The Value Trap

Generating value revenues at a price your group can afford

Featuring Robert Matthews

At the AMGA 2018 Annual Conference, leaders from medical groups and health systems across the country took part in a multitude of networking opportunities, educational presentations, and critical discussions pertaining to some of the industry's most pressing challenges. Among the most highly rated sessions was "Generating Value Revenues at a Price Your Group Can Afford," led by Robert Matthews, vice president for quality at PriMed Physicians and president and CEO of MediSync. Matthews described essential pathways to succeeding with value-based contracts.

Matthews began by observing that many of the nation's health systems and medical groups have found themselves in a precarious position during the transition between volume-based care and value-based care. For example, the majority of health systems and medical groups still rely on fees for their financial lifeblood. However, erosion in fees is creating increasing financial distress for virtually all groups and systems. Each year, CMS and many commercial payers raise fees 0.5% while overhead costs go up 3% to 4%. This has been going on for 16 years. "If you say the future of your group is in fees, you're not thinking ahead," said Matthews. "That fee business is sunk or sinking fast."

Meanwhile, medical groups and health systems venturing into the space of value-based care are experiencing a variety of challenges. "We got excited many years ago that we were somehow or other going to a model that was going to reward those of us who could do a better job for a better price," said Matthews, "but there were many details that weren't clear—like exactly how and how much will we get paid for better value." Today, many of those answers still aren't clear. "We were going in this direction toward value, knowing that we did not know the end destination in terms of a specific revenue model. So, after almost a decade without much clarity, today is a pretty nutty time. Most businesses want to understand their revenue model."

So, groups are stuck between a dying payment modality and one that is, as yet, unclear. Medical groups and health systems transitioning to a value-based system are finding themselves spending more money in their efforts to lower their costs than they can make back from their resulting cost-saving initiatives. Over the entire field is a general awareness that patients are not being well served in the current model and that the costs of U.S. health care are unsustainable for patients, employers, and the government.

From Matthews' perspective, for health systems and independent medical groups to keep their transition to value from becoming a bottomless money pit, there are two key elements. The first is to secure the right contracts that will give the system or group the opportunity to earn real money for real performance improvement. The second is being able to improve quality and reduce total cost at a price that the groups can actually afford. "We can't spend $1 million to save $800,000," said Matthews. "That's just not a sustainable model."

Matching Price to Performance

Matthews believes one cannot assume that the insurers are trustworthy, particularly when it comes to value contracts. The terms insurers offer on value contracts are, in Matthews' words, "terrible, because they provide groups with only a tiny portion of the improvements that they make in reducing the total cost of care." Further, sensing provider anxiety about value agreements, insurers hide the paltry rewards they offer by proposing that the contracts have no downside risk. Careful analysis would show that they don't have much or any upside opportunity either. Often enough, the results are contract terms in which the insurance company will realize $20 per member per month (pmpm) worth of savings, but only provide $2.98 pmpm to the group or system.

Planning Is Essential

Another common mistake is that some groups incur significant costs for improvements before they have a contract that will pay for improvement. This type of behavior lends truth to Matthews' argument that many groups lack a well-thought-out, written, or commonly agreed-upon value strategy or plan and are, basically, winging it.

As Matthews put it, "Ask what your organization will do if you're the dog that catches the bus. You get a good value contract and the big exposure to the total cost of care. What are you going to do that's going to make your organization successful?

