Total Transformation: How ACA Is Driving Changes in the Provider Landscape

Motivated by Affordable Care Act provisions designed to put the brakes on rapidly increasing health care costs, employers are adopting numerous strategies for creating greater efficiency in how they purchase health care. The strategies are centered on holding providers more accountable for improving patient outcomes and reducing unnecessary expenses. In conjunction with the federal agency for health care, Centers for Medicare and Medicaid Services (CMS), they will drastically transform the provider landscape. This article discusses those strategies, along with their potential impact on providers.

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For all the debate and controversy that has surrounded the Patient Protection and Affordable Care Act (ACA) of 2010, it’s fairly well-accepted that the desire to provide better access to health care lies at the heart of the sweeping reform. What most people don’t realize is the law also contains numerous provisions designed to spur much-needed action in terms of lowering health care costs and driving efficiencies in the U.S. health care system.

Granted, the desire to achieve these two goals is nothing new. Plagued by skyrocketing costs, employers have struggled for years to identify strategies that would allow them to continue providing the valued benefit while keeping a lid on expenditures. While opponents of ACA claim it will result in even higher health care costs and supporters believe the opposite, one observation seems clear: ACA has lit an absolute fire under employers and providers and set the stage for true transformation in the $2.7 trillion U.S. health care system.

Spearheaded by groups like the National Business Group on Health and Catalyst for Payment Reform (CPR), one emerging employer focus centers on promoting better value in U.S. health. Employers must, with equal focus, address the declining health of their employees and families and exert pressure on health plans and providers to change how we direct people to—and how we pay for—health care services.

At the heart of such initiatives is a major push to change the way providers are compensated.

According to a 2014 Aon Hewitt survey of nearly 1,300 large and midsize U.S. employers covering more than seven million employees, 53% said moving toward provider pay-
ment models that promote value in the form of cost-effective, high-quality health care will be a part of their future health care strategy. One in five respondents identified it as one of their three highest priorities (Figure 1).

The current provider payment structure is problematic because it rewards doctors and hospitals for volume and complexity of services without regard for value or clinical outcome. With a system in which each expensive, cutting-edge procedure increases revenue, it’s no wonder little consideration is given to whether certain treatments are necessary or a less expensive alternative would produce a similar outcome.

Employers are seeking to eliminate these kinds of scenarios by aggressively pushing for reform in the provider payment system. They are embracing strategies that hold doctors and hospitals accountable for producing better outcomes more cost-effectively—and decreasing or increasing their compensation based on meeting specific performance targets. According to Aon Hewitt’s survey, 31% of employers have already adopted such a provider payment strategy, while an additional 44% say they are considering doing so in the next three to five years. The result will be a competitive, retail-like setting in which providers are no longer rewarded for the number of procedures performed but will be forced to compete for business based on quality and price.

**Paying for Value, Not Volume**

Pay-for-value models are not a completely foreign concept to the world of health care. Many of the original staff model health maintenance organizations (HMOs) contained provisions for providers to earn bonuses for meeting certain quality criteria. Granted, such bonuses were fairly minimal, but they were an acknowledgment that there is considerable variation in physician practice.

Medicare has been experimenting with value-oriented reimbursement methodologies for some time, and the commercial market is eager to catch up. Traditionally, large commercial carriers like Aetna, Cigna and United pressured hospitals to provide additional discounts in exchange for additional members. Recently—and prior to the passage of ACA—carriers had been experimenting with performance-based contracting, issuing bonus payments to hospitals for meeting certain quality metrics. As a result, we began to see the emergence of narrow networks that didn’t contain all the hospitals in a given market, simply because they didn’t want to forgo standard rate increases in exchange for a fees-at-risk arrangement. In the aftermath of ACA, narrow networks have become commonplace as carriers pressure providers to agree to such pay-for-value contracts in order to be competitive on the public exchanges.

