



# Change is local

**A market-level analysis  
of healthcare's emerging  
value economy**



# Introduction

**The United States healthcare system is at a critical inflection point. The transition from a payment system that has historically rewarded volume over value to one that pays for more efficient, lower cost and higher quality healthcare is accelerating. We can now see a future where clinical and economic objectives align and quality, rather than quantity, of healthcare will be incentivized, measured and rewarded in virtually every healthcare payment model. This period of convergence will result in a transition to a new payment and delivery value proposition that has implications for every stakeholder operating in the marketplace.**

Every healthcare payer, physician network and provider organization across the country should be evaluating the value-added contribution of their unique assets in a health system that ties economic incentives directly to value. Healthcare executives who understand the tenets and pace of this transformation will have a competitive advantage over others who may be pursuing payment and delivery innovations that have already left them behind. However, not all markets are created equal and each local healthcare marketplace is guided by its own set of economic dynamics, policy and political characteristics, health risk factors, and competitive interests. Thus, the pace of change will vary substantially by market.

Companies contemplating their investment, strategy and tactics should have an understanding of the drivers and relative pace of transformation in their markets. While a moderate pace of change in some markets may not necessarily imply deficiency or failure, waiting too long to appropriately realign the assets of the business in other markets may result in a loss of strategic influence over the destiny of the healthcare enterprise.

This paper introduces our perspective on how healthcare organizations should evaluate the current transformative environment. The first two sections reflect on the policy and market activity driving the transition. Next, we introduce a proprietary methodology that captures the core drivers of change in the marketplace. As a demonstration of how healthcare organizations can apply the methodology in any market, we analyze three local markets – Dallas, New Orleans and Minneapolis – that are representative of particular dynamics and challenges driving the pace of change. It is our intention, in the months ahead, to publish additional content related to other markets that exemplify particular impediments and opportunities in the transition to value-based care.

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# Policy developments driving the transition

**The move from Fee-for-Service (FFS) to value-based payments and provider accountability seems inevitable. However, stakeholders are reluctant to leave behind the certainty of income generated under the current FFS system in favor of risk-based arrangements and value-based payments without appropriate incentives or regulatory change. This has been a watershed year, as significant regulatory and legislative activity has hastened the erosion of the status quo for all healthcare stakeholders.**

**An overview of major legislative developments over the past few years follows:**

**1** **ON JANUARY 26, 2015**, HHS Secretary Sylvia Burwell set a goal for CMS to transition **30 percent of all Medicare payments to value-based payments through alternative payment models by 2016**, and that 50 percent of payments should be delivered through alternative payment models by 2018. Meeting these objectives will not be possible without significant effort. While announcements do not guarantee a smooth transition, this particular announcement helped focus the attention of the entire healthcare community and gave purpose to a transition that had already begun for many payers and providers.

**2** **ON MARCH 10, 2015**, CMS announced its **Next Generation ACO Model**. In an effort to expand on the lessons learned in the Medicare Shared Savings Program (MSSP) and Pioneer ACO program, CMS is allowing selected providers to receive additional financial incentives, and more flexibility on how they receive payment. These will be tied to quality in managing the care of attributed seniors. Under such programs, provider groups are rated on how they perform financially against historical spending trends, as well as how they perform on quality measures that were set for all program participants.<sup>i</sup> The additional financial risk and program flexibility moves these organizations closer to the model of Medicare Advantage plans, which may result in improved financial management and better short- and long-term clinical outcomes.

**January 26:** Sec. Burwell announces a goal of tying 30% of traditional Medicare payments to alternative payment models by the end of 2016 and tying 50% of payments to these models by the end of 2018.

**March 10:** CMS announces launch of The Next Generation ACO, which purports to set more predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care and aims to attain the highest quality of care.

**June 4:** CMS releases final rule revising the Medicare Shared Savings Program (MSSP), which will impact all current accountable care organizations (ACOs) as well as those joining the program beginning January 1, 2016.

