Attached please find the results of CPR's new evaluation of vendors that facilitate reference-based pricing solutions. **As a reminder, you agreed to keep this confidential and not share it outside of your staff/organization.**

Developing the evaluation questions and specifications

In 2020, CPR launched an evaluation of vendors who provide reference-based pricing (RBP) solutions to employers and other purchasers of commercial health insurance. RBP ties payment for health care services to a rationalized external benchmark – typically Medicare. Under an RBP model, vendors re-price claims at a multiple of Medicare's rates (usually somewhere in the ballpark of 140-180 percent), and pay providers at this rate, with or without a contract. Providers will either accept the payment, which is usually much lower than what they would receive from a commercial health plan, or they won't, in which case the provider will bill the patient for the balance. If a patient is balance billed, the RBP vendor's team of advocates and legal representatives fights the provider or negotiates on the patient's behalf until they reach a settlement.

Over the course of nine months, CPR conducted market research around reference-based pricing in the self-funded employer space, and the vendors who supply these services.

Conducting evaluations of RBP vendors

CPR invited 30+ companies to participate in an evaluation. Nine consented to be evaluated. The resulting summary scorecards provide the high-level findings from our evaluations of these nine vendors. In the attached materials, you will also find the full list of companies CPR invited to participate. We summarized key findings, themes, and recommendations in a publicly available white paper on the risks and rewards of implementing an RBP health plan.

This work was supported by the Peterson Center on Healthcare as well as financial contributions from five of the vendors we evaluated. Vendors' financial contributions were voluntary – there was no "pay to play." CPR evaluated any vendor that agreed to participate even if they did not provide financial support. Contributors received the added benefit of detailed evaluation results, and were interviewed for the public report, and were featured in an email to CPR's followers. However, no vendor had any influence over CPR's scoring of their offerings.

What's next? We need to hear from you!

CPR would like to continue evaluating vendors in areas that support your high-value purchasing efforts. To help our team prioritize, we need your feedback on whether this type of resource is valuable to you.

- **If you have any initial feedback,** please reach out to Julianne McGarry or Emma Wager us and share it while it is fresh.
- **If you are currently considering an RBP strategy,** we welcome a quick discussion to see how we can support you.
- **If you have any questions or would like to schedule a follow-up meeting with a specific vendor,** we're happy to make the introduction.
- **If you are not yet a CPR member, but are interested in learning more joining CPR, please reach out to Ryan Olmstead, Director of Member Services**

Kind regards,

Julianne McGarry, *Director of Projects and Research*
Emma Wager, *Project and Research Assistant*

BACKGROUND & GUIDANCE

INTERPRETING CPR'S SUMMARY SCORECARDS

How did we evaluate & rate participating companies?

1. **Fielding the RFI:** CPR sent evaluation questions to each participating bundled payment vendor. We gave each respondent approximately 1 month to submit its written response in a standardized Excel template.

2. **Evaluating & rating vendors:** CPR compared each answer the vendors provided to CPR's specification and assigned a rating based on how well current capabilities met the specification. The toolkit also provides purchasers with what they need to replicate detailed evaluations of vendors on their own.

3. **Synthesizing detailed results into Summary Scorecards:** To make the results digestible, CPR condensed the detailed evaluation questions into "sub-categories" representing core competencies for each vendor.

4. **Sharing results back with vendors:** Companies who opted to make a financial contribution received detailed results, offered their perspectives for CPR's white paper, and received additional marketing benefits. Because it was important to CPR to avoid a "pay to play" situation with the evaluations, CPR allowed vendors to participate in the evaluation for free. Five of the nine respondents selected this option.

5. **Sharing results with CPR members:** **Per your agreement to the confidentiality statement, please do not distribute these scorecards outside of your organization.**

Email Julianne McGarry (jmcgarry@catalyze.org) with questions or feedback on the process or results.

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RBP VENDORS

CPR INVITED 36 COMPANIES TO PARTICIPATE,* 9 AGREED

Participants	
6 Degree	ELAP Services
AMPS	Health Scope Benefits (TPA)
Apostrophe Health	HST
Azeros	Payer Compass
ClaimDOC	

Declined or Non-Respondent			
90 Degree Benefits	Context 4 Healthcare	Health Cost Control	Medibid
A & G Healthcare	Corporate Synergies	Health Joy	Professional Benefit Administrators
ACS Benefit Services	Crumdale Partners	Health Now	Sidecar Health
AmeriBen	Corporate Benefit Services	Healthgram	Trustmark
Assured Benefits Administrators	Custom Design Benefits	Healthsmart	Redirect Health
Benefit Design Specialists	EBMS	HRGi	Trustmark
Chernoff Diamond	FairPrice	Innovative Benefit Planning	Varipro
CohnReznick	HHC Group	Lucent Health	Wellnet
Complete Payroll Solutions	Health Comp	Map Health	Zelis

***Vendor list based on CPR research**

WHAT'S NEXT?

WE WANT TO HEAR FROM YOU!

We hope this CPR members-only resource is valuable to you.

Please reach out to Julianne McGarry (jmcgarry@catalyze.org) with general feedback or if:

1. You have specific questions or feedback about CPR's specifications, evaluation process, or results.
2. You are interested in inviting any of the RBP vendors that we evaluated to present to your organization.
3. You'd like to use CPR's toolkit to evaluate an RBP. We can provide support as needed!
4. You can think of another vendor category that is ripe for an evaluation.

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2021 Reference-Based Pricing Evaluation

Summary Vendor Information:
6 Degrees Health works with companies nationwide and covers over 100,000 lives, as of October 2020. 6 Degrees partners with employers of any size, including clients with as few as eleven members. They offer provider market analyses, reasonable value claim reports, claim negotiations, and reference-based repricing. 6 Degrees uses its proprietary platform, MediVI, to integrate hospital financial and quality data from multiple sources to determine fair and defensible pricing.

Rating Key:				
N/A or unable to grade	Does not meet purchaser-defined criteria	Partially meets purchaser-defined criteria	Meets purchaser-defined criteria	Exceeds purchaser-defined criteria

Section 1: Administrative Model and Fees			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Administrative fee structure	Purchasers prefer PEPM or PMPM pricing model as opposed to a variable pricing model like % savings.		Offers PEPM fee structure
Basic services covered under vendor's administrative fee	Preferences may vary by purchaser, but at a minimum, administrative fee should cover the following services: • Claims re-pricing • Claims auditing • Patient advocacy • Patient education • Provider outreach • Navigation/Transparency • Customer reporting		Administrative fee covers all core services recommended for administering an RBP plan: • Claims re-pricing • Claims auditing • Plan member advocacy • Plan member education • Provider outreach • Navigation/Transparency • Customer reporting
Other services covered under vendor's administrative fee	Ungraded		• Access to transplant network, specialty care network and cost containment services • Plan design consulting • Prospective single case contracting or negotiation as needed for provider access issues • Licensed access to MediVI for TPA, medical management and plan

Acceptance of full ERISA responsibility	ERISA co-fiduciary liability means added protection for purchasers/plan sponsors but the implications for patients who are balance billed are complex. CPR discusses the benefits and limitations of ERISA co-fiduciary protections in our State of the Marketplace Report. For the purpose of the scorecard, the vendor's inclusion of ERISA co-fiduciary responsibility as part of their administrative fee is provided for informational purposes only.[1]		Accepts full ERISA co-fiduciary responsibility

Section 2 - Provider Contracting and Rates			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Network configurations available	• Vendor should allow RBP solution to be combined with a PPO. • Vendor should offer multiple customizable configurations of an RBP solution (physician only, hospital only, OON only, etc.)		Several configurations of RBP available including full replacement, facility only, and facility only + physician out-of-network.
Pricing strategy & percent of Medicare rates	Ungraded		Customizable by the customer, but default rate is 140% of Medicare for facility charges and 120% for professional services.
Criteria vendor uses to select providers for direct contracts	• Vendor should engage in direct contracts with providers where appropriate, as this provides additional protection for purchasers and plan participants. • Vendor should consider quality, as well as cost and credentialing, in any contract negotiations with providers.		Did not disclose criteria for provider contracts.
Inclusion of alternative payment models (APMs)[2] in provider contracts	Although not typically core to an RBP model, vendors should consider value-based payment arrangements, such as bonuses for quality, shared savings, or episode bundles for providers with whom they have formal contracted relationships.		Utilizes bundled payment in some of its direct contracts, but other payment models would not qualify as APMs as they do not include incentives for quality.

