

Should My Healthcare Organization Accept a Value-Based Payment Opportunity?



NATIONAL
RURAL HEALTH
RESOURCE CENTER

May 2021



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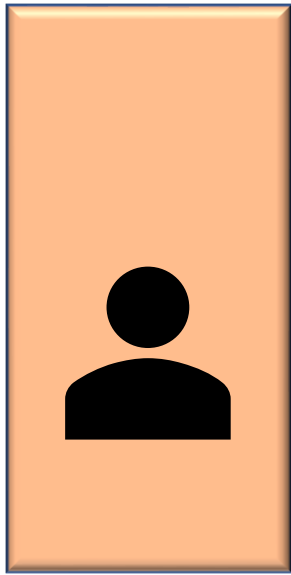
This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award with 100% funded by HRSA/HHS and \$0 amount and 0% funded by non-government sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by HRSA/HHS, or the U.S. Government.

Considerations for Today

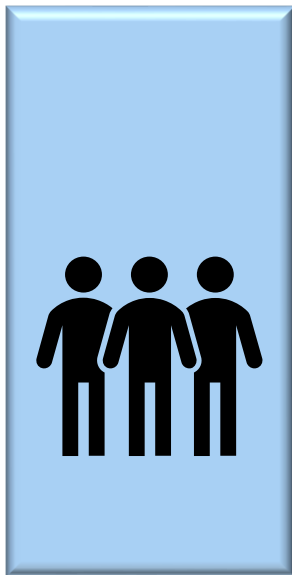
- “If I’m offered a value-based payment contract, should I sign it?”
- Corollary – “If a value-based payment system is forced upon me, what should I have done to prepare for it?”



Triple Aim



Better patient care



Improved community health



Smarter spending



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Triple Aim Leads to *Value*

$$\text{Value} = \frac{\text{Quality} + \text{Experience}}{\text{Cost}}$$

But we have a problem...

The Value Conundrum

You can always count on Americans to do the right thing – after they've tried everything else.

- Fee-for-service
 - Capitation
 - Market
 - Single payer
- **What about paying for healthcare value?**



(If Churchill didn't say it, he should have!)

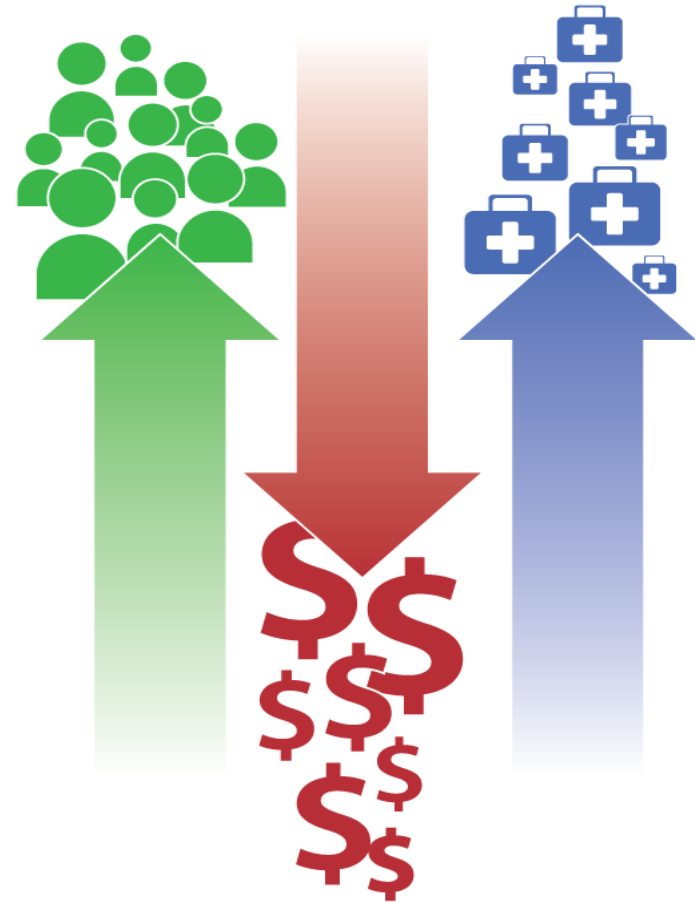
The Nuances of *Value*

- More than the Triple Aim
- More than a quick equation
- A nuanced concept
 - What is value?
 - Whose perspective?
 - How to prioritize?
- Perfect is the enemy of good.
- The *volume-to-value* transition should continue.



