

APPROACHING VALUE-BASED HEALTHCARE

Learning Objectives

Upon completion of this chapter, you should be able to

- recognize the “iron triangle” of value in healthcare, including better quality, lower cost, and better access;
- understand the impetus behind volume-based healthcare;
- appreciate the historical evolution of healthcare in the United States;
- apply risk adjustment in evaluation of the resources used in consuming healthcare;
- create strategies to deliver value in healthcare;
- compare various models of healthcare delivery that focus on delivering value;
- demonstrate how pay-for-performance can encourage value in healthcare;
- enumerate ways in which value in healthcare is defined through clinical outcomes;
- explain how healthcare providers are increasingly being held accountable for the outcomes of the care they provide; and
- examine the changes needed in the current healthcare delivery system in the movement to enhance value.

Introduction

What is value? Imagine you went to an expensive store and purchased an elegant traveling bag for an extremely high price. The service provided at the store was terrible, but you still purchased the bag, thinking it was worth the money. You then went on a long-planned trip, only to find that the bag broke along the way and did not live up to its promise. Thus, even though you paid a high price, you had a bad experience that you did not value.

Healthcare in the United States exhibits a similar dichotomy between the price society pays and the value it derives from the healthcare it consumes. When prices are high but outcomes are less than what practitioners promise

or what consumers and patients desire, patients are left unsatisfied. Our current healthcare situation is a product of a variety of historic, economic, and political realities that must be fully understood if value is ever going to be fully integrated into healthcare. If we fail to adequately address these realities, potential solutions will likely fail.

The 2010 passage of the Affordable Care Act (ACA) was supposed to herald a paradigm shift in US healthcare, away from the old model of **volume-based healthcare** and its emphasis on “heads in beds.” Under the volume-based model, both consumers and providers believed that more is better and sought to maximize the volume of services provided. Hospitals would often adopt strategies to increase inpatient census, and providers would be incentivized to provide unnecessary services, which would drive up revenue. At the time the ACA was passed, this volume-based approach was becoming recognized as obsolete.

Although political debates over the ACA have taken the spotlight, the reality behind the law remains: Healthcare that is not value driven is unsustainable. The value of healthcare is determined not by the amount of care delivered but by the outcomes of that care, in comparison with the outcomes of similar care delivered in other systems. The goal should be to get the maximum amount of effective care for each dollar spent on healthcare. Regardless of any potential changes to the law in the years ahead, the ACA gave momentum to a movement in healthcare, and it catalyzed market shifts. In response, key stakeholders have positioned themselves to take advantage of the law and to benefit from the opportunities afforded by its implementation.

As part of this paradigm shift, healthcare is taking a leaf from the rule-book of other industries by making patient satisfaction a measurable deliverable. The sustainable systems of the future will be operationally efficient, and they will deliver care across a variety of disease conditions in a manner that can be measured. Providers will be evaluated based on appropriateness of care and on outcomes. They will also be incentivized to deliver care that is considered value based. This distinction may be driven by a combination of clinical, economic, political, and outcomes metrics.

The debates surrounding the adoption of the ACA reflect a division in the way healthcare is viewed in the United States. If healthcare is regarded as a pure commodity, then its cost should reach its inherent actuarial value. However, if healthcare is a service, then society has an obligation to provide the service universally (Starr 2011). As Starr explains, the ACA reflects a compromise between these two possibilities. Given that healthcare has an enormous impact on the US economy—in 2009, it accounted for 17.6 percent of the nation’s gross domestic product (GDP), and that percentage is expected to reach 19.8 by 2020 (Keehan et al. 2011)—the ACA seeks to mitigate the share of the GDP consumed by healthcare.

volume-based healthcare

A traditional healthcare paradigm in which consumers and providers sought to maximize the volume of services provided.

Effective healthcare must work to reduce barriers to access, and the number of people who are uninsured is a common metric for such barriers. The ACA aimed to expand health insurance to more than 30 million previously uninsured individuals, which led to concerns from people opposed to the law that the overall cost to society would go up. However, if true value is achieved in the delivery of healthcare, the per-capita cost of care should be reduced, and care should be provided for more people. Enhanced preventive care and population health initiatives are expected to reduce the overall cost of healthcare to society, which would counterbalance the cost of increasing the number of people insured. Thus, the expansion of insurance should result in efficient use of healthcare, with an increase in preventive care (Buchmueller et al. 2005). In addition, regulatory changes have introduced market incentives to ensure efficient healthcare delivery that minimizes waste and harm, leading to significant private-sector activity.

The ACA sought to fund its mandate through a variety of methods, including an excise tax, emphasis on preventive care, and cost containment. However, a substantial portion of the law deals with costs related to clinical decisions and intersects significantly with issues of quality. The law—as well as its variants or any successor laws—will need to ensure that the value equation produces tangible savings to fund the costs of implementing or expanding the value-driven healthcare that people desire. Only by doing so will the whole edifice be sustainable.

In light of these changes, the emphasis is shifting to creating sustainability in healthcare organizations through a quality and value paradigm. This value paradigm will probably take several decades to play out comprehensively. Although the traditional forces shaping hospital finance, operations, and strategy remain important, these forces will need to be viewed through a lens of quality and value. As a result, healthcare administrators will need to become familiar with the various facets of quality in healthcare, and they will need to keep value in mind as they carry out the responsibilities of running a healthcare enterprise.

