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Reclaiming  
Lost Medical Value  
*Three Models for  
Healthcare Change*



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## EXECUTIVE SUMMARY

*Rising costs are forcing the entire U.S. healthcare industry to find ways to unlock and enhance medical value by delivering higher-quality, more affordable care to empowered and engaged consumers.*

*To create meaningful change, the system needs to adopt approaches that are holistic and highly collaborative, bringing together the distinct capabilities of payors, hospitals, and physicians. This Perspective outlines three models—population care, healthcare products, and focused transformation—that address the issue of reclaiming lost medical value in a comprehensive and sustainable way. Each model incorporates scalable, coherent changes to the three key components for unlocking medical value—care delivery redesign, payment innovation and consumer engagement—to improve affordability while maintaining or improving medical outcomes.*

## KEY HIGHLIGHTS

- Successful medical value models rely on collaborative partnerships throughout the healthcare environment.
- Models must address care delivery redesign, payment innovation, and consumer engagement.
- The population care model addresses care delivery for entire patient populations, with supporting payor-provider incentives.
- Healthcare products that combine medical services into a single offering establish a more transparent, retail-oriented market.
- The focused transformation model provides targeted solutions for healthcare cost drivers such as high-cost, highly utilized procedures.
- Each model requires strategic investments in enabling capabilities.

## TOWARD A MORE HOLISTIC MEDICAL SYSTEM

Facing an affordability crisis, the U.S. healthcare system is under pressure to find new ways to deliver medical value. With nearly one-third of all medical spending lost to waste and structural inefficiencies,<sup>1</sup> a new definition of medical value, rooted in patient results rather than the amount of care provided, is emerging. Reclaiming lost medical value requires healthcare ecosystem participants—payors, providers, and consumers—to work for change in three critical areas: care delivery redesign, payment incentives, and

patient engagement. To successfully lower costs, any model for improvement must also be holistic and highly collaborative, given the tight interdependence of these three critical areas of the overall healthcare system.

Deep and lasting change begins with a shared vision. Here we put forth three distinct models that may help ecosystem participants frame the problem of unlocking medical value and consider alternative ways of instituting change that will lead to improvement.

The models—population care, healthcare products, and focused transformation—all address the three critical areas of the healthcare system. For starters, any approach to enhancing medical value will rely heavily on redesign of the care delivery system. New processes that emphasize proven effectiveness and coordinated care

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## MODELS TO UNLOCK MEDICAL VALUE

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will be necessary to correct current patterns of overuse, misuse, and dangerous underuse of medical resources.

The models also entail innovation in payment methods that will shift from fee-based services to bundled payments for the full spectrum of care per episode or for a specific population. They also include providers and payors to share in the gains—and risk—of developing new methods that create and enhance medical value.

Finally, the three models also share a common emphasis on the demand side of healthcare with new approaches to consumer engagement. In addition to improved support for patient decision making within the care delivery system, our models call for more transparent, consumer-focused market approaches to generating medical value.

Truly effective transformation requires all-encompassing systems with well-aligned incentives. Any of these three models can be applied in a measured, coherent fashion and tailored to take into account local market dynamics and the goals of each individual partner. These models serve as guides, but investments in capabilities, technology, and processes are essential to their successful execution.

### Population Care

The objective of this model is to create medical value by managing an entire patient population. The population might be a plan's total membership, or a patient population with a chronic disease or living in a geographic area.

Care delivery is coordinated across the life cycle of a specific patient group with interventions at different stages of the care continuum that make the

best use of healthcare resources. For healthier people, that might mean a shift to screenings and preventive care in settings outside a hospital or physician's office. Alternative locations, such as retail pharmacies, could lower overall costs and make screenings more convenient. For patients with multiple chronic conditions, this model outlines population health management strategies, such as integrated preventive care and disease management programs.

The payment structure of the population care model initially entails shared responsibility and savings for health plans and providers in the form of bonuses or fee-for-service rate increases. Eventually, though, providers will need to take on a portion of financial risk in the system. Risk sharing goes two ways in this model, which is based on agreements between payors and providers that set a price for specific medical interventions. If the provider is able to treat the patient for less than the agreed-upon price—while also meeting quality metrics and care guidelines—the provider and the payor share the amount saved. They might agree to split the savings 50/50 or by any other formula that creates incentives for effective cost management within that individual partnership.

