

THE ACADEMY LUMERIS STRATEGIC TRACKING SURVEY

Q2-Q3 2018 TRACKING: THE EVOLVING PAYMENT
MODEL & HEALTH POLICY

SEPTEMBER 2018

THE EVOLVING PAYMENT MODEL & HEALTH POLICY

INTRODUCTION

As health systems continue to move toward value-based care, many organizations are implementing alternative payment arrangements and taking on greater levels of risk. While the transition to value-based payment has historically been slow, health system executives continue to prioritize providing high-quality care while managing the total cost to succeed in this environment.

This report discusses the results from The Academy Lumeris Q2 and Q3 2018 Tracking Surveys, assessing the evolving payment model and health policy.

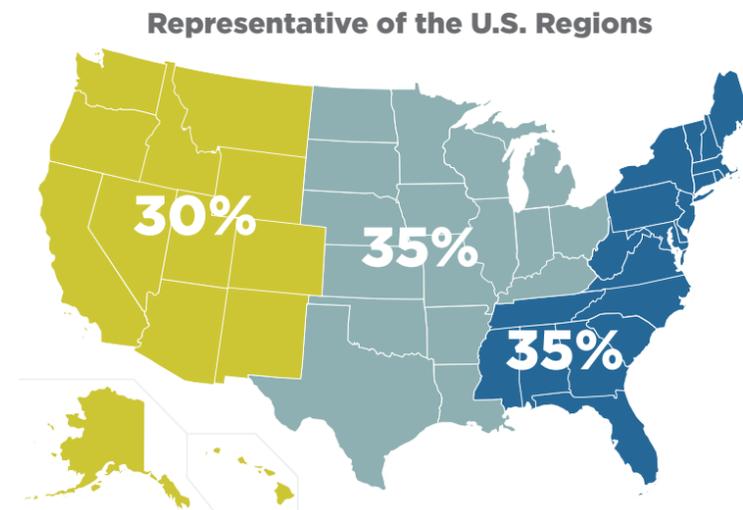
METHODOLOGY

In May and August 2018, The Health Management Academy (The Academy) conducted the fifteenth and sixteenth round of phone interviews for its quarterly strategic survey among Leading Health System executives, including: CEOs, COOs, CFOs, CMOs, CNOs, and CSOs.

The survey for the interview consisted of:

1. A tracking section that provides insight into trends around primary strategic areas; and
2. A special topic area that allows for an in-depth look into a timely developing issue.

