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Journey to value-based care

Insights and implications from Deloitte's 2015 health plans executive interviews

Introduction

The shift from volume- to value-based care (VBC) is gaining traction through the US health care industry, challenging health plans to change their traditional, payer-focused role in the ecosystem. To better understand VBC's growth and its implications for health plans, Deloitte interviewed senior executives at more than a dozen regional plans in late 2014 and early 2015, all of whom are leading players in their respective markets (see sidebar article for a description of the interview process).

These dynamic conversations yielded fascinating observations and opinions about VBC's potential impact on health plans' future: Given the strong marketplace momentum in the market, interviewed executives believe that enabling VBC will be fundamental to sustainable growth in the future as insurance margins and discount differentials continue diminish. They expect the transition to value to expand, despite concerns about providers' slow adoption of downside risk and their underestimation of the investment needed to effectively manage risk. Interviewees highlight a number of factors that may be crucial to the industry's successful transition to VBC. These include:

- Increased provider collaboration
- Enhanced consumer engagement
- New approaches to care management
- Level of investments in infrastructure
- Emergence of disruptive business models

Further, executives posit that, though the ride may be bumpy, in three to five years, VBC will likely produce a more equitable health care market built upon aligned incentives, transparency, and consumer and provider engagement. In the meantime, health plans should use this transition period to select the right high-value providers, invest in capabilities and enterprise-level business model changes that can help position them favorably in the evolving landscape.

This paper shares insights from the executive interviews and offers perspective on the implications of VBC for health plans and other health care stakeholders along the journey from volume to value.

About the Deloitte health plans VBC interviews

To determine health plans' views on VBC, Deloitte interviewed 15 regional health plans C-Suite and senior executives in fall 2014 and winter 2015. Interviews were conducted both face-to-face and by telephone, and all subjects were assured of full confidentiality and the deidentification of responses. The majority of the participating organizations were large, regional health plans.

Interviews focused on health plans' VBC strategies, market conditions, and driving forces. Questions were developed based on insights Deloitte has gained while leading provider and payer-focused VBC engagements across the country. These questions included VBC-related aspects of the following areas:

- Market outlook
- Payment types
- Challenges/barriers
- Scale and adoption
- Required capabilities
- Capital investments
- Provider integration
- Consumer engagement

Responses were catalogued and aggregated to distill trends and insights, which are summarized in this paper.

Journey to Value: Insights and implications from Deloitte's 2015 health plans executive interviews

1. A value-based model is fundamental to winning in the future health care marketplace

As the US health care market and its stakeholders embark on the journey from volume-based to VBC, interviewed health plans executives say that shifting to a model in which providers take contractual responsibility for the cost and quality of a defined population is fundamental to future sustainability and profitability. These executives are committed to a value-based model which impacts both health care cost and quality. Two main drivers of the transition are:

- Providers demanding a shift to value and a share of premium risk
- Purchasers demanding VBC to control costs through narrow networks, differential pricing arrangements with high-value providers, and new benefit structures

Market insight: A VBC model is deemed a core business strategy for health plans to meet emerging provider and purchaser needs to improve health care affordability, access, and quality. The respondents also see VBC as a defensive strategy to avoid disintermediation by potential competitors, including providers becoming payers themselves. Notes one interviewee, "If we don't give employers value, they will go out and contract directly with the health care systems, potentially disintermediating health plans' traditional insurance role in the marketplace." The executive also says that plans should expect some disruption from nonunion groups, in particular, that are looking to drive down costs, and from third-party players that are trying to exert leverage over hospitals and health systems by expanding into financing care.

> "We see this as a new way of life. It's not a question of if but of when and how."
>
> — [SVP Strategy]

Implications for health plans: Given the strong marketplace momentum towards value, interviewees believe that more can be done across the health care value chain to develop or enhance enterprise-level strategies to deliver value in health care. However, most providers are not prepared to participate in risk-based contracting, so they are likely to need help. Health plans are positioned to lead the charge by modernizing payment models and enabling providers to support a restructured delivery system to better coordinate and manage health care performance. To do so, health plans will need VBC as a core enterprise strategy, supported by provider and consumer transformation, to help create value across both the supply and demand sides of the care continuum. They can do so by sharing learnings and leading practices from plans in other markets which are evolving to a more value-driven ecosystem.

