First Year Results Under a New Medicare Advantage Payer-Health System Value Based Reimbursement Partnership

Author
Powelson, Jill

ISBN
978-0-438-34902-5

Abstract
Value based reimbursement (VBR), defined as payment for the perceived value of services, is increasing as a trend in the U.S. healthcare system. Medicare Advantage contracts often include VBR incentives for providers and facilities to meet quality thresholds and manage the cost of care. In this context, a large healthcare delivery system located in the southeast U.S. (the System) entered a new partnership with an insurance company (the Payer) to form a Medicare Advantage plan with VBR incentives. The purpose of this research is to evaluate the impact of the partnership in its first year, including specific metrics, and to explore the reasons for the impact, including specific tactics. A qualitative case study research method was used, incorporating interviews of key informants from both the System and the Payer. Metrics for new patients served and hospital utilization performed better than goal.

Metrics for PCP network composition, membership, and gain share did not meet goal. The researcher concluded that the one year evaluation period was too brief for a new VBR partnership, due to the number of changes required; a 2–3 year evaluation period would have been more suitable. Themes of value creation for the System beyond the metrics included: learning about VBR, a competitive advantage, learning HCC coding and RAF scores, increasing patient satisfaction, reducing unnecessary PCP visits and improving health care access. The tactics identified as having the greatest impact upon the metrics were Payer employed extensivists and Payer clinics for high risk patients.

Policy implications of this research are: 1) Federal policies should be considered to require improved transparency of data between payers and health systems with common patients. 2) If Medicare Advantage plans demonstrate superior patient outcomes and lower the cost of care, then federal funding to Medicare Advantage should not be reduced. 3) The Center for Medicare and Medicaid Innovation should consider testing payment models which pay primary care providers via capitation to determine if it results in improved approaches to caring for patients with traditional Medicare.

Advisor
Pink, George H.

Committee member
Greene, Sandra; Reiter, Kristin; Silberman, Pam; Song, Paula

University/institution
The University of North Carolina at Chapel Hill

Department
Health Policy and Management