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TRANSITION ECONOMICS

STRATEGIC CHALLENGE AND OPPORTUNITY



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Transition Economics – Strategic Challenge and Opportunity

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There is general agreement that the current state of the healthcare industry is not sustainable. Social, economic, and political factors have set the stage for major transformations in the ways health care is provided and paid for. However, the specific details and timing of change remain uncertain, making some providers hesitant to craft a clearly defined strategy amidst so many fluctuating variables.

Developing an effective strategy requires leaders to make choices about what the organization will and will not do. While today's uncertainty make such choices increasingly risky, the greatest opportunities for game-changing success typically occur during periods of industry transformation. Of the myriad changes on the horizon, the most critical uncertainty facing healthcare organizations relates to the degree and pace of migration from volume based to value based payment schemes. This economic transition has the potential to disrupt the traditional financial model of hospitals and health systems. Given today's higher stakes, now is the time for healthcare leaders to reinvent their strategic plans employing scenario analysis, to mobilize leadership teams around a shared vision of the future and the path to manage the transition.

Starting Now with “No Regrets”

There are three primary industry trends that will occur with high degrees of certainty and affect the future environment for nearly all providers:

Reimbursement will decline. Medicare funding was reduced by an additional \$120 billion over 5 years as part of the recent healthcare legislation. State budget shortfalls have led to Medicaid rate freezes or decreases as well as benefit limits. Commercial payers face increased government rate regulation, tougher medical loss ratio requirements, and the establishment of health insurance exchanges increasing transparency and forcing premiums downward. Given these pressures across the major payer classes, payments to providers will suffer.

Variations in care and utilization of services will be identified and challenged.

There has been increasing media and government scrutiny on disparities in provision, cost and outcomes of care. Payers and policymakers have begun to incorporate clinical comparative effective research and other related standards into new payment mechanisms; punitive payment structures are already in place in some areas for never-events and inappropriate readmissions. Payers and government agencies will continue to scrutinize care variations, and attempt to diminish them, through incorporating cost, outcomes, and quality of care metrics into payment models.

Alternatives to fee-for-service reimbursement will continue to emerge. While many organizations may opt-out of the Medicare Shared Savings Program, the CMS guidelines are likely a leading indicator of future payment structures. Regulators have articulated a payment evolution from fee-for-service towards pay-for-performance, episode-based bundled payments and population-based reimbursement. While each of these mechanisms has its own architecture, they follow a path of increasing provider accountability. Commercial payers, providers and state agencies have accelerated the adoption of alternative reimbursement concepts with several successful programs underway.

Organizations that plan for these and other identifiable “known” trends and build the competencies required for future success will ultimately find themselves in an improved competitive position. We have identified four “no regrets” initiatives that most health systems should undertake immediately (Figure 1).

FIG. 1 **Industry Trends and “No Regrets” Initiatives**

Industry Trend	“No Regrets” Initiative
Reimbursement will decline	Cost management: Reduce costs, redesign care delivery, and rebalance assets and offerings
Variations in care will be scrutinized	Care Management: Collaborate with physicians to achieve and demonstrate superior clinical effectiveness across the continuum and all sites of care
Alternatives to fee-for-service reimbursement will continue to emerge	Network Management: Solidify the necessary network of relationships to achieve relevance with employers and payers Population Health Management: Experiment with different payment models and incentive structures in pilot situations that leverage the organization’s current strengths

These initiatives and essential competencies are the subject of a previous whitepaper entitled *Improving Performance and Building Capabilities During Turbulent Times* written by The Chartis Group’s Advanced Operations Practice. We encourage readers to refer to that paper for more detail on these initiatives.

Identification and agreement regarding the known trends and organizational competencies required for the emerging environment is an essential component of any strategic plan. In today's dynamic environment a strategic planning process must focus leadership attention on the critical market and competitive uncertainties.

Managing the Transition

Implementation of “no regrets” initiatives will establish capabilities important for the future. However, these tactics do not comprise a strategy for sustainable competitive advantage. Developing a winning strategy requires facing the critical uncertainties regarding when, and to what degree, disruptions will occur and how decisions made by payers, providers and patients will influence those developments.

Economic disruption is perhaps the most significant issue facing healthcare leaders. The evolving economic model will redefine the value of health system assets and organizational capabilities, with fundamental shifts in the basic building blocks of the value equation (Figure 2).

