Driving the Transition to Value-Based Care: A Point of View from Kaufman Hall

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The nation's healthcare providers have faced three "pivot points" in less than five years. First was development of the Patient Protection and Affordable Care Act (ACA) during 2008–09 and its signing into law in March 2010. With this pivot, providers recognized that, accelerated by reform and the nation's fiscal challenges, a value-based business model would ultimately emerge to reduce healthcare costs and increase quality and access.

The second pivot was the Supreme Court's June 2012 ruling upholding the constitutionality of the ACA. After this ruling, many providers started in earnest to re-evaluate their readiness for, and formalize their commitment to, gaining the skills and competencies[1] required to position their organizations for success.

Based on 2012 election results that bring more certainty about the ACA's implementation, the third pivot—executing on value—occurs now. All healthcare stakeholders will be required to do their share. But hospitals and health systems should drive the transition to value and move thoughtfully, and as rapidly as possible, away from the current volume-based model, which is widely recognized as ineffective in delivering care at a cost the nation can afford.

The value-based model will bring a fundamental shift in how providers deliver and are paid for services (see **Exhibit 1**). The transitional period will be challenging; payment models and care models will not align in the near term. Healthcare boards and management teams have a fiduciary responsibility to ensure effective and efficient care in their communities, while preserving the clinical and financial integrity of their organizations. From a mission perspective, value-based care delivery is simply the right thing to do for the patient. For this reason, leading organizations nationwide have been pursuing transformational models, long before legislation required it.

Exhibit 1: Elements of Change in the Old/New Business Model

Element of Change	Today →	Future
Care focus	Sick care	"Healthcare," wellness and prevention, disease management
Care management	Manage utilization and cost within a care setting	Manage ongoing health (and optimize care episodes)
Delivery models	Fragmented/silos	Care continuum and coordination (right care, right place, right time)
Care setting	In office/hospital	In home, virtual (e-visits, home monitoring, etc.)
Quality measures	Process-focused, individual	Outcomes-focused, population-based
Payment	Fee-for-service	Value-based (outcomes, utilization, total cost)
Financial incentives	Do more, make more	Perform better on measures, make more
Financial performance	Margin per service, procedure (bed, physician, etc.)	Margin per life

Source: Kaufman, Hall & Associates, Inc.

Organizations that learn how to operate in a value-based environment will gain critical experience; organizations continuing to follow the status quo will have little to no strategic flexibility and will become vulnerable as the rest of the market realigns. The time to reposition and intensify efforts around the core competencies is short. The federal government is committed to operationalizing the health insurance exchanges and other key pieces of the health reform law in 2014. Non-governmental payers are already working on assembling cost-effective narrow networks. The choice of provider inclusion or exclusion from such networks is controlled by local payers. It is conceivable that within a few years a significant number of providers may be excluded from their current contracts. For providers included in contracts, payers are setting higher and more realistic thresholds for risk assumption because, in past years, many payers were "stuck holding the bag" on provider risk arrangements when the provider clearly wasn't ready to accept risk.

Meanwhile, payer mix and utilization will continue to deteriorate for hospitals and health systems as individuals transfer into the exchange-based products, and as employers shift a bigger share of costs to employees and change the way they provide health benefits (see **sidebar 1**).

1 Core competencies are tight physician integration, care coordination and management capabilities, information system sophistication, rational service distribution, cost management/cost structure, scale and market essentiality, brand identification, payer relationships and contracts, financial strength and capital capacity, and enterprise risk management.

Sidebar 1: Examples of Current Trends in Employer-Sponsored Health Insurance

- From defined-benefit plans to defined-contribution plans: Sears Holding (with 90,000 eligible employees) and Darden Restaurants (with 45,000 employees) are giving their employees a fixed sum of money (a "defined contribution"), allowing them to choose their medical coverage benefits and insurer from an online marketplace.
- Moving a greater share of healthcare costs to employees: General Electric put its white-collar workers on a high-deductible health plan, which effectively reduced employees' overall use of health services—particularly utilization of MRIs and CT scans (these dropped by as much as 25 percent).

