# Matching Payment Reform to Local Markets: Using a Market Assessment Tool

Market Assessment

## THE PAYMENT LANDSCAPE IS CHANGING

Considerable activity is underway nationally to reform how we pay health care providers. We have seen a dramatic shift of payments from volume-based payments—fee-for-service (FFS) or diagnosis-related groups (DRGs)—to value-based payments, which create incentives for providers to deliver higher quality, more affordable care. The largest single payer in the United States, the Centers for Medicare and Medicaid Services (CMS), is driving many of these changes. The Center for Medicare and Medicaid Innovation (CMMI) was created inside CMS by the Affordable Care Act with a mission to experiment with new payment and delivery models. CMS and CMMI have developed and deployed accountable care organizations (ACOs), patient-centered medical homes (PCMHs), and bundled payment arrangements with providers nationally. Many of these innovations were already underway in the private sector, but the CMMI has accelerated initiatives by employers, health plans, and providers. There has been a push by both sectors towards population-based payments over other payment approaches, such as pay-for-performance (P4P), in order to encourage greater care coordination.

## MARKET VARIATION IMPACTS SUCCESS

However, neither the ACA nor the CMMI analyzed the influence that local health care market dynamics will have on the success of different types of payment reforms. Given the importance of variation in markets, there is reason to question whether a one size-fits-all approach to new payment models will deliver optimal outcomes across the board. A model that is the next logical step for reform in one market may take another market further from its goals. For example, blended payment for maternity care, in which the payer splits the differential in the payment amount between cesarean and vaginal deliveries, could save money in a market where cesareans are prevalent, but add greater costs in markets where the rates are lower. Also, certain population-oriented payment reforms may accelerate provider consolidation; evidence suggests that higher prices usually follow mergers and acquisitions.[1] Simply allowing providers or payers to unilaterally choose which type of payment reform to pursue may yield benefits for a particular organization but not improve the system as a whole.

## CREATING A MODEL FOR MARKET ASSESSMENT

An ideal approach for reforming payments to providers would be to customize the type of payment reform to the market in which it is likely to create the most value. However, there is little knowledge about the impact certain reforms are likely to have in different types of markets.[2] In examining the literature, we were unable to find a model that would help payment reformers determine which methods would most benefit a market based on its dynamics. This prompted us to create a conceptual and evaluative model to help anticipate the potential successes, failures, and unintended consequences of pairing different payment reforms with various market types. Our conceptual and evaluative model is decidedly heuristic, aimed more at helping communities frame discussions about matching payment reforms to their local markets, rather than at making definitive recommendations.

## CATALYST FOR PAYMENT REFORM'S MARKET ASSESSMENT TOOL (MAT)

We designed the Market Assessment Tool (MAT) to provide stakeholders in a market with a systematic method for evaluating three key elements: the characteristics of the market; how those characteristics interact and impact options for payment reform, and the potential unintended consequences of different reforms. For example, the MAT would examine which payment reforms would fare best in a market with strong purchaser activism and innovation, but also considerable provider consolidation.

Creating the MAT required substantial research, interviews and analysis. First, we defined eight distinct types of health care markets. Then, we sorted the wide variety of payment reform options into five categories. Lastly, we paired the five payment reform categories with specific market types and, using principles from game theory,[3] analyzed likely actions and reactions in each scenario based on input from more than 35 subject matter experts with policy, research, or practical experience in payment reform in local markets.[4] From these discussions, we were able to develop recommendations for which reforms fit best with particular market types. Below, we describe each of these steps in greater detail.

