A Roadmap for Healthcare Convergence

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Executive Summary:
The U.S. healthcare industry is undergoing a wave of radical change and disruptive innovation.

As reimbursement evolves from fee-for-service to fee-for-value, payers and providers are searching for different ways to collaborate to distribute and mitigate the risks of the new model. The goal of this transformation is to improve the overall quality of care while driving down, or at least containing, the nation's rising healthcare costs. While that growth has slowed in recent years, the trend still is regarded as unsustainable, and public and private payers are pushing risk back onto hospital systems and physicians. The key to succeeding in this tumultuous environment is to breach the walls among payers, providers and patients, leveraging advanced technologies and experimenting with various business models. All players will assume aspects of each other's traditional roles; that is, those roles will converge. This will demand new capabilities. This article defines those capabilities and provides a road map for developing them.

Road Map to Healthcare Convergence: The Big Risk Shift

Few issues in recent years have attracted so much attention in the United States as healthcare reform. All the traditional methods of delivering healthcare in America have been called into question; all the players in the healthcare space are focused on devising innovative ways to provide care in more effective, less costly ways. For many years, a revolution in U.S. healthcare delivery has been called for. After many fits and starts, it finally has arrived — albeit to varying extents across different populations and markets.

The seeds of this revolution were planted long ago — in the baby boom. That aging population now is developing the expensive-to-treat, inevitable long-term chronic conditions that drive rising, unsustainable healthcare costs, as well as swell the Medicare rolls. Without bending that curve, it has been estimated by the Centers for Medicare & Medicaid Services (CMS) that healthcare costs will reach **20 percent of gross domestic product in 20 years**. Some estimates run higher.

Responding to this crisis, the 2010 Affordable Care Act (ACA), designed (in part) to control these costs, has accelerated the move from the traditional fee-for-service reimbursement model to pay-for-performance or fee-for-value, shifting financial risk from payers to providers. By 2017, the ACA will require Medicare to modify payments to all physicians and physician groups based on risk-adjusted quality and cost metrics. The ACA already has led CMS to reduce payments to hospitals with what it considers poor outcomes: excess readmissions of patients with acute myocardial infarction, heart failure or pneumonia. And the CMS has proposed expanding this list of applicable conditions for 2015.

At the same time, patients are becoming more sophisticated about healthcare costs as employers either move employees to ACA-mandated health insurance exchanges, where employees must shop for their own policies, or offer policies with higher deductibles, thereby shifting financial risk to employees.

The first step for any organization on this path is to assess what capabilities it currently possesses. Only then can it identify what needs to be done to ready itself for all the steps that will follow.

All this risk shifting is occurring as advanced technologies make it feasible to understand and manage the health risks of both individuals and large patient populations. Big Data and analytics can help payers and providers stratify populations with ever-greater granularity to distribute and mitigate risk, as well as develop evidence-based treatment protocols to standardize and improve care. Mobile technologies give patients greater access to providers, and vise versa, and allow for better personalization of care through follow-up treatment. And at the cutting edge of science, the field of genomics promises a new era of highly individualized treatment of disease.

These transformations in both the technological and financial underpinnings of the healthcare industry, combined with the critical importance of managing risk, have led to a plethora of emerging business models based on payer-provider collaboration, a convergence that runs the gamut from strict vertical integration to looser affiliations and value-based

contracts among insurers, hospitals and physicians.

For example, in 2010, Humana, a for-profit managed healthcare company, acquired more than 300 Concentra medical centers operating in 42 states, thereby expanding into medical services. Last year, Highmark, the largest not-for-profit insurer in Pennsylvania, acquired West Penn Allegheny Health System, an academic medical center in Pittsburgh, to form a Kaiser Permanente-type integrated system offering both insurance and hospital operations. And UnitedHealth/Optum offers managed care plans under UnitedHealth and health services (population health management, health information technology (HIT) and pharmaceutical services) under Optum.

