Value-Based Care: What's all the fuss?

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The learner will be able to...

1. Understand the overarching tenets of value-based care in the US.
2. Describe existing models of providing value-based care today.
3. Explore the benefits and challenges of providing value-based care.
4. Connect current practice to next steps in a value-based care journey.

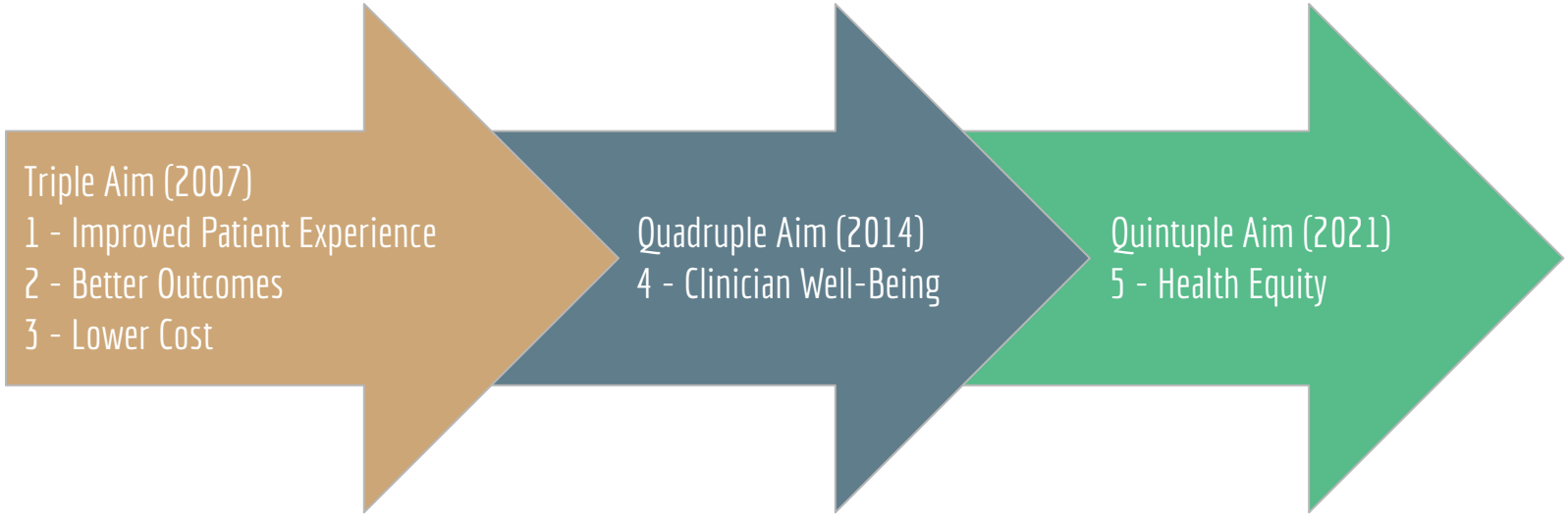
Poll Question #1

What is your experience level with value-based care work?

