

AN HFMA REPORT

# Health Care 2020

A series of reports examining how to prepare for major healthcare market trends over the coming years

REPORT 1 of 4

## Transition to Value

# Health Care 2020

## Report 1 Transition to Value

Upcoming reports in the  
*Health Care 2020*  
series include:

- Consumerism
- Consolidation
- Innovation

Visit [hfma.org/HealthCare2020](http://hfma.org/HealthCare2020)  
to view upcoming releases.  
The full series will be released by  
December 2016.

Reporting by Lola Butcher,  
HFMA contributing writer

# Contents

From the Chair .....	1
Executive Summary .....	2
Health Care's Ongoing Transition to Value .....	4
Value via Payment Reform .....	5
Reforms That Work Best .....	6
The Pace of Change .....	7
Value via Consumer Choice .....	8
Consumer Power .....	10
Value via Consolidation .....	12
Value via Innovation .....	14
The Value Journey .....	15
Sidebars	
Action Steps to Value from a Healthcare- Purchaser Representative .....	10
Action Steps to Value from a Health Plan Representative .....	12
Action Steps to Value for Health Plans .....	15
Interviewed for This Report .....	16

# Dear Colleagues

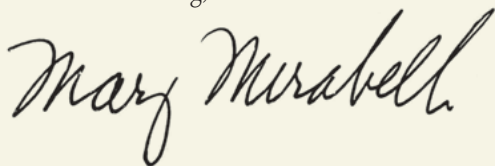
As HFMA Chair, I've made it my mission this year to foster a spirit of resiliency and to encourage healthcare finance professionals to thrive in a rapidly changing industry. That's why I am particularly excited that HFMA is publishing *Health Care 2020*—a unique four-part series intended to provide healthcare business and clinical leaders with forward-looking information about the trends that will shape our future. This information is designed to help leaders plan strategies not just for today but for the next several years.

This first report in the series tackles one of our biggest challenges today: the evolution from volume- to value-based payment models. It provides context and perspectives on this ongoing transition, including the pace of change we can expect. The report also explores the impact of value-based insurance design on consumers and the power that consumers can wield when making healthcare decisions. Finally, it touches on the relationship of value to consolidation and innovation—topics that, along with consumerism, will be explored in greater depth in future installments of this series.

Most would agree that collaboration is key to successful endeavors, and the development of the *Health Care 2020* series is no exception. HFMA greatly appreciates the contributions of the following individuals who served as resources in the development of this report: Amy Bassano; Leemore Dafny, PhD; Suzanne F. Delbanco, PhD; A. Mark Fendrick, MD; Daniel Finke; Sonal Kathuria; Mark McClellan, MD, PhD; Jason O'Riordan; Natasa Sokolovich; Eric J. Topol, MD; and Mike Waters. They are among the most highly respected thought leaders in the healthcare industry, and it is an honor to include their thoughts and insights in these pages.

As you review this report and those that follow in the series, I'm confident you'll find information and examples you can use to lead your teams in meeting the challenges of this new era. I hope you'll also be inspired to view the ongoing changes in our industry as opportunities to learn, grow, and leverage to improve the health of your communities. Cultivating such a perspective will not only help our organizations and our industry thrive but also move us toward that next level—a level defined by better patient experiences, reduced costs, and improved population health.

*Yours in thriving,*



**MARY MIRABELLI, HFMA**

2016-17 CHAIR, HFMA

# Executive Summary

In conjunction with the release of this *Health Care 2020* report on the transition to a value-oriented healthcare system, HFMA issues the following guidance for stakeholders.

## The Value Journey

Health plans, hospitals, and physician practices need to collaborate to create equitable payment models that reward all stakeholders only when high-quality, resource-efficient, cost-effective care is provided to the patient. Successful models will require the flow of financial and clinical data among internal and external stakeholders to efficiently manage care, transfer the appropriate type and amount of risk to providers based on their financial wherewithal, and engage patients in care processes. (See page 3 for recommendations on value via consumer choice.)

Hospitals and physician practices need to accurately determine the true internal cost of producing their portion of the care provided under an outcomes-based payment model. Sharing this information with those on the front lines of care delivery will allow them to eliminate operational inefficiencies. Freeing up these funds in turn will support the investments in infrastructure necessary to manage outcomes. Further, as hospitals and physicians systematically reduce their internal costs, a portion of that savings should flow through to purchasers (individual consumers, employers that provide coverage to their employees, and taxpayers) in the form of a decreased per member year-over-year trend.

Although gauging the internal cost to produce care will be necessary under emerging outcomes-based care models (as it is under fee-for-service), additional insight will be required. The “virtual delivery network” of a hospital or physician practice has a significant impact on the longitudinal cost of care to purchasers. Giving providers access to knowledge distilled from claims data allows them to identify opportunities to reduce unnecessary utilization—and, in turn, the total cost of care—through alignments with high-quality, cost-efficient organizations across the continuum.

As part of these innovative payment models, health plans should provide model participants with access to claims data—both raw claims feeds and aggregated management

reports. Raw claims feeds will allow sophisticated organizations to conduct their own analyses, while aggregated reports will provide smaller physician practices with actionable financial data. While access to longitudinal claims data allows hospitals and physicians to retrospectively identify opportunities to improve care, access to real-time clinical data allows for faster interventions that prevent unnecessary utilization, improve outcomes, and in some instances (particularly with medications) save lives.

Seven years after the HITECH Act and its associated funding and penalties, the sort of interoperability standards that would allow real-time access to clinical data remain elusive for most providers. Hospitals and physician groups must push their vendors to provide true data interoperability across electronic health record platforms—without additional financial costs. Regional health information exchanges (RHIEs) also are part of the solution, but their promise has remained largely unrealized for want of a sustainable business model and development of a unique patient identifier. All stakeholders must work with consumer groups to develop a protocol for unique patient identifiers that balances the societal expectation of privacy with the need to provide caregivers with potentially lifesaving comprehensive patient clinical data.