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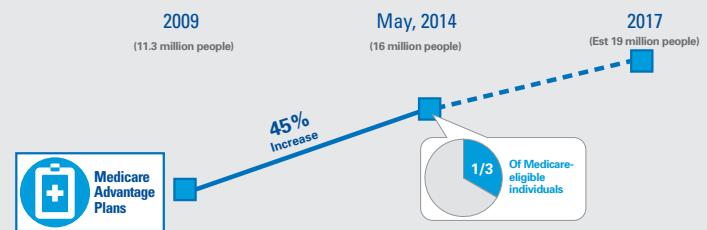
**January 28:** Healthcare Transformation Task Force launches a private-sector alliance dedicated to accelerating the transformation of the U.S. healthcare system to value-based business and clinical models aligned with improving outcomes and lowering costs.

**April 16:** President Obama signs the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) into law. This repeals Medicare's sustainable growth rate (SGR) formula and creates a narrow pathway to higher Medicare payments, largely through a consolidated and expanded incentive program called the Merit-Based Incentive Payment System (MIPS).

**August 4:** CMS announces Comprehensive Care for Joint Replacement Model. The first mandatory bundled program will require 800 hospitals in 67 markets to accept bundled payments covering all services for hip and knee replacement procedures, starting with hospital admission and extending for 90 days.

**3** **ON APRIL 16, 2015**, Congress completed a successful bipartisan effort to **repeal the long-maligned Sustainable Growth Rate (SGR) formula** for provider payment level-setting by Medicare.<sup>ii</sup> This formula will be replaced by annual physician payment updates and programs beginning in 2019 that will tie incentives to the adoption of alternative payment models or successful financial and quality performance. This will impact physicians who do not transition deliberately away from fee-for-service Medicare payments. Most notably, providers receiving a threshold amount of revenue through alternative payment models will see a five percent payment bonus. These changes will help facilitate models of healthcare delivery that improve outcomes but are currently not reimbursed or reimbursed only in part. These might include virtual care (e.g., telemedicine and telehealth solutions); mobile health; coordinated care across specialties; home- and community-based programs, and more.

**4** **IN AUGUST 2015**, CMS announced a program mandating bundled pricing for knee and hip replacements performed at hospitals in 67 markets, under the **Comprehensive Care for Joint Replacement (CJR) program**. In 2014, there were more than 400,000 hip and knee replacement procedures costing an average of \$16,500 to \$33,000 in total surgery, hospitalization, and recovery costs. The program will contribute to the alternative payment reform goals set by HHS by aiming to improve the quality and efficiency of care for Medicare beneficiaries. Risk distribution will be retroactively determined beginning in April 2017 (with performance data flowing in 2016).



These changes, combined with the Bundled Payment for Care Improvement (BPCI) initiative, State Innovation Model (SIM) grants, Delivery System Reform Incentive Payment (DSRIP) awards, state Medicaid reforms, and a wide range of commercial activity, are signposts that portend meaningful market transformation.

Healthcare payers seem to be focusing on changing the structure of how they bear and diffuse risk while actively exploring new ways to achieve tighter vertical integration with providers to create more value. Fundamentally, all payers are attempting to foster fuller alignment of clinical and economic objectives throughout the healthcare ecosystem.

# Market factors influencing the transition

**In addition to strong regulatory and policy pressures, market forces are converging to push the healthcare system toward value-based models. Hospital systems and physician groups are actively exploring risk-bearing models and experimenting with novel payment and delivery modes. Commercial insurers are working closely with providers to manage populations more effectively. Medicare Advantage and Medicaid Managed Care programs that closely monitor patients, particularly the chronically ill, continue to grow. Throughout the system, patients, providers and payers are joining to align risk with improved care and lower costs.**



**Accountable Care Organizations (ACOs)** are assuming responsibility for the cost and quality of care delivered to defined populations. Since 2010, the number of these organizations has grown from a few dozen to well over 700 covering more than 23 million people.<sup>iii</sup> Commercial providers also expect to grow the percentage of their businesses paid through value-based arrangements. A survey by Leavitt Partners and Trizetto found that hospitals expect the percentage of revenue derived from value-based arrangements to grow from 30 to 58 percent over the next few years, while physicians expect increases from 29 to 45 percent.<sup>iv</sup>