Value-Based *Payment*

- **Payment** for one or more parts of the Triple Aim
- Not payment for a *service*; that is, not fee-for-service
- Historic emphasis on cost reduction (with hopes that better care and improved health tag along)
- Emphasis unlikely to change with new administration

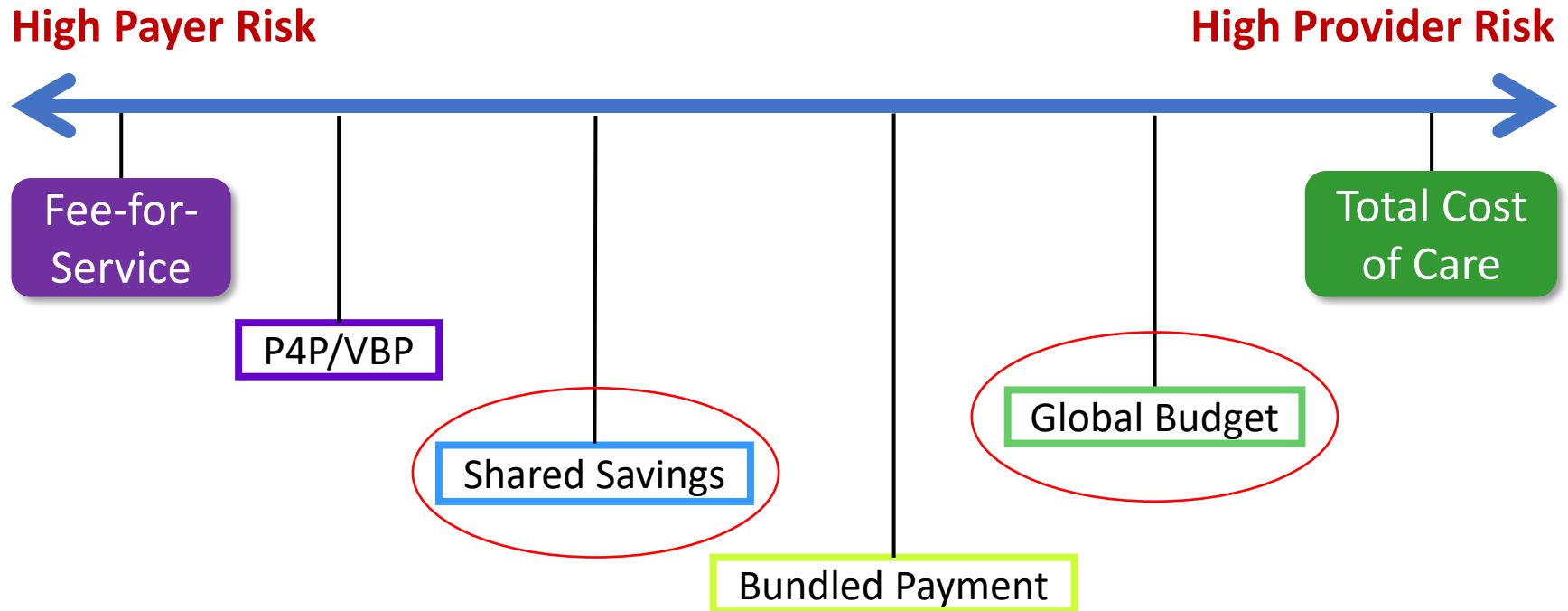


Form Follows Finance

- How we deliver care depends on how we are paid for care.
- Payment reform involves **transfer of financial risk** from payers to providers.
- Decisions require cost/benefit analysis, or **RISK assessment**.
- Consider a financial risk continuum.



Financial Risk Continuum



Accountable Care Organizations

- Groups of providers (generally physicians and/or hospitals) that receive financial rewards to maintain or improve quality of care for a group of patients while reducing the cost of care for those patients.
- CMS's largest value-based payment program
- Accountable Care Organizations
 - > 1,000 public and private ACOs
 - ~ 33 million patient enrollees
 - 477 Medicare ACOs (January 2021)
 - Nearly 30% of Medicare FFS beneficiaries are served by an ACO.