This chapter will survey the various aspects of healthcare organizations that are being affected by the shift toward **value-based healthcare**. It will explore evolving structures, financing mechanisms, and information technology that will be needed to meet the mandates of the new paradigm. Later chapters will deal with these issues individually and in greater detail. The overarching goal of this book is to examine in depth what value in healthcare means, what tools can be used to achieve this goal, what metrics are needed to guide healthcare's evolution, and what changes are needed to finance healthcare with quality and value in mind. The book will explore in some detail what clinical elements that incorporate value will look like. It will also provide perspective by discussing the historical evolution of different players in the industry, which in turn will help drive sustainable value-driven change.

value-based healthcare
An approach that seeks to reduce the cost of healthcare delivery while increasing quality of care and patient satisfaction.

Value in Healthcare

Value in healthcare refers to the health outcomes that are achieved for every dollar spent. Better quality, lower cost, and better access can be considered the three points of the “iron triangle” of value in healthcare (Kissick 1994). Value should define performance in healthcare, and it should be structured around the patient. Value depends on outcomes, not on inputs. Value is not measured by the processes of care that are used. Process improvement and measurement are important tactics, but they cannot replace the focus on outcomes and the cost related to these results (Porter 2010). Because outcomes capture multiple inputs, they are condition dependent and multifactorial. Cost should reflect the entire cycle of care for the patient’s medical condition. Such measures must account for the risk profile of the population being served (Porter 2010).

Risk adjustment considers the health status of the patient and ensures that the outcomes/cost equation is being evaluated on an equal footing. Thus, a sicker patient may have the same outcome as a healthier patient but will require more costly inputs. Value delivered in this case would be the same despite the higher cost for one of the patients to achieve the same outcome. Thus, when determining the cost of care for a patient with diabetes, the cost of care to manage that patient’s hypertension, obesity, and hypercholesterolemia should also be factored in, since these conditions are the sequelae of diabetes. The cycle of care incorporates complications, recurrence, and partial recovery as well. Thus, value calculations require incorporation of outcomes and costs longitudinally over time (Stowell and Akerman 2015). Patients with multiple chronic conditions require that outcomes and related costs be calculated for each condition, with other conditions present factored in for risk adjustment.

Although recent trends emphasizing process improvement and the evaluation of process measures are laudable, these efforts should not replace outcomes measurements. Without outcomes measurements, the efforts can only lead to incremental change—not to the paradigmatic shift needed for the movement from volume-based to value-based care (Cosgrove 2013). In the hierarchy of measuring outcomes, the most important issue is that the individual’s health status is achieved or retained. This measure is defined by survival, followed by the extent of health or recovery achieved. For instance, a patient with an osteosarcoma will first be interested in ensuring survival beyond a few years. The patient will also want to be disease free and have an element of functional status. Once survival is ensured, the process of recovery gains relevance, as determined by the time necessary for the patient to return to normal activities. Porter (2010) points out that cycle time during this phase is important to outcomes as well. Cycle time to recovery can be affected by diagnostic delays, unnecessary treatments, complications, errors, and treatment-related discomfort. Finally, another important outcomes measure is the sustainability of health, which can be affected by recurrence of disease as well as **iatrogenic conditions**.

iatrogenic condition

A condition that occurs as a result of an intervention by a provider.

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A value-based health system should pay attention to these stages of outcomes and make the results public. Such transparency will help ensure that stakeholders compete to ensure acceptable outcomes and accelerate innovation. Costs should also be measured around the patient, in the manner that outcomes should be measured. Outcomes that are normalized for such a holistic cost assessment will help identify structural cost-reduction opportunities, eliminate non-value-added services, ensure better use of capacity, shorten the cycle time, and provide appropriate level of care at the correct location (Cosgrove 2013; Porter 2010).

A major flaw in the value proposition of healthcare in the United States has been the concept of zero-sum competition. This concept assumes that the resource “pie” can only be divided, not expanded; thus, no one wins, including the patient. This mentality has driven competition that has undermined value, primarily seeking to shift costs, increase bargaining power, capture patients, and reduce costs by restricting services (Chase 2015). As a result, even if individual stakeholders see value within their silos, the economy as a whole loses out on value. The silo mentality in healthcare often leads to stakeholders working to optimize their own departments while compromising the overall system.

Given the prevailing mentality that diseases or conditions should be treated by individual departments or specialties, the patient has often not been at the center of the system’s efforts. If competition among providers is measured for value delivered in treating the overall disease, patients are more likely to be served at lower cost and with more effective care. In the example of knee surgery, healthcare organizations must compete at the level of outcomes around knee surgery, instead of across an entire service line dedicated to orthopedic surgery. Furthermore, the outcomes data must be made public so that the consumer—whether the patient or the payer—can use free market principles to select the most value-oriented provider. Such an approach will force providers to focus on value, expertise, and collaboration across the healthcare spectrum, yielding better outcomes and lower costs (Yong, Olsen, and McGinnis 2010).

