What Does Value-Based Care Mean for Individuals?

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So you may ask, "What would a member experience in Value-Based Care?" And, you know, the great thing is the majority of members will not see a difference in what their day-to-day activities are.

If you're someone who sees a physician for a physical once a year, has an occasional, you know, minor illness, you're not going to notice anything. Health care is still going to be available for you. We do want to make improvements in member experience and access over time. But in terms of how population health programs and value-based care programs are going to impact you as a healthy person, there's not a tremendous amount.

We want you to participate in the wellness programs. We want you to reach out when you need support. We want you to seek care when you need to seek care, complete all of your appropriate preventive screenings, et cetera. But we're not going to see a whole lot of change for the majority of the healthy population.

The nature of population health programs and value-based care is that an awful lot of utilization and cost and, really, sometimes not-so-great outcomes are concentrated in a small portion of the population. So we really are focused there.

So if a member has a number of chronic diseases and is struggling to control them, they're going to feel the difference with value-based care. They're going to feel that their practice, their provider, their PCP is reaching out to them more frequently. They may have a care manager assigned to help them. They may be enrolled in a special program to help, for example, with diabetes management. So there, we're going to be monitoring their medications more closely through the pharmacy program. So there's an awful lot that someone who is struggling to manage chronic disease or multiple chronic diseases will experience.

And then someone who is really dealing with a very serious health issue would also experience a different interaction with the health care delivery system. They will have more focus. They will have more access. They will have more help navigating from specialist to specialist with the help of the care manager.

And what we're doing, what we've done in the past is our management was a payer function. What we're doing now is that our payer care managers are partnering with the providers' care managers, and we're sitting together and looking at the population together, figuring out how we can address the needs of those that have high need in the population to get better results on that population.

So it's a real focus on where the biggest opportunities for improvement are. We also, in addition to those that are managing multiple chronic diseases, or dealing with a very serious illness, we're still constantly watching for opportunities to improve quality. We talked about gaps in care a lot. Some of those gaps in care are not for sick people. There are mammograms and call colonoscopies, and routine screenings that need to be done in the pediatric

population. It's making sure that the wellness checks are done. That's making sure that the vaccinations are done on time.

So we're constantly measuring and monitoring and providing feedback to our partners to help them be successful on these programs. All of our value-based programs have minimum quality requirements. So even if a provider were to earn an incentive from a financial perspective, if they don't meet minimum quality standards, that incentive will not be paid.

And that is because we want everyone to stay focused on quality and not just focused on cost, because poor quality in the near term will result in much higher cost in the long term.

So this is a great investment in the health of your population as an individual, your health, and as an employer, the health of your population over time—which obviously yields lots of benefits not only to you as a person, to your company, but to society more broadly.