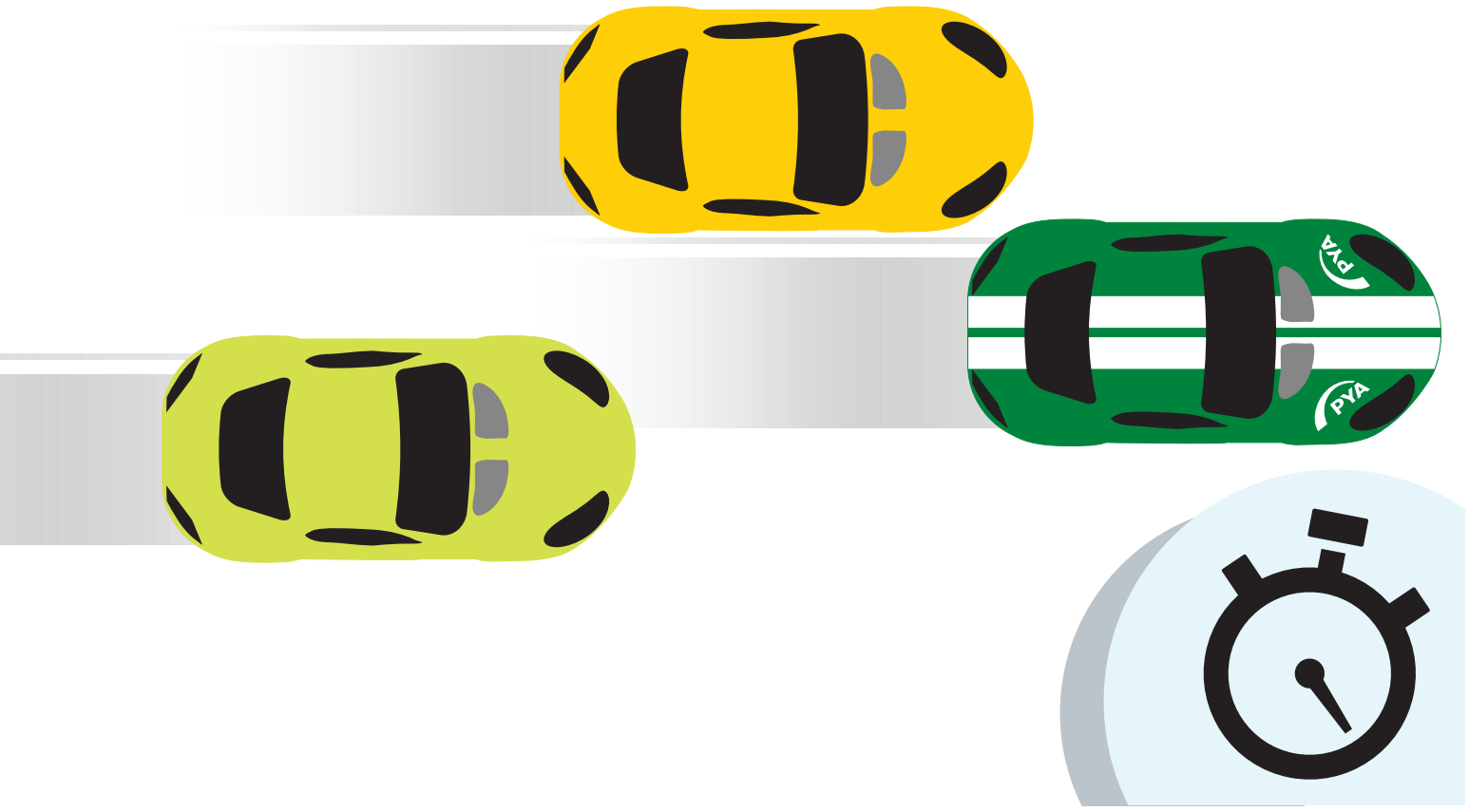
Strategic Positioning for Healthcare Transformation:

Timing Is Everything



The transformation of the healthcare industry – driven by the transition from volume-based to value-based reimbursement – is gaining momentum. The rate at which it is proceeding, however, is not consistent across markets or providers. Since success under value-based reimbursement may require providers to take action that reduces fee-for-service (FFS) payments, making the transition too soon runs the risk of undermining a healthcare organization's financial stability. Waiting too long to make necessary investments, however, exposes the organization to the same risk.

