Drivers of Market Change: Value-Based Payment Reform

"Value-based purchasing (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures in an effort to achieve better value by driving improvements in quality and slowing the growth in health care spending." [1]

Industry leaders and policy makers have long argued that a major cause of the quality and cost problems in U.S. healthcare is that payment systems encourage volume-driven rather than value-driven care. Under the traditional Fee-For-Service (FFS) payment system, providers are paid for each service performed and therefore have a strong financial incentive to deliver more services to more people, leading to increased total expenditure without regard to quality or necessity of the services performed. This system creates a perverse incentive where providers are "penalized" for providing better care and preventing sickness because they will not be paid if services are not performed. Research has shown that more services and higher spending do not result in better outcomes and can often even be harmful. [2]

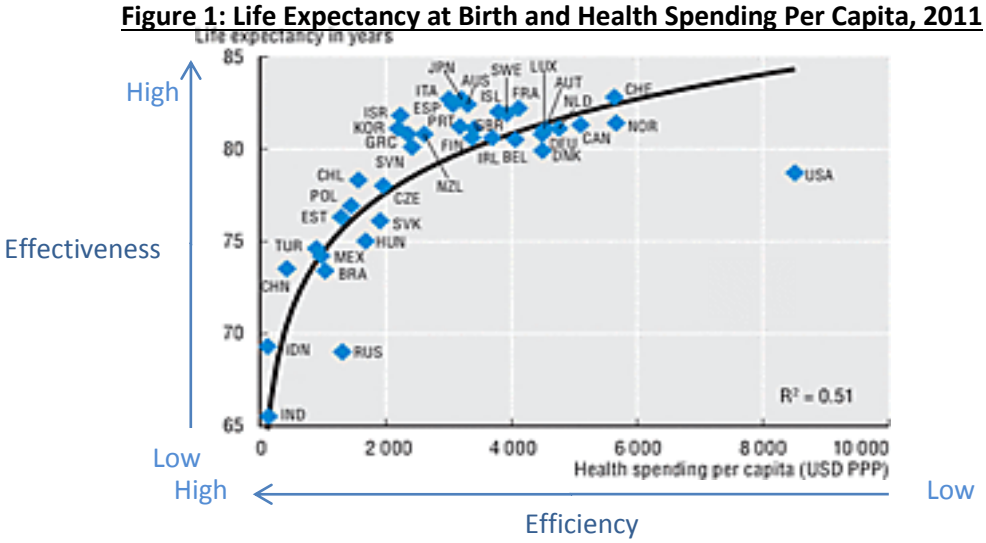
Over the last few decades, payors and providers have been experimenting with new approaches to reimbursement that aim to improve the quality, efficiency and overall value of care by providing financial incentives to providers to carry out improvements and achieve optimal outcomes. **While studies of these programs have yielded mixed results, the continued financial pressures and quality gap remaining in healthcare are pushing payors and providers to move forward with new transformation models even in the absence of compelling evidence**. Some even describe the value efforts as an "arms race" to see who can achieve the greatest payment reforms most rapidly. [3] Most stakeholders are betting that the value-based strategies will be successful in the end and many blame the difficult and expensive transition time for the lack of results to date. Many also argue that the fragmented approaches of different payors make it difficult to fully transform clinical operations since a value-based model with one payor may contradict the financial incentives to perform more services for their FFS models with other payors.

History of Value-Based Reforms

Payors attempted to improve the efficiency of care delivery in the 1990s by moving towards managed care contracts that aimed to reduce excessive or unnecessary care. However, these models focused exclusively on cutting costs without regard to the quality factor of the value equation. By the early 2000s, the Institute of Medicine published two major reports highlighting serious concerns about the quality of U.S. healthcare[4]. These reports served as a major impetus to begin measuring and rewarding value and public and private payors began to experiment with value-based payment strategies. However the slow, fragmented, and varied approaches led to little improvement in valuable care.[5] Faced with continuing financial pressures on the industry and a significant gap in healthcare value compared to other developed countries[6] ***(as illustrated in Figure 1)***, the Affordable Care Act of 2010 aimed to push forward more radical reforms for a more coordinated and complete transformation of care delivery focused on value.

