THE NEXT DECADE OF VALUE-BASED CARE

PROVIDERS WHO GAIN A FOOTHOLD IN VALUE-BASED CARE TODAY WILL BE BETTER POSITIONED FOR THE FUTURE OF CARE DELIVERY
KEY TAKEAWAYS

- The percentage of value-based payments has risen three years in a row, and provider organizations are now facing federal and state pressure to take on real risk in these arrangements.
- A number of factors – including bipartisan support for value-based programming, the rise of Medicare Advantage and the demand from consumers for more convenient care – suggest that a future in which health systems are held accountable for patient outcomes is inevitable.
- To prepare, healthcare leaders must commit to building on early progress and make significant financial, procedural and personnel investments that create efficiencies and improve care coordination.
- Doing so successfully requires investing time and money into developing care teams, creating the right incentive structures and adopting data-driven tools and technology.

VALUE-BASED CARE, BY THE NUMBERS:

36% More than a third of national reimbursement contracts are now value-based, according to the Health Care Payment Learning & Action Network. This percentage has trended upward every year since 2015.

65% In New York state, the rate is even higher – more than two-third of managed care organization spend is value-based as part of the state’s Delivery System Reform Incentive Payment Program.

54% Nationally, more physicians are participating in at least one accountable organization than not – this figure jumped 10% over the last two years, according to the American Medical Association.¹
The Affordable Care Act launched the country’s transition from a purely fee-for-service system to one that rewards value instead of volume, and over the last ten years there has been a slow but steady increase in the percentage of payments tied to value-based care.

According to the most recent data released by the HCPLAN, the percentage of value-based payments reached nearly 36% in 2018, up from 34% in 2017, 29% in 2016 and 23% in 2015. Meanwhile, more than half of all providers are now participating in at least one ACO type, including Medicare, Medicaid and commercial programs.

Over the last decade, a challenge for health systems has been that while these percentages continue to trend upward, the vast majority of system revenue remains through the fee-for-service model. As a result, some providers have been slower to transition than others. But the paradigm is shifting – the future of healthcare is a model where consumers have more power than ever, and quality and value are competitive differentiators.

For this reason, and in light of value-based trends from payers and consumers, health systems must embrace these models as tools for future success. This will require developing truly integrated care teams, establishing the right financial incentives and making increased investments in data tools and technology.

VALUE-BASED PROGRAMMING IN NEW YORK STATE

While the federal government has played an important role in driving reimbursement reform nationwide, states have made substantial inroads, too. New York state has embraced a number of innovation waivers, reimbursement models and value-based pilots. Below are two of the major value-based initiatives in the state.

Delivery System Reform Incentive Payment Program
This collective effort to transform the state’s Medicaid healthcare delivery system was built around the primary goal of reducing avoidable hospital use by 25% over five years. The program comprises three levels of risk, beginning with Level 1, or fee-for-service and upside-only shared savings. Level 2 is fee-for-service with upside and downside risk, and Level 3 is per-member-per-month capitation or outcome-based bundled payments with both upside and downside risk. As of April 2019, just under 75% of total Medicaid MCO expenditure is in Levels 1-3. The DSRIP waiver expired at the end of March 2020. A four-year extension and $8 billion requested by the state was not approved by the federal government.
THREE PREDICTIONS FOR THE NEXT DECADE OF VALUE-BASED CARE

1. Reimbursement reform will maintain bipartisan federal support.

The Affordable Care Act kickstarted the creation and implementation of value-based care models, and while the law itself is controversial, value in healthcare is a bipartisan issue.

Seema Verma, President Trump’s pick for CMS administrator, recently argued that value-based care is the nation’s only alternative to Medicare-for-All, imploring health systems to “choose to put patients first by moving to a system of competition and value, giving patients the choice and control they want, the affordability they need and the quality they deserve.”

Most recently, the Trump administration further demonstrated commitment to value-based care by proposing reforms to Stark Law regulations to make it easier for physicians entering into value-based arrangements to collaborate without fear of reprisal.

