First Steps in the Era of Value-Based Health Care Purchasing

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Practice Area: Health Law & Health Intellectual Property

In health care, where disagreement can be found far more often than agreement, payers and providers appear to have accepted the inevitability of value-based health care purchasing. Payers of all kinds are beginning to shift payments away from traditional fee-for-service reimbursement, and toward pre-set budgeted amounts aimed at population health management. However, this shift in reimbursement is happening incrementally in most markets, and achieving any meaningful provider involvement in value-based initiatives is proving to be as difficult and complex as most of us expected.

As of May 2012, virtually all of the major commercial payers in the United States have begun value-based provider contracting. UnitedHealthcare, Anthem, Humana and many others are rolling out pay-for-performance programs that attempt to limit unnecessary utilization, while also incenting quality. But even these small-step initiatives are not occurring without difficulty. Why is value-based contracting so challenging, and how can providers best navigate through these largely uncharted waters? This update outlines several of these challenges, including self-funded payers' concerns over funding pay-for-performance initiatives, the source and accuracy of payer-specific performance data, and variation in metrics between payers. This update also offers suggestions for providers as participation in value-based initiatives becomes more and more prevalent.

Retroactive Funding
Providers should understand the difficulty associated with retroactive funding of pay-for-performance initiatives by self-funded payers. In many markets, large national carriers will be administering both insured and self-funded health plans. This split makes payment of retro-funded incentive dollars (e.g., shared-savings) difficult because self-funded payers are not ready or able to accurately accrue bonus payments based on prior services rendered.

To illustrate this difficulty, let us assume a simple shared savings program offered by a payer will distribute 50% of the dollars saved if a defined population's per member per month costs fall below a specified target for a certain time period. If the time period measured is calendar year 2012, final cost calculations will not be prepared until several months into 2013. If one-half of the payer's health plans are self-funded, this means that approximately 50% of the shared savings dollars should be paid by self-funded plans (e.g., large employers who fund their own claims, but use the payer to administer the claims).

Generally, self-funded employers will not have dollars set aside in June 2013 for health care services provided to their employees and dependents during calendar year 2012. Even if self-funded employers endorse value-based purchasing in concept (which many do), it is difficult for them to accurately estimate such shared savings bonus payments.

Over time, as value-based performance metrics and funding arrangements become more standardized, sophisticated third party administrators may be able to help self-funded entities estimate these amounts. But for now, self-funded entities are reluctant to agree to uncertain future payment expectations, and this reluctance is slowing the development and implementation of retroactively funded value-based initiatives.

Payer-Specific Performance Data
Most self-funded entities also do not have sufficient covered populations to generate payer-specific performance data and outcomes. For example, a physician working under a value-based contract with a large payer may have hundreds of attributed patients, but only a handful from any one self-funded employer. As a result, the physician's performance could be based entirely upon interactions with patients who are not covered by a particular self-funded plan.

Despite this fact, payers are currently requesting that self-funded entities contribute bonus dollars based on the number of members attributed to physicians participating in value-based initiatives. Such requests can cause problems for self-funded entities (many of whom have a fiduciary duty to ensure that plan assets are used for the exclusive benefit of the plan's participants), when a requested bonus payment is based largely or entirely upon provider encounters with patients who are not even covered by the self-funded entity at issue.

The Resulting Dilemma: Limit Value-Based Contracting or Proactively Fund Performance?
Today, the inability to effectively incorporate self-funded plans into retroactively funded value-based contracting initiatives limits what commercial payers can achieve in the short-term. They must either restrict their value-based contracting to insured or Medicare Advantage blocks of business or find ways to proactively fund or reward performance.

One example of the latter approach used by a large, national payer involves tying providers' future fee-for-service reimbursement increases to prior performance. For example, if a provider performs well on mutually-determined quality and/or efficiency metrics in a current time period, that provider's "trend" or per unit reimbursement increase in the upcoming year will be enhanced. This way, self-funded payers can "share" in the funding of the bonus dollars. Unfortunately, with this funding mechanism there is no direct connection between the value-based savings achieved by self-funded payers in a prior year, and the monies subsequently paid out by self-funded payers in current and future years.

Data and Metrics for Providers
To the extent commercial payers are willing to fund value-based initiatives with their own money (i.e., without material contributions from self-funded plans), such initiatives are primarily based on efficiency (i.e., cost reducing) metrics rather than quality metrics. As a result, the data used to measure performance comes mainly from the payers' claims systems, and not from providers' clinical data sources.

Therefore, providers should take steps (e.g., via contract language) to identify the source(s) of the performance data and secure reasonable audit rights. Providers must also be sure to evaluate any baseline performance data from which improvement targets will be set. And if at all possible, providers should attempt to negotiate the use of their own data when appropriate metrics are used. For example, providers can use their own data to measure performance under clinical quality metrics such as diabetic bundles (e.g., hemoglobin A1c testing, LDL-C screens, and eye exams performed), and under quality/efficiency metrics such as readmission rates (i.e., assuming readmissions at all facilities are not required to be included), and average lengths of stay.

Providers should also seek to limit variations in metrics between and among payers. When feasible, providers should establish the same or similar metrics in all payer agreements. Medicare-participating providers should negotiate the same measures that are already drawing administrative time and attention due to the Medicare-based initiatives mandated by the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General. Recently, CMS has prioritized measures that assess outcomes (e.g., hospital acquired conditions and readmissions), chronic conditions (e.g., diabetes, coronary artery disease, and congestive heart failure), and coordination of care (e.g., coordination of Part A and Part B services including multiple co-morbidities and end of life care). Providers will perform best when they are measured on the same, non-payer-specific criteria.

In addition, while keeping in mind the goal of reducing or controlling the cost of health care, providers should evaluate whether the bonus dollars that are reasonably available from a payer bear any similarity to the revenue lost plus the resources expended in administering the specific value-based initiative. Some payers' value-based offerings possess no rational proportionality between avoided health care costs and the incentive dollars available to providers. Consequently, providers should take steps to protect themselves by negotiating contract terms that create bonus opportunities which are reasonably tied to the actual dollars saved by the payer(s).

Looking Forward
Today's value-based initiatives are largely temporary. Shared savings will eventually disappear as efficiencies are identified and realized. Only so many generic prescriptions can be written before every generic drug that can be substituted has been prescribed and dispensed. Providers that can maximize their performance under value-based, shared savings, and pay for performance contracts right now will at least have a share of the reward. Eventually, value-based purchasing will take the form of bundled payments and population management within pre-set budgets. While providers may not see a return to straight capitation, various forms of significant financial risk are coming, and today's forays into value-based contracting are helpful and necessary preparations for that future.

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