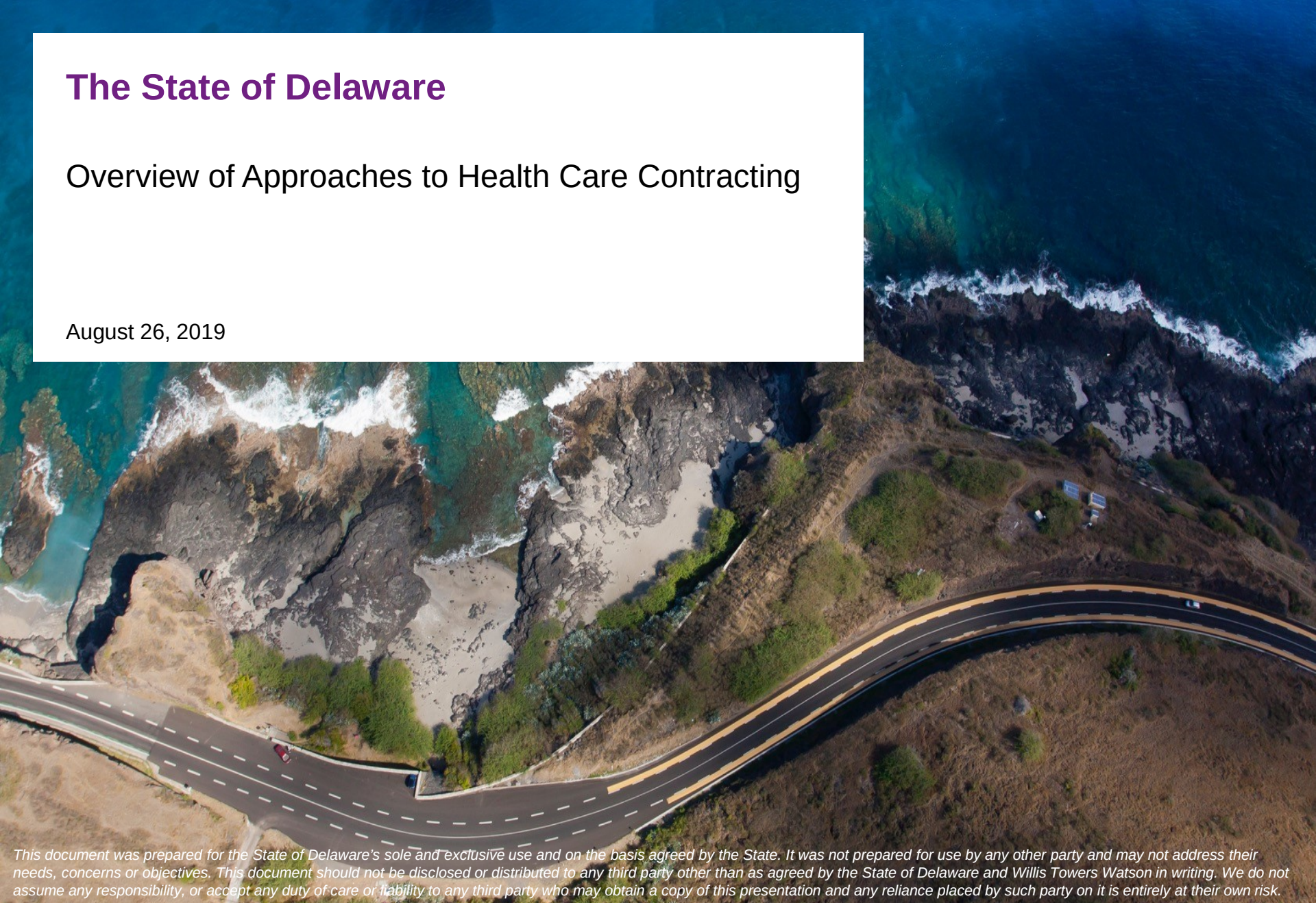
The State of Delaware

Overview of Approaches to Health Care Contracting

August 26, 2019



Willis Towers Watson

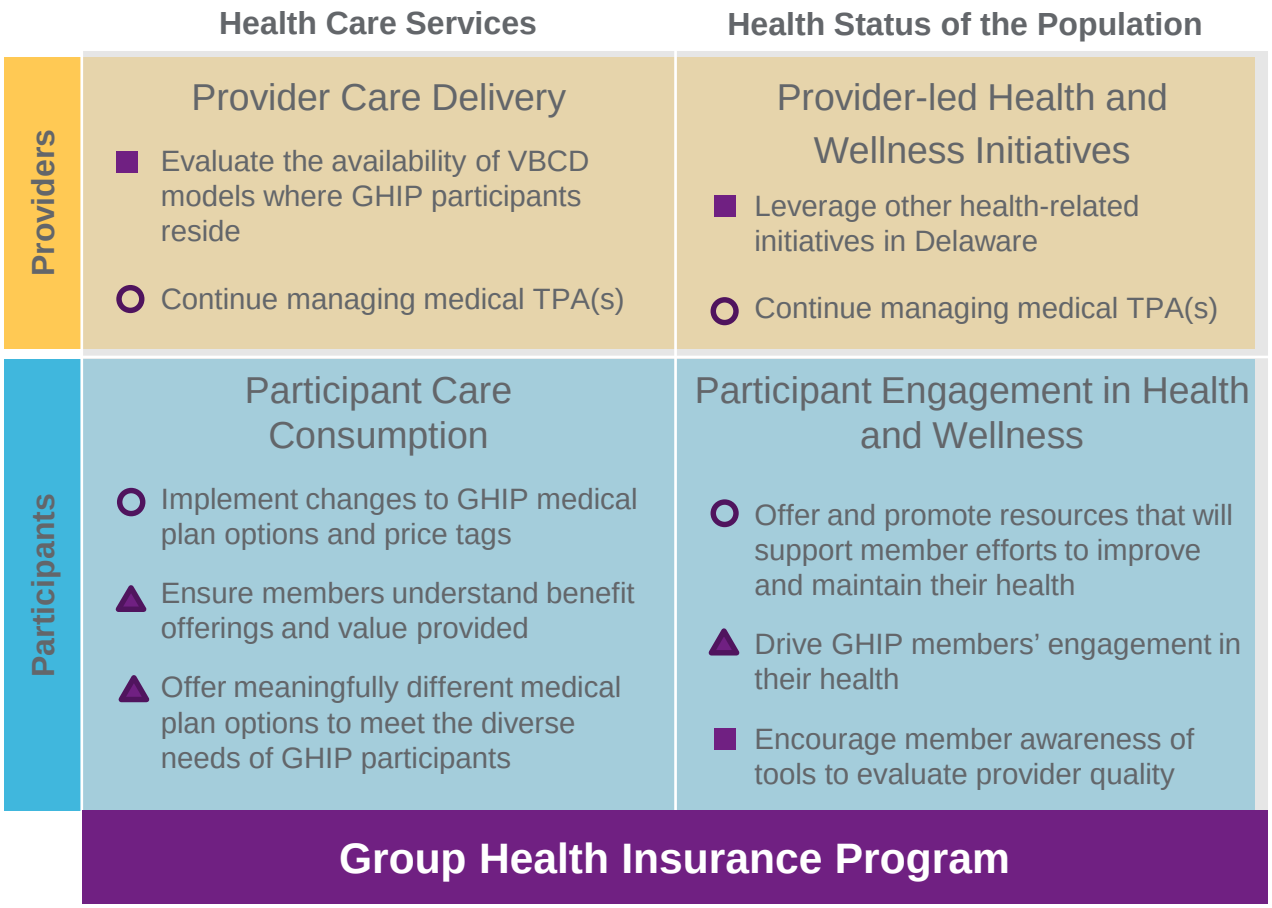
Today's discussion

- Conceptual framework
  - Role of supply and demand
  - Alternative Model Payment (APM) Framework
- Provider contracting overview
  - Provider contracting and payment basics
  - Categories of payment models within the APM Framework
  - Other approaches that fall outside of APM Framework
- Medical vendor presentations

GHIP strategic framework acknowledges role of *supply* and *demand* in managing cost and quality of care

Framework for the health care marketplace

GHIP strategies – *Linked to GHIP goals*



Goals:

