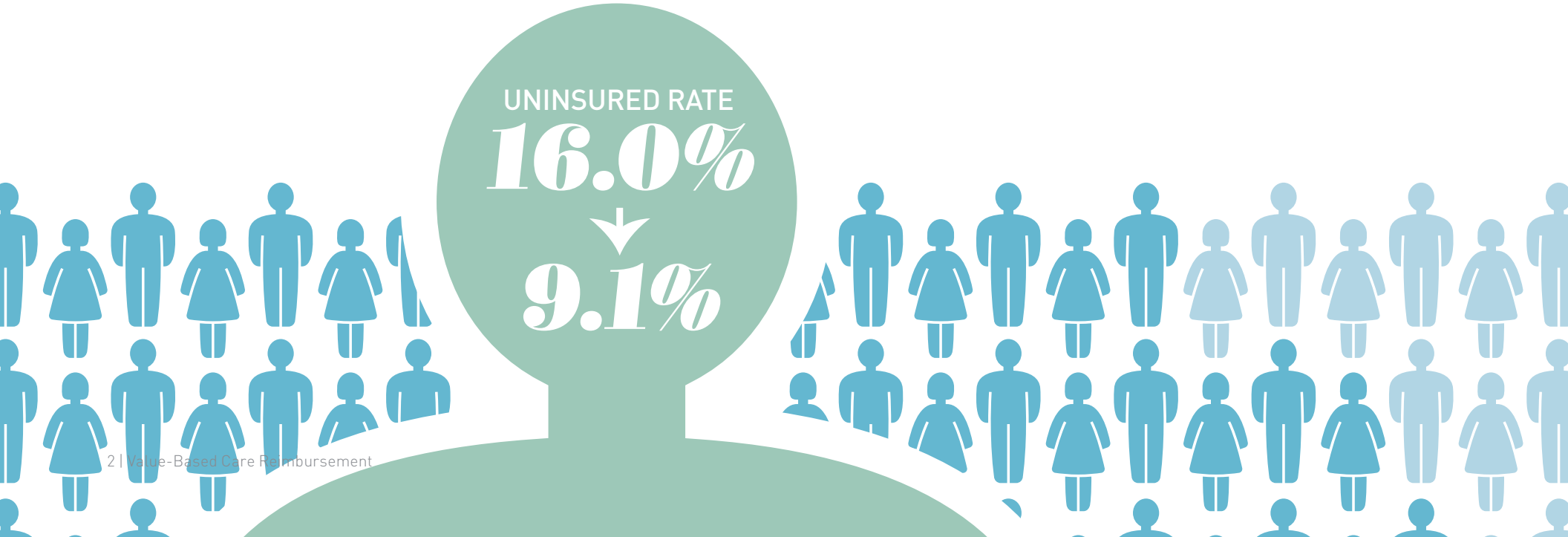
HEALTHEDGE

Value-Based Care Reimbursement

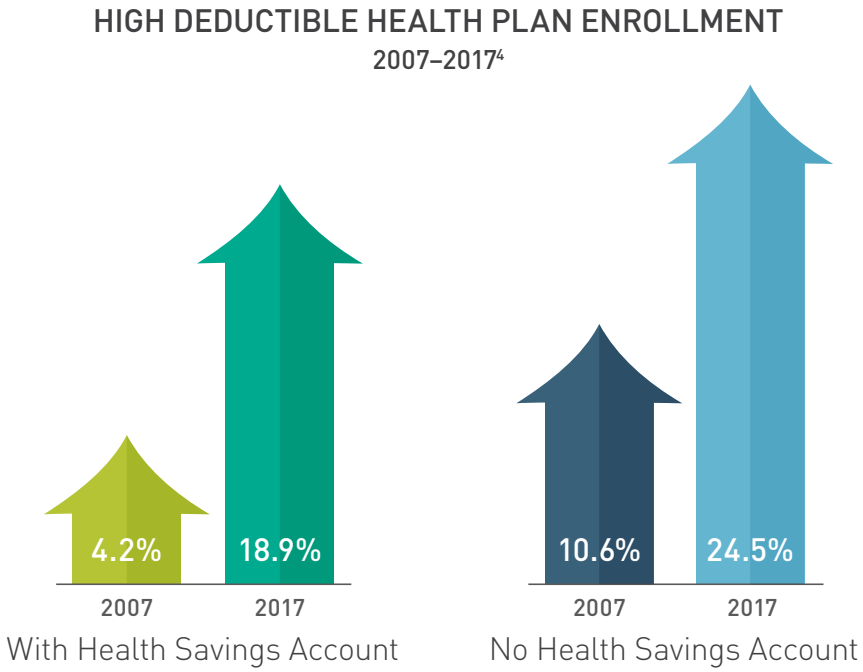
How we got here, what's working, and who's doing it well

