Managing the Transition to Value-Based Payment

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Presentation Outline

• What’s Driving the Transition to Value?
  – Declining Payment Rates
  – Alternative Payment Models
  – Cost-Sharing and Consumerism

• Value-Driving Capabilities
  – People & Culture
  – Business Intelligence
  – Performance Improvement
  – Contract & Risk Management

• Your Value Proposition
Declining Payments

Hospital Payment Reductions Related to ACA, the Sequester, and the ATRA Exceed $365B Over the Next 10 Years

Sources: https://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf and HFMA Analysis
Limited Ability to Cost Shift

Please respond to the following statements:

- Could offset declining gov't payer revenue with increased commercial rates
  - 7% Not Sure
  - 71% No
  - 22% Yes

- Consumer could find accessible and reliable information on quality for my organization and competitors
  - 16% Not Sure
  - 46% No
  - 38% Yes

- Could provide clear explanation of charge structure
  - 16% Not Sure
  - 42% No
  - 42% Yes

- Understand actual cost of services and can price based on actual costs
  - 9% Not Sure
  - 42% No
  - 49% Yes

- Aware of relative price/quality position vis-à-vis competitors
  - 4% Not Sure
  - 15% No
  - 81% Yes

Source: HFMA Value Project Survey, October 2014
CMS Accelerates the Tipping Point

“...HHS goal of 30 percent traditional FFS Medicare payment through alternative payment models by the end of 2016... 50 percent by the end of 2018”

HHS Press Office 1-26-15

85% of payment tied to quality and value metrics (ex. Hospital Value Based Purchasing, Hospital Readmission Reduction Program)
With Change Also Anticipated on Commercial Side

Please indicate overall percentage of your payments from commercial payers that incorporate value-based mechanisms today and likely percentage in three years.

Source: HFMA's Executive Survey: Value-Based Payment Readiness (May 2015), sponsored by Humana. Available at http://www.hfma.org/value-basedpaymentreadiness/
Payment Models in Flux

Bundled Payment?

Shared Savings?

Global Payment?

Fee for Service?

Pay for Performance?
Shared Savings: Mixed Results

- Quality has improved for MSSP participant ACOs, but little correlation between quality and cost.
- ACOs that receive shared savings tended to start with higher cost benchmarks (i.e., had more opportunity to cut costs).
- Improved performance correlates with time in program (1 year in – roughly 20% achieved savings; 4 years in – roughly 50% did).

Source: Presentation by David Muhlestein, Leavitt Partners, for the Accountable Care Learning Collaborative, September 14, 2016. Analysis based on CMS data for 2015.
Bundled Payments: From Voluntary to Mandatory

CJR Mandates a 90-Day Episodic Payment for Lower-Joint Replacement for 25% of IPPS Hospitals

Comprehensive Care for Joint Replacement

Consumer Fact Sheet

Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries and can require lengthy recovery and rehabilitation periods. In 2013, there were more than 400,000 inpatient primary procedures costing more than $7 billion for hospitalization alone.

While some incentives exist for hospitals to avoid post-surgery complications that can result in pain, readmissions to the hospital, or protracted rehabilitative care, the quality and cost of care for these hip and knee replacement surgeries still varies greatly. For instance, the rate of complications like infections or implant failures after surgery can be more than three times higher at some facilities than others, which can lead to hospital readmissions and prolonged recoveries. And the average Medicare expenditure for surgery, hospitalization, and recovery ranges from $16,500 to $33,000 across geographic areas.

HFMA Executive Summary: http://www.hfma.org/Content.aspx?id=45125
More Bundles on the Way

Like CJR, CMMI’s Next Mandatory Bundles Will Meet Three Criteria

- High Cost/Volume
- Relatively Defined Care Path
- High Outcome Variability

Newest Models Include:
- AMI
- CABG
- Surgical Hip/Femur Fracture Treatment

And may qualify as APMs under MACRA
Private Sector Bundling Efforts

Employers Have Contracted with “Centers of Excellence” for Specific Conditions and Encouraged Employees to Use These Centers

Sources:
1) http://thehealthcareblog.com/blog/2012/10/18/walmart-moves-health-care-forward-again/
2) http://my.clevelandclinic.org/about-cleveland-clinic/newsroom/releases-videos-newsletters/lowes_expands_heart_healthcare_benefits
Consumers: High Cost Sharing

2016 Product Enrollment

Family OoP:
Ded: $11,601
Max: $13,292

Family OoP:
Ded: $6,480
Max: $12,270

Sources:
2) https://www.healthpocket.com/individual-health-insurance/silver-health-plans#.V8m4BkTSnDA
3) https://www.healthpocket.com/individual-health-insurance/bronze-health-plans#.V8m4XUTSnDA
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, by Firm Size, 2009-2016

* Estimate is statistically different from estimate for the previous year shown (p< .05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

Increasing Burden of Healthcare Costs

A Bigger Bite
Middle-class families’ spending on health care has increased 25% since 2007. Other basic needs, such as clothing and food, have decreased.

