Value-based health care

An overview of value-based health care
Dr Omer Saka
rsaka@Deloitte.com
What is the motivating the change in reimbursement models? Can we move healthcare to a model of predictive maintenance and performance optimization?
Today globally there is high pressure on provider organizations to demonstrate high-quality and cost-effective provision of care.

In turn provider organizations focus on value, alignment with payers and operational efficiency.

**Healthcare system perspective**
- DRG systems increase competition
- Increased focus on provider organizations to offer more specialized care
- Focus on quality of care
- Gradual introduction of outcomes-based reimbursement systems

**Patient perspective**
- Rising expectations for excellence of clinical care
- Transparency of patient outcomes
- Higher autonomy in selecting provider of choice
- **Consumerism**

**Provider perspective**
- Establishing strategic alliances with other providers to focus specialized care
- Designing cross-disciplinary treatment pathways to reduce LoS
- Care coordination beyond the hospital organization to decrease rates of re-hospitalization
- Enhanced monitoring of quality of care, clinical performance and patient outcomes
- Sourcing via global procurement organizations has increased providers’ capabilities to enforce price competitiveness between suppliers

**Value-based health care**
What is the **unmet clinical need?**

- Gaps in established clinical care
- Inefficiencies in established treatment pathways
- Proof of additional benefit – in favor of new solution

---

What is the **common coverage landscape?**

- Established reimbursement standards
- Policy-making towards value-base health care

---

What are the **established payment standards:**

- Established fee-structures
- Flexibility for solution pricing
- Operational prerequisites for payment, e.g. coding, outcomes-based data

---

What does it take for **winning key stakeholders?**

- Requirements for evidence needs, patient-reported outcomes
- Requirements for financial benefits

---

VBHC represents strategic business opportunities ... 
... as the positioning of medical solutions with an evidence based assessment of key medico-economic factors would provide a clear advantage in the European markets
Value-based health care stipulates the alignment of the healthcare system perspective and the patient perspective.

Value-based health care

Healthcare system perspective  

Patient perspective

\[
\text{Value} = \frac{\text{Outcomes that matter to patients}}{\text{Cost to achieve these outcomes}} = \text{\$}
\]

"... Value is defined as the outcomes that patients experience relative to the cost of delivering those outcomes. Value-based health care, or VBHC, is health care that delivers the best possible outcomes to patients for the lowest possible cost." - [ICHOM²]

≠ Inefficient activities

a) Oversupply of technologies that do not work well

b) Undersupply of technologies that can solve problems

c) Unwarranted variation
Principles of value-based care

- Value is created in caring for a patient’s medical condition over the full cycle of care – NOT by a hospital, a site, a specialty, an episode or an intervention.

- The most powerful single lever for reducing cost is improving outcomes.

Source: Porter, M. 'Value based health care delivery: strategy for health care leaders'. 2015 Health Forum Summit (link)
How to find the right target population

In order to present an accurate case successful programs will have to identify specific sub-populations and leverage interventions, incentives and technologies that motivate users.
How to position medical solution with the access method
Payers consider alternative reimbursement schemes to enhance cost-effectiveness, outcome certainty and budget control

Theoretical framework

Potential objectives for data collection on the outcomes of a solution

High budget impact

Matured solution status

Outcomes-based payment

Pilot development to support evidence development

Low budget impact

Budget cap
(price that is linked to the demonstration of a economic outcome)

Regular procurement context

To improve positioning of the solution
Industry firms would need to collect data on:
• Clinical effectiveness
• Identification of patient sub-populations
• Competitive positioning
• Patient perception

In alignment with: Vitry and Roughead (2014). Managed entry agreements for pharmaceuticals in Australia.
Alternative reimbursement methods

MEAs are indicated with a variety of terms that are related to each other, but cannot all be considered as synonyms.
German Statutory Accident insurance - seen as value-based care
Network of 20 clinics to achieve the maximum attainable treatment outcome for a patient after an accident with a focus on restoring patient’s capability to return to normal life

Rehabilitation Management

Example:

BG Universitätsklinikum Bergmannsheil Bochum
Qualifications to provide excellence in care:
- Certified supraregional trauma center
- Burn trauma center
- Center for care of paraplegic
- Center for hand surgery
- Center for rehabilitation – with a focus on neurorobotic mobility training
- Two helicopter landing sites
- Stroke unit
- Center for sleep medicine

Example:

European research pilot on neurorobotic mobility training
- In Japan already 300 HAL-Exoskeletts are in use for rehabilitation
- In Europe this clinic is leading research with exoskeletons – for the first time outside Japan
- The exoskelett is unique, being controlled by nerve impulses, registered by electrodes on the patients’ skin and transformed into movement of electric motors
- Case studies of patients with spinal cord injuries already demonstrated significant improvement of senso-motoric functionality

Example:
What value-based care methods have in common
Several core, integrated capabilities are needed to drive success under VBHC models – many of which are also valuable in a fee-for-service environment.

