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Elizabeth Mitchell,
President & CEO of
Purchaser Business
Group on Health

VALUE-BASED CARE?

Employers are starting to question whether it will take hold.

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STILL WAITING FOR VALUE- BASED CARE

Elizabeth Mitchell, president and CEO of Purchaser Business Group on Health, is one of a growing number of industry leaders voicing skepticism about the movement to implement value-based care.

BY LOLA BUTCHER
HFMA Contributing Writer

The effort to adopt value-based payment in healthcare is losing some of America's biggest healthcare purchasers: large employers, many of which are giving up on the concept.

"It has been a failure to date because obviously we do not have value in healthcare," said Elizabeth Mitchell, president and CEO of Purchaser Business Group on Health (PBGH), which is shifting a big part of its focus on other cost-saving strategies.

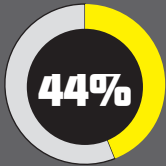
PHOTOS BY MARSHALL CLARKE

FROM THE FIELD

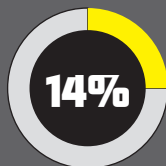
HFMA conducted a survey of 105 healthcare finance executives, with selected results found throughout this report.



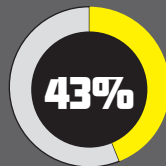
In order to survive, do providers need to make the transition from providing healthcare to ensuring health?



YES



NO



UNSURE/
TOUGH TO
CALL

Source: HFMA survey of 96 healthcare financial executives in February and March.

The group's members are nearly 40 huge employers and public purchasers — Microsoft, Walmart, Boeing are a few of them — that collectively spend \$350 billion on healthcare annually. They, among others, have lost confidence that the so-called value movement in healthcare is the salvation it was supposed to be. Without employers' insistence, it's unclear if value-based care will ever take hold.

"Prices have gone up dramatically and quality has not," Mitchell said. "So value has decreased, and I do not see any serious attempts to change that by most of the industry players."

Economists Michael Porter, PhD, MBA, and Elizabeth Teisberg, PhD, coined the term *value-based healthcare* to envision a system in which physicians and hospitals are

rewarded for value — the best quality of care at the lowest cost — instead of volume, where they rack up revenues with fee-for-service (FFS) payments.

Many important stakeholders — CMS, health systems and commercial insurers — saluted the vision of value-based care. In the past 15 years, hundreds of experiments to replace FFS contracts with alternative payment models (APMs) have launched. Many of them have reduced costs and improved quality — and many have not.

NOT GIVING UP

APMs still have a sizable number of supporters. Management at Allina Health, a two-hospital system serving Minnesota and western Wisconsin, was disappointed with its early value-based

arrangements, but its board of directors recommitted to value-based care in 2019.

"We are doing it because we believe it's the right thing to do for our community," said Ric Magnuson, MBA, the system's CFO.

And in the long run it's also the right thing to do for health systems because CMS, the nation's biggest payer, is doubling down on value-based care.

"We're definitely in a better place, especially because I don't think the status quo is going to be an option," Magnuson said. "And if you're not on this journey to value-based care, there's going to be a wake-up call someday."

Years ago, OSF HealthCare, based in Peoria, Illinois, reached the point where it could attribute about 26% of its patients to value-based contracts. But since then, it has been stuck at that level.

"We have interest in it, and we have had some success, particularly in our shared-risk and capitation agreements," said Michael Allen, FHFMA, MBA, CFO of the 15-hospital health system. "But we have not seen an appetite from the payer side to do more."

COSTS KEEP CLIMBING

Skeptics point out that, despite all the attention to value in the past two decades, healthcare costs overall have continued to rise almost every year. CMS actuarial estimates show that national health spending grew by an average of 4.8% annually from 2011 to 2021, arriving at a total of \$4.3 trillion in 2021, which is 18.3% of gross domestic product.



We have interest in [value-based care], and we have had some success, particularly in our shared risk and capitation agreements."