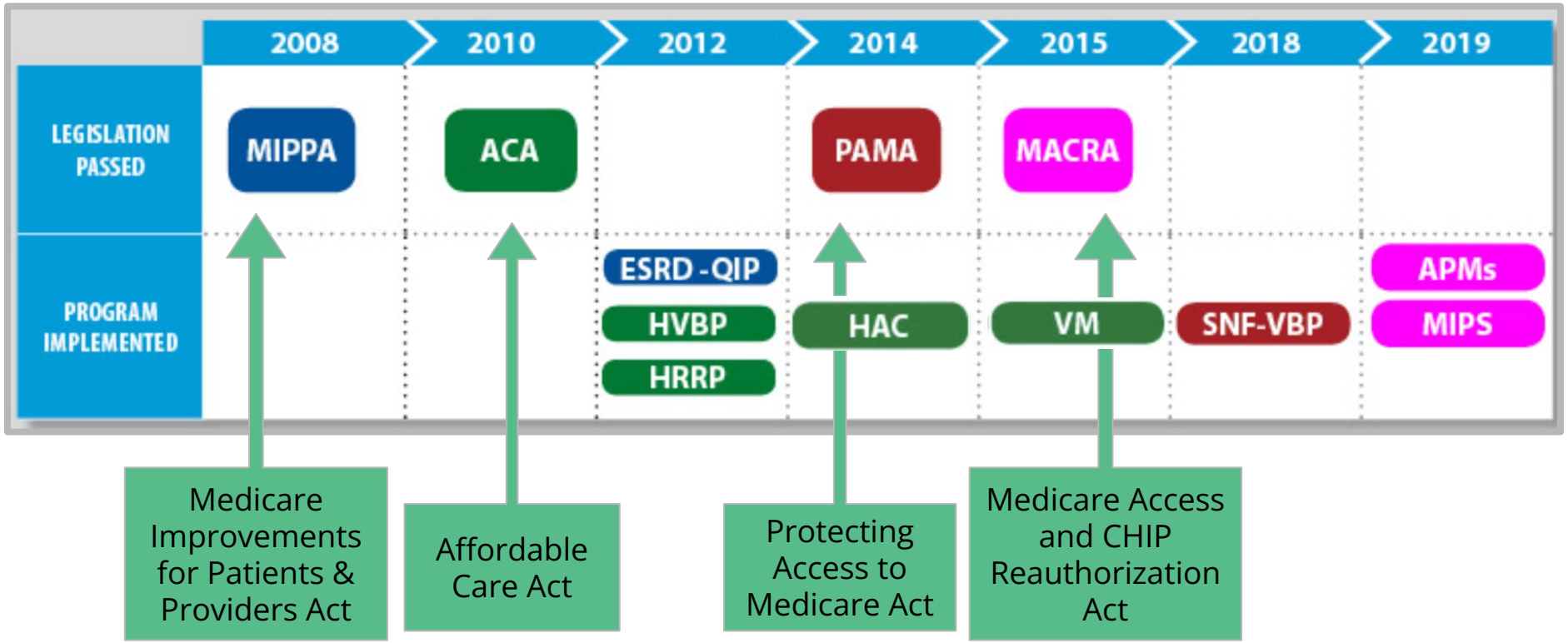
A. Rock Star - VBC is where I truly shine!
B. Warm Up Band - I can sing the tune, but sometimes I'm a little pitchy.
C. Stagehand - I know how to put it all together and make others look good.
D. Fan - I like what I see, but I'm not a performer (yet).
E. Grumpy Parent - the music is too loud and I don't like it!

Let’s start at the very beginning...
...it’s a very good place to start!

What are we aiming for?



How did it all begin?



Pioneer ACO Model (2012-2016)
9 Participants

Health care organizations already experienced in coordinating care for patients across care settings; allowed more rapid movement from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program.

CPC Initiative (2013-2017)
7 Regions

442 Participants
Population-based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five "Comprehensive" primary care functions.

Next Generation ACO Model (2016-2021)
35 Participants

Built on Pioneer Model; set predictable financial targets, enabled providers and beneficiaries greater opportunities to coordinate care, and aimed to attain the highest quality standards of care.

CPC+ Initiative (2017-2021)
2610 Participants

National advanced primary care medical home model that aimed to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.

2012 **2013** **2016** **2017**

2012 **2015** **2016** **2017**

Advance Payment ACO Model (2012-2015)
35 Participants

Physician-based and rural providers who volunteered to give coordinated high quality care to Medicare patients; participants received upfront and monthly payments, which they could use to make important investments in their care coordination infrastructure

Comprehensive ESRD Care Model (2015-2021)
33 Participants

Designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD).

ACO Investment Model (AIM) (2016-2019)
45 Participants

Model that built on the experience of APM and tested the use of pre-paid shared savings to encourage new ACOs to form in rural and underserved areas and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk.

Vermont All Payer ACO Model
1 Participant

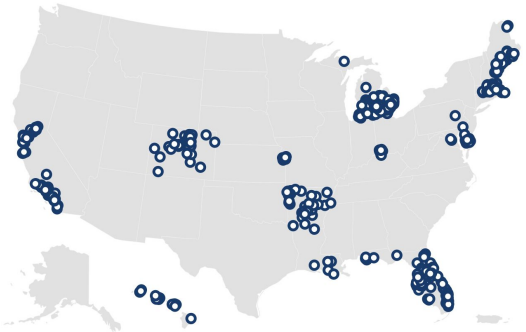
Test of an alternative payment model in which Medicare, Medicaid, and commercial health care payers incentivize health care value and quality, with a focus on health outcomes, under the same payment structure.

MSSP: Medicare Shared Savings Program (2012 → current)

Primary Care First

Voluntary alternative five-year payment model offering an innovative payment structure to support the delivery of advanced primary care. Primary Care First is based on the principles underlying the existing Comprehensive Primary Care Plus (CPC+) model design: prioritizing the clinician-patient relationship; enhancing care for patients with complex chronic needs, and focusing financial incentives on improved health outcomes.