2. Providers will be pushed to take on more downside risk.

CMS’ dramatic overhaul of the Medicare Shared Savings Program, the largest value-based payment program in the nation, indicates that the government will continue to pressure providers to take on real risk in the coming years, and commercial payers will likely follow suit.

With 518 ACOs treating 10.9 million beneficiaries as of July 2019, CMS now requires participating ACOs to assume downside financial risk sooner. Previously, an ACO could participate in a shared-savings track for six years before assuming downside risk; now ACOs will only have two or three years depending on their organization.

VALUE-BASED PROGRAMMING IN NEW YORK STATE

NYS PCMH

As a State Innovation Model from the Centers for Medicare and Medicaid Services, New York’s State Health Innovation Plan aims to achieve 80% of the population receiving care through an integrated care-delivery model like the New York State Patient-Centered Medical Home. In collaboration with the National Committee for Quality Assurance, the NYS PCMH recognizes primary care providers that achieve healthcare delivery transformation. The designation requires practices to participate in at least one value-based payment program, and practices may be eligible to receive other enhanced reimbursement opportunities.
Another example is the Next Generation ACO Model, an initiative for ACOs experienced in population care coordination. Participating provider groups take on more risk, and access higher rewards, than through other payment models. In its first year, the Next Generation ACOs generated $62 million in savings.\(^7\)

In New York, the goal outlined in the DRSIP waiver is more than 35% of MCO spend in Level 2 or higher by the end of the year, representing additional downside risk for providers in the state.

3. The rise of Medicare Advantage will increase pressure on providers to participate in value-based arrangements.

Medicare Advantage plans are designed to improve the health of beneficiaries through efficiency. These plans and their provider partners have adopted value-based models quickly and more successfully than other payers – in 2016, more than $4 of every $10 in Medicare Advantage was paid through an alternate payment model.\(^8\)

This trend is especially significant as Medicare Advantage plans grow in market share. The number of Medicare Advantage beneficiaries has nearly doubled over the last decade to more than one-third of total Medicare beneficiaries. By 2029, that percentage is expected to grow to almost half.\(^9\)

At the same time, CMS and Congress have continued to give Medicare Advantage flexibility to innovate when it comes to value-based models, including structuring benefit plan designs to encourage the utilization of high-value providers by eliminating or reducing cost-sharing for beneficiaries and increasing telehealth access. Altogether, Medicare Advantage’s success with alternate payment models, combined with nationwide plan growth and increased innovation, suggests further pressure on providers to participate in these models.
WHAT IT TAKES TO DELIVER HIGH-QUALITY, VALUE-BASED CARE

The increasing percentage of value-based reimbursement is daunting, no matter the sophistication or experience of the organization. It requires, as it has for the last decade, having a foot in both worlds and optimizing two different infrastructures. For example, systems must maintain the administrative capability to handle fee-for-service claim processing, while also investing in and implementing the HIT required to achieve value-based care metrics.

Even early participants in shared savings programs may find the increasing trend of downside risk concerning. But while upside-only contracts may comprise the majority of value-based arrangements today, the national focus on price and value will increasingly push providers to take on more responsibility when it comes to utilization and cost, and a majority of value-based relationships could include both upside and downside risk within three to five years.\(^{11}\)

In response, health systems must approach the concept of value-based care with a spirit of innovation – a proactive response will protect against obsolescence in the new future of value-based care. Doing so will require systems to invest in integrated care teams, the right incentives and data tools.

**Integrated care teams:** Much of health spending is concentrated in a small population of high utilizers, and treating these patients effectively requires dedicated care coordination. An integrated care team would ideally represent inpatient, outpatient and primary care providers, including nurses, general practitioners, hospitalists and clinical pharmacists, as well as case-specific clinicians, such as physical therapists or behavioral health providers.

Research on care teams’ impact on value-based arrangements has been limited, but reports indicate the potential for cost reduction. Consider this case study from Johns Hopkins Community Health Partnership, which resulted in $113.3 million in savings.

