Five Predictions for the Fate of Value-Based Health Care in 2022

written by Theresa Hush | January 7, 2022

Only a few days into 2022, it seems obvious that many predicted “trends to watch” floated in late 2021 won’t, in fact, be what will matter most in this critical year for health care. Not that these issues aren’t important, but they are not new (if you’ve been paying attention and, hopefully, planning your strategies). The major predictions are underwhelming:

> Telemedicine and other types of virtual care will continue to advance.
> Digitization of health care for consumers will disrupt traditional channels of information and engagement.
> There will be more collaborations and blurred lines between payers and providers, and even more consolidation among health care networks themselves.
> Health equity and behavioral health will propel changes in coverage, technology, services, and collaborations.

These trends will continue to unfold, whether or not you are watching. What providers really need in 2022, however, are the signals of what is to come as we transition health care toward

greater accountability—under worse economic circumstances.

Perhaps these unremarkable predictions about health care in 2022 have been simply upstaged once again by COVID-19, the ultimate disruptor for futurists. But in fact, here's another prediction circulating: Value-Based Care will be sidelined in 2022, as regulators try to relieve stressed-out providers. And here's why that prediction is both remarkable and misleading.

A Case for Realistic Health Care Predictions for 2022

Without doubt, health care providers have weathered enough in two pandemic years to be entitled to wistfulness and wishful thinking. Everyone wants a return to "normalcy." But reading the Center for Medicare and Medicaid Innovation (CMMI) refreshed strategy, 2021 Reports from MedPAC and American Health Insurance Plans (AHIP), there is little room to question the urgency of stakeholders' positions about Value-Based Care.

More than at any time in the past, there is a strong consensus that Value-Based Care is the vehicle for implementing the reforms essential for an effective health care system. Value-based payment models are now envisioned to go beyond affordability and quality outcomes, and ensure health equity, access, home care, consumer health care rights, and even recovery from COVID-19 setbacks. Moreover, the central movement away from Fee-for-Service and toward alternative or value-based payment models has broad bipartisan consensus. Many of the programs being expanded were started in the Trump administration and have been enlarged in scope in the Biden program.

If you are a provider who doubts that 2022 will be the pivotal year for expansion in Value-Based Care, let's examine the evidence of the consensus for change and urgency.

CMS Has Publicly Laid Out a Detailed Timeline for VBC for the First Time

In an August 2021 article in *Health Affairs*, CMS laid out its vision for Value-Based Care over the next 10 years. Five key points are worth noting: First, CMS will avoid proliferating multiple competing payment models with the same goals, in favor of piloting fewer models and growing participation over time. Second, health equity must be a part of every payment model, to ensure that quality health care resources can be accessed by everyone. Third, payment models must be designed to favor provider participation, and downside risk for providers must be based on providers having the tools (such as data) to change health care delivery. Fourth, the CMS strategy will go beyond Medicare, and expand into Medicaid as well as partnerships with payers, states, and communities. And finally, transition from Fee-for-Service and other cost

reforms are central to the plan.

CMS officials also said that the agency may plan to make certain payment models mandatory. A few months later, CMMI released its full strategy "refresh" with more detail on specific initiatives and the time frame for roll-out.

Historically deploying both the carrot and the stick to influence action, the Physician Payment Rule released in the fall of 2021 is clearly intended to induce providers to move into alternative payment models like Primary Care First (PCF), Direct Contracting (DC), and Accountable Care Organizations (ACOs). Once providing incentives for traditional Fee-for-Service providers to report quality and implement improvement activities for cost and quality, the 2022 MIPS program now threatens providers with weighing the Cost component as 30 percent of the overall score, equal to Quality, with steep penalties up to 9 percent of revenues for poor MIPS performance.

The Private Market Is Also Expanding Value-Based Payments

Medicare has been the clear leader in promoting alternative payment models under Value-Based Care. But the private insurance industry also has implemented higher levels of payment model changes. In its December 2021 release of survey results for tracking alternative payment models, it reported that over 40 percent of health care payments for 80 percent of covered people were made under alternative payment models in 2020, during the pandemic. Almost 60 percent of health care payments for Medicare Advantage plans were tied to value-based payments in 2020. Across commercial insurance, Medicare and Medicaid, value-based payments are rising.

Predictions for Key Value-Based Care Developments in 2022

Here's the list of what we predict you should expect this year and beyond:

1. Medicare's Global and Professional Direct Contracting and Primary Care First will both expand as hospital and other multi-specialty groups seek to participate in value-based payment models under early favorable incentives. Primary Care First proved to be a safer first step for providers to test alternative payment adoption, while Global and Professional Direct Contracting was implemented on a smaller scale. Look to CMS and providers to be more receptive to expansion in Round 2, as many health systems have substantially improved their data and infrastructure for Risk. Some key provider players will see the advantages of avoiding

MIPS penalties while implementing a provider-directed growth strategy through direct contracting rather than Medicare Advantage.

2. CMS will increase emphasis on Medicaid Value-Based Care. Lagging Medicare in alternative payment models, CMS will motivate states to abandon volume-based fees. Why will this matter? Academic centers (some of which have higher Medicaid beneficiaries) lose money under low volume-based rates and can potentially do well under value-based payments. Often serving Medicaid beneficiaries with poorest health outcomes, many now have the infrastructure and broader network for providing Value-Based Care for poorer patients. Inner city hospitals, still very vulnerable, may also benefit from the predictability of population-based payments and alliances built across their communities. Look for Medicare's residency program support and disproportionate share payments to be tied to participation.

3. ACOs will remain stable or slightly decline in numbers in 2022, as organizations continue to transition their model toward Risk. Many ACOs continue to struggle with insufficient data and infrastructure as their participants straddle volume-based fees and Risk. ACOs will face a choice in 2022: take up the banner of greater Risk, participate in direct contracting efforts, and expand tools—or lose to other providers and Medicare Advantage.

4. Consumer-focused initiatives will greatly expand in 2022, with payers such as Medicare and health plans—and pharmaceutical companies—leading efforts to align patients with primary or specialty providers, help them navigate lifestyle and treatment changes, and use cost transparency to direct care towards affordable options. We will see direct-to-consumer initiatives from payers, employers, pharmaceutical companies, and device companies seeking a direct line to help change patient behavior or change provider selections.

5. Business will up the ante to compete with traditional providers, as equity-backed practices and retail health care grow to be primary care hubs for patients. Business will use that advantage to participate in global or professional payments with Medicare and private health plans or employers, securing growth. Many of these businesses will start developing partnerships with traditional providers to broaden their reach.

This year won't be quiet on the Value-Based Care front, as some predict. The pandemic has heated the environment, not diverted attention from costs and quality, and has brought the vulnerabilities of the current delivery system to the fore. Providers would be wise to prepare for more realistic predictions for health care in 2022. Building the tools to be successful under risk-based payments requires a substantial lead time to create the available data, to engage with technology vendors or build internal capacity, and to develop cost and quality performance measurement. It's really past time to get started.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Florian Roost