- 2021 Performance Year Start
- 2515 Participants
- Payments made directly to the practice
- Ok to also be in an MSSP ACO (payments count in the total spend)

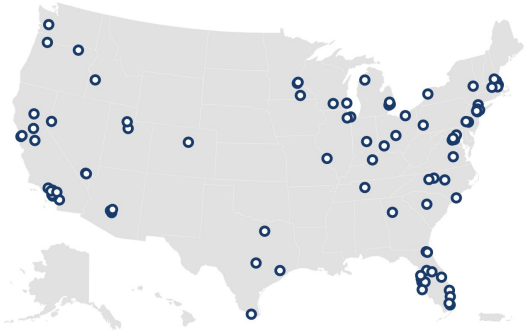


Source: Centers for Medicare & Medicaid Services

ACO REACH

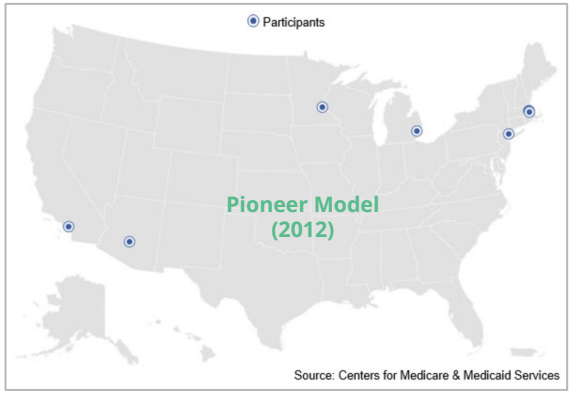
ACO Realizing Equity, Access, and Community Health

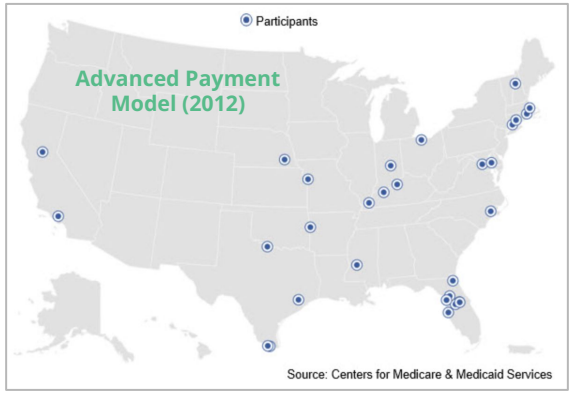
1. **Advance Health Equity to Bring the Benefits of Accountable Care to Underserved Communities.** Requires that all model participants develop and implement a robust health equity plan to identify underserved communities and implement initiatives to measurably reduce health disparities within their beneficiary populations.
2. **Promote Provider Leadership and Governance.** The ACO REACH Model includes policies to ensure doctors and other health care providers continue to play a primary role in accountable care. At least 75% control of each ACO's governing body generally must be held by participating providers.
3. **Protect Beneficiaries and the Model with More Participant Vetting, Monitoring and Greater Transparency.** CMS will ask for additional information on applicants' ownership, leadership, and governing board to ensure participants' interests align with CMS's vision.

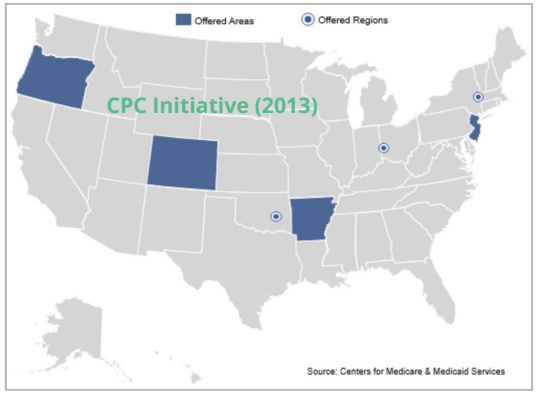


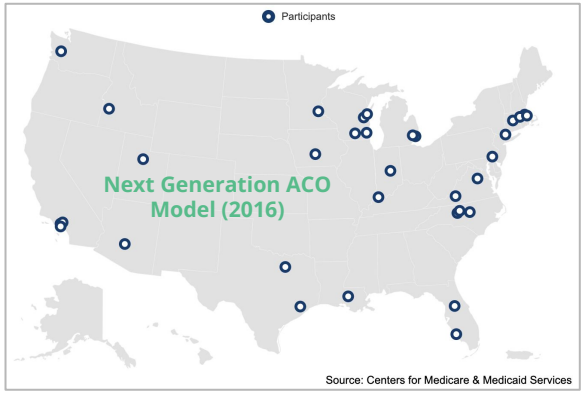
Source: Centers for Medicare & Medicaid Services