Timing, therefore, is everything, and varies in each market. Decisions on when and how to change payer contracting strategies and underlying operational platforms must be informed by four key considerations:

- Government policy drivers
- Local and regional market drivers
- The organization's current position/profile with regard to value-based transition
- The organization's strategic intent for adoption of new care models

Together, these considerations provide a framework for making key decisions regarding the speed of transition from FFS to value-based reimbursement in a manner that is on pace with the local market.

1 Government Policy Drivers

One driver in common with all providers is the federal government's push to value-based reimbursement in the Medicare program. In essence, the Centers for Medicare & Medicaid Services (CMS) sets the "floor" on the level and pace of change required.

For the first time in the history of the Medicare program, CMS has set explicit goals for alternative payment models and value-based payments. CMS already has achieved its first goal tying 30% of traditional Medicare payments to alternative payment models, such as accountable care organizations (ACOs) or bundled payment arrangements. CMS now is working on its goal of moving that number to 50% by the end of 2018. The agency also set a goal of tying 85% of all traditional Medicare payments to metric-based programs (e.g., the Hospital Readmissions Reduction Program and the Physician Value-Based Modifier Program) by 2016, growing to 90% by 2018.

State Medicaid policies provide a different type of driver for providers. While the goals are the same from the payer's perspective (i.e., lower per-capita cost, consistent quality), alternative payment models for Medicaid populations offer providers the opportunity to minimize losses through more effective management. In other words, there is less downside on transitioning away from FFS given lower reimbursement rates, but there is a potential upside in minimizing the use of high-cost services, which providers often furnish to this population at a loss.

2 Local Market Drivers

While federal and state initiatives provide a consistent floor for transition, there is significant variation at the local market level. To manage the pace of change consistent with the local market, it is important to understand the forces that drive value-based transition at this level and to track them over time.

The five key market drivers are:

- Population Size/Density
- Market Costs/Use Rates
- Commercial Payer Activity
- Employers
- Competitors

A. Population Size/Density

Large, urban populations are more likely than smaller populations to attract payer attention for cost management. For example, if a Blue Cross plan rolls out a state-wide ACO development initiative, it is more likely to initially target the largest three metropolitan statistical areas (MSAs) in the state rather than the three smallest MSAs or rural areas. Medicare Advantage plans and national commercial payers, which drive most of the commercial value-based activity, also are more likely to target the larger markets.

Markets with larger, dense populations also offer the critical mass of patients essential to achieve the necessary economies of scale to support expensive population health infrastructure.

B. Market Costs/Use Rates

Data on healthcare costs at the market and provider level are becoming increasingly transparent. Markets that are outliers for high costs and utilization will attract the attention of insurers and ultimately, local employers and consumers. McAllen, TX is a case in point. Six years after his seminal *New Yorker* article highlighting McAllen as a community with double the average Medicare spending, Dr. Atul Gawande returned to McAllen to find inpatient admissions down 10%, home health costs down 40%, and overall Medicare cost per beneficiary down by almost 20%.[1] Without a doubt, the national spotlight on this outlier helped drive the dramatic transformation.

C. Commercial Payer Activity

Clearly, the appetite for change among commercial payers is a driver for providers. In markets where a national payer seeks an ACO partner, first-mover advantage is an important motivation for pace. For example, Aetna has approximately 60 commercial ACO agreements, with two-thirds featuring risk-sharing arrangements.[2] In many markets, however, Aetna has selected only one partner. Systems such as Banner Health and Memorial Hermann have enjoyed national attention and local market presence due to their Aetna partnerships. In smaller markets and rural areas where there may be limited (or no) competition for health plans, payers are less likely to drive change and may even lack interest in discussing value-based models.

D. Employers

Large, self-insured employers often drive value-based contracts. In an effort to control continuously rising and unpredictable healthcare costs, large employers are seeking direct partnerships with health systems to manage costs and reduce variability. If a market is dominated by self-insured employers, the need to address healthcare costs directly is more urgent than a market characterized by smaller employers.

As with payers seeking partnerships, first-mover advantage will drive the pace for health systems to partner directly with employers. A direct contract with the market's largest private employer could rapidly impact market share. This impact may be felt more acutely in rural markets, where a single, dominant employer (e.g., a school system) can force local providers to accelerate the rate of change.