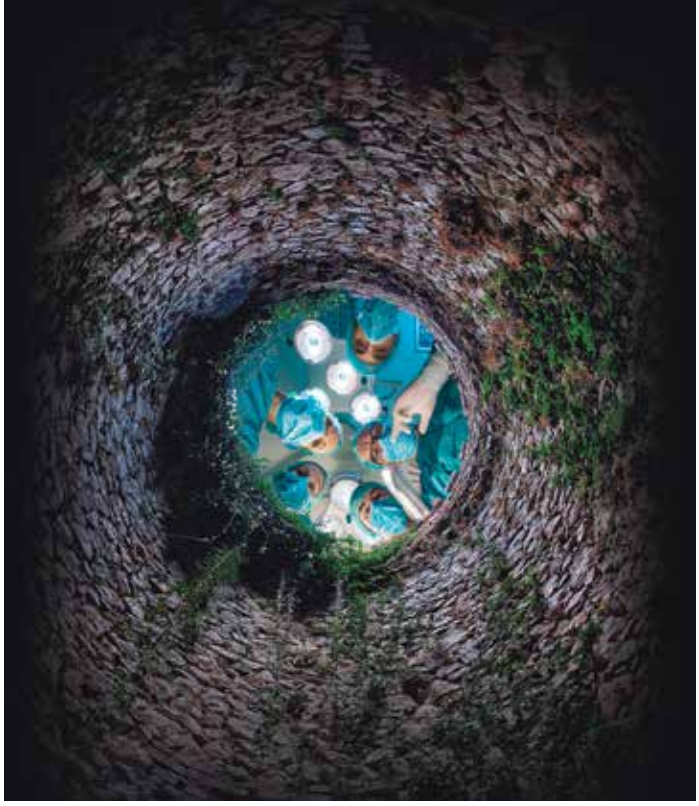
"In many instances, we're not appreciating value as a new ballgame," added Matthews. "A lot of groups make this change and this little tweak here or there to their old model. That is not going to get us to real, meaningful reductions in the total cost of care. You need a runway that allows and supports continuous improvement over a long period of time. One-shot improvements are fabulous if they work, but they're still one-shot deals, and you're going to have to have more than that to win in real value agreements."

For groups, it's important to think about the endgame and the fact that it is going to cost the organization money—both upfront monies and ongoing operating monies—to bring down the total cost of care and improve quality.

Eliminating Waste versus Addressing the Disease Burden

Matthews distinguishes two separate, important pathways to lower the total cost of care: the systematic identification and elimination of waste, and the management of the health/disease burden placed on the already-covered population of patients.

When it comes to identifying and eliminating wasteful spending, it is a matter of identifying and eliminating bad habits that developed during the days when we were paid fees and when the total cost of care was not our problem. These habits range from prescribing expensive medicines when they are not necessary, diagnostic studies that are ultimately unwarranted, unnecessary ER utilization, and a lack of coordination



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—Robert Matthews

from site-to-site or specialty-to-specialty, among many other examples. And while eliminating such wasteful spending is an important start to lowering costs, it is typically not sufficient enough to achieve total cost-of-care reductions over the long term or to a sufficiently large extent.

While eliminating waste is good, it isn't enough. Matthews proposes that the distinguishing characteristic of the organizations that are really successful in value are those that manage their patients' health and disease burden most successfully. The Commonwealth Fund and others report that 75% of total health spending is for chronic diseases. To be successful, an organization must be able "to crush" the chronic diseases in their population.

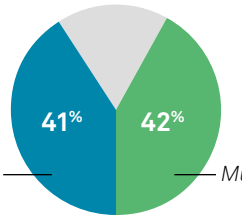
Matthews was critical of many methods for quality and cost improvement in use today. In many instances, groups or health systems run analytics, come up with lists of patients who are at great risk due to their health status, and then turn these lists over to care or case managers. Care and case managers cost between $50,000 and $100,000 per year with benefits, depending upon their credentials.

The "old school" way to improve quality involves retroactively inspecting and repairing prior work to find errors and then fixing the errors. Rework is inefficient and expensive, and winds up failing in the long term anyway.

"In new school quality theory," said Matthews, "you want to get the work done right the first time. Your goal, which is never fully achievable, is, 'Let's get it right all the time and we won't have a list of things we screwed up when we run the error-list tomorrow.'"

