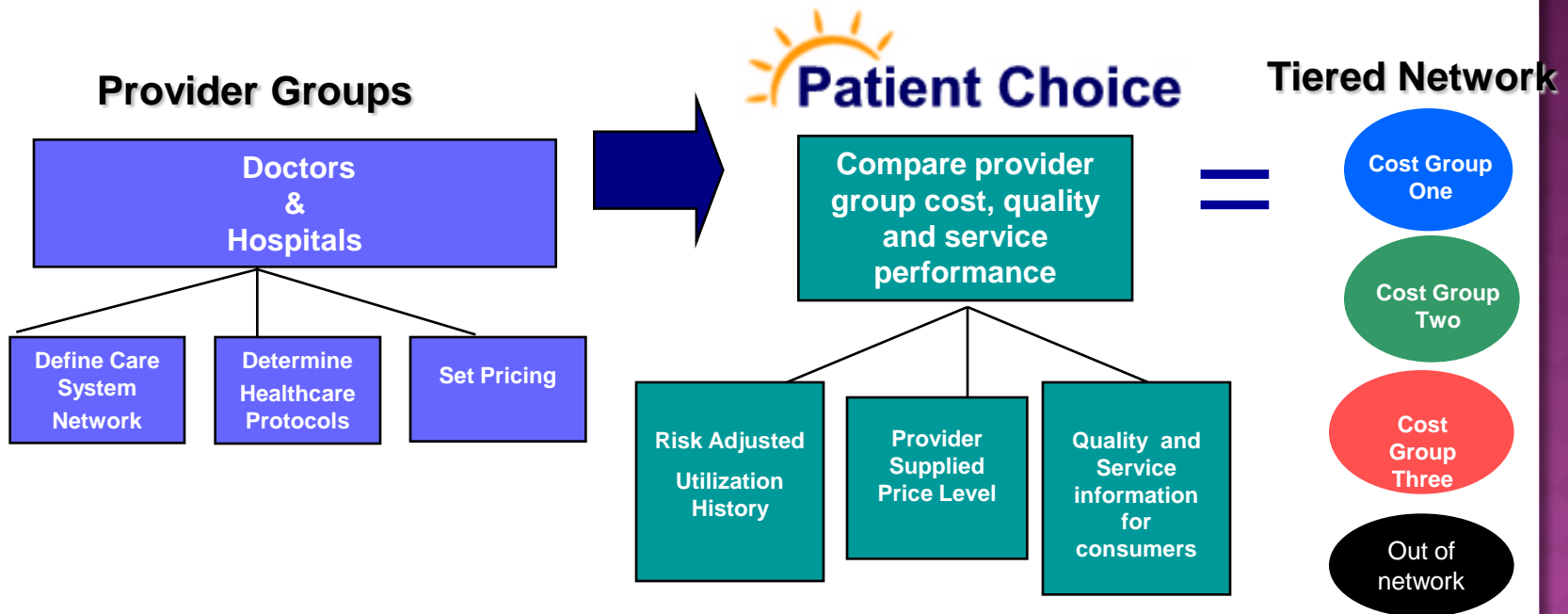
VIII. PROVIDER FEE LEVELS ADJUSTED QUARTERLY

- Actual risk adjusted provider performance against bid target calculated and compared to bid quarterly
- For FUTURE payments, performance better than bid results in next quarter fee increase, performance worse than bid results in next quarter fee decrease

