Which risk-based reimbursement model should my organization tackle first?

The movement toward value-based care is not simply inevitable, but required to ensure a viable health care delivery system.

There is a greater percentage of reimbursement dollars contingent upon patient outcomes—the center of the value equation. Providers are now taking steps to understand how to approach and improve a patient's full episode of care, rather than measuring separate points along the care path. Continuing to drive this industry transformation from fee-for-service to value-based care is the mandate from Health and Human Services (HHS) tying 30 percent of traditional Medicare payments to quality or value through alternative payment models by the end of 2016, and 50 percent in 2018.

The vast majority of our nation's hospitals have taken a "wait and see" approach to the transition to risk-based reimbursement. In a recent survey, 60 percent of surveyed hospitals and health systems said they had not yet begun adopting alternative payment models for value-based care, but they will be in the future.[1] Not surprisingly, facilities with greater than 1,000 beds were on the road to adopting alternative payment models, while those with fewer than 500 beds had not yet started.

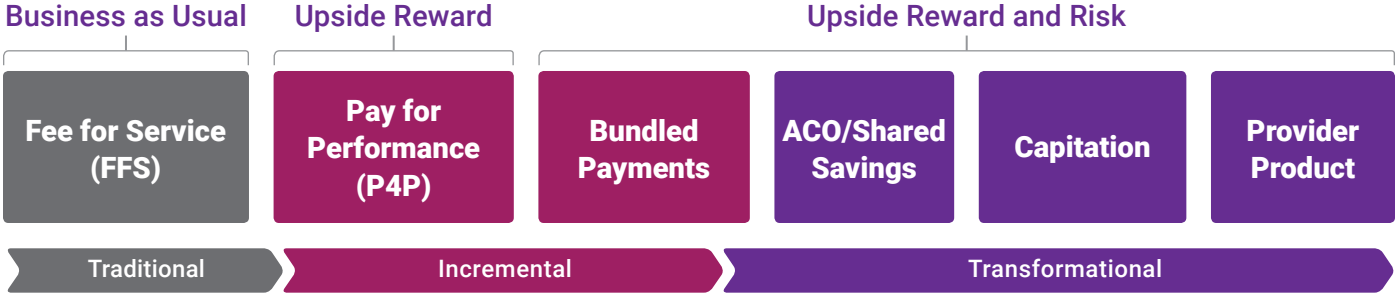
The value-based reimbursement continuum

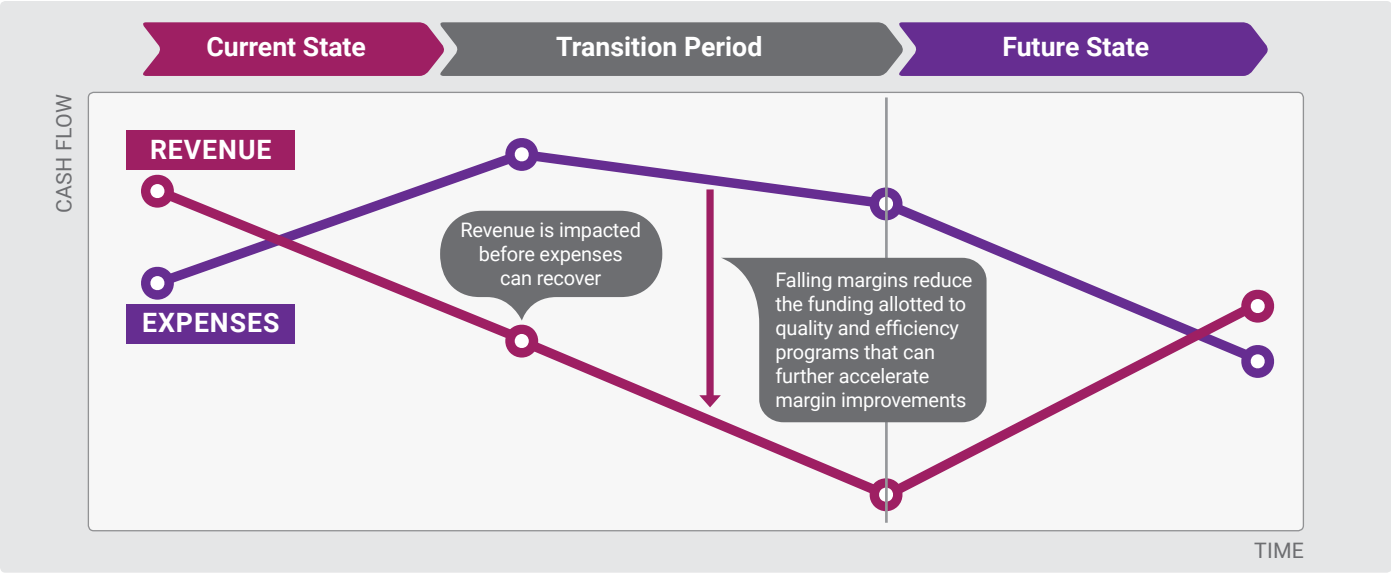
Which care and risk model should an organization undertake to begin their journey? Read on to learn more about various types of risk-based reimbursement models that your organization should consider tackling sooner – rather than later – to begin the inevitable transition to value-based care.

