GOVERNANCE THOUGHT LEADERSHIP SERIES

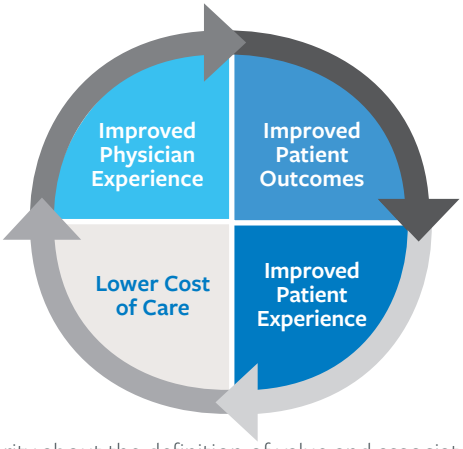
Texas Healthcare Trustees

A New Era: Understanding the Shift to Value-Based Payments

Providing education, resources, leadership development to inspire excellence in health care governance.

With health care costs growing at roughly double the rate of growth in gross domestic product, the U.S. health care system and its future sustainability is a growing concern. As this trend continues, health care delivery systems are under pressure to transform and provide greater value to consumers. This is challenging, given the current misalignment between reimbursement systems and the contrasting "value-centric" care delivery models needed to support population health objectives. As a result, it is no surprise that operating budgets of health care organizations are under pressure as the industry navigates through this complex value revolution while trying to achieve quadruple aim objectives.

The Quadruple Aim



Lack of clarity about the definition of value and associated goals has led to divergent approaches and slow progress in reducing the cost of health care to ensure we have a sustainable delivery system in the future. In order to survive the value transformation currently underway in health care, achieving high value for patients must become the overarching goal of health care delivery systems, with value defined as the health outcomes achieved per dollar spent.

Since improving performance and accountability depends on having a shared goal that unites the interests and activities of all stakeholders, we must first begin with defining "value" as it relates to health care. In simplest terms, value-based health care is intended to be a patient-centric way to design and manage health care delivery systems to provide improved health outcomes at significantly lower cost.

Although value has been a health care buzzword for several years, it is clear the industry lacks consensus on what this term means. Improving performance and accountability depends on having a shared goal that unites the interests and activities of all stakeholders.

In health care, organizations and stakeholders have numerous, often conflicting, goals associated with "value" such as:

- Providing access to services.
- Achieving high quality.
- Containing or reducing cost structures.
- Ensuring patient safety.
- Maintaining organizational profitability.
- Focusing on patient-centeredness.
- Achieving high patient satisfaction.

This goal is what matters for patients and it unites all stakeholders. If value improves, patients, payers, providers and suppliers can all benefit, thus improving the economic sustainability of the health care ecosystem.

Health Care Value Equation

In order to simplify the discussion and allow organizations to move forward, the following equation is helpful to visually convey what value is intended to accomplish within the framework of a health care delivery system.

The value-based approach to care has three inherent principles, which all health care organizations need to incorporate into daily operations as well as strategic planning if they are to be successful in this new environment:

First, organizations must do a better job of systematically measuring the health outcomes that matter to patients and the costs required to deliver said outcomes across a full continuum of care. We must begin to break down silos and collaborate across the continuum of care.

Second, organizations must develop methods to track outcomes and costs connected to particular population segments over time to truly demonstrate the efficacy of the health care delivery system. Considering a single hospital admission or emergency department encounter is not enough to yield the significant cost improvement needed to bring sustainability back to the health care system.

Third, organizations must become more proficient at developing customized interventions that yield better outcomes at lower costs for each population segment served. This may be the most difficult challenge, as providers balance the expectation of delivering "individualized patient care" with the reality that reducing care variation for given population segments affords the best opportunity to reduce costs over time.

Focusing on these principles requires, to some extent, a reimbursement framework that allows health care organizations to function differently than they do today. Although there is uncertainty with regard to the future of health care, most agree that reimbursement systems are moving away from fee-for-service, volume-driven revenue streams where providers are paid by transaction or per interaction with their patients, and into a world where value-based payment programs become more standard. In 2016, the Centers for Medicaid and Medicare Services was able to integrate alternative payment models into 30 percent of their Medicare payments. CMS has a goal of transitioning 50 percent of Medicare payments into alternative reimbursement structures by 2018, and current reports indicate they are on pace to exceed this target. Some of the programs with the largest impact are the Bundled Payments for Care Improvement, Shared Savings Accountable Care Organizations, and the Medicare Access and CHIP Reauthorization Act of 2015's Quality Payment Program for physicians.

These programs are reshaping how health care systems are measured and reimbursed. As organizations focus on improving outcomes at lower costs, they find themselves scrambling to develop improved care delivery models and remain competitive.

To be successful in the future, clinicians and hospitals must address common characteristics of value-based payment programs. First, improving quality and/or reducing costs must be achieved, and most of the value-based payment programs require both to happen simultaneously in order to optimize reimbursement. Second, new quality and cost metric reporting systems require continuous improvement. It will not be enough to make one-time modifications to care delivery models. Rather, it is intended that cost and quality continuously improve in order to maintain or improve reimbursement results year over year.

It is expected that hospitals and clinicians will be required to collaborate like never before as value-based payment models continue to be introduced throughout the industry. Sharing common goals will bring tremendous opportunities and challenges to stakeholders until payment incentives are better aligned to deliver value to patients. Obvious operational considerations include:

1. Evolving care management programs to focus on clinical variation to reduce cost and increase quality.
2. The need to manage end-to-end continuum of care over the acute and post-acute episode, thereby affording the opportunity to develop new partnerships with post-acute service providers.
3. Clarity around which stakeholder/partner is bearing risk and receiving penalties/rewards.
4. Enhancement of measurement processes to support new quality and performance data to demonstrate value and earn incentives.
5. Integrating physician engagement activities to align with value-based program priorities.

As leaders continue to position their organizations for success and sustainability, it is important that each organization develop an intimate understanding of what "value" means in health care today. Creating organizational dialogue and competency around delivering value is perhaps the most important role of leaders in today's health care environment.

There is a lot to keep up with in health care. Texas Healthcare Trustees is here to help our members, trustees of hospitals and health care systems throughout Texas, with resources that will help you stay up-to-date on important information that can impact how you lead your organization. THT's Governance Thought Leadership Series is one of many resources THT has available for health care board members. To learn more about this series and to view other tools and resources available, visit **www.tht.org**.

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