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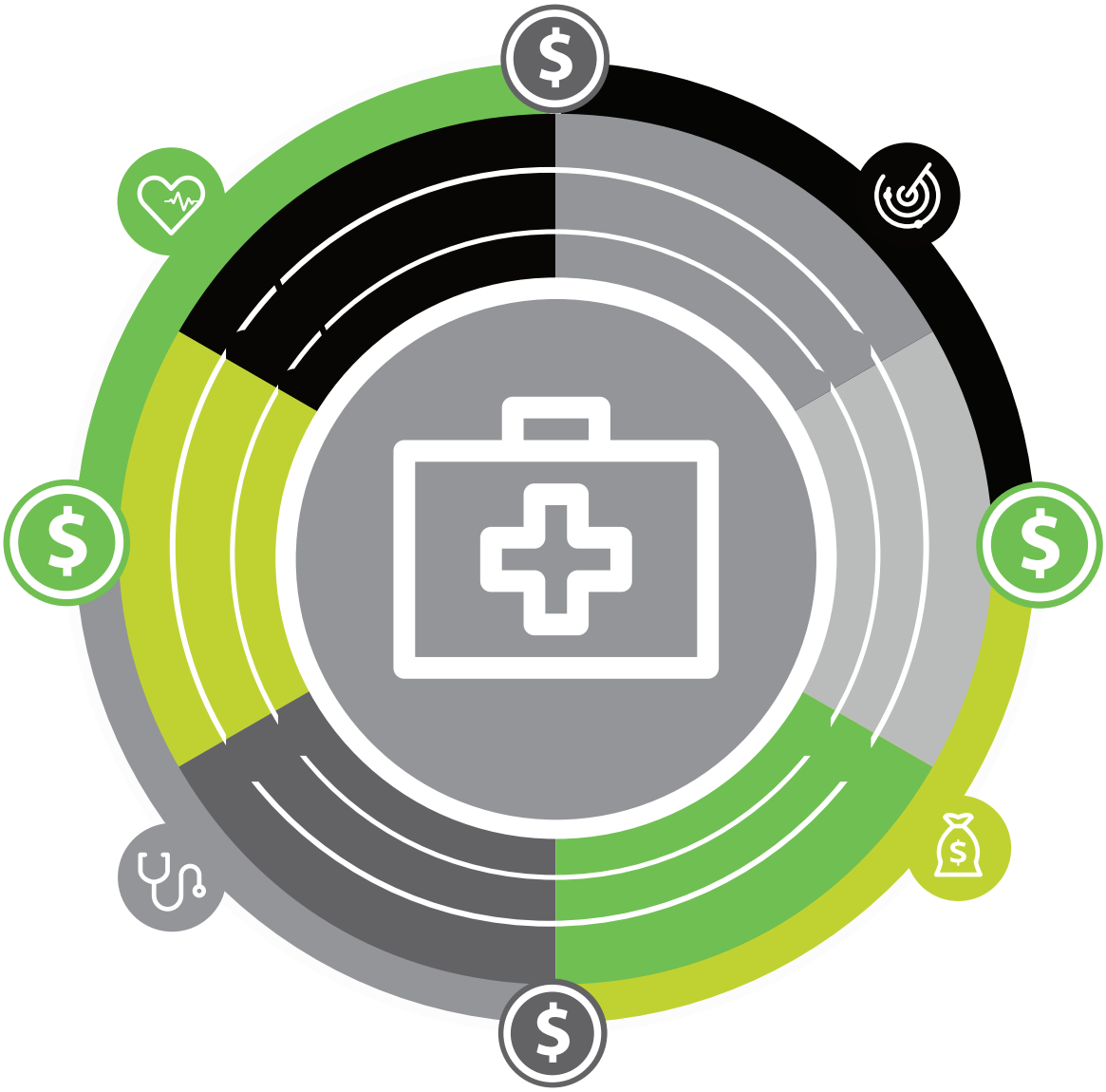


