Humana

ISSUE BRIEF

Assembling the Missing Pieces to Achieve Success in Value-Based Care

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INTRODUCTION

The transition away from fee-for-service reimbursement is accelerating as providers, payers, and policymakers start to realign care delivery around principles of increased value, better outcomes, and better experiences.

Value-based care arrangements are becoming increasingly common. In 2017, 59 percent of all healthcare payments from public and private payers flowed through some sort of arrangement linked to quality and value, according to the Health Care Payment Learning & Action Network. This represents a significant shift over a relatively short period of time considering that less than 40 percent of payments were paid through value-based mechanisms as recently as 2015.

The speed with which the industry has embraced novel payment models is encouraging, and optimism is generally high that the resulting changes to care delivery will bear fruit for patients, providers, and entities taking on the responsibility of paying for care.

However, these innovative payment structures are creating new challenges for healthcare providers—and along with changing expectations often comes friction between key stakeholders. Misaligned incentives, inconsistent methodologies for measuring quality, cultural resistance from staff members, and significant gaps in evidence around the impact of changing care strategies are leaving some organizations questioning whether their investments will truly bring financial and clinical value.

At the 3rd Annual Value-Based Care Summit hosted by Xtelligent Healthcare Media, Humana convened a group of forward-thinking industry leaders to discuss the obstacles, opportunities, and gaps in research surrounding value-based care. "Our goal was to listen carefully to understand how Humana can remove barriers and make it easier to transition to value-based care while improving patient outcomes," said Worthe S. Holt, MD, vice president, Humana.

The group of clinical executives, quality improvement experts, physicians and other advanced practitioners and population health management directors identified several main obstacles affecting their ability to transition smoothly to value-based care. Additionally, these healthcare leaders offered a number of solutions to some of the most pressing questions facing healthcare.

Success with value-based care at scale will depend on enacting meaningful sustainable behavior change across the entire care continuum, they agreed. In order to drive change, the industry must re-examine its existing relationships and develop evidence-based strategies for collaborating more effectively to produce tangible, positive results.

EXPLORING THE COMPLEXITIES OF AN ECOSYSTEM IN FLUX

Value-based care requires healthcare providers and payers to make significant changes to the way they operate and communicate. An outcomes-based approach also requires the realignment of policies and contracts with these new methods for delivering care.

As stakeholders work to overhaul the healthcare system, they are finding that solving fundamentally complex problems of culture, finances, and technology will take strong commitment and unwavering determination from all parties involved.

Misaligned incentives leave providers feeling unable to engage in proactive patient management

The financial stresses of moving away from the fee-for-service environment were evident among participants, most of whom hailed from organizations that have one foot on either side of the value-based reimbursement divide. The fragmentation of payment models that comes from being in the process of transitioning from one form of reimbursement to the next brings with it added frustration for physicians.

"Doctors are just confused right now. Everyone is confused," said a primary care physician focused on delivering care for complex patients. "This patient here is billed one way; this one here is billed in another. That brings a lot of mixed messages and administrative burden that is actively causing cognitive exhaustion and burnout."

Financial misalignment between hospitals and physicians contributes to the atmosphere of fragmentation, added the chief medical officer of a community-based independent physician association (IPA).

Many hospitals are finding it difficult to leave their fee-for-service models behind because of the very nature of acute, inpatient care. As a result, their financial motivations are misaligned with what physicians are being asked to accomplish.

"It's a little better in accountable care organizations (ACOs) with a hospital participating, but not everyone is in that situation," he said. "Alignment hasn't been driven down through the whole system yet, and that puts both the hospitals and the physicians in a very difficult position."

Providers also feel pressure when expectations are higher than reimbursement rates, said a physician and population health director from a regional nonprofit hospital.

"We're being asked to stake our income on measures related to patient behaviors, like keeping A1C under control, but we don't get paid adequately for the time and effort we put into providing the services and education that can change those behaviors," he said. "We know that intensive behavioral therapy can have benefits for the treatment of obesity, for example, but that's not a covered service in a lot of contracts. How are we supposed to help our diabetic patients lose weight if we're not getting paid?"

Payers may not be moving quickly enough to offer adequate supplementary payments that cover patient education and complementary services such as consults with nutritionists,

social workers, care managers, and community service organizations, agreed several of the participants.

"Payers are in the position to change that, but not all of them are listening to what providers are asking for," the population health director said. "Yet they're still demanding results and holding us financially accountable for not delivering on very high criteria."

