



# A Transition in Flux: How Health Plans Can Optimize Value-Based Care Initiatives

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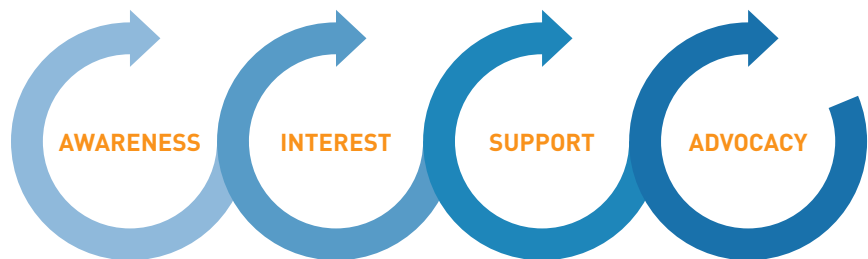
To control the surging costs of U.S. healthcare spending and improve patient outcomes, the Centers for Medicare and Medicaid Services and commercial health plans are switching from traditional fee-for-service arrangements to value-based care (VBC) programs. This change is causing a seismic shift in how providers are paid. Estimates suggest that value-based payment initiatives accounted for anywhere from 34% to 47% of U.S. healthcare payments in 2017, and are continuing to increase.

Despite progress, the transition from a care model based on volume (the number of services performed) to one based on value (the quality of care and patient outcomes achieved) has been rocky. Health plans are committed to VBC and risk sharing, but until now, it has been difficult to get a finger on the pulse of providers' perceptions of this transition. Are health plan efforts to change the way that physicians deliver patient care working? After all, changing incentives without inciting a meaningful change in care delivery will do little to solve the healthcare cost crisis.

To shed light on these issues, we conducted phone interviews with practitioners and executives with oversight of thousands of primary care physicians (PCPs) across the U.S. We also surveyed 1,019 PCPs to find out what they know about VBC, what their drivers and barriers to VBC participation are and what kind of support they want from health plans.

The results paint an uneven picture of transformation. There's no doubt that numerous VBC efforts aim to restore the PCP as a central figure in healthcare delivery—and our survey results confirm that payment transformation is under way. The PCPs surveyed expect the percentage of revenue tied to non-fee-for-service arrangements to climb from 30% today to 50% five years from now. However, clinical transformation has not occurred at the same pace. Only one in nine PCPs surveyed have engaged in a VBC program that was highly impactful to the way they deliver care and, ultimately, to patient health.

We identified four categories in which health plans can tackle these challenges. Understanding these categories can help health plans improve their relationships with providers, increase VBC participation and positively impact patient care and cost trends.



- + **Awareness:** What do providers know about VBC? What is their current state of participation?
- + **Interest:** What draws providers to alternative payment models and what factors increase their willingness to participate?

- + **Support:** What are the activities or mechanisms that help providers transition to VBC and allow them to succeed and transform care delivery?
- + **Advocacy:** What makes providers feel confident in their ability to succeed in a VBC program and pave the way to expand participation or assume more risk?

Here’s how to improve VBC success through each of these categories, based on our research.

### Awareness: Building Consideration Among Providers

Providers reported high awareness of various value-based care payment models, but there is room to improve. While 70% of providers recognize pay-for-performance programs, knowledge of other programs ranges from 42 to 54%.

Forty-seven percent of respondents said that they participate in a VBC program today. Of this cohort, 80% are highly aware of pay-for-performance programs. This drops sharply to 57 to 59% for shared savings, bundled payments and shared risk models.

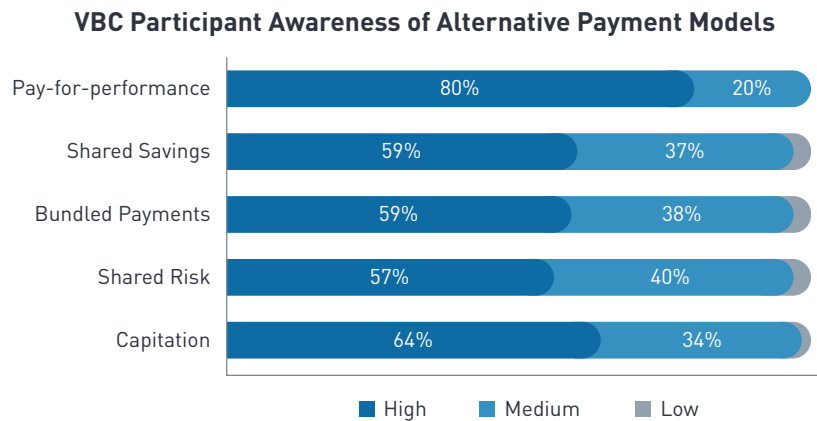


Figure 1: Participants tend to be highly aware of payment models, with awareness being highest for low-risk APMs.