**Health insurers are also making aggressive strides** toward value-based payments. More than 130 commercial insurers have entered into ACO arrangements,<sup>v</sup> and the national carriers have all significantly expanded their value-based contracts.<sup>vi</sup> During this same period, insurers have increasingly created narrow networks, which allow them to offer lower costs to consumers that make insurance purchasing decisions.<sup>vii</sup> As more and more people have enrolled via health insurance exchanges, value-based product offerings have begun to take hold.<sup>viii</sup>

## **The growth of government-backed health insurance programs, including Medicare Advantage and Managed Medicaid**

**Managed Medicaid** is further evidence of the transition toward value-based arrangements. Under Medicare Advantage plans, Medicare beneficiaries elect to receive their care from a specific group of providers. Since 2005, the percentage of Medicare beneficiaries enrolled in these plans has grown from 13 to 31 percent.<sup>ix</sup> For beneficiaries, this shows a willingness to exchange traditional fee for service for potentially lower out-of-pocket costs, increased care coordination and higher rates of satisfaction.<sup>x</sup>

## **State Medicaid departments are increasingly moving enrollees toward managed care plans.**

Since the passage of the Affordable Care Act, states have seen Medicaid enrollment grow by over 12 million people,<sup>xi</sup> concentrated in states with expanded Medicaid eligibility.<sup>xii</sup> Under these programs, insurers receive fixed premium payments and must meet quality benchmarks.<sup>xiii</sup> States are also increasingly contracting for Medicaid ACOs directly with providers, offering incentives for better managing their assigned populations.<sup>xiv</sup> Over the next few years, we expect the trend to continue.

# Our methodology\*



**Employers are also more actively managing their insurance offerings** to control healthcare costs. Despite rising premiums and increased regulatory challenges, 84 percent of employers report being fully committed to providing health insurance to their employees in the future.<sup>xv</sup> Some employers, such as Boeing<sup>xvi</sup> and Intel,<sup>xvii</sup> are directly contracting with providers to manage their employee populations, while others are identifying value-based insurance offerings to help manage risk.<sup>xviii</sup> With an increased interest in retaining employees and improving their health, employers will continue to pursue, and even champion, value-based models.

Market participants from providers to payers to employer purchasers are increasingly testing and adopting value-based models. Coupled with strong policy pressures to manage populations under risk-based contracts, these developments will continue to drive the healthcare market toward these new models.

We have attempted to discipline market analysis as it relates to the transition from volume to value by quantifying the prevailing trends with a methodology design that finds its basis in the *Diffusion of Innovations* theory. This methodology considers the adoption of an idea by “innovators,” “imitators,” and “laggards,” classifications that align well with healthcare organizations. This approach yields: 1) a projection of the percentage of total care that will align with some form of risk-based payment, and 2) the percentage of providers that will accept some form of risk-based payment over the next ten years. (For the second point, we use a cutoff of 10 percent of total physician reimbursement, a measure based on the feedback of national experts.)

The methodology relies on 26 factors that are currently hastening or inhibiting organizations’ transitions. These factors and their relative weights were identified and refined by an expert panel of specialists, representing payers, providers, state and federal government officials, academics, economists, and vendors.<sup>1</sup>

While competing definitions and methods abound, we define value-based reimbursement as population-specific payments that are contingent on such performance measures as quality, resource utilization, and patient experience, or as full-risk economic arrangements, including capitation and bundling. Payment models that focus on process metrics are intentionally not included. We should acknowledge that the approach does not differentiate between the relative risk of disparate payment models at this time. Instead, it highlights the core, structural migration away from FFS to reimbursement models that align the clinical and economic interests of all stakeholders.

\* The methodology described in this paper has been developed by Leavitt Partners.