— Michael Allen, CFO, OSF HealthCare



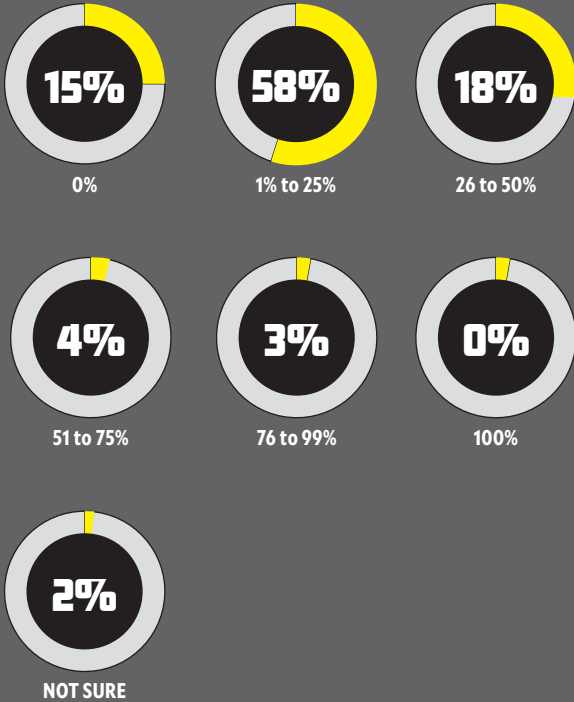
If you're not on this journey to value-based care, there's going to be a wake-up call someday."

— Ric Magnuson, CFO, Allina Health

FROM THE FIELD



How much of your care is covered by value-based contracts with downside risk?



Source: HFMA survey of 95 healthcare financial executives in February and March.

“You probably could find evidence of improved care coordination here and there and on reducing waste kind of on the edges,” she said. “But as for affordability, APMs do not address high unit prices, and year after year, all of the evidence shows that it’s prices, not utilization, that’s driving up commercial costs.”

CLINGING TO FEE-FOR SERVICE

In a survey conducted by HFMA for this report, 43% of respondents said they were unsure or found it too tough a call whether or not providers should transition to focusing on health from a focus on providing healthcare in order to survive. Another 14% said such a shift was not needed.

David Johnson, HFMA board member and founder and CEO of 4sight Health, said the pivot away from FFS to value-based care contracts stalled out because many so-called value-based arrangements are based on FFS rates.

“Despite all this talk about value the last 10 years, we still have 80%-85% [of payments] in fee-for-service,” he said. “Health systems continue to cling to the payment model.”

There is an incentive to do so when per-unit prices are high. In Johnson’s view, the majority of healthcare services are routine, meaning the health system knows just what to do when the patient presents for care. In other industries, that situation typically triggers price reductions as a way to compete, he said.

“Basically, what we’re saying as an industry is it’s



We forget that we are actually trying to achieve lower total cost of care and better health outcomes. The payment method is just in service to those goals.”

— Elizabeth Mitchell President and CEO, Purchaser Business Group on Health



All of the evidence shows that it’s prices, not utilization, that’s driving up commercial costs.”

— Andréa E. Caballero, interim co-executive director of Catalyst for Payment Reform

“We have lost the plot when we talk about value-based care,” Mitchell said. “It’s lots of complicated contract elements, but we forget that we are actually trying to achieve lower total cost of care and better health outcomes. The payment method is just in service to those goals, and I feel like people forget that.”

The nonprofit Catalyst for Payment Reform (CPR) — whose members include private employers, public purchasers, state health insurance

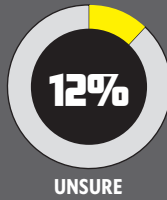
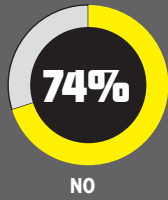
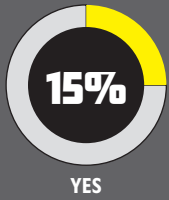
exchanges and others — was founded in 2009 to push for value-based payments. In 2010, CPR estimated that just 1%-3% of healthcare dollars were tied to quality; in 2022, its estimate surpassed 60%.

Andréa E. Caballero, MPA, CPR’s interim co-executive director, finds little satisfaction in that progress. APMs were designed to increase affordability and improve quality by reducing waste and improving care coordination, and they have been only incrementally successful.

FROM THE FIELD



Is the industry ready to accurately measure value and quality?