[1] Rand Corporation, "Measuring Success in Health Care Value-Based Purchasing Programs." March 2014. (link)
[2] NRHI/Robert Wood Johnson Foundation, "From Volume to Value." November 2008. (link)
[3] Delbanco, Suzanne. Health Affairs Blog, "The Payment Reform Landscape: Overview." February 2014. (link)
[4] ACMQ Medical Informatics Forum, "IOM Reports Composite Summary." (link)
[5] Health Affairs, "Health Policy Briefs – Pay for Performance." October 2012. (link)
[6] The Commonwealth Fund, "Mirror, Mirror on the Wall, 2014 Update." June 2014. (link)

Figure 1: Life Expectancy at Birth and Health Spending Per Capita, 2011



Source: *OECD Health Statistics 2013*; World Bank for non-OECD countries. (link)

Models of Value-Based Payments

While the Affordable Care Act aimed reforms at Medicare and Medicaid payments, both CMS and commercial payors are moving forward and adopting new payment models. Without significant evidence of which models are more effective than others, the industry is still in a relatively experimental phase with new models being innovated and tested constantly. Many early program designs have evolved over time to include a broader set of measures for cost and quality performance and larger financial incentives to impact physician behavior.

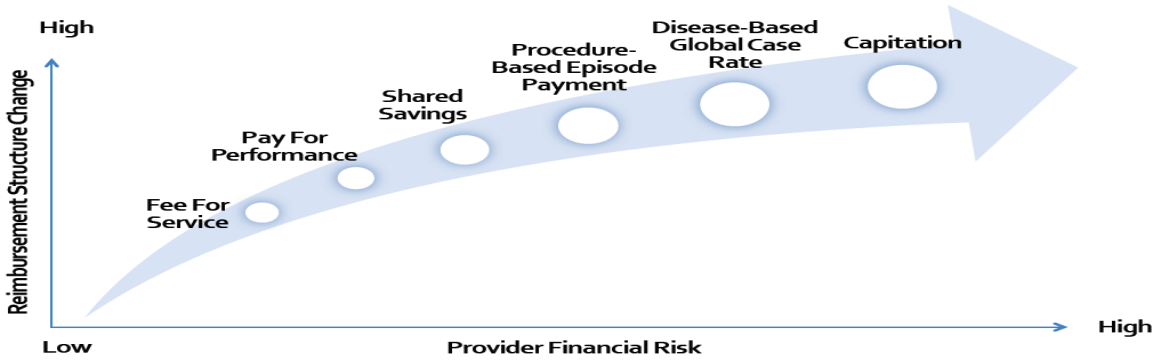
Assessments of current models often agree that a method of payment can only be considered value-based if it addresses both the efficiency and quality components of care. **Though there is no consistent evidence to date, popular opinion in the industry is that the success of reducing costs increases as the provider takes on more financial risk**. As financial risk progressively shifts from the payor to the provider, the provider takes on more responsibility for controlling excess costs and promoting quality of care. Financial risk includes two distinct types of risk[7]:

- **Severity Risk** is the risk related to the degree of complication in treating each patient's illness/injury. When a provider takes on severity risk, they take on the financial risk of the cost of treating each patient case that exceeds the budgeted payment for that treatment.
- **Incidence Risk** is the risk that an illness/injury will occur in a population. When a provider takes on incidence risk, they take on the financial risk of excess costs if the incidence of illness/injury exceeds expectations and the resulting total cost of services provided to the population exceeds the budgeted pool of payments.

While the possibilities for payment reform models are broad, most models can be categorized along a continuum that varies based on the reimbursement structure change away from Fee-For-Service and the level of total financial risk assumed by the provider.

[7] American Academy of Actuaries, "An Actuarial Perspective on Accountable Care Organizations." December 2012. (link)

Figure 2: Evolving Payment and Risk Structures



Adapted from National Quality Forum (as presented at Pay For Performance Summit 2015)

Details of the payment structure and application of each model of payment seen in Figure 2 can be found in the Appendix.

