The winding road to value: Understanding VBC dynamics in each market

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Whether you look at the growing number of beneficiaries participating in CMS risk-sharing models[1] or the findings of prominent payer surveys,[2] market trends suggest that a solid understanding of how to succeed in value-based arrangements is necessary for providers now and going forward. This white paper looks at some of the key market dynamics that are driving the shift to value-based care.

Value-based care (VBC) contracting goes by many names: value-based payments, alternative payment models, risk arrangements, risk-sharing agreements, and a handful of other similar-sounding phrases and acronyms. Regardless of what you call it, these types of payment arrangements are becoming increasingly common in the U.S. healthcare system and abroad. It is estimated that in 2022 about 41% of healthcare payments in the United States were based on some form of value-based contracting linked to the cost of care.

Traditional fee-for-service (FFS) reimbursement rewards volume over value, can encourage overutilization of services, and doesn't reflect quality levels, patient outcomes, or patient experience. Traditional tools often used to combat these challenges can be difficult for physician groups or accountable care organizations (ACOs) to implement—think unit price negotiations, prior authorizations, utilization management policies, etc. As employers, policymakers, and payers try to align financial incentives for care, we have observed a shift from fee-for-service to value-based reimbursement.

The types of VBC contracts vary across a spectrum: ranging from quality-incentive payments to upside-only arrangements, upside and downside arrangements, episode-based or bundled payments, condition-specific capitation, percentage of premium arrangements, and global capitation arrangements. Each type serves a different objective and purpose, often tailored to the desired objectives of the payer and provider involved in the arrangement. They involve different ways to transfer risk and differing levels of risk transfer.

[1] CMS (January 17, 2023). CMS Announces Increase in 2023 in Organizations and Beneficiaries Benefiting From Coordinated Care in Accountable Care Relationship. Press release. Retrieved January 31, 2024, from https://www.cms.gov/newsroom/press-releases/cms-announces-increase-2023-organizations-and-beneficiaries-benefiting-coordinated-care-accountable.

[2] HCP-LAN. 2023 APM Measurement Effort. Retrieved January 31, 2024, from https://hcp-lan.org/workproducts/apm-infographic-2023.pdf.

The Health Care Payment Learning and Action Network (HCP-LAN) developed a widely adopted framework for categorizing VBC agreements. A high-level overview of the framework, which was originally introduced in 2016 and refreshed in 2017, is shown in Figure 1. The exact terms of payment models will certainly vary, but generally, as a provider moves along this continuum from Category 1 to Category 4, they are taking on more financial risk for managing the care of the population. Value-based contracts that fall into Categories 3 and 4 are considered risk arrangements or value-based contracts where providers take on financial risk for the quality and efficiency of care provided rather than reimbursement based on the volume of services provided.

FIGURE 1: LEARNING AND ACTION NETWORK (LAN) ALTERNATIVE PAYMENT MODEL FRAMEWORK

This paper covers an overview of considerations for providers participating in VBCs in different markets that are essential best practices for succeeding with VBC arrangements.

VBC contracts and strategies are different depending on the source of health benefit coverage. While there may be some similarities in desired objectives, there are unique considerations depending on whether the contract is for a commercial,[3] Medicare Advantage, Medicare FFS, or Medicaid population. Even within some of these markets, there are additional factors that need to be considered. There is rarely a one-size-fits-all solution to value-based care. In addition to each of these markets, there is a trend moving healthcare markets toward a more high-touch care model, which has been studied in senior populations[4] and is having an increasing impact in all four of the coverage types considered in this paper.

Also, while we have considered each market separately, providers should ensure they are viewing all VBC arrangements with a broader lens to ensure that the overall VBC strategy can be achieved as the details are worked out for VBC contracts more generally.

[3] For purposes of this paper, we use the term "commercial" to include nongovernmental, full benefit health insurance, such as employer group coverage for active employees and individual insurance through the ACA exchanges.

