Value-Based Payment Basics

Summary of Alternative Payment Models (APMs)

September 2022

Washington State Health Care Authority

What is value-based payment? (VBP)

- VBP is the concept of **paying for quality rather than quantity** of health care.
- In traditional fee-for-service (FFS) payment, each service has a set price.
  - Services include exams, procedures, tests, etc.
  - This creates a system that rewards providing a lot of expensive services, whether or not they improve patient health.
- Shifting to value-based payment means creating a system where **patients get the care they need, when they need it**…
  - …and *don't* get a lot of expensive, unnecessary care.

Fee-for-service

When a health care provider is paid for each service they provide, regardless of the quality or patient's need for that service.

Value-based Payment

When a health care provider is paid for providing high-quality and high-value care to their patients.

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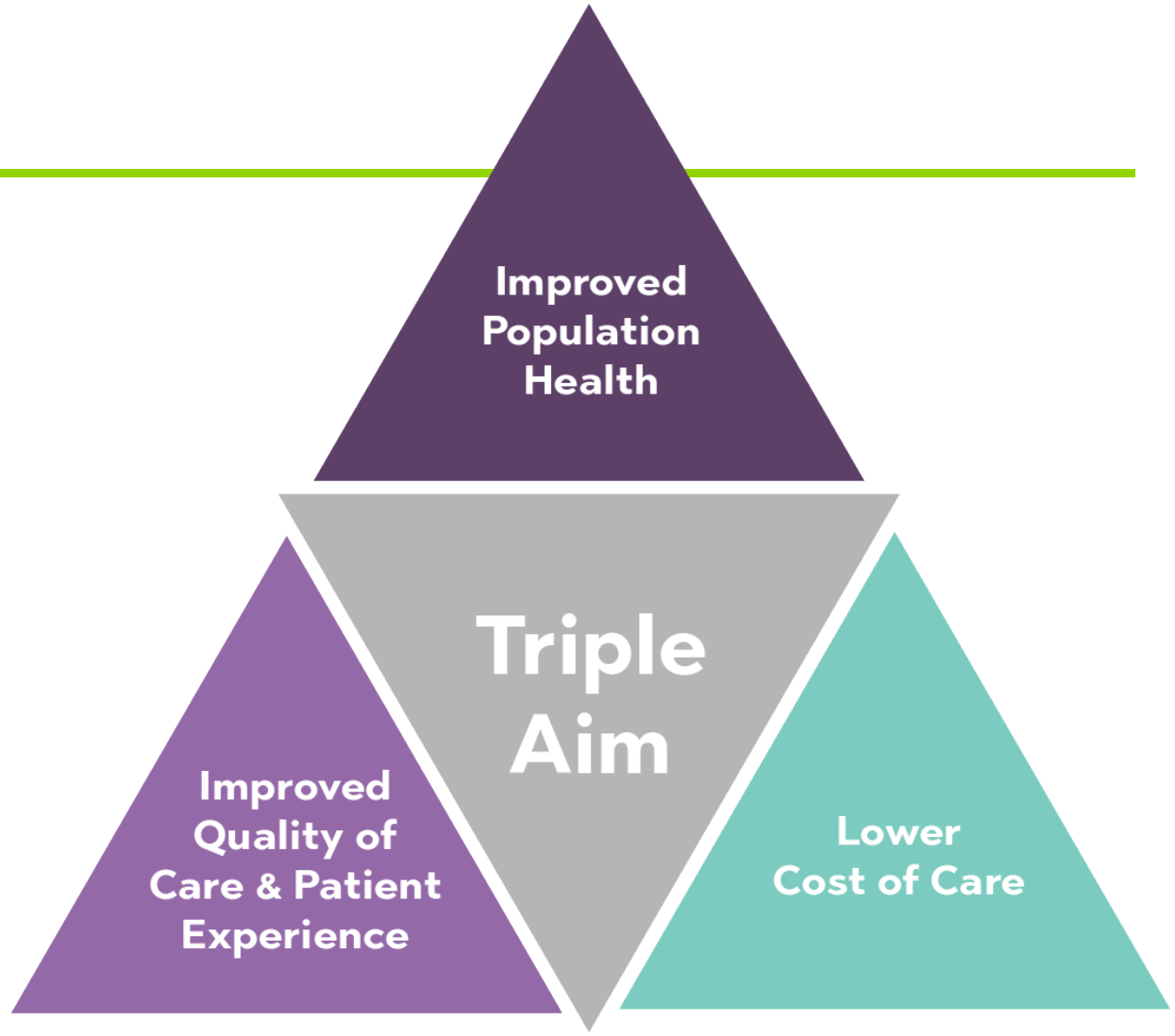
What is “value”?