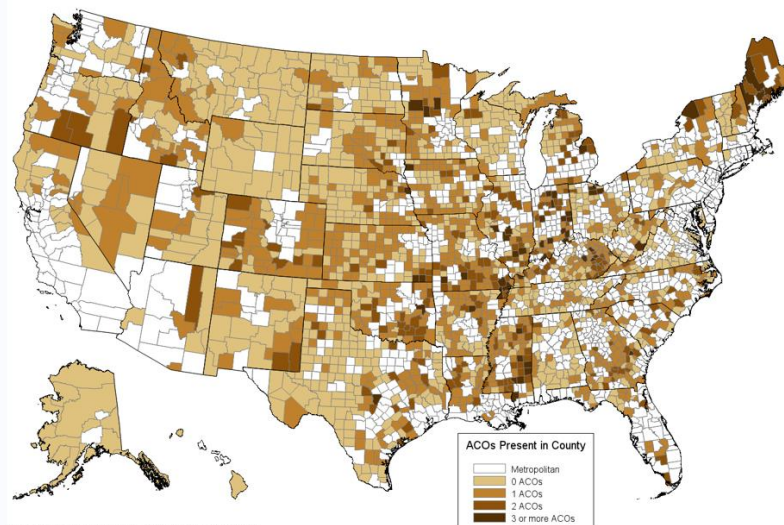
<https://www.healthaffairs.org/doi/10.1377/hblog20200110.9101/full/>

Shared Savings Plans (ACOs)

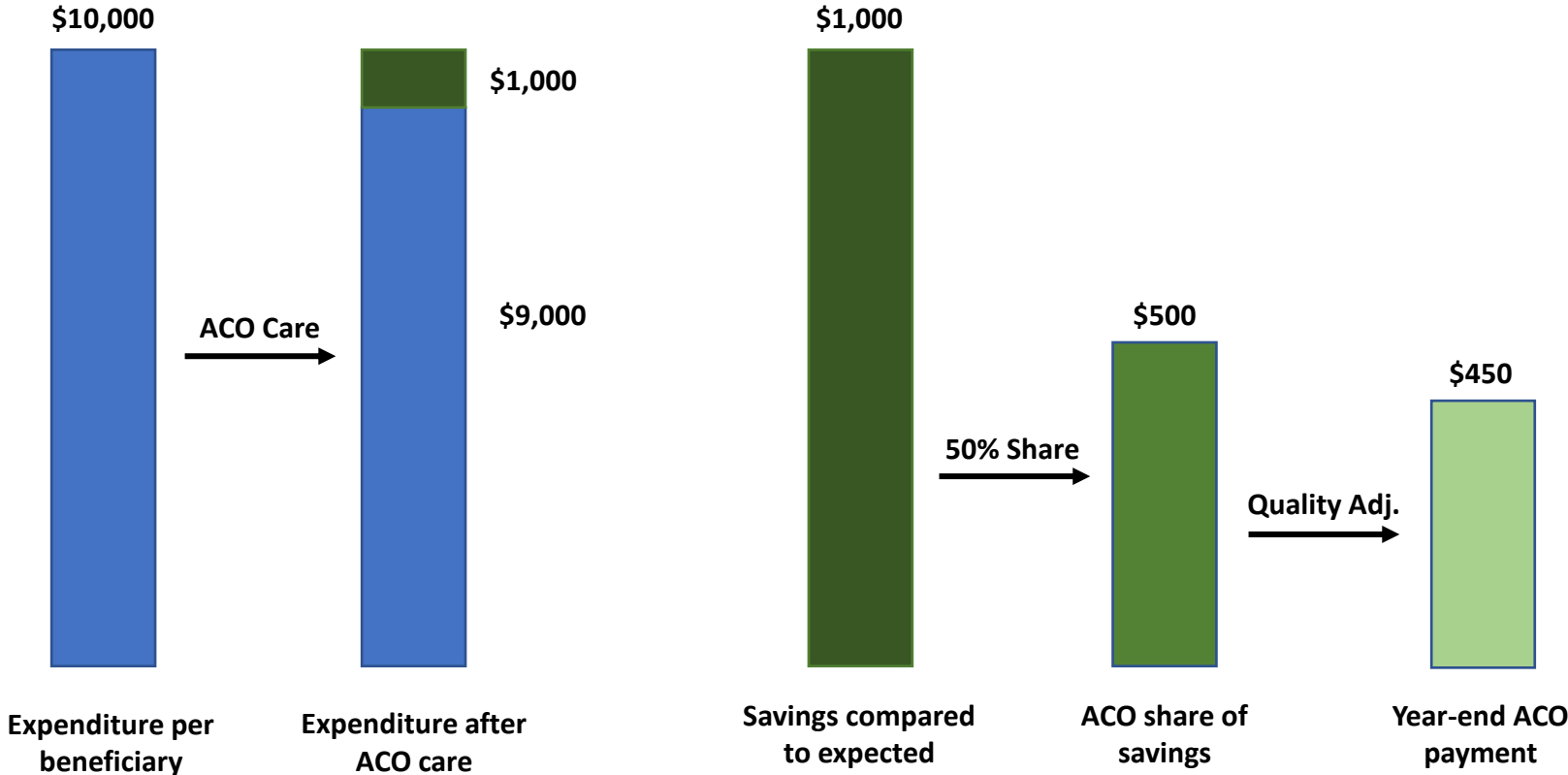
- Cost-savings and quality performance required
- CMS **shares savings** (if any) with the ACO.
- Quality measures assess outpatient care (not hospital care!).
- Patients are attributed to ACO through primary care visits.

