Value-Based Care Amid COVID-19: Stories from the Frontlines

How HCTTF Members are leveraging value-based arrangements during the COVID-19 pandemic

The COVID-19 pandemic and public health emergency (PHE) swiftly disrupted the health care industry in the United States and globally. As the number of confirmed COVID-19 cases in the U.S. increased, primary care practices closed their doors to in-person visits, elective surgeries were cancelled, and hospitals quickly pivoted capacity to treat the influx of COVID-19 patients.

Health care systems participating in traditional fee-for-service medicine saw a precipitous drop in patients seeking care, starving them of revenue at the exact moment they needed resources to respond to COVID-19. In comparison, organizations participating in value-based payment arrangements had teams with existing capabilities to address population health needs, and access to a more resilient funding model to maintain access to patient-centered care. These organizations were better prepared to respond to the evolving public health crisis.

The Health Care Transformation Task Force (HCTTF or Task Force) was founded on the recognition that creating a better health care system requires rethinking how we pay for and deliver care. Task Force members have experienced firsthand how participation in value-based payment arrangements offered an advantage in emergency COVID-19 response, and have shared stories about how they were able to leverage their investments in population health infrastructure to respond to patient needs during the pandemic. These examples, which are detailed further below, include:

- Leveraging existing operational capabilities in new ways
- Utilizing existing partnerships and arrangements to maintain operations
- Providing extra attention to unmet social needs and behavioral health
- Rapid development of new communication tools

© October 2020 HCTTF

Leveraging existing operational capabilities in new ways

- Population-based risk stratification and identification of sub-population needs are core components of population health models supported by APMs. Trinity Health had invested in population health analytic capabilities on top of their internal multi-payer medical economics claims data warehouse, and was able to quickly leverage these capabilities to identify, segment and develop comprehensive care plans for patients at risk for COVID.
- Cambia Health Solutions launched a new health solutions platform powered by data, innovation, and people to ensure personalized, simple, and better care. The platform, known as Journi, is designed to meet the complex demand of COVID-19 while delivering real-time access, data-driven personalization, and 24/7 care guide support.
- Anthem's Care Management and Health Economics teams developed a model that generated ("COVID risk rosters") for early identification and segmentation of membership at high-risk for an adverse outcome if they were to contract COVID-19. The risk rosters were piloted externally with value-based care providers with a goal to improve engagement and management with Anthem members. The model is currently being scaled to allow value-based care providers to see dashboards displaying their COVID-19 positive cases as well as their high-risk patients.
- Atrius Health quickly pivoted to treat many patients via telehealth, establish a COVID-19 call center that has received as many as 1,500 calls a day, and offer COVID-19 screening at more than ten testing sites.
- Mass General Brigham (formerly known as Partners Healthcare) utilized established population health information systems – including data from clinical sources, claims reports, and risk capture efforts – to identify high-risk patients. Mass General Brigham developed real-time dashboards to merge geography, demographics, and clinical characteristics of patients with COVID-19 to better understand disease incidence, drive service 5 delivery decisions, and identify "hot-spots" among vulnerable communities.
- Evolent Health produced a COVID-19-specific risk stratification approach to identify and engage individuals at highest risk of contracting the virus and having the most severe complications from it. The COVID-19 Risk Stratification Playbook describes Evolent's multidimensional approach, which combines a rich set of clinical and social determinants data with the latest virus research. Evolent staff members reached out to tens of thousands of high and moderate risk members to educate them on virus prevention and ensure they had the food, medications and medical equipment needed to maintain social distancing.
- Trinity Health's Medical and Nursing students have been deployed to make well-being checks, with 25 percent of outreach efforts resulting into appointments, including video visits, for needed follow up care.

© October 2020 HCTTF

- Sentara Healthcare is expanding its twenty-year-old tele-intensive care unit to respond to COVID-19. The program was implemented in 2000 at two hospitals to give the ICU setting an extra set of clinical eyes to help improve patient outcomes. The program is now at eight of twelve hospitals and monitors patients with COVID-19 symptoms 24/7 by command center nurses with real-time access to patients' vital signs and labs.
- Building from success with telehealth Palliative Services in the community, MedStar Health created the Palliative Care Telehealth Consultation to expand inpatient capacity by 25 percent. Additionally, as part of an innovative payer partnership, a palliative care screener was launched across all hospitals for earlier identification of potential consults. Overall, palliative care volumes increased 33 percent during the COVID surge.
- Mass General Brigham's Home Hospital-Mobile Integrated Health (MIH) programs provide acute level of care to patients in their homes as a substitute for inpatient hospital care. By leveraging MIH paramedics to further support home-based medical care delivery during the pandemic, these programs expanded capacity to prevent potential COVID-19 exposure in patients requiring hospital care and to monitor COVID-19 patients recovering at home, reducing inpatient utilization and preserving higher-acuity resources.

