Value-Based Reimbursement

As opposed to traditional fee-for-service (FFS) reimbursement, which is based on quantity of services provided, value-based reimbursement (VBR) is designed to shift the basis of reimbursement from volume to value by utilizing incentives to improve financial and clinical performance. A true shift to VBR involves not only shifting incentives, but also an emphasis on population health, new partnerships between healthcare organizations, new partnerships between healthcare organizations and payers, and investments in the tools and services to support these new innovative models of care.

The overall objective of VBR is to align incentives, which will lead to lower cost and higher quality of service. In VBR models, the Department of Health and Human Services (HHS) reports that, "healthcare providers are accountable for the quality and cost of the care they deliver to patients. Providers have a financial incentive to coordinate care for their patients – who are therefore less likely to have duplicate or unnecessary x-rays, screenings, and tests."\(^1\)

General types of VBR models include:

- Pay for performance (P4P) is a financial model that links a portion of a provider’s revenue to quantifiable performance standards that can reflect process or outcome criteria.
- Bundled payment is a financial model in which providers accept a prospectively or retrospectively determined price to manage an episode of care.
- Shared savings/accountable care organization (ACO) is an administrative model in which provider organizations collectively manage the health of a defined population.
- Capitation compensates providers based on a fixed amount, generally on a per member per month (PMPM) basis.

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\(^1\) "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value," U.S. Department of Health and Human Services, January 26, 2015, at [http://www.hhs.gov/news/press/2015pres/01/20150126a.html](http://www.hhs.gov/news/press/2015pres/01/20150126a.html). Another model is a patient-centered medical home (PCMH), in which a primary care provider (PCP) or a group of providers is responsible for managing the delivery of services to a defined population.
Overview of Government VBR Initiative

In January 2015, the Department of Health and Human Services (HHS) announced that it set a goal of tying 30 percent of traditional FFS Medicare payments to quality and value through alternative payment models, such as ACOs or bundled payment arrangements, by the end of 2016, and 50 percent by the end of 2018. HHS also set a goal of achieving 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018. This announcement marked the first time in the history of the Medicare program that HHS set explicit goals for alternative payment models and value-based payments.²

Medicare payments through alternative payment models have increased from almost no payments in 2011 to 20 percent of Medicare payments today. Medicare’s announcement represents a 50 percent increase by 2016, doubling the $362 billion in payments in 2014 by 2016.³

HHS Secretary Sylvia M. Burwell seeks to extend these goals beyond just Medicare with the creation of a Health Care Payment Learning and Action Network, through which HHS will work with commercial payers, employers, consumers, providers, state Medicaid programs and their partners to expand alternative payment models to their programs. HHS reported that it would “intensify its work with states and private payers to support adoption of alternative payments (sic) models through their own aligned work, sometimes even exceeding the goals set for Medicare.”⁴

Healthcare Transformation Task Force

The Healthcare Transformation Task Force is an industry consortium comprised of patients, payers, providers and purchasers who are committed to having 75% of their respective businesses operating under value-based payment arrangements by 2020.⁵ The Healthcare Transformation Task Force hopes to provide a critical mass of policy, operational and technical support from the private sector to combine with the work done by the Centers for Medicare & Medicaid Services (CMS) and other public and private stakeholders in order to increase the momentum of delivery system transformation.⁶

The Healthcare Transformation Task Force suggests that value-based delivery and payment systems must be designed to deliver the Triple Aim of better health, better care, and lower costs. The Healthcare Transformation Task Force defines value-based arrangements as “those which successfully incentivize and hold providers accountable for the total cost, patient

² Ibid.
³ Ibid.
⁴ Ibid.
experience and quality of care for a population of patients, either across an entire population over the course of a year or during a defined episode that spans multiple sites of care.”

Work groups devoted to specific issues include:

- **ACO Workgroup**, which “will develop aligned public-private action steps and recommendations to improve the design and implementation of the ACO model in commercial, Medicaid and Medicare programs, including through an organized and coordinated response to the...Medicare Shared Savings Program proposed rule.” 2015 contributions will include policy recommendations for CMS on improving patient attribution, financial stability, quality measurement, and patient engagement; and publishing best practices for ACOs.

- **Bundled Payment Workgroup**, which “will identify and evaluate existing episode-based bundled payment models according to collectively developed criteria and desired outcomes.” 2015 contributions will include 1.) conducting a scan of all bundled payment approaches being used in the public and private sectors, 2.) developing evaluation criteria for measuring the open source and proprietary bundle definitions, and 3.) developing a comparative profile of current bundled payment options.