Percent change in middle-income households’ spending on basic needs (2007 to 2014)

- Health care: 24.8%
- Food at home: -3.6%
- Housing: -6.0%
- Total: -6.3%
- Transportation: -6.4%
- Total food: -7.6%
- Food away from home: -13.4%
- Clothing: -18.8%

Sources: Brookings Institution analysis of Consumer Expenditure Survey, Labor Department, THE WALL STREET JOURNAL.
Future State?

"Just look for something in my price range."
The Value Equation

\[ \text{VALUE} = \frac{\text{Quality}^{1}}{\text{Payment}^{2}} \]

{1} Composite of patient outcomes, safety, and experiences

{2} Cost to all purchasers of purchasing care
A Fundamental Shift in Focus

View value ...

... through the purchaser’s lens
Value-Driving Organizational Capabilities

Collaboration, accountability, and communication

People and Culture

Data and metrics

Business Intelligence

Measurement, assessment, and mitigation of risk

Elimination of variation, unsafe practices, and waste

Performance Improvement

Contract and Risk Management
Key Capability Focuses

• **People and Culture:**
  – Emphasize change management
  – Align incentives with strategic goals
  – Cultivate clinical leadership

• **Business Intelligence:**
  – Implement EHRs/clinical decision support
  – Refine costing capabilities
  – Develop analytical capabilities

• **Performance Improvement:**
  – Identify clinical variations and work on standardization
  – Remember that performance improvement must occur across the organization (not just clinical)

• **Contract and Risk Management:**
  – Develop ability to mitigate risk by understanding population-specific drivers of utilization and cost

Source: HFMA Value Project, June 2011
People and Culture
Build a Patient-Focused Culture

HEALTHCARE DOLLARS & SENSE™

Price Transparency

Patient Financial Communications

Medical Account Resolution

hfma.org/dollars
Educate Consumers

- Describes how to request price estimates, step by step
- Clarifies what estimates may or may not include
- Explains in-network and out-of-network care
- Defines key terms
- Available for posting on your website at no charge
- Hardcopies available for purchase in bulk at a nominal price through AHA’s online store: ahaonlinestore.org

hfma.org/dollars
Train Front-end Staff for Expanded Roles

- No longer a purely transactional role
- “Soft skills” and communication skills are key
- The patient’s financial experience is in their hands

hfma.org/dollars
Demonstrate Commitment to Your Community

- Adopters to date (85 hospitals and 68 clinics) include:
  - Duke University Hospital
  - Geisinger Health System
  - MetroHealth System of Cleveland
  - St. Luke’s Health System (Kansas City)
  - UAB Medicine

- Recognition demonstrates commitment to best practices in patient financial communications

- Based on HFMA review of an application and supporting documentation

- All provider organizations may apply. Recognition valid for two years

hfma.org/dollars
Change the Patient Payment Model

**Historical State**

- **At Service:**
  - Most billing processes are post-service, amounts due based on data gathered after service, calculated retrospectively.
  - Patients notified of financial obligations after insurance is billed & paid.

**Future State**

- **At Service:**
  - Providers bill at or right after time of service. Many times, patients know in advance what they owe & agree on terms.
  - Insurance bill verifies what the patient already expects.

**Gather info before & at the time of service.**

- **Pre-Service:**
  - Gather basic info before & at the time of service.
  - Prospectively calculate expected out-of-pocket costs.

- **Post-Service:**
  - Pre-Service: Prospective Data Gathering and Processing
  - At Service
  - Post-Service: Retrospective Data Gathering and Processing
Business Intelligence
Please rate the following capabilities on importance in three years.

- Interoperability
- Real-Time Data Access
- Business Intelligence
- Eligibility Verification
- Post-Discharge Follow-Up
- Chronic Care Management
- Care Standardization
- Assessing ROI
- Flexible Models for Physician Compensation

Source: HFMA’s Executive Survey: Value-Based Payment Readiness (May 2015), sponsored by Humana. Available at http://www.hfma.org/value-basedpaymentreadiness/
But Current Capabilities Lag

Please rate your organization’s capabilities related to the areas below.

