Value Based Care: Transition Challenges for Providers

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Executive Summary

There doesn't appear to be a yellow brick road to value-based care. With so many different versions of value-based care, it seems more like numerous forks in the road that lead to many different decision paths for providers. A single destination of Emerald City does not exist in the context of value-based care.

The United States has been attempting to overcome its relatively high cost and low-quality healthcare system for many years, yet the transition to value-based care is moving at a snail's pace. In a survey of clinicians, clinical leaders, and executives, 75% responded that payer and provider organizations are either not very or not at all aligned in working toward value-based care (NEJM Catalyst, 2022).

Although it will be difficult to make a meaningful transition until everyone can get on the same page and variations of payment models are simplified, there are steps that providers can take now to improve back-office processes enabled by technology that can accommodate common features across different value-based care programs.

Framing the Issue

The United States (US) healthcare system is by far the most expensive in the world. Yet, the quality of care in the US ranks well at the bottom of the world. Contributors to these problems include the following: significant administrative costs; not having one governing body or healthcare system; a bifurcation between a market justice and social justice approach; and a multiple payer system that is complex and inefficient.

The US spends nearly 20% of GDP on healthcare, and healthcare costs each patient approximately $12,000 per year, on average (Peterson-KFF, 2022). Both key metrics are roughly double the corresponding costs in all other developed countries across the world. The US healthcare performance scores are at the very bottom and far below all other developed countries, with life expectancy in the 70's while all other countries are in the 80's (Peterson-KFF, 2022). Costs are growing at an approximate annual rate of 10% with spending of over $4 trillion per year, of which $1 trillion is spent on administrative costs (McKinsey & Company, 2021). Making change has been difficult due to a fragmented system where half the industry is treating healthcare as an economic good in a market justice system and the other half is treating healthcare as a social good in a social justice system. The country has effectively compromised whereby about half our health insurance is private (mostly facilitated though our employers), and the majority of the other half is provided through government, which is largely in the form of Medicaid for low income and Medicare for elderly.

Despite these challenging performance results and a disintegrated operating structure, many attempts have been made to lower healthcare costs and improve performance through concepts that are broadly referred to as value-based care. The idea behind value-based care is to advance an initiative called triple aim. Most people in the US seem to favor the triple aim

approach that includes the following objectives: improve population health; reduce per capita healthcare costs; and provide better experiences for patients.

Many initiatives have been undertaken to achieve value-based care with formal acts dating back to 2008. However, progress has been slow. For example, only 6.7% of value-based care related payments make up primary care revenue today (MGMA, 2022).

The approach to making a shift to value-based care essentially requires changing how healthcare providers are paid. Today, providers are primarily paid through fee-for-service models that pay a certain amount for providing a certain procedure. For example, Medicare pays $92 for a 20- to 30-minute office visit (a CPT 99213). There are no quality performance measurements in this model, and the model incentivizes doctors to perform as many procedures as possible. Moreover, doctors are only paid to treat the sick with effectively no compensation for keeping patients healthy and preventing them from getting sick. The intent of value-based care is to compensate and reward doctors for improved outcomes, lower costs, increased patient engagement and satisfaction, reduced readmission rates, and helping create overall better health of the population.

Although the objectives of value-based care are seemingly great for everyone, the reason for the slow transition may be that there are too many different structures and methods for payment. Value-based care models come in several different forms.

The general idea for the evolution of value-based care was to go through phases of shared rewards, then to shared risks, and then onto entirely new payment models. Rather than a traditional fee-for-service (specified rate for each treatment) model, new arrangements have been set up such as per-patient-managed fees and bundled payments for treatments to be coordinated across multiple providers. Although there has been some adoption of these models, progress is

limited, and we now have several different models with different payers that are taking different approaches. This has made it challenging for providers to revise their processes and back-office infrastructure to accommodate multiple models that all come with different requirements.

Evolution of Value Based Care

Value based programs arose out of the Medicare Improvements for Patients & Providers Act (MIPPA) of 2008 and the Affordable Care Act (ACA) of 2010. More programs were added that were designed to reward physicians for efficiently providing quality care. The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) and the Merit-Based Incentive Payment System (MIPS) of 2019 were two more formal programs that attempted to advance value-based care, but both came with expanded types of payment models and additional requirements that caused more complications.

The Centers for Medicare and Medicaid Services (CMS) has been primarily responsible for leading value-based care initiatives. Commercial payers often follow CMS, and many have done so with value-based care by introducing new concepts and payment models.

