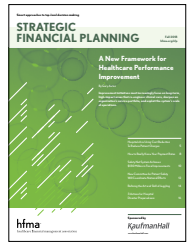


STRATEGIC FINANCIAL PLANNING

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The Strategic Value of Value

By Carl Couch

Even fee-for-service healthcare organizations can profit from adopting value-based strategies.

The healthcare business has never been tougher. Delivering high quality care at the lowest possible cost while remaining profitable keeps most senior leaders awake at night. Consider a 2015 *Health Affairs* article surveying more than 3,000 facilities:

- > 55 percent lost money on the majority of their patients
- > One-third had a net profit of less than \$1,000 per discharged patient
- > Only 12 percent had profits of more than \$1,000 per patient

Most systems lose money on Medicare, Medicaid, and of course, on self-pay patients, and the era of cost-shifting losses to commercial payers is over. Employers are finding healthcare costs unsustainable and incompatible with their corporate profitability. Patients, too, are burdened. The average income for a family of four in the United States is \$55,775, according to data from Department of Numbers, while the Milliman Medical Index found that their cost of health care is \$25,826. Annual increases in healthcare costs outstrip general inflation.

Where does a thoughtful leader in health care focus future investment? Pursue volume in the fee-for-service (FFS) world or make more investments in value and population health, betting on future payment shifts?

It's Not Volume or Value. It's Both

Let's quickly agree on a definition of value. One option is Value = Quality/Cost. There's no question that we have a

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national value problem: Our health care costs too much for the outcomes we get.

Recent Centers for Medicare and Medicaid Systems (CMS) initiatives, such as the Medicare Access and CHIP Reauthorization Act (MACRA) that pays providers based on quality and effective care, mandate that even in the pure FFS world, failure to deliver high quality and cost-effective services will result in substantial penalties. Even commercial payers may soon implement MACRA-like requirements, according to a HealthPayer Intelligence article.

MACRA is targeted at physicians for good reason: The majority of healthcare expenditures require physician orders. As a game-changer promoting better value, MACRA may be much more effective than the Affordable Care Act. As physicians accept ownership of their role in controlling costs, remarkable reductions in waste can occur.

Many healthcare leaders recognize that FFS payments, which reward quantity over quality, are the greatest drivers of healthcare costs, a Center for American Progress article reports. It's difficult to ignore the incentive of getting paid more to do more.

Baylor Scott & White Quality Alliance Five-Year Quality Performance		
Baylor Scott & White Quality Alliance (BSWQA)—an accountable care organization—five-year performance shows a reduction in costs on a per-member-per-month basis.		
Year	BSWQA Cost (PMPM)	Dallas-Fort Worth Community Commercial Cost (PMPM)
2012	\$470	\$470
2013	\$469	\$520
2014	\$500	\$551
2015	\$501	\$576
2016	\$470	\$605
Source: nThrive. Used with permission.		

Accountable care organizations (ACOs) with alternative payment models, like the Medicare Shared Savings Program, bundled payments, and partial or full capitation, have experienced varying degrees of success, yet, in reality, most systems depend on FFS to pay the bills.

Furthermore, building capability for population health requires significant investment in disease management, significant physician alignment, data and analytics, a strong primary care base, and contracts that incentivize patient engagement.

Some providers have met these challenges and are succeeding in value-based models. For example, Baylor Scott & White Quality Alliance (BSWQA), an ACO owned by Baylor Scott & White Health in Texas, shows that high-value care can be achieved. This ACO, now in its fifth year, has 5,700 physicians and more than 50 hospitals. BSWQA's five-year performance reveals that cost-effective care for the first 34,000 patients—the longest running contracted population with longitudinal performance data—was also high-quality care. Quality metrics for that population, such as emergency department reduction and adult preventive service delivery, were met or exceeded.

The aggregate savings in this single population over five years is more than \$65 million, and the cost of their care has remained dramatically flat compared to a 30 percent increase in cost of care per member per month increase in the community. By addressing financial waste, BSWQA has been able to invest additional dollars into population health.

Committed organizations like Baylor Scott & White Health can improve value and deliver better care. But the investments are significant, and it takes a long time to build population health expertise. And it's hard to visualize the strategic value of such investments when the majority of hospital payments come from FFS.

However, even FFS organizations can realize benefits when they develop population health capabilities, such as the following:

Develop population health capabilities. Using population health strategies creates better outcomes. For example, thorough pre-hospital care of diabetic surgical patients reduces hospital acquired infections and diabetic complications. Reducing such complications can improve the financial picture.

Understand the impact on volume. The ability to demonstrate high quality at low cost attracts markets. Payers and employers know hospitals' clinical outcomes and costs. High quality, lean care providers are attractive to other stakeholders. Value almost always attracts volume.

Take action. Although movement toward alternative payment models has not emerged in some communities as rapidly as predicted, eventually they will arrive. Hospitals that wait to develop their population health capabilities will be behind the curve.

Be a pioneer. Investing in population health capabilities may actually move a local market toward risk-based payments. Being a first mover can create a definite advantage.

Steps to Take Today

Value-focused population health capabilities can be initiated without breaking the bank. The following initiatives offer strong returns without significant financial outlays:

Integrate with willing physician communities. Use relationships and insider knowledge of the system to coordinate care. Forming well-integrated systems requires strong physician leadership and win-win initiatives to create the trust needed between physicians and hospitals.

Emphasize primary care. Investing in primary care is important for FFS and vital for value-based payments. You may need to assist your primary care physicians to become patient-centered medical home (PCMH) certified. High functioning medical homes save lives and reduce unnecessary costs.

Establish population health data systems.

Successful organizations must know their highest cost and sickest patients and proactively support disease management for those patients outside of FFS encounters. Integrating claims data and clinical data gives physicians and administrative leaders a comprehensive view of outcomes and cost. Physicians like to see that data longitudinally and view it in comparison to their peers.

Develop disease management programs.

Assigning disease managers to the top 5 percent of sickest patients pays great dividends in improving outcomes and reducing the two most costly events in health care: hospital admissions/readmissions and emergency department visits. ■

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