[1] CPR recommends purchasers consult legal counsel to determine the optimal strategy for their individual circumstances

[2] Per Health Care Payment Learning and Action Network (HCP-LAN) guidelines: https://hcp-lan.org/apm-refresh-white-paper/

Section 3 – Patient/Member Support			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Member navigation services & transparency tool – features and modalities	Vendor should offer an app/website as well as telephonic support free of charge. Navigation tool should offer the following information about providers: • Price • Quality • Likelihood of accepting RBP rate Tool should be included in vendor's base fee.		Provides multi-modality navigation support (online tool and live support). App, phone and email options available, which tell plan members the likelihood that the provider will accept RBP. Patient Navigators have access to provider quality performance via MediVI platform; however, patient-facing navigation tools do not offer information on provider quality.
Member education services	• Vendor should demonstrate commitment and accountability to plan member education • Vendor should demonstrate that it has a plan and strategy for patient education. • Education materials should be multi-media, customizable, and included in fee		Customizable, multi-modal member education services are included as part of the base administrative fee.
Member advocacy; process if member is balance billed	• Vendor should defend the balance bill for the life of the claim • Vendor should provide a dedicated member advocate as a single point of contact for any member who receives a balance bill • Vendor should offer credit repair services in the event that collection agencies are engaged • Service should be included in the vendor's base cost		Demonstrates comprehensive member advocacy. If member receives a balance bill, provides frequent, multi-modal communication, available on demand. Offers credit repair services for members if needed.

Section 4 – Client Reporting and Results			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Components and methodology of vendor's opportunity analysis for prospective customers	Vendor should offer a prospective customer analysis that is customized based on customer-provided data inputs, such as a claims file, purchaser census data, and current plan design.		Provides a prospective client savings analysis that is customized based on client-provided data.

Cost of care savings methodology used in reporting for existing customers	Cost of care savings should be based on average PPO rates (or customer's previous PPO rates) rather than % of billed charges. All health plans negotiate discounts off of billed charges, so savings from billed charges do not reflect the impact of the RBP program.		Customer savings are calculated relative to provider billed charges; savings relative to previous PPO discounts available upon request.
Quality metrics provided in reporting for existing customers	Customer reporting should include quality outcomes data that uses nationally recognized metrics of prevention, care management and care outcomes.		Customer reporting does not include quality metrics.
Member experience metrics provided in reporting for existing customers	Vendors should collect member experience data through member surveys, as opposed to via proxy measures such as call response times. This information should be shared with customers in vendor's reporting		Customer reporting does not include patient experience data.
Average expected savings (%) for customers who use vendor's RBP solution	Ungraded		Savings average between 20-40% compared to PPO plans.
Percent of vendor's total medical spend (billed charges) that is balance billed to patients	The % of claims that are balance billed is a reflection of the vendor's ability to pre-negotiate with providers (even outside a contract) and steer plan members to providers who are likely to accept RBP. Customers prefer solutions where <3% of claims result in a balance bill.		Less than 3% of claims are balance billed.

***Disclaimer**: This scorecard summarizes vendor's solution and services at a specific point in time and is intended to educate CPR members and other health care purchasers, brokers and consultants . CPR's evaluation is based on vendor's written responses to a Request for Information. This summary is not intended to replace an employer-purchaser's formal Request for Proposal process. For additional information about CPR's reference-based pricing evaluation project, please contact connect@catalyze.org.*

Vendor Statement (no more than 500 words):
6 Degrees Health declined to provide a vendor statement.

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2021 Reference-Based Pricing Evaluation

amps

Summary Vendor Information:
Advanced Medical Pricing Solutions (AMPS) is available in all 50 states with clients in all 350+ metro areas throughout the country. Their reference-based pricing solution can be paired with AMPS America – a network of hospitals and provider groups across the country. As a named fiduciary, AMPS is responsible for payment determinations on hospital and physician claims and offers indemnification for customers and plan members. AMPS combines Medicare pricing with multiple reference points to arrive at defensible provider payment amounts.

Rating Key:				
N/A or unable to grade	Does not meet purchaser-defined criteria	Partially meets purchaser-defined criteria	Meets purchaser-defined criteria	Exceeds purchaser-defined criteria

Section 1: Administrative Model and Fees			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Administrative fee structure	Purchasers prefer PEPM or PMPM pricing model as opposed to a variable pricing model like % savings		Operates on a PEPM model but has the flexibility to operate a percent-claims model.
Basic services covered under vendor's administrative fee	Preferences may vary by purchaser, but at a minimum, administrative fee should cover the following services: • Claims re-pricing • Claims auditing • Patient advocacy • Patient education • Provider outreach • Navigation/Transparency • Customer reporting		Access to care navigation app and direct contracts, are only available through percent claims pricing model.
Other services covered under vendor's administrative fee	Ungraded		• Physician-led medical bill review • Pre-care denial assistance • Post care settlements • Plan co-fiduciary • Plan sponsor legal defense services

Acceptance of full ERISA responsibility	ERISA co-fiduciary liability means added protection for purchasers/plan sponsors but the implications for patients who are balance billed are complex. CPR discusses the benefits and limitations of ERISA co-fiduciary protections in our State of the Marketplace Report. For the purpose of the scorecard, the vendor's inclusion of ERISA co-fiduciary responsibility as part of their administrative fee is provided for informational purposes only.[1]		Accepts full ERISA co-fiduciary responsibility

Section 2 - Provider Contracting and Rates			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Network configurations available	• Vendor should allow RBP solution to be combined with a PPO. • Vendor should offer multiple customizable configurations of an RBP solution (physician only, hospital only, OON only, etc.)		Multiple network configurations available, including facility only or facility + physician solution. Can be paired with multiple professional networks.
Pricing strategy & percent of Medicare rates	Ungraded		Prices anchored in Medicare; average payment is 147% of Medicare. If Medicare rate does not exist or is not appropriate, utilizes historical data and other benchmarks to determine rate.
Criteria vendor uses to select providers for direct contracts	• Vendor should engage in direct contracts with providers where appropriate, as this provides additional protection for purchasers and plan participants. • Vendor should consider quality, as well as cost and credentialing, in any contract negotiations with providers.		Leverages quality data to encourage member utilization of high-quality hospitals, but this information does not currently influence contracting strategy.

[1] CPR recommends purchasers consult legal counsel to determine the optimal strategy for their individual circumstances

Inclusion of alternative payment models (APMs)[2] in provider contracts	Although not typically core to an RBP model, vendors should consider value-based payment arrangements, such as bonuses for quality, shared savings, or episode bundles for providers with whom they have formal contracted relationships.		Does not use provider contracting models that qualify as APMs per HCP-LAN guidelines.

Section 3 - Patient/Member Support			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Member navigation services & transparency tool – features and modalities	Vendor should offer an app/website as well as telephonic support free of charge. Navigation tool should offer the following information about providers: • Price • Quality • Likelihood of accepting RBP rate Tool should be included in vendor's base fee.		Online solution is still in development. Current navigation service is personnel based and accessible by phone and email. Navigators insight into whether providers will accept the rates, and navigators consider quality in referral recommendations. However, these services are a buy-up under the PEPM model administrative model.
Member education services	• Vendor should demonstrate commitment and accountability to plan member education • Vendor should demonstrate that it has a plan and strategy for patient education. • Education materials should be multi-media, customizable, and included in fee		Offers customizable, multi-modal plan member education services, including worksite visits, as part of the base administrative fee.
Member advocacy; process if member is balance billed	• Vendor should defend the balance bill for the life of the claim • Vendor should provide a dedicated member advocate as a single point of contact for any member who receives a balance bill • Vendor should offer credit repair services in the event that collection agencies are engaged • Service should be included in the vendor's base cost		Provides comprehensive member advocacy, dedicated member point of contact. Offers member credit repair services if needed and acts as co-fiduciary.

Section 4 - Client Reporting and Results

[2] Per Health Care Payment Learning and Action Network (HCP-LAN) guidelines: https://hcp-lan.org/apm-refresh-white-paper/

Vendor Attribute	CPR Specification	Vendor Rating	
Components and methodology of vendor's opportunity analysis for prospective customers	Vendor should offer a prospective customer analysis that is customized based on customer-provided data inputs, such as a claims file, purchaser census data, and current plan design.		Prospective client analysis is customized based on client-provided data and also includes disruption analysis.
Cost of care savings methodology used in reporting for existing customers	Cost of care savings should be based on average PPO rates (or customer's previous PPO rates) rather than % of billed charges. All health plans negotiate discounts off of billed charges, so savings from billed charges do not reflect the impact of the RBP program.		Savings methodology based on difference between billed charges and allowed charges.
Quality metrics provided in reporting for existing customers	Customer reporting should include quality outcomes data that uses nationally recognized metrics of prevention, care management, and care outcomes.		Customer reporting does not include quality metrics.
Member experience metrics provided in reporting for existing customers	Vendors should collect member experience data through member surveys, as opposed to via proxy measures such as call response times. This information should be shared with customers in vendor's reporting.		Tracks proxy measures of patient experience (e.g., rates of provider pushback) but does not survey plan members directly.
Average expected savings (%) for customers who use vendor's RBP solution	Ungraded		Typical customers experience discounts 25% to 30% better than a traditional PPO, depending on geography, service type, and plan design.
Percent of vendor's total medical spend (allowed charges) that is balance billed to patients	The % of claims that are balance billed is a reflection of the vendor's ability to pre-negotiate with providers (even outside a contract) and steer plan members to providers who are likely to accept RBP. Customers prefer solutions where <3% of claims result in a balance bill.		Approximately 3.6% of claims receive a balance bill.

