



Aligning health plans and providers: Working together to control costs

US health care costs continue to rise more rapidly than is sustainable.

Health care spending was \$3.2 trillion in 2015, a 5.3% increase from 2014, and is expected to continue to grow 5.8% annually for the next decade¹. Health care as a percentage of the US gross domestic product (GDP) has steadily risen from 13.8% in 2000² to 17.8% in 2015³, and is predicted to be 20.1% by 2025⁴.

While the Affordable Care Act (ACA) improved access to coverage for many Americans⁵, the recent Presidential election has created uncertainty about the future of this law. Whether access comes through subsidies on ACA exchanges, expanded Medicaid, or other legislative solutions or we return to higher levels of uninsured, health care spending per covered person will continue to be a challenge. How will continued health care cost increases be paid for, and how can these increases be dampened?

Large rate increases aren't the answer for health plans.

Higher premiums can deter healthy people from voluntarily purchasing insurance products, resulting in a higher average level of "risk" or illness burden in the group that does buy coverage. This creates a "vicious cycle" of even higher premiums as the risk deteriorates. The industry should consider focusing on identifying and implementing strategies to bend the medical cost curve while improving health outcomes.

Concerns over the cost of care aren't new. Rapid, but expensive, improvements in technology, the shift from commercial to government payers while care systems have negative margins on government paid patients and unaffordability of premium rates, give payers and providers greater incentives to collaborate on population health approaches. This paper explores innovative ways that providers and health plans can work together to accomplish these goals.

Background

Payers have always had to manage health care costs to maintain affordable premiums without resulting in negative margins. With the passage of the ACA in 2010, health plan profitability has been challenged. The health care exchanges and Medicaid expansion increased the number of insured Americans by 20 million between 2010 and 2016⁶. However, Aetna, Humana, and UnitedHealth's 2016 exit from many of the health care exchange markets exposed some of the significant challenges of pricing the product for the population's acuity level.

Traditionally, health plans focused on managing health care cost trend through utilization review, care management, and provider contracting. Health plans worked primarily with utilization and claims data well after the services actually occurred. This approach does not engage the physicians to contribute to the solutions for generating additional efficiency without sacrificing quality. In addition, fee-for-service payment models continued to drive utilization, contributing to unsustainable trend rates. Without addressing the root cause and altering behavior across the continuum of care, any temporary reductions in cost will likely be just that—temporary.

Although many health plans have developed value-based contracts with small segments of their provider network, the broader base of providers still do not have downside risk that captures their attention enough to change the way that they practice. However, it isn't appropriate to put providers at risk without providing them with the information they need to understand how they can perform better.

Value-based care has the long-term potential to change the health care cost trajectory. A number of physicians have the impression that it won't work because of previous experiences. However, the skill, approaches, information available, and risk mitigation techniques are now much better than they were in the early days of value-based care. As is discussed below, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) may give a strong incentive for physicians to participate in value-based care leading to a more rapid deployment for some of the key components enabling value-based care.

Deloitte's perspective

At Deloitte, we recognize the importance of payers and providers working together to impact the future of health care quality and cost, and our clients are making great strides to that end. Value-based care encourages providers and health plans to align their interests, allowing payers to more easily lower the cost trajectory of health care costs and offering providers the tools to help effectively deliver quality care. Utilizing both claims and outcome data, payers can help providers employ a comprehensive cost and quality management approach that is appropriately tailored to geography and market factors. The following is a summary of some of the potential strategies that can be employed to better enable a productive payer-provider relationship.