- People sometimes misinterpret “value” to mean “cheaper.”
- Paying for value saves money by **improving quality and efficiency**, not cutting corners in care.
  - **Quality:** patients receive the right care for their needs and circumstances, at the right time and in the right setting.
  - **Efficiency:** resources are used wisely to achieve the goal outcome.
- Expensive care is still “high-value” if it fits the patient’s needs and circumstances and helps achieve the patient’s health goals.
- Over time, VBP will reduce the need for expensive acute care by rewarding preventive care that keeps people healthy.

The triple aim

VBP is intended to achieve the triple aim by:

- Reducing unnecessary and low-value health care (lower cost)
- Rewarding preventive and whole-person care (better health)
- Rewarding the delivery of high-quality care (better quality and experience)



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Appeal of fee-for-service (FFS) structure

Despite its problems, FFS payment remains popular with payers and providers because it is:

- Familiar and entrenched
- Relatively simple to understand and explain
- Adaptable (it's easy to increase reimbursement for a specific service in an emergency, like a pandemic)
- Predictable (as long as health care utilization remains predictable)
- Highly documented (we know how each dollar is being spent)

Appeal of VBP

Although it can be confusing to understand, VBP can benefit our health system by:

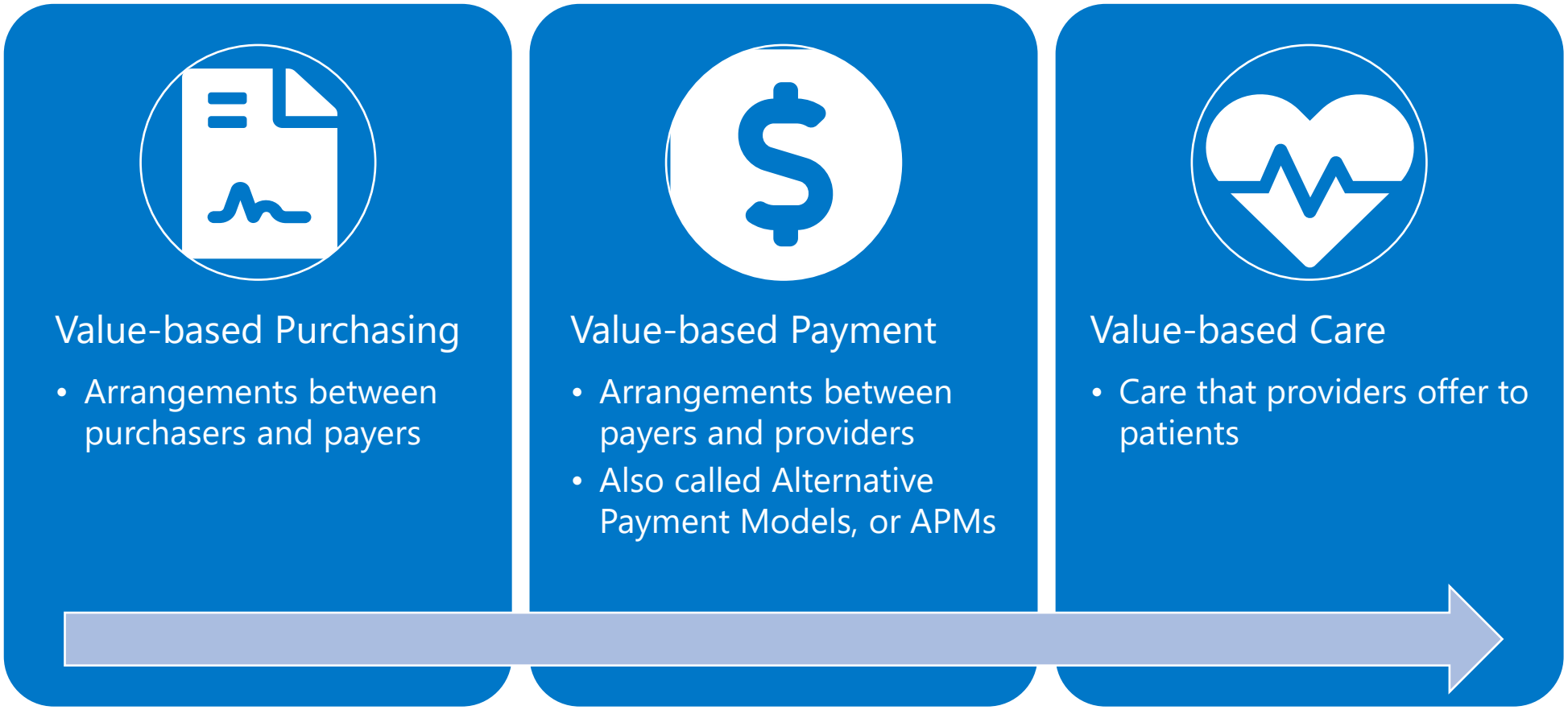
- Rewarding high-quality, efficient care and discouraging low-quality, inefficient care
- Allowing providers to think about patient needs holistically, beyond a list of individual services
- Providing flexible yet predictable funding for health care organizations and purchasers
- Simplifying administrative processes by streamlining billing and coding