Value-Based
How We Got Here

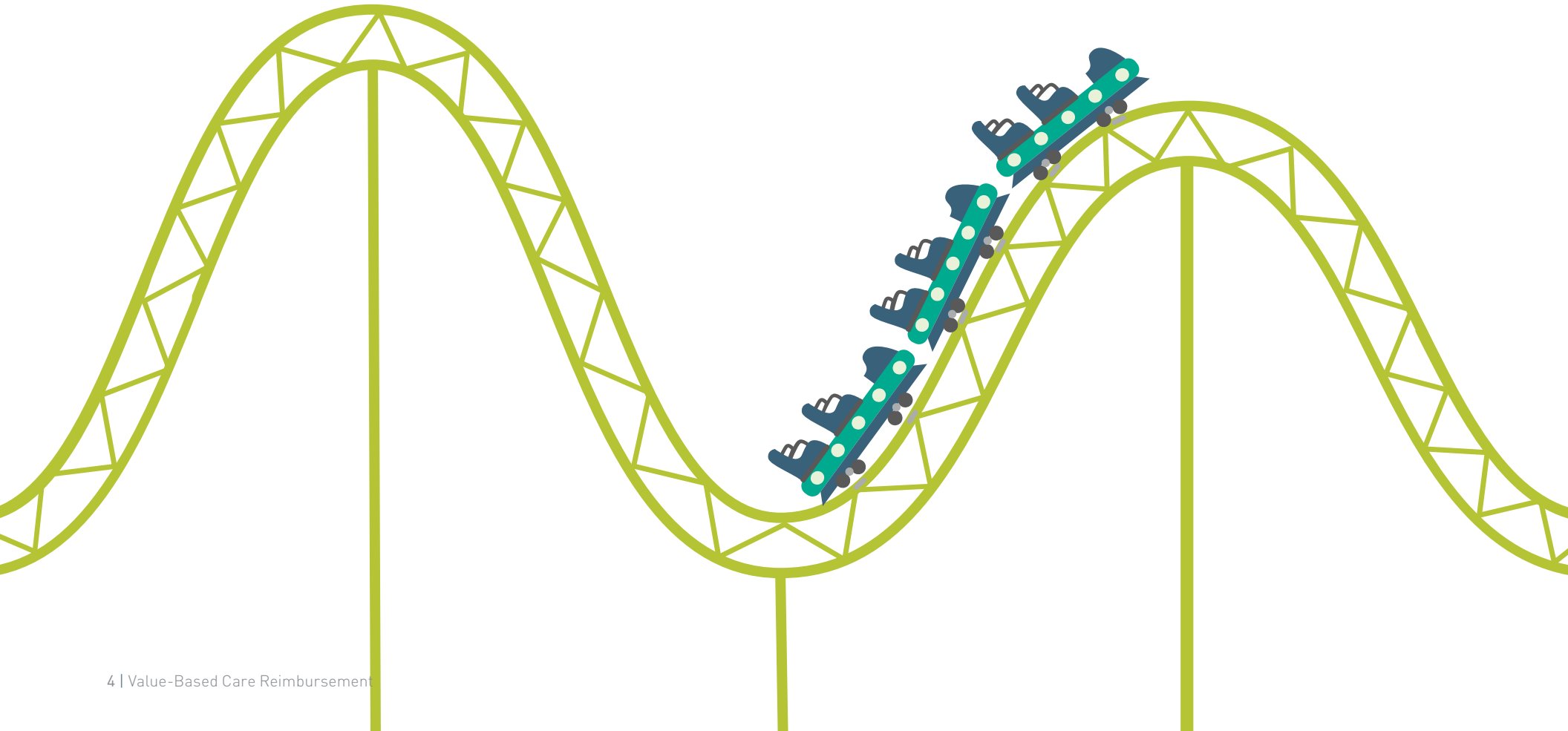
In 2016, the U.S. government sponsored a comprehensive look at the progress made from the Affordable Care Act. In the report,[1] published by the Journal of the American Medical Association, the government touted the decline in the uninsured rate from **16.0 percent in 2010** to **9.1 percent in 2015.** According to the U.S. Census,[2] in 2019, the percentage of uninsured adults remained mostly unchanged at 9.2 percent. The transformation of the payment system from fee-for-service to value-based reimbursement has led to improvements to the overall quality of care delivered, and better financial security for patients through a reduction in medical debt collections. It could be said that at least two of the three tenets of the Triple Aim were being directly and successfully addressed.



