Achieving the Promise of Value-Based Care for All

RECOMMENDED STEPS TO SUSTAINABLE, PREVENTION-FOCUSED PATIENT CARE

Value-based care – addressing the whole health of a patient rather than requiring reimbursements for each visit, test and procedure – is a necessity if we are to have a healthcare system that is both economically sustainable and focused on patient health. Yet the transition to a system focused on value and wellness is not moving as rapidly as its advocates would wish. Fewer than half[1] of traditional Medicare beneficiaries are currently cared for through Accountable Care Organizations (ACOs).

On January 25, 2024, the Healthcare Leadership Council – an association of leading executives from all disciplines within American healthcare – led by two member companies – AdventHealth and Wellvana – convened a roundtable discussion with more than 70 leaders from health systems, payers, purchasers, patient advocacy, retail health, public policy, and academia. At this roundtable, leaders developed consensus to advance value-based care which will transition our health system from one focused on sick care to one equally dedicated to prevention and caring for the whole patient.

In 2023, AdventHealth made a historic commitment[2] to improve the health of patients by establishing a new primary healthcare division. The health system partnered with Wellvana to support high-performing primary care providers on the path to improving population health.

A Sense of Urgency

Value-based care, where the provider's compensation is dependent on quality and outcomes, is a reimbursement model designed to elevate preventive care. Industrywide, healthcare companies and leaders support the philosophy that incentivizing the value of care over the volume of services will improve both patient health and the financial sustainability of the nation's healthcare system.

At the Centers for Medicare and Medicaid Services (CMS), federal healthcare leaders remain committed to a 2030 goal[3] for 100% value-focused accountability in Medicare. This goal requires transitioning every patient from conventional fee-for-service Medicare into a value-based payment model. The pace must quicken to achieve the goal in the next six years.

The shift in payment structures has not been an easy one for providers – from the largest health systems to the smallest independent practice. The Affordable Care Act advanced the concept of accountable care through ACOs, which are now evolving into full-risk models. At first, there was no risk on providers. They had nothing to lose if they failed to reduce costs and improve quality. The results from this no-risk model were modest[4], and many ACOs became little more than vehicles for referrals.

> *"To truly advance prevention-focused, patient-centered care we need all segments of healthcare to come together to help reshape care delivery. That's where HLC can play a leading role."*

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The introduction of full-risk models in both ACO Realizing Equity, Access, and Community Health (ACO REACH) and Medicare Advantage plans suggest that true value-based care should mirror capitation, so providers are rewarded for cost savings and held accountable for greater cost spend. Because the financial risk of moving into capitated models requires significant reserve capital, providers are more likely to succeed when they seek support from a risk-bearing entity that can take the risk on behalf of providers and share in the upside.

However, for all its flaws and detractors, the historic model of fee-for-service healthcare and the certainty it promises has proven challenging to discard. Even providers with the greatest stability and size are cautious about the transition. While the outcome could be better for patient, provider, payer and purchaser, the uncertainty is too great, and the risk is still too high.

Value in the Gaps

Value-based care isn't just a new reimbursement model. It requires clinical innovation to improve patient care, especially between appointments when progress can abate with non-compliance. But these real-world examples show the power of offering additional support:

- *A patient from Arizona is out of town, recovering from a stroke with dangerously low blood pressure when his remote nurse care manager reconnects him with his home primary care physician in order to appropriately adjust his new medication.*
- *A patient in North Carolina with uncontrolled diabetes needs help using a continuous glucose monitor when his provider and care manager team up to make it happen. As a result of the intervention, his sugar levels drop back into a safer range.*
- *A patient in Tennessee without transportation is trying to manage diabetes and renal failure in a hot house with a broken air conditioner when a nurse finds a local church to replace the AC unit.*

Policymakers understand the financial dilemma of trying to help patients outside the usual reimbursable services. More help is needed so every provider can invest in high-impact care management.

Tipping the Scales

20% THE HARRIS POLL 2023[5]
Nearly 1 in 5 patients think the health system focuses on injury and illness to the detriment of wellness and prevention.

12.7% HUMANA 2023 VALUE-BASED CARE REPORT[6]
fewer ER visits compared to non-VBC patients.

46% 2022 COMMONWEALTH FUND SURVEY[7]
of primary care physicians receive some kind of value-based payments.

Patients may not be able to explain what value-based care is, but they know they haven't been getting as much value as they'd like out of a healthcare system.

Paying physicians for quality rather than quantity is starting to deliver on the promise of person-centered care coordination. ACOs topped $1.8 billion in savings in 2022, capping a 6-year streak of reducing unnecessary costs. And this streak is paying off for patients, with large value-based programs reporting increased preventive care services and fewer hospitalizations.

> *"It's been far too challenging for even the most sophisticated health systems to make the leap to value-based care. Policymakers have an opportunity to bridge the divide so every patient can benefit from providers solely focused on keeping them well."*
>
> **KYLE WAILES**
> *President and CEO, Wellvana*

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But providers are caught in a balancing act. They're being asked to operate in a fee-for-service environment with most commercial payers while focusing on value within Medicare and Medicaid to care for the whole patient.

Patients need value-based care more than ever, and they need policymakers to help providers deliver on the nation's ambitious patient-centered care goals.

Recommendations to Accelerate Value and Accountability

The multi-sectoral group of experts convened by HLC developed consensus on several policy and practice recommendations. They include:

1. **Strengthening incentives to encourage provider participation in full-risk models. Taking on full-risk accountable care responsibilities necessitates significant upfront investments and developing new opportunities to support patients when they are not in the direct care of a clinician, such as:**

- Extending ACO REACH, which is currently the only full-risk program in traditional Medicare. To invest appropriately, providers need to be assured that full-risk ACOs are here to stay. Bridge funding mechanisms can enable the costly upfront transition from fee-for-service to accountable care.
- Congress must approve the Value in Health Care Act, which extends for two years the Medicare Access and CHIP Reauthorization Act (MACRA) incentive payments for providers, significantly improves value-based programs, and mitigates disincentives for rural-based ACOs.
- Incentives should encourage specialist participation in ACOs alongside primary care providers and span the full field of payer types including Medicare Advantage, Medicaid, and commercial payers.

2. **Improved data integration and interoperability, such as from Medicare Advantage, the Medicare Shared Savings Program and ACO REACH, are essential to assess success in value-based care, to eliminate low-value care, and to advance health equity goals.**

- An optimal information sharing system must include timely data transfer.
- New models should eliminate current fragmentation in data collection and storing. Delivery of value-based, whole-person care necessitates access to a patient's clinical, psychological, social, and health utilization data.
- Data collection and dissemination should minimize the administrative burden for patients and healthcare providers.

3. **Value-based care programs must be designed to meet patients where they are, while engaging them to improve their health.**

- For value-based care to be successful, its reach and impact must extend beyond traditional clinical parameters. Care should be available to patients in their home, within the community, or through virtual connections.
- Social determinants of health impact patients significantly and should be considered within every value-based model.
- Value in healthcare must be more clearly articulated so that patients and providers consider quality alongside cost considerations.

> *"Until somebody cures all diseases, we're going to still need hospitals. But the hospital should be the last whistlestop on the healthcare train, not the first."*
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> **TERRY SHAW**
> *President and CEO, AdventHealth*

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