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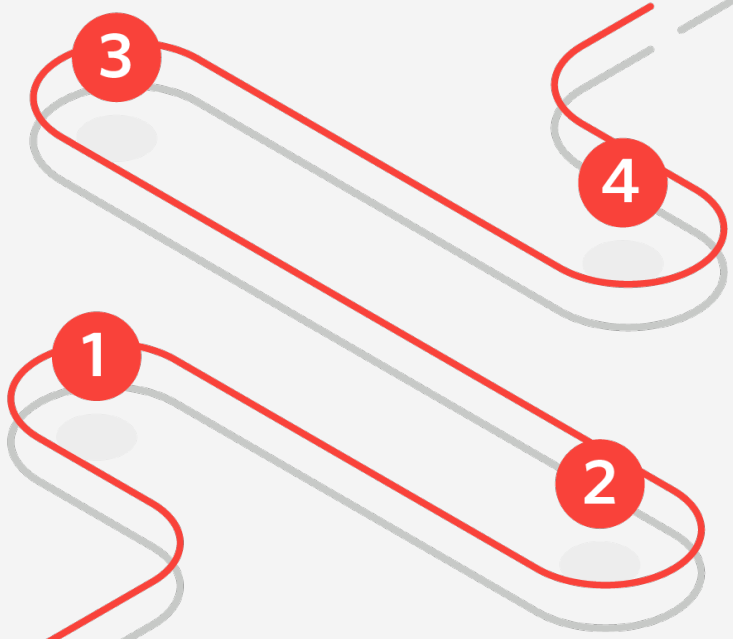
All Roads Lead to Value-Based Care

Part 2: Value-based Care Across Payers



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Educational Webinar Series

Value-Based Care Across Payers

The learning objectives for the session:

Understanding Value-Based Care (VBC) Payers

Rationale for Transition to VBC among Payers

Strategies for Promoting VBC Adoption among Payers

Importance of Data Sharing and Analytics

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Do you currently build performance targets into your provider contracts?

a. Yes
b. No
c. N/A

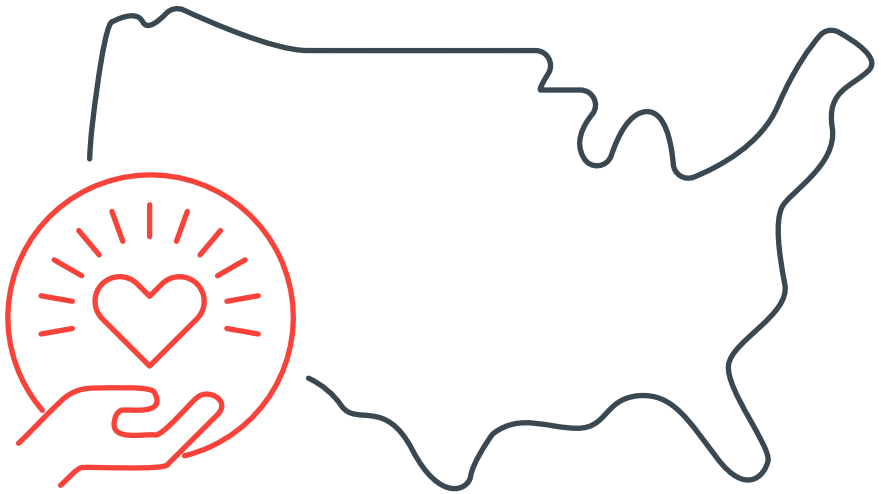
Value-Based Care Across Payers

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.

Largest Healthcare Payer



- The Centers for Medicare & Medicaid Services (CMS) is the single largest payer for health care in the United States.
- According to the White House in 2022, **63 million Americans rely on health care benefits through Medicare** and **89 million Americans rely on health care benefits through Medicaid**.

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Medicare vs Medicaid

MEDICARE

- An **age-based program** available to individuals aged 65 and older, regardless of income, as well as **certain individuals with disabilities who are under 65**.
- **Administered by federal government**.
- Covers medically necessary services, such as hospital care, doctor visits, lab tests, preventive screenings, and medically necessary procedures.
- Medicare consists of different parts, including:
  - Part A (hospital insurance),
  - Part B (medical insurance),
  - Part C (Medicare Advantage plans), and
  - Part D (prescription drug coverage).

MEDICAID

- A **means-tested program** primarily designed to provide healthcare coverage to low-income individuals and families.
- **Joint federal and state program, primarily administered by states**, with each state having flexibility to design their own Medicaid program, eligibility rules, and benefit structures. subject to certain federal guidelines and standards.
- Provides a broad range of healthcare services, including doctor visits, hospital care, prescription drugs, preventive care, and long-term care services. **Covered services may vary by state**, as states have flexibility in determining their Medicaid benefits package within federal guidelines.

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Private Insurance

Private Insurance

- Private health insurance is a type of insurance coverage that individuals or families can purchase from private insurance companies either independently, through employers or health exchanges.
- Some individuals purchase private health insurance to **supplement their existing public insurance coverage, such as Medicare**, to fill in gaps in coverage or to access additional benefits.
- Insured individuals or their employers **pay regular premiums to the insurance company**. Premiums can vary based on factors like the level of coverage, the individual's age, their health status, and the insurance provider.
- Private health insurance can cover a wide range of healthcare services, such as doctor visits, hospital stays, prescription drugs, preventive care, and even alternative therapies like chiropractic care or acupuncture. **The exact coverage will depend on the specific policy.**
- Insurance policies **often come with deductibles**, which are the amount you must pay out of pocket before the insurance starts covering expenses.
- After meeting the deductible, the insured individual **may still have to pay a portion of the costs through co-payments or co-insurance**.