Current Status & Future Goals

Despite the modest evidence of success, the entire healthcare industry appears to be committed to moving ahead with payment reforms towards value-based healthcare. Many concerns have been voiced about the difficulty of transforming care delivery when payment reform is slow and fragmented but recent advancements and goals announced in both the public and private sector signal that value-based payment reform is forging ahead.

In January 2015, CMS announced a commitment to continue moving forward with value-based payment reforms and set a goal to have 85% of all Medicare FFS payments tied to quality or value, with 30% specifically in alternate payment models such as ACOs and Bundled Payments. By 2018, those goals increase to 90% and 50% respectively. Currently, ~80% of Medicare FFS payments are tied to value, primarily through Pay for Performance programs, with 20% in alternate payment models.[8] These alternate models include 405 ACOs in the Medicare Shared Savings Program and 19 ACOs in the Pioneer ACO program.[9] CMS also announced that it will create a Health Care Payment Learning and Action Network designed to help private payors, employers, consumers, providers, states, Medicaid partners and others to expand alternative payment models.[10]

In the private sector, insurers and employers are also moving ahead with payment reforms. The latest update from Leavitt Partners in July 2014 counted 284 Commercial ACO contracts. [11] **The 2014 National Scorecard on Payment Reform**

Figure 3: National Scorecard on Payment Reform - 2014

Payment Model	% of Total Commercial Payments
Pay for Performance	12.8%
Shared Savings (1-Sided)	2.0%
Shared Risk (2-Sided)	1.0%
Bundled Payment	0.1%
Partial Capitation	1.6%
Full Capitation	15.0%
Other Value-Based Arrangement	7.5%
Total Value-Based Payment	**40%**

Source: Catalyst for Payment Reform

[8] HHS Press Office, "Better, Smarter, Healthier." January 2015. (link)
[9] Evans, Melanie. Modern Healthcare, "89 ACOs Will Join MSSP in January." December 2014. (link)
[10] Mangan, Dan. CNBC, "Big Change: Feds to Tie More Medicare Payments to 'Value'." January 2015. (link)
[11] AAFP, "ACOs Flourishing in 2014, Study Reports." July 2014. (link)

released by the non-profit organization Catalyst for Payment Reform (CPR) found that 40% of commercial sector payments flow through value-oriented payment methods linked to quality or designed to cut waste, which reflects a dramatic increase from the findings of 11% in 2013. [12] **A detailed percentage breakdown of these payments by type is shown in Figure 3**. Following the CMS announcement in January, 6 of the largest health care systems and 4 of the largest payors, joined by purchaser and patient stakeholders, announced the formation of the Health Care Transformation Task Force dedicated to accelerating transformation and committing to put 75% of their business into value-based arrangements by 2020. [13]

Impact & Implications

It is becoming increasingly clear that the industry will continue to move towards **"value",** but there is still much uncertainty remaining around which models will be successful. Many stakeholders in the industry are beginning to discover that a major hurdle to value-based reform and evaluating the success of payment models is the difficulty in defining value. Since the majority of early programs have focused on primary care and prevention, some progress has been made in identifying process of care measures and total cost per member measures that help to define value in this realm. However, there have been limited experiments in payment reform in acute and specialty care to date. **In cancer care specifically, there have not been any clear or consistent definitions of value in any attempted payment reforms**. Attempts thus far have focused quality assessments primarily on process of care measures, without consistently defining or measuring outcomes. Furthermore, cost assessments have been based on incomplete DRG-based accounting, which underestimates cancer care costs by excluding cancer-associated procedures that are coded outside of the oncology service line (i.e. surgical procedures), and often rely on drug costs as a proxy. Trying to keep pace with industry changes, payors and providers appear to be moving forward with "value-based" reforms in oncology even without a good definition of either cost or quality to guide value measurement.

