

## HFMA'S VALUE PROJECT: PHASE 2

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# Defining and Delivering Value

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**hfma** educational foundation  
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# ABOUT THE VALUE PROJECT

Of all the transformations reshaping American health care, none is more profound than the shift toward payment for value. Medicare payment is factoring in quality and patient satisfaction, while private payers are pursuing performance and risk-based payment structures. Meanwhile, rising healthcare costs are creating more price sensitivity among healthcare purchasers, including government agencies, employers, and patients themselves, who are being asked to pay higher premiums, copayments and deductibles for their care.

These financial pressures make it imperative for all providers of care to develop collaborative approaches that combine strong clinical outcomes with effective cost containment.

Phase 1 of HFMA's Value Project, which was initiated in 2010, identified four organizational capabilities as strategic imperatives for providers. These include:

- **People and culture:** The ability to collaborate, effectively manage change, communicate a value message, and create accountability to value-driven goals
- **Business intelligence:** The ability to collect, analyze, and connect quality and financial data to support organizational decision-making
- **Performance improvement:** The ability to eliminate clinical variation, unsafe practices, and waste
- **Contract and risk management:** The ability to assess the potential risks and benefits of acquiring other providers or engaging with them contractually to build a value-focused network, and to predict and manage different forms of patient-related risk under different payment methodologies

With the support of 16 leading hospitals and health systems (listed at the back of this report), which serve as the project's steering committee and research sponsors, Phase 2 of the Value Project was initiated in November 2011. Its objectives include the following:

- Gain insights into stakeholder perspectives on how new payment methods can create value.
- Understand what purchasers and payers seek from value providers.
- Learn how providers are preparing for value-based payment.

*Defining and Delivering Value* is the first of a series of reports to address these objectives. Together with McManis Consulting, HFMA has engaged in the primary research for this report, including surveys and interviews with executives representing payers, purchasers, and government agencies to gain external stakeholder perspectives on value metrics and value-based

payment methodologies. Organizations interviewed include the following:

America's Health Insurance Plans	Leapfrog Group
Catalyst for Payment Reform	Lockton Companies
Office of Clinical Standards and Quality, the Centers for Medicare & Medicaid Services (CMS)	MedPAC
Center for Medicare and Medicaid Innovation, Medicare Demonstrations Group, CMS	National Association of Insurance Commissioners
Excellus BlueCross BlueShield	National Business Group on Health
	National Quality Forum
	State of Maine
	United HealthCare

Additionally, HFMA interviewed hospital, medical group, and health system CFOs to better understand their planning efforts related to business intelligence and costing capabilities. Individuals from the following hospital organizations participated in these interviews:

Advocate Health Care  
Beth Israel Deaconess Medical Center  
Bon Secours Virginia Health System  
Bothwell Regional Medical Center  
Dean Health Clinic  
Fairview Health Services  
Howard County Medical Center  
Longmont United Hospital  
Novant Health  
Providence Health  
UAB Medicine | UAB Hospital  
University of Iowa Healthcare

HFMA also conducted two industry surveys. The first, on value metrics, was conducted in December 2011 and focused on trends in contractual payment and other arrangements between commercial health insurance carriers or large employers and provider organizations whose payment arrangements were based on value metrics.

The second survey, conducted in February 2012, focused on the role of costing and business intelligence in a value-based payment environment.

Subsequent Value Project Phase 2 publications will detail the strategies and tactics that various types of provider organizations are pursuing to prepare for value-based payment. For additional information, visit the Value Project website at [www.hfma.org/ValueProject](http://www.hfma.org/ValueProject).

# EXECUTIVE SUMMARY

f the many forces transforming our nation's healthcare system, none is more significant than the turn from payment based on volume to payment based on value.

Value is driving a fundamental reorientation of the healthcare system around the quality and cost-effectiveness of care. As in any industry, value in health care is defined through the relationship of two factors: the quality of care and the price paid for it.

Increasingly, key stakeholders—including government payers, commercial health plans, employers, and patients—expect to know the value of the healthcare services they are purchasing. They are seeking out providers who will give them this information and follow through with cost-effective care. In other words, they expect to receive value.

Phase 1 of HFMA's Value Project, initiated in 2010, identified four capabilities as strategic imperatives for hospitals to prepare for this new payment environment. These include:

- People and culture
- Business intelligence
- Performance improvement
- Contract and risk management

With the support of 16 leading hospitals and health systems, Phase 2 of the Value Project began in November 2011. Its objectives include the following:

- Gain insights into stakeholder perspectives on how new payment methods can create value.
- Understand what purchasers and payers seek from value providers.
- Learn how providers are preparing for value-based payment.

Phase 2 findings are based on research conducted by HFMA and its partner, McManis Consulting. This research included interviews with 13 executive leaders at organizations representing payers, purchasers, and government

agencies. Additionally, HFMA fielded two surveys of provider organization CFOs, one focusing on value metrics and the other on costing and business intelligence capabilities, and conducted interviews with 12 finance officers at a range of organizations regarding their business intelligence and costing capabilities.

All stakeholders recognize that the future will focus on value improvement, with an emphasis on effective cost management. Payers recognize the need for a more focused set of value metrics. CMS has indicated that, longer term, the triple-aim based National Quality Strategy will be utilized to align Medicare and Medicaid performance programs and metrics. Based on these findings, HFMA recommends the following guidelines for the development and use of value metrics:

- Work to replace process metrics with patient-centered functional outcomes.
- Align value metrics with the “triple aim” of improving care for individuals, improving the health of populations, and reducing the per capita costs of health care.
- Focus on a limited set of metrics to drive performance.
- Use payment incentives and penalties selectively, emphasizing performance on metrics that have been proven or stakeholders agree are most likely to drive the most desirable quality or cost outcomes.
- Report provider-specific performance to end users in a way that is understandable and actionable.

The findings from HFMA Value Project research and interviews indicate that payers, purchasers, and providers anticipate a real commitment to pursuing value-based payment methodologies over the next three to five years. Stakeholders believe the path forward is largely one of experimentation with payment methods. Leading providers are actively identifying and proposing bundled payment models to payers, and some are leapfrogging to address population risk management. Meanwhile, external

stakeholders and providers view care delivery as the key to improving value in health care. Payers and purchasers are encouraging new care delivery models. Leading providers are proactively experimenting with new partnerships and approaches.

Leading hospitals also are investing in core business intelligence and costing capabilities, with a more immediate emphasis on clinical information system enhancements. Some organizations are moving from “directional” costing data to more precise and granular information across care settings.

Additionally, leading providers are creating opportunities for physicians and front line staff to identify and execute on initiatives to improve value, according to Value Project research and interviews. They are actively and purposefully fostering agile environments of aligned physicians and engaged staff who can drive the necessary changes forward.

Based on the initial research in Phase 2, providers are encouraged to take the following action steps.

**Do not delay in developing the four value-driving capabilities required to adapt in a new payment environment.**

Leading organizations are making improvements in all four areas, with each determining how best to balance and sequence these initiatives.

**Embrace strategic agility for your organization.** Providers are laying the foundation to change course successfully, and sometimes quickly, as strategies evolve in a highly dynamic healthcare market environment.

**Seek stakeholder alignment around a common set of value metrics that are meaningful to their intended end users.** HFMA recommends that, in the near term, provider organizations use contract negotiations with commercial carriers to push for alignment of contract value-based metrics with CMS value-based metrics, to enable greater organizational focus.

**Explore strategic partnerships and opportunities with payers, employers and patients.** Leading organizations are pursuing unique arrangements with key stakeholders that emphasize focus on the critical healthcare needs of the providers’ patient populations.

**Prepare to differentiate the effectiveness of care provided by your organization within a value-driven, competitive marketplace.** Although the extent to which changing market dynamics will drive purely price-sensitive purchasing of health care remains uncertain, provider organizations need to be thoughtful about the value proposition they intend to offer purchasers.

Work on the Value Project continues. Both Phase 1 and the research to date on Phase 2 reveal that, in some ways, different types of providers, especially hospitals and health systems, are pursuing divergent paths through the transitioning payment environment. Subsequent Phase 2 publications will advance the Value Project by detailing strategies and tactics different types of provider organizations are pursuing to prepare for value-based payment.

# DEFINING VALUE

**A**s established in *Value in Health Care: Current State and Future Directions*, the first report of HFMA's Value Project, value is located at the intersection of a purchaser's perception of the quality of a good or service and the amount he or she is willing to pay for that good or service.

As in other industries, value is a concept of relative worth. In health care, measuring value remains elusive. The *definition of quality varies* depending upon the stakeholder—and there are many stakeholders in health care, among them patients, employers, payers, and providers. In many cases, because of how health insurance is typically financed, *the full amount paid for health care is not apparent*. And, under the traditional payment system, *providers typically are not compensated for producing value*; instead, they are rewarded for the volume of services they provide:

**Value = Quality\* in relation to total payment for care\*\***

**\*= a composite of patient outcomes, safety and experiences**

**\*\*= the cost to all purchasers of purchasing care**

This report uses the term *payer* to describe insuring entities, such as CMS or a commercial insurance company. However, insuring entities play a dual role in that they also function in part as purchasers of healthcare services. *Purchasers* include the patient (primary purchaser), employers, and/or state and federal programs, such as Medicaid and Medicare (secondary purchasers), and commercial health plans (serving as an intermediary between purchasers and providers.) *Provider* is intended as an umbrella term encompassing hospitals, health systems, and physicians.

To avoid confusion, this report uses the term *payment* to describe the cost of purchasing services—the amount paid by the patient, employer, and government purchasers—and the term *cost* to describe the healthcare provider's cost of providing the service. In a purchaser-centered value equation, the provider's cost is relevant to the purchaser only to the extent it drives the amount of payment. But the cost of providing care remains an important consideration for providers, who are tasked with maintaining financial viability while improving quality of care.

Interviews conducted with executive leaders at 13 organizations representing payers, purchasers and government agencies provide the external perspective on value metrics and value-based payment methodologies examined in this report. This section of this report summarizes findings related to:

- Purchasers' definitions of value
- The role of care delivery as the key to value improvement
- Approaches to value performance standards and value-based payment
- Commitment to pursuing value-based payment
- Views on the role and likely effectiveness of consumers in driving value
- Predictions about the near-term impact of insurance exchanges in driving quality improvement

## PURCHASERS' DEFINITIONS OF VALUE

The interviews revealed that purchasers generally define value as a combination of quality and price—"the right care for the right price"—and believe this is not what they are getting.

**Employers.** Employers continue to offer health benefits to employees to remain attractive to job-seekers, and to help ensure a healthy and satisfied workforce. Although they generally perceive value in health care to be a function of both quality and payment, employers of all sizes who were interviewed by HFMA are generally much more concerned about containing the cost of health insurance benefits for their employees than they were even a few years ago. Today, human resources directors are increasingly being held accountable for maintaining a budget for health insurance expenditures. In some cases, C-suite executives are becoming directly involved in health insurance negotiations.

Employers use a variety of tactics to contain their health-care costs. Most employers continue to increase employee cost-sharing in plan design as a primary tactic to contain insurance costs. Some employers are eager to utilize provider-specific price and quality data to differentiate them into preferred and nonpreferred (e.g., tiered) networks, typically with cost sharing that encourages utilization of preferred providers. More knowledgeable employers and consultants express concern about providers' cost-shifting efforts and attempt to ferret out evidence of cost shifting in contract negotiations.

The interviews revealed significant frustration among employers regarding the topic of value in health care and the difficulties they experience obtaining meaningful quality data and measures of performance. As one interviewee noted, “Most employers don’t have the patience to deal with health care’s peculiarities. Engaging employers in how hard it will be to provide the right care at the right price won’t go far; the employer response will be, ‘Be competitive the way I need you to be.’” An employer leader noted that larger employers in general are not particularly interested in process indicators as a measure of quality: “They want to know outcomes.”

The employer perspective on the definition of healthcare value varies, depending on the size, sophistication, and level of engagement of the employer in their healthcare purchasing decisions. Employers in the “mid-size” range of 1,000 to 10,000 employees shop on price, in part because quality data that differentiate among providers are hard to obtain and difficult to utilize in practice. Employers of this size in general continue to define quality in terms of network breadth, access, and employee satisfaction. Further, it is very difficult for employers of this size to persuade a health plan to customize a network or plan design.