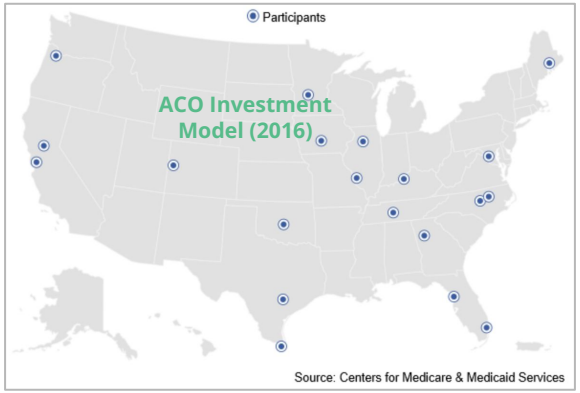
Did it work?

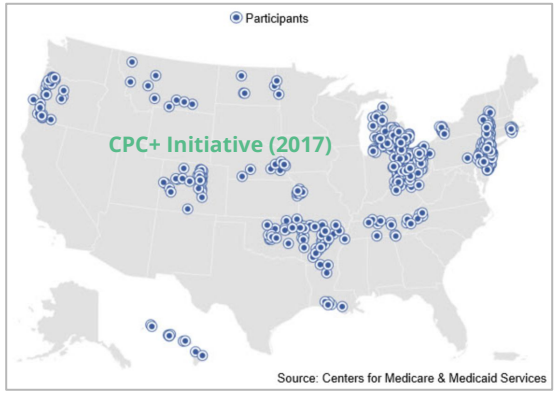

Participants
Pioneer Model (2012)
Source: Centers for Medicare & Medicaid Services


Participants
Advanced Payment Model (2012)
Source: Centers for Medicare & Medicaid Services

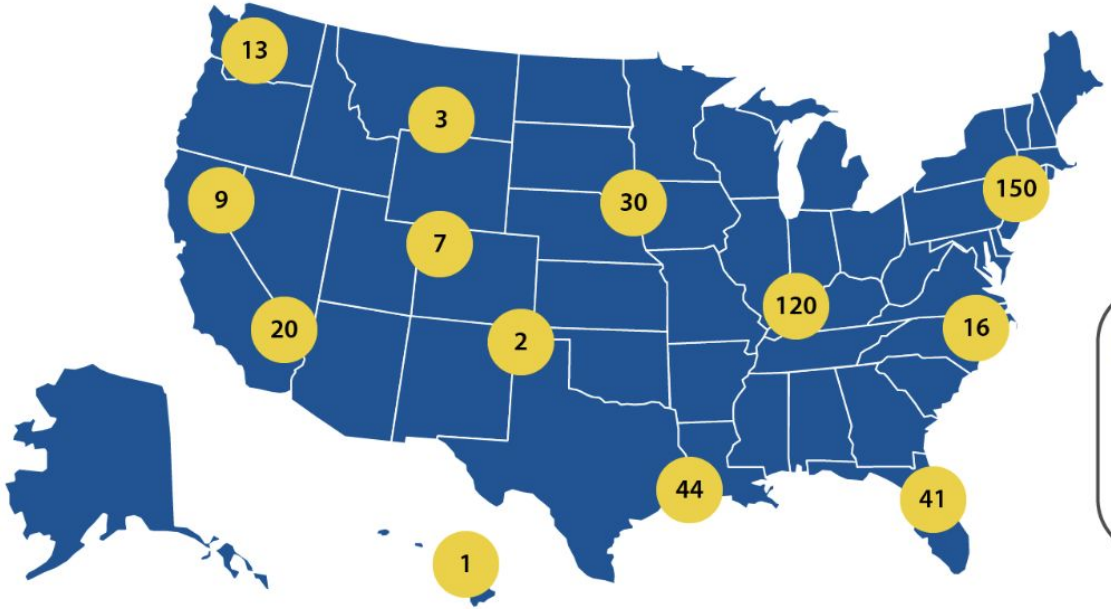

Offered Areas
Offered Regions
CPC Initiative (2013)
Source: Centers for Medicare & Medicaid Services


Participants
Next Generation ACO Model (2016)
Source: Centers for Medicare & Medicaid Services


Participants
ACO Investment Model (2016)
Source: Centers for Medicare & Medicaid Services


Participants
CPC+ Initiative (2017)
Source: Centers for Medicare & Medicaid Services

It did!



456 Shared Savings Program ACOs are providing care to 10.9 million beneficiaries

 # Number of ACOs in the area.

NOTE: This area may cover organizations serving beneficiaries across multiple states.

source: Performance Year 2023 Medicare Shared Savings Program Accountable Care Organizations

Poll Question #2

What is the goal for VBC uptake in the US?

