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Exploring Value-Based Care with Margaret Braxton

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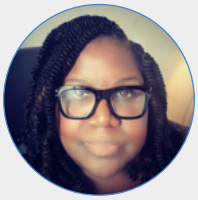

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Key Takeaways

Geographic Proliferation of Value- and Risk-Based Reimbursement Models – Why Some States and Not Others?

- Markets controlled by hospital systems are likely to be slower to meaningfully adopt value-based care models given that: (i) shifting large health system and their associated provider networks is a heavy lift and arduous task and (ii) value-based care reimbursement models are often at odds with hospital legacy revenue models and are perceived to leave hospitals with less potential upside.
- Markets with robust independent providers are more likely to experience consolidation that is, in turn, conducive to more organized and viable adoption of value-based care models.
- Markets with heavy Medicare Advantage patient populations are also likely to see meaningful migration to value- and risk-based models.

Views on the Florida Value-Based Care Landscape

Adoption of value-based care models in Florida has been driven by:

- Heavy Medicare Advantage population
- Legacy of more flexible payer policies in terms of required member thresholds to adopt value- and risk-based models, as well as more appetite for partnering with multiple parties within the same market & line of business

Heavy competition in Florida leaves smaller payers at a disadvantage – lacking in membership critical mass. Expect some of these smaller players to leave, or invest less in, the Florida market as they experience challenges achieving success in the market. Oscar Health is one recent example of a payer leaving the Florida market.

What Makes for Successful Payers in Today's Market?

Keys to success:

- Strong presence in Medicare Advantage
- Diversified presence across lines of business
- Strong supporting services programs that extend payer reach into practice ownership, care coordination, PBM, practice / value-based care management services, etc.

Examples of high-performing payers:

- UHC / Optum
- Cigna / Evernorth
- Aetna / CVS

- Payers that are smaller, single line of business-focused, and lacking a strong support services arm may face competitive challenges over time. Expects these players to either (i) perform strong in a particular line of business and represent a potential acquisition target or (ii) face a steep competitive hill to climb over time

Health Equity Emerging as a Key Theme Across the Market

- The ACO Reach program includes requirements and incentives for health equity. This is the first meaningful incorporation of health equity into a CMS program incentive structure
- Expect government programs to increasingly include with incentives for health equity, including across social determinants of health and non-medical services (e.g., food inequality, transportation, etc.). Payers are likely to follow suit and extend their reach and services to address these variables.
- City Block is company to study as an example of a practical implementation health equity strategy

Will Hospitals Adopt Value-Based Care?

- Hospital adoption of value-based care is challenged by competing financial interests. Value-based care pursues lower total cost of care and hospitals often operate at the top of the "fee-for-service food chain" in their provision of in-patient care. Further, hospitals will face execution challenges shifting their legacy infrastructure and large provider networks to value-based models.
- That being said, expect hospitals to gradually adopt value-based care, especially when they are faced with more credible competitive alternatives in the local market.
- There are many case study examples of successful value-based care models within hospitals. Relative to adopting value-based care outside of the hospital, expect hospital migrations to:
  - Require long, arduous and complicated negotiations with payers
  - More customized and sophisticated value-based models
  - More complex operational transitions
- A key turning point / milestone is achieving 50% of health system patients under value-based care models. Materially below that point and value-based care models are often not given sufficient attention within the system. At and above that threshold and hospitals are forced to confront, embrace and invest in truly succeeding within a value-based model paradigm.

Background

My background in healthcare spans 35 plus years. I've worked on the provider side in health systems, specifically in behavioral health leading teams on the operational side. The other half of my career has been spent with payers - UnitedHealthcare and Cigna - leading teams and contract negotiations across the full spectrum from fee-for-service to full risk, both within primary care and specialty care.

Prior to joining SCALE, I most recently served as a Senior Advisor of Value Based Contracting at Cigna where I led negotiations and developed contracting strategies in the Southeast region covering seven states, including FL, AL, AR, GA, SC, NC and TN. Partnering with market leadership, we developed strategies to improve cost trends, quality of care and access. This included developing and implementing regional dashboards that provided transparency into critical data points of primary care performance in value-based agreements to help better inform short- and long-term goals within the market and region with respect to STARs, Risk Score and MLR.

