An Insider's Playbook: Advancing Success in Value-Based Care

Value-based care isn't going away, that's a good thing.

Value-based care represents a seismic shift in the delivery of healthcare, moving patients to center stage. The basic premise: organize our healthcare system in a way that compensates the provider of care for delivering value to their patients. Rather than being paid for tests and office visits as is now the case, physicians are rewarded for delivering better patient outcomes.

After a combined 30+ years in healthcare at health plans and solution vendors, leading cost of care analytics teams as well as running analytics, actuarial and health economics operations, our team of healthcare veterans has a unique perspective on the challenges health plans and provider organizations face and know firsthand the barriers plans and providers must overcome in order to win in value-based care.

We developed this reference guide as a resource for health plans and healthcare organizations, honed from decades spent in the trenches and speaking the language of analytics. We see the good, the bad and the ugly and aim to enable health plans and provider systems to achieve greater success with value-based care by bringing these insights to you.

In this guide you will find:

- An overview of Value-Based Care (VBC) fundamentals
- Recent examples of VBC successes and learning opportunities across the industry
- Our perspective on essential elements of successful VBC programs
- Lessons learned from our lived experiences about pitfalls to be aware of and key questions to ask on your journey towards embracing value-based care
- Emerging trends in VBC - people, process and technology
- Closing thoughts on the importance of collaboration and transparency, the foundations of trust and essential elements for any VBC contract

We hope that you use this guide as a resource to learn and spark conversations within your organizations with regards to how you can embark on or enrich your value-based care strategies. If you would like to discuss how we can help, contact us here.

An overview of Value-based care (VBC) fundamentals

It's true that alternative payment models (APM) have been around for some time. The term "value-based care" (VBC) entered into the healthcare lexicon in 2006. Michael Porter and Elizabeth Olmsted Teisberg are credited with introducing this phrase in their book Redefining Health Care.

The modern US reimbursement system has not been primarily value centric. In most cases, starting with the largest payer - CMS (Centers for Medicare and Medicaid Services) to the typical healthcare insurer (i.e. United, Cigna, BCBS, etc.), healthcare is reimbursed or paid for on what's referred to as a Fee-For-Service or FFS basis.

This simply means that when you or I go to a healthcare provider (i.e. an individual physician such as a Primary Care Physician (PCP) or a facility such as a hospital emergency room (ER)) there are costs incurred for the services rendered during that visit. The provider will express the costs of these services as charges and will typically produce an itemized bill for reimbursement.

Depending on who's responsible for payment (you, the individual, or perhaps your employer if you have employer based coverage or maybe the government if you are enrolled in Medicare or Medicaid), there is a predetermined fee the provider has agreed to accept as payment for services. This fee is typically negotiated upfront as part of the contractual agreement between the provider and the payer, and itemized to specific units of care provided (e.g. the visit/consultation from the doctor, the room fee, the pills delivered and administered, etc.).

The issue with this concept is that the actual value - or health outcome you as a patient receiving care - achieved does not enter the FFS equation. Under a FFS construct, the provider is paid regardless of whether your health improves or your condition worsens. If, however, the provider has entered into a value-based arrangement with your insurer (payer), then they would potentially receive a bonus payment if your health status sustains or improves, particularly if a hospital visit, preventive condition or expensive, medically unnecessary procedure is avoided.

Depending on the type of arrangement, they might also incur a penalty (or a loss) if your condition worsened or you experience an adverse outcome, like a related ER visit or a readmission to the hospital. This is why you will hear value-based care often referred to as incentive based payment. A VBC reimbursement method inherently incentivizes your provider to look beyond the service he/she is providing and consider the totality of your health, and what are the right steps to take to improve it.

It's like taking your car in for a full service oil change, paying the bill and then having your engine fail because the dealership failed to check if your air filters need replacing. Why is this important? Well, you may not know that driving with a dirty or damaged engine air filter impacts your engine's performance, blocking the flow of clean air and preventing fuel from burning correctly. Over time, the air filter becomes less effective at filtering clean air into the engine, impacting your car's overall performance. So, it's standard practice for most repair/service shops to inspect your air filters during an oil change to prevent costly engine replacements down the road.

In a FFS world, the repairman gets paid for the oil change and you get stuck with a costly engine replacement or worse, having to get a new car. Under value-based care, the repairman is held accountable for the overall health of your vehicle and is incentivized to do a complete and thorough inspection in order to flag any concerns that could damage your vehicle over time.

