# Issue Brief:
# The Need to Standardize Network Value-Based Purchasing Requirements

**AAPAN Provider Affairs Committee**

## Introduction

During the past year, the Provider Affairs Committee of the American Association of Payers, Administrators and Networks (AAPAN) met on a monthly basis to assess how to best standardize the wide range of value-based purchasing requirements that are applied to preferred provider organizations (PPOs), health plans and other network-based offerings. This issue brief summarizes some of the most important points that were discussed during the year by the Committee, and makes a number of important recommendations on how we can begin to standardize key quality and performance benchmarks.

In addition, this issue brief provides a short history of how network operations have evolved over the past four decades, and showcases how PPOs and other network offerings continue to serve a critical role in today's health care marketplace. The analysis also addresses key concepts associated with value-based purchasing, including a definition of the concept, the need for standardization and a few recommended principles to follow. Among other concluding thoughts, the Committee endorses a "functional" approach to standardization as an effective way to benchmark network operations in a diverse and dynamic marketplace.

## The Evolution of Networks

The evolution of health insurance networks is quite interesting when you look back at the past four decades. The "network" movement really gained momentum with the passage of the Health Maintenance Act (HMO) of 1973. Since then, a combination of public and private sector initiatives has promoted a fair amount of innovation and change. In today's marketplace, networks come in all shapes and sizes, and can be customized to provide a defined set of services depending on the health care arrangement.

### *HMO Networks*

Health maintenance organizations (HMOs) are prepaid, network-based health care offerings. Although some HMO-type offerings date back to the early 1930s, they really gained market share during the 1970s and 1980s following the passage of the Federal HMO Act. HMOs can be classified into several basic types:

- **IPA Model.** IPA-based HMOs contract with independent provider groups or multi-specialty practices to make up its provider network. The providers serve as independent contractors. The HMO employs full time staff to administer the operations and to provide clinical support. Traditionally, most IPA-based HMOs are for-profit.
- **Staff Model.** The Staff Model HMOs typically hire their providers as full time employees and are more likely to own their own facilities and clinics. Staff Model HMOs traditionally have been non-profits.
- **Group Model.** Group Model HMOs usually contract with one or more independent provider groups or group practices to provide care to the health plan enrollees. Often, the group gives care in HMO-owned and managed facilities. The HMO compensates the group or groups in bulk, and the physicians decide within each group how the funds are distributed.
- **Network Model.** Network-based HMOs typically contract with multiple provider groups or group practice associations to provide medical care. Care is usually provided in facilities owned and managed by the medical groups. In many ways, this is the combination of IPA and Group HMO models. The HMO contracts with some combination of multi-specialty physician group practices, independent practice associations and fully independent physicians to provide medical services.

### *PPO Networks*

Preferred provider organizations (PPOs) gained momentum as a viable health coverage option during the mid-1980s. The first generation of PPOs focused on the formation of provider networks as a mechanism to reduce costs through pre-negotiated, discounted fee-for-service (FFS) payment scales. Subsequently, PPO products and business models have become much more dynamic, complex and fluid.

Although defining what a PPO is may appear to be a relatively simple task, the actual answer is more complicated because of the range of PPO products. The term "PPO" is used generically to describe a variety of different arrangements, each with unique characteristics. There are literally dozens of PPO products and arrangements. As the old adage states, "If you've seen one PPO, you've seen one PPO."

However, all PPOs still share one common trait: a "network" of health care providers who have agreed to provide care to patients subject to contractually established reimbursement levels. Beyond that, PPOs can be categorized in many different ways, including by these three categories:

- **Leased PPO Network.** This type of PPO rents its panel of network providers to another network or insurer. Emphasis is typically on expanding provider access and negotiated discounted fee-for-service fees. This type of PPO can be thought of as "wholesale" since it does not sell directly to patients, but rather is accessed through an intermediary.
- **Non-Risk PPO.** This PPO contracts with providers in a specific region to form an interconnected network of providers and services. Non-Risk PPOs lease and rent its networks for a fee to insurance companies, self-insured employers and so on.
- **Risk PPO.** The Risk PPO is similar to a Non-Risk PPO, except that this PPO assumes the financial risk for the enrollee's medical costs. Typically, insurance companies will offer Risk PPOs

that include a benefit plan and network services provided by the Risk PPO or leased from the Non-Risk PPO.

