TheAcademy

The Health Management Academy

Strategic Survey Q3 2019:
The Evolving Payment Model and Health Policy

September 2019

The Evolving Payment Model and Health Policy

Introduction

Risk-based contracting and value-based delivery models continue to become more prominent among health systems. As government-sponsored programs encourage providers to take on more financial risk, health systems have had to evaluate their pace toward value-based care delivery. Health systems are also navigating other legislative and policy proposals, including those aiming to address coverage gaps and surprise medical billing.

In this report, The Health Management Academy (The Academy) continues to track the evolving payment model and the top health policy priorities among Leading Health Systems (LHS).

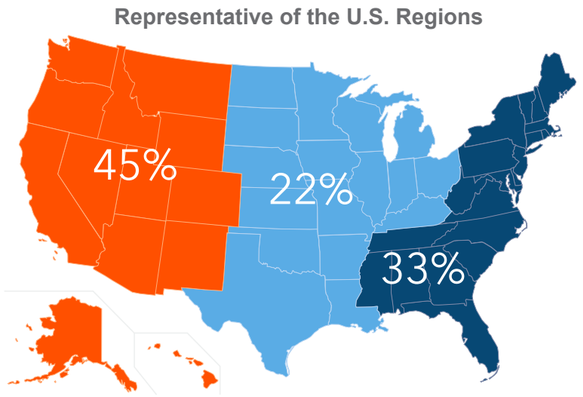
Methodology

In July and August 2019, The Academy conducted the twentieth round of phone interviews for its quarterly strategic survey among LHS executives, including: CEOs, COOs, CFOs, CMOs, CNOs, and CSOs.

The survey for the interview consisted of:

1. A tracking section that provides insight into trends around primary strategic areas; and
2. A special topic area that allows for an in-depth look into a timely developing issue.

Profile of Participating Health Systems



MEDIAN REVENUE

$3.6 BILLION

OWN OR OPERATE **215 HOSPITALS** WITH **45,067 BEDS**

SINGLE-STATE SYSTEMS: **67%**
MULTI-STATE SYSTEMS: **33%**

Key Findings

1

Payment

Value-based payments continue to increase among health systems and currently account for over one fourth (27%) of care delivered across LHS.

2

Medicare for All

A majority of health system executives support increased access through universal health coverage, yet are wary of proposals such as Medicare for All.

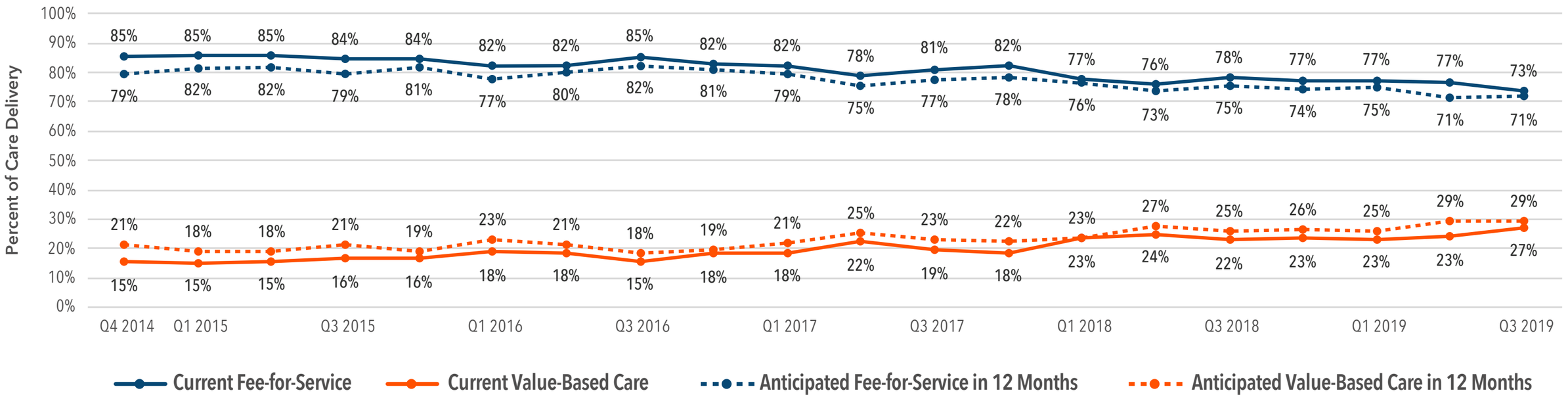
3

Surprise Billing

Health system executives acknowledge the need for policy reform to address surprise billing, but believe arbitration/independent dispute resolution to be a more effective approach than benchmark rates.

