Sui Generis Health

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Overview of Value-Based Care

It's intended to assist with the current/on-going transition from "Volume to Value" as is mandated via the PPACA (current - Obamacare) and that which is forthcoming ("Trumpcare"). It includes a brief history and year-to-date status to assist your team with proper context.

Background

Applicable Healthcare Legislation is cumulative in nature starting with the Medicare Modernization Act of 2003. This effort was in response to the lack of "performance" and overall instability of the Federal platform. At that time, it was widely recognized that the Federal provider system (CMS/VA/DoD) was under-performing in terms of Clinical Outcomes and Cost Savings and radical change was necessary to ensure a sustainable platform moving forward.

However, as is the norm, rapid/expansive change is difficult and within this environment the necessary efforts had to be measured to ensure success. Slow acceptance/implementation, coupled with dramatic "pulls" on the economy (e.g. 2003 Iraq invasion/financial crisis 2007-2008) resulted in the wide spread recognition that the Federal System was unsustainable and on the verge of imploding unless immediate action was taken. Hence, the HITECH Act of 2009 and the PPACA in 2010 via the Obama Administration.

Politics aside, these efforts were viewed as necessary to "right the ship". We're well aware of the controversy surrounding Obamacare – it is an imperfect piece of legislation made up of 10 Titles (sections). However, what the clear majority of people don't know is that eight (8) of the ten (10) Titles had/have Bi-Partisan support and the remaining two (2) Titles are the cause of the angst & anxiety in DC. They include the individual mandate, small business mandate, Health Insurance Exchanges and tax/entitlement related issues - these are problematic and require review/revision.

There are a number of facts that are often overlooked within the repeal/replace debate, they include, but are not limited to –

- Pre-SCOTUS Decision of 2012 the "Big Six" (UHC/Aetna, etc.,) announced that regardless of the decision, they would move forward with Value-Based Care due to the obvious opportunities related to outcomes/savings for the patient and overall system.
- The GOP sponsored "Patient Centered Care" initiative embraces Value-Based Care and the applicable aspects of the remaining 8 PPACA Titles as previously mentioned.
- Value-Based Purchasing/Value Based Payment is not a new concept. It was recognized and in widespread use during the Clinton/Bush Administrations and commonly referred to as "Pay for Performance" (P4P). Obamacare re-labeled P4P as VB and "Trumpcare", regardless of its final form, has recognized/embraced same moving forward.

Value-Based Care is mandated for rapid expansion across the entire spectrum of Healthcare – Rx and Major Medical Benefits. Currently, approximately 70% of all insured individuals have a Value-Based component associated with their benefit structure. It is estimated that this will grow to 80% in 2018 and 90% in 2019 (full saturation). This includes segments such as the VA/DoD, Pharmacy, Skilled Nursing Facilities, Workers Comp and any/all applicable platforms wherein patient care is delivered. Said expansion allows for applicable products/services to be positioned as Value-Based, and when performance meets/exceeds expectations, allows for the provider to position for a Value-Based Incentive (VBI).

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Overview of Value-Based Care (continued)

The Cornerstone of Federally Mandated Value-Based Care

Moving forward, all providers must demonstrate proof that they have identified/vetted and implemented applicable Value-Based products/services in order to participate in the patient care continuum and maximize returns. System wide adoption is mandated and rapid implementation is necessary to ensure platform sustainability.

The Cornerstones are as follows -

- Content (products/services) must be validated –
  ~ Scientific/Clinical Validity
  ~ Clinical Utility
  ~ Health Economic Modeling demonstrating cascading impact on Gain-Share/P4P
- Care-pathway must be validated via an HRO/Military Acuity Model to ensure Products/services are delivered in an efficient/effective, zero-defect manner.
- Common/Core Access Points must be established to ensure rural care.
- Data Collection/Real-Time Reporting on adoption/incremental gains.

The Strategy of Introduction and Implementation of Value-Based Care

There are two fundamental levels of strategy: Executive Level Strategy and Business Unit Strategy. Executive Strategy defines what set of Therapeutic Categories to participate in, while Business Unit Strategy describes how to compete in each.
While both are essential, Business Units typically account for 90% or more of economic performance—and therefore are the focus of the strategy work.

The Business Unit, and not the platform overall, is the core level of strategy. Therefore, a parallel effort must be followed to secure Value-Based Care within a given care continuum in an expedited manner.

Executive Level support/participation, coupled with Business Unit implementation, is necessary for rapid acceptance. Accordingly, it's important to stage the effort to ensure system wide understanding of the effort –

- **Stage I** – Introduction/implementation of Value-Based products/services into care-continuum
- **Stage II** – Introduction/Implementation of HRO/Military Acuity Model
- **Stage III** – Introduction/Implementation of Data Collection/Reporting
- **Stage IV** – Data Stratification/Submission for VBI