OHS CONNECTICUT Office of Health Strategy

CEDARBRIDGE GROUP

Value-Based Care Informational Resource

Purpose:

To provide a high-level overview of what *Value-Based Care* (VBC) is, and how it is applied in healthcare delivery systems for Primary Care and Community Health Reforms (PCCHR) Workgroup members who may not be as familiar with VBC concepts. This informational resource defines what is meant by "value-based," and offers several real-world examples of models and resources currently used in Connecticut, and throughout the United States. This document also provides members with additional resources on VBC and contacts at the Office of Health Strategy (OHS) to engage with to learn and discuss VBC in more detail.

Figure 1 - The Learning and Diffusion Group at the Center for Medicare & Medicaid Innovation (CMMI) – The Fundamental Shift to Value-Based Care (Link – about 20 minutes)

Value-Based Care Background Information:

The Centers for Medicare and Medicaid Services (CMS) define value-based care as "paying for health care services in a manner that directly links performance on cost, quality and the patient's experience of care." Value-based care models are commonly categorized across insurance providers, health plans, governments, non-profits healthcare organizations, and health systems using the Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Model (APM) Framework shown in Figure 2, below.

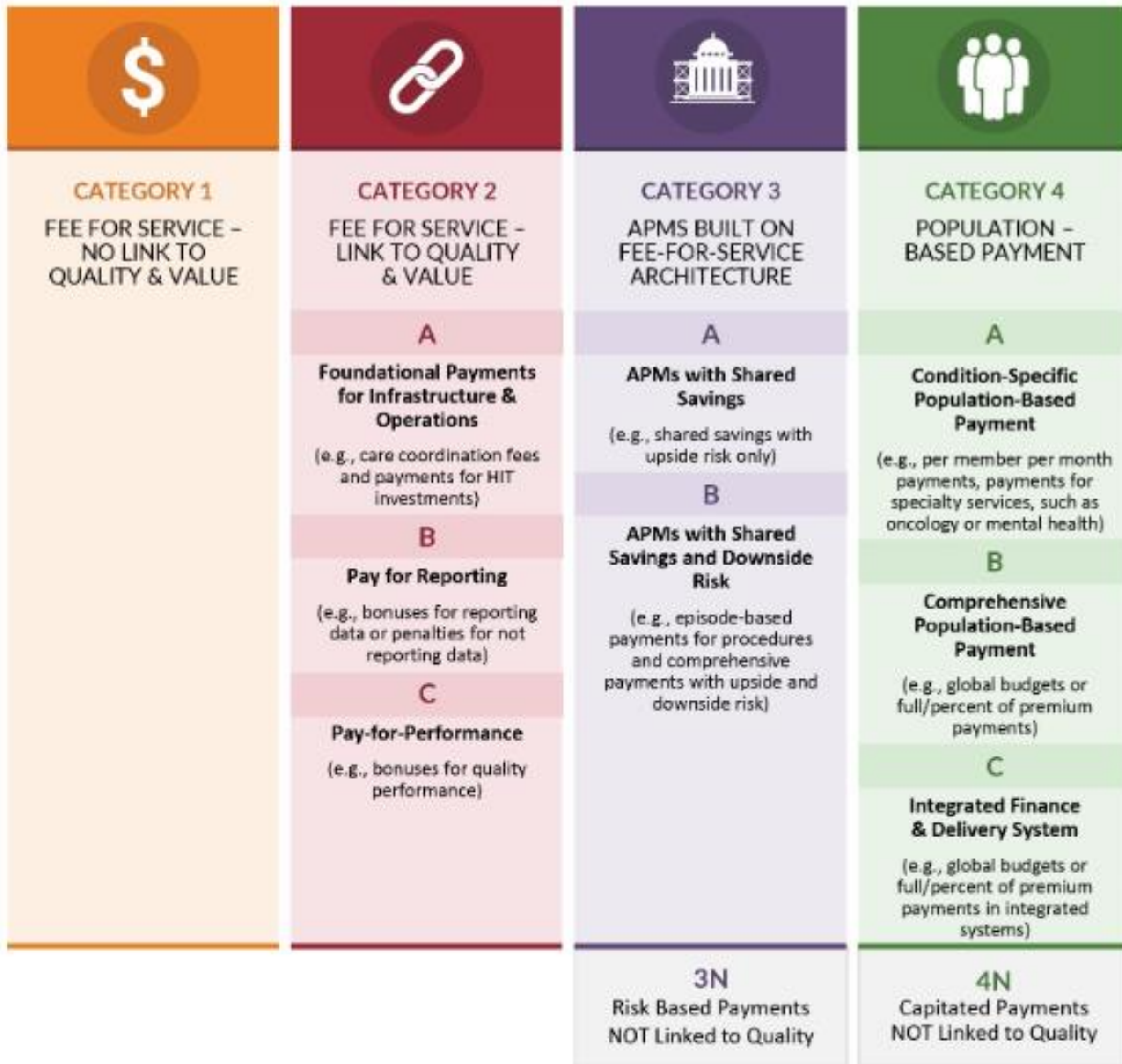

Figure 2- HCP-LAN APM Framework (2017 Refresh)

The LAN introduced a four-category framework for conceptualizing payment models, shown in Figure 2, above. This framework is useful for examining payment models for any type of health care service including primary care.

- **Category 1:** Fee for Service (FFS) payment, "which remains the dominant method of primary care payment... contributes to the challenges of delivering high-value primary care."[1]
- **Category 2:** Includes many of the models seen over the past 20 years, including pay-for-performance (P4P), pay-for-quality (P4Q), pay-for-care management, and various versions of Patient Centered Medical Home (PCHM).
- **Category 3:** Includes episode-based payments for procedures (e.g., cardiovascular surgeries) and shared savings with upside and downside risk linked to quality metrics.
