Inflammatory Bowel Disease Shared Value Initiative

July 2022

IBD

Summary of Themes

Advancing principles for value in addressing inflammatory bowel disease

As the Center for Medicare and Medicaid Innovation (CMMI) continues to advance value-based payment (VBP) models to address quality and total cost of care in primary care and large-scale populations, many stakeholders are grappling with how to build VBP models for chronic specialty and subspecialty conditions for smaller populations, such as inflammatory bowel disease (IBD).[1] Some believe that VBP models have the potential to improve patient and cost-related outcomes in IBD, and while some commercial payers and practice partners are experimenting with such models, most of these efforts remain nascent.

Beginning in 2021, Tapestry Networks engaged a diverse group of stakeholders—including payers, self-insured employers, gastroenterologists and clinical specialists, patient advocacy organizations, industry representatives, and others—in its IBD Shared Value Initiative to address the challenges and opportunities surrounding value-based care (VBC)[2] and VBP models in IBD. The initiative culminated in the May 2021 Progress Summit.[3] Following the summit, many stakeholders noted that establishing consensus-based principles for value in IBD could help guide those looking to pilot new approaches. Therefore, throughout 2021 and early 2022, Tapestry continued discussions with key stakeholders to consider what those principles might be. From this broader group, a small subset of payers and providers, chosen for their roles and leadership in care delivery and contracting, collaborated to draft a publication on the topic.

In June 2022, the draft framework publication was presented to the larger stakeholder group for further insights. Meeting participants also discussed considerations for practical implementation of the framework, including the incentives and resources necessary to advance the principles proposed in the draft. The meeting also provided a forum for candid discussion among stakeholders for continuous learning, and more such meetings may be convened in the future.

This *Summary of Themes* provides a brief overview of the key points discussed during the meeting. *For a list of meeting participants and publication coauthors, please see the appendix on pages 7 and 8.*

Stakeholders discussed how to enhance the framework's draft principles

The draft framework outlined three principles: comprehensive risk stratification, holistic and tailored treatment, and continuous monitoring, which one author described as *"mile markers for VBC approaches in IBD"* that the broader community could consider. Participants, who were able to see a draft version of the framework, voiced no serious objections to its proposed principles, but considered ways to enhance the framework's discussion on risk stratification and treatment. Stakeholders noted that a risk stratification process which includes both clinical and functional patient assessments (e.g., mental health and diet) is crucial, given the impact that factors outside of the gastrointestinal tract have on healthcare utilization.[4] *"Risk stratification is a key vehicle for decision making. If you've stratified patients, you've allowed yourself to be able to provide recommendations … and it is important to consider the patient in full context,"* one clinician said.

> *"We're trying to assess risk so that we can predict which patients are going to need the most service and apportion our resources correctly."*
>
> – Provider

Some stakeholders suggested that shared decision making and patient engagement, which are highlighted in the framework, require an even greater emphasis. Several clinicians encouraged a nuanced approach to capturing patient resilience and the ability of patients to engage in their care, which they said should be prominently factored into risk stratification and the framework's discussion of it: *"Is a patient confident about their health? Confidence factors in mental health, health literacy, and other social determinants of health and drives a lot of healthcare utilization."* Measuring patient confidence or resilience may become increasingly significant as the demographics of IBD patients shift. *"We are seeing a significant increase in prevalence of disease from [minority] communities,"* one clinician said, *"and there are now more social determinants of health issues, which requires tremendous resources to address."*

Participants also shared how the principles could address treatment optimization. Some noted that a tailored treatment plan, as highlighted in the draft framework, could better reflect patient preferences and needs with regard to therapy. In breakout discussions, some clinicians noted that although the various IBD therapies do not vary significantly in terms of efficacy, they do in terms of convenience for patients: *"I have patients who travel across the world constantly, so setting up infusions is difficult … Patients want to live to their potential and want to pick a therapy that fits best with their lifestyle."* Others emphasized the need for rapid, intensive monitoring of patients' current treatment to ensure timely changes, if necessary.

Several implementation challenges remain of concern

For much of the conversation, participants focused on the real-world applicability and execution of the framework's principles: *"We've been talking about these principles for well over a decade and nothing has really changed … VBP models always get hung up at the*

implementation stage." For example, some participants agreed that while it is easy to assert that comprehensive risk stratification should be a vital component of care, it is *"not fully adopted because it is really hard to do."* Stakeholders highlighted the following barriers that prevent more widespread implementation of VBP models in IBD:

- **The investment and scalability hurdles are significant.** The transition to VBP models requires sizable data aggregation, infrastructure, and expertise, *"the cost of which far exceeds any generated revenue."* For many payers and providers, the necessary investment stands in the way of an immediate transition and is a major hinderance to even gradual transitions to VBP models. Even if investment challenges could be overcome, a few stakeholders raised concerns about the ability to scale models in IBD. The IBD population is relatively small, which is why some payers stressed the importance of generalizability: *"If we can make [models] applicable across different [disease] environments, there's a better opportunity for traction."* For payers and practices that do establish VBP agreements, fragmentation presents an additional challenge. A payer said, *"One struggle we have is clinician engagement. We can build value-based relationships with a practice, [but] we may not capture the whole practice in VBP programs."* Reflecting on this fragmentation, a digital health stakeholder noted that *"clinicians simply do not change their workflows based on a subset of patients tied to one specific insurer, so we need to look for a different way to do this."* Outside of select specialty centers, IBD represents only a small fraction of patients within GI practices, which is also a disincentive to change workflows.
- **Point solutions may have limited utility as payers move toward primary care–centered models, such as accountable-care organizations (ACOs)**. While solutions targeted to the IBD population may be the focus of the framework and those around the table, one participant encouraged stakeholders to consider the broader healthcare landscape: *"From a very high level, what has CMS [Centers for Medicare & Medicaid Services] done? They're turning over risk to population-based total-cost-of-care entities like ACO REACH. They're paying primary care providers to do high-touch care, and what's happening? They're lowering the cost of care. I think that gastroenterologists need to find our place in these total-cost-of-care risk models, not as a carve-out, but as a nest-in."* If commercial payers continue to follow CMMI's example by prioritizing similar primary care–focused entities, there may be a need to reexamine the primary and specialty care overlap in gastroenterology (GI).
- **Financial risk bearing could be a path forward but remains contentious.** Outside of contracting with ACO-like entities, there may still be opportunities to embrace a financial risk-bearing approach for total cost of care in GI and IBD. One clinician noted, *"Commercial payers need to lead the way with total-cost-of-care contracts … And in this new era, gastroenterologists need to commit to lower overall costs."* However, practices in specialty care have traditionally shied away from taking on risk, especially

for total cost, which one participant believes is due to the scope of contracts: *"Contrary to popular belief, I've found that clinicians are willing to be accountable for things they can control. They are rightfully afraid of being held accountable for things they can't control."*

The time is still ripe to pilot VBP models in IBD

> *"It can take 17 years for guidelines and best practices to take hold in healthcare, but we really don't have that time here."*
>
> – Payer

Despite these challenges, meeting participants were optimistic that now is the time to advance VBP models in IBD. The GI private-practice landscape is changing drastically, with rapid consolidation and investment from private equity firms. Technological advances now provide clinicians with the ability to measure care and outcomes at a population level, and the expansion of telemedicine grants patients greater access to multidisciplinary teams that can contribute to improved outcomes. One clinician reflected, *"Unlike 10 years ago, we now have the scale and the tools to take advantage of the opportunities in VBC."* Among the opportunities discussed were the following:

- **Third-party entities.** Although some leading payers are prioritizing ACOs, other payers, self-insured employers, and industry are still interested in experimenting with VBP models for specialties. Participants said that some payers and their practice partners are turning to new, risk-taking third-party solutions for the IBD population, and early results show promise for reducing emergency department visits and hospitalizations. *"During the first year, our partners got a very significant payout on shared savings, so we are already taking big steps in the right direction,"* one payer confided, referring to a third-party risk-taking entity. Third-party entities are demonstrating that they can serve as platforms to implement some of the framework's proposed principles of risk stratification, holistic and tailored treatment, and continuous monitoring.
- **Altered partnerships and stakeholder roles.** With the knowledge that change can take time in healthcare and that risk transfer is a particularly challenging topic for clinicians, stakeholders discussed other ways to encourage VBC in the near term. Some focused on subsidizing the investment and ongoing costs to clinicians of VBC and VBP model implementation. Some asked whether foundations or industry could play a role in supporting data aggregation, procuring tools, and providing ancillary staff for stratification and monitoring activities. Additionally, some stakeholders suggested that in this new era of VBP models, the payer-provider relationship might evolve to be more collaborative. A payer said, *"We have providers coming to us now to bargain, saying, 'If I do X, would we be able to share savings?' We are now taking them up on those offers. So don't wait on commercial payers—push them, force them to think about new contracts."*

- **Processes and resources related to therapy selection.** Clinicians said that removing the need for prior authorization for drug therapy would be one tangible way to help the community make significant progress toward VBC. *"I quantified the amount of time I spent on prior authorization, and it was 40 hours a month,"* lamented one clinician. Payers responded that prior authorization serves as a guardrail to avoid *"paying for inappropriate care"* as not every therapy *"utilizes evidence-based medicine."* Nevertheless, various payers brainstormed ways to quantify the cost of prior authorization and discussed how those costs could be reinvested in activities like enhanced risk stratification if prior authorization were eliminated. Some payers also noted that prior authorization would likely go away in the near future for practices that are designated as value-based partners. A *"TSA checklist"* of high-quality, value-oriented practices in IBD, for which the framework aspires to help lay an initial foundation, could be a starting point for expanding these partnerships to more practices. This checklist approach would align well with investments that professional societies are already making in platforms designed for rapid posting and updating of guidance for clinicians, especially on treatment selection and iteration.

Conclusions

Meeting participants felt that hearing from other stakeholders provided them with a more comprehensive understanding of the barriers and potential solutions to advance the principles of the IBD value framework. One stakeholder commented, *"This is not an easy topic, and that's exceptionally clear. But there's a willingness here from everyone to collaborate, and from what has been shared in this open and transparent forum, we now have more empathy to understand the other perspectives and advance the cause."* Participants broadly agreed that mutual education and learning across all stakeholders are necessary for advances in IBD.

