

The Health Management Academy

Strategic Survey Q1 2019: The Evolving Payment Model & Health Policy

March 2019

The Evolving Payment Model and Health Policy

INTRODUCTION

With increased participation in risk-based contracting and value-based delivery models, health systems will continue to focus on improving quality and managing the total cost of care in 2019. While the transition to value-based payments is gradual, the impact on health system strategies is evident. As health system executives consider the health policy landscape amidst this transition, they are acutely aware of changes that can impact operating costs and ultimately their bottom line.

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).

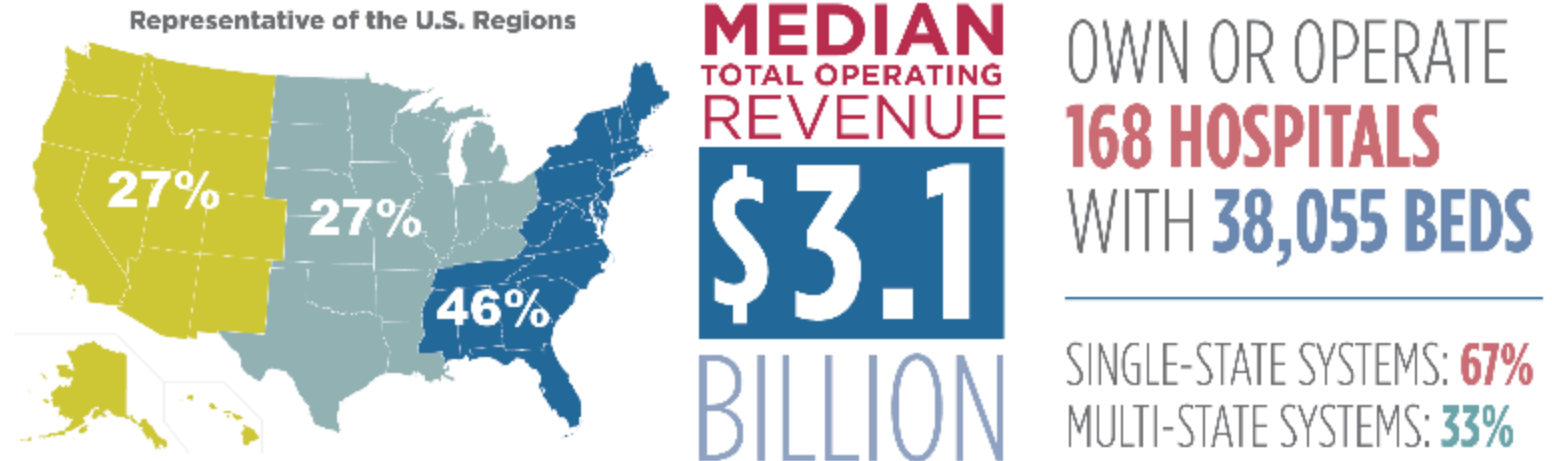
METHODOLOGY

In February 2019, The Academy conducted the eighteenth 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



Key Findings

1

Payment

Despite increased prioritization of and participation in risk-bearing arrangements, value-based payments still account for only 23% of care delivered across LHS.

2

State Policy

At the state level, health system executives most commonly note Medicaid expansion and changes to Certificate of Need regulations will be most impactful to their organization in 2019.

