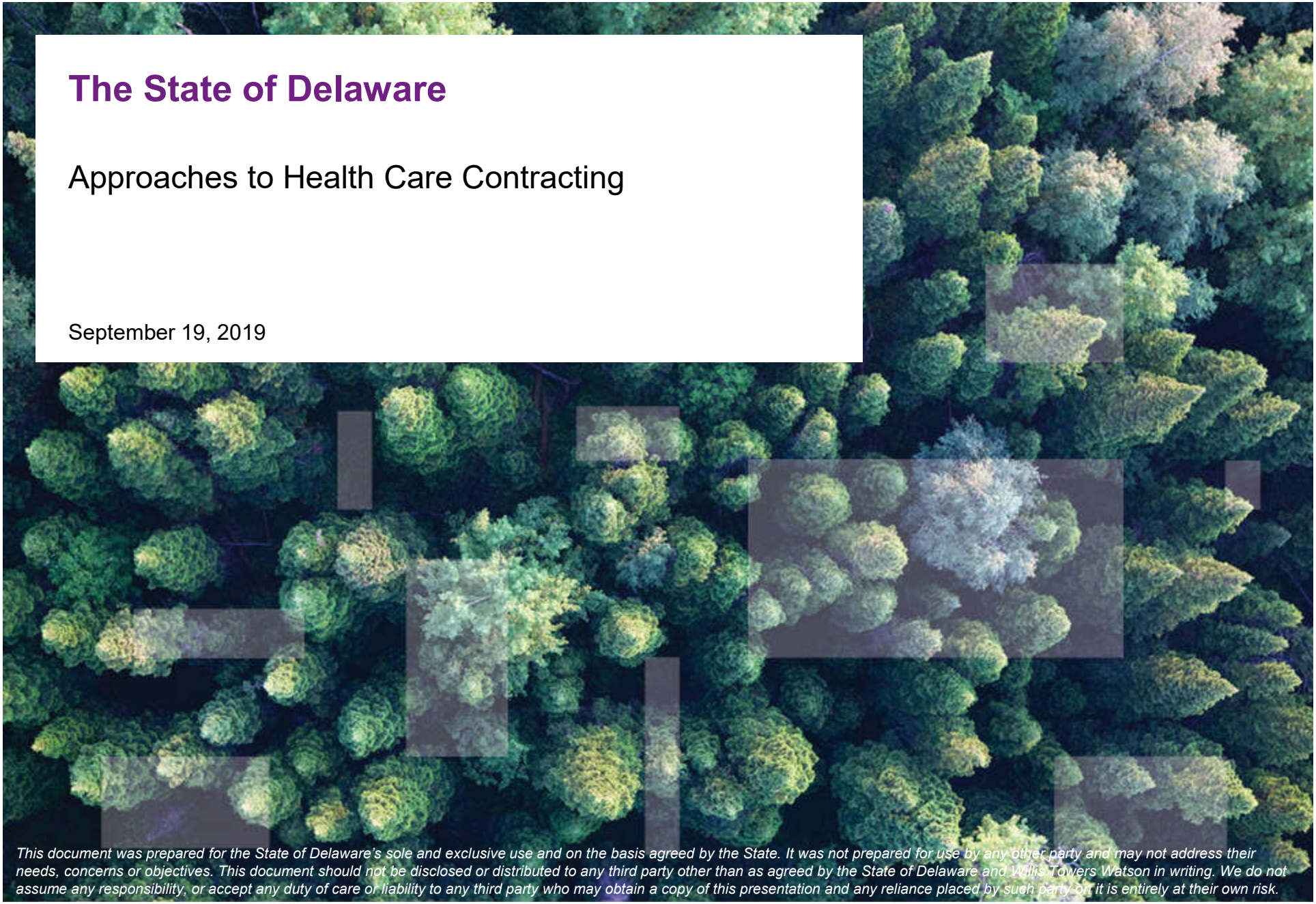


The State of Delaware

Approaches to Health Care Contracting

September 19, 2019

Willis Towers Watson

Today's discussion

- Conceptual framework
  - Role of supply and demand
  - Alternative Model Payment (APM) Framework
- Reference based pricing
  - Overview
  - Recent activity from other states
- RAND hospital price transparency project

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*

	Health Care Services	Health Status of the Population
Providers	**Provider Care Delivery** ■ Evaluate the availability of VBCD models where GHIP participants reside ○ Continue managing medical TPA(s)	**Provider-led Health and Wellness Initiatives** ■ Leverage other health-related initiatives in Delaware ○ Continue managing medical TPA(s)
Participants	**Participant Care Consumption** ○ Implement changes to GHIP medical plan options and price tags ▲ Ensure members understand benefit offerings and value provided ▲ Offer meaningfully different medical plan options to meet the diverse needs of GHIP participants	**Participant Engagement in Health and Wellness** ○ Offer and promote resources that will support member efforts to improve and maintain their health ▲ Drive GHIP members' engagement in their health ■ Encourage member awareness of tools to evaluate provider quality

