Driving Value and Equity in Health System Transformation

By Rick Gilfillan, M.D., Independent Consultant

Hospitals and health systems are squarely on the horns of the "Innovator's Dilemma." After a heroic response to COVID, many now face financial and operational challenges that threaten their viability. America's decline in life expectancy and ever higher healthcare costs continue to clarify the need for higher value and more equitable healthcare. But hospitals and health systems seem to be pulling back on the limited efforts they made in that direction. Meanwhile, for-profit innovator firms, operating in a gold rush mentality under the banner of "value-based care," have built alternative delivery approaches that threaten the key drivers of hospital sustainability. Now, the largest for-profit organizations in the U.S.—Amazon, Walmart, and CVS—are acquiring and scaling up those disruptors to position them to control much of the total national healthcare spend, projected to be $6.6 trillion by 2031.

The dilemma: hospitals and health systems need to decide whether they will disrupt their current business model to compete with these firms or simply stay the course and risk becoming a commoditized minor player in healthcare's future.

››› KEY BOARD TAKEAWAYS

The board can start now by diving into a deep, generative discussion with the following questions as a guide:

- ✔ Is the CEO clearly and visibly committed to leading this transformation?
- ✔ What is the organization's stated strategic intent regarding becoming a high-value health system that addresses inequities and SDOH?
- ✔ Is the strategy reliant on indiscriminate provision of more health services or on producing better health for the population served?
- ✔ What are the strategic objectives that capture this intent?
- ✔ What are the specific goals that are targeted to demonstrate success?
- ✔ How can the organization overcome the internal and external obstacles to transformation?
- ✔ Are the internal incentive systems aligned with the value transformation and health equity objectives?
- ✔ Are the resources provided for the value and health equity objectives adequate to drive the desired results?
- ✔ How has the organization approached the cultural changes required to be successful?
- ✔ Is the board willing to take bolder action to hold management accountable for transformation?

The Case for a High-Value and Equitable Health System

America's Health Is Declining

America's life expectancy has decreased for two years and diverged from that of other countries for over 40 years (see **Exhibit 1**). We now live six years less than people in comparable countries.

Healthcare Spending Uses More Resources Producing Worse Health Status

Healthcare accounts for 20 percent of the difference in health status. Seventy (70) percent is due to the "social influencers of health" (see **Exhibit 2** on the next page). We spend much more on "sick care" than on efforts to address prevention.

And despite much higher poverty rates, as seen in **Exhibit 3** on the next page, U.S. social spending lags behind comparable countries while we spend twice as much on healthcare.

Persistent inequities continue with Blacks seeing a life expectancy of about six years less than whites.

