

Value-Based Care in the COVID-19 Era: Enabling Health Care Response and Resilience

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Key Themes

- The COVID-19 pandemic has created significant challenges for health care organizations, requiring them to quickly ramp up testing and tracing strategies and maintain continuity of care for patients with ongoing medical and social needs, while safety concerns have caused a massive drop in elective services and shifted most care to telehealth.
- The ability of health care organizations to respond to these demands has partly depended on whether they participate in a value-based payment structure. These models offer more financial flexibility and stability, helping organizations develop new capabilities that improve care delivery.
- Drawing from interviews and research, we describe a wide variety of organizations who have leveraged value-based models (including rural and urban, safety net, primary care and specialists, hospitals and independent practices) to respond quickly to COVID-19 challenges.
- Further efforts should offer more opportunities for organizations to participate in value-based payment models, ensure that they can improve disparities and equity in health care, and overall create a more resilient health care system for the future.

The COVID-19 pandemic has created significant challenges for health care organizations. It has required them to develop a range of COVID-19 specific care practices, as well as implement the widespread testing, tracing, and surveillance activities needed to mitigate transmission and enable the safe reopening of businesses, schools, and other institutions. They have also had to implement new strategies to maintain continuity of care for patients with ongoing medical and social needs. At the same time, safety concerns have caused a massive drop in elective services and required many organizations to shift quickly to telehealth.

A key factor influencing a health care organization's ability to meet COVID-19 challenges is the payment structure under which it operates: fee-for-service (FFS), value-based payment (VBP) with primarily prospective payments, or somewhere in between.

Payment structures have had a significant impact on a practice's financial stability and its ability to adapt patient care to new circumstances. Organizations that received [a greater proportion of prospective payments](#) had more financial protection against FFS downturns during the pandemic, since their payments were less affected by declines in service volume. Also, as we describe in more detail below, VBP model flexibility allows practices to pivot quickly to develop and sustain effective care models during the public health emergency, regardless of whether the services or activities are reimbursed (or not) under a fee-for-service system. Moreover, VBP models, with their rewards based on measures of quality and value, encouraged practices to invest in infrastructure and build or re-purpose partnerships to address people's medical and social needs.

This issue brief describes health care strategies implemented by diverse organizations supported by a range of VBP reforms to provide better care during the COVID-19 pandemic. The descriptions derive from an environmental scan of health care organizations' ongoing response to COVID-19 and interviews with health care delivery organizations, including ACOs, other capitated or risk-bearing delivery organizations, VBP-enabler organizations, and other experts. In short, value-based models are an important tool that provide needed flexibility for care delivery organizations to adapt care models to their patients' needs and circumstances, and which can be combined with other policies and supports to provide better care. The brief ends by describing policies that can support health care providers during the pandemic and promote greater use of VBP arrangements that improve care and create a more resilient health care system.

Payment Model Impact on Providers for Financial Stability and Care Model Flexibility

Over the past decade, multiple types of VBP models have been implemented by the Centers for Medicare and Medicaid Services (CMS), states, and private insurers (see Figure 1 for continuum of payment models). For example, over 44 million Americans received care through an Accountable Care Organization (ACO) as of 2019, the most common

type of VBP arrangement. In addition, there are primary care payment models like [Comprehensive Primary Care Plus](#) and [Primary Cares](#); longitudinal episode-based payments for specialized care, including [maternity](#), [cancer care](#), and major procedures; and accountable care models for specialized care, like [chronic kidney disease](#). Many models provide prospective payments such as “per-member, per-month” payments or similar payment related to a person or a whole episode of care rather than the volume of services.

