The ABCs of Value-Based Care: What You Need to Know

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Learning Objectives

Understand	Explore	Develop
The **tenets of value-based care** in primary care	The physician-led **ACO model**	The **benefits of value-based care** and physician-led ACO participation to physicians, staff and patients

Introductions

Rebecca (Becky) Jaffe, MD

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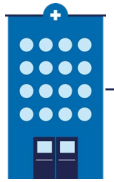
What is your practice focused on right now?

Maintaining Independence

Keeping ownership of your practice, care delivery and how you get paid



Administrative Burdens

Checking boxes for payers, programs and multiple reporting requirements

Technology & Data

Battling with costly technology that complicates workflows and doesn't deliver helpful data or analytics

Patient Engagement

Reaching at-risk patients with limited resources and inadequate staff training

Financial Sustainability

Juggling declining reimbursement and minimal influence on payment

Workforce Shortages

Struggling to fill open positions and retain qualified staff

What is value-based care? And is it better than what you're doing right now?

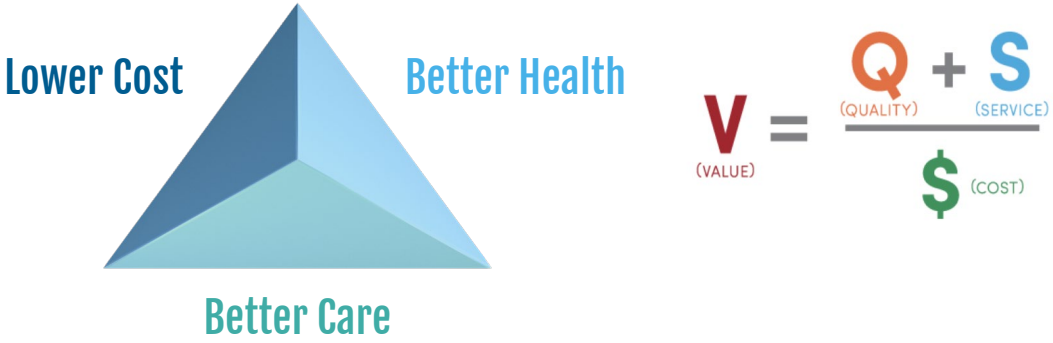
U.S. health care spending is expected to reach $6.2 trillion by 2028.

Value-based payment is a systemic intervention with the potential to affect all drivers of excess health spending and growth, including administrative and clinical waste

Centers for Medicare and Medicaid Services (CMS), National Health Expenditures 2021 Highlights; Abigail Zuger, MD, reviewing Speer M et al. Am J Public Health 2020 Dec Milstein B and Fielding J. Am J Public Health 2020 Dec, "Tallying the waste in American healthcare"

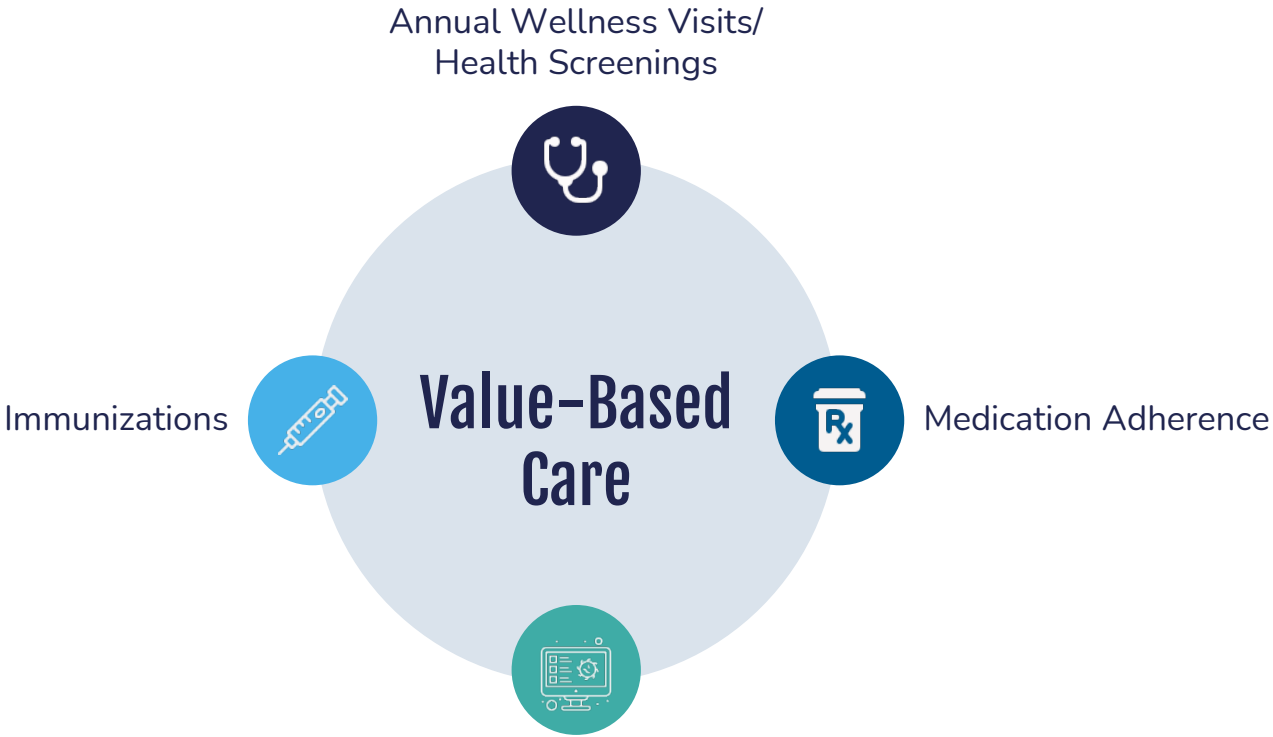
A high-value health care approach advocates for better patient care and lower costs.

