# Minding the Gap!

## Managing the Challenging Transition from Fee For Service to Value-Based Care

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# Today's Agenda

- Where are We Now & How Did We Get Here?
- Value-based Care (VBC) Displaces Fee-For-Service (FFS)
- Understanding Provider Value-based Contracts & Risk Types
- Defining and Minding the FFS-VBC Gap
- VBC Success Factors
- Key Takeaways

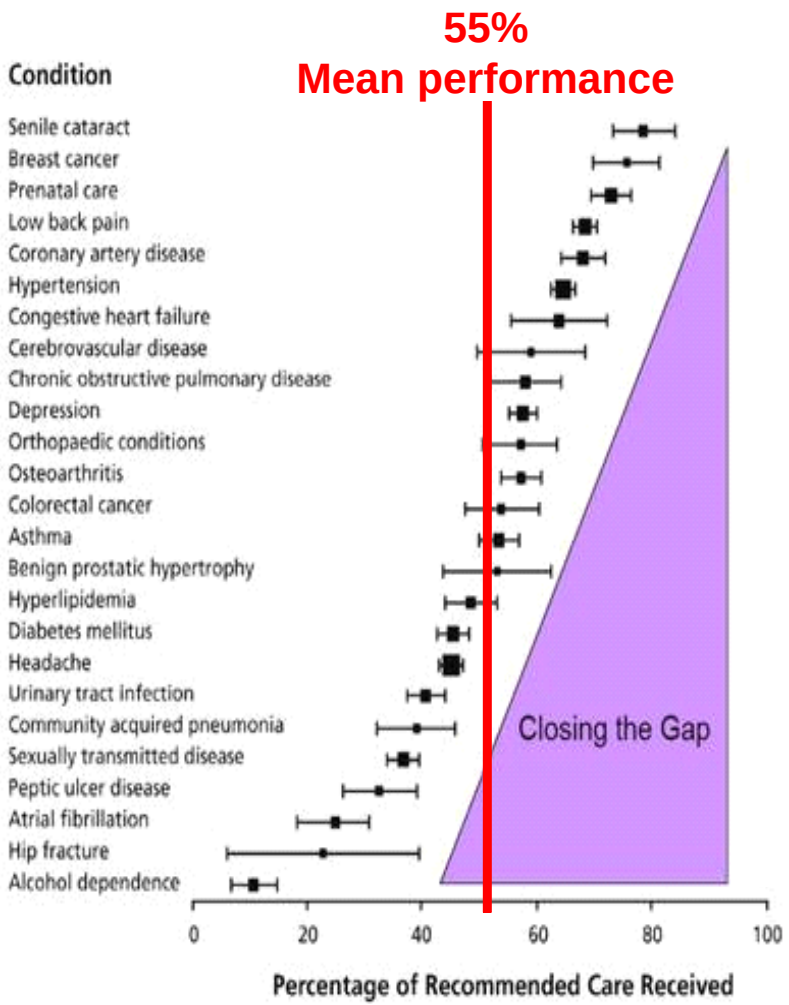
# The Value Problem

Fundamental healthcare challenge for providers, for consumers, for payers, and for society at large

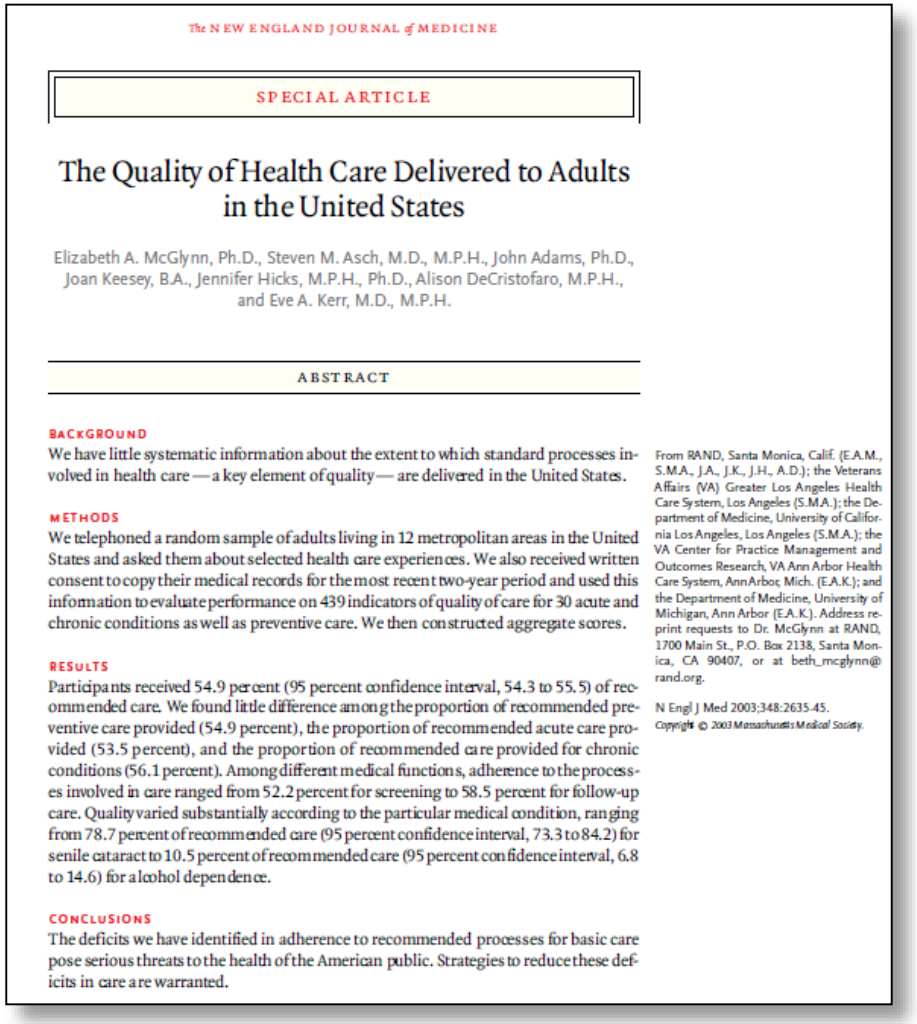
- There are serious disparities between the **care we should receive** and the **care we actually receive** (McGlynn, NEJM 2003)
- Healthcare **quality & safety** are far from best among OECD countries
- **U.S. healthcare cost** is the highest – >2% higher than CPI or GDP (4.8% trend in 2016)
- **Quality gaps** abound, **clinical inertia** is commonplace, **diffusion of best practices** notoriously slow
- **Variation in cost and quality** are widely present across geographies, all system types and maturities
- Not unexpectedly, we now face a **value mandate** from consumers, employers, govts

# Value Problem Example 1

"Coin Toss Healthcare"




**"Our results indicate that on average, Americans receive about half of recommended medical care processes."**



The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

## The Quality of Health Care Delivered to Adults in the United States

Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D., Joan Keesey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H., and Eve A. Kerr, M.D., M.P.H.

