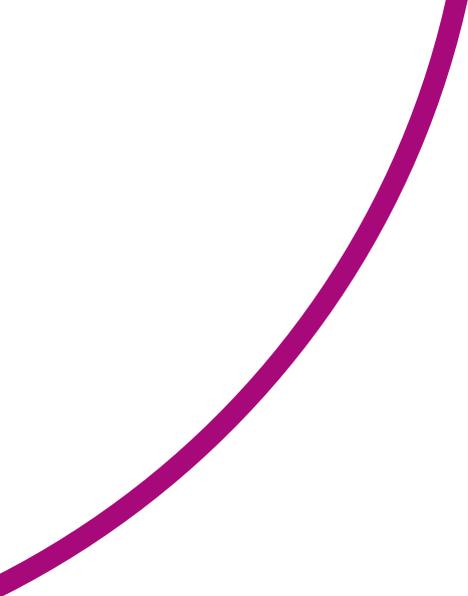


# Value-Based Care for Therapy:

A Provider's Guide



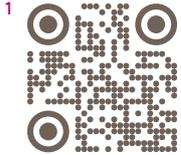
The American Occupational Therapy Association (AOTA), the American Physical Therapy Association (APTA), and the American Speech-Language-Hearing Association (ASHA) have come together to outline important knowledge and key considerations for therapy providers who are exploring value-based payment arrangements. In this booklet we address the following key topics.



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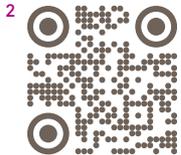
## What Is Value-Based Care?



APM Framework

Therapy providers have historically been paid under the **fee-for-service (FFS) system**<sup>1</sup>, in which providers are paid for each particular service they perform. This model has caused a number of unintended consequences, including:

- An incentive for health care providers to perform and bill more services;
- Lack of coordination between health care providers;
- Focus on sick care instead of wellness and prevention; and
- Productivity requirements that limit a provider's ability to provide high-quality care.

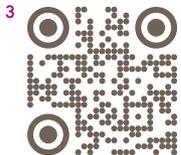


Value-Based Care:  
Alternative Payment  
Models

However, the health care system is shifting away from FFS, which rewards sheer volume of services, to **value-based care**<sup>2</sup>, which rewards the value of services provided. Value-based care seeks to identify and reward interventions that improve outcomes and decrease downstream costs while disincentivizing low-value care. Under **a value-based care model, payment could be based on outcomes achieved per dollar spent**<sup>3</sup>, thus incentivizing efficiency, functional outcomes, interprofessional collaboration,

and carryover. These models typically account for the clinical complexity of the patient and their social determinants of health (SDOH, or nonmedical factors affecting their health-related behaviors and access to health supports and care).

The Centers for Medicare & Medicaid Services (CMS) has stated that by 2030, all Medicare health care plans and most Medicaid health care plans will include accountability for the quality and total cost of care.



Value-Based Care:  
What It Is, and Why  
It's Needed

# Understanding Upside and Downside Risk in Health Care

A risk-based arrangement is an agreement in which a provider, group of providers, organization, or institution is held financially responsible for the quality and cost of care delivered in exchange for flexibilities regarding the way they deliver care.

## Sharing Financial Responsibility for Patient Outcomes With the Payer or Other Providers

*Upside Risk* ← ————— → *Downside Risk*

Reward for exceeding expectations

Penalty for not meeting expectations or targets

Additional revenue earned by delivering high-quality care at a lower cost than anticipated

A loss of revenue when the cost of care exceeds a set threshold or if care fails to meet quality standards

