

INTELLIGENCE THAT WORKS

Value Based Care

Evolution and Current Trends

October 2023

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What do patients, payers and providers value?

- val·ue: /'vallyoō/

noun

1. the regard that something is held to deserve; the importance, worth, or usefulness of something. - "your support is of great value"

- Similar:

- merit
- worth
- usefulness
- use
- utility
- practicality
- advantage

What is it?

$$\text{Value} = \frac{\text{Cost}}{\text{Quality}}$$

At its core, value-based care is a reimbursement system that ties healthcare payment to the quality of care provided and rewards providers for efficiency and effectiveness. It is a model in which providers, including hospitals and physicians, are reimbursed based on health outcomes **rather** than service volume.



VBC Arrangement

Choosing the right arrangement and negotiating the right terms can be difficult. Unlike traditional FFS payments, where providers are reimbursed for each service they perform, VBC ties reimbursement to quality and cost outcomes, so a provider needs to understand its capabilities, strengths, and weaknesses.

Category	Model Description
Fee for Service (FFS)	Healthcare providers are reimbursed for each service performed.
Pay for Reporting/ Performance	Rewards providers for meeting predefined targets for quality indicators or efficacy measures
Patient-Centered Medical Home	Team of physicians and personnel manages patient's primary care to improve quality and care coordination.
Shared Savings (with Downside Risk)	Network of physicians, hospitals, and other providers who form an ACO. ACOs are accountable for total cost and quality of care over a defined performance period and can share in savings they generate during the performance period.
Episode-Based Payment Models	Holds providers accountable for the cost and quality of care received by beneficiaries during an episode of care following an event. Providers can share in savings they generate during the episode of care.
Primary Care Capitation	Payer makes a prospective unit of payment per patient, for a limited set of primary care services, regardless of the actual quantity of services provided.
Global Capitation	Payer makes a prospective unit of payment per patient, for most health services, regardless of the actual quantity of services provided.

Source: BRG analysis of HCPLAN Alternative Payment Model (APM) Framework

The Dominate International Trend: Global Payment and Explicit Quality Incentives (GPQI)

Rational:

- Its Hard! They have tried to make changes and only 2 work in the US – Simple works!
 - Capitation / tightly closed networks : Kaiser
 - Capping / linking Reimbursement
- The rigid connection of global rates (bundles) and quality (desired outcomes) drives the best macro value

What doesn't work about traditional Value Based / quality “bonus” threshold contracting

- It doesn't move the needle - best case ... minor episodic improvements
- Quality indicators that are technical (e.g.: some poorly aligned process improvement)
- Pay for Performance has produced little impact to outcomes and unless applied to a very tight micro environment it does little to change provider behaviors
- When stand alone able VBC contracting is TOO aggressive, provider subscription erodes and limits to care provided appear.

