



Moving the needle on payment reform

**Designing policies that incentivize
the shift to value-based models**

A guide for countries, states, and
health plans

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Introduction

Governments across the globe continue to face the same central policy challenge: how to improve population health, while keeping costs at controlled and affordable levels. And while lessons have been

learned from both successful and less successful healthcare reform attempts, optimizing the value delivered by a healthcare system continues to grow in relevance as costs continue to rise, demand continues to grow, and technology continues to advance.

Each journey towards value will vary depending on the configuration of the systems that pursue it. This is a function of how medicine is practiced, the regulatory and legislative authority the government wields, and the relationships between stakeholders and how healthcare is financed, to name only a few factors. Yet, no matter how different the actual organization of healthcare systems internationally, the way in which physicians, hospitals, and other organizations are paid has an undeniable impact on the financial and quality outcomes of care delivered. As a result, changing reimbursement incentives to align with desired outcomes through payment reforms will alter both the cost trajectory for healthcare expenditure and the outcomes of care experienced by patients.

Our report aims to bridge the gap between those seemingly contradictory objectives of concurrently improving quality while maintaining costs at manageable levels. Based on our analysis of delivery reform across the globe, we suggest that a key reason for the difficulties experienced in meeting both objectives

simultaneously is rooted primarily in the policies initiated and how the incentives driving each side of the value equation (both cost and quality) are (mis)aligned. The purpose of this report is to inform policy makers how to approach reforms that enhance system value through modifying payment *incentives*.¹

In addition to offering international insights and examples of leading practices from four case studies, this paper offers policy makers a framework for approaching value-based payment (VBP) reforms and tackling some of the tradeoffs inherent in any policy implementation. There is no one-size-fits-all manual to solving the problem of producing higher quality while also making healthcare more affordable, nor should policy makers expect one. However, by focusing on principles that have been proven to work, our report offers a framework for policy makers that can increase the likelihood of reform success.

This report can help policy makers and related stakeholders apply our adaptable framework and lessons learned from past case studies in their own pursuit towards aligning incentives and driving healthcare delivery reform in a sustainable, value-based manner.

¹ Throughout this paper, the terms 'incentives reform', 'payment reform', and 'value-based payment reform' will be used interchangeably.



Guiding principles of value-based payment reform

The following section outlines a series of four principles that should guide healthcare delivery reform.

These principles are based on economic and behavioral theory as well as observations from lessons learned in practice. With experience in implementing delivery reform across multiple state and local governments, KPMG LLP (KPMG) has a thorough understanding of the interplay of market pressures, economic trends, and successful healthcare delivery systems.

To measure is to know

As with any transformation journey, payment reform should start with a deep understanding of the way the current system realizes the prioritized functions. This is not a silo-per-silo analysis, but rather an analysis that starts from the outcomes and costs of care from the perspective of the patient's care needs. Our first guiding principle is: **Policy makers must understand where and to what degree there are value opportunities in the market that can be supported through payment reform.**

Taking a snapshot of a current system to assess its state, including which outcome goals are being met and which require improvements, is the first step toward identifying value opportunities. Put simply, this breaks down into three exercises:

1. Defining value

In general terms, *value* is defined as the relationship between the price of a good or service and the quality of that good or service. In healthcare, value is the relationship between the outcomes of care for a patient's care need and the total costs of that care. Outcomes and costs are measured across the continuum of care.

For example, if minimizing the number of low-birth-weight babies is an important health outcome goal, the costs of care should include the maternity care continuum: from pregnancy to the care for the newborn.

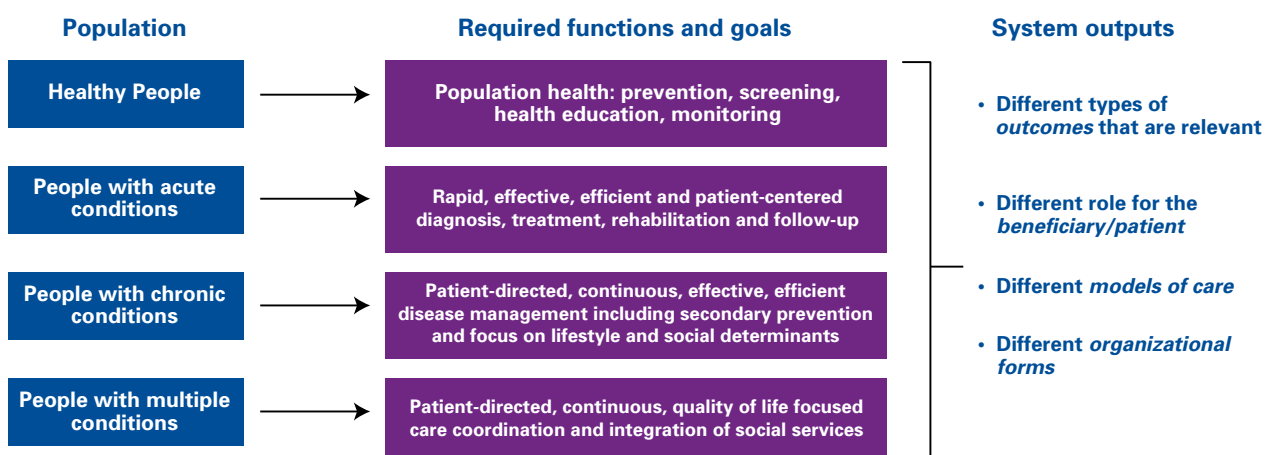
Similarly, the value of chronic care is the relationship between the total costs of that care and its primary goals, such as reducing complications and exacerbations associated with chronic conditions. In managing diabetes, for example, a core goal is to keep the patient as healthy and stable as possible, preventing the development of kidney issues, deterioration of eyesight, and nerve damage.

The outcomes that matter most vary depending on the types of conditions at hand: for the growing group of frail and elderly individuals with significant comorbidities, the key goal often shifts from optimally managing the individual conditions to optimizing the quality of life.

2. Choosing the patient lens

Value, then, is not measured through the lens of the individual provider, but through the lens of patients' needs and their journey through the health care continuum. This requires analysis at the condition(s) level, across the provider silos. Doing this, it quickly becomes apparent that different patient groups have different care needs, which require very different types of care to meet these needs. Not surprisingly, the different types of care also each have different types of outcomes that matter, different roles for the patient, and different leading practices how to optimally organize this care. Figure 1 (below) can be deployed as a high-level framework to help identify these categories of care, cutting across the continuum of care.