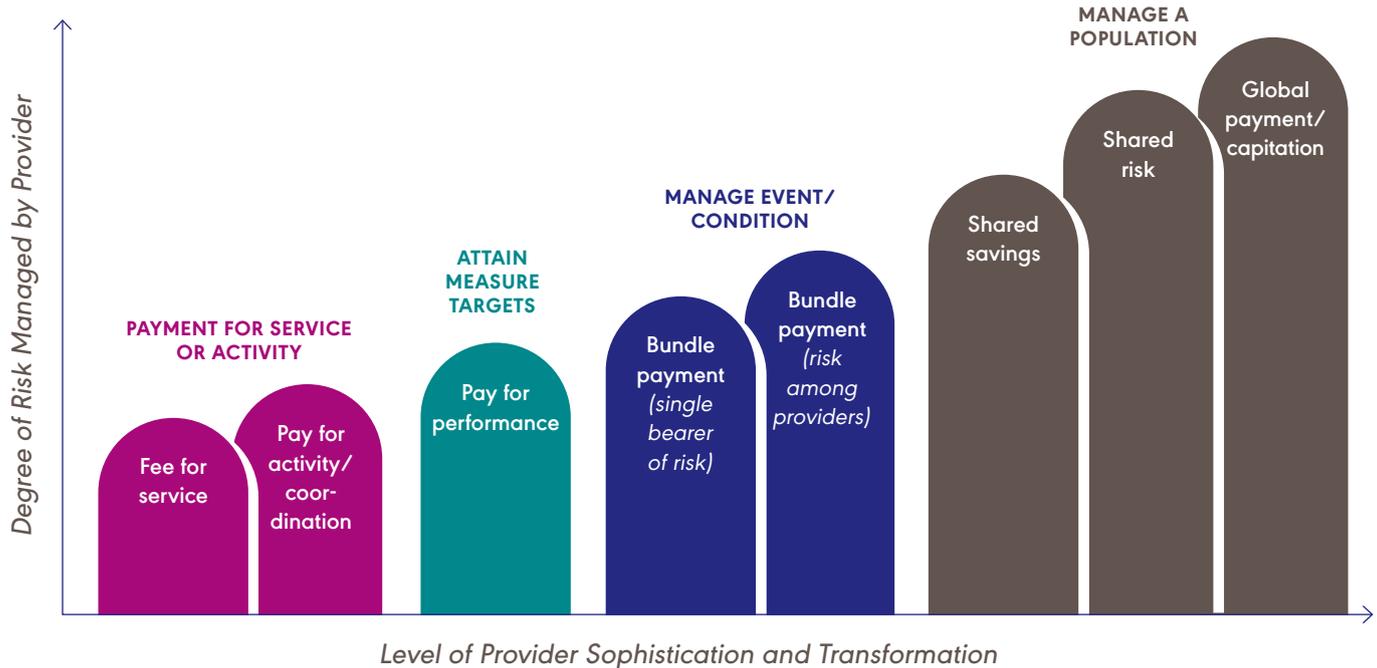
One-sided risk arrangement

Two-sided risk arrangement

In order to achieve success in a risk-based arrangement, providers must:

- Know their cost(s) for providing care;
- Be able to influence the cost(s) of providing care; and
- Have some level of confidence that they will perform well against the established thresholds for the cost of care.

# Levels of Value-Based Care



This framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer,

as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the framework captures a continuum of clinical and financial risk for provider organizations.

# Levels of Value-Based Care, Continued

LEARN MORE



CATEGORY 1

FEE FOR SERVICE - NO LINK TO QUALITY & VALUE



CATEGORY 2

FEE FOR SERVICE - LINK TO QUALITY & VALUE



CATEGORY 3

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE



CATEGORY 4

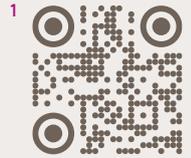
POPULATION-BASED PAYMENT

- A Foundational Payments for Infrastructure and Operations**  
(e.g., care coordination fees and payments for health information technology investments)
- B Pay for Reporting**  
(e.g., bonuses for reporting data or penalties for not reporting data)
- C Pay-for-Performance**  
(e.g., bonuses for quality performance)

- A APMs With Shared Savings**  
(e.g., shared savings with upside risk only)
- B APMs With Shared Savings and Downside Risk**  
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

- A Condition-Specific Population-Based Payment**  
(e.g., per-member per-month payments, payments for specialty services, such as oncology or mental health)
- B Comprehensive Population-Based Payment**  
(e.g., global budgets or full/percent of premium payments)
- C Integrated Finance and Delivery System**  
(e.g., global budgets or full/percent of premium payments in integrated systems)

|   |  |
|---|--|
| <b>3N Risk-Based Payments<br/>NOT Linked to Quality</b> | <b>4N Capitated Payments<br/>NOT Linked to Quality</b> |
|---|--|



Risk-Based Arrangements in Health Care

# Quality Measures and Outcome Measures

Measuring outcomes is an important aspect of value-based care programs. To shift incentives from volume of care to improved health outcomes, value-based care programs use quality measures to reward, penalize, and compare providers based on their performance. Quality measures are used to measure processes, outcomes, patient perceptions, and organizational structure and/or systems.