2. Gaining scale requires more plan-provider collaboration

Health plans and providers will need to collaborate, not be adversaries, if they want to gain scale in the new value-driven marketplace. Interviewed health plans executives say that, increasingly, their organizations are partnering with providers to move payment models away from the outdated fee-for-service system to one that rewards quality, value, better health outcomes, and supports sharing of patient and financial information. These collaborations can take various forms, including patient-centered medical homes, shared risk arrangements, and payer-provider joint ventures (JVs).

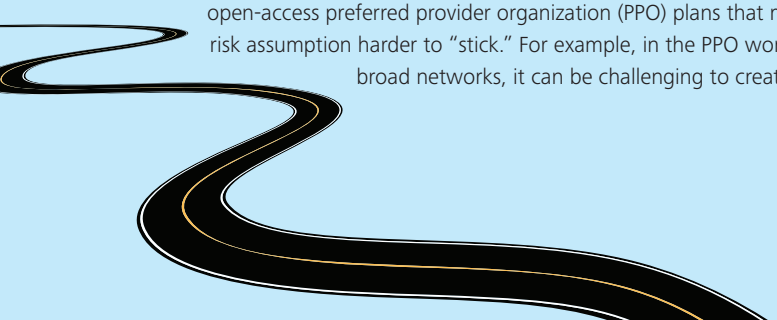
Almost all interviewees believe that to truly deliver population health, provider-plan collaboration is a must. Many interviewees express concern that because risk-bearing contracts remain just a fraction of providers' business they will not make meaningful investments in necessary infrastructure and capabilities. However, health plans can play a crucial role in enabling scale and risk adoption.

> "Any conversation we have with the providers going forward, should be value based."
>
> — [SVP Networks]

Market Insights: The end goals for plan-provider collaboration models are increased risk sharing and improved population health through total cost-of-care contracts or capitation, in which a provider negotiates a global fees for taking on a patient's medical risk, but the on-ramp to capitation may be dependent on market sophistication and is expected to remain bumpy.

- In less advanced markets, health plans executives interviewed feel that a logical starting point is focusing on primary care physicians (PCPs) with upside-only bonuses or gain-sharing agreements and some level of Management Services Organization (MSO) support, enabling data insights, patient care, and technology infrastructure to manage costs and outcomes. There are concerns around collaboration strategies for independent physicians, given fragmentation in many markets due to numerous smaller practices.
- In more advanced markets (those with more risk experience and penetration), plans are equally focused on hospital and professional physician strategies. In these markets, payment innovation typically spans shared savings, bundled payments, global capitation, and, in some instances, insurance products.
- Across the board, interviewed plans struggle with driving specialist group-based risk arrangements, given the lack of standardized specialty-focused quality metrics.

Even with an arsenal of collaboration options, provider risk adoption remains largely upside. Interviewed health plans executives are not surprised about the low level of provider downside risk or "skin in the game." Interviewees say that, while they understand providers see the long-term value in taking on meaningful risk, doing so is challenging for two reasons: the scale needed to provide the expertise and investments to take on risk and the proliferation of open-access preferred provider organization (PPO) plans that make risk assumption harder to "stick." For example, in the PPO world of broad networks, it can be challenging to create financial accountability, as PPO enrollees can go anywhere for care and this makes it difficult to hold providers accountable for their performance serving those patients.



Securing provider C-Suite and physician support is another big hurdle plans have to overcome. One respondent recounts from personal experience how "nothing really happens until the provider C-Suite says this is one of their [organization's] top priorities, [they] need to invest resources, and constantly reinforce [the message]." In addition, interviewed executives acknowledge that it is difficult to change provider culture, especially in today's environment of loose hospital-physician affiliations and large pool of independent physicians.

Implications for health plans: Health plans will likely need to be selective andneed a spectrum of collaboration strategies across both professional physicians and hospitals to support change tailored to each provider's risk-related readiness and willingness. To execute on these strategies, plans should consider selecting high-performing hospitals and physician groups based on their existing capabilities, readiness to take on risk, and willingness to address the long-term change management challenges that go hand-in-glove with VBC transformation. By focusing on high-performing providers at the onset, it could trigger market-level changes driving other providers to make similar changes or go away. In some situations, health plans might be able to address "white space" by facilitating collaborations across hospitals, multispecialty or PCP groups (e.g., creating clinically integrated networks). In other instances, plans should seek to address tactical issues facing providers, including physician alignment and capital investment constraints, by offering at-risk capability, and strategy and transformation support. Plans have an opportunity to drive change by offering this support through a well-defined blueprint for risk contracting and enablement that meets a provider's specific needs.

