HEALTHEDGE

SURVEY REPORT

Voice of the Market Survey Series

Health Insurance Executives: The Outlook for Value-Based Reimbursement and Barriers to Success

Health Plans Face Barriers to Achieving Success in Value-Based Reimbursement, But Flexible Technology That Supports Data-Sharing Offers Promise

Despite the uncertainty around the Affordable Care Act (ACA) and other healthcare reform efforts, it's clear that value-based care and the reimbursement models that underpin it are here to stay. What isn't as clear is the inconsistency in adoption rates nationwide and which strategies are working well.

The pace of the shift to value-based models is largely regional. Places like California have moved into value-based reimbursement (VBR) more aggressively while other areas like the Northeast have seen more resistance. Further, the approaches tried by payers — ACOs, bundled payments, and so on — have appeared somewhat scattershot. Results have been reported for some programs, but these seem largely anecdotal. One thing we can say for certain about value-based reimbursement is that the Centers for Medicare and Medicaid Services (CMS) is pressing the gas pedal vigorously on multiple fronts, rolling out many new programs and mandates that tie reimbursement to improved patient outcomes and lower costs. While new models may open interesting avenues for payers, most do not yet have a sustained track record that reflects the delivery of significant, longer-term savings to payers, providers and of course members.

> "I'll tell you a lot of what I do in my role running CMMI as senior adviser to Secretary Azar is to **blow up fee for service,** that's one of our prime goals—is to get rid of fee for service."
>
> ADAM BOEHLER, DIRECTOR, CENTER FOR MEDICARE & MEDICAID INNOVATION

Because of the rapidly changing landscape and lack of a clear picture of how payers are approaching VBR, HealthEdge chose this critical dynamic to explore in the first "Voice of the Market" survey of 2019.

How Health Plans Are Succeeding — Or Not — In VBR

Similar to HealthEdge's 2018 studies, HealthEdge — in partnership with market research firm Survata — conducted a survey of more than 150 health insurance executives to understand payer experiences with VBR. The goal was not only to understand the challenges associated with rolling out these initiatives, but also to uncover which strategies are garnering success and what barriers still stand in the way. In contrast to previous Voice of the Market studies, the results of this survey did not provide a clear strategy frontrunner. This outcome represents what most health insurance leaders deal with every day — no one strategy has emerged as the "most successful" for VBR.

When asked, "What value-based program do you believe is most successful?" respondents were almost evenly split between VBR programs for patient-centered medical homes (31.1 percent), accountable care organizations (28.5 percent) and bundled payments (23.2 percent) – with episodes-of-care programs trailing (17.2 percent). No survey participant chose the 'other' option, which is contrary to HealthEdge's previous experience with this audience. This signals that

alternative ideas either haven't been tested, or they've tried others that just didn't produce measurable results.

> ***There is no silver bullet for VBR, with respondents nearly evenly split on which programs are most successful.***

Payers have a very challenging road ahead with difficult choices, because all the programs appear to hold some promise, and yet it does not appear that new ideas are coming to the forefront. That might not be as surprising as it seems when considering typical challenges around VBR. For payers, designing and launching any new program can be challenging; the need for provider alignment, complex contracting arrangements and strong member engagement only adds to the complicated nature of VBR.

In fact, this Voice of the Market study found that more than 50 percent of health insurance leaders think that provider and member engagement — two externally facing factors — are the top challenges to implementing VBR. Another external challenge, regulatory and policy concerns was close behind in the survey results. Payer executives also cited internal challenges, namely technology & infrastructure, and administrative burden as significant barriers to implementation. When considered together, these results underscore a key insight for payers: in order to find success, health insurers must overcome the internal barriers to VBR so they can effectively tackle external changes like provider and member engagement while also dealing with regulatory mandates.

KEY TAKEAWAY

For payers to have a significant chance at success with VBR programs, they must have modern and flexible technology systems that can easily collect and share data, quickly test and model new programs, and are designed to build more trust among providers of all types. The "trust" and "sharing data" points are particularly important, because they not only speak to creating more provider alignment, but they also are attributes that HealthEdge has heard echoed by value-based payment leaders. HealthEdge regularly speaks with industry experts regarding their VBR experiences to supplement the Voice of the Market study series.

One executive made a very interesting point regarding primary care physicians (PCPs) and why they are such a challenge for payers implementing VBR models. Bringing PCPs together either in a virtual organization or an ACO is only the first step; getting them invested to manage patients — and not losing their VBR "buy-in" in the process — is the key.

But, how do health insurers get PCPs engaged in the process? Some connect with provider organizations already participating in VBR programs and put them into virtual groupings. Then, after tracking the group's collective financial performance, health insurers start sharing more data with PCPs, promising incentives and financial rewards for keeping costs lower than projected. The process usually takes a few years before PCPs see any gains, which is the most important element

for providers agreeing to "put more skin in the game", incorporating downside risk into the partnership.

This Voice of the Market study shows health insurance executives are not projecting much growth in VBR in the next two years. Implementing these arrangements effectively is a critical decision point, because of the resources required to execute them at a scale and in a manner that will be worthwhile. In addition, for a variety of reasons, physicians often don't want to be bundled into virtual groupings. Finally, health insurers are concerned about upsetting the status quo on existing margins and must decide on the risk/reward of taking on the challenge.

The reality for health insurers is that the competitive and market pressures for entering into more VBR arrangements means that they must figure out a way forward. This requires a total commitment by the health insurer's senior management team and the ability to share data so that providers know how they are doing, and the health insurer can accurately measure the success of shared goals. These study findings drive home the point that provider alignment (the top barrier to VBR success) requires building greater trust through more transparent data-sharing capabilities. Similarly, member alignment, largely gained through an ability to more easily collect the necessary data, closely follows in importance. Both underscore that there is a technology imperative required to successfully implement effective and scalable VBR programs.

