The Policy-Driven Health Plan: A Road Map for Value-Based Reimbursement

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Value-based reimbursement represents a fundamental shift in the way health plans pay providers for care. Rather than creating incentives for providers to deliver high-quantity care—a downside of the fee-for-service (FFS) model—value-based reimbursement aims at creating incentives for providers to achieve high-quality care. Because value-based reimbursement is focused on driving healthcare value, improved population-based outcomes are an expected result.

The challenge for health plans lies in the details. How do you implement value-based reimbursement? How do you get to the point at which you are reimbursing providers on the basis of value? Establishing a value-based, policy-driven philosophy within the health plan can be a critical success factor.

Reimbursement Reform: Better, but More Complex, Solutions

To deliver improved, more affordable healthcare solutions, health plans today are busy evaluating new benefit designs, piloting new care models, and weighing new reimbursement strategies. These efforts can be seen in initiatives such as patient-centered medical homes, accountable care organizations, and a variety of value-based reimbursement strategies, including blended payments, bundled payments, partial capitation, and more.

New reimbursement strategies typically require more complex, multifaceted contractual arrangements between the health plan and the care provider to achieve the desired outcome. That in itself poses challenges. The core systems in place today in most health plans were not designed to accommodate these payment and reimbursement innovations. Many of today’s claims systems, for example, will not readily incorporate the complex logic required to determine which provider contract and reimbursement methodology should apply to a given claim.

It is also worth noting that manual claims editing and payment processes—the fallback process for claims that legacy systems cannot handle easily—are incompatible with value-based reimbursement. To scale any type of reimbursement reform will require the efficiency and accuracy of technology. If aligned and integrated properly, automated solutions can ensure that medical, payment, and provider contract policies are applied consistently and effectively to ensure the greatest value.

A Road Map for Creating a Policy-Driven Environment

The nature of a value-based reimbursement system involves a set of logical choices that ultimately align a reimbursement plan with a benefit plan, a care provider, and a medical event. Given the number of potential permutations, the process of mapping these elements properly can be extremely complex.

To manage this complexity, health plans should strive for a policy-driven environment. This entails using a set of coordinated and aligned policies for payments, benefits, and medical events, each of which is developed to reinforce each other and is executed consistently across the systems involved with processing claims and payments. Through the use of these policies, it becomes possible to reimburse correctly, consistently, and in a manner that drives value. The following 4 steps are crucial in this process:

- Establishing reimbursement policies
- Aligning network design
- Creating the benefits to complement the reimbursement model
- Setting up contracts.

Step 1. Establish Reimbursement Policies

The path toward a policy-driven environment begins with policy design. A plan must establish policies for payments, benefits, and medical events. Consider the scenario depicted in Figure 1, involving a health plan male member with several medical conditions—diabetes, hypertension, and mildly elevated cholesterol. The health plan defines a set of benefits for members. To facilitate reimbursement, the health plan defines a set of policies that can be applied automatically to pay the care providers. In this case, the policies include:
• Global payment for diabetes services provided within a medical home
• FFS payments for diabetic testing supplies
• FFS payments if the member is covered under preferred provider organization (PPO) and medical home plans
• Partial capitation for referrals to a cardiologist for treatment of hypertension.

This, however, is just the first step in a multistep process. Once the reimbursement policies have been defined, care networks need alignment with the reimbursement policies.

**Step 2. Align Network Design**

Consider the “hybrid PPO” strategy modeled in Figure 2. It offers subscribers a variety of options for care, and each option is associated with certain networks and provider reimbursement policies.

As seen in Figure 2, the benefit and policies in the top row are designed to support steerage to designated networks in the second row. Members’ out-of-pocket (OOP) costs are an important consideration when defining benefit options; they can act as a lever, steering members to the network that is most appropriate for the care they need. Similarly, health plans must design the supporting networks to deliver a variety of care options to meet the needs of both the members and the providers within those networks.

**Figure 1** Creating the Reimbursement Policies

**Diabetes medical home with enhanced reimbursement for specific services, and reimbursement for nonphysician and nonoffice services**

- Global payment for diabetes services provided within the medical home
- FFS for diabetes testing supplies
- FFS if member is covered under PPO and medical home
- Partial capitation for referrals to cardiologist for hypertension

**Figure 2** Aligning Supporting Networks with Reimbursement Policies

**Benefit plan: hybrid PPO**

- 10% reduction if in chronic care ACO
- $0 copay in quality network
- 15% penalty for PPO network

- Diabetes ACO network
- Narrow network
- General PPO market

- Shared-savings model based on prospective budget
- Global budget target (50%-90% of budget)
- Performance target (10% of budget)
- FFS for specialty services
- Capitation for primary services
- Acute episodes
- FFS + for preventive services
- FFS for all services
- Higher price for members in exchange for choice
- Low margin for health plan

ACO indicates accountable care organization; FFS, fee for service; PPO, preferred provider organization.
In the third row of the figure, the policies defined in Step 1 are aligned with the care networks themselves. With a policy-driven approach, plans can associate different reimbursement policies with various networks quite easily. In addition, just as the OOP costs can act as an incentive to drive members toward certain optimized networks, the reimbursement policies can act as an incentive to drive providers toward certain networks. Each ensures that members and providers are moving toward an interaction that emphasizes a high-quality outcome at an affordable price.

**Step 3. Create the Benefits to Complement the Reimbursement Model**

Consider the individual care events or encounters that constitute a total knee replacement episode, as presented in Figure 3.

