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Medical Network and Payment Reform Strategies to Increase Health Care Value

By Emma Hoo
and David Lansky, PhD

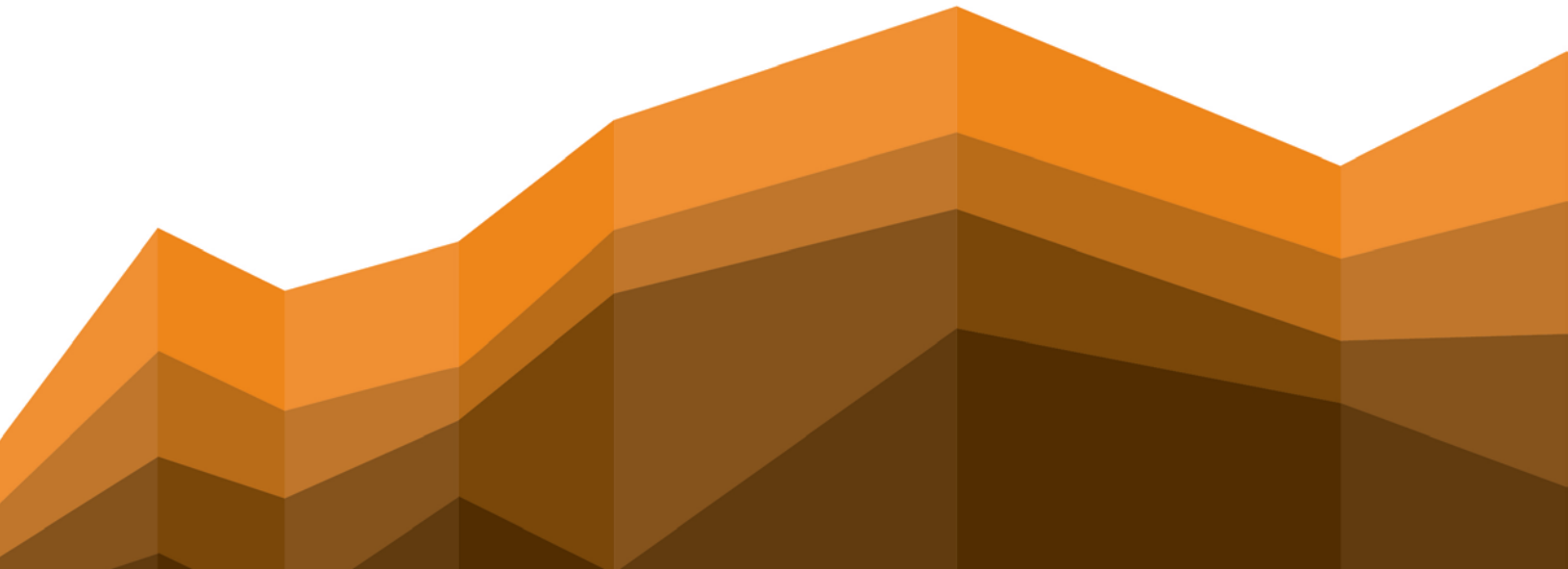


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Introduction

The trajectory of rising health care costs has moderated in recent years but remains unsustainable, for both government and American businesses alike. In contrast to government, though, large employers have a unique opportunity to be a catalyst for better health system performance that delivers on the Triple Aim of better quality, care and affordability. Employers recognize that most underlying payment structures incent volume, not value, in health care today. Meanwhile, major variation persists in the price and quality of care delivered. The root cause – as well as opportunities for improvement – lies in the organization and payment of physicians and hospitals.

As a result, employers are increasingly looking beyond traditional health plan relationships for solutions by working directly with providers, designing their own medical networks and promoting alternative payment models. Having consolidated health benefit offerings through a handful of national carriers, employers traded high-performing regional plans and provider relationships for administrative cost savings and broad geographic coverage. Underlying variation among providers is hidden through aggregated network discounts and plan-level quality measurement. Even as employers seek to offer the highest performing physicians and hospitals in terms of both quality and cost, carrier and provider consolidation limits choice and has reduced their negotiating leverage.

The heavy reliance on the traditional fee-for-service discounts between health plans and providers perpetuates the current market dysfunction, where providers are rewarded for volume instead of value. In the face of persistent challenges in cost and quality, large employers are embracing a new imperative to change this dynamic, not only by stepping up their value-purchasing strategies, but also by changing expectations about the transparency of performance differences.