Sources: A. W. Mathews, "Big Firms Overhaul Health Coverage," *The Wall Street Journal,* September 26, 2012; and K. Linebaugh, "GE Feels Its Own Cuts," *The Wall Street Journal,* September 17, 2012.

Exhibit 2: Redesigning Care to Impact the Value Proposition: Partners HealthCare: 20 Tactics

<table>
<tr><th></th><th colspan="2">Longitudinal Care</th><th colspan="2">Episodic Care</th></tr>
<tr><th></th><th>Primary Care</th><th colspan="2">Specialty Care</th><th>Hospital Care</th></tr>
<tr><td rowspan="3">Access to Care</td><td colspan="2">Patient portal/physician portal</td><td colspan="2">Optimize site of care</td></tr>
<tr><td colspan="2">Extended hours/same-day appointments</td><td colspan="2" rowspan="2">Reduced low-acuity admissions</td></tr>
<tr><td colspan="2">Expanded virtual visit options</td></tr>
<tr><td rowspan="7">Design of Care</td><td colspan="4">Defined process standards in priority conditions (multidisciplinary teams, registries)</td></tr>
<tr><td rowspan="2">High-risk care management</td><td rowspan="2">Required patient decision aids</td><td>Readmissions</td></tr>
<tr><td>Hospital-acquired conditions</td></tr>
<tr><td rowspan="2">Provide 100% preventive services</td><td rowspan="2">Appropriateness</td><td>Hand-off standards</td></tr>
<tr><td>Continuity improvements</td></tr>
<tr><td colspan="4">EHR with decision support and order entry</td></tr>
<tr><td colspan="4">Incentive programs (recognition, financial)</td></tr>
<tr><td rowspan="3">Measurement</td><td colspan="4">Internal variance reporting/performance dashboards</td></tr>
<tr><td colspan="4">Public reporting of quality metrics: clinical outcomes, satisfaction</td></tr>
<tr><td colspan="2">Costs/population</td><td colspan="2">Costs/episode</td></tr>
</table>

Source: Timothy Ferris, M.D., "The Engaged Provider Response to the Current Health Care Policy Environment." Presented July 18, 2011. www.commonwealthfund.org.

Execution Prerequisites

Hospital and health system leaders must move their organizations aggressively forward. What will it take for providers to obtain and execute on value-based contracts?

A "value mindset." Improving outcomes *and* costs under value-based contracts will require a different organizational mindset, culture, incentive system, and management and reporting structures. Leaders must accept and embrace the fact that value-based care delivery will lower inpatient utilization, and will likely also reduce revenues and margins. In risk arrangements, utilization creates expense, not revenue, and hospitals, outpatient facilities, and physician offices become cost centers.

Organizations and physicians must work collaboratively to develop new systems to manage the care of patients—particularly those with chronic illnesses—incentivizing physicians to treat patients in lower cost settings. As noted by Stephen Shortell, dean of the School of Public Health at U.C. Berkeley, "When 30 percent of your business is in a non-fee-for-service model, your structure starts to change."[2] Governance and management structures should support the delivery of value, moving away from a site-centric approach to more system-centric models. Management incentive programs, and operating and reporting lines must be reshaped to support the behavioral change required to succeed under the new model.

Removal of *all* unnecessary work from the organization. This involves much more than reducing labor and supply chain costs; organizations must engage physicians and hospital staff in tough conversations about what care *is* required and what *is not.* A proactive approach to care provision involves identifying and redesigning inefficient care processes and improving patient flow through streamlined and consolidated operations. "Institutionalizing" maximum efficiency, as monitored and improved through effective measurement systems, is required. Rethinking end-of-life care will be critical.[3]

In redesigning care to improve the organization's value proposition, Partners HealthCare uses what it calls the "20 tactics" related to access to care, design of care, and measurement issues across primary, specialty, and hospital care settings. Each gray box in **Exhibit 2** represents a priority focus for improving value. Innovative hospitals, such as Cincinnati Children's Hospital, have begun applying systems engineering tools—such as queuing theory—to reduce the cost of hospitalization, increasing their patient flow by as much as 15 percent without adding staff.[4] Kaiser is offering 24/7 urgent care, pharmacy, radiology, and laboratory services that are designed to improve access and increase efficiency of care delivery.

