

## Unlocking the potential of value-based care in Medicare Advantage

### Executive summary

Are health plans effectively engaging providers in testing value-based care (VBC) arrangements in Medicare Advantage (MA)? Results from Deloitte's 2015 Study of MA Health Plans and Providers suggest that there is great – and unrealized – potential. As yet, the business case for VBC in MA is not evident to all stakeholders.

Several forces are aligning to encourage VBC arrangements in MA. While many health plans' MA enrollment may be smaller than their commercial lines of business, it represents a growing opportunity, especially given the potential for care and cost improvements in this population.<sup>1</sup> In addition, MA business contributes considerably to overall health plan revenue, and profit margins are holding steady at five-to-six percent.<sup>2</sup> Finally, the combination of Medicare Star ratings bonuses, risk-adjustment revenue, and the federal government's focus on strengthening value and quality in Medicare has helped to refine the approach to MA contracts.

Four overarching themes about VBC in MA emerged from this study:

- **Most health plans and providers are experimenting with VBC arrangements in MA:** Nearly all of the surveyed health plans and providers have some type of VBC arrangement in place for their Medicare populations. Patient-centered medical homes (PCMH) are the most common arrangement reported by health plans. Providers report more VBC activity with traditional Medicare than with MA health plans.
- **VBC strategies are similar in commercial and MA lines of business, but health plans see greater value potential in MA:** Most health plans' overall VBC strategy is strongly aligned across commercial and MA lines of business. However, MA's high per-member/per-month (PMPM) costs and disease burden can present greater opportunities for savings and quality improvements.

- **Federal policies, initiatives, and regulations influence MA VBC strategies:** Aspects of the MA program that help health plans optimize revenue (e.g., quality bonuses and risk adjustment) are important drivers of VBC strategy in MA. Medicare Star ratings bonuses and other quality-focused initiatives encourage a systematic approach to quality improvement that is best achieved through health plan and provider collaboration.
- **Health plans and providers have challenges to overcome in the MA VBC space:** Many of the surveyed health plans struggle to identify the right provider partners and work with them effectively. Meanwhile, providers have mixed feelings about VBC contracting in MA. Provider respondents acknowledge that VBC arrangements can lead to higher-quality care and patient satisfaction, but many are skeptical about VBC's impact on cost, their bottom line, and staff satisfaction. Few are convinced that VBC arrangements with health plans are a win-win. As a result, many providers are reluctant to take on risk, which has slowed adoption of VBC models. Moreover, despite active encouragement from health plans, there is little evidence of provider adoption of clinical innovation in care delivery.

The study's findings highlight a tension between health plans and providers: as yet, health plans have not effectively sold providers on the business case for MA VBC. To accelerate adoption, both plans and providers should consider investing more in data-sharing and analytics capabilities. Health plan respondents suggest that their organizations have deep analytics expertise and the ability to combine medical and pharmacy data; providers bring to the table clinical expertise and granular clinical information. Joining forces and data will likely be essential to achieve the Triple Aim and unlock the full potential of MA VBC arrangements.

## Introduction

For many health plans, Medicare Advantage (MA) represents a substantial and growing share of overall enrollment and revenue. MA enrollment has grown in recent years; currently, 30 percent of all Medicare beneficiaries are in MA plans.<sup>3</sup> Profit margins continue to stay around five or six percent.<sup>4</sup>

Across all lines of business, health plans are under immense pressure to control costs and improve quality. Purchasers – whether employers, states, or the federal government – are demanding payment reform, lower costs, and better outcomes. The US Department of Health and Human Services (HHS) and US Centers for Medicare and Medicaid Services (CMS) have set clear goals and a timeline for shifting Medicare reimbursements from volume to value and are testing new models through various payment reform initiatives. Health plans are responding with, among other

things, the launch of the Health Care Transformation Task Force, whose members aim to have 75 percent of payments based on value by 2020.

Within this context, Deloitte researchers sought to determine to what extent health plans participating in MA use it to test VBC arrangements. In addition, we sought to identify barriers and drivers, explore differences, and determine characteristics of leading VBC arrangements in the MA marketplace. (See Appendix 1.)

Findings from the *2015 Study of Medicare Advantage Health Plans and Providers* suggest that there is great – as yet unrealized – potential for both health plans and providers in MA VBC arrangements.

## HHS and CMS Medicare reform initiatives

-  HHS has set clear goals and a timeline for shifting Medicare reimbursements from volume to value (90 percent by 2018).
-  600+ accountable care organizations (ACOs) served more than 50 million patients in 2014, and recent changes to the Medicare sustainable growth rate (SGR) formula will accelerate change. At the beginning of this year, CMS also launched the Next Generation ACOs.
-  The Delivery System Reform Incentive Payment (DSRIP) Program aims to fundamentally restructure the health care delivery system to a fee for value model. Six states have implemented DSRIP initiatives.
-  There is growing momentum across the market in incentive and value-based contracts, including launch of the Health Care Transformation Task Force (whose goal is 75 percent by 2020).
-  CMS is increasingly interested in testing new VBC models with MA plans, including value-based insurance design (VBID) model testing and requesting information on VBC contracting arrangements from MA plans.

## Most health plans and providers are experimenting with VBC arrangements

The great majority of the health plans and providers participating in Deloitte's study are experimenting with variations and combinations of five main types of value-based payment models. (See Figure 1.)

**Figure 1. What are value-based payment models?**



### **Patient-centered medical home (PCMH)**

A team-based model of care, typically led by a primary care physician who is focused on the whole person and provides continuous, coordinated, integrated, and evidence-based care. Physicians may receive additional payments (e.g., care coordination and/or performance-based incentives) on top of fee-for-service (FFS) payments.



### **Shared savings**

Generally calls for a provider organization to be paid using the traditional FFS model, but at the end of the year, total spending is compared with a target; if the organization's spending is below the target, it can share some of the difference as a bonus.



### **Shared risk**

In addition to sharing savings, if a provider organization spends more than the target, it must repay some of the difference as a penalty.



### **Global capitation**

A provider organization receives a per-person, per-month (PP/PM) payment intended to pay for all individuals' care, regardless of what services they use.



### **Bundles**

Instead of paying separately for hospital, physician, and other services, a payer bundles payment for services linked to a particular condition, reason for hospital stay, and period of time. A provider organization can keep the money it saves through reduced spending on some component(s) of care included in the bundle.

Source: Deloitte Center for Health Solutions, "The road to value-based care" (<http://dupress.com/articles/value-based-care-market-shift/>)

**"The vast majority of compensation for care is not in VBC contracts today. It likely will take several years before VBC becomes a significant portion [of our business]."**

