




Value-Based Care in 2024

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February 15, 2024



Meet the Presenter



Michael Wolford

Principal

Healthcare Strategy & Finance

FORVIS' HEALTHCARE PRACTICE

FORVIS Knows Healthcare

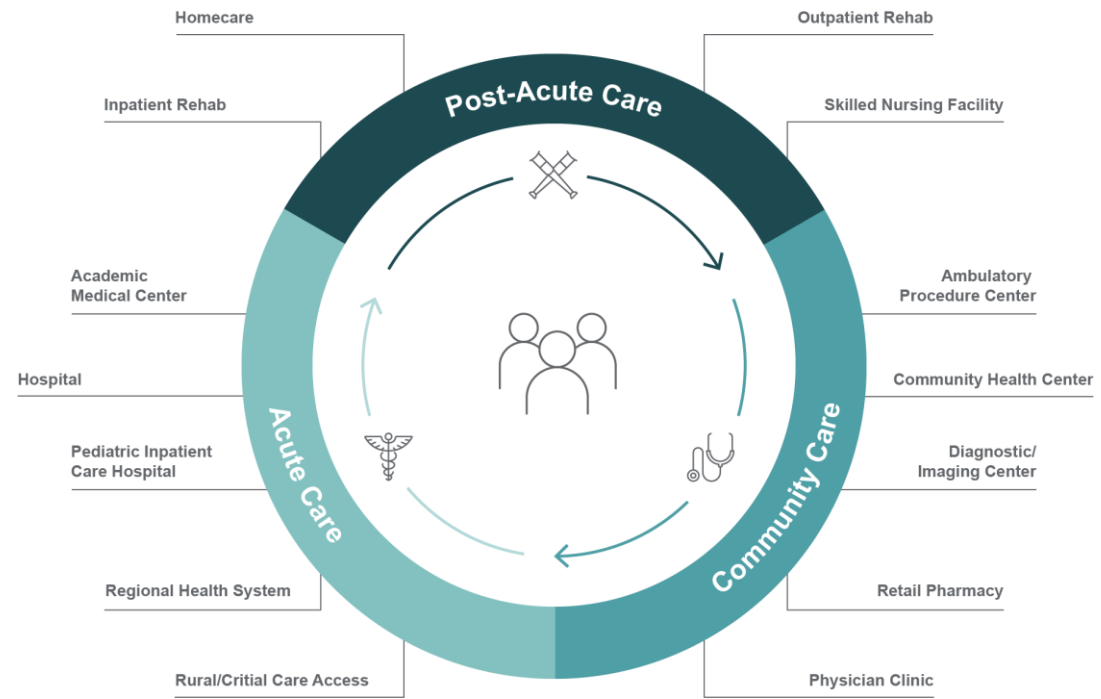
1,030+
team members

5,200+
Healthcare clients

175+
PPMDDs

FORVIS

Serving the Entire Continuum of Care



Modern
Healthcare

92

Healthcare Net
Promoter Score



9th

Largest Healthcare
Consulting Firm



1st

Largest Healthcare
Auditor

2nd

Largest Healthcare
Tax Preparer

Sources: UCX survey NPS score; Modern Healthcare's Largest Management Consulting Firms 2023 ranking; OMB data via the Federal Audit Clearinghouse based on HHS CFDA's for number of Single Audits performed; and Cause IQ based on Form 990s for non-profit healthcare providers

Today's Objectives

1. Reflect on how value-based care has evolved in the last 10 years
2. Evaluate your organization's urgency for value-based care innovation
3. Prepare for future value-based care imperatives

