

Emerging Payment Models

Navigate the current state of financial uncertainty
to prepare for the future of health care spending



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THE KINETIX GROUP

The Kinetix Group

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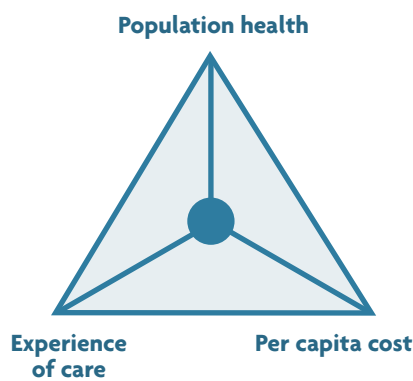


SECTION 1: Landscape Overview

The Changing Landscape of Payment Models

With national health care spending in the US continuing to rise drastically, it is estimated to reach nearly \$5 trillion, or 20% of the gross domestic product (GDP), by 2021.¹ Furthermore, the implementation of the Affordable Care Act (ACA), along with various cost controlling measures, challenges healthcare providers to better manage and treat patients at a lower cost. In an effort to reduce costs and enhance outcomes, the healthcare delivery system in the US is undergoing a fundamental shift from volume to value based care. Key stakeholders within the healthcare sector are increasingly engaged and investing significant efforts towards achieving the Triple Aim to improve patient outcomes, enhance the patient experience, and reduce per capita costs.

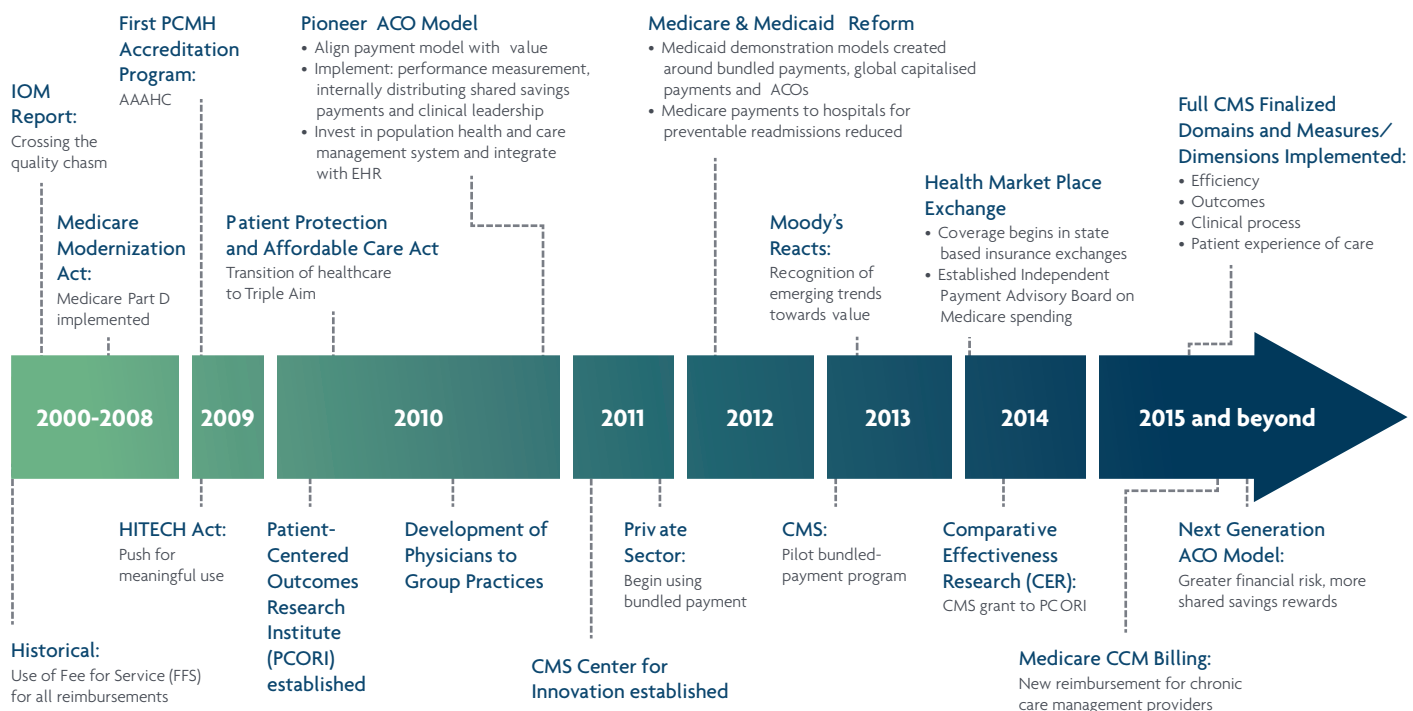
Figure 1: The Triple Aim



More specifically, there is renewed focus on alternative payment models which align incentives on improved health outcomes and focus on distributing risk across stakeholders. Stakeholders across the continuum (e.g. providers, consumers, and employers) will have to take on greater responsibility and risk in regards to both cost and quality. Reimbursement models of particular note include shared risk, shared savings, pay for performance, and capitated/bundled payments.

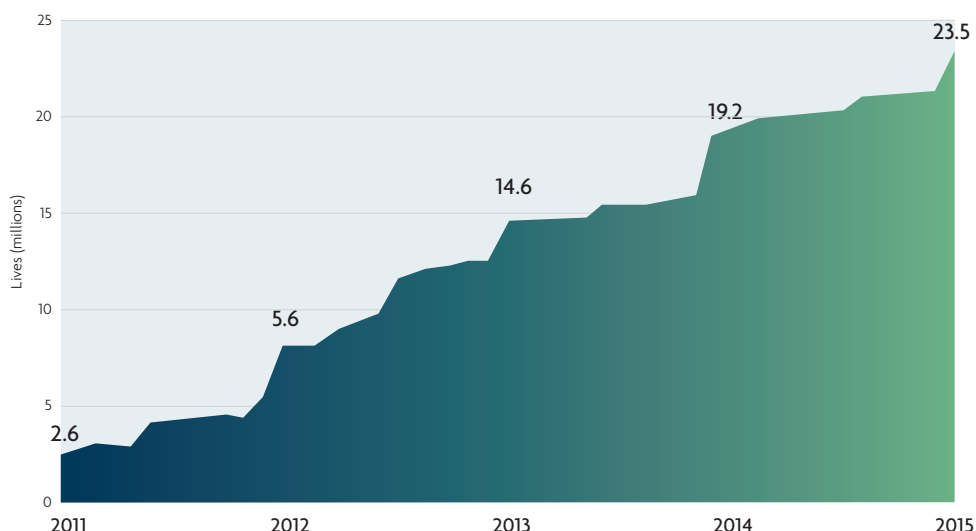
Accountable Care Organizations (ACOs) and Medicare Advantage (MA) plans serve as just two examples of the movement towards value-based care delivery, whereby providers, payers, and plans are all incentivized to provide high value care.³ An estimated 23.5 million people in the United States were covered in Accountable Care arrangements in 2014, 16 million of which were covered by commercial payers and/or Medicaid.⁴ ACOs are now in all 50 states and 90% of all Hospital Referral Regions.⁵ The Centers for Medicare and Medicaid Services (CMS) pioneered the ACO model, after which variants were fostered by different commercial payers.

