PREPARING FOR A VALUE-BASED PAYMENT CONTRACT

Value-based health care payment opportunities are in the news. In fact, a value-based payment contract may be on your desk right now! But you and other rural health care organization leaders may be wondering how your organization can best test the waters of value-based care. This guide will help you and your organization prepare to deliver value-based care and evaluate your readiness to sign a value-based payment contract.

Background

First, some background on value-based care and value-based payment is in order. In 2008, Berwick and colleagues proposed a Triple Aim for the U.S. health care system; that is, the U.S. health care system should simultaneously pursue three aims: improve the experience of care, improve the health of populations, and reduce per capita costs of health care. Since then, the Centers for Medicare & Medicaid Services (CMS) and others have applied the Triple Aim to policy and practice, shifting health care payment and delivery. Value-based *care* delivers the Triple Aim, and value-based *payment* financially rewards value-based care.

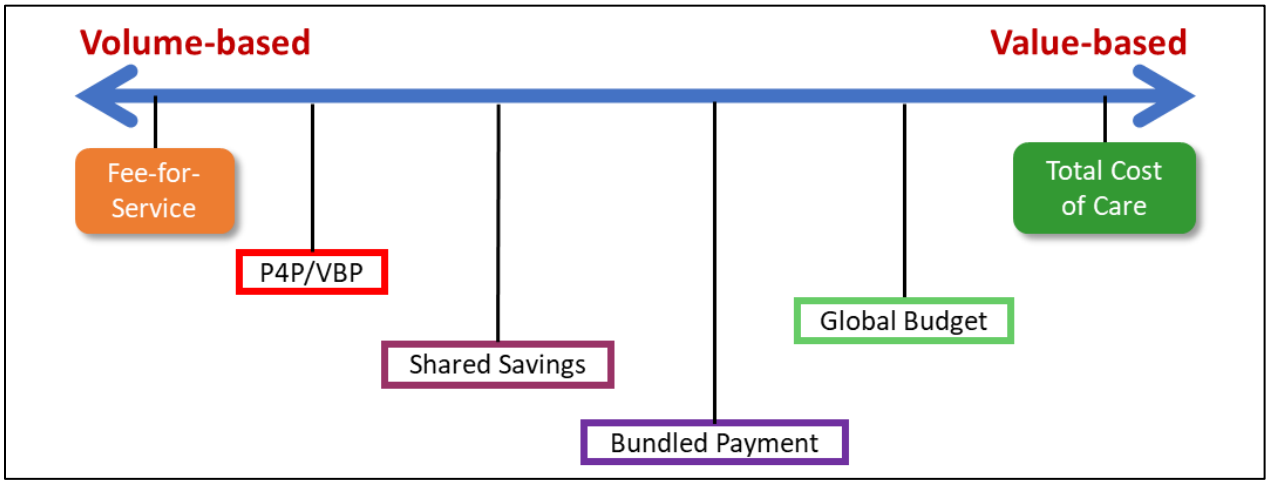
It seems self-evident that people wish to receive value-based care (i.e., health care of high quality and safety, delivered with compassion and sensitivity, and provided at reasonable cost.) And furthermore, people wish that their family, friends, and neighbors receive similar care. But a fee-for-service (FFS) payment system does not necessarily reward value-based care. FFS financially rewards increased volume. Thus, the greater the number of health care services provided, the greater the revenue received (whether the services help, hurt, or do nothing for the patient). Economic theory suggests that FFS incentivizes different behaviors than, say, a fixed budget (an example of a value-based payment). In addition to treating sickness, a fixed budget incentivizes maintaining health to avoid unnecessary health care utilization. Thus, how health care is delivered is partly predicated on how health care is paid. If a health care payment goal is to optimize health care value, then payers should pay for value, not volume!

Quantifying health care value can be challenging. To start, we can consider health care value simply as a combination of clinical quality and patient experience adjusted by health care cost – in other words, the Triple Aim. But health care value is nuanced by *perspective* (whose cost is being considered?), *time* (value interpretation may differ over time), and *weighting* (of the three value components).* These are valid issues, but they do not change the fact that FFS does not directly incentivize health care delivery of value. In the interest of the Triple Aim, we should not let perfect be the enemy of good. And indeed, value-based payments have markedly expanded since passage of the Patient Protection and Affordable Care Act, 2010.