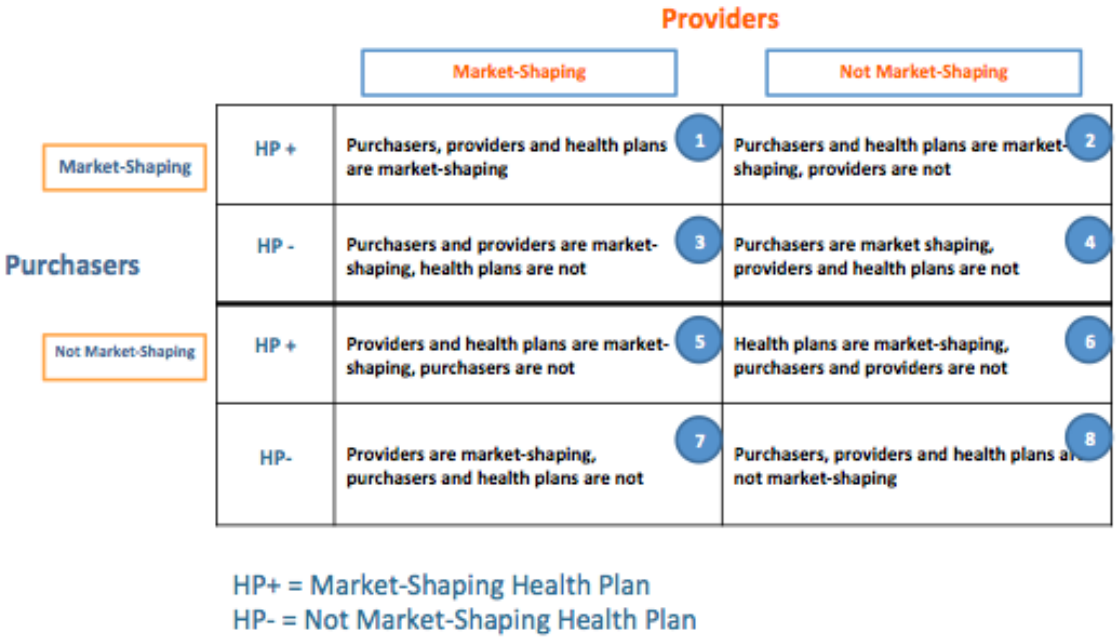
### CREATING A MARKET TYPOLOGY

To create the market types, we drew from CPR's purchaser expertise to identify the variables that have the greatest impact on the potential for reform. Many factors influence a market's receptiveness to different payment methods, but the most important are the actions of employers and other purchasers, payers (health plans), and health care providers. Each of these groups' interest in and capacity to respond to new payment models, along with their negotiating power, has a profound effect on the ability of a payment model to succeed in a

given market. State regulations and policy influence market dynamics as well, but largely through their impact on the key stakeholders.

By determining the relative ability of purchasers, health plans, and providers to "shape the market"—i.e., have negotiating leverage or ability to insist on or reject substantive changes in contractual terms and conditions—we created eight distinct market types, illustrated in **Figure 1**. The right and left columns separate markets into those in which providers are shaping the market (left) and those in which providers are not (right) (see **Table 1** for definitions of key terms). The top and bottom rows divide markets into those in which purchasers are shaping the market (top) and those in which purchasers are not (bottom). Then, within those two purchaser categories, there is the added dimension of the power and capacity of the health plan to shape the market, which further divides the four main quadrants into eight separate market types.

Figure 1. Market Types




SOURCE: Catalyst for Payment Reform

Our characterizations as market shaping—meaning dominant, capable, strong, progressive, etc.—are necessarily qualitative given the lack of objective evidence or standard definitions. However, as we describe below, the final assessment of a single market's "market type" is largely a product of the extensive interviewing conducted with local stakeholders and key informants.

## CATEGORIZING PAYMENT REFORM OPTIONS

One way to categorize payment reforms is to focus on the risk placed on providers: upside only financial risk; downside financial risk; or two-sided risk (both potential upside and downside financial risk).

In our categorization of payment reform options, we also include two additional choices even though neither is strictly payment reform, but both are mechanisms that can be used by purchasers or state regulators to shape the market: consumer shift and regulatory options. Both are important to either be paired with payment reform or act as an alternative in the absence of viable payment reform strategies. This paper does not address regulatory options.

Definitions for each of these reform categories, along with examples, are in **Table 2**.

Table 1. Working Definitions of Key Market Types

**Market-shaping Providers:** Providers who typically have significant market power, either due to market penetration or reputation, and are in a position to dictate the terms of payment models they are willing to accept.