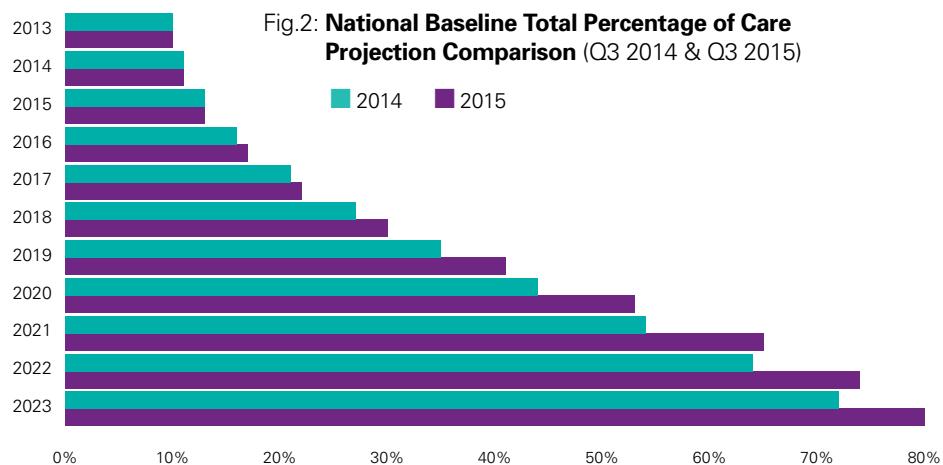
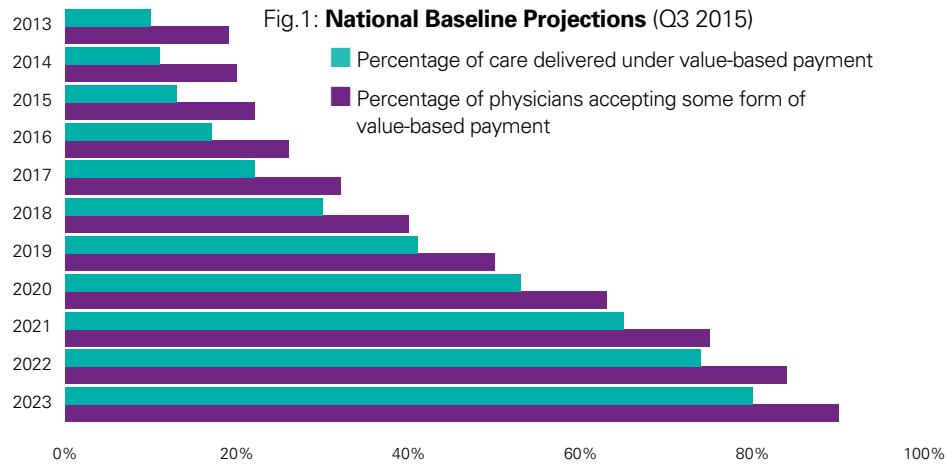
1 Notable contributors were Dr. James Madara, CEO, American Medical Association (AMA); Dr. David Blumenthal, former National Coordinator for Healthcare IT, HHS; Ron Williams, former Chairman and CEO, Aetna; Rick Foster, former Chief Actuary, CMS; and Governor Mike Leavitt, former Secretary of HHS.

# National baseline projections for change

Our methodology predicts that, over a ten-year period, value-based payments will grow from 10 percent to 80 percent of total care, with a noticeably strong acceleration beginning in 2018 when payment models and quality measures are more established and additional financial incentives for participation in alternative payment models begin to take effect in 2019. This acceleration indicates the large number of imitators and laggards that will begin to engage in value-based contracting once payment models are tested and/or rewards and penalties are systemically prevalent. Figure 1 outlines the core national baseline projections, as of Q3 2015.

The aforementioned policy and market activity is eroding organizations' inertia about transitioning away from FFS, even though measurable growth over the past two years (2014-2015) has been minimal. Innovators are moving forward more aggressively and paving the way for faster adoption by laggards. The most influential factors in initial years are provider consolidation, vertical integration of payers and providers, employer/provider direct contracting, and the success of early accountable care models. Developments in public programs – such as the increasing proliferation of Medicare ACOs, the start of CJR in 2016, and the implementation of MACRA incentive payment changes starting in 2019 – will have a powerful effect as providers prepare and engage in these programs.

