The Future of Value-Based Care: 2021 and Beyond

January 11, 2021 – The coronavirus pandemic has disrupted all corners of the health care system and its long-term impacts are not yet known. Despite the uncertainty, industry experts and policymakers agree that COVID-19 has only emphasized the need for significant payment and delivery transformation, showcasing the advantages of prospective, non-FFS-based alternative payment models (APMs), coupled with new regulatory flexibilities, technological innovations, and cultural shifts to fast-track adoption.

Building on our recent year-end recap of 2020's major developments in the world of value-based care, this brief considers how the shifting economic, political, and cultural forces will shape the value movement going forward, outlining expectations for various health care stakeholders, and highlighting value-based trends to watch in 2021.

Providers

The health care industry faced unprecedented challenges in 2020, with provider organizations being among those hardest hit by the pandemic – financially, clinically, operationally, and even spiritually. Over the last 10 months, the delivery system has worked heroically to expand capacity, creatively redesign staffing models and workflows, and to adopt new virtual solutions to reach patients and their caregivers, all while facing drastic drops in revenue, PPE shortages, and a patient population plagued with misinformation about the seriousness and spread of the virus. In many markets, provider organizations continue to battle rising COVID-19 case rates – a trend that is expected to worsen over the coming weeks as we see the repercussions of holiday travel and group gatherings. What's more, now these very provider organizations who remain in the COVID-19 trenches – namely hospitals and skilled nursing facilities (SNFs) – have also been tasked with leading and supporting vaccine distribution, as well as navigating significant logistical challenges without much guidance from government officials.

Across provider types, organizations with the following characteristics fared better:

- Strong missions/cultures to encourage action, agility, and innovation
- Scale and financial strength
- Diversified, non-FFS revenue streams such as an owned health plan, meaningful participation in non-FFS-based VBP contracts (e.g., capitation)
- Existing infrastructure to readily adapt to delivery and operational changes

While not yet out of the woods, delivery system leaders are beginning to shift their attention from short-term pandemic response toward post-pandemic recovery, redesign, and reinvestment. Various segments of the delivery system were impacted differently by COVID-19 and these provider types will also be faced with different opportunities and obstacles in advancing value-based care going forward.

Primary Care Practices

The coronavirus pandemic made major waves in the primary care market, causing significant financial hardship for many practices, while offering growth opportunities for others. On one hand, the majority of independent physician practices struggled to survive as outpatient visits abruptly plummeted, leading to substantial reductions in FFS revenue. While federal officials took steps to help practices by expanding

access to telehealth services and increasing reimbursements for virtual visits (with some private insurers in tow), most of the federal financial relief went to hospitals and larger medical groups. Many private insurers offered financial relief in the form of advanced payments, with some payers even utilizing this financial support to encourage independent practices to join value-based payment (VBP) programs.

Conversely, for advanced primary care organizations whose very business models are built on sophisticated VBP models – namely full-risk, capitated contracts with Medicare Advantage (MA) plans for patients' total cost of care – 2020 represented a major growth year. Instead of reducing services and furloughing employees, organizations like ChenMed, Oak Street, and Iora Health ramped up chronic disease management via frequent virtual touchpoints and select in-person services, also leveraging their intact and flexible revenue to address patients' social needs during the pandemic. While many FFS-dependent organizations struggled to stay afloat, these high-touch, full-risk primary care organizations were protected against losses from dramatic declines in volume, with several organizations even announcing plans for rapid expansion of new locations, new partnerships, and an IPO.

While the pandemic drained FFS providers of revenue when patients stopped seeking care, capitated practices continued to collect their monthly fees, which for many was a financial lifeline. The COVID-19 pandemic could prompt more medical practices to accept capitation or other, lower risk value-based payment arrangements as a steppingstone toward full risk. While the financial instability providers are facing entering 2021, as well as the clear advantage that providers already in capitation experienced, *should* result in widespread adoption of capitation, this is not a shift that can happen overnight. Some may choose to double down on their FFS efforts, though for many primary care practices this strategy is not as lucrative as for procedural or surgical based practices. Ultimately, suffering practices will need a financial lifeline, and if neither FFS or value-based payment is feasible for them, they may begin to seek outside support through acquisitions, mergers, or other partnerships.

Hospitals & Health Systems

Many hospitals also experienced great financial distress in 2020, as elective procedures were put on hold and outpatient department visits reduced dramatically. Hospital and health systems also leveraged technology to supplement revenues and to reach patients in different settings, including acute care services in the home.