**Non-Market-shaping Provider**: Providers who have significant competition or, for other reasons, do not have the leverage to refuse to participate in payment reforms and who may lack the capacity, due to smaller size, to accept downside or two-sided risk sharing.

**Market-shaping Purchaser:** These markets have purchasers who are active and organized, with a history of payment innovation and a willingness to push for payment reform.

**Non-market shaping Purchaser:** Purchasers are unable or unwilling to leverage their buying power for payment reform. These markets may not have purchasers large enough to dictate or influence change in the market.

**HP+:** Market shaping health plans are those that have the leadership, capacity and perhaps market power to push payment reform into their provider contracting.

**HP-:** Non-market shaping health plans are those that do have the leadership, capacity or market power to push for payment reform in their provider contracting.

SOURCE: Catalyst for Payment Reform

Table 2. Payment Reform Options

| Payment Reform Categories | Examples |
|---|---|
| **Upside only for providers:** Payment reforms in which the payment changes give health care providers the chance for a financial upside, but no added financial risk, or downside. | PCMH/payment for care coordination<br>Payment for shared decision making<br>Payment for nontraditional visits (e.g. e-visits)<br>Hospital-physician gainsharing<br>Pay-for-performance<br>Shared savings |
| **Downside only for providers:** Payment reforms in which the payment changes give health care providers the possibility of being at financial risk in the event that added resources are needed to care for a patient, which could have been averted. | Hospital penalties (e.g. non-payment for preventable hospital- or health care-acquired conditions or readmissions, never events, warranties, length of stay) |
| **Two-sided risk:** Payment reforms in which health care providers have both a possible financial upside and downside. | Bundled payment<br>Global payment/capitation<br>Shared risk in an Accountable Care Organization (ACO)-type setting (e.g. Pioneer ACO model of CMS Shared Savings) with shared savings potential, but also the risk that the provider will absorb costs if they spend over budget or do not meet quality targets) |
| **Consumer Shift to Higher-Value Providers:** Provider contracting and/or benefit design arrangements that encourage consumers to seek care from higher-value providers. | Public reporting & transparency<br>Tiered and narrow networks<br>Reference and value pricing<br>RFPs for specific services<br>Centers of Excellence |
| **Regulatory Options:** Intervention by a federal, state or local regulatory agency or other governmental body to reform health care payment or the dynamics in the market that surround it. | Rate setting<br>Oversight of health plans<br>Exchange design<br>Mandatory public reporting or data submission<br>Global Budgeting |

SOURCE: Catalyst for Payment Reform

## MATCHING PAYMENT REFORM OPTIONS TO MARKET TYPES

We conducted interviews with 35 of the leading payment reform implementation, academic, and research experts in the country about which payment reform categories could function best in each of the eight defined market types. During the interviews, we posed various scenarios and discussed possible advantages and challenges of implementing a particular payment method in a certain market. There were several areas of broad agreement.

