Appendix D

Medicare Payment Systems

Joseph P. Newhouse

October 11, 2016

Disclosure and a Caveat

- I am a director of Aetna
- Medicare's reimbursement systems are complex; I will leave out many details and try to focus on the main ideas

The Inpatient Prospective Payment System (IPPS)

- Since 1983 Medicare has used the IPPS to pay most hospitals, $147 billion (2014)
- It's a take-it-or-leave it price, no negotiation
- Starts with a per stay (per admission) base payment and makes some adjustments
  - Physician services are excluded from the IPPS
  - A detail: There are separate systems for operating and capital expenses, but they function similarly

The IPPS: The Base Payment

- All admissions are classified into one of 751 groups defined by the principal diagnosis, whether there are additional diagnoses and how severe the diagnosis is ("complication or comorbidity" or "major complication or comorbidity"), and whether certain procedures were done
  - The groups are called MS-DRG's

The Base Payment, cont.

- Each group has a weight that corresponds to Medicare's estimate of its relative cost
  - For example, the weight for a bone marrow transplant is 4.37 and for a prostatectomy is 1.0, so, other things equal, the hospital is paid 4.37 times as much for the bone marrow transplant*
- Each year Congress sets a "conversion factor," which says how many dollars will be paid for a weight of 1.0; future conversion factors were reduced to pay for the ACA

*These are the weights with no complicating conditions. If there are complicating conditions, the weights are higher.

The Wage Adjustment

- Each hospital is classified into a labor market area and hospitals are paid more or less according to how high wages are in that area
  - Massachusetts has had an exception for the wage index for the past few years, although it will lose that for 2017 through an error
    - Massachusetts hospitals will lose $160 million*

*Boston Globe, May 2, 2016; CMS denied Massachusetts' appeal to rectify the error on August 2.

Other Adjustments

- The IPPS also has hospital-specific payments: Graduate Medical Education (GME) $ and Disproportionate Share Hospital (DSH) $
  - GME's intent is to reimburse the higher costs of teaching hospitals; it multiplies the base amount by a multiple of the number of residents/bed and also reimburses a percentage of resident salaries
  - DSH's intent is to help pay for uncompensated care; it pays hospitals with high numbers of Medicaid patients more
    - It is being reduced as the uninsured rate comes down

Other Adjustments, cont.

- Outliers: 5% of base payments go to pay for individuals with very costly stays; these payments are budget neutral
- Technology: Certain expensive new technologies get add-on payments since the base weight does not account for them
- Bad debt: Medicare reimburses for 65% of Medicare bad debt

Other Adjustments, cont.

- Quality/Value-Based Purchasing:
  - Penalties for excessive readmissions: Imposed on 78% of hospitals nationally in 2016; but only 15% of hospitals lost 1% or more of Medicare revenue and only a few lost the maximum 3%
  - Around 2% of base payments were redistributed according to quality measures, including infection rates

*Numbers are national numbers; I don't know the Massachusetts number.

Incentives of the IPPS

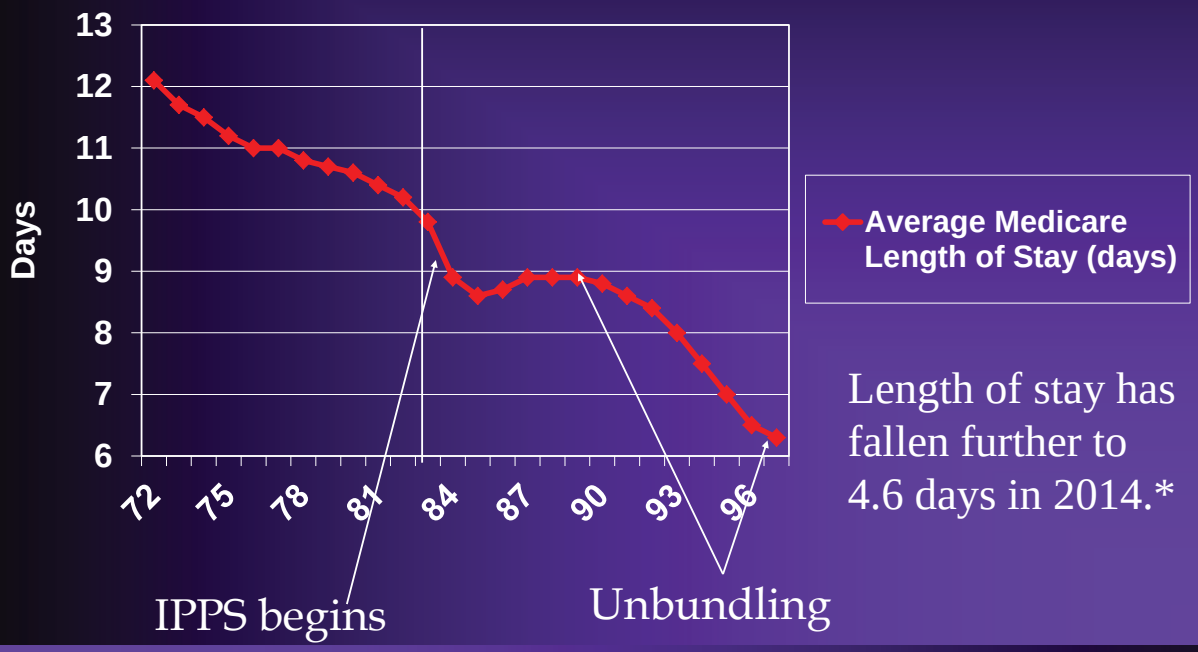
- Per stay payment ⇒ incentive for *efficiency*
  - Major reduction in length of stay
- Within-MS-DRG variation⇒ incentive for *selection*
  - Early evidence* of modest "dumping" (selecting against high cost cases) to safety net hospitals (generally public hospitals) and also to exempt** hospitals which continued on cost reimbursement up to a limit; those studies have not been repeated

*Dumping to last resort: Newhouse, HCFR, 1989; to exempt hospitals: Newhouse and Byrne, JHE 1988.
**Psychiatric, rehabilitation, and long-term hospitals were initially exempt from the IPPS.

Incentives of the IPPS, cont.

- Marginal Revenue = 0 ⇒ incentive to *unbundle* and possibly *stint*
  - Growth of post-acute and outpatient services since the 1980's from unbundling (shifting last days of stay out of inpatient to post-acute)

Fall in Hospital Length of Stay*



Length of stay has fallen further to 4.6 days in 2014.*

*Sources: HCFA Statistical Supplement, 1999, p. 130 and MedPAC Data Book 2016, Chart 6-9.

The Outpatient Prospective Payment System (OPPS)

- System used for hospital outpatient departments (OPD's) excluding MD's; $53 billion (2014)
- Introduced in 2000, same principle as IPPS
- Uses Ambulatory Payment Classification (APC's), similar to MS-DRG's, 700 groups
- Adjustments: Wage index, new technology

Physician Payment: The Medicare Fee Schedule (MFS)

- For decades Medicare paid fee-for-service, some change lately; $69 billion in 2014*
- CMS specifies relative fees for 7,000-8,000 procedures and services; Congress sets a conversion factor
- Also adjusted by an input price index
- Separate components for "work" (take-home), practice expense, malpractice cost

*Includes payments to allied health personnel such as psychlogists and chiropractors, but the great bulk is to physicians.

Incentives of the MFS

- To cover fixed cost (e.g., rent) fees must exceed marginal cost, so an MD paid this way can always earn more by doing more
- How to handle "practice costs" for the same service across different sites has been a problem

Site-of-Service Differentials

- Medicare reimbursement for facility costs *for the same procedure* differs by site: OPDs; MD offices; ASCs;* inpatient hospitals
  - These are "practice expenses" in MD offices; APC amounts include these costs in ASC weights, as do MS-DRG weights in hospitals
  - Because the three** payment systems differ, payment for same patient getting the same procedure differs by site

*ASC = Ambulatory Surgery Center. Procedures commonly done in ASC's include cataract removal and colonoscopy.
**3 systems: MD office, OPD's and ASC's, inpatient hospital.

A Site-of-Service Differential*

TABLE 2–1

Medicare and beneficiaries pay more for a 15-minute E&M office visit provided in an OPD than in a freestanding physician's office, 2013

	Service provided in freestanding physician practice*	Service provided in OPD		
		Physician facility rate*	OPPS rate	Total, OPD rate
Program payment	$58.00	$39.76	$58.94	$98.70
Beneficiary cost sharing	14.50	9.94	14.74	24.68
Total payment	72.50	49.70	73.68	123.38

Note: E&M (evaluation and management), OPD (hospital outpatient department), OPPS (outpatient prospective payment system). The Current Procedural Terminology code for this visit is 99213.
*Paid under the Medicare physician fee schedule.
Source: MedPAC analysis of payment rates in the 2013 physician fee schedule and OPPS.

Medicare paid 70% more (=123.38/72.50) for a 15 minute physician visit in the hospital OPD than for the same 15 minute visit in an office.

*Source: MedPAC, June 2013.

Another Site-of-Service Differential*

Reimbursement was almost double ($738/$389) in the OPD

Table 2. Payment rates to physicians and OPDs for laser eye procedures, 2012

	Payment amount	Calculation
Current payment rates		
Service in physician office		
Payment to physician	$389.01	Work/PLI ($171.53) + Non-Facility PE ($217.49)
Service in OPD		
Payment to physician	359.51	Work/PLI ($171.53) + Facility PE ($187.98)
Payment to hospital	378.93	Hospital outpatient department rate ($378.93)
Total payment	$738.44	
Policy that aligns rates across settings- *Service in OPD*		
Payment to physician	359.51	Work/PLI ($171.53) + Facility PE ($217.49)
Payment to hospital	29.51	Non-Facility PE ($217.49) - Facility PE ($187.98)
Total payment	$389.01	

Note: OPD (hospital outpatient department), PLI (professional liability insurance) PE (practice expense). Payments include both program spending and beneficiary cost sharing.
Source: MedPAC analysis of payment rates in the 2010 physician fee schedule and outpatient prospective payment system.

*Source: MedPAC staff presentation, October 2012.

Why Are Many Cardiologists Becoming Hospital Employees?

- Medicare has, seemingly unwittingly, been driving a major change in the organization of US medical care; MD's historically were self-employed in small scale practices; increasingly they are becoming employees of large practices

Payment for Echocardiograms in the OPD Is 2.5X the Office!

TABLE 2-3 Differences in payment rates for level II echocardiogram without contrast provided in physician's office and OPD, 2013

	Payment amount	Calculation
Current payment rates		
Service in physician's office		
Payment to physician	$188.31	Work ($) + PLI ($) + nonfacility PE ($)
Service in OPD		
Payment to physician	$62.40	Work ($) + PLI ($) + facility PE ($)
Payment to hospital	$390.49	OPPS rate ($)
Total payment	$452.89	

If the cardiologist is a hospital employee, the hospital can share the difference in reimbursement with the cardiologist.

