Understanding VBP

VBP stands for Value-Based Payment

- A new concept: a set of contracting terms which move away from typical fee-for-service claims payments
- Usually includes 3 key features:
  - Better coordination of care
  - Quality metrics to measure quality, and where quality scores affect payment levels
  - Fundamentally changed financial incentives, such as shared savings, shared losses, or eventually capitation/population-based payments, etc.
- NYSDOH calls it "paying for value instead of paying for volume"
- Under DSRIP, CMS is paying NYSDOH $8 billion over 5 years to fund this transition
- DOH has produced a guidance document called "the Roadmap" which highlights key steps in this fundamental transition

VBP Example

- A group of providers commits in a contract to undertake improved coordination of care for a defined set of patients, including smoother hand-offs between providers and/or elimination of provider silos
- Quality of care data will be collected. Target quality scores will be established.
- Spending targets will be set, such as $100 per member per year.
  - Claims will continue to be paid on a fee for service basis at the standard fee schedule.
  - At year end a tabulation occurs.
  - If actual aggregate claims costs are (for example) $96 pmpy, there is a savings of $4 pmpy.
  - Under a 50/50 split, the health plan pays a lump sum of $2 pmpy to the providers at year end. Under shared losses, aggregate costs of $104 pmpy would require the providers to pay $2 pmpm to the health plan at year end.
  - High quality scores might increase that year-end shared savings payment to $3 pmpm.
  - Low quality scores might decrease that year end shared savings payment to $1 pmpm.
- One purpose of VBP is to blunt financial incentives thought to encourage providers to simply bill more claim forms for more visits