Value-based competition should typically exhibit the following features (Porter and Teisberg 2006):

- Delivery should be geared towards the patient.
- Competition should be results oriented.
- Care should encompass the entire disease spectrum.
- Value-based care ultimately should be less expensive.
- Outcomes should be measured at the provider level and should incorporate experience, scale, and knowledge.
- Competition should be regional or national.
- Outcomes data should be widely available.
- Incentives should be created to reward value-oriented innovations.

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Case Example: Cleveland Clinic

The following case has been adapted from Cosgrove (2013).

Cleveland Clinic, a premier integrated health system, has been positioned to deliver value-based care. Physicians are reimbursed at a rate that is fixed regardless of the volume of care delivered. Thus, compensation is unchanged by the number of patients evaluated, procedures performed, tests ordered, or surgeries completed. Short-term contracts that need to be reviewed annually hold physicians accountable. Dashboards evaluate providers on quality metrics, and clinical outcomes are used to review performance annually. Patient-evaluation teams include physicians from various specialties so that the burden of coordinating care across disparate specialties does not fall upon the patient. A patient with an illness such as breast cancer would be seen by a multispecialty group consisting of medical oncologists, surgical oncologists, plastic surgeons, radiation oncologists, and radiologists. The patient is seen in a single visit by all these specialists, who then determine the appropriate care and communicate with the patient to reach a shared decision. Because the clinic negotiates bundled payments, services before, during, and after an episode of care are combined into a single charge.

Cleveland Clinic and other similar organizations have facilitated the development of a patient-centered, disease-specific focus. The clinic is required to publish outcomes and cost data, and data and clinical details are captured on electronic medical records. These data are mined for patterns, variations, and outliers. Such efforts have contributed to the development of enhanced, evidence-based protocols; the delivery of streamlined and better-coordinated care; and a reduction in unnecessary utilization.

exchange

Marketplaces mandated by the Affordable Care Act for the purchase of health insurance.

Medicaid

An insurance program in the United States, cosponsored by the federal and state governments, that assists people with low income and limited resources.

Legislative Response to the Need for Value-Based Healthcare

Even though political controversy continues to surround the ACA and changes to the act are possible, several provisions in the law related to value are likely to remain. This section will examine the ways that value-based care is facilitated through the ACA. (See appendix 10 for additional discussion of the ACA.)

The ACA aims to curtail the unsustainable growth in health expenditure without explicitly rationing care. By linking quality and outcomes to reimbursement, and by introducing several innovative structural changes, the act introduces value-based healthcare delivery to the landscape. The ACA is the first concerted effort in the United States to sequentially create the infrastructure to allow for value-based healthcare. It reflects a combination of public and private partnerships.

The ACA seeks to increase access to care through the use of health insurance **exchanges** and the expansion of **Medicaid** (DPCC 2015). However,

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the exchanges have encountered challenges related to profitability, and some people believe that the Medicaid expansion may be financially unsustainable. As the political debate continues around these elements of the ACA, changes will likely be introduced to bring more of a value proposition to the expansion aspect of the law so that the per-capita cost comes down. Some options include introducing more **managed care** products on the exchanges and providing block grants to states to administer Medicaid funds (DPCC 2015). As the tax code is readdressed, deduction limits and the closing of loopholes will have an impact on healthcare. This initial phase to fund some of the ACA mandates also creates the need for the healthcare sector to restructure itself and reduce its cost structure by increasing efficiency.

managed care
Use of various forms of control to avoid unnecessary utilization of care and other value-eroding activity; essentially, consumers trade unfettered access to care for lower cost.

Case Example: Molina Healthcare

A publicly traded health insurer based in Long Beach, California, Molina Healthcare operates in several states. It has focused on cost control, limited networks, and close management of patients' health to outperform rivals in the exchange marketplaces. By establishing narrow networks of doctors and hospitals, the insurer has excluded some of the highest-profile hospitals in the Los Angeles market. Patients who have signed up with the insurer may need to give up prior physicians who do not accept Molina and be seen in another clinic; however, these restrictions have made the premiums significantly lower for patients.

This strategy propagates the idea of value-based care and has allowed Molina to thrive where other insurers have struggled. Margins are slim, at less than 2 percent, but the company has remained profitable on the exchanges—though it has recently engaged in cost-cutting initiatives due to pressure on the profitability (Edwards 2017). The company has succeeded by replicating its core business of managing Medicaid plans. These programs are geared to lower-income individuals who can otherwise not afford insurance and often have chronic health conditions.

Success stories such as Molina's reflect an evolving marketplace, where the successful exchanges have tightly managed plans that follow the health maintenance organization (HMO) model of coordinating care, establishing narrow networks, and delivering protocol-based care. Enrollees must select or be assigned a primary care doctor and set up an appointment soon after enrolling in the plan. During that appointment, providers can gauge the health needs of the patient and work to avoid unnecessary hospitalizations and complications associated with long-standing but unaddressed chronic conditions. Additional services include a dispensing machine for common prescriptions, which helps reduce pharmacy trips; free shuttle service to facilitate clinic visits; and a 24-hour free nurse line, to help avoid emergency room visits (Mathews 2016).

