GoHealth™

State of Value-Based Care in Medicare Advantage: 2021 Outlook

A path to achieving lower costs and higher quality for seniors

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Objectives:

- Examine the transition to Value-Based Care (VBC) in Medicare Advantage
- Understand how VBC can lead to more personalized care and better outcomes
- Discuss what the future of VBC in Medicare Advantage means for seniors

BRIEF HISTORY OF VALUE

If we charted Value-Based Care (VBC) adoption in America, it would reveal a graph with spikes of interest spanning decades, from the integrated health systems of the 1940s to the HMO craze of the 1970s and 1990s. In 2008, HHS and CMS first began incentivizing **quality of delivery** over **quantity of services** through alternative payment models.[1]

Collective intentions were good, yet the system faced harsh realities. A transition to value-based reimbursement came with growing pains. Both providers and carriers discovered that finding value would be difficult without practice, coordination, and resources to match. Risk-based contracting needed fertile grounds for testing in order to grow, along with a structured approach to achieving better quality at a lower cost.

TIMELINE OF VBC

Since the 1960s, total U.S. healthcare spending has continued to outpace inflation, reaching over 17.7% of the nation's GDP in 2019.[2] During this time, per capita spending on Medicare beneficiaries spending rose from **$353 per person in 1970 to $11,582 in 2019.**[3]

Today, insurance carriers and providers are embarking on a slow, yet steady, march across the risk-sharing continuum, from traditional fee-for-service (FFS) to alternative payment models. None as fast as those in Medicare Advantage, outpacing Medicaid, Original Medicare, and Commercial segments in the adoption of population-based payments at 17.2% compared to 5.9%, 4.4%, and 2.5%, respectively.[4] Why is this so?

ALTERNATIVE PAYMENT MODEL (APM) FRAMEWORK

CATEGORY 1: FFS

Fee-for-service

No link to quality & value

CATEGORY 2: P4P

Pay-for-performance

Link to quality & value

CATEGORY 3: SS

Shared savings

APMs built on FFS

CATEGORY 4: VBC

Population health

Population-based payments

Medicare Advantage presents the perfect incubator in which VBC can thrive, especially given the shared focus of value over volume and population health over service velocity. Both constructs work best when incentives align towards better care and outcomes.

THE COST AND QUALITY EQUATION FOR SENIORS

VBC in Medicare Advantage challenges the notion that more is better. Instead, it asserts that better is more by redefining what value means to each stakeholder and replacing **volume and price** with **cost and quality.** The result? Aligned outcomes.

A typical senior's healthcare journey, from plan selection to care delivery and benefits navigation, involves points of friction that increase cost and chip away at quality. Disjointed experiences stem from barriers to interoperability, stakeholder miscommunications, and limited ownership over outcomes. Although care coordination is no easy task, such high levels of fragmentation are preventable through collaboration.

As carriers delegate more care and utilization management functions to providers, the gap in resources to meet evolving contract economics widens. Who will facilitate access to improve efficient and effective care uptake?

STAKEHOLDER	GOAL
Senior	Live longer, pay less, and receive quality care.
Provider	Deliver quality care at a low cost.
Plan	Improve population health outcomes.
CMS	Strengthen and modernize America's healthcare system[5].
GoHealth	**Improve access to healthcare and help you find a plan for you and your budget.**

"Medicare beneficiaries, and those aging into it, are tasked with navigating their own health insurance, and too many do it on their own, landing them in either financial debt or worse, poorer health due to misused care. The patient journey is fragmented, all the way from enrolling in an insurance plan to navigating the health system to understanding payments."

– Paul Hain, M.D.
Chief Medical Officer at GoHealth.

As we know, cost is a challenging variable to isolate and control. In January of 2021, CMS released a report reviewing the first three performance years for the Comprehensive Primary Care Plus (CPC+) payment model.[6] Long-term effects are still unknown, but interim results were mixed at best, with incremental gains in quality and higher costs instead of savings for FFS beneficiaries. Such data suggests that it is premature to link value-based reimbursement with lower spending for seniors directly. However, there are hints that payment reform coupled with care delivery innovation, awareness of the social determinants of health (SDOH), and tailored supplemental benefits could lead to cost containment and better quality.