A. 20M Medicare beneficiaries in VBC by 2025
B. 25M Medicare beneficiaries in VBC by 2025
C. 30M Medicare beneficiaries in VBC by 2030
D. 40M Medicare beneficiaries in VBC by 2035

The move to VBC is accelerating

In 2021

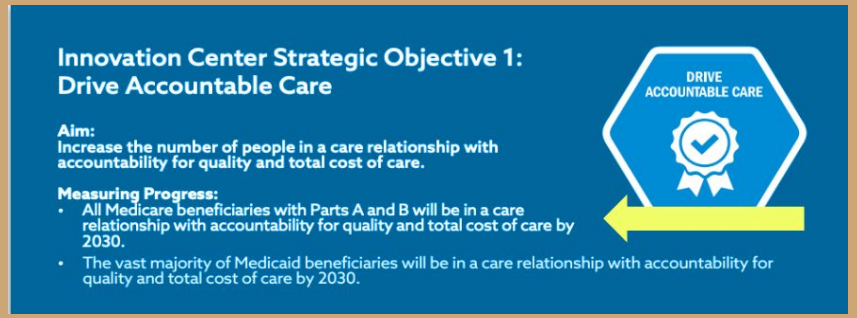
10 million
original Medicare beneficiaries in VBC

In 2022

11 million
original Medicare beneficiaries in VBC

By 2030

30 million
(all) Medicare beneficiaries in VBC (CMS goal)



The MSSP Basics

What is an ACO?

Accountable Care Organizations (ACOs) are groups of clinicians who assume responsibility for the quality and cost efficiency of the health care for a designated patient population.

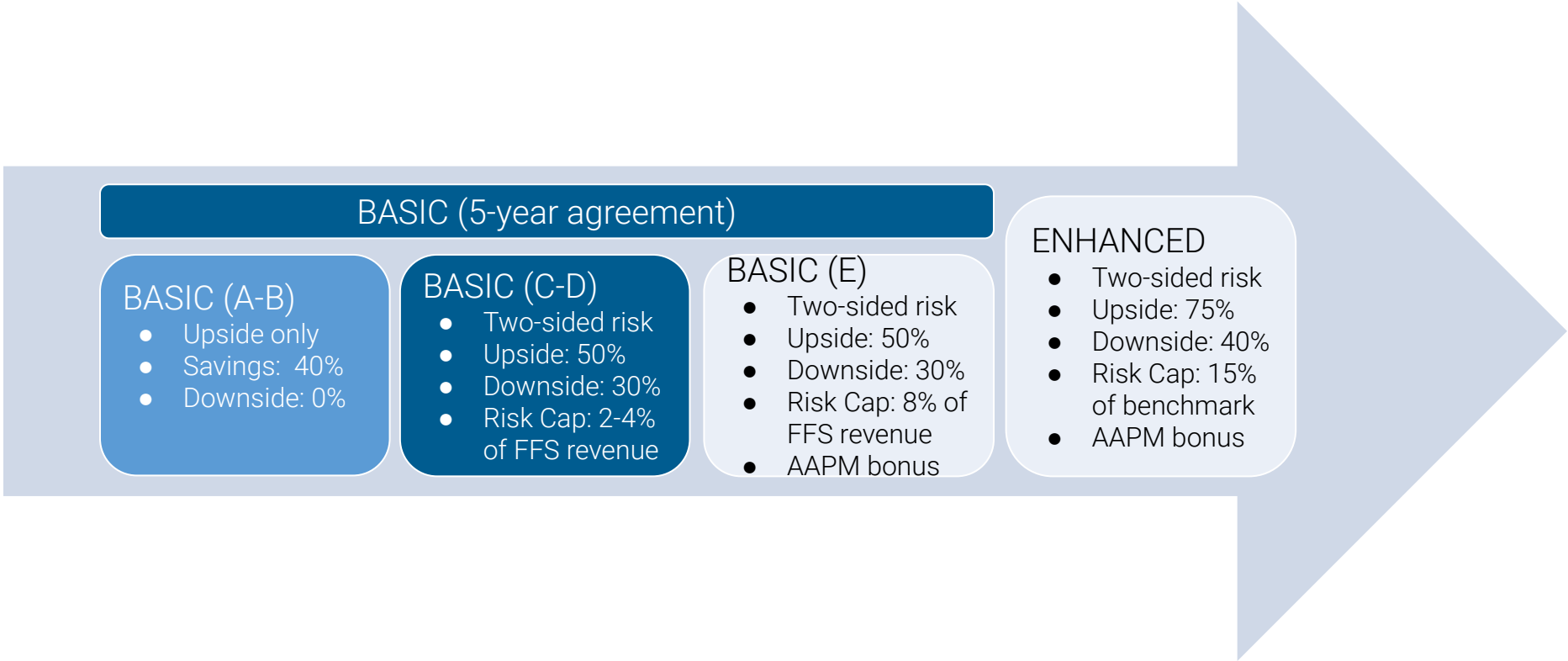
The goal of Medicare Shared Savings Program (MSSP) ACOs is for participating clinicians to work together to offer coordinated, high-quality care to their Medicare beneficiaries.

