MARKET-SHAPING ENTERPRISES

New Vendors Want to Rescue Health Care

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FOR PAYMENT REFORM

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It's Time for a Less Costly, More Compassionate Health Plan.

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INTRODUCTION

It's become a universal convention in health care to begin every report, white paper or presentation with a homily on the devastating dysfunction that plagues health care in the United States. Even smidgens of good news gloss over disturbing trends:

- The prevalence of value-based payment contracts has reached an all-time high, *but* costs continue to rise, and the United States ranks last in health care quality compared to other high-income countries;[1,2,3]

- Health care prices rose more slowly than inflation in 2022 *but* that's likely only a temporary respite induced by the multi-year nature of insurer-provider contracts, and prices are poised to spike again in 2023;[4,5]

- The rate of hospital mergers appears to have decelerated *but* that's only because the supply of independent hospitals has become vanishingly small, and the rate of hospital "mega mergers" (under which the smaller of the merging hospitals has an annual revenue >$1B) nearly doubled in 2021.[6]

> "The system conspires against reasonable price control. There is no real transparency into what something is going to cost or what it is going to actually achieve with respect to patient outcomes."
>
> **Brad Kimler**, Chief Commercial Officer, Embold Health

So, while we may have experienced a brief reprieve in cost inflation during the COVID-19 pandemic (when low utilization of elective services dampened cost inflation), experts agree we're poised for another health care cost shockwave in 2023.[7] And, more ominously, there's no give left to absorb it. Already, nearly one-third of households lack enough savings to pay their deductibles under employer-based coverage, 41 percent of American

[1] Health Care Payment Learning and Action Network, "2020 & 2021 Measurement Efforts," https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/
[2] Kurani, N. and Wager, E., "How does the quality of the U.S. health system compare to other countries?" Peterson-KFF Health System Tracker, September 30, 2021. https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/
[3] Wager, E., Ortaliza, J., Rakshit, S., Hughes-Cromwick, P., Amin, K., & Cox, C. (2022). Overall inflation has not yet flowed through to the health sector. Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/brief/overall-inflation-has-not-yet-flowed-through-to-the-health-sector/
[4] Ibid.
[5] Corlette, S. (2022). Party's Over: Health Plan Premiums Poised to Spike in 2023, After Period of Modest Growth. Center on Health Insurance Reforms. https://chirblog.org/party-over-health-plan-premiums-poised-to-spike
[6] Landi, H. (2021). Here are key trends that could impact dealmaking next year, PwC reports. Fierce Healthcare. https://www.fiercehealthcare.com/finance/health-services-m-a-deals-surged-2021-here-are-some-trends-could-impact-deal-making-next
[7] Corlette, S. (2022)

adults are currently in medical debt, and two-thirds of bankruptcies in the U.S. are tied to medical issues.[8,9,10]

> "If you sit out in front of a finance department at a hospital and watch the number of people being put on payment plans because they cannot afford health care."
>
> **Tom Wittick,** Senior Vice President of Growth, Imagine360

Meanwhile, health care remains one of the most profitable sectors of the U.S. economy.[11] The largest insurance companies experienced a windfall in the early days of the pandemic, when precipitous drops in utilization caused the largest health insurance companies to see their profits double in 2020.[12] Surprisingly, however, many hospitals *also* continued to profit during COVID-19. Researchers from Johns Hopkins University found that funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act offset financial losses for the most financially vulnerable hospitals, and generated millions in profit for some of the wealthiest.[13,14]

> "Costs and prices continue to rise because there are no real countervailing forces to reduce the *systemic financial inflammation*. This has created a *chronic business interruption disease* for employer-purchasers that constantly drains dollars, hours, and energy away from core business priorities. All actors in the health care system continue to maximize their financial interests and advantage to the detriment of employer-purchasers and their plan members."
>
> **Neil Quinn**, Chief Strategy Officer, Vitori Health

And thus, we find health care purchasers in a world where health care prices rise unabated, where mega health systems profit while community hospitals starve for funds, and where the entities charged with negotiating on behalf of purchasers appear powerless to

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[8] Young, G., Rae, M., Claxton, G., Wager, E., & Amin, K. (2022). How many people have enough money to afford private insurance cost sharing? Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/brief/many-households-do-not-have-enough-money-to-pay-cost-sharing-in-typical-private-health-plans/

[9] Levey, N., "100 Million People in America Are Saddled With Health Care Debt," *Kaiser Health News,* June 16, 2022. https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/

[10] Konish, L., "This is the real reason most Americans file for bankruptcy," *CNBC,* February 11, 2019. https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html

[11] Gaynor, M. (2021). More Than 20 Years of Consolidation Have Led to a Dysfunctional Health Care Market. ProMarket. https://www.promarket.org/2021/06/02/consolidation-dysfunctional-health-care-market-prices-competition/

[12] Holpuch, A., "US health insurers doubled profits in second quarter amid pandemic," *The Guardian,* August 14, 2020. https://www.theguardian.com/us-news/2020/aug/14/us-health-insurers-coronavirus-pandemic-profit

[13] Van Beusekom, M. "Hospitals stayed financially viable in pandemic—some even did better," *University of Minnesota Center for Infectious Disease Research and Policy (CIDRAP),* May 13, 2022. https://www.cidrap.umn.edu/news-perspective/2022/05/hospitals-stayed-financially-viable-pandemic-some-even-did-better