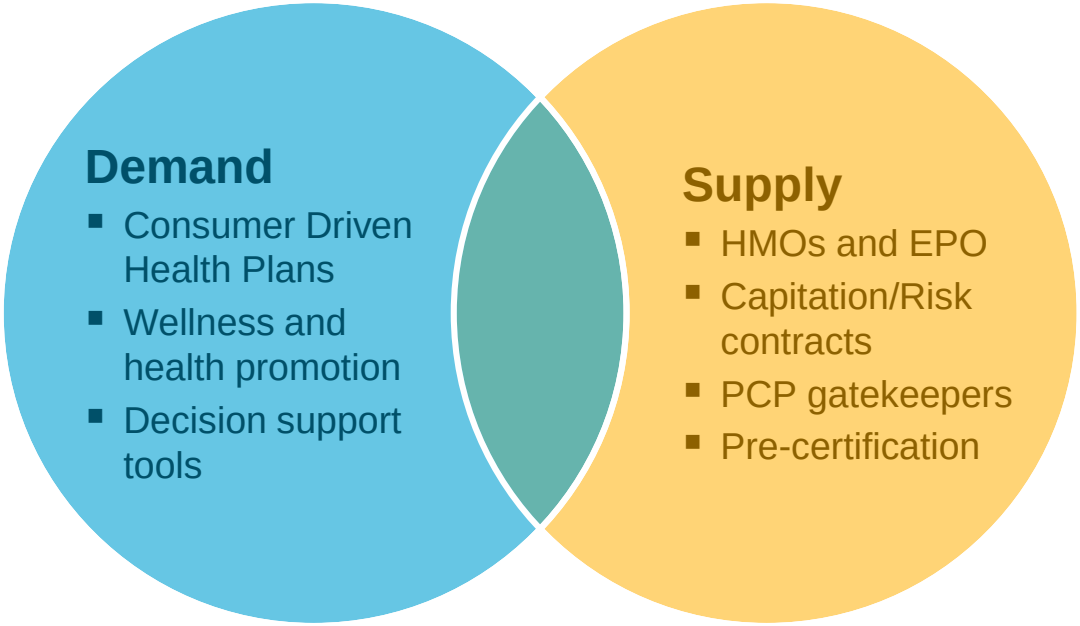
- Addition of at least net 1 value-based care delivery (VBCD) model by end of FY2018
- Reduction of gross GHIP medical and prescription drug trend by 2% by end of FY2020[1]
- GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of FY2020[2]

Supply

Demand

Traditionally, health benefits often cycled between either supply or demand strategies to impact cost and quality of health care services

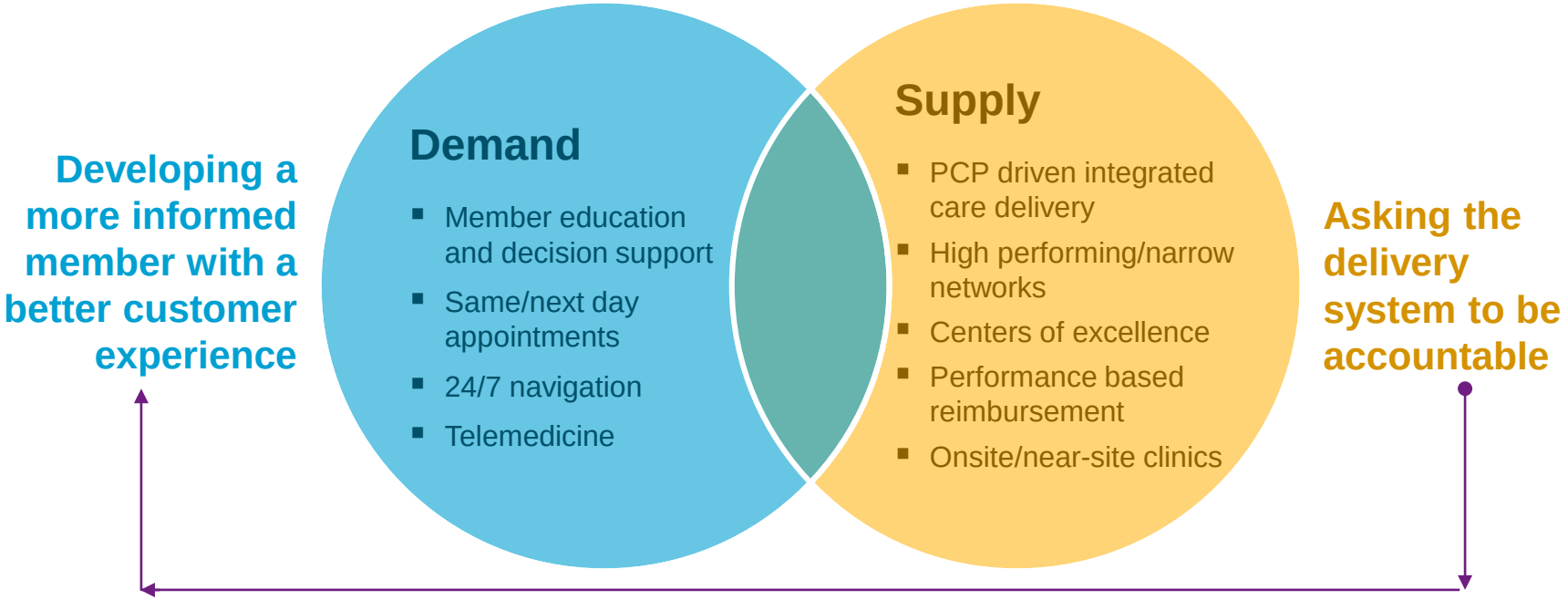
Asking the member to take the lead in managing care



