Alternative Paths to Value

If your hospital isn't ready to form an ACO, consider a vendor strategy

By Thomas Dixon and Christine Malcolm

Health care's competitive landscape is changing from one that rewards volume aggregation to one that rewards value creation. Though legislatively sparked, market dynamics now fuel this transformation.

Across the country, common dynamics are emerging — commercial insurers are shifting risk to providers; physician groups, facing deteriorating practice economics, are embracing pay-for-value reimbursement models in an attempt to stabilize or grow incomes; and integrated delivery networks are serving as value-based market-makers, forcing their competitors to reposition their organizations or face obsolescence. While the legislative trajectory may change, local differences in Affordable Care Act implementation exist and timing remains unclear, the move to value-based competition appears certain.

In light of these changes, accountable care strategy or clinical integration now rivals partnerships and mergers as the prevailing strategic agenda item in health system C-suites and boardrooms. The once-prevalent wait-and-see approach now seems anachronistic; and in some markets, fear is mounting that independent, physician-led accountable care organizations will relegate inpatient services to a commodity.

Reframing the Dialogue

To date, many health systems have engaged in a simplistic accountable care dialogue. Two strategies are almost universally considered: start an ACO or clinically integrated network and/or prepare for the new market (meaning pursue scale, quality improvement and cost-reduction and hope that the organization remains relevant). Moreover, a strong bias to rapidly form an ACO has emerged, often justified by hospital leaders' desires to have more control over payment streams and disintermediate Wall Street and large payers.

However, health systems enjoy a broader array of accountable care strategies than the two most often discussed, and, for myriad reasons, a more intricate accountable care dialogue is warranted. In other words, for most health systems, ACOs are not a panacea.

First, many systems (even those launching ACOs) simply are not ready to function as ACOs. These models, rewarded for keeping patients healthy and out of hospitals, depend heavily on primary care networks and highly effective care management that operate across the care continuum. By implementing hospitalist models and unwinding the employed primary care groups built during the 1990s, hospitals have spent

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the last 15 years distancing their organizations from the very physicians essential to successful ACO efforts. The lack of primary care networks and daunting ACO resource and capability requirements, such as information technology, care processes and protocols, data mining and clinical call centers, leaves many health systems ill-equipped to rapidly reconstitute themselves as ACOs.

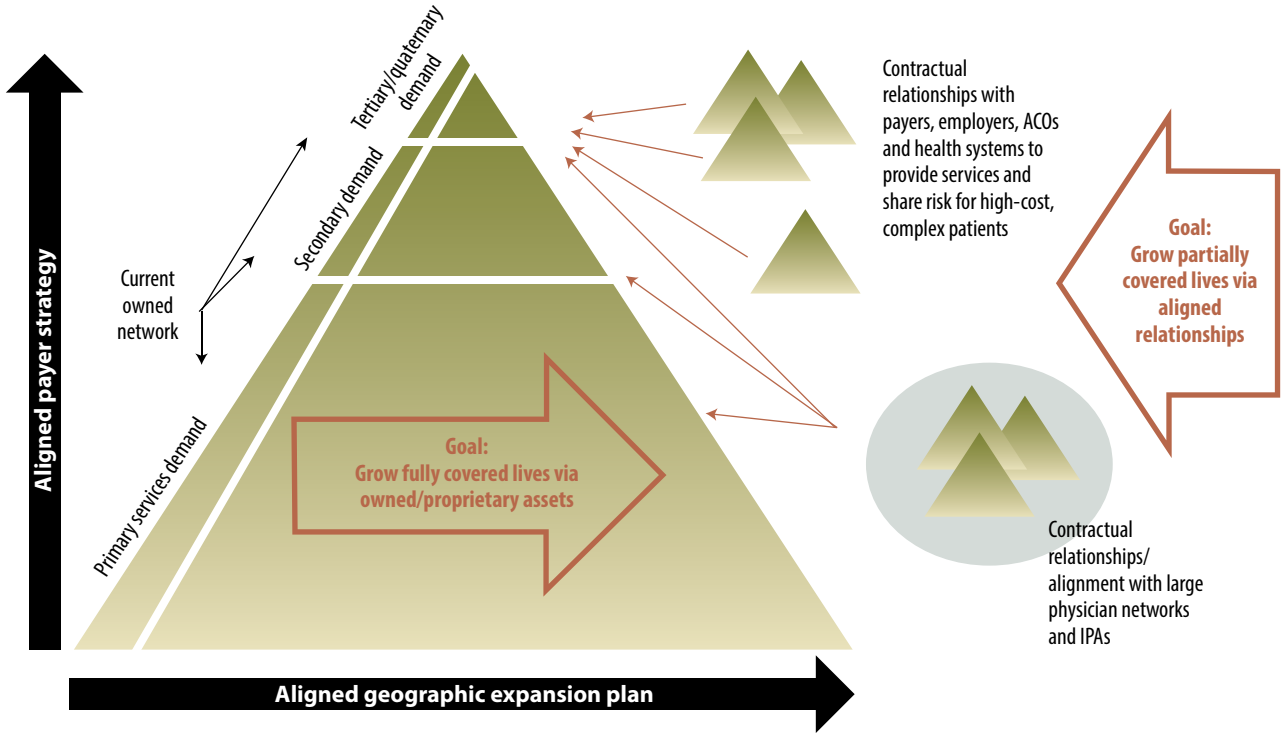
Second, despite the staggering pace of change, many markets have yet to evolve structurally to accommodate full-fledged ACOs. Fragmented, individually focused physician practices and adversarial hospital-payer relationships often characterize these communities. Absent employed or willing physician partners and insurance solutions, health systems' ACO aspirations prove fruitless. Powerful and successful delivery systems are seeing their strategies to capture enrolled lives deliver results of only 5,000 or 10,000 enrollees, while health plans' enrollees number in the hundreds of thousands.