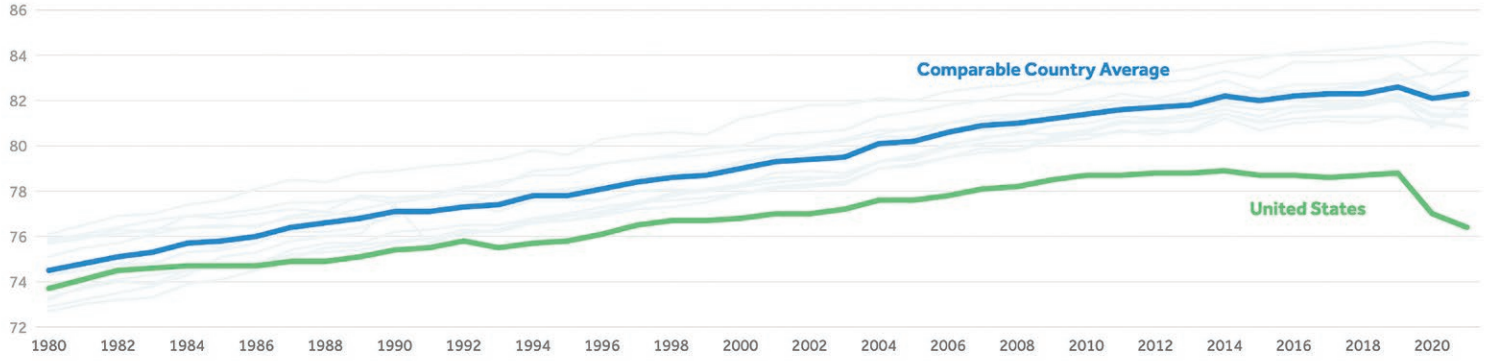
We Need to Move the Money

We need to redirect spending from an inefficient "sick care" system to leveraging social support systems that can truly improve health. The need to move to a higher-value and more equitable health system has never been clearer.

Current Environment for Providers

Prior to the COVID pandemic, the movement towards high-value and equitable care was gaining significant momentum. But these efforts have now stalled because, after a heroic response,

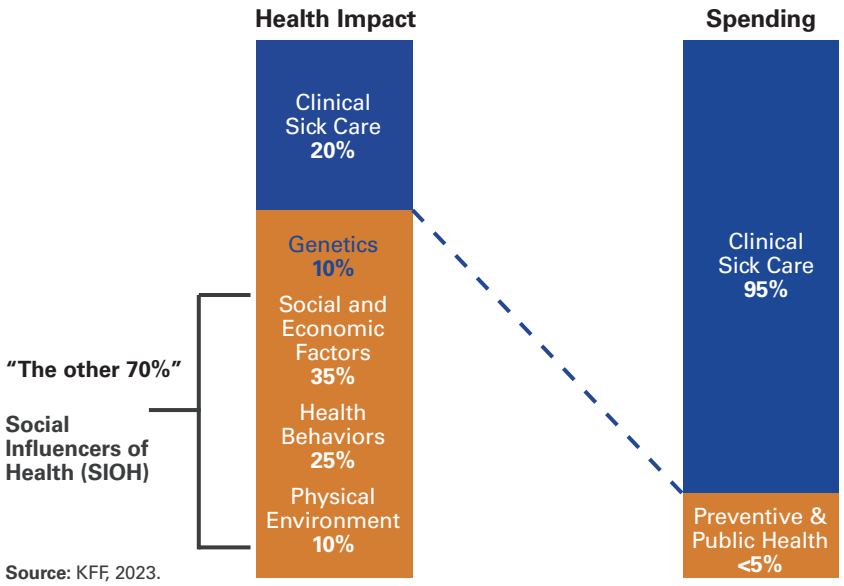
Exhibit 1: Life Expectancy in America vs. Other Countries



Notes: Comparable countries include Australia, Austria, Belgium, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, and the U.K.

Source: KFF analysis of OECD and U.K. Office for Health Improvement and Disparities data.

Exhibit 2: Most Spending Goes to Sick Care Not Prevention



Source: KFF, 2023.

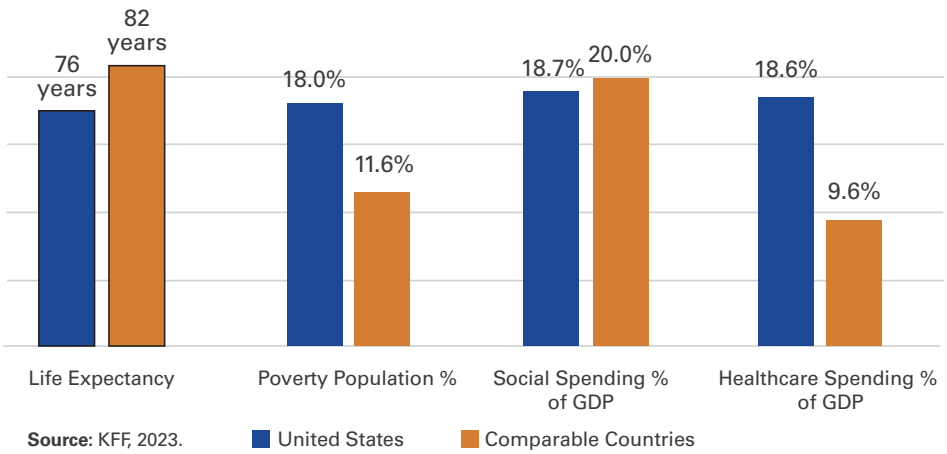
non-profit healthcare providers are facing a major existential crisis driven by:

- Capacity limits
- Revenue shortfalls
- Staffing shortages and wage inflation
- Supply inflation
- Decreased volumes

While some of the strongest non-profits with typically strong market positions have reestablished a sustainable margin, the majority face continued financial losses. The natural result has been to decrease investments in what are seen as marginal or non-essential activities, including their value and equity transformation initiatives. The Governance Institute's 2023 biennial survey of hospitals and healthcare systems shows a continued decline in activity since 2019 at the board and management level regarding value-based care strategies, setting goals and metrics related to value, staffing, adding board members with specific skills, and other related activities.[1] The decline in activity in these areas is most significant from 2021 to 2023; for example, 11 percent of responding organizations added value-based payment goals to their strategic and financial plans in 2023, compared with 38 percent in 2021.

Gold Rush: The rapid influx of fortune seekers to the site of newly discovered gold deposits.

Exhibit 3: Life Expectancy, Social Spending, and Healthcare Spending in the U.S. and Other Countries



Source: KFF, 2023.

What Would a High-Value Integrated Health System Look Like?

- 50 percent of population served are aligned with system PCPs.
- Payment for aligned patients would be full capitation—through ACOs.
- 50 percent of patients served are receiving acute episodic care via value-based contracts/episode-based payment.
- All physician services are billed as office, not facility based.
- All outpatient services are reimbursed via Medicare Fee Schedule.
- Outpatient services are built as free-standing—not hospital based.
- There are internal pre-authorization or appropriateness screening systems.
- Physicians are paid via non-productivity systems.
- PCP practices are heavily incented to focus on prevention.

The Healthcare Gold Rush

At the very time hospitals and health systems are pulling away from value-based care efforts, the projected $7 trillion healthcare spend by 2031 has attracted a rush of for-profit new entrants that invested over $1 trillion dollars over the past 10 years and $205 billion in 2021 alone. Investors are pursuing two tracks that pose a direct threat to non-profit health systems:

1. **For-profit skimming of profitable clinical delivery services:** Investors have established new entities to systematically peel away the more profitable clinical services from hospitals. These include inpatient facilities in high-income areas, outpatient surgery sites, imaging facilities, specialist practices, urgent care sites, and micro-hospitals in high-income areas, among others.
2. **Total-cost-of-care contracting:** Payers have historically used risk contracting to align providers with efforts to decrease costs. Simply put, this creates a total medical cost target for a population based on historical spending. They then give a provider responsibility to manage that total cost. If the

1 Kathryn Peisert and Kayla Wagner, *Think Bold: Looking Forward With a Fresh Governance Mindset*, The Governance Institute's 2023 Biennial Survey of Hospitals and Healthcare Systems.

Obstacles to Value Transformation

Hospitals and health systems face internal and external obstacles:

Internal:
- Today's financial challenges
- "Status quoism"
- Fear of self-disruption

External:
- Limited payer commitment
- Policymaker view of non-profits
- Competition

Addressing these will entail a great deal of effort that will require CEO leadership and clear board support. Internal obstacles will vary in strength greatly by institution but there are many no-regret strategies for all health systems:
- Build the primary care network to grow accountable population.
- Build a low-cost outpatient network.
- Build care coordination across the system—including hospitals.
- Grow attributable population.
- Build relationships with other accountable entities.
- Consider owned MA plan or partner with insurer.
- Decrease cost of production.
- Continue digital transformation.
- Participate in Medicare ACO programs.
- Participate in Medicare Episode-Based Payment Program (BPCI).
- Build analytical capabilities.

