

Models of Value-Based Reimbursement

A Valence Health Primer

Today’s hospitals and other healthcare providers who deliver traditional, fee-for-service medicine are in the midst of navigating significant changes in the way they conduct business and care for their patients.

Competition among providers and increasing pressure from public and commercial payers to lower costs and improve care are driving them away from long-standing volume-based healthcare models, and toward so-called “value-based care” models. These models seek to more fully align payment and objective measures of clinical quality.

Indeed, the only questions most of today’s providers will face in the not-too-distant future—if not already—are not *if* they’ll be joining the value-based healthcare movement, but *when* and, beyond that, which particular care and risk model to join.

The various models, several of which will be presented herein, fall along a continuum, with the resources and level of clinical and financial integration needed for a given provider to succeed steadily rising, along with a concurrent rise in risk and rewards for each type.

Indeed, the payment models cannot be separated from changes in care delivery; thus, they require increasingly tight hospital-physician alignment, which can be achieved through physician employment, entering into service line co-management arrangements, clinical integration, or other methods.¹

Historically, one payment model has dominated the healthcare provider payment landscape: fee-for-service (FFS). Generally speaking, FFS describes the arrangement under which a healthcare provider renders a treatment or test to a patient in return for payment, either from the patient directly, from a third party, such as an insurance company, or some combination thereof.

It is widely acknowledged, however, that the FFS model rewards volume and intensity of service. Essentially, the more admissions, testing, procedures, and treatments a provider or hospital delivers, the more money that provider stands to earn. Indeed, the FFS model is widely seen as an underlying driver for the skyrocketing cost of healthcare over the past 30 years.

Attempts began in the 1980s and 1990s to reign in these rising costs through the concept of managed healthcare organizations. But the concept fell out of favor with the public and legislators, owing largely to its payor-centric implementation and emphasis on limiting utilization of healthcare services, particularly specialty services.

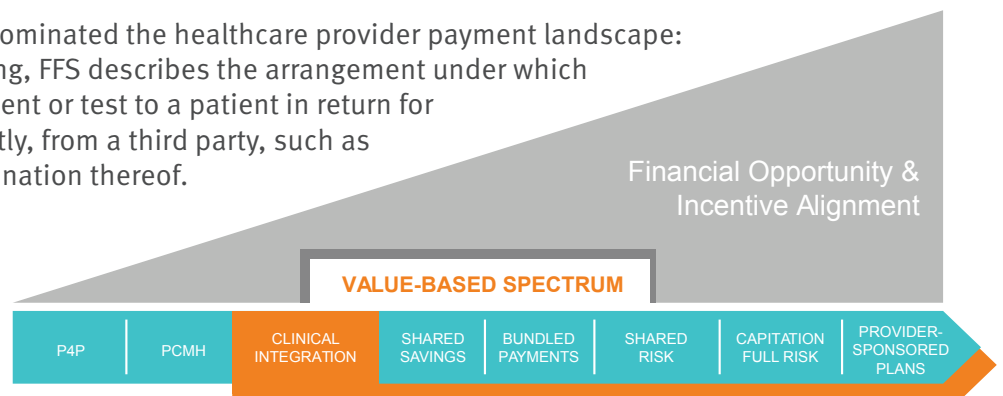


Figure 1: Value-Based Spectrum

Pay for Performance (P4P)

In the early 2000's, the concept of "pay for performance" (P4P) emerged as a more popular tactic for aligning provider payment with value. Under the typical P4P model, financial incentives or disincentives are tied to measured performance; they may also involve performance thresholds, improvement thresholds, or relative performance cut-offs. The provider organization receives performance-based adjustments to its FFS rates, usually bonuses for exceeding standards in a particular metric, and occasionally clawbacks for falling short.

For example, a P4P immunization program could be set up where the goal for a given pediatric practice is to immunize 80 percent of its patients by age 2, in accordance with the nationally accepted immunization guidelines. A provider that exceeds that goal and immunizes 90 percent of its patients would receive bonuses in addition to the standard FFS reimbursement rate from the payer.

