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# What We Learned in a Healthcare Crisis – Current Patterns in Value-Based Care

The COVID-19 pandemic altered virtually every aspect of American life. We can see that some things have changed irrevocably; the way we deliver healthcare is one of them. The pandemic presented unprecedented challenges to the medical establishment and forced us to devise creative solutions that in some cases were long overdue. We adopted more stringent safety protocols. We developed and refined new technologies to stay connected to our patients. And we learned some important lessons about how different delivery models work in a changed world.

Understandably, some practices have struggled during the height of the pandemic; but other practices were able to thrive even as fee-for-service patient volume declined precipitously.[1] It's important to understand *why*. Creative innovations in patient care hold the potential to sustain positive health outcomes that are also cost-effective. They also may hold the key to determining whether a practice prospers moving forward. If innovative delivery models can keep a practice in the black even during the worst of times, we must ask ourselves: what can they do for us in the best of times?

## HOW THE PANDEMIC FURTHER EXPOSED DEFICIENCIES IN THE FEE-FOR-SERVICE MODEL

The majority of outpatient practices continue to rely on fee-for-service (FFS) payments — and therefore rely on in-person visits as a major driver of revenue.[2] In the last weeks of 2020, outpatient visits began to approach those at the beginning of March (the last week before lockdowns began), but they were still 5%-6% lower than average for that time of year. At the time of the study, there was no sign of a further uptick in outpatient visits; while FFS volume remained stable, it had effectively hit a plateau. This has made it more difficult for struggling practices to recoup a months-long drop in revenue, forcing them to cut back just as in-person visits began to increase.[3, 4]

According to a study conducted by the Commonwealth Fund (in collaboration with researchers at Harvard University and Phreesia), when the pandemic first hit, **outpatient visits declined by nearly 60% over a single month.**

## WHEN PATIENTS STOPPED COMING, HEALTH OUTCOMES WORSENED

Every physician's first priority is the health of their patients. Under an FFS model, achieving that is fairly straightforward. A patient comes in with a complaint, like a sore throat or a persistent ache; a physician examines them; and then that physician prescribes a course of treatment. In the case of something fairly simple like a urinary tract infection (UTI), the treatment is quick, easy, and cost-effective.[5] A physician will often prescribe an antibiotic, thereby slowing the spread of infection and the need for acute care.

There's a built-in flaw with this delivery model, one that became apparent during the COVID-19 pandemic. What happens when the patient decides not to come in at all? Treatment becomes far more involved; far more expensive; and far more dire. Neglecting a UTI can result in a trip to the hospital with a bladder or kidney infection. By avoiding ambulatory care, the patient can end up in an acute care setting.[6]

In patients with type 1 diabetes (T1D), UTIs are common precursors to diabetic ketoacidosis (DKA); which means that an acute condition, left untreated, can exacerbate a chronic condition to serious consequences.[7] That's exactly what we saw happen during the pandemic: a spike in DKA admissions for both type 1 and type 2 diabetes patients.[8, 9] Similar trends occurred for patients with congestive heart failure. Understandably afraid of how contracting COVID-19 might aggravate their condition, CHF patients would delay evaluation for advanced congestive symptoms and end up suffering worse outcomes.[10]

According to the CDC's Morbidity and Mortality Weekly Report, avoidance and delay of medical care during the pandemic may have contributed to needless excess deaths from health conditions both chronic and acute.[11] The American College of Cardiology estimates that there was a significant increase in deaths from cardiovascular diseases alone during the early months of the pandemic; and delays in cancer screenings could lead to thousands of excess deaths from breast and colorectal cancer.[12, 13]

The problem extended beyond infection and physical disease. Primary care physicians are often a patient's first line of defense for a wide range of medical issues, including mental health and personal safety. During an in-person appointment, they can see whether an elderly patient has gained or lost weight since their last visit, which will prompt them to ask questions about the patient's nourishment and mental state.[14] Physicians are also trained to look for mental health cues that could lead to progressive mental illness; without early detection, early intervention becomes more difficult.[15]

Intervention in cases of domestic violence may have suffered as well. According to the National Commission on COVID-19 and Criminal Justice, cases of domestic violence in the U.S. increased by a staggering 8.1% during lockdowns.[16] Physicians often discover signs of domestic abuse when conducting a physical examination; not only may they notice physical trauma, but they can observe a patient's behavior for warning signs. And clinical evaluations provide a rare degree of privacy for victims of abuse, who often cannot safely connect with support services outside of a confidential setting.[17] Sometimes, a doctor's visit may be the only recourse they have.

A decline in FFS visits means a decline in health outcomes; and you can't have a healthy practice without healthy patients.

## NEGATIVE HEALTH OUTCOMES, NEGATIVE BALANCE SHEETS

Under the FFS model, poorer health outcomes led to poorer financial outcomes for physicians. When FFS volume dropped during the pandemic, so did claim reimbursements. According to one study by Avalere Health, Medicare FFS claims alone declined by up to 51% in the first months of 2020.[18] Meanwhile, operating costs (rent, equipment investment, payroll, and more) didn't just remain constant — in many cases, they increased, due to the added investment in personal protective equipment (PPE).[19] Federal Payroll Protection Program (PPP) loans under the March 2020 CARES Act helped to mitigate some of the losses.[20, 21] Practices could borrow 2.5x their average monthly payroll from the preceding twelve months; but as the pandemic dragged on, revenues remained much lower than the previous year's average.

By one estimate — and assuming a mere **25% reduction** in revenue — some private practices were looking at a **62.5% drop in annual profits**).[22]

## WHEN FEE-FOR-SERVICE VISITS DROPPED, VALUE-BASED CARE MADE ALL THE DIFFERENCE

Practices that had already entered into value-based care (VBC) contracts with payers prior to March 2020 were in a much better position to weather the pandemic. Not only did they already have structures in place to provide for better health outcomes in the absence of in-person visits, but they had the revenue to invest in technologies that would allow them to continue FFS appointments remotely.

## POSITIVE HEALTH OUTCOMES FOR PATIENTS

Understanding your patient population, and anticipating their needs, are hallmarks of value-based care. Around the world, different value-based models have already demonstrated improved health outcomes, often while implementing significant cost-saving measures.[23]

Physicians who participated in value-based care contracts prior to March of 2020 already had an apparatus in place to stay on top of their patients' health. They had identified their patients who were at high risk for certain conditions and implemented follow-up strategies for preventive screenings and annual wellness visits. They took a view of patient care that extended beyond the four walls of their practice, examining social determinants like food insecurity that may negatively affect a patient's health.

All of this might sound familiar even to physicians who don't participate in value-based care contracts. Having taken the Hippocratic oath, they all do whatever they can to ensure that they deliver the best possible care. They already follow up with their patients. They already prescribe the appropriate medications and referrals. So, the fundamental question for physicians is: why not get paid more for something you're already doing?

## A RELIABLE SOURCE OF REVENUE

Physicians who participated in value-based contracts with payers were far better positioned to thrive during the pandemic. For those whose practices relied primarily on FFS claims, when patient visits stopped, so did revenues. Not so for those with value-based care contracts in place.

Value-based care contracts reward physicians for keeping costs down through preventive care; and the more risk a physician takes on, the greater the reward. In upside-only shared savings agreements, payers reimburse clinicians — they share the savings — when they keep healthcare expenditures low. All it takes to do that are some simple steps: for example, checking in regularly with patients with chronic conditions, to make sure they're adhering to a preventive care regimen, or coordinating medical records with referred specialists to avoid duplicative testing. The extra effort may be minimal, but the rewards can be great.

And in the event that costs go up under a shared savings agreement, the physician may not receive that bonus, but they also won't be financially liable, either, because they've assumed none of the risk. In upside-only contracts, a clinician may look forward to receiving a quarter of the shared savings with the payer, as well as care-coordination bonuses for meeting clinical benchmarks.[24] That may sound like a lot — and in the case of larger practices, it may be — but it's only a fraction of what clinicians can receive when they begin to assume a greater share of the risk.

Clinicians who opt for shared risk do assume some financial liability. This downside-risk model means that when a Medicare patient's actual healthcare costs exceed their predetermined spending threshold, the physician would be responsible for the difference. The potential for losses can be intimidating at first: In the years before the pandemic, one survey found that only 39% of accountable care organizations (ACOs) opted for shared-risk arrangements.[25] But by assuming shared risk, clinicians stand to receive a far greater share of savings from their payers: 50%, 75% and even 100% under full risk models. For some practices, that can add up to millions of dollars per quarter.

## AN EASIER SHIFT TO TELEHEALTH

Those additional revenue streams helped immensely when it came time to invest in telehealth. March 2020 saw an unprecedented 154% increase in telehealth visits from the year before.[26] Telehealth technologies became essential to increasing FFS volume once the pandemic hit.[27] They also played a key role in helping clinics in value-based care agreements to continue performing routine check-ins with their patients. New hardware, software, and even the installation of secure data lines could create unexpected increases in overhead; but that financial hit would be easier to bear for practices with revenue from value-based care contracts.[28]

## VALUE-BASED CARE IN THE FUTURE: EMBRACING CHANGE, DISPELLING DOUBTS

The pandemic may have accelerated a shift in the prevalence of value-based care models, but the shift was already underway. More and more, commercial and government payers seem to be embracing the more innovative payment models. Despite this trend, there's still an ingrained resistance to value-based care contracts among many providers. It's important to understand why that is — and why a lot of that resistance may stem from some essential misconceptions about the bureaucratic and regulatory hurdles in value-based care.

## ALL SIGNS POINT TO A VALUE-BASED FUTURE

Volume-based reimbursements were on the decline even before the pandemic began. As far back as 2017, the Health Care Payment Learning & Action Network reported that more than half of all healthcare payments were value-based. The next year, according to an MGMA survey, 56% of all healthcare leaders said their groups participated in value-based care contracts.

It makes sense. According to a 2018 study by Change Healthcare, value-based care created an average cost savings of 5.6% for payers.[29] And in 2019, national health expenditures amounted to $3.8 trillion — meaning value-based care may have created a savings equal to $212.8 billion.[30] That's $212.8 billion waiting to be disbursed among providers who assume shared risk in their value-based care contracts.

The National Academy of Medicine has estimated that **Americans spend $210 billion on unnecessary (or unnecessarily costly) healthcare each year.** It's this wastefulness that value-based care contracts were designed to remedy.

It's clear to see which way the wind is blowing. But why, then, do some providers treat it as a headwind instead of a tailwind?

## MISCONCEPTIONS VS. INNOVATIONS

A majority of providers may participate in some form of value-based care contracts; but for almost two-thirds of them, those contracts make up 20% or less of their overall contracts. And a sizable minority does not participate in value-based care contracts at all. Reasons for eschewing those contracts are many, including:

- Not knowing how to start
- Skepticism toward the effectiveness of value-based measures
- Lack of bandwidth to take on new contracts (the idea that it will be too much work)
- Aversion to what they perceive as increased regulatory burdens.[31]

## GO AT YOUR OWN PACE

Physicians who are unsure of where to begin can start with a simple shared savings agreement. With no financial downside, they can gauge for themselves just how effective value-based care models are without taking on any added liability. Once they feel more comfortable working under those contracts, they can start to take on more risk as they feel comfortable.

## A MORE EFFICIENT, MORE AGILE OFFICE

As for the fear that taking on new contracts may be too much work for already overburdened clinicians: value-based care can actually improve a practice's workflow. That was certainly the case during the pandemic. Groups that participated in value-based care contracts already had schedules in place for regular calls and home visits with their Medicare patients; this made the post-lockdown shift far less abrupt than it was for physicians who relied solely on FFS. (For example: whereas a practice might send a nurse practitioner on house calls once a month under normal circumstances, they might send them out more frequently during the pandemic. The shift was merely one in volume, not strategy.)

According to a joint research study by MGMA and Humana, value-based care fostered more clinical interaction with patients, which led to improvements in overall patient care. It also seemed to improve staff morale and engagement.[32] (MGMA has found that the keys to making value-based care contracts include clearly defined roles, responsibilities, and routine communication pathways within a practice — all of which will help a practice thrive no matter what payment models they may rely on.)[33]

And to further streamline the process, practices can narrow down the number of Medicare payers they partner with, choosing the ones that are most mutually beneficial to both practice and payer. Instead of 12, for example, they can limit the Medicare Advantage payers they partner with to three and ask their Medicare patients to shift their plans to those specific payers. Not only will it cut down on the red tape involved, it can set providers up for even greater potential bonuses, by increasing the aggregate savings under each payer.

## LOWERED REGULATORY HURDLES

In years past, both the Physician Anti-Referral Law (also known as the Stark Law) and the Anti-Kickback Statute (AKS) have acted as barriers to entry for clinicians who might have been interested in pursuing value-based arrangements. But in 2020, the Centers for Medicare and Medicaid Service (CMS) updated the Stark Law to provide "new, permanent exceptions to the physician self-referral law for value-based arrangements," including:

- Upside-only remuneration paid under value-based arrangements;
- Value-based arrangements with meaningful downside financial risk (such as downside-risk sharing contracts); and
- Value-based arrangements with full financial risk.

CMS also established new safe harbors under the Anti-Kickback Statute, including in-kind remuneration between participants in value-based arrangements, regardless of the level of downside risk.[34, 35]

That's good news for value-based care: in a 2018 MGMA survey, 94% of respondents said regulatory burdens were a major factor in how they allocated healthcare spending.[36] Wary clinicians might have felt that the Stark Law or the Anti-Kickback Statute would hinder them from acting in what they believed to be their patients' best interest under value-based arrangements. They no longer need to worry.

## MAXIMIZING OUTCOMES: HOW TO MAKE VALUE-BASED CARE WORK FOR YOU

Signing a value-based care contract isn't a guarantee of rewards. It takes a real commitment to eliminating inefficiencies. That commitment can take many different forms:

- **An investment in analytics.** According to the MGMA/Humana study, 89% of practice leaders who participate in value-based agreements reported implementation of data analytics and reporting software. That investment will make it easier to stay on top of key performance indicators (KPIs), track patient progress, and identify areas that still need improvement.

- **Technology upgrades.** Upgrading EHR systems, registry platforms, and patient interfaces may constitute a significant upfront investment, but can help to simplify workflows in the long term. For example, creating educational resources for high-risk patients can diminish the need for emergency visits — and lead to greater cost savings.

- **Opening up the schedule.** Sometimes, acute care becomes necessary because patients can't get in to see their PCP in a timely manner. As mentioned earlier, a routine examination and a prescription may be all it takes to treat a simple UTI; but if it takes three weeks to get in to see a doctor, the problem may become much worse. By carving out time in the schedule for last-minute appointments — even if it means staying in the office a half an hour later or getting there earlier — a clinician can increase the likelihood of positive, cost-effective health outcomes.

- **Partnering with the right specialists.** Every practice, regardless of their payment model, relies on a robust network of specialists for referrals. With value-based agreements, it's especially important to make sure that those specialists have the same priorities when it comes to cost savings. Do they frequently order unnecessary procedures or services? Do they send back notes to referring physicians in a timely fashion, so they can take proactive measures as quickly as possible? Though it may lead to some delicate conversations with colleagues, PCPs need to make sure they're on the same page with their preferred specialist partners … or send their referrals elsewhere.

There's a lot to consider before heading into a value-based care agreement, regardless of the level of risk assumed. But once made, the initial investment of both time and money can yield huge dividends.[37, 38]

## VALUE-BASED CARE IS HERE TO STAY; USE IT TO YOUR ADVANTAGE

According to an April 2021 survey, 44% of all practices report that visit volumes are still down below pre-pandemic levels, even as more cities and states have reopened without restrictions. Whether that's due to safety concerns, reduced clinic capacity, or school closures, one thing is clear: in order to not just survive, but thrive, more practices will need to embrace alternative payment models.[39] The best time to make the shift may have been in 2019 — but the second best time is now.

## MARSHA S. BOYLE

ENTERPRISE SALES EXECUTIVE, FINANCE AND OPERATIONS IN VALUE-BASED CARE, ALLSCRIPTS

Marsha's background spans many sides relating to the financial side of healthcare. She has served as the chief financial officer of a provider-owned health plan and ACO in Tennessee. Before that she was the senior financial analyst reporting directly to the CFO of a 300-physician, hospital-owned, multispecialty group, supporting financial operations of the nine-hospital system in East Tennessee. Marsha helped develop the position of engagement executive with Humana in Humana's Mid-South region. Many of the approaches she and her team developed were implemented nationwide by Humana, in the shared- and full-risk environment with providers. At Humana, she was tasked to integrate specialty pharmaceutical consumption data to risk-contract performance in Medicare Advantage populations, largely predicated on her direct involvement in group practice and health system operations and her financial expertise.

Marsha's experience includes building successful engagements with providers that result in sustainable risk payouts in the millions over and above Medicare FFS, while relating well to providers and understanding group practice and hospital workflow/contract performance dynamics. Marsha holds a Bachelor of Business Administration in finance from East Tennessee State University and an MBA from Bryan College.

## KORTNEY GUNTHER

SENIOR SOLUTIONS MANAGER, ALLSCRIPTS

Kortney has more than 15 years of experience in healthcare IT as both customer and vendor. Kortney has helped hundreds of ambulatory physician practices achieve success using EHRs and surround solutions across multiple vendors. As an IT business analyst inside a large hospital organization, Kortney continued to lead ambulatory organizations to success in various initiatives.

In her current role at Allscripts, her unique blend of experience has provided the opportunity to apply a deep understanding of customer needs as they transition to value-based care. Most recently, her focus has been on improving clinical and operational workflows through the development of products and services. In addition to her current role, Kortney is a leader on the Product Insights Board for Allscripts Professional EHR. She collaborates with physicians and clinicians across specialties on future product and market innovations. Kortney holds a Bachelor of Science in communications from East Tennessee State University.

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