

The value-based health care movement appears to be gaining momentum. In addition to providing an update on the state of value-based care in the United States, this article offers a framework for evaluating value-based reimbursement arrangements.



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by | Ross D. Weiler

Transforming Health Care Through Value-Based Reimbursement

With nearly half of large companies considering contracting with accountable care organizations (ACOs) by 2020¹ and efforts by federal and state governments to shift Medicare and Medicaid to value-based reimbursement models, momentum appears to be building in the movement toward value-based care.

Value-based reimbursement is transforming health care delivery, and the process could help reduce health care costs and improve quality. This article will describe current trends in value-based care and approaches to value-based reimbursement and will offer tips for plan sponsors interested in implementing a value-based reimbursement model.

What Is Value in Health Care?

It's no secret that the fee-for-service (FFS) reimbursement system has significant drawbacks. First and foremost, FFS rewards volume over value. Also, most patients still do not have the necessary information to identify, or incentives to utilize, high-value health care services and providers. As a result, the FFS reimbursement system has led to significant waste of health care dollars.

In fact, nearly 50% of the \$750 billion the Institute of Medicine (IOM)² identified as the annual sum of wasted medical

The Costs of Health Care Waste

According to the Institute of Medicine, nearly 50% of the \$750 billion of annual wasteful medical care in the United States can be attributed to unnecessary, inefficient services, which negatively impact both costs and quality.

This includes:

- Unnecessary services: \$210 billion
 - Overuse, use beyond benchmarks, use of high-cost services
- Inefficiently delivered services: \$130 billion
 - Mistakes, operational inefficiencies, care fragmentation

spending in the U.S. can be attributed to unnecessary and inefficient services. This negatively impacts both costs *and* quality. While not completely to blame, the FFS reimbursement system has played a key role in producing this waste.

Value-based reimbursement rewards providers, including hospitals and physicians, for delivering high-quality, cost-effective care that produces positive outcomes. (The term *value in value-based care* takes on different definitions; fundamentally, though, it's the ratio of quality, outcomes and costs.³) (Figure 1)

Achieving a balance between quality, outcomes and costs should be the overarching goal of our health care system. As the value equation improves, patients, purchasers (including employers), payers (i.e., insurers and third-party administrators) and providers all benefit, and the economic sustainability of our health care system increases.

As Michael Porter wrote in his seminal 2010 paper *What Is Value in Health Care*:

“Cost reduction without regard to the outcomes achieved is dangerous and self-defeating, leading to false “savings” and potentially limiting effective care.”⁴

