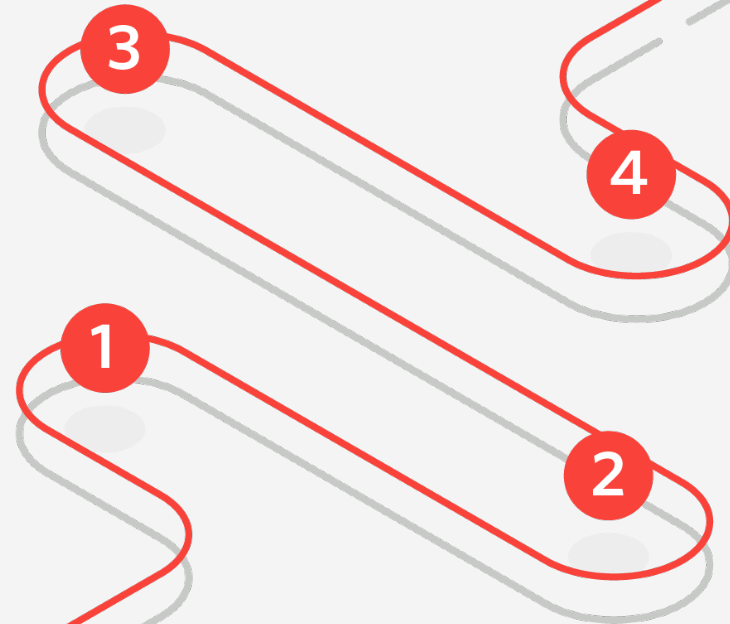
All Roads Lead to Value-Based Care

Part 3: Value-based Care Across Settings



Value-Based Care Across Settings

The learning objectives for the session:

Understand Value-Based Care (VBC) in hospitals, nursing facilities and primary care

Challenges and Opportunities for hospitals, nursing facilities and primary care

VBC Contracting Provisions

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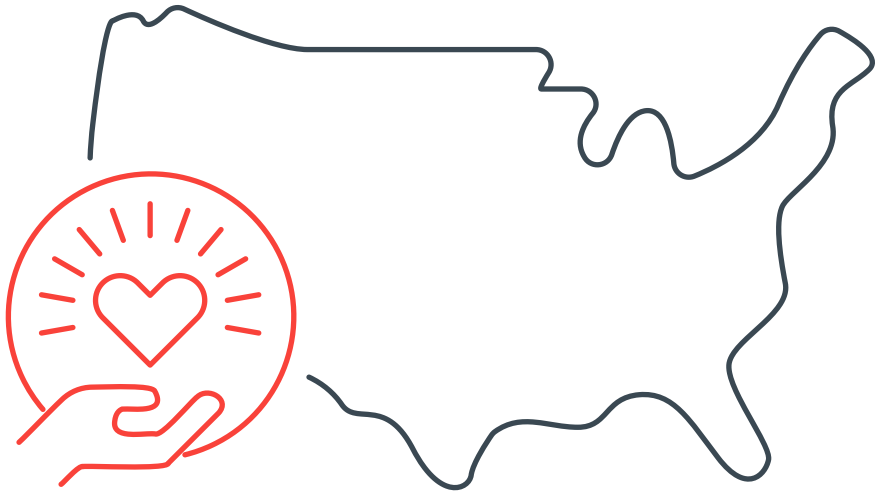
Do you currently participate in a VBC programs with:

a. Medicare
b. Medicaid
c. Commercial Insurance
d. None
e. N/A

Value-Based Care Across Settings

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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Value-Based Care in Hospitals

Hospital Value-Based Purchasing (HVBP) Program

Program Objectives

- Quality Improvement
- Efficiency and Safety
- Adverse Event Reduction
- Evidence-Based Care
- Patient Experience
- Transparency
- Recognition for High-Quality, Cost-Efficient Care

Payment Adjustment Mechanisms

- Inpatient Prospective Payment System (IPPS) Payment Adjustments based on the quality of care they deliver
- Withholding a percentage of Medicare Payments, typically 2%
- Value-Based Incentive Payments
- Claim-by-Claim Adjustment Factor

