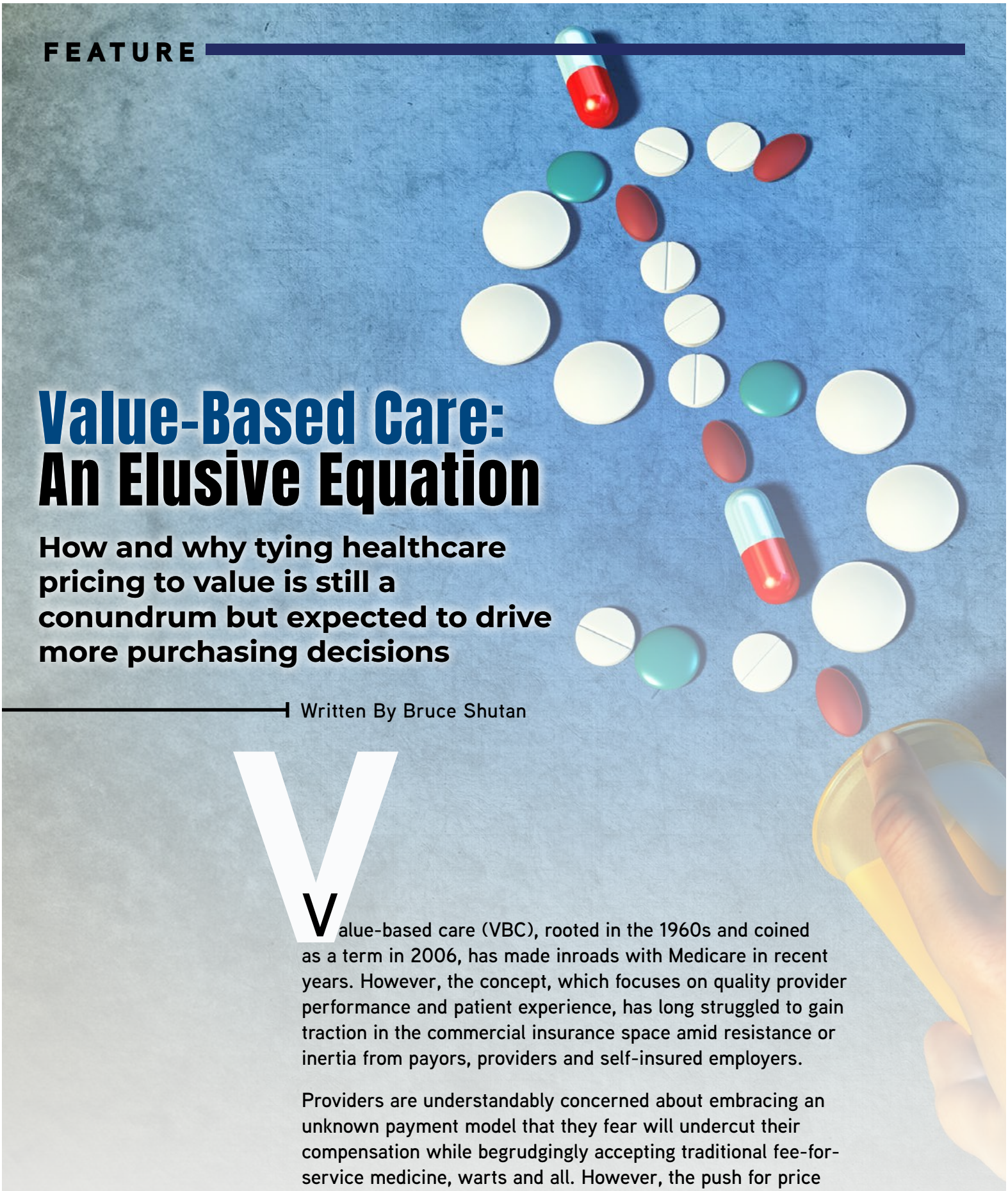

Value-Based Care: An Elusive Equation

How and why tying healthcare pricing to value is still a conundrum but expected to drive more purchasing decisions

Written By Bruce Shutan

Value-based care (VBC), rooted in the 1960s and coined as a term in 2006, has made inroads with Medicare in recent years. However, the concept, which focuses on quality provider performance and patient experience, has long struggled to gain traction in the commercial insurance space amid resistance or inertia from payors, providers and self-insured employers.