Transitioning From Volume to Value

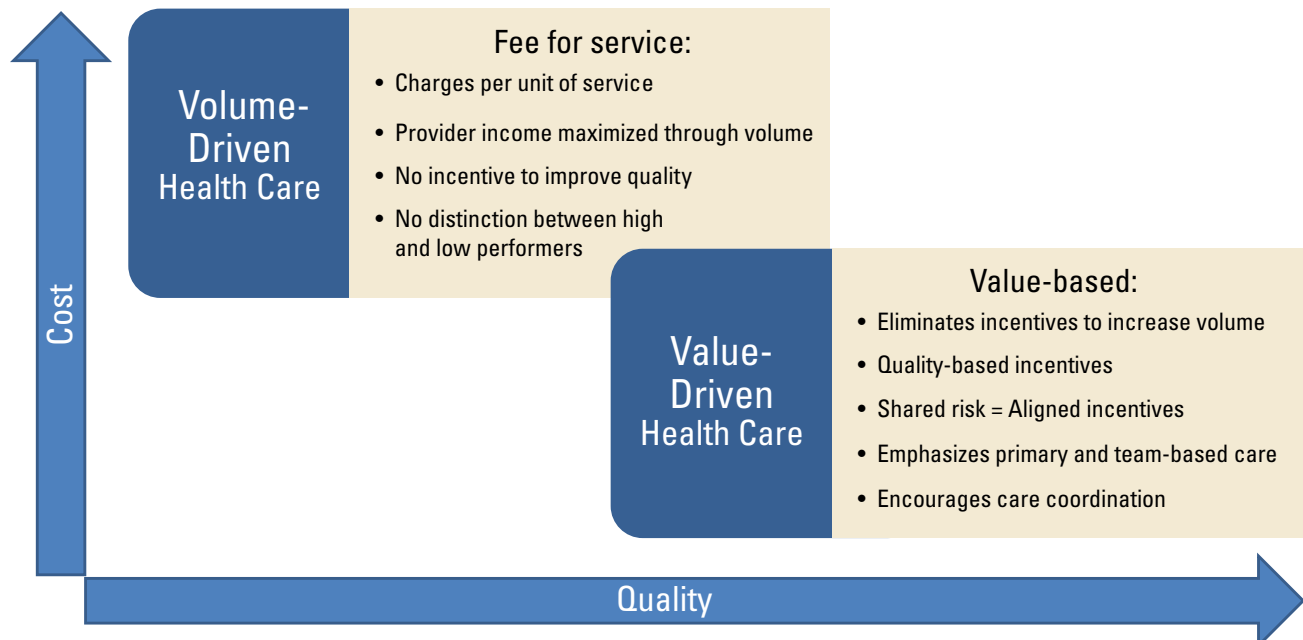
As we gradually shift to a value-driven health care system, incentives will shift from volume to quality, and outcomes-based risk will be a responsibility shared between payers and providers. Incentives throughout the system will be more appropriately aligned. Providers that emphasize primary and team-based care, link to social determinants and behavioral health, and provide well-coordinated care should thrive in a value-based environment.

For patients and purchasers, the result should be higher quality health care at a more reasonable cost.

takeaways

- Value-based reimbursement rewards health care providers, including hospitals and physicians, for delivering high-quality, cost-effective care that produces positive outcomes.
- A value-based model replaces the fee-for-service (FFS) reimbursement model, which has been tied to waste in health care spending.
- Employers have indicated they will increasingly focus on value purchasing opportunities, with nearly half of large employers considering offering accountable care organizations (ACOs) by 2020 and 88% expecting to use centers of excellence (COEs).
- Succeeding in a value-based environment requires a significant investment on the part of payers and providers, including potential restructuring to improve payer-provider coordination and collaboration.
- Small employers interested in value-based reimbursement could work with their brokers, consultants and local plans to identify value-based product options, such as a local ACO or cobranded payer-provider product.
- Larger employers could work through one or more health plans to offer an ACO, COE or “high-performing” network option. Some may be able to work directly with providers.

FIGURE 1



Successfully transforming from volume to value requires a fundamental change in how health care is organized and delivered. To make this transition, the entire health care ecosystem must participate. To that end, the Centers for Medicare and Medicaid Services (CMS) established the Health Care Payment Learning & Action Network (LAN) in 2015 as a collaborative network of public and private stakeholders from across the health care community to help categorize, accelerate the adoption of and measure progress in the adoption of value-based reimbursement approaches, or *alternative payment models* (APMs), across the U.S. health care system. The result is the APM Framework,⁵ which is a helpful way to look at the variety of value-based reimbursement approaches.

The APM Framework consists of four categories (with the level of financial risk and degree of care coordina-

tion, provider integration and accountability increasing substantially from Category 1 to 4).

Category 1 includes traditional FFS payment models (i.e., payments made for units of service) that are not linked to quality or value.

Category 2 includes FFS payment models that are adjusted based on performance metrics such as infrastructure investments to improve care or clinical services, whether providers report quality data or how well providers perform on cost and quality metrics. This could include:

- Payments for infrastructure and operations (e.g., care coordination fees, payments for health information technology investments)
- Pay for reporting (e.g., bonuses for reporting data or penalties for not reporting data)
- Pay for performance (e.g., bonuses for quality performance).

Category 3 payments provide a mechanism for rewarding the effective management of a set of procedures, an episode of care or all health services provided to individuals. To accomplish this, payments are based on cost performance (and occasionally utilization) against a target. Payments are structured to encourage providers to deliver effective, efficient and quality care and can include shared savings arrangements (with upside and downside risk or upside risk only).