Depending on setting and payment model, quality measures measured by the facility or health care system could include:

- Potentially Preventable 30-Day Post-Discharge Readmission
- Discharge Function - Capacity to Perform Daily Activities Related to Self-Care and Mobility
- Percent of Residents Experiencing One or More Falls with Major Injury
- Discharge to Community
- Cognitive Function
- Medication Reconciliation.

Practitioners play a vital role in improving the health outcomes of their clients, which can boost an organization's performance in quality measures. Practitioners understand which quality measures are used in their setting and organization.

Quality measures do not replace the best practice of using assessment tools that provide objective patient information. In some cases, practitioners might choose assessment tools that complement quality measures when indicated.

## *Find assessments for your clinical practice:*

- [AOTA Quality Toolkit](#)<sup>1</sup>
- [APTA Tests and Measures](#)<sup>2</sup>
- [ASHA Assessment Tools, Techniques, and Data Sources](#)<sup>3</sup>
- [Shirley Ryan Rehabilitation Measures Database](#)<sup>4</sup>

## *Quality Measure Resources:*

- [AOTA Quality Measures](#)<sup>5</sup>
- [CMS New to Measures](#)<sup>6</sup>
- [CMS Quality Reporting and Value-Based Programs & Initiatives](#)<sup>7</sup>
- [Physical Therapist Quality Portfolio](#)<sup>8</sup>

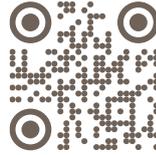
## RESOURCES

Patient-reported outcome measures are becoming more prevalent in value-based care programs in order to elevate the experiences and perspectives of the patient. Patient-reported outcome measures capture information directly from the patient's perspective on health status, function, symptoms, and quality of life.

## Examples of Patient-Reported Outcome Measures:

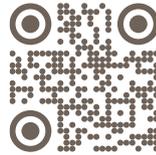
- [Patient-Reported Outcomes Measurement Information System \(PROMIS\) Measures<sup>9</sup>](#)
- [Patient-Specific Functional Scale<sup>10</sup>](#)
- [Patient-Reported Outcome Forms<sup>11</sup>](#)
- [Canadian Occupational Performance Measure<sup>12</sup>](#)

1



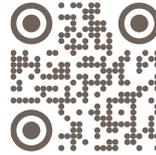
AOTA Quality Toolkit

2



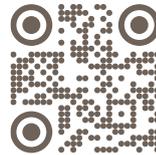
APTA Tests and Measures

3



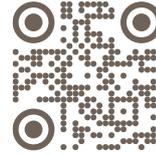
ASHA Assessment Tools, Techniques, and Data Sources

4



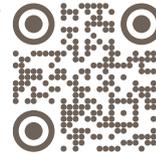
Shirley Ryan Rehabilitation Measures Database

5



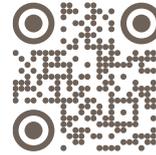
AOTA Quality Measures

6



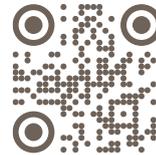
CMS New to Measures

7



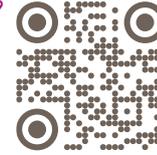
CMS Quality Reporting and Value-Based Programs...

8



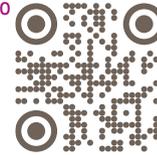
Physical Therapist Quality Portfolio

9



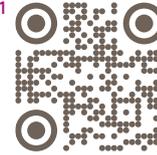
Patient-Reported Outcomes...