In 2021, hospital leaders will continue to dedicate large portions of capital budgets toward digital transformation efforts, such as virtual care, remote patient monitoring, and improved analytics and forecasting, as well as other health IT capabilities. One such capability may be referral management systems to enable hospitals and health systems to better engage with physicians. As health systems begin to think strategically about how to better scale investments and spread costs across a larger customer base, digital solutions could help to manage and grow referrals from independent practices and to prevent leakage from their owned physician networks.

Patient volume instability and cost management will remain key challenges for hospital-centric providers in 2021, driving some to consider value-based contracting as a potentially promising payment mechanism, particularly in the longer-term if providers can eventually work toward full-risk models. As with physician practices, adopting global capitation or budgeting could also be seen more favorably by hospital and health system leaders compared to pre-pandemic perceptions. However, unlike physician practices and medical groups, organizations with inpatient and emergency department (ED) assets face a

different set of challenges when attempting to adopt capitated payment models given their competing financial priorities. Specifically, for integrated delivery networks that include hospitals and employed physicians, CFOs will face significant tension in appropriately allocating resources to cover the fixed and variable costs of inpatient care while also funding alternative, low-cost sites of care.

Further, CMS recently finalized the hospital price transparency rule, which has received considerable pushback from the industry, particularly from AHA which pursued legal action in an attempt prevent the rule from taking effect on the first of the year. The rule was ultimately implemented, and hospitals are required to provide clear pricing information for the services they provide. However, hospitals and the AHA have argued that the demands of the pandemic and a lack of federal guidance have made compliance with the rule difficult. The penalty for non-compliance is a $300 a day fine, which many hospitals may decide is favorable over price disclosure.

Post-Acute Care Providers

Skilled Nursing Facilities (SNFs) have suffered from major COVID-19 outbreaks during the pandemic and are still in the trenches. The congregate living environment and particularly vulnerable patient population living in these facilities has posed a treacherous challenge for operators. SNFs are unlikely to become major direct partners in VBP contracts and risk-bearing providers will continue to focus on PAC optimization by minimizing SNF utilization in favor of lower-cost settings (e.g., home health), putting further pressure on the industry. However, when skilled nursing services are needed, providers with a value focus will favor their "preferred" SNFS and those that can demonstrate good outcomes.

Home health saw a surge in adoption and innovation in 2020, driven by necessity due to COVID restrictions that limited in-person interactions and by technological innovations that made it possible to safely deliver some care remotely. In-home health monitoring has been leveraged to manage chronic conditions, oversee pregnancy, and detect medical emergencies early on, with several new ventures and partnerships capitalizing on the boom. Risk-bearing providers will leverage these advancements to deliver even more services in this convenient and lower-cost setting. CMS is further advancing this shift to home-based care through its recent kidney care APMs which incentivize home-based dialysis (Kidney Care Choices and ESRD Treatment Choices), and its Hospital at Home Waiver which allows some patients to receive hospital-level care outside of the hospital setting. However, not all home-based care providers are well positioned to participate in CMS models or negotiate value-based contracts with MA plans. Smaller "mom and pop" firms may be left behind while large national firms continue to grow.

Hospice providers also had a year of growth, with more opportunities for innovation and value-based involvement on the horizon. Starting this year, hospice and palliative care providers will be able to partner with MA plans through the Value-Based Insurance Design model. This carve-in represents the first opportunity many hospice providers have had to formally engage in a value-based contract, and success in this arena could pave the way for greater value-based investment in the sector in coming years, as hospices work to build out their offerings and prove themselves to be attractive partners. One strategy gaining popularity among hospices looking to draw the attention of MA plans is community-based palliative care, which aims to bring palliative care services out of facilities and into patient homes.

Payers

Unlike providers, private payers reported skyrocketing profits amid the COVD-19 pandemic, as patients deferred care in droves. Even as utilization began to tick back up after the spring, primary care and labs

rebounded quicker than procedures and other higher cost services. However, payers are not authorized to retain all of these excess funds. MLR regulations require that between 80 and 85 percent of premium dollars be spent on medical care, and estimates show many insurers have not hit that threshold this year. This means they must either invest this money in additional medical services for their members or refund it directly to them through rebates.

In addition to a growth in revenue, payers also continued to grow their value-based care portfolios in 2020. Although activity in some CMS alternative payment models has been delayed as a result of the pandemic, private sector adoption of value-based contracts continued in 2020, with a particular focus on bundled payments and ACO arrangements for MA members, including several specialty-specific contracts for targeted subpopulations. Private payers will continue to advance their value initiatives in 2021.

Congress, in March, passed the Families First Coronavirus Response Act, requiring health insurers to cover the cost of COVID-19 testing and increasing access to treatment. Many health insurers took additional actions to support members and providers, such as increasing access to virtual visits by waiving cost sharing and reimbursing providers at parity, though some have begun to pull back these benefits. Several insurers also offered financial relief to providers in the form of advanced payments, with some even utilizing this financial support to encourage independent practices to join value-based payment (VBP) programs.

