



Huntington
Hospital

The Challenges and Opportunities for Hospitals and Health Systems in Value Based Care

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Value Based Care

Also Known as:

- Accountable Care
- Population Health Management
- At-risk contracting
- VB Payment, contracting, purchasing, reimbursement
- Alternative payment methods
- Outcomes based pricing
- Cost, Quality, Outcomes




$$\text{VALUE} = \frac{\text{OUTCOMES}}{\text{COSTS}}$$

Value Based Care

Definitions:

- The best care at the lowest cost with incentives for improved quality, access, and patient satisfaction.
- Integrated Care coordination that assures that the patients get the right care, by right provider, in right place, at right time.
- Care that rewards providers with incentive payments for the quality of care they provide.
- Form of reimbursement that ties payments for care delivery to the quality of care provided, rewarding providers for efficiency and effectiveness (based on outcomes).



Changing Worldview

Capacity-Focused Approach

Business model:

1. Identify the best-paid services
2. Build capacity for those services
3. Fill that capacity



Needs-Based Approach

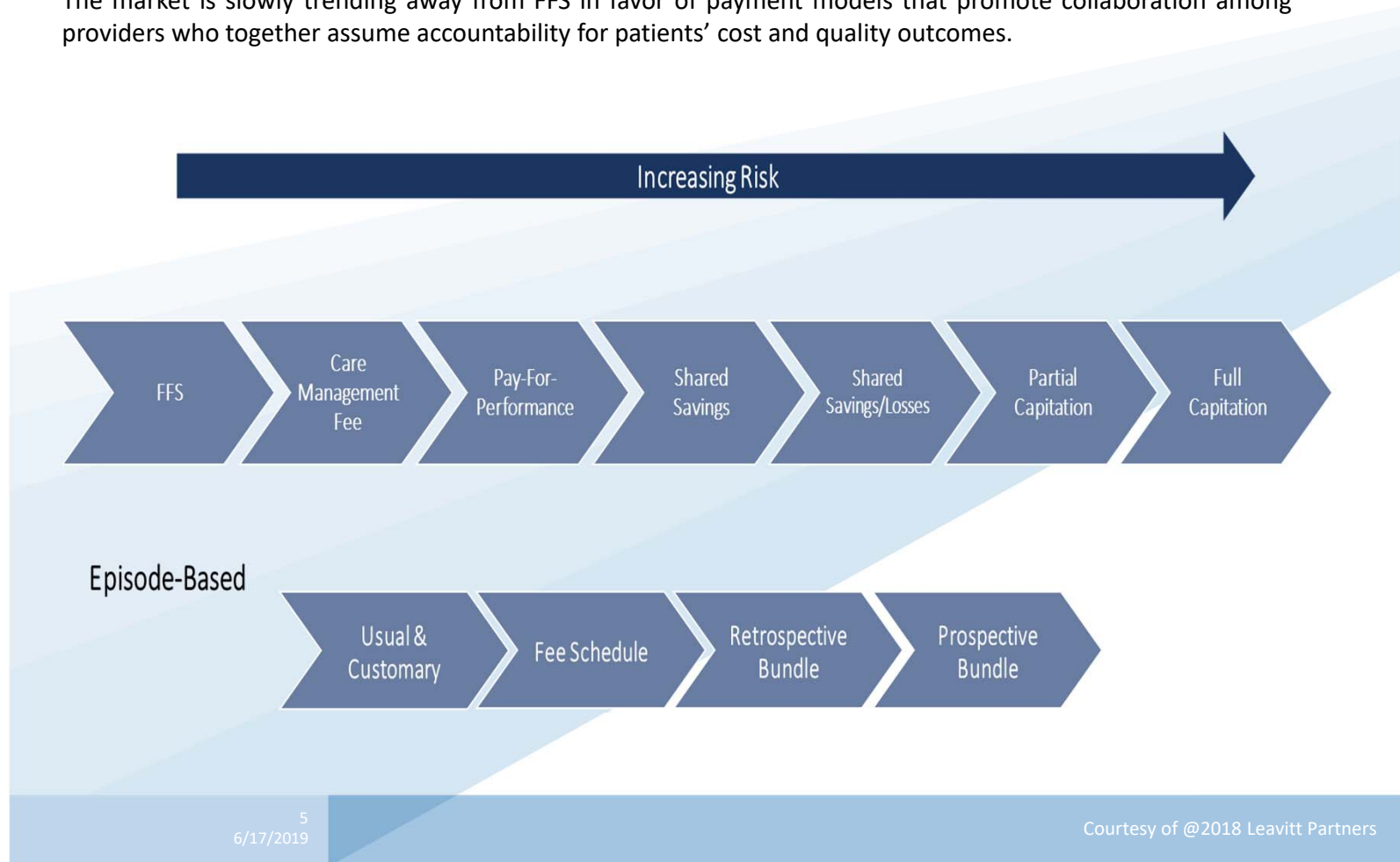
Business model:

1. Identify patients' needs
2. Build low-priced services to fulfill needs
3. Prevent high-cost care



Progression of Provider Payment Arrangements

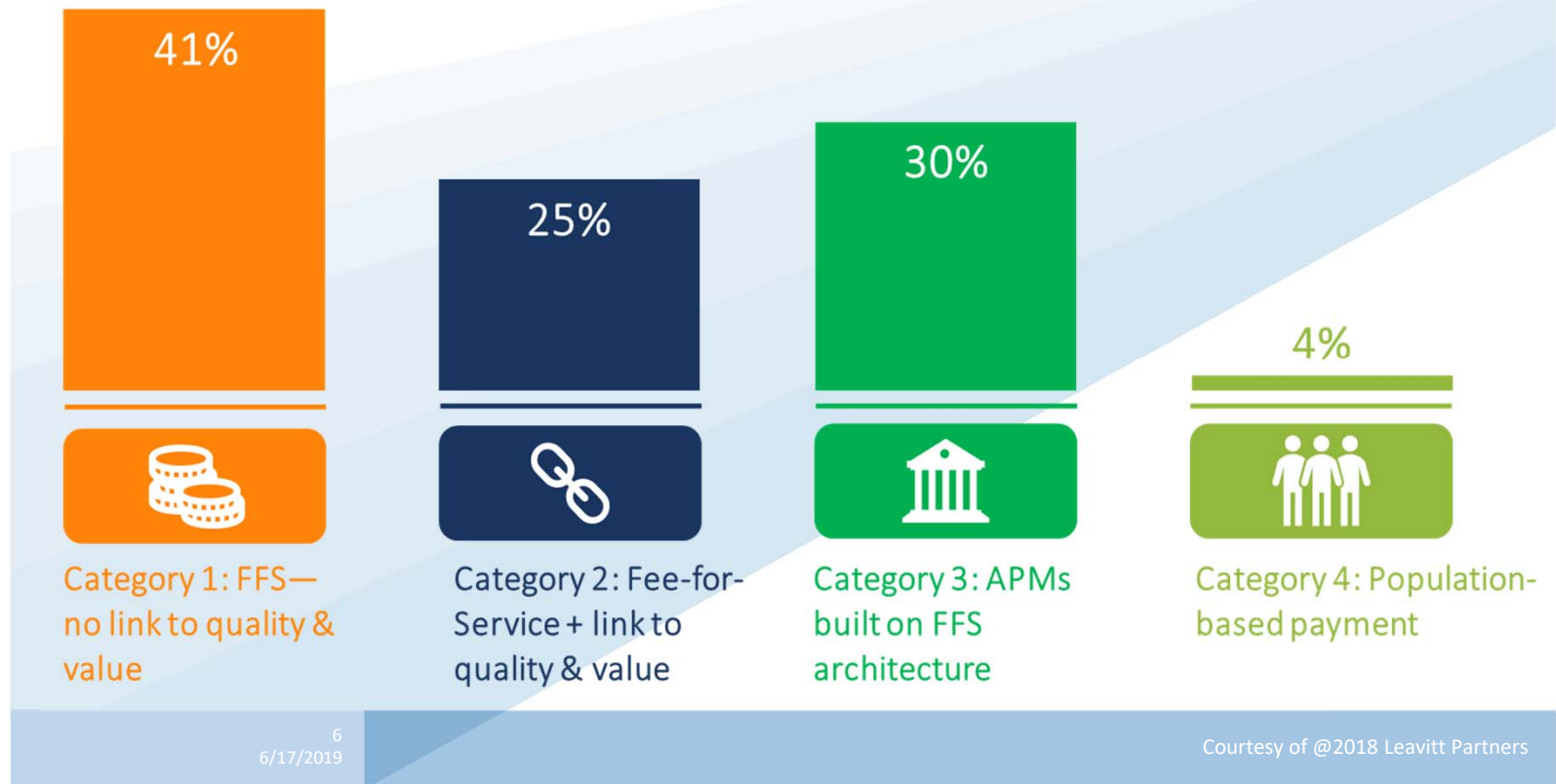
The market is slowly trending away from FFS in favor of payment models that promote collaboration among providers who together assume accountability for patients' cost and quality outcomes.