What Happens After Health Plans Successfully Implement VBR Programs?

Successfully implementing VBR programs is only half of the equation. After achieving stakeholder alignment, health plans must successfully measure program results.

When asked what the greatest barrier was to succeeding in VBR, health insurance executives once again were split between engagement issues and technology challenges. The study found that provider engagement and patient engagement were nearly even as the top barriers (a combined 60%). However, more than 40 percent named technology-related challenges (technology & infrastructure, and analytics) as the top barriers. This 60/40 split demonstrates that long-term success is predicated on consistent alignment with all stakeholders, largely facilitated through data availability, analytics capabilities and modern, agile technology infrastructure.

40% of respondents named technology-related challenges as a top barrier to VBR

There is overall agreement that provider trust, alignment on key performance metrics and the data necessary to fuse the two is the way to VBR success. Many payers have experimented with their own quality measures but having too many overly complex measures is difficult for providers to handle from an administrative standpoint. The scores already used by the government in many areas of healthcare are often familiar to providers and do not require additional administrative work. Together, payers and providers must align on shared goals and the metrics to use, which requires increased data-sharing capabilities between all parties. Whether its claims data or comprehensive clinical records, the devil is in the data details.

CONCLUSION

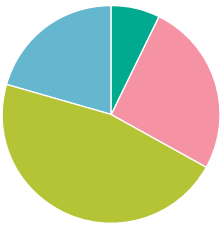
In order for VBR to work as it should, everyone agrees trust is key. For payers to gain provider trust, they first need to build strong relationships with them through win/win agreements, and then provide actionable data. But getting the data right can be a daunting task for any payer. It's not just about claims, it's about putting information into a digestible format and providing it in real-time to all stakeholders in the continuum of care. Part of building provider, member and employer trust also means being perceived as innovative. The common threads that run through this study's results and the expert interviews are that both implementing and succeeding in VBR arrangements for payers is extremely difficult technologically and requires an advanced ability to extract and unify the data. From payers' internal customer-service, IT and claims-processing teams to their external partners and members, everyone must have the ability to contribute and receive relevant, actionable data in near-real-time and without friction.

About HealthEdge

HealthEdge provides modern, disruptive healthcare IT solutions for core administration and care coordination that health insurers use to leverage new business models, improve outcomes, drastically reduce administrative costs and connect everyone in the healthcare delivery cycle. Our next-generation enterprise solution suite, HealthRules™, is built on modern, patented technology and is delivered to customers via the HealthEdge Cloud or onsite deployment. An award-winning company, HealthEdge empowers health insurers to capitalize on the innovations, challenges and opportunities that await in the new healthcare economy.

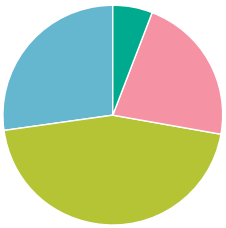
Survey Results

1) What percentage of your provider contracts are currently tied to value-based reimbursement?



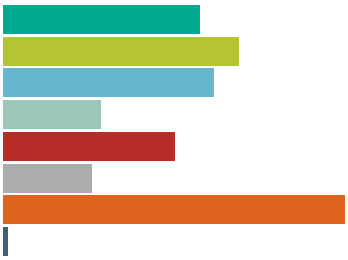
7.3% 0–25%
25.8% 25–50%
46.4% 50–75%
20.5% 75–100%

2) By your best estimate, what percentage of your provider contracts will be tied to value-based reimbursement two years from now?



6% 0–25%
21.9% 25–50%
45% 50–75%
27.2% 75–100%

3) Which lines of business are you currently engaged in, or have plans to be engaged in when it come to value-based reimbursement? Please select all that apply

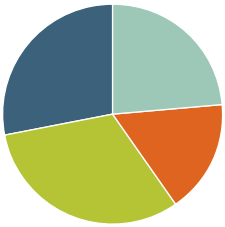


57.6% Commercial
68.9% Medicare
61.6% Medicaid
28.5% Duals
50.3% Individual
25.8% TPA
100% Other
1.3% None of the above

4) Of the following, what is the biggest barrier to implementing a value-based reimbursement program within your organization?

- **15.2%** Technology/ Infrastructure
- **19.9%** Regulatory/Policy
- **28.5%** Provider Engagement
- **23.2%** Patient Engagement
- **13.2%** Administrative Burden

5) Of the following, what is the **biggest barrier** to succeeding in value-based reimbursement within your organization?

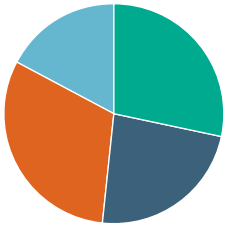


- **23.8%** Technology/ Infrastructure
- **16.6%** Analytics
- **31.8%** Provider Engagement
- **27.8%** Patient Engagement

6) Of the below, which are the **two most important** catalysts to implementing a value-based reimbursement program?

- **50.3%** Lowering Costs
- **57.6%** Improving Patient Outcomes
- **27.2%** Compliance with Government Regulations
- **36.4%** Closer Alignment with Providers
- **28.5%** Increased Engagement with Community Resources

7) What type of value-based program do you believe is **most successful?**



- **28.5%** Accountable Care Organizations (ACOs)
- **23.2%** Bundled Payments
- **31.1%** Patient-Centered Medical Homes
- **17.2%** Episodes-of Care

METHODOLOGY DETAILS

This survey was conducted by Survata, an independent research firm in San Francisco. Survata interviewed 151 online respondents between December 18, 2018 and January 07, 2019. For further information, visit www.survata.com.

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