***Disclaimer**: This scorecard summarizes vendor's solution and services at a specific point in time and is intended to educate CPR members and other health care purchasers, brokers and consultants. CPR's evaluation is based on vendor's written responses to a Request for Information. This summary is not intended to replace an employer-purchaser's formal Request for Proposal process. For additional information about CPR's reference-based pricing evaluation project, please contact connect@catalyze.org.*

Vendor Statement (no more than 500 words):

AMPS offers a holistic program that attacks the problem of growing medical benefit costs from every possible angle. Analysis shows that as AMPS RBR program has evolved, it generates as much savings as any program in the industry - with less disruption. AMPS guiding principal to pay Providers fairly has the added benefit of building relations with area Providers that are more conducive to direct contracts and service agreements for AMPS clients.

• Experience Matters: AMPS 16 years of experience and historical reimbursement data is a critical differentiator as facilities and providers change strategies and tactics. AMPS mature reference-based pricing program has a proven track record and as a more mature product, has address issues and offers a more complete product than our competitors.

• All in One: AMPS offers all of the services needed to run a successful RBP program including claim repricing, member advocacy, legal negotiation and indemnification. By having all services under one roof, processes are more streamlined than solutions that rely on multiple vendors.

• Technology Driven and physician led claim auditing solution. As the first in the industry to embed this solution into an RBP payment methodology, AMPS reviews every claim by our technology driven, Physician Led solution using Board Certified, Practicing Physicians across multiple medical disciplines. Our proprietary system and process allows Physicians to efficiently review medical claims. With machine learning technology that improves with each claim, we can remove the claim errors and utilize intelligent pricing to come up with a fair, and acceptable reimbursement.

• Professional Advocacy: Experienced and empathetic team to hold members hand throughout any pre-care and post care issue. Customizable communication plan to educate employees on change prior to go live and then ongoing communication to ensure adherence and better consumerism.

• Provider Relations Team: AMPS has a dedicated Provider Relations team that proactively negotiates contracts and continuous discount agreements with Facilities and Professionals on behalf of both AMPS narrow network (AMPS America) as well as on behalf of the client. AMPS also supports administering contracts obtained by the group prior to becoming an AMPS client. AMPS offers access to our national safe harbor program which includes hospitals and healthcare providers across the nation that have agreed to accept AMPS members at Medicare benchmarked rates. With 200+ years of experience negotiating and communicating with health systems and providers. Building safe harbors when and where need arises.

• Legal Expertise: In order to provide the best protection and experience to the Member and Plan, AMPS in-house Legal Department utilize all the protections that are mandated within federal regulations such as: ERISA, Fair Billing Practices Act, Fair Debt Collection Practices Act, etc., with in house attorneys and legal defense indemnification

• Strong leadership team that comes from every facet of healthcare: TPA Owners, CIO for Healthcare Software Development, Hospital Medical Director, COO for Claim Auditing and Cost Containment.

• Next-Generation Portal and Analytics Platform: Provides visibility into claims flow, performance metrics, and trends. High-level performance data is available as well as specific claim-level detail data. AMPS utilizes Quantros quality data and provides quality data to members so they can find high quality and high value providers.

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2021 Reference-Based Pricing Evaluation

apostrophe
intelligent health benefits

Summary Vendor Information:
Founded in 2017, Apostrophe Health offers its reference-based pricing (RBP) solution in Arizona, Colorado, Florida, Georgia, Indiana, Illinois, Michigan, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee and Texas, and currently services a client base comprising 35,000 covered lives. Apostrophe offers an integrated service model, which includes care management, utilization management, and claims processing. This supports its ability to report on care outcomes as well as cost savings, and identify strategies to optimize benefit design to improve clinical outcomes, cost of care and member engagement.

Rating Key:				
N/A or unable to grade	Does not meet purchaser-defined criteria	Partially meets purchaser-defined criteria	Meets purchaser-defined criteria	Exceeds purchaser-defined criteria

Section 1: Administrative Model and Fees			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Administrative fee structure	Purchasers prefer PEPM or PMPM pricing model as opposed to a variable pricing model like % savings		Offers PEPM fee structure.
Basic services covered under vendor's administrative fee	Preferences may vary by purchaser, but at a minimum, administrative fee should cover the following services: • Claims re-pricing • Claims auditing • Patient advocacy • Patient education • Provider outreach • Navigation/Transparency • Customer reporting		Administrative fee covers all basic services per specification.

Other services covered under vendor's administrative fee	Ungraded		• Configurable benefit design • Digital health solutions including virtual care programs • Eligibility administration • White glove member care • Apostrophe open network + direct purchasing with ProviderPay • Utilization and care management • Claims processing • Pharmacy administration • Invoicing and medical claim funding • Stop loss coordination • Renewal support
Acceptance of full ERISA responsibility	ERISA co-fiduciary liability means added protection for purchasers/plan sponsors but the implications for patients who are balance billed are complex. CPR discusses the benefits and limitations of ERISA co-fiduciary protections in our State of the Marketplace Report. For the purpose of the scorecard, the vendor's inclusion of ERISA co-fiduciary responsibility as part of their administrative fee is provided for informational purposes only.[1]		Not an ERISA Co-fiduciary

Section 2 - Provider Contracting and Rates			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Network configurations available	• Vendor should allow RBP solution to be combined with a PPO. • Vendor should offer multiple customizable configurations of an RBP solution (physician only, hospital only, OON only, etc.)		Multiple network configurations are available.
Pricing strategy & percent of Medicare rates	Ungraded		Prices anchored in Medicare rates. Range of prices relative to Medicare depends on the individual market and what it will bear.

[1] CPR recommends purchasers consult legal counsel to determine the optimal strategy for their individual circumstances

Criteria vendor uses to select providers for direct contracts	• Vendor should engage in direct contracts with providers where appropriate, as this provides additional protection for purchasers and plan participants. • Vendor should consider quality, as well as cost and credentialing, in any contract negotiations with providers.		Considers quality metrics (via Quantros) as well as cost in selecting providers for direct contracts.
Inclusion of alternative payment models (APMs)[2] in provider contracts	Although not typically core to an RBP model, vendors should consider value-based payment arrangements, such as bonuses for quality, shared savings, or episode bundles for providers with whom they have formal contracted relationships.		Payment models include case rates and bundled payment, but do not include financial incentives for quality improvement.

Section 3 - Patient/Member Support			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Member navigation services & transparency tool – features and modalities	Vendor should offer an app/website as well as telephonic support free of charge. Navigation tool should offer the following information about providers: • Price • Quality • Likelihood of accepting RBP rate Tool should be included in vendor's base fee.		Navigation services provided online and by phone. Information includes the likelihood that provider will accept rates; patient navigators attempt to steer members toward higher quality providers.
Member education services	• Vendor should demonstrate commitment and accountability to plan member education • Vendor should demonstrate that it has a plan and strategy for patient education. • Education materials should be multi-media, customizable, and included in fee		Offers customizable, multi-modal plan member education services as part of base administrative fee.

[2] Per Health Care Payment Learning and Action Network (HCP-LAN) guidelines: https://hcp-lan.org/apm-refresh-white-paper/

Member advocacy; process if member is balance billed	• Vendor should defend the balance bill for the life of the claim • Vendor should provide a dedicated member advocate as a single point of contact for any member who receives a balance bill • Vendor should offer credit repair services in the event that collection agencies are engaged • Service should be included in the vendor's base cost		Member advocates operate in pooled model (no dedicated POC). Contact is generally by mail, but complete record of patient, advocate and provider communications is available to member on demand. Access to legal services offered as a buy-up.