Six types of models

The various risk-based reimbursement models in health care today fall along a continuum, with the financial risks – and rewards – increasing as the integration of clinical resources also increase.

This shift in the health care paradigm is intended to push health systems to reduce costs while offering an improved quality of care. The rationale and belief behind bundled payments as an underlying foundation for value-based care includes:





- Episodic payment is a means of incenting increased coordination of care
- There will be more predictable prices and lower costs to both payer and patient
- Bundled payment will improve overall quality of care

But bundled payments are just one reimbursement model option. Quality improvements require time, and the transition between the current fee-for-service state and the future value-based care state will impact cash flow. The financial impact is in potentially falling margins that reduce funding allotted to quality and efficiency programs that can then further accelerate margin improvements.

Moving too quickly into value-based payment models to support the overall business goals is likely to impact revenue and margins during the transition. A careful consideration of the continuum of six risk-based payment models is prudent because one model may not fit the risk tolerance for every organization.

Fee for Service (FFS)

This model is the most pervasive and the simplest to manage relative to the other reimbursement models. It reimburses a provider directly for a treatment, test or other service provided to a patient, with payment coming from the patient, an insurance company, Medicare or a combination. In this model, a provider's revenue does not increase with improved patient outcomes, but instead with more volume of services. These underlying incentives of the model are now in question, especially with the increased scrutiny on the rising costs of health care.

Pay for Performance (P4P)

This model links a portion of a clinician or hospital's revenue to certain performance criteria, for example setting a target goal for immunizations at a pediatric practice. The provider is reimbursed as usual under FFS, but now can earn a bonus or an increase in future earnings based on their performance on quality measures (or, they may suffer a clawback for not meeting the criteria). This model serves as a good entry point to start tackling value-based care, and requires establishing quality benchmarks, tracking measurements and reporting results.

Bundled payments

These are single payments to providers for all services rendered for a specific condition or procedure, and are often referred to as an episode-based payment or simply "episode of care." The distribution of this payment is not limited to a single health system, but instead to all facilities that participate in the patient's care. This payment can be administered on a prospective or retrospective basis.

The key to this model is that providers assume financial risk for the cost of services related to the index condition or procedure, and the costs associated with preventable complications. There are multiple industry methodologies for episode definition. Additionally, care is coordinated by a principle accountable provider, which acts like the quarterback for the care coordination team. Financial settlement is more complex than FFS because reconciliation of the contracted bundled payment

for services delivered from multiple providers within an episode can be challenging.

As of January 1, 2016, CMS requires mandatory participation in the Comprehensive Care for Joint Replacement (CCJR) bundled payment model, which will modify reimbursement for MSDRGs 469 and 470. Key success factors for these bundled payments include: provider alignment, implementation of the right care design to minimize patient risk, better outcomes and lower spend per episode. Ultimately, controlling costs and resources during the transitions of care from one setting to another will drive success.

The broadest reaching program to date, the Center for Medicare & Medicaid Innovation (CMMI) Bundled Payments for Care Improvement Initiative (BPCI), has more than 6,000 providers participating as of mid-2015. Organizations enter into one of four payment arrangements that represent a range of financial and performance accountability for episodes of care.

ACO/Shared Savings

This model relies on FFS as the underlying reimbursement mechanism and also rewards providers a "share" of savings achieved due to reduced health care spending and improved quality of care. The concept is that – without achieving savings targets – these amounts would have been borne as costs by the payer, and thus are "shared" with providers when achieved.

