

INTELLIGENCE THAT WORKS

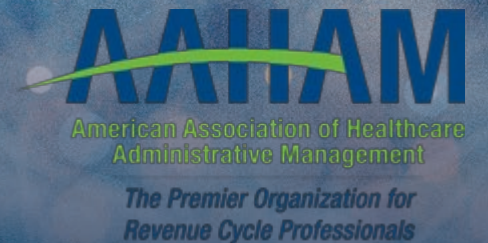
Value Based Care

Key Concepts and Evolution

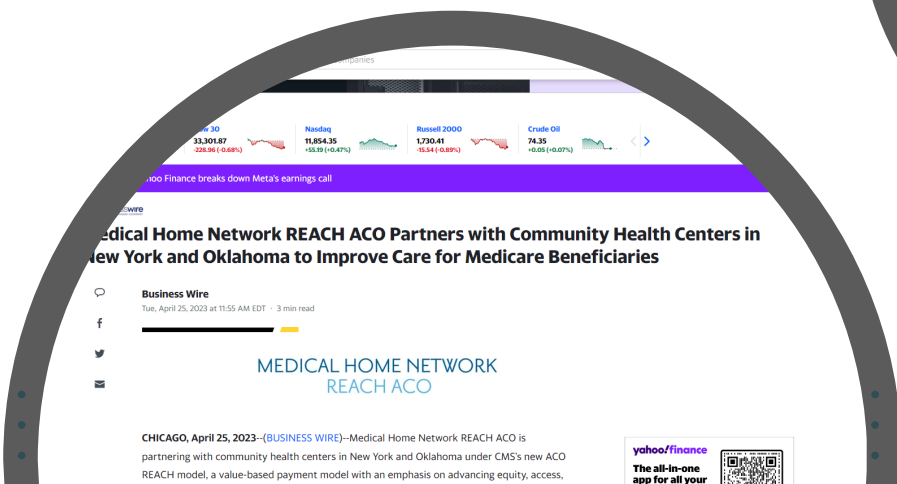
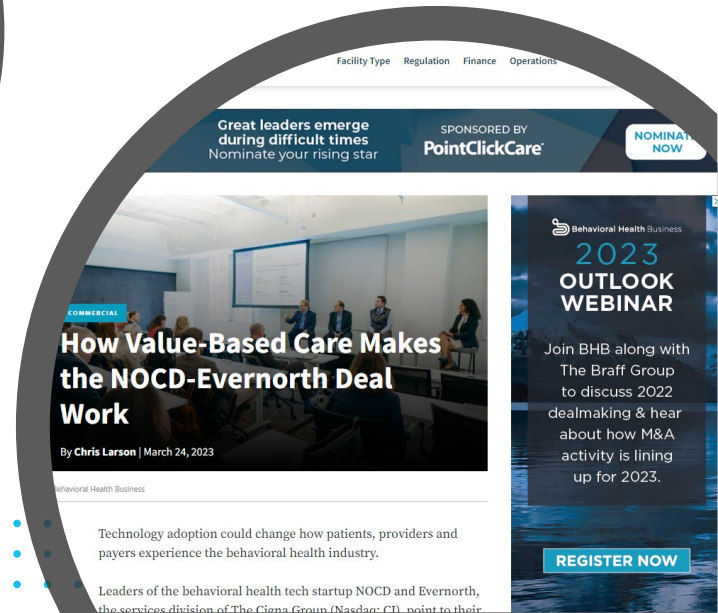
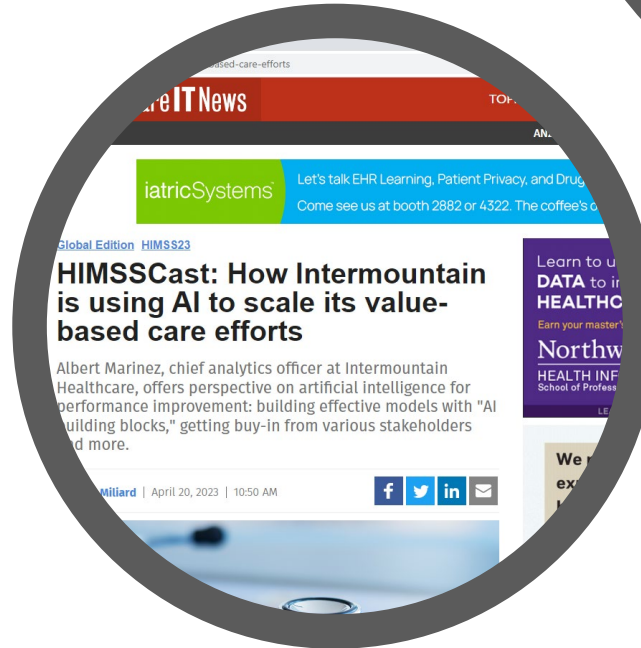