ACOs agree to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population.

There are different options (tracks) that allow ACOs to assume various levels of rewards and risk.

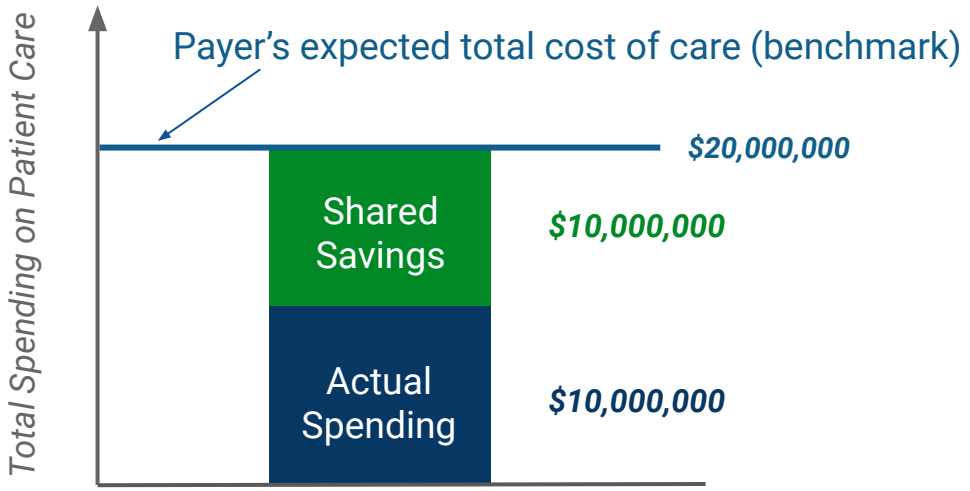
ACOs earn a portion of the savings they generate for the Medicare program as payment for their efforts.

Current MSSP ACO Models



How do ACOs earn shared savings?

1. **Set the benchmark annually** by honestly, accurately, and completely describing patients' relative health and vulnerability via appropriate ICD-10 diagnosis coding (captured each year between January 1 and December 31).
2. Implement workflows and processes that build on the outstanding primary care provides to improve patients' health status and quality of life, which results in **reduced overall healthcare costs**.

