REFORM IS A MARKET ISSUE

Rick Wesslund, Founder and Chairman, BDC Advisors, LLC

Often lost in our national discussion about health reform is the fact that health care delivery is a market. There are buyers and sellers. The federal government is the largest buyer in this market as well as the regulator of the market. What has become clear since the passage of PPACA is that other purchasers in this market seek similar results as the federal government – but will likely move faster and be more innovative as they seek to buy care based on ***value*** not just price. Sellers (hospitals, physicians, health systems) will discover that the most efficient way to organize for value is to clinically integrate, and to take contracts that drive private practice physicians and hospitals to work together to deliver value to the buyers.

PPACA is the government response to deep and long standing problems in the market for health care services: many of our citizens cannot afford to enter the market and we see increasing numbers of uninsured. There has been an unsustainable cost escalation, and buyers see little connection between the price and the quality of the care delivered.

Four components of PPACA illustrate this:

- **Coverage Reform** puts everyone into the market for health care by mandating that everyone be covered by insurance, and extending subsidies to many Americans who are not getting coverage through work. This has proven highly controversial and will only be resolved by the US Supreme Court.

- **Delivery System Reform.** The proposed regulations issued by CMS on Accountable Care Organizations and the Medicare Shared Savings program may prove unworkable – but all the buyers in this market (commercial health plans, state governments, employers and individuals) are demanding that providers address efficiency, cost, and effectiveness deficits. The primary tools already being employed in the delivery market are Clinical Integration and Patient Centered Medical Homes.

- **Payment Reform.** In 2012, the Medicare Hospital Value Based Purchasing (VBP) program will cover all acute care providers, and in future years the program will expand to cover outpatient care. CMS describes the VBP as the latest stage of the evolution of CMS from *a "passive payer of claims*

based on volume to an active purchaser of care based on the quality of care beneficiaries receive." Under the VBP, providers will for the first time be paid a portion of their inpatient Medicare revenues for meeting specified quality goals – clinical and patient experience – not just on the volume of cases they treat.

- **Quality Improvement**. A hospital admissions reduction program for preventable Medicare inpatient hospital admissions starting in FY 2013 which can reduce payments by one percent for targeted cases and up to 3% in 2015 and subsequent years. Starting in 2015, hospitals in the top quartile for risk adjusted hospital acquired conditions (HAC) will have their payments reduced by another one percent.

While many of the regulations resulting from PPACA are still to be revealed – the underlying drivers are clear. Cost must be addressed. Quality and patient experience of care are on the table, and there is an imperative to reduce the number of uninsured.

Reform is now a market issue – because the market is demanding a system that delivers value. The health care delivery system needs to act on both organizational and payment reform. This fact forms the agenda for both providers and commercial payers in today's market.

Towards a Value-Based Business Model

Ironically, while we are far from having a consensus on the PPACA, the actors in the healthcare delivery market do have answers on how to move forward.

- **Clinical integration and accountable care are the DNA of a value based business model.** There is general support in the provider community and among insurers for the principals of clinical integration and "accountable care" as the primary vehicle for delivery system reform. There is also general support for the concept of Patient Centered Medical Homes (although the financing mechanisms still need work) which are proving in early demonstrations to both improve care and reduce costs – and which can be a building block for accountable care.

- Experience from early clinical integration efforts indicates **motivated physician and executive leadership are the most important determinants of success** – a variety of organizational structures can work, so long as there is a clear perspective on the need for change and shared consensus on goals.

- **The health care market is open to reform**. There is a growing understanding of the need for payment reform which encourages care delivery to be organized around customer needs and value – and which links financial rewards to better care, improved health, and lower costs.

- **Organizations are learning how to "bend the cost curve" by organizing around customer value without sacrificing quality or service**. There is general support for the concept of "shared savings" between providers and insurers which can be the financing vehicle for "accountable care" and value based contracting.

- **The Medicare reductions in DRG payments as part of the VBP, and future penalties for hospital readmissions, or hospital acquired conditions (HAC), pose real risk for underperforming providers and will serve as a catalyst for further reforms.**

As a result, developing a value-based business model is no longer just one of several strategic options for most organizations. It has become ***the*** strategic priority on which organizations must focus if they are to be successful going forward.

Clinical Integration is the Core of a Value-Based Health System

Value-based care is predicated on growing evidence from a variety of markets that clinically integrated systems can simultaneously impact patient satisfaction and clinical outcomes – while reducing costs associated with waste and inefficiency.

