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The Health Management Academy

Value-Based Contracting

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Introduction

As the healthcare industry continues to undergo transformative change and emphasize improved quality with lower total cost of care, health systems are making the shift from volume to value. While most health systems are still operating in a primarily fee-for-service environment, many are working toward a value-based care model in which the health system takes responsibility for the outcomes and wellness of the patient population. Historically, the pace of change has been slow to adopt value-based models, with health systems encountering a variety of challenges and barriers to success.

The country's Leading Health Systems are gradually moving toward value-based care, according to a new survey of 22 systems by The Health Management Academy (The Academy). However, follow-up interviews with leaders from 12 of those organizations show that they are at different stages of progress and face a variety of challenges they must overcome to achieve success. This report covers the findings of the follow-up qualitative interviews. Results from the initial quantitative survey can be found in the Appendix.

Key Findings

- Common challenges to value-based programs include aligning physician incentives with quality and cost goals, transforming care delivery, developing capabilities and expertise traditionally associated with payers, and collecting, aggregating, and disseminating actionable data to drive clinical and financial performance.
- As value-based care requires transformation across the entire organization, health systems involve a team of C-suite executives in decision making regarding value-based programs, commonly including the CEO, CFO, CMO, COO, and physician group leaders.
- Many participating health systems indicate a preference for building value-based programs and capabilities in-house, rather than partner with an outside vendor.
  - Those that have opted to partner commonly partner around information technology and data analytics, and highly value trust and cultural fit when it comes to potential outside partners.

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Results

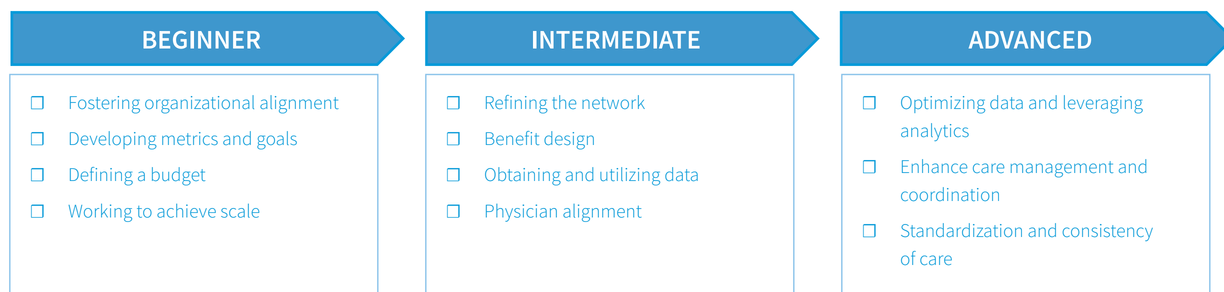
At the time of the quantitative survey, 86 percent of the respondents reported that they are participating in some type of downside-risk contract with payers. Fifty percent were Medicare ACO contracts, and 45 percent commercial ACO contracts. Forty-one percent of risk-based contracts fell into other categories, including Medicare Advantage, Medicare Part D and state Medicaid contracts.

While most health systems are moving into some value-based arrangements, follow up interviews with key executives at these health systems indicate health systems fall across a spectrum in their journey to value, with experience levels ranging from beginner to advanced (**Figure 1**).

Those in the early stages of developing value-based contracts are primarily focused around foundational work such as fostering organizational alignment around metrics and goals, developing organizational infrastructure and defining a budget, and working to achieve scale. Intermediate health systems, those that have implemented programs and are working to refine them, are focused on benefit design and refining the network, aligning physician incentives, and utilizing data to measure progress and manage a population. Advanced health systems have been successful in achieving many of their financial and outcomes goals and are working to optimize their current programs, commonly focusing on optimizing data usage and leveraging analytics, enhancing care management and coordination and standardizing care throughout the health system.

Figure 1: The Journey to Value

Health systems have different focuses and encounter different challenges as their value-based contracts become more mature.



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Challenges Around Value-Based Payment Models

Although health systems may be in different stages of developing and implementing value-based contracts and programs, similar challenges and opportunities arise as health systems work to define and improve their programs.

