The Value-Driven Provider: Healthcare Delivery in 2020

Fall Managed Care Forum

November 11, 2016

David A. Gregory

Principal, Healthcare Consulting Practice Leader

What will value-driven healthcare provider look like in 2020?

This presentation will:

- Discuss the impact of VBC on healthcare delivery
- Identify the changes in healthcare delivery during this "value-based transformation" period
- Present potential strategies to assist providers in preparing for the future of healthcare delivery

Healthcare Reform Prompts Service Line Changes

Traditionally	Reformed
Fee-for-service payment	Pay-for-performance, at-risk, shared savings, penalties
Focus on QUANTITY of services	Focus on QUALITY of services
Acute response focus	Proactive "stay healthy" approach
Index admission focus	Episode of care, long-term focus
Individual patient utilization and costs	Population utilization and costs

3

Health Care Reform Changes Integration and Financial Risk

Small % Financial Risk | **Moderate % of Financial Risk** | **Large % of Financial Risk**

Limited Provider Integration | **More Developed Provider Integration**

4

Who bears what risk?

- Risk is the liability and exposure to the costs of care throughout the patient's period of care.
- **Cost risk control** plays an essential role in the financial success of the payer and provider.

Who bears the financial risk?

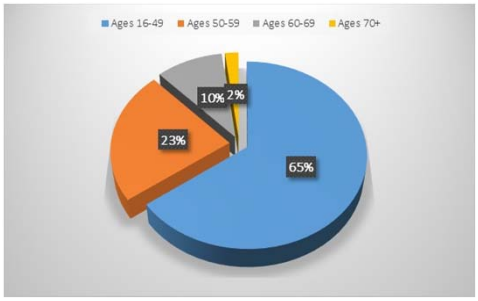
Form of Payment	Utilization	Unit Cost	Incidence
FFS	Payer	Payer	Payer
Bundled Payment	Provider	Provider	Payer
Capitation	Provider	Provider	Provider

5

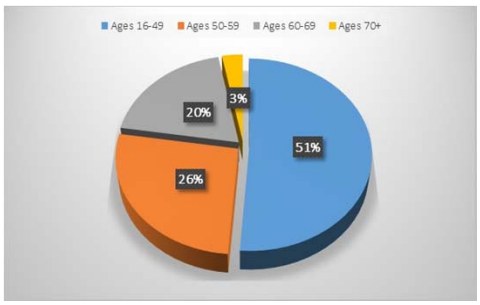
Population Demographics

U. S. Civilian Labor Force By Age

2013



2020 (projected)



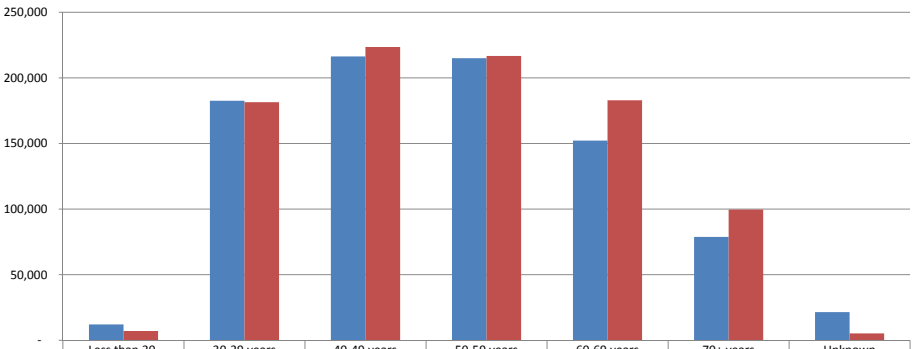
Ages 16 – 49	- 22%
Ages 50 – 59	+ 13%
Ages 60 – 69	+100%
Ages 70+	+ 50%

Bureau of Labor Statistics 2013

Cigna's Book of Business results – Neal Sweeney, Cigna Healthcare

6

Trends in Physician Demographics



	Less than 30	30-39 years	40-49 years	50-59 years	60-69 years	70+ years	Unknown
2012	12,047	182,536	216,234	214,936	152,175	78,794	21,472
2014	7,025	181,452	223,472	216,643	182,918	99,554	5,200