In a traditional FFS model, a member pays something (a copay or a portion up to a deductible amount) at each encounter—for the primary care provider (PCP) visit, the specialist, and so on. In a value-based reimbursement approach, however, a health plan would develop member benefit models that would complement the different reimbursement models. These must be adjusted to ensure that the member does not have to pay for each visit within that episode of care. The reduced OOP expenses can act as incentives to draw members into various programs. Examples include:

- FFS with a PPO: a standard deductible, with the member paying a set percentage after meeting that deductible
- Consumer-directed health plan, with episode bundling: a health reimbursement arrangement covers the first $100; after that, care is covered at 100%
- Episode PPO: a $100 flat fee for an entire episode of care.

**Step 4. Set Up Contracts**

Finally, plans must set up contracts with varying types of care providers, as depicted in Figure 4. Depending on the network alignments set up in Step 2, the benefit models created in Step 3, and the contracts set up in Step 4, members could receive care in any of the 3 settings depicted in Figure 4. The way a provider is reimbursed then depends on which provider the member actually visits, and what type of service the member requires.

For example, a member may visit a family practice; that provider’s reimbursements are outlined in Contract 1. However, the PCP may refer the member to hospital B for a total knee replacement procedure, in which case the provider’s reimbursement becomes part of the bundled payment governed by Contract 3.

Conversely, the PCP may refer the member to an orthopedic surgeon at hospital B for something other than total knee replacement. According to Contract 3, that would indicate a FFS reimbursement strategy rather than the bundled payment method assigned to the total knee replacement procedure (including surgery, follow-on physical therapy, and more, as outlined in Figure 3).
Optimizing the Policy-Driven Environment

Given the complexity of this environment—with its range of members, products, services, sites, providers, and contracts—a policy-driven approach to value-based reimbursement requires technologies that can work with very sophisticated selection criteria. The systems supporting a policy-based approach must be able to identify and act on the details associated with members, products, networks, contracts, and the care provided.

Available technologies can provide the sophisticated services required to enable this kind of policy-driven environment, based on reimbursement program design tools that integrate with contract negotiation tools, which then integrate with reimbursement program execution tools, reporting tools, and provider collaboration tools.

Working together, as depicted in Figure 5, these systems create a feedback loop that can continuously monitor, manage, and refine the processes supporting the health plan’s core activities. In deploying the technology that can enable a policy-driven environment, a plan must remember to integrate and align these systems to:

- Make data available to providers to optimize
- Provide feedback on performance and quality
- Improve provider tools to manage their own data
- Allow for visibility (dashboards, etc) to increase feedback speed
- Align analytics solutions to rapidly gauge success

- Design programs compatible with delivery reforms
- Model based on proposed incentives
- Create incentives for member participation

- Negotiate contracts with select providers
- Align networks around established objectives

- Adopt systems that automate contract and reimbursement initiatives at scale
- Create differentiated payment for testing

If these requirements are not considered when deploying the technology to enable a policy-driven environment, a plan will constrain its ability to gain the full spectrum of benefits that arise from this environment.

Facilitating Provider Transparency

One component of the policy-driven environment depicted in Figure 5 worth calling out on its own is a set of provider collaboration tools. Health plans need tools that make it easy for providers to access information about policies and claims. If a plan wants to drive provider behavior toward value, the providers need to understand how their decisions about care affect their reimbursement. Exposing information about policies, claims editing rationales, and which claims have been paid (and which have not, and why), can help accomplish this.

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Conversely, these same provider collaboration tools can create a way for providers to interact more easily with a plan’s core system. A provider portal, for example, would provide the insight they desire into policies and claims processing, and would also enable them to update information about their practices and their specialties. Enabling the providers to ensure that their information is up to date can streamline claims processing, while lessening the information collection burden that would
otherwise fall on the shoulders of personnel within the health plan itself.

The Advantages of a Policy-Driven Environment

Ultimately, a policy-driven environment is critical to the realization of value-based reimbursement. By using the tools to enable a policy-driven environment, you can:

- Automate the entire reimbursement lifecycle, from reimbursement policy design to contracting, claim editing, pricing, and optimization
- Reduce manual data entry by automating the propagation of provider data from enrollment to contracting, and by automating the loading of executed contracts into the reimbursement engine
- Increase the autoadjudication rate of claims by improving the integrity of data for claims processing
- Increase payment accuracy per contract intent, because the claims editing and pricing processes can access network, provider, and contract data in detail, facilitating accurate price alignment
- Automate the alignment of product, network, and reimbursement designs to enforce referential integrity and the rule-driven implementation of policies
- Support provider- and contract-level variations in policies, gaining the flexibility to institute exceptions—a change in episode definition, for example—without losing the ability to codify and electronically transmit a claim that will be adjudicated properly within the system
- Decrease information technology integration costs by creating a single point of integration for claims editing, provider selection, episode bundling, and pricing.

With the ability to create and manage products, contracts, and reimbursements more efficiently and effectively, a policy-driven environment will enable the health plan to create the necessary conditions for steering members and providers toward the highest quality of care, delivered at the most affordable price. Such an environment provides integrated mechanisms for creating and refining incentives, for mapping benefits to members, providers to networks, and reimbursements to contracts. In the end, based on our experience in the healthcare industry, this translates to better outcomes for everyone.

Author disclosure statement

Mr Evans has no conflict of interest to report.

References