If we compare our previous year's results, established in Q3 2014, to the projections we have made encapsulating this year's activity, we see a marked increase in the projected pace of change, as detailed in Figure 2.



# One market

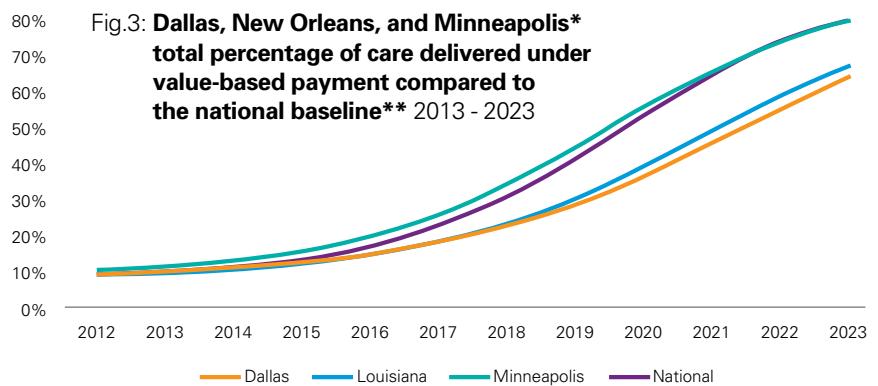


## If you have seen one market, you have seen just one market

There is widespread variability among healthcare markets in relation to care delivered under value-based payment. Figure 3 shows comparisons among the three markets for which we have conducted preliminary analysis – Dallas, New Orleans, and Minneapolis – using our methodology. We also examine how each compares to our current national baseline.

We selected these three markets because of the variation in progress they reflect. We intend to study other markets in the coming months and memorialize our findings through updates to the methodology and subsequent addendums to this paper.

Payer, provider, purchaser, and patient stakeholders at the market level influence variability and can affect the pace of change in their markets by collaborating on innovative platforms. Policies enacted by state and federal governments over the next two years will also contribute to the significant acceleration of the pace of change predicted for the period from 2017 to 2022. (Additional methodological detail and insights for each of these markets is available upon request.)



\* The findings conveyed in this paper are based on preliminary market insights.

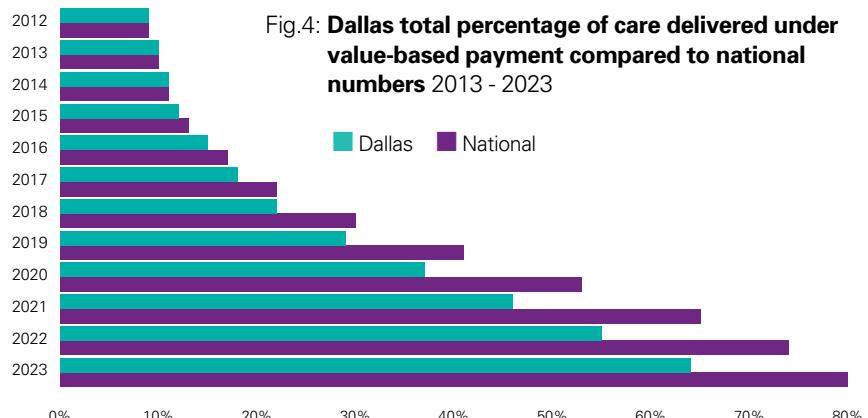
\*\* The analysis for these three markets was conducted by Leavitt Partners.

# One market: Dallas\*



In Dallas, hospital systems with physician group partners are driving value-based payment more than independent providers or payers. Driving their influence is the heightened interest in and pursuit of direct-to-employer contracting and a disproportionately high number of ACO arrangements, both private and public. While there seems to be a significant provider infrastructure, progress in catalyzing a substantive number of payment arrangements has been slow.

In Dallas, hospital systems with physician group partners are driving value-based payment more than independent providers or



One obstacle is that, there are a small number of commercial payers in the market and none have fully engaged in meaningful value-based payment activity. Payers have little incentive to explore value-based payment; there are few provider-sponsored health plans in the Dallas market and the delivery system is fragmented with independent physicians both operating independently and affiliating with a variety of systems and institutions. Further, the state has not expanded Medicaid and, experts predict, is unlikely to do so in the near term.

