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4. VOLUME TO VALUE CHOOSING YOUR STRATEGY FOR VALUE-BASED COMPETITION

by John M. Harris and Bonnie Frazier

For decades, hospitals have vigorously competed for patients, physicians, and market prominence. But the impending transition from volume to value may transform our perspective on what it means to compete. Call it disruptive innovation, aggressive competition, game-changing strategies, or betting the farm. The coming years are likely to be a high-stakes wild ride.

In the new environment, you must decide on your best strategy based on a deeper understanding of your own organization, your competitors, and the market dynamics driving competition.

Real Competition

Many healthcare theorists have been calling for increased competition based on value as a means to drive improvement throughout the healthcare system. Now the traditional barriers to competition are starting to peel away (Exhibit 4.1), spawning a highly competitive market based on the value of services purchased. The payer world is driving much of the change through benefit design and contracting changes, which are having a profound impact on providers. The speed and degree of this impact vary and should be monitored for each local market.

With the shift from volume to value, the healthcare industry is experiencing something closer to true competition than it ever has before, forcing providers to concentrate on value. To succeed in this environment, hospitals and health systems must focus on lowering the total cost of care and improving quality and the patient experience.

Insurance marketplaces under the Affordable Care Act fuel competition by allowing individual choice. Consumers may choose to purchase insurance based on their budgets, forgoing expensive providers in exchange for lower premiums or co-payments. Consumers can also compare quality and satisfaction scores to guide their choice. Though these choices are primarily available to participants on the public insurance marketplaces, private insurance marketplaces could bring similar dynamics to a greater proportion of the population. And given that hospitals have high fixed costs, even small shifts in market share can have a significant financial impact.

As competition increasingly focuses on value, providers are seeking to manage the total cost of care while improving quality and increasing patient satisfaction.

About the Authors

John M. Harris, MBA, is director at Veralon, management consultants to the healthcare industry. He advises hospitals and health systems, health plans, clinically integrated networks (CINs), accountable care organizations (ACOs), physician–hospital organizations, independent practice associations, and conversion foundations. Harris supports clients on strategy and facilitates planning retreats. He assists clients with mergers, acquisitions, and affiliation strategies. He guides development of physician alignment strategies and supports the creation of CINs and ACOs as well as optimization of their performance. Harris is a frequent author and speaker for the Healthcare Financial Management Association, the American Association of Integrated Healthcare Delivery Systems, and other organizations.

Bonnie Frazier, MHA, is a senior associate with Veralon, where she focuses on strategic business and financial planning for healthcare organizations, physician alignment strategies, new payment models, and fair market valuations.

Exhibit 4.1 Increasing Competition in Healthcare

Historical Barrier to Competition	New Competitive Environment
Employers select health plans with broad networks to avoid upsetting employees.	Individuals select health plans on insurance marketplaces, increasing the likelihood that some will choose a narrow network plan (trading choice for lower premiums).
Rich benefits plans buffer patients from costs.	High-deductible health plans increase price sensitivity among consumers.
Patient out-of-pocket costs are the same for high- and low-cost providers.	Differential co-payments based on provider pricing increase consumers' ability to shop by price.
Fee-for-service payments are adequate to meet physicians' income goals.	As fee-for-service payments tighten, physicians are more willing to take responsibility and be rewarded for managing population health costs.
Only a small minority of payers provide incentives to manage costs; insufficient incentives exist for providers to change focus and transform care delivery.	As Medicare, many Blue Cross plans, and national health plans reward providers for managing quality and cost, there is critical mass for providers to pursue these strategies.
Health plan quality is not rewarded.	Medicare Advantage payments reward high-quality plans; ACOs must meet quality standards to receive incentive payments; Medicare Bundled Payments program recognizes performance in quality metrics.
The inability to define quality and measure performance weakens purchasers' ability to compare provider value.	Increasing acceptance of quality indicators and efforts to aggregate data create more accountability for quality.
An imbalance of information means patients usually relinquish control of healthcare decision making to their physicians.	Mobile apps and Internet information sources enable patients to be more active in their medical decision making and to be more informed consumers of healthcare.

With this motivation, three major strategies are crystallizing. The first is the most commonly discussed: health systems becoming accountable for population health costs and quality. The second strategy is a reaction to possible market developments that put physician entities at the center of managing population health. The third strategy focuses on low unit costs as the means to attract market share.

Accountability for Population Health

Most advisors encourage hospitals and health systems to develop the capabilities to become accountable for population health. Strong systems can tie in patient populations and provide care at a lower overall cost by minimizing avoidable admissions and services.

A population health strategy promises to improve quality and the patient experience through better coordination of care. Our disjointed healthcare marketplace still has plenty of room for this, and a strategy focused on population health is a good vehicle for driving such improvements.

