Healthcare 2015: Turning the Corner

PYA

VISION BEYOND THE NUMBERS

Introduction

Last year, in Healthcare 2014: Embracing the New Normal, we commented on the industry's dawning realization that payment reform was real, profound, and somewhere on the horizon. We foresaw an extended period of turmoil and confusion as providers struggled to understand the implications of reform.

With 20/20 hindsight, we see that we correctly identified key trends, but we underestimated how rapidly value-based payment models would move from being the exception to becoming the rule. That's not to say fee-for-service reimbursement has been displaced; instead, the industry is now turning the corner and heading directly into the transition from volume-to value-based payments.

Secretary Sylvia Burwell's recent announcement regarding Medicare's goals drives this point home:

> **Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models [*i.e.*, accountable care organizations and bundled payment arrangements] by the end of 2016, and 50% of payments by the end of 2018.**[1]

As a result, providers have no time to waste on turmoil and confusion. As payments are increasingly tied to quality and efficiency, healthcare delivery systems will have to evolve rapidly to meet these changing incentives.

While we don't know exactly where this evolution will take the industry, we can identify key survival skills. In the "new world," providers will need to be more **collaborative, adaptive, patient-centered** and **tech-savvy**.

As providers turn the corner in 2015, they will face numerous challenges for which they will need their still-emerging value-based skill set. We drill down on these challenges below, considering how the fittest will survive.

[1] S.M. Burwell, Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care, New England Journal Of Medicine (Jan. 30, 2015).

col·lab·o·ra·tive /kəˈlab(ə)rədiv/ (adjective)

produced or conducted by two or more parties working together

1. Collaboration - not consolidation - will drive industry transformation.

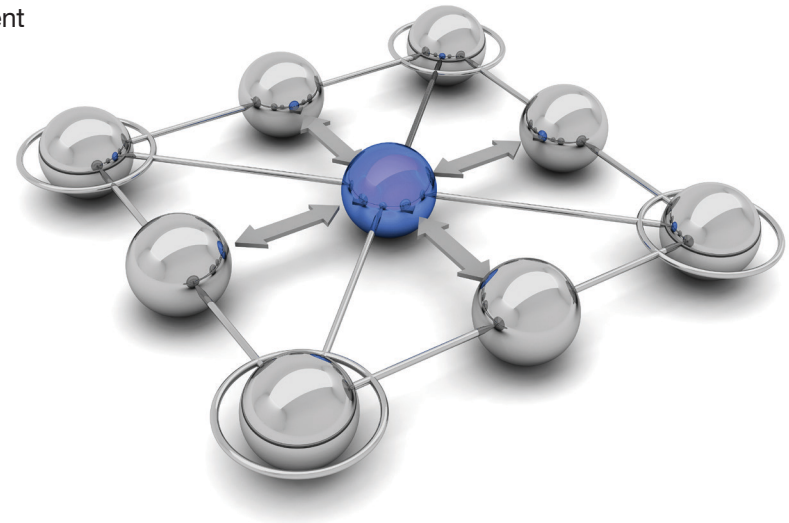
Many see industry consolidation as inevitable in the face of payment reform, believing that only large, integrated delivery systems can effectively manage risk-based contracts. The thinking is that those providers who remain independent will find themselves on the outside looking in.

Based on this belief, many providers have pursued consolidation – mergers, acquisitions, management agreements, hospital employment of physicians – as their payment reform strategy. However, that party appears to be winding down, as we see a rapid transition to a buyer's market. Health systems now are adopting more stringent criteria by which to evaluate potential transactions to ensure they support broader, long-term strategic goals.

Many systems will face significant post-transaction challenges in 2015 as they try to realize promised efficiencies. Sharing the same taxpayer identification number does not automatically lead to sharing the same mission, vision and values. Left unaddressed, cultural differences will undermine efforts to align incentives and deliver value under new payment models.

Watching (or experiencing) these struggles, more providers have begun to see strategic affiliations as a viable alternative to consolidation. Working collaboratively, community providers can define, implement, and enforce standards of care and effectively manage patients through the care continuum without losing their independent identity and valued community asset.