Category 3 also includes episode-based and other types of bundled payments that are designed to encourage providers to better coordinate care by reimbursing in one lump sum all services related to a procedure that may be delivered by multiple providers rather than paying for each service and to each provider separately. Bundled payments are often tied to specific procedures, such as hip replacement or back surgery.

Payment models classified as **Category 4** involve prospective, population-based payments. Payment types in this category include:

- Condition-specific population-based payments (e.g., per member per month payments including payments for specialty services such as oncology or behavioral health)
- Comprehensive population-based payments (e.g., global budgets) paid to provider organizations or integrated finance and delivery systems (e.g., joint ventures between insurance companies and provider groups, insurance companies that own provider groups, or provider groups that offer insurance products).

Trends in Value-Based Reimbursement

There are many positive trends related to value-based reimbursement in the commercial sector.

According to the NBGH 2018 *Health Care Strategy and Plan Design Survey*,⁶ surveyed employers indicate that they will increasingly focus on value purchasing opportunities within the delivery system and improving the experience for health care consumers. The survey showed:

- More than one in five (21%) planned to promote ACOs in 2018, but that number could double by 2020 since another 26% are considering offering them.
- More than four in five (88%) expect to use centers of excellence (COEs), with up to almost half of COE contracts incorporating value-based reimbursement models such as bundled payments.

See the sidebar “ACOs and COEs Defined.”

At the federal level, CMS set an ambitious goal of tying 90% of Medicare FFS payments to quality and 50% of overall spending to value-based reimbursement arrangements by 2018, and the agency continues to encourage the development of ACOs and medical homes. The 2015 Medicare Access and CHIP Reauthorization Act (MACRA) changed the way that Medicare rewards clinicians for value over volume and offers bonus payments for participation in eligible APMs. Medicare’s Quality Payment Program, established through MACRA, rewards value and outcomes in one of two ways: through a merit-based incentive payment system (MIPS) or via advanced alternative payment models.

As for Medicaid, more than 40 states have a state-initiated plan or strategy to move toward value-based payments. As of this writing, 17 states have adopted or are considering

ACOs and COEs Defined

An *accountable care organization* (ACO) is a group of providers that work together to deliver seamless, high-quality care. ACOs are responsible for maintaining a patient-centered focus and developing processes to promote evidence-based medicine, encouraging patient engagement, reporting on quality and cost, and coordinating care. ACOs are typically reimbursed through shared savings or shared risk (alternative payment model Category 3).

A *center of excellence* (COE) is a health care organization that, through a high degree of experience and expertise in an area of specialization, delivers care in a highly organized, interdisciplinary manner that produces the best patient outcomes possible. Some of the primary areas of specialty for COEs include cardiology, orthopedics, oncology, ophthalmology, bariatric surgery and neurology. Reimbursement approaches for COEs vary, but many COE contracts include bundled payments (also alternative payment model Category 3).

adoption of ACOs or ACO-like entities. Medicaid ACOs are designed to improve care coordination and delivery by holding providers financially accountable for the health of the patient population they serve. This accountability is generally achieved through three key activities: implementing a value-based reimbursement structure, measuring quality improvement, and collecting and analyzing performance data.

Reimbursement Across All Sectors Is Now Largely Tied to Value

A 2018 survey by LAN⁷ shows that, in 2017, 34% of commercial, Medicare and Medicaid payments combined were tied to APMs (Categories 3 and 4 of the APM framework discussed earlier), with another 25% representing FFS payments with a link to quality (Category 2). This leaves 41% tied to FFS with no link to quality (Category 1).

For this survey, reimbursement data was collected from 61 health plans, three managed FFS Medicaid states, and Medicare FFS, representing almost 226 million of the nation’s covered lives and 77% of the U.S. covered population.

