Local Markets Driving Adoption of Value-Based Care Delivery

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The alarm went out long before the government threw its weight behind value-based purchasing. Economists held forth on the damage that the rising cost of healthcare was having and would continue to have on the economy, and various employer and payer organizations began considering how to dampen the growing provider and patient enthusiasm for more technologies, procedures, and treatments.

The U.S. is buying the wrong healthcare services resulting in the need for more healthcare. The word "value" began ascending into the conversation about healthcare delivery, and large employers were quick to embrace it through the Leapfrog Group and other coalitions focused on quality and patient safety. And the race was on for moving value-based purchasing of healthcare into the broad spectrum of the delivery system.

The National Business Coalition on Health's Value-Based Purchasing Council defined value-based purchasing as "a demand side strategy to measure, report, and reward excellence in healthcare delivery…[which] involves the actions of coalitions, employer purchasers, public sector purchasers, health plans, and individual consumers in making decisions that take into consideration access, price, quality, efficiency, and alignment of incentives."[1] Michael Porter of the Harvard Business School simplified the definition by describing value in healthcare as: "Value = Patient Health Outcomes per Dollar Spent."[2]

As market forces took hold and CMS instituted its value-based purchasing policies with their commensurate reimbursement impact, providers reacted by focusing on reducing readmissions, decreasing hospital-acquired conditions, and enhancing patient satisfaction, all of which created value. Payers began to follow CMS's lead, and employers soon began to shift costs to their employees through the use of consumer-driven health plans with high deductibles. Currently, 41 percent of all U.S. workers are in high-deductible health plans and over 80 percent of consumers purchasing insurance on the healthcare exchanges chose plans with high deductibles, providing consumers with the incentive to utilize services only when absolutely necessary and to seek out services that were lower priced, but offered good quality.[3] Suddenly, in markets that have high adoption of these insurance products, consumers were shopping for healthcare providers on the Internet as if they were choosing a restaurant on Yelp, looking at star ratings and cost information, and determining what they judge to be value. But have they been misled? And how does a health system rise above the Web site evaluation to establish the true value of the care it delivers?

Value-based purchasing, the demand side of our healthcare economics equation, does not always guarantee value-based care delivery, the supply side, and many providers are caught between the two. A health system with excellent CMS-defined quality indicators for a hip replacement rarely takes into account the bottom line for the patient, which is how well the patient functions after leaving the system provider—how well do they feel, how soon can they return to work, and how free of pain or discomfort are they over what period of time? Providers are judged on low costs by major payers and self-insured employers, but do they really know their costs? Hospitals have utilized charges for billing purposes, which have no relationship to true costs, and few systems have a true cost accounting system.

However, the train has left the station, and most healthcare providers that do not book a seat will be left behind. Bundled payments for a total episode of care are under testing by CMS, and it has stated that it would begin moving 30 percent of its payments into non-fee-for-service models by the end of 2016, and 50 percent by the end of 2018.[4] CMS has also indicated that it will tie 85 percent of fee-for-service payments to quality or value in some fashion by the end of 2016 until value-based payments are responsible for 50 percent of all government reimbursement. The recent elimination of the Medicare Sustainable Growth Rate (SGR) included the requirement for physicians to be reimbursed through payment models focused on value versus volume. A new coalition of providers, payers, purchasers, and patient advocacy groups have created the Health Care Transformation Task Force with the mission of

Key Board Takeaways

The healthcare system is quickly moving toward value-based payment and delivery models. As boards think strategically about how to stay competitive and provide value-based care in their own markets, here are a few items for consideration:

- The healthcare system is currently delivering a lot of "sick care," but not enough healthcare. Moving forward, the focus will be on population health and eliminating unnecessary hospitalizations, treatments, and diagnostics.
- Payers (Medicare and employers) are moving the country towards value-based care delivery by modifying payment.
- Patient engagement is driven by insurance plan design. Many patients now have high-deductible health plans, causing them to be much more interested in the price and quality of healthcare services.
- Local market factors will determine the timing of value-based care delivery opportunities.

