Value-Based Payments

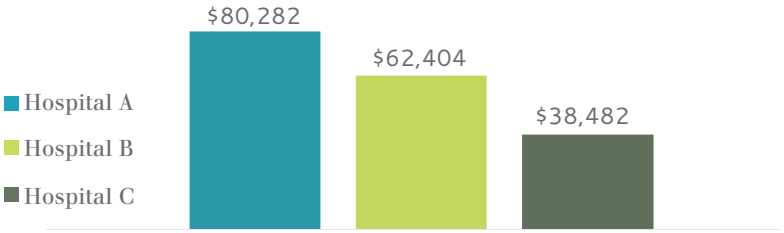
What is Value-Based Payments (VBP)?

Value-Based Payments (VBP) is a full-service Reference-Based Pricing solution from Health Cost Solutions (HCS). VBP delivers facility care with fair, up-front prices based on Medicare.

Why Value-Based Payments?

There is a staggering lack of clarity in the U.S. around the actual price of health care services, putting plan sponsors and patients at the mercy of arbitrary pricing and deceptive discounts.

[1]There can be more than 400% variance in pricing for the same procedure at facilities located less than 10 miles apart.



A hip replacement requiring a 3-day stay varies in cost over $40,000 just in this one city

BILLED CHARGES $75,000
PPO DISCOUNT 40%
TOTAL $45,000

VBP PAYS $22,250
+ 140% OF MEDICARE
MEDICARE COSTS $15,892

VBP challenges the standard with a bottom-up pricing strategy. While traditional PPO prices start at the top with billed charges, which vary by location, then subtract a discount, VBP starts from the bottom with Medicare pricing, adding a fair provider reimbursement for a lower overall payment.

[1]http://www.payercompass.com/#!price-map-main/cer7

VBP in Action:

1. Provider determines treatment and calls for pre-certification
2. Prior to treatment, a fair price is agreed on based on Medicare
3. Treatment is rendered
4. Provider submits bill to HCS for payment
5. HCS remits pre-priced payment to provider
6. Member pays deductible and co-insurance
7. HCS issues an EOB to the provider and member

How VBP creates a better health plan for your clients:

- Fixed fee (PEPM) VS percentage of billed charges
- Integrate pre-pricing navigator estimate at point of authorization
- Balance billing handled by Patient Advocacy Center
- Collaborative VS adversarial
- Achieves lowest claims cost by combining reference pricing, fixed fees and stop loss discounts
- Comprehensive databases establish price to value

Who is a good candidate for VBP?

Any group wanting to provide members with quality care at a lower cost while improving out-of-pocket predictability and lessening the uncertainty of reimbursement rates.

How do members experience VBP?

VBP applies open-access and negotiated pricing to facility claims. 90-95% of scheduled surgery and hospital care is priced up-front prior to treatment. Doctor visits, both regular and specialists, are excluded and covered by a physician-only network. Covered services include:

- Hospitals
- Urgent Care Facilities
- Surgery Centers
- Emergency Rooms
- Dialysis Centers
- Substance Abuse Facilities
- Home Health Care
- Skilled Nursing Facilities

Are members balance billed?

On average, 98% of VBP payments are accepted in full on receipt. A rare 2% of cases may see members receive a balance bill. Balance billed members must call the HCS Patient Advocacy Center (PAC). *The PAC will resolve the situation fully.*

What happens if the provider declines the VBP price?

VBP reimbursement acceptance rate is 98%. If a provider declines our reimbursement rate, our PAC negotiates an amount higher than 140% of Medicare. In rare cases, the plan recommends alternative facilities to the member if the hospital and plan cannot agree on price.

What will renewal inflation look like with VBP?

Fully insured: **12%** Self-funded: **8%** **VBP tracking** Medicare: **1%**

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