CONVENING REPORT

Advancing Value-Based Care in Medicare Advantage

BY BETTER MEDICARE ALLIANCE
APRIL 2019

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Overview

In November 2018, Better Medicare Alliance (BMA) convened a group of approximately 30 thought leaders, including health plans, providers, researchers, community partners, and policymakers to discuss promoting the adoption and diffusion of value-based care models within the Medicare Advantage program.

BMA is a community of 130 ally organizations that share a commitment to improving health care for seniors through a strong Medicare Advantage. At BMA, we believe that seniors deserve value-driven, quality health care. Medicare Advantage is a large-scale, public-private partnership that is addressing the needs of today's beneficiaries by working to improve health outcomes and lower costs by advancing the adoption of value-based approaches.

At our convening on value-based care, participants discussed their experiences designing and implementing value-based arrangements and shared their vision for how the shift to value can continue to deliver better results for beneficiaries in Medicare Advantage in the future. The group also identified barriers that stakeholders must overcome to speed the adoption of value-based care and aligned on recommendations for accelerating the development of new alternative payment models (APMs) and value-based arrangements to spur clinical innovation, improve outcomes, and decrease costs in Medicare Advantage.

This report summarizes key discussion points from the convening, including:

1. The current landscape of payment reform and value-based care in Medicare Advantage
2. The roadblocks facing both payers and providers in creating innovative models
3. The role of the government and the Centers for Medicare and Medicaid Services (CMS) in fostering that collaboration
4. How experience in traditional Medicare fee-for-service (FFS) models can be leveraged in Medicare Advantage
5. Strategies for fostering further adoption of value-based arrangements in Medicare Advantage

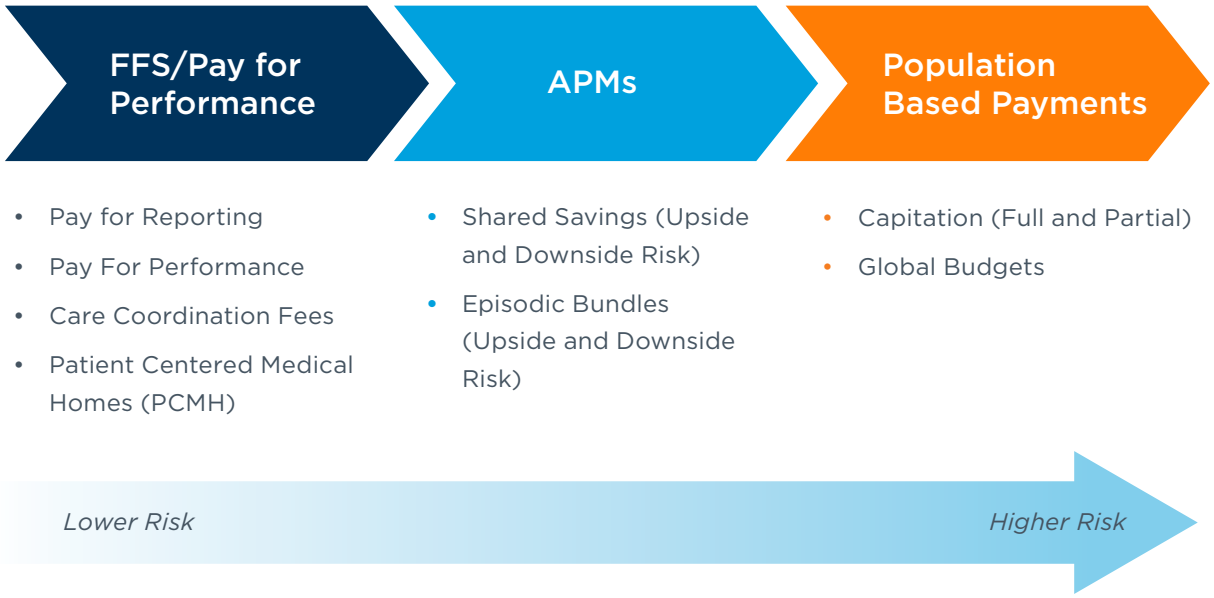
Medicare Advantage Is a Driver of Innovation in the Medicare Program

