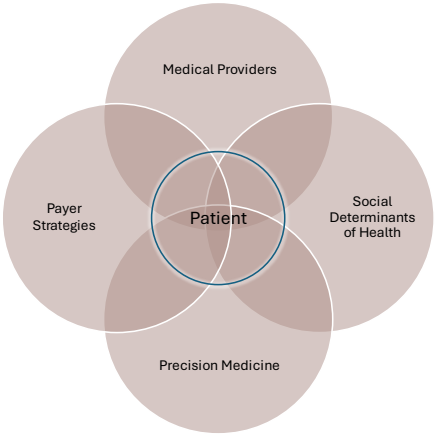
THE TIME TO ADOPT VALUE-BASED CARE HAS COME

ARE YOU READY?

Value-Based Care (VBC) has been around for quite some time in healthcare, but it has been a slow burn to adoption. Over the past several years, due to the Affordable Care Act (ACA) and exploding Medicare (and Medicare Advantage) costs, the drive to consider VBC has been gaining momentum, but there is still much to do. In this article, we will lay out the key "need to know" information about VBC and insights into how payors should approach evolving into a VBC model.

Value-Based Care (VBC) is a healthcare model that ties healthcare providers' compensation to the quality, equity, and cost of care they deliver. The model focuses on improving patient outcomes, such as health quality and satisfaction, while also promoting cost-effective care. Providers are incentivized to deliver better care by focusing on the overall health of patients, addressing preventive care, and coordinating treatment. This model contrasts with the traditional fee-for-service system, where providers are paid based on the volume of services delivered rather than patient outcomes.

The U.S. spends significantly more on healthcare than other countries but has poorer health outcomes, including higher rates of infant mortality and preventable deaths. Longstanding disparities in access to care have led to worse health outcomes among marginalized populations. Experts attribute some of these issues to the fee-for-service system, which rewards healthcare providers for the number of services they perform, not the effectiveness of those services. Value-based care aims to shift this dynamic by rewarding providers for improving patient health while controlling costs.



Key Features of Value-Based Care

Collaboration & Coordination

Healthcare professionals, including doctors, work together to manage a patient's overall health, coordinating care, reducing unnecessary visits, and avoiding emergency room visits or hospitalizations when possible.

Focus on Health Outcomes

Rather than being reimbursed for the number of services provided, providers in a value-based care system are reimbursed based on the health outcomes they achieve. This means better health for patients at lower costs, with more emphasis on preventive care.

Personalized Care

Providers in value-based care understand that each patient has unique health goals. This can mean addressing not only medical conditions but also non-medical factors that might affect health, such as transportation issues, social support, or access to food.

Patient-Centered Care

This model encourages treating the whole person — addressing physical, mental, behavioral, and social needs. A more holistic approach to care includes coordinating social services, educational resources, and disease prevention programs.

Role of the Patient

In value-based care, patients are encouraged to be active participants in their healthcare. They collaborate with providers to create personalized treatment plans and communicate their concerns or questions.

Health Equity

VBC emphasizes health equity by focusing on improving outcomes for all populations, especially underserved ones. Providers are encouraged to address social determinants of health and ensure equitable access to care, such as connecting patients to food banks, transportation, or interpreter services as needed.

Benefits of Value-Based Care:

Several studies have tested value-based care programs, including those led by the Centers for Medicare & Medicaid Services (CMS). These studies suggest that value-based care can reduce costs and improve care quality, although results have varied. Potential benefits include:

- Reduced hospital admissions and emergency department visits.
- Better care coordination, leading to fewer redundant tests or services.
- The opportunity for providers to deliver care in a more personalized and preventive manner.
- Potentially improved health outcomes, especially for complex or marginalized populations.

Measures of Success in Value-Based Care:

Providers are held accountable for a range of goals tied to quality, cost, and equity. Key areas include:

1. **Quality**: This can include effectiveness (evidence-based care), efficiency (avoiding unnecessary resources), patient safety, timeliness, and patient-centeredness.
2. **Cost**: Providers are rewarded for reducing unnecessary or high-cost care, such as hospitalizations or emergency visits, while maintaining or improving care quality.
3. **Equity**: Value-based care increasingly focuses on addressing disparities in healthcare access and outcomes for marginalized groups, particularly people of color and low-income populations.

Strategies Promoting Value-Based Care:

To incentivize healthcare providers, a variety of strategies are employed, including:

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- **Financial incentives**: Payment models that reward providers for meeting quality and cost-efficiency goals. These can include upside (bonus payments) or downside (penalties) risk, where providers stand to gain or lose depending on performance.
- **Non-financial incentives**: Participation in value-based care can enhance a provider's reputation and offer greater flexibility in delivering patient-centered care.
- **Measurement**: Providers' performance is assessed based on several metrics, including patient outcomes, care efficiency, and equity.

