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INVESTING IN POPULATION HEALTH

Collaborative approaches to moving
to value-based care

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INVESTING IN POPULATION HEALTH: COLLABORATIVE APPROACHES TO MOVING TO VALUE-BASED CARE



Most Medicare spending tied to value-based payment arrangements by 2025.

Many commercial insurers were pressing for an aggressive shift to risk-based payment, which holds providers accountable for the quality and cost of patient care. Will COVID-19 significantly delay the move to value? Or will the pandemic — which has disrupted volume-dependent, fee-for-service revenue streams — further incentivize hospitals and health systems to take on financial risk for patient populations? During a virtual executive dialogue, hospital leaders discussed these and other questions about the future of value-based care. Top of mind among participants was the importance of building a population health infrastructure and identifying the financial return of population health investments.

KEY FINDINGS

- 1** Negative revenue impacts from the COVID-19 pandemic are causing some hospitals to consider **ramping up their entry into capitated and other full-risk payment arrangements** that offer a revenue guarantee even when elective procedure volumes are low.
- 2** **Investments in value-based population health** capabilities are helping hospitals improve health outcomes and reduce unnecessary utilization.
- 3** Some hospitals and health systems that have invested in building population health capabilities are **not seeing anticipated financial returns from shared savings** and other value-based payment arrangements. As they contemplate committing additional dollars, they are looking for advice on how to determine a return on investment.

VIRTUAL PARTICIPANTS



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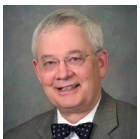
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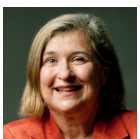
MERCYONE | DES MOINES, IOWA



David Raney

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MODERATOR Suzanna Hoppszallem

SENIOR EDITOR, AHA CENTER FOR HEALTH INNOVATION

AMERICAN HOSPITAL ASSOCIATION | CHICAGO, ILLINOIS

MODERATOR: (*Suzanna Hoppszallern, American Hospital Association*): **What have your organizations accomplished so far in the value-based payment space, and how is COVID-19 affecting those efforts?**

SANJEEBKHATUA, M.D. (*Edward-Elmhurst Health*): We are a two-hospital health system serving the western suburbs of Chicago. We decided to become an accountable care organization (ACO) in 2013. We partnered with a for-profit physician group and another health system to create Illinois Health Partners ACO. To date, we've been able to get some dollars out of shared savings. In addition, we are starting to engage in Medicare Advantage through commercial payers.

COVID-19 has forced us to think about shifting quicker to risk-based payment. Health care organizations in more capitated structures have done much better during the pandemic than those in mostly fee-for-service arrangements. It made us think about how we can transition from a hospital system that focuses mostly on providing acute care to an integrated health system that provides the full continuum of care for a patient population.

DAVID RANEY (*CoxHealth*): I'm also curious about capitation, especially in light of COVID-19. As with a lot of others in the field, we've seen revenues decline due to postponing elective procedures and routine care. If we'd been on capitation on some of these deals, our revenue stream would have been a little more fixed.

CoxHealth is somewhat advanced when it comes to population health and value-based payment. About 28% of our clinical revenue is tied up in some sort of shared savings or shared-risk arrangements.

We are also highly integrated. We employ about 600

physicians and own most of the services across the continuum. We also have had our own health plan for 20 years.

For the past three years, we've participated in Medicare's Next Generation ACO Model, although we won't be participating next year. We don't think the direct-contracting approach makes sense for us. We're going to participate in MIPS [Merit-based Incentive Program System] next year. We feel that our physicians will perform well, and it gives us a chance to figure out our next steps.

We are also active in the Medicare Advantage space, which offers us a place to build some muscle memory as we learn how to bend the cost curve.

DEREK NOVAK (*MercyOne*): I think MercyOne's work in building our population health management structure has put us in a better position to respond to COVID-19 in assisting with

care coordination for patients outside the hospital. Our 200-plus care managers who are stationed in ambulatory and post-acute settings, as well as our community health workers, have been able to support our clinicians in outreach through the surges. They have been following up with COVID-19 patients after discharge to ensure that care is coordinated.

