Academic Health Focus
*A Quarterly Governance Institute Newsletter*
**AUGUST 2021**
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# Making Value-Based Care More Attractive to AMCs

By **Andrew M. Snyder, M.D.**, Principal and Chief Medical Officer, and
**Yomi Ajao**, Principal and Chief Consulting Officer, *COPE Health Solutions*

**As we all hope to lift our heads out of the COVID cloud, we must reimagine, plan for, and rebuild post-pandemic healthcare so public health becomes the focus to drive value-based care and the long-term sustainability of our delivery system amidst a growing and aging population.** While we struggle with the aftermath of SARS-CoV-2, monitoring immune protection and vigilance over new outbreaks and variant strains, the pressure to improve efficiencies of healthcare delivery has never been greater.

Far outpacing overall inflation, costs for straight fee-for-service healthcare are increasingly unsustainable. To stem the tide, the Centers for Medicare & Medicaid Services is shifting from programs with downside financial risk of 20 percent to as much as 100 percent through Medicare Direct Contracting. Some state Medicaid programs also have added greater financial risk for providers. Commercial plans are following suit even as they ratchet down fee-for-service payments and refuse to pay for some care.

> Value-based care is "a healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way."[1]

1 NEJM Catalyst, "What Is Value-Based Healthcare?," January 1, 2017.


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As a result, senior leadership and boards should prepare their organizations for financial risk transfer. Like it or not, population health is moving beyond a pilot, so healthcare leaders need to understand and plan how to make this change in a way that ensures academic medical centers continue to thrive.

## AMCs Lag on the Move to Value-Based Care

For value-based care to transform healthcare, provider organizations across our communities, especially academic medical centers, need to re-evaluate and re-engineer their entire delivery system. AMCs and our largest hospital systems are central to our communities and our lives. Often the largest employers in their regions, they serve as the super-subspecialist for the tertiary and quaternary services many of us and our loved ones are so very thankful for as well as support some of the greatest research infrastructures in the world.

For all the good they do, AMCs face unique challenges with value-based care. For one, their mission of training future physicians and healthcare staff tends to create a higher expense that is frequently not factored into risk relationships. Also: How do we resolve

### ➜ Key Board Takeaways

Boards and leadership need to continue to understand the external pressure to progress towards full financial risk transfer and begin making and executing large-scale plans to ready their AMCs and systems:

- Establish a two-pronged approach: Build population health management infrastructure from the "bottom-up" but recognize the entire system needs re-engineering from the "top-down."
- Develop and implement foundational physician-level and system-level clinical integration strategies.
- Insist on true physician-alignment strategies towards value-based care to drive the necessary cultural changes across patient care delivery.
- Make build, buy, and design decisions to acquire and implement new core competencies of delegated services, capitation management, clinical risk management, and more.
- Pursue data and analytic strategies for combined clinical, quality, social, contractual, and cost informatics across the entire attributed populations.


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the seeming mismatch between fixed costs and beds with the value-based push to reduce utilization and shift to lower-cost care settings? What is the best quality and cost path for AMCs as they treat the sickest patients and most complex cases for which traditional value-based risk adjustment is not necessarily adequate?

## A Lot of Investment, Little Reward

So far, in the complex calculus called population health and shared savings, the calculations by system boards and leadership for AMCs often add up to: It's not yet worth it.

Many hospitals and systems have put their proverbial toes in the water. They agree to manage a relatively small and constrained population under value-based arrangements as "proof-of-concept." That approach has mostly proven unsuccessful as a carve-out department or as a population health "experiment." The shared savings have yet to directly cover most large-scale infrastructure costs.

The modest shared savings are split between the plan and the system. The system then splits the savings further across the organization and providers. Savings are further reduced by some quality percentage. Any yield becomes a fraction of a fraction of a fraction and very difficult to trace back to any specific investment or to a positive ROI.

With no apparent broad-scale silver bullets, it takes continuous improvement across the continuum of care to smooth transitions and find all efficiencies. While savings are measured per capita, they come from across all hospital spend, ambulatory surgery centers, pharmacy spend, specialty usage, radiology spend, and so on. Direct return on investment is hard to trace and any individual effect becomes diluted across other pools and programs.