ABSTRACT

BACKGROUND
We have little systematic information about the extent to which standard processes involved in health care — a key element of quality — are delivered in the United States.

METHODS
We telephoned a random sample of adults living in 12 metropolitan areas in the United States and asked them about selected health care experiences. We also received written consent to copy their medical records for the most recent two-year period and used this information to evaluate performance on 439 indicators of quality of care for 30 acute and chronic conditions as well as preventive care. We then constructed aggregate scores.

RESULTS
Participants received 54.9 percent (95 percent confidence interval, 54.3 to 55.5) of recommended care. We found little difference among the proportion of recommended preventive care provided (54.9 percent), the proportion of recommended acute care provided (53.5 percent), and the proportion of recommended care provided for chronic conditions (56.1 percent). Among different medical functions, adherence to the processes involved in care ranged from 52.2 percent for screening to 58.5 percent for follow-up care. Quality varied substantially according to the particular medical condition, ranging from 78.7 percent of recommended care (95 percent confidence interval, 73.3 to 84.2) for senile cataract to 10.5 percent of recommended care (95 percent confidence interval, 6.8 to 14.6) for alcohol dependence.

CONCLUSIONS
The deficits we have identified in adherence to recommended processes for basic care pose serious threats to the health of the American public. Strategies to reduce these deficits in care are warranted.

From RAND, Santa Monica, Calif. (E.A.M., S.M.A., J.A., J.K., J.H., A.D.); the Veterans Affairs (VA) Greater Los Angeles Health Care System, Los Angeles (S.M.A.); the Department of Medicine, University of California Los Angeles, Los Angeles (S.M.A.); the VA Center for Practice Management and Outcomes Research, VA Ann Arbor Health Care System, Ann Arbor, Mich. (E.A.K.); and the Department of Medicine, University of Michigan, Ann Arbor (E.A.K.). Address reprint requests to Dr. McGlynn at RAND, 1700 Main St., P.O. Box 2138, Santa Monica, CA 90407, or at beth_mcglynn@rand.org.

N Engl J Med 2003;348:2635-45.

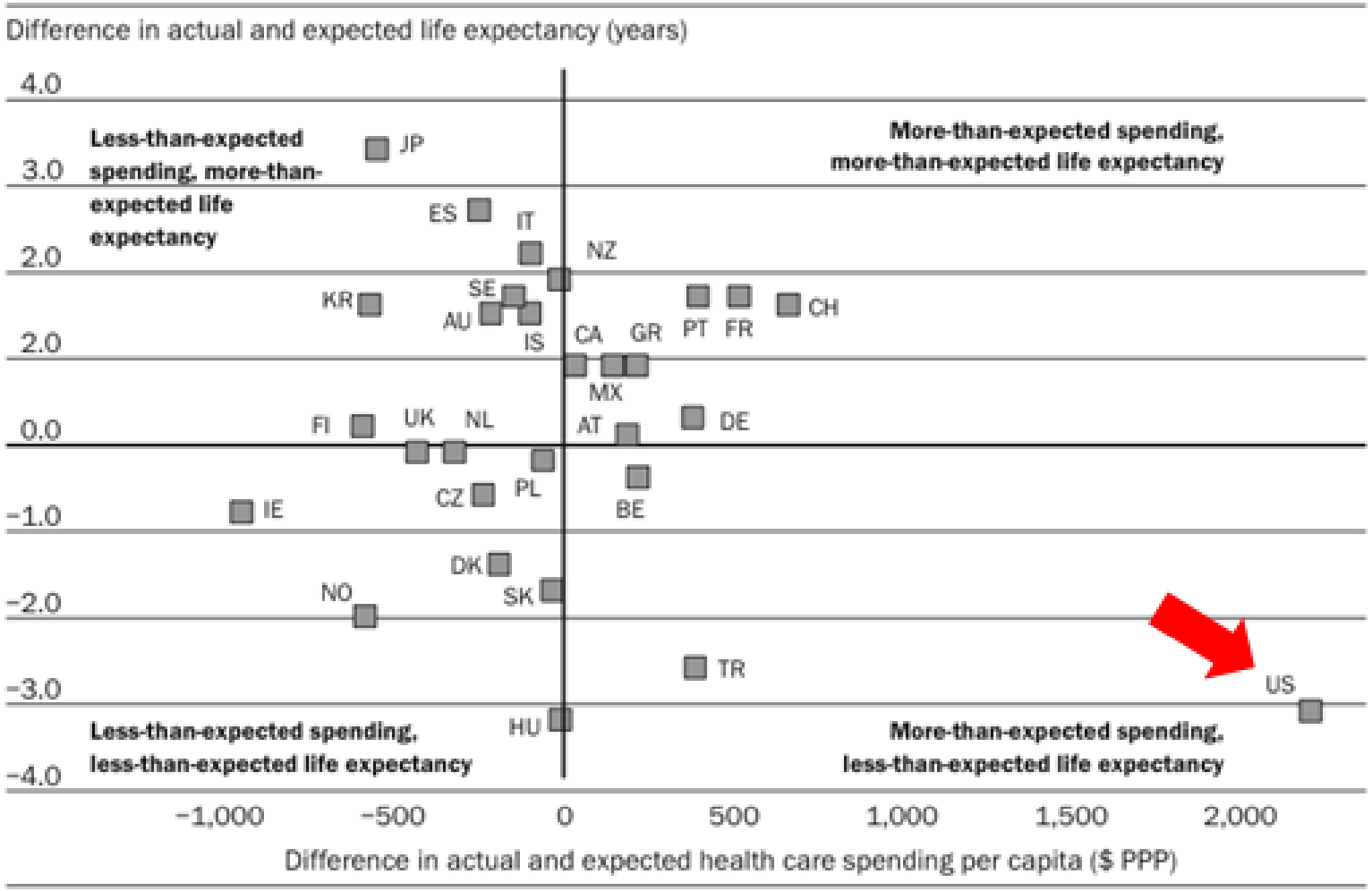


McGlynn EA et al. The Quality of Health Care Delivered to Adults in the United States *NEJM* 06-JUN -2003; 348(26): 2635-2645