Blue Shield of California, rather than acquiring hospitals, identified 16 facilities with strong results for knee and hip replacements and informed its California Public Employees' Retirement System (CalPERS) members that it no longer would fully cover costs for those procedures if performed at other medical centers.

Providers also have been active. Georgia-based WellStar Health System, for instance, with five hospitals, is forming regional alliances to manage population health and will be offering insurance plans later this year.

The competition to create these new organizations, and form these alliances, can be fierce. In March 2014, the 200-doctor Whittier Independent Practice Association in Massachusetts left the private-equity-owned, 11-hospital Steward Health Care System (a vertically integrated operation) after two years to re-establish a loose affiliation with Boston's Beth Israel Deaconess Medical Center. Whittier's physicians, initially attracted to Steward by financial incentives, wanted to be able to refer patients to Beth Israel Deaconess with what Whittier adjudged to be its greater ability to manage complex cases and, therefore, the Whittier doctors' risks.

The theme in all these cases is the same: To compete, payers and providers must establish new relationships. And to develop these relationships and business models, the participants in this roundelay in which everyone is experimenting, expanding, converging and (as with the Whittier group) choosing sides, parties must improve their clinical and financial capabilities.

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Seven Core Capability Requirements for Convergence

To help organizations identify and assess the capabilities required for convergence and Accountable Care readiness, FTI Consulting has developed a Convergence Maturity Model. It is a matrix consisting of seven areas in which excellence in pay-for-performance or an Accountable Care environment is necessary and includes five levels against which organizations can benchmark their progress. These core capabilities include the following:

1

A Culture of Physician Engagement

At the Base Camp (or lowest) level, doctors are uncoordinated and minimally involved with the hospital's strategic and operational goals. There is little or no peer review, medical committees may be politicized and physicians compete for resources in unproductive ways.

At the Innovating (or highest) level, physicians understand, support and promote a hospital's mission and strategy. They are engaged, and there are strong processes in place to manage and resolve issues without tension or acrimony.

Graduating from Base Camp to become an Innovating organization demands that doctors must sit at the strategy table. But before that can happen, formal programs are needed to train physicians to assume leadership roles. On the clinical side, physician performance needs to be measured, and those metrics must be transparent, with the physician's success tied to the organization's.

Measuring and analyzing outcomes are the first steps toward improving performance. Geisinger Health System, a self-described integrated system, began collecting outcomes data, shared them with its physicians and, in collaboration with its health plan division, established evidence-based medicine guidelines for treatment. This dramatically improved outcomes across a range of conditions. After studying five years of data, Geisinger reported that its best practice guidelines lowered in-hospital mortality by 67 percent and reduced the chance that patients would need transfusions during surgery by nearly 50 percent, with concomitant savings. Indeed, Geisinger was so encouraged by these results that it is offering to cover the entire cost of any follow-up care provided by Geisinger clinicians in Geisinger facilities for Health Plan members who experience avoidable complications within 90 days of a covered procedure. That's a powerful competitive offer, and Geisinger is so confident in its ability to manage the risks that it is planning to offer this warranty to members of other insurance plans.

2

Clinical Integration

At Base Camp, there's active resistance to standardized clinical pathways. It's every physician for him- or herself. This often results in high readmit rates, unnecessary and often unpleasant one-day stays, and low referral rates that come from unhappy patients and doctors.

At the Innovating level, there's a strong emphasis on patient and physician satisfaction driven by feedback loops that improve care models and clinical processes.

Getting from Base Camp to Innovating requires first identifying and then actively managing areas of waste by establishing cross-functional teams for care integration, design and management. These teams should be incentivized with rewards for participating (and improving), and their performance must be monitored through quality metrics that should be continually raised, never lowered. Eventually, lean practices should be taught and deployed to identify areas of inefficiency and waste.

