Solutions For Value-Based Care

Industry Perspective

Dispelling the Myth that Size Makes Might for Value-Based Payments

Valence Health®

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By Philip Kamp

You've likely heard it said: Value-based purchasing models only work for academic medical centers or sprawling hospital systems. Owning providers is how you control them, the argument goes, and controlling specialists is how you manage costs. And isn't it true that large systems and academic players boast the billboard-worthy brands to succeed under value-based payments?

We politely disagree.

In our view, middle market hospitals – such as community medical centers – are ideally positioned to sign value-based contracts. After 20 years of helping organizations accept the responsibility and rewards for better managing their patient populations, we at Valence Health have learned that sphere of influence – not size – is the critical factor for value-based success.

In fact, a smaller hospital may have distinct advantages when it comes to value-based care. We believe that if your organization can say yes to the majority of the following questions, you are well-positioned to succeed in value-based care:

1. **Do you have significant control over the care continuum?**
   Control over the continuum is imperative because it's that ability to keep all the pieces working together, with patients and their care plans flowing through the system, that drives up quality and down cost. But control does not necessarily imply ownership. So ask yourself: From primary care to specialists to acute and post-acute providers, do you have or can you build sufficient relationships and structures to allow these groups to work together? For example, imagine if yours was the only hospital in a town or county. If you have good relationships with physicians; a well-functioning PHO; and relationships with a lab, urgent care center, imaging centers, rehab and long-term care facilities, then you are well-positioned to coordinate care. Likewise, a 250-bed county hospital with relationships with 150 primary care and specialist physicians and ties to a 300-resident rehab and long-term care facility can succeed at value-based care as well or better than an urban system with ten hospitals and 2,500 owned physicians. It's not raw scale that counts with value-based care, but rather the ability coordinate and integrate care.

2. **Does your target patient population comprise a significant portion of provider panels and payor members for success?**
   The number of patients you propose to manage is important in two ways. From the perspective of delivering quality care, value-based care calls for changing patient and provider behavior. Patients will respond to physician-led health management, research shows, so changing provider behavior is critical. However, in order to sway providers, our experience suggests you must influence at least 30 percent of their workflow. In other words, the desired value-based arrangements must impact 30 percent of physician's patient panels. Any less than that, the inertia to change workflow is too large, and the financial rewards too small, for success.

   At the same time, the scale of patient population under coordination must provide an upside opportunity for payors. While this certainly can be construed to be a "size" issue, the reality is that the critical mass of lives will vary greatly based on market conditions. In some markets, you may only need to aggregate 10,000 lives to attract payors to a risk-based contract. For providers seeking to start their own health plan, the number of lives varies again. The good news, though, is that the number may not be extraordinarily large – and certainly does not preclude middle market players from entering such arrangements.

3. **Are you the low-cost providers in your market?**
   You most likely already know this answer, and if you don't, you can look to your state's cost database for information.

The good news is that community hospitals likely have a significant advantage in this area. Academic medical centers and often large hospital systems, carry the cost burden of teaching, research and the purchase of the latest, most expensive technologies. Middle market providers may also benefit from not having purchased physician practices: they carry less debt. So if a risk contract includes primary care quality goals, a middle market hospital with ties to primary care providers is maybe more efficient and nimble than a mega-hospital system.

4. **Can your organization's leaders commit to aligning incentives and making required changes?**
   It takes committed leadership to ensure that your reimbursement model makes sense for all stakeholders: patients, providers and payors. Fortunately, leadership is not about how big an organization is, but rather where an organization chooses to focus. With all the talk about new reimbursement models, let's remember that very few people – including administrators - are involved in medicine to simply make a dollar. Their personal mission is to care for people and help them live full and healthy lives. Of course, hospitals must make a profit to survive, so a successful leader will leverage clinical and financial rewards, as well as moral calls to action, to motivate change.

Your healthcare delivery system need not possess all the skills and abilities stated above to succeed. But if your organization can say yes to the majority of these questions, you can partner, rent or purchase the skills and bandwidth to move forward.

The bottom line: If given the right market conditions, *every provider* should consider risk and lots of hospitals can succeed at it, even if yours isn't the biggest player on the bench.

About the Commentator

Philip H. Kamp co-founded Valence Health in 1996 and leads the company's efforts in creating patient-focused, data-driven solutions that can be implemented across a health care organization. Mr. Kamp has more than 30 years of managed care experience focusing on integration strategies for health systems. As a partner in the consulting and accounting firm of PricewaterhouseCoopers, he led the formation of numerous IPAs, PHOs and provider-sponsored Health Plans. Mr. Kamp has served as interim CEO and CFO for several risk-bearing PHOs/IPAs and HMOs. Mr. Kamp and Valence Health co-founder Todd Stockard, were selected for induction into the 2010 Chicago Area Entrepreneurship Hall of Fame.

About Valence Health

Valence Health provides value-based care solutions for hospitals, health systems and physicians to help them achieve clinical and financial rewards for more effectively managing patient populations. Leveraging 20 years of experience, Valence Health works with clients to design, build and manage customized value-based care models including clinically integrated networks, bundled payments, risk-based contracts, accountable care organizations and provider-sponsored health plans. Providers turn to Valence Health's integrated set of advisory services, population health technology and managed services to make the volume-to-value transition with a single partner in a practical and flexible way. Valence Health's more than 800 employees empower 85,000 physicians and 135 hospitals to advance the health of 20 million patients. For more information, visit us at: www.ValenceHealth.com.