Overall, providers believe payers to be responsible for mismatched incentives and care management payments they feel are too low to make a difference.

"The insurance companies are holding the purse strings, and they have the power to influence the system to change," said the complex care physician. "We know what we need to accomplish as providers. Most of the time, we know how to accomplish it, too. But if we're not implementing everything we should, that's often because the payers aren't compensating us adequately for it."

Payers, however, have a somewhat different perspective on the situation. While more and more revenue is moving through models tied to quality and outcomes, relatively few of these arrangements require participants to shoulder any significant downside risk.

Additionally, in some cases, payers require policy changes that allow them to fully reimburse for additional services, such as those meant to address social determinants of health. Only 12.5 percent of healthcare spending was in downside risk models in 2017, the Health Care Payment Learning & Action Network observed in its analysis.

The rewards when providers put revenue at risk can be greater, and they may be high enough to cover the investment necessary to fund enhanced patient management. Medicare Shared Savings Program (MSSP) ACOs that only accepted upside risk in 2016 denied themselves access to nearly a billion dollars in potential shared savings tied to reimbursement models with downside risk, according to an Avalere analysis in January 2018. Assuming more risk could also qualify organizations as Advanced Alternative Payment Models (Advanced APMs) under the Quality Payment Program, adding a five-percent bonus to their incentive payments under the regulatory framework, CMS says.

Yet clinicians are extremely averse to committing to downside risk, despite urging from commercial payers and recent warnings from CMS that downside risk will increasingly be required in the Medicare value-based care environment.

A recent survey from the National Association of ACOs (NAACOS) found that nearly three-quarters of MSSP ACOs would rather quit the program than assume downside risk, raising doubts about their stated commitment to traveling the path of value-based care. Reducing misalignment will likely require providers to engage more consistently in downside risk at the same time as payers examine how to best offer robust payments for population health management activities.

"Until the real risk equation is changed, and every provider is truly responsible for what he or she is doing, we are not going to achieve our goals," stressed the executive from an IPA. "The first step will be taking on full responsibility—without that motivation, very little is going to change."

THE MISSING PIECES

The industry is in search of more evidence that stakeholders are moving in the right direction. Part of the challenge of generating reliable data is defining the right questions. Through original research and numerous partnerships, Humana is committed to helping inform the next steps toward value-based care. Throughout this roundtable discussion, participants raised new questions that will require answers in order to move forward effectively.

- Does accepting downside risk support meaningful change in provider organizations? If so, how can the industry collaborate to apply downside risk structures most effectively?
- Can reducing payment uncertainty through physician employment or stop-loss mechanisms in value-based contracts reduce concerns about treatment choices for patients with different insurance?
- Could changes to physician-centered billing enhance the use of care teams and encourage the delivery of coordinated, patient-centered care?

Lack of consensus around quality measures stymies establishing shared goals and strategies

The quality measurement landscape is, perhaps, even more fragmented than the financial one. Providers are feeling overwhelmed by thousands of quality measures to choose from and numerous independent organizations attempting to validate, endorse, and promote differing subsets of these measures.

"There is very little alignment between payers in terms of what measures they are using and how they are defining those measures," said one physician executive. "It's especially tough for organizations with populations fairly evenly split between payers."

"They are getting different instructions for each different contract, and it's hard to correctly collect and report on the right data. Workflows are becoming so convoluted that a lot of them just revert to what they were doing before in an effort to reduce the stress."

For the population health director, a lack of controlled, trustworthy evidence connecting processes with outcomes makes it challenging to convince providers that reporting on quality measures is actively contributing to better health for patients.

"Quality measures don't actually tell us whether value-based payments improve outcomes," he asserted. "We're just assuming that there's a correlation between a lab result and a utilization rate, and the utilization rate and the outcome, but we haven't studied this with our patients and our providers and our underlying socioeconomic environment."

"A lot of the measures that we're being asked to report on are based on guesswork that sort of seems right," he continued. "That's not really adequate anymore."

The quality measurement landscape is also missing the patient perspective, said a senior quality improvement advisor from a state-level innovation center. Patient-reported outcomes measures are few and far between. What's more, they may not adequately capture data on key factors that contribute to better outcomes.

"There is a lack of awareness about the capacity of patients, especially those with multiple chronic conditions," she said. "We need them to get all their screenings and tests regularly so we can do well on our quality measures, but what is the quality of that experience for them? What are we asking them to change about their lives, or add to their lives? How are our behaviors impacting them? Those questions should be part of how we measure our performance."

