Understanding Value Based Care

Roadmap to Success

Value Based Care - What Does This Mean?

Value Based Care is a health care delivery model under which providers — hospitals, labs, doctors, and nurses — are paid based on the health outcomes of their patients and the quality of services rendered. Under some value-based contracts, providers share in financial management with health insurance companies.

The Change: Volume versus Value

Past

- Care given in compartmentalized setting
- Outcomes measured in various ways
- Focus on treatment of disease and complications (acute and post-acute episodic care)
- Quality care was subjective, and experience based
- Payment for visits only- PPS only

Present

- Care is organized in “continuum”- more access to data
- Outcomes measured by coding/performance and decreased unnecessary utilization
- Focus shifted to prevention and management
- Quality is defined by coding and patient satisfaction
- Payment for visits and quality improvement/outcomes

How will this impact my health center?

- Your **PPS Payment Rate (Prospective Payment System)** will still occur.

  A Prospective Payment System (PPS) is a method of reimbursement in which Medicare/Medicaid payment is made based on a predetermined, fixed amount.

- During the change, payers will begin to offer quality payments in return for increased quality performance and coding.
- Payers will offer Care Management Fees (CMFs).
- Payers will offer shared savings opportunities.
- Heath Center will access your patient attribution
- Health Center will track quality/financial performance through payor portals.
- Health center will perform patient outreach to improve quality care.
- Health Center will code/bill to obtain quality credit

Value Based Care

- Payer/Provider Collaboration- Data Sharing
- Payer Focused on Quality and Value less on Quantity
- Increased Transparency- Payer portals include patient attribution and quality data
- State is holding payers accountable for quality performance
- Movement from Fee-For-Service to Pay-For-Performance
- CPT II coding/billing for quality credit
- Alternative Payment Methodology

