The Rocky and Essential Transition to Value Based Care

By Ken Terry
November 28, 2023

Investing in value based care (VBC) should be a no-brainer, right? Nobody argues that adequate access to primary care is not a prerequisite for value based care. Internist Jeffrey Millstein, a regional director for Penn Primary Care and the author of a recent *STAT* article, however, bemoans what VBC is doing to primary care access. He complains that VBC is actually decreasing primary care access by requiring clinicians to spend more time on preventive and chronic care services as part of better population health management.

As a result, Millstein argues, some patients who need acute care services can't see their doctors on a timely basis. Instead, they seek the care they need in urgent care centers or emergency departments. There is no doubt that it can take too long for patients to schedule primary care appointments when they're sick. Blaming value based care for this predicament defies logic. Great care management creates value by reducing demand for acute care services.

Talk about turning a problem upside down. Ignoring preventive care services isn't the answer. A physician who sees a patient with a sore throat and doesn't ask about diabetes is not much of a doctor. Unfortunately, with the pressure on physicians to see more patients, comprehensive office visits that take all of a patient's problems into account are still more the exception than the rule.

In my opinion, we should blame that on fee-for-service incentives that treat patients as widgets attached to a billing code rather than as individuals with unique sets of health needs. It is not the fault of the VBC model that the majority of practices still have not reoriented themselves in response to the new incentives from some payers.

PAYMENT INCENTIVES MATTER

One indication that most primary care practices require major reengineering is the astounding fact that, as of 2019, only 4% of Medicare beneficiaries eligible for chronic care management (CCM) services received them, according to a report from the Department of Health and Human Services (HHS). This negligible performance occurred even though their doctors were able to bill for those services.

Similarly, the report finds the percentage of eligible Medicare patients who received transitional care management (TCM) services after hospital discharge was just under 18%.

Some analysts attribute the low uptake of CCM services to inadequate payments. Evidently, delivering better care for patients isn't enough incentive.

HHS researchers studied the types of practices that provide CCM services. They found that 12.3% of practices affiliated with accountable care organizations (ACOs) had eligible Medicare beneficiaries receiving CCM, compared to just 3.8% of non-ACO practices. Since ACOs are or should be committed to value-based care, it would appear that VBC increases the likelihood of patients receiving appropriate chronic care management between visits.

This finding also suggests that practices that take financial risk for managing their patients' care are more willing to make the investment in the requisite infrastructure than traditional fee-for-service practices. This makes sense. Risk-based payment models reward risk-taking groups when they keep populations healthy. Healthy people needed fewer healthcare services. This isn't rocket science.

Dr. Millstein praises the VBC movement but he notes that there are not enough primary care physicians to cover the U.S. population. With primary care doctors in non-concierge practices commonly handling panels of 2,000-3,000 patients each, he argues, the VBC model is impractical because it inevitably leads to reduced access.

The primary care shortage is real and getting worse. This is the primary reason for the long waits for patient appointments. However, while the supply of primary care physicians must be increased for VBC to succeed on a broad scale, there are ways to improve the ability of clinicians to provide comprehensive, appropriate and timely care right now.

CARE TEAMS AND TECHNOLOGY TO THE RESCUE

Dr. Millstein makes two recommendations for expanding the reach of primary care practices: increase the number of advanced practice clinicians and expand the use of team-based care. The availability of nurse practitioners and physician assistants is growing, although there are limits to what they can do. Meanwhile, ACOs and other VBC-oriented organizations emphasize the use of care teams. Much more can be done to increase their impact.

In a 2014 paper, Thomas Bodenheimer, M.D., and his colleagues described the building blocks of high-performing practices. At the core of their success, the authors said, was the use of care teams. "Clinicians without teams caring for a panel of 2,500 patients would spend 17.4 hours a day providing recommended acute, preventive and chronic care," they noted. In contrast, practices using well-trained care teams could add capacity and reduce the burden on clinicians.