3

Federal Policy

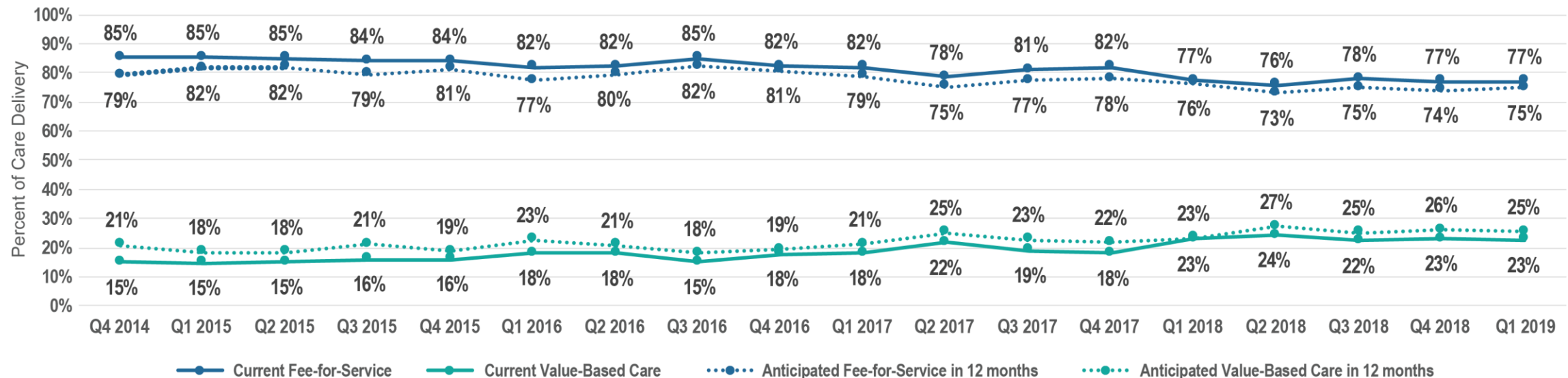
The cost of pharmaceuticals is a top policy concern for health system executives, particularly in light of the proposed changes to the 340B Program and legislation seeking to control runaway drug prices.

Movement to Value-Based Care is Slow But Steady

The transition toward value-based payment among LHS remains slow but steady in first quarter of 2019. Fee-for-service (FFS) payments still account for a significant majority (77%) of care delivered among the health systems surveyed, while value-based care (VBC) payments account for the remaining 23%.