While the Affordable Care Act made great strides in increasing access to healthcare, costs continue to increase. National health spending is projected to ***grow at an average annual rate of 5.4 percent*** from 2019-2028 and to reach ***$6.2 trillion by 2028.***[3]

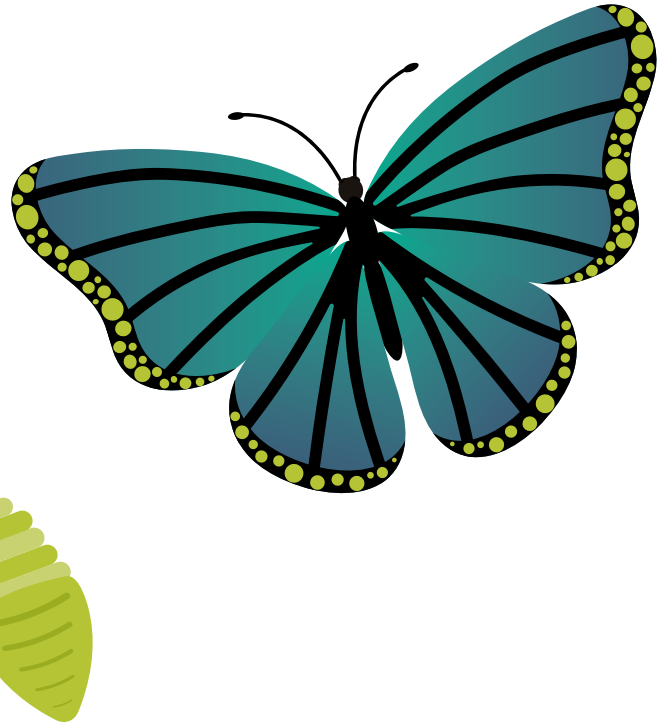


Thankfully there is hope for a critical path where both payers and providers can rein in costs while improving the quality of care for their members. This path, the adoption of value-based models, is showing positive signs of success, even if the industry is still in the early days of making this transition.



Where Value-Based
Is Succeeding

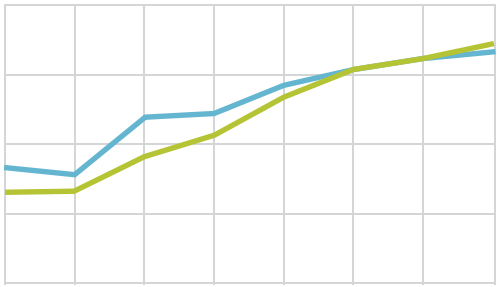
Value-based models can take many forms — shared savings, upside risk, downside risk, pay-for-performance between risk and quality measures — all the way to full capitation. Things are moving in the right direction with some payers working to bring about the change so desperately needed by embracing the shift toward value. ***The Center for Medicare and Medicaid Innovation (The Innovation Center) within CMS, has been leading the transition to value-based programs, with Medicare Advantage demonstrating both cost savings and improved patient outcomes.*** The Innovation Center continues to roll out demonstration programs for selected procedures and services that are value-based by definition.



A national study of 120 payers conducted by ORC International and commissioned by Change Healthcare[5] found that:

Medical cost savings in value-based arrangements topped 5.6 percent on average, with almost a quarter of respondents noting ***savings in excess of 7.5 percent.***

