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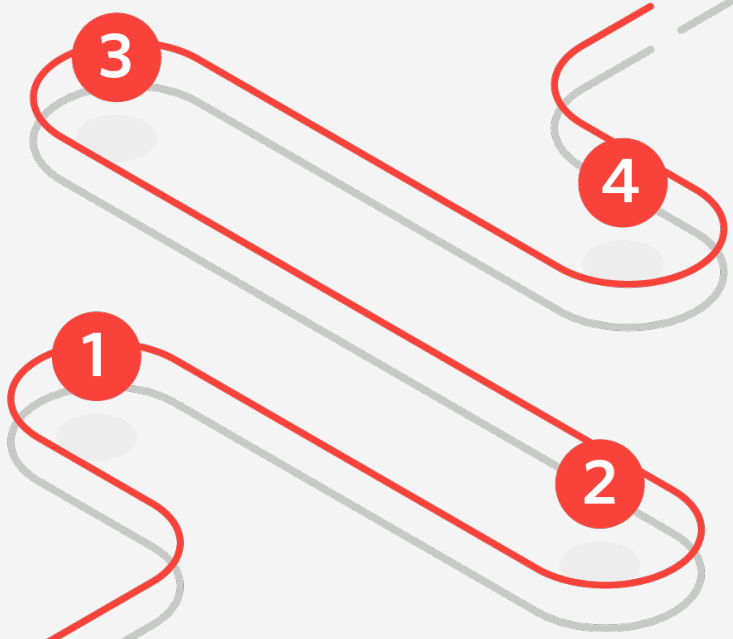
All Roads Lead to Value-Based Care

Part 1: Intro to Value-based Care



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Educational Webinar Series

Intro to Value-Based Care

The learning objectives for the session:

Define Value-Based Care (VBC)

Rationale for Transition to Value-Based Care

Identify and describe various value-based care models

Features and Incentives of Each VBC Model

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Intro to Value-Based Care

Centers for Medicare and Medicaid Services (CMS) is displaying a strong commitment to transitioning the healthcare system towards 100% value-based care (VBC) by 2030.

This ambitious goal signifies a significant shift from the traditional fee-for-service model to value-based payment models.

These models prioritize the quality of care provided to patients over the sheer quantity of services rendered.

CMS Vision, Oversight, and Direction

- Overarching goal: **to transform the health system** into one that achieves **equitable outcomes** through high quality, affordable, person-centered care
- CMS **administers** value-based programs at a Federal Level
- CMS **approves** State Medicaid VBP programs
- CMS direction toward a more holistic view of value-based care **across healthcare settings and payers**
- CMS intends to bring **more alignment among programs** within a setting (e.g. the Medicare SNF VBP program and State NF Medicaid VBP programs)

Core Principles of Value Based Care

Emphasis on Patient Outcomes

Quality and Safety

Cost Efficiency

Care Coordination

Patient-Centered Approach

Prevention and Population Health

Data Driven Decision Making

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Value-Based Care Payment Models

Pay-for-Performance (P4P)

- Providers are rewarded financially based on **specific quality metrics and outcomes**
- Providers receive **supplemental payments or incentives** when they meet predetermined **performance targets**

Shared Savings

- Providers form **accountable care organizations (ACOs) or similar networks**
- ACOs are **responsible for managing the health of a defined population** and **sharing in any cost savings** achieved
- If the ACO is successful in **reducing healthcare costs while meeting quality targets**, it receives a portion of the savings

Full-Risk Capitation

- Providers assume **full financial risk** for the cost and quality of care for a defined population
- They receive a f**ixed payment per person ("capitation")** and are responsible for managing all aspects of care
- Providers who can successfully **manage costs while maintaining high-quality care** can achieve significant financial rewards

What are your major concerns about transitioning to value-based care? (choose all that apply)

a. Administrative burden
b. Risk of patient selection
c. Financial viability and uncertainty
d. Data and technology infrastructure
e. Accuracy of performance metrics

Pay-for-Performance (P4P)

Pay-for-Performance (P4P) is a healthcare payment model that ties financial incentives to the achievement of specific performance goals and outcomes.

While it still utilizes the fee-for-service system, it nudges providers toward value-based care because it ties reimbursement to metric-driven outcomes, proven best practices, and patient satisfaction, thus aligning payment with value and quality.

How Pay for Performance Works

Quality Metrics and Targets

Define specific quality metrics and targets that healthcare providers must meet or exceed to receive financial incentives.

Measurement and Evaluation

Providers' performance is regularly measured and evaluated against the defined quality metrics using various sources of data.

Financial Incentives

If healthcare providers meet or exceed the quality targets, they become eligible for financial incentives or bonuses.