Successful value-based care requires that health systems have many new capabilities and structural elements in place. Interview respondents identified data collection and analytics as a place where they're seeking outside help, but it is just one of several areas where health systems are struggling to take on unfamiliar roles and tasks.

Physician alignment

Value-based care necessitates a network of engaged, aligned physicians who are able to focus not just on the patient in front of them but on improving the health of the patient population. Health systems indicated challenges in this area around building incentives into physician contracts that reward them for keeping people healthy, providing doctors with data, and having the tools and training needed to take on population health. For a majority of health systems, the dominance of fee-for-service payment muddles financial incentives and hampers physician behavior change.

"[We] want to beat the [performance] trend consistently year over year. The reason we haven't and the reason we may not is that every incentive underneath the trend-based deals we have is fee-for-service." [CSO]

Consistent care delivery and system scope

Additionally, organizations face challenges around maintaining care delivery uniformity across the health system. The effort entails addressing variations in care, sometimes among independent physicians, and between different hospitals and other facilities throughout the system. Initiatives are often not scaled across the system, but must be evaluated for overall impact. Care management also must be consistent, which requires implementation of a care management program across the system.

Value-based care also requires health systems have enough breadth to manage population health. This means they must offer the range of providers and care sites needed to provide patients with access to the right care in the right setting at the right time and at the right cost, while also ensuring the patient population is aware of its offerings to prevent patients from seeking care elsewhere. Many responding health systems are challenged by the magnitude and complexity of identifying and filling gaps in delivery capacity, coordinating care and preventing patient leakage.

"At least half of the patients don't even know that they're a part of something. As a result, I don't think there is a great ability to influence their behavior. The other part [is] we're a fragmented industry to begin with. We're a fragmented organization to begin with. Getting all the stars aligned in that is a challenge." [CFO]

Figure 2: Core Competencies Required For Success In Value-Based Arrangements

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Payer functions

Most participating health systems are not in the insurance business and are therefore unfamiliar with benefit design, physician-payer contract negotiations, actuary science, and other elements of taking on population risk in a financially viable way. Some participating health systems are struggling with the task of either building a business model with these capabilities or finding a suitable outside partner that has these skills.

Data, analytics and IT tools

Population health management hinges on collecting timely and accurate data from disparate sources, aggregating them, analyzing them, and then sharing the results with providers in a way that enables them to track care quality and efficiency in their patient panel, their practice, and ultimately the entire population. However, many health systems struggle to obtain and utilize relevant and timely data to be able to implement value-based care and population health effectively.

"… we have not been able to have the actionable data we need to change the outcomes real time. Even if we had all the data real time, I don't have full confidence we have the right processes in place throughout the programs to take the right actions. [We] have pieces of that, but not the full, comprehensive plan." [CFO]

Physicians also need information technology tools at their fingertips that help them manage patient care. One health system CMO said: ***"We still don't have what I would consider the ideal tools in the hands of the physicians to help them better manage [our commercial ACO] patient population."***

Pace of Change and Economic Viability

Although seventy-three percent of responding health systems rate the transition to risk-based delivery models as a high or very high priority, pace of change remains slow in most cases due to market forces, unwillingness of payers, lack of organizational readiness, and a hesitance to take on risk. However, executives agree that both the public and commercial markets are gradually moving toward value-based care and health systems need to prepare.

"We've had to push the payers, as opposed to the payers pushing us. … If we're not driving the change and getting ahead of it, it's going to hurt later on." [CFO]

Pace of change

The speed at which health systems need to move to value-based care is highly market dependent. Variables include the size of the opportunity, competitive dynamics, and payer willingness to collaborate. One CMO said that, as the front-runner in the value-based space, the health system is positioning itself as the low-cost leader in its area. This combined with its care quality gives the health system a competitive edge that promises to increase its market share. A CFO in a faster-moving market says that value-based care isn't just an asset but an imperative. ***"If you're not driving value, you're not even at the table."*** (CFO)

Recognizing this inevitable shift, health systems early in their journey are moving to value-based contracts in order to learn how to be successful in this new space as well as capitalizing on a potential growth opportunity.