Even with access to real-time clinical data and to knowledge generated from claims data, and with investments in care delivery infrastructure, payment models that transfer risk to hospitals and physician groups must be implemented with caution. Outcomes-based payment models need to be designed such that they transfer only the technical risk associated with delivering care, as opposed to insurance risk. As such, these models will need to be risk adjusted for both the clinical and socioeconomic factors present in the underlying attributed population. Even with risk transfer limited to technical risk, hospitals and physician groups need adequate reserve capital or a repayment mechanism available in their contracts to ensure they can sustain losses and remain economically viable. These safeguards will protect consumers and the broader community from losing access to necessary healthcare services if the at-risk provider assumes significant losses.

### Value via Consumer Choice

Physicians and hospitals need to clearly articulate their value proposition to both individuals and institutional purchasers of care (e.g., employers, health plans). The value proposition must be supported with quantifiable data related to cost and quality outcomes. This information allows a provider to make a compelling business case to partner with health plans and other purchasers in contracts that align incentives across the care continuum and other contracting platforms. Part of this approach should include collaborating with health plans and employers to incorporate value-based design into the employee benefit package, to engage employees in their own care.

This approach, if coupled with a tiered network structure based on value criteria, will benefit all stakeholders. For consumers, it will ensure that clinically indicated care is affordable, obviating a key concern regarding traditional, “blunt” high-deductible health plan products. It also allows access to a relatively broad network if the consumer believes a certain provider is worth the out-of-pocket cost-sharing differential between network tiers. For employers and other purchasers, this benefit design provides consumers the choice of a relatively broad network while maintaining incentives to control costs. The cost-sharing structure encourages consumers to question services that clinical evidence suggests are of marginal benefit and rewards them for utilizing “preferred” high-value providers. Value-based insurance design (VBID) in combination with tiering supports population health by removing financial barriers that prevent patients from receiving clinically indicated care while rewarding high-value providers with incremental volume to support the organization’s fixed costs.

However, benefit designs that incorporate VBID and value-based tiered concepts in isolation are insufficient. In today’s environment, consumers need tools and education to help them navigate their coverage and related network options. This need will only grow as benefit designs increase in complexity. For insured patients, purchasers must offer transparency tools that are easy to access, navigate, and understand. A good tool allows consumers both to determine their out-of-pocket cost for a given episode of care (including spending related to facilities, physicians, and other service providers) and to view meaningful quality data for each component of the episode in an easy-to-understand format. This information allows consumers to engage in their care and make value-based purchasing decisions.

For the uninsured or patients who are seeking care out-of-network and have limited coverage, hospitals and physicians need to provide information on cost and quality—similar to what is provided to the insured—to help them understand both their out-of-pocket costs and opportunities to access financial assistance. These estimates should identify which services are included.

### Value via Consolidation

Merger and acquisition (M&A) activity between hospitals, physicians, and health plans will continue at a brisk pace moving forward. Traditionally, M&A activity in the healthcare sector has increased one stakeholder’s ability to negotiate per unit price concessions from another industry participant without either noticeable improvement in the quality of care received by patients or a reduction in their healthcare costs.

For these transitions to be consummated moving forward, the parties involved should have to show regulators and consumers how the deal will improve quality, reduce the overall cost of care on a per member per month basis, or both. Once a deal is consummated, the on-paper synergies underpinning the merger must translate into actual improvements in quality and cost.

Transactions between providers should focus on:

- Improving access to necessary services within the affected communities
- Hardwiring connections across the continuum of care within markets to better manage care transitions
- Decreasing administrative and operating costs as a result of improved economies of scale
- Achieving the critical mass necessary to bolster the IT and care coordination infrastructure to support outcomes-based payment models

Transactions between health plans should focus on:

- Reducing administrative expense
- Improving care coordination systems to support providers as they manage outcomes-based care
- Equipping providers with knowledge from claims data that can support care management across the continuum

### Value via Innovation

In today’s environment, the business case for innovative, technology-driven care delivery models remains difficult to prove. However, many of these innovations will become financially viable as changes in the payment system accelerate and consumers grow unwilling to tolerate the inconvenience inherent in many traditional care delivery models.

Organizations need to pilot innovative delivery models today to gain experience with such models and to understand how to create sustainable business models for these services. Otherwise, organizations from outside health care will leverage technology-driven care models to disrupt traditional health plans and systems.

# Health Care's Ongoing Transition to Value

As the healthcare industry continues its journey to value, two things about the near-term future are clear: First, healthcare providers will increasingly face both upside and downside financial risk in their arrangements with health plans, whether through traditional contracting mechanisms, new partnerships with insurers, provider-sponsored plans, or direct-to-employer arrangements.

Second, consumerism will influence the success or failure of providers and health plans to a greater degree, requiring organizations to meet the increasing demand for convenience and for quantifiable information about the value of services they offer.

Most experts contend that the traditional volume-based healthcare business model is economically unsustainable. Payment reform has resulted in the development of a plethora of new payment models and variations. In fact, Congress created the Center for Medicare & Medicaid Innovation (CMMI) through the Affordable Care Act to better study the impact of new models and reduce expenditures. Demonstrations continue to increase in number and have been organized into seven categories:

- Accountable care
- Episode-based payment initiatives

- Primary care transformation
- Initiatives focused on the Medicaid and Children's Health Insurance Program (CHIP) populations
- Initiatives focused on the dual-eligible population
- Initiatives to accelerate the development and testing of new payment and service delivery models
- Initiatives to speed the adoption of best practices

The healthcare industry is spinning through a cycle of payment experimentation. As a result, providers will assume greater risk for outcomes, and collaboration between health plans, physicians, and hospitals will become increasingly important.

“There’s no question—between what public purchasers like Medicare are doing and what the commercial payers are looking to do—that shared risk is going to become more prevalent,” says Suzanne Delbanco, PhD, executive director of Catalyst for Payment Reform, a coalition of many of the nation’s largest employers and other healthcare purchasers. “If I were a healthcare provider, I would want to get ahead of that curve and figure out how to handle it before it becomes more than a small portion of my payment.”

# Value via Payment Reform

After years of incremental steps to encourage provider organizations to improve the value of the care they deliver, the Centers for Medicare & Medicaid Services (CMS) is ready to take more aggressive steps.