Health care affordability

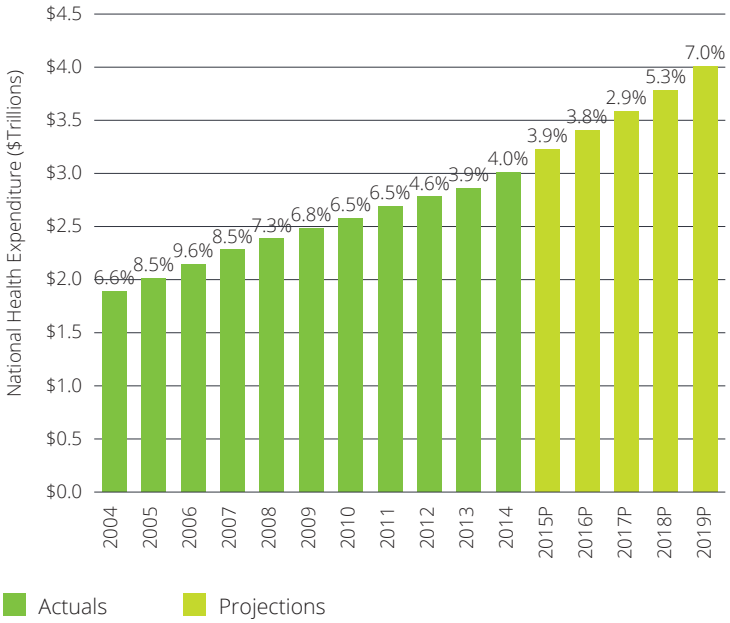
VBC transformation

What's at stake?

The cost of health care in the United States has been on an unsustainable rise for some time, driven by fundamental delivery and financing challenges. Escalating costs and decreasing affordability pose daunting challenges for everyone who pays for health care—health plans, governments, employers, and consumers—and intensify the imperative to shift to a new, value-based strategic framework (Figure 1).

Figure 1. Why is Affordability Important to Health Plans?

National Health Expenditures and Annual Growth Rates[1]
Actuals 2005-2014, Projections 2015-2019



Source: [1]Centers for Medicare and Medicaid Services (CMS) "NHF Tables" and "Historical and Projections 1960-2014"; [2]SNL Financial Benchmark Data; [3]"The Facts on Medicare Spending and Financing," Kaiser Family Foundation; [4]Medicaid's Share of State Budges," MACPAC; [5]Kaiser/HRET Survey of Employer Sponsored Health Benefits

Impact on Health Care Payers

Health Plans

From 2010 to 2015, the average health plan medical loss ratio increased from 86% to 90%[2]

Governments

The Medicare Hospital Insurance trust fund is projected to be depleted in 2029[3]

From 2010 to 2015, Medicaid's share of funded state budgets increased from 12% to 16%[4]

Employers

From 2010 to 2015, average employer contributions to employee premiums increased by 28% from $9,733 to 12,591[5]

Consumers

From 2010 to 2015, average employee contributions to premiums increased by 24% from $3,997 to $4,955[5]

Among key trends that are driving financial pressures across the U.S. health care landscape:

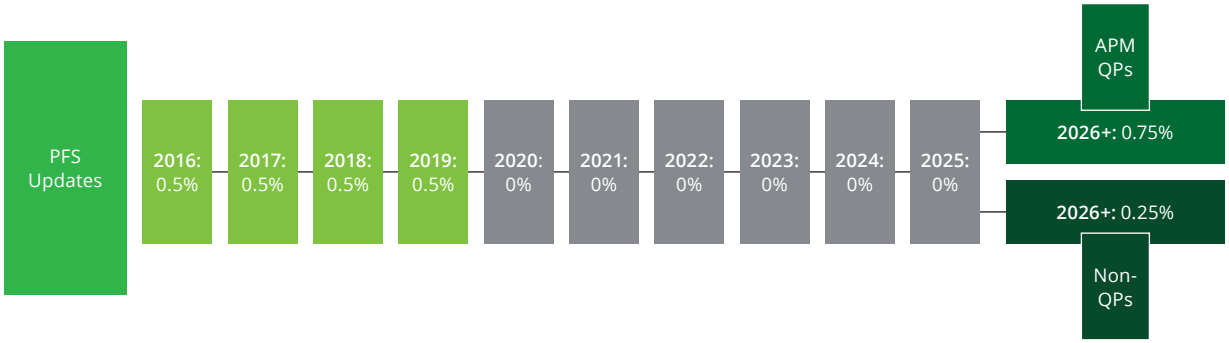
- **Reduced and unstable premiums.** Enrollment in government subsidized plans continues to increase though funding is uncertain; Medicaid payments provide low margin and Medicare Advantage payments continue to be reduced
- **Product commoditization.** As exchanges and regulation increase transparency and consumer choice, consumers are becoming more price-sensitive and less loyal to a particular brand
- **Rising medical and drug costs.** An aging population drives medical and pharmacy PMPM costs, creating pressure to optimize outcomes through innovative population health and provider/PBM collaboration
- **Regulatory compliance costs.** New government policies insurance exchanges, reporting requirements and data security considerations have resulted in significant investment in technology and human capital to meet regulatory requirements.