Prior to Cigna, I was at UnitedHealthcare where I was both the Director of Value Based Strategies – Bundled Payments, as well as the Director of Contracting. As the Director for Value Based Strategies, I drove pipeline development and evaluation of underlying specialty medical spend and emerging trends. I also oversaw strategic performance of bundle payment programs nationally. As the Director of Contracting, I led a team of physician contractors supporting all lines of business, directing and approving negotiation strategies.

From your lens, having negotiated value-based care contracts on behalf of payers, what does the landscape look like today? What are the programs that are available, and how do those programs vary from one state to the next?

Value-based care is a continuum. It is organized care that measures outcomes with alignment to a reimbursement model that's applicable to both primary care and specialty spaces. Typically, value-based contracting aligns with the line of business, so commercial line of business, Medicare Advantage, and Medicaid.

The primary care value programs are similar across the spectrum. That being said, we understand that with population health, you're dealing with different age groups and different social dynamics within each population. So, if I took a step back, the things that are consistent across primary care value-based models are concepts such as HEDIS measures and clinical coordination. Medicare Advantage has additional focus levers, such as Medical Loss Ratio ("MLR"), which is a measure of the percentage of the cost spent on the patient's care. There are also levels of value-based care across all lines of business - there are incentives programs, there are shared savings programs, and there are risk programs.

If you ask what varies across the country, in the Medicare Advantage space, it's similar. Each health plan is grappling with the same thing. How do they get healthier outcomes? How are they getting patients in compliance with their healthcare, medication adherence, diabetic testing. So it's similar across the country.

The execution of the type of model in the commercial space may vary based on state regulations, but again, it's very similar from state to state. Of course, if you look at South Carolina, you have a sicker population than you do in California. So, there are variations based on the population and the health of that population, but the underlying value models are very similar across the country and across payers.

Given those similarities, why do we see an abundance of global risk primary care groups in certain states versus others?

Within the primary care market, you see lots of group aggregation - consolidation through acquisition, practices aligning together in IPAs, etc. - driving the progression toward value-based care models. Primary care models are moving to what we call total cost of care programs, which can be risk or non-risk based. In total cost of care programs, the patient is attributed to the primary care provider, and then it becomes the primary care provider's responsibility to manage the cost of care across the holistic patient care. The funds are typically paid to the primary care, and then the primary care has contracts with specialists and other entities that are providing care to that patient. There are many variations to the model, but in all of them, the primary care is the sort of gatekeeper of the funds and the gatekeeper of access to care for that patient. Depending on the line of business, not necessarily in a formal gatekeeper sense where the patient needs a referral, but at least in an informal sense, where the primary care provider is accountable for the total care of that member and the coordination of care for that member. And so you see primary care groups aligning to participate in those types of value-based models.

There are some markets, however, where this dynamic is less prevalent and more difficult to achieve. For example, you don't see that happening as much is in states such as Georgia, North Carolina, some of the northeast states, Louisiana.

One of the key reasons is that it is often more difficult for true progress toward value-based care to play out where you have health system laden markets.

If you think about the dynamic with health systems, their revenue is generated by inpatient hospitalization, ED visits and outpatient testing that cost more than your, for example, freestanding imaging center. And so there's always sort of a tension with the health system participating and moving value-based care models forward – they perceive having less upside benefit potential by moving into value-based care models. Conversely, where primary care groups operate outside of the health system environment, they are more inclined to pursue aggregation and then use that aggregated platform to help move the needle forward in participating in value-based care models where there are upside incentivizes based on the total cost of care.

Florida has been very, very busy in primary care global risk. Lots of new entrants, new brands. Some of the largest brands in the country have their origins in Florida. I'm thinking of companies such as Cano Health, Genuine Health and others. Why were they all so successful coming out of Florida, given that the Florida that I know still has some pretty powerful health systems?

For most payers, Florida has the number one member enrollee count in Medicare Advantage. This drives and draws primary care needs and providers to that state. A lot of membership, a lot of access needs.

Secondly, Florida has a dynamic that is interesting to me that I've not experienced or noted in other markets I've worked in. In Florida, payers seem to have a very, I don't want to say a different approach, but different views of applying membership thresholds and different levels of ability to negotiate contracts with multiple providers in the same market and same type of contract. For example, typically a threshold for a risk contract would be 5,000 to 10,000 members. I've seen risk contracts with 1000 members in Florida. The providers will say, "It doesn't make sense for me to be in a shared savings program or an incentive-based program. I'm ready for full risk. Let's jump in at 1000 members," and the providers are willing to accept that risk. From a payer perspective, if the provider is willing to accept that risk, you're shifting management of the liability, the dollars, the cost, to the provider and away from the payer. The payer thinks, "Okay. If that's really what you're able to demonstrate and willing to do." Now, when you're in a risk contract, there's reinsurance, deficit coverage. There are a number of things that the provider is required to have in place, but Florida's just a dynamic with a history of more flexibility in terms of required membership threshold starting points.