A transformed health care system that continuously innovates and delivers better value necessitates changing provider payments to reward effective management of the total cost of care and holding providers accountable for health outcomes over time. To better activate key drivers for improving health care quality and efficiency, employers are strongly encouraging providers to redesign payment to promote innovation and value. When providers jointly hold financial risk for overall performance, there is less of an incentive to shift cost to other stakeholders, and providers are collectively motivated to coordinate services and improve clinical integration.

Background

Large employers rely heavily on health plans to deliver a suite of services, including benefits administration, medical management, customer service and network management. In self-funding health care services, costs are passed through from providers to health plans to employers. In the commercial sector, employers are the ultimate payers and bear most of the insurance risk of how the system performs. Yet employers have had very little control over health care delivery because the vast majority of dollars flow through Medicare and Medicaid, and providers primarily respond to those programs' rules and incentives. Worse, payment shortfalls in these public programs results in cost shifting to the private sector. Prescription drugs are another major cost driver and are addressed in a separate publication.¹

To date, employers have relied on relatively blunt instruments for managing health care costs – selecting health plans based on network discounts and provider access, and increasing consumer cost-sharing to mitigate cost trends. Changes in benefit design have increased adoption of consumer-directed health plans and high deductible health plans, but such approaches have had a limited impact on cost trends. Promotion of traditional wellness and disease management programs have had an even more modest effect.ⁱⁱ

The employers' tool box is changing. Employers are doubling down on opportunities to impact health care quality and costs at the source – by working more closely with high performing providers through select networks and providing better information to help employees make higher-value health care choices. Employers have been at the forefront of testing improved health care delivery models from primary care medical homes to telehealth. There is also a growing recognition that shifting the nexus of health management and education programs from remote health plan service centers to the provider-patient level significantly increases patient engagement and program effectiveness. However, such approaches can be challenged by disruption of legacy relationships, limitations in the existing administrative infrastructure, resource intensity for oversight and implementation, and potential for fragmenting care delivery.

The opportunity for employers has been augmented by changes in the policy environment and the Affordable Care Act (ACA), which have spawned an alphabet soup of pilot programs and payment models designed to reorganize how health care is delivered and increase provider responsibility in managing how health care dollars are spent.ⁱⁱⁱ The U.S. Health and Human Services administration set a goal to have 30 percent of Medicare payments in alternative payment models by the end of 2016 and 50 percent by 2018.^{iv} This goal has been met earlier than expected, with an estimated \$117 billion out of a projected \$380 billion Medicare fee-for-service payments were linked to alternative payment models as of January 2016.^v At the state level, the Medicaid waiver program has extended reform models to a broad array of providers and community clinics and many states are implementing State Innovation Models that bring private and public programs together.^{vi}

A Primer on Provider Network Models and Their Payment Structures

Many large employers recognize a need to change the current dynamic of volume-based incentives to value-based contracting strategies that better reward quality care and efficiency in resource management. But employers no longer believe that the key differentiation is among health insurance plans; it's about the differentiation of their provider networks and the underlying provider contracting arrangements.

One of the major challenges in transforming health care delivery is the large portion of employees enrolled in traditional PPO or Preferred Provider Organization insurance products. These plans rely on selective networks of doctors and hospitals that agree to a contracted rate of payment in exchange for volume or potential steerage of members. PPO enrollment has increased by 15 percent over the last 15 years.^{vii} Even as employers have adopted high deductible health plans and consumer-directed health plans, the underlying provider networks and delivery system remain on the fee-for-service-based PPO payment model.

Under PPOs, most providers enter into contracts individually or as small group practices, with little integration beyond traditional primary care to specialist referral patterns. The patient touchpoints are generally siloed with minimal interaction across physicians and their staff, hospitals and their discharge planning or other services, health plan utilization management and case management support – other than an occasional authorization process. For the most part,

providers are paid fee-for-service with their total revenue depending on more visits and more hospital stays from more patients.

More fully integrated provider systems began to emerge with the managed care revolution of the 1980s, which also introduced a wave of new payment designs that involved varying degrees of capitation and shared financial risk. Health maintenance organizations, or HMOs, often contracted with organized medical groups and their preferred hospital partners. However, the managed care backlash unwound many of these financial arrangements. Initial cost savings were not sustained as physician organizations and hospitals largely dismantled their jointly held, risk-based contracts. The value proposition of HMOs declined as each party sought to maximize payment under their own contractual arrangements and incentives were no longer aligned to jointly manage resource utilization and coordinate care. There are also a number of integrated health plan and provider systems. Examples of these high-performing health care delivery models include Kaiser, Health Partners (Minnesota), Intermountain (Utah) and Geisinger (Pennsylvania). Integrated care delivery models have fostered many innovations and quality care, but their efficiencies often do not translate to price leadership. However, many of the highest performing health systems serve only specific regions, which is challenging for large employers who find it easier to work with a single benefits administrator and want to provide and communicate consistent benefits offerings across the whole country.