A unified, organization-wide "persistence of attitude." Although many large organizations are continually striving to

2 Stephen Shortell, Ph.D., M.P.H., as quoted in Thomas Lee, "Massachusetts Health Care Reform: An Academic Provider's Perspective," *Health Affairs Blog,* Aug. 13, 2012.

3 Kenneth Kaufman, "Perspectives on Developing Issues in Healthcare: Fixing Medicare," *The Kaufman Hall Point of View Series*, Feb. 2012.

4 Arnold Milstein and Stephen Shortell, "Innovations in Care Delivery to Slow Growth of U.S. Health Spending," *JAMA,* Oct. 10, 2012.

improve quality, cost, and service, the "rubber meets the road" in the way physicians take care of patients while in the hospital and in their offices. Physicians have the biggest impact on organizational costs, quality, and overall results. Their goals and objectives must be aligned with the hospital's goals and objectives. The organization's role is to ensure that clinicians have the data and resources needed to redesign care and service systems for effectiveness and efficiency.

> One standard of care is mandatory whether patients are covered by fee-for-service arrangements or risk arrangements. Moving to value is the right thing to do, and while payment is likely to lag behind care delivery improvements, all patients should benefit from the enhanced quality, outcomes, access, and efficiencies achieved by healthcare organizations.

Transforming to a "healthcare model." To deliver on value, the current "sick care model," which focuses on disease management, must be replaced by a true "healthcare model," which focuses on health management. With the latter model, organizations define their mission as developing and offering the best set of services to improve the health of individuals in the communities they serve. Preventive health maintenance through thorough screenings to identify problems early on, and proactive management of acute-care patients, those at risk for readmissions, and those with chronic health conditions, are the focus under a healthcare model. Managing a population's health is enabled when provider organizations are aligned with payer organizations to assume risk, or when providers develop partnerships with organizations that have the ability to do so.

The Approach to Execution

To start significantly reducing reliance on fee-for-service payment, providers should obtain value-based contracts, shifting their business to risk-bearing, performance-based arrangements. At this point in time, the majority of hospitals and health systems have limited experience with value-based contracting, and "upside only" contracts are the predominant arrangement for participating organizations.[5] Anecdotal evidence suggests that participating provider organizations have moved a very small percentage of their business (likely less than 5 percent) to value-based contracts.

The use and level of risk contracts varies widely across different markets. Parts of California (Los Angeles, San Francisco) and Minnesota represent progressive markets with payers, providers, and contracting entities driving the change. Transitioning markets, such as the Chicago area, typically have one or a few providers driving the change. In lagging markets, little has changed from past decades and little preparation is underway. Because there's wide disparity in capabilities and contracting by market, provider migration to value-based contracts will take place at different speeds. However, all hospitals and health systems must prepare for the rapidly approaching transformation. Maintaining the status quo is no longer an option in any market.

To prepare for the change, we recommend the following approach.

Assess the healthcare environment and the organization's readiness for value-based contracting. Such assessment includes gaining a thorough understanding of what is occurring in the local and regional market; organizational issues related to infrastructure, risk tolerance, capital, and human resource requirements; and financial, operational, legal, and implementation considerations (see **sidebar 2**). Organizations that decide not to compete on value will have to compete on price, and will contract through payers or other providers who will manage population health risk.

