



NAVIGATING THE RISE OF VALUE-BASED CARE:

A STRATEGIC APPROACH FOR HOSPITALS TO SUCCEED UNDER SHARED-SAVINGS CONTRACTS

Andrew Goodman, MPH, Consultant, Lumeris

EXECUTIVE SUMMARY

Navigating the rise of value-based care: A strategic approach for hospitals to succeed under shared-savings contracts

The future viability of the U.S. health care system and the country's economic stability depend upon reducing the costs of health care while increasing its quality. The change from traditional fee-for-service payments to risk-based and value-based arrangements disrupts the traditional business model for hospitals, more than for any other stakeholder in the health care system. This whitepaper outlines a strategic planning approach necessary for hospitals to succeed under shared-savings contracts.

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NAVIGATING THE RISE OF VALUE-BASED CARE: A STRATEGIC APPROACH FOR HOSPITALS TO SUCCEED UNDER SHARED-SAVINGS CONTRACTS

The future viability of the U.S. health care system and the country's economic stability depend upon reducing the costs of health care while increasing its quality. In the past several years, leaders from the public and private sector have forecast dire financial scenarios without a fundamental change to the health care financing system.^{1,2,3} The Patient Protection and Affordable Care Act of 2010 attempted to address this problem, most notably with a provision that encouraged the formation of Accountable Care Organizations (ACOs) including the Medicare Shared Savings Program (MSSP).

An ACO is a contract between a payer and a group of providers that offers incentives for physicians to serve a defined population with the most efficient, high-quality delivery of health care. The ACO concept is an evolution of several different types of payment models.⁴ Its incentives place providers “at risk” for the quality of care and the costs for the identified population. Providers who reduce overall costs share in a portion of the savings — but if costs are higher than projected, providers may have to return a portion of the revenue.

The MSSP concept has become quite popular, despite skepticism about the model's potential to result in savings.⁵ In January 2013, the Department of Health and Human Services announced 106 new MSSP awardees, bringing the total number of government-sponsored ACOs to more than 250.⁶ ACOs are developing in the private sector, too, with insurance companies acting as the primary payer, rather than Medicare. In a recent analysis of 80 commercial ACOs, 51 had private-payer contracts (17 of which had contracts with multiple payers) and 29 had both private- and public-payer contracts.⁷

THE CHALLENGE FOR HOSPITALS

The change from traditional fee-for-service payments to risk-based and value-based arrangements disrupts the traditional business model for hospitals, more than for any other stakeholder in the health care system. Hospitals have done well in the current fee-for-service system, and without a strategic approach an abrupt change in financing could be disastrous. Reducing overall costs ultimately requires a reduction in acute care utilization, meaning fewer emergency room visits and admissions. Shifting services to lower-cost outpatient settings will be necessary. Lowering the cost of inpatient services — through lower prices — will result in an equivalent revenue reduction to hospital systems.

¹Orszag PR, Ellis P. The challenge of rising health care costs — a view from the Congressional Budget Office. *N Engl J Med* 2007;357:1793-5.

²Chernew ME, Baicker K, Hsu J. The specter of financial Armageddon — health care and federal debt in the United States. *N Engl J Med* 2010;362:1166-8.

³Chernew ME, Hirth RA, Cutler DM. Increased spending on health care: long- term implications for the nation. *Health Aff (Millwood)* 2009;28:1253-5.

⁴Frakt AB, Mayes R. Beyond capitation: how new payment experiments seek to find the ‘sweet spot’ in amount of risk providers and payers bear. *Health Affairs* 2012; 9: 1951-1958.

⁵Eddy DM, Shah R. A simulation shows limited savings from meeting quality targets under the Medicare shared savings program. *Health Affairs* 2012; 11.

⁶Centers for Medicare & Medicaid Services. Program news and announcements for Medicare Shared Savings Program on CMS website: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html>

⁷Fisher ES, et al. A framework for evaluating the formation, implementation, and performance of accountable care organizations. *Health Affairs* 2012; 11: 2368-2378.

This reality clearly concerns many hospital leaders, as seen in their reluctance to enter into risk-based arrangements. A recent Commonwealth Fund survey of nearly 1,500 hospitals showed that only 13 percent were participating in an ACO or planning on joining, and 75 percent were not planning to join any ACO.⁸ While avoiding a shift to accountable care may reduce near-term risk for hospitals, it leaves ACO development solely in the hands of health plans and physician groups.