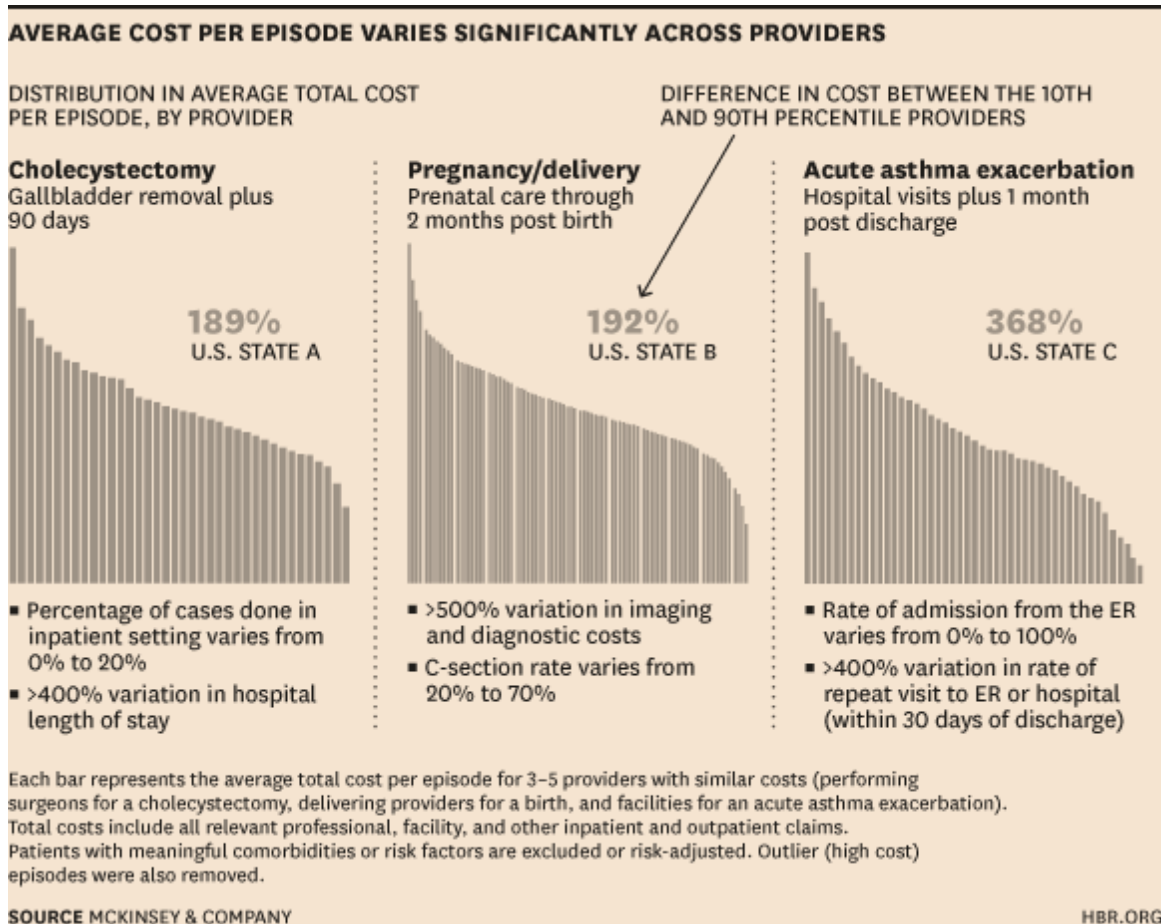
As health plans sought to differentiate themselves and offer lower cost options, they began to identify and offer products comprised of selected providers - narrow networks. While such approaches may have increased competition in select markets, employers often couldn't tell if these networks were designed based on deeper discounting, quality differentiation, or a combination of the two. Health plans began offering such high-performance networks to self-insured employers, but typically for an additional access fee pegged to an amount in-between the negotiated contract savings and the typical expected cost of using the full provider network. Perversely, networks presented with deeper discounts can beget higher volume and waste as providers increase billable services in response to lower unit prices.

Employers recognize a need to change the current dynamic of volume-based incentives to value-based contracting strategies that better reward quality care and efficiency.