[4] Ghany, R. & Tamariz, L. (August 28, 2018). High-Touch Care Leads to Better Outcomes and Lower Costs in a Senior Population. *American Journal of Managed Care*. Retrieved January 31, 2024, from https://www.ajmc.com/view/hightouch-care-leads-to-better-outcomes-and-lower-costs-in-a-senior-population.

Medicare FFS

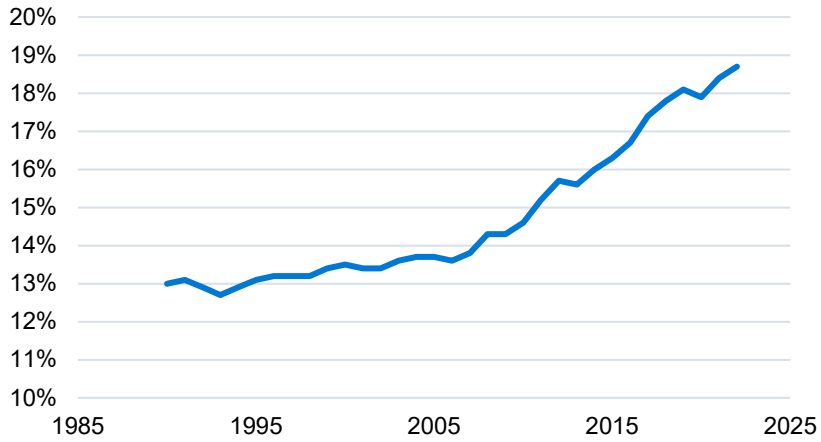
MARKET CONSIDERATIONS

Medicare is a federally run program primarily providing healthcare coverage to people over age 65, though younger beneficiaries may also be covered by Medicare if they have qualifying disabilities or end-stage renal disease (ESRD).

Under traditional Medicare, or what is often referred to as Medicare fee-for-service (FFS), providers are typically reimbursed based on predetermined fee schedules developed by the Centers for Medicare and Medicaid Services (CMS). These fee schedules are updated annually and can vary by geography and the complexity of the services provided. As of 2023, approximately 30 million Medicare beneficiaries were covered by traditional Medicare (with close to the same number enrolled in a Medicare Advantage plan).[5]

As shown in Figure 2,[6] the percentage of the U.S. population eligible for Medicare has increased significantly over the last 15 years.

FIGURE 2: PERCENTAGE OF PEOPLE COVERED BY MEDICARE IN THE UNITED STATES, 1990-2021



Hastened by an aging population, the proliferation of value-based reimbursement models is a strong indicator that CMS believes value-based care should become a significant focus in the Medicare space in an attempt to shift financial incentives from service volume to care quality, patient outcomes, and a reduction in the per capita cost of care.

VALUE-BASED CARE TRENDS

While the percentage of Medicare-eligible beneficiaries enrolling in Medicare Advantage plans continues to grow, traditional Medicare still covers approximately 49% of the total eligible population, with a significant proportion of those dollars flowing through value-based payment arrangements with ACOs. The Medicare Shared Savings Program (MSSP) began in 2012 and has grown to include approximately 11 million Medicare FFS beneficiaries as of 2023.[7] The Realizing Equity, Access, and Community Health, or ACO REACH model, covers an additional 2 million beneficiaries. In addition to those two programs, the Center for Medicare and Medicaid Innovation (CMMI) continues to announce new programs, such as the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model and the Making Care Primary (MCP) model.