Better care. Lower cost. Improved experience. All good things - no wonder we see such significant growth in alternative payment models, or value-based care, across the industry. Projections indicate that by 2030 shared accountability models will apply to 50% of commercial and Medicaid expenses and almost 100% of Medicare expenditures.

Nevertheless, there remains a lot of hesitancy about the shift to value-based payment, and as an industry, we seem to be stuck in place. Insurance companies who pay for care and physicians who provide care are often deadlocked in manual processes, inefficiencies and imprecision, fundamental issues that create friction and underlie a persistent lack of trust and transparency. Generally, payers and providers are ill equipped to address these challenges with their existing infrastructure and processes.

Recent examples of VBC successes and learning opportunities across the industry.

Despite the aforementioned issues that malign broad VBC adoption, there are signs of life

across the industry with albeit mixed results.

The Centers for Medicare and Medicaid Services, CMS has long been a pioneer of the alternative payment model movement going back over a decade with a long list of payment innovation models that have not panned out; only 6 out of 50+ models have delivered statistically significant cost savings. Winning models include:

1. Pioneer ACO
2. ACO Investment Model
3. Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Model 1
4. Home Health VBP 2
5. Medicare Care Choices 2
6. Maryland All Payer Model

Within the private sector, there have been a range of wins and losses. Commercial insurers have tried different flavors of APM in an attempt to find models that can scale across populations that are less stable than Medicare/Medicare Advantage and are far more susceptible to cost swings due to greater choice and variability in plan composition.

Let's look at a few winners:

- Blue Cross North Carolina's Blue Premier program stands out as a successful VBC program for both scale and performance. Since 2019, the program has produced over $350 million dollars in cost savings, covers over 850,000 lives and maintained agreements with over 10 health systems and 850 physician practices.
- Cigna's Collaborative Care program wins points for longevity, having been in place since 2008, the program boasts agreements with over 230 primary and specialty physician groups in 32 states.

On the other hand, there have been some programs that have not fared as well on the path to value:

- In 2018, much ado was made about Haven, a program birthed as a result of a partnership between JP Morgan Chase, Amazon and Berkshire Hathaway that was billed as a way to "disrupt" traditional models and find more cost-effective solutions for high, rising costs of employee health care. Ultimately the parties disbanded in 2021 because of poor timing, misaligned incentives, insufficient knowledge of the inner workings of healthcare and a lack of true collaboration.

- Further back in time, a 2014 partnership between Boeing and Providence St. Joseph's Health to create an Accountable Care Organization (ACO) that would bypass private insurance through a direct contract, ended in 2018 after failing to achieve financial sustainability.

Essential elements of successful VBC programs

Across all the trial and error that has gone into rolling out alternative payment models in public and private sectors, we can observe several elements that when taken together tend to lend themselves to a formula for success. First, a disclaimer, no model is perfect and APMs are not one size fits all, therefore it's important to consider your organization's unique needs and circumstances as you weigh the merits of the proposed elements below. Second, it's imperative that we establish what we mean by successful VBC programs.

In simple terms, we define success as programs that 1) yield meaningful, validated cost savings (compared to a baseline or cohort comparative analysis), 2) produce statistically significant improvements in quality of care/patient outcomes and 3) demonstrate a "positive experience" (as measured by patient/member and provider satisfaction). In other words, programs that have proven success are aligned with the objectives of the Quadruple Aim: lower cost, improve outcomes, increase patient experience, improve physician engagement.

That said, success leaves clues and the eight tactics that follow have been battle tested over the course of time as those most associated with successful value-based care programs.

1. **Population-level measurement:** Effective population-level based programs support a whole- person approach to measuring care delivery and treatment, accounting for many factors like costs, services, and utilization. Population-level programs are typically referred to as total cost of care payment models and require that providers and payers have a comprehensive grasp of the model's key metrics, such as quality measures, performance benchmarks, and financial incentives or penalties. This clarity enables providers to align their care delivery processes accordingly and fosters accountability for both parties to improve outcomes and lower the cost of care.
2. **Defined attribution model:** the assignment of accountability of a patient to a responsible provider, is the way to organize and distribute individual members under one of three typical methodologies: the doctors they choose, the doctors they use, or the ones they've been assigned to. Even the most well thought out approaches are fraught with risks, have plenty of devilish detail issues, and tend to be the key

debatable element of value based deals. The best payment models take a disciplined and transparent approach to defining the process for determining which members to assign to a program. Great programs routinely refresh and communicate who is eligible and who isn't, ensuring there are no surprises with regards to the attribution rules for a given program.

