Value-Based Care Prioritizes the Health of People First while Improving Health Outcomes

Value-based care aims to improve quality, outcomes and population health—while lowering costs—and can be a central driver in the delivery of people-centered care. Value-based care models engage providers to consider the whole person—including clinical needs and social supports—by linking payment to the quality and outcomes of services delivered. In addition, value-based care can reduce administrative waste by putting the decision-making into the hands of providers. Trinity Health is committed to care delivery that holds providers accountable for the health of the people and communities we serve, and advances health equity across populations.

Trinity Health’s Commitment to Value-Based Care

- Taking total accountability for clinical and cost outcomes for more than 1.5 million Trinity Health patients in alternative payment models (APMs) that give providers accountability for quality and cost of care, including approximately:
  - 275,000 lives in Medicare accountable care organizations (ACOs).
  - 165,000 lives in Medicare Advantage models.
  - 1 million lives in commercial and Medicaid alternative payment models (APMs).
- Committing more than 26,000 physicians and advance practice professionals to 17 clinically integrated networks (CINs).
- Maintaining consistent success. Since 2016, Trinity Health’s national ACOs and its bundled payment programs have saved the federal government $216 million, returning $135 million of that savings to Trinity Health.
- Achieving year-over-year quality improvements in our CINs, with our ACOs recently recognized with a high score of 97.4% for quality and clinical outcomes.
- Investing in $10 million per year in community infrastructure such as housing, economic revitalization and access to healthy food.
- Assuming total cost of care accountability to improve outcomes and dramatically reduce costs by delivering the right care, in the right setting, at the right time.

What Can Policymakers Do?

Promote Provider Participation and Accountability for Better Health Outcomes

Recommendations:

- Design population-based payment models that support care coordination and hold providers accountable for total cost of care and outcomes.
- Design models with different levels of accountability or risk to allow providers with varying experience with value-based care arrangements – small, rural, and safety net providers, including critical access hospitals – to participate.
- Advance models that hold providers accountable for outcomes with meaningful, uniform quality and performance measures.
- Ensure models targeting rural providers account for challenges unique to rural settings.
- Risk adjust payment arrangements to account for not only patients’ health but also social and economic needs (e.g. social influencers of health (SIOH) to help address health equity)).
Value-Based Care

Support Population Health

**Recommendations:**
- Develop population-based payment models that integrate providers across the care continuum and incorporate successful innovations from models such as the Next Generation ACO into Medicare Shared Savings Program.
- Design models that enable providers to identify and address SIOH (e.g. through screening tools or social service eligibility data).
- Ensure access to real-time claims and other data – alerts related to admissions, discharges, transfers, insurance coverage eligibility, provider consultations – to support interventions at the point of care and streamline/standardize data formats across models.
- Eliminate barriers to care integration, including alignment with 42 CFR Part 2 privacy requirements relating to the use of substance use disorder treatment records with the Health Insurance Portability and Accountability Act.
- Design models that allow members of the care team to practice at the top of their license to increase access to care.

Increase Flexibility to Drive Desired Cost and Quality Outcomes

**Recommendations:**
- Structure payments to support comprehensive delivery of sustainable, effective, high-quality services across the care continuum and move away from fee-for-service based models.
- Include incentive or prospective payments to support innovative partnerships and coordination between health care providers and other service providers that increase access to care (e.g. ride share, community health workers).
- Structure payments to support investments in infrastructure necessary for long-term health care transformation (e.g. workforce, health information technology).
- Ensure models last a minimum of five years to allow sufficient time for transformation and assessment.
- Grant or maintain benefit and payment waivers (e.g. telehealth, alternatives sites of care, home visit) to support flexibility to deliver the right care at the right time.
- Reduce and streamline administrative billing, reporting and documentation requirements across insurers and programs to decrease burden.

Expand Participation in Value-Based Care Models

**Recommendations:**
- Encourage commercial insurer participation in value-based care models through payment arrangements that create shared savings.
- Level the playing field between ACOs and Medicare Advantage by aligning program requirements/flexibilities including benchmarks, risk adjustment, and the ability to offer supplemental benefits.
- Adopt a common attribution methodology across models.
- Require health insurers to participate in total cost of care accountability models with providers.
- Enroll beneficiaries who are dually enrolled in Medicare and Medicaid into financially integrated care models and promote policies that support and expand the Program of All-Inclusive Care for the Elderly (PACE).
- Support states developing provider-based APMs in Medicaid through 1115 waivers and state directed payments.
- Align quality measures, reporting and risk score methodology across insurers and programs.
- Incentivize beneficiary alignment to providers participating in value-based arrangements to support greater movement of beneficiaries into these models and allow beneficiaries to participate in ACOs at any time through voluntary alignment.
- Reduce regulatory barriers to participation in value-based care arrangements (e.g. Anti-Kickback Statute and Physician Self-Referral Law).
- Include mechanisms to protect against unpredictable loses—such as stop-loss or risk corridors—to support movement of more providers into population-based payment models.
- Address administrative waste in our nation’s health system (e.g. arbitrary payment denials) which increase costs and reduce funding for improving health outcomes, including value-based payment arrangements.
- Extend the Advanced Alternative Payment Model Incentive Payment authorized by the Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act.

**Mission**

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

**Core Values**

Reverence • Commitment to Those Who Are Poor • Safety • Justice • Stewardship • Integrity

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