VIEW POINT

VALUE BASED CONTRACTING AND REIMBURSEMENT: THE NEW PAYMENT PARADIGM

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Today Americans may not be receiving optimal value for their Healthcare spend; we continue to over-spend for Healthcare Benefits often times with unclear outcomes and hospitalizations than our counterparts. The US continues to rank low on measures of patient safety, care coordination and patient-centeredness. Traditional Fee-For-Service (FFS) Reimbursement continues to contribute to the ongoing high cost - rewarding Providers often without regard to care effectiveness or outcomes. Value Based Reimbursement (VBR) shifts Healthcare Reimbursement from volume to value incorporating incentives to improve financial and clinical performance. Americans are living longer today and Reimbursement Transformation requires new thinking and approaches to reflect Population Health, broader Chronic Disease Management, Intra and Inter-relationships between disparate Healthcare organizations, and adequate investments in Tools and Services to support innovative models of care delivery.

A New England Journal of Medicine study examined relationships between increased Healthcare spend and changes in life expectancy in the United States between 1960 and 2000 and found that increase in spending provided "reasonable value" overall; however the study also found diminished returns related to additional Healthcare spend particularly amongst the elderly - suggesting that Healthcare spend discussions must consider the potential incremental benefits associated with expanded spend.

Incenting Providers to deliver improved Patient outcomes and value is now front and center; the Affordable Care Act (ACA) requires "a greater quality system that wastes less and encourages efficient and effective care" and accelerates broader Value Measurement and VBR efforts. The ACA supports a series of demonstrations to explore innovational organizational Models and Arrangements for Healthcare delivery. These demonstrations support analysis of different approaches to observe and assess which models may be the most impactful, how the local market dynamics shape the outcomes and performance of these new models, as well as when to deploy as a proven initiatives.

Implications and Impact

The implications and impact of a less-than-effective Value Based Contracting and Reimbursement approach often challenge optimal Revenue and Margin realization. Ideally your Organization has the appropriate insight to select high performing Providers to participate in your VBC process; however this is not always the case. Additionally, Organizations are often constrained to improve Quality and lower Costs during their FFS to Value Based Contract transition period.

The VBR Revolution

VBR adoption changes the rules – and relationships - governing reimbursement and associated income streams and now reflect other factors including Quality and Patient Safety, Recommended Care provisioning, and of course avoidance of wasteful care. Effective VBR incorporates two components: Value Measurement and Payment Reform so that reimbursement better reflects value. VBR introduces new payment approaches each designed to better align incentives for more effective care, and hold Providers accountable for adverse clinical events (i.e. Readmissions).

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Pay-for-Performance (P4P): A financial model links a portion of Provider incentives or disincentives to quantifiable, measured performance standards or improvement thresholds to reflect process or outcome criteria. The Provider receives an adjustment to its FFS rate bases on performance often in the form of a bonus for meeting and/or exceeding an established metric or sometimes a clawback for falling short. P4P often requires less IT infrastructure and integration than other models making this popular among smaller or newer provider organizations. However, the model usually requires a clinical quality benchmark be established and the ability to monitor and report results. Often incentives may be too small to motivate Provider behavior or the patient population is too small to influence. It resembles an FFS model however Providers receive higher payments for rendering more justified services. Expect P4P to grow 3X in the next 5 years.

Patient Centered Medical Home (PCMH): Care Model where a Primary Care Practice/Group is accountable for specific Healthcare Services delivery for a defined population. As a Primary Care-driven initiative, Medical Homes focus on building a team of Healthcare Professionals (Physician, RN Case Manager, and Medical Assistant) who coordinate Patient care across a continuum and provide higher quality and better Care Coordination particularly for Chronic Condition Patients and to prevent hospital readmissions and ED visits. Medical Homes increasingly leverage EMRs, Disease Registries and data repositories to facilitate. Providers often negotiate a FFS rate increase or a Per Member Per Month (PMPM) payment on top of standard FFS payments to cover Staff Care Coordination costs and infrastructure overhead. This model often requires additional and specific IT Asset (e.g., EHRs) be in place. Today, many IT Systems are not effectively aligned with VBR for optimal impact and require further clinical buy-in and engagement for VBR success.