Value-Based Payment Categories

Value-based payment is payment received for delivering value-based health care, not payment for service volumes (i.e., FFS). Value-based payments have been described as alternative payment models (APMs) that deviate from traditional FFS. APMs represent a health care payment continuum from volume-based (FFS with links to quality and value) to value-based (payment for the Triple Aim). The following figure provides health care payment examples along the continuum.

Health Care Payment Continuum



Similarly, the Health Care Payment Learning & Action Network (HCPLAN) defines four health care payment categories: (1) FFS – no link to quality & value, (2) FFS – link to quality & value, (3) APMs built on FFS architecture, and (4) population-based payment.

Value-Based Payment Future

In a 2021 Health Affairs blog, the Center for Medicare & Medicaid Innovation (CMMI) states that it will drive accountable care "by rewarding providers when they deliver high-quality, coordinated, team-based care that proactively promotes health." In other words, CMMI

* For research exploring the nuances of health care value, see The State of Value in Healthcare. University of Utah. Accessed October 12, 2020. https://uofuhealth.utah.edu/value/.

(through CMS) will make value-based payments to providers that deliver value-based care. Berwick and Gilfillan recently suggested that CMMI make accountable care organization (ACO) involvement mandatory for all Medicare-participating clinicians and hospitals. Berwick further suggested in a 2021 speech that all hospitals should operate under a global budget. And a 2020 National Rural Health Association policy paper suggests that policy and regulations should be modified to allow Critical Access Hospitals, Rural Health Clinics, and Federally Qualified Health Centers to participate in federal APMs. These influential public statements suggest that the volume-to-value transition will continue to advance and pure FFS payments will continue to decline. Although some are concerned about financial risk associated with APMs, reliance on a FFS status quo is not risk-free! Many rural health care organizations are finding that prices per unit of service are not keeping pace with rising health care delivery costs (e.g., technology and labor).

The continued expansion of value-based payment is a safe bet. Thus, most health care leaders will need to consider the question, "How do I prepare for a value-based payment contract?" To receive contractual value-based payments, a health care organization must deliver value-based care (i.e., care designed to deliver the Triple Aim, not simply volume). So, how should you as a health care leader prepare your organization to deliver value-base care and thus receive value-based payment? Here's a suggested plan.

Preparing for Value-Based Payment

The Rural Health Value team suggests that you concentrate on three primary tasks to develop value-based care capacity and prepare for value-based care payment contracts – culture creation, capacity building, and contract evaluation.

1. Create a culture that supports value-based care.

The health care organization leader should recognize that success in value-based care (to receive value-based payment) requires an organizational culture-shift from volume-focus to value-focus. Illness and injury treatment continues, but the health care organization must *expand* its operational emphasis to illness/disability prevention and health promotion that will consequently decrease health care utilization. Importantly, this new emphasis directly counters the FFS financial incentive of greater volume. Many value-based care goals, such as clinical quality/prevention, person centeredness, and community health may be already reflected in the health care organization's mission. A non-profit board's *duty of obedience* – ensuring that the organization adheres to its mission – may thus require an organizational focus on value. Furthermore, Collins suggests in *Good to Great: Why Some Companies Make the Leap ... And Others Don't* that organization operations aligned with mission are associated with success.

Creating a culture of value-based care is best accomplished if the organization's operations support value-based care; that is, "walk the talk." Examples of operational characteristics that actualize, and thus support, a culture of health care value might include:

- Leadership structures and titles (e.g., Chief Innovation Officer and Community Engagement Liaison),
- Performance metrics (e.g., *avoided* inpatient admissions and emergency department visits rather than admissions counts and average daily census),
- Budget (e.g., a specified percentage of total revenue devoted to developing value-based care capacity),
- Job descriptions (e.g., highlighting in each position a required commitment to proactive, value-based care), or
- Employee performance expectations and compensation (e.g., patient health and function goals rather than service volume goals).