The Affordable Care Act and the resulting “innovation” programs launched by the federal Centers for Medicare and Medicaid Services (CMS) has led to a proliferation of new models of care delivery, ranging from primary care medical homes (PCMHs) that tout team-based care, improved patient support and seamless delivery of health care to accountable care organizations (ACOs) that accept a population-based payment and financial risk for effectively managing the health care of that population. Most commercial health plans have created ACO products to respond to the changes in Medicare contracting, and also enticed their commercial customers to bring their populations into these same ACO products. Arguably, ACOs are not that different from the provider organizations that were contracted to provide integrated care delivery under the HMO designs introduced in the 1980s. Still, the payments for many of these “high-performance networks” are fee-for-service based, rewarding providers based on volume over value. The promise of improved care coordination and disease management leave employers wondering what they had been paying for in the first place through their plan contracts and ASO (administrative services only) fees for network access and care management.

Variation in Care and Cost

Apart from the structural challenges in how large employers pay for health benefits and implement value-based purchasing strategies, clinical variation in care is a persistent problem. Even though frequent measurement of select quality indicators for preventive and chronic care have reduced the gap in variation, major differences still persist. Addressing clinical variation is an important step in improving the quality and efficiency of health care delivery.



Beyond variation in the quality of care, the geographic differences in health care costs may be even greater. Volume differences in Medicare services have been well documented in The Dartmouth Atlas.^{viii} It is important to distinguish the variation driven by provider decision-making and differences in regional costs. For example, treatment of acute asthma that results in a hospital admission varies up to 100%, with more than 400% variation in repeat visits to the Emergency Department or hospital within 30 days of discharge.^{ix} Both may be unwarranted.

In 2009, Atul Gawande wrote about the problem of unnecessary care in McAllen, Texas, a community with nearly twice the Medicare per-capita costs than the national average.^x Whether influenced by public scrutiny or Medicare innovation programs, McAllen's costs dropped almost three thousand dollars per beneficiary between 2009 and 2012. Two primary care-driven accountable care organizations formed and subsequently saved Medicare a total of twenty-six million dollars, with 60 percent of those savings going back to the groups.^{xi} The Congressional Budget Office reports total per capita healthcare spending ranging from \$4,000 in Utah to \$6,700 in

Massachusetts. The Dartmouth Atlas found that among 306 hospital referral regions, Medicare spending per patient ranged from more than \$13,000 in some areas to \$6,900 in others.^{xii}

Provider (and consumer) treatment choices may reflect regional practice patterns, which in turn can reflect medical education as well as the supply of hospital beds in a community (such as for elective knee replacement surgery). Geographic cost variation can be impacted by local wage and price indices, as well as the level of provider consolidation and market competition.^{xiii} Importantly, geographic cost differences may also vary based on product lines, i.e., a favorable total cost of care rating for HMO products in one area does not guarantee a similar position for PPO products depending on both network composition and the structure of the contracts.

In opting for administrative savings through single national carriers, employers may forego medical cost savings opportunities through optimized provider contracts. The health plan with the best combination of high quality and efficient providers in Pennsylvania is likely not the same as the highest performing plan in Texas, let alone the highest performing network in Philadelphia compared to San Antonio. Even within a region, there can be marked differences in costs due to the level of provider consolidation. These cost differences translate directly to employers' bottom line in the pricing of their health insurance premiums and the cost of services delivered to their employees, retirees and covered dependents.

In the face of persistent challenges in cost and quality, large employers are facing a new imperative to change this dynamic, not only by ramping up their value-purchasing strategies, but also by turning up the heat on transparency of these performance differences. To better understand the potential levers on health care quality and cost, employers are moving deeper into provider-facing strategies that not only address how care is delivered, but also how provider payments ultimately impact the design of the health care system.

Provider Payment Models and Their Implications for Value

Employers no longer believe that ratcheting down unit prices – the traditional discounts negotiated by their health plan – will get us to a transformed health care system that continuously innovates and seeks to deliver value. This observation necessitates two developments: arranging payments that reward overall efficiency of resource use and holding providers accountable for the patients' outcomes over time. By shifting financial risk to the providers, employers hope to encourage innovation and competition and ultimately reduce total cost. The level of financial risk greatly influences the degree to which incentives are aligned among physicians, hospitals and other providers, which in turn promotes clinical integration. When providers jointly hold financial risk for overall performance, there is less of an incentive to shift cost to other stakeholders, and providers are collectively motivated to coordinate services.