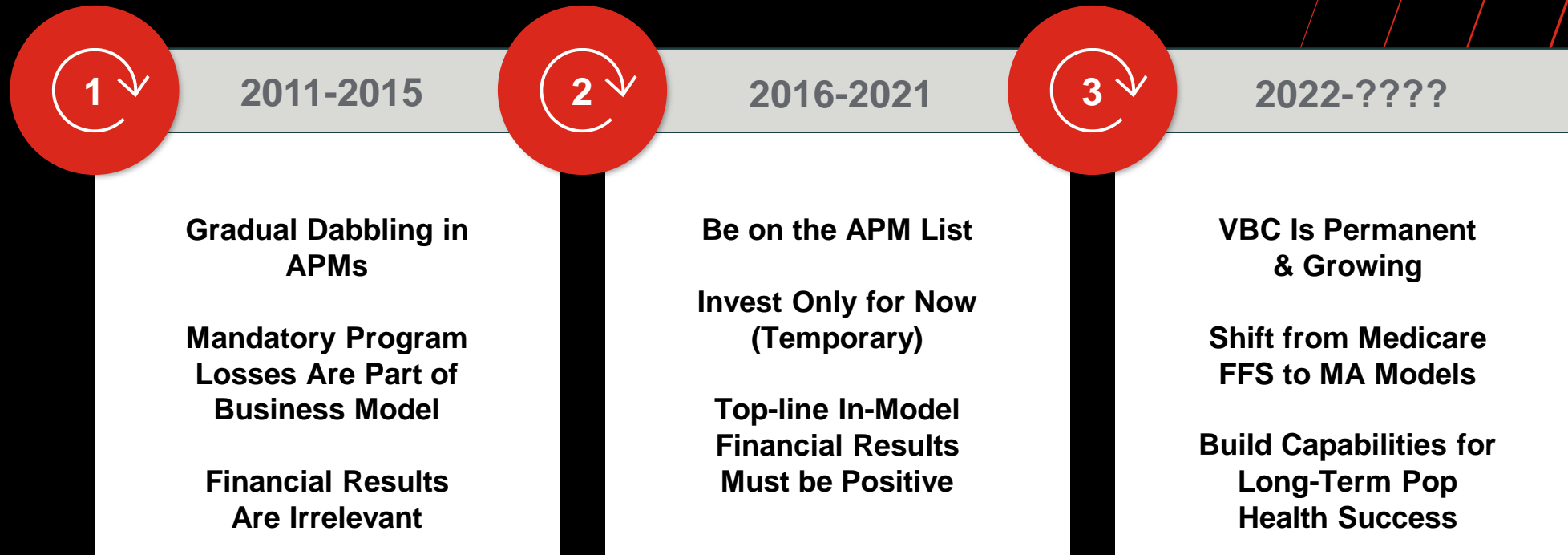
Value-Based Care (VBC): What Is It?



“Value-Based Health Care is a framework for restructuring health care systems around the globe with the overarching goal of value for patients.”

- Professor Michael Porter, Harvard Business School

The Third Business Cycle of VBC



Three Common Profiles



VBC is an integrated part of our mission

Dictates managed care contracting



Managed Care & VBC should collaborate more than they do

Fee for service managed care contracting & VBC teams are existing in parallel universes