Asking the delivery system to be fully responsible

Interventions that operate in a silo by addressing only supply or demand do not work well to simultaneously control cost in a sustainable way, make the provider more accountable and change the member health care shopping habits

Value-based payment models are grounded in supply-based strategies that leverage higher quality care to drive changes in demand



Other payment models – such as reference based pricing – do not necessarily focus on provider quality and differ philosophically from value-based payment models

Health Care Payment Learning & Action Network (LAN)

- Launched by the US Department of Health and Human Services (HHS)
- Public-private partnership established to accelerate transition in the healthcare system from a fee-for-service payment model to ones that pay providers for quality care, improved health, and lower costs
- Established the Alternative Payment Model (APM) Framework to track progress toward payment reform

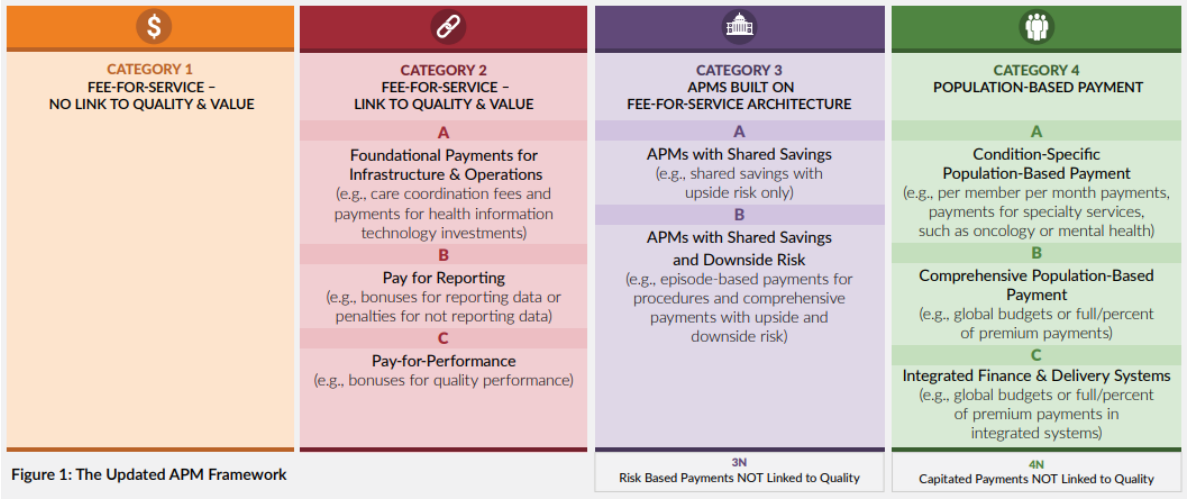


Figure 1: The Updated APM Framework

As payments move away from fee-for-service and towards pay-for-value…

Total cost of care ↓

Quality of care ↑

Overview of provider contracting will define APMs using the above framework as a guide

Principles of the APM Framework

1. Changing providers' financial incentives is not sufficient to achieve person-centered care, so it will be essential to empower patients to be partners in health care transformation.
2. Reformed payment mechanisms will only be as successful as the delivery system capabilities and innovations they support.
3. The goal for payment reform is to transition health care payments from FFS to APMs. While Category 2C APMs can be the payment model for some providers, most national spending should continue moving into Categories 3 and 4.
4. Value-based incentives should ideally reach care teams who deliver care.