Measures Used

- Mortality and Complications
- Healthcare-Associated Infections
- Patient Safety
- Patient Experience
- Efficiency and Cost Reduction

Scoring and Performance Evaluation

- Achievement and Improvement Scores
- Total Performance Score

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Hospital Readmission Reduction Program (HRRP)

Program Objectives

1. Improving Communication and Care Coordination
2. Reducing Avoidable Readmissions

Payment Adjustment & Calculation

CMS calculates the payment reduction and component results for each hospital based on its performance during a rolling performance period. The payment adjustment factor is the form of the payment reduction CMS uses to reduce hospital payments. Payment reductions are applied to all Medicare fee-for-service base operating diagnosis-related group payments during the FY (October 1 to September 30). The payment reduction is capped at 3 percent (that is, a payment adjustment factor of 0.97).

30-Day Risk-Standardized Unplanned Readmission Measures

- Acute Myocardial Infarction (AMI)
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure (HF)
- Pneumonia
- Coronary Artery Bypass Graft (CABG) Surgery
- Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA)

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Medicaid Hospital Value-Based Payment Initiatives

State Medicaid Authorities

1. 1115 Waiver Authorities
2. State Plan Amendments
3. Managed Care Directed Payments

State Medicaid Examples

1. Supplemental Payments for Hospital Quality Improve Initiatives
2. Managed Care Directed payments for Hospital Performance Improvement
3. Managed Care contract requirements

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Value-Based Care in Nursing Facilities

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

Program Objectives

- Aims to incentivize skilled nursing facilities (SNFs) to enhance the quality of care provided to patients.
- The program publicly reports SNF performance on quality metrics. This promotes transparency and allows patients and the public to make more informed decisions about their healthcare providers.

Payment Adjustment Mechanisms

- CMS withholds 2% of SNFs' Medicare fee-for-service (FFS) Part A payments to fund the program.
- Between 50% and 70% of the withhold is redistributed to SNFs as incentive payments.
- CMS redistributes 60% of the withhold to SNFs as incentive payments.
- The remaining 40% of the withhold is retained in the Medicare Trust Fund.

Measures Used

- For the FY 2024 Program year, the SNF VBP Program will award incentive payments to SNFs based on their performance on the SNF 30-Day All-Cause Readmission Measure (SNFRM).

Scoring and Performance Evaluation

- SNFs are assessed on both improvement and achievement, and the higher of the two scores is considered.

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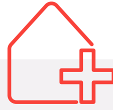
Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Program Objectives

- To improve the quality of care provided in skilled nursing facilities (SNFs) by collecting and publicly reporting data related to the quality of care and patient outcomes in these facilities.

- This promotes transparency and allows patients and the public to make more informed decisions about their healthcare providers.



Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)

- Requires standardized and interoperable assessment data for quality measures, resource use, and other domains.
- Promotes the exchange of data among post-acute providers and other healthcare entities.
- Aims to enhance Medicare beneficiary outcomes through shared decision-making, care coordination, and improved discharge planning.

Payment Adjustment

Each Fiscal Year (FY) if a SNF fails to submit the required quality data, the SNF will be subject to a two percentage (2%) point reduction in the Annual Payment Update (APU) for the applicable performance year.

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Medicaid Nursing Facility Value-Based Payment Initiatives

State Medicaid Authorities

1. State Plan Amendments
2. Managed Care Directed Payments

State Medicaid Examples

1. Supplemental Payments for Nursing Facility Quality Improve Initiatives
2. Managed Care contract requirements
3. Managed Care Directed payments for Nursing Facility that are Pay-for-performance

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Value-Based Care in Primary Care

Merit-based Incentive Payment System (MIPS)

Program Overview

- MIPS is a program within the Quality Payment Program framework, and it serves as a mechanism for eligible healthcare providers to participate in value-based care initiatives.
- MIPS participants have the opportunity to earn payment adjustments for Medicare Part B-covered professional services based on their performance in various categories. These adjustments can be positive, neutral, or negative, depending on the provider's performance.

