REPRINT DECEMBER 2012

hfm
healthcare financial management association hfma.org

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delivering value to multiple stakeholders 2013 and beyond

Four strategies can help payers and providers give their customers more value for the dollar as healthcare reforms emerge over the next few years.

Hospitals, physicians, and payers are facing greater pressure than ever to deliver more value for the dollar. As we enter 2013, a variety of factors—including programs administered by the Centers for Medicare & Medicaid Services (CMS), state reforms, and increased competition for patients facing increased personal responsibility to cover their own healthcare costs—are combining to make not just promising, but also *delivering* value to patients a strategic priority (see the sidebar on page 2).

With value as the new imperative in this era of cost containment and soft volume growth, where should an organization begin? Top payers and providers are employing four strategies to deliver more value for the dollar:

> Measuring value (defining the value metrics payers and providers should measure and manage)
> Creating value (determining how best to continuously create value at the point of care and the point of health insurance enrollment)
> Packaging and pricing value (determining how to develop products and price them to optimize the organization's margin, market share, and mission)
> Organizing for value (designing the organizational structure to ensure it will excel in delivering valuable products and services to the market, so it is a "must have" payer or provider over the long term)

Success Factor No. 1: Measuring Value

Whether an organization is a payer or a provider, it should measure and manage value by first defining what its business partners and end customers want.

To attract business partners such as physicians, top health systems tend to express their value in terms of structural metrics (such as a seat on a committee or a clinical directorship role) and process metrics (such as on-time operating room availability or adherence to a clinical rule set for diabetics). Payers use similar metrics to qualify providers most capable of succeeding in a high-performance contracting network. Hospitals and

AT A GLANCE

To deliver greater value, top payers and providers should:

> Measure the value they deliver to their business partners and customers
> Create value through continuous performance improvement
> Package and price value to optimize their margin, mission, and market share
> Organize for value through new legal entities, employed medical groups, or both

physicians also use these process and structural metrics to fix key care gaps and prioritize capital investments, such as new electronic health record (EHR) functions.

But are these metrics sufficient to measure and manage value for patients? When it comes to improving value, many believe that these process and structural metrics are not nearly as helpful as tracking *health outcomes* relative to price.

Factors Driving the Industry's Increasing Focus on Value

Among the factors that are causing healthcare providers to view the delivery of value to patients as a strategic priority, the following four are playing a predominant role.

The Hospital Value-Based Purchasing Program administered by the Centers for Medicare & Medicaid Services (CMS). The hospitals participating in the Hospital Value-Based Purchasing Program began to receive incentive payments on Oct. 1, 2012. Those incentive payments were based on the hospitals' performance from July 1, 2011, to March 31, 2012. CMS estimates that roughly half of participating hospitals will receive a net increase in payments as a result of this rule, while the rest will receive up to a 1 percent net decrease in payments in FY13.

State reforms. Some states (such as Maryland) have already implemented potentially preventable complications (PPCs) payment adjustment factors for excessive complications (www.hscrc.state.md.us/init_qi_MHAC.cfm). Other states are planning to implement payment adjustments for excessive readmissions and complications in upwards of 2.5 to 5 percent of total inpatient expenditures and 1 to 2 percent of total hospital expenditures.

CMS Physician Quality Reporting System (PQRS) and incentive program. Under Section 3002 of the Affordable Care Act, physicians will face a 1.5 percent penalty for nonparticipation in the physician quality reporting system starting in 2015. Under section 3007 of the act, CMS will also begin applying a value-based payment modifier to its physician fee schedule starting in 2015 based on 2013 performance.

Increased patient costs and competition. On Main Street America, increasing patient out-of-pocket costs and competition for patient loyalty require payers and providers to be much more deliberate about delivering value to both business partners and customers. Simply creating a "me too" value proposition (such as "we will deliver high-quality, low-cost service to patients and steer new insured lives to our partners") with no follow-through will not fly with patients or business partners.

Unfortunately, health outcomes are more difficult to capture. But that's beginning to change. An increasing number of payers and providers are using a multipronged research agenda that includes focus groups and individual interviews, randomized sample-based surveys, and descriptive modeling techniques to pinpoint the "value drivers" of patient choice and behavior. One such modeling technique is regression, which researchers are using to isolate the factors that lead to more cost-conscious behavior changes by clinicians and patients at the time of enrollment and point of care delivery.