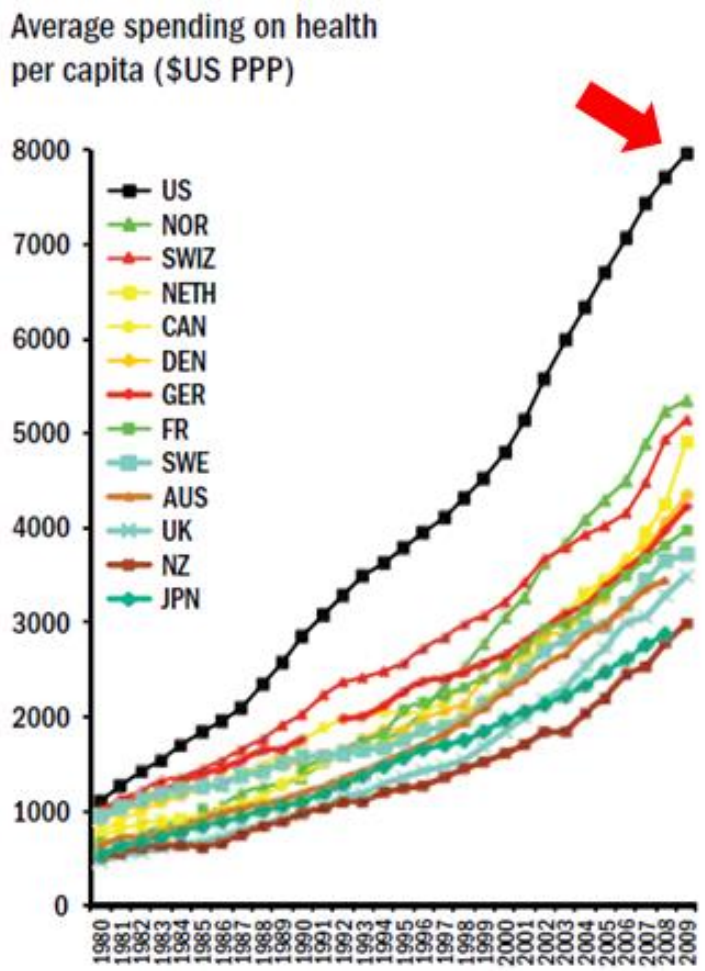
# Value Problem Example 2

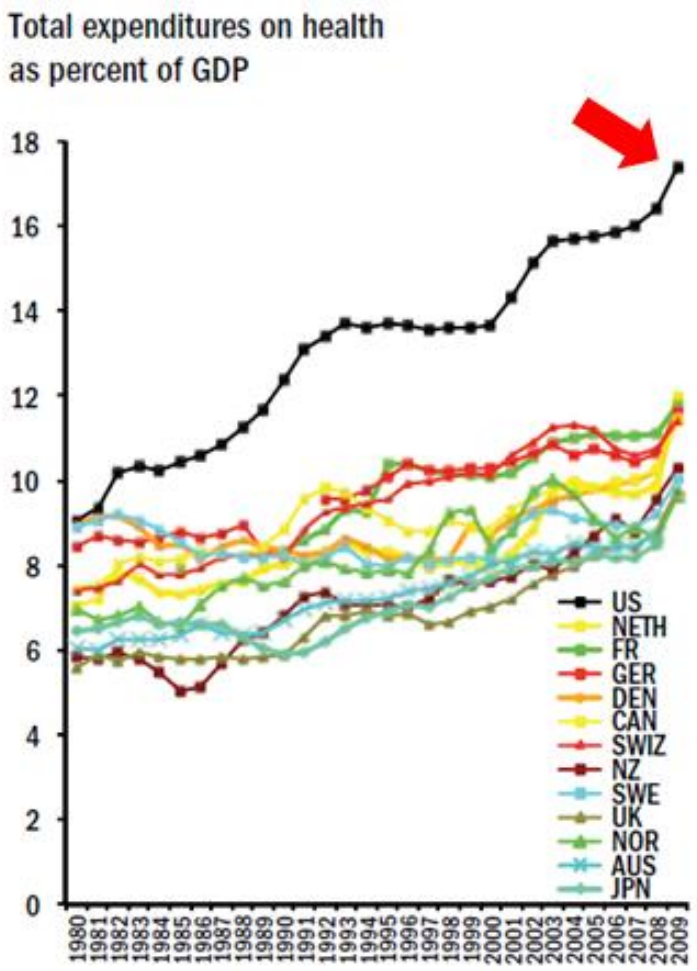
**Cost >> Quality**

**Difference Between Actual And Expected Health Care Spending Per Capita And Actual And Expected Life Expectancy In Organization For Economic Cooperation And Development (OECD) Countries, 2005**



# Value Problem Example 3




**Volume >> Value**

Note: PPP = Purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned.
Source: OECD Health Data 2011 (Nov. 2011).

# How Did We Get Here?

A healthy healthcare system requires a balance of Specialization and Integration

## Specialization

- Reductionist
- Cartesian view
- Essence defined by parts (machine)
- Scientific method
- Chemistry, physics
- Organ-centric care
- Disease focus
- Curing orientation
- Fragmenting

## Integration

- Holistic
- Aristotelian view
- Whole is greater than sum of parts
- Systems theory
- Complexity, chaos
- Pt-centered care
- Health focus
- Prevention orientation
- Defragmenting

# Driver #1: Yin of Specialization >>> Yang of Integration

Perceived rewards of specialization > those for integration of care delivery

## Specialization

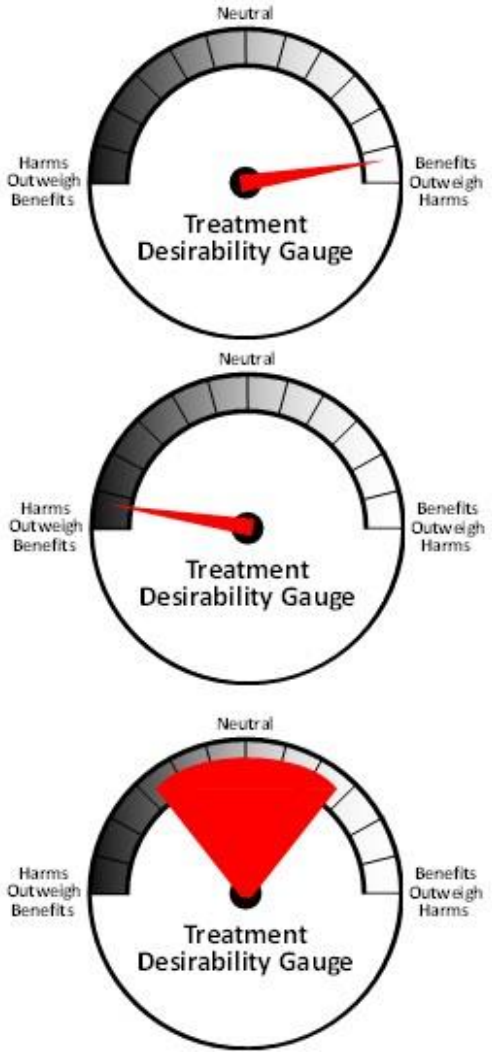
- Uncoordinated care
- Process focus
- Navigation hard
- Continuity lacking
- Limited data exchange
- Waste, duplication
- Curing vs. caring
- Volume-based pay
- Incentives to do more

