Section 2.3 Plan

Business and Reimbursement Models for CCC

This tool provides an overview of reimbursement models and identifies challenges in transitioning to new reimbursement structures. It also includes tools and resources to support development of new business model(s) being contemplated.

Time required: 1 hour to review tool; 5–10 hours to develop a pro forma business model

Suggested other tools: CCC Maturity Assessment; CCC Program Staffing Models; Matrix of CC-related Activities and Roles; Resource Checklist for CCC

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How to Use

1. **Review** the overview of reimbursement models and consider the challenges in moving from FFS to VBP structures.
2. **Understand** the type(s) of VBP structure that will be the foundation for a new or modified business model.
3. **Use** the Cost-Benefit Analysis tools to assist in building a pro forma business model that will most likely result in a sustainable organization or enterprise.

Reimbursement Models

The traditional reimbursement model for providers has been ***fee-for-service*** (FFS), potentially discounted via contractual agreement with a health plan and/or employer to guarantee volume of patients. Other reimbursement models, such as pay for performance and capitation/global payments, have been tested as a way to lower costs.

Today, it is generally agreed that these traditional models focus on *volume* to the detriment of *value*—that is, better quality at lower cost. As a result, the focus is now on new models that not only incorporate a payment strategy but encourage primary care transformation through patient-centered medical homes, speeding adoption of evidence-based best practices, and other strategies that are being tested and evaluated.

Essentially these models focus on creating a healthier population of patients who will use fewer services. But instead of reducing reimbursement as would be the case in the fee-for-service environment, a ***value-based purchasing*** (VBP) model rewards providers for improving the health of the population.

As the health care industry transitions to more of a value-based payment model, hospitals and physicians have become more focused on the implementation of **care coordination** tactics among organizational entities. Much of the value-based transition has been influenced by CMS enacting programs (such as the Medicare Shared Savings, Pioneer, Readmissions, and Value-based Purchasing programs, among others) to motivate providers to implement value-based care concepts. Care coordination is one of them, and has become a key approach in helping to improve quality and reduce costs for providers and for the health care system in general. (See "CMS and Providers Nationwide Placing Emphasis on Care Coordination," available at http://leavittpartners.com/2014/08/cms-providers-nationwide-placing-emphasis-care-coordination/.)

Challenges in Moving from FFS Reimbursement to VBP Structures

There are two major challenges associated with moving from FFS to VBP:

1. *Not all payers are ready to move to VBP*, so providers must undergo a transition. Even if all payers were offering VBP, there are many options currently being tested. As a result, any given provider transitioning to VBP must manage its reimbursement/payment portfolio very carefully. Types of VBP models are described in the section below.
2. *VBP focuses on population health*, not just on treatment of patients who are ill. This shift in focus can impact the provider community's organizational structure, information technology needs, and professional culture, and may require a risk-based approach to financial management. Standardized performance measurement, transparency, public reporting, and informed consumer choice are essential for successfully adopting payment innovation.

   Implementing a community-based case coordination (CCC) program is highly desirable, but is not in itself the answer to improving population health.

Types of VBP Models

As noted above, VBP today represents only a small proportion of a given provider's reimbursement – from nothing to possibly five percent. Experts predict that by 2016 or so, 75 to

80 percent of a provider's revenue will come from VBP and will very likely include a portfolio of various models of VBP structures.

The Centers for Medicare and Medicaid Services (CMS) is leading the way in VBP, with a variety of innovative models (see http://innovation.cms.gov/initiatives/#panel-categories for additional information).

