UT LAW CLE | THE UNIVERSITY OF TEXAS SCHOOL OF LAW

PRESENTED AT

28th Annual Health Law Conference

April 21-22, 2016
Houston, Texas

Managed Care: Trends in Medicaid and Commercial Partnerships and Reimbursements

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1) Introduction

The debate surrounding the nation's healthcare system is driven in large part by a recognition that current trends in healthcare spending are unsustainable. According to CMS actuarial projections, the healthcare share of the GDP will rise from 17.4 percent in 2013 to 19.6 percent in 2024.[1] Moreover, the percentage of the GDP devoted to healthcare has doubled in just the last 30 years.[2]

Given that the Affordable Care Act dates back only to 2010, the reforms in that legislation, including expanded coverage, cannot be the only reason for this trend line. In fact, the Bipartisan Policy Center concluded that there are a range of reasons driving health care costs, including:

- fee-for-service reimbursement;
- fragmentation in care delivery;
- administrative burden on providers, payers and patients;
- population aging, rising rates of chronic disease and co-morbidities, as well as lifestyle factors and personal health choices;
- advances in medical technology;
- tax treatment of health insurance;
- insurance benefit design;
- lack of transparency about cost and quality, compounded by limited data, to inform consumer choice;
- cultural biases that influence care utilization;
- changing trends in health care market consolidation and competition for providers and insurers;
- high unit prices of medical services;
- the health care legal and regulatory environment, including current medical malpractice and fraud and abuse laws; and
- structure and supply of the health professional workforce, including scope of practice restrictions, trends in clinical specialization, and patient access to providers.[3]

The first driver on that list is worth noting—fee-for-service reimbursement. Many believe that a healthcare system that does not incentivize providers to manage quality or quantity of care, but instead pays for each service provided, is not sustainable or optimal. The second factor listed, care fragmentation, again underscores the notion that our current healthcare system does not operate efficiently—and the result is more care, but not necessarily better care.

As our healthcare system faces the certainty of other cost drivers listed above—the aging of the baby boomer population, increases in chronic and complex diseases, and limited resources in the healthcare system—healthcare providers and health plans are working to rapidly implement other types of reimbursement in hopes of creating a better and more efficient healthcare system.

This paper briefly reviews several trending types of reimbursement for healthcare services and then explores common arrangements between health plans and healthcare providers, considering both the regulatory issues commonly presented by these arrangements and practical considerations for structuring and operationalizing each type of arrangement.

2) Brief Overview of New Methods of Reimbursement

a) Value-Based Purchasing

Value-based purchasing ("VBP") refers to a broad set of performance-based payment strategies that link financial incentives to providers' performance on certain defined measures. This term is used by both commercial and governmental payers in a wide variety of contexts—in fact, it may be easiest to think of VBP as any quality-linked payment model that is not purely fee-for-service. In this paper, the VBP sections address quality-linked payments that do not involve risk-sharing.

Medicare and Texas Medicaid

VBP efforts are well underway in both the Medicare and Medicaid programs. Over a decade ago, the Department of Health and Human Services ("HHS") and the Centers for Medicare and Medicaid Services ("CMS") began testing VBP models with their hospital pay-for-performance demonstrations, known as the Premier Hospital Quality Incentive Demonstration and the Physician Group Practice Demonstration, which provided financial incentives to physician groups that performed well on quality and cost metrics.

At present, the core Medicare VBP program is the Hospital Inpatient Value-Based Purchasing ("Hospital VBP") Program. The Hospital VBP Program is voluntary and reduces participating hospitals' Medicare payments by a specified percentage and uses the pool of the estimated total amount of those payment reductions to fund value-based incentive payments to participating hospitals based on their performance. For FY 2016, the reduction was 1.75% of the base operating diagnosis-related group (DRG) payments for the year.[4]

Payment adjustments are applied to each participating hospital at the individual claim level based on each hospital's Total Performance Score ("TPS") on the Hospital VBP measures for that year. The TPS determines the hospital's value-based payment adjustment factor, which may be positive or negative, and the factor is then multiplied by the base operating DRG payment amount for each Medicare fee-for-service discharge in a fiscal year. This means that a participating hospital may ultimately be paid more, less, or the same amount as the withheld reduction depending on that hospital's adjustment factor.

Texas Medicaid, which operates primarily through a statewide managed care model, also has a number of initiatives to promote value-based purchasing. Among those are the Pay-for-Quality Program and Health Plan Value-Based Contracting.

Title search: Managed Care: Trends in Medicaid and Commercial Partnerships and Reimbursement

First appeared as part of the conference materials for the
28th Annual Health Law Conference session
"Managed Care: Trends in Medicaid and Commercial Partnerships and Reimbursement"