Bundled Payment/Episode of Care: Here the Provider accepts a determined price to manage episodes of care; this Model is often applied to acute episodes however may be adapted to chronic conditions. Bundled Payment/Episode of Care provides a negotiated payment for all services for a specified procedure or condition including knee and hip replacement surgery, certain cardiac procedures, pregnancy and birth, and ties Provider reimbursement amounts to established standards of care, risk stratification, and complication allowances. It incentivizes Provider performance based on a comprehensive scorecard. Providers benefit from savings they generate through efficiency within episodes as well as from preventing unnecessary services. Payers save money by paying out less per episode or per patient than in the past. Moreover, Payers know in advance how much will be spent and do not have to wait to determine if additional savings may be realized. A potential downside for Providers using this model is having to cover the costs of services for procedures that exceed agreed-upon reimbursable amounts. Providers often realize the requirement to treat more episodes to increase their income and thus the Bundled Payment Model resembles another form of FFS; some are currently developing Bundled Payment Programs for specific procedures including diabetes, congestive heart attacks, joint replacements, hypertension, etc.

Aligned Shared Savings

Shared Savings Models potentially represent another 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 for Providers offering PCMHs who are often challenged to maintain previous performance levels and ratings. Shared Savings Programs reward Providers that demonstrate total Healthcare Spend to their patients below an expected level usually set by the Payer; ideally a Payer spends less on a patient's treatment and the Provider realizes more revenue than otherwise expected.

Shared Savings Programs often suffer from several shortcomings including not paying for certain Primary Care services for chronic disease patients nor physician phone or email consults. Some Providers have experienced additional upfront spending to implement the processes or technologies necessary to achieve success. Thus, while revenue may increase from such a program it may take an extended period of time before performance has been accurately assessed. Additionally, Providers with higher rates of admissions or unnecessary procedures may not realize a revenue benefit and Providers with lower costs and higher quality of care are already "saving" Medicare and other payers' money but not receiving a reward for doing so. Numerous Shared Savings Programs have been challenged to prove sustainability as Payers may find it difficult to continue making shared savings payments indefinitely based on previous savings achieved.

Shared Risk

Shared Risk Models are an advanced level of Risk arrangements whereby Providers receive performance-based cost sharing and/or savings combined with disincentives to share the excess costs. This Approach leverages an agreed-upon budget and calls for the Provider to assume some costs if savings targets are missed; this cost might be in the form of a percentage of the premium or predetermined amount. Under this model Providers take on more upside and/or downside risk with the opportunity (usually) greater for upside financial gain. This model requires that Payers structure the Shared Risk Program to effectively meet the needs and capabilities of the Provider organization and often include scheduled Review Points for Program validation.

Provider organizations look to Third Parties for Stop-Loss Insurance should the Payer look to transfer more financial risk with the Provider organization paying a fixed fee to the Third Party Insurer to accept financial risk beyond a certain level. Providers can also limit their exposure by carving out certain patients or conditions – where they agree to serve patients or conditions better aligned to their business model and where they can control outcomes. Risk Corridor arrangements have been moderately successful to protect from high losses but also limit opportunities for gains.

Shared Capitation Models

Under a Capitated Payment Model Provider organizations receive a set payment per patient from the Payer for specified medical services. The Provider is responsible for all the covered patient and services risk. Payment is often via a monthly per-patient-fee with fees determined by actuarial analysis of historic costs of the patient population to be covered; these are sometimes further adjusted to reflect the level of risk associated with the patient population. This requires the Provider organization to divide up the payment and often disburse via a combination of incentives and fee-for-service agreements. There are two main Capitation Models:

- Global Capitation is an arrangement where a Provider receives a single fixed payment for the entirety of healthcare services a patient/member could receive
- Partial Capitation reflects a single Provider monthly fee and covers a defined set of healthcare services; Services not covered are usually still paid for on a FFS basis

Provider Sponsored Health Plans (PSHPs)

PSHPs represent the most comprehensive of value-based healthcare models. A Provider Network assumes 100 percent of the risk for insuring a given patient population. PSHPs directly collect the insurance premium from an employer or individual and represent the greatest span of financial control. Providers are positioned well with respect to Care Delivery and how much is spent; numerous large Health Systems are pursuing this strategy going forward.

PSHPs offer several advantages to Providers including more control over benefit plan design which often determines the care that is delivered. PSHPs can support delivery of more coordinated and quality care across the continuum – often at a lower cost. PSHPs may also generate additional revenue that is less sensitive to fluctuating care delivery revenues. Advantages of PSHPs include more rapid and increased market penetration, ability to more effectively address shifting Revenue mix and Patient/Member Populations and increased financial rewards for participation. A shifting/evolving Revenue mix from Commercial to Medicare/Medicaid impacts your bottom line as these latter patients are noticeably less profitable.

