

Structuring Value-Based Payment Arrangements: A Primer for Hospitals and Physicians

Providers across the spectrum of care will need to collaborate to ensure financial success.

OVERVIEW

Health care providers need to respond strategically now that health care purchasers and payers are adopting “pay for performance” arrangements. These arrangements are already maturing into more sophisticated value-based payment (VBP) models that provide incentives to redesign the delivery and payment of health care services. In the near future, a myriad of such payment incentives will be available as the market evolves into a model that pays for value, as measured by quality, efficiency, and patient experience.

Providers need to develop a strategy regarding VBP in order to strengthen their position in this evolving market. While elements of fee-for-service will remain, they will be more closely tied to value-based payment in the future. For a significant period of time, there will be multiple payment systems, ranging from fee-for-service to a form of capitation (a set fee per patient regardless of the services provided). VBP arrangements will continue to grow in importance, complexity, and financial impact.

THE FUTURE OF VBP

The current elements of VBP fall into four categories:

- Quality (outcomes and process)
- Systems/data reporting capabilities
- Care coordination/management
- Financial results (total cost of care)

As VBP matures, some of the basic elements will be phased out, in particular, those related to process, data reporting, and systems development. After that, payers will focus on care coordination through health care (medical) homes, chronic care management, and management of costs through global payments or targets. By fully participating in the currently available VBP arrangements, providers can position themselves for success as this payment system evolves.

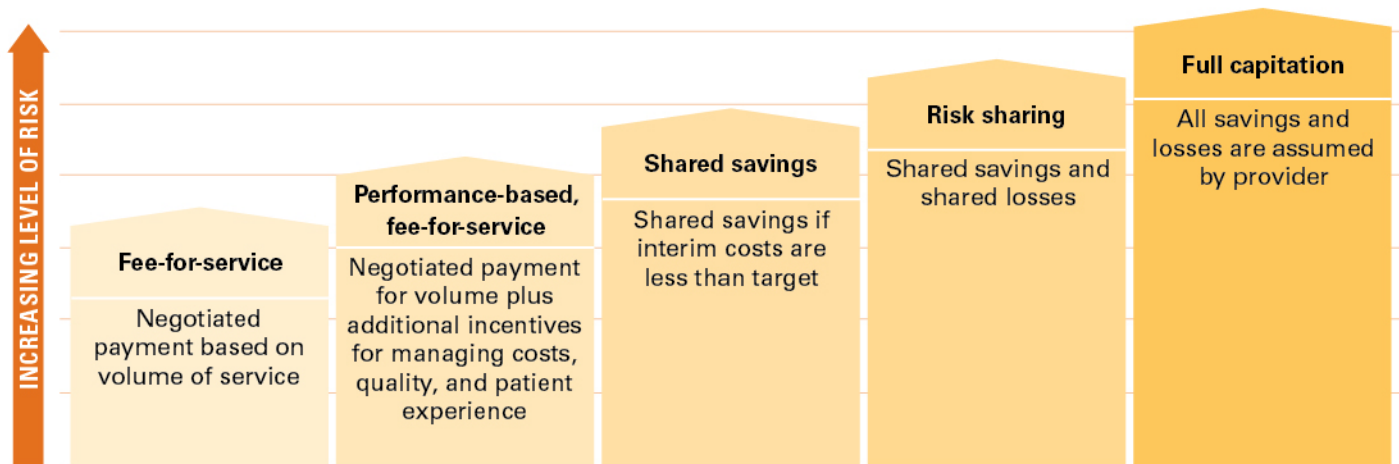
ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

One evolving form of VBP is accountable care organizations (ACOs), which are provider-sponsored entities responsible for improving quality and financial outcomes for a defined population. Much of the focus has been on Medicare ACOs, but the commercial market, led by the major health plans and acute care systems, has already been experimenting with similar models. Though lagging behind, state Medicaid programs will probably pursue ACO-like models as well. Given this widespread interest in ACOs, provider shared-savings and risk-sharing models are likely to emerge in nearly all health care markets. The full spectrum of global payment models is shown in the graph below.