The P4P model requires less integration and information technology (IT) infrastructure than do other more advanced models, making this model popular among smaller, or newer provider organizations. However, in most cases, the model requires the abilities to establish clinical quality benchmarks, as well as to collect, measure, and report results. P4P models are a fundamental stepping stone to more advanced forms of value-based care.

The P4P model is not perfect. Often the incentives are too small to change physician behavior, or the patient population being affected is too small to institutionalize change. It also remains essentially a FFS model with respect to "rewards," with providers receiving higher payments in return for rendering more service.

Bundled Payment/Episode of Care

As its name suggests, the bundled payment/episode of care model provides a single negotiated payment for all services for a specified procedure or condition, such as pregnancy and birth, knee and hip replacement surgery, and certain cardiac procedures. The model bases provider payment amounts on the costs of adhering to clinical standards of care, risk stratification, and complication allowances. It also incentivizes provider performance based on a comprehensive score card.²

Under an episode-of-care payment system, providers automatically benefit from any savings they generate by improving efficiency within episodes. Under a comprehensive-care payment system, providers can also benefit from the savings they achieve by preventing unnecessary episodes of care. The payer, meanwhile, saves money by paying a provider less money per episode or per patient than it has in the past. Moreover, the payer knows up front how much it will be spending, rather than having to wait to see whether any savings will be achieved.³

Under a Centers for Medicaid and Medicare Services (CMS) bundled payment model being piloted at a handful of hospitals, a single discounted payment is provided to the hospitals and physicians for an episode-of-care, such as a surgical or medical diagnosis-related group (DRG). In turn, the hospitals may pay physicians up to 125 percent of Medicare FFS rates and share up to 50 percent of savings with Medicare beneficiaries.⁴ For the CMS pilot, hospitals must be accepted into the program, have the ability to demonstrate superior quality, and successfully align with physicians to lower costs and improve efficiency.

One financial downside for providers associated with this model, of course, is having to cover the costs of services for such procedures or conditions that exceed the agreed-upon reimbursement amount. Another drawback is that providers are ultimately forced to treat more episodes to increase their income; in some respects, this makes episodic-based payment arrangements yet another form of FFS. Some providers are already working with private insurers to develop bundled payment programs for specific service lines. The PROMETHEUS program, for example,

issues episode-based payments for heart attacks, hip and knee replacements, diabetes, congestive heart failure, and hypertension.

Patient Centered Medical Home (PCMH)

As a primary care-driven initiative, the medical home focuses on building a team of professionals—the physician, RN case manager, medical assistant, and in some cases, pharmacists—who are responsible for coordinating their patients’ care across the healthcare continuum. The intent is to provide higher quality and better care coordination, especially for those with chronic conditions, and prevent hospital readmissions and emergency department visits. Highly functioning medical homes use electronic medical records, disease registries, and central data repositories to facilitate care coordination activities, and require physicians to follow a limited set of evidence-based care guidelines.⁵ To cover the costs of infrastructure and staff for care coordination, providers can often negotiate a FFS rate increase or a per-member-per-month (PMPM) payment on top of standard FFS payments.