1. **Aligned Network & Physicians**
   Developing a system of high performing physicians who feel as ‘co owners’ in the development of new care models.

2. **Integrated Analytics & Health IT**
   Platforms that integrate clinical and financial insights to support decision-making, enable care coordination and drive quality improvement.

3. **Lasting Governance Models**
   Flexible and effective governance process and leadership that can align stakeholders and drive accountability.

4. **Financial Incentives & Risk Management**
   Payment Models that align incentives and support providers taking on risk as well as the ability to manage financial risk arrangements.

5. **Clinical Integration & Transformation**
   Care Coordination and population health management across stakeholders to support improved quality and outcomes.

6. **Patient Engagement**
   Defined programming and processes to support patient involvement in their own healthcare, including access to care and satisfaction rates.
Mapping capabilities onto BCCG outcomes-based contract

The system core, integrated capabilities are needed to drive success under VBHC models

1. **Aligned network & physicians**
   - Integrated provider network covering all levels of care provision

2. **Integrated analytics & health IT**
   - All BG clinics are connected to a joint IHE-compliant IT system allowing to share patient data across all locations\(^1\)

3. **Lasting governance models**
   - As a non-profit organization all earnings are reinvested into staff and clinical infrastructure

4. **Financial incentives & risk management**
   - The collaboration between clinics in a joint organization allows to build financial resources across provider organizations

5. **Clinical integration & transformation**
   - The BG clinics continuously refine their clinical system of treatment pathways for patients suffering an accident

6. **Patient engagement**
   - Patient engagement is an important element of rehabilitation, which lasts beyond hospital treatment and may even involve support by welfare workers

---

1. IHE: Integrating the Healthcare Enterprise
Value Based Care is gaining momentum

We are seeing a shift in the marketplace that is being further escalated by recent public and private announcements, building on the foundation of initial Centers for Medicare and Medicaid Services (CMS) demonstration projects and exploration.

**Department of Health and Human Services** has set clear **goals** and timeline for shifting Medicare reimbursements from **volume-to-value-based** (90% by 2018).

**States driving adoption of new care delivery models** through Delivery System Reform Incentive Payment programs (7 states launched to date) and State Innovation Model grants (~35 states received awards to date).

Payers like United Healthcare and Aetna have announced their intention to pay **50% of all reimbursements under VBC models** in the next 5 years.

**The Health Transformation Task Force**, a consortium of 20 leading health plans and health systems, has committed to 75% of payments under VBC structures by 2020.

**Growth of VBC Arrangements**

- Medicare
- Non Medicare

<table>
<thead>
<tr>
<th></th>
<th>Q4 2011</th>
<th>Q4 2012</th>
<th>Q2 2013</th>
<th>Q2 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>101</td>
<td>122</td>
<td>253</td>
<td>626</td>
</tr>
<tr>
<td>Non Medicare</td>
<td>101</td>
<td>59</td>
<td>235</td>
<td>329</td>
</tr>
</tbody>
</table>

~20M lives covered as of Q2 2014
Centers for Medicare & Medicaid Services (CMS) programs are driving new models of care

As a regulatory body and payer, Medicare’s payment innovation is accelerating the transition to population health and various models of collaboration and innovation

1. CMS Pilot and MSSP ACO Performance

   Performance results from the first and second generations show:
   - Significant improvements on nearly all quality metrics
   - Medicare savings that resulted in $445 million in shared savings payments
   - Successful models require targeted capability investment to properly manage risk and population health

2. CMS Next Generation ACO Model

   Built off results of previous pilots, CMS has launched a higher risk higher reward partnership in 2016:
   - Higher level of risk and reward, using more predictable benchmarking that rewards attainment and cost containment
   - Selection of payment mechanisms with benefit enhancement tools to improve beneficiary engagement
   - Those with strong population health engagement will see early success

3. CMS Readmission Program

   Penalizes health systems with high 30-day readmission rates around a growing list of pre-defined conditions
   - 1-3% of hospital inpatient revenue is at risk
   - Close alignment with other payment reforms amplifies the financial/strategic value of readmission reduction
   - Managing care across the continuum with new population health capabilities can avoid penalties

4. CMS Bundled Payment Care Initiative

   Rewards financial and performance accountability for episodes of care around nearly 50 conditions
   - 2-3% minimum discount rate required by CMS
   - Gain sharing flexibility offers tangible near-term benefits for participating providers with disease-specific care management paradigms and an understanding of population health needs
There is a shift in care delivery from process to outcomes.

