November 2016

Value-Based Care Innovation to Support Population Health Management

eHealth Initiative Roundtable

GOP and Healthcare Reform

Now that the dust has settled and the elections are over, what does this mean for healthcare?

During the 2016 presidential campaigns President-elect Donald Trump made it known that he planned to repeal and replace the Affordable Care Act (ACA). One week post-elections although this remains on the table, the President-elect's strongly opposing stance may have somewhat softened. In a recent press conference, Donald Trump reiterated the GOP's intention to repeal and replace the ACA, but also stated that he will consider keeping beneficial parts of the Act such as the provision forbidding discrimination based on pre-existing conditions and to allow young Americans to remain on their parents' healthcare plans.

At the Roundtable discussion, all policy decision alternatives were discussed at length denoting the potential impacts of each possibility. Reflecting on the history of U.S politics, an entitlement program has never been repealed and annulling the ACA will remove benefits from over 20 million Americans. This will also create a hole in the Medicare Trust Fund of about $800 million over the next ten years, which the GOP will need to propose a plan to fill. To further compound this, CMS Actuaries project that the Trust Fund reserves will run out by 2034- another challenge for the incoming party to meet. Furthermore, repealing the ACA will stop Medicaid expansion and remove the 90% match to states, allowing the financial burden of Medicaid development to fall totally on the State.

It was discussed that repealing the ACA will not affect MACRA- Medicare Access and CHIP Reauthorization Act of 2015, which was passed with strong bipartisan support. However, we can expect to see a lot of sub-regulatory guidance and potentially more changes from CMS in the upcoming months, but nothing radial is anticipated. It is also not predicted that there will be changes to HITECH- Health Information Technology for Economic and Clinical Health (HITECH) Act. However, if HITECH is repealed it will be scored as a budget loss as most of incentive payments are already paid out, so this will hit as a deficit which will make it a candidate for reconciliation.

The GOP's plan to allow health insurance companies to sell across State lines per discussion may not have a significant impact on access to healthcare. If anything, this will result in consolidation within the industry instead of making care more affordable for consumers. The underlying problem to be addressed is the cost structure of the insurance. Insurance companies need to increase the number of young and health beneficiaries in their risk pools, this will make premiums lower and more affordable. The hope is that by expanding their territory across state lines they will be able to do just this.

Overall, for the GOP to repeal the ACA this will require a change in the appropriation of funds and will trigger reconciliation rules once Medicare is affected. Although this is a highly probable

outcome, it is likely that the Republicans will be pressured to keep parts of the ACA that are highly demanded by consumers intact.

Level-Set: The current state of Value-based Care

How does the change in political landscape affect the push towards Value-Based Care?

Based on consensus, value-based care will not be affected. The Centers for Medicare & Medicaid Services- CMS has been going down this path for over thirteen years and there is a long history of Congress pushing providers towards value-based care. This was started in the 60s by the quality improvement movement in the U.S healthcare industry which was championed by the Institute of Medicine (IOM). Today, the industry is in its best shape due to improved access to data to better manage risk, more established clinical practice guidelines to reduce variability and the increased adoption of bundled payment systems to reduce per capita health expenditure. Thus, in summary value-based care is here to stay, but how it will evolve is what is left to be predicted.

The main challenge to value-based payment models is that impetus to reduce cost will be at the expense of someone else's revenue. Many hospital executives are facing the dilemma of how to earn rewards by keeping the beds empty, which ultimately drives down per capita utilization. Some have found the answer to be by expanding their dominator through acquisitions. Others have joined Affordable Care Organizations (ACOs) which allows firms to achieve up to 1.2% in Medicare beneficiary savings. However, only 26% of ACOs reduced spending enough to qualify for shared savings. Forming an ACO is no easy undertaking considering the structural, cultural and financial implications. However, an executive and participant of the roundtable noted that the claims data that becomes available through the ACO network is extremely valuable looking at the big picture of population health. A missing piece of the value-based puzzle as discussed is how can we get payment mechanisms to reimburse for preventative-care or incentivize the "upstream approach". Currently, 90% of reimbursement is still tied to volume while just 10% is tied to value. More incentive and policy changes will be needed to shift the ratio towards reimbursing for value.

Key Insights: Washington Post Survey of Hospital Executives

What are the observed trends in the shift towards Value-Based Care?

According to a Washington Post survey of 345 hospital executives 30% of the respondents were in an ACO and another 15% were considering signing up for one. 30% of the respondents indicated that they were under bundled payment model whereas 60% said that they were not. There are still quite a few hospitals who are not exposed or willing to sign

up for ACOs. However, there is no risk to enrollment. There's a chance of winning and no chance of losing. All the same running an ACO is a whole different competency and requires a different skill set that is not commonly available.

The survey found that 14% of revenue is tied to value-based payment in the form of patient experience, readmission, outcomes, cost and process. This is hypothetical risk that you can get penalized for if you fall below normal range. However, 95% of hospitals do not get penalized.