Medicare is the largest payer for health care services in the United States. Medicare Advantage, the private health plan option available to beneficiaries, now provides coverage for nearly 22 million beneficiaries, more than one-third of all people with Medicare; by 2028, 42 percent of beneficiaries are projected to be enrolled in Medicare Advantage.[i] As more beneficiaries switch from traditional Medicare into Medicare Advantage plans, the Medicare Advantage program will become an increasingly important driver of high quality care with Medicare. For example, research shows that Medicare Advantage is already achieving better health outcomes at comparable or lower costs than FFS Medicare for high-need Medicare beneficiaries and those with chronic conditions.[ii]

Medicare Advantage plans manage the full spectrum of risk for the beneficiaries who choose to enroll. The program's capitated payment structure creates incentives to manage and coordinate care for beneficiaries and the program's rules allow health plans to offer additional benefits that are not covered in the traditional FFS Medicare program (e.g., dental and vision coverage). As a public-private partnership that aligns the incentives of health plans and providers, Medicare Advantage is well-positioned to catalyze change that can improve beneficiary outcomes and experience.

FIGURE 1:

Value-Based Care Encompasses a Range of Models



Value-Based Care Can Improve Beneficiary Health Outcomes and Lower Costs in Medicare Advantage

As concerns about the cost of healthcare grows and the focus on high-quality care continue, the healthcare industry is undergoing a fundamental shift from reimbursement based on volume of services provided to reimbursement based on the value of health outcomes delivered. Underpinning this transition is a realignment of incentives – health plans and providers are committing to delivering improvements in care for beneficiaries and are taking on an increasing amount of financial risk (i.e., providers and plans have a financial incentive to meet their goals of providing higher quality care at a lower cost, and may be "at risk" of losing money if they do not). Value-based care encompasses a number of tools and strategies to support this paradigm shift from lower to higher risk, such as innovative care delivery models to increase coordination and dynamic payment arrangements to incentivize progress toward better health outcomes for beneficiaries at lower costs.

Value-based care arrangements are all designed to hold providers and plans accountable for the outcomes they deliver, but different models require participants to assume varying levels of financial risk. For instance, these models can range from APMs that share savings or provide bonus payments for performance, to population-based capitated payments, where there is a set payment amount and providers and payers must deliver care that meets quality targets within the agreed upon amount. As stakeholders become more familiar with value-based care, the number of value-based arrangements will continue to grow across the industry, increasing the efficiency and quality of care.

MEDICARE ADVANTAGE IS LEADING TRANSITION TOWARDS VALUE-BASED CARE

A recent report from the Duke Margolis Center for Health Policy identified several aspects of the Medicare Advantage program that position it to be a leader in reforming payment to incentivize improving beneficiary outcomes, including:[iii]

- **Market Share:** The size and national reach of the Medicare Advantage program enables plans and providers to engage in value-based arrangements in numerous markets and positions them to make meaningful progress toward reforming payment, especially for target populations, such as beneficiaries who need joint replacements or cardiac care.
- **Financing:** Medicare Advantage is structured to incentivize plans to provide the same services as traditional Medicare at a lower cost and they can attain bonus payments for providing high-quality care. Because the design of the program means that participating plans and providers are already focused on achieving the key goal of value-based care (high quality care at a lower cost), even those that have not yet entered into a value-based arrangement may be more readily able to enter into more formal agreements than plans and providers in other markets.
- **Flexibility:** Medicare Advantage plans are able to offer more services than traditional Medicare and to target those services to the beneficiaries the will benefit the most (e.g., providing additional support services to beneficiaries with diabetes or other chronic conditions). This flexibility allows Medicare Advantage plans and their partners to provide more holistic, coordinated care (e.g., services that address social determinants of health), which allows them to drive better outcomes.

Value-Based Care Models Achieving Results for Medicare Advantage Beneficiaries: Spotlight on Presentations from the Convening

At the convening, participants highlighted their experiences with improving care for beneficiaries through implementing value-based arrangements, including:

Tandem 365 Program

The Tandem 365 program aims to reduce hospital readmissions by closing service gaps for older adults who are age 55 and have complex care needs and high costs. Care is customized for the beneficiaries using a single point of contact—a nurse or social work navigator—to help coordinate in-home services. The program's contract has a risk-sharing/shared savings component and lowered the cost of care by 35 percent while reducing inpatient stays and emergency department visits by 38 percent and 52 percent, respectively.