It should be emphasized that these three categories are broad types; there are many variations within each category. Moreover, many PPOs are mixed-model types, and blend together aspects of two or three of the categories. However, the majority of the PPO market fits into one or both of the first two categories. PPOs often partner with an insurance carrier or self-funded employer that contract with the PPO directly. Overall, PPOs are designed to fit between the traditional HMO and fee-for-service offering. The PPO can bring discipline to previously unstructured medical practices without the bureaucracy and inflexibility of usual HMO plans. It puts the employer back in control of the employee health insurance benefit with the ability to manage and stabilize overall health care costs.

***POS Networks***

A point-of-service (POS) or open-panel network is a concept that means many things to different people. The "POS movement" in managed care combines all types of "open panel" product offerings. Historically, these arrangements were sponsored by closed-panel HMOs that were addressing consumer demand to have some access to out-of-network providers.

POS products assume many different forms and functions. The one common denominator is that a POS plan is offered through an open-panel network platform, meaning that the covered life or enrollee has the option to stay in-network or go out-of-network for care. Similar to PPOs, the individual who elects to go out-of-network will likely absorb additional costs in terms of higher co-payments or deductibles, as well as less coverage (e.g., greater coinsurance responsibility borne by the covered life).

***ACO Networks***

An accountable care organization (ACO) is a network-based operation that integrates the provider and administrative functions and seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. ACOs are typically made up of doctors, hospitals and other health care providers who come together voluntarily to give coordinated, high quality care to their patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. ACOs can leverage many different network functions in their product offerings as described above.

ACOs exist both in the public and private sectors. For example, CMS offers three types of ACO arrangements:

- **Medicare Shared Savings Program.** A program that helps Medicare fee-for-service program providers become part of an ACO.
- **Advance Payment ACO Model.** A supplementary incentive program for selected participants in the Shared Savings Program.
- **Pioneer ACO Model.** A program designed for early adopters of coordinated care.

ACOs have taken off in the private sector, which include health plan offerings that provide both a vertical and horizontal approach to integrating business and clinical operations. This has empowered many large provider systems to implement health plan offerings in their communities.

One of the hallmarks of an ACO offering is to drive an integrated approach to care through enhanced benefit designs and risk sharing strategies to promote a value-based purchasing model. Of course, the

financial performance of ACOs will need to be monitored over the coming months and years to ensure that this type of network-based offering can survive in a post-reform marketplace.

### *Specialty Networks*

PPO networks have expanded and now operate in a number of different markets and specialty areas. Most of this publication addresses issues associated with group health plans covering both private and public-sector “books of business”. However, PPO networks support a range of specialty services including:

- Workers’ Compensation
- Auto Medical
- Mental Health
- Dental
- Alternative Medicine

PPO networks can also support unique populations covering a continuum of health care needs such as government employees, union members, prison populations, military personnel, injured employees, the disabled, poor and more. One of the challenges that deserve additional research is how we can standardize value-based purchasing criteria between markets and populations. For example, a workers’ compensation network should be more focused on supporting rehab services rather than immunizations for the groups that they serve.

Because of the wide range of network types, service goals and populations served, policymakers who help establish value-based purchasing criteria must consider an array of different measurement types that might or might not be applicable in a given situation, all while still trying to standardize quality benchmarks where possible.

With the constant innovation in health care, networks will undoubtedly continue to evolve to meet marketplace demands.

## Network Operations Today

Network-based operations have evolved to keep pace with the evolution of networks. The original network-based operations were primarily in the commercial group health market space and focused on:

- **Contracting.** Expanding networks and contracting with others to add participating providers.
- **Credentialing.** A review of participating provider applications and supporting documents, primary source validation of licensure and validation of insurance up to NCQA or URAC standards.
- **Demographics.** Maintenance of provider demographics such as name, addresses, phone numbers, specialty, TIN, languages spoken and hospital affiliation.
- **Fee schedules.** Develop and maintain fee schedule tables, a.k.a. rata tables. Facility tables include rates based on DRG, case rates, per diems, carve outs, cost plus, revenue codes and ASC groupers. Provider tables include rates based on a derivation of RBRVS, UCS, MDR (medical data research) and AWP.
- **Re-pricing.** The application of pre-negotiated contracted rates to claims submitted by clients.
- **Management.** Management of shared-risk contracts.