Larger employers tend to have more leverage in the market, and some are exerting it. For example, a few large employers are beginning to contract directly with preferred providers (Lowe’s with Cleveland Clinic, PepsiCo with Johns Hopkins). The state of Maine is an example of a large public employer with sufficient market clout and political cover to utilize quality and price data to drive provider tiering decisions.

**Insurers.** Insurers—including commercial carriers and CMS—also define value in health care as a relationship between quality and the amount paid for care. CMS’s strategies to improve value will be consistent with the National Quality Strategy announced by the U.S. Department of Health and Human Services in March 2011; its core goals are better care for individuals, better population health, and more affordable care. Commercial insurers are pursuing similar aims, although their tactics differ depending on the size and markets of the carriers. For example, one plan reported it is largely pursuing quality-focused metrics in its provider contract negotiations. Another carrier, however, is insisting upon quality and efficiency metrics.

## CARE DELIVERY TRANSFORMATION

Nearly every interviewee commented on the need to drive changes in the structure and process of healthcare delivery as the key means of improving value. All interviewees are using levers at their disposal to encourage care delivery transformation.

**Encouraging new care delivery models.** A CMS representative described emerging payment mechanisms as “forcing a level of coordination” in a provider community. Numerous CMS programs, such as the Community-Based Care Transitions Program, are specifically designed to encourage improved care coordination across provider organizations. A commercial carrier described its payment strategies as intended to “move providers along the continuum” of being able to accept financial risk. Some of the interviewees emphasized that payment is a blunt mechanism to improve value, and is not “the end goal.” As one stated, “It’s about business process reengineering.”

Payment mechanisms are generally designed to encourage, but not dictate, delivery system alignment. For example, a CMS leader commented, “As soon as (value-based purchasing) becomes more outcomes-oriented, you have to look outside your walls to be successful.” CMS is not aligning the delivery system, but rather “providing opportunities for providers to innovate.” An employer representative stated that employers and health plans should lay out their goals—good outcomes, patient safety, efficiency, and reasonable price—and “let providers figure out the solution.”

**Experimentation with care delivery models.** Several of the interviewees indicated that the key to care delivery transformation is through experimentation. “There are many good ideas out there; they need to get more traction and spread across the industry,” one person commented.

All of the interviewees are pushing such experiments. For example, the National Association of Insurance Commissioners (NAIC) sees opportunity to drive value by setting the risk adjustment methodology required for plans participating in the insurance exchange to reward carriers for enrolling and managing the risk of patients with chronic disease, versus “cherry picking” healthy applicants. Employer organizations are pushing payment initiatives that would penalize care practices that are known to put patients at risk, such as nonpayment for elective induction of labor before 39 weeks.

CMS's Innovation Center was established to experiment with different programs to improve healthcare value. Commercial carriers are offering menus of value metrics and payment terms in provider contract negotiations, as well as analytical and clinical consulting services to assist provider organizations in understanding their patient populations and improving care coordination.

**Emphasis on primary care and deemphasis on inpatient care.** Many interviews revealed a strategic emphasis on shoring up primary care. One commercial carrier is offering incentives and technical support for the development of patient-centered medical homes (PCMHs). America's Health Insurance Plans (AHIP) reported that "contracts for medical homes are appearing in all states now." The state of Maine requires all of its preferred contracted primary care practices to be certified medical homes. Both carriers and employers indicated they are paying additional fees for care coordination as part of their PCMH contracts. These findings are consistent with data presented in a 2011 Medical Group Management Association (MGMA) study,<sup>1</sup> which indicate that 4.3 commercial health plan or multi-payer PCMH pilots and demonstrations were underway in April 2011.

Commercial carriers generally appear to be focusing more on primary care and medical groups than on inpatient care. One interviewee commented that they are working primarily with medical groups (not hospitals) to reduce readmissions. That individual cited reduced readmissions and the Affordable Care Act provisions on medical loss ratios and insurance rate reviews as having significant implications for hospitals.

The MGMA PCMH study indicates that although physician-owned practices represent about 54 percent of established PCMHs, only 22 percent are represented by hospital-owned medical practices. An insurance executive noted, "Hospitals that are stepping up healthcare IT and changing their business models are the vanguard of the future."

### VALUE PERFORMANCE STANDARDS

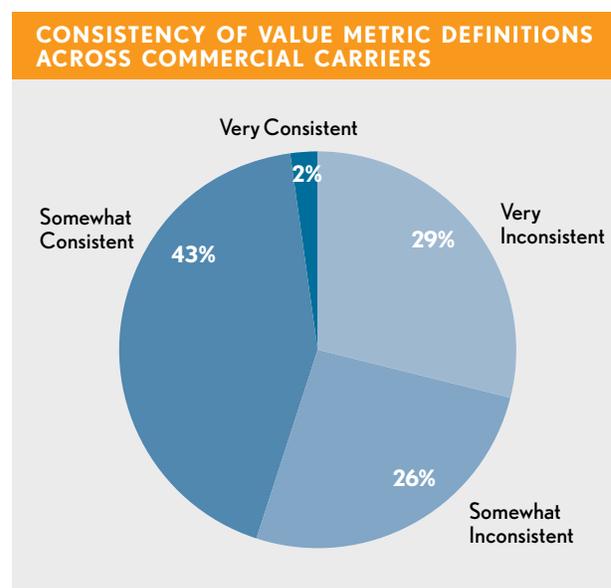
A recent HFMA survey of hospital CFOs revealed a high degree of variation among commercial carriers in the type of quality and value indicators in the marketplace. The respondents commented on the internal challenges, such as lack of focus and insufficient resourcing, that can result from managing to a multitude of performance indicators.

As one respondent put it, "Different metrics pull the organization in different directions."

**Commercial carrier actions.** Both commercial carriers and CMS expressed interest in creating more consistency in the value metrics in the marketplace. "We do not see competitive value in having unique measures," one commercial carrier leader stated.

In some ways, the commercial carriers interviewed are taking steps to reduce the variability of performance metrics. For example, both commercial carriers interviewed are pursuing "menu-driven" value metrics that can be tailored to a specific provider organization. These metrics range from process indicators to population management. Reasons for selecting particular metrics include factors like addressing specific performance gaps or accommodating the risk readiness of the provider organization. One carrier is leveraging CMS metrics already in the marketplace, while another carrier incorporates metrics based on nationally defined evidence-based standards.

However, in other ways, commercial carriers may be proliferating the number of performance metrics at a facility—and that is a matter of concern for both carriers and providers. "Organizations cannot move a great deal of metrics quickly," one commercial carrier leader said. For example, one carrier may utilize provider-specific claims analysis in contract negotiations to push providers to focus on areas of underperformance, while another carrier may use the data to zero in on something else.



Source: HFMA Value Project Survey, December 2011.

<sup>1</sup> The Patient-Centered Medical Home: 2011 Status and Needs Study; Medical Group Management Association, 2011, www.mgma.com/pcmh.

## GUIDELINES FOR THE DEVELOPMENT AND USE OF VALUE METRICS

Interviews with purchasers, payers, and provider organizations revealed some dissatisfaction with value metrics in use today. These criticisms highlighted an over-emphasis on processes rather than outcomes, the inconsistency and proliferation of metrics, and the lack of usefulness of performance data to purchasers.

In 2008, HFMA defined five principles to guide reform of the healthcare payment system: quality, alignment, fairness/sustainability, simplification, and societal benefit.<sup>2</sup> Consistent with these principles, and based upon interviews with purchasers, payers, and providers, HFMA proposes to all stakeholders the following guidelines for the improvement of metrics and reporting to promote the quality and cost-effectiveness of healthcare delivery.

**Work to replace process metrics with patient-centered functional outcomes.** HFMA's 2008 payment reform white paper notes that, consistent with the principle of quality, "wherever possible, payments should reward positive outcomes, rather than adherence to processes." Employer organizations consistently expressed that patient-centered functional outcomes, such as return to functioning or number and kinds of complications after a certain type of surgery, are preferable to process-based measures, and conveyed frustration that the market is lagging in providing these types of metrics. Providers, too, expressed significant interest in functional outcomes measures, with many indicating they are superior to process indicators as measurements of healthcare quality. Organizations requiring process metrics should work to establish the connection between these metrics and quality or cost outcomes.

**Align value metrics with the "triple aim" of improving care for individuals, improving the health of populations, and reducing the per capita costs of health care.** HFMA's 2008 white paper on payment reform encouraged alignment of payment reform with the nation's health goals. Since that time, there has been broad coalescence around the Institute of Healthcare Improvement's "Triple Aim," including its role as foundation for the National Quality Strategy.

In furtherance of these goals, value metrics should align incentives for providers to coordinate care. Hospitals and health systems note that in some cases they are incentivized to coordinate care, but other providers with whom they interact (e.g., independent physicians) do not have similar incentives available. To optimize payment as a lever to coordinate care, all providers involved in care coordination efforts should be incentivized to work together more effectively.

**Focus on a limited set of metrics to drive performance.** Although many things can be measured, a much fewer number of metrics should be selected to drive performance. Consistent with HFMA's payment reform principle of simplification, value metrics should be used to judiciously target high-priority areas of improvement for the healthcare system, minimizing administrative burdens and optimizing the use of limited organizational resources. This guidance applies to payers in their contractual negotiations with providers as well as to providers, which may benefit from highlighting a select number of performance metrics for strategic organizational focus.

**Use payment incentives and penalties selectively, emphasizing performance on metrics that have been proven or stakeholders agree are most likely to drive the most desirable quality or cost outcomes.** Payment mechanisms are a blunt way to drive provider behavior and, if used indiscriminately, can result in unintended consequences such as underuse of services in a capitated model. This issue relates to HFMA's payment reform principle of fairness/sustainability.

Just as stakeholders should focus on a limited number of high-impact metrics and refine them over time, so should payers be careful in how they drive provider performance through experimentation with payment. Understanding the intended and unintended consequences that result from payment experiments will be critical to refine approaches to value-based payment over time.

**Report provider-specific performance to end users in a way that is understandable and actionable.** Consistent with the HFMA principle of alignment, provider-specific quality and price data should be accessible to purchasers in an understandable format. For example, patients may require straightforward rating systems that distinguish among providers' performance on quality and price.

Further, to be actionable, it is important that performance standards allow for distinction among providers over time. For example, if all providers are incentivized to achieve performance within an extremely narrow range, that may not allow a purchaser to distinguish provider performance. Payers should be careful to convey performance expectations in a way that not only continually focuses on high impact areas, but also at levels that allow purchasers to discern excellent from average performers.

<sup>2</sup> See *Healthcare Payment Reform: From Principles to Action*, HFMA, September 2008, available at [hfma.org/reform](http://hfma.org/reform).

Carriers do not seem to be working among themselves to standardize performance expectations. For example, although each carrier interviewed is attempting to tap into already-defined metrics, one carrier signaled an intention to incorporate both quality and efficiency in its metrics, while the other is utilizing quality-focused metrics without an efficiency component.

**CMS strategies.** Today, there are many different measures across several different CMS quality reporting and performance programs that impact hospitals. Among these are Inpatient Quality Reporting, Hospital Value-Based Purchasing, Medicare Shared Savings Program, Outpatient Quality Reporting, and the Readmissions Reduction Program. Performance measures within certain programs are numerous, such as those for the Medicare Shared Savings Program, which encompasses standards related to preventive health, care coordination and patient safety, patient/caregiver experience, and at-risk populations. But despite the complexity involved in dealing with a number of CMS programs and metrics, one employer organization leader described a sense of coalescence within the healthcare industry that stems from a convergence around key metrics, such as those used to demonstrate meaningful use and to benchmark quality of care in accountable care organizations.

A CMS representative indicated that eventually, the National Quality Strategy (NQS) will align performance standards across these CMS programs, noting, “We are working toward a common approach to measurement.” For example, in the 2013 proposed Inpatient Prospective Payment System rule, CMS recommends that the six NQS measurement types become the domains for value-based payment determination in 2016.

