Five Lessons from Big Business on Value-Based Health Care

written by Theresa Hush | February 8, 2018

Last year we predicted that CMS would step back from the complex requirements of its Value-Based Health Care initiative, in favor of reducing provider burdens for quality reporting and reducing regulation, in general. While MACRA MIPS and the move toward financial risk still remain, we correctly anticipated that Medicare would focus its efforts on its own beneficiaries—and less on leading the charge for cost control in health care.

We hoped that providers would seize the opportunity to take ownership of making health care work better, rather than respond to external requirements. Instead, despite several organizations that have pushed the agenda for change in their systems, most provider-based health initiatives have been too small, too slow and too focused on gaining leverage against the competition—all in anticipation of "managing" patients under VBHC.

That window of opportunity to take the lead in health care reform may have closed, now. Some new leaders have entered the picture who have the motivation and resources to demand change.

Big Business Has Stepped Up in Health Care

In the past two months, Big Business has made announcements that promise to shake up and change the course of health care. Three announcements, in particular, represent the strongest statements of intent that the health care fortress is about to be breached:

> CVS-Aetna Merger
> Apple Health Records app for iPhones
> Amazon, Berkshire Hathaway and JP Morgan Chase creation of new health care company for their employees

Judging from the industry's quiet response—marked by a "many have tried and failed" attitude toward the supposed naïveté of business entering the fray of health care costs—it appears that providers may think Big Business efforts are tangential. But do health systems leadership teams really believe that Big Business has no expertise to offer? That would be a risky miscalculation for providers.

Health Care Organizations' Response to VBHC—Get Bigger

Provider health systems have been caught in a feverish pace of acquisition and mergers. These transactions assume that providers can take the lead in shaping the future course of services and care under Value-Based Health Care. Indeed, health care has been growing so much that it's hard to keep track of who is purchasing or merging with whom. But these mergers don't seem to be helping to keep costs under control, as measured by prices paid by employers, consumers and patients.

Despite evidence pointing to even higher costs coming from the merged enterprises, there has been an unrelenting march toward ever-bigger provider health systems. There is so much consolidation occurring that there is an uptick in both anti-trust activity and refusals of mergers.

Yet, already many communities face concentrations of health systems that threaten competition and therefore keep health care prices high, as well as endanger consumers by holding them captive.

Providers say that the investment in technology and other infrastructure needed to size up for Value-Based Health Care warrants the expansion. They point to the need to manage population outcomes and cost through a continuum of services, from primary care through specialty

hospital services, and beyond.

The effect on the industry has been staggering, prompting a sharp decline of independent physicians. Attracted by both compensation and practice support for dealing with VBHC demands, plus the need to buffer their futures against financial risk, less than half of the country's physicians now remain independent.

At the same time, as health care systems have gained size and resources such as technology, their failure to produce savings—even when they have created their own ACOs—leads to loss of credibility in both the VBHC model as well as provider systems. This failure to produce savings should not be a surprise; the system still supports fee-for-service reimbursement, has low risk for health care systems, and does not envelope patients in methods to increase value in health care decision-making. It's a tiptoe transition to accountability that assumes ample time to evolve.

CVS-Aetna Merger Is An Appeal to Consumers

The CVS purchase of Aetna has many interesting possibilities for disrupting the health care system. Industry watchers have focused on the use of the CVS pharmacy benefit plan for Aetna-covered patients, or the potential for aggregating data for use by consumers. These are important features that may help whittle down costs.

But these are not the most significant features for this transaction. What is? The growing community-based clinic operations that provide more and more primary care. By linking coverage, data and real community providers, consumers have an alternative way to get fast, efficient, convenient and quality-driven primary care. They also have a path to trust more in their insurance company, because that insurance company is now focused on giving them better data and more value.

The CVS-Aetna merger is *at least* as much focused on consumers as it is on administration of benefits and costs, and likely much more. Case in point: Where did you get your flu shot? My doctor gave me a choice last year. "You can get your flu shot here and it will cost you $85," she told me. "Or, you can go to CVS and it will cost you $15." This year, I didn't pay anything when I went to a retail pharmacy.

