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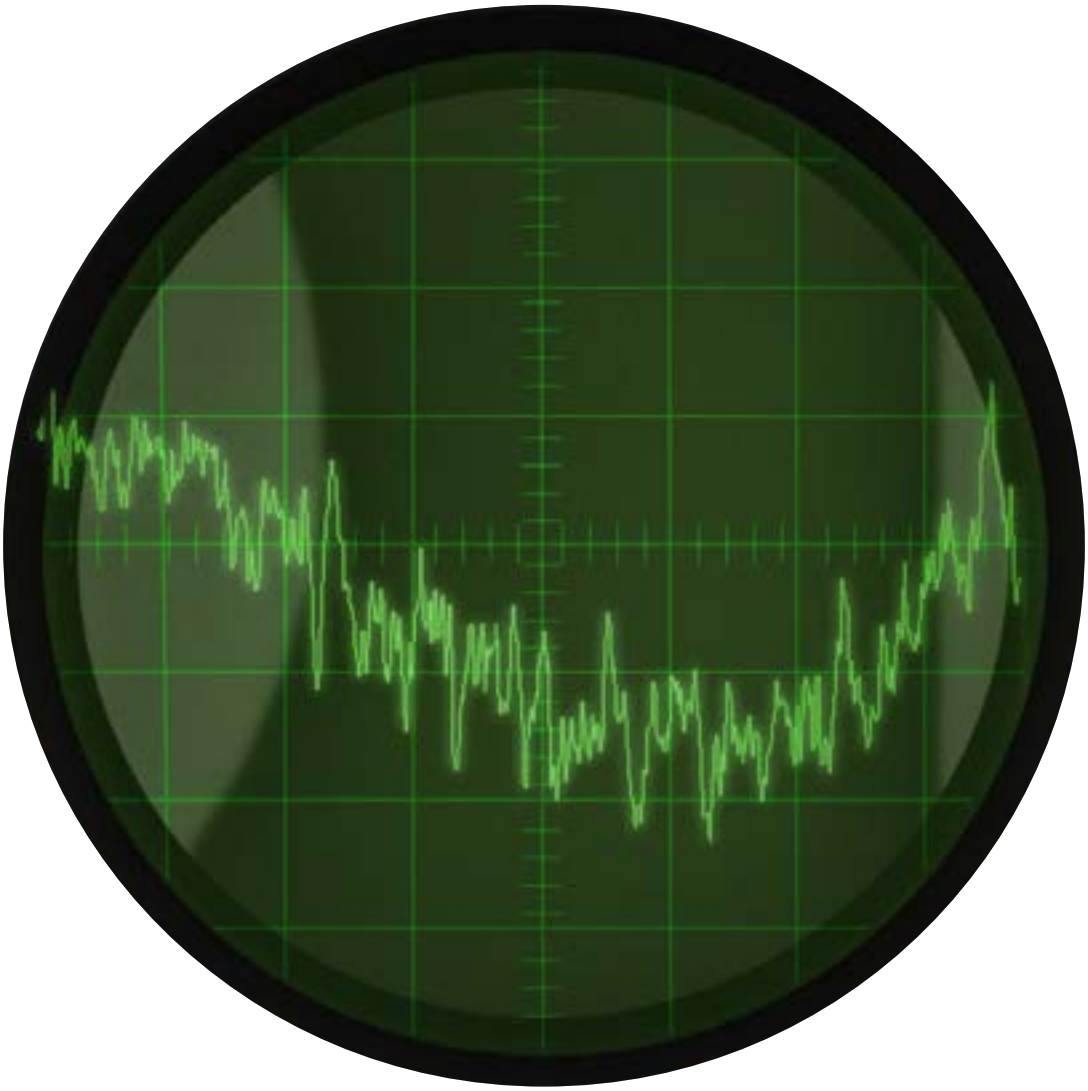

Value based care transformation: Providers

4-Part Blog Series

MAKING AN IMPACT THAT MATTERS since 1845

Intro

Fueled in part by consumer expectations, cost pressures, and regulatory actions many health care provider organizations are pursuing value based care (VBC) business models. In these models, providers work to change their delivery models to improve patient outcomes and promote population health, while reforming payment models to shift payments from the traditional fee-for-service (FFS) reimbursement model. These new payment models tie reimbursement to quality, cost, patient experience, and outcomes – broadly defined as VBC arrangements. Unlike FFS, VBC arrangements align incentives around reducing health care spend and improving patient health outcomes. This shift, intersecting with the underlying goals of the Quadruple Aim, is changing the boundaries of traditional health care and shaping our vision for the Future of Health™.