The National Quality Strategy contains three national aims, which are based on the Triple Aim. These include:

- *Better care:* Improve overall quality, by making health care more patient-centered, accessible and safe.
- *Healthy people/healthy communities:* Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and environmental determinants of health, in addition to delivering higher-quality care.
- *Affordable care:* Reduce the cost of quality health care for individuals, families, employers and government.

The table at right shows the core principles of the NQS alongside the types of measures to which each principle maps.

**Efficiency metrics.** Measurements of efficiency can take different forms, from eliminating inappropriate care to reducing overutilization to delivering necessary care more efficiently. Some efficiency metrics, such as those proposed by CMS related to the NQS, will require hospitals to collaborate effectively with other providers. To date, both commercial carriers and CMS have placed more emphasis on the quality component of value than efficiency.

A commercial carrier noted that efficiency measurement could be an area where CMS and national clinical organizations should take a leadership role. CMS is already making moves in this direction. As noted previously, various types of efficiency and cost-reduction metrics are envisioned as part of the plan to deliver on the affordability component of the NQS. Additionally, the Center for Medicare & Medicaid Innovation’s (CMMI) Bundled Payments for Care Improvement pilot uses the PROMETHEUS Payment® methodology, which pays evidence-based case rates for processes, structures, and outcomes of care related to particular procedures.<sup>3</sup>

CORE PRINCIPLES OF NQS	
NQS Principle	Type of Quality Measure
<b>Making care safer</b>	Patient Safety <ul style="list-style-type: none"> <li>• HCACs, including HCLs</li> <li>• All cause harm</li> </ul>
<b>Ensuring person/family engaged as partners in care</b>	Person and Caregiver-Centered Experience and Outcomes <ul style="list-style-type: none"> <li>• CAHPS or equivalent measures for each setting</li> <li>• Functional outcomes</li> </ul>
<b>Promoting effective communication and coordination of care</b>	Care Coordination <ul style="list-style-type: none"> <li>• Transition of care measures</li> <li>• Admission and readmission measures</li> <li>• Other measures of care coordination</li> </ul>
<b>Promoting effective prevention and treatment practices for leading causes of mortality</b>	Clinical Quality of Care <ul style="list-style-type: none"> <li>• HHS quality of care and CV quality measures</li> <li>• Prevention measures</li> <li>• Setting-specific measures</li> <li>• Specialty-specific measures</li> </ul>
<b>Improving community health</b>	Population and Community Health <ul style="list-style-type: none"> <li>• Measures that assess health of the community</li> <li>• Measures that reduce health disparities</li> <li>• Access to care and equity measures</li> </ul>
<b>Making quality care more affordable</b>	Efficiency and Cost Reduction <ul style="list-style-type: none"> <li>• Spend per beneficiary measures</li> <li>• Episode cost measures</li> <li>• Quality-to-cost measures</li> </ul>

Source: Patrick Conway, MD, MSc, CMS CMO and director, Office of Clinical Standards and Quality, April 2, 2012.

<sup>3</sup> For more information on the PROMETHEUS Payment program, see *Transitioning to Value: PROMETHEUS Payment Pilot Lessons*, available at [hfma.org/prometheus](http://hfma.org/prometheus).

Clinical organizations, too, are contributing to discussions on efficiency measurement by providing leadership on the issue of medical appropriateness. In March 2012, nine national clinical associations, including the American Academy of Allergy, Asthma & Immunology and American Academy of Family Physicians, produced a collective list of 45 evidence-based recommendations to reduce overuse and misuse of specified services. This kind of information could prove useful to payers, purchasers and providers as they focus their efforts to demonstrate and improve efficiency.

The National Quality Forum (NQF) is another stakeholder that is beginning to focus on efficiency measures, which a leader there defined as “quality over resource use, at the population level.” NQF sees efficiency measures as a key step to eventually defining value in health care. At this point, NQF is working on measures of resource use. These initiatives are focused on diabetes care, capturing all patient costs (not just those attributed to the patients’ diabetes) over a measurement year. The organization is also working on episode-based approaches in two areas: hip and knee replacement and pneumonia. For both approaches, data across all care settings will be gathered so that costs can later be broken down and attributed per care setting.

Employer organizations, too, are pushing measures of efficiency. Several organizations interviewed are sponsoring payment mechanisms related to elective early inductions of labor, with the goal of minimizing or eliminating payment for these unnecessary procedures. Leapfrog is starting to work with employers on identifying other overused procedures, including unnecessary episiotomies.

**Functional outcomes metrics.** Employer representatives cited “outcomes first” as the most important measures of quality. For purchasers, outcomes research and measurement can identify potentially effective strategies they can implement to improve the quality and value of care. Employer organizations noted that these kinds of metrics are the most difficult to find in health care, aside from CMS’s measurements of readmissions and mortality. Some employers and providers interviewed for Phase 2 of the Value Project also faulted CMS and commercial payers for focusing heavily on certain process-of-care indicators that “don’t deliver value to the patient.”

A subset of outcomes measurement is assessment of return to functioning. These types of measures assess how people function after an acute event (such as complications or return to function after a knee replacement), or with management of a chronic condition. According to the Agency for Healthcare Research and Quality, “The difference between traditional clinical measures for a disease and the outcomes that matter to patients can be dramatic.”<sup>4</sup>

Functional outcomes measures are generally under-represented in quality assessment in the United States. CMS requires Medicare Advantage plans to distribute the Medicare Health Outcomes Survey to samples of patients, so that they can self-assess their functional status. Similarly, the Consumer Assessment of Healthcare Providers and Systems survey contains questions related to health and functional status. These approaches, however, do not yet require active participation of the delivery system in understanding and driving to improve functional outcomes. Development of additional functional outcomes measures is among the goals of CMS in assessing progress on the NQS.

The U.S. is lagging other nations in measuring and reporting on functional outcomes. For example, Sweden requires every hospital and county to report annually on certain functional outcomes related to orthopedic services. The Picker Institute, the Foundation for Accountability, and the PROMIS team have produced numerous instruments and measurements of quality, with an emphasis on “symptoms, functioning and outcomes that matter to people.”<sup>5</sup>

**Process-of-care metrics.** As noted above, interviewees confirmed that employers are less interested in process-of-care metrics than they are in performance on outcomes. However, process-of-care metrics are heavily featured in CMS’s approach to value measurement to date. Another concern related to process-of-care metrics is that, as defined, they are likely to drive providers to performance within a narrow band. This approach could have two impacts of concern to providers. First, it could result in providers expending resources to get incremental improvement on an already high level of demonstrated performance. Second, it may not enable providers to compete on the basis of quality, since it will not be distinguishable.

<sup>4</sup> “Outcomes Research Fact Sheet,” Agency for Healthcare Research and Quality, [www.ahrq.gov](http://www.ahrq.gov).

<sup>5</sup> Lansky, D., “Public Reporting of Health Care Quality: Principles for Moving Forward,” *Health Affairs*, <http://healthaffairs.org/blog/2012/04/09/public-reporting-of-health-care-quality-principles-for-moving-forward>.

# VARIATIONS IN VALUE-BASED PAYMENT MECHANISMS

Although HFMA's interviews suggested that payers and purchasers are interested in creating greater focus in value measurement, they also confirmed that payers and purchasers intend to experiment with a variety of value-based payment mechanisms. When asked what specific type of value-based payment they expected to be most prevalent in three to five years, the typical response from payers was "not to place bets" on any one methodology.

There are several reasons for this approach. A key reason is the lack of certainty about which payment mechanisms most effectively drive results and which might create unintended consequences. As Suzanne Delbanco, executive director and founder of The Catalyst for Payment Reform, states, "The big problem is moving from national standards of performance to a standard method of payment, because no one knows yet what will work best."

For purposes of this report, value-based payment methodologies include:

- Pay for performance relative to quality, utilization, or efficiency benchmarks
- Bundled payments based on episode of care
- Shared saving and loss programs
- Capitation or global payment

The need for flexibility in provider contract negotiations, based on providers' structure, ability to manage population

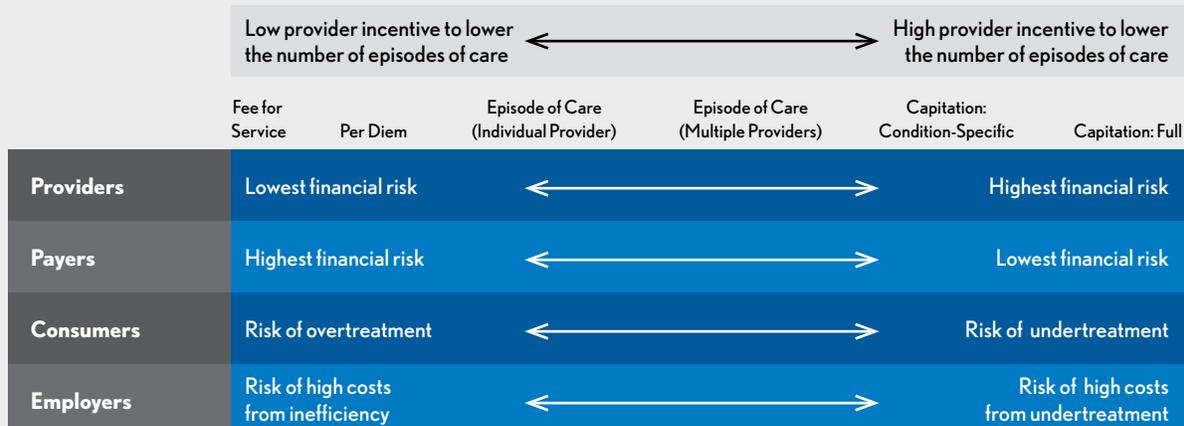
risk, and other factors, also was cited by payers and purchasers. Although payers are attempting to use various payment mechanisms to push providers toward greater integration and assumption of financial risk, this can be a difficult process. As one executive stated, "Payment policy is best used in support of care redesign, but it's not necessarily simple."

The fact that geographic market variation also affects payment models is another reason to experiment with a variety of value-based payment mechanisms, carriers and employer organizations say. As one employer organization leader suggested, "You can do very different things in California, where capitation is more common."

In terms of which specific payment methodologies might become most prevalent, several interviewees commented that a fee-for-service "chassis" could still be used, provided that gainsharing issues could be resolved. One interviewee commented that claims systems are not configured for bundled payment, while another stated that capitation is insufficient because it does not allow for containment of trend.

Shared savings and loss programs are expected to gain traction. As one interviewee noted, "Whoever can figure out how to own the patient, the patient's data, and patient management will be the successful entity." In this leader's view, this could be the employer, a payer, or, in some markets, a provider.

## UNDERSTANDING PAYMENT REFORMS IN THE CONTEXT OF STAKEHOLDER RISK



Source: HFMA, *Healthcare Payment Reform: From Principles to Actions* (2008).

## COMMITMENT TO PURSUING VALUE-BASED PAYMENT

All payers interviewed expressed a commitment to pushing value-based payment. CMS has communicated its schedule for increasing the percentage of hospital payment at risk for performance, and in 2015, will introduce value modifiers for professional services. Both cost and quality data are to be included in calculating payments for physicians. MedPAC leaders have expressed openness to experimenting with value-based payment methods. One commercial carrier's goal is to have 75 percent of commercial, nonmanaged care members in a plan that utilizes value-based contracting by 2015; currently, fewer than 5 percent of its members are in such a plan. Another carrier estimates that 20 percent of its providers will experience some form of financial risk sharing within five years.

Business leaders generally expressed optimism that employers are increasingly becoming more willing to take stronger positions on value-based payment, especially where there is a clear quality argument. As better provider-specific quality and price data emerge, these leaders expect that employers will be more willing to tier, if not eliminate, providers from their networks. In anticipation of this, a carrier interviewed by HFMA is building capabilities for products that offer highly modular network configurations.

Other levers to drive value include the following.

**Consumer engagement.** Viewpoints on the potential for patient engagement to improve value ranged from skeptical to strongly supportive. Some indicated little optimism that consumers will drive value in any meaningful way, since this has not been demonstrated to date. One interviewee noted that achieving transparency is more difficult than one might expect. "If I find out that Hospital X is best at outpatient care, but my orthopedist doesn't practice there, what do I do, fire my doctor?" one interviewee commented. And concerns about provider-specific data reliability led one commercial carrier leader to state, "We're not big fans of consumer transparency."