Group Health Insurance Program

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

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

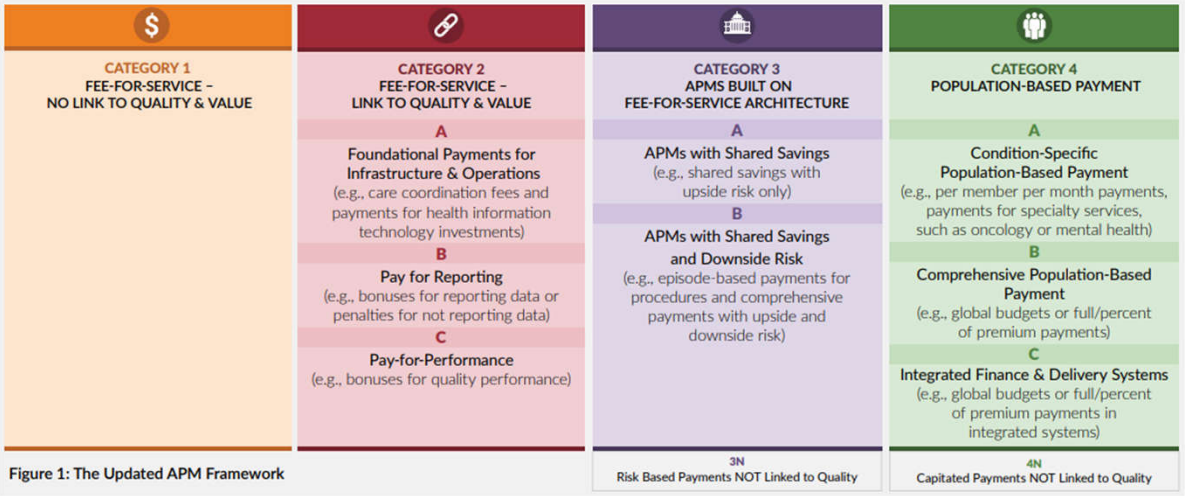


Figure 1: The Updated APM Framework

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

Total cost of care ↓

Quality of care ↑

Overview of provider contracting provided to SEBC on 8/26/19 defined 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.
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.

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

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

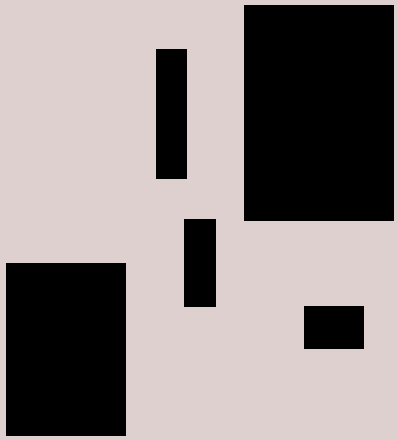
Ultimate goals of payment reform – *according to the LAN*

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

Reference based pricing



Reference based pricing overview

- Involves capping health care payments to providers at a fixed amount or "reference" price (e.g., at a fixed multiple of the Medicare reimbursement rate), in lieu of paying a discounted rate off the billed provider charge
- Philosophically different than pursuing a value-based contracting approach – ***falls outside of the APM framework***
- Introduces the potential for significant provider disruption and possibly balance billing
  - Health plan members must pay the difference in price if they select a more costly health care provider or service above the reference price
  - Balance billing likely if patient obtains care outside of the designated providers that have agreed to reference-based price
  - May be difficult to avoid depending upon the scope of the designated provider network
- Implementation would require significant up-front investment of time and resources
  - Substantial member education, communications, member advocacy and decision support tools are critical
- Historically, reference based pricing has been limited to a small number of elective procedures, usually those with high cost and local competition
  - More recently, some large public employers have considered global reference based pricing, in which reference prices are established for all services delivered by a given type of provider

Recent activity from other states

Several states have implemented or explored global reference based pricing:

- **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; modified during 2019; scheduled to take effect in 2020
  - Original plan:
    - Reference ceiling set at average of 182% of Medicare
    - Agreed to by nearly 28,000 providers (including 5 hospital systems), which will become the "NC State Health Plan Network"
    - Met with significant opposition from other NC-based providers
  - Revised plan:
    - Increased average reference ceiling to 196% of Medicare
    - BCBS NC broad PPO network to be offered alongside NC State Health Plan Network
      - Providers that did not agree to reference ceiling will keep their existing contracted pricing with BCBS NC
    - Providers in the NC State Health Plan Network will eventually be offered the opportunity to participate in alternative payment (value-based) arrangements (pending further details)

Compliance considerations for global reference based pricing

- ACA limits cost-sharing for essential health benefits in a non-grandfathered group health plan to $7,900 for self-only coverage and $15,800 for other than self-only coverage (2019)
- Employers offering a reference-based plan should:
  - Ensure adequate and timely access to high quality providers accepting the reference-based price
  - Have an easily accessible exceptions process when access to a provider that accepts the reference price is unavailable, or would compromise the quality of services for a particular individual
  - Exclude emergency services from reference-based plans, as members do not have the opportunity to shop
- Plans should fully disclose information about the pricing structure, including the services to which it applies and the exceptions process
- In addition, plans should provide the following specified information upon request:
  - A list of providers that will accept the reference price for each service;
  - A list of providers that will accept a negotiated price above the reference price for each service; and
  - Information on the process and underlying data used to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.

