



## Value based health care models in a shifting economy

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# What is value based care?

Fueled by regulatory actions, consumer expectations, cost pressures, and an overall shift in the health care landscape, we are expecting to see an acceleration in the transition from traditional fee-for-service (FFS) reimbursement models to payment models which tie reimbursement to quality and cost, broadly defined as “value based care arrangements.” Unlike FFS, value based care models incentivize reducing spending while improving quality and outcomes. The focus of providing value based care can be thought of in the context of the quadruple aim: better outcomes, lower costs, improved patient experience, and improved clinical experience.

There are four main types of value based payment models:



**Performance-based payment:**

In addition to traditional FFS payments, an organization receives an additional payment based on achievement of certain metrics or completion of certain activities.



**Bundles:**

Instead of paying separately for hospital, physician, and other services, a plan bundles payment for services linked to a particular condition, procedure, or service (e.g., hospital stay, office visit). A provider organization can keep the money it saves through reduced spending on some component(s) of care included in the bundle.



**Shared savings and risk:**

An organization is paid using the traditional FFS model, but at the end of the year, total spending is compared with a target; if the provider organization's spending is below the target, it can share some of the difference as a bonus. If a provider organization spends more than the target, it must repay some of the difference as a penalty. The amount of upside or downside is negotiated or otherwise set according to the model and may not include a requirement to pay out in the event spending is above target.



**Capitation:**

In the case of global capitation, a provider organization receives a fixed payment (e.g., per-person, per-month), intended to pay for all individuals' care, regardless of what services they use. Another common type of capitation is primary care capitation, which pays a provider organization a fixed amount for provided primary care services for a selected individual.

# Why act now?

Historically, the industry discussion surrounding payment models was characterized by a strategic choice: FFS or value based care. However, it is quickly becoming apparent that value based care is no longer an opt-in decision. Rather, it is becoming a critical part of any health care stakeholder's short- and long-term strategy to create top-line revenue and contain costs. Health care players are being driven toward value based care by market pressures, regulatory support, and shifting consumer demands; delays in shifting to value based payment models can put stakeholders behind in the marketplace and their ability to deliver high-quality, cost-effective care.

Additionally, if we consider this transition against the backdrop of a pandemic, the need for value based care is increasingly apparent. COVID-19 is affecting every aspect of our lives and is changing the landscape of health care. As part of this rapid acceleration of change, the shortcomings of the fee-for-service (FFS) payment model are being amplified. Physicians and hospitals are losing millions of dollars through the curbing of nonessential care, and the gap will not be easily closed as the economy reopens. The continued dramatic shift to telemedicine and alternative sites of care delivery will further exacerbate the problems being caused by our FFS model. Although it is impossible to argue that building a payment model designed specifically to thrive during a pandemic is a strong strategic approach, it would also be naïve to think that additional stressors akin to these will not test the health care system in the future. The “new normal” for health care will require a different risk-sharing mechanism between payers and providers. If you don't start preparing your health care organization for our new reality, you will quickly fall behind.

The need for a shift from FFS can be found in the data. The total annual cost of US health care waste is around \$935 billion, accounting for roughly 25% of total health care spend.<sup>1</sup> CMS predicts that national health expenditure will rise to 20% of GDP by 2025, while health care costs as a percentage of total family income will rise to unsustainable levels.<sup>2</sup> Fortunately, value based contracts can help improve the quality of care while slowing the cost curve; some studies have shown reduction in total claim spend by more than 10% after adopting value based practices.<sup>3</sup> Federal, state, and

local governments have taken notice of the benefits of value based contracts and have supported the payment model with new laws and regulations designed to increase adoption.

Here are some regulatory examples:

- **MACRA:** 2015 legislation that rewards clinicians for value over volume
- **Stark Law Reform:** 2019 proposed legislative reform designed for greater flexibility for providers engaging in value based purchasing arrangements

Financial and regulatory headwinds have been pushing the industry toward value based care for several years. More recently, health care players are increasingly facing shifting consumer preferences as patients demand higher-quality care, lower costs, and increased access and transparency with respect to data and services. In order to continue to effectively engage patients, care delivery is becoming more consumer-centric and wellness-focused, accelerated by virtual health and the opportunity for consumers to receive care from home. Priorities are shifting toward prevention, education, patient-provider communication, consumer-facing tools, psychosocial support, coaching, lifestyle analytics, and social drivers of health. In order to attract and retain consumers within the system and promote improved outcomes and healthy living, provider organizations are creating differentiated and fully integrated consumer experiences by removing friction from plan and provider services and refining consumer platforms to drive omnichannel outreach and engagement. Value based care is becoming a strategic lever that must be addressed moving forward.