Value-oriented changes that are becoming embedded in the marketplace as a result of the ACA include the following (Federal Register 2013):

- Creation of a website to allow fair comparisons of health insurance products so that consumers can make informed decisions
- Eliminating lifetime limits on insurance coverage so that medical decisions are not driven by simple cost considerations
- Free provision of preventive care, including mammograms and colonoscopies
- Ensuring access to insurance for people with preexisting conditions
- Enabling young adults, up to age 26, to remain on their parents' insurance plans
- Improved care coordination and care transitions
- Increased access to services at home and in the community
- The linking of payment to quality outcomes (value-based purchasing)
- Encouraging the creation of integrated health systems (accountable care organizations)
- Expanding authority to bundle payments
- Increasing Medicaid payments for primary care doctors
- Additional funding for the Children's Health Insurance Program
- Prohibiting discrimination based on preexisting conditions or gender
- Eliminating annual limits on insurance coverage
- Ensuring coverage for individuals participating in clinical trials
- Establishing affordable insurance exchanges
- Increasing access to Medicaid
- Allowing insurers to sell policies in multiple states
- Eliminating Medicare's "donut hole" prescription coverage gap and providing assistance to individuals affected by it

The ACA focuses on delivering value to patients, not just on reducing costs. By requiring certain results to be made public, it brings much-needed transparency into the opaque system that has long governed healthcare. By emphasizing overall spending per beneficiary, it brings focus to the overall cost of the care received by patients. By tying reimbursement to outcomes and patient satisfaction, it puts pressure on providers and payers to take into account the voice of the customer and to retool operations around the customer's needs. By opening up competition across state lines, it serves to make competition global, not just local. The law promotes population health and allows for sharing in savings, which encourages innovations that increase value. The stakeholders introducing these innovations now have a mechanism to appropriately participate in the gains made.

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The Implications of Value-Based Competition for Providers and Payers

For healthcare providers, the primary goal is to deliver excellence in patient value. Value-based healthcare makes such considerations as range of services, reputation, financial metrics, and provider size secondary to the health outcomes achieved when normalized for cost and adjusted for risk (Porter and Teisberg 2006). If providers do not deliver on this fundamental equation, they will likely fail in the new landscape that is now being drawn. As a result of value-based competition, providers will redefine their businesses around medical conditions; choose services in which they excel; organize around integrated practice units, such as service lines that encompass all aspects of care around their service; measure and share outcomes around these practice units; provide pricing transparency to allow accurate cost comparison; and develop locally in areas of strength (Porter and Teisberg 2006). Some critical competencies that providers are developing to deliver on the value paradigm are introduced in this section and further developed throughout the book.

Clinical Innovations to Eliminate Waste

A key aspect of delivering value in healthcare is avoiding waste and eliminating anything that does not add a clinical benefit to a patient's care. For example, because of the fragmented nature of healthcare, a patient might receive two X-rays for the same condition, or a physician might prescribe medication that the patient cannot afford and therefore does not take, leading to avoidable complications. Alternatively, a patient who has been discharged from a hospital might be readmitted because the patient was unable to see the doctor in a timely manner following discharge. All these instances demonstrate waste that adds to healthcare costs but does not enhance health.

To reduce waste, clinical innovations in value-based healthcare focus on the following key elements:

1. Coordination of care
2. Readmission prevention
3. Palliative care
4. Better transitions between care

Efforts to achieve clinical targets may include care delivery structures with aggressive patient outreach and comprehensive systems such as patient-centered medical homes. These elements will be discussed in greater detail in the next chapter.

Pay-for-Performance Innovations

Clinical innovations will not be enough to deliver value-based care if payment reform is not fully implemented. This reform must incorporate

pay-for-performance metrics. Generally, *pay-for-performance* refers to the paradigm in which providers are compensated for care based on outcomes. Such a system includes incentives for better care and for utilization of processes that minimize wasteful care. Such processes should result in better outcomes, which are in turn incentivized with payments tied to such outcomes. Avoidable complications, in turn, are penalized and result in lower reimbursement. These elements of pay-for-performance are discussed in greater detail in chapter 3.

Health Insurance and Payment Reform

A fundamental premise of the effort to expand insurance is that insured individuals are more likely to become informed participants in their healthcare and will use preventive services more frequently, thus minimizing the development of preventable chronic conditions. Though the ACA has had its share of judicial, political, and legislative challenges, this key premise seems to have been settled, and healthcare organizations have begun work to follow the law's provisions. Innovations such as health exchanges are an important step (Federal Register 2013). However, additional steps must be taken to ensure that extending access to insurance does not simply provide perverse incentives to replicate volume-based care. Instead, innovations centered around managed care present an opportunity to increase access and value.

An important component of value-based competition is the effort to incorporate all aspects of cost related to a complete unit of care delivered (Porter 2010). Thus, high cost of one element can be offset by the low cost of another element that might be downstream. This paradigm is reflected in the **essential health benefits** required in the exchange products. Such requirements promote preventive care and eliminate discriminatory practices that can lead to selective preference for healthier patients (Center for Consumer Information and Insurance Oversight 2015; Federal Register 2013). Health insurance products should be developed in a manner that promotes value-based healthcare with an emphasis on prevention, effective primary care access, and coverage across the entire lifespan and disease spectrum of individuals. These health benefits are further discussed in appendix 10.