During the 1990s and early 2000s, many leased PPO networks began to export participating provider demographics and fee schedules to their clients. This allowed payors to re-price their own claims and reduce network operations expenses. The consequence was twofold. First, payors did not always properly

apply the contracted rate creating participating provider dissatisfaction. Second, the leased PPO networks did not consistently receive data back regarding which providers were utilized, how providers billed, how much providers billed, etc. Without this data, PPOs were not properly armed when it came to renegotiating provider contracts and rewarding those providers offering the best value.

Leased PPO networks understand the need and benefit of controlling their data, and in the late 2000s, early 2010s, they began to bring their data back in-house. PPOs no longer exported fee schedules to their clients. This allowed networks to capture 100% of claim form data and manage their participating providers more tightly.

Today's PPO marketplace has expanded to offer additional and different functions and services such as:

- Data analysis of claims data to identify provider utilization and performance
- Utilization of data and quality indicators to reshape networks and create and maintain sub-networks, narrow networks and tiered networks
- Connecting and coordinating care on behalf of their clients, including payers or upstream networks
- Assisting or coordinating patient enrollment, customer service and education
- Supporting administrative functions
    - Claims acquisition and transcription
    - Provider look up portals
    - Benefit or medical necessity determinations
- Coordinating with third party administrators, plan fiduciaries and others

**Value-Based Purchasing Overview**

Value-based purchasing is an effort by payors, employer groups and others to promote both quality and value. Rather than treating health issues as they manifest, value-based purchasing reconciles cost with quality of care in order to promote higher quality health care at a better price. Essentially, value-based purchasing seeks to report and reward excellence in health care delivery by linking provider payments to improved performance by providers. It can also help employers view health benefits as a chance to improve an employee's health, productivity and bottom line rather than as an employee recruitment tool. Providers performing effective health care services are rewarded with stronger reputations through public reporting, enhanced payments through differential reimbursements and increased market share.

Value-based purchasing also seeks to improve population health management. As companies continue to struggle in the recovering U.S. economy, comply with the remaining provisions of the Affordable Care Act (ACA) and engage in other initiatives, many employers are implementing innovative value-based purchasing strategies to reduce costs and improve health care, including consumer-directed health, accountable care organizations (ACOs) and care management and wellness programs. In fact, value-based purchasing aims to redefine the essence of health care to disease prevention and population health improvement. Maintaining an employee's health by preventing illness and managing chronic conditions improves productivity and competition among employees; it can also lower health care costs over time.

Value-based purchasing can also generate short-term savings that can fundamentally transform the health care industry, which is currently infested with fragmentation, inefficiencies, wide variations in quality and cost, and illness-centered care rather than population health management as an outcome. Provider and health insurance incentives for consumers contribute to these flaws in the delivery system. That being said, current incentives need to change in order to spur change in the overall health care delivery system. The burden of this change falls to consumers of health care to implement the strategy of value-based

purchasing. Consumers need to shift their thinking to focus on buying health care based on quality, value and cost instead of just cost. This shift will drive the health care system towards population health improvement and management, as well as a value-driven system in which ever-increasing quality of care is achieved at the lowest possible cost.

***Emergence of Smart Networks***

The ability to customize network operations, combined with valued-based purchasing initiatives, allows the sponsors of health care arrangements to create smart networks. This is where quality and efficiency are combined to create high-touch networks. For example, several major health plans have launched smart networks by:

- Offering additional compensation if certain quality benchmarks are met (e.g., P4P initiatives)
- Requiring additional qualifications to become a participating provider (e.g., concierge network)
- Certifying key functions within the network (e.g., RadSite Assessment Program for imaging services)

**The Quest for Standardization**

Although we have made steady progress in defining and implementing outcomes-based measures that promote a more efficient and higher quality health care delivery system, there are literally hundreds of different standards depending on what public and private markets a particular network serves. Inconsistent standards make it difficult to create meaningful comparisons to evaluate performance and establish effective feedback loops to optimize network operations. For example, many HEDIS measures are geared to fully functioning health plans, but not specialty networks per se. That being said, holding all PPOs to a HEDIS measurement set often does not make sense based upon the specific services and functions they provide.