Figure 1 - Illustration of Various Delivery System Functions to Meet Certain Health Goals



To measure is to know (continued)

3. Measuring value (costs and outcomes) of care

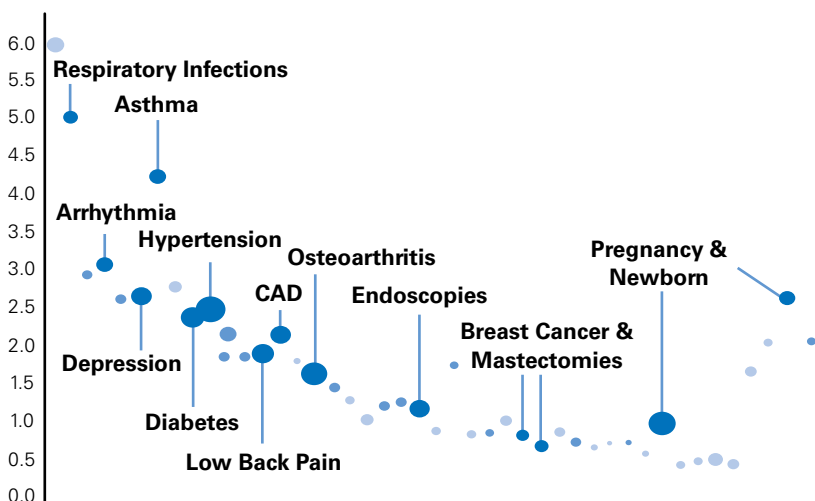
While measuring the cost of managing a condition, illness, or subpopulation is relatively straightforward, defining which outcomes are key and subsequently measuring them is more complicated. Outcomes of care can be measured along many dimensions, and the data required (such as patient-reported outcome measures or clinical data) are often not systematically available. In addition, the number of quality measures for certain conditions is enormous, which creates a significant challenge in deciding which factors to include in an overall quality of care assessment.

In recent years, however, measures have emerged that draw upon data sources available across the care continuum (for example, claims data), which are able to capture the overall quality of care delivered for many types of conditions and subpopulations. For example, a key goal of treating patients with chronic conditions is preventing complications and exacerbations. Given the absence of in-depth clinical or survey data, using claims data to calculate the risk-adjusted percentage of patients that remain complication-free in a given year is a powerful and accessible way to determine overall quality.

Potentially avoidable complications (PACs) for chronic conditions have been endorsed by the U.S. National Quality Forum (NQF) and consist of emergency room visits and hospital (re)admissions for uncontrolled diabetes, number of doctor visits and use of rescue treatments for Chronic Obstructive Pulmonary Disease (COPD), post-surgical wound infections, a second cardiovascular event after recovery from a stroke, etc. The cost of complications such as these can be analyzed as a proportion of the total costs of managing a condition, conducting a procedure, or even managing care for a subpopulation of patients. The resulting data can also be used to assess the relative value of all care delivered to a patient across providers.² The *Prevention Quality Indicators* (PQI) developed by the Agency for Healthcare Research and Quality (AHRQ) are conceptually similar to the PAC concept. These indicators focus on a smaller set of chronic conditions, and they limit potential PACs to hospital admissions.

By way of illustration, Figure 2 highlights the analytical approach KPMG uses with healthcare clients, which stems from a methodology developed by the Healthcare Incentives Improvement Institute (HICI3), which is a part of the Altarum Institute.

Figure 2 - Variability in Costs and Outcomes of Selected Procedures and the Care for Selected Conditions



A number of common conditions and medical procedures are ranked by their degree of price variability (coefficient of variation, the vertical axis). The size of each bubble in the chart represents the volume of medical spend for that condition or procedure. The blue hue represents the percentage of medical spend that is consumed by avoidable complications: deeper blue means more spent on complications. A large, blue bubble located high up in the chart would thus indicate significant opportunities for value improvement.

These analyses can be used to help providers, payers, patients, and governments understand where value is 'leaking' from their system, and where their focus to improve outcomes and reduce costs should be. They provide the foundation for value-based contracting and for any systematic effort to improve the overall value of care delivered to a population. However, such improvements and reform plan mapping have to be made in the context of existing market dynamics, as shown in the next section

² There are two types of PAC measures: PAC count and PAC percentage costs. The PAC Count measure is NQF-endorsed for a series of chronic and acute conditions. PAC percentage costs (as a percentage of total costs) are primarily used to identify areas payers and providers should try to improve.

Consider market dynamics

Guiding principle number two is: **Policy makers must understand the characteristics and market dynamics of their system and how its current organization impacts their most suitable payment reform approaches.**

Reform efforts must consider healthcare system supply and demand trends within a market at a given point in time. A market evaluation should include the current political and economic levers available to policy makers, existing market forces that influence the shape of the supply and demand curves, and a thorough analysis of the greatest value opportunities. For example, a snapshot of the market today and policy environments in Singapore, the United States, England and other European countries would lead to different reform efforts than those that (would) have been enacted several years ago. Healthcare markets are dynamic, reform efforts yield results that reshape market forces, and consumer demands and needs for health services also evolve on both the individual and population level.

A closer look at healthcare market differences across the United States

Let us consider the environment in the United States in 2015. The funding of healthcare comes from three main sources: Medicaid, which covers the economically disadvantaged; Medicare, which covers the elderly; and commercial insurance, which primarily covers the employed.³ The Affordable Care Act (ACA), has helped to bring the number of uninsured individuals to a historic low, with a portion of the previously uninsured now enrolled in Medicaid and another portion enrolled in commercial plans. The mix of the three insured populations vary significantly across geographies, which suggests that the approach to reforms be tailored to the geography.

Each of the three insured populations have different characteristics. For example, a large number of Medicaid beneficiaries are pregnant women, as Medicaid funds more than 48 percent of all births in the United States.ⁱ Most of those covered by commercial insurance are relatively healthy, although a significant percentage have one or two chronic conditions. Additionally, Medicare beneficiaries often have multiple chronic conditions and other illnesses associated with aging.ⁱⁱ

From another perspective, the *organization* of the healthcare market varies significantly from state to state and even within states. Many northeastern states have large health systems that exert significant market power and price their services above the national average,

resulting in higher premiums for the commercially insured. The accompanying fragmented payer market can rarely counter the pricing demands of such provider organizations.ⁱⁱⁱ Conversely, many southern and Midwestern states have concentrated payer market share, which enables payers to maintain lower provider prices.

In addition to these varying market forces, the regulatory authority of state insurance departments and departments of health also varies, with some states having a history of strong regulatory authority, such as Rhode Island, and others having a far more limited one, such as Georgia. Those with a more robust regulatory infrastructure will be more likely to drive policies to reform provider incentive payments.^{iv}

Market dynamics inform payment reform approaches

These differences observed within the United States exist throughout the world and affect both the degree to which certain health policy goals are actionable and the level of provider and patient receptiveness. Most payers, whether private or public or whether municipalities, states, or countries, start their reform efforts within the context of specific market dynamics. Payers or governments should carefully assess the interplay between the specific opportunities they want to pursue and the market environment to determine the likelihood of success.

In Part 2, we propose a framework to assess the market dynamics, risk appetites, and regulatory authority that policy makers should consider as they design their VBP reform efforts.



³ Other large programs in the United States include CHIP – the Children’s Health Insurance Plan which provides low-cost coverage for children in families ineligible for Medicaid, and benefits covered by Veterans Affairs.

Balance incentives between supply and demand

Our third guiding principle is: **Supply and demand incentives must be balanced as part of any reform effort.** For example, Singapore was able to achieve its health policy goals by ensuring that its citizens had easy access to clinics and healthcare providers capable of delivering much-needed immunizations and health education, thereby improving population health. These goals would have been much more difficult to achieve if patients had faced financial barriers in accessing preventive services.

Singapore could have asked that all services be provided free of charge, but that might have led to an increase in service usage overall, not simply the services that were critical to success. Instead, the government instituted a health plan benefit design that eliminated the vast

majority of financial barriers to preventive care while creating cost sharing for other services. The providers' financial incentives were designed so that they were compelled to collect patients' share of costs for services that required it. These two financial levers – provider payment and managed plan member benefits – are necessary in appropriately incentivizing the supply and demand of services.