Source: HFMA survey of 95 healthcare financial executives in February and March.



Chestnut Health Systems Inc., whose nurse manager, Erica Quick, is seen above with patient Maurice Betts, is one of four federally qualified health centers participating in OSF HealthCare's Medicaid Innovation Collaborative.

OSF readies for value-based care in Medicaid

The majority (70%) of OSF HealthCare's business is paid for by Medicare and Medicaid, prompting Mike Allen, FHFMA, MBA, the system's CFO, to identify Medicaid as presenting the next big opportunity for assuming risk.

"Trying to wade into a value-based agreement for the Medicaid population is not for the faint of heart, but we're cautiously watching for the opportunity to do that," he said. To prepare, OSF contracted with the state of Illinois to provide virtual pre- and post-partum services to obstetric patients covered by Medicaid.

It is not an insurance contract, but a services contract for patients living in a certain part of the state. In its efforts to engage patients who might not otherwise be able to access appropriate care, OSF works to help mothers avoid potentially devastating — and expensive — problems for themselves and their babies.

OSF already convened the Medicaid Innovation Collaborative (MIC), a partnership between OSF and four federally qualified health centers. The state-funded, five-year initiative is designed to improve outcomes, decrease disparities and reduce costs using sustainable programs, according to OSF.

"As we learn more about how to deliver those kinds of services and prove we can reduce the cost of care for those services, that gives us the opportunity to consider Medicaid as a potential value-based payer," Allen said.

— Lola Butcher



Sachin H. Jain, CEO of SCAN Health Plan said the culture of being a CFO in healthcare needs to change.

OK to charge premium prices for routine services because we're healthcare," he said. "And I just don't think the wider marketplace accepts that anymore."

Sachin H. Jain, MD, MBA, CEO of SCAN Group and SCAN Health Plan, has also soured on valued-based care as a panacea to America's healthcare cost crisis. Provider organizations still measure their success by growth, which means increasing revenues.

"We need to change the culture of being a CFO in American healthcare," said Jain. "Maybe in a world where everyone is healthier, healthcare organizations don't grow — they shrink. The next generation of CFOs needs to

challenge themselves on a new set of metrics above and beyond top-line and bottom-line revenue as a measure of performance."

SO WHAT'S THE ANSWER?

PBGH's goal: Zero growth in healthcare costs.

"At least two of our members have achieved a flat trend with better outcomes, so we know it's possible," Mitchell said.

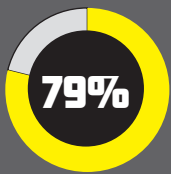
In her view, reducing specialty care spending by prioritizing advanced primary care that incorporates behavioral health is the success strategy over specialty care. But PBGH members don't believe that traditional health systems and health plans will deliver it. Their evidence: PBGH's Health Value Index, which tracks health plan performance against PBGH priorities, shows a disconnect between what purchasers want to buy and what's available in the market.

"We're going into our third year; our members are saying

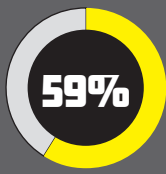
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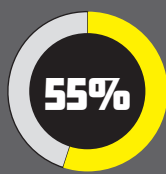
What areas of improvement is your organization targeting to provide a more consumer-focused patient care experience? (Choose all that apply.)



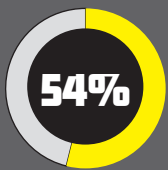
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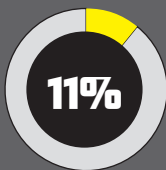
DISCHARGE,
FOLLOW-UP AND
HOME CARE



BILLING/
TRANSPARENCY



CONTINUITY OF
CARE/CLINICAL
DECISION-MAKING



OTHER*
(PLEASE SPECIFY)

*Cited were digital front door, complex care clinic, equitable access and care, throughput efficiency and all of the above.

Source: HFMA survey of 95 healthcare financial executives in February and March.

TIPS FOR NEGOTIATING VALUE-BASED CONTRACTS

BY LOLA BUTCHER

HFMA Contributing Writer

OSF HealthCare participates in CMS' Medicare Shared Savings Program and in capitation, shared risk, shared savings and pay-for-performance contracts with commercial payers, so CFO Mike Allen's years of experience negotiating value-based contracts have yielded some valuable lessons.