Health care's unprecedented regulatory, financial, and competitive disruption is requiring stakeholder organizations to evaluate how they can bend the cost curve and provide affordable care. In one major move, many major payers and providers are turning to value-based, alternative payment models (APMs). The Health Care Payment Learning & Action Network reports that 29 percent of health care payments in 2016 were made through APMs (i.e., shared savings, shared risk, bundled payments, accountable care organizations [ACOs] or population-based payments), up from 23 percent in the prior year. This represents a significant advancement in the proportion of payments in these models.[1] In addition, the nation's largest health insurers, UnitedHealth, Aetna, and Anthem , say they are paying out nearly 50 percent of their reimbursements via value-based care arrangements with doctors and hospitals.[2]

The government is also ramping up its investment in alternative payment models: the Department of Health and Human Services (HHS) has set a goal to have 50 percent of Medicare payments in APMs (payment categories 3 [alternative payment models built on fee-for-service architecture] and 4 [population-based payment]) by the end of 2018.[3] Powering the government's push toward these targets is the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which offers significant financial incentives for health care professionals to move away from the traditional fee-for-service (FFS) payment system and participate in risk-bearing, coordinated care models (Figure 2). MACRA and other government policies that transfer more financial risk to providers could narrow the traditional value proposition of health plans, which could lead to substantial disintermediation.

The first payment adjustment under MACRA is scheduled to take effect on January 1, 2019. The Act is expected to have a cascading effect and spur increased participation in APMs across all payers.

Figure 2. Payment updates under MACRA



Under MACRA's Quality Payment Program (QPP), clinicians have two distinct paths for payments under the PFS going forward:

Advanced Alternative Payment Models (APMs)

- Risk-based, care coordination models
- For Qualifying Participants (QPs), temporary bonuses from 2019-2024 (5% of Medicare PFS payments)
- Increasing thresholds for QP status over time
- All-Payer Combination Option begins in performance year 2019

Merit-based Incentive Payment System (MIPS)

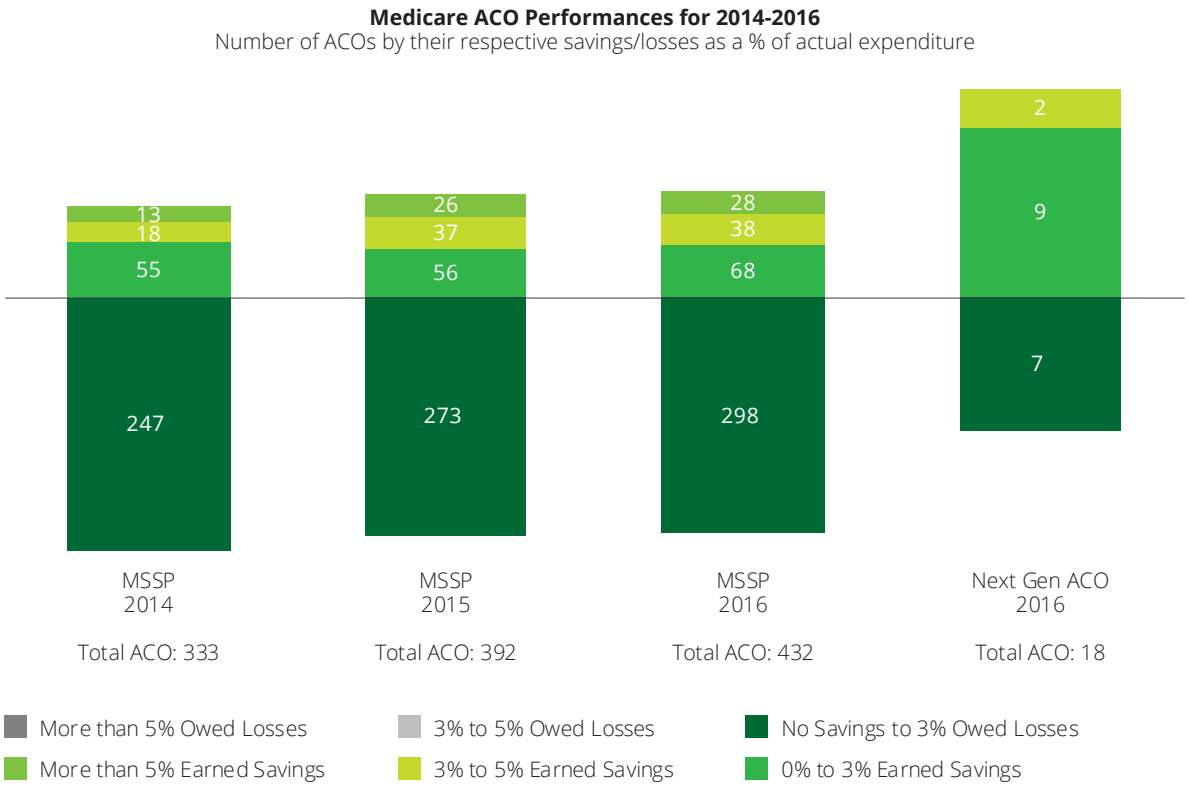
- Consolidates Meaningful Use, Physician Quality Reporting System (PQRS) and Value-based Modifier
- Budget-neutral payment adjustments based on clinician performance
- +/-4% for 2019, progressively increasing to +/-9% for 2021 and subsequent years