On the other hand, some interviewees view consumer transparency as a vital complement to value-based payment mechanisms. For example, a CMS representative described it as "incredibly important;" he sees consumer engagement as an outcome of CMS's efforts to drive improved reporting.

Meanwhile, a commercial carrier described consumer transparency as a "key ingredient" for driving improved value.

All interviewees agreed that the quality and price data available to healthcare consumers today are insufficient. Many commented on the need for a simple rating system of providers, although one CMS leader stressed the need to have population-specific ratings (e.g., for the elderly, lower-income mothers and children). A CMS leader stated that developing data useful to consumers will require "a dialogue among CMS, patients, medical boards, private payers, and the private sector."

Several interviewees noted that consumer engagement today may be inhibited not only because of lack of transparency and understandable metrics, but also for other reasons. One issue that surfaced pertains to benefit design, and the sense that today's benefit structures don't necessarily make it easy for the patient to "do the right thing." Others mentioned that fragmented care delivery can also impede the patient's ability to engage appropriately in his or her care.

**Insurance exchanges.** None of the interviewees who discussed the insurance exchanges sees them as a vehicle for driving quality in the near term. Most states are concentrating on getting core technical capabilities in place by January 2014, and will be "passive," meaning they will not set many rules or requirements about participation in the exchange. According to the NAIC, once the exchanges are up and running, and the market and government have had some time to assess the impact, states might become more active purchasers and more assertive about quality standards for plan participation. Employer representatives generally expressed the same viewpoint and conveyed disappointment that the exchanges would not be more insistent about quality initially.

Research suggests that consumers using the insurance exchanges will be sensitive to price. A study of likely consumers of health insurance exchanges in 2014 by PwC Health Research Institute revealed that individuals who are likely to be Medicaid- or subsidy-eligible consider price to be more important than benefits when choosing health insurance. This study also showed that price becomes a more important consideration than benefits as self-reported health status worsens.<sup>6</sup>

<sup>6</sup> *Change the Channel: Health Insurance Exchanges Expand Choice and Competition*, PwC Health Research Institute, July 2011.

# DELIVERING VALUE

Interviews and surveys conducted with hospital and health system leaders indicate that they are beginning to invest and organize in preparation for the emerging payment environment. This section of the report reveals areas of synergy between external stakeholders and providers. Most notably, external stakeholders and providers:

- Recognize that the future requires them to focus on cost containment
- Anticipate a real commitment to pursuing value-based payment methodologies over the next three to five years
- Believe the path forward is largely one of experimentation with payment methods
- View care delivery as the key to improving value in health care

This section examines these topics from the perspective of the provider and also discusses findings related to:

- Approaches providers are taking toward experimentation with care delivery and payment methodologies
- Plans for investment in costing and business intelligence capabilities
- How organizational leaders are developing more change-oriented cultures and workforces
- Outcomes providers anticipate from these efforts

## FOCUS ON COST CONTAINMENT

Regardless of the emergence of value-based payment or state or federal healthcare legislation, interviewees predict a future of reduced revenue and noted that their organizations are working toward improved efficiency.

“We’ll get paid less for each unit of service,” says Dominic Nakis, CFO of Oak Brook, Ill.-based Advocate Health Care, “We need to become more cost-efficient.” Cost containment initiatives at Advocate include (but are not limited to) labor productivity, supply cost management in physician preference items, logistics and commodity purchases, and clinical effectiveness initiatives such as length of stay variability analysis, cardiac order sets, blood and radiology utilization, and management of ventilation days for ICU patients.

Dean Health in Madison, Wis., recognizes that the employer community cannot withstand the double-digit premium increases of the past. Dean Health’s goal for 2012 is to wring out \$20 million in costs, having already successfully cut a similar amount from last year’s budget.

Longmont United Hospital, based in Longmont, Colo., has maintained a focus on cost containment. For example, the hospital put case managers in the emergency department, which accounts for 70 percent of the hospital’s inpatient admissions, to more appropriately triage what route (inpatient or other) these patients take for care. Neil Bertrand, Longmont’s CFO, estimates this practice costs the organization \$10 million in revenue annually, but stated, “It is the right way to deliver care.”

UAB Hospital of Birmingham, Ala., has already tackled key initiatives, including productivity analyses and supply cost containment. The hospital’s overall goal is to reduce cost while maintaining or improving quality.

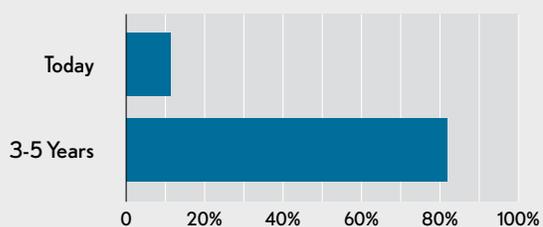
## PROVIDERS' EXPECTATIONS OF VALUE-BASED PAYMENT METHODOLOGIES

The HFMA value metrics survey revealed that respondents anticipate a substantial increase in the prevalence of value-based payment. Roughly 80 percent of providers surveyed expect that 5 percent or more of their commercial payments will be based on value-based mechanisms within three to five years, up from slightly more than 10 percent of providers today. Hospital and health system interviews validated that at most organizations, executive leaders have created awareness among board members of this emerging payment shift and its potential implications.

Although the use of value-based payment mechanisms today is generally limited, respondents anticipate growth in all of them, particularly pay-for-performance benchmarks and bundled payment arrangements.

### ANTICIPATED GROWTH IN USE OF VALUE-BASED PAYMENT MECHANISMS

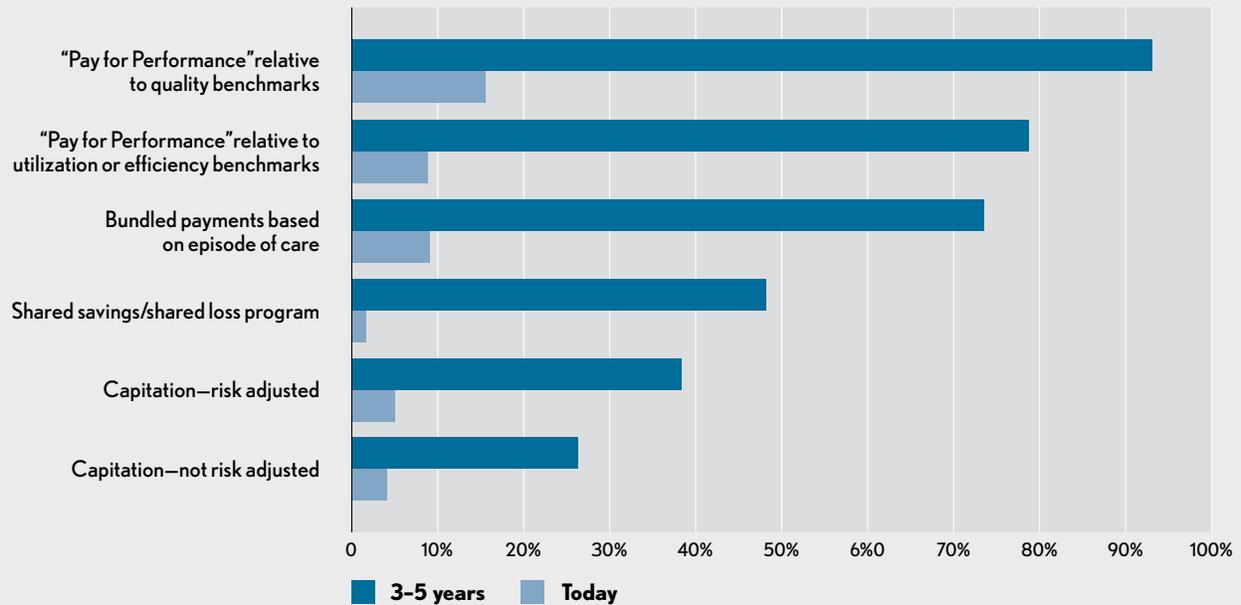
Percentage of survey respondents indicating that 5 percent or more of their commercial payments are (today) and will be (within 3 to 5 years) based on value-based mechanisms.



Source: HFMA Value Project Survey, December 2011.

## ANTICIPATED GROWTH IN VALUE-BASED PAYMENT, BY PAYMENT MECHANISM

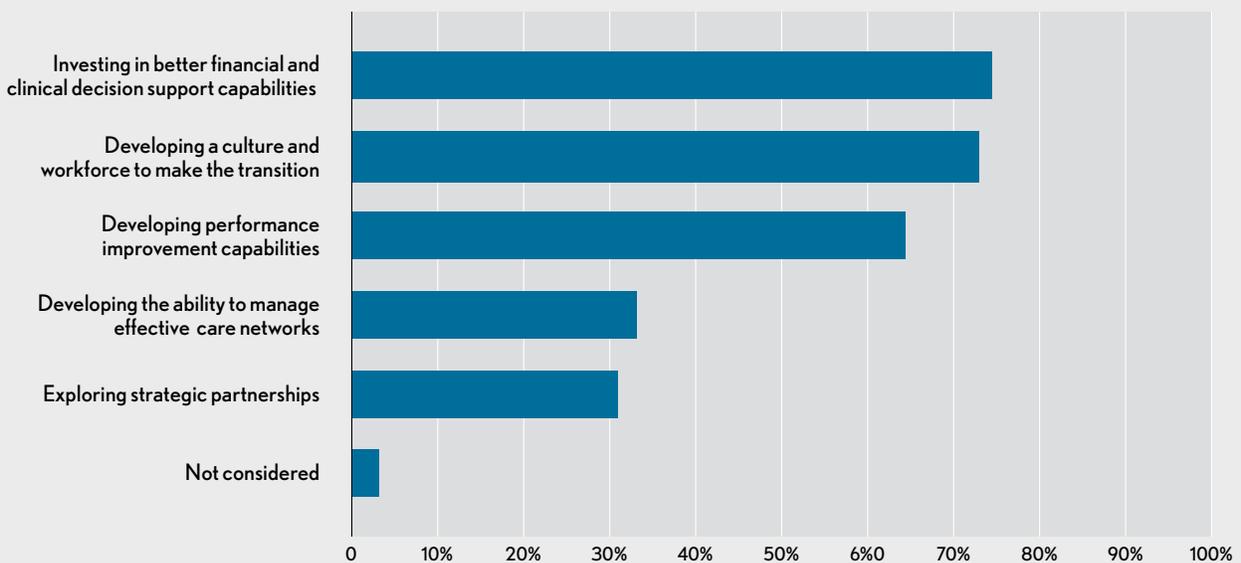
Percentage of survey respondents indicating that mechanisms will account for 5 percent or more of payment from commercial carriers.



Source: HFMA Value Project Survey, December 2011.

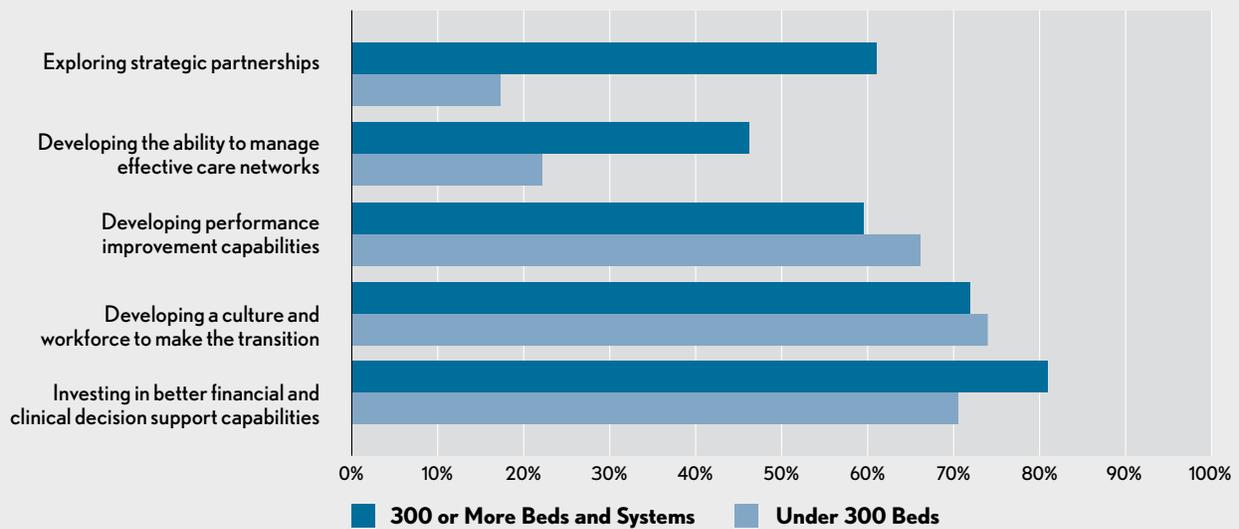
## STRATEGIES TO PREPARE FOR VALUE-BASED PAYMENT

Almost 9 in 10 hospitals and health systems responding to the survey have initiated more than one of the strategies below.