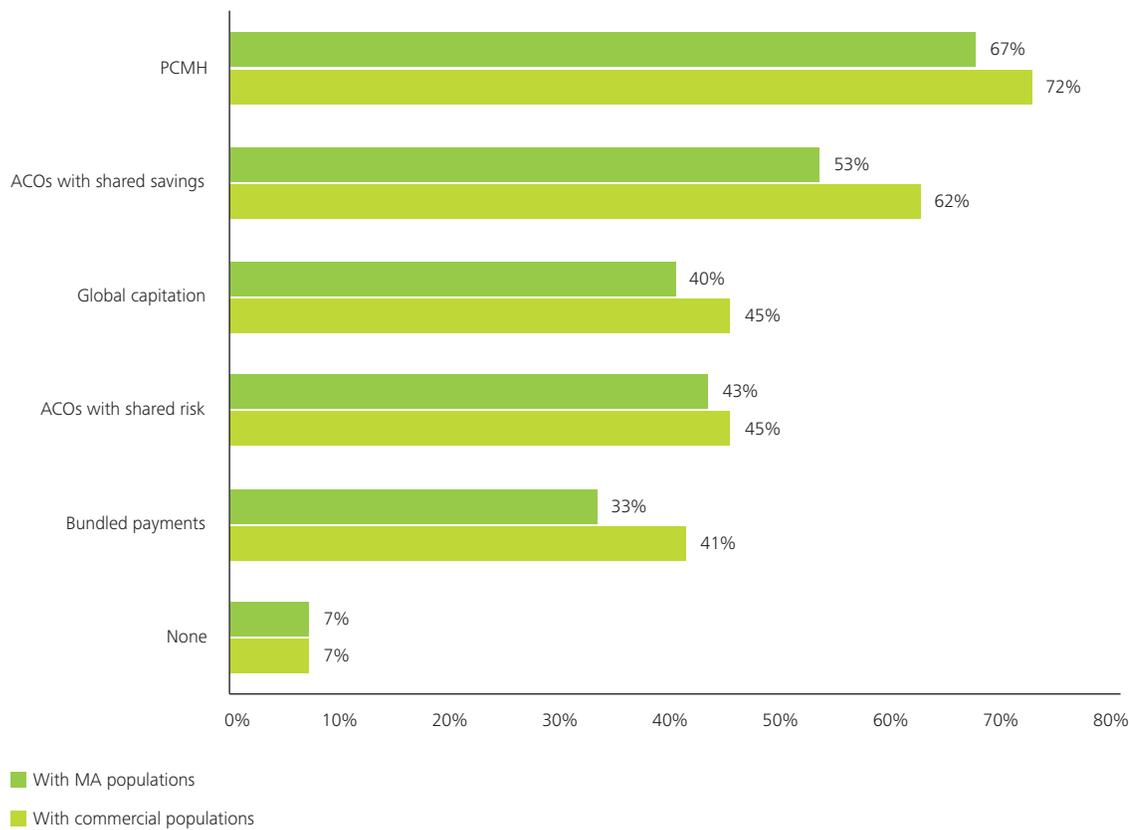
VP, Networks, Regional Health Plan

### Health plan perspective on VBC contracting

Nearly all (93 percent) of the health plan respondents say they have some type of VBC arrangement in place. Many of these arrangements are in early stages and often carry upside-only risk for providers. Health plans report more activity with commercial populations than with MA populations across all types of VBC arrangements.

PCMHs are health plan respondents' most common VBC arrangement: 67 percent report having PCMH arrangements in their MA population, and 72 percent have one or more PCMHs in their commercial population. (See Figure 2.)

**Figure 2. Types of VBC arrangements reported by health plans**



Source: Deloitte Center for Health Solutions, 2015 Study of Medicare Advantage Health Plans and Providers

The PCMH model strengthens health plans' relationships with physicians and enables better coordination around care management (CM) and closing gaps in care. These benefits are, perhaps, why health plans have high PCMH adoption rates. PCMH arrangements allow health plans to work with physicians to capture member conditions and acuity and drive Medicare Star ratings. Required health risk assessments have a dual purpose of helping health plans to identify newly enrolled members or those due for an annual "wellness" visit and to encourage members to see their primary care provider (PCP). Health plans actively encourage PCPs to carefully evaluate and document members' conditions during these visits.

In-depth interviews with health plan leaders that have implemented PCMH arrangements suggest that while PCMH arrangements differ, health plans often structure them as a modified FFS reimbursement model, which makes adoption easier both for physicians and for health plans. Most interviewed health plans share data with physicians at least once a quarter and make other significant investments, including higher payment rates or additional care coordination fees; health plan-funded staff resources such as nurse care managers and/or pharmacists; and analytics support around clinical integration and population health management.

Local market dynamics may inform health plans' choice of VBC arrangements. Plans with a large local market share, for example, typically attempt to engage with most of the provider community, making PCMH a top priority. On the other hand, health plans with a relatively small local market share tend to partner with health systems rather than with smaller provider organizations. This suggests a preference toward partnering with relatively sophisticated organizations, perhaps those that already have experience with CMS accountable care organizations (ACOs).

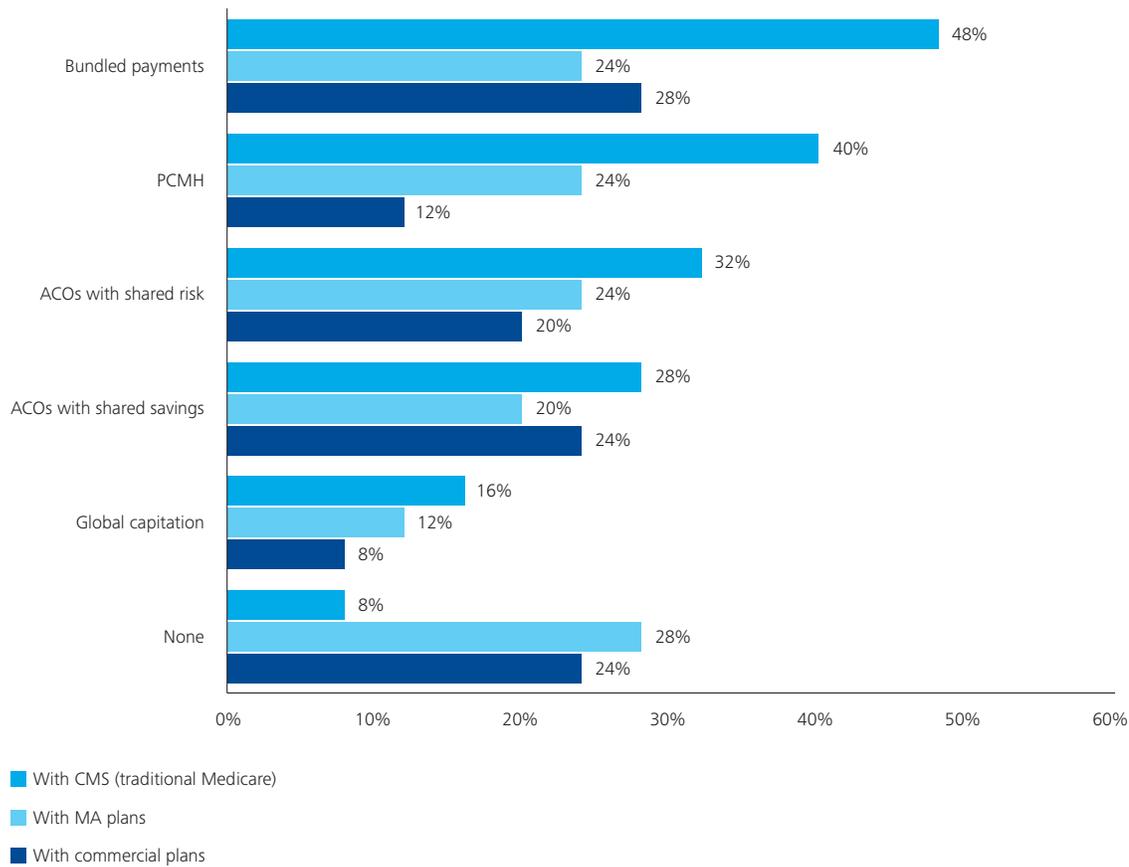


### Provider perspective on VBC contracting

The study results suggest that CMS is the largest source of VBC contracts for providers, and most providers' VBC activity is in traditional Medicare. Twenty-eight percent of provider respondents indicate they do not have any VBC contracts with MA plans, and 12 percent (not shown) say they have no VBC contracts with private health plans. The most commonly reported VBC arrangement is bundled payments with CMS (48 percent), which may be a reflection of the recent rollout of the CMS bundled payment initiative.<sup>5</sup> (See Figure 3.)