To give a sense of where practices fit into the payment model categories in Figure 1, the most recent Health Care Payment Learning and Action Network (HCP-LAN) [survey](#) estimated that 64% of health care payments were made either through traditional FFS or FFS with a link to quality or value in 2018 (also known as LAN categories 1 and 2). Organizations receiving primarily FFS payments have been particularly hard hit by [the rapid decline in service volume and revenue](#), especially [smaller independent practices without significant reserves](#). Declines in revenue have led many organizations to [furlough staff](#) or close altogether. Organizations still operating face the challenge of taking on additional responsibilities related to COVID-19 (e.g., testing, tracing) while maintaining care delivery to other patient populations, a daunting task without access to additional funds.

Effects of Value-Based Payment on COVID-19 Response

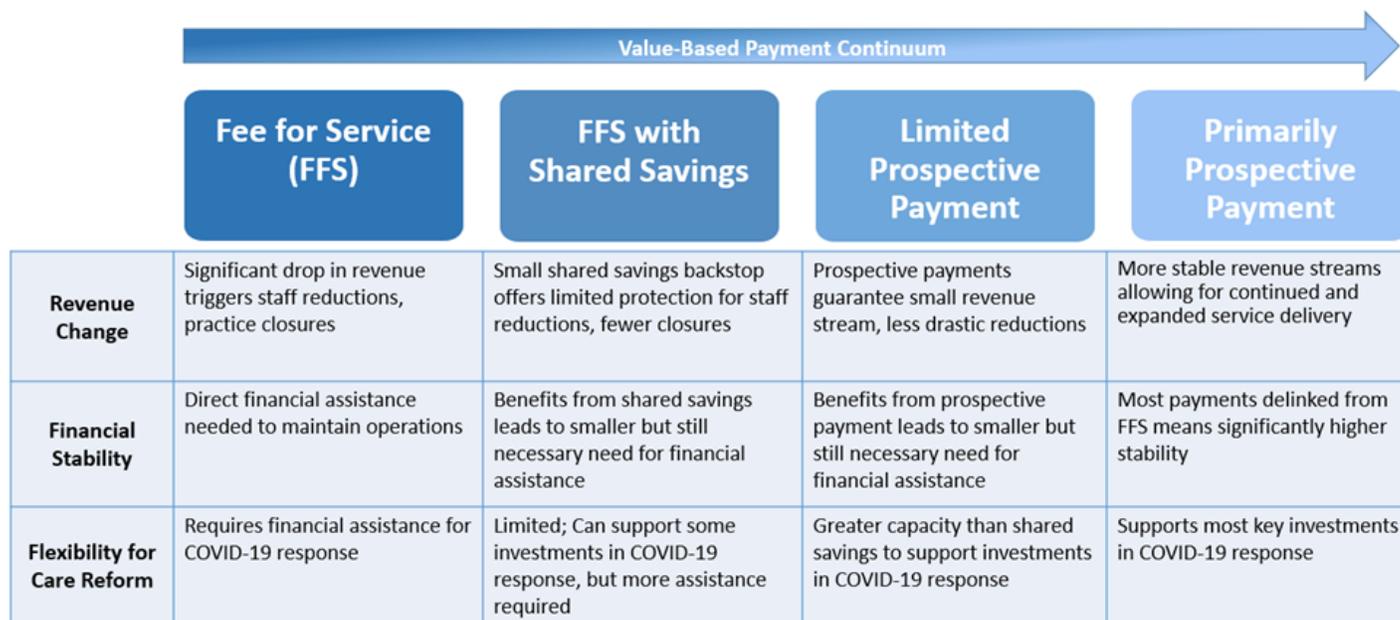


Figure 1. Effects of different types of payment models on providers' financial stability and ability to implement new care models during COVID-19 pandemic.

Current VBP arrangements predominantly fit into one of the middle two categories of Figure 1. Some “starter” VBP models pay providers through FFS, but also offer financial rewards (e.g., bonus payments) for satisfying spending and quality benchmarks. Participating organizations still [face many of the same short-term revenue challenges](#) as organizations receiving FFS payments only—that is, additional payments compensated for only a small degree of lost revenue. However, their shared savings payments, assuming they received them, provide a financial cushion for practices and allow them some financial flexibility for new care models. In 2018, approximately 21% of provider payments fell in this payment category (also known as LAN category 3A).

