Advancing Value-Based Care through Value-Based Contracting: Lessons Learned

MedNetOne HEALTH SOLUTIONS

CME Disclosure

I have no actual or potential conflict of interest in relation to this program and presentation.

Learning Objectives

- Define value-based care (VBC) and value-based reimbursement (VBR)
- Describe the history of VBC
- Explain key value-based care terms and concepts
- Describe the link between VBC and population health
- Identify different healthcare stakeholders and how they influence value-based care

- What do you want to learn today?
- With whom will you share the information obtained today?

Researching VBC

The Origin of the Concept of Value-Based Care

- The term “value-based care” first appeared in the book ***Redefining Healthcare*** written by Harvard professors Michael Porter, PhD and Elizabeth Olmsted Teisberg, PhD and published in 2006
- The book concentrated on the concept of shifting the focus away from compensating providers based on the number of services they performed toward patient outcomes as a result of the care provided

Principles of Value-Based Competition

- Focus on value for patients, not just lowering costs
- Unrestricted competition based on results
- Competition should center on medical conditions over the full cycle of care
- High quality care should be less costly

Principles of Value-Based Competition

- Value is driven by provider experience, scale, and learning at the medical condition level
- Information on results and process needed for value-based competition must be widely available
- Competition should be regional and national, not just local

Research Revealed

- Following a ten-year review of VBC programs and interviews, Alyna Chien, M.D. of Harvard Medical School and Meredith Rosenthal, PhD of the Harvard School of Public Health published a report in 2019
- ***"A 3D Model for Value-Based Care"*** identified infrastructure support as the missing dimension that accompanies quality and spending-reduction incentives

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Five Themes Emerged

1. Value-based programs require substantial organizational change
2. Shared data is the foundation of successful VBC relationships
3. Increased capacity in care management strengthens the practice
4. Re-setting payer provider relationships unlocks innovative program design
5. Leadership commitment and stamina are critical success factors

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Defining Terms and Frequently Used Terms

Definition of Value-Based Care

- An innovative way to pay health care providers that is designed to focus on quality of care, provider performance and the patient experience

CMS and BCBSM

Risk and Risk-Bearing Arrangements

- Risk is the uncertainty associated with potential financial gains or losses
- Risk-Based Arrangement is an agreement in which a participant is held financially responsible for the quality and cost of care delivered to a payer's members in exchange for flexibilities regarding the way they deliver care

Upside Risk

- Often referred to as a “one-sided risk arrangement”
- If participants keep their spending below specific thresholds while meeting quality targets, they can keep a portion of the savings

Downside Risk

- Sometimes called “two-sided risk”
- Providers are financially responsible for failure to meet cost and quality benchmarks
- There is uncertainty associated with assuming financial responsibility for the actual cost and quality of care against established cost or quality benchmarks

Frequently Used Terms in VBR Relationships

- Accountable Care: A person-centered care team takes responsibility for improving quality of care, care coordination and health outcomes for a defined group of individuals, to reduce care fragmentation and avoid unnecessary costs for individuals and the health system
- Care Coordination: The organization of an individual's care across multiple health care providers

Frequently Used Terms in VBR Relationships

- Collaborative Care Model (CoCM): An evidence-based approach to integrating mental health and general medical care in primary care settings developed by the American Psychiatric Association and the Academy of Psychosomatic Medicine
- CoCM involves a primary care team that includes a primary care provider, care manager, and a consulting psychiatrist

