Value-Based Care Defined: Know the Vocabulary of Health Care Reform

written by Theresa Hush | March 12, 2020

Today, as we confront a viral threat that is challenging our health system, its capacity, and how care is financed, it seems appropriate to review some fundamentals. Health care reform has been speeding down a particular track, changing how health care is covered, paid, delivered, and organized. These reforms may seem to be about health care financing, but will make a future difference in health care access and patient outcomes.

Medicare is driving the train with its huge budget and rulemaking capabilities. But insurance

companies, in lockstep, are rapidly implementing similar changes.

Understanding all those changes is no easy task. The bureaucratic jargon of health care reform continually expands and morphs, as words and phrases change meaning or are spun by marketing gurus. Many practicing physicians are too busy to pay attention to the business end of health care; most consumers are too busy at their regular jobs and caring for loved ones to research what it all means for them.

As we test the prowess and stability of our health care system in its evolved modern state, we should also evaluate the impact of crisis-fueled demand. So, let's start by defining the vocabulary of health care reform. As we continue our examination of how providers can take financial risk for the costs of patient care, both providers and consumers can benefit from a common understanding of the basics.

1. What is Value-Based Health Care?

Value-Based Health Care, or Value-Based Care, is a reform movement that grew out of efforts by private health plans to incentivize professional providers for quality care, called Pay for Performance.
By focusing on Value, the movement's goal was for purchasers—including consumers—to expect good quality and patient experiences from the health care dollars they spend.
As the effort progressed, Medicare took the lead under the Affordable Care Act and, later, under MACRA legislation and rules to make Value-Based Health Care an umbrella for many initiatives to contain health care costs while maintaining or improving quality care.
In the last two years, Medicare has made significant changes in its Value-Based programs and put greater emphasis on cost control and changes in reimbursement systems.

2. What is a health care payment model?

A health care payment model is a system for paying providers that determines fair rates and defines the basis on which providers will receive reimbursement for services.
Fee-For-Service (FFS) is one payment model, as are a variety of others under Value-Based Health Care, including Bundled Payments, Capitation, and various Alternative Payment Models (APMs).

3. What is Value-Based Reimbursement, also known as Value-Based Payments?

Value-Based Reimbursement and Value-Based Payments refer to several payment

models for health care providers that include incentives for cost controls or quality, and usually include both.

There are two main categories of Value-Based Payments in Medicare: one focused on individual providers or their group practices participating in Traditional Medicare, and one focused on organized groups of providers who are working together to lower cost and achieve quality under an APM such as an ACO.

Individual/group providers under Traditional Medicare are still paid via Fee-for-Service, but the provider or group is scored according to a point system for meeting cost and quality criteria. The results of that score are applied to the traditional FFS payments as a reward or penalty.

Organized entities participating in an APM will have a unique payment method associated with their particular model, but most of these models include a target or ceiling on expenses for patient care, and incentives or penalties for being under or over such targets. Value-Based Payments can also include prospective payments like Bundled Payments or capitation under Direct Contracting.

Medicare has recently emphasized the inclusion of some provider financial risk for patient care costs in its Value-Based Payments.

4. What is Fee-for-Service?

Historical payment of all health care providers, including doctors, hospitals, and other providers, was based on a Fee-for-Service method. Most facilities are now on a different type of payment system, but FFS remains the payment system for physicians and other professionals.

FFS allows physician groups to bill Medicare for each type of service, including office visits, consultations, procedures, administration of vaccines, and so on.

Since most Value-Based reform efforts now focus on reducing costs, the FFS payment system has been targeted for change.

5. What are Risk-Based Payment Models?

Risk-based payment models refer to any of the Value-Based APM payment structures under which some component of provider fees is under financial risk if patient care costs exceed the expenditure target. Under these models, risk means that the provider must live within the target expense level and aggregate capitation payments or face financial losses—while also making a required repayment to Medicare. According to Medicare rules, physicians must bear some of the risk of the APM. These models include:

- Medicare Shared Savings Plans (MSSP ACOs), which are on one of the tracks to Risk, as all will be in the future;

Next Generation ACOs, which have a payment model engaging their providers at a higher level of risk, up to 100 percent of costs.

Direct Contracting Entities that will receive a global or partial capitated payment per beneficiary, and also be held to total-cost-of-care limits. Direct Contracting is just beginning, with providers recently completing applications for the implementation year. Performance year will begin in 2021.

Primary Care First is a small practice payment model that is also risk-based, with a partial capitation payment and total cost targets.

6. What is Partial or Global Capitation?

Capitation is a payment model under which providers receive a monthly rate per beneficiary who has chosen to align with that provider for primary care and coordination of other health services. Capitation was a popular payment model used by HMOs in the 1980s and 1990s, particularly in certain markets such as the West Coast, Chicago, and Boston.

Partial capitation is the payment associated with primary care services and related costs, but not inclusive of payments to specialists, hospital care, or other costs. Because the other more expensive costs are excluded, partial risk may not represent as high a risk to providers. However, that risk also depends on other parts of the payment model. For example, there may also be a total expenditure limit that requires payback to Medicare; in the case of private insurance or some Medicare models, the expenditure limit may involve a front-end withhold as collateral for keeping within the expenditure limit.

Global capitation is payment associated with primary care and all downstream medical costs, with the exclusion of drugs and other defined expenses. Global capitation represents the highest risk but also the highest opportunity for financial gain. In order to achieve the gains, providers will most likely negotiate payments or set up payment models for their specialists and other providers.

The vocabulary of Value-Based Health Care makes it clear that Medicare is promoting payment models that provide leverage for change in health care. Cutting costs is a top priority, and CMS's preferred models reflect an underlying belief that putting providers at financial risk is the key to engaging them in that effort.

Risk may produce provider engagement, but producing results will depend on how providers work with patients to improve health status, while preventing as many intensive services as possible. Innovation and drive for clinical excellence, provider enthusiasm, and respectful relationships with patients will be key ingredients for their success. That's the agenda and vocabulary we all need to succeed in reforming our health care system.

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