PROFILE OF PARTICIPATING HEALTH SYSTEMS



**MEDIAN
REVENUE**
\$4.4
BILLION

OWN OR OPERATE
280 HOSPITALS
WITH **51,442 BEDS**

SINGLE-STATE SYSTEMS: **60%**
MULTI-STATE SYSTEMS: **40%**

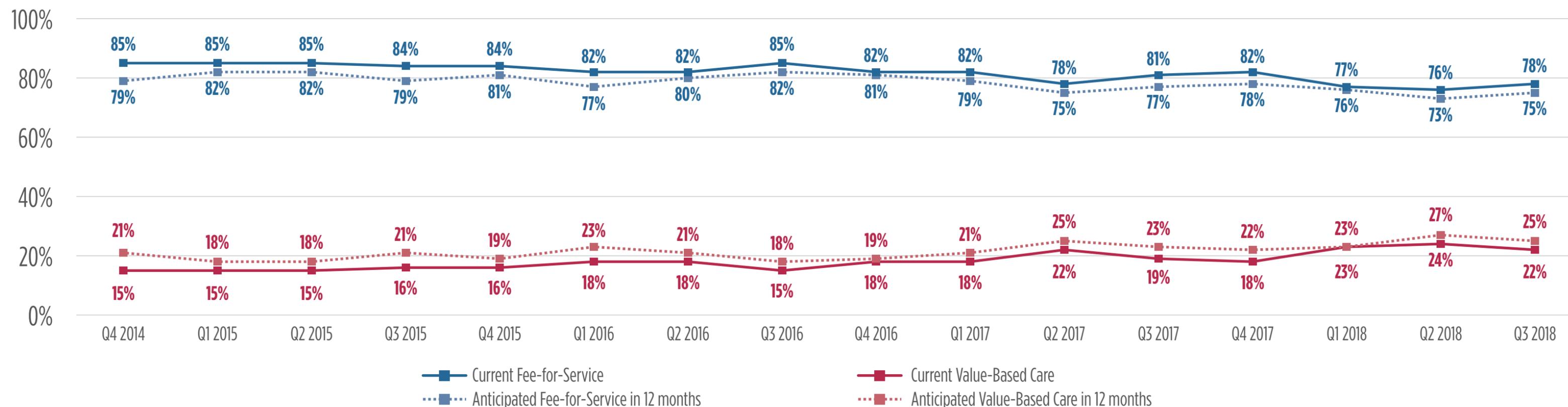
KEY FINDINGS

1. Fee-for-service payments still account for the majority (78%) of care delivery among responding health systems.
2. Forty-six percent of responding executives described their organization's pace of change toward value-based payment as quick or very quick, up 14 percentage points from Q2 2018.
3. Health systems understand the total cost of care for Medicare patients, with 50% reporting that they understand the cost well or very well. However, many executives indicate understanding costs for other payers (e.g., Medicaid, commercial) is more challenging.

MOVEMENT TO VALUE-BASED CARE REMAINS SLOW

Movement toward value-based care at Leading Health Systems remains slow in Q3 2018, with value-based payments comprising 22% of care delivery. Fee-for-service payments still account for the majority (78%) of care delivery, though this percentage has decreased five percentage points over the last year. Health system executives expect a modest growth in value-based care in the next year, projecting an average of 25% of care to be delivered through value-based payment arrangements by Q3 2019.

CURRENTLY, WHAT PERCENT OF YOUR CARE DELIVERY IS FEE-FOR-SERVICE AND VALUE-BASED? WHAT DO YOU EXPECT YOUR CARE DELIVERY TO LOOK LIKE IN 12 MONTHS?