The pandemic will fundamentally shift insurers' broader strategic priorities in 2021 and beyond. Plans will focus even more attention on expanding their value-based initiatives, with an eye toward bundles and risk-based contracts tailored toward high-cost members, such as those with cancer, diabetes, and chronic kidney disease. Riding on the digital care boom of 2020, insurers will double down on investments in digital health tools, offering more services and supports to members and providers. Lastly, insurers will continue to explore strategies to support social determinants of health for their members, both through extending coverage for unique services and forging new partnerships.

One major development in payer strategy and investment is a greater shift toward meaningful alignment or integration with provider systems, either through the acquisition of delivery assets, new partnerships, or provider-owned health plans. For the first time since 2017, health plan executives were more likely to say they are prioritizing the focus of their operating model in 2021 on the physician-patient relationship versus members directly. The CMS final interoperability rules may help accelerate their plans, allowing them more opportunities to provide actionable data to help physicians and hospitals succeed in value-based care models.

Purchasers

For industries whose operations were scaled down or eliminated altogether during the pandemic, including hospitality, travel, and service industries, employers and health plan purchasers are under more pressure than ever to find affordable ways to supply coverage to employees. This pressure may result in a renewed commitment from these purchases to explore new ways to manage healthcare costs via value-based payment models that incentivize delivery transformation.

States are also facing immense financial pressures in the coming budget year. COVID-related job loss has resulted in less tax revenue while increasing the number of Medicaid enrollments, perhaps pushing more states to consider managed Medicaid. Medicaid programs must either begin working with providers to

negotiate value-based contracts or begin reducing their FFS payment rates. Of the two options, a shift to value is sure to be the most popular tactic, though it also requires significant effort on the part of state officials and providers.

Pharmaceutical Manufacturers

Amid rising death tolls and overburdened hospital systems, one major success of the year was the impressive and record-breaking development of several COVID-19 vaccines, due in part to the efforts of Operation Warp Speed. Despite the expedited timeline, confidence in the COVID-19 vaccine has been rising, and with it, public confidence in the industry. While burgeoning interest in outcomes-based pricing was largely overshadowed by the immediate needs of the COVID-19 pandemic in 2020, as a growing number of people receive the vaccine and the biopharmaceutical industry experiences a boost in public sentiment, broader implementation of value-based pricing and purchasing models for drugs and devices may be more plausible in 2021 than it has been in the past.

Further, recent changes to the Medicaid Drug Rebate Program have removed barriers which previously made it difficult for manufacturers and payers to negotiate drug prices. As new life saving medical technologies emerge, including advances in gene therapy, value-based pricing could help to ensure the expense of these innovations does not limit their application, especially as hospitals grapple with a reduction in operating budget. The speed of the vaccine roll-out, not just in research and development but in regulatory response, also bodes well for future innovation. Some lawmakers are already seeking to formally update the FDA approval process to expedite future innovations that could be beneficial to patients.

In fact, while COVID policy activity will be highest on Biden's health care agenda, the administration may seek to begin developing policies around prescription drug pricing, as it remains a bipartisan issue and an important one to patients. Among other policies, President-elect Biden aims to limit drug price increases to the rate of inflation and to use international reference pricing and other tools to limit launch prices for drugs. His administration may begin to advance these and other goals through the rulemaking process in 2021. States are also expected to push for new drug pricing reforms as their Medicaid programs face dire financial pressures.

Patients

As providers quickly adapted delivery practices to accommodate the demands of the COVID-19 pandemic, patients too had to adjust to changes in how they received health care services and interacted with their providers. While many providers faced major declines in patient visits and reimbursement, others were seeking ways to expand the capacity of overburdened care teams and staff. In either case, reductions in regulatory restrictions and an increase in reimbursement rates allowed providers to leverage virtual platforms to meet the needs of their practices and to keep patients out of high-risk clinical settings. Not only did patients respond well to this change as a necessity of the pandemic, recent surveys show many prefer it over traditional in-person visits. In the coming year, patients will likely continue to favor providers who can accommodate virtual services, including telehealth visits, online appointment scheduling, and the ability to text or email providers rather than speaking on the phone.

In addition to a change in the site of care, 2020 also saw a shift in the type of care patients were seeking. Many elective procedures were cancelled or delayed, and evidence suggests even essential visits were

forgone by patients fearful of contracting COVID-19 in high-risk health care settings. Though this drop in non-essential care has begun to rebound for most providers, the changes could have implications for patterns in care-seeking behavior going forward, with patients, providers, and payers gaining awareness of which high-value services should be prioritized and which services can safely be delayed or eliminated altogether.