Figure 2: Embracing the Primary Care Model ²



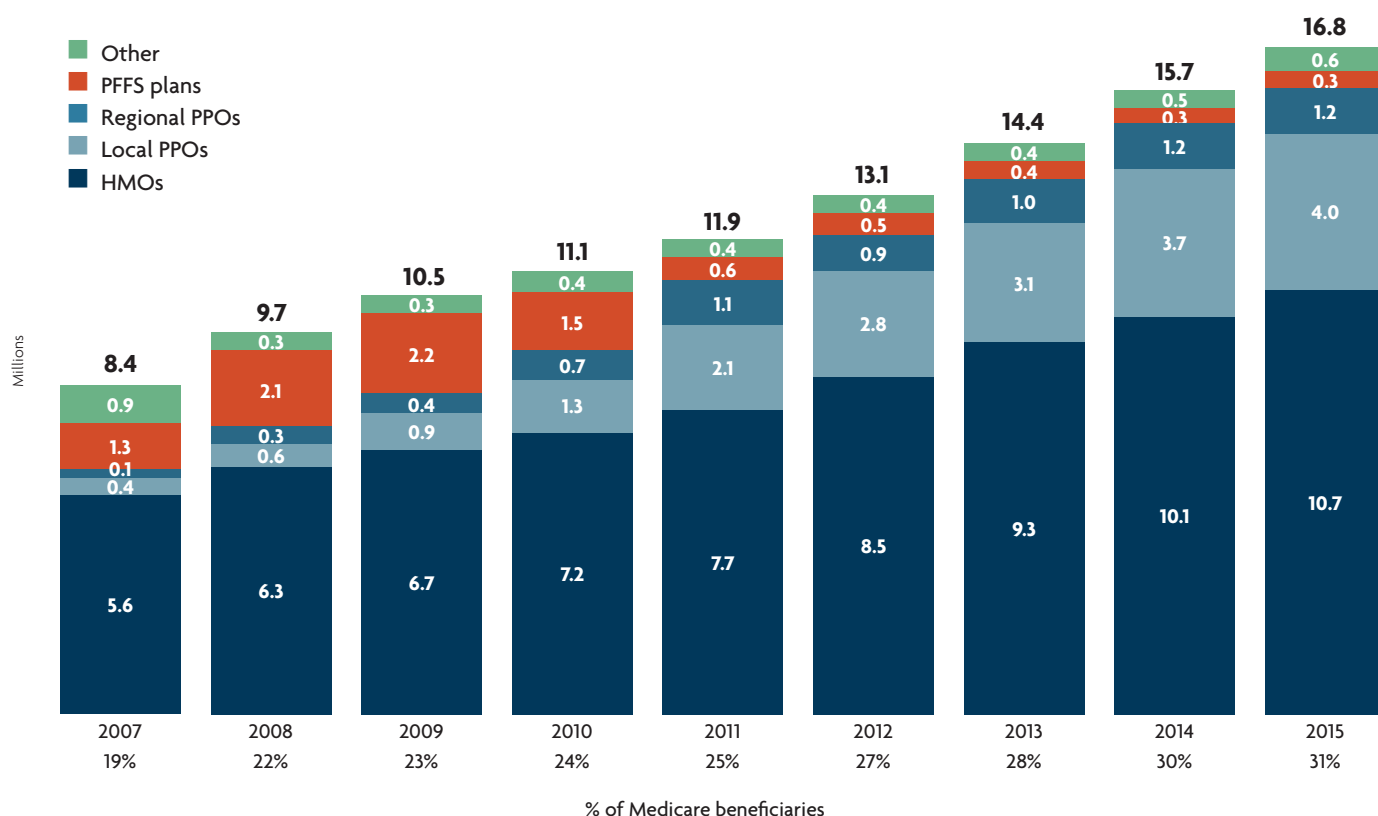
The widespread expansion and adoption of ACOs across the country provides sufficient evidence highlighting the success of the model as a driver of both quality improvement and cost control.⁶

Figure 3: Growth and Dispersion of ACOs In 2015 ⁴



Similar to the widespread adoption of ACOs, the number of Medicare beneficiaries enrolling in Medicare Advantage Plans has continued to accelerate (as illustrated in Figure 4). Since the implementation of the Affordable Care Act, MA enrollment has increased by 5.6 million, or 50%. As of March 2015, 31% of Medicare beneficiaries representing 16.8 million people were enrolled in an MA plan.⁷

Figure 4: Total Medicare Advantage Enrollment, by Plan Type 2007-15 ⁷



“Traditional lines between payers, physician groups, and hospitals are being blurred. Many stakeholders, including health plans, health care systems, and Centers for Medicare and Medicaid Services, are attempting to be leaders in this new value-based world.”

Amidst the shift from volume to value, traditional lines between payers, physician groups, and hospitals are being blurred. Many stakeholders, including health plans, health care systems, and Centers for Medicare and Medicaid Services, are attempting to be leaders in this new value-based world.

Health Plans:

To be seen as key differentiators, the current marketplace requires that health plans compete for covered lives and value-based initiatives. Examples of health plans investing in these efforts are as follows:

- Anthem adopted a program in 2012 that provided doctors with an opportunity to share in the savings if they met key quality metrics and reduced per capita spending. The initiative reduced costs by approximately 3.3%, with net savings between \$81 million and \$102 million for the patient population. Most of the cost savings can be attributed to a reduction in hospital admissions, outpatient surgeries, and emergency room costs⁸
- By 2018, Cigna hopes to have 90% of payments through value-based initiatives and 50% of payments from alternative payment models. Additionally, Cigna will offer incentives to healthcare providers who provide high quality care to vulnerable and at-risk patient populations⁹
- Aetna and the Value Care Alliance recently announced a new accountable care agreement, designed to improve coordination and delivery of patient care to Aetna members in Connecticut¹⁰
- Blue Cross Blue Shield has 570 value-based programs, and has engaged more than 228,000 participating providers to reduce healthcare spending and improve quality (as illustrated in Figure 5)¹¹

Figure 5: Blue Cross Blue Shield Value-Based Programs ¹²



37 Blue Plans

have 570 value-based programs in market or in development, with more than 228,000 participating providers providing care to more than 25 million members



450 ACOs

in 32 states with more than 111,000 physicians



69 PCMH models

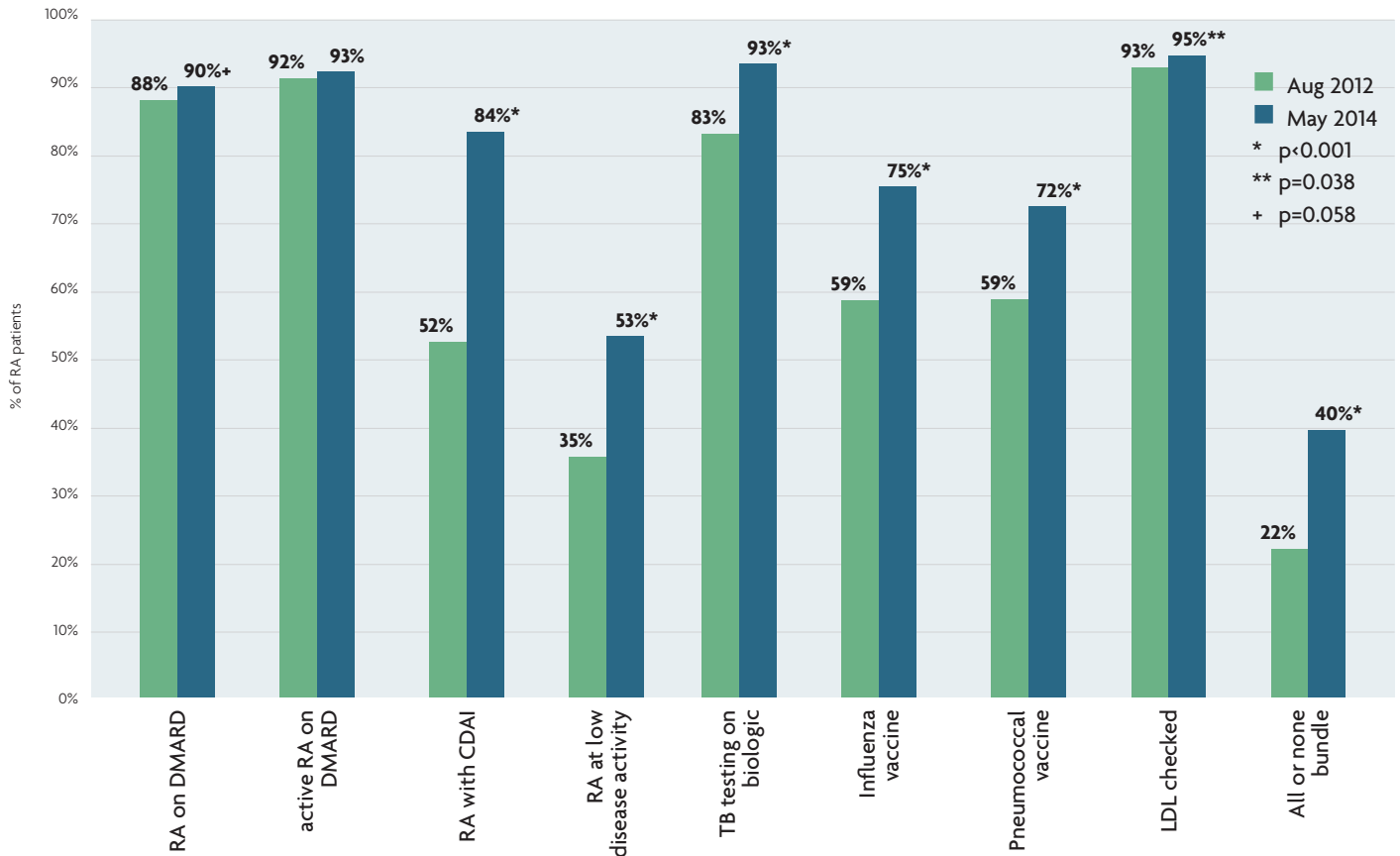
in 43 states and D.C. with more than 56,000 physicians participating