If, on the other hand, the provider spends more than expected, both partners accept part of the loss. As a result, providers have flexibility to spend what is necessary to meet quality standards. In order for providers to succeed in this new paradigm, health plans must provide assistance in collaborative care management, evaluating financial risk and using predictive trend analysis based on plan data.

Managed-care models in the 1980s proposed this type of total-cost-of-care budget for patient populations, but this new population care model provides more sophisticated approaches to the way care is delivered and financed. The total cost of care is tied to historical levels of spending, and future increases are linked to the Consumer Price Index. Instead of mandating reimbursement rates, as in old-style managed care, payors collaborate with providers to meet cost-of-care targets by participating in care redesign. For example, payors can use their data and analytic capabilities to identify gaps in care and help shape incentives that encourage collaboration for effective care management.

Appropriate patient engagement is crucial to the success of population-based payments. Scalable approaches to

patient incentives need to be incorporated to engage broad patient groups and encourage better health self-management, especially for those with chronic ailments. Patient engagement might include online or telephone-based health coaching, remote monitoring of at-risk factors for common chronic diseases, and compliance incentives, such as lower premiums for patients who follow medication regimes or rewards programs for healthy behaviors.

The population care model is perhaps the most ambitious of the three and is likely to have the best chance of success in markets with a limited number of payors and large, integrated provider networks that already have a strong history of collaboration. In markets without those traits, arrangements like accountable care organizations (ACOs) can be constructed to help hospitals and physician groups take a more comprehensive and sustainable role in the well-being of their patients.

In one example of a population care approach, Fairview Health Services, a Minneapolis-based nonprofit system, is partnering with Blue Cross and Blue Shield of Minnesota in a team-based ACO that puts the responsibility on primary care providers to

coordinate prevention and appropriate levels of treatment across patient populations. Blue Cross Blue Shield of Massachusetts (BCBSMA) has also launched partnerships that include elements of the population care model.<sup>2</sup> Nine provider groups working with BCBSMA have agreed to be accountable for clinical performance measures of their processes, medical outcomes, and the patient experience at their inpatient and ambulatory care facilities.

As for incentives, providers in the Fairview system are paid a base salary and receive annual bonus payments of as much as US\$15,000.<sup>3</sup> Quality indicators account for 70 percent of the bonus structure, while 15 percent is based on efficient use of resources and another 15 percent on patient satisfaction. BCBSMA is working with its providers through an alternative quality contract. The arrangement combines a global per-patient budget that allows for annual increases in line with inflation and performance-based incentives set by nationally recognized measures of quality, efficiency, and patient experience. Quality incentives can make up 10 percent of the overall budget.

Some early indications suggest that this model can work. An ACO pilot involving the California Public

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Employees' Retirement System (CalPERS),<sup>4</sup> Blue Shield of California HMO, Catholic Healthcare West, and Hill Physicians Medical Group produced an estimated \$15.5 million in savings in its first year. The pilot study, which began in January 2010, also reported reductions of 17 percent in the average patient length of stay, 14 percent in the total patient length of stay, and 50 percent in the number of patients with a 20-day or longer length of stay through October 2010.

Though many of these efforts are excellent starts and illustrate the potential of population-based models, the capabilities are not yet in place to support wide-scale implementation while lowering overall costs, and none have incorporated many of the patient engagement tools required to make these models effective and palatable to patients.

#### Healthcare Products

A second model, based on the creation of specific healthcare products, is designed to recoup medical value through consumer-focused offerings that bundle all the services associated with a single episode of medical care. These episodes could range from something as simple as a screening colonoscopy to a more complex procedure such as a hip replacement to an even more complex disease management episode such as diverticulitis. In this scenario, coverage extends from initial diagnosis through final resolution of the case, which could range from hospital discharge to the completion of rehabilitation to enrollment in a disease management program for chronic illness. The notion of product-based care may extend even further, with one healthcare system providing comprehensive orthopedic care and

another providing comprehensive oncologic care for the same patient. Clear-cut healthcare products give consumers the ability to direct their business to providers that deliver the best results for a competitive price.