Who are the Leaders? Maryland / Massachusetts, Netherlands, Norway, England



Global Payment and Explicit Quality Incentives

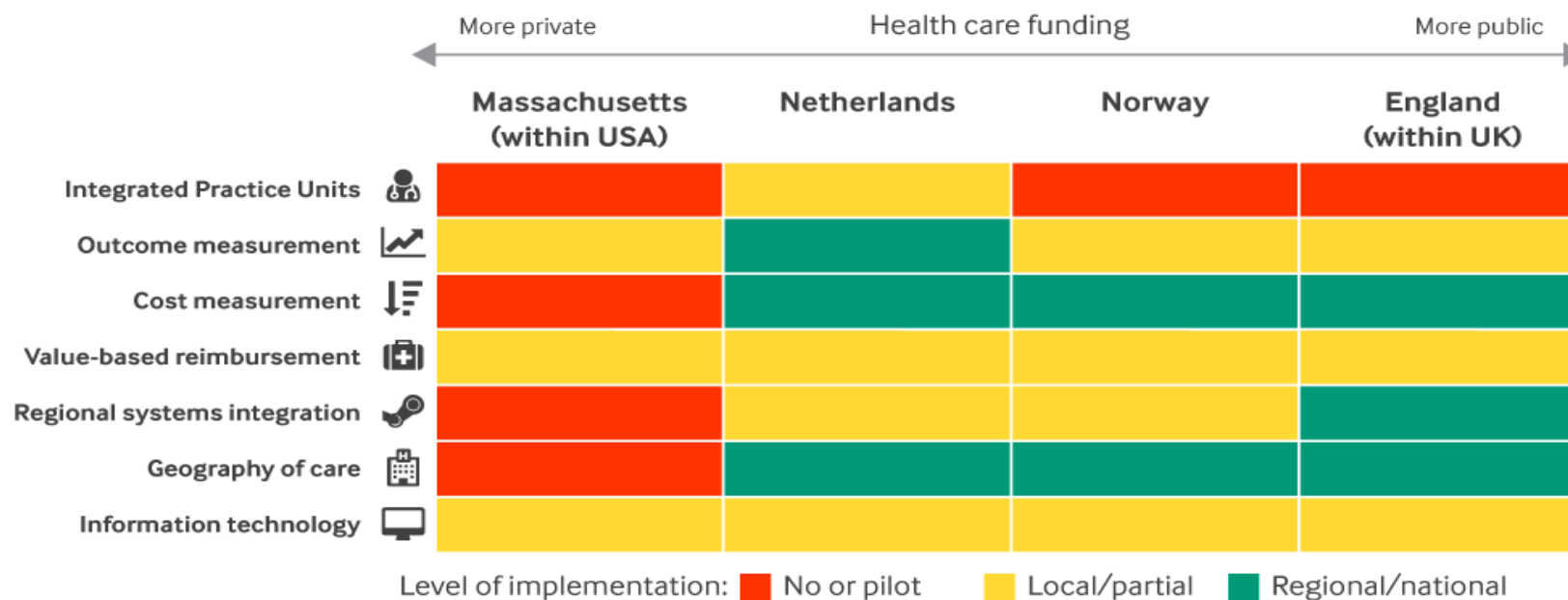
Best Features

- Predefined Population: By setting your population parameters, the conversation moves from helping maintain reimbursement to supporting people in a local population
- Integrated Practice Unit (IPU). Contract entities that are organized around a medical condition or a set of closely related conditions and has a co-located multidisciplinary team that regularly meets to discuss care plans for patients.
- Limit the scope: The complexity of monitoring and controlling a patient population from cradle-to-SNF for risk makes fusion energy look like Wordle.
- Standardized Data: All outcome data should follow measures for a specific medical condition, cover multiple aspects of patient health, be relevant for both clinicians and patients. Technical measures should be de-emphasized. Outcomes should be provider driven. The MD is the leader.
- Cost: THE ACTUAL COST of delivering care to a patient with a certain condition are measured from the bottom up, by looking into what happens to a patient in the course of a treatment and what specific costs of all processes are associated with it. Proxy will be necessary (Dutch heavily rely on Bed Days) Biases will be plentiful (US costs are skewed to support fee-for-service infrastructure.
- Good Risk Balancing: Flexible Value Base Reimbursement / Bundled payments are risk-adjusted contracts made with providers for all services over a full care cycle or a defined time period and across providers that can be regularly updated.



Global Payment and Explicit Quality Incentives

Implementation of the Value-based Health Care Elements in Massachusetts (USA), the Netherlands, Norway, and England (United Kingdom) as of August 2020.



Note: The 7 elements here are based on Reference 3: Porter ME, Lee TH. The Strategy that will Fix Health Care. Harvard Business Review. October 2013.

Source: The authors

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society



What are the interesting national trends?

$$\text{Value} = \frac{\text{Cost}}{\text{Quality}}$$



No Place Like Home: Inpatient At Home



Trends and Characteristics

- The concept has been around for a while but COVID accelerated acceptance.
- Patients receive acute-level care in their homes, rather than in a hospital. Hospital-at-home care is well-suited for medium acuity patients who need hospital level care but are considered stable enough to be safely monitored from their homes.
- Some hospitals run the program out of the emergency department (ED) and admit eligible patients to their homes, while others rely on community paramedics or specialty clinics to refer patients into the program.
- *The Short IP Stay Replacement:* Hospitals focus on a specific patient population for hospital-at-home care, such as providing oncology care, chronic obstructive pulmonary disease (COPD), diabetes or cellulitis or post-surgical monitoring at home, enabling a planned “home admission”.
- New Rural Option: Hospitals also are adapting home hospital care to meet patient needs in rural regions.

No Place Like Home:

Trends and Characteristics

- Requirements include being consistently connected to their care team through a combination of in-person visits, video visits and continuous biometric monitoring via telehealth technologies.
- Hospitals are ramping up mobile services in the home setting, including:
 - Diagnostic studies such as electrocardiograms, echocardiograms, and x-rays;
 - Treatments such as oxygen therapy, intravenous fluids, intravenous antibiotics and other medicines
 - Services such as respiratory therapy, pharmacy services and skilled nursing services.



Transmittal 11191

Revenue Code 0161

Occurrence Code 82: The from/through dates of a period of hospital at home care provided during an inpatient hospital stay.

Subcategory Definition: Room & Board – Hospital at Home

Standard Abbreviation: R&B/Hospital at Home

Effective Date: July 1, 2022

Going Small

The Explosion of Micro-Hospitals

- Micro-hospitals serve low-acuity patient populations requiring minimal inpatient, outpatient, diagnostic and emergency services. They are VERY efficient and cost effective vs a typical short stay hospital. They range from 8 to 30 beds and 15,000 to 60,000 square feet.
- Micro-Hospitals can't usually perform surgery or deliver babies (some facilities are building operating rooms and creating ancillary OBGYN partnerships), they do offer a lot of emergency services and support typical short stay requirements. They can accommodate patients suffering from diseases and conditions such as acute abdominal pain, sprained and broken bones, dehydration, heart attacks, pneumonia, seizures, minor trauma, bladder infections, lacerations, and more
- There are more than 60+ micro-hospitals currently in operation across 19 states. Most were developed by or in partnership with local health systems or private equity within the past five years. Another 40 new projects are coming online in the next two years



Small but are they mighty?

- Micro-hospitals are priced higher than urgent care centers, but far less than a full-service hospital emergency center or inpatient facility.
- Following guidance from the Centers for Medicare & Medicaid Services, the Joint Commission is no longer conducting accreditation surveys at hospitals with an average daily census of fewer than two inpatients. The absence of accreditation would result in a facility not receiving Medicare reimbursement as an acute care hospital.
- Questions have arisen (similar to those specific to the free-standing EDs) as to whether micro-hospitals are increasing total costs of care by encouraging ED utilization for health problems that could be treated in lower-acuity settings such as urgent care centers and retail store clinics.
- Health care institutions must be careful when considering the opening of a micro hospital. Albeit small, a micro hospital must still meet all of the requirements of a hospital under both state and federal law.