The study included both acute care intervention and community intervention of Medicare and
Medicaid patients. The ACI bundle aimed to improve post-discharge transition planning, while the CI initiative included care coordination and behavioral support from primary care sites. The care coordination effort resulted in reduced hospitalizations, emergency visits, readmissions and avoidable hospitalizations and an average savings of $1,643 per beneficiary per quarter.\textsuperscript{12}

Integrated teams take a patient-centered view of care episodes that span multiple disciplines and care sites. They can also incorporate community resources to address social determinants of health. To do so first requires identifying the relevant social risks for a system’s patient population, which may include food insecurity, tobacco management, medication access, housing and transportation. Once a “social diagnosis” has been identified, a “social prescription” or referral can be made through alliances with social services groups.\textsuperscript{13}

Health systems in New York state and nationally have invested at different levels when it comes to care team programming, and this is an area of opportunity. Many systems are coordinating at the practice level, but few have system-wide strategic plans when it comes to care management.

The right incentives: When it comes to working with private payers or other non-government entities, providers should feel empowered to advocate for and seek out arrangements that set them up for success. They can work with payers to clearly identify the targeted population(s) and service(s), arrive at a shared definition of value that all participants buy into – including outcomes, utilization and patient satisfaction – and determine the appropriate level of risk or reward to take on. Commercial value-based contracts vary widely and finding the right combination of the above factors is crucial for providers’ success.

When it comes to government programs, providers have less influence over the specifics of particular value-based programs, but that doesn’t mean that they can’t successfully advocate for continued reform. Payment innovation is still very much in the early stages, and there is an opportunity for all impacted
stakeholders to have a voice in shaping the future. Health systems can take a leadership position in advocating for policies that support improved patient outcomes while also ensuring system sustainability.

**Data tools and technology resources:** You can’t manage what you can’t measure, and value-based care requires providers to assume a mindset in which everything is potentially improvable. From the reduction of unnecessary imaging and the real-time tracking of preventative care, to the insight and integration necessary for aligning services with better outcomes at lower costs, the success of value-based models absolutely hinges on having the right data.

Historically, a lack of current cost and quality information has been the biggest limiting factor for physicians navigating the volume-to-value transition. Over the past few years, however, a number of technology vendors have emerged with solutions that give providers access to real-time clinical data and insights that bridge gaps in care and help them manage care more efficiently.

In addition to lack of data, the prevalence of disparate technology systems has also been a core issue. However, many of the same solutions that now deliver real-time data to providers have EHR-agnostic designs and have been created to slot into existing provider workflows.

Adopting and implementing this technology represents an upfront investment for health systems, but it also represents a long-term vision for both better care coordination and the subsequent upside rewards. Beyond making it easier to succeed in value-based arrangements, these platforms also position providers for financial success in Medicare Advantage, a multibillion-dollar market.
IMPLICATIONS FOR HEALTH SYSTEMS

Whether value-based payment models ever become the primary reimbursement structure for health systems or not, there’s no doubt the system of the future will continue to place substantial emphasis on quality and costs – and holding providers accountable. Here are four recommendations for hospitals and health systems.

**Recognize that value isn’t an all-or-nothing game.**
It’s unlikely that the healthcare system will complete a transition to a fully value-based reimbursement model in the next decade, but it is also unlikely that payers seeing success in both quality and cost outcomes will reverse course any time soon. For most providers, revenue management will remain a balancing act.

**Look for value-based incentives beyond contracts.**
Payers look poised to tie more reimbursement to value, which will likely accelerate provider transitions. But there are other business reasons to build a foundation for value-based care. As consumers demand more patient-oriented care, quality and patient satisfaction will have tangible competitive advantages.

**Build or update your strategic technology plan**
Coordinating care among an integrated team of clinicians will require interoperable technology, but the digitization of data, better cloud-sharing and the advent of AI mean that technology investments must be strategic. Systems can stagger their investments to address pressing needs while preparing for future advancements.

**Pursue partnerships to improve outcomes.**
In the next decade, healthcare will continue to decentralize from the hospital and into the community. To meet patients where they are and to provide them with the resources they need, hospitals and health systems will have to align with primary care practices, top-of-the-funnel care sites such as urgent care and social services organizations.
10. CMS: “Medicare Advantage Value-Based Insurance Design Model Calendar Year 2021 Fact Sheet.” Published: 2019.
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