- **High Cost Patient Workgroup**, which “will identify and evaluate key areas that drive costs for patients in health care systems.” 2015 contributions will include: 1.) Addressing risk stratification of high cost patients and implementation of programs to improve coordination among high-risk integration care programs and assure patient/family-centric care, better outcomes, and lower costs; and 2.) discussing, developing and disseminating best practices for identifying and improving care for patients at the end of life, high-cost events, and patients with multiple chronic diseases, including those with underlying chronic behavioral health, where traditional disease and case management may not be effective.

In 2015, Healthcare Transformation Task Force’s membership included a variety of providers, payers, purchasers, and patients and families, including:

- 6 Payers: Aetna, Blue Cross Blue Shield of Michigan, Blue Cross of California, Health Care Service Corporation (HCSC), Blue Cross Blue Shield of Massachusetts, and New Mexico Health Connections.
- 24 Providers, including hospitals, healthcare systems, a provider association, and an academic medical center.
- 3 Patient and Family Organizations: Community Catalyst, National Health Law Program (NHeLP), and National Partnership for Women and Families.
- 4 Partners: The Dartmouth Institute, Mark McClellan Brookings Institution, Patient Ping, and Remedy Partners.

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8 Ibid.
9 “Members,” at http://www.hcttf.org/members/.
Resources available on Healthcare Transformation Task Force’s website include white papers\textsuperscript{10} as well as numerous comment letters and responses to the Senate Finance Committee, CMS, and the Health Plan Innovations Initiative.

An overview of the major types of VBR programs follows:

**Pay for Performance**

A typical pay-for-performance (P4P) program provides a bonus to providers if they meet or exceed quality or performance measures. P4P may also reward performance over time, such as year-over-year decreases in hospital readmissions. Quality measures include, but are not limited to:

- Process measures: activities that contribute to positive health outcomes for patients, such as whether patients were counseled to quit smoking or whether aspirin was given to heart attack patients.
- Outcome measures: effects on patients, such as whether a patient’s diabetes is under control based on laboratory tests.
- Patient experience: patient satisfaction with their healthcare experience, usually based on surveys. For example, how patients perceived the quality of communication with their physicians and nurses.

The ACA includes provisions designed to improve quality of care, including:

- Medicare’s Hospital Readmissions Reduction Program, which can reduce payments to hospitals that have high rates of readmissions.
- Hospital Value-Based Purchasing Program: hospitals are rewarded for how well they perform on a set of quality measures and how well they improve relative to a baseline. ACA also required CMS to develop value-based purchasing programs for other facility types, including home health agencies, skilled nursing facilities, ambulatory surgery centers, specialty hospitals, such as long-term care facilities, and hospice programs.
- Medicare Physician Quality Reporting System, which provides financial incentives to physicians for reporting quality data to CMS.
- MA plan bonuses, which provide bonuses to MA plans that achieve a specified star rating.

CMS has initiated a number of demonstration projects testing a variety of approaches among different types of providers. Many state Medicaid programs have also experimented with P4P programs. Many private sector P4P programs currently exist.

**Bundled Payments**

Bundled payments provide for a single, “bundled,” payment that covers services provided by two or more providers during a single episode of care or over a specified period of time. For example, if a patient has a cardiac bypass surgery, the payer may combine the payments for a

\textsuperscript{10} \url{http://www.hcttf.org/members/}.
single episode of care instead of making separate payments to the hospital, the surgeon, and the anesthesiologist. Another example is hip replacement surgery, for which a bundled payment could apply to the pre-surgical workup, the actual procedure, and through rehabilitation.

Reimbursement arrangements may vary. In some cases, a single payment may be made to an ACO, for example, which would subsequently apportion the payment among participating physicians and providers. In other instances, the payer may reimburse the physicians and other providers independently, but adjust each payment according to negotiated, pre-determined rules to ensure that the total payments to all providers do not exceed the total bundled amount. The latter type of reimbursement methodology is referred to as “virtual” bundling.

Bundled payments have been used by commercial payers for some time, although they are becoming more popular to apply to a wider array of services. Medicare implemented a Bundled Payments for Care Improvements (BPCI) model of care, which links payments for multiple services that patients receive during an episode of care. The objective of BPCI is to achieve higher quality and more coordinated care at a lower cost to Medicare. BPCI was developed by the Innovation Center and includes four different models.  

Shared Savings and ACOs

The Medicare Shared Savings Program rewards ACOs that lower their growth in health care costs while meeting performance standards on quality of care. Providers continue to be paid for services rendered to Medicare beneficiaries on a FFS basis. In addition, the ACO may be able to receive a shared savings payment. ACOs may choose between two available “Tracks.” Track 1 is a one-sided model in which providers share in the savings, but not the losses, for the first year of ACO participation. Track 2 includes both shared savings and losses. The benchmark is set using historical beneficiary expenditures for Parts A and B services for Medicare FFS beneficiaries assigned to the ACO. A new benchmark is assigned each year and the benchmarks are risk adjusted using the CMS Hierarchical Conditions Categories (HCC) risk adjustment model that was developed for the Medicare Advantage (MA) program, also known as Part C.