Pay-for-performance incentives will linger for the foreseeable future, but a bolder approach appears necessary to significantly improve value. In January 2015, Health & Human Services Secretary Sylvia Burwell announced a goal of making 30 percent of Medicare payments through alternative payment models (APMs)—arrangements that can include two-sided risk or population-based payment—by the end of 2016. Having announced March 3, 2016, that it already had met this goal, CMS now will set its sights on achieving its 2018 target of 50 percent.

Also in early 2015, the Health Care Transformation Task Force—a coalition of major health systems and commercial health plans—announced a plan to shift 75 percent of members' contracts to value-based payments by 2020. (According to the task force's definition, a *value-based arrangement* is one that holds providers accountable for the total cost, patient experience, and quality of care either across an entire population of patients over the course of a year or during a defined episode that spans multiple sites of care.)

Shortly after that, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law, triggering an overhaul of physician payments. Physicians can choose to be paid on a fee-for-service (FFS) basis with pay-for-performance incentives and penalties, but MACRA offers a financial incentive to participate in an APM. Participating organizations receive a 5 percent annual lump-sum incentive payment in 2019-24 and benefit from a higher physician fee schedule growth rate starting in 2026. Only two-sided risk programs will qualify as APMs under MACRA, according to the proposed rule from the Centers for Medicare & Medicaid Services, with the list including:

- Comprehensive End-Stage Renal Disease Care
- Comprehensive Primary Care Plus
- Medicare Shared Savings Program Tracks 2 and 3
- Next Generation ACO
- Oncology Care Model (with two-sided risk)

“MACRA encourages participation in all APMs but does put particular emphasis on APMs that include financial risk,” says Amy Bassano, director of the Patient Care Models Group at CMMI.

CMMI is watching its existing APMs—accountable care organizations (ACOs), bundled payments, primary care initiatives, and other types—with the goal of fine-tuning them based on lessons learned. But Bassano and her colleagues are particularly focused on developing APMs for specialty physicians—and determining how to incorporate financial risk. “Beyond procedures, the challenge with specialist models is how to attribute responsibility for the outcome and spend,” says Chad Mulvany, director, healthcare finance policy, strategy and development, for HFMA. “One of the things CMS is trying to sort through in developing additional APMs is how to assign responsibility for the multiple physicians involved in an episode for their contribution to the total cost of care.”

The first such specialty concept, the Oncology Care Model, was created before MACRA. Designed to improve value by emphasizing care coordination and incentivizing oncology practices to help patients avoid unnecessary emergency department (ED) visits, hospitalizations, and other healthcare services that do not improve quality, the Oncology Care Model includes both an upside-only and a two-sided risk option. In the upside-only risk option, Medicare discounts the risk-adjusted target price by 4 percent before comparing it to actual FFS expenditures. In the two-sided risk option, the Medicare discount is 2.75 percent.

“That’s one of the things we are hashing out, because there’s reference [in the legislation] to more-than-nominal risk—what does that mean?” Bassano said.

Regardless, the general direction of increasing downside risk is set.

“As we come out with more and more models, we are trying to go a little bit further with each of them,” Bassano says.

## → KEY TAKEAWAY

The financial incentives in MACRA will accelerate the transition to APMs not only in the public sector but in the private sector as well.

## → ORGANIZATION TO WATCH

The Health Care Transformation Task Force, a consortium of patients, health plans, providers, and purchasers, issued an action memo, “[Key Elements to Consider in ACO Agreements](#),” that reflects the experience of its members. The memo identifies best-practice contracting strategies in three areas: patient experience and access, cost, and quality of care. Task force members include Advocate Health Care, Catholic Health Initiatives, Providence Health & Services, Trinity Health, and several other major health systems.

## Reforms That Work Best

Despite vast experimentation, it is too soon to tell which new payment models will prove to be effective in the long term. “There is very mixed evidence for almost every type of payment reform,” Delbanco says. “So I can’t pick a winning horse in this race.”

Mark McClellan, MD, PhD, inaugural director of the Duke-Robert J. Margolis, MD, Center for Health Policy at Duke University, thinks the new models will continue evolving in the foreseeable future as each proves or disproves its effectiveness in various situations.

For example, he thinks ACOs that include providers that wish to lead in the value movement should shift to at least partially capitated payments. As long as they are paid through the FFS system, ACOs are challenged to fully embrace high-value access points such as telemedicine because the shared savings that comes from avoiding a hospitalization does not fully offset the net revenue that comes with an admission. A 2015 study concludes, “Although [physician] practices in ACOs provide higher compensation for quality, compared with practices at large, they provide a similar mix of compensation based on productivity and salary. Incentives for ACOs may not be sufficiently strong to encourage practices to change physician compensation policies for better patient experience, improved population health, and lower per capita costs.”<sup>a</sup>

On the other hand, physician-only ACOs win financially every time they prevent a hospitalization. “Over the next few years, you might see some smaller primary care groups continuing to succeed with this shared-savings model, but the large organizations really are going to need to move to more downside risk and farther away from fee-for-service in order to succeed,” McClellan says.

Similarly, bundled payments for procedures as they are currently configured may not prove to be the most effective approach to reducing unnecessary utilization, McClellan says. The Comprehensive Care for Joint Replacement Model, which began in April 2016 in 67 markets, holds the hospital where a hip or knee replacement and other selected procedures take place accountable for the quality and costs of care from the time of the surgery through 90 days after discharge. CMMI hopes that during the five-year pilot, hospitals, physicians, and rehabilitation facilities will coordinate care in a way that improves patient outcomes while reducing costs.

“Hip and knee bundles as CMS has created them will probably have some impact in the next few years on reducing readmissions and reducing high-cost post-acute care,”

McClellan says. “But it’s not going to have a more fundamental impact on the way that patients with degenerative joint disease are really treated.”

That’s because the bundled payment approach applies only to joint-replacement surgery cases. Many patients would probably forgo surgery if they were led through a shared decision-making approach that allowed them to evaluate all their options. Moreover, if patients had access to a good degenerative joint disease management program, McClellan says, replacement surgery might not even be needed.

“You need an episode that goes further back and is really about the diagnosis itself, based more on patient symptoms or functional status rather than whether or not you’re getting a procedure,” McClellan says. “Doing a bundled payment episode more at the person level rather than a procedure level is harder, and it’s a farther shift away from fee-for-service. But I think we’ll eventually see those kinds of episode models become more prevalent.”

