Data-Driven Insights Key to Advancing Value-Based Care

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For health plans to succeed, they need to manage health care costs while at the same time not sacrificing quality of care. This is especially true for provider-sponsored health plans. This has been a challenge since the early days of managed care in the 1980s – and it persists today. While value-based contracting has shifted the thinking on managing health care costs, most health plans and provider organizations continue to struggle with its implementation.

Approximately 25-50% of provider practices participate in some form of value-based contracting. Most are still based on a fee-for-service (FFS) reimbursement model with a value-based financial reimbursement component. All have varying degrees of metrics for quality of care, efficiency, effectiveness and patient outcomes. Unlike FFS models, which pay for each service rendered, reimbursement in a value-based model rewards high-quality, high-value, and lower cost services.

It is commonly accepted that approximately 30% of health care delivered in the United States is unnecessary. Various sources such as Choosing Wisely, HEDIS, U.S. Preventive Services Task Force and others help delineate unnecessary or "low-value" care from high-value care. Low-value care includes services that:

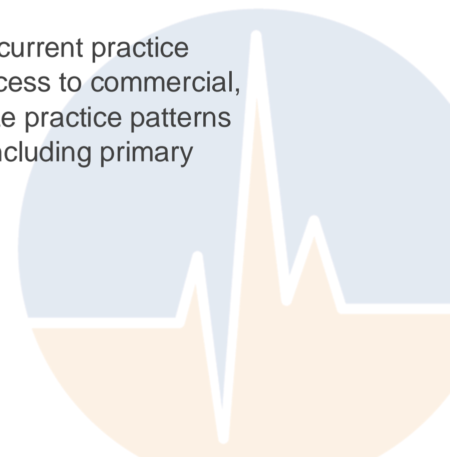
- Are overused and often unnecessary
- Provide little or no value to the patient
- Are higher cost, when equally effective lower cost alternatives are available
- May result in harm

A simple example of low-value care is routine Vitamin D testing without a clear-cut clinical indication. There is strong evidence that in North America almost everyone has low vitamin D levels. This is most likely due to spending time indoors and using high SPF sunscreens, which reduce the chances of developing skin cancer, but also reduce vitamin D production. Rather than perform an unnecessary test, it makes sense to just treat by prescribing Vitamin D supplements.

The question for most health plans and provider organizations is how to implement value-based behavior into their current practice thinking and workflows which have historically been based on fee-for-service. The answer varies depending on the organization. **To change provider behavior across their entire panel of patients, at least 25% of the provider contracts need to be value-based.** Understanding the amount of high and low-value services in current practice patterns is key for easing the transition to value-based care.

Focusing on unnecessary care can reduce health care costs without lowering quality.

The use of clinical data and information is critical for obtaining insights into how current practice patterns will position a provider for a value-based model. Organizations with access to commercial, Medicare, Medicaid claims, and all-payer claims databases (APCDs) can analyze practice patterns and perform risk-adjusted comparisons to peer benchmarks within specialties, including primary care. Regional and geographic adjustments can also be made when necessary.



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This data and information can be used in one of several ways by the health plan and provider organization to bring about change

Self-Assessment

The health plan can work with providers to assess how he or she practices compared to their peers. If they see that they have a higher rate of unnecessary care, then they can work with their colleagues to adopt a “best practice” approach and eliminate redundant, unnecessary, or low-value care. Only by measuring the behavior can one know what to do. By then acting on it, one can make significant improvements. The incentive for providers to do so will require value-based contracts with metric goals built in that are designed to shift to high value care by *x* percent.

Specialty Referrals

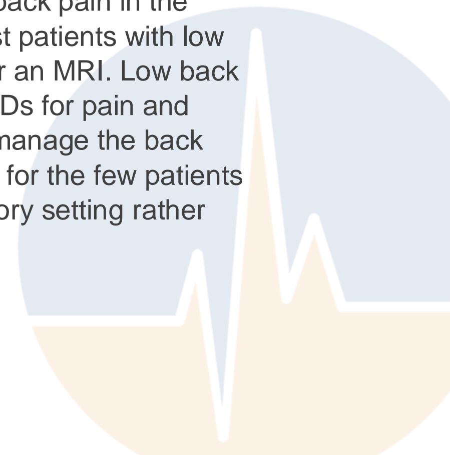
A provider can see how their referral patterns compare to their peers. If they see that they are referring to less efficient providers at a higher rate than their peers, they can change their referrals to more efficient, high-quality providers. Again, if the health plan has value-based contracts which include measuring referrals to high-value specialists, then provider patterns will change. At the same time, specialists themselves who fall into the first category described above and can improve their practice patterns.

Diagnostic Referrals

With the proper use of data, a provider can shift diagnostic testing referrals. One such example is advanced imaging. An MRI performed in the hospital setting will cost more than one performed in an ambulatory setting within a reasonable distance for the patient. Without sacrificing quality, the same diagnostic information can be obtained for appropriate patient management while saving costs. If the health plan includes metrics that measure inpatient versus ambulatory services in their value-based contracts, provider behavior will be encouraged to change.

From a practical point of view, what can health plans and providers do to improve efficiency and eliminate unnecessary or wasteful services?

One example is advanced imaging – in particular, the use of MRI scans for low back pain in the absence of red flags. There is strong evidence in the medical literature that most patients with low back pain will respond to conservative care within six weeks without the need for an MRI. Low back pain (in the absence of red flags) can be treated with physical therapy and NSAIDs for pain and inflammation. These patients don’t need an MRI, which not only does not help manage the back pain, but comes with a high cost and can lead to further unnecessary care. And for the few patients who may need an MRI, it is more cost-efficient to perform the test in an ambulatory setting rather than in the hospital.



Another example is pre-operative testing for low-risk surgery. Often pre-operative tests such as chest x-rays, electrocardiograms, and blood tests are routinely ordered based on historical precedent, when anesthesia was in its infancy. There is lots of evidence that such testing is not necessary for low-risk surgery. And such testing often leads to more testing and possible surgical delays which may result in complications.

These two examples are measurable and peer comparison is possible. If the health plan develops incentives in their value-based contracts collaboratively with providers, there will be sufficient motivation to change provider behavior. **Collaboration between the provider and the health plan is essential in developing the metrics and goals that go into the value-based contract. Providers need to be part of the solution.**

Improving efficiency in other ways will also reduce health care costs without sacrificing quality. The pandemic has accelerated the adoption of virtual visits by both providers and patients. A virtual visit will use fewer resources than an office visit, freeing up resources to address those conditions that truly require the patient to be seen in the office. Perhaps 10-20% of primary care can be rendered virtually. Metrics can be developed by providers and health plans around what percent of primary care visits should be virtual visits vs. in-office visits

A big challenge for providers is that certain procedures and tests make up the “bread and butter” of fee-for-service arrangements. A certain level of reimbursement is necessary to keep the practice viable. As stated above, freeing up resources currently used for low-value care enables those resources to be used for higher acuity care and its associated reimbursement.

In conclusion, Dr. Chauhan shares his personal perspective based on his years of experience as a family practice physician:

> **If I were in practice in today’s value-based reimbursement environment and I learned that I was not a “high-value” provider, I would look at the data to see where I could improve my own practice behavior.**

And if I were referring to specialists who were not “high-value” providers, I would change my referral patterns. As a provider, I would want to collaborate with the health plan to develop metrics and define what improvement goals were reasonable and necessary to achieve a financial incentive for each measurement period. This is essential to keep my practice viable in today’s value-based contracting milieu and to ensure that my patients receive the best possible care without wasting resources on unnecessary care.