The long-term strategic risk of sacrificing hospital leadership in ACO development is significant. As advocates and stewards for their organizations' sustainability, administrators can help entities from health plans to hospitals understand the impact of value-based contracts on their revenue streams and cost patterns. They are in a powerful position to help steer the ongoing development of a value-based payment system, and at the same time mitigate near-term risk with a variety of strategies and techniques.

Accountable care providers focus on reducing unnecessary utilization through improved access to care and active outreach to high-risk beneficiaries and those with chronic conditions. In accordance with the Institute for Healthcare Improvement's goals of its Triple Aim initiative,⁹ this approach should reduce overall costs, with an equivalent reduction in provider revenue. In addition, it shifts revenue streams among providers, sometimes dramatically. Since hospital services represent approximately 50 percent of expenditures within any population, more efficient health care delivery produces a substantial impact.

As a result, a shared-savings financial modeling framework has proved useful to health care organizations interested in developing strategies for transitioning to value-based payment and accountable care. The framework design combines an actuarial payer model with a provider revenue model, which enables organizations to understand, plan for, mitigate and monitor risks and benefits relating to accountable care delivery. By utilizing this approach, organizations can create models to track variables of shared-savings arrangements that affect financial success, such as changes in utilization, "leakage" (patients attributed to an MSSP or other risk-based contract who utilize services outside of the hospital system) patterns, case mix, "backfill" (balancing out the reduction in inpatient admission with patients wanting elective or other surgeries) services, physician visit volume and shared-savings payments across all organizations involved.

UNDERSTANDING REVENUE CHANGES UNDER ACCOUNTABLE CARE

Taking a holistic view of a marginal change in delivery is the first step in assessing financial impacts of the transition to accountable care. No organization we are aware of is moving its entire population from volume-based to value-based payment in the near term. Therefore, both payment structures affect the overall revenue stream.

Looking beyond the direct impacts on the population segment that is undergoing transition (e.g., Medicare beneficiaries for a MSSP launch), leaders must recognize how changes in delivery for these members produce costs and opportunities across an organization's entire spectrum of patients. This area of consideration includes understanding how and when providers change their care patterns for all patients, including "spillover impact" for those outside the accountable care segment.

Hospital systems can target patient leakage reduction and case-mix changes specifically as opportunities to increase their revenue streams. In particular, reduction of patient leakage can provide an immediate revenue boost, sometimes before the impact of accountable care begins to reduce overall hospital utilization within the transitioning population. Leakage reduction should also benefit patients within an accountable delivery system. Additional revenue opportunities may surface as utilization decreases, in the form of backfill to populations outside of the ACO contract.

⁸ Audet A. Hospitals on the Path to Accountable Care: Highlights from a 2011 National Survey of Hospital Readiness to Participate in an Accountable Care Organization. The Commonwealth Fund 2012: Issue Brief Vol. 22.

⁹ For a Triple Aim initiative framework overview, see the Institute for Healthcare Improvement website: <http://www.ihl.org/offerings/Initiatives/TripleAim/Pages/default.aspx>

In order for hospitals to thrive in the new health care environment, planning efforts also need to include the following aspects:

- **Strengthening information ties between hospital systems and physician organizations.** Whether these arrangements are formal or informal, stronger relationships are vital to generating positive change and better care coordination. Sharing data between primary care physicians and the hospital system allows for easier discharge planning and follow-up within the ACO. Deployment of customized information tools equip primary care physicians to partner more effectively with a system's network of specialists, as well as its inpatient service lines (such as cardiology) that exhibit significant leakage.
- **Modeling changes to hospital case mix.** Increasing the effectiveness of care delivery will impact case mix and may affect a hospital's bottom line. Medical admissions frequently present opportunities for improvement in care delivery. Accountable care physicians may seek to reduce admissions for plan members with chronic conditions through active outreach and patient management, as well as improving access to primary care and concomitant reductions in use of the emergency room for their patients. In the transition to accountable care, hospital administrators typically see significant reductions in medical admissions and a marginal to insignificant change in surgical admissions. Revenue may increase since plans tend to pay surgical admissions at a significantly higher rate. Case-mix changes that impact margins and profitability can decrease wait time for surgeries, thereby increasing patient satisfaction. Eventually, hospitals can utilize this type of modeling effort to redistribute capital budget expenditures from inpatient to outpatient considerations (e.g., allocating dollars to primary and urgent care centers instead of using capital budget to build new beds and surgical suites).
- **Leveraging competitive advantages in local markets.** Apart from the transitioning population, newly available hospital beds generate opportunities for revenue enhancement. As accountable physicians improve care delivery and reduce medical admissions, hospitals can grow revenue through backfill by assessing the competitive market and focusing on specific service lines. To begin the process, administrators identify underserved population needs in the context of their system's demographic and health status and that of competing hospital systems. Many hospitals attempt to build or bolster "centers of excellence" that can serve as a magnet for elective admissions.
- **Understanding the nature and expected impact of a specific shared-savings or value-based contract.** To forecast total revenue impacts, leaders apply relevant benchmarks and knowledge of the specific nature of the comparison population. The presence or absence of risk adjustment, minimum savings (loss) corridors, the shared savings percentage and other minor contract details can impact a system's strategy significantly. Administrators also need to understand how to apportion shared-savings revenues between the hospital system and physician groups. Primary care physicians serve as a linchpin for generating impact, which adds importance to gaining their buy-in with appropriately structured incentives.

