WHICH CMS VALUE-BASED PROGRAM IS RIGHT FOR YOU?

The U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services (CMS) has certainly been in a major rush to implement changes in the way primary care is delivered. In fact, its "big, hairy goal" is to entirely transform primary care payment models to uncover ways to deliver better value for patients throughout the entire healthcare system.

In pursuit of this goal, CMS created alternative payment models, or APMs, which are still works in progress to some extent. Nonetheless, the writing is on the wall, so providers need to start implementing transformations within their office environment now to maximize future reimbursement potential. A previous Amazing Charts Knowledge Drop looked at the Primary Care First (PCF) initiative, which was scheduled to begin testing in January 2020. PCF is a streamlined, potentially higher-paying Alternative Payment Model, or APM, which builds and expands on the underlying principles of the Comprehensive Primary Care Plus (CPC+) model that was launched in 2017.

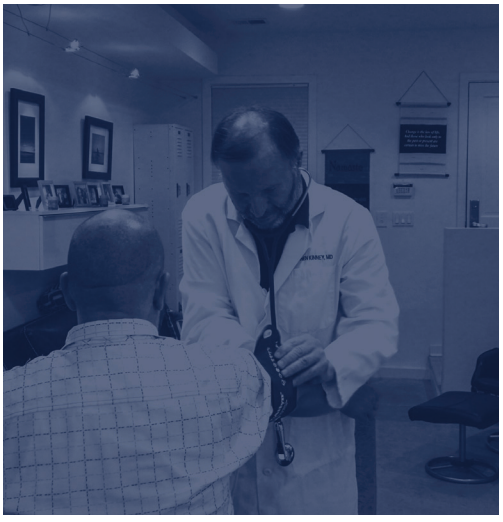
PCF will ultimately be offered in 26 states and metropolitan regions, with the promise of offering providers a "flat revenue stream" for each patient. When patients stay healthy and out of the hospital, practices receive a bonus, but if patients end up sicker than expected, practices will bear responsibility for the extra spending up to a certain share of revenue. PCF is geared toward smaller primary care practices that focus on comprehensive care coordination and management for Medicare beneficiaries as well as seriously ill patients.

In the new payment models, the focus is on delivering value-based care, with the dual goals of promoting enhanced population health while simultaneously reducing systemic healthcare delivery costs. The Value Based Program, or VBP, uses alternative payment models to create a combination of incentives and disincentives which are intended to encourage better health care decision making by tying compensation to performance measures.

Value based healthcare takes an enlightened approach to provider reimbursement by reducing the current reliance on payment for services rendered. It measures outcomes of specific patient services against the cost of providing those services, and concentrates solely on the quality of care provided, rather than the number of patients seen. Most value-based care initiatives focus on three objectives:

- Better care for individuals
- Better health for populations
- Lower costs for all

This Knowledge Drop provides an overview of several CMS value-based programs, and discusses the positive effects of transitioning to a value-based system of care. Medical practices which can successfully acclimate to these ch-ch-chchanges will find that they not only improve patient outcomes, but also increase practice profitability.



WHAT ARE THE VALUE-BASED PROGRAMS?

According to CMS, its value-based programs are designed to reward health care providers with higher incentive payments for improving the quality of care given to patients with Medicare. These programs are part of a larger quality strategy to reform how health care is delivered and reimbursed. CMS feels that its value-based programs are important because they will help the medical community move toward paying providers based on the quality, rather than the quantity, of care provided to all patients.

There are seven value-based programs, each with the goal of linking provider performance of quality measures to provider payment:

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
This first of its kind program for Medicare changes the way CMS pays for the treatment of ESRD patients. A portion of each facility's payment is directly linked to its performance on quality of care measures. After a performance period is completed, CMS will assess the facility's performance based on the designated comparison period and calculate a score for each measure. The individual scores are then combined to create a Total Performance Score, or TPS, for each facility. If a facility's TPS does not meet or exceed the performance standards that were established during the comparison period, it may incur payment reductions of up to two percent for the entire payment year.

Hospital Value-Based Purchasing Program (VBP)
The VBP Program rewards acute care hospitals with incentive payments for the quality of care they provide in the inpatient hospital setting. It is anticipated that the program will improve inpatient care by encouraging participating hospitals to improve the efficiency, patient experience and safety of care provided to Medicare beneficiaries. VBP withholds participating hospitals' Medicare payments by 2%, with the estimated total amount of those reductions being used to fund value-based incentive payments based on each hospital's performance in the program.