Providing a Health Plan requires that Providers assume new responsibilities including Claims Payment, Insurance Reporting, Customer Service and other Administrative operations. Provider organizations can develop these capabilities in numerous ways:

- Build: Providers can develop these capabilities internally and hire the requisite staff and install the necessary technologies
- Buy: Providers can acquire the requisite Resources from an existing Health Plan
- Partner: Providers may elect to partner with an entity to leverage existing Assets
- Outsource: Providers may select an Outsourcing Partner to provide the requisite capabilities under another Provider's brand and guidance.

Challenges and Considerations

Reconciling Value Based Reimbursement in an FFS Environment: Shared Savings Models incentivize Providers to reduce spending for defined patient populations by offering a percentage of realized net savings. Accurately tracking performance via this Model can be difficult as it requires keeping track of multiple payment systems simultaneously with previous reimbursement based on a FFS basis and now having to calculate Shared Savings Reimbursement/Payment at the end of the year.

Tracking Broader Quality Measures: Today's Value Based incentives and penalties rely on Quality measures. Providers are used to submitting quality measures including Hospital Inpatient Quality Reporting (IQR), Hospital Outpatient Quality Reporting (OQR) and Physician Quality Reporting System (PQRS). In 2016 Providers must demonstrate they're meeting Quality standards and improving Patient Outcomes - while cutting costs. This requires sophisticated analytics – measured on a continuous basis - to track financial and quality performance across patient populations. Several years ago Medicare began requiring hospitals to track 30-day readmission rates for heart attack, heart failure and pneumonia patients; Medicare recently added three additional populations to this requirement.

Margin Optimization: Providers transitioning from FFS to a Value Based Reimbursement Model may experience reduced utilization to accommodate procedure volume reductions which in turn may yield reduced revenue. Short-term, pressure on your existing FFS Revenue stream may increase faster than Value Based Reimbursement Revenue; thus Providers may have to look for alternatives to improve margins as much as possible. Providers must effectively manage Shared Savings Programs to improve Quality and subsequently maximize reimbursement. Additionally, the need exists to identify areas to streamline operations and improve operating costs to deliver Care more efficiently and standardize work processes as well as efficiently expand patient volumes as Employers will begin to incent Employees to select high-performing Hospitals via the Value Based Reimbursement environment.

The Role of Analytics

Providers and Health Systems will continue to experience Industry and Regulatory changes and challenges; this has become the new normal. This requires a more agile Information Architecture coupled with a robust Data Warehouse Platform and transformed Master Data Management foundation. A 360-degree view of the Member/Patient may now include more Clinical information coupled with pertinent Claims and Financial data, as well as other relevant administrative data – now visually delivered; this provides a more sustainable Value Based Reimbursement environment that drives Performance improvement and maximizes Revenues and Margins.

Beyond traditional analytics, tools exist today that provide Visualization displaying integrated Clinical, Financial and Administrative data in a more information-rich 360 degree view better supporting advanced capabilities such as Population Health Management. Visual Data Mining capabilities finds relationships in underlying data and brings to life and integrates information not previously correlated including structured and unstructured data.

How Infosys Can Help

Infosys delivers a pragmatic, executable Strategy and Approach to your Value Based Contracting and Reimbursement process. We can help you validate Administrative Optimization opportunities; review and refine your Metrics and Performance Measures and conduct Value Lever Impact Analyses; and assess your Information Governance across your Enterprise Data Warehouse and Business Intelligence environment as well as examine your Analytics Maturity and how this supports your various Business Segments and Operations.

Our Approach yields better insight and decisioning to support forecasting and management of fluctuating Revenue and Margins; promotes Evidence-based Preventative Care and delivers enhanced Outcomes and Care Mgmt. Quality Ratings further optimizing Medical Costs; more effectively supports monitoring Provider Performance per Contract; and enhances Member/Provider Engagement supporting Wellness and Quality Initiatives that support Chronic Care and other Patient Health initiatives.

Infosys Summary

Value Based Reimbursement - when implemented as mixed Payment Models common today - are often complex and costly to implement, scale, manage and measure without the right strategy, tools and stakeholder buy-in. Next-Gen digitally transformed and social media-enabled enterprises require invigorated process optimization and automation, greater Member | Patient | Payer | Provider collaboration and connectivity – with mastery of Analytics to drive more effective decisioning and Business Performance.

Today's Healthcare CIO is more focused on Information Strategy and Governance including Quality, Integration, Optimization and Master Data Management. The goal should be to transition from Information overload to predictable Insights and Business Performance.

Anticipating future Health System Information usage needs will continue to be difficult; this is why it is important that your Information Architecture align with your Business Architecture that begins to view Information as an Asset and establish an Information Usage capability to monitor its business contribution – both qualitatively and quantitatively.

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For more information, contact askus@infosys.com

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