"Eventually we need to figure out how to manage a population and take on more risk to get a bigger chunk of the premium. A commercial ACO is the first step – there is no downside risk the first year, and limited risk the following year." [CMO]

Struggling with economic viability

Several systems touched on the difficulty of making the economics of shared-savings contracts work, especially long-term. Some are taking on such contracts before they have the tools and programs in place to drive the behavior change that improves cost and care quality.

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“We grow at-risk lives faster than our target every year. … but we haven’t been good at doing it profitably. [We’re] losing money on it because we don’t have the infrastructure to deliver it reliably.” [CFO]

Some systems focus on high-cost, high-risk patients and meet value targets by managing their care. One system has had success with this technique in Medicare and is rolling it out in Medicaid. However, in the commercial market, there are fewer high-cost, high-risk patients, so savings will be harder to achieve. Moreover, tackling costs is only one part of the transformation equation—systems must also consider quality outcomes and cultural/behavioral changes.

For those that have achieved savings and value, challenges arise around continuing to meet shared-savings targets as they get tighter as the systems get better at managing their populations. One health system CFO wonders: ***“Are we giving all the value away as we start the next [contracting] cycle and starting at square one? How [do we] create value longitudinally?”***

Additionally, health systems are uncertain around the role of payers and navigating the payer/provider relationship under value-based contracts. One CFO whose system is beating market trends now wonders not only how long the organization can continue to do so, but whether doing so helps insurers to provide better rates to competitors at the health system’s expense.

“The reality is the reimbursement system is going to drive how fast this moves. Insurers are an interesting lot in this. [They] came out of the block pushing for quality-based payments, etc., but then [had] a wake-up moment where they realized if they push risk to providers, what’s their role?” [CFO]

Leadership and Budgeting for Value-Based Contracts

Survey respondents indicate similarity in the decision-making process on pursuing value-based programs but reveal some disparity in their approach to budgeting.

Team-based leadership

Typically several C-suite executive leaders are involved in decision-making around value-based contracting — most often the CEO, CFO, CMO and COO. Frequently, physician group leaders, hospital leadership and quality leaders are included, while systems that own a health plan also involve the health plan president in decision-making.

This cross-functional leadership is essential for success. Value-based care requires transformation across the entire organization, so buy-in throughout the organization is needed to achieve that change. The shift toward value takes time; therefore, executive leadership must be committed to the endeavor over the long haul.

One health system’s approach not only involves the entire executive team, including the CEOs of each hospital and medical group, but also includes a set of report card metrics against which the executive team is measured. ***“If one institution falters, it affects me personally. The entire leadership is the focus of attention.”*** (CFO)

Budgeting varies

Three-quarters (75 percent) of health systems have a defined budget for establishing or improving value-based contracts, however the levels vary significantly. Some spend in the $2 million to $5 million range, but about half of organizations with a budget report that it is $10 million or more.

Other systems don’t have a defined budget but fund value-based care activities with contributions from various areas of the system. Those without a defined budget (25 percent) indicate that their health system is prepared and expecting to spend money on their value-based programs, even though the amount has not been delineated.

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Strategies on Vendor/Partner Relationships

Many participating health systems indicate a preference for building value-based programs and capabilities in-house, rather than partner with an outside vendor. However, those organizations that have opted to partner with vendors commonly look to partner around information technology and data analytics.

