Health Equity in Value Based Care

Rural Health Symposium
April 2024

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What is Value in Healthcare?

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross Blue Shield Association.
**What is value-based care?**

**Fee-for-service**
- Payment is based on the number of services provided.
- Based on volume of care and can result in increased cost.
- No rewards for improved outcomes, quality of care or patient experience.

**Value-based care**
- Payment is based on the outcomes and quality of care for a population.
- Allows for innovations in care not associated with fee for service payment.
- Incentivizes keeping patients healthier and improving the patient experience.
What do we need to know about our patients?

**Medical risk:** What are the patient’s chronic conditions?

**Social risk:** What are the patient’s social risk factors?

**Behavioral health:** What behavioral health issues does the patient need to have addressed?

**Patient engagement:** How can we more actively engage patients in their care?
Why would providers want to move into value-based care

**Patient experience**
Improved patient experience by engaging with patients based on their needs.

**Provider experience**
Providers able to hire care teams that work at the top of their license to support patients.

**Reduced cost of care**
Allows the ability to decrease cost of care by implementing innovative methods to care for the population not addressed in a fee for service model.

**Population health**
Shift in mindset from closing gaps to keeping patients healthier to improve outcomes.

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross Blue Shield Association.
Strengthen data collection and analysis based on demographic factors like race, ethnicity, language, geography and disability.

Develop new models and modify existing models to address health equity and SDOH.

Increase the number of beneficiaries from underserved communities that receive care through value-based payment models.

Evaluate models for their impact on health equity.

Strengthen data collection and analysis based on demographic factors like race, ethnicity, language, geography and disability.

Physician Group Incentive Program
Provides infrastructure funds to Physician Organizations to be able to build out the programs to make them successful in the move into value-based care

Blueprint for Affordability Program
Value based care contracts that hold providers accountable to outcomes, allowing providers to share in risk
PGIP is a proven organizational asset
BCBSM’s Value Partnerships programs have long supported BCBSM and the provider community for 18+ years

Launched in 2005, **40 physician organizations**, representing ~20,000 primary care and specialist physicians throughout Michigan, participate in provider-led clinical quality improvement efforts.

PGIP is the Organization’s primary way to **transform care practices** that impact the vast majority of Michigan residents.

PGIP participants **collect data, share best practices, and collaborate on initiatives** that improve the health care delivery system in Michigan.

PGIP allows us to **quickly respond to needed environmental changes** in the delivery of care (e.g. COVID-19, behavioral health, opioid epidemic) and **meet customer expectations** (e.g. unconscious bias training, Flint water crisis), and **CMS needs** (provider directory data quality concerns).

PGIP allows us to **quickly engage and assemble** groups of statewide providers and partners by using our platform to **disseminate information broadly and timely**.

Participating PGIP PCPs and specialists combined represent **89% of total commercial, professional spend**.

Participating POs are evaluated and rewarded on **transformation of health care delivery, quality metric performance, and performance enablement** – all efforts designed to improve the overall value of care delivered while reducing the total cost of care.

Ensures **revenue capture** for the organization, as well as meet the **organizational accreditation needs**.

Located in 82 of Michigan’s 83 counties, nearly 85% of Blue Cross PCPs are engaged in PGIP.

PGIP was **foundational** in spring boarding **Blueprint for Affordability** efforts: We moved away from cost performance with the expectation that POs would engage in Blueprint for opportunities to be rewarded on cost performance/taking on downside risk.

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The PGIP portfolio continues to evolve, developing capabilities that are interdependent and built upon one another.

- **Patient Centered Medical Home**: PCMH provides the foundational capabilities for providing high quality care to populations.
- **Provider Delivered Care Management**: PCMH providers delivering care management & coordination.
- **Behavioral Health**: Collaborative Care and Medication Assisted Treatment.
- **Addressing Health Disparities**: Unconscious Bias Training, SDOH screening, Supporting CHWs, Social Risk Adjustment.
- **Population Health CQI**: INHALE MCT2D MSHIELD MIMIND
Social Determinants of Health (SDoH) affect health outcomes more than care provided in a clinical setting.

Determinants of Health

- Socio-economic Factors
  - Education
  - Job Status
  - Family/Social Support
  - Income
  - Community Safety

- Physical Environment
  - Work/School
  - Home

- Health Behaviors
  - Tobacco use
  - Diet & Exercise
  - Alcohol Use
  - Sexual Activity
  - Stress, Mental Health

- Health Care
  - Access to Care
  - Quality of Care

SDoH factors can make it difficult or almost impossible to either receive care or follow a doctor’s recommended treatment plan.

Social Determinants can include:
- Housing quality and stability
- Access to transportation
- Ability to afford and purchase quality food
- Ability to afford health care
- Social support system
- Community safety
- Education and employment status
If you could address social needs of patients, where would you focus your efforts?

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PGIP social needs and health equity strategy

**Unconscious Bias Training**
Required for all Primary Care Physicians to have training in Unconscious Bias Awareness to receive Value Based Reimbursement

**Screen for Social Determinants of Health**
Incentive to support increased SDoH screening and infrastructure for data aggregation

**Community Health Worker Initiative**
Funding CHWs to work with patients to support needs identified through additional screening efforts

**Social Risk Adjustment Initiative**
Engage POs using the Area Deprivation Index score to support practices caring for patients with high levels of social needs impacting their overall health

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Background of social risk adjustment

When social needs are not addressed there can be an adverse effect on the health outcomes of individuals.