Moving Away, But Still Grounded in FFS

The Fee-for-Service Chassis of Value-Based Payment

According to the Health Care Payment Learning & Action Network (LAN) Annual Payer Survey, 96% of payer contracts are still built on a foundation of FFS.



Types of Value Based Care



1. Shared Risk
 - Keep spending at/below targets
2. Bundles
 - Profit comes from effective utilization in a few key areas
 - Length of Stay
 - Implants, High Cost RX (Variable Cost)
 - Post-acute care component
 - OR Patients choose which elements of service they want
3. Global Capitation (Professional + Institutional)
 - Patient cost are shared (mix of high/low cost)
 - Per member/per month contracting (PM/PM)
4. Shared savings
 - Target spend on volume based payment

Challenges with Transformation

- ▶ Change is hard, change when times are good is nearly impossible
- ▶ Current business models and systems are built around FFS
- ▶ Lack of organizational preparedness and leadership support to fully adopt new business models
- ▶ There has not been a precipitating event to cause markets to “tip”

Obstacles to making the business case:

- Experimentation vs roll-out
- Changing worldview
- Governance

Traditional Objectives for Health System Leaders

1. Increase Market Share
2. Increase Margin
3. Improve Brand



Value Objectives for Health System Leaders

1. Lower total cost of care
2. Decrease amount of services needed
3. Improve Brand



Challenges

Governmental

- Unpredictable policy/payment reform
- Multiple models for payment
 - No standardized data set
 - No standard reporting
 - Required change in processes may not improve care
- Regulation/auditing/correction resources
- Conflict between state/national plans
- Publicly available quality info inaccurate/incomplete/aged



Challenges

Electronic Health Record

- Cost
- Difficulty in implementation/acceptance
- Interoperability (LHR including Rx)
- Integration with other agencies
- Revenue cycle problems
- Integration of affiliated (not employed) providers
- Data platform (clinical, claims)



Challenges

Operational

- Far less population data vs contractors
- Need for real time data
- Less predictable revenue stream
- Claims processing/reimbursement designed for FFS, Bundle, Case rate
- Resources:
 - SMEs for population health
 - Actuarial
 - Contracting for VBP
 - Data mining/analytics
 - Integrated care management
 - Provider payment (aligned) models
 - Telemedicine
 - Radiology
 - Behavioral Health
 - Primary care/specialty care



Opportunities

Community Partnerships

- Public Health
- Local Government
- FQHC
- Schools
- Charitable organizations
- Religious institutions/organizations



