

Emerging Healthcare Value-based Payment Models for Improving Patient Outcomes and Cost Efficiency

WHITE PAPER / DECEMBER 2018

Table of Contents

Introduction	3
Background	3
Value-based Payments and CMS.....	4
Emerging Value-based Payment Models.....	6
The Healthcare System of the Future	7
Conclusion.....	8

INTRODUCTION

The health insurance industry in the United States is on a collision course. Current costs and payment models are unsustainable. There are gaps in care and variation of quality. Current payment models reward providers for the number of procedures performed rather than for the quality of care provided. In fact, lower quality of care may result in higher payments when factors such as hospital readmissions are considered.

The federal government projects that healthcare spending will increase from \$2.8 trillion to \$4.8 trillion in the next decade. This represents 20% of the US economy. ¹The Affordable Care Act (ACA) is causing the government to require payers to improve outcomes, lower cost and increase access to care.

Health Payers are looking for ways to change their focus from claims payment to being more involved in patient care. This includes focusing on wellness, care management and looking for ways to share the risks involved in payment for services.

This has led to the emergence of value-based contracting models. These models represent an evolution in clinical and payment methodologies aimed at creating better quality and cost outcomes, greater provider accountability, and improving cost efficiency.

This represents a revolution in the healthcare industry. Plans are working to drive business outcomes because evolving regulatory mandates and market conditions are creating both challenges and opportunities. This new paradigm is creating a demand for critical thinking and foresight. The successful plan will use both to create a new type of healthcare system

BACKGROUND

Fee-for-service originated as indemnity health insurance – you get a service, submit your claim, and your insurer covers your incurred expenses. This method of payment has been in place since before WW2.

The growth in healthcare costs led to the advent of managed care and health maintenance organizations (HMOs), which purports greater control over healthcare utilization. HMOs were designed as a method to reduce spending, improve outcomes and slow healthcare costs; however, they failed to meet these goals.

Increased restrictions on care led to a patient- and provider-driven backlash. Eventually less restrictive models of healthcare payment, like Preferred Provider Organizations (PPO), replaced more restrictive closed-network health management organization (HMO) models.²

This has resulted in the conundrum that exists today. Healthcare spending is out of control. The US has the highest healthcare spend in the world but not the highest outcomes. The ACA is dictating that

payers reduce cost and increase quality. The government, like payers, is looking for new ways to accomplish these goals.

There is a prevailing theory that the fee-for-service (FFS) model of claims payment is a major culprit in the uncontrolled growth of healthcare costs.

The amount paid for services is usually negotiated between insurers and providers. For government payers, fees are calculated using specific formulas. There are some restrictions based on coding and medical guidelines, but not outcomes. FFS can be applied across all types of providers equally. There are accommodations for geographic locations and cost of living. FFS is a straightforward, efficient payment method. Providers know what payment to expect for services rendered.

There is little or no consideration for the number of services provided or the quality of care. Paying separate fees for each individual service to different providers of care also facilitates fragmented and uncoordinated delivery of care and accommodates wide variations in treatment patterns for patients with the same condition. FFS provides no safeguard against unnecessary procedures or poor quality of care. In fact, in some cases poor quality of care can result in higher payments to providers. There are no incentives to coordinate care with other providers or to manage care by methods other than face-to-face visits.

These factors have led to the emergence of value-based payments. Value-based payments provide shared savings between providers and payers. They incentivize payers to provide higher quality care, to coordinate with other providers and to be more involved with their patients' well-being.

VALUE-BASED PAYMENTS AND CMS

Medicare is leading the way in the application of value-based reimbursement.

The Affordable Care Act mandated that by 2015, Centers for Medicare and Medicaid Services (CMS) begin applying a value modifier under the Medicare Physician Fee Schedule. Both cost and quality data are to be included in calculating payments for physicians. The following adoption schedule will apply:

- Physicians in group practices of 100 or more will be subject to the value modifier in 2015, based on their performance in calendar year 2013.
- Physicians in group practices of 10 or more providers who participate in Fee-For-Service Medicare will be subject to the value modifier in 2016, based on their performance in calendar year 2014.
- For 2015 and 2016, the value modifier does not apply to groups of physicians in which any of the group practice's physicians participate in the Medicare Shared Savings Program, Pioneer ACOs, or the Comprehensive Primary Care Initiative.
- All physicians who participate in Fee-For-Service Medicare will be affected by the value modifier starting in 2017.

