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Healthcare Payment and Delivery Reform: Is it Capitation 2.0?

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Why is this time different?

The healthcare industry faces three major calls to action: reduce costs, improve quality, and improve the overall health of our citizens.

Today's predominantly Fee-For-Service (FFS) reimbursement model does not sufficiently align provider economic incentives to achieve these objectives. As a result, there is growing momentum behind "payment and delivery reform," or a fundamental, systemic shift away from traditional FFS to value-based payment mechanisms that increase provider accountability for population health management, quality and efficiency.

Several models, such as shared savings, episodic bundling and global payments have emerged as likely alternatives to the traditional FFS reimbursement model. Arguably, episodic bundling and global payments may be seen as the "next generation" of capitation from the 1990s.

Since most experts agree that previous capitation efforts were flawed in both approach and execution, why will it be different this time around?

Accenture's perspective is that healthcare has reached a new inflection point, differentiated by today's unsustainable market conditions, the maturation of business models to better align risk and reward, and the strengthening of core capabilities and infrastructure.

1

Today's Unsustainable Market Conditions

While the U.S. healthcare system has long been strained, the confluence and magnitude of current market conditions have created an unprecedented need for urgent, broad-based, transformative action:

- Healthcare expenditures now top 17% of the GDP and continue to outpace inflation. They have reached unaffordable levels at a time of general economic recession.
- Care delivery is inefficient and data is proving that more care does not necessarily equate to better care, as shown by the widely cited 2008 Dartmouth Atlas study.
- Population health management has not sufficiently curtailed preventable, chronic conditions and the U.S. has not kept pace with other developed countries. Potentially avoidable complications from asthma, CAD, CHF, COPD, diabetes, and hypertension alone, account for 40 cents of every dollar in healthcare spending.¹

In response to this critical situation, government and industry leaders are mobilizing. However, today's efforts should not be viewed as a case of déjà vu. Key stakeholders are incorporating the "lessons learned" from previously unsuccessful efforts to address issues of healthcare cost and quality. Furthermore, the strengthening of core organizational and infrastructure capabilities across the industry indicates that the failures of the past can be averted and value-based payment mechanisms effectively enabled.

2

Maturation of Business Models to Align Risk with Reward

Today's emerging business models are being carefully developed to address the inherent flaws of capitation from the 1990s.

In particular, these new incentive models are being designed to better align provider risk and reward, as characterized by the following:

- One size does not fit all, giving way to tiered risk models
- Strengthened pay for performance models used in conjunction with the evolving forms of base payment (e.g., shared savings, episodic bundling and global payments)
- More extensive provider integration and adequately sized patient populations to sufficiently "spread" risk
- Robust modeling, historical cost analyses and adjustment for patient severity/acuity to adequately establish and fund the cost of care
- Reporting and increased transparency to further influence provider behavior and empower consumers.

In addition to this significant evolution in methodology and approach, current market trends provide evidence of strengthening organizational and infrastructure capabilities that are necessary to enable value-based payment mechanisms and achieve high performance.

¹ "Waste in U.S. Healthcare Spending: Potentially Avoidable Complications, Chronic Condition Care," RWJF, June 2009

Payers are utilizing a combination of funding and incentive mechanisms to accelerate the adoption of healthcare IT among its providers.

3

Strengthened Capabilities and Infrastructure

Spurred by unprecedented levels of Health Information Technology (HIT) government funding, the catalyzing Patient Protection and Affordable Care Act (PPACA), myriad demonstration projects to test new payment mechanisms and vehicles for provider alignment and care delivery (e.g., Prometheus, CMS ACO demonstration Projects and the Brookings-Dartmouth ACO Learning Network), and a revived sense of market urgency, payers and providers are gaining traction across five core capabilities:

- Provider Alignment, including strengthened provider networks in number and types of physicians (e.g., primary care and specialists) and new contracting vehicles such as ACOs
- Payment Setting and Management, that increases provider accountability for both cost and quality of care, while addressing the flaws of capitation
- Integrated Care Delivery Models, with increased focus on population health, care coordination, particularly across care transitions, chronic condition management, including prevention of avoidable complications and hospital readmissions and prevention of disease onset
- Information Technology and "Connected Health" in the form of EMRs, EHRs and HIEs to enable point of care data capture, clinical decision support, streamlined workflow, patient referral and tracking and critical data exchange
- Data Management and Analytics to enable more sophisticated use of Business Intelligence (BI) and management and operational reporting in the areas of cost, utilization and clinical outcomes

Underlying the strengthening of these capabilities is also evidence of increased payer-provider collaboration to build and support these needed capabilities. For example, payers are utilizing a combination of funding and incentive mechanisms to accelerate the adoption of healthcare IT among its providers. Moreover, according to a 2008 report by AHIP, a variety of new health plan-hosted technologies are helping doctors identify and address gaps in evidence-based treatment.² Finally, as we are seeing among our own clients, payers and providers are pursuing innovative business arrangements to enable the formation of ACOs. There is growing momentum behind payers potentially acting as "services providers" to the ACOs in the area of population health management, leveraging payer infrastructure, tools, technology, and staff.

Why Act Now?

Accenture anticipates that a major shift away from traditional FFS will occur incrementally and firmly take root over the next three to five years. Market leaders wisely recognize they cannot wait.

- CMS is looking to the market to test and innovate around different payment and delivery models (e.g., ACO demonstration projects); market leaders should seize these opportunities to influence CMS' ultimate direction
- Issues of unsustainable cost, inefficiency and suboptimal care coordination and quality are well established; they demand action now, regardless of legislative uncertainty and / or the failures of previous efforts (e.g., capitation)
- The significant scope and complexity of change to build the needed capabilities is a multi-year process, requiring that providers and payers actively begin planning and designing for the required changes

Though payment reform may have once seemed impossible, it is now a viable and growing reality for which all healthcare stakeholders must begin preparing.

For more information on how your organization needs to position itself to be a market leader in this time of dramatic change across the healthcare landscape, please look for our next installment, "Healthcare Payment and Delivery Reform: The Core Capabilities that Redefine High Performance."

² "Trends and Innovations in Health Information Technology," AHIP Center for Policy and Research. September 2008. <http://www.ahipresearch.org/pdfs/CPRTrendsInHealthIT.pdf>.

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