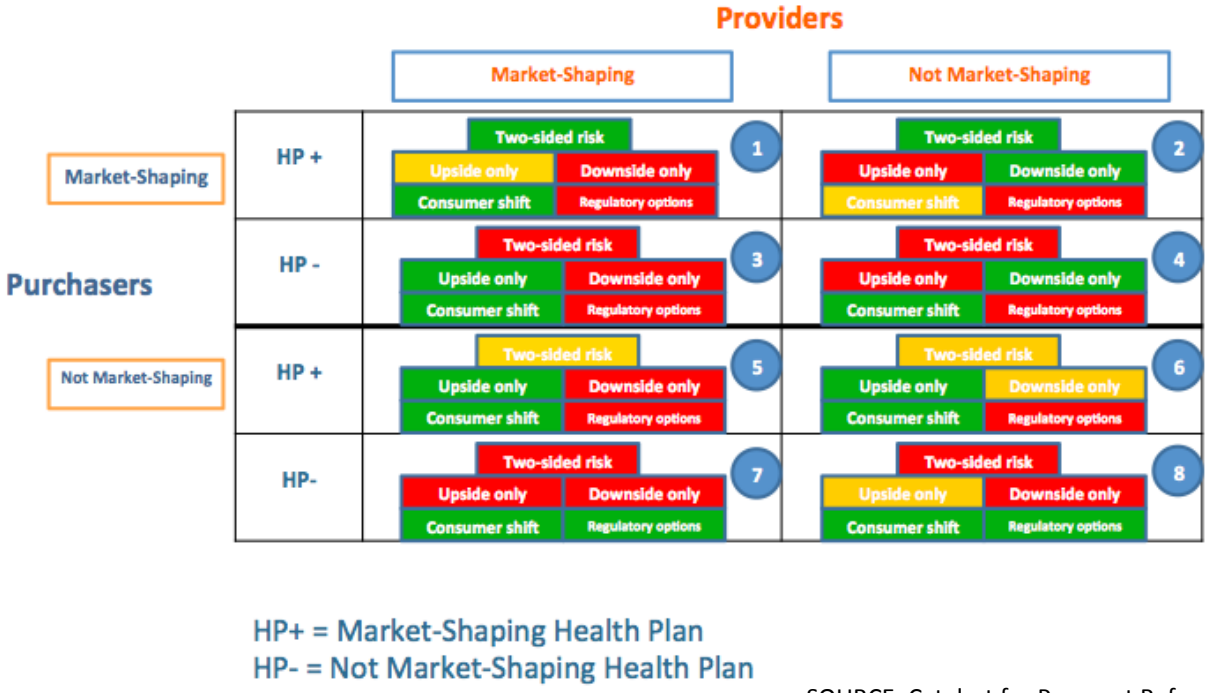
In most markets, experts felt the first step would be to organize the purchasers, as they would most likely create reforms that would benefit consumers. Experts also stressed that price and quality transparency—using standardized metrics and a coordinated approach between private and state or local public purchasers—were necessary for payment reform to thrive. Additionally, they underscored the importance of considering whether organizations are ready to manage risk and pay for care or accept payments using methods other than fee-for-service.

Other areas of consensus in perceptions of health care markets included: i) the ideal market encourages competition based on value, i.e., the highest quality at the lowest price; ii) organizations are looking to maximize price, even if they are committed to, and simultaneously pursuing, better quality; iii) greater market share and/or a strong reputation for health care providers means more negotiating leverage to increase prices to commercial payers or purchasers[5]; and iv) while alignment between current Medicare initiatives and the private sector may have benefits, there are markets that may not have the ability to align because of unintended consequences unique to that market, which could potentially drive up costs.

Given the current pace of provider consolidation, we considered in detail what payment reform options would be best in markets where providers have strong negotiating leverage. From our conversations with the experts, we concluded that in markets where provider systems dominate and resist payment changes, plans and purchasers should, in addition to trying to mirror CMS' non-payment policies, either offer upside-only incentives (e.g. pay-for-performance, shared savings) or turn to changes in benefit design (e.g. differential cost sharing, reference pricing).[6] In these markets, larger provider systems may be more ready and willing to take on risk; however, market concentration alone does not mean a provider is ready to accept new forms of payment. In the case that health plans are resistant to administering benefit or network design changes, purchasers themselves can administer benefit designs to steer patients to particular providers or services, although purchasers may not be willing to do so if they wish to minimize disruption for their enrollees.[7] In markets where there is plenty of competition among providers, it is more feasible to negotiate risk-based arrangements (e.g. non-payment policies, shared-risk arrangements), though a health plan's lack of experience with these methods can be an impediment.[8]

Throughout the interviews, a clear pattern emerged, signaling directional agreement among the experts regarding reform options for the different market types. In **Figure 2**, we indicate which payment reform categories and other strategies would best fit each market type. The payment categories in green are those that the experts identified as having the highest likelihood of success in each market type. Those in yellow were the ones that experts felt were less likely to succeed ("proceed with caution") or might be premature for the market's evolutionary stage. Categories in red are those that experts recommend against as either a starting point or at any time for that market type. This shows that success is multidimensional, taking into account the market's ability to implement a reform option, as well as the likelihood that increased value will result.