Quality includes elements such as level of satisfaction, outcomes measurement, and preferred access. Such metrics seek to quantify the impact of processes that plans and providers administer, whether that be promoting utilization, managing network access, navigating transitions of care, optimizing for CAHPS scores, or scheduling preventive care visits and arranging transportation.

Nevertheless, recent net promoter scores (NPS) and persisting disparities indicate a salient unmet need in the member experience "bucket," overshadowing pilot results and headlines that paint a rosier picture of curtailed costs and quality improvements. This all happens at a time in which the COVID-19 pandemic is driving virtual care preferences, with nearly half (49%) of current Medicare beneficiaries being open to the idea. Another 20% have already seen a doctor virtually.[7]

Learn more about GoHealth's Biannual Medicare 2020 report.

If we are willing to accept that "things will never be the same," how should we go about rebalancing the equation in a way that results in fewer bills to pay and happier seniors?

GREAT DISPERSION ACROSS THE LANDSCAPE

Everyone agrees that managing risk for an entire population is no simple feat, but the real question is if "the juice is worth the squeeze." Most plans and providers will tell you that moving from a few pay-for-performance quality incentives to total cost of care is an arduous undertaking. Some tout significant growth from participating in global capitation, where they take full upside and downside risk.

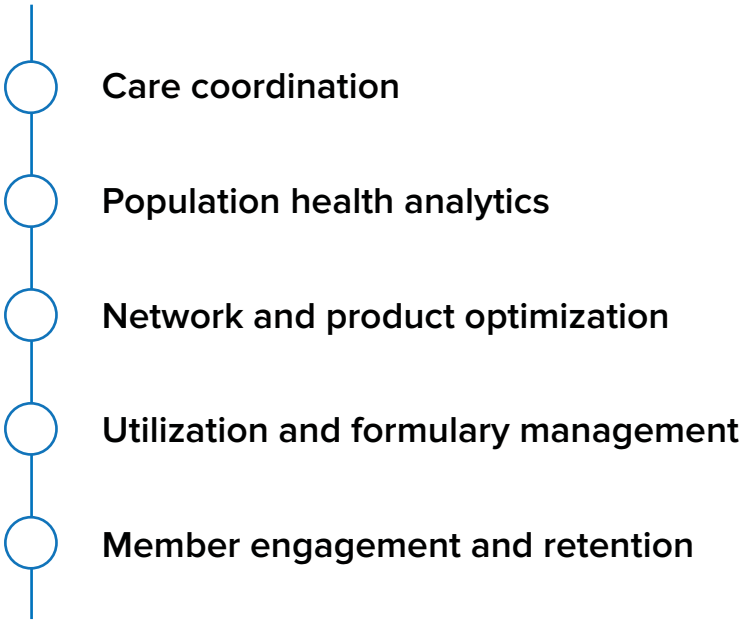
It is no secret that those transitioning from legacy technology and processes face significant barriers along the way. Akin to the digital divide, the gap between organizations making the jump to VBC and those not investing in risk-based arrangements is likely to grow larger. Much of this stems from worries of short-term revenue losses, unpredictable volume, and payment delays. All of which the pandemic has only exacerbated. Simultaneously, those who committed to full capitation realized how revenues could grow even **while panel sizes and service volume shrank.**[8]

Definition of capitation:

Capitation is a payment model where providers receive a set amount for each enrolled person, over a set period of time whether or not that person seeks care

Ongoing disruption is ushering in a new class of "next-generation" primary care, equipped with technology-enabled solutions for capturing historically muddy pools of cost and quality. Fully capitated physician groups are bending unit economics to make VBC work for everyone. At the same time, they are challenging what care delivery looks like, with concepts ranging from primary care and senior clinics to home visits and telehealth. An incredibly resilient clinician workforce fuels progress, coupled with health systems supporting seniors with hospital-at-home models and post-acute care.

All this to say that the rules of engagement are changing. Healthcare is likely to look different in a not-so-distant future, driven by an aging population of trailing edge boomers and site-of-service displacements caused by the pandemic. Designing better outcomes will call for a new set of guiding principles and capabilities.



Population health managers serve as case in point, excelling at high-touch primary care for seniors with chronic conditions. In a recently published AJMC study, increasing patient contact with doctors cut Medicare Advantage costs by 28% and led to 50% fewer hospital admissions for seniors.[9] How, you ask? Physicians spent an average of 200-250 minutes per year with their patients, making the under 20-minute benchmark that most of us receive pale in comparison.[10]

The proof is in the pudding.