I hear Humana is described in New Jersey as an impossible party to negotiate with, and then I see the same Humana in Florida referenced as the number one growth engine for certain provider groups. Cano Health is a good example - a longstanding strategic partnership, and a lot of that value creation is attributed to their very robust Humana partnership. It does seem to be quite interesting that the same payer brands play a very different role in one state versus the other.

Cano has been in place for a bit, and the Humana contract has been in place for a bit. In fact, when I was at Cigna, that Humana contract was in place. Humana, this year, has had a deep reorganization. In fact, they've recently stated that they will be moving out of the group employee coverage business. Humana is going through major overall, and so I'm not sure if some of the decisions were made prior to that or in light of that. I think we will see a different Humana emerging as we move forward, and I don't know any more details about Humana's contract with other states.

Oscar Health has now backed out of Florida, so what do you think of that?

I think Florida is overcrowded with providers. In order to be successful in a value-based program, there are many things that have to be in place and one of them must be volume – that is, having an adequate number of members that covers catastrophic cases and allows you to provide robust care for that membership, in addition to value-added services such as transportation and meeting food insufficiency needs. Florida is a crowded space, and again, there are players that, I think, don't have sufficient membership. As they are finding that there's difficulty to achieving success, I think you'll find more of these players backing out of the market.

It's inevitable, and then the players that emerge as doing this will with sufficient membership will be well-positioned to be increasingly successful.

Certain value-based care initiatives seem to be introduced and then retracted. Do you keep track of some of these other variations of value-based care, and do any of them come with a warning sign? Because I think about them, as an operator. If I've gone and built a large business, sunk a lot of money into a value-based strategy based on a particular program, and then suddenly it's removed from me a year-and-a-half later, I'm left holding a bag.

So ISNPs, DSNPs - they're still in existence. These programs target specific patient populations and are expected to continue to be administered as they are today. DCE is another program that is still fundamentally in place though it has evolved. The concept behind DCE was administered and still is administered by CMS, through their MSSP Shared Savings Program, and now their ACO Reach, which is new just this year. So while you may see changes to these programs or new names for these over time, the fundamental underlying concept remains in place.

I've seen what you're saying where some new programs emerge and then are shut down, especially in the specialty space where value programs are deployed and later sunset either because the value that was in that program has reached its maximum, or they realized that the intended outcome was not accomplished or achieved. Some value-based models, you hope, will yield a specific outcome, and once you've deployed it, you realize, they won't succeed. Either you don't have the right levers in the program, or it just didn't accomplish what was intended. And so you take a step back, and you may, then, try another model. I've seen that in the orthopedic space. We've seen orthopedic bundles - they were deployed probably 10 plus years ago, starting with CMS, and then payers followed CMS' lead. The payers have now started to either sunset the program or change the programs, because upfront there were obviously savings, especially moving the site-of-service from inpatient to outpatient and/or to an ASC. Well, once you've accomplished those initial savings, what else is there in that program to accomplish that realizes incremental savings? And so then the cost to run the program no longer makes sense, because it's not offset by realized savings, so you'll see that in the value-based space periodically.

Any thoughts on this distinction that seems to exit between two groups within the payer market. The first group includes large payers - United being the largest, along with Cigna and Aetna. These payers are seeing significant wins, large profits, and are generating earnings through other programs such as, in the case of United, their reliance on Optum and, in turn, Optum's reliance on provider ownership. The second group includes, for example the Centene's of this world, who is squarely focused on Medicaid as a payer, doesn't have much else going on notwithstanding a few more recent acquisitions, and who has underperformed as a result. Do you think about the payer landscape in that context, group A versus group B?

Yes, in fact, having been with United for a number of years, at some point, there was a significant shift. In the commercial payer space, there's very little profit margin. There was a shift once Medicare privatized Medicare into Medicare Advantage. There has since been more focus on Medicare Advantage by just about every payer, and a shift away from the commercial space. That doesn't mean the payers won't continue to administer commercial benefits, but the focus is clearly more so on Medicare Advantage.

