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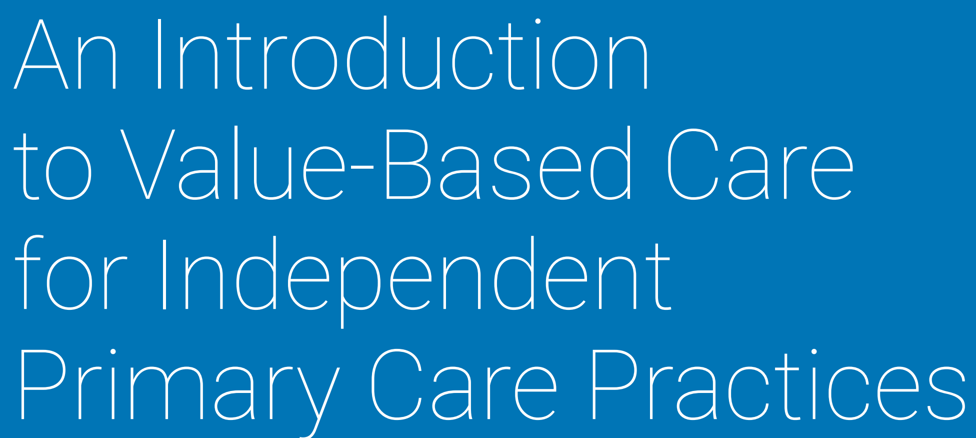
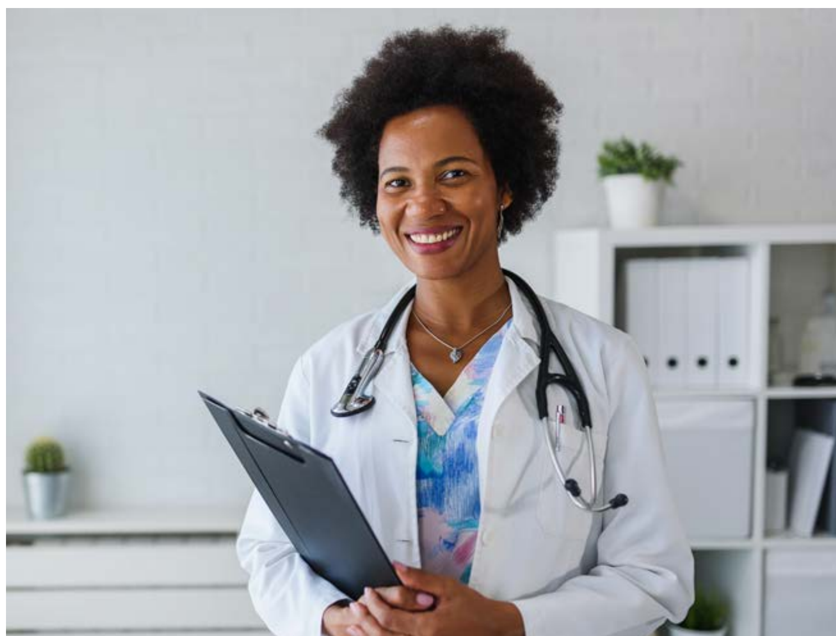


An Introduction to Value-Based Care for Independent Primary Care Practices

Introduction

Over the past decade, the health care industry has gone through significant change. From the implementation of the Affordable Care Act to the widespread adoption of electronic health records (EHRs), primary care clinicians like you have had to keep pace with a series of disruptions to the way they practice medicine.



These changes have proven especially challenging for your primary care colleagues working in independent practices and community health centers.

Initially, these new concepts, workflows, and requirements can be confusing and frustrating for physicians who are already stretched to their limit caring for patients, but the world of value-based care is also full of exciting opportunities to improve patient outcomes while thriving financially.

Value-based care, also known as accountable care, is designed to help practices achieve the "Quadruple Aim" of health care: producing better patient experiences, improving the clinical experience for providers, and fostering improved population health across communities while reducing the nation's high health care costs.

In this guide, we will explore the fundamental building blocks of value-based care and how your practice can incorporate these ideas to thrive in this promising environment.

