Executive Roundtable: Sponsored by InterSystems

What healthcare system leaders say about the value-based care journey

A discussion about the challenges and best practices for healthcare systems transitioning from fee-for-service healthcare strategies to value-based care strategies and the role of data in that journey.

As the COVID-19 pandemic unfolded and in-person visits to hospitals and physician offices dwindled, one thing became clear: In this environment, fee-for-service (FFS) models were no longer generating income and changes were needed.

"A lot of providers during the pandemic explored moving to capitation," said Lynda Rowe, senior advisor, Value-Based Markets, InterSystems. "But they found that they needed access to more data, as well as insights and actionable information from that data."

Most (36%) survey respondents said the biggest challenges around the adoption of value-based care was accessing and using data, according to a November 2021 report by Guidehouse, in which 100 health system CFOs and finance and managed care executives were surveyed.

In this HFMA executive roundtable, moderated by Katie Gilfillan, HFMA director of healthcare finance policy, physician and clinical practice, executives for health plans and health systems share how their organizations are moving in the journey toward value-based care. The roundtable was conducted in November 2021.

What has changed within your organization from both the health plan and provider perspectives regarding moving away from fee-for-service and toward value-based-care?

MICHAEL BROWNING: Since COVID-19, nothing has substantially changed for us, especially with government reimbursement enhancements. Government relief has helped tremendously with the cost increases we've all been experiencing on the provider side. We discuss the value-based care model every day, but we haven't done a lot to react to it. The additional government funding has allowed the industry more time to prepare for it.

PENNY CERMAK: From the perspective of balancing an integrated system with a health plan and care delivery, it's interesting. Our health plan and providers all contract with each other, and it's not a closed system at all. One thing we've seen over the past year is a real change in how we are able to drive some of that value-based agenda farther and faster — think video visits and telehealth. As we look at hospital-at-home, it's been really difficult to get off the ground, but it is necessary as we consider capacity issues. Currently, our hospitals are full with COVID-19 patients. We are seeing a need to create capacity in our hospitals and get that care into different settings. We are also considering how payment arrangements are helping to influence that shift as well. We have to figure out how to do this differently.

KEVIN BOREN: We've grown a bit in confidence during COVID-19 because things *didn't* go haywire, which they could have. There have been big trend disruptions, but they've hit the industry pretty uniformly. So, our value-based agreements have performed adequately during this time.

AREN LALJIE: During COVID-19, we saw a surge of providers wanting to move to capitation. We had many patients who didn't show up in a care provider's office because they were afraid of contracting COVID-19, so most of the fee-for-service revenue was lost. But Medicaid Florida had a patient contract where they would pay a set amount per member, and we had some challenges there. We were able to work with providers and payers and talk them through the changes. But if you don't have the infrastructure system to manage patients, you're going to lose money. We were eventually able to bring them back to a better system.

What barriers exist to prevent you from moving toward value-based care?

LALJIE: We need to invest in people and infrastructure. Without that, you're just hoping that you'll get the results.

GILFILLAN: Do you foresee them starting to build that infrastructure? To head in that direction?

LALJIE: They're still thinking about it. But what's in the market right now — most systems have been designed to be organization

specific. There's a lack in the market right now for a healthcare data system that works for multiple organizations.

LYNDA ROWE: Some large payers I've spoken with said they were knocking on provider doors before COVID-19, but nobody wanted to talk about their contracts. But then they started to see capitation as an attractive alternative, and doors started to crack open. I'm wondering if that's been your experience from either the plan side or the provider side.

TOM CHAN: You have to evaluate risk and variation in contracts. In our state right now, with our payers, we take a value-based contract, which is different from capitation. For example, within the contracted payer, they assign certain numbers of beneficiaries to us, and we take risk based on the past data to determine a PMPM [per member per month] claim cost that's lower than the past. If we achieve lower PMPM claim dollars for the assigned beneficiaries, we get a certain percentage of the savings. To me, that is value-based. Capitation is experience-based. Value-based contracting requires improvements from the past to earn savings. The concepts are very different. Then you really need to ask the next question, "Why am I taking the role of payer risk?" It will get more difficult as each year passes.

For us it's very different because now, with a move to value-based, we need to speed up our processes to develop an integrated delivery system, including ASC specialists, and primary doctors. Right now, we are buying specialists like crazy. They don't necessarily want to be employed, so we came up with an exclusive contract approach where we pay them based on their productivity. We take them on and pay them a certain amount per RVU [relative value units] that they produce. So they keep their autonomy, so to speak.