A smaller share of VBP models featured some level of prospective payments. The most recent HCP-LAN survey reports that approximately 9% of payments to providers involved some limited shared downside risk (LAN category 3B), and 5% were made through “population-based” arrangements (primarily capitated) in 2018 (LAN category 4). Based on expert interviews for this brief, we estimate prospective payments are often a small proportion of total revenue for many organizations, but around 10% of practices may receive significant prospective payments (more than 30% of their total revenue). The most likely place to find organizations taking on full capitation is in Medicare Advantage (MA), where 14% of total payments are population-based.

The financial flexibility to use prospective payments, or at least shared savings, for activities not covered under FFS has helped VBP organizations develop a wide range of capabilities. Adapted as needed, these tools are critical for effective COVID-19 responses. These capabilities include:

- dedicated staff and workflows to support care coordination and information sharing across providers and settings, including home- and community-based settings;
- robust data infrastructures enabling population health management, proactive identification of and communication with at-risk patient groups, and continuous monitoring and management of patients with chronic conditions; and
- established telehealth platforms capable of handling quick shifts from in-person care delivery to technology-supported virtual care delivery and management.

Health care organizations of all types and sizes are participating in value-based payment models that support these organizational capabilities. [Larger practices](#) and [hospital-based health systems](#) have built the needed infrastructure by leveraging capital reserves in their organizations (sometimes combined with access to investment capital, or bonds and debt for non-profit systems), and their economies of scale and capital reserves have also helped them manage financial risk. Smaller practices—including those focused on primary care, mental health, and specialty care—[often partner](#) with health plans, “VBP-enabler organizations” like [Aledade](#) and [Caravan](#), or delivery and payment experts for infrastructure, logistical, and administrative support.

Examples of VBP Used to Support COVID-19 Detection and Containment

Effective COVID-19 containment that reduces the risk of infection and transmission requires sustainable testing of symptomatic individuals and some at-risk asymptomatic individuals, isolation and treatment of COVID-19 patients, and the identification and quarantine of individuals in close contact with those who test positive. Health care organizations have an important role to play as they work with public health and businesses to minimize COVID-19 risks. Prior to COVID-19, VBP organizations were already leveraging their data infrastructure to identify people at risk of overall poor health, poor chronic condition outcomes, or hospitalizations or emergency department (ED) visits, and they leveraged relationships with other provider organizations across settings to better manage people’s health. VBP organizations can now apply those capabilities towards reducing COVID-19 infection and transmission by collecting and sharing key COVID-19 related data with public health agencies (Table 1).

Proactive outreach to prevent COVID-19 infection and transmission

To help patients prevent infection and transmission of COVID-19, health care organizations can engage in population health and prevention activities related to proactive identification, outreach, and support. This includes identifying individuals who may need testing or help limiting potential exposure to or transmission of the virus. Many VBP organizations have used claims and clinical data to create algorithms and other tools for identifying high-risk individuals and the support they need. They also use digital applications and other tools to facilitate screening, testing, and follow-up.

Table 1. Example Strategies for COVID-19 Detection and Containment by VBP Organizations

Strategy	Implementation Examples	Bundled/ Episode-Based Payments
<i>Proactive Outreach and Support to Prevent Infection and Transmission</i>	<ul style="list-style-type: none"> Algorithmic, data-driven identification of patients at overall risk for COVID-19 or poor outcomes from the disease Virtual wellness checks with directions for testing and care when needed 	<ul style="list-style-type: none"> Data infrastructure to track patient population Timely analysis of key data Workforce and networks to carry out patient outreach Infrastructure support from VBP-enabler organizations for smaller practices
<i>Access to Facilitated Testing & Supplies</i>	<ul style="list-style-type: none"> Optimized COVID-19 treatment and identification across VBP partners PPE protocols to reduce waste across VBP networks Leverage market presence to obtain supplies and share with partners 	<ul style="list-style-type: none"> Supply chain organization Clear and aligned protocols across practices
<i>Collection & Sharing of COVID-19 Data</i>	<ul style="list-style-type: none"> Acquisition and timely sharing of test results and other key data to address patient needs EHR-supported tracking of critical COVID-19 metrics Customized tools that efficiently gather and present COVID-19 data 	<ul style="list-style-type: none"> Interoperable data collection system