3. Patient engagement: If you build it, they will come

Economically empowered consumers and engaged patients will be critical to the long-term success of VBC, interviewed health plans executives say, because VBC calls for patients to be active participants in their health care decisions. For example, consumers can drive value by using online quality and cost data and social media to choose high-value providers and treatments. One executive points out that Medicare Part D is a good example of consumers enabling VBC that (s)he would seek to replicate. In this example, tiered formularies and lower copays for generics created the incentive for consumers to shift to VBC — in other words, if health plans build it, they will come.

Market Insights: Most consumers want both low cost and broad access to health care but may value low cost more. Executives speak of tension between the cost and service attributes; while consumers historically cared about flexibility and having a variety of care options, this is changing. One interviewee notes that (s)he was pleasantly surprised that consumers were willing to choose a product that limited access and included hefty patient contributions. Other executives say that, unlike employers, many consumers remain price sensitive and that premium price matters more than anything else. "When you push price sensitivity down to the individual consumer level, the actual premium price matters more. So we need to focus on tiered networks and high-value networks," states one executive.

Many executives say that the shift to high-deductible health plans could be a more powerful driver of provider-plan collaboration than providers' desire to take on risk. The interviews suggest that options which include consumer-friendly product design, pricing, engagement, and health and wellness may be best positioned for long-term success. Many health plans leaders think more retail-focused initiatives will engage consumers by making health care similar to more consumer-centric industries.

Implications for health plans: Health plans are well positioned to use their data and relationships with consumers to bridge provider and patient by helping to coordinate care and assisting patients trying to navigate a complicated delivery system. To help strengthen consumer engagement, health plans should develop innovative benefit designs, programs, and services to give patients incentives to obtain preventive care, participate in wellness programs, and choose lower-cost, high-quality treatments and providers. Health plans can also empower patients to make informed health care decisions by providing cost and quality data to compare provider and treatment options, online access to personal health records, and mobile apps to help patients manage chronic conditions or self-report postoperative progress. Doing so will call for a people-, process-, technology-, and community-based effort that enables a consistent patient engagement experience across all settings of care and service delivery.

4. Provider-led care management is coming

Almost all of the interviewed health plans leaders feel that providers manage care most effectively and will drive this activity in the future, especially given providers' universal dissatisfaction with plan care managers as potential deniers of care. The executives believe that health plans will still have a role in care management, but it is likely to be very different than today. In the future, plans are likely to play a more enabling role in care management, helping providers to take on population health through infrastructure support, including data and insights, except in fully capitated situations where providers will likely own end-to-end care management with little assistance from plans.

Some executives express concern about delegating care management functions to providers and passing on the fees to the employer or enrollee. Specifically, their concern is that this may create a perception problem among employers and lead them to question the value of health plans care management services if a provider is managing care. Health plans may need to respond with new strategies for care management product sales, pricing, purchaser communication strategies, and business models.

Market insight: Interviewees predict that in the next three-to-five years, with the exception of full capitation, care management in most situations will increasingly require a hybrid, plan-provider-led care management model in which:

- Providers would drive coordination and care services for high-risk and chronic patients to direct points of care and manage outcomes.
- Health plans would enable high-risk management and deliver wrap-around maintenance and support services to enable population health through centralized chronic support (e.g., CRM solutions), wellness, and prevention.

Hybrid care model types are likely to vary based on provider profile (large Integrated delivery networks versus community hospitals), their capability readiness, selected payment model (e.g., shared risk versus bundled payment), and providers' trust in managed care plans compared to other care management services providers. Some of the interviewees share concern that, given the explosion of players in the population health marketplace, regional health plans' care management support may be disintermediated. Therefore, they are considering making their own investments in population health technologies and capabilities akin to what some of the national health plans have done.