TERRY WEATHERS: We typically work with providers, and try to get our value-based products to market. We found that pre-pandemic and through the pandemic, there was more interest. As opposed to capitation, where you can clearly get more dollars in and people coming through for service. This is another way to control your own destiny — have an attributed set of employer commercial lines that can be brought in. We saw a lot of new interest and new partners coming in during the pandemic. The challenge for us has been, having this new value-based product being brought to market, the employers have to adopt it too. During the pandemic, people were not very willing to change their health benefits. Now that people are seeing the light at the end of the COVID-19 tunnel, they are seeing the value being added for self-insured employers. They are starting to see the benefits of a value-based contract as opposed to a risk-based contract.

CERMAK: I think we are starting to see the shimmering light at the end of the tunnel from COVID-19 that adoption of these products by self-insuring employers is actually starting to improve. That's true for all our geographies in the Dakotas or in Nebraska and Washington and Oregon. The employers are finally starting to see what is a value-based not a risk-based contract. But I feel like it's been on hold for 18 months as we grapple with when doors open.

PETER SABAL: Yes. We are structured to be an open network. I don't think there is a lack of people who are willing to do value-based contracts with us. Our challenge is balancing what the consumer wants, what the employer wants and also our network. If we start shifting someone from one system to another, they might want out, which creates a gap. So we have to manage all of our population, and we have two million people in Washington and Alaska.

The second part of the problem is, when you have an open network product, your customers expect to be able to go see whoever they want and have it paid for. That's very hard to change. We both created a bundled product that has a semi-restricted benefit. And we've talked to customers who say they don't want the insurance plan to pick their provider — even if the insurance plan has chosen that provider with good intention, even if we're sending them to the provider who has the highest quality and the lowest readmission risk. They would rather listen to their neighbor, who is a normal person and not an expert. The consumer's expectation needs to shift. I'm not sure how to do that, other than by engaging earlier in their surgical journey. And we have a whole department of targeting experts who do that by creating algorithms. But it's still very difficult.

Panelists

KEVIN BOREN
CFO East Region, Essentia Health in Duluth, Minn.

MICHAEL BROWNING
CFO, OhioHealth in Columbus, Ohio.

PENNY CERMAK
Executive vice president and CFO, HealthPartners in Bloomington, Minn.

TOM CHAN
CFO, Meritus Health in Hagerstown, Md.

AREN LALJIE
CFO, Miami Children's Health Plan in Miami.

LYNDA ROWE
Senior advisor, Value-Based Markets, InterSystems in Cambridge, Mass.

PETER SABAL
Senior vice president, Network Contracting, OptumCare in Las Vegas.

JEFFREY SMITH
Vice president of finance, OhioHealth in Columbus, Ohio.

TERRY WEATHERS
CFO, Sunflower Health Plan in Lenexa, Kan.

We've had patients that wanted to choose sketchy providers for services based on recommendations from personal contacts, even when those providers have malpractice suits and poor outcome records. Even after offering to send them to, for instance, Duke, they insisted on their chosen provider. Then after the surgery went bad, we ended up sending them to Duke anyway, and the outcome was positive. People want to pay as little as possible, but they also want a choice. I don't necessarily know how to bridge that gap. CFOs talk about value and reducing cost. But for a member in a group, value means something different. They want to be paternalistic; they want to give the members the best possible care. Sometimes the best possible care is letting them choose. It might not be right, but I don't know if we can ever get to the next level there.

How important is data in value-based care?

CERMAK: I often hear from providers that one of the keys to having a successful value-based system is trust. Also, you have to have reliable data transparency. And without trust, transparency is very difficult. Whether you're on the provider or payer side, what has been your experience regarding data transparency, sharing data and trust?

JEFFREY SMITH: I prefer accounting in the fee-for-service world because you produce something and then you get paid for it. Accounting in the risk-based or value-based world is more difficult because of the timing of the data. Our fiscal year ends June 30th, but all the insurance companies we work with are calendar year. I don't see issues with trust, but there are issues with data in timing. When you think you're doing well and then all of a sudden, the quality metrics come in, and maybe you're not doing quite as well as you thought. Then you do chart audits and say, "Hey, we can just move a few more beans, then we're going to do well."

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>
> — KEVIN BOREN, CFO EAST REGION, ESSENTIA HEALTH

CERMAK: If the data feedback was more frequent, would that help?

SMITH: Without a doubt, especially if the [contracts] are value-based. I'd rather get them paid multiple times during the year.

BOREN: I think it varies greatly, but payers are working on it. They're all at different stages in development. Using MSSP [Medicare Shared Savings Program] as an example, it's a challenging contract. You don't get enough data feedback until August, and that goes back to December 31 of the previous year. You don't know what the data and the benchmarks will be, or how you will settle. That's a challenge.

