

Can Value-Based Reimbursement Models Transform Health Care?



Traditional fee-for-service (FFS) reimbursement contributes to the high cost and low quality of care that plague the U.S. health care system today. FFS reimbursement rewards providers for delivering more services and fails to differentiate payment based on quality. Value-based reimbursement (VBR) is designed to shift the basis of reimbursement from volume to value by incorporating incentives to improve financial and clinical performance. However, simply changing incentives is not sufficient to achieve the transformation that policymakers and private industry seek in an effort to meet the health care needs of an aging population. That transformation will require a holistic approach to VBR that includes a new emphasis on population health, new alliances between health care organizations, and investments in the tools and services needed to support innovative models of care.

There is a simple truth about U.S. health care: Americans do not necessarily receive the value they could experience for the money they spend. Health care costs nearly doubled from 1980 to 2010,¹ and Americans now spend on health care — as a share of gross domestic product — nearly twice as much as people in other developed countries do.² At the same time, whether Americans benefit from spending so much on health care is unclear. U.S. patients are hospitalized more often for chronic conditions than are people in many other developed countries, and the United States ranks low internationally on measures of patient safety, care coordination and patient centeredness.³

The current fee-for-service reimbursement system rewards physicians and hospitals when they deliver more care to their patients — often without regard to the effectiveness of that care. FFS actually penalizes providers financially for maintaining the health of their patients and reducing patients' need for clinical services. The net effect is to encourage the delivery of services that result in potentially little or no clinical benefit. At the same time, a study published in the *New England Journal of Medicine* that examined the relationship between increased health spending and changes in life expectancy in the United States from 1960 to 2000 found that increases in spending have provided "reasonable value" in the aggregate.⁴ However, the authors also seem to find diminishing marginal returns to additional spending — especially among the elderly, whose spending rose most dramatically. The authors argue that discussions about health spending need to consider the incremental benefits associated with that spending.

Rewarding providers for delivering greater value to their patients has become a matter of national policy. The Patient Protection and Affordable Care Act (PPACA) calls for “a greater quality system that wastes less and encourages efficient and effective care” by accelerating value measurement and VBR efforts.⁵ The PPACA mentions “value” 214 times in Title III: Improving Quality and Efficiency of Health Care.⁶

But simply paying providers for more value is not sufficient. VBR is one component of a more complete transformation that will take time — and investments — to achieve. That’s one of the reasons that the PPACA also calls for a series of demonstrations to explore the effect of new organizational arrangements and innovative models of health care delivery. Experimenting with different tactics and approaches will enable the industry to learn which clinical models are most effective, how the attributes of local markets influence the performance of clinical models and organizational structures, and when to expand pilots into larger health care initiatives.

The VBR evolution

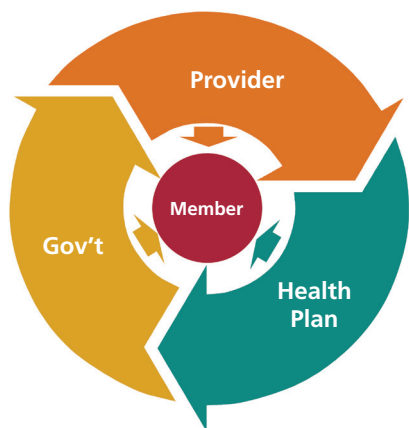
VBR changes the rules that govern provider reimbursement so that income depends “not just on the provision of a service but also on other factors, such as quality and safety measures, provision of recommended care and avoidance of wasteful care.” VBR encompasses two components: measuring value and reforming payment so that payment reflects value.

In practical terms, VBR is not new and includes a variety of payment methods designed to establish and align incentives for efficient and effective care, hold providers accountable for adverse clinical events, and adopt transitional strategies to create the right infrastructure for support of VBR.

Figure 1: Aligned incentives due to value-based reimbursement

VBR: Aligned incentives, focused on the member

Leading to lower cost and higher quality service



- **Lower cost**
 - Generate savings for potential gain-sharing
 - Focus on the clinical need for procedures
 - Encourage more evidence-based clinical decisions
 - Focus more clinical attention on population health rather than on individual patients
- **Higher quality**
 - Provide rewards for good outcomes
 - Reward providers for adhering to established protocols
 - Lower reimbursement for adverse events

There are four distinct VBR models:

- Pay-for-performance (P4P): A financial model that links a portion of a provider’s revenue to quantifiable performance standards that can reflect process or outcome criteria.
- Patient-centered medical home (PCMH): A care model in which a primary care practice or a group of practices accepts responsibility for managing the health of — and the delivery of specific services to — a defined population. This model often requires use of specific information technology (e.g., electronic health records [EHRs]).
- Bundled payment: A financial model in which one or more provider organizations accept a prospectively determined price to manage an entire episode of care. Bundled payments usually are applied to acute episodes but can be adapted to chronic conditions.
- Shared savings/accountable care organization (ACO): An administrative model in which provider organizations collectively accept responsibility for managing the health of a defined population across a broad scope of services.

