2022 NCOIL Spring Meeting

Value Based Care: Better Outcomes for All

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About AHIP

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

Overview

- Value Based Care (VBC)
  - What is VBC
  - Traditional Fee for Service Payment System vs. VBC
  - Overview of Models and Payments
- Measuring Progress
- COVID-19
- What’s Next

Key Terms

- **Value-based care (VBC):** The idea of improving quality and outcomes for patients.
- **Value-based payment (VBP):** Often used interchangeable with VBC, this simply refers to VBC that involves a payment model.
- **Alternative payment model (APM):** Medicare's term for a VBP.
- **Accountable care organization (ACO):** A popular APM/VBP model.
- **Fee-for-service (FFS):** The predominant, historic payment system in the US that pays physicians for each covered service they provide.
- **Quality measures:** pre-defined measures that evaluate providers on metrics like patient safety, outcomes, and satisfaction. These are often incorporated into VBPs/APMs.

Value Based Care Models

There is no single approach to APMs, or value-based models, that will work for all practices or specialties.

Outcomes-Based. The predominant payment approach in the US is fee-for-service (FFS), which pays providers for each service they provide ("volume-based"). In contrast, paying for "value" ties reimbursement to objectives other than the volume of services delivered, such as improving patient outcomes in a cost-efficient manner.

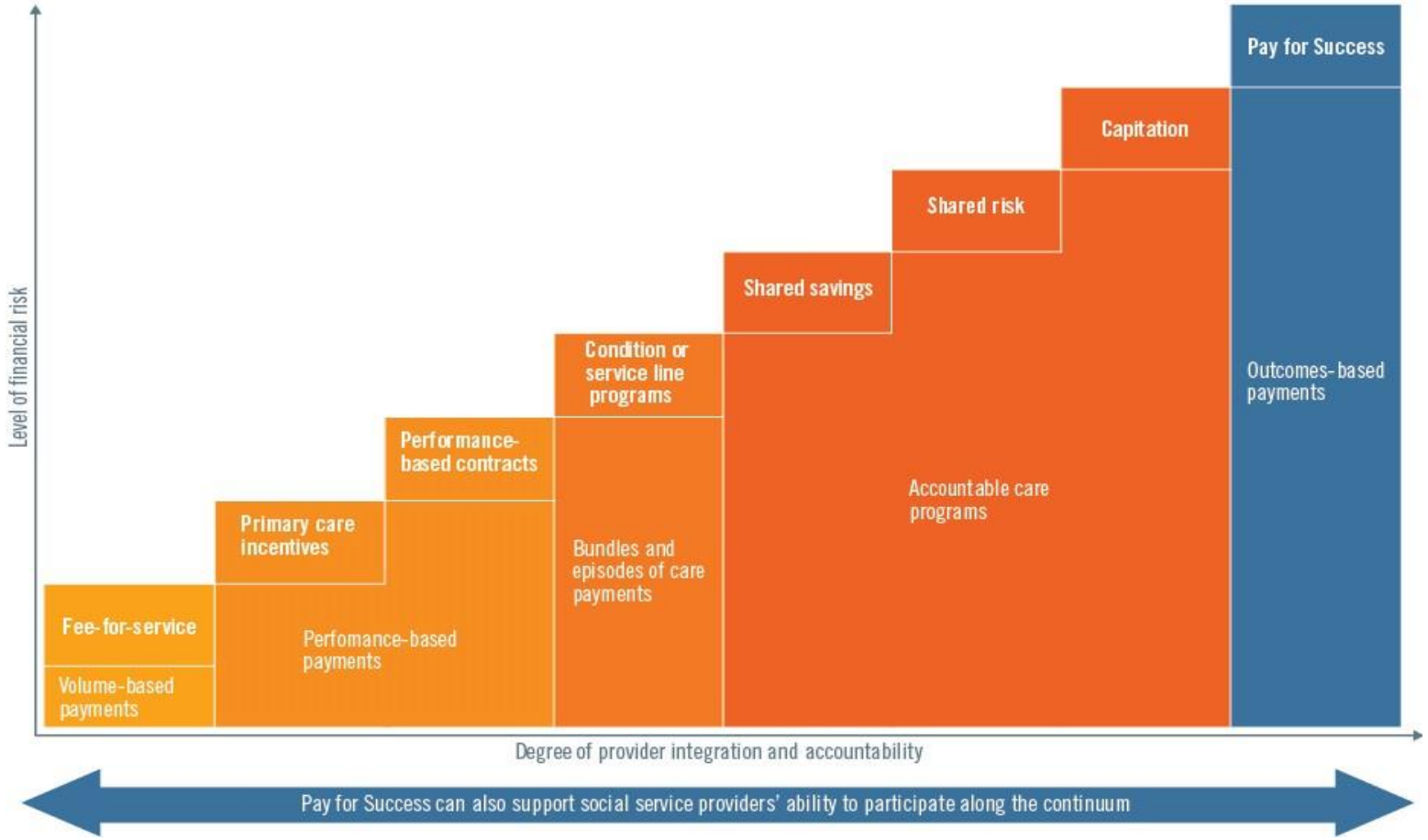
Financial Risk. Value-based payment models entail some degree of financial risk, where physicians agree to take responsibility in some way for the costs of furnishing care to patients. In return for accepting financial risk to furnish cost-effective, high-quality care, providers can enjoy in savings generated for the payer.