Notable Progress Towards Value-Based Care in Q3

Fee-For-Service vs. Value-Based Care Delivery: Current and Anticipated

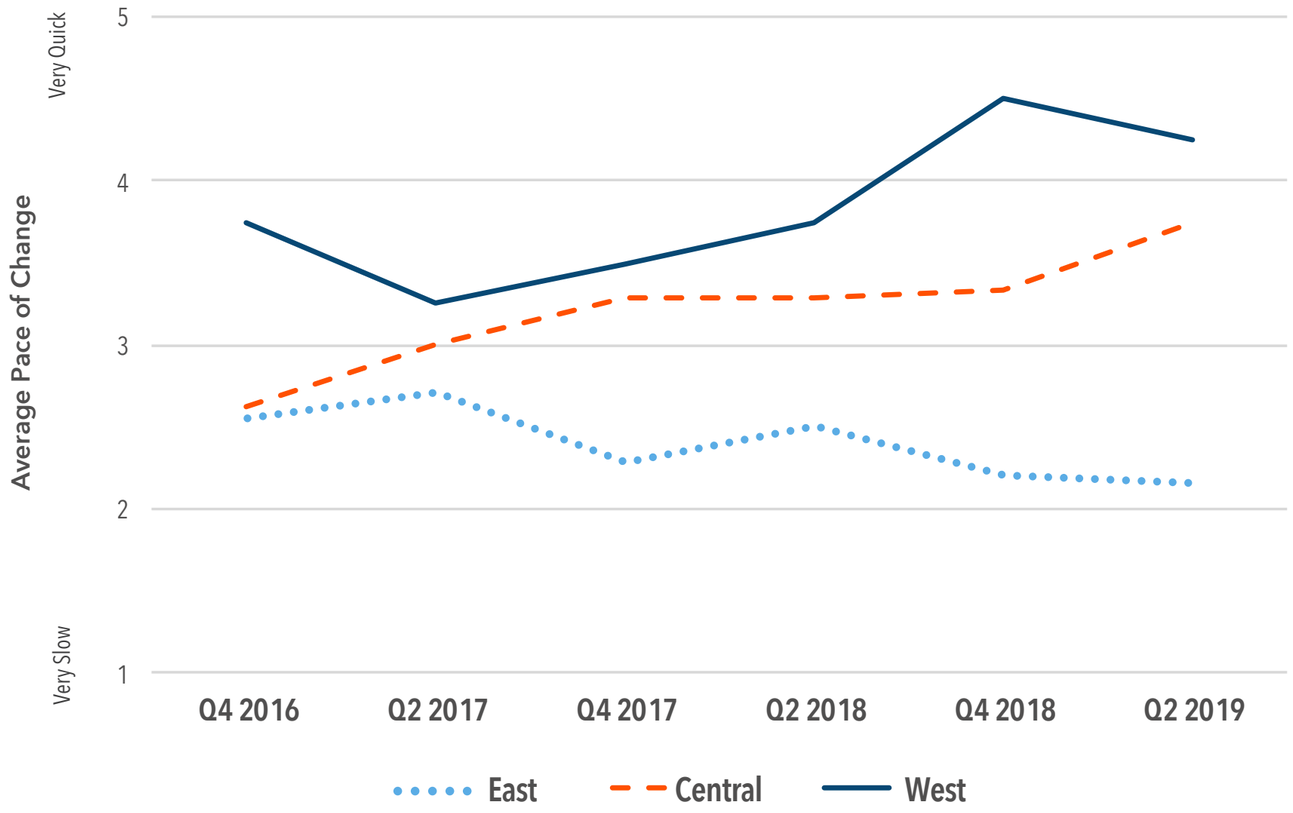


There is notable progress towards value-based care (VBC) in the third quarter compared with previous quarters. While fee-for-service (FFS) payments still account for the majority (73%) of care delivered among health systems surveyed, VBC accounts for over a fourth (27%) of payments. This represents a four-percentage point increase in VBC payments from last quarter and a five-percentage point increase year over year.