There was keen interest from all involved to dive deeper into the real-world implementation of the framework, with the knowledge that such implementation could make a difference in outcomes: *"The consequences of being wrong in IBD can be bad, so we need to focus on creating value for patients now."* A patient advocate shared a sense of optimism while acknowledging the hard work ahead: *"Today's discussion does give me hope as a patient and as a community leader for several patients. I'm just really hoping that [everyone] can get together and make this happen."*

The framework's coauthors will look to integrate the broader IBD stakeholder perspectives into the publication, and stakeholders involved in this effort will further consider the need for additional learning forums and pilots in this space with the framework's principles in mind.

About this document

This *Summary of Themes* reflects the use of a modified version of the Chatham House Rule whereby comments are not attributed to individuals, corporations, or institutions. Italicized quotations are comments made by participants before and during the meeting.

Tapestry Networks is a privately held professional-services firm. Its mission is to advance society's ability to govern and lead across the borders of sector, geography, and constituency. To do this, Tapestry forms multistakeholder collaborations that embrace the public and private sector, as well as civil society. The participants in these initiatives are leaders drawn from key stakeholder organizations who realize the status quo is neither desirable nor sustainable and are seeking a goal that transcends their own interests and benefits everyone. Tapestry has used this approach to address critical and complex challenges in corporate governance, financial services, and healthcare.

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Appendix: Participants

- Aetion: Nirosha Lederer, Director, Real-World Evidence Strategy
- Anthem: Kevin Bowman, Staff Vice President, Enterprise Clinical Quality; John Yao, Chief Medical Officer, Blue Cross of California
- AT&T: Luke Prettol, Lead Benefits Strategy Consultant*
- Brown University: Samir Shah, Clinical Professor of Medicine; President, American College of Gastroenterology
- Capital Digestive Care: Michael Weinstein, President and CEO
- Center for Healthcare Quality and Payment Reform: Harold Miller, President and CEO
- Color of Crohn's and Chronic Illness: Latonia Ward, Director of Community and Special Events
- CVS Health: Joe Couto, Senior Director of Specialty Program Evaluation and Outcomes*
- Geisinger: Phil Krebs, Director, Medical Policy and Clinical Guidelines*
- GI Alliance: Paul Berggreen, Chief Strategy Officer*
- Horizon Blue Cross Blue Shield: Joe O'Hara, Director, Accountable Care Organization Solutions*
- Mayo Clinic: Jami Kinnucan, Senior Associate Consultant, Department of Gastroenterology and Hepatology
- New York University: Lisa Malter, Director of Education for NYU Langone Health IBD Center
- Oshi Health: Sameer Berry, Chief Medical Officer
- Pfizer*:* Jessica Friedberg, Rheumatology/GI Franchise Payer & Access Lead; Martin Rost, Value & Access Strategy Business Unit Lead, Inflammation & Immunology
- Purchaser Business Group on Health: Emma Hoo, Director, Value-Based Purchasing*
- Rubicon Partners: David Johnson, Clinical Operating Partner*
- Sepsis Alliance: Paul Epner, Board Member; Former CEO of Society to Improve Diagnosis in Medicine and IBD patient advocate
- SonarMD: Larry Kosinski, Chief Medical Officer*
- Specialty Networks: Kevin Harlen, President, GastroGPO; Wanda Wilt, Vice President, Customer Success, PPS Analytics
- Takeda Pharmaceuticals *(sponsor):* Rachel Adams, Director, US Medical External Affairs; Ninfa Candela, Medical Director, Gastroenterology, US Medical Affairs

- Trellus: Laurie Keefer, Cofounder; Director, Psychobehavioral Research (Division of Gastroenterology)
- University of Chicago: Michele Rubin, Associate Director, IBD Center
- University of California, Los Angeles: Fola May, Director, Quality Improvement in Gastroenterology
- UMass Memorial Medical Center: Barbara Olendzki, Director, Center of Applied Nutrition
- University of Michigan Medical Group: John Allen, Physician Advisor to the Executive Vice Dean; Treasurer/Secretary, American Gastroenterological Association
- VIVIO Health: Bhargav Raman, Director of Clinical Product

**Asterix denotes framework coauthor*

Endnotes

[1] Robert King, "CMMI Plots Ways to Grow Specialty Care Providers' Role in Value-Based Care," Fierce Healthcare, May 12, 2022.

[2] VBC seeks to enhance patient quality of life by improving health outcomes. VBC may be incentivized by a diversity of VBP models, as noted by the Cleveland Clinic.

[3] "Laying the Foundation for Greater Value in Inflammatory Bowel Disease Care," Tapestry Networks, June 2021.

[4] Adjoa Anyane-Yeboa, Sandra Quezada, David T. Rubin, and Sophie Balzora, "The Impact of the Social Determinants of Health on Disparities in Inflammatory Bowel Disease," *Clinical Gastroenterology and Hepatology* (2022).