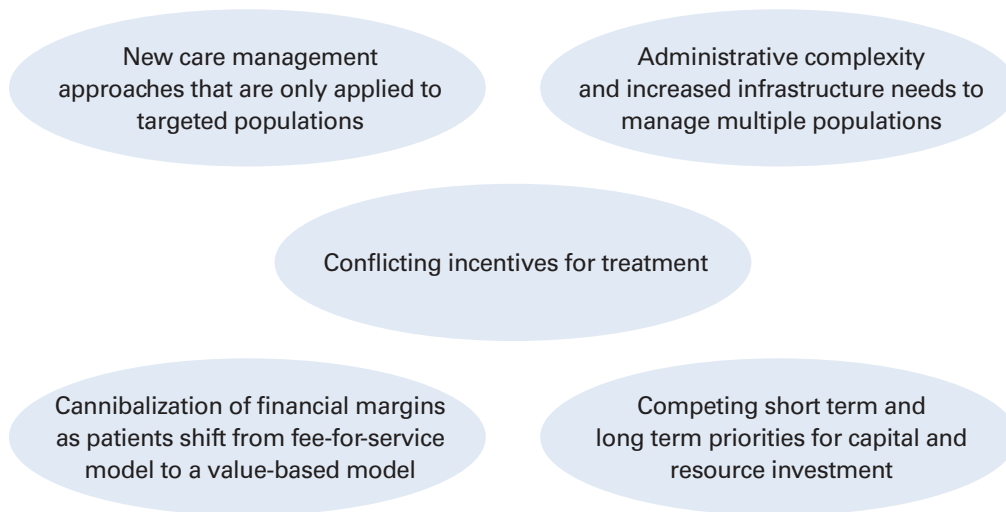
FIG. 2 **Today: Paid for Volume – Tomorrow: Paid for Value.**

	TODAY <i>Paid for Volume</i> An economic model driven by utilization and fee-for-service reimbursement	TOMORROW <i>Paid for Value</i> An economic model driven by size of defined population served and the cost of care to provide desired outcomes
Physician Role	Referral generator focused on specific care specialty	Manager of comprehensive patient health
Hospital Role	Profit centers	Cost centers
Patient Acquisition	Focus on broad referral network	Focus on defined population
Revenue Source	IP admissions, procedures & OP encounters	Aligned with size of population and clinical outcomes
Margin Driver	Geographically distributed acute care platform	High-performing medical management

As reimbursement evolves to include rewards for achieving desired outcomes, reducing growth in costs for defined populations and other definitions of improved value, the role of the physician must expand from referral generator and specialty services provider to include health management activities. Similarly, hospitals will be under significant pressure to demonstrate competitive costs and the value of their services. Hospitals will also need to broaden their traditional focus on referral growth to include an in-depth understanding of the health status and needs of the patient populations seeking treatment across the system’s continuum of care. Under the anticipated future environment, enterprise strategies will no longer be predominantly focused on building facilities in a wider geographic area to capture increased volume, but rather focused on proactive and comprehensive care management across sites of care.

The key strategic challenge for health systems is determining the speed and dynamics of the switch from “today” to “tomorrow” in their market. Planning for that tipping point is a delicate balance. Providers that implement future economic models faster than the market evolves may prematurely reduce their revenues; providers that do not adequately invest and prepare for the economic shift will lack the capabilities to thrive when the transition is imminent. That said, having one foot in both worlds can be challenging; as pilot programs are implemented, providers will need to address the challenges of balancing a mixed portfolio of fee-for-service payment and reimbursement models that reward different behaviors. Operating successfully in both worlds will result in new operational and financial challenges (Figure 3).

FIG. 3 Examples of Transition Economics Challenges



It is unreasonable to expect providers to exist in this dichotomous world for any lengthy period. As care management capabilities are honed, operations made more efficient, and human nature works to decrease the dissonance created by these two worlds, the new models of care will predominate even for patients that remain under traditional payment models. The key is to anticipate and strategically manage this transition. This can be accomplished by initially attempting to segment the pilot

populations by physician, condition, site of care, or employer, for example. More importantly, a proactive strategy to identify the migration path toward comprehensive care management of a defined patient population is essential to diminish the longer term impact of the challenges listed above. An in-depth assessment of the organization’s patient population segments and relationships with payers and physicians is required to optimize pilot program selection and the timing of enterprise-wide transformation.

There are several markets well into the transition process. In many cases, the shift was initiated or accelerated by pilots driven by commercial payers. Blue Cross Blue Shield of Massachusetts has partnered with 19 provider organizations to manage 500,000 HMO lives under global budgets with quality and experience incentives; in the first year, every provider met the cost target and received incentive payments. The Blue Cross Blue Shield of Minnesota incentive contract with five of the state’s largest health systems provides shared savings for managing the overall cost and quality of care; BCBS now plans to extend this model to all PPO and HMO contracts for 2.7 million covered lives in the state. In markets where these programs have been established, “fast followers” are likely to emerge, initiating rapid population shifts from fee-for-service to alternative payment structures. Providers who have not planned for this inflection point risk being left behind. We have profiled three organizations that effectively identified these triggers and implemented programs to build the capabilities required and manage the transition to the future while minimizing cannibalization of today’s margins.