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Spectrum of Payment Models for Health Plans and Providers



The Centers for Medicare and Medicaid Services (CMS) intends to deliver on the legislative directive to make ACOs available to Medicare beneficiaries by 2012. The “interim final” rules have been issued but are expected to change significantly before being finalized. Though it is unlikely providers will develop a Medicare-only ACO, they may consider a Medicare element as a complement to their commercial ACO business model.

In addition to the creation of ACOs, the Patient Protection and Affordable Care Act (PPACA) creates VBP provisions for hospitals, physicians, and other providers. In this environment, providers across the spectrum of care will need to collaborate to ensure financial success. The initial provisions apply to hospitals, with penalties for high 30-day readmission rates and a disproportional number of hospital-acquired conditions. There are incentives for achieving quality and patient experience measures, as well as options to develop bundled payments for episodes of care. Furthermore, the PPACA directs CMS to develop a Medicare physician payment system that is based on quality and cost of care measures by 2015.

KEY ELEMENTS OF VBP CONTRACTING

One of the emerging VBP methods focuses on achieving a financial target for a defined population. This is sometimes referred to as a “total cost of care” arrangement (TCOC). These can take many forms, ranging from performance-based, fee-for-service to full capitation. However, all of these models have the same structural elements that usually include the following:

- Patient attribution
- Global financial target
- Global target trend
- Risk adjustment
- Sharing financial gain (loss)
- Cash flow and interim payments
- Quality measures and performance standards
- Medical management responsibilities

Patient attribution

The first step in structuring a TCOC arrangement is defining the population being served. For instance, providers must figure out how they are going to identify and organize this specific group of patients for accounting and care coordination purposes. This can be done most efficiently when patients are required to select (or be assigned to) a specific provider group responsible for managing their care and the related costs. However, most health insurance arrangements, including Medicare, do not currently have that requirement and rely primarily on claims history to attribute patients to providers.

Although patient attribution models are typically retrospective, their specific components vary, and provider groups will have to work with multiple models. For example, attribution methods for a medical home arrangement may differ from a TCOC agreement. How far back claims are reviewed may vary, as will the methods for assigning patients to specific providers (though it is typically based on the outpatient evaluation and management services provided). Each payer must have a consistent methodology of assigning patients that prevents inclusion in another group.

Global financial target

Once patients are assigned to a provider group, a global financial target is established based on historical spending and utilization data. This is used to project budget benchmarks for future performance periods. This target includes all covered health care services delivered in and out of the provider group’s network and is normally expressed as a per member/per month (pmpm) amount, including the patient’s cost-sharing amount.

The payer must provide this baseline data using reported claims information incurred during a defined period (often the prior year). The pmpm calculation is based on the contractually allowed charges of the providers in the payer’s network. This



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data should be reported by broad service categories, such as hospital inpatient, hospital outpatient, pharmacy, primary care, specialty care, and emergency room services. Providers should analyze the information based on the specifics of the TCOC arrangement.

Global target trend

A provider's next step is to project forward the global target to the performance year, which can be done by looking at historical cost trends, negotiating an inflationary index, or using a combination of those factors.

Providers will need to request data from the payer for the most recent two to three years. The cost and utilization information should be converted into pmpm calculations. This can be used to calculate and analyze the cost and utilization trends over that period of time as well as going forward.

Other factors that may be considered in projecting the global target include:

- Potential future benefits of care coordination
- Evidence-based guidelines
- Changes in provider reimbursement or practice patterns

The market pressures to contain health care costs, (i.e., not to exceed general inflation) must also be considered when setting future targets. Providers must realistically assess their ability to manage within these targets, which requires a thorough analysis of the data and an assessment of their own capabilities to provide good results efficiently and cost effectively (bend the cost curve).

Risk adjustment

When establishing the baseline target and projecting it forward based on trends, it is important to adjust for the risk profile of the patient population. Providers can make adjustments by incorporating basic demographic factors such as age and sex, or apply more sophisticated models that predict future health care utilization.

Another form of risk adjustment excludes expenses beyond a defined threshold (e.g., \$50,000) when measuring performance against the global target. This “stop loss” arrangement between the provider group and payer protects the provider from assuming “insurance” risk, and allows it to focus on what it can medically manage.