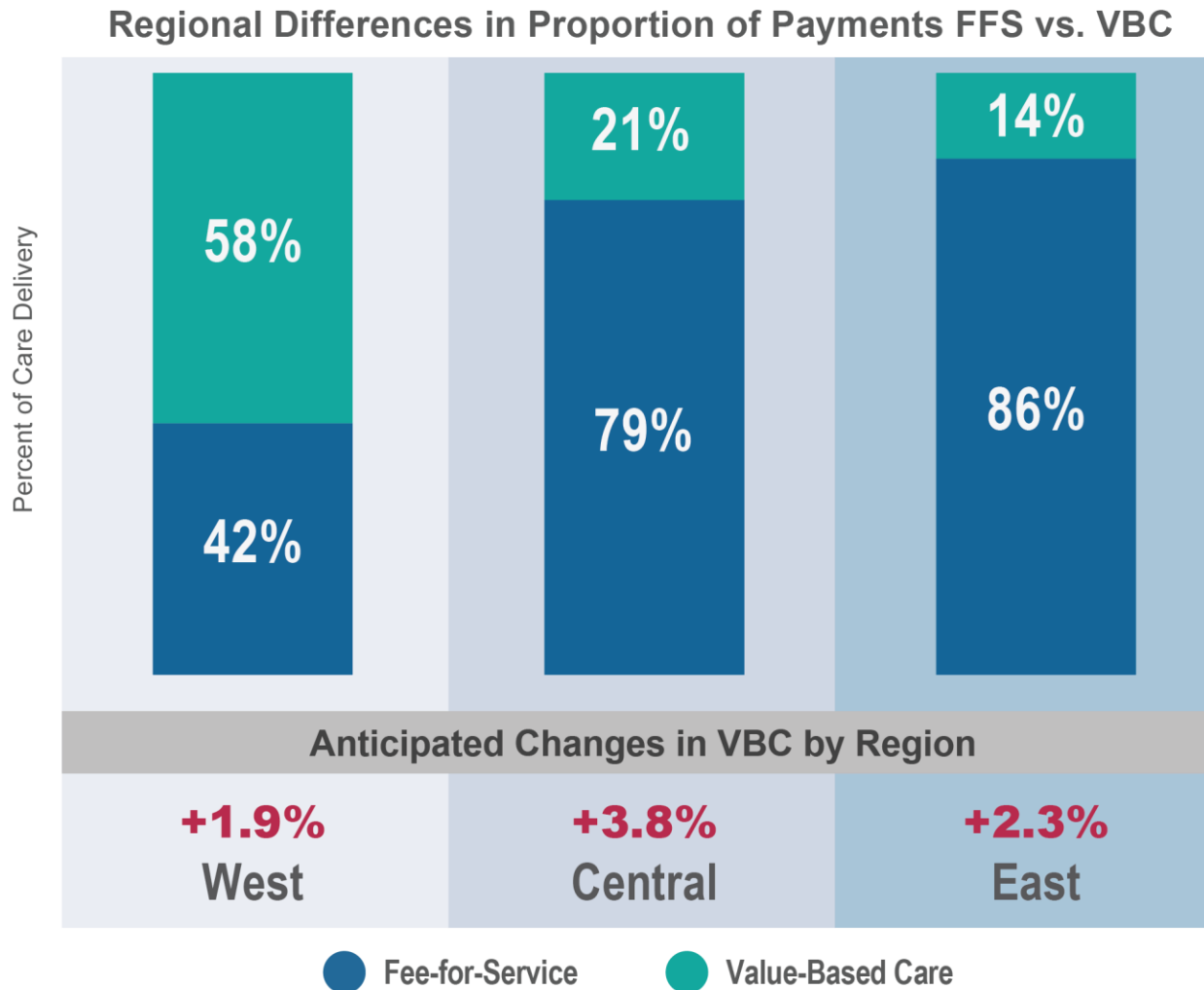
Despite health systems' growing participation in risk-bearing arrangements and increased commitment to delivering value¹, the payment breakdown between FFS and VBC payments is relatively consistent with where it was a year ago. While health systems are increasingly implementing value-based models, the number of lives covered under VBC contracts is relatively small compared to the overall volume of care being delivered in the traditional FFS model. This illustrates the concentrated scope of value-based contracting and how many more lives will need to be impacted to truly move the needle.

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



¹The Health Management Academy, Strategic Survey Q1 2019: Strategic Priorities and Market Share

Western Region LHS Have Made the Most Significant Strides Towards Value-Based Care



The landscape of healthcare payments and the priority level for growing a health system's risk portfolio is highly dependent on market dynamics and payer influences in its local region.² For this reason, it is necessary to look at the evolving payment model by geographic area. When categorizing health systems in this way, it is evident that systems in the Western Region of the country have moved towards value-based payment models much more extensively than their counterparts in the Eastern and Central Regions. This is largely because Western Region health systems started taking on risk and adjusting their overall strategy to accommodate risk decades before systems in other parts of the country.

When looking at anticipated changes in care delivery over the next 12 months, Central Region health systems expect the largest increases in VBC payments, with an expected growth of 3.8 percentage points. Reflective of the fact that Western Region health systems already have a significant portion of revenue tied to risk, they expect a more modest increase of 1.9 percentage points in the next year.