Source: HFMA Value Project Survey, December 2011.

## LARGER ORGANIZATIONS MORE LIKELY TO EXPLORE STRATEGIC PARTNERSHIPS OR NETWORK DEVELOPMENT



Source: HFMA Value Project Survey, December 2011.

Most providers are actively preparing for value-based payment by investing in better financial and clinical decision support capabilities and focusing on developing a culture and workforce to make the transition to a different payment environment (see the exhibit at bottom left).

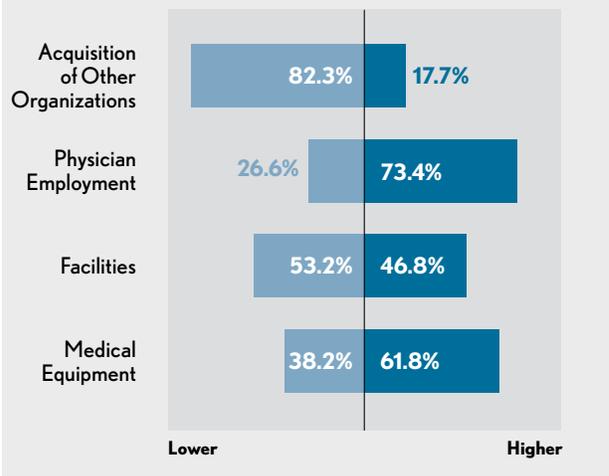
When these data are split by size, hospitals or systems of 300 or more beds are substantially more involved in exploring strategic partnerships than smaller hospitals. Interviews with larger organizations confirmed that many of them are proactively pursuing customized arrangements with carriers and purchasers. Advocate, for example, has a unique shared savings arrangement with Blue Cross Blue Shield of Illinois. Dean Health is working directly with an alliance of self-funded employers to pursue a unique risk-based payment arrangement. And Fairview Health Services in Minneapolis, Minn., has unique payment arrangements established with all major commercial carriers in Minnesota.

The emerging payment environment is not the only driver of organizational strategy. Other strategic priorities compete with investment in business intelligence capabilities required for value-based payment. For a majority of survey respondents, employment of physicians and investments in medical equipment are a higher strategic priority than investments made in business intelligence capabilities.

Business intelligence is not the only place organizations are investing as they prepare for value-based payment.

## BUSINESS INTELLIGENCE COMPETES WITH OTHER STRATEGIC PRIORITIES

Investments in physician employment and medical equipment are higher strategic priorities for survey respondents.



Source: HFMA Value Project Survey, February 2012.

Organizations are also shaping their care delivery structures, processes, culture, and alliances and are creating new internal relationships and forums to prepare for a new payment environment. In fact, research in Phase 2 of the Value Project confirms that leading organizations are developing in each of the four value-building capabilities described in Phase 1: people and culture; business intelligence; performance improvement; and contract and risk management.

## CARE DELIVERY AS THE PRIMARY MECHANISM TO IMPROVE VALUE

Like external stakeholders, provider organizations interviewed see care delivery as the primary mechanism to maintain or improve quality while driving out cost. As noted by Fred Hargett, CFO of Novant Health in Winston-Salem, N.C., “The key to improving cost structure will be through changes in care delivery.” Melinda Hancock, CFO of Richmond-based Bon Secours Virginia Health System, was more specific, saying, “The only way to manage business is through primary care physicians. They are critical for population health and disease management.” This emphasis on clinical care management resulted in numerous care delivery-focused investments and experiments.

**Investment in clinical systems.** HFMA’s costing and business intelligence survey revealed that most respondents are investing primarily in clinical performance improvement systems, followed by coding systems. Interviews confirmed that this was generally true in terms of the sequencing of activities as well as the amount of dollars allocated.

University of Iowa Healthcare prioritized clinical performance improvement highest among its investments in business intelligence. Mark Henrichs, assistant CFO at the University of Iowa, explains that the organization sees opportunity in expanding their existing clinical decision

support capabilities to do better clinical performance improvement, utilizing functionality related to best practices and protocols. This functionality will help them reduce clinical variation. At Bothwell Regional Health Center in Sedalia, Mo., CFO David Halsell explains, “We are underperforming on coding accuracy. We must step up quickly; it will help with revenue.” Halsell also indicates that investment in coding systems will help the organization “get more focused on clinical quality improvement.” Novant Health is in the midst of its electronic medical record (EMR) implementation, and is de-prioritizing costing system improvements until the EMR is in place.

### Forums to identify and execute care delivery initiatives.

In addition to investing in clinical and coding capabilities, many of the organizations interviewed are leveraging or building new forums to identify opportunities to improve value through care delivery. Typically, the establishment of these forums requires strong change management that encourages a culture of physician partnership and front-line engagement.

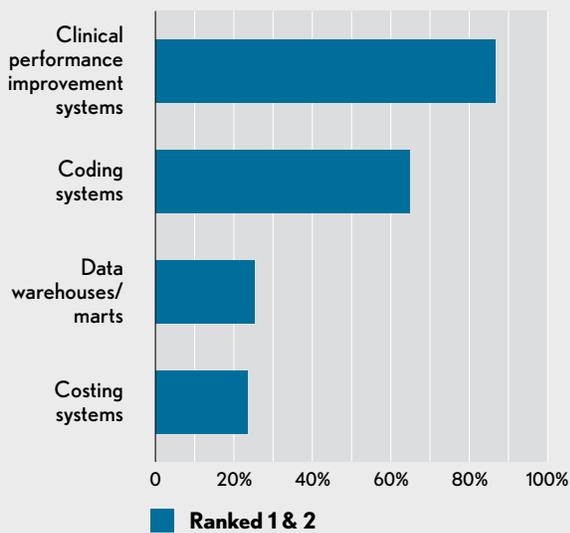
In 2008, Dean Health, based in Madison, Wis., established a Medical Value Program (MVP) to identify and follow through on opportunities to reduce variation in care delivery. The work of this group is central to the organization’s strategic planning and budgeting process. Its efforts resulted in initiatives that saved Dean Health \$20 million in 2011, and it is expected to achieve another \$20 million in savings in 2012.

This forum consists primarily of clinical leaders from the hospital, health plan, and medical group. Today, the team is proactively proposing a pipeline of projects to affect future annual budget cycles. Each initiative has an estimated budget impact associated with it, to help with prioritizing. The organization has mechanisms in place to financially align employed physicians to these goals.

Bon Secours of Richmond, Va., also has an established approach for identifying care delivery initiatives, such as reduction in pressure ulcers and reduction in hospital-acquired infections. Unlike most organizations surveyed, Bon Secours has processes and structures to quantify the financial impacts of each initiative. These projects result from collaboration among the CFO, CMO, and CIO. In 2009, this work resulted in \$12 million in savings, and in 2010, \$19 million. In 2011, 80 percent of the initiatives undertaken met financial performance goals.

## PLANNED ALLOCATION OF BUSINESS INTELLIGENCE INVESTMENTS

Percentage of survey respondents ranking each area as first- or second-highest priority.



Source: HFMA Value Project Survey, February 2012.

The organization today is focusing on initiatives that favorably affect cost per case, with a particular focus on those that affect fixed versus variable cost.

Novant Health, serving North Carolina, Virginia, South Carolina, and Georgia, recently established an Innovation Group, a “bottoms up” forum to share ideas for improving or maintaining quality while reducing cost in clinically oriented areas as well as in support departments. So far, the ideas submitted have been small in scale, but creative. The organization is not yet measuring the cost impacts of ideas generated by the Innovation Group: At this early stage, CFO Fred Hargett notes, “You have to go on faith that there’s a favorable cost impact.”

As described in HFMA’s *People and Culture* report, some leading organizations are augmenting their care delivery improvements by involving patients directly in the process. At Spectrum Health, leaders established patient and family advisory councils to help prioritize and design improvement activities. Similarly, the Cleveland Clinic created an Office of Patient Experience to involve patients and care-givers directly in care improvement initiatives.

**Experimentation with care delivery approaches.** A number of interviewees indicated that they are experimenting with different approaches to care delivery. For instance, one multihospital system is forging a new relationship with community long-term care facilities to collaboratively improve management of readmissions from those settings.

Longmont United Hospital, Longmont, Colo., is pursuing innovative arrangements with other providers. The hospital recently organized a co-management agreement forming a limited liability company (LLC) with all orthopedic surgeons and neurosurgeons in the area.<sup>7</sup> Immediate goals of the LLC are to establish and manage to quality and efficiency measures. Ultimately, the goals of this organization are to:

- Create aligned incentives
- Prepare for bundled payment
- Foster behavior modification on the part of all parties

Additionally, Longmont United is participating in the newly created Boulder Valley Care Network (BVCN). BVCN was created at the urging of the Boulder Valley School District, which sought help from area providers to manage

costs and care in its self-funded plan. BVCN is a provider consortium including Boulder Community Hospital and Avista Hospital and their related medical staffs. Including the hospitals’ medical staffs, a total of seven provider entities are involved in the BVCN.

In collaboration with the community school district, BVCN medical leaders are starting to analyze chronic disease in the district’s population. BVCN and the school district have designed incentives for savings, to be distributed among the providers. BVCN is also discussing the possibility of applying for ACO status. BVCN providers are not linked electronically, but hope to leverage the Colorado Regional Health Information Organization (CORHIO) for that capability.

Some organizations indicated they are beginning to focus on their own self-funded population of employees as a means of gaining experience with population care management. Longmont United Hospital intends to contract with the BVCN and utilize the care management approaches there as a means of better analyzing, identifying, and executing opportunities to improve care management for the Longmont United Hospital insured population.

**Contracted networks.** Many interviewees commented that their organizations are working to align their contracted physicians with their cost and quality efforts. Whether they are successful could impact their ability to manage outcomes-based payment arrangements.

Most interviewees are working to ensure that network physicians are on EHRs. One organization is considering a carrot-and-stick approach to this issue, offering subsidies, but with a deadline to implement or risk contract termination.

Dean Health is well along the path toward aligning its contracted network. Over time, Dean has developed the “Dean Value Contract,” which CFO Steve Caldwell described as a process of aligning physicians to value in contractual terms that are “as sophisticated as possible.” The Dean Value Contract has migrated contracted physicians to be accountable for key metrics of importance to Dean Health, including patient satisfaction, total cost of care, clinical quality, and generic drug metrics.

<sup>7</sup> This model is consistent with an HFMA co-management case study from Iowa Health-Des Moines, available at [hfma.org/IowaHealthCaseStudy](http://hfma.org/IowaHealthCaseStudy).

# PURPOSEFUL EXPERIMENTATION WITH VALUE-BASED PAYMENT METHODOLOGIES

To prepare for value-based payment, some hospitals and health systems are pursuing a path of experimentation (e.g., with bundled payments), while others are pushing commercial carriers to move directly to shared savings arrangements. Experience with financial risk management and market environment appear to influence which path organizations take. The organizations pursuing shared savings arrangements tend to have more experience with financial risk management, with greater leverage in markets moving more aggressively toward value-based payment methods.

**Experimentation.** Many organizations interviewed are proactively positioning to experiment with different value-based payment methodologies, as a strategy to learn what is required to be successful in these different arrangements. This approach is emerging regardless of the current degree of market pressure to include value-based payment mechanisms in contracts. For example, UAB Hospital is proactively pursuing bundled payment arrangements. UAB pulled together a cross-functional team that used data from disparate sources to identify opportunities. The organization packaged a chronic obstructive pulmonary disease (COPD) proposal for CMS, which it plans to submit in June 2012. Additionally, leaders for the organization are meeting with UAB's major commercial carrier, Blue Cross, to push for a unique payment arrangement related to the COPD bundle.