Implications for health plans: Health plans should leverage their current medical management operating model to drive efficiencies and create a road map to concurrently disaggregate care management and add new "all payer capabilities" — like analyzing, measuring and improving clinical outcomes — to help providers assume increasing responsibility for care management. Health plans should determine how to meaningfully collaborate and manage care with providers — one size may not fit all. This could require different care models to support a variety of risk-sharing arrangements (e.g., global versus shared risk versus bundled payments). Even with these variations, there may be an opportunity to help providers take on population health by using a consistent care management template with some a la carte options. Looking ahead, health plans should evaluate how their current medical management model may fare against a provider-led care model and how that may influence future population health and technology investments.

5. Provider consolidation may impede VBC adoption

Health plans executives agree there is room for US health care delivery system consolidation. However, they are concerned that hospitals are merging to secure pricing power. A bigger health system has more purchasing clout because it offers more physicians and services rather than competing on cost and quality. Also, plan executives state consolidation in concentrated provider markets may delay VBC adoption since providers can simply refuse to participate in payment reform and clinical care initiatives. One of the executives says that, "While ten percent of what I hear coming from them [providers] is 'yes, I'd like to be transformative,' the rest [of that sentence] is that they want to protect and preserve the status quo." This perception strengthens the call for payer-provider collaboration.

Market insights: Most interviewed executives say that best-in-class value-based models are integrated (financing and delivery), so they provide low costs and high efficiency. But "payers becoming providers or providers becoming payers" is not likely to help nonintegrated entities succeed in delivering value. Rather, "virtual integration" via enhanced financial and operational collaboration between providers and health plans can quickly allow organizations to become more efficient with fewer risks. Few plan executives in this interviewed sample are currently seeking formal JVs for driving virtual integration with providers. Executives are generally open to JVs if they do not undermine their relationships with other providers in the marketplace. Most interviewed executives suggest supporting closer integration through an MSO agreement or a branded product model.

The larger issue is making the right choices and bets with the "right" high-value providers who can enable change and drive value. Health plans should find efficiencies through closer integration with selected providers and build long-standing relationships that can drive value over time.

Implications for health plans: The health care system transformation already underway involves new approaches to delivering and accounting for care, often relying on collaborative relationships between health plans and providers rather than anticompetitive provider mergers. Health plans that drive more coordinated care, payment for value, and information technology (IT) use to support high-quality, efficient care may be able to guide like-minded providers to form coalitions and JVs rather than consolidate. Regional health plans cannot "play favorites" with providers but could bring together providers of different yet complementary capabilities, network strengths, and needs.

6. The devil will be in the details

Delivering affordable, value-based health care solutions likely will require health plans and providers to make considerable investments in infrastructure, technology, and clinical processes. Specifically, health plans may need to evaluate new benefit designs, pilot new care models, and weigh new reimbursement strategies. Even as plans try to deliver improved, more affordable health care solutions, these strategies typically require more complex (and, therefore, challenging) contractual arrangements between health plans and providers to achieve the desired outcome. Additionally, the nature of a value-based payment system involves a set of logical choices that align a payment policy with a benefit design, a provider, and a medical event. Mapping these elements can be extremely complex and require larger investments to incorporate. For example, most health plans' current claims systems were not designed to accommodate innovative payment methods (e.g., bundled

payments), and they cannot readily incorporate the complex logic required to determine which provider contract and which payment methodology should be applied to a given claim.

On the other hand, many providers are in a "catch 22" situation: To assume risk, they need enough "skin in the game" and revenue potential to make investment worthwhile as well as confidence in their own ability to manage risk effectively — which depends on infrastructure investments. However, providers typically do not have the capital to make these investments, unless they are a large, integrated system or are already operating under a risk-based business model.

Market insights: Nearly all of the interviewed health plans executives say their organization is making IT data and analytics infrastructure investments; most of these are directed at enabling provider care and risk management, but they are also taking steps towards enhancing the plan's ability to price and drive improved risk arrangements and economic models. A few of the interviewees also say they have invested in partnership programs and consulting staff and provider-based care management to support these activities. Plans may help providers and strengthen their own capabilities by:

- Aggregating important data (clinical and claims), including data from multiple payers (payer-agnostic)
- Analyzing information and making it easier for physicians to act on information
- Building high-value networks and steerage models
- Offering resource models and consulting support to manage care and risk
- Providing transparency on performance
- Supporting patient engagement
- Investing through financial/capital support through at-risk or outcomes-based pricing
- Promoting training and change management to enable alignment

Implications for health plans: Health plans have the ability to support development of a VBC infrastructure but may need a road map of initiatives and investments. Bringing payment reform to scale likely will require the efficiency and accuracy of new analytics and core operations technology to enable and verify that medical, payment, and provider contract policies are applied consistently and effectively. In addition, plans may be disrupted if they do not help enable providers take on risk and manage care. Given the crowded population of the health marketplace, there are likely numerous opportunities to do this — including potential alliances — but plans should weigh each opportunity against existing platforms and potential build/buy/rent opportunities.

