Payers — Get Ready for What’s Next with Payment Reform

WHITE PAPER
What is Payment Reform?

Discussion about healthcare payment reform typically centers on the move from a fee-for-service (FFS) reimbursement model to a value-based reimbursement (VBR) model. VBR has emerged as an absolute requirement for the U.S. healthcare system because the fee-for-service model does not incent either providers or members to manage the costs of treatment and achieve positive outcomes. With FFS, the more tests a provider orders, the more the provider gets paid. With this reimbursement approach, it is no wonder that healthcare costs, health insurance premiums and deductibles are spiraling out of control. Total healthcare costs in the U.S. are now at 17.8 percent1 of the Gross Domestic Product (GDP), and growing each year.

Value-based reimbursement is a significant change — a disruptive, financial incentive framework that requires providers to keep people healthy and achieve positive outcomes while controlling spending. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), a bipartisan federal legislation that was signed into law in April 4, 2015, establishes the parameters for VBR for Medicare Part B reimbursements and provides a measurement period to prepare for MACRA reporting and compliance, which began in January 2017, with payments starting in 2019. MACRA provides a framework that focuses on alternative payment models (APMs) for quality care improvements. According to The Centers for Medicare and Medicaid Services (CMS),2 APMs are “specific value-based payment (VBP) arrangements or initiatives that represent a meaningful shift away from the traditional volume-driven provider payment model and toward population-based provider payments such that the provider is accountable for both cost and quality of care for beneficiaries.” MACRA will affect clinicians, health systems and health plans, and while the rules for compliance and compensation begin with Medicare, the law is written with intent to expand to Medicaid and commercial contracts, ultimately impacting all provider reimbursements.

Will the New Administration Impact VBR Implementation?

The short answer seems to be no — VBR appears to be politics-proof. While Republicans and Democrats vehemently disagree on many elements of the Affordable Care Act (ACA), the Republican commitment to develop patient-centered reform is not expected to impact the previous administration’s commitment to VBR. MACRA was approved by a 92-8 vote in the Senate and 392-37 in the House of Representatives, clearly demonstrating bi-partisan support for the legislation.

In a recent Medical Economics article,3 Gary Herschman and Kevin Malone of Epstein Becker & Green, one of the largest healthcare law firms in the U.S., comment, “Although a full repeal of the ACA would likely slow implementation, the trend toward greater adoption of value-based payment (VBP) will almost certainly continue unabated...Absent major changes by the Trump administration, most importantly MACRA, VBP will continue to be a major factor in the Medicare and Medicaid programs.”
**How Are Insurers Responding?**

According to McKesson’s *Journey to Value, The State of Value-Based Reimbursement in 2016:*[^1]

- Payers report they are 58 percent along the continuum towards full value-based reimbursement, a 10 percent jump since 2014.
- 61 percent of health insurers expect VBR to have a positive financial impact on their organizations.
- 74 percent of health insurers report tracking improvements in patient outcomes.

The nation’s largest health insurers say they are paying out almost half of their reimbursements via value-based care models. Here are some examples:

- 45 percent[^5] of UnitedHealth Group’s $115 billion in “total annual medical spend” is based on VBR.
- Anthem has more than 43 percent[^8] of payments tied to shared saving programs, with a goal to hit 50 percent by 2018.
- Approximately 63 percent[^9] of Humana’s membership is served within a value-based care environment.

Obviously, many health insurers are well on their way to executing to value-based care payment models.

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**Are You Ready for Whatever Comes Next?**

Change will come in many forms, whether it is regulatory reform, a change in the commercial arena, a new competitor coming into your territory, or an opportunity to open a new line of business. If you have not started to prepare your organization to address these changes, you should start now!

CMS has a stated goal of tying 50 percent[^10] of payments to quality or value models by the end of 2018. MACRA is firmly in place even with a new administration in Washington. And, commercial insurers are aggressively pushing value-based reimbursements in their provider networks. For these reasons, every payer must prepare themselves with a set of capabilities and business model changes that will successfully transform the way they pay their providers. And payers must start now because the next round of contracting with your providers will be tying payments to outcomes and quality measures.

**How One Insurer is Working on The Shift to Reform**

Medica, a healthcare payer that serves 1.7 million members and provides coverage to employers, third-party administrators, and government programs in multiple states, has been using APM components in government programs and commercial business since the early 2000s. In fact, Medica has already embraced the necessary technology to transform their core administration and care management systems and has achieved remarkable results: an increase in operational efficiency, improvement in first call resolution and auto adjudication rates, reductions in nurse reviewer times and customer service training times. For payers who are just starting the journey, Medica executives offer the following suggestions:

- Develop your own APM strategy
- Align your strategy with that of your key providers
- Directly engage your provider partners around MACRA
- Identify ways you can help enable their adoption using data and analytics

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– Gary Herschman and Kevin Malone

Epstein Becker & Green
Align a quality focus to your providers’ MACRA strategy based on that data.

Make “performance” a part of the assessment of providers.

Technology — An Important Part of the Equation

The reason VBR can now happen is because the technology is available to support it. Here are the four technologies that payers need to consider to transform to VBR:

> Workflow and automation is important because you need to automate, automate, automate every manual process to lower costs. However, before you automate, you must transform your current processes to rapidly adapt to new payment models and roll out Line of Business (LOB) and benefit designs quickly.

> Analytics provide key insights regarding both individual and population health assessments, chronic conditions, and necessary measures.

> Payers and providers must share critical, actionable information in real time.

> The combination of core administration and care coordination technology systems helps stakeholders use clinical data, provider network information, and cost implications to make informed decisions about care delivery.

Final Thoughts

Payment reform is at the core of the move to value-based care and value-based reimbursements. From data collection to analytics that help us better understand leading indicators, and innovative programs that keep members healthy while effectively treating those with chronic conditions, payers need to help providers see “beyond the visit” and treat the whole member. Focusing on outcomes constitutes a major shift for the entire healthcare system and payers must lead the charge to ensure not only their own business survival, but the survival of a cost-effective healthcare delivery system.

For more information, visit: healthedge.com or call: 781-285-1300

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