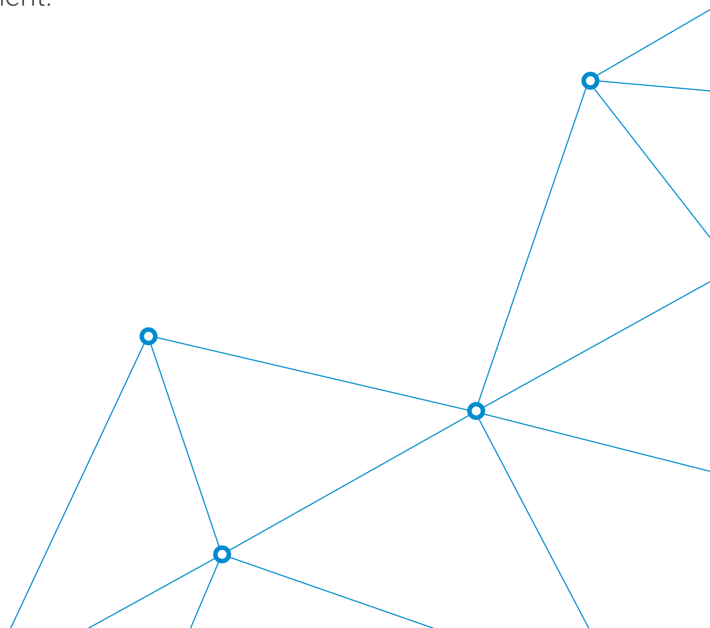
VALUE-BASED CARE

Produce better patient experiences

Improve the clinical experience for providers

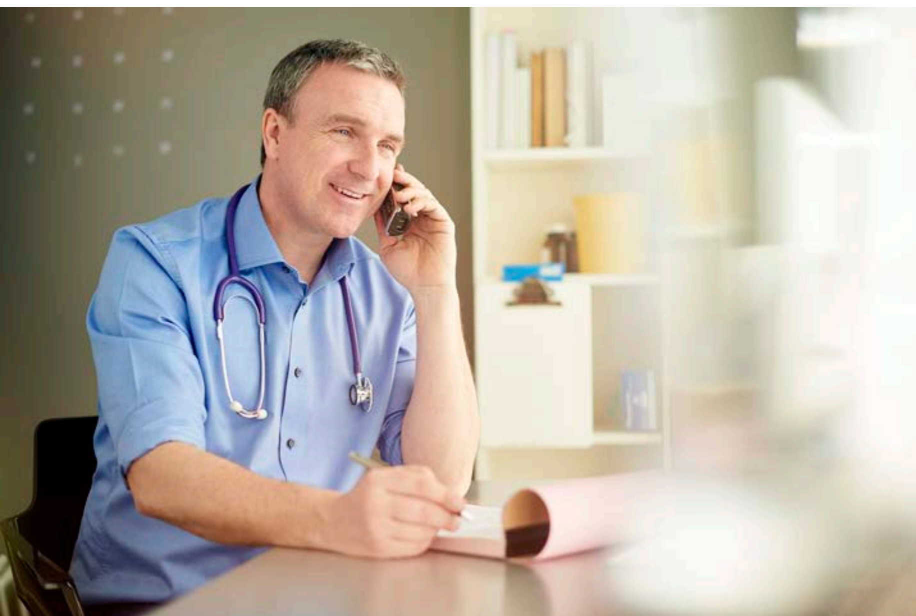
Foster improved population health across communities

Reduce the nation's high health care costs



Defining the basics of value-based care

Health care has always been full of acronyms, abbreviations, and complex terminology—and the world of value-based care is no different. While some of these terms may be familiar to you, others are unique to the accountable care ecosystem. Here are some of the most important definitions to know.



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Value-based care

Value-based care is the concept that health care professionals should be reimbursed based on the quality of care they provide instead of the volume of services. The goal is to support individuals at their highest possible level of wellness rather than wait to provide care until patients get sick, which is often more complex and expensive.

In value-based care arrangements, health care providers contract with payers, such as Medicare, Medicaid, and commercial insurance companies, to care for a defined set of patients, known as their "attributed patients."

Physicians can earn financial rewards or avoid negative payment adjustments by meeting specific performance and quality measures tied to better long-term outcomes for patients.