In Western European countries in particular, significant cost sharing is politically difficult to realize. When payers or governments start to incentivize providers to reduce cost growth, the incentives for demand and supply are at odds. This creates tensions and frustrations for both providers and citizens, where successful reform cannot succeed without a partnership between the two.



Form follows function

Our last and fourth guiding principle reads: **The form of the delivery system should always stem from the desired functions and outcomes it aims to achieve.**

The required functions of a delivery system depend largely on both the needs of the population it serves and the health policy goals that are defined for it (see Figure 1). Once the needs and goals are clear, incentives can be designed to reinforce the desired outcomes, and drive the transformation of the way care is delivered within and across provider silos. In an adaptive system, the delivery or form of the service will adjust to meet the incentivized goals and evolve as needs and goals change.

In practice, the reverse process is more common. Many governing authorities start with defining the structure of the delivery system or the incentives (*the form*), often working from the system's current state of the system and the provider silos as they have historically grown.

Government authorities and systems taking this approach tend to struggle to achieve their goals. Creating high-value care for chronic conditions (*the function*) cannot be achieved by solely focusing on one of the silos (primary care, for example): it requires integrating care across the organizational boundaries of primary care, specialty care, inpatient care, home care, and so forth. Taking one of these existing silos (*form*) as a starting point ignores the fact that it may be only responsible for a part of the total cycle of care. It also may lack the flexibility to customize the services to the population needs that are the focus of the reform.

It is key to recognize that existing healthcare organizations are generally set up to serve a highly divergent set of care needs, with limited attention to whether they are equipped to deliver all that care at the same quality level and equally limited attention to the many different touchpoints between their organization and the organizations caring for these patients up- and downstream from them. Throughout the world, general hospitals often try to offer the entire spectrum of care, across all medical specialties, while concentrating e.g. cancer care in specialized hospitals may significantly increase the quality and reduce the cost of cancer care. Similarly, the optimal organization of primary care is likely not having a (group of) individual doctor(s) seeing a waiting room full of patients one by one. Rethinking the existing organizational structures within the silos, then, is key when starting from the *function* the health care system should fulfill.

Payment, and in particular VBP arrangements, is a way of aligning incentives with desired outcomes, which fits well with the approach of letting function drive form. VBP arrangements are, however, not tools for imposing a particular delivery system design. There is no single VBP arrangement that is innately better than another or that all payers and providers should aim to adopt. Rather, there are several types of VBP arrangements, each of which is suitable to specific types of patient and outcome goals. These arrangements must be adapted to local policy goals and market conditions.

Figure 1 illustrates this concept. First and foremost, governments, payers, or health system organizations should start by looking at the patient populations they serve, the clinical functions that are required to meet the population needs, and the desired financial and quality outcomes. It is important to get a holistic view by looking at the cost and outcomes per condition or patient need across all providers. From there, the appropriate VBP structure can be selected and applied. In section three of this paper, the case study on the Medicaid reform program in New York State illustrates this approach.



Form follows function (continued)

A quick look at delivery reform in Singapore and England

When the government leaders of Singapore set out to reduce the impact of communicable diseases in rural areas, they outlined clear outcome goals and reformed the required components of the care delivery system to meet them. They subsequently took the time to create a compensation scheme for providers that would reinforce the importance of the goals and encourage organization of the system around those goals. The community-based outpatient clinics that resulted are recognized for delivering strong outcomes and continue to evolve to meet changing patient needs.

When England's National Health Service (NHS) decided to improve the coordination of physician care across the country, it instituted administrative structures that are currently known as Clinical Commissioning Groups (CCGs). The principal goal of CCGs is to commission healthcare services to meet the needs of the country's local populations and to manage the costs of care within a specified budget, including specialty and inpatient care. As such, they were to operate much like fully capitated groups, with the appropriate incentives to improve the value of the care they contract for their populations. Yet existing budgeting and provider governance regulations excluded both primary and tertiary care budgets from their control, and limited their capability to contract non-established providers.

The key difference between these two approaches is the point of departure for reform efforts. Singapore started by defining the patient and population outcome goals and the functions required to serve them, leaving providers (in whatever form) at liberty to define the structures that would be needed to help meet these goals and provide the stipulated services. The English NHS aimed to achieve very similar goals, but designed its reforms while attempting to protect its strong primary care infrastructure, and ensure that supra-regional tertiary care functions would not be destabilized. This structured the CCGs (*the form*) in a way that limited their capability to achieve the function for which they had been established.



2

An assessment framework for payment reform

The success of value-enhancing reform efforts hinges on the potential impact of market dynamics, the risk appetite of the various actors that shape the market, and the current regulatory environment.

To assess these factors, we offer seven dimensions of market dynamics, risk factors and regulatory considerations that interact and create a complex web of interests. To facilitate simpler navigation and integration of these dimensions, we offer a framework to help policymakers determine whether current dynamics are conducive to payment and delivery system reform.

Market concentration

Heavier consolidation on either the provider or payer side can slow the pace of change. Conversely, a highly fragmented market can also hinder the progress of market transformation, unless payers work collaboratively. As illustrated below, there is less risk to reform efforts when the payer market is consolidated than when the provider market is. It is, therefore, important to understand the concentration properties of the market to mitigate risks to reform implementation.

High Concentration Provider Market

In a highly consolidated provider market, payment reform may only be possible with the explicit buy-in of provider organizations. It is also important to consider the specific function that requires attention (Figure 1). Focusing on all functions simultaneously (such as payment bundling in the Accountable Care Organization (ACO) model) tends to stimulate further consolidation and ‘merging’ of the different silos. As an increasingly abundant global literature points out, however, concentration tends to drive price increases in both private and mixed healthcare systems, while the promise for improved quality is rarely met. Focusing on a specific function (chronic care, cancer care) across the care continuum creates a very different market dynamic, challenging the silos themselves, and making it easier for new parties to enter the market.

Low Concentration Provider Market

Lower provider consolidation reduces the “bargaining power” of potential opponents to reform in the provider community, where reforms may align better with the self-interests of some providers more than others. Further, provider consolidation may be so low that integrating care across the continuum may be hampered by e.g. a lack of interoperability of medical record systems and the ability to integrate information to better enable patient flow and outcomes measurement.

High Concentration Payer Market

In highly consolidated or “single payer” markets, the pace of change will be dictated both by the ability of the payer to implement the new payment model and by provider concern over the financial impact of that reform. If the government is the only payer, the same principles hold true, because every time the government changes policy, it affects the entire provider market. As a result, the stakes are higher for the supply side, which will tend to increase resistance to change. Rather than negotiations, resistance will likely result in political action, which can make a single payer even more reluctant to drive change.

Low Concentration Payer Market

In fragmented payer markets, the impact of payment reform on any individual provider might be negligible, thus decreasing the likelihood that payers will drive transformation. If payers are incented to collaborate and concentrate the revenues they represent to leverage against the provider (which in practice usually requires government intervention), reform progress will likely accelerate.



Data access critical to payment reform

Whether the provider market is fragmented or consolidated, providers have a significant incentive to resist sharing patient data to retain patient volume. Similarly, payers are reluctant to share data for fear of losing competitive advantage. The asymmetrical access to patient data creates a significant barrier to the continuity of care, the quality and safety of care, and the measurement of outcomes (both quality and cost). There are specific policy options that can be taken to mitigate this effect. One is to mandate and/or financially incentivize the flow of health

information through information exchanges that act as central repositories and clearinghouses and are controlled locally or nationally to ensure market neutrality. Another policy option is to legislate patient ownership of health data and mandate that all clinical records be made available to the patient or a designee. Both options will stimulate standardization of data formats, which, although often difficult to achieve, will speed up rapidly once regulatory or financial incentives are firmly in place.