### → KEY TAKEAWAY

Look for ACOs and bundled payment arrangements to evolve quickly in the private sector as providers and health plans gain experience with what works and what does not, and for models that prove effective to quickly gain widespread adoption.

**“Doing a bundled payment episode more at the person level rather than a procedure level is harder, and it’s a farther shift away from fee-for-service. But I think we’ll eventually see those kinds of episode models become more prevalent.”**

— Mark McClellan, Duke University



# The Pace of Change

The traditional Medicare program used APMs—many of which were upside-risk only—for 20 percent of its payments in 2014.<sup>b</sup> On the private-payer side, 40 percent of payments were funneled through “value-oriented” contracts, according to the National Report Card on Payment Reform, issued by Catalyst for Payment Reform in 2014. But only 1 percent of payments were in shared-risk arrangements and just 0.1 percent were bundled payments.

Delbanco expects those shares to go up when multiyear health plan-provider contracts come up for renewal. “We’re on the verge of more, but not a lot more yet,” she says. “What it will take to get there is providers having the infrastructure to monitor their quality performance and their financial performance in near-real time, so they can truly afford to take on the risk. That’s one impediment right now—many providers don’t have the information they need to manage that risk successfully.”

While noting that “the exact tipping point is difficult to define,” James H. Landman, JD, PhD, director of healthcare finance policy, perspectives and analysis, for HFMA, says, “Once an organization has between 25 and 30 percent of its payments tied to risk, it will likely find it increasingly difficult to maintain a balance between the fee-for-volume and fee-for-value worlds.”

Until an organization reaches that threshold, Landman says, “Low exposure to risk-based payments can make it difficult for provider organizations to justify the investments in IT, clinical and financial analytics, and care management infrastructure needed to successfully take on risk. Nonetheless, it is important for providers to assess their current capabilities and understand what changes will be needed to transition to value-based payment models that include downside risk.

“Once an organization begins to take on risk and starts to adjust care delivery models, changes in utilization patterns and revenue can occur very quickly. Organizations that have anticipated and are prepared for these changes will be well-positioned to succeed as the pace of change accelerates.”

That’s why Aetna is using a variety of payment models to help provider organizations transition to shared-risk contracts. “It’s really important to customize, based on a health system’s own capabilities and needs, and help them begin to manage risk at their own pace,” says Daniel Finke, CEO of Aetna Accountable Care Solutions.

**“There’s no question—between what public purchasers like Medicare are doing and what the commercial payers are looking to do—that shared risk is going to become more prevalent.”**

— Suzanne Delbanco, Catalyst for Payment Reform

Aetna, an inaugural member of the Health Care Transformation Task Force, is on track to reach the goal of having 75 percent of total spending in value-based contracts by 2020. This year, 37 percent of its claims—worth about \$26 billion—are in such contracts; of those, roughly one-third each are in pay-for-performance arrangements, ACO contracts with upside-risk only, and shared-risk arrangements.

Aetna’s shared-risk arrangements are proving to be value leaders, Finke says. But he foresees health plan-provider relationships going further. An example of Aetna’s ideal high-value arrangement is Innovation Health Plan, jointly owned by Aetna and Northern Virginia-based Inova Health, in which health plan and provider share profits and losses. “We’re very committed to a joint-venture structure as an end vision, but we recognize that this is a journey,” he says.

## → KEY TAKEAWAY

Providers who are not yet in value-based contracts, as defined by the Health Care Transformation Task Force, should be looking for health plan partners willing to experiment with new pay models. Being experienced will pay off when value-based payments become the norm.

## → ORGANIZATION TO WATCH

An ACO formed by Aetna, Houston-based Memorial Hermann Health System, and Memorial Hermann Physician Network cut costs by 11 percent—through fewer ED visits and more frequent generic prescriptions, among other improvements—between 2013 and 2014. During that time the ACO exceeded targets on all six quality measures, including screening rates for cancer and testing for patients with diabetes.

# Value via Consumer Choice

Although the healthcare payment landscape in the next few years is hard to predict, the future of insurance benefit design is coming into clearer focus. A shift to value-based insurance design (VBID) will incentivize consumers to choose healthcare services based on value—and, in McClellan’s view, may be the primary source of improved value in the foreseeable future.

VBID embeds financial incentives into benefit design to encourage high-value decision making. Perhaps the most common example is offering a reduction in an employee’s insurance premium in exchange for completing a health risk assessment or smoking-cessation program.

Delbanco sees that general concept taking off in new directions as health plans introduce financial incentives that encourage their members to choose higher-value providers and to opt for cost-effective treatment options. “We’re going to see benefit designs evolving and really broadening from what we’re used to seeing historically,” she says.

Currently, high deductibles are the primary design feature that encourages health plan members to curtail their use of healthcare services. That blunt instrument works against providers that are focused on population health management, says Jason O’Riordan, a senior vice president at Kaufman Hall.

Research shows that consumers often do not differentiate between needed care—primary care visits and preventive care that can limit ED and inpatient utilization—and unnecessary care, such as high-tech scans at the first report of lower-back pain. Though the Affordable Care Act mandates that some preventive services be made available at no cost to consumers, high-deductible plans that require patients to pay out-of-pocket for other low-cost preventive care do not promote value-oriented decision making.

While O’Riordan doesn’t expect the high-deductible trend to subside, the details around deductibles and copayments will become more nuanced. “VBID is the opportunity to address that,” he says. “Let’s fine-tune cost sharing so that we increase it for low-value services, and first and foremost lower it for high-value services.”

A. Mark Fendrick, MD, director of the Center for Value-Based Insurance Design at the University of Michigan, echoed those thoughts during a presentation at HFMA’s Thought Leadership Retreat in October 2015.

“I support high deductibles and high cost sharing—but only on the healthcare services we should not be buying in

the first place,” Fendrick says. However, he notes, “A specific healthcare service is hardly ever high-value or low-value. For example, cardiac catheterization, imaging for back pain, and colonoscopy can each be classified as a high- or low-value service depending on the clinical characteristics of each person, when in the course of the disease it is provided, and where it is delivered.”