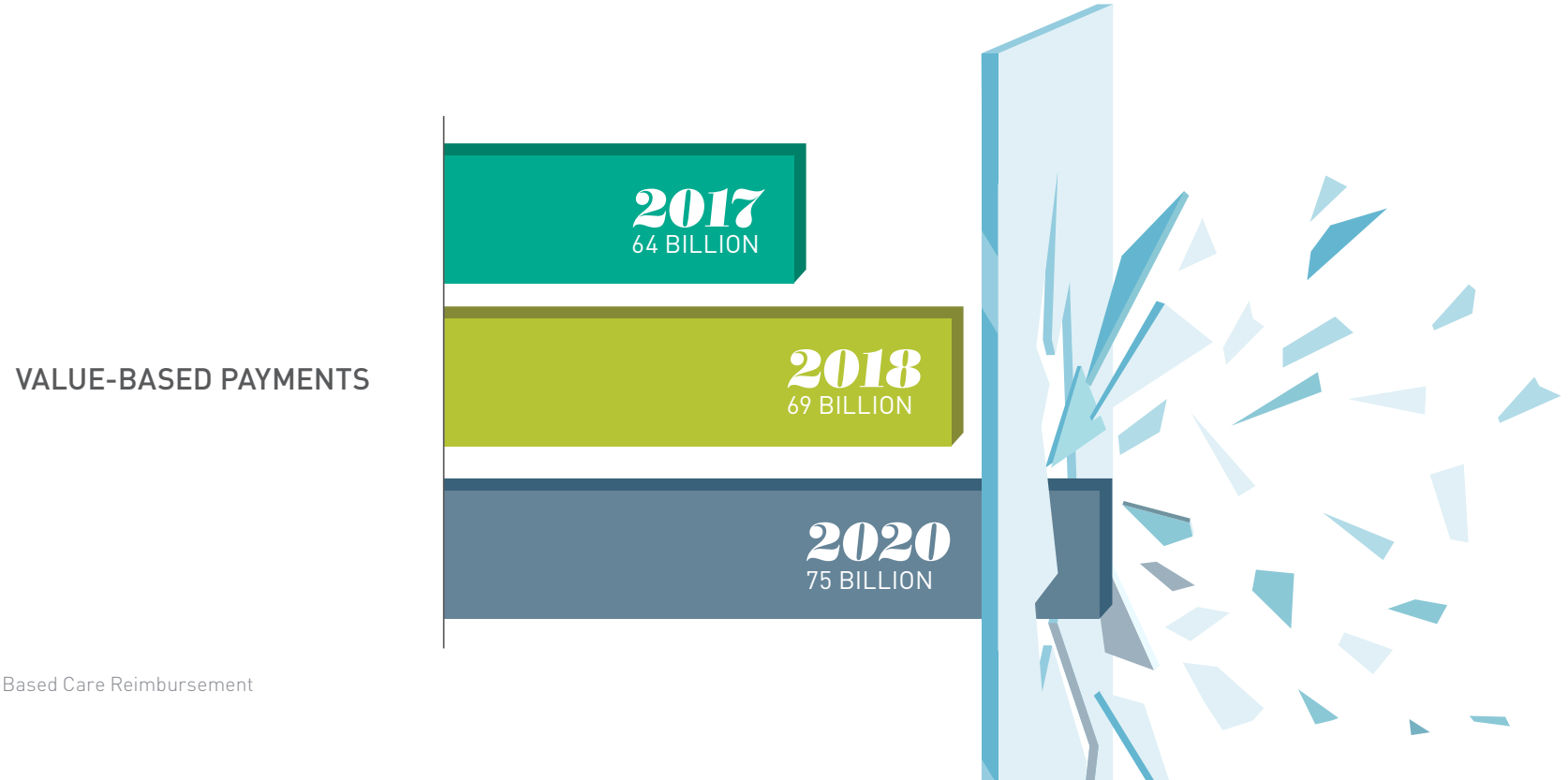
33 percent of payers report a great improvement in care quality, while 30 percent report great improvements in provider engagement and 20 percent in patient engagement.



For the first time, commercial lines and not government lines of business are ***leading adoption, advancement, and innovation of value-based care models and strategies.***

Drilling Deeper
Into What's Working

UnitedHealth Group spent $69 billion on value-based payments in 2018, up from $64 billion in 2017, according to Forbes.[6] The amount UnitedHealth pays its provider networks under value-based contracts represents nearly half of its annual reimbursements. The company is tracking ahead of its goal to transition $75 billion in payments to value-based contracts by 2020.[7]



Medicare Advantage is one of the only products in health insurance that can achieve the triple aim of healthcare: improving care, lowering costs, and enhancing member experience. According to Humana's 2020 Value-Based Care Report,[8] its **2.4 million Medicare Advantage members** who benefit from value-based care, saw significant results.

Members Benefit from Value-Based Models

Spent **211,000 fewer days** in the hospital and ER

ER visits **down 10.5%**, hospital admissions **down 29.2%**

Cumulative savings of **$4 billion** as compared to traditonal Medicare

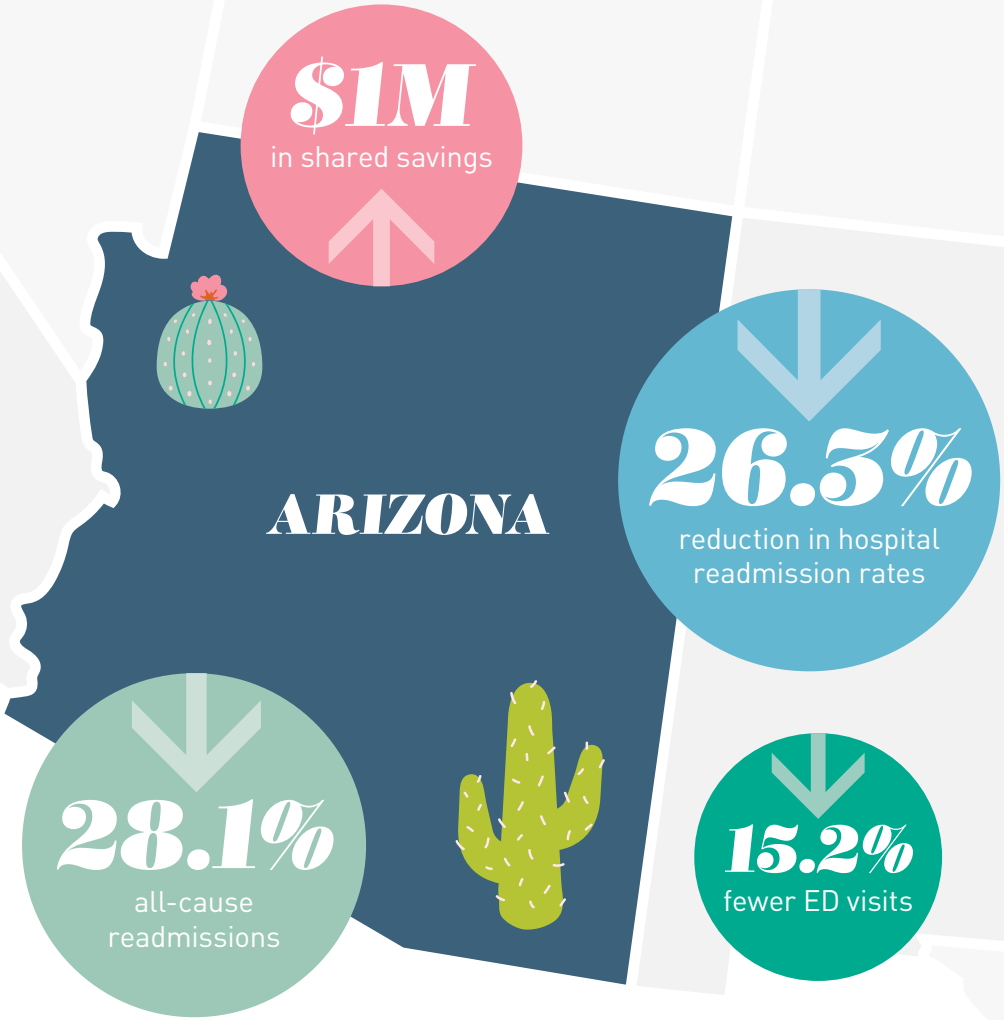
Blue Cross and Blue Shield of Arizona (BCBS AZ) has put initiatives in place to increase quality and reduce costs. Results from the first year BCBS AZ's value-based care initiative:[9]

> Reduced 30-day hospital readmission rates by 26.3 percent

> Generated shared savings of $1M for 600 providers who met quality and patient outcome goals