Section 4 - Client Reporting and Results			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Components and methodology of vendor's opportunity analysis for prospective customers	Vendor should offer a prospective customer analysis that is customized based on customer-provided data inputs, such as a claims file, purchaser census data, and current plan design.		Provides a prospective savings analysis that is based on customer-provided data.
Cost of care savings methodology used in reporting for existing customers	Cost of care savings should be based on average PPO rates (or customer's previous PPO rates) rather than % of billed charges. All health plans negotiate discounts off of billed charges, so savings from billed charges do not reflect the impact of the RBP program.		Can provide savings relative to PPO rates, as well as compared to billed charges.
Quality metrics provided in reporting for existing customers	Customer reporting should include quality outcomes data that uses nationally recognized metrics of prevention, care management, and care outcomes.		Customer reporting includes comprehensive quality outcomes and utilization data.
Member experience metrics provided in reporting for existing customers	Vendors should collect member experience data through member surveys, as opposed to via proxy measures such as call response times. This information should be shared with customers in vendor's reporting.		Tracks proxy measures for patient experience (e.g. balance bill summary, member engagement metrics) but does not survey plan members directly.
Average expected savings (%) for customers who use vendor's RBP solution	Ungraded		Plan sponsors can expect to realize savings between 10-30% dependent on the product/solution & plan design.

Percent of vendor's total medical spend (allowed charges) that is balance billed to patients	The % of claims that are balance billed is a reflection of the vendor's ability to pre-negotiate with providers (even outside a contract) and steer plan members to providers who are likely to accept RBP. Customers prefer solutions where <3% of claims result in a balance bill.		Less than 2% of all claims result in a balance bill.

Disclaimer: *This scorecard summarizes vendor's solution and services at a specific point in time and is intended to educate CPR members and other health care purchasers, brokers and consultants. CPR's evaluation is based on vendor's written responses to a Request for Information. This summary is not intended to replace an employer-purchaser's formal Request for Proposal process. For additional information about CPR's reference-based pricing evaluation project, please contact connect@catalyze.org.*

Vendor Statement (no more than 500 words):
Apostrophe Health declined to provide a vendor statement.

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2021 Reference-Based Pricing Evaluation

AZEROS aither health

Summary Vendor Information:
Azeros is an RBP vendor that specializes in claims re-pricing, partnering with Aither Health for third-party administrator services. Azeros works primarily with organizations in the Northeast, but is expanding nationwide. Azeros covers approximately 40,000 lives as of January 2021, and is open to contracting with organizations with anywhere from fifty to 10,000 members.

Rating Key:				
N/A or unable to grade	Does not meet purchaser-defined criteria	Partially meets purchaser-defined criteria	Meets purchaser-defined criteria	Exceeds purchaser-defined criteria

Section 1: Administrative Model and Fees			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Administrative fee structure	Purchasers prefer PEPM or PMPM pricing model as opposed to a variable pricing model like % savings		Offers PEPM fee structure
Basic services covered under vendor's administrative fee	Preferences may vary by purchaser, but at a minimum, administrative fee should cover the following services: • Claims re-pricing • Claims auditing • Patient advocacy • Patient education • Provider outreach • Navigation/Transparency • Customer reporting		Administrative fee does not cover provider outreach or plan member education, but covers all other core services associated with administering an RBP plan: •Claims re-pricing •Claims auditing •Plan member advocacy •Navigation/Transparency •Customer reporting
Other services covered under vendor's administrative fee	Ungraded		None

Acceptance of full ERISA responsibility	ERISA co-fiduciary liability means added protection for purchasers/plan sponsors but the implications for patients who are balance billed are complex. CPR discusses the benefits and limitations of ERISA co-fiduciary protections in our State of the Marketplace Report. For the purpose of the scorecard, the vendor's inclusion of ERISA co-fiduciary responsibility as part of their administrative fee is provided for informational purposes only.[1]		Accepts limited co-fiduciary liability in partnership with the Phia group.

Section 2 - Provider Contracting and Rates			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Network configurations available	• Vendor should allow RBP solution to be combined with a PPO. • Vendor should offer multiple customizable configurations of an RBP solution (physician only, hospital only, OON only, etc.)		A PPO wrap around network can be accessed for professional services only if customers select a hospital-only RBP model.
Pricing strategy & percent of Medicare rates	Ungraded		Payments range between 150% and 200% of Medicare.
Criteria vendor uses to select providers for direct contracts	• Vendor should engage in direct contracts with providers where appropriate, as this provides additional protection for purchasers and plan participants. • Vendor should consider quality, as well as cost and credentialing, in any contract negotiations with providers.		Cost is the primary qualifier. Does not consider quality or other performance metrics.
Inclusion of alternative payment models (APMs)[2] in provider contracts	Although not typically core to an RBP model, vendors should consider value-based payment arrangements, such as bonuses for quality, shared savings, or episode bundles for providers with whom they have formal contracted relationships.		In the process of implementing bundled payment.

[1] CPR recommends purchasers consult legal counsel to determine the optimal strategy for their individual circumstances

[2] Per Health Care Payment Learning and Action Network (HCP-LAN) guidelines: https://hcp-lan.org/apm-refresh-white-paper/

Section 3 - Patient/Member Support			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Member navigation services & transparency tool – features and modalities	Vendor should offer an app/website as well as telephonic support free of charge. Navigation tool should offer the following information about providers: • Price • Quality • Likelihood of accepting RBP rate Tool should be included in vendor's base fee.		Single modality (phone) for member navigation. Navigation support does not factor in provider quality.
Member education services	• Vendor should demonstrate commitment and accountability to plan member education • Vendor should demonstrate that it has a plan and strategy for patient education. • Education materials should be multi-media, customizable, and included in fee		Minimal formal patient educational materials. Focus is one-to-one contact between advocates and members by phone or email.
Member advocacy; process if member is balance billed	• Vendor should defend the balance bill for the life of the claim • Vendor should provide a dedicated member advocate as a single point of contact for any member who receives a balance bill • Vendor should offer credit repair services in the event that collection agencies are engaged • Service should be included in the vendor's base cost		Member advocates operate in pooled model without a dedicated point of contact for members. Legal defense services are delegated to third-party with limited co-fiduciary responsibility. These services are included in base administration fee.

Section 4 - Client Reporting and Results			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Components and methodology of vendor's opportunity analysis for prospective customers	Vendor should offer a prospective customer analysis that is customized based on customer-provided data inputs, such as a claims file, purchaser census data and current plan design.		Does not provide savings analyses to prospective customers.

Cost of care savings methodology used in reporting for existing customers	Cost of care savings should be based on average PPO rates (or customer's previous PPO rates) rather than % of billed charges. All health plans negotiate discounts off of billed charges, so savings from billed charges do not reflect the impact of the RBP program.		Customer savings are calculated relative to providers' billed charges.
Quality metrics provided in reporting for existing customers	Customer reporting should include quality outcomes data that uses nationally recognized metrics of prevention, care management and care outcomes.		Customer reporting does not include measures of provider quality.
Member experience metrics provided in reporting for existing customers	Vendors should collect member experience data through member surveys, as opposed to via proxy measures such as call response times. This information should be shared with customers in vendor's reporting.		Customer reporting does not include patient experience data.
Average expected savings (%) for customers who use vendor's RBP solution	*Ungraded*		Expected savings of 15%-20% over PPO rates and 40% from billed charges.
Percent of vendor's total medical spend (allowed charges) that is balance billed to patients	The % of claims that are balance billed is a reflection of the vendor's ability to pre-negotiate with providers (even outside a contract) and steer plan members to providers who are likely to accept RBP. Customers prefer solutions where <3% of claims result in a balance bill.		About 10% of claims are balance billed.

Disclaimer: *This scorecard summarizes vendor's solution and services at a specific point in time and is intended to educate CPR members and other health care purchasers, brokers and consultants.. CPR's evaluation is based on vendor's written responses to a Request for Information. This summary is not intended to replace an employer-purchaser's formal Request for Proposal process. For additional information about CPR's reference-based pricing evaluation project, please contact* connect@catalyze.org.

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Vendor Statement (no more than 500 words):
Our decades of health plan experience is rooted in paying the right amount and paying it quickly. An outstanding back-office TPA/RBP engine and negotiating objective is integral to making a health plan work. Though the following functions are critical, the payer industry is generally lacking: - Setting an RBP factor (e.g. 160%-200% of Medicare) that a reasonable payer and reasonable provider can mutually accept, whether or not a formal Fee Agreement has been contracted. - Paying the provider quickly (e.g. 5 working days) to earn credibility. - Offering a live Customer Service unit and engaging the plan member promptly (one week) to explain the RBP EOB and provide a Patient Advocate name, phone number and email address. - Continually reaching out to key providers to negotiate global Fee Agreements. We appreciated the opportunity to participate in this project.

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2021 Reference-Based Pricing Evaluation

ClaimDOC
Fair Payment Solutions for Health Plans

Summary Vendor Information:
ClaimDOC is a claims audit and member advocacy firm. Like other reference-based pricing vendors, ClaimDOC generates value for client organizations through re-pricing. However, ClaimDOC also completes a through line-by-line audit of each claim over $2,000 to uncover savings opportunities missed under auto-adjudication and re-pricing to a reference point. Customers can also purchase auditing services for problem claims on a claim-by-claim basis under ClaimDOC's Bill Review and Incidence Management (BRIM) product. ClaimDOC's Pave the Way™ program proactively reaches out to educate providers about the RBP solution and ensure they have all necessary information to accept and submit claims. ClaimDOC is available in all fifty states and works with employers with 100 or more members.