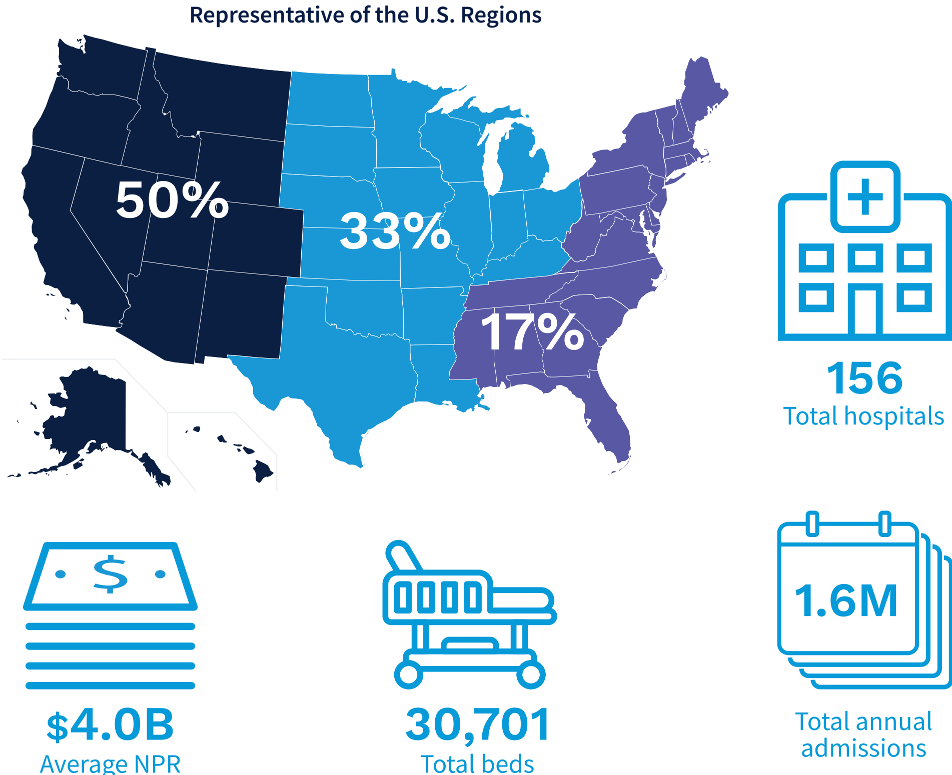
“[We have] no partners outside of technology partners. We think we know what we’re doing. We’ve had some strong experience. … [We’re] not looking for a consultant who’s going to come in and tell us how to manage care.” [CFO]

Other health systems recognize they may not have the full range of core capabilities needed to succeed in value-based contract arrangements, and have elected to partner with vendors to help fill these gaps. Some systems have involved partners with insurance expertise, with one vice president of payer innovation commenting, ***“We thought it would be beneficial to have a partner to help us understand the dynamics of managing the premium dollar.”***

At least one health system is considering creating a value-based services organization so it can eventually sell program capabilities to other health networks. It’s brought in an outside vendor to help figure out what form that organization might take. But, says the system’s CFO: ***“[We] don’t envision having an outside partner embedded inside that model.”***

For organizations that have or are looking for partners, top priorities are trust, common values and cultural fit. As one CFO said, ***“[They’ve] got to have values alignment and we can trust them. … [We] look for someone where our interested are clearly defined—rising and falling together.”*** Other qualities viewed as an asset are understanding of challenges faced by health systems, adaptability and willingness to take on risk.

Profile of Participating Health Systems



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Participating Health Systems

Methodology

In September 2016, The Health Management Academy (The Academy) conducted a quantitative survey of 22 Leading Health Systems regarding performance of value-based contracts. Using the data from the quantitative survey, The Academy identified 12 health systems for follow up qualitative interviews regarding the structure, governance, and performance of their value-based contracts.

This report covers the findings of the follow-up qualitative interviews. Results from the initial quantitative survey can be found in the Appendix.

The Health Management Academy, "The Academy"

The Academy is a leading research and analysis company serving the largest 100 health systems. The Academy provides services to the C-suite, including research, analytics, health policy, consumer research, fellowship programs, and Collaboratives.

The Health Management Academy provides unique, peer-learning and networking opportunities, complemented by highly-targeted research and advisory services, to executives of Leading Health Systems. These services enable health system and industry members to cultivate relationships, perspectives, and knowledge.

In 1998, The Academy created the first knowledge network exclusively focused on Leading Health Systems. This learning model, refined over 19 years of working side-by-side with members, combines peer learning (Executive Forums, Trustee Institute, Collaboratives), research (Health System, Consumer, Health Policy, Advisory), and leadership development (Leadership Programs and Fellowships).

Lumeris

Lumeris serves as a long-term operating partner for organizations that are committed to the transition from volume- to value-based care and delivering extraordinary clinical and financial outcomes. We guide health systems and providers through seamless transitions from volume to value, enabling them to deliver improved and more affordable care across populations—with better outcomes. And, we work collaboratively with payers to align contracts and engage physicians in programs that drive high-quality, cost-effective care with satisfied consumers—and engaged physicians.