“Payment” vs “purchasing”

- There are 4 big roles in our health care system:

Purchasers	Payers	Providers	Patients
• Organizations (such as HCA) that buy health care for groups of people	• Health insurance companies	• Clinicians (like doctors and nurses), facilities (like hospitals), and others	• People seeking care

“Payment” vs “purchasing”



What is an alternative payment model (APM)?

- VBP is the concept of paying for value. APMs are the financial arrangements that reward the delivery of high-value care.
- Almost any payment arrangement that is not the traditional FFS structure can be considered an APM.
- APMs vary widely.
  - The Health Care Payment Learning and Action Network (HCP-LAN) developed a framework for putting APMs into categories based on similar features.

Categorizing APMs

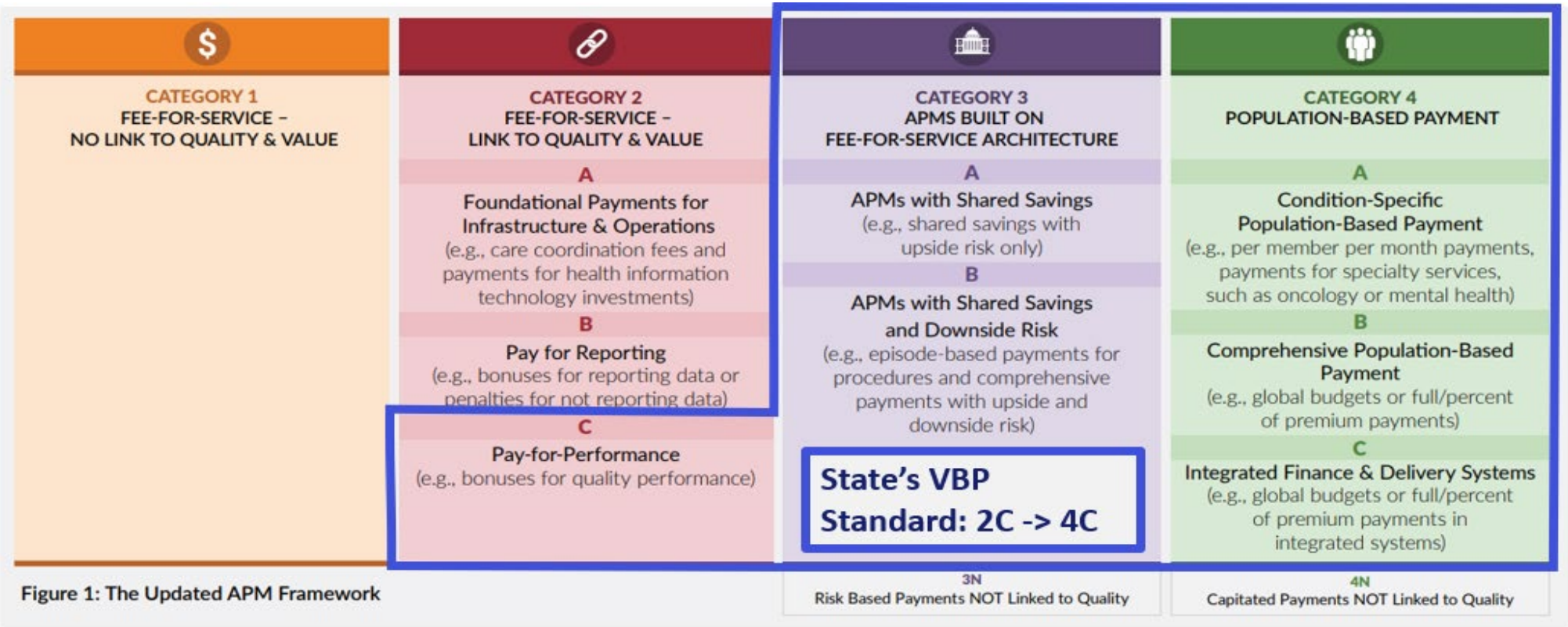


Figure 1: The Updated APM Framework

This framework was developed by the Health Care Payment Learning and Action Network.

HCA's VBP standard only includes those APMs that directly tie payments to quality.

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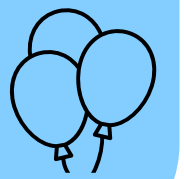
Analogy: party planning



- Imagine you are a party planner.
- In a fee-for-service world, you have a set fee and a set budget for every type of party.
- You receive the same fee whether the party is great or terrible.
- But in a VBP world, there are many different ways to arrange payment for your party planning services.

2C: pay-for-performance

- APMs in category 2C are based on an FFS structure (one price per service), but payments are later adjusted based on the quality of care.
- Providers are rewarded for performing well on chosen quality metrics.
