Advancing Value-Based Care: Lessons Learned

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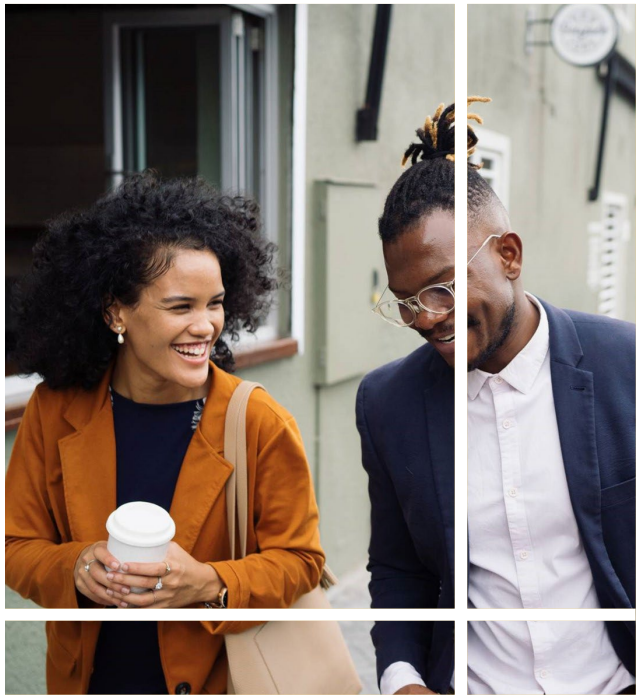
CME Disclosure

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



Share your Thoughts

- What do you want to learn today?
- Why is this topic important to you?
- With whom will you share the information?

Learning Objectives

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

The Origin of the Concept of VBC

- The term “value-based care” first appeared in the book ***Redefining Healthcare*** published in 2006. and written by Harvard professors Michael Porter, PhD and Elizabeth Olmsted Teisberg, PhD
- The concept of shifting the focus away from compensating providers based on the number of services they performed toward patient outcomes because of the care provided was introduced
- Value-based care has gone from an experiment to and expectation

Principles of Value-Based Care

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

Principles of Value-Based Care (cont.)

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

VBC Model Analysis

- Ten-year analysis of VBC programs “A 3D Model for Value-Based Care” by Layna Chien, M.D., Harvard Medical School and Merideth Rosenthal, PhD, Harvard School of Public Health recognized that infrastructure support was the missing dimension that accompanied quality and spending-reduction incentives

Research Revealed Five Themes

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

https:www.unitedhealthgroup.com/newsroom/posts/2019-10-02-havard-study-vbc.html

Frequently Used Terms

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

Accountable Care Organization

- An Accountable Care Organization (ACO) is a group of healthcare providers, such as doctors, hospitals, and other healthcare professionals, who work together to coordinate care for a specific group of patients
- ACOs are accountable to patients and payers for the quality, appropriateness, and efficiency of the healthcare provided and aim to improve patient care, reduce costs, and improve health outcomes for a defined population

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

A Push for Risk Sharing Arrangements

- 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
- Pushing for downside risk in healthcare aims to incentivize providers to focus on cost-effective, high-quality care by holding them accountable for both financial and clinical outcomes
- VBC shifts the burden of risk to providers, in theory leading to improved efficiency, better patient outcomes, and reduced overall healthcare spending

Risk and Risk-Bearing Arrangements

- Risk is the uncertainty associated with potential financial gains or losses
- A risk-bearing arrangement holds participants 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 providers 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”
- There is uncertainty associated with assuming financial responsibility for the actual cost and quality of care against established cost or quality benchmarks
- Providers are financially responsible for failure to meet cost and quality benchmarks

Medical Loss Ratio

- Many insurance companies spend a substantial portion of premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing
- The Affordable Care Act requires payers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR)
- The Affordable Care Act requires payers to spend at least 80% or 85% of premium dollars on medical care

Medical Loss Ratio

- A higher MLR indicates that the insurer is spending a larger proportion of its premium revenue on patient care, which is seen as a positive indicator for policyholders but not the payer

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, community-based organizations and others to achieve positive health outcomes

Michigan Market Examples

Blueprint for Affordability

- In December 2019, BCBSM announced an innovative program “Blueprint for Affordability”
- Blueprint for Affordability is considered an umbrella term to encompass all BCBSM shared and full-risk provider partnerships
- Several Physician Organizations agreed to engage in the “at risk” program based on their success in managing their patients’ health, thereby lowering their total cost of care