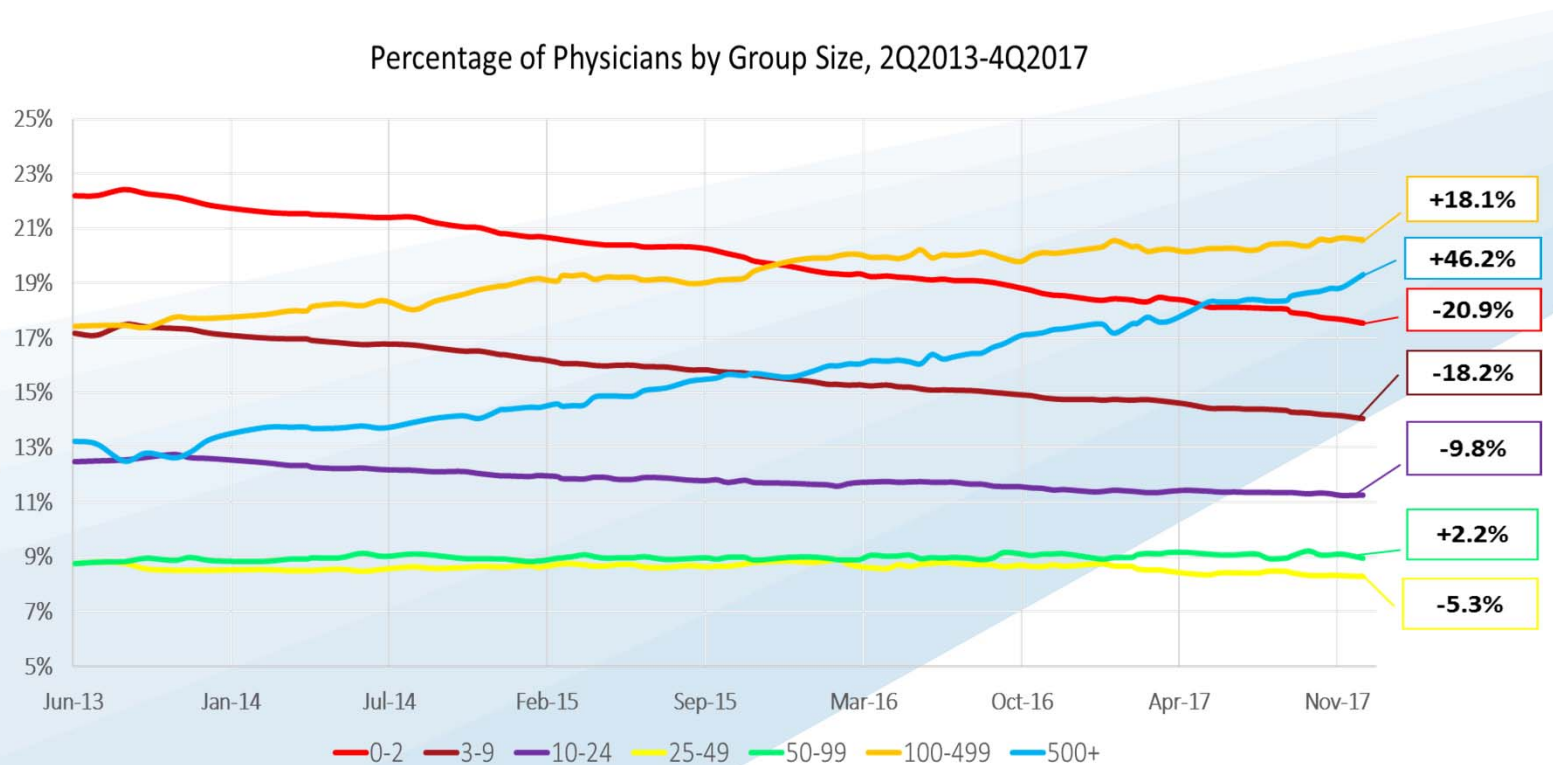
Opportunities

Business Partnerships

- Competitors
- Post-acute Care Organizations
- Ambulatory: ASCs, Imaging, Urgent Care facilities
- Physician groups
- Charitable organizations
- Joint ventures