## Integration

- Teamwork
- Systems of care
- Triple Aim +2
- Care transitions
- EMR, PHR, HIE
- Medical homes
- Participatory care
- Cost-effectiveness
- Value-based pay
- Incentives to do better

# Driver #2: Most Medical Care is Discretionary

Medical science lags far behind medical practice




**Treatment Desirability**

**"White Zone"**

- Compelling evidence supporting
- Consensus of evidence-based CPGs
- Minimal variation in clinical practice
- Meets health plan "medical necessity"
- Benefits outweigh harms

**"Black Zone"**

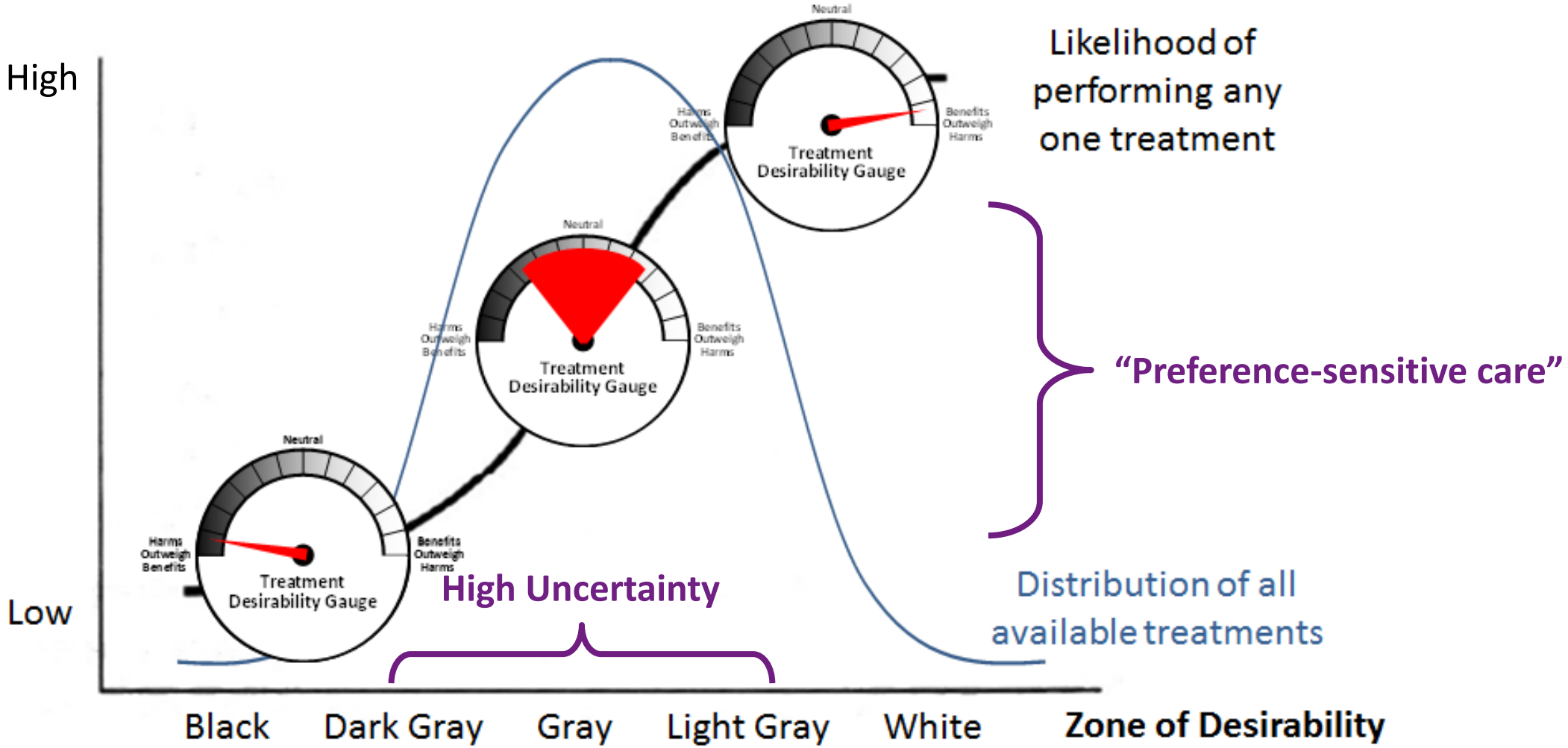
- Compelling evidence opposing
- Consensus of evidence-based CPGs
- Minimal variation in clinical practice
- Health plans view as experimental
- Harms outweigh benefits

**"Gray Zone"**

- Too little or contradictory data
- Lack of evidence-based CPGs
- Investigational studies ongoing
- Large regional variation in clinical practice
- Neutral, ambiguous, subjective

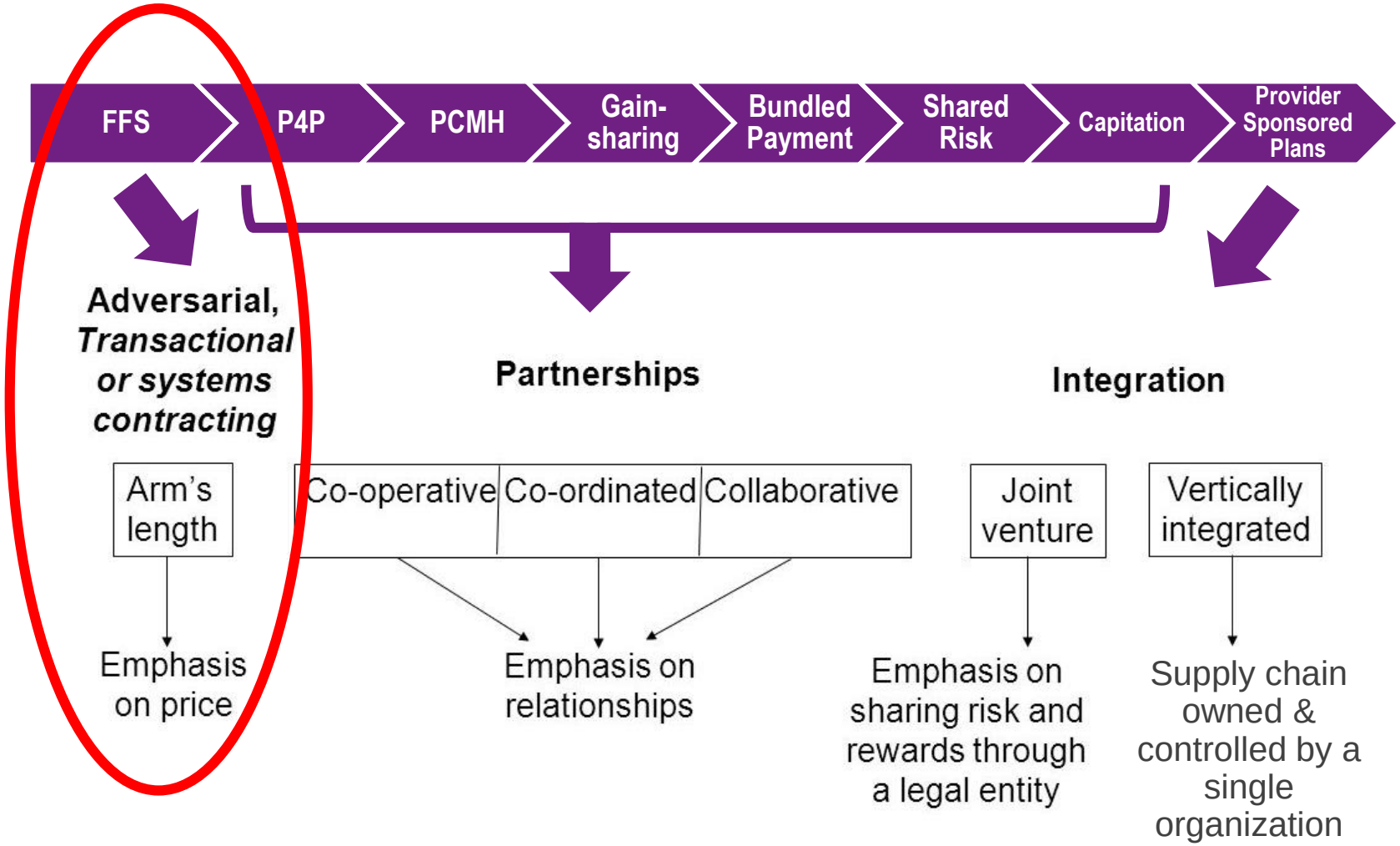
# Driver #2: Most Medical Care is Discretionary