Source: MedPAC, June 2013 Report.

The Consequences

Table 9. E&M office visits and cardiac imaging services are migrating from freestanding offices to HOPDs, where payment rates are higher

Type of service	Share of ambulatory services performed in HOPDs, 2012	Per beneficiary volume growth, 2010-2012	
		Freestanding office	HOPD
E&M office visits (CPT codes 99201–99215)	10.7%	-2.3%	17.9%
Echocardiograms without contrast (APCs 269, 270, 697)	34.6	-9.9	33.3
Nuclear cardiology (APCs 377, 398)	39.0	-16.8	24.3

Note: E&M (evaluation and management), HOPD (hospital outpatient department), CPT (Current Procedural Terminology), APC (ambulatory payment classification).
Source: MedPAC analysis of Standard Analytic Claims Files from 2010, 2011, and 2012.

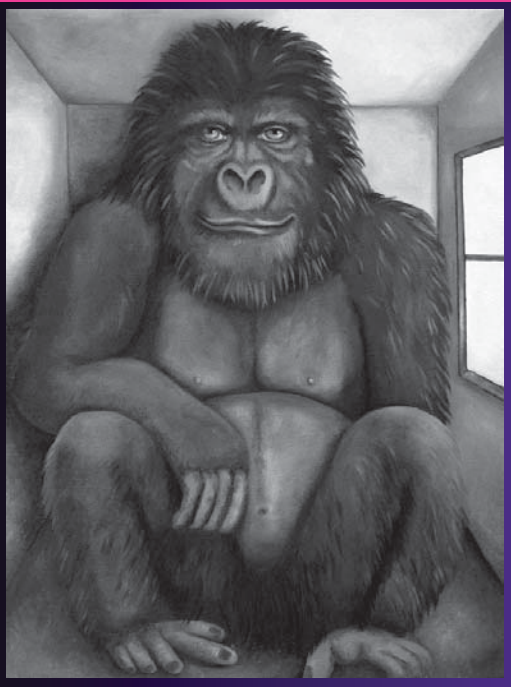
HOPD = Hospital Outpatient Department. See notes to slide for other acronyms.

Source: MedPAC, unpublished. MedPAC has also computed data for 2013-2014 changes for echocardiograms (-5.7% in the office, +7.0% in the HOPD) and nuclear cardiology (-9.6% in the office, +1.1% in the HOPD).

A Bow in the Direction of a Fix

- The Bipartisan Budget Act of 2015 allowed the site-of-service differentials for existing hospitals to remain in place, but restricted new ones
  - My take: The horse is out of the barn

Health Policy Has Recently Seen Two 800 Pound Gorillas



The ACA

MACRA

MACRA: In 2019 Medicare Physician Payment Changes

- Starting in 2019, almost all MD's will be paid under one of two new payment models, the Merit Based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APM's); CMS estimates 90% will be paid under the MIPS, and I will focus on the MIPS

The New Payment Methods

- CMS issued a proposed rule in April 2016 (900+ pages)
- MIPS: Payments to an individual MD can go up or down 4% in 2019, 5% in 2020, 7% in 2021, and 9% after that based on quality, use of EHR's, clinical practice improvement, and cost*
  - The actual adjustments for any individual MD will depend on the distribution of scores to in order achieve budget neutrality

*Plus there is an extra 10% bonus for "exceptional" performance that is not subject to the budget neutrality adjustment, $500 million in total.

MIPS, cont.

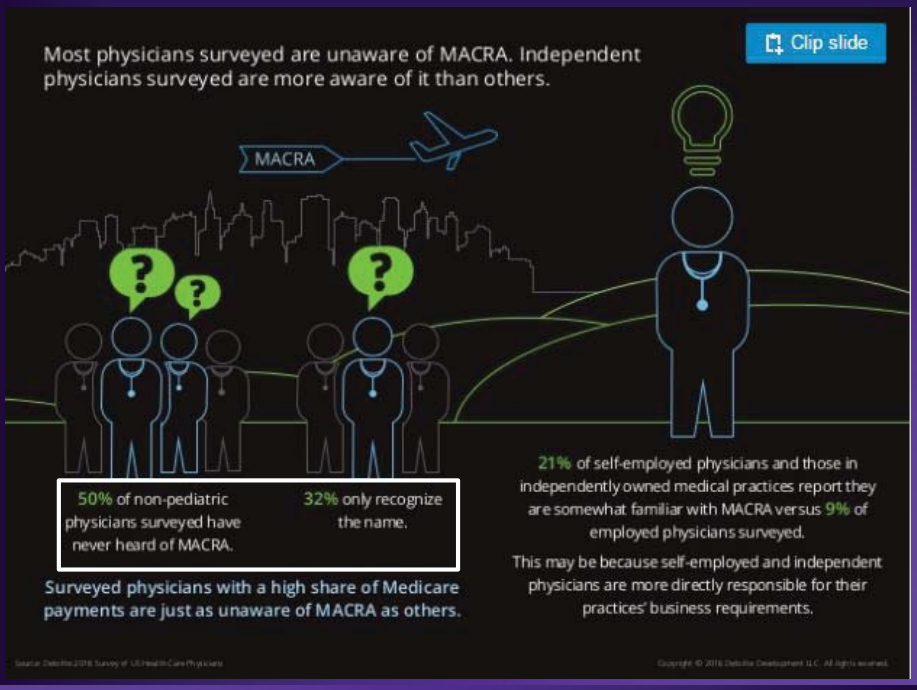
- Although the payment adjustments (±4% in 2019 for incentive payments, going up to ±9% in 2022) don't start until 2019, they are based on performance in 2017 and then the adjustment is applied to Traditional Medicare billings in 2019, so from an MD's point of view the new system starts in a few months

The Politics of MACRA

- MACRA was enacted with substantial bipartisan support so although the details may be modified, it is likely to remain policy irrespective of the election results*
  - The many Republican bills in the House to repeal the ACA exempted its delivery system reforms, which was the heart of the changes in MACRA

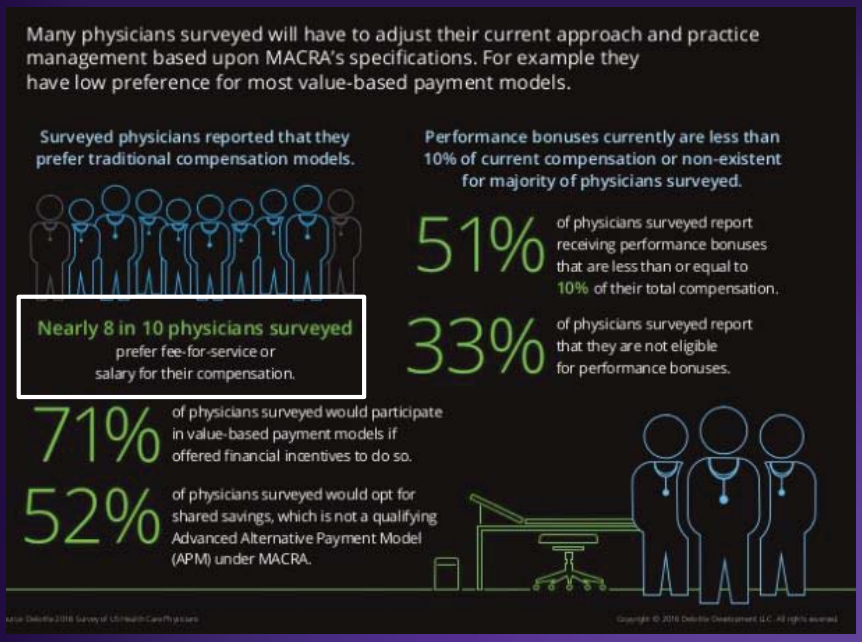
*I expect the Final Rule to be issued in November.

Despite MACRA's Importance Most MD's Don't Know of It*



*Source:http://www.slideshare.net/DeloitteUS/2016-survey-of-us-physicians-physician-awareness-perspectives-and-readiness-for-macra

And MD's Like FFS Reimbursement or Salary*



*Source: Same as prior slide.

And a Month Ago CMS Took Its Foot Off the Gas Pedal

- September 8, 2016: CMS says it will effectively allow a physician to push implementation off a year; all he or she has to do to avoid a negative adjustment is to report some (as yet unspecified) data
- Or the physician can report for part of the year and get a positive adjustment
- Or he or she can participate in the MIPS or the APN as originally specified

My Take on Future Physician Payment

- Moving from the fee-for-service system is going to be a slow process
- Even if an organization like an Accountable Care Organization takes some financial risk, individual physicians may have a large part of their compensation paid under fee-for-service

Conclusions

- Running administered price systems like Medicare's is difficult; prices that are misaligned with cost induce distortions, which may be under- or overprovision of various services or shifts to employed physicians
  - New products and gains in productivity from experience are hard to account for

Supplemental Slides

The Merit Incentive Payment System (MIPS)

Box. The 4 Components of the Composite Performance Score of the Merit-Based Incentive Payment System

Quality (50% Decreasing to 30% in 2021)

Physicians must report on at least 6 quality measures, including 1 outcome measure if available, from an annually updated inventory (example outcome measures include functional improvement following surgery and depression remission).

Resource Use (10% Increasing to 30% in 2021)

These measures will be calculated by CMS using claims, including 2 general measures that assess the total cost of care for beneficiaries during a year or surrounding a hospitalization, as well as 40 clinical episode measures, as a basis for rewarding efficient physicians.

Advancing Care Information (25%)

This category replaces meaningful use measures on health information technology with fewer and more flexible reporting requirements intended to promote interoperability and data flow relevant to a physician's practice, rather than electronic health record capabilities per se.

Clinical Practice Improvement Activity (15%)

Clinicians must attest to several of a wide range of practice-level activities, such as delivery of telehealth services, participation in registries, and provision of 24/7 access.

Fee-for-service remains; these are adjustments up or down to a physician's payments under TM; more in class 15. CMS estimates ~90% of MD's will be in MIPS in 2019.*

*https://www.aamc.org/advocacy/washhigh/highlights2016/459692/042916cmsreleasesproposedruleformacraphysicianpaymentsystem.html

MACRA Pushes MD's Toward Risk-Based Entities*

Provisions Related to Advanced Alternative Payment Models

For clinicians who take a further step towards care transformation, the law creates another path. Clinicians who participate to a sufficient extent in Advanced APMs would qualify for incentive payments.

Importantly, the law does not change how any particular APM rewards value. Instead, it creates extra incentives for participation in Advanced APMs. For years 2019 through 2024, a clinician who meets the law's standards for Advanced APM participation is excluded from MIPS adjustments and receives a 5 percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

Standards for Advanced Alternative Payment Models (APMs)

Under the law, Advanced APMs are those in which clinicians accept risk for providing coordinated, high-quality care. As proposed, to be an Advanced APM, models must be a CMS Innovation Center model or a statutorily required demonstration and must generally:

1. **Require participants to bear a certain amount of financial risk.** Under our proposal, an Advanced APM would meet the financial risk requirement if CMS would withhold payment, reduce rates, or require the entity to make payments to CMS if its actual expenditures exceed expected expenditures.

*Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf.

APM's

- 5% bonus on TM payments for being in an APM; APM's may be Patient Centered Medical Homes or risk-bearing entities like an Accountable Care Organizations, but they have to save money to qualify for a bonus and the amount of financial risk necessary to qualify rises over time*
- Starting in 2026 physicians in APM's are to get 0.75 pct pt updates vs 0.25 for others**

*See slide above; the proposed rule also pushes delivery systems or physician groups toward risk-based contracting in commercial insurance, since commercial contracts count starting in 2021. **This compounds over time.

MassHealth Presentation to the Special Commission on Provider Price Variation

Executive Office of Health & Human Services

Discussion document
November 1, 2016

Agenda

- MassHealth FY16 summary
- Ambulatory payment methodology
- Hospital payment methodology
- Supplemental payments summary
- Questions

MassHealth: FY16 Overview

Focus of today's discussion

- 1.9 million members, 28% of Massachusetts population
- $15.7 billion in FY 2016 program + supplemental spending spend:
  - $6.8 billion on managed care capitation payments
  - $3.9 billion on direct payments to LTSS providers (e.g., Nursing facilities, Home Health agencies, PCAs)
  - **$4.0 billion on direct payments to medical providers**
    - **$1.9 billion rate payments to ambulatory medical providers**
    - **$1.2 billion rate payments to hospitals**
    - **$0.9 billion supplemental payments to hospitals**
  - $1.0 billion on Medicare premiums and other payments

Payment Methodology: Ambulatory medical providers

- $1.9 billon FY16 spending on ambulatory medical providers, e.g.:
  - Physicians
  - Community Health Centers
  - Clinical Labs
- Rate-setting process:
  - 27 Rates set by regulation M.G.L 118E Sec. 13C, 13D, in accordance with state law
  - Multi-step process to develop + promulgate rates:
    - CHIA analysis
    - Stakeholder engagement
    - Public hearings
    - Final adoption
- Payment methodology:
  - Class rates (i.e., same for any participating provider) for each procedure code
  - Procedure codes billed reflect unique services provided to each member
    - E.g. Office visit, knee replacement

Payment Methodology: Acute Care Hospitals

- $1.2 billion FY16 hospital rate payments (inpatient + outpatient)
- Bundled rates for inpatient + outpatient hospitals set annually in single hospital contract ("RFA")
- Inpatient payments cover all hospital services provided during a **single admission**
  - State-wide base rate established by RFA
  - RY 17 base rate = $10,207
  - Base rates adjusted for:
    - Acuity (calculated using 3M APR-DRG discharge grouper), e.g.:
      - Chest Pain= 0.3808 x base rate
      - Liver Transplant: 11.0454 x base rate
    - Area wage index (+/- 0.1%)
    - Outlier payment add-on for admissions with costs > $25,000
    - Readmission penalty – Hospitals are evaluated based on their ability to limit readmissions. The base rate penalty reduction ranges from 0% - 4.4%

Payment Methodology: Acute Care Hospitals (continued)

- Outpatient payments cover all hospital services provided during a **24-hour episode**
  - State-wide base rate established by RFA
    - RY 17 base rate = $252.00
  - Outpatient base rates adjusted for:
    - Acuity (calculated using 3M EAPG ambulatory grouper), e.g.:
      - Skin Repair (i.e., stitches) = 0.6899 x base rate
      - Arthroplasty = 14.10 x base rate
    - Outlier payment adjustment for episodes with costs > $2,100
  - Prior to Dec 1 2016, hospitals receive a fixed Payment Amount Per Episode ("PAPE") that reflects the hospitals' historical acuity + outlier cost.
  - After Dec 1 2016, rates will be adjusted for acuity and outlier costs in real time (APEC)
- Pay for Performance Program – In addition to rate payments, hospitals can earn additional payment for delivering high quality care.
  - $20 million in RY16 paid on the basis of performance against prescribed measures

Summary of Supplemental Payments

In addition to hospital rate payments, MassHealth makes approximately $0.9 billion in supplemental payments not tied directly to hospital admissions/episodes

Program	Recipients	Qualifications	FY16 Value ($M)
Delivery System Tranf. Initiative (DSTI)	7 Hospitals	Hospitals with Medicaid volume >1 SD above statewide mean + commercial volume >1SD below statewide mean	200.0
Pubic Service Hospital	2 Hospitals	Authorized in 1115 Waiver specifically for CHA and BMC	140.0
Public Hospital Transf. Initiatve (PHTII)	1 Hospital	Authorized in 1115 Waiver specifically for CHA	220.0
MassHealth Essential	5 Hospitals	Non-profit teaching hospitals affiliated with state-owned medical school or public acute hospital with Medicaid patient days ≥ 7%	213.0
High Medicaid Discharge Hospitals	12 Hospitals	Hospitals with > 2.7% of statewide Medicaid discharges	115.0
High Public payor	35 Hospitals	Hospitals whose Medicaid + Medicaid volume >= 63%	24.0
High Complexity pediatric	4 Hospitals	Pediatric Hospitals that treat high complexity children	15.0
		Total	**927.0**

Questions?

Health Care Contracting & Market Forces

Special Commission on Provider Price Variation
November 29, 2016

Professor Gwendolyn Roberts Majette
The Center for Health Law and Policy
Cleveland-Marshall College of Law

Agenda

- Introduction
- Challenges in the Massachusetts Health Care Market
- History of Health Care Contracting
- Health Care Contract Provisions
- Recent Cases & Initiatives
- Market & Regulatory Solutions: Reducing Price Variation
- Component Contracting
- Key Take-Aways

Challenges in the Massachusetts Health Care Market

- Fragmented care
- High volume in a primarily fee-for-service payment system
- Increasing consolidation in the market
- Increasing health care costs

History of Health Care Contracting

- Managed Care Revolution (mid-1990s)
  - Selective contracting – i.e. plans are looking for specific providers to adhere to cost containment principles and accept their payment methodology
  - Growth of hospital systems
- Consolidation & Integration (mid-1990s - 2004, post Affordable Care Act)
  - Cost-containment initiatives – i.e. risk-based contracting
  - Large health care systems & large health insurance companies

Health Care Contract Provisions

- All-or-Nothing*
  - Clause requiring the purchase/use of unwanted goods/services as a condition to obtain the desired good/service.
  - In MA, all-or-nothing language in limited- and tiered-network plans is prohibited under Ch. 176O Section 9A(a)(3) (2010).
- Anti-Incentive/Anti-Steering
  - Clause prohibiting a payer from steering consumers to high-value, low-cost providers.

*This is different from tying in the anti-trust context, which is linking goods or services across different markets.

Health Care Contract Provisions

- Price Secrecy
  - Clause prohibiting a payer from sharing the price/cost of a good or service.
  - In MA, Ch. 176O Section 9A(d),(e) (2010) and Ch. 224 prohibit price secrecy and require providers and payers to share price and cost-sharing information with consumers.
- Quality/Performance Secrecy
  - Clause prohibiting a payer from sharing quality, efficiency, or performance data.
  - In MA,
    - Ch. 224 requires providers to report quality measures to the Center for Health Information and Analysis (CHIA). CHIA must make quality information available to consumers on its website.
    - Ch. 176O Section 7 (2010) requires payers to make available provider quality information (CHIA – Standard Quality Measure Set) upon member enrollment or request.

Health Care Contract Provisions

- Most Favored Nation
  - Clause under which a dominant plan/provider demands the best price and precludes the other party from offering similar terms to its competitors.
  - In MA, these clauses are banned under Ch. 176D Sections 3 & 3A (2010).
- Out of Network Billing
  - An out-of-network bill arises when an insured individual inadvertently receives care from an out-of-network provider.
  - Examples:
    - Individual taken to an out-of-network emergency room
    - Service provided by an out-of-network provider within an in-network facility. This occurs most often with emergency, radiology, anesthesiology, and pathology services (ERAP).
  - Under Ch. 224, a consumer is not responsible for out-of-network charges if he/she did not have a "reasonable opportunity" to choose to have the service performed by an in-network provider.

Recent Cases & Initiatives

- CA Senate Bill 932 (Apr 2016)
  - Prohibits all-or-nothing language (tying), anti-tiering/steering, and price secrecy.
  - Limits rates for emergency room out-of-network providers.

- Federal Trade Commission (FTC) ACO Policy (Oct 2011)
  - Identifies four types of conduct that raise competitive concerns when exercised by ACOs with market power.
    - Anti-tiering/steering, guaranteed inclusion, and most favored nation clauses
    - All or nothing language (tying)
    - Mandating exclusive contracting with providers
    - Price, quality, performance secrecy

- UFCW & Employers Benefit Trust v. Sutter Health (2014)
  - Union and self-insured employer vs. Northern California provider
  - Alleges that certain contract provisions are anti-competitive: all or nothing language (tying), anti-incentive, exclusive dealing, price secrecy.

- US/NC v. Carolinas Healthcare System (2016)
  - US Dept of Justice and North Carolina vs. major North Carolina hospital system
  - Alleges that several contract provisions (no tiering/narrow networks and price/quality confidentiality) violate the Sherman Anti-Trust Act by unreasonably interfering with competition.

Market & Regulatory Solutions: Reducing Price Variation

- Market Solutions
  - Prohibit anti-competitive* contract provisions
  - Encourage transparency – price and quality information
  - Incentivize use of high-value providers
    - Ex: Tiered- and Limited-Network Products
- Regulation
  - All-payer rate setting (Maryland)
  - Rate caps

*Anti-competitive practices are "unfair business practices that are likely to reduce competition and lead to higher prices, reduced quality or levels of service, or less innovation." Federal Trade Commission, *Anticompetitive Practices*, https://www.ftc.gov/enforcement/anticompetitive-practices (last visited Nov. 10, 2016).

Component Contracting

- Evanston FTC Order (2007)
  - Two Illinois hospitals merged in 2000.
  - The FTC retroactively reviewed the impact of the merger and found that prices had increased.
  - The FTC imposed a conduct remedy requiring separate contracting for 10 years. Payers, however, did not take advantage of this option.
    - Each hospital was required to create separate negotiating teams and establish firewalls.

Component Contracting (cont.)

- Benefits of Component Contracting
  - May reduce rates paid to certain providers.
- Disadvantages of Component Contracting
  - Increased administrative costs
  - Difficult to monitor/regulate
  - Duration
  - Changing dynamic in the health care market

- The FTC has not ordered a component contracting remedy since Evanston.
- The reviewing court heavily criticized the component contracting requirement that was part of the proposed anti-trust settlement between Partners HealthCare and the Commonwealth of Massachusetts, when Partners' proposed mergers with South Shore and Hallmark Hospitals.

Key Take-Aways

- Provider price variation exists across the country.
- Health care contracts are a product of dynamics in the health care market and have a role in price variation.
- Solution is likely a combination of both market and regulatory actions.
- Any solution will need to be phased in over time.