Elasticity of the supply chain

Payment reform and transformation are better enabled in markets with high elasticity of the supply chain, meaning that pricing can adapt rapidly to market demands. In markets where supply is inelastic, considerable focus must be dedicated to reform efforts that open up the market to more competition or that create a glide path that allows transformation without sudden disruption to existing providers. Overall, the elasticity of the supply chain is largely dependent on the degree of consolidation and the sensitivity to the net effect of incentives in the alternative payment program.

The often heard argument that reform is not possible because there are not enough professionals available tends to be false, especially regarding physicians in Western countries. In most instances, traditional working patterns are highly inefficient and greater delegation of tasks to nurses or other professionals tends to eliminate or greatly reduce the issue of physician shortages. Such challenges in the workforce can and should often be a key consideration in designing the reform in the first place.



Fostering supply chain elasticity in a rural setting

The issue of inelastic supply is most common in rural areas. Consider a rural region in which there is only one acute care facility. Policy makers may have observed that outcomes for patients with chronic conditions are below average. The policy makers, therefore, launch a new voluntary program aimed at improving outcomes by defining quality measures and evaluating costs of care. They also launch an alternative payment program that could yield substantial margins per patient when hospitalizations and acute exacerbations are avoided. The acute care facility, which has recently borrowed money to increase its hospital bed capacity, will likely opt out of the new program. The success of the program will, therefore, hinge almost entirely on the flexibility of ambulatory care providers to organize themselves to care for chronically ill patients. If those physicians are employed by the hospital, it is unlikely that the initiative will succeed. If they are independent, then they will likely be able to participate in the initiative.



Elasticity of demand

The effect of the price patients have to pay on healthcare consumption has been extensively researched, and the research suggests elasticity on price is significant, particularly for non-emergency or elective treatments and diagnostics. One of the reasons that countries like Singapore maintain high cost sharing for patients is that this ensures consumer acceptance of price changes in the market and enables them to “vote with their feet.” Demand elasticity is affected by a number of factors: the acuity of the need, the availability of information to support informed choices, and the degree to which patients share in the medical cost. In circumstances where care is critical, demand will tend to be highly inelastic, where acuity of need trumps the assessment of value to the patient. For critical care, payers and policy makers should play a key role in ensuring that both quality of care and the associated costs continue to reflect value for the patients given the inability to “vote with their feet” in most critical and acute situations.

For other types of care such as non-emergency and elective treatments and diagnostics, the availability of relevant price and quality information to patients has the potential to greatly enhance demand elasticity. In this case, policy makers should aim for making relevant cost and quality information available to empower patients to make rational and informed choices. However, there are many factors that may impede data transparency, thereby reducing the patient’s ability to make informed choices or the system’s ability to support them. For example, if patient data does not flow from one physician to another, elasticity is reduced. If patients have to spend considerable time and energy transferring their medical records, this will discourage changing providers. Policy makers should, therefore, be aware of the importance of providing consumers with easy access to such price and quality data and mandate the seamless flow of patient data to patients and between providers.

Lastly, from the point of cost sharing to boost demand elasticity, the balance between higher elasticity of demand and ensuring affordability (so that lower-income individuals are not prevented from accessing much-needed care) is essential in ensuring access to appropriate care. This can be managed by, for example, having a public/private insurance system with well-designed cost-sharing components, thus removing barriers to preventive care, discouraging unnecessary utilization, and enabling provider choice.



Accessing information aligned to the patient’s care, not the provider

The availability of information can empower patients through transparency in the value of services being offered by providers. However, for most jurisdictions, this information, like the system itself, is siloed and comprises the prices of each constituent part of care. At its most basic, transparency into the costs of an individual CT scan or doctor visit should be made available and comparable against other providers. In an information-mature and integrated situation, consumer-patients have visibility into the costs, quality, and outcomes aligned to the care they need: where should I go for the best diabetes care, for example, and what results can I expect for the dollars I have to pay for the total care for my hip-replacement.



The need for volume

Rewarding and contracting value requires sufficient volumes of patients to be able to impact and measure outcomes across the care continuum, and avoid financial risk. The size (measured both as population numbers and dollars spent) of a local healthcare system or market will thus influence the nature of and approach to effective payment reform.

Small Markets



In markets with smaller population sizes, it can be difficult to achieve adequate volumes, especially for payment arrangements focused on subpopulations or (combinations of) conditions. Strategies to mitigate this are outlined below.

- Including physicians with a reasonable number of targeted patients (keeping in mind that this could significantly reduce the number of providers in the initiative)
- Grouping physicians together, virtually or through real consolidation
- Establishing risk corridors that limit loss potential in the event of negative outcomes
- Focusing payment reforms on simpler arrangements (such as capitated models) that encompass larger patient groups, rather than parsing payment structures into smaller, more specific care bundles
- Tailor value-based-payment arrangements for each contracting entity (hospital, ACO, physician group) based on population size

Large Markets



In markets with large population sizes, there is more flexibility to introduce more specific payment arrangements but the risk for providers increases since the absolute value of the potential losses to be incurred increases with population size. And when the stakes are high, engaging providers in an initiative becomes more difficult. Strategies to mitigate provider concern over payment reform include:

- Gradating the risk of loss, starting, for example, with only the potential for gain
- Introducing the potential for losses over time, as balanced against the opportunity to achieve higher gains
- Creating risk corridors that limit loss potential by capping loss amounts for any individual case and across all cases through reinsuring higher risk tranches



The risk of low volumes: the “random variation effect”

The “random variation effect” can be thought of as the luck of the draw, which represents the adverse selection of patients with negative outcomes even though the total number of patients with negative outcomes in the entire population is predictable and manageable. In other words, patients are seldom evenly distributed among providers, and some providers might end up with a larger proportion of patients that incur a negative outcome. The larger the volume, the higher the likelihood that the providers’ patient mix will match that of the larger population.

Population demographics

Population demographics will largely determine which types of value-based payment arrangements make sense. This could vary considerably from region to region and even within larger cities. In order to correctly match VBP types to the population, the ability to analyze population and claims data to detect largest areas of value opportunity will be imperative to all and any reform efforts – aligned to each of the sub-populations which comprise the broader population.

For example, Medicaid in the United States covers all young mothers and newborns. A maternity bundle within the Medicaid program, which includes the pregnancy, delivery and first 30 days of the newborn, would, therefore be a very appropriate arrangement. Conversely, the population of 65 years and older that is insured by Medicare would benefit from arrangements that target frequently co-occurring chronic conditions in one holistic package.



Risk transfer

In designing new payment and plan member coverage models, policy makers should understand the degree to which financial risk is being transferred from payers to providers or patients and how capable these market actors are of managing that risk. When dealing with risk transfer it is important to bear in mind our guiding principle of balancing incentives between supply and demand constituencies.



