VALUE-BASED CARE

Leading the Way on Value-Based Payments

To address the shortcomings of fee-for-service medicine, the health sector is moving toward paying for outcomes. For these Alternative Payment Models (APM) to be successful in any market, three key components of value-based health care must exist: Trust, Transparency and Transformation. Without all three, the value-based model will fail.

The Three "Ts" of Value-Based Health Care

Trust

Develop a relationship between payers and providers in which values, mission, objectives and financial incentives align.

Transparency

Codify and measure objectives, performance and quality standards in an open fashion by requiring data sharing, interoperability and collaboration.

Transformation

Leverage data to redesign care models that identify and avoid unnecessary or low-value care and intervene early, enabling clinicians to provide services at the top of their licensure.

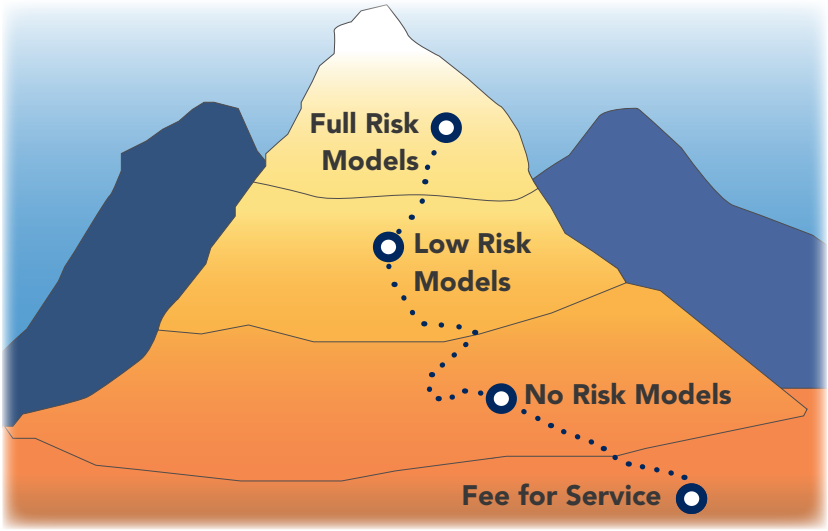
Additional points of note:

- Provider engagement relies on transparent, trusted data that providers have confidence in.
- Provider contracting should account for the organization's business objectives and ensure a return on investment for providers.
- Payers and providers need to analyze the same data in the same way.

Aligning objectives, incentives and transparent use of data enables health plans to invest more resources in addressing root causes of poor health (biological, psychological, or social) of poor health. Health plans can invest more attention addressing clearly identified root causes through transparent use of data when objectives and incentives are aligned.

Embark on your journey to the summit of transformation

The journey to value-based care requires more resources the further a plan progresses beyond fee-for-service. Compare the journey to hiking up a mountain. A hiker needs more advanced tools the higher she climbs. A hiker can walk a simple 2-mile flat hike on their own. However, to climb the greatest peaks in the world, a hiker requires dedication, training, sophisticated equipment and partners to reach the summit.



Historically plans have focused on APMs that involve no-risk models, which provide performance bonuses on top of fee-for-service rates. It's the equivalent of a short hike; these are an easier lift for provider and plans because they rely on existing strategies that require fewer resources and less investment—the equivalent of trail markers.

The Three Ts in Action: HAP and Henry Ford

In the state of Michigan, a strong relationship between Henry Ford Health System and Health Alliance Plans (HAP) has enabled a shift toward more advanced APMs. The model—which includes two-sided risk on all products—includes working together on data sharing, community partnerships and engagement and reimagining care delivery.

This collaborative approach has empowered HAP and Henry Ford to address underlying social factors. The organizations work together to understand their shared populations from a geospatial and individual risk standpoint to pinpoint targeted outreach—ensuring that community health efforts are effective.