Utilizing existing partnerships and arrangements to maintain operations

- Aledade, Evolent Health and Trinity Health facilitated access and adoption of telehealth platforms for independent practices in ACOs that did not yet have a solution.
- Trinity Health had in place in each market a network of SNFs that they work closely with for population-based and episodic-based APMs. These relationships enable Trinity Health to quickly implement daily two-way communication when a market is surging or a SNF had an outbreak, and provide rapid response when help is needed. It is critical to connect with post-acute partners to determine capacity to accept admissions and staff. To do so, Trinity Health touched base weekly with skilled nursing facilities and home health agencies.
- Kaiser Permanente partnered with post-acute care facilities to shift priority resources to them and improve processes supporting the identification and treatment of older adults with chronic conditions at a high-risk of contracting COVID-19.
- Aetna partnered with WellBe Senior Medical to deliver primary care services to nearly 10,000 high-risk seniors in their homes. Through this partnership, eligible seniors have access to 24/7 at-home care, lessening the burden of getting a ride to an appointment or venturing to a medical facility during the pandemic.

© October 2020 HCTTF

- Mass General Brigham leveraged its integrated care management program of nurse, social workers, and community health workers to provide outreach to patients at increased risk for adverse COVID-19 outcomes, including the elderly, frail, and those with complex health conditions. The care team provided wellness checks, COVID-19 education, and conducted serious illness conversations clarifying goals of care before patients presented to the hospital.
- CommonSpirit Health and Kaiser Permanente partnered together to provide expertise in establishing the Los Angeles Surge Hospital and were assigned to oversee management of the hospital. The Los Angeles Surge hospital is a temporary facility that expands access to additional beds and ICU capacity for COVID-19 patients.
- MedStar Health leveraged existing partnerships with skilled nursing facilities to prevent and support COVID-19 outbreaks. Utilizing both telehealth and on the group support, geriatric teams assisted with patient triage, testing, cohorting and care management. Of the 27 Maryland skilled nursing facilities connected to MedStar Health, all received COVID-19 universal testing kits.

Providing extra attention to unmet social needs and behavioral health

- MedStar Health partnered with the Baltimore Accountable Community for Health and the Maryland Primary Care program to utilize health workers in vulnerable areas to screen for social needs and connect patients to community-based organizations and care managers to provide acute care transitions and longitudinal care management. In one month of the surge, they reached more than 1,000 patients.
- Anthem has increased payment for behavioral telehealth, a financial investment which is reflected by operational development driving increased integration of behavioral health with Anthem's provider payment innovation programs.
- Kaiser Permanente increased partnerships in their community-based health network to increase access to emergency housing and food and focused efforts to support people of color.
- Mass General Brigham adapted existing behavioral health management, substance use disorder treatment, and digital health programs to address the behavioral health needs of the patients they serve. Mass General Brigham identified patients at high risk of mental health conditions and used primary care-based resources to intervene on acute anxiety and stress. Substance use disorder programs were adapted to include virtual recovery coaching, and supported medication assisted treatment (MAT) when new regulations allowed prescribing without an initial face-to-face visit.

© October 2020 HCTTF

- Trinity Health developed a call center and social care hub with a dedicated line for social needs and screening for social isolation and depression. If patients screen positive, Trinity schedules regular check-ins and provides online and/or telehealth support. Trinity Health also connected patients with meal delivery, grocery delivery, and delivery of 90-day medication supplies.
- Evolent Health partnered with Stay Clean to expand virtual recovery support services for those battling substance use disorders in Kentucky.