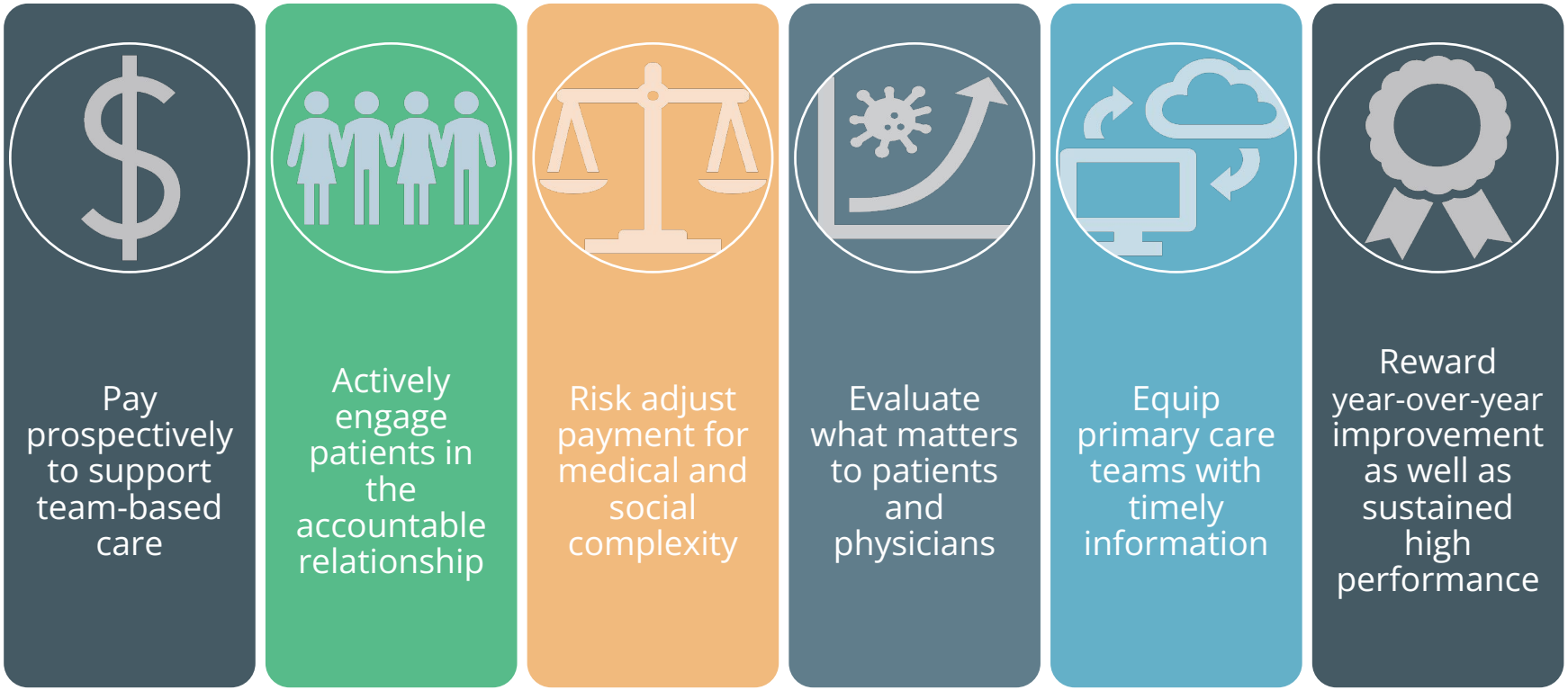


Poll Question #3

What is the biggest barrier to increasing your footprint in the VBC space?

Where is the AAFP?

AAFP Guiding Principles for Value-Based Payment



AAFP Guiding Principles for Value Based Care

1. Value-based payment (VBP) models should be **aligned across payers** and **provide predictable, prospective revenue streams**. Within practices and other health care organizations, individual physicians should share in the financial rewards that accrue from their performance.
2. Methodologies used to determine the patients for which physicians and care teams are held accountable must **prioritize existing patient-physician relationships** over less reliable claims or geographic methods while ensuring physicians and primary care teams have reliable, timely information about the patients for whom they are held accountable.
3. Risk-adjustment methodologies should incorporate **clinical diagnoses**, **demographic factors**, and other relevant information such as **social determinants of health** without exacerbating health care disparities or expanding the administrative burden on primary care practices.
4. Financial benchmarks in VBP models should incentivize high-quality, efficient, accountable care delivery by establishing targets that **reward both improvement and sustained performance** over time.
5. Performance measures should focus on processes and outcomes that **matter most to patients** and have the greatest impact on overall health and unnecessary spending.
6. Clinically relevant and actionable **patient information should be readily available** in a timely, accurate, secure, and efficient manner that does not place unnecessary administrative or financial burdens on primary care practices.

Making Care Primary

What is Making Care Primary?

- ✓ 10.5-year multi-payer model
- ✓ 3 participation tracks
- ✓ builds upon previous primary care models (CPC, CPC+, PCF, MDPCP)

MCP aims to improve care for beneficiaries by **supporting the delivery of advanced primary care services** and will provide a **pathway for primary care clinicians with varying levels of experience in value-based care** to gradually adopt prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration and drive **equitable access to care**.

State Medicaid agencies will commit to designing Medicaid programs to **align with MCP** in key areas.

Domains for MCP Care Delivery

- ✓ **Care Management**: participants will build their care management and chronic condition self-management support services, placing an emphasis on managing chronic diseases such as diabetes and hypertension, and reducing unnecessary emergency department (ED) use and total cost of care.
- ✓ **Care Integration**: in alignment with CMS' Specialty Integration Strategy, participants will strengthen their connections with specialty care clinicians while using evidence-based behavioral health screening and evaluation to improve patient care and coordination.
- ✓ **Community Connection**: participants will identify and address health-related social needs (HRSNs) and connect patients to community supports and services.

Note: each of these domains has specific care delivery requirements for participating organizations in each track.

MCP will offer three tracks

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.

