



VALUE-BASED PAYMENTS

October 2017

OBJECTIVE

The goals of VBP are to link provider payments to the cost and/or quality of health care services.

KEY FACTS

Benefits of VBPs include: improved quality of health care services, provider incentives to keep costs down, improved state Medicaid budget certainty, and reduced Medicaid spending.

STATUTORY REFERENCES

Patient Protection and Affordable Care Act (ACA) of 2010 created the Innovation Center within CMS to test different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) modifies how Medicare payments are tied to the cost and quality of patient care and promotes provider participation in alternative payment models.

Senate Bill 7 (821), 2011 requires HHSC to report on quality based payment models in hospitals.

Senate Bill 7 (83R), 2013 provides for payment reform in Medicaid.

Senate Bill 200 (84R), 2015 directs HHSC to create a pilot to encourage use of value-based payments by MCOs.

Value-based Payments (VBP) are alternative methods to the traditional fee-for-service model used to reimburse health care providers (e.g. physicians, hospitals, clinics, etc). VBPs are structured to incentivize providers to deliver quality care in the most cost effective manner. Historically, health care payments to providers rewarded volume (e.g. more care is better care) over quality. VBPs incentivize health care providers to focus on patient-centered goals, such as preventative care and patient outcomes. A subcategory of VBP is Alternative Payment Models (APM). CMS differentiates between VBPs and APMs by specifying that APMs have shared risk and large value-based incentives that drive health care delivery systems to evolve.

THE ROLE OF THE INSPECTOR GENERAL AND ALTERNATIVE PAYMENT MODELS

New payment methods bring new opportunities for fraud, waste, and abuse (FWA). As the payment structure for health care services continues to evolve so does the need for the methods to detect it. Some VBP methods, like APMs, rely heavily on data and technology (e.g. electronic health records) to inform not only MCO and provider payments, but to monitor health care quality and patient outcomes. Federal and state entities, like the OIG and HHSC, must ensure that data collected and used in new payment models is timely, accurate, complete, and secure because its use will be vital to ensuring accurate payments and ensuring quality services are provided.

VALUE-BASED PAYMENTS AND HOW THEY WORK

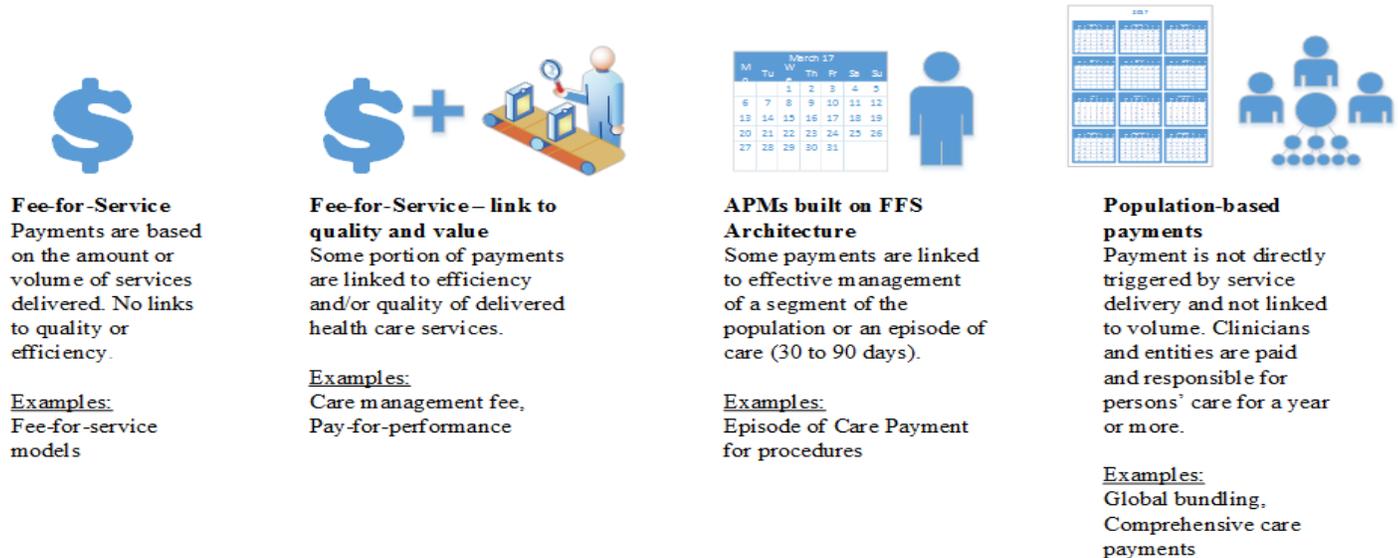
Numerous methods exist to reimburse health care providers for the services they deliver. On one end of the continuum is the fee-for-service (FFS) reimbursement model that pays providers per service provided without any incentive or link to quality or efficiency. At the other end of the continuum are VBPs that hold providers responsible for the management of a population's health over a period of time. In between both ends are various combinations that seek to improve client access to care, improve quality of care, and reduce government health care spending. Figure 1 shows the payment model continuum and examples of each payment model. Several VBPs are in use across the country resulting in wide variation in payment approaches in state Medicaid systems. Below is a summary of six VBP models in use:

- (1) A **care management fee** is an additional amount of money paid to a provider or entity that acts as patient-centered medical home and agrees to deliver services not typically covered in a FFS model. These services may include patient education, coordination of care for patient transitioning from one setting to another, medication management, and care planning. In this model, the provider or entity is paid a per member per month fee to help cover the cost of care that does not occur during a traditional office visit. The goal of the care management fee payment is to improve patient outcomes (e.g. improved medication adherence, improved self-management of chronic conditions, and increased patient satisfaction) by assisting those patients who need additional attention or help due to diagnosis, age, or other factor.
- (2) **Pay-for-Performance (P4P)** is a payment model designed to financially reward managed care organizations and/or providers that demonstrate improved performance by meeting or exceeding certain goals or benchmarks. The goal of a P4P model is to incentivize providers or entities to provide preventive services, improve clinical outcomes, and increase satisfaction.

In this model, outcome measures, benchmarks or other evaluation methods are used to determine if the provider or MCO earned the additional P4P payment. Some states incorporate a P4P model in Medicaid MCO contracts. For example, a state may withhold part of an MCO's capitation payment, but allow the MCO to earn it back by meeting predetermined benchmarks or other measures.

Figure 1: Centers for Medicaid and Medicare Services Payment Framework, 2016.

Source: Centers for Medicaid and Medicare Services (CMS)



(3) **Shared Savings Arrangements** require a provider organization or other entity to meet pre-established performance or quality measures and reduce costs to certain groups of patients within a specified time period, usually one year. Savings may be determined by comparing the actual costs for a group of patients to a pre-established benchmark using historical cost and/or utilization data. With this model, organizations are not penalized if benchmarks are not met.

(4) **Shared Risk Arrangements** are similar to shared savings arrangements except participating provider organizations also share in the risk of this payment model. In other words, they not only share the savings, but also share the costs with an MCO or other entity when savings are not achieved. For example, if the actual costs of providing care to a group of patients exceeds the pre-established benchmark, then the provider organization is responsible for a portion of these costs.

(5) An **Episode of Care (EOC) Payment (i.e. bundled payments)** is a pre-determined amount paid to providers for a set of services to treat a specific health event of a patient (e.g. knee replacement) over a specified period of time, usually between 30 and 90 days. The payment, typically, is for multiple services delivered by multiple providers. The EOC payments are based on established clinical protocols and can be adjusted to take into consideration differences in patients. The payments can be made to providers on a prospective or retrospective basis. Using a prospective method, the payment is made based on a pre-determined fixed amount, while the retrospective method requires the actual expenditures of the cost of care to be reconciled against the pre-determined amount which can result in providers sharing in the savings or expenses.

(6) **Global Payments** are a pre-determined amount paid to a provider to deliver the health care services a person needs over a defined period of time, typically, one year. The payments may be adjusted to take into consideration the variation in patients' age, gender, diagnoses, or other characteristics and may include safeguards and rewards for underutilization and high performance, respectively.

FRAUD, WASTE, AND ABUSE IN VALUE-BASED PAYMENT MODELS

Identifying FWA in VBPs and APMs will be a new challenge for federal and state Medicaid program integrity entities. One component in MACRA requires federal officials to research and report the effect APMs will have on current FWA prevention and detection efforts in the Medicare program. The study will analyze whether federal fraud prevention laws apply to items and services that are provided through an APM, identify APM vulnerabilities to FWA, and make recommendations for improvement. To date, the report has not been published.