Beyond adopting high performance networks and Centers of Excellence to advance value and innovation, large employers need to consider how to promote reform in underlying payment structures that advance delivery system redesign. In some cases, employers use third party administrators (TPAs) to manage alternative payment designs such as bundled payment that traditional health plans may have difficulty implementing. To understand alternative payment models, it is helpful to describe commonly used payment strategies and how they impact provider behavior. The descriptions below summarize the current state and application of specific payment models, noting their impact on provider behavior and value.

Fee-for Service (FFS) Payment Model

Most Medicare and commercial payments are based on a negotiated rate or multiplier that establishes an allowed amount for individual procedures defined through CPT® or current procedural terminology.

- Common methodologies for physician or professional services use a rate factor based on service line (e.g., medical, surgical). The Medicare resource-based relative value scale (RBRVS) uses a “work” factor that accounts for resource intensity and risk, a geographic factor, and a financial multiplier.
- Payment for hospital services are typically based on day rates (per diems) or case rates for limited services such as maternity. The Medicare Inpatient Prospective Payment System assigns an MS-DRG to each inpatient stay using the diagnosis codes.

Commercial payments are often calculated based on 100 percent of Medicare rates plus an additional percentage. Even under many shared risk arrangements, the underlying payments are FFS-based, which in some cases may drive deeper discounting of services and channeling to preferred provider contracts, rather than true re-engineering and integration of care delivery.



- Providers are incented to increase the volume of services since payments are unit-based.
- Providers are paid more for complications; FFS creates a perverse incentive to increase severity and complexity of codes

Pay-for-Performance (P4P) or Blended Payments

P4P typically adjusts the provider’s total payments by a factor linked to quality or operational performance thresholds, with negotiated weights on measurement categories. This approach can be limited insofar as the incentives are usually applied separately, based on differing measures, to physicians and hospitals. This category may also describe PMPM fees for primary care medical home or case management, designed to offset some of the marginal costs of resources required to coordinate care. The impact may be more limited due to the relatively small percentage of payments linked to quality and periodicity of payments (often annual, four to six months after the close of the year).



- Providers are incented to achieve performance targets.
- May perform to the test.
- Small dollars do not get provider attention.

Shared-risk or Shared Savings

This model uses a targeted budget or price point, at which payers and/or providers bears some financial risk for performance. The budget may be based on a combination of FFS, capitation or bundled payments. Sometimes a quality performance threshold may apply before a provider can access the “bonus.” Providers often



- Providers are incented to improve quality and manage resources, but not necessarily together.
- Adjudication of costs is often retrospective.
- High cost drugs and outliers are often excluded.

negotiate exclusions such as for specialty drugs or prosthetic devices.

- Downside or two-sided risk typically implies provider risk for sharing in a negotiated percentage of gains or losses.
- Upside risk, gainsharing or shared savings usually implies distribution of a portion of savings based on achieving costs below the target level.

Bundled Payment

Similar to a case rate, a bundled payment combines multiple services into a single payment to physicians or healthcare facilities (or jointly to both) for all services based on a defined condition or course of treatment including follow-up services, also known as an episode of care. Medicare has recently launched a series of pilots through its Bundled Payment for Care Improvement (BPCI) initiative, Oncology bundled payments, and the Comprehensive Care for Joint Replacement (CJR) model. The Medicare Ambulatory Payment Classification (APC) is a bundled payment for outpatient hospital services. In some advanced models, a bundled payment with a warranty, can actually result in reduced compensation. Providers are incented to manage and coordinate care because they assume financial risk for the cost of services along with costs associated with preventable complications.



- Providers are incented to coordinate care over the long-run.
- Prospective payment may drive more collaboration, but frequent use of retrospective payment reconciliation reduces direct provider accountability and engagement.

A related term, **Reference Pricing**, is the benefit design corollary to a bundled payment or case rate, where the plan sponsor sets a threshold amount, above which is a member's financial responsibility if services are obtained from a non-designated provider.

Population-Based Payment or Capitation

Population-based payment entails a fixed dollar payment per member per month (PMPM) for a specified population or defined scope of services. Variants include specialty or contact capitation where a specific diagnosis or service triggers a set fee for a defined period. In an optimal population-based payment model, providers jointly assume risk for the total cost of care. Notably, providers often negotiate exclusions such as for specialty drugs or prosthetic devices.



- Providers are incented to work together and optimize outcomes
- Financial risk motivates resource management
- Providers share in the savings

Traditional fee-for-service contracting between health plans and providers have contributed largely to the current disconnect between what large employers pay for health care and the care that employees and their dependents actually receive. Increasing the portion of provider payments under alternative payment models such as population-based payment and bundled payment are important in redirecting resources and aligning incentives to improve efficiency and assure that the right care is delivered at the right time, and the right place. Creating financial risk arrangements – whether gainsharing or with downside risk, introduces incentives for physicians, hospitals and other providers to work together to improve quality, service and importantly, care transitions that can reduce avoidable complications and unnecessary care.