The need for value based care has been highlighted during the COVID-19 pandemic. Value based contracts can help diversify provider revenue streams in the face of reduced patient volumes while also better aligning incentives to address social drivers of health, whole-person care, and well-being. In the face of a global pandemic that has curbed millions of dollars in nonessential care, plan and provider organizations will need to work together to develop value based payment models to recover and grow.

# Stakeholder perspectives on value based care

Various health care stakeholders face unique opportunities and challenges when it comes to successfully implementing value based care practices. Even within specific industries and functions, individual organizations should view implementing value based care practices through their unique, strategic lens. In the sections below, we will address how value based care practices affect providers, plans, large employers, the federal government, and life sciences firms.

## Providers

When value based care is discussed, health care providers are often thought of as the primary stakeholders. This is largely due to the fact that providers are ultimately responsible for making the care delivery changes necessary to enable value based contracting. Providers are motivated to implement value based care models to enable preventative care delivery models, improve the patient and clinician experience, align financial incentives around the quadruple aim, and reclaim revenue lost to FFS rate pressures. Although the benefits of value based care delivery models for specific patient populations have been clear for some time, we are seeing increased engagement in activating value based care practices at a systemic level as providers see improved health and financial outcomes for broader patient populations.

Adoption of value based contracts has steadily increased over the past several years and is expected to continue accelerating in the near future. This is especially true with Medicare populations, where providers have shown an increased willingness to take on value based models.<sup>4</sup> However, adoption in commercial and Medicaid populations has not been as high; in 2017, the National Scorecard on Commercial Payment Reform found that only 53% of all commercial payments made to providers were value-oriented, while 47% were status quo payments.<sup>5</sup> Although there are examples of movement toward value based care models, there are still systemic headwinds slowing increased adoption. Identifying and mitigating these challenges is critical for any organization looking to expand its value based care model.

Successfully implementing a value based care delivery model requires balancing the competing business models of FFS and value based care, developing a clear implementation strategy amongst internal business leaders, and ensuring a robust network that properly aligns contract incentives. Of the key challenges



to implementing a value based care model, developing a strong strategic plan is the most critical step for organizations. For many providers, transitioning into a value based care model involves a significant business model shift. To do so, providers must engage in strategic planning around which business units and service lines should switch to value based care and when they should transition. Critical in this planning is the development of provider compensation models. These models must evolve to incent the behaviors that drive quality, cost, and wellness enhancements rather than continuing to encourage volume. Without careful strategic planning, providers risk short-term revenue losses and organizational misalignment. In addition to creating a clear strategy for implementing a value based care model, organizations must develop specific capabilities.

At Deloitte, we have developed a value based care capability maturity assessment framework for providers to support in developing and enhancing the capabilities needed to successfully deliver value based care:

## VBC capability assessment framework

### Leadership, governance, and talent

Ability to align and engage executive leadership, staff, physician leaders, and governance structure(s) to promote effective, efficient decision-making, establish accountability, and advance Allina toward an innovative model of care

### Performance management and analytics

Ability to use data analytics to generate descriptive and prescriptive reports on outcomes and performance (e.g., cost, utilization, and quality), informing the care team with actionable insights

### IT infrastructure and interoperability

Ability to leverage integrated systems and processes that support business requirements of value-based care models, enhance communication between providers, and advance care coordination

### Patient experience and consumer engagement

Ability to create a differentiated, high-quality patient experience in order to help retain patients in the network and promote improved outcomes and healthy living

### Financial, contracting, and risk management

Financial readiness to become a risk-bearing entity and ability to manage risk across multiple categories: performance, financial, and insurance

