Part 4: The Value Mandate
What it Means for Your Organization

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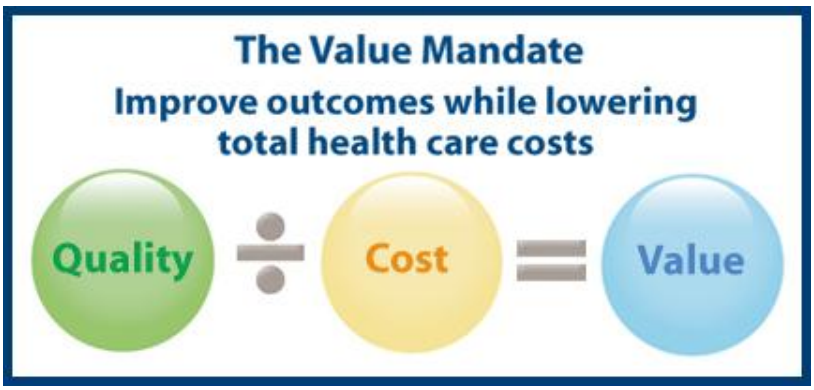
This is the fourth in a four-part series examining emerging research and best practices to help health care providers get in front of the challenges and pressures of providing patient care in a post-reform era. Part I set the stage by examining the improve quality/reduce costs value mandate. Part 2 highlighted research studies that identify opportunities to lower costs without negatively effecting health outcomes by reducing and eliminating the 20+ percent of discretionary and medically unnecessary tests and procedures. Part 3 addressed the challenges and benefits of coordinated and cost-effective care.

The Status and Future of the Value Mandate Equation

The outcome of the 2012 presidential election paves the way for implementation of most provisions of the Affordable Care Act (ACA) over the next four years. While health care providers will benefit from expansion of insurance coverage to 30 million more Americans, growing pressure to lower national health care expenditures will require hospitals and health systems to be more vigilant than ever to ensure that care is provided in the most efficient manner in the most cost-effective settings.

As noted throughout this four-part series, the new mantra for health care providers is to deliver value, meaning that quality and outcomes must be improved while health care costs are lowered, as shown in the value mandate equation below.



To date, more progress has been made on the numerator of the value equation - quality improvement - than on the denominator - cost reduction. Going forward, greater emphasis must be placed on cost reduction, although any major initiative to lower health care costs will no doubt mention the need to simultaneously maintain or improve quality of care.

Cost and Quality: What the ACA Says and ACO Pitfalls

Various elements of the ACA directly address both cost and quality. Several new payment mechanisms make Medicare reimbursement contingent upon achieving quality of care goals. The ACA also promotes development of new payment models, such as bundled payments and creation of accountable care organizations (ACOs), which can share the cost savings they achieve for the Medicare beneficiaries they care for, subject to quality thresholds. Private insurance companies have begun to adopt similar pay-for-performance models.

Conceptually, ACOs offer great promise for both improving quality and lowering costs. The focus on population health management, better coordination of care, a greater role for primary care physicians and physician extenders, reliance on evidence-based medicine, the alignment of financial incentives among providers, and the opportunity for shared savings all have the potential to positively affect both parts of the value equation.

However, an article in the November issue of *Health Affairs* , authored by Lawton Burns and Mark Pauly, health care management experts at the Wharton School of the University of Pennsylvania, suggests that ACOs "may have difficulty avoiding the failures of integrated delivery networks of the 1990s." Burns and Pauly structure their analysis around a 2011 publication of the Brookings Institution that identifies several principles key to the success of both Medicare and private-sector ACOs. Burns and Pauly researched government, academic, medical, and health services literature in an attempt to determine whether and how each of the capabilities listed below affected cost and quality.

Provider Capabilities Needed for Successful Medicare and Private-Sector ACOs

- Physician-hospital alignment
- Care coordination
- Disease management
- Patient-centered medical homes
- Health information technology
- Pay-for-performance and shared savings

Based on the evidence they gathered, Burns and Pauly conclude:

"The evidence ... suggests that components of accountable care organizations have limited and uncertain impact, especially on cost savings ... If the organizations increase 'value' (quality or outcome divided by cost), at best they raise the numerator but do not lower the denominator."

Rewards for First Movers

Burns and Pauly's sobering findings, coupled with the knowledge that true physician-hospital alignment is difficult to achieve, that care coordination remains an elusive goal, that primary care physicians will remain in short supply, and that health information systems are expensive and often difficult for providers to assimilate, leads us to conclude that the expected benefits of health reform, as least as they relate to the value equation, should be significantly tempered.

Moreover, the required organizational changes will be expensive and time consuming. The University of Pittsburgh Medical Center recently announced a five-year, $100 million investment to create a sophisticated data warehouse that brings together clinical, financial, administrative, and genomic information to foster personalized medicine. And while the Center for Medicare & Medicaid Services wants ACOs to assume both upside and downside risk within three years, Burns and Pauly's research suggests that five to seven years is a more realistic window.

At the same time, first movers who get it right - who build the necessary primary care base, put physicians in leadership roles, set up robust clinical information systems, and create a culture that supports change - will thrive, broadening the population base they serve at the expense of competitors struggling to survive. The challenges are great. So are the opportunities for those who lead the way to new solutions.

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