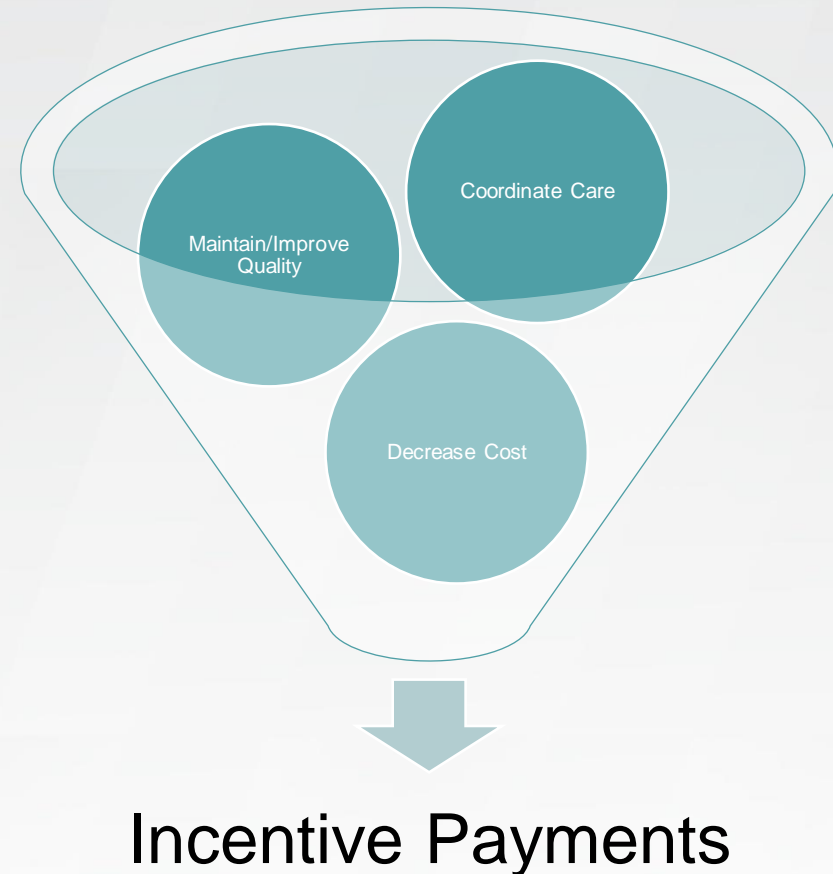


Hang on tight to FFS; don't give away rates on voluntary VBC arrangements

- Not an imperative
- Minimal payor pressure
- Not central to the mission
- Less competitive markets

Alternative Payment Models (APMs): What Are They?

- An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.



Poll: Does your organization participate in any APMs?

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Fundamental Challenges to APM Adoption Persist



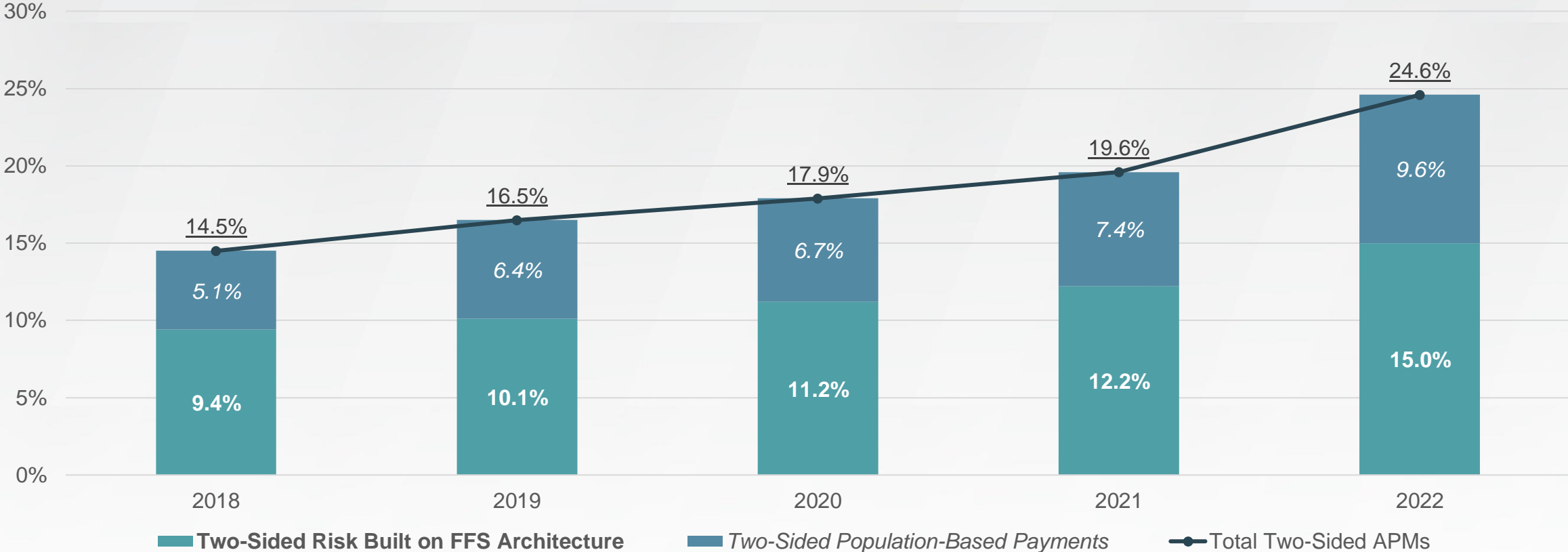
- 89% of senior healthcare executives believe that engaging in more APMs is a “strategic need” for their organization, yet **fewer than half** (48%) of respondents agreed that their organization was “capable” of meeting this strategic need
- In short, many providers’ fundamental capabilities fall short of their goals and needs