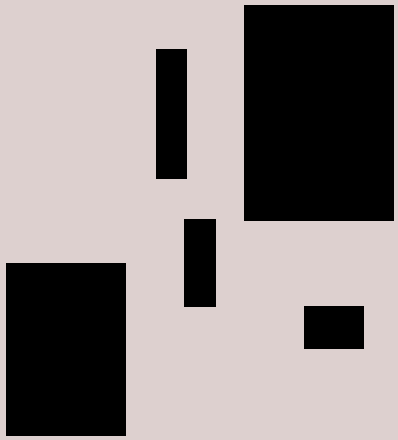
If a plan sets such a low reference price that few (if any) providers would be willing to accept the reference price as payment in full, the plan must count a participant's payments above the reference price toward the plan's overall cost-sharing limit. - ACA FAQs Part 31),

Willis Towers Watson Point of View

- Organizations considering reference-based pricing should seek substantial information regarding potential member liability, operations, and compliance
- The market is evolving rapidly, and hybrid plans are emerging that have some network contracting along with reference-based designs
- Organizations considering reference-based pricing should seek opinion from their counsel to be sure that plan complies with all appropriate laws and regulations
- Reference-based pricing will likely lead to more queries and complaints to Human Resources, which will need to be staffed and prepared for this

Disclaimer: *Willis Towers Watson shares available medical and pharmacy research and the views of our health management practitioners in our capacity as a benefits consultant. We do not practice medicine or provide medical, drug, or legal advice and encourage our clients to consult with both their legal counsel and qualified health advisors as they consider implementing various health improvement and wellness initiatives*

RAND hospital price transparency project



Background on the RAND hospital price transparency project

- Study is an ongoing employer-led initiative to measure and report publicly the prices paid for hospital care at the hospital- and service-line level
- Negotiated (allowed) prices paid by employers/TPAs were compared to Medicare reimbursement rates for the same procedures and facilities with adjustments for the intensity of services provided

Round 1	Round 2	Round 3
▪ Released October 2017 ▪ Data contributed by 12 self-funded employers representing about 225,000 covered lives ▪ Limited to 120 hospitals in Indiana ▪ Based on claims data from mid-2013 through mid-2016 ▪ Fully funded by the Robert Wood Johnson Foundation	▪ Released May 2019 ▪ Data contributed by about 50 self-funded employers, two state-based all payer claims databases (CO, NH) and health plans representing about 4 million covered lives **[Delaware not included]** ▪ Included nearly 1,600 hospitals in 25 states ▪ Based on claims data from 2015 to 2017 ▪ Funded by the Robert Wood Johnson Foundation and self-funded employers	▪ Results scheduled for release in Q1 CY2020 ▪ Delaware will be participating and will receive a custom report for GHIP experience ▪ Study authors are currently seeking additional participants (public and private sector employers) ▪ Based on claims data through 2018

Key findings from Round 2 of the RAND study

From **236%** to **241%**

Overall average employer payments to hospitals as a % of Medicare payments for the same services, from 2015 to 2017

Hospital Inpatient **204%**

Hospital Outpatient **293%**

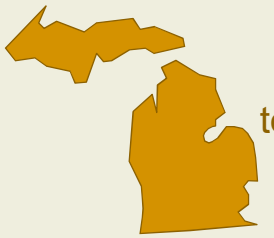
Multiple of Medicare pricing paid by employers, overall average in 2017

150% to **300%**

Variation in hospital pricing from state to state as % of Medicare in 2017

150% to **400%**

Variation in hospital pricing by hospital system as % of Medicare in 2017



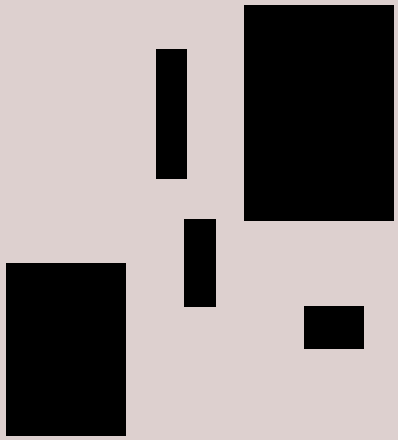
From **168%** to **156%**

Michigan: only state to experience a decrease in overall multiple of Medicare pricing, from 2015 to 2017

Medicare multiples for hospital inpatient and outpatient services were about equal for eight states

(MI, MO, TN, LA, NY, MA, NH, ME)

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).