3. **Primary care-based*:** Findings of a study examining health care waste in Washington state showed that nearly half of 1.3 million patients received care that is considered low value or wasteful, contributing to an estimated $282 million in unnecessary health care spending in 1 year in Washington. Primary care physicians or PCPs are a first line of defense for ensuring appropriate, high value care is delivered and as a result, are often viewed as the best chassis to develop a shared incentive program around. The asterisk here calls out an emerging trend in evolving models centered around specialists as well, particularly in conditions where the specialist coordinates care in consideration of a patient's chronic condition.

4. **Physician-led:** Physician-led decision-making and evidence-based education at the forefront of innovation, ensures that providers succeed and thrive under payment innovation models. Aligned expectations between providers and payers are crucial in ensuring the success of value-based care contracts. However, physician-led programs create a clinical thread linking the payer's goals, such as cost savings, improved patient experience, or reduced hospital readmissions, to practice transformation strategies, creating incentives to appropriately tailor care delivery.

5. **Account for patient experience, health equity and social determinants of health:** Unmet social needs pose a huge problem to patients' health and well-being. Rolling health-related social needs into value-based arrangements allows for maximum flexibility. We can empower a care team to decide that a $300 air-conditioning unit is going to do more for their COPD patient on hot summer days than five trips to the emergency department.

6. **Guard against upcoding:** Transparency among payers and providers that supports accurate, defensible coding is essential to success in all value-based arrangements. By accurately documenting disease burden, and correctly billing the services rendered to patients, providers and payers can fairly adjust for severity, paid services, and monitor changes in cost and utilization without unintended impacts from new services, high severity patients, etc.

7. **Upfront Investments:** VBC transformation requires acknowledgement of the barriers to entry for small physician group practices and healthcare providers with

less capital, who tend to care for underserved communities. Cash flow problems are a reality and need consideration and coordination to keep these practices engaged. Successful value-based care programs often include Care Coordination fees, fee schedule adjustments, or other upfront investments to promote resource-intensive physician workflow changes needed to maintain operations prior to the first performance period's reconciliation.

8. **Create a glide path to two-sided risk:** Trust requires alignment and confidence that there's a shared goal. From a provider perspective, alignment of value-based payment arrangements across multiple payers is critical and payers have varied terms, rules, and methodologies today. Acknowledging and removing opaque language from contract terms will help with payer/provider trust-building, and give providers better line of sight to drivers of performance variations between payers. Payers committed to shifting to value based care reimbursement best support the glide path by incorporating the progression in multi-year arrangements and providing tools and resources that give providers more opportunity to understand possible outcome scenarios.

In the trenches: Lessons learned through lived experiences

If the last decade taught us anything about VBC, it is that progress is possible but slow and challenging. Frankly speaking, this is harder than we thought. As an industry, healthcare underestimated the difficulty of moving to value-based care. Though we've learned much and made progress, the change has been, and will continue to be, difficult. Meaningful risk is not the same as value-based payment. Despite significant growth in the percentage of dollars tied to value-based care, the percentage tied to meaningful risk remains small. And in some examples, while meaningful risk arrangements constitute a high portion of spend, the links to quality of care and patient experience are more ambiguous, transfering the financial risks but less directly incorporating value. This impedes overall transformation efforts, as the incentive opportunity hasn't yet outpaced the potential FFS magnitude.

Successful VBC requires both financial and clinical transformation. VBC is not one journey but two, simultaneous transitions. Transforming the financial model without changing the clinical model, or vice versa, is like only solving half of the equation. With the hyper-fragmentation of the healthcare industry, payers and providers typically have an overwhelming number of contracts to manage. The documentation burden is equally heavy on providers and payers. Both sides are often understaffed, under-experienced and overburdened. This is a core challenge for the adoption of value-based models. If this workforce burns out before we reach a critical mass of transition to value based contracting, we run the risk of not fully capturing the potential of value-based care to transform care

delivery.

VBC programs are not one size fits all. VBC is different for each line of business though there are commonalities between risk in Medicare, Medicare Advantage, Medicaid, and Commercial populations. But so far, succeeding in each line of business requires a different value based care strategy. Future progress depends on achieving success across multiple lines of business, and differentiating the mechanisms used to accomplish it.

VBC Continues to Evolve: What's New & Next?