Source: 2014 FSMB Census of Licensed Physicians

7

Cost of care by age…

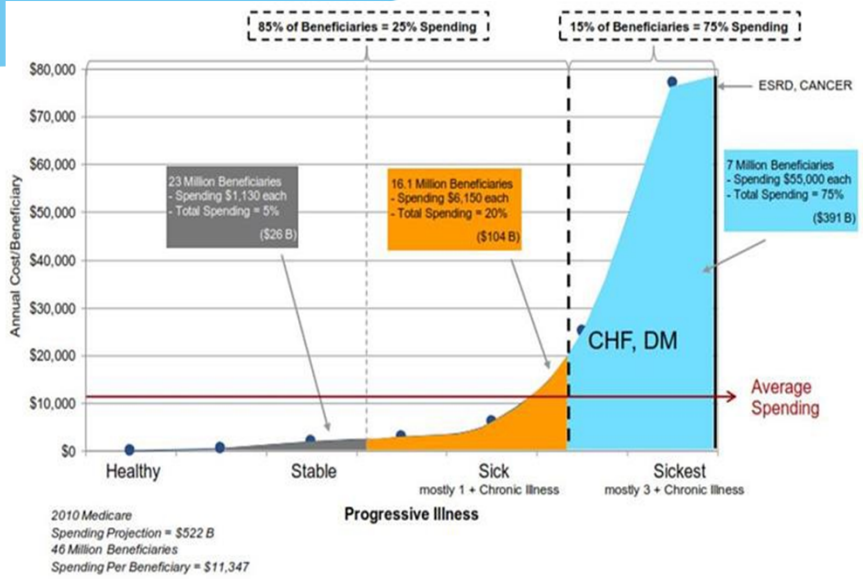
Healthcare costs are:

- 40% greater between the ages of 40-49 than between 30-39
- 40% greater between the ages of 50-59 than between 40-49
- 47% greater between the ages of 60-69 than between 50-59
- 35% greater over the age of 70 than between 60-69

Cigna's Book of Business results – Cigna Healthcare

8

"85/15 Rule" of Costs to Patients



CAIN BROTHERS

9

The (Near Term) Future of Healthcare

- Almost everyone wants more patients on value-based or alternative payment models ASAP
- HHS seeks to have at least 50 percent of Medicare beneficiaries in APMs by 2018
- A task force of providers, insurers and employers has committed to shift 75% of its members' business into contracts with incentives for health outcomes, quality and cost management by January 2020

10

Trends that will expand…

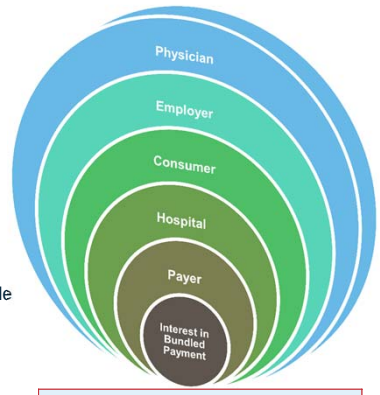
- Increasing percentage of patients covered under Medicare and Medicaid (with less reimbursement than private health plans)
- MACRA sets sail in 2017 and will be an enhanced catalyst for transformational activities at the provider level
- Narrow "high-performing" networks with limited OON options will become commonplace by 2020

11

Key APM: The Bundled Payment Evolution

CMS and commercial payers will continue to push the continued evolution of alternative payment models:

- Additional conditions (Next slide)
- Additional geographic areas
  - Go beyond the 67 MSAs
- Tiering/steerage toward bundled arrangements
- Shift additional risk to providers (i.e. full capitation)
- Migrate more payments from retrospective payment to prospective
- As investments are made in infrastructure more payments with be made upfront eliminating financial reconciliations
- Extending the episode term (i.e. 180 days, 360 days)
  - To mitigate potential gaming – delaying care to post episode (91+ days)
- Integrating behavioral health into the management of the bundled patient
  - Direct impact on the high cost of poorly treated chronic mental and physical health conditions
- Concern – How does the bundled payment model continue to generate value (savings) after initial opportunities are exhausted? How far can bundled payments take us?



Bundled Payments: Payers have the highest interest & Physicians have the least interest.

12

The Bundled Payment Evolution – What's Next?