Sidebar 2: Key Elements of Assessing Readiness for Value-Based Contracting

- Financial considerations: capital and resource requirements, unit costing and tracking, and actuarial assessment and predictive modeling
- Operational considerations: contracting capabilities, governance structure and efficiency, business intelligence capabilities and reporting requirements, and accreditation permits and licensing
- Implementation considerations: start-up investments, accountability, reimbursement/payment methodologies, delegation of services scope, performance measurement and reporting, risk management
- Other considerations: legal, human capital, pre-contracting investments

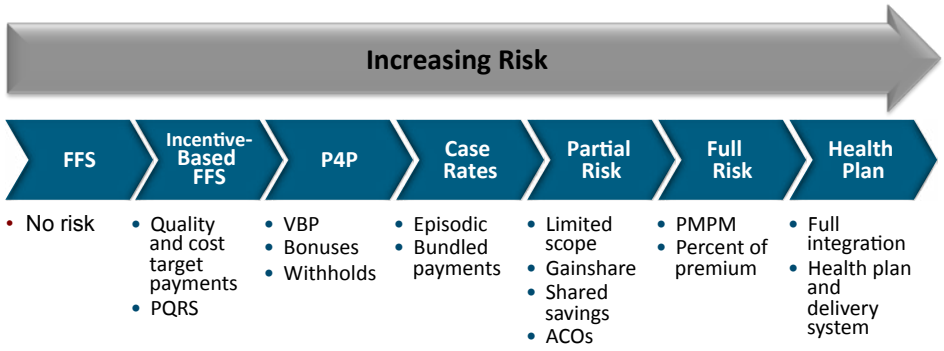
Source: Kaufman, Hall & Associates, Inc.

5 Survey conducted at the October 2012 Kaufman Hall Healthcare Leadership Conference.

Identify the range of value-based options. Markets will likely present a variety of options based on existing payers, providers, costs, and sophistication. It is possible to get into value-based contracting under the current fee-for-service model through pay-for-performance and other incentive-enhanced arrangements. If there's time and willingness on the payer side for an incremental transition, hospitals and health systems can start with programs with upside risk only, or those heavily weighted to upside risk, and then move into full risk as they gain experience and build infrastructure (see **Exhibit 3**). National payers have begun to take a position that shared risk arrangements are the only way to drive results. Shared risk arrangements have upside potential but also downside potential if performance doesn't meet expectations. In early-stage, value-based arrangements, both upside gains and downside risks are usually "bracketed" to give reasonable protection to both sides.

Develop a defensible value proposition and bring that proposition to payer(s), employers, and the community. Hospital and health system executives must take the lead with value; payers are unlikely to do so in most markets. The strength of the provider value proposition will hinge on the strength of the following: the proposed primary care physician network and its geographic and service line coverage; requisite infrastructure to allow for data sharing with patients, payers, and other providers; and in many cases, the inclusion of an academic medical center or tertiary/quaternary facility. The payer must be convinced that this platform can deliver on lower costs and better outcomes or it will not participate.

Exhibit 3: The Range of Value-Based Arrangements on the Risk Continuum



Source: Kaufman, Hall & Associates, Inc.

To establish and sustain a successful program, organizations must focus on bringing down costs in a way that will help payers reduce *their* costs while improving quality and service levels. This will typically require a mechanism to share financial incentives with physicians in order to drive and accelerate change. Providers need to be willing to exchange a lower base rate with the opportunity to earn up to and beyond current rates when they meet and exceed quality, service, and efficiency goals. The proposal offered to payers must be big enough to be meaningful to them, with the quantification of "big" varying by market. A track record of positive administrative experience and capability in managing populations and costs will position the organization for negotiating success. The long-term winners will likely be those entities that partner with the best primary care physicians, who have a proven record of success in delivering preventive, effective, and efficient care.

Understand that achieving success in managing risk takes time. Initial start-up investments with value-based care and risk contracts will be significant, and efficiencies will not be immediate. Behavior change and experience take time. Worst-case, expected-case, and best-case scenario planning are required throughout the transition. Organizations should be prepared to sustain initial losses for three to five years, as has been the experience of national payer organizations when they enter new markets. During this period, *one* standard of care is mandatory whether patients are covered by fee-for-service arrangements or risk arrangements. Moving to value is the right thing to do, and while payment is likely to lag behind care delivery improvements, all patients should benefit from the enhanced quality, outcomes, access, and efficiencies achieved by healthcare organizations.

Because it's far better to lead change than to await the impact of change, Kaufman Hall urges all hospitals and health systems to consider what they can do in their communities and with their payers to drive the transition to value-based care.

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