There remains a possibility for further consolidation of providers in the marketplace as hospitals look to strengthen their market positions. Even so, we believe Dallas will continue to face a physician shortage given the low number of available residencies. The relatively small number of primary care physicians makes it difficult for Dallas to engage in effective value-based payment arrangements without appropriate physician extenders. Finally, there is no functional Health Information Exchange (HIE) or other information sharing mechanism yet today, so clinical integration remains in the realm of closed systems.

In sum, **payers are the key to meaningful market change in Dallas.** Figure 4 compares value-based care in Dallas to the nation as a whole.

\* The findings conveyed in this paper are based on preliminary market insights.

# One market: New Orleans\*



Cost pressure on private payers is a crucial factor in explaining the healthcare market in New Orleans. Current

market conditions coupled with the continually rising cost of healthcare have caused businesses to reexamine their health benefit options. There are predictions that the small group market will contract, although at a much slower pace than we see nationally. Meanwhile, mid-level and large-group employers will continue offering medical benefits contingent on medical cost inflation normalization and/or potential return on investment realized through such innovations as defined contribution, medical management programs, and narrow networks.

The predominant view of the New Orleans Health Information Exchange (HIE) is that it will not be able to provide the functionality physicians and hospitals are seeking, thereby establishing a role for closed systems promoted by payers, major health systems, and third parties. There will be sustained, non-transactional partnership arrangements that aggregate hospitals by larger incumbent systems or other conveners rather than the formal acquisitions or mergers of the past.

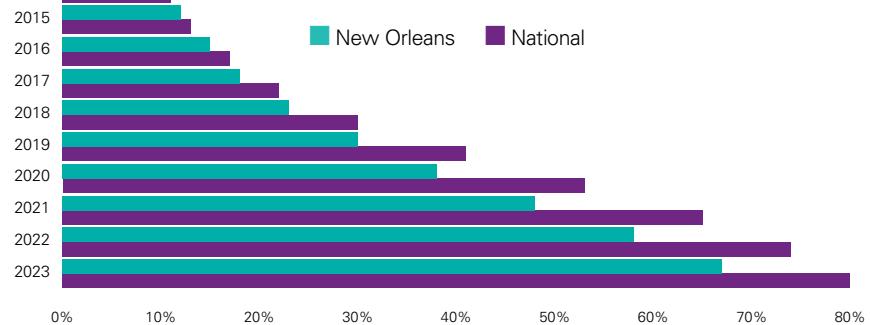
Much of this scenario results from the broader community's concern about the readiness of independent physician groups to bear substantive risk. Although there is a general reticence to bear financial risk (beyond pay-for-performance arrangements), many hospitals and some physician groups are beginning to make modest investments in infrastructures that would allow them to manage and coordinate care for specific clinical, quality, and experiential purposes.

Institutional development of risk-bearing assets is slow, primarily because the predominant commercial carriers have not signaled a substantive desire to move the payment system further toward value. Similar to Texas, Louisiana has not yet expanded Medicaid, but is likely to do so in the next three years.

In sum, **commercial carriers are the key to meaningful market change in New Orleans.**

\* The findings conveyed in this paper are based on preliminary market insights.

Fig.5: **New Orleans total percentage of care delivered under value-based payment compared to national numbers 2013 - 2023**