Lean strategies, drawn from the Toyota Production System, focus on preserving value with less work. At ThedaCare, a northeast Wisconsin health delivery system with more than 6,000 employees, lean strategies increased employee productivity by 12 percent, saving the hospital over $27 million annually. These savings have allowed ThedaCare to keep its costs low and improve its competitive position, attracting insurers and patients.

Lean improvements need not be dramatic. For example, at 155-bed Jordan Hospital in Massachusetts, a cross-functional team identified a small inefficiency that was creating waste and tension. When a surgical team member placed a cart in an elevator to send surgical instruments to the sterilization team, the cart often was arranged in the elevator with the handles facing inward. To get the cart out of the elevator, the sterilization team member had to squeeze past the cart to turn it around. The surgical team thought it took too long to get the surgical instruments to their destination, and the sterilization team felt intimidated. Everyone was at odds. Once the problem was identified, it was easily addressed, saving time and money and reducing tension.

3

Technology and Analytics

Organizations in Base Camp have invested little in health information technology and electronic health records, and the tools they do have are underutilized and poorly integrated. Innovating organizations have up-to-date technologies that help identify population needs and change healthcare delivery processes accordingly, mitigating risks by improving population health.

Acquiring HIT capabilities begins with rolling out electronic health records and other HIT enablers such as population analytics, quality metric tracking and dashboards that make data visible to administrators and physicians. Data must be shared as seamlessly as possible with both employed and affiliated physicians. Ultimately, the data also should be shared outside the hospital walls with ambulatory care. Evidence-based medicine guidelines and pathways need to be embedded into electronic health records.

At Boston Medical Center, which, as the city's safety-net hospital, was under

severe financial pressure due to cutbacks in CMS reimbursement, data were made available to the clinicians, and analytics identified areas of inefficiency and waste that physicians and administrators were able to address collaboratively. The hospital's financial profile now is much improved.

A similar instance of analytics directly leading to cost control occurred at Crystal Run Healthcare, a large physician-owned multi-practice group in New York State. A pilot analytics program on diabetes control allowed Crystal Run to drive down costs 20 percent in one year without any adverse impact on the quality of care.

4

Population Health Management

Care focused on individuals, provided by practitioners who have minimal communication with other caregivers and health resources, is characteristic of Base Camp providers. Innovating organizations, by contrast, use population data to improve outcomes throughout the entire system. High-risk segments (that consume a disproportionate amount of resources) are identified, and providers emphasize preventative and wellness programs to serve these specific groups.

To become an Innovating organization, care must be coordinated to distribute and limit financial risk (such as excessive readmissions). Caregiving teams must be able to share information about patients, and additional physicians need to be brought into the network to provide a comprehensive range of services. Analytics are used to stratify populations, and patients are engaged in their own care by participating in self-help programs and by leveraging HIT.

For instance, the Northeast Physician Hospital Organization, a management service entity that works with an independent physicians' organization with more than 300 doctors, created a diabetes registry, pulled from patient electronic health records, that it shares with physicians to generate monthly performance reviews. Using these reports, the organization met its 2012 performance targets for 60 percent of diabetic patients, up from 33.6 percent in 2010, thereby helping physicians meet pay-for-performance targets.

5

Legal and Governance

In an Accountable Care environment, performance will be tracked and regulation increased. But Base Camp organizations have minimal monitoring and reporting processes in place, and the compliance teams are underfunded and weakly supported at the top levels. Funding and supporting the compliance function — and establishing robust performance tracking mechanisms while creating standardized treatment paths and processes — are hallmarks of Innovating organizations.

The road to improvement for Base Camp organizations begins with gap assessment. Risks relevant to the ACA must be identified, and staffs must be trained on ACA provisions. At the same time, reporting procedures to payers and government agencies should be standardized, with a commitment to value-based process development coming from the top.