Commercial insurers are following with variations on the CMS models:

- **Accountable Care**
  Accountable care is one VBP model intended to incentivize providers to be accountable for a patient population. Accountable care organizations (ACOs) are one form of the accountable care model. Various forms of ACOs, and the accountable care model in general, are currently in place. To simplify these models, they can be categorized as shared savings or shared risk.
    - In a *shared savings model* (also called one-sided model), providers can earn a portion of the savings that result from population health. Various strategies are being tested to apportion the savings, including using various process and outcomes measures. In a shared savings model, if there are no savings there is no penalty to the provider (from the payer – although the provider's costs may have increased).
    - In a *shared risk model* (also called two-sided model), providers will share in savings but must also share in losses. The shared risk model offers a greater percentage of savings in return for the assumption of greater risk. Very few shared risk models have yet been fully implemented. Although it was initially proposed that ACOs would ultimately have to move from a shared savings to a shared risk model, some predict that this model may be applicable only in certain, limited types of markets.
- **Bundled Payments**
  Bundled payments for care improvement moves payment from individual providers taking care of patients to all providers for an episode of care. The primary care provider, specialist, hospital, and post-acute and long-term care may all be bundled together such that savings are achieved when all providers work together to effectively manage the resources provided to patients.
- **Primary Care Transformation**
  Primary care transformation is viewed as fundamental to the success of VBP. However, rather than treating them as "gatekeepers" who could keep patients from getting potentially needed services in order to stay within the allocated reimbursement structure, primary care providers are seen as the key point of contact for patients' healthcare needs. Generally "advanced primary care practices" utilize the structure of the patient-centered medical home (PCMH) that uses a team-based approach – emphasizing prevention, use of information technology, care coordination, patient self-management, and shared decision making between patient and provider.

- **Other Models**
  Models being experimented with also focus on expanding Medicaid to ensure access to care. The Children's Health Insurance Program (CHIP) and the Medicare-Medicaid enrollees ("dual eligibles") are two key programs. Dual eligibles account for a disproportionate share of health care expenditures and it is postulated that a fully-integrated, person-centered system of care would help reduce costs in this population – although tapping into this patient population to engage them in such a system of care is especially challenging. It is anticipated that, starting in 2017, states will have to find ways to supplement the initial federal funding for this expansion.

Cost-Benefit Analysis

In determining whether or not to adopt any of the new VBP programs, it is important for each provider organization independently, and collectively within a community, to determine the likely costs and benefits. As previously noted, this should include an analysis of multiple VBP programs that may be adopted as a portfolio as it is unlikely that over time only one model will be adopted. Pro forma financial statements should be drawn up for the different portfolio scenarios, and be adjusted at least annually as the landscape changes.

Adopting a VBP program or programs can be anticipated to carry significant capital investments in infrastructure, especially for network development and management; electronic health records (EHR) and other clinical information systems (CIS); care coordination, quality improvement and utilization management; and data analytics. The American Hospital Association (AHA) in 2011 published a study entitled "The Work Ahead: Activities and Costs to Develop an Accountable Care Organization" (available at: http://www.aha.org/content/11/11apr-aco-workahead.pdf) in which several examples of startup and ongoing costs for various size hospitals are provided.

The Cost Analysis Tool below is based on the AHA cost structure. Cost categories are described here:

- **Network Development and Management**
  These items refer to the cost of planning, organizing, and managing the ACO or other model of organization for VBP.

- **EHR and Other Clinical Information Systems**
  Capital requirements for EHRs and other CIS have been somewhat offset by the federal Meaningful Use (MU) incentive program, but remain substantial. Such systems are critical for efficient data gathering and reporting. Despite this they are not required under the Medicare Shared Savings Program (MSSP) and some vendors are suggesting that tapping into a centralized registry of Medicare data about patients is sufficient for the ACO. Medicare data is important but does not provide the clinical specificity needed for assessing specific patient data against evidence-based best practices and does not support the various care coordination structures implicit in patient-centered medical home (which does require an EHR for accreditation) and other structures.

  In addition, most VBP programs need to expand capability to share data throughout the community. This may be aided by forming or using an existing health information exchange organization (HIO), although the connectivity between a given provider and the central hub is the provider's responsibility. Not only are there enhancements required to the physical communications technology but also to the elements of achieving

interoperability to enable exchange of useful information. The cost of adopting standards and opening EHR and CIS platforms will not be borne solely by providers, but is probably the biggest unknown cost today.