In 2017, United and Aetna said that they were paying out almost half of their reimbursements via value-based care models.⁸ That number was around 60% for Anthem.⁹

ACOs Are Growing Rapidly

The increasing prevalence of ACOs has contributed great-

ly to the growth in value-based reimbursement. From the first quarter of 2017 to the first quarter of 2018 there was a net increase of 88 ACOs across the country, bringing the nationwide total to 1,011.¹⁰ Approximately 52% of total ACO-covered lives were in commercial ACOs, 36% in Medicare ACOs and 12% in Medicaid ACOs.

Many ACO payment arrangements start with a shared savings (APM Category 3) approach and, over time, move to shared risk (also Category 3) arrangements or population-based payments such as global budgets (Category 4).

Driving a Wave of Cobranded Payer-Provider Products

With the growth of value-based reimbursement has come an increase in joint ventures and cobranded products between payers and providers. According to Oliver Wyman,¹¹ payer-provider partnerships continue to deepen, with 71% of the partnerships launched in 2017 being joint venture or fully cobranded insurance products. More than four in five (86%) of these arrangements emphasize value-based reimbursement. These relationships expand on the concept of narrow networks through increased collaboration and coordination, resulting in closer clinical and operational alignment and a deeper focus on patient/member experience and care management. Their primary goal is to improve alignment between payers and providers around reducing the cost of care.

FFS Payments Declining Among Larger Payers but Still Dominate the Commercial Market

According to a June 2018 payer survey conducted by Change Healthcare,¹² the proportion of larger payers' business aligned with FFS payments is declining rapidly. In 2018, for payers with at least 250,000 members, only 37% of payments across product lines were FFS. This is expected to decline to only 25% by 2021.

However, many providers are still receiving substantial FFS payments for commercial patients. In a December 2017 survey from the American Medical Group Association,¹³ responding providers predicted that 2018 FFS payments would equal 70% of total commercial revenues. By 2019, FFS payments are expected to decrease to 63% of total commercial revenues. Only 39% of total federal revenues are expected to come from Medicaid or Medicare FFS payments in 2019.

The survey also identified significant impediments that

remain for providers in transitioning to a value-based environment. The biggest obstacles involve data, particularly the lack of access to administrative claims data, health plan data that is not current or actionable, requirements to report performance data to duplicative quality measurement programs, and the need to develop and finance the infrastructure necessary to take risk.

Despite the challenges in moving to a value-based approach, however, 60% of respondents stated they would be ready to take downside risk within two years.

Positioning Payer-Provider Partnerships for Success

Succeeding in a value-based environment requires a significant investment on the part of payers and providers, including potential restructuring to improve payer-provider coordination and collaboration. It's critical that both parties have access to a technology infrastructure, actionable data and analytic expertise that allows for a broad and deep understanding of the patient population and ongoing analysis of clinical impacts and outcomes. Siloed approaches to data and analytics simply won't work in a value-based environment.

Value-based arrangements won't succeed unless payers and providers are able to build a level of trust that hasn't been possible in the FFS environment. This requires clearly defined, common goals; aligned incentives; a mutual commitment to and joint focus on patient engagement and popula-