Generally speaking, *pay for value* is an umbrella term used to describe any initiative that seeks to improve the overall value of health care by paying financial incentives to hospitals, physicians and other health care providers for achieving optimal patient outcomes. Pay-for-value programs rely on quantitative metrics to determine...
whether preestablished measures have been met and what percentage of the provider’s compensation can be tied to achieving specific clinical benchmarks. Such programs also can impose disincentives, such as eliminating payments for failing to achieve specified cost savings or for negative consequences of care resulting in injury, illness or death (so-called never events).

A small but growing number of employers are entering into direct contracting arrangements with health systems, offering financial incentives for improved access and lower cost, higher quality medical care. Nearly one-third of large employers are interested in direct contracting, according to Aon Hewitt research. Such arrangements give employers the ability to secure care at lower prices and greater oversight with regard to quality, access and patient experience. Not surprisingly, only the largest employers have the necessary resources to enter into such agreements, with the likes of Boeing and Intel among the first to announce they have inked direct contracts.

**Marketplace Metrics**

The key difficulty in establishing an effective pay-for-value program lies in choosing appropriate benchmarks. Over the last 10-15 years, we’ve gotten much better at collecting data and understanding variations in medical practice. We know what constitutes good practice and what constitutes bad practice but, clearly, every carrier cannot have a different set of metrics for defining quality of care. Likewise, each employer cannot have its own custom-designed set of metrics used to establish quality.

We must settle on some common metrics and collectively apply pressure in the marketplace to ensure those metrics are measured. This must be a collaborative effort, bringing together providers, carriers and employers to decide on the right metrics and the methodology to collect them. That’s why groups like CPR are so important. CPR not only has brought together large employers to come up with a common set of metrics that constitute cost-efficiency and quality, it also has been meeting with carriers and state regulators to find out exactly what each is doing as it relates to both the quality metrics and reducing costs.

This is where another key component of provider payment reform comes in: transparency. Once all this data is collected, it has to be made widely available in order to help achieve the original goal of higher quality care at a lower cost. CPR is making all the information it collects publicly available and also is pressuring state governments to change laws to make cost and quality information more available to the public. Not only are such metrics useful in designing and managing effective pay-for-value programs, but employers can use them to help inform employees and their dependents and steer them to facilities that have demonstrated best value in terms of cost and quality. Over the past three years, a cottage industry of “transparency solutions” from health plans and independent third parties has emerged to help address this need.

**Payment Methodologies**

While pay-for-value has received the bulk of the attention, there clearly is not one “silver bullet” payment methodology. Carriers and CMS have embraced a number of different approaches to holding providers accountable for delivering quality service more cost-effectively. Here are a few examples.

In a shared savings methodology, hospitals and physicians agree to a specified budget for a given population. If they deliver care while staying under budget, they reap a monetary reward in the form of a percentage of the savings. The potential to earn a financial incentive serves as a powerful motivator for a provider to manage the total cost of care. When they sign on to this kind of payment arrangement, however, providers accept a certain element of risk. If the care they deliver goes over budget, for example, the doctor or hospital may have to pick up the tab for the additional costs.

A similar methodology, the bundled payment model, signs a fixed, negotiated fee to cover a set of treatment services, such as all services related to a surgery or care for a chronic condition over a defined time period. This encourages providers to manage costs while meeting standards of high-quality care.

Under a global capitation payment arrangement, a doctor, medical group, hospital or integrated health system receives a flat fee each month for each enrolled person assigned to it,
regardless of the actual cost of the care delivered during that period—with a few exceptions built into the contract for more unusual types of care. The amount paid is based on the average expected health care utilization of that specific patient, adjusted to account for age, race, sex, type of employment and geographical location, with greater payments made for patients with a significant medical history. Each month, the payment is made regardless of whether that person actually seeks care. Given that the majority of individuals enrolled in a health plan tend not to use health care services within a given month, capitation arrangements are believed to naturally balance out the “high utilizers” with enrolled members who rarely use their health care benefits.