Healthcare Systems:

Healthcare systems have similarly been supporting value-based programs, a trend that has recently accelerated as noted by the following examples:

- AIM FARTHER is a novel care model for Rheumatoid Arthritis (RA) developed by Geisinger Health System. The program uses people, processes, and IT in highly effective ways to optimize care delivery. As illustrated in Figure 6, the program has demonstrated improvement in quality measures and reduction in cost of care for over 2,300 RA patients in the health care system¹³

Figure 6: AIM FARTHER quality measure improvements at 22 months¹³



- Dignity Health has committed to distribute 50% of its payments through accountable care initiatives by 2018, and up to 75% by 2020⁹
- The Northwest Metro Alliance is an accountable care model between Health Partners and Alina Hospitals and Clinics, focusing on improving the health of at-risk health plan enrollees. Results from the first year indicate that Northwest Metro Alliance reduced the rise of medical expenditure from an 8% to a 3% growth rate, reflective of more than \$6 million in reduced medical costs.⁹

Centers for Medicare and Medicaid Services:

The Centers for Medicare and Medicaid Services (CMS) is at the forefront of developing and piloting innovative delivery models across key stakeholders.

- The Medicare Advantage (MA) Value-Based Insurance Design Model offers Medicare Advantage plans flexibility to improve beneficiary health, reduce avoidable high-cost care, and reduce costs. The model focuses on MA enrollees with various chronic conditions such as diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD).¹⁴
- CMS' Oncology Care Model is designed for physician practices to enter into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients¹⁵
- The Premier Hospital Quality Incentive Demonstration, a collaboration with Premier, Inc. across 250 hospitals in 38 states, offers financial incentives to improve the quality of care across five clinical areas: acute myocardial infarction (AMI), pneumonia, heart failure (HF), coronary artery bypass grafting (CABG), and hip and knee replacement¹⁶

“The movement towards value-based payment models has heightened the need for data management and data analytic capabilities among providers.”

SECTION 2: Key Impacts of Payment Models:

Emerging payment models within the industry focusing on value, quality, and reduced costs have transformed numerous aspects within the healthcare landscape. Of the various themes that have emerged, the following three are the most prominent:

- Investment in Data Management Capabilities
- Transformation of Systems of Care
- Increase in Provider Accountability

Investment in Data Management Capabilities:

The movement towards value-based payment models has heightened the need for data management and data analytic capabilities among providers (e.g. health systems, hospitals, provider groups, etc.). Renewed emphasis on care coordination among multiple providers and sites of care has catalyzed the movement towards data sharing and interoperability. Interoperability requires the implementation of clinical data analytics, which plays a key role in the improvement of quality outcomes and patient care processes. Clinical data analytics is estimated to grow from an adoption rate of 10% in 2011 to 50% in 2016.¹⁷

Additionally, Health Information Exchanges are attracting more participants as they offer a low-cost, high-impact way to securely share healthcare data.¹⁸ A few Health Information Exchanges that successfully share data include California Regional Health Information Exchange, CareSpark, Colorado Community Health Network, HealthBridge, Indiana Health Information Exchange, and Mass E-Health Collaborative.

Transformation of Systems of Care:

Systems of Care (SoC) focus on organizational efficiency, reduced cost structure, and data analytics to provide coordinated, high value health care across settings. SoCs specifically focus on improving coordination of care for high risk/high cost patients (e.g. those with chronic diseases); implementing evidence-based medicine; reducing redundancy and overutilization; improving efficiency; and optimizing resource utilization.

The current marketplace is optimum for the adoption of SoCs as providers now have access to the resources needed to enter into capitated arrangements, including improved data analytics to appropriately assess risk. As such, they are reshaping compensation models for both employed and sub-contracted providers so individual and group compensation are rooted in data analytics. Ultimately, SoCs that make the transition to value will be those that can successfully assess and manage risk.

Figure 7: Priorities of Systems of Care



Increase in Provider Accountability:

Emerging payment models are increasing providers' accountability for the cost and quality of care they deliver, aligned with two distinct types of risk: performance risk and utilization risk. While performance risk continues the production incentive of the current fee-for-service system, it further requires that providers meet elevated performance standards to maintain profitability. Bundled payments offer one such example. On the other hand, utilization risk requires tighter alignment to standards of care, such that only services that are truly necessary are provided, appropriately decreasing utilization. It also entails knowing more about where your patients are receiving their care. The shared savings model, for example, introduced utilization risk.¹⁹

Additionally, the new payment models have pushed providers towards practicing more patient-centered care that focuses on prevention and avoiding expensive, acute care incidents. Physicians practicing patient-centered care improve their patients' clinical outcomes by improving the quality of the doctor-patient relationship, while at the same time decreasing the utilization of diagnostic testing, prescriptions, hospitalizations, and referrals.²⁰

Case Study: The Quality Blue Primary Care Program

Traditionally, the three themes mentioned above are key elements of fully integrated systems. Examples of these integrated systems include Kaiser Permanente, Intermountain Healthcare, and Geisinger Health System. The rapid introduction and adoption of payment models will require systems to focus on these three areas in order to be sustainable and improve care delivery. An example of such a model is the Quality Blue Primary Care (QBPC)

program implemented by Blue Cross and Blue Shield of Louisiana. The QBPC program is a population health management and quality improvement program focusing on multiple cardio metabolic conditions via effective risk management. This program effectively incorporates the 3 themes: investment in data management capabilities, transformation of a SoC, and an increase in provider accountability.

Investment in Data Management Capabilities:

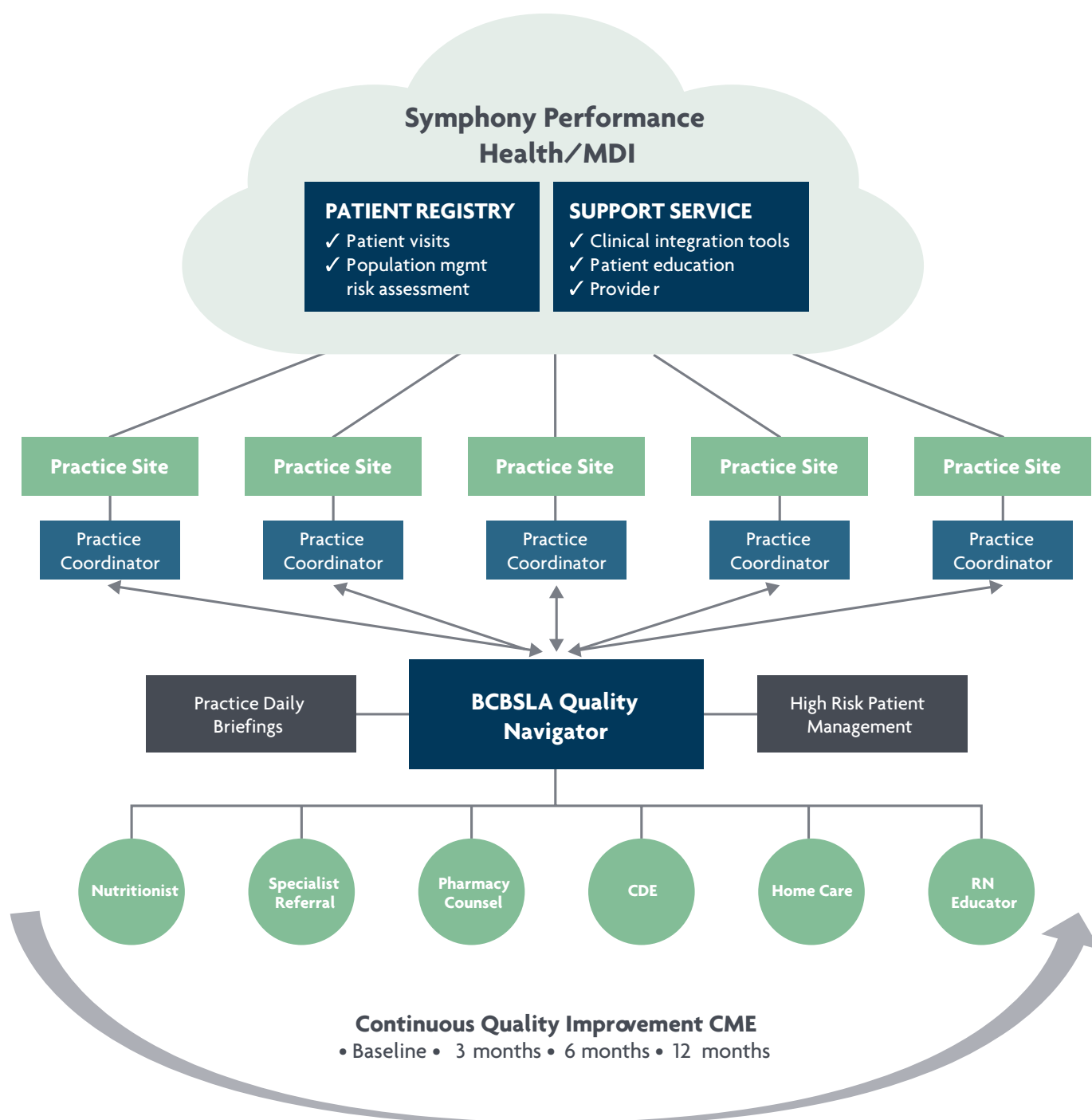
Investment in data and data analytic capabilities is important in order to understand a patient's complete health history based on claims data. Data can be leveraged to track and collect all relevant clinical and quality elements, in order to improve processes and delivery the best possible care to patients. The QBPC program leveraged a population health software program to share a patient's complete health history based on claims data.²¹