An industry recognized leader, Lumeris was awarded 2017 Best in KLAS for value-based care managed services for helping clients deliver improved clinical and financial outcomes. This was the second year we received this distinguished award. For the past seven years, Essence Healthcare, Lumeris' premier client with more than 63,000 members in Missouri and Illinois, has received 4.5 to 5 Stars from the Centers for Medicare and Medicaid Services. We enjoy working with all of our clients, delivering these same results, and aligning our proven multi-payer, multi-population model with their value-based care vision.

The Academy extends its appreciation to Lumeris for providing the funding for this project.

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Performance of Value-Based Contracts Quantitative Survey Results

Methodology

In September, 2016, The Health Management Academy conducted a survey of 57 Leading Health Systems regarding the performance of value-based contracts, sponsored by Lumeris. The 22 responding C-suite executives (response rate of 39%) represent health systems with an average Net Patient Revenue (NPR) of $5.6 billion that own or operate 446 hospitals with over 94,000 beds.

Key Findings

- Almost two-thirds (73%) of responding health systems rate the transition to risk-based care delivery models as a high or very high priority.
- Most responding health systems (86%) report participating in downside risk contracting with payers, including Medicare ACO (50%) and Commercial ACO (45%) contracts.
- A majority (61%) of health systems have a license to offer health plan products, including Medicare Advantage (35%), Managed Medicaid (30%), and Commercial/fully managed employee population (35%).

Results

Almost two-thirds (73%) of responding health systems rate the transition to risk-based care delivery models as a high or very high priority, compared to other system objectives (**Figure 1**).

Most responding health systems (86%) report participating in downside risk contracting with payers, with half (50%) participating in a Medicare ACO contract and 45% participating in a Commercial ACO contract (**Figure 2**).

Other risk-based contracts health systems reported include Medicare Advantage, state Medicaid, Medicare Part D, medical assistance, and capitation.

Of the health systems that do not have any downside risk contracts (14%), one plans to implement a Medicare ACO and a Commercial ACO contract within the next 9-15 months.

Figure 1: Compared to other system objectives, how much of a priority is the transition from fee-for-service to a fee-for-value or risk-based care delivery model at your health system?

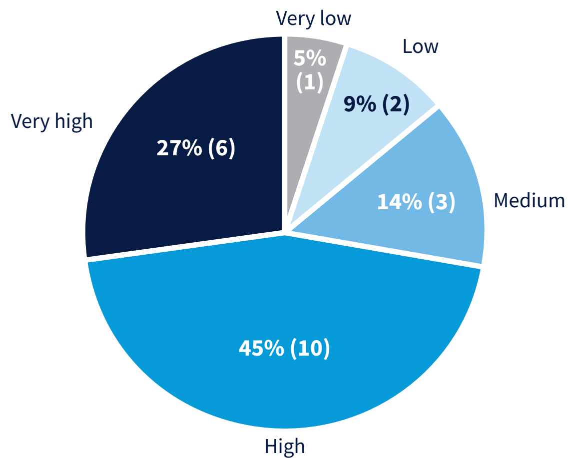
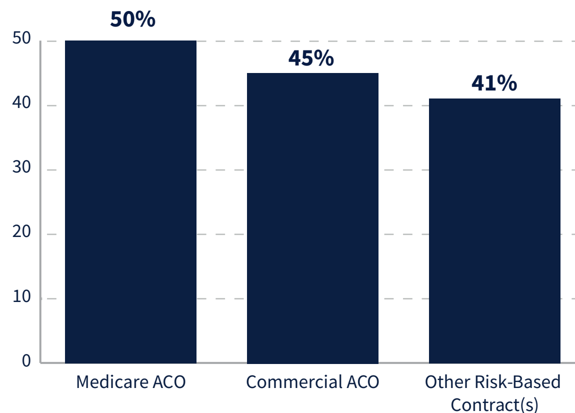


Figure 2: Does your health system participate in any downside risk contracting with payers? (Please check all that apply.)



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APPENDIX

A majority (64%) of Medicare ACO contracts are meeting all or most of health systems' objectives, while just over one-third (36%) are meeting only some objectives (**Figure 3**).