- 2C arrangements can focus on a few aspects of quality, or many.

- You throw the party and get paid.
- If the party was great, you may receive a bonus afterward.
- There is no direct consequence if the party was bad.

CATEGORY 2

FEE FOR SERVICE – LINK TO QUALITY & VALUE

C

Pay-for-Performance

(e.g., bonuses for quality performance)

2C example

Anthem – Quality In Sights Hospital Incentive Program

- Annual hospital rate increases shift to an at-risk model where increases are only earned based on demonstrated performance on key value metrics
- Hospitals "earn" their increases in payment rates based on standards like post-discharge planning, adherence to a safety checklist, and patient satisfaction.
- **Results:** improvements across a spectrum of patient safety and quality metrics

Category 3

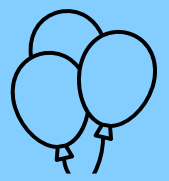
CATEGORY 3

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

- APMs in Category 3 incorporate cost as well as quality.
- Providers are asked to meet a financial or utilization benchmark for:
  - A set of related procedures (e.g., all care related to a hip replacement),
  - A particular condition (e.g., cancer)
  - An episode of care (e.g., a hospital stay)
  - The total cost of caring for a patient in a set time period (e.g., one year)
- Category 3 models typically pay for care on an FFS basis, with retrospective financial adjustments after the period of service.
- APMs in Category 3 should incorporate safeguards to ensure patients receive all the care they need.

3A: APMs with shared savings

- APMs in Category 3A allow for "shared savings," also known as "upside risk."
- If the cost of care stays below the set benchmark, providers receive a portion of the savings as a reward.