Four Categories of APMs

Category 1 	Category 2 	Category 3 	Category 4 
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	FEE FOR SERVICE – LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION-BASED PAYMENT
	A	A	A
	Foundational Payments for Infrastructure & Operations (e.g. care coordination fees and payments for HIT investments)	APMs with Shared Savings (e.g. shared savings with upside risk only)	Condition-Specific Population-Based Payment (e.g. per member per month payments, payments for specialty services, such as oncology or mental health)
	B	B	B
	Pay for Reporting (e.g. bonuses for reporting data or penalties for not reporting data)	APMs with Shared Savings and Downside Risk (e.g. episode-based payments for procedures and comprehensive payments with upside and downside risk)	Comprehensive Population-Based Payment (e.g. global budgets or full/percent of premium payments)
	C	C	C
Pay-for-Performance (e.g. bonuses for quality performance)			Integrated Finance & Delivery System (e.g. global budgets or full/percent of premium payments in integrated systems)
		3N	4N
		Risk Based Payments NOT Linked to Quality	Capitated Payments NOT Linked to Quality

Slow Growth of Two-Sided Risk Contracts

Proportion of U.S. Healthcare Delivery Payments in Two-Sided Risk APMs



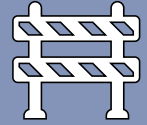
Accelerators and Barriers to APM Adoption

Accelerators



- Health plan interest/readiness
- Provider interest/readiness
- Provider willingness to take on financial risk

Barriers



- Provider willingness to take on financial risk
- Provider interest/willingness
- Provider ability to operationalize

Payers' Perspective on APMs

PAYERS' PERSPECTIVE

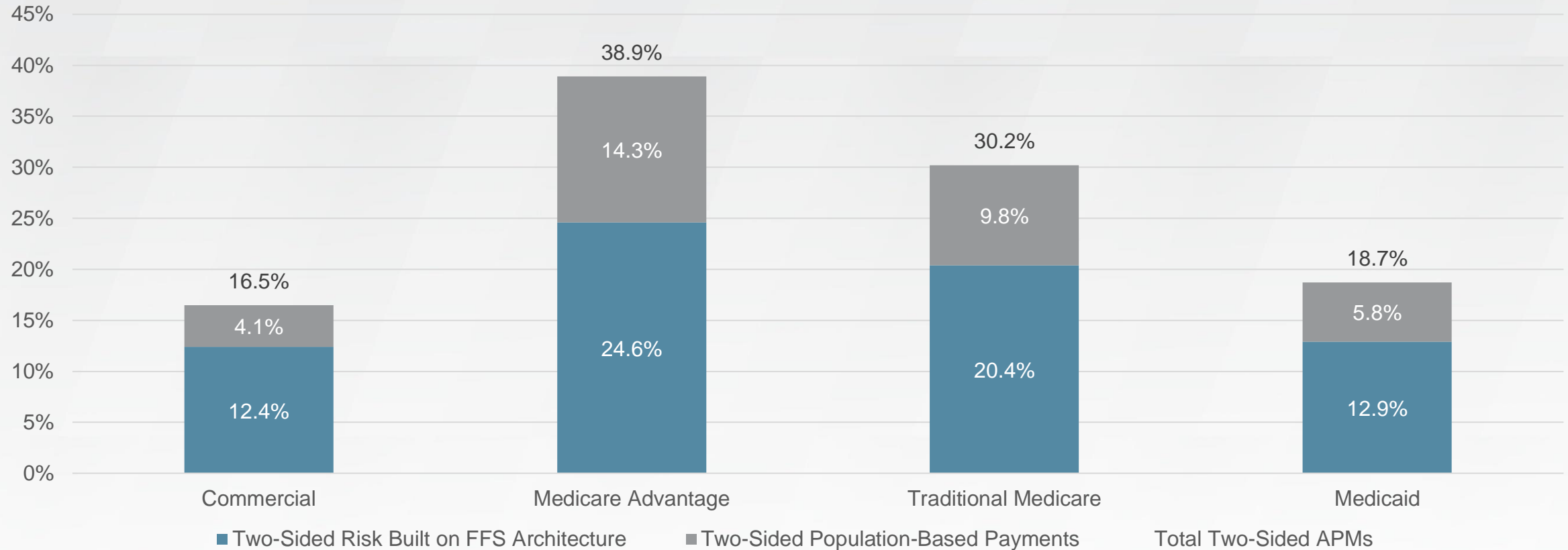
WHAT DO PAYERS
THINK ABOUT
THE FUTURE
OF APM
ADOPTION?