Similar concept applies to *direct contracting* between an employer and a provider

5. Payment models that do not take quality into account are not considered APMs in the APM Framework, and do not count as progress toward payment reform.
6. Value-based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery, without subjecting providers to financial and clinical risk they cannot manage.
7. APMs will be classified according to the dominant form of payment when using more than one type of payment.
8. Centers of excellence, accountable care organizations, and patient-centered medical homes are examples, rather than Categories, in the APM Framework because they are delivery systems that can be applied to and supported by a variety of payment models.

Source: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

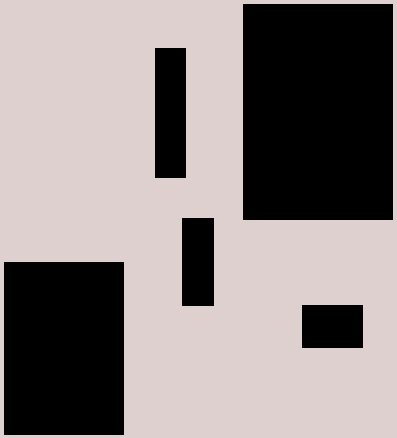
Ultimate goals of payment reform – *according to the LAN*

Making positive impacts on patient care and health

Patient-centered care: Patients and their care teams form partnerships around high-quality, accessible care, which is both evidence-based and delivered in an efficient manner, and in which patients' and caregivers' individual preferences, needs, and values are paramount.

Source: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

Provider contracting overview



Provider contracting and payment basics

- **In-network**: providers under contract with the health plan ("participating")
- **Out-of-network**: providers not under contract with the health plan ("non-participating")

	In-network / Participating	Out-of-network / Non-participating
Plan participant benefit level	"Preferred" benefit levels for participants in exchange for discounted payment terms for providers	"Non-preferred" / reduced benefit levels for participants
Reimbursement / payment bases *(defined in Appendix)*	Physician fee schedule, percentage discounts, capitation, performance-based risk sharing, inpatient per diem or DRGs (Medicare Diagnostic Related Groups)	"Reasonable and customary" (R&C), "usual and customary" (U&C) or percentage of Medicare physician fee schedule
Balance billing	Not allowed – Providers agree to accept contracted amount as payment in full	Possibly – Providers may balance bill excess of actual charges over plan reimbursement basis
Member cost sharing	In-network cost sharing based on plan's reimbursement basis	Out-of-network cost sharing based on plan's reimbursement basis, plus balance billing liability, if applicable
Other contract terms	Providers agree to abide by various plan rules (e.g., prior authorization) and to file claims on behalf of members	N/A

Special situation: OON hospital-based physicians (ERAPs – emergency, radiology, anesthesiology and pathology) who are under contract with in-network hospitals

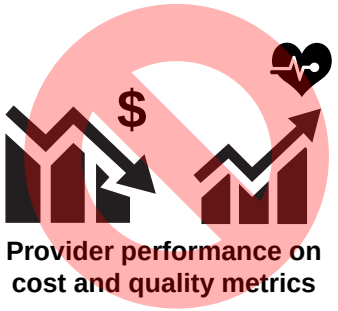
APM Category 1

Fee for Service – No Link to Quality & Value

- **Fee-for-service (FFS):** claims-based payments for units of service provided that are not linked to quality or value
- Payments are <u>not adjusted</u> for:

Infrastructure investments (e.g., health information technology)

Provider reporting of quality data



Provider performance on cost and quality metrics

- Includes bundled payments that are not linked to quality and value, such as:
  - Diagnosis related groups (DRGs) used to reimburse a group of services delivered within a hospitalization (due to hospital billing practices which are similar to physician FFS billing)
- Managed through “Demand”-based interventions
  - Reduced service utilization
  - Improved health status