The success of these non-economic alignments depends in large part on effective governance structures that create trust environments. Control over organizational decision-making is not a function of ownership; instead, decisions are motivated by collaborative goals and made by consensus among participants. This demands a new way of thinking for many, but shared commitment to delivering value (and thus achieving financial success) will motivate change.



a·dapt·ive /ə'daptiv/ (adjective)

characterized by or given to adjustment to new conditions

2. If at first you don't succeed, try something else.

Delivery system reform is a process, not an event. We should expect a number of false starts. The failure — or less than stellar success — of early initiatives should not lead one to abandon hope. Only through trial and error will providers learn to excel under new value-based payment models.

Take, for example, the early results from the Medicare Shared Savings Program (MSSP). During the first year, only one in four accountable care organizations (ACOs) received shared savings distributions. Many critics jumped on these results as proof the model is not a viable cost-saving strategy. A closer analysis of the data, however, reveals several strategies an ACO can pursue to generate more significant savings, such as a laser-beam focus on reducing post-acute care costs. Also, that data revealed to the Centers for Medicare & Medicaid Services (CMS) weaknesses in and challenges to the MSSP's operations, causing the agency to propose significant revisions to the implementing regulations.

Hospital employment of physicians is another example. In the early part of this decade, hospitals had an insatiable appetite for physician practice acquisition due in part to the belief that physician alignment only could be achieved through the exercise of control. Now, many hospitals find themselves ill-equipped to run physician practices; others are frustrated by the fact that their employed physicians are not committed to the hospital's goals. In both cases, hospitals are experiencing significant financial loss and physician dissatisfaction in their employed physician practices.

During 2015, many physician employment agreements will come up for renewal, giving hospitals and physicians the opportunity to redefine their relationships. In the face of value-based payments, hospitals will need to push away from compensation models based solely on productivity. Hospitals, however, cannot expect to merely dictate a new formula; instead, they will need to engage physicians in creating compensation models which more clearly align the parties' incentives. The process starts with education on how market changes demand adaptation.

While many physicians will elect to continue employment, some will choose to pursue new opportunities. Some physicians will have this choice made for them, as hospitals choose not to renew employment agreements. We also expect hospital practice acquisitions to slow as health system boards and executives exercise more scrutiny and selectivity, aligning with those physicians who pursue mutual goals and shared success.

Additionally, many independent physician practices have found safe haven in independent physician associations (IPAs), many of which now operate as ACOs. In fact, physician-led ACOs comprise the majority of MSSP ACOs, and have turned in the best performance among the program's participants. These IPAs provide physicians with needed support services and collaborative relationships, allowing them greater control over their destinies.

Thus, we expect 2015 to mark the resurgence of the independent physician practice. While many of these independent practices will mirror historical modus operandi, we anticipate that an increasing number of practices will explore alternatives such as Medicare-only, cash-only, house calls and other concierge-like structures intended to improve patient care while controlling overhead costs.

Second, we foresee that physician-hospital organizations (PHOs) will be reinvigorated. As hospital executives realize they cannot simply LEAN into efficiency, they will look to engage physicians in cost-reduction strategies. We expect to see more gainsharing arrangements and more interest in bundled payment initiatives.

In the words of Albert Einstein, "*The measure of intelligence is the ability to change.*" As you confront these revolutionary changes in healthcare, we offer three suggestions to help raise your healthcare IQ:

KEEP COOKIE CUTTERS OUT OF YOUR TOOLBOX. We are asked on a daily basis to explain how other providers have achieved success under value-based payment models. And, every day, we disappoint the person asking the question by saying there is no proven solution because each situation is different and no one has done this before. For years, healthcare providers have relied on off-the-rack strategies to improve performance, but now the rack is empty. Be prepared to start from scratch, with a thorough understanding of where your organization is today and where it needs to be headed in the near future.