*Due to rounding, these figures do not equal 100%.

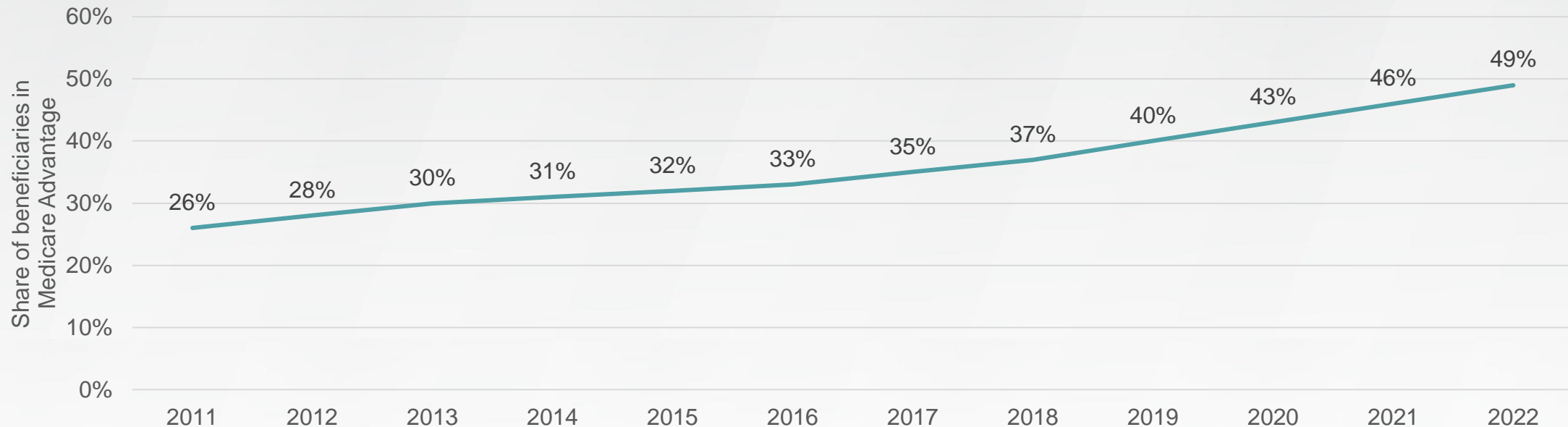
Medicare Advantage Leading APM Adoption

U.S. Healthcare Delivery Payments in Two-Sided Risk APMs by Payer

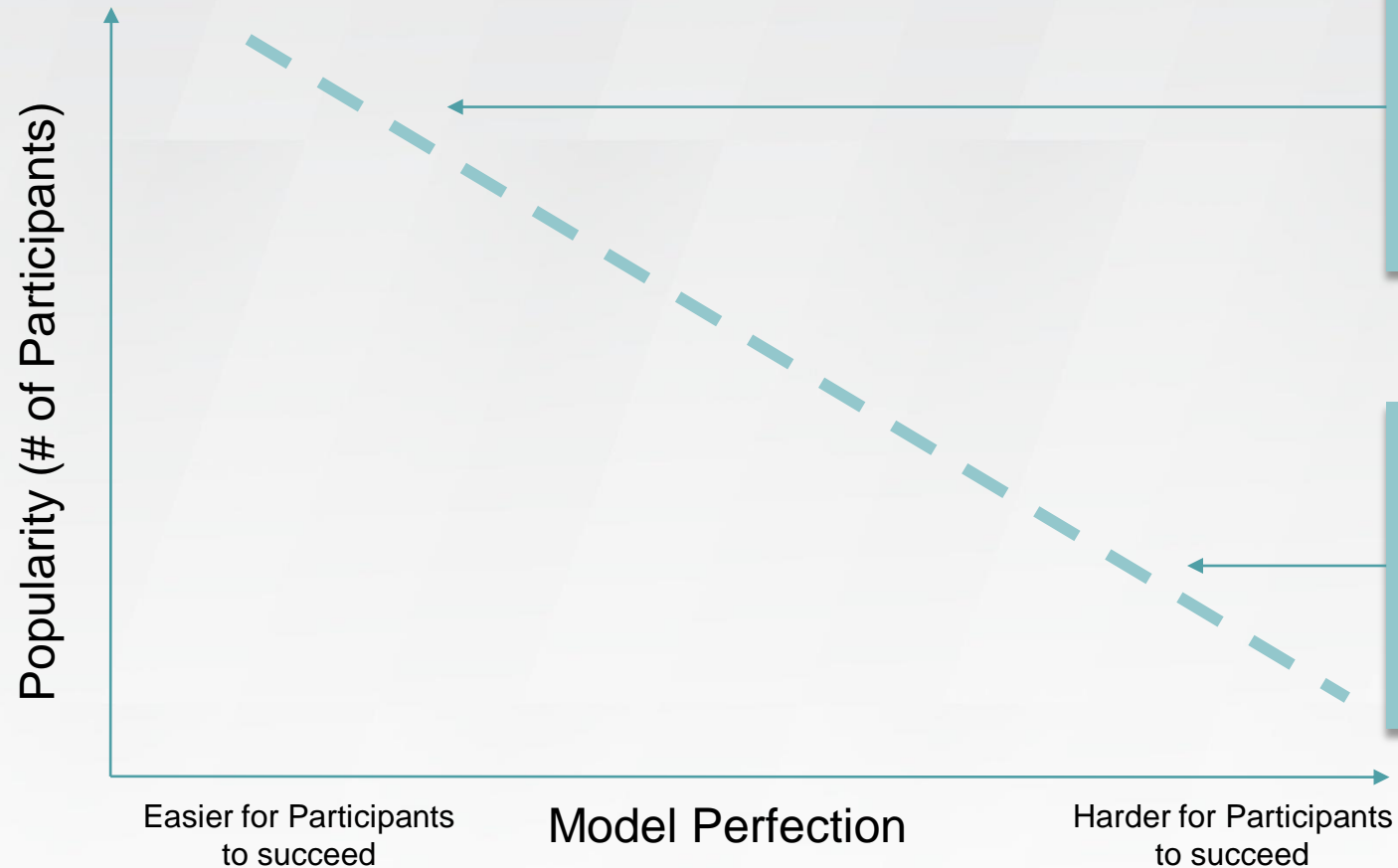


Rapid Increase in Medicare Advantage Enrollment

The share of Medicare beneficiaries with both Part A and Part B coverage who chose to enroll in Medicare Advantage plans grew rapidly from 2011 to 2022—rising from 26% to 49%.