Many provider respondents (65 percent) believe that participating in VBC programs with CMS will help them succeed in VBC arrangements with health plans. A smaller proportion (55 percent) also says that VBC arrangements with health plans will help them be successful with CMS.

**Figure 3. Types of VBC arrangements reported by providers**



Source: Deloitte Center for Health Solutions, 2015 Study of Medicare Advantage Health Plans and Providers

### Investments in new clinical models

While many health plan respondents (77 percent) think that VBC creates opportunities for clinical innovation that improves access to care at the right time and the right place, provider respondents are less likely to think so (40 percent), and our study found little evidence of provider-based innovation thus far.

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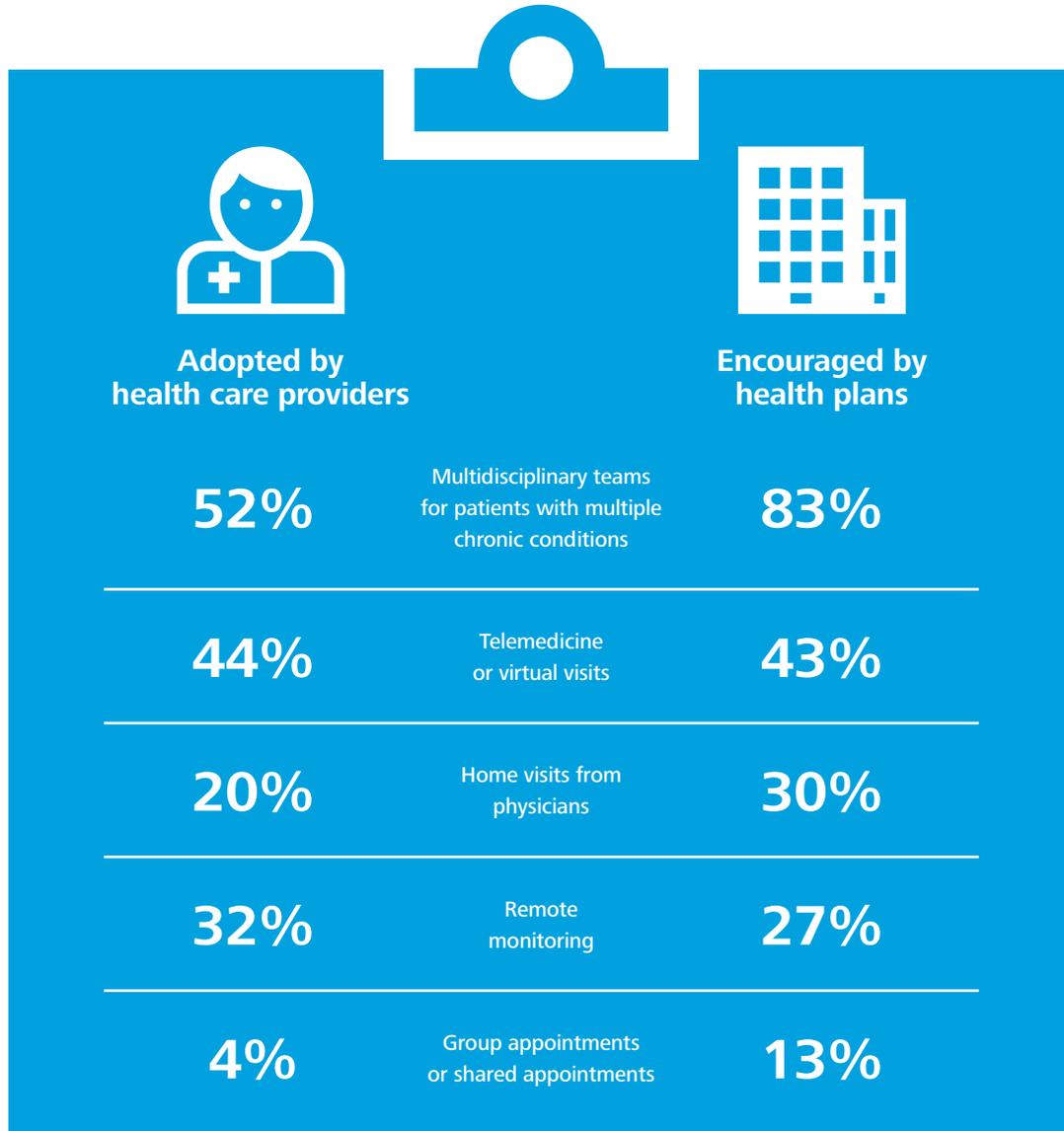
“Twenty percent of readmissions are due to patients not taking their drugs correctly post-discharge. Investing in pharmacy gives the best bang for the buck. We do this with highest-risk patients: congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), heart attack, pneumonia. [We] also have a catch-all category – we call it “social” – no matter what we do they are at high risk of readmission. Additionally, the pharmacists can identify problems; they can send a PA [physician assistant] or NP [nurse practitioner] for a home visit, for a more detailed evaluation.”

Medical Director, Provider-sponsored Plan

In-depth conversations with health plan executives point to several clinical areas where plans have invested or plan to invest: care in the home, medication therapy management (MTM), end-of-life care, and behavioral health. (See Appendix 2.)

Because health plans’ efforts are in the early stages of planning or implementation (except for MTM, which is more common), we did not observe widespread adoption of clinical innovation. Most health plan respondents (83 percent) are actively encouraging providers to take a multidisciplinary approach to care; half of providers (52 percent) indicate they have adopted this. Forty-three percent of health plans encourage and 44 percent of providers use telemedicine or virtual visits. Other forms of innovation, such as home visits, remote monitoring, and group appointments, are less common. (See Figure 4.) Reimbursement methodologies may not be keeping pace with new types of clinical activities, slowing their adoption. In addition, new approaches often require practice and workflow redesign, which takes time.

Figure 4. Innovative approaches to care delivery are not yet widely adopted



Source: Deloitte Center for Health Solutions, 2015 Study of Medicare Advantage Health Plans and Providers

### Commercial and MA VBC strategies are similar

As health plan-provider relationships evolve, existing medical management approaches that have demonstrated their worth across multiple lines of business will likely remain relevant in VBC arrangements, with more of the medical management responsibilities migrating to providers. Care and utilization management are critical components of VBC strategies for most health plans operating in MA and typically are part of their larger VBC strategy across all lines of business.

“High utilization provides [an] opportunity to cut out more fat in MA than in commercial. More prominent opportunities come in the form of disease and case management.”

VP, Networks, Regional Health Plan

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“CM for CHF has a big positive ROI. For ROI, you need to have a condition that you can predict there will be a costly event in a short window of time and you can do something to avoid those costly occurrences. Diabetes has a negative ROI; the payoff is 10-20 years down the line. COPD, asthma – we can ID risk, but it is difficult to do early intervention; payoff is not as good.”

Medical Director, Regional Health Plan

### Care management

Health plan respondents are focusing CM efforts on the five “classic” conditions: for asthma, COPD, CHF, coronary artery disease (CAD), and diabetes.