A major risk of the lack of adequate value definitions is an emphasis on cost without quality measurements and a resulting commoditization of cancer care. If providers set "total prices" for bundled treatments, the risk arises that competing providers will simply undercut the price of that same treatment and devolve into a price war where quality will eventually suffer.

If providers continue down the path of risk-bearing arrangements, they may eventually evolve to fully capitated arrangements where populations of patients are allocated to a specific provider network for total care. Since these arrangements often require or prefer patients to remain within the "network", patients may have limited ability to access other providers.

While implementation has so far been fragmented and seen minimal success, full adoption of value-based payments in the future has the potential to transform the healthcare industry and reengineer the way that cancer care is delivered.

[12] Delbanco, Suzanne. Health Affairs Blog, "The Payment Reform Landscape: Value-Oriented Payment Jumps, And Yet." September 2014.(link)
[13] Health Care Transformation Task Force, "Major Health Care Players Unite to Accelerate Transformation of US Health Care System." January 2015. (link)

Appendix: Value-Based Payment Models

- **Pay For Performance** programs pay providers on a normal FFS schedule but set specific annual quality targets and provide a year-end bonus for meeting or exceeding the target and/or conversely impose financial penalties where providers must refund a portion of the payments received through FFS if they fail to achieve the quality or cost savings goals. The percentage of total reimbursement that is tied to the incentive or penalty is considered "at risk."

  Several examples have proven that P4P programs can improve quality but the model often does little to contain costs and improve affordability. This model tends to be seen as a relatively easy starting point for providers with little or no experience in value-based payments to begin focusing on quality and a stepping stone to move towards efficiency and models with more financial risk. [14]

- **Shared Savings** programs pay providers on a normal FFS schedule throughout the year but the providers are held responsible for the total annual cost of care for the defined patient population through retrospective reconciliation to a benchmark, target, or control group cost. Shared Savings agreements also have defined quality targets to ensure that appropriate care is being delivered and cost savings are not the result of limiting necessary care. Even if costs are below threshold, providers often must meet the quality target to be eligible to receive the bonus. While risk is shared with the payor, the providers in this model begin to accept both severity and incidence risk which affect the total cost of care for the population. Risk arrangements can be structured as one-sided or two-sided.
  - **1-Sided (Upside Only):** If the providers maintain costs below the established threshold, they are eligible to receive a substantial portion of the generated savings as an annual bonus.
  - **2-Sided (Upside & Downside):** Providers are eligible for upside bonus described above but conversely are penalized to refund the excess payments if total costs instead exceed the threshold. These arrangements typically offer proportionately larger potential bonuses in exchange for taking on risk.

  The Shared Savings model is expected to help control total costs and improve value more than Pay for Performance because providers begin to take on risk and consider efficiency of care in addition to quality. **This model appeals to newly formed ACOs who are learning to coordinate care and manage costs without taking on full risk. However, early experiences with the model have found it ineffective in its current form because of the difficulties of benchmarking. If saving is calculated based on comparison to prior performance, the system actually rewards low performers who have more "excess" costs to save from the benchmark while it penalizes high performers who are already operating efficiently and have little possible savings from past performance.** The program is unsustainable if providers are able to improve efficiency to a point where year over year savings do not qualify for incentives and they are no longer rewarded for high performance. [15] Most stakeholders see Shared Savings as another stop along the path to further risk with providers using it as a transition period and taking on higher risk with the potential for higher reward once efficiencies are reached.

- **Procedure-Based Episode Payment** is still built on the Fee For Service structure of pricing per services delivered but considers the total cost of the group or "bundle" of services needed to provide a given treatment. In this model, providers agree to a target price for the total bundle of services and assume financial risk if the cost of the treatment exceeds the bundle price. Risk in bundled payments includes only

[14] Health Affairs, "Health Policy Briefs – Pay for Performance." October 2012. (link)
[15] Center for Healthcare Quality & Payment Reform, "Is Shared Savings the Way to Reform Payment?" (link)

severity risk or variance for each individual case and does not include incidence risk. [16] While the concept is consistent, the timeline and method of payment can vary among different arrangements.