Under the Track 1 model, the required Minimum Savings Rates ranged from 2 to 3.9 percent, and under the Track 2 model, the Minimum Savings Rate and Minimum Loss Rate is 2 percent. Therefore, the ACO in the two-sided model shares losses with CMS if the per capita costs for beneficiaries assigned to the ACO exceed the benchmark by an amount greater than 2 percent. ACOs are liable for up to 60 percent of the entire difference between the actual expenditures

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and the benchmark, depending on their quality performance.\textsuperscript{13} ACOs share in savings only if they meet both the quality performance standards and generate shareable savings.\textsuperscript{14}

Modern Healthcare reported in an article titled, “Few Medicare ACOs earned bonuses in 2014,” that, of the 353 ACOs in 2014, Medicare announced that 97 ACOs earned bonuses totaling $422 million, out of $833 million in savings they produced.\textsuperscript{15}

On June 4, 2015, CMS issued a Final Rule that updated the Shared Savings Program in order to encourage ACOs to take on greater performance-based risk, including, but not limited to, the following changes:\textsuperscript{16}

- Allows eligible ACOs to continue participation under the one-side (Track 1) model for a second agreement period;
- Modified Track 2 to allow ACOs to choose from a menu of options for setting their minimum savings rate and minimum loss rate. This same flexibility is extended to Track 3 ACOs; and
- Added a new risk model, Track 3, which offers a higher sharing rate than Tracks 1 and 2 and beneficiaries will be prospectively assigned to the ACO rather than preliminarily assigned to ACOs with a retrospective reconciliation.

CMS also indicated in the preamble to the Final Rule that it intended to propose and seek comment on a new benchmarking methodology to apply to ACOs beginning in 2017 or later because “it is important to move quickly to a benchmarking methodology that sets and updates ACO benchmarks largely on the basis of trends in regional FFS costs, rather than ACO’s historical costs.”\textsuperscript{17}

\textbf{Capitation}

Under capitation, providers receive a fixed, generally per-member-per-month (PMPM) fee regardless of the amount or intensity of services provided. Capitated payments are often used between health plans and primary care providers, but may also be used with specialists, multispecialty medical groups, hospitals, laboratories, and other providers.

\textsuperscript{13} \textit{Ibid.} Losses are subject to loss limits.
\textsuperscript{14} F.R. 32695, Vol. 80, No. 110, June 9, 2015. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule.
\textsuperscript{17} F.R. 32697, Vol. 80, No. 110, June 9, 2015. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule.
Capitation was most popular in the 1990’s when more than half of physicians reported that some form of its revenues were in the form of capitation. Capitation has since declined in popularity. Capitation has been, and continues to be, more prevalent in the West Coast than other parts of the country.

Certain states, such as New York, have implemented standards for financial risk transfer between insurers and health care providers. New York, for example, requires providers to demonstrate financial responsibility with a financial security deposit of at least 12.5% of the estimated annual in-network capitation revenue to be received from the insurer.18

**Blue Cross Blue Shield of Massachusetts’ VBR Program**

Blue Cross Blue Shield of Massachusetts (BCBSMA) was an early adopter of payment reform. In 2009, BCBSMA implemented the Alternative Quality Contract (AQC) model, which reimburses providers based on a risk-adjusted global budget. BCBSMA reports that each AQC agreement has several elements:19

- A global budget, which applies to all of an AQC group’s medical expenses for its population of health maintenance organization (HMO) members, including primary care, specialty care, hospital care, ancillary services, behavioral health, and pharmacy expenses. The budget is adjusted for the population’s health status. The AQC group’s share of the surplus or deficit depends on its performance on the quality measure set.
- Quality performance incentives, in which a group can earn additional revenue based on how well it performs against measures of clinical quality, outcomes, and patient experience. There are incentives for continuous improvement over the five-year contract period.
- Data, reports, and performance improvement support, in which BCBSMA provides each AQC group with data on a daily, monthly, quarterly, or twice a year basis. BCBSMA regularly meets with each AQC group to review performance data and discuss improvement goals and strategies. BCBSMA also regularly convenes AQC groups for educational and best-practice sharing forums.

