

MOVING TOWARD VALUE-BASED PURCHASING PROGRAMS FOR VULNERABLE POPULATIONS: IMPLEMENTATION ISSUES FROM THE PROVIDER PERSPECTIVE

Introduction

This new paper is a follow-up to the Kodner paper I circulated a few weeks ago called **Value-Based Purchasing in Health Care: Strategic Implications for Vulnerable Populations**. In the companion paper we point out that individuals in vulnerable population groups (and their family caregivers) face numerous obstacles in coping with their conditions on an ongoing basis, accessing a wide array of services and supports, and effectively managing and coordinating complex needs on their own and through multiple providers in health care settings and beyond. As pointed out in the previous companion paper on VBP, these populations would best be served by an integrated network of providers committed to the provision of comprehensive services and capable of providing coordinated, person-centered, and condition-sensitive care and support on a continuous basis within the context of a “global” payment arrangement.

We now turn to the difficult issues on the best approaches to implementation. We find again the literature and research reports are limited as to evidence supporting any particular model or even good sources on best practice models. It is somewhat surprising to find such a limited reservoir or body of research to call on to help guide our work on value-based payment methods.

On one hand, the field is wide open and ripe for the opportunity to be innovative in designing the future for effective uses of VBP. On the other hand, the caution flags need to be up because finding the right balance between all the factors that affect the lives of our vulnerable populations, requires some patience on the part of our providers and policy makers.

In all the papers I commission, I try to gather the best information to help our providers think about and get prepared for the future. As I have said, value-based payment models are both game changers and innovative approaches to achieve cost effective and efficient quality care.

The VBP world is new for most providers who serve vulnerable populations and I would suggest they are new for policy makers, as well. While we don't know enough now, we trust that there will be a process to gather the best information and thinking to make implementation good for all those we care about.

MOVING TOWARD VALUE-BASED PURCHASING PROGRAMS FOR VULNERABLE POPULATIONS: IMPLEMENTATION ISSUES FROM THE PROVIDER PERSPECTIVE

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INTRODUCTION

In order to contain difficult-to-control costs, enhance system and provider performance, expand access to care, and improve health outcomes for both individuals and communities, the U.S. health care system is moving toward a promising new method of paying for publicly- and privately- funded health care services in which providers are both incentivized and held accountable for improving health care value, i.e., the overall quality and costs of care provided

to a defined population.¹ Known broadly as “Value-Based Purchasing” (VBP), this innovative approach inherently rejects the conventional volume-driven, fee-for-service (FFS) “production” model in which providers are financially rewarded to do more, rather than to do better.² In its place, VBP offers several outcomes-oriented payment mechanisms that tie together the intricacies of quality and cost and broadly encourage providers to measure and improve health care and health.

A previous companion paper in this series³ summarized the theory, practice and known effects of VBP, including its strategic implications for vulnerable populations. Despite the growing importance and level of activity of VBP nationwide, its impact on health care quality and costs are still not well-established. While the outcomes of various VBP programs are beginning to move in the right direction, much more work needs to be done to refine and expand the outcome measures used, as well as build models with more reliable quality and cost effects. All populations are affected by these shortcomings. However, people with vulnerable conditions⁴ are most seriously disadvantaged. Existing VBP models largely ignore the special needs and unique circumstances, risks, priorities and outcomes of vulnerable populations; this threatens to perpetuate the serious “quality gap” that these individuals have historically faced, and still remains.

While there will always be individuals with vulnerable conditions who end-up being served by providers in more mainstream VBP programs, there will ultimately be new and emerging “total care” programs that are organized specifically around these complex subgroups, especially for Medicaid and dually eligible (Medicare and Medicaid) beneficiaries. As pointed out in the previous companion paper on VBP, these populations would best be served by an integrated network of providers committed to the provision of comprehensive services and capable of providing coordinated, person-centered, and condition-sensitive care and support on a continuous basis within the context of a “global” payment arrangement.

Health care organizations seeking to design population-specific VBP programs should begin to consider how to make such models both predictable and sustainable. This paper briefly identifies and discusses the major implementation challenges that are likely to be involved from the provider perspective.

IMPLEMENTATION ISSUES FROM THE PROVIDER PERSPECTIVE

Implementation of a population-specific VBP program will demand the following activities and capabilities:

Establish an integrated network of providers

The previous companion paper points out that individuals in vulnerable population groups (and their family caregivers) face numerous obstacles in coping with their conditions on an ongoing basis, accessing a wide array of services and supports, and effectively managing and coordinating complex needs on their own and through multiple providers in health care settings and beyond. Because the organization and delivery of services for these individuals are disjointed and lacking in continuity, this situation almost always results in delayed or missed treatment and care,

¹ The concept of health care “value” is perhaps easiest understood by the following formula: Value=Quality÷Cost; see Agency for Healthcare Research and Quality (AHRQ). (2002). “Evaluating the Impact of Value-Based Purchasing: A Guide for Purchasers,” Rockville, MD: AHRQ.

² Foster, A. et al. (2012). “Accountable Care Strategies: Lessons from the Premier Health Care Alliance’s Accountable Care Collaboration,” New York City: The Commonwealth Fund.

³ Kodner, D. (2015). “Value-Based Purchasing in Health Care: Strategic Implications for Vulnerable Populations,” Brooklyn, NY: Arthur Webb Group Ltd.

⁴ For our purposes, “vulnerable populations” include the frail elderly, as well as people with complex or multi-morbid chronic conditions (including HIV/AIDS), physical and intellectual disabilities, and serious mental illness (including substance abuse disorders).

poor quality of care, high risk for unwanted or unneeded hospitalization or institutionalization, and poor health outcomes and quality of life. Health care costs are also negatively affected.

Policy experts, clinicians, and advocates for the most part agree that the total care demanded by these complex patients/clients is best provided within integrated provider networks that are geared to their special needs, held accountable for all outcomes, and paid for on a global basis. Networks are vertically integrated entities that bring together health care organizations such as hospitals, physicians, home care agencies, nursing homes, and other providers, and use aligned incentives to achieve clinical, quality and financial outcomes.⁵ There are ten main ingredients found in successful provider networks which focus on vulnerable populations:⁶

1. Organized network of providers from the health care, mental health, LTSS, and social support systems;⁷
2. Direct control over a comprehensive package of services as needed to address the total care needs of the target population;
3. Person-centered focus on people with complex needs, including careful targeting, high-risk identification, and especially the active participation and support of patients/clients and families in the communication, information-sharing, caring and support processes (see below for further discussion);
4. Total responsibility and accountability for the identified population and all of their outcomes;
5. Emphasis on care coordination (see below for further discussion);
6. Evidence-based team care;
7. Active involvement of family physicians and population-specific specialists;
8. Innovative use of population health management tools and integrated information technologies and systems;⁸
9. Common organizational umbrella or “home,” including shared inter-agency culture and policies; and,
10. Alignment of financial incentives.

In theory, such provider networks can be configured as part of an Accountable Care Organization (ACO), medical/health home, and/or dual eligible health plan. And global payment arrangements are the best way to pay for and incentivize performance and quality care within this framework. However, it should be recognized that putting together these entities will be a complex, time-consuming and costly task.

⁵ For a compact overview of networking in integrated care, see Kodner, D. (2009). “All Together Now: A Conceptual Exploration of Integrated Care.” *Healthcare Quarterly*, 13 (Special Issue, October).

⁶ Kodner, D. (2013). “Integrated Care in a Nutshell,” paper presented to the C.D. Howe Institute Board of Directors, Toronto, Canada, November 22, 2014.

⁷ Depending on the vulnerable population, providers could include organizations such as schools and housing providers.

⁸ Integrated information technologies and systems have become an especially important tool in the new world of VBP and accountable care. Its use goes far beyond internal tracking and analysis of utilization and cost data to include quality of care, coordination of care and patient-centeredness measures, as well as various reporting functions.

Make person-centered care real

Person-centered care has not only become a central aim for the U.S. health care system⁹, but also a major focus of the care and support of vulnerable populations. First identified in the Institute of Medicine's (IOM) landmark 2001 report, *Crossing the Quality Chasm*, studies since then have shown that person-centered care¹⁰ has the potential to improve patient/client satisfaction with care and support, enhance clinical outcomes, and reduce underuse/overuse of health services.¹¹

Person-centered care has six main goals:¹²

1. Improve the experience of care and support for patients/clients, families, and caregivers;
2. Promote patient/client engagement, shared decision-making and empowerment;
3. Enhance communication (especially between patients/clients and physicians), education and knowledge, and information-sharing and collaboration;
4. Ensure recognition of the whole person by giving the patient/client and family an important voice in shaping care, as well as respecting individual values, preferences, goals, and cultural traditions;
5. Provide the patient/client with emotional support, alleviation of fear and anxiety, and physical comfort; and,
6. Enable patients/clients and their families to gain ready access to needed services, as well as navigate, coordinate and manage their needs across the care continuum with the active support of an engaged, pro-active care team.

From a clinical point of view, person-centered care also entails the identification of high-risk individuals, comprehensive assessment of their needs, development of individualized care plans for targeted populations, and the monitoring and measurement of clinical performance.

Person-centered care is more than a philosophy of care. It is designed to shift a measure of control and power out of the hands of those who provide care and into the hands of the patients/clients who receive care.¹³ Therefore, the concept must be carefully defined, developed, operationalized, supported, monitored, measured, and evaluated in order to leverage the broadest possible impact. This will require:

⁹ The Affordable Care Act (ACA) of 2010 places the consumer at the center of the health system. It encourages the use of a patient-/person-centered approach—along with care coordination—in the delivery of health care, LTSS, and services for people with disabilities.

¹⁰ Also referred to as “patient-centered care” and “person- and family-centered care.” The latter is especially related to home- and community-based settings.

¹¹ Shaller, D. (2007). “Patient-Centered Care: What Does it Take?” New York: The Commonwealth Fund; also, Millenson, M. (2012). “Building Patient-Centeredness in the Real World: The Engaged Patient and the Accountable Care Organization.” Highland Park, Ill: Health Quality Advisors, LLC and National Partnership for Women and Families.

¹² There are many goals of person-centered care. Those used in this paper are based on the following: Feinberg, L. (2012). “Moving Toward Person- and Family-Centered Care.” Washington, DC: AARP Public Policy Institute; Keitzman, K. (2012), “Using a Person-Centered Approach to Improve Care Coordination; Opportunities Emerging from the Affordable Care Act,” *Journal of care Management* (Fall); and, D. Shaller, op cit.

¹³ For example, see: Berwick, D. (2009). “What ‘Patient-Centered’ Should Mean: Confessions of an Extremist,” *Health Affairs*, 28(4). Berwick is the former Administrator of the Centers for Medicare and Medicaid (CMS) and President & CEO of the Institute for Healthcare Improvement.

- Leadership at the Board and CEO levels.
- Clearly defined strategic vision and its ongoing communication.
- Formal standards, policies, procedures and tools.
- Provider and staff development, training, incentives and rewards.
- State-of-the-art and evidence-based practices and programs designed to encourage and support consumer direction, shared decision-making and communication, as well as promote needed patient/client and family education and counseling.
- Active involvement of patients/clients and families at all levels, not just in the care enterprise.
- Identification of outcomes, and systematic measurement of interventions and feedback.
- Enabling health information technology (HIT).

Build an effective model of care coordination

Care coordination is not only a critical factor in high-performing and high-quality health care, but also in successful VBP programs. The consensus is that care coordination is fundamental to integrating services, eliminating fragmented care, promoting continuity of care, improving health outcomes, and reducing overall health care costs.¹⁴ There are many definitions of care coordination. The National Coalition on Care Coordination (N3C), for example, defines care coordination as a “person-centered, assessment-based, interdisciplinary approach to integrating health and social support services in which a care coordinator manages and monitors a person’s needs, goals and preferences based on a comprehensive plan.”¹⁵ All of the definitions of care coordination point in the same direction, namely it is a mechanism that connects patients/clients and families with appropriate resources and services delivered by the right providers at the right time and place in order to ensure that good health is achieved.¹⁶

Needless to say, care coordination is especially relevant to the complex needs and circumstances of vulnerable persons of any age who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition requiring total care on an ongoing basis. These individuals depend on multiple services from the health, mental health, LTSS, and social service systems; these often include supports that are not considered an integral part of health care, e.g., housing, vocational development, and educational services. And these are the same people who most frequently experience uncoordinated, disjointed, and poor quality care with less than optimum health outcomes.

¹⁴ Schultz, E. et al. (2013). “A Systematic Review of the Care Coordination Measurement Landscape,” *BMC Health Services Research*, 13:119.

¹⁵ Berenson, R. and Howell, J. (2009). “Structuring, Financing and Paying for Effective Chronic Care Coordination: A Report Commissioned by the National Coalition on Coordinated Care.” New York: National Coalition on Coordinated Care.

¹⁶ See Antonelli, R., McAllister, J. and Popp, J. (2009). “Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework.” New York: The Commonwealth Fund; Families USA (2013). “The Promise of Care Coordination: Transforming Health Care Delivery.” Washington, DC: Families USA; and, Schultz, E. et al., op cit.

Care coordination is a person-centered, proactive and planned process that has many functions:¹⁷

- Guides comprehensive, standardized assessment of needs.
- Facilitates individualized care planning, including clinical and personal goal-setting, referral, monitoring and follow-up.
- Fosters population-specific, outcome-oriented and culturally-sensitive care.
- Links patients/clients and families with needed services whenever and wherever needed.
- Supports inter-professional team care.
- Enables patients/clients and families to navigate the continuum of care.
- Provides patients/clients and families with education and training to build self-care skills.
- Ensures effective communication, information-sharing and collaboration throughout the care continuum.
- Anticipates, plans for and manages care transitions.
- Builds strategic relationships across the community to establish shared accountability; support comprehensive, person-centered, coordinated care; enhance quality of life; and, reduce health disparities.

Care coordination varies in terms of setting, complexity, intensity, and duration; it can be provided face-to-face and/or by telephone, email/texting/instant messaging, video conferencing, interactive web sites, group visiting, etc.

Like the effective translation of person-centered care—an overlapping concept—the specific design of care coordination matters. Therefore, achieving improved health and patient/client experience will depend largely on how care coordination programs are developed and implemented. Careful consideration must be given to defining the principal characteristics, competencies, functions, services, policies and procedures, and outcomes involved, particularly through the lens of the target population group. The single greatest challenge will be how to best coordinate and monitor the very complex and wide range of services used by vulnerable populations, as well as effectively link in a supportive way with the community.

Refine and expand outcome measures

In the previous companion paper, we identified and discussed a number of strategic concerns about the shortcomings of VBP outcomes measurement as specifically related to vulnerable populations. First, most VBP programs rely on too narrow a range of outcomes. Second, they largely ignore all-important measures of health and functioning

¹⁷ There is confusion between the overlapping concepts of care management and care coordination. Care management is traditionally focused on the medical side of the health system, commonly disease-oriented, and frequently considered an adjunct to disease management. In contrast, care coordination goes beyond the care management function. It considers a wider range of health and social support services, including the functional, social, behavioral, developmental, educational and financial needs of patients/clients and families—whether or not they are covered in the benefit package.

(physical, cognitive, behavioral, and social). Third, with the exception of quality outcomes for more common chronic conditions such as diabetes, hypertension, heart failure, and coronary artery disease, population-specific outcomes that pertain to the various vulnerable groups are ignored. Overall, this presents a glaring weakness in terms of VBP's potential fit with vulnerable populations; it is also cause for great concern. Without vulnerable-sensitive outcomes, VBP threatens to shortchange this significant population in terms of quality care and health.

Generally speaking, outcome measures should reflect the goals of the specific VBP program, and at least address three major aims: improved population health, improved patient experience, and lower per capita cost.¹⁸ Clinical quality measures could include preventive care measures, chronic care measures, and patient mortality and safety measures. Patient experience and patient-centered measures could include measures of culturally competent care, patient access to care, patient satisfaction with care, management of care transitions, self-care, monitoring of care, and team-based performance. Cost measures could include care management resources, inpatient readmissions, inpatient utilization, ER visits, and preventable hospitalizations.

A good place to start would be to look at the 33 ACO quality measures used in the Pioneer ACO shared savings program. The measures are divided as follows: patient/caregiver experience; care coordination/patient safety; preventive health; at-risk population/diabetes; at-risk population/hypertension; at-risk population/ischemic vascular disease; at-risk population/heart failure; and, at-risk population/coronary artery disease. While this is the largest set of outcome measures found in any VBP program nationally, it still fails to capture health and functional measures that are critical to understanding the status of vulnerable populations. Moreover, measures of person-centeredness do not adequately relate to the experiences of vulnerable populations. For example, they do not include obvious items such as self-management support, patient/client and family engagement, patient/client and family counseling, caregiver support, psychosocial adaptation, social relationships, community participation, and patient/client motivation and empowerment. Finally, measures of care coordination—a critical aspect of quality care—are limited in their scope.

It is hard to believe that this is the place we are given the decades of innovation and experience with home- and community-based services, On Lok/PACE, coordinated care and case management initiatives, transitional care management programs, special needs and dual eligible plans, etc. Be that as it may, substantial work needs to be done in the outcomes field with respect to vulnerable populations; this is one of the greatest obstacles to developing and implementing appropriate and sustainable VBP programs for these at-risk groups. Providers will not be able to do this on their own. It will take the coordinated efforts with CMS, state Medicaid programs, and organizations such as the National Quality Forum (NQF), National Association for Healthcare Quality (NAHQ), Long Term Quality Alliance (LTQA) and other groups with a stake in fostering quality improvement.

Shape a workable global payment method

Global payment goes hand-in-hand with the total care provided by health networks and other forms of integrated health care delivery, especially for vulnerable populations requiring multiple, specialized, and relatively costly services on a long-term and continuous basis. The arrangement encourages the most flexible delivery of holistic, person-centered, coordinated care and supports to individuals with complex needs.

Under the model, the provider network receives a fixed, per-person payment (e.g., monthly capitation) for a comprehensive package of services over a defined period, often annually. Further, it is risk-adjusted by factors that

¹⁸ American Accountable Care Organizations. "Top Questions about ACOs & Accountable Care: How Should Quality Care be Measured?" Retrieved July 26, 2015. <http://www.accountablecarefacts.org/topten/how-should-quality-outcomes-be-measured-1>

best explain major validated differences between the target groups in terms of resource use and costs, e.g., acuity, health status, and functioning. Finally, a risk-sharing arrangement is usually combined with the payment model.¹⁹

As VBP is designed to hold networks accountable for quality/health outcomes as well as costs, the organization's total quality score²⁰ is factored into the final payment received. This is usually implemented one to two years after operations begin. In this pay-for-performance mode, shared savings and losses dollars are ultimately put at stake with financial consequences accruing to the network.

Shaping a workable global payment model would be a complicated undertaking, especially since there are still so many unknowns. First, the characteristics of population-specific outcomes are an unsettled matter, and will take considerable time to develop and test. Second, calculating total costs of care for various vulnerable populations would be difficult because of the wide range of services and supports received in the health care, mental health, LTSS, and social support sectors. Moreover, devising an appropriate risk-sharing arrangement would be challenging. One thing is certain, however: Given the newness of a vulnerable population-based VBP model, it would need a generous phase-in period of more than two years.²¹

SUMMARY AND CONCLUSIONS

Venturing into uncharted territory is never easy. This paper has briefly examined what it would take for providers to develop and implement a predictable and VBP program for vulnerable populations. Five critical implementation issues were identified and discussed:

- Establishing an integrated network of providers.
- Making person-centered care real.
- Building an effective model of care coordination.
- Refining and expanding outcome measures.
- Shaping a workable global payment method.

Overall, major challenges are involved. It will take substantial time and resources to develop a predictable and sustainable model which effectively brings together the integrated delivery of services and supports with global payment. At the same time, we should work hard to make mainstream VBP programs as sensitive as possible to the special needs and circumstances of vulnerable populations. Both approaches will inform each other.

¹⁹ In the Pioneer ACO model, for example, risk-sharing can be one-sided or two-sided. In the former, the Pioneer ACO is eligible to receive a payment from CMS if it generates a minimum amount of savings. In the latter, the entity also owes CMS if it produces a minimum amount of losses. Savings and losses are based on a complex formula which takes into account a reference population of Medicare fee-for-service beneficiaries, as well as the organization's historical expenditures; see U.S. Government Accountability Office (GAO) (2015). "Results From the First Two Years of the Pioneer Accountable Care Organization Model." Washington, DC: GAO (April).

²⁰ That is, the degree to which the VBP achieves the core quality/health outcome benchmarks.

²¹ To address ongoing quality concerns, the achievement of quality/health outcomes would still be reported prior to implementation of risk-sharing.