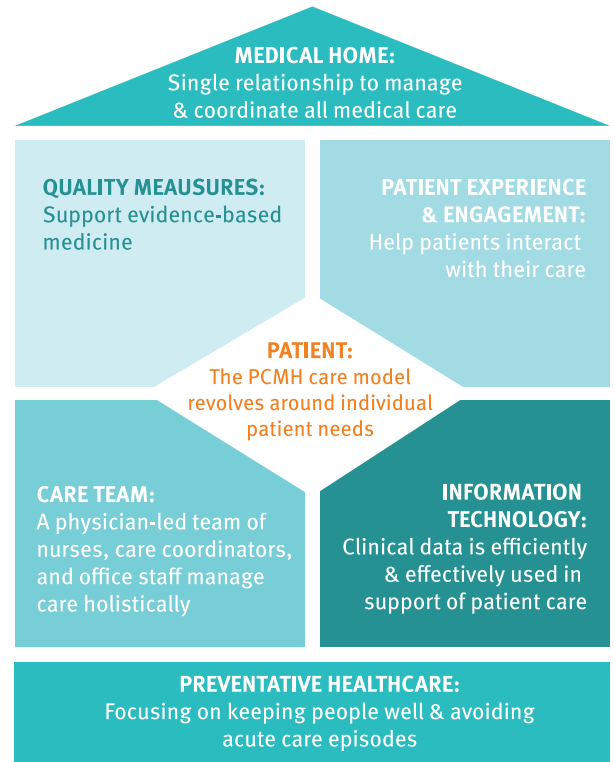


Figure 2: Patient Centered Medical Home

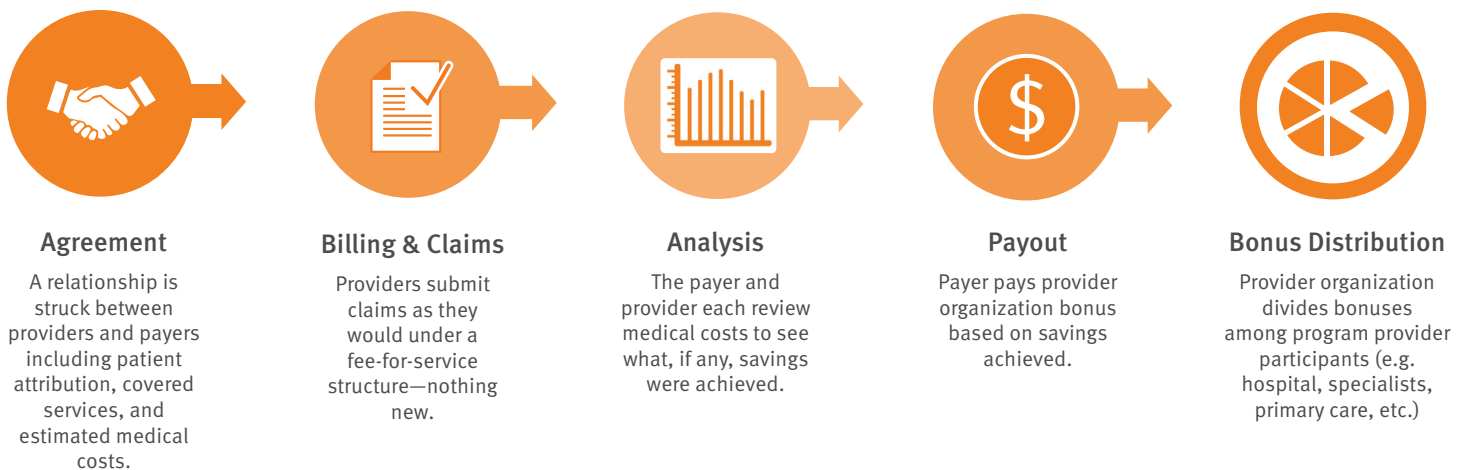
Shared Savings (One-Sided Risk)

Shared-savings arrangements represent a potentially higher level of reward for providers. While PMPM payments and FFS rate increases generally cover only the added infrastructure and staff resources, shared-savings can be an enticing incentive because providers offering patient-centered medical homes are often challenged to maintain previous productivity levels.⁶

Often combined with fee-for-service, P4P, bundled payments, global payments, or capitation, shared savings programs reward providers that reduce total healthcare spending on their patients below an expected level set by the payer. The provider is then entitled to a share of the savings. The idea is that the payer spends less on a patient’s treatment than it would have otherwise spent, and the provider gets more revenue than it otherwise would have expected.⁷

Typical Shared Savings Payment Cycle

Figure 3: Shared Savings Payment Cycle



Medicare is employing the “shared savings” concept as a key element of its Physician Group Practice Demonstration and in its Accountable Care Organization model. Large, integrated groups earn bonuses for demonstrating slower spending growth for patient care relative to their peers. Any savings above 2 percentage points are shared with CMS, with up to 80% for the physician group. In addition, the program further incentivizes quality. The higher the quality of the provider’s performance, the higher its share of savings.