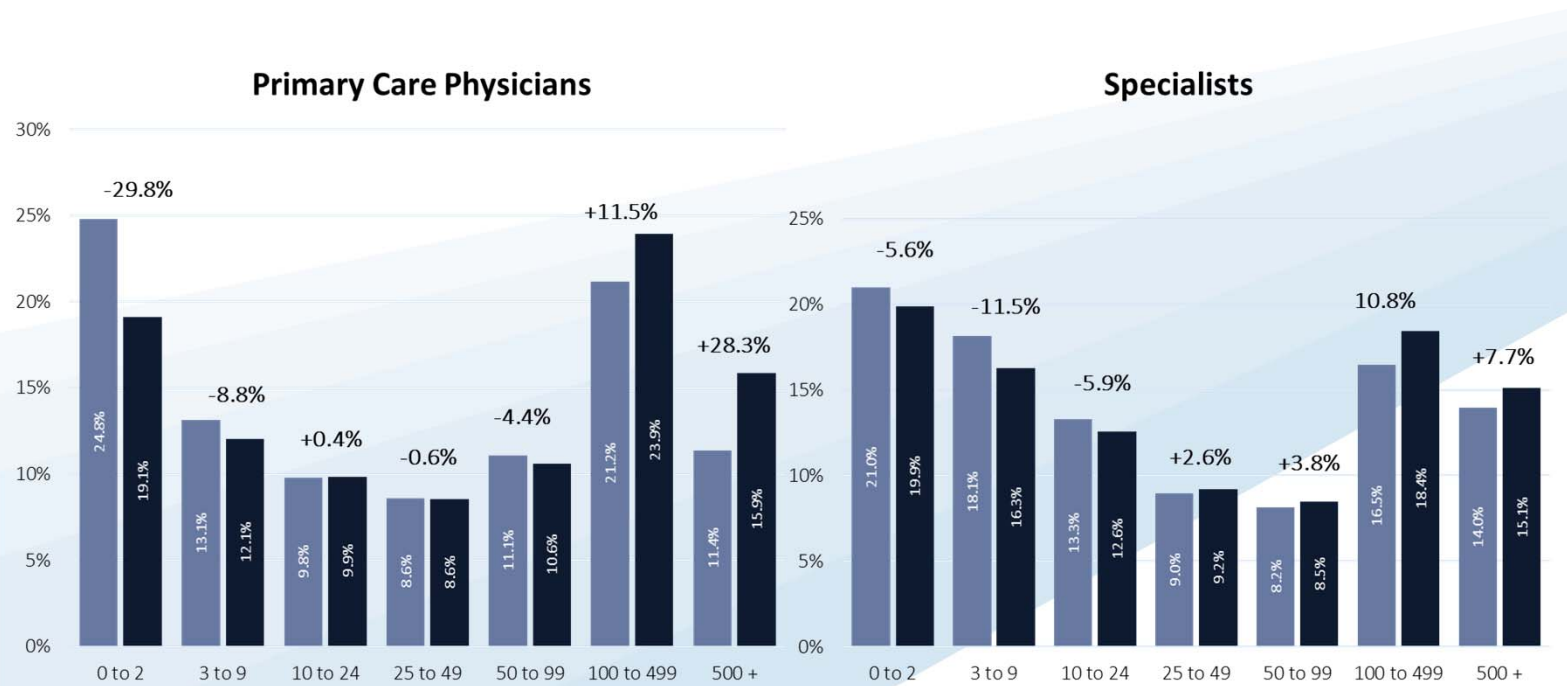


Physician Consolidation



Source: Leavitt Partners Analysis of Medicare Physician Compare Data

Primary Care and Specialist Consolidation



Source: Leavitt Partners Analysis

Opportunities

Physician Collaboration

- Meaningful quality
- Specialist engagement (supplies, implants)
- Best practice implementation
- Leverage team care
- High risk management