Sharing financial gain (loss)

The new TCOC models offer providers the incentive to manage health care costs by sharing in the financial gain when savings are achieved against the global target. Most of the current models are shared-savings arrangements, though the proposed Medicare rules provide the option of starting with shared savings and moving toward risk sharing.

Provider groups must determine the level of risk they are willing and able to assume. Most will begin with shared-savings arrangements and avoid risk until the group has confidence it will be successful. However, there is greater potential upside to risk-sharing models. Incentives might include an increase in the provider's fee-for-service payments, a percentage of the savings, or a lump sum payment.

The patient populations served under these models vary considerably, and therefore, so does the risk. Patients may have a chronic condition (e.g., congestive heart failure) or have been attributed to providers based on claims history. To be successful, provider groups not only need to effectively manage health care services for patients, they must also ensure they have a sufficient group of patients to make the necessary investments pay off.

Providers should consider developing a TCOC business model so they can proactively approach the payer and purchaser communities. The discussions may begin by acknowledging their need to contain future premium increases. The goal is to determine what can be done collectively with the payers to make that happen.

Good financial modeling tools can illustrate the effects of entering into a global TCOC arrangement with a payer and show the resulting impacts of a variety of actions. These tools are instrumental in realistically planning and developing your TCOC arrangements.

Cash flow and interim payments

The key piece of any TCOC arrangement is determining how funds will flow to the provider group. Options include:

- Payment on a fee-for-service basis
- Partial capitation (e.g., for primary care services)
- Full capitation

Most of the commercial insurance models and the proposed Medicare ACO model pay providers on a fee-for-service basis, with a reconciliation against the global target at various intervals.

Supplying partial or full capitation to the provider group makes resources available up front to finance quality and process improvements. It also enables discretion in offering health care services that may be appropriate or beneficial (e.g., e-visits), but which may not be covered on a fee-for-service basis. However, capitated arrangements require that patients are assigned to a primary care physician, which may not be attractive to some. They also require the provider group to assume at least some downside risk.

Other possibilities include a coordination fee for the services of a primary care medical home, paying a bundled amount for a defined episode, or negotiating alternative fee-for-service rates. Many payment options are possible, so provider groups must examine all the alternatives to determine what is best suited for them.

Quality measures and performance standards

To ensure the delivery of appropriate and high-quality care, provider groups will need to report on key quality and patient experience measures. Achieving a certain level of performance, as reported through those measures, is typically a condition for earning financial incentive payments through a TCOC arrangement. However, some arrangements are designed to include bonus incentives, beyond the shared savings, if certain performance levels are met. Provider groups must negotiate a quality incentive provision with payers that is meaningful yet achievable.

Medical management responsibilities

One of the most important arrangements to be worked out between the provider group and payer is the responsibility for conducting medical (utilization) management activities for the defined patient population. Traditionally the payer has accomplished this through prior-authorization or utilization-review mechanisms. However, a key objective of the new TCOC arrangements is to have the provider group assume the role because it is in a better position to coordinate care and apply evidence-based clinical practices for their patients. The TCOC agreement must clearly define the roles of all involved.

SUMMARY

Payment reform will evolve in different ways and at a different pace in each market. The adoption of value-based payment models is inevitable, but the speed will depend on payer interest and provider readiness. Providers should begin developing the capability to manage health care services for a defined population, but must be realistic about the significant challenges of doing so. Participating in this new system may mean developing an integrated provider network or joining a network sponsored by other providers.

This paper has outlined the critical elements of developing a TCOC arrangement from the perspective of the provider. The various risk/reward models currently range from performance-based, fee-for-service to full capitation. Providers need to determine where they fit along that spectrum in terms of assuming financial risk and their ability to effectively manage health care services with new requirements for quality and performance.

The process of preparing for VBP reform starts with understanding the key elements and principles and assessing how reform is playing out in your market. The next step is to determine how to position your organization in this new order. These first steps will provide a foundation to strategically approach a future already being influenced by health care reform.