Performance Categories

- Quality
- Cost
- Improvement Activities
- Promoting Interoperability

Reporting Options

- Traditional MIPS
- Alternative Payment Model (APM) Performance Pathway (APP)
- MIPS Value Pathways (MVPs)

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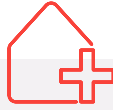
Making Care Primary (MCP)

Program Overview

- Geared towards smaller, independent organizations that want to participate in value-based care independently.
- The model is designed to provide a progressive pathway to value-based payment, through three tracks that increase in care delivery and payment advancement over time. year.
- Eight states were selected for MCP: Colorado, North Carolina, New Jersey, New Mexico, New York, Minnesota, Massachusetts, and Washington.



Model Design

- **Track 1 –Building Infrastructure**
  Payment for primary care will remain fee-for-service (FFS) and CMS will provide additional financial support to help participants build advanced care delivery capabilities. Participants can begin earning financial rewards for improving patient health outcomes.
- **Track 2 – Implementing Advanced Primary Care**
  Payment for primary care will shift partially to prospective, population-based payments and CMS will continue to provide additional financial support as participants build capabilities. Participants are eligible to earn increased financial rewards for improving patient health outcomes and achieving savings
- **Track 3 – Optimizing Care and Partnerships**
  Payment for primary care will shift to fully prospective, population-based payment while CMS will provide additional financial support to sustain care delivery activities while participants can earn greater financial rewards for improving patient health outcomes and achieving savings.

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Medicaid Primary Care Value-Based Program

State Medicaid Authorities

1. 1115 Waiver
2. State Plan Amendment
3. Managed Care Directed Payments

State Medicaid Examples

1. Patient Center Medical Homes
2. Comprehensive Primary Care Plus (CPC+)
3. Accountable Care Organizations (ACOs)
4. Managed Care contract requirements

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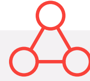
Provider Challenges & Opportunities

Provider Challenges

Financial Uncertainty

The transition to VBC can be financially challenging, as it often involves moving away from fee-for-service models to risk-based payment structures.



Data and Technology

Effective VBC requires advanced data analytics and health information technology.

Risk Adjustment

Accurately assessing patient risk and severity is essential for fair reimbursement in VBC.

Quality Reporting Burden

Compliance with VBC models often involves extensive reporting requirements and meeting specific quality metrics.

Resource Constraints

Providers often operate with limited financial and staff resources, which can make it difficult to implement VBC models.

Care Coordination

Providers may face challenges in aligning care delivery with other providers and care settings.

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Provider Opportunities

Cost Control

Providers can benefit from VBC by effectively managing costs and reducing unnecessary hospital readmissions and complications.

Quality Improvement

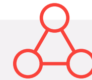
VBC models provide a strong incentive for providers to focus on the quality of care they deliver.

Patient-Centered Care

VBC encourages a more patient-centered approach, which can result in increased patient satisfaction and engagement in their care.

Population Health Management

Providers can develop population health programs to proactively address the health needs of their communities.



Collaboration and Integration

VBC encourages collaboration between healthcare providers, including providers, primary care physicians, specialists, and other care settings.

Innovations in Care Delivery

Providers can explore innovative care models, telehealth, and technology solutions to improve patient care and meet VBC goals.

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Do you currently have a data exchange and/or technology infrastructure strategy in your VBC contract:

a. Yes
b. No
c. N/A

Value-Based Care Contracting Provisions

VBC Contracting Provisions

Financial Terms and Payment Structure

Quality Metrics and Performance Measures

Quality Improvement Initiatives

Performance Improvement Incentives

Care Coordination

Population Health Management

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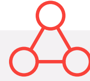
VBC Contracting Provisions

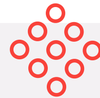
Network Adequacy



Data Sharing and Reporting

Risk Adjustment

Patient Engagement and Experience



Telehealth and Health Information Exchange

Contract Duration and Termination Clauses

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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

Stop by our VBCExhibitHall.com Virtual Booth!

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The PointRight Difference

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Thank you!

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