Goal: Value-based models give physicians the resources and flexibility they need to take accountability for the aspects of cost and quality they can control or influence.

The Traditional FFS (volume) Payment System vs VBC (value) System

FFS System	Challenge	VBC System
Pays only for defined set of services	Does not reimburse for non-traditional services like phone calls, emails; care management, nurse visits; use of technology; patient supports like transportation/food/education	Allows provider flexibility to change the number and type of services furnished to patient without financial losses
Rewards for volume of services	Can encourage utilization, discourage cost efficient care. Payers utilize cost containment strategies that frustrate providers, patients (e.g., prior authorization)	Includes financial accountability by adjusting payment up or down based on performance; eliminates cost containment protocols
Does not consider quality of care	Patient satisfaction or outcome of care is absent from payment	Develops quality metrics and adjusts payment based on performance
Does not consider patient acuity, socioeconomic status	Can contribute to inequities, may discourage care for high-risk patients	Includes risk adjustment, other factors in payment rates

Value Based Payment/Model Continuum

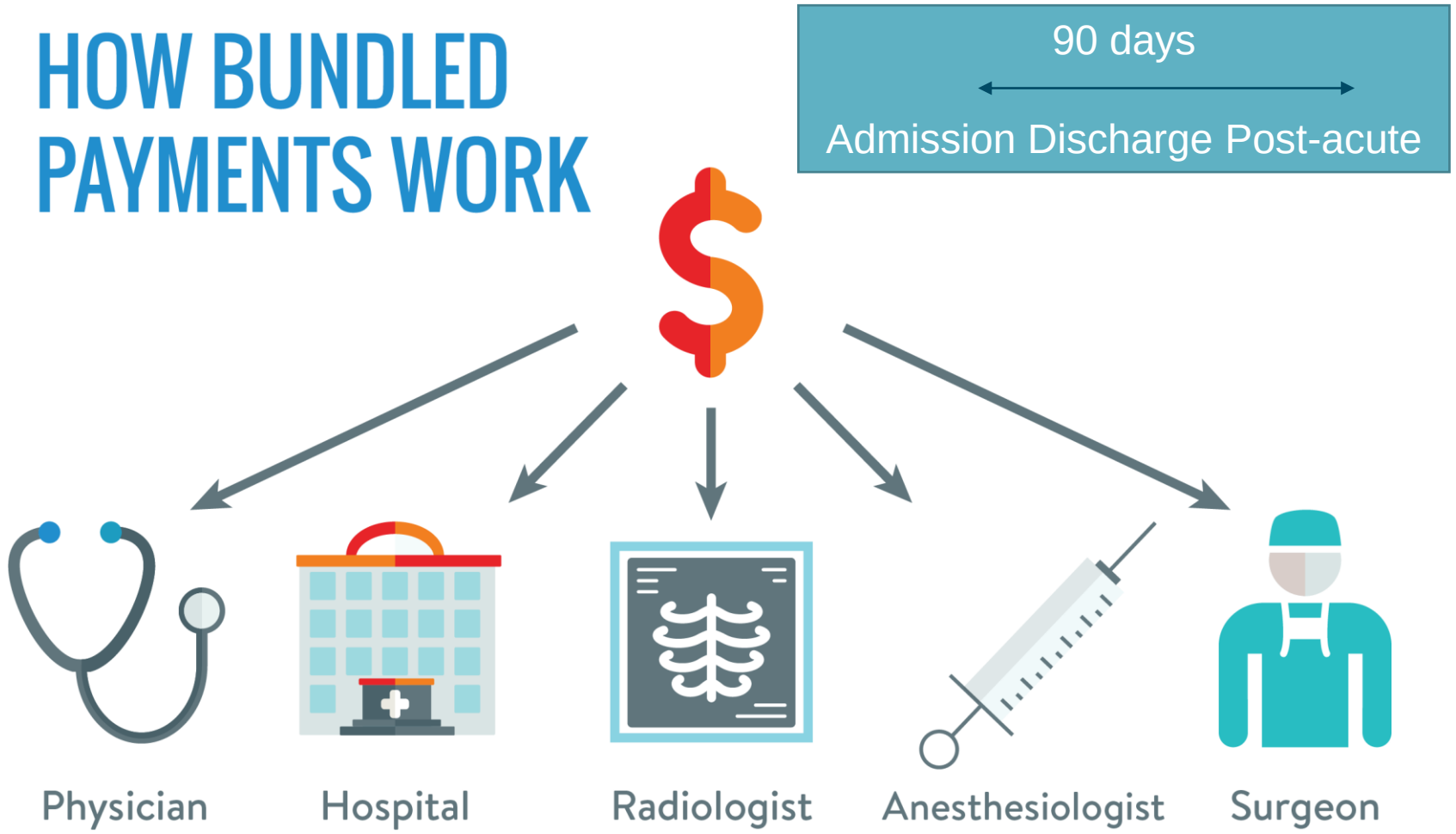


https://www.chcs.org/resource/key-considerations-gaining-traction-medicaid/

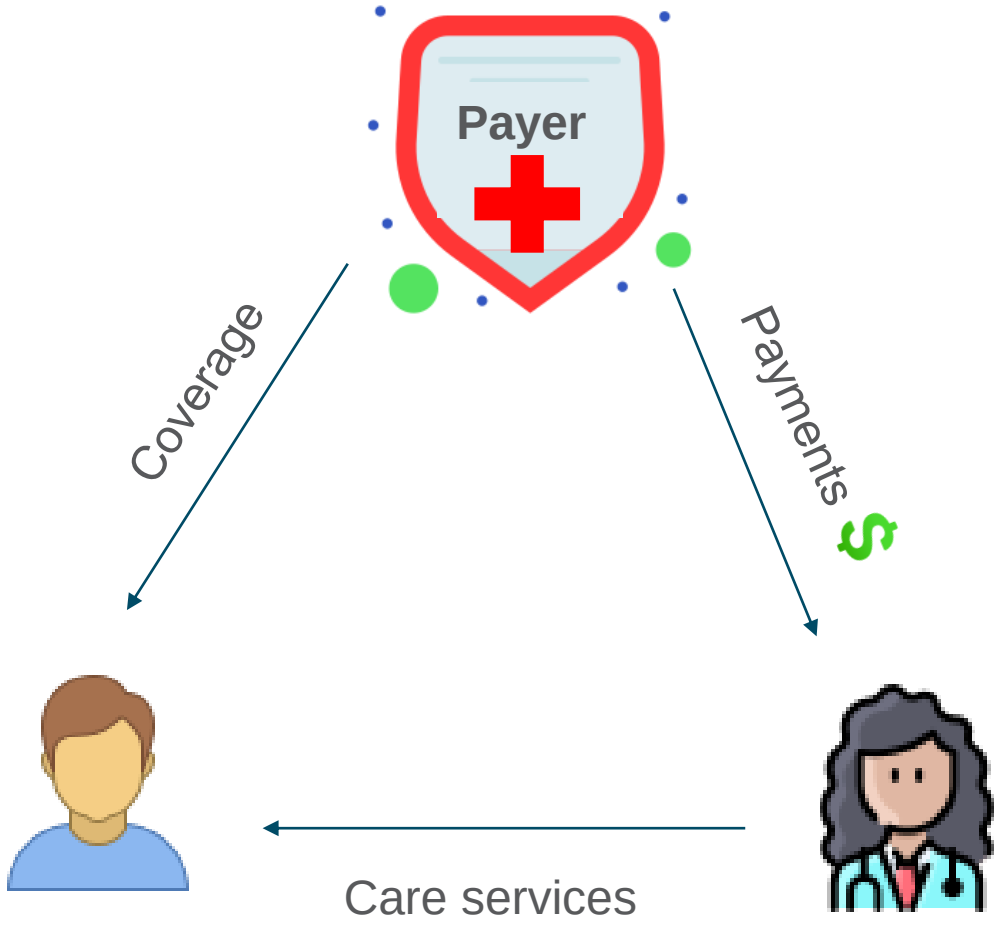
Example: Episode of Care & Bundled Payments