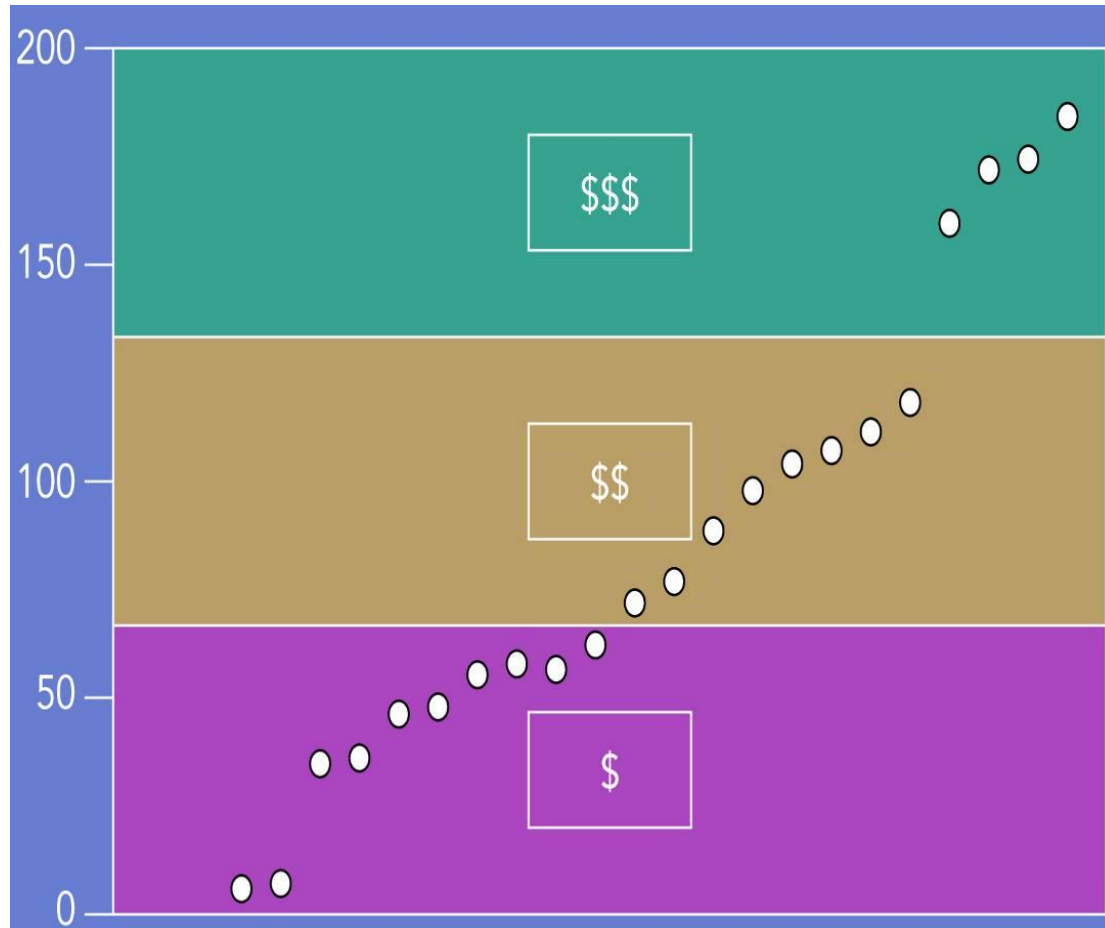
IX. PROCESS IS REPEATED ANNUALLY

- Providers submit new bid target
- Providers re-tiered relative to one another
- Consumers reconsider provider choices

PROVIDER GROUPS BID PRICES, PATIENT CHOICE DETERMINES TIERS



PROVIDERS TIERED RELATIVE TO EACH OTHER BASED ON RISK ADJUSTED TOTAL COST



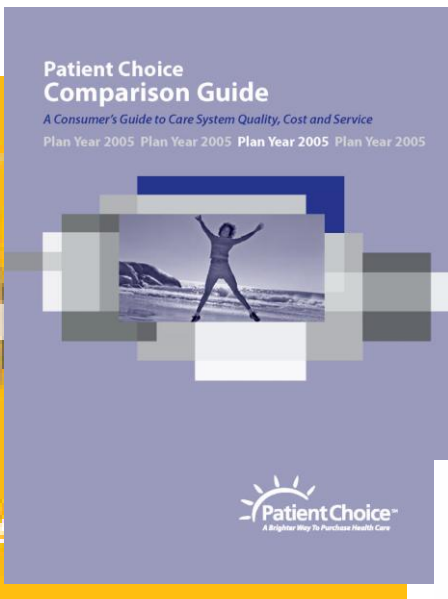
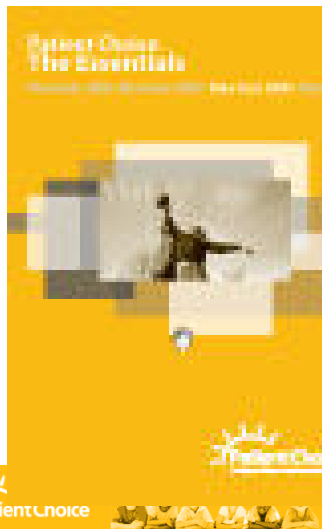
Each circle is a provider group

Providers within tier band are all presented at equal cost to consumer

Access to providers in higher tiers requires more premium or more cost sharing for consumers

Three tiers is arbitrary and done for administrative simplification purposes. More would be better

CONSUMERS SEE COST DIFFERENCES COMBINED WITH CONSUMER INFORMATION



- About Us
- Provider Directory
- Consumers
- 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

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

Report on Appendectomy

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. Being a member of one of the primary focus of The Leapfrog Group is a coalition of more than 100 public and private organizations that provide health care benefits to more than 24 million individuals.