10



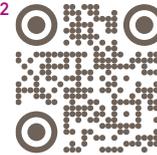
Patient-Specific Functional Scale

11



ASHA Patient-Reported Outcome Forms

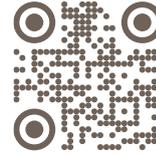
12



Canadian Occupational Performance Measure

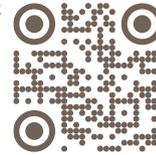
## LEARN MORE

1

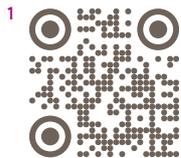


CMS Quality Measures

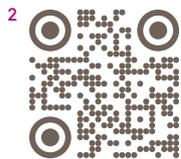
2



Clinical Potential of Patient-Reported Outcome Measures in Occupational Therapy



The Basics of Risk Adjustment



Social Determinants of Health



## Risk Adjustment

Risk adjustment is a process used to account for variations in patient acuity. It uses a patient’s health status, underlying conditions, social determinants of health (SDOH), and age to predict patient outcomes and resource utilization and to determine payment.

Without risk adjustment, providers with higher-acuity patients could be unfairly penalized when compared to providers treating lower-acuity patients. Providing an accurate and comprehensive description of each

client is important to ensure that risk adjustment models are effective.

Hierarchical Condition Category (HCC) is a commonly used risk adjustment model. HCC uses diagnostic codes and demographic data to assign risk levels. CMS uses HCCs to determine payment for Medicare Advantage plans and traditional Accountable Care Organizations.

# What to Look for When Considering a Contract

When entering a value-based care arrangement with any payer, a provider should ask questions about the specific payment model, performance metrics used to measure quality, patient population attribution, data sharing requirements, financial risk involved, support for care coordination and technology needs, access to clinical decision support tools, and the process for dispute resolution and appeals to fully understand the implications and potential benefits of the agreement.

## Key areas to focus on:

### **Payment Model:**

- What type of value-based care model is being proposed (e.g., shared savings, downside risk, bundled payments)?
- How will payments be calculated based on quality metrics and patient outcomes?
- What is the incentive structure for exceeding quality targets?

### **Quality Measures:**

- What specific quality metrics will be used to evaluate performance?
- How will these metrics be calculated and weighted?
- What are the thresholds for achieving bonus payments or incurring penalties?
- Will the services you provide make an impact on the quality metrics you will be judged on?

### **Patient Population:**

- How will patients be attributed to the provider for performance measurement?
- What are the demographics and health conditions of the assigned patient population?
- How will patient risk adjustment be factored into the payment calculations?

### **Data and Reporting:**

- What data elements will need to be submitted to the payer for performance evaluation?
- What reporting frequency is required?
- What technology platforms will be used for data collection and reporting?

### ***Care Coordination and Support:***

- What support services will be provided to facilitate care coordination across different providers and settings?
- How will the payer support the implementation of new care management strategies?

### ***Financial Risk:***

- What level of financial risk is associated with this agreement (upside only, downside risk)?
- What are the potential financial implications of not meeting performance targets?

### ***Contractual Terms:***

- What is the duration of the agreement?
- What are the termination clauses and conditions?
- How will disputes regarding payment calculations be resolved?

### ***Important Considerations:***

- **Practice readiness:** Assess your practice's current capabilities for data collection, care coordination, and quality improvement initiatives before entering a value-based care arrangement.

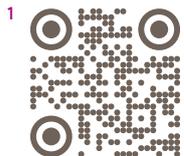
- **Clinical expertise:** Understand the clinical implications of the chosen quality measures and how they align with your practice's patient population.
- **Technology needs:** Evaluate your electronic health record (EHR) system and practice management software to see if they're able to support the data reporting requirements of the value-based care agreement.



## Other Important Questions to Ask

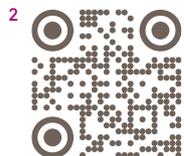
- What is the plan's definition of occupational/speech/physical therapy?
- Are there limitations in the number of visits, sites at which services may be received, or yearly costs incurred for therapy services?
- Is there a network of providers that a therapist must join to bill? Can a patient "opt out" of the network, and if so, what financial disincentives exist?
- Does the plan offer case management services for some conditions?
- Does the plan pay a fee for service or is payment for therapy "bundled" into a group of services (e.g., a set amount for all rehabilitation services)?
- Does the payer require specific credentials for therapy providers?
- Does the payer require that the therapist or health care facility or clinic join a provider network?
- Is the client responsible for co-payments, deductibles, or other out-of-pocket expenses? Under what circumstances?