CareMore at Home

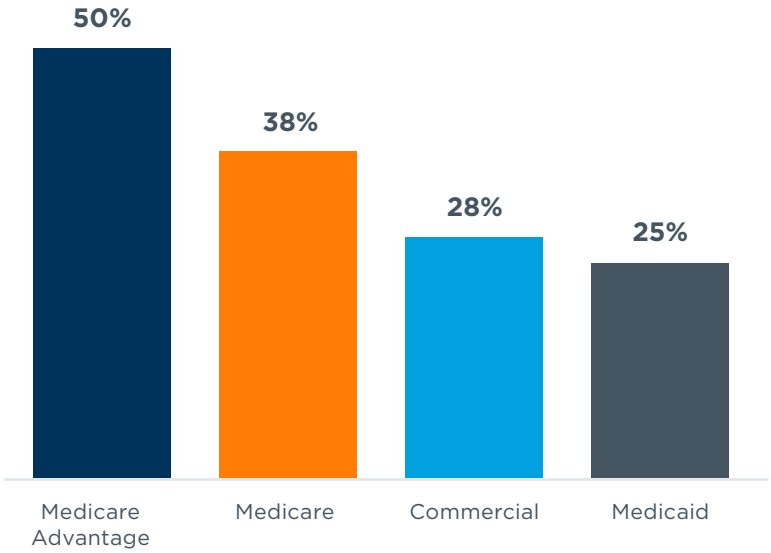
This model seeks to reduce utilization for the most complex beneficiaries, including dual eligible beneficiaries, who receive highly fragmented care. To limit rehospitalizations, the program co-manages beneficiary care in the clinic through a hospitalist, rather than through the primary care physician.

The Medicare Advantage program is built around the goal of improving beneficiary health while increasing efficiency, and the deliberate move to new value-based models is giving plans more tools to continue to improve outcomes. Not surprisingly, Medicare Advantage plans and their provider partners have moved more quickly than any other payor to adopt value-based arrangements. For example, in 2016, more than $4 out of every $10 in Medicare Advantage was paid through APMs, significantly more than in other public programs.[iv]

POLICYMAKERS AIM TO FACILITATE GREATER ADOPTION OF VALUE-BASED CARE IN PUBLIC PROGRAMS, ESPECIALLY MEDICARE ADVANTAGE

FIGURE 2:

Rate of APMs by Payer



Source: LAN 2018 APM Measurement Survey

CMS has recognized the central role that the Medicare Advantage program is playing in the shift to value and, as it takes steps to encourage more value-based arrangements, is looking to Medicare Advantage plans to continue to lead innovation.

The Center for Medicare and Medicaid Innovation (CMMI) New Directions strategy highlighted Medicare Advantage Innovation Models as a key focus area.[v] In addition to Medicare Advantage APM demonstrations, CMMI has also established provider incentives through All-Payer bonuses and is expanding the Value-Based Insurance Design (VBID) Model, which is testing a range of Medicare Advantage innovations to enhance quality of care for beneficiaries and improve the coordination and efficiency of health care service delivery. In particular, the VBID model aims to allow Medicare Advantage organizations to further target benefit design to enrollees based on chronic conditions, particularly for low-income and dual-eligible populations.[vi] Ultimately, these demonstrations will help Medicare Advantage plans identify which strategies result in better outcomes for beneficiaries and incorporate these successful approaches into their care models more widely.

Generating the Evidence for Value-Based Care: Spotlight on PCORI Presentation at the Convening

At the convening, a representative from the Patient-Centered Outcomes Research Institute (PCORI) emphasized the organization's efforts to develop and implement shared decision-making tools to educate beneficiaries and engage them in value-based care. PCORI is an independent research institute authorized by Congress that funds comparative clinical effectiveness research engaging patients and other stakeholders.

In particular, PCORI has funded 239 projects related to service utilization or costs of care, 90% of which capture patient-reported outcomes (e.g., quality of life, satisfaction with care). These metrics can support decision making around the most appropriate and effective care for patients.

Additionally, PCORnet, PCORI's National Patient-Centered Clinical Research Network, seeks to overcome interoperability challenges by allowing data from multiple electronic health record (EHR) systems to coalesce through a Common Data Model. For example, PCORI funded a study that used PCORnet to track 3,500 patients across multiple sites of care to reveal high-value care options for patients.

In addition to policy initiatives focused specifically on Medicare Advantage, CMS is taking steps to promote value-based arrangements and remove obstacles more broadly. For example, through the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) which seeks to improve quality by enhancing quality measures, providing financial updates for adoption of value-based arrangements, and by promoting physician specialty models.

However, while CMS is partnering with Medicare Advantage and other stakeholders to make exciting improvements, there is still work to be done to make it easier for plans and providers to participate in value-based arrangements and to ensure that all stakeholders are incentivized to provide high-quality care to beneficiaries.