Figure 2. Payment Reform Recommendations by Market Type




SOURCE: Catalyst for Payment Reform

## EXAMINING THE MARKET TYPES

In Market Type 1, each of the major stakeholder groups has the ability to shape the market. The providers here may have market power as a result of size, consolidation, or reputation. While they will resist any downside-only risk or regulations on pricing, they are likely large enough to assume financial risk for the care of a given population. With health plans able to administer new payment models and strong purchasers willing to adopt them, two-sided risk (bundled payment, shared risk, etc.) could lead to lower overall costs and rewards for providers. Conversely, if dominant providers perceive that they are better off with the status

quo (FFS, DRGs, etc.), they may resist any payment reform, leaving purchasers no choice but to turn to consumer shift strategies to encourage their populations to seek care from certain providers—those that offer high quality care at a lower cost. In this type of market, health plans would likely be capable of administering a tiered or performance-based provider network. However, overly aggressive actions by purchasers or plans could lead providers to demand placement in-network or in their preferred tier, to refuse to contract with them, or to further consolidate to protect their revenues.

Our assumption is that many urban markets in the United States fall into Type 5, where purchasers are neither dominant nor organized, but both providers and health plans have consolidated and/or have some ability to shape the market.[9] In this type of market, purchasers may not have enough influence to convince providers to take on financial risk through new payment methods (unlike those providers in more competitive markets on the right side of the schematic). Therefore, if purchasers are interested in pushing reforms, it may be best to start with upside only payment reforms, such as pay-for-performance or shared savings. Given that upside-only approaches may not help to contain costs, purchasers can also turn to consumer shift approaches to encourage their enrollees to seek specific services or care from certain providers. For instance, facing these market conditions in Sacramento, California, and elsewhere, the California Public Employees' Retirement System (CalPERS) used reference pricing to move covered lives to higher-value providers for specific services and saved $5.5 million over two years.[10]

By contrast, let's examine Market Type 2. Given that there may be greater competition among providers and a strong purchaser and health plan presence, those purchasing care would strive to spread their risk by sharing it with providers through payment methods with either downside financial risk only or two-sided risk. Generally, in this type of market, purchasers and payers should not bother with upside only arrangements because they have the ability to share risk with the providers. Additionally, with these risk-based payments in place, they would not need to resort to consumer shift (though there would likely be choices in the market) or regulation since providers would be competing for their business.[11] However, as mentioned, there is a risk that if plans and purchasers are too aggressive, an unintended wave of provider resistance to contracting or provider consolidation could result.

Market Type 3 is similar to 1 in that the providers and the purchasers are market-shaping, but different in that the plans in this market have limited market-shaping abilities. In this structure, there are potential unintended consequences for purchasers. Market-shaping provider organizations may choose, for example, to participate in the CMS-sponsored Medicare Shared Savings Program, which encourages coordination and integration, and could increase their size in order to integrate care. In the process, they would accumulate sufficient market

dominance to drive price increases through relatively weak health plans and other payers on the commercial side.

## IMPLEMENTATION OF THE MARKET ASSESSMENT TOOL

The MAT offers a three-pronged data collection platform. The process begins with a tool that CPR developed to gather statistical data about the specific geographic market and its stakeholders. In particular, the tool seeks data about the market's population size, the breakdown in sources of insurance coverage and percent uninsured, the largest representatives of each of the major stakeholder groups and their percent of market share, and measures of market concentration among health plans and hospitals.

The second step is a multi-stakeholder online survey. The survey contains a series of targeted questions and data requests posed to key stakeholders in the market to further understanding of the market's dynamics. The stakeholder groups can include: employers and other health care purchasers (e.g. state employee health benefit plan agencies); physicians; hospitals, and health systems; health insurers; consumer groups; and/or representatives of state and local government. Each stakeholder group responds to a survey designed specifically for its role in the market.

The third component of the MAT's data collection process is either in-depth interviews with or detailed requests for information (RFIs) from key leaders in the market. This includes employers and other health care purchasers, physicians, hospitals and health systems, health insurers, consumer groups and representatives of state and local government. These interviews and/or RFIs round out the online survey results, by providing more nuanced, detailed responses and insight.