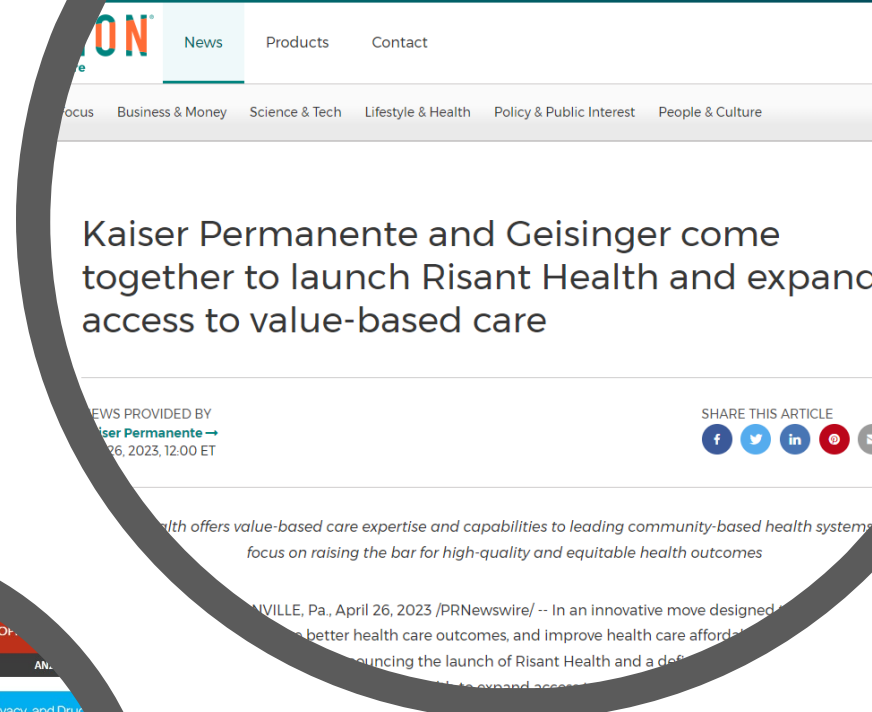
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Value based agreements and delivery are the primary tools used today to rationalize and control healthcare spending