For example, a payer's ability to provide meaningful data about patients, claims, trends and benchmarks is essential to success in value-based contracts. OSF HealthCare has exited some contracts because the payer could not provide data.

"If the agreements were not designed in a way that would allow us to understand how to improve the cost of care for a particular group of patients, then we unwind ourselves from those agreements," Allen said.

Besides the mandate for payers to provide data, here are some additional tips worth considering from Allen and the CEO of Atrius Health, Patrick Holland, who also has extensive experience in value-based models.

1 Ask for financial support to get started. When provider organizations are new to value-based contracts, payers may be willing to provide support. "Try to negotiate some management fee dollars that will help you start building the centralized programs that you will need to be successful in the long run," said Holland.



Patrick Holland, CEO, Atrius Health, said providers should ask for financial support from payers to get started in value-based payment arrangements.

it's very important to them that a higher percentage of spend goes into advanced primary care, and the trends are actually going in the other direction," Mitchell said.

Johnson of 4sight Health agrees that care delivery, not just payment method, needs to change.

"The industry needs major restructuring," he said. "Part of what needs to happen is a shift of resources out of acute and specialty care into health promotion, primary care, chronic disease management and behavioral health."

GOING DIRECT

Direct employer-to-provider contracts for elective surgeries have been a winning strategy for PBGH members, and the organization is building on that concept. It is working to build a national primary care center of excellence network, with specialty referrals based on quality.

That network may not include traditional health systems. When PBGH issued a request-for-information from organizations interested in

providing advanced primary care to its members, Mitchell was surprised by the strong response.

Employers and clinicians have the same aims and employers going direct enables new and aligned relationships. The intermediaries haven't served employers' needs, Mitchell said.

CPR, meanwhile, is pivoting its energy from payment reform to regulation.

"Our shared agenda for 2023 is to push hard by playing the policy card," Caballero said. "The marketplace interventions that we and others have been working on for a decade have made incremental changes in the system, but we have some significant issues that we think only state policy intervention will be able to help with."

Knowing that not all states will be amenable to the same policies, CPR has developed five menus of policy options ranging from penalties for engaging in anticompetitive behavior to price regulation. It intends to start by focusing efforts in three states to identify what policy interventions might work best in each of those states and to push for adoption of those policies.

"We are seeing evidence that this can be a winning strategy," she said. "Purchasers in states like Indiana, Montana, Colorado and a variety of others are definitely coalescing around the idea that outside forces need to be deployed to help address the issue of high commercial prices."

CPR still believes that value-oriented payments are



David Johnson, HFMA board member and CEO, 4sightHealth, says fee-for-service payments stand in the way of easing price growth.

essential to lowering America's health cost crisis.

"They are very much an element to address affordability, but it's not the only ingredient," Caballero said. "But addressing high prices that undermine the potential of alternative payment models is also an ingredient."

100 YEARS OF CHANGE IN ONE DECADE

Johnson thinks forces from the marketplace will change healthcare delivery more in the next decade than it has in the last century, and the industry may be reshaped along the way.

"There's no doubt it will be a messy decade," he said. "We've been making incremental changes and don't have a lot to show for it. This increases the likelihood that it will be more of a catastrophic-level change like Medicare bankruptcy or a collapse of the provider system."■

Lisa Eramo contributed to this article.

About the author

Lola Butcher is a regular contributor to *hfma*.

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Keep quality metrics separate from financial risk, if possible. Value-based contracts typically include quality measures, but Atrius tries to avoid tying financial risk to quality goals. "We like to think of quality and cost as separate but related parts of the model," Holland said. "So we try hard to negotiate upside-only for quality. But if quality is a gate to financial risk, then we work closely with our quality and safety department as well as the health plan to make sure the measures are reasonable, and we can be very confident we can meet them."