Sharing risk

MACRA has accelerated the move to payment models that contain financial risk sharing by adjusting Medicare reimbursement based on performance and risk taking. "That's a very important and broad-based driver for physicians, because almost all physicians are paid by Medicare, with very few exceptions like pediatrics," said Esther Nash, MD, a Specialist Leader

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Esther Nash, MD
Specialist Leader Health Care Strategy and Operations
Deloitte Consulting LLP

¹ <http://www.modernhealthcare.com/article/20160713/NEWS/160719963>

² <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf>

³ <http://www.modernhealthcare.com/article/20160713/NEWS/160719963>

⁴ <http://content.healthaffairs.org/content/35/8/1522>

⁵ <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>

⁶ <http://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates>

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Specialist Leader Health Care Strategy and Operations
Deloitte Consulting LLP

in Health Care Strategy and Operations at Deloitte Consulting LLP in Philadelphia.

Commercial health plans have also been leaders in innovative risk sharing payment arrangements. For example, in 2009 Blue Cross Blue Shield of Massachusetts started the Alternative Quality Contract⁷, a global budget payment method. It now includes 85% of the plan’s providers, which receive global budgets covering their patients’ care, including outpatient, inpatient, rehabilitation services, and prescription medications. In these risk-sharing agreements, providers agree to focus on managing health care spending while improving quality, and they may receive financial incentives for doing so.

Bonuses only go so far in changing provider behavior, though. “It’s not until there’s some downside risk that providers pay attention to these models,” said James Whisler, a Health Care Principal at Deloitte Consulting LLP in Minneapolis. Taking on financial risk should be paired with useful data at the point of care, so providers can be in a position to determine the right care protocol to lower the cost of care while maintaining or increasing quality. “You don’t want to put providers in a situation where they take financial risk without the tools to do well under that risk arrangement,” Whisler said.

Measuring provider performance

To offer providers the appropriate tools to bear risk, payers should consider establishing an effective measurement approach. Measuring provider performance is a complex challenge that requires a thoughtful approach in assessing behavior across a broad spectrum. This process must take into account the unique, highly variable practices each individual physician employs while still finding a way to compare physicians’ performance in a fair way. Appropriately defining the local market geography and the specialty practice of a given physician is important. Another key is establishing an effective attribution methodology.

In the past, individual member expenses were commonly attributed to one physician and/or facility visit. While this approach may be appropriate in some HMO type contexts, to more fully appreciate the big picture, alternatives should be considered. For measuring provider performance, “an episodic approach is more effective,” said Whisler. It accounts for each physician having a different mix of patients, even within the same specialty or episode type. With advanced analytics, physicians accept the information and use it to learn and change behavior. “Even physicians performing well get insight into areas where they can be performing better. Especially as they get more into value-based models, they’re asking for information that gives them confidence to make needed changes. It allows them to see how they’re performing differently than their peers,” Whisler said.

In addition to providing validated, trusted, and risk-adjusted analytic feedback about physicians’ performance, it’s crucial to also provide an action plan. This action plan should include detailed physician performance in key areas, including radiology utilization, length of stay, or prescription drug prescribing patterns, to name a few. This action plan should vary based upon the provider’s most common episodes of care and services performed in order for the provider to get the most out of the information. “Providers, whether hospitals or physicians, need to have buy-in, and not make it a one-sided information delivery,” Nash said. “It has to be collaborative.” Providing actionable information is key in measuring and improving performance in any walk of life, and this is especially true with providers.

⁷ <http://www.nejm.org/doi/full/10.1056/NEJMsa1404026#t=article>

Population health data analytics

In addition to individualized performance measurement, payers can provide physicians with population health data showing macro trends within a market, like the number of MRI scans, back surgeries, proportion of a particular event performed in an inpatient vs. outpatient setting, etc. A provider system's experience can also be compared to "best in class" markets that have demonstrated superior performance, which is important as regional practice patterns can become ingrained even when not best practices. This type of information can point to system-wide patterns that could lead to cost savings; however, granular analytics isn't accessible in-house to most provider organizations and advanced approaches are only just developing at many health plans. The importance of this information is recognized as demonstrated by the growth in health care analytics. The health care analytics market globally is currently valued between \$4 billion and \$5 billion⁸, but expected to rise to \$18.7 billion by 2020⁹.