While the return on investment (ROI) varies across these conditions, CM interventions have shown quality improvements for asthma, CHF, CAD, and diabetes and cost-savings for asthma, COPD, and CHF.<sup>6</sup> Anecdotally, health plan executives see “quick wins” with CHF but questionable ROI with diabetes. Additionally, many plans have invested in CM for specialty conditions such as cancer, autoimmune diseases, HIV/AIDS, and transplants.

Today, much of the CM expertise resides with health plans, but many executives expect that CM will become provider-led and the role of health plans in CM will be to serve in enabling capacity through analytic support of population health management activities.<sup>7</sup>

### Utilization management

Utilization management (UM), which controls costs by evaluating medical necessity, appropriateness, and efficiency in the use of health care services, procedures, and facilities, has become a critical profitability lever. This is primarily because MA plans typically pay unit prices at 100-105 percent of traditional Medicare in non-capitated arrangements with providers, which is considerably lower than in commercial contracts.<sup>8</sup> Additionally, health plans have more flexibility in MA than in traditional Medicare to manage the site of care (e.g., members can be admitted to a skilled nursing facility without a hospital stay, and joint replacement procedures can be performed on an outpatient basis). Including pharmacy in most (86 percent in 2015) MA benefit designs<sup>9</sup> creates opportunities for an integrated

approach to UM that sets MA apart from commercial plan designs (in which drug utilization is much lower and pharmacy benefits are often carved out) or traditional Medicare (where there are few opportunities for a coordinated approach to medical and pharmacy utilization).

Health plans are increasingly leveraging their UM expertise and sharing data with providers to help them understand their utilization patterns and identify cost drivers (e.g., patient leakage to competing providers outside of the ACO or integrated delivery system network, use of high-cost facilities and specialists, and readmission rates).

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**“In MA you have unit costs that resemble traditional Medicare, so it becomes really important to manage utilization.”**

**VP, Network and Contracting, National Health Plan**

### **Differences between commercial and Medicare Advantage lines of business**

Most interviewed health plans approach VBC strategy similarly when managing the two distinct populations in commercial and MA lines of business: prevention, focus on primary care, disease and care management, and principles of medical necessity are equally applicable. However, there is wide agreement that high per-member-per-month costs and disease burden present greater opportunities for savings and quality improvements in MA than in commercial lines of business.

A small number of health plan executives disagree that VBC arrangements can be used with equal success in commercial and MA lines of business because commercial populations do not lend themselves to investments in population health. As one interviewee notes, *“In MA you look at an attempt at a marriage, whereas in commercial you look at a one-night stand. In commercial, you are really managing unit cost – things like maternity and accidents. You are not going to affect those incidents.”* These executives say that commercial populations are more transient than MA populations (e.g., an employer can move an entire large group to a different plan; members move due to job changes). In their view, heterogeneity of commercial populations and different member needs and plan designs across group, individual, and health insurance exchange products make population health management much more challenging and elusive than in MA.

**Federal policies, initiatives, and regulations influence MA VBC strategies**

**“The single most important facet to be profitable in MA is to be excellent in working with physicians to code to the greatest level of acuity specificity. Whether global capitation or not, this is still a function of topline revenue.”**

VP, Network and Contracting,  
National Health Plan

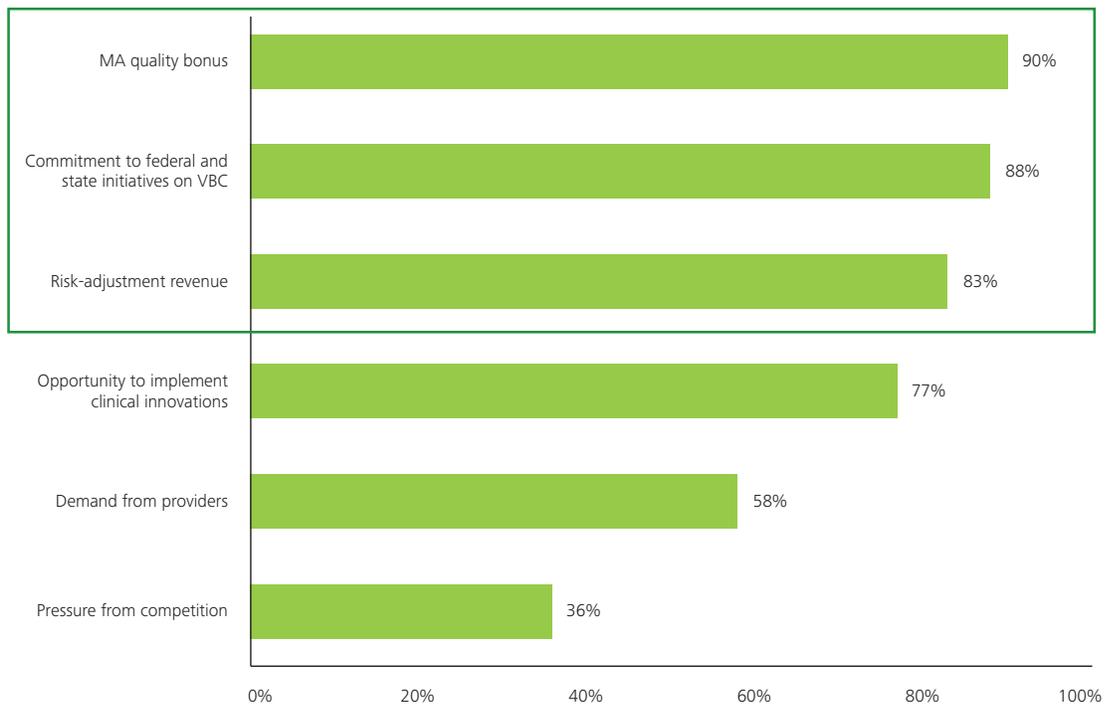
**Drivers and regulatory challenges**

Most respondents agree that quality bonus (90 percent) and risk adjustment revenue (83 percent), in combination with a commitment to federal and state initiatives on VBC (88 percent), are core drivers of MA health plans’ VBC strategies. (See Figure 5.)

In 2009, CMS paid health plans approximately 114 percent of traditional Medicare services. Since passage of the Affordable Care Act (ACA) in 2010, CMS has been trying to bring MA payments to parity with traditional Medicare. Health plans face strong downward pressure from lower benchmarks (and, thus, lower rebates), rebate percentages tied to quality ratings that are lower than pre-ACA rates, increased scrutiny around coding practices, and a coding intensity adjustment factor that reduces risk-adjusted revenue from the government.<sup>10</sup>

**Figure 5. Health plans list revenue-enhancing policies as core drivers of MA VBC strategy**

Percentage of respondents who replied “Important” or “Extremely important” when asked how they would rate the importance of each factor on their value-based strategy in MA