Growth in provider participation in value-based care arrangements, and ACOs in particular over the last decade (and the continued push in the coming years), has been facilitated by physician practices that are often aided by an increasing number of “aggregators”—

[5] Ochieng, N. et al. (August 9, 2023). Medicare Advantage in 2023: Enrollment Update and Key Trends. KFF. Retrieved January 31, 2024, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.
[6] Statista. Percentage of People Covered by Medicare in the United States From 1990 to 2022. Retrieved January 31, 2024, from https://www.statista.com/statistics/200962/percentage-of-americans-covered-by-medicare/.
[7] CMS (January 1, 2023). Shared Savings Program Fast Facts. Retrieved January 31, 2024, from https://www.cms.gov/files/document/2023-shared-savings-program-fast-facts.pdf.

organizations that specialize in the recruitment of providers for participation in VBC initiatives, without particular regard for provider system affiliation. CMS has a stated goal of 100% participation in accountable care relationships by the year 2030.[8]

OPPORTUNITIES AND CHALLENGES

Relative to prevailing commercial contracts, provider systems operating under VBC contracts typically see considerably lower per service revenue when caring for beneficiaries covered by traditional Medicare. VBC arrangements, such as ACO participation, give provider systems the opportunity to gain additional revenue for providing care to these beneficiaries via shared savings, although some arrangements include exposure to shared losses. However, provider systems that are experienced with efficiently managing care of their patient populations may be well positioned to bolster revenue through a traditional Medicare value-based care program.

A challenge with arrangements focused on total cost of care savings is that savings are generated by reducing per capita cost of care, which is contrary to the service-volume-based incentives that were the custom under traditional Medicare. Provider systems that are not as well versed in managing care and the risk of their patients may find achieving shared savings difficult, or that the shared savings they are achieving do not make up for reductions in utilization. To succeed in these programs, provider systems must improve efficiency and make up lost service revenue through additional patient volume and reducing out-of-system service utilization (i.e., leakage). Performing well in this space often requires organizational restructuring, implementation of new technology and workflows, and overcoming other administrative hurdles, which may delay or dampen the financial return on investment (ROI) that participating provider systems seek from these programs and, depending on the nature of the risk arrangement, can expose the provider organization to risk they are ill-equipped to manage.

As of this writing, some of the challenges that come from diving into value-based care arrangements can be eased for entities deemed to be qualifying participants (QP) in an Advanced Alternative Payment Model (Advanced APM), such as the ACO REACH program or participants in certain MSSP tracks. These benefits include exemption from Merit-Based Incentive Payment System (MIPS) reporting and payment adjustments and the potential to qualify for a bonus on a portion of Part B payments.

Medicare Advantage

MARKET CONSIDERATIONS

Under the 2003 Medicare Prescription Drug Improvement and Modernization Act, Medicare began allowing approved health plans to offer private coverage, known as Medicare Advantage (MA).[9] Today, MA covers approximately 50% of Medicare-eligible beneficiaries nationwide[10] with significant variation across states and counties.

Given the level of MA penetration, the growth in the Medicare-eligible population in general, and the prevalence of VBC in the Medicare FFS program, it is not surprising that the take-up of VBC in MA has proliferated in recent years.

Profitability on Medicare patients paid at Medicare fee schedule rates can be marginal for many health systems. So many providers are moving toward taking financial risk on their MA populations. Initially this may be upside-only arrangements, transitioning to two-sided risk sharing and/or capitation over a period of a few years. Some health systems have gone as far as launching their own health insurance plans. Launching insurance plans helps health systems control the premium while also diversifying their revenues. Building a MA plan is an expensive proposition, because it requires both building infrastructure that is very different from providing care delivery, and capital for funding reserves. It also requires a different way of thinking, which can often be at odds with the provider's core goals. So some providers are using a traditional insurer as a partner in arrangements referred to as joint ventures (JVs). By leveraging both parties' capabilities and aligning incentives, this arrangement can decrease time to market, lower costs, and reduce regulatory burden. While a JV approach typically involves less capital for a provider than launching its own health plan, it is still not without risk, not least the necessity to enroll sufficient members to make it a viable proposition.

[8] CMS. Innovation Center Strategy Refresh. Retrieved January 31, 2024, from https://innovation.cms.gov/strategic-direction-whitepaper.

