Value-Based Care, Demystified

Presented by
Advisory Board Research

Messages to take from today

- **How your provider organizations make money has changed, is changing, and will continue to change.** This could be a cause concern but it's also an opportunity.
- **Value-based payment is just a different financing mechanism.** Under value-based payment models, providers organizations are incentivized to keep quality high and costs low instead of increasing their volumes.
- **Value = Quality / Cost**. The value of care is the quality of care relative to the cost required to deliver it. Value is usually defined and measured by the payer.
- **Risk inherent in value-based payment**. Any value-based payment means some or all of a provider organization's reimbursement is at-risk. Risk can take the form of incentives (upside), penalties (downside) or total (capitation).
- **The shift to value-based payment is surprisingly well underway**. Though most provider organizations are still driven mostly by fee-for-service, they are well on their "path to value."
- **And only likely to continue**. The ongoing effects of Covid-19 have provider organizations, payers, and the Biden administration all increasing their interest in value-based payment models.

What is value-based care?

Free word association

The first thing that comes to mind when I hear “value-based payment models” is…

First, let's define key terms

VOLUME x PRICE

Fee-for-service

- Success measured by maximizing volumes and revenues
- Little standardization around clinical evidence and widespread quality and cost variation
- Focus on improving efficiency of acute services

QUALITY / COST

Value-based payment

- Success measured by outcomes
- Integrated care delivery, treatment pathways
- Consistency with evidence-based care and utilization practices
- Focus on reducing total cost of care

Value-based payment a different financing mechanism

Incentives reward provider organizations for delivering more cost-effective care

Fee-for-service (FFS)

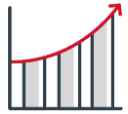
Providers are reimbursed for each service they provide

Providers are incentivized to perform a higher volume of services

No incentive to improve quality or coordinate care

Value-based payment

Providers are reimbursed based on performance

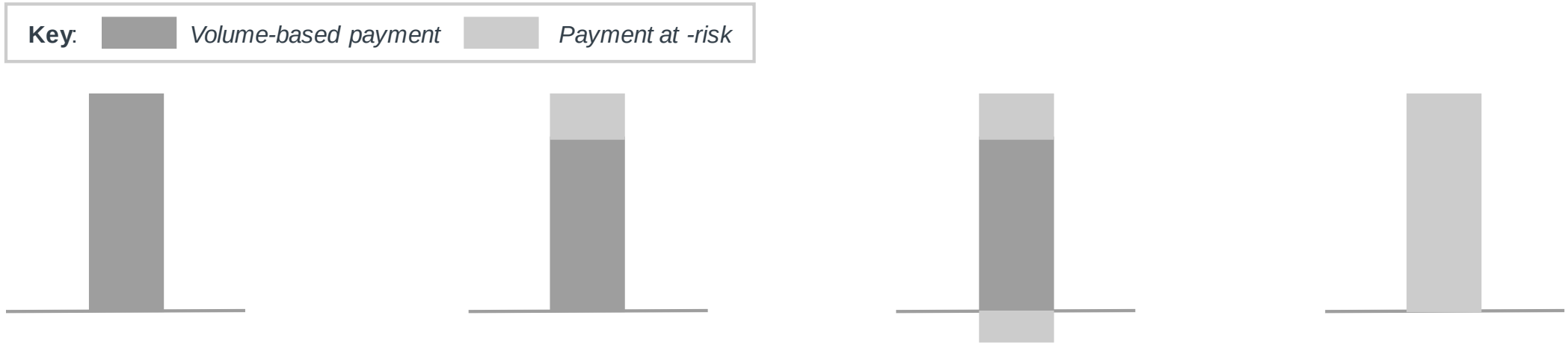


Providers are incentivized to provide high-quality care at a lower cost

High-performing providers can share in savings, while underperformers can be penalized

Provider payment is at-risk under value-based payment

Generalization of different types of risk-based payment



No-risk

- Traditional fee-for-service
- Volume x Price

Upside risk

- Provider rewarded with a portion of savings if any are generated
- Considered entry point to risk-based payment

Up and downside risk

- Provider rewarded with a portion of savings if any are generated
- Provider loses money if they miss spending and quality targets

Capitation

- Entire payment at-risk
- Payment tied to the patient or the population
- Often referred to as population-based or PMPM[1]

1. Per-member per-month.

Most risk-based contracts work on the same premise

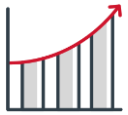
General principles of risk-based contracts

Define network and covered population

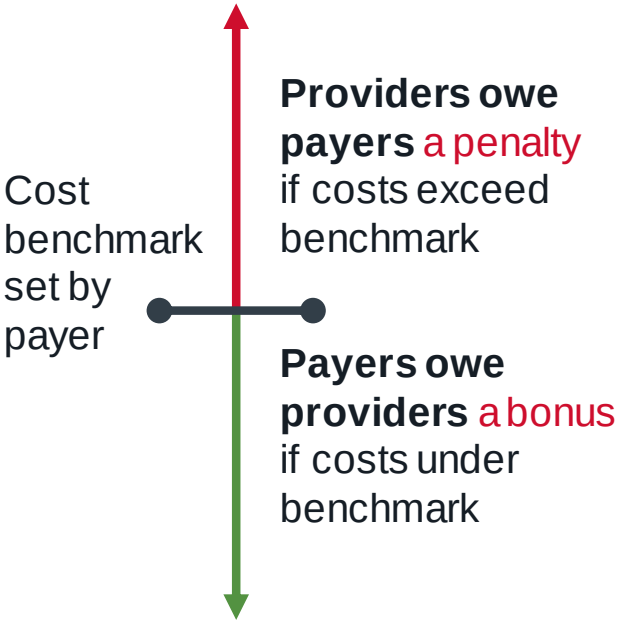
- Provider organization and payer agree on contract
- Includes a number of covered lives of the payer's members
- Defines reimbursement rates, risk-levels, and providers in-network

Establish cost of care benchmark

- Payers define expected cost benchmark based on health of the covered population
- Provider organizations work to maintain or improve quality and decrease cost



Measure performance relative to benchmark



Advisory Board interviews and analysis.