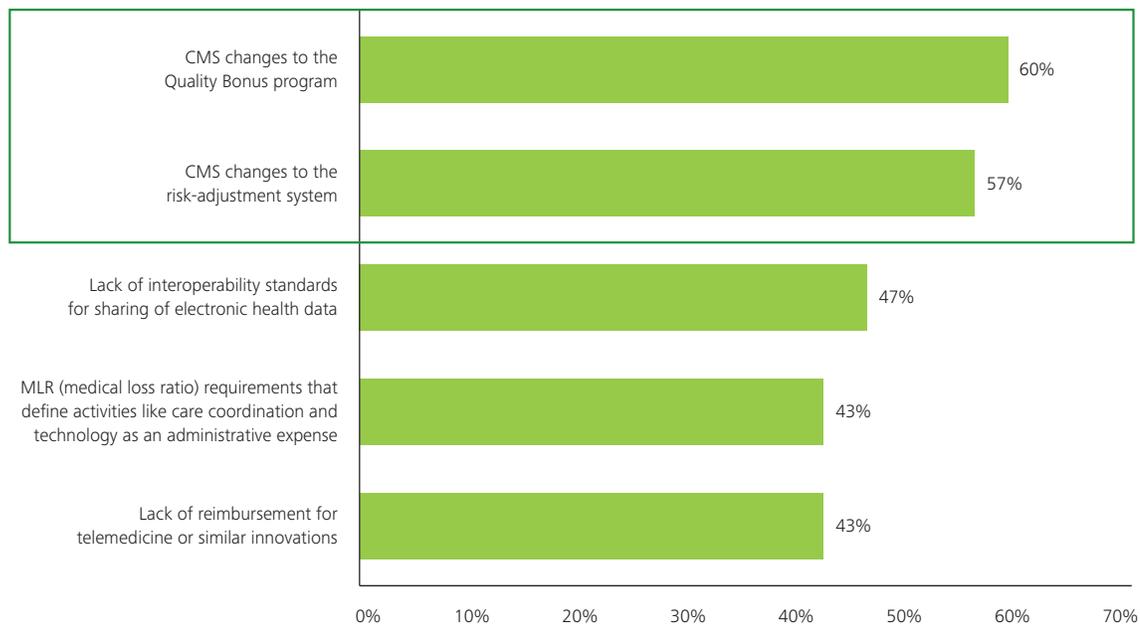
Source: Deloitte Center for Health Solutions, 2015 Study of Medicare Advantage Health Plans and Providers

As a result, changes to the quality bonus program (60 percent of respondents) and risk-adjustment system (57 percent) pose the greatest regulatory challenges and opportunities for health plans. Interoperability standards, medical loss ratios, and lack of reimbursement for specific clinical activities are smaller challenges, but still concern MA health plans. (See Figure 6.)

Health plans have invested in strategies to optimize quality bonus and risk-adjustment payments; at the same time, these MA program elements can create additional opportunities for health plan-provider collaboration. (See sidebar on page 13.)

**Figure 6. Changes to certain policies and/or regulations could pose challenges for health plans attempting VBC contracts in MA**

Percentage of respondents who answered the following to the question, “What regulatory issues have you observed that may present challenges in value-based contracting in MA?”



Source: Deloitte Center for Health Solutions, 2015 Study of Medicare Advantage Health Plans and Providers

## MA program elements create opportunities for VBC arrangements

Three distinct characteristics of the MA program create opportunities for health plan-provider collaboration and contracting tied to revenue optimization, quality improvement, and cost reduction.

1. Health plans' revenue is risk-adjusted based on the documented conditions of their enrolled beneficiaries, which encourages collaboration between plans and providers to accurately capture diagnoses and aligns financial incentives through CMS-compliant revenue optimization gain-sharing arrangements.
2. Health plans' revenue is also affected by Medicare Star ratings, which present another opportunity to align plan-provider gain-sharing incentives to drive quality improvement. The quality bonus program that is tied to the ratings can have a substantial impact on many health plans' revenue; those that receive at least four stars earn 105 percent of the benchmark. For instance, one large health plan gained an additional \$533 million in revenue from its 2016 Star ratings, while another lost \$244 million for the same year.<sup>11</sup> The ratings also have market share implications: health plans with ratings lower than two stars face a threat of contract termination, while health plans with five-star ratings enjoy the benefit of continuously marketing to and enrolling beneficiaries throughout the year outside of the open enrollment period.
3. The fact that health plans' revenue is risk adjusted and capitated serves as an economic incentive for plans to proactively identify and manage high-risk members, close gaps in care, and drive cost reductions. This creates opportunities for plans and providers to collaborate on CM and wellness initiatives at the point-of-care to control costs and improve care coordination. Risk adjustment also mitigates "adverse selection," so plans are less likely to suffer financial consequences for enrolling higher numbers of individuals with chronic diseases and comorbidities than their competitors.

## How CMS can expand VBC through the MA program

Health plan respondents believe that federal regulators could do more to encourage greater adoption of VBC, and they view CMS as a partner in the VBC journey. Respondents feel that greater data transparency from CMS could help health plans analyze provider practice patterns more quickly and thoroughly. For example, CMS may have administrative data that, if de-identified at the beneficiary level, could offer insights into utilization and efficiency patterns of individual providers. Many health plan respondents also would value greater flexibility from CMS in traditional Medicare VBC models to help move providers toward value-based thinking for all of their populations. (See Figure 7.) For instance, site-neutral payment rules or waivers from specific eligibility requirements around the level of care may prompt providers to reevaluate their referral patterns and site-of-care preferences.

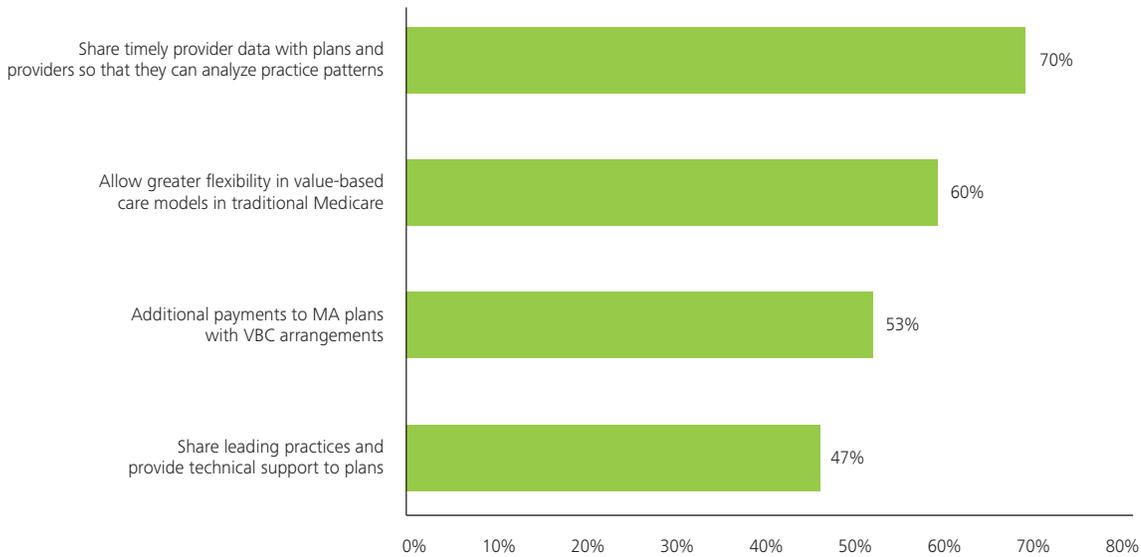
Respondents believe that CMS initiatives in the traditional Medicare program have benefited MA plans or have the potential to do so in the near future.

HHS' goal to tie 50 percent of traditional FFS Medicare payments to alternative payment models, such as ACOs, by 2018 and other initiatives are creating pressure for providers to develop VBC capabilities.<sup>12</sup> CMS also requires health plans to have quality improvement programs, which must include chronic care improvement programs. Many respondents say these requirements often drive investments and quality improvement priorities for their organization.