No Commercial ACO contracts are meeting all of health systems' objectives, while just under one-third (30%) are meeting most objectives and half (50%) are meeting some objectives.

A majority (61%) of health systems have a license to offer health plan products, including Medicare Advantage (35%), Managed Medicaid (30%), and Commercial/fully managed employee population (35%) (**Figure 4**).

Other health plan products health systems reported include CHIP, Medicaid plans, short term disability, workers' compensation, and the exchange market.

Over one-third (39%) of health systems do not offer health plan products; however, of these health systems, 75% plan to offer Medicare Advantage (50%), Managed Medicaid (25%) and/or commercial/fully managed employee population (25%) plans in the next 9-15 months.

Figure 3: Are your risk-based contracts meeting your health system's objectives?

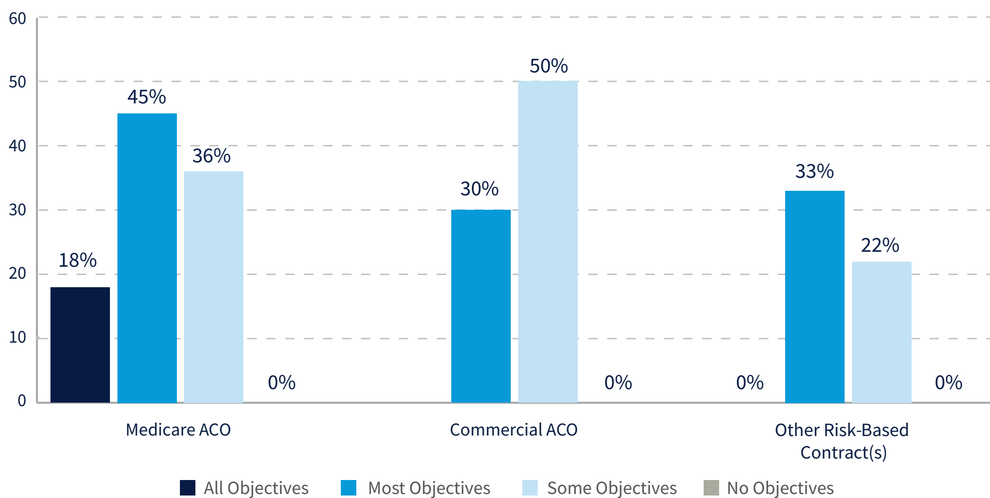
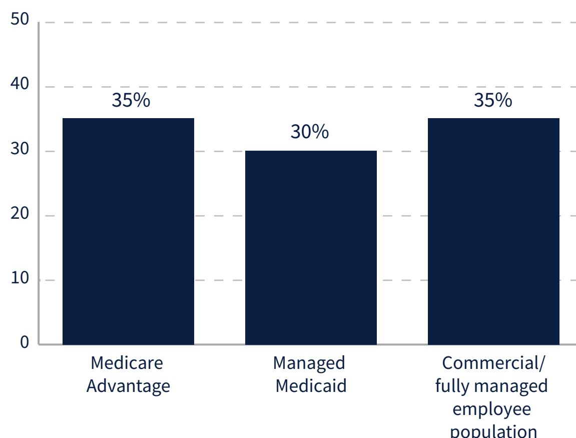


Figure 4: Does your health system (or a subsidiary) have a license to offer any of the following health plan products? (Please check all that apply.)



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Health plans are generally meeting health systems' objectives, with a majority of Medicare Advantage (63%), Managed Medicaid (86%), and commercial/employee population (63%) plans meeting all or most objectives (**Figure 5**). However, one executive elaborated, ***"MA and commercial/employee plans are generating significant operating losses."***

Most health systems view establishing a payer contracting strategy (71%), physician alignment and engagement (62%), and Clinically Integrated Networks (57%) as strengths, rating them as a 4 or 5 on a 5-point scale (**Figure 6**). Health systems recognize challenges around developing effective care management (62%) as well as data and analytics capabilities (52%), with a majority rating these as a 3 or below.

Figure 5: Are your health plan products meeting the objectives set by your health system?