E. Competitors

Last, but not least, the required pace of change will be heavily influenced by competitor activity. In a market

1 "Five Things Atul Gawande Learned on His Return to McAllen, TX," Bookings Institution, May 8, 2015.
2 "Aetna's ACO Success: Meet Providers Where They Are," *Fierce HealthPayer,* April 29, 2015.

where health systems and large physician groups are aggressively developing population health capabilities, building networks, and signing value-based contracts, rapid action may be required. If none of the other providers in the local market (or potentially encroaching markets) are driving the market toward value-based models, the pace of change will be less urgent.

Overall, when evaluating local market factors, it is important to note that even markets with limited local pressure will require change based on federal and state healthcare programs. In fact, many rural markets that show limited commercial pressure are heavily dependent on Medicare and Medicaid which are, for the most part, transitioning faster than commercial payers.

Organizational Profile

Once the external drivers are clear, it is important to understand the organization's current position or profile with regard to value-based models of care. This profile reflects the impact of several factors including the external market forces described above; the organization's history, culture, and leadership; and the opinions and preferences of its aligned physicians.

While there is no one "right answer" for an organization at any point in time, leaders and stakeholders must have a clear and common understanding of where the organization currently stands – and why.

This common understanding creates the platform for change and reveals the influences that led to the current state. To assist in understanding the organization's status with regard to value-based positioning, we have defined the four profiles identified in **Table 1**.

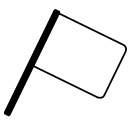


Table 1: Current Status Profiles for New Care Models

Current Status Profile	Description
Watching and Waiting	Not convinced that the transition to value-based models will endure. Reactive to changes in federal and state initiatives as required for reimbursement, but not proactively seeking changes in underlying operations or contracting.
Beginning the Course	Recognizing the need to change gradually, but not willing to risk current FFS reimbursement. Developing low-cost components of the infrastructure necessary for population health management and entering into low-risk models such as one-sided, shared-savings models.
Mid-Course/Into the Corner	Balancing FFS and value-based reimbursement. Experiencing significant tension associated with transition. Well-developed infrastructure for population health management including one or more ACO contracts. Beginning to make organizational decisions which risk short-term FFS payments in favor of supporting the transition, but still heavily reliant on FFS payments.
In the Final Lap	Transitioned to an operating framework, in coordination with key stakeholders, built around "Triple Aim" objectives. A substantial portion of revenue stream is value-based, including two-sided or per-capita risk.

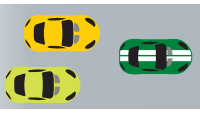
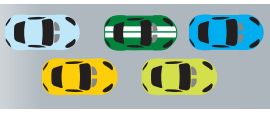
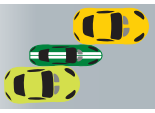
In assessing the current organizational profile, three elements of the process are important:

- Discussions must include broad stakeholder involvement – including "critics" as well as "champions."
- The assessment must be honest and reflect how the organization really behaves rather than how it would like to think of itself – or the image it would like to project.
- The assessment must include a reflection on what has influenced the organization to be in this position at the current time. Is it strictly a reflection of external factors? Does it reflect a risk-averse culture? Were there historical experiences that still influence the perspective (e.g., bad experience with risk-based contracting in the 1990s)?

4 Strategic Intent

Once we understand the status of the local market and the current position of the health system, the next set of questions revolves around the organization's strategic market intent with regard to value-based models. Specifically, how does the system want to be positioned in the future, and what pace of change is required to achieve that goal? While the circumstances for every system are unique, it is helpful to create a framework to facilitate discussion. The framework we have developed for this purpose is summarized in **Table 2**.