All of the providers who participated in the program received a customized Continuing Medical Education (CME) module and quarterly data reports, as well as comparison reports to regional peer groups and other participating provider groups. Data leveraged from these reports was used to demonstrate outcomes on the improvement of various quality and disease measures.²¹

Transformation of Systems of Care:

The QBPC program's pilot, ATGOAL, was a collaborative effort between Blue Cross, Consortium of Southeast Hypertension Control (COHSEC), and 10 primary care practices to decrease the risk of cardio metabolic conditions among patients whilst improving care coordination within practices. As illustrated in Figure 8, the transformation of the care provided was instituted by a well carved out implementation model, based on fixing identified care gaps and improving work flows and processes. In turn, this has led to an improvement in the experience of patients with chronic conditions.²¹

Figure 8: QBPC Implementation Model²¹



Increase in Provider Accountability:

The QBPC program pilot facilitated improvement in risk factor management by giving primary care physicians a performance improvement initiative. Aligned with the program's quality and improvement core measures, the providers were incentivized by Blue Cross and Blue Shield's care management fee compensation. Figure 9 provides an example of tracking measures against a practice's baseline, current, and improvement rates.²¹ Fostering accountability and using the payment tier system to reward providers has led to the delivery of high-quality care, improved health outcomes, and lower healthcare claims costs.

Figure 9: Sample Physician Dashboard

Condition	Measure	Baseline (08/13)	Current	Improvement
HTN	BP <140/90	67%	87%	+30%
CKD	Optimal care	48%	85%	+77%
Diabetes	Optimal care	32%	50%	+56%
	BP <140/90	72%	87%	+21%
	LDL <100	54%	67%	+24%
	A1c <8.0	69%	76%	+10%
	Tobacco free	83%	88%	+6%
Vascular disease	Optimal care	27%	58%	+115%
	BP <140/90	73%	92%	+26%
	LDL <100	62%	76%	+22%
	ASA use	58%	95%	+64%
	Tobacco free	73%	77%	+5%



SECTION 3: Emerging Payment Models

Introduction

As outlined in the first section, several payment models have emerged focusing on the Triple Aim within the healthcare industry, such as the models outlined in figure 10.

Figure 10: Snapshot of Payment Models ^{22,23}

- **Fee for Service (FFS):** The most traditional of healthcare payment models, FFS requires patients or payers to reimburse the healthcare provider for specific, individual services provided. This model provides no financial incentive to implement preventative care strategies, prevent hospitalizations, or undertake other cost-saving measures
- **Pay for Coordination:** Pay for Coordination involves payment for specified care coordination services, facilitating care among the primary care provider, the specialists, and the extended care team. The most typical example of this payment model is the medical or health care home model
- **Pay for Performance (P4P):** P4P or Value Based Purchasing can be defined as a payment or a financial incentive that is linked to achieving defined and measurable goals related to care processes and outcomes, patient experience, resource use, and other factors
- **Bundled Payment or Episode of Care Payment:** Bundled or Episode of Care payments are single payments for a group of services related to a particular procedure and/or diagnosis that are rendered within a defined time period. A single practice or physician acts as the conductor who orchestrates the full spectrum of care for a service or procedure
- **Total Cost of Care Payment (TCC):** Under a TCC payment model, a single risk-adjusted payment is provided for the full range of health care services needed by a specified group of people for a fixed period of time
- **Shared Savings Program:** A Shared Savings Program offers incentives to providers to deliver enhanced care to specific patient populations, which generates savings that providers then share
- **Partial or Full Capitation:** In this payment model, providers receive per-member, per-month (PMPM) payment that is based on the individual patient's age, race, sex, lifestyle, medical history, and benefit design. Payment rates are tied to expected usage regardless of the number of actual patient visits
- **Global Budget:** A global budget is a fixed total dollar amount that is paid annually for all care delivered. However, participating providers can determine how the dollars are spent

Strategic, technologic, and methodological shifts have enabled the change towards the emerging payment models. In this section, we will examine three such models along with best practice case studies to fully illustrate the decisions and outcomes that accompany each model. The three models include:

- Pay for Coordination Model
- Bundled Payment/Episode of Care Model
- Total Cost of Care Model

Pay for Coordination Model

The Pay for Coordination model goes beyond the Fee for Service model by coordinating care among the primary care provider, the specialists, and the extended care team. Coordinating care among multiple providers can help patients and their families manage a unified care plan, reduce redundancy in expensive tests and procedures, and minimize the delivery of inefficient care. The most typical example of the Pay for Coordination model is the Medical Home model.²³

Figure 11: Key Pieces of a Patient-Centered Medical Home ²⁵



The Patient-Centered Medical Home (PCMH) is a team-based and collaborative care delivery model. It promotes coordination of the patient's treatment through the primary care physician and aims to increase engagement between the physician practice and its patients, particularly around chronic conditions. Most PCMH programs that are sponsored by commercial insurers pay an enhanced per-member, per-month payment to primary care physicians.²⁴

The Patient Centered Medical Home model creates a framework, a common language, and an opportunity for change. As illustrated in Figure 11, a few of the principles of a PCMH framework include a trained personal physician to provide continuous, comprehensive care; a physician-directed medical practice; coordinated care; quality and safety; and enhanced access to care. In order to implement this framework, strategies need to be undertaken such as ensuring primary care access, focusing on integration and accountability, leveraging health information technology, and encouraging evidence-based best practice.

In recent times, an increasing number of specialists within health care systems are adopting Medical Homes. For example, The University of Pittsburgh Medical Center (UPMC) has collaborated with the UPMC health plan to implement an Inflammatory Bowel Disease (IBD) medical home aiming to provide high-quality, comprehensive, cost-effective, patient-centered health care for patients with Crohn's disease and ulcerative colitis.

The medical home model is grounded in the use of data and evidence based medicine. The ability to measure and report patient data helps physicians track the progress and outcomes of individual patients. It also provides feedback to help physicians understand how the process of care is improving, particularly as it relates to caring for patients with chronic conditions. Finally, measuring and reporting relevant data back to providers helps them understand their patients' experience - like the experience of using scientific evidence to make better diagnostic and therapeutic choices - and helps the provider to not only improve the experience, but also the outcomes. Evidence-based decision making is the cornerstone of providing this kind of patient experience.

Data from a number of medical home pilot programs conducted across the US serve as evidence of their value and acceptance as a model for how primary care should be organized and delivered throughout the health care system. PCMHs have demonstrated outcomes such as increased standardization of care and net revenue, improved preventive care and quality measures, and reduced emergency department utilization and readmissions.

COTA -RCCA- Cigna Medical Home Initiative Case Study

The need to bring value to the health care system, by avoiding under and over utilization of resources, is essential to optimize patient outcomes and reduce the cost of care. Cancer Outcomes Tracking and Analysis (COTA), Regional Cancer Care Associates (RCCA), and Cigna have collaborated to start a value-based medical home initiative that aims to improve care for patients receiving chemotherapy. COTA is identifying and tracking all CIGNA-RCCA cancer patients who receive chemotherapy and are eligible for enrollment into the CIGNA medical home. This initiative is an extension of Cigna Collaborative Care.²⁶

“The need to bring value to the health care system, by avoiding under and over utilization of resources, is essential to optimize patient outcomes and reduce the cost of care.”