2

Implementing Advanced Primary Care

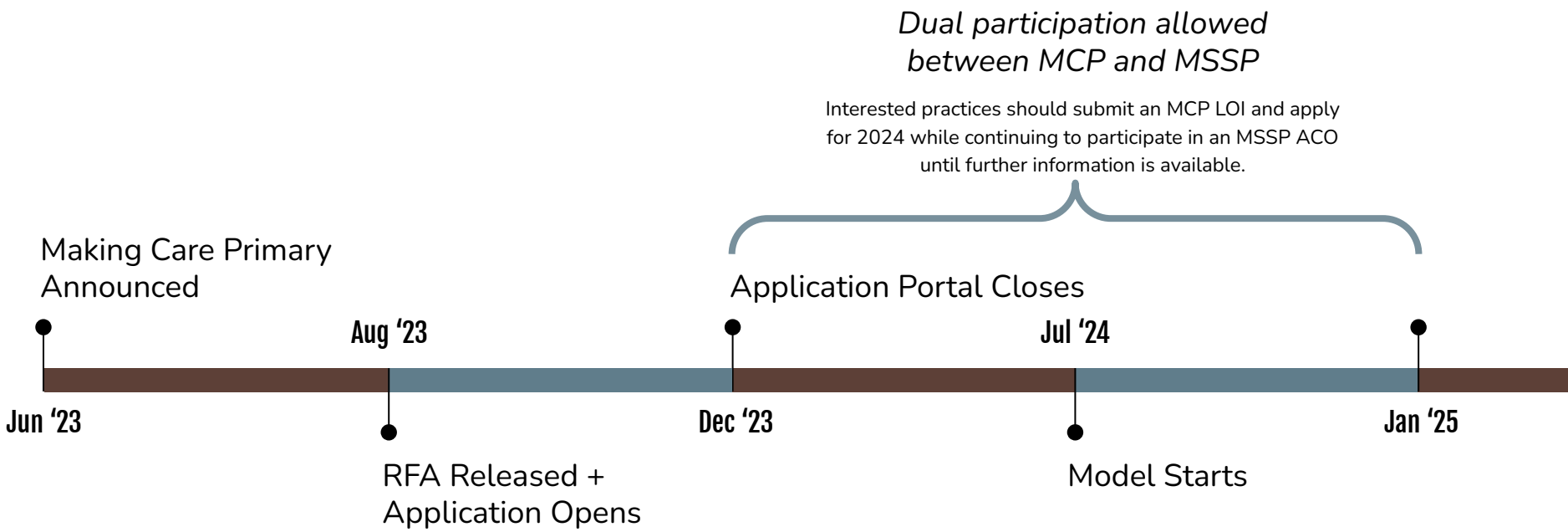
Payment for primary care will shift partially to prospective, population-based payments and CMS will continue to provide additional financial support as participants build capabilities. Participants are eligible to earn increased financial rewards for improving patient health outcomes and achieving savings.

3

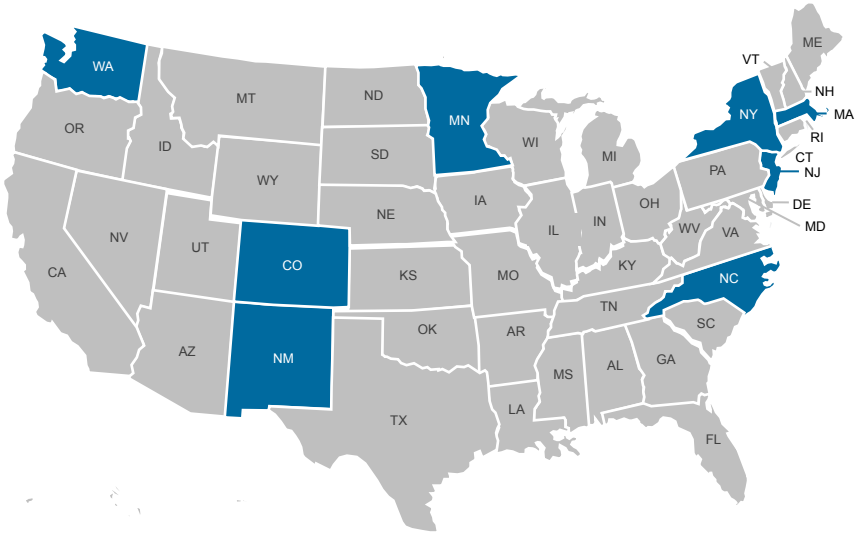
Optimizing Care and Partnerships

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.

Making Care Primary (MCP) Timeline



MCP Footprint



Who is eligible?

- Solo primary care practices
- Indian Health Programs
- FQHCs (not RHCs)
- Group practices
- Health systems
- Certain Critical Access Hospitals

Rural Health Clinics, concierge practices (practices that collect a fee from patients for access to their services), current Primary Care First (PCF) practices, current ACO REACH Participant Providers, and Grandfathered Tribal FQHCs are not eligible for MCP. Organizations will not be able to concurrently participate in the Medicare Shared Savings Program and MCP after the first six months of the model.

Questions?