- If you throw a great party AND stay under budget, you get to keep a portion of the savings.
- If the party goes over budget, you just get your regular fee, regardless of quality

CATEGORY 3

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A

APMs with Shared Savings

(e.g., shared savings with upside risk only)

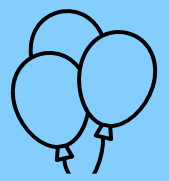
3A example

CMS Comprehensive Primary Care (CPC) Initiatives

- Participating practices receive a monthly care management fee for each Medicare FFS beneficiary (and Medicaid FFS beneficiaries in cases where the state Medicaid agency is participating).
- Each CPC practice may share in savings that result from improved care to their patients who are Medicare beneficiaries
- Annual savings to the Medicare program are calculated at a regional level and distributed to practices according to their performance on quality metrics.
- **Results:** CPC practices that demonstrated high quality care and reduced spending above a threshold shared in savings generated for Medicare.

3B: APMs with shared savings and downside risk

- APMs in Category 3B incorporate both shared savings *and* "downside risk."
- This means that if the cost of care goes above the set benchmark, providers are responsible for a portion of the extra cost.



- If you throw a great party *and* stay under budget, you get to keep a portion of the savings.
- If the party goes over budget, you are responsible for some of the extra cost, regardless of quality.

CATEGORY 3

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

B

APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

3B example

Capital District Physicians' Health Plan (CDPHP®) -Enhanced Primary Care (EPC) Program

- Primary care doctors move from FFS to a risk-adjusted global payment with the addition of a quality bonus. Together, these allow physicians to increase their earning potential by an average of 40 percent.
- Quality is assessed using HEDIS metrics or composites in four categories.
  - CDPHP creates an aggregate quality score, which is then used to create an effectiveness score that determines the size of the quality bonus or penalty.
- CDPHP also offers resources for practice transformation and culture change.
- **Results:**
  - 2.9 percent overall cost reduction in 2014
  - $20.7 million annual total savings in 2014
  - Rate of visits increased for those with the greatest need (Medicaid, Medicare, and the sickest 10 percent of patients).

Category 4

CATEGORY 4

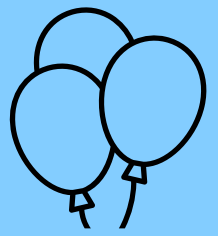
POPULATION – BASED PAYMENT

- APMs in Category 4 incorporate cost and quality *prospectively* (up front) instead of retrospectively, and cover *populations* instead of procedures.
- Instead of providing care and then calculating shared savings or downside responsibility, providers in Category 4 APMs receive payment up front to cover all care for a particular population during a set time period.
- APMs in Category 4 should incorporate safeguards to ensure patients receive all the care they need.

Category 4

CATEGORY 4

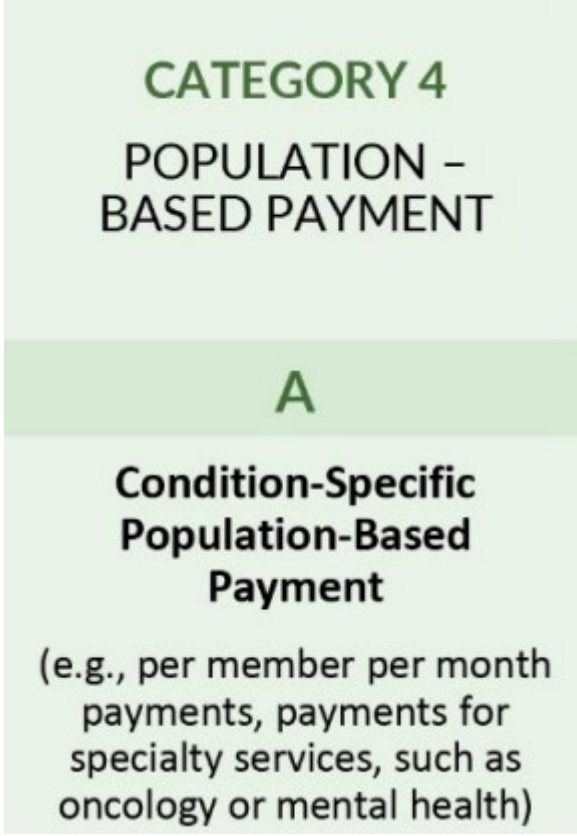
POPULATION – BASED PAYMENT



- Instead of getting paid after the party, the client pays your fee and gives you the full party budget before planning begins.
  - If you throw a great party *and* stay under budget, you get to keep the savings.
  - If you throw a great party but go over budget, you are responsible for the extra cost.
  - If you throw a bad party, you will face a financial penalty.
- This structure is the same for Categories 4A and 4B.