Rapid development of new communication tools

- Evolent Health launched a COVID-19 Resource Center for Providers and Health Plans, featuring virus prevention resources, regulatory updates and policy updates relevant to our audience.
- Trinity Health created communication tools to provide their network of independent providers ready access to clinical information, guidance for use of PPE (and access to pricing discounts for PPE), patient-facing materials and support, all updated multiple times a day. Trinity Health provided daily outgoing communication with links to newly posted/updated materials and provided them with guidance and support on understanding waivers and funding, implementing telehealth and other rapid solutions. Trinity Health also developed a package for providers to share with local employers to educate their employees about how Trinity is providing safe care and how to keep their employees safe and not delay getting care.

© October 2020 HCTTF

Stories from the Frontlines: Trinity Health

How Trinity Health's Experience in APMs and Building a Population-Based Clinical Approach Aided their Response to COVID-19

Trinity Health is committed to rapid, measurable movement toward value in the delivery of and payment for health care, including the assumption of total cost of care accountability and risk. Trinity Health has eleven markets participating in Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), including six partnering together as a national MSSP Enhanced Track ACO; four markets partnering as a Next Generation ACO; two participating in Comprehensive Primary Care Plus (CPC+); thirty-three hospitals participating in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative; and three hospitals in the Comprehensive Care for Joint Replacement (CJR) program. Trinity's work—and experience in value-based contracting—also extends beyond Medicare as illustrated by their participation in one-hundred and twenty-three non-CMS APM contracts.

> Experience in alternative payment models (APMs) creates health system resiliency in the form of advanced, flexible, and responsive clinical and operational capabilities. This is because experience in APMs builds a population-based clinical approach that aligns with population-based payment.

Clinical capabilities

The clinical team within a population health-based enterprise is skilled at assessing and identifying the needs of the whole person. Value-based payment arrangements align with the approach most clinicians believe is more effective, which is to create a care plan that addresses clinical and social needs aligned with the patient's own priorities.

Trinity's clinical teams were able to quickly apply the same expertise that was developed to manage patients attributed to their APMs to develop a whole-person plan of care for *all* patients at risk of COVID-19 or being monitored for COVID-19.

Within their ACO in Syracuse NY, the care team created patient-centered care plans for over 13,000 individuals in the community at risk for COVID-19 due to underlying clinical conditions. Patient education was provided to teach sign and symptom management, ensure patients were safe and knew how to keep themselves healthy, had their medications (or set up home delivery), knew when to call a provider, and other preventative measures. Prior to the coronavirus pandemic, his approach would be used for patients to prevent exacerbation of chronic disease, and the ACO was able to quickly pivot and apply to patients at risk for COVID-19. Of note, the teams did this for the entire population of patients at risk for COVID-19, including but not limited to patients attributed to an alternative payment model.

In each of their markets, Trinity set up social care hubs to respond quickly to the social needs for patients at risk for COVID-19 and also to reach other at-risk populations with social needs that were amplified by the pandemic. Trinity was able quickly do this because

© October 2020 HCTTF

of their long-standing commitment to the health of the communities they serve, and the network of services and supports previously developed.

Operational capabilities

The operational capabilities Trinity Health built to support APMs helped them respond to the impacts of COVID-19. For example, a core component of success in APMs is population-based risk stratification and identification of sub-population needs. Trinity has built population health analytic capabilities on top of an internal multi-payer medical economic claims data warehouse and was able to quickly leverage these capabilities to identify, segment and develop comprehensive care plans for patients at greatest risk for complications from COVID-19.

Because most physicians in their Clinically Integrated Networks are independent providers in the communities they serve, Trinity built network support capabilities that could be deployed to support independent providers in responding to the pandemic. Trinity created communication tools to provide ready access to clinical information, guidance for use of PPE (and access to pricing discounts for PPE), patient-facing materials and support, all updated multiple times a day. Trinity provided daily outgoing communication with links to newly posted/updated materials, and also provided guidance and support on understanding waivers and funding, implementing telehealth and other rapid solutions.

Prior to the pandemic, Trinity Health had in place in each market a network of Skilled Nursing Facilities partners in both population-based and episodic-based APMs. Because those relationships preexisted to support success in APMs, Trinity Health was able to quickly stand up daily two-way communication when a market was surging and/or when an outbreak hit one of the SNFs. Trinity Health provided rapid response education, testing, and clinical support for those SNFs.