The National Academy of Medicine has developed a widely accepted approach that describes high-value health care as: **safe, timely, effective, efficient, equitable and patient-centered – STEEEP** for short.



The Institute for Healthcare Improvement (IHI) later translated this into a framework for action, the **Triple Aim, which is made up of better patient outcomes, improved patient satisfaction and lower costs**. The Triple Aim has since been expanded to the Quadruple Aim, which includes physician and health care professional well-being.

Value-based care rewards practices for focusing even more on quality and cost of care, with multiple, new revenue opportunities.



Value-based care is a critical component in efforts to improve access, equity and quality.

Vulnerable populations are at **greater risk for poor outcomes** than the general population.

- More likely to receive **low-value care** (also known as unnecessary, overused, or inappropriate services)
- Racial and ethnic minorities insured by Medicare are more likely than whites to receive a **disproportionate number of inappropriate services**

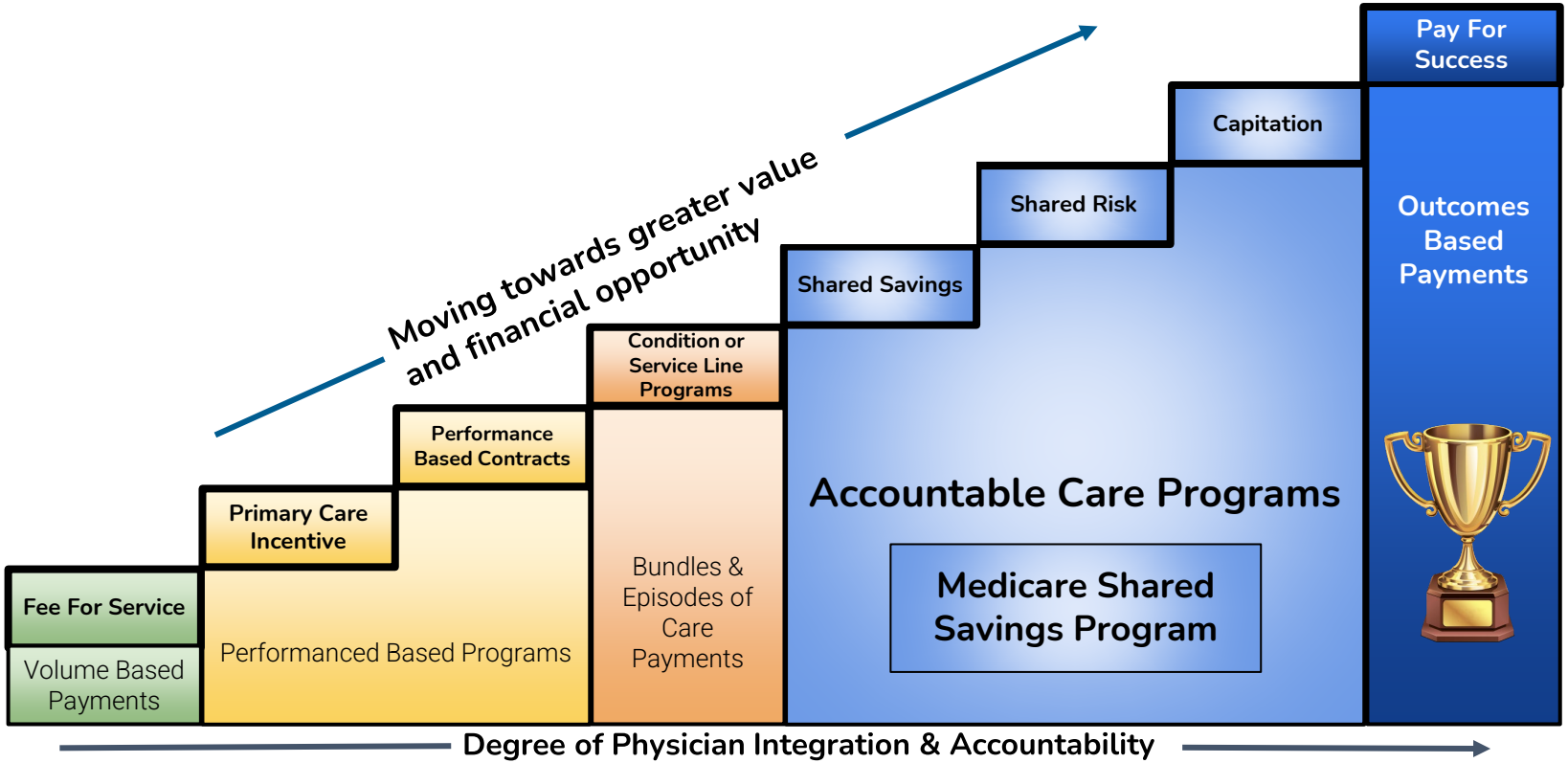
Value-based care improves the health of vulnerable populations by **replacing low-value and low quality services** with high-value, high quality care.