4A: condition-specific population-based payment

- APMs in Category 4A focus on the treatment of *populations with specific conditions*, such as cancer or diabetes.
- In Category 4A, providers are responsible for the total cost and quality of care for the patient, including care that is not related to the condition.
  - Category 3: providers are responsible for the total cost and quality of cancer treatment
  - Category 4: providers are responsible for the total cost and quality of all health care for patients with cancer.
- Over time, many 4A arrangements evolve into 4B.



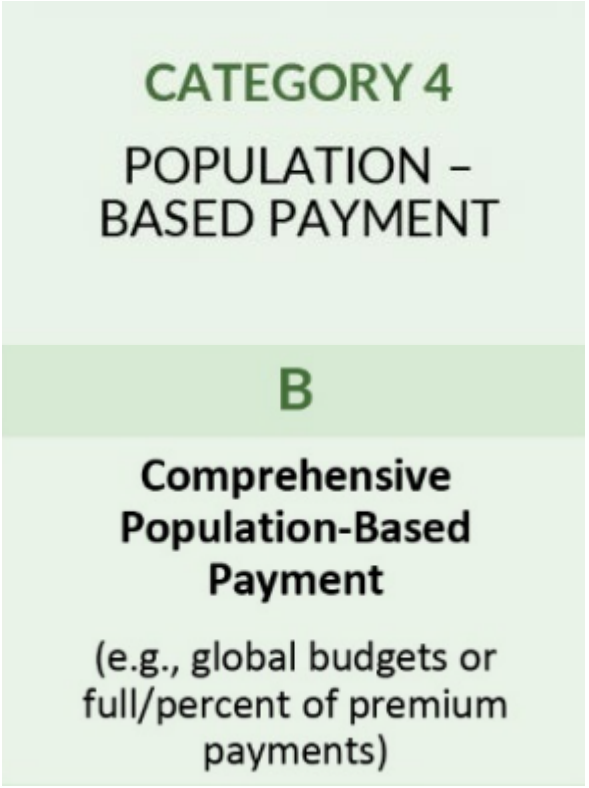
4A example

Medicare's Comprehensive Primary Care Plus (PCP) Track 2

- Providers receive prospective payments for care coordination and quality incentives.
- Half of the quality incentive is tied to inpatient and emergency department utilization, and the other half is tied to care quality and patient experience.
- Providers that do not meet quality performance benchmarks must repay the incentive money.

4B: comprehensive population-based payment

- APMs in Category 4B focus on the treatment of *specific populations*.
- Populations can be defined in many ways. Common examples include:
  - Patients of a particular clinic
  - Patients on a particular provider's panel
  - Patients with a particular health insurance plan
- In these APMs, the payer gives the provider a global budget or per member per month (PMPM) payment which serves as the budget for the total cost of care.



