As payers seek to manage rising healthcare costs as well as reform legislation and address employer dissatisfaction with the status quo, many are considering new provider-reimbursement models that reward the value, not volume, of care delivered.

Value-based reimbursement (VBR) models that fit local market conditions can improve quality and reduce costs by altering the incentives for volume-driven care and reducing unwarranted variations in care. Properly designed VBR models also can help payers establish or improve payer-provider collaboration, get ahead of government mandates, and satisfy employer demands for more effective and innovative benefit options. Successful VBR programs require automation, which enables payers to achieve scale and efficiency.

Payers cannot be successful without meaningful and deep provider support and collaboration. From the beginning, therefore, VBR must be a provider strategy as well as a payer strategy.
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Executive Summary
For decades, the fee-for-service model has rewarded U.S. healthcare providers primarily for the volume, not the effectiveness, of the services they deliver. Medical costs now exceed 17% of gross domestic product. National healthcare spending in 2009 grew 5.7%, up from 4.4% in 2008, further evidence of a healthcare affordability crisis. In response, employers, at-risk commercial insurers, and the government increasingly are pursuing a new approach to provider reimbursement—one that emphasizes value.

Value-based reimbursement (VBR) is a category of reimbursement methods that reward physicians and other providers for taking a broader, more active role in the management of member health and pays them for results instead of solely for visits or procedures.

This paper discusses the power of VBR to enable payers and providers to meet market demand for value and the potential of VBR to address key challenges associated with healthcare reform. The discussion is supported by results of research commissioned by TriZetto in 2009 and 2010 and conducted by an independent research firm. The research assessed key healthcare stakeholders’ views of VBR and other topics.

VBR models seek to use reimbursement as a lever to change the way providers deliver care, improving quality as well as cost-effectiveness. Many forms of VBR involve shifting clinical and financial risk from payers to providers when providers are better-positioned to manage that risk. In particular, payment bundling and/or episode-of-care payments, some forms of accountable care organizations and some versions of the patient-centered medical home take focused approaches to placing the right degree of risk with provider organizations. An imperative for the success of these models is that payers must deliver to providers the necessary information and appropriate incentives to manage risk. Healthcare reform legislation enacted in 2010 is accelerating the industry’s movement toward these and other VBR models.

A recent survey sponsored by the TriZetto Group, Inc., shows that market enthusiasm for VBR is high, particularly among employers and payers. The researchers also surveyed clinicians, primarily focusing on specialists, who might be expected to be the least willing to adopt VBR models. A surprisingly large percentage of these clinicians favored reimbursement models that reward value and quality, suggesting that properly designed and executed VBR programs can meet the needs of employers, payers and providers simultaneously.

Providers, especially physicians, control the majority of healthcare costs through decisions about diagnosis and treatment. Oliver Wyman has estimated that more than 70% of the reductions in healthcare spending that will be needed over the next five years, as the industry seeks to "bend the cost trend," will require direct modification of the behaviors of providers (versus consumers or payers), stated Tom Main at the TriZetto 2010 Vision Summit. Payers that want to reduce costs, improve quality and meet future governmental requirements must embrace and drive VBR through their provider networks and should be developing VBR initiatives today.

Given that all healthcare delivery is local, the first step for payers that wish to implement VBR programs is to assess the unique conditions of local markets. Some markets are led primarily by payers or self-funded employers, others are led by providers in medical groups, while others are driven by large hospitals or hospital systems. A program that does not reflect local provider and employer needs and conditions is unlikely to succeed.

The second step is to establish a compelling business case for one specific implementation of VBR such as bundled payments. The business case must demonstrate a "win-win-win" outcome for patients, providers and plans, with real and sustainable value improvements for employers. For value-based models, such an outcome is possible largely because of the current volume-based system’s tremendous inefficiencies and waste, estimated at more than $800 billion per year, or a staggering 30% of total healthcare spending. However, any strategy that succeeds at the expense of one of the participants—patients, providers or plans—will be viewed as "more of the same" and will perpetuate the current cycle of short-term win-lose negotiations, non-transparent pricing, and conflicting objectives that characterize many markets today.

“Our nation’s ability to successfully compete in a global economy will suffer until we find solutions that can improve the health of all Americans and advance quality and control costs.”
Andrew Webber, president and CEO, NBCH, www.nbch.org.