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CERMAK: What specific data would be most helpful? Obviously, care costs are essential, but is there an aspect of transparency that is aided by better clinical data?

LALJIE: If we are getting value-based agreement, you need to have data that identifies any care gaps or areas you can work to achieve better outcomes for the patient. You get the reports, and these are the metrics you're seeing. Here are your bottom scores this quarter. Next quarter, there's changes. Then you may say, "We have to go back and figure out what happened." Clients need to have these really strong systems to monitor. I think from a data side, the clients haven't invested enough.

GILFILLAN: Everybody wants data, but how in the world do we create the infrastructure to make sure that it's easy to collect the outcomes to really, truly evaluate how the patient is doing and get information? That can be challenging because, to get that quality clinical data, you have to work within the healthcare system and with providers' offices. I don't think we currently have a good system to make it easy to collect, integrate and evaluate the data.

How has COVID-19 changed your approach or strategy regarding value-based care?

SMITH: We haven't changed any of our compensation philosophies for our physicians. They like getting paid for the work they do. The challenge in primary care is where our patterns have changed the most. There's a lot more communication work to be done. Physicians need to make more phone calls, emails and texts, and they aren't compensated for that increased workload. We need to address that.

GILFILLAN: We have to learn how to navigate the increasing digital component of patient care. Patients have more access and expectation to communicate with their provider, through messaging and telehealth and touching base between office visits. Providers have to find a way to do that effectively but also to set boundaries. If they don't, they risk getting burned out from constant accessibility. But when you think about value-based care, sometimes those [times] in between [when you touch base is when you] can make a huge difference in patient success.

ROWE: In Massachusetts, we have ACOs for Medicaid, and we are under a capitated arrangement. We get enhanced government funding right now to support the telehealth

rates. The concern is what happens when those rates drop out, or we can only do voice conferencing. How will those be reimbursed? Having some sort of PMPM coming into your practice helps cover these non-clinical things to get us through COVID-19. It's uncertain whether we would receive the same aid for value-based care.

SMITH: Telehealth is the obvious answer, but there are some obvious challenges there that have changed with COVID-19. There are real challenges in rural communities with lack of reliable internet access.

COVID-19 has fostered more focus and attention to social determinants of health, such as access to broadband, housing, food, etc. Is that something your health systems are looking at?

WEATHERS: In Medicaid managed care, there is the unique opportunity to outsource state waiver populations. That includes folks with disabilities and a host of other challenges. Those individuals rely on their healthcare payer to live — everything from housing to attendant care, which allows them to work or maintain living at home versus being institutionalized. In this situation, COVID-19 had even more potential to disrupt individuals' lives as it was not just healthcare we were dealing with.

CERMAK: We've had a dental group for a long time. We have about 1.8 million members, and 600,000 of those are dental members. It's been interesting to view this as broader than what we would traditionally consider healthcare. Knowing that 80% of healthcare outcomes are driven by sources outside the healthcare system, we are looking at things like food equity and transportation in our Medicare advantage plans and our Medicaid program, making sure our patients have access to those necessary elements for their wellness.

ROWE: Are your patients/members within your network, or do they seek care outside of the network?

CERMAK: We are a payer that contracts with all providers, and we are a provider that contracts with all payers. Within both sides of that equation, especially on the payers' side, we are making sure that we're looking at all of the things that impact a person's wellness. On the care side, it's the culture that's been ingrained because we were a health plan before we even had hospitals. And so that culture just carries through in terms of how we take the next step to help people be well.

ROWE: And do you get data from your outside partners both on the plan side and on the provider side? In other words, how easy is it to get data that you need both today and in the future?

CERMAK: We have up-to-date data, but it's a little bit more difficult on the social determinants piece. I will say, we've been a great architect of data within our own health plan. But in terms of when we're working with other payers, that's a little bit harder to come by.

SMITH: Something that is unique is that several CEOs of the hospitals there were able to collaborate around COVID-19 and approach it as a community versus targeting it as a health system.

GILFILLAN: We've seen that in multiple states as well, where competitors came together and said, "We have to do what's best for our community." It was really the first time we saw competitors set aside their own priorities to put people first. That's a lesson we can learn about value-based care. If we just tackle it as a health system or as a payer, we're never going to get there. We're going to have to work together and compromise.

The roundtable executives agree that we have made progress in the journey towards value-based care. They have also identified a need to be able to collect patient outcomes, identify gaps, and coordinate care among internal and external systems. The availability of this actionable data, as well as analytics, will be important to health systems and plans on the path toward greater adoption of value-based care. ■