Reducing the burdens of quality measurement is a high priority for payers, many of whom are participating in industry workgroups to create more consensus around defining and measuring performance.

Aligning quality measures across disparate payers and varying contracts will be crucial for streamlining workflows, creating meaningful data to analyze, and accurately gauging the value generated by innovative care delivery strategies.

"Our work in Kentucky to develop an agreed set of quality healthcare measurement priorities through a transformational public-private partnership between the Kentucky Department for Medicaid Services, within the Cabinet for Health and Family Services and the Kentuckiana Health Collaborative is a start," shared Misty Roberts, associate vice president, clinical quality officer of Humana. "But, now the challenge will be to align healthcare organizations around this shared focus, leveraging these measures to drive better health outcomes. This is a microcosm for what we all need to do together at a national level."

THE MISSING PIECES

- Can existing data systems and quality metrics incorporate more patient-reported outcomes such as functional status and health-related quality of life?
- How can providers and payers better leverage quality measurement to understand the relationships between processes, costs, experiences, and outcomes?
- How can payers engage with federal, state, and local stakeholders to build consensus-based quality metrics that target the health needs of specific communities?

The disconnect between the health system's expectations and patient behaviors is creating friction

Managing individuals more proactively and holistically through population health management strategies is an essential component of success in value-based care. However, providers often struggle to effect lasting behavior changes in high-risk populations.

Concerns about being held accountable for behaviors outside of the clinical care provider's direct control are not new, but the problems of generating truly effective patient engagement remain unsolved.

Attendees of the roundtable session are keenly aware of the importance of addressing the social determinants of health (SDOHs) and developing more robust and lasting relationships with patients. But they also feel as if they are lacking the strategies, time, and data that will allow them to assist patients with the social, economic, cultural, and educational factors that influence outcomes.

Chronic diseases are incredibly common among individuals of all ages, backgrounds, and economic statuses, but some groups have been affected particularly strongly by diabetes, obesity, heart disease, asthma, and chronic kidney disease.

"Most of the chronic diseases we are treating are really social diseases," said a physician participant. "These problems started a lot time ago, and society has a lot to do before we solve them. In the meantime, for those already afflicted with diseases that society has wrought upon them, what can we do? How can we help them change when their circumstances aren't changing fast enough to support them?"

More affordable prescriptions will play an important part in reducing risks associated with chronic disease, he continued. Increased insurance coverage for patient education and chronic disease management classes will also be vital to equipping individuals with the skills necessary for effective self-care.

Other attendees suggested that the ability to write prescriptions for healthy foods could help change dietary choices, while non-traditional strategies such as subsidizing the purchase of air conditioners for asthma patients could reduce ED utilization and hospitalizations during times of poor air quality.

Without the ability to manage these non-clinical factors, patients already struggling to make ends meet will continue to be unable to prioritize healthy lifestyle choices. Alongside the efforts of payers and providers to take a holistic approach to patient care, they must work to inform policymakers on reforms necessary to helping address these non-clinical health factors.

"Social determinants are 90 percent of the problems I see in my patients," added a director of care management at a clinically integrated network serving both rural and urban regions.

"They might have health insurance coverage, but because they are purchasing insurance, they're not paying for something else. They're not paying for food, or a car, or their utilities. We can talk all we want about how horrible it is for them to get fast food for dinner, but if that's what's available and cheap, that's what they're going to eat."

Most patients would prefer to interact with the healthcare system as little as possible and wish to be healthy and low-cost, said the senior quality improvement advisor.

While the instinct to get frustrated with patients who fail to achieve these goals is natural, blaming unhealthy behaviors on willfulness or ignorance likely fails to account for mitigating circumstances in the daily lives of patients.

"We simply don't have a good enough handle on what drives patient behaviors," she said. "And we don't have a standardized way to capture data on these factors, either. Maybe the person has three jobs, and McDonald's is the only place open at 3AM when they get off their last shift."

"We're just not clued into that on the level that we need to be, but we still expect everyone to be eating kale and quinoa and getting to the gym three times a week. Until we change some of our attitudes towards patients and our expectations for activation and ability to self-manage, we're not going to see the results we're looking for."

Identifying individuals with complex socioeconomic needs will require innovative solutions from across the industry, noted Dr. Holt.

"The first step with social determinants of health is to figure out which patients are struggling with these barriers to health," he said. "The United States Department of Agriculture (USDA) and University of California in Los Angeles (UCLA) have simple screens to identify food insecurity and loneliness, respectively. But once you know you have a patient with one of these barriers, then what do you do? Providing accessible, effective resources to patients is a real challenge."