**What happens today...**
- Services are organised around clinical departments/ specialties.
- Cost accounting is driven by ‘charges’ and not ‘cost’.
- Patient visits different services, that are not entirely integrated and do not communicate with each other efficiently across the whole care cycle.
- We measure **processes**.

**... How is it tomorrow?**
- Services are organised around **patients**, with similar sets of needs, which span specialist and professional boundaries.
- **Value accounting** is driven by ‘cost’ and not ‘charges’.
- **Integrated practice units (IPU)** are responsible for the full cycle of care, that is co-located and always coordinated centrally in an IPU.
- We measure **outcomes**.

**What does this mean for the industry?**
- **Craft a value story** so that the value to payers is clearly illustrated and they can see a tangible benefit.
- This implies understanding the **added value to the process of healthcare provision** and being able to **describe for each stakeholder involved**.
- **Suggest solutions to clinical problems** to improve care provision and support payer capabilities to measure outcomes.
Several risk-based payment models currently exist to scale up the episode of care and degree of risk.

Value-based payment models vary in the level of risk required from providers.

Performance Targets
- Bundled Payments
  - Arrangement with pre-determined reimbursement for defined episodes
  - Can include downside risk
- Incentives for meeting pre-defined cost and/or quality metrics
- No downside risk

Shared Risk
- Arrangement with upside and downside risk within a pre-determined corridor
- Members attributed to provider (typically by PCP)

Global Risk
- Full-risk arrangement with provider bearing the full impact of any upside or downside risk
- Provider receives PMPM for attributed lives
- Provider (or its partners) operates as a payer
- Often seen as an emerging competitor to providers’ MCO customers

Success Factors
- Robust reporting and quality improvement programs
- Care coordination
- Physician engagement
- Integrated data and analytics
- Network and incentive alignment
- Health plan-like capabilities
- Insurance license
- Regulatory and capital requirements

Market Examples
- P4P
- PCMH
- SIM Grant
- CMS BPCI
- Case Rate
- MS-DRG
- Pioneer ACO/MSSP
- Partial capitation
- CMS PACE programs
- Global capitation
- Providers with payer capabilities

Increasing Level of Risk and Capabilities Required
Deloitte Effective value assessment framework

As roles and decision-making change, stakeholders have varying perceptions and definitions of value, requiring different types and levels of evidence for demonstration of value, specific to MedTech.

What are the intended uses of the framework for this technology?
Who are the stakeholders under consideration for this effective value assessment?

For this stakeholder, what is the full range of potential value drivers of the technology, and overall care provision to the health system?

How does the value varies across patient populations, and over what time horizons should impact and effective value be assessed?
What is the appropriate body of evidence given the product type, level of innovation, lifecycle stage, ad value proposition?
What is the resulting expected impact of the technology to the target stakeholder and health system?
Local value assessment framework - AdHopHTA

Providing decision makers with contextualized assistance on how to make sound investment decisions on innovations to ensure that good-value innovative health technologies reach clinical practice

- Tailoring HTA to specific hospital circumstances (i.e. comparators, care organization, BIA)
- Keeping a sharper focus on the HTs that are specific interest for hospitals
- Timely adjustment to hospital context
A standardized process to design risk/gain sharing contracts is required to determine how gains/losses will be shared between the stakeholders; this produces a set of potential models rather than an exact tool.

### Standard Process to Design Risk/Gain Sharing Contracts

1. Establish modeling goals in a facilitated kick-off session.
2. Review guiding principles for risk/gain share model designs.
3. Create a joint, cross organizational team to explore issues, opportunities, risks.
4. Perform benchmarking analysis to establish baseline levels.
5. Develop management and physician buy-in with a collective go/no-go decision.

### Risk/Gain Sharing Guiding Principals

- Don’t overdesign – keep the model simple but not simplistic.
- Risk sharing model should distribute risk across the parties most able to influence the services.
- Risk sharing model should provide quality and utilization management targets and incentives aligned with strategic goals.
- Targets, parameters, and results must be clearly defined and measureable.
- The program should allow a process for revision, as the experience evolves.
- There must be clear communication and trust amongst all parties involved.