At Longmont United, the BVCN will participate in CMS's bundled payment initiative with PROMETHEUS. The hospital will be one of just two providers in Colorado participating in this initiative. Longmont is now sending data to PROMETHEUS so that the vendor can help identify bundled payment opportunities, with a goal of finding three to five high-volume or high-cost areas with variation in care.

Novant Health's strategy is to approach value-based payment through experimentation, Hargett says. He noted that Novant is open to trying different types of value-based arrangements. The organization has negotiated numerous pay-for-performance arrangements already with commercial carriers while continuing to evaluate shared savings or episode-of-care payment arrangements.

**Shared savings.** Because of its long history in running its own health plan, Dean has tremendous experience in population risk management. The organization's goal is to pursue population-based payment methodologies. Its efforts to contract on a shared savings basis with a major local self-funded consortium has had some success through pay for performance, and the parties are discussing moving to gainsharing in the future. Dean has applied for the Medicare Shared Savings program, to begin in July. The organization is less interested in bundled payment or pay for performance, and is very willing to take full risk with payers.

Fairview Health Services, based in Minneapolis, has shared savings agreements in place with all four major commercial health plans in its market. Altogether, Fairview has roughly 300,000 patients in commercial shared savings arrangements. Additionally, Fairview has been approved as a Pioneer ACO, and anticipates that about 19,000 Medicare patients will be involved. Fairview is also considering methods of bundled payment; however, its primary focus related to value-based payment is population health management.

Effective Jan. 1, 2011, Advocate Health Care, based near Chicago, initiated a commercial shared savings arrangement with Blue Cross. Advocate CFO Dominic Nakis describes this as a deliberate move on Advocate's part to pursue population-based risk arrangements and to gain experience with this particular payment methodology. Additionally, Advocate has had capitated payments "for quite some time," through Medicare Advantage plans and other commercial HMO contracts, Nakis says. He estimates that about 275,000 lives are covered under these capitated arrangements. Advocate is not pursuing bundled payments.

Fairview and Advocate shared some common first experiences as they embarked on population risk management. Notably, each invested in care coordinators. Both are also learning how to analyze and act upon longitudinal claims data.

Daniel Fromm, Fairview's CFO, notes, "We want to receive patient-level claims data as frequently as we can get it." Some commercial carriers have been willing to provide Fairview with longitudinal data, and others have provided aggregated statistics. Fairview created an analytics function

within the finance department to work with these data; however, both finance and clinical staff review and use the data to assess aspects of care and cost (such as per-member, per-month costs for pharmaceuticals, total cost of care, and high claims management) and to find opportunities to manage patients well in lower-cost settings. They also try to use the data to manage capacity at a particular location.

Blue Cross sends Advocate complete longitudinal patient data for the patients attributed to Advocate in the shared services arrangement. Advocate invested in a population health management system in early 2011, which allows for the aggregation of total spend for each attributed patient across all healthcare providers, whether they are within or outside of the Advocate network. This in turn allows for data mining to find opportunities to deliver care across venues in more cost-effective ways, and identify higher-cost situations that can be managed by case managers. Advocate hired an actuary to work with the data, whose analyses are then shared with case managers.

A few organizations interviewed expressed reservations about shared savings arrangements and ACOs in particular because of the lack of accountability required of the patient. Leading organizations such as Advocate and Fairview are mitigating this concern by obtaining and analyzing as much longitudinal data as possible, and by experimenting with care coordinators to best meet the clinical service needs of patients participating in these shared savings arrangements.

Interviewees noted that tackling emerging payment methodologies created some stronger relationships within their organizations. Specifically, partnerships among contracting, finance and physician leaders were beginning to emerge. At UAB, efforts at defining episodes of care for bundled payment are tightening these relationships. At Longmont, some commercial carriers are proposing specific areas of focus, with associated payment arrangements; in these cases, contracting staff work with the quality improvement department to determine what is feasible.

# COSTING AND BUSINESS INTELLIGENCE INVESTMENTS

As provider organizations grapple with a future of reduced payment, a key issue is where to focus attention. Effective business intelligence and costing systems can help to identify internal trends of cost growth as well as facilitate comparisons to evidence-based standards of care.

Many organizations interviewed acknowledge that they require improved costing and decision support capabilities to be successful in a value-based payment environment. As noted previously, organizations surveyed are prioritizing clinical system investments, but they also anticipate dramatic improvements, particularly in their inpatient costing capabilities.

HFMA's costing and business intelligence survey revealed that most hospitals lack significant capabilities, particularly with respect to producing cost data per patient on a timely basis and over a defined period of time in an inpatient setting. Hospitals today have stronger capabilities to understand contribution margin by inpatient product or service line and to separate inpatient costs from overhead down to the patient level. Significant improvements are expected in these capabilities.

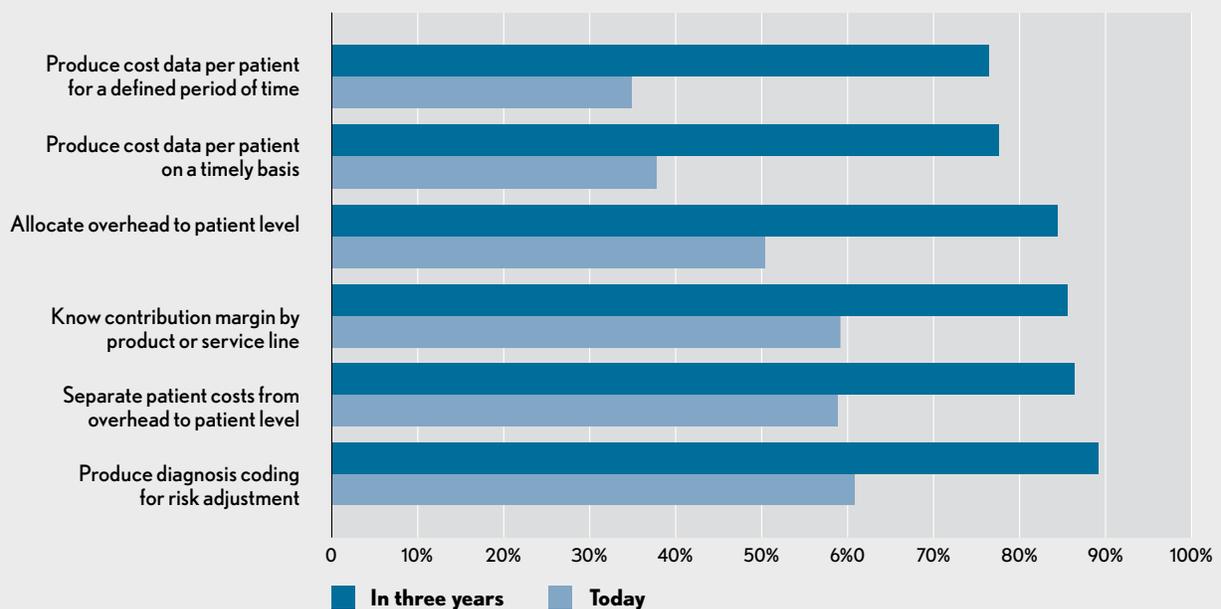
Those surveyed also anticipate dramatic improvements in their costing capabilities across care settings. The greatest degree of improvement is expected in outpatient costing. Several interviewees explained the lack of emphasis on costing capabilities in post-acute settings by noting that often, post-acute care is outside the walls of the organization.

Organizations interviewed clarified that improving costing systems with relatively less investment should be possible because the price of costing systems pales in comparison to clinical systems. Some hospitals are focusing on better leveraging the systems they already have in place through improved data mining.

Survey responses indicated that few organizations currently have capabilities that will be important for success in a value-based payment environment. Very small percentages of respondents today have significant ability to attribute per patient costs across the care continuum and few organizations are able to quantify the financial impact of quality improvements. This skill will be important as organizations determine how to reduce their cost structure over time to remain market-competitive. Fewer than 10 percent have significant capabilities to

## ANTICIPATED IMPROVEMENTS IN INPATIENT COSTING-RELATED CAPABILITIES

Percentage of survey respondents indicating moderate or significant capabilities today and in three years.



Source: HFMA Value Project Survey, February 2012.

assess profitability per physician, which is another capability required to understand organizational cost structure and network effectiveness. Survey respondents anticipate significant improvement in these capabilities in the next three to five years.

**Range of approaches.** The organizations interviewed represent a spectrum of approaches to costing and decision support capabilities. A general theme is that organizations working to improve costing capabilities are trying to move from “directional” data to more precise, granular costing data.

Fairview is trying to mine more from its current costing system. The organization’s costing system has been in place for many years, and it provides a rich hospital data set. Finance staff work with clinical managers on a regular basis to update RVUs. “This process has been in place for a long time. We’d miss it if it weren’t available to us.” They believe the costing data are both accurate and consistent. However, what Fairview lacks are costing capabilities related to physicians’

practices, whose costing information is not as sophisticated or detailed as it needs to be to determine financial performance by physician. Improving costing capabilities for physician practices is an area of focus for the organization. The CFO’s view is that the costing system can house the information; Fairview will focus on the processes, assumption sets, and allocation models needed to make improvements in this area. Additionally, Fairview is concentrating on building data warehouses and decision support capabilities that enable access to clinical, financial, and other data.

The University of Iowa has worked to update cost allocation tables in its existing costing system, with a goal of making the data more granular and accurate. For example, the University of Iowa has developed more specific allocations of utilities. Assistant CFO Mark Henrichs notes that the budget decisions they need to make using costing data are becoming much more consequential. “In the past, cost accounting systems were directional. As budgets get tighter, the precision has to increase.”

## TOWARD GREATER PRECISION IN COSTING

Costing inquiries are driven by the question of what needs to be answered with cost data—the cost objective. If the cost objective is determining whether payment for a unit of service (e.g., procedure, encounter, RVU) will be adequate, costing information must be developed related to that payment unit. If the objective is determining the impact of specific performance improvement activities, costing information needs to be developed around the process of care under study.

Other industries have developed sophisticated approaches to answer these questions because of increasing price pressure driven by purchasers. In health care, this pressure is intensifying. As University of Iowa Healthcare assistant CFO Mark Henrichs notes, “Budget decisions are becoming much more consequential. In the past, cost accounting systems were directional. As budgets get tighter, the precision has to increase.”

### From Directional to Precise

Narrowing the definition of the cost objective adds granularity to the cost information presented, but it also increases the time and expense of collecting the data. Provider organizations need to consider the costs and benefits of moving along the costing precision continuum.



Key components of precise costing systems include a clear delineation of direct and indirect costs. Direct costs are unambiguously associated with the cost objective. Indirect costs are everything that is not direct and are usually allocated to the cost objective in some general fashion. As an example of how costing can produce less directional, more precise data, consider how greater precision might be defined for the three major cost categories below.

Cost Category	More Precise Definition
Indirect and Overhead	Rationally allocated based on actual usage (e.g., an OR uses far more electricity per square foot than a standard patient room)
Direct Labor	Applied at a cost objective level using, for example, a time-driven activity based costing approach
Direct Supply	Through the requisition system, accurately charging for all items consumed at the cost objective level

## WHY PRECISION MATTERS

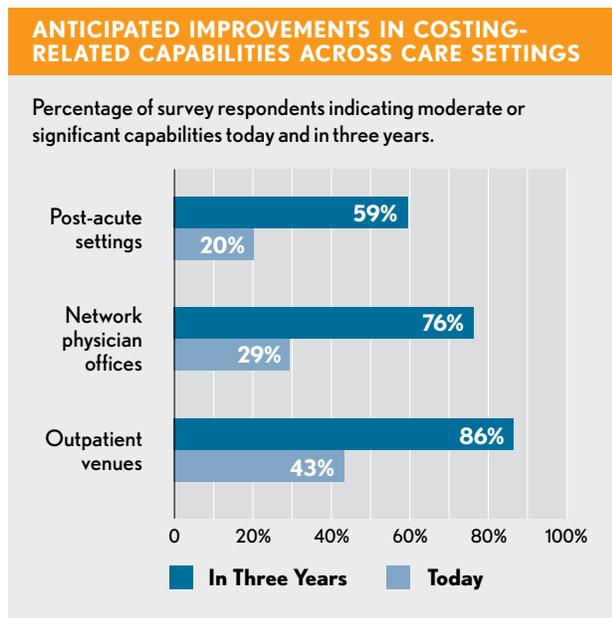
Below are some examples of decisions that more precise costing data will help support as organizations work to improve the quality and cost-effectiveness of care.