In 2014, the Harvard Medical School, together with Massachusetts General Hospital, BCBSMA, Tufts University School of Medicine, Beth Israel Deaconess Medical Center, and the National Bureau of Economic Research evaluated the spending and quality measures during the first four years of BCBSMA’s AQC program, the results of which were published in the New England Journal of Medicine, concluding that, “As compared with similar populations in other states, Massachusetts enrollees in the AQC had slower spending growth in the period from 2009 through 2012. Savings were mostly concentrated in the outpatient facility setting and explained by both reduced prices and reduced utilization after 4 years. Improvements in process and

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18 New York State Insurance Department Regulation No. 164 (11 NYCRR 101) Standards for Financial Risk Transfer Between Insurers and Health Care Providers, §101.5.
19 White paper titled, “Massachusetts Payment Reform Model: Results and Lessons,” BCBSMA.
outcome quality in the measured domains were generally larger than those seen outside Massachusetts.”

Included along with this paper is an additional handout on BCBSMA’s AQC program. Also helpful are articles on BCBSMA’s AQC program in the:


Future Movement Towards Implementing VBR in MA Plans:

On September 1, 2015, CMS announced the MA Value-Based Insurance Design model and provided preliminary guidance to MA organizations wishing to participate. CMS will conduct the test model through the Center for Medicare & Medicaid Innovation under Section 1115A of the Social Security Act (42 U.S.C. § 1315a, added by Section 3021 of the Affordable Care Act), which authorizes CMS to test health care payment models that have the potential to lower Medicare, Medicaid, and Children’s Health Insurance Program spending while maintaining or improving beneficiaries’ care. While commercial plans have increasingly used value-based programs, MA and MA/Part-D plans have not been able to do so because of the existing MA “uniformity” requirement that an MA plan’s benefits and cost sharing be the same for all enrollees.

The Value-Based Insurance Design model will begin January 1, 2017 and run for five years in seven states—Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. The model will test the hypothesis that giving MA plans flexibility to offer supplemental benefits or reduced cost sharing can lead to higher-quality and more cost-efficient care for enrollees with the chronic conditions of diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), past stroke, hypertension, coronary artery disease, mood disorders, and combinations of these categories.

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23 The seven states were selected to be generally representative of the national MA market. CMS reported that the seven states have “urban and rural areas, areas with both high and low average Medicare expenditures, high and low prevalence of Low-Income Subsidies and areas with varying levels of penetration of and competition within MA. Test states have also been selected based on the availability of appropriate paired comparison areas for the purposes of evaluation.” See www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-01.html.

Eligible MA plans in the selected states, upon CMS approval, may offer varied plan designs that may reduce cost sharing and/or offer additional services to targeted enrollees based on one or more design modifications:

1. Reduced cost sharing for high-value services;
2. Reduced cost sharing for high-value providers;
3. Reduced cost sharing for enrollees participating in disease management or related programs; and
4. Coverage of additional supplemental benefits.

CMS states that it will rigorously evaluate the model to assess whether it: 1.) improves enrollee outcomes, satisfaction, and out-of-pocket costs; 2.) results in lower expenditures for participating health plans; and 3.) translates into lower bids over time, resulting in savings for Medicare and/or for enrollees.

The MA Value-Based Insurance Design model is open to all qualifying MA and MA/Part-D plans in test states that submit acceptable programmatic proposals to CMS. Only HMO, HMO-Point of Service, or local Preferred Provider Organization plan types are eligible to participate.

**Implementing VBR Programs**

Once a VBR model is selected, it is important for payers and providers to work closely together throughout the process of implementation under VBR. The New England Journal of Medicine article on BCBSMA’s AQC program concluded that, “Going forward, the relationship between payers and providers will be crucial for the success of reforms in payment and delivery systems.”

Similarly, an article published in the Journal of the American Medical Association titled, “Accountable Care Organizations: Accountable for What, to Whom, and How,” emphasized the importance of payer/provider relationships, stating, “It is likely that the success of ACOs (and the many other payment-reform initiatives included in the Affordable Care Act) will depend in large part on whether the Centers for Medicare & Medicaid Services, private payers, physicians, and health system leaders can work together to establish a tightly linked performance measurement and evaluation framework that not only ensures accountability to patients and payers, but also supports rapid learning, timely correction of policy and organizational missteps, and broad dissemination of successful organizational and practice innovations.”

28 Ibid.
Both payers and providers should involve various operational departments during the contract negotiation and implementation process as well as subsequent regular measurement, including:

- **IT**, to ensure that the appropriate software is in place to be able to share data and monitor performance; assist in producing relevant reports to the various stakeholders.
- **Finance**, to ensure that both parties understand the financial aspects, upside potential associated with potential VBR arrangements, and downside risk. Finance departments from both the payer and provider should agree upon the type of data both parties are required to share and the frequency (daily, weekly, monthly, quarterly, semi-annually, annually, etc.).
- **Data analytics personnel**, possibly within the finance team, to ensure that both parties understand and agree to the assumptions and methodologies relied upon in the data models that are used to project performance. Actual to projected performance should be evaluated to determine whether to investigate and address significant deviations.
- **Legal**, regarding contract development (ensuring the terms are well defined), negotiation and implementation.