CMMI will begin experimenting with VBID in 2017, when the Medicare Advantage (MA) Value-Based Insurance Design Model launches in seven states. The five-year program—which focuses on patients with diabetes, congestive heart failure, and several other chronic conditions—allows MA plans to tweak benefit design with the goals of improving patient health, reducing the use of avoidable high-cost services, and cutting costs for all parties. For example, plans could waive copays for eye exams for patients with diabetes or offer additional tobacco-cessation services for patients with chronic obstructive pulmonary disease.

Delbanco and colleagues at Catalyst for Payment Reform see the need to pair benefit designs with payment methods so that consumers and providers are incentivized for the same actions. Consider the potential of a provider with a pay-for-performance contract that incentivizes high rates of preventive services (e.g., mammograms, smoking cessation) serving consumers whose VBID plans waive copays for those services. “That could increase screening rates where we want them to be increased,” Delbanco says.

Narrow or “preferred provider” networks frequently are positioned as “high value” because limiting access to a small group of providers is a way to reduce the cost of premiums. But as the VBID concept matures, McClellan says, that thinking will not hold.

“A lot of the narrow networks that exist today are not true value-focused networks, but just a bunch of providers who individually happen to be lower-cost getting pooled together in an insurance plan,” he said. “For this to really count, in our book, you need performance measures and providers who are accountable not just for doing a particular service at a low cost, but really getting lower costs and better results for the patients.”

However, the current state of quality measurement and reporting often is inadequate to support confident decision making by consumers. Readily available facility-level measures, such as cardiac care process measures, do not assure a patient that all services performed at a given hospital are likely to be complication-free. Identifying high-value care involves payment reforms that require providers to demonstrate improved outcomes at lower cost on the specific services a given patient needs.

The effort to streamline and improve quality measures received a boost in February 2016, when CMS and major

**“Let’s fine-tune cost sharing so that we increase it for low-value services, and first and foremost lower it for high-value services.”**

– Jason O’Riordan, Kaufman Hall

commercial health plans joined with physician groups and other stakeholders to release seven sets of clinical quality measures. Participating commercial payers, which cover 70 percent of Americans with private insurance, pledged to join CMS in using the measures for reporting as soon as possible.

A guiding principle of the initiative was to ensure the core measure sets are meaningful to healthcare purchasers and physicians. Participating groups promised to monitor the progress of implementation, invite broader participation, and add measures and measure sets as needed.

VBID also will influence value through patient engagement. In most APMs, payers and providers share the financial benefits of lower-cost care, while the patient watches from the sidelines. “When patients feel like they can get good information and they understand the savings, they will behave significantly differently,” McClellan says. “I think that’s what’s really going to drive health reform.”

He envisions VBID plans that, for example, point a cancer patient to an oncology practice that uses chemotherapy appropriately and prevents unnecessary hospitalizations, while rewarding the patient for choosing that provider.

“That could be thousands of dollars in savings to consumers, not just a little bit of a discount on a premium,” McClellan says. “That’s going to be the biggest thing to drive change, and I do see that being feasible down the road as we get much better at measuring the quality of care and consumers gain more confidence about their healthcare choices.”

#### → KEY TAKEAWAY

VBID will speed patients’ understanding of the variation in cost and quality of services among providers. Health systems that cannot offer high value in certain specialties may need to seek partnerships or consider exiting some service lines. In some markets where employers are resistant to force their employees into narrow network products, high-value providers have been able to use benefit design to create “narrow by choice” networks that allow them to capture market share.

#### → ORGANIZATION TO WATCH

The Aetna Leap plan introduced in southeastern Pennsylvania this year uses a VBID strategy—cost tiers—to encourage members to choose high-value providers. The plan network includes PinnacleHealth System and Lehigh Valley Network, with providers categorized as Tier 1 or Tier 2 providers.

After patients reach the Tier 1 deductible level—typically \$3,500 for an individual—they are covered in full as long as they continue to use Tier 1 providers. If they choose a Tier 2 provider, they keep paying toward a higher deductible, typically about \$6,850.

In these plans, a service requires a copay or is subject to the deductible, but copays count toward the deductible. No referrals are required.

“It’s very simple for members to understand their out-of-pocket costs,” Finke says. “It’s simple to know where they can go get care when it is needed. We are doing a lot of education up front about the plans as well as giving members mobile and web access to see which providers are in their network. And we’re incenting them to be accountable for their own behaviors, such as wellness activities and gaps-in-care activities. I see a big push in this direction.”

## Consumer Power

Consumers have more healthcare choices than ever before, and in the years ahead those choices will reward some organizations at the expense of others.

For health plans, hospitals, and physician groups, two value-oriented consumer decisions trump all others: the choice of a health plan and the choice of where to seek care.

Employees historically have enrolled in the health plan of their employer's choosing. However, 6 million people chose coverage from an array of options on a private health insurance exchange in 2015, and that number is expected to rise substantially—to anywhere from 24.4 million to 60 million—in the next five years.<sup>c</sup>

About 12.7 million people enrolled in health plans in the public insurance exchanges in 2016. And nearly 17 million

seniors chose an MA plan in 2015, opting out of traditional Medicare. That group represents 32 percent of the 55 million total Medicare beneficiaries as of May 2015.

Just like those with employer-sponsored coverage, individuals who buy their own insurance have seen their out-of-pocket responsibility grow steadily. Of those choosing coverage on the public exchanges, about 70 percent buy Silver plans, which require 30 percent of total healthcare costs to be covered out-of-pocket. The average deductible amount in these plans is \$3,177 per person and \$6,480 for a family in 2016.

In an environment in which increasing numbers of consumers are making healthcare coverage purchasing decisions, a health plan's success hinges on being the most attractive choice on the exchange. That means offering an appealing provider network at a price consumers are willing to pay.

Sonal Kathuria, director and value-based care lead for Deloitte Consulting's healthcare practice, and her colleagues recently interviewed executives at 12 regional health plans and found that cost is a top priority. "Most consumers want

### ACTION STEPS TO VALUE

## FROM A HEALTHCARE PURCHASER REPRESENTATIVE

South Carolina's Medicaid program and the state's largest commercial insurer adopted a policy of declining to pay for elective deliveries before 39 weeks of gestation—and saw early deliveries drop by 50 percent. That improved birth outcomes, keeping premature babies out of neonatal intensive care units, and saved \$6 million in Medicaid spending in a single quarter.