Accountable Care

Medicare ACO Presence, Nonmetropolitan Counties: 2018



Shared Savings Methodology



ACO Benefits

- A toe in the value-based payment water
- A learning opportunity
- *Relatively* low financial risk
- Do it for the data!
- Still a fee-for-service platform
 - Volume-driven
 - Shifts care to less expensive providers



ACO Risks

- Some upfront investment – consider this an R+D cost.
- Down-side shared risk is increasingly prevalent.
- Value-based care requires:
 - Financial risk management
 - Population health management
 - Data analytic capacity
- Primary care engagement is critical for success.
 - Outpatient quality measures
 - Patient attribution via primary care visits
 - Physicians determine site of care (AKA cost of care!).

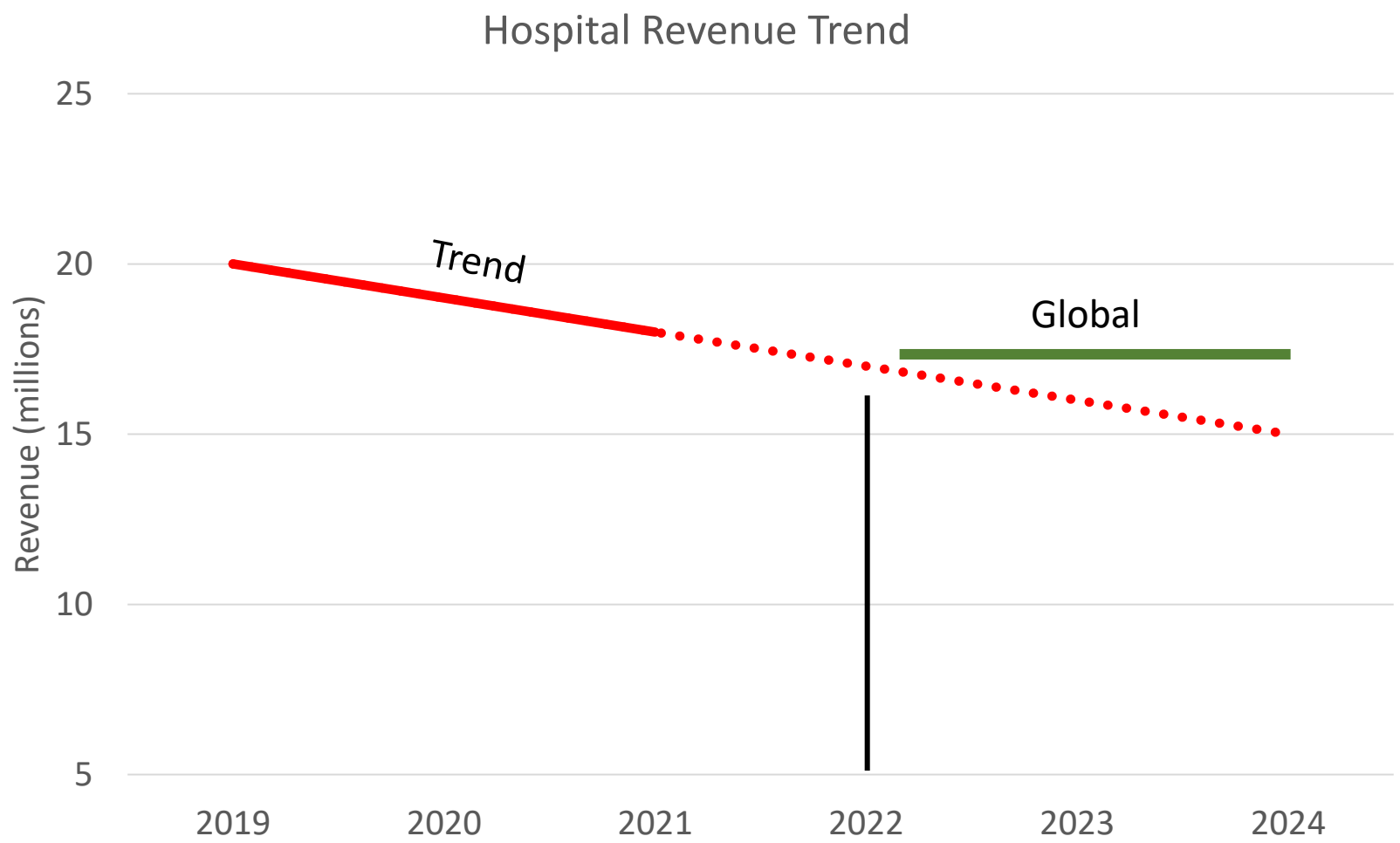


Hospital Global Budget

- A fixed amount is paid to hospital per time period.
- Amount does not vary by the number of services provided.
- Allows health maintenance focus instead of illness treatment focus.
- Current CMMI models
 - Maryland TCOC Model
 - Pennsylvania Rural Health Model
 - Community Health Access and Rural Transformation (CHART) Model – pending



Revenue Trend vs. Global Budget



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Global Budget Benefits

- Financial “breathing room”
- Appropriate if:
 - Downward revenue trend
 - Declining population
 - Financially distressed hospital
- Likely *not* appropriate for organizations with upward revenue trend