CARE DELIVERY, REIMAGINED

Recent regulations and legislation could also help clear remaining barriers that stand in the way of VBC realizing its true potential. Much-needed relaxation of HIPAA telehealth regulations led to telehealth's rapid uptake during the pandemic, enabling physicians to provide virtual care to homebound patients. Requirements for patient access and provider directory APIs go into effect this July, paving the way toward a more unified data infrastructure.[11] A healthy outlook for supplemental benefits, telehealth reimbursement, and Direct Contracting (DC) and Primary Care First (PCF) demonstrations signals further growth opportunities ahead.

Although prospects look bright, we would be remiss not reminding ourselves that nothing changes overnight in healthcare. Complex pain points and disparities persist, demanding public-private collaboration, payer-provider alignment, and consumer-driven innovation.

The average wait time for seeing a primary care physician has reached 29.3 days.[12] COVID-19 mortality rate proves how outcomes are worse in minority communities, much higher among Black (88%) and Latino (54%) Americans than White (40%) and Asian (36%) Americans.[13]

Now, more than ever before, the spotlight shines a bright light on health inequities, physician burnout, consumerism, and other instabilities that come with fee-for-service reimbursement. Confronted with deferred care and decreased volumes, payers and providers start to realize that risk-based payments could indeed be more sustainable. They just need supporting care delivery that leverages the power of empathy, technology, and transparency to improve the operating margins.

CONCLUSION

As care rapidly moves from the hospital to the home and redefines itself according to social determinants of health (SDOH), this could just be the very beginning. Overall awareness of risk factors earlier in disease progression and outside of traditional care pathways may be the much needed inflection point we have all been waiting for.

Shifting market dynamics may force us all to rethink risk stratification, engage in preventative, interdisciplinary care, and tailor member engagement to evolving mindsets. Now is the time to involve seniors and caregivers in shared decision-making. We can start by simplifying unusually complex journeys riddled with unnecessary friction.

It takes team effort to engage members in supplemental benefits, promote efficient utilization, and support aging-in-place. By manifesting the spirit of aligned incentives, together we can build a better future for seniors and improve access to healthcare in America.

The transition from FFS to VBC in Medicare Advantage draws a sturdy bridge between parties, aligning goals around personalized care that can improve quality while reducing costs. GoHealth is proud to play a role in helping seniors achieve this mission and secure better outcomes.

> *I was diagnosed with prostate cancer, and Merrill helped me find a plan that wouldn't charge me a penny for a series of chemotherapy injections that cost $5,000 each. He explained everything to me with such care and calmness that many don't take the time to genuinely do. Because of his efforts, I won't have to pay a single penny for my treatments and doctor visits. On top of that, I now have $50/month that I use at my local grocery store for healthy foods, and $100/month for over-the-counter items like ibuprofen and cold medicine.*
>
> ***– Eduardo T.***
> *GoHealth Medicare Member*

ABOUT GOHEALTH, INC.

GoHealth is a leading health insurance marketplace and Medicare-focused digital health company. We unravel the confusing details of health insurance and Medicare to make every piece easier for you. Our goal is to help you reach your optimum position of health and financial wellness, starting with enrolling you in a plan that meets your needs at the right cost.

And we don't stop there. After enrollment, we help people utilize their plan and support them along their healthcare journey from checking benefits, explaining claims, finding doctors/specialists, and even setting up appointments.

We're here to help. Please contact Ben Miller to learn more about GoHealth's industry-leading Encompass platform.

Ben Miller
Senior Vice President of Strategic Partnerships
partnerships@GoHealth.com

THANK YOU.

As a leading health insurance marketplace and Medicare-focused digital health company, GoHealth's mission is to improve access to healthcare in America. Enrolling in a health insurance plan can be confusing for customers, and the seemingly small differences between plans can lead to significant out-of-pocket costs or lack of access to critical medicines and even providers.

GoHealth combines cutting-edge technology, data science and deep industry expertise to match customers with the healthcare policy and carrier that is right for them. Since its inception, GoHealth has enrolled millions of people in Medicare and individual and family plans. For more information, visit www.gohealth.com.

CONTACTS

Investor Relations, IR@gohealth.com
Media Relations, pressinquiries@gohealth.com
Strategic Partnerships, partnerships@GoHealth.com

APPENDIX

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