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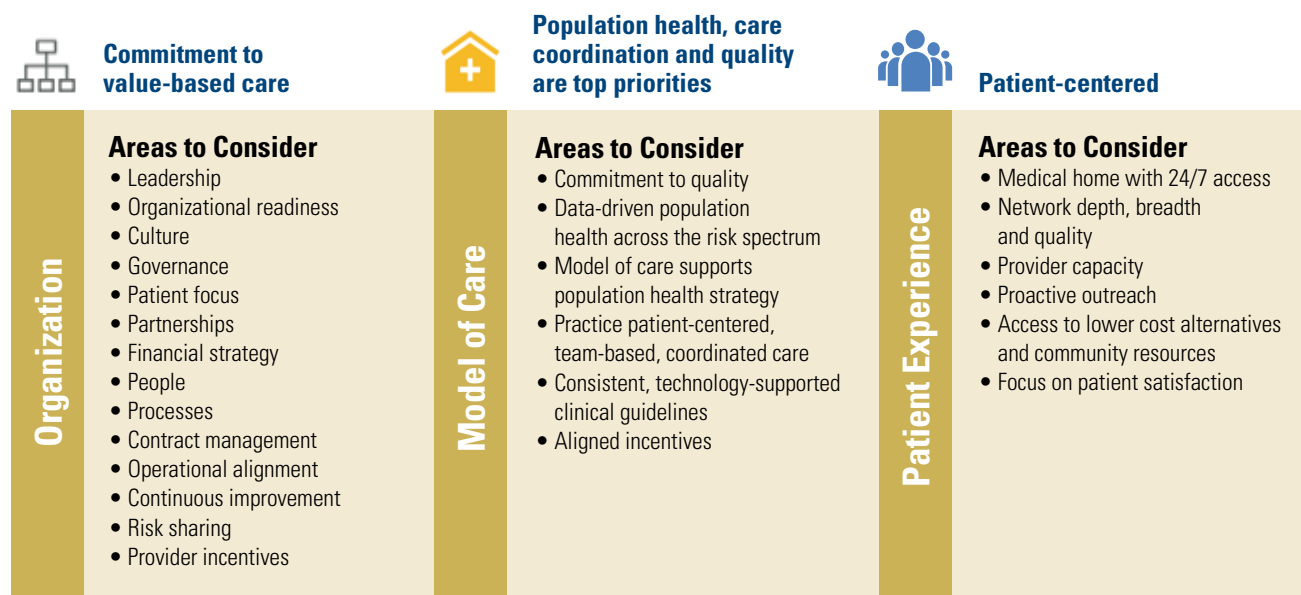
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Shared Values—Shared Results

Dee W. Edington, Ph.D., and Jennifer S. Pitts, Ph.D.
Edington Associates. 2016.

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FIGURE 2



tion health; and the recognition that each party brings different strengths and commitments to making the most of those strengths.

A Framework for Evaluating Value-Based Arrangements

For employers and employees, value-based options should continue to expand. Options will differ for large and smaller employers, and the pathway each employer chooses will depend largely on its specific health care strategy and local or regional presence (i.e., number of employees within a market), as well as the degree to which payers and providers in each local/regional community have made the transition to value-based care.

Small employers could work with their brokers, consultants and local plans to identify value-based product options. These options could include a local ACO or cobranded payer-provider product. In evaluating these options, most employers will want assurance

that their employees and dependents have reasonable access to quality providers who have experience with value-based care and can demonstrate positive results.

Larger employers have different options. For example, a large employer could work through one or more health plans to offer an ACO, COE or “high-performing” network option. Employers with a large local or regional presence may be able to work directly with providers on a tailored value-based reimbursement arrangement. For these employers, it’s critical that the health care needs of employees and dependents are well-understood and that any decisions on which option(s) to pursue are data-driven. This is important to ensure not only reasonable access to quality providers but also that the underlying health conditions of the employer’s population are effectively addressed. Pursuing this pathway requires access to and the expertise to evaluate clinical and financial data, as well as the resources to negotiate, manage payer/

provider relationships, monitor results and make adjustments as needed.

As outlined in Figure 2, employers and other health care purchasers seeking to evaluate value-based arrangements may want to focus on the payer’s/provider’s:

- Commitment to and readiness to provide value-based care (organization)
- Prioritization of population health, care coordination and quality (model of care)
- Focus on and ability to offer a patient-centered experience that produces high levels of patient engagement and satisfaction (patient experience).

Effectively evaluating value-based reimbursement arrangements requires a multidimensional approach.

A Long-Term Commitment

The transition to value-based care will not happen overnight. For example, according to recent CMS data,

bio



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the longer an ACO is in operation the greater the savings they generate. Quality of care also improves over time. Therefore, all stakeholders, including payers, providers and purchasers, must take a long-term view.

Successful value-based arrangements can positively impact health care outcomes, improve the member experience and ultimately reduce costs. If that's the case, the investment and patience required to succeed will be well worth it. 🎯

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