Figure 2: Value-based reimbursement payment methods

Type of VBR	Description	Comment
Pay for reporting	Providers receive additional fees when they supply information — usually clinical or quality data — that is not part of the standard claim form.	Transitional strategy designed to collect information needed for other models
Pay for adoption	Providers receive financial support to subsidize investments in clinical infrastructure and technology (e.g., EHRs).	Not tied directly to patient care objectives
Prospective payment	Providers are paid according to rules that are set in advance depending on a patient’s underlying clinical condition care requirements.	Aggregates services into a single payment unit over time but usually not across providers
Warranty services	Providers are not paid for services that result from adverse outcomes or ineffective treatments. Includes policies related to hospital-acquired conditions and never events.	Risk adjustment is an issue. Warranty services often not provided by initial clinician
Gainsharing	Financial model in which providers receive a portion of the savings attributable to changes in clinical practice that achieve specified financial objectives.	Constrained by existing statutes

Source: Optum

The federal government has been conducting demonstration projects to assess these tactics because it recognizes that the Medicare program “has an important influence on the shape of the health care delivery system in the United States” and that it is “incumbent on the Medicare program to spend limited funds wisely by providing incentives for beneficiaries to seek, and providers to deliver, high-value services.”

However, Medicare, “as mighty as it is, can only move the needle so far,” according to *Health Affairs* editor in chief Susan Dentzer, who says that “unless private insurers implement similar reforms, providers will rationally try to maintain their incomes by charging those insurers more.”⁹ In this context, the development of health benefit exchanges under the PPACA will strengthen the competitive pressures on private insurers and force them to identify and adopt new strategies for improving the value that customers receive from their health care dollars.

Existing research involving federal and commercial VBR pilot programs does not suggest that any single model is clearly superior. The Centers for Medicare & Medicaid Services (CMS) continues to explore a variety of options involving prospective payment, shared savings and bonus arrangements tied to specific performance criteria. There is a lot to learn, and it is important not to embrace policies without thorough assessment. This is illustrated by the Medicare Premier pay-for-performance demonstration wherein findings were promising but later research found no improvements in patient outcomes.¹⁰ What seems clear is that strong financial incentives are needed to influence provider behavior and that the public and private sectors will need to work in tandem and send providers consistent signals “if we are to witness the full benefit of lowering health care spending.”¹¹

Patient-centered medical homes have drawn considerable attention from both public and private organizations because of their emphasis on health promotion and the potential shared-savings aspects of that care model. A study of PCMH pilots in Colorado, New Hampshire and New York primary care practices showed encouraging signs of meeting cost, utilization and quality objectives.¹² Another evaluation — which focused on the Massachusetts Patient-Centered Medical Home Initiative involving 45 primary care practices participating in the Massachusetts Medicaid program — illustrates some of the complexities and opportunities the industry faces in developing new and effective care models. In particular, the evaluation found that:

- **Specification of the model can be contentious.** (“Each design choice exhibits tensions between conflicting goals and interests, and a balance must be struck”¹³)
- **Entities need and must be able to pool payer data and align performance measures.** (“The lack of a coherent and unified program works at cross purposes with true system redesign”¹⁴)
- **Providers must be grouped together for the purposes of measurement and incentive distribution.** (“Without grouping, the statistical instability of measures leads to very wide confidence intervals, which precludes the use of meaningful payment thresholds”¹⁵)
- **There is a need for risk adjustment to account for patients with varying needs and health behaviors.** (Payers might unintentionally discourage providers “from caring for the highest-need patients unless mitigating strategies such as outlier provisions and risk adjustment are employed”¹⁶)
- **Providers need better information about the care their patients receive outside their practices.** (“Insurers must begin to share meaningful, user-friendly data in a timely fashion that allows willing practitioners to identify high-risk patients, assess potential overuse, and track quality metrics”¹⁷)

Attempts to implement specific tactics can be difficult and the benefits uncertain, but health care organizations engaged in VBR experimentation can learn valuable lessons about what works for them. How much the industry can learn from individual prototypes is less certain because different tactics may be more appropriate for different delivery systems, market conditions, or insurance products. That said, the industry as a whole will benefit by accumulating evidence from individual prototypes, and recent efforts by CMS to promote demonstrations will accelerate our learning.