Providers are understandably concerned about embracing an unknown payment model that they fear will undercut their compensation while begrudgingly accepting traditional fee-for-service medicine, warts and all. However, the push for price transparency and more aggressive steerage to high-quality providers in an increasingly data-driven marketplace has


Robert Gelb, CEO

industry observers hoping for greater adoption. The writing is on the wall, and pressure to rethink healthcare purchasing is mounting.

Robert Gelb, CEO of Vālenz, compares the plight of VBC to reference-based pricing, which has long sought a fair market rate for services provided that was something other than 3,000% of Medicare. How it relates is that VBC is perceived as an Accountable Care Organization (ACO)-driven upside-downside risk wherein providers agree to take on risk as they seek to achieve the best possible outcomes.

FACING MULTIPLE OBSTACLES

However, he cautions that this isn't the only way to look at the VBC model, noting that it's about ensuring appropriate cost and quality, as well as utilization of proper care. While that may involve securing a fixed rate from a provider with a high-quality rating as part of, say, a bundled surgical solution, he says the challenge is actually measuring quality when it can be a bit subjective.

There's also a steep uphill climb when demand for healthcare services exceeds supply because people are willing to pay more. "You're seeing more physicians leave and retire, and fewer come in," he notes. "You're seeing health systems fail."

Another area for improvement is marketplace clutter. VBC is showing that allowing multiple suppliers in the member's chain of custody creates inefficiency and a lag in the ability to make smarter, better, and faster healthcare decisions. "And so, I think point-solution fatigue is setting in with employers," he says, predicting the emergence of a fully integrated model with one supplier that leverages a full spectrum of data at every junction of care for each member.

"It doesn't have to be a traditional ACO-style approach to just get that for value-based care suppliers that have enabled world-class solutions in the seven to 10 different points you're buying from multiple suppliers," Gelb explains.

"You can buy it in one place and have it be seamless to the member journey and allow the plan to actively be involved in what's happening real-time with their members – something they're unable to do consistently today."

An inherent problem with for-profit medicine, of course, is that it's missing many of the anti-competitive guardrails found in other industries, says Julie Selesnick, senior counsel for Berger Montague. Also, the monopolistic and duopolistic markets that have emerged with the help of small but powerful groups with a vested interest in preserving the status quo make it exceedingly difficult to try anything new, "never mind an entirely new way of paying," she adds.

INFLUENCING PATIENT BEHAVIOR

Whenever Amanda Volner, sales director for Medefy Health, talks with consultants and executives about VBC, there's always hesitation rooted in concerns about member education and appropriate plan engagement. "Members don't know how to interact with this model," she says, adding that employers often don't see the arrangement starting to pay off until year two and possibly three.