QUESTIONS

MASSACHUSETTS
HEALTH POLICY COMMISSION

Demand-side incentives to address provider price variation

December 13, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Overview**
- Key policy strategies
  - Insurance Design
  - Consumer Engagement and Shopping
  - Fostering Choice and Competition
- Q&A

Demand-side incentives can improve health care value

- Demand-side incentives in health care encourage purchasers of coverage and services (i.e. individuals and employers) to make higher-value choices
- Demand-side incentives can result in cost savings
  - Lower out of pocket spending and lower premiums
- Demand-side incentives can reduce price variation
  - By encouraging patients to use higher-value (e.g. lower-priced, high quality) providers, demand-side incentives can incentivize higher-priced providers to reduce prices

HPC

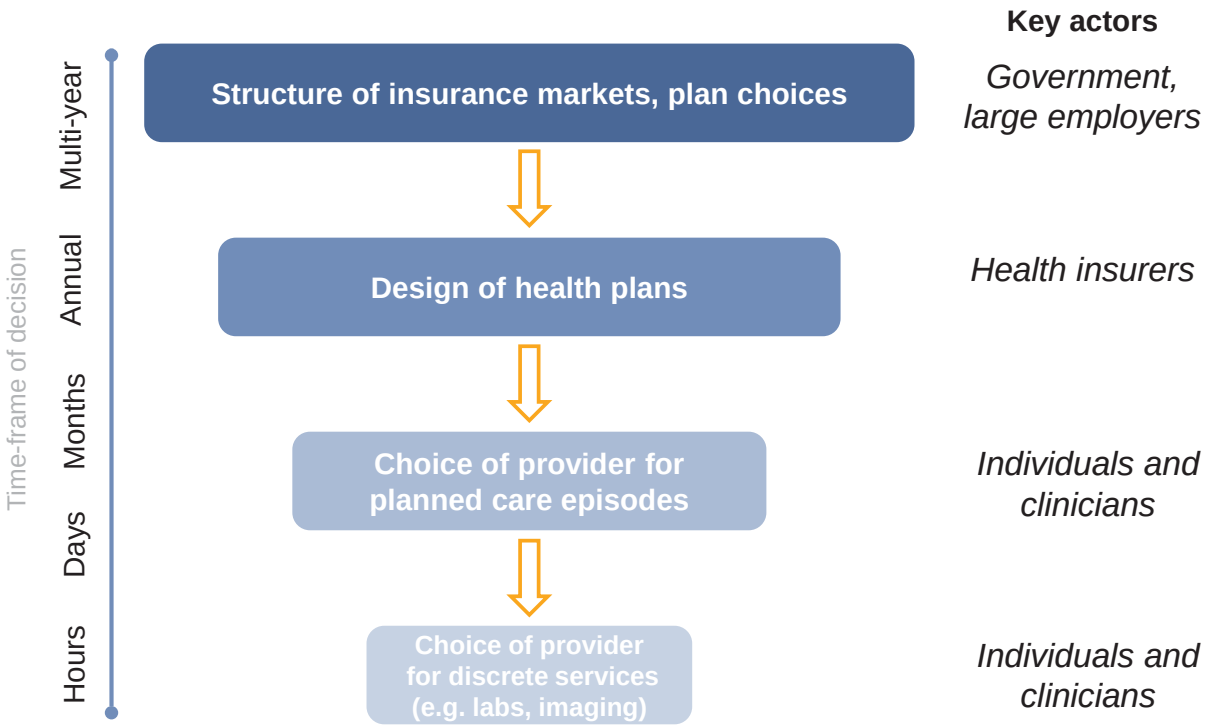
Limitations of demand-side incentives

- Demand-side incentives tend to play a smaller role in health care
  - Consumers often prioritize health over cost
  - Insurance and subsidies limit exposure to the cost of care
  - Consumers don't know what health care services they need - and depend on providers to make care decisions
  - Quality is hard to judge; consumers sometimes assume higher prices mean with higher quality*
- Demand-side incentives may not work for all types of care. They tend to work best for:
  - Planned episodes of care
  - Situations where quality is transparent or doesn't vary much
- Demand-side incentives may create financial burdens for some consumers

HPC

* These findings are partly informed by a series of focus groups conducted for the HPC by Amy Lischko et al, as described in "Community Hospitals at a Crossroads," Health Policy Commission, March, 2016

Where can demand-side incentives be applied in health care?



HPC

MASSACHUSETTS HEALTH POLICY COMMISSION

AGENDA

- Overview
- Key policy strategies
  - **Insurance Design**
  - Consumer Engagement and Shopping
  - Fostering Choice and Competition
- Q&A

Tiered and limited network plans: Evidence of savings in Massachusetts

Limited network plans exclude higher priced/lower value providers from network

- The GIC used a premium holiday in 2012 to encourage employees to switch to limited network plans
- Those who switched had 36% lower spending with no reduction in quality of care (Gruber and McKnight, 2016)
  - Savings resulted from reduction in both prices and quantities of hospital and specialist care used; spending increased on primary care

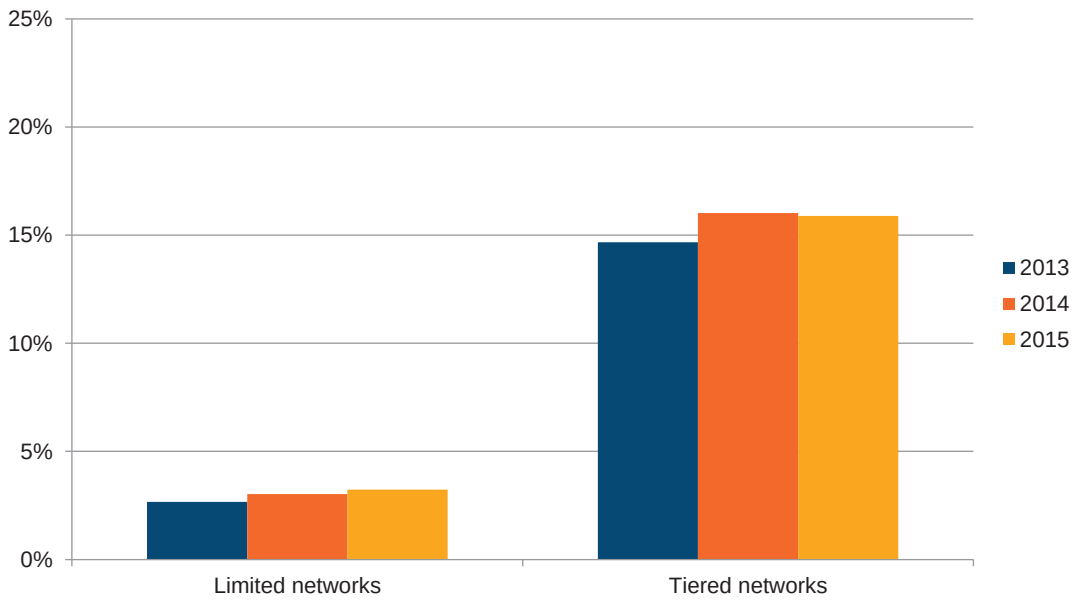
Tiered network plans assign higher cost-sharing to higher priced/lower value providers

- BCBS of MA introduced tiered network plans in 2007, enhanced in 2009
  - $150 copay for preferred hospitals vs $1,000 (with $2,000 deductible) for non-preferred
  - Radiology: $75/250; Outpatient surgery: $150/$500
- The design shifted ~7% of hospital admissions from non-preferred to preferred hospitals (Frank, Chernew et al, 2015)
  - There were also impacts on radiology, outpatient, and total spending…study forthcoming

Frank, Matthew B., et al. "The impact of a tiered network on hospital choice." *Health services research* 50.5 (2015): 1628-1648
Gruber, Jonathan, and Robin McKnight. *Controlling health care costs through limited network insurance plans: Evidence from Massachusetts state employees*. No. w20462. National Bureau of Economic Research, 2014.

Enrollment in tiered and limited network plans in Massachusetts, 2013-2015

Percent of commercial members enrolled in each plan type



Tiered and limited network plans: Considerations and limitations

- Tiered and limited network plans change provider choice and reduce spending
- There is anecdotal evidence that some providers seek to reduce prices to be in a preferred tier
- However,
  - Consumers do not like having limited provider choices
    - *Especially if they don't feel they directly benefit from the savings*
  - These plans can be complex for employers to explain and for consumers to understand
  - These plans may work in tension with ACOs and care coordination
  - Cost-sharing differences aren't relevant if consumers are over out of pocket maximum

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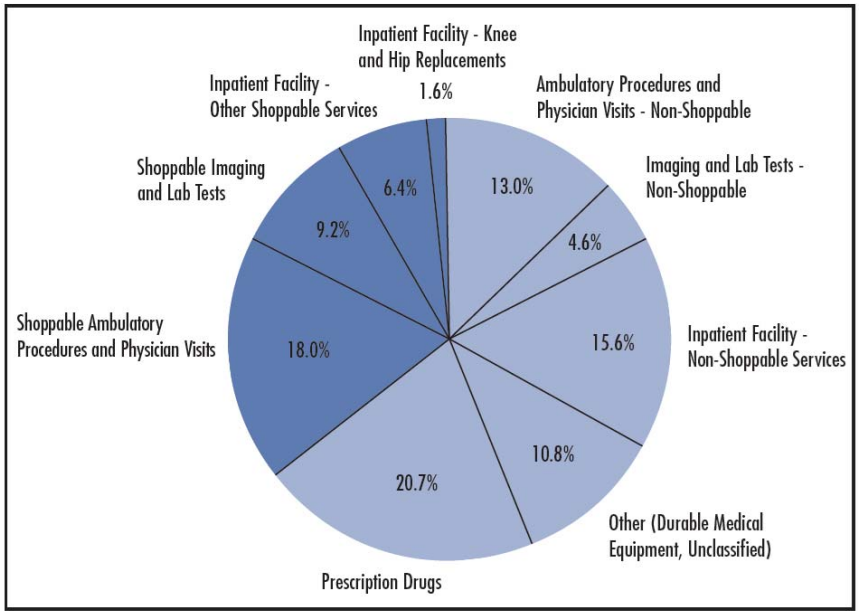
About 30-40 percent of health spending is 'shoppable' (dark blue)

Figure 1
Shoppable Services Account for One-Third of Total Spending



Note: Shoppable services were identified in claims data based on the diagnosis-related group for inpatient facility stays or the Healthcare Common Procedure Coding System and Current Procedural Terminology codes for outpatient facility and professional services.