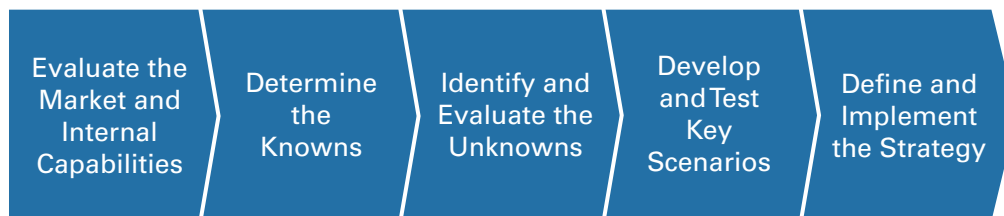
See sidebars for select case examples of institutions which have begun to address this transition.

Using Scenario Analysis to Plan for the Future

Scenario analysis provides a structured, dynamic process for leaders to develop and evaluate strategic options against several alternative future states. While much has been written about the application of scenario analysis in other industries¹, the literature bears very few healthcare provider examples. Given the strategic challenges and uncertainties facing healthcare leaders today, this is the optimal time to apply scenario analysis to the healthcare industry.

The general process for scenario planning is the same in health care as in other industries (Figure 4).

FIG. 4 **Scenario Analysis Approach to Strategic Planning**



CASE EXAMPLE

Montefiore Medical Center Bronx, NY

Background: In the early 2000s, in collaboration with New York payers, Montefiore Medical Center (MMC), created an Independent Physicians Association (IPA) and Care Management Organization (CMO) to manage the clinical care of defined Bronx populations under capitated risk agreements to manage the care of defined populations as target “no regrets” initiatives.

Strategic Decision: In creating its 2020 strategic plan, MMC leadership assumed a future where their financial margin would be driven by reducing the total cost of care for the majority, rather than a subset of their Bronx based patient population. This economic shift, coupled with MMC’s distinctive care management competencies, led to a strategy to be at the forefront of accountable care models in New York and to significantly increase investment in resources to transition to a value-based care delivery organizational model.

Results: MMC has restructured its contract with Emblem Health to include an accountable care arrangement and is in discussions to create similar risk-based contracts with other payers. They are aggressively expanding their care management capabilities, investing in ambulatory care expansion, redistributing acute care services across their system, and transforming the primary care delivery model in over 20 sites to fully functioning NCQA recognized medical homes.

Scenario-based strategic planning is more comprehensive than the typical strategic planning process, incorporating perspectives from all direct and adjacent stakeholders related to healthcare provision in the market. This more extensive analysis will provide a clearer picture of market dynamics including the most influential players in the market; it sets the stage for a broad range of strategic options, and infuses the strategic planning process with various perspectives that may not have otherwise emerged. The initial market and internal assessment, coupled with the market knowns, provide both the baseline for future scenarios and the groundwork for immediate “no regrets” initiatives. While we identified some key trends and “no regrets” initiatives earlier that apply to most providers, there may be several others applicable to a specific market or organization.

Identifying and preparing for the unknowns is the most challenging and most subjective step in scenario-based strategic planning. It is also critical to help anticipate and mitigate future risk. Variables with the most uncertainty and the highest potential impact on strategy provide a basis for future scenarios against which organizations can plan. These important and unpredictable factors can significantly alter the organization’s strategic direction and ability to succeed if they occur. The pace and degree of transition from volume to value-based is one of the most significant unknowns for most providers.

Scenario-based planning forces the strategic planning team to think through the causes of each potential future state and the subsequent moves for each player in the market. Based on the scenarios, which incorporate the knowns and key potential unknowns, the leadership team can develop an enterprise-wide strategy and determine how successful the strategy would be under each scenario.

The best scenario planning processes narrow the hundreds of “what-if” and “if-then” statements that traditionally arise in leadership retreats and board meetings to 2-4 portraits of the potential market and organizational future. This approach enables leadership teams to minimize risk and feel more secure in the strategic investments they are making today.

From Transition to Transformation

Organizations that thoughtfully develop plans and a strategic approach to the impending changes will be positioned to either drive the transition in their respective markets or rapidly adapt when the time is right. Organizations that fail to plan and act are at risk of survival in the new competitive environment. In the near term, healthcare leaders should carefully consider three key recommendations to best prepare for the uncertain future.