However, awareness and participation has not translated into meaningful interest in engaging in VBC programs. Only 30% of respondents are highly interested in VBC participation. For example, PCPs say that these contracts are simply “thrust upon them,” not something they opted into, or that they’re participating in them because it’s “worth rolling the dice” to get a possible bonus.

Further, provider interest in VBC does not vary significantly across practice settings. For example, providers affiliated with accountable care organizations (ACOs) or integrated delivery networks (IDNs) are not significantly more interested in VBC than those in other settings (36% of ACO participants and 38% of IDN participants are highly interested).

Making providers aware of alternative payment models is not enough. Educating them so they’re truly knowledgeable about them is crucial.

## Interest: Overcoming Barriers to Participation

As the data shows, health plans have some ground to make up in terms of building and sustaining provider interest and active participation. This requires pinpointing barriers limiting provider participation and overcoming them.

“Focusing on a few meaningful measures is much more likely to drive provider engagement than a laundry list with unclear links to improving outcomes.”

-PCP

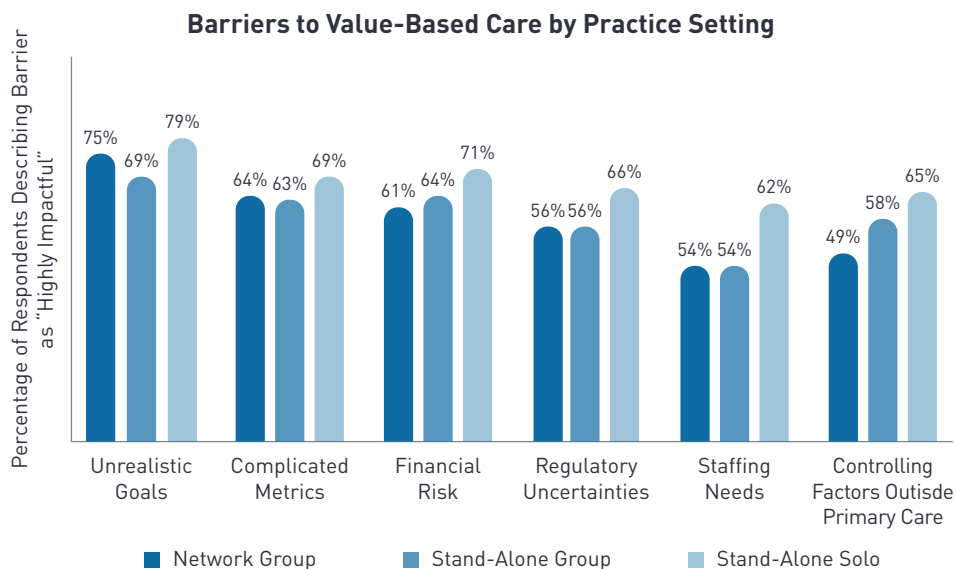


Figure 2: Unrealistic goals, complicated metrics and financial risk are most commonly cited as top barriers. Financial risk and staffing needs are more commonly cited by stand-alone practices.

According to our survey, the biggest areas in which health plans have room to fill that interest gap are:

- + **Unrealistic Goals:** Seventy-four percent of providers say that programs have unrealistic goals, making this the top barrier to VBC interest. This concern is exacerbated among high-performing and long-tenured VBC participants, who liken their goals to “sprinting toward a finish line that they can’t always see” or that they perceive to be perpetually elongating.
- + **Complicated Metrics:** Sixty-five percent of providers cite complicated metrics as a barrier to VBC participation. Troublingly, providers also lack confidence that they can meaningfully impact many of the metrics included in their VBC programs. PCPs tend to prefer metrics that they can directly control, such as flu vaccines, over metrics that may be less controllable but more closely linked to patient outcomes, such as medication adherence. This introduces a core design element in value-based care programs: achieving a balance of process metrics that can engage providers in quick wins with metrics that more closely correlate with outcomes and total costs of care.
- + **Approach to Risk and Compliance:** Sixty-four percent of providers also cite financial risk as a barrier to VBC participation. Unsurprisingly, the level of risk aversion decreases for PCPs who are part of larger networks or systems because they have access to a larger number of resources and

support elements. As one provider told us, “Independent physicians, due to government and insurance mandates, are being increasingly driven to systems. Without financial and staff support, we will die out and costs will go up regardless of the value or quality [of the] program.” Health plan support measures such as stop-loss insurance may address these needs.

- + **Program Length and Payment Lag:** Further, the program length (typically annual), combined with a delayed payment cycle, makes it challenging to incent behavior when PCPs do not know when or what they are being rewarded for. Forty percent of VBC participants are either unaware of the payment timing or report a payment lag of one year or greater from the end of the measurement period.

### Support: Tailoring Efforts to Provider Needs

Beyond VBC design, almost all providers (92%) want health plans to support them in program implementation and transformation of care delivery. While this is an encouraging statistic for health plans, the current one-size-fits-all approach is not working.

In our survey, we asked providers to list the forms of health plan support that they want the most, as well as the forms of support they currently receive in their largest VBC program.

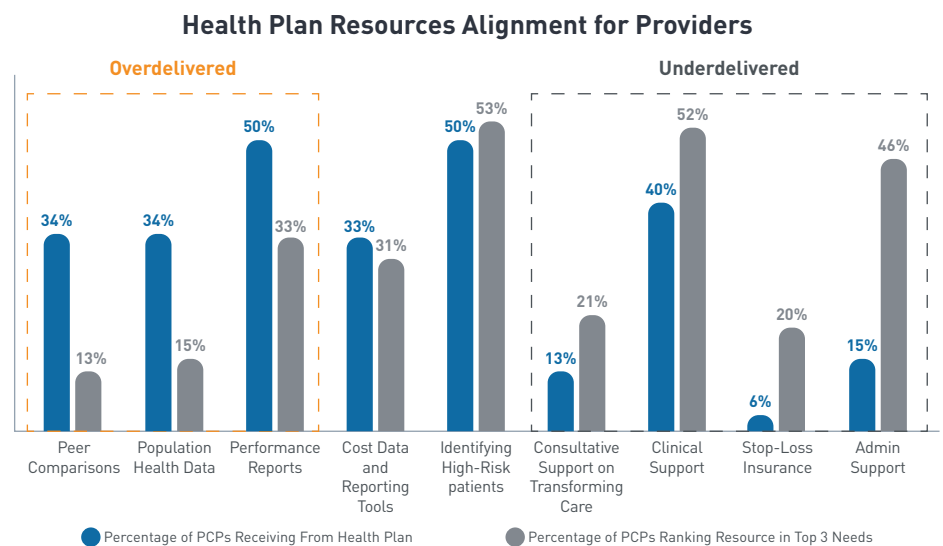


Figure 3: Peer comparisons and performance reports are commonly overdelivered, while the largest gap is in admin support.

Most providers say that these forms of support are “table stakes” for succeeding in VBC: administrative support, clinical support and identifying high-risk patients. Among these, both administrative support and clinical support have delivery gaps

that health plans can address more consistently. This is even more pronounced with stand-alone, solo practice PCPs—with only 12% receiving health plan administrative support, compared to 51% who want it.

Conversely, PCPs said they are inundated with data and reports—perhaps more than they needed. This sentiment is consistent with [industry perspectives](#) that cite the unintended consequences of over-reporting, and is something that health plans should carefully consider to improve their communication with providers.

The health plan support gap is a significant deterrent to provider interest and engagement in VBC. Overall, only 35% of VBC providers said that they receive the support they need from the health plan with whom they have their largest VBC contract. Why does this matter? The percent of PCPs who participate and are highly interested in VBC increases from 37 to 49% when they receive the right level of health plan support.