United Healthcare, very early on, created Optum. Optum is so large. I was speaking to United's New York CEO, Friday, and he and I just sort of laughed, because it's huge. Even UnitedHealthcare employees don't have insight into all that Optum offers, so I'll just tell you some of the services that I know they offer. Bundled program services - UnitedHealthcare hires Optum to bundle their services. Optum now offers some contracting on behalf of UnitedHealthcare. They also offer education and training to UnitedHealthcare and other payers around RAF scoring and coding. They have Optum Care and have acquired practices, all to manage that total cost of care and that dollar from A to Z, so they don't have to send as much out and so they don't have to entrust and downstream contract with a specialty provider to provide services. They also have their own PBM.

Cigna, three years ago, decided, "Hey, we're going to replicate that," and they created Evernorth. Evernorth is the business engine for Cigna, just like Optum is the business engine for UnitedHealthcare. Aetna and CVS, same thing. They have a PBM and offer other services. And, the services they're offering are not just to their own members but also externally, and so that's partly where the success and the revenue generation comes, is by the business services entity.

I think Centene, Emblem, and these local, regional, small national players are positioned as acquisition targets if there's something unique that they bring to the market. Centene has been successful in the Medicaid space, and so where a payor may not have had success in Medicaid, one of the larger payer lines of business, they may be interested in acquiring them. If not, then Centene will eventually not exist, as we know it today. We've seen that with small payers throughout the years. They're either acquired or they dissolve.

So let's shift into health equity, and let's put on your health equity hat. So start with basic fundamentals. From your vantage point, what do you think health equity means from a business standpoint?

So health equity means, and I'll just say this is what it means, and then we can talk about it from a business perspective, providing a fair and just opportunity to the highest level of care for all. We saw, during COVID, the magnitude of inequity and disparities in healthcare. While it has existed in our country for time, the pandemic was a light shown on our healthcare system in that regard. And so, as a result, government entities - CDC, CMS, Health and Human Services - have made a public commitment to bring a shift in this area. We know it's multifaceted. It is not one answer. It's not one question.

From a business perspective, I think it's not new, but it's new in terms of it being a question on all of our minds. We're being challenged now from many stakeholders to think about the intersection of health equity in the work that we do day-to-day. So for healthcare delivery, what does health equity mean from primary care to hematology, to oncology, to neurology? What does that look like, and what does that mean in terms of how we behave and the expected outcomes?

I follow a company called City Block that emerged five years ago, and their primary mission is to address health equity and disparities.

They've built practices in disparate communities. They manage through a value-based model. They provide value-added services that meet the specific and unique needs of their patients across food insecurity, transportation, and various other needs to build trust and partnership around their care. That's an entire shift in thinking.

The emergence of a program and healthcare model that speaks just to health inequity. That's where I think the opportunities are.

In terms of what's coming next from the federal government and then further down into the state level, you might see, because coordinated care seems to be working somewhat, government funding increase towards the problem and the solutions of health equity, health equity being a coordinated care problem in itself. It's hard to fix health inequity with one solution.

What I see is a commitment for funding as an incentive. What I mean by that, and you mentioned Medicaid, is that there may be additional funding to support non-medical factors of care. So we know that 80% of good, healthy living is non-medical - the social determinants that drive good healthy living. While Medicaid was essentially a payer providing the medical service, it was not a coordinated effort to address the whole care of the person and their social services and it was not coordinated care. What I see is, from a federal level, is the funding to pull those services together to ensure that there's coordination, that the non-medical needs are met, and that the providers of those services have revenue to support them. I see ACO REACH, for the first time in a CMS program, includes a health equity component, which is an added incentive to providers that participate in ACO REACH.

The edict is to develop what they think is the right model, what the provider thinks is the right model. The core task, really, is to provide access, right? So that's a core component of the inequity issue. If you look around at the landscape, there are emerging healthcare delivery models that are forming to address this issue specifically. Some of those are privately funded, not all are government funded. I think it's early, but we do see some emergence from the government perspective and private perspective in this space.

Do you see capitation, in its form today, ultimately being replaced, in a broad sense, by value-based care, or will it continue to exist in some shape or form?