A central premise of the Committee's findings is that even though the health care marketplace is diverse and dynamic, standardization is possible through a function-by-function approach. This entails identifying the key business activities within PPOs and related network offerings and then implementing consistent value-based purchasing requirements through a modular assessment methodology. Only when quality and performance criteria are correlated to the services rendered does a meaningful assessment system work.

**Challenges**

Although a functional approach to standardization may make sense, several key challenges remain:

- **Identifying the right quality metrics.** Historically, most benchmarks used to assess network quality performance have been "process" and "structure" measures. Going forward, identifying outcome measures will become a more common requirement. Of course, there is an inherent challenge because networks typically have a limited role in what they do when you factor in the broader health insurance marketplace, so all types of network assessment criteria must be configured to reflect on what networks can actually influence.
- **Measurement consistency.** Different payers may treat situations differently, creating the need for reconciliation for each relationship.
- **Statistical validity.** Each payer has a unique cross section of a particular providers' practice. If one payer has all the "complicated" cases, their scoring may be very different than those with another population, even if the practice patterns are identical.
- **Dynamic network and product offerings.** As referenced throughout this issue brief, a significant challenge is the quest for standardizing quality-based metrics in a marketplace that is

diverse and dynamic. This includes the types of network offerings existing today, the services that they render and the populations that they serve, among other variables.
- **Comparative effectiveness.** Even if a payer can effectively measure and rate their network, this cannot be used as a means to differentiate unless a customer has good access to it. Rolling up scores at the group level or only allowing the scores to be shared with existing customers limits its effectiveness. Real comparative effectiveness demands data transparency, data sharing and data aggregation to create meaningful benchmarks.

**Key Principles**

The Committee deliberated for months on how to best standardize the wide range of value-based purchasing requirements that exist in the market today. Rather than select one specific type of value-based set of measurements over another, the Committee agreed that several key principles should be established as a way to promote standardization. These recommend guidelines are:

- ***Transparency.*** All metrics needs to be transparent.
- ***Objectivity.*** An objective third party with the means to collect, analyze and report the data (such as the National Quality Forum) should be used.
- ***Participatory.*** Key participants must buy-in to the approach, including the provider community.
- ***Comparability.*** When different measures are used, they should be open to comparability to promote "apples to apples" assessments.
- ***Accountability.*** The measures must create a paradigm of accountability.
- ***Accessibility.*** All stakeholders and constituents should have a chance to review and provide feedback on any metrics used.
- ***Affordability.*** The measures should not be unreasonably expensive to comply with.
- ***Reliability.*** The measures should be based upon the latest statistical and/or evidence-based criteria.
- ***Effectiveness.*** Measures should focus on effective and meaningful outcomes measures rather than bureaucratic "process-oriented" requirements.

Ultimately, the Committee recommends a "functional" approach to standardization by utilizing the "TOPCAAARE" principles above as an effective way to benchmark network operations in a diverse and dynamic marketplace. A customized but consistent approach to matching the specific network services is critical without compromising standardization.

**Conclusion**

Of course, there are no easy solutions to ensuring that the network-based health care arrangement is encouraging better clinical and financial outcomes when promoting a transparent and accountable method. The Committee members spent many hours discussing the challenge facing most networks to respond to a myriad of value-based purchasing criteria that sometimes are very helpful and sometimes are not appropriate for a particular health care arrangement. This issue brief is an attempt to provide a series of snapshots to help public policymakers and others understand the challenges and opportunities associated with promoting a standardized approach to outcome measures versus one set of standards. Stay tuned as AAPAN continues to make recommendations impacting network-based plans.

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