A 3D model for value-based care:

The next frontier in financial incentives and relationship support

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In collaboration with:

UnitedHealthcare®

Contents

Foreword

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Driving More Value in Health Care Requires Looking Beyond the Financials

Despite the United States spending more on healthcare than any of its peer countries, Americans are not any healthier and are not necessarily getting the most in return for what they spend. That is why increasing healthcare value is a national priority that requires all of us across the system to be actively involved.

We are delighted to have worked alongside researchers at Harvard Medical School and the Harvard T.H. Chan School of Public Health to explore the next frontier of value-based care (VBC). In this study, Harvard introduces an exciting new concept: a 3D model for VBC.

In addition to the two financial dimensions commonly used in VBC models – spending reduction incentives and quality improvement incentives – Harvard researchers added a critical third dimension: infrastructure supports. These are the non-financial, process and data sharing supports that are becoming ever so important as payers and care providers work more closely together.

We are also grateful to the physician and health system leaders who gave their time to be interviewed and share their learnings and best practices as a supplement to this research. It's powerful to hear their perspective on how these non-financial factors are indeed essential to enabling them to transform their organizations to effectively deliver upon the promise of VBC. Their experience brings alive the relevance of applying the 3D model to how we work together.

At UnitedHealthcare, we've been committed to VBC over many years now. While we're proud of how much we've been able to achieve to date, we're fully aware there remains much more to do. The findings of this research affirm our sense that, as an industry, we make the greatest progress when we work in true partnership with care providers and always keep the patient experience at the center of everything we do.

Harvard's recommendations set out a shared agenda for the future of VBC program design that will inform and shape our own efforts at UnitedHealthcare. We hope that the 3D model and the insights presented through this report offer a fresh way of thinking about a familiar challenge, and how we can all work together to build a more sustainable healthcare system.

Section 1 Executive Summary

A 3D model for value-based care

Dr. Alyna T. Chien and Professor Meredith B. Rosenthal of Harvard Medical School and the Harvard T.H. Chan School of Public Health, respectively, conducted a systematic review of VBC models implemented over the past decade. The goal is to use this research to inform and guide future attempts to increase the value of care delivered in the U.S. and draw greater attention to the types of non- financial factors that can drive success.

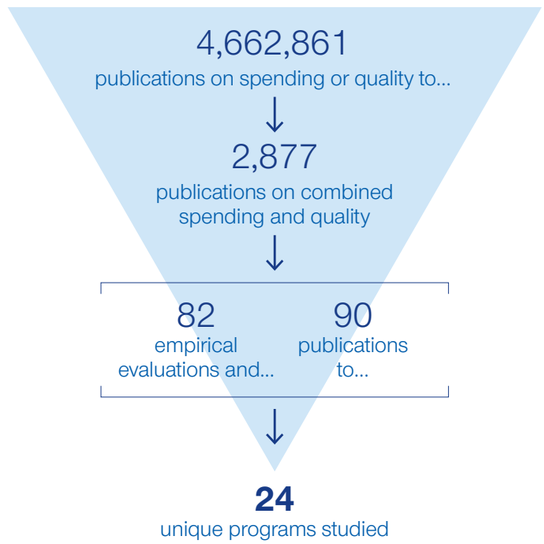
For years, the aim of VBC has been to align healthcare payments with healthcare value by using incentives to reduce spend, increase quality or both. VBC has been considered one of our nation's chief strategies for better aligning healthcare. Yet it remains difficult to draw lessons from these efforts to date because much of the research has focused independently on programs that reduce spending or those that improve quality. Few efforts have attempted to focus on the two when used together, and then add a third dimension beyond the financial incentives – infrastructure supports. This study sets out to tackle that issue in two ways:

1. It focuses on a sub-set of VBC programs that combine both spending reduction and quality improvement – what Dr. Chien refers to as 'Spending and Quality' VBC.
2. It analyzes the nature of the infrastructure supports (e.g., non-financial dimensions such as data sharing) that frequently accompany these programs. To date, these have been largely overlooked, yet potentially play a pivotal role in successful outcomes.

After a thorough review of 82 empirical evaluations on 24 different VBC programs, Dr. Chien and Professor Rosenthal formed the view that successful value-based models have three core dimensions. The first two are the financial incentives that are commonly used to reward care providers for reduced spending and improved quality. However, the third dimension relates to the types of non-financial infrastructure supports that care provider organizations may receive in their work with payers. This third dimension is the potential diamond in the rough that this study sets out to highlight, revealing a 3D model for value-based healthcare.

This study identified six commonly occurring categories of infrastructure support. In the 24 VBC programs that have been empirically reviewed, all but one incorporate some form of support, and most offer four or more. These types of infrastructure supports merit consideration because they may be critical to the success of VBC arrangements.

The research process



Common forms of infrastructure supports

- **Raw data**
- **Analyzed data**
- **Technical assistance**
- **Access to care management and tools**
- **Risk management support**
- **Infrastructure payments**

As one care provider interviewed reported, 'financial incentives in VBC programs can motivate provider organizations to change, but infrastructure supports actually enable organizations to make the change.'

For all stakeholders in the healthcare system who aim to improve and accelerate the impact of VBC, the Harvard team puts forward five recommendations for further action and exploration.

1. Use the full construct of the 3D model of spending + quality + infrastructure supports to design value-based care programs.

Beyond the often researched aspects of spending reduction and quality improvement, the third dimension of VBC programs identified by this study relates to the number and type of infrastructure supports that an organization typically receives. These may be critical to the successful delivery of VBC programs. Therefore, the first recommendation of this study is to embrace the 3D model in future VBC program design and in the evaluation of VBC programs.

2. Increase the share of provider group reimbursements tied to value-based payments.

While a large proportion of provider groups participate in at least one VBC contract, those payments still represent a minority of total reimbursements. This means that fee-for-service remains the dominant mechanism, making provider groups rationally unwilling to make the organizational changes necessary to shift.

3. Build stronger payer-provider relationships based on organizational alignment.

Shared data is a valuable mechanism for establishing organizational alignment between payers and providers. It also helps to create a shift in the relationships between payers and providers from a historically adversarial tone to a more collaborative, and a more aligned healthcare system.

4. Align measures across different payer contracts.

Care provider groups are faced with an enormous number of mismatching measures across both public and private payers. The burden of tracking and reporting against these different expectations represents a very significant challenge for provider groups, in both cost and resources.

5. Better align individual physician incentives with value-based contract incentives.

It is unclear how much line of sight individual physicians have into VBC contract incentives. For VBC models to have the greatest impact, provider organizations need to develop value-based compensation models that reach the physician level and ensure there is clarity throughout the organization, end to end, of what is expected and how success will be measured.

Care providers are at the very heart of delivering on the potential of VBC, so it is crucial to understand how to support their success. In the second half of this report, starting on page 25, the leaders of four provider organizations participated in in-depth interviews to offer insights on their journey toward VBC.

'It gives us a once in a lifetime opportunity to create exceptional alignment in healthcare.'

Mount Sinai · catalyst health network · BalladHealth · Rhode Island Physicians Corporation Primary Care

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Section 1

A 3D model for value-based care

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1.1 Why explore the value-based care frontier now

Chapter Summary

The ultimate goal of this systematic review is to inform and guide future attempts to increase the value of care delivered in the United States (U.S.) because although the U.S. spends a considerable portion of its gross domestic product on healthcare, the amount of health that Americans receive in return lags behind that of other developed nations.

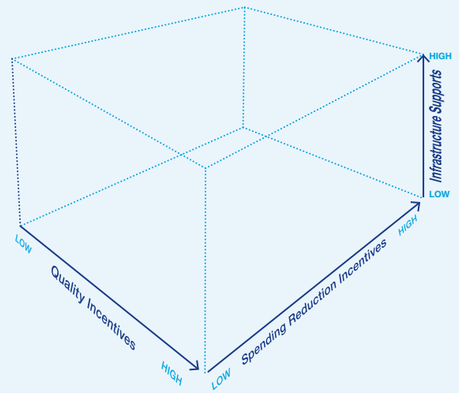
VBC attempts to realign healthcare payments with care value by introducing incentives that can reduce spending, raise quality, or achieve both goals. Examples of prior and ongoing VBC efforts include pay-for-performance (which focuses on care quality) and alternative quality contracts (which target both spending reduction and quality improvements). Some VBC programs are more recognized for their focus on practice transformation (e.g. patient-centered medical home initiatives) even though they include pay-for-performance or shared savings rewards as part of redesign efforts.

VBC is our nation's chief strategy for better aligning healthcare payments with desired outcomes and an innumerable number of efforts are underway. The activity in this field can make it difficult to glean important take-home lessons from ongoing VBC experiments.

This systematic review tackles this problem in two new ways. First, it explicitly focuses on the subset of VBC programs that combine spending reduction incentives with quality improvements. We will heretofore call this type of VBC program 'Spending and Quality' VBC to distinguish this subset of VBC programs from those that apply pay-for-performance tactics without spending reduction targets (Figure 2). Second, it supplements a traditional systematic review approach (evaluating the study rigor of these programs to assess effectiveness) with an analysis of the infrastructure supports that frequently accompany VBC programs, which has often been overlooked in these reviews as an increasingly popular element in VBC programs (Figure 1).

Figure 1.

This report's systematic review targets VBC programs that incentivize spending reduction and quality improvement, referred to as Spending and Quality VBC, while also exploring a critical third dimension around infrastructure supports. The upper right-hand corner of the 3D box to the right denotes the strongest combination of incentives and infrastructure supports for value-based programs.



The United States healthcare system needs to improve its value

The U.S. invests heavily in the health of its citizens by spending almost a fifth of its gross domestic product on healthcare. Although the U.S. leads other developed nations in healthcare expenditure, it lags those same nations in life expectancy, i.e. deaths 'amenable to healthcare' like cardiovascular disease, suicide, or maternal mortality.'

A wide array of important stakeholders in the healthcare system — employers, state and federal governments, commercial health plans, and provider organizations — have been trying to better align healthcare spending with better outcomes through the design and use of incentives.

Healthcare incentives can be better aligned with healthcare value

Historically, physicians and hospitals have been rewarded for the quantity of healthcare that they have provided, not the quality of it. The term 'fee-for-service' describes almost exactly what occurs under this payment method — providers bill for and receive reimbursement for office visits and procedures irrespective of whether such services are needed or achieve their health objectives. 'Capitation' signifies when providers are paid a fixed budget for a group of patients who exist on 'panels' for physicians and earnings are dictated by the difference between that fixed budget and healthcare spending; capitation can proceed without specific reference to the content or quality of the care being delivered.

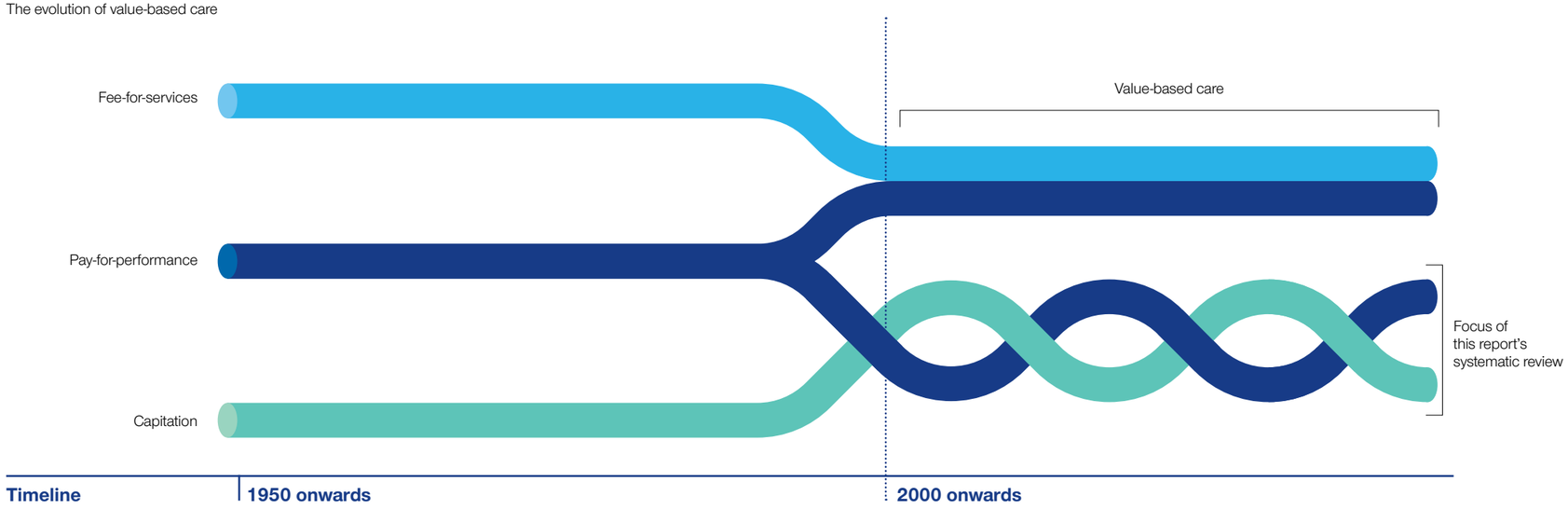
In contrast to fee-for-service and capitation, 'pay-for-performance' ties bonuses and penalties to measures of care quality. Today, pay-for-performance targets thousands of available measures that represent evidence-based healthcare processes considered necessary for achieving desired healthcare outcomes (e.g., whether hemoglobin A1c levels are checked in patients with diabetes), desired health outcomes themselves (e.g., whether the hemoglobin A1c level is in range), and increasingly involves measurements of the patient experience (e.g., how well patients feel physicians have communicated with them). When such measures are not available, payers also try to reduce certain types of utilization thought to be indicators of patients experiencing a poorer state of health (e.g., that requiring emergency or inpatient or hospital admission).

Each of the above reimbursement models serves as a building block for VBC and different blends of incentives allow payers to retain the strengths of these previous models, while addressing their weaknesses.

Fee-for-service tends to reward providers for doing more, so it can promote healthcare access and limit concerns about whether providers will avoid more complex patients. Capitation rewards providers for doing less, so it can dissuade providers from pursuing unnecessary or wasteful services and thereby reduce the cost of healthcare. Pay-for-performance rewards dimensions of care quality, so it can help providers shift their attention towards the content of what healthcare is delivering over the quantity of it.

Initial VBC programs mainly introduced pay-for-performance bonuses on top of the base payments of fee-for-service or capitation. More recently, VBC efforts have been focusing on simultaneously reducing spending and improving quality, typically by introducing capitation in combination with pay-for-performance (Figure 2).

Figure 2.
The evolution of value-based care



Value-based care 'experiments' have been occurring for a decade — what have we learned?

An innumerable number of VBC efforts are now underway. VBC programs have been sponsored by governmental (Medicare and Medicaid) and commercial health plans, as well as by all-payer and multi-payer coalitions (governmental payers in combination with commercial ones).

Key learnings are frequently difficult to recognize while in the fray of VBC efforts. Not all programs labeled 'VBC' follow the same definition and the vast majority of VBC initiatives can only be informally assessed. Even prior systematic reviews on the subject were only able to group VBC programs that only focus on pay-for-performance tactics with those that combine capitation with pay-for-performance. Additionally, among VBC programs that have been empirically evaluated, the rigor of the study designs can range from simple cross-sectional studies, to pre- and post-intervention comparisons, to sophisticated quasi-experimental designs with randomized features.

Lastly, available VBC reviews have tended to focus on the financial components of program design without specific attention to the infrastructure supports, or non-financial incentives, that frequently accompany these programs and make them more actionable.

1.2 How we approached our systematic review

Chapter Summary

When we began to think about our systematic review, we were aware that hundreds, perhaps thousands of VBC 'experiments' were taking place across the U.S. and that several higher-profile VBC programs had been studied empirically. We also recognized that many efforts could qualify as a VBC program incentivizing spending reduction and quality improvement, but lack the specific 'VBC' label. Moreover, we had the sense that the infrastructure supports that typically accompany VBC programs and were potentially playing pivotal roles in VBC experiences, were not being well-characterized or included in evaluations.

Thus, this systematic review is unique in its focus on empirically-studied 'Spending and Quality' VBC, not pay-for-performance only VBC. It is also novel to combine information on the effectiveness of VBC programs with an analysis of the infrastructural supports that delivery systems also tend to receive as part of a VBC program.

We focused on finding 'Spending and Quality' value-based care programs that have been empirically evaluated

Three main concepts grounded our search strategy and key terms (visualized in Figure 3):

1. Healthcare spending

- Cost, Healthcare
- Cost Savings
- Health Expenditures
- Spending

2. Healthcare quality

- Quality
- Quality Assurance, Health Care
- Quality improvement
- Quality of Healthcare

3. Alternative payment models

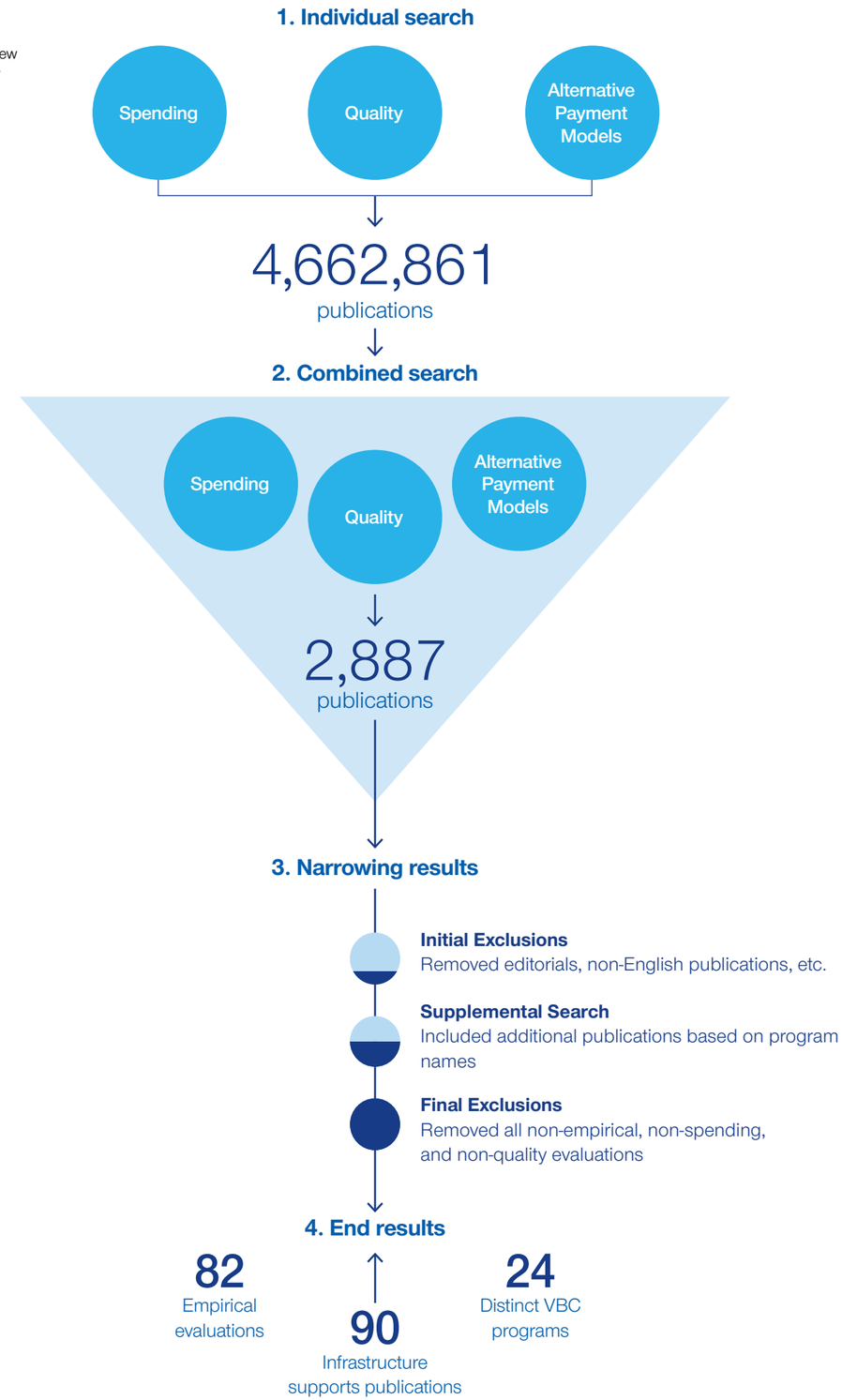
- Accountable Care Organizations
- Bundled Payment
- Enhanced Payment
- Episode of Care
- Episode Payment
- Gainsharing
- Global Budget
- Global Payment
- Patient Care Bundles
- Shared Savings
- Value-based Purchasing

We then queried Medline® and Cochrane libraries using terms that mapped to our main concepts and used keyword strings and PubMed filters to sift through all the available literature to identify VBC efforts meeting our inclusion criteria and occurring within the U.S. We excluded non-English publications, editorials and industry newsletters.

To make sure that we uncovered all possible VBC programs and their corresponding program descriptions, we engaged in a multistep process that started with 4,662,861 publications.

Ultimately, we reviewed the titles and abstracts of the 2,887 publications and identified 24 unique VBC programs that incentivized both spending reduction and quality improvement and were empirically evaluated. Those 24 VBC programs corresponded to 82 empirical evaluations and over 90 publications regarding the infrastructure supports associated with these programs.

Figure 3.
Systematic review search strategy



The 24 value-based care programs that made the 'cut'

Five different types of payers or payer coalitions are represented in the 24 unique 'Spending and Quality' VBC programs that met our inclusion criteria: Medicaid (2), Medicare (8), commercial health plans (6), multi-payer groups (5), and an all-payer initiative (3). Each included VBC program is referred to by its most common abbreviation and name (Figure 4).

Among the 24 identified 'Spending and Quality' VBC programs that made our 'cut,' three initiated in the years between 2005 and 2007, eight between 2008 and 2010, 11 started between 2011 and 2013, and two began in 2014 or later (Figure 5), so the bulk of the VBC programs being assessed in this systematic review have occurred in the past decade.

Figure 4.

Program Legend
The identified 24 VBC programs by common program name.

Key

Multi:
- Multi-Payer
- All-Payer

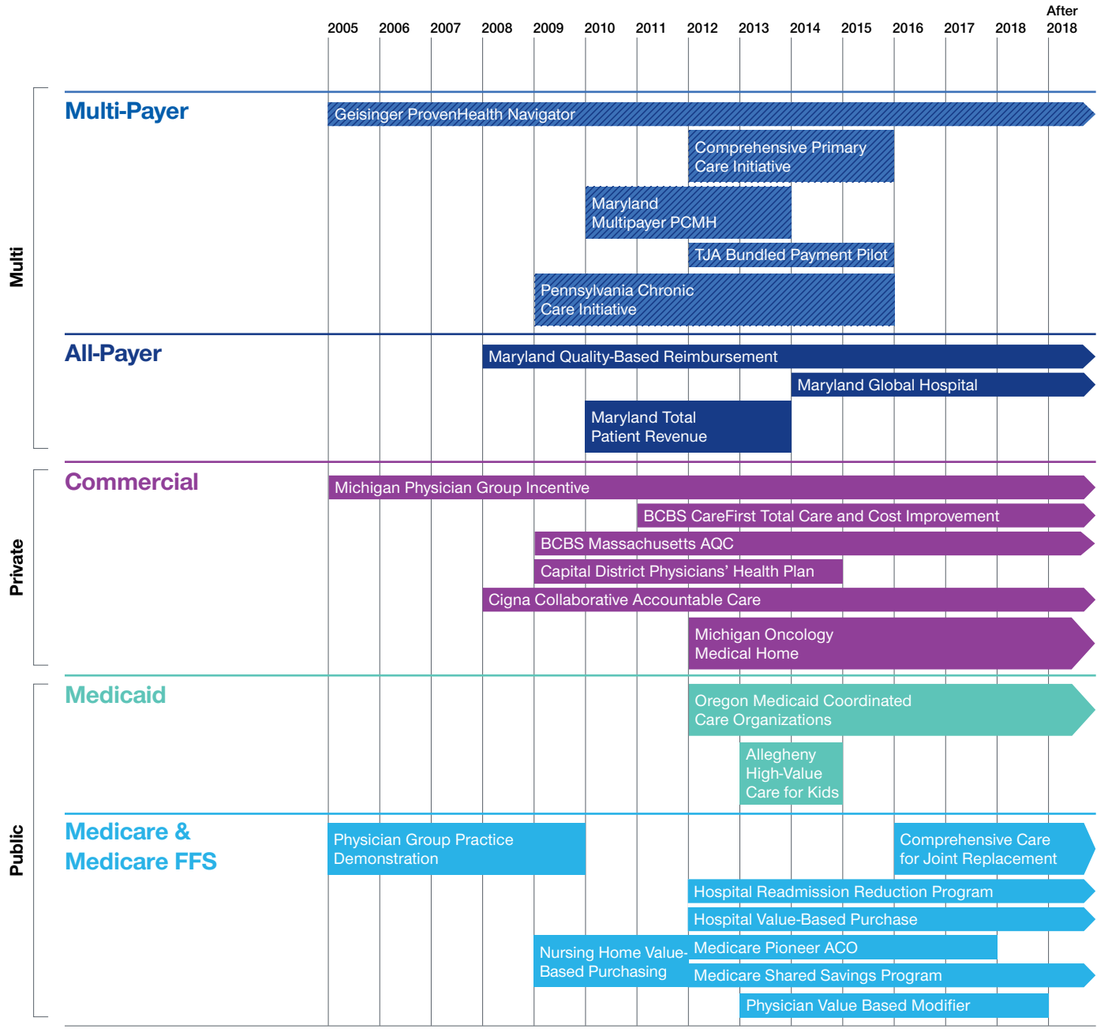
Private:
- Commercial

Public:
- Medicaid
- Medicare

Note: Acronyms correspond to each included VBC program's most common name; color coding illustrates payer type.

A	Allegheny High-Value Care for Kids
CF	Blue Cross Blue Shield (BCBS) CareFirst Total Care and Cost Improvement
AQ	Blue Cross Blue Shield (BCBS) Massachusetts Alternative Quality Contract
CD	Capital District Physician's Health Plan
C	Cigna Collaborative Accountable Care
CJ	Comprehensive Care for Joint Replacement
CP	Comprehensive Primary Care Initiative
PH	Geisinger ProvenHealth Navigator
RR	Hospital Readmission Reduction Program
H	Hospital Value-Based Purchasing
MG	Maryland Global Hospital
MM	Maryland Multipayer Patient Centered Medical Home
MQ	Maryland Quality-Based Reimbursement Program
MT	Maryland Total Patient Revenue
SS	Medicare Shared Savings Program
MO	Michigan Oncology Medical Home
MP	Michigan Physician Group Incentive
N	Nursing Home Value-Based Purchasing
O	Oregon Medicaid Coordinated Care Organizations
PA	Pennsylvania Chronic Care Initiative
PG	Physician Group Practice
VM	Physician Value-Based Modifier Program
P	Pioneer Accountable Care Organization Model
TJ	TJA Bundled Payment Pilot

Figure 5.
Timing of our 24 identified VBC programs.



*The start year is the first year that achievement on quality was tracked (in contrast to reporting on quality measures).

1.3 Understanding the dimensions of value-based care program design

Chapter Summary

After identifying our 24 ‘Spending and Quality’ VBC programs and 82 corresponding peer-reviewed evaluations, we turned our attention to understanding the features of VBC program design. For this part of our review, we supplemented peer-reviewed evaluations (which frequently contained some information about the financial aspects of VBC contracts) with over 90 pieces of publicly available descriptions of VBC program content.

Throughout that process we grew to consider the VBC program as having three core dimensions — the first two dimensions correspond to each of the financial incentives in play (spending reduction and quality improvement) while the third relates to the number and type of infrastructure supports that organizations typically received as part of a VBC program.

Dimension 1:

Financial incentives for spending reduction

Financial incentives for spending reduction exist along a continuum of the range of expenditures for which payers require provider organizations to be responsible and the level of risk that provider organizations take on (Figure 6).

Provider organizations take on ‘full’ financial risk when they take responsibility for total annual medical expenditures for a population of patients, agree to gain financially according to the degree to which they can deliver care within a fixed budget, and accept commensurate loses if budgets are exceeded. These organizations undertake ‘partial’ risk when they preserve earnings when operating within a fixed budget, but cap their losses if budgets are exceeded. Such insurance models are commonly referred to as ‘shared savings’ or ‘upside only’ models. Organizations may also limit risk by limiting the scope of expenditures for which they are financially responsible to a particular healthcare setting (e.g., inpatient) or clinical condition (e.g., total knee replacement). These latter strategies are also known as rate setting and bundled payments, respectively. Organizations take on the lowest amount of financial risk when they receive a bonus or penalty according to their performance on one or more resource efficiency measures, such as per-beneficiary spending.

Dimension 2:

Financial incentives for care quality

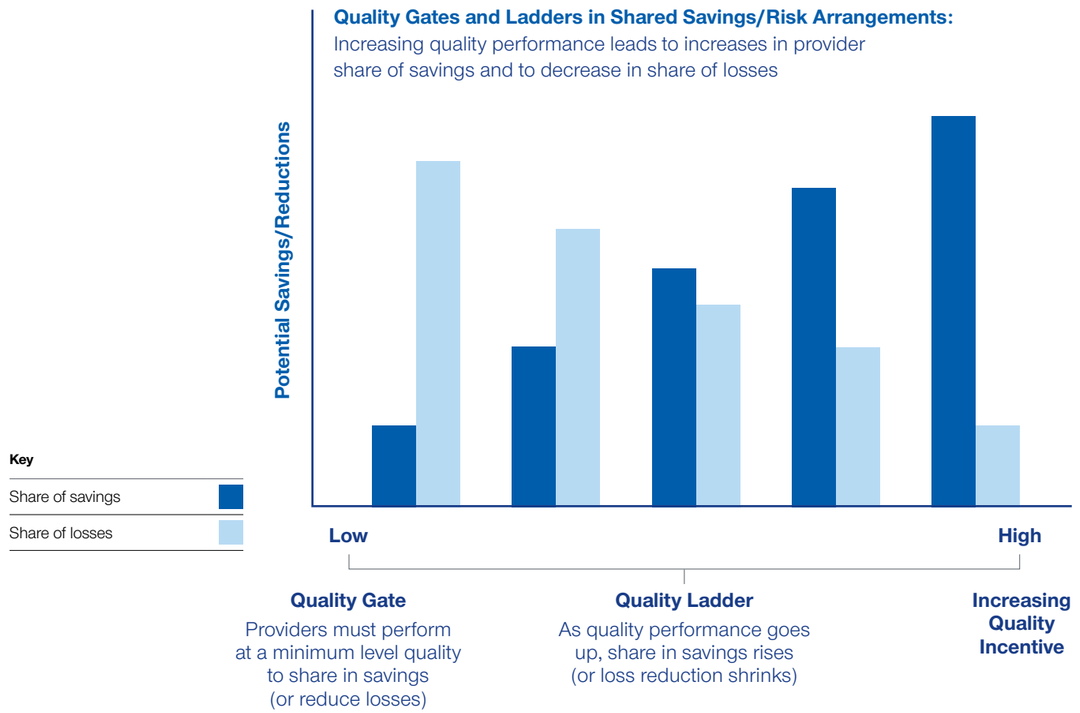
The quality measures in a VBC program typically span facets of clinical processes and outcomes (e.g., whether a patient with an acute myocardial infarction is receiving recommended care), but also measures of patient experience and efficiency.

The strength of the financial incentives tied to care quality also exist along a continuum, from weak to strong, depending on the degree to which they use traditional pay-for-performance tactics without ties to shared savings (weak) or incorporate quality gates (moderate) and ladders (strong) (Figure 6).

Pay-for-performance programs give provider organizations financial bonuses or penalties based on a predefined set of quality measures. Pay-for-performance can be oriented towards meeting minimum thresholds for performance or improvement (‘Quality only’ programs), but what distinguishes ‘Quality only’ VBC from ‘Spending and Quality’ VBC is the eligibility for, and the magnitude of, shared savings awards that may depend on an organization’s quality performance. A quality gate is the minimum level of performance that an organization can achieve and receive a shared savings award. A quality ladder mediates the size of shared savings (or shared losses) according to the level of quality performance.

Figure 6.

How quality incentives can be intertwined with spending reduction incentives in VBC programs



Dimension 3:

Infrastructure supports

While the financial components of VBC programs may provide some of the motivation that provider organizations need to change, infrastructure supports may be necessary to deliver the skills and experience that enable organizations to do so. Infrastructure supports are not a new feature of payer-provider relationships, but deserve attention because they may be critical to the success of VBC arrangements. To our knowledge, few have systematically characterized and tallied the types of infrastructure supports that are being deployed as part of VBC programs.

We gathered information on the different types of infrastructure supports that could accompany VBC programs and found six common categories of support: raw data, analyzed data, technical assistance, access to care management tools, risk management support, and infrastructure payments. Analyzed data and technical assistance were the types of infrastructure supports that were most frequently used in VBC programs (Figure 7). All but one program in our review offered at least one technical support, with most contracts offering four (data not shown).

Figure 7.

Types of Infrastructure supports for the 24 organizations included in this study and the frequency at which they are being used in VBC programs (percent)

Infrastructure Supports – 6 types	Description	Number of VBC Programs (%)
Analyzed Data or Reports (AD)	Reports related to care spending, quality, or other key metrics. Report type, frequency and level of aggregation can vary. Although report delivery mode was not typically mentioned, some payers developed or provided access to web-based portals for on-demand report creation.	22 (92%)
Technical Assistance (TA)	Technical resources (e.g. performance improvement or redesign ideas and methods) that are typically geared toward building new capacities. **Low intensity:** Self-serve training materials, to interactive training sessions via webinars **Medium intensity:** One-on-one direct assistance from consultants, coaches **High intensity:** Peer-to-peer learning opportunities and collaboratives	20 (83%)
Raw Data (RD)	Unanalyzed administrative or claims-based data.	15 (63%)
Infrastructure Payment (IP)	In-kind or direct financials supports oriented towards capacity building and not typically contingent on performance achievement.	12 (50%)
Risk Management Support (RM)	Additional strategies to protect participants from large losses or catastrophic individual claims. Usually accomplished via a claims cap at an absolute dollar amount or percentile of the distribution.	8 (33%)
Access to Care Management and Tools (CM)	Personnel or tools that help patients get the care they need in a timely manner or coordinate care distributed across different providers.	7 (29%)

A three-dimensional view of the 24 ‘Spending and Quality’ value-based care programs that have been empirically-evaluated to date

When we used a three-dimensional approach to examine VBC program design, we observed that 10 of the 24 empirically-evaluated VBC models of interest (41 percent) applied financial incentives in the ‘partial’ range (e.g., used ‘shared’ or ‘upside-only’) alongside quality incentives that could be considered ‘modest’ to ‘strong’ (e.g., quality gates and ladders) and had four to five different types of infrastructure support.

The maximum set of incentives and infrastructure supports were being applied in four VBC programs (Oregon Medicaid, BCBSMA’s AQC, MSSP, and Pioneer). These VBC programs provided ‘full’ financial risk in combination with ‘strong’ quality incentives and up to five unique infrastructure supports tactics. The minimum set of incentives and supports were being applied in three VBC programs (HVBC, PVBM, and Michigan PGI). Minimum-strength VBC programs provided financial risk incentives by tying pay-for-performance bonuses or penalties to measures of resource efficiency and clinical quality, rather than using shared savings and also tended to apply two different types of infrastructure supports tactics.

Thus, the take-home observation from this systematic review is that studied VBC programs predominantly reflect partial spending reduction incentives, modest quality incentives, and a few distinct infrastructure supports.

Spending Reduction Incentives:

Global Payment: Providers have a defined pool of resources to provide care for a defined patient population or set of services (e.g., hospital-based services). Global payments vary by their scope and the degree of risk to which they expose providers (full risk, shared savings/ shared risk, shared savings only.)

Bundled Payment: Providers receive a defined budget for services involved in a specific medical episode (e.g., procedure or diagnosis). Like global payments, bundle payments can also expose providers to a spectrum of financial risk.

Rate Setting: Providers receive a fixed price for specific medical services based on the resources required to provide that service.

Resource Efficiency Incentive: Providers receive a bonus or penalty according to their performance on one or more resource efficiency measures such as per-beneficiary spending; this usually occurs within the context of fee-for-service.

Quality Incentives:

Gate: Providers meet a minimum quality performance threshold to receive a shared savings award.

Ladder: As quality performance goes up, share in savings rises (or loss reduction shrinks).

Pay-for-Performance: Financial bonuses (or penalties) are tied to performance of care quality process or outcome measures.

Figure 8.

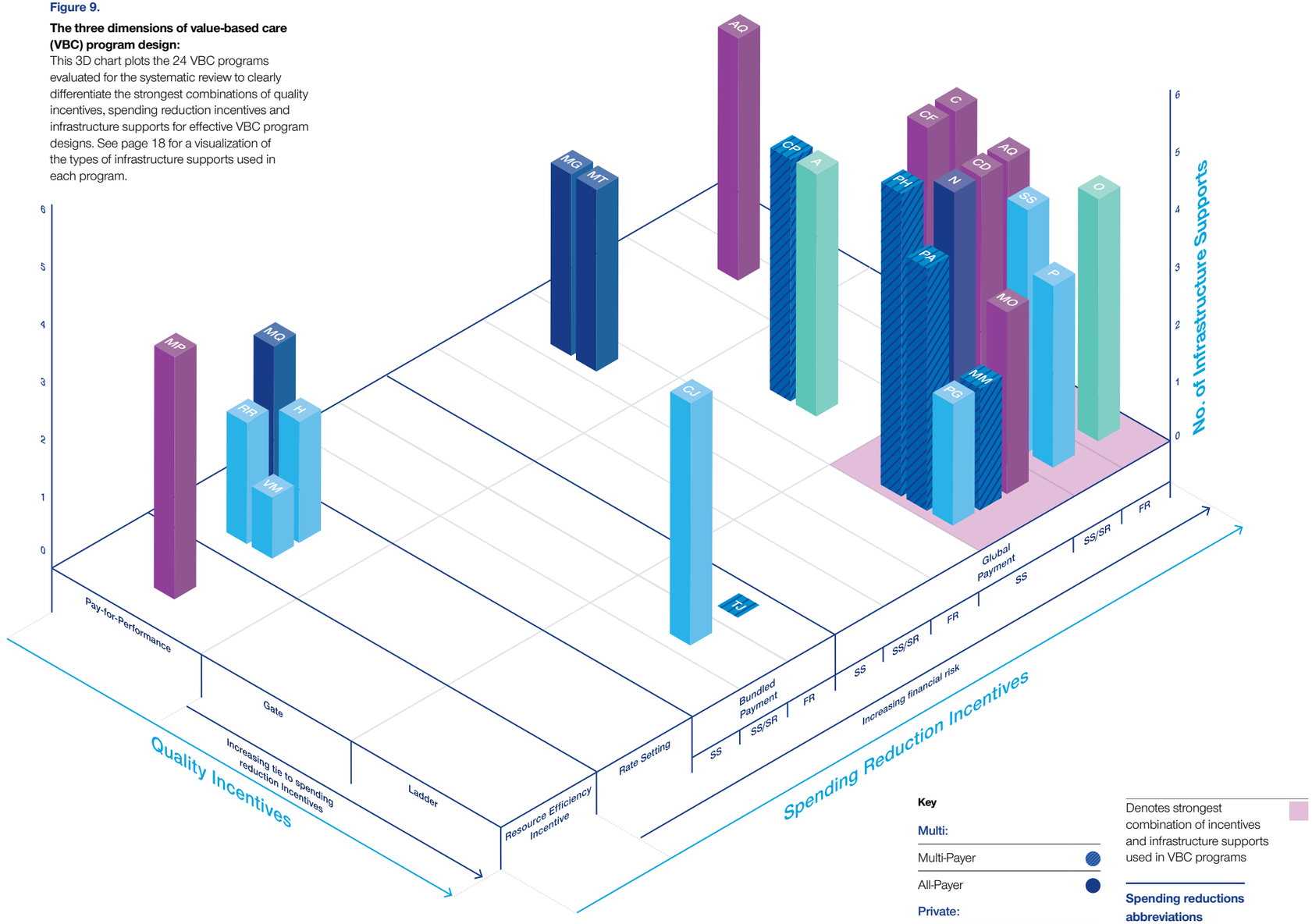
Number and types of infrastructure supports included in each program.

Key	Program Name	Count of Infrastructure Supports	Type of infrastructure supports across programs*
A	Allegheny High-Value Care for Kids	4	AD, TA, CM, IP
CF	Blue Cross Blue Shield CareFirst Total Care and Cost Improvement	6	RD, AD, TA, CM, RM, IP
AQ	Blue Cross Blue Shield Massachusetts Alternative Quality Contract	5	RD, AD, TA, RM, IP
CD	Capital District Physicians' Health Plan	5	RD, AD, TA, CM, IP
C	Cigna Collaborative Accountable Care	6	RD, AD, TA, CM, RM, IP
CJ	Comprehensive Care for Joint Replacement	4	RD, AD, TA, RM
CP	Comprehensive Primary Care Initiative	4	RD, AD, TA, IP
PH	Geisinger ProvenHealth Navigator	5	AD, TA, CM, RM, IP
RR	Hospital Readmission Reduction Program	2	AD, TA
H	Hospital Value-Based Care	2	AD, TA
MG	Maryland Global Hospital	3	RD, AD, TA
MM	Maryland Multipayer PCMH	5	AD, TA, CM, RM, IP
MQ	Maryland Quality Based Reimbursement	3	RD, AD, TA
MT	Maryland TPR	3	RD, AD, TA
SS	Medicare Shared Savings Program	4	RD, AD, TA, RM
MO	Michigan Oncology Medical Home	3	AD, CM, IP
MP	Michigan Physician Group Incentive	4	RD, AD, TA, IP
N	Nursing Home Value-Based Purchasing	2	AD, TA
O	Oregon Medicaid Coordinated Care Organizations	4	RD, AD, TA, IP
PA	Pennsylvania Chronic Care Initiative	4	RD, AD, TA, IP
PG	Physician Group Practice	2	RD, AD
VM	Physician Value-Based Modifier	1	AD
P	Pioneer Accountable Care Organization Model	3	RD, TA, RM
TJ	TJA Bundled Payment Pilot	0	

* See page 18 for key.

Figure 9.

The three dimensions of value-based care (VBC) program design:
This 3D chart plots the 24 VBC programs evaluated for the systematic review to clearly differentiate the strongest combinations of quality incentives, spending reduction incentives and infrastructure supports for effective VBC program designs. See page 18 for a visualization of the types of infrastructure supports used in each program.



Key

Multi:

- Multi-Payer
- All-Payer

Private:

- Commercial

Public:

- Medicaid
- Medicare

Denotes strongest combination of incentives and infrastructure supports used in VBC programs

Spending reductions abbreviations

Full Risk	**FR**
Shared Savings	**SS**
Shared Risk	**SR**

Figure 10A.

This is a detailed breakdown of the types of infrastructure supports used by the 13 VBC programs that had the strongest combination of incentives and infrastructure supports in their program design.

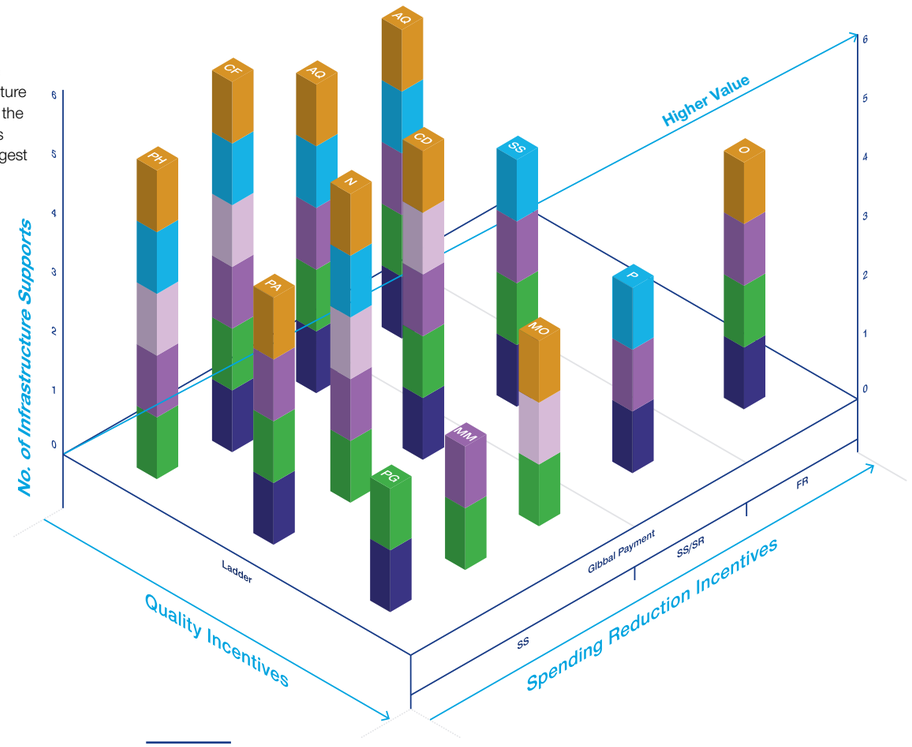


Figure 10B.

Combinations of infrastructure supports for VBC programs with strongest incentive design

Key	Program Name	Analyzed Data or Reports	Technical Assistance	Raw Data	Infrastructure Payment	Risk Management Support	Access to Care Management Tools
CF	Blue Cross Blue Shield CareFirst Total Care and Cost Improvement	✓	✓	✓	✓	✓	✓
AQ	Blue Cross Blue Shield Massachusetts Alternative Quality Contract	✓	✓	✓	✓	✓	
CD	Capital District Physicians' Health Plan	✓	✓	✓	✓		✓
C	Cigna Collaborative Accountable Care	✓	✓	✓	✓	✓	✓
PH	Geisinger ProvenHealth Navigator	✓	✓		✓	✓	✓
MM	Maryland Multipayer PCMH	✓	✓		✓	✓	✓
P	Pioneer Accountable Care Organization Model		✓	✓		✓	
SS	Medicare Shared Savings Program	✓	✓	✓		✓	
MO	Michigan Oncology Medical Home	✓			✓		✓
N	Nursing Home Value-Based Purchasing	✓	✓				
O	Oregon Medicaid Coordinated Care Organizations	✓	✓	✓	✓		
PA	Pennsylvania Chronic Care Initiative	✓	✓	✓	✓		
PG	Physician Group Practice	✓		✓			

Key
Types of Infrastructure Supports

- Raw Data
- Analyzed Data or Reports
- Technical Assistance
- Access to Care Management Tools
- Risk Management support
- Infrastructure Payment

Abbreviations

Full Risk	FR
Shared Savings	SS
Shared Risk	SR

1.4 Evaluating value-based care outcomes

Chapter Summary

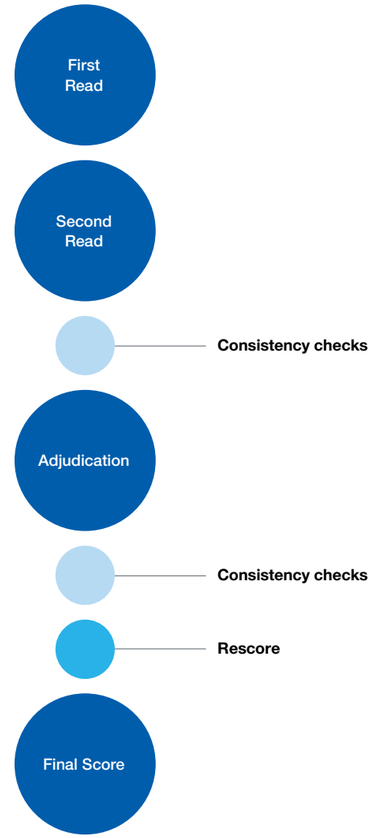
After isolating the final set of empirically-studied VBC evaluations, we graded evaluations for their study rigor (Figure 11). This allowed us to encapsulate the potential relationship between 'Spending and Quality' VBC programs and desired outcomes in terms of spending reduction, utilization, and care quality (as reflected by claims-based clinical quality metrics, patient experience and mortality).

At least two readers independently graded each VBC evaluation using the Downs and Black tool, which was modified for this study to account for quasi-experimental studies which are frequently used in this field. Per protocol, discrepancies were adjudicated through discussion and tool refinement.

Overall, we found the majority of the evaluations of VBC programs were able to use quasi-experimental or pre-post designs, while few tended to be randomized or cross-sectional. We also observed VBC evaluations that were focused on quality outcomes were slightly more rigorously conducted than those aimed at understanding spending outcomes.

Figure 11.

Steps in grading VBC evaluations for study rigor



Value-based care programs have been evaluated for their affect on healthcare spending, utilization, clinical care quality, patient experience and mortality outcomes.

VBC evaluations examined the impact of 'Spending and Quality' VBC contracts on healthcare spending, utilization (usually of emergency or inpatient services which can be viewed as a proxy for a diminished health state), claims-based process measures (which recommend clinical quality), mortality, patient experience or combinations of the above

We graded each VBC evaluation for each outcome of interest, so we graded 82 unique evaluations a total of 161 times. This was necessary to capture the fact that evaluations may study one outcome more rigorously than the other. We also aggregated outcomes to the VBC program level when the same outcome was assessed multiple times. For example, spending could be considered to have a 'mixed' result if an evaluation found that spending did not change in one year but did reduce significantly in other years.

Value-based care evaluations of quality outcomes had stronger study designs than those examining spending.

Taking all VBC evaluations together, the majority of evaluations used quasi-experimental or pre-post designs. A few had randomized study designs and similarly, a few had cross-sectional designs.

Study rigor scores were fairly similar across spending and quality outcomes, but the study rigor scores for quality outcomes was slightly greater than those for spending outcomes.

1.5 Value-based care may be reducing spending without reducing quality

The degree to which currently available VBC evaluations indicate that VBC is achieving its intended targets is depicted in the following two 'see-saw' illustrations (Figures 12A and B), one for spending and one for quality. The slope of the see-saw on its fulcrum corresponds to the magnitude of the effect observed in the VBC evaluation.

When effect sizes or significance are small, the slope of the see-saw is slight. We also placed VBC evaluations on the bench according to their study rigor so that readers can relate study findings to study rigor qualitatively.

Overall, VBC evaluations associate VBC with spending and utilization reductions and without a negative impact on claims-based measures of clinical quality, patient experience, and mortality. While one would like VBC to raise healthcare quality, the fact that these early programs do not hurt quality when spending is very modestly reduced is reassuring.

Key

Multi:

- Multi-Payer
- All-Payer

Private:

- Commercial

Public:

- Medicaid
- Medicare

Figure 12A.

Spending

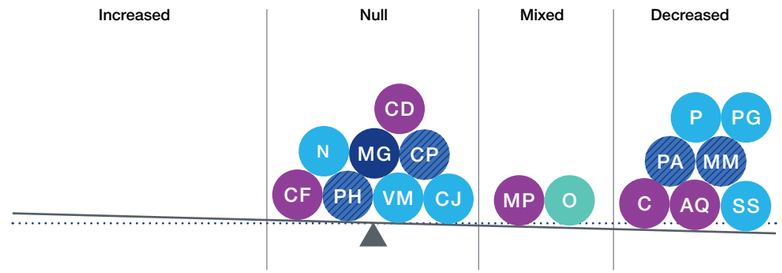
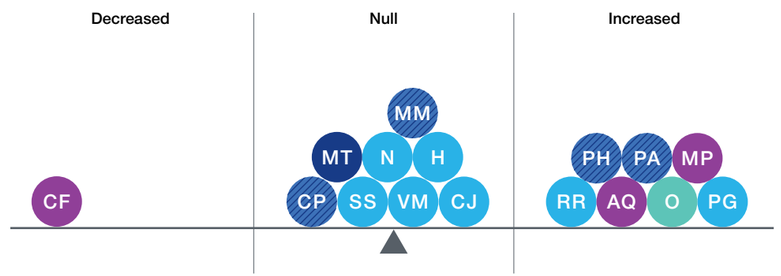


Figure 12B.

VBC and Quality: Process Measure Outcomes



1.6 The next frontier in value-based care program design

Recommendations

The ultimate goal of this systematic review has been to inform and guide future attempts to increase the value of healthcare delivered in the U.S. In our research, we have focused on the role of infrastructure supports in VBC, an area that has been largely overlooked to date.

We found that the use of infrastructure supports is growing, but they are still not frequent or consistent. In our view, they represent an important third dimension in VBC program design that needs to be further explored and evaluated. For all stakeholders in the healthcare system who aim to improve and accelerate the impact of VBC, we recommend five areas for future action:

1. Use the full construct of the 3D model of spending, quality and infrastructure supports to design value-based care programs.

This study identified that VBC programs can be considered to have three core dimensions. The first two correspond to each of the familiar financial incentives in play, spending reduction and quality improvement. The third relates to the number and type of infrastructure supports that an organization typically receives as part of a VBC program. It appears from this review that it is necessary to pay greater attention to this third dimension because it may be critical to embedding the skills and experience that enable care provider organizations to be successful in delivering VBC programs. Therefore, the first recommendation of this study is to embrace the 3D model in future VBC program design and also in the evaluation of VBC programs.

2. Re-examine the effect of value-based care when more reimbursements are tied to value-based care.

While a large proportion of provider groups participate in at least one VBC contract, those payments still represent a minority of total reimbursements. Because FFS remains the dominant payment mechanism, provider groups are rationally unwilling to make organizational changes that are incompatible with FFS. For VBC to have greater impact on care delivery, the share of provider group reimbursement tied to VBC should increase.

3. Build stronger payer-provider relationships based on organizational alignment.

The common types of infrastructure supports include raw data, analyzed data and reports, and also technical supports geared towards building new capacities. These mechanisms help to align the systems and expectations of payer and provider organizations. In particular, it appears that payers and providers benefit from data sharing, with payers providing more of the financial information and patient touch points throughout the healthcare system, and provider organizations providing more of the data on total population health (across all payers). Should such data sharing be commonly occurring, it could represent a shift in the relationships between payers and providers from a historically adversarial tone to a more collaborative, aligned one.

4. Align measures across different payer contracts.

Across the 82 evaluations included in this study, a wide variety of measures were used when assessing our five outcomes of choice. For spending alone, there were dozens of metrics that studies would track. Though some categories were broadly consistent, such as emergency department, outpatient, and inpatient spending, many evaluations chose to do subgroup analyses on things like pharmaceutical spending, skilled nursing facility spending, etc. As for quality and utilization, the variation increases immensely. Evaluations would use anywhere from six to over twenty different process measures to investigate changes in care quality and oftentimes, evaluations would use different sets of measures depending on their study design and outcome of choice. As for utilization, studies used anywhere from a few major measures (inpatient, outpatient, emergency department stays) all the way up to over a hundred measures of different utilization subgroups. The implication here is that the cost and complexity of tracking and reporting on spending and quality measures is not insignificant in terms of time and financial resources for provider groups. Alignment of these measures across the range of payer contracts is required to deliver better value care throughout the system.

5. Better align individual physician incentives with value-based pay contract incentives.

Questions remain around how much exposure individual physicians have to VBC contract incentives on the spending reduction and quality improvement fronts. The quality improvement component of VBC contracts are transmitted to individual providers more often due to organizational – and individual – provider-led experience with pay-for-performance. Frontline physicians are infrequently incentivized to reduce the healthcare spending of their individual case load due to legitimate concerns around risk adjustment and accounting for random variation in healthcare costs within small patient groups. If spending reduction is incentivized at all, it is at a larger level of aggregation, such as at the provider group level. Thus, most physicians are shielded from upside and downside risk, even if their organization is in a VBC arrangement. For VBC models to have the greatest possible impact, however, provider organizations need to develop value-based compensation models for physicians.

Section 2

Care provider perspectives

Authored by
Lucy Parker, Senior Partner, Brunswick Group

Section 2 Executive Summary

Care provider perspectives

Care providers are at the very heart of delivering on the potential of VBC, so it is crucial to understand how to make it work for them. Senior leaders from four care providers participated in interviews to accompany Harvard's systematic review: Mount Sinai, Ballad Health, Catalyst Health Network and Rhode Island Primary Care Physicians Corporation (RIPCPC).

The perspectives of all these providers reinforce the central proposition of Harvard's study that delivering on the promise of VBC means looking beyond the focus on financial incentives to a greater understanding of the 3D model. They agree that payers have a major contribution to make through non-financial infrastructure supports. Indeed, they go further: they view these as essential enablers to their ability to deliver the changes needed in their organization structure and care delivery model.

Across these different types of physician and health system leaders, five common themes emerge that inform thinking about the next frontier in VBC.

1. Value-based programs require substantial organizational change

Delivering on VBC requires constructing an entirely different type of organization. Every detail of the day-to-day running of provider operations needs to be reconfigured to deliver on this new model:

- In making this long transition, they all cite the proliferation of mismatched measures as one of the greatest challenges they face and a drain on their resources – as highlighted by Harvard's recommendations.

2. Shared data is the foundation of successful VBC relationships

The providers affirm Harvard's proposition that data sharing is a powerful mechanism for rebasing payer-provider relationships positively; the key to defining shared plans and goals:

- Yet there is a high degree of frustration about how this works in practice today, with each payer supplying data in different ways – and lack of timeliness which reduces its potential value significantly.
- Mount Sinai stands out as an organization with experience of writing into their contracts what data will be provided and when, underscoring how they see it as integral to successful delivery.

3. Increased capacity in care management strengthens their practice

Across all types of provider organizations, expanding resources in care management (in its various forms) is seen as one of the great practical benefits of shifting to VBC:

- For physicians, this is a tangible benefit for their patients, an expansion of their own working capacity and an improvement in the effectiveness of their entire practice.
- The greatest area of contention is whether these roles should be delivered by the provider or the payer, with the providers believing strongly this is an extension of care that they are best positioned to deliver.

'Value-based care requires you to create a completely different type of organization.'

4. Resetting provider-payer relationships unlocks innovative program design

As part of establishing successful VBC arrangements, these providers have achieved a profound shift in their working relationships with payers – that they describe as 'transformative' or even 'heart-warming':

- The new mindset is symbolized by the commitment of all parties to 'sit down' together – payers and providers, sometimes with employers – with a determination to take a long view and identify mutual wins.
- The opportunity for 'collaborative design' is considerable – typically on focused, purpose-built projects that allow them to create all aspects of the desired outcome together, from scratch.
- These care providers also suggest that payers have a key role to play in the success of VBC by guiding consumer behavior through product design. They believe this would result in better utilization of healthcare resources and better health outcomes for their patients.

'There's a ton of common ground if you're willing to look for it.'

5. Leadership commitment and stamina are critical success factors

All these organizations encounter internal concern and resistance because the journey is long, the degree of organizational change is enormous, the investment is significant and the risk is real. For all those reasons, they highlight the commitment and staying power of leadership as a primary driver to success:

- They all dedicate a significant amount of their time to winning the hearts and minds of their people – and sharing success stories is their strongest asset.
- Embedding physician leadership has proven to be valuable in sustaining momentum.
- Their insights reinforce the point made in Harvard's study that while VBC remains only a small part of the overall payment regime of an organization, it cannot reshape the culture. To be effective, it has to reach further into the organization – even potentially to the physicians themselves.

All the leaders participating in this study have been working in pursuit of VBC for many years. Though their experiences underline the challenges involved, they say it is worth it and necessary. They are motivated by the opportunity to design a more aligned health system.

'It gives us a once in a lifetime opportunity to create exceptional alignment in healthcare.'

Care provider contributors

The leaders of four care provider organizations gave their time to participate in in-depth interviews for this report. They bring to life what Harvard has called a '3D model for value-based care.' In the pages that follow, their voices are quoted directly and extensively, in order to capture their first-hand experiences and insights.

Mount Sinai Health System

7,400+ Physicians

4.1 million Patients per year

New York City

- Established in 1852. An integrated healthcare system, including 38 research, educational and clinical institutes and top-ranked Icahn School of Medicine at Mount Sinai.
- Comprised of eight hospital campuses with over 400 practice locations.
- In 2013, Mount Sinai Medical Center integrated Continuum Health Partners to merge the hospital system with primary care services.

Interviewees

Niyum Gandhi,
Executive Vice President and Chief Population Health Officer

Dr. Jeremy Boal,
M.D., Executive Vice President and Chief Clinical Officer

Stephen Furia,
Senior Vice President, Population Health

Catalyst Health Network

570 Physicians

900,000 Patients per year

Texas: Dallas-Fort Worth metroplex

- Established in 2014, one of only seven Clinically Integrated Networks in the country, with URAC full accreditation achieved in 2017.
- Comprised of and led exclusively by physicians, including 180 practice locations.

Interviewees

Dr. Chris Crow,
President

Jeff Lawrence,
Executive Director

Dr. Joe Lambert,
Medical Director

Ballad Health

1,400 Physicians

103,000 Patients per year

East North Tennessee & Southern West Virginia

- Established in 2018, through a merger of two major regional health systems, Wellmount and Mountain States Health Alliance.
- An integrated healthcare system covering 21 counties.

Interviewees

Marvin Eichorn,
Chief Operating Officer

Paula Claytore,
VP Managed Care

Dr. Shari K. Rajoo,
Medical Director of Population Health Services, Medical Group

Rhode Island Primary Care Physician Corporation (RIPCPC)

162 Physicians

170,000 Patients per year

Rhode Island:

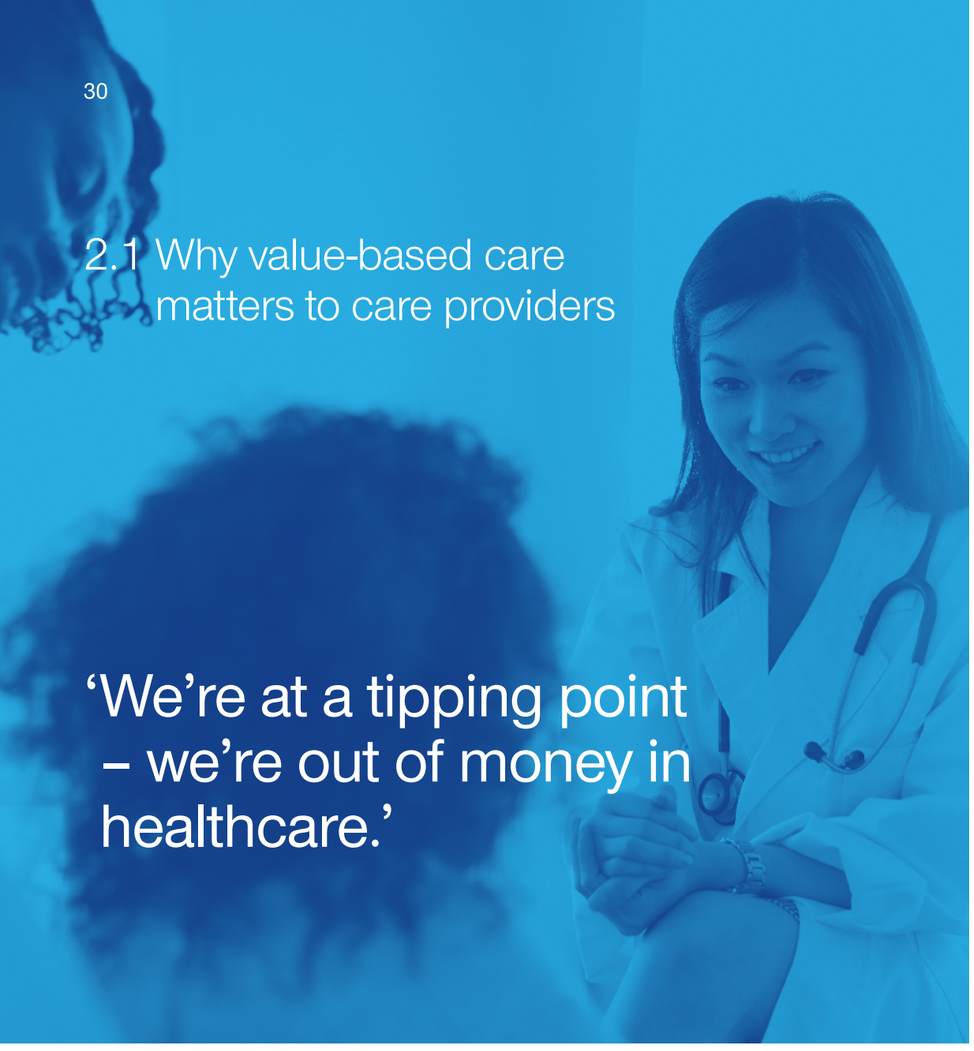
- An independent practice association, established in 1994.
- 78 practice sites as managers.
- Medicaid and Medicare combined 49 percent; Commercial 51 percent.

Interviewees

Noah Benedict,
Chief Operating Officer

Andrea Galgay,
Director of Accountable Care

Dr. Gregory Steinmetz,
Independent Physician



2.1 Why value-based care matters to care providers

‘We’re at a tipping point – we’re out of money in healthcare.’

When asked why their organization set off on the path toward VBC, all the care providers interviewed point first to the economic unsustainability and rising costs in the U.S. health system. They are stark in their expression of how the current cost crisis renews the urgency of getting this right as quickly as possible.

> We’re at a tipping point – we’re out of money in healthcare. The fact is that we’re paying too much for the outcomes that we get.

> The No.1 impetus is, unfortunately, how much healthcare costs. Period. People’s experience is that healthcare hasn’t got any better over the last 10 years and the costs have almost doubled.

> The healthcare system is in such a state of peril as it is, we have to do something. I feel we have to assist in that effort. What do we do if we don’t, at least, go down this path?

In this regard, their starting point is the same as the research conducted by Dr. Chien at Harvard. They have all been on this journey for years, even decades. They have experienced several iterations of contractual arrangements before what is now talked of as VBC, and the challenge of attempting to minimize costs while sustaining quality is not new to them. However, no one is talking only about the money; they are making two additional points. This is a strategic imperative, and they are motivated by a sense of mission.

Driven by a strategic imperative

Embarking on VBC, for them, is about taking a proactive, strategic approach to long-term structural pressures. Niyum Gandhi of Mount Sinai, sees it as his leadership responsibility:

> In the fee-for-service world, there’s just going to be continued reimbursement compression. Versus, if we own the total cost of care problem: we take out the unnecessary organizational cost; we manage health better and keep people healthier; and we get some financial value from the new contracts. And that way we’re part of the solution, not part of the problem.

Rhode Island Primary, though very different from the large New York-based hospital system, came to a similar conclusion. Starting in the ‘90s with Pay for Performance and progressing through the Patient Centered Medical Home model to become an Accountable Care Organization today, they also took the view that, as a leadership team, instead of squeezing the old system harder, they needed to walk toward the challenge with a completely different frame of mind:

> We saw the market evolving, and we saw many provider groups saying we want more dollars for fee-for-service. Our Board had the foresight, before many others did, to step back and say: ‘Alright, we know what the outcome needs to be, so let’s walk into these negotiations recognizing the payers have a bottom line, we want to do better financially and we want to improve outcomes. So how do we do that?’ When we sit across the table with a partner, everybody has to win. The patient has to win, the provider group has to win, the insurance company who is paying the bills needs to win.

Marvin Eichorn, who leads Ballad Health in Tennessee and has also been on this journey for some 20 years, echoes the sentiment that the drive toward VBC is necessitated by a mix of external pressure and internal commitment to fundamentally change how the system works:

> This began to be mandated way back because of the unending rise in the cost of healthcare and, I guess, rightly so. So, today, part of it is imposed on us by outside entities; the Federal Government, managed care organizations, even employers. But part of it is a proactive effort on our part to do something that’s different. It’s something that makes sense to do. If you’re going to be successful, you’ve got to provide something that’s of value to people.

Motivated by the mission

For all these leaders, this journey is a continuation of strategic imperative and their commitment to their mission, as expressed by Dr. Crow, President of Catalyst Health Network:

> It's right there in our mission statement that we're here to deliver long-term community value. You need to do some things that may not make money for you in the short run, in order to get to the long run. Because one thing you can count on is that you're going to have a harder and harder time getting the full reward in the old way; that cannot be your business model. So, at some time you're going to have to shift. Do you want to be forced to do it? In which case, you might not be the CEO anymore – or do you want to go ahead and choose it?

Crow grew up in a rural town in Texas where three family physicians provided all the care that was available, and where they also served on the City Council, the school and church boards. Seeing how they acted as 'leaders who took care of people's health but cared for the whole community as well' inspired him to become a physician. Today, leading a network committed to VBC, he still draws directly on the lessons of his childhood:

> We're not only taking the role of physical healers, but also community leaders. My whole purpose now is how I work to help communities thrive. Health as a pillar of community. That means making sure that there's a market for great quality care, at a reasonable price – which, ultimately, you're going to call VBC.

Ballad's Eichron shares Crow's life-long commitment to strengthening the fabric of the community he works in – and his belief that VBC is a mechanism for achieving that:

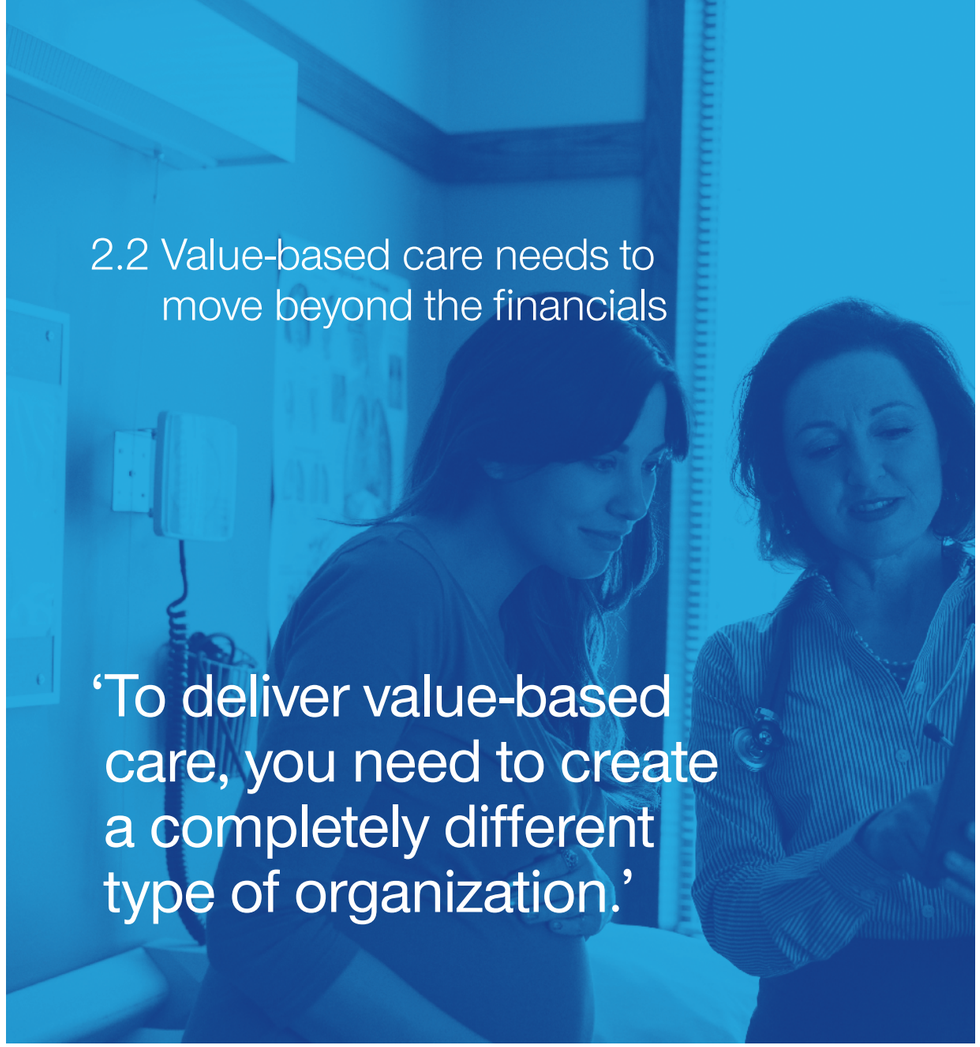
> I really believe that if Ballad Health can do this – and if we, as an industry, can do this – to the best of our ability, we can make a real difference in the health of people. To me, that's fundamentally exciting. It gives us an opportunity to do some things that maybe almost no one in the country has had the opportunity to do before.

Joseph Lambert, Medical Director of Catalyst, presses home the point: in a system where he thinks 'every interaction has become about the money,' he talks about 'turning the tables' on how the problem is viewed:

> We're not just trying to save money. We're trying to provide efficient, evidence-based care, and if we're able to do that, we will save money. That means solving the problem from the other end of the equation. That is a better way of looking at it, in the end.

Even at Mount Sinai, a huge city-based health institution, the motivation was based in their core purpose set out over 150 years ago:

> Our stakeholders are the community and, as a not-for-profit, that's who we exist to serve. This is the right way for us to meet the needs of our community 50 years from now – so we should be starting on that journey now.



Harvard's research opens up the question of whether the next frontier is VBC using what Dr. Chien calls a '3D model' to guide program design – i.e.: reducing costs and improving quality combined with the third dimension of non-financial infrastructure supports.

The perspectives of the care providers participating in this study confirm that this third component of infrastructure supports is not only a desirable addition, but an essential enabler of their ability to deliver the changes that are needed. Their view is neatly summed up by Dr. Boal from Mount Sinai:

> If you're going to start to pay providers based on the size of the panel that they're responsible for and the outcomes that those patients are achieving, then you need to support them with the resources, the workflow, the data and IT systems to be able to drive those outcomes.

Building a different type of organization

All these leaders stress the huge degree of change required inside their organizations in order to deliver on value-based contracts. They are having to reconstruct their entire operating model and systems in real-time. From the daily practice of their physicians to the shape of the workforce; from the use of data to the myriad measures applied to performance; from the expanding network of professional relationships to managing the increased burden of risk and investment. Everything changes – while continuing to deliver higher quality care consistently. As Niyum Gandhi puts it:

> The actual contracts are the easy part; changing a contract takes a stroke of a pen. Changing the actual clinical delivery takes years.

It was this recognition that led Mount Sinai to take the critical step of creating a new unit entirely dedicated to delivering value-based care.

Niyum Gandhi,
Mount Sinai

> It's hard to deliver because it's so completely different. To change to VBC is not as simple as just adding a bit more data and maybe adding another role to the team. It's not possible to shift something that's perfectly built for fee-for-service with just a few tweaks to become perfectly designed for value. In the traditional model, it's more financially advantageous to see a complex patient for only 10 minutes and get them referred out to a specialist, so that the doctor can get on to the next patient. You're focused on the 23 patients who are coming in today because that's how you get paid; there's no time to think about the 2,300 who you're responsible for who aren't coming in today. All of these things are built into the day-to-day operations. It's two completely different outcomes you're going after; it's really two completely different types of organization.

Adopting a new organizational structure to drive Mount Sinai forward, leadership pulled contracting out from under finance where it would usually sit, pulled some of the clinical programs out of where they would normally sit, and built an integrated team for population health. According to Sinai's Gandhi, that was meaningful and an important milestone.

> One key breakthrough was the organizational structure we decided to adopt to drive us forward. We pulled contracting out from under finance where it would usually sit, pulled some of the clinical programs out of where they would normally sit, and built an integrated team for population health. That was meaningful and an important milestone.
>
> We said, let's suspend all of our assumptions about what primary care looked like in the past and let's instead think about what a purpose-built model for VBC would be. Would we even have the same roles? And the answer is no. Almost every job description is completely different – as though cut from a wholly different cloth. The things we want people focused on, the tools that we give them, the way they structure their days needs to consider how to manage all 2,000 patients that they're responsible for, whether or not that patient is coming in, whether or not they get paid for a face-to-face visit with that patient.

What stands out from Mount Sinai's experience of transforming the business model is the balancing act it requires, between committing to a different form of contract and constructing a new clinical delivery capability:

> We view it as travelling along a diagonal: if we end up in the bottom right where we've changed the clinical model but not the contract, we would bankrupt ourselves – and if we ended up in the top left where we changed the contract but not the clinical model, we bankrupt ourselves. At the bottom left, optimizing fee-for-service, the math in there works. The upper right corner of VBC, where everything you do is optimized to deliver a clinical model for population health, that works. Every step in between is inevitably inefficient. Our job is to try and manage the balance as we go along that diagonal path.

This explanation highlights why the issue is not whether financial incentives work, but rather what else needs to be in place in addition to the financial incentives to support the change process going on inside the organization.

The financial incentives are necessary, but not sufficient

The focus of this study is on the non-financial and infrastructure elements of the journey to VBC, partly because – as identified by Harvard's research – this is an area much less fully explored. However, it is important to note that all the care providers interviewed confirm the power of the financial incentives. 'Getting the financial drivers right is foundational to success', as one voice said. The leaders of Ballad and Catalyst explain what it means to their ability to drive change:

> If structured right, the financial incentives are by far the biggest thing that will achieve the value-based goals, and the absence of those incentives is by far the biggest detriment to it moving forward. It is not just about those financial incentives, but I do need to know first that I have got the ability to put in the resources we need to do all this.

> I am contracted that if I save $20 million, we get to keep half of it – so the financial incentive is there. Plus the care co-ordination fees give me the funds to create a system that the physicians can plug into. That way I have what I need to build something the physicians value, in terms of their time, their money, their reputation – and I am able to serve all those factors with this operating model.

For these organizations, financial 'incentives' are not simply a reward or a boost for having hit the goals. In effect, they represent the funding necessary to make the transformational organizational changes required to deliver in the value-based model.

Aligning the measures

Intrinsic to establishing the financial incentives are the metrics by which the organization's performance will be measured. They encapsulate the change in paradigm everyone is seeking to achieve. However, one of the pain-points that all the interviewees share is the proliferation of non-aligned measures involved in value-base arrangements.

Their experience underscores the importance of Harvard's recommendation on the need to better understand how to align these measures so as to reduce the significant drain on time and cost they represent for care provider organizations.

In part, the providers struggle with the sheer number of metrics they have to juggle. Eichron has counted up well over 500 measures that his teams at Ballad Health are required to track; zero infections, ED throughput, patient satisfaction and onwards. Faced with this 'near impossible task', he considers 'sustainability' the greatest performance challenge his organization now faces: how to sustain the gains made in one focus area, without 'slipping back' as they continually have to turn their attention to improving in new areas.

Beyond the challenge of quantity, however, is that each payer requires somewhat different measures. Shari Rajoo, a doctor herself, who leads on embedding new ways of operating into Ballad Health, is working to protect the physicians from the complexity this adds to delivery of care:

> One of the most difficult things is that every payer wants things slightly differently and has a slightly different definition of their metrics. Diabetes control is a good example; one is looking for the proportion of your patients over nine percent hemoglobin, another for eight percent. A lot of work goes into satisfying that. But the last thing I want is for a physician on the front line to be wondering whether they have to do a different thing for this payer or that payer; that's not what a front-line clinician should be concerned about.

This sentiment, echoed by Catalyst, shows up the dual challenge they all struggle with. The management burden of the vast quantity of inconsistent measures, is combined with a cultural gap between payer-provided data and its relevance to the day-to-day reality of the doctors:

> Simplifying all the different data feeds that come in different file formats and definitions is definitely one of the most difficult aspects of VBC. One payer's definition of re-admission is different from another payer's definition of re-admission. We have to manage the discrepancies between each contract separately. And the measure is typically, for example, ERs per thousand or specialist visits per thousand. But physicians don't think of things in the thousands; our lives are full of the individual patients we see every day. So, my job is to translate those measures into something that doctors can work with – and the problem is that costs a lot of money too.

Eichron identifies three essential elements to being successful under this pressure: the ability to 'sustain' improvements made, the 'discipline' to keep adjusting plans along the way, and access to 'timely information'.

Data is a critical enabler

Universally, the care providers agree that payers can contribute a great deal more than financial incentives and, first and foremost, everyone cites data sharing.

Rhode Island's Noah Benedict acknowledges the huge benefit added through both the claims and population data provided by the payers which gives his people access to information they did not have at their fingertips only a few years ago. One of Harvard's findings is that the value of the data is more than the information itself; where data sharing exists it can 'represent a shift in the relationship between payers and providers from a historically adversarial tone to a more collaborative one.' Benedict's reflections are evidence of exactly how that can happen:

> It works because it creates transparency in how we operate together. The payers tell us exactly where they believe most of the waste is happening in our particular system. They look straight at me and tell me, for instance, where they see my ED rates are higher than others in the region and where the top opportunities are to improve that. That helps us; it's data-driven. Then we can begin to have a conversation. And although I know that they want to save dollars, I'm comfortable because I can see how this concern is warranted: they can identify where the waste is; they can save dollars and we can benefit from launching the programs to tackle that. I know they're not just trying not to pay claims. I give that data to our teams to validate their assumptions from the point of view of our organization, to confirm that this really should be a focus for us. And we sit back down at the table and agree on the steps we need to take.

In that picture, the shared data is the basis of a shared plan between Rhode Island and the payer. Meanwhile, for Steinmetz who faces Rhode Island's physicians in particular, the data provides a persuasive external evidence-base that pinpoints ways of improving clinical practice:

Dr. Gregory Steinmetz,
RIPCPC

> Doctors are very competitive, generally speaking. They take a lot of pride in their work and they want to feel they're delivering care to the highest quality. So, when it comes to seeing our data in comparison to our peers, it's a highly motivating factor; we want to be toward the top of the list. In our group, we have to believe we're doing everything we could possibly do to limit emergency room visits, for example. But when you see data that shows that ER visits in this region are higher than elsewhere, that gets you to step back, to re-explore how we can do things a little better – and maybe not think complacently. It gives us that proper perspective.

Yet everyone expresses frustration with the way this works in practice. They all experience similar problems: consistency and timeliness. Working intensively on a plan that they will be measured and rewarded on, they are often not able to get the relevant data until possibly six months later. Shari Rajoo at Ballad explains the challenge:

> Payers do supply data. But the issue that comes with it is that every payer delivers their data in a different way on a different timetable. The time lag is something we really struggle with. I might be looking at data about something that happened at the beginning of the year and now the year is almost over, so it's really hard for me to effect a change in anything for the remainder of that year. And we have to work with them all individually because they all have different platforms and different requirements. That's one of our biggest challenges.

Mount Sinai's description of the situation gives a sense of the scale of the task in a large organization. Their VBC teams have instituted working groups with each of the health plans, meeting every two weeks or month, focused on quality metrics, on total cost of care reduction opportunities and on pharmacy because that is such a high cost area. Boal highlights how the data challenges described above by Ballad are similar to those for Mr. Sinai, and also how intertwined they are with the topic of metrics:

> The information we get is very fragmented right now. Having access to all payer databases with timely information is very useful – but most of the payers tend to have proprietary approaches to performance programs and they all have slightly different variants on the metrics that they include. That creates a lot of chaos on the provider's side because it's extremely hard to unify around a set of measures that we can share with our physicians, office staff and hospital staff, so they know what they need to focus on to do better for their patients. So we've invested an extraordinary amount of money and energy in developing our own all claims database to try and make it easier.

Managing multiple metrics and multiple payers has led Mount Sinai to become more explicit in their value-based contracts about data, in order to be comfortable that they can deliver on the metrics they will be held accountable for:

> It's shown us we need to get agreements into our contracts around timeliness of reporting and what data we're actually going to get. What we can't get agreement on across all the payers is one standard unified set of measures because they're not ready to unify at this point. They view those as market differentiators. That's why we've learned to write a lot into the contracts about having access to unadjudicated claims information.

The experiences shared by these care providers tell us that not only can payer-provided data be considered an additional incentive to help VBC become more effective, but that it needs to be considered an essential factor underpinning care providers' ability to deliver. From the perspective of care providers, the next frontier in VBC requires seeing timely, consistent data as an intrinsic part of value-based arrangements not as an option on top of financial incentives.

Care support is a critical extension of physician resources

Another main category of infrastructure supports identified by Harvard where payers have the potential to make a considerable contribution is in enhancing care management and other care extension and coordination roles. The care providers participating in this study all agree with that premise. As Shari Rajoo describes it, this is an area which has proven to make a real difference in the interaction between physicians and patients at Ballad Health:

> In this journey, what has really facilitated the difference in the delivery of care here today versus five years ago are the additional team members we've been able to put in place. We now have teams who can assist the physicians with concerns they don't have the time or means to solve in the office. People who can help the patient with those things or direct them to other resources. So that person is getting cared for – but not everything is resting on the physician's shoulders.

So, the challenging issues arise not with whether to augment and strengthen these care support roles, but with how that capacity is delivered: who does it and how is it paid for. The main area of contention is who should fulfill the role. The common view, illustrated here by Mount Sinai, is that these roles represent an extension in care and should be delivered by care providers:

> We have two sets of people trying to do it now. In my experience, it has not been successful for the payer to do this work. I think medical care should be left with the provider and utilization review can happen with the payer.

> In general, our belief is, as we move more and more toward risk on any individual contract or with any individual payer, we think we could do a better job of managing the care management needs because we're closer to the patient, rather than leaving that with the insurer.

Mount Sinai adds however that there are times when, in their experience, the payer is 'a better fit' for delivering care co-ordination, citing in particular specialty care such as hip or knee joint surgery. At present, a challenge for all providers contractually is whether a per patient fee applies, making the total cost of care figure more expensive, versus providing the resources directly to the care provider, allowing the organization to employ those individuals as part of their overall operating expenses.

Reflecting on the nature of the working relationship between care providers and payers, the baseline that everyone is starting from is clear:

> We're chipping away at years and years of ossified relationships that are built on an adversarial approach and reframing of the conversation – and that happens at the individual person level.

In the leadership interviews, the way people describe how they transform this historic divide was startlingly fresh and all to do with human interaction:

> This has been one of the most interesting and exciting parts of the work. It takes progressive leadership on both sides to make this happen. It's not enough for the payers to say we'd love to try some new things, the providers need to do that as well. It's not enough for the providers to do it, the payers have to do that as well. That's really important: to look for common ground. And there's a ton of common ground, if you're willing to look for it.

Listening to these care providers, it is clear how the opportunity to establish new ways of operating with payers, aligned around the same goals, has proven to be an area of real creativity and potential.

Sitting down together

At Mount Sinai, it started at the top. 'One important step was building a different type of relationship with the health plans at the most senior level that we could – with folks that were not the normal head of network at health plans', explains Niyum Gandhi:

> The six of us sat down, their team and ours, and talked for 90 minutes about where they are going and where Mount Sinai is going. There was no negotiation there. It was relationship building. And on the heels of that, they reached out and invited us to spend time with a set of their executive leadership. I brought my team that does a lot of the health plan relationship and some new parts of my team that are focused on finding win-win opportunities. And we spent a full day with them. Now we have monthly check-ins just to see where things are in our organizational relationship. So, we have that to rely on as we work through the difficult work.

That has become common practice across all their health plan relationships. Jeremy Boal, Mount Sinai's clinical lead on VBC, is focused on determining where the mutual benefit lies:

Dr. Jeremy Boal,
Mount Sinai

> We had to come up with a new way of doing business where maybe none of the parties get exactly what they're looking for, but it gives us an opportunity to start on different kind of work together. Sitting down eye-to-eye and working out the details, trying some things and being willing to not have it all be our way or their way is, I think, how you build trust. Then to have a few successes, to continue the dialogue and try a few new things, a few more things.

This step-by-step, progressive approach has proven to be key to building delivery capacity while taking on greater risk in the contracts. Boal stresses the importance of having people from their team involved who continually consider the financial implications of the new approaches being developed.

'Having experts in the room who we feel confident are really thoughtful about how not to break the bank as we do the work,' as he puts it:

> You have to recognize that we're in this for the long haul. It's not all about getting the biggest win on the first contract. It's about creating a series of building blocks so that we learn together and evolve together: we try a few things that are not too risky for either side out of the gate and we go from there and try a few new things.

The power of 'sitting down together' to come up with a new way of working together was a recurring theme in the interviews. In Rhode Island, because it is a small state, the Healthcare Commissioner has played a catalytic role in 'getting all the parties at the table together', as Andrea Galgay explains. She believes it helped payers understand more clearly the real importance of primary care in the new delivery model:

> Often, we have multiple payers and multiple provider groups in the room when we are discussing new types of activities. There's always going to be a level of tension between payers and providers, but we're all marching along the same path. So, the first thing is to build trust and that means taking a leap of faith to try some of these new things – understanding that we might not perform at 100 percent at first, but we're going to learn together and then improve our programs accordingly. It's very important that providers like us are willing to do that.

The readiness to work in this open way is, in itself, an act of building trust. It creates shared buy-in to the solutions:

> One thing that successful payers are doing now is bringing together people who all have a part of the solution. Too often, historically, health plans have thought, 'We're the organizer of the supply chain here; we know best, so here's what the solution is; we want you to buy it'. But, of course, when that happens everybody else abdicates their responsibility to the solution. Wherever we've seen improvements in value, it's almost always when all the parties get together at the beginning of a process – saying, 'Forget what we all do today for a second, and let's all play a role in creating the solution.'

No one is claiming that this is easy or quick. All of them cite the need for transparency, meaning shared, data-led, evidence-based decision-making and monitoring of progress. They also refer often to transparency of motives; the need for everyone to be clear what their goals are in the shared enterprise – 'everything out on the table'. However, if those criteria are in place, they are all confident that it is possible to create win-win relationships with positive benefits for patients.

Collaborative design

The success stories that these care providers shared are born out of this profoundly new way of working. They are created in a spirit of what Stephen Furia at Mount Sinai calls 'collaborative design' and, typically, they are focused, new initiatives that create the opportunity to design a solution from scratch:

> There's a lot of collaborative design going on. That gives us a chance to build a new vessel for how we deliver VBC in our organization. There are places where it's not a zero-sum game; where if we think together with payers about reasonable quality metrics, we'll be focused on the right thing. Where if we think about the data we need to share back and forth, we'll be focused on the right thing.

The instances where Mount Sinai has had particular success with collaborative design are worksite programs and specialty care. (See case studies pages 44 and 45). What these case studies have in common is that they are innovative projects, focused on a small enough scale to allow everyone involved to design a new way of operating together and then to deliver that project jointly. The mutual wins and measurable results have led Mount Sinai to replicate this approach in other work site locations in other sectors and across other forms of specialty care, including hip, bariatric and cardiac surgery.

The win for the patient was measured in health outcomes and experience, but also in affordability. In a situation where the typical family today may be taking home around $50,000 a year in income on average and facing deductibles on their healthcare of $1,500 on average, Dr. Boal's team are pleased with being able to deliver this new model often with zero out of pocket for the surgical procedures for the patient.

These success stories serve as a source of inspiration to those on the long journey toward VBC. As Mount Sinai's Stephen Furia says:

> You get discouraged when you think about the scale of the problem of getting hundreds of thousands of parties to change. But you get encouraged when you work together on a smaller scale and you can really see that this is possible; this really can work.

At a personal level for the individuals involved, the opportunity to play an active part in designing a new care model for the future is energizing and meaningful. Furia likes working on innovations that may be deployed with all his patients a few years from now:

> For these new offerings that we put out there, we have the freedom to start to rethink everything. To sit together and say, 'What if we didn't have to live by the current benefits structure, the current reimbursement roles, the current care delivery models? What if we could create something that is purpose-built to deliver value? What would that look like? It gives us a once in a lifetime opportunity to create exceptional alignment in healthcare.'

Shaping consumer behavior in health

Product design is another contribution payers can bring to table, in the view of the Rhode Island team. Based in a state where there is a significant challenge with consumers self-referring for specialty visits and high ER utilization, they are acutely aware of how the cost of care can ramp up without a commensurate improvement in health.

These leaders all expressed concern about how to shift consumer behavior. They fear that without tackling that, the efforts of the professionals throughout the system are doomed to fail. In that context, they believe that payers have an important contribution to make, as Rhode Island's Noah Benedict outlines:

Noah Benedict,
RIPCPC

> The way payers can design their products could shape patient behavior in a way I don't believe we, as care providers, are capable of with just education or training. If their product is telling consumers, for example, that a visit to the Emergency Department without checking in with your doctor will cost you a lot more, it might give people pause before incurring that charge. Money shouldn't be the only factor here, of course, but it is a very powerful one.

Benedict sees the next step as enhancing the collaboration with insurance companies and employer groups to co-design insurance products that drive consumer behavior to ensure improved outcomes and drive down costs.

Case study
A worksite health center built on a commitment to primary care

The problem

Mount Sinai partnered with a labor union in Atlantic City to help them figure out how to improve the health and productivity of their union workforce and, at the same time, crack the nut on the affordability crisis.

The union had decided to invest in a 10,000 square foot health center and hire a third party to develop and deliver an exemplary version of the primary care model. Right from the outset, everyone agreed that fee-for-service should play no part in the vision for the center.

> We began with what we think is the important thing for the future: we sat down with them and their health plan administrative partner and we designed collaboratively the model we thought would produce the greatest value.

The solution

Together they developed a financial structure where Mount Sinai was incentivized to spend the necessary amount of time with patients to try to help them on a course towards prevention. They articulated a shared mantra: 'Refer less, refer smart.'

A few key decisions were critical to success:

- Ensuring patients consume healthcare within the center, as much as possible – and only referring out to a specialist when really necessary.
- Only referring out to specialists in the community who practice evidence-based medicine.
- Operating an open-access schedule, expanding the hours of the health center.
- Conducting a significant community engagement program, including reaching out to patients with chronic illness with a number of service enhancements made possible through the investment in primary care.

In addition, since so much of a poor patient experience comes from the lack of a strong connection between the roles of the care provider and the payer, the center offers a level of navigation services that is not typical. A person at the front-desk from the care provider team is able to answer patient questions about health plan benefits – and vice-versa: there is a direct transfer from the center to a dedicated account rep at the health plan offices.

The results

Mount Sinai improved their business from the population health standpoint, improved the health plan's stickiness with the employer and provided better service to both the employer and the employees.

The new, co-created model delivered results in the first year:

- The volume of visits to the Emergency Department reduced by around a third, flowing through into cost savings.
- The center achieved a Net Promoter score of 86.

> We took it back to some basic questions. What if we didn't have to play by the existing rules? What if we really invested in primary care to make it deliver what we think it should, what would that look like?

Case study
Transforming the delivery of specialty care

The problem

Mount Sinai initiated a bundled payment program for knee replacements. They identified two priority challenges to focus on in specialty care. First, waste across the system. Second, the difficulty of persuading consumers to engage more effectively in their recovery – leading to multiple, non-necessary visits to the emergency room.

All the parties involved sat down together to map out a program to transform the outcome. They identified a fixed price that everybody could be comfortable with – and would save the customer money.

> We started to build out processes in front of the surgery itself – including asking, 'Should this surgery even be done?' You have to define the rationale for how you will deliver each process step because that's where the waste is.

The solution

Mount Sinai was incentivized to consider not only the intervention of the surgery itself, but the spend along the entire continuum of the treatment. That led them to change how they approached the process end-to-end:

A few key decisions were critical to success:

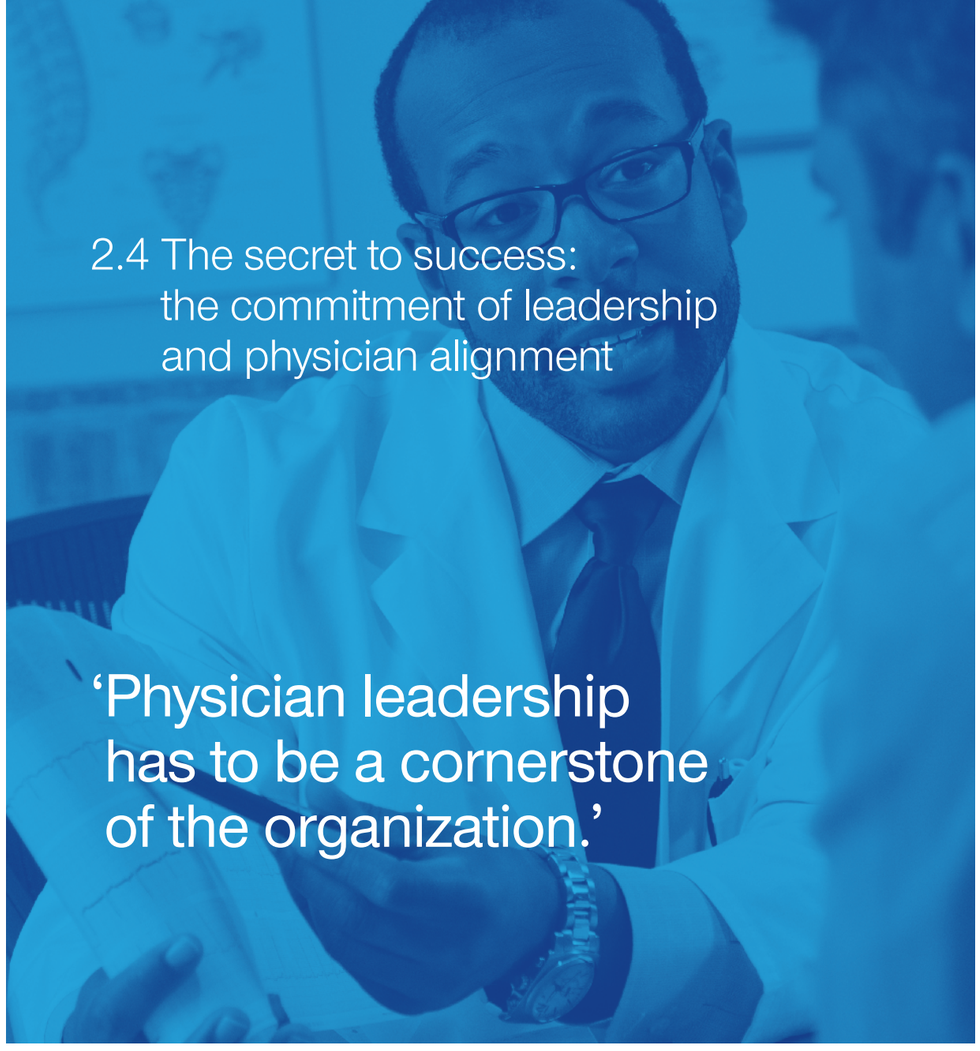
- Preparing people for the surgery, a Joint School was set up to explain to patients what the journey would be like.
- Interviewing the patients in their home to assess practical risks, such as the potential for a fall.
- Providing services that previously would not have been part of the service, including free rides to follow-up appointments.
- Appointing a navigator to guide patients through the entire journey, staying close while they are in the hospital, reviewing the care plan for their return home and acting as a resource when they need to answers to questions – eliminate the need to go to the emergency room to get attention.

The results

In each of the first two years, the results showed an improvement in both the denominator and numerator of value:

- It saved the customer $800,000.
- It achieved 91 percent patient satisfaction, because people recognized that they were getting more than a surgery; the outcome was improved mobility and reduced pain.

> This is one of the greatest win-win-wins that I've seen in my 20-year healthcare career. The patient got a win, the customer got a win, the payer got a win and, as the provider, we also got a win. We got more business, not in the old-fashioned way by hiring more physicians – but because we've created value and earned more business from a customer who likes the value that's been created.



Each one of the participating care providers homed in on the leadership of commitment as essential to success:

> No.1: it's got to be something the organization's committed to all the way to the top – including the Board of Directors that we're ultimately accountable to. It all starts at the top.

> It all starts with the vision and leadership. Because, if you're a health system and your leadership is looking just at the next two years, you'd keep fee-for-service. If you're a good leader, you have to look at it and say, 'In the middle of the next decade – we're all going to have to start living on a budget'. And you could get discouraged because you realize you're going to have to change so much – so you don't respond. Or, you can start on it today and say, 'I'm going to have a deliberate multi-year plan such that when we get to the middle of the '20s, we know how to do this'.

Staying power

The significance of leadership commitment is explained not only in terms of setting the strategic vision, but of staying power. Stephen Furia, whose role at Mount Sinai is to operationalize VBC, knew he had the determination of leadership behind him:

> Any time I found that I was running into serious barriers, he would say, 'Whether we do it over six months or we do it over two years, we have to move in this direction'. So, as an example, the conversation of changing how we pay several hundred primary care physicians is pretty meaningful and, of course, there were bound to be people who didn't want to change it. But he's committed to this new organization, so he just states again that this is the direction we're going in and continues to push for it.

Furia's colleague, Jeremy Boal, explains that even for an organization the size of Mount Sinai, every dollar spent on VBC is a dollar not spent on something else:

> It takes a significant amount of internal fortitude and commitment to see this through. Because it's very easy to get put off by the types of investments that are required – but, on the other hand, I do think that under capitalizing this kind of transformation is a real risk for organizations.

Rhode Island Primary's experience has been similar, requiring resilience in leadership:

> The CEO had to stand strong and say: 'We are in this together, we are going to help each other and this is the way it's going to be.' Just maintaining that culture.

The challenges of change range from reshaping the way people are paid, committing to high levels of investment, persuading experienced professionals to learn new ways of operating – and even asking the best performing players to share their success in support of their lesser performing colleagues. They all operate on the basis that they are going to meet resistance along the way and, as Crow from Catalyst Health puts it:

> You have to be persistent in your messaging. And consistent in your messaging. And you have to be passionate. Make sure people see activities that show you are serious. This is not a passing fancy.

Physician leadership

At Rhode Island Primary, with 150 doctors in the network, Noah Benedict identifies physician leadership as the critical success factor for his organization. They have set up committees focused on quality, on utilization, and even committees specific to pharmacy and behavioral health, all physician-led:

> True physician leadership has to be a cornerstone of an organization like ours in the collaboration you have with payers on value-based reimbursement. I truly believe that. When you have one practicing physician explaining to another physician why these changes are necessary, how it improves patient care and perhaps improves the financial aspects of the practice as well, that rings true to people.

The Rhode Island Primary team also highlighted another success factor: the sharing of leadership responsibility. Dr. Gregory Steinmetz, who is credited by his colleagues as being a lynchpin of the transformation, has a structure around him that helps him share the load and amplify the effectiveness of the change program:

> There are at least 20 of us who are of one mind when it comes to how we proceed with this vision. We share that vision. So, when issues arise there are many of us able to speak with the doctors who may have concerns. They can explain how the issues have been handled by the Board – with physicians at the table – how those concerns have been debated in an open forum and how the decisions were made. This structure really opens it all up. We're not having to go person to person to convince them this is the direction we should move.

So, at Rhode Island Primary, beyond the core of 20 or so people, there are 40 more participating at the committee level, whose role is not simply to rubber-stamp, but to develop protocols that are recommended to the Board of Directors that are then adopted throughout the organization. Steinmetz describes is how it is designed to embrace more people as the new model takes root:

> Everyone feels part of the change that's happening; they feel part of the progress. And if you want to participate, there is a place for you.

Harvard's research found that, while a large proportion of provider groups today participate in at least one VBC arrangement, these still represent a minority of the total reimbursements, therefore making it only rational for organizations to be unwilling to make changes that are incompatible with the historic fee-for-service model. Dr. Crow recognizes that tension at Catalyst Health, saying:

> It's really hard in a health system where the main way of making money is still butts and beds to align activities so that they show a different kind of value – and it creates cynicism.

Furia at Mount Sinai – which has shifted fast from around 20 percent value-based arrangements in 2014 to 80 percent today – describes handling this dichotomy as:

> It's somewhat schizophrenic but absolutely necessary. We have pockets of physicians who are incredibly happy. Many of those started out as skeptics but it's working for them. They're comfortable with their reimbursement and they're getting more help in getting the work done. On the other hand, we have a lot of physicians who haven't had a lot of exposure to this yet and they're justifiably nervous still.

Their experiences reinforce Harvard's observation that increasing the share of provider group reimbursement tied to value-based arrangements may, in itself, act as a catalyst to delivering greater impact on care delivery – and that there is an opportunity to explore further the potential for value-based incentives to be attached to individual physician performance, rather than only to the organizations.

Winning hearts and minds

The teams at the helm of these transformation programs are conscious that it is absolutely essential to take people in their organization with them on the journey. Niyum Gandhi is very clear this is a top priority, 'Because we can't do this as just a few executives working on it; we need the army of the entire organization moving in this direction.' That is why he spends 30 percent of his time winning hearts and minds of Mount Sinai's 40,000 strong workforce:

> When they get over their initial skepticism of what this is, they're very receptive. At first, they're asking: is this just a way to squeeze us more? And the answer is: no, actually, we can give you more resources so you can deliver better healthcare. So you can spend time with your patients in a different sort of way. In the hospitals, talking to the people working in the emergency room, they're used to their workflow being focused on just admitting patients and hoping the hospital can figure it out tomorrow and all the costs associated with that. So if we can decompress their days a little, if we can give them more resources, if we can give them more time to get patients safely transitioned home, they're receptive.

They all agree how important it is to recognize the validity of the concerns expressed by people in the organization. This is risky and, in many ways, it is counter-intuitive, as Ballad's Marvin Eichorn explains:

> You have to do something that you wouldn't normally ever do as a business – and that's to take proactive steps that ultimately result in you having less volume. If I get a report from our hospital that we've got three percent fewer admissions than last year, that's now a good thing. I shouldn't feel positive if it had gone up because it means our efforts to keep people out of the hospital aren't being successful. That's very difficult to do; very difficult.

Marvin Eichorn,
Ballad Health

Success stories of VBC in action are without fail their greatest asset in building confidence among their colleagues, the case study from Mount Sinai cited in the previous section, specialty care. 'There will be a lot of moments where people are going to want to go backwards or say this isn't working, or it's not worth the investment. And just being committed to moving slowly and inexorably in this direction is the only way,' reflects Gandhi.

Dr. Crow goes back to the original impetus for setting off on the journey in the first place, the synthesis between the strategic imperative to respond to rising costs for everyone involved, including the patients, and the sense of mission that people bring with them into healthcare:

> If you understand the basic problem which so many of our patients face that their healthcare cost has doubled; it's eating into their income and now they have to make trade-offs about transportation, food, clothing and education. Who wouldn't want to be on the winning team in fixing that? Who doesn't want to be part of a solution that is better for them and makes you feel good?

Dr. Chris Crow,
Catalyst Health Network

Appendix:

Glossary and references

Appendix: Glossary and references

Base Payment Models

Global: Providers accept accountability for the healthcare spending of a group of patients.

Episode: Providers receive a flat budget for all services involved in a specific medical episode (procedure or diagnosis)

Rate setting: Providers receive a fixed price for specific medical services based on the resources required to provide that service

Fee-for-service with resource efficiency incentive: Providers receive a bonus or penalty according to their performance on one or more resource efficiency measures such as per-beneficiary spending; fee-for-service as usual otherwise.

Financial Risk

Full risk: Providers assume 100 percent of the insurance risk and are paid a flat per patient fee (i.e., total payment does not vary based on the actual services provided).

Shared upside and downside risk: providers receive fee-for-service payment throughout the year. At year's end, if the organization's spending is below a negotiated target, it can share in a portion of the savings. Conversely, if spending exceeds the benchmark, the organization pays back some of the difference.

Shared savings: Providers receive a portion of any savings generated, but are not responsible for any losses that occur if spending exceeds a negotiated target.

Quality Incentives

Quality gate: Providers meet a quality performance threshold to be eligible to receive a shared savings award.

Quality ladder: Providers' shared savings (or losses) vary according to the level of quality performance.

Pay-for-performance: Providers receive financial bonuses or incur penalties based on predefined measures.

Spending Reduction

Global Payment

In global payment arrangements, providers have a pool of resources to provide care for a specific population of patients or for a set of services (e.g., hospital-based services). The size of the resource pool may be based on the number of patients attributed to the organization (typically known as capitation) or a calculated benchmark, such as the prior year's total healthcare expenditures.

Because payment does not depend upon the number or intensity of services provided, global payment arrangements blunt providers' incentives to increase the volume of medical services. To counter the shortcomings of first-generation global payment models (stinting on care, cherry picking the healthiest patients), modern global payment models incorporate quality measurement and performance incentives.

Similar to VBC as a whole, global payments exist along a continuum. The first dimension along which global payments can vary is the scope of the population and services for which the provider organization is responsible under the contract. In its largest scope, global payments cover total medical expenditures (TME) for all patients attributed to the organization. The services included in TME often encompass physician, hospital, and post-acute care, but may also include prescription drug spending. A smaller scope of global payment is one that covers only one part of the delivery system, such as global budgets for hospital care. The state of Maryland, for example, has been experimenting with global hospital budgets since 2010 for hospital inpatient and outpatient departments.

The second dimension along which global payments can vary is in the degree of risk to which they expose providers. In full-risk models, providers assume 100 percent of the insurance risk for covered patients and are typically paid a flat per patient fee. Full-risk global payment contracts, however, may not be feasible for some organizations in the near or even far term. Organizations without experience in holding risk-based contracts may be hesitant to transition from the fee-for-service world to full-risk in one fell swoop. Organizations with small numbers of patients cannot spread risk over a large enough patient pool to account for the random variation in healthcare spending that can occur within a population. Shared risk/savings models and shared savings-only models are generally viewed as a – middle-way along the path to full-risk global payment.

Under shared risk/savings models, provider groups are paid throughout the year under traditional fee for service. At year's end, if the organization's spending is below a predefined target, it can share in a portion of the savings. Conversely, if spending exceeds the benchmark, the organization must pay back some, but not all, of the difference. In shared savings-only models, providers receive a portion of any savings generated, but are not responsible for any losses that occur if spending exceeds the target. For some organizations, these arrangements may be transitional. Many payers, including Medicare, stage in risk from shared savings-only models to shared savings/risk, and perhaps ultimately, to more robust forms of population-based payment such as global capitation.

To qualify as VBC in our review, global payment models must include a tie to quality—through the presence of pay-for-performance incentives alongside the population payment or quality measures that directly mediate shared savings or losses.

Bundled Payment

Bundled payments involve a flat budget for all of the services involved in a specific medical episode, such as a joint replacement, or for a particular condition. Under bundled payment, instead of paying for each step involved in a procedure like a joint replacement – e.g.: a physician office visit, the joint replacement surgery, two days in a skilled nursing facility – the components are bundled up and priced together in advance as a single unit. In the joint replacement example, the medical episode occurs across multiple care settings and providers. All of the different providers involved have a shared interest in coordinating to control spending because they are working against a fixed budget and are held financially responsible if the actual spending exceeds that budget. If the actual spending is less than the bundle price, the providers involved will receive some, or all, of the surplus.

Like global payment, bundled payments can vary in the degree of risk to which they expose providers, in theory ranging from full-risk to shared savings only. In practice, the majority of episode-based payment contracts are shared risk/savings.

To be considered value-based, the bundled payment program must incorporate quality measurement. Such quality measurement may be used to determine eligibility for reconciliation payments.

Rate Setting

Rate setting is not a new strategy and has been in place in the Medicare program for hospitals since 1984 (the diagnosis-based prospective payment system, PPS) and physician services since 1992 (the resource-based relative value scale, RBRVS). Under the PPS, hospitals receive a fixed payment based upon the treated Medicare beneficiary's diagnosis — regardless of how long the patient is in the hospital or type of care delivered. Under the RBRVS physicians services are paid according to a schedule, which combines physician work, practice expense, and professional liability insurance.

Both the PPS and RBRVS aim to capture the resources required to provide a particular medical service and set prices accordingly. In a perfectly competitive market, this type of price setting is not necessary – the efficient price for a particular good or service is determined through the interaction of individual buyers and sellers. The healthcare market is different from other markets due to health insurance (i.e., patients pay something less than the full price for a given service) and information asymmetry (i.e., providers have significantly more clinical knowledge than patients). Market power also plays a role in determining prices in specific geographic locations. Ten states have experimented with all-payer rate setting, i.e., establishing a single rate that all insurers pay for a service.

To be considered value-based, rate setting must occur in conjunction with performance incentives.

FFS with resource efficiency incentive

Providers receive a bonus or penalty according to their performance on one or more resource efficiency measures such as per-beneficiary spending; FFS payment proceeds as usual otherwise. To be considered value-based, quality measures other than efficiency must also be incentivized (e.g., process measures of care quality, patient experience).

Quality

Quality gate and/or ladder

In models with shared risk/savings, both the eligibility for, and the magnitude of, shared savings awards may depend on an organization's quality performance. The performance measures in a VBC contract typically include a combination of care quality, efficiency, access, and patient experience targets; participants determine the array of quality measures as a term of the VBC contract.

Performance on the measure set can function as a – gate and/or – ladder. A quality gate is the minimum level of performance that an organization can achieve and receive a shared savings award. A quality ladder mediates the size of shared savings (or shared losses) according to the level of quality performance. Quality gates and ladders are often used together.

Pay-for-performance

Pay-for-performance initiatives are payment arrangements in which providers receive financial bonuses or incur penalties based on predefined measures. To be considered a VBC, the pay-for-performance incentive must occur in conjunction with a payment model designed to reduce spending or include one or more measures that directly incentivize resource efficiency. An example of the former is a pay-for-performance program launched within a global payment contract. A pay-for-performance measure that incents efficiency is spending per beneficiary

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