APM Category 2

Fee for Service – Link to Quality & Value

- Payments are still based on FFS, but <u>are also adjusted</u> for one or more of the following:

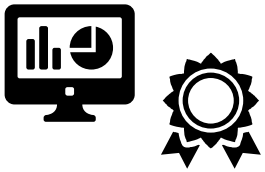
✓ **Infrastructure investments (e.g., health information technology)**

Category 2A

Payments for investments that can improve quality of patient care (no adjustments for quality outcomes)

Examples:

- Staffing for care coordination nurse
- Upgrades to electronic health records



✓ **Provider reporting of quality data**

Category 2B

Provide positive or negative incentives for reporting quality data to health plan and the public

Examples:

- Bonuses for reporting data
- Penalties for not reporting data

✓ **Provider performance on cost and quality metrics**

Category 2C

Reward providers that perform well on quality metrics[1] or penalize providers with poor quality metrics[1]

Examples:

- Higher/Lower updates to FFS baseline
- Receive % reduction or increase on all claims paid

1 Measured on a limited set of metrics, not aggregate cost targets.

APM Category 3

APMs Built on Fee for Service Architecture

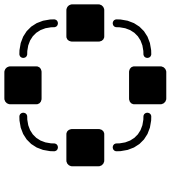
- Payments are still based on FFS, but provide mechanisms for effective management of a set of procedures, an episode of care, or all health services provided to individuals
- To do this, payments are based on:

Other features of Category 3:

- ✓ Provider accountability for measures of *appropriate care*[1]
- ✓ Multiple providers responsible
- ✓ Retrospective basis for risk payments

✓ **Cost performance against a target**

(regardless of how benchmark is established, updated or adjusted)



✓ **Encourage providers to deliver effective and efficient care**

(via care coordination and financial accountability)

Category 3A

Shared savings for providers that meet cost (and sometimes utilization) targets, if quality targets are met

<u>Does not</u> compensate payers for portion of losses if target is missed

Example: Shared savings with upside risk only

Category 3B

Shared savings for providers that meet cost (and sometimes utilization) targets, if quality targets are met

<u>Does</u> compensate payers for portion of losses if target is missed

Example: Shared savings with upside *and* downside risk

1 Adheres to evidence-based guidelines and comparative effectiveness research; avoids unnecessarily costly, harmful and unnecessary procedures; intensity is commensurate with patient's preferences; and reflects outcome of shared decision-making among patients, their caregivers and their clinicians.

APM Category 4

Population-Based Payments

- Payments are prospective and population-based, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within one of the following:

✓ **A defined scope of practice**

Category 4A

Bundled payments for comprehensive treatment of specific conditions

Examples: Bundled payments for comprehensive treatment of specific conditions or for care delivered by particular types of clinicians

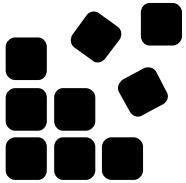
✓ **A comprehensive collection of care**

Category 4B

Cover the entirety of an individual's health care needs, in which payers and providers are organizationally distinct

Examples:

- Global budgets
- Full/percent of premium payments



✓ **A highly integrated finance and delivery system**

Category 4C

Cover the entirety of an individual's health care needs, in which payers and providers are integrated

Examples:

- Insurance companies that own provider networks
- Delivery systems that offer their own insurance products

Other features of Category 4:

- ✓ Prospective basis for risk payments
- ✓ Payments are *person-centered* -- include stronger incentives to promote health and wellness throughout the care continuum (for a primary or chronic condition, a limited set of specialty services, or an entire population)

Other approaches that fall outside of APM framework

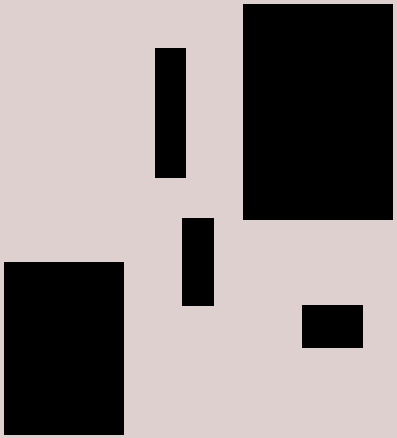
Global reference-based pricing

- Involves capping health care payments to providers at a fixed amount or "reference" price (e.g., at the Medicare reimbursement rate)
- Philosophically different than pursuing a value-based contracting approach
- Introduces the potential for significant provider disruption and possibly balance billing
- Implementation would require significant up-front investment of time and resources