Table 2: Strategic Intent Profiles for New Care Models

	Strategic Intent Profile	Description
	*Protect and Defend Current Status*	Organizations in this profile remain convinced that FFS reimbursement will endure as the prevailing payment model in the local market for the foreseeable future. They "double down" on traditional FFS strategies, regardless of what competitors are doing. This intent also may reflect a belief that the organization does not have sufficient resources to invest in (or endure) a transition. This approach may optimize short-term financial performance, but risks missing a transition point in the industry (e.g., "Blockbuster Video"). Pace of change is minimal.
	*Catch Up to the Market*	This profile applies to organizations that recognize they are lagging behind regional competitors or payer/employer demand and want to ramp up value-based capabilities to establish competitive parity. This intent implies some urgency in the pace of change.
	*Steadily Advance with the Market*	Many organizations prefer to pace their value-based development activities consistent with the market. They do not want investments to far exceed returns (i.e., "bleeding edge"), but do not want to be left behind either. As a result, they will steadily develop the necessary capabilities to be effective on the value-based front, while acknowledging the continuing role of FFS reimbursement. By definition, this intent does not seek significant competitive advantage in the area of value-based transformation. This intent implies a moderate, but consistent, pace of change.
	*Disrupt the System and the Market*	This intent is for the true believers who are convinced that a full transition to population-health-based care is inevitable and that revolutionary change is necessary to create a viable long-term care model. These systems seek first-mover advantage to developing advanced networks, care management expertise, and innovative payer contracts. They are willing to risk short-term financial pain to make the transition and are financially strong enough to do so. Depending on current position, the pace of change can be very rapid.

Closing the Gap

Once the organization has identified both its current profile and its intended profile, it can accurately quantify for its leaders and stakeholders the gap between the two positions—the larger the gap, the more extensive the change effort required of the organization. As shown in **Table 3**, even to "Protect and Defend Current Status," those who are "Watching and Waiting" will need to manage a moderate level of change based on CMS targets for value-based reimbursement and alternative payment models.

Table 3: Degree of Change Required to Move from Current Profile to Strategic Intent

Current Status Profile	Strategic Intent Profile: Protect and Defend Current Status	Strategic Intent Profile: Catch Up to the Market	Strategic Intent Profile: Steadily Advance with the Market	Strategic Intent Profile: Disrupt the System and the Market
Watching and Waiting	Moderate	High	High	Very High
Beginning the Course	Low	Moderate	High	Very High
Mid-Course/ Into the Corner	N/A	Low	Moderate	High
In the Final Lap	N/A	N/A	Low	Moderate

Monitoring Market Movement

The pace of change required from **Table 3** relies, to some extent, on how quickly the local market is transitioning. Given the rapid pace of change in recent years, many organizations have found that their market-based goals are moving targets.

Because the market drivers discussed earlier are crucial to determining the degree and pace of change, organizations must continually monitor them to determine optimal timing for key initiatives (e.g., significant investments in data analytics capabilities). By addressing the following three questions, the organization can establish an effective market monitoring capability:

- What are the *few* strategic-level market metrics needed to monitor to inform major decisions?
- How do these differ based on a system's current position and strategic intent?
- What are the "trigger points" that indicate a significant market shift?

Table 4 summarizes common market metrics for tracking the pace of change in a given market:

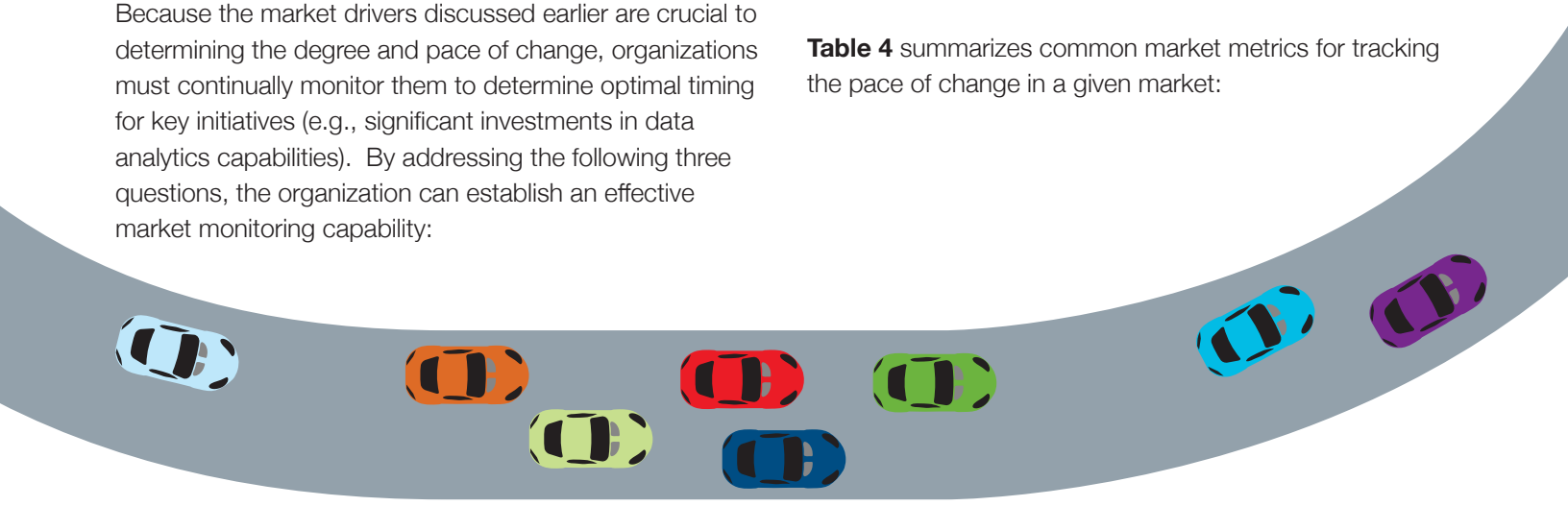


Table 4: Market Metrics

Category	Example Metrics
Population Size/ Density	Since the population size and density for a particular market do not change rapidly, the key metrics here are relative to activities in leading indicator markets. These markets may be larger markets in the state or region (e.g., Miami, Orlando, and Tampa are leading indicators for Gainesville and Tallahassee). For larger markets, the leading indicators would be national (e.g., St. Louis may look to Chicago, Dallas, and Denver). Also for these markets, value-based contracting initiatives of leading national payers are key indicators. The primary metric here is the level of commercial value-based adoption. For example, if Blue Cross Blue Shield has already implemented a value-based model in the top three MSAs in the state, organizations in the fourth largest MSA should expect to be next.
Market Costs/ Use Rates	These metrics also are sensitive to regional changes. How do the use rates and costs for a particular market compare to national, state, and regional MSAs? • Dartmouth Atlas data (Medicare comparisons) • Commercial costs per capita (claims databases) • Hospital charge comparison data • Media coverage hospital rates
Payer Activity	• Enrollment market share trends for commercial and Medicare Advantage plans • Local impact of national insurer mergers • Launches of new alternative-based payment programs • Private health exchanges
Employers	• Number of locally based self-insured employers • Arrangements with providers, e.g., provider-direct contracting, occupational health initiatives, on-site primary care delivery • Activity of local/regional/state employer coalitions
Competitors	• Attributed lives estimates for commercial and Medicare Advantage plans • Clinically integrated network/ACO network size: number of providers, especially primary care physicians (PCPs) • Participation in Medicare alternative payment models (ACO, bundled payment) • Participation in commercial alternative payment models • Number and geographic reach of access points (e.g., PCP offices, urgent care, major ambulatory centers) • Transparent/competitive consumer-based pricing • Mergers/acquisitions/affiliations

The degree of monitoring required for these indicators will vary based on the organization's current status and strategic intent. For example, those who want to "Steadily Advance with the Market" need to be particularly attentive to these market indicators, especially if they are "Watching and Waiting." "Advanced Stage Providers" will look increasingly to regional and national, rather than local, market levels.

In some cases, these metrics can serve as trigger points that indicate significant market shift demanding immediate action. The recent wave of national insurance mergers may be one of those indicators for certain markets. A significant uptick in competitor network development and value-based contracting activity would be another.

While the industry continues to evolve to alternative payment and care models, a more nuanced approach is emerging for individual systems. By honestly assessing who they are and where they want to be positioned in their market, healthcare systems can pace their change to reflect the reality of their local markets and proactively manage the risk of transition.

How We Can Help

PYA has extensive experience in assisting healthcare organizations with the development and implementation of innovative strategies to properly navigate the transition to value-based reimbursement. Specifically, we can help with:

- Strategic plan development
- CIN and ACO development
- Board education and retreats
- Market and competitive assessments
- Payer strategy and contracting assistance
- Affiliation planning and assistance
- Service demand and financial assessment

For more information regarding strategic planning and positioning for value-based reimbursement, please contact:

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