- Eligibility Verification
- Post-Discharge Follow-Up
- Real-Time Data Access
- Care Standardization
- Business Intelligence
- Flexible Physician Compensation Models
- Chronic Care Management
- Assessing ROI
- Interoperability

Source: HFMA’s Executive Survey: Value-Based Payment Readiness (May 2015), sponsored by Humana. Available at http://www.hfma.org/value-basedpaymentreadiness/
Creating a “Readiness Gap”

Interoperability
Business Intelligence
Real-Time Data Access
Chronic Care Management
Assessing ROI
Care Standardization
Flexible Models for Physician Compensation
Post-Discharge Follow-Up
Eligibility Verification

Source: HFMA’s Executive Survey: Value-Based Payment Readiness (May 2015), sponsored by Humana. Available at http://www.hfma.org/value-basedpaymentreadiness/
Where to Start?

- High-volume areas
- Primary disease/condition categories with high-intensity utilization
- Areas of mandatory penalty/reward: readmissions, HACs, CJR, etc.
- Clinical areas with significant variation in cost per case
- “Key drivers”
New Payment Models Require New Levels of Understanding

DRG 470, Spending by Setting

- Hospital
- Physician
- HHA
- SNF
- IRF
- Readm

$0 $5,000 $10,000 $15,000 $20,000 $25,000 $3

≈60% of spending is outside of hospital

PAC Setting vitally important to manage:
- Discharge status
- Picking PAC partners

Readmission often is over 2x the “spend” of non-readmitted patient

Ex. Target Price = $24k
And New Levels of Collaboration
Performance Improvement
## Areas of Greatest Opportunity

### Opportunities to Achieve Savings

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical process/workflow redesign/greater use of clinical pathways and evidence-based medicine</td>
<td>61%</td>
</tr>
<tr>
<td>Improvements in productivity management</td>
<td>41%</td>
</tr>
<tr>
<td>Establishing a high-performing network of physicians to ensure best quality/low cost choice for payers and consumers</td>
<td>29%</td>
</tr>
<tr>
<td>Centralization of administrative/operational functions (e.g., shared physician office functions, shared IT)</td>
<td>27%</td>
</tr>
<tr>
<td>New partnerships/affiliation/merger to achieve economies of scale</td>
<td>24%</td>
</tr>
<tr>
<td>Service rationalization (e.g., fewer heart surgery programs)</td>
<td>7%</td>
</tr>
<tr>
<td>Asset rationalization (e.g., fewer or smaller facilities)</td>
<td>5%</td>
</tr>
</tbody>
</table>

*What have you identified as the greatest opportunities to achieve savings, either directly or through utilization impacts, over the next three years?*
Strategies for Clinical Performance Improvement

- Let clinicians lead
- Quantify cost, but focus on quality
- Build multi-disciplinary teams centered on conditions, not procedures
- Define a common vocabulary
- Insist on evidence and appropriateness
- Account for patient preferences and needs
Business Office Performance Also Critical

Contract & Risk Management
Be Clear About Organizational Ability

How could the following impact your organization’s ability to accept risk in a value-based contract?

- Analytical Support (BI and/or actuarial competency)
- Consistent Measures for Care Quality
- Patient-Level Monitoring of Regimen Adherence
- Encouraging Patient Engagement
- Reduced Complexity of Payment Designs
- Defined Clinical Value for the Clinician
- Access to an All-Payer Claims Database
- Defined Economic Value for the Clinician
- Neutral Mechanisms Connecting Providers and Payers by Market

= High Impact

= Very High Impact
Consider Organizational Structures That Can Help Achieve Goals

- **Low Degree of Integration**
  - Affiliation
  - Collaborative
  - Management Services Agreement
  - Sale of Minority Interest
  - Joint Operating Agreement
  - Sale of Controlling Interest

- **High Degree of Integration**
  - Change of Corporate Member
  - Merger
  - Consolidation
  - Sale/Acquisition

- **Less Than Fully Integrated**
- **Fully Integrated**

Source: Kaufman Hall
Find Willing Partners: Bellin Health

• **What They Saw:**
  – Self-funded and fully insured employers seeking a full spectrum of products (P4P to shared savings) to improve the value of care.

• **What They Did:**
  – Enter into shared savings agreements where:
    ▪ A long-term contract is in place
    ▪ A willing partner looks at and responds to data
    ▪ A willing partner innovates with Bellin on plan design and health and healthcare solutions (Note: Bellin does *not* require employer exclusivity)
What Is Your Value Proposition?

• Be clear about what sets (or should set) your organization apart
• Focus your efforts on maintaining your advantage or achieving your goal
• Improve value delivered to care purchasers—and communicate value improvements
Questions?

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