Shared savings programs, however, do suffer from several significant shortcomings. For one, they may not pay for primary care services such as nurse care managers for chronic disease patients, and phone and email consults with other physicians. In many cases they also require upfront spending by the provider to implement the processes or technologies necessary to achieve success. While revenue may increase from such programs, it could be months or years in the future before performance improvement has been assessed.

Also, providers with the highest rates of hospital admissions, highest use of unnecessary procedures, and other wastes of resources benefit most under the shared-savings model. In contrast, the best performers—those with relatively low costs and high quality of care—are already “saving” Medicare and other payers significant amounts of money, but receiving no reward for doing so. Through the shared-savings model, the first group can improve relatively easily, thus becoming eligible for a large reward, while the second may need to invest significantly more resources to obtain the rewards.

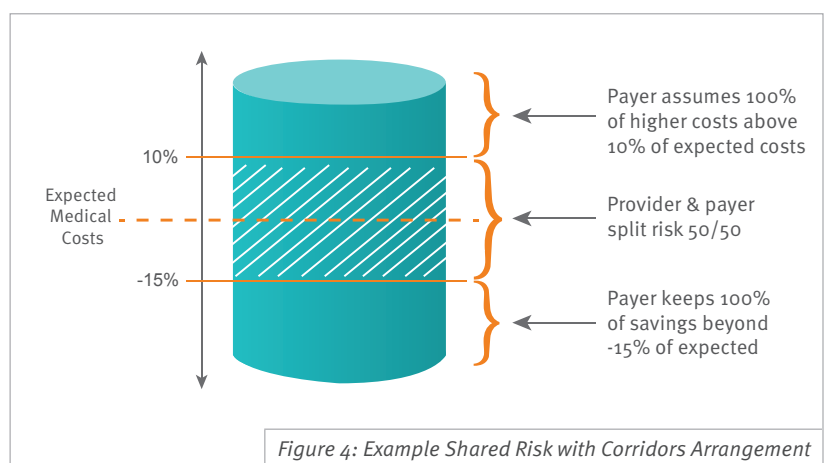
Finally, shared savings programs ultimately may prove unsustainable. Even if costs remain lower than they would otherwise have been expected to remain, critics say, payers will find it difficult to continue making shared savings payments indefinitely based on savings achieved in the past, particularly as the providers and their patients change over time. This may deter providers from making large investments in care improvements that would need to be paid off over a multi-year period.

Shared Risk

Shared risk models could be described as the “next-level” of risk arrangements, under which providers receive performance-based incentives to share cost savings combined with disincentives to share the excess costs of healthcare delivery. This model is based on an agreed upon budget with a payer, and calls for the provider to cover a portion of costs if savings targets are not achieved; this portion could be a percentage of the premium (e.g., 30% of the overall premium flows to provider) or a set amount (e.g., 50/50 sharing of excess costs). As expected, there is a relationship between risk and reward. Because under this model providers take on more risk, essentially upside and downside, most often the opportunity for upside financial gain is larger.

However, this model requires that payers are willing to structure a shared risk program that meets the needs and capabilities of the provider organization.

If the payer is interested in passing along more risk to the provider than that organization is willing to accept, the provider organization can look to third parties to offer what is referred to as stop-loss insurance. In such arrangements, the provider organization pays a fixed fee for that third party insurer to accept all the financial risk beyond a certain level. Another way that providers can limit their risk in this or any other value-based model short of a provider-sponsored plan is to carve out certain patients or conditions. In this fashion, providers can accept risk for only those patients or conditions where they

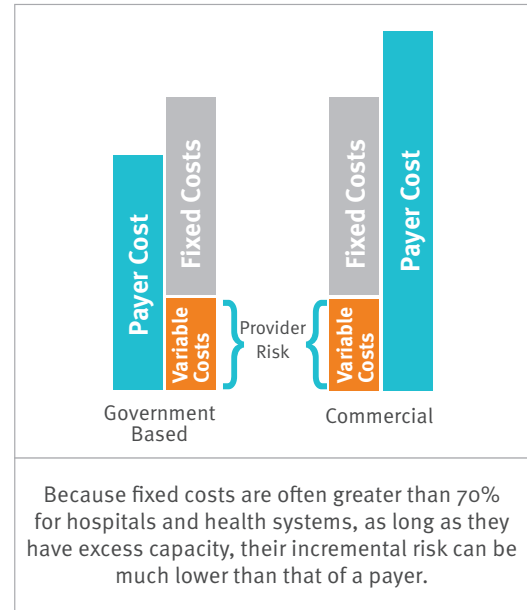


feel they have the ability to control risks and influence outcomes. An alternate method of limiting risk is including risk corridor arrangements. Corridors protect from high losses, but also obstruct opportunities for gains. All of these risk limiting strategies increase the likelihood that the payer and the provider organization can reach an agreement.

