Preparing for Value-based Reimbursement
Deborah Walker Keegan, PhD, FACMPE

We are in the midst of a massive experiment in the U.S. to determine the "best" reimbursement method for physicians for the future. The most recent National Physician Payment Reform Commission Report (March 2013) calls for the end of fee-for-service reimbursement in the next five years. We are moving to value-based reimbursement in a material way, requiring medical practices to adjust their financial and delivery system processes to work in this new space.

Each of the following reimbursement methods is currently in experimental or trial stages with payers and medical practices:

- Pay for performance
- Pay for cost and quality
- Shared savings
- Bundled payment
- Episodes of care
- Case rates

Value Contracts

Many of the payers are entering into ACO-like contracts with medical practices based on shared savings models. A shared savings model is an intermediate vehicle for reimbursement – once the savings have been wrung out of the system there won't be much left to share. (Thus, there may be early entrant advantages for some practices that participate in shared savings models in the near-term.)

Other payers are paying case rates or a flat fee per patient to medical practices to help them develop the infrastructure and support for a new delivery system of care. They articulate their expectations for care and case outreach, 24-7 access, and virtual medicine as they work to create the delivery system of the future.

Still others are contracting with medical practices for bundled payment or flat rates for a defined episode-of-care. These payers are banking on care coordination as a cost savings tool, with the hospital and physicians working together to improve quality at a lower cost.

Evaluating Cost

The payers are now working to compare the cost of one medical practice to treat a diagnosis, perform a procedure, or manage an episode of care with another practice conducting the same work. As an example, one of the payers determines the regional average cost for an episodic treatment group. It then compares your medical practice's cost with the regional practice expected cost and calculates an efficiency ratio for your group. So, for example, let's say the peer average cost for a certain procedure is $3,500

and your practice did 100 of these procedures. Your practice expected cost is $350,000. The payer then compares your actual cost to the expected cost and calculates your efficiency score. Let's say your costs are $400,000. Your efficiency ratio is $400,000 divided by $350,000 in this example, or 1.14 which signals that your practice is less efficient than the regional average. Based on this efficiency ratio and how your practice scored on defined quality measures, the payer places your group into Tier 1 or Tier 2. If your practice is identified for Tier 1 patients are effectively incented to seek care from you, as they will be required to pay less out-of-pocket for copayment and coinsurance. This approach to value-based reimbursement serves to "steer" patients to Tier 1 groups.

The Morphing of Payers

BIG DATA is driving many of the payers to resemble large information technology firms. They now have readily accessible data and business analytic tools to analyze outcomes and cost of care via multiple technologies, including electronic health records, practice management systems, claims data, and patient satisfaction surveys. The ability to combine all of this data and apply business intelligence will likely drive many decisions in the future as we move to evidence-based care and value-based reimbursement.

Beyond a focus on business intelligence, some payers are purchasing medical practices; others are purchasing health care delivery systems; and still others are merging, effectively shaking out the payer market. Some payers are also working in joint collaboration with physicians and health systems to effectively integrate the financing and delivery of healthcare.

Timeline for Value-Based Reimbursement

The transition from payment for volume to payment for value will likely proceed in stages, rather than via a turnkey approach. That said, in 2015 the value-based modifier is scheduled to go into effect for large medical practices treating Medicare patients, with full implementation targeted for 2017. This will transition reimbursement from pay for volume to pay for value, differentiating reimbursement to physicians based on quality and cost (once risk-adjusted and geographically adjusted). The value-based modifiers will be budget-neutral, meaning that some practices will be paid more than others for the same services based on their quality and cost scores.

The commercial payers are not waiting for Medicare to lead the way. They are proceeding aggressively in their payer contracting negotiations to transition to a value-based world. The payers appear to be proceeding market-to-market and practice-to-practice at the present time so the transition to value will be faster in some markets than others and proceed payer by payer.

Prepare for the future now:

1. Improve your business intelligence. Understand your costs and outcomes by diagnosis, procedure, episode of care and revenue stream.
2. Become proficient at PQRS. This is the launch platform selected for Medicare's value-based modifiers. By participating with PQRS a medical practice can master the learning curve for increased quality and cost reporting with a reasonable number of measures – before many more measures are added.
3. Create a value plan. Tackle the "low-hanging fruit" that we already know has been targeted, such as generic prescribing, reducing preventable emergency department visits and reducing readmissions within 30 days.
4. Expand patient access to care. Develop your Web portal for patients, expand care outside of the physical constraints of the exam room via secure, email messaging, telehealth and other venues.
5. Promote your value – to patients, to payers, and to employers. Make sure your community understands who you are, what you do, and how you provide value in the marketplace.