Now, in light of the COVID-19 pandemic, the need for VBC business models has only become more apparent. Many providers with revenue streams built primarily on FFS payments have realized the shortcomings of this model, initially through the curbing of non-essential care. More recent analysis estimates that nearly 40% of hospitals may face negative margins this year, in spite of the prospect of a smooth vaccine rollout and a decline in COVID-19 hospitalizations.[1] Beyond its financial impact, the pandemic has led to care delivery model changes as well. The increased adoption of virtual care and telehealth has transformed how care is delivered, resulting in a "new normal" that will require providers to understand consumer preferences and deliver care on their terms. It will also require different risk sharing mechanisms for sharing risk with payers.

As health care leaders prepare to emerge from the COVID-19 crisis in this new reality, VBC should be a critical consideration for any recovery strategy, not just in the near future but also for long-term success. Over the course of this four-part series, we'll examine some of the shared experiences provider organizations have encountered in their evolution to VBC. We'll focus on four key moments:

01. **Motivators:** What factors are convincing providers the time to act is now, and driving increased participation in value based arrangements?
02. **Smart first steps:** What immediate actions can be taken to execute on near term strategy, with line of sight to longer term initiatives?
03. **Balancing between two canoes:** How do you transition to a VBC enterprise while continuing FFS operations?
04. **Long-term success:** What are some of the must-have requirements for a long-term roadmap to success under VBC?

PART 1

Motivators: *What factors are convincing providers the time to act is now?*

A confluence of internal and external factors is driving the health care industry's investment in value based business models, with implications that span strategic, financial, clinical, operations, technology, and change management for provider organizations. From regulatory, and market pressures, to the lasting impact of the COVID-19 pandemic – here are some of the common motivators prompting providers to act.

Regulatory changes

In 2019, 41% of Medicare payments, 30% of commercial payments, 53% of Medicare Advantage payments, and 23% of Medicaid payments were tied to alternative payment models (APMs).[2] With the growing number of laws and regulations that continue to pave the path for APMs, coupled with a commitment to VBC expressed by new CMS and CMMI leadership, we can expect those numbers to increase as regulatory drivers, such as increased data-sharing, price transparency, greater flexibility in physician compensation, and the rise of virtual health, continue to push the market towards VBC.

Case example

The Deloitte Center for Health Solutions conducted a survey in the fall of 2020 with 30 finance executives (CFOs, finance VPs, and revenue cycle VPs) of large health systems (revenue greater than $500 million) to better understand their approach to new regulations around data-sharing and price transparency rules from CMS and HHS. When asked how the industry would most likely benefit from data-sharing regulations, survey respondents widely agreed that these efforts would lead to "accelerated adoption of value based payment models".[3]

Changing consumer expectations

Supported by findings from the Deloitte Center for Health Solution's survey of U.S. health care consumers, digital tools and other technologies are helping consumers play a more active role in the management of their own health. With increased engagement, we are also seeing changes in expectations, with greater emphasis placed on high quality, convenience, and lower costs. Simply put, the empowered patient is redefining health, increasing focus on well-being, and demanding more customized products, offerings and experiences. Providers can better meet growing expectations through innovative care models that use virtual and home health, and by rethinking consumer relationship and patient engagement strategies. A key set of capabilities – such as robust, interoperable digital platforms that enable a comprehensive picture of a patient's clinical, financial, and socioeconomic data, will be required to meet the demands of a consumer-driven patient population. Beyond care delivery, different payment models will be necessary to remain economically viable as providers move from traditional care models to increased use of virtual care and a greater focus on wellness.

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Case example

A non-profit regional health system strategically committed to embracing population health and better serving its community engaged Deloitte to assess its readiness to enter into more value-based payer arrangements, particularly Medicare Advantage and Employer Benefits solutions. Deloitte completed an assessment of its existing capabilities and provider footprint and based on gaps identified in care management and analytics, recommended strategic partnerships with health plans that possess these capabilities in order to meet the care delivery needs of their attributed patients, improve their consumer engagement, and properly manage risk.

Market pressures and competition

While the pace of transition from traditional FFS to VBC varies by market, we often see a more rapid shift from first movers to others following suit. Laggards in the market may risk losing market share to competitors moving more aggressively towards alternative payment models. This is because the way providers win in a value based payment landscape is fundamentally different than with FFS. In many value based payment models, the goal is to gain attributed lives and try to manage more of the total spend for a given consumer, while also earning revenue for keeping them healthy. Since providers are competing for a finite number of patients in a given market, subsequent movers often realize they need to move quickly. Providers will need to consider their alignment with health plans beyond traditional FFS to avoid falling behind.