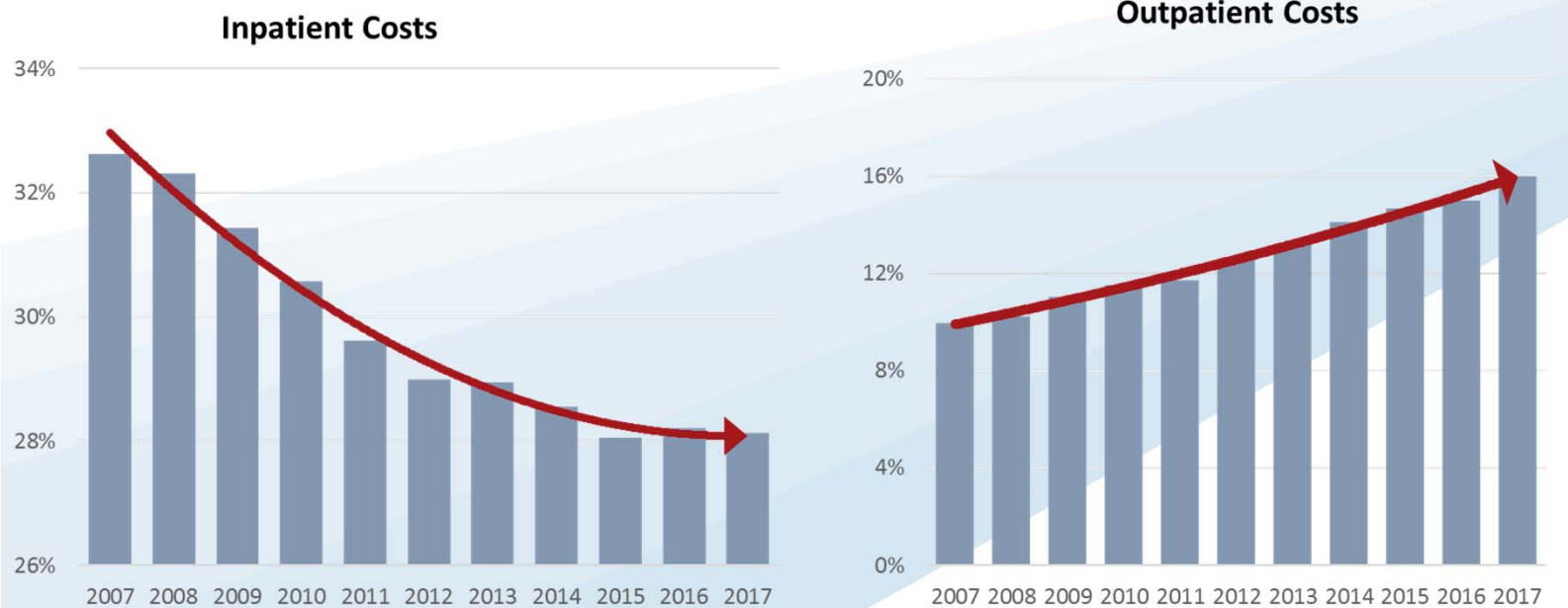
Opportunities

Advances in Care

- Accessibility
- Telehealth
- Medical home (including BH)
- Reduction in admissions/readmissions/HAC
- Aging in place
- Better care coordination