### Quality, care coordination, and management

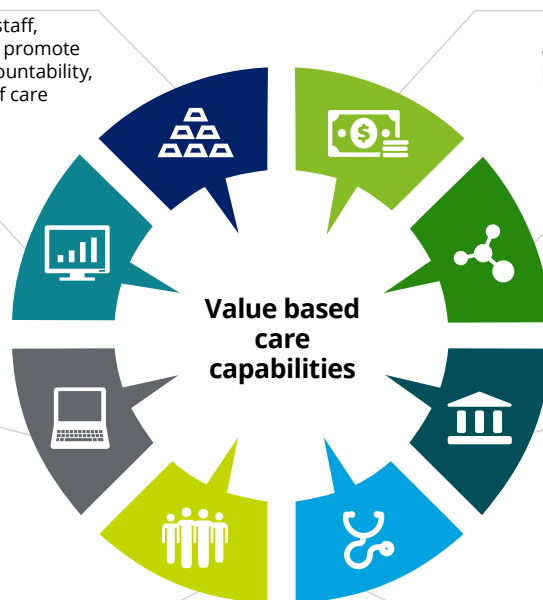
Ability to utilize best practices around chronic disease management, care coordination, complex care management, and performance reporting to enhance quality and service across the continuum of care

### Business and clinical operations

Existence of capabilities and processes to ensure high-quality care, enhanced outcomes, reduced costs, regulatory compliance, and success in VBC performance incentive structure

### Network and physician engagement

Ability to engage physicians and other providers to lead VBC model transformation, with a focus on increased quality, decreased costs, better patient outcomes, and improved health and well-being of populations





## Plans

Although the relationship between plans and providers is often seen as adversarial, value based arrangements offer an opportunity to better align incentives between the parties. Plans who successfully enter into value based contracts are able to drive better outcomes for their members, enhance the member experience, reduce overall health care costs, grow relationships with their networks, and grow market share through offering a differentiated product. These factors lead to more satisfied members, reduced premiums, and a stronger provider network. National health plans are taking note of these benefits and engaging in value based contracting. Explore a few examples at the bottom of the page.

## With the benefits to value based care so clear for plans and some of the limitations systemic, how can plans continue to move forward with value based contracting?

It is important to note the challenges plans face in moving toward large-scale implementation of value based contracts. First, it can be difficult to articulate the benefits of value based contracts to plans given the switching costs involved with any change. Additionally, variances in payment models, quality measures, and other parameters can make value based contracts difficult to administer. Finally, a lack of access to clinical data can compromise a plan's ability to understand the full health picture of its members; while claims data may exist, clinical data can be difficult or impossible to capture. With the benefits to value based care so clear for plans and some of the limitations systemic, how can plans continue to move forward with value based contracting?

### Plans are adopting value based care contracts:

- **Anthem<sup>6</sup>** has increased their efforts in the space, also aiming for 75% of payments to be fueled by value based contracts by 2020. Anthem was three percentage points ahead of Aetna at the end of 2018, with 56% of payments having downside risk.
- **Humana<sup>7</sup>** made a large push to increase its value based care contracts in their Medicare Advantage business, which led to \$3.5B in cost savings. Medical costs for members in Humana's VBC plans were 20% lower than comparable benchmarks.
- **UnitedHealth Group<sup>8</sup>** estimates that by 2020, it will have \$75B of payments tied to value based care relationships, up from \$64B in 2017. Currently, more than 15M members nationwide are accessing care from a value based care physician.
- **Blue Cross Blue Shield** is beginning to see the benefits of value based care contracts as it begins to implement them in states such as North Carolina, New Jersey, Nebraska, and Kansas.

To successfully implement value based care contracts as a plan, key capabilities are required. At Deloitte, we have developed an assessment framework to support plans in developing and enhancing the capabilities they need to successfully transition to value based care contracts in their network:

Strategic category	Capability lever	Key capabilities
Develop Strategy	Enterprise Network Strategy Development	<ul style="list-style-type: none"> <li>Network Strategy and Planning</li> </ul>
	VBC Strategy Development	<ul style="list-style-type: none"> <li>VBC Opportunity Identification and Measurement</li> <li>VBC Competitive Assessment</li> <li>VBC Strategy Definition</li> <li>VBC Strategy Articulation</li> </ul>
Design & Maintain Products and Networks	Network Definition	<ul style="list-style-type: none"> <li>VBC Network Adequacy Standards Definition</li> <li>Network Modeling</li> <li>Provider Segmentation</li> </ul>
	Network Configuration	<ul style="list-style-type: none"> <li>Network Setup</li> <li>VBC Network Integration</li> <li>Network Maintenance</li> </ul>
	Healthcare Partner Management	<ul style="list-style-type: none"> <li>Partner Planning</li> <li>Partner Delegation and Evaluation</li> <li>Operations Coordination</li> </ul>
	VBC Product and Offering Development	<ul style="list-style-type: none"> <li>Product Ideation and Determination</li> <li>Product Research</li> <li>Product Strategy and Design</li> <li>Product Regulatory and Policy Management</li> <li>Product Development</li> <li>Sales Orchestration</li> </ul>
Establish & Manage Contracts	VBC Contract Formation	<ul style="list-style-type: none"> <li>VBC Contract Modeling</li> <li>Value Based Program Parameter Definition</li> <li>Provider Responsibilities Definition</li> <li>Provider Contract Development</li> <li>Contract Negotiations Support</li> <li>Contract Setup</li> </ul>
	Provider Contract Administration	<ul style="list-style-type: none"> <li>Member Population Identification</li> <li>Provider Quality Performance Measurement</li> <li>Provider Financial Performance Measurement</li> </ul>
	Financial Performance Management	<ul style="list-style-type: none"> <li>Risk Adjustment</li> <li>Financial Settlement</li> </ul>
Support and Engage Providers & Consumers	Provider Engagement	<ul style="list-style-type: none"> <li>Trainings and Tools Provision</li> <li>Provider Consultation</li> <li>Provider Enablement Services</li> <li>Referral Support</li> <li>Provider Relationship Development</li> <li>Clinical Decision Appeals Management</li> </ul>
	Purchaser Engagement	<ul style="list-style-type: none"> <li>Health Coaching &amp; Consumer Education</li> <li>Benefit Navigation Support</li> <li>Care Navigation Support</li> <li>Social &amp; Community Support Enablement</li> <li>Member Involvement</li> <li>Consumer Analytics</li> <li>Employer Group Engagement</li> </ul>
	Care Management	<ul style="list-style-type: none"> <li>Care Management Synchronization</li> <li>Care Management Program Design</li> <li>Care Coordination &amp; Transition Management</li> <li>Medical Utilization Review &amp; Management</li> <li>Member Wellness Management</li> <li>Member Prescription &amp; Adherence Monitoring</li> <li>Chronic Condition Management</li> <li>Integrated Behavioral Health Management</li> <li>Post Acute Care Planning</li> </ul>
Generate Analytics and Distribute Reports	Insights Generation	<ul style="list-style-type: none"> <li>Data Sharing and Management</li> <li>Population Health Analytics</li> <li>Member Health Analytics</li> <li>Provider Performance and Analytics</li> <li>Pharmacy Analytics</li> </ul>
	Member, Provider, and Group Reporting	<ul style="list-style-type: none"> <li>Member Reporting</li> <li>VBC Provider Reporting</li> <li>Group Reporting</li> </ul>
	Program Reporting	<ul style="list-style-type: none"> <li>VBC Executive Performance Reporting</li> </ul>
	Regulatory Reporting	<ul style="list-style-type: none"> <li>Regulatory Filing Orchestration</li> </ul>
Continuously Improve	Program Evaluation	<ul style="list-style-type: none"> <li>VBC Program Evaluation</li> <li>Capability Maturity Assessment</li> <li>Network Performance Analysis</li> <li>Care Management Program Evaluation</li> <li>Member Feedback Management</li> </ul>
	Strategic Objective Measurement	<ul style="list-style-type: none"> <li>VBC Process Improvement</li> <li>Operational Excellence Assessment</li> </ul>

### State and federal government

As one of the largest providers of health care services, state and federal governments have a clear incentive in implementing value based care. Much like health plans, government plans look to value based care systems to deliver health care to citizens at a lower cost, resulting in better health outcomes. Additionally, value based care systems can provide increased access to care, especially for vulnerable populations. Both federal and state governments are moving to increasingly require that payments be tied to quality and cost.

At the state level, several State Medicaid Agencies have implemented standards for adoption of value based contracting. From 2014 to 2018, there was a 7x increase in the number of states and territories implementing value based programs.<sup>9</sup> Furthermore, all but four states (Georgia, Indiana, Mississippi, and West Virginia) are engaged in some value based programming or have implemented targets or mandates. Out of these states, New York, Pennsylvania, and Vermont are leading the transition to value based care models, with 23 other states having value based payment targets or mandates that plans and providers have signed.<sup>10</sup>

At the federal level, there are several avenues government is using to drive adoption of value based care. The Centers for Medicare and Medicaid Innovation (CMMI) continues to roll out innovative payments models, including some that have mandatory participation. The Centers for Medicare and Medicaid Services (CMS) continues to invest in Medicare Advantage as a way to reduce costs by transferring risk to commercial health plans. Regulators across the federal government have released legislation aimed at increasing price transparency, promoting interoperability, and reducing information-blocking, all with the goal of increasing participation in value based arrangements.

