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Minute

INTERVIEW OF THE SEMESTER

Value-Based Healthcare Evaluation Post-COVID 19

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Interviewer: Christian Renaudin, TMTG CEO

INTERVIEW

CR: Thank you for the interview, please tell us how much you have been and continue to be involved with Value-Based Care?

BP: My first exposure to Value-Based care was back in the 90s. 1997 was when I first started dealing with Value-Based care, and that was in the South Florida market. I've been affiliated with Florida for close to 30 years. Florida is considered to be a hotbed for Value-Based care, and then obviously, you've got quite a few other pockets of Value-Based care in the US.

CR: Value-Based Care is defined as a patient-centric healthcare model that prioritizes patient outcomes and experiences, shifting away from a focus on service volume, and controlling costs by aligning incentives with care quality and efficacy. Do you agree or would you have a different definition?

BP: I would agree with that.

CR: What are the benefits and challenges of Value-Based Healthcare?

BP: I would say that the entire healthcare system has been based on volume, right? This is how healthcare provider's bill. It's a fee-for-service environment, with the exception of a few geographies and a few provider types that have obviously been involved with Value-Based care.

That is the main challenge there, Value-Based care for a number of healthcare providers is something that's very difficult to understand. For the last 50+ years that entitlement programs like Medicare and Medicaid have existed, that's definitely something that has been all fee for service. That's a shift that is challenging for providers.

The second thing is the availability of healthcare data and the sharing of healthcare data. Only recently with the Fast Healthcare Interoperability Resource standards, that are still not well adopted at this point, will definitely have an impact on Value-Based care and promote Value-Based care, but at this point it is definitely still a challenge.

The third item is the technology, the analytics; there hasn't been a strong adoption of analytics platforms because there has been limited data sets available to feed into those platforms.

[For] the benefits, I think your definition of Value-Based care explains basically the benefit that it's all about. It's focused on the patients, it's focused on health outcomes, it's managing those two things with a limited set of resources. In order for Value-Based care to be effective, healthcare providers and patients, quite frankly, need to work together so that they minimize the use of healthcare resources and still generate a very strong and positive outcome for patients.

CR: To what extend has our HealthCare Systems embraced Value-Based Healthcare? What would be your estimated percentage of penetration of Value-Based care or acceptance?

BP: Somewhere in the 10-15%. I would say a lot of those health systems are considering it. They're looking at it. But, because it is a mindset shift, it is a very difficult rollout, and there are different approaches to getting it started. You don't have to start sprinting right away. There is definitely a good awareness of Value-Based care, just not an adoption of it. The adoption is still very low.

Some of the things that the government has done, and primarily CMS with a number of programs from the CMMI, have helped promote Value-Based care; at least the awareness of it and also, in some cases, the adoption. You also have to think about the fact that Value-Based care is really prevailing in the insurance, in the payer space, but payers are not everywhere in the U.S. If you think of Medicare Advantage […], and although we are experiencing an increasing Medicare Advantage penetration, it is still very much concentrated around major metropolitan areas. You have a lot of rural areas [where] there is not a Medicare Advantage presence, or at least it's still very low.

So I would say, with the accountable care organizations, and especially with the ACO REACH program, which is focused on Rural areas, that's definitely something that is going to continue to promote Value-Based Care. I applaud any administration that is pushing for this type of policy and is pushing for the expansion of Value-Based Care. Right there that tells you that they understand, they see the value of it, and they want to continue to push for it. So when you have the federal government that's behind a concept in a way of doing business and delivering care, it's only going to help accelerate Value-Based Care.

CR: There's a lot of bullish hope and a lot of optimism around future adoption. We'll come back to that. Who do you think, as an organization, has demonstrated a great adoption of VBC, health system or payer, in particular other than CMS?

BP: I would say Kaiser Permanente was probably one of the very first adopters of Value-Based Care. You're talking about a health system, hospitals, that back in the day were using a fixed premium and delivering care within that, and they were, in my mind, the early adopters of Value-Based Care.

Some of the national brands like Humana are definitely strong believers and adopters of Value-based care. I would say they have done a good job at spreading and promoting Value-Based Care. They've displayed this in their earnings calls and the investors days where they had charts comparing the outcomes performance between Value-based care and non Value-Based Care environments, even going back ten to twelve years.

United is definitely right there as well. Although they've had more challenges because they've got a strong commercial presence, and I think that has been a bit of a distraction for them, they really started getting big into Value-Based Care. When they bought PacifiCare back in 2005, that's really when they started getting big into Value-Based Care.

From a health system perspective, I would say you've got three other main health systems that have done a fantastic job at Value-Based Care. One is Ochsner in New Orleans. You've got Advocate in the Chicago area. And then you've got Montefiore in the Bronx. Those are three organizations with their own kind of care management. Organizations within the health systems that are very selective at which primary care physicians can really participate in a Value-Based Care arrangement. They look at basically a peer comparison of efficiency and effectiveness at managing care within a defined pool of money. And so those are those I would say are the main ones.

CR: How has the paradigm shifted around Value-Based Healthcare post-COVID?