> Reported 15.2 percent fewer ED visits per one thousand patients

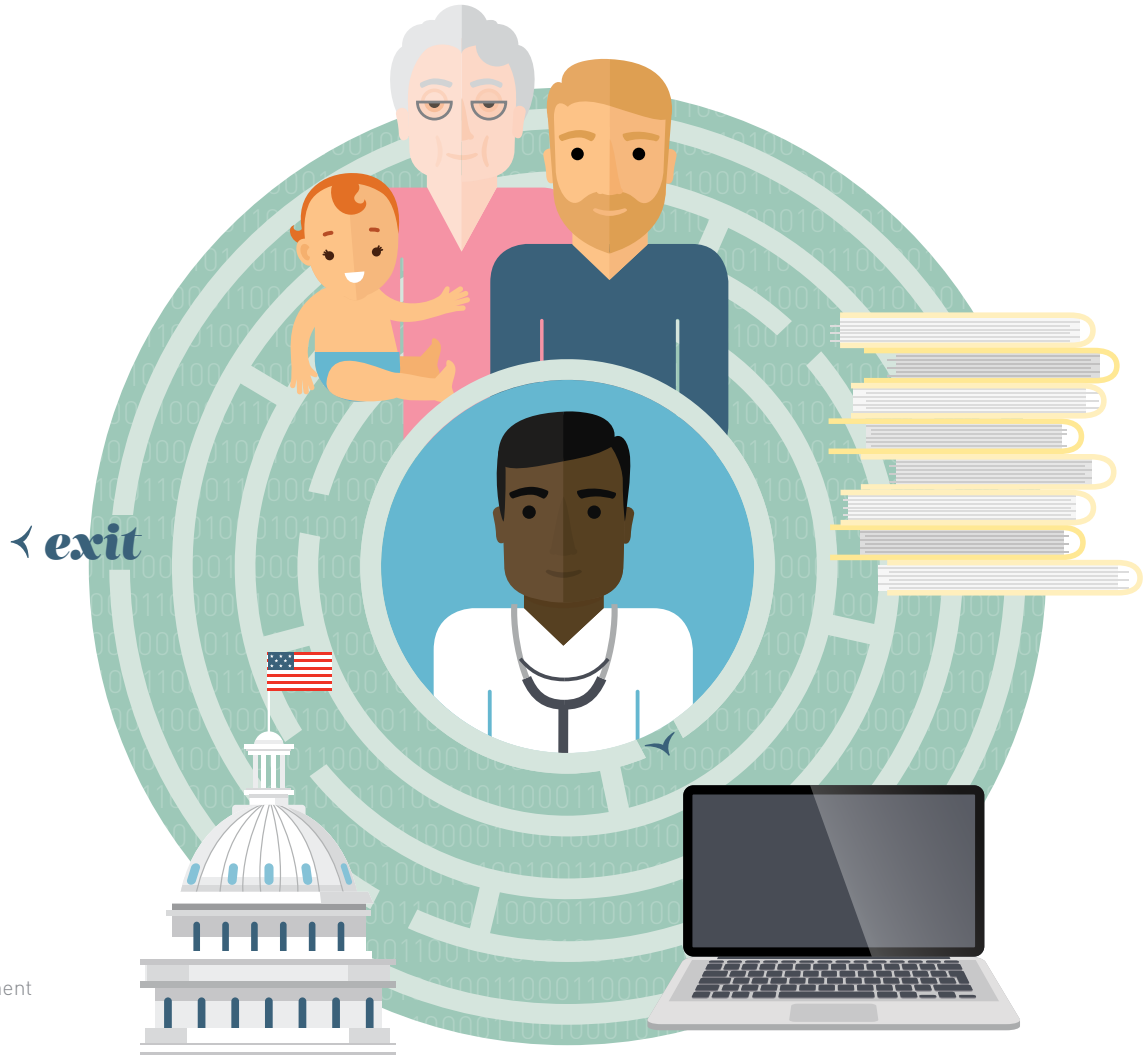
> 28.1 percent reduction in all-cause readmissions



The Challenges Ahead

CMS is taking steps to simplify the administrative burden for physicians under the Medicare Access and CHIP Reauthorization Act (MACRA) by removing some of the reporting requirements. ***However, the percent of eligible clinicians who participated in the Merit-based Incentive Payment System (MIPS), the standard strata of payments, increased from 95% in 2017 to 98% in 2018.***[10] This demonstrates that there is tangible progress in Medicare, despite the additional work involved. This success should serve as a model and catalyst for commercial health insurers to follow suit.

Primary care physicians are at the epicenter of value-based programs and stand to gain the most. ***But many providers don't feel they have the resources, skills and data to succeed with new payment models.*** According to a recent study by the RAND Group,[11] many physicians don't understand the complex new payment models under commercial or public plans. Yet these are the practices that stand to gain the most from value-based programs because community and primary care physicians are the quarterbacks directing patients to the right care setting at the right time, proactively managing chronic conditions and effectively keeping those patients out of the hospital.



While hospitals may have the expertise to succeed under value-based contracts, their business models still largely depend on heads in beds. For hospital-based systems to make the transition, they need to affect significant cost transformation, according to a recent report by Kaufman Hall.[12] The threat hospitals are facing from urgent and retail care is real and represents a model generally favored by Millennials and Generation Z.