Perfect vs. Popular



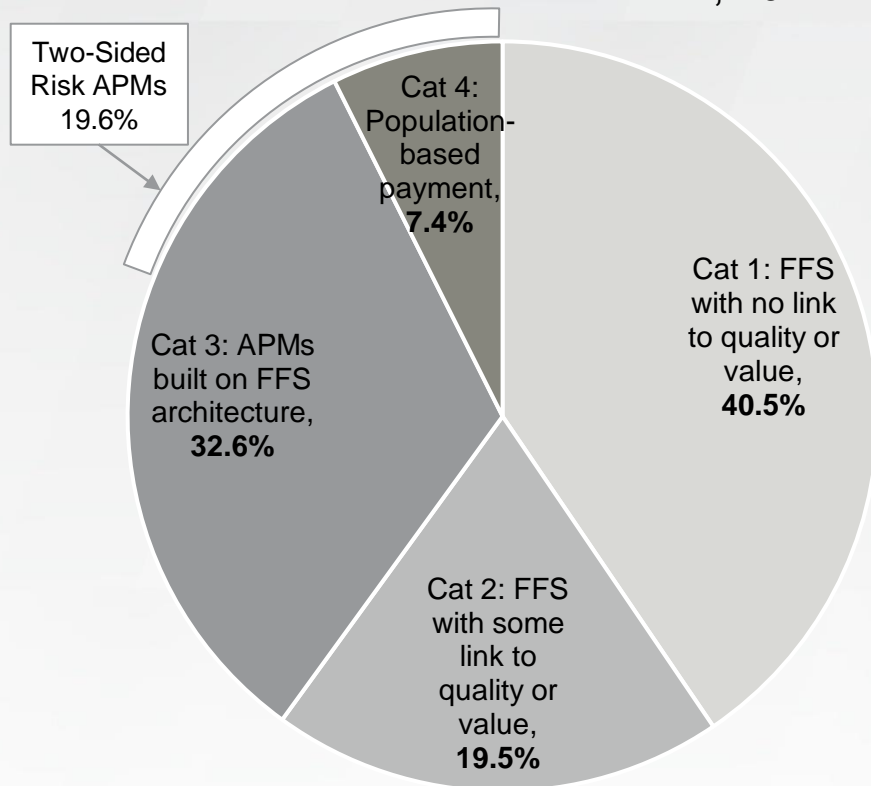
“Perfect” models require active management participation to capture gains and avoid losses. These are generally less popular.



“Imperfect” models allow passive participation with less risk of negative financial results. These are generally more popular.

Revenue Portfolio Design

America's Revenue Portfolio, 2022



- What is your current revenue portfolio?
- What is your *ideal* revenue portfolio?
- How do you anticipate that revenue portfolio will change in the next 3 years? What factors will accelerate, decelerate, or alter that projection?
- What new capabilities will be required to succeed with a new revenue portfolio?

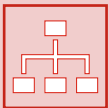
From Popcorn Project to Core Strategy



Learned that post-acute utilization was out-of-line with industry norms (high, expensive)



Participated in Medicare Bundled Payments with goals to right-size post-acute utilization

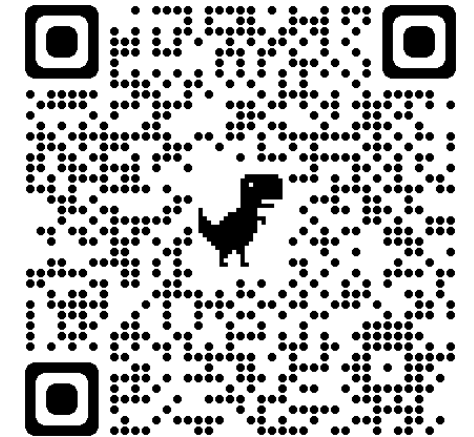


Focused on organization-wide operational changes



Earned profits from BPCI-A in eight (8) consecutive periods

***BPCI-Advanced:
A Story of Success
Leading into Model
Year 7 (2024)***



Moving Towards a Larger VBC Strategy is Imperative

Benefits of a system-wide VBC program

- Opportunity for a more system-wide approach to care management
- Gaps in the continuum of care are better addressed
- Leverage data and technology to track care
- Stronger communication and alignment among physicians
- Gain traction ahead of anticipated mandatory programs

Questions CFOs should address

- Do we have the right physician leaders in place to promote VBC?
- What are our known thresholds for financial viability of VBC programs?
- Do we have properly trained staff in place to manage and provide VBC?