Recent community partnerships include joint COVID vaccination efforts and support for the Ruth Ellis Center to address housing and health care for LGBTQ+ youth and Gleaners to address food insecurity. The organizations also have a joint focus on maternal health and mortality, as well as school-based health, with HAP funding interventions to address social determinants of health needs within the Detroit Public Schools and Henry Ford Health System operating school-based clinics.

Data sharing efforts include reconciling shared rosters and aligning care management. Care delivery redesign efforts include growing partnerships for hospital at home, moving to virtual care and supporting device-based examinations in the home.

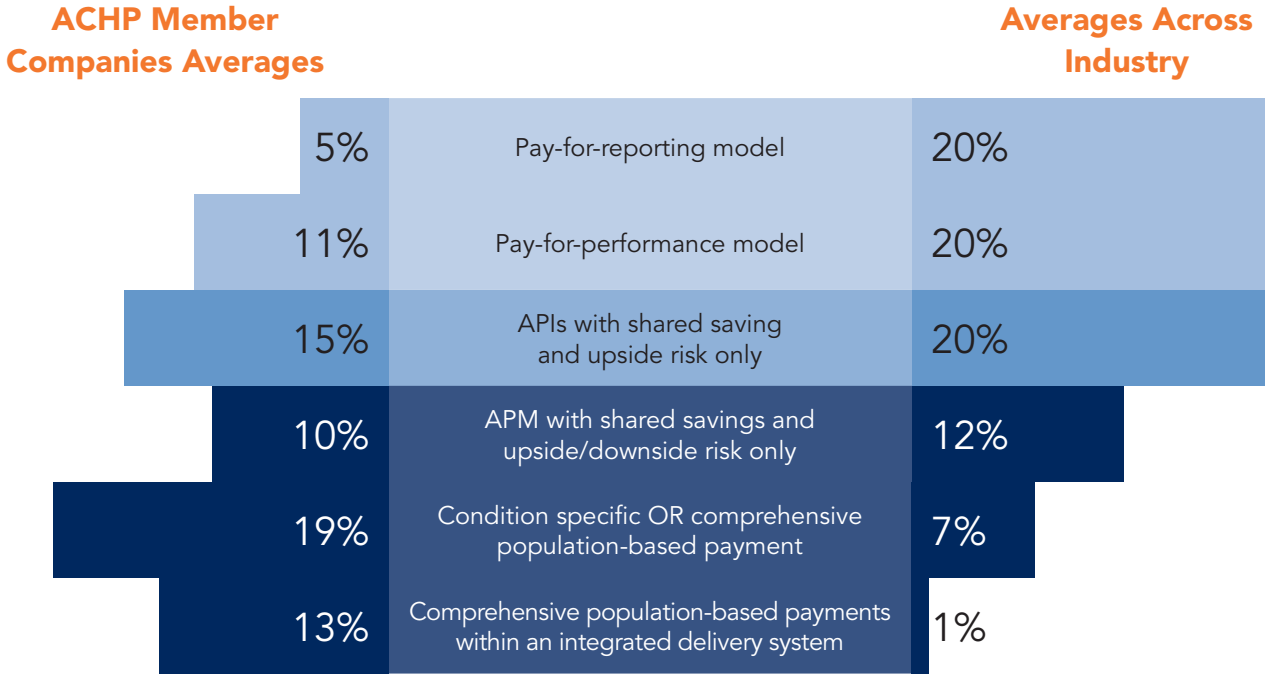
Today more plans are experimenting with low-risk APMs, aka upside-risk arrangements, where they share savings with providers through health care efficiencies. It's similar to a challenging but manageable climb; these models require deeper commitments but do not entail a complete transformation of the relationship between payer and provider—the equivalent of climbing partners and specialized equipment.

Few organizations have begun exploring full risk models—where providers share in savings but also payers recoup losses—or population-based payment arrangements. These models are the equivalent of summiting a mountain. These require long-term investment in infrastructure and a strong commitment to building transparent and trusting relationships with providers—the equivalent of specialized knowledge and experience, sophisticated equipment, experience and guides.