- **Category 4:** Moves to population-based payment, typically paid on a per-member per-month basis, or fixed fee payments for specific conditions (e.g., heart disease, cancer, diabetes) or a more limited set of services such as

[1] Health Care Payment Learning & Action Network. (2017). Accelerating and Aligning Primary Care Payment Models. Retrieved from https://hcp-lan.org/workproducts/pcpm-whitepaper-final.pdf , page 5.

primary care or behavioral health. Population-based payments can also apply to comprehensive care for an entire population (i.e., global budgets) with links to quality.

Examples of Value-Based Care Models

Table 1 - Value-Based Care Model Examples

Payer Type	Agency / Organization	Value-Based Care Model	Description
Federal	Centers for Medicare and Medicaid Services (CMS)	Comprehensive Primary Care Plus (CPC+)	Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S.). To support the delivery of comprehensive primary care, CPC+ includes three payment elements: 1. Care Management Fee (CMF): Both tracks provide a non-visit-based CMF paid per-beneficiary-per month (PBPM) and risk-adjusted for each practice to account for the intensity of care management services required. 2. Performance-Based Incentive Payment: CPC+ pays a performance-based incentive based on how well a practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care. 3. Payment under the Medicare Physician Fee Schedule: Track 2 practices' FFS payment will be reduced to account for CMS shifting a portion of Medicare FFS payments into Comprehensive Primary Care Payments (CPCP), which will be paid in a lump sum on a quarterly basis and will be larger than the FFS payment amounts they are intended to replace.
	Centers for Medicare and Medicaid Services (CMS)	Merit-based Incentive Payment System (MIPS)[2]	MIPS is one way to participate in CMS' Quality Payment Program. Under MIPS, CMS evaluates clinician performance across four categories that lead to improved quality and value in our healthcare system: 1. Quality: assessing the quality of care using performance measures

[2] Centers for Medicare and Medicaid Services, Quality Payment Program, MIPS Quick Start Guide, retrieved Dec. 1st, 2020 - https://qpp-cm-prod-content.s3.amazonaws.com/uploads/819/2020%20MIPS%20Quick%20Start%20Guide.pdf