These measures may include the delivery of routine and preventive care services (such as delivering vaccines or conducting regular screenings for common cancers), and chronic disease management services (like effectively controlling a diabetic patient's blood sugar).

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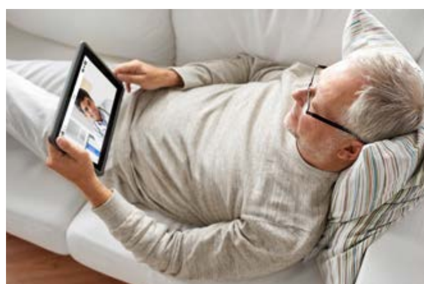

Population health management

Value-based care requires providers to employ population health management strategies.

You may have heard population health defined as, “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.”

In practice, population health management is the idea that health care providers can optimize outcomes for an entire group of people by delivering standardized, holistic services for every individual patient.

To succeed in population health management, you first need to be able to categorize patients by their health risks and unmet needs. Health IT tools and data analytics are critical for providing this visibility. With the right digital tools, primary care practices will be able to stratify patients by risk, close gaps in care, and identify areas for performance improvement.

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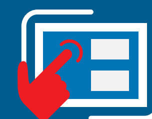
Evidence-based preventive care, such as cancer screenings, chronic disease management programs, transitional care management (TCM), and regular wellness assessments, have been proven to catch rising risks early enough to avoid hospitalizations, ED visits, and other high-cost interventions.



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The performance and quality metrics in value-based care arrangements are designed to ensure that a practice is providing these services to the entire group of attributed beneficiaries. Quality and performance measures may also gauge how well these activities prevent negative outcomes and control spending.

Accountable care organizations (ACOs)

Accountable care organizations are at the heart of the movement toward value-based health care.

An ACO helps physicians formalize their approach to value-based care and population health management. ACOs are groups of practices that contract with a payer to achieve the shared goals of improving outcomes and reducing unnecessary spending.

ACOs can contract with many different types of payers, including Medicare, Medicare Advantage, Medicaid, and commercial insurance entities. An ACO may be composed of different types of providers (e.g., a hospital, specialists, and primary care practices) or a single type of provider (e.g., just primary care providers).

Financial risk and the opportunity to earn incentives for positive results are what makes these arrangements so innovative.

If an ACO successfully meets its quality and spending targets, the practices in that ACO could receive a portion of the resulting shared savings, or the difference between what the payer expects to spend and what the payer actually spends on care for those attributed patients.

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Many ACOs choose to start cautiously, with upside only risk models, meaning they receive a check for shared savings if they succeed, but are not required to return any money to the payer if they spend more on care delivery than expected.

But accountable care organizations have other options as well. If an ACO is interested in potentially earning a larger proportion of any shared savings, it can accept downside risk, also known as two-sided risk.

In a downside risk model, an ACO that meets its quality and spending benchmarks gets a higher percentage of the shared savings than it would in an upside only model. However, if the ACO spends more than the payer expects, the ACO is required to pay a percentage of those losses back to the payer. More risk, but more reward.

Medicare Shared Savings Program (also known as Pathways to Success)

The Medicare Shared Savings Program (MSSP) is the largest single value-based care initiative in the United States. Launched in 2013, the MSSP now includes more than 500 ACOs that care for more than 11 million Medicare beneficiaries.

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The MSSP requires ACOs to meet a number of quality and performance benchmarks, and then offers shared savings when they achieve their goals.

In 2018, the Centers for Medicare and Medicaid Services (CMS) redesigned the program and gave it a new name: Pathways to Success. The fresh moniker was intended to reflect some major changes to the way ACOs moved through the various tracks and options in the program.

One of the biggest changes in Pathways to Success is the requirement that ACOs should shoulder increasing levels of financial risk over time. ACOs can begin their journey in one of several upside-only risk categories. But as they mature, they have to embrace downside risk.