OBJECTIVE: To create a value-based initiative using incentives to engage physicians and help drive improved health, affordability, and the patient experience

Actions

- COTA:**
- Precisely classify patients based on prognostic features to permit "apples to apples" analytics and provide insights on quality and care
 - By accounting for "biologic variation" through precise classification algorithms, measure "treatment" variance that drive clinical and cost outcomes
 - Provide real-time care management insights to providers based on real world data and comparisons of quality measures
 - Adjudicate value-based payment models by providing payers and providers with summary outcome statistics of care provided
 - Implement a deeper clinical analysis of the top 14 cancers that comprise of 80% of all cancers
- RCCA:**
- Follow evidence-based medicine guidelines for cancer care
 - Designate a registered nurse or an advanced care practitioner as the group's oncology care coordinator who will assist patients with their care
 - Expand access to daily acute care with same-day appointment availability, after-hours access, and clinical advice, including 24/7 access to clinical triage staff
- Cigna:**
- Compensate the medical group with a one-time care management payment for each of its patients undergoing chemotherapy treatment
 - Provide a collaborative care associate who will assist the medical practice's oncology care coordinator
 - Provide oncology case management services for customers and their families
 - Provide additional support and information such as inpatient management and discharge planning, care planning and post outreach therapy, hospice care coordination, transition of care services, access and referral coordination, etc.

Projected outcomes

- Reduce unnecessary hospitalizations and visits
- Improve affordability and health outcomes
- Enhance the overall patient experience

Bundled Payments/Episode of Care Model

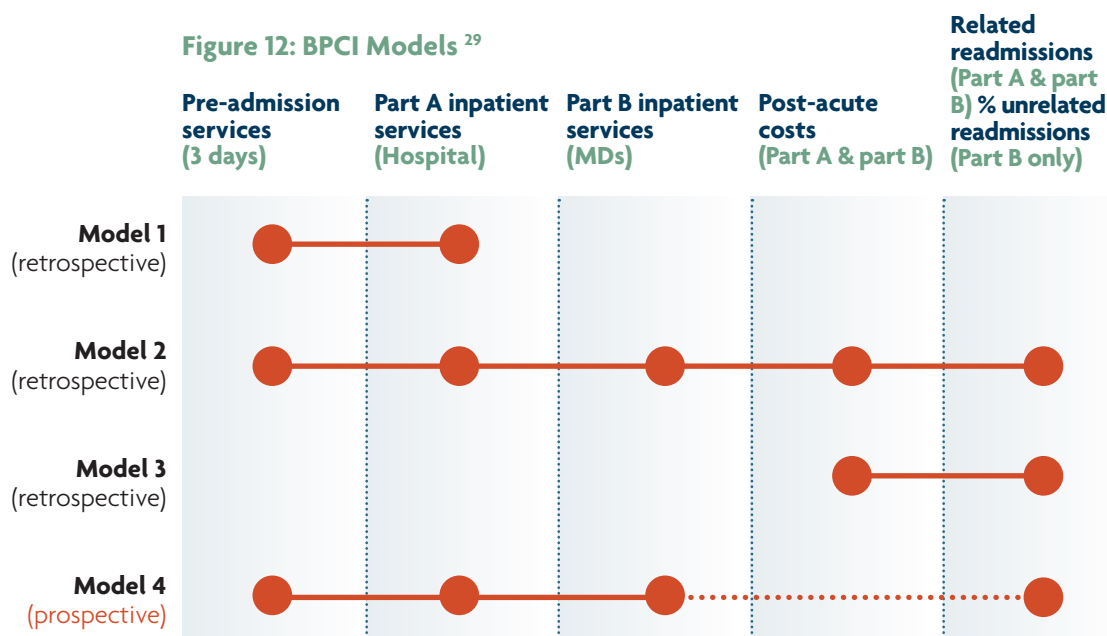
Bundled or episodic payments are single payments for a group of services related to a treatment or condition that may involve multiple providers in multiple settings. An episode can be built around almost anything, as long as it is possible to define it in terms of related costs, related services, and a timeframe. The primary focus of this payment model is to engage specialists in the total care continuum and create a medical neighborhood under the primary care models. Of all the Triple Aim models, the bundled payment or episode of care model is more targeted and manageable, as it does not require the same kind of significant infrastructure that an ACO or PCMH model does.

While still in the early stages of adoption, bundled payments promise to save costs, improve quality, and enhance communication and collaboration among major providers throughout the continuum of care. Stakeholders across the country, including Medicare, Medicaid, employer groups, and commercial health plans, are recognizing the model's potential to address some of the issues of over-utilization of services and fragmented care.²⁷

The early success of bundled payment initiatives hinges on an organization's ability to focus on distinct episodes of care, rather than taking on a complete payment system overhaul. The bundled payments for particular episodes of care can be created, in large part, using existing claims data. As illustrated in Figure 12, The US Centers for Medicare and Medicaid Services' (CMS) Bundled Payments for Care Improvement initiative (BPCI) defines four financial and performance models for 48 episodes of care. The episodes of care include diagnosis related groups (DRGs), which allow healthcare organizations to use claims data to estimate a bundled payment.²⁸ The more distinct the episode of care, the easier it is to correctly estimate a

bundled payment. While payers have claims data readily available, they may not have the technology infrastructure in place to automatically analyze that data. However, several third parties can provide that service.

Figure 12: BPCI Models ²⁹



Remedy Partners: Total Hip Replacement Bundled Payments Program

Remedy Partners is one of the few companies working as an Awardee Convener with the Centers for Medicare and Medicaid Services (CMS) to help providers with the bundled payment demonstration via the BPCI initiative.³⁰ Remedy Partners is working with more than 1,200 hospitals, hospitalist organizations, physician groups, skilled-nursing facilities, and home health agencies across all fifty states. A few of the organizations that Remedy Partners is working with include Sharp HealthCare, University of Pennsylvania Health System, and University Medical Center, Lifespan.

To implement a bundled payment program for total hip replacement, Remedy Partners worked with an acute care hospital, an independent group of orthopedic surgeons, a home health agency, and a small group of aligned skilled nursing facilities for patients in a regional commercial health plan.³¹ The success of the program was contingent on well-defined goals, such as patient home discharge and a well carved out care model throughout the episode.

OBJECTIVE: To improve the quality of care and decrease post-hospital costs

Actions

- Physician Leadership: The program was led by 2 model surgeons who were champions and ensured that both the quality of care for the full episode was maintained and the expectations for a home discharge were conveyed to patients
- Case Management Coordination: Case managers facilitated key messages for patients in the program
- A well-designed and articulated model of care throughout the episode, encompassing pre-operative assessment and preparation in hospital care, as well as type, duration, and frequency of post-hospital services
- Engagement of 3 skilled nursing facilities (SNF) and a SNF physician therapy leader who ensured expedited discharge home when patients met their functional goals

Outcomes

- Improved quality of care for patients across the inpatient and post-acute care continuum, through provider alignment and patient engagement
- Decrease in next site of care discharges to post-acute rehabilitation facilities, contributing to post-acute care savings
- Increase in patients being able to be safely discharged, follow procedures, and receive coordinated, follow-up care

UnitedHealthcare: Oncology Episode Payment Program

UnitedHealthcare offers the full spectrum of health benefit programs for individuals, employers, and Medicare and Medicaid beneficiaries. The plan contracts directly with more than 800,000 physicians and care professionals, accounting for 6,000 hospitals nationwide.³²

UnitedHealthcare collaborated with five medical oncology groups who volunteered to launch a three year episode payment program to reward physicians for improving quality and reducing the total cost of cancer care. As a part of this program, nineteen clinical episodes were created for patients with breast, colon, and lung cancer. The five medical oncology groups included The West Clinic, Northwest Georgia Oncology Centers, Center for Cancer and Blood Disorders, Advanced Medical Specialists, and Dayton Physicians LLC.