Source: Authors' calculations using 2011 claims data from nonelderly privately insured autoworkers and dependents

Shoppable Services

Planned in advance

Choice of providers

Quality and price information are potentially available

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White, Chapin, and Megan Eguchi. *Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle*. Research brief #18. Mathematica Policy Research, 2014. Health Care Cost Institute, Spending on Shoppable Services in Health Care, 2016

Getting consumers to shop

- Price and quality information, by themselves, do not tend to lead to comparison shopping and reduced spending (Gabel, 2016; Desai et al, 2016)
- But, they are a necessary ingredient for successful programs that combine price and quality information with:
  - easy-to-use programs/interventions
  - Immediate and significant savings
- Examples: reference pricing, redirection for imaging services, cash-back programs

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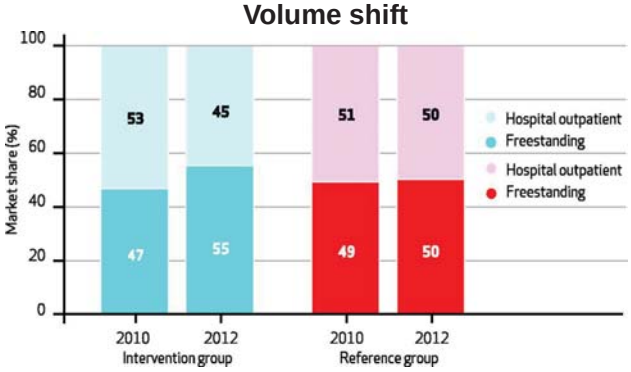
Jon Gabel et al., "Price Transparency Tool Attracts Users But Does Not Lead to Use of Lower-Priced Services," Changes in Health Care Financing & Organization, Issue Brief, September 2016.

Desai, Sunita, et al. "Association Between Availability of a Price Transparency Tool and Outpatient Spending." JAMA 315.17 (2016): 1874-1881.

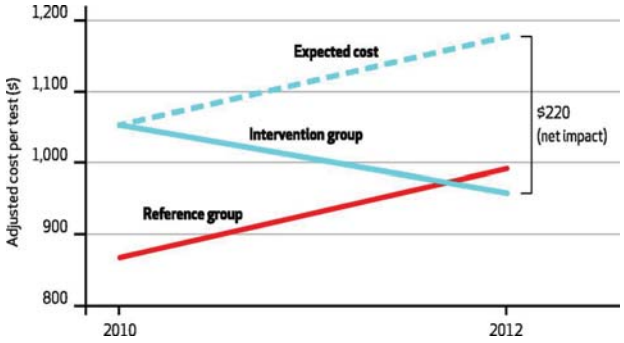
Consumer choice intervention: patient redirection for MRI services

- A specialty benefits management company implemented a voluntary, nationwide program taken up by some employers under BCBS but not others
- Employees scheduled for an MRI were called by a benefits manager if there was a nearby alternative at lower cost and comparable or better quality
- The benefits manager rescheduled the appointment if the patient agreed
- Consumers who received calls from benefits manager saved 19% on MRI spending
- The program also appeared to spur competition: Unit prices dropped $360 for hospital MRIs, and rose $85 for freestanding (compared to controls)

Volume shift



Cost reduction



Sze-jung Wu et al. Health Aff 2014;33:1391-1398. ©2014 by Project HOPE - The People-to-People Health Foundation, Inc..

Cash-back programs

Cash-back programs are similar to the previous example, but across a wide set of services, and with immediate cash savings to the consumer

- Insurers typically use an add-on vendor such as Vitals Smartshopper™
- Member uses website to search for services and prices
- If member chooses low-cost provider via website and fulfills service, gets a refund check, e.g. colonoscopy (max savings: $250), MRI ($150), gastric bypass surgery ($500), blood draw ($25), physical therapy ($150), hysterectomy ($500)

Some self-insured employers set up similar programs along these lines

Anecdotal evidence of competition-induced changes in provider market

Fallon, HPHC and now Unicare offer these programs in the GIC

New Hampshire state employees program claims $1.7m savings in 9 months (though not a rigorous evaluation)

From New Hampshire's program for state employees using SmartShopper via Anthem Blue Cross
https://das.nh.gov/hr/documents/VitalsSmartShopperIncentiveList.pdf; Employers Reward Workers who shop around for health care, Boston Globe, November 28, 2016: https://www.bostonglobe.com/business/2016/11/27/employers-rewarding-workers-who-shop-around-for-health-care/JKkmu5BI7q6fNFgbZzyZmN/story.html

MASSACHUSETTS
HEALTH POLICY COMMISSION

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Competitive insurance market structure

- Market structure can foster take up of efficient plans (e.g. a narrow network plan that excludes high-cost providers).
- Optimally, these conditions would be met:
  - Plans must be <u>available</u> to employees (i.e. choice of plans)
  - Plans must be <u>understandable</u> and ideally, comparable or standardized
  - Employees must realize significant <u>savings</u> from choosing these plans
    - Defined contribution
    - Premium holidays (GIC) or other incentives to choose low-cost plans
- The Massachusetts Connector and the GIC are good examples, though private exchanges and large firms can also create these conditions

Pro-competitive features of the Mass Connector

Standardized plans support apples-to-apples comparisons

Fixed-dollar subsidies require enrollees to pay the full difference in premiums between plans, increasing competition based on price

The Connector is an **active purchaser**, allowing no more than 5 plans per region – which combined with the large market volume (200,000 enrollees), gives it leverage to only accept the most competitive plans into the market

The ConnectorCare program prioritizes carriers that have experience serving Medicaid populations to facilitate transitions between the two programs. But this prioritization also empowers Medicaid MCO carriers to offer commercial plans that **leverage the greater scale of Medicaid membership** in the negotiation of provider contracts

Individuals purchasing their own insurance are more likely to choose plans with a more selective and competitively-priced provider network, while employers that can only offer one or two choices tend to purchase broader-network plans to meet the needs of all members of the group

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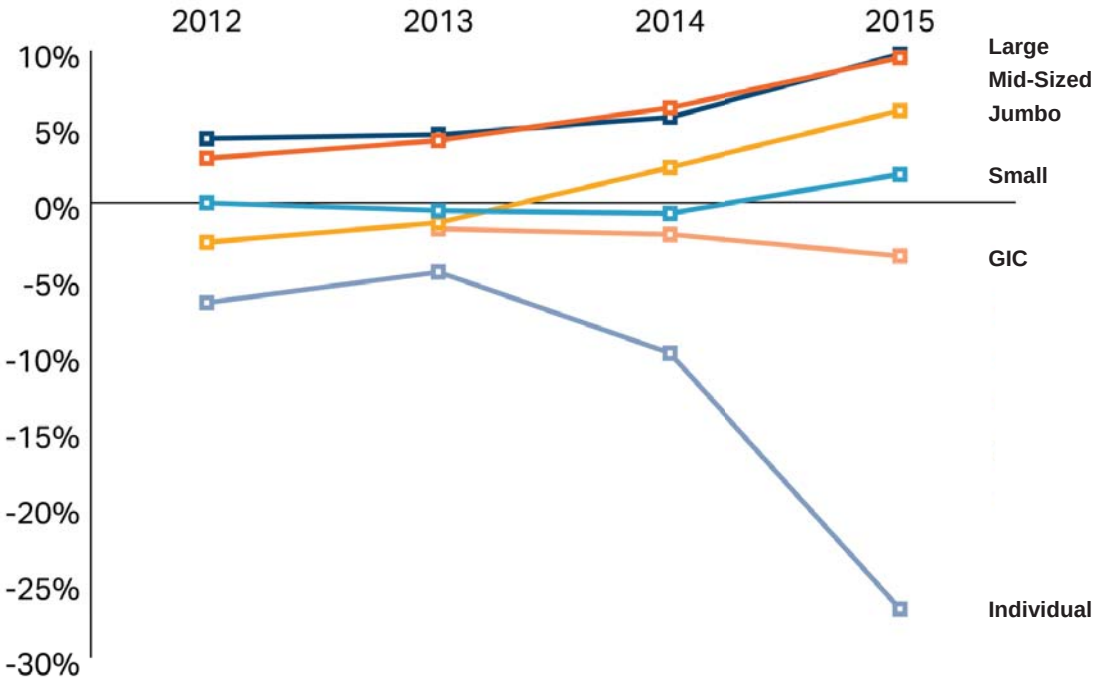
GIC and the individual market have competitive structures and the lowest premiums

Premiums by group size relative to 2012 small group premiums, 2012-15



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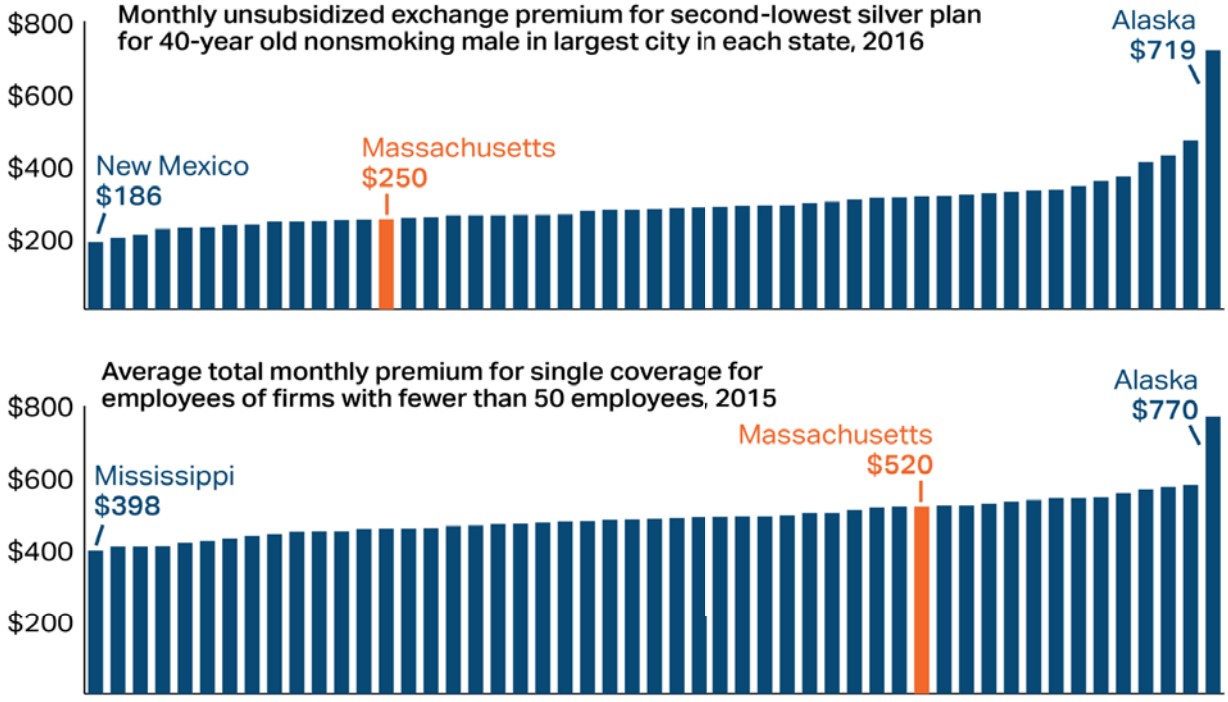
Source: Data from the Center for Health Information and Analysis and Oliver Wyman Consulting. Premiums are adjusted for enrolees' age, gender and actuarial value of the plan.