In a January 2012 interview with the *Wall Street Journal* about ACOs, former CMS administrator Donald M. Berwick said, “Many capable organizations seem to want to try. Some of those that try will fail, but, in an era when new methods of care coordination are emerging and thriving, I suspect that many will succeed.”¹⁸

A December 10, 2012, article in *American Medical News* supports Berwick’s statement that many organizations are eager to try the ACO model. According to the article, “the number of ACOs is expected to go up fast in 2013” as CMS approves new Medicare program participants and as commercial insurers announce “new ACO program participants on a regular basis and plan to expand these initiatives so even the smallest participants can take part.”¹⁹

Taking incremental steps toward VBR

Early-adopter payers and providers that have started or are about to start down the road toward linking reimbursement and quality will benefit from the firsthand experience they gain — either with actual savings and/or improved outcomes or with valuable feedback and information that will help them refine their VBR strategies.

Efforts by CMS and commercial health plans to develop and deploy VBR strategies already suggest certain important issues:

- The right technology and data methodologies/transparency are intrinsic to success.
- Relationships among providers must change dramatically.
- VBR program failures actually are important learning opportunities.

Organizations participating in successful VBR arrangements generally need to make significant new investments in information technology. At a minimum, health care organizations need technology to administer payment and clinical operations. Depending on how such operations get implemented — for example, bundled payments — the arrangements can require a risk-bearing provider entity to consolidate claims from participating providers and submit a combined billed to the payer. The risk-bearing provider will also need technology to distribute payments to other participating providers, to reconcile payments as appropriate and to otherwise administer the bundle. Alternatively, payers can accept responsibility for bundling claims, in which case they too will require new technology. Regardless, payers will need an expanded claim-editing function to ensure payment accuracy and enhanced reporting that monitors provider performance.

Value-based reimbursement presents special challenges to the traditional functions of a health plan, especially when each function operates in its own isolated silo. For example, network management will usually be responsible for developing VBR arrangements and deploying them across segments of the provider network, but claims operations will ultimately be responsible for administering whatever is agreed upon by the health plan and its network. Many forms of VBR require more timely and complete sharing of clinical information among providers and the health plan, which means that information technology departments need to be part of the planning process as well. Because VBR aligns financial incentives across health care organizations, it should also promote more cooperation both within and across organizations to serve the common interests of those organizations’ members and patients.

Improved health information technology is also important to support clinical enhancements (e.g., care redesign and care coordination). Because providers often share financial and clinical risk with health plans under VBR, it is essential that all parties also share information about patients' clinical conditions and the services patients receive. At a high level, health care organizations participating in VBR arrangements need timely access to appropriate clinical information, performance measurement and monitoring, clinically meaningful risk adjustment, and transparent and actionable information that describes provider performance. Ideally, all of this needs to be built on top of a dynamic data warehouse that pools information from multiple sources and then delivers actionable information to providers at the point of care.

On the provider side, the adoption of EHRs is one of the first steps toward VBR. One of the hallmarks of the PPACA is financial incentive to encourage the implementation of EHR systems, because EHR systems serve as the technological foundation for improved clinical data management. Although the adoption of EHRs five years ago was sporadic, the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology recently found that since the 2009 enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act, the percentage of doctors who have implemented EHRs has increased from 48 percent to 72 percent.²⁰

EHR implementation is an important piece of the VBR puzzle — especially in an integrated delivery network — because EHRs enable multiple providers to view and understand what has been done to treat a patient. Providers can make clinical decisions knowing what tests have been performed, what the results were, what prescriptions have been written, and what the current status of the patient is from a comprehensive clinical perspective. Without EHRs, inclusive care coordination would be virtually impossible to achieve. EHRs, in tandem with important information provided by patients' health plans, enable physicians to quickly query all of the data in the system to inform their care plans.

The creation of a shared data asset that supports both payer- and provider-oriented functions illustrates how VBR can reconfigure relationships between payers and providers. Advocates of VBR envision a world in which payers and providers depend on each other and work collaboratively to deliver increased value to their shared customer base. In other words, VBR has the potential to align the incentives of various stakeholders and to blur current distinctions between payer and provider organizations. In the context of a marketplace in which health plans and provider organizations compete more aggressively for covered lives through various types of exchanges, it is easy to speculate on how VBR could radically change the way we organize the delivery of health care services.