In the healthcare products model, providers in diverse settings, such as primary care offices, hospitals, or rehabilitation centers, work together to provide care delivery, leading to better coordination, less duplication, and potentially lower costs. Participants in this model also share responsibility for the development, rollout, and ongoing refinement of their products. Effective use of the healthcare products model relies on the development and continuous monitoring of evidence-based guidelines to shape integrated products.

New payment structures guiding healthcare products are devised jointly

*Clear-cut healthcare products allow consumers to use providers that deliver the best results for a competitive price.*

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by payors and providers. The comprehensive price of each product is calculated as the cost of bundled services plus a fair profit margin. Payors and providers jointly identify opportunities to reduce the cost of the product. Price hikes are then limited, and benefit design can be used to attract patients to the products, thus increasing volume and reducing per-patient costs further.

This model builds on ideas championed by Harvard Business School professors Michael Porter and Regina Herzlinger<sup>5</sup> by extending the concept beyond providers to also include health plans and consumers. Health plans are an essential part of the model because they can assemble the volume of patients necessary to encourage providers to develop and offer all-encompassing healthcare products. Plans can also help simplify billing and assist in aggregating the data for evidence-based solutions to help structure products.

Patient engagement is indispensable in this model, which succeeds best when enabled by consumer choice. To guide the consumers, education is critical. First, the model requires decision support that helps consumers to comparison-shop for healthcare products. During care, continued education enables patients to adhere to product-specific clinical guidelines, potentially reducing costs and improving outcomes. Benefit design can be used to foster personal responsibility by using financial incentives, such as co-pay levels, rewards programs, and premium reductions, to encourage consumers to adopt healthy behaviors and to comply with treatment regimens. Finally, patient-specific interventions can be targeted through products that draw on patient health information, potentially gathered from personal health records.

The healthcare products model works best in competitive, consumer-driven markets where patients receive a

relatively high number of expensive, high-risk procedures that could be structured as products. The model would typically require some history of payor-provider collaboration. However, it does not demand the highest levels of integration, such as when physicians work in closed networks or the payor function operates within an overall integrated system.

In Florida, a major health plan is collaborating with several providers to create healthcare products for lung cancer treatment, hip and knee replacement, and coronary artery bypass surgery.<sup>6</sup> The goal of this initiative, known as Healthcare of the Future, is to take the current 80/20 ratio of traditional fee-based care to healthcare products and flip it to 20/80. The Robert Wood Johnson Foundation's not-for-profit Prometheus Payment is also engaged in pilots of healthcare products covering chronic conditions including congestive heart failure, chronic obstructive

*The healthcare products model works best in competitive markets where patients receive a lot of high-risk procedures.*

pulmonary disease, asthma, coronary artery disease, and hypertension.<sup>7</sup> Surgical and procedural products, including hip and knee replacement, coronary artery bypass, coronary catheterization, bariatric surgery, and hernias, are also under study.

Pennsylvania's Geisinger Health System offers a healthcare product for elective coronary bypass surgery that bases payment on a typical provider's estimated costs for a 90-day episode of care with 50 percent of the costs of complications paid up front. A pilot designed by the Centers for Medicare & Medicaid Services (CMS) under way at five hospitals provides bundled payments for cardiology and orthopedic treatments.<sup>8</sup> CMS pays the hospitals a lump sum for all inpatient and outpatient services and physician fees. The hospitals are able to provide bonuses to physicians if they reduce costs while still adhering to protocols. In the CMS pilot, seniors are eligible to receive incentive payments of over \$1,000 for choosing the participating hospitals' bundled orthopedic or cardiology healthcare products.

Healthcare products are showing success in generating medical value through improved quality and savings. Since Geisinger instituted its cardiac

bypass program in 2006, its 30-day readmission rate dropped 44 percent for patients in the program, and 21 percent fewer patients experienced complications. Baptist Health System in San Antonio, which is participating in the CMS pilot, has reduced spending on devices and supplies by \$4 million and has been able to award \$558,000 in bonus pay to 150 physicians. Nearly 2,000 patients have received a total of nearly \$6,000 in incentive payments.

Product-based models appear to be slowