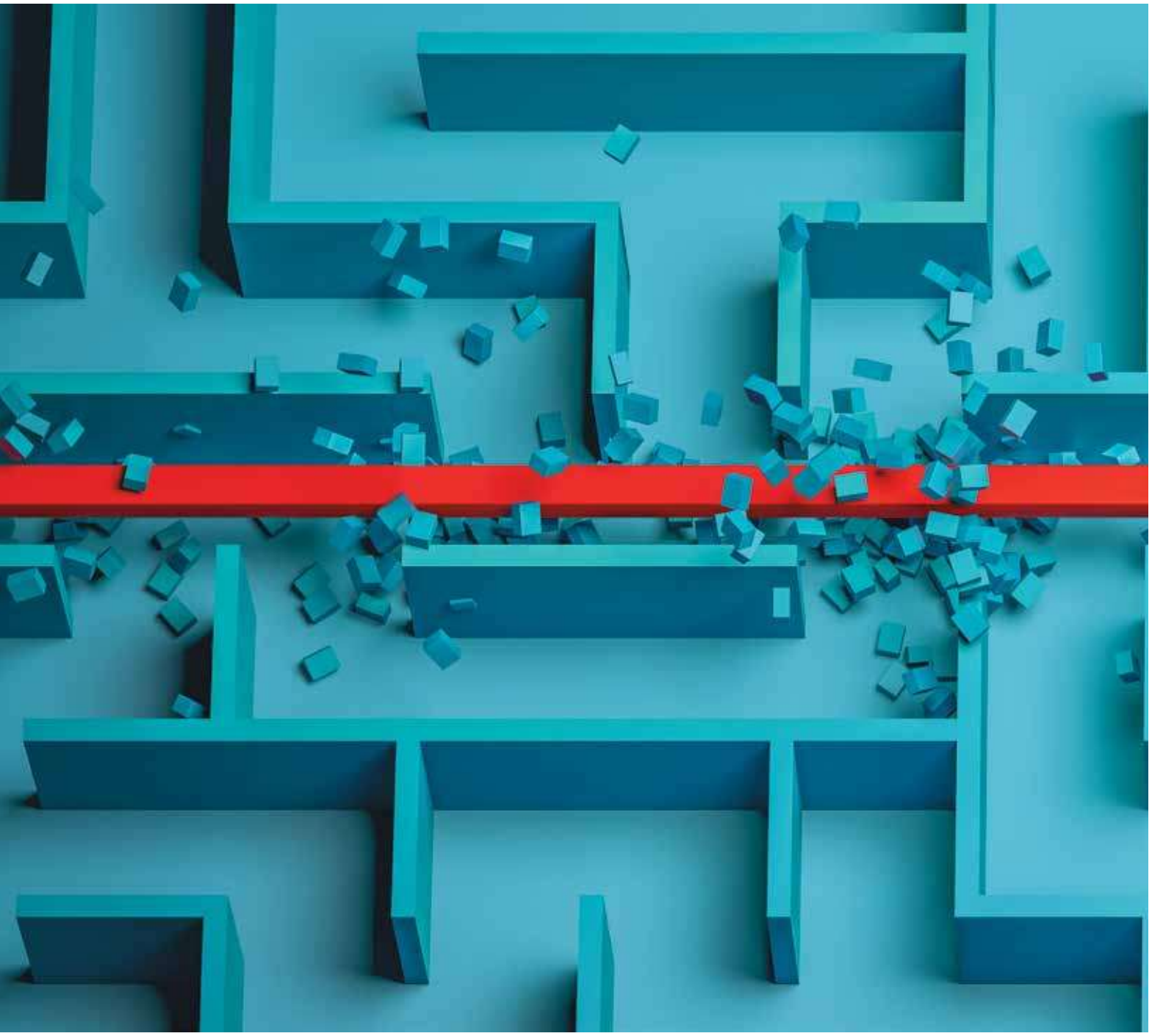

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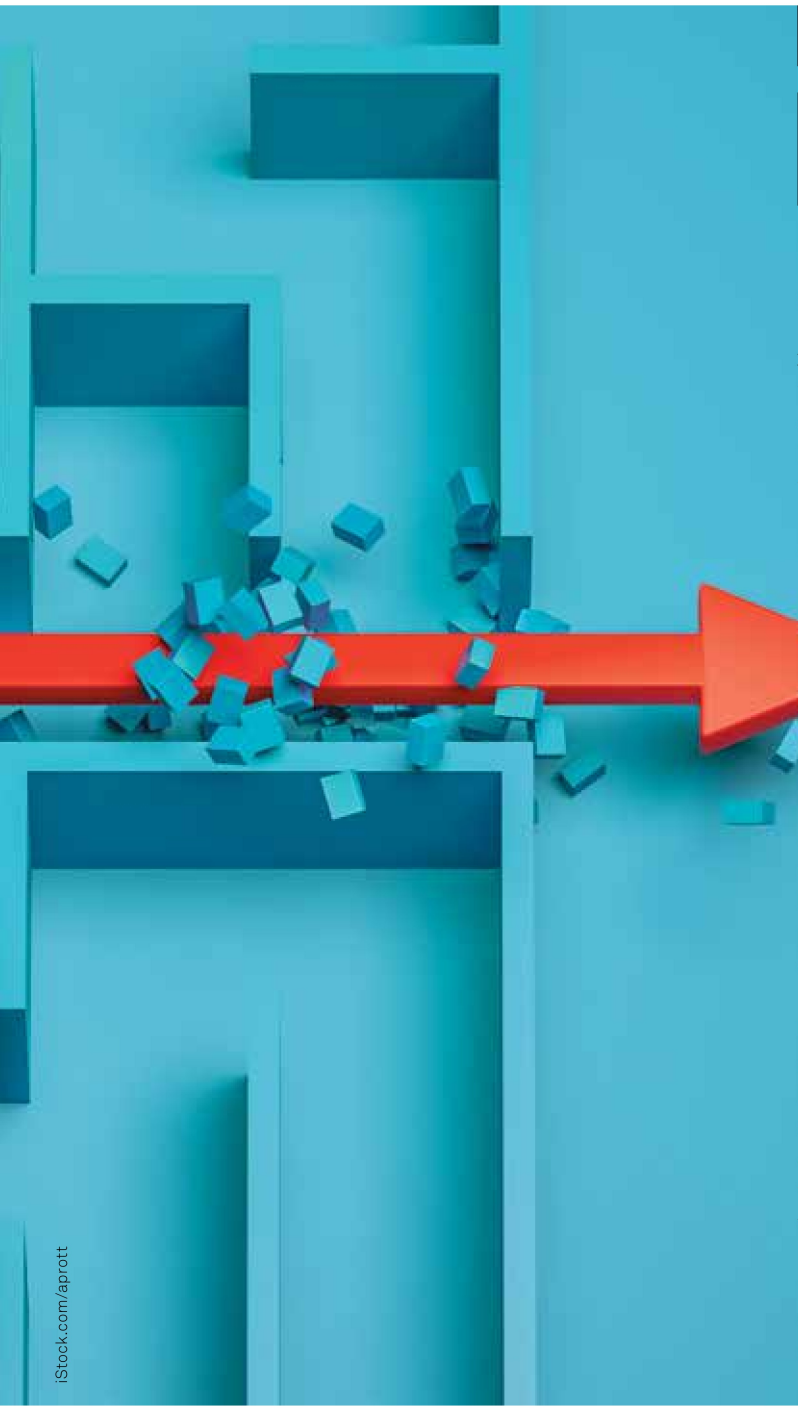

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By Craig Parker, JD, CPA

Providers and payers in the U.S. healthcare system have been involved in a decades-long struggle related to utilization, compensation, and risk. From capitation and HMOs to pre-authorization and alternative payment models, the one thing that hasn't changed is that patients are stuck in the middle of a fierce battle over who gets paid what and when.

Increasingly, organizations are offering an alternative to the zero-sum game to provide both insurance *and* care in a model that appeals to patients with a satisfying experience and significantly diminished friction. This model, in which payers become providers and providers offer insurance in addition to care, has come to be known as the "payvider" model.

Now, as entities work to combine varied approaches to care, compensation, and risk, the market clearly sees possibilities for widespread adoption of a successful model that delivers improved, responsive, and cost-effective healthcare. In turn, seeing these possibilities accelerates openness to cooperation between providers and payers seeking enhanced control over the care their members receive.

The success of payviders results largely from the efforts of dynamic organizations that shed traditionally contentious contract negotiations and moved to a collaborative approach that incorporates the "triple aim" goals of low cost, high quality, and patient satisfaction. The growing payvider space is indicative of the future-ready position of organizations in our current healthcare system.

As stakeholders continue to face unprecedented challenges from the pandemic, they increasingly regard payvider arrangements as one of the best next steps in advancing healthcare access, quality, and financial performance. They are expanding investments in these relationships to provide coverage centered on risk-based arrangements that offer the opportunity for payviders to become aggressive about value-based care (VBC).

In fact, nearly 60% of more than 100 health systems responding to a recent survey conducted by the Healthcare Financial Management Association (HFMA), which represents hospital executives, plan to diversify their

System

Expanded payvider model spawns success

Care guidance reduces the total cost of care and contributes to improvements in patient appointment attendance, health outcomes, patient experience (CX), and reported satisfaction and quality metrics.

risk-based payment strategies.[1] For example, 52% of respondents plan to enter commercial employer-based risk contracts, 49% Medicare payment models, 36% managed Medicaid, and 33% direct-to-employer partnerships.

Rewarding Quality

While traditional fee-for-service reimbursement models tend to increase the *quantity* of healthcare services provided, emerging reimbursement programs are changing healthcare service delivery by rewarding providers for the *quality* of care they render based on standardized VBC metrics. This addresses the same challenges of at-risk patient populations who experience health inequities attributed to negative social determinants of health (SDoH) and other disparities.[2]

In today's VBC environment, the Medicare Shared Savings Program (MSSP) enables provider organizations to perform as payviders and allows them to decide how to balance care, cost, and risk.[3] The Centers for Medicare and Medicaid Services (CMS) reported that 67% of MSSP Accountable Care Organizations (ACOs) are in a two-sided risk model in which they receive savings but must repay Medicare for missed targets, and 33% are in a one-sided model in which they receive a share of savings but do not take on financial risk.[4] CMS have also expressed dissatisfaction with the one-sided model, meaning ultimately participants will likely be forced to take on and manage risk.[5]

CMS have also introduced an array of Quality Payment Programs (QPPs) as a value component in the ACO model, broadly defined as groups of doctors, hospitals, and other healthcare providers that come together voluntarily to provide coordinated high-quality care to Medicare recipients.[6] Additional QPPs include the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM), adding incentive payments to providers for patient scores that reward high-quality and cost-efficient care (or in some cases penalize providers for missing the mark).[7,8]

The key to unlocking the "value" in these value-based incentives is to create new ways to interact with patients—especially outside of clinic walls and in areas of need that may not directly relate to healthcare. Finding and resolving problems in SDoH has proved essential to qualifying for value incentives, and well-designed programs that go beyond clinical navigation increase savings.

Care guidance (a form of patient activation beyond mere engagement) is a logical extension of QPP models. Working in the space between the "outside life of a patient" and the care journey inside clinic walls, highly trained "care guides" operate within a scalable, technology-enabled platform to motivate patients and their families and uncover and resolve practical, nonclinical issues and barriers experienced during their care journey. Following structured AI-assisted workflow protocols ensures that potentially relevant clinical information escalates to proper clinical care or social service teams, and care guides promptly initiate proactive interventions to resolve nonclinical barriers to care.

CMS validates care guidance to reduce unnecessary emergency room (ER) visits, hospitalizations, and readmissions.[9] In doing so, care guidance reduces the total cost of care and contributes to improvements in patient appointment attendance, health outcomes, patient experience (CX), and reported satisfaction and quality metrics in VBC arrangements.[10]

For example, studies have shown that care-guided patients are significantly less likely to require readmission, revealing significant reductions in utilization among acute and targeted conditions. Care guidance scoring documents showed improved patient adherence.[11,12]

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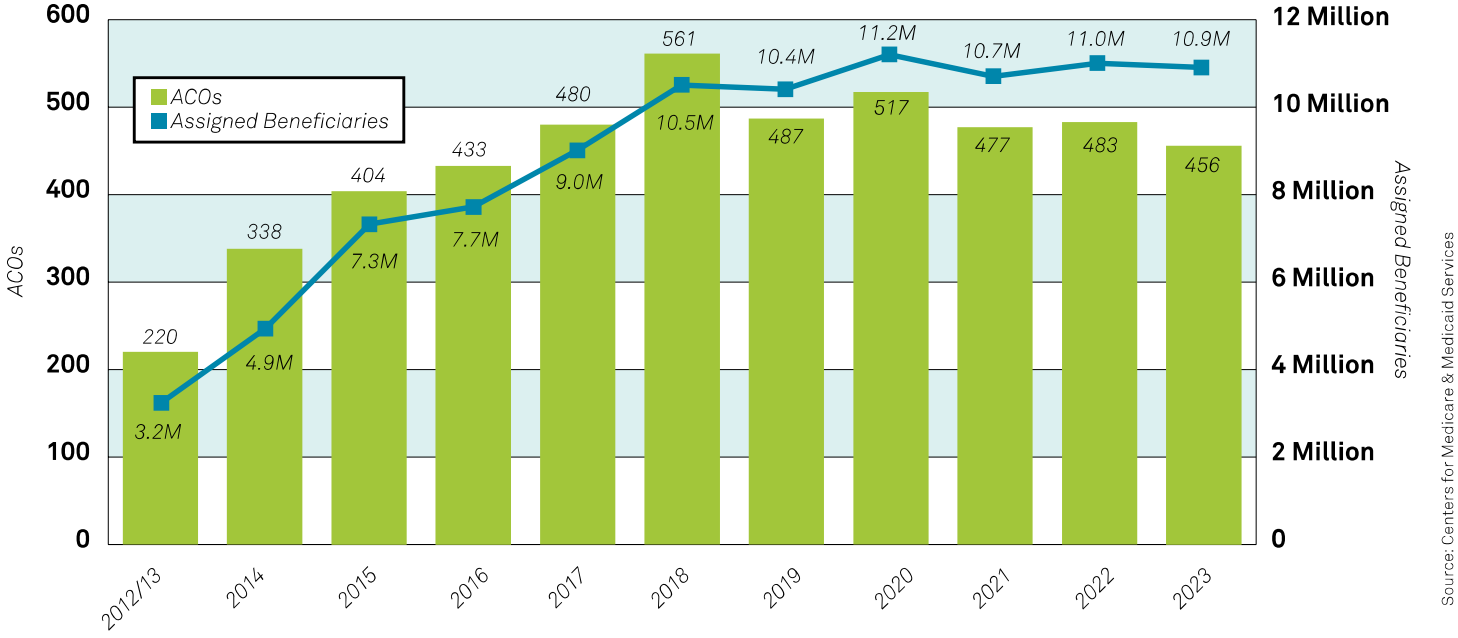
Figure 1

Shared Savings Program Participation and Coverage



Source: Centers for Medicare & Medicaid Services

Care guides also provide hospitals and healthcare facilities with effective value-added support services, functioning as an extension of their clinical teams and freeing labor, time, and resources so that nurses and staff can focus on high-value clinical tasks. This shift improves healthcare providers' patient-centered care delivery, considering each patient's unique needs and delivering care in ways that generate the best possible patient outcomes and value for stakeholders.

New Health Equity Plan

Finding and resolving barriers to care and impediments embedded in SDoH is a central theme of the CMS ACO Realizing Equity, Access, and Community Health (ACO REACH) Model, which allows providers to assume financial risk and offers full or partially capitated payments.[13,14] The Model has a new requirement for providers to create and implement a health equity plan, which calls for the identification and mitigation of social risk factors affecting care.

The redesigned ACO REACH Model reflects government priorities and responds to feedback from stakeholders and participants. One important change is to "advance health equity to bring the benefits of accountable care to underserved communities."[13] The ACO REACH Model promotes health equity and focuses on bringing the benefits of accountable care to Medicare beneficiaries in underserved communities.

This statement from CMS captures the intent of ACO REACH:

"Increasing the number and reach of ACOs in underserved communities will help close racial and ethnic disparities that have been identified among people with traditional Medicare in accountable care relationships.... The focus of this coordinated care is to ensure that patients get the right care at the right time by reducing fragmentation between providers, which has several benefits, including avoiding unnecessary duplication of services and preventing medical errors."[15]

CMS expect that new policies will drive growth in participation—particularly in rural and underserved areas—promote equity, advance alignment across the accountable care initiatives, and increase the number of beneficiaries assigned to ACOs participating in the program by up to four million over the next several years. Increasing the number and reach of ACOs in underserved communities will help close racial and ethnic disparities among people with traditional Medicare plans in accountable care relationships.

This long-awaited recognition of the importance for advancing health equity requires providers to find new ways to complement and augment their existing capabilities to effectively address these

barriers. It is no longer sufficient to perform a survey and "find" SDoH issues. Providers—especially primary care providers—must implement workflows to solve the SDoH barriers. Doing so will finally allow organizations and their management leaders to deliver on the promise of resolving disparities in care. This effort requires healthcare organizations to build and deploy new tools. Care guidance proved to be one of the most effective tools in this area by adding the "human touch" to care coordination and resolving nonclinical barriers to accessing care.

Alternative Payment Models

Particularly in the last two presidential administrations, the federal government has reinforced its commitment to transition from a traditional fee-for-service healthcare model to VBC and the adoption of APMs that give added incentive payments to provide high-quality and cost-efficient care as described above.[16]

Despite efforts to "sweeten" this shift from volume to value, providers say there are not enough financial incentives for them to build affordable programs to fully reach patients in extremely underserved communities.[17] As a result, providers may find it difficult to decide where and how to invest limited resources to achieve the best possible operational and financial performance. In some cases, this is the result of providers' tendencies to under-focus their efforts on barriers embedded in SDoH that can be difficult for clinical resources to identify and solve. This potential disconnect points to the critical need to build and deploy models of patient interaction to address social determinants in cost-effective ways.

To ensure quality, cost containment, and astute fiscal management of provider at-risk arrangements requires providers to understand and identify the SDoH in communities in which patients live to ensure that everyone can access quality healthcare resources.

Increasing the number and reach of ACOs in underserved communities will help close racial and ethnic disparities among people with traditional Medicare plans in accountable care relationships.

The Health Care Payment Learning and Action Network (LAN; **hcp-lan.org**) recently released the results of its calendar year APM survey, which showed that, on average, 40% of U.S. healthcare payments flowed through APMs across all payer types.[18]

The Advanced APM program is critical in Medicare's continued transition to VBC, ensuring that Medicare offers the incentivized support providers need.

Readmissions Reduced

A study published in the *Journal for Healthcare Quality* substantiates these conclusions. The researchers found that socioeconomic factors such as race, income, and payer status correlate with rehospitalization rates, and patients with certain conditions, including heart failure, chronic obstructive pulmonary disease (COPD), and renal failure, also have high rates of readmission.[19]

These results further support the value of care guidance services, which have proved to reduce readmissions, including 31% reductions in congestive heart failure hospital readmissions as well as 41% reductions in COPD readmissions.[20] Adding a care guidance component to payviders' portfolio of services boosts at-risk organization revenue opportunities.

Care guidance is meeting the goals of important leaders:

- The newly formed National Alliance to Impact the Social Determinants of Health (NASDOH), a national advocacy organization of healthcare industry stakeholders—both payers and providers—focuses national attention on SDoH to improve health and well-being while reducing long-term spending on healthcare.
- Care guidance is helping hospitals achieve optimal Health Plan Employers Data and Information Set (HEDIS) scores that advance health equity. Published by the National Committee for Quality Assurance (NCQA) for Social Need Screening and Intervention (SNS-E), care guidance implements a multipoint Service as a Solution Model to positively influence HEDIS metrics, Consumer Assessment of Health Providers and Systems (CAHPS) scores, and Medicare Stars Ratings through outbound interactions and active identification and resolution of healthcare barriers related to SDoH.
- According to NCQA leaders, these new measures are part of an organization-wide effort to advance health equity and encourage health plans to assess and address the food, housing, and transportation needs of their member populations. (See NCQA Updates & Releases New Quality Measures for HEDIS® 2023 with a Focus on Health Equity.[21])

Lessons Learned

Today's payviders seek to minimize financial risk, increase profit margins, and provide measurable quality care that retains members. The experience of payviders that largely failed due to high financial

risk, noncompetitive prices, and soaring utilization costs in the 1990s has spawned a new breed of payviders that are demonstrating significant successes. The addition of care guidance to their portfolio of services represents a positive opportunity.

Medicare Advantage is the fastest growing segment of health insurance, and more than 28 million people are enrolled in a Medicare Advantage plan. As payviders enter the market with a new game plan that emphasizes a specific line of business, primarily Medicare Advantage and Managed Medicaid, they must be equipped to gain competitive advantages over traditional health plans.

Managed Medicaid care continues to grow, and according to Kaiser Family Foundation (KFF), 39 states (including DC) have now adopted Medicaid expansion.[22] GPJ

***Craig Parker, JD, CPA**, CEO at Guideway Care, has spent most of the last 25 years operationalizing solutions that leverage technology and people to improve patient care and outcomes.*

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