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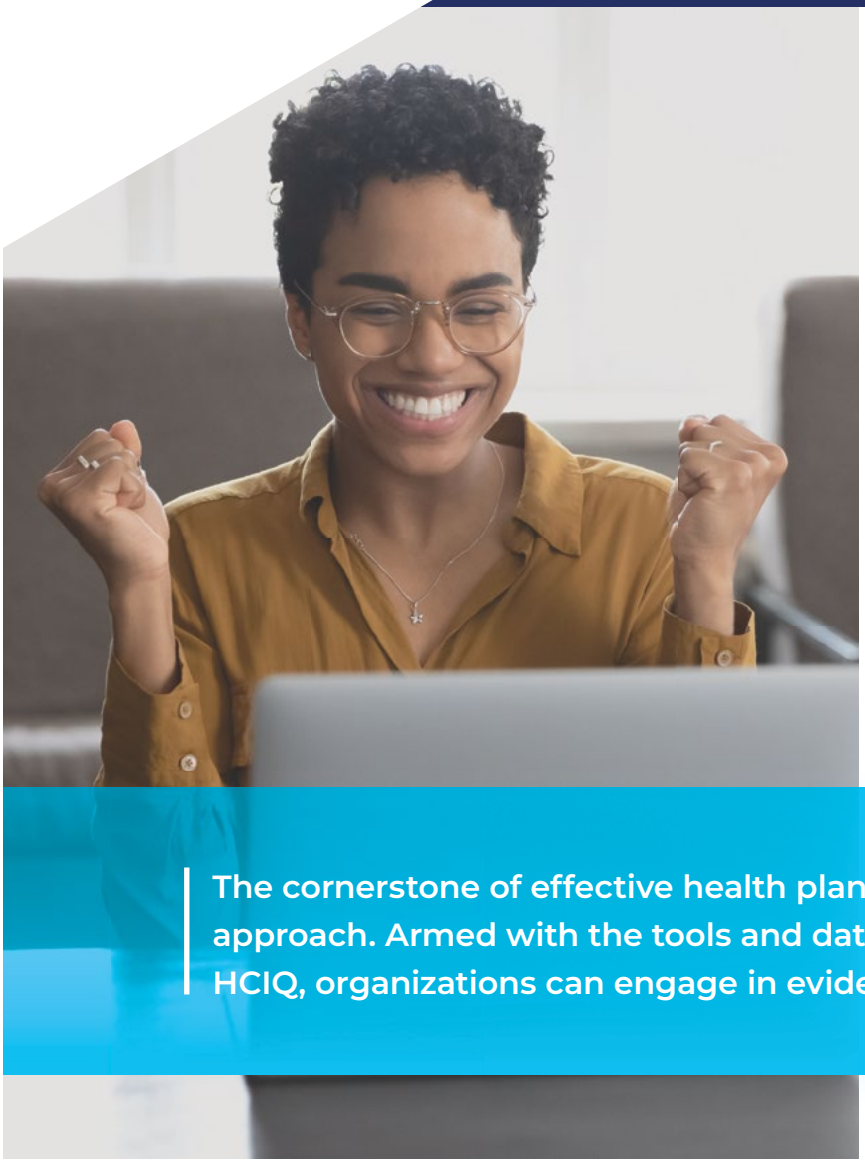

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Indeed, the one element providers cannot effectively control that places them at higher risk is patient behavior, explains Jeff Greene, CEO of MedEncentive. As a result, he says their mission-critical task is learning

Jeff Greene, CEO

"how to master the science and art of nudging people's behavior in a fashion that bends the overall cost curve as a result of improved population health."

Poor health is largely confined to individuals who engage in risky health behaviors for various reasons. Studies suggest that the single strongest determinant of a person's health status, life expectancy and cost is their health literacy score, not their health habits or genetics, he says. Given this backdrop, Green references a psychology called KIMA response, which stands for knowledge, impairment, motivation and adherence. "It teaches when people become knowledgeable, they become empowered, and when they become empowered, they're more motivated to be adherent," he notes.

He says providers must have confidence that their patients will do their part in order to comfortably take on risk and be open to VBC models. His message to providers who want to hop off the fee-for-service merry-go-round and take some risk or full capitation is to "look into reward-induced information therapy as a means to nudge your patients to a state of better health through self-care."

EXPERIMENTING WITH INCREMENTAL CHANGE

Convincing more providers to try VBC starts with education and a willingness to experiment with implemental change.

"It might not be realistic to expect plans to go from a fully fee-for-service model into some aspirational fully value-based model without any transition,"Selesnick suggests, noting that there could even be a mix of payment models to avoid massive disruption.

One approach could be to guarantee certain upfront payments to introduce an element of stability with additional amounts that increase or decrease depending on health outcomes. They also could dip their toe in the water with bundled payments for hip or knee surgery, study the results, and re-evaluate the next steps.

She senses that most providers would be willing to risk some profits for greater satisfaction with their profession in the face of physician shortages and burnout, as well as strike a better work-life balance. That could involve securing a predictable patient load. So instead of rushing through visits with 50 patients a day, for example, Selesnick says the upside is that they could get to know their patients on a deeper level, much like a subscription-based concierge medicine model featuring direct primary care.

When assessing whether to roll the dice on VBC, Gelb believes projected savings of 15% or greater is needed, "or CFOs just don't see value in making a change. That seems to be the low watermark." He adds that result would be meaningful with a healthcare spend that exceeds $1 million and enough for C-suite buy-in.