BP: I think a lot more providers realized the value of capitation payments. When everything was shut down for a month and a half or two, there were no patients going into offices, there was no billing going on. Obviously, a lot of financial stress on those organizations. Those provider groups in a capitation arrangement, the dollars kept coming, and they kept getting their primary cap or their specialty cap, and for them, the financial stress was not as severe as others that were getting paid 100% on a fee-for-service basis.

CR: What factors, such as provider type, have the greatest impact on the level of acceptance of Value-Based Healthcare?

BP: It's easy to think that, and I can see why someone would go straight to for-profits as strong adopters of Value-Based Care. It's not something that I would say is 100% true. I think it has to do with, in general, the mindset of the leaders of those provider organizations and their desire to do well by doing good by their patients. I'm sure there's some data out there that will tell you that for-profits are, in a large extent, early adopters or strong adopters of Value-Based Care, but I've seen some not-for-profits as well .

CR: What growth trends do you expect in Value-Based Healthcare in the next ten years, as compared to Volume-Based Healthcare? You talked about potential acceleration; what do you see?

BP: So, you've got this commercial space, you've got the government programs, Medicare, Medicaid. As far as government programs, I see a strong acceleration. I mean, quite frankly, with the introduction of Accountable Care Organization programs, we saw already a very strong acceleration there. There was a big jump, so I would tell you we are approaching the 50% mark from a Medicare Advantage penetration perspective. If you include MA, I could see in the next ten years definitely being over 50% for Medicare beneficiaries in some sort of Value-Based arrangement on the Medicare side. As far as Medicaid, it varies by state, but the states where there is already a strong Value-Based Care understanding and some good adoption, That's probably somewhere in between 35% to 45%.

In the next ten years on the commercial side, that's a little more challenging because when you think of Value-Based care in the commercial space, it's not the traditional Value-Based Care that people might think about; it's your bundled payments. So knee replacement, hip replacements, those are also Value-Based Care arrangements because you get a fixed amount of money that a hospital, a surgical room, gets paid for. They manage effectively around that, minimize the use of resources, drive the right outcome. That's fairly spread across the U.S., but it's really limited. It's procedure-based Value-Based Care.

CR: When you talk about bundle payment, typically, what kind of contract is it? Are they sixty days — or ninety days — on the hook for free readmission if something bad happened?

BP: It's whatever you can negotiate. If you're a provider, you'll try to negotiate fifteen, thirty days. If you're the payer, you'll try to negotiate a lot more than that.

CR: Our recent internal survey of hospital Radiology Administrative directors found that the majority of institutions are willing to pay a price premium for better patient outcomes. Are you surprised by these findings?

BP: I guess I am a little surprised. That is not a data point that I had been exposed to, so that is interesting.

CR: How do you think medical device manufacturers will respond to an increase in the popularity of Value-Based Healthcare?

BP: They should probably be rushing towards new technology, or expanding the technology, or promoting their current technology that might be able to support that. Especially as you are thinking about those tech companies that have patent protection, I could see where they would definitely try to position their services or products in this case.

CR: Twisting that question a little bit. If you oversimplify, the old adage was: create a CPT code for your technology, get good reimbursement for it, and then cash in. You basically promote the usage of your technology based on that CPT code. We split the profit — oversimplified, but the provider would say, 'I get a cut of that, and of course, it allows me to pay you.' Do you think that model will continue to be viable, or do you think there's a different approach as we talk about this topic?

BP: So you're hinting at volume again within Value Care. My approach, if I'm the risk-bearing entity, I would say, 'I'll pay you fee-for-service, I'll pay you volume, but if that exceeds a certain expected per member per month cost […] or anything below this, I'll share in the savings. Anything above that, you put your fees at risk.'

CR: Are there other models that are emerging or growing in popularity?

BP: Value-Based Care covers a broad number of models. We talked about how most people, when you think of Value-Based Care, they think about member-centric, but that's heavily supported by primary care physicians, so you get your ACOs. Most of the Medicare Advantage Value-Based Care arrangements are exactly around that, but you also have the bundled payments that have been in place for years as well. In terms of others, you get your risk-sharing models that we talked about, so same thing, that's something that's been in place for quite a while. You get your standard capitation arrangements, for specialty care, and a number of other services that are covered or paid through a capitation arrangement.

In terms of other emerging — I would say it's more how some of the technology is being used and applied, and how that drives off some of those fixed payments. Not necessarily something driven by volume, but by patient volume per month as opposed to patient volume per service.

CMS also launched a Home Health Value-Based Program in the last couple years. That's another form of Value-Based Care.

CR: Are there other models that are emerging or growing in popularity?

BP: As someone with very solid whitepapers, evidence in there, and strong ROI results, I can definitely see a land grab at some point. You certainly have the PE firms that are there to push for rapid expansions of their assets, private investors. One company that is known for this as something that can support their baseline business, and they'll buy that company or that technology or service or that expertise. That's United Health. They have made no secret that anything that's going to enhance their base service and base revenue line […] anything that's going to improve their margins, they will buy that technology, they will buy that service, they will buy that company."

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