Health plans expect CMS initiatives – whether in FFS Medicare or MA – to help move providers toward value-based thinking for all of their populations. For example, CMS already has an initiative to create episode groupers and provide feedback to providers through Supplemental Quality and Resource Use Reports.<sup>13</sup> The Value Modifier program will prompt providers to think about cost and quality performance for their FFS Medicare patients.<sup>14</sup> Beginning in 2019, many of these programs will be absorbed into the Merit-Based Incentive Payment System, which may also encourage physicians to consider cost and quality in Medicare. Finally, the large-scale bundling initiative is expected to make providers aware of the cost and value of specific services within the bundle.<sup>15</sup>

**Figure 7. Regulators can encourage health plans' VBC adoption through focused changes**

Percentage of respondents who answered the following to the question: "If you were to give advice to regulators such as CMS or National Association of Insurance Commissioners, what actions would you recommend in order to increase investment in value-based care by health plans?"



Source: Deloitte Center for Health Solutions, 2015 Study of Medicare Advantage Health Plans and Providers

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“On the plus side, CMS makes it a requirement, so at least it brings providers to the table. In the past if we were to approach a hospital directly, they would not be interested. Now, the providers have to do it anyway, so they might as well work with us. If they are putting in processes to reduce cost of care for CMS, it probably will spill over to us anyway.”

VP Networks, Regional Health Plan

**Health plans and providers have challenges to overcome**

**“You cannot drive change in the system without rewarding the docs.”**

Medical Director, Regional Health Plan

**“If we start with the assumption that the cost of health care is too high, we can’t keep providers whole and reduce costs.”**

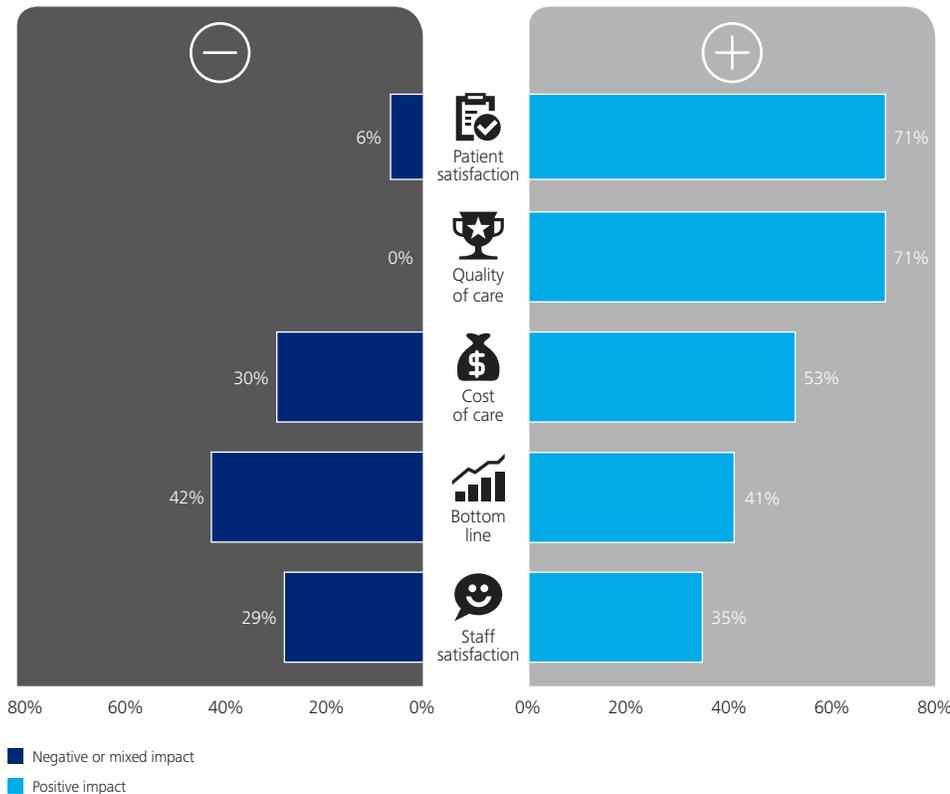
VP Networks, Regional Health Plan

**Business case for providers is unclear**

Provider respondents have mixed perspectives on VBC contracting. Most acknowledge that VBC arrangements are good for care quality and patient satisfaction, but they are also skeptical about its impact. While half believe that VBC arrangements have had a positive impact on the cost of care, a third of provider respondents feel that the impact has been negative or mixed. Opinions are split on the impact of VBC on providers’ bottom line and staff satisfaction: 42 percent view the impact on the bottom line as negative or mixed while 41 percent see it as positive; regarding staff satisfaction, the proportions are 29 percent versus 35 percent, respectively. (See Figure 8.) Many are not convinced that VBC arrangements with health plans are a win-win for both parties. This provider reluctance and unpreparedness to take on risk has slowed adoption of VBC models.

**Figure 8. Provider respondents have mixed perspectives on VBC contracting**

Percentage of respondents who described impact as positive, negative or mixed in response to the question “What has been the impact of value-based care on the following outcomes?”



Source: Deloitte Center for Health Solutions, 2015 Study of Medicare Advantage Health Plans and Providers

### Health plans and providers view challenges differently

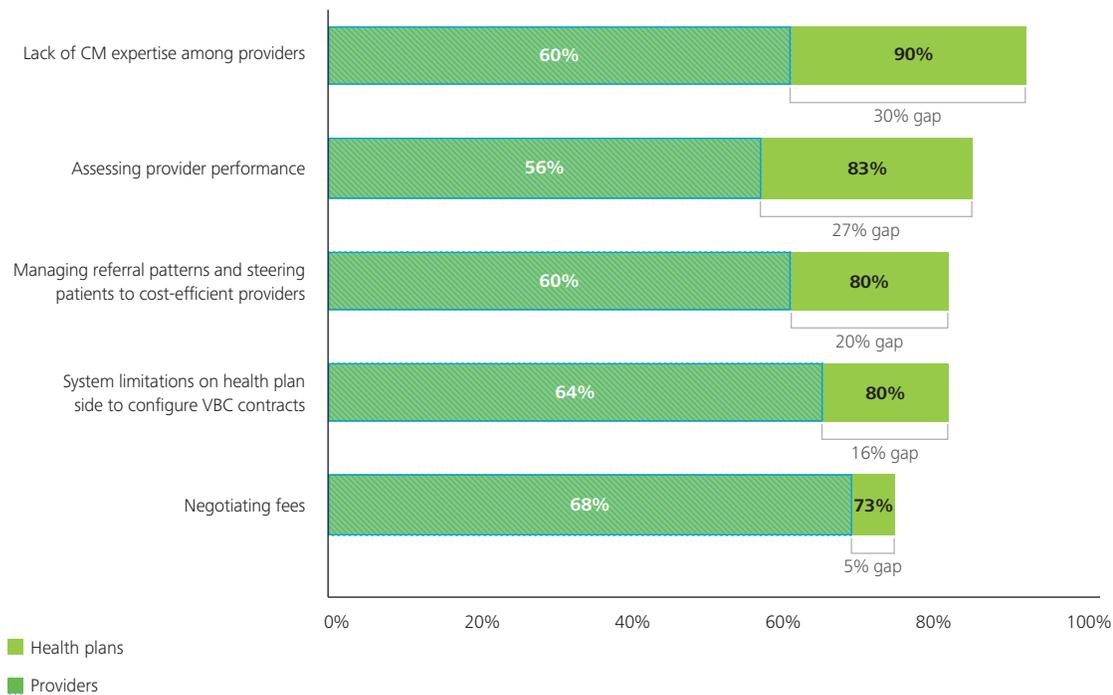
Health plans and provider respondents differ in their perceptions of VBC-related challenges. Health plans view lack of provider care management experience (90 percent) and assessing provider performance (83 percent) as challenges. Providers are less likely to see these as top challenges and are more concerned about negotiating fees with health plans (68 percent). (See Figure 9.)