[9] CMS. History: CMS's Program History. Retrieved January 31, 2024, from https://www.cms.gov/About-CMS/Agency-Information/History.

[10] CMS (2023). MA State/County Penetration 2023 01. Retrieved January 31, 2024, from https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/ma-state/ma-state/county-penetration-2023-01.

Many MA VBCs include payments from plans that are either not at risk or have minimal risk. These payments help providers fund the various investments in technology and care management needed to be successful in VBC. They can also help improve contribution margins on MA patients by being reimbursed at levels greater than Medicare payment rates.

VALUE-BASED CARE TRENDS

As the growth in MA VBC continues, we are seeing more providers take higher levels of risk, including many taking full capitation for the total cost of care of the populations they manage. As is the case in the Medicare FFS space, physician practices joining aggregators is increasingly common. There are an increasing number of sub-capitation arrangements in MA, many revolving around primary or specialty care risk. And there are many examples of co-branded or "white label" plans or other more formal joint ventures between health providers and health plans.

OPPORTUNITIES AND CHALLENGES

From a provider perspective, MA VBC contracts can have greater upside potential than commercial agreements. Because most MA VBC arrangements are structured as a percentage of the payer's CMS and member premium revenue, the opportunity to potentially increase revenue payments can be a significant advantage. Incentives to improve coding accuracy and quality can enable the provider to generate savings and increase Medicare Advantage reimbursement without having to cut utilization (and hence potential FFS revenues).

Payer revenue per member per month (PMPM) for MA members is significantly higher than commercial members because the underlying benefit costs for covering people over age 65 and those with disabilities and/or ESRD are much higher, and certain VBC arrangements enable the provider to gain a share of this large premium dollar.

As with many VBC contracts, the major challenges are situations where the transfer of risk and/or other financial incentives between payer and provider are misaligned or do not reflect each party's ability to manage and control the risk being transferred.

Additionally, the MA program is subject to substantial external regulatory and legislative risk, which plans and providers are often unable to control or mitigate. That said, appropriately structured MA VBC contracts can be a win-win for both payers and providers and can be a platform for collaboration.

Commercial

MARKET CONSIDERATIONS

When discussing VBC contracts in the commercial market, it is helpful to separate the market into three categories: 1) individual Affordable Care Act (ACA) coverage, 2) fully insured small group/large group coverage, and 3) self-funded group coverage. A general challenge that all of these segments face is ensuring that the financial targets (whether trend or PMPM targets) are aligned with the population assigned under the value-based contract. This typically requires adjustments for key factors such as morbidity, region, plan design, and network discounts. Each of these categories within the commercial market has opportunities for VBC arrangements, but each one has unique considerations, some of which are highlighted below.

An important consideration specific to the ACA market is the impact of risk adjustment on any shared savings arrangements. While the risk adjustment program can help facilitate adjusting for risk in VBC arrangements, the risk adjustment transfers are lagged, and contracts will need to accommodate transfer payments into the settlements. Providers should also be aware that ACA risk adjustment is concurrent, meaning it is based on conditions identified during the measurement year, which differs from the prospective model used in Medicare (based on conditions identified in the prior year).

VBC for fully insured small group and large group coverage will often utilize a percentage of premium type arrangement, which introduces the challenge of accounting for non-claims-based expenses in the premium. There should be a clear definition of what is and is not included beyond claims as part of the value-based contract. In general, it is appropriate to only include costs that can effectively be managed by the provider taking on the risk.

The self-funded commercial market is one of the more challenging markets to implement VBC because of the difficulty of setting a benchmark that appropriately accounts for the population risk, benefit plan design, and reimbursement shifts that tend to occur over time. Where the self-funded group is setting premiums and relying on a third-party administrator (TPA) for network and claims management, having more than two parties involved in the VBC arrangements can introduce additional complications. Where this is often most successful is if a self-funded group contracts directly with a provider organization. Even though this approach has its own set

of challenges from a VBC perspective, this strategy facilitates aligning incentives between the two organizations and helps simplify setting targets and sharing savings and losses.