Source: Public Law 114-10 (April 16, 2015)

Our take

Despite government and private payers' generally unified efforts to promote value-based care (VBC) via APMs, results to date vary significantly. A review of published Medicare ACO savings for 2014-2016, for example, shows both winners and losers (Figure 3).

Figure 3.



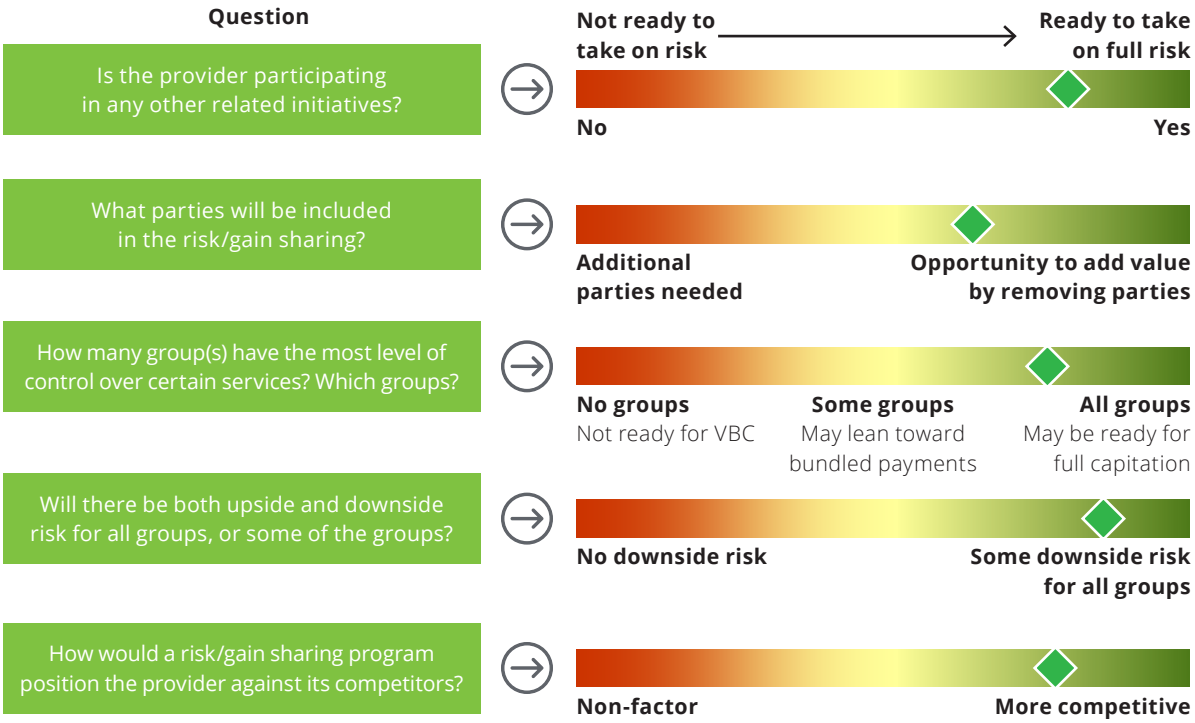
Source: CMS's Shared Savings Program Accountable Care Organizations (ACO) Public-Use Files
Link: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/SSPACO/

How should health plans design and execute their APMs to lay a strong foundation for sustainability? What differentiates alternative payment models that succeed from those that don't? We have observed four common themes among health plans that are experiencing positive results from their value-based APMs:

1. **Level set on payment model type**
   Payment models are generally divided into four categories with increasing levels of risk: Category 1—FFS (no link to quality/value; Category 2—FFS plus a link to quality and value; Category 3—FFS architecture with upside/downside risk; and Category 4—population-based payment. Selecting the "right" payment model requires assessing each provider partner's risk appetite and existing capabilities (Figure 4).