Policy Barriers and Market Challenges Are Hindering the Adoption of Value-Based Care in Medicare Advantage

At the convening, participants agreed that implementing value-based care arrangements that achieve savings and results for beneficiaries requires a significant amount of coordination between plans, providers, and other partners, as well as sophisticated use of data and analytics. Further, current policies, designed for a system based on volume rather than value, may not give plans and providers the flexibility they need to pursue innovative solutions. Through roundtable conversations, the convening participants identified specific barriers that may impede adoption of value-based arrangements from the payer, provider, and beneficiary perspectives. Figure 3 highlights the key barriers identified by participants, which are discussed in detail below.

FIGURE 3

Key Policy Barriers and Market Challenges

1. Lack of Incentives to Participate

- Without external industry pressure or compelling program incentives, providers and plans will be slow to adopt value-based arrangements in place of FFS, delaying improvements for beneficiaries
- Current incentives are difficult for providers to achieve and are ineffective at encouraging further adoption
- Initial startup costs and increased administrative needs deter smaller plans and providers from participating, limiting the number of beneficiaries engaged in value-based models.

2. Limited Insight into Effective Models

- Lack of research and evidence on the success of value-based care arrangements create plan, provider, and beneficiary hesitation

3. Compliance Challenges

- Lack of clarity on regulations hinders development of innovative approaches to improve beneficiary care and increase risk for participants
- Strict network adequacy requirements limit a plans' ability to negotiate and contract providers that deliver high-quality outcomes for beneficiaries

4. Insufficient Data to Drive Care Transformation

- Providers and plans often lack access to timely and accurate data to track beneficiaries throughout the care continuum and manage outcomes
- Lack of interoperability and limited guidance around infrastructure solutions create significant operational challenges for plan and provider partnerships.

1. LACK OF INCENTIVES TO PARTICIPATE

Without external pressure or compelling program incentives, providers and plans may be slow to adopt value-based arrangements in place of FFS, delaying improvements for beneficiaries

While many Medicare Advantage plans are early adopters of value-based care arrangements, as noted earlier, broader uptake has been slower. Providers have long been working within the FFS framework of incentives and structure – transitioning to a new system requires changes in infrastructure and work patterns that take time to implement. In addition, even those providers who do some of their work within value-based arrangements continue to do a portion of it within the FFS system. Without consistent market pressure for plans and providers to invest in care transformation and assume greater financial risk, many organizations have been hesitant to make the transition. Simply stated, as long as FFS is prevalent in many markets, some stakeholders may not feel pressure to move from payment based on the volume of services they provide to contracting based on the outcomes achieved for beneficiaries.

Further, the misaligned incentives between providers and payers inherent in the FFS model have, in some cases, generated mistrust between plans and providers. To successfully partner to address inefficiencies in the care that they are providing to beneficiaries, stakeholders must first overcome the negative dynamics and suspicion that have developed under FFS.

Current incentives are difficult for providers to achieve and may be ineffective at encouraging further adoption

Provider incentives for value-based care adoption established by MACRA are significant, yet difficult for most providers to achieve. Specifically, providers are eligible for a 5 percent bonus payment if their value-based care arrangement qualifies as an Advanced

Plans, Providers, and Policymakers May Need to Increase Efforts to Educate Beneficiaries and Engage Them in Value-Based Care

When beneficiaries hear the term "value," they may perceive it as euphemism for "lower-quality," sparking concern that they will receive fewer services or experience a lower standard of care. While plans, providers, and policymakers are taking steps to educate beneficiaries that the "shift to value" is focused on reducing inefficiency while maintaining or improving quality, misperceptions persist.

Skepticism among beneficiaries also may make it challenging for the providers who work closely with them and may feel that transitioning to value will result in pushback from their patients. As stakeholders increasingly consider how to incorporate the patient perspective into value frameworks, it may become easier to demonstrate to beneficiaries that the shift to value will result in outcomes that matter to them, such as improved health and quality of life. Policymakers can play a key role in educating the public and increasing awareness of the benefits of the ongoing shift to value for beneficiaries.