Lessons learned: Provider-payer alliances

In Maine, a payer and a provider recently worked together on a Medicare Advantage (MA) program that is similar to an accountable care organization in that the MA program focused on shared data, financial incentives and care management to improve health outcomes for about 750 MA members.²¹ A case study of this arrangement found that the patient population in this program had 50 percent fewer hospital days per 1,000 patients, 45 percent fewer admissions, and 56 percent fewer readmissions than statewide unmanaged Medicare populations.

The case study authors identify the following components of that arrangement as contributing to such success: robust data sharing and information systems that support it, analytical support, care management and coordination, and joint strategic planning with close provider-payer collaboration.²² They note that a provider-payer collaboration "drives both parties to refine and improve care delivery, particularly for members with chronic and advanced illness."²³

Examining the experiences of others that have forged new alliances demonstrates that the recasting of relationships can be difficult but is important to long-term success.

VBR implementation considerations

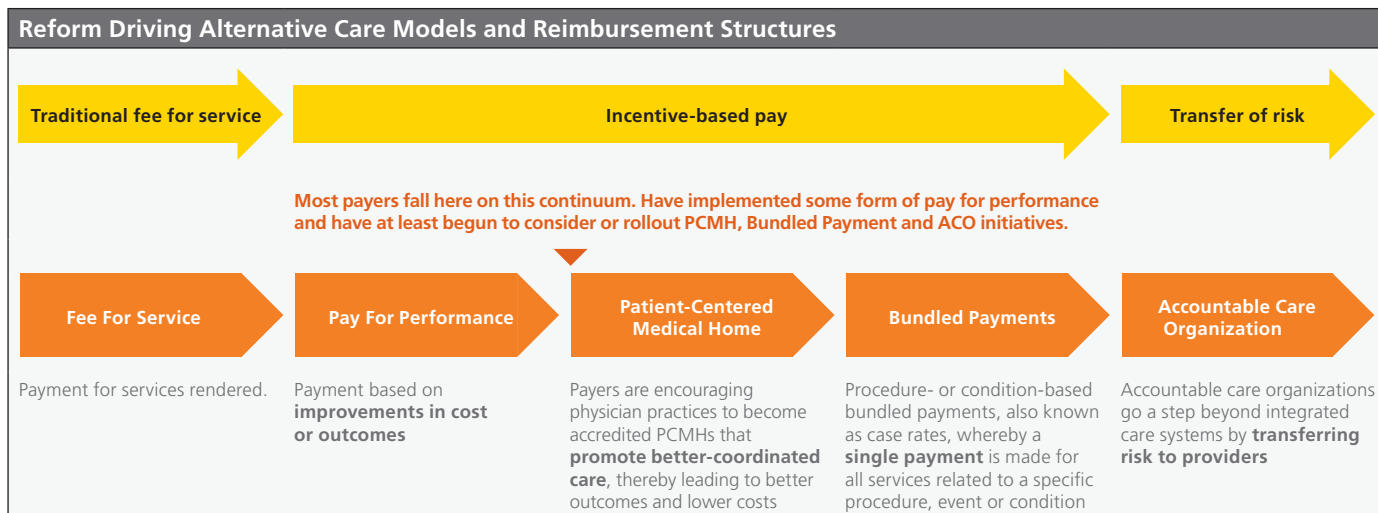
Although plans and providers have been living with such VBR approaches as P4P, prospective payment and various forms of capitation for some time, new challenges — as well as new opportunities — are emerging as VBR gains more traction as a linchpin in PPACA implementation.

That said, the current, modest pace of progress reflects the uncertainty regarding which models would be most effective and the cost of the investments that will be required. Most payers have some experience with P4P. Many have experimented with models that promote coordinated care and high performance. Some are considering or piloting patient-centered medical homes, bundled payment and ACO initiatives. However, the truth is that most health services are still reimbursed under traditional, fee-for-service arrangements.

The payer/provider convergence continuum

Most payers are migrating toward models that promote more-coordinated care and high performance by using new reimbursement models to recast financial incentives and transfer risk to providers.