THE MISSING PIECES

- How can the health system quantify the impact of the social determinants of health on adherence, spending, and utilization choices?
- How do mental health issues such as depression and anxiety influence patient behaviors, and how can providers address these conditions effectively?
- What are the key components of patient engagement and education that produce lasting behavior change?
- What financial support is required to ensure that providers can take an active role in addressing the social determinants of health?
- How can providers and payers work effectively with community service organizations, public health, schools, faith-based organizations, and other groups to bring positive change to communities?

Evidence about the effectiveness and long-term impact of value-based care is still missing

Clinicians are trained to use the best available evidence to support their decision-making, and they take the use of high-quality data seriously when evaluating new therapies or diagnosing diseases.

However, evidence-based guidelines are still being developed for value-based care. Many providers believe they are being asked to act on theories that have not yet been proven, which leads to uncertainty and reluctance, said one director of care management.

"Many physicians are on the fence about value-based care because they want proven, tried-and-true pathways to make sure they can hit their targets," she said. "They want to know that if they do ABC with this type of patient, it will produce XYZ result. Right now, there's no pathway to follow. That's creating a lot of skepticism."

Randomized controlled trials (the gold standard for scientific research) are difficult to conduct quickly and efficiently—especially in the realm of population health where the sheer number and complexity of the variables can prevent researchers from uncovering clear answers.

"We aren't sure about the parameters for studies," said the medical director of value-based care from the large academic health system. "And we don't have clear criteria for success."

"That's not to mention the fact that every organization is serving a different population. How could we apply those findings to patients in Texas, New York, California, and North Dakota when the circumstances and resources are so different across the country?"

Lag time is another concern, said the complex care physician.

"One of the big problems with really good, controlled research is that you can't ask the questions that you want to answer today. You can only ask questions that you want to answer in seven years," she noted.

"By the time you actually do the trial and analyze the data, you're looking at a five- to seven-year delay, and the data might not even be relevant anymore. How are we supposed to cope with the speed at which value-based care is coming when we simply won't have the data we need for another half a decade?"

Slow-moving academic research requires patience, which is not always an attribute common in executive leaders, especially those with financial pressures to manage, added another attendee.

"We don't know how to convince our leaders that we have to think of ROI in a longer-term manner," she said. "They want to see results in six months, because they are accountable to shareholders, in many cases, or board members."

"But what kind of change can you really enact in six months? We need two, three, maybe five years to overcome inertia and implement real cultural and behavioral change. Unless our leadership is willing to invest in substantial, long-term efforts, we aren't going to be able to achieve the alignment we need."

Both public and private payers are in an optimal position to support actionable research into value-based care. With comprehensive visibility into claims data and increasing volumes of clinical data from provider electronic health records, payers can act as data hubs that track individuals across multiple health systems or settings of care. Partnering with academic medical centers and research institutions may help to close some of the distance between raw data and actionable insights.

Participants in the discussion were eager for more research into optimizing value-based care workflows, the relationship between process and outcomes measures, and the impact of community-based initiatives on patient behaviors and lifestyle change.

Payers, policymakers, and providers will need to work collaboratively across the care continuum to equip organizations with evidence that value-based care is an effective and impactful use of their time and resources.

"Partnering with academic centers and professional organizations to conduct peer-reviewed, relevant research for physicians and other healthcare stakeholders is critical," said Courtney Brown, PharmD, Humana. "We have valuable data we can share but we need partners to identify the most meaningful research questions that can inform and improve the delivery of healthcare."

THE MISSING PIECES

- How can stakeholders generate trustworthy, timely evidence that new protocols and strategies can produce positive change? Which organizations should take the lead?
- How can these pilots and studies integrate perspectives from across the patient, provider, and payer spectrum to create balanced benefits for all?
- How can stakeholders effectively share best practices with partners across the care continuum?

WHERE DO WE GO FROM HERE?

The questions around value-based care might appear to outnumber the answers, but organizations still have plentiful opportunities to take advantage of lessons learned from their partners and peers.

Creating coordinated, highly effective, and measurable strategies to improve outcomes and achieve financial sustainability under value-based care models will require changes in behavior, outlook, and operations for all stakeholders.

"Culture is always going to come first," said the senior quality improvement advisor. "That's the basis for everything. And naturally, it's one of the hardest things to do because every single organization is going to be unique in its makeup."

Transparency and communication between all groups will be essential for reducing any lingering tensions stemming from traditional business roles or competing incentives.