VBC arrangements in the commercial market will also need to consider the reimbursement levels the payer has negotiated more broadly, the extent to which VBC savings are built into the rates, and the actuarial values of the benefit plans offered. Similar to Medicare Advantage, there may be opportunities to have narrow network products where a payer will design plans with only VBC providers in-network to help facilitate negotiating reimbursement levels. Narrow network products can also help facilitate VBC efforts by simplifying the process for identifying which members are attached to a value-based contract (a process called "attribution"). This is because all members enrolling in the narrow network product are automatically attributed under the value-based contract.

VALUE-BASED CARE TRENDS

The commercial market continues to adopt VBC arrangements, but the adoption rate varies by geography. What we typically see is that, as various VBC arrangements are integrated into the Medicare FFS and Medicare Advantage markets, certain aspects of these types of arrangements continue to spill over into the commercial market with small differences to tailor the arrangements to the commercial population and market dynamics.

Where such a large share of individuals in the healthcare system are in the commercial market, providers will likely continue to consider and participate in VBC arrangements in this area. As this happens, it will be increasingly important for providers to 1) ensure they understand the VBC arrangement and associated risks, as there is more variation in commercial plan designs than typically seen in the two Medicare markets previously discussed, and 2) have appropriate attribution methods established so that they are taking risk for members where they can appropriately influence care.

OPPORTUNITIES AND CHALLENGES

There are specific opportunities and challenges in the commercial market for value-based care:

- The commercial market accounts for almost 50%[11] of the coverage for people with health insurance. This creates a significant opportunity for providers to grow volume.
- Payers are increasingly interested in entering VBC arrangements in the commercial space to provide efficient care and offer more affordable premiums.
- Underlying reimbursement used for setting benchmarks and targets is typically higher than in Medicare, but it varies from payer to payer, which can add complexity to ensure that shared savings arrangements are minimally impacted by reimbursement changes.
- Turnover from individuals changing group coverage (i.e., job changes) or moving in and out of the individual market can make it challenging for providers to have attribution where they can meaningfully impact the care management of individuals.

Medicaid

MARKET CONSIDERATIONS

Medicaid provides coverage primarily to low-income and disabled individuals. Some of these individuals are also covered by Medicare and are known as dual-eligible beneficiaries. The services covered by Medicaid are similar to Medicare, but they also include some services not covered by Medicare, such as long-term supports and services (LTSS) and community-based mental health treatment. Medicaid is funded jointly by the state and federal governments, and states have considerable flexibility regarding covered services and eligibility criteria.

