HEALTHCAREDIVE

Tipping point is in sight: Value-based care is driving meaningful financial results

Liz Kirk shares her reflections on value-based care from the 41st annual JPMorgan healthcare conference held in San Francisco.

By Liz Kirk

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After several years of virtual JPMorgan Healthcare Conferences, the 41st annual event was back in person and in full swing. Thousands of attendees came together in San Francisco to close deals, find partners, announce big wins, and give us a preview of what's to come in 2023 and beyond.

Seventeen major health systems from across the country presented at the conference: large, national faith-based organizations like Common Spirit and AdventHealth; major regional players such as Baylor Scott & White and Intermountain; smaller regional health systems, such as INOVA; AMC-centric organizations like Indiana University Health and highly specialized providers, including musculoskeletal powerhouse, Hospital for Special Surgery.

Aggressive Cost Cutting and Risk Readiness Are the Roadmap for 2023

Among the stories of resilience through COVID-19 and impressive transformations to expand access through digital health, a line was drawn in the sand. With only one exception, the health systems reporting the strongest and most consistent financial performance from 2020 to 2022 — with operating margins between 6% to 12% — either have sizable health plans or a significant number of covered lives in value-based or shared savings plans.

Health systems that have not taken risk find themselves with more typical margins of 1% to 4% or, in striking contrast to those that have taken risk, reporting substantial operating losses.

The health systems with the largest losses are launching or are in the early stages of major margin improvement initiatives. One national health system reported a $2 billion cost reduction target and are planning to use a "command and control" approach to the cost take-out effort they perfected during COVID-19 surges.

Among the largest health systems, leveraging scale to centralize core functions and provide a consistently high level of service was a key strategy, with the idea that being large only adds complexity and cost if health systems aren't leveraging their scale.

Every system, regardless of size, current risk profile or margin, is looking to round out their continuum of care, increase access and enable a frictionless patient experience to provide patients with the care they need in the right setting — in their homes, their neighborhoods, an ambulatory surgery center or the hospital. They are becoming "risk-ready," in the words of a CEO who had not yet entered into risk contracts. Many leaders referred to an "asset-light"

digital strategy as a way to enter desirable markets with largely healthy populations. The health system leaders acknowledged the importance of partnerships with vendors, outsourcers, and post-acute providers to accomplish their goals, especially given the labor shortage.

Have we reached the tipping point for broad adoption of value-based care?

A skeptic would say that this is what you'd expect to see. Health plans and capitated revenue provided a great financial hedge as patients sought less care throughout the pandemic. High-margin elective cases were paused. Hospitals provided more low-margin but high-intensity care to millions of people, including many who lost insurance coverage. All the while, wage rates and supply costs were skyrocketing.

In principle, that's true, but the attitude feels different now. With 48% of the eligible Medicare population enrolled in Medicare Advantage plans and, the CMS committed to having 100% of enrollees in a value-based care program by 2023, the tailwinds are pushing at-risk arrangements forward in a big way.

Health system leaders are also pushing it forward. At least five presenting CEOs at the JPMorgan conference said that taking on full risk gives them the freedom to do what is right for the patient. Not only does this encompass healthcare services as we typically think of them, but it also addresses housing insecurity, nutrition, and other social determinants of health. One CEO said that "taking risk for the health of underserved populations is the best way to provide the services that are needed."

With payer rates lagging behind the cost of care, many health systems are negotiating with payers off-cycle just to cover costs. Most health systems are asking for a couple of points of increase but are expecting to see escalating denials and underpayments that effectively offset the gains. Many health systems are asking for full risk. Most are also looking to grow, partner, or start health plans so that they can be paid the "full healthcare dollar" and can better manage their patients' health.

For-profit companies are also seeing the advantage of taking on risk

On the other side of the coin are for-profit companies. There are at least 10 companies that are enabling providers — typically primary care practices — to have data and a slick, automated workflow to successfully manage the care of enrolled patients so that they have fewer acute episodes, hospital visits and readmissions. Then there are companies that are taking full risk for typically challenging patient populations to manage, such as dual eligible Medicare/Medicaid patients, rural Medicare patients, veterans and even oncology and end of life care patients. Medicare Advantage and Managed Medicaid patients are the sweet spot for many of these companies, largely because there is so much opportunity to better manage their health conditions and social determinants of health issues.

Interestingly, payers are typically the buyers for these new products. These startups are taking full risk which most traditional healthcare providers have emphatically said no to — and are providing the patients with the care they need to stay healthy and out of the hospital.

The results are stunning. They show considerable savings for the covered populations and boosted patient satisfaction ratings. In most models, savings are shared among the companies and the payer or practices.

Several of these companies said they'd thought about selling to health systems, and a few had attempted to do so, but all said that health systems are too slow to move and their "incentives are not aligned to work with ours." The incentives issue was often around fee-for-service and driving volumes, not total cost, of care and outcomes.

Given the clear shift toward wanting to take more risk and an openness to partnerships, this trend may change in the coming year, especially as Medicaid and Medicare reimbursement covers increasingly less of the cost of care. Why wouldn't health systems want to keep these patients in their network, improve their health and reduce unnecessary hospital visits? Keeping those patients out of the "most expensive hotel room in town," except for when they really need to be in the hospital, would open more capacity for patients who need really it and whose care would likely be reimbursed at a higher level.

What's different this time? Will we get to the tipping point?

Health systems want to take on risk because it can be more financially advantageous and better for patients, but they often struggle to fund and put together all the pieces to really provide patients with the services they need to lead healthier lives — proactive, coordinated primary care, housing, food, transportation, behavioral health coaching, post-discharge management and more. They know they need partnerships to accomplish this at scale.

Startups have the technology, care models, roles and workflows to manage even the most difficult patient populations. Moreover, they have ROI, better health outcomes and highly satisfied patients. But there are simply too many of these companies right now, with each focusing only on a subset of the population. The thought of managing multiple vendors and having varied user experiences creates too much complexity for health systems and physician practices that may have different platforms for patients enrolled with different health plans.

However, once there is consolidation in this space, and there certainly will be in the next two to three years, the tipping point will come quickly. Health systems — or payers, if the health systems don't take the opportunity — will have the tools, data, and workflows to confidently take on risk. They will be able to provide lower cost, higher quality care that is easily accessed and actually improves the lives of the people who are in the care of the health system or enrolled in these health plans.