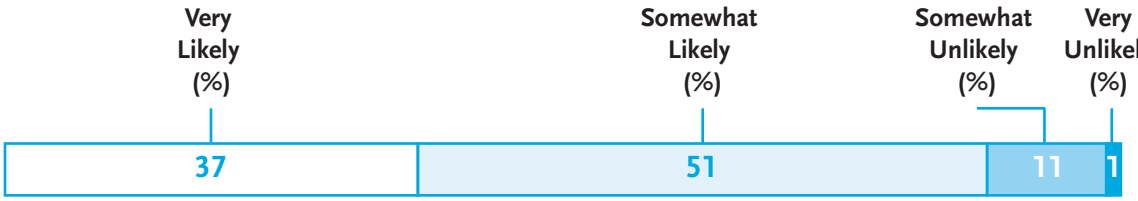
This strategy includes arrangements with payers to share savings or otherwise reward success in managing population healthcare costs. However, these models often drive down the use of hospital services, and the shared savings or other incentives typically do not make up for the revenue decline. Systems pursuing a population health strategy must gain market share to offset potential volume and revenue decreases.

Some providers have resisted population health strategies for fear of driving down utilization and not securing the necessary market share gains. However, health system leaders increasingly recognize that if they do not manage utilization, competitors will do it for them. Those competitors can be other health systems grabbing market share or physician entities such as those described in the second strategy.

FUTURESCAN **SURVEY RESULTS:** Volume to Value

A **narrow network** provides a more limited choice of physicians and hospitals to health plans in exchange for net lower plan costs.

How likely is it that the following will be seen in your hospital's area by 2020?

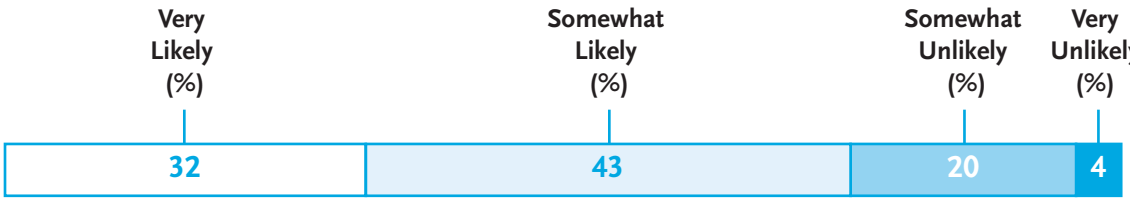


Higher-cost hospitals will see a greater decrease in volume than lower-cost hospitals.

Large independent physician entities will be more successful at managing the total cost of care than entities that include hospitals along with physicians.

Hospitals will be able to increase volume in their service lines by offering bundled payment arrangements.

How likely is it that the following will be seen in <u>your hospital</u> by 2020?



More than 20 percent of your hospital's patients will be covered by a narrow network insurance product in which your hospital participates.

Note: Percentages may not total to exactly 100% due to rounding.

What Practitioners Predict

Higher-cost hospitals will experience greater decreases in volume. Most (88 percent) of those answering the survey predict that higher-cost hospitals will experience a larger decrease in volume than will lower-cost hospitals by 2020.

Total cost of care will be equally or better managed by entities that include both hospitals and physicians than by those with physicians alone. Survey respondents are more divided on this question, but the majority (60 percent) consider it unlikely that large, independent physician entities will be better able to manage the total cost of care by 2020 than will entities that include both physicians and hospitals.

Bundled payment arrangements may help increase volume in service lines. A little more than three-quarters (78 percent) of those responding to the survey predict that, over the next five years, offering bundled payment arrangements could increase volume in hospital service lines.

Narrow networks will cover at least 20 percent of patients. About 75 percent of survey respondents think that by 2020 at least one-fifth of their patients will be covered by a narrow network health plan.

While a population health management strategy allows organizations to align clinically and financially with both providers and patients, fully realizing this strategy requires significant resources and critical mass. Success requires organizational cooperation, physician onboarding, patient engagement, and a major investment in information technology and data management capabilities. All of these components require time, scale, coordination, and financial investment. Antitrust concerns could prove to be a barrier to reaching the critical mass required to support this investment, particularly in smaller markets.

The end game for some health systems is to vertically integrate and develop an insurance capacity as well. Whether health systems become insurers or simply contract with insurers on a value basis, the success of a population health strategy will depend on how competition evolves among and between providers and payers in each local market.

Physician Networks: Partnering with Potential Disruptors

Health systems will need to keep an eye on physician networks because these potential disruptors can leverage their patient relationships and be rewarded by health plans for managing population health. Patient-centered medical homes, physician-sponsored ACOs, and risk deals give primary care physicians the opportunity to partner with health plans and keep population health savings for themselves, treating hospitals as cost centers. In a more extreme extension of this approach, some health plans are acquiring primary care practices.

Will physicians succeed at this strategy? Fewer than half (40 percent) of *Futurescan* survey respondents think it likely that large, independent physician entities will be more successful at managing the total cost of care than will a joint physician–hospital entity. It can be difficult for physicians to invest sufficiently to succeed in these models. Half-hearted efforts are likely to yield poor results.

Yet physician groups do have the potential to compete successfully. Many physician groups could be fierce competitors. Even relatively small groups can drive down hospital utilization and shift referrals to lower-cost or more cooperative hospitals.