### Health Plan VBC Support Alignment

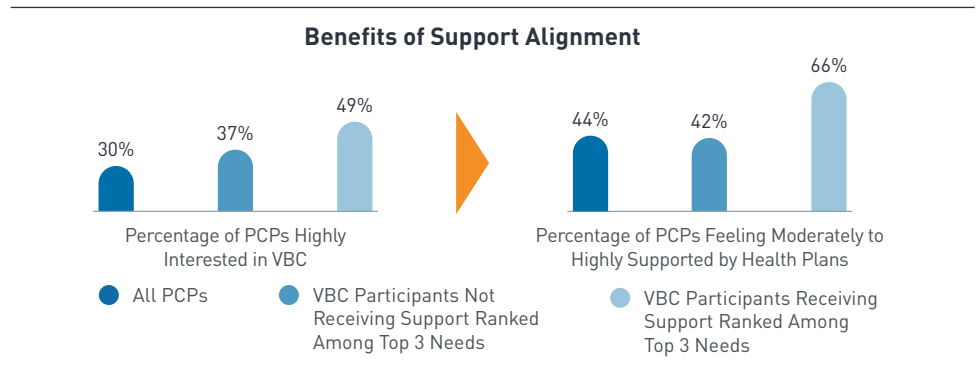


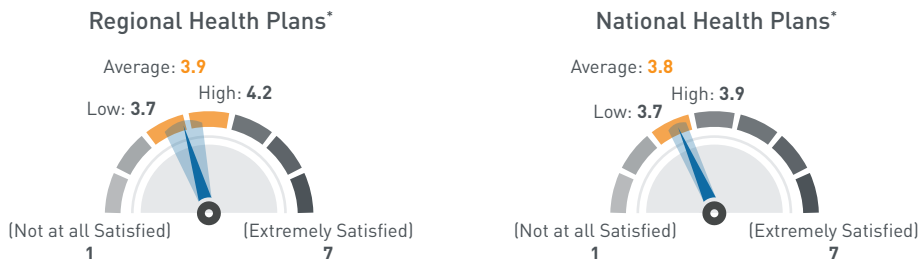
Figure 4: All VBC participants are more interested in VBC than non-VBC participants, but receiving desired support from health plans dramatically boosts positive sentiment towards plans.

While the promise of better support alignment is clear, all health plans have an opportunity to improve in this area. The highest rated health plan [a regional BCBS affiliate] had only 44% of their providers say they received their desired forms of support.

### Advocacy: Enabling Providers to Thrive

While effort has been made to tailor VBC program designs to health plans' needs, providers often don't feel a reciprocal accommodation. Providers we surveyed are unable to meaningfully differentiate between health plans and overall report a lack of enthusiasm for these programs. For example, the health plan that scored highest in overall VBC program satisfaction among its PCP participants has only 21% of PCPs reporting high satisfaction. The data shows that advocacy largely does not exist in today's iteration of VBC.

### Average PCP Satisfaction With Health Plan VBC Programs



\* Regional health plans were defined as plans with coverage in fewer than 10 states, while national plans covered 10 states or greater.

Figure 5: Overall, satisfaction with VBC programs is moderately low. Additionally, providers perceive most VBC programs as similar, showing an opportunity to create positive differentiation among health plans.

“The health plan made a major investment in clinical staff to support primary care practices, with the express purpose of asking those clinical staff to monitor the sickest patients.”

–Executive of large provider practice that participates in VBC

Taking early and consistent actions to establish themselves as true partners with providers during the initial VBC transition helps health plans build advocacy early. Providers who can offer input during the contracting process are twice as likely to rate their VBC programs as highly impactful to their care delivery. Additionally, providers who receive support at the onset of the transition, such as preventive care resources and EMR coding assistance, report higher impact on their care delivery compared to those who do not receive such resources.

### The Path to Value-Based Care 2.0

What does this mean for health plans? There’s a lot of noise around designing the perfect program, often fueled by provider feedback regarding ineffective metrics and unreachable goals. While our research confirms these challenges, health plans can build on their existing foundations rather than starting anew. For VBC success, the relationships between health plans, providers and members must be improved. The figure below illustrates the key outcomes, health plan levers and provider indicators required for VBC success, and how health plans and providers engage as a system to achieve it.