Components of Value-Based Care

1. Care centered on medical conditions
2. Measure outcomes & cost for every patient
3. Aligning reimbursement with value
4. Integration of systems for care effectiveness
5. Ensuring access to quality care
6. Health IT that supports value-based care delivery

William L. Schpero, Nancy E. Morden, Thomas D. Sequist, Meredith B. Rosenthal, Daniel J. Gottlieb and Carrie H. Colla. For Selected Services, Blacks and Hispanics More Likely To Receive Low-Value-Care Than Whites. Health Affairs, Vol. 36, No. 6: Pursuing Health EquityJune 2017.

Value-based care means we are moving towards outcomes over volume.



The proliferation of value-based care programs: Alternative payment models are a growing opportunity for practices.

- CMS has set a goal to have all Medicare beneficiaries and a majority of Medicaid beneficiaries **covered by an accountable care arrangement by 2030**
- Commercial payers, like Humana and Aetna, have made value-based care **a formal business commitment**
- A growing list of states including California, New York, Oregon and Texas have introduced **Medicaid alternative payment models** rooted in value

Success in value-based care means making fundamental changes to how your practice operates on a daily basis.

Inaccessible clinical data

Trouble collecting, reporting or viewing timely data about patients

Lack of system integration

Interoperability issues; isolated platforms; lack of predictive data analytics

Fragmented care delivery

Poorly managed care transitions; miscommunication with other care providers

Outdated practice workflows

Inefficient processes; lack of automation; ineffective use of technology and resources

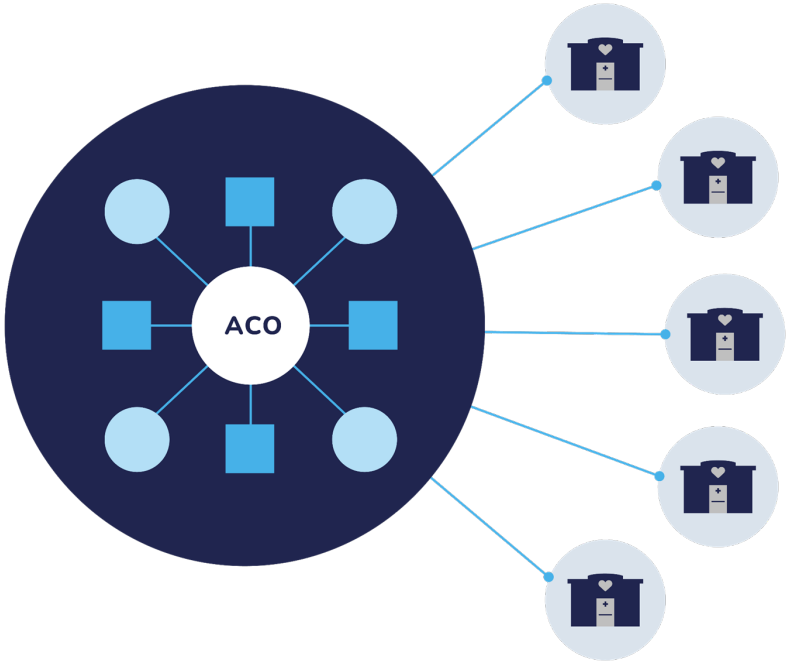
Limited internal resources

Overburdened staff; understaffing challenges; untrained staff

What is an ACO?
And what are your options?