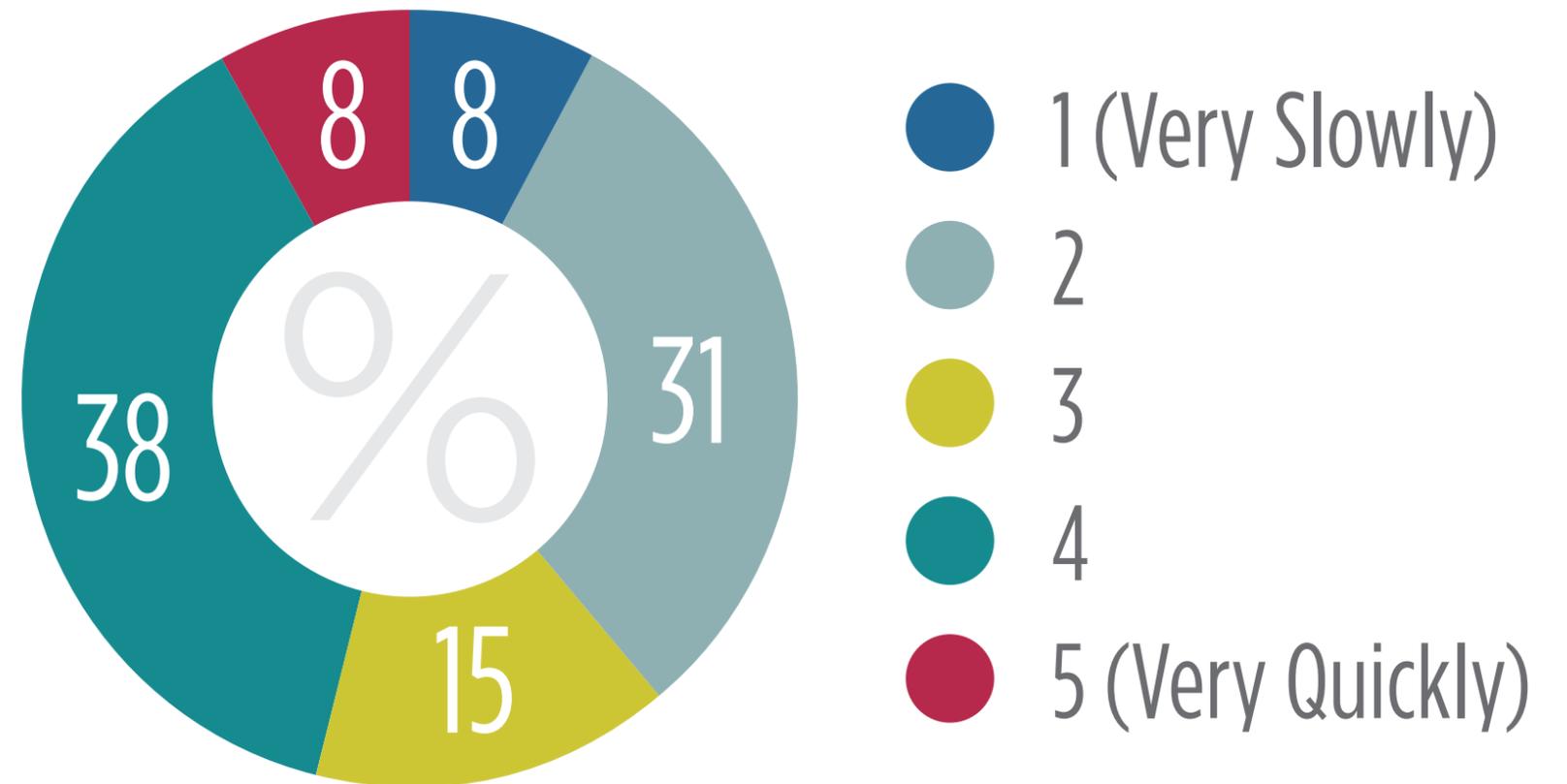


PACE OF CHANGE TOWARDS VALUE ACCELERATES

Although movement toward value-based payment has been fairly slow in recent years, health system executives indicate the pace of change may be increasing. In Q3 2018, 46% of responding executives described their organization's pace of change toward value-based payment as moving quickly or very quickly (4 or 5 on a scale of 1 to 5), up 14 percentage points from Q2 2018.

Additionally, 62% of health systems indicated that they plan to assume additional risk in the next 12 months. Of these, ACOs (46%), Medicare Advantage (31%), and bundled payments (23%) were common methods for increased risk assumption.

ON A SCALE OF 1-5, HOW WOULD YOU DESCRIBE THE PACE OF CHANGE TOWARDS VALUE-BASED PAYMENTS AT YOUR HEALTH SYSTEM?



VALUE-BASED METRICS TIED TO COMPENSATION

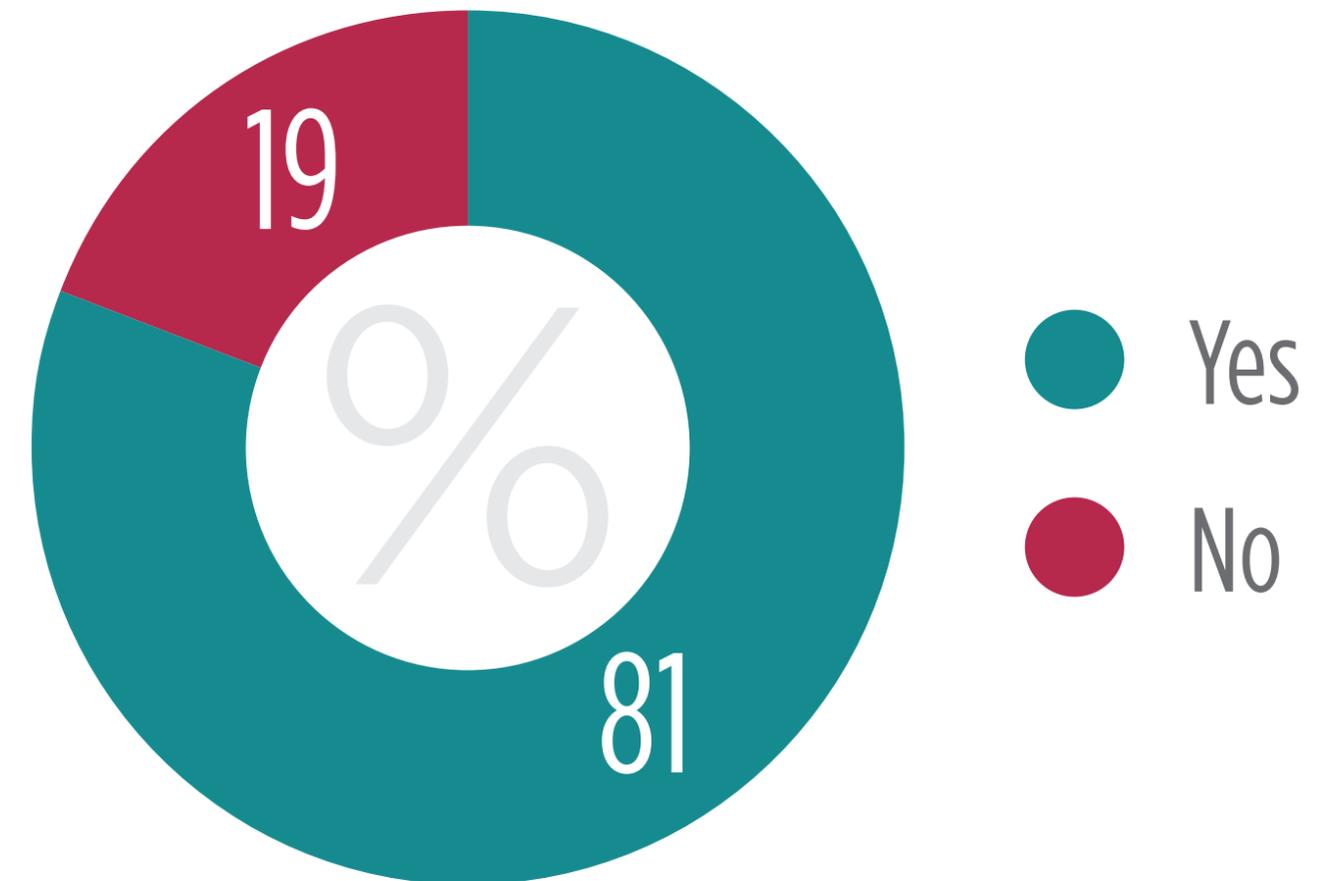
Reflective of health systems' continued movement toward value-based payment models and to ensure alignment across the organization, most (81%) health systems have adjusted compensation structures to include value-based metrics for employees, including physicians, nurses, executive leadership, and/or C-suite executives.