[14] Cantor J, Qureshi N, Briscombe B, Chapman J, Whaley CM. Association Between COVID-19 Relief Funds and Hospital Characteristics in the US. JAMA Health Forum. 2021;2(10):e213325. doi:10.1001/jamahealthforum.2021.3325. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2785399

countermand market trends. It's five minutes to midnight in health care and purchasers desperately need a hero: one that is strong enough to move markets, brave enough to challenge the status quo, and nimble enough to navigate through the obstacles that perpetually dog traditional health insurance carriers. This kind of "rescued from a burning building" story may sound like hyperbole (it is); but a new cache of vendors has recently entered the health care marketplace, looking to succeed where the traditionalists have fallen short. These vendors adopt disruptive network and benefit design strategies that elevate high-value providers; they hold providers accountable through alternative payment models; they hand purchasers the steering wheel by enabling direct contracting. Some of these vendors are TPAs, but others aren't in the business of paying claims. We call these vendors *Market-Shaping Enterprises (MSEs),* and they are the focus of CPR's most recent product evaluation.

ABOUT THIS REPORT

Catalyst for Payment Reform (CPR) is a national, independent, nonprofit organization with a mission to catalyze employers, public purchasers, and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace. For over a decade, CPR has championed efforts to rebalance health care market power and hold the delivery system accountable for outcomes, patient experience and affordability. It is for this reason that CPR launched its latest product and vendor evaluation, assessing the capabilities of seven vendors who offer at least one market-shaping strategy.

Consistent with our previous product evaluations, and in conjunction with our members, CPR developed a request for information (RFI), and recruited health care vendors to participate and respond. Across these vendors there is a broad and overlapping spectrum of approaches to shaping the market, which, by CPR's definition, include the following:

1. Alternative payment models
2. Reference-based pricing
3. High-performance networks
4. Centers of excellence
5. Direct contracting
6. Value-oriented benefit design (i.e., incentives for utilizing high-value providers and services)

Simultaneously evaluating seven vendors with unique constellations of product offerings and capabilities posed unique challenges; however, CPR fixated on evaluating vendors on *how well* they met specifications that were relevant to their product offerings. In our mixed fruit-bowl of vendors, we strived to avoid judging a banana for not being a pineapple.

> "We don't view ourselves as a disruptor or as someone trying to create friction. We are trying to bring parties together in a rational way where everybody can point to a common data set with respect to how we measure quality and how we impute value within the health care system. It requires all of the different stakeholders to see and understand the measures that are being developed and delivered and then trying to act on them in a useful manner"
>
> **Brad Kimler**, Chief Commercial Officer, Embold Health

This report shares our most salient findings and answers the following questions:

- What are *market-shaping strategies*? How and why can they be effective?
- What factors should purchasers consider in determining whether a market-shaping strategy is a good fit?
- What capabilities and services should *all* market-shaping enterprises offer, regardless of the type of product or strategy?
- How must purchasers prepare for a partnership with an MSE?

THE NEED FOR MARKET-SHAPING ENTERPRISES

Chances are that anyone with the inclination to read this report is already well-aware of the strategies that MSEs pursue. Most are not new – alternative payment models and high-performance networks have been around for over a decade; for example, the Boeing Corporation famously launched its direct contract strategy with Memorial Care in 2016. This raises two important questions:

1. Why should anyone care about these market-shaping strategies if they've been around and the market is still broken?

2. Why are new market entrants, who lack the patient volume to negotiate toe-to-toe with health care heavyweights, in a better position to execute these strategies?

The answer to both of these is the same: despite their heft and scale, large, few traditional health care vendors have been unable to pull off these strategies with widespread success. The problem isn't the approach, it's the execution.

WHY HAVEN'T TRADITIONAL VENDORS SUCCEEDED?

The six market-shaping strategies discussed in this report essentially fall into two approaches: (1) change the economic incentives that govern the health care delivery system, or (2) shift consumer demand toward high-value providers and services. The reason most traditional carriers fall short on both fronts is because their trade is in broad networks and their currency is in discounts.

> "Health care companies are having difficulty containing rising costs because they rely on their provider contracts and discounts, which do not address the actual cost to provide the care. These higher costs are being passed down to employers and their plan members."
>
> **Rod Kastelitz**, Executive VP of Sales, Imagine360

In the late nineties, when Health Maintenance Organizations (HMOs) fell out of fashion, the *preferred provider organization* (PPO) emerged as the standard of employer-sponsored health insurance. PPOs offer the broadest networks of health care providers, including access to most medical professionals and facilities. For decades, health insurance companies competed fiercely to offer the broadest networks with the highest price discounts. But "discounts" beg the question – discounts off of *what*? Thanks to the Hospital Price Transparency Rule, some state laws and other research, we can now see what (some) hospitals charge for major services, and the rates they have negotiated with each payer. But comparing charges (the list price on the chargemaster) to allowed amounts (the amount that the provider has negotiated with each payer) only confirms what we already know: hospital list prices are completely uncorrelated with the cost of care delivery, and even patients who are *uninsured* don't usually pay list prices.[15] If chargemasters are meaningless, then discounts based on it are similarly irrelevant.

> "Too often the firemen are the arsonists. Traditional plans have neither incentives nor external pressure significant enough to bring down health care costs. Entrenched stakeholders aren't going to disintermediate themselves."
>
> **Neil Quinn**, Chief Strategy Officer, Vitori Health

[15] Rader Wallack, et al. "Can We Please Stop Fixating on Hospital Chargemasters?" *National Academy for State Health Policy,* January 17, 2020. https://www.nashp.org/can-we-please-stop-fixating-on-hospital-chargemasters/#:~:text=They%20are%20little%20more%20than,between%20chargemaster%20rates%20and%20costs.