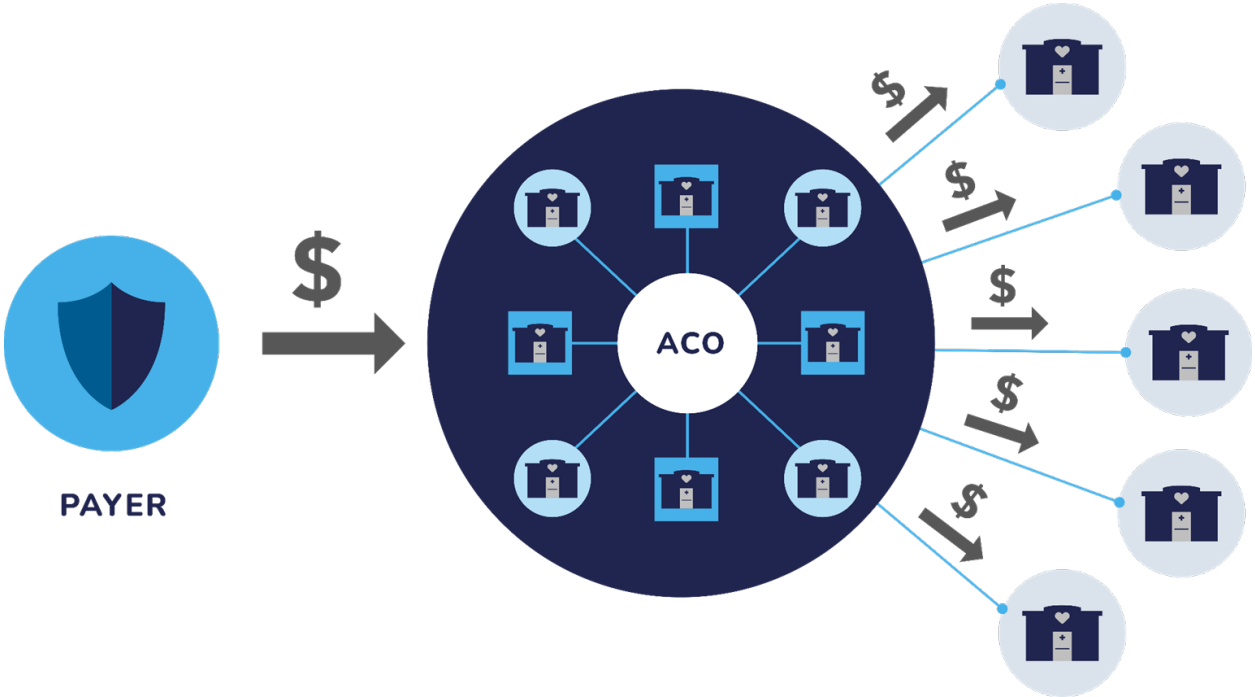
Accountable Care Organizations are the cornerstone of the value-based care model.

An ACO is a group of physicians and other providers who work to deliver coordinated care and are collectively accountable for the cost and quality of care.



ACOs better align payer terms, rewarding practices for the value they provide.

Savings from higher quality, lower cost care are shared between payer and ACO, then shared with members.



Not all ACOs are the same.

Characteristics of a successful ACO
according to the Patient-Centered Primary Care Collaborative