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

program and about information and technology to implement goals and are highlighted below.

Internet Capabilities

There is growing interest among health plans 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	Appointment Scheduling	Billing, Invoicing, etc.	Prescription Refills	Lab Result Reporting	Emphasis	Physician Staff
Centennial Health Systems	1	1	1	1	1	1

Customer Service Capabilities

Many Care Systems have developed innovative programs and service enhancements to better meet your needs. This information will help you learn about some of the programs and services available. Care Systems have a place to prominently offer your care experience.

Care Systems Cost Group 1	Forming & Invoicing Apps	Same Day Refill Requests	24 Hour Health Advice Line	Medical Social Services	Electronic Prescribing	Health Educ. Programs
Centennial Health Systems	1	1	1	1	1	1

Patient Satisfaction and Access

This information shows what individuals think about key aspects of services and their overall care experience with Care Systems. Also shown is the overall patient satisfaction index with services provided to their children.

Care Systems Cost Group 1	Access & Continuity	Components of Adult Satisfaction	Physician Access	Integration of Care	Physician Time	Overall Satisfaction Adult Care	Overall Satisfaction Children Care
Centennial Health Systems	1	1	1	1	1	1	1

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 prevention care, as well as service and satisfaction levels. Care Systems that choose to participate were scored in three categories, resulting in corresponding health 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 for 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 Perf/Level	Physician Experience	Clinical Care	Patient Perf/Level	Physician Experience	Clinical Care	Patient Perf/Level	Physician Experience		
Centennial Health Systems	1	1	1	1	1	1	1	1	1	1	1

MULTIPLE CATEGORIES OF CONSUMER INFORMATION, NO ROLL UP METRIC

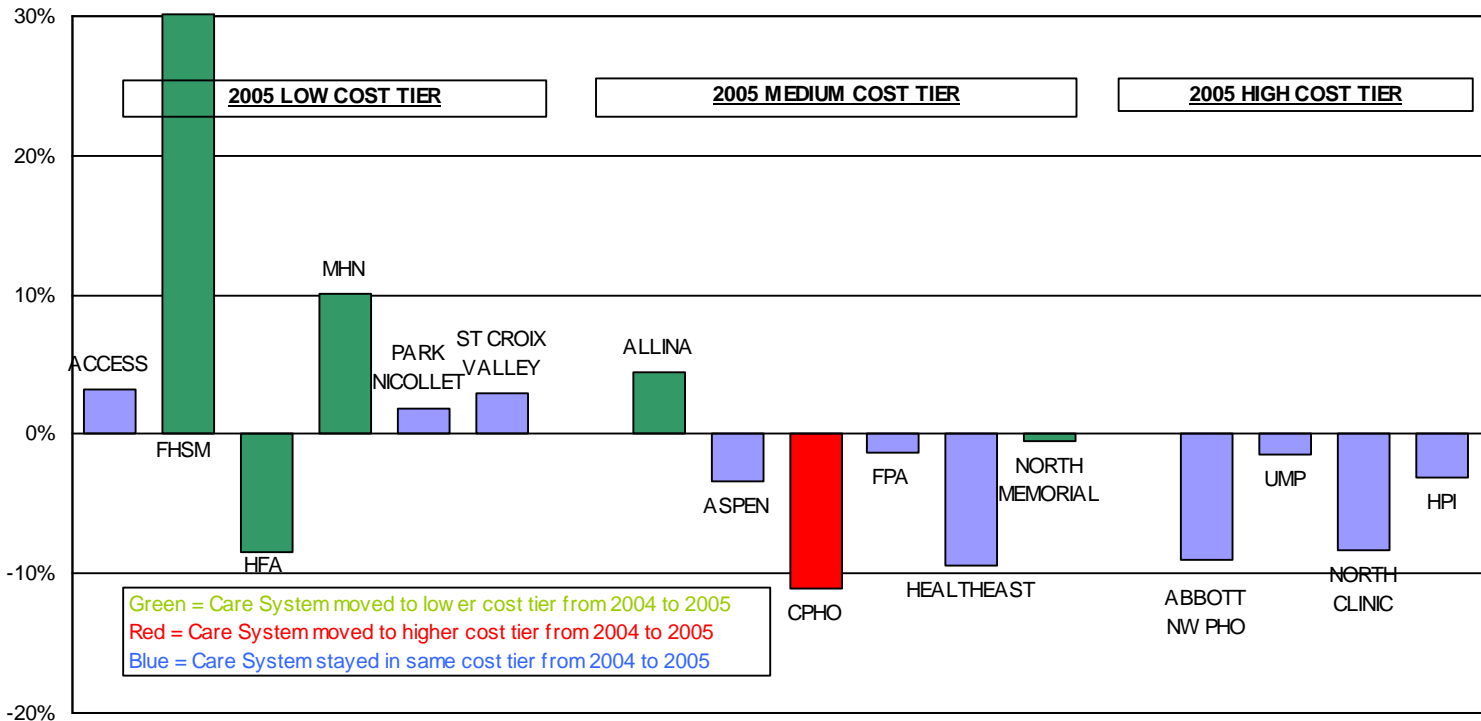
- ◉ Condition specific clinical performance
 - Diabetes, Asthma. CAD, Prev.
 - Care management capabilities
 - Outcomes (from MN Comm Measurement)
 - Condition specific patient feedback
- ◉ Customer service capabilities
 - Extended hours
 - Same day appointments
 - 24 hour health advice
 - EMR
 - ERx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