Enough Buzzwords .. What is it?

Value-based programs are contracting vehicles between payers and providers that aim to reward health care providers with incentive payments for the quality of care they give to people. These programs are part of a larger strategy to reform how health care is delivered and control the “spend”.

- BRG completes an annual tracking poll of more than 2,500 providers, nearly 80 percent of providers believe they have moved to some level of performance-based payment risk tied to VBC. Only 20 percent report pure fee-for-service (FFS) reimbursement, but more than 90 percent expect their payments will be tied to value by 2025.
- Payers reported that 39 percent of payments were still FFS based, with 60.7 percent having some link to VBC, according to 2020 HCPLAN data, the most recent year available. The HCPLAN survey revealed that 87 percent of payers expect Value Based Care (VBC) to increase going forward.

As the industry moves into the middle innings of VBC implementation, the foundational principles remain the same. At its core, value-based care is a reimbursement system that ties healthcare payment to the quality of care provided and rewards providers for efficiency and effectiveness. It is a model in which providers, including hospitals and physicians, are reimbursed based on health outcomes rather than service volume.



VBC Arrangement

Choosing the right arrangement and negotiating the right terms can be difficult. Unlike traditional FFS payments, where providers are reimbursed for each service they perform, VBC ties reimbursement to quality and cost outcomes, so a provider needs to understand its capabilities, strengths, and weaknesses.

Category	Model Description
Fee for Service (FFS)	Healthcare providers are reimbursed for each service performed.
Pay for Reporting/ Performance	Rewards providers for meeting predefined targets for quality indicators or efficacy measures
Patient-Centered Medical Home	Team of physicians and personnel manages patient's primary care to improve quality and care coordination.
Shared Savings (with Downside Risk)	Network of physicians, hospitals, and other providers who form an ACO. ACOs are accountable for total cost and quality of care over a defined performance period and can share in savings they generate during the performance period.
Episode-Based Payment Models	Holds providers accountable for the cost and quality of care received by beneficiaries during an episode of care following an event. Providers can share in savings they generate during the episode of care.
Primary Care Capitation	Payer makes a prospective unit of payment per patient, for a limited set of primary care services, regardless of the actual quantity of services provided.
Global Capitation	Payer makes a prospective unit of payment per patient, for most health services, regardless of the actual quantity of services provided.

Source: BRG analysis of HCPLAN Alternative Payment Model (APM) Framework

The Risk to Reward Conversation

Payers often refer to a “spectrum” or “continuum” of value-based care, meaning that different types of arrangements grow increasingly complex and offer higher levels of potential upside reward and financial responsibility. Payers will generally offer more than one Value Based Arrangement and are supportive of providers taking an “on ramp” to risk. This means they are willing to work with providers to gain experience at lower levels of risk before moving along the continuum of arrangements to higher levels of risk.

<i>Less Risk</i>						<i>More Risk</i>	
HCPLAN Category 1		HCPLAN Category 2		HCPLAN Category 3		HCPLAN Category 4	
FFS	Pay for Reporting or Performance	Patient-Centered Medical Home	Shared Savings	Episode-Based Payments	Shared Savings with Downside Risk	Primary Care Capitation	Global Capitation
<i>examples</i>	<ul style="list-style-type: none"> - Cataracts (OPT) - Physical Therapy - SDoH 	<ul style="list-style-type: none"> - Diabetic (Tele) 	<ul style="list-style-type: none"> - TJR (Ortho) - Labor & Delivery - Colonoscopy 	<ul style="list-style-type: none"> - Chronic (MSWs) - Cancer Care 	<ul style="list-style-type: none"> - Medicare Advantage (PCP) - Crohn's or IBD (GI) - SUD (Behavioral) 		

Source: BRG analysis of HCPLAN APM Framework.