Furthermore, if a carrier must include every provider in its network,[16] it severely hampers the carrier's negotiating leverage. To paraphrase American author and entrepreneur James Altucher, "if you can't walk away from a negotiation, then you aren't negotiating. You're just working out the terms of your servitude." Also, as the self-insured market grows, a greater share of third-party administrators' profit derives from administrative fees, not premiums.[17] This does not mean that insurance companies are *intentionally* complicit in causing health care cost inflation. In the same way that traditional fee-for-service payment creates incentives for volume over value, the economic forces that drive the health insurance market also point in the wrong direction. In words attributed to American engineer and educator W. Edwards Deming, "Every system is perfectly designed to get the results it gets."

But this still doesn't explain why new, nontraditional vendors can find traction with market-shaping strategies. In fact, there seem to be several reasons:

1. They cater to a market of commercial purchasers who are looking for an alternative to a traditional PPO. As long as a carrier is compelled to offer a broad network – an inherent feature of a PPO – it cannot afford to alienate any powerful provider organization through a curated network or benefit design strategy. Nor can it compel providers to accept lower prices or alternative payment models.

2. They don't have baggage. In their efforts to achieve steeper discounts, many carriers have backed themselves into a corner with powerful health systems, accepting anticompetitive contracting clauses that effectively prevent them from excluding or reducing the use of powerful health systems.

3. They are nimbler and more adaptive. The advantage of traditional carriers, i.e., their national scale and high volume of customers, can also be an Achilles' heel. Large, traditional carriers inevitably acquire administrative bulk and tend to be slower to adopt new strategies.

4. Providers seem to like working with them. CPR's research finds that many providers are willing to accept lower prices from smaller vendors just because they aren't traditional carriers and because they represent only a small fraction of the provider's revenue. Another advantage of being small is that a smaller volume of plan members poses less risk to a provider. New market entrants give providers the opportunity to venture into risk-based payment models like prospective bundled payment, without putting a sizable portion of their revenue at risk.

As a result, traditional carriers produce high-performance networks (HPNs) that include low-value providers because they must. Furthermore, a vanishingly small percentage of their APMs include downside risk, and many have stopped administering benefit designs that elevate high-performing providers – or they include providers in the top tier who haven't earned their spot.

[16] Which, frankly, every carrier who offers a Medicaid Advantage plan *must* do.
[17] With respect to their fully-insured lines of business, insurance companies' profits derive largely from the difference between the amount they take in as premium revenue and the amount they pay out in claims. For their self-insured business, however, profits derive solely from the difference between the insurance companies' administrative fee revenue and the cost of processing claims and other administrative tasks. As such, the profitability from self-insured clients does not depend on the prices that the insurance company negotiates.

WHAT DOES IT MEAN TO BE MARKET-SHAPING?

Among the universe of TPAs and other point solution vendors, there are market-takers and market-shapers. Market-takers accept the health care market dynamics as they are and try to squeeze out a few marginal dollars of savings using the same set of tactics that have been deployed for decades. Market-shapers, on the other hand, are poised to upend the status quo with strategies that fundamentally alter the incentives that govern the status quo. This section explores these market-shaping strategies: what they are, how they work, and what qualities or capabilities health care purchasers should seek in potential MSE partners.

"Market-shapers are always great simplifiers. The sweet spot includes transparency-focused payment solutions, net lowest cost Rx pricing technology, direct primary care, and bundled value-based contracting. These and other strategies create a consequential rebalancing of market power towards purchasers, while often removing financial barriers for plan members and patients."

Neil Quinn, Chief Strategy Officer, Vitori Health

ALTERNATIVE PAYMENT MODELS

WHAT ARE ALTERNATIVE PAYMENT MODELS?

Alternative Payment Models (APMs) are methods of paying health care providers that incentivize high-quality and cost-efficient care by holding providers accountable for costs, care outcomes and the patient experience.[18] APMs are designed to transform the incentive structure that drives profitability within the delivery system under traditional fee-for-service. APMs deliver value to health care purchasers and their plan participants by creating incentives for care coordination, population health management and more efficient care delivery. These models also have the potential to transform health care at scale, since they compel providers to engage in practice transformation for all patients – not just those patients whose plan has negotiated APMs.

[18] Berenson, R., et al., "Matching Payment Methods with Benefit Designs to Support Delivery Reforms," *The Urban Institute*, May 2016., https://www.urban.org/research/publication/matching-payment-methods-benefit-designs-support-delivery-reforms

WHAT MAKES FOR AN EFFECTIVE APM?

The jury is out on whether APMs (on their own) live up to the promise of improved quality at a lower cost. But there *is* consensus that two major factors underpin the strength of an APM: the degree to which providers have financial accountability for cost and quality outcomes and the significance and relevance of the quality metrics tied to receiving payment. The Centers for Medicare and Medicaid Innovation (CMMI) found in their evaluation of APM pilots that programs that expose providers to financial penalties as well as financial rewards (aka two-sided risk) are most likely to generate savings.[19] Examples of APMs that can incorporate downside risk include (but are not limited to) total cost of care models for accountable care organizations or ACOs, episode-based bundled payment, and partial and full capitation.

With respect to accountability for quality, APMs that evaluate the effects of care on patient health (aka outcomes measures) are preferable to those that measure compliance with evidence-based guidelines (aka process measures).[20] For example, whereas a process measure would evaluate the percentage of people with hypertension who had their blood pressure taken in the past year, a related *outcome* measure would evaluate the percentage of people with hypertension whose blood pressure is under control. While process measures can often be ascertained through claims data, outcomes measures often require clinical data that can only be extracted from a patient's medical record, and therefore require integration and data sharing between administrators and providers.

