A Podiatric Physician's Guide to Value-Based Care

It's the trend of the future, but is it for you?

BY MARK TERRY

Although value-based care (VBC) originally came to the forefront in the late 1960s with the initiation of Health Maintenance Organizations (HMOs), the approach took on significantly more urgency with the launch of the Affordable Care Act (ACA) in 2010. Part of the ACA introduced Accountable Care Organizations (ACOs), bundled payments, and a Hospital Readmissions Reduction program to help to accelerate the programs. With more than 15 years having gone by, it's reasonable to ask: Is VBC going to become a broad-based approach to healthcare in the U.S.? The answer seems to be: sort of.


Dr. Guiliana

John Guiliana, DPM, Medical Director—Podiatry for Modernizing Medicine (Boca Raton, FL), says, "The trend is certainly here, and moving very slowly away from fee-for-service. What's happening are hybrid models where there is some fee-for-service, but providers and entities are incentivized based on their outcomes and cost savings."

Michael King, DPM, Chief Medical Officer of Upperline Health, says, "Yes." Of course, Upperline Health and ACO Reach is one of the few really successful VBC-based organizations in the U.S.

King adds that the U.S. Centers for Medicare and Medicaid Services (CMS) is aiming for all traditional Medicare beneficiaries and most Medicaid beneficiaries to be enrolled in VBC arrangements, such as ACOs, by 2030. That alone will place pressure on physicians and healthcare systems to develop VBC approaches.

Patrick DeHeer, DPM, with Upperline Health in Indiana, says, "I do feel that it's gaining momentum. Private practice is becoming more and more challenging from a reimbursement expense standpoint. And the regulatory burden makes it difficult for the individual practitioner."


Dr. King


Dr. DeHeer

What Is Value-Based Care?

CMS defines value-based care as "Designing care so that it focuses on quality, provider performance and the patient experience." Other terms CMS uses often within the context of value-based care include:

- *Accountable Care:* "A person-centered care team takes responsibility for improving quality of care, care coordination and health outcomes for a defined group of individuals, to reduce care fragmentation and avoid unnecessary costs for individuals and the health system."
- *Care Coordination:* "The organization of an individual's care across multiple healthcare providers."
- *Integrated Care:* "An approach

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to coordinate healthcare services to better address an individual's physical, mental, behavioral and social needs."

• *Person-Centered Care:* "Integrated healthcare services delivered in a setting and manner that is responsive to individuals and their goals, values and preferences, in a system that supports good provider-patient communication and empowers individuals receiving care and providers to make effective care plans together."

The problem with these definitions, at least at a high level, is that they don't seem to differentiate from traditional, routine care. After all, hasn't much of this been the role of the primary care provider, in particular, and any physicians, in general?

Risk-Sharing

In traditional healthcare, payers, such as insurance companies, hold the bulk of the financial risk. VBC shifts that risk to providers—except putting it that way doesn't seem like much of an incentive to physicians. Generally, there are three types of risk-sharing arrangements:

• *Upside risk (one-sided):* In this arrangement, providers may earn financial rewards by meeting or exceeding quality targets and cost reductions.

• *Downside risk (two-sided):* In this model, providers are financially responsible for a percentage of any losses if they don't meet cost and quality benchmarks but are also eligible for incentives for success.

• *Full-risk capitation:* In this model, a physician receives a fixed payment per patient to cover all

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What Can a DPM Do to Head in a Value-Based Model Direction?

1 **Baby steps.** Short of buying into an existing ACO already operating under a VBC system, you're much more likely to have success by taking small steps. It's okay to have big goals, but it's better to start small. Begin by analyzing the benefits and risks of any changes you make. Consider your practice's performance if things go badly and consider the benefits if everything goes perfectly. Make sure you're tracking and measuring outcomes when you make changes.

2 **Establish your baseline.** If you plan to make changes, you need to understand your practice's current performance. If your practice doesn't have value-based contracts, still review your fee-for-service quality measures. Healthcare Effectiveness Data and Information Set (HEDIS) measures are used for most VBC models and for gain share agreements (where both parties share in the financial benefits). Analyze and understand your HEDIS numbers.