With pubic and private payer announced goals of 80% - 90% of reimbursements to be made under a value based reimbursement methodology by 2018 we expect:

- CJR to be expanded to ALL hospitals
- Additional procedures to be included in mandatory bundled – episodic reimbursement models
  - **Cardiac care (heart attack, by-pass surgery) – Announced July 25, 2016**
  - **Hip & Femur Fractures – Announced July 25th, 2016**
  - Spinal fusion (Cervical & non-Cervical)
  - Additional joint procedures (i.e. Shoulder, Ankle)
- Additionally, CMS is likely to pilot mandatory bundled payment models for other clinical episodes as well as new episode designs. For example:
  - **Bundles that trigger at diagnosis**
    - **Example:** Crohn's disease, osteoarthritis
    - Mitigates overutilization of diagnostic tests and creates opportunity for earlier patient engagement
  - Bundled payments for chronic conditions (i.e. diabetes, coronary artery disease, cancer, COPD)

13

More trends to anticipate…

- Medicare managed care penetration at 45%-50% by 2020, increase from current 20% range
- Medicaid: Today, nearly half of Medicaid recipients are enrolled in managed care; predict that approximately 90% of Medicaid enrollees will be in managed care by 2020
- Commercial: By 2022, 50% of American workers who have employer-based insurance may be asked to secure their own insurance
- Hybrid delivery options: By 2025 or sooner, the majority of delivery systems will have an insurance offering

14

New Patient Incentives Coming…

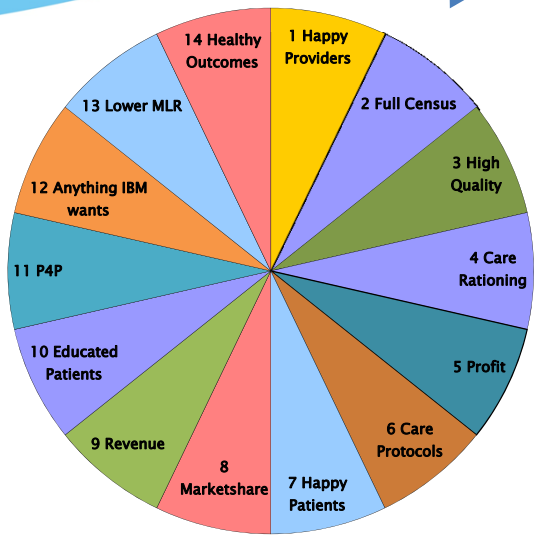
- Benefit Designs – Value-Based Insurance Design Model (VBIDM)
- CMS' VBIDM will test the hypothesis that giving Medicare Advantage (MA) plans flexibility to offer targeted extra supplemental benefits or reduced cost sharing to enrollees who have specified chronic conditions can:
- The goal is to improve beneficiary health, reduce the utilization of avoidable high-cost care, and reduce costs for plans, beneficiaries and the Medicare program
- Model will begin January 1, 2017 and run for five years in AZ, IN, IA, MA, OR, PA and TN

15

Wheel of Survival – Payers

16

Wheel of Survival – Delivery Systems



17

Healthcare Providers Becoming Healthcare Payers

- Reasons health systems are becoming health insurers
  - Need for new revenue streams
  - Health insurance exchanges – new markets
  - Evolution to population health – new delivery model
  - Aging population – not new…
  - Cost and reimbursement pressures – not new at all…
- June 2015 survey of 100+ hospitals: 34% own health plans; another 21% plan to launch a health insurance plan by 2018

18

New Managed Care Facilitators: Helping Systems Become a Provider-Payer

They offer:

- Investments in efforts for seamless delivery to manage cost and improve quality warrant effective reimbursement, i.e., offering own insurance product
- Small employer groups are appealing targets because coverage decisions are based on the local healthcare networks where employees receive most of their care
- Business model: Narrow network to be closely managed to control coordination, quality and cost, but providing access and convenience
- Broader geographic coverage and sufficient revenue may require provider partnering to be competitive

19

Providers: Interdependent Strategies for Value Transformation

- Clinical integration
- Organizational integration
- Financial integration
- Patient Engagement
- Information technology – for patient care
- Information technology – for decision-making
  - Measurement of quality, costs and outcomes

20

Clinical Integration

- Organization of services around a patient's medical condition
  - E.g., diabetes, kidney and eye care
- Coordination among providers along the continuum of care
  - Post-acute care
  - Behavioral healthcare
- Collaboration among providers to maximize overall outcomes as efficiently as possible
- Track/review data on performance to improve care and facilitate best practices

