In principle, health system and physician executives know what they need to do over the next decade or so. The Patient Protection and Affordable Care Act (PPACA) contains a fairly clear itinerary: Depart without delay from the familiar territory of fee-for-service and travel to the as yet undefined new world of value-based care—a world in which care delivery companies will compete on value, producing better outcomes more cost effectively year after year, and once and for all taming medical trend. The stakes have never been bigger. The private healthcare system itself hangs in the balance.

An itinerary is not a roadmap, though. At this stage, value-based care is still mostly hypothetical. The rules are not yet written; only a handful of market participants have practical experience with value-based models; and there are few examples to learn from. And the change required is transformational. Under the fee-for-service model, every patient touch produces revenue; under fee-for-value, every touch generates costs. The basic economic unit will shift from visits or days to episodes or diseases, while improved margin performance will be a matter of effectively managing the cost of care while producing exceptional outcomes. New leadership, competencies, culture, and systems will be essential.
To find out how leading organizations are preparing for fee-for-value, Oliver Wyman conducted in-depth interviews with 40 healthcare executives. It should come as no surprise their local market strategies were as varied as the participants themselves, but we also heard strong shared themes that transcend geographies and organizational types. In this paper, we summarize four of these themes, as well as Oliver Wyman’s perspectives on the key unresolved issues.

#1 This one is for real

The most striking feature of our interviews was that executives are now virtually unanimous in believing that the system is on the verge of a shift from a volume-based to a value-based model over the next decade. This is hardly the first time that healthcare executives have heard the rumblings of imminent revolution. From the boom and gradual demise of HMOs to the rise and fall of provider risk sharing arrangements in the early 90s, new ideas have come and gone, with limited impact on how healthcare is actually delivered—and making no more than a tiny dent in medical trend. “Usually chatter fails to transpire into real change,” we were told by Tom Priselac, president and CEO of the Cedars Sinai Health System in Los Angeles. “But this time it’s different.” Our interview subjects cited several reasons:

- The **current transactional fee-for-service model** for healthcare is a low-value formula that produces high costs with highly variable outcomes—and is gradually bankrupting America. Art Nichols, CEO of Cheshire Medical Center–Dartmouth Hitchcock Clinic, agrees: “I truly believe that fee-for-service is unsustainable,” he says. “We’re seeing it in the erosion of health insurance. And doctors are on such a treadmill.”

- **Medicare and Medicaid funding shortfalls** will inevitably lead to regulated price controls under PPACA. “The healthcare reform bill is a disaster,” says the CEO of one of the largest group practices in the country. “The bill has no regard for funding sources. It dumps people into Medicaid and state budgets that are already constrained.” The worst cuts are still several years off, but hospitals are already feeling the pinch.

- The **slow-growth, high-unemployment economy** makes a bad situation worse—driving down the tax base, weakening labor markets, increasing the uninsured population, and cutting into families’ discretionary income.

Without a strong labor market and a bigger tax base, there is no silver bullet for healthcare; the industry must either transform the system from fee-for-service to fee-for-value or prepare for price controls and rationing.
#2 Up or down, the same or different?
The market is not just stressed, but increasingly hard to predict. “Take the question of capacity,” says Warren Green, president and CEO of LifeBridge Health, a regional healthcare organization based in Baltimore. “One model shows a surge in admissions based on an aging population. Another model shows reduced need based on accountable care organizations [ACOs]. Nobody knows if we will need more beds or less.”

On the one hand, the signs all indicate that volume will rise. The population is aging, and average health status is declining. The government is about to spend $900 billion over ten years to bring the previously uninsured into the market. New medical technology is abundant. That all sounds like good news for the industry. On the other hand, margins seem poised to plunge. Funding sources across the board are approaching insolvency and can no longer support rate increases that outpace the growth of the economy. Until recently, the US government was able to tap into public debt markets to fund its growing healthcare liabilities. No more. As a result, Medicare and Medicaid are trying to balance their budgets by ratcheting down reimbursements. Commercial payers, already following their lead, will step up the pace as they are hit by PPACA’s restrictions on medical loss ratios. Thus, even though Congress has delayed the 24.9 percent Medicare reimbursement cut scheduled for January 2011, providers will still feel the squeeze.