MODERATOR: **Are you seeing anything else in the market that might be speeding up the transition to risk-based payment?**

RAY HERSCHMAN (*Cerner*): I think the commercial insurance market is moving more aggressively toward bundles. The rules are really different from those of the Medicare world. Commercial payers are going to negotiate a fixed \$19,000 for a knee replacement. It's a bundle, but it's full risk. For a

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— Sanjeeb Khatua, M.D. —
Edward-Elmhurst Health

commercial knee bundle to be a good deal for providers, you need to know how to make money within the \$19,000 fee.

In addition, the price you set for the knee replacement is going to drive utilization. On the benefit design side, commercial insurers are going to tell beneficiaries, 'You can go wherever you want for a knee replacement.' If providers want to charge patients \$30,000 for a knee replacement, that's their business, but the insurer is only going to cover \$19,000. So, insurers will be using reference pricing to encourage patients to choose high-value providers.

MODERATOR: Anne, where is Holy Redeemer in the value-based strategy?

CATINO: Holy Redeemer is a small integrated health system that can provide the full continuum of care for our patients. In addition to a 239-bed acute care hospital, we have a large home care and skilled nursing presence. We also have a collaborative partnership, called Innovative Wellness Alliance, with 90 primary care physicians who work with us on covered lives.

We are feverishly working in the bundled payment space. We are in Medicare's Bundled Payment for Care Improvement Advanced program for several 90-day bundles. We are doing well and looking to reestablish for January 1, 2021. Even though the program is not mandatory, we feel it's a good priority for us to become facile in how we approach the future, because we all know that we will soon be in risk-based payment arrangements whether we want to or not.

MODERATOR: William, what about Blanchard Valley Health System? How would you describe your journey to value-based payment?

WILLIAM KOSE, M.D. (Blanchard Valley Health System): Blanchard is a small, independent health system with a critical access hospital and a main hospital with 150 beds. From the standpoint of value-based purchasing, we made a conscious decision in 2009 not to become an ACO. We weren't big enough, and we weren't interested in taking on any kind of risk then. Even today, we are strictly fee-for-service. We don't have any risk contracts of any sort. Our payers

have not been interested when we approached them about taking on risk. We're just not big enough, and our costs are low enough that nobody has looked at us. Looking forward, our board has asked us to look into what we can do with population health and community benefit. So, we're starting to strategically plan around that.

MODERATOR: Derek, can you tell us about MercyOne's value-based payment activities?

NOVAK: We started our ACO journey in 2012 as we were one of the first in the state to join Medicare as well as commercial shared-savings programs.

Today, we manage more than 25 value-based and risk-based agreements, and about 43% of our fee-for-service dollars are now connected to some type of risk-based contract.

We've taken more than \$150 million worth of cost out of the system and returned a little more than \$100 million in revenue back into our health system and our provider partners — 30% of which we earned in the most recent year. So, we're on an upward trajectory when it comes to that work.

MODERATOR: Ray, where would you say the hospital field is today in terms of being ready to take on partial or full financial risk?

HERSCHMAN: I would organize the industry into

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— Derek Novak —
MercyOne

three buckets with regard to their risk readiness: first movers, fast followers and late followers.

The first movers are the hospitals and health systems that have been at this for a long time. They've invested heavily in the population health capabilities, and they already care for a significant number of patients in risk-based payment arrangements. At this point, the first movers are asking, 'We think we have done well in terms of building our program, but how do we demonstrate and improve the efficacy and the return on investment? Should we re-justify our investments or slow down?'

Then there's a segment of the provider market that are fast followers. They have one foot in the boat and one foot on the dock. It's getting harder to operate effectively in the dual mode of fee-for-service and value-based payment. They're asking themselves if it's time to double down and go all in so they can lock in more financially beneficial value-based payment arrangements versus trying to negotiate contracts from a lower base rate.

Then the third category, the late followers, are the hospitals and health systems that are just realizing that the value-based care train is coming and they can't wait any longer. They need to start developing the population health infrastructure to do well under risk-based payment. The question is: Do those that are getting in late have to go through the same 10-year journey that the first movers went through, or can they get to maturity quicker?

MODERATOR: Can you describe the capabilities your organizations have put in place to manage patient populations, as well as improve quality and reduce costs?

KHATUA: One creative thing we've done at

Edward-Elmhurst is to build a transitional care clinic for inpatients who need extra support after discharge. The focus is on helping all high-risk patients, not just those with certain diseases, and we are engaging patients in different ways than we traditionally have. For instance, we are looking at social determinants of health, such as food insecurities, and connecting patients to needed community services. The clinic is run by a hospitalist and an advanced practice nurse. Other clinicians, including pharmacists and social workers, also work with patients. The pharmacy piece is proving to be critical.