Organizations are also deploying care coordinators to connect with individuals at risk for contracting COVID-19 or those who have already tested positive. Care navigators are well-versed in identifying unmet needs and are already experienced in adapting workflows and allocating resources to manage them.

The list below highlights several examples of proactive outreach efforts from organizations receiving different types of value-based payments:

- [Carilion Clinic](#) is an Accountable Care Organization operating in Virginia. It has used claims and clinical data to identify patients at high-risk for either COVID-19 or other complications during the pandemic. It also implemented an outreach program to contact these individuals and inquire about their health status, as well as whether they needed information about COVID-19, assistance managing chronic conditions, or help addressing social needs.
- [Oak Street Health](#) has conducted similar outreach via a [remote care program](#). As part of the program, wellness checks are done via telephone and, if necessary, individuals are triaged to a COVID-19 hotline for further care. Patients with suspected or confirmed infections

are then enrolled in the organization’s COVID Care Disease Management Program.

- [Central Ohio Primary Care](#) is an organization of over 75 primary care practices that participates in payment arrangements involving shared savings, full risk, and per-member per-month pre-payments. It has reached out to over 4,000 high-risk patients to screen for COVID-19 symptoms and additional medical and social needs, while ensuring that patients can access ongoing telehealth-based outreach efforts.
- VBP-enabler organizations like [Aledade](#) also report widespread use of existing data analytics to identify the patients most at-risk from COVID-19—often older patients with chronic respiratory conditions—with subsequent outreach to schedule a “Stay Well at Home” visit via telehealth.

Facilitating access to testing and testing supplies

While most organizations no longer face critical shortages of tests and most supplies, they still face challenges managing their supply chain and ensuring providers can safely carry out any in-person visits. Connecting patients with testing and [obtaining the personal protective equipment \(PPE\)](#) needed to safely interact with patients is challenging, particularly for under-resourced skilled

nursing facilities (SNFs) and smaller, independent practices. By building cross-provider and cross-setting relationships, VBP organizations have been able to better implement screening and testing protocols, access necessary supplies, and quickly distribute them to smaller, under-resourced partner organizations. Efforts like this—which aim to improve population health outcomes and reduce total costs without focusing on a particular, reimbursable treatment—are often not possible under FFS models.

[Kaiser Permanente](#), an integrated delivery system in California, collaborated with partner 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 high-risk of contracting COVID-19. [Physicians of Southwest Washington \(PSW\)](#)—an independent physician association in Washington state that supports the management of full risk health plan contracts and ACO implementation—also created a distribution process in the early stages of the pandemic across the independent practices it supports, directing the delivery of PPE and gowns to SNFs and other high need facilities.

Collecting and sharing COVID-19 related data

To ensure effective COVID-19 testing and tracing activities, VBP organizations have collected and shared test and tracing data with appropriate health care and public health partners. They have done this by adapting preexisting data infrastructure and workflows to collect information about patient needs, coordinate services across providers and settings, and monitor the quality of delivered services.

Accountable Care Organizations like [New York City Health and Hospitals](#) are leading efforts to leverage existing data infrastructure and capabilities to track COVID-19 patients across settings of care, identify areas where utilization is surging, and allocate resources effectively. Other organizations use data to develop customized dashboards or tools specifically designed to gather and report COVID-19 related data in an easy-to-use format. [Providence St. Joseph Health](#) in Washington State developed the CoVERED Tool, which tracks COVID-19 case volume and resource utilization inside facilities; describes infection activity at a local geographic level for resource allocation and care support decisions; and leverages predictive analytics for decisions about triage, tests, and treatment.