			2. Costs: assessing the cost of care provided based on Medicare claims 3. Improvement Activities: clinical operations supporting patient engagement, care coordination, and patient safety 4. Promoting Interoperability: focuses on the electronic exchange of health information to improve patient care and access to information The MIPS performance categories have different “weights” and the scores from each of the categories are added together to give clinicians a MIPS Final Score. Participants receive a positive, negative, or neutral payment adjustment based on their MIPS Final Score for the performance year.
State	Connecticut Department of Social Services (DSS)	Person-Centered Medical Home (PCMH) and Person-Centered Medical Home Plus (PCMH+) Models[3]	The PCMH initiative includes limited embedded care coordination, extended hours and use of Electronic Health Records. PCMH supports free practice coaching, enhanced rates, performance and year-over-year improvement payments. The PCMH+ initiative includes enhanced features of care coordination, supplemental care coordination payments to FQHCs, and an upside-only shared savings approach. PCMH+ has incentivized FQHC participants with supplemental care coordination payments in support of behavioral health integration and expansion of care teams to include community health workers (CHWs). Participating entities (PEs) may receive shared savings payments through an Individual Savings Pool and a Challenge Pool.
	Oregon Health Authority (OHA)	FQHC Advanced Payment and Care Model[4]	The Oregon Health Authority (OHA), in partnership with the Oregon Primary Care Association (OPCA), developed the Advanced Payment and Care Model (APCM) through a Medicaid State Plan Amendment for FQHCs. The program was designed to align payment and transform care and services to promote optimal health and health equity for safety-net patient populations. The payment model of APCM allows care teams to focus on patients instead of visits. Under the APCM program, the fee-for-service Medicaid reimbursement generated through the Prospective Payment System (PPS) for health centers is converted into a per-member, per-month (PMPM) payment while FQHCs are held accountable to quality, access, and patient satisfaction measures. This fixed fee approach to payment gives community health centers the opportunity to tailor their care and services to the unique issues and circumstances of their patients, as well as to adjust where, how and what kind of care and

[3] Department of Social Services, Person-Centered Medical Home Plus (PCMH+) Overview - https://portal.ct.gov/dss/Health-and-Home-Care/PCMH-Plus

[4] Oregon Primary Care Association Alternative Payment & Advanced Care Model Overview, retrieved December 2nd, 2020 - https://www.orpca.org/initiatives/alternative-care-model

			services they provide. With this flexibility, health centers can focus on partnering with patients to create a plan for supporting better health. With the latitude created by the alternative approach to payment, the APCM care model encourages care teams to address root causes of illness and well-being in the lives of their patients. With revenue no longer directly tethered to the provision of individual medical encounters, community health centers can focus on developing a more effective approach to improving population health.
	Connecticut Office of the State Comptroller (OSC)	Networks of Distinction	This innovative "episode of care" delivery and payment model establishes a new industry standard by aligning clinical and financial incentives for the state employee health plan and the Connecticut partnership Plan, totaling more than 220,000 members. Under the initial agreement, 180 health care provider groups have committed to meet a set of quality care standards at the lowest possible cost. The Network of Distinction program significantly reduces variations in costs by setting fixed prices for certain health events that may be delivered by multiple providers across multiple sites, a model known as an "episode of care" payment. Over 20 procedures and conditions will be available at launch including knee replacement, colonoscopy, cataract surgery and care related to pregnancy. Also featured is a comprehensive spine episode aimed at helping members avoid surgery. Signify Health is supporting the state with its set of episodes of care solutions that include identifying, contracting with and supporting all of the providers in the Network of Distinction, as well as all other providers that have agreed to fixed, guaranteed episode pricing. This allows the state to improve patient outcomes and secure significant savings by contracting with a large portion of the network and the highest-quality options.
Commercial Insurance and Managed Care Plans	Blue Cross Blue Shield of Michigan	Physician Group Incentive Program (PGIP)[5]	"PGIP is a collection of clinical and quality-based initiatives that improve patient care in Michigan. PGIP is part of a larger program at Blue Cross Blue Shield of Michigan called Value Partnerships… PGIP fosters teamwork among Blue Cross physician organizations and practitioners to transform how care is delivered. As part of these efforts, the program embraces fee-for-value reimbursement instead of the traditional fee-for-service model. There are two components to the fee-for-value reimbursement model: 1. Rewarding physician organizations for actively engaging in PGIP initiatives with financial incentives paid through the PGIP reward pool

[5] Blue Cross Blue Shield of Michigan – Value Partnerships: Physician Group Incentive Program (PGIP), PGIP Basics (PDF), retrieved December 1st, 2020 - https://www.bcbsm.com/content/dam/public/Providers/Documents/physician-group-incentive-program-basics.pdf