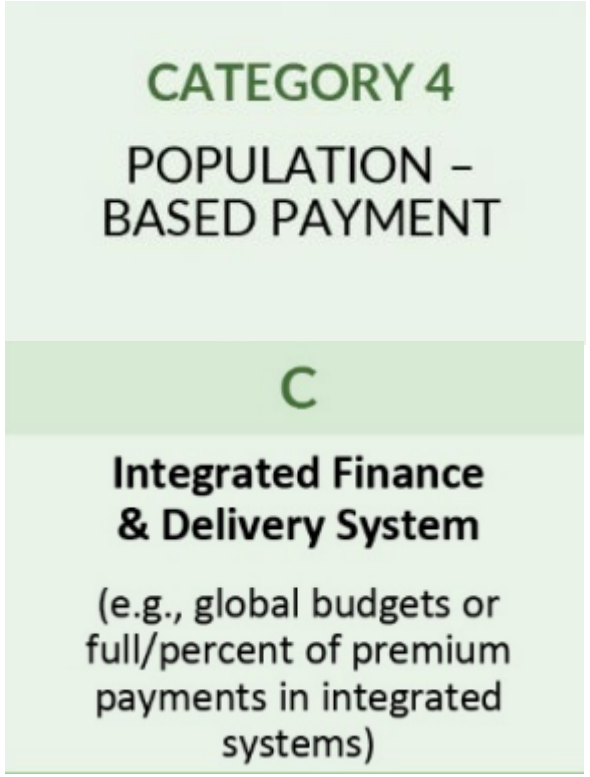
4B example

Tufts Health Plan, Watertown, Massachusetts

- Tufts Health Plan works with providers to set an annual budget target based on prior claims, which is adjusted for severity and other factors as appropriate.
- If the total cost is less than the budget target (surplus), the provider will receive a percentage of the surplus. If the total cost is more than the budget target (deficit), the provider will pay Tufts Health Plan a percentage of the deficit.
- **Results**: Early results indicate a more favorable total medical expense trend for global payment providers than for FFS.

4C: Integrated Finance and Delivery Systems

- In Category 4C, the payers and providers work within the same organization. Common examples include:
  - Joint ventures between provider groups and insurance companies
  - Insurance companies that own their provider network
  - Provider groups that offer insurance
- Incentives across all three areas of the triple aim (better care, better experience, lower cost) are most strongly aligned in highly integrated systems.

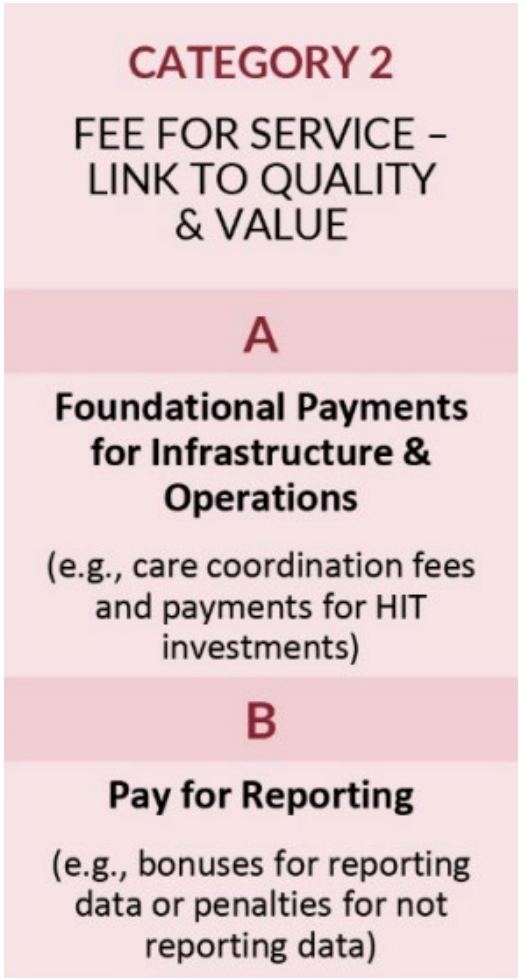


4C example

Kaiser Permanente

- Kaiser Permanente consists of a non-profit health insurance company, hospital systems, and for-profit regional medical groups that exclusively provide care for members.
- The medical groups receive prospective PMPM payments for all care members are expected to receive (inpatient and outpatient). Physicians are salaried with financial incentives available for quality, patient satisfaction, and group financial performance.
- All three entities are financially intertwined, creating aligned financial incentives. This also eliminates the incentive to withhold care in the interest of short-term savings, since doing so is more expensive long-term.

APMs not based on value: 2A, 2B, 3N, 4N



- HCA does not consider these APMs "value-based payment" because payment is not tied to quality or outcomes.

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Appendix: Definitions

- **Bundled payment:** a defined payment for all the services related to a specific episode of care.
- **Capitation:** paying a set rate for each person ("*per capita*") covered by a health plan or served by a provider. Often takes the form of a set dollar amount per member per month (PMPM).
- **Downside risk:** the risk that a provider will have to take responsibility for the extra cost if the cost of care exceeds the budget
- **Episode of care:** a single condition or event, like cancer treatment, back surgery, having a baby, or staying in the hospital.
- **Upside risk:** the "risk" that a provider will get to keep extra money if the cost of care is less than the budget.