As soon as 2016, it’s expected that 50% of major health plan contracts will be value-based, consisting of one or more of these new pay-for-value methodologies. Medicare already is closing in on 50% of the funds it pays every year being some kind of value-based mechanism. On the commercial side, it currently stands at just over 10%, but carriers are hard at work changing their existing contracts from fee for service to one of these new pay-for-value mechanisms. It’s a monumental task. Aetna, Cigna, Anthem Blue Cross Blue Shield and UnitedHealthcare have somewhere in the range of a half-million contracts between them. It won’t happen overnight, but it will happen—and soon.

Provider Pushback
Understandably, there is a certain degree of pushback from the provider community, which is not too keen on embracing the level of personal financial risk built into these payment arrangements. Take global capitation, for example. Theoretically, the methodology is believed to lower health care costs because physicians will be motivated to invest in preventive care with the goal of decreasing long-term medical costs—and increasing their personal incomes—through disease prevention and early treatment. However, providers argue that capitation has the potential to increase patient health risk if the level of capitation is inadequate to cover preventive service delivery, subsequently encouraging patients to defer care. With the bulk of the financial risk transferred solely to physicians in a capitated arrangement, their personal financial risk can be quite high, particularly if a number of patients develop catastrophic or chronic, high-cost illnesses.

Health care providers have always accepted traditional risks, such as workers’ compensation, health care professional liability and medical malpractice, all of which have insurance-based specific risk transfer vehicles associated with them. For this new variety of emerging payment risk, however, there are simply no clean, pure risk transfer vehicles. As they move away from being paid for volume toward a model that holds them responsible for outcomes, it becomes critical for physicians to eliminate some of the unnecessary utilization, clinical variation and poor quality for which they historically have been compensated. At this point, providers are continuing to operate in the fee-for-service world where they are paid for volume, while preparing to make the transition to more value-based, outcome-based reimbursement arrangements. It’s a schizophrenic scenario that is posing many challenges for providers.

Employers and carriers must enter into these kinds of arrangements with the full recognition that the act of providing health care is extremely complex and some factors that affect cost simply cannot be controlled, even by the best physicians and hospitals. Therefore, we need to strike a balance between exerting pressure on providers to control costs, while also being respectful of the fact that what they do is very challenging. In the end, we must concede they know best how to deliver care, but at the same time, they must be willing to rationalize their delivery of care in order to meet market needs.

Partnering for Results
A growing number of employers have also begun working directly with health plans to adopt more aggressive techniques to fix, at the same time, the health care delivery system and the way they purchase health care. This has led to a massive interest in integrated delivery models, such as patient-centered medical homes, to improve the effectiveness of primary care, a fundamental piece of the ACA structure. According to Aon Hewitt research, just 14% of employers currently use such models, but a whopping 61% say they plan to do so in the next several years.

Seeking to bolster their primary care
offering, many hospitals have either bought or found ways to affiliate with primary care groups in their marketplaces. Recognizing the heightened value being placed on primary care, they also have taken to publicizing their strong support for—and promotion of—wellness, prevention and primary care rather than hyping their specialty and inpatient services. This will enhance the likelihood that employers will view them as a “must-have hospital” in a given carrier network.

In recent years, there’s been an explosion of accountable care organizations (ACOs). Prior to ACA, there were 20 to 30 of these fully integrated health care systems in existence. Now, there are just under 600 of them. Under ACA’s definition, an ACO is required to create a formal governance structure and agree to take on risk for an attributed population. Once that structure is in place, it can apply to programs like the Medicare Shared Savings program or the Pioneer program to enter into risk-based payment for government programs. To become an effective ACO, a single electronic record needs to connect the participating hospitals and physicians. Because that requires a significant investment in information technology infrastructure, it has led to major consolidation among hospital systems, such as the recently proposed merger of Northwestern Memorial HealthCare and Cadence Health in the Chicago area.