3 **Get an expert.** Value-based care, particularly where it stands now, is complicated. You may not be up to analyzing your own payer data or may not be receiving enough payer data to make an effective, realistic analysis. Get an independent assessment from an expert. This individual can also help analyze your fee-for-service agreements and value-based metrics to establish your baseline.

4 **Get buy-in.** Although this hasn't been brought up in this article, it's a common mantra in practice management strategies—get staff buy-in. Identifying, documenting, and managing patient risk requires a coordinated team effort. It requires everybody involved to understand the goals and strategies, and to work to make them happen.

5 **Learn value-based coding.** Value-based reimbursement uses HCC coding, especially within Medicare Advantages. Everyone in the practice needs to understand how HCC coding and reimbursement works, what the benefits are, and what the goals are. It will probably be most effective to hire or outsource a certified risk-based coder.

6 **Collaborate.** Because it is a risk-based strategy, value-based care requires collaboration and partnerships. This not only includes potentially working with consultants and professional HCC coders and analysts, but partnering with payers, community organizations, tech vendors, and legal and financial advisors. PM

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healthcare needs for a defined period. The provider keeps any savings from managing the patient's care effectively and efficiently but also is responsible for additional costs.

Guiliana believes that the eventual implementation will involve the evolution through various hybrid models. "What they seem to be hoping to eventually establish is the next generation, which is a bundled payment-type of arrangement with large groups and entities where you're provided a bundled payment to manage a certain chronic disease. And the ultimate goal is for providers, groups, and entities to be a full-on risk-bearing entity. In other words, they will not have any fee for service, they would not have bundled payments, but instead, they will share in a portion of the costs that are mitigated by their care."

How Does It Work?

Disclaimer: What follows is largely a description of how VBC works in terms of podiatry for Upperline Health. It is not meant to be an advertisement or endorsement for Upperline Health. Other healthcare organizations may use different approaches, and have, although many to date have failed.

That said, Upperline Health appears to be making VBC work, earning millions of dollars of incentive payments from CMS and operating, King says, with a medical loss ratio (MLR) of about 85%, compared to typical Medicare Advantage plans that run around 120% to 140%. Upperline currently has about 2,100 providers of which 400 are podiatrists.

King notes that podiatry seems to be a particularly good model for value-based care initiatives. "Podiatrists in particular, and specialists in general, see their patients much more frequently than primary care physicians. The ACO models and VBC models have been designed around primary care. They've not done so well because PCPs see people once every 12 months or so, and they focus on one particular issue."

King adds that podiatrists typically "see the sickest of the sick." Which is to say, elderly, diabetic patients, etc. And due to the way podiatrists often see the same patients on a regular basis—every eight to 10 weeks, for example—it's easier for them to track other health conditions, or the overall health, of the patient.

DeHeer emphasizes, "We're not taking over for the primary care provider, but we're supplementing."

King describes it as having a podiatric patient coming into the office. The podiatrist may be aware that the patient has COPD, congestive heart failure, an arterial bypass in his left leg, has high blood pressure, and is a bit overweight. It all appears in the podiatric physician's chart.

"The podiatric physician can then recognize the presence of that disease and let CMS know that this person has certain things that have not been treated or are still existing," says King. "And if they are, in fact, not being treated or not being managed, we then connect them to a nurse practitioner who is part of our group, who gets them managed on the spot."

The idea is to not let the patient's condition move downstream and get ignored. "The bottom line," King says, "what we're finding is that instead of denying services for patients, if you provide them, they stay healthier, which saves money. That's value-based healthcare in a nutshell."

How Does Billing Work?

In the ideal model of VBC, providers are paid for the overall quality of care and patient outcomes. This ties in physician financial incentives with patient health, with an emphasis on preventive care and efficiency. The ultimate goal is based on three types of approaches:

1) Bundled payments. In this, providers receive a single, predetermined lump sum for all services the patient receives for a specific care episode.

2) Pay-for-performance. Providers receive a bonus for meeting or exceeding designated quality and cost benchmarks, such as decreasing hospital re-admissions or improved patient satisfaction.