Examples of VBP Used to Ensure Continuity of Care

Stay-at-home orders combined with efforts to promote physical distancing and limit safety risks have required health care organizations to develop and implement new strategies to ensure continuity of care for patients, whether through care at home or in settings that limit the risk of exposure. This will remain an ongoing concern as the country reopens, particularly for high-risk individuals (e.g., older adults with chronic conditions), those testing positive for the virus, or those exposed to it. To manage these challenges, VBP organizations have rapidly shifted to telehealth (as has many other care delivery organizations). But they have also implemented a range of additional, reinforcing steps to redesign care, supported by IT infrastructure and building on the capabilities they developed prior to the pandemic. These steps help VBP organizations reorient staff and workflows to support patients at home, develop and leverage partnerships to address unmet non-medical needs tied to health risks, and expand remote monitoring and use of alternative, lower-risk sites of care (Table 2).

Leveraging existing telehealth platforms and expanding telehealth offerings

Health care organizations have vastly increased the use of telehealth since the start of the pandemic, taking advantage of the [telehealth flexibilities](#) put in place by states and CMS. Such visits are significantly more convenient for patients and often preferred, but their effectiveness for many patients is uncertain, especially if clinicians have limited capability to deliver care remotely and limited experience doing so. Telehealth [utilization peaked in April](#), a sign that there may also be a natural limit to the number of visits an organization can do via telehealth alone. However, a recent [McKinsey study estimates](#) that \$250 billion in health spending could be virtualized. To succeed, health care organizations will need to implement financially sustainable models that utilize telehealth, diverse provider teams, and supporting technology in ways that can improve care equity, access to care, and overall quality.

Before the pandemic, VBP models gave organizations flexibility to regularly use telehealth-based models, using prospective payments or shared savings to invest in expanding platforms. These capabilities made them more prepared to ramp up their telehealth usage rapidly as shelter-in-place orders began.

[Coastal Medical](#), a Rhode Island primary care practice and ACO, expanded a texting platform

Table 2. Example Strategies for Ensuring Continuity of Care by VBP Organizations

Strategy	Implementation Examples	Bundled/ Episode-Based Payments
<i>Leverage & Expand Virtual Care</i>	<ul style="list-style-type: none"> Repurposed text alerts assessing the status of COVID-19 patients Broadened scope of virtual care based on patient needs and preferences (e.g., portals, audio-only, email, video) Shared services with partner organizations lacking established virtual care 	<ul style="list-style-type: none"> IT capacity for text messaging and video-conferencing Flexible tools to ensure equal access, especially to vulnerable populations, and ease of use
<i>Reorient Staff & Workflows</i>	<ul style="list-style-type: none"> Outreach and screening for health status and unmet medical and social needs Training staff on new care responsibilities Re-purposing staff such as care coordinators to new roles (such as patient outreach) 	<ul style="list-style-type: none"> Process to screen for medical and social risk factors in COVID-19 context Flexible staff with diverse skillset
<i>Address Social Needs</i>	<ul style="list-style-type: none"> Home delivery of essential goods, suitable meals, and prescriptions Connecting to mental health and community-based organizations Account for impact of social isolation 	<ul style="list-style-type: none"> Process to catalogue and record patient needs Established transportation network Partnerships with community organizations, businesses, and national delivery services
<i>Site-of-service shifts</i>	<ul style="list-style-type: none"> Adopt protocols to deliver services like advanced rehab, chemo infusion, and hospital care at home Move other procedures to various community settings with lower risks of COVID-19 transmission 	<ul style="list-style-type: none"> Training, workflows, and infrastructure to provide in-home services Provide patients with appropriate in-home monitoring tools and educate on their appropriate use

originally used to manage heart failure and hypertension to contact individuals at high-risk for COVID-19. The texts ask patients who have or are assumed to have COVID-19 whether they have a fever or difficulty breathing and how they feel compared to the day before. Almost 75% of patients responded in two hours, and clinicians follow up with those reporting problems. Additionally, VBP-enabler organizations such as Caravan Health and Aledade are providing partner organizations with [telehealth tools to help connect with patients in rural settings](#). VBP-enabler organizations have also [facilitated access to telehealth platforms for partner organizations](#) who have not yet built out their own capabilities.

