
VALUE-BASED CARE

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Reforming the U.S. Health-Care System

Are lower health-care costs and quality patient experiences possible?

Without meaningful reform, the current health-care system is unsustainable. While health-care inflation has moderated from the double-digit increases of the late 1990s and early 2000s, it continues to outpace general inflation and consume a growing portion of our economy. Yet, despite the high cost, quality results are mixed. Compared to our industrial peer countries, the United States generates the highest per capita health-care spend but has the lowest overall rating for health system quality, efficiency, access to care, equity, and health lives, according to a 2014 Commonwealth Fund survey. A recent study by the Dartmouth Institute for Health Policy and Clinical Practice finds that 30% of U.S. health-care spending is waste.

By Molly Loftus, Mercer

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of back surgeries are not medically appropriate.

This is not just an economic issue. Significant variation exists in treatment patterns nationally with physicians having different opinions and preferences regarding the appropriate course of treatment. Even where evidence-based treatment protocols have been established, compliance may be inconsistent. A recent study by Surgical Neurology International, an online-only journal, found that 61% of back surgeries are not medically appropriate. In addition to wasted medical expense, unnecessary surgery exposes a patient to medical risk, lengthy recovery process, lost wages and lost productivity, all without resolving the medical issue.

Ensuring that patients are receiving the right service, at the right time, in the right care setting, not only lowers costs but improves outcomes — a win for both the employer and the employee. This is the focus of value-based care (VBC).

The Role of VBC in Health-Care Spending?

As employers and payers continue to look for ways to curb health-care spending, attention has increasingly focused on the role of the provider in managing spend. Physicians, in particular, have a significant impact on the level of spend; the treatment plans they develop for their patients may include specialist referrals, lab and imaging tests, prescriptions for drugs, etc. Payment reform has become an industry buzzword as payers seek to change provider incentives by moving their reimbursement system from a fee-for-service approach to a fee-for-value approach.

Consider the current fee-for-service world and the incentives that it creates. A provider is paid based on the volume and complexity of services provided. The more services are rendered, the more the provider is paid. It does not matter if the service is unnecessary or, even worse, of poor quality.

In a fee-for-value system, provider payment is tied to cost and quality outcomes. Cost targets are established for the provider's patient population, and to the extent that the provider manages cost to below that target, the provider may share in those savings in the form of a performance bonus. The immediate concern in this type of arrangement would be whether providers now have an incentive to withhold necessary care. To address that concern, the provider also must satisfy specified quality standards. If those standards are not satisfied, then the amount of bonus payment is reduced or eliminated.

Creating appropriate financial incentives is not enough. Providers must change how they approach managing the cost and care of an entire population. This has led providers to create new organizational structures to address these needs, the most common of which are Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs).

ACOs and PCMHs both involve groups of providers who in partnership collectively enter a contractual relationship with a payer. These groups take on responsibility for managing the cost and quality outcomes of an assigned patient population.

A PCMH is comprised of primary care physicians, who coordinate the care of their patients and manage cost and quality through both their direct patient care as well as through their referral patterns.

An ACO is a fully integrated delivery system that includes primary care physicians, specialists, and hospitals. This system of providers work together to coordinate the care of their assigned patients, often using a common electronic health record system to ensure all providers in the ACO have full insights into all of a patient's medical data.

Once the ACO or PCMH is organized, and the contract is signed, the delivery model must be transformed to realize the goals of cost and quality. This care transformation focuses on managing total population health, which means not simply treating those patients who are scheduled for an appointment, but also identifying and resolving gaps in care across all patients.

It also involves treating a patient holistically and in a coordinated manner, avoiding duplicative testing and addressing all of their symptoms and comorbidities.

While the application of care transformation is complex, there are some high-level elements that are critical for success.

Both IT infrastructure and governance play a critical role in establishing a successful VBC model. Population health management is dependent upon data, including the health conditions of the patient population, predictive analytics to identify at-risk patients, insights into member utilization patterns and data on individual physician practice patterns to monitor compliance with evidence-based medicine.

Governance is equally important as long-established practice patterns can be difficult to change. The governing body must have an appropriate level of authority, access to individual physician and facility performance data, and clinical expertise to drive practice transformation and monitor the impact on population outcomes. Individual physicians must understand and buy into the new compensation structure.