Bundled

- A bundled payment is a single, comprehensive budget that “bundles” payments for defined set of services furnished to a patient by multiple providers throughout a fixed timeframe, such as a surgical procedure (“episode of care”).
- The bundled payment is reduced if providers do not meet spending targets or do not meet or exceed quality performance goals



Example: Population-based/Capitation Payments



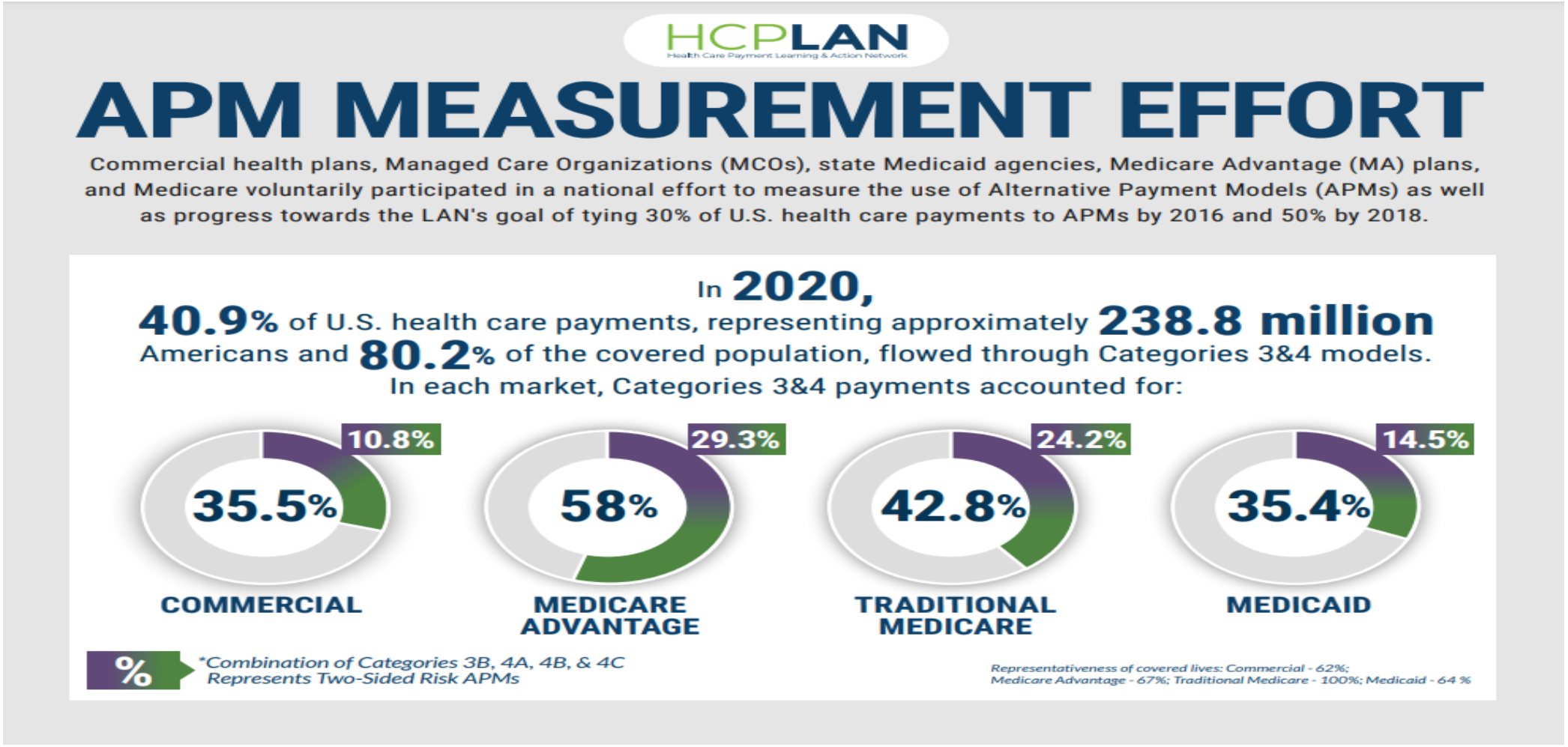
Population-based
• Providers/entities receive fixed, prospective payments for mix and volume of defined activities for a specific population. • Capitation may be total or partial, with partial excluding certain services from the capitated payment and separately paying for those services under a different mechanism. • Can also include capitation-like payments covering a range of providers operating under a common governance structure. Payments may be risk-adjusted.