ACHP member companies are especially well positioned to explore more advanced APMs than non-ACHP competitors—reflecting their rich history of unique relationships with providers, transforming care and developing innovative approaches to coverage.

Shifting to more advanced APMs requires a cadre of experts who can implement such a radical transformation, either by hiring outside consultants or building an internal department dedicated to shepherding the process.

While no-risk and upside risk arrangements enable organizations to begin implementing value-based models on a limited scale, dual-risk and condition-specific or population-based arrangements lay the groundwork for a widespread and permanent transformation toward more effective alternative payment models.



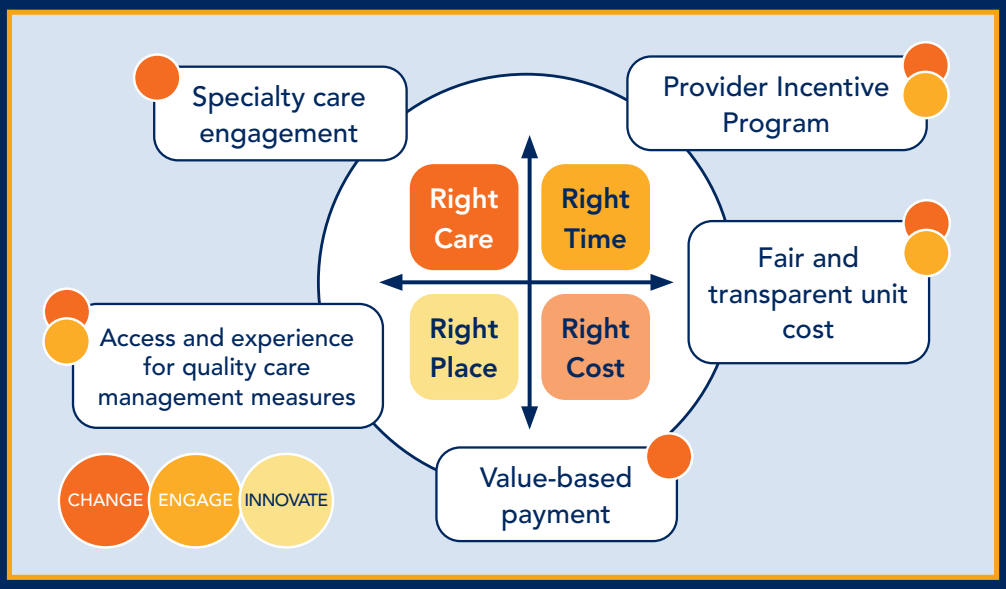
Approximate breakdown of provider enrollment in different types of value-based, risk-sharing agreements. On average, ACHP member companies have a higher percentage of high-risk sharing agreements. Industry data based on data from HCP LAN.

Finding What Works: Priority Health

Since 2017, Priority Health in Michigan has offered shared savings and two-sided risk arrangements that reward provider partners based on quality outcomes and total cost of care. Priority leverages its relationships with physician organizations and physician hospitals, including its own Corewell Health, to execute risk-based contracts.

Priority Health developed an APM readiness assessment tool to look at providers' trends and determine likelihood of success moving from shared savings to downside risk. The plan also collaborated with the Michigan Multipayer Collaborative and Andrew Ryan, PhD, who performed a comprehensive study on the effectiveness of various APM models in commercial markets.

Using data from 2017-2020 to profile provider spending, Priority Health developed separate profiles for physician organizations and hospitals. Patient data was risk adjusted for age, gender and co-morbidities, and claims were standardized to account for variation in prices across contracts.



The results showed:

- Shared savings models and capitation (global and primary care) had the most significant cost savings in areas with large PO and PCP penetration.
- Bundled payments are more effective when patients have access to many post-acute care facilities.
- Narrow networks result in savings for the health plan and help members control their costs.
- Capitation is a model for success.

