What is Value Based Payment?

Value Based Payment (VBP) is an initiative to move from the traditional method of paying for health care services based on volume (fee-for-service) to paying for value.

- Value is often defined as paying for high quality at a reasonable cost
- VBP payment models have evolved to include a hybrid of several different payment models to incentivize and tie together desired behaviors (improved health outcomes at a reduced, reasonable total healthcare spend)

Traditional forms of payment from third party payors:

- Fee-For-Service – a payment model in which services are unbundled and paid separately based on the number of units provided (e.g. per procedure, per visit)
- Quality Incentive (Bonus) Payments - payments made to providers for attaining certain, payor-specific metrics/measures (e.g. process, quality, patient satisfaction)
    - Capitation – a payment arrangement in which a provider is paid a set amount for each enrolled person assigned to them, per period of time (e.g. per member per month, or PMPM), whether or not that person seeks care
      Sub-Capitation (partial-risk)– the provider is responsible for a subset of covered services available to the enrollee/member
    - Global Capitation (full-risk) – the provider is responsible for the full scope of covered services available to the enrollee/member (responsible for paying claims to network providers who provide services to the provider's attributed patients)
- Risk-Sharing - payment arrangements in which the provider can share with the payer in the losses and surpluses (shortfalls and savings) of overall healthcare expenditures for enrollees/members assigned to the provider
- Surplus-Sharing - a risk-sharing arrangement in which the provider shares in only the surpluses (savings) in overall healthcare spending for enrollees/members assigned to the provider (no downside risk)

New York's VBP Roadmap:

- By the end of the DSRIP project period (March 31, 2020), DOH expects MCO payments to providers to be value-based as follows:
    - 80-90% in VBP Levels 1, 2 and 3
    - 50-70% in VBP Levels 2 and 3

VBP Risk Level	Description
0	**Enhanced FFS.** Providers may receive a quality bonus, be subject to a quality withhold, or receive a payment for enhanced care coordination. There is no provider risk.
1	**Upside only shared savings without provider risk.** Providers still receive FFS payments, but have incentive to reduce costs and improve quality through a shared savings arrangement tied to cost benchmarks and quality metrics. There is no "downside" risk, so providers do not have to pay money to MCOs if they exceed cost benchmarks.
2	**Upside and downside risk-sharing arrangements.** As in Level 1, providers have a shared savings incentive, but are also accountable if costs exceed benchmarks and must reimburse MCOs a percentage of the excess amount if this is the case.
3	**Prospective payments that largely replace FFS.** MCOs pay providers on a per-member, per-month (PMPM) basis for a patient's TCOC. Providers may also be paid on a prospective basis for a bundled payment for a specific episode of care or for managing a specific chronic condition.