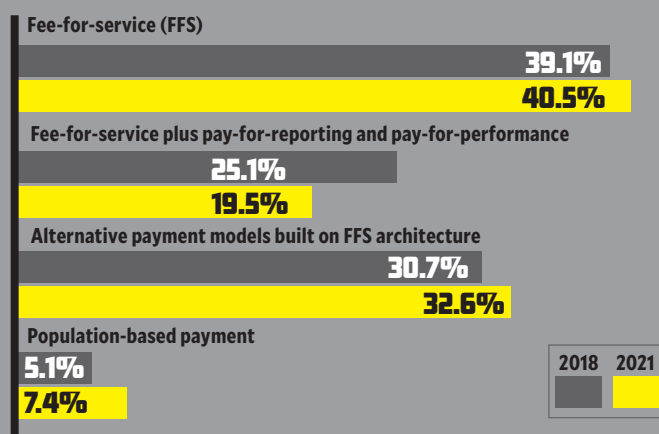
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Be smart about the risk you take. Only accept risk for the medical expenses that you have control over, Holland said. For a primary care-only group, that may mean accepting risk only for professional services. If you don't want to manage pharmacy costs, negotiate that in the contract.

4

Don't allow black box calculations from the payer. Transparency in payments is essential because health systems must understand how their new care models lower the cost of care. "If I just get this number that said, 'you got this much shared savings,' if we can't figure out what we did to get there, it doesn't help us," Allen said. Likewise, the payer must be able to explain how its members are attributed to the contract in a way that makes sense. Health systems should not be held responsible for misattributed patients. "Are we getting attributed patients that maybe touch our health system, but we really don't have enough interaction with them to help manage their care?" Allen said.

Percentage of payments in models with a connection to quality or value for all payers



Source: Health Care Payment Learning & Action Network

BY PAUL BARR
HFMA Senior Editor

As a component of HFMA's third year publishing the Healthcare 2030 series, which looks at major trends in the healthcare industry, supporters of the series have provided an analysis of Part 2 of the four-part series. Part 3 will look at social determinants of health and Part 4 will examine personalized care. Learn more about past and current installments at [HFMA.org/healthcare-2030](https://www.hfma.org/healthcare-2030).

WAIT SHOULD BE WORTH IT IN THE LONG RUN



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MIKE MORRIS

President and CEO
Xtend Healthcare

The hype and hope surrounding value-based care models has not yet produced its intended benefits. For decades, the healthcare industry has explored a variety of alternative payment models to promote better health outcomes at a lower cost of care. Despite these efforts traditional fee for service payment models continue to account for 90%+ of provider revenues. That trend shows no signs of reversing anytime soon, so providers must remain focused on the fundamentals of traditional revenue cycle management.

Although fee-for-service continues to be the dominant reimbursement model, large employers will continue to push for more efficient ways to incent better health outcomes at a lower price point. Providers can and should play a prominent role in guiding that exploration. There are some prudent things for providers to consider on this long journey:

- **Know your data:** If a cohort of patients move to a value-based reimbursement model, it is important to analyze any resulting loss in fee-for-service revenue from that patient group. A realistic understanding of the net impact of revenue shifts as well as expected cost savings will help

providers avoid entering into value-based models that don't make economic sense.

- **Recognize the uniqueness of each opportunity:** The success of value-based care can vary based on factors such as the specific healthcare system, geographic region and in-scope patient population. What works well in one scenario might not have the same impact in another, making it crucial to tailor strategies to individual contexts.
- **Collaborate with stakeholders:** The pursuit of value-based care requires collaboration among healthcare providers, payers, policymakers, employers and technology companies. Innovations in data analytics, telehealth, and patient engagement technologies are continuously being developed to support the mutual goals of stakeholders.
- **Empower your patients:** Giving patients more information and involving them in their care decisions can lead to better outcomes. Stakeholders can develop patient education resources, support shared decision-making and leverage telehealth solutions to increase patient engagement and active participation in value-based care models.

Fee-for-service reimbursement is still the dominant model today and will continue to be for years to come. But the potential material benefit to all stakeholders of transforming to a value-based care model makes the slow journey worth the time investment to get it right.

LESS COMPLEXITY, MORE INCENTIVE NEEDED



FORV/S

DANIELLE SOLOMON

National Industry Partner, Healthcare
Forvis

STILL SALVAGEABLE

Value-based care has progressed more slowly than expected. Rather than casting the entire movement and everything involved in it as a failure, it's more valuable to isolate the root causes of why value-based care hasn't met lofty expectations.