“To get to better quality, we don’t need to pay more: We need to pay smarter, and by paying smarter, we can change the way care is delivered, improve quality, and have more resources to expand coverage.”
In addition, any successful VBR strategy must be scalable, both in terms of participant acceptability and technical implementation. The payment-reform landscape is awash in pilots, proof-of-concept projects and beta tests that have been developed with the willing few but that lack the technical enablement necessary for widespread adoption.

Broad organizational support within the health plan is vital, because VBR models affect the entire enterprise. For example, VBR requires the collection and sharing of data regarding providers, members, contracts, claims, health status and more, and this carries important technological ramifications. To support and scale most VBR models, payers’ core administration systems, which house data regarding eligibility, claims and benefits, must interface with network management solutions, sources of non-claims data (performance, utilization and quality), and specialty software. Best practices indicate the necessity of viewing payment reform as a strategic imperative from executive leadership.

Many VBR models are not new. However, the door is now open to make implementation and scalability of these strategies a reality based on:

- Advancing technology
- Proof-of-concept trials and demonstration projects
- Evolving body of evidence-based medicine
- New sources of data available to payers and providers
- Healthcare reform legislation, which accelerates awareness and adoption of new reimbursement models

More importantly, there has been a realization within the industry that fundamental change is necessary. The current system excels at the volume-focused delivery of care it was designed to produce; to change the result, it is necessary to change the method.

One of the most compelling approaches to improving the value of healthcare spending is the Triple Aim for Healthcare. This initiative of the Institute for Healthcare Improvement seeks to help healthcare organizations simultaneously improve the individual experience of care, the health of the population, and the per-capita cost of care. The Centers for Medicare and Medicaid Services (CMS) recently chose to adopt Triple Aim’s goals. Many plans and provider organizations also have embraced Triple Aim in connection with healthcare-reform efforts, and VBR provides a means to achieve it.

Efforts to improve population health require many distinct initiatives, and one is to align provider decisions with provider-compensation methods. Appropriate incentives can help encourage providers to deliver the right care—including preventive and wellness care as well as care for the sick—in the right setting at the right time. In addition, the patient experience can be improved through the alignment of such factors as outcomes, access to providers, and patient attitudes with the provider-compensation methodology. Many experts believe that VBR and the incentives it delivers have the potential to be the primary means of reducing the cost of care.

**Spiraling costs, unwarranted variations in care**

In 2009, the United States spent more than $2.5 trillion on healthcare, a greater share of gross domestic product than any other industrialized nation spent, yet it ranked 49th in life expectancy globally and 37th in health status. In addition, Americans receive the correct treatment only about half the time, according to a report by the Commission on U.S. Federal Leadership in Health and Medicine.

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**The Triple Aim goals for healthcare:**

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of care
A major contributor to out-of-control costs and unimpressive results has been pervasive unwarranted variations in care. These are variations in medical care—tracked across geographic regions—that do not improve patient health and that cannot be attributed to illness, scientific evidence or well-informed patient preferences. David E. Wennberg, M.D., an expert on unwarranted variations, notes that annually these account for $600 billion to $800 billion in unnecessary care in the United States.5

Care can be grouped into three major categories—effective care, preference-sensitive care and supply-sensitive care—and, as Wennberg and other experts point out, unwarranted variations occur within all three categories.

Paying for units produced also has consequences—albeit unintentional—in places such as hospitals, where the sicker a patient gets, the more money the hospital makes,” notes Jeff Margolis, founder, chairman emeritus, and former chief executive officer of The TriZetto Group, Inc. “While no one wishes to harm patients, there is often no incentive to use evidence-based protocols in order to follow best practices, thereby reducing variation in care that so often leads to complications.”


1. **Effective care** is care that has been shown clinically to deliver desired results. Unwarranted variations in effective care occur when such care is not systematically provided by clinicians. For example, the use of beta blockers following a heart attack is known to be effective. When patients don’t receive effective care, including appropriate preventive care, they tend to become sicker and their care costs more over time. There is now a substantial body of evidence-based medicine in many areas to guide the effective delivery of care.

2. **Preference-sensitive care** is care that involves consumer choices among therapies. For example, patients experiencing lower-back pain typically have a choice between surgery and a combination of physical therapy and weight loss. Unwarranted variations in preference-sensitive care often involve a failure of providers to present full information about treatment options and outcomes to patients. When all the information is presented, patients in general are more conservative than are physicians in the selection of treatments.