Beyond replacing appointments, future efforts will more effectively ensure virtual care will provide flexible access to care. These new capabilities will

help improve outreach to vulnerable individuals, monitor individuals' health needs, and deliver essential services. For example, [Community Care Cooperative](#)—an ACO of Federally Qualified Health Centers—has a telehealth platform that delivers primary and behavioral health services and is [expanding to integrate population health programs, chronic care management, and other services](#).

Reorienting staff and workflows to support patients during COVID-19

During the pandemic, VBP organizations have used their flexibilities to quickly revise workflows and care pathways and retrain existing staff to new care models. This has allowed them to better coordinate efforts for people avoiding in-person care due to social distancing and ensure their chronic medical or mental health conditions can be managed effectively at home or in the community.

[Oak Street Health's](#) reorientation of its outreach and transportation program used structured tools to identify an individual's physical, mental, and emotional needs. Outreach callers then contacted individuals and screened for unmet needs in those domains. If needed, staff coordinated the delivery of medical supplies, food, and other appropriate services to patients by its fleet of drivers and vans traditionally used to transport patients to and from clinic appointments. [In a practice supported by Caravan Health](#), nurses reached out to patients with known diagnoses of depression or anxiety to check-in, assess their mental health status, identify any unmet mental health needs, and connect them with appropriate support.

Developing processes to address social needs

In addition to identifying and addressing medical needs, VBP organizations have also taken steps to address new social risk factors during the pandemic. Most VBP organizations have already built some level of population health management capabilities, equipping them to respond more effectively as the scale and types of need evolved with COVID-19. Stay-at-home orders make ensuring access to safe housing and essentials such as fresh and healthy food even more critical, but also more challenging. Addressing social needs can flow naturally from similar efforts to ensure continuity of care, reinforcing the importance of effective care coordinators. In addition, partnerships with community organizations or businesses have enabled VBP organizations to direct resources to non-medical supports that help avoid health complications.

[ChenMed](#), a full-risk primary care provider organization, developed a program to identify ways to keep individuals safe and healthy at home and prevent avoidable emergency department and hospital admissions. One particular facet of this program uses the Instacart App to facilitate [home delivery of meals, prescriptions, and household goods](#) to patients who are unable to travel or who are sheltering-in-place as a COVID-19 precaution. Similarly, [Triad Healthcare Network \(THN\)](#), an ACO, implemented a heart healthy meal program for its Heart Failure patients in an effort to prevent diet-induced heart failure exacerbations and prevent any unnecessary trips to the hospital. This outreach coincided with a Medically Tailored Meal project using a national vendor to provide food to cardiac and ESRD patients where poor food choices may contribute to ED and hospital utilization. To stand up their COVID outreach, THN partnered with philanthropy and collaborated with local restaurants to develop a week's worth of reasonably priced, readily available meal options that met the American Heart Association's guidelines for heart healthy

eating. These meals were delivered to their patients using a local transportation service and members of the health system whose positions were furloughed.

Further, [MedStar Health](#), leveraging its work with a Baltimore Accountable Community for Health and the Maryland Primary Care Program, has trained community health workers in vulnerable zip codes to perform social drivers of health screenings and connect people to community-based organizations and care managers to provide acute care transitions and longitudinal care management. After COVID, these community health workers and care managers mobilized to create a common COVID discharge protocol across all hospitals to assess self-isolation needs, such as food and supplies, caregiver support, home health needs, prescriptions fill status, symptom check-ins, and the scheduling of follow-up appointments. In one month, they reached out to approximately 1000 COVID-positive discharges, with 80% of them resulting in connections and more than half of successful connections needing one or more of the above services.