## Infrastructure and Upskilling Needs



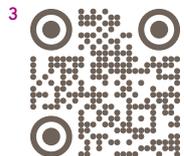
PACIO Project

Value-based care arrangements require therapy providers to embrace new skills and technology to accurately track, analyze, and coordinate patient care to achieve the best value or outcome for the cost.



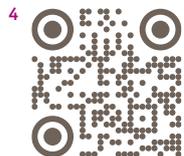
PACIO's  
Implementation  
Guide

**EHRs** allow providers to easily access health information across clinicians, facilities, and time. EHRs also facilitate cost and quality data tracking. Some EHRs include patient-facing portals that allow for increased patient engagement in their care.



Social Determinants  
of Health | AOTA

**The Post-Acute Care Interoperability (PACIO) Project<sup>1</sup>** is a multidisciplinary, collaborative effort with a mission to advance interoperable health data exchange. Using the International Classification of Functioning, Disability, and Health, **PACIO's Personal Functioning and Engagement Implementation Guide<sup>2</sup>** provides a framework for exchanging information related to mental functions, mobility, self-care, communication, and voice and speech functions.



What are SDOH? |  
ASHA

**Data analytics** allow providers to gain insights from their patient data. Cost and utilization tracking, quality metrics and monitoring, and targeted interventions based on patient needs can lead to improved outcomes and reduced cost.

Interprofessional collaborative practice is key to avoiding wasteful duplicative care and ensuring that the patient is being treated holistically. According to the National Academies of Practice, interprofessional collaborative practice refers to the strong focus on promoting and advocating for health care practices where professionals from different disciplines work together collaboratively to deliver high-quality patient care, emphasizing shared decision-making and coordinated efforts across various health fields. Communication, shared decision-making and coordinated efforts from providers in different health fields keep the focus on the patient and their health outcomes.

**SDOH<sup>3</sup>** are nonmedical factors that influence health outcomes and patient well-being. **Examples of SDOH<sup>4</sup>** include housing stability, transportation, food security, and economic stability. These factors have significant impacts on health outcomes, but they have historically fallen outside of the health care system. Under value-based care arrangements, providers are encouraged and incentivized to identify and make referrals to address these factors to improve outcomes and reduce cost.

# Evidence-Based Practice

In a payment system where cost and quality are carefully tracked and monitored, it is essential that the care provided is effective, efficient, and evidence-based. There is no time nor any health care dollars to waste on treatments that are not supported by evidence. Nonevidence-based care can lead to poor health outcomes and unnecessary health care spending. The following resources can help you ensure that your interventions have a strong evidence base.

- [Evidence-Based Practice \(EBP\)<sup>5</sup>](#)
- [Practice Guidelines and Evidence-Based Clinical Resources<sup>6</sup>](#)
- [Evidence-Based Practice Resources<sup>7</sup>](#)

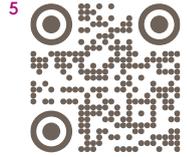
Occupational therapy practitioners, physical therapists, and speech-language pathologists are experts in rehabilitation and habilitation, performance enhancement, prevention, and risk-reduction services who can help patients achieve better health outcomes through expert screening, evaluation, treatment, and education. Health systems can improve their quality scores and reduce their



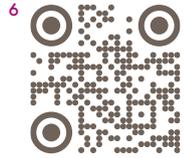
costs through the integration of therapy practitioners at all points along the continuum of care.

The payment landscape is changing, and therapy providers are well-positioned to help patients, their families, and the overall health system succeed by improving outcomes and using health care dollars efficiently.

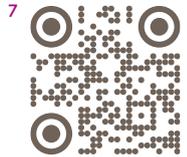
LEARN MORE



Evidence-Based Practice (EBP)



Practice Guidelines



Evidence-Based Practice Resources

Questions can be directed to:

**OCCUPATIONAL THERAPY**

[Regulatory@aota.org](mailto:Regulatory@aota.org)

[Quality@aota.org](mailto:Quality@aota.org)

**PHYSICAL THERAPY**

[Advocacy@apta.org](mailto:Advocacy@apta.org)

**SPEECH-LANGUAGE PATHOLOGY**

[Reimbursement@asha.org](mailto:Reimbursement@asha.org)