A relatively new component in the delivery of value-based health is value-based insurance. In this system, financial barriers, such as copayments, are lowered for high-value clinical services. Meanwhile, preferred services with uncertain value may still be accessed by patients, but with increased **cost sharing**. Such value-based insurance programs are geared to comply with the direction set forth in the ACA. The goal is to encourage effective primary care, reward value over volume, and improve care for patients with chronic conditions. Such a system also endorses the idea that some providers are more effective than their peers (Fendrick, Smith, and Chernew 2010).

Some value-based plans are introducing provider tiering, whereby patients face less cost sharing if they use high-value providers. Tiering programs will require data transparency so that patients can see providers who score well on

essential health benefits

A set of benefits mandated by the Affordable Care Act for any health insurance product being sold on an exchange.

cost sharing

The amount of the total cost of care that must be paid by the patient; this amount may include copayment and coinsurance.

quality metrics. One criticism of these programs involves the lack of consensus about the appropriate level of cost sharing. Another is that the evidence base is changing continuously and high-value services may evolve. Finally, the experience of programs such as Medicaid with value-based insurance is minimal. Because Medicaid serves low-income populations, patients may be especially sensitive to small changes in cost sharing. The goal is to balance standardization and innovation to enable patients to compare options while receiving the value intended in the law. A number of states have established their own health insurance exchanges, and the array of choices is broad. Some states, however, have opted to have the federal government step in to establish their exchange. Early evidence indicates that states are balancing a simple shopping experience for insurance with a design that still promotes innovation (Corlette et al. 2013).

Section 2713 of the ACA mandates that services receiving a high rating from the US Preventive Services Task Force be provided by health plans without cost sharing. This provision is exemplary of value-based competition that will steer consumers to high-value services by providing appropriate financial incentives (Fendrick, Smith, and Chernew 2010). In this situation, the health plans are required to provide care that has a strong evidence base showing its usefulness in promoting overall health. For instance, a 55-year-old male will be more likely to receive a colonoscopy if it is available without any cost sharing, since the financial barrier has been removed. The colonoscopy, in turn, may help detect precancerous polyps that can be removed to reduce the risk of colon cancer downstream, thereby avoiding a condition that would be significantly more expensive to treat and have a higher rate of morbidity and mortality.

As value-driven competition develops, health plans will start disseminating outcomes information to subscribers and providers to encourage the use of high-value services. They will also work with patients and providers to provide comprehensive disease-management and prevention services around the full cycle of care. The plans will need to adopt pricing transparency, with single bills for entire episodes and cycles of care.

Plans are also being prohibited from reunderwriting subscribers—that is, raising premiums when individuals become ill—and ultimately are likely to move to multiyear contracts (Porter 2010). As a result, if a healthy patient develops diabetes in the first year of a health insurance contract, the presence of diabetes may not be used by the health plan to raise the premiums when the patient seeks insurance the next year. Also, if a patient is in the first year of a five-year health plan contract, the presence of the chronic disease cannot be used to increase the premium in the second year.

Sections 1301 and 1302 of the ACA specify the requirements for health insurance. The act states that qualified health plans will cover essential health benefits (EHBs) in ten statutory benefit categories (GPO 2010):

1. Ambulatory patient services
2. Emergency services

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3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance-use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

The ACA requires a benchmark approach for determining a plan's compliance with the elements of an EHB, linked to a standard plan that may be provided by an employer in a given state. Once the basic elements that are covered in a plan are determined, the law requires a calculated actuarial value of the plan. This value is calculated as the ratio of total average costs for benefits that a plan will cover to the amount that is the responsibility of the beneficiary. The ACA defines the levels of plans through a "metal" system based on the percentage of the actuarial value paid by the plan. Section 1302(d)(2) delineates these categories as follows:

- Bronze: Plan provides a level of coverage that is 60 percent of the full actuarial value.
- Silver: Plan provides a level of coverage that is 70 percent of the full actuarial value.
- Gold: Plan provides a level of coverage that is 80 percent of the full actuarial value.
- Platinum: Plan provides a level of coverage that is 90 percent of the full actuarial value.

The US Department of Health and Human Services has made an Actuarial Value Calculator and methodology document publicly available at <http://ccio.cms.gov/resources/regulations/index.html#pm>.

As these and other developments illustrate, legislative initiatives have helped boost the momentum toward value-based care, with new requirements for uniform provision of benefits to all consumers. Though such legislative mandates do require resources, emerging innovations toward the delivery of value will likely erode the cost of delivering benefits.

The Implications of Value-Based Competition for Suppliers

Suppliers also play a critical important role in value-based competition. They can partner with payers and providers to help them thrive by delivering value

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to the consumer. Suppliers need to focus on the entire cycle of care and use evidence of long-term clinical outcomes and cost to demonstrate value. The ACA authorizes an outcomes research institute to determine comparative effectiveness of therapeutic options and make this information public (GPO 2010). Suppliers will need to develop products focused on increasing success of treatment rather than usage. To reduce cycle time of care, suppliers will need to develop products that are effective and minimize errors (Porter 2010).