Shifting site of service closer to home and community

For procedures and services that require contact with health care providers, VBP organizations have reformed care pathways to increase access to services in home or in community-based settings. These approaches not only reduced risk of COVID-19 exposures but were often more convenient and less costly for patients. For example, Penn Medicine, a health system participating in value-based contracts, has transitioned some chemotherapy patients [to receive at home treatment](#) for conditions that once required hospitalization. In addition to providing cancer treatments at home for a lower cost without sacrificing quality, significant potential exists to expand the successful [Hospital-at-Home](#) model (such as with an [Oncology Hospital at Home](#).) Advocate Aurora Health, which operates 3 ACOs, launched two programs – [Home Hospital and Recovery at Home](#)—in just five weeks following the delay or cancellation of in-person services. In each program, providers carry out virtual home visits to manage the transitions from the hospital to post-acute care to home care while providing patients with oxygen or a pulse oximeter to help report vitals.

Lessons Learned & Policy Implications

The preceding examples demonstrate the variety of ways in which a care infrastructure supported by VBP provides flexibility that allows organizations to adapt and pivot their care delivery models based on local needs and people's goals, even in a pandemic.

The financial flexibility and stability offered by prospective payments, and often possible under shared savings arrangements, allowed organizations to develop, implement, and be reimbursed for innovative care approaches and to implement strategies not directly linked to reimbursement. Amidst COVID-19, VBP organizations have used this flexibility in the following areas to develop capabilities critical for an effective response:

- **Data Infrastructure:** Robust data systems helped VBP organizations quickly identify and reach out to individuals at-risk of contracting COVID-19 and to keep high-risk patients out of the hospital due to worsening chronic conditions
- **Telehealth and Home-Based Care:** Using their existing telehealth infrastructure, VBP organizations were able to more rapidly ramp up virtual appointments supported by digital technologies and care teams. VBP organizations could thus continue the management of their patients' medical and social needs, minimize the time commitment required of patients to obtain necessary care, and allow for more efficient outreach as need arise. Expanding telehealth capabilities also helped organizations better determine which advanced services could be delivered safely and cost-effectively at home.
- **Workforce:** Redeploying staff hired to support value-based care, such as care coordinators, offered greater flexibility for monitoring patients during social distancing and addressing key risk factors.
- **Social needs:** A patient's non-medical risk factors can often have just as strong of an impact on their overall health and COVID-19 risk. By redeploying staff and leveraging their existing partnerships, VBP organizations were able to address a broader range of social needs.

Increasing opportunities for organizations to participate in VBP reforms can help them respond more effectively to COVID-19. Public and private payers could offer short-term funding to begin implementing the capabilities described here in exchange for a commitment to participate in VBP arrangements in the near future. This approach could mirror programs like the [ACO Investment Model](#).

Such investments would help providers participate in pandemic response and care reforms. Recent

legislation (e.g., [Paycheck Protection Program and Health Care Enhancement Act](#)) and the [CARES Act](#) have provided financial relief to health care providers, helping to retain staff and better serve patients. But prior relief has included only limited support or pathways for providers to implement feasible and sustainable care reforms. The CARES Act also allocated funds for public health data surveillance and infrastructure modernization efforts at the Centers for Disease Control and Prevention as well as at state and local health departments. However, these legislative actions included only limited steps to encourage provider and public health collaboration around effective testing of symptomatic individuals, isolation and community-based treatment, and contact tracing – for example, by supporting providers that implemented adjustments to their IT systems to share timely electronic data and participate with state and local public health initiatives to contain outbreaks.

Similarly, while CMS, states, and many private payers now pay for telehealth visits at parity with in-person visits during the pandemic, several challenges remain. As with data capabilities, many organizations lack the capital to develop supporting technologies and hire the additional staff necessary to move beyond individual visits into well-developed virtual systems of care. The [Health Resource Services Administration's \(HRSA\) Telehealth Network and Telehealth Resource Centers Grant Programs](#) and the [Federal Communications Commission's \(FCC\) COVID-19 Telehealth Program](#) offer some support, but the \$316 million in total funding may not be adequate, especially to support monitoring and care teams.