Prior Experience

Leadership and Culture

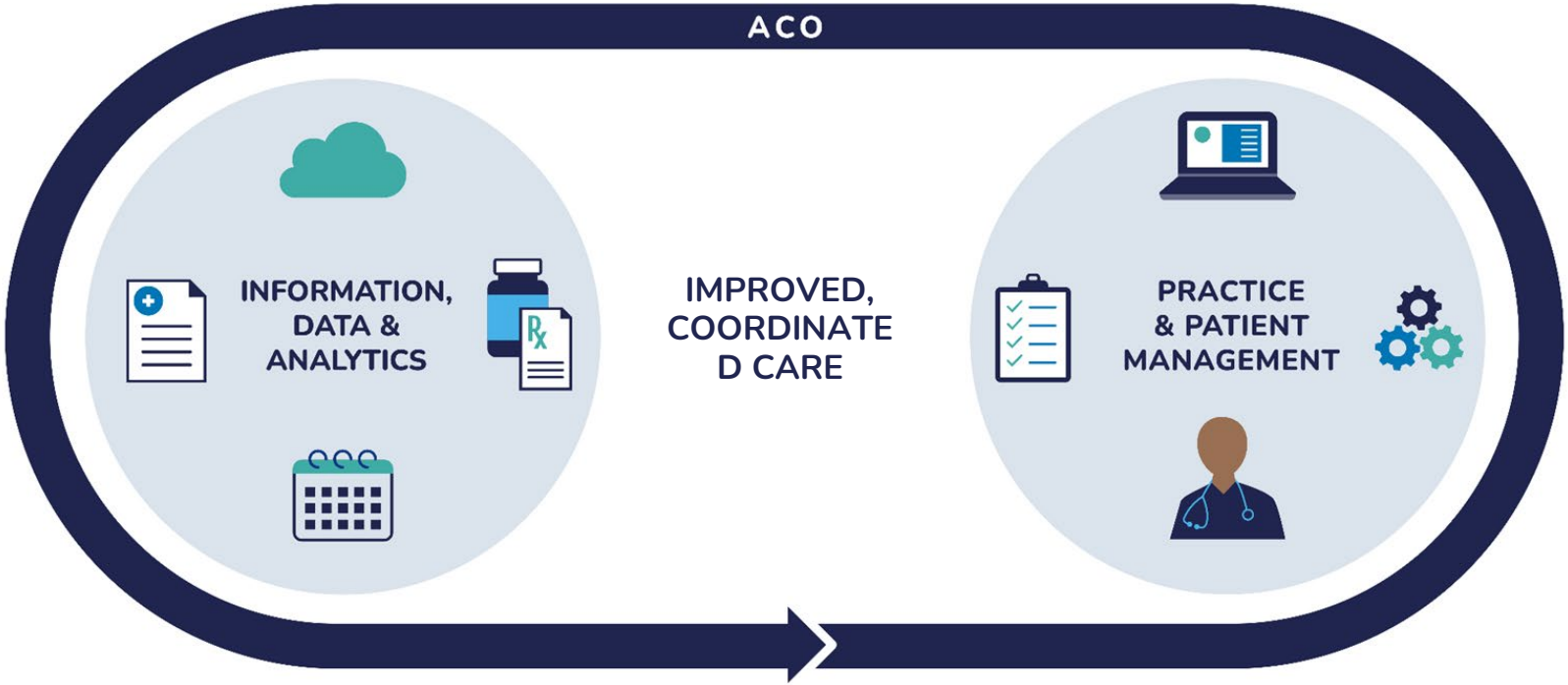
Health IT

Organizational and Environmental Factors

Care Management Strategies

Proven Success

ACOs help empower their members to create value by providing the information, technology and tools needed to deliver even better care, more efficiently.



For Medicare, there are two primary options.

The majority of Aledade clients participate in MSSP,
but some practices are a fit for ACO REACH.

Aledade Advantage Practice Analysis

MSSP

- Proven: In operation for 10+ years
- Generally more achievable savings
- No capitated monthly payments
- Larger total revenue opportunity

ACO REACH

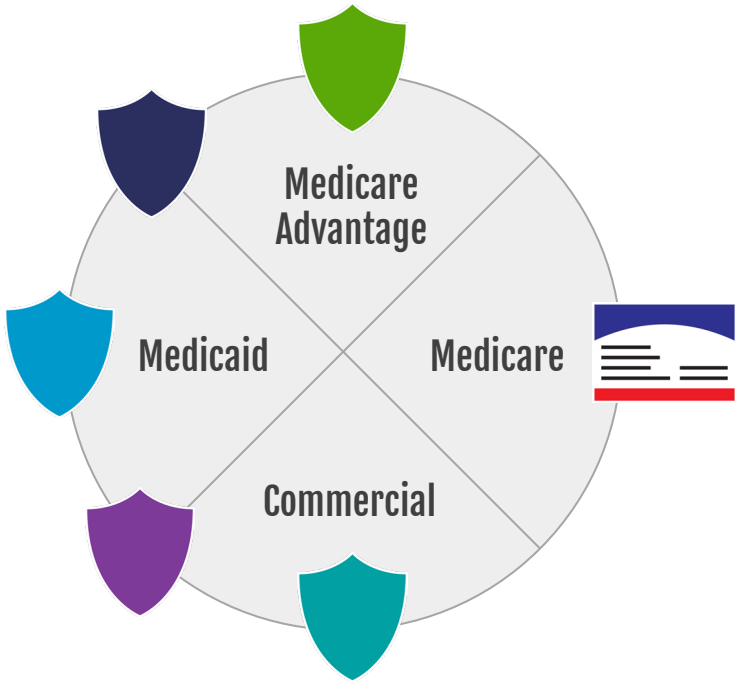
- Pilot: Running through CY2026
- Harder to achieve savings
- Capitated monthly payments
- Lower total revenue opportunity