2. Build organizational capacity to develop and sustain activities supporting value-based care. Concurrent with shifting organizational culture from volume to value, and like other industries, health care organizations should invest in research and development (R&D). Health care R&D is an appropriate opportunity to build value-based care capacity. R&D investment decisions will task you with balancing between two unacceptable extremes: blind inaction and exhausted reserves. Value-based care R&D examples might include:

- Hiring or appointing a Chief Innovation Officer,
- Focusing quality improvement resources on those processes directly leading to value-based care,
- Purchasing or leasing population health management software, or
- Redesigning organizational mission, leadership structure, job descriptions, performance, evaluations, and compensation packages to highlight and support value-based care.

As noted above, the status quo (inaction) is not risk-free. Therefore, a value-based care strategy is required – with detailed objectives, action steps, resource commitments, deadlines, and accountabilities. But how do you develop a value-based care capacity-building strategy? Start by using the Rural Health Value Value-Based Care Assessment to assess your health care organization's current state of value-based care readiness and to identify opportunities for value-based care capacity-building. The Assessment is designed to be completed by your leadership team and includes eight value-based care domains:

- *Governance and Leadership* – A transition from volume-based care to value-based care requires a concerted and comprehensive focus on value that starts with leadership actions and organizational policies. It is these actions and policies that begin to shift a culture that prioritizes volume to a culture that prioritizes value.

- *Care Coordination* – Reducing duplication and avoiding unnecessary utilization, driven by care coordination, are value-based care goals. Patients should receive the right care, with the right provider, at the right time.
- *Clinical Care* – Clinical care is the essence of a health care organization's mission. Value-based clinical processes focus on proactive health care that improves health without FFS volume mandates.
- *Community Health* – Value-based care requires consideration and relationships beyond the four walls of a hospital or clinic. Community health improvement takes a village.
- *Patient and Family Engagement* – Value-based care may be best assessed from a patient and family perspective. Thus, value-based care focuses on patient engagement and shared decision-making.
- *Performance Improvement and Reporting* – Performance improvement requires measurement. The trend of accountability through performance reporting will continue in value-based payment policies.
- *Health Information Technology* – Newer technologies such as electronic health records, telehealth, and population health management systems are necessary to deliver proactive clinical care, increase access to care, and measure performance.
- *Financial Risk Management* – The shift from volume to value reduces the opportunity to increase revenue by increasing health care service volumes. Thus, value-based care requires financial risk analysis more complex than simply predicting service payments and volumes.

3. Build financial models to inform value-based payment decisions.

After prioritizing value over volume in organizational culture and investing (R&D) in value-based care capacity-building, the last step to answer the question "Should I sign a value-based payment contract?" is to perform a thorough financial pro forma that compares the FFS status quo to future financial performance under the proposed value-based payment contract. The pro forma requires your *informed and honest* assumptions about future service volumes, market share, prices, and organizational capacity for change. The pro forma should also employ a sensitivity analysis to develop probable and defensible future projections. Here are two helpful Excel-based tools from the Rural Health Value team to aid Critical Access Hospital financial pro forma development: Critical Access Hospital Financial Pro Forma for Cost Reimbursement and Critical Access Hospital Financial Pro Forma for Shared Savings. Financial analyses are critical because in addition to the duty of obedience, health care leaders have a fiduciary duty to the organization. Fiduciary duty mandates decisions to help ensure that the organization remains a going concern. Therefore, your decisions should not violate either the duty of obedience to mission (which may include value-based services and outcomes) or fiduciary duty (which requires fiscal prudence).

Conclusion

Preparing for value-based contracting requires three fundamentals – organizational culture change (from volume to value), value-based care capacity building (R&D), and financial projection (a thorough and honest pro forma). Fortunately, wise health care leaders such as yourself have the skills to complete these value-based care and value-based payment prerequisites. Although the pace of change from volume to value can be uncertain, the transition to value-based payment that rewards value-based care is here to stay.

Developed with funding from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $500,000 with 0% financed with non-governmental sources. The contents are those of the authors(s) do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. Government.