Measuring Progress: The Health Care Payment Learning & Action Network

- The Health Care Payment Learning & Action Network (HCPLAN or LAN) is a public private partnership, of which AHIP is a partner, that is dedicated to accelerating the percentage of US health care payments tied to quality and value in each market through the adoption of two-sided risk APMs and measuring value-based care adoption across public and private payers.
- Progress: HCPLAN data shows adoption of two-sided models has been increasing steadily year-over-year:
  - ***Payments/Covered Lives:***
    - In 2017, 33% of dollars were made through such a model.
    - In 2019, 38.2% of health care payments, which represented 72.5% of covered lives, flowed through an APM.
    - In 2020, these percentages grew: 40.9% of health care payments, representing 80.2% of covered lives, flowed through an APM, showing increasing adoption despite the pandemic.
  - ***Market:***
    - 58% of health care payments from MA plans were tied to APMs in 2020, compared to 42.8% in original Medicare.
    - Commercial adoption of APMs increased from 30.1% of payments in 2018 to 35.5% in 2020.
    - Medicaid moved from 23.3% of payments through APMs in 2018 to 35.4% in 2020.

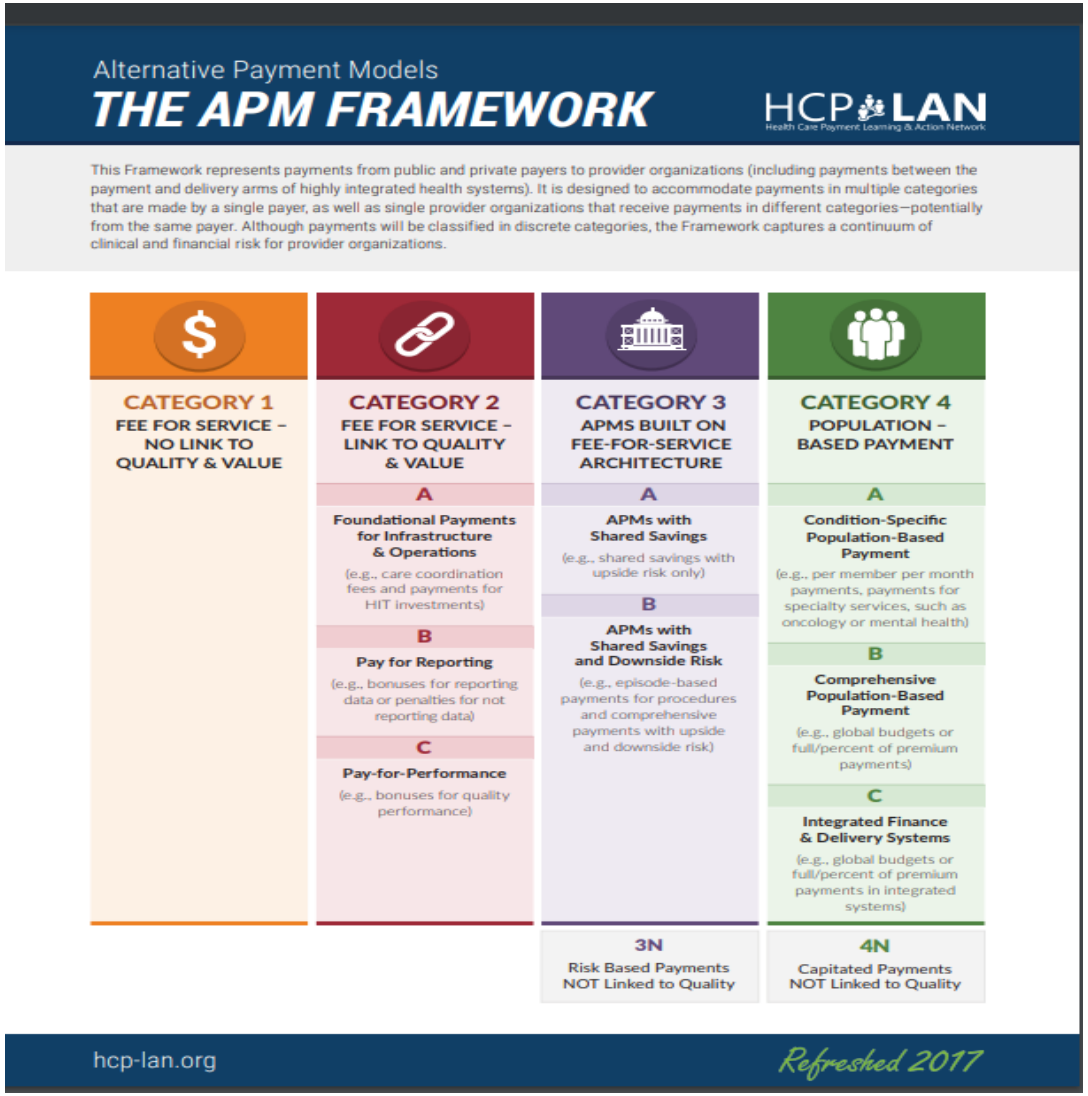
https://hcp-lan.org/apm-measurement-effort/