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)

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Policy and Regulation

Medicare Access and CHIP Reauthorization Act (MACRA)

Introduced the Quality Payment Program (QPP), which provides two tracks—the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)—for Medicare reimbursement.

Medicare and Medicaid Initiatives

Medicare and Medicaid have been instrumental in driving the adoption of VBC. CMS has introduced initiatives such as the Medicare Shared Savings Program (MSSP) and the Center for Medicare and Medicaid Innovation (CMMI).

Anti-Kickback Statute and Stark Law Reforms

Recent changes to regulations surrounding the Anti-Kickback Statute and Stark Law enable greater flexibility for VBC arrangements. These reforms provide more leeway for providers to collaborate, share resources, and align incentives without violating anti-fraud regulations.

State-Level Initiatives

State governments often launch their Medicaid initiatives to promote VBC, such as Medicaid managed care programs that incentivize care coordination and preventive services.

Quality Measurement and Reporting

Government agencies set standards for quality measurement and reporting, requiring healthcare providers to track and report on specific quality metrics. These metrics may include patient satisfaction, clinical outcomes, and adherence to evidence-based practices.

Data Interoperability and Exchange

Regulatory efforts focus on promoting health information exchange (HIE) and interoperability, enabling different healthcare providers to share patient data securely. This facilitates care coordination and ensures that relevant information is available across the care continuum.

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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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Strategies for Promoting Value Based Care

Alternate Payment Models (APM)

Data Sharing and Analytics

Quality Improvement Initiatives

Risk Stratification and Care Management

Long-Term Contracts

Public Reporting

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Alternate Payment Models

Alternative payment models (APMs) are a broad category of healthcare reimbursement models that differ from traditional fee-for-service (FFS) payments, with the aim of improving the value and quality of care.

These models often focus on rewarding healthcare providers based on the quality and outcomes of care, rather than the volume of services provided.

Alternate Payment models

Pay-for-Performance (P4P)

Utilizes the fee-for-service system and payers provides financial incentives to provides for the achievement of performance metrics and outcomes.

Accountable Care Organizations (ACOs)

A group of healthcare providers that assume responsibility for the cost and quality of care for a defined population. They may receive shared savings or shared risk payments based on their performance.
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Capitation

Pays a fixed amount per patient per month (or year) to healthcare providers or organizations, regardless of the number of services rendered. Providers are responsible for delivering comprehensive care within this budget.

Bundled Payments

A single payment for all services related to a specific medical condition or episode of care, such as a joint replacement surgery. Providers are responsible for managing costs while maintaining quality.

Quality Withholds

A portion of provider payments is withheld initially and returned if specific quality and cost targets are met. It incentivizes providers to achieve better quality and cost-efficiency.

Patient-Center Medical Homes (PCMH)

PCMHs receive additional payments for providing comprehensive, coordinated, and patient-centered care. They often serve as a central point for managing a patient's healthcare needs.

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What Alternative Payment Model(s) are you currently using or considering? (choose all that apply)

a. Pay for Performance (P4P)
b. Accountable Care Organization (ACO)
c. Capitation
d. Bundled Payments
e. Patient Center Medical Homes (PCMH)

Data Sharing and Analytics

Data sharing and analytics play a crucial role in the implementation of value-based care (VBC) models.

In VBC, data sharing and analytics provide actionable insights that enable healthcare stakeholders to make informed decisions, improve care quality, reduce costs, and ultimately enhance patient outcomes.

These tools are instrumental in achieving the goals of value-based care by emphasizing the delivery of high-value, patient-centered care.

Data Sharing and Analytics

Data Aggregation

Involves collecting health information from various sources, including electronic health records (EHRs), claims data, patient-reported data, and more. Aggregating this data into a central repository is essential for comprehensive analysis.

Interoperability

Ensuring that different healthcare systems and technologies can share data seamlessly is critical. Health information exchanges (HIEs) and standardized data formats facilitate interoperability, enabling a comprehensive view of a patient's health history.

Risk Stratification

Analytics tools can help identify high-risk patients who may benefit the most from care management and interventions. This enables healthcare organizations to allocate resources effectively.

Performance Measurement

Data analytics are used to measure healthcare providers' performance against quality and cost benchmarks. These metrics can include patient outcomes, readmission rates, preventive care adherence, and cost per patient.

Quality Improvement

Data analytics identify areas where healthcare quality can be improved. For example, analytics can reveal gaps in preventive care or chronic disease management and help providers make necessary improvements.

Population Health Management

Analytics tools enable healthcare organizations to understand the health needs of their patient populations, allowing for targeted interventions and proactive care planning.

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Data Sharing and Analytics

Resource Allocation

Understanding healthcare utilization patterns and resource needs helps organizations allocate staff and resources efficiently, reducing waste and improving cost-effectiveness.

Predictive Analytics

Forecast patient needs, such as identifying individuals at risk of hospital readmissions or worsening health conditions, allowing providers to intervene proactively.

Financial Analytics

These tools help organizations track the financial aspects of VBC, such as cost s avings and shared savings calculations in accountable care organizations (ACOs) or bundled payment programs.

Compliance Reporting

Data analytics assist healthcare organizations in generating reports required for compliance with VBC programs and government regulations.

Feedback Loops

Analyzing data on an ongoing basis allows healthcare organizations to create feedback loops for continuous improvement, adjusting care models and strategies as needed.

Data Security and Privacy

Ensuring the security and privacy of patient data is critical. Robust data governance and security measures are essential to protect sensitive health information.

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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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Questions? Erica.Archuleta @nethealth.com

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