



Payment Matters: The ROI for Population-based Payment

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What is Population-based Payment?

In a population-based payment arrangement, a provider entity agrees to accept responsibility for the health of a group of patients in exchange for a set amount of money. If the provider effectively manages cost and performs well on quality of care targets, then the provider may keep a portion of the savings generated. However, if the provider delivers inefficient, high-cost care, then depending on the structure of the arrangement, it may be held responsible for some of the additional costs incurred. The goal of this type of payment arrangement is to align the financial incentives of the providers with the interests of the patients and the payers so that everyone wins if patients are healthy and costs are held down. This model is also sometimes called “global payment” or “total cost of care payment.” Population-based payment is the underlying payment model used in Accountable Care Organizations.

Population-based Payment: Good Return on Investment for Employers

As the largest purchaser of health care in America, employers are paying a high price for care of variable quality. To check soaring costs, some employers are switching from the inefficient fee-for-service model of paying for care, which encourages high volume and low quality, to payment models that reward high value.

For example, there is emerging evidence that population-based payment programs are yielding a good return on investment for employers. In this brief, we highlight the early successes of the California Public Employees’ Retirement System and describe the plans of Intel Corporation and the Maine State Employee Health Commission, all of which are convinced of the benefits of adopting a population-based payment model.

Many other organizations have been impressed with the promise of population-based payment programs and have begun to pursue the model, including the Centers for Medicare and Medicaid Services (CMS).¹

Case Study #1: The California Public Employees’ Retirement System Saved More Than \$20 million in Costs

In January 2010, the California Public Employees’ Retirement System (CalPERS) launched a two-year population-based payment pilot program in collaboration with Blue Shield of California, and providers Catholic Healthcare West and Hill Physicians (CHW and Hill) in Sacramento. Blue Shield agreed to pay CHW and Hill a pre-determined amount to provide care to 41,500 CalPERS employees and dependents. By the end of the first year, the pilot had exceeded all expectations—saving more than \$20 million in costs. More than \$15.5 million of these savings went toward preventing a health insurance rate hike for CalPERS employees and the remaining savings was divided among the three partners. Over the first three years of the project, CalPERS has seen \$32 million in aggregate savings. In addition, the partners saw a meaningful reduction in utilization including a 15 percent reduction in inpatient readmissions, a 15 percent reduction in inpatient days, and a 13 percent reduction in surgeries. By giving providers the opportunity to share in the savings for keeping patients healthy, rather than just paying them to provide services to the sick, CHW and Hill successfully shifted the



focus to population health management—targeting patients with chronic illnesses and medically complex conditions, and reducing unnecessary care. Due to the project's success, \$5 million in savings was built into CalPERS's 2011 health plan rates and an additional \$12 million in savings was built into the 2012 rates. Blue Shield has also committed to working with CalPERS to expand the program across the state, starting with two programs in Orange and San Joaquin Counties. An independent evaluation of the pilot will be conducted by the University of Southern California.²

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Case Study #2: Intel Corporation Takes the Initiative

According to senior health program manager James Dickey, Intel felt that it was “time for the employer market to step up” and help move the health care system toward better performance at a lower cost. As a result, in 2010, Intel began a “two-year journey to reshape what health care should be for Intel families.” Instead of just paying for services, Intel wanted to pay based on outcomes and quality of care. Intel worked directly with the Presbyterian Health System in Albuquerque to create the “Connected Care” program, a narrow network benefit that offers care through a Patient-Centered Medical Home model. Starting in January 2013, in exchange for caring for 10,000 of Intel's employees and their families, Presbyterian agreed to put a certain percentage of its revenue at risk using a risk-reward style program: if Presbyterian performs well, it gets the at-risk amount back. If Presbyterian does *really* well, it will receive additional performance payments. Intel is hopeful that this approach will reduce costs and improve care.³

Case Study #3: Maine State Employee Health Commission Puts a Health System at Performance Risk

Concerned about the high cost of care at MaineGeneral Health (MGH)—a system of hospitals and physician practices—the Maine State Employee Health Commission (SEHC) was considering dropping the system from the preferred tier of their tiered network benefit design. Instead, MGH agreed to move in a step-wise fashion toward significant payment reform that would guarantee the SEHC improved quality of care and cost savings. For Fiscal Year 2013, the partners signed an agreement that will

How You Can Implement a Population-based Payment Arrangement

1. Speak with your plan administrator about his or her experience with population-based payment. Many are undertaking such arrangements.
2. If you have a large concentration of employees in one or more geographies, approach the largest medical group and/or health system that serves your population and ask about their experience with population-based payment programs, and their willingness to apply their program or develop a new one to serve your employees.
3. Read Catalyst Payment Reform's brief on implementing population-based payments.
http://www.catalyzepaymentreform.org/images/documents/CPR_Action_Brief_Global_Payment.pdf
4. Read about the success of Blue Cross Blue Shield of Massachusetts Alternative Quality Contract through this Aligning Forces for Quality (AF4Q) Bright Spot article. <http://forces4quality.org/af4q/download-document/4370/1667>
5. Gather resources from the Aligning Forces for Quality (AF4Q) initiative to help build coalitions and implement payment reform. <http://forces4quality.org/a/6/payment-reform#featured-resource>

guarantee savings for SEHC. This contract requires MGH to meet certain quality benchmarks and per member per month cost targets that if met will yield \$1 million in savings for SEHC. The partners have committed to moving to a full global payment model in FY2014; MGH will take on greater risk for SEHC.⁴

Endnotes

1. Centers for Medicare and Medicaid Services. Accountable Care Organizations (ACO) www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/ (accessed January 11, 2013).
2. Email correspondence with Kathy Donneson on December 12, 2012; Helfand D. “Healthcare Partnership pays big dividends” Los Angeles Times, August 2, 2011. <http://articles.latimes.com/2011/aug/01/business/la-fi-healthcare-savings-20110802>. Accessed December 13, 2012. Donneson, K., Boynton, A. Memo to Members of the Health Benefits Committee, California Public Employees' Retirement System, Health Plan Administration Division. Sacramento, CA. October 18, 2011. CalPERS savings calculations were self-reported and have not been verified by the Robert Wood Johnson Foundation. Results may not necessarily be replicated by other employers.
3. Telephone interview with James Dickey, December 7, 2012.
4. Telephone interview and email correspondence with Frank Johnson, on December 10, 2012 and November 28, 2012, respectively.