### After a “go” decision is made, stakeholders should:

1. Confirm owners of each risk/gain sharing section.
2. Create work groups and schedule check points.
3. Design risk/gain sharing program.
4. Implement program (IT, preparation, training, program roll-out, monitoring results, reconciliation, process for revisions, etc.).
Successful VBC arrangements require a multi-faceted approach with critical components that are similar, but different from a standard delivery model.

**Clinical Integration & Transformation**

- **Physician Leadership**
  Leadership from both the hospital and physician group have equal voice in the strategic direction of the partnership; share in the risks and rewards of effective and efficient care delivery.

- **Analytics & Reporting**
  Consumer-centric analytics provide insight into VBC performance: trends, gaps, and opportunities to improve population health management.

- **Patient Engagement**
  Online tools are available for chronic disease patients to track health and interact with providers between visits.

- **Change Management**
  Nurses, care managers, and other providers from participate in training together to improve care across the continuum.

- **High-Risk Identification**
  Frequent ED utilizers are flagged in the system and immediately assigned a case manager (and a PCP, if necessary) upon discharge to ensure adequate follow-up care with health care providers.

- **Care Coordination**
  Care managers have access to an integrated delivery network of providers across clinics and the hospital to better manage transitions of care.
Patient Engagement
Providers who leverage patient engagement capabilities and programs to enact improvements can differentiate themselves in the marketplace, and unlock value for patients.

Optimizing these tools to satisfy guest needs across the patient lifecycle is imperative...

Sample desired experiences:
- "All the awareness, access, and event information I need is in one place. Check-in is easy and hassle-free”
- "The facility is noticeably clean and there are great, healthy food options”
- "The facility is really tailored to a specific culture – you all built something special”
- "I can’t wait to share my experience with others”
- "Billing provided great customer service”
- "I will come back for all of my healthcare needs!”

From first impressions... ...to lasting impressions
Integrated Analytics & Health IT

VBC arrangements employ analytics to generate a 360 degree view of the patient, identify trends, spot gaps, and enable focused healthcare delivery with significant cost savings.

Sample metrics to measure patient engagement, satisfaction, plan of care, and membership analytics

- Proactive Plan of Care and Follow-up
  - Medication Reconciliation
  - 30 Day Post Discharge Physical Visit
  - Measure of Process of Care (MPOC-28)
  - Plan of Care Compliance

- Patient/Care Giver Experience
  - Communication with Nurses
  - Communication with Doctors
  - Call Center – Hold time
  - Responsiveness of Hospital Staff

- Patient/Membership Analytics
  - Member Insurance Affiliation
  - Dual Eligibility
  - Employer Affiliation
  - YTD Total Medicare Membership Growth
  - Termed Group Count

- Patient Engagement
  - Success of Member Education
  - Patient Education/Outreach Participation
  - Patient Channel Responsiveness
  - Young Adult Health Care Survey (YAHCS)

Integrated care coordination

Improved patient engagement and population health management
Creating national screening programs

**Action plan-elements to consider**

- Implementation of screening programs requires, first of all, the definition of the target population
- Target pop. will be invited to receive the eye disease screening test
- Results will be interpreted and communicated to patients
- Treatment should be offered to every patient (as required)
- Data management systems would be in place to input results from screening tests
- Ongoing monitoring and evaluation

**Stakeholder Engagement**

- Ministry of Health (owner)
- TOD (owner)
- Turkish Public Health Agency (MoH)
- General Directorate of Health Development (MoH)
- World Health Organization
- Social Security Institution
- Other pharmaceutical and medical device companies
Establishing an information system for eye care is recommended to track epidemiological changes, assess treatment outcomes and to improve quality of care. This will result in a better monitoring of the performance and understanding of causes.

**Action plan-elements to consider**

- Evaluate needs and assess scope of action: Implementing IT frameworks enabled South Korea to evaluate healthcare quality. In the UK, it enabled to reward GP’s for their delivered quality instead of the delivered quantity.
- Establish/Revise legislative infrastructure to distribute/share data among public and private stakeholders
- Integrate IT systems nation-wide
- Consider value based tendering
- Incentivize academic studies
- Collaborate with private companies and KOLs

**Stakeholder Engagement**

- Ministry of Health (owner)
- General Directorate of Health Information Systems (MoH) (owner)
- Ministry of Science, Industry and Technology
- Turkish Public Hospitals Agency
- TUBITAK, TOD, Key Opinion Leaders
- Healthcare Related IT System Development Companies