Physician disruptors are not limited to primary care. In a more narrowly focused example of this strategy, some specialists are using bundled payments to retain the savings they achieve in orthopedics and cardiac care. If this is the situation in your market, it may be beneficial to position yourself as a potential partner to these physician groups, bringing them under an umbrella of affiliation and integration from which both parties benefit. Close alignments can provide some of the benefits of physician employment without the high price tag that most employment models bring.

Connecting to physician networks that are pursuing population health strategies comes with a price tag. They will expect cooperation and support in managing the flow of care and good pricing to support payer contracts that reward them for managing care costs. Finally, physicians will want to be sure that care is provided in the most cost-effective setting. High-priced hospital outpatient services will likely be bypassed in favor of lower-cost freestanding alternatives.

Lower Unit Costs: The Alternative

If robust population health capabilities are not on your organization's horizon, the path to success could be in becoming a low-cost provider. Although less trendy than a population health focus, this strategy can be effective.

At its core, the total cost of care is a function of the number of units multiplied by the cost per unit. Even in value-based payment models, somewhere in the mix there is a unit of service and a cost identified for that unit.

The population health strategies described in this essay focus on reducing the number of units, particularly units of service that can be avoided, such as hospitalizations for uncontrolled diabetes. In a market with competition based on total cost of care, hospitals focus on population health strategies so they can retain higher per-unit payments by not wasting resources on avoidable services.

As prices of healthcare services become more transparent, hospitals and health systems that are able to point to good quality scores and low costs may be able to compete effectively with market-specific brands, attracting the volume required for success. Looking toward 2020, almost 90 percent of *Futurescan* survey respondents believe that higher-cost hospitals will see a greater decrease in volume than lower-cost hospitals.

Several competitive mechanisms may drive this shift. Consumers at risk for costs may choose lower-cost providers. Physician entities pursuing population health strategies may steer patients to lower-cost providers so they can perform better in their insurance contracts. Health plans may narrow or tier their provider networks to steer patients to lower-cost providers.

When competing for inpatients, lower-cost hospitals will be able to tap into these competitive mechanisms to gain market share.

However, competing for outpatient services will be more difficult. Almost every hospital is high cost relative to a freestanding outpatient provider.

A key risk of the lower-unit-cost strategy is being squeezed out of the market by hospitals that pursue a population health management strategy and control referrals. In the long run, those hospitals will not be able to maintain pricing that is above what the market will bear, but in the short run they could limit patient access to lower-cost providers. Be sure you have access to patients through payer contracts and alignment with physicians.

For some organizations in certain markets, focusing on becoming a lower-cost provider may be a better strategy than developing population health management capabilities.

Implications for Hospital Leaders

Understand market players. Consider your competitors and their strategies. Going head-to-head with the strongest competitor is rarely the best strategy. Instead, determine what opportunities that competitor's strategy creates for your organization.

You will need to determine which strategy will support success in your market—and whether or not you will be able to achieve that success on your own. Conducting a full evaluation of potential partners will help you decide which healthcare organizations or physician groups, if any, might be a good fit.

Consider physician strategy. If you are pursuing a population health strategy, including both independent and hospital-employed physicians in a clinically integrated network (CIN) can be an effective approach. Be sure physicians have a strong leadership role and see the value of the CIN through appropriate rewards.

Although many organizations believe that employment is a surefire way to secure your market position, you can never "own" your physicians. Contracts eventually end, and physicians who are uninspired by their employment arrangements and role in the health system may seek alternatives. If independent groups are being rewarded by health plans in a population health strategy, they may be able to offer higher compensation.

Set a payer strategy. Monitor payer initiatives closely. The traditional strategy of negotiating for the highest rate may drive away volume as consumers or physicians choose lower-cost providers. If payers are driving change through physician incentives, then that behavior will bolster a population health strategy led by physician groups. If payers are willing to partner with hospitals for population health, a hospital-driven population health strategy may be viable.

Slim down. Whether your organization pursues a population health management or a lower-cost strategy, keeping the cost of operations under control will increase the chances of success. If you are pursuing a population health strategy through a CIN, traditional approaches to managing operating costs can be bolstered through actively engaging physicians in these efforts.

Consider teaming up. All of these strategies beg the larger question of whether you need to merge or affiliate with a larger entity to succeed. Assessing your strategy based on a competitive analysis will help you make that decision.

Getting on Board or Going Overboard?

In this new competitive environment, there will be winners and losers.

The challenge will be to select your strategy and gauge how much, how quickly, and in what way your local market will move into this age of intensified competition. If you move too quickly, you may reduce operating margins. At the same time, being last to the party will also threaten market share.

Conclusion

The best strategy for your organization will depend on the degree and speed of transformation toward value-based competition in your market. The days of five-year plans and linear projections of utilization and revenue are long gone. As the shift from volume to value causes competition to intensify, healthcare organizations will need new and more sophisticated ways to analyze strategic alternatives. FS

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