I think it'll continue to exist in some shape or form. In the current CMS models as well as in value-based models administered by payers, there's a level of both capitation and fee for service. So I think some utilization of capitated payments will continue to exist as part of models when it makes sense and if the payer is able to administer capitation. I also think fee-for-service will continue to exist. I mean, it's a sound model. The factors are geographic, relative value, effort, conversion. It's a well-thought-out formula, though admittedly not perfect. The challenge with fee-for-service is always the same - it's transactional and there's less cost accountability with fee-for-service billing. That notwithstanding, in some respects, I think it's necessary for the foreseeable future as a payment model within certain specialties.

As value-based care evolves and becomes more prominent in these historically fee-for-service practices, what is the infrastructure requirement? What are the differences in infrastructure requirements to support value-based care versus fee for service?

We're walking through this with one of our practices now. What's the right support for the practice to manage well and how do you maximize your revenue? So it really requires strong analytics. This requires specialized resources that can help pull data from your systems on the patients that are in these value programs to ensure that the metrics attached to those patients are met. It's both prospective and retrospective. In other words, identifying for the provider, "You're going to see Patient X today," and she needs her annual wellness, if it's Medicare Advantage, and it's time for her A1C, and she's not taking her medication because the pharmacy feeds into your system and says she hasn't gotten it filled in 60 days. It's the infrastructure, the analytics and then the human being that is calling the member to manage and execute on their specific care plan needs. It requires a plethora of resources depending upon where you are on the value-based care continuum, but it really starts, I think, with good, strong analytics, and office support that will engage with your patient base to ensure that you are meeting those measures.

The fee for service model is most familiar, right? The providers continue to do what they've always done. The challenge, I think, is changing the behavior to align with value. The fee for service is already very familiar and so therefore it's not a challenge for most physicians.

The other thing I want to say here is that accountability in these situations does not just sit with the provider. The payer is still ultimately accountable. The payer is also in a position of giving feedback through performance reporting for value and feedback on your fee-for-service billing and that doesn't stop in value-based care models - that continues to exist, in terms of how you're billing, volume you're billing, level of codes that you're billing. The payer is still a partner.

From your experience, do you see the beginnings of weaving value-based into hospital and health system contracting?

Absolutely. As one case study, a large health system converting FFS to FFV lasted a year to complete. Their Medicare Advantage rate was 105, 107. Just to level set, the Medicare Advantage rate in mature markets typically now is 100% if you have the volume of a health system. In this case study, which occurred back in 2015 – 2016, we were introducing value for the first time. A request for an increase was on the table, and that unit cost increase was untenable. The discussion, which took place for literally over a year, evolved from a zero-sum discussion into, "you are a partner." Eventually, this health system carried over 40,000 members in Medicare Advantage with a wraparound benefit of a $0 copay, but before that, the discussion really was shifting their spend from fee for service to value.

We implemented what we call a glide path, where we took 1% of their Medicare spend, tying it to value over three years, so there was eventually a shift from fee for service to value. It was a long conversation on how we would be able to accomplish that. We came out with a value program that was customized for that particular health system.

In this case, the health system had over 1000 physicians, 400 to 500 of them were primary cares, the remainder were specialists, sub-specialists of, obviously they had all of the ancillary infrastructure, ED, the entire thing.

And so yes, and they are long, difficult discussions, because if you think about the tenants of value, you're looking for outcomes, and some of those outcomes have to do with quality, but some of them have to do with cost reduction. You're saying to a health system who wants to keep their beds full, "We're trying to move patients out of your hospital, and we're trying to move patients out of your ED and into the right setting for their care at the right cost." And so yes, you have to dig deeply, but that's where partnership evolves. One of the things I so deeply saw, just in a contracting role, is that a fee-for-service negotiation can be adversarial. A value conversation becomes a partnership. How do we, together, render the right care at the right cost with the right outcomes for the member, the payer's member, and the health systems' patient? When you make that shift, then together you work at getting to the right position and the right percentage of value.

I read a statistic recently that said the value-based shift - and I use the word shift because it involves all of the quality oversight and behavioral changes that go along with value-based programs - becomes profoundly felt when a health system has about 50% of their population in a value model. I saw that with this health system. I saw a major, major shift. There was a major investment on their part with their EMR, and there was a major shift in investment in building out a specialized clinical team. In the end, it was beneficial both from a revenue perspective as well as to the market. 40,000 people in one market, just in Medicare Advantage, are beginning to have different health outcomes because of this model. So, the answer is, yes, health systems are gradually adopting value-based care models albeit often at a slower pace and through laborious discussions and processes as well as customized partnership models.