

Value Based Care in Provider Organizations



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U.S. Healthcare is Changing

Price
Transparency Act

**Alternative
Payment Models**

Value Based Care

No Surprises Act

**Accountable Care
Organizations**

*Provider
Compensation*

Affordable Care Act

What is Value Based Care?

Value Based Care: 101

HEALTHCARE: WHERE IT'S BEEN — FEE FOR SERVICE

Fee for service (FFS) is the traditional payment model where healthcare providers are reimbursed by insurance carriers and government payers for the volume of care/services provided to patients. Downsides of this payment model include a potential for health services overuse, increasing costs, and reduced focus on preventive health care.

HEALTHCARE: WHERE IT'S GOING — VALUE BASED CARE

Value-Based Care (VBC) is a reimbursement methodology that moves provider incentive from being volume driven to providing high-quality, cost-effective care across the care continuum. VBC accomplishes this by placing greater value on coordination and quality of care, patient outcomes, population health, utilization management, and clinical practice redesign. This is achieved by changing provider behavior, rethinking compensation structures, and aligning payors and providers to the same goals through risk-sharing and value-based contracting.

$$\text{VALUE} = \frac{\text{Quality} \times \text{Patient Experience}}{\text{Cost of Care}}$$

**Managing to the Lowest Cost of Care
while Improving Outcomes and Provider
and Patient Experience**

Value Based Care / APM Spectrum

Alternative Payment Model (APM) Framework

- Starts as a payment model classification system originally presented by CMS;
- Classifies APMs based on the extent to which payments reward value of services rather than volume of services;
- Advances the goal of moving payments away from fee-for-service (FFS) payments and into APMs that reduce the total cost of care while improving quality;
- Has become the foundation for implementing APMs and evaluating progress toward health care payment reform;
- Establishes a common vocabulary and pathway for measuring and sharing successful payment models.

APM Framework

\$	🔗	🏛️	👤
CATEGORY 1 FEE-FOR-SERVICE - NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE-FOR-SERVICE - LINK TO QUALITY & VALUE <ul style="list-style-type: none"> <li data-bbox="942 313 1018 385">A <li data-bbox="737 587 1223 803">Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for health information technology investments) <li data-bbox="942 803 1018 875">B <li data-bbox="737 846 1223 976">Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data) <li data-bbox="942 976 1018 1048">C <li data-bbox="737 1019 1223 1091">Pay-for-Performance (e.g., bonuses for quality performance) 	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE <ul style="list-style-type: none"> <li data-bbox="1556 313 1633 385">A <li data-bbox="1377 587 1863 717">APMs with Shared Savings (e.g., shared savings with upside risk only) <li data-bbox="1556 731 1633 803">B <li data-bbox="1377 760 1863 1005">APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk) 	CATEGORY 4 POPULATION-BASED PAYMENT <ul style="list-style-type: none"> <li data-bbox="2170 313 2247 385">A <li data-bbox="1914 587 2503 803">Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health) <li data-bbox="2170 803 2247 875">B <li data-bbox="1914 875 2503 1005">Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments) <li data-bbox="2170 1019 2247 1091">C <li data-bbox="1914 1048 2503 1206">Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Figure 1: The Updated APM Framework