Through analyzing the online survey, interview, and/or RFI findings with structural data about the market, we can characterize purchasers, health plans, and providers as market shaping or non-market shaping, and determine the market type. Then using the guidance of **Figure 2** (red, yellow, green), we can translate the information we have collected into detailed payment reform recommendations for the specific market, taking into consideration local nuances and particular purchasers, providers, and plans.

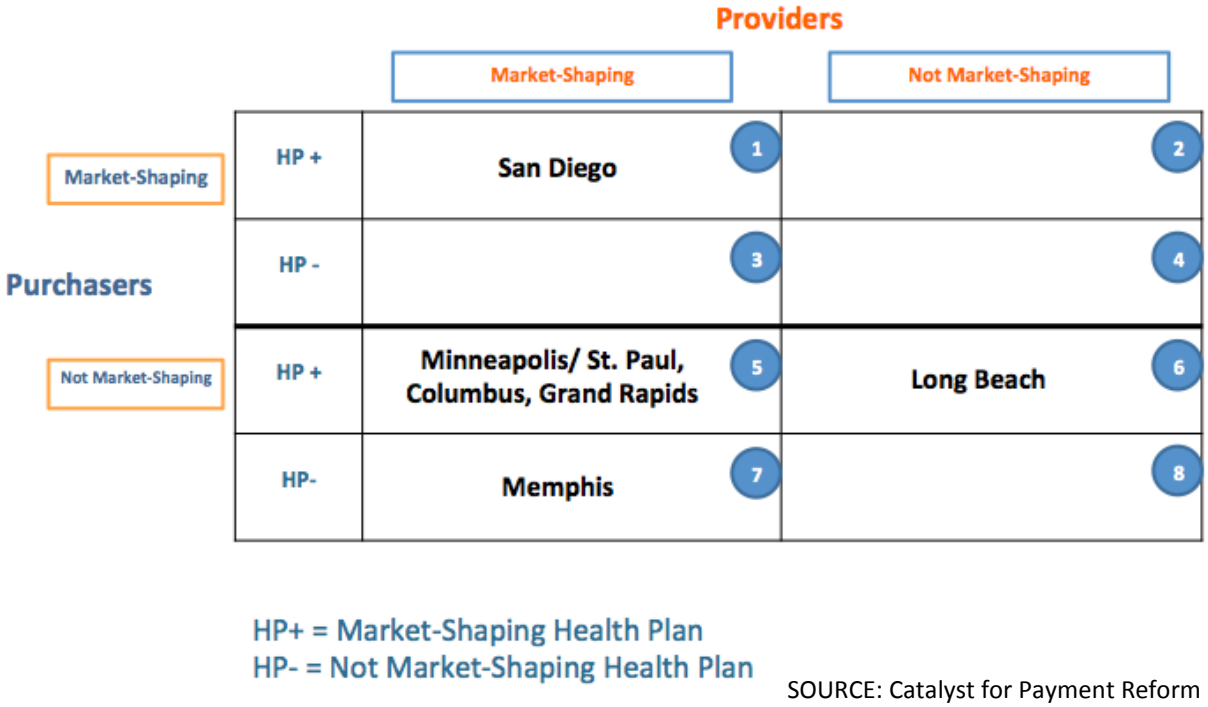
## APPLICATION OF THE MARKET ASSESSMENT TOOL

To date, CPR has conducted assessments of six markets: Columbus, Ohio; Grand Rapids, Michigan; Long Beach, California; Memphis, Tennessee; Minneapolis-St. Paul, Minnesota; and San Diego, California. Each market we analyzed has helped us to refine the MAT process. In addition to providing directional payment reform guidance, sponsors of local market assessments commented that gathering the information creates a valuable, tangible asset for

stakeholders. Through its application, CPR found the MAT process to be most successful when the sponsoring organization is well-connected within the market, enabling the identification and participation of the right stakeholders and key informants.

The market types for each of the markets assessed to date are included in **Figure 3**.

Figure 3. Market Types of CPR Assessed Markets




SOURCE: Catalyst for Payment Reform

## CASE EXAMPLE: MINNEAPOLIS-ST. PAUL

### Our Approach

First, CPR gathered publicly available structural data about physicians and health systems, health plans, and purchasers in the Minneapolis-St. Paul market, as well as the mix of insurance coverage. Next, twenty stakeholder representatives responded to the initial online survey. Lastly, CPR conducted in-depth interviews with twelve key informants. Survey respondents and interviewees represented large health care systems, professional medical associations, physicians, large payers, large purchasers, legal and regulatory bodies, as well as researchers.