BETTER PERFORMING PROVIDERS ATTRACT MORE PATIENTS

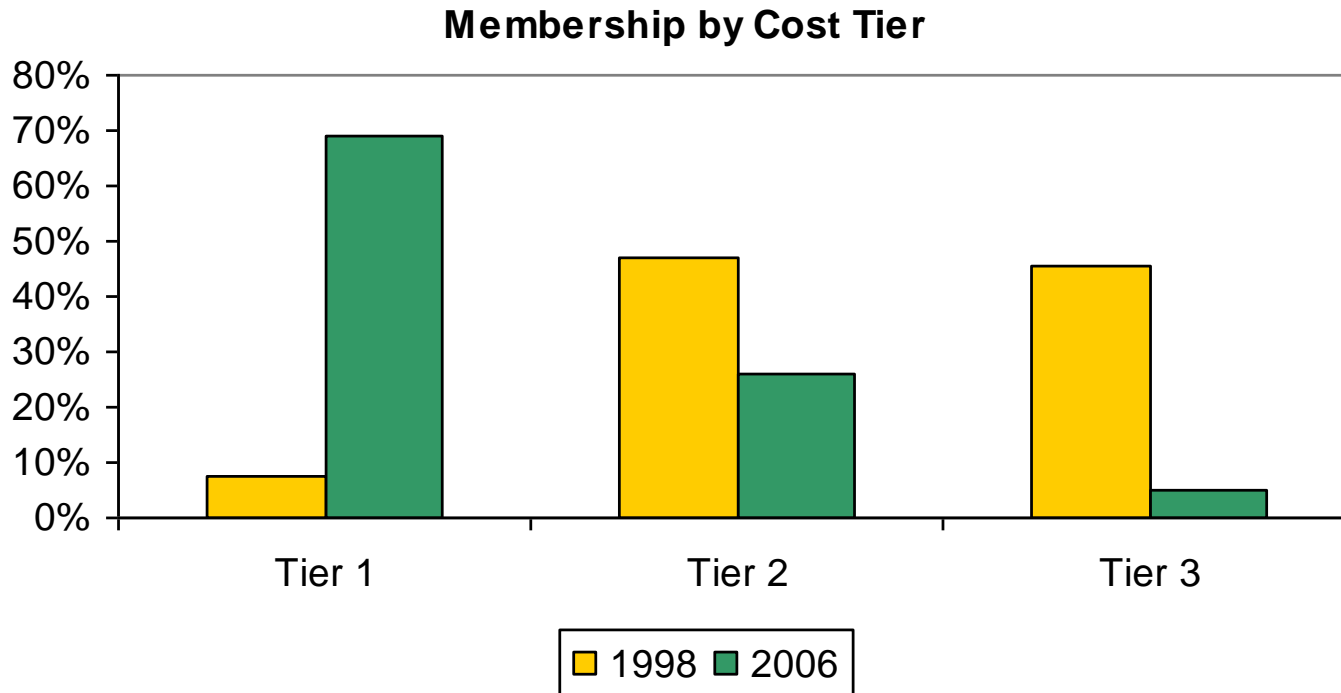
(SMALL INDEPENDENT GROUPS OFTEN PERFORM BEST)