3. **Supply-sensitive care** is care that is delivered largely only because it is available. Unwarranted variations in supply-sensitive care are driven by an over- or under-supply of specialists, diagnostic equipment and treatments. For example, in some regions with a surplus of hospital beds, researchers have found that disproportionate numbers of patients are hospitalized.

Payers can leverage VBR to help reduce unwarranted variations in care in all three categories. VBR also can help payers manage chronic illness more effectively and lead providers to engage members and fellow providers in coordinated treatment management, preventive care, and better lifestyle choices.

**Transitioning to value-based reimbursement**

Value-based reimbursement isn’t a new concept. More than a decade ago, the Institute of Medicine urged the industry to “align financial incentives with the implementation of care processes based on best practices and the achievement of better patient outcomes, and enable providers to coordinate care for patients across settings and over time.” It also called for the use of VBR methods such as bundled payments. However VBR presents difficult challenges for payers and especially providers, as it requires practice transformation and a willingness to take new financial risks. One reason to pay healthcare providers differently is to affect changes in the way providers deliver care, yet this impacts workflows, revenues and costs. VBR will work at scale only if the new payment structures lead to changes in care delivery.

Federal healthcare reform legislation has stimulated additional interest in value-based approaches to reimbursement. CMS is piloting a variety of VBR methods and has plans to expand the successful pilots within Medicare, Medicaid and the Children’s Health Insurance Program (CHIP).

**Value-based reimbursement models**

VBR is a category of reimbursement approaches that reward physicians for taking a broader, more active role in the management of member health and pays them for results instead of solely for visits or procedures. Generally, VBR transforms compensation from the status quo of volume-based methods to an alternative value-based approach that increases the value to the payer and/or the patient. This is in contrast to the fee-for-service approach, which pays chiefly for volume of services, although some VBR methods are supplements to fee-for-service. Many VBR models are being piloted or are in broader use by payers today.
Overview of Notable VBR Models

| Accountable Care Organization (ACO) | A health system model with the ability to provide and manage, with patients, the continuum of care across institutional settings. These settings may include ambulatory (outpatient), inpatient hospital care, and/or primary care. ACOs can plan budgets and resources and are of sufficient size to support comprehensive, valid and reliable performance measurement. There is a great deal of variation in payment models, ranging from fee-for-service plus a percentage of any savings accomplished, to models of partial and full capitation, to an extreme of direct contracting with purchasers. |
| Payment Bundling | A group of providers agrees to accept a single fee prospectively to deliver all the care for a single patient in a well-defined episode of care. This type of episodic payment can reduce costs for payers and increase compensation for providers. |
| Patient-Centered Medical Home | A physician or physician group agrees to intensively manage the care and wellness of patients, providing more services and effort than is common today. Associated payment models can include fee-for-service plus a monthly payment based on population size and/or a pay-for-performance incentive. The physician or physician group is expected to demonstrate specified organizational and structural capabilities, including extended office hours, use of electronic health records and electronic prescribing and patient disease registries, to name a few. |
| Pay for Performance | In addition to fee-for-service, providers receive compensation for complying with specific clinical-process goals that improve quality and/or efficiency. |
| Pay for Reporting | Providers receive fees for reporting additional data (clinical and/or quality) to the payer in addition to receiving fee-for-service reimbursements. |
| Pay for Use/Other | Providers receive fees for using designated technologies such as electronic medical records or for achieving other non-clinical goals. Fees are in addition to fee-for-service reimbursements. |
| Certification/Recognition | These programs certify that a provider meets a standard and/or offer public recognition of provider achievement. This is an aspect of transparency in healthcare. It may or may not be tied to financial rewards. |
| Readmission Management | Avoidable hospital readmissions are paid under different terms (or not paid at all). |
| Hospital Never Events | Hospital reimbursements do not cover care that treats conditions that should not have arisen; for example, hospital-acquired infections or surgery on the wrong part of the body. |
| Prospective Payment | Payment of fixed fees for the care delivered by a single provider, such as Diagnostic Resource Group (DRG) or Ambulatory Payment Category (APC) payments. |
| Risk-Sharing | Providers accept some or all of the risk for a patient. Models include capitation, partial or limited capitation, division of financial responsibility, and hybrids. |

Key Provisions of Reform Legislation Promote and Enable VBR.