Frequently Used Terms in VBR

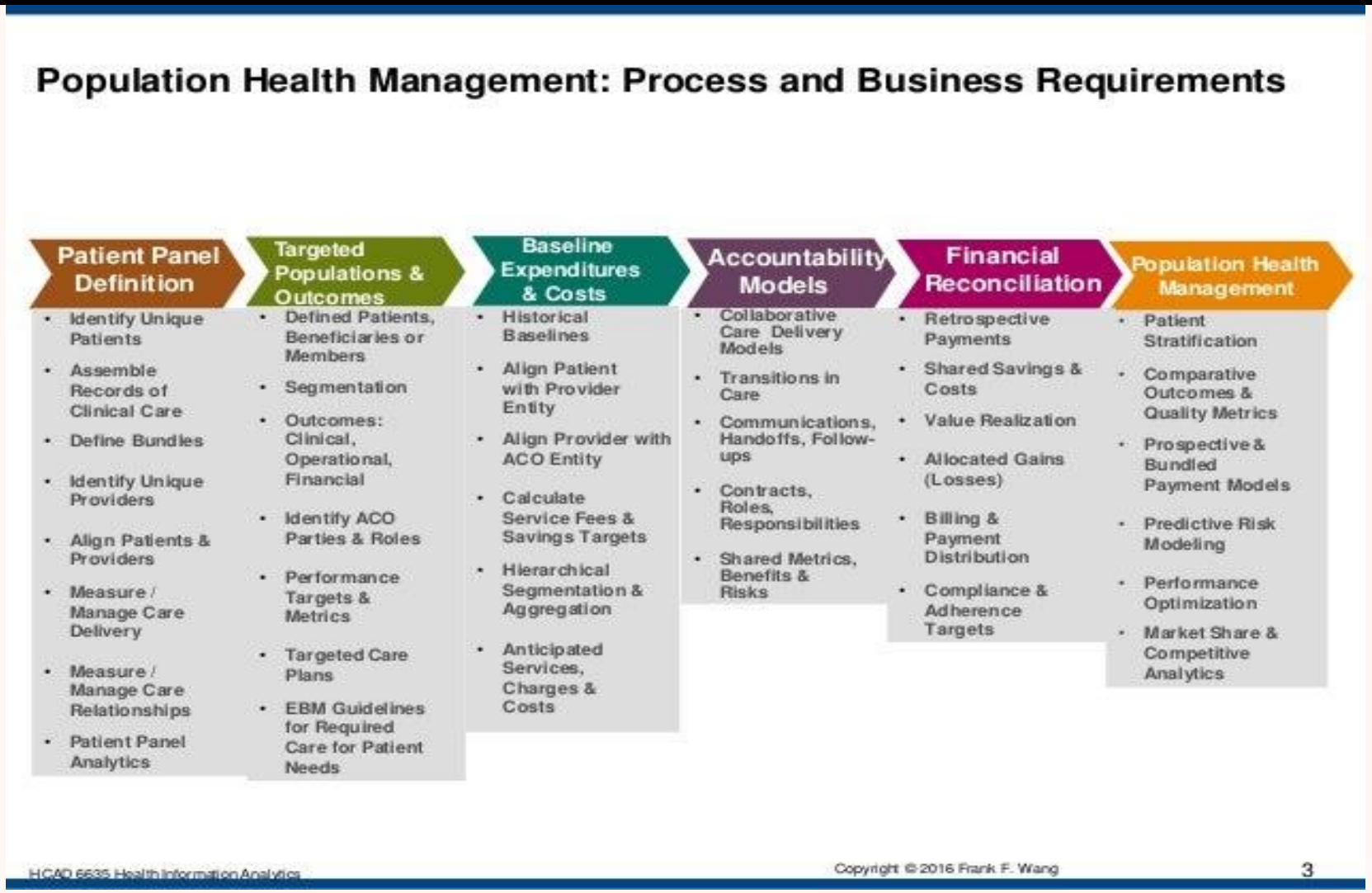
- Integrated Care: An approach to coordinate health care services to better address an individual's physical, mental, behavioral and social needs
- Person-Centered Care: Health care services delivered in a setting and manner that is responsive to individuals and their goals, values and preferences, in a system that supports good provider-patient communication and empowers individuals receiving care and providers to make effective care plans together

Frequently Used Terms

- Population Health: An interdisciplinary, customizable approach that utilizes non-traditional partnerships among different sectors of the community such as public health, industry, academia, health care, local government entities, and others to achieve positive health outcomes

One Healthcare Organization's VBC Experience

Stages of Achieving Value-Based Care



Transitioning to a Value-Based Payment Model

- Transitioning processes to a VBR model are not easy for healthcare organizations
- VBR models require extensive data analytics capabilities, population health management tools, EHR, excellent documentation skills, coding acumen, and a well-trained team

Comparing Capitation to Value-Based Payments

- Capitation refers specifically to a payment model where health care professionals receive fixed payments per patient, regardless of services rendered
- Value-based payments have broader principles aimed at improving healthcare quality and outcomes while controlling costs
- The “value” in value-based care refers to what an individual values most

Value-Based Care Needs Team Care

- In value-based care, doctors and other health care professionals work together to manage a person's overall health, while considering an individual's personal health goals
- Providers and their team might coordinate care at the time of the visit so that the patient does not need to schedule a return visit
- Team care helps people avoid the emergency department and readmissions