Full Risk: Capitation Models

Under a capitated payment model, a provider organization, or group of organizations, receive from the payer a set payment per patient for specified medical services. In this way, the provider takes on 100% of the insurance risk for the covered patient and services. These payments are usually in the form of a monthly per-patient-fee. These fees are determined by actuarial analysis of historic costs of the patient population to be covered by the capitated model. These fees are adjusted to reflect the “acuity” or “level of risk” associated with the patient population. Then the provider organization or group of organizations must determine how to divide up the single capitated payment. More often than not, this fund disbursement is done using a combination of incentives and fee-for-service agreements.

Figure 5: Payer Risk vs Provider Risk



There are two basic capitation models - “Global” or “Full Capitation” and “Partial” or “Blended Capitation”.

- **Global Capitation** describes an arrangement where a provider organization, or group of organizations, come together to receive a single fixed payment for the entirety of healthcare services a patient (or “member” in the eyes of the payer) could receive. This includes primary care, hospitalizations, specialist care and ancillary services.
- **Partial Capitation** is where the single monthly fee that is paid to the provider only covers a defined set of healthcare services. Services not covered are usually still paid for on a fee-for-service basis. For example, it is not uncommon to see a partial capitation model that only includes physician services (primary care and specialty) and laboratory services, but excludes hospital-based care, pharmacy, and mental health benefits.

Regardless of whether the capitation is global or partial, the provider is at full risk for the services that are covered. This means that providers reap the rewards of providing care at a cost below the capitated rate, but also bear the risk if the cost of care exceeds the capitated amounts. As with other forms of risk, providers can employ stop-loss insurance to limit the upper end of their exposure.

Provider-Sponsored Health Plans (PSHPs)

Provider-sponsored health plans (PSHPs) represent the most comprehensive of value-based healthcare models. In this model, a provider network—most often led by a hospital system—assumes 100 percent of the financial risk for insuring that patient population. Because the PSHPs collect the actual insurance premium directly from employers or individuals, PSHPs represent the furthest upstream that a provider can get in terms of financial control. Providers are in the driver’s seat with respect to how care is delivered to patients and how much is spent on delivering that care.

PSHPs offer several advantages to providers:

- **Control** – Because providers are in control of both the insurance and the care side, they are in more complete control over benefit plan design, which, in turn, often determines the care that is delivered.
- **Care coordination** – With integrated systems, PSHPs can support the delivery of more coordinated care across the entire spectrum.
- **Quality** – Research by the Commonwealth Fund and statistics released by Centers for Medicaid and Medicare Services indicate that provider-sponsored plans are higher quality and lower cost than traditional payers.
- **Alternative revenue streams** – The plan, which contracts with more than just the provider organization’s own providers, has the opportunity to be a significant generator of revenue that is less sensitive to the vicissitudes of care delivery revenues. In many cases, such as Driscoll Children’s Health Plan and Texas Children’s Health Plan, the PSHP generates more in revenue than the delivery organization.

Building and implementing these arrangements requires the organization to obtain an insurance license and obtain approval as a healthplan for each state in which they operate commercial, Medicare Advantage or Medicaid plans. Providing a healthplan means providers need to assume new responsibilities – claims payment, customer service, insurance reporting, and other administrative operations. Provider organizations can develop these capabilities in one of four ways:



- **Build** – Working from the ground up, providers can develop these capabilities internally, hiring personnel and installing the necessary technologies.
- **Buy** – The provider organization can acquire the assets and personnel of an existing health plan.
- **Partner** – The provider organization can partner with an existing plan, leveraging their technology, people, and infrastructure.
- **Outsource** – In this model, providers work with a vendor in an outsourced relationship to provide the necessary capabilities under the provider organization’s brand and guidance.