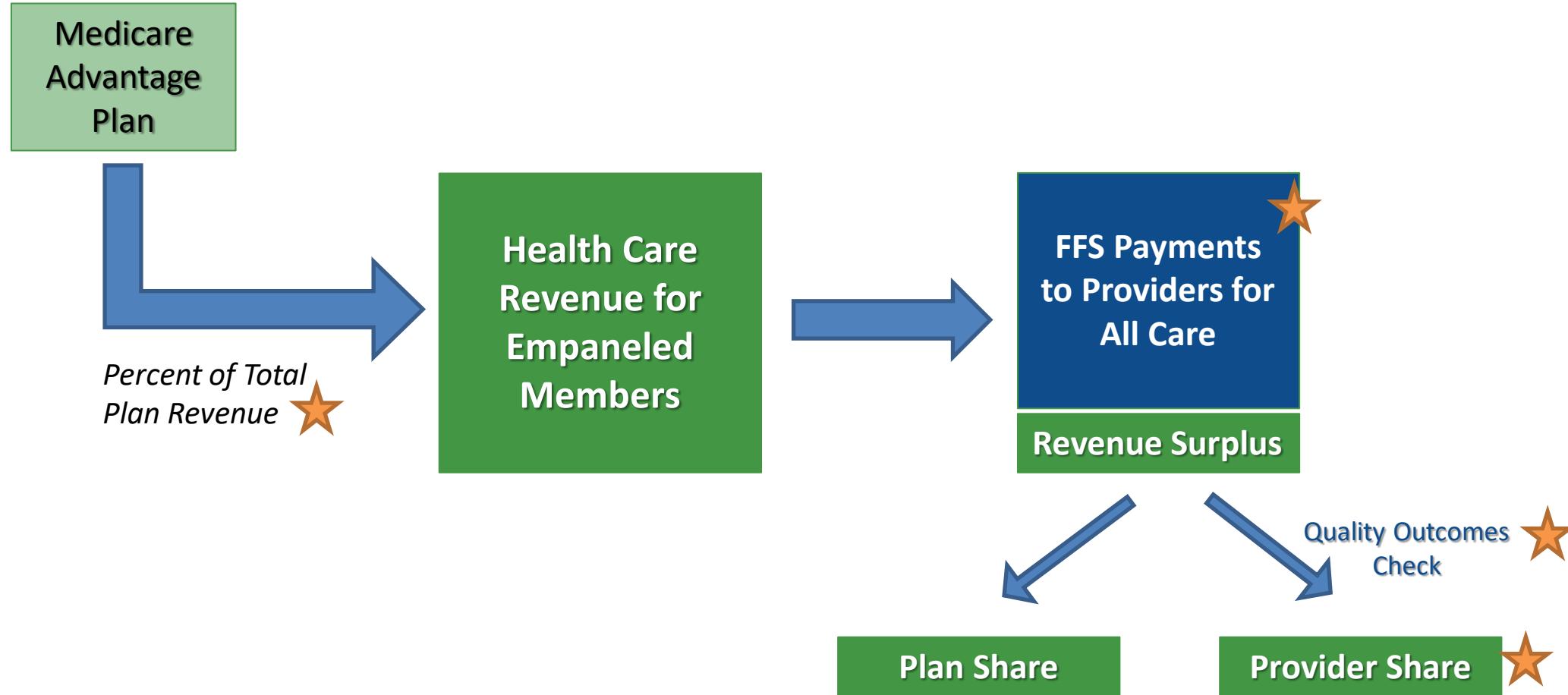
Source: <https://hcp-lan.org/workproducts/apm-factsheet.pdf>

Why Should Providers Care About VBC?

Why Value Based Care

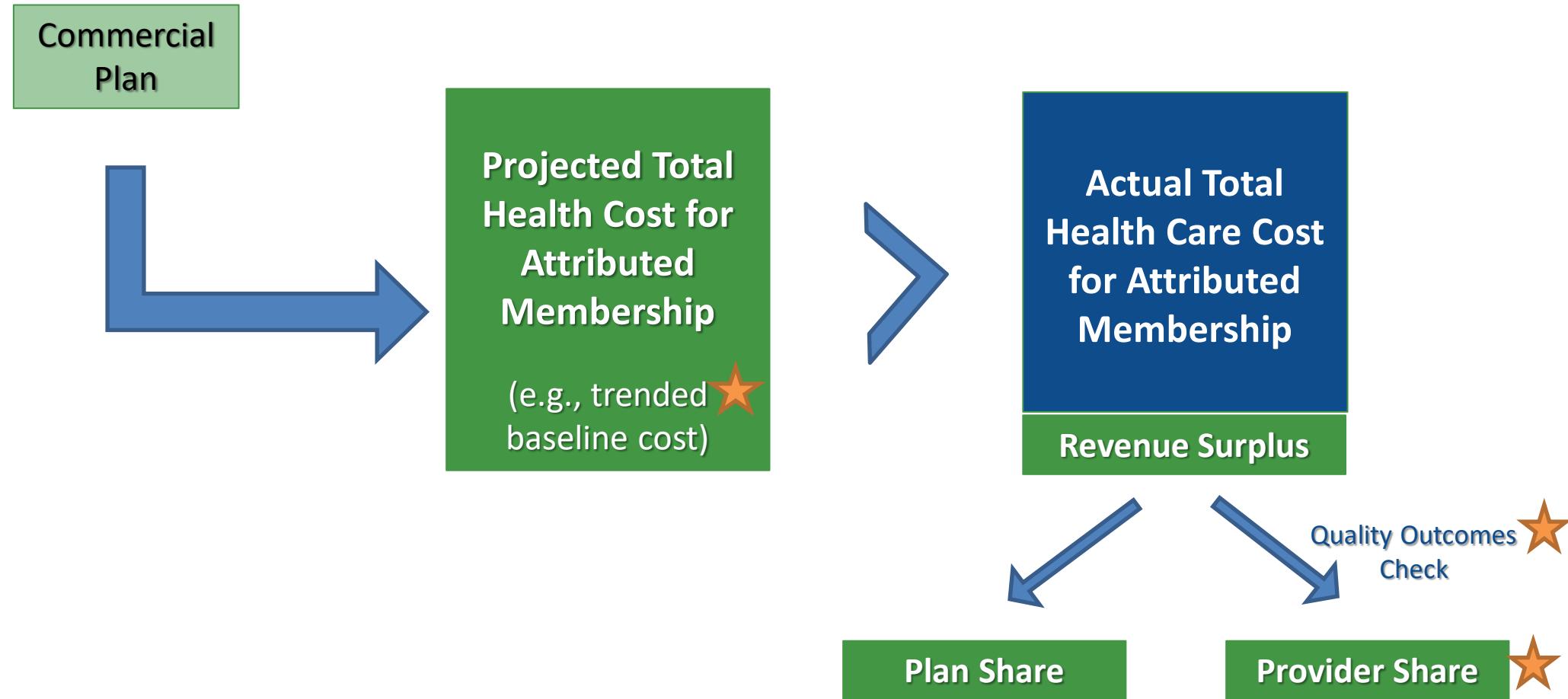
- Existing FFS reimbursement methodologies and health care costs are unsustainable
- Reimbursement landscape is changing; exploring VBC now can help providers prepare for the future
- VBC prioritizes patient-centered care models and emphasizes whole person care
- VBC does not mean narrow networks or lack of choice
- Consumers increasingly seek value and focus on actual outcomes