VBC features several components, including performance-based and shared-savings programs, bundled payments, and capitation models. Selesnick says the best models emphasize preventative care in managing chronic conditions and behavioral change, but they need to be fully embraced and implemented. While upfront costs are involved, evidence shows the investment pays off.

"Some self-contained value-based type systems are extremely successful and have cut costs in half," she reports. One example is the Southcentral Foundation's Nuka System of Care in Alaska, which describes itself as "a relationship-based, customer-owned approach to transforming healthcare, improving outcomes and reducing costs."

With health outcomes increasingly tied to costly specialty drugs that treat a myriad of serious and chronic conditions, the Rx space is expected to play a more significant role in shaping VBC. Two of the biggest opportunities for self-insured prescription drug plans will be in the diabetes and cardiometabolic space, opines Justin Jasniewski, CEO of Serve You Rx, a PBM.

"These disease states are common enough that almost every plan has some exposure, and the increasing popularity of GLP-1s like Ozempic and Wegovy highlight the need for tying payment to outcomes or value received," he says.

When ensuring proper use, adherence and monitoring of prescription drugs, Jasniewski notes that pharmacy benefit managers can tie value to outcomes by placing fees at risk contingent on measurable endpoints being met. The strategy is "an effective way for self-funded plans to minimize their risk while enhancing the benefits they offer," he adds.

FACTORING IN GREATER OVERSIGHT

Justin Jasniewski, CEO

Even if these increasingly big-ticket items aren't tied to value purchasing just yet, compliance with growing government oversight may finally force the issue. Gelb notes that intensifying pressure on the healthcare market to offer transparent pricing will drive more self-insured health plans to embrace VBC. The No Surprises Act has nudged more providers to get contracted and move certain members in-network from services that were going out-of-network.

"You're seeing it with some of the large BUCAHs who are now talking about 8% to 9% of charges flowing out of network where it used to be 12% to 15%," he reports. When transparency from the Consolidated Appropriations Act is layered on top, he explains that an effort is made to ensure that in-network, the best quality providers at a green level of cost are being identified.

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Although the U.S. healthcare system has long been complex, Greene offers a simple solution. "If I were king for a day," he says, "the two things I would do is capitate in a way that makes providers whole. Then, I would educate, motivate, and empower patients to practice better self-care. You do those two things, and it will solve our healthcare crisis." ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 35 years.


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EYEING EFFORTS TO SEED MORE VALUE-BASED INCENTIVES

Two key developments to watch along the legislative and regulatory landscape on this topic involve the Value in Health Care Act (VHCA) and Medicare's advanced alternative payment model. Known as the APM, the latter is designed to reward good clinical outcomes with a 5% incentive for boosting quality and reducing costs. Both efforts have rare bipartisan support.

Jamie Miller

Provisions of the VHCA, which was introduced in the U.S. Senate in December and House last July, have passed, according to Jamie Miller, senior director of government relations for the American Medical Group Association and member of the Alliance for Value-Based Patient Care. "The main one we're paying attention to the most is the extension of the APM model," he adds, noting that it was about to expire soon.

More than 630 national healthcare organizations have urged Congress to extend the APM for another two years. A decision on the fate of this risk-bearing model, created by the 2015 Medicare Access and CHIP Reauthorization Act, was pending as this issue went to press. A possible sticking point, he suggests, is that extending the APM will cost an estimated $1.5 billion to $2 billion per year at a time when there's little to no appetite for increased spending.

Preserving APM incentives, which were previously extended two years ago, is largely seen as a bellwether for the commercial insurance market. "Medicare obviously is a huge payer," Miller explains.

> "So commercial insurers tend to follow what Medicare is doing in payment rates and models. There have been multiple commercial payors that have expressed interest in going to value-based care."

He acknowledges that a cultural shift in payment processes doesn't happen overnight and will take time to germinate. However, evidence is mounting about the value of this approach. One example is Accountable Care Organizations, a popular form of value-based arrangement that produced about $1.8 billion in savings to Medicare in 2022.