Noteworthy, most hospitals indicated that they invest in Electronic Health Records, patient portals, IT security and telemedicine. However, very few indicated that they invested in predictive modelling, care gap analysis and home monitoring which are essential for population health. This is due to a lack of a business case for population health investment, as the short-term return in the existing payment models is not attractive.

Altogether, not everyone is going to love value-based payment as the readmission that is avoided is still counts as a loss of revenue. The payment models in healthcare need to evolve to properly reimburse for preventative care and population health initiatives.

Engaging Patients: A Business Imperative

How can technology enhance relationships between providers and patients?

In a journey mapping study of the experience of a sample of patients, the summary finding was that patients are longing for someone to connect with and the providers are longing to connect with their patients. Technology was found to be the best way to connect patients and providers. A major opportunity identified was for patients to take control of their health by utilizing open APIs (application programing interfaces) through mobile patient-facing applications and websites. These platforms will allow the patient to access vital information and aggregate their own health data and become their own HIE (health information exchange) source. This will be great for providers who can go directly to the patient for information, eliminating the competitive pressures of having to go to another health organization for patient data. Furthermore, patient mediated data exchange can go around legal barriers of privacy that restrict data access. However, as these apps are not controlled under HIPAA the patient assumes the risk of giving the apps access to their data.

A concern that came up is that it is anticipated that the EMR vendors will eventually come up with their own patient-facing applications and restrict the flow of data from the EMR to the rest of the consumer apps on the market. We need to put laws in place that will protect consumer rights and patient access to data, so that patients can freely share their data, which will be beneficial for population health analytics. The diagram below depicts the entrance of vendors as a divergent to consumer mediated data exchange.

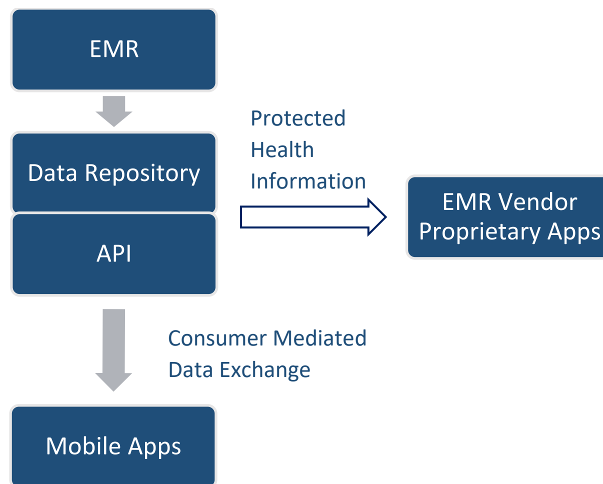

Diagram 1: The flow of data from EMR to Patient-Facing Applications

Finally, the underlying use of all technology should be to enhance relationships between providers and patients. Relationship enhancement should be measured as a key performance indicator for patient-facing technology use in healthcare.

Transitioning to Value-Based Care

How to get premium dollars to pay for population health?

T traditionally, the keys to success for a healthcare organization has been revenue cycle, volume growth and cost control. So far the push for value-based care has only stacked quality metrics and data mining on top of the underlying volume-based structure. The change from volume to value will require an uprooting of the traditional mindsets of fee-for-service and a replacement with reimbursement incentives that pay for prevention and population health. Some healthcare organizations have begun to focusing their dollars on wellness programs, mental health and the built environment to improve the health outcomes of communities. However, we need insurance companies to come on board the value-based care train and pay for population health programs and services.

Final Recommendations

Whose behavior needs to change the most for VBC to work? Providers/ Patients/ Employers?

T The blanket answer is all the above. All stakeholders still have a considerable way to go to move from volume to value and change the way healthcare is delivered. Physicians need to be ready to walk away from the fee-for-service model, patients need to change behavior and adopt healthier lifestyles and employers need to invest in the health of their employees. Technology can be a big change agent in influencing patient behavior and changing the social norm to motivate people towards healthy living.

In lieu of the roundtable discussion, most of the opportunity for revenue generation and value creation was found to be in post-acute care. There is significant potential in post-acute care for providers to maintain relationship with patients, meaningfully utilize technology and diversify the range of services offered outside of the acute setting.

There are also opportunities at the State level for public health to take front and center in the push for value-based care. The public health departments need to work closely with both public and private firms to bridge the silos that exist at a local level and foster a collaborative approach to achieve population health.

What will change the way that we do business in healthcare will be the incoming generation that demand technology, price transparency and value because they will only know high deductible plans and high out of pockets costs. This revolutionary change in healthcare delivery will not occur three years from now, it may take ten years. Right now, we need to focus on tailoring services to consumers; the patient-centered approach.

In summary, as an industry we are all aligned conceptually, it is the correct execution of value-based care that is left to be deciphered. The industry is struggling on the "how to?" and we can only find a solution with when all stakeholders decide to put their money where their mouth is and invest in value creating measures.