Treatments in the Gray Zone Have higher variation



# Driver #3: FFS Reimbursement System

Reimbursement sets tone of Payer-Provider relationships



# From Zero-sum FFS Game to Aligned Interests for VBC

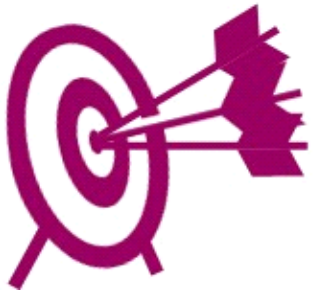
## What employers want

- Better cost efficiency
- Limit HCC trend (CPI+1?)
- Higher quality, reliability
- Better experience of care
- Simpler care navigation
- Better care coordination

## What providers want

- Fair pay
- Consistent quality
- Less burnout, more control, work-life balance
- Happier patients
- Less 3rd party regulation

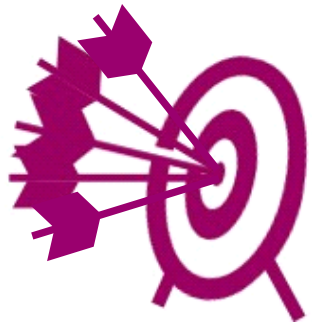
**Value-based Care**



- ✓ Improved cost
- ✓ Improved patient outcomes
- ✓ Improved patient experience

## What patients want

- Transparent cost & quality info
- Easier navigation of ecosystem
- Better coordination of care
- Good service, good outcomes
- Caring health providers



- ✓ Improved cost
- ✓ Improved Pt. outcomes
- ✓ Improved Pt. experience
- ✓ Improved Provider satisfaction
- ✓ Prov. financial stability

# Game Theory Example

Consider the following market scenarios

Given:

- Two systems control 100% of the healthcare dollars: System A and System B
- Equally sized – each system has 50% market share
- Equal in terms of cost, quality, member satisfaction, system profitability, etc.
- Simple point in time example – each system can select either FFS or VBC (value-based care)

Consider what happens to the payouts and incentives under two scenarios:

- **No External forces** – the market is stable, there is no other movement pushing the market
- **With External forces** – these forces are akin to today's situation which push the incentives away from FFS and towards VBC
  - High healthcare trends
  - Increased consumer focus on cost efficiency
  - Better technology and data causing improved market transparency
  - CMS push towards value-based care
  - Employer demand for population health and lower cost trends
  - Etc.

# Point in Time Game Theory Example – Illustrative Incremental Business Margins

## No External Forces

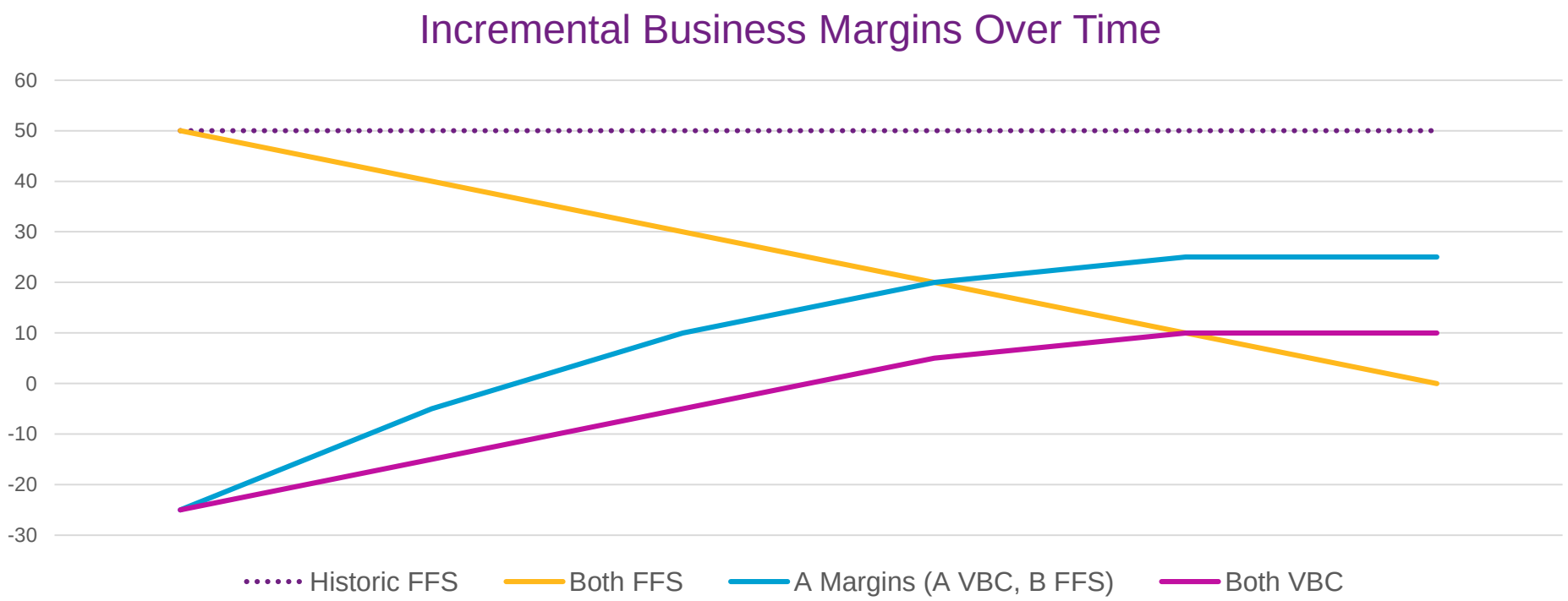
| | | System B | |
|---|---|---|---|
| | | FFS | VBC |
| System A | FFS | +50, +50 | -25, +25 |
| | VBC | +25, -25 | +10, +10 |