Penalties or Withholdings

Providers may face financial penalties or withholdings if they fail to meet the quality metrics. Penalties may result in reduced payments or lower reimbursement rates

Focus on Patient-Centered Care

Encourages healthcare providers to focus on patient-centered care and take proactive steps to improve patient outcomes and overall quality of care.

Continuous Improvement

Aim to drive continuous improvement in healthcare delivery. Providers are motivated to make changes and implement best practices to enhance patient care and meet or surpass quality targets.

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Shared Savings

Shared savings is a specific approach in which groups of healthcare providers form accountable care organizations (ACOs) or similar networks that collaborate to manage the care of a specific population of patients.

They share financial responsibility for the overall cost and quality of care provided to their patients. ACOs are rewarded financially when they achieve cost savings below a predetermined benchmark or target.

Full-Risk Capitation

Full-risk capitation is payment arrangement where a healthcare provider or organization assumes financial responsibility for all the healthcare needs of a defined patient population.

Under a full-risk contract, the provider or organization receives a fixed, predetermined payment per patient (often on a monthly or annual basis) to cover all the costs associated with that patient's care.

How Shared Savings Works

Formation of a Provider Network or ACO

These groups consist of primary care physicians, specialists, hospitals, and other healthcare entities that work together to deliver coordinated care to a defined patient population.

Establishing a Benchmark

Establishes a cost goal for caring for a specific patient group, often using historical spending data and adjusting for factors like age and health.

Quality Measures

These measures often focus on clinical outcomes, patient satisfaction, and patient safety.

Patient Attribution

Assigns patients to a provider network or ACO based on criteria like their primary care physician, making them part of the accountable population.

Financial & Risk Sharing

Providers share savings with the payer if they reduce costs below the benchmark while meeting quality standards, but they also share financial risk if they miss cost and quality targets.

Care Coordination

Providers work together to ensure that patients receive appropriate care, avoid duplicative services, and are not unnecessarily hospitalized.

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How Full-Risk Capitation Works

Contractual Agreement

A healthcare provider, such as an accountable care organization (ACO), physician group, or healthcare system, enters into a contractual agreement with a payer.

Defined Patient Population

The contract defines a specific patient population for which the provider or organization is responsible.

Risk Assessment

The provider assesses patient population risk by considering demographics, health conditions, and past healthcare usage to estimate expected healthcare costs.

Fixed Payment

The payer provides the provider or organization with a fixed, predetermined payment for each patient in the defined population. This payment is often referred to as a "capitated payment" or "per-member per-month (PMPM)" payment.

Comprehensive Care

Under capitated payment, the provider must deliver all essential healthcare services to the defined patient group, including preventive, primary, specialist, hospital, and other medical care.

Quality Metrics

Full-risk contracts include performance metrics for providers to maintain or enhance care quality, covering clinical outcomes, patient experience, and preventive measures

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How Full-Risk Capitation Works

Care Coordination

Providers in a full-risk contract often emphasize care coordination and population health management to ensure that patients receive appropriate and timely care.

Financial Accountability

Providers assume financial accountability for managing costs.

Risk Mitigation Strategies

Providers may implement various risk mitigation strategies to manage financial risk, such as utilization management, population health analytics, etc.

Data Sharing and Reporting

Robust data sharing and reporting mechanisms are essential for monitoring patient outcomes, utilization patterns, and financial performance..

Patient-Centered Care

Full-risk contracts emphasize patient-centered care, patient engagement, and shared decision-making.

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Bundled Payments

Bundled payments involve a single payment to cover all services related to a particular episode of care or medical condition.

Bundled payments are particularly relevant in cases where patients may require multiple services from different providers to manage a specific medical condition or undergo a planned treatment course.

This payment model encourages care coordination among various providers involved in a patient's treatment and incentivizes cost-effective care.

How Bundle Payments Work

Episode of Care Definition

Defined around specific episodes of care or medical conditions, such as joint replacement surgeries, heart procedures, maternity care, or treatment of chronic conditions like diabetes

Single Payment

A fixed payment covers all services within a defined episode of care, including hospitalization, physician fees, post-acute care, rehabilitation, and more, rather than paying for each service separately.

Care Coordination

Different healthcare providers involved in the patient's treatment work together to coordinate care efficiently.

Quality Metrics

Providers must maintain high care standards, with measures evaluating patient satisfaction, readmission rates, complications, and other quality indicators.

Gainsharing and Risk-Sharing

Providers gain financially for cost savings and meeting quality targets, while they bear financial responsibility for exceeding the bundled payment amount.

Predictability and Transparency

Enhance cost predictability and transparency for patients and payers. Patients are aware of total episode of care costs upfront, and payers can budget for healthcare expenses more effectively.

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The transition to value-based care payment models is a complex process that requires collaboration among healthcare stakeholders, investment in data analytics and technology, and a focus on patient-centered care. It aims to create a more sustainable healthcare system that delivers better outcomes for patients while controlling healthcare costs.

Q&A

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