> The number of urgent care centers in the U.S. reached 9,616 as of November 2019, representing ***growth of 9.6%*** from the prior year
>
> THE URGENT CARE ASSOCIATION

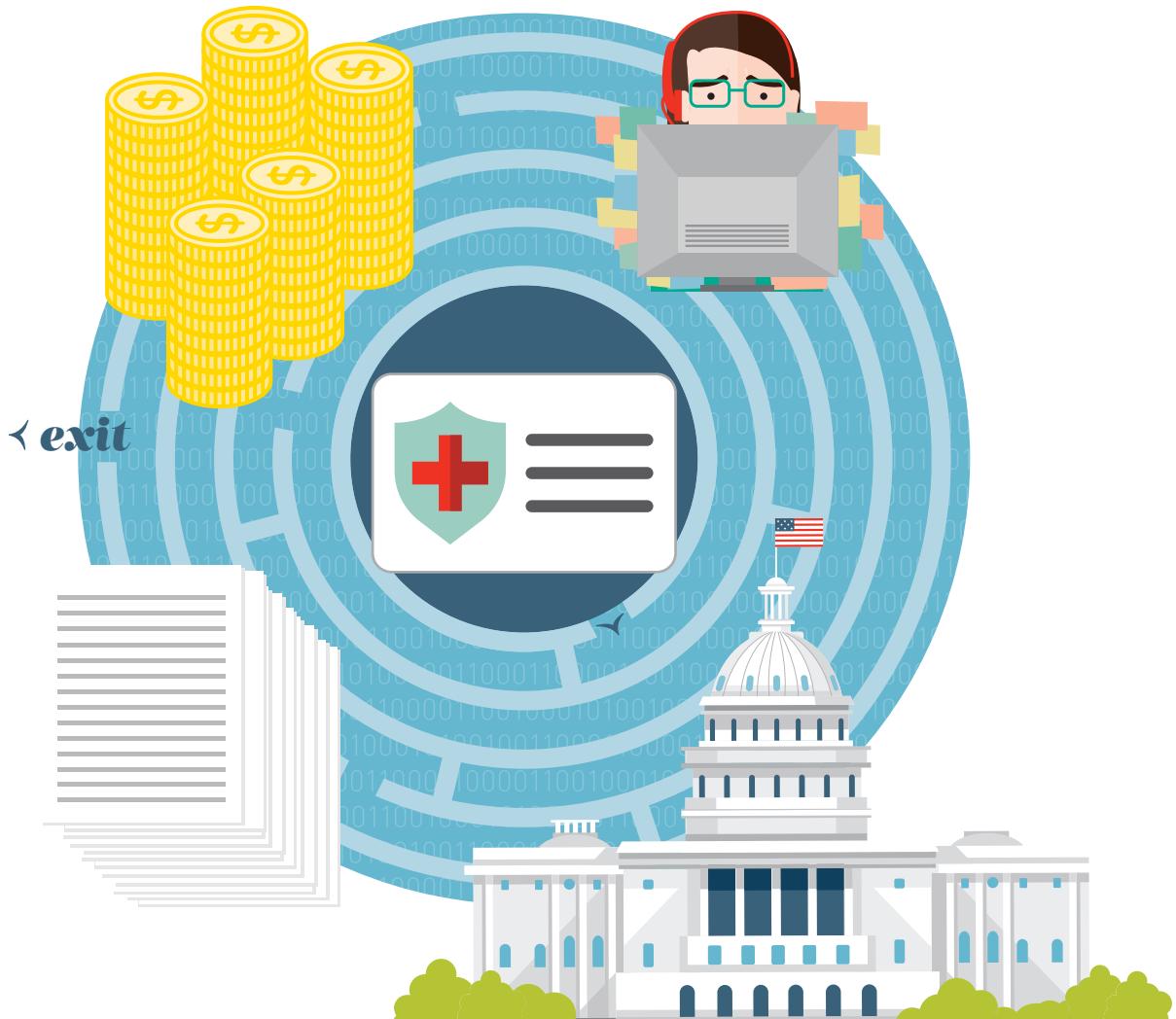
> Almost ***97% of urgent care patient encounters lasted one hour or less,*** demonstrating the quick and convenient service that meets the on-demand access to care important to patients today.[13]
>
> THE URGENT CARE ASSOCIATION

vs.

Payers, while slowly embracing value-based contracts to date, have their own challenges. They too, are in many cases tied to their fee-for-service past and are working on strategies to move toward value-based contracts.

