VALUE-BASED PAYMENTS

Overview of value-based payments.

Delaware aspires to make substantial improvements in health, health care quality and patient experience, and affordability of health care over the next several years. The strategy for achieving these goals includes transitioning to value-based payment models that will reimburse clinicians for more holistic coordination of care and link compensation to achieving defined and measurable goals related to access, continuity of care and clinical outcomes. Practice transformation support for practices is intended to accelerate progress towards successfully implementing care coordination, securing continual care coordination funding and adapting to new value-based payment models. This document provides an introductory overview of the basic elements of these payment models (note that it does not represent the Delaware Center for Health Innovation's position on specific design decisions).

The two types of value-based payment models for primary care are pay-for-value models and total cost of care models.

Pay-for-value (P4V) models enable clinicians to earn bonuses for meeting both a set of quality measures and managing resource utilization. Payers are likely to engage clinicians in contract discussion on design elements of their pay-for-value programs. Some clinicians may already be participating in existing pay-for-value programs through commercial payers.

Total cost of care (TCC) models reimburse clinicians for controlling growth in the per capita total cost of care including primary care, medical care, behavioral health care and pharmacy. This model will be most relevant for larger practices, including those that are affiliated with a health system or Accountable Care Organization (ACO), and some clinicians may already be expecting to participate in the Medicare Shared Savings Program.

ELEMENTS OF PAY-FOR-VALUE MODELS

Pay-for-value models link reimbursement to improvements in quality and better management of utilization for a panel of patients, primarily based on the metrics defined in the Common Scorecard. Key elements of pay-for-value models include:

Bonus payout schedule: Clinicians may earn bonuses for performance on a set of quality measures and resource utilization (e.g., ER visits, inpatient admissions, generic dispensing rate, specialist visits). Bonuses may be tiered for existing level of utilization efficiencies.

Quality: Demonstrated performance on quality metrics will play a critical role in participation and success in new pay-for-value models. Quality requirements may be used to qualify practices for bonus payments. Key elements of quality elements for pay-for-value models include:

- Metric baseline: Baselines may be calculated from data sources such as claims or medical records, performance on the Common Scorecard, or national or statewide averages.
- Performance benchmarks: Performance may be measured against an absolute goal by meeting a fixed threshold or closing the gap to a fixed threshold by a certain percentage. Performance targets may be determined against a practice's own baseline, their peer group or national/statewide averages.
- Minimum metric requirements: Minimum metric requirements may be set as a certain level of performance on quality standards or based on a top percentile of PCPs in a designated region.

Weighting of measures: Bonus payments may be driven by quality metrics, utilization metrics or some weighting of both metrics (e.g., practices may have a weighted index score across all "accountable" metrics, for a certain percentage of predefined metrics, for a certain percentage of self-selected metrics).

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ELEMENTS OF A TOTAL COST OF CARE PAYMENT MODEL

Total cost of care (TCC) models link reimbursement to improving quality and better managing costs (with the savings shared between payers and clinicians). Key elements of TCC models include:

Quality requirements: Payers may define some minimum quality requirements to qualify for shared savings payments.

Calculation of total cost of care: Payers will define the subset of costs to be included or excluded from this calculation (e.g., medical, behavioral, pharmaceutical, managerial costs, care coordination fees).

Minimum panel size: Payers may define a larger minimal panel size to ensure that all savings have not been achieved by chance (e.g., 5,000–10,000 attributed patients per payer).

Shared savings structure: There are multiple options for the percent of total savings or losses that could accrue to the clinician. Shared savings could be asymmetrical or "upside only" (e.g., 30–50 percent of savings that are achieved against the benchmark). Shared savings could also be symmetrical "upside and downside" (e.g., 85 percent of savings that are achieved, as well as 85 percent of cost increases against the benchmark). Typically, the greater level of shared savings from participation in a symmetrical payment model reflects the greater risk assumed by clinicians in that approach.

Minimum savings rate (MSR): Some shared savings programs may require that savings or losses be greater than a set MSR in order for clinicians to share in savings or risks. Savings may be distributed beginning at the first dollar or beginning at the incremental dollar above the MSR.

Maximum savings/losses: Some shared savings programs may deem that clinicians are not responsible for savings or risks above a certain threshold (e.g., 10–15 percent of total cost of care).

COMMON ELEMENTS OF VALUE-BASED PAYMENT MODELS

Value-based payment models typically include the following common elements:

Panel definitions: Performance and cost metrics for value-based payment models will be calculated based on a defined panel of patients.

- Attribution method: Patients may be attributed to a clinician for purposes of measuring and rewarding performance. Patients may be attributed by selecting or being assigned to a practice or clinician at the beginning of a year. Claims-based data may also be used to attribute patients to the clinician or practice who managed the greatest share of their primary care over a defined time period or during the performance period.
- Minimum panel size: Payers may define a minimal panel size to ensure actuarial soundness. Payment programs may define a minimum panel size for inclusion in the program overall and may specify a minimum denominator for a quality or utilization measure to be included in payout calculation. Smaller panel sizes are more likely to be adopted for utilization measures than for quality measures since they are less susceptible to chance.
- Aggregation: Clinicians may choose to aggregate to achieve minimum panel sizes and/or share capabilities. Payers may define criteria for provider aggregation (e.g., agreements with ACOs).

Quality requirements: Minimum performance on defined quality metrics may be used to qualify providers for participation in select payment models. Distinctive performance on defined quality measures may be used to inform reimbursement for clinicians.

Baseline definition: Payers may evaluate performance and/or costs in the current year against a baseline in a defined period (e.g., one-year, two-year, three-year, regional average).

Benchmark trend: Benchmark trends may be applied to costs or performance baselines to account for anticipated trends or changes. Benchmarks may be calculated from a historical average, a budgeted/negotiated trend, a local ambient trend or a national ambient trend.

Risk adjustment: Performance or costs may be adjusted for differences in patients' health status and treatment needs.

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