Initially, value-based care concepts offered incentives to improve care with no downside risk. CMS, along with many commercial payers, proposed to share any cost savings with healthcare providers who could lower total costs while meeting or exceeding quality metrics and patient satisfaction thresholds. Shared risk models later arose that had downsides for providers that spend too much or have low patient quality scores. As value-based payment programs became more sophisticated, it led to capitation payments (fixed amount per patient with quality benchmarks) and bundled payments (several different providers coordinating and cooperating on care episodes and treatment plans).

Today, there are many different value-based care models. Most include provider claim reimbursement mechanisms that require much different and several additional measurements than traditional fee-for-service models. Under the new models, providers are incentivized to use evidence-based medicine, engage patients, upgrade health IT, and use data analytics to receive payment for their services by demonstrating improved quality of care that is efficiently delivered. In addition, multi-provider coordination/cooperation models require that providers work across their combined processes and systems to collectively manage each episode. All of this requires significant process changes and system enhancements.

To simplify, the following four categories broadly summarize the primary types of value-based care approaches to physician claim reimbursement that are in place today:

- Shared Savings – Providers are paid a portion of any savings they generate when they come in under budget.
- Shared Risk – Providers are financially penalized for excessive costs and low quality.
- Bundled – A single payment for services provided for an entire episode of care for which providers are at risk if their costs exceed the amount paid. It can be a set amount for multiple providers that must coordinate the care and cooperate on payment.
- Global Capitation – Payment model is based on a fixed fee per period (e.g., per-person, per-month) contract and often covers multiple providers that are responsible for the patients.

Although the four types of approaches listed above tend to be general approaches to value-based care, there are many different payment models, especially when considering the differences payer by payer. This makes it difficult for providers to accommodate multiple payers

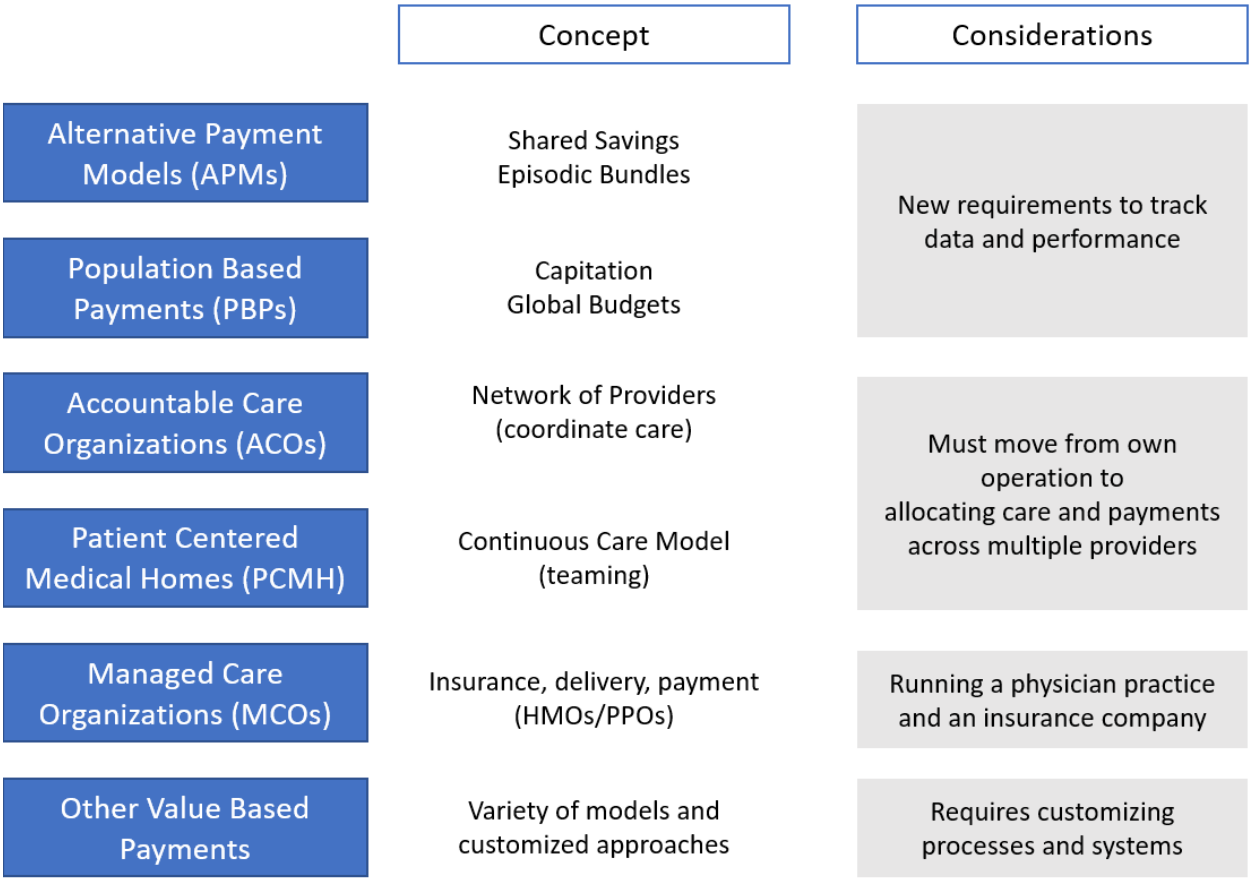
through value-based models, because providers need different processes, performance measurements, and reporting requirements for each model.