The Challenge for Employers

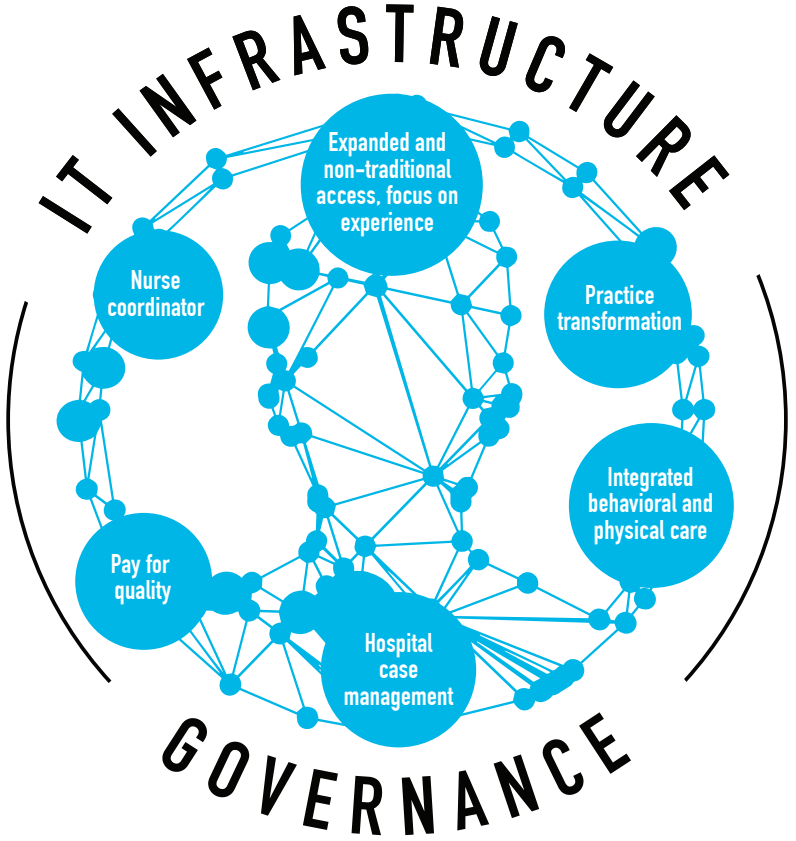
Most national health plans have embraced the value-based-care movement. Mercer's 2015 national Value Based Care RFI (request for information) captured more than one thousand commercial VBC arrangements between provider systems and health plans, with roughly two-thirds of the U.S. population having access to a value-based-care system.

Initially, the focus from health plans was to establish VBC arrangements with provider systems and provide them with the data and tools needed to support their development. Employers wishing to promote VBC solutions were largely limited to soft steerage through communications campaigns.

More recently, health plans have begun rolling out network — based solutions that are built upon VBC systems, such as narrow networks or tiered networks. Through these networks employers can steer their members more directly to providers who participate in VBC arrangements.

As you think about your benefits strategy, keep in mind that health care is local in nature, with different parts of the country facing different

Figure 1 | Elements of a VBC Model



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health-care challenges and different areas of opportunity. Similarly, the availability of VBC solutions is highly variable across the country and across health plans. Speak with your current health plan to ask about their solutions, including:

- What local provider systems are under a VBC arrangement?
- What financial and quality outcomes have been achieved by these systems?
- What types of network or plan design options exist to steer to these systems?
- How are these providers reimbursed? For example, what is the range of care coordination fees, and are providers in these systems eligible for a shared savings bonus? Do any of these providers take downside risk?
- What reporting can they provide to demonstrate utilization of these providers by your employers and your costs and savings?

Minimum Steps Employers Should Take

It is not uncommon for employers to take a wait-and-see approach before rolling out the newest industry solutions to their employees. The VBC evolution is still in early days, and there is limited information currently available to compare results across health plans and across provider systems on a consistent basis. Many employers don't realize that VBC is happening now, and their employees may already be participating.

The VBC contracts between a health plan and a provider system are typically embedded in their broad PPO networks. If a member utilizes a provider who is part of that contract, the member may become "attributed" to that delivery system, generating care coordination payments and possibly shared savings bonuses. For a self-funded employer, these charges are often funded directly from the employer's bank account — similar to any other claim. In other instances, they may show up as a new line item on a monthly or quarterly invoice. Employers at times are not even aware of these new charges.

As the health plans continue to expand the use of VBC contracts, the volume of these new charges is growing. Employers should ask their health plan provider to furnish VBC reporting: How many members are considered attributed to a VBC provider system? What VBC charges have been paid? What savings have been realized? How have utilization patterns and clinical outcomes been affected? If you are paying for something, you should understand what value you are receiving.

Why VBC Is Favorable

Value-base care holds great promise for transforming the health-care system. Through payment reform and enhanced care coordination, VBC aims to deliver lower cost, improved quality and a better patient experience. Like all new solutions, this will not happen overnight. It is likely that local results will be highly variable as health-care providers experiment with different approaches to care transformation. Employers should talk with their current health plan provider to understand what their employees are experiencing today and what future options exist to fully leverage the VBC opportunity. ws

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