For example, in 2012, providers organized as accountable care organizations (ACOs) that meet quality standards will be allowed to share in cost-savings they help the Medicare program achieve. That same year, the legislation will expand Medicaid demonstration projects that use bundled payments for designated episodes of care. And in 2013, an additional Medicare pilot that utilizes bundled payments will be established. CMS is also mandated to focus on new primary care models such as the patient-centered medical home, which is yet another vehicle for delivering greater value.

The most promising cost-containment options involve changing the methods of paying for healthcare services, according to a study by RAND Corp. The study was requested by the Massachusetts Division of Health Care Finance and Policy, which asked RAND to develop a menu of cost-containment strategies and options and determine how these would affect all sectors of the healthcare system in Massachusetts. ⁷
Numerous studies and demonstrations have shown that VBR can favorably impact cost, quality or both. Some notable examples of VBR currently are being tested; these include payment bundling, the patient-centered medical home, pay for performance, and prospective payments and capitation.

**Payment bundling.** Early results of these programs indicate that both hospitals and physicians enjoy a 20% to 25% increase in profit, and patient quality and satisfaction increase. Payment bundling stimulates collaboration among providers, aligning their financial interests and increasing care coordination. Such collaboration can result in improved utilization, reductions in complications and other forms of unwarranted variations in care and resulting negative outcomes, while care coordination can help reduce lengths of stay and improve hand-offs among providers.

Although different methods of payment bundling carry distinct advantages, TriZetto believes that a prospective approach is the most effective. Provider incentives should be closely tied in time and size to the change in behavior sought. Creating payment bundles at the time of adjudication focuses the incentive on the action and fosters care collaboration with clear boundaries and incentives. TriZetto researchers have found that many payers intend to adopt payment bundling in 2011 and 2012.

**Patient-centered medical home.** The medical home model’s clinical and economic potential is promising; however, the precise features of an optimally successful program are somewhat elusive, according to a report by Deloitte. Researchers at Deloitte recently examined the current state of the PCMH under new federal health reform legislation, reviewed primary results from several pilots programs and, in the report, discussed how PCMHs may evolve going forward. Findings include:

- With significant investment, the PCMH model yields results
- Physician adoption is a major challenge
- HIT is the essential front-end investment
- One size does not fit all
- Access to an adequate supply of primary care providers is an issue
- Incentives must be aligned and realistic

In a separate study, researchers found that most of the medical practices that participated in a two-year national demonstration project of the patient-centered medical home model "achieved positive results in quality of care, chronic disease care and prevention outcomes," according to a recent report published in *The Annals of Family Medicine.*

Broadly, the evidence shows that patient-centered initiatives that coordinate care, improve access, focus on wellness and offer physician-directed care management are effective in reducing unwarranted emergency-room utilization, redundant and unnecessary diagnostics, improving patient medical compliance, and providing other benefits.

For example, The Boeing Company recently completed a PCMH pilot intended to improve the quality of care and substantially reduce spending for the predicted highest-cost quintile of Boeing employees. The project was managed by Renaissance Health in partnership with Regence BlueShield of Washington, Healthways, ValueOptions, and leaders of three physician groups. Each care plan was developed in partnership with the patient and executed through in-person, telephone, and e-mail contacts. This included frequent outreach by a registered nurse, education in the self-management of chronic conditions, rapid access to and care coordination by the provider team, and direct involvement of specialists.

Compared with a control group of Boeing employees who did not receive primary care from the PCMH physician groups, unit-price-standardized per-capita spending for the participants dropped approximately 20%. Functional status scores, HEDIS intermediate outcomes scores, depression scores, patients’ experience-of-care scores, and employee-absenteeism scores improved significantly compared with baseline. Qualitative results included the refinement of care managers’ patient-engagement skills, more proactive care and care coordination, and more convenient patient access to providers.
Pay for performance. P4P programs continue to increase in popularity, covering more product types and increasingly addressing specialty care, according to a recent annual survey by MedVantage. Over 70 plans participated in the industry-wide survey.\textsuperscript{13}

Properly designed P4P programs have demonstrated improvements in both cost and quality. For example, The Premier Hospital Quality Incentive Demonstration (HQID) has yielded $2 billion in savings over two years for the 225 hospitals involved in this P4P trial. The savings are attributed to improved quality. In addition, the researchers reported a 23% decrease in mortality at hospitals that provided P4P-incentivized evidence-based medicine more than 91% of the time.\textsuperscript{14}