Most executives indicate value-based metrics are included in physician and leadership compensation plans, most often tied to the organization's incentive plan.

“Selected quality metrics are part of physician compensation. Quality goals are established annually for the entire network, and are part of the leadership incentive package.” (CSO)

“Our C-suite and top leaders have a performance bonus plan based on a balance scorecard. A lot is based on Medicare Advantage stars, health outcomes, value-based performance, and engagement in hospitals and clinics.” (CSO)

HAS YOUR HEALTH SYSTEM ADJUSTED COMPENSATION STRUCTURES TO INCLUDE VALUE-BASED METRICS FOR EMPLOYEES?



PRIORITIZING CONSUMER LOYALTY

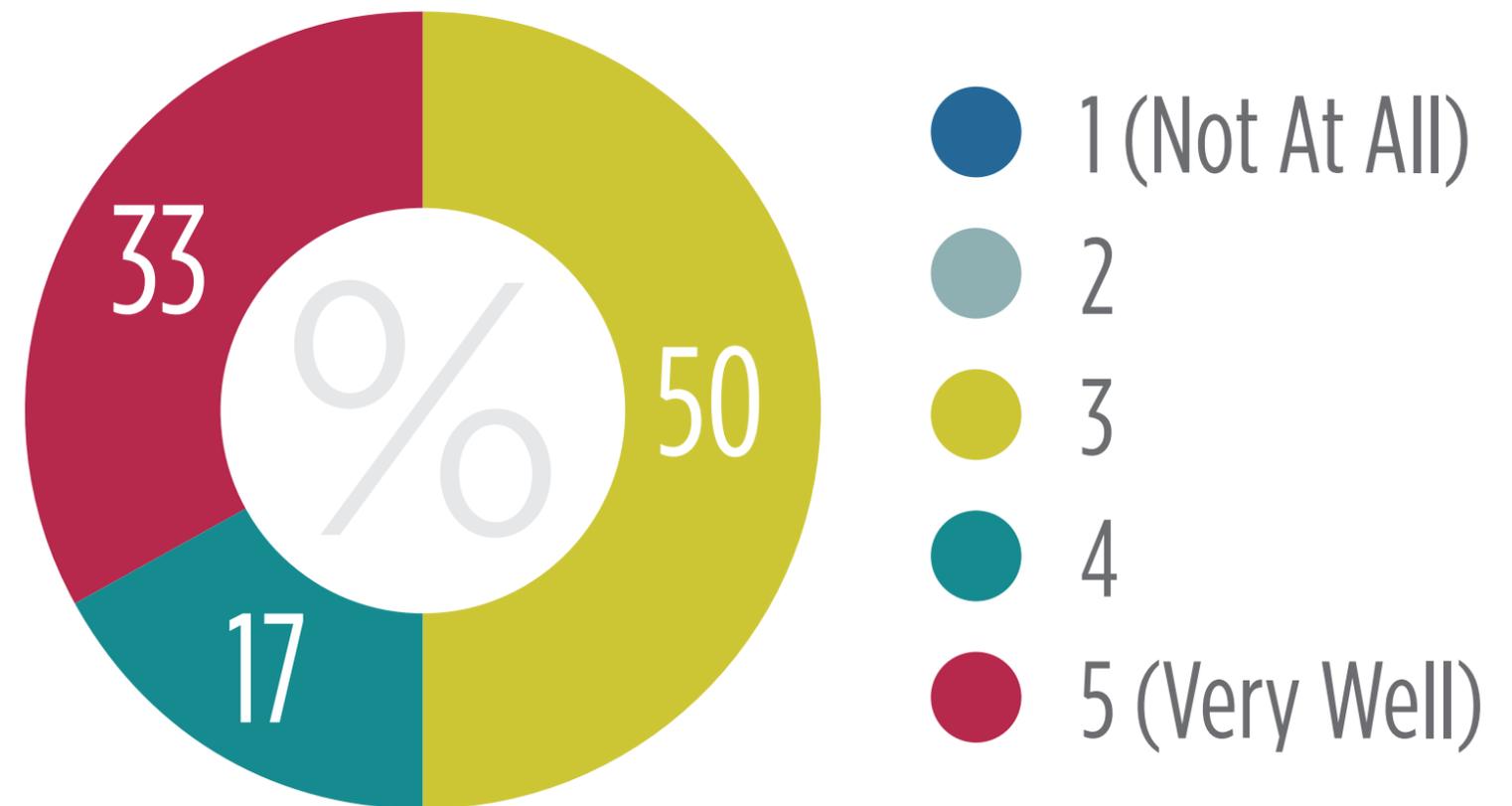
Health systems understand the total cost of care for Medicare patients, with 50% reporting that they understood the cost well or very well.