21

Hospital/Physician Alignment

Key in the transition to performance-based payment structures that focus on best practices and clinical outcomes

Service line co-management arrangements have been a common vehicle but…

…new performance-based payment systems require that service lines must work cooperatively across the continuum of care to achieve quality and cost-effectiveness goals so…

…there is a need to expand the single service line co-management arrangement into a system-wide arrangement, i.e., Hospital Efficiency Programs (HEP)

22

Hospital Efficiency Programs

- Similar to a service line management arrangement, the broader HEP has two (2) components:
  - Pre-identified fixed tasks addressing daily operational requirements
  - Performance-based incentives requiring the achievement of specific objectives and performance thresholds tied to compensation
- HEP's performance-based metrics require collaboration across multiple service lines and address hospital-wide goals, e.g.,
  - Reduction in readmission rates
  - Reduction in HAI rates
  - Reduction in cost per case by a fixed percentage across the hospital
  - Increase in PCP contacts

23

Next Generation Accountable Care Organizations (ACOs)

- As of the end of January 2016, the number of public and private ACOs was identified to be approximately 800 with service areas in all 50 states and DC (an increase of approximately 10% over the past year)
- The Next Generation ACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients
- These ACOs will assume higher levels of financial risk and reward than are available under the current Pioneer Model and Shared Savings Program
- Commercial ACOs: they are struggling to move the cost-of-care needle relative to meaningful impacts on premiums…why?

24

Other Trends…Dynamic Patient Engagement

From a capability development and technology enablement perspective, providers need to behave dynamically and develop three key "skills" necessary to do so:

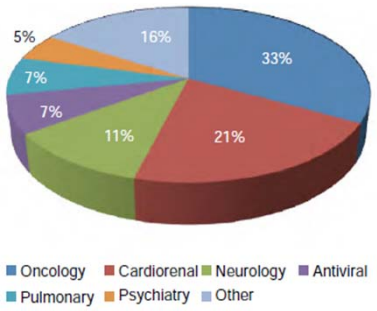
- Harness market intelligence on a continual basis (understand what your served population needs, how they behave, how they want to interact with you)
- Leverage that market intelligence through patient-focused engagement, across the channels of interaction that matter and that create the best experience and most effective interaction
  - Operational Efficiency Improvement
  - Care Pathway Optimization
  - Medical Management
  - Service Line Specialization & Optimization
  - Integrated Network Design
- Employ high-quality individuals that are focused on patient satisfaction (personal experience, quality care, etc.)

25

Growth of Personalized Medicine

- An effort to utilize genetic testing to inform the most effective course of treatment for each patient.
- The current $42 billion market is estimated to reach $60 billion in 2019.
- Drugs in the Oncology and Cardiorenal specialties are most active in the field of personalized medicine.

Review Activity in the Personalized Medicine Space - 2012



Source: FDA report - Paving the Way for Personalized Medicine

26

Digital Technologies for Clinicians and Consumers

- Enable new care delivery models
  - Physicians mobile use
  - Patients mobile self-management
  - Digitized medicine
  - Bio-sensing technology (“wearables”)

27

The Future of Healthcare: Characteristics of High-Performance Health Systems

- Patient-centered culture/engagement
- Evidenced-based care protocols
- Integrated/coordinated care across the continuum of providers
- Continuous peer review
- Information flow transformation
- Value-based incentives (bonuses for cost-effectiveness not volume of production)
- Digital technology optimization
- Promotion of community health, prevention, and wellness (population health)
- Participation in cost-effectiveness research (CER) programs

Note: Change must focus primarily of the supply side of the marketplace.

28

Impact of Being Ready…

- Providers that are value-driven now may gain early advantages that will enable them to compete more effectively in the future and gain marketshare
- You can become the provider of choice in your local marketplace (if you are already, you may LOSE that status if you do not embrace a patient-centric, value-based approach)
- Financial performance can likely improve with the right value-based incentives in place

29

Contact Information

David Gregory, FACHE
Principal, Healthcare Consulting Practice Leader
Baker Tilly Virchow Krause, LLP
One Penn Plaza, Suite 3000
New York, NY 10119
201 612 0561
david.gregory@bakertilly.com

30