Agenda

- Wide Angle Lens
- Transition in Real Time
- Continuing Evolution
- Market Dynamics
- Discussion and Questions

Market Dynamics: Wide Angle Perspective

Approaching the Tipping Point

- Leadership transitions are redefining institutional strategies
- Markets are driven by dramatically new purchaser expectations
- Acute care capacity may become commoditized
- The traditional ecosystem is experiencing business model step-change from unprecedented disruption
- There is an urgent need for significantly enhanced governance sophistication

Beyond the Tipping Point

- Value-based care framework must be based on risk capability goals and clearly-defined economic expectations based on reliable financial modeling
- Well-articulated PHM / VBC goals must go beyond "term of art" and crisply define the necessary supporting tool(s) and associated return-on-investment expectations
- A game plan for targeted clinical transformation is required to execute value based care, using responsibly-implemented population health tools, at the clinical level, led by fully-engaged clinicians with governance and compensation alignment

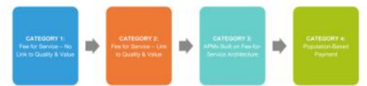
Approaching the Tipping Point: Risk Capability 1.0

Beyond The Tipping Point: Risk Capability 2.0

The Old Model

The New Model

Categories of Payment



Category 1

- Key Attributes
  - Professional and Facility services billed separately
  - Payment retrospective
  - Fee Schedules based on various methodologies & payer edit logic decreases reimbursements
  - Low Data Analytics Capabilities
  - No Integration necessary
- Fundamental Drivers
  - The more you do = the more you make
  - The more highly reimbursed the code = the better to bill
  - Quality not a consideration

CATEGORY 1
Fee for Service – No Link to Quality & Value

SUCCESS FACTORS
- **Negotiate increases annually**
- **Compare contracts using Medicare as a base**
- **Ultimate leverage is market share**

Category 2

- Key Attributes
  - FFS reimbursement architecture w/ added financial incentives tied to quality/efficiency metrics
  - Requires formalized process/investment by healthcare team to ensure quality metrics and cost efficiency measures are met
  - Minimal integration and data analytics capabilities necessary
- Fundamental Drivers
  - Financially incentivizes and rewards providers & healthcare team to target quality/efficiency metrics
  - Improves outcomes for given patient population
  - Potential for reduction in total medical expense

CATEGORY 2
Fee for Service – Link to Quality & Value

SUCCESS FACTORS
- **Establish realistic goals & baseline quality/cost efficiency metrics being measured**
- **Understand the reporting/reconciliation process; what, when, who and how**
- **Recognize exposure for downside potential and/or withhold**
- **Requires investment in infrastructure that can improve quality of care**

Category 3

- Key Attributes
  - FFS reimbursement architecture w/ added financial incentives and potential penalties tied to quality and efficiency
  - Performance measured compared to established 'target'
  - Includes Bundle Payments (tied to procedures), Shared Savings/Risk
  - Requires higher degree of integration and collaboration across the care continuum and higher level of data analytics capabilities
- Fundamental Drivers
  - Improves outcomes for given patient population and minimizes 'waste'
  - Encourages collaboration and establishes accountability between multiple providers – professional, ancillary and facility
  - Access to greater financial incentives and rewards providers for improving quality and lowering costs for a given population

CATEGORY 3
APMs Built on Fee-for-Service Architecture

SUCCESS FACTORS (ALL IN CATEGORY 2 AND…)
- **Requires sustainable resources and more advanced infrastructure to achieve goals**
- **Must meet cost AND quality measures in order to access rewards**
- **Trust and collaboration between providers and payers critical**

Category 4

- Key Attributes
  - Payment architecture reflects total cost of care for treating a primary (e.g., chronic) condition or managing an entire population
  - 'Person Focused' cover a wide range of services focused on preventive/maintenance
  - Requires the highest degree of integration and collaboration across the care continuum and highest level of data analytics capabilities
- Fundamental Drivers
  - Encourages providers to deliver well-coordinated, high quality person level care within a defined condition and/or population
  - Holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients

CATEGORY 4
Population-Based Payment

SUCCESS FACTORS (ALL IN CATEGORY 2 & 3 AND…)
- **Necessitates virtual integration for some models or vertical integration for highly integrated models**
- **Requires most advance transformational thinking about delivery system reform**

Impacts of Transition

- Traditional FFS
  - Emphasis on volume
    - Work RVUs
    - Big funnel
  - Salary Model
    - Productivity Model "Eat What You Kill"
  - Little to no incentive to manage care
  - No sharing of savings realized
- Value Based
  - Emphasis on the right kind of volume
    - Preventative care
    - Wellness
    - Care management
    - Primary care assignment and attribution
  - Salary Model
    - Productivity
    - Quality incentives
    - Outcome measured
    - Shared savings pool
    - Payment for care management
  - Incentive to manage care of defined population
  - Cost of care savings shared
  - Importance of actionable information

Focused Perspectives

- Ongoing Demand for Value //
  - Total U.S. spending expected to hit $5.7T by 2026
  - Spending continues to outpace developed countries
  - 60% of excess is due to pricing per unit; 40% is due to over utilization
- Purchaser Focus //
  - CMS continues to pursue value based payments (i.e., BPCI-A)
  - If you're not pursuing a value based model, you're behind the curve
  - Changes in payment models are spanning all payer and purchaser types
- Mixed Results To-Date //
  - Bundles are creating savings; ACOs showing mixed results but maturing
  - Wellness programs and price transparency having limited impact
  - Care management, access (telemedicine, urgent care) and medication adherence showing positive results
- Clinical Enterprise Maturity //
  - Quality, value, transparency and outcomes are the norm, not an innovation
  - Strong physician leadership / governance is required 'beyond the walls'
  - Compensation plans must incentivize PHM / VBC objectives
  - Data transparency and analytics are required for PHM / VBC design and performance
  - Clinical enterprise must organize around the PHM / VBC initiatives that show results