#3 My ocean liner has to become a what and by when?
Almost all the physician and health system leaders we interviewed saw substantial opportunities in the health system to eliminate excess spending while improving overall value. But the key to seizing these opportunities is new care models that integrate care across the care continuum, and our interview participants were unclear on what care models should look like, how to deploy them without eroding the fee-for-service cash engine, and where their organizations stand on value today. “If you asked me to draw a value-based cardio model, I couldn’t,” confessed Ed Brown, CEO of the Iowa Clinic. “I really don’t know where I’m currently at from a value standpoint, and I really don’t know all of our total costs that well.”

Many executives believe physician integration and leadership will be essential. As Jim Skogsbergh, president and CEO of Advocate Health Care, Illinois’ largest healthcare system, told us, “We are betting the farm on physician integration.” And most CEOs we interviewed estimated hospital-based physician employment will increase from 10 percent today to more than 50 percent by 2015.
Hospital-centric integrated models are likely to compete directly with large multi-specialist practices that contract for hospital services. A number of large multispecialty groups we talked to have already realized they can preempt the hospitals. “If [physicians] organize together, we can turn the hospital into a cost center,” the head of one of these practices told us.

Hospital executives know this all too well based on their own experiences. We have talked with CEOs who worry that they could destroy their organizations if they move to a more effective care model too rapidly. One described the launch of an integrated care model so successful that it cost the hospital thousands of admissions in the course of a year—without a reimbursement scheme that would have allowed it to share in the savings it produced for payers. He posed the trillion-dollar question: “How do we transform ourselves with the right tempo to not cannibalize our business and to keep up with the curve?”

Based on our interviews, the healthcare system forecast is clear and cloudy—clear on the need for change and the shift to fee-for-value (see The Migration to Fee-for-Value, below) and cloudy on the pathway, the pace, and the design of new care models. Ed Brown captures the cloudy part of the forecast well: “People are unclear about what the value-based world looks like, and they’re unsettled on what clinical integration really means. And nobody has really made it work.” In the meantime the ocean liner has to stay on course.

The Migration to Fee-for-Value

Today, more than 80 percent of hospital-employed physicians work under the fee-for-service model. Oliver Wyman estimates that by 2020 that figure will be less than 20 percent, with the bulk of physicians working under a variety of fee-for-value models.

Sources: AHD Acute Data; SK&A, NEJM; RWJ Foundation; HIMMS; Commonwealth Fund; Oliver Wyman Analysis
Executives we talked to recognize that the shift to a value-based strategy will have enormous economic and clinical consequences. Most executives consider it an irreversible step. Understandably, roughly 60 percent of the leaders we talked to are looking for a greater level of certainty around value based reimbursement changes before they pull the transformation trigger. Many are starting in the boiler room and taking out costs before grappling with how to fly a plane. “We will adopt ACOs if it makes business sense,” explained Bruce Moore, president of Outpatient Services for HCA. “But if we swing for the fences [on value] too early, we could do some real damage to our organization.”

Despite market uncertainties, 40 percent of CEOs have already begun to transform their organizations. In plotting their course, most see a spectrum of choices that vary across geography and care model rather than a systemwide bet one way or the other. One such CEO is Dr. Richard Afable, of Hoag Memorial Hospital Presbyterian, in Newport Beach, California. Like many hospital system CEOs we talked to, Dr. Afable realizes that though each hospital is managed as a single P&L, hospitals are actually aggregations of care models (such as transactional outpatient services and complex surgical episodes of care), and that the care model level is where fee-for-value migration strategies must be worked out. He shared with us the strategy framework his organization is using to shift the system from fee-for-service to fee-for-value over the next decade (see Plotting a Course, below). The framework helped Hoag to select the first care model in its shift to value: an orthopedic center of excellence.