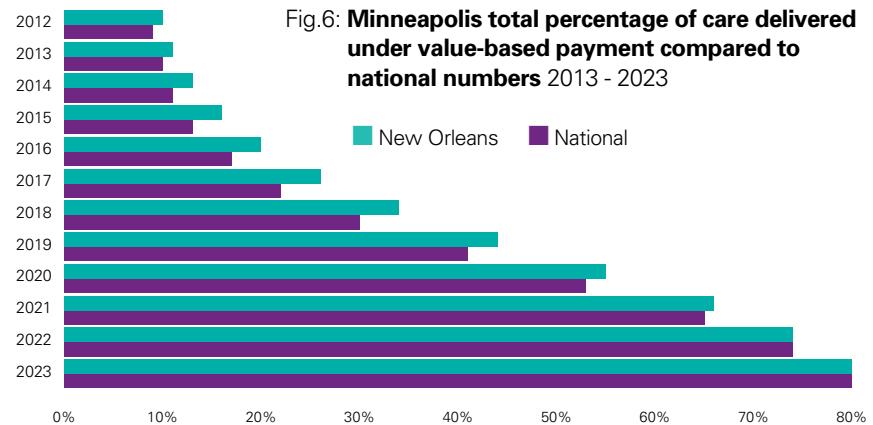


# One market: Minneapolis\*



Unlike Dallas and New Orleans, Minneapolis boasts a slightly higher percentage of total care delivered

under value-based payment contracts relative to the nation. Experts predict that the market will outstrip national growth until 2022. After that, growth will slow down, even though the market is starting at a higher baseline. Several factors come into play.



The provider market in Minneapolis is competitive. However, recent consolidation, particularly among specialists, and the increased influence of provider-sponsored health plans are causing stakeholders to re-invent themselves and consider value-based payment more seriously. Minneapolis has a high percentage of ACO-covered lives, both private and public, which are increasingly better coordinated through HIT platforms and statewide quality measurement and transparency initiatives. Although there are large, independent multi-specialty groups, most of the provider community aligns with a health system and is subject to some form of value-based payment.

The commercial payer community in Minneapolis is notable because large for-profit insurers are beholden to state law that prohibits their practicing there, while non-profit insurers are competitive and innovative. Those who can practice have become more sophisticated and willing to engage in value-based payment arrangements, particularly because providers are developing value-based assets.

Medicare Advantage is a phenomenon to watch in Minnesota given that it functions as a Medicare Cost Plan instead of a traditional Medicare Advantage plan. Many anticipate, however, that this will change in the next five years, and payers today are preparing for it. Further, Minnesota expanded its Medicaid eligibility, and the state is actively fostering value-based payment, for example, by forming Medicaid ACOs.

In sum, **with payers and providers actively making the directional shift to value-based care, finding incentives to speed the transition of specialty physicians will be key to reaching the full potential of value-based care in Minneapolis.**

\* The findings conveyed in this paper are based on preliminary market insights.

# National implications & research conclusions

**The American healthcare industry is moving inexorably toward value-based models of care and reimbursement. National, state and local policymakers are actively pushing the transition. Other drivers include the unsustainable growth in costs, the availability of enabling health information technology, and the introduction of novel payment models. Meanwhile, payers and providers are learning how to make the required payment and delivery models work.**

While each local market presents different dynamics and varying timelines, provider organizations in many markets across the country will ultimately shift to value-based models. Right now, organizations need to prepare by assessing their capabilities, understanding the opportunities and challenges of their respective markets, and developing customized strategies that will increase the chance of success in the evolving system.

There are certainly barriers to this change. In certain markets, payers, physician groups, hospitals, and/or other stakeholders may have sufficient economic power to slow the transition by remaining focused on their own short-term economic self-interests. For example, in communities where the appetite for clinical integration is limited or clinical footprints are fragmented, it is difficult to achieve the cost containment and better outcomes that can result from coordinated care.

It is worth noting that a myriad of other factors may change the pace and trajectory of this transition. For example, if the US economy recedes, pressure on Congress and CMS will increase, further accelerating the need for payment reform. Other exogenous events could shift federal or state budget priorities, impeding the change. The degree to which consumers accept or reject narrow-network, high-value models will determine the pace of success in the commercial market.

Ultimately, provider organizations need to make the right infrastructure and competency investments to drive meaningful and sustainable change to care management in a volume-based payment system.



# KPMG's approach

We believe our model and approach reflect a unique viewpoint on the importance of anticipating market-specific activity that portends macro changes to the delivery system. While each market will indeed move at a different pace and defy comparison with other markets, KPMG has identified five key areas of focus common to successful value-based organizations.