Balancing Risk Between Providers, Patients and Payers

The manner in which financial incentives are designed to influence the demand and supply of healthcare services is based, either implicitly or explicitly, on a fundamental decision of how to allocate risk among the three main agents in the healthcare market: third-party payers, providers, and patients. For the most part, European countries have accepted that the majority of the financial risk will rest with the primary third-party payer, most often the State. These payers are increasingly shifting responsibility to providers, but patients are mostly shielded from significant risk. Countries like Singapore, on the other hand, have split the risk between payers and patients in an effort to influence demand for services.

Provider Risk

Moving away from pure fee-for-service (FFS) payment models will result in providers taking on more of the financial risk of the system. In payment schemes such as global per capita budgets, providers take on the entire financial risk associated with an assigned population and are responsible for the care costs that exceed the global budget.

Patient Risk

Moving away from first-dollar (no deductible or co-pay) health plan beneficiary coverage transfers some financial burden to the patient. Pure indemnity plans, which are similar to catastrophic coverage plans, transfer even more financial risk to patients.

Payer Risk

The need to pay attention to risk transfer holds true whether there is a single payer system or not. For example, in Singapore, the government decided long ago that health insurance beneficiaries should shoulder a significant portion of financial risk in order to create some control over the demand of healthcare services. Conversely, when it comes to Great Britain and their health system or Medicaid in the United States, the governments have chosen to insulate beneficiaries from most financial risk. Policy makers should be aware of the limitations of risk transfer stemming from regulatory constraints, collective bargaining, cultural norm, or simply the delivery system design.

Risk transfer (continued)

Policy makers should be sensitive to the three types of risk in healthcare, what produces those risks, and the extent to which they want to apportion them, partially or in whole, to the various agents in the system. These three risks are:

Insurance risk

or the likelihood that a health event will occur. Patient-specific characteristics combined with health-related policies have the most impact on insurance risk. For example, the frequency of pregnancies and deliveries is a function of the age of the insured population and national policies encouraging or discouraging reproduction.



Technical risk

or the level of professional excellence with which a health event is managed. Of course, provider skill has the most impact on technical risk, but patient behavior also has an influencing effect. For example, the skill of a physician in managing a patient's diabetes will be reduced if the patient fails to comply with self-care recommendations, such as controlling weight and exercising.



Choice-utility risk

or the phenomenon where patients decide between spending money on healthcare services or deferring treatment for the sake of other goods and services.



Deciding whether or not, to what extent, and to whom to apportion these risks greatly influences the types of incentive reforms that should be instituted on both the supply and the demand side.

Overall, the more that insurance risk and technical risk are borne by providers, the greater the emphasis on supply side constraints. From an overall budgetary perspective, shifting risk to providers can be successful in keeping costs growth in check, but this often comes at the expense of waiting lists and limited organizational innovation. The more choice-utility risk that is passed on to a patient, the greater the emphasis on demand side constraints. Shifting risk to the patient can also be a way to keep cost growth in check. In this case, however, patients may inappropriately not consume care.

An example of the latter policy is the combination of fee-for-service payments to providers in the United States coupled with high-deductible health plans for consumers. That policy reflects a desire to control costs through consumer self-rationing, which many studies have shown to be effective.^v As in the previous case, the challenge is that most consumer self-rationing of care fails to distinguish high-value care from lower-value care. In addition, the fee-for-service payment system incentivizes providers to pull patients in, disregarding whether the care provided adds value from the patient perspective or not.

It is clear that the intersection of provider and patient interests can either reinforce productive behaviors and decrease overall risk, or foster the opposite.⁴

⁴ More on this topic can be found in the Health Care Incentives Improvement Institute (a part of the Altarum Institute)'s publication, "Improving Incentives to Free Motivation" (URL <http://www.hci3.org/content/improving-incentives-free-motivation>)

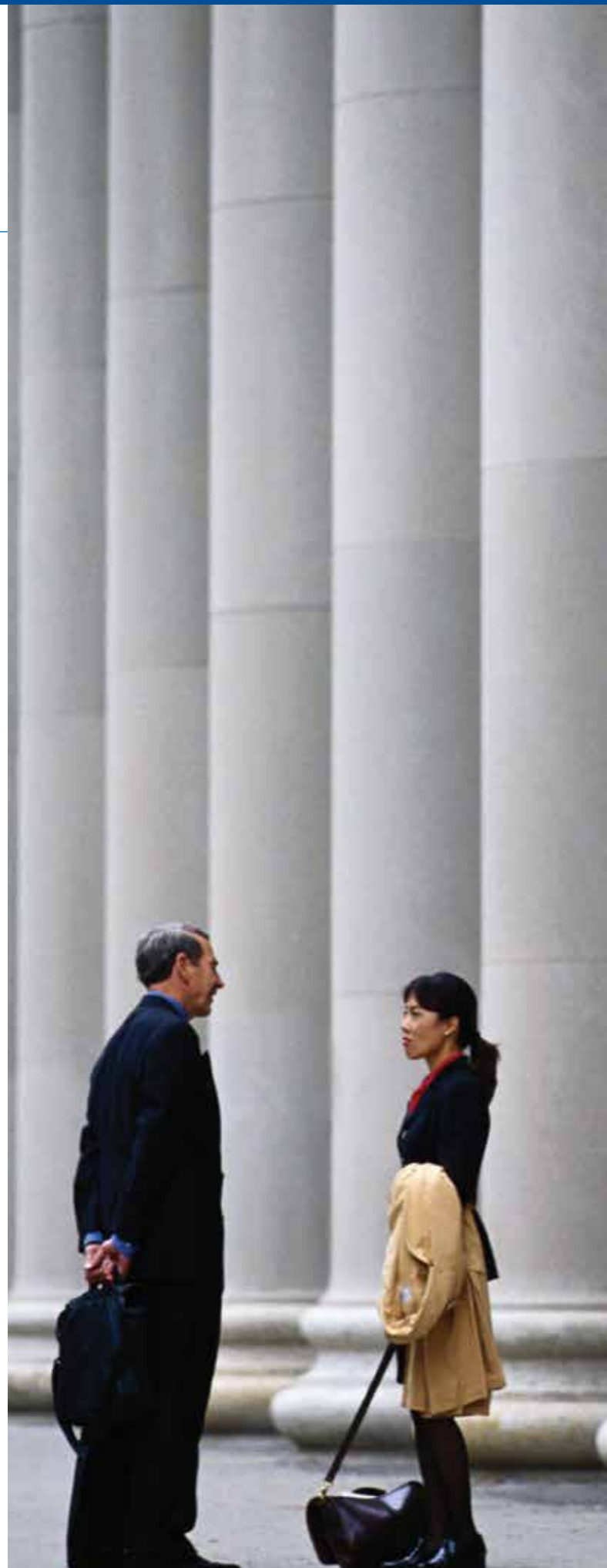
Regulatory authority

Regulatory authorities, in which we include the mechanisms governments use to manage health care budgets, have a large impact on how health care markets operate. Government regulations on access to insurance, for example, largely determine patient risk. Even in the US, the healthcare market is deeply shaped by the way Medicare and Medicaid manage budgets (usually silo by silo) and the corresponding regulatory frameworks that solidify these silos even further. Regulatory authorities thus have the ability to funnel market forces to make or break payment reform, stimulating or obstructing a focus on function over form, and impacting and including how risk is transferred among various market players.