### Our Findings

Through the assessment, CPR found that health plans in the Minneapolis-St. Paul market have taken on a market-shaping role. While the larger health care systems clearly are leading and implementing reforms as well, most stakeholders agreed the plans are

exerting greater influence than any other stakeholder in the market. Private employers have receded from having an active role, though the State as a purchaser has begun to shape market dynamics through legislation passed in 2008 and innovative payment and benefit designs that have followed.

### What's Next?

These dynamics influence what might be the most logical next steps in implementing payment reform in this market. Based on structural data and stakeholder input, CPR determined that the Twin Cities market most resembles Market Type 5. While upside only payment reform is likely to thrive in this type of market, in the case that costs do not moderate, there is a likelihood that plans will simply pass on increased premiums to employers and other purchasers. To counteract this, payment reform options that focus on either 'two-sided risk' or 'consumer shift' may be a stronger fit. Given the active role that state purchasers have taken, CPR provided specific recommendations to 1) create alignment between the state and private sector; and, 2) take steps to open up future opportunities for payment reform. Between the market type and the local data we gathered, we identified an appetite and readiness for shared risk in the market. Consequently, CPR recommended expanding programs with shared savings to include financial risk for providers. Additionally, given that consumer shift is an ideal reform in markets with the dynamics of the Twin Cities, CPR recommended tiered and narrow networks as another next logical step.

## CASE EXAMPLE: SAN DIEGO

### Our Approach

Our assessment of San Diego was commissioned by a key player in the market who acted as our liaison in requesting participation from other stakeholders. Through a combination of publicly available data and data for purchase, we gauged the structural aspects of the market and identified important characteristics, such as significant participants, their market share, and plan-provider arrangements. Next, we fielded a survey of leaders in the health care market representing physician groups, health systems and health plans, to enhance our understanding of the market dynamics. From this survey, we gleaned information about stakeholders' ability to implement and/or participate in reforms as well as the payment methods currently in play. Lastly, we constructed and fielded requests for information (RFI) from health systems and health plans, with detailed questions about their innovations nationally (to gauge their capabilities) and in the San Diego market in important areas—e.g. payment reform programs, accountable care organizations (ACOs) and patient-centered medical homes

(PCMHs), maternity care, primary care, price transparency, behavioral health, etc. All four health systems and five health plans that we invited provided a response.

### Our Findings

Combining all of the information we gathered helped us understand more fully the dynamics and key stakeholders in San Diego, which led us to determine that the market is closest to Type 1. San Diego consists of several large, competing integrated delivery systems who have a history of quality improvement activities and most of whom have extensive experience with payment methods beyond traditional fee for service, including those that require taking on financial risk. Additionally, most health plans in the market have some experience with delivery and payment reforms and are at different stages of implementing them locally. There are some strong health care purchasers in the market and both health systems and health plans operating in the market are open to partnering with purchasers to experiment further.

### What's Next?

This market appears ready to handle new health care delivery models and alternative payment methods. Several health plans are also ready to support innovative consumer shift strategies to encourage their members to seek care from particular providers, such as those who deliver high quality care at a low cost. As ACOs become more prevalent in San Diego, purchasers and payers have an opportunity to push for shared risk arrangements and narrow or tiered networks that could support the ACO by encouraging patients to seek care from them.

## CHALLENGES AND OPPORTUNITIES

Several challenges need to be addressed to help the MAT play a useful role in accelerating successful payment reform. First, our classification of market and payment reform types is somewhat subjective and our predictions of the impact of different reforms in different markets need to be validated. Each market in the United States is unique and there are micro markets within larger markets that deserve their own analysis (e.g., the north and south shores of the Boston area). Furthermore, the characteristics of markets are not static and can change over time; appropriate recommendations for a specific market are also likely to evolve, which requires interested researchers and funders. The tool may be most helpful in communities that take a multi-stakeholder, organized approach to payment reform and this has not been the rule across the country. In the majority of cases, strategies are arranged between providers and either CMS or commercial payers alone. Private purchaser involvement has been sporadic, although there is growing interest and engagement, especially by large public purchasers, e.g., state employee agencies.