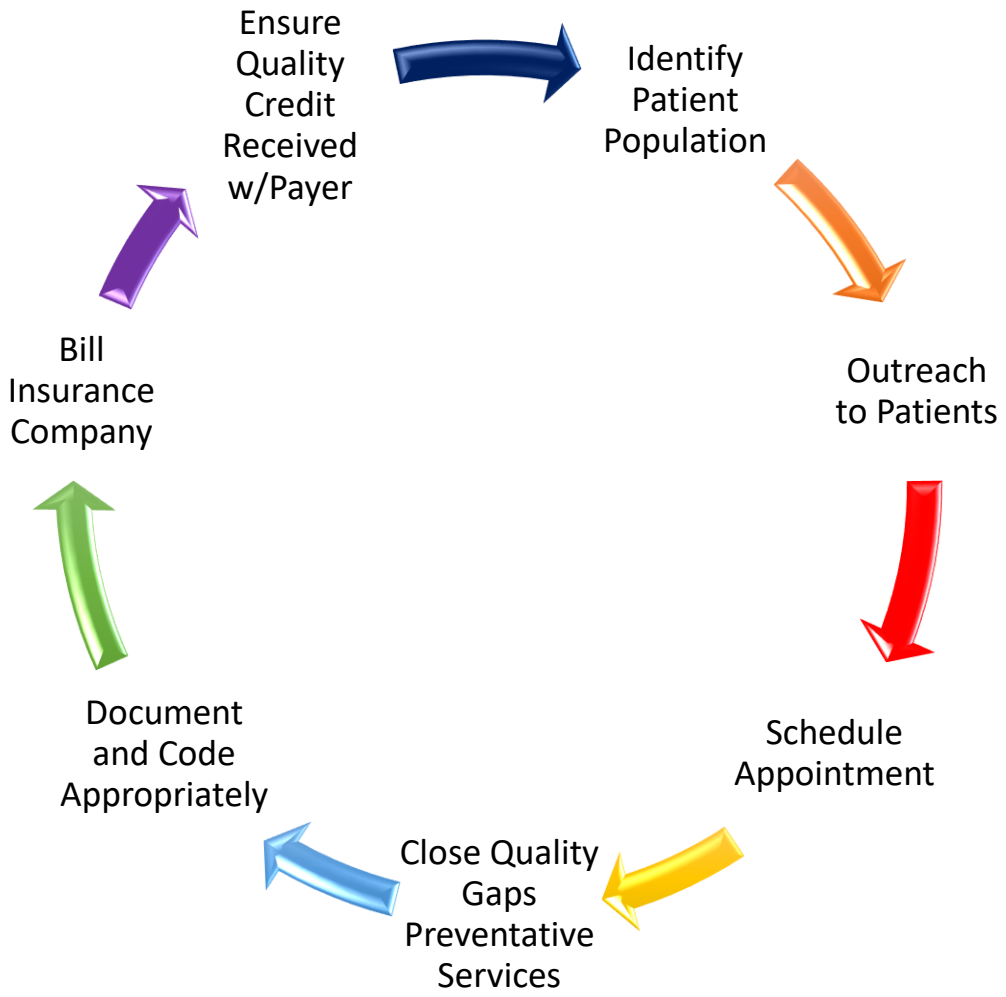
Value Based Care Contract Terms

- Partner with payors to manage the patient population.
- Patient attribution defined
- Stop Loss protection
- LDH chooses HEDIS quality measures
- Budget set by payor using historical financials
- Shared Savings opportunity for providers
- Payers sharing quality and financial data with providers
- CMF/PMPM payments

Primary Care Provider Focus

- Value-Based Care Programs are centered around Primary Care Providers (PCPs):
  - Patient Assigned to providers using multiple scenarios
    - Patient choice, auto assignment, and/or claims-based attribution methodology
  - Validate Provider's Panel is open with payers
  - PCP is Driver of Quality Outcomes
  - Care Management Fees Paid to PCPs
  - Referral Management is Imperative to Control Costs
  - Coding/billing for quality credit
  - Coordination of patient care

Steps to Success



Step #1: Know your Patient Attribution Obtain access to Payer Portals

- Build relationship with each payer representative
- Open panels vs closed panels
- How many lives are attributed to your health center?
- Quarterly claims-based attribution mandated by LDH
- Meet with each payer to review their process related to claims-based attribution and audit patient attribution
- Use payer portals to create call campaigns

Step #2: Know Your HEDIS Quality Performance

HEDIS Measure: Eligible Patients	Compliant	Non-Compliant	Performance	Goal	# Patients to meet Goal
CBP: 158	87	71	55.06%	55.25%	1
A1c <8: 58	39	19	67.24%	82.97%	10
BCS: 55	25	30	45.45%	58.64%	5
CCS: 390	222	168	56.92%	59.12%	9

Step 3: Patient Outreach/Call Campaigns

- Utilize payor portal HEDIS reports
- Prioritize patient outreach
- Identify clinical/nonclinical staff to perform patient outreach
    - Chronic disease patients- Diabetes/ HTN
    - Well visit /Preventive gaps in care
    - ER/Hospital discharge follow up appointments
- Educate staff to use standardized scripting, scheduling protocols and processes for flagging clinical teams
- Appointment reminder phone calls/text
- Regular clinical team meetings to manage patient population.
- Create standardized protocols to manage chronic disease patients

Step 4: Maximize your Electronic Medical Record (EMR)

- Develop EMR to support your VBC contracts and quality
- Automate CPT II coding when applicable
- Send electronic CCDA files to payers to support quality performance
- Educate billing and clinical team on proper use of EMR
- Validate claims with payers to ensure quality credits are achieved

Step 5: Know Your Total Cost of Care Breakdown from Payor

Financial Report	As of June 2021
Membership/Patient Lives	4488
Total Premium	$24,122,035
Cost Breakdown from Payer	
• Inpatient Claims	$4,544,427
• Outpatient claims	$5,871,958
• Professional claims	$3,758,872
• Pharmacy claims	$6,411,188
Total Cost of Care	$20,586,445

Share in Savings

What does this mean?

How does this work?

Max potential?

Next Steps

- Review existing contracts
- Schedule meeting with payors
- Validate provider roster
- Request HEDIS performance
- Choose HEDIS measures that matter to your organization
- Obtain access to payor portals
- Request MLR performance
- Create a plan
- Identify resources to do this work