"That bold move is one of my favorite examples of evidence-based care and paying for value that I've seen to date," says Suzanne Delbanco, executive director of Catalyst for Payment Reform (CPR), a coalition of many of the nation's largest employers and other healthcare purchasers.

The payment strategy was one of many elements of the state's Birth Outcomes Initiative, a joint effort by the South Carolina Department of Health and Human Services, BlueCross BlueShield of South Carolina, the South Carolina Hospital Association, and the March of Dimes. The initiative demonstrates how healthcare providers and health plans can improve the value of care when they work collaboratively with other stakeholders—and CPR's members want to see more of it.

Delbanco also says organizations should be aware of where they stand relative to their competitors. Purchasers do not want to push payment reform so quickly that they hurt provider organizations, but they are concerned about the wide variation in care and costs from one organization to the next.

"Most people understand it's going to take providers some time to be perfect partners in producing high-value care," Delbanco says. "But everyone feels desperate about how much money they are spending on health care and very frustrated about the uneven value that they are getting for their dollar, because of the variation in quality and the wide range of payment amounts they are making for the same care, regardless of quality."

both low cost and broad access to health care but may value low cost more,” she says. “While consumers historically cared about flexibility and having a variety of care options, this is changing.”

In general, narrow network products—and the lower premiums that come with them—will continue to be popular with shoppers on the exchanges, O’Riordan says. But that big-picture trend must be coupled with information about consumers’ attitudes and preferences regarding providers in a specific market. As in the previously mentioned case of Innovation Health, constructive partnerships between health plans and providers are required to develop products that appeal to consumers.

For example, Utica Park Clinic in Tulsa, Okla., capitalized on initial successes with population health management efforts to “demonstrate to self-funded employers that it can deliver high-quality care while lowering the employers’ total health-care costs,” write Jeffery Galles, DO, chief medical officer and chairman of the clinic’s quality improvement council, and Karen Handmaker, MPP, vice president of population health strategies at Phytel, in the March 2016 issue of *hfm*.

“By creating high-performing narrow networks of providers and hospitals, the organization has increased market share and improved the financial performance of the entire health system.”

Similarly, knowing how consumers want to access care is essential to a provider’s success in the era of population health management. Consumers may prioritize convenience over staying in a provider’s clinically integrated network for routine care, for example, but health systems need to keep patients in-network so they can manage their care.

That means a health system must provide access points—traditional clinics, quick-access clinics, urgent care, virtual care—that make it easy for their patients to choose the system every time. “It’s important to provide an access strategy that makes them not even consider going to a different system, because you’re giving them what they want when they want it, whether that is virtual care, urgent care, or other access points,” O’Riordan says.

In addition to convenience, consumers also need help navigating the health system to receive the services within the network.

“That requires more accountability on behalf of the providers,” Aetna’s Finke says.

## → KEY TAKEAWAY

Deep understanding of market-specific consumer price sensitivity (for both out-of-pocket and premium costs) and preferences related to convenience and access will convey competitive advantages for both health plans and health systems in the near future. To make themselves attractive partners to health plans looking to maintain low premiums, health systems will need to understand both their per unit price relative to their competitors and the overall cost of care for an episode in which they are involved—and determine what they can do to reduce production costs and overall episode prices.

## → ORGANIZATION TO WATCH

Providence Health & Services, one of the biggest health systems in the western United States, is working to add about 1 million primary care visit slots in the foreseeable future, focusing on access points that move care closer to patients’ homes. New modalities include express clinics, virtual visits, on-site employer-based clinics, and home visits, all designed to support the system’s population health management initiatives, says Mike Waters, senior vice president of physician services.

By mid-2017, Providence will open 50 eXpress Care clinics, including 25 Providence-owned clinics embedded in Walgreens stores. Initially those clinics will offer traditional retail-clinic services such as strep tests and flu shots, but eventually they will expand to provide chronic care management.

Waters points out that a consumer is likely to visit a Walgreens store 20 to 30 times a year. That access to chronic care services at a lower cost point is good for consumers and payers now, and receiving more frequent care should improve patients’ health outcomes and thus save costs in the long term.

“What an amazing opportunity for us to better manage a patient’s diabetes-related needs through these sites,” he says. “That’s the future we are looking at, managing chronic care and also preventative care in these locations. With a partner like Walgreens, we think we’re going to be able to do that more effectively.”

## Value via Consolidation

The notion that there is strength in size and volume will continue to fuel healthcare provider consolidation, Kathuria says. Indeed, Deloitte projects that only half of today's health systems will remain independent a decade from now.

Healthcare industry sectors such as pharmacy benefit managers, pharmaceutical companies, and wholesalers already have consolidated, gaining negotiating power and economies of scale. The top three pharmacy benefit management firms have nearly 80 percent market share, and the

top five health plans control 60 percent of the insurance market (prior to the approval of pending mergers between Anthem and Cigna and between Aetna and Humana, which, as of publication of this report, are being challenged in lawsuits filed by the federal government), making health systems and provider organizations seem overly fragmented by comparison.

Many health systems and physician groups cannot afford the investments in technology and infrastructure—urgent care clinics, retail clinics, health coaches, and more—needed to succeed under value-based payment models. In the context of population health management, a healthcare organization may need a certain number of lives under management to justify the requisite investments in analytics and staffing. Kathuria says organizations will need scale to afford it.

### ACTION STEPS TO VALUE

## FROM A HEALTH PLAN REPRESENTATIVE

Provider organizations need to develop both care management and patient navigation capabilities to succeed in accountable care organizations (ACOs), says Dan Finke, CEO of Accountable Care Solutions for Aetna.

“We are focused on making sure that we support the industry evolving to a new care-delivery model, where insurers, health systems, and doctors are all working together, focused on *healthy days*,” he says.

Over time, Aetna will do less care management via call centers that reach out to patients, although it will continue to provide care management services while providers are building this capability.

“Doctors at the point of care will use information that we share with them around gaps in care,” Finke says. “Their role will be helping to keep the member in the system, healthy, and more productive.”