Rating Key:				
N/A or unable to grade	Does not meet purchaser-defined criteria	Partially meets purchaser-defined criteria	Meets purchaser-defined criteria	Exceeds purchaser-defined criteria

Section 1: Administrative Model and Fees			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Administrative fee structure	Purchasers prefer PEPM or PMPM pricing model as opposed to a variable pricing model like % savings		Operates on a variable cost model, but will accept a PEPM fee structure on a case by case basis.
Basic services covered under vendor's administrative fee	Preferences may vary by purchaser, but at a minimum, administrative fee should cover the following services: • Claims re-pricing • Claims auditing • Patient advocacy • Patient education • Provider outreach • Navigation/ Transparency • Customer reporting		Administrative fee covers all core services associated with administering an RBP plan
Other services covered under vendor's administrative fee	Ungraded		None

Acceptance of full ERISA responsibility	ERISA co-fiduciary liability means added protection for purchasers/plan sponsors but the implications for patients who are balance billed are complex. CPR discusses the benefits and limitations of ERISA co-fiduciary protections in our State of the Marketplace Report. For the purpose of the scorecard, the vendor's inclusion of ERISA co-fiduciary responsibility as part of their administrative fee is provided for informational purposes only.[1]		Accepts full ERISA co-fiduciary responsibility.

Section 2 - Provider Contracting and Rates			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Network configurations available	• Vendor should allow RBP solution to be combined with a PPO. • Vendor should offer multiple customizable configurations of an RBP solution (physician only, hospital only, OON only, etc.)		Offers multiple configurations of an RBP solution, including total network replacement, facility only with a physician network wrap, out of network only claims, dual choice and dialysis carve out.
Pricing strategy & percent of Medicare rates	Ungraded		125% of Medicare or 120% of cost to charge ratio, whichever is greater and a line by line audit of all claims over $2,000
Criteria vendor uses to select providers for direct contracts	• Vendor should engage in direct contracts with providers where appropriate, as this provides additional protection for purchasers and plan participants. • Vendor should consider quality, as well as cost and credentialing, in any contract negotiations with providers.		Contracts directly with providers that meet certain cost and access criteria, but does not consider quality.

[1] CPR recommends purchasers consult legal counsel to determine the optimal strategy for their individual circumstances

Inclusion of alternative payment models (APMs)[2] in provider contracts	Although not typically core to an RBP model, vendors should consider value-based payment arrangements, such as bonuses for quality, shared savings, or episode bundles for providers with whom they have formal contracted relationships.		Willing to consider but does not currently offer alternative payment models.

Section 3 - Patient/Member Support			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Member navigation services & transparency tool – features and modalities	Vendor should offer an app/website as well as telephonic support free of charge. Navigation tool should offer the following information about providers: • Price • Quality • Likelihood of accepting RBP rate Tool should be included in vendor's base fee.		ClaimDOC's Member advocates can offer navigation services based on provider price, quality and willingness to accept RBP, but this information is not yet available through ClaimDOC's patient-facing app or website.
Member education services	• Vendor should demonstrate commitment and accountability to plan member education • Vendor should demonstrate that it has a plan and strategy for patient education. • Education materials should be multi-media, customizable, and included in fee		Customizable, multi-modal member education services are included as part of the base administrative fee.
Member advocacy; process if member is balance billed	• Vendor should defend the balance bill for the life of the claim • Vendor should provide a dedicated member advocate as a single point of contact for any member who receives a balance bill • Vendor should offer credit repair services in the event that collection agencies are engaged • Service should be included in the vendor's base cost		Demonstrates comprehensive member advocacy. If member receives a balance bill, provides frequent, multi-modal member communications, and a record of these communications is available on demand. Offers credit repair services for members if needed.

[2] Per Health Care Payment Learning and Action Network (HCP-LAN) guidelines: https://hcp-lan.org/apm-refresh-white-paper/

Section 4 - Client Reporting and Results			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Components and methodology of vendor's opportunity analysis for prospective customers	Vendor should offer a prospective customer analysis that is customized based on customer-provided data inputs, such as a claims file, purchaser census data and current plan design		Provides a prospective client savings analysis that is customized based on client-provided data input.
Cost of care savings methodology used in reporting for existing customers	Cost of care savings should be based on average PPO rates (or customer's previous PPO rates) rather than % of billed charges. All health plans negotiate discounts off of billed charges, so savings from billed charges do not reflect the impact of the RBP program.		Customer savings are calculated relative to provider billed charges; however, savings *can* be reported in comparison to previous PPO rates.
Quality metrics provided in reporting for existing customers	Customer reporting should include quality outcomes data that uses nationally recognized metrics of prevention, care management, and care outcomes.		Customer reporting does not include quality metrics.
Member experience metrics provided in reporting for existing customers	Vendor should collect member experience data through member surveys, as opposed to via proxy measures such as call response times. This information should be shared with customers in vendor's reporting.		Collects feedback from website and Member Advocates but does not survey plan members systematically.
Average expected savings (%) for customers who use vendor's RBP solution	Ungraded		Average of 68% savings off of billed charges across all claims in 2019.
Percent of vendor's total medical spend (allowed charges) that is balance billed to patients	The % of claims that are balance billed is a reflection of the vendor's ability to pre-negotiate with providers (even outside a contract) and steer plan members to providers who are likely to accept RBP. Customers prefer solutions where <3% of claims result in a balance bill.		Approximately 2-3% of claims are balance billed.

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Vendor Statement (no more than 500 words):

Claim DOC does not treat co-fiduciary status as an a la carte option for plans engaging our services because without co-fiduciary status we do not have the ability to provide full, transparent protections for members. The cost savings achieved through RBP are shortsighted and short-lived without the protections afforded to members through our co-fiduciary status. We refuse to sacrifice positive member experience for cost-saving and believe our model provides the greatest value to plans because it achieves both. Our responsibility to protect the member comes directly from the language we require the plans we work with to include in their summary plan descriptions. This language defines our obligations as co-fiduciary and decision maker which provides transparency to members and providers alike, and solidifies our commitment to the plan to provide the highest level of member protection and support possible while simultaneously generating cost-savings to the plan. It is an integral part of our program and a baseline requirement that allows us to actively advocate for and defend vulnerable members from egregious provider billing practices.

Like our status as plan co-fiduciary, Claim DOC's open access plan also reflects our commitment to a positive member experience without sacrificing plan savings. Open access allows plan members to drive the relationships we seek to establish with providers. This model inherently prioritizes quality through member choice. Our Pave the Way Program supports members navigating our open access plan by proactively reaching out to member-identified providers, relying on the member's assessment of provider quality through their personal experience.

The flexibility offered by our open access plan is also demonstrated by our openness to alternative payment models through contracted relationships. Although not our default offering, alternative payment models such as value-based payment arrangements and episode bundles can be negotiated and supported by Claim DOC to best support the goals of the plan and the best interests of the members.

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2021 Reference-Based Pricing Evaluation

Summary Vendor Information:
Founded in 2007, ELAP offers reference-based pricing services to over 500 employer sponsored health plans, who cover 350,000 covered lives nationwide. ELAP's model is built upon the principles of ERISA as it applies to cost efficient plan design, claims auditing, provider engagement, member advocacy, and legal defense. ELAP partners with *Imagine Health,* a third-party administrator (TPA) offering a high-performance network of providers in 12 markets. ELAP leverages its RBP solution for providers outside *Imagine Health's* network and supplies plan members with transparency into the price *and* quality of these physicians and facilities.

Rating Key:				
N/A or unable to grade	Does not meet purchaser-defined criteria	Partially meets purchaser-defined criteria	Meets purchaser-defined criteria	Exceeds purchaser-defined criteria

Section 1: Administrative Model and Fees			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Administrative fee structure	Purchasers prefer PEPM or PMPM pricing model as opposed to a variable pricing model like % savings		Offers PEPM fee structure.
Basic services covered under vendor's administrative fee	Preferences may vary by purchaser, but at a minimum, administrative fee should cover the following services: • Claims re-pricing • Claims auditing • Patient advocacy • Patient education • Provider outreach • Navigation/Transparency • Customer reporting		Administrative fee covers all core services associated with administering an RBP plan.
Other services covered under vendor's administrative fee	Ungraded		• Plan design consulting • Life of claim legal defense for plan and member • Quality and cost guidance • Client implementation and support • Integration with TPA, pharmacy, stop-loss and other third parties

Acceptance of full ERISA responsibility	ERISA co-fiduciary liability means added protection for purchasers/plan sponsors but the implications for patients who are balance billed are complex. CPR discusses the benefits and limitations of ERISA co-fiduciary protections in our State of the Marketplace Report. For the purpose of the scorecard, the vendor's inclusion of ERISA co-fiduciary responsibility as part of their administrative fee is provided for informational purposes only.[1]		Accepts full ERISA co-fiduciary responsibility.

