ALLIANCE FOR VALUE-BASED+ PATIENT CARE

Value-Based Care: Fact vs. Fiction

Value-based care means physicians and other types of clinicians and healthcare organizations provide the right care, at the right time, and in the right setting.

Value-based care takes many forms, including Advanced Alternative Payment Models (AAPMs) that provide payments from the Medicare program to support the delivery of high-quality patient-centered care while lowering costs. Eligibility to earn these payments is set to expire at the end of 2022, which could result in tens of thousands of clinicians no longer practicing value-based care. It would be a big step backwards for patients, Medicare, and U.S. healthcare.

Congress must extend financial incentives that support value-based care models—which are proven to improve patient outcomes and save Medicare money.

The facts about value-based care for Medicare beneficiaries

Fact:

Patients will not have the same access to high-quality, value-based care if the Medicare incentives to clinicians go away. The Centers for Medicare & Medicaid Services estimates that as many as 100,000 clinicians currently participating in value-based care models may stop doing so if Congress does not extend the Medicare incentives, meaning care coordination and services meant to address patients' social needs could go away.

Fact:

Value-based care is not a form of Medicare "privatization." Patients in value-based care models remain in traditional Medicare and retain all the rights and benefits of traditional Medicare, including the freedom of choice to go to any Medicare provider.

Fact:

Value-based care never moves patients into care plans they can't opt out of. Value-based care programs must send letters to patients notifying them that their doctor is part of the program. Patients in value-based care models remain in traditional Medicare and retain the freedom of choice to go to any Medicare provider.

Fact:

Value-based care does not lead to "middlemen" denying patients care. Value-based care models cannot restrict provider networks or limit access to care through utilization management tools such as prior authorization. Patients remain in traditional Medicare and retain all their rights and benefits, including freedom to choose their provider. Physicians and other clinicians in value-based care programs work to coordinate fragmented care to emphasize an efficient patient experience that eliminates waste and reduces frustration. Failure to meet quality and cost benchmarks precludes AAPMs from receiving savings generated from value-based care, thus ensuring that patients receive all medically necessary services.