REFERENCE-BASED PRICING

WHAT IS REFERENCE-BASED PRICING?

Whereas APMs attempt to improve health care value by increasing quality and efficiency, reference-based pricing (RBP) plans constrain cost inflation by tying provider payment to an external, rationalized benchmark – usually a multiple of Medicare rates. As such, RBP plans reshape the traditional negotiating practices between payers and providers. Instead of negotiating discounts based on a hospital's chargemaster file, RBP plans set rates based on a rationalized benchmark, Medicare or otherwise. In more recent years, many RBP plans have evolved to having more formalized relationships with providers. These plans have established contracts with providers who are willing to accept their rates and offer navigation support to channel patients to them. Even some more traditional plans have incorporated RBP into their payment strategy but exclusively for out-of-network care. A third model is to use the principles of RBP negotiation, but instead of using Medicare as the

[19] Burton, R., & Gerhardt, G. (2021). CMMI's development and implementation of alternative payment models. Medicare Payment Advisory Commission (MedPAC). https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/meeting-materials/cmmi-apms-medpac-jan-2021.pdf

[20] Jevaji, S. "The Q Series: What are the Types of Quality Measures?" *National Committee for Quality Assurance,* January 2016. https://www.ncqa.org/blog/the-q-series-what-are-the-types-of-quality-measures/

benchmark, the payer leverages other, more contextual data, such as a "cost plus" calculation that bases rates on the provider's breakeven point and adds a margin.

> "What our plans reimburse facilities is a fair reimbursement that generates a profit for the hospital based on the cost they have reported to provide their services. We want to pay a fair and reasonable price that works for everyone involved to help control costs."
>
> **Rod Kastelitz**, Executive VP of Sales, Imagine360

WHAT MAKES FOR AN EFFECTIVE RBP STRATEGY?

While RBP plans have the potential to deliver considerable cost of care savings compared to traditional health plans, they are not without risk. CPR wrote extensively on specifications for RBP plans in our 2021 State of the Marketplace Report (Reference-based Pricing: Risks and Rewards of Playing Health Care Hardball).[21] Operating a health plan without provider contracts is akin to walking on a tightrope without a net, and purchasers must obtain assurance that if their plan members receive a balance bill from a provider, the RBP vendor has the educational, advocacy and support structures in place to intercede and prevent patients from paying the balance. Then, there's the question of quality. RBP plans are designed to steer plan members toward providers who will accept their payment rates, but building a network around a "coalition of the willing" without any accountability for care outcomes puts plan members at risk for receiving substandard care. RBP vendors should have robust, multi-channel navigation resources to guide plan members to providers who accept the vendor's rates, *and also* include intuitive metrics on the quality of care to help plan members identify high-*value* care. A third consideration is access. Rather than haggle with patients and RBP vendors over balance bills, some providers conclude that they are better off avoiding patients on RBP plans altogether. In some markets, a dominant health system's decision to refuse RBP patients creates an opportunity for small independent providers to attract more business – but in others, there may be no accessible alternative.

HIGH-PERFORMANCE NETWORKS

WHAT ARE HIGH-PERFORMANCE NETWORKS AND HOW DO THEY SHAPE THE MARKET?

A high-performance network, or HPN, begins with an acknowledgement that cost and quality vary across providers and that these two factors are rarely correlated. An HPN curates a subset of health care providers that vendors select for a combination of their lower prices, higher quality, and more efficient delivery of care.

[21] https://www.catalyze.org/product/reference-based-pricing-report/

Beyond the inherent benefits to plan members and purchasers of receiving care from high-performing providers and facilities, HPNs have the potential to stimulate competition by driving plan members away from over-priced providers of middling quality, thus creating incentives for low value providers to improve their performance and negotiate further on their prices.

HPNs are hardly a new concept; large national carriers have offered plan options that they advertise as having these characteristics for over a decade. However, new market entrants may be in a better position to establish HPNs than their established competitors. This may seem counter-intuitive given that providers typically offer lower prices in return for a higher volume of patients, and large carriers use their significant share of the market for patients to negotiate lower prices. But CPR's research shows that this logic doesn't always hold in provider negotiations:

1. Large health plans must retain amicable relationships with all providers to support their other lines of business (i.e., Medicare and Medicaid) and broad commercial PPOs. They therefore cannot afford to exclude and alienate powerful, high-cost providers.
2. In a similar vein, many national health plans have long-standing, established contracts containing anti-competitive provisions that *prohibit* them from excluding these providers from their networks or placing them in a lower tier.[22]
3. The history of antagonism between carriers and providers creates fertile soil for new market entrants to make in-roads. Many providers are willing to take a haircut on revenue simply because the vendor is not a national or large regional insurance company.[23]

[22] Delbanco, S., Caballero, A., McGarry, J. and Berenson, R., "Do Health Plans Have a Plan to Help Employer-Purchasers Get Better Value?" American Journal of Managed Care, May 13, 2021. https://www.ajmc.com/view/contributor-do-health-plans-have-a-plan-to-help-employer-purchasers-get-better-value-

[23] Delbanco, S. "Why It's Time for You as an Employer to Rethink How You Purchase Health Care," *Inc.,* September 7, 2021. https://www.inc.com/suzanne-delbanco/why-its-time-for-you-as-an-employer-to-re-think-how-you-purchase-health-care.html

WHAT MAKES FOR AN EFFECTIVE HPN STRATEGY?

Two critical factors underpin the integrity of an HPN strategy: how the network is constructed, and how it is maintained.