Costing Object	Purpose	Why Precision Matters	When Used?	Considerations
Service line analysis	Determine contribution to margin/profitability per service line	Need to understand which services lines generate actual profits or losses	Evaluating organization's cost structure or service line strategy	Precise data on all three major costing categories is essential to determine true profits or losses
Physician practice pattern variations	Identify performance improvement opportunities  Quantify financial impacts of performance improvement initiatives	Costs of actual supplies used can vary significantly among physicians—need actual costs on a per-case basis  Must know if expenses involved in improving performance are matched or surpassed by cost savings	Under any payment method—from DRG to capitation—to optimize margin or profitability	A focus on direct costs will be most useful in this analysis
Profitability per physician	Determine resource allocations	Get physician alignment strategy and compensation structure right	DRG or bundled payment systems	Indirect cost and overhead allocation can greatly impact findings
Bundled episode of care or DRG (commercial carrier) margin analysis	Pricing payment for the bundle/DRG	More precisely calculate average cost per case to ensure adequate margin/profit per episode or DRG	In a pricing-competitive marketplace	Allocation across episode may differ based on venues within bundle
Cost-effectiveness per provider	Determine care allocations	Make sure utilization is focused on most cost-effective providers	Shared savings, capitated, and global payment systems	Although computation of costs may differ by provider type or venue, computation should be consistent within a venue (e.g., all outpatient facilities) so valid costing comparisons can be made
Total cost of care per patient across the continuum	Identify patients who may need better coordinated care or additional services support  Analyze the financial impact of treating chronic condition patients to develop strategies for managing utilization and minimizing costs.	Make timely interventions in patient care to improve outcomes and cost-effectiveness	Shared savings, capitated, and global payment systems.	Costs for contracted providers are not relevant, except to the extent they drive the price charged to the contracting organization.  Organizations will want to determine per patient utilization of contracted providers to identify opportunities for better care management.

UAB has aggressive plans to improve and maintain its costing and decision support capabilities. The organization invested \$1.5 million in cost accounting systems and improved decision support. The new systems went live in late April. The cost accounting systems will house labor, supply, overhead, and “catchall” costing data to cover all aspects of UAB operations. For inpatient data, UAB is conducting time-motion studies to make the RVU estimates more specific to UAB, and is refining its supplies cost schedule and assumptions related to overhead allocation.

Finance staff will audit these schedules on a regular basis to ensure the accuracy of the data. For physician office data, UAB uses a blend of general ledger allocation and more specific costing data. The decision support system contains cost, quality, and patient satisfaction data, with clinical data spanning pre-admission to post-admission. Analytical staff was trained to query the decision support system.

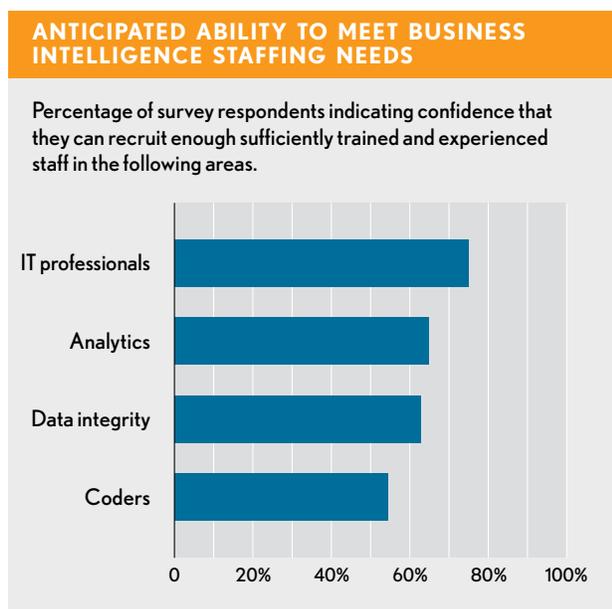
**Differing views and approaches.** A couple of the interviewees pointed out that their organizations are investing in costing capabilities not specifically because of transitioning



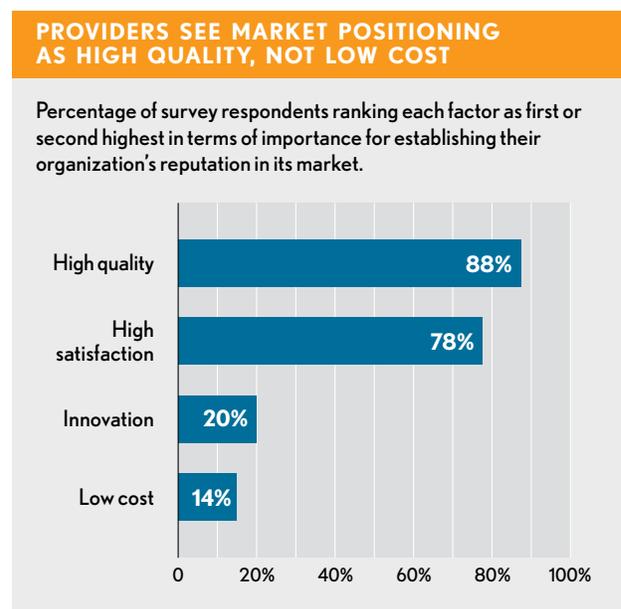
Source: HFMA Value Project Survey, February 2012.



Source: HFMA Value Project Survey, February 2012.



Source: HFMA Value Project Survey, February 2012.



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payment methodologies, but rather because organizations will experience reduced revenues. One interviewee noted that his organization will invest in cost accounting capabilities “to get to the level of granularity in cost data that we’ll eventually need to run our business.”

A few interviewees questioned the need for better cost accounting. One commented, “We are generally satisfied with our cost accounting systems. How is cost accounting going to help us?” Another stated, “Costing is not a pressing issue. I feel as if we know where we need to go.”

Some organizations are deemphasizing investment in costing and business intelligence capabilities and instead putting more organizational energy now toward engagement of front-line staff and aligning with physicians. These change management efforts are geared toward creating a culture that embraces value improvement and is well-positioned to execute on improvements in care delivery. An example is Novant, which, as noted, is focusing on creating cross-functional forums to identify and execute on opportunities to improve care delivery and is deemphasizing investment in costing until some point in the future.

**Staffing.** To some degree, concerns about staffing—both in regard to volume and capabilities—varied by type of facility and market. For example, a rural hospital CFO in the Pacific Northwest indicated his facility is sufficiently staffed with coders and felt that this was a function that could be outsourced. However, a larger facility in Boston observed, “There are not enough coders to go around.” Of greater concern to rural hospitals is their ability to recruit an appropriate number of skilled data analysts. Across provider types and markets, survey respondents and interviewees expressed the greatest degree of confidence in finding the IT staff necessary for future operations.

## ANTICIPATED OUTCOMES

Although the future of health care will be defined by reduced revenue and investments in capabilities to improve cost structure, survey respondents overwhelmingly aim for their organizations’ reputation to be based on high quality, not low cost.

Those who participated in interviews following HFMA’s value metrics survey clarified why they believe a reputation of quality is paramount.

“Nothing trumps quality,” says Mark Henrichs, assistant CFO at the University of Iowa. “If you say you are the

low-cost provider, you scare people away.” In three to five years, Henrichs believes healthcare organizations will see more customers purchasing on the basis of cost, but “This is not happening today.”

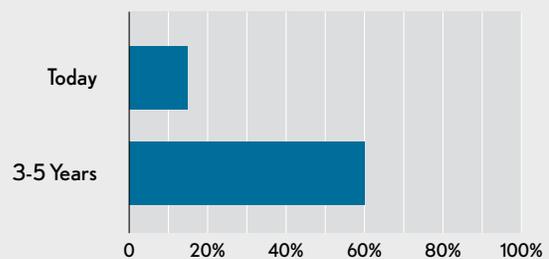
One CFO of a multi-hospital system noted that being “low cost” is not a good marketing point for hospitals and health systems. “It doesn’t draw patients,” she says. “Patients want to hear about quality.” She indicated it will be about five years before there is a sufficient level of transparency and cost pressures at the patient level for patients to use that kind of information in their decision making. The CFO of a rural facility agreed: “If our hospital doesn’t have a reputation for quality and satisfaction, we will not get return business; it would go instead to a hospital 20 miles away.”

One rural hospital CFO indicated that affordability is second on his list, behind quality, as cost “is a significant concern for our patients.” During a series of interviews, HFMA encountered examples of hospitals that are purposefully aiming for a lower-cost position in the market with respect to contracts negotiated with payers. Most, however, aim to be at price parity with the market. As one CFO explained, “We charge what the market will bear.”

Survey respondents expressed confidence about the future of their organizations. Sixty percent predict an increase in market share in a three- to five-year period. This finding appears incongruent with external stakeholders’ efforts to reduce inpatient utilization. As one interviewee noted, “There will always be a need for bricks and mortar, but I would not expect more patient utilization in the future.”

### IMPACT OF COMMERCIAL CARRIERS’ USE OF QUALITY AND COST DATA ON PATIENT UTILIZATION AT YOUR ORGANIZATION TODAY AND IN 3 TO 5 YEARS

Percentage of survey respondents anticipating a positive impact from commercial carriers’ use of quality and cost data to encourage patient utilization of certain providers.



Source: HFMA Value Project Survey, February 2012.

# RECOMMENDATIONS

Research conducted in Phase 2 of HFMA's Value Project reveals a marketplace environment in transition, with myriad quality metrics and a strong desire on the part of purchasers and payers for more efficiency and functional outcomes metrics. Payers intend to purposefully experiment with value-based payment methodologies over the next several years, developing an array of approaches to encourage providers to accept greater financial risk over time. New payment approaches and performance measures are geared toward facilitating provider-led efforts to streamline care delivery.

Although initial value-based payment arrangements offer providers opportunities to share or retain savings or earn incentives, the ultimate goal of these approaches is for savings to accrue to healthcare purchasers, thereby creating value for the customer. It is expected that these payment models will evolve over time, and that, to be successful, providers will need to demonstrate their ability to deliver quality care at a lower price to the purchaser.

In simultaneously managing today's dynamic environment and preparing for a future of risk-based payment, providers are utilizing technical and change leadership skills to transform care delivery while investing in capabilities to drive performance improvement. Moving forward, we recommend that provider organizations take the following steps to position for success in this emerging payment environment:

**Recommendation No. 1: Do not delay in developing the four value-driving capabilities required to adapt in a new payment environment.** Phase 1 of the Value Project identified four key capabilities required for success in the emerging payment environment (see the sidebar at right). Research conducted to date in Phase 2 of the Value Project further validates that organizations are preparing for payment changes by developing these capabilities. Particular steps that leading organizations are taking now include the following:

- Developing change management capabilities to prepare an agile workforce and organizational culture (people and culture)

- Establishing strategic plans with incentives to align organizations to the most important goals (people and culture)
- Cultivating physician leadership (people and culture)
- Implementing clinical decision support systems/EHRs (business intelligence)
- Refining costing capabilities to move from a directional to a more precise view of costing data (business intelligence)
- Identifying variations and work on standardization (performance improvement)
- Developing the ability to mitigate risk by understanding population-specific drivers of utilization and cost under risk-based contracts and identifying actionable leverage points for influencing these drivers (contract and risk management)

HFMA's research indicates that, although value-based payment is just emerging in most markets today, the majority of organizations are taking proactive steps to ready for this new future. Some are articulating organizational goals aligned with value improvement, and determining mechanisms to incentivize focus on the most critical initiatives. Most are anticipating that improvements in care delivery processes and structures will be the primary vehicle by which they deliver greater value, and are investing in clinical and coding capabilities. Many organizations are establishing

**THE FOUR VALUE-DRIVING CAPABILITIES**

- **People and culture:** The ability to instill a culture of collaboration, creativity, and accountability
- **Business intelligence:** The ability to collect, analyze, and connect accurate quality and financial data to support organizational decision making
- **Performance improvement:** The ability to use data to reduce variability in clinical processes and improve the delivery, cost-effectiveness, and outcomes of care
- **Contract and risk management:** The ability to develop and manage effective care networks and predict and manage different forms of patient-related risk

or leveraging internal forums to identify and act upon opportunities to improve clinical care. To be effective, these types of forums typically require physician leadership, alignment, and buy-in, as well as engagement by front-line staff. Developing staff capabilities to be involved in performance improvement is a priority in many organizations.