Increasingly, providers are looking to suppliers to enter into risk-sharing agreements whereby a portion of the revenue due to the supplier is tied to the outcomes promised with the use of the product. Thus, if outcomes are better than anticipated, the supplier stands to obtain a bonus. However, if outcomes are worse, then the supplier is paid a lower amount. As a result, the incentives of the provider and the supplier are aligned.

A similar situation can be seen with pharmaceutical companies. In exchange for a certain medication being placed on a formulary, the pharmaceutical company agrees to enter into a risk-sharing agreement. Such arrangements encourage the suppliers to be responsible partners with providers or payers; instead of just making a sale to the provider and pocketing the revenue, the supplier becomes part of a long-term relationship. The supplier is then incentivized to provide the correct medication to the provider or payer. This type of arrangement has become increasingly important as customers are paying a higher proportion of the cost of prescription drugs. Over the two-year period from 2014 to 2016, prescriptions spending in the United States increased 25 percent to \$425 billion (Loftus and Mathews 2016).

Case Example: Cigna

In 2016, the *Wall Street Journal* reported that the health insurer Cigna will receive price discounts from pharmaceutical companies if new hyperlipidemia drugs are found to be less effective than expected, reflecting a major move toward tying drug costs to their efficacy. The arrangement applies to a new class of cholesterol drugs that are so-called PCSK9 inhibitors and made by Sanofi and Amgen. The drugs cost \$14,000 a year, and Cigna negotiated a discount off this list price. Under the arrangement, if the drug proves to be less efficacious in reducing low-density lipoprotein (LDL) levels than what was reported in studies, the drug companies will provide a discount across all patients using the drug. If the efficacy is as reported, then the original negotiated price will remain. Although administrative challenges may be an impediment, the arrangement is a promising step, since Cigna will be able to monitor adherence, clinical results such as lipid levels, and drug interactions.

(continued)

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Similarly, the drug maker AstraZeneca signed an agreement with a pharmacy benefits manager (PBM) whereby the PBM would be reimbursed costs of a new lung cancer drug if a patient stopped treatment before the third prescription refill. AstraZeneca has also signed an agreement with a regional health plan whereby, if a patient sustains a higher-than-expected rate of heart attacks after being treated with the cardiac drug Brilinta, the drug maker would cover a portion of the costs (Loftus and Mathews 2016).

The Implications of Value-Based Competition for Consumers

patient activation

The knowledge, ability, and willingness of patients to manage their own healthcare.

patient engagement

The active involvement of patients in their own healthcare and in activities and decisions that support their health.

The activation and engagement of patients are critical elements of the value-based health paradigm. **Patient activation** is the knowledge, ability, and willingness of patients to manage their own healthcare. **Patient engagement** is a broader concept that incorporates patient activation and includes interventions designed to promote healthy patient activity (James 2013). The engagement of consumers in their own care helps prevent catastrophic health issues and thus enables providers to better keep costs under control (Heath 2016). Patients need to take ownership of their healthcare choices, and they will be encouraged to do so with financial incentives, data transparency, and emerging technology that provides real-time information. The focus is now moving from acute care intervention to chronic care management. Ultimately, the emphasis will move to wellness maintenance and disease avoidance (Halfon et al. 2014). The heightened emphasis on making value-based choices about treatment and avoiding futile care will in turn increase patient education and empowerment (Porter 2010).

Advances in healthcare technology have facilitated communication between patients and providers outside the clinical setting. Such communication can greatly supplement infrequent office encounters, and it can help reduce costs, since small healthcare needs can be addressed sooner, preventing patients from falling seriously ill (Heath 2016). Patient-provider communication has increased via email, patient portals in electronic medical records, and text-messaging. Increasingly, providers are also working to grow patient engagement through enhanced technological offerings. Examples include the tracking of self-care activities and the merging of information stored on mobile devices or wearable technologies with the patient portal (Westgate 2016).

Leadership Skills Needed for the Evolution to Value-Based Care: Change Management

This chapter has illustrated many of the significant changes involved in the transition from volume-based care to value-based care. Every stakeholder in

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health delivery will be affected by this shift. Payers are placing a greater emphasis on data-based performance metrics, and many organizations are grappling with this transition. Consolidation, convergence, and connectivity are adding to the difficulties. Leaders must understand these challenges of value-based transformation, and they must lead the charge toward effective data sharing and usage to extract value from the available information. Filling the gaps will require deep analytic talent. Data can be quite unstructured and error prone, and technology and staff often are not equipped to handle these challenges. Leaders of organizations must establish population health programs that use aggregated data so that stakeholders can access the right information at the right time (Brown and Crapo 2017).

Often, the major obstacles to system success are behavioral. Multidisciplinary teams must be empowered by leaders to drive adoption of value-based practices. Organizations must be ready for increased audits and willing to focus on performance metrics and cost control. They must also address patient concerns, such as difficulties engaging with their providers. Many providers are reluctant to embrace value-based initiatives such as bundled payments because of concerns about their ability to manage significant financial risk. Leaders will need to help providers integrate value-oriented practices into their workflow and daily operations. The ability for providers to understand the risk and optimize value-based payment models in their practices will require technology and data integration (Brown and Crapo 2017).