While changing care delivery structures can be challenging in the private sector, there are additional headwinds in the public sector that further complicate transitioning to value based care models.

First, health care has been politicized in a way that makes any change challenging. Additionally, the financial viability of the current system is so fragile that locating any funding for a transition, regardless of the long-term benefit, is difficult and can stymie initial action. Finally, the stratified populations not only across states, but also across and even within cities, creates a challenging situation as developing programs and payment models that effectively serve populations with divergent needs and coverages is no simple task. There is not a one-size-fits-all solution at the state and federal level. In order to deliver effective value based care at these governmental levels, specific capabilities are required.

Although there are challenges to adopting value based care delivery models at the state level, specific capabilities, when built, can lead to great financial and health results for communities. Deloitte has effectively partnered with state agencies to revolutionize the way they deliver value based care to their communities. In order to effectively deliver value based care models first, strong partnerships within the local health care community must be developed and fostered. From there, it is critical to offer a comprehensive and complementary portfolio of care models that bring a variety of providers into the value based care model. Next, enablement capabilities must be developed to help providers achieve desired outcomes. With partnerships and a network enabled, proof points measuring the value of contracts and capabilities must be shared and publicized to generate buy-in. To continue to improve health outcomes, state governments must build care management capabilities around chronic care, care coordination, medication adherence, social drivers of health, behavioral health, post-acute care, and wellness. Finally, for successful value based care model implementation, there must be strong data governance and management, as interoperability and coordination are key across stakeholders. If implementing value based care models were simple, this would be the standard care delivery model by now. While transitioning can be challenging, we have the experience and capabilities to drive this change, and the end results will affect millions of lives.



### Life sciences

An emerging set of players in value based care model conversations, life sciences firms are increasingly engaged in developing ways to tie payment for pharmaceuticals, medical devices, and therapeutics to patient outcomes. Some of this action is driven by necessity; plans, providers, and patients are pressuring life sciences firms to demonstrate the value of their products and therapeutics. For plans, drug costs are rising, forming a larger portion of the member's total expense. For these reasons, we see an initial trend of plans wanting to engage in performance-based risk-sharing agreements with pharmaceutical companies, especially for specialty medications.<sup>11</sup> While there is a clear rationale for life sciences firms to move toward embracing value based care models, specific capabilities need to be developed to encourage this transition, as developing evidence showing treatments have differentiated outcomes is challenging and costly.

Life sciences firms need to develop specific capabilities to transition to value based care models in a similar manner as plans and providers. These capabilities often align more to life sciences firms' need to demonstrate their market value to consumers. This is a positive shift, as a firm's ability to match reimbursement rates to consumer value improves the market as a whole and reduces monopolistic practices. More specifically, life science firms must define their value drivers and the way they plan to capture that value, provide evidence that supports these value claims, and monitor performance to manage the capture of value while providing differentiated, complementary services and solutions.



## Employers

Like the other stakeholders discussed, employers are looking for ways to reduce the total cost of health care services while keeping their people healthy and coming to work. Partnering with health plans and/or providers to implement value based care models can reduce overall health care spend while increasing satisfaction, health, and access for their employees and their families.

The practice of employers contracting directly with plans or providers is not widespread, but the trend is increasing, as a large percentage are considering making the move to value based care models. As recently as 2019, only 6% of employers contract directly with providers, but 22% are considering moving toward direct contracting.<sup>12</sup> Although there is momentum in employers shifting toward engaging in value based care contracting, there are challenges.

Often hindering employers from engaging directly with value based care contracts is the reality that this is not a core competency of

most organizations. Unless there is sufficient scale that warrants either building out such expertise or hiring a third party to manage the employer-provider contract administration, engaging in traditional insurance models can be more efficient. Additionally, many large employers span multiple states, complicating contracting agreements. Although there are challenges, the benefits of employers engaging in value based care contracts are clear.

In order to effectively implement a value based care model as an employer, it is critical to identify community partners, provider systems, and health plans that can act on value based arrangements. Although this lift can be initially challenging to employers, the benefits of implementing a value based care model not only reduces costs for the firm and employees, but also leads to better health outcomes. Firms that are frustrated with their current health benefits structure are primed to have strategic conversations about how to engage in value based care models.