Policymakers should also consider whether providers see a long-term [sustainable path for care reforms](#) that should be continued beyond the pandemic. If telehealth is to remain a major mode of care delivery, particularly for high-risk groups, broader flexibility will be important to sustain it, as well as [remote physiologic monitoring \(RPM\)](#) and site-neutral chronic care or advanced management. CMS does not have the authority to [extend these models](#) broadly [after the public health](#) emergency, in part because the budgetary costs are likely substantial. In contrast, broader telehealth coverage is already available in Medicare's advanced alternative payment models. Consequently, these reforms will be more sustainable and affordable if more providers move into VBP arrangements. Supports for such shifts to VBP now, tied to further relief payments, will give providers a clearer path to making the needed investments to sustain home- and community-based care models.

Conclusion

The COVID-19 pandemic has placed unprecedented demands on all health care organizations, but organizations participating in VBP arrangements are best positioned to respond to them. Financial flexibility has allowed for more comprehensive delivery models that support care coordinators, data infrastructure, telehealth, and other home-based care capabilities that improve COVID-19 care and continue to meet broader health and social needs. These examples illustrate how a shift toward value-based payment could allow more health care organizations to respond effectively to this pandemic and build a more sustainable health care system for the future.

Acknowledgements

We would like to thank the following individuals and organizations for talking with us during our information gathering stage for this issue brief. They provided crucial insight as well as answered key questions we had, and we greatly appreciate their time and contributions to this work. The viewpoints expressed in this brief do not necessarily reflect the viewpoints of the individuals below nor their organizations.

- Mara McDermott, McDermott+Consulting
- Art Jones, Health Management Associates
- Lisa Dombro, Agilon Health
- William Wulf, Central Ohio Primary Care
- Ryan Knopp, Stonecreek Physicians ACO
- Meena Seshamani, MedStar Health
- Vicki Loner, OneCare Vermont
- Ashley Ridlon, Niko Lewine, and Josh McPhee, Evolent
- Will Shrank, Humana
- Travis Broome and Annette Dubard, Aledade
- Melanie Matthews, Physicians of Southwest Washington
- Stephen Petzinger and David Chokshi, New York City Health+Hospitals
- Debra Thompson, Vidant
- Stephen Parodi, Kaiser Permanente
- Griffin Myers, Oak Street
- Elissa Langley, Triad Healthcare Network
- Rhonda Medows, Providence St. Joseph Health and Ayin Health Solutions

We would like to thank members of our broader research team at Duke University's Robert J. Margolis for strategic guidance and support, including Patty Green, Elizabeth Murphy, and Don Taylor.

Mark B. McClellan, MD, PhD, is an independent board member on the boards of Johnson & Johnson, Cigna, Alignment Healthcare, and Seer; co-chairs the CEO Forum for the Health Care Payment Learning and Action Network; and receives fees for serving as an advisor to Blackstone Life Sciences, Coda, and Mitre. Dr. Bleser has previously received consulting fees from Merck on vaccine litigation unrelated to this work and serves as Board Vice President (uncompensated) for Shepherd's Clinic, a clinic providing free healthcare to the uninsured in Baltimore, MD. Robert Saunders has a Consulting Agreement with Yale-New Haven Health System for development of measures and development of quality measurement strategies for CMMI Alternative Payment Models under CMS Contract Number 75FCMC18D0042/Task Order Number 75FCMC19F0003, "Quality Measure Development and Analytic Support," Base Period. The Duke-Margolis Center for Health Policy values academic freedom and research independence, and its policies on research independence and conflict of interest are available at: <https://healthpolicy.duke.edu/research-independence-and-conflict-interest>.

Support for this brief was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation. We would like to acknowledge specific support and interest from Katherine Hempstead, PhD.

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