Shift from Inpatient to Outpatient Care



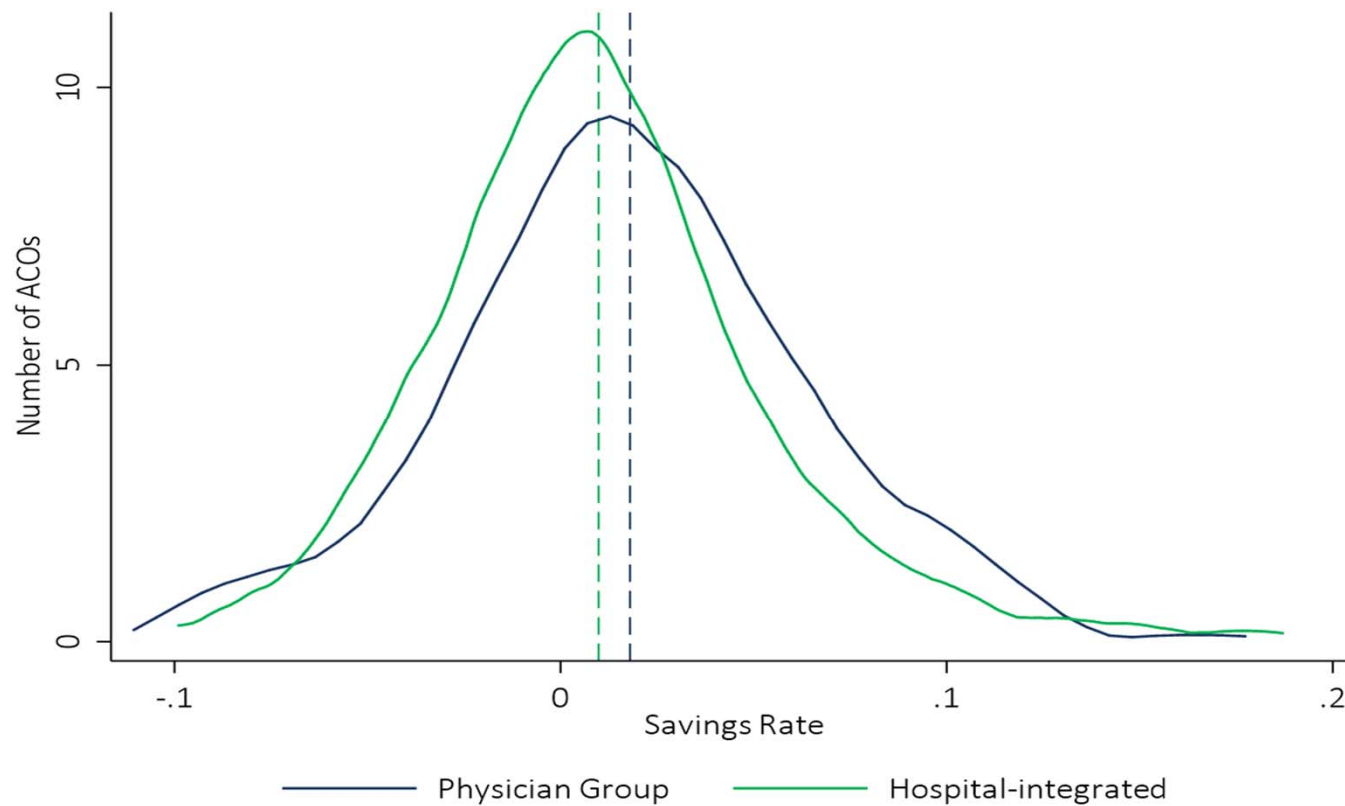
Source: Leavitt Partners analysis of Centers for Medicare and Medicaid Services data