Several states have implemented or explored this strategy:

- **Montana** – implemented in 2016; has seen $13.6M of savings in three years
  - Reference ceiling set at 234% of Medicare across all service types
- **Oregon** – legislation passed in 2017; will take effect for all state employees by 1/1/20
  - Reference ceiling set at 200% of Medicare across all service types
- **North Carolina** – passed by state board of trustees in 2019; scheduled to take effect in 2020
  - Reference ceilings have been recently revised by State Treasurer's office; average payments to medical providers increased reference ceiling from 182% to 196% of Medicare
  - Met with significant opposition from NC-based providers; while nearly 28,000 providers (including 5 hospital systems) agreed to reference ceilings, this number is less than half the total number of providers included in NC's State health Plan network for 2020
    - BCBS NC broad PPO network will be offered alongside NC State Health Plan Network for 2020 plan year

Medical vendor presentations

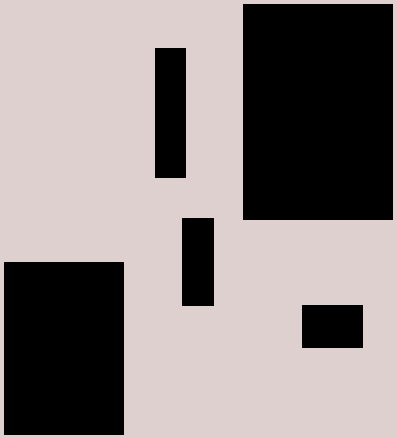


Medical vendor presentations

- Highmark and Aetna have been invited to update the SEBC on their efforts to establish APM contracts with Delaware providers
  - Highmark will present at today's meeting
  - Aetna will present at the next SEBC meeting on September 23rd
- Both vendors were asked to develop their presentations using the APM framework as a guideline which will allow the SEBC to compare both vendors' efforts using the same conceptual framework
- Each vendor will also present the results of a worksheet that quantifies the types of commercial APM contracts in place:
  - For the State Group Health plan vs. all other payers (public and private sectors)
  - For providers in Delaware, Maryland and Pennsylvania
  - For primary care vs. all other care (including inpatient and outpatient encounters)
  - For 2018 actuals and 2020, 2022 projections
- Note: The Committee may move into Executive Session for the purpose of discussion pursuant to 29 Del. C. § 10004(b)(6) to discuss the content of documents excluded from the public record under 29 Del C. § 10004(l)(2) (Trade secrets and commercial or financial information obtained from a person of a privileged or confidential nature)

Commercial Contract Description	LAN APM Category Type	Total Revenue	Total Claims Processed ($)	Total Fees at Risk ($)	Upside Fees at Risk		Downside Fees at Risk	
					%	Total	%	Total
Primary care only - State Group Health plan only	▪ Category 1 - Fee for Service - No Link to Quality & Value ▪ Category 2 - Fee for Service - Link to Quality & Value ▪ Category 3 - APMs Built on Fee for Service Architecture ▪ Category 4 - Population-Based Payment							
Primary care only - All other payers (public & private sectors)								
All other care - State Group Health plan only								
All other care - All other payers (public & private sectors)								