Network Structure. There are two critical decisions that dictate the structure and impact of an HPN. The first concerns which provider types the HPN will include. Although it is possible to curate networks based on both physicians *and* facilities, it's much more feasible to select a single anchor point (PCPs, specialists or facilities).[24] The second decision concerns inclusion criteria and the mechanism by which vendors evaluate providers. Vendors must consider unit price, total cost of care and quality performance, particularly patient outcomes and patient experience. Vendors should leverage nationally-recognized sources of price and quality data for this type of analysis, and preferably focus on outcomes measures (as opposed to claims-based process measures). If the vendor's network is anchored around physicians, quality metrics should tie to the physician's specialty (including primary care); if the network is anchored around facilities, quality metrics should include measures of hospital safety, such as those curated by The Leapfrog Group. Regardless, vendors should be upfront and transparent about their sources of quality data, their benchmarking methodology and threshold criteria.

Network Management. Provider selection is only the first step of constructing an HPN. Vendors should measure provider performance regularly (preferably at least annually), offer supportive consultation to providers if their performance declines, have protocols in place to remove consistently low-performing providers, and protocols to communicate changes to clients and plan members. Vendors should share performance data and reporting with providers and meet with them regularly to discuss successes and opportunities. If APMs are not already embedded in a vendor's provider contracts, vendors should establish a pathway to APMs, to hold providers financially accountable for quality and efficiency.

CENTERS OF EXCELLENCE

WHAT ARE CENTERS OF EXCELLENCE AND HOW DO THEY SHAPE THE MARKET?

Like HPNs, centers of excellence (CoEs) start with a recognition of variation in provider cost and quality. The key difference lies in specificity. Whereas an HPN will designate an entire hospital as "high-performing" a CoE model offers designation at the procedure level - usually for high-cost, elective procedures. For example, a single hospital may receive a CoE designation for orthopedic surgery, but not heart surgery. Some CoE vendors offer a very narrow network of providers and require purchasers to offer a travel benefit to transport patients to their chosen location – these vendors have calculated that adding the cost of airfare and lodging for a patient and their loved one to the cost of care at the CoE is less expensive than the local market rate. Other vendors broaden the network to ensure plan member access within driving distance. Either way, a CoE strategy stimulates competition within a given region or even across the country by shifting patient volume

[24] McGarry, J. "You Can't Build a Network by Casting a Net," *Catalyst for Payment Reform,* July 29, 2019. https://www.catalyze.org/network-design-high-performance/

toward providers selected for their affordable cost, quality of care, and efficiency. Purchasers typically couple a CoE strategy with benefit design incentives to encourage plan members to use the CoE when appropriate.

WHAT MAKES A COE STRATEGY EFFECTIVE?

Like HPNs, the success of a CoE strategy also depends on how it is constructed and managed. We discuss the design requirements in greater detail in CPR's recent evaluation, *Bundled Payment Options in the 2020 Marketplace*.[25] The following specifications for CoE programs impact how effective the strategy will be in improving value and reshaping incentives:

Network structure and management. Similar to an HPN, a CoE vendor must strategically develop and manage its network of providers, using nationally recognized measures of quality and standards of care. However, the CoE approach must be more nuanced because it is geared toward specific services and/or procedures, whereas an HPN offers designations of providers across the care continuum and for all specialties. It's incumbent upon the CoE vendor to conduct ongoing operational meetings and reviews of quality performance with its selected provider partners.

Upfront evaluation and second opinion paid for separately. Although CoE vendors offer savings by directing plan members to higher-quality, lower-cost providers for elective procedures, they can *also* generate savings by helping plan members avoid high-intensity care, like surgery, altogether. CoE vendors should offer their contracted providers payment for an upfront evaluation that is separate from the payment for a procedure, such that providers continue to earn revenue regardless of whether they perform a high-intensity intervention, like surgery.

Episode-based bundled payment for the remaining episode. A CoE program should couple its network design with episode-based bundled payment, an APM that can combine all of the services after the initial evaluation and second opinion into a single payment amount, therefore placing risk on the provider to deliver care within a pre-determined budget.

DIRECT CONTRACTING

WHAT IS DIRECT CONTRACTING AND HOW DOES IT SHAPE THE MARKET?

Direct contracting refers to arrangements under which a purchaser negotiates directly with a health care provider to procure health care services rather than through an intermediary like a health insurer or other type of third-party administrator. The scale and scope of direct contracts between purchasers and providers can vary drastically. For example, a purchaser

[25] https://www.catalyze.org/product/bundled-payment-options/

might contract directly with a provider to administer annual flu shots to health plan members; a broader arrangement could involve a purchaser-provider agreement for primary care or behavioral health services. Purchasers can contract with providers exclusively for specific expensive or complex procedures (e.g., a center of excellence model) or for most, if not all, services a patient may need (e.g., with a health system as an accountable care organization).

Purchasers establish direct contracts with the intent of making the delivery of health care services more responsive to their needs and those of health plan members. The strategy puts the purchaser in the driver's seat, negotiating prices, payment models and performance expectations and guarantees directly, without an intermediary. If done independently, the strategy requires sophistication and bandwidth on the part of the purchaser. However, in recent years, new vendors have entered the marketplace with a business model designed to facilitate purchaser-provider direct contracts. These vendors continue to place the purchaser in the driver's seat but offer assistance with navigating and steering the car. For example, direct contracting vendors may include services such as:

- Shepherding purchasers through the negotiation process, including the construction of alternative payment models, performance guarantees and care model.
- Providing data and analytics to help purchasers understand their baseline cost and quality of care outcomes (and the provider's).
- Administering/paying claims.