Hospital Readmission Reduction Program (HRRP)
HRRP is a Medicare value-based purchasing program that lowers payments to Inpatient Prospective Payment System hospitals which experience excessive readmissions. Such hospitals will have an added incentive to improve communication and care coordination, so caregivers and their patients become more actively involved in post-discharge planning.

Value Modifier Program (aka the Physician Value-Based Modifier or PVBM) (VM)
Value Modifier measures the cost and quality of care provided to Medicare patients under the Medicare Physician Fee Schedule (PFS). This program provides rewards for lower costs and quality performance.

Hospital Acquired Conditions Reduction Program (HAC)
The HAC Reduction Program encourages hospitals to increase patient safety and reduce the number of hospital-acquired conditions such as pressure sores, infections, and hip fractures after surgery.

Skilled Nursing Facility Value-Based Program (SNFVBP)
Similar to hospitals, this program rewards skilled nursing facilities (SNFs) with incentive payments based on the quality of care provided to Medicare beneficiaries. Under this value-based program, Skilled Nursing Facilities are evaluated on measured on their performance related to hospital readmissions, and scored on both improvement and achievement. They receive quarterly feedback reports containing information about their performance, and earn incentive payments based on that measured level of performance.

Home Health Value Based Program (HHVBP)
The HHVBP Model is designed so that Medicare-certified home health agencies (HHAs) can receive incentives to provide higher quality and more efficient care. HHA payments are adjusted based on quality of care provided in a given performance period, not just quantity of services.

PRIMARY CARE FIRST MODEL OPTIONS

Primary Care First Model Options is a set of voluntary five-year payment options that will reward value and quality with an innovative payment structure. PCF's goals are:

- Prioritizing the doctor-patient relationship.
- Enhancing care for patients with complex chronic needs and high need, seriously ill patients.
- Reducing administrative burdens.
- Focusing financial rewards on improved health outcomes.

The initiative includes five value-based payment models through two tracks: Primary Care First (PCF) and Direct Contracting. PCF is geared towards smaller primary care practices and includes two payment models that reward practices for delivering value through advanced primary care, while Direct Contracting contains higher levels of financial risk and is designed for larger organizations with value-based payment experience. The five models are:

- Primary Care First – General
- Primary Care First – High Need/Seriously Ill Populations (SIP)
- Direct Contracting – Global
- Direct Contracting – Professional
- Direct Contracting – Geographic

Applications are currently available for the PCF model, but not the direct contracting model. Primary Care First applicants may choose to participate only in the General component, only in the SIP component, or in both components. The option for High Need Populations encourages advanced primary care practices, including providers whose clinicians are enrolled in Medicare and typically provide hospice or palliative care services, to take responsibility for seriously ill, high need beneficiaries who currently lack a primary care practitioner and/or effective care coordination.

To participate in the SIP payment model option, practices must demonstrate relevant capabilities and care experience in their application. They will have the option to furnish services to SIP patients CMS identifies in their service area who express interest in the model, and will then be responsible for reaching out to these patients with a focus on ensuring that their care is coordinated and that these SIP patients are clinically stabilized. Practices will also be allowed, on a case-bycase basis, to accept certain SIP patients who are referred to the practice and deemed eligible by CMS.

The payment options are designed to test whether enhanced delivery of advanced primary care can reduce the overall costs of patient care while still improving patient outcomes.

WHAT CAN PRACTICES DO NOW TO PREPARE FOR VALUE-BASED PROGRAMS?

In order to prepare to participate in the move toward value-based programs, medical practices are advised to:

- Become more aware of, and responsive to, community and population need.
- Focus on various methods for improving overall patient satisfaction levels.
- Adapt to different practice organizational models and models of care.
- Be open to increased implementation of advanced health information technology, while encouraging its effective spread.
- Ensure compliance with Electronic Health Record, or EHR, requirements.
- Improve clinical workflow.
- Focus more on the potential tangible improvements in clinical outcomes than on the number of patients seen.
- Increase communication with patients through patient portals.
- Continue to reduce per capita costs of health care.
- Incorporate evidence-based performance measures.
- Participate in interoperability initiatives with other medical care providers.
- Rely on more accurate, transparent, scientifically valid, and timely data.
- Become aware of internal reliance on quantity-based initiatives, and promote education and awareness of value-based practice goals.
- Strive towards quality improvement and cost reductions throughout the medical practice.
- Become more accountable to patients, providers, payers and vendors.
- Involve all providers and team members in program design and implementation.

While there may be some glitches, or stops and starts, in the march toward value-based care, it is still apparent that there are indeed some changes on the horizon for health care providers. Those that will succeed and prosper will likely be the ones that take the time now to become informed and plan ahead to make the right choices for their patients, as well as their practice profitability.