The Patient's Experience of Care

- A care team member can
  - contact patients between medical visits to see how they are doing, following an ED visit, or problem-solve issues they encounter
  - explain options such as how to receive care or how to communicate with their providers including telehealth
  - recommend an opportunity to participate in a disease prevention program at the PCP level
  - provide educational resources about their health issue including directing them to specific group visits

VBC and Whole Person Care

- Value-based care puts greater emphasis on integrated care, meaning health care team works together to address a person's physical, mental, behavioral and social needs
- Providers and the care team treat an individual as a whole person, rather than focusing on a specific health issue or disease

VBC and Whole Person Care

- Patients might be asked about nonmedical factor, social determinants of health (SDOH) that could have a direct impact on their well-being
- Examples of SDOH factors:
  - access to reliable transportation
  - healthy food
  - relationships with family
  - Challenges with paying for bills
  - General living conditions

VBC Supports Activated and Engaged Patients

- Patients are active partners with their physicians, care teams and other health care professionals
- Patients receiving VBC collaborate with their care team members to design their treatment plans, and they let their care team members know if they have any questions or concerns

VBC Advances Health Equity

- Focus on the health outcomes of every person, including those from underserved populations
- Encourageshealth care professionals and care teams to screen for social needs and work with individuals to develop personalized treatment plans that can address each person's unique needs such as connecting them to a local food bank, engaging with interpreter services, arranging transportation or other accommodations

VBC Advances Health Equity

- Requires health care professionals to monitor and track outcomes across populations to assess for disparities and intervene as necessary to help close gaps in access or care
- Supports the use of Community Health Workers

Enablers: Lessons Learned

- Through shared risk models, payers and health care entities agree upon a set budget and quality performance thresholds
- Health care entities must cover part or all the healthcare costs if they cannot keep costs lower than the set benchmarks
- Enablers partner with health care organizations
- Current focus is the Medicare and Medicare Advantage population

Enablers Expand Services: Lessons Learned

- While negotiating with a potential enabler perform a SWOT analysis and outline capabilities
- Provide resources, tools and expertise necessary to support VBC
- Discuss and document deliverables with timelines including the staffing model
- Discuss and negotiate favorable terms including incentives
- Transformation through partnership

Negotiating Agreements with Payers

- Health care entities should review arrangements with health plans and partners
- Incentives based on improved care delivery
- Improved care delivery includes
  - Artificial intelligence
  - Care coordination activities
  - Care teams
  - Patient registry
  - Other tools and capabilities

Examples of Enablers in Michigan

- Agilon
- Aledade
- Honest Medical Group
- Village MD

A Word About Incentives

- There are various incentives
  - Pay for Performance
  - HEDIS and Stars
  - Cost of Care - Savings
- Incentive distribution is based on an organization's methodology

Michigan Market Example

One Michigan Example of VBC

- In December 2019, BCBSM announced a program "Blueprint for Affordability"
- Physician organizations agreed to put a portion of their payments from Blue Cross "at risk," based on their success in managing their patients' health, thereby lowering their total cost of care
- "Blueprint for Affordability" is considered an umbrella term to encompass all BCBSM shared and full-risk provider partnerships

Participants

- More than 50% of the total attributed Blue Cross commercial and Medicare Advantage Michigan-based membership is covered by physicians who participate in the shared-risk payment model
- A total of 22 physician organizations signed onto the Blueprint shared-risk program, making it one of the largest payment models of its kind nationally

Recent Results

- In both 2020 and 2021, Blueprint primary care providers outperformed their non-Blueprint peers in key measures related to affordability and quality
- More than 60% of participating physician organizations outperformed their affordability targets for Blue Cross commercial members and earned a share of the savings generated by the program

Results

- Providers in the shared-risk Blueprint contract performed better than plan average on various quality metrics, including rate of breast cancer and colorectal screenings, childhood immunizations and diabetic control measures
- In 2021, for Blue Cross commercial members, using a quality composite score made up of 14 different quality metrics, providers participating in a shared-risk Blueprint contract outperformed other providers by nearly five percentage points

Why the Push for Risk Sharing

- Upside and downside risk-based arrangements play a part in transforming the nation's health care system from one that rewards volume to one that rewards value

Summary

- Value-based programs require substantial organizational change
- Shared data is the foundation of successful VBC relationships
- Increased capacity in care management strengthens the practice
- Re-setting payer provider relationships unlocks innovative program design
- Leadership commitment and stamina are critical success factors

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