WHAT MAKES DIRECT CONTRACTING EFFECTIVE?

Whether a purchaser elects to contract directly with a provider on its own or with the assistance of a vendor, the following program features are critical for success:

Plan member incentives to seek care from the provider. Providers are more likely to discount their prices if purchasers can guarantee volume. To that end, direct contracting models should include incentives to encourage plan members to seek care from the contracted provider. Coupling the direct contract with a rich benefit design (i.e., low deductible, out-of-pocket maximum, copays, etc.), including low or no plan member contributions can encourage plan members to select the directly-contracted provider. In addition, working with providers to establish a concierge-style experience, including extended hours and easy scheduling, can be another perk that encourages plan enrollment.

Performance measure prioritization and alignment. Both purchasers and providers require transparency to understand how well the strategy is working. However, establishing and monitoring performance on dozens of measures can create more noise than signal. Instead, purchasers and providers should focus on establishing a small, yet diverse set of operational and outcomes measures, ideally aligning the quality measures with nationally recognized indicators of care.

Solve for any plan member pain points upfront. A purchaser doesn't get many (if any) second chances to earn a plan member's trust with a new health care program. Building in

a long runway leading to the launch of the program allows time to identify and mitigate potential issues before they negatively impact the experience of plan members.

A strong partnership between purchaser and provider. Even for carefully planned program implementations, issues will arise. It is important to build in regular meetings between purchaser and provider to check in and work together to resolve the bumps in the road.

BENEFIT DESIGN

On a near annual basis, purchasers tweak deductibles, co-payments, and co-insurance – and plan members have become accustomed to reassessing changing benefits at annual enrollment. Benefit design with incentives for behavior change can be quite effective. Consumers have come to expect that they will have richer coverage if they seek care from an in-network provider versus out-of-network. They consider when to utilize urgent care or the emergency room, knowing they will pay more for the ER. They have a growing familiarity with telehealth and when it makes sense to use it in place of in-person care. In summary, benefit design can shape plan member behavior.

While benefit design is ultimately at the discretion of self-insured purchasers, MSEs can help purchasers align the incentives embedded in their benefits with strategies that re-shape the market while also bringing higher-quality and more cost-effective care to plan members. We profile examples of market-shaping benefit designs below:

Encourage plan members to seek care from high-performing providers. Even within a broad PPO plan, purchasers can incorporate an in-network tier of high-value primary care providers, specialists, and facilities, and create financial incentives (i.e., reduced cost-sharing) for plan members to select them for care. To encourage plan members to enroll in a high-performance plan, purchasers can reduce the deductible, out-of-pocket maximum, and co-payments as compared to what plan members would pay for using a broad PPO plan. Some high-performance plans also prohibit coverage for all out-of-network care except emergency care. In all cases, plan member communications are critical to explain that these providers offer a better combination of cost and quality.

Encourage plan members to use lower-intensity sites of service. Most health plans already include benefit designs that encourage members to use urgent care rather than the emergency room (when appropriate). In a similar vein, purchasers can extend this type of strategy through richer benefits that encourage plan members to seek care from appropriate low-cost sites of service. For example, a purchaser may offer a lower cost-share for freestanding rather than hospital-based imaging centers; or for selecting an ambulatory surgery center instead of a hospital for low-risk, elective procedures.

CONSIDERATIONS FOR PURCHASERS

Not every market-shaping strategy will work for every health care purchaser. Prior to embarking on a market-shaping strategy, purchasers should first ensure that the strategy is a good fit for its plan member population by considering the following:

- Geography: Are plan members located in markets with an adequate supply of providers to support a high-performance network or other benefit design that highlights high-value providers? If not, is the purchaser willing to have their plan members travel for care (and possibly cover the cost of the travel)?

- Administration: Does the vendor's product provide coverage in all markets where purchaser's plan members reside? If not, is the vendor willing to administer a traditional PPO for plan members outside of the reach of the HPN?

- Plan member communication and education: Purchasers need to work with vendor partners to ensure that plan members understand how to use and navigate the vendor's product. Absent such education, plan members may unknowingly seek care from providers that lead to out-of-network claims and/or higher out-of-pocket costs,

- Tolerance for complexity: Any strategy that disrupts the traditional incentives in health care can feel…disruptive. The purchaser will want to assess its administrative capacity and what resources it can devote to implementing an MSE into its existing portfolio of health care programs. Some approaches require more elbow grease than others; the purchaser should be realistic about how much time and resources it is willing to devote.

SPECIFICATIONS FOR All MARKET-SHAPING ENTERPRISES

While specifications can vary with each of the high-value strategies we have outlined, some capabilities are table-stakes for every TPA and point solution vendor (and health plans for that matter). Those listed here represent only a fraction of the capabilities and assurances that purchasers will want to confirm in a vendor partner; we focus on this subset because each capability either:

A) Provides infrastructure for any and all market-shaping strategies, or
B) Describes a high-value approach to health care for which all vendors should be accountable.

We discuss these two categories and the capabilities within below.

INFRASTRUCTURE FOR MARKET-SHAPING STRATEGIES

TRANSPARENCY AND NAVIGATION

A cross-cutting requirement common to all market-shaping strategies is to designate high-value providers and services and help plan members identify and access them. To this end, MSEs must make accurate, comprehensive and *comprehensible* information available to plan members *and* to referring clinicians and provide multi-channel support to help plan members find a match with the care they need.