However, a multi-stakeholder, proactive approach to payment reform using a predictive tool to guide discussion may produce better community-wide outcomes, with fewer unintended consequences, than the current, largely ad hoc process. The MAT could provide a framework for collecting data on what is working in different environments and, as market types become better defined and understood, changes in payment could be better tailored to specific markets. Proliferation of best practices including, in some cases, what to avoid, could also be targeted to relevant markets. Developing and using this type of database would require not only resources but also researchers on the ground in the markets.

## CONCLUSION

The truism that "health care is local" suggests that communities will experience different risks and benefits from similar types of payment reform. The Market Assessment Tool provides a heuristic approach, establishing a framework to assess what type of payment reform is likely to have the most favorable impact on the quality and affordability of care for people with both public- and privately-funded insurance in a given community. The model integrates 'macro' elements of local culture, politics, history, and delivery system structure with a 'micro' view of what works for provider or payer organizations. While there is not yet a thriving evidence base to support our model, and others could create differing market archetypes and evaluations, the testing of the MAT in the six markets has furthered understanding of market dynamics and their relationship to payment reform. This has also helped local health leaders make resource and policy decisions about reform efforts in an increasingly proactive fashion.

## ENDNOTES

1. Rosch JT. Federal Trade Commission. Remarks before the ABA Section of Antitrust Law Fall Forum. Accountable Care Organizations: What Exactly Are We Getting? http://www.ftc.gov/sites/default/files/documents/public_statements/accountable-care-organizations-what-exactly-are-we-getting/111117fallforumspeech.pdf. Published November 2011.

2. Rosenthal MB. Beyond pay for performance—emerging models of provider-payment reform. *New England Journal of Medicine*. 2008; 359(12):1197-1200.

3. Dixit, Avinash K., Nalebuff, Barry. The art of strategy: a game theorist's guide to success in business & life. *New York: W.W. Norton & Co*. 2008.

4. To access the Appendix, click on the Appendix link in the box to the right of the article online.

5. Berenson RA, Ginsburg PB, Kemper N. Unchecked provider clout in California foreshadows challenges to health reform. *Health Aff (Millwood)*. 2010;29(4):699-705.

6. Ginsburg PB, Pawlson LG. Seeking Lower Prices Where Providers Are Consolidated: An Examination of Market and Policy Strategies. *Health Aff (Millwood)*. 2014;33(6):1067-1075.

7. Christianson JB, Trude S. Managing costs, managing benefits: employer decisions in local health care markets. *Health Serv Res*. 2003;38(1 Pt 2):357-373.

8. Harbrecht MG, Latts LM. Colorado's Patient-Centered Medical Home Pilot met numerous obstacles, yet saw results such as reduced hospital admissions. *Health Aff (Millwood)*. 2012;31(9):2010-2017.

9. Numerous analysis available indicating increasing trends of both provider and health plan consolidation. For example, see:

9a. American Medical Association. Competition in Health Insurance: A Comprehensive Study of U.S. Markets. 2013 ed. Chicago; 2013.

9b. Berry E. Health plan market primed for further consolidation. http://www.amednews.com/article/20120903/business/309039969/6/. Published 2012.

9c. Dafny L, Duggan M, Ramanarayanan S. Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry. *American Economic Review.* 2012;102(2):1161.

9d. White C, Bond AM, Reschovsky JD. High and varying prices for privately insured patients underscore hospital market power. http://www.ncbi.nlm.nih.gov/pubmed/24073466. Published 2013.

10. Cowling D, Boynton A. CalPERS Pension & Health Benefits Committee, Agenda Item 7 for June 18, 2013. http://www.allreadable.com/f1063Ham. Published 2013. Accessed June 2014.

11. Bailit Health Purchasing L. Payment Matters: The ROI for Bundled Payment. Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404563/subassets/rwjf404563_1. Published 2013.