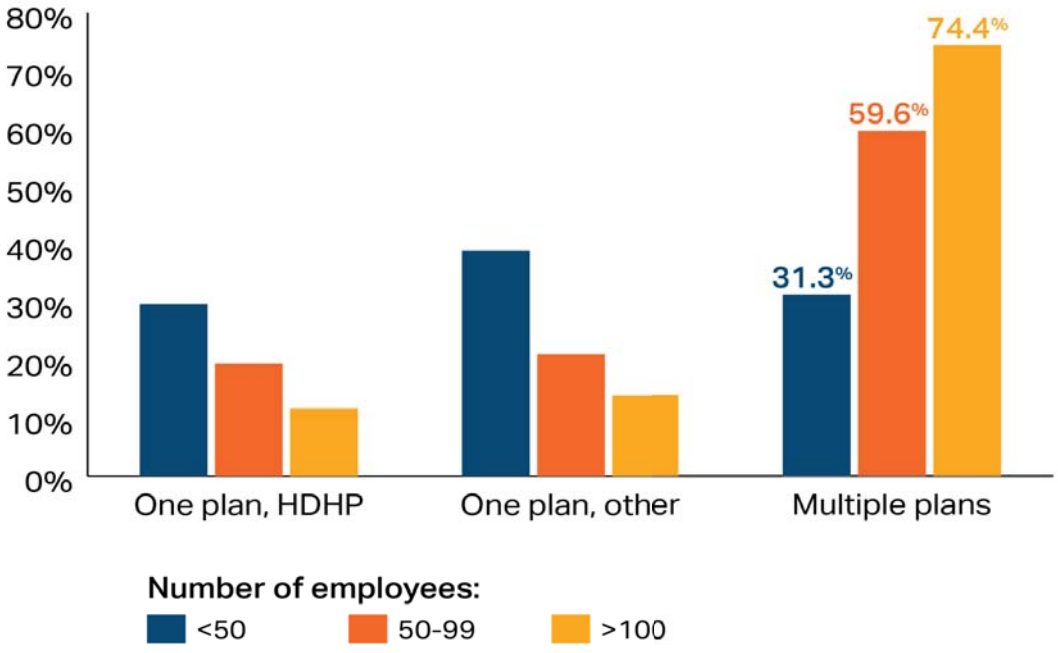
Mass Connector premiums are also low by national standards



Top: Kaiser Family Foundation, State Health Facts, 2016
Bottom: AHRQ, 2015, Medical Expenditure Panel Survey

On the other hand, most smaller businesses in Massachusetts struggle to even offer employees a choice of plans

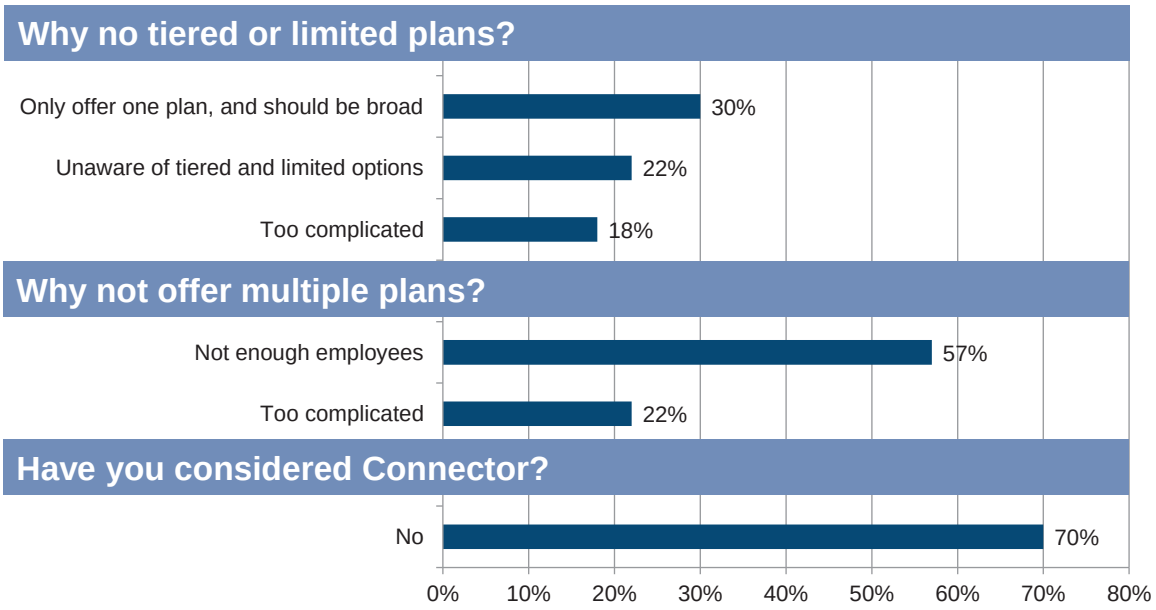
Among employees offered coverage by their firms, percent with plan choice by company size, Massachusetts, 2014



Source: CHIA Massachusetts Employer Survey, 2014

Small and mid-sized businesses noted challenges in creating a competitive insurance marketplace

Percent of firm representatives answering yes. Multiple affirmative responses allowed



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HPC/AIM survey of 188 employers, 2015

Demand-side incentives summary

1. Use of demand-side incentives can increase the use of efficient plan designs, shift volume to higher-value providers and reduce spending and prices through competition
2. Encouraging examples and innovations exist, but thus far, use has not been widespread enough to drive market-wide changes by themselves
3. Fostering a competitive environment through market structure and price and quality information can spur innovation and efficiency

Contact Information

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Visit us: http://www.mass.gov/hpc

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E-mail us: HPC-Info@state.ma.us

Patient Choice, Price Transparency, and High-Value Care

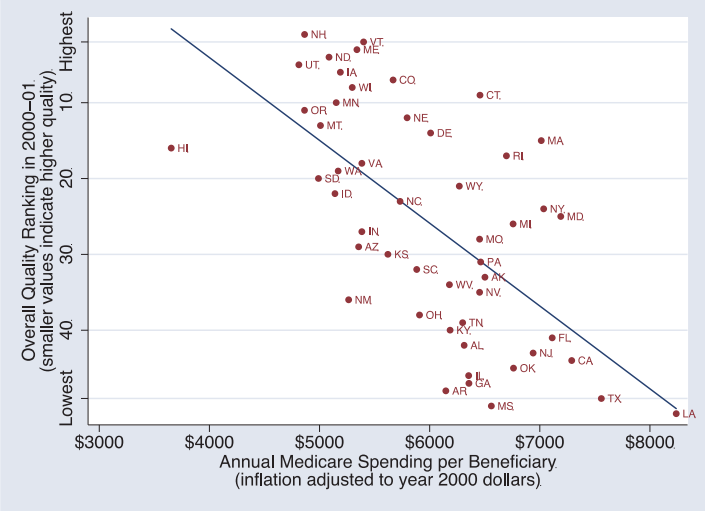
Katherine Baicker
C. Boyden Gray Professor of Health Economics
Harvard T.H. Chan School of Public Health

Agenda

- Context for deploying transparency tools
- Evidence on patient responses to cost-sharing
  - Effects on utilization, value, and health
  - Interaction with payment policy
- Complementing transparency
  - Addressing behavioral factors

Moving Towards High-Value Care

- Ample evidence that health care resources not put to best use
- Insurance coverage alone doesn't guarantee high-quality care
- Care varies even when prices don't



Source: Baicker and Chandra, *Health Affairs*

Evidence of Underuse and Overuse

Underuse of High-Value Care		
Statins	Reduce mortality and heart attacks	Adherence < 70%
Beta-blockers	Reduce mortality post heart attack 25%	Adherence < 50%
Anti-diabetics	Decrease cardiovascular mortality (OR .74) (7)	Adherence < 65%
Immunosuppresants for Kidney Transplant	Reduce risk of organ rejection seven-fold	Adherence < 70% (9)(10)
Recommended Preventive Care	Effective immunizations, disease management, follow-up care post surgery	< 40% of diabetics receive semi-annual blood tests; Recommended immunization rates 60% for children
Pre-natal care	Reduces infant mortality	< 50 % receive adequate or better care
Overuse of Low-Value Care		
MRI for low back pain	Increase the number of surgeries with no resultant improvement in outcomes	16% of doctors report routine use of MRI
PSA testing	No significant mortality change	49% of 50- to 79-year old men tested in past 2 years
Prostate cancer surgery	No difference in overall survival	57% of patients receive radical prostatectomy or radiation as initial treatment
Antibiotics for children's ear aches	At best modest improvement, but with common side-effects (rashes, diarhhea)	98% of visits result in antibiotic Rx

Source: Baicker, Mullainathan, and Schwartzstein, *Quarterly Journal of Economics*

Patient Prices Matter . . .

- Decades of evidence that patients respond to prices
  - Demand slopes down!
  - Transparency is necessary
- Prices patients face now hamper some efforts to improve value
  - Medicare FFS
  - ACOs

. . . But Not Exactly as Economics Alone Would Predict

Study	Price Change	Change in Use	
		High Value	*Lower Value*
Chandra (2010)	$7 increase in drug copay (from ~$1 to ~$8)	Elasticity of around.15 for acute care and chronic care Rx	Elasticity of around .15 for "lifestyle" Rx
Goldman (2006)	$10 increase in copay (from $10 to $20)	Compliance with cholesterol meds among high risk drops from 62% to 53%	Compliance with cholesterol meds among low risk drops from 52% to 46%; medium drops from 59% to 49%
Selby (1996)	Introduction of $25-$35 ER copay	9.6% reduction in visits for emergency conditions	21% reduction in visits for non-emergency conditions
Johnson (1997)	Increase from 50% coinsurance with $25 max to 70% coinsurance with $30 max	40% reduction in use of antiasthmatics; 61% reduction in thyroid hormones	40% reduction in non-opiate analgesics; 22% reduction in topical anti-inflammatories
Lohr (1986)	Cost-sharing vs. none in RAND	21% reduction in use of highly effective care; 40% reduction in beta blockers, 44% reduction in insulin	26% reduction in less effective care; 6% reduction in hayfever treatment, 40% reduction in cold remedies, 31% reduction in antacids
Tamblyn (2001)	Introduction of 25% coinsurance, $100 deductible, $200 max for Rx	9.1% reduction in essential drugs	15.1% reduction in non-essential drugs

Importance of Behavioral Factors

- Traditional problem: "moral hazard"
  - Insurance provides valuable risk protection, but drives higher use
    - Affects insurers' plan design and individual choices
  - Cost-sharing should balance effects on use and financial protection
- "Behavioral hazard": Choice errors change that calculus
  - People may not respond "rationally" to prices
  - Copays should balance effects on health care use and health outcomes

Small Price Changes Can Matter a Lot

Study	Price Change	Use Change	Health Value
Chandra (2010)	$7 ↑ in drug copay	Elasticities: -.15 to -.23 for essential drugs, asthma, depression meds	6% ↑ hospitalization
Chernew (2008)	Drug copays ↓ from $5 to 0 for generics; from $25 to $12.50 for name brands	Elasticities: -.12 ACE inhibitors; -.11 beta blockers; -.14 diabetes drugs	Beta blockers post heart-attack ↓ mortality by 20-30%
Hsu (2006)	Imposition of $1000 annual cap	Adherence to antihypertensives, statins, diabetes drugs ↓ 30%	13% ↑ nonelective hospital use; 9% ↑ high cholesterol; 16% ↓ glycemic control
Goldman (2006)	$10 ↑ in copay	10 percentage point ↓ in statin adherence	Statins ↓ risk of major coronary event by 25%
Lohr (1986)	Cost-sharing vs. none in RAND	↓ in use of insulin of 44%, beta blockers 40%, antidepressants 36%	Diabetes meds can reduce hospitalization risk by 7 ppt
Selby (1996)	Introduction of $25-$35 ER copay	9.6% ↓ in visits for emergency conditions	Conditions including heart attack, appendicitis, respiratory failure, etc.
Landsman (2005)	Addition of third drug tier (moving top payment from $10 or $20 to $35 or $40)	Elasticities: -.16 for ACE inhibitors; -.10 for statins; -1.15 for antidepressants	70% ↑ relapse of depression when meds discontinued

Source: Baicker, Mullainathan, and Schwartzstein, *Quarterly Journal of Economics*

So How Can Prices Help?