Health systems continue to report the shift to VBC while building a greater risk portfolio to be heavily dependent on market dynamics, particularly payer influences. Commercial payers have been slow to support value-based contracts, especially payers who own a large share of the local market. Due to the need for payer support, health systems that own health plans report a greater ability to place the populations they serve in higher risk models.

Western Region Continues to Lead the Way in VBC

Perceived Pace of Change Towards VBC by Region



Overall, health systems report a steady pace of change towards VBC compared to previous quarters, ranking the average pace as a 3 on a scale of 1 (very slow) to 5 (very fast). However, there is notable variation in pace by health system region.

Variation by Region

Western region health systems perceive their pace of change towards VBC as very quick (average: 4.25), whereas Eastern region health systems find themselves changing more slowly (average: 2.17) and Central region health systems find themselves in the middle (average: 3.75). Over time, these differences in the pace of change among the three regions have become more pronounced: Western and Central region systems have moved more quickly towards VBC, while Eastern region systems have slowed.

With VBC comprising an average of 41% of care delivered, systems in the Western region of the country have integrated value-based payment models much more extensively than Eastern (average 21% VBC) and Central (average 20% VBC) health systems.[1] Their perceived pace of change reflects how the more advanced systems in the West are continuing to push rapidly to take on high levels of risk.

[1] The Health Management Academy, Strategic Survey Q1 2019: The Evolving Payment Model & Health Policy.

Most Plan to Increase Risk & Support Universal Coverage

Concern Around Impact of Medicare for All

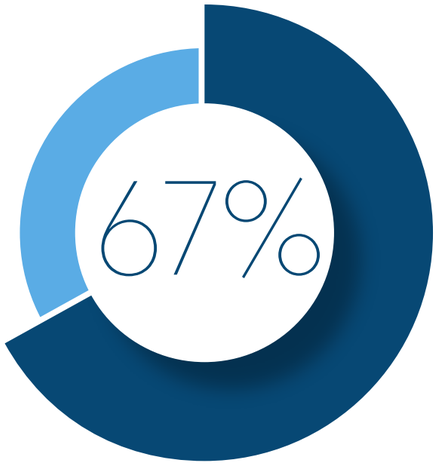
Health system executives have been following the Medicare for All (M4A) discussions occurring in the Democratic primaries; however, there is uncertainty around what version of a M4A policy may be adopted, if any. Due to this uncertainty, a majority of health systems view M4A discussions as preliminary and only a few have begun modeling what implementation of this policy would look like for their organization.

State-level policies also impact LHS readiness for M4A if it were to be enacted. Whereas health systems in states that have not expanded Medicaid are modeling what expansion impacts, health systems in states with large Medicaid populations are already accustomed to managing lower payment rates.

Although executives support universal coverage, many cite hesitation around policies that rely on government-set payment rates, which are substantially lower than commercial payment levels. Leaders note that moving toward a system based solely on government rates would likely destabilize the entire healthcare delivery system.

"Expansion of coverage is of course welcomed, but a true single payer/ M4A system is not the solution. Medicare/Medicaid reimbursement rates do not cover the cost of providing care. If provider organizations were to only be reimbursed at Medicare/Medicaid rates for their entire business, it would create an unsustainable system." – COO