In short, leaders must facilitate their organizations' achievement of the overall goal of strengthening healthcare.¹ This effort involves extending affordable coverage and making it more secure, improving the quality and safety of care delivered, reducing healthcare costs while enhancing effective and high-value care, ensuring access to culturally competent care, protecting vulnerable populations, and improving the meaningful use of technology. The continuing paradigm shift requires visible and determined leadership and a culture of continuous learning. Leaders must be stewards of high-value care while maintaining their organizations' financial health. They must engage steadfastly with frontline staff, management, and other organizational leaders to evaluate performance. They must promote a culture of continuous quality improvement (Cosgrove et al. 2012).

The transition to value-based care involves significant changes, and such changes often engender concern and resistance among stakeholders. Successful leaders therefore must master the art of change management with respect to strategy execution and implementation of value-based initiatives. Physicians may prefer traditional payment models, and they may be worried about being penalized under the new models for factors they cannot control. Some may be concerned that value-based models will limit their ability to make care decisions for patients or overlook quality improvements that do not fall under specific performance goals. Leaders must address these and other concerns

while maintaining trust and credibility among stakeholders. They must clearly convey the message that value-based programs reinforce patient-centered care, and they must help stakeholders understand the need for alignment of quality improvement efforts with specific performance results and incentives. Value-based care requires change through the incorporation of telehealth, incentives for adherence, and health outcome innovations. Effective leaders need to help those who are resistant to change to become more comfortable with these new approaches.²

Successful leaders can help lead this change through personal leadership, transparency, accountability, and a clear communication strategy. Success will also depend on a blueprint that the organization can follow and value-based healthcare metrics or scorecards that can provide visible evidence of progress (Taninecz 2012). Some relevant metrics may include percentage of funds remitted for bundled payment programs with quality-of-care components in the prior year; funds paid through capitated contracts; funds paid through a quality-based capitation program; and funds paid through shared-risk programs.³

Leaders must articulate that the shift toward value-based care is reaching all facets of the healthcare system. Payers and providers have been affected, and consumers have been exposed to the movement through value-based benefit designs, which encourage enrollees to use providers of high-value care. Enrollees are being incentivized to adopt healthier lifestyles, use high-performing providers, and access evidence-based care.⁴ The changing landscape will produce an escalating market demand for value in healthcare. Effective leaders must be able to anticipate such trends and understand what form they will take. Such an ability will help organizations manage the change more effectively (Nowicki, Pickering, and Nobel 2012).

Change management skills can help leaders overcome challenges associated with obtaining, integrating, and using data; maintaining the momentum of change; motivating the people involved to remain engaged; encouraging insured individuals to use their benefits; creating an effective communication program; understanding the evolving healthcare landscape; and gaining support from stakeholders (Nowicki, Pickering, and Nobel 2012). Given the novelty of value-based care and the challenges in implementing the concept, dashboards and benchmarks are important for keeping track of achievements and challenges and ensuring accountability.

Transformations like the one taking place in healthcare have occurred in other fields, yet studies have found that more than 60 percent of transformation initiatives fail (Sirkin, Keena, and Jackson 2005). Effective change management depends on the ability of leaders to influence attitudes and organizational culture, improve communication, and disseminate a vision. It also requires organizations to track measurable metrics, communicate the importance of these metrics, and rapidly execute on the information obtained (Sirkin, Keena, and

Jackson 2005). Long-duration change projects—such as a transformation into a value-based health system—require frequent review to ensure that stakeholders remain on target. By scheduling milestones and assessing their progress, leaders can help maintain momentum and identify gaps and risks (Sirkin, Keena, and Jackson 2005). When expected milestones are not achieved, stakeholders have an opportunity to evaluate the cause, implement a corrective action plan, and take steps to avoid future failure.

Organizational performance integrity allows for the development of reliable teams that consistently deliver on goals. Leadership must ensure that member roles are clearly defined and that people are committed and held accountable. Leaders should carefully select team members with a diversity of thought, experience, skills, and networks. The teams should be inclusive and accepting of widespread input (Sirkin, Keena, and Jackson 2005). Effective team leaders have a results orientation and good problem-solving skills. They are motivated, methodical, tolerant of ambiguity, responsible, aware of organizational dynamics, and comfortable with sharing credit (Sirkin, Keena, and Jackson 2005). Effective teams have the wherewithal to effect and sustain transformation by leveraging their core strengths.

Leaders, however, also must have realistic expectations. In any organization, people are already busy with their daily responsibilities, and change management will fail if staff are expected to engage in additional change activities without some reduction in their other workload. For instance, a line manager may need to devote time to gaining the skills, education, and insight to adapt to the changes needed in her unit; however, while this transformation is occurring, the regular operations must proceed seamlessly. Organizations will be hampered in their efforts to engage change if they do not make arrangements to prevent current work from being affected (Sirkin, Keena, and Jackson 2005).

The transition to value-based healthcare necessitates a paradigm shift in how business is done, and an understanding of change management is essential for engaging with this change. Success in such an effort will depend largely on the leader's effective communication of the need for change, a clear idea of the roadmap for change, commitment across the enterprise, the empowerment of appropriate personnel to facilitate change, the hiring of the right people, realistic milestones, frequent reevaluation, and the use of dashboards to measure progress.