To construct accurate estimates of the impacts of migrating a segment of the population to accountable care, administrators need to understand as much as possible about the organization's current state. The variables described in this paper are only a sample of possible considerations, and each one's significance will differ by market and by hospital. After building an initial model, administrators need to track and modify variables over time, while continuing to monitor financial performance within a particular contract for a specific population.

MODELING PROCESS

A sound model analyzes claims and enrollment details, along with cost data from provider organizations. This preliminary stage of analysis identifies system leakage patterns and historical case-mix for the population being studied, as well as total cost and revenue for the population undergoing transition. It also analyzes local market patterns to aid in understanding of the competitive landscape, regional population demographics and health patterns, and to identify underserved health needs. The next step is comprehensive analysis of the shared-savings contract itself, which identifies critical success factors and risks inherent to the specific payment system, such as benchmark risk.

THE PATH FORWARD FOR HOSPITAL SYSTEMS

Although the transition to accountable care poses real and significant financial opportunities and risks to hospitals, the risks become manageable when hospital leaders deploy solid strategic planning. Their scope of planning must include gaining an understanding of the unique challenges and opportunities of value-based payment arrangements so that leadership can make informed decisions about entering or avoiding them.

Administrators can plan for change that improves their organization's financial health, along with the wellbeing of patients. They can gain actionable insights through effective utilization of models and forecasts of the explicit impact of various value-based payment systems and scenarios. And, as they gain confidence in interventions that lead to appropriate utilization reductions, these leaders equip themselves to undertake contracts with additional risk or full risk.

Modeling and monitoring the impact of shared-savings contracts is an essential part of the value that hospital participation adds to accountable care. As the U.S. health care system continues to transition to accountable care, hospitals must remain active contributors in the process. Their leadership role is necessary to ensure sustainable development of a more efficient and higher-quality health delivery system.

ABOUT THE AUTHOR

ANDREW GOODMAN

Andrew Goodman, MPH, joins Lumeris as a Consultant with unique academic and practical experience in health care measurement, clinical improvement, and population health. After studying at the Dartmouth Institute, he worked in program management and product development at Health Dialog, including a stint working directly with general practitioners in the United Kingdom. He previously worked at the Dartmouth Hitchcock Medical Center and with AmeriCorps.

ABOUT LUMERIS

Lumeris is an accountable care delivery innovation company offering health systems, payers and providers operational support, technology and consulting services. Our technology-enabled solutions and services help health care organizations design, build, operate, measure and optimize any accountable care model to accomplish the Triple Aim *Plus One*: better health outcomes, lower costs and improved patient *plus* physician satisfaction. The depth and breadth of Lumeris' solutions—combined with its near decade of experience in accountable care—make the company an ideal partner for any health care organization seeking the benefits of a better connected, aligned and informed accountable delivery system. For more information, 1.888.586.3747 or Lumeris.com.

ABOUT THE ACCOUNTABLE DELIVERY SYSTEM INSTITUTE

The Accountable Delivery System Institute (ADSI) is the premier resource for hospitals, health plans, and large physician groups seeking proven solutions and practical guidance on establishing successful models of accountable care.

ADSI is led by the seasoned experts who established one of the nation's first successful accountable delivery systems — long before “accountability” was an industry buzzword or there was an acronym to describe it. Through their efforts, they improved the management and delivery of health care by instituting rational economics, new operational processes, and innovative technology to enable value-driven health care decision-making throughout the enterprise. The result: improved revenue, lower per-capita costs, and better patient outcomes.

The ADSI faculty's years of refining this accountable delivery system have yielded valuable insights into what does and does not produce accountable health care. Through ADSI, these insights and solutions are now available to others seeking help in building their own accountable delivery system.

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