Consolidation already was widespread throughout the

Source: Irving Levin Associates, Inc., and H2C.
health care industry prior to ACA. There has long been a continual merger-and-acquisition environment, as financially sound hospitals snatched up financially distressed hospitals in the interest of expanding their reach into new markets. In the past decade, we’ve seen more physicians warming up to the idea of being employed by hospitals because it reduced the pressure of having to see a certain number of patients in order to maintain a desired level of compensation while in private practice (Figure 2).

ACA acted as a catalyst, hastening the pace at which providers joined forces. In particular, ACA’s definition of an ACO led to a vast acceleration of hospitals banding together with physicians to become such an organization and reap the benefits. Such consolidation also gives a provider the scale necessary to negotiate effectively with carriers in the marketplace. The Federal Trade Commission is keeping a close eye on all this activity to ensure that price fixing is not occurring in the affected geographical marketplace.

All of this consolidation has caused some hospital systems to become so large that they have decided to become their own health plan, cutting out the middleman. As a result, a number of plans around the country now are provider-sponsored. That is, a large health system applies to the insurance department of its state to obtain an operating license for a health plan. It either rents or buys a third-party administrator to handle claims. If it has enough geographic coverage, it can rely on its own network of hospitals to provide services. If not, it may rent an additional network to strengthen its geographic coverage.

As with pay for value, provider-owned health plans are not a new phenomenon. In the heyday of the HMO movement, from the 1970s to the early ’90s, a significant percentage of HMOs were sponsored by hospitals. However, they fell by the wayside due to increasing data requirements and growing competition from the national plans.

At the same time as they are joining forces, providers are also being pressured to deliver a consumer-focused health care experience. We’re not talking about comfortable waiting rooms outfitted with Keurig coffee makers. Rather, the focus is increasingly on things like online appointment scheduling, after-hours access, family support during inpatient stays and better clinical integration to drive superior health outcomes. In addition, carriers increasingly are expected to provide enhanced decision support tools, as the public exchanges created by ACA continue to propel the provider industry toward consumer-directed health care. As the exchange market matures and some providers become health plans, they, too, will be required to focus on the individual consumer and deliver the requisite consumer-facing tools like decision support and social media apps.

Fortunately, ACA is being rolled out slowly over several years. That gives all stakeholders, but particularly the providers, some time to change the health care delivery system to meet the needs of a changing demographic, to balance the needs of a vast population of senior citizens—shifting care from intensive inpatient settings to post-acute care, nursing homes, extended care and hospice—with the expectations of a new generation of health care consumers who would...
rather text a list of symptoms to their doctor along with a request for the appropriate prescription to treat whatever ails them.

**Conclusion**

While we have a pretty good idea where we are going, there unfortunately is no reliable road map to help providers figure out how to get there. At this point, it's somewhat like trying to figure out a Rubik's Cube, the ubiquitous 1980s 3-D puzzle toy that proved nearly impossible to solve. Only through trial and error, innumerable twists and turns and attempted and aborted strategies could one learn if he or she was on the right path to achieving the goal. The same holds true for the health care provider landscape.

Currently, providers are struggling to figure out what to do. Savvy providers are using this time to hunker down and become as efficient as possible. They are becoming clinically integrated, assessing the various options for managing their financial risk portfolio and generally waiting for the dust to settle before making key decisions such as whether to stay independent or merge into a larger health system. Even then, there won't be one single path to provider transformation. Each market has its own set of unique quirks that makes that path different, and the resulting end state will vary drastically for providers in each market.

There are some nascent efforts at collaboration between all stakeholders (employer, provider and carrier) to more equitably design the right path and, more importantly, to sustain it. This represents a fundamental behavior change and will require some time and transparency to become what Malcolm Gladwell branded “contagious” in his seminal work, *The Tipping Point*.

Debate over whether ACA was fundamentally right or wrong likely will continue unabated for decades. However, there's no denying it set us down the path to unprecedented change. We stand at the brink of an absolute transformation in the health care landscape. The provider world is undergoing a massive transformation that will change not only the way doctors, hospitals and health care systems are paid, but also how they are assessed in terms of quality and value, how and where services are rendered and how employers purchase this vital benefit.

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