Value Based Care Incentive Example 1



★ = Negotiated between plans and providers

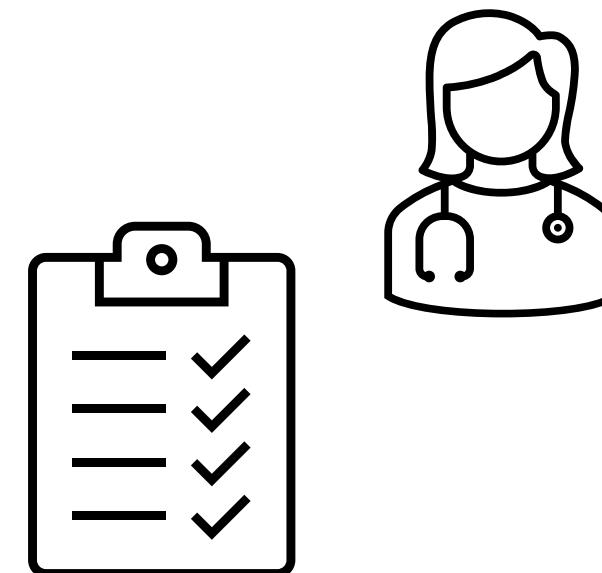
Value Based Care Incentive Example 2



 = Negotiated between plans and providers

Provider Performance Levers – The Power of Providers

- Coding and documentation (capturing risk of the patient population)
- Addressing quality outcomes
- Managing referral patterns
- Managing total spend/total cost of care



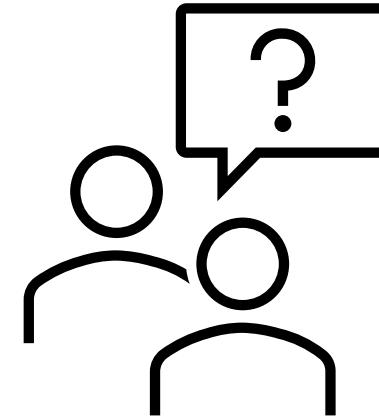
VBC Landscape in Alaska

- Extremely high health care costs (for employers and consumers)
- Limited presence of value-based care payment models
- Limited presence of clinically integrated/high-performance networks
- No Medicare Advantage plans
- No Managed Medicaid programs



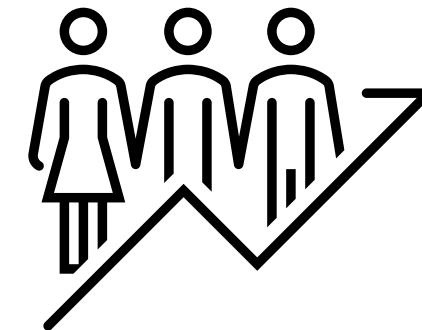
Why No VBC Alaska?

- No CMS pilots?
- Employers not pushing for it?
- The SOA not pushing for VBC?
- Insufficient education on what VBC can do?
- Satisfaction with the status quo?
- Hesitancy to contract with new plans?
- Other barriers?



Value Based Care Opportunities

- Reducing total cost of care for patients, employers, the state
- Aligning provider incentives to focus on patient outcomes
- Partnership opportunities: physician-led clinically integrated networks, high-performance networks
- Increasing patients benefits
- Improving patient and provider satisfaction



Thank You!