His advice to provider organizations:

- **Hire and train care navigators to anticipate and then meet the individual needs of each consumer in support of population health management.** “Consumers need to know what it means to be part of an ACO, and that will require more accountability on their behalf by the provider,” Finke says.
- **Ensure consumers covered by an ACO product feel like part of something special.** “If we are going to create this consumer model around an ACO provider network, the providers need to offer a differentiated experience so the members have more access to care when they need it and feel like they are in a coordinated model of care rather than just a narrow network,” he says.
- **Be prepared for continual change.** Aetna's ACO contracts with providers are customized based on each organization's current capabilities; specific office hours and consumer-friendly amenities are not stipulated. As ACOs mature and success strategies become clear, Finke expects contracts will evolve to require consumer-oriented best practices.

## Deloitte projects that only half of today's health systems will remain independent a decade from now.

"I think there is a lot of room for consolidation," she says. "It's going to mirror many of the other healthcare-related sectors that have already consolidated to seek efficiencies and value."

Consolidation may, in fact, create value for the merging organizations. But history shows the benefits generally do not extend to the consumers they serve, says Leemore Dafny, PhD, a professor of strategy and director of health enterprise management at Kellogg School of Management, Northwestern University.

Examples of mergers that have documented measurably better outcomes or lower costs are hard to come by, she says. Providers may have the best of intentions, but studies show that mergers result in higher prices.

"Taking the perspective of either a regulator or a consumer, I'm concerned that once you swallow up your competition, any ideas you had about doing things differently—which require a lot of painful trade-offs—won't be implemented because you won't have any rivals breathing down your neck that effectively force you to," Dafny says.

The same assessment holds for insurance mergers, Dafny says, a key point given the potential mergers between Anthem and Cigna and between Aetna and Humana. Dafny's research shows that insurance premiums go up when fewer insurers are competing in a given market.

If health plans and providers truly are interested in improving value, Dafny says, they will consider the ideal scenarios for care delivery and insurance coverage from a consumer's perspective and collaborate, align incentives, and create transparency within a local market to implement those scenarios.

That approach contrasts with the typical pattern in which merging provider organizations cite shared values as a rationale for consolidation. "That is not putting the patient first," Dafny says. "That is putting the providers' employees and mission, as they construe it, first: We'll end up in a much better place if we focus on business as usual, but just try to get bigger."

### → KEY TAKEAWAY

Regulators have shown they will aggressively challenge mergers that excessively concentrate market power. Be ready to demonstrate how a merger will increase value to healthcare purchasers (e.g., employers, individuals) and the broader community.

### → ORGANIZATIONS TO WATCH

Mountain States Health Alliance, a 13-hospital system serving northeastern Tennessee, southwestern Virginia, southeastern Kentucky, and western North Carolina, and Wellmont Health System, a six-hospital system serving northeastern Tennessee and southwestern Virginia, have pledged to improve value if their merger proposal wins regulatory approval.

The two systems have committed to several investments over the next decade that will be made possible through financial efficiencies stemming from the merger: at least \$75 million in population health improvements, such as programs that reduce the incidence of low-birthweight babies and the prevalence of childhood obesity; at least \$140 million to expand community-based mental health services, addiction recovery programs, and substance abuse prevention; at least \$85 million for research and training of health professionals; and up to \$140 million on an IT platform that will support regional exchange of health information.

"Unlike traditional mergers and consolidation, the proposed organization also commits to reduce the pace of growth in healthcare costs to below the national average by placing limits on negotiated rates with insurers," the two organizations stated in a news release.

For any commercial payer that accounts for more than 2 percent of the merged system's total net revenues, the merged system will reduce existing fixed-rate increases by 50 percent for the first full contract year after the merger. For subsequent contract years, the merged system commits to increase hospital rates by no more than the consumer price index for hospitals minus 0.25 percent, and physician and outpatient rates by no more than the consumer price index for medical care minus 0.25 percent.

## Value via Innovation

As technology helps health care extend access beyond the four walls of the traditional examination room, the need for bricks-and-mortar outpatient clinics may be significantly reduced because of virtual clinic visits and other technology-enabled innovations.

Although payers have been slow to warm to telemedicine, that is changing. UPMC Health Plan in Pittsburgh pays for technology-enabled primary care visits as a strategy to improve access while lowering costs. Its analysis of 542 patient televisits in 2013 and 2014 found that, on average, such visits cost \$86.64 less than ED, urgent care, retail, or primary care office visits.

The future described by Eric Topol, MD, director of the Scripps Translational Science Institute, La Jolla, Calif., already is emerging. It's hard to know when these or the many other innovations described in his books—*The Creative Destruction of Medicine* and *The Patient Will See You Now*—will become standard practice. But the extent of innovation's impact on the value of health care is easy to gauge.

"Everywhere you look, there's opportunity and hope for a new model that will be better care at a lower cost," he says.

Health system executives may find it difficult to redeploy resources in preparation for a future that looks very different. But Topol, a practicing cardiologist, professor of genomics, and cofounder of the West Wireless Health Institute, says convenience-oriented consumers, insurers, and employers will gravitate to providers that make full use of innovative technologies.

That means construction projects being planned today need to be carefully considered. Yes, there will always be physician office visits and hospital admissions, but the delivery system of the foreseeable future will be dramatically different.

"While hospitals will still have emergency rooms and operating rooms and ICUs, the rest of the hospital will ultimately be proven unnecessary and, in fact, far more expensive than having people monitored in the comfort and safety of their own home," Topol says.

### → KEY TAKEAWAY

Remote monitoring and other technology-enabled care delivered at or near a patient's home will become standard practice in the foreseeable future. Health systems that cannot provide such care will be at a competitive disadvantage.

### → ORGANIZATION TO WATCH

The University of Pittsburgh Medical Center (UPMC) Health System is using telemedicine as a key strategy for its move to value-based care delivery. Natasa Sokolovich, JD, UPMC's executive director-telemedicine, says telehealth allows the system to manage patients better, thereby reducing avoidable hospitalizations and ED visits.

UPMC's Anywhere Care visits—primary and urgent care provided online—are primarily handled by nurse practitioners. UPMC recently expanded its direct-to-consumer Anywhere Care to include e-dermatology, giving consumers access to a diagnosis and treatment plan from a board-certified dermatologist within three business days.