Section 2 - Provider Contracting and Rates			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Network configurations available	• Vendor should allow RBP solution to be combined with a PPO. • Vendor should offer multiple customizable configurations of an RBP solution (physician only, hospital only, OON only, etc.)		Vendor partners with Imagine Health, a TPA that offers a high-performance network (HPN). In the 12 markets where Imagine Health is available, vendor's RBP solution provides a means of paying for out of network claims. In all other markets, vendor's RBP can be configured as facility only, physician only or full network replacement.
Pricing strategy & percent of Medicare rates	Ungraded		Pricing methodology for facility claims based off the higher of Medicare + 20% or the specific health system's reported actual costs + 12%.
Criteria vendor uses to select providers for direct contracts	• Vendor should engage in direct contracts with providers where appropriate, as this provides additional protection for purchasers and plan participants. • Vendor should consider quality, as well as cost and credentialing, in any contract negotiations with providers.		Leverages Imagine Health's HPN, which comprises the highest performing 25-30% providers in each market.

[1] CPR recommends purchasers consult legal counsel to determine the optimal strategy for their individual circumstances

Inclusion of alternative payment models (APMs)[2] in provider contracts	Although not typically core to an RBP model, vendors should consider value-based payment arrangements, such as bonuses for quality, shared savings, or episode bundles for providers with whom they have formal contracted relationships.		Although ELAP/Imagine Health's provider contracts do not include APMs (as defined by HCP-LAN), their high-performance network screens for providers who meet quality and efficiency criteria. .

Section 3 - Patient/Member Support			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Member navigation services & transparency tool – features and modalities	Vendor should offer an app/website as well as telephonic support free of charge. Navigation tool should offer the following information about providers: • Price • Quality • Likelihood of accepting RBP rate Tool should be included in vendor's base fee.		Provides multi-modality navigation support (online tool and live support); informs members of provider prices, provider quality and likelihood that provider will accept rate.
Member education services	• Vendor should demonstrate commitment and accountability to plan member education • Vendor should demonstrate that it has a plan and strategy for patient education. • Education materials should be multi-media, customizable, and included in fee		Dedicated education/communication team provides on-site and virtual education sessions, multiple forms of communications collateral, customizable to customer's needs.
Member advocacy; process if member is balance billed	• Vendor should defend the balance bill for the life of the claim • Vendor should provide a dedicated member advocate as a single point of contact for any member who receives a balance bill • Vendor should offer credit repair services in the event that collection agencies are engaged • Service should be included in the vendor's base cost		Demonstrates comprehensive member advocacy. If member receives a balance bill, provides frequent, multi-modal communication to update member on balance bill status. Communications history and associated documents are available on demand. Offers credit repair services for members if needed.

Section 4 - Client Reporting and Results

[2] Per Health Care Payment Learning and Action Network (HCP-LAN) guidelines: https://hcp-lan.org/apm-refresh-white-paper/

Vendor Attribute	CPR Specification	Vendor Rating	
Components and methodology of vendor's opportunity analysis for prospective customers	Vendor should offer a prospective customer analysis that is customized based on customer-provided data inputs, such as a claims file, purchaser census data, and current plan design.		Provides a prospective client with savings analysis that is customized based on client-provided data.
Cost of care savings methodology used in reporting for existing customers	Cost of care savings should be based on average PPO rates (or customer's previous PPO rates) rather than % of billed charges. All health plans negotiate discounts off of billed charges, so savings from billed charges do not reflect the impact of the RBP program.		Can provide savings relative to PPO rates, in addition to savings relative to billed charges.
Quality metrics provided in reporting for existing customers	Customer reporting should include quality outcomes data that uses nationally recognized metrics of prevention, care management, and care outcomes.		Customer reporting includes data from Quantros on provider quality, including readmissions, complications and provider-specific patient satisfaction scores.
Member experience metrics provided in reporting for existing customers	Vendors should collect member experience data through member surveys, as opposed to via proxy measures such as call response times. This information should be shared with customers in vendor's reporting.		Collects member experience data through direct surveys of every patient who receives a balance bill.
Average expected savings (%) for customers who use vendor's RBP solution	Ungraded		Average savings achieved in year one of moving from a traditional PPO solution are a 15-30% reduction in health care spending .
Percent of vendor's total medical spend (allowed charges) that is balance billed to patients	The % of claims that are balance billed is a reflection of the vendor's ability to pre-negotiate with providers (even outside a contract) and steer plan members to providers who are likely to accept RBP. Customers prefer solutions where <3% of claims result in a balance bill.		Overall balance bill rate is <1%.

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Vendor Statement (no more than 500 words):

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ELAP Services provides a powerful alternative to traditional health insurance, allowing self-insured employers and their employees to take back control of their healthcare costs. ELAP's reference-based pricing solution promotes the responsible and sustainable management of healthcare costs while providing concierge-level support for plan members.

Founded in 2007, ELAP has over half a million members nationwide and has helped more than 500 employer sponsored health plans reduce their medical spend as much as 30%. ELAP has earned a world-class NPS score of 78 – a testament to their clients' satisfaction. Visit www.elapservices.com.

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2021 Reference-Based Pricing Evaluation

HealthSCOPE BENEFITS

HealthSCOPE Benefits is a third-party administrator (TPA) that administers reference-based pricing (RBP) programs offered by multiple vendors. As such, the vast majority of questions and specifications within CPR's RFI are not applicable to HealthSCOPE's functions in the RBP space. Moreover, as the sole TPA participating in CPR's RBP study, CPR is unable to compare HealthSCOPE to other TPAs that may offer similar services. Consequently, this Summary Scorecard profiles HealthSCOPE's capabilities in implementing, administering and supporting RBP programs, but does not offer ratings of these capabilities.

Summary Vendor Information:

HealthSCOPE Benefits (HealthSCOPE), a UnitedHealthcare company, is a TPA that administers RBP programs through partnerships with RBP solution vendors, including four vendors profiled in CPR's RBP study: ELAP, HST, 6 Degrees and AMPS. HealthSCOPE's top geographic markets for RBP clients include Pennsylvania, New Jersey, Delaware and Florida, but it also serves national, multi-site customers. Currently, 46 clients representing 42,000 members have active RBP solutions in place. As a TPA, HealthSCOPE can offer RBP plans through multiple network configurations, and pair reference pricing with value-based payment contracting, custom benefit design, as a full replacement or as dual-option alongside a UnitedHealthcare network.

HealthSCOPE's Role in Administering RBP Plans

- Helping customers choose the right RBP plan: HealthSCOPE can play a consultative role to help clients identify an RBP plan that meets their needs, both in terms of cost savings and tolerance for member disruption.
- Optimizing plan design: HealthSCOPE's experience working with multiple RBP vendors gives them insight into how to complement an RBP plan with the right network, benefit design and member support services to meet individual customer goals. HealthSCOPE can also build custom networks and direct contracts for clients in alignment with their RBP plan, if necessary.
- Managing and coordinating all point solution vendors: HealthSCOPE's role extends beyond paying claims. As a TPA, they operate as a hub, coordinating the cadre of point solution vendors and support services that purchasers need for the seamless operation of an RBP plan.
- Analyzing, editing and auditing claims: Claims auditing and editing are core competencies of RBP vendors, but also of TPAs. HealthSCOPE complements an RBP vendor's claims analysis with additional scrutiny to help customers identify patterns that may indicate concerning billing practices and warrant referral for investigation and review.

HealthSCOPE's Role in Supporting RBP Customers

HealthSCOPE Benefits provides customized communication materials that explain the nuances of RBP. HealthSCOPE's Benefits team and RBP vendor partners collaborate to develop a communication plan for employees to understand the move to an RBP plan. They provide initial and ongoing education on how benefits work under an RBP plan, and how to seek help when an issue arises. HealthSCOPE's educational materials can be mailed, emailed or hand distributed to the employee population, posted on the client's intranet site and on HealthSCOPE's web portal. They also provide live, employer work-site support to assist with health fairs and employee meetings.