Another study found that P4P incentives for higher-quality care, when applied to well-established ambulatory-care measures, led to incremental improvements in quality. The researchers studied the Integrated Healthcare Alliance (IHA) of California, a multi-stakeholder program, including seven major payers, which in 2009 paid out $52 million to physician organizations in its P4P program.\textsuperscript{15}

Although some early P4P trials focused only on quality measures and did not result in savings, TriZetto believes that P4P programs can be effective in reducing costs when these programs are properly structured and deliver proper incentives.

Prospective payments and capitation. The Medicare prospective payment system for inpatient care has reduced the growth in Medicare spending without harming access to or quality of care, according to government researchers. Capitation generally has been found to reduce costs, although it triggers high levels of dissatisfaction among consumers and providers.\textsuperscript{16}

Additional options for commercial payers that wish to use prospective payment include the use of APCs and payment bundling. It is important to note that capitation works well in some parts of the country and that new models of partial and limited capitation are increasingly the focus of payment reform efforts in many regions.

Stakeholders believe VBR methods will help improve quality

All key healthcare stakeholders view VBR strategies as an effective way to reduce unnecessary care and improve quality, according to results of an online survey conducted in October-December 2009 by a third party on behalf of TriZetto. A key intent of the survey was to gauge healthcare stakeholders’ perceptions of VBR. Reliability of results is at the 95% confidence level. Respondents consisted of payers, brokers, employers, providers and consumers.

Two key themes that emerge from the survey results:

Rewarding clinicians for quality is critical to reducing costs. The majority of respondents in all key stakeholder groups agree that rewarding clinicians for high-quality care is somewhat important or very important in the drive to reduce overall healthcare costs.
For VBR to be effective, incentives or payment restructuring must be large enough to motivate a change in behavior. A corollary is that a provider regards VBR as important only if it represents a large portion of the provider’s payer mix. Two strategies for payers are:

- Focus primarily on the providers where that payer has a major portion of the provider’s patients
- Join with other payers (including the government) to create multi-stakeholder programs that appear monolithic to a provider

Clinicians are buying in. Clinician buy-in is likely to be essential to the success of VBR, and the survey results suggest that clinicians are buying in. A full 80% of the clinicians participating in the survey are specialists or sub-specialists in private practice—a population that will be affected directly and significantly by new reimbursement models.

Yet, as the chart above indicates, most respondents say that rewarding clinicians for high-quality care is important in the drive to reduce overall healthcare costs. The survey also indicates that most clinicians agree that VBR will drive adherence to evidence-based medicine guidelines in the treatment of patients, with 75% saying that VBR will have a moderate to high impact in this area.

What payers can do today

VBR represents a strategic opportunity for payers to reduce costs and improve quality. It may be a mistake to remain on the sidelines, awaiting government mandates or market advances by competitors. Payers can take specific actions today to begin to reap the advantages that VBR can deliver.

1. Start with shared payer/provider objectives and then align provider reimbursement.

   For most payers, reducing the cost of care is the primary objective of new reimbursement strategies. Other payer objectives might include business growth through innovative offerings to employers, improved provider relations or network development, quality improvement, transfer of care management to providers, supporting new product design, or transforming care delivery.

   However, providers also must see that value accrues to them if they are to participate in new reimbursement models. This may be different from the value perceived by the payer, and may take the form of higher volumes, faster throughput, improved patient satisfaction or reductions in accounts receivable. As payers develop VBR programs, such provider-reimbursement strategies will need to focus on those objectives that also are supported by providers. By starting with a clear idea of those strategic goals that are shared, payers can more readily select appropriate forms of VBR for the local or regional market. In some cases, there may not be any shared goals that involve reimbursement changes which is vital to discover early in the process for both payers and providers.

   For some payers and providers, the Triple Aim objectives of population health, positive patient experience and cost control can serve as a neutral framework for balancing payer and provider objectives. Although reducing the cost of care is a primary goal for most payer organizations, cost-cutting in itself doesn’t take into account the complex realities of healthcare. Few providers will start with this as a primary objective unless they already accept significant financial risk. The Triple Aim gives payers and providers the latitude to focus on different objectives while nonetheless sharing a common vision.