Figure 4. Assessing risk appetite

In order to evaluate payment models, providers must first assess the current state and desired future state of their risk arrangements.



Level of readiness assignments are illustrative

Source:

2. **Establish equitable contracting terms**
   The process of getting to an equitable, aligned, incentive-based payment model requires solid market data to determine target benchmarks (accounting for a price point that will result in a competitive premium rate) and the appropriate share/target for each involved party based on their assumed level of risk. Health plans should collaborate with provider partners to establish payment model contracting terms that are:
   - **Reasonable:** Terms are grounded by the industry's leading or common practices.
   - **Attainable:** Goals can be achieved without substantial investment and within a reasonable timeframe.
   - **Measurable:** Outcomes can be objectively and effectively measured, audited, and tracked by both parties.
   - **Meaningful:** Each metric is purposeful and constructive to patients' quality of care.
   - **Timely:** Results are based on the most recent information available and assessed periodically.

3. **Identify key support areas based on provider partner's current level of capabilities and readiness**
   Based on a provider partner's current level of capabilities and readiness, health plans should identify areas where they may need to provide direct or partial support. These may include care management, risk management and contracting, patient access and engagement, network management, regulatory, performance improvement, and technology.

4. **Provide timely and actionable data to help provider partners proactively manage their at-risk population**
   Once alternative payment model arrangements are in place, it is important that health plans collaborate with their provider partners to track and monitor performance and to compile data at an actionable level so results can be analyzed in real time (Figure 5). For example, an enhanced view of provider relationships allows for deeper insight into performance and efficiency by adding the impact and influence each provider plays in the network. The ability to drill down into efficiency measures by key components helps identify and reinforce positive practices as well as further improve these practices. And individual physician performance dashboards can assess performance in an equitable fashion relative to peers, facilitating performance improvement efforts.

Figure 5. Program monitoring

Monitoring emerging experience on a timely basis will help recognize successful payment models and enable continuous improvement

Source:

Path forward

Implementing the right alternative payment model is only half the battle–taking the following steps may help health plans achieve sustainable success in the new value-based world:

- Become the payor of choice by aligning partnership terms to the incentive structure laid out by MACRA. While health plans have flexibility to define their own APMs, being consistent with CMS/MACRA initiatives will make it easier for provider partners to scale care coordination initiatives and increase adoption of alternative payment models.
- Develop strategies to engage physician partners through service offerings, financial models, and messaging that will resonate with them. Services may include care management solutions that align with provider's current business model and incentives from health plans; and actuarial and financial services, such as designing a VBC product that aligns financial benefits with appropriate member behavior.
- Establish a project management office (PMO) with focused oversight and effective tools to drive VBC transformation through a consistent approach to planning, approving, executing, managing, and tracking initiatives.
- Capitalize on investments in analytics and data management to provide leading insights and help drive network optimization. Examples include physician efficiency scoring to measure cost efficiency at the individual physician and physician group level; shared patient analysis to visualize the strength and direction of a physician's connections, better understand how the network impacts performance, and identify cost reduction through steerage; and network optimization that uses outputs from the physician efficiency scoring and shared patient analysis to design alternative networks which meet specific business requirements.

Bottom line

There is no one-size-fits-all approach to designing and implementing value-based alternative payment models. Health plans will need to tailor their approach based on their partnering providers' risk appetite and VBC readiness and their own VBC offering maturity (e.g., ability to share provider performance data). However, health plans that design and execute their APMs in line with the following common themes (Figure 6) would be laying a strong foundation for APM sustainability.

Figure 6. Foundation for APM sustainability

Source:

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Endnotes

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2. "UnitedHealth, Aetna, Anthem Near 50% Value-Based Care Spending," Forbes, February 2, 2017, https://www.forbes.com/sites/brucejapsen/2017/02/02/unitedhealth-aetna-anthem-near-50-value-based-care-spending/#401cf92c1d4e. Accessed January 31, 2018
3. "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume," CMS press release, January 26, 2015, (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html)

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