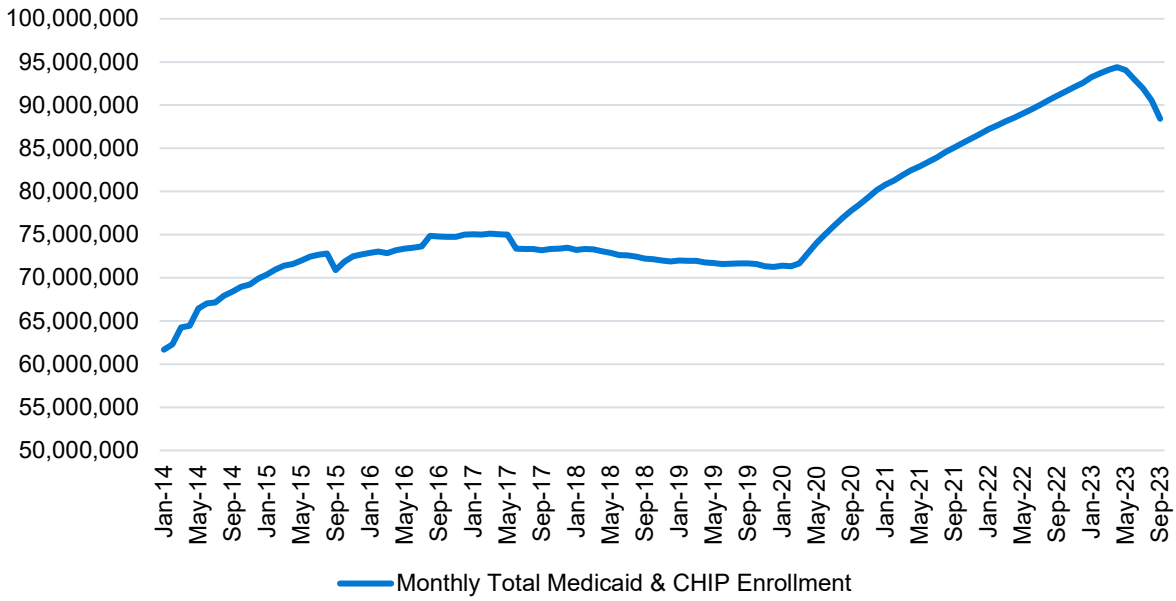
The portion of the U.S. population covered by Medicaid grew substantially during the COVID-19 public health emergency (PHE), covering around 95 million individuals at the peak in early 2023.[12] A key reason for the population growth was the pause in Medicaid eligibility redeterminations, meaning that states were not able to review income and other criteria for enrolled members and remove those members who did not meet eligibility criteria. This suspension of Medicaid policy by the federal government means that very few

[11] KFF (2022). Health Insurance Coverage of the Total Population. Retrieved January 31, 2024, from https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[12] KFF (June 2023). Medicaid in United States. Retrieved January 31, 2024, from https://www.kff.org/affordable-care-act/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

individuals left the Medicaid population from March 2020 through March 2023, while new individuals continued to add to the rolls due to normal churn. Starting in the second quarter of 2023, states were allowed to resume redeterminations, which has resulted in a steep drop in enrollment that is expected to continue until states complete their redetermination processes sometime over the next year, as shown in Figure 3.

FIGURE 3: MEDICAID COVERAGE



In the majority of states, the Medicaid agency contracts with managed care organizations (MCOs) to cover Medicaid-eligible beneficiaries. A few states operate Medicaid fee-for-service programs that do not involve managed care. The managed care plans are paid a capitated rate from the state to cover a defined set of services (which may be comprehensive or could be limited to a narrower set of services, such as dental or behavioral health).

From a VBC perspective, there are several unique considerations for Medicaid arrangements.

- There is wide variation by state in terms of eligibility criteria, covered services, rating/pricing structures, involvement of managed care plans, and reimbursement levels. Providers should not necessarily assume that their results in one state are predictive of results in another state.
- Medicaid encompasses a wide range of specialized cohorts, such as long-term institutionalized individuals, disabled children, foster children, and individuals with severe behavioral health needs. Providers often will not want to take on risk on the "entire" Medicaid block and instead may choose to focus on the populations where they believe they can influence the cost and quality of care. This reality creates some unique opportunities for providers that have specialized expertise for managing patients with complex needs to excel under VBC arrangements.
- In states with managed care, VBC arrangements can be established between providers and MCOs or between the providers and the state. Even if the VBC arrangements are technically between the provider and the MCOs, states have varying degrees of control over the terms of the VBC agreement. The Ohio Comprehensive Primary Care program[13] is an example of a situation where the state has established the methodology and is highly involved in the administration of the program. However, providers in Ohio can also negotiate separate VBC arrangements with MCOs.

[13] Ohio Department of Medicaid. Comprehensive Primary Care. Retrieved January 31, 2024, from https://medicaid.ohio.gov/resources-for-providers/special-programs-and-initiatives/payment-innovation/comprehensive-primary-care/comprehensive-primary-care.