- Requires candid pro forma regarding price trends and volume predictions



Global Budget Risks

- Risk of *increased* volume/costs
- Global budget locks in historic revenue, but risks remain:
 - Reducing costs remains difficult
 - Future budget adjustments unknown
- Still requires coded claims for risk-adjustment, co-pays, and quality assessment
- Note: Many hospitals are *already at financial risk*.
- The status quo is not risk-free.



Back to Today's Considerations

- “If I’m offered a value-based payment contract, should I sign it?”
- Corollary – “If a value-based payment system is forced upon me, what should I have done to prepare for it?”



Your Value-Based Payment To-Do List

- *Start here:* Assess your capacity to deliver value-based care.
- Resource: [Value-Based Care Assessment Tool](#)

Five Tasks

1. Assess financial risk.
2. Engage physicians.
3. Expand community care coordination.
4. Embrace interdependence.
5. Understand culture change.



1. Assess Financial Risk

- The concept of *risk* – upside and downside
- Loss aversion concept – an irrational human bias
- Fixed/variable cost ratio impact on value-based payment profit
- Pro formas and sensitivity analyses
- Informed and honest assessment
- Resource: [Critical Access Hospital Financial Pro Forma for Cost Reimbursement](#)



2. Engage Physicians

Proactive physician involvement and meaningful physician influence that lead the organization toward a shared vision and a successful future.