While analyzing past behaviors is important, there is additional opportunity in using the data for predictive models. "Targeting medical management support to patients who are anticipated to have a high-cost event or expected to need additional help navigating the health system is the ultimate goal," Nash said. Ultimately, both health plans and providers want to generate insights from complete datasets that include clinical EMR and claims data, as well as patient-generated wellness data. "We're not there yet, but there's so much power in this information," Nash said. A physician may believe that their care plan and instructions are being followed, but seeing the aggregate information can be eye-opening. "The most well-intentioned physician gives evidence-based recommendations to individual patients and thinks they've done a great job, but the aggregate data sometimes tells a different story," said Nash.

Consumer transparency

Providing patients with information on comparative quality, cost, and safety of the various provider and treatment options can enable patients to make better medical decisions, while lowering the cost of care. Consumers can and should use this information in their decision making process; in parallel, primary care physicians must be provided this same information. With greater transparency of provider quality and outcomes, consumers are better positioned to enable these smaller networks to be the higher quality and lower cost option. Where comparative information is available, consumers can choose providers with higher quality and/or lower cost.

Primary care physicians (PCPs) understand that much of the patient's medical expense is downstream; nevertheless, PCPs can have a significant impact on total patient cost of care via referrals to the most appropriate specialists and hospitals. "Payers can assist by analyzing these referral patterns, showing when physicians refer within their networks and to whom they refer," said Kristin Braun DiObilda, a Senior Manager in Deloitte Consulting LLP's New York City Health Plans practice.

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Health care analytics market value



Source: Markets and Markets

⁸ <http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-dchs-provider-analytics-report.pdf>

⁹ <http://www.marketsandmarkets.com/PressReleases/healthcare-data-analytics.asp>

“To assemble a high-performing network, payers should analyze individual provider performance as well as the performance of their referral network.”

James Whisler
Principal
Deloitte Consulting LLP

Sharing medical management insights

Medical management activities, such as utilization review and care coordination, aren't new to health plans' efforts to control quality and cost. However, health plans are increasingly evaluating what portion of this activity should remain internal and what portion providers can effectively offer in their setting—especially as providers begin sharing financial risk. To fully support their patients, health plans and providers should work together to avoid duplicating these medical management efforts. Not only is duplication costly, but it is an inconvenience to the patient. Health plans can share skills, such as actuarial evaluation and population health management, to help providers more effectively coordinate care and provide chronic care management.

Appropriately utilizing health care data to provide care requires detailed analytics to determine areas of opportunity for both health plans and providers. For example, providers could tap into data analytics to focus their efforts on patients with chronic conditions, such as diabetes, or to change behaviors for specific services, such as proper radiology imaging referrals. Providers might also want to work with particular inpatient or post-acute facilities that appear less efficient contributors to overall episode costs. While providers might have HIPAA concerns with sharing this information, if the activities involve treatment, payment, or certain health care business operations, the sharing of patient data may be deemed appropriate.¹⁰

Health coaching

In this era of patient-centered care, many health plans and providers are working hard to deliver information to patients, to assist them in making the best decisions for their health. Nonetheless, availability of information and the best clinical recommendations do not guarantee patient adherence to care plans or long-term behavior change.

Many health plans are using care managers in broader roles beyond traditional case management as chronic condition or lifestyle behavior change coaches. Coaches are provided with a list of those patients most at risk or with the greatest need for improvement. By arming these coaches with behavior change coaching skills and data, they can work with members to help manage chronic conditions. Some forward-thinking health plans and medical groups are embedding care managers in outpatient provider offices and hospitals, when it makes sense from a volume and workforce perspective.