Based on feedback from providers, Priority Health has determined that providers are most likely to succeed when they manage their patients with a hybrid payment model that includes three components: a capitation payment, fee-for-service payments and shared savings or two-sided risk. Ongoing cash flow to the practice is essential to run programs to manage cost trend.

Meeting Payer and Provider Needs

Payers and providers view value-based care differently and have different concerns about shifting to value-based models.

Providers are paramount for improved outcomes. Providers see less volatility in their monthly income the higher they go up the mountain, but they must be able to trust that high-quality metrics support their unique knowledge of appropriate care. If providers are going to be held accountable for outcomes across populations, they need to be reimbursed according to the different risks inherent in their populations and supported in addressing the non-clinical drivers of equitable outcomes.

According to data from Change Healthcare, providers are more likely to cite the following concerns:

- Unclear or Conflicting Performance Measures (29 percent)
- Regulatory Changes/Political Uncertainty (18 percent)
- Data Quality, Desire for Payers to Standardize Data (36 percent)

The Long Trek to Success: UPMC's Shift to Shared-Risk Models

In 2011, Pittsburgh-based UPMC Health Plan introduced the Premier Partners, its longest-running value-based payment initiative that has grown to more than 1,800 providers and more than 700 practice sites.

The program—which covers 45-65 percent of all UPMC Health Plan members across Commercial, Medicare, Medicaid and ACA products—is an upside/downside shared savings model, in which primary care practices may earn a share of the savings achieved or may be required to repay a share of additional spending, depending on the financial agreement and performance on clinical quality and utilization measures.

Practices in the Premier Partners Program continue to show impressive results compared to non-participating practices. Specifically, they have achieved:

- 7-18 percent higher quality performance across all measures
- 12 percent higher incidence of depression screening
- 1-4 percent improvements in medical expense ratio, depending on the line of business
- Higher sustained levels of telehealth utilization, especially since the start of the public health emergency

As the health sector faces increasing demands to provide affordable coverage and care that delivers high-quality outcomes, scaling the value mountain becomes imperative. Organizations, such as ACHP member companies, embracing the three Ts are poised to reach the summit, advancing the necessary value transformation of the health care system.

Payers are the pathfinders that providers need to encourage value-based payment adoption. Value-based payment arrangements allow payers to meet unique needs and transform coverage and care for their consumers. These efforts take upfront investment in the right tools and technology so payers can offer providers the necessary transparency for buy-in of the arrangement's value and success.

According to the same data from Change Healthcare, payers are more concerned about:

- Lack of or Limited IT Infrastructure (25 percent)
- Developing APIs (22 percent)
- Co-Developing Risk Management Programs with Providers (22 percent)

In order to bridge the gap between differing concerns, payers and providers need to lean on The Three T's. The joint commitment to Trust, Transparency and Transformation will enable both groups to summit the proverbial mountain and realize the benefits to value-based payment.

Head for the summit! The results reward everyone along the journey.

The shift toward value-based care won't happen overnight—it will take years of developing the expertise, trust and infrastructure necessary to shift to more advanced models. But no matter where an organization is in the climb, it won't have to do it alone.

Success comes with assembling the right team—whether that's internal experts that gain expertise over time, or experienced partners who bring valuable insights to the table.

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About ACHP

The Alliance of Community Health Plans (ACHP) represents the nation's top-performing nonprofit health companies, which serve tens of millions of Americans in 37 states and D.C. ACHP member plans collaborate with providers on high-quality coverage and care — leading the industry in practical reforms.

ACHP is the voice of a unique payer-provider partnership model advancing proven solutions that deliver better value for patients, employers and taxpayers. Contact us for case studies and data about member innovations and results.

Created in collaboration with Change Healthcare.

For more information please contact Ginny Whitman at **vwhitman@achp.org**.