HealthSCOPE's Role if a Patient is Balance Billed
HealthSCOPE partners with the RBP vendors to support members if they receive a balance bill to coordinate communications between customer, patient, vendor and provider. HealthSCOPE endeavors to work proactively with providers at the time of pre-certification to avoid balance billing and member issues. They also reprocess claims based on these final pricing agreements with providers. If a provider refuses to see a patient due to the RBP plan and an alternate provider cannot be found for the member, HealthSCOPE's Customer Care team will contact the provider, suggest a letter of agreement and will initiate that process with the pre-negotiations team if the provider agrees.

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Vendor Statement (no more than 500 words):
As a third-party administrator, HealthSCOPE Benefits considers reference-based pricing strategies and tactics to be valued and effective in the right circumstances. Understanding the nuanced ways in which plan sponsors evaluate these strategies is critically important. When considering the optimal approach, we urge our clients to plan for every possible scenario and caution them that extreme circumstances may arise, as is the case with any type of plan. Accounting for these adverse situations in advance may help mitigate or minimize their disruption, but not necessarily eliminate it.

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2021 Reference-Based Pricing Evaluation

HST
REVOLUTIONIZING HEALTHCARE

Summary Vendor Information:
HST covers over 800,000 lives across all fifty states, working with employers with as few as fifty or as many as 85,000 employees. HST is unique among RBP vendors profiled in this study in its incorporation of alternative payment models (APMs) into its provider contracts, including bundled payment and gainshare agreements. HST's service offerings include *Pathfinder*, a precertification/pre-pricing navigator that estimates prices during prior authorization before services are rendered, which minimizes the risk of balance billing.

Rating Key:				
N/A or unable to grade	Does not meet purchaser-defined criteria	Partially meets purchaser-defined criteria	Meets purchaser-defined criteria	Exceeds purchaser-defined criteria

Section 1: Administrative Model and Fees			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Administrative fee structure	Purchasers prefer PEPM or PMPM pricing model as opposed to a variable pricing model like % savings		Offers PEPM fee structure.
Basic services covered under vendor's administrative fee	Preferences may vary by purchaser, but at a minimum, administrative fee should cover the following services: • Claims re-pricing • Claims auditing • Patient advocacy • Patient education • Provider outreach • Navigation/Transparency • Customer reporting		All core services are included in the base administrative fee.
Other services covered under vendor's administrative fee	Ungraded		None provided

Acceptance of full ERISA responsibility	ERISA co-fiduciary liability means added protection for purchasers/plan sponsors but the implications for patients who are balance billed are complex. CPR discusses the benefits and limitations of ERISA co-fiduciary protections in our State of the Marketplace Report. For the purpose of the scorecard, the vendor's inclusion of ERISA co-fiduciary responsibility as part of their administrative fee is provided for informational purposes only.[1]		Does not accept ERISA co-fiduciary responsibility. When necessary, claims are referred to general internal counsel for legal settlement, not litigation.

Section 2 - Provider Contracting and Rates			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Network configurations available	• Vendor should allow RBP solution to be combined with a PPO. • Vendor should offer multiple customizable configurations of an RBP solution (physician only, hospital only, OON only, etc.)		Offers facility-only RBP with physician out-of-network RBP OR facility + physician RBP. Supports physician/ancillary-only PPOs.
Pricing strategy & percent of Medicare rates	Ungraded		Prices are generally 140–200% of Medicare. Average rates are 155% of Medicare for facilities and 125% of Medicare for physician claims.
Criteria vendor uses to select providers for direct contracts	• Vendor should engage in direct contracts with providers where appropriate, as this provides additional protection for purchasers and plan participants. • Vendor should consider quality, as well as cost and credentialing, in any contract negotiations with providers.		Engages in direct contracts that consider both cost and quality (CMS Star ratings).

[1] CPR recommends purchasers consult legal counsel to determine the optimal strategy for their individual circumstances

Inclusion of alternative payment models (APMs)[2] in provider contracts	Although not typically core to an RBP model, vendors should consider value-based payment arrangements, such as bonuses for quality, shared savings, or episode bundles for providers with whom they have formal contracted relationships.		Offers alternative payment models with incentives for quality outcomes, including bundled payments and gain share arrangements based on performance.

Section 3 – Patient/Member Support			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Member navigation services & transparency tool – features and modalities	Vendor should offer an app/website as well as telephonic support free of charge. Navigation tool should offer the following information about providers: • Price • Quality • Likelihood of accepting RBP rate Tool should be included in vendor's base fee.		Provides multi-modality navigation support (online tool and live support); Online tool includes provider prices, quality information (CMS Star ratings), and the likelihood that the providers will accept the rate. Additionally, HST's pre-pricing estimates give providers insight into payment rates in advance of elective procedures. Providers can then decide whether they will accept the rate before delivering care, reducing the probability that a patient will receive a balance bill.
Member education services	• Vendor should demonstrate commitment and accountability to plan member education • Vendor should demonstrate that it has a plan and strategy for patient education. • Education materials should be multi-media, customizable, and included in fee		Multiple forms of communications collateral, customizable to customer's needs. Included in administrative fee.

[2] Per Health Care Payment Learning and Action Network (HCP-LAN) guidelines: https://hcp-lan.org/apm-refresh-white-paper/

Member advocacy; process if member is balance billed	• Vendor should defend the balance bill for the life of the claim • Vendor should provide a dedicated member advocate as a single point of contact for any member who receives a balance bill • Vendor should offer credit repair services in the event that collection agencies are engaged • Service should be included in the vendor's base cost		Demonstrates member advocacy. If member receives balance bills, provides frequent, multi-modal communication, available on demand. Credit repair service is not included in administrative fee, but available as a buy-up.

Section 4 - Client Reporting and Results			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Components and methodology of vendor's opportunity analysis for prospective customers	Vendor should offer a prospective customer analysis that is customized based on customer-provided data inputs, such as a claims file, purchaser census data, and current plan design.		Provides a prospective client savings analysis that is customized based on client-provided data.
Cost of care savings methodology used in reporting for existing customers	Cost of care savings should be based on average PPO rates (or customer's previous PPO rates) rather than % of billed charges. All health plans negotiate discounts off of billed charges, so savings from billed charges do not reflect the impact of the RBP program.		Can provide savings relative to PPO rates, as well as billed charges.
Quality metrics provided in reporting for existing customers	Customer reporting should include quality outcomes data that uses nationally recognized metrics of prevention, care management, and care outcomes.		Utilization reporting includes Medicare Stars rating for each facility; however, reporting does not include quality data specific to the customer's covered population
Member experience metrics provided in reporting for existing customers	Vendor should collect member experience data through member surveys, as opposed to via proxy measures such as call response times. This information should be shared with customers in vendor's reporting		Conducts member experience surveys and includes results in customer reporting.
Average expected savings (%) for customers who use vendor's RBP solution	Ungraded		Average savings of 70% off of billed charges, and 20-30% savings compared to average PPO rates.

Percent of vendor's total medical spend (allowed charges) that is balance billed to patients	The % of claims that are balance billed is a reflection of the vendor's ability to pre-negotiate with providers (even outside a contract) and steer plan members to providers who are likely to accept RBP. Customers prefer solutions where <3% of claims result in a balance bill.		Less than 2% of claims are balance billed.

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Vendor Statement (no more than 500 words):
Since 2009, HST has redefined reference-based pricing. Now part of MultiPlan, HST enables Value-Driven Health Plans for employers of all sizes, working with or without a network for professional services. HST's technology objectively determines the value of medical services and equips both plan members and their healthcare providers to make optimal use of their plan benefits. Together, we drive cost out while preserving member and provider relationships.

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2021 Reference-Based Pricing Evaluation

PayerCompass

Summary vendor Information:
Payer Compass offers reference-based pricing (RBP) technology and support solutions to both self-funded purchasers and health plans. Operating in all 50 states and serving approximately 1,000 unique employer customers, PayerCompass negotiates unique, customer-specific direct contracts between its customers and providers. A unique aspect of PayerCompass's RBP model is that they enable direct contracts between customers and providers but does not hold the contracts itself. This allows individual customers to negotiate unique contracts with providers, according to the customer's specific needs. In a similar vein, PayerCompass allows its customers to set their own reference price points with providers and can model potential access and balance billing outcomes. PayerCompass's transparency tool, CompassConnect, informs plan members which providers in their area are high-quality and most likely to accept RBP payment.