Among participating health systems,



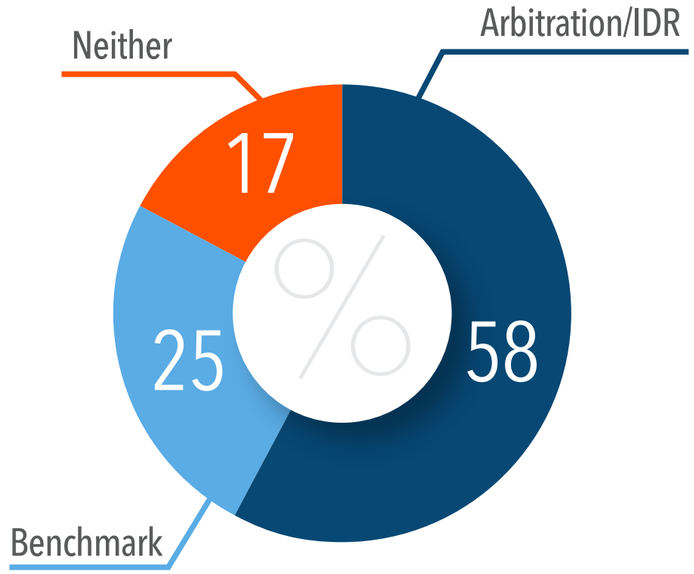
plan to take additional risk in the next 6 months

Reflective of the overall moderate pace of change, 67% of health systems are considering assuming additional risk in the next six months, primarily through government programs. Specifically, health systems are planning to accomplish this by creating new Medicaid Managed Care Organization contracts, increasing ACO enrollment, moving to ACO tracks with greater downside risk, participating in BPCI Advanced and other bundles, and engaging in direct-to-employer contracts.

Arbitration is Preferred Approach to Surprise Bill Resolution

With rising national attention on healthcare access, costs, and affordability, surprise medical billing is a pressing issue for LHS. Congress has primarily been attempting to resolve surprise medical billing through benchmarking proposals, in which the government would establish a benchmark rate based on national or regional in-network rates, but only 25% of health systems surveyed support a benchmarking approach. The majority of health systems (58%) prefer an arbitration/independent dispute resolution (IDR) approach, in which health systems would be able to negotiate directly with payers in the event of a billing dispute.

"Because we are in a low reimbursement/ low wage area, we would be better with a national benchmark, but only if it's one of the industry-supported national benchmarks. We would not want geographic benchmarks based on the median contracted rate. It would disincentivize half the payers in our market to stop contracting with us." – COO



"Once the patient and consumer are protected from surprise billing, providers and insurers should be permitted to negotiate payment rates without government interference. We strongly oppose any legislative proposal that specifies a default benchmark rate. We have already seen insurance companies anticipate the situation by canceling hundreds of hospital-based provider contracts to reset the mean contracted price lower." – CEO

There are a variety of actions health systems are pursuing to address surprise billing. Patient-centric strategies include providing out-of-pocket estimates to patients for elective procedures, assisting patients with the negotiation process when bills do arrive, and reworking bills to make them more patient-friendly. Operational strategies include integrating physician networks, requiring non-employed ED physicians to contract with payers, and creating direct agreements with payers. Certain states (e.g., New York, Florida) have also made it more straightforward for health systems and patients by passing legislation prohibiting balanced billing altogether. While perspectives vary on the ideal resolution strategy, health systems agree that pricing should be more transparent and that patients should not be put in the middle of payment disputes.

About the Academy

The Health Management Academy (The Academy) is a membership organization exclusively for executives from the country's Top-100 Health Systems and most innovative healthcare companies. The Academy's learning model identifies top priorities of health system leaders; develops rich content based on those priorities; and addresses them by convening members to exchange ideas, best practices, and information. The Academy is the definitive trusted source for peer-to-peer learning in healthcare delivery with a material record of research and policy analysis. Offerings include C-suite executive peer forums, issues-based collaboratives, leadership development programs, research, advisory, and media services. The Academy is an accredited CE provider. More information is available at hmacademy.com.

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About Lumeris

Lumeris is a value-based care managed services operator for health systems and providers seeking extraordinary clinical and financial outcomes. Lumeris aligns providers and payers across populations with technologies, processes, behaviors and information to achieve high-quality, cost-effective care with satisfied consumers – and engaged physicians. For the past eight years, Lumeris with Essence Healthcare, its inaugural client with more than 63,000 Medicare members in Missouri and Illinois, has received 4.5- to 5-Star Ratings from the CMS and produced the highest consumer and physician satisfaction scores in the industry along with significantly better clinical outcomes and lower costs. For more information, go to www.lumeris.com.

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