

***Patient Choice Health Care
Payment Model
Case Study***

NRHI Payment Reform Summit

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What Were We Trying to Fix

- Provider apathy on cost and quality
- Consumer entitlement attitude and lack of awareness of cost/quality
- Black Box of health plan
 - All providers look the same to the consumer
 - No reason for providers to improve cost or quality



How Did It Work?

- Invented 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 virtual provider organizations
 - 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 participated
- In original product, providers contracted their own network. Newer product, INSIGHTS, contracts separately for specialists and hospitals

II. DATA ANALYSIS AND DISTRIBUTION

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

III. PROVIDERS SUBMIT BID: Claim Target = Unit prices X 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 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

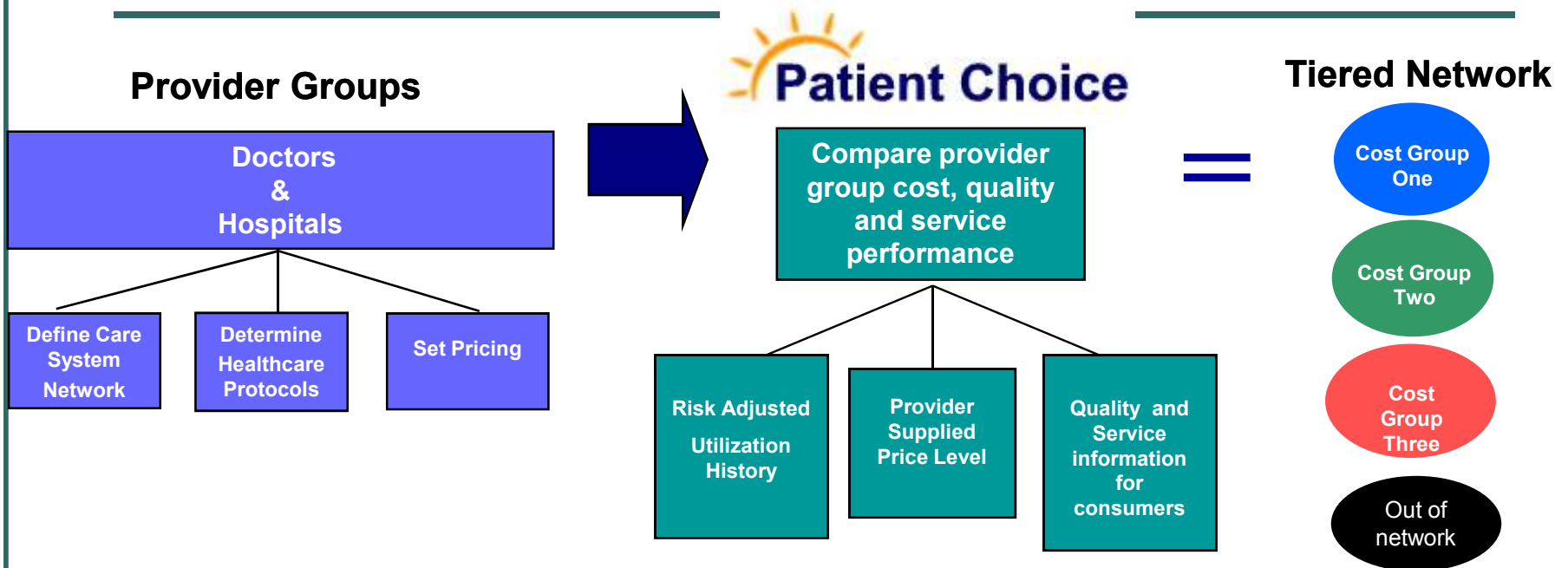
VIII. PROVIDER FEE LEVELS ADJUSTED QUARTERLY

- 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

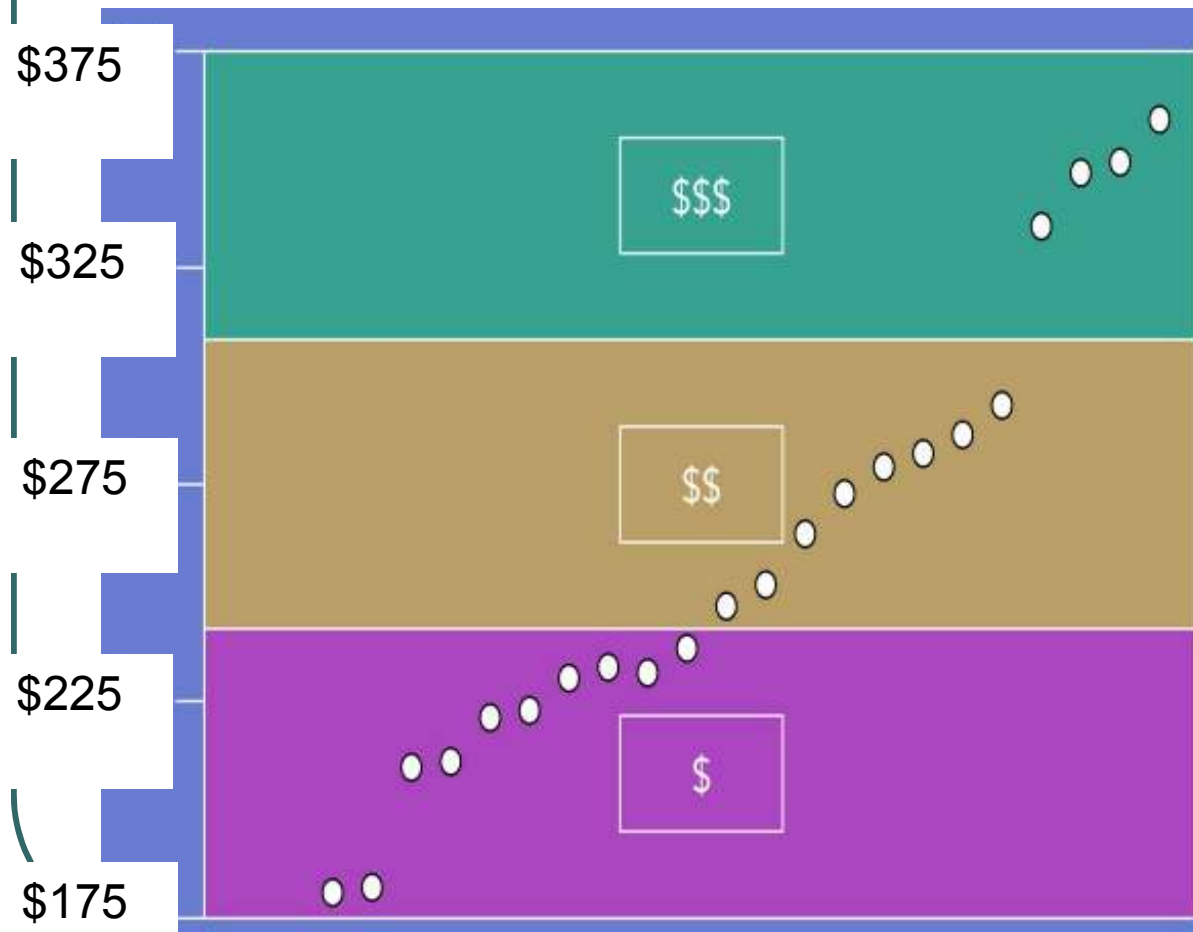
IX. PROCESS IS REPEATED ANNUALLY

