VALUE-BASED CARE

OVERVIEW

DEFINING VALUE-BASED CARE

The goal of value-based care payment arrangements is to transform clinical care practices by rewarding high value care via changes in payment mechanisms.

Currently, most payment for healthcare services is structured around fee-for-service (FFS) payment mechanisms. Under an FFS payment system, clinicians furnish care and providers are paid per service rendered. Many value-based payment models maintain the FFS payment structure, while providing incentives for providers to alter clinical care practices that improve outcomes and improve quality of care furnished.

Value-based care describes the changes in the healthcare delivery framework that improves quality and outcomes for patients, and there are many different payment arrangements and model types that can achieve these goals. Examples of different model types include:

- Episode-based payment arrangements
- Primary care transformation models
- Accountable care models
- Global payment/capitation

Under Medicare, clinicians can participate in an advanced alternative payment model (APM) within the Quality Payment Program to satisfy statutory requirements to participate in quality arrangements.

VALUE-BASED CARE SUPPORTING PATIENTS

A major component of APMs is ensuring the right patient receives the right care from the right provider at the right time, preventing duplicative services and waste within the healthcare system. The financial incentives created in value-based care arrangements incentivizes clinicians to ensure patients receive coordinated, high-quality care. Further, under traditional Medicare, value-based payment arrangements do not limit patient networks; the beneficiary right to provider choice continues to be protected and championed.

THE TRANSITION TO VALUE-BASED CARE

The transition to value is a dimmer switch and not a light switch. To continue supporting the transition, practices will continue to need the technical, financial support to participate in value-based care arrangements.

63% of surveyed medical group practices stated they would be interested in participating in an APM, however, 80% indicated that there is not a clinically relevant APM currently available for practices to participate in. Many group practices recognize the importance of participating in value-based payment models under the Center for Medicare ad Medicaid Innovation (CMMI), yet they have not yet been afforded the opportunity to participate.

CONGRESSIONAL ASK

Congress must extend the 5% APM incentive payment until at least 2030 to provide critical funding for practices participating in an APM. This critical funding supports increased access to care, greater clinical transformation, and will greatly spur participation in APMs.

MGMA
Medical Group Management Association®

VALUE-BASED CARE

MEMBER SPOTLIGHT

THE IMPACT OF THE 5% APM INCENTIVE PAYMENT ON ADVANCING VALUE-BASED CARE

PRACTICE NAME: Coastal Carolina Care

SPECIALTY: Primary Care

LOCATION: North Carolina

CLINICAL STAFF: 30 Primary Care Doctors

ADVANCED APM: Medicare Shared Savings Program (MSSP)[1]

LESSONS LEARNED IN VALUE-BASED CARE

- Early adopters of value-based care arrangements began participating in some value-based care arrangements beginning in 2012.
- Began in non-risk bearing arrangements (if spending exceeded benchmarks, they were not accountable for paying back any money).
- Potentially receiving the 5% APM incentive payment pushed the practice to engage in higher risk arrangements.
- Successfully transitioned to MSSP ENHANCED and received the 5% APM incentive payment.
- Between 2011 and 2021, emergency room and hospital visits for the patient population declined by 30%.

5% APM INCENTIVE PAYMENTS SUPPORT PRACTICES

- Being able to invest the 5% APM incentive payment back into their practice was essential for Coastal Carolina Care's continued success in MSSP.
- Critical investments made because of 5% APM incentive payments:
    - Supporting wrap around care and preventing patients from going into the hospital which began to create fundamental shifts in care delivery, spilling beyond just patients enrolled in MSSP.
    - Investments in extended care units to support practice redesign.
    - Additional funding to support clinical and administrative staff retention.

---

[1] *The Medicare Shared Savings Program (MSSP) is the primary accountable care organization (ACO) model that offers practices the opportunity to be accountable for the quality, cost, and experience of care across an assigned Medicare FFS beneficiary population. The voluntary MSSP program encourages providers to furnish high quality, cost-effective care to Medicare beneficiaries. Within the program, ACOs participate in different tracks and assume different levels of risk. More information about MSSP can be found on the CMS* ***program website****.*

MGMA GOVERNMENT AFFAIRS
1717 Pennsylvania Ave., Suite 600, Washington, DC 20006
202.293.3450 | govaff@mgma.org
www.mgma.com/advocacy
@MGMA | #MGMAAdvocacy