Appendix



Glossary of terms

Terminology	Acronym	Definition
Accountable Care Organizations	ACO	Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients.
Administrative Services Only	ASO	When an organization funds its own employee benefit plan, such as a health insurance program, and it hires an outside firm to perform specific administrative services. Also referred to as “self-funded”.
Bundled Payment	—	Lump sum payment covering all health care services related to a specific procedure, episode of care, or population. Bundle is usually based on an acute event plus some specified time period following the event. Payments may be risk adjusted based on the severity of illness/injury or complexity of the procedure(s) covered.
Capitation	—	Fixed payment amount (per member) to a physician or group of physicians for a defined set of services for a defined set of members. Fixed or “capitated” payment per member provides physician with an incentive for meeting quality and cost efficiency outcomes, since the physician is responsible for any costs incurred above the capitated amount. May be risk adjusted based on the demographics of the member population or changes in the member population. Often used for Bundled Payments or other Value Based Payments.
Chargemaster	—	Provider price list by procedure code, billed by providers to payers for each service rendered. Hospitals update their Chargemaster to ensure payers are not charged less than what payers initially agreed to pay. Chargemaster prices are generally set above the level that any insurer will pay to avoid losing potential revenue.
Diagnosis Related Group	DRG	A statistical system of classifying any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement. Payments may be risk adjusted based on the severity of illness/injury or complexity of the procedure(s) covered.
Direct Contracting	—	An approach in which an employer enters into a contract with a health care provider directly (as opposed to indirectly through a third-party administrator) for the provision of health care services to the employer’s covered population, usually with a value-based payment structure.
Evidence Based Medicine	—	An approach to medical practice intended to help providers make decisions about the best possible care for individual patients by using the best evidence available from well-designed, scientifically tested research.
Fee-for-service	FFS	A traditional method for reimbursing medical providers for the services they administer to patients, in which a provider is allowed to charge a fee for each service rendered to a patient. Fees for providers who participate in a third-party administrator’s network are typically determined as a percentage discount off of the provider’s billed charge.
In-Network	INN	Providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount and a contract that prohibits balance billing.
Inpatient Per Diem	—	A fixed payment for one patient day in the hospital, regardless of the hospital’s costs incurred for caring for that particular patient.
Metric Based Pricing	—	See Reference Based Pricing.

Glossary of terms

Terminology	Acronym	Definition
Out-of-Network	OON	Providers or health care facilities not contracted with a patient's insurance company, who may charge patients their full fees and collect any amount not covered by the patient's insurance company.
Patient Centered Medical Home	PCMH	A primary care physician who coordinates a team of clinicians providing a holistic approach to caring for a patient. Requires coordination across all elements of the health care system, including specialty care, hospitals, home health care, and community services. Often includes some sort of value-based payment to encourage favorable cost and quality outcomes. Also requires consistent and continual use of technology and data sharing to promote evidence based medicine and provide an enhanced patient experience.
Pay-for-Performance	P4P	See Value Based Payment.
Pay-for-Value	P4V	See Value Based Payment.
Percentage Discount	—	Negotiated reduction applied to the total list price by procedure that is excluded from the final charges billed to payers for services rendered.
Performance Based Risk Sharing	—	Contract arrangements that base payment for health care services on the health outcomes associated with those services. Performance based risk sharing requires data collection and either implicitly or explicitly links pricing, reimbursement and/or revenue to health outcomes/results.
Physician Fee Schedule	PFS	A list of charges for health care services. Health care providers keep fee schedules in their offices to specify the amount of compensation they want for providing selected services. Managed care organizations and other medical insurance providers publish lists representing the maximum charges they will reimburse for the same services. In many instances, the reimbursement offered by insurers is less than that charged by health care providers, in exchange for driving patient volume to those health care providers.
Reasonable & Customary	R&C	A charge that matches the general prevailing cost of that service within a geographic area. R&C charges are calculated by insurers to determine how much they are willing to pay for a given service in an specific geographic area. If a doctor charges above the reasonable and customary charge, the patient may have to pay the remainder not covered by the policy.
Reference Based Pricing	RBP	Plan sponsors pay a fixed amount or "reference" price toward the cost of a specific health care service, and health plan members must pay the difference in price if they select a more costly health care provider or service.
Usual & Customary	U&C	Allowable charges are based on community standards. Increasingly allowable amounts are paid based on a percentage of Medicare which can lead to higher member cost sharing.
Value Based Payment	—	Paying a medical provider for meeting a predetermined set of performance goal, including quality, cost efficiency and/or referral/prescribing patterns of care. The payment structure and performance goals will vary based on the provider's willingness to accept responsibility for meeting the goals (i.e., "upside" risk may include a bonus payment if goals are met, "downside" risk may require the provider to pay a penalty to the third-party administrator if goals are not met).