These factors have made it very difficult for AMCs and their boards and senior management to justify heavily investing in population health, especially at a scale that can affect larger populations. Successful population health strategies only succeed by lowering the per capita spend rate from anywhere within the total cost of care.

## AMCs Need to Go All in on Population Health

How do we correct the current calculus that leaves most systems, AMCs, and other provider organizations less than motivated to implement sufficient changes across


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the delivery system? Counterintuitively, perhaps, the answer is by accepting ***more*** financial risk.

Global risk can dramatically change the formula, moving AMCs and systems upstream toward the full premium dollar. Shared savings and/or partial risk does not result in enough of the premium to grow and doesn't pay enough to rationalize transforming large-scale direct assets.

Given the payer trend toward downside and global risk, healthcare systems across many communities will be financially accountable for large groups of their populations or be forced downstream in the reimbursement river. Boards and leadership that embrace the move towards full risk can instead swim upstream, drive the change, and compete and thrive on new value creation. The entire system needs to transform together, under full, or global, risk. Incrementalism for "learning" can no longer close the chasm.

There are a few systems leading the charge. Their board strategies march towards developing a reengineered delivery system that can do more, reach farther into their communities, into their patients' homes, providing linkage and access to many direct and community resources, and through scale manage their populations with relatively high quality and efficiency. They have committed to this investment and are using this transitional period to get to the other side. As they concomitantly assume greater financial risk of their patients, they are right-sizing their facilities and direct assets for tomorrow's medicine, today.

It is not the time to back down from population health. It is time to double-down and swim upstream.

## The Path Forward

To succeed, boards and leadership need to adopt and apply a new definition of clinical integration. Clinical integration is the foundation upon which to build—and clinical integration not only in the traditional sense, which is required yet insufficient.

Systems have been developing clinically integrated networks to align physicians in a structure that allows for physician governance, more of a seat at the table for the physician enterprise, and a stable vehicle for independent practices to survive. However, it's critical to approach clinical integration in a broader, systemwide strategic context to capture more of the premium dollar.


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Full risk requires the right amount of services and resources across the continuum to optimally manage the organization's attributed population. It may include:

- Integration with community hospitals in innovative ways to best right-size services across a community
- Programs that seamlessly reach from inpatient to outpatient to home
- Predictive modeling of the population to best meet their needs including preventive, acute, and chronic care programs and interventions

To move forward, AMCs and systems need to understand their community, population, and strengths and weaknesses in local resources. Potential programmatic integration with smaller, community, and/or rural facilities can stretch capacity during times of emergencies.

## Investing to Support Clinical Integration and Population Health

New core competencies are required under full risk. If you own the risk, you need to have the infrastructure of delegated services to make authorization decisions, manage appeals and grievances, manage extended network credentialing, and most importantly, leverage wider data aggregation and analytics abilities.

Boards and leadership need to take a system-level, strategic planning approach so departments are not pitted against each other, cancelling out progress. If your population health department is trying to decrease utilization, especially at hospitals, then is it a wonder why hospitals haven't gravitated towards this strategy large-scale?

But we also cannot just flick the switch into new delivery models and assume accountability for the total cost of care without broad programmatic, staffing, and training changes. System-wide solutions will need to include:

- Data and analytics meant for non-episodic non-transactional longitudinal care yielding actionable clinically impactable events
- Financial alignment across the care continuum especially with sub-specialists
- Aligned physician and provider network and cultural buy-in
- Community-wide integration and partnerships with local resources
- Systematic programmatic approaches to mitigate fragmented care delivery and improve care continuity
- System(s) integration across financial and clinical data that can improve care and efficiency at the point-of-service


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You know the two-canoe theory of keeping one foot in fee-for-service and the other in population health? Risk adjustment, capitation management, division of financial responsibility, per member per month, total cost of care—the business model has already changed under our feet. Boards take heed: The canoes of healthcare are drifting apart and it's time to commit so you aren't dumped overboard mid-stream and instead safely land on the other side in this brave new world of healthcare.

*The Governance Institute thanks Andrew M. Snyder, M.D., Principal and Chief Medical Officer, and Yomi Ajao, Principal and Chief Consulting Officer, COPE Health Solutions, for contributing this article. They can be reached at asnyder@copehealthsolutions.com and yajao@copehealthsolutions.com.*

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