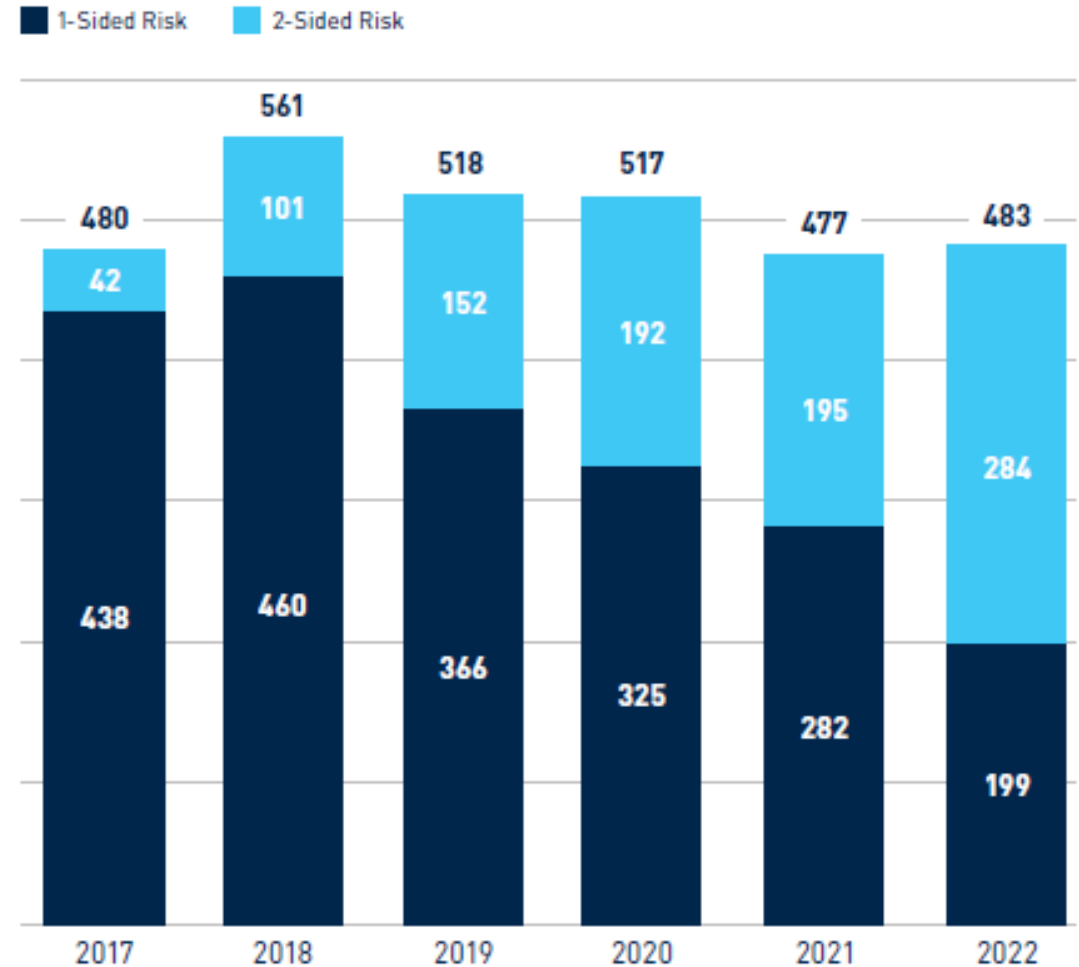


VBC In the Market

Value Based Agreements (VBA's) have made significant inroads in certain lines of business. CMS leads the way with 85 percent of spend flowing through some type of VBAs, with a vast majority of the spend in upside-only arrangements, although participation in downside-risk arrangements has increased over time.

More than 60 percent of total US healthcare payments in 2020 flowed through VBAs, with between 13 and 35 percent flowing through downside risk models.

This demonstrates a marked increase from the just 25 percent of spending flowing through VBAs in 2015



Source: BRG analysis of CMS "Shared Savings Program Fast Facts – as of January 1, 2021."



Key Components to a VBA

Like snowflakes, no two agreements are the same but each type of VBA has six common elements that define the program parameters and requirements. These elements are critical, and all VBC contracts should outline expectations and requirements for each programmatic area. Providers entering VBC contracts must understand each program element before signing a VBA.