And ACOs help practices do this for more than just Medicare.

While private plans have diverse value -based programs, the federal government offers two value-based programs for patients covered by Medicare.

PRIVATE HEALTH PLANS

- Value-based programs specific to each payer

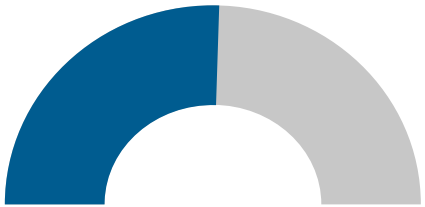


FEDERAL GOVERNMENT

- Medicare Shared Savings Program (MSSP); *or*
- ACO REACH

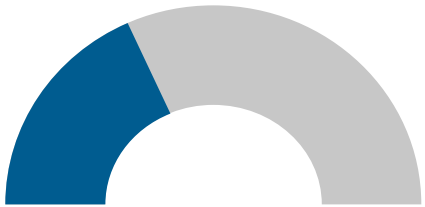
Physician participation in accountable care continues to grow.

In early 2022, CMS projected that over 11 million people with Medicare would be served by Shared Savings Program ACOs in that year.



~55%

of physicians reported participation in at least one type of ACO (Medicare, Medicaid, commercial) in 2020, up 11 percentage points from 2016



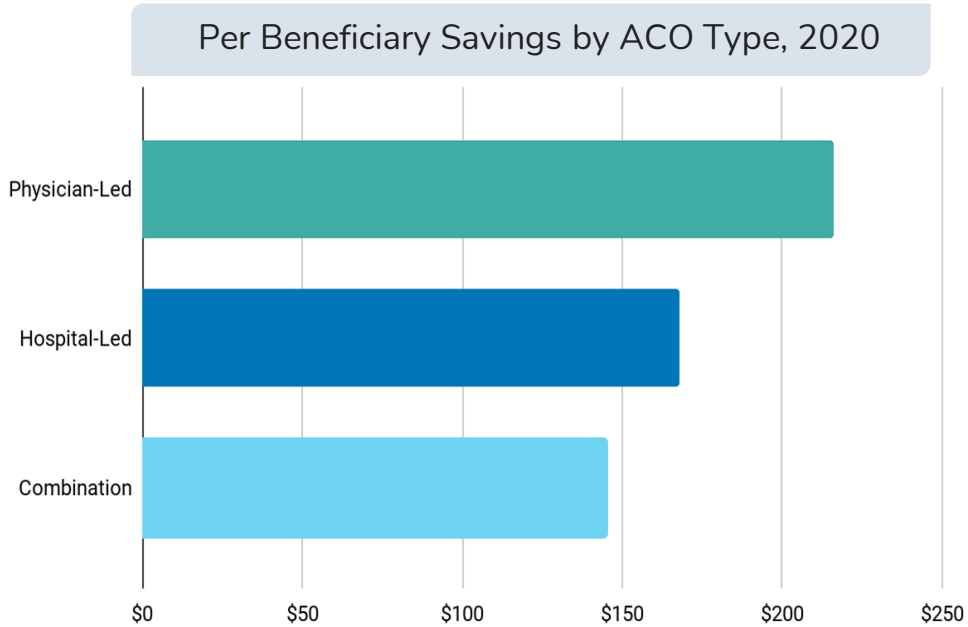
~37%

of physicians in practice report being involved in Medicare ACOs in 2020, up almost 10 percentage points from 2014.

Source: AMA Physician Practice Benchmark Survey https://www.ama-assn.org/about/research/physician-practice-benchmark-survey

What's the difference between physician-led and hospital-led ACOs?