PATIENT CHOICE CARE SYSTEM : % CHANGE IN MEMBERS ENROLLED IN BOTH YEARS
2005 OVER 2004

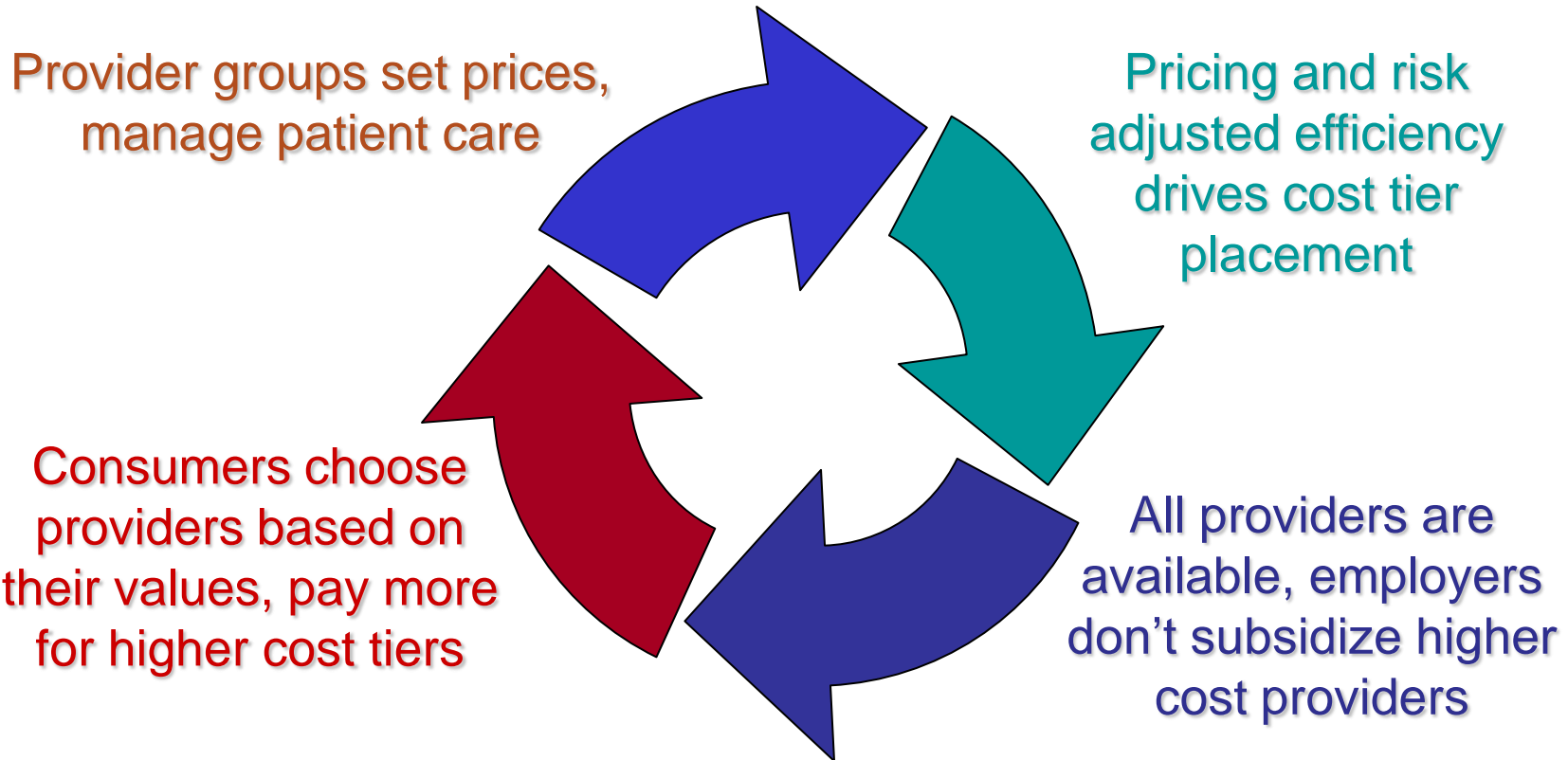
Metro Care Systems, Fully Implemented Employers



MARKET MIGRATES TO BETTER PERFORMERS



CREATES ONGOING DOWNWARD PRESSURE ON COSTS...



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

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	Manage resource use and prices	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

- ⦿ Offers a lower cost alternative
- ⦿ Doesn't require radical change or unacceptable levels of consumer or provider financial exposure
- ⦿ Gives consumers information so they choose their providers based on value
- ⦿ Creates a business case for quality

“85% of the value in health care is created at the provider organization level.

Patient Choice gets at the crucial issue in health care—how to drive change at the provider organization level by responsible consumer choice.”

Alain Enthoven, Stanford University, June 18, 2002

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, vs 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 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