Continuing Evolution

Understanding the Trends

Clinical & Patient Inclusion / Exclusion

Narrow Inclusions
Providers Happy

Broad Inclusions
Payors Happy, Critical Mass

Due to critical mass concerns, most programs include most services

Understanding the Trends

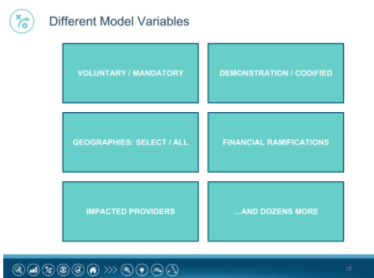
Prospective / Retrospective

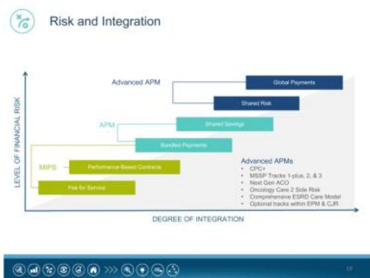
Prospective
Tighter Provider Alignment

Retrospective
Technically Easier with FFS Infrastructure

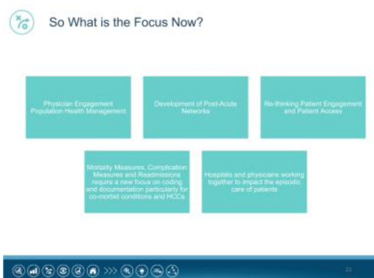
Prospective BPCI Model 4 is riddled with technical problems, low participation

Retrospective reconciliation is widely popular today

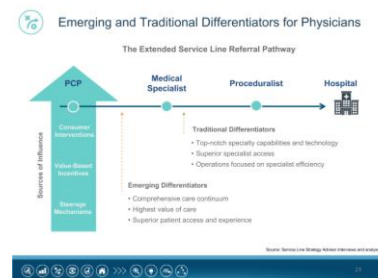

Different Model Variables
VOLUNTARY / MANDATORY
DEMONSTRATION / CODIFIED
GEOGRAPHIES: SELECT / ALL
FINANCIAL RAMIFICATIONS
IMPACTED PROVIDERS
...AND DOZENS MORE


Risk and Integration
LEVEL OF FINANCIAL RISK
Advanced APM
Global Payments
Shared Risk
APM
Shared Savings
Bundled Payments
MIPS
Performance-Based Contracts
Fee for Service
Advanced APMs
CPC+
MSSP Tracks 1-plus, 2, & 3
Next Gen ACO
Oncology Care 2 Side Risk
Comprehensive ESRD Care Model
Optional tracks within EPM & CJR
DEGREE OF INTEGRATION

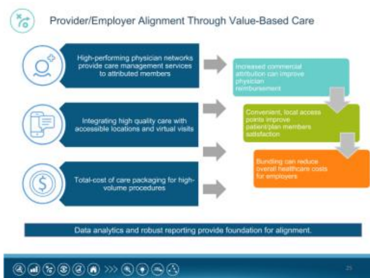
Market Dynamics


So What is the Focus Now?
Physician Engagement Population Health Management
Development of Post-Acute Networks
Re-thinking Patient Engagement and Patient Access
Mortality Measures, Complication Measures and Readmissions require a new focus on coding and documentation particularly for co-morbid conditions and HCCs
Hospitals and physicians working together to impact the episodic care of patients

Patient Engagement and Access
Digital communication strategies
Appointment scheduling protocol
Office hours
Provider availability
Telehealth
Source: Think Stock


Emerging and Traditional Differentiators for Physicians
The Extended Service Line Referral Pathway
PCP
Medical Specialist
Proceduralist
Hospital
Sources of Influence
Consumer Interventions
Value-Based Incentives
Steerage Mechanisms
Traditional Differentiators
Top-notch specialty capabilities and technology
Superior specialist access
Operations focused on specialist efficiency
Emerging Differentiators
Comprehensive care continuum
Highest value of care
Superior patient access and experience
Source: Service Line Strategy Advisor interviews and analysis

Characteristics of a Traditional vs. Retail Market
Characteristics of a Traditional vs. Retail Market
Traditional Market
Retail Market
Passive employer, price-insulated employee
1 Growing number of buyers
Activist employer, price-sensitive individual
Broad, open networks
2 Proliferation of product options
Narrow, custom networks
No platform for apples-to-apples plan comparison
3 Increased transparency
Clear plan comparison on exchange platforms
Disruptive for employers to change benefit options
4 Reduced switching costs
Easy for individuals to switch plans annually
Constant employee premium contribution, low deductibles
5 Greater consumer cost exposure
Variable individual premium contribution, high deductibles


Provider/Employer Alignment Through Value-Based Care
High-performing physician networks provide care management services to attributed members
Integrating high quality care with accessible locations and virtual visits
Total-cost of care packaging for high-volume procedures
Increased commercial attribution can improve physician reimbursement
Convenient, local access points improve patient/plan members satisfaction
Bundling can reduce overall healthcare costs for employers
Data analytics and robust reporting provide foundation for alignment.

Some People Don't Agree
This year thousands of men will die from stubbornness.
NO WE WON'T

DHG
healthcare
Bill Hannah, Principal
DHG Healthcare
Fort Worth, Texas
P: 817.276.4122
C: 404.561.0227
bill.hannah@dhg.com
DHG