- **FFS With a Cap** – Target price is pre-determined but provider is paid on a FFS basis throughout the treatment. FFS payments discontinue if cap is reached and provider becomes responsible for the excess cost.
- **Retrospective Reconciliation**– Target price is pre-determined but provider is paid on a FFS basis throughout the treatment. At the end of the treatment period, total costs are reconciled to the target price and the provider is responsible for repaying excess costs or is rewarded the difference if costs were below the target.
- **Prospective Payment**– Provider is paid one up-front lump sum of the negotiated price and is responsible for any costs in excess of this payment or keeps the profit if costs are below the payment.

Procedure-Based Episode Payments are best suited to certain types of care that are common and have easily identifiable start and end points, such as joint replacement or labor and delivery. Episode payments show promise in integrating care around a specific treatment and standardizing quality and cost of the treatment since providers assume full risk above the target and are therefore incentivized to prevent adverse events that drive up costs and reduce quality. **Episode arrangements seem to be the best fit to specialty care or major procedures and can often be carved out of other total cost of care models that focus on primary care and prevention. However, the primary concern with procedure-based episode payments is the risk of commoditization and price-cutting if quality is not well defined.** Additionally, while the model helps to reduce excess costs from adverse events or duplicative services within a treatment, it does little to prevent the adverse incentives of FFS if there is no control on overuse of episodes and providers are still incentivized to perform more procedures.

- **Disease-Based Episode Payment (Case Rate)** includes all covered services to treat a patient for a single illness or condition regardless of selected care pathway. This model is intended to standardize outcomes and total price of treating a disease rather than standardizing process or treatment pathway. Providers agree to a target price for total treatment of the disease and assume financial risk if the cost of the treatment exceeds the target price. Risk in this model includes only severity risk or variance for each individual case and does not include incidence risk. While this model is based around a total disease rather than a specific procedure, payments can be structured in the same ways as the Procedure-Based Episode Payments described above: FFS with a Cap, Retrospective Reconciliation, or Prospective Payment. [17]

  Disease-Based Episode Payments are best suited to chronic or complex diseases that require ongoing care from specialists. This model works best for providers that are more centralized and vertically integrated so that all care delivery included in the disease treatment can be effectively coordinated and managed without duplicative services. This model is often touted as the best way to reform payment for complex diseases and standardize outcomes and costs associated with different care pathways for a disease, but difficulty in defining a price and implementing this model has prevented adoption and there are few examples to provide evidence of success. Similar to procedure-based episode payments, this model still continues the concern of overuse of episodes but can also be combined with or carved out of a total cost of care model that focuses on primary care and prevention.

[16] Delbanco, Suzanne. Health Affairs Blog, "The Payment Reform Landscape: Bundled Payment." July 2014. (link)
[17] Healthcare Incentives Improvement Institute, "Evidence-Informed Case Rates." (link)

- **Capitation** refers to a "per capita" payment or a fixed dollar payment per covered beneficiary for all care that beneficiaries may receive in a given time period. In this model, providers take on full incidence and severity risk and are responsible for services provided to the covered population that exceed the pool of payments or keep the profit when the payments exceed the total cost of care. Capitation requires a large enough covered population to help protect against incidence risk.

  As long as capitation is paired with quality measurement to ensure that necessary services are not withheld from patients as a method to control costs, this model is often seen as an end goal of payment reform where providers are fully responsible for the management of cost and quality of care delivery and the perverse incentives of "sick care" in FFS are eliminated and providers are able to focus on maintaining health of the population. **Since this model requires providers to control total care delivery, it works best for providers in integrated, well-managed systems with sufficient infrastructure to support care management. In order to control total care, capitation also necessitates that providers be able to keep patients from seeking care outside the network either through lack of competition in the area or exclusive insurance coverage through a "narrow network" plan that does not cover care outside the network.** [18]

[18] Evans, Melanie. Modern Healthcare, "Reform Update: Capitated Payments More Acceptable to Providers, Survey Finds." October 2014. (link)