Emerging Products and Employer Strategies

Value-based contracting may take a variety of forms and much of the recent growth in this area has been focused on contracting with Accountable Care Organizations (ACOs). The Medicare Shared Saving Program called for organizations to take accountability for a patient population and redesign care processes for high quality and efficient service delivery. The number of ACOs has grown rapidly over the past few years, increasing from 157 in March of 2012 to 782 in December of 2015. Similarly, the number of lives covered by ACOs has increased from an estimated 7 million in March of 2012 to 23 million in December of 2015.^{xiv} A number of large provider systems initially applied and were designated Pioneer ACOs, meaning they took on two-sided risk. However, many of these organizations subsequently withdrew from the program, opting for lower risk exposure through one-sided gainsharing models.

An ACO can take many different forms as a provider entity, including a medical group (primary care or multi-specialty), an independent physician association (IPA), or an integrated delivery system comprised of doctors, a hospital(s) and potentially other service providers. To the extent that an ACO is defined more narrowly (e.g., a medical group), it needs to establish contractual relationships with hospital and ancillary providers to offer services across a variety of care delivery sites with aligned incentives that reinforce the ACO's performance goals. The range and types of products in the marketplace have been evolving rapidly:

- Integrated systems like Kaiser Permanente and Geisinger are well-established and also operate their own health plans.
- Carriers have also entered into a number of ACO contracts under a variety of brands, such as Cigna's Collaborative Accountable Care and Anthem's Enhanced Personal Health Care Program. To varying degrees, health plan-based ACOs have risk-sharing arrangements, sometimes with a quality performance threshold.

Health systems have also entered into formal alliances to improve their competitive position in response to Medicare's alternative payment initiatives.

- Seven Southern California hospital systems joined Anthem in offering a new product, Vivity, that facilitates cross-referrals across the organizations while achieving a lower price point than traditional PPO products by agreeing to a DRG-based reimbursement, which bundles a set of inpatient hospital services by condition and/or procedure.
- Other health plan and provider joint vendors have emerged such as Innovation Health, formed by Aetna and Inova Health System, and OMNIA Health Alliance, between Horizon Blue Cross Blue Shield of New Jersey with seven health systems and a multispecialty physician group.

- Trinity Health System, an 86-hospital system active across 21 states, is joining forces with the 34,000-physician Heritage Provider Network to provide population health management in select markets.
- Provider-sponsored health plans have also proliferated in a number of markets.^{xv} Examples include Memorial Hermann Health Plan in Houston and Premier Health Plan in Ohio.

Health plans continue to experiment with Centers of Excellence and other targeted condition-specific initiatives supported by hospital recognition programs. Often, the selection criteria are quite broad or entail an open application process. Several health plans have also introduced specialty care programs such as oncology medical home or bundled payment models. Typically, such programs are subject to an employer-buy-up for access, while others are still being tested on a limited pilot basis.

Signaling a degree of frustration with the slow progress of health plan-based innovation, lack of health plan design flexibility, or the absence of a demonstrable savings relative to additional service or access charges, employer-designed models have also proliferated:

- Boeing offers its Preferred Partnership ACO to 50,000 employees in Seattle, WA, St. Louis, MO and Charleston, SC, with additional sites to be launched in 2017. By directly contracting with providers, Boeing establishes a range of quality and access performance metrics, specific program designs serving individuals with medically complex conditions, along with downside risk for the total cost of care.^{xvi}
- Intel Corp. designed its Connected Care program with its ACOs to provide targeted interventions for “actionable chronic conditions.” The program measures performance relative to 5 major goals: 1) Right care: Use of evidence-based medicine to improve population health, 2) Right time: Timely access to care, 3) Best outcome: Patient satisfaction 100 percent of the time, 4) Right price: Material decrease in the cost of care, and 5) Best life: Rapid return to productivity.^{xvii}
- Toyota, Home Depot and other employers have engaged specialty vendors and/or third party administrators to conduct market assessments, procure and administer direct provider network contracts in specific markets with high membership volume.
- Lowe’s, Wal-Mart, McKesson and JetBlue use the Employers Centers of Excellence (ECEN) program with bundled payments. This model uses a TPA for customer service and claims administration. The ECEN program has been adopted by some employers for high volume procedures such as joint replacement and spine surgery in an effort to improve quality outcomes and reduce inappropriate care.^{xviii}
- Both IBM and GE have made major investments in the primary care medical home (PCMH) model, in some cases aligning onsite employee clinics with this model. The PCMH model emphasizes patient-centered care with enhanced primary care access, health coaching and care coordination.
- Marriott International contracted with near-site hospitals to provide primary care and urgent care access through outpatient clinics.