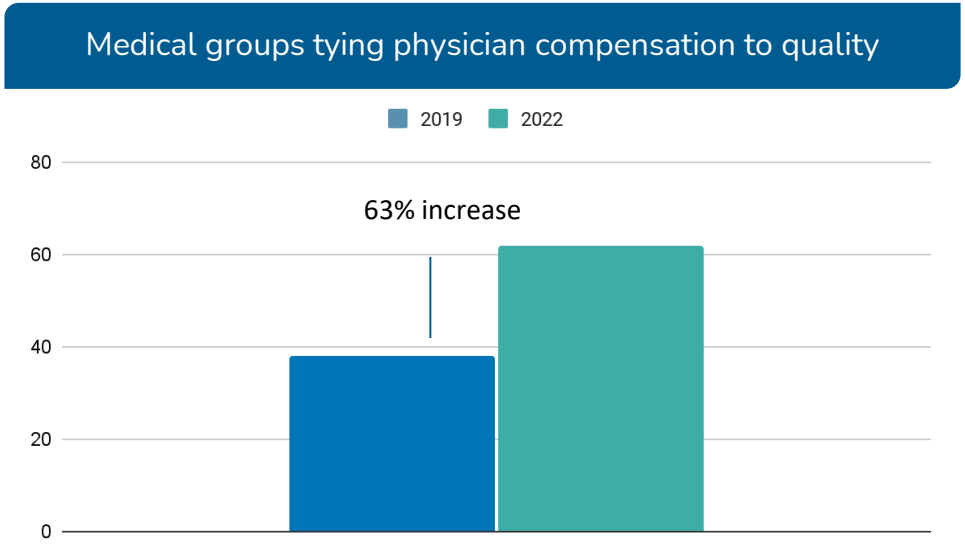
Physician-led ACOs consistently and dramatically outperform hospital-led ACOs.



Source: 2021, Accountable Care Learning Collaborative at Western Governors University Intelligence Brief

Physician compensation is increasingly tied to quality outcomes.

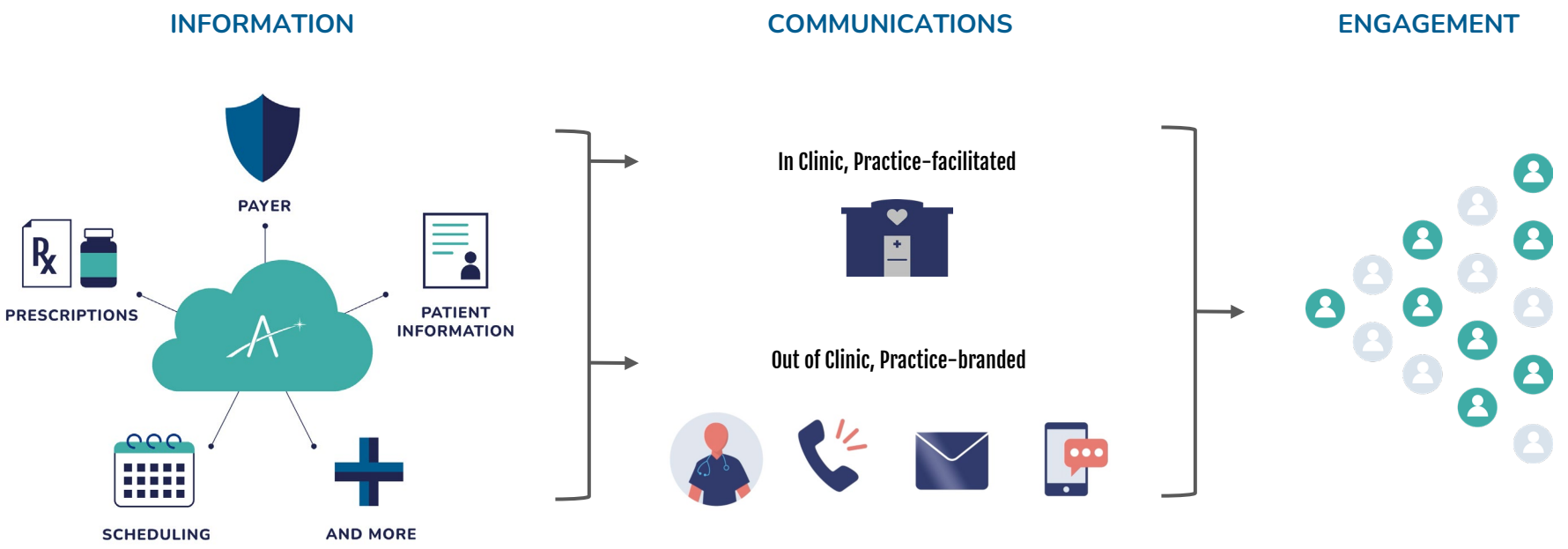
The COVID-19 pandemic has accelerated the share of physician compensation tied to quality performance.