## With External Forces

| | | System B | |
|---|---|---|---|
| | | FFS | VBC |
| System A | FFS | 0, 0 | -50, +25 |
| | VBC | +25, -50 | +10, +10 |

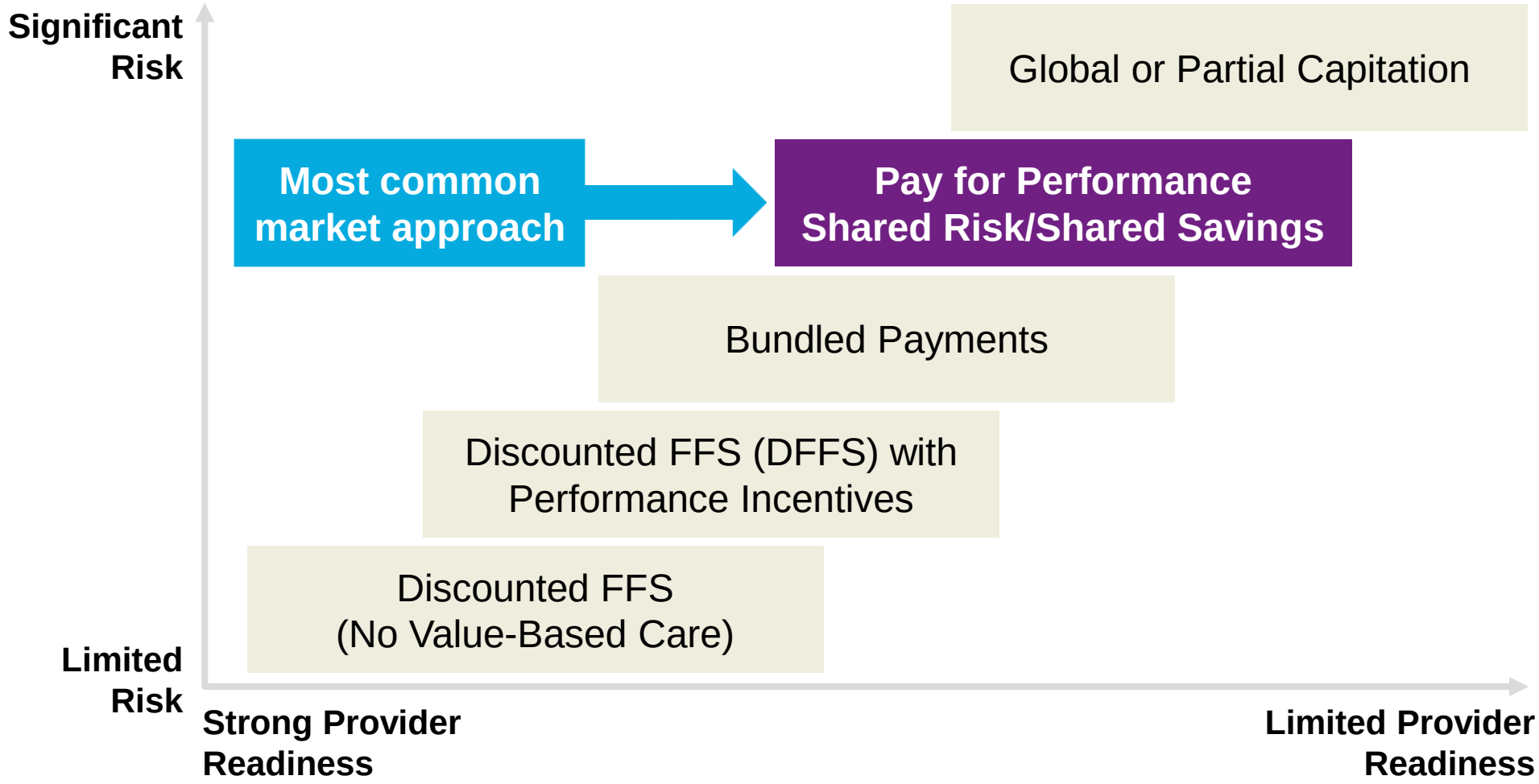
- With **no external forces**, systems are incentivized to stay in a FFS environment
- With **external forces**, systems are becoming incentivized to move to VBC, with the first movers able to capture market share and economic advantages
- In this frictionless environment, systems might “jump” to VBC today, however this transition is far from frictionless
- Let’s consider the same market dynamics and external forces but look at a multi-year view with more realistic profit trajectories over time

# Game Theory Multi-Year Example




- Historic FFS profit margins are likely not sustainable, regardless of choice
- Moving to VBC creates losses in early years, however, the long term outcome is better than FFS
- If one system moves to VBC first, it gains an early advantage that could become permanent
- Actual market dynamics will cause these results to vary considerably, this is why system level financial modeling is essential for each instance

# Progression of Value-Based Contract Risks in the Market



# Primary Risk Categories in Value-Based Contracts

## Contract Risk

Risk that the contract structure and targets do not sufficiently represent the costs required to provide the outlined services for the covered population and/or provide adequate protection against variables impacting costs that are outside of the health systems control.

- Are initial cost targets appropriate? Are the risk adjustment mechanisms sufficient? Is attribution method appropriate? Is there sufficient catastrophic claim protection relative to the size of the attributed population?

## Performance Risk

Risk that system will not achieve targeted quality metrics, clinical efficiencies and cost controls included in the contract.

- Benchmark current performance against market norms and best practice to understand potential for hitting targets and achieving savings.
- Identify network or contracting gaps that limit savings opportunities.

## Large Claims and Medical Expense Risk

Risk that large claims, random claim cost variability or new treatments, outside of the health systems control, will adversely affect measured performance.

- Do the contracts contain sufficient reinsurance provisions relative to the size of the covered population and the systems risk tolerance?
- Does contract have language protecting against new treatments or pandemics that would impact target costs?

# Quantifying the Risk Assumed in Value Based Contracts

## Model Individual Contract and Overall System Risk

Financial modeling is essential to understanding the impact that risk and volatility of value-based contracts will have on overall health system performance.

