Uncertainty from government regulations brings uncertainty to hospitals, especially as leaders prepare for possible changes to the Affordable Care Act. Medicaid expansion, minimum requirements for health insurance plans, the individual mandate and the state health insurance exchanges all may change or go away. For hospitals adapting to alternative payment models, the work of the Centers for Medicare and Medicaid Services (CMS) Innovation Center and the future of Medicare experiments will likely take new twists and turns.

Regardless of what happens, the most efficient and high-quality health systems will be winners, according to Nate Kaufman, strategic advisor to Huron and managing director and founder of Kaufman Strategic Advisors, LLC. The following are excerpts of our interview with Nate about the future of value-based care systems.

Q: WHAT HAVE WE LEARNED FROM EFFORTS TO IMPROVE HEALTHCARE VALUE?
A: There is a strong correlation between lowering cost, improving quality and clinical variation, so health systems that want to emerge as the value players in their markets must reduce clinical variation. But hospital executives can’t drive this process alone. Experience suggests that practicing physicians, not physician administrators or businesspeople, must drive the development of these standard protocols. If physicians and other caregivers who will be using the protocols don’t develop them, they are less likely to adopt new care pathways and best practices for more standardized treatments.

We also know that financial incentives are necessary, but not sufficient, for promoting physician alignment. Hospitals often talk about gain-sharing with physicians as an incentive for participation in alternative payment models. Those agreements work only when there are ongoing gains to share. After a few down years, physicians will disengage.

Instead, the key to success for a high-functioning integrated delivery system is the creation of a physician hierarchy that creates a culture committed to financial and clinical accountability and quality. This takes time. It took one of my clients, Memorial Hermann Physician Network — the exceptionally successful Memorial Hermann ACO — more than eight
years to fully develop this physician culture, but it was worth the wait. Health systems that aggressively pursue a strategy with underdeveloped competencies and physician support will fail.

Q: HOW FAR ALONG ARE HOSPITALS IN MEASURING TRUE COST OF CARE?
A: Not far enough. Five years ago, Harvard Business School professors Michael Porter and Robert Kaplan identified hospitals’ inability to measure true cost of care. Without accurate cost accounting systems, hospitals have difficulty linking costs to process improvements or outcomes; they lack actionable data that leads to improvement. With a data-driven approach, hospitals will have insight into areas such as knowing what clinical variation is unwarranted, driving higher costs and reducing quality. The good news is that once hospitals get their hands around their true costs per unit, cost per episode and the quality of care they deliver, they are taking the step toward becoming a high-value network. That’s because if the equation for value is quality plus patient satisfaction and cost, you cannot measure and manage value without knowing costs. As a result, hospitals are better positioned to negotiate with all payers, and they will have a strategic competitive advantage.

Q: WHAT DOES THE FUTURE HOLD FOR POST-ACUTE CARE?
A: The variation in the use of post-acute care is the primary driver of variations in Medicare spend per beneficiary (MSPB). Managing post-acute care is a huge potential area of cost savings under any kind of value-based model. When orthopedic joint surgeons discharge their surgical patients to home with the support of in-home clinical services, the use of expensive skilled nursing facilities and long-term rehab is going to decline significantly and contribute to a reduction in the MSPB. In some cases, hospitals still need to refer patients to long-term post-acute care facilities, and they are identifying criteria for post-acute partners. These criteria include sharing data, having a five-star rating from CMS and coordinating care with hospital-affiliated “extensivists,” physicians trained in care transitions.

Q: WHAT IS THE FUTURE OF BUNDLED PAYMENTS?
A: Large employers such as Lowe’s, PepsiCo, Krogers and Wal-Mart have embraced bundled payments, and we expect that list to grow. Since 2011, the California Public Employee Retirement System has used reference pricing for joint replacement, colonoscopies, elective cataract surgeries and arthroscopies. This benefit design sets a reference price point for a certain bundle of services, and it asks beneficiaries to pay the difference if a hospital and physicians charge more — thus forcing hospitals and physicians to develop a lower total cost of high quality for the same procedures or episodes of care. We will see
more employers contracting with health systems for flat rates for certain episodes of care and using benefit design to drive volume to the bundler with the best value.

Whether bundled payments, as defined today, will survive, the strategies behind them are still essential. In the long run, we can expect the government to ask hospitals to accept more risk (e.g., in the form of bundled payments), and we can expect more risk-based ACOs or some other net new reimbursement systems. Recall that diagnosis related groups (DRGs) were intended to stem rising medical inflation for inpatient care. DRGs attach “case rates” (e.g., bundled rates) for an inpatient stay regardless of the actual cost of care.

Essentially, CMS forced hospital administrators to alter the behavior of the physicians on their medical staff or the hospital would suffer financially. Bundled payments resemble DRGs, picking up where DRGs leave off, including adding sites of care and service providers, and they are not limited to the inpatient stay. Additionally, unlike DRGs, bundled payments reward providers for good outcomes and efficient care.

Q: WHAT IS YOUR ADVICE FOR HOSPITALS?

A: All payers are evaluating all providers, e.g., physicians and hospitals, on their cost and quality per episode of care. Many payers are using financial incentives such as co-payments or pay-for-performance bonuses to steer patients to the most cost-effective providers.

Regardless of the changes that Congress may enact, we know this much: Health systems that collaborate with their physicians to develop a care delivery model that ensures every patient receives highly efficient and appropriate care, optimal outcomes, great service and reasonable access will be well-positioned for the future.