- 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

...Combined With Array of 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 The Essentials

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 options you should consult to select a hospital, always consult your physician about what is best for you. [Click here for more information.](#)

Name	Rank	Index	Patient(s)/yr	Mortality	Complications	LOS	Cost
North Memorial Medical Center	1st	1.67	2nd	1st	2nd	1st	1st
Methodist Hospital	2nd	3.33	1st	9th	1st	2nd	2nd
Robert-Northwestern Hospital, Inc	3rd	2.67	3rd	1st	4th	4th	3rd
Healthnet St. John's Hospital	4th	5.00	5th	1st	3rd	3rd	5th
Fairview Southdale Hospital	5th	3.33	4th	1st	5th	5th	4th

Hospital Patient Safety

Internet Capabilities

Customer Service Capabilities

Patient Satisfaction and Access

Clinical Performance

Care System (Last Group)	Diabetes Care			Premenstrual Care			Gonorrhea/Chlamydia		
	Overall	Good	Not Good	Overall	Good	Not Good	Overall	Good	Not Good
North Memorial Medical Center	●	●	●	●	●	●	●	●	●
Methodist Hospital	●	●	●	●	●	●	●	●	●
Robert-Northwestern Hospital, Inc	●	●	●	●	●	●	●	●	●
Healthnet St. John's Hospital	●	●	●	●	●	●	●	●	●
Fairview Southdale Hospital	●	●	●	●	●	●	●	●	●

