7 New Value-Based Health Care Directions You'll See in 2021

written by Theresa Hush | December 10, 2020



Everyone who's reeling from 2020 is hoping for light in 2021.

Health care, especially—systems, hospitals, clinical practices and their providers—wants the pain to stop. What might lie ahead for health care next year? Here's what we're thinking about the near future, and what you should watch for in 2021.

1. Health care providers will be fortified.

If one thing is clear from the election results, it's that relief is coming to help providers on the pandemic's front line. Money won't be free-flowing, but it will be targeted to areas of financial distress. We should expect initiatives to centralize purchasing and distribution of personal protective equipment stockpiles, ending the competition between hospital systems and between states—and probable actions against price gouging. Likewise, efforts to monitor staffing resources and create mechanisms to send medical staffing to hotspots should emerge, as well as information exchanges to share best practices, treatments, and experiences in health care settings. Reporting related to vaccine distribution and administration will also be more centralized and transparent, with time.

Beyond the pandemic, health care providers will be supported for adopting targeted telehealth, perhaps tied to clinical depth and population health. For example, patient telehealth with video and capture of clinical values from wearable devices may trigger incentives for providers (and sometimes patients). The potential for measurement of these visits and their applicability in patient engagement efforts will heighten telehealth's value.

2. Value-Based Health Care will shift from a focus that is mostly on cost of care to include health equity and access.

Biden campaigned on an agenda of universal access and reduction in health care inequities, along with recovery from the pandemic. The current administration has favored free market health care decisions, such as allowing lower cost coverages for employers based on restricted benefits and provider networks. Incremental privatization of Medicare, by favoring enrollment in private Medicare Advantage plans, was viewed as a positive development—and potentially a transition to fixed fees for coverage. The emphasis in Value-Based payment models was creating accountability for providers through financial risk for providers and shared costs for patients, while creating transparency to enable better consumer medical choices.

You should expect the idea of "Value" to continue, but be redefined to include health equity and access, and tied into efforts to strengthen the Affordable Care Act. CMS will begin to measure health outcomes by population groups and to foster initiatives to eliminate inequities. The CMS definition of Value will be broadened to include long-term outcome improvement, as opposed to just quality processes, in addition to health equity. Quality reporting under the Merit-Based Incentive Payment System (MIPS) will continue, but there will be changes in measures and performance requirements that reflect the standard of care as well as the accountability of providers, and that ensure patients' voices will be heard.

3. There will be more support for ACOs and other APMs that continue to develop infrastructure and power for better health care—demonstrated by data.

CMS took aim at ACOs during recent years. The new administration is more likely to want to shift away from Medicare Advantage, after evaluating whether it is really helping patients and not just selectively enrolling healthy patients.

While ACOs have been an important Value-Based Health Care strategy, they have had mixed success and have lost much support. The number of ACOs has also remained stagnant, because of CMS efforts to induce risk.

The new CMS is likely to offer and possibly support ACOs with strong network capacity and resources for expansion, while evaluating changes that need to be made. There will be pressure on ACOs to achieve health equity and long-term health outcomes, have community presence and support, and foster more transparency and outreach to consumers and patients. But ACOs also have the opportunity to grow, and CMS will offer more tools to ACOs to help them achieve a greater presence in their own organizations.

The new administration will want to organize its Value-based efforts on organized delivery systems, such as ACOs and/or health systems, with existing infrastructures to coordinate and improve care. Like previous administrations having a “systems” focus on health care equity, access, and achieving quality and cost performance, the Biden administration will certainly

invest in making health care work better. But it will do so by working to improve what providers are delivering, rather than primarily using payment models.

Backing off provider risk in ACOs is unlikely, because there will be an urgency for the program to show savings. Capitation programs within ACOs and use of other negotiated payment mechanisms may also be present or expanded, such as Direct Contracting within ACOs, so that ACOs actually have more leverage in their environments. Experimentation with payment models for ACOs, or ACOs given latitude to develop broader, coordinated networks under negotiated rates, is a distinct possibility as long as equity can be ensured. The primary goal for CMS is to motivate providers to progress along the track of cost and outcome accountability, while helping them develop the tools to do so.