By collaborating, more than 60 measures of quality and cost for the episodes were developed. This collaborative program demonstrated that cancer therapy can be measured by payers by combining insurance claims with clinical data measurements provided by physicians. Additionally, the pilot has the potential to identify best practices by comparing the performance of medical groups and chemotherapy regimens for similar patient populations. The implementation of the program required leadership to manage change and re-design processes. The business managers for each medical group acted as essential leaders while the practice managers supported the changes in standard billing practices for the episode payment program.³⁴

Given that the pilot yielded significant costs savings without adversely affecting the quality of care, UnitedHealthcare has indicated that it will add six additional groups in 2015 to the episode-based program, quadrupling the number of patients in the project.³⁵

OBJECTIVE: To create an episode payment program designed to reward quality and cost improvement

Actions

- Each of the five participating medical oncology groups selected the optimum chemotherapy regimen for each episode and submitted basic clinical information at the time of initial presentation to determine the correct episode grouping
- The clinical information/data was merged with each patient's health insurance claims to create a longitudinal record
- The drug margin was calculated for each episode by using the existing fee schedule for each group. This sum was compared to the national average for that episode and the larger amount became the new episode fee
- The episode fee was paid immediately with the presentation of a new patient and the chemotherapy drugs were reimbursed at average sales price (ASP), whereas all other services were paid on a fee-for-service basis

Outcomes

- The medical oncology episode-based payment pilot reduced cancer care costs by 34%, or approximately \$40,000 per chemotherapy patient despite spending 179% more on chemotherapy³⁶
- Medical cost savings approximated to \$33.36 million³³
- The program enrolled 1024 patients and the data of 810 patients was used for cost analysis³³



UnitedHealthcare: Oncology Episode Payment Program Data:

Figure 13: Time to Progression Calculations for Patients with Relapse Measures

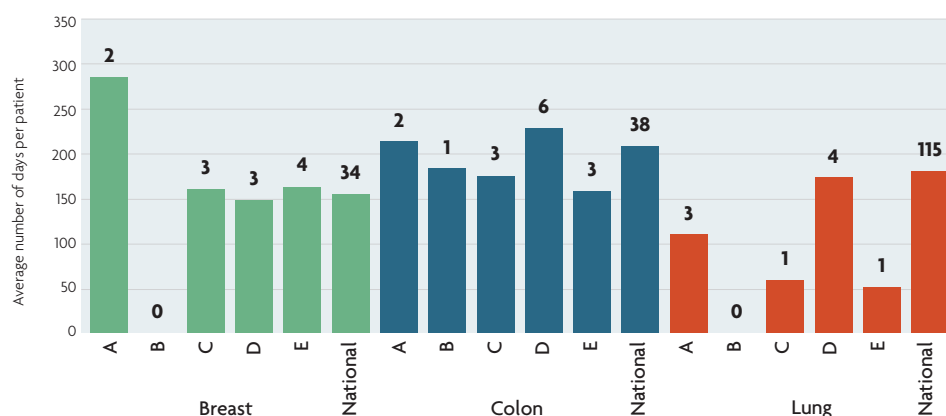


Figure 14: Average Total Cost per Episode for Patients with Early Stage Breast Cancer

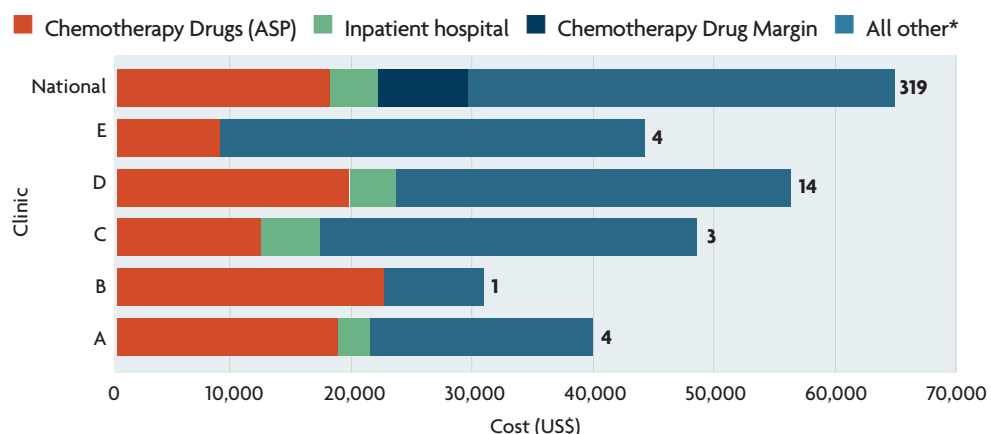
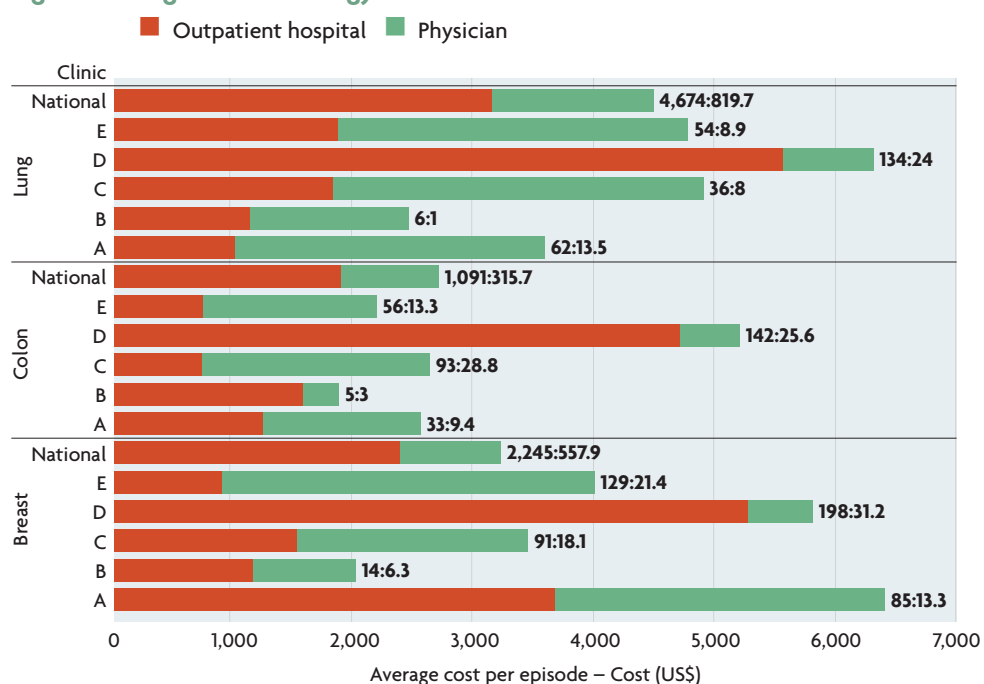


Figure 15: Diagnostic Radiology Cost and Use for Patients with Metastatic Cancer



Horizon Blue Cross Blue Shield of New Jersey: Episodes of Care/Bundled Payments Model

Horizon Blue Cross Blue Shield of New Jersey's leadership identified episodes of care/bundled payments as an essential strategy to achieve clinical integration among multiple providers and to promote broader, long term system transformation. The episodes of care model is the strategy used to engage specialists in the transformation and migration from fee for service to fee for quality/value. Episodes was piloted from 2010-2013 for total hip and total knee replacement. At the end of 2013, there had been enough success in achieving the Triple Aim that a decision was made to scale the program. During 2014, four new episodes were launched: Knee Arthroscopy, Pregnancy, Colonoscopy, and Adjuvant Breast Cancer. In addition, Horizon launched Episodes in CHF, lung, and colon cancers in 2015.

Horizon has the largest commercial Episodes program in the country; currently, there are orthopaedics, obstetrics, cardiology, gastroenterology, and oncology programs, but the program is expanding rapidly. Considered a national leader in the implementation of the episode of care model, the organization serves as advisor to CMS and other plans and providers around the country.

Horizon's program is retrospective; all providers of care within the continuum of the episode are paid at their contracted fee for service rates, and episode assessment is made post episode. Assessment includes the review of quality targets, member satisfaction thresholds, and financial targets. The Plan provides data analytics and contracting expertise, investing in key software that defines the bundles and automates the reconciliation process. Horizon utilizes the PROMETHEUS Payment algorithms for several of its episodes and COTA (Cancer Outcomes Tracking and Analysis) software for the oncology episodes.

Horizon holds regular meetings with providers to keep them abreast of claims data for contracted bundles. Data sharing has helped providers build a better understanding of care provided by downstream providers and the cost of those services. Horizon indicated that these sessions offer participants the opportunity to discuss new practice improvement ideas and ways to better coordinate with other providers.