Plotting a Course

A hospital may be a single P&L, but it contains multiple care models, and the care model is the level where value-migration strategies need to be worked out. Here is the framework used by Hoag Memorial Hospital Presbyterian in selecting an orthopedic center of excellence as the starting point for its shift to fee-for-value.

Source: Hoag Memorial Hospital Presbyterian
Oliver Wyman Observations
It is hard to turn an ocean liner, an analogy that certainly holds true for the $2.5 trillion U.S. healthcare system. A whole range of factors keep that vessel on course: well-established leadership models, information systems, cultures, profit engines, and organizational models and competencies. But those same factors tend to stifle significant change as well. Accordingly, industry leadership often rotates away from the incumbent company to the innovator when industries go through transformational change. After all, the innovators have much to gain, little to lose, and are not held hostage by the economics of prevailing business models.

Who will the innovators be? Oliver Wyman expects to see an unprecedented number of partnerships, as payers, providers, health information companies, and Web 2.0 companies work together to invent new value-based care models. The trend is already well under way: McKesson recently acquired U.S. Oncology; United Health Group and Aetna have been rolling up a series of health information management companies; Ascension is piloting Web 2.0 models with Cisco and American Well; Walmart is rolling out on-site clinics with integrated pharmacy offerings; and large, integrated multispecialty groups are positioning themselves to redefine their roles and the basis of competition in their markets.

How do organizations move forward in the face of uncertainty?
Many leadership teams have used scenario planning in combination with strategic hedging to create a path forward and prevent the loss of precious time. The concept is straightforward: Identify initiatives that will make the cut whichever way the wind blows, bet on the relative certainties of the future market, and hedge against large, high-impact uncertainties. Most importantly this time around, CEOs, working with their boards and leadership teams, must understand the nature of the uncertainties they face and their potential impact on the business. They also need to clear away organizational impediments to change, because change is certainly coming.

What types of physician integration make sense? When bringing physicians into a health system, it is important to ask: Do they advance our long-term clinical strategy and bring us closer to the value-based model we have chosen—or have we selected them just to drive fee-for-service volume in the short run? For the best results, the basis of alignment should be as specific as possible. For example, if the health system aims to become a risk-bearing population health management company or ACO, the focus in integration should be on patient-centered medical homes, chronic care management models, hospitalists, and home care programs.
What competencies will be needed in the value-based marketplace?
The shift to value-based care will require health systems and physician organizations to invest heavily in new competencies, including:

- clinical risk management
- care model management for episodes, diseases, and populations
- population management
- predictive modeling
- retail and Web 2.0 capabilities
- the use of integrated multidisciplinary teams for complex patient care and patient engagement.

The good news is that the new world of healthcare will reward disruptive innovators that improve the quality and lower the cost of care. Leaders will grow market share and margin as they learn how to compete on value. Though the barriers to change are numerous and high, there is massive opportunity in the current system to improve access, quality, and affordability. As one health system CEO put it; “We have the opportunity to do the right thing.”
About Oliver Wyman

With more than 2,900 professionals in over 40 cities around the globe, Oliver Wyman is an international management consulting firm that combines deep industry knowledge with specialized expertise in strategy, operations, risk management, organizational transformation, and leadership development. The firm helps clients optimize their businesses, improve their operations and risk profile, and accelerate their organizational performance to seize the most attractive opportunities. Oliver Wyman is part of Marsh & McLennan Companies [NYSE: MMC].

Oliver Wyman’s Health & Life Science’s practice serves clients in the pharmaceutical, biotechnology, medical devices, provider, and payer sectors with strategic, operational, and organizational advice. Deep healthcare knowledge and capabilities allow the practice to deliver fact-based solutions.

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