ACO Growth



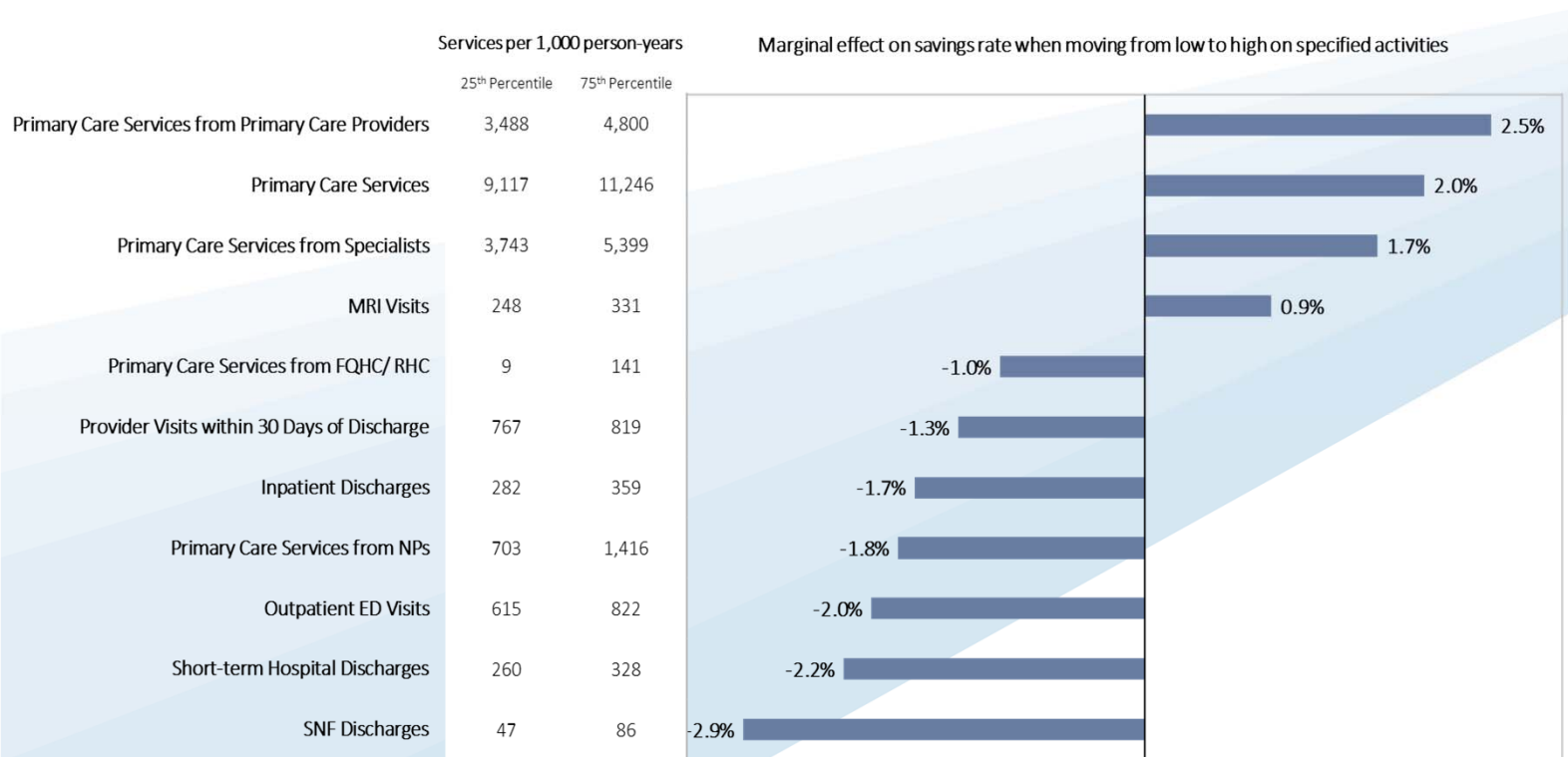
Source: Leavitt Partners Centers for Accountable Care Intelligence

There is wide variation in performance of all types of ACOs



Source: Leavitt Partners

Utilization Impact on ACO Savings



Percentages shown are the marginal effect of moving from the bottom quartile to the top quartile of the specified activities, controlling for aligned beneficiaries, total benchmark expenditures, year, and patient risk scores. For percentiles, values are services per 1,000 person-years.

In Transition



- Create a plan for migration—Cultural “buy-in”
- Balance FFS & VBP payments
- Morph organizational structure to support new processes (competencies)
- Understand the needs of your population
- Collaboration for the “right” quality indicators
- Minimize waste
- Reevaluate what you are doing and stop what you don’t/won’t need

Questions?

Comments?



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thank you