We should see a reconsideration of ACO success factors, organizational models, and other factors that inhibit development or growth, and more evaluation of the progress of various models. There may be a merging of various models, and more teeth—yes, not less—to ensure that the models produce both savings and better long-term costs.

4. Some Value-based models will be discontinued.

All Value-based payment models will be vetted, and federal support for some payment models will disappear based on results, provider support, and how well they fit into a general health care agenda for Value.

For example, Geographic Direct Contracting, just announced, is

an unlikely initiative without strong community support. With the model focused on super-coordination across multiple health care entities and specifically targeted to organizations already capable of managing risk, the geographic Risk model could be payer-organized in most regions. Keen competition between providers—and a lack of centralized provider or public health infrastructure to support geographic operations and data—could prohibit provider direction of the model. A payer-fostered Geographic Direct Contracting program would inevitably be labeled as a Medicare privatization program.

Likewise, Direct Contracting outside of ACOs and other payment models like Primary Care First may be seen as a distraction and better accomplished within a redesigned ACO program. Specialty care models, however, may endure with modifications and support from providers and patients.

5. MIPS will continue, with reinforcement of central values.

MIPS came about shortly before the end of the Obama administration, and it took some time to gather steam. Its requirements and incentives/penalties were relaxed during the pandemic, and CMS has focused on streamlining measures, including an upcoming plan to create a core set of quality process measures. The Quality component of MIPS has never achieved its potential, not only because of selective reporting of measure results, but also because these are process measures rather than outcome improvement measures. We should expect CMS to continue a reexamination of how MIPS works, but continue its framework while strengthening the requirements. CMS will be more transparent about its cost measurement processes, and more

focused on providing data and tools to improve performance.

Improvement Activities and Promoting Interoperability will be areas of focus beyond 2021, as efforts to help ensure progress toward health equities and improvement of data-sharing continue.

6. There will be more efforts to engage and inform consumers.

Spurred by COVID-19 and the vaccine, consumer education and engagement will be a big priority. The current administration took important steps to enable cost transparency, which providers have protested. While there may be some forgiveness on the aggressive schedule of the initiatives, the transparency requirements themselves may well remain in place.

But cost transparency is just the beginning. We should see strong support for an active consumer voice. Expect consumers to share their concerns, experiences, and stories well beyond current mechanisms, and weigh in on quality of care measurement in new ways. The cause of health equity alone will generate processes to ensure that consumers are heard.

Likewise, use of patient-reported outcomes plus technology that permits direct patient-to-provider clinical data for incorporation into EMRs will be established as part of measures and programs. Private industry and technology will play an important role for consumers, and the administration may create partnerships that legitimatize and expand their consumer-based applications and devices.

7. Efforts to strengthen the Affordable Care Act (ACA) will also bolster Medicare and Medicaid.

With the ACA partially gutted, coverage remains unaffordable or unavailable. The reluctance of some states to invest in expanding Medicaid is one factor. CMS is likely to begin evaluating Medicaid restructuring as part of a health equity, quality, and financial package that leaps beyond these limits while ensuring that states control costs of entitlement programs. A Medicaid restructure strategy may deploy Medicare's potential for centralizing health care reimbursement and payment models, while maintaining some decentralized beneficiary operations. However, if there is a public option, you can expect the inclusion of employers and private health plans in all-patient projects to demonstrate cost and quality.

As the lynchpin for ensuring the financial viability of the health care system as well as patients, the ACA will serve as a central platform to reinforce the tenets of quality, affordability, equity, and patient voice in Value-Based Health Care across all coverages.

While the road ahead will be full of twists and turns, here's one certain trend for 2021: the health care industry will be far from calm, but the journey promises to be full of interesting challenges and new opportunities.

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: Walter Walraven