Total Cost of Care Payment Model

The Total Cost of Care (TCC) payment model involves providing a single risk-adjusted payment for the full range of health care services needed by a specified group of people for a fixed period of time.

In essence, TCC is a composite measure of costs and utilization for a person or a population. As the sum of all medical expenditures, it is more than just a metric or an approach; it is an overriding, unifying concept that enables all metrics related to access, quality, and costs to be brought together to measure the overall, cost of care impact. TCC offers a comprehensive way to look at the totality of care and to determine how each initiative, each intervention, impacts the entire system of care. Through a TCC strategy, payers and providers can assess the impact of effectively utilizing care and financial resources, better managing the care of patients and populations and aligning incentives of a population-based system.

TCC measures the influence programs have on the whole health system or on an individual patient. TCC is critical to determining and measuring actions related to healthcare transformation, with an emphasis on how it impacts the delivery of better care. Each discrete performance measure, whether it is related to access or quality, for example, is important,

“Horizon has the largest commercial Episodes program in the country; currently, there are orthopaedics, obstetrics, cardiology, gastroenterology, and oncology programs, but the program is expanding rapidly.”

but rolling it up to the larger, system-wide metric, to TCC, helps to gauge its full impact. For organizations seeking to modify their business models to either more effectively share or better manage risk, an understanding of TCC across a variety of dimensions is fundamental. Other metrics, such as access, cost, utilization, and quality, are essential, but TCC is the metric to which they all relate.

Colorado Medicaid: Total Cost of Care Model

An example of the relationship between TCC and better health is evident in the value-based approach implemented by Colorado Medicaid. The Colorado Medicaid Accountable Care Collaborative (ACC), implemented in 2011, is working to improve health outcomes through a coordinated system that proactively addresses population health needs and controls costs by reducing avoidable, duplicative, and inappropriate utilization.³⁷

When designing and implementing this program, it was well understood that changing the Medicaid system would be an evolutionary process. After one year, even without full-scale implementation, the ACC is showing significant progress toward meeting this goal.

In addition to health improvements, the Colorado ACC is also showing cost savings. According to the 2012 ACC annual report, using a wide array of statistical methodologies, the department calculated “a range of estimated gross program savings between \$9 million and \$30 million” for FY 2011-2012.³⁹

The ACC Annual Report also concluded that “[t]he metrics...frequently use non-ACC clients as a control group.” However, non-ACC clients who are receiving care from practices enrolled as PCMPs in the program may also receive some of the program’s benefits, since the ACC Program is designed to transform the delivery system at the practice level. The potential for positively influencing results for clients in the control group may in turn negatively skew the program’s performance results. It is therefore possible that the “positive results reported here underestimate an even greater positive program impact.”³⁹

Objective: Improve care and costs through an immediate focus on cost and clinically-effective utilization of services

Actions

- Healthcare providers utilized illness burden risk scores
- Utilized additional key performance indicators to advance care management for complex, costly population segments and patients
- Care coordinators provided non-medical, high quality, and efficient services

Outcomes

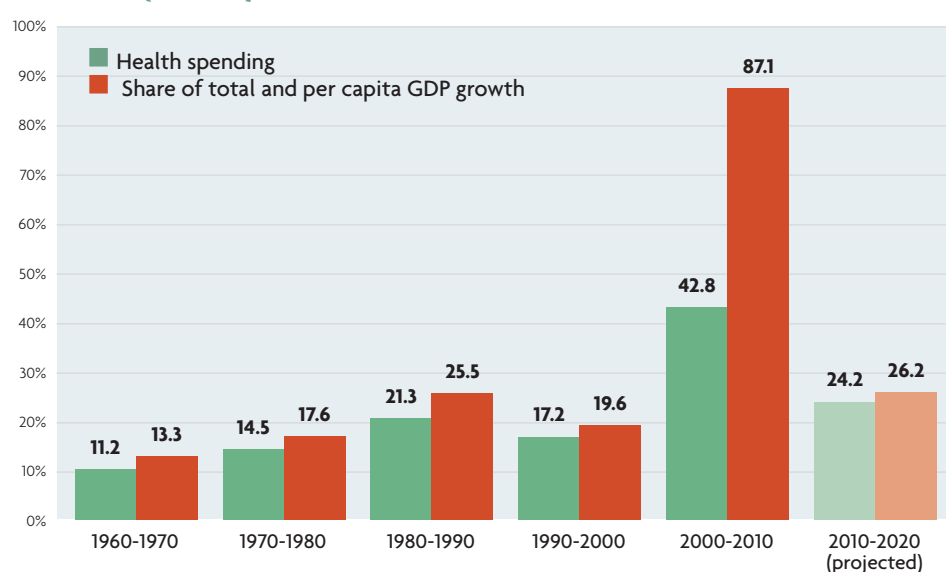
- Reduced hospital readmissions by 8.6%
- Reduced utilization rates of high cost imaging services by 3.3%
- Lower rate of increase (0.23%) in ER utilization compared to non-enrollees (1.47%)
- Decreased number of Potentially Preventable Events (PPP) by 73% and decreased preventable admissions by 27.1%
- Decreased preventable readmissions for adults with diabetes by 32.6%
- Estimated gross program savings between \$9 million and \$30 million for FY 2011-2012

SECTION 4: Outlook

Introduction

This brief illustrates the rapid movement from volume to value care supported by multiple Organized Customers: commercial insurers, CMS, proactive employers, and health systems. As we have discussed, the emergence of new value-based payment models is the result of the continuous, unsustainable increase in health care costs. These costs are attributed to multiple factors including a few major cost drivers such as an aging population, prevalence of chronic disease, expensive clinical procedures, new drug therapies, and end of life care.

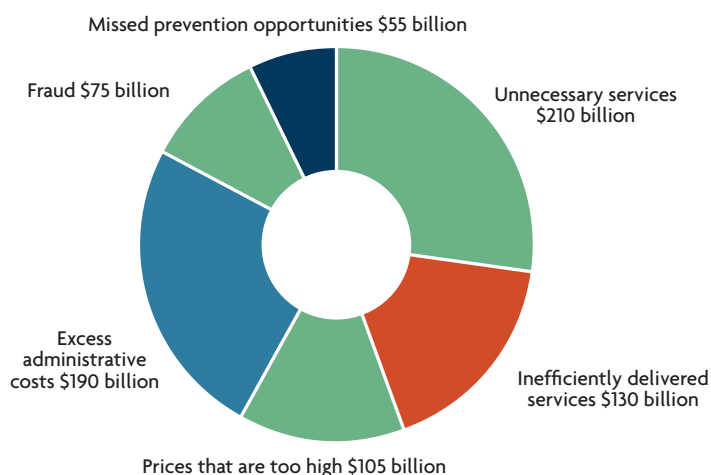
Figure 16: Health Spending as Share of Total and per Capita GDP Growth, 1965-2020 (Percent)



Source: CMS National Health Expenditure data. GDP data from CBO and Federal Reserve Economic Data

However, fee for service reimbursement is ultimately an underlying causative factor in each of the major cost drivers. Traditionally, providers of care have been reimbursed for the volume of services provided and, as in any free market model, a certain percentage of the current provider community focuses upon the volume of services in order to maximize reimbursement. As illustrated in Figure 17, unnecessary services, inefficiently delivered services, and prices that are too high are all elements of the free for service model.

Figure 17: Health Care Overspending ³⁹



In the past, a similar focus on cost fueled the 1980's growth of the Health Maintenance Organization (HMO). Primarily based on the early adoption of the capitated HMO model, the western United States is often referred to as the front line of managed care. The capitated model paid providers per patient a monthly fee to manage patient care. Unfortunately, this model created the "utilization management" concept with multiple payor treatment assessment structures designed to delay or deny expensive treatments, procedures, and drugs. The flaw in the model was the singular focus on cost without the link to clinical quality metrics and outcomes. The capitated HMO model created a negative public perception, leading to its discontinuation by most health plans. However select regions and health systems continued to use the basic HMO concept, gradually incorporating quality measures to improve patient clinical outcomes and increase patient satisfaction. The west and northwest of the US are the most prominent examples of long term success with a capitated fee structure.