² The Health Management Academy, Strategic Survey Q1 2019: Defining Risk

Health Systems are Focused on State Policy in 2019

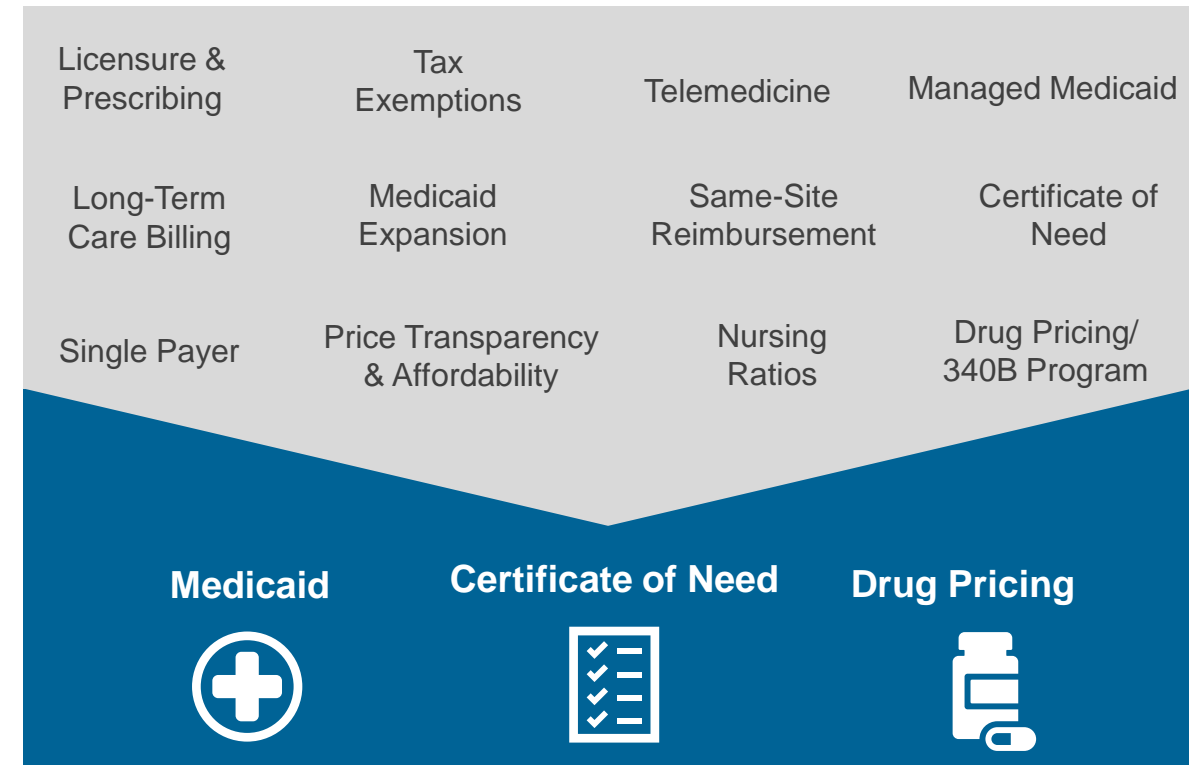
“The new governor has brought in experts to really rethink Medicaid and move more towards a value-based model. 25% of our payer mix is the Medicaid population, and right now we’re being reimbursed at 42 cents on the dollar. Even though we’re not at risk, we essentially are because we’re losing 58 cents on the dollar.” (CFO)

In light of the midterm elections this past November and the resultant “blue wave” that saw many progressives reclaiming seats in both federal and state legislatures, health system executives are most attuned to state-based initiatives and policy changes in 2019. While many regulatory topics were mentioned, these executives most commonly expect that changes to Medicaid, Certificate of Need, and drug pricing will be most impactful to their health systems this year.

Within Medicaid, there is attention to the expansion of both program eligibility as well as value-based delivery, with states increasingly assessing and implementing Managed Medicaid programs. Some executives are also closely tracking the discussion around eliminating their respective state’s Certificate of Need legislation. The removal of these regulations can have a significant impact on pricing and competition within their market.

At the federal level, drug pricing is the most commonly mentioned issue. Many executives are hopeful for reform to help curtail their ever-increasing drug spend and drive costs down. Moreover, executives are concerned potential changes to the 340B Program could further diminish drug reimbursement rates.

Health Reform Areas of Greatest Anticipated Impact



About The Academy

The Health Management Academy, “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 www.academynet.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, Essence Healthcare, Lumeris' inaugural client and learning laboratory with more than 65,000 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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