1 Centers for Medicare and Medicaid Services website – www.cms.gov

2 The Atlantic Moving away from Fee for Service [Julie Barnes](#) **May 7 2012**.

CMS will use Quality Resource and Use Reports (QRURs) to determine the value modifier. The QRURs will preview information about a groups' quality and cost performance rates for the value modifier starting with the 2012 QRURs. In September 2013, CMS made available QRURs, based on care provided in 2012, to group practices that had at least 25 eligible professionals. The 2012 QRURs contain quality of care and cost performance rates on measures that will be used to compute the value-based payment modifier. The 2012 QRUR also show how a group's payments would be affected if the group elected the Quality-tiering option.

CMS has established a Medicare Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

The Shared Savings Program is designed to improve outcomes and increase value of care by promoting accountability, requiring care coordination for all Medicare services and encouraging investment in infrastructure.

The Shared Savings Program will reward ACOs that lower their growth in healthcare costs while meeting performance standards on quality of care and putting patients first. Participation in an ACO is voluntary.

The Pioneer ACO Model is designed for healthcare organizations and providers that are already experienced in coordinating care for patients across care settings. It will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Services Program. And it is designed to work in coordination with private payers by aligning provider incentives, which will improve quality and health outcomes for patients across the ACO, and achieve cost savings for Medicare, employers and patients.

The Comprehensive Primary Care initiative is a multi-payer initiative fostering collaboration between public and private healthcare payers to strengthen primary care. Medicare will work with commercial and State health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients. There are 481 participating sites involved in the Comprehensive Primary Care Initiative. This represents 2,347 providers serving approximately 2,559,427 patients, of which approximately 385,016 are Medicare and Medicaid beneficiaries as of August 2014.

The Affordable Care Act established a new [Center for Medicare and Medicaid Innovations \(Innovation Center\)](#) that will test innovative care and service delivery models.

Working in concert with the Shared Savings Program, the CMS Innovation Center is testing an alternative ACO model and the Pioneer ACO Model. The CMS Innovation Center is also testing the Advance Payment ACO Model, which will provide additional support to physician-owned and rural providers participating in the Shared Savings Program who would benefit from additional start-up resources to build the necessary infrastructure, such as hiring new staff or improving information technology systems.

As CMS rolls out and standardizes these programs the commercial world will not be far behind. Plans are struggling to comply with the Affordable Care Act and to make their way in a very different healthcare market than the one to which they are accustomed.

This new paradigm is creating a demand for critical thinking and foresight which is leading to a revolution in the healthcare industry. Health plans are creating opportunities to drive business outcomes, Evolving regulatory mandates and market conditions are creating challenges and opportunities.

The successful plan will use both to create a new type of healthcare system

EMERGING VALUE-BASED PAYMENT MODELS

The Affordable Care Act (ACA) places primary care physicians (PCPs) front and center in the mission to improve the health of Americans, and lower overall healthcare costs. New ACA-derived payment models are emerging that reward value, not volume. In the next two to five years, the shift from fee-for-service (FFS) to value-based reimbursement will be even more dramatic.

Many private payers are now entering into ACO-like contracts with medical practices based on shared savings models. Other payers are paying case rates or a flat fee per patient to help practices develop infrastructure and support for a new system of care delivery. Payers are also contracting with medical practices for bundled payments or flat rates, betting on care coordination as a cost saving measure.

There are five major models emerging: pay for performance, shared savings, bundled payments, capitation, and hybrid models.