BECOME A DISCIPLE OF THE 70 PERCENT SOLUTION. The U.S. Marines are credited with formulating the 70 Percent Solution: when you are 70 percent ready and have 70 percent consensus, it's time to act. In an environment where information is imprecise and ever-changing — like the healthcare industry today — the 70 Percent Solution drives an organization to the best possible decision under challenging circumstances.

BE WILLING TO BUILD IT WHILE YOU FLY IT. This is the corollary to the 70 Percent Solution: be prepared to improvise. Do not commit to a specific solution to the point that you are unable or unwilling to make course corrections. Instead, regular performance evaluations and adjustments should be built into your project work plan so that your organization can continue to adapt to a dynamic environment.

cen·tered /sen(t)ərd/ (adjective)

having the specified subject as the focal element

3. Investments in patient-centered strategies will return impressive dividends.

Under the current fee-for-service model, the payer – not the patient – is the true consumer of healthcare services. And, because they are not the consumers, patients have little access to information and knowledge that can help them participate in, let alone guide, their own care.

Success in a value-based world is increasingly dependent on patient engagement and compliance with individualized care plans. One key strategy for success under value-based payment models is to treat the patient as a valued consumer. In fact, providers need to take the lead in educating patients how to be wise consumers of healthcare services.

We see providers using several tactics in pursuing this strategy:

INFORMED DECISION-MAKING. Patients should be provided with accurate, straightforward information regarding the relative effectiveness and cost associated with different treatment options. Among the excellent resources available are the patient resource guides developed by Consumer Reports and various specialty societies as part of the Choosing Wisely program.

LOYALTY PROGRAMS. Providers should purposefully use tools that more closely connect patients with their organizations, *e.g.*, reaching out with regular reminders to receive recommended preventive services; boldly steering patients to recognized low-cost, high-quality providers.

CARE MANAGEMENT. Providers can more efficiently expend resources by identifying and engaging high-cost/high-risk patients through a formal ambulatory care management program. With Medicare now paying for chronic care management – and other payers expected to follow suit – providers now can receive fee-for-services reimbursement for developing the competencies that will help them survive and thrive under value-based models.

CLINICAL DOCUMENTATION IMPROVEMENT (CDI). Providers must more fully and accurately capture a detailed description of each patient's condition. A CDI program not only will improve coding accuracy with the advent of ICD-10, it will enhance reimbursement- based hierarchical condition codes.

tech-sav·vy /tek-savē/ (adjective)

practical understanding of the applied use of modern technology in specified circumstances

4. Technology will provide valuable tools, not just create a record of what's already happened.

In the first half of this decade, the focus was on electronic health **records**; for the second half, the focus will be on electronic health **tools**. While it is interesting and helpful to have immediate access to a patient's history – diagnoses, procedures, and outcomes – new technology will expand providers' impact on their patients' health. The technology will drive the treatment, not merely generate a record of it.

Presently, we are drowning in data and raw information but we are parched for knowledge and intelligence. For example, we can calculate the total cost of care for a specific patient population; now we need to use that information to identify appropriate interventions to improve outcomes and enhance efficiency. We have mobile apps that can generate reams of biometric readings; now we need to rapidly recognize and respond to warning signs.

For the immediate future, the holy grail of health information technology will be what we call the *population health workspace*. The workspace involves the automated application of recognized clinical guidelines and metrics to a compilation of relevant health-related information (both real time and historical) for individuals within a defined population. This produces a prioritized list of tasks to be accomplished by the assigned care team.

The crusades to find this holy grail will meet with many challenges: interoperability, patient privacy and security concerns, recognition of clinical guidelines, resistance to change, lack of qualified care team members. And, of course, the cost of bringing these systems on-line will be significant. However, with fee-for-service payments for care management and other value-based payments, the incentives now are aligning. And, thus, the industry is turning the corner.

PYA's integrated team of experts – physicians, nurses, executives, accountants, attorneys, data scientists, and policy analysts – are ready to help your organization prepare for what's around the corner. Let's talk.

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