As we work to obtain subjective assessments of social needs from members, using an objective area level measure of social risk as a proxy for individual social needs is a good option.

The current methodologies of risk adjustment underestimate the total cost of care of patients who have socially complex issues. These patients also often have higher healthcare utilization.

Directing payments to providers who care for more socially disadvantaged patients would provide additional resources that would help in closing social need gaps.
What are social risk indices and why did we align on ADI

Social risk indices use social risk factors that include a broad range of characteristics, assessed at the individual, group, or area level, that reflect inequitable social conditions and are associated with health-related outcomes.

Social risk factors encompass social determinants of health (SDoH) as well as health-related social needs (HRSN), two related concepts currently used in the health equity literature.

WHY ARE WE USING ADI?

- ADI predicts health outcomes. Patients in higher ADI areas are shown to have **worse outcomes and higher costs**.
- ADI is measured at a block level for adjustment based on a small area where the member lives.
- ADI is updated annually to account for neighborhood changes at a regular cadence.
- CMS is using ADI in ACO REACH model to adjust for social needs.
Based on State of Michigan ADI

ADI scores from within this state alone are ranked from lowest to highest, then divided into deciles (1–10).

Clare Gladwin Rd, Farwell, Michigan, 48622
Block group within Clare County
State Decile: 8
National Percentile: 86

Neighborhood Atlas - Mapping (wisc.edu)
Area of Deprivation Index: Mount Pleasant

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Using ADI to address patient’s social needs

**Identify**
Compare BCBSM member level data to Area Deprivation Index annually to identify areas in need of added support

**Deliver**
Deliver payment to POs based on patient attribution with a high ADI. Funds are intended to be used to address specific needs

**Goal**
To empower POs to support unique needs specific to their affiliated practices as they seek to address those needs in order to improve health outcomes
Social risk adjustment funding use

**Acceptable Incentive Fund Uses**
- Housing Instability
- Homelessness
- Food Insecurity

**Prohibited Uses**
- Insurance copayment
- Insurance deductible
- Insurance premium payment
- Copay for medication
- Any insurance benefit that is covered in members' plan but has copay or deductible
- Ambulance services
- To pay for the purchase of drugs, biologics or other medications
- To pay for CME or training
Social risk adjustment opportunity-How the PO’s will use it

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Focus of SRA Funding

- Elder Abuse: 5
- Intimate Partner Violence: 6
- Health Literacy: 7
- Social Connection: 8
- Patient Employment: 9
- Stress: 9
- Material Hardship: 12
- Housing Instability: 15
- Connect Members to Community Resources: 19
- Transportation: 21
- Food Insecurity: 22

PO count
What PO’s are doing with the SRA Funds

**Community Health Workers**
- Centralized CHW support and transportation services.
- Putting in place two CHW that work directly with patients both in person and via telephonic and mail.
- Adding Community Health Worker skill set.

**Community Connection**
- We are restarting our community resource fair for practices to bring to them all of the resources available for the predominant SDOH in our population.
- Money went to Council on Aging to expand programs such as meals on wheels, Chore and house repair for elderly, transportation of elderly. We also helped expand a local program that aids in supply children basic needs.
- Incorporate home visits in the assessment and resolution of SDOHs when the care manager believes they are inadequately able to assess SDOHs for patients with whom they are working/engaged in care management or conducting annual wellness exams.

**Food Insecurity**
- We plan to use these funds to expand our current Farm program which delivers fresh produce to our patients with food insecurity.
- Partnering with several of our practices that have food insecurity concerns and our farming community resources to expand the education, availability and access to healthy food.
- Having the gift cards to distribute, being able to immediately respond to an identified need, gave the physicians and practice staff a feeling of empowerment which is not necessarily what they feel when referring a patient to a food pantry.

**SDoH Data**
- Expanding on Social Needs Coordinator (SNC) team who are working with practices on SDOH screening, follow-up with patients, and LOOP CLOSURE.
- Planning to work with our practices that have not been able to screen for SDOH and build this functionality electronically for them to assist in increasing the number of patients being screened for SDOH needs.
- Goal would support a brand-new community garden at a practice in area with ADI 10.
What’s next in PGIP’s health care Disparities efforts?

**Measure and Learn**
- Hold Best Practice sharing meeting for POs participating in SRA initiative
- Evaluate impact of SRA on utilization and outcomes

**Report**
Aggregate SDOH screening data by PO and geographic regions to inform SDOH needs and gaps

**Build and Improve**
Build and improve programs to support improving health equity for patients in Michigan

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<tr>
<th>BCBSM is the first commercial health plan to institute a payment adjustment methodology to <strong>support providers who care for patients with social needs.</strong></th>
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<tr>
<td>As we work towards <strong>improving outcomes and delivering value in healthcare</strong>, it is important to consider <strong>how we address social needs</strong> as these are many times a patient’s biggest risk factor for poor health outcomes.</td>
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<td><strong>The PGIP Social Risk Adjustment Initiative</strong> will provide funding to Physician Organizations to <strong>address specific patient needs and improve health outcomes.</strong></td>
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