- **Pay for performance** models aim to compensate physicians on clinical and cost-saving outcomes rather than being reimbursed for services and procedures. These measures take many forms, including the Physician Quality Reporting System (PQRS) and the Value-Based Payment Modifier offered by the Centers for Medicare and Medicaid Services (CMS). There are many Patient-Centered Medical Home (PCMH) models.
- These models are based upon the fact that PCPs help more patients with managing chronic illnesses. If they are successful in reducing hospital readmissions, unneeded diagnostic tests, and brand-name drugs contribute it will contribute to healthcare savings.
- Pay for performance models reward physicians who can keep track of how they keep patient care
- **Shared savings** models consists of a group of physicians (and possibly other medical professionals), joining together to form an accountable care organization (ACO). An ACO contracts with payers to provide care for a patient population. They are contracted to meet certain quality and cost benchmarks for that population over a set period of time.
- If the ACO can provide care at a lower cost than the predetermined threshold, it shares the savings with the payer. If the care costs exceed the threshold, the ACO absorbs the difference. The ultimate goal is to give the participants a financial incentive for improving patient outcomes and lowering the cost of care.
- The expectations are that providers will provide care that's actually needed versus care that isn't, help manage chronic conditions, reduce administration, improve access and focus on the patient by lower costs and more convenience to the patients.

- **Bundled Payments** allow payers and providers to negotiate fixed payments for episodes of care. Under the bundled payment model, two providers who would otherwise have different incentives would be put under the same budget for risk purposes. For example, if a patient receives a knee replacement, the hospital, the orthopedic surgeon, and the physical therapist would all fall under the same budget.
- These models are based on the premise that coordinating care among different providers and setting a budget will result in more communication between providers discouraging unnecessary care and encouraging coordination across providers.
- In 2013, CMS launched the Bundled Payments for Care Improvement (BPCI) initiative. It's testing four bundled payments models at organizations across the country for 48 different episodes of care, including stroke, congestive heart failure, and diabetes
- **Capitation** involves prepayments to physicians or medical groups for pre-defined services. The compensation is typically calculated based on the range of services provided, the number of patients involved, and the period of time that the services are provided
- Capitation rates vary from region to region because of local cost differences. In many plans, a risk pool is established and money in the pool is collected throughout the year. If the plan does well financially the money is paid to the physician. If it does not, the money is kept to pay the deficit expenses
- Capitation agreement includes a list of specific services that must be provided to patients. Typical services include preventive, diagnostic and treatment services, injections, immunizations, and medications administered in the office, outpatient lab work performed either in the office or a designated laboratory health education and counseling services performed in the office, and routine vision and hearing screening
- Capitation lowers the risk of patients being over-treated since physicians, committed to the aim of reducing costs, and should only be prescribing necessary treatments. The cost of treatment is also lower per patient since costs are shared with other members in the system.
- The last option is to have a **hybrid** model which can incorporate two or more of these models with fee-for-service.
- The hybrid model removes costly steps, such as payers rejecting claims and providers re-submitting claims. It lowers the operational and administrative costs of claims processing. These changes alone should drastically decrease many of healthcare's operational costs. It will also help drive quality and appropriateness of care.

THE HEALTHCARE SYSTEM OF THE FUTURE

Insight, agility, and operational efficiency are watchwords for success as health plans begin to navigate a transformed business environment.

One cannot overstate the need to successfully capture data – both structured and unstructured – and then effectively and efficiently turn it into actionable information. Increasingly, healthcare payers must be equipped to quickly and accurately calculate the potential impact of various reimbursement scenarios as well as changes to membership numbers, demographics, and population health on their business and bottom line.

Timely and actionable information will be essential to managing emerging Value based payment scenarios. Health plans will need to merge claims data with clinical and outcome data to determine the appropriate reimbursement.

For example, CMS is introducing value-based modifiers in 2015 with full implementation by 2017. Providers will be required to submit outcome data which must then be converted to the appropriate modifier. These modifiers will determine if a provider gets the standard payment, a bonus payment or a deduction from the standard payment.

Payers need to act quickly and decisively to implement changes required to administer these payment models or they will not be successful. They need to be able to accurately process claims, apply modifiers, determine outcomes, make incentive payments, distribute capitated payments and continue to evolve new models. They need to be able to scale value-based payments quickly to as many providers as possible in order to realize maximum savings and efficiency.

As such, healthcare payers seek greater agility – including in their IT systems, which support modern enterprises. Specifically, they require the ability to quickly introduce new payment models as well as support efforts to reduce operating costs and take advantage of emerging opportunities.

However, many payers' legacy systems are decades old and require costly and time-consuming hard-coding to make even simple changes, whether configuring plans or adjusting rates. Increasingly, payers seek and require rules-based systems that enable line of business managers to readily make changes to support new processes, requirements, and opportunities.