When plan members seek care, the following should be readily available and easily accessible:

- The vendor's assessment of the provider's quality, which should be:
  - Relevant for the provider's service (e.g., maternity measures for ob-gyns, safety measures for hospitals, prevention and care management measures for primary care providers)
  - Based on nationally recognized standards of care
  - Based on care outcomes, rather than care processes
  - Available for all provider types and sites of service (where applicable)

- The vendor's estimate of cost of care, including:
  - Contracted price of provider's services for professional and facility fees
  - Plan member's expected out-of-pocket cost, based on member-specific benefit information such as co-payment, co-insurance and remaining deductible

It's not enough to make information available: anyone who pays close attention to health care can attest to the complexity of navigating through provider data on cost and quality, and even the best-designed website or app may be inaccessible or infeasible for most plan participants to utilize. As such, vendors should provide navigation support that is multi-modal, enabling plan members to reach a human being who is trained to help them interpret and assist with decision-making. Finally, it's critical that referring clinicians *as well as plan members* can access the vendor's navigation services and data. After all, approximately 75 percent of new specialist visits stem from PCP referrals, not self-referrals.[26]

REPORTING RESULTS

No matter *what* a vendor promises, they must back up their claims with reports that are accurate, timely, purchaser-specific. Most TPAs can report medical trend, utilization, and even plan member risk factors and high-cost claimants. But for MSEs the bar is higher; they should be able to demonstrate *how* their product and services influence provider and plan member behavior through measures such as:

- Cost of care and cost trend compared to regional and national benchmarks and/or the purchaser's previous carrier experience.
- Percent of plan members utilizing high-performing providers and lower-cost sites of service.
- Percent of plan members utilizing navigation tools or support to shop for care.
- Nationally recognized indicators of the quality of care, including year over year performance.
- Measures of patient experience obtained by surveying plan members directly.

These reports should be made available to purchasers at least quarterly and preferably on demand.

MSEs should also have capabilities to model outcomes for prospective customers, using the purchaser's claims history to project cost of care savings, access, disruption and administrative costs. Above all, MSEs should be fully transparent about the inputs and methodology that inform their savings projections and be willing to offer performance guarantees.

"Hospitals are increasingly more worried about how to manage their value-based contracts. They will be the first to tell us, *we know how we perform at the aggregate level, but we have no idea who contributes to a loss or a surplus on our staff, but you can tell us that*."

Brad Kimler, Chief Commercial Officer, Embold Health

[26] Aliu, O. et al, "Specialist Participation in Healthcare Delivery Transformation: Influence of Patient Self-Referral," *American Journal of Managed Care,* January 14, 2014. https://www.ajmc.com/view/specialist-participation-in-healthcare-delivery-transformation-influence-of-patient-self-referral

TOOLS TO HELP PROVIDERS SUSTAIN PERFORMANCE

Winnowing the universe of providers using the tools of network and benefit design is one approach to shaping the health care market; a complementary and equally important strategy is to collaborate with and assist providers in delivering high-value care. An MSE can do this by supplying providers with the data and analytics they need to make high-value referrals, manage population health, and improve their performance; at a minimum, MSEs should make their data easily accessible to providers through tools that integrate with the provider's electronic health record (EHR) system.

INTEGRATION WITH OTHER POINT SOLUTIONS

As purchasers consider and rationalize a portfolio of vendors offering point solutions, they should assess the ability of these vendors to share and integrate health care data. Anecdotal evidence from CPR members and their consultant partners suggests purchasers face increasing frustration trying to manage multiple vendors who cannot communicate or coordinate with each other.[27] MSEs should be able and willing to integrate their own data into purchasers' existing applications and work with purchasers' existing portfolio of solutions to ensure a seamless experience for plan members, providers, and HR benefits teams.

STRATEGIES TO ADDRESS SPECIALTY AREAS

MATERNITY

Comprehensive maternity benefits have long been a central part of many purchasers' health care programs. However, not all maternity care providers deliver the high-quality care purchasers and plan members expect. One aspect of maternity care that needs focus is Nulliparous, Term, Singleton, Vertex (NTSV) cesarean sections. Medically unnecessary cesarean sections are associated with higher risks to mother and baby[28] and are also significantly more expensive; on average cesarean sections cost over $9,000 more than a vaginal birth.[29] As such vendors with high-value maternity care strategies should have initiatives to reduce the rate of NTSV cesarean sections, such as creating new incentives through APMs, including non-traditional clinicians in-network, encouraging lower cost sites of care, and discouraging use of low-performing providers or facilities.

BEHAVIORAL HEALTH

While behavioral health care has long been a focus for purchasers, the COVID-19 pandemic has brought this area further under the spotlight. While the stigma surrounding mental health has begun to diminish, barriers to care related to stigma, access and cost still exist.

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[27] Cawley, M. and Carlson, E. "Surviving Point Solution Overload," *Mercer Consulting,* April, 2022. https://www.mercer.us/our-thinking/healthcare/surviving-point-solution-overload.html

[28] Ben-Joseph, E. "Can I Request to Have a C-Section?," *Nemours Children's Health,* January, 2021. https://kidshealth.org/en/parents/cesarean.html

[29] Hurst, A. "The Cost of a C-Section Is More Than $9,000 Greater on Average Than a Vaginal Delivery," *ValuePenguin,* May, 2021. https://www.valuepenguin.com/cost-of-vaginal-births-vs-c-sections

MSEs with strong behavioral health strategies for purchasers should have initiatives in place that improve behavioral health care access, cost, and quality. This can include offering virtual visits, implementing APMs, integrating behavioral health with primary care, and measuring the quality of behavioral health care, among others.