If properly executed, a Clinically Integrated Network (CIN) can be the "do no harm" business model that supports a full range of payment mechanisms from fee-for-service, to pay-for-performance, bundled payments, shared savings or full or partial capitation.

Advocate Physician Partners in Chicago is a good example of a large, physician-led organization making the transition from a "fee-for-service to a fee-for-value model." APP has a clinically integrated business model, and pay-for-performance (P4P) contracts with all of its commercial insurers based on a clearly defined set of quality metrics. They are distributing an additional $50 million this year to about 3,900 physicians that are part of its network to reward them for meeting quality targets, and the extra work it takes to make a clinically integrated system work.

As APP's CEO, Lee Sacks, M.D. said recently, "Physicians like clinical integration because it makes it easier for them to demonstrate the quality of care they provide and simplifies their quality reporting requirements." It is hard to imagine a health care delivery system in 2015 that will not have hospitals and private practice physicians closely connected in some form of CIN.

Clinical Integration Does Not Depend on the Government

Government action has been an important catalyst in motivating providers to begin to move towards clinically integrated health systems. The real innovation engine, however, will be commercial insurers – who are innovating because the same pressures that are driving government action also are impacting commercial payers:

- Medical costs are increasing far in excess of overall inflation with premium increases >15% seen in most markets threatening the sustainability of core commercial book of business.
- Insurance companies are under increasing pressure to justify value to their customers since increased pricing transparency and incentives prompt patients to shop for lower cost health care.
- There is a need to maximize heavy investments in infrastructure technology that most payers have already made.

Private insurers have started to “change before they have to” to paraphrase GE’s Jack Welch. HealthNet, Aetna, Cigna, WellPoint and UnitedHealthcare have all established payer-provider collaborations. Blue Cross of Illinois recently announced a Total Cost of Care Contract (TCOC) with Advocate Physician Partners in which they will receive a share of the savings for the care provided by network physicians as compared to physicians in the community not in the network. Similar TCOC contracts have been signed between the major providers and payers in the Minneapolis market, and in Massachusetts, where the Blue Cross Blue Shield Alternative Quality contract has been signed by more than a dozen providers (covering over 500,000 members).

While these experiments vary in size and scope, they have been put in place with rapidity unimagined by government and structured to provide early successes for physicians and providers who have signed up for the work.

Final Thoughts

For providers, measuring and improving the value delivered to the buyers in our market is the greatest challenge facing our industry. In turn, commercial payers need to improve value to their customers (employers and individuals).

For delivery systems, this will ultimately require a fundamental change in mindset to focus on population health and wellness at the health system level – as well as in developing new cooperative relations with payers. The commercial payers, in fact, are likely to emerge as the financial engine that will fund both the early adapters and fast followers of initial clinical integration efforts since the commercial payers are far more nimble (and easier to deal with) than CMS.

CMS has set a goal of an underlying inflation rate of 1% annually as its target. Private insurers have similar objectives to “bend the cost curve.” This means reducing revenue growth overall and shifting revenues towards providers and intermediaries who can demonstrate their value.

For systems in competitive markets, this slowing healthcare inflation will require a laser like focus on increasing market share, but market share increases will only come from

demonstrating superior value. Clinical integration appears to be one of the best available strategies for accomplishing this goal.

The trend towards value-based payment creates a market challenge. Providers who are not able to demonstrate value will lose share to those who can – and physicians who are not allied with a clinically integrated network will not be able to share in the performance incentives and shared savings which are built into payment reform because there will be no way to measure their quality or cost performance.

Many organizations have already started down the road to clinical integration. Regardless of when you started, you will need to have positive answers to five important questions to have favorable odds for success.

- Does your leadership team – boards, physicians and executives – have a unified perspective on the pace and intensity of the movement which will be required to move towards a value-centered business model?
- Is your organization ready and willing to embrace a fundamental change in your relationship with payers in order to provide the financing necessary to make a value-based delivery system work?
- Do you have a business model and infrastructure that will allow you to both measure and improve quality and cost – and which will enable you to address the entire continuum of care?
- Do you have a clear idea of who your most economically valuable patients are, and have a plan for engaging them and building your share of their business?
- Is your change effort actually being physician led or are they mainly observers in the process?

Failure to have a positive answer for all five of these questions will place your organization's strategic position at risk, but if your organization has successfully addressed these issues (and have adequate resources in place) then you are on the right path. Persistence and determination will be what you need most to finish the job.

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For more information, contact Rick Wesslund, Founder and Chairman,
BDC Advisors, LLC at 305-873-8750, or rick.wesslund@bdcadvisors.com.