The Pharmaceutical Industry: Reach and Frequency

After the discontinuation of the HMO model by most health plans, fee for service medicine returned to dominate the provider community for 20+ years beginning in the mid to late 80's. This corresponded with the introduction of many excellent pharmaceuticals to treat chronic illnesses such as diabetes, cholesterol, musculoskeletal pain, gastrointestinal disorders etc. These chronic diseases are treated by a network of care providers such as primary care providers, ancillary care, specialists etc. With that in mind, the pharmaceutical sales and marketing departments developed effective clinical education programs delivered to the provider community by field sales, specialty representatives, industry seminars, and expert speaker programs. Consequently, as illustrated in Figure 18, the sales force in the pharmaceutical industry grew rapidly in the late 80's and early 90's. The clinically oriented marketing programs required additional pharmaceutical staffing and were the genesis for the industry reach and frequency model: gain the mindshare of the provider community. The intense pharmaceutical marketing effort supported blockbuster drugs that improved the treatment of chronic diseases and the quality of patient care.

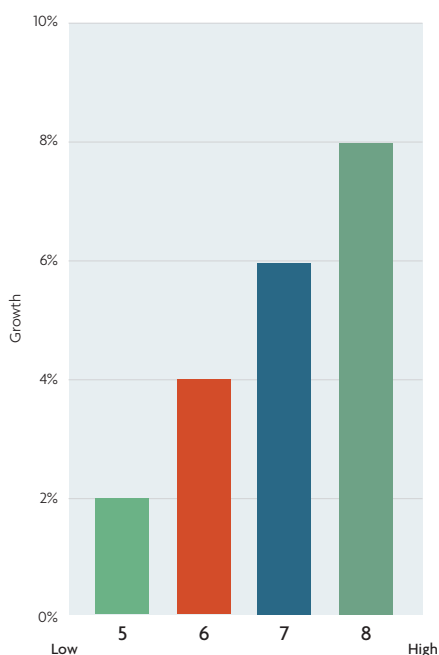
The recognition of the unsustainable rise in health care costs gave birth to the Affordable Care Act and the active role of CMS to manage costs. Unlike the limitations of the HMO model, CMS linked payment reform to the value created through improved outcomes and increased patient satisfaction.

Also, an increasing number of Organized Customers are keenly focused on value-based solutions to manage patient populations. The population management model expands beyond the narrow clinical treatment into a view of all of the factors impacting improved outcomes: environmental, lifestyle, adherence, and mental health. The traditional pharmaceutical reach and frequency model remains effective in select fee for service markets but has limited applicability in value based contracting.

The Pharmaceutical Industry: Short Term Solutions

A survey conducted by The Kinetix Group of integrated delivery networks diverse in size and geography indicated that only 40% of systems currently partner with the pharma/life sciences industry. However, 96% of health system leaders indicated that they would utilize pharma's non-branded resources to improve patient care. In the currently shifting landscape from fee for service to value, health systems are in great need of resources. Hence, pharmaceutical companies that provide products and services that contribute to value based emerging

Figure 18: Pharma Sales Force Ranking and Sales Growth, 1988-1990 ⁴⁰



“Ideally, a pharmaceutical company would develop a strategic platform that includes many of the above described components, enabling the health system to utilize the required platform components to address a population need.”

payment models will be given access to providers and embraced as partners. The key element to gain access is to move from tactics to participating in solutions. Listed below are examples of solutions:

Patient Compliance/Adherence: There are multiple examples of product specific patient compliance/adherence programs provided by the pharmaceutical industry to the Organized Customer. A key challenge to keep in mind that continues to be a topic of discussion relates to the customer's need to manage an entire population rather than the patients on a particular medication. Regardless, an adherence program adds value to the pharmaceutical company, the patient, and the health system

Transitions of Care: An effective COPD product that included a transition of care education program that resulted in a large health system requesting the Key Account Manager to be a member of the internal transition of care committee

Chronic Disease Patient Education: A large medical group selected a pharmaceutical diabetes education program to engage and educate all diabetic patients about patient self-management. As a result of the success of the program, it was integrated into the medical group's disease management delivery model

Coordinator/Navigator Education: A medical group undergoing the transformation to value based care has partnered with a pharmaceutical company to educate the new patient coordinators/navigators

Patient Support Services: A large multi- hospital health system utilized a pharmaceutical company's patient hub model to coordinate care for a specialty pharmacy delivered biologic. Currently, every new patient identified is introduced to the program

HEOR: A major health care system utilized a pharmaceutical HEOR department to support the population management quality goals of a chronic disease. Most pharmaceutical companies have a greater depth of knowledge regarding clinical and patient information based upon the analysis of millions of patient data in select therapeutic areas

Risk Based Contracting: This area has long been considered an aspirational concept for a pharma and Organized Customer relationship, and is still in the early evaluation phase. However, listed below are several examples of successful partnerships between pharma and the Organized Customer for risk based contracting:

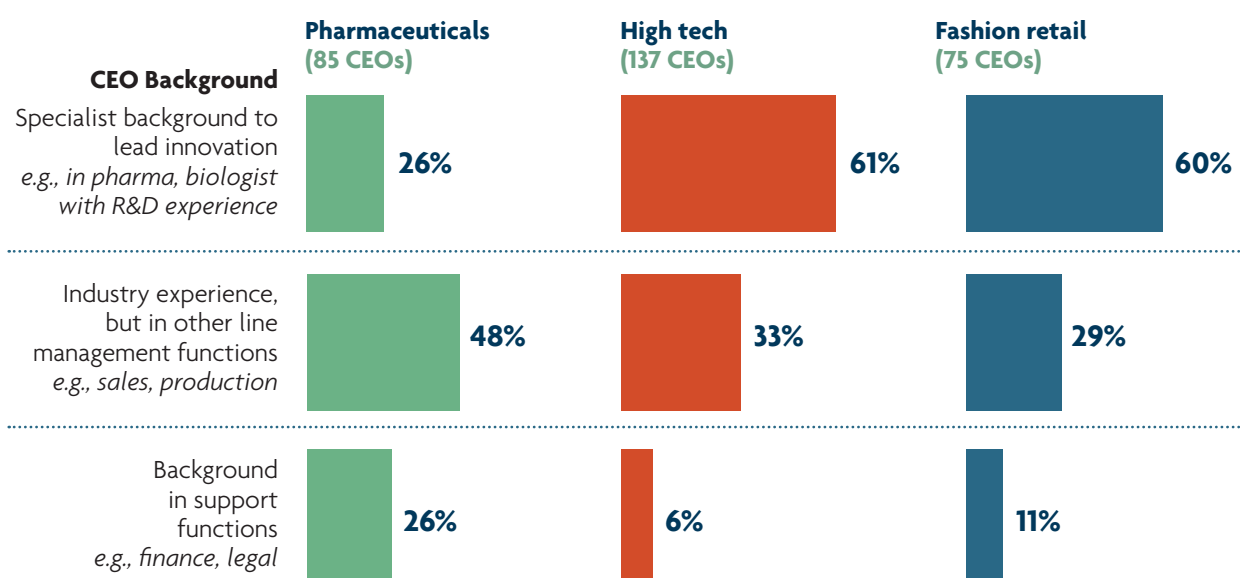
- A Northeast Health Plan: Utilizes a service offering from pharma to support a risk model for chronic care management
- A Large Midwest Health System: Developing three chronic disease protocols for system adoption based on a quality risk arrangement
- An Integrated, West Coast Medical Group: Utilized a pharmaceutical field team to educate a network of primary care physicians on a new program with a drug-specific focus

Ideally, a pharmaceutical company would develop a strategic platform that includes many of the above described components, enabling the health system to utilize the required platform components to address a population need. Incorporating multiple components into a strategic platform, however, are inhibited by the silos created by the traditional marketing functions: direct-to-patient, primary care physician, managed markets, trade, consumer, etc. Pharmaceutical commercial management would be well served to have a senior level marketing integration function to package a strategic platform and tailor the tactics to the specific customer function.

The Pharmaceutical Industry: Long Term Solutions

The movement to value based reimbursement has garnered support and has led to rapid adoption by multiple stakeholders. The clinical integration of Organized Customers promotes the Triple Aim and is a core component of the ACO movement. This model deconstructs regulatory barriers to preferred and exclusive referrals, enabling the ACO to develop optimal care delivery models. The pharmaceutical industry is burdened by major regulatory and legal constraints prohibiting many of the B2B elements required to provide solutions to health systems.

Figure 19: CEOs lacking Specialist Background to Lead Innovation ⁴¹



Many companies tout the “beyond the pill” mentality, yet very few operational executives implement that message. Most leaders have participated in the reach and frequency model for years but have a minimal understanding of the rapid changes in the health care landscape. The result is gradually restricted market access to all healthcare delivery segments. The pharmaceutical industry should consider the legal implications in becoming a clinical integration partner with ACO’s and other delivery structures.

It’s time for a change.

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