Physician Organizations Engagement

- More than 50% of the total attributed BCBSM commercial and Medicare Advantage Michigan-based membership is covered by physicians who participate in Blueprint
- 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

Blueprint 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 BCBSM commercial members and earned a share of the savings generated by the program

Changes in the Blueprint Agreement

- 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

https://www.bcbsm.com/content/dam/microsites/corpcomm/provider/the_record/2025/apr/Record_0425j.html

Changes in the Blueprint Agreement

- Starting July 1, 2025, both the Physician Group Incentive Program (PGIP) and Blueprint for Affordability allocations will change to further support BCBSM value-based opportunities for health care providers
- The Blueprint allocation will be reduced from 1.5% to 1%
- PGIP allocation will increase from 6% to 6.5%
- The total allocation percentage will remain the same

https://www.bcbsm.com/content/dam/microsites/corpcomm/provider/the_record/2025/apr/Record_0425j.html

Value-Based Care: One Experience

Stages to Achieving Value-Based Care

Population Health Management: Process and Business Requirements

Patient Panel Definition	Targeted Populations & Outcomes	Baseline Expenditures & Costs	Accountability Models	Financial Reconciliation	Population Health Management
• Identify Unique Patients	• Defined Patients, Beneficiaries or Members	• Historical Baselines	• Collaborative Care Delivery Models	• Retrospective Payments	• Patient Stratification
• Assemble Records of Clinical Care	• Segmentation	• Align Patient with Provider Entity	• Transitions in Care	• Shared Savings & Costs	• Comparative Outcomes & Quality Metrics
• Define Bundles	• Outcomes: Clinical, Operational, Financial	• Align Provider with ACO Entity	• Communications, Handoffs, Follow-ups	• Value Realization	• Prospective & Bundled Payment Models
• Identify Unique Providers	• Identify ACO Parties & Roles	• Calculate Service Fees & Savings Targets	• Contracts, Roles, Responsibilities	• Allocated Gains (Losses)	• Predictive Risk Modeling
• Align Patients & Providers	• Performance Targets & Metrics	• Hierarchical Segmentation & Aggregation	• Shared Metrics, Benefits & Risks	• Billing & Payment Distribution	• Performance Optimization
• Measure / Manage Care Delivery	• Targeted Care Plans	• Anticipated Services, Charges & Costs		• Compliance & Adherence Targets	• Market Share & Competitive Analytics
• Measure / Manage Care Relationships	• EBM Guidelines for Required Care for Patient Needs				
• Patient Panel Analytics					

Transitioning to a VBR Model

- VBC bas gone from experiment to expectation
- The power of collaboration is driving meaningful change
- Transitioning processes to a VBC 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 Value-Based Payments to Capitation

- 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

The Impact of Team Care

- In value-based care, physicians 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 care 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, urgent care and readmissions

Team Care and the Patient 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 visits
  - 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 services

VBC and Whole-Person Care

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

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 (action pland and goal setting), 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
- Encourages physicians 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 with a social group, a local food bank, engaging with interpreter services, arranging transportation or other accommodations
- Supports Community Health Workers

Value-Based Care: One Experience

Various VBC Models Exist

- The greatest challenge in VBC is effective execution
- There are many solutions and organizations around
- Clinical and financial models already exist but aligning the resources, capital, and leadership to deliver VBC is hard

https://www.advisory.com/topics/value-based-care?

What is an Enabler

- Organizations that assist physician organizations, physicians and health plans in implementing and managing VBC arrangements
- They may play a crucial role in facilitating the transition to VBC by addressing complex challenges and offering necessary tools and expertise
- They may offer various services, including consulting, technology solutions, data analytics, and support to improve patient outcomes, reduce costs, and optimize performance

https://www.advisory.com/topics/value-based-care?

Enablers in Michigan

- Agilon
- Aledade
- Evolent
- Honest Health
- Pearl
- Privia
- Village MD
- Wellvana

Enablers and Partners

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

Physician Organizations Partner with Enablers

- Review contractual arrangements with health plans including Medical Loss Ratio (MLR)
- Incentives based on improved care delivery
- Improved care delivery includes
  - Artificial intelligence
  - Care coordination activities
  - Care teams
  - Patient registry
  - Other tools and capabilities

Before Engaging Formally With an Enabler

- While negotiating with a potential enabler perform SWOT analysis
- Identify and document capabilities and competencies
- Evaluate resources especially tools and expertise to support VBC
- Address administrative and clinical staffing model
- Develop a project plan with timelines
- Discuss and negotiate favorable terms including incentives
- Transformation begins through partnership

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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Consider the Power of Value-Based Care

Open Discussion

THANK YOU

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