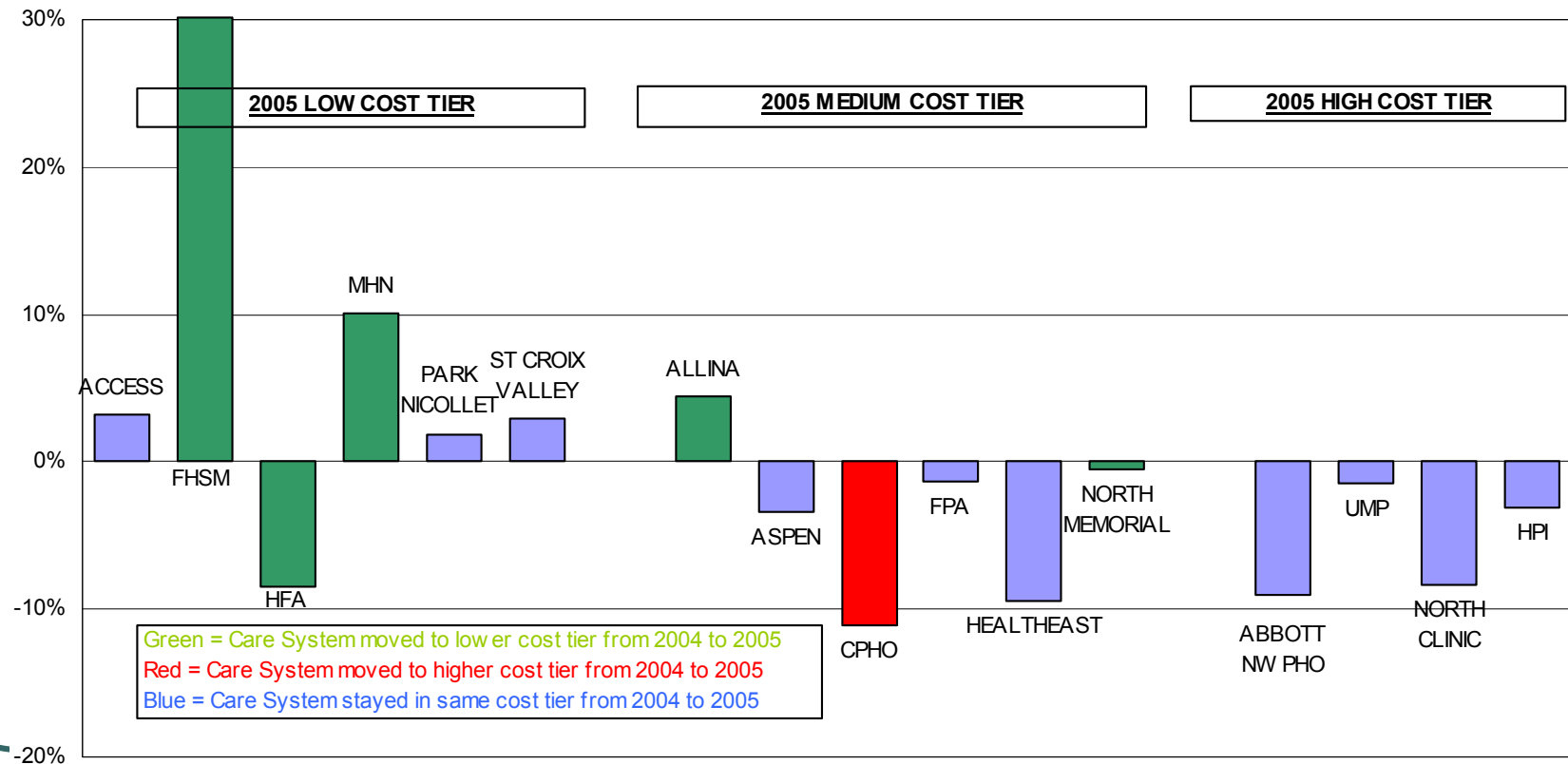
Multiple Categories of Consumer Information, No Rolled Up Metric

