Sailing into

On June 11, 2024, I had the privilege of providing opening remarks for AMGA's Value Roundtable Summit in Washington, D.C. I would also label it a relief to go first, as I was followed by a series of heavy hitters in the value-based care (VBC) arena.

Phil Oravetz, MD, MPH, MBA, chief population health officer at Ochsner Health, shared how his organization—one deeply experienced in VBC—is executing strategies to ensure its financial objects are in sync with the delivery of high-value care. Scott Hines, MD, chief quality officer at Crystal Run Healthcare and chair of AMGA's Public Policy Committee, was joined by Darryl Drevna, MA, senior director of regulatory affairs, and Lauren Lattany, director of government relations with AMGA, to discuss recent and forthcoming legislative updates that will affect the transformation toward a healthcare system centered on value. Stephen Beeson, MD, author of *Practicing Excellence*, shared expert guidance on how to leverage team engagement, culture, and skill development in order to bring VBC to fruition in periods of rapid change.

And that's just a taste. With networking meals and breakout sessions, we had a truly full day of collaborating and sharing best practices, all leading into Capitol Hill Day the following day.

Aric Sharp's insights at the Value Roundtable Summit

By Kevin McCune, MD

Headwinds

Advancing VBC Success

Aric Sharp, MHA, CMPE, FACHE, CEO of Value-Based Care for Clover Health, led the opening session for the Summit. He's a great person to talk about change, as he shared early in his presentation.

"I've been in a lot of different roles in the last 30 years in healthcare," he said. "You start out in your career and think, 'Gosh, this is a great organization—I think I'll be here forever.' And then all of a sudden you start making changes. In the past 10 years, I think I've been in five different organizations."

Sharp explained the draw of his current organization, saying, "Clover Health is really in three buckets. We have an MA (Medicare Advantage) plan with lives in New Jersey, Georgia, South Carolina, and smaller membership in a couple other states. We also have a physician group in New Jersey that provides all of its care on a home-based model for very complex, sick patients, addressing their barriers to care and social determinants of health. In the third bucket is our technology development under the label Counterpart Health. The technology we've developed has really helped drive our value-based results."

These three "buckets" combine to create the ideal environment for confronting the challenges in moving to value. And those challenges aren't going anywhere anytime soon.

Roadblocks

"I think it's safe to say that it's not getting any easier if you look around at the value-based industry and space," Sharp lamented. "I'd say it's more competitive than ever. Secondly, insurance companies perhaps aren't always making it easy to move to value."

Regulatory changes aren't helping the situation. Sharp said, "The thing that really stands out to me are the changes in MA. Those changes are creating pretty significant headwinds. This year, we're facing—really for the first time—the benchmark actually going down. That seems maybe a little counterintuitive given the historical favorable growth rate trend, but a combination of changes to variable results in a net reduction."

He explained that the coding shift from CMS-HCC Version 24 to Version 28 "makes a material difference." While the risk documentation efforts in the industry are improving in accuracy, "the changes to V28 will decrease the risk adjustment for illness burden. That will present new challenges within value-based contracts."

Compounding these challenges, the Inflation Reduction Act will have a big impact on Medicare Part D in 2025. "That ends up changing the math on the insurance side, likely resulting in a broader impact to benefit plan design for many MA plans," Sharp said. "It stands to reason that will increase the difficulty in negotiating value-based agreements. In addition, many MA plans have reported higher utilization trends at the end of 2023 and the beginning of 2024."

The consequence of these roadblocks? "I'm beginning to hear from some providers that they are actually beginning to pull back from taking risk," he said.

Exodus, or Stay the Course

"If you think about the dialogue over the last decade, it's really been, 'Let's get into risk. Let's try to be successful. Let's move further faster. Now, I think there's a realization that if the math is not working, providers need to be wise about picking where they take risk and where they don't," Sharp said.

He shared news from a colleague: "I was just talking with a chief strategy officer at a large health system late last week. They have their own MA plan, and they're exiting. They have four and half stars, and they're exiting. They said, 'We can't make it work.'"

This is not an isolated occurrence. "I could probably list off more than a handful of groups who have decided to terminate some of their MA agreements," Sharp said, "allowing patients to re-disperse to more favorable contracts."

Is it premature to exit?

A Strong Hull, Foundational for Success

Sharp shared a useful way of conceptualizing the industry. "I like to think about the value-based landscape as a sailboat sailing into the headwinds," he said.

This construct works in two parts. "One is the hull of the ship," he explained, "and the other is the sails. The hull is really that foundation keeping you afloat. You should be focusing on this first and foremost. Then the sails are what help you move forward and be successful—what drives your performance."

Referring to the hull of the ship, Sharp identified three key components:

1. Leadership: Clinical leadership with the courage to change
2. Insights: Analytics and AI/machine learning (ML) at the point of care
3. Incentives: Meaningful incentives for providers and staff

"Ask yourself if you're really aligned on leadership," he said. "Are clinicians driving your value agenda? Not all organizations are made the same. Some drive to value more administratively than clinically. A dyadic model can be very beneficial, but at the end of the day, this is a clinical exercise."

Sharp warned: "If you're not driving value clinically, you're probably going to fall a bit short of your aspirations."

As for insights? "I can remember—going all the way back to 2012 and first getting into value—we knew that we needed data and to get that data into a common database. And if we just get that data together, that's the panacea, right? Not really," he admitted.

"I suspect you all have been through myriad vendors along the way, trying different methods to get data into the right places and surface insights to care teams and providers with a lot of great effort," he continued. "But now there's this shift taking place with AI and machine learning, and we really should be changing our expectations of what we can get to be successful."

The key to incentives, Sharp said, is ensuring they "drive behavior in your organization." If your incentives aren't aligned to your value-based strategy, "they might not draw the attention of clinicians who see that the fee-for-service bucket is still far greater than value-based dollars."

Wind in the Sails, and Gaining Momentum

In contrast to that foundation of the hull, the components of the sails drive performance. Sharp identified the parts of the sails as:

1. Continued quality improvement to address gaps in care
2. Post-acute management

3. Accurate documentation and early diagnosis
4. Risk delegation strategies
5. In-home complex care management

Starting with covering gaps in care, Sharp posed a series of simple questions: "What is good? What does good care look like? Are your results getting to where you're in the 90th percentile? Or if you were to frame that in stars, are you approaching five stars?" What if you're not? "I think you have to step back and ask the question: Why?" he said. "What are the barriers that may be keeping you from achieving the highest levels of success? Is it the data? Is it a process? Is it that you don't have adequate resources to reach out to patients?"

For post-acute management, Sharp said, "I think we all know there's a great opportunity in this space, right? All you have to do is take an MSSP [Medicare Shared Savings Program] for a large health system and your skilled nursing facilities. The average length of stay is probably 28 days. If you've not done anything to address that yet, you can maybe get that down into the low 20s. But if you look at an MA plan, that number is going to be in the mid-teens."

The most effective way Sharp has found for building these post-acute management programs is: "If you can get the skilled nursing facilities to actually be taking a risk in some way with you, you will get your incentives aligned. Not every program affords you the ability to do that, but the ACO REACH model has been structured with contours that allow you to do that, where you can actually negotiate lower rates for skilled nursing facilities and have them earn back the difference through their performance. That can be highly effective."

The traditional MSSP track does not allow that approach, but Sharp insisted on finding a way to measure their performance. "Come up with a report card that looks at readmissions and length of stay and other quality factors within their control," he advised. "Many organizations drive quality performance by making their results transparent. Physicians are very competitive in that regard, and if they see they're lagging, they'll probably up their performance."

Sharp described accurate documentation as "digging a little deeper." He said, "What really has driven us is a desire to diagnose earlier because we want to intervene earlier. This really gets down to the beginning, going back 10 years, where we believed if we could just get the data in the right place, we'd get the insights and diagnose earlier and begin treatment earlier. Newer opportunities are coming to the surface where this is happening."

Those new opportunities are not to be ignored. He cautioned, "If you're not leveraging AI or machine learning in this space in some way, there's room for improvement." Proper leveraging of your data for clinical decision-making drives lower costs and accurate revenue for the illness burden.

Shifting gears to the fourth sail—risk delegation—Sharp said, "If you have a value-based agreement, particularly on the MA side, you should ask the question: Who else should I be working with to help manage that risk? There are a number of organizations out there to cover the risk management expertise that may be missing from your own organization. If you can partner with someone who is really good at managing that care and that cost associated with it, enter an agreement with them. Say, 'If you can give me a guaranteed rate of return, a guaranteed savings'—maybe it's 3%, as an example—'we'll share in the savings.' Beyond that, you've just locked in performance improvement on that cohort that you may not have had control over at all."

"If you're not leveraging AI or machine learning in this space in some way, there's room for improvement."
Aric Sharp, MHA, CMPE, FACHE, CEO, Value-Based Care, Clover Health

Finally, Sharp shared just how significantly in-home care for complex patients can be. In a case study of Clover Health's in-home care, 1,000 new, high-risk patients were enrolled with an annualized medical expense over $59 million. Over the study period, utilization decreased by 25.9%, with the most recent actuarial study showing a $475 per-member, per-month net savings, and a Net Promoter Score of 94, representing astoundingly high customer satisfaction.

Full Speed Ahead to Success in VBC

No, the waves of challenges aren't going anywhere, and the transition to value-based care is truly complex. But as Sharp emphasized and made apparent through his analogy, that transition is necessary to address the issues of healthcare quality and rising costs. With technology and data analytics as essential enablers for this transition, we can realize our common goals of the right care at the right place at the right time. GPJ

Quick Read

Aric Sharp, CEO of Value-Based Care for Clover Health, shared insights on advancing value-based care (VBC) success at AMGA's Value Roundtable Summit in June 2024. His presentation highlighted the challenges and strategies in the evolving healthcare landscape.

Current Challenges in Value-Based Care

1. **Increased Competition:** The VBC industry is becoming more competitive than ever.
2. **Insurance Company Resistance:** Some insurers are not facilitating the transition to value-based models.
3. **Regulatory Changes:** Recent changes in Medicare Advantage are creating significant obstacles:
   - ▶ Decreasing benchmarks
   - ▶ Shift from CMS-HCC Version 24 to Version 28, affecting risk adjustment
   - ▶ Inflation Reduction Act's impact on Medicare Part D in 2025
4. **Higher Utilization Trends:** Observed at the end of 2023 and beginning of 2024 by many MA Plans.
5. **Provider Pullback:** Some healthcare providers are retreating from risk-bearing contracts due to these challenges.

Strategies for Success in Value-Based Care

Sharp used a sailboat analogy to describe key components for success in VBC:

The Hull (Foundation):

1. **Leadership:** Clinical leadership with the courage to drive change
2. **Insights:** Analytics and AI/ML at the point of care
3. **Incentives:** Meaningful incentives for providers and staff aligned with VBC goals

The Sails (Performance Drivers):

1. Continuous quality improvement to address care gaps
2. Effective post-acute management
3. Accurate documentation and early diagnosis
4. Risk delegation strategies
5. In-home complex care management

Key Takeaways

1 Clinical Leadership: VBC should be driven by clinicians rather than administrators.

2 Data and Technology: Leverage AI and machine learning for better insights and early diagnosis.

3 Aligned Incentives: Ensure incentives drive behavior toward VBC goals.

4 Post-Acute Care: Consider risk-sharing agreements with skilled nursing facilities to align incentives.

5 Risk Management: Partner with specialized organizations to manage specific areas of risk.

6 In-Home Care: Clover Health's case study showed significant cost savings and high patient satisfaction with in-home care for complex patients.

Despite the challenges, Sharp emphasized that the transition to value-based care is necessary to address healthcare quality and rising costs, with technology and data analytics serving as essential enablers.

***Kevin McCune, MD**, is senior advisor on value, AMGA, and chief physician executive, AMGA Consulting.*