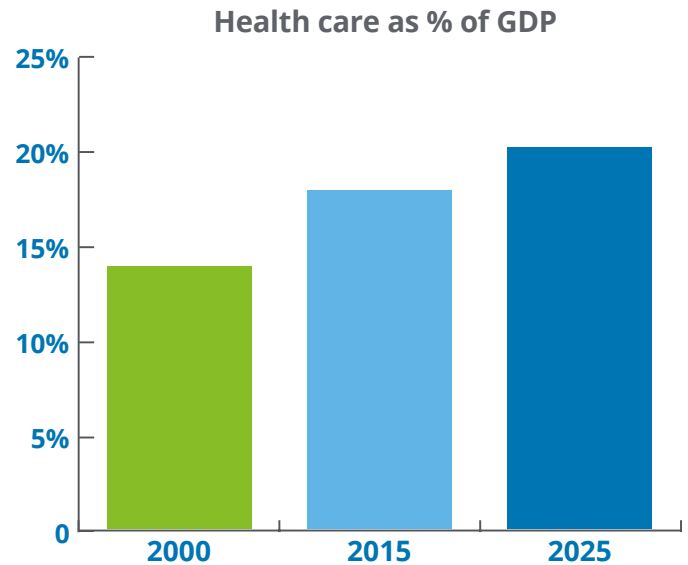
The San Francisco Health Network embedded multidisciplinary teams in a primary care practice to provide services to patients with complex medical needs. The program was found to significantly reduce costs, including hospital stays and emergency department visits, while increasing patient engagement and physician satisfaction.¹¹

¹⁰ <https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2014/05/how-to-share-compliant-data>

¹¹ <https://innovations.ahrq.gov/profiles/primary-care-based-multidisciplinary-teams-provide-care-management-services-complex>

¹² Rising to the challenge: Meeting health insurance exchange consumers' expectations, a 2016 Deloitte Center for Health Solutions survey.

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Source: Kaiser Family Foundation

Creating high-performing networks

Armed with the tools of an effective means of measuring provider performance and enabling providers to access actionable information, health plans are more equipped than ever to create high-performing networks. While patients traditionally preferred the flexibility of wider provider networks, the tide appears to be turning as consumers understand that a “narrower” network may result in lower costs. More than a quarter of exchange consumers said they would accept a smaller network of hospitals and physicians if that meant lower premiums or costs¹². Using the advanced analytics described earlier, health plans can create networks with some of the best-performing, highest value providers. These networks compete not on size, but on value for the premium dollar.

New tools for developing high-performing networks consider the specific needs of that health plan coverage model and the local medical practice patterns. It's important to consider where care goes when a clinic is eliminated from the network. If these members end up out of network or in the emergency room the medical expenses can actually go up, even if the clinic eliminated from the network is very inefficient. In addition, the desirability of the insurance product needs to be considered. Certain name brand care systems may be important to making sure the network is desirable to consumers.

Using narrower networks is the quickest and easiest lever health plans can use to control costs. “It's hard to change behavior. If plans can figure out who is already operating in an efficient and high-quality fashion, they don't need to retrain them,” Whisler said. To assemble a high-performing network, payers should analyze provider practices and referral patterns that feed into network optimization.

Conclusion

Working collaboratively, providers and health plans can recognize that processes to increase quality and lower costs are long-term efforts. “It's putting a process in place that's different than the former process. In our engagements, clients don't just want us to catch some fish, but rather teach them how to fish on their own,” Whisler said.

Looking beyond rate increases, health plans have options to better define their networks with high performing providers, working together to lower the cost of care. With claims and population data increasingly available, both payers and providers can use this information to better understand their patients' needs, referral patterns, quality, and performance metrics. By continually providing providers and patients with information on treatment cost and effectiveness, the care options become more transparent and all parties have the ability to make better treatment decisions.

Contacts

James Whisler

Principal
Deloitte Consulting LLP
jwhisler@deloitte.com

Brian Flanigan

Principal
Deloitte Consulting LLP
bflanigan@deloitte.com

Esther ("Es") Nash, MD

Specialist Leader Health Care Strategy and Operations
Deloitte Consulting LLP
enash@deloitte.com

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