- 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

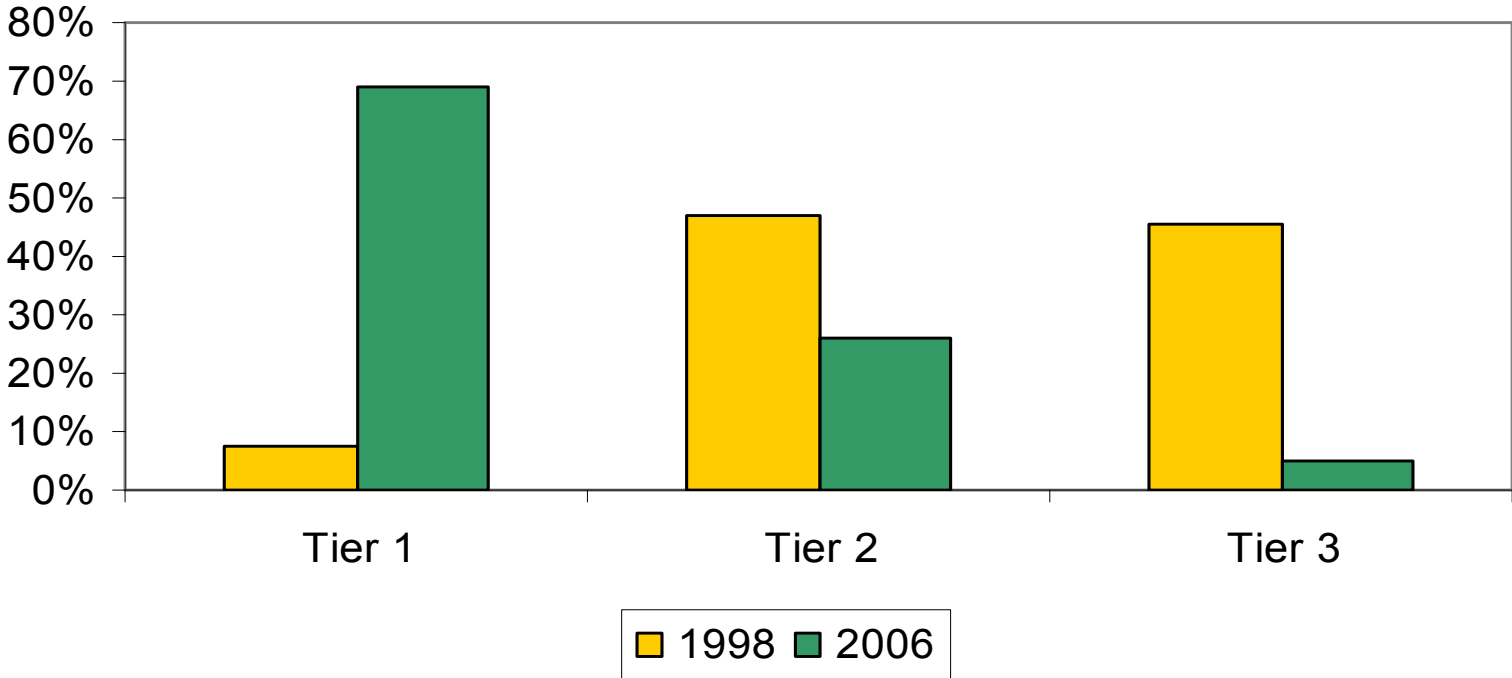
PATIENT CHOICE CARE SYSTEM : % CHANGE IN MEMBERS ENROLLED IN BOTH YEARS 2005 OVER 2004

Metro Care Systems, Fully Implemented Employers



Consumers Choose Providers

Membership by Cost Tier



Creates Ongoing Downward Pressure On Costs...

Provider groups set prices,
manage patient care

Pricing and risk
adjusted efficiency
drives cost tier
placement

Consumers choose
providers based on
their values, pay more
for higher cost tiers

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

THIS IS NOT 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

Consumer and Provider Incentives

Global Capitation	Patient Choice	Fee for Service
<p>Consumer: OOP cost is the same regardless of provider performance</p> <hr/> <p>Provider:</p> <ul style="list-style-type: none"> Consolidate to share risk and improve clout Maximize capitation amount Manage total cost including resource use and unit price Avoid sick patients 	<p>Consumer: OOP cost reduced by choosing providers that better manage risk adjusted total cost and quality</p> <hr/> <p>Provider:</p> <ul style="list-style-type: none"> Differentiate on cost, quality and service Manage total cost including resource use, unit price, pharmacy, avoidance of adverse outcomes, selection of specialists and facilities, etc. Attract and aggressively manage chronically ill (risk adjustment allows providers with sicker patients to compete fairly) 	<p>Consumer: OOP cost based on copays/coinsurance. No info on cost or quality variations. HDHP causes consumers to shop by unit price. No incentives after OOP met</p> <hr/> <p>Provider:</p> <ul style="list-style-type: none"> Consolidate to improve clout Maximize unit price Invest in high margin capacity Maximize volume of services Attract sicker patients to generate revenues

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

External Analysis of Results

- Consumers migrate to better performing care systems (AHRQ summer '02)
- Care systems respond:
 - Improved quality of care (Health Affairs 1/02)
 - Higher quality doesn't equal higher costs (J of Amer Mgd Care 5/02)
- “:...worthy of further consideration as a national model of healthcare reform.” (Financial Strategy for Managed Care Organizations, 2002)
- “Cause For Hope” (the Advisory Board, 12/02)

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 kind of provider infrastructure
- Could be modified for smaller, less organized markets, set up more like Patient Choice Insights
- Could bridge to other more granular approaches to reimbursement, eg Prometheus
- Plans can (and should) create similar products
- May work best in an individual, rather than a group, market
- Market conditions creating renewed interest in this type of solution, eg proposed legislation in Minnesota