1 National Business Coalition on Health, *Value-Based Purchasing Guide* (available at www.nbch.org/Value-based-Purchasing-A-Definition).

2 Harvard Business School, Institute for Strategy & Competitiveness, "Value-Based Health Care Delivery" (see www.isc.hbs.edu/health-care/vbhcd/Pages/default.aspx).

3 Kaiser Family Foundation, "2014 Employer Health Benefits Survey," September 10, 2014.

4 Sylvia Mathews Burwell, "Progress Towards Achieving Better Care, Smarter Spending, Healthier People," U.S. Department of Health & Human Services, January 26, 2015.

moving 75 percent of their businesses to a value-based payment and delivery model for achieving the Triple Aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of healthcare.[5]

But a patient who describes value in healthcare may not see it just as cheaper care or more positive procedural outcomes. Rather, patients may see it as care that keeps them healthy, or living independently, or working to full capacity, and that is where the real disruptive strategy comes into play for a board member who is involved in the direction of a health system. Care delivery no longer stops at the walls of the acute care hospital or the ambulatory clinic, and a value-based delivery system does not begin with a patient's entry into the system for treatment or a surgical episode and end with the completion of the chart. The value-based system is also focused on maintaining the health of a population and eliminating unnecessary hospitalizations, treatments, and diagnostics. Michael Porter described the value-based care that will change the delivery of care as treating patients in Integrated Practice Units (IPUs) through which "a dedicated team made up of both clinical and non-clinical personnel provides the full care cycle for the patient's condition. IPUs treat not only a disease but also the related conditions, complications, and circumstances that commonly occur along with it—such as kidney and eye disorders for patients with diabetes or palliative care for those with metastatic cancer."[6]

The gain for an innovative healthcare provider that is able to move from a capability to meet the expectations for value-based purchasing to a fully developed value-based delivery system will be leadership in the national healthcare system, market leadership for its services, and possibly a broader geographic reach through its proven excellence. Walmart has named six health systems that will be the designated locations for any of its employees to have

heart, spine, or transplant surgeries due to the value that these systems provide for those conditions and procedures.[7] While the loss of volume in any market specific to this employer is likely to be small, the real impact will come from more employers translating this type of benefit design to more clinical conditions and segmenting providers in a local market. In geographies where there are shortages of providers or capacity, the effect is likely to be minimal. However, in markets with excess capacity there can be dramatic movements.

In this time of tumultuous consolidation and affiliation in the industry, boards need to be delving deeply into strategic questions around what challenges their organization will have to surmount to stay competitive and understand the likely pace of change in their market regarding value-based healthcare delivery. In some cases, it may mean giving up a service line because the system does not have enough cases to provide the efficiency and quality that value represents. In other circumstances, it may mean closing or relocating clinics or having smaller hospitals focus primarily on ambulatory care or emergency services, which has an impact on communities, but supports the overall value proposition for the health system's population. In many situations, health systems will need to invest precious resources in the infrastructure needed to develop ACOs or CINs to ensure that patients will receive coordinated care at every point of entry in the delivery spectrum. The local market dynamics determine how quickly a system can and should travel along the value-based delivery curve. For boards, the focus is on ensuring that the organization's strategic plan accounts for these issues and includes specific goals and deadlines for achieving the necessary steps along the journey to providing value-based care.

There is no question that the healthcare system today demands value, but it is up to those who deliver the care to supply that value. The leaders who continually move the bar up and find cost-effective and innovative options for delivering real value-based care will be the initial winners, but there is a clear place for those who observe, note, and put into place the leading best practices that will eventually move the entire healthcare system forward.

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5 Emily Rappleye, "20 Major Health Systems, Payers Pledge to Convert 75% of Business to Value-Based Arrangements by 2020," *Becker's Hospital Review*, January 28, 2015.

6 Michael E. Porter and Thomas H. Lee, "The Strategy That Will Fix Health Care," *Harvard Business Review*, October 2013.

7 "Company's New 'Centers of Excellence' Program Is First-of-Its-Kind Partnering with Six of the Nation's Foremost Health Care Systems to Provide Better Care," Walmart, October 11, 2012.