Value-Based Care Payment Models

Common value-based care models are highlighted in Figure 1 below. However, these are generally broad categories, and each of these models can include many different variations and often have differences between payers. For example, a CMS offering for a certain type of model can have different features than a same type of model offered by commercial payers, and it could also be different from payer to payer.

Figure 1

Types of Value-Based Care Models



Alternative payment models (APMs) come in a variety of forms as CMS led the way by deploying multiple alternative payment models that increasingly tie Medicare payments to value (quality and efficiency of the care delivered). Commercial payers also have multiple APM offerings. In general, an APM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can be set up for traditional treatment methods or can apply to a specific clinical condition or care episode. APMS are commonly structured in the forms of shared savings arrangements and bundled payments.

A CMS alternative to APMs is merit-based incentive payment system (MIPS), where providers receive performance-based payment adjustments for the services provided to Medicare patients. Participating providers are required to report data to MIPS and in turn receive MIPS scores and payment adjustments (positive, negative, or neutral). Evaluations are based on quality, cost, promoting interoperability, and improvement activities.

Population based payments (PBPs) are models that generally do not include fee-for-service reimbursement features, as opposed to other alternative payment models that tend to build off of fee-for-service structures. PBPs can include condition-specific and comprehensive population-based payment models as well as integrated finance and delivery systems models. The condition-specific population-based payment models are often those that payers reimburse providers through per member per month payments for members with a particular health condition. The comprehensive population-based payment model covers all of the costs of a member's care when that member falls under a member population with a specific condition. The amount of payment is based on expected costs of care for the member population and may take the form of a full or percent premium payment for members in that member population. The

integrated finance and delivery systems model are organizations that are formed to be both the provider and the payer entity, similar to managed care organizations explained below.

Accountable care organizations (ACOs) are networks of hospitals, physicians, specialists, and other combinations of providers that collectively contract with a payer to share the medical and financial responsibility for coordinating the care of an assigned population. The ACA introduced ACOs as another effort to move towards value-based care, and many commercial payers have adopted the concept. ACO contracts are designed to emphasize prevention and wellness through incentive payments and financial risk arrangements and not just rely on payments for treating the sick. ACOs can earn more for delivering care that improves population health, shortens lengths of stay, and ultimately results in care that keeps patients healthy. Typical payments structures are set up for providers to receive fee-for-service payments throughout the performance period. At the end of the period, payers adjust the payments based on the ACO's quality performance on specified metrics. All of this requires coordination on the back-office scheduling, accounting, payment, and collection processes among the various providers in each ACO.

Patient centered medical homes (PCMHs) are typically structured as a care delivery model that coordinates patient care through a primary care physician. The primary physician is responsible to provide continuous care and is designated as the primary contact for the patient. The PCMH provides patients with a centralized care setting that manages the various needs of a patient. Providers deliver patient-centered care, team-based methods, population health management, personal care management, care coordination, and consistent quality care. PCMHs have many different forms of payment models that range from fee-for-service to per-member-per-month to various other types, depending on the arrangement. The business and technology

requirements are similar to ACOs whereby processes and workflows need to consider the full cycle of care across multiple providers and specialties.

Managed care organizations (MCOs) provide both the care delivery and the health insurance financing. MCOs also have many different formats. Common types include health maintenance organizations (HMOs), preferred provider organizations (PPOs), point of service (POS), and exclusive provider organization (EPO) plans. Managed health care plans are health insurance plans that have contracts with health care providers and medical facilities. Payment structures are often set up to share the medical cost financial risks between members, their insurance plans, and members of the managed care network, with a primary care physician appointed to coordinate with all participants in the MCO.