In addition, UPMC offers 34 types of subspecialty visits via telemedicine services available at more than 20 locations. Coming this year: an expansion and relaunch of its remote monitoring program, which previously served only congestive heart failure patients, to also provide at-home monitoring for patients with chronic obstructive pulmonary disease and diabetes.

**"While hospitals will still have emergency rooms and operating rooms and ICUs, the rest of the hospital will ultimately be proven unnecessary and, in fact, far more expensive than having people monitored in the comfort and safety of their own home."**

— Eric Topol, MD, Scripps Translational Science Institute



# The Value Journey

For most provider organizations, the road ahead has many twists and turns. Although public and private payers expect provider organizations to accept greater financial risk through APMs, the details of new payment approaches that will partially replace fee for service are very much in flux—and will continue to be until payers and providers gain more experience with models that prove to be successful.

Consumers, now responsible for paying for a greater share of healthcare services, will wield increasing influence as they learn to shop wisely for a combination of quality, cost, and convenience. Emerging VBID concepts will reinforce consumers' need to be proactive in choosing providers that offer the best value. As narrow networks continue to gain traction, insurers and providers must make sure consumers are informed about which providers are included in narrow network plans.

The trend toward consolidation, giving providers the economies of scale that can support the investments and changes needed to succeed in value-based care, is expected to continue. But regulators and consumer organizations will be watching closely, concerned that increased market power will lead to higher costs instead of higher value.

Innovation in care delivery will take place as providers seek a competitive advantage through improved access and convenience, lower per unit costs for consumers, or lower total costs of care for health plans. Continual experimentation with new technologies and access strategies—and rapid adoption of those that work well—will become ever more important to provider success.

The transition to value-based payment systems that encourage high-quality, low-cost care—and discourage care that does not fit that description—will be a long, difficult journey. But the prize is invaluable: a healthier population and a sustainable healthcare delivery and payment system. Leading organizations already are on their way to the future.

## ACTION STEPS TO VALUE FOR HEALTH PLANS

Deloitte offers the following guidance for health plans in its “[2015 Health Plans Outlook, United States](#),” by Gregory Scott, principal, U.S. health plans sector leader.<sup>a</sup>

- Health plans are seeing increased pressure to demonstrate value. In response, plans will need to develop strategies to align with providers under new payment arrangements (such as accountable care or value-based care), even as old business models persist. In the traditional power struggle between providers and payers, providers are gaining leverage. Regaining balance will require greater collaborations and partnerships—between providers and plans and between plans and nontraditional players like niche technology companies.
- Health plans that understand consumers' wants and needs, and are able to activate the right behaviors in the right consumers at the right time, will prevail and grow in the redefined, consumer-centric healthcare marketplace.
- Integration along the value chain also presents opportunities for growth. Collaboration between health plans and providers to drive value-based care and better health outcomes offers tremendous opportunities to expand and increase market share.
- Health plans pursuing innovation should adopt a more encompassing definition of “product” to include provider networks, different financial arrangements, and consumer engagement models. They should also consider consumer-focused strategies to drive engagement (in shopping for health plans, selecting providers, taking care of their own health) and improve the customer experience—all of which can help increase health plans' value. Efficient, scalable, and rapidly deployed technology and sophisticated analytics will be key for health plans to bring innovative strategies and consumer experiences to life. Today's health plan technology is incapable of enabling the strategies needed for tomorrow's enterprise growth and margins; plans should make technology investments a strategic priority.

a. Scott, G., “2015 Health Plans Outlook, United States,” Deloitte, 2015.

### Footnotes

- a. Ryan, A.M., Shortell, S.M., Ramsay, P.P., and Casalino, L.P., “Salary and Quality Compensation for Physician Practices Participating in Accountable Care Organizations,” *Annals of Family Medicine*, July/August 2015.
- b. Conway, P.H., Gronniger, T., Pham, H., et al., “MACRA: New Opportunities for Medicare Providers Through Innovative Payment Systems (Updated),” *Health Affairs* blog, Sept. 28, 2015.
- c. Sources: Accenture; Jim Bonnette, MD, of the Advisory Board; and the Aite Group.

# Interviewed for This Report

**Amy Bassano**, director, Patient Care Models Group,  
Centers for Medicare & Medicaid Services

**Leemore Dafny, PhD**, Herman Smith Research Professor  
in Hospital and Health Services, and program director,  
Health Enterprise Management Program, Northwestern  
University

**Suzanne F. Delbanco, PhD**, executive director, Catalyst  
for Payment Reform

**A. Mark Fendrick, MD**, director, Center for Value-Based  
Insurance Design, and professor of Internal Medicine and of  
Health Management and Policy, University of Michigan

**Daniel Finke**, CEO, Accountable Care Solutions, Aetna

**Sonal Kathuria**, strategy and operations, Health Care &  
Life Sciences, Deloitte Consulting

**Mark McClellan, MD, PhD**, director, Duke-Robert J.  
Margolis, MD, Center for Health Policy at Duke University

**Jason O'Riordan**, vice president, Kaufman, Hall &  
Associates, LLC

**Natasa Sokolovich**, executive director, telemedicine,  
University of Pittsburgh Medical Center

**Eric J. Topol, MD**, Gary and Mary West Endowed  
Chair of Innovative Medicine, and professor, Department  
of Molecular and Experimental Medicine, Scripps  
Translational Science Institute

**Mike Waters**, senior vice president, physician services,  
Providence Health & Services

PUBLISHED BY

---



**hfma**<sup>™</sup>

healthcare financial management association

With more than 40,000 members, HFMA is the nation's premier membership organization for healthcare finance leaders. HFMA builds and supports coalitions with other healthcare associations and industry groups to achieve consensus on solutions to the challenges the U.S. healthcare system faces today. Working with a broad cross-section of stakeholders, HFMA identifies gaps throughout the healthcare delivery system and bridges them through the establishment and sharing of knowledge and best practices. Our mission is to lead the financial management of health care.

**Healthcare Financial Management Association**  
**3 Westbrook Corporate Center, Suite 600**  
**Westchester, Illinois 60154-5700**  
**[hfma.org](http://hfma.org)**

**Health Care 2020:  
Transition to Value**

Copyright 2016