Simulate system-level revenue and margin under different market scenarios to understand the true impact of value-based contracts on total revenue and margin.

- Helps to understand the most significant risks to the system in order to add protections within the contracts, if feasible
- Helps to identify risk to system-level risk and financial returns of entering into the value-based contracts

As the exposure to value-based reimbursement increases, it is vital for health systems to understand:

- The total and marginal revenue impacts to the health systems current reimbursement on value-based contracts
- The potential downside risk assumed in any individual value-based contracts
- The potential financial exposures assumed across the health systems portfolio of value-based contracts

**Systems need to have mechanisms in place to quantify their risk exposures and mitigate risk to tolerable levels while aggressively transforming care to optimize their risk/reward positions.**

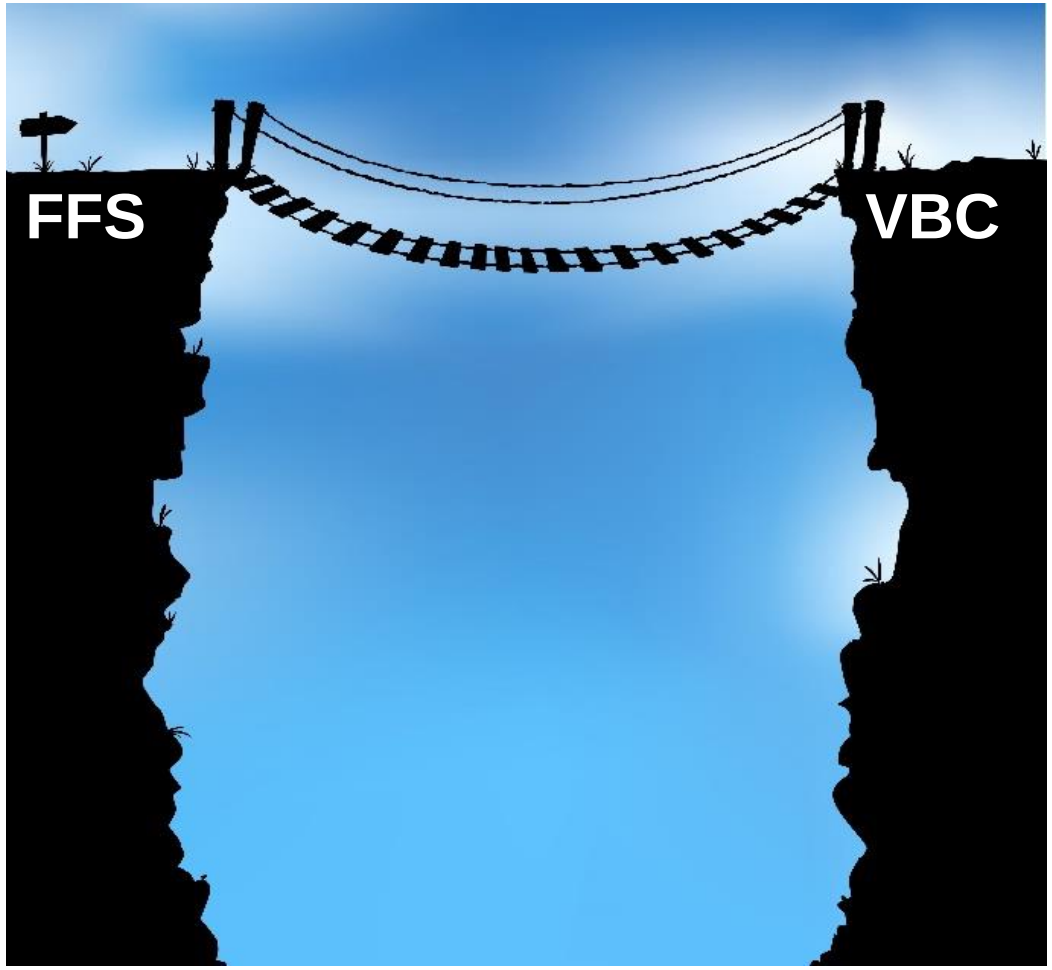
# A Useful Metaphor from the London Underground






# Revenue Challenge of FFS-VBC Gap

- Between proficiency and profitability managing health care under FFS and under VBC reimbursement lies a period of time when providers must **cope with both** paradigms simultaneously
- This creates an **awkward gap period** that must be proactively managed
- Simultaneously unlearning old FFS habits, designs, & operating processes while learning and implementing new VBC models, processes is **challenging, complex,** and **confusing** for all stakeholders
- This transformation must be viewed as a long-term destination and the full transition will take considerable time – quarter-over quarter **conventional KPIs** will not be a reliable gauge of eventual success or failure

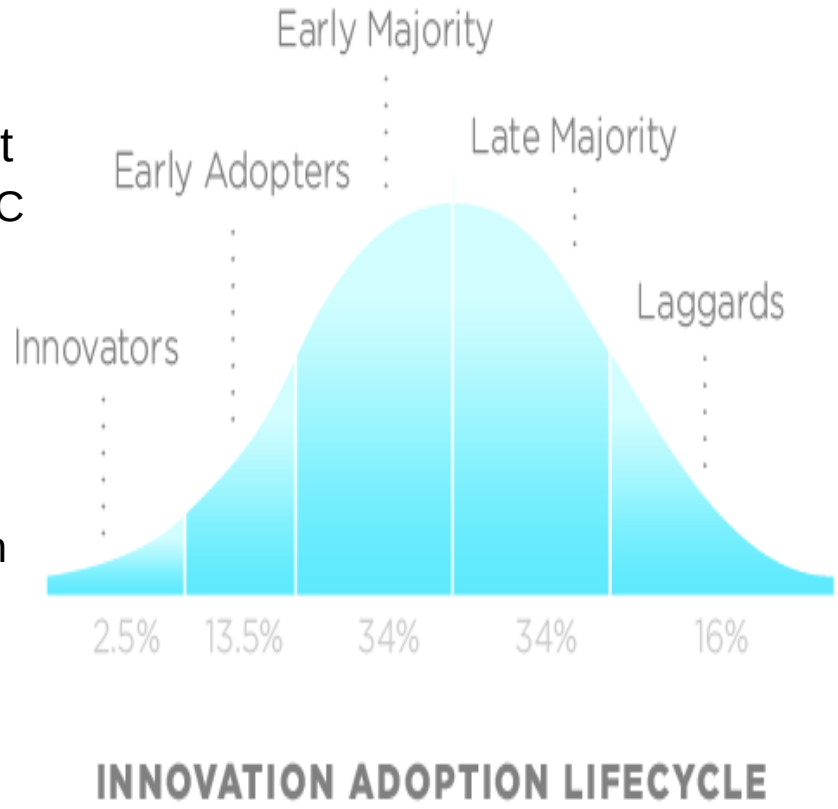


# Timing & Pacing the VBC Transformation

- **Start too soon** – leave potential FFS revenue on the table
- **Start too late** – may not have desirable seat at local VBC table when finally ready
- **Move too quickly** – may overlook critical competencies, talent, infrastructure needed for success
- **Move too slowly** – may cede market share to more advanced local competitors
- **Proceed alone** – bear substantial design and execution risk alone
- **Proceed with partners** – must be very strategically aligned to navigate differing priorities and coordination challenges
- **Proceed with advisors** – choose those who understand the VBC landscape, purchaser demands, and other stakeholder responses
- **Delay, defer decisions** – avoids gap issue, but VBC train may leave station without you

