The Benefits and Challenges of Engaging with Multiple Payers and Various Value-Based Care Programs

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Engaging in Value-Based Care Programs

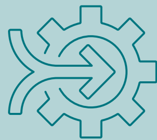
Value-Based Care (VBC) can drive meaningful improvements in patient care by aligning payment with value. While many payers have VBC programs, differences in structures and requirements can leave practices with an unbalanced focus on program requirements, which can create a burden that pulls resources away from patient care. Creating a quality VBC strategy allows practices to harmonize various programs ensuring quality patient care while minimizing practice burden.

Benefits

Practices that form an overall quality strategy and juggle the complexities of multiple programs will improve patient care and realize financial gains. These financial gains are used to support practice transformation resulting in improved quality, patient experience and patient outcomes. Although there are many benefits to participation, it is imperative practices understand what is needed for success.

Transformation of both the care team and the care delivery process is essential.

Focusing on patient care improvement activities is paramount to success. Simply doing the minimum will not bring the level of performance needed to improve quality patient care and earn full financial benefits. Care teams must consider the purpose of the program with the main goal of improving patient care. For example, program requirements, such as standards or quality measures, should be implemented in a manner to reach the desired result in patient care, not just check the box.



Program-specific changes to care delivery must be integrated into the practice's current care delivery processes.

Practices have the option to redesign operational components of care completely or identify focused interventions depending on the type of VBC program(s) in which they participate. Incremental changes or focused interventions are usually the best way to work on VBC models such as a focus on navigation services for high-risk patients. Wholesale operational changes place a significant burden on the entire care team and could potentially result in diminished quality of care.

The commitment of the practice and the payer to achieve success requires collaboration and ongoing communication.

This can foster a strong relationship with payers and allows the practice to provide feedback on the program structure and requirements of current models with a keen focus on patient care improvement activities, which deepens collaboration in the design of future programs. Participating in multiple programs means more time invested in building multiple payer relationships but allows the practice to truly transform care and earns the practice a reputation as a leader in VBC.

Practices must adopt a continuous quality improvement mindset to be successful. Quality performance and cost reduction in the early years may be easy, but continued improvement year over year requires diligence in reviewing performance and identifying new opportunities.

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Challenges

The most challenging aspect for a practice participating in multiple VBC models is that none of the programs are exactly the same. Variation in quality and operational metrics contribute to this challenge. Further, there can be measures from multiple programs that are similar with subtle differences or there could be numerous measures with the same intent or goal.

One type of VBC program with differences in measurements are evidence-based pathways. Payer-specific pathways, Value Pathways powered by NCCN and other evidence-based pathways are all subsets of NCCN Guidelines. However, every payer has slightly nuanced clinical pathways required in their medical policy, which drive different practice behaviors, increases the complexity of care, and can unintentionally reduce the quality of care provided.[1]

An example of similar measures that differ in the intent and patient population are the hospitalization measures. One program may measure the number of patients hospitalized who have had a treatment in the last 30 days, while a total-cost-of-care program would measure all-cause hospitalizations. Practices must be able to focus resources on similar patient populations to ensure outcomes are improved.

As stated in a recent AJMC article, "Oncology Alternative Payment Models: Lessons From Commercial Insurance," cancer cannot be well described in claims, and this leads to data exchange challenges.[2] Some VBC programs, like pathways programs or gold-carding, often require consistent data exchange between practices and payers on specific types of data. On the other hand, VBC models like medical home and shared savings require extensive data sharing. The proper data infrastructure (SFTP or the like), analytical expertise to drill into the data, and an engaged team that has been educated on the methodology and intricacies of data are needed to improve quality and cost.

Another significant challenge inherent in VBC programs is the need for the practice and payer to agree on attribution logic, eligibility and program enrollment. This is necessary so the practice can identify patients and target initiatives specific to that patient population. The payer needs to identify members, pull their claims, and provide consistent data for these patients. Payers typically have attribution logic for primary care VBC programs; however, this logic is usually adjusted for an oncology VBC program to ensure members are assigned to the oncologist for performance measurement and to avoid potential duplicate shared savings payments.

[1] American Society of Clinical Oncology Criteria for High-Quality Clinical Pathways in Oncology, Robin T. Zon, Stephen B. Edge, Ray D. Page, James N. Frame, Gary H. Lyman, James L. Omel, Dana S. Wollins, Sybil R. Green, and Linda D. Bosserman, *Journal of Oncology Practice*, 2017 13:3, 207-210

[2] Oncology Alternative Payment Models: Lessons from Commercial Insurance, Elizabeth Shaughnessy, MA, David C. Johnson, MD, MPH, Aaron J. Lyss, MBA, Ravi B. Parikh, MD, MPP, Steven R. Peskin, MD, MBA, MACP, Blasé N. Polite, MD, MPP, Julie A. Royalty, Bhuvana Sagar, MD, MBA, Erin Smith, JD, Lindee Goh, PhD

Creating a Quality Strategy

The best approach to mitigate these challenges is to ensure continuous communication across the entire practice with goals, financial incentives methodologies, workflows, and performance for all VBC programs. This allows staff to develop a strategy for success with continuous quality improvement. Ensuring alignment of practice staff from ideation to implementation is an integral part of your overall VBC program strategy.

Successful performance in VBC programs can be defined as improved quality of patient care and outcomes; a reduction in the cost of care for the patient, payer, and employer; and the realization of practice financial benefits tied to performance. Creating an overall quality strategy keeps the practice focused on the key initiatives that can drive performance across programs.

Practices can no longer count on a single quality lead to manage performance; developing a strategy is a team effort. This team may include a physician champion, quality director, quality program lead, and data analysts, as well as a quality committee with representatives from both clinical and administrative stakeholders. For example, if participating in evidence-based treatment guidelines or gold-carding, an internal pharmacy and therapeutic committee will be needed for governance.

Execution of the strategy requires engagement and understanding across all members of the administrative and clinical teams, for example:

- The financial counselor needs to understand how their counseling may impact a patient's decision to proceed with treatment or a specific drug.
- Schedulers must be able to clearly articulate why appointments and referrals are being made so patients can understand the importance to their care and will follow through with scheduling and keeping those appointments.
- Medical assistants need to know how the completion of important screenings and entering the results in the medical record allows providers and nurses to act based on those results.
- Physicians need to consider the entire patient journey and patient goals when making treatment decisions.

To develop the strategy, first map out the requirements for all VBC programs. Compare the similarities and differences in the data elements used to measure practice performance. Look at how the score is calculated, and the methodology used to determine the financial benefit. Second, continually review the current performance for each program, at the practice and individual provider level, to see where ongoing improvement is needed.

To form your strategy, start with high-level key drivers such as access to care, NCCN guidelines, care coordination, and end-of-life care, and then drill down to the individual requirement and measure for each of the areas to identify specific action items for staff. Keep the patient perspective and care improvement in the forefront as you determine the priorities.

When measures are similar but requirements vary, implement a process that will meet measures across all programs. For example, if screening for depression is required yearly for one program and every six months for another, the process should be every six months for all patients to reduce variability. If one program has a measure for avoidable emergency department visits and another is based on total cost of care, steps taken to increase access for patients and communicate same-day visit or telehealth availability can improve performance in both programs.

Communicating the Quality Strategy

Once the quality team sets the strategy, a communication plan should be developed. Only when the right team of providers, leaders and staff can confirm the practice's ability to adapt the workflows needed for success can the practice begin communication. This step is critical to change management while maintaining patient care. Engage physicians and practice leaders first, then share the

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VBC program overview and high-level details with the quality committee and other relevant leadership. Following practice approval, share the VBC program in detail with all providers and staff. Team members responsible for change processes or creating new workflow have already been engaged up front when deciding to engage in a VBC program. Those team members help in communicating the new VBC program including process, metric collection and monitoring, and ongoing performance. VBC program updates are shared consistently with the quality committee, and clinic site updates are shared at regular intervals.

Gap analysis and planning work happens prior to implementation. This piece can be frustrating when the practice decides a new VBC program reward may not be worth the time, energy and resources. Sometimes it doesn't pay to move forward with a program. If it is too expensive to implement, if there is risk, or if the time it takes just isn't worth it, the practice can decline participation. This can turn into a negotiation with a payer, but it's important to note there are times practices choose to say no or negotiate better terms. In the end, practices need to be nimble and innovative to move forward to the next idea without putting too much of a burden on physicians and all staff, which raises the final component: physician engagement.

Engaging Physicians

With an evolving electronic medical record, new drugs coming to market, administrative and leadership responsibilities, and ongoing work on quality and patient experience, the practice demands on physicians have increased. The team responsible for quality and VBC programs needs physician engagement to be successful. At the same time, that team must keep an eye out for physician burnout or burnout of anyone on the care team. You may recall, in the early 2000s when IHI and Dr. Don Berwick first started using Triple Aim terminology to evaluate quality and VBC programs, there was originally a fourth leg, physician engagement versus physician burnout. The idea was that physicians are on the edge of burnout and practices need to do whatever they can to keep them engaged rather than overwhelmed. This component remains vital today. When adding to or altering a physician routine, keeping improved patient care and engaging physicians at the forefront cannot be understated.

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