Care for the **Common Good**

Provider-Driven Value-Based Care

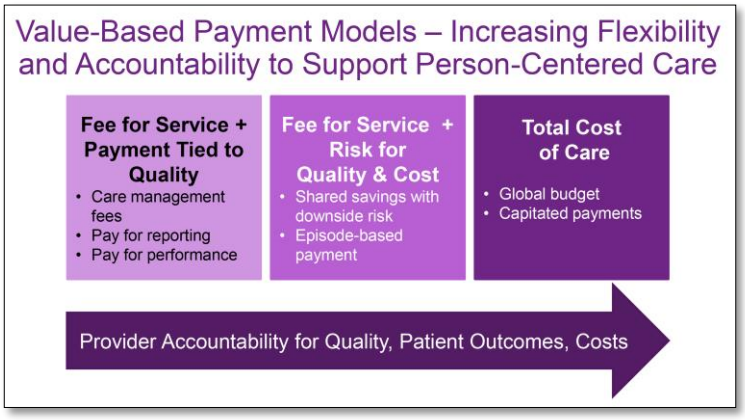
Improving Health Outcomes for Patients

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation, serving diverse communities across 27 states. We advocate for public policies that promote care for the common good and advance our mission, including fair payment, a strong workforce, coverage for all that bridges social care, and total cost of care payment models.

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

A value-based care payment model paired with a whole-person care approach has the potential to transform community and population health by holding providers accountable for improving the health outcomes of patients.

Trinity Health believes the most impactful value-based payment models are provider driven and incentivize providers to not only address clinical needs but also 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 the administrative costs that are added to the system by payers by putting the decision making into the hands of providers, allowing for investment into new care models for high-risk populations and the delivery of the right care, in the right setting, at the right time. Trinity Health is committed to this mode of care delivery, holding providers accountable for the health of the people and communities we serve while advancing health equity across populations.

Trinity Health's Commitment to Value-Based Care

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

- 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:
  - 220,000 lives in Medicare accountable care organizations (ACOs).
  - 250,000 lives in Medicare Advantage models.
  - 990,000 lives in commercial and Medicaid 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 $309.5 million, returning $227.6 million of that savings to Trinity Health.
- Achieving year-over-year quality improvements in our CINs, with our ACOs all surpassing scores of 80% for quality and clinical outcomes.
- Investments of nearly $70 million in community infrastructure such as housing, economic revitalization and access to healthy food.

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.
- Advance models that hold providers accountable for outcomes with meaningful, uniform quality and performance measures.
- Adjust payment arrangements to account for not only patients' health but also social and economic needs.

Value-Based Care

Support Population Health

Recommendations:

- Develop population-based payment models that reward integration of care across the care continuum and incorporate successful innovations into the Medicare Shared Savings Program.
- Design models that enable and incentivize providers to identify and address health-related social needs.
- 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.

Increase Flexibility to Drive Desired Cost and Quality Outcomes

Recommendations:

- Require Medicare Advantage plans to enter into contracts for value-based payment arrangements directly with providers and give providers accountability for total cost of care and outcomes.
- Encourage employers and states to contract directly with providers who take accountability for total cost of care and clinical outcomes.
- 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., transportation, housing and food security).
- Structure payments to support investments in infrastructure necessary for long-term health care transformation (e.g., data aggregation and analytics, 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 and eliminate increased administrative and reporting requirements related to Merit-Based Incentive Payment System (MIPS) activities such as promoting interoperability.

Expand Participation in Value-Based Payment Models

Recommendations:

- Require commercial insurer participation in value-based payment models to appropriately reward providers for taking accountability for total cost of care and outcomes.
- Require health insurers to participate in total cost of care accountability models with providers.
- Level the playing field between Medicare ACOs and Medicare Advantage by aligning program requirements/flexibilities including benchmarks, risk adjustment, and the ability to offer supplemental benefits.
- Offer fully-financially integrated plans to dually enrolled beneficiaries in Medicare and Medicaid including options for ACOs to participate in such plans, and promote policies that 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 across programs with the Centers for Medicare and Medicaid Services universal measure set.
- Incentivize beneficiary alignment to support greater movement into value-based models and allow recipients 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 losses—such as stop-loss or risk corridors—to support movement of more providers into population-based payment models.
- Extend the 5% Advanced Alternative Payment Model Incentive Payment bonus for clinicians participating in advanced alternative payment models and eliminate qualifying thresholds.