This model is notably in use by Medicare via the Medicare Shared Savings Program and Physician Group Practice (PGP) Demonstration; both programs are a result of the Patient Protection and Affordable Care Act and are key elements of Accountable Care Organizations as defined by Medicare. Providers that have not yet reduced hospital readmissions, or have a higher than average amount of unnecessary procedures, stand to gain the most from the improvements made under a Shared Savings program. The advantages of Shared Savings programs will likely diminish over time as health care providers continue to achieve quality and cost improvements.

Capitation

A global payment, also known as full capitation, is a single payment to a group of providers for the care that a single patient receives in a specific time period. It is not limited to a specific condition or procedure the way that a bundled payment would be defined. This payment is typically severity adjusted to reflect the patient's health status and needs. Providers are rewarded for coordinating care to reduce unnecessary services and preventable complications.

Global capitation payments often include incentives for providers that improve the quality of care, or the health outcomes of the patient. This model is common in markets with a history of large medical groups or integrated delivery networks, such as California, Massachusetts, and Minnesota. Many staff model plans, like Kaiser Permanente, have used global payments for years with demonstrated results in reducing cost and improving care.

Provider-sponsored health plans

The provider network insures the patient population and assumes the full risk, but also has full control. This model represents the most comprehensive approach to taking on risk and owning the responsibility for delivering value-based care. In addition, as the health plan spans providers beyond the confines of the health system or ACO, it has the potential to generate more revenue per patient than the health system could generate itself.

No action is not really an option

The reality is that if a hospital provider has any patients on Medicare, they have already accepted a form of risk-based reimbursement. With programs from CMS like the Hospital Readmission Reduction Program and Value Based Purchasing, hospitals and health systems are already in the position of receiving penalties and reduced reimbursement related to patient outcomes.

The real risk is in delayed action. By not beginning the iterative process now to reduce cost, improve quality and understand the reimbursement picture across a patient's entire continuum of care, providers are putting themselves at risk to lose market share and volume.

As providers takes on more risk with each of these risk-based reimbursement models, they must improve levels of clinical integration concurrently. Without a clinical transformation driving an improvement in quality and reduction of costs, the financial transformation will not be profitable or sustainable.

The value in value-based care is unlocked with financial and clinical transformation

Winning in this new marketplace requires matching value-driven payment models for cost-effective, high quality services and products.

Already, the move to value-based care has begun to change market dynamics across the US in several ways:

- Commercial payers are establishing narrow networks with those providers perceived as "high value" that offer a high quality of care at reduced costs – excluding providers that do not meet the standards.
- Employers are starting to establish exclusivity with specific high-value providers for specific procedures. A recent example is how Walmart negotiated a bundled payment contract with the Cleveland Clinic for cardiac surgery, covering more than 1 million employees and their dependents on Walmart's health plan for travel to the Clinic, with the company covering deductibles and travel costs.[2]
- Employers have begun setting reimbursement limits on procedures, establishing such "reference pricing" with their chosen health plan. For example, California Public Employees' Retirement System (CalPERS) negotiated a maximum price of $30,000 for hip and knee replacements in its contracts with hospitals.
- Competing health care providers that can offer consumers more transparent pricing and convenience may have a leg up on gaining market share. An emerging competitor that most health systems might not recognize is the largest pharmacy company in the US: newly branded CVS Health. With CVS' recent acquisition of Target's pharmacy and clinic businesses, its reach increased nationwide for both pharmacy services and its MinuteClinic® walk-in medical clinics.[3]

The decision of which risk-based reimbursement model an organization should tackle requires an understanding of market dynamics, identification of the quality and cost measures that need improvement, and the drive to achieve improved patient outcomes with improved clinical integration. With this perspective, providers will be able to accomplish the move to value-based care and remain relevant in their markets in the future.

Source

1 "Healthcare Revenue Cycle Management: 2015," Peer60.com, June 2015. N=122 Providers

2 "Working Together to Contain Costs: What Hospital Leaders Need to Know for Successful Direct Contracting With Employers," Becker's Hospital CFO, June 27, 2014

3 "CVS to Buy 1,600 Drugstores From Target for $1.9 Billion," New York Times, June 15, 2015

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