Table 1: Pros & Cons of Acquiring Payer-Like Capabilities

MODEL	PROS	CONS
Build	<ul style="list-style-type: none"> • Control • Specificity of design 	<ul style="list-style-type: none"> • \$10-20 million in start-up costs, PLUS risk-based capital • Execution risk due to lack of experience
Buy	<ul style="list-style-type: none"> • Immediate capability • Experienced operators 	<ul style="list-style-type: none"> • Scarce supply of assets to buy • Very expensive costs between \$500–\$1000 per covered life
Partner	<ul style="list-style-type: none"> • Immediate capability • Experienced operators 	<ul style="list-style-type: none"> • Scarce supply of partners • Possible misalignment of incentives • Lack of control
Outsource	<ul style="list-style-type: none"> • Immediate capability • Experienced operators • Can custom design relationship 	<ul style="list-style-type: none"> • Few experienced vendors • Requires relationship management

And while the idea of taking on such responsibilities may seem overwhelming, the rewards can far outweigh the risks. The advantages of PSHPs include increased market penetration, more effective population health management, and greatly increased financial rewards for participating providers.

Table 2: Profit Margins of Provider-Sponsored Plans

Plan	State	2008	2009	2010	2011	2012	Average
Geisinger Health Plan	PA	5.5%	5.1%	4.2%	5.1%	5.0%	5.0%
Health First Health Plans	FL	4.3%	1.9%	2.2%	2.9%	0.2%	2.3%
Providence Health Plans	OR	-0.2%	3.0%	5.6%	6.7%	4.7%	3.9%
Gundersen Lutheran	WI	1.1%	0.5%	0.9%	0.7%	0.6%	0.8%
Dean Health Plan	WI	0.8%	0.9%	0.9%	-0.2%	-0.1%	0.5%
 Driscoll Children’s Plan	TX	12.4%	-0.2%	6.8%	2.5%	7.6%	5.8%
Health Plan of CareOregon	OR	15.2%	5.3%	2.9%	6.7%	3.7%	6.8%
 Texas Children’s Health Plan	TX	2.8%	1.9%	7.0%	8.6%	2.5%	4.5%

 Valence Client

Source: 5-year financial performance summaries from 2012 that are submitted to and available from the NAIC.

Conclusion

Hospitals and other healthcare providers today are in the midst of navigating significant changes in how they conduct business and deliver care. Indeed, industry dynamics are such that healthcare payment reform will happen no matter how “Obamacare” ultimately plays out in the political arena. Each organization needs to determine the answer to the following key questions in order to determine the best type of value-based care for their organization:

- What is my organization’s capacity to change?
- What financial limitations are in place?
- How will the organizational mission be impacted?
- How will internal and external stakeholders react?

By exploring the answers to these questions, each organization can take advantage of the “right” value-based model for them.

About Valence Health

Valence Health provides healthcare organization solutions for value-based care, helping them better manage their patient populations and accept financial responsibility for the quality of the care they provide. With unique data collection and analysis solutions, Valence Health has emerged as a leader in population management and clinical integration, serving dozens of clients from physician groups to standalone hospitals to large IDNs such as Cleveland Clinic. In-depth actuarial analysis combined with operational excellence allows Valence to not only advise but also provide ongoing services to provider organizations operating under various value-based reimbursement models. From risk-based contracting to accountable care organizations (ACOs) to administering provider-sponsored health plans, Valence has been helping providers appropriately accept and manage financial responsibility while improving clinical quality since 1996. Headquartered in Chicago, with three other office locations, Valence Health serves more than 30,000 physicians and 100 hospitals, helping them manage the health of over 15 million patients nationwide. For more information visit www.valencehealth.com.

¹ (Dunn)

² (Rosenthal)

³ (The Center for Healthcare Quality & Payment Reform)

⁴ (Dunn)

⁵ (Dunn)

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⁷ (The Center for Healthcare Quality & Payment Reform)

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