Third, for health systems with many advanced and specialized clinical programs, such as academic medical centers, ACO formation represents a culturally incongruent strategy and, more importantly, one that will never provide the volume needed to maintain services. AMCs have built subspecialty-led and focused organizations and largely have abdicated primary and secondary services to community hospitals and physicians. Said more positively, AMCs understand that competing with their principle referral sources is foolhardy. They realize that a 100 percent owned, enrolled life strategy requires millions of enrollees to support transplant, neurosurgery and other high-end services and realize the folly of going headlong into that undertaking.

Finally, for many providers, ACOs will prove insufficient as the sole vehicles upon which to compete for value and sustain market position. For example, our analysis suggests between 175,000 and 235,000 covered lives are required to support a moderately sized surgical heart program. For less common procedures, such as transplantation or some types of neurosurgery, the numbers are often in the millions. By contrast, half of ACOs had fewer than 10,000 covered lives in May 2012, according to the Healthcare Intelligence Network. Competition, insufficient local population and locally focused primary care networks will prevent many hospitals from amassing sufficient bases of covered lives to support advanced (that is, tertiary and quaternary) programs via ACOs alone. Instead, many hospitals will be forced to support advanced programs with a constellation of accountable care strategies.

This leads sophisticated providers into balanced, multifaceted strategies that include building capabilities in population health to "grow enrolled lives" and serving health plans, referring physicians, referring hospitals, employers, other networks and payers via what can be called vendor strategies. They involve providing

Accountable Care Strategic Framework



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services for a discrete portion of the care continuum, often on an at-risk, contractual basis. These strategies work to synergistically sustain and improve market positions of health systems or physician groups, often as complements to an ACO.

Vendor Strategies

Historically, many AMCs, regional referral centers and their aligned physicians have served as tertiary and quaternary vendors to community hospitals and physicians. The vendor strategies used by these centers to compete for referrals and transfers in the old volume-based model likely will remain relevant in the new, value-based system.

Further, as the competitive climate shifts, innovative vendor strategies continue to emerge, including bundled payments, service-line ACOs and ACO-affiliate networks.

Service/access strategies. When the financial crisis hit the U.S. economy, health care expenditures stabilized and volumes declined, as many Americans postponed or altogether declined elective procedures. Inpatient volumes have yet to return to pre-2008 levels, but throughout all of this, two services that rarely are described as such have continued to grow — complex transfers and referrals.

Many physicians have said that this phenomenon is a natural outgrowth of pay for performance and the quality movement. Physicians and hospitals want to maintain strong quality scores and demonstrate cost-efficiency. In the past, physicians might hold patients in less-advanced hospitals while they "figured out what was going on." Now, hospitals and physicians face penalties for doing so.

Before the focus on value emerged, many referral centers devoted resources to building world-class processes, infrastructure and capacities to accept complex inpatient transfers and referrals. Though these strategies initially were aimed at aggregating volumes, they clearly exhibit value-creation potential. For example, access strategies that connect a referring physician and his or her subspecialty physician partner in a single phone call, coupled with information technology linkages and shared protocols for transfer and follow-up care, deliver value under almost any reimbursement model. These strategies also build relationships that can sustain the transition to accountable care.