Throughout this experience, Trinity Health has seen first-hand how the clinical and operational capabilities they have built over nearly a decade of strong commitment to value-based care and population health made the health system more resilient to respond to a once-in-a century global pandemic. The collaborations Trinity Health has built with other systems, payers, employers, and patient members of the Health Care Transformation Task Force allows for continued learning and spreading of effective interventions and best practices across a national learning community.

Trinity's experience deploying population-health clinical and operational capabilities to address the impacts of COVID-19 has amplified that APMs create and support health system resiliency—they scale and translate effectively and foster innovation and collaboration. COVID-19 has demonstrated the importance of paying for value. In the current payment system that largely relies on fee-for-service, providers are strained caring for COVID-19 patients, even with their strong commitment to alternative payment models. The faster the health care system can transition away from volume-drive fee-for-service reimbursement and towards true population-based payments models, the more resilient the national health system will be.

© October 2020 HCTTF

Stories from the Frontlines: Cleveland Clinic and Anthem

How Cleveland Clinic and Anthem's Primary Care Capitation Partnership Aided their COVID-19 Response

Brief History of the Cleveland Clinic-Anthem Relationship

The ongoing COVID-19 pandemic has highlighted the need to accelerate the shift from fee-for-service to value-based care. The PHE has reinforced several of Anthem and Cleveland Clinic's separate value-based care initiatives, while spurring further innovation and engagement within their relationship. Both organizations have leveraged or expanded clinical and operational capabilities since the onset of the COVID-19 pandemic.

Anthem's Care Management and Health Economics teams developed a model ("COVID-19 risk rosters") for early identification and segmentation of membership at high-risk for an adverse outcome if they were to contract COVID-19. The risk rosters were piloted externally with value-based care providers with a goal to improve engagement and management with Anthem members. The model is currently being scaled to allow value-based care providers to see dashboards displaying their COVID-19 positive cases as well as their high-risk patients. Recognizing the pandemic has led to patients delaying important care, Anthem waived member copays to remove barriers to access and to sustain increased integration of behavioral health with Anthem's provider payment innovation programs. Anthem also offered financial assistance on a limited basis directly to qualified independent primary care groups, providing needed capital during this time of financial uncertainty. Cleveland Clinic also developed a risk prediction model for health care providers to forecast an individual patient's likelihood of testing positive for COVID-19 as well as their outcomes. This prediction model factors in age, race, gender, socioeconomic status, vaccination history, and current medications to detect COVID-19 risk and help tailor care decision-making.

Both Anthem and Cleveland Clinic's response to the COVID-19 pandemic leveraged their collective value-based care efforts. Anthem and Cleveland Clinic have long-standing value-based-care relationships serving over 92,000 commercial and Medicare Advantage patients, and a long history of working together to increase access to and improve consumer health care. In 2018, the relationship evolved to launch a narrow network Medicare Advantage plan – Anthem MediBlue Prime Select (HMO). Enrollees of the Anthem MediBlue Prime Select (HMO) plan utilize Cleveland Clinic's network for all their physician and hospital care needs, providing them the continuity of care to achieve the best health outcome possible. Some services, such as outpatient dialysis and skilled nursing facilities, are available through independent providers affiliated with the health system. Through the value-based care relationships, Cleveland Clinic and Anthem work together to coordinate services and close care gaps, ensuring patients receive the care they want and need to lead healthier lives.

© October 2020 HCTTF

High Risk Care Management during COVID-19

When the COVID-19 pandemic reached Ohio, the Cleveland Clinic and Anthem recognized they needed to meet the challenge with an all-hands-on-deck approach. The two organizations partnered to co-manage 2,400 Medicare Advantage (MA) patients that the Clinic identified at high risk for COVID-19 related morbidity and mortality as well as patients at risk for hospital utilization. These patients were transitioned to Anthem's MA Case Management team for weekly touches starting in March 2020, and a joint Clinic/Anthem team was developed for seamless flow of patients that needed escalation due to new or uncontrolled symptoms, benefit counseling, scheduling or medication refills. This collaboration made the transition back to Cleveland Clinic Care Management smooth and allowed minimal disruption to services for the patients.

A key success factor in this collaboration has been the recent embedding of an Anthem Care Manager in the Cleveland Clinic's Ambulatory Care Management Team. Serving as a bridge between the two organizations, the embedded Care Manager helped representatives from each organization navigate the other, so that the patients received timely and well-coordinated fulfillment of needs identified through the weekly outreaches. The Clinic's data shows that these frequent touches helped to reduce emergency department and inpatient utilization compared to an age- and risk-matched control group.