7. Innovate or be disrupted

Interviewed executives are quick to point out that, without substantial innovation and a measurable focus on value, health plans are at risk of being outflanked by disruptive innovators. There is no silver bullet to fix all the problems of today's fragmented and hugely expensive health care industry. However, plan executives agree that health care is seeing rising levels of innovation and there is no lack of creativity in finding solutions. With this trend

> "As providers move to an ACO model they don't want to do any of the administrative work. We are in the process of letting people know we are going to be here for the long haul — pay claims, integrate information, etc."
>
> — [Chief Executive Officer]

comes the potential for market disruption in which nontraditional players significantly impact the health care value model. Interviewed executives point to numerous areas where this may occur; for example, building provider networks, organizing independent physicians, enabling data interchange, driving patient engagement, and instituting new payment models.

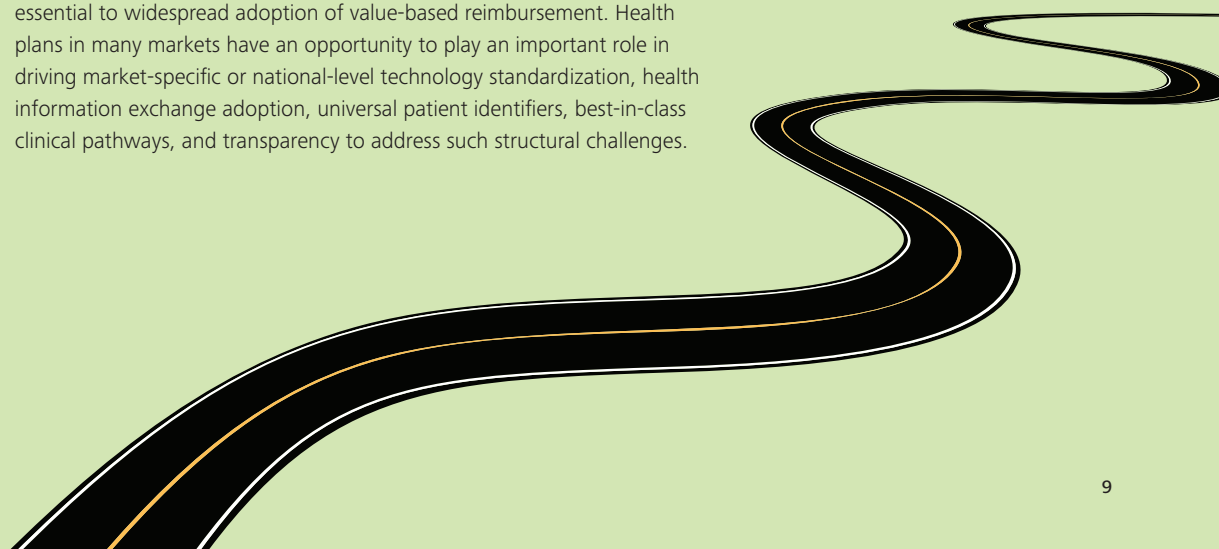
Market insight: All of the interviewed executives say they are trying to quantify and deliver value without a common definition of value or knowing what drives it. One states, "There are a thousand different ways to get there. I do not believe there is a SINGLE value equation or a SINGLE perfect care model to do this; at least not that we've identified yet." Most of the interviewees are skeptical that a proven model will benefit patients; this issue will need to be addressed through disruption or innovation before VBC adoption can become more widespread. "Right now, VBC is the buzzword; everyone is rushing to do something. If it doesn't do a good job at controlling health care cost trends, it will quickly fall out of favor," asserts one executive. [CMO]

Implications for health plans: To help head-off disruption, health plans should act quickly and confidently and demonstrate their value to providers, employers, and individual consumers. However, demonstrating VBC's value across the triple aim of health care will likely require more alignment among health plans and among health plans and providers, such as integrating patient data to prevent unnecessary emergency room admissions; designing new payment models that can be readily adopted; and incenting consumers to improve health behaviors. Sometimes, demonstrating value may be as simple as sharing health care data (e.g., creating "Yelp" or "Open Table" for health care within a plan's local ecosystem). It is not an initiative's scale that will be important, but the extent of its impact across costs, patient experience, and quality that can enable VBC. The health plans of the future should not just help with financing; it also should be the facilitator and enabler of achieving better health through a consumer- and provider-focused platform.