Super-Users

Out of the 5% of healthcare users who consume 50% of spending, there are two clinical categories that represent most of those expenditures:



Serious mental health diagnoses: $87,236 per person per year

Multiple chronic diseases: $77,833 per person per year

Source: *Health Affairs*, ©2015 Project HOPE, The People-to-People Health Foundation, Inc.

So, having analytics and a staff to find the errors in the patients we cared for last month is inherently too expensive and inherently ineffective. We need to re-engineer practice to get care right in real time.

Inverting the Pyramid

Within the bucket of chronic health and disease, one of the most popular means of managing cost has been addressing what Matthews calls "the 5%." In all studies of medical costs, a small percentage of patients—typically 5%—account for close to half of the spending. The belief is that by concentrating on this small yet costly pool of patients, organizations will be able to successfully bring their spending down and obtain substantial savings.

Unfortunately, as Matthews points out, "in that 5%, a lot of it is not really amenable to cost improvement, so there's a lot of cost in there that's really not going to change, no matter what you do." Further, such an approach—studying one expensive patient at a time—often fails to understand what can be done with these populations.

Matthews offers an alternative perspective on a group's population costs. For him, opportunities to save both lives and money stem from three areas of care: cancer, end-of-life, and chronic disease.

To improve cancer care, Matthews advises that organizations enter into formal partnerships with oncologists, getting them on the same page as your group. "If cancer's a big cost and you're not working with groups that are very dedicated to being good at it, it's not going to go well," said Matthews. "You want them to be accountable for their medication choices, both in efficiency and cost, and we'd like to have a very clear connection about palliative and hospice care."

When dealing with patients who are in decline and are reaching the end of their life, Matthews argues that health systems have often behaved like pinball machines. "In the old pinball, you shot the silver ball up and at the top of the pinball deck, the ball would bounce around among all those bumpers, and you would get points. As patients are aging and moving into a very frail end-stage of life, what too often happens is they get shot up into a health system where they bounce around the various specialty and service bumpers out of context. But they aren't getting points—they are spending dollars." For organizations, it is crucial to identify these patients as early as possible and invite them and their families into a special care system, recognize the patient's status, and maximize their comfort while providing the care that is necessary to meaningfully extend life and/or to add quality of life.

The Big Opportunity

For Matthews, the most important cost management opportunity is to better control chronic diseases. According to the Commonwealth Fund, 75% of the monies spent on health care in the U.S. are for the treatment of the chronically ill. Matthews believes the groups that do the best addressing chronic diseases will be the groups that succeed best in value.

"If you look at the top 12 chronic diseases," he said, "those are the people who are going to have emergency room visits; they're going to have heart attacks, strokes, TIAs, renal failure, amputations, vascular interventions, etc. They're the ones who are going to get admitted and readmitted, go to the ER, and are going to have a ton of secondary comorbidities. The bottom line is that we have to be all over that."

Once these patients show up in an institution, that becomes a sunk cost. Better management keeps more patients out of institutional care. CMS data shows that organizations that are able to help patients get control over their multiple chronic conditions save the most money in total cost by reducing institutional episodes and major interventions. The key lies in this control of chronic diseases—lowering blood pressure, LDL, and A1c; developing faster diagnoses of heart failure and COPD; and more effective asthma management, etc. For MediSync and PriMed, the goal is to get 90% of their patients to goal in all 12 of the top chronic diseases. The national average in hypertension is only 50%, and in diabetes it is much lower than that.

Ultimately, Matthews says, medical groups and health systems need to be patient and be willing to wait for real value contracts to apply proper care and case management, address site and partner cost differentials, redo frail and end-of-life care, and redo cancer care. In the meantime, early focus on the chronic outcomes using the systematic processes that should be undertaken is critical. "The top 12 chronic diseases are a long journey," said Matthews. "You don't just turn this on like a light switch." GPJ

***Healthcare leaders like Robert Matthews will share strategies from around the country at the AMGA 2019 Annual Conference, March 27-30, 2019, at National Harbor, Maryland (near Washington, D.C.). For more information and to register, visit* amga.org/ac19.**

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