Incentives for providers of all types are not significant enough to entice a complete shift in business and operating model fundamentals – especially when the majority of financial upside resides in inpatient beds. The bottom line is that models are too complex, and incentives are too small to justify provider investment. Until both are addressed, our paced progress will unfortunately continue.

WORKING TOGETHER

Stakeholders should collaborate across payer, provider, patient, and employer groups in markets to define specific metrics that are valued by all and allocate enough at-risk dollars in contracts to those metrics to incentivize value-based behaviors.

REGULATORS' ROLE

Fee-for-service payment structure has become the backbone of American healthcare finance. However, the time has come to return our attention to reimbursement mechanisms that reward value.

The push in the near term for providers should be to bring the concept of value to the very center of their strategic and operational decision-making. In the long term, anything beyond the secondary use of fee-for-service will hamper providers' attempts to be the catalysts of change they should aspire to be. So now is the time for regulators to increase their pressure on fee-for-service payment models and their disincentivizing impact on the pursuit of value.

WHAT ELSE CAN BE DONE?

There is a laundry list of strategies we could list, but likely the most important next step might be a mindset shift – health versus healthcare. Any spending or savings that focuses on one's health versus healthcare is a step toward long-term value (improved quality at a lower aggregate cost). A quote in a Healthcare 2030 article challenged the reader and noted that we all have a responsibility to do what we can to make people healthy, and every CFO needs to say, "what am I doing to contribute to that?"

The hope is that we all become part of an enterprise that generates health rather than promoting cure. If we take on that mindset, keep it rooted in our culture, decision making and priorities, we will make progress to limit cost growth and improve quality *and* have a healthier community.

“Now is the time for regulators to increase their pressure on fee-for-service business models.”

USE WHAT WORKED, DROP THE REST



CHARTIS

MAUREEN WARD

Principal
Chartis

VALUE-BASED CARE'S CURRENT STATUS

Health systems have been executing against the value-based care business model for the last decade. Value-based care isn't failing—in many cases an organization's desire or ability to align care delivery and financing requirements hasn't been fully tested or realized. The total cost of care has to materially decrease to be successful. We are afraid to make intentional decisions to decrease our (already thin) margins by introducing more cost-effective care, or we don't have the patient scale required to measure and prove the value we have created.

GETTING BACK ON TRACK

Stakeholders must revisit the value-based care business model and prioritize the patient cohorts that have proven financial performance at scale. Value-based care is very different from heterogeneous fee-for-service care delivery. Patient segmentation by payer and medical spend (utilization) is required for insights into business model implications. The value-based care business model does not work if the patient cohort and the associated care delivery model and financial objectives do not have significant overlap. Organizations can determine care delivery and

financing or cost goals with patient segmented information, and they can create value by achieving incremental results toward those goals for a segmented cohort.

GETTING THE INCENTIVES RIGHT

In addition to patient segmentation, providers and care teams should be incentivized in their work to achieve those important outcomes and cost results. Fee-for-service won't be going away any time soon. There is more momentum to be created by incenting organizations rather than reducing the use of fee-for-service payments. Creating programs with accessible, timely incentive payments will pull organizations into value-based care more effectively than pushing them with reduced fee-for-service payments.

WAYS TO LIMIT COST GROWTH AND IMPROVE QUALITY

Several tactics need to be incorporated more assertively into care delivery, care financing and the value-based care business model. They include high performing networks, care delivery moved to the lowest-cost sites of service, targeted interventions specific to patient segments, patient benefit design and consumer accountability. Private equity and public, for-profit organizations are rapidly developing and scaling businesses focused on value-based care efforts. Health systems have opportunities to evaluate and emulate these models. For example, care delivery for seniors with Medicare Advantage coverage has rapidly evolved to high-touch and virtual interventions to reduce emergency room and inpatient utilization, low/no copays to improve medication compliance and manage health status, and advanced care planning to include palliative care and hospice services, effectively reducing the cost of care at end of life.

“Creating programs with accessible, timely incentive payments will pull organizations into value-based care.”

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Healthcare Financial Management Association

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