Barriers to Employer Adoption of Provider-Based Models

Narrow and high performance network products have had varying degrees of success to date. There has been greater uptake in individual and small market segments, which tend to be more price sensitive. Narrow networks have also been widely used in both the federal and state-run health insurance exchanges.^{xix} Health plan-designed narrow network products have not been widely used among large private employers, although Centers of Excellence are more commonly used for high-cost services like transplants or for services such as bariatric surgery, where outcomes vary significantly. Many employers opt for traditional preferred provider networks and communication about higher performing providers through consumer choice tools. Key barriers to adoption by large employers include concerns about employee access and disruption, credibility and stability of health plans' designation of higher performing providers (whose price advantage may disappear in next year's rate negotiation), limited geographic availability of high performance networks, and the administrative burden of managing and communication about additional health plan options. Collaborative efforts such as the [Health Transformation Alliance](#) create economies of scale as well as leverage collective purchaser volume in the marketplace.

Implementation Considerations for Provider-Based Models

To drive health care transformation beyond the status quo, a higher standard that advances payment reform and care delivery re-engineering is necessary. As employers look for high value provider relationships and implementation approaches to improve the return on the health care dollars they invest, network discounts and geographic access are no longer sufficient. Relying solely on health plans or consultants to identify and build networks of providers delivering the best value is not an adequate solution. Medicare and Medicaid reforms are accelerating; however, too often they rely on prevailing payment structures and are limited by provider resistance to changing the current infrastructure.

Payment reform and re-engineering of care delivery are necessary to drive health care transformation.

Increasingly, employers are constructing their own high performance networks through accountable care organizations, primary-care medical homes, and centers of excellence. Employers may implement different provider-facing strategies depending on their local market conditions and geographic concentration or distribution of their employee population. Additional considerations may include coordination with onsite clinics as well as other health management initiatives. It is important that employers, including large public purchasers, create aligned incentives while also setting high performance expectations. By leveraging their purchasing power together, large employers can send a powerful message to the market. Rather than creating competing goals, large employers working together can help focus provider efforts to accelerate transformation. Establishing a set of guiding principles is central to an effective value-contracting strategy.^{xx} There may be different types of network designs and payment structures en route to financial risk-sharing and accountability, but applying a common set of principles can help keep incentives aligned and help define a set of shared goals.

Affordability and Cost Containment. Employers can establish requirements for value-based contracting where providers must commit to and be accountable for stewardship of health care resources, including management of its ancillary workforce to perform at the highest level of licensure. Specific cost or budget targets should be defined, such as managing the cost trend increase to Consumer Price Index (CPI) plus one percent. Reducing waste should also be a discrete objective, linked to quality and utilization measures such as avoidable hospital readmissions, reduced duplication of services, and reduced emergency department use.^{xxi}

Outcomes-Focused Quality Standards. Performance measures should be outcomes-focused, relevant for employers and consumers, and include cost and patient-experience. Working together, employers and providers should set minimum performance benchmarks and aspirational targets for continuous performance improvement. Employers should use a focused set of metrics that holds providers accountable for evidence-based care that improves health outcomes and reward results, even as providers may additionally rely on measures of structure and clinical processes for ongoing quality improvement. By setting an expectation for maintaining an advanced data infrastructure and information architecture, organizations should report quality performance from clinical registries and electronic health records, not just administrative claims. Quality measures should be both population-based and targeted, reporting on outcomes for elective surgery and management of complex chronic illness. Examples include clinical outcomes, functional status, appropriateness, patient experience, care coordination, and resource use.

Patient-Centeredness. Employers should look for organizations that use a patient-centered, team-based approach to care delivery and member engagement that supports shared decision-making between patients and providers. Services should include multidisciplinary health professionals who deliver coordinated patient education and health maintenance support, as well as engage patients in self-care, self-management and risk reduction. Patients must be included in the care process and be given ready access to their health information.

Promote Health, not Health Care. Care coordination and health management should be geared to optimizing the health goals and productivity of the individual, not just managing a health condition. Providers should manage health prospectively, identifying and modifying future risk (including socioeconomic and environmental drivers of health), rather than treatment of past conditions. Closely aligned with a focus on quality outcomes, such an approach also takes into account the impact on workplace performance and productivity.