2. Think locally. All VBR is local—meaning that the attributes of local or regional markets will impact the success of any specific payment-reform idea. This makes sense, as quality and cost of care are largely determined by the decisions of local providers and by local delivery-system factors.

   These factors include payer mix, provider consolidation, levels of provider integration, the availability of certain clinical services, the health characteristics of the local population, local forms of unwarranted variations in care, and the relative market and negotiating strengths of key providers versus payers. A market dominated by a single hospital that employs local primary care physicians might be inclined to reject VBR solutions designed to reduce hospital utilization; for example, P4P incentives to the primary care physicians based on after-hours access. In such a market, it might make more sense to consider a VBR strategy that plays to the hospital’s position. This might entail offering a payment-bundling program that maximizes the value of the hospital’s having a large share of the payer’s volume. Such an approach gives the hospital a way to increase profit.

   Because of this variation, no single form of provider contracting will be universally effective in transforming efficiency and quality. A payer that operates in multiple markets will need to contemplate local realities when choosing a VBR strategy. A payer in a single market will need to consider all the choices, rather than choosing a single VBR focus.
3. Consider administrative realities. Too many VBR programs start with a system design that makes sense from a clinical and provider-relations perspective but that includes administrative requirements that cannot easily be automated. In developing the business case for a VBR model, it’s important that payers take into consideration their existing and future technology base, especially with respect to automation and scalability. VBR models that can be supported largely by existing technologies are a safer bet than models that cannot be automated, require multiple new technologies, or require extensive re-engineering of existing technologies.

If current technology allows a payer to implement prospective payment for APCs and DRGs, for example, that might present an appropriate starting point. Later, with supplemental technology added to current systems, the payer might implement a payment-bundling program, taking incremental steps toward longer-term goals. After such programs prove successful, the payer might seek to foster risk-taking ACO relationships that base payment on information from a health information exchange containing clinical data from hospital systems. It is also critical that payers consider the ability of the provider partner to administer its part of the program. It does little good to create a program that provider systems cannot manage or administer, even if the program is “successful” in a proof-of-concept environment.

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**EXAMPLE OF IT INFRASTRUCTURE FOR PAYMENT BUNDLE AUTOMATION**

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4. Think systematically. Health plans can pull many levers to improve value. These include case management, disease management, utilization management, pharmacy formulary, product design, underwriting, benefit design, and value-based benefits. All these options are largely under plan control, yet plans often view these activities individually, not systematically, and rarely see “internal” strategies as critical components of VBR strategy. However, aligning and coordinating both member and provider incentives seems essential, especially given that members see their physicians, not their health plan, as the key influencer of health improvement and care decisions. Members’ benefit-plan options must align with the corresponding VBR programs used in that market, and vice versa.

If the payer rewards providers with a bonus for compliance with mammogram guidelines, then the payer also needs to confirm that members are not financially disincented to obtain a mammogram, due to a high-deductible plan design. As barriers are raised or lowered on one side of the patient-provider relationship, corresponding barriers must be raised or lowered on the other side. This may mean creating disincentives as well as incentives that can be applied not to whole employer groups, but to individual members based on demographics and health conditions.
Colonoscopies for young patients with no symptoms and no family history of colon cancer, for example, are not only costly, but they also can harm patients, says Mark Fendrick, M.D., of the Center for Value-Based Insurance Design. Yet, as Fendrick points out, many payers neither raise barriers for low-value colonoscopies for young, healthy members nor lower barriers for high-value services such as annual eye exams for diabetic members.\textsuperscript{17}

In a similar way, provider compensation can and should vary based upon the evidence for and value of delivering specific care to a targeted portion of the population or to a specific individual.

5. **Go big, go cooperatively, go together.** Incentives must be large enough to drive sought-after changes in behavior. Trials of pay-for-performance have demonstrated that impacting only 2\% or 3\% of a physician’s overall compensation may be insufficient to accomplish meaningful change and, in some ways, may impede more substantial efforts to compensate providers differently.\textsuperscript{18} In many markets, competing payers may have to coordinate their reimbursement programs so that providers are not asked to adopt different VBR programs and different reporting metrics for different payers. For this reason, it is important that commercial plans fast-follow any CMS VBR pilot program successes, given the typically high volume and disease burden Medicare and Medicaid members represent for most providers. Performance-measurement overload at the provider level is real and happens quickly. Additional reasons to increase the percentage of a provider’s patients involved in VBR programs include measurement problems with small sample sizes and claims of different performance levels for other payers. These problems are common and easily doom the best efforts of payment reform. Competing on value, not on measurement, should drive provider behavior.