Overcoming the external obstacles will require health systems to be seen as committed to value transformation. National and state provider associations will have to become strong advocates for this path. The goal would be to convince policymakers at all levels to demand that payers, often dependent on government programs, implement total-cost-of-care contracts with health systems.

costs end up being less, the provider keeps the savings. If more, they accept the loss. The intent was to decrease costs to the insurer and thus the ultimate payer.

Medicare Advantage (MA) is the privatized version of Medicare through which CMS pays private insurance companies to provide benefits to individuals that enroll directly into their plans. Expected to provide coverage for less and save the government money, over 35 years these companies instead have cost the government much more. Estimates of these overpayments are $75 billion in 2023 and over $600 billion over the next eight years.[2] One major driver is the ability of MA plans to make their patients appear sicker by submitting more diagnoses to CMS. The sicker a patient appears, the greater the overpayment from CMS.

MA plans have added one wrinkle to the total-cost-of-care contract. They base the medical cost target on a percentage of the payment they get from CMS. Because the payment is based on the number of diagnoses, the at-risk provider now has a powerful interest in submitting more diagnoses. Investors have created new companies like Oak Street Health and Agilon Health to take advantage of these contracts. With investor backing and strong stories about easy profits, these groups have grown rapidly. United Healthcare's Optum subsidiary is the largest total-cost-of-care contracting entity and is now providing more than 50 percent of United's $20 billion in annual profits.

Summit Health and Duly Health and Care (formerly DuPage Medical Group) are two examples of firms that have done similar total-cost-of-care contracting with commercial insurers. In those contracts, the main savings opportunity is to simply redirect care away from expensive hospitals sites to their own outpatient sites of care.

The success of these total-cost-of-care contracts has caught the attention of large, publicly owned companies that are pursuing America's total healthcare spend. CVS/Aetna spent $10 billion to acquire Oak Street and Signify, two MA coding-based driven firms. Walgreens has acquired Summit Health for $5 billion. Amazon acquired Medical One/Iora Health for $3.9 billion, and now Walmart is rumored to be acquiring ChenMed, an MA firm, for billions. Google, Apple, and Microsoft are all eying the healthcare spend trying to find their way into it as well.

In short, the largest publicly traded tech companies and healthcare insurers in America are positioning to take control of a large majority of America's healthcare spend at the same time that providers are backing away from taking risk. Often these ventures result in dividends, profits, and stock repurchasing for the corporation *without showing any tangible benefits for patients, families, and communities.* Nor do they translate into lower premiums for employers and employees. Moreover, these kinds of ventures increase segmentation of an already overly segmented and complicated delivery system. If this continues, the total healthcare spend, funded by taxpayers, employers, and individuals, will be captured by for-profit firms maximizing their gain not patients' health.

> *Too often this is a convenient excuse—that payers have a more powerful lobby in D.C. and there is nothing more to be done. But there is always more that can be done and the more voices contributing to this will amp the volume significantly.*

In this world, control of the dollars will mean control of the delivery system. The questions boards need to be asking themselves and their senior leaders are:
- Who will drive the direction of healthcare now?

2 Steven M. Lieberman, Paul Ginsburg, Ph.D., and Samuel Valdez, Ph.D., *Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments,* USC Schaeffer Center for Health Policy & Economics, June 13, 2023.

- Should it be for-profit payer/provider corporations such as United/Optum and CVS/Aetna, for-profit systems such as Tenet and HCA, the tech giants, or private equity?
- Or could it be non-profit integrated health systems?

Making the Case for True Transformation

The Innovator's Dilemma

Higher-quality care improves outcomes—and it is the right thing to do—but has not been shown to result in low costs, despite 30 years of hoping that it would. The only way to spend less on healthcare is to spend less. This means providing fewer services and paying less per unit of service. To be successful in that context means hospitals and health systems must transform to become high-value providers. (See sidebar on page 6 on what a high-value provider might look like.)

As for-profit disruptors expand their steal of the profitable pockets of the delivery model, our patients and communities are vulnerable to a healthcare industry that is no longer mission-driven.