- Health systems indicated they best understand the cost of care Medicare patients in specific value-based payment arrangements (e.g., Medicare ACOs, Medicare Advantage).
- Cost of care for other payers, such as Medicaid and private commercial payers, were more opaque.

Almost all health systems have plans in place to prepare for and evaluate the impact of proposed policies that would cut payment rates to outpatient hospital departments to 40% of current rates, as a broader push towards site neutrality. Most health systems intend to move away from hospital-based outpatient care and focus on providing care in lower cost settings.

“Looking at our business model, I think this is the right thing. Site neutrality changes are actually a good thing for healthcare—as both a patient and a consumer. One of our top priorities is to move to full risk by 2021.” (CSO)

ON A SCALE OF 1-5, HOW WELL DOES YOUR SYSTEM UNDERSTAND THE TOTAL COST OF CARE FOR YOUR MEDICARE BENEFICIARIES?



ABOUT THE ACADEMY

The Health Management Academy (The Academy) is a membership organization exclusively for executives from the country's Top-100 Health Systems and most innovative healthcare companies. The Academy's learning model identifies top priorities of health system leaders; develops rich content based on those priorities; and addresses them by convening members to exchange ideas, best practices, and information. The Academy is the definitive trusted source for peer-to-peer learning in healthcare delivery with a material record of research and policy analysis. Offerings include C-suite executive peer forums, issues-based collaboratives, leadership development programs, research, advisory, and media services. The Academy is an accredited CE provider. More information is available at www.academynet.com.



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ABOUT LUMERIS

Lumeris is a value-based care managed services operator for health systems and providers seeking extraordinary clinical and financial outcomes. Recognized nationally by KLAS in 2018 for Value-Based Care Managed Services, Lumeris aligns providers and payers across populations with technologies, processes, behaviors and information to achieve high-quality, cost-effective care with satisfied consumers — and engaged physicians. It was the third straight year Lumeris received the distinguished Best in KLAS award. For the past seven years, Lumeris with Essence Healthcare, its inaugural client and learning laboratory with more than 65,000 Medicare members in Missouri and Illinois, has received 4.5- to 5-Star Ratings from the CMS and produced the highest consumer and physician satisfaction scores in the industry along with significantly better clinical outcomes and lower costs. For more information, go to www.lumeris.com.

**THE HEALTH MANAGEMENT ACADEMY EXTENDS ITS APPRECIATION
TO LUMERIS FOR THE FINANCIAL SUPPORT FOR THIS PROJECT.**

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