Alternative Payment Model (AAPM) and the provider meets patient and payment thresholds. These thresholds have increased over time and are out of reach for many providers. In 2019, a physician must have a minimum of 50 percent of payments or 35 percent of patients pass through the payment model to qualify for this bonus.[vii] In addition, many providers have a mix of Medicare Advantage and FFS, which may make it even more challenging to achieve AAPM thresholds. Further, in 2026, the current 5 percent incentive will be reduced to a 0.5 percent annual increase to fee schedule payments. [iii] For many providers, this potential bonus is not a sufficient incentive to overcome the administrative time and investment required to establish a value-based care arrangement.

Initial startup costs and increased administrative needs may deter smaller plans and providers operating in Medicare Advantage from participating, limiting the number of beneficiaries receiving care through value-based models

Even in Medicare Advantage, developing plan-provider partnerships can be challenging, and organizations considering entering into value-based agreements are faced with the difficult task of pricing these arrangements, developing administrative processes to support them, and harnessing data to monitor performance. Many providers and plans, especially smaller organizations, may have less sophisticated infrastructure and will struggle to systematically produce the information necessary to appropriately account for key components of the arrangement (e.g., beneficiary health status). Further, small organizations many not be able to easily access adequate funding at the outset to operationalize new value-based arrangements. These barriers may be daunting and prevent some plans and providers from considering pursing value-based approaches, particularly because there are not incentives for plans similar to those for providers under MACRA.

2. LIMITED EVIDENCE BASE TO HELP STAKEHOLDERS IDENTIFY AND DEVELOP SUCCESSFUL MODELS

Lack of research and evidence on the success of value-based care arrangements may create plan, provider, and beneficiary hesitation

While there is significant and steady progress towards increasing the prevalence value-based arrangements in Medicare Advantage, the shift toward value is still in its early days, which means that research has not yet caught up with the speed with which the market is moving. While there is robust research showing that the models that CMMI has tested in FFS Medicare have been effective, it provides limited insight into how these models can be translated into the Medicare Advantage market. Though initial studies have indicated that value-based care arrangements in Medicare Advantage have resulted in improved quality and decreased costs, there are numerous different models, which make may make it difficult for plans and providers considering pursuing value-based arrangements to identify which approaches would work best for them and their beneficiaries. Further, unless plans and providers have clear, easy-to-articulate evidence for employing new approaches, beneficiaries may fear that any changes to care models may disrupt their treatment plans and relationships with their providers.

More data on value-based arrangements in Medicare Advantage, and their impact on beneficiaries, should soon be available (e.g., CMS is making a new source of data, Medicare Advantage encounter data, publicly available), but there have yet to be broad-based, methodologically rigorous academic evaluations of across different models over a long period of time in Medicare Advantage. Without access to a broad, generalizable evidence-base, some providers and plans may not feel prepared to pioneer new approaches -- without accessible, adaptable models and clear evidence that value-based care arrangements can deliver the intended impact on beneficiaries and costs, plans and providers are hesitant to invest.

3. COMPLIANCE CHALLENGES

Lack of clarity on regulations hinders development of innovative approaches to improve beneficiary care and increases risk for participants

Plans and providers considering value-based arrangements often struggle to determine the extent to which innovative programs and contracts align with current law and regulations, many of which predate the policy shift to value. Ambiguity around how plans and providers can ensure their value-based arrangement is compliant with legal requirements may force them to develop a more cautious, less innovative models, or even cause some to refrain from participation altogether. In particular, plans and providers often have concerns that certain arrangements may not be permitted under fraud and abuse laws, such as the Stark Law, or anti-kickback regulations.

Recently, the Bipartisan Budget Act (BBA) of 2018 increased the penalties for fraud and abuse violations under Medicare and Medicaid, further raising stakeholders' concerns. The BBA doubles statutory civil fines and quadruples some criminal fines, including those under Anti-Kickback Statute (AKS).[viii] Despite some AKS clarifications in the BBA, more well-defined rules and procedures are necessary. Regulations around anti-kickback rules are especially difficult for stakeholders to decipher, as violations are determined on a case-by-case basis, rather than prospectively outlined guidelines. Plans and providers considering value-based care may be discouraged by a lack of understanding around what constitutes a legally acceptable value-based care model from pursuing interventions that could meaningfully improve beneficiary outcomes.