6. **Get organizational buy-in, identify longer-term objectives.** VBR is a major commitment that involves far more than simply changing provider contracts. Executive leadership and organization-wide buy-in from payers, providers and employers are key to the success of VBR initiatives, because of the widespread impact that models such as the patient-centered medical home, for example, can have. Within the payer organization, these models impact people, processes and technologies across the enterprise. Payers will find it easier to win and maintain executive support if they take many incremental steps toward achieving larger goals rather than attempting one giant leap into a value-based strategy. The same holds true for provider organizations. Payers can quickly be seen as the problem when VBR programs languish or bring about unanticipated consequences.

7. **Cultivate provider leadership, partnership, and trust.** Most payers understand all too well the challenges of re-contracting and the tensions that exist between payers and many providers. Because VBR is about new collaborative contracting methods and transformation of care delivery through provider contracting, the critical barrier—and opportunity—involves establishing the right relationship with providers. Put another way: VBR programs need to resolve, not exacerbate, the tensions between payers and providers. The good news is that well-designed VBR programs may eliminate the zero-sum relationship in provider contracting today and replace it with models that benefit both the provider and the payer. Education and trust are the keys to removing provider suspicion that VBR is “another payer scheme.”

Listening first to providers and understanding their goals, minimizing or staging financial risk, communicating with providers early and often, treating them like partners rather than “suppliers,” and involving them early in the design of VBR programs are best practices for provider adoption and compliance. Plans should find and enable leadership in the provider community and then support these champions with trust and open communication. In selecting candidates for provider leadership in VBR, a plan may be well served to identify respected providers who are critics of the plan today. When VBR is done correctly, it has the power to convert challengers into allies who have the credibility to convince other providers.
8. **Be selective when choosing partners.** The days of “any willing provider” may be coming to a close. VBR often involves working with some providers to the exclusion of others, or creating incentives to reduce the utilization of some providers. For example, in the current CMS demonstration project of payment bundling, CMS pays an incentive to members who choose to receive care at a facility offering lower-cost and higher-quality bundles. Providers will adapt in order to create the increase in value that such initiatives seek to deliver. Once the referring providers have a reason (financial incentive) to take note that a teaching hospital, for example, charging $6,000 for an MRI that is available elsewhere for $600, the providers’ referral patterns will change, leading the teaching hospital to accept the loss in volume, change its pricing or demonstrate more value for the higher price it charges.

9. **Think about sustainability.** In many VBR programs, early success may not be sustainable. Too often, years two and three of a VBR program fail to deliver the same benefit achieved in year one. This may be due to poor design, where the expectations of providers increase but incentives don’t increase with them. If a physician spends extra time reducing ER utilization by 10% in year one, the plan will need to increase the physician’s reimbursement, or face a setback, if it expects an additional 10% reduction in year two. Payers also need to recognize that early adopters typically are not representative of providers overall. In addition, innovation fatigue must be taken into account along with the workflow challenges already facing providers with respect to EHR adoption and meaningful-use compliance.

   One strategy to address such risk is to establish long periods of “baseline” utilization. If providers know that they can benefit for five years by making specific changes in practice patterns, the plan will obtain a greater result than if the standards change each year.

10. **Focus on quality, the necessary companion of efficiency.** Quality improvement is not simply a fig leaf hiding the efficiency goals of VBR. There are numerous reasons plans should care about improving quality in connection with VBR initiatives. In many cases, high-quality care is also efficient care, even in the context of the patient churn associated with commercial insurance. Higher quality is a form of the value that VBR can deliver. VBR stands in sharp contrast to a system that pays for volume without much regard for quality. Additionally, quality measures are an important way to safeguard against underutilization and other unintended consequences. Quality performance is a critical requirement of meeting new medical loss ratio (MLR) requirements, ACO standards, CMS reimbursement expectations, as well as numerous regional and national purchaser expectations. Quality also is a primary motivator for providers. Many VBR programs include higher requirements for providers on quality compliance and/or outcomes, and these often serve as a primary threshold for participation in the financial upside.