For example, Coastal Carolina Health Care, created through a merger of several medical groups, has 11,000 Medicare beneficiaries, with half its seniors enrolled in a traditional fee-for-service model. By participating in

the Medicare Shared Savings Program (MSSP) authorized by the ACA to create Accountable Care Organizations (ACO), Coastal Carolina's leadership hopes to succeed in commercial risk-based contracting. It purchased a medical records system and began implementing standardized guidelines for conditions and procedures. It also installed dashboards at point-of-care locations to remind physicians of necessary care guidelines. Using data mining and physician nominations, Coastal has been stratifying its patient population to enroll those who would most benefit in a value-based ACO, receiving advance funding from CMS to pay for these transformations. As Coastal's capabilities improved, the main hospital in the area has sought advice on how to lower its readmission rates. This will drive greater coordination with the hospital's emergency room and, Coastal believes, will attract commercial payers to its ACO.

6

Quality and Cost Measurement Capabilities

As reimbursement moves toward pay-for-performance, performance (obviously) will have to be measured. Base Camp organizations have difficulty doing that. They don't have metrics for emergency room waiting times, clinical throughput and the like. The metrics they do have are focused narrowly on market share and revenues, holdovers from fee-for-service.

Innovating organizations have sophisticated metrics that support continuous process improvements and focus on eliminating wasteful and unproductive variations in both clinical and administrative processes. Reducing variation almost always improves quality while lowering costs.

To reduce variation, the patchwork quilt of poorly integrated HIT point solutions for quality and cost measurement must be replaced by a single platform accessible to analytics. Dashboards should be installed to track quality, safety and performance metrics such as revenue per available bed per day, cost per discharge and so on. Outcomes also should be tracked and gaps in care identified to create efficiencies and reap savings.

The fruits of these improvements ripen quickly. In New York State, hospitals worked with government agencies to track the incidence of central-line associated bloodstream infections. Consequently, the rate of infection in neonatal intensive care was reduced 67 percent.

7

ACO Financial Reporting and Contracting

Standardized financial reporting increasingly is a critical part of ACA compliance, and expertise in contracting is essential to controlling costs. However, Base Camp organizations are characterized by fragmented reporting across departments, and contracting is limited by CMS requirements.

Today, remaining competitive depends greatly upon rolling up financial reporting across departments to identify waste and gain economies of scale. Integrated reporting also allows Innovating organizations to accurately assess their risks and discover new revenue opportunities. This is why organizations readying themselves for Accountable Care reimbursement models should standardize financial reporting and pilot pay-for-performance contracting strategies. Organizations also must begin conducting external benchmarking both to assess their performance relative to the competition and to find opportunities for revenue enhancement.

Tennessee-based Summit Health Solutions, an MSSP Accountable Care Organization with 36,000 Medicare patients — knowing it needed to improve its capabilities in managing claims data to succeed as an ACO — is developing a direct data feed from the east Tennessee health information exchange to its Optum Care Suite to identify at-risk patients and to aggregate paid claims data. And it's hiring a health economics specialist to complement data analysis capabilities. Summit is talking with both commercial payers about ACO contracting and with local employers interested in value-based arrangements.

Today, Everyone Has Skin in the Game

In the transforming, converging healthcare environment, all stakeholders — payers, providers, patients, employers and the government — are increasingly interconnected. Therefore, it makes sense that these groups should begin assuming roles and responsibilities that heretofore were the exclusive purview of one or the other, collaborating and integrating to get all stakeholders on the same page, with common incentives to improve quality while controlling costs.

The healthcare sector must take its cues from industry. That means reducing variation (in financial reporting, information technology systems, treatment paths and procurement); emphasizing teaming (to provide continuity of care and reduce harmful, avoidable errors); focusing on outcomes, not services (as the reimbursement model changes); and striving for continual improvement in a competitive landscape that will punish organizations that don't — although the extent of that punishment likely will vary considerably in different regional markets.

In these ways, healthcare costs can be controlled as quality improves. Healthcare players that improve their capabilities along the lines described in this article will be best positioned for success. ■

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