Strict network adequacy requirements may limit a plan's ability to negotiate and contract with providers that deliver high-quality outcomes for beneficiaries

Medicare Advantage plans must include a certain number of providers within a region in-network to meet standards. In some cases, particularly in areas with fewer providers, meeting network adequacy standards may limit plans' negotiating power when developing value-based arrangements. This can affect the ability of plans to contract with high-quality providers of their choice and reduce their ability to persuade providers to accept risk. For example, in an area with few providers, a plan may be forced to include a particular specialist in its network. In this case, the specialist may not have any incentive to partner with the plan on a value-based arrangement, as the plan has no option but to include the specialist in network. In 2018, CMS finalized a proposal to begin reviewing Medicare Advantage networks on a three-year cycle, rather than only when a plan applies or renews a program, further increasing the pressure to meet network adequacy requirements.[ix]

4. INSUFFICIENT DATA FOR CARE TRANSFORMATION

Providers and plans often lack access to timely and accurate data to track beneficiaries throughout the care continuum and manage outcomes

Success in value-based care arrangements relies heavily on the ability of plans and providers to closely coordinate and manage patient care using data. Many providers may have neither access to the data infrastructure nor the staff resources necessary to quickly and accurately report patient data to plan partners. In addition, even providers that do have efficient systems in place to capture data while beneficiaries are inpatients may struggle to do so once the beneficiary leaves the facility. Without real-time data showing provider partners how patients are tracking along the care continuum, providers must attempt to manage outcomes through other means, such as personal patient follow-up calls and visits, which can be time consuming and ineffective.

Provider organizations may be deterred from value-based care participation because they are ill-equipped to effectively collect data and do not "trust" data provided directly by plans. This lack of trust may mean that providers do not proactively use available data to identify and reach out to high-risk beneficiaries, limiting their ability both to improve beneficiary health and to provide efficient care. At the same time, plans struggle to appropriately coordinate care if they do not have accurate, up-to-date information about beneficiaries from providers, which can also lead to less optimal outcomes for beneficiaries and tensions between plan and provider partners. These challenges can be amplified because plans and providers are often required to collect data to track beneficiary outcomes against different sets of measures (e.g., APM and Star Ratings measures). Without adequate systems and staff to more efficiently use data to inform care, and greater trust between plans and providers, it will remain difficult to effectively manage beneficiary outcomes and system costs.

Lack of interoperability and limited guidance around infrastructure solutions create significant operational challenges for plan and provider partnerships

Currently, many health plans and providers use dissimilar data collection systems and methodologies, making them unable to interface effectively. The lack of guidance and solutions to interoperability issues among plans and providers has placed additional stress on how partners can successfully share data and collaborate on performance tracking. According a 2017 Humana survey of 117 hospital finance executives, over 70 percent felt that interoperability must improve over the next three years to ensure success of value-based care.[x] The lack of interoperability readiness makes data sharing and performance tracking between provider and plan partners extremely challenging. This misalignment can create inconsistent findings among plan and provider partners, creating a large divide and resulting mistrust between partner organizations.

Policy Recommendations for Increasing and Improving Value-Based Care in Medicare Advantage

Convening participants discussed strategies for overcoming the barriers to the proliferation of value-based arrangements that they identified and made several recommendations to address the most pressing challenges, as described in detail below. By moving toward these goals, stakeholders can speed the adoption of value-based care models that are proven to have an impact on beneficiary health and on beneficiary and program costs.

POLICY RECOMMENDATIONS FOR INCREASING AND IMPROVING VALUE-BASED CARE IN MEDICARE ADVANTAGE			
1. Set National Goals for Improving Beneficiary Outcomes by Increasing Value-Based Care in Medicare Advantage	**2.** Provide Additional Opportunities for Plans and Providers to Partner to Address Beneficiary Needs Through Value-Based Care Demonstrations in Medicare Advantage	**3.** Develop Guidelines and Best Practices for Data Sharing and Collection	**4.** Streamline Performance Measures Across Programs to Reduce Administrative Burden and Incentivize Greater Focus on Health Outcomes
5. Create Template Model Designs to Assist with the Development of Value-Based Care Contracts and Facilitate Adoption of Best Practices	**6.** Provide Additional Flexibility Around Benefit Design to Spur Innovation in Care	**7.** Increase Beneficiary Understanding of Value-Based Care	

1. SET NATIONAL GOALS FOR IMPROVING BENEFICIARY OUTCOMES BY INCREASING VALUE-BASED CARE IN MEDICARE ADVANTAGE

In 2015, CMS set a goal of increasing the percentage of Medicare payments made through APMs to 30% and, in 2016, achieved it.[xi] Setting this goal helped create a framework for CMS to collaborate with stakeholders to align on a vision for and a pathway towards increasing quality and efficiency. While the Trump Administration continues to evaluate whether to pursue similarly specific goals for increasing payments made through APMs, it should consider working with plans and providers to develop milestones for the shift to value in Medicare Advantage.