In a later article, Bodenheimer cited research in Boston-area primary care practices and at Intermountain Healthcare showing that team-based chronic care reduced hospitalizations and ED visits. In an interview, Bodenheimer told me that the main barrier to expanding team-based care delivery is fee-for-service reimbursement, which doesn't compensate doctors for staff members who provide team-based care.

An essential support for team-based care is the optimal use of information technology to deliver higher quality care. Prior to COVID, doctors used telehealth primarily for minor acute care and follow-up visits. Post-COVID, doctors use telehealth for a much broader range of services, including chronic care management, hospital-at-home, some kinds of specialty care, and behavioral healthcare services.

Though less widely adopted, remote patient monitoring is making inroads in post-acute care, chronic care and even prevention. Artificial intelligence predicts which patients are likely to be readmitted or will need certain kinds of care. These technologies make it easier to embrace VBC without decreasing patient access to primary care.

In a recent *Health Affairs Forefront* article, Sean Cavanaugh, William H. Shrank and Farzad Mostashari noted that online care management companies working with primary care physicians and specialists can now deliver specialized chronic care effectively. Many firms that offer such solutions are trying to enter the market, they said, but the difficulty of recruiting appropriate populations and silly regulations have slowed their growth.

Medicare requires that billing providers initiate referrals to such online firms with a face-to-face encounter. This requirement

applies to ACOs in the Medicare Shared Savings Program, but not to risk-bearing providers that contract with Medicare Advantage plans. The authors contend this regulation isn't necessary. ACO primary care doctors already have relationships with attributed patients before they refer any of them to an online care management firm, they note, so an in-person visit is unneeded.

While the *Health Affairs* article details access to specialty care, it also underlines the increasing use of web-based technologies to deliver care in non-office settings. As more care migrates into the home with the help of these technologies, physicians and care teams will provide better care to an expanding patient base, improving primary care access.

The rise of VBC is also helping to fill the void of primary care in some underserved urban areas, thereby increasing health equity. A recent analysis found that there are more primary care clinics owned by private VBC companies such as Oak Street Health and ChenMed located in disadvantaged areas of Chicago and Philadelphia, than clinics operated by regional health systems or academic medical centers.

Medicaid programs in some states have promoted VBC in underserved areas. In south Chicago, for example, Medical Home Network (MHN) has a Medicaid ACO that includes 13 federally qualified health clinics and three health systems. By spreading the risk of capitation contracts among all these providers and by using a team-based care approach, MHN has been able to stay within its budget while providing excellent care. (Details are included in a policy brief available to members of the Institute for Advancing Health Value.)

Abigail DeVries, M.D., market medical director for MHN, told me that value based care is critically important to improving health equity. "I've been working in [community] health centers since 2005 and have been dreaming about the kind of flexibility that allows you to do population health, address social determinants of health and provide between-visit care," she said. "You can't do that when you're stuck in fee-for-service…We really need to be able to have the funds to take care of patients the way they need care."

TIME TO DOUBLE-DOWN ON VBC

VBC's emphasis on prevention and chronic care management has the potential to reduce the overall demand for acute care services, aligning with the ultimate goal of healthcare: keeping populations healthy.

The data pointing to underutilization of services like chronic care management and transitional care management among Medicare beneficiaries signals a need for systemic reengineering of primary care practices. This transformation would entail embracing team-based care and advanced practice clinicians, leveraging technology for telehealth services, and aligning payment incentives with the provision of comprehensive, high-quality care.

Moreover, the successful integration of VBC in underserved urban areas presents a compelling narrative of how it can serve as a vehicle for health equity. By adopting risk-based models and fostering team-based care, organizations can deliver effective and equitable care, even within the constraints of limited budgets.

Therefore, the healthcare industry should double down on VBC, not only as a financial strategy but as a moral imperative. By reorienting towards VBC, we can expand access, enhance the quality of care and address the broader determinants of health. It is a commitment to a sustainable and equitable healthcare system where the value of care patients receive is paramount.

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