- **Care Coordination, Quality Improvement, and Utilization Management**
  Startup costs for care coordination, quality improvement, and utilization management may be proportionally smaller than other capital costs – especially for communities with some of these functions already in place. Ongoing costs for these functions, however, must be anticipated. Successful programs will likely see these costs increase, even as they may be offset by improved sharing of savings. It should be noted that costs for these functions are not solely for personnel costs related to the care coordinator, quality improvement manager, and utilization manager roles, but also for specific training and administrative support for the persons performing these functions.

- **Data Analytics**
  Data analytics costs can also be expected to grow over time as more tools become available and as their value becomes more integrated into the fabric of VBP. Data analytics requires complex algorithmic processes and specialized staff who can interpret the results and integrate them into point-of-care systems. Many provider organizations will likely tap into a professional service for their data analytics, but they will also need to monitor that their point-of-care systems are upgraded to report results to providers and patients in the right format, at the right time, and in the most accurate manner.

Cost Analysis Tool[1]

Cost Categories	Startup Cost Estimates	Annual Ongoing Cost Estimates
Network Development and Management		
1. Providing ACO management and staff		
2. Leveraging the health system's management resources		
3. Engaging legal and consulting support		
4. Developing financial and management information support systems		
5. Recruiting/acquiring primary care professionals, right-sizing practices		
6. Developing and managing relationships with specialists		
7. Developing and managing an effective post-acute care network		
8. Developing contracting capabilities		
9. Compensating physician leaders		
EHR and Other Clinical Information Systems		
10. EHR system and upgrades/expansion for enhanced use		
11. Intra-system EHR interoperability (hospitals, medical practices, others)		
12. Linking to an HIE organization		
Care Coordination, Quality Improvement, and Utilization Management		
13. Disease registries		
14. Care coordination and discharge follow-up		
15. Specialty-specific disease management		

Cost Categories	Startup Cost Estimates	Annual Ongoing Cost Estimates
16. Hospitalists		
17. Integration of inpatient and ambulatory approaches in service lines		
18. Patient education and support		
19. Medication management		
20. Achieving designation as a patient-centered medical home		
Data Analytics		
21. Analysis of care patterns		
22. Quality reporting costs		
23. Other activities and costs		

Benefits Analysis Tool

Before undertaking a benefits analysis, it is advisable for an organization contemplating the feasibility of participating in VBP to:

1. *Consider whether their current fiscal status will allow for the anticipated initial capital investment* as described in the cost analysis above. The organization's debt policy, current level of debt, and debt capacity should be considered. If capital resources are needed from external sources, these should be identified and explored initially at a cursory level to determine feasibility, and then at a more specific, detailed level with return on investment data (e.g., payback period) and pro forma financial statements.
2. *Create a cash flow analysis for best case, anticipated case, and worst case scenarios* that includes the total portfolio mix. The tool below may be helpful in conducting this analysis. This spreadsheet accommodates three types of reimbursement models for each scenario, and uses examples of FFS, discounted FFS (D-FFS), and ACO. It is likely that the portfolio mix will change year over year, not only with different percents attributable to each type of model, but also as models are added, modified or deleted. If necessary, create a spreadsheet that analyzes these scenarios, using a five year average for the Cash Flow Analysis. In addition, it may be appropriate to separate fixed costs from variable costs in order to reflect changes over time.

Cash Flow Analysis

	5-Yr Best Case			5-Yr Anticipated Case			5-Yr Worst Case		
	FFS	D-FFS	ACO	FFS	D-FFS	ACO	FFS	D-FFS	ACO
Costs									
Savings									
Payback period									

As with any other investment portfolio, the cash flow analysis and pro forma financial statements should help an organization determine what is feasible and the level of risk that is being incurred.

References

[1] (Adapted from the American Hospital Association (2011) "The Work Ahead: Activities and Costs to Develop an Accountable Care Organization.")

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For support using the toolkit

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