Because Medicare Advantage is an important driver of innovation in the Medicare program, as more Medicare Advantage plans and providers consider engaging in new value-based arrangements, it is imperative that they have clear and consistent support from CMS. A statement of targeted goals from the agency around value-based care specific to Medicare Advantage could serve as an impetus to increase value-based care and provide stakeholders with additional channels for ongoing engagement with CMS. In particular, working in close

partnership with CMS to meet specific goals could help plans speed the development of new services and systems to improve beneficiary outcomes and increase value for the Medicare program. For example, as discussed above, plans and providers may be hesitant to pioneer new approaches because of lack of clarity around CMS' intent and the potential compliance risks. A more iterative process, combined with an established framework of goals against which to measure innovations, can help catalyze the growth of value-based approaches. In addition, pairing these goals with reforms both to align Medicare Advantage and MACRA measurements and to facilitate strong collaboration between APMs under Medicare Advantage and MACRA can make it make it easier for even more providers to participate in value-based payment arrangements.

2. PROVIDE ADDITIONAL OPPORTUNITIES FOR PLANS AND PROVIDERS TO PARTNER TO ADDRESS BENEFICIARY NEEDS THROUGH VALUE-BASED CARE DEMONSTRATIONS IN MEDICARE ADVANTAGE

Given the early indications of the success of and interest in the MA-VBID model, which will be expanded to all 50 states in 2020,[xii] CMMI should work with stakeholders to design additional demonstrations focused on testing value-based approaches in Medicare Advantage. Developing smaller pilot programs will give plans and providers the opportunity to refine strategies for effectively collaborating and engaging beneficiaries within set guidelines. Further, through these demonstration CMS and stakeholders can take steps to build the evidence-base around value-based arrangements. Then, successful approaches that are producing higher-quality and more cost-effective care can be scaled, similar to the MA-VBID demonstration. To achieve the full potential of the demonstration process, it will be crucial that, rather than waiting years for final results, CMMI share data about the success of the models at various points throughout the demonstration. That way, these models can inform the efforts being made by plans and providers in Medicare Advantage outside of the demonstration models as well as among demonstration participants.

3. DEVELOP GUIDELINES AND BEST PRACTICES FOR DATA SHARING AND COLLECTION

The ability to collect complete and accurate data, and then to use the data to target care to high need patients and to evaluate outcomes, is crucial for developing value-based approaches. As outlined in the previous section, plans and providers often struggle to effectively gather and share data in a timely manner. CMS should bring together stakeholders who are successfully leveraging data in value-based arrangements and facilitate consensus around best practices for creating and maintaining efficient reporting systems and using data in real time to better coordinate care for beneficiaries.

Similarly, CMS should convene plans and providers who are early in the process of transitioning to more value-based arrangements to gain a robust understanding of the largest data challenges they face and the tools and information that would be most helpful. Based on these conversations, CMS could lead efforts to develop tools (e.g., va for sharing data), best practices (e.g., guidelines around data collection practices for providers), and other resources that plans and providers could use improves their ability to analyze data in real time.

4. STREAMLINE PERFORMANCE MEASURES ACROSS PROGRAMS TO REDUCE ADMINISTRATIVE BURDEN AND INCENTIVIZE GREATER FOCUS ON HEALTH OUTCOMES

Plans and providers must be able to measure their progress against the most important goals of value-based care – improving beneficiary outcomes and reducing inefficiency. However, while measurement is essential, it is not a goal in and of itself, and complying with the current burdensome measurement system is taking too much time away from focusing on improving care. CMS must align the ACO, MIPS, and Stars measures so that plans and providers are able to more easily and quickly assess their progress towards key outcomes. Further, these measures must be designed so that they reinforce focus on outcomes (e.g., improvements in beneficiary health and better coordination of care) rather than on compliance and process measures. Under the current system, plans and providers, particularly those that are smaller or just starting to consider value-based arrangements, may be overwhelmed by the requirements to comply with several different and overlapping systems of quality measurement.

5. CREATE TEMPLATE MODEL DESIGNS TO ASSIST WITH THE DEVELOPMENT OF VALUE-BASED CARE CONTRACTS AND FACILITATE THE ADOPTION OF BEST PRACTICES

As more evidence on successful models becomes available, CMS and other stakeholders should collaborate to develop frameworks for value-based arrangements that providers and plan partners can use a base for further customization. These "template model designs" could include best practices based on other plans' and providers' experiences and may ease entry into value-based care, particularly for plans and providers that may be less familiar with these types of arrangements.