Beyond market share from a patient perspective, health systems are also competing for alignment with independent physician groups. Value-based networks such as accountable care organizations (ACOs) offer health systems a way to expand their patient population more cost-effectively than via direct employment through alignment with independent practices. Physician practices also stand to benefit by gaining access to the resources and capabilities to better manage population health that they otherwise might not have, as well as through shared savings for better outcomes and lower costs. Value based arrangements, particularly those with competitive shared savings distributions, will be necessary to maintain adequate physician engagement.

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Case example

In 2020, a national health system with a clinically integrated network (CIN) faced a substantive threat to market share when the largest commercial insurer in one of its regional markets offered a prepayment arrangement to primary care physicians (PCPs) in response to the uncertainty of the pandemic. For PCPs in the market, entering into this arrangement was dependent on their participation in an ACO contract with that insurer, a value-based contract this health system did not have. As such, many of the PCPs in the market felt it necessary to join a competitor's CIN. For health systems looking to maintain their physician relationships, the ability to offer independent physician groups an array of contracting options will be a differentiator, with downstream implications for patient retention and continuity of care.

COVID-19

Before the pandemic, most health systems approached value based arrangements with caution, particularly those with downside risk. Analysis from the Catalyst for Payment Reform found that, although the percentage of dollars flowing through value-oriented methods in commercial health insurance has increased (from 10.9% in 2012 to 53% in 2017), only a small share of total dollars (~5%) is at risk, and this share has not changed over time. We see parallels in the public sector: 71% of 2019 Medicare Shared Savings Program participants were in upside-only arrangements.[4] With most of providers' revenue still tied to FFS, there was little business need for organizations to reorient their care models and physician compensation around value.[5]

However, COVID-19 has drastically changed this dynamic for provider organizations. The pandemic has disrupted the financial security of many health systems and physicians as traditional revenue streams reliant on FFS plummeted and patient volumes significantly decreased. In late summer 2020, an American Medical Association (AMA) survey of patient care physicians found that 81% of physicians surveyed reported revenue that was still lower than pre-pandemic, with an average decrease in revenue of 32%.[6] Beyond 2020, the pandemic has created a growing backlog of patients waiting for elective care and has amplified many long-term conditions of patients awaiting treatment. It is likely that the issues and developments arising from responses to COVID-19 could act as a catalyst for wider adoption of VBC arrangements, making VBC strategy as important now as ever.

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Case example

Our team has talked with a number of physician practice groups throughout the past year to help them think through the various challenges they face due to a decline in business since the outbreak. Several groups cited difficulty mitigating fixed costs in the short term, resulting in employee furloughs and layoffs. Others recognize a need for accelerated telemedicine capabilities due to the transition from clinic-based care to virtual appointments. As providers continue to confront these challenges, they will need to consider not only how to respond and recover, but also how to set themselves up for success in a changed, postcrisis space.

Conclusion and transition to part 2

In health care's traditional landscape, many providers were given the latitude to protect their core business, and "wait and see" what VBC would mean to them. Now, as health care executives survey the state of local market conditions, it's likely that one of these factors is evident and already influencing strategy of either their own organization or a major competitor's. Individually these factors can push one organization to consider VBC models, but taken together, they create mounting pressure on the market as a whole. Shifting to VBC is no longer a decision between protecting the core or positioning for transformation – in health care's new reality, it's becoming a requirement to stay viable.

In the next part of this series, we'll discuss what we've seen from some organizations who have taken steps to position themselves as value based players, through both payment model reform and care model innovation, both of which are required to succeed in the transformation from volume to value.

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Sources:

1. Robert King, "Kaufman Hall: Nearly 40% of hospitals may face negative margins this year even with smooth vaccine rollout," Fierce Healthcare, March 23, 2021.
2. Health Care Payment Learning & Action Nework (HCP-LAN), "APM Measurement Effort," 2019.
3. Anne Phelps, Christi Skalka, Wendy Gerhardt, and Christine Chang, "Greater transparency and interoperability in health care: Uncover strategic opportunities for health systems," Deloitte Insights, January 25, 2021.
4. Catalyst for Payment Reform, National Scorecard on Payment Reform 2.0 – Lookback Edition, 2018.
5. Mark Bethke, Randolph Gordon, Natasha Elsner, and Hemnabh Varia, Equipping physicians for value-based care, Deloitte Insights, 2020.
6. American Medical Association, "COVID-19 financial impact on physician practices," 2020.

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