What's Next in the VBC World?

- Further Push Toward Providers Accepting/Managing Risk
- Mandatory Governmental Programs
 - CMS Stated Strategic Direction
 - All Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.
 - The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.
 - Mandatory Bundle Programs: Expect details in mid-2024 with model start 2026
 - Cross-Model Capability Development
- Voluntary Governmental Program
 - Medicare Shared Savings Program (MSSP) – Advance Investment Payment (AIP) Model
- Blurring Lines in Medicare Advantage Relationships

Thank you!

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Healthcare Consulting

Practice Overview

Combined 5200+

Healthcare Clients

950+

team members

\$303M

in revenue

175+

PPMDDs

Consulting Capabilities



Analytics



Valuations



Performance Improvement



Reimbursement &
Regulatory Compliance



ESG & Climate Risk



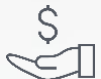
Internal Audit
& Risk Advisory



Strategy



Tax Advisory



Finance



IT Risk & Compliance



Transaction
Advisory Services



SOC & HITRUST

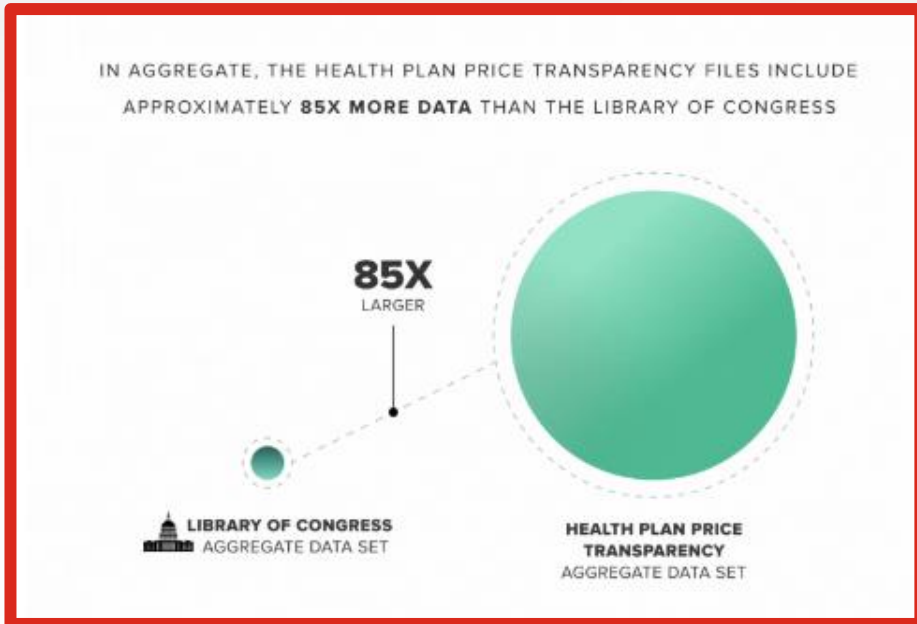
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Data Issues

The health plan price transparency files contain billions of “phantom rates,” meaning that health plans have posted negotiated rates for thousands of billing codes that an individual provider was not trained to perform.

For example, a health plan might post rates for cardiology or obstetrics procedures for a physical therapist.

As a result, understanding the identity of and services rendered by every provider is foundational to **connecting a negotiated rate to a specific provider at a specific location**.



```
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3  "last_updated_on": "2022-12-15",
4  "version": "1.0.0",
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43             ],
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45           }
46         ]
47       }
48     ]
49   }
50 ]
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- 1 Mix of Type 1 and Type 2 NPIs for a small dental practice in Rhode Island
- 2 Taxpayer Identification Number (TIN) associated with the dental practice
- 3 CPT code for the technical component of an x-ray of the knee
- 4 A three-view x-ray of the knee cannot be captured via telehealth (02) and is unlikely to have been delivered in a dentist's office, school (03) or substance abuse facility (57)

Source: Trilliant Health analysis of Health Plan Price Transparency machine-readable files.

Pricing Transparency Data Uses