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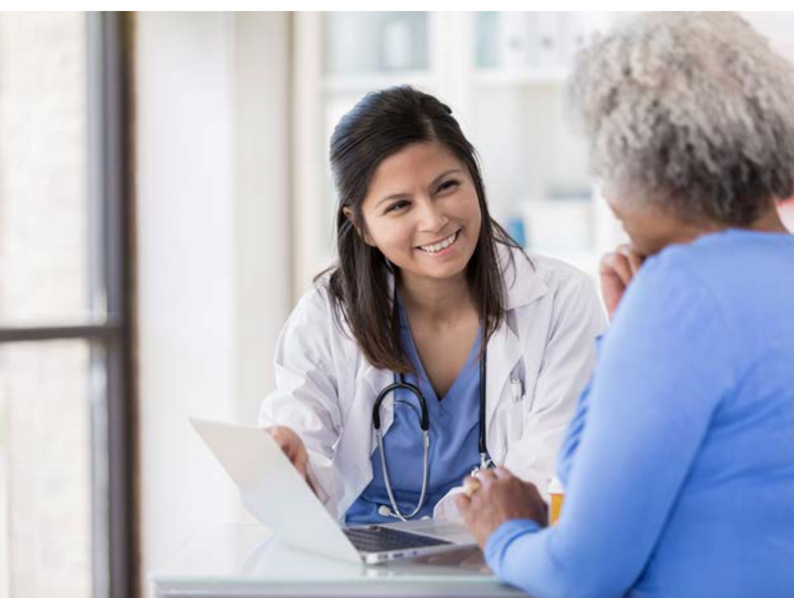
But the move to more risk is clear. CMS has been very upfront about its intentions to rely much more on risk-based models to create value for patients and taxpayers. The nation's largest payer is committed to using its industry clout to shepherd practices toward value-based reimbursements at a steady rate.

Merit-Based Incentive Payment Program and Alternative Payment Models

2015 was a pivotal year for Medicare as Congress and CMS introduced the Quality Payment Program (QPP), a unified replacement for health care's three major quality reporting programs.

The QPP is divided into two major tracks: the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (AAPM) option.



MIPS combines the EHR Incentive Programs (Meaningful Use), the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VBPM) into a single structure. This single program measures the quality of care, the costs of care, health IT interoperability, and practice improvement all in one.

Much like other accountable care initiatives, MIPS includes incentives to achieve high scores and excel at value-based activities.

For example, primary care practices participating in certain approved alternative payment models (APMs), including all tracks and levels within Pathways to Success, have the opportunity to take advantage of a special scoring system, one that is designed to let participants focus on quality care delivery.

Some types of ACOs also qualify for the AAPM track. These programs require participants to use CEHRT, meet participation thresholds, and bear more than a minimal degree of downside financial risk. In exchange, qualifying providers are eligible for a five percent incentive, certain APM-specific rewards, and exemption from the MIPS program.

The connections between MIPS and Pathways to Success are important for motivating providers to participate in high-level accountable care arrangements. Providers who succeed can maximize their incentives while minimizing administrative burdens.

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Putting value-based care into action

You may be wondering how you can take all of these ideas and translate them into better care and increased revenue for your primary care practice.

While there are many different value-based care strategies, all successful providers agree that proactive, preventive, comprehensive care is essential for improving outcomes and lowering costs across entire communities.

Technology also plays an important role in coordinating care, closing gaps in quality, and supporting patients in their journey to better health. Health IT tools equip providers with the insights they need to make informed decisions alongside their patients.

Aledade has found that combining innovative workflows with intuitive technologies, focused on four core activities, can significantly impact patient health and help practices achieve their value-based care goals.

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An AWV is a once-a-year visit between a patient and a primary care physician. These visits allow physicians and patients to update information about a patient's health status, set shared goals for the year ahead, and close any gaps in care.

1. Access and prevention

Better access to preventive care can have a dramatic effect on patient wellness.

For example, the Medicare Annual Wellness Visit (AWV) plays a critical role in keeping patients connected to the care they need.

An AWV is a once-a-year visit between a patient and a primary care physician. These visits allow physicians and patients to update information about a patient's health status, set shared goals for the year ahead, and close any gaps in care. AWVs offer a dedicated time and place to focus on preventive care, long-term needs, and topics that might not be covered in other visits.

Physicians and patients can also use the AWV to discuss emotional and mental health, daily functioning, and any social determinants of health (SDOH) challenges that may have an impact on their self-care and wellbeing.

