EXECUTIVE INSIGHTS

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Provider Network Innovation: On the Straight and "Narrow" Toward Value-Based Care

We are rapidly approaching an inflection point in the movement toward value-based care (VBC). On one hand, growing competition born by retail exchanges, intolerance for continued sharp rate increases, and limited confidence in accountable care organizations' (ACOs) ability to implement changes for a value-based framework are all driving payers to innovate with their provider networks. On the other hand, resistance to VBC has been understandable given past failures and entrenched fee-for-service (FFS) processes.

Payers and providers need to embrace the true commitment, perseverance and deep understanding of wholesale changes required to implement a new VBC model. Since a combination of market forces and federal mandates are forcing significant changes, tomorrow's winners will be those that reap the benefits from first-mover advantages.

Culture Shock

The value-based way of operating is not new, but it is still uncomfortable for many providers. Transitioning from the FFS model to VBC will be difficult, as providers have focused on maximizing procedure volume and reimbursement pricing and not on care coordination. They also fear lost patient volume and lower contract rates. Many providers simply do not know how to proceed or where to focus their efforts. Further, in many local markets there are few or no existing models that can serve as benchmarks.

Perhaps the biggest stumbling block to a successful partnership is the need to defend provider revenue streams. A simple plan to channel greater volume in exchange for discounted rates is insufficient. Based on L.E.K.'s experience, there is no price point where payers can move enough volume to even come close to making up for discounted rates (e.g., a 10% discount will not drive a sufficient increase in volume to make providers whole). What's more, the inherent difficulty in straddling both FFS and VBC operating models simultaneously stifles meaningful change, especially when nearly every operating process is geared to FFS. Providers can't be value-based on Tuesdays and Thursdays and FFS the rest of the week. And while many new industry players are rushing to sell services that facilitate the transition, few have real operating experience in value-based or delegated risk environments.

Lessons Learned & Next Steps

In the 1990s, the transition to value-based models led by physician practice management companies (PPMs) failed because it was poorly executed, not because it was strategically unsound. Shifts in compensation models were

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not accompanied with robust shifts in operating practices (e.g., population-heath, risk management, payer-provider data sharing). Today, payers can avoid missteps by focusing on nine success factors (see right):

There are no shortcuts to success. If the transition to value-based care is only an evolved discount scheme, it will fail – and payers will again be left holding the bag. For a new VBC model to work, payers must sustain the significant investments required in care management, albeit not necessarily payer-based care management, until providers can take this on. Success also depends on the ability to systematically profile provider networks, leverage best available market intelligence, and continually improve and adapt from lessons learned. As noted at the outset, we are reaching an inflection point, and payers need to move quickly and effectively to operationalize the shift to value.

Value-Based Care: Nine Success Factors

1. **Think broad-based.** Payers must work with providers to build consistent care management/coordination across populations (commercial, Medicare, Medicaid) and age and disease bands.
2. **Establish a solid starting point.** Payers must objectively assess the capabilities needed to support and manage a narrower provider network.
3. **Pick the right markets.** Each MSA has a unique market structure (payer market share, provider competitive landscape, employed vs. independent physicians, MA penetration, etc.); some structures are more conducive to VBC than others.
4. **Work with the right providers.** Reengineering care delivery takes extraordinary vision and courage; accepting less from partners is a recipe for failure.
5. **Collaborate, don't just contract.** Contract structures are important, but ultimately a small part of the collaboration.
6. **Align with other payers.** Unless a payer has 80%+ market share, the impact of VBC models will be muted by the confusion across payers as providers manage their full patient panels.
7. **Rapidly move past price for volume arrangements.** It's difficult to move enough volume or pay enough "bonus" to offset price declines, and the core trend is not redressed with this approach.
8. **Support knowledge transfusion.** It is essential to think beyond technology implementation to effective information sharing and usage.
9. **Use management services organizations (MSOs) judiciously.** Tightly qualify MSOs and ensure they are neither over- nor under-utilized.

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