- States that want to have direct oversight over VBC arrangements must work within the boundaries of various regulatory requirements. For instance, states may need to use a 438.6(c) preprint to implement the VBC arrangement as a state-directed payment (SDP) or use a separate authority through an 1115 waiver, both of which are subject to CMS review and approval. States must also ensure that total provider payments do not exceed certain limits, often set at the average commercial rate (ACR).
- As noted earlier, Medicaid eligibility has begun to decline rapidly and is expected to continue trending downward through the middle of calendar year 2024. This decline is expected to have a material effect on population acuity, as the individuals losing enrollment likely have different risk profiles from those who will remain. The magnitude and pace of this decline will vary widely by state, as will the effect on population acuity. Additionally, a high rate of churn is expected as beneficiaries lose coverage temporarily before reapplying for Medicaid, which could further complicate VBC arrangements.

VALUE-BASED CARE TRENDS

VBC adoption in Medicaid has generally lagged behind the Medicare and commercial markets. The slower adoption may be related to the complications discussed earlier in this section and in other Milliman white papers.[14] However, this varies widely by state; some, such as Massachusetts,[15] have well-established VBC programs that shift a significant amount of risk to providers.

Many states now collect data from MCOs on the portion of their spending that is related to VBC and, in some cases, there are financial bonuses or penalties for MCOs to achieve required levels of spending through VBC arrangements. For providers, this means that MCOs may be incentivized to establish VBC agreements with them.

Medicaid programs are increasingly focusing on social determinants of health (SDOH) and often view VBC arrangements as one component of their SDOH strategies. Additionally, the VBC arrangements may incorporate SDOH into risk adjustment, quality measurement, or other aspects of the arrangement with payers. One example is the inclusion of homelessness or other ICD-10 codes related to SDOH in the risk-scoring methodology.

OPPORTUNITIES AND CHALLENGES

- Providers have opportunities to make material improvements in cost and quality as the VBC environment is often less mature than commercial and Medicare markets, with rapid growth in recent years.[16]
- Providers may be in a better position than MCOs to reach individuals who have not been actively engaged in the healthcare system. While these beneficiaries may benefit from interventions, they may also have structural barriers to accessing care and/or be less receptive to provider outreach.
- Reimbursement is generally lower under Medicaid than commercial and Medicare, which in turn means shared savings payouts will be lower, all else being equal.
- The capitation rate-setting process used by the states typically targets profit margins of less than 2% for MCOs, leaving less room for shared savings in contracts tied to a medical loss ratio (MLR) target.

[16] Hunt, Z., Johnson, R.L., & Larson, A. (January 2019). Seven Key Challenges for Medicaid States Considering Alternative Payment Models. Milliman White Paper. Retrieved January 31, 2024, from https://us.milliman.com/en/insight/seven-key-challenges-for-medicaid-states-considering-alternative-payment-models.

[16] Mass.gov. Massachusetts Delivery System Reform Incentive Payment Program: Accountable Care Organizations (ACOs). Retrieved January 31, 2024, from https://www.mass.gov/info-details/8assachusetts-delivery-system-reform-incentive-payment-program#accountable-care-organizations-(acos)-.

[16] HCP-LAN (2023), Progress of Alternative Payment Models, op cit.

Wrapping it up

As VBC efforts become a larger part of the reimbursement strategy for providers, it will be important to consider the unique dynamics in each market they enter. The Medicare FFS market is relatively mature and features multiple well-established VBC models, along with the frequent introduction of innovative models from CMS. The prevalence of VBC arrangements in MA has picked up in recent years, following in the footsteps of Medicare FFS, but the financial models used in MA are separate from Medicare FFS. The commercial market is vast and penetration of VBC models has been growing; however, providers should be cognizant of varying characteristics of the ACA, fully insured, and self-funded submarkets. In Medicaid, VBCs have become a key area of focus for some states, although the complicated interaction among states, capitated health plans, and providers requires nuanced approaches to establishing models that create the proper incentives.

The approach to the various markets will vary for each provider organization but arriving at the optimal approach requires an understanding of the forces and trends within the markets.

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