Medicare allows your practice to bill for these visits using three distinct HCPCS codes, depending on details of the visit. These codes typically offer enhanced reimbursement compared to a similar E/M visit.

Since many practices already conduct very similar annual check-ins, you can easily enhance revenue and deliver even better care by taking advantage of this Medicare feature.

2. Emergency department (ED) follow-up

ED care is among the most expensive, creating a strong incentive for ACOs to reduce the number of avoidable or unnecessary visits. Population health management strategies (such as monitoring rising risks and making it easier to access low-cost, high-quality primary care) can aid in this effort.

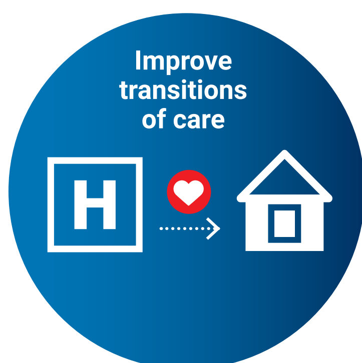
For patients who do need to utilize the ED, a speedy follow-up with primary care is critical. Primary care practices should ensure patients have access to their medications, understand any changes to their self-care routines, and can remain safe and well at home. Practices should also schedule a follow-up appointment to make sure patients can get back on track with their health.

Follow-up after an ED visit can be difficult for primary care practices that often struggle to get information about recent ED activity from their local hospitals or emergency clinics. That is why ACO initiatives typically encourage practices to leverage health IT tools that include admission, discharge, and transfer (ADT) alerts and other notifications of patient activities outside of the primary care environment.

For patients who do need to utilize the ED, a speedy follow-up with primary care is critical.

Practices that adopt robust, interoperable, and workflow-friendly applications geared toward the needs of primary care have a better chance of getting ahead and staying ahead of disruptive and expensive patient events.

3. Post-hospital care



Follow-up after an inpatient admission is equally important. Primary care practices should use transitional care management (TCM) strategies to maintain continuity of care during the post-discharge period and manage any issues that could lead to avoidable readmissions.

Just like with AWVs, Medicare provides specific enhanced reimbursement codes for qualifying TCM activities. The requirements of the TCM codes are highly structured and include interactive contact, a face-to-face visit, certain non-face-to-face services, and medication reconciliation activities.

Different types of providers in a practice's care team can work together on these tasks to contact the patient in the appropriate manner within the prescribed time frames. This multidisciplinary, collaborative approach to patient management is a hallmark of accountable care and population health management.

In order to succeed with TCM, practices need complete visibility into the activities of their attributed beneficiaries. Once again, the right technologies and associated workflows will have a major impact on a practice's ability to connect with the most patients in a timely, effective manner.

4. Closing quality and risk gaps

ACOs are built around quality and performance measures. Practices are responsible for documenting their activities in detail so they can report on their progress to their contracted payers. If a practice does not document all aspects of patient care appropriately, they may leave gaps in quality care or miss out on credit, like quality-based incentives, for their work.

Claiming appropriate credit begins by understanding the attributed population's underlying clinical burdens. Accurate risk coding is key for explaining why a practice is delivering certain services to each patient and measuring how much progress those patients are making.

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Busy practices that have access to technology tools to provide risk coding suggestions may have an easier time capturing risk adjustment opportunities during a patient's office visit. This may lead to better care for those patients, and more revenue for the practice.

In conclusion

Value-based care is growing rapidly in popularity as providers, payers, patients, and regulators search for ways to improve the health system. By shifting away from traditional fee-for-service reimbursement and prioritizing quality-driven accountable care, participating practices are making health care better for patients in need.

For independent primary care providers, value-based care can bring even more benefits. The potential to earn shared savings and other revenue enhancements can provide financial relief while allowing clinicians to strengthen the rewarding patient relationships that are the backbone of primary care.

The movement toward value will only accelerate as more practices and payers align around the shared goals of the Triple Aim. Preparing your primary care practice for the new opportunities of value-based care can help you continue to provide exceptional care to the people in your community.

To learn more about value-based care and how it can work in your practice, please email outreach@aledade.com.