"In places where the financial friction has been eliminated—I'm thinking about organizations where the incentives are aligned because they are both a payer and a provider—we can see that value-based care does work," said the medical director from a regional hospital.

"I'm not saying everyone has to become a large, integrated, payer-provider network by any means. But we can take some lessons from entities that have been very intentionally designed to streamline the clinical delivery of care, the payment for that care, and the role of the patient within that process."

Creating unified cultures by carefully calibrating financial and clinical processes and effectively educating providers about their changing responsibilities can support the development of a new value-based approach to care.

Organizations can also work with community organizations, professional societies, non-profit associations, academic entities, payers, and fellow providers to reengineer care teams, offer patient education, or rise to the challenge of developing new financial strategies.

"There's work that needs to be done from top to bottom," said the CEO of a rehabilitation hospital. "And it has to happen across all groups. What if I got all the data I actually need from the inpatient provider and the PCP when a patient comes to rehab? What if I didn't have to enlist a whole army of case managers to chase people down to get an order for home health? And what if, as a result, the patient received better care, didn't end up back in the hospital, didn't cause a readmissions penalty, and didn't cost the payer additional money in claims?"

"Everyone benefits from that kind of collaboration. There is no downside," she stressed. "But we are all aware that it is going to take a lot of work."

Attendees of the roundtable identified several high-priority areas to address within their own organizations, including:

- Integrating the patient voice into the process of designing and executing interventions
- Partnering with community groups to address the social determinants of health
- Using internal resources to appropriately create efficient care teams
- Actively deploying pilots and programs that will generate evidence for future investment
- Taking a measured, considered approach to developing their value-based care contracts
- Leveraging data analytics to target services more appropriately
- Expanding chronic disease management programs to include pharmacists, nutritionists, and other providers
- Shifting the burdens of financial decision-making off the shoulders of physicians
- Streamlining quality reporting to improve workflows and generate meaningful data

Key takeaways for healthcare stakeholders

No single party bears all the responsibility of making value-based care a success. Embracing new payment models, new processes, and new relationships requires concerted effort from every entity involved in the delivery, payment, and receipt of care.

Payers, policymakers, providers, and patients can all contribute to improving the status quo by making positive changes in their own areas of operation.

For payers, moving more quickly to align financial incentives with performance requirements could offer more support to provider groups looking to advance into the innovative

payment model environment. Communicating more clearly and consistently with providers about expectations, measures, and potential rewards may also help to reduce confusion and generate enthusiasm for value-based care.

Payers will need to continue developing strategies to offer additional support for clinicians to help them with educating their patients about changing responsibilities and the importance of engagement. With significant financial clout and broad visibility into critical data sets, payers are in a strong position to keep accelerating the transition away from fee-for-service reimbursement.

Clinical leaders will need to play their part by focusing on creating cultures of continuous improvement.

Executive leaders will be key for setting the tone for behavior change and ensuring that new processes and strategies are filtering through the organization appropriately.

Setting high expectations for clinicians, while being mindful of the cognitive and administrative burdens that may accompany change, will be a demanding task for most organizations. But without strong buy-in and a greater acceptance of potential risks, providers may find themselves leaving financial opportunities on the table.

For policymakers and regulators, balancing the needs of providers and payers to create equitable, profitable structures for both parties may prove challenging. Acting as conveners and integrating perspectives from all points along the care continuum will be essential to developing effective industry guidelines.

Patients are the last piece of the puzzle, but by no means the least. Clinicians and payers will both need to continue investing in education and engagement tools to help create savvy consumers with the knowledge and activation to keep costs low and meet their self-management responsibilities.

Patients will also need to take a more proactive role in communicating with their providers, especially around the barriers and obstacles likely preventing them from making healthy choices or utilizing care appropriately.

Without actionable information and continuous engagement from patients, clinicians and payers will not be able to deliver the right services at the right time to the right individuals.

Assembling all these components into a seamless, high-functioning ecosystem of quality care will require every entity to be flexible, transparent, communicative, and willing to accept a certain degree of risk. In order to create lower costs and better outcomes, the healthcare industry as a whole will need to realign around the principles of evidence-driven, person-centered, and value-based care.

“This interaction clearly demonstrates the continued and extensive friction points that create challenges for us all in value-based care. Most, if not all of these, can be effectively addressed with a healthcare industry working collaboratively as we move forward,” concluded Holt.

ABOUT HUMANA

Humana

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To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools—such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions—combine to produce a simplified experience that makes health care easier to navigate and more effective.