RAND recommends that payers consider the following steps to reduce burdens and improve morale among providers:

- Help practices invest in data management and analysis, and supply timely, actionable performance data to succeed in alternative payment models (APMs)
- Simplify APMs to help practices improve patient care as the preferred strategy for earning financial rewards
- Slow the pace of change in APMs to benefit practices
- Consider offering upside-only APMs, or help practices manage downside risk

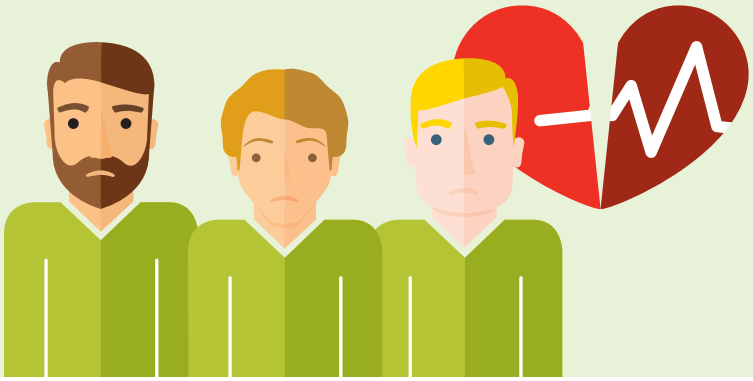


How a *Nimble Payer Works*

Independent Health, a non-profit health plan in Buffalo, New York began operations in 1980, and services over 400,000 members. Despite being nearly 40 years old, the health plan has moved quickly to embrace value-based reimbursement for its providers living in the Western New York area.

One of the key ingredients for Independent Health's transformation from fee-for-service to having nearly 98 percent of its primary care practices in full capitation contracts was partnering with HealthEdge. Being nimble enough to adapt on the fly is the one capability health insurance organizations must have to succeed under value-based payments.

Dave Mika, Vice President of Enterprise Core System Operations at Independent Health, recounts the story of one cardiology group in its network that wasn't nimble enough to adapt to this new landscape. "Our CEO was approached by a colleague from medical school who asked for a 15 percent rate increase to stay in business," shares Mika. "We had the difficult task of denying his request, explaining that his group's outcomes were below standard and that his peers were experiencing better quality outcomes at much lower costs. That specialty cardiology group is no longer in business because it couldn't adapt."



Simultaneously, another cardiology group within its network demonstrated strong and positive clinical outcomes, which led to a 3.5 percent reduction in medical costs. Independent Health also saved $14.8 million by targeting approximately 5,000 member where it could partner with providers in a post-acute care setting to reduce avoidable admissions and wasteful readmissions.

> There's no silver bullet. But if you throw in one chip at a time, eventually you build up enough small wins to ante up and generate strong results, all amidst an evolving landscape. Our aim is to continue to invest in this mechanism of transforming primary care delivery and reimbursement.
>
> DAVE MIKA
> VICE PRESIDENT OF ENTERPRISE CORE SYSTEM OPERATIONS
> INDEPENDENT HEALTH

Results from value-based contracts ***require trust and communication*** between various entities and transparent sharing of as much data bi-directionally as possible. This type of nimbleness and ability to exchange data with providers is possible because Independent Health is leveraging better technology. They are now looking to strategically reshape primary care delivery in Buffalo through participating in CMS's Comprehensive Primary Care Plus initiative and increase the reimbursements paid to primary care physicians.

Leadership in the Industry

Gartner cited HealthEdge as a Sample Vendor for its next-generation core administration system in its August 2020 Hype Cycle for U.S. Healthcare Payers Report, for the tenth consecutive year.[14] HealthEdge is helping health insurers of all sizes, geographies and lines of business transform their business to meet the changing demands of today's healthcare landscape. Our customers report dramatic results and the ability to stay resilient to change, creating a competitive advantage as they scale their businesses.

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14. Hype Cycle for U.S. Healthcare Payers, 2020, Analyst(s): Bryan Cole, Jeff Cribbs, Mandi Bishop, Published: 5 August 2020 ID: G00444809

About HealthEdge

HealthEdge provides modern, disruptive healthcare IT solutions that health insurers use to leverage new business models, improve outcomes, drastically reduce administrative costs, and connect everyone in the healthcare delivery cycle. Its next-generation enterprise solution suite, HealthRules, is built on modern, patented technology and is delivered to customers via the HealthEdge Cloud or onsite deployment. In 2020, HealthEdge was acquired by Blackstone, becoming the first healthcare and second transaction for Blackstone Growth (BXG). HealthEdge's portfolio includes HealthRules Payor,® HealthRules CareManager,® and Burgess Source.® Follow HealthEdge, on Twitter @HealthEdge or on LinkedIn.

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