

Ohio Joint Medicaid Operating Committee – Value Based Purchasing

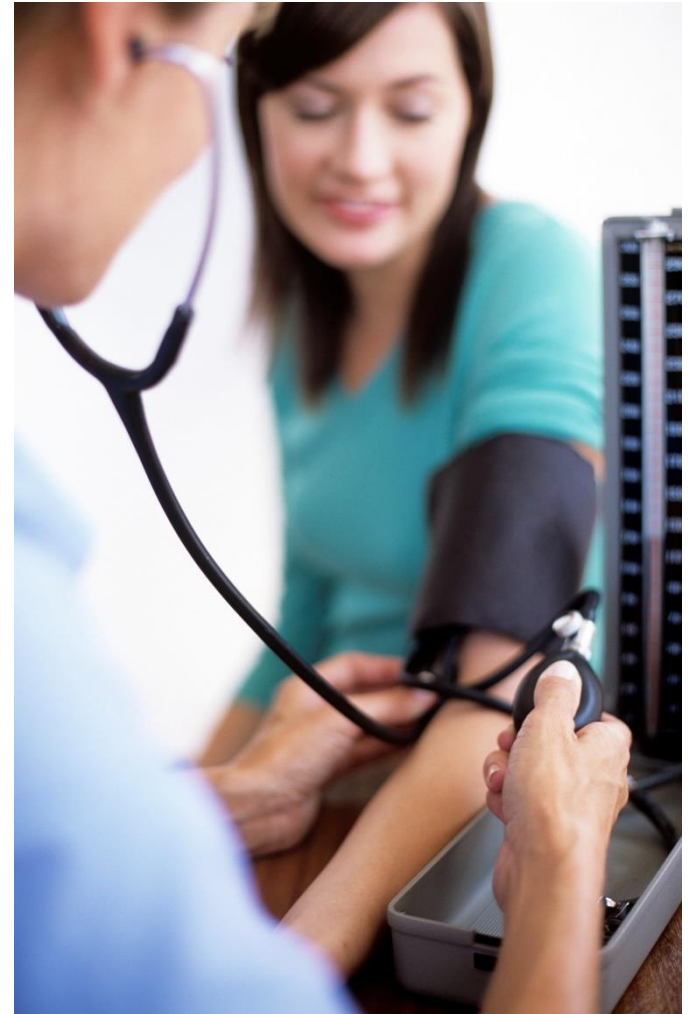
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- What is value-based care and why does it matter?
- Health Care Payment Learning Action Network – APM Model Framework
- Examples of Anthem value-based programs



What is value-based purchasing and why does it matter?



The standard approach to contracting and reimbursement based on paying fee-for-service has created notable gaps in the quality of care received and ballooning healthcare costs.

- Fee-for-service mechanism of paying physicians is a contributing driver to higher health care costs in the United States
- 86¢ of every health care dollar spent goes toward people with chronic and mental health conditions
- Insufficient care coordination results in lower quality and increased cost, especially for persons with chronic conditions



Primary Care

- ~5-10% of spend
- Whole-person care
- Lowest RVUs



Specialty Care

- ~35% of spend
- More focused expertise
- Highest RVUs



ER, Inpatient, Surgery

- ~50+% of spend
- Emergency
- Care of last resort

Value-based reimbursement is emerging as an alternative to standard, fee-for-service contracting / reimbursement. **Value-based care intertwines two core concepts – payment innovation and care transformation – and aligns rewards for providers for both efficiency and effectiveness for the quality of care provided**, transforming the delivery paradigm.

- Payment innovation holds providers accountable for cost and quality outcomes through value-based incentives
- Care transformation is providing specialized support, data, and tools to help providers succeed and members thrive

And without a major transformation, the cost of care will continue to escalate for lower quality, uncoordinated care

Health Care Payment Learning & Action Network



HCP LAN Revised APM Goals

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models (Categories 3B and 4 of the LAN APM Framework).

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

Increasing Provider Accountability

 CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	 CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE	 CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	 CATEGORY 4 POPULATION – BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		C Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

ODM Revised APM Goals

	Small Providers 6-499 members across all MCOs		Large Providers 500+ members across all MCOs	
	APM LAN Categories 3A/3B/4A/4B/4C	APM LAN Categories 3B/4A/4B/4C	APM LAN Categories 3A/3B/4A/4B/4C	APM LAN Categories 3B/4A/4B/4C
CY 2023	Reporting Only	Reporting Only	Reporting Only	Reporting Only
CY 2024	Reporting Only	Reporting Only	Reporting Only	Reporting Only
CY 2025	30%	0%	75%	10%
CY 2026	40%	0%	80%	15%
CY 2027	50%	0%	90%	20%
CY 2028	60%	0%	100%	30%
CY 2029	75%	0%	100%	40%
CY 2030	90%	0%	100%	50%

Anthem Medicaid Value Based Payment Initiatives Overview



FFS Network



**Category 1
Fee for Service –
No Link to Quality & Value**



Payments are based on volume of services and not linked to quality or efficiency.

Social Determinants of Health Provider Incentive Program (SDOH PIP)
Pay for Quality (P4Q)



**Category 2
Fee for Service –
Link to Quality & Value**



At least a portion of payments vary based on the quality or efficiency of health care delivery.

Provider Quality Incentive Program (PQIP)



**Category 3
APMs Built on
Fee-for-Service Architecture**



Some payment is linked to the effective management of a segment of the population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.

Delegated Risk Capitation



**Category 4
Population-Based
Payment**



Payment is not directly triggered by service delivery so payment is not linked to volume. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 year).



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