# Strategies for Minding the Gap by Early Adopters

- Grow **market share** via wholesale and retail strategies
  - COEs, HPNs, ACOs, destination care for large employers (“magnet care”)
- Use workforce as **domestic laboratory** for early learning, refinement
  - Self-insured employers gain immediate financial returns from domestic VBC
- Embrace **consumerism** in parallel with **standardization**
  - Triple Aim transparency is key for attracting B2B & B2C business
- Master **population health** competencies
  - Team-based primary care delivery models (PCMH)
  - Clinical pathways, decision support, patient engagement, early intervention
- Perfect **seamless transition handoffs** across continuum of care
  - Key to reducing avoidable readmissions, ER visits, excessive LOS
- Use **data analytics** to identify gaps & perfect care model over time
  - Don’t assume good data ➡ good reports ➡ clinical insights ➡ VBC behavior
- **Culture, leadership, incentives** matter more than ever
  - Fundamentals significantly impact provider engagement and behavior



# Geisinger Health Systems' Gap Formula

- Develop systems, processes, incentives, and disciplines to support high reliability Triple Aim care
- Affiliate/acquire/connect smaller hospitals and providers in catchment area and develop extensive urgent care network throughout
- Secure destination care status from Fortune 50 employers (Walmart)
- Master transitions of care to offer bundled cardiac, ortho, high risk maternity COE services
- Offer "warranty care" to payers and directly contracting employers
- Develop embedded population health resources and processes within an advanced medical home primary care delivery model
- Review benchmarked Triple Aim performance data monthly with all members of medical home teams
- Provide anticipatory guidance to all scheduled patients prior to visit to fill gaps in care, order labs/imaging in advance, optimize visits
- Form collaboratives with like-minded systems to share VBC learnings

# Ask Yourself: As a Provider of Healthcare, Does Your Future Success Rely On…

- Not reducing the 30% of healthcare expenditures considered by healthcare experts to be waste?
- Sticking on what has worked in the past and not innovating to improve outcomes, cost, & experience of care for all patients?
- Avoiding public transparency in cost, quality, and experience of care?
- Employing a defensive “moat” of referring MDs surrounding the institution to keep it solvent?
- Becoming too big or monopolistic to be carved out of high performance networks, regardless of measured performance?
- Relegating population health improvement to public health authorities and/or remote health plan staff and vendors?
- Viewing all care delivered outside your walls as somebody else’s problem?
- Relying entirely on specialty care excellence over primary care access and population health delivery model?
- Ignoring the value of the healthcare you deliver from the perspective of employers and consumers?

# If So, Then You Are NOT Minding the Gap Properly!

## (And Your VBC Success is Far From Assured)

# Value-Based Care Success Drivers Health Systems

## High Value Offering

1. A well articulated product/service offering with a compelling value proposition
2. An aligned, configured network to deliver on the value proposition
3. Contracting structure and terms that support the value proposition
4. Appropriately priced offerings, reflecting short- and long-term risk

## Target Market and Consumers

5. A clear, focused target market for value-based services
6. A holistic perspective on individual consumer behavior
7. A practical, flexible sales and marketing approach for value-based offerings

## Operating Platform to Deliver

8. A next generation integrated clinical delivery approach that achieves Triple Aim goals
9. A practical analytics and reporting approach to manage value-based operations
10. An efficient, expert financial structure to manage and mitigate risk

# With Great Planning & Teamwork, You Can Bridge the Gap

## But It Will Likely Require Stretch Efforts, Practice, and Time!

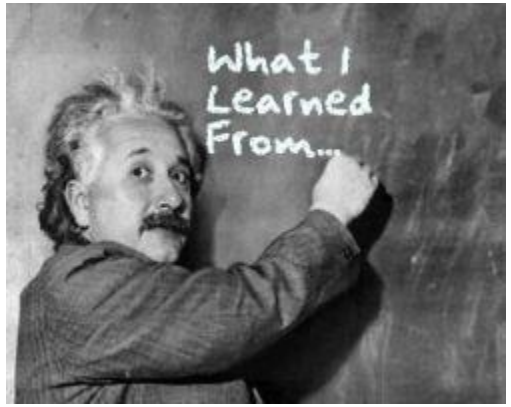
# Political Landscape and the Fate of VBC Evolution

***"It's tough to make predictions, especially about the future."***

- **Uncertainty** prevails about the extent to which this Administration and Congress will slow down or halt the progress to date on VBC movement
  - Many observers believe VBC mandate is supported by both parties and will continue
  - Congressional "sobering up" is emerging as majority realizes public acceptance is related more to the replacement than the repeal and they will own this
  - Other legislation besides ACA is driving this movement - MACRA had widespread bipartisan support in Congress
- Pundits have opined that the major "**repeal targets**" are Medicaid expansion, public exchanges, and Cadillac tax, not provider payment reform
  - However, the rapid pace and variety of CMS/CMMI alternative payment experiments may slow with shifting control from agencies to Congress
  - Conversion of early models to mandatory adoption may await stronger outcomes data showing which are performing consistently well
- With aging population, rising deficit, trends >>CPI or GDP, downward pressure on **health care cost inflation & better value** will not likely lessen
  - Healthcare cost inflation ~CPI+1% still seems a likely uniting goal for payers

# Key Takeaways

- It's taken a long time to make significant progress toward value-based care, and finally we are making meaningful headway
- Hopefully, this momentum will not be undermined by ACA R&R (or tinkering)
- You can't succeed in VBC in the short run – it's a marathon and not a sprint – but you can fail in the short run by failing to anticipate and manage the gap
- Being the last health system to start the transformation in your market may concede significant market share to competitors
- Key lessons have been learned by early VBC pioneers – new adopters would be wise to learn as much as possible from them
- Many of the old rules for success as a provider and as a health system will not assure success under VBC – as new rules apply, new behaviors are needed
- Employers seeking higher value from health care can and should exert their market pressure on local providers/systems committed to VBC
- Employers should be alert to direct contracting and other partnering opportunities with VBC provider systems as your interests increasingly align
- Support health system carve-in of care for continuity of care, integration of data, team-based care, aligned incentives, improved experience of care




It's only a
**failure**
if you don't
**learn**
something

# Thank You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