And this: My daughter flew in from New York for Christmas with a terrible cough and congestion. We didn't even discuss the possibilities of calling her previous physician or going to an emergency room. She went to a Walgreens Minute Clinic, was seen the same day and received great service.

What should providers take away from these transactions? First, there are some significant consumer-facing businesses that believe affordable pricing, convenience and customer service are the way to build a patient base. Second, they have demonstrated that consumers are voting with their wallets for price transparency and other mechanisms to lower their costs.

Providers' response to the CVS-Aetna threat of movement into their more distinct provider space? You guessed it: Just get bigger.

Can Apple's Health Record Impact Health Care Decisions by Patients?

The two-decade effort to digitize patient health care information has benefited hospital analytics. But it didn't do much for patients. Stripped of critical information that would have allowed them to consult with others and obstructed by layers of bureaucracy and cost, consumers have not had full access or ownership of their own data.

Apple's data integration is built on a platform of EMR data contributed by health care systems, placed in consumers's palms via their phones. This may be a real game changer in the movement to help patients monitor their health status and make health choices. As the data and interpretive tools improve, it may become commonplace to evaluate our diets, exercise and other activities through this window. It may also be a method to convey our own data to practitioners, facilitate specialized care or create data for precision medicine.

The Apple initiative is all the more important because some very prestigious health care systems will participate in the initial round. After years of protective data generation, these forward thinkers have stepped up, along with their EMR vendors, to slay the interconnectivity dragon. Broad industry support of the fledgling effort is refreshing as well as cost-effective for providers, who would otherwise face exorbitant costs to redesign systems to meet the full consumer needs and collect patient-provided data. The Apple Health Record creates a DMZ between provider and patient data that still must be navigated for its value and use.

Equally important, Apple has given providers a very good lesson by demonstrating that access to health care data is something consumers want and are willing to use to improve their health status. The tech giant may have learned this from their Apple Watch, a lesson that defies providers' complaints that they can't get patients to change their behavior. The real question for consumer involvement in their health care: not If, but How.

Amazon, JP Morgan Chase and Berkshire Hathaway—Strong Consumer Focus and Consumer-Infrastructure

The details are murky on the three giants' objectives in creating a health care company for their employees. Many health care provider systems think it naïve for the trio to expect to curtail costs. Beyond these organizations, there is more exuberance for Big Business initiatives to disrupt health care and excitement about the possibilities of on-demand care, better avenues for consumers to get information, and support for cost-effective choices.

Regardless of what will eventually grow out of this enterprise, it is likely to have significant impact simply because of the players involved. Providers should be taking home some lessons on why this is happening and what to do next. And what are those lessons? Let's start with how Big Business will take charge of reforming health care, if they lose faith that health care systems themselves will do it. And then we should consider whether three very consumer-directed organizations, who have focused on convenience and price, will be creating innovative alternatives for their employees. Finally, do we really think they will stop there?

Five Lessons For Providers From Big Business

Taken together, the central themes of these initiatives involve two important concepts. First, Big Business is done waiting. If providers do not act to address costs now, business is prepared to take matters into its own hands. Regulating providers into cost control is a tricky path, but competition is what these folks know how to do.

Second, these businesses respect the consumer as the decision maker and value customer service in a way that differs from most health care enterprises. For providers, the "customer" is often the physician, their participating health plans and employers. Their patients are the recipients of care, but that doesn't necessarily translate into "customers" to which they are accountable. As a result, they struggle with developing customer-service-friendly practices, shared data, encouraging patients to consider options, shared decision-making and price transparency.

Health care systems should carefully consider what Big Business is making clear through these initiatives:

> The time is up for minimum effort and pilots to improve health care cost performance.
> Price, convenience and customer service are still the way to get patients.
> Patient decisions will be the future of cost control, because providers have not been able

to get there (yet). Price transparency, quality data and decision support for patients are viable services used to lower costs.
Consumers want access to their health care data and are willing to engage with that data to improve their choices.
Streamlined, on-demand health care services and support for health care decisions will be the most important tools for providers to develop.

The health care system must change, and the only question is who will be on the leadership team. It could be business, or health care providers, or a combination of the two. How fast providers can develop their own businesses to be customer-focused—toward the patient and prospective patient, that is—will determine their place in the industry.

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