Rating Key:				
N/A or unable to grade	Does not meet purchaser-defined criteria	Partially meets purchaser-defined criteria	Meets purchaser-defined criteria	Exceeds purchaser-defined criteria

Section 1: Administrative Model and Fees			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Administrative fee structure	Purchasers prefer PEPM or PMPM pricing model as opposed to a variable pricing model like % savings		Offers a PEPM model, with flexibility to operate other variable-cost models (e.g. percent of savings) if desired.
Basic services covered under vendor's administrative fee	Preferences may vary by purchaser, but at a minimum, administrative fee should cover the following services: • Claims re-pricing • Claims auditing • Patient advocacy • Patient education • Provider outreach • Navigation/Transparency • Customer reporting		Administrative fee covers most basic services. However, the provider navigation app is offered as a buy-up.
Other services covered under vendor's administrative fee	Ungraded		• Gap fill claim pricing • Plan modeling and analytics • Escalated balance bill support • Plan appointed claim evaluator • Fiduciary support

Acceptance of full ERISA responsibility	ERISA co-fiduciary liability means added protection for purchasers/plan sponsors but the implications for patients who are balance billed are complex. CPR discusses the benefits and limitations of ERISA co-fiduciary protections in our State of the Marketplace Report. For the purpose of the scorecard, the vendor's inclusion of ERISA co-fiduciary responsibility as part of their administrative fee is provided for informational purposes only.[1]		Accepts limited co-fiduciary responsibility through a third party.

Section 2 - Provider Contracting and Rates			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Network configurations available	• Vendor should allow RBP solution to be combined with a PPO. • Vendor should offer multiple customizable configurations of an RBP solution (physician only, hospital only, OON only, etc.)		Offers multiple network configurations, with market-specific options available: 1. Physician only PPO, RBP for all facilities 2. RBP for out-of-network only 3. RBP claim repricing only (advocacy & balance bill support from other vendors) 4. RBP for selected locations 5. RBP direct contracts with selected facilities and providers 6. PPO arrangements with RBP for specialty services only such as dialysis, transplants, oncology, or single case agreements
Pricing strategy & percent of Medicare rates	Ungraded		Allows customers the flexibility to set rates relative to Medicare anchor pricing. Offers the following recommendations: • Inpatient: 140-160% of Medicare • Outpatient: 140-160% of Medicare • Physician: 120-140% of Medicare • Ancillary: 140-160% of Medicare

[1] CPR recommends purchasers consult legal counsel to determine the optimal strategy for their individual circumstances

Criteria vendor uses to select providers for direct contracts	• Vendor should engage in direct contracts with providers where appropriate, as this provides additional protection for purchasers and plan participants. • Vendor should consider quality, as well as cost and credentialing, in any contract negotiations with providers.		Not applicable. Payer Compass initiates contracts at the discretion of its customers and does not hold the contract itself. Criteria are therefore driven by customer needs.
Inclusion of alternative payment models (APMs)[2] in provider contracts	Although not typically core to an RBP model, vendors should consider value-based payment arrangements, such as bonuses for quality, shared savings, or episode bundles for providers with whom they have formal contracted relationships.		Not applicable. Payer Compass does not hold provider contracts

Section 3 – Patient/Member Support			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Member navigation services & transparency tool – features and modalities	Vendor should offer an app/website as well as telephonic support free of charge. Navigation tool should offer the following information about providers: • Price • Quality • Likelihood of accepting RBP rate Tool should be included in vendor's base fee.		Digital tool is available but not included in the base administrative fee. This tool indicates the likelihood that a provider will accept the rate, but does not provide any information on provider quality.
Member education services	• Vendor should demonstrate commitment and accountability to plan member education • Vendor should demonstrate that it has a plan and strategy for patient education. • Education materials should be multi-media, customizable, and included in fee		Offers customizable, multi-modal plan member education services as part of the base administrative fee.

[2] Per Health Care Payment Learning and Action Network (HCP-LAN) guidelines: https://hcp-lan.org/apm-refresh-white-paper/

Member advocacy; process if member is balance billed	• Vendor should defend the balance bill for the life of the claim • Vendor should provide a dedicated member advocate as a single point of contact for any member who receives a balance bill • Vendor should offer credit repair services in the event that collection agencies are engaged • Service should be included in the vendor's base cost		Provides a dedicated member advocate who proactively communicates, educates and supports any member who receives a balance bill. However, member credit repair services are relatively hands-off.

Section 4 - Client Reporting and Results			
Vendor Attribute	**CPR Specification**	**Vendor Rating**	
Components and methodology of vendor's opportunity analysis for prospective customers	Vendor should offer a prospective customer analysis that is customized based on customer-provided data inputs, such as a claims file, purchaser census data, and current plan design.		Provides a prospective savings analysis that is customized based on customer-provided data inputs.
Cost of care savings methodology used in reporting for existing customers	Cost of care savings should be based on average PPO rates (or customer's previous PPO rates) rather than % of billed charges. All health plans negotiate discounts off of billed charges, so savings from billed charges do not reflect the impact of the RBP program.		Can provide savings relative to PPO rates in addition to savings relative to billed charges.
Quality metrics provided in reporting for existing customers	Customer reporting should include quality outcomes data that uses nationally recognized metrics of prevention, care management, and care outcomes.		Customer reporting does not include clinical quality metrics.
Member experience metrics provided in reporting for existing customers	Vendors should collect member experience data through member surveys, as opposed to via proxy measures such as call response times. This information should be shared with customers in vendor's reporting.		Tracks proxy measures of patient experience (e.g. balance bill outcomes) but does not survey plan members directly.
Average expected savings (%) for customers who use vendor's RBP solution	Ungraded		Cost savings are expected to be 20-30% below typical PPO discounts.

Percent of vendor's total medical spend (allowed charges) that is balance billed to patients	The % of claims that are balance billed is a reflection of the vendor's ability to pre-negotiate with providers (even outside a contract) and steer plan members to providers who are likely to accept RBP. Customers prefer solutions where <3% of claims result in a balance bill.		Balance bill rate of <2%.

***Disclaimer**: This scorecard summarizes vendor's solution and services at a specific point in time and is intended to educate CPR members and other health care purchasers, brokers and consultants. CPR's evaluation is based on vendor's written responses to a Request for Information. This summary is not intended to replace an employer-purchaser's formal Request for Proposal process. For additional information about CPR's reference-based pricing evaluation project, please contact connect@catalyze.org.*

Vendor Statement (no more than 500 words):

Payer Compass restores rationality and transparency to healthcare pricing, to reflect the true cost of care for Self-funded organizations.

Our unique Reference Based Pricing (RBP) solution, Innovate360, results in savings everyone can appreciate — driving down employers' costs for claims reimbursement by more than 25% over traditional networks, lowering out-of-pocket costs for employees and minimizing balance bills to < 2%, while working diligently to quiet the noise for both the plan and the member. The program's Per Employee Per Month (PEPM) structure makes budgeting more predictable and is far less costly than percent-of-savings models.

The core of our solution is next-gen technology — Visium™, a multi-faceted pricing platform — and Innovate360 our exclusive, end-to-end RBP program. Combine those with an emphasis on proactive member support, communication and RBP education, and Payer Compass is enhancing the member experience, while dramatically reducing the cost of healthcare claims for today's employers.

Self-funded employers, Third Party Administrators, Brokers and Stop-Loss Carriers prefer our Innovate360 solution for its multiple advantages:

- A turnkey solution that includes claim pricing, patient advocacy, benchmark analytics and reporting, non-adversarial balance bill strategy and appeals resolution with fiduciary support
- Fixed cost, PEPM subscription model to optimize operational spend and health plan savings
- 99.9% claim pricing accuracy with Process Trail to defend pricing and provider reimbursement
- Proprietary capability to process any claim type with one-of-a-kind Gap-fill technology, which draws real-time comparable claims data from Medicare, Medicaid, Commercial, RBP, VA, TRICARE, Tribal, or Indigent claims records
- Customizable RBP claim pricing and editing logic to set reimbursement levels that suit the specific requirements of each plan
- All claim pricing, member advocacy and analytics are managed in house
- Fully-integrated partnership with the industry's reputable legal experts, The Phia Group
- 98% RBP reimbursement acceptance by providers
- Flexibility to adjust RBP to any plan model including OON, Direct Contracting, Narrow Networks, Single-Case Agreements, and Transplant/Specialty Cases
- Member and provider education efforts and resources

Forward-thinking innovation and leadership is exemplified in our actions. Our latest development includes being one of the only Self-funded solution providers to achieve HITRUST CSF Certification, protecting group and plan member data integrity and privacy at the highest standards. Payer Compass' price transparency solution, CompassConnect, encourages educated healthcare consumerism through an accessible portal with the ability to search for RBP-accepting providers and compare procedure pricing. The platform's latest release includes the addition of quality ratings to also search and compare providers. At the helm of legislative changes in healthcare, we are expanding our solution capabilities to prepare and support the Self-funded community's strategy for addressing the No Surprises Act and Transparency in Coverage Rule.

Payer Compass is optimistic in our newfound relationship with the Catalysts for Payment Reform. Aligning ourselves with CPR, its members, and other members of the Self-funded community will support the change we all seek to bring rationality to the cost of care. Learn more at Payercompass.com.