NAVIGATING
THE TRANSITION TO VALUE-BASED CARE

The healthcare industry is in the midst of a transition to value-based care. A major component of this transformation, called payment reform, creates arrangements where healthcare payers and providers share financial risk in order to improve the quality of care while lowering healthcare spending.

To help the industry navigate this transition, the Society of Actuaries (SOA) sponsored a review and analysis of payment models. As experts in the consequences of health risk, actuaries are well positioned to analyze these and other pressing issues facing the industry today.

The following highlights the SOA's insight, which seeks to ensure the industry-wide move to value-based care creates positive outcomes.

KEY FINDINGS >>

THERE ARE SEVERAL KEY CONSIDERATIONS FOR A TRANSITION TO A PAYMENT REFORM MODEL:

INVOLVE ALL STAKEHOLDERS

A coordinated effort across all health system participants is critical.

EVERY ORGANIZATION IS DIFFERENT

Each payment model presents risk and opportunity, and should be individually assessed for different healthcare providers.

RESULTS ARE DECIDEDLY MIXED

Accountable Care Organizations in particular, have generated varying levels of success at this stage.

INSURANCE COMPANIES PLAY AN IMPORTANT ROLE

Insurance companies have access to information and resources that can reduce financial risk.

FACTORS FOR SUCCESS >>

THE SOA UNCOVERED SEVEN FACTORS THAT DETERMINE THE SUCCESS OF A PAYMENT REFORM MODEL:

1. An integrated and efficient health system providing coordinated patient care
2. Effective care management initiatives to ensure patient health
3. A well-designed network to foster cost savings
4. Collaborative payer and provider networks to reduce costs
5. A reasonable method to determine patient costs within the network
6. An equitable process for allocating quality incentives among participating healthcare providers
7. A holistic risk management approach

PAYMENT AND SERVICE DELIVERY MODELS, EXPLAINED >>

FEE-FOR-SERVICE:

Healthcare providers are reimbursed separately for each individual service.

GLOBAL CAPITATION:

Providers are paid a fixed rate for each member they agree to treat within a given time period.

SHARED SAVINGS MODEL OR ACCOUNTABLE CARE ORGANIZATION (ACO):

a group of healthcare providers who provide coordinated care for patients. Participants are paid based on improvements in the health of patients they treat.

DIAGNOSIS-RELATED GROUPS (DRGs):

A classification to combine all related in-patient hospital services to a single code. Providers are paid a single rate per patient admission.

BUNDLED PAYMENTS:

a single payment for all services to treat a given condition.

REFERENCE PRICING:

a health plan sets a target price for a specific medical procedure or service.

PAY-FOR-PERFORMANCE:

a system where payment is adjusted to include incentives for higher quality of care.

You can view the full report, and analysis of the risks associated with individual payment models here.

SOCIETY OF ACTUARIES