While some challenges are universal, there remains significant opportunity to improve value-based care across all lines of business on common issues such as data interoperability, health equity, and behavioral health. Below is a short list of new and innovative ways value based care adoption is unfolding right now—and what to expect in the coming years:

- Health Equity (through ACO REACH): The ACO Realizing Equity, Access, and Community Health (ACO REACH) model promotes health equity and focuses on bringing the benefits of accountable care to Medicare beneficiaries in underserved communities. The program aims to include policies that promote provider leadership and governance as well as protect beneficiaries with increased vetting, monitoring and transparency.

- Behavioral health: Trends toward value-based care (VBC) models in behavioral health are emerging due to greater coordination between payers and providers, allowing the standardization of measurable and meaningful outcomes.

- Specialty care, including ESRD, oncology, and post-acute care: While primary care remains central to total cost of care or population-level APMs, many patients are facing greater clinical and health system complexity. To complement population-based models, fully achieving whole-person care requires the additional depth and scope of services offered by specialty care and the effective coordination of primary and specialty care providers.

- Hospital-At-Home/End of Life/Hospice Care: The Centers for Medicare & Medicaid Services (CMS) continues to examine value-based care models along all points along the care continuum including home health and hospice. National insurers are taking notice and making investments in home based care to improve care coordination.

Accelerating Value Based Care: The Case for Tech-Enabled Contracting Workflows

It's no secret that health plans & providers have struggled to align on payment innovations programs at scale. Progress has been made over the past decade regarding participation in alternative payment models vs FFS, but these models are largely built on FFS infrastructure, and adoption of population-based payment models continues to lag.

When we talk about scale - we're talking about infrastructure, systems and processes that automate redundant tasks, save time and build trust. Health plans and providers struggle to scale value based programs because the majority of organizations are using manual processes and outdated systems, taking, on average, 6-12 months to negotiate contracts and feeling unsure that what they contracted will net a positive result.

Taken together, we see a lack of confidence in knowing what models yield the best outcomes and persistent inefficiencies that waste time and fracture trust between payers and providers.
VBC contracting remains a bumpy process at best, and utter chaos at its worst. Today, health plan actuaries, analysts and network managers work in silos using a patchwork of analog tools to model projected savings and negotiate contracts with providers who then need to wade their way through murky, complex terms & "black box" math in order to determine their revenue potential.

For over a decade, tech-enabled solutions have turned their focus downstream and offered options for population health, care intervention and clinical practice transformation. Today, new solutions are emerging that offer a better way for each stakeholder at every step in the process - from data ingestion and modeling contracts to measuring performance and managing the portfolio of arrangements.

Tech-enabled contracting solutions focus upstream and solve workflow and collaboration challenges for internal and external teams. Leveraging solutions that provide infrastructure and tooling specifically designed for value-based care can offer:

- Financial and data stewards the accuracy, credibility and fidelity to ensure right data and best fit models.
- Network management teams a bridge between contract parameters and financial assumptions, empowering them to move negotiations forward.

- Providers a way to improve transparency through shared math – with real time insights into how VBC models can generate better outcomes and improve their bottom line.

Beginning with ingesting and validating data and contract inputs, tech-enabled contracting solutions can support teams in building contract models that can be configured to address specific attribution, cost and quality parameters. Moreover, as users model scenarios they can easily compare projected savings estimates to budget targets and evaluate key differences.
Finally, when a model is approved for negotiation, robust contracting solutions can securely enable the ability to view proposals, make adjustments, accept and finalize contract terms - all within one platform yet traceable for required audits and validations.

Organizations seeking to create efficiency and scale in their value-based care strategies are wise to seek out tech-enabled contracting solutions that can truly partner on building value-based care arrangements: fostering trust, transparency and transformation.

The future of value-based care is cooperative.

Ultimately, value-based care is a team sport. It requires health plans, provider organizations, patients and everyone in between to work towards the common goal of making healthcare better and more affordable for all.

As your organization looks to power the future and embrace payment innovation, be sure your strategy:

- Supports top line growth through leveraging incentive based models as strategic, competitive assets fortified by greater confidence in “best-fit” design
- Accelerates the shift to value based care by deploying tech-enabled contracting solutions that save time, streamline and automate workflows - creating faster speed-to-market and finally,
- Becomes a vehicle for collaboration, strengthening relationships through shared accountability.

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At Syntax, we believe a better healthcare system is possible with value-based care that incorporates transparency and trust at all stages. We believe the system works better when there

is less friction and when everyone has access to the same information. We believe the future should be more cooperative. And we're ready to make it happen. Let's talk if your organization is ready to turbo-charge your value-based care strategy. We can help you simplify the math, demystify the process & empower both sides to win.