

Care for the Common Good

Provider-Driven Value-Based Care

Improving Health Outcomes for Patients



Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation, serving diverse communities across 25 states. We advocate for public policies that promote the common good including sustaining our faith-based mission, improving community health, and growing our workforce while addressing the continuously shifting national health care system landscape.

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

Value-based payment reforms the traditional system by shifting payment away from rewarding volume (fee-for-service) to rewarding providers for keeping patients healthy, managing chronic conditions, and reducing costs.

Trinity Health believes the most impactful value-based payment models are provider driven and incentivize providers to address clinical and social needs. By linking payment to the quality and outcomes of services delivered, these models ultimately make care more accessible and affordable.

If designed correctly, value-based payment can reduce costs for patients. This happens when:

- Decision making is in the hands of providers not insurers, thereby reducing administrative costs.
- Care increasingly gets less emergency based and more preventative based, reducing the use of more costly care settings like inpatient beds or emergency rooms.
- Dollars can be invested in additional patient and provider supports.

Value-Based Payment Models – Increasing Flexibility and Accountability to Support Person-Centered Care

Fee for Service + Payment Tied to Quality

- Care management fees
- Pay for reporting
- Pay for performance

Fee for Service + Risk for Quality & Cost

- Shared savings with downside risk
- Episode-based payment

Total Cost of Care

- Global budget
- Capitated payments

Provider Accountability for Quality, Patient Outcomes, Costs

Trinity Health's Commitment to Value-Based Care

Trinity Health is leading innovative efforts to deliver high-value, whole-person care by:

- Taking financial accountability and risk for clinical and cost outcomes of more than 1.4 million Trinity Health patients in alternative payment models (APMs) including approximately:
 - 200,000 lives in Medicare accountable care organizations (ACOs).
 - 200,000 lives in Medicare Advantage models.
 - 705,000 lives in commercial and Medicaid APMs.
- Committing more than 26,000 physicians and advance practice professionals to 12 clinically integrated networks (CINs).
- Maintaining consistent success. Since 2016, Trinity Health's national ACOs and its bundled payment programs have saved the federal government \$355.8 million, returning \$261.6 million of that savings to Trinity Health.
- Achieving year-over-year quality improvements and clinical outcomes with our national ACO earning an average quality score of more than 90% over the past 8 years.
- Investments of \$75 million in community infrastructure loans such as housing, economic revitalization, and access to healthy food.

What Can Policymakers Do?

Promote Provider Participation and Accountability for Better Health Outcomes

- Create meaningful incentives that increasingly reward providers for taking accountability for the total cost of care and improving financial performance for the Medicare Trust Fund.
- Advance models that hold providers accountable for outcomes with meaningful, uniform and reportable quality and performance measures.

Value-Based Care

- Update benchmarking methodologies to reward providers who reduce total cost of care rather than penalizing them for inaccurate trend projections. Remove the Accountable Care Prospective Trend (ACPT) in Medicare Shared Savings Program (MSSP) until Medicare develops an accurate administrative benchmark approach.
- Adjust payment methodologies to account for patients' clinical, social and economic needs.

Support Population Health

- Develop population-based payment models that promote care integration and proven innovations into the MSSP.
- Ensure providers have access to real-time claims and other actionable data, such as admissions, discharge and transfer alerts, to support timely interventions at the point of care and enable standardized data exchange across models.
- Allow beneficiaries to "sign-up" or voluntarily align to ACOs similar to Medicare Advantage and the Program of All-Inclusive Care for the Elderly (PACE), and provide identification materials that strengthen the beneficiary-provider relationship.
- Review policies, around timeliness of approvals from payers, to determine impact of prior authorization delays and associated care costs ensuring providers in these models are not held responsible for payer profit-driven behaviors.
- Incentivize the adoption of Fast Healthcare Interoperability Resources (FHIR), national interoperability requirements.
- Require Certified Electronic Health Record vendors to comply with all Medicare regulations regarding electronic quality reporting (eCQM), promoting interoperability and data connectivity.

Increase Flexibility to Drive Desired Cost and Quality Outcomes

- Require Medicare Advantage plans to contract directly with providers in value-based payment arrangements, ensuring provider accountability for total cost of care and outcomes within their scope of influence.
- Encourage employers and states to contract directly with providers who take accountability for total cost of care and clinical outcomes.
- Offer incentive or prospective payments to support partnerships between health care providers and other service providers that improve access to care (e.g., transportation, housing and food security).
- Structure payments to fund infrastructure essential for long-term health care transformation, including data aggregation and analytics, workforce development and health information technology.
- Maintain and expand benefit and payment waivers (e.g., telehealth, alternatives sites of care, home visit) to support flexible delivery of appropriate care.
- Streamline administrative billing, reporting and documentation requirements across insurers and programs to reduce burden, especially related to Merit-Based Incentive Payment System (MIPS) activities such as promoting interoperability for ACOs.

Expand Participation in Value-Based Payment Models

- Require health insurers participate in value-based payment models that reward provider accountability for total cost of care and outcomes.
- Extend the Advanced Alternative Payment Model Incentive Payment and hold steady qualifying thresholds.
- Create a sustainable pathway for meaningful health system participation in total cost of care models by rewarding reductions in avoidable emergency department visits, admissions, and complications.
- Level the playing field between Medicare ACOs and Medicare Advantage by aligning program requirements/flexibilities including member outreach, benchmarks, risk adjustment, and the ability to offer supplemental benefits.
- Offer and expand fully-financially integrated plans to dually enrolled beneficiaries in Medicare and Medicaid including ACO participation and broader support for PACE.
- Align quality measures across programs with the Centers for Medicare and Medicaid Services universal measure set and require adoption by Medicare Advantage plans.
- Incentivize beneficiary alignment to support greater movement into value-based models and allow recipients to participate in ACOs at any time through voluntary alignment and benefit design.

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 Experiencing Poverty • Safety • Justice • Stewardship • Integrity