What is population health?

Population health management (PHM) "refers to the process of improving clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models." *–American Hospital Association*

Primary aims

Reduce the **total cost of care**

Provide **proactive, preventative, and targeted** care

Reduce **inappropriate demand** for treatment

Sample of key investments

- Risk stratification and data analytics
- Care management and coordination
- Chronic disease management
- Community partnerships
- Social determinants of health
- Behavioral health integration
- Senior services
- Primary care
- Palliative care

Sample objectives

Enable **self-management** of patients' chronic conditions

Address the **wider determinants** of health (not just clinical care)

Surface and address **behavioral health** needs

Source: "Population Health Management," American Hospital Association, https://www.aha.org/center/population-health/population-health-management.

Physician Executive Council interviews and analysis.

Messages to take: What is value-based care?

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- **Risk inherent in value-based payment**. Any value-based payment means some or all of a provider organization's reimbursement is at-risk. Risk can take the form of incentives (upside), penalties (downside) or total (capitation). If you know the amount at risk and whether it's an incentive or a penalty, you know what your customer cares about.
- **Contracts vary.** And this is the toughest part. A single provider organization likely has several different contracts with different payers that all look different.

What does the future of value-based care look like?

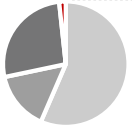
The carnival game

Your best guess: What percentage of provider organization reimbursement is still based on only fee-for-service (volume times price)?

Industry transformation already well underway

Pace of transition to risk highly variable across payer segments

Progression to alternative payment methodology

	Traditional fee-for-service	Pay-for-performance	Shared savings and bundles	Population-based payments[1]
 **Medicare Advantage**	48.0%	2.5%	39.2%	10.3%
 **Original Medicare**	10.5%	51.2%	33.8%	4.5%
 **Medicaid**	67.8%	7.2%	20.8%	4.2%
 **Commercial**	56.5%	15.2%	26.6%	1.7%
All-payer	**41.0%**	**25.4%**	**29.8%**	**3.8%**

1. Prospective PMPM payments, global budgets or full/percent of premium payments, and integrated delivery systems.

Source: "Progress of alternative payment models," HCP LAN, 2018.

Health care expenditure on the rise

U.S. health care spending rising at faster rate than GDP[1]

Factors driving up health care utilization

1 **Aging population**

13% vs. 21%

Percentage of population over the age of 65, 2010 vs. 2030

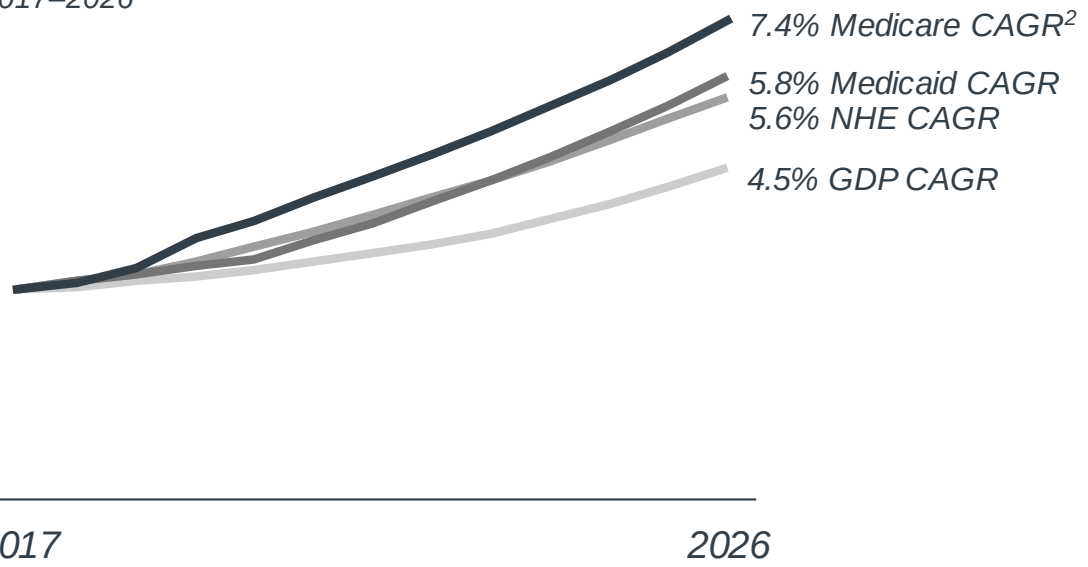
2 **High incidence of chronic disease**

42%

Percentage of population with more than one chronic condition

Projected growth GDP, national health expenditures (NHE), Medicare, Medicaid, commercial

2017–2026

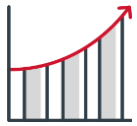


Source: "Chronic Conditions in America: Price and Prevalence," RAND, July 12, 2017, available at https://www.rand.org/blog/rand-review/2017/07/chronic-conditions-in-america-price-and-prevalence.html; "NHE Fact Sheet," Centers for Medicare and Medicaid Services, available at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html.