Not only will IT and analytics play an important role in identifying opportunities for savings and tracking performance, payers will also look to control overall IT costs and seek to focus resources on core competencies.

Driving down total cost of ownership (TCO) is vital as IT teams are increasingly held accountable not only for the cost of initial technology investments but the financial burden of integrating systems, maintaining those complex integrations, and managing and upgrading environments moving forward. As such, payers will be looking to improve overall IT efficiency and gain more predictable costs. A growing number of payers are considering cloud-based solutions for core IT requirements. Reliability, security, and TCO are key considerations when going this route. Payers must carefully consider an organization's reputation as well as the terms of the agreement, which might contain hidden costs related to management and upgrade projects.

As a means to control TCO, healthcare payers are also looking to leverage engineered systems – solutions that combine hardware and software optimized to work together. In addition, many seek more open as well as scalable solutions that can cost effectively expand to meet changing requirements.

CONCLUSION

The landscape is changing rapidly for healthcare payers. In the next decade there will be significant change to the current payment models. This change is being spurred by the Affordable Care Act, but is also driven out of the need for change.

It is not possible for the US economy to sustain the current level of growth in healthcare costs. Currently the US spends more per capita on healthcare than any other country. The US also has the fastest rate of growth compared to gross domestic product than any other nation. Despite all of this, spending and growth in spending the US does not have the best outcomes in the world.

Many attribute the gap between spending and outcomes to the current methods of reimbursement to providers of care. They are incentivized to perform many services but not to coordinate care or drive outcomes.

The emerging value-based payment models are beginning to change this paradigm. In these models there are more rewards for better outcomes and more assumption of risk for providers. The expectation is that these models will prompt providers to follow up with their patients more closely, coordinate care with other providers and to more closely determine the need for procedures.

These models require healthcare payers to have better access to data and tools than they currently possess. Many payers' systems require significant time and effort to modify. Value-based models will emerge and change requiring payers to have agile and open systems to meet the market demands.

Payers will need to merge clinical and claims data to provide the necessary information for accurate payment. Currently this data is self-reported but that will likely change in the next decade. The need for flexibility will be paramount to meet these requirements.

Total cost of ownership will also be a factor. In order to reduce healthcare costs it is necessary to decrease administrative fees. Models need to emerge that are less expensive to administer. Many payers will look to new delivery methods such as the cloud instead of owning hardware and software.

The only certainty is that change will continue to shape the healthcare market. The successful payer will be able to meet that change head on by having insight, agility and operational efficiency.

ORACLE CORPORATION

Worldwide Headquarters

500 Oracle Parkway, Redwood Shores, CA 94065 USA

Worldwide Inquiries

TELE + 1.650.506.7000 + 1.800.ORACLE1

FAX + 1.650.506.7200

oracle.com

CONNECT WITH US

Call +1.800.735-6620 or visit oracle.com/insurance. Outside North America, find your local office at oracle.com/contact.

 blogs.oracle.com/insurance

 facebook.com/oraclefs

 twitter.com/oraclefs

Integrated Cloud Applications & Platform Services

Copyright © 2018, Oracle and/or its affiliates. All rights reserved. This document is provided for information purposes only, and the contents hereof are subject to change without notice. This document is not warranted to be error-free, nor subject to any other warranties or conditions, whether expressed orally or implied in law, including implied warranties and conditions of merchantability or fitness for a particular purpose. We specifically disclaim any liability with respect to this document, and no contractual obligations are formed either directly or indirectly by this document. This document may not be reproduced or transmitted in any form or by any means, electronic or mechanical, for any purpose, without our prior written permission.

Oracle and Java are registered trademarks of Oracle and/or its affiliates. Other names may be trademarks of their respective owners.

Intel and Intel Xeon are trademarks or registered trademarks of Intel Corporation. All SPARC trademarks are used under license and are trademarks or registered trademarks of SPARC International, Inc. AMD, Opteron, the AMD logo, and the AMD Opteron logo are trademarks or registered trademarks of Advanced Micro Devices. UNIX is a registered trademark of The Open Group. 1218

White Paper Emerging Healthcare Value-based Payment Models for Improving Patient Outcomes and Cost Efficiency
December 2018



Oracle is committed to developing practices and products that help protect the environment

ORACLE®