Pay Providers for Value, not Volume. Employers should consider how organizations structure payment internally to support integrated care and reward performance. Beyond managing the total cost of care, use of strategies like bundled payment, shared risk and gain-sharing can help align incentives among physicians, medical groups and hospitals. Such payment should also address workforce issues and support primary care availability. Provider organizations should support non-payment for “never events,” errors and inappropriate use, holding the patient harmless.

Transparency. Employers should seek to work with organizations that report dashboard measures at multiple levels including individual physician and/or facility site and service line. Sharing information about clinical performance and financial arrangements is critical to performance accountability. Participation in collaborative measurement and reporting performance at the level that matters for individual decision-making is essential to helping consumers access the right care at the right price based on their needs.

Marketplace Competition. Related to transparency, employers should be cognizant of promoting competition through their value-based contracting strategies. Beyond providing consumers with information about the relative performance, cost and efficiency of providers, organizations should be transparent regarding provider financial arrangements and refrain from contractual prohibitions on provider differentiation by payers. Providers must also refrain from contractual non-disclosure provisions that preclude community-level quality and efficiency measurement, consumer access to information and comparative performance reporting.

Health Information Management. Employers should expect providers to use health information technology for clinical decision support, clinical integration, and information exchange. Key to reduced waste and duplication of services is clinical integration and information-sharing among medical providers. A flexible information infrastructure and technology also distinguishes organizations that have the ability to leverage external sources of “big data” and non-traditional data sets such as consumer demographic and retail information.

Benefit Design Alignment. Additional considerations include contribution and benefit design that encourages employees to choose high performing providers. Employers may consider premium reductions or lower out-of-pocket cost-sharing as means for promoting selection and use of high-value models. Employers may use complex criteria and payment models to develop high performance network partnerships, but basic employee communication is an ongoing need. Education is critical for assisting employees and their dependents to use quality information in provider selection and treatment choice.

Conclusion

There is broad agreement that new approaches for care delivery and provider payment are needed to address shortfalls in health care quality and cost drivers. This paper summarizes key limitations in the current payment structures and the prevalent design of health care delivery in the United States. Adoption of value-differentiating strategies that lead to true innovation rather than incremental improvement requires bold changes in how employers buy health care services. For too long, employers have been limited by the incremental steps taken by the industry. As new delivery models expand, private employers have a unique opportunity to work directly with provider organizations and be a catalyst for greater health system accountability for delivering on the Triple Aim of better quality, care and affordability.

Author Biographies

Emma Hoo

Director, Pacific Business Group on Health

Emma Hoo focuses on care redesign and payment reform initiatives to promote effective health management and provider accountability. She has managed joint purchasing initiatives for California HMO services, disease management, pharmacy benefit management and retiree coverage. The overall goal of these initiatives is to encourage consumers to take control of their health care, and ensure that providers are rewarded for delivering efficient and quality care. Other work includes adaptation of the eValue8 Request for Information for Covered California's Qualified Health Plan assessment and administration of performance standards and guarantees. Hoo has served on the NCQA Disease Management Measurement Advisory Panel and National Quality Forum Behavioral Health Measures Committee. She currently participates in the Business Action Collaborative of the IOM Roundtable on Population Health Improvement and on the High Cost Patient and Bundled Payment Workgroups of the Health Care Transformation Task Force.

David Lansky, PhD

President and CEO, Pacific Business Group on Health

David Lansky, PhD, is the President and Chief Executive Officer of the Pacific Business Group on Health (PBGH) and directs its efforts to improve the affordability and availability of high quality health care. Since 2008, David Lansky has led the coalition of 60 large employers and health care purchasers representing over 10 million Americans, including CalPERS, Wells Fargo, Intel, Lowe's, Walmart, Boeing, and the University of California. PBGH also collaborates with diverse stakeholders on national health care policy issues through the Purchaser Value Network.

A nationally-recognized expert in accountability, quality measurement and health IT, Lansky has served as a board member or advisor to numerous health care programs, including the National Quality Forum, the federal Health IT Policy Committee, the Catalyst for Payment Reform, the Joint Commission, the National Patient Safety Foundation, the Leapfrog Group, and the Medicare Beneficiary Education Advisory Panel. He currently serves as vice-chair of the Health Care Transformation Task Force, on the Guiding Committee of the HHS Learning and Action Network, the Congressional Budget Office Health Advisors Panel and the Board of the Alliance for Health Reform.

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