Summary

Value-based healthcare represents a unique opportunity to deliver high-quality care to consumers without the hindrance of escalating costs. The outcomes/cost equation needs to be adjusted for risk, but the risk adjustment should

grow smaller as the general health of the population improves and the average burden of disease declines. The aligned interests of all stakeholders in the healthcare delivery system should facilitate this process.

The structural realignment that is currently under way will take several years, and it will likely experience many successes and setbacks. Innovative public and private initiatives will further our understanding of this paradigm shift, and evolving technologies will facilitate the process. Regulatory reforms that have developed innovative risk-sharing structures should align incentives for all stakeholders, ultimately bending the cost curve.

The goal of value-based healthcare is to ensure that the consumer has access to better-quality health at a lower cost with an improved patient experience. This evolution toward value-based health involves all stakeholders. Providers are changing the ways they deliver care to eliminate waste. Suppliers are entering risk-based agreements and assuming more risk for products that do not live up to their clinical expectations. Payers are becoming more discerning and are demanding more value from providers and suppliers, while at the same time adhering to regulatory requirements that have challenged traditional underwriting principles. Patients are increasingly engaged and becoming active partners in their own health.

On this voyage toward achieving value in health, changes will extend beyond the immediate healthcare field. They will encompass housing, nutrition, transportation, public health, education, global policy, and other areas. The challenges will be significant, but the opportunity to redefine the field is exciting. Future leaders in healthcare will need to appreciate these forces and harness them to effectively guide the system across the chasm it is traversing. The remaining chapters in this book will provide further perspective on these issues.

Notes

1. The US Department of Health and Human Services discusses the goal of strengthening healthcare at www.hhs.gov/about/strategic-plan/strategic-goal-1/index.html.
2. Flow Health provides additional information about managing the change toward value-based care at <https://flowhealth.com/blog/2016/02/value-based-care-can-we-get-there-with-current-tools/>.
3. A discussion of metrics for measuring transformation related to value-based payments, presented by the Health Care Incentives Improvement Institute, can be accessed at www.hci3.org/tools-resources/metrics-tracking-transformation-us-health-care/value-based-payment-metrics-transformation.

4. A comprehensive discussion of value-based benefit design, presented by the National Business Coalition on Health, is available at <http://vbidcenter.org/wp-content/uploads/2014/08/VBBDPurchaserGuide1.pdf>.

Discussion Questions

1. Discuss whether process measurements in value-based purchasing are useful. Should outcomes measurements completely replace process measurements?
2. What strategies should healthcare organizations pursue to ensure that the incentives of key stakeholders are aligned to deliver value? How does misalignment create perverse incentives that destroy value in healthcare?
3. Many experts believe that healthcare, given its competitive nature, is a zero-sum game. Discuss whether a focus on value can shift the paradigm away from this zero-sum mentality. Provide examples of how this shift may occur.
4. Although value-based health delivery is a laudable goal, it is possible that the cost for an organization to comply with the paradigm may exceed the benefit. Is a form of penalty needed to ensure that healthcare organizations comply?
5. Discuss how shared savings can provide alignment among providers to deliver value-based care to patients.
6. Why does the patient experience matter in the calculation of rewards and penalties in value-based purchasing?
7. Consider the following case: Plumeria Inc. is a local employer of more than 5,000 employees that manufactures metal parts for automobiles. It provides health insurance for its employees and their families. Over the last five years, the premium costs of the insurance have been rising at an average rate of 30 percent annually. Next year, the premium is expected to rise another 28 percent. Health benefits now account for more than 30 percent of the cost structure. The operating margin for the company is 3 percent per year. Revenue growth during the same period has been 8 percent per year. Health costs have grown faster than revenue growth. The company's chief financial officer has advised that next year's budget will show a 1 percent margin, and if the cost structure does not improve, the company will operate at a loss in two years. Leadership has identified that, along with a general cost-cutting strategy, a targeted reduction in healthcare costs is critical to ensure sustainability and profitability. You are the company's chief human resources officer.

- a. What strategies can be used to reduce the cost of healthcare? Your answers should include current strategies in the marketplace as well as value-based options. You can extrapolate from the discussion in this chapter as well as your research of the available literature.
- b. You are considering a value-based benefit design, and your health insurance company is willing to explore this option. Provide a framework that may be successful in engaging your employees to accept such a program. What features will you include in this product? What challenges can be expected in rolling out such a plan?
- c. Delineate a rollout strategy for the insurance design. Your strategy should include a communications element, and it should specify the roles various stakeholders will play in ensuring the design is accepted.
- d. What metrics will be important in monitoring the success of this product? Create a dashboard that will be used by senior leadership to track adoption, medical and administrative expenses, and general health of the membership insured. Consider metrics such as medication compliance rates, use of preventive services, use of health and disease management programs, and use of high performing providers.
- e. Provide a strategy you will use to promote acceptance of this initiative.
- f. Consider the milestones that must be achieved to reduce the cost of the health insurance being provided. Provide a timeline that is realistic.
- g. Write a three-page memo outlining the strategy, techniques to measure progress, expected benefits, and anticipated challenges.