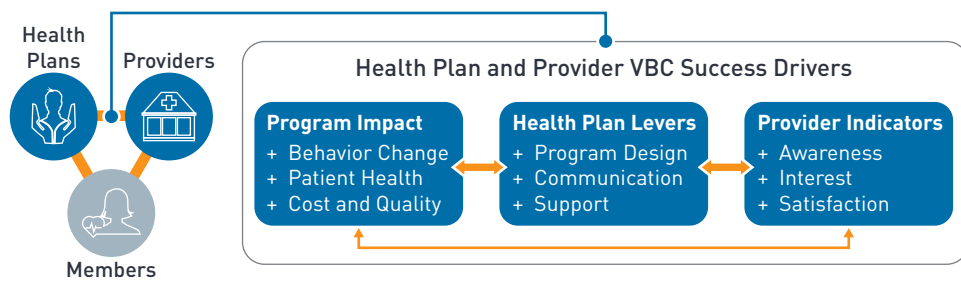


Figure 6: How health plans and providers engage as a system to achieve success in VBC.



“The most important thing is that program design can’t be top-down. Plans must engage those close to the front line who can ensure the program is realistic and be advocates for its success.”

–Medical director of a large integrated plan/provider system

Here are four key areas for plans to optimize their VBC programs:

- + **Conduct a VBC health check.** While overall satisfaction with health plan VBC remains low, the drivers of satisfaction vary widely by provider, and thus by program. To pinpoint and prioritize the largest areas to tackle, health plans must build a singular view of alternative payment models to assess the health of their entire portfolio of programs. This includes (but is not limited to) 360-degree feedback from provider partners, members, clients and distribution partners (brokers) and personnel from various corporate functions. Audit and document metrics used, operational process flows and existing support mechanisms. Use the results to refine program designs, tailor support by provider and reset KPIs to monitor ongoing success across all value-based programs.
- + **Build and nurture a feedback ecosystem.** Leading health plans are actively incorporating the voice of the provider throughout the year (through town halls, physician councils and third-party surveys) to better understand the current state, identify ways to course correct and deepen feelings of trust. These programs underscore the importance of communication and include both the “front-line” PCPs and other stakeholders in an office setting or administrators in a larger system. As a medical director for a large integrated plan/provider said, “The most important thing is that program design can’t be top-down. Plans must engage those close to the front line who can ensure the program is realistic and be advocates for its success.”
- + **Invest in data and analytics capabilities.** Health plans are increasingly discussing the need to develop “attribution factories” to measure the impact of value-based programs at the portfolio level rather than at a program level. Doing so will not only better inform future program design but also will bolster communication efforts that can increase provider buy-in. For example, an administrator told us that his team had a hard time adopting VBC until the organization had the ability to demonstrate how it improved outcomes for patients. Better data and analytics can also help health plans give providers the consultative support to improve care that our research shows they’re looking for. In some instances, this may require health plans to assess their data quality and completeness to effectively execute VBC.
- + **Take the long view on the value-based transition.** Rather than focusing on moving PCPs to risk-based contracts as the endgame, health plans should focus on provider satisfaction and impact measurement no matter the model type. Clear and compelling program explanations and ongoing change management efforts tailored to experience and practice setting will engender feelings of support and trust. This will promote sustained behavior change and increase willingness to take on higher risk programs. Further, widening the scope of VBC programs to include specialist and post-acute care will reinforce the mindset across the provider ecosystem and increase confidence among those already participating.

The U.S. healthcare affordability crisis continues to occupy center stage as the era of cost shifting approaches its practical limits. Americans are not just looking toward value-based care as a possible solution, they are demanding it to achieve meaningful changes in healthcare cost and quality. Providers have felt this shift and are keenly aware that it will continue in the next five years. While the PCPs we surveyed largely viewed all health plans' VBC efforts similarly, there's significant room to change how programs are designed and implemented. Health plans that pay attention to providers' needs and create the ideal conditions that meaningfully engage them in their VBC programs will be best positioned to succeed.

### About the Author



Peter Manoogian is a principal in ZS's Boston office and a leader in ZS's health plan and provider industry practice. Peter advises national and regional health plans across a range of business issues including customer-centricity, go-to-market strategy, value-based transformation and advanced analytics.

Peter regularly contributes his insights to publications including Modern Healthcare, Business Insider and Managed Healthcare Executive. Peter also writes for ZS's health plan-focused blog, [Health Plan IQ](#).

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