But hospitals and health systems are in the position of incumbents facing the disruptive innovators Clay Christensen described in *The Innovator's Dilemma*.[3] Becoming high-value providers that decrease their prices and volume of services threatens current results at a very challenging time. But for-profit disruptors with control of total-cost-of-care spending will bring that about anyway. Cost-of-care contracts can offer health systems a bridge to a new sustainable model. The question is whether non-profit hospitals and health systems will fight to be total-cost-of-care providers or cede this opportunity to others.

Value-Based Care Commitment to Date

The ACA, passed in 2010, created multiple opportunities for incumbents to begin a transition to higher-value care. Most prominently, the ACO model provided an entry ramp with minimal risk but limited upside opportunity. Today, over 400 ACOs provide care to 13 million Medicare beneficiaries. Over 1,400 hospitals and 500,000 physicians are participating in ACOs. But results to date have been marginal with an average savings of 1–2 percent. Furthermore, physician-based ACOs have been almost twice as successful as hospital-based ACOs.

Policy makers have concluded that hospitals and health systems are not serious about value transformation. Many involved in value work in health systems feel that the commitment has been limited and efforts are at least paused for now, if not in retreat.

The Board Must Be the Driver

There are at least three primary reasons hospitals and health systems can and should lead the value transformation:

- Business sustainability
- Consistent with the charitable mission
- Helps to maintain a mission-driven healthcare industry

Driving this transformation in a larger, wider, more accelerated manner now will require a longer lens. Boards must make the difficult decision to "disrupt" themselves. We have already seen the results of inaction, as health systems are gradually losing business to aggressive innovators who are unencumbered by yesterday's business model. Accountable care models from CMS and others have shown only marginal results, primarily because they are still built on a fee-for-service chassis.

Internally, system transformation requires commitment and execution. Externally, boards need to do more advocacy to create a reasonable business opportunity for true value transformation.

The following paragraphs outline actions boards can take now to drive this transformation.

Changing the Payer Relationship

It is widely understood that the primary reason the value transformation hasn't happened yet is due to barriers related to payers and payment models. But boards and senior leaders can do more to push payers to move into the value space and take this journey together with providers.

Ask for meetings and explore the offers with each payer in your market. Engage payers to partner with you in designing new systems that are sustainable rather than preserving old systems, to create a viable value-based care model that includes a meaningful approach to impact SDOH.

Furthermore, boards should encourage their chief executives to push the AHA to make this point louder in the national discourse and place more pressure on Congress to force payers to change the way they do business. Too often this is a convenient excuse—that payers have a more powerful lobby in D.C. and there is nothing more to be done. I argue that there is always more that can be done and the more voices contributing to this will amp the volume significantly. Advocacy is a core responsibility of the non-profit healthcare board, and always an area that is overlooked due to other concerns that may seem more important. At the end of the day, if you don't try, there won't be change.

Conclusion: Why Do It?

Change is hard. We know the status quo, so when we come into work every day, we know what to do and we can keep doing it. We worry that if we move towards value too fast it will erode our revenue, so we don't want to be the leaders in the value space—we want to wait and see how others do it and if they can be successful before dipping our toes in. But treading water is impossible in a cyclone created by the rush of healthcare disruptors. Take a hard look at your organization's mission and think about whether you can continue to fulfill it without this transformation. What is the right way to keep people healthy? What is your fiduciary responsibility today, when the old business model is fading or failing? As for-profit disruptors expand their steal of the profitable pockets of the delivery model, our patients and communities are vulnerable to a healthcare industry that is no longer mission-driven. It's time to focus on solutions, to stop "waiting and seeing," and become the drivers of positive change that put America back on track to be the healthiest, not just the wealthiest country in the world.

The Governance Institute thanks Rick Gilfillan, M.D., Independent Consultant, for contributing this article. He can be reached at gilfillanr9@gmail.com.

3 Clayton M. Christensen, *The Innovator's Dilemma: The Revolutionary Book That Will Change the Way You Do Business,* Harper Collins, 2011.