- Prices are a powerful tool – but must be deployed with nuance
  - Transparency is necessary – but far from sufficient
- How, when, and by whom info presented is key
  - Trusted source
  - Quality vs. price
- "Nudges" can augment price and transparency levers

Using Nudges to Complement Transparency

- Info about costs vs. benefits
  - Misperception of risks
  - Salience of symptoms, benefits, cost
  - Delay of benefits vs. payments
- Cognitive overload and complexity
- Reference dependence
  - Framing as gain vs. loss
- Benchmarks
  - Social comparisons

Principles Apply More Broadly

- Many stakeholders – all people!
  - Transparency and framing key at many junctures
- Patients/enrollees
  - Health care: utilization, compliance
  - Insurance: take-up and enrollment, choice of plans
  - Health behaviors: smoking, obesity
- Insurers and Payers
  - Plans offerings, how to price/subsidize, recruitment tools
- Providers
  - Intensity of treatment, compliance with best practices
    - Choice architecture matters a lot here
    - Transparency and framing

PROVIDER PRICE VARIATION & THE COST OF HEALTHCARE IN RHODE ISLAND

Presentation to the Massachusetts Special Commission on Provider Price Variation

January 31, 2017

Dr. Kathleen C. Hittner, Health Insurance Commissioner

Agenda

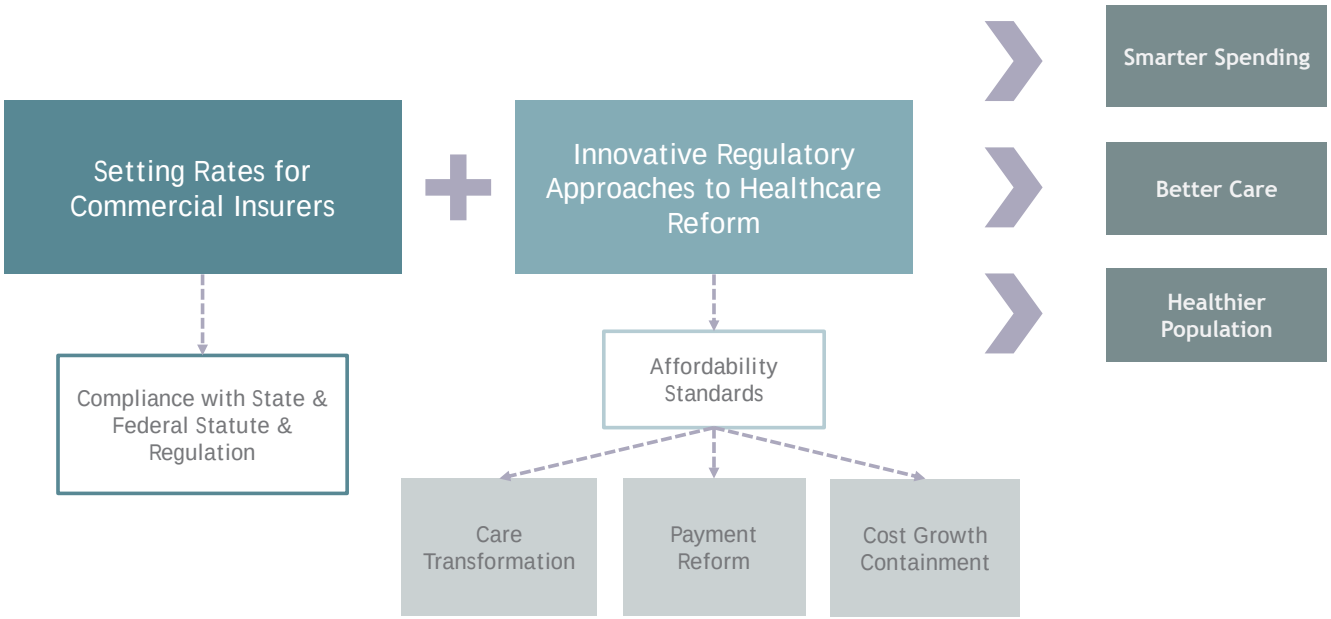
- Background on OHIC
  - OHIC Theory of Action
- Why OHIC Cares About Price Variation
- OHIC Efforts to Curb Spending Growth
  - Price Transparency
  - Innovative Regulation

OHIC's Legislative Charge

"View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access"

R.I. Gen. Laws § 42-14.5-2

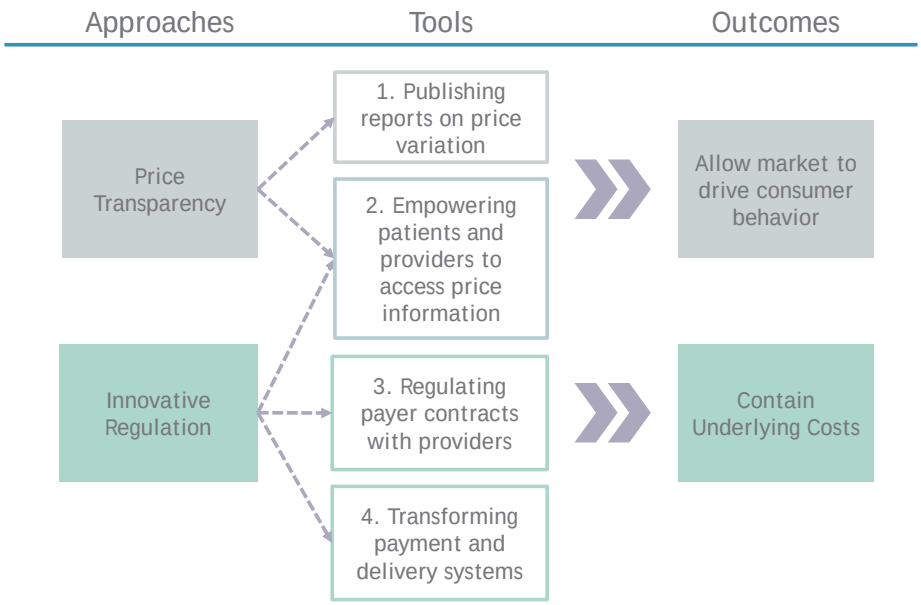
OHIC Theory of Action



Why does OHIC care about Price Variation?

- The price of healthcare services is a significant factor in the level and growth of healthcare expenditures, which impacts premiums.
- Variation in prices paid by different payers translates into a differential cost burden borne by different healthcare purchasers.
- There is no apparent link between payment rates and quality of care.
- State efforts to curb excessive healthcare spending growth should focus on price variation, among other factors, including price inflation rates, unnecessary utilization of services, etc.
- OHIC's efforts to curb health expenditure growth encompass several mechanisms that drive our delivery system toward value-based, efficient, and high-quality care.

OHIC Efforts to Curb Spending Growth



1. Publishing Reports on Price Variation

Variation in Payment for Hospital Care in Rhode Island: A 2012 Study

- In 2012, OHIC and EOHHS commissioned a study on hospital payment variation
- The study used a dataset of 2010 inpatient and outpatient claims from public and private payers in RI, spanning 11 general hospitals and 2 psychiatric hospitals.
- Payments were casemix adjusted to allow for apples-to-apples comparison

1. Publishing Reports on Price Variation

Variation in Payment for Hospital Care in Rhode Island: Key Findings

- Considerable variation in payments for similar services
- Commercial plans paid the most
- Medicaid FFS ranked relatively high as a payer

Table 3.1.1

Examples of Variation in Payment for Specific Services

	Medicare FFS	Medicare Mgd Care	Medicaid FFS	Medicaid Mgd Care	Commercial Plans		
Service	**Overall**	**Overall**	**Overall**	**Overall**	**Overall**	**Lowest-Paid Hospital**	**Highest-Paid Hospital**
Inpatient Care							
Pneumonia, severity 3 (APR-DRG 139-3)	$8,518	$9,217	$10,374	$11,401	$12,566	N/A	N/A
COPD, severity 2 (APR-DRG 140-2)	$6,496	$6,761	$5,615	$9,163	$12,627	N/A	N/A
Knee joint replacement, severity 1 (APR-DRG 302)	$15,147	$13,667	N/A	N/A	$22,405	$22,911	$26,758
Vaginal delivery, severity 1 (APR-DRG 560-1)	N/A	N/A	$3,386	$3,716	$7,043	$5,413	$7,663
Outpatient Care							
Colonoscopy, including related services	N/A	$745	N/A	$954	$1,440	$802	$2,343
Evaluation of chest pain (note 1)	N/A	$888	$813	$508	$918	$480	$2,035
Typical ER evaluation (note 2)	$231	$365	$206	$188	$638	$482	$1,214
Typical advanced imaging service (note 2)	$398	$413	$321	$395	$486	$376	$808

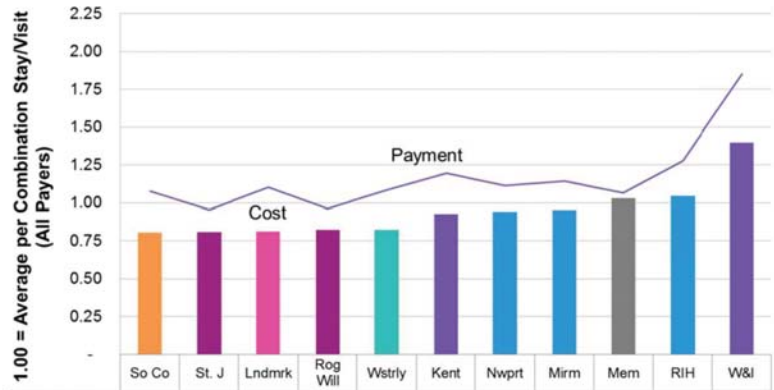
Notes:

1) Evaluation of chest pain refers to the total payment for a patient seen in the ER for evaluation of chest pain, including related services. Patients who were admitted to inpatient care or who underwent cardiac catheterization were excluded from this definition. See Appendix Section B.6.4.
2) "Typical" ER evaluation and advanced imaging services refer to a weighted average index of procedure codes, e.g., 99281-99285 for ER evaluation. These figures refer to the specific procedure codes only; related services are excluded. See Appendix Section B.6.5.
3) Data are shown only for services where the hospital performed at least 50 services for a specific payer in 2010. Other cells are shown as N/A.
4) Examples shown are for purposes of illustration. Overall analysis of variation in cost and payment was done using all stays and visits, typically using APR-DRGs for casemix adjustment of inpatient care and EAPGs for service mix adjustment of outpatient care.
5) Detailed Medicare FFS data for outpatient claims were not available, so the cells for colonoscopy and evaluation of chest pain are shown as N/A. Medicare FFS payment figures for the ER evaluation and advanced imaging service indexes were calculated using APC fees applicable in Rhode Island.