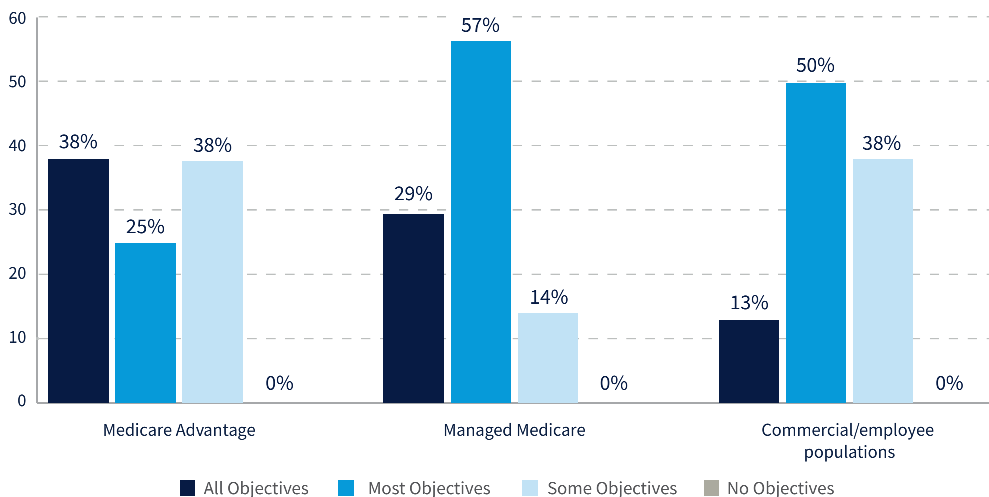
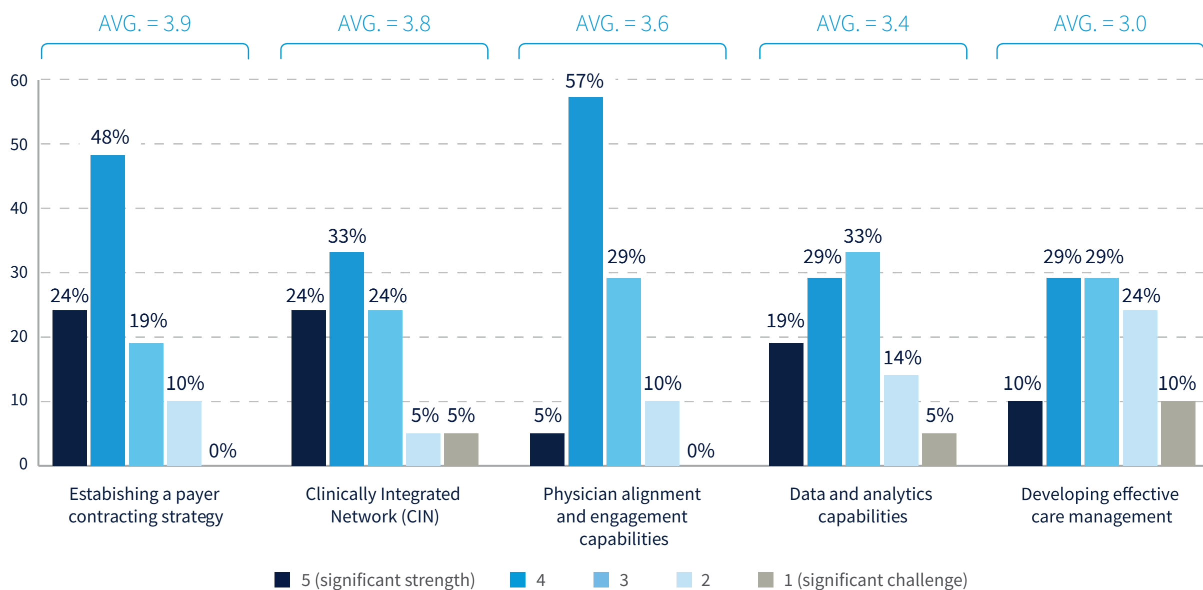


Figure 6: Please rate from 1 to 5 your health system's experience with the following as it moves to a population health model and optimizes its risk and value-based contracts with your payer partners:



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