- Performance-based contracting
- Modernized governance
- Coordinated care
- Measurement and Outcomes
- Patient engagement

These five areas of concentration must be addressed concurrently to create true value-based healthcare organizations where payments tie to quality. The objectives of all healthcare industry players should be aligned to ensure a common understanding of value and a willingness to work together to achieve value-based care. As many organizations have learned, these changes cannot happen overnight and will require close collaboration between providers, payers, governments, and other new entrants to the healthcare delivery system. Over time, the proportion of payments at risk will increase to enable continued practice improvement.

## Key considerations for value-based healthcare organizations

### Performance-Based Contracting

As performance-based contracts replace traditional fee-for-service contracts, healthcare organizations must reward value and align incentives between providers and payers. A transition period will likely be necessary to evolve to increased financial risk for both provider and payer, with rewards for sustained system change.

### Modernized Governance

Value-based care organizations need to reach a variety of objectives across several different entities, all within a rapidly changing healthcare and regulatory environment. Organizations should have centralized authority and decentralized decision-making to form a culture of continuous improvement and accountability. Organizational governance structures should be modernized and adjusted to enable changes necessary to support value-based contracting.

### Coordinated Care

Effective coordination of care requires engaging the right provider partners to manage patients across the complete care pathway. Coordination can occur under at least three different models: focused clinics for patients with a single health condition; embedded structures comprising regional care providers and preferred, subcontracted suppliers coordinating care for specific health conditions; and fully coordinated care under which patients with multiple health conditions and chronic diseases receive care across different organizations working in collaboration.

### Measurement and Outcomes

Providers and payers must clearly define outcomes that they want to measure and select reliable instruments for measurement, which should include patient-reported outcome measures or patient-reported experience measures. Organizations must assess measurement protocols over time to ensure they capture actual care improvement (e.g., increased post- vs. pre-study scores).

### Patient Engagement

Patient engagement requires systems and programs that support shared decision-making, transparency and, ultimately, satisfaction. Patients should play an active role in the design of care pathways, including desired outcomes and indicators that form the basis of providers' pay and bonuses. When possible, patient-reported outcome measures should be included to assess the effect of treatment on quality of life.

# How KPMG can help

**As organizations and health systems around the world seek to deliver integrated, value-based care, KPMG's dedicated network of healthcare professionals is working with them to help navigate this complex change journey. Our teams are working with clients in a number of different ways, including:**



## Defining a strategic vision.

Value-based care means different things to different organizations with alternative payment models dependent on the issues and environmental factors they face. KPMG member firms are working with payers, providers, governments, and patient groups to help define the optimal model to meet the needs of specific populations. Engagements include patient risk assessments and stratification, as well as analyses of organizations' capabilities and maturity levels. We help our clients envision what a functional, sustainable future state would look like across their health economy.



## Assessing readiness for accountable care.

Any transition of this scale has the potential to disrupt operations on a day-to-day basis. Our healthcare teams work with clients to understand and mitigate those risks by assessing the current state and performing gap analyses related to financial, operational, compliance, and cultural readiness. Our healthcare practice has deep, practical knowledge of every aspect of the industry, which allows us to assess the impact of a transformation, not only on operational and technical processes, but also on our clients' people, culture and supporting activities.



## Identifying strategic options and alternatives.

With a consistent focus on delivering better outcomes and lower costs, we work with our clients' senior leaders to identify and work through the key choices and trade-offs they will need to make along the change journey. These include questions related to sustainable flow of funds, interoperable healthcare IT, strategic use of advanced data and analytics, operational collaboration, and clinical/corporate governance. Our teams can then support clients in developing a robust financial and business case for their chosen direction.



## Developing a path forward.

KPMG's healthcare practice is helping organizations develop systematic implementation strategies that take into account other improvement initiatives and the key interactions among partners and stakeholders. Once we define a clear strategic direction, we assist in the management and delivery of a complex portfolio of projects designed to move an organization closer to a future-state vision encompassing care coordination, outcome and quality measurement, value-based contracting, and change management.

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