1. Publishing Reports on Price Variation

Variation in Payment for Hospital Care in Rhode Island: Key Findings

Chart 4.2.3
Commercial Payment Compared with Total Cost
Cost includes medical education



	So Co	St. J	Lndmrk	Rog Wil	Wstrly	Kent	Nwprt	Mirm	Mem	RIH	W&I
Cost incl med ed	0.80	0.81	0.81	0.82	0.82	0.92	0.94	0.95	1.03	1.05	1.40
Payment	1.08	0.96	1.10	0.96	1.08	1.19	1.11	1.14	1.06	1.28	1.85

Payment and cost figures are relative to statewide averages. Hospital-specific figures are for the commercial population specifically. The difference between payment and cost reflects differences in the relative positons of the hospitals; it is not a profit margin. See Appendix Section A.4.2.

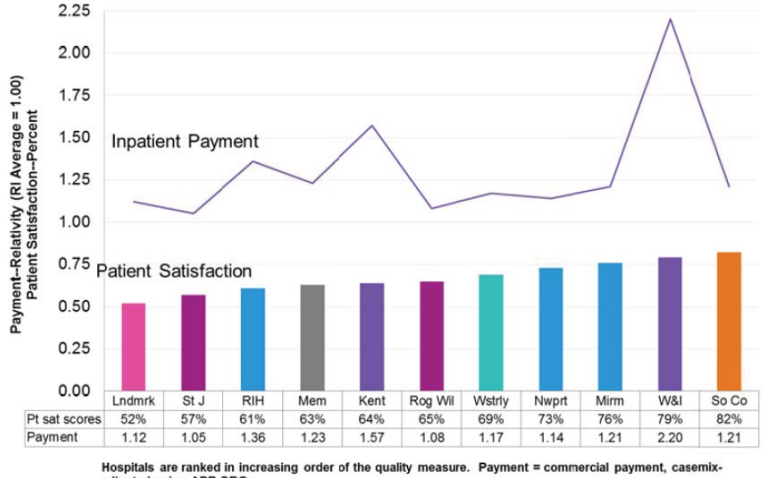
- Commercial plans tended to pay more to Lifespan and Care New England than to other hospitals
- Considerable variation in costliness across hospitals
- Higher cost hospitals tended to be paid more

1. Publishing Reports on Price Variation

Variation in Payment for Hospital Care in Rhode Island: Key Findings

- While quality data were limited, no link between quality and payment was found

Chart 4.3.1
Commercial Payment and Patient Satisfaction



	Lndmrk	St J	RIH	Mem	Kent	Rog Wil	Wstrly	Nwprt	Mirm	W&I	So Co
Pt sat scores	52%	57%	61%	63%	64%	65%	69%	73%	76%	79%	82%
Payment	1.12	1.05	1.36	1.23	1.57	1.08	1.17	1.14	1.21	2.20	1.21

Hospitals are ranked in increasing order of the quality measure. Payment = commercial payment, casemix-adjusted using APR-DRGs.

1. Publishing Reports on Price Variation

Variation in Payment for Hospital Care in Rhode Island: Key Findings

Price variation for hospital services is a problem everywhere, and if payments vary less in Rhode Island, it may be because of our smaller, more tightly regulated provider and insurer markets.

Table 3.5.1

Variation in Inpatient Payment by Private Plans for Specific Inpatient Services

APR-DRG			Median Hospital		Difference from Lowest-paid Hospital to Highest-paid Hospital	
	RI Low Hospital	RI High Hospital	RI	MA	RI	MA
139-3 Pneumonia, severity 3	$9,330	$12,538	$11,967	$12,420	30%	1350%
140-2 COPD, severity 2	$7,207	$21,291	$10,691	$7,455	200%	520%
302-1 Knee joint replacement, Sev 1	$18,041	$26,758	$21,882	$21,241	50%	980%
540-1 Cesarean delivery, Severity 1	$6,334	$12,405	$7,935	$7,598	100%	490%

Notes:

1) The source for the Massachusetts data is Massachusetts Executive Office of Health and Human Services, Division of Healthcare Finance and Policy, *Massachusetts Healthcare Cost Trends: Price Variation in Healthcare Services* (Boston: DHCFP, June 2011), p.9.

2) In 2010, Rhode Island had 11 general hospitals while Massachusetts had 79. Rhode Island figures are for hospitals with at least five stays for each DRG, while the Massachusetts figures are for hospitals with at least 30 stays for each DRG. Rhode Island data are for 2010 while Massachusetts data are for 2009.

2. Empowering Patients and Providers to Access Price Information

Regulation 2, Section 12: Price Disclosure

- OHIC's Price Transparency requirements are written into Regulation with the intention to empower consumers and providers to make cost-effective healthcare decisions within the realm of the insurer's network. The two key requirements are:

Disclosure of Price Information to Providers

Insurers must disclose price information to designated providers (upon request) for the purposes of:

- Making cost-effective referrals
- Engaging in care coordination
- Making treatment decisions

Submission of a Comprehensive Price Transparency Plan

Insurers created comprehensive Price Transparency Plans that include:

- An Implementation Timeline
- Services, products, and supplies subject to price disclosure
- Appropriate limitations on disclosure
- FFS and APM price information

Innovative Regulation: OHIC Affordability Standards

The Affordability Standards were written into regulation in 2010 to influence the affordability of healthcare by focusing on three key strategies:

Care Transformation	Improving the efficiency and quality of care by transforming primary care practices
Payment Reform	Moving from volume to value by increasing the amount of payments that are tied to quality and cost efficiency
Cost Growth Containment	Slowing the rate of rising healthcare costs by limiting the rate increases of hospital based services and ACO total cost of care budgets

3. Regulating payer contracts with providers

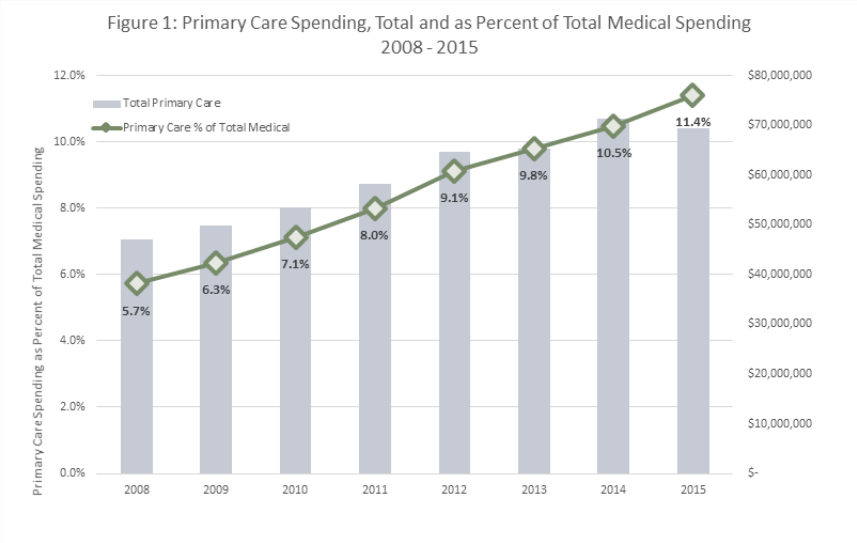
Containing Medical Cost Growth

- Recognizing that health insurance rate increases are driven not only by fee-for-service payment structures, but also by systemic medical expense trends, the Affordability Standards include requirements that limit the annual rate increase of medical services.

	Hospital Contracting Requirements	ACO Contracting Requirements
Annual Rates for:	Inpatient and outpatient services	Total cost of care for services
Affordability Standards Requirement:	Average rate increases shall not exceed the CPI-Urban percentage increase plus 1%	Increase in the total cost of care shall not exceed the CPI-Urban plus 3.0% in 2016, plus 2.5% in 2017, plus 2.0% in 2018, and plus 1.5% in 2019.

4. Transforming Payment and Delivery Systems

Increasing Investments in Primary Care



The Affordability Standards ensure the financial support of primary care

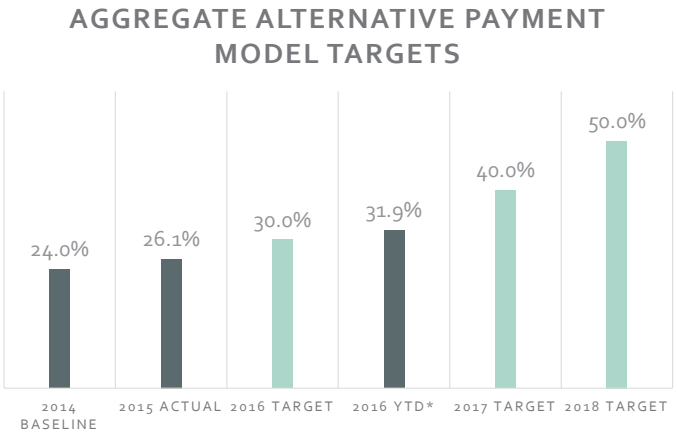
- Between 2010 and 2014, insurers were required to increase primary care spending by 1 percentage point (of total medical spend) each year
- Now, primary care expenses must comprise at least 10.7% of total medical spend
- Investments in primary care reinforce ongoing care transformation work

4. Transforming Payment and Delivery Systems

Reforming Payment Models

The Affordability Standards call for significant reductions in the use of fee-for-service payment as a payment methodology by commercial insurers

- **Target:** 50% of an insurer's annual commercial insured medical spend will be in the form of APM payments by 2018
- OHIC's Alternative Payment Methodology (APM) Committee establishes annual targets for commercial insurers



*2016 YTD figures include data up to the end of May 2016

THANK YOU

Any Questions?