Measuring Progress: The Health Care Payment Learning & Action Network



https://hcp-lan.org/workproducts/APM_Infographic_2021.pdf

Measuring Progress: The Health Care Payment Learning & Action Network



http://hcp-lan.org/workproducts/apm-framework-onepager.pdf

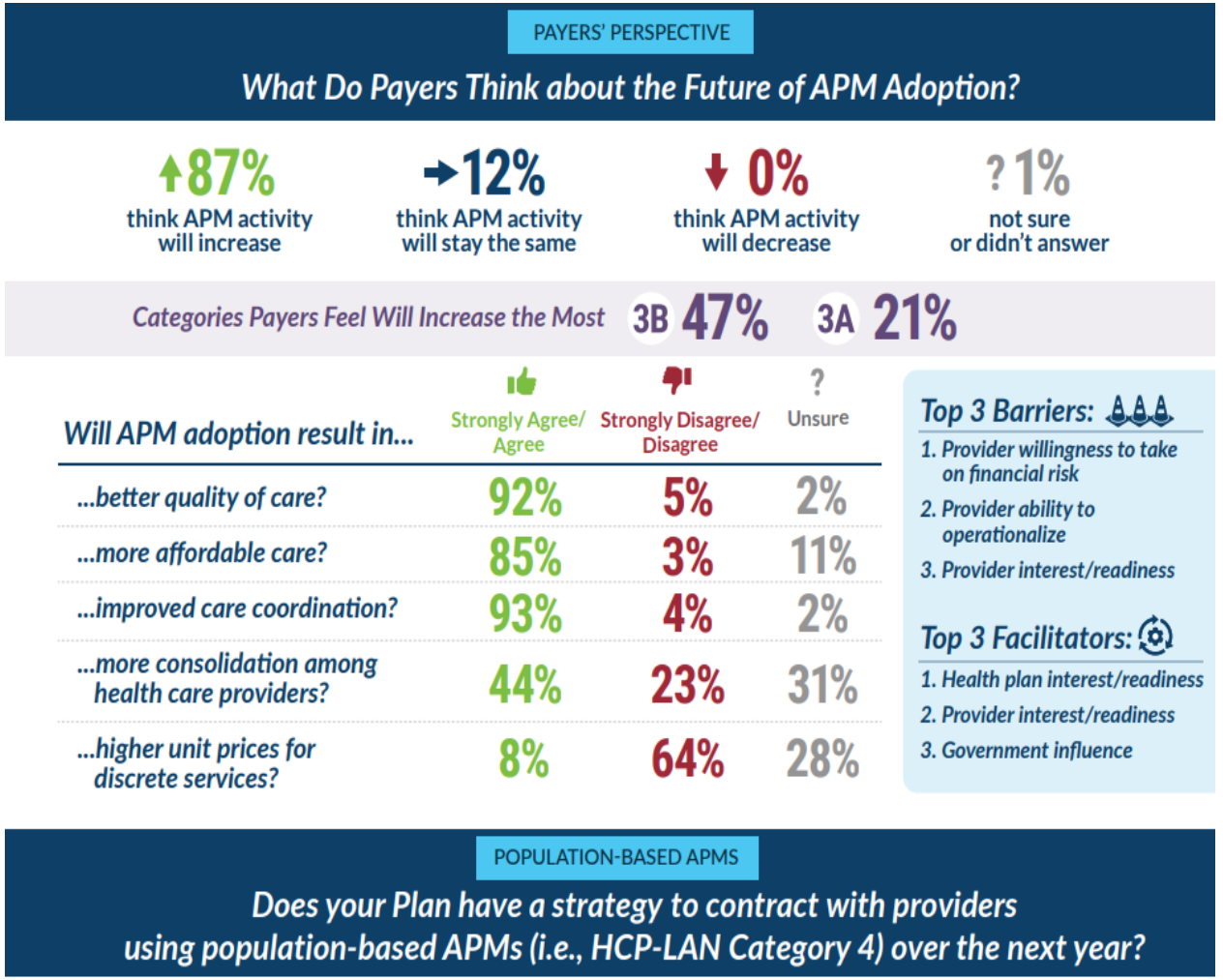
COVID-19: VBC Lessons

- COVID-19 Challenges
  - COVID-19 specific care
  - Continuity of Care
  - Elective Services
  - Telehealth
  - Payment system – volume of services

- Providers participating in VBC Models had
  - More financial flexibility and stability
  - The resources to develop the new capabilities to improve care delivery – data infrastructure, telehealth platforms

What's Next: What Do Payers Think about the Future of APM Adoption?

- 87% percent of payers believe APM adoption will continue to increase.
- Over 75% of plans are leveraging value-based provider arrangement to incent the reduction of health disparities.
- A majority of these arrangements involve screening for socioeconomic barriers to health, referrals to community-based organizations, and care coordination for services that address socioeconomic barriers to health.



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Thank you.

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