Recommendation #1:

Implement the “no regrets” initiatives. *Establish the infrastructure, competencies and capabilities to effectively manage total cost and quality of care.*

Conduct an enterprise-wide assessment of the current state of your organization’s capabilities in cost management, care management, network management and population health management. Understand where both strengths and gaps exist. Develop

CASE EXAMPLE

Advocate Health System Chicago, IL

Background: Advocate leaders long recognized the need to align with physicians to improve patient care and demonstrate value to payers, resulting in a “no regrets” clinical integration and care management joint venture between physicians and the health system with over 3,800 of Advocate’s affiliated physicians now part of Advocate Physician Partners.

Key Strategic Decision: To prepare for the likely future Chicago market environment, Advocate entered into an agreement in 2011 with Blue Cross Blue Shield of Illinois to manage over 300,000 HMO and PPO lives under an accountable care payment structure, shifting over \$1 billion of the Chicago-area commercial health care market towards a new economic model.

Results: At the time of Advocate’s 2010 Blue Cross contract renewal, the Chicago market was still largely fee-for-service. Advocate leaders placed their bets on a strategy to more closely align with physicians and be first to market with a substantial accountable care model. This contract may create a tipping point in the Chicago market taking full advantage of Advocate’s first mover status.

detailed tactical plans to rapidly implement the aforementioned “no regrets” initiatives. Depending on the current state assessment of the organization, these initiatives alone could prove to be challenging, requiring significant time and investment. While these capabilities have been deemed as “no regrets,” they should not be mistaken for “quick wins” or “low hanging fruit.”

Recommendation #2:

Anticipate and manage the economic transition. *Minimize cannibalization of margins under existing fee for service reimbursement while simultaneously preparing for the risk-based payment future.*

An in-depth understanding of the patient population served, payer and physician relationships, and profitability under each of the payment models will enable healthcare leaders to strategically prioritize which pilots to develop under alternative payment mechanisms. Organizations that strategically prepare for the tipping point in their respective markets – the point where a large enough proportion of payers demand provider accountability, will invariably emerge in a better financial and market position than those who take a “wait and see” approach.

Recommendation #3:

Use scenario analysis as a key component in strategic planning. *Develop a clear and reasoned view of the organization and the market’s most likely futures.*

It is never too soon to align the leadership team around a vision and goals and to strategize according to the market’s potential end-states. As part of the scenario planning process, identify any other trends that may lead to additional “no regrets” initiatives in your market. Most importantly, isolate the factors that have the most uncertainty and biggest impact on the outcomes and use these factors to create viable future state scenarios. Establish the key trigger points, define the tipping point for your market, and be prepared to drive change. Proactively define the timing and sequencing of transition to a new economic model based on the potential outcomes of the developed scenarios.

One caution is to avoid employing a “me too” strategic plan based on a successful strategy executed by others. Strategic planning in healthcare is market specific. The timeframe for change, potential for first mover advantage, payer and competitor dynamics and organizational capabilities vary highly. What works in one market or for one health system will not necessarily work elsewhere. A tailored planning process that pushes the organization beyond its “no regrets” capabilities involves a broader set of stakeholders and perspectives, and incorporates scenario analysis to allow the leadership team to make thoughtful and informed bets that turn the challenges of transition economics into a strategic opportunity.

CASE EXAMPLE

HealthPartners *Minneapolis, MN*

Background: Minneapolis is perhaps one of the most futuristic looking markets, with high consolidation, a focus on transparency, and several pay for performance and other alternative payment mechanisms in place. Because of this, HealthPartners already successfully implemented “no regrets” initiatives around cost management, network management, and care management over the past several years.

Key Strategic Decision: In examining the future scenarios, HealthPartners made a conscious decision to transition care delivery in the system to a medical home based model. HealthPartners leaders identified design principles for the transition that would be beneficial both in today’s environment and the future, including: transferability across all conditions; increased provider efficiency; the right person doing the right work; reduced variation in all workflows; support for the patient-provider relationship; aligned accountabilities; and, most significantly, utilization of no incremental resources.

Results: HealthPartners’ model transforms the traditional office visit into a broader relationship with the patient that extends beyond the visit. HealthPartners has since demonstrated dramatic, simultaneous improvements across the measures of health (41% of patients with optimized diabetes control), experience (98% of patients would recommend HealthPartners clinics), and affordability (10% below statewide total cost average). HealthPartners has reached benchmark levels of employee satisfaction, improved physician satisfaction and clinical productivity, and increased access to providers.

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