So far, the research and models show that patients most value (and are most likely to choose) providers, payers, and treatments based on:

> Confidence in their anticipated medical outcomes, such as functional improvements and avoidance of complications
> Past satisfaction or dissatisfaction
> Cost, including dollars and "down time" associated with recovery
> Level of trust in the payer or provider

Yet these four metrics inconsistently appear in providers' and payers' consumer-oriented websites, dashboards, or internal incentive systems. So to differentiate value for their customers, payers and providers need to experiment with new ways to measure and reward value. Here are a few examples of potential value metrics:

> An outcomes metric that tracks patient confidence in, and ultimate adherence to, the treatment plan
> An outcomes metric that tracks the organization's ability to deliver high-quality care with 10 to 15 percent fewer resources (e.g., lab tests, images, surgical procedures) than in the past, and at a total cost that is also 10 to 15 percent lower—or that is trending to that level
> True functional outcome metrics, such as improvements in pain, vitality, physical functions, and mental health, using industry standards, such as the Short Form 36 (SF-36) Health Survey

Success Factor No. 2: Creating Value

With a common set of value metrics in place, payers and providers can focus on better strategies to create value for their customers. One such strategy for payers and providers is to adopt a collaborative approach to continuous performance improvement. Why is this needed? Many payers and providers get lax after a cycle or two of traditional, independent "Plan-Do-Check-Act" (PDCA) improvements within their own organizations. They also tend to focus their efforts in areas where improvements come most easily, such as the supply chain, the revenue cycle, and patient throughput. Although this approach helps to trim costs for a short time, it's not enough to reduce systemic costs and deliver value over the long term. And although many organizations blame their inability to achieve more substantial cost, quality, and access improvements on poor data, limited resources, or organizational misalignment, this shortfall is often due to a lack of continuous focus on the metrics that matter most to business partners and end customers.

Fortunately, an increasing number of forward-thinking payers and providers are focused on a collaborative approach to continuous performance improvement. First, they are tackling unwarranted variations and avoidable costs in ambulatory and post-acute care operations, where unexplained variation is highest. Organizations such as Norton Healthcare, Louisville, Ky., are doing this by mapping out how patients receive value along the continuum of care, from diagnosis to discharge and follow-up. Second, these organizations are creating lower-cost substitutes (for example, replacing high-cost surgical procedures with lower-cost interventional radiology services). Third, these payers and providers are actively sharing cost/benefit information with patients prior to expensive surgery (such as customized, video-based decision aids for patients with knee pain). Fourth, these organizations are providing timely feedback to patients on their health status, cost of care, and potential health outcomes to influence healthy choices. For example, Geisinger Health System in Danville, Pa., uses "OpenNotes" technology, which gives patients access to their physicians' notes so they can track their performance to plan and communicate with their caregivers. Fifth, these providers are examining their infrastructure and staffing levels to ensure they are appropriate to care for community-based patient populations (such as people with diabetes), not just patients with acute conditions.

Success Factor No. 3: Packaging and Pricing Value

The next step for payers and providers is to package and price their offerings in a way that drives margin, mission, and market share. Packaging value means gathering and compiling what the organization does into products and services customers will buy. Payers and providers are packaging together acute and chronic payment bundles, disease management programs, population health management programs, tiered insurance benefits, health coaches, and personalized care plans to differentiate their services from those of other organizations.

Let's face it: The "old days" when hospitals simply "sold" bed days and insurance companies sold health insurance are over. Nowadays, providers are going to market with payers to deliver lower-cost/higher-value insurance, care bundles, and wellness products built on a common IT and care management infrastructure.

But there are challenges, namely setting market prices that reflect the value of these products. Here's why:

> Many large, urban markets have price spreads ranging from 300 to 500 percent or greater between the low-cost and high-cost providers.
> Providers face enormous pressure from purchasers and payers to cut their prices in exchange for participation in insurance products or bundles that promise to steer new business to their facilities.
> Providers often match a competitor's price decrease, particularly if there is excess capacity in the market. As a result, many providers are victims of price wars where prices drop below levels required to maintain value and sustain the enterprise.

Fortunately, there are several ways to avoid price wars that destroy long-term value for payers, providers, and patients alike.

First, providers should deliberately manage point-of-enrollment and point-of-care pricing decisions (such as the payer/provider contracted rate, the patient premium contribution at open enrollment, and the patient cost-sharing at the point of care). As providers consider numerous offers to reduce their prices in return for new lives on a health insurance exchange or a private label product, they should consider how the end customers (such as patients and employers) will benefit.

Consider the case of a provider that has received an offer to join a private insurance exchange network at a 20 percent discount off its current fee schedule. Through discussions with brokers in the community, the provider learns that the patient might never see the discount, depending on how the benefit design and patient premium contribution is structured. Upon further discussion and modeling, the payer and provider jointly approach select employers (instead of the initial list of 100), agree to how patients and the employers would benefit in the second and third year from reduced cost trends, and settle on a shared savings agreement. In this agreement, savings from avoidable utilization and underlying costs would go toward shutting down excess physical capacity and incentivizing patients to take more control of their health. The provider thereby averts a price war and aligns incentives to reduce avoidable utilization and underlying costs over multiple years.

Second, providers should not trade discounts for steerage without a clear plan to deliver more lives or more volumes. They should beware of full-choice insurance networks and products that promise to steer volumes to the organization in return for a discount.