We also have created a post-acute network, partnering with local, skilled nursing facilities. Our physician medical directors and advanced practice nurses work in these partner facilities. As a result, we've been able to decrease inpatient utilization significantly, which has helped us in our bundles.

ERIC ESKIOGLU, M.D. (Novant Health): I've teamed up with our chief financial officer to achieve the goal of becoming Medicare-neutral by bringing down our costs to match Medicare payment rates. We've invested heavily in data analytics to identify where the variations in care are. I have 45 clinical data and analytics

people who report to me. I've also established a separate clinical variation team that includes members from our contracting department; they have been able to get us data from our payers, which had been a black box for us for many years.

To align our physicians in our work, we have developed what we call a 'KEP score.' It looks at all the costs for a given DRG [diagnosis-related group] adjusted for the case mix index for each surgeon. The score also looks at clinical effectiveness, as determined by quality metrics that the physicians choose.

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Cerner

On the dashboard, our physicians can click on their respective scores and see where they land in terms of costs and clinical effectiveness compared with their colleagues. We are also working on incorporating external benchmarking data.

Eventually, we hope to use the KEP score to help determine physician compensation. We currently use an RVU [relative value unit] approach, but that is misaligned as far as incentivizing physicians to engage in value-based care. In the future, we might make 50% of a physician's pay incentive-based, based on the KEP score.

MODERATOR: Some of you, such as MercyOne and CoxHealth, have a population health service organization (PHSO) to oversee and integrate population health activities. Ray, can you explain what a PHSO is?

HERSCHMAN: The concept of a PHSO has evolved over time. In the first wave of managed care, there was a lot of activity around setting up PHOs, or physician-hospital organizations, to interface with managed care payers. In parallel, hospitals were developing medical service organizations, or MSOs, to help physician practices with administrative capabilities like patient scheduling and billing.

The PHSO is kind of a hybrid of a PHO and MSO. There's a lot of variation in how PHSOs are designed. But the underlying purpose of every PHSO is to help hospitals and health systems build and organize needed competencies — including data analytics, network design, and care delivery and management — so they can scale and take on value-based arrangements and risk.

MODERATOR: One issue that came up earlier was how to determine an ROI on population health

investments. Can you talk more about it?

KHATUA: We have not seen the financial benefits that we expected under shared-savings arrangements. Some of that has to do with the fact that we were already a low-cost, high-quality provider from the beginning of our journey. Our initial per member per year expense for our MSSP population was significantly lower than national and regional averages. Getting shared savings is a lot more difficult having a lower per member per year baseline.

RANEY: We're investing about \$6.5 million a year into our PHSO, not a small portion of which is data management and data analysis. And we've started asking whether we can prove that we are getting \$6.5 million back. Setting aside whether we are doing the right thing clinically, are we generating a financial return?

MODERATOR: Does anyone have advice on how to determine the ROI of population health investments?

HERSCHMAN: Showing an ROI in population health management is hard. Everyone in health care is throwing the kitchen sink at the goal of improved value. We're doing various interventions all at the same time, including analytics, patient navigators and primary care redesign. This makes it difficult to draw a line between a specific intervention and a specific financial impact.

There is a new type of analytics called causal analytics that may help with the ROI question. It involves mapping your interventions to what you think the effect of the intervention will be. For instance, how does patient engagement avoid a readmission or encourage patients to use telemedicine?

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CoxHealth

NOVAK: Historically, we've also struggled with the financial return question. Early in 2019, we went through an exercise in which we looked at six of our population health interventions to see whether they were impacting the key performance indicators we identified. For example, one intervention is our post-discharge, acute care management protocol, which is intended to prevent unnecessary readmissions.

For these six interventions, we determined the fee-for-service margin we achieved as a hospital

system, as well as margins associated with value-based arrangements.

As a result, we were able to determine the actual net impact of doing the right thing for patients by serving them in the lowest-cost, most appropriate setting. We have found that our per member per month investment equates to a 1-to-3 return on investment. We see this as an opportunity to distinguish our services in the market by providing better quality of care while generating alternative revenues for our organization.

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