Most providers are assessing their costing and decision support capabilities and determining how best to ensure the breadth and depth of data they need to identify clinical improvement opportunities, ensure physician engagement in these improvement efforts, and measure results.

Organizations are first ensuring the consistency of their costing data, and many are investing further to achieve the precision and appropriate granularity in these data that increasing price pressures and new payment methods might require. Organizations also are determining what analytical skills and resources are necessary to utilize the data to help drive decisions.

An organization that has not yet begun to assess the impacts of the shifting payment environment is at risk of lagging the market. Beginning the process through scenario analysis, financial planning, and board discussions are good initial steps. Additionally, assessing the current state of capabilities required, as described in the HFMA report *Value in Health Care: Current State and Future Directions*, is important.

Leading organizations are not only assessing what capabilities they need, but also determining how best to balance and sequence them as they navigate the emerging payment environment. Some organizations are placing more emphasis on physician alignment and front-line engagement and development, for example, while others are more focused on technical capabilities such as decision-support. Although business intelligence, contracting and risk management, performance improvement, and emphasis on workforce are all important in the emerging payment environment, leaders should assess how best to organize these efforts based on the capabilities of their organizations and their markets.

**Recommendation No. 2: Embrace strategic agility for your organization.** Become comfortable with ambiguity and with learning from both successes and failures as your organization experiments with change. Simplify organizational structures and decision-making processes to empower front-line staff to seek solutions. Balance

a culture of accountability with a culture of creativity (i.e., while managers should be held accountable for targets, they must also be encouraged to create/innovate).

In today's dynamic market environment, it is important for organizations to develop the ability to be strategically agile—that is, to lay the foundation to change course successfully, and sometimes quickly, as strategies evolve. Leading providers are developing strategic agility in different ways:

- Many providers are proactively readying for a variety of payment methodologies, intending to experiment as a way to gain knowledge about what it takes to be successful under these new payment arrangements. Providers purposefully embarking on a path of experimentation with payment models are determining what level of detail is required in their costing data and whether that level of detail can be obtained through improved data mining, better maintenance of costing data, or investments in new costing systems.
- Many organizations are pursuing ways to foster greater physician engagement in improvement efforts. Numerous provider organizations are creating internal cross-functional forums to identify initiatives, execute them and measure results. To ensure physician participation, some providers are paying physicians to participate in these forums, and discussing what kinds of incentive structures best align physicians to these efforts. Some organizations are determining how best to involve contracted physicians in improvement activities. For example, the Dean Value Contract utilized by Dean Health specifies that contracted providers must achieve performance on patient satisfaction, total cost of care, clinical quality, and generic drug metrics.
- Provider organizations are creating opportunities and environments in which front-line staff are empowered to identify and act on initiatives to improve and streamline care delivery. Key to fostering this engagement is leadership's acceptance that some performance improvement initiatives will fail while others succeed; the emphasis is on failing fast, extracting key lessons, and using that knowledge in the next iteration of experiments. *Value in Health Care: Current State and Future Directions* offers examples of two health systems—Sharp HealthCare in San Diego, Calif., and Bellin Health in Green Bay, Wis.—that have developed processes for periodic evaluation of programs to identify successes and failures so resources can be redeployed to pursue more promising opportunities.

- Shifting care to lower-cost settings and other market dynamics create financial vulnerabilities for hospitals. The most successful organizations of the future are now beginning to create flexibilities in their operating structure (e.g., by concentrating on fixed as well as variable cost reductions and by designing facilities in purposefully modular fashions).

Organizations that are proactively experimenting with different payment methods, aligning with physicians, empowering staff, and discussing ways to create more nimble infrastructure are beginning to develop more agile cultures. As healthcare leaders know, it typically takes a long time to change cultures. These are important first steps to position healthcare organizations for success in a highly dynamic environment.

**Recommendation No. 3: Seek stakeholder alignment around a common set of value metrics that are meaningful to their intended end users.**

Given widespread acknowledgment of CMS’s leading role in developing value metrics, in the near term, provider organizations should use contract negotiations with commercial carriers to push for alignment of contract value-based metrics with CMS value-based metrics. Recognizing the limitations of current metrics, longer term, all stakeholders should embrace the refinement and adoption of value metrics consistent with the following guidelines for the development and use of value metrics suggested by the Value Project’s Phase 2 research:

- Work to replace process metrics with patient-centered functional outcomes.
- Align value metrics with the “triple aim” of improving care for individuals, improving the health of populations, and reducing the per capita costs of health care.
- Focus on a limited set of metrics to drive performance.
- Use payment incentives and penalties selectively, emphasizing performance on metrics that have been proven or stakeholders agree are most likely to drive the most desirable quality or cost outcomes.
- Report provider-specific performance to end users in a way that is understandable and actionable.

External stakeholders, including employer organizations, CMS, and commercial carriers, acknowledge that expecting providers to focus on too many performance

metrics at one time can diffuse focus and effectiveness. Providers, too, emphasized this point.

Virtually all hospitals are now participating in CMS’s value-based purchasing program. The performance standards required for incentives in this program can serve as a useful starting point for providers in their negotiations with health plans on what types of performance metrics to include in commercial contracts. Leveraging already-required metrics in this manner will help providers focus more effectively on fewer performance standards.

Longer term, value metrics will require refinement. HFMA advocates that value metrics be refined consistent with principles including working to replace process metrics with more outcomes-oriented performance indicators, aligning value metrics with the goals of IHI’s “Triple Aim,” and focusing on a limited set of influential performance drivers. The National Quality Strategy is an emerging framework of quality metrics that may, over time, serve to align stakeholder interests in performance improvement.

**Recommendation No. 4: Explore strategic partnerships and opportunities with payers, employers and patients in your service area.**

For commercial carriers, action items could include:

- Partnering to identify opportunities to improve care and contain costs in employer-sponsored insurance, individual insurance, and Medicare Advantage plans
- Developing chronic disease management programs

For self-funded employers, action items could include:

- Working to understand/define employer goals for employee health (e.g., smoking cessation, weight reduction, exercise) and productivity (e.g., days absent for illness of employee or family member)
- Developing on-site workplace clinics
- Developing chronic disease management programs

For the benefit of patients, action items could include:

- Incorporating patient perspectives in operations and planning (e.g., patient advisory councils)
- Compiling data on patient expectations and actual outcomes for common procedures and using these to set patient expectations and track performance
- Establishing partnerships with other community health partners (e.g., physicians, social services agencies, etc.) to support desired patient outcomes

Depending on its market environment and internal capabilities and capacity, there may be an opportunity for a provider to improve care in partnership with commercial carriers, community health leaders, self-funded employer purchasers, and patients. For example, a provider could examine available clinical and financial data specific to its patient population to identify areas of concern, such as obesity, excessive use of the emergency department, or overuse of services within a clinical department. Community leaders or an influential area employer also could approach a commercial carrier with a proposal to jointly focus on improving care in a specific area; this could be an effective way to prepare for value-based payment while forging new strategic partnerships.

Many organizations contacted for this project are proactively finding ways to identify and act on strategic improvement opportunities of highest importance to their patient populations. For example, Longmont United Hospital of Longmont, Colo., is working with other local community providers to meet the healthcare needs of the area school district and other large employers. This arrangement better positions Longmont United to identify and act on opportunities to improve care in partnership with important purchasers.

Some providers are working directly with patients to obtain their input on and prioritize care delivery improvements. For example, as noted in HFMA's report *Building Value-Driving Capabilities: People and Culture*, Spectrum Health has established a patient advisory council to engage patients directly in performance improvement.

Depending on an organization's internal capabilities and capacity as well as its external market environment, an opportunity may exist for a provider to be proactive in approaching local purchasers about outcomes measurement. Employers are particularly interested in outcomes as a measurement of value, and the market is lagging in providing these data, particularly on a severity-adjusted basis. A provider may have a unique opportunity to provide leadership and influence in this area by identifying, defining, and demonstrating performance on outcomes.

Further, pursuing outcomes measurement creates a unique opportunity to involve patients in defining expectations related to return to functioning.

**Recommendation No. 5: Prepare to differentiate the effectiveness of care provided by your organization within a value-driven, competitive marketplace.** Be explicit about the value equation (quality in relation to total payment for care) that your organization intends to offer the market. Shift the organization's focus from procedure-based pricing to total payment for care. Ensure that the benefits of your delivery system are seen and enjoyed by purchasers (i.e., maintain focus on value through the purchaser's perspective).

Although the degree to which the insurance exchanges and other market dynamics will drive purely price-sensitive purchasing in health care is uncertain, research conducted through HFMA's Value Project confirms that the price of health insurance and health care is of escalating concern to purchasers. With the increasing availability of provider-specific quality and efficiency data, purchasers will be armed with the information necessary to determine provider networks and drive decisions at the point of care. As price sensitivity escalates, these decisions will likely be based more on price over time.

Given these market dynamics, provider organizations should be thoughtful about the value proposition they intend to offer purchasers. In many organizations, the optimal position will most likely involve the capability to demonstrate lower total cost on the array of services provided. Other providers may opt to maintain a higher price position while carefully defining the factors (e.g., better clinical outcomes or higher levels of patient satisfaction) that accompany the higher price. If much better quality comes at a slightly higher price, a purchaser can still enjoy value provided that the higher price position is acceptable.

Providers that heavily cross-subsidize across payers should bring a laser focus to this effort. Market dynamics such as escalating price sensitivity across payers, employers' increasing understanding of the impacts of cross subsidization, and regulators' authority to influence plans available

on insurance exchanges suggest that significant cross subsidization will not remain a viable financial strategy for long.

It is important that providers that heavily cross-subsidize across payers objectively analyze and segment each customer base to do the following:

- Understand what value equation is viable in each market segment
- Determine which patient segments should remain as part of the provider's patient base in the future
- Determine aggressive plans to accomplish that end state

Recognizing that it will take time to transition to the leaner cost structure that will likely be required to reduce cross subsidization, providers should work with state and federal regulators and representatives to explain the challenges, implications, and multi-year plan to minimize cross subsidization.

Providers have work to do internally and externally to ready for this future. As noted, providers should be explicit about the value equation (quality in relation to total payment for care) that they intend to offer purchaser segments, and should focus internal efforts toward that goal. As noted, decision support and analytical capabilities, an engaged workforce, improved contracting capabilities, and performance improvement skills are necessary to develop a more streamlined and flexible operation.

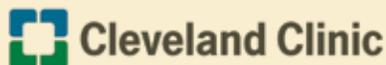
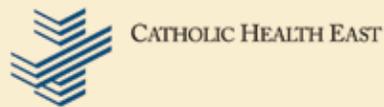
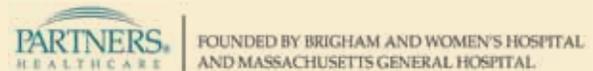
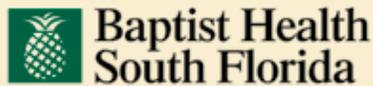
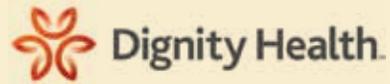
Providers also should begin to engage in internal discussions about the steps necessary to transition successfully from a "quality" reputation to one based on "value." Many providers already realize that higher cost to the purchaser often indicates lower quality due to overtreatment. Externally, provider organizations would be well served to begin discussions in their communities about how, in health care, there is little relationship between high quality and high cost of care. ■



## RESEARCH SPONSORS

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### **HFMA'S VALUE PROJECT: PHASE 2 DEFINING AND DELIVERING VALUE**

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