These customizable templates can help plans and providers to more clearly understand their respective roles in the partnership and how to approach allocating risk. Further, those considering value-based arrangements could more easily understand the infrastructure required to develop successful partnerships (e.g., data and reporting systems, necessary support staff, etc.). This could be helpful not just for plans and providers poised to enter into a partnership, but also for those that are seeking to understand the steps they would need to take before considering an agreement.

6. PROVIDE ADDITIONAL FLEXIBILITY AROUND BENEFIT DESIGN TO SPUR INNOVATIONS IN CARE

To make value-base arrangements successful, plans and providers must have the flexibility to test new approaches, ranging from providing non-medical supplemental benefits to using technology in innovative ways to engage beneficiaries. For example, allowing more flexibility around the use of telehealth, particularly in areas where there are gaps in network adequacy, could help plans more effectively contract with high-quality providers and reach out the beneficiaries who live in remote areas. In addition, permitting plans and providers more ability to tailor the services they provide to specific groups of beneficiaries (e.g., those with chronic condition or those who are low income) or by county segment can enable more targeted interventions to improve health outcomes.[1]

At the same time that it is imperative to that plans and providers have the flexibility to test what works, they must also have the ability to discontinue what does not. For example, plans must be able to exclude low-value providers from their networks. CMS can help develop guidelines and best practices for plans and providers that are evaluating their existing arrangements and partner with them to ensure they are able to course-correct during the length of an agreement.

7. INCREASE BENEFICIARY UNDERSTANDING OF VALUE-BASED CARE

Speeding the shift to value is a major undertaking for all stakeholders, and beneficiaries deserve to have their perspectives included; beneficiaries must be engaged for the transition to value-based care to be truly successful. As previously discussed, value-based arrangements can incentivize meaningful improvements in beneficiary health and experience. For example, value-focused approaches can help ensure that plans seek to include the highest quality, most efficient providers in their networks. Further, the rigorous tracking and measurement central to value-based arrangements can help plans and providers to better target benefits to the high need beneficiaries who could benefit most. However, many beneficiaries remain apprehensive.

While many plans and providers are making an effort both to educate beneficiaries about the shift to value and to assuage their fears that "value" means "lower quality," CMS must take on a larger role in in increasing beneficiary awareness and engagement. In particular, CMS should consider an education campaign targeted at beneficiaries that highlights the success of value-based approaches at improving health outcomes and make it clear that, through PCORI and other stakeholders, beneficiaries' interests are being systematically represented and included in value-based care. In addition, CMS should provide plans and providers with additional educational resources to enable them to engage more effectively with beneficiaries.

[1] Note: BMA's convening was held in November 2018, before the January release of the new proposed changes to supplemental benefits included in Part II of the 2020 Advanced Notice and Call Letter.

Conclusion

Medicare Advantage is uniquely positioned to drive value for beneficiaries and for the government. Medicare Advantage is able to adopt and grow the use of value-based care to support improved health, higher quality and better clinical outcomes, and lower health care costs for beneficiaries. In particular, the underlying incentive structure makes Medicare Advantage plans key drivers for testing and implementing payment and care delivery innovations that align the interests of patients, providers, and payers, including the federal government. While Medicare Advantage is well ahead of all other players in the shift to value, more can be done to sustain and strengthen this drive to high-quality and cost-effective care. Plans, providers, beneficiaries, policymakers, and other stakeholders must work together to overcome the remaining barriers and support the efforts that are improving health outcomes and lowering costs through value-based arrangements.

Resources

[i] The Congressional Budget Office. June 2018 Baseline Projections.

[ii] Avalere Health. Medicare Advantage Achieves Better Health Outcomes and Lower Utilization of High-Cost Services Compared to Fee-for-Service Medicare. July 2018. https://avalere.com/press-releases/medicare-advantage-achieves-better-health-outcomes-and-lower-utilization-of-high-cost-services-compared-to-fee-for-service-medicare

[iii] Duke Margolis Center for Health Policy. Gauging Payment Reform Progress in Medicare Advantage: Current State and Opportunities for Improvement. May 2018.

[iv] Healthcare Payment Learning and Action Network (LAN). Measuring Progress: Adoption of Alternative Payment Model in Commercial, Medicare Advantage, and State Medicaid Programs. 2016.

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