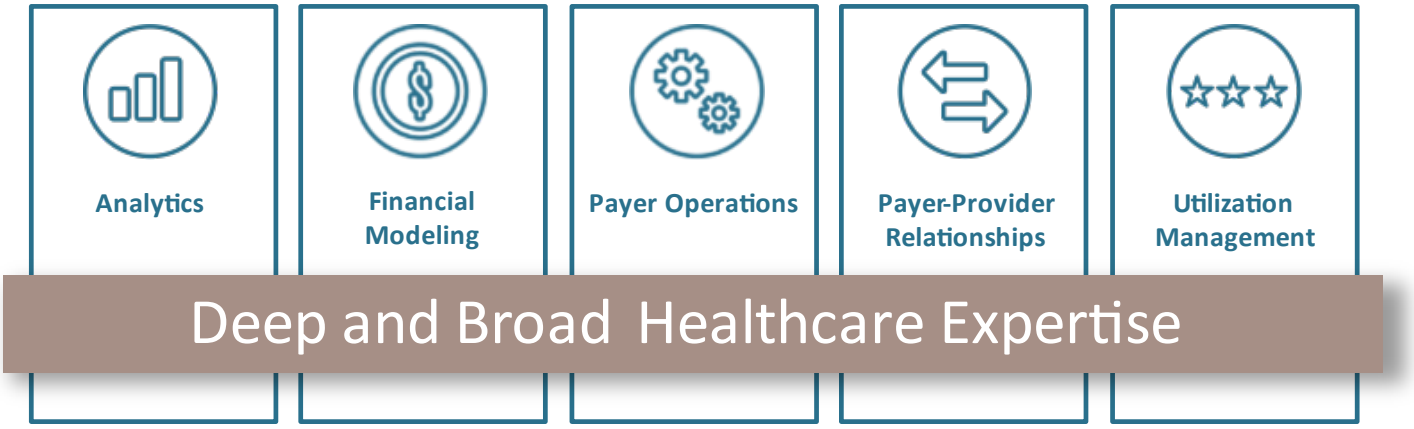
Challenges and the Future of Value-Based Care:

Despite growth in value-based care models, many providers still operate under traditional fee-for-service systems. There is ongoing work to improve the financial viability and accessibility of value-based care, particularly for providers serving rural or disadvantaged populations. CMS aims for significant adoption of accountable care models for Medicare and Medicaid by 2030.

It is critical for payors to assess their opportunity and outline a strategy on how to approach replacing their fee-for-service models. Developing the optimal roadmap and timing will ensure a smoother path forward.

Are you Ready to Explore Strategies and Begin Your Transformation?

The Well Solutions Group brings significant expertise in Payer Operations, Payer-Provider Relationships, Utilization Management, Financial Modeling, and Analytics aimed at improving payer performance and developing efficient organizations.



Some of the key areas where we focus in developing effective VBC models include:

1. **Designing Interdisciplinary Care Models**:
    - Successful healthcare organizations are shifting to care models that prioritize collaboration across different disciplines. This approach ensures that patients receive comprehensive, coordinated care, which is critical for engaging patients and effectively managing their clinical outcomes.
2. **Patient Engagement and Active Clinical Management**:
    - Programs that keep patients engaged in their health, including proactive management of chronic conditions, are essential. Such programs often leverage health coaches, care managers, and technology to monitor patient progress and intervene early when needed.
3. **Technology-Enabled Solutions for Population Health Management**:

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- To manage large populations of patients effectively, organizations need robust technology solutions. These can range from electronic health records (EHRs) to sophisticated data analytics tools that help identify at-risk patients and guide treatment decisions.

4. **Designing an Optimal Care Network**:
    - Structuring a network of providers that can deliver high-quality, cost-effective care is fundamental. This may involve creating strategic partnerships, selecting providers who align with value-based care principles, and optimizing care coordination.
5. **Addressing Healthcare Disparities**:
    - The next step for organizations is ensuring equitable care by addressing disparities in healthcare access and outcomes. This may involve focusing on underserved populations and implementing community health initiatives.
6. **Aligning Economic Models**:
    - A sustainable economic model is crucial to achieving success in value-based care. Organizations must align financial incentives to support coordinated care, including the potential for shared savings or performance-based reimbursements.
7. **Expanding Payer-Provider Partnerships and Other Revenue Streams**:
    - Healthcare organizations are diversifying their revenue models, including forming payer-provider partnerships, exploring direct-to-employer strategies, and engaging with government programs like Medicare and Medicaid. These approaches can provide new income streams while sharing the risk and rewards of value-based models.
8. **Unlocking Internal Clinical and Analytical Capabilities**:
    - Building internal capabilities in both clinical and analytical areas helps organizations manage risk and optimize care delivery. This includes investing in clinical leadership, data infrastructure, and decision-support tools that align with value-based care goals.
9. **Practical Knowledge and Executive Experience**:
    - By leveraging experience from former executives at health plans and risk-bearing providers, organizations gain valuable insights into how to execute these strategies effectively.

This strategic framework is intended to guide healthcare organizations in navigating the shift towards value-based care, ensuring that they are positioned to capture more lives under Medicare Advantage and other risk-based models while improving both patient outcomes and financial performance.