Bundled payments. This may be the archetypal accountable care vendor strategy. In these arrangements, hospitals, health systems and physician groups contract with payers or employers to provide specific services at a fixed price, effectively assuming risk for follow-up care and readmissions. Bundled-payment agreements are focused on high-incidence, high-cost procedures, such as cardiovascular surgery and joint replacement, and enable payers and employers to receive discounts from specialty providers. While the benefit to hospitals may remain limited, bundling is an excellent tool to align physicians and systems in redesigning care and delivering improvement — without destroying margins — and to attract patients outside a core geography.

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The Cleveland Clinic made bundled payments prominent when it formed an agreement with Lowe's in 2010 to provide select heart surgery procedures and expanded the program in subsequent years to include a handful of other large-scale, *Fortune* 500 employers, including Walmart and Boeing.

Clearly, its national brand catalyzed its bundling program's success. Nevertheless, hospitals and systems lacking national brand recognition are actively piloting bundling arrangements. For instance, in partnership with BlueCross BlueShield of South Carolina, Providence Hospitals in Columbia, S.C., launched a coronary artery bypass graft bundling program; the flat fee includes "all services related to [the surgery] performed over 90 days."

BlueCross of South Carolina is further supporting Providence's value-creation efforts by providing the hospital system with comparative performance data and sharing its cost-savings.

Hospitals with distinguished cost and quality performance for high-incidence procedures exemplify ideal bundling strategy candidates. Beyond abilities to perform to predictable cost and quality outcomes, bundling table stakes include: a nationally or regionally renowned brand, clinical decision support, pricing and distribution methodologies (potentially via a payer partner), volume scale to reduce adverse selection risk, and tight physician alignment to enable performance-improvement initiatives.

Service-line ACOs. Bundled payments are the most common, but not the only, vendor strategy that enables risk-sharing. Recently, Baptist Health South Florida, in conjunction with Advanced Medical Specialists (an oncology physician practice) and insurer Florida Blue launched an oncology ACO.

Initially, Florida Blue contributed 500 to 1,000 of its commercial cancer-care patients to the ACO, with stated plans to expand the program to its Medicare Advantage patients. The reimbursement model rewards Baptist South Florida and its physician partner for value delivered (cost and quality performance) in treating

the most common cancer types, and focuses on care planning, adherence to best-practice care protocols and avoiding hospital admissions and emergency department usage.

Florida Blue hopes to extend this innovative model across other providers and service lines throughout the state, but piloted with Advanced Medical Specialists and Baptist South Florida because of a history of working together on quality protocols.

Hospitals or systems that built an organized, high-volume continuum of services, related to high-cost, high-incidence disease states should consider service-line ACOs. Like bundling, this strategy requires predictable cost and quality performance, volume scale, clinical decision support, pricing and distribution methodologies and tight physician alignment. Additionally, an effective service-line ACO necessitates an organized care continuum of relevant services.

ACO affiliate networks. An ACO affiliate network is another vendor strategy that merits consideration. The Mount Kisco–Massachusetts General Hospital affiliation provides an example.

Mass General affiliated with the Mount Kisco Medical Group in 2005. Now a Medicare Shared Savings ACO, MKMG is a multispecialty physician group that employs more than 270 physicians serving southern New York. The affiliation provides MKMG patients with access to subspecialty services at Mass General, opportunities to participate in Mass General clinical trials and invitations to jointly sponsored educational programs in Mount Kisco's service area. Further, MKMG physicians can access Mass General training programs, and Mass General helps MKMG identify Harvard Medical School graduates with interest in relocating to southern New York.

Hospitals with unique, subspecialty services across multiple programs should consider building ACO affiliate networks. Building these networks requires a regionally strong brand and a substantive affiliate services menu, such as exportable care protocols, training programs, recruiting support, transfer processes, and protocols and technological linkages, to justify membership and coordinate clinical care.

Fewer Risks

As hospital boards and C-suites navigate the transition to value-based competition, they should seek to develop balanced, multifaceted strategies, incorporating ACOs and vendor strategies as appropriate. Compared with ACOs, in which health systems assume total cost-of-care risk for a defined population, vendor strategies can be lower-risk, limiting accountability to specific procedures, disease states or continuum phases. As such, vendor strategies are often appropriate vehicles to enable organizational learning and capability development as bridges to launching full-scale ACOs.

In addition, health systems with tertiary and quaternary programs will be forced to use a collection of accountable care strategies in the future. To amass sufficient covered lives, these organizations will need aligned ACOs in their local markets, while deploying vendor strategies to extend tertiary and quaternary reach beyond the geographic confines of their employed primary care networks.

Across the country, hospital boards and C-suites are talking about ACOs on an almost daily basis. Given the accelerating transition to value-based competition, it is time to include vendor strategies in the discussion and create a broader dialogue about the sophisticated accountable care strategies that will be required to thrive in the future. **T**

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