Component	Purpose	Examples
Performance Period	Identify time period during which performance is measured.	<ul style="list-style-type: none"> > Performance year = 12 months > 90-day episode duration > 6-month episode reconciliation period
Participation Requirements	Outline activities or structural components a provider is required to have in place to participate in the program.	<ul style="list-style-type: none"> > Maintain minimum attributed population > Complete practice transformation activities > Governing board composition
Patient Attribution	Link member and provider to identify which provider is responsible for member's care, all individually attributed members make up the attributed population.	<ul style="list-style-type: none"> > E&M-based attribution in ACO models > Specific diagnosis-related group (DRG) codes "trigger" episodic
Quality Measurement	Standardize way to measure outcomes.	<ul style="list-style-type: none"> > 30-day all-cause readmissions > Diabetes care HbA1c poor control > CAHPS survey
Payment Terms	Determine financial rewards or penalties associated with the payment arrangement, including the process for calculating and distribution/recouping financial rewards/penalties.	<ul style="list-style-type: none"> > Baseline, trend, and target calculations > Method to calculate Per Member Per Month (PMPM) payments > Reconciliation procedures and timeframes
Data and Reporting	Outline obligations relating to data sharing and submission throughout the duration of the program.	<ul style="list-style-type: none"> > Frequency and type of data providers must submit for quality measurement > Frequency and type of data and reports payor will share with participating providers

Shared Savings and Episodic Arrangements

One of the most common VBAs is the shared savings model. In this model, providers join to form an accountable care organization (ACO) where they are accountable for the total cost of care for a defined patient population. In shared savings arrangements, the **payer** sets a financial target for the ACO attributed population. If the ACO successfully manages costs below the target, the ACO can share a portion of the saved costs.

In some cases, when an ACO is at downside risk, the ACO may be liable to repay health plans if the costs for the attributed population are higher than the target.

Episode-based payments are similar to shared savings models in the sense that providers are responsible for total costs, but they are responsible only for costs related to a defined episode, usually triggered by, and typically 90 days after, a procedure, though this can vary depending on the patient's condition. Providers and suppliers would be paid under the usual payment system rules and procedures. The actual episode spend will be reconciled against an established episode target price (e.g., \$10,000). If a provider is below this target, the provider will share the difference with the payer, but if a provider is above the target, they will owe the payer the difference

Attribution The Key Concept in These Models

Attribution determines the population that providers will be accountable for per agreement. ACO attribution is driven by primary care visits.

Generally, members will be attributed to an ACO when they have a majority of their primary care visits with one of the ACO affiliated physicians. It is essential for providers to understand the attribution methodology of any VBA they participate in.



How to Succeed in VBA's

Succeeding in VBAs is no small feat, especially as arrangements become more complex and providers begin to take on increased financial risk. Success in VBAs requires thoughtful preparation and strong internal process and operations. Here are twelve key things organizations must do to succeed in VBC.

Success Factors		
Data and Analytics	1	EMR that shares data
	2	Robust analytic platform capable of collecting data to measure health outcomes and monitoring cost of services provided
Population Health & Care Management	3	Ability to segment patients into groups according to health-related needs
	4	Successfully manage transitions of care
	5	Solidify referral networks
	6	Integrate behavioral health
	7	Consider ways to integrate SDoH data
Payor Relations	8	Determine negotiation priorities for contract before entering negotiations
	9	Develop and maintain strong health plan relationships; position yourself as a valued partner
Operations	10	Interdisciplinary, collaborative teams organized to quickly address health-related needs
	11	Measurable reporting for all contract requirements; monitor performance drivers in real time
	12	Patient engagement services pre- and post-visit protocols, and documentation procedures

Are you ready to take the leap into Value Based Care?

- How does your business compare to others in its category?
 - Note: Sometimes “bigger” only delivers bureaucracy not scale and drags down VBA performance
- What are the gaps in services, staff, patient engagement and infrastructure?
 - Analytics, Contracting / Staff Capacity and Patient Outreach Prowess
- Based on your “readiness,” what level of VBA arrangement—or risk—is best?
 - Risk to Reward journey
- What is the right target price for a shared savings arrangement?
 - Is it better or worse than the FFS reimbursement?
- What type of partners do you need to gain the best arrangement and have the most success?
 - The market is rich with vendor solutions but frequently poor in measured \$
- Do your reimbursement rates account for the amount of work involved in improving and maintaining performance on quality measures, and tracking and reporting the results?
- Can you redesign key revenue cycle components to bill and track episodes of care or trends in a way that makes sense