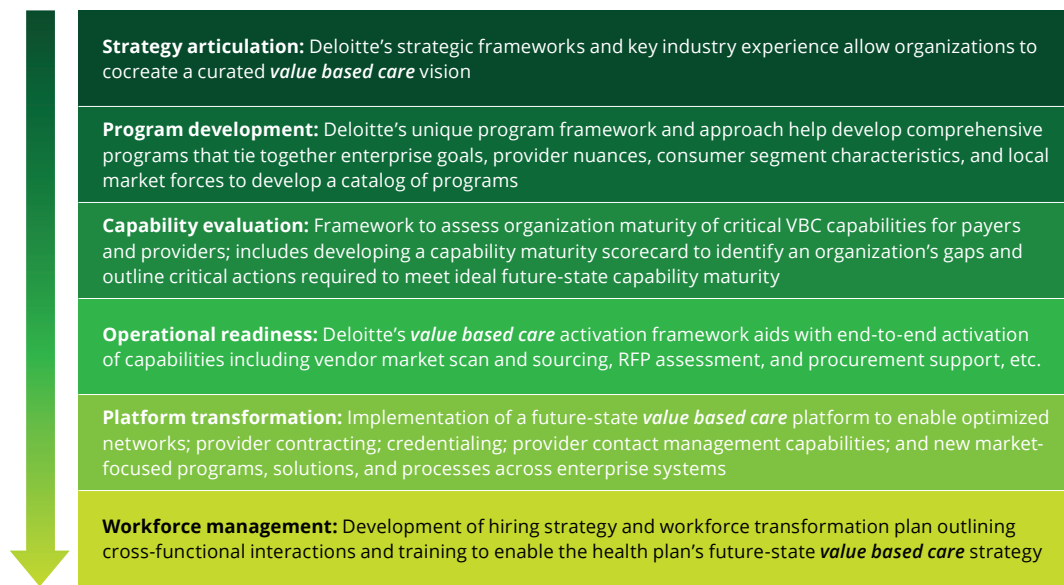
# Deloitte value based care value proposition

Deloitte recognizes that value based care is more than just changing a payment model—it's also helping organizations transform care delivery, financing, and diagnostic and therapeutic discovery with the aim to advance patient outcomes, reduce total cost of care, and enhance the consumer experience.

## What are the elements of a successful transformation?

-  Enterprise-level strategy and business model transformation
-  Payment model design
-  Care delivery model design
-  Analytics
-  Virtual health
-  Technology and interoperability
-  High-performing, comprehensive provider network design and contracting
-  Ecosystem partnerships

Deloitte offers a broad range of services across strategy, operations, technology, and human capital needs to enable and activate a plan's value based care vision:



There are different ways of implementing value based care that may help ease the financial investment; fluidity in implementation allows for more customizable models to better fit your organization. For example, health care organizations may adopt incremental value based payment models to ease their transition, beginning with methods such as shared savings and pay-for-performance, which involve limited financial risk for the providers. Many health systems and hospitals are developing accountable care organizations (ACOs) or other partnering arrangements for implementation. Partnerships may allow for preferential market share through arrangements with plans or, for those aiming to be less heavily involved, may allow for less pressure in their markets. They also allow organizations to pool resources and share in investments. Certain value based payment models may require more sophisticated IT platforms, extensive data analytics, and future-state planning. Investments may be needed based on the current capabilities of the particular health system or hospital, requiring investments in new systems and processes or partnerships that already have them. It's important for health care stakeholders to work together where possible to align value based care models to ensure critical attributes such as quality measures, payment arrangements, and attribution models are standardized across contracts and lines of business.

Here are a few ways that your organization can get the ball rolling:



**Evaluate where you are and where you are going:**

Understanding your organization's current position and existing capability maturity related to value based care, both independently and with respect to the market, will help you develop a short- and long-term strategy for incorporating value based arrangements.



**Assess your capabilities and understand gaps:**

How far along are you in your journey toward the successful integration of value based payment models? What capabilities does your organization possess that you can leverage in your transition? What capabilities, from IT to network partnerships, do you require in order to accelerate your journey?



**Create a governance structure:** The transition away from fee-for-service requires all hands on deck and will involve the coordination of a number of different functions in your organization. Be sure to establish a governance structure for smooth navigation of both the transition period and the long-term future state.



## Conclusion

The market shift to value based payment models is accelerating, driven by the pressure to reduce costs and improve quality and outcomes; there is no single "right" approach that will work for all stakeholders or in all markets. The choice of model (or combination of models) will depend on each stakeholder's capabilities, market position, financial situation, and value based care goals.

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### Endnotes:

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