Third, providers should insist that new payment models are at least margin-neutral with current payment models after accounting for volume reductions, shared savings, and underlying cost reductions.

Fourth, providers should become more proficient in health plan pricing, including how competitive premiums are set. This entails studying underwriting techniques and understanding per-member-per-month costs at a population level, not just a "per click" level. Unfortunately, many traditional, population-based pricing (underwriting) models used by payers lack inputs and data to accurately project patient utilization patterns when faced with new insurance choices. Such patterns include changes caused by an influx of newly insured lives into the market. They also include the movement of lives from an open network to a closed network product, from a fully insured to a self-insured product, from a low- to a high-deductible health plan, and from Medicaid to a health insurance exchange product. Without the ability to project such patterns, the result is either overpriced products that do not sell or underpriced products that lose considerable money.

In the end, the real secret to minimizing the impact of a price war is to get serious about creating—not just redistributing—value through products and features, such as timeliness, personalization, and convenience. In the end, certain customers may be willing to pay more for these kinds of benefits.

Success Factor No. 4: Organizing for Value

Many providers are still organized to deliver acute care and maintain managed care contracts with automatic, annual price increases. What they need to do, however, is reorganize their system in two new ways. First, on the clinical delivery side, providers need to organize to deliver cross-continuum care with fewer emergency department (ED) visits and avoidable bed days per capita. Second, on the business side, providers need to become more adept at packaging their services into networks and products they sell to patients and purchasers at competitive prices.

Some health systems are creating a brand-new legal entity or division to budget, develop, productize, deliver, and sell new care models directly to employers. Others are attempting the same strategies using their current, employed

SAMPLE APPROACH FOR UNIFYING ORGANIZATION AROUND VALUE METRICS AND METHODS TO CREATE AND COMPETITIVELY PRICE VALUE

Sample Value Metrics	Sample Practices to Create Value	Sample Practices to Price to Value	Sample Practices to Organize to Value
A 3 percent annual medical cost guarantee to an employer. Five-to-one ROI guarantee for a specific care coordination program for 5 percent of the population that incurs 50 percent of the cost. A 20 percent reduction in physician practice variation related to the use of antibiotics.	Leverage interventional neuroradiologists to convert open surgery to interventional procedures that reduce the total recovery time and cost of care by 50 percent. Replace old operating rooms with more flexible procedure rooms. Systematically reduce post-acute care variation by implementing evidence-based care guidelines related to who should undergo an operate and how to manage post-acute care.	Create a robust pricing model that sets your go-to-market price based on market prices, input costs, outcomes, and total cost of care. Avoid simply waiving copayments and taking discounts off current fee schedules.	Patient alerts/reminders, patient access to the electronic medical record, online visits, and health reimbursement accounts for patients. Integrate the managed care team and business development team to build a network that attracts lives. Ensure the clinical team focuses on reducing avoidable utilization and costs across the continuum.

medical groups. The systems that are linking their new care models and insurance products to their employed medical groups tend to be more integrated, operating in markets where employed medical groups are the norm. In contrast, the systems that are creating a new division akin to an accountable care organization (ACO) within their corporate structures tend to be larger health systems with multiple locations. These systems seek to leverage their infrastructure and accommodate both employed and independent physicians, typically under the banner of an integrated delivery network.

Whether the entity reports to the medical group or becomes a new entity within the health system, the core team should include:

> Cross-continuum care design and delivery specialists—e.g., a physician, two care managers, and an expert in skilled nursing facilities and home health—whose aim is to use new tools and protocols to reduce underlying costs and resource utilization
> A dedicated medical economics/analytics shop that tracks the avoidable costs (such as readmissions and unnecessary lab tests) and shares the results with purchasers and patients
> Managed care contracting and business development staff that sign the pay-for-performance, steerage, and shared savings/risk contracts with payers
> A dedicated business development and marketing team that develops new networks and products that will attract patients to the payer and provider.

These four functions should share a common budget and goals. For example, they might aim to create products that sell to specific employers and involve delivery of care for 5 percent of the population while incurring 50 percent of the costs, all at a reduced cost and higher quality. Clarifying each function's role and responsibility is critical to successful execution of these goals.

The Role of Finance

Finance leaders at both payers and providers can play a profound role in value measurement, pricing, and creation. For one, finance leaders can help make budgeting, accounting, and pricing

processes more timely and transparent, particularly for new products and services that are intended to drive value and margin.

Finance leaders also have an opportunity to identify and cultivate leaders across functional departments (such as from the hospital's ED and the payer's network contracting team) who can rally different groups around a core set of value metrics. Ultimately, this helps create accountability.

Healthcare reform makes delivering value more important than ever for payers and providers. Finance leaders play a key role in helping their organizations unify around a common picture of success, budget it, and undertake the key changes required to provide value to an increasingly competitive and complex marketplace. With the 2014 budget cycle looming, the time to act is now. ●

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