1. Gross domestic product.
2. Compound annual growth rate.

Fee-for-service world contributes to growing costs

FFS' role in inefficient care



Overutilization of services

FFS encourages providers to boost the volume of services that a patient receives, rather than focus on appropriate, value-focused care.

Fragmented, uncoordinated care

FFS fails to emphasize or incentivize streamlined communication between providers across the care continuum.

KEY DEFINITION

Fee for service – a payment method through which physicians and other health care providers are paid for each service (like tests and office visits) performed.

Source: HealthCare.gov; "86% of physicians are still paid under fee-for-service payment model", Modern Healthcare, October 2016, available at: https://www.beckersasc.com/asc-coding-billing-and-collections/86-of-physicians-are-still-paid-under-fee-for-service-payment-model-5-takeaways.html.

CMS, CMMI look to payment innovation to slow cost growth

Federal agencies focus on improving quality, managing total health care spend

Centers for Medicare and Medicaid Services (CMS)

U.S. government agency under HHS[1]

Sets regulatory agendas and payment policies

Provides coverage for nearly 100 million Americans

Center for Medicare and Medicaid Innovation (CMMI)

Center within CMS, created by the ACA[2]

Develops and tests new payment and service delivery models

Aims to improve care quality, lower costs, and push providers towards value-based care

1. Department of Health and Human Services
2. Affordable Care Act

How will Covid-19 impact the future of Value-Based Care?

Advisory Board interviews and analysis.

Efforts likely to slow short-term as payers provide flexibility

Potential moves payers could deploy to mitigate COVID's impact on risk-based contracts

Government payers

- Extend deadlines
- Reduce reporting burden by moving to pay-for-reporting instead of P4P[1]
- Ignore 2020 performance when calculating benchmark for 2021
- Exclude COVID-related diagnoses[2]
- Waive mandate to move to downside risk for 2020 and likely 2021[3]
- Waive reporting requirements or penalties altogether for 2020

Private payers

- Extend 2020 performance period
- Exclude crisis period from performance evaluation
- Use previous year performance data when calculating 2020 payment
- Pause downside risk for 2020 and likely 2021
- Cap or reduce shared losses through risk corridors

Advisory Board insight

- Private payers will likely follow CMS' lead in reducing operational burdens and negative financial implications from value-based care contracts
- Provider organizations should proactively reach out to payers to discuss options in amending contracts
- Provider organizations should identify which flexibility option suits them best
- Both providers and payers should document amendments to 2020 contracts for legal purposes via email or meeting minutes

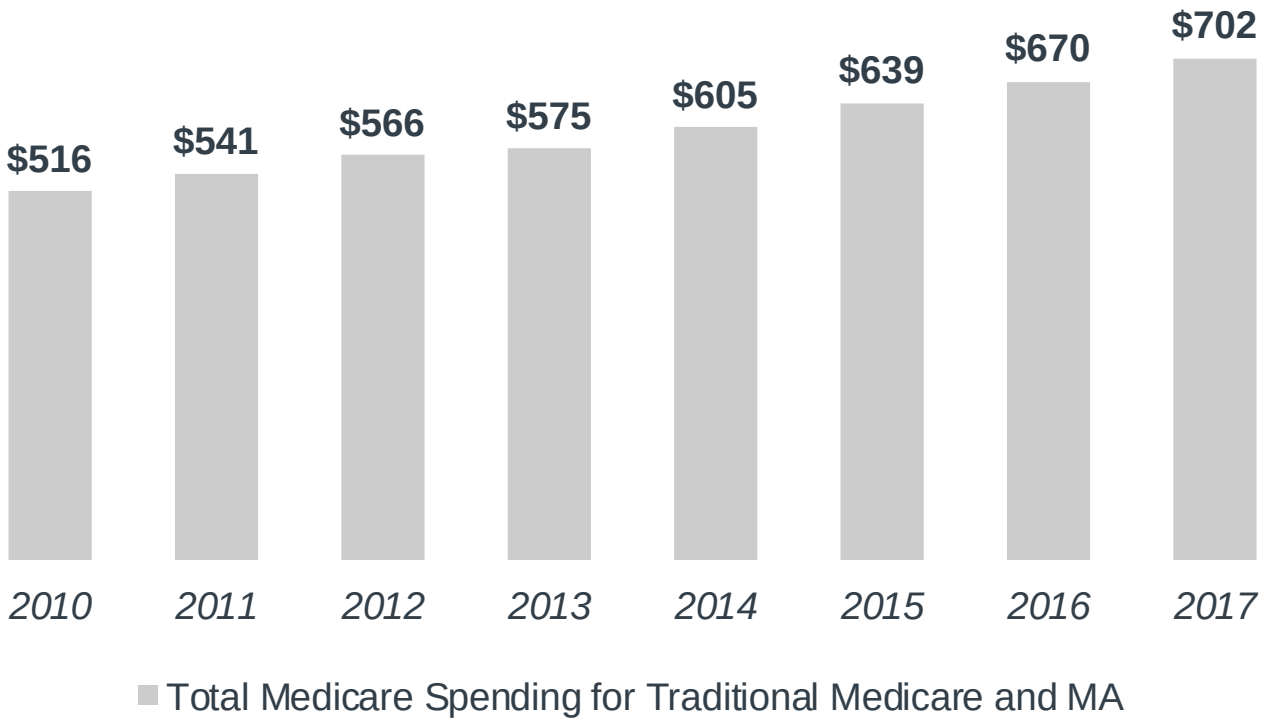
1. Pay-for-performance.
2. When calculating a provider's cost performance.
3. For Medicare Shared Savings Program ACOs scheduled to move to downside risk.