Regulatory authorities should set conditions for VBP arrangements (by creating standard episode definitions, (sub)population definitions and outcome measures) to ensure that financial incentives are well-aligned with the realization of high quality outcomes and efficient care delivery. The key is to prevent that 'form' ultimately prevails over the targeted functions through entrenchment of existing provider silos and other inflexible market structures. This creates a more level playing field for provider and payer innovation to play out.

Regulatory authorities can take additional actions. For example, if significant market consolidation stifles competition and reduces provider and payer adoption of alternative payment models, they may be in violation of anti-trust laws. Further, authorities can reduce potential barriers to patient migration by mandating health information exchanges, as well as publication of prices and quality reports for different provider organizations. Finally, authorities have the ability to waive regulations that forbid financial agreements between providers or that impose significant burdens of proof before allowing providers to enter into payment modalities that involve financial losses and gains. It is an unfortunate fact that these types of regulations can inadvertently encourage provider consolidation, which, in time, will ironically lead to decreased competition.

The complexity of payment reform increases with the number of regulatory authorities. For example, in the United States, state departments of insurance regulate the extent to which providers can assume financial risk in payment schemes. Conversely, the Federal Department of Justice and Trade Commission governs how providers interact and the extent to which they can enter into revenue- and profit-sharing arrangements. The resulting challenge is finding payment reform avenues that fit within the legislative boundaries of both authorities.



Executing the payment reform framework



Understanding the context in which a market transformation will play out is an essential ingredient to successful payment reform. Some market dynamics are fixed or, at the very least, difficult to change. Others can be influenced. Over time, the success or failure of an intervention will create its own effects, circling back around to modify market dynamics once again and, thereby, creating more opportunities.

In the following section, we explore through case studies how these dynamics play out and highlight where aspects of our proposed framework are being instituted.

3

Approaches to payment reform – case studies

The New York State Medicaid payment reform program



The United States healthcare system is one of the most expensive in the world, while lagging behind most other western countries in terms of quality.

Some 40 percent of total healthcare spending in the United States is attributed to the federal and state government funded Medicaid program (for individuals and families with low income), and the federally funded Medicare program (for individuals above the age of 65). Within Medicaid, New York State has some of the highest costs in the country, with only average health outcomes, and below average performance on prevention and avoidable hospital use and cost.^{vi} New York serves the second-largest Medicaid population in the country (approximately six million beneficiaries), and spends around \$USD 60 billion annually on their healthcare making Medicaid the single largest payer in the state.

After implementing a series of successful budget controlling policies in 2010, the State of New York turned its attention to delivery system redesign and payment reform in 2014. By that time, Medicaid costs had been reduced as a result of the budget policies, but two key challenges remained. On the one hand, the delivery system was highly fragmented, with an overemphasis on hospital infrastructure and clear underinvestment in a robust primary and community based care environment. On the other hand, the quality of care remained in the bottom half of national rankings in many areas. New York State's Medicaid Managed Care Organizations (MCOs - health plans contracting care for their members) largely continued to pay their contracted providers on a fee-for-service scheme, with some examples of more advanced bundled or capitated arrangements to be found throughout the state. Many of the State's current problems (fragmentation of care, high readmission rates)

are rooted in the structure of the delivery system, which is in turn a consequence of the fee-for-service payment structure. As long as an avoidable readmission is rewarded more than a successful transition to integrated homecare, and as long as providers are primarily dependent on the volume of services they deliver to maintain their revenue streams, high quality, efficient care remains an uphill battle.

In addition to the challenging structure of the delivery system and the fee-for-service payment system, New York faces some other practical challenges:

- **Uneven population distribution**

The Medicaid population in the state is not distributed evenly. Roughly half of the six million beneficiaries live in the New York City area. The rest of the beneficiaries are spread throughout the rest of the state where population densities are lower and the distribution of services often sparser.

- **Poor health outcomes**

The Medicaid population is typically characterized by high rates of chronic illnesses, behavioral health and substance abuse problems throughout although there are large variations to what primarily drives the healthcare costs between regions and even between neighborhoods in the more densely populated areas.

- **Skewed provider distributions**

The density and specificity of the provider organizations emulates that of the population: in sparsely populated areas such as the mountainous North Country there is a relative lack of healthcare resources versus the relative abundance in the New York City metropolitan area. The skewed distribution of providers and population characterizes the need for tailor-made reform approaches since patient needs and ability to adapt the networks of care will vary wildly based on geography.

The New York State Medicaid payment reform program (continued)

As part of its federally funded Delivery System Reform Incentive Payment (DSRIP) Program which kicked off in 2014, New York pledged to transform 80-90% of its Medicaid MCO payments into non-fee-for-service systems that reward value over volume by 2020. The details of the transformation plan were presented in a five-year Value-Based Payment Reform Roadmap which was published in June 2015.⁵ The Centers for Medicare and Medicaid Services (CMS), the New York State Department of Health and core stakeholders (MCOs, providers, unions and patient organizations) actively collaborated on its creation. This helped to ensure buy in for the reform process early on, while also addressing provider and MCO concerns regarding the speed and scale of reform impacts.

There are at least three key ingredients baked into the New York State Roadmap that characterize the payment reform approach.

1. The Roadmap does not present a *one-size-fits-all* approach to payment reform. The Roadmap starts with a clear vision of the functions that an integrated delivery should be able to provide its population coupled to a clear set of outcomes per function, which subsequently translate to relevant VBP arrangements. As suggested above, the definitions of these VBP arrangements are standardized, and are independent of existing provider silos. Example of VBP arrangements include:

– Maternity care

Medicaid pays for 50 percent of all births in the State. To improve maternity care (by achieving a reduction in maternal and neonatal mortality, fewer pre-term births, minimal teen-age pregnancies, improved access to prenatal care and education), a *maternity bundle* was created to cover care during the pregnancy, delivery, post-partum, and the first month of the newborn baby's life.

– Chronic care

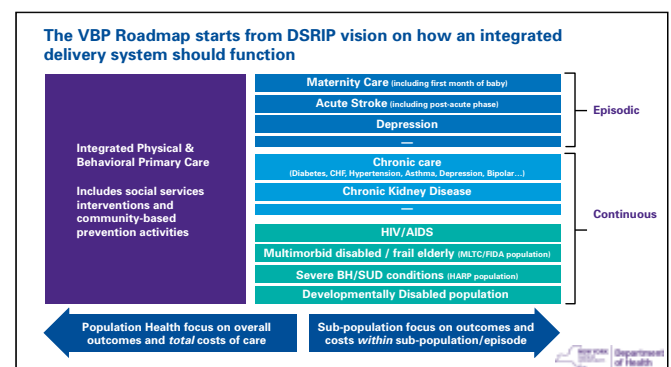
Chronic conditions are highly prevalent among Medicaid beneficiaries. There is a need to integrate chronic care, reduce exacerbations and complications through disease management, care coordination, improved medication compliance, and interventions related

to poor housing conditions.⁶ To this end, the DSRIP program devised a list of specific *chronic episodes* (both physical and behavioral). As multi-morbidity is the norm, multiple episodes are, by default, treated and priced as one, *integrated chronic bundle*. Finally, as part of the broader NYS Medicaid strategy to strengthen primary care, the chronic bundle will be subsumed under an Integrated Primary Care contract.