For providers, two challenges surpass all others: managing data and data flow across disparate technological platforms (88 percent) and operating in the dual world of FFS and VBC (80 percent). (Not shown.)

Providers face difficulties with integrating data internally and externally: Various parts of the health system and other providers they regularly work with may be on different electronic health record (EHR) platforms. There may or may not be connectivity among clinical, billing, case management, and practice management systems. Dealing with multiple health plans can mean using different processes or interfaces for UM or claims submission, and it is not uncommon for providers to still transact business by fax.

**Figure 9. Health plans and providers disagree about the biggest challenges in VBC contracting**

Percentage of respondents who replied that the following is a “Major challenge” or “Moderate challenge” when asked about challenges for their organization across all types of value-based contracts.



Source: Deloitte Center for Health Solutions, 2015 Study of Medicare Advantage Health Plans and Providers

## MA health plans can be a partner in analytics

“Because we are a large proportion of their panel, we can be very sophisticated, help understand their population, their health conditions, what drives costs [and] utilization. Then we can design a program together to get better outcomes, how to allocate resources.”

VP, Care Innovation and Integration,  
Regional Health Plan

In contrast to providers, health plans generally have better data about member behavior and utilization patterns and can analyze the data at the member, physician, and population level. Health plans also tend to have deeper data analytic capabilities than the typical provider organization: Most plans have developed and refined over time predictive models to identify high-risk beneficiaries for CM interventions. Sharing such data with providers in a way that is actionable and timely could enhance and complement providers’ own efforts. Today, many health plans already share their data but often there is a considerable time lag; the information is poorly integrated in providers’ workflows and perhaps not easy to use. Certain gaps in care remain unaddressed because such activities fall outside traditional roles and are not yet reimbursed. Over time, the data exchange between health plans and providers will likely evolve to combine claims history and clinical information from EHRs; providers then would be able to access the data on demand and at the point of care.

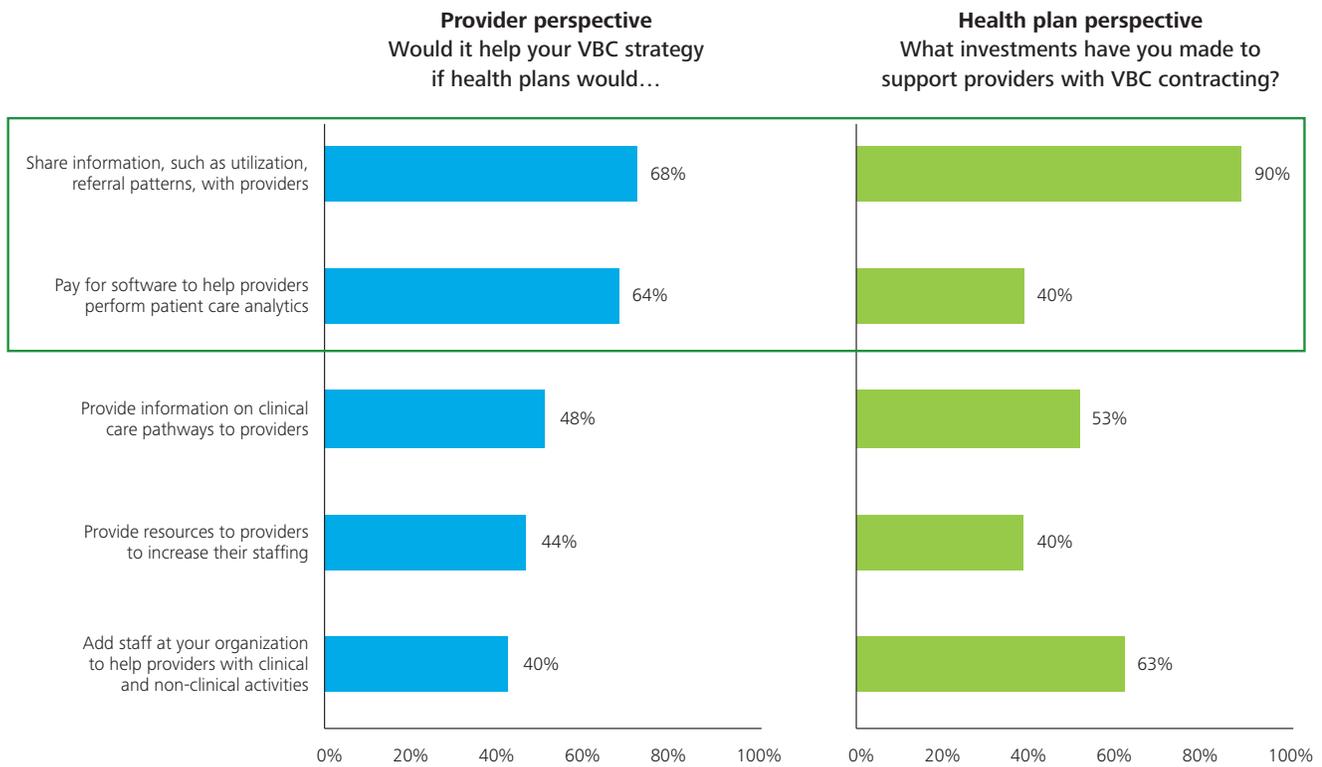
Providers recognize the need for analytic capabilities, and while it may not be feasible for health plans to directly fund analytics software for providers, sharing data in new ways and lending support in collecting and analyzing providers’ own clinical data could ameliorate this need. In other areas (e.g., data sharing, clinical care pathways, and staffing) plans’ investments appear to align with what providers value. (See Figure 10.)

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“We share data with health systems, showing 30-40 percent leakage from their network of employed physicians. Because we have more visibility into longitudinal care – care outside their walls – we show we can increase keepage in their system. We are able to track progress over time, showing providers’ incremental changes in their utilization patterns.”

Medical Director, National Health Plan

**Figure 10. Alignment of health plan investments with provider needs**



Source: Deloitte Center for Health Solutions, 2015 Study of Medicare Advantage Health Plans and Providers

Health plan respondents strongly believe that MA presents great opportunities for VBC due to high per-member costs, disease burden, and defined populations. In fact, health plan leaders expressed during the in-depth interviews that they believe contracting with MA plans is a better way for providers to develop VBC capabilities than starting with CMS. Unfortunately, few health plans are effectively conveying this message to providers. Despite the clinical and demographic similarities between MA and traditional Medicare patients, providers are more cautious about VBC arrangements with MA plans than with CMS.

Health plans could emphasize that MA VBC relationships can offer more flexible arrangements, innovative reimbursement to improve clinician engagement, greater data transparency,

streamlined performance measures and analytic support. Because providers have varying levels of sophistication, case mixes, and physician engagement strategies, health plans may need to customize analytic processes and outputs to provider needs. Health plans also may need to educate providers on how to use and interpret the data and integrate it into their workflows, which may require health plans to acquire additional capabilities.

Most respondents are optimistic about the future of VBC. They believe that collaboration is the way forward, with technology and data serving as key enablers.