			2. Providing fee uplifts to PGIP primary care physicians and specialists associated with high-quality, cost-efficient care based on claims data The reimbursements are used for building PCMH and OSC capabilities, lowering costs and improving quality performance." (PGIP Basics, BCBS of Michigan)"
Employer Models	Value-Based Insurance Design Consortium	Value-Based Insurance Design[6]	The SIM Program Management Office and the Office of the State Comptroller released streamlined Value-Based Insurance Design Employer Manuals for Self-Insured and Fully-Insured Employers. The manuals contain templates and supporting documentation for employers interested in developing value-based insurance design plans. Value-based insurance design (V-BID) is an innovative insurance strategy that seeks to improve health and control rising health care costs by promoting the use of high value services and providers through consumer incentives. High-value services are those that have a strong evidence-base, enhance clinical outcomes, and increase efficiency. V-BID plans utilize "clinical nuance", a concept that recognizes that medical services differ in the benefit provided, and that the clinical benefit derived from a specific service depends on the patient using it, as well as when, where, and by whom the service is provided. The aim of V-BID is to increase healthcare quality and use healthcare dollars more effectively by implementing differential cost sharing for consumers to promote use of high value services and providers and decrease use of low value services.
	Intel Corporation	Connected Care - Case Study: Providence Health & Services [7]	Since 2013, Intel Corporation has been investing in an innovative approach for providing healthcare to employees and their families, under an employer-sponsored and facilitated accountable care program known as Connected Care. Connected Care health plans are offered in several regions of the country where Intel has large employee populations. At each site, Intel has contracted with one or two large healthcare organizations to deliver a high-touch, highly coordinated healthcare experience to Connected Care members; these organizations are known as Intel's Delivery System Partners (DSPs). In early 2014, Providence Health & Services responded to Intel's RFP for Connected Care and was awarded a contract to provide healthcare services as one of the health plan choices available to Oregon employees. The annual performance measures for each DSP are developed through a collaborative but rigorous process. National measures are used as a starting point and are evaluated and improved

[6] Value-Based Insurance Design - https://portal.ct.gov/OHS/SIM-Work-Groups/Value-Based-Insurance-Design-Consortium/Publications

[7] Connected Care: Electronic Data Exchange Essential to Intel's Innovative Accountable Care Model - https://cedarbridgegroup.com/wp-content/uploads/2019/05/ConnectedCare_0419.pdf

			upon through an agile methodology. First, baseline metrics are developed for the DSPs, and the improvement goals are set together with Intel. Measures are tied to a set of principles known as Intel's Five Requirements. Within these requirements, several measures are mutually agreed upon by Intel and each DSP. When performance measures are exceeded, the DSP will receive a bonus payment, and if a metric falls short of its target threshold, the DSP could end up owing Intel a penalty payment. Each of these quality measures is evaluated and selected based on relevancy, feasibility, and measurability criteria. By mid-2017, with claims and member survey data, as well as clinical quality data from each of the Oregon DSPs scrubbed and validated for the 2016 calendar year, it was clear that Intel's second Connected Care region was exceeding company expectations. Health outcome measures showed improvement, and significant cost avoidance was demonstrated in a side-to-side comparison to employees with similar demographics and health statuses who were receiving care under other health plan offerings.

Additional Resources:

- Connecticut State Innovation Model - Primary Care Payment Reform: Unlocking the Potential of Primary Care - http://www.healthreform.ct.gov/ohri/lib/ohri/pttf/pcpm_report/pcpm_report_&_recommendations_final_20180614.pdf
- CMS Value Based Care Presentation - https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/nursing/meetings/2018/nacnep-sept2018-CMS-Value-Based-Care.pdf
- HCP-LAN Alternative Payment Model Framework - https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf
- HCP-LAN Accelerating and Aligning Primary Care Payment Models - https://hcp-lan.org/workproducts/pcpm-whitepaper-final.pdf
- Center for Health Care Strategies *"Recognizing and Sustaining the Value of Community Health Workers and Promotores"* Issue Brief January 2020 - https://www.chcs.org/media/CHCS-CHCF-CHWP-Brief_010920_FINAL.pdf

Contact:

To learn more about general value-based care concepts, please reach out to Brent Miller, OHS Lead Planning Analyst, at Brent.Miller@ct.gov or Jamal Furqan, CedarBridge Group Consultant, at Jamal.Furqan@cedarbridgegroup.com to schedule an informational discussion.