– HIV/AIDS

The prevalence of HIV/AIDS in New York is still relatively high, although the number of patients who have kept their viral load low has improved. To truly end the epidemic requires aggressive implementation of optimal care principles: tracking of undetected cases, ensuring that HIV-positive patients are on appropriate drug regimens, and increasing the use of pre-exposure prophylaxis (PrEP) for those who are at increased risk. To stimulate the further development of an integrated delivery system, an HIV/AIDS subpopulation was defined. Serving this subpopulation involves assuming risk for its total cost of care, for example through HIV/AIDS ACOs with separate incentives for reducing the incidence of new HIV/AIDS cases.

Figure 3 - New York Value-Based Payment Roadmap Framework



⁵ New York State Department of Health, A Path Towards Value-Based Payment, New York State Roadmap for Medicaid Payment Reform, June 2015.

⁶ In New York City, both Asthma and COPD exacerbations have been shown to be significantly reduced by improving the housing conditions of these patients.

The New York State Medicaid payment reform program (continued)

2. The Roadmap allows MCOs and providers to choose the level of risk the involved providers are willing and able to assume. Given the large variation in maturity and integration levels among state Medicaid providers, not all providers can start the value-based payment journey with the same level of risk. By offering options, MCOs and provider groups will be able to orchestrate their own glide paths to successful reforms. At the end of the five-year transformation journey in 2020, over 80 percent of MCO payments to providers should be captured by Level 1 arrangements, and over 35 percent by Level 2 arrangements or higher (See Figure 4 below).

3. The Roadmap addresses the entirety of the Medicaid program in a holistic fashion, rather than carving out pieces to focus on first. Part of the reason New York State is able to take this approach is because it is the single entity funding all Medicaid MCOs, and it has the regulatory authority to specify principles and targets for VBP in its contracts with these health plans. By addressing the full program, the reform process actually becomes less complex for providers and plans to manage, since it eliminates the need for two different administrations (one for the old, and one for the new).

In the first quarter of 2016, the Department of Health, MCOs and providers around the state initiated the first large scale pilots to test drive the payment reform process and to help fine tune the various financial parameters and quality measures. Full-scale implementation starts in 2017.

Access to Medicaid data

Given the fragmented nature of the Medicaid market in New York, the state determined there is a pressing need for them to play a central role in the exchange of data. The VBP Roadmap lays out a plan for a state-run data and analytics platform, which will give providers and MCOs direct and secure access to the most recent data in the state’s Medicaid Data Warehouse. It will make the value (cost and quality) information of the care delivered in all installed VBP arrangements transparent. Because of the importance of this information to patients and other stakeholders, the state will not only provide this information for the VBP contractors and MCOs that contract these VBP arrangements, but for all providers and MCOs.

Figure 4 - New York State Value-Based Payment Levels

Level 0 VBP Does not count as VBP in the NYS Medicaid VBP Roadmap	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy ⁷)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

⁷ PCMH refers to Patient Centered Medical Home, APC refers to Advanced Primary Care, and PMPM refers to Per Member Per Month

Enabling system reform in Alzira, Spain



Spain's financial pressures began to impact its healthcare system in the 1990s.

The country had an unwieldy, publicly financed universal healthcare system, which was delivered through an aging infrastructure. In some instances, such as in the Alzira district in Valencia, there was no physical infrastructure in place for acute and specialist care, nor were there linkages between providers at the primary, acute, and specialist care level, resulting in patients self-navigating a freely accessible system. Tasked with maintaining the integrity of a publicly accessible and universal system while mitigating downside financial risk in the face of rising delivery costs, policymakers enacted regulatory reform that separated the financing, purchasing and provision of health services. This separation allowed for private sector participation with the system run by a public/private partnership that would deliver services under capped funding arrangements tied with quality metrics. The Alzira district was one of the first to take advantage of these public-private partnerships opportunities by inviting a private consortium not only to build a brand new hospital, but to run it as well.

Ribera Salud, the health management company behind the Alzira model, established a P3 model which facilitated better access to care, sustainable costs, improved health outcomes, and more efficient system performance. The model was designed based upon four key pillars:

- **Public financing**

The district pays a capped annual rate on a per capita basis to Ribera, which then contracts with providers (many of whom are government employees) and covers all treatment costs for the designated population.

- **Public ownership**

The service delivery network and infrastructure (including the hospital being constructed) are owned by the public and situated on public property.

- **Public control**

Ribera is accountable to the partnership agreement, which includes profit capping at 7.5 percent of revenue,

with the remainder returned to the government for reinvestment. System performance, population health, and outcome measures are tracked and Ribera is also held responsible for care provided to the designated population outside of the contracted Alzira network.

- **Private delivery**

Through contracting on a long-term basis of 15-20 years and promoting accountability for costs and outcomes, Ribera functions as a single, integrated provider across the continuum. Effective delivery is enabled by creating clinical pathways, integrated EMRs, multidisciplinary teams, and provider performance measurement.

Overall, the P3 model established in Alzira offered a new method of improving care, access, and infrastructure across Spain, and it was expanded to other districts inside and outside the region. The P3 model was attractive as it showed that capitation can yield multiple, simultaneous benefits that were once deemed mutually exclusive: cost certainty; cost-effective system management; and governmental oversight of quality and access to care.

While the P3 model works well in Spain to help combat the effects of the economic pressure, there are elements to it that may not work well in other situations or in the event that Spain's economic climate and health needs evolve. For example, the Alzira model uses a method of designated patient populations to lock in the capitated arrangement for the contracting provider system. Such a method of 'forced allocation' may be less appealing to residents in metropolitan areas with overlapping provider networks and more choice. Further, as the needs of the population shifts, there might be a rationale for specialized "carve-outs" that can more efficiently and effectively manage specific population needs than a single organization. The limitations of the P3 model are paralleled in structures such as the Accountable Care Organization (ACO) model. While both are under capitated funding models, the single managing entity is often too large and unwieldy to realize truly community-based primary care. At the same time, they are usually too small to include the systemic capacity to address the needs of highly specialized services (such as pediatric cancer) where economies of scale and quality requires expanding beyond the network.

Pharma and value-based payments



Ever increasing costs of healthcare, pressured budgets and reduced added efficacy of newer and more expensive drugs is starting to challenge the status-quo of paying pharma companies for every pill or prosthesis.

In many countries, we observe examples of governments controlling total pharmacy costs at the national level by setting maximum allowed prices, conducting collective negotiations, creating formularies and emphasizing generics over specialty products. Even the United States could be entering its last years as the only Western country that has shunned national government-led price regulations.

The regulatory and market dynamics that shape pharma's market power

For pharmaceutical products, approval and access to the healthcare market rely heavily on studies that show improved outcomes for patients in a research setting. In some cases, such as the UK's National Institute for Health and Care Excellence (NICE) program, evidence of marginal cost-effectiveness over existing medications is required in order to gain approval and entrance into the national market.

Once granted listing on a formulary, however, the focus on *value* is dropped, and the medication becomes part of its own fee-for-service, volume-based payment cycle, with related budgets, payers and regulations. If there was a push to show cost-effectiveness in the research stage, this tends to not factor into the actual market situation as improvements to measures such as Quality Adjusted Life Years (QALYs – used by NICE in the UK) do not make a direct difference to the bottom line of the public or private payer footing the bill for the medicated patient.

In the US, the arrival of new, expensive specialty drugs, price hikes of generic drugs and record-breaking prescription drug spending have outraged lawmakers across party lines and may lead to government interventions that would have seemed impossible only a few years ago. Already, the Medicare Bundled Payment for Hip or Knee Replacement includes the cost of the prosthesis as part of the episode of care contracted by providers. Since orthopedic surgeons or hospitals generate savings that Medicare shares with them, renegotiating the cost of prostheses is an obvious target.