## Appendix 1. About the Deloitte 2015 Study of Medicare Advantage Health Plans and Providers

### Research objectives

- Understand common types of VBC arrangements in the MA marketplace
- Identify differences in VBC approaches between MA and Commercial
- Understand current drivers, benefits, and challenges of VBC arrangements
- Identify regulatory barriers to VBC contracting
- Explore differences in perspectives between health plans and providers
- Determine characteristics of leading VBC arrangements and accelerators that could be used to achieve results faster

### Surveys of health plans and health care providers

30 health plans surveyed

25 providers surveyed

12 in-depth open-ended interviews with health plan leaders

## Appendix 2. Examples of clinical innovation investments mentioned during interviews

Area of investment	Details
<b>Care in the home</b>	In partnership with providers and a third-party vendor, one health plan is instituting a program where a physician-led, multidisciplinary team (nurses, pharmacists, social workers, dieticians) provides care in the home for members with complex care needs. Clinicians on the care team will diagnose, treat, and prescribe medications and assess environmental conditions at a patient's home. The program is expected to reduce emergency visits, hospital admissions, and readmissions; increase access to care; and improve member experience. Other health plans see home health as an opportunity to decrease post-acute care facility costs.
<b>Medication therapy management (MTM)</b>	Several health plans use MTM to reduce readmissions. Says one medical director: <i>"In hospital, their meds are often changed. One cause of readmission: patients go home and get back on old meds."</i> For care transition MTM, health plans would refer high-risk patients to the pharmacy team, which contacts the patient and/or caregiver within days of discharge to review all prescription and non-prescription drugs, and identify and resolve any potential medication problems (e.g., therapy duplication, drug-drug, drug-disease, or tolerability issues). <sup>16</sup> Important components of MTM include consulting and educating the patient on proper medication use, follow-up and ongoing monitoring, and coordinating with the care team.
<b>End-of-life care</b>	Working with providers, one health plan identifies patients who are likely to have a terminal illness. Trained staff members engage in discussions with these patients and their families about end-of-life options, including palliative care, do-not-resuscitate orders, living wills, and the pros and cons of various treatments. This program also helps patients and families to connect with community services and support programs. As one respondent put it, <i>"Some providers are hesitant to have end-of-life discussions. If we can provide ancillary support for these types of discussions, it takes the burden off of the provider."</i>
<b>Behavioral health</b>	Recognizing the link between behavioral and physical health, health plan executives expect to place more focus on this area going forward, especially as it relates to geriatrics. One respondent's organization is <i>"looking at quality measures for mental health, depression, dementia – these are not yet measured by HEDIS or Stars."</i>

## Endnotes

1. Congressional Budget Office (CBO). "Congressional Budget Office's March 2015 Medicare Baseline." CBO website, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf>, accessed November, 2015.
2. Office of the Assistant Secretary for Planning and Evaluation (ASPE). "The Medicare Advantage Program in 2014." ASPE website, [https://aspe.hhs.gov/sites/default/files/pdf/76846/ib\\_MedicareAdvantage.pdf](https://aspe.hhs.gov/sites/default/files/pdf/76846/ib_MedicareAdvantage.pdf), accessed November, 2015.
3. Medicare Payment Advisory Commission. A Data Book Healthcare Spending and the Medicare Program. Washington, D.C.: MedPac. <http://medpac.gov/documents/data-book/june-2015-databook-health-care-spending-and-the-medicare-program.pdf?sfvrsn=0>.
4. Office of the Assistant Secretary for Planning and Evaluation (ASPE). "The Medicare Advantage Program in 2014." ASPE website, [https://aspe.hhs.gov/sites/default/files/pdf/76846/ib\\_MedicareAdvantage.pdf](https://aspe.hhs.gov/sites/default/files/pdf/76846/ib_MedicareAdvantage.pdf), accessed November, 2015.
5. Centers for Medicare & Medicaid Services. Proposed Rule. "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services." Federal Register 80, no. 134 (July 14, 2015): <https://federalregister.gov/a/2015-17190>
6. Agency for Healthcare Research and Quality. "Designing and Implementing Medicaid Disease and Care Management Programs." <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/medicaidmgmt/medicaidmgmt8.html>, accessed November 2015.
7. Deloitte. "Journey to Value-Based Care Insights and Implications from Deloitte's 2015 Health Plans Executive Interviews." Deloitte website, <http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-journey-to-value-based-care-final.pdf>, accessed November 2015.
8. Berenson, Robert A. et al. "Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices." Health Affairs 34 (2015). Accessed November 16, 2015. doi: 10.1377/hlthaff.2014.1427
9. The Henry J. Kaiser Family Foundation (KFF). "Medicare Advantage." June 29, 2015. KFF website, <http://kff.org/medicare/fact-sheet/medicare-advantage/>, accessed November 2015.
10. Goetsch, Eric and Brett Swanson. "Medicare Advantage Funding Cuts and the Impact on Beneficiary Value." Milliman, February 18, 2015. <http://bettermedicarealliance.org/sites/default/files/Report-Medicare-Advantage-Funding-Cuts-and-the-Impact-on-Beneficiaries.pdf>, accessed November 2015.
11. James, Sarah. "CMS Releases MA Star Ratings: HUM Sees a Decline and United a Boost to Expected 2016 and 2017 Payments." Webdush Pac Grow Life Sciences, October 8, 2015. <https://equities.webdush.com/clientsite/Research/ActionAlertFilePreview.asp?UUIID=B604FFAE-A584-433F-865B-F3029856C3A0&ViewerID=B2B9215F-2318-4075-8B60-210715E16A85>, accessed November 2015.
12. U.S. Department of Health and Human Services. "Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals And Timeline For Shifting Medicare Reimbursements From Volume To Value." Press release, January, 26, 2015. HHS website. <http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>, accessed November 2015.
13. Centers for Medicare and Medicaid Services (CMS). "Medicare FFS Physician Feedback Program/Value-Based Payment Modifier." CMS website, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html>, accessed November 2015.
14. Centers for Medicare and Medicaid Services (CMS). "Computation of the 2016 Value Modifier." CMS website, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-VM-Fact-Sheet.pdf>, accessed November 2015.
15. Centers for Medicare & Medicaid Services. Proposed Rule. "Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services." Federal Register 80, no. 134 (July 14, 2015): <https://federalregister.gov/a/2015-17190>
16. Academy of Managed Care Pharmacy (AMCP). "Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model." AMCP website, <http://www.amcp.org/uploadedFiles/Core%20Elements%20-%20MTM%20including%20AMCP%20endorsement.pdf>, accessed November, 2015.



## Authors

### **Lucia Giudice**

Director and Government Programs Practice Leader  
Strategy and Operations/Life Sciences and Health Care  
Deloitte Consulting LLP  
lgiudice@deloitte.com

### **Natasha Elsner, MS**

Research Manager  
Deloitte Center for Health Solutions  
Deloitte Services LP  
nelsner@deloitte.com

### **Claire Boozer Cruse, MPH**

Health Policy Specialist  
Deloitte Center for Health Solutions  
Deloitte Services LP  
cboozer@deloitte.com



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Harry Greenspun, MD  
Director  
Deloitte Center for Health Solutions  
Deloitte Services LP

Sarah Thomas, MS  
Research Director  
Deloitte Center for Health Solutions  
Deloitte Services LP

555 12th St. NW  
Washington, DC 20004  
Phone: 202-220-2177  
Fax: 202-220-2178  
Toll free: 888-233-6169  
Email: [healthsolutions@deloitte.com](mailto:healthsolutions@deloitte.com)  
Web: [www.deloitte.com/centerforhealthsolutions](http://www.deloitte.com/centerforhealthsolutions)



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