In addition to value-based care models described above that each come with multiple variations, there are also many other types of value-based payment arrangements. For Medicare alone, CMS has several other programs such as hospital value-based care, hospital-acquired condition reduction, hospital readmissions reduction, end-stage renal disease quality incentive, skilled nursing facility value-based purchasing, and home health value-based purchasing programs. Commercial payers also offer many other value-based care models.

In summary, there are numerous value-based care models that can be quite different from program to program. They can also vary from payer to payer. However, there are some common objectives across these models. They generally all appear to be attempting to address our high cost and low-quality results of healthcare in the US. There are steps that providers can take to transform their back-office to enable operating and reporting process that will accommodate many requirements of these value-base care models.

Transition Requirements and Challenges

A primary reason that value-based care has had limited progress over the last 15 years is because there are too many different models. Providers seem to be "throwing up their hands" at the notion of having to try to accommodate different programs that come with different back-office requirements. Their systems were built for fee-for-service models that have workflow processes focused on coding diagnoses and treatments followed by preparing and sending invoices to insurers with these codes. This is regularly followed by extensive back-and-forth in attempts to collect from payers, who are notoriously slow to pay and consistently deny payment for various reasons.

Most providers' traditional systems do not have features that are necessary for various value-based payment models. Examples of missing features are measuring and reporting on quality of health, ability to analyze profitability measures of treatment types for understanding how to evaluate pricing of new models, tools for process and workflow decision support, tracking patient experience scores, and integrating data and operating functions across multiple payer processes and systems. All of this requires capturing data that is generally not captured through traditional systems, computing new performance measurements, performing enhanced analytics and reporting, and the abilities for interoperability across multiple providers' platforms.

Solutions Considerations

The critical requirements that providers need to accommodate value-based care may be prioritized depending on the specialty of the provider along with the design of the existing operating model and infrastructure. For example, primary care providers likely need more interoperability and financial decision support capabilities to be care coordinators that interact with other providers and manage capitation fee payment models, respectively. Alternatively,

some providers have chosen to become affiliated with an organization designed for value-based care that will take care of these needs for them, such as an ACO or MCO. Although this can be a fast and complete switch for a provider from fee-for-service to value-based care, these types of models generally only allow for seeing patients that participate in the program, and it is not for those providers that want to be more independent.

In general, there are key capabilities that providers can build into their back-office processes to make significantly more progress towards participating in value-based care payment programs. These capabilities include:

- Quality Reporting – identifying, capturing, analyzing and reporting key quality performance indicators
- Per-Patient Cost and Profitability Measures – analytical computations on detailed profitability measures to ensure that contracted rates are profitable
- Integration of Systems and Data with Other Providers – ability to share data across providers while adhering to HIPAA standards along with seamless workflow management across operating processes and systems
- Patient Experience Tracking – collections and reporting on patient reviews and satisfaction scores
- Population Health Information Management – information readily available on benchmarks and social determinants with ability to compare performance against standards
- Automated Accounting Computations – relying on computers, rather than excessive spreadsheet-based labor, that can compute GAAP based revenue for different payment models as well as quantify contingent liability exposure of fixed fee payment models

Conclusion

Although there is not a yellow brick road to value-based care, there is a pathway that providers can take to equip themselves for the future of value-based care. Figure 2 presents seven steps that providers can undertake to transform their back-office operations and systems to address most common requirements across the various value-based care payment models. These steps address the capabilities needed (as described above) and will be most successfully accomplished by having dedicated resources to design, implement, and manage these new capabilities.

Figure 2

Back-office Transformation Steps for Value-Based Care

1. Benchmarks and key performance indicators for patient health quality including calculations that measure quality performance payments
2. Understand costs of care per patient and per type of patient to know what per-patient pay rates are necessary to make money
3. Robust and reliable interoperability data to share patient data between providers' systems while complying with HIPAA standards – (e.g., primary care doctor sending medical record to knee replacement doctor)
4. Decision support systems to efficiently manage patient care and maximize quality through systematic workflows and assignment of care personnel – especially in care coordination models
5. Patient experience measurements and tracking
6. Population health data sharing with social determinants information necessary for understanding performance results and benchmarks
7. Revised accounting processes such as GAAP-based revenue recognition requirements that accommodate new payment models as well as how to record liabilities exposure of capitation payments that may be insufficient

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