3) Risk-based models. These go back to the upside bonuses and downside risks mentioned earlier.

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However, at Underline Health, King says "We bill exactly the way we bill for any fee-for-service visit." For example, if a patient comes in with an at-risk foot care, a callus, a nail problem, they will bill the same way to Medicare as they always have. "The difference is we're a full-risk program. So if the patient comes in to me for at-risk foot care, I bill him just the same way I would within my scope of practice within my license. And Medicare gets that information. But if the patient all of a sudden ends up with lymphoma, I'm also paying for that. So we are in essence becoming the insurance company," King says.

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DeHeer says that they're still charging for their services, "but we don't treat the other things." What Upperline has done is added all the support components. For example, we have nurse practitioners. If we have a patient with high blood pressure, when they come into our office, we can get a nurse practitioner on a telemedicine appointment with them right away and they can go over their medications and make sure they don't have any problems with that. Same thing with the dietician and a pharmacist. If the patient is having problems with medications, we can get one of our pharmacists on the telemedicine with them right when they're in our office and intervene instead of the patient just trying to figure it out on their own. We have the support staff to help them and fix the problem on the spot as much as we can, and also collaborate with their primary care provider to make sure that there's appropriate follow-up."

He adds that there's no real difference with this VBC model compared to his previous, traditional practice, except "asking the patient when they come in about their overall health, noting those diagnoses and if they're being treated for it, and if it's stable, acting on it right then and there."

From the perspective of payments, King says, for example, the practice receives a certain amount of money from CMS for high-risk patients. For example, "If someone has really bad circulation, Medicare gives us more money to manage that patient. If somebody comes in who's really pretty healthy, exercises regularly, and doesn't take any medications, CMS is going to give us less money."

Which is where the paperwork starts to differ from traditional fee-for-service.

Hierarchical Condition Category Codes (HCC) and Risk Adjustment Models (RAF)

CMS developed the HCC codes to estimate healthcare costs by grouping diagnosis codes based on cost and severity. This approach, which is a risk-adjusted model (RAM), helps determine patient risk scores and affects payments to providers.

HCC codes are part of the RAF score and are leveraged to predict a patient's future healthcare costs. A patient's RAF score, which includes HCCs and various demographic information like age and gender, is used to calculate payments. Sicker patients with complex conditions generally have a higher RAF score.

The coding depends on ICD-10-CM codes submitted on claims. The healthcare provider has to document the condition in the patient's medical record, including his or her assessment or plan for case management at least once a year.

King says, "When our doctors collect those HCC codes, there's a set amount of money that goes to each of those different types of diseases that Medicare gives to us to manage. Then it's up to us to manage that patient across all spectrums. Not just podiatrists, but everybody in the organization."

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Conclusion

If you're a solo podiatric practitioner, can you shift your practice over to value-based care from a fee-for-service program? Probably not.

DeHeer said, "I don't think it's possible for a small group—certainly not an individual practitioner. It's a risk-based model, so you're given a cohort of patients, and you're given X number of dollars to take care of them. If that spend exceeds that number, then you're on the hook for it, so that's where you really need good data analytics and good resources to manage those patients and look at improving their health as opposed to just constantly trying to put out fires with them."

But, if the trends continue, there will be continuing pressure for healthcare to move to a value-based model. Are there things that a practicing podiatric physician can do to head in that direction? The sidebar on page 48 outlines 6 possible steps.

Is value-based care the future? Certainly CMS thinks so.

DeHeer says, "It's still an evolving process, for sure. But I don't think our healthcare system can continue as it is and expect to remain solvent and still provide care for patients. We may have to try something that's a little outside of the norm from what we're doing, and these value-based care models might be the solution." **PM**

Mark Terry is a freelance writer, editor, author and ghostwriter specializing in healthcare, medicine and biotechnology. He has written over 700 magazine and trade journal articles, 20 books, and dozens of white papers, market research reports and other materials. For more information, visit his websites: www.markterrywriter.com and www.markterrybooks.com.