11. **Beware of unintended consequences.** In designing VBR programs, do not assume that all possible results of these programs have been anticipated and addressed. The possibility of unintended consequences is not a reason to avoid VBR, but it is a good reason to help ensure that program measurement and evaluation tools as well as program governance mechanisms are in place and can help the payer identify such consequences. Solid, two-way communication with provider leadership will also help improve the identification and mitigation of unintended consequences.

12. **Leverage the healthcare reform law.** The Patient Protection and Affordable Care Act requires the piloting and evaluation of numerous VBR models. Payers that serve Medicare, Medicaid and CHIP will have opportunities to play a part in these pilots, get ahead of federal mandates and develop competitive advantages over other payers. In addition, reform legislation has established new MLR expectations that focus on quality-improvement goals and apply to all members. Many network management activities such as ICD-10 compliance and credentialing are considered administrative expenses in the new MLR definitions. However, a broad range of VBR programs, including PCMH, value-based insurance design, and payment bundling qualify as medical expenses when specific quality-improvement goals are established as part of the program design.
Of special importance in the reform legislation is the Center for Medicare and Medicaid Innovation (CMMI). The center is eager to receive innovative ideas from commercial payers regarding ways in which commercial insurance, private Medicare or private Medicaid, and standard Medicare and Medicaid can collaborate in VBR programs in specific markets. The center has the power to waive legal barriers, participate in program evaluation and oversight, and even offer funding for initiatives that can show quality and cost improvement. Plans should thoughtfully approach CMMI with ideas for VBR initiatives that would benefit from CMS participation. CMMI approval can eliminate barriers (gain-sharing restrictions or access to Medicare data, for example), increase credibility with providers, and lead to the inclusion of CMS members in the initiative, which will increase the effectiveness of the VBR program because a larger part of a provider’s payer mix is included.

TriZetto® value-based reimbursement solutions
TriZetto® value-based reimbursement solutions provide an automated, cost-effective approach to VBR models. A wide range of VBR models can be built and administered based on existing capabilities within current TriZetto solutions, including the Facets™ and QNXT™ core systems for payers, and the QicLink™ core system for benefits administrators, as well as the NetworX Pricer® application, which prices claims. These solutions automate the administration of select VBR models, and partially automate the administration of others.

In addition to the VBR capabilities of current TriZetto technology solutions, TriZetto is developing new VBR solutions and creating hardened integrations with select partners that can provide VBR capabilities.

One example of innovative solutions created specifically for VBR is TriZetto’s new NetworX Payment Bundling Administration product. It is tightly integrated with current TriZetto technology solutions and may also work with other claims-processing systems that can support the necessary web service calls. This product, along with the associated payment-bundling services TriZetto is developing, enables payers to administer payment bundling at scale. NetworX Payment Bundling Administration supports both prospective and retrospective models and includes built-in capabilities that measure quality-outcome indicators.

Conclusion
Market demand for value-based reimbursement is growing, and constituents across the spectrum generally hold favorable views of VBR. Healthcare reform legislation is expected to accelerate the growth of VBR programs over the next three to five years. VBR can help payers reduce costly unwarranted variations in care, improve quality, meet employer demands and establish a competitive edge. The value-based approach also represents an important step toward achieving Integrated Healthcare Management. Now is the time to lay the groundwork for delivery of VBR initiatives consistent with local needs and market conditions and that can deliver ROI.
**Powering Integrated Healthcare Management®**

Integrated Healthcare Management is the systematic application of processes and shared information to optimize the coordination of benefits and care for the healthcare consumer. It is fueled by the convergence of core benefit administration, care management, and constituent engagement. The intersection of these competencies enables payers to leverage data to more systematically stratify, engage and reward constituents and personalize interactions with them in order to motivate healthy behaviors, increase the effectiveness of treatments, reduce the cost of care and drive better results. Only TriZetto has invested in a long-term architectural approach to bring core, care and constituent capabilities together and enable payers to achieve the vision of Integrated Healthcare Management. Health plans have the opportunity—today—to begin the transformation to IHM and to drive increased value by developing VBR initiatives that encourage providers to deliver effective care and that discourage the delivery of ineffective/unnecessary care.

**Footnotes**


To learn more about how TriZetto can leverage integrated management technology to improve efficiencies, drive profits, and be competitive in a value-driven health reform landscape, call 1-800-569-1222 or visit www.trizetto.com.

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