Another innovation includes the patient in the equation. For example, Blue Cross Blue Shield of Massachusetts has introduced what it calls *Value-Based Benefit Design*, which reduces patient copays for essential drugs to almost zero in an effort to foster compliance and, ultimately, better outcomes. It is important to note that such models often lead to higher drug utilization initially, but, by ensuring compliance to maximize outcomes, overall costs of care should eventually decrease.

Both approaches rely on the possibility to transfer financial risk to providers and/or the patient. In many publicly organized health care systems, however, providers cannot assume risk and supply elasticity is non-existent; similarly, countries or governments emphasizing the right to optimal access of care often prohibit the use of financial incentives to influence demand or bar access to drugs or devices.

Yet even when the market dynamics, the regulatory environment and the ability to transfer risk are aligned, giving providers 'skin in the game' to control the cost of care has its limits. It becomes difficult, for example, when expensive specialty drugs come in the picture. In such cases, pharmaceutical costs dwarf all other care costs, and one more patient requiring the drug can make the difference between savings or losses. Likewise, the market power of a large pharmaceutical company dwarfs any negotiating power VBP contractors could have. VBP contractors should not be exposed to such 'insurance risk', and such high cost specialty drugs are often excluded from episode- or population based VBP arrangements.

A solution in such cases is to directly include the pharma and device manufacturers in the creation of value-based pricing schemes. This concept is still in its early stages – but as discussed above, the key insight is that the value of a drug is ultimately determined by the impact it has on the overall outcomes and costs of care for the patient. Here, however, it is not a group of professionals or providers that weigh the costs versus the benefits of building a drug into their care pathways. In these cases, the manufacturer negotiates directly with the public or private payers, taking a financial stake in realizing the outcomes it promises.

Pharma and value-based payments (continued)

Spreading risk to pharmaceutical providers

This can be done, for one, through *capitation*: limiting the total cost of the treatment of an individual to arrive at an outcome with excess costs borne by the pharmacy company. In the UK, for example, the usage of Novartis' Lucentis for macular degeneration is capped at 14 injections. When more injections are required or applied, Novartis bears the additional costs for any treatments in excess.^{vii}

Another route to tie the drug's price directly to outcomes is *paying for results*, in which contracts directly tie payment to the responsiveness/ effectiveness of the drug on the patient's outcome. In Italy, for example, Nexavar for renal cancer is not reimbursed if the renal tumor progresses during treatment of hepatocellular carcinoma.^{ix} This is a crucial break away from the 'fee for service' approach that characterizes much of health care but is still omnipresent in the pharmaceutical and device world. The payment here is tied to the outcomes of the overall care process: whether Merck's Januvia does not adequately improve HbA1c, for example, could be due to the patient not using the drug appropriately.^x Here, the manufacturer takes responsibility for the efficacy of the product in the total cycle of care, thus creating 'skin in the game' to achieve high value (high quality and efficient) care.

These examples demonstrate the need to expand the envelope of value-based payments to all contributors to a patient's outcome. While regulations have historically tied payers' hands in negotiating drug prices, reforms have both empowered payers by discerning who will have access to their market based upon clinical and cost efficacy, in addition to their willingness to be held at-risk for the patient's outcome.



The Indian paradigm



A current snapshot of the Indian health system reveals a highly fragmented payer and provider market, with a negligible role for the government, a very small number of individuals covered by government-sponsored health insurance, a thin layer of government-paid providers, and very few regulations governing the system.

In other words, the Indian health system shows the best and worst of ‘pure’ market forces at work, with individual consumers bearing most of the cost of care and very little of the third-party payer dynamic that impacts most other countries’ health systems.

Classic market failure due to information asymmetry here predictably destroys value. The patient/consumer has little information about the cost or quality of services delivered. Worse, the main source of this information is the provider who stands to gain by selling its services to the patient/consumer who must often turn to the provider in times of distress. On top of this, most Indians cannot afford the types of treatments for anything but minor conditions.

The observed upside of the ‘free market’ situation in India is that providers have organized themselves to meet the needs of a very diverse and large population because it is that population that directly pays for health care services.^{xi} For example, there are mobile health clinics that extend the reach of hospitals to rural areas in which the selection of providers is often very limited. This offers residents of villages that might otherwise have to cover long distances to get to a hospital direct access to better-trained clinicians. And since the mobile health clinic providers must compete on both price and perceived quality, the diffusion of these providers is not simply a scheme to charge more, but rather to increase the capture area for market share. Similarly, there are several private hospital chains that have emerged to specialize in certain procedures. For example, Apollo Hospitals has emerged as one of the leading Centers of Excellence in India offering cardiac, orthopedic and other procedures at a single bundled price, with a warranty period. In addition, patients with certain chronic or acute conditions can also receive comprehensive care at Apollo facilities, all at pre-published prices.

By many accounts, the outcomes of the current Indian health system are lagging other countries.^{xii} If the Indian government were to decide to improve certain health outcomes for certain populations, our proposed framework would suggest a highly targeted approach. That is because the lack of current regulatory power and the fragmentation

of the delivery system coupled with poor access reduces the ability for broad scaled changes. However, government could concentrate on specific population needs, define the desired function of the delivery system to meet those needs, and then develop a clear set of financial incentives and metrics to monitor success. For example, amplifying the scope of the mobile health clinics to cover a broader scope of primary care, or instituting primary care clinics as was done in Singapore. This would hold true for any state in India. The challenge will be to build a low-cost primary and community care infrastructure to allow for sustainability and to keep the reliance low on the more expensive, high tech hospital services. In addition, the government could leverage the existing private sector infrastructure to buy certain services for secondary and tertiary care at a nationally negotiated discount. For example, it could negotiate with Apollo Hospitals and others a single rate for all orthopedic procedures for certain disadvantaged populations.

Ultimately, the Indian example demonstrates the results generated by a high self-pay, largely unregulated health system. Providers will tend to ‘cherry-pick’ the customers and the types of care they deliver, leaving gaps – both systemic and coverage gaps although the care that is supplied may be done so in an efficient manner. Governments in a situation such as India should try and build on the system that is present to fill in the gaps in population health management themselves.



Conclusion

There is no one-size-fits-all solution to reforming a healthcare delivery system and producing higher quality, more affordable healthcare, nor should any policy maker expect one. There are, however, proven approaches to achieving these goals, and this report lays out a framework that can increase the likelihood of reform success.

The bedrocks of success are the principles of (1) allowing function to drive form in designing a value-based payment model; (2) understanding the impact of provider payment and health plan benefits on balancing supply and demand of services; (3) identifying opportunities for improvement through measuring and understanding your population using innovative analytics; and (4) tailoring your alternative payment models and incentive programs to the market dynamics underlying your system. Further, the likelihood of success will be impacted by the degree to which policy makers adapt their reform efforts by influencing the transfer of risk, the regulation of the various players in the system, and the use of other regulatory levers to create the conditions for VBP feasibility.

This report provides both a theoretical framework as well as case studies that illustrate how governing authorities have implemented changes in payment and delivery systems. The obstacles are real, but the possible rewards in terms of population health, the economic benefits resulting from that, and manageable cost growth are an outcome worth the challenge.

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