35% have reported they have increased the share of compensation tied to quality in the past two years.

Source: 2022 MGMA DataDive Provider Compensation

Patient communications and outreach improves care and cost outcomes.



Start your value-based care journey today and thrive in practice.

The right information helps you prioritize what matters most, resulting in healthier patients, a healthier practice and a healthier business.

INCREASING ACCESS

HIGH RISK REDUCTION

REDUCING HOSPITALIZATIONS and REHOSPITALIZATIONS

COMPLEMENTARY CARE

Understand your TCM calendar.

TCM Calendar understanding clarified...

Example 1	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week One	**Discharge Day**	**Outreach day 1**	**Outreach day 2**				
Week One	**Billing Day 1**	**Billing day 2**	**Billing day 3**	**Billing day 4**	**Billing day 5**	**Billing day 6**	**Billing day 7**
Billing code wk 1	**99496**	**99496**	**99496**	**99496**	**99496**	**99496**	**99496**
Week Two	Billing Day 8 =99495	Billing Day 9 =99495	Billing Day 10 =99495	Billing Day 11 =99495	Billing Day 12 =99495	Billing Day 13=99495	Billing Day 14=99495

Example 2	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Wk 1					**Discharge Day**		
Wk1					**Billing day 1 =99496**	**Billing day 2 =99496**	**Billing day 3 =99496**
Wk 2	**Outreach day 1**	**Outreach day 2**					
Wk 2	**Billing day 4 =99496**	**Billing day 5 =99496**	**Billing day 6 =99496**	**Billing day 7 =99496**	Billing day 8 =99495	Billing day 9 =99495	Billing day 10 =99495
Wk 3	Billing day 11 =99495	Billing day 12 =99495	Billing day 13 =99495	Billing day 14 =99495			

Outreach Call- 48 hours (2 business days, weekend does not count) **Timing for billing. Day 1= Discharge day**

What is advance care planning, and why is it important for health centers?

Advance care planning (ACP) helps patients think about their futures.

ACP allows patients and their families to plan their future health care wishes if they become unable to communicate their decisions. Advance directives, or living documents that provide instructions for care, may be part of this discussion.

Clinicians can be reimbursed for ACP in value-based care.

ACP services can be offered in facility and non-facility settings and billed in any care setting. ACP may be billed with another CHC visit or as a stand-alone visit and may involve forms, advance directives, and discussions about care decisions.

ACP and advance directives are valuable components of end-of-life care.

ACP makes an often difficult subject for patients easier by establishing a plan for end-of-life care needs. As health center populations in the 65+ age group continue to grow, it's important to advocate for these conversations.

https://www.commonwealthfund.org/medicare-data-hub/traditional-medicare
https://www.medicare.gov/basics/get-started-with-medicare#:~:text=Medicare%20is%20health%20insurance%20for,also%20called%20Lou%20Gehrig's%20disease).

Evaluating your practice

1. Pick a champion
2. Process Improvement/PDSA (Plan Do Study Act)
3. Business Process Re-Engineering
4. “Secret Shopper” Patient - in-person visit, call in to practice
5. Patient Advisory Councils

What does a practice need to thrive?

- Financial Stability
- Resources eg PPE
- Staff
- Morale
- Physical health
- Emotional health

- Safe physical environment
- Patients
- Innovation/Technology - resources, HIT, integration, data, telehealth
- Other
- YOU!

Thriving in practice with value-based care through adversity- TOP 10

1. Goal setting - set specific, smaller, realistic measurable (SMART) goals that are time limited, and share the goals with your staff
2. Financial outlook for the year (build a budget if you are able) and diversify income streams, consider VBC
3. Evaluate your practice business plan or create one if you don't have one
4. Reassess your payor panel, talk with your biller
5. Know Physician Fee Schedule changes for each payor
6. Telehealth strategies and best practices especially for 2023 and 2024 Medicare contracts
7. Focus on prevention, eg AWV, patient access/hours
8. Mark your progress - set a schedule when you will revisit your goals and action plan
9. Choose a good partner to help and keep you accountable. Someone who will help you sustain change and grow with changes in regulations and compensation.
10. Take steps to recognize burnout, build staff morale, ensure staff safety/PPE - commit to self compassion, reframing, gratitude, and rewarding work

Questions?