Figure 3: Traditional fee for service still the most common payment method



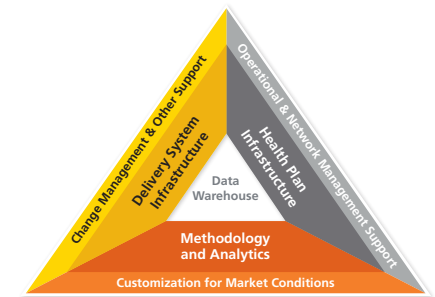
Source: Optum

As health plans assess where and how to deploy VBR models, they need to consider the amounts of clinical integration, organizational integration and financial integration that may be required for success.

- Clinical integration involves population health management and tools (e.g., predictive analytics, patient registries, and provider/member engagement), evidence-based-medicine (EBM) strategies and tools (e.g., EBM methodology and clinical pathways), and clinical decision support tools, such as clinical work flow and outcome variance reporting.
- Organizational integration involves the development of a shared infrastructure that enables payers and providers to collaborate in support of their common clients. Connectivity, performance management, product formation and claims/payment transformation are the main operational elements that must be in place. Without an underlying architecture that enables payers to connect to and share data with providers, the transition to VBR will be difficult. Payers also need measurement and feedback tools, new products (e.g., contracting and risk pricing), and grouping methodology and claims administration.
- Financial integration involves the creation of new work flows and processes to support VBR. Some of the barriers to the transition from FFS to VBR involve simple things, such as processes for preparing and adjudicating claims that bundle services across providers and time. Payers and provider organizations exploring VBR models will need financial and risk management tools to manage the changes associated with risk sharing, including patient financial management, network assessment and risk adjustment.

For example, if a plan's network includes a few relatively large, integrated delivery systems, opportunities for clinical and organizational coordination across the delivery system enhance the chances that a bundled-payment or pay-for-performance model will be successful. Conversely, a plan that does not have a significant concentration of services within its network may not have enough mass to influence the behavior of individual providers. Such plans might want to consider narrowing their network and using a medical home model to encourage at-risk providers to manage cases more effectively.

During a plan's exploration of different options, communication with providers and a steady flow of data and information will be important in making care improvements and building an infrastructure to better manage care at both ends of the care continuum.



There are three primary facets to a comprehensive value-based reimbursement strategy, according to Optum: (1) delivery system infrastructure, (2) health plan infrastructure, and (3) methodology and analytics. Around each element are enabling services that help the elements achieve their VBR goals: change management and other support, operational and network management support, and customization for market conditions. At the center of the triangle are data and information, which enable entities to make informed decisions and analyze results. Shared data assets, according to Optum, represent the core or foundation upon which effective VBR should be based.

For the data and information used in facilitation and support of VBR to be effective, they must be transparent. A plan needs to determine how it is measuring value conceptually (e.g., over entire episodes), whether its measurement process is tightly associated with the payment process, and how broadly it is defining the unit of care for which payment is being made. Operationally, plans must determine (1) whether clinicians should be allowed access to information that improves clinical decision making and (2) the support that exists within the delivery organization to foster new care models.

Changing reimbursement paradigm that requires trial and error

Today, early adopters are in a period of trial and error. Health care organizations are learning what works and what does not work for their populations and markets. The lessons learned will enable the industry to refine current reimbursement and care models and to determine the circumstances under which different models are appropriate.

Optum content experts have experience on both the provider and payer sides of the care equation, and they can act as agents to help health plans understand their options and build on their offerings. As an impartial broker and adviser, Optum brings clients knowledge about (1) tactics; (2) VBR implementation such as performance measurement, architecture and clinical redesign, pricing services and risk management; and (3) the right tools to help them navigate the VBR maze.

For a VBR strategy to work, it has to be built around a plan's business needs, priorities and capabilities. Optum works with plans to understand their preferences and the context within which they operate. Optum also can help a plan lay the foundation for a reimbursement program that will help the plan manage its medical costs while increasing benefits to members. As plans explore which tactic is the best fit for their businesses, the journeys they take will also help them determine ways to differentiate themselves from competitors.

Under the PPACA, reimbursement change is inevitable. Moving toward a value-based system will not be easy or quick, but it will lead to sharper focus on the health of a plan's members and on more-appropriate and cost-effective care. The only way for plans to find out which approach will work best is to start.

About Optum

Optum is an information and technology-enabled health services business platform serving the broad health marketplace, including care providers, plan sponsors, life sciences companies, and consumers. Its business units — OptumHealth™, OptumInsight™, and OptumRx™ — employ more than 35,000 people worldwide who are committed to building sustainable health communities.

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