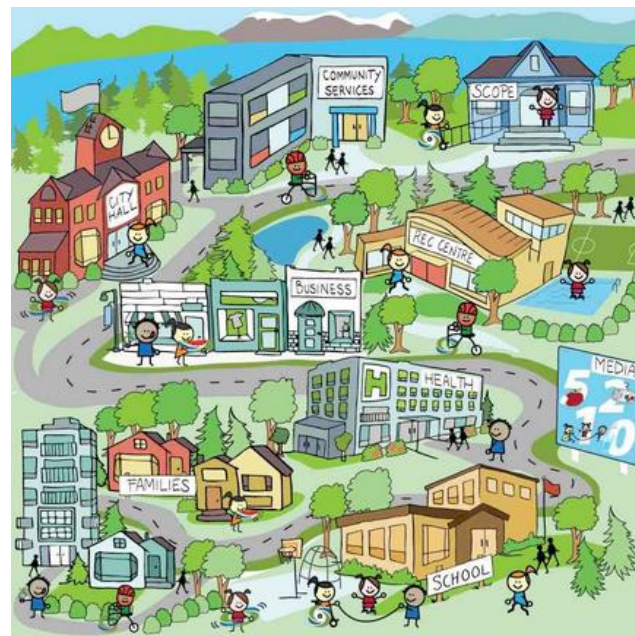
- Physician employment does not necessarily ensure physician engagement!
- A *cultural* phenomenon
- **Trust**
- Resource: [Physician Engagement – A Primer for Healthcare Leaders](#)



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3. Expand Community Care Coordination

- More than discharge planning or utilization review
 - Right care, right time, right place – and no duplication
 - Community-based organizations
 - Person-centered medical home
 - Data analytics
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- Resource: [Community-Based Care Coordination: A Comprehensive Development Toolkit](#)



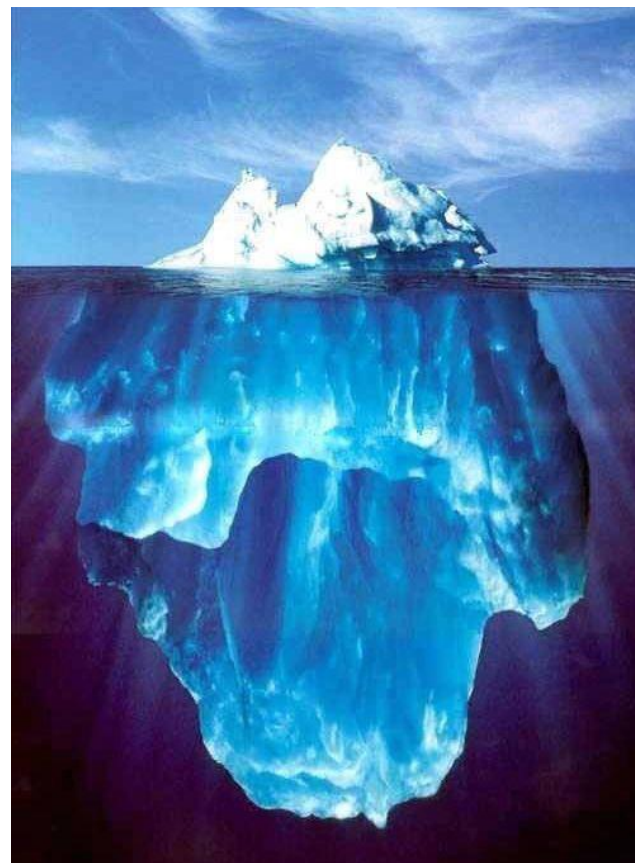
4. Embrace Interdependence

- Small size and fewer resources is a barrier to participation
- Economies of scale
- Analytic and managerial infrastructure
- Global budgets change competition focus
- However, M&A is not the only way to interdependence
- Resource: [Enlightened Interdependence](#)



5. Understand Culture Change

- A new healthcare culture
 - From volume to value
 - From sickness to health
- **What we *do* becomes what we *believe*.**
 - Personal behavior
 - Governance behavior
 - Organizational behavior
- The *volume-to-value* transition
 - Exciting managerial challenge
 - Aligns incentives
 - Best for what matters



Healthy Communities



Collaborations to Spread Innovation

- ✓ Rural Health Value Project
<https://ruralhealthvalue.org>
- ✓ Rural Policy Research Institute
<https://www.rupri.org>
- ✓ The National Rural Health Resource Center
<https://www.ruralcenter.org/>
- ✓ The Rural Health Information Hub
<https://www.ruralhealthinfo.org/>
- ✓ The National Rural Health Association
<https://www.ruralhealthweb.org/>
- ✓ The American Hospital Association
<https://www.aha.org/front>