Path forward

While there is little agreement on how quickly capitation and "downside" risk-based arrangements may become the norm, there is consensus among the interviewed health plans executives that the eventual transition to increasing risk is inevitable. However, the speed of change will vary by provider segment, market type, and beneficiary product/segment. Providers, for example, are anticipated to move cautiously as they try to replace lost revenue — they likely will take on more risk for Medicare Advantage (MA) enrollees, with slower growth among commercial enrollees, except those in health maintenance organization (HMO) plans. Health plans, meanwhile, will likely need to address a number of market-specific issues that may present both opportunities and challenges:

- **Transforming through data** — Health care's transition to value involves extensive standardization in clinical and claims data to drive actionable insights. To date, there is little momentum around sharing technology- and payer-agnostic information. Health plans in a given market have an opportunity to come together with providers to address this fundamental problem or risk losing market share to other disruptive entrants.
- **Demonstrating value** — After a decade of experimentation, the general pattern in Medicare Shared Savings Programs is that a small fraction of accountable care organizations (ACOs) generate most of the savings, and that excessively high prior spending, rather than investments in infrastructure and clinical model investments, may be the real reason for those successes. On the commercial side, most contracts are still upside, but some providers are agreeing to large unit cost discounts upfront to enter into commercial ACOs that are really narrow-network PPOs. While many health care executives have embraced population health in concept, it is our experience that many of their physicians are not participating in a meaningful way. We believe the new world savings may come from a shift in volume to high-performing providers from low-performing providers, who may likely perish in future. It is important, therefore, for health plans to select the right high-value providers and work with providers to identify savings drivers to help design a care model that can enable providers to deliver the right interventions at the right time in the right setting to drive impact.
- **Measuring outcomes** — One of the challenges in measuring clinical outcomes is a lack of true cost data on providing care at a patient level. To determine value, providers will need to measure costs at the health-condition level, tracking expenditures (e.g., resources, equipment, etc.) for all events required to treat the condition over the full cycle of care. By doing this, the cost of caring for a health condition can be compared with the achieved outcomes. However, most health care organizations currently do not track costs at that level. The challenge for many health plans is to identify ways they can help providers more accurately and consistently measure outcomes, especially as bundled payments and other value-based reimbursement models take hold in the marketplace.
- **Countering provider-sponsored plans** — A potential unintended consequence of transitioning to risk-based arrangements is that providers already in such an arrangement may originate and/or sponsor their own plans to capture performance and value from their own investments. In response, health plans can get ahead of the game in creatively working with providers to let go of potential retaliation and enable them to deliver value and capture more volume by allowing them a piece of a specific market.
- **Enabling clinical integratio**n — Addressing infrastructure constraints that hinder clinical integration — for example, lack of hospital, physician and payer financing connectivity to enable care and risk management — is essential to widespread adoption of value-based reimbursement. Health plans in many markets have an opportunity to play an important role in driving market-specific or national-level technology standardization, health information exchange adoption, universal patient identifiers, best-in-class clinical pathways, and transparency to address such structural challenges.



- **Increasing consumer benefits** — As many consumers' share of health care costs continues to rise, they are becoming more and more cost sensitive. Health plans should collaborate with providers to offer programs, tools, and coaching to help consumers make effective and affordable health care decisions that result in more value for money spent. Given the increase in consumer-directed health benefits, there is also an opportunity to collaborate with providers in managing the revenue cycle to prevent potential bad debt.

Health plans executives interviewed view VBC as a step-change to health care industry transformation. They envision increasing scale, adoption of provider risk and population health, the rise of the consumer and purchaser in driving change, and hard lines around affordability. All of these factors spell massive changes for health plans and, in some cases, potential disintermediation. While challenging, the transition from volume to value also may provide an opportunity for plans that are ready to lead and innovate.

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