HEALTH EQUITY

The COVID-19 pandemic brought to light what many Americans already knew through their own experience: pronounced disparities in health care quality, outcomes and experience persist among racial, ethnic and other groups who have historically experienced discrimination. Now more than ever, purchasers are paying closer attention to health inequity among their covered populations. Studies have revealed large health disparities across chronic conditions, maternal health, substance use disorders, and behavioral health among enrollees with employer-sponsored coverage; some of the most significant differences are associated with race.[30]

MSEs have an important and irrefutable role to play in helping to reduce care disparities and promoting health equity. These can include but are not limited to supporting independent community practices, thoughtful network design, robust care navigation tools and support, and APMs that reward providers for improving health equity and addressing social determinants of health.

CARE DELIVERY REFORM

Efficient and high-quality care – ensuring employees get the right care at the right time at the right place with the right provider – is key to any high-value health care strategy. One major focus in the reform of health care delivery is the need to reduce inappropriate care, which is both harmful to patients and costly to purchasers and plan members. Vendors looking to help purchasers implement care delivery reforms should offer strategies to reduce inappropriate care. Examples include, but are not limited to, second opinion services, benefit design incentives to seek appropriate care, navigation support, and APMs that hold providers accountable for efficiency.

[30] Pearson, C., Rein, D., Mancino, M., Brault, M., Clausen, M. "Health Disparities in Employer-Sponsored Insurance," *NORC at the University of Chicago*, July 2022. https://www.jpmorganchase.com/content/dam/jpmc/jpmorgan-chase-and-co/who-we-are/our-business/documents/jpmc-morgan-health-norc-report-ada.pdf

HEALTH CARE PURCHASERS ARE *ALSO* MSEs

Catalyst for Payment Reform is founded on the belief that if employers and other health care purchasers can send consistent signals to insurance carriers and the delivery system, they can catalyze the evolution and reformation of health care toward greater affordability, quality, access and equity. Since our inception, we have recognized that health care purchasers have the potential to become market-shaping enterprises. But one thing is clear: health care purchasers cannot reshape the market by selecting the broadest PPO with the steepest discounts and the shiniest new digital app.

"There is this assumption that you have to go with one of the big-name brand entities to control cost. Our challenge is to educate employers, brokers, and consultants and let them know there are options in the marketplace that are innovative, outside the box and control costs. These solutions can sometimes be labeled as "disruptive" -- disruptive meaning different than what people are used to and challenging the status quo."

Rod Kastelitz, Executive VP of Sales, Imagine360

And to be clear, partnering with an MSE alongside or instead of a traditional health plan introduces new layers of complexity in what is already a highly complicated and convoluted arena, which, chances are, has little to do with most purchasers' primary business or product offering. This is particularly true for large employers spread across multiple geographies, who may find themselves compelled to manage and administer multiple health plans, networks, products and communications strategies. It's no walk in the park.

"We want to find places in employers' strategies or environments that are right for steering people toward higher value physicians and where our data can be plugged in and used toward any strategy that helps improve the quality and affordability of health care."

Brad Kimler, Chief Commercial Officer, Embold Health

As Einstein famously said, *the definition of insanity is doing the same thing over and over and expecting different results.* If purchasers want different (i.e., better) results from their health plan, they won't achieve their goals by passively accepting the status quo. Equally important: market-shaping strategies, whether administered by the purchaser itself or through an MSE partner, don't just improve value for individual purchasers and their plan members. As the use of these strategies gains traction, purchasers aren't just rescuing themselves, they are making the healthcare marketplace more responsive to those who use and pay for health care.

> "Employer-purchasers need to let go of their "devil you know" mindset and stop buying into the narrative that their employees can't handle change. Although there may be risks, they are far smaller than the risk of comfortable inaction, which has enabled a vast transfer of wealth from working Americans to the medical industrial complex."
>
> **Neil Quinn**, Chief Strategy Officer, Vitori Health

HOW PURCHASERS CAN ANSWER THIS CALL TO ACTION

For purchasers seeking more information on MSE vendors and their attributes, CPR offers the following resources:

MSE EVALUATION TOOLKIT

Purchasers who want to initiate their own exploration of MSE vendors can download CPR's RBP Evaluation Toolkit at no cost; health plans, vendors, providers and others can also access this resource for a nominal fee. The toolkit includes the MSE request for information (RFI) template, which comprises evaluation questions and specifications.

MSE VENDOR SUMMARY AND DETAILED SCORECARDS

CPR evaluated 7 vendors to produce detailed and summary scorecards that provide insights into each vendor's performance against specified attributes. The vendors we evaluated include:

- Aspire Integrated Healthcare Solutions
- Centivo
- Embold Health*
- Health2Business (H2B)
- Imagine360*
- Nomi Health*
- Vitori Health*

DETAILED SCORECARDS

Include ratings for all questions in the RFI and are available to CPR members for free. All other purchasers who want access to CPR's detailed scorecards can contact Ryan Olmstead (rolmstead@catalyze.org) to discuss membership.

SUMMARY SCORECARDS

Include ratings for a subset of the most salient and differentiating RFI questions. The set of summary scorecards is available to CPR members for free and is available for sale to all other health care purchasers and verified brokers and consultants.

**These vendors acted as contributors to our research and contributed financially to support this project. Vendors' financial contributions were voluntary and did not impact CPR's evaluation of their products and services; we evaluated any vendor that agreed to participate even if they did not provide financial support. Contributors gain the added benefit of receiving detailed evaluation results, the option of being interviewed by CPR for the public report and being featured in an email to CPR's followers. Again, no vendor had any control or influence over CPR's evaluations.*