This year will also bring more empowered consumers. In late December, the Office of the National Coordinator for Health Information Technology (ONC) released its final rule on interoperability, which, among other things, ensures patients' electronic access to their healthcare information. Another rule, passed on the first day of this year, requires hospitals to publicly disclose the prices they negotiate with consumers. Together, these rules, as well as other recent policy changes, give patients greater control over their care.

Policymakers

Going into 2021, policymakers face a monumental task in continuing to fight the COVID-19 pandemic and beginning to help the country recover from the economic, public health, and social repercussions of the last year. Though the COVID-19 response and recovery will likely take first priority for the incoming Biden administration, already the president-elect's team has signaled that addressing health disparities and restoring the ACA will also be among the administration's top priorities. With the results of the Georgia run-off solidifying Democratic control in both chambers, the incoming president will have greater ability to manifest his policy agenda and appoint like-minded leaders. However, the democratic majority in the senate is slim, meaning bipartisan collaboration will still be necessary in order to push through any major legislation.

In addition to its major insurance coverage provisions, the ACA acts as a vehicle that drives several significant value transformation efforts. By necessity, the new administration will have to look to advance value-based payment mechanisms through many of the provisions afforded by the ACA. In the coming year, the administration will work to reverse the ACA revisions undertaken during the Trump administration and to continue the work of expanding the law. This will likely include a reinvigoration of the individual market through more generous subsidies and other mechanisms, furthering Medicaid expansion and increasing enrollment, and continuing to leverage CMMI to test and expand the adoption of value-based payment across the nation.

CMMI's strategy, however, may shift under a new administration. While every new leader brings with them a unique policy agenda and preferred approach to value, policy experts have been signaling the need to revisit CMMI's processes and direction for some time, a sentiment that gained traction after director Brad Smith revealed that only five CMMI models succeed in generating significant savings. As such, the center may undergo a more drastic overhaul than from previous leadership changes.

The economic imperative to change the health care system, the reality that the status quo is unsustainable, is a key driver of the value movement. In the wake of trillion-dollar spending on COVID-19 response and relief, the already unsustainable national debt has reached new levels, One way the repercussions of the national debt will manifest is in the imminent exhaustion of the Medicare trust fund, which some experts estimate could happen as early as 2024. In the absence of drastic changes, cuts will have to be made to FFS reimbursement rates or tax dollars will have to subsidize the program to keep it

afloat. More fully committing Medicaid to value-based payment would be is an alternative to easing taxes or cutting rates.

Lastly, the president-elect Biden and Rochelle Walensky, his nomination to be the new director of the CDC, have signaled that the administration views public health as an asset, and intends to restore confidence in science and public health, both within the government and broadly. The pandemic has increased awareness of the importance of a robust public health system. With this awareness may come funding and greater integration of public health into other existing systems.

Resolution, Recovery, and Resilience in 2021

In many ways the pandemic highlighted the resilience of value-based payment models – those with significant risk-based contracts weathered the storm better. However, for providers in mixed models, relying on both value-based and FFS payments, the reduction in elective procedures was majorly disruptive. Undoubtably, 2021 will see a renewed commitment to value-based payment and delivery transformation among major purchasers of healthcare – including CMS, states, and self-insured employers – as a lever for managing the total cost of care. Adoption of these value-based payment arrangements will be further accelerated by an increased appetite among provider organizations to move away from FFS and assume greater levels of financial risk for their patient populations in exchange for predictable, prospective payments. Many organizations that were already engaged in these arrangements will look to expand their value-based contract portfolios, including both the breadth (number of covered lives) and depth (degree of financial risk) of their activity.

The value movement is not driven by politics, it is driven by economics, both domestic and global. Policymakers on both sides of the aisle agree that the coordination, thoughtful spending, and focus on outcomes that the value movement incentivizes are better than the volume-driven incentives of FFS. However, adopting the principles of value cannot happen overnight. The movement emerged in the 90's and has played a role in the way health care is delivered and paid for since, but much of our health care system is still built on a foundation of FFS. The financial pressures the country is facing going in to 2021 may lead to more aggressive investment in value-based models, and greater commitment to abandoning the FFS foundation which was unable to support the demands of the public health emergency.

About the ACLC

The Accountable Care Learning Collaborative (ACLC) is a non-profit organization with a mission to accelerate the readiness of healthcare organizations to assume value-based payment models. Founded by former Secretary of Health and Human Services Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services Mark McClellan, the ACLC serves as the foundation for healthcare stakeholders across the industry to collaborate on improving the care delivery system. To learn more about the ACLC, visit accountablecareLC.org