Primary Care Capitation

In 2019 the Cleveland Clinic began working with many of its payer partners to transition to primary care capitation. The goal was simple: redesign the primary care workday to be more in alignment with total panel management, not just that day's schedule management.

Cleveland Clinic and Anthem were early partners in the move to primary care capitation for its 92,000 shared patients across the commercial and Medicare segments. This required significant effort by both organizations' contracting, finance, and clinical teams, and served as a template for the Clinic's transition to capitation across most of its payers. By the end of 2020, approximately 70% of the 550,000 patients in Cleveland Clinic's Ohio primary care network will be in the capitated model.

By shifting reimbursement from how care is delivered to what outcomes can be achieved, it allowed Cleveland Clinic's primary care staff to fully realize the potential of team-based care. Teams now have greater opportunity to work together and use the analytics provided by the health system as well as its payers partners to improve quality, manage utilization, and collaborate with other stakeholders along the care continuum. Furthermore, the increase in flexibility and local autonomy that came with the move to capitation significantly increased staff engagement and reduced burnout. Also, important to note is that during the COVID-19 pandemic and resultant temporary shutdown, the primary care capitation model allowed for a rapid pivot to alternative means of access (e.g., virtual and telephonic visits) and the seamless continuation of care.

© October 2020 HCTTF

Future Directions: Enhanced Cap, Carving in Specialties, etc.

As Anthem and Cleveland Clinic continue to collaborate and move towards higher level of risk sharing in future periods, they will continue to build a strategy that moves to actual Commercial capitation in 2022 and continues to build from there. They will also look at the multiple lines of business and work towards a One Anthem strategy that will allow more population-wide focus on patients (regardless of LOB), significantly reduce the administrative burden multiple contracts per line of business create, and free up a significant amount of providers time to do what they do best and deliver world-class care and treatment to their patients.

As Anthem is working diligently to build out a commercial capitation model and developing the IT infrastructure to support such an arrangement, priority on moving towards sharing more risk with providers as well as providing a level of guaranteed, predictable revenue during these times. As an interim solution, Anthem and Cleveland Clinic partnered to develop a "shadow cap" model. This model uses all of the same financial data & principles as the standard value-based care arrangements. However, shadow cap approach identifies a negotiated set of services to be treated as "capitated" while still being reimbursed through FFS rates. These services are carved out of the total cost of care settlements and apply slightly different reconciliation steps to mimic the effects of an actual capitated arrangement. This approach allows providers to act with more certainty about their revenue, including during times of uncertainty, so the focused can be on delivering high-quality, patient centered care.

Shadow Capitation in Value-Based Arrangements

Shadow capitation uses all of the underlying value-based care methodology already in place while adjusting the end-of-period settlement process. Providers remain responsible for the total cost associated with attributed patients and can earn incentives if they match a total savings with superior quality performance. As Anthem and Cleveland Clinic developed the framework for this model, it was important to find as much alignment to current processes as possible, ensure as little disruption in daily operations, and create a model that allowed providers to focus on the care and treatment of their patients rather than understanding of a new model.

© October 2020 HCTTF

About the Health Care Transformation Task Force

The Health Care Transformation Task Force is a unique collaboration of patients, payers, providers and purchasers working to lead a sweeping transformation of the health care system. By transitioning to value-based models that support the Triple Aim of better health, better care and lower costs the Task Force is committed to accelerating the transformation to value in health care.

This document was developed by the HCTTF Promoting Value Advisory Group, which pursues opportunities to publicly promote the benefits of value-based payment and care delivery by showcasing both the collective efforts of the Task Force in moving towards value, and the related work of individual Task Force members.

Acknowledgements

The Health Care Transformation Task Force recognizes and thanks Task Force member organizations who contributed to this document and for their continued effort in combatting COVID-19.

A special thanks to Emily Brower and Jennifer Nading of Trinity Health, Dr. Greg Whisman, Connie Tirpak Murch, Katherine Koehl, and Rachel Reardon of Anthem, Inc. and Laura Baciu, Michelle Edwards, Gunes Raack, and Dr. Nirav Vakharia of Cleveland Clinic for developing their respective case studies.

© October 2020 HCTTF