Advisory Board interviews and analysis.

Looming Medicare insolvency reveals need for reform

Medicare spending for traditional Medicare and MA[1] rising steadily

Expenditures in billions of dollars



DATA SPOTLIGHT

Medicare is on the road to insolvency

2024

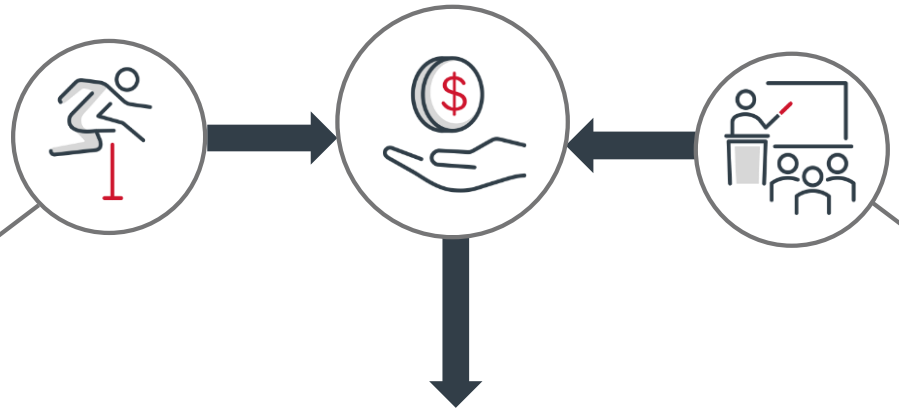
Declines in tax revenue due to Covid-19 accelerate projections of insolvency to 2024, up from previous projections of 2026

Source: "The Facts on Medicare Spending and Financing", Kaiser Family Foundation, June, 2018, https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing.

1. Medicare Advantage.

Will participation return as primary focus of VBC efforts…

Or will new administration continue Trump-era goal of improving performance?



Performance

- Mandatory models
- Downside risk for providers
- Favorable terms for providers most likely to generate savings
- Little cushion for providers unwilling or unable to make changes quickly
- **Ambition: Provable, near-term cost and quality improvements**

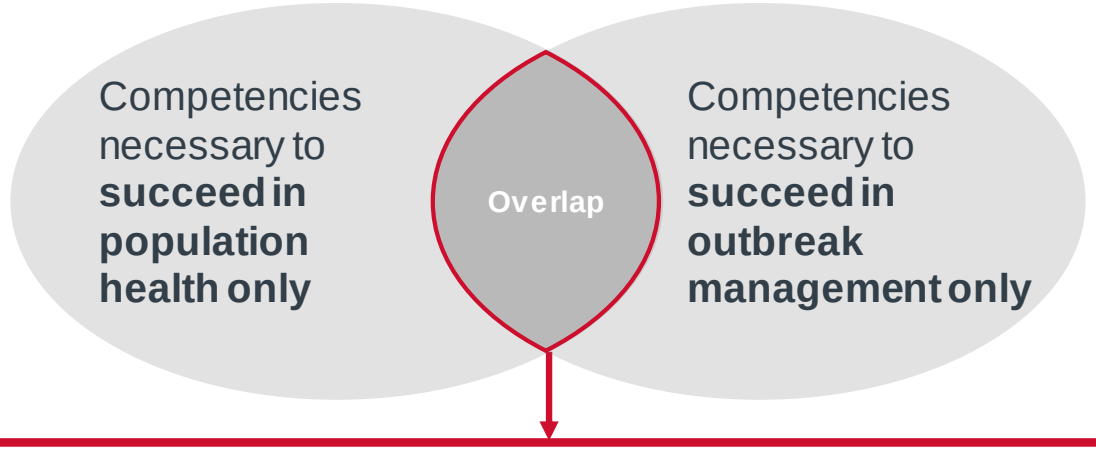
Advisory Board perspective:

- Medicare's migration to value goes on
- Programs created by CMS under both Obama and Trump (ACOs, specialty models, bundled payments, etc.) will continue to evolve
- Expect a hard look at Medicare Advantage plans—particularly coding and quality bonuses—to gauge appropriateness

Participation

- Voluntary models
- Upside-only risk
- Terms designed to attract wide range of participating providers
- Ample opportunity for providers to make and learn from mistakes
- **Ambition: Industry-wide transformation over time**

Significant overlap in PHM and Covid response capabilities



Competencies necessary to succeed in both

Analytics and interoperability

- Risk segmentation and analytics
- Identification of vulnerable populations
- Information sharing across partners

Chronic disease management

- Care management
- Disease prevention and education
- Provision of patient self-management support
- Incorporation of psychosocial needs to provide holistic care

Collaboration with partners

- Cooperative decision-making
- Hospital diversion techniques
- Consistent messaging across partners

Physician Executive Council interviews and analysis.

Paradoxically, Covid-19 increases provider interest in VBP

How will Covid-19 will affect the transition to value?

Set it back ⟷ **Accelerate the transition**

Organizations that haven't made significant investments in VBC or risk-based arrangements are **unlikely to want to shake things up now**

The **comfort of capitated or global payments** will be of greater interest to providers and payers when volumes are unpredictable

Advisory Board interviews and analysis.

Rumors of VBP's demise are greatly exaggerated

Covid-19 only amplifies forces driving value-based payment

Patients

- Population getting older and sicker
- Covid-19 exacerbates patient acuity with missed care, effects of social isolation on mental health, and consequences of the disease itself

Provider organizations

- Many health systems lost money in 2020
- Moved significant portions of business to lower-cost settings like telehealth or at-home
- Unsure if volumes will ever return to normal
- Desire payment certainty in an uncertain future

Regulators

- Believe in value-based payment
- Likely to seek increase in number of providers participating in value-based payment models
- Need to act to stabilize Medicare trust fund

Payers

- Concerned about major increase in utilization with more acute patients as volumes recover
- Prepared to use significant resources and influence in the short-term to advance agenda

Advisory Board interviews and analysis.

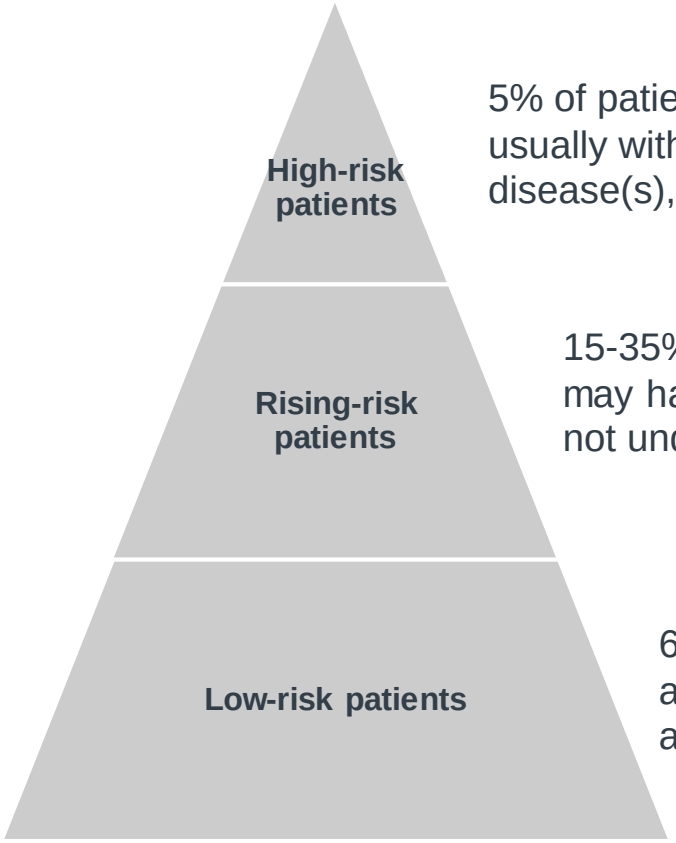
Messages to take: What is the future of value-based care?

- **The shift to value-based payment is surprisingly well underway**. Though most provider organizations are still driven mostly by fee-for-service, they are well on their "path to value."
- **And only likely to continue**. The ongoing effects of Covid-19 have provider organizations, payers, and the Biden administration all increasing their interest in value-based payment models.
- **Short-term decrease, long-term increase.** Some in the health care industry are concerned the Covid-19 pandemic will derail the industry shift to value-based payment. While a short-term stall is likely as provider organizations recover from the pandemic, it's likely the net result of the pandemic is an increase in the shift to value-based payment.

How to succeed at population health

Attained financial success from patient management

Managing three types of revenue streams



5% of patients; usually with complex disease(s), comorbidities → Trade high-cost services for low-cost management

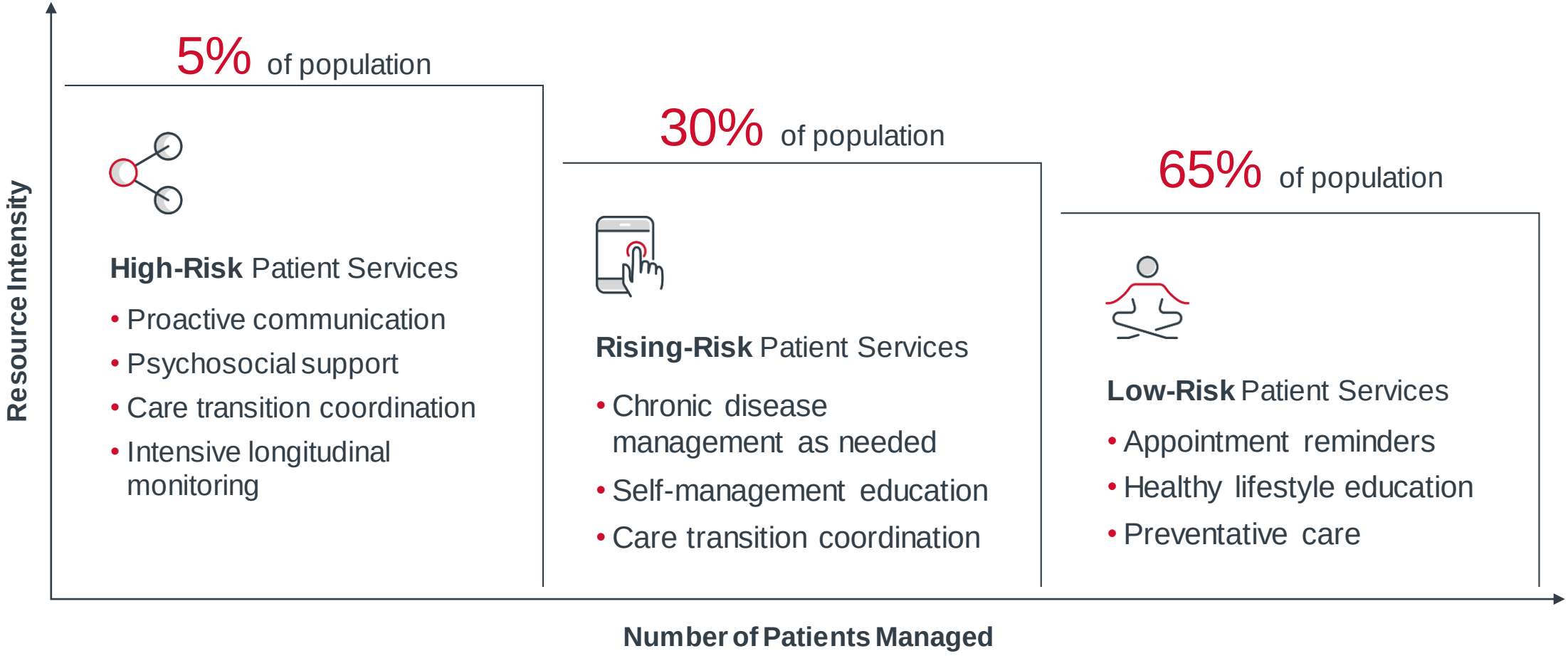
15-35% of patients; may have conditions not under control → Avoid unnecessary higher-acuity, higher-cost spending

60-80% of patients; any minor conditions are easily managed → Keep patient healthy, loyal to the system

Physician Executive Council interviews and analysis.

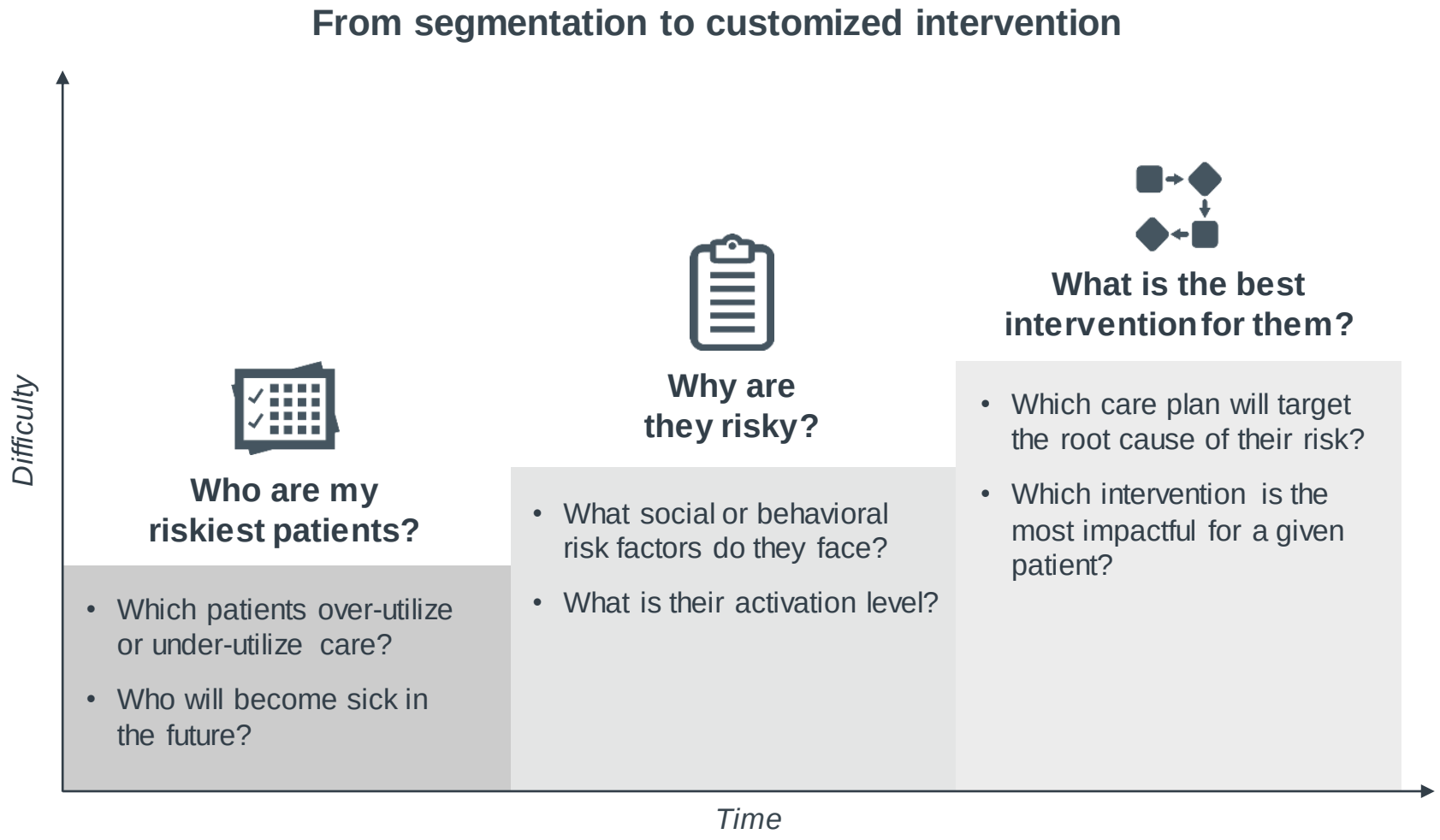
Care management not limited to high-risk populations

Tailor management to acuity level to achieve scale



Advisory Board interviews and analysis.

Analytics the foundation of patient prioritization



Physician Executive Council interviews and analysis.

Tailor ambulatory care plan by clinical, social needs

Vanguard's multidimensional assessment informs referral orders

Patient care planning process

Risk areas	Risk category
7+	Very high risk for health management
4-6	High-risk for health management
4-6	High-risk due to <30-day hospitalization
4-6	High-risk due to behavioral health issues
4-6	High-risk due to social frailty
1-3	Not considered high risk

1. Principal diagnosis of diabetes
2. Prior hospitalization

1. Principal diagnosis: diabetes
2. Prior hospitalization
3. **Poor health literacy**
4. **Limited patient support**

1. Principal diagnosis: diabetes
2. Problem medications
3. Polypharmacy
4. **Psychological needs**

Not high-risk

High-risk: social frailty
Sample intervention: geriatrician/NP home visits

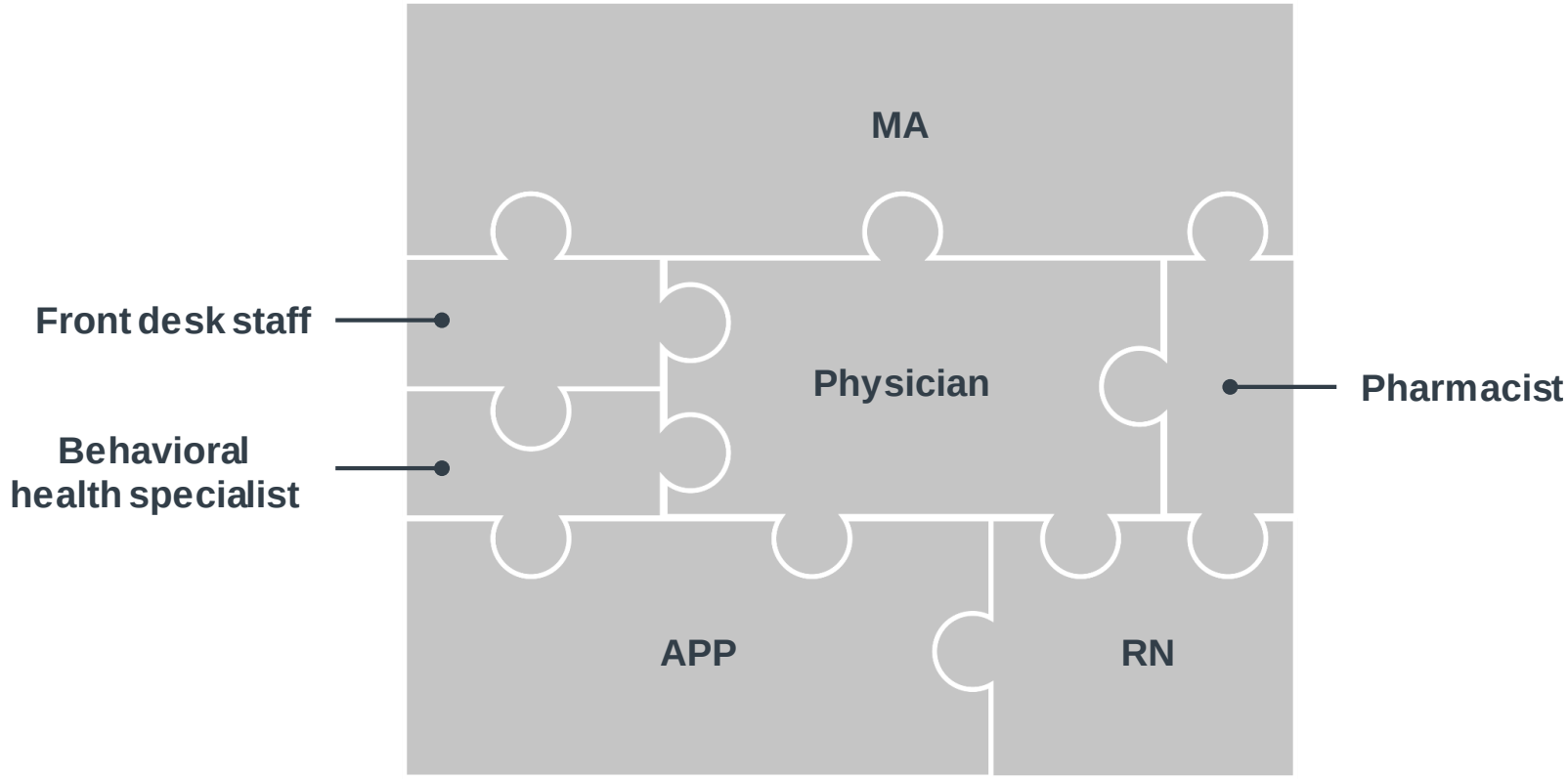
High-risk: behavioral health
Sample intervention: referral to behavioral health

Physician Executive Council interviews and analysis.

Need for comprehensive approach to the care team

Evaluate all roles at once to ensure team works in tandem, at top-of-license

Solution: Holistic care team redesign and collaboration



Advisory Board interviews and analysis.

Rank specialists to streamline referral decisions

Marbury Medical Group[1] uses algorithm to create personalized referral list

1 Physician determines referral need and identifies appropriate specialty

2 Referral algorithm scores physicians on seven metrics

3 Tool creates ranked list, prioritizing patient and physician preference

4 Referral management specialist schedules appointment using list

Referral metrics

- Patient preference
- Physician preference
- Patient insurance
- Time to appointment
- Likelihood physician will refer back to Marbury
- Quality
- Cost

Physician rankings

1. Physician A
2. Physician B
3. Physician C

DATA SPOTLIGHT

150K Reduction in annual calls made by clinical staff

1. Pseudonym.
2. Referral management specialist.

Source: "Seven Steps to Reducing Referral Leakage in Your Medical Group," Advisory Board Medical Group Strategy Council, 2019.

Value-based organizations consider ranking by cost

Privia Health drives performance with customized database

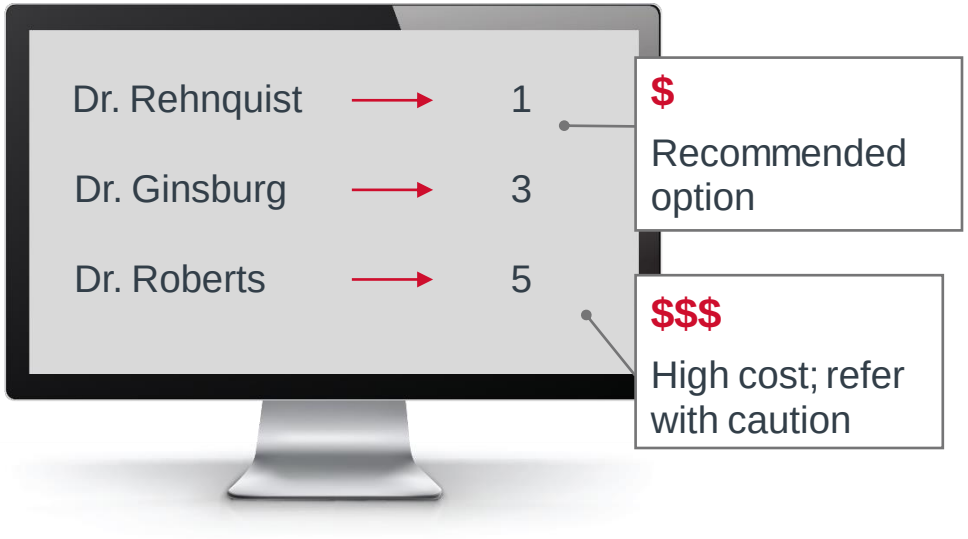
Privia's development process

Created a preferred specialist partner list based primarily on physician recommendations

Prioritized top five[1] specialties for referral volumes; collected raw data from payers

Compiled and analyzed payer data; assigned physicians cost score of 1 to 5; embedded score in Athena EHR for quick access

Specialists ranked by cost in EHR



1. Cardiology, gastroenterology, orthopedics, ophthalmology, and dermatology.

Taking a more strategic view on physician loyalty

Mount Sinai flips historical definition of physician loyalty on its head

Six best surgeons chosen for COE program

Health system contracts with local union, 32BJ

System selects six highest-quality surgeons

Surgeons follow standardized care pathway, deliver **$12,000 savings** per case to employer

10% » 60%

Shift in market share for lower-extremity joint replacements

> "In the past, we were always reliant on surgeons to bring cases to the system. Now, the system is also bringing cases to the physicians."
>
> —Niyum Gandhi
> Chief Population Health Officer, Mount Sinai

Assess your strategic ambition with organizational realities

	Keeping pace	Ahead of the curve	Leading the market
1) Where can we improve organization-wide **care management?**	• Tiered support based on patient risk focused in 30 days post-discharge • Ongoing disease education to equip patients to self-manage • Effective coordination across care team	• Care managers build a trusting relationship, assist with complex social needs, and find patient-centered solutions to behavior change • Customized care plans used by all members of care team	• Duration of patient management extends longitudinally in ambulatory setting and transitions to lower level of support when appropriate • Patient encounters include a mix of at-home, in-clinic, phone, and web-based visits • Web-based support tools available to reinforce health education and address one-off questions
2) Where can we profitably push services to **virtual channels?**	• On-demand replacement for virtual care • Synchronous video visits • Email communication with patients	• Asynchronous visits • Planned chronic care visits • Standard criteria for determining which visits should be virtual	• AI-backed asynchronous visit (SmartExam, chat bot, etc.) • Remote patient monitoring for high-cost chronic conditions
3) How can my organization support the **rising behavioral health (BH) needs** of the community?	• Universal BH screening • Defined process for referrals to BH specialist	• Integration of BH providers in primary care • Self-management support app with education and self-care tools	• Proactive identification of patients who will benefit from BH support based on risk stratification • Peer support program • Self-management support app with easy access to care team
4) Where can my organization support the **root causes of health inequity?**	• SDOH screening • Defined process for referrals to community-based organizations	• Psychosocial care navigation • Robust partnerships for prevalent social needs • Proactive outreach to at-risk regions and disengaged communities	• Broad community-led coalition centered on structural root causes: poverty and structural inequities • Staff embrace cultural competency and humility

Physician Executive Council interviews and analysis.

Messages to take: How to succeed at population health

- **Analytics the foundation of successful population health.** While getting actionable, timely data is difficult, the ability to segment patients by level of risk is the most important capability for any organization to be successful under risk. If there is a place where an executive should over invest their resources, this is it.
- **Care models must evolve.** Success under value-based payment fundamentally means segmenting the patient population and providing varying levels of service based on patient risk. This requires doing some things differently for some patients. Medical groups can't take a one-size-fits-all approach. And they must evolve their care model as care advances and contracts change.
- **Telehealth is here to stay.** And this is great for provider organizations' population health efforts IF they continue to evolve and improve their virtual care offerings. If you don't do a good job, someone else will.
- **Behavioral health is the new must have.** The pandemic only exacerbates the demand for behavioral health services even outside the traditional bounds of population health. Using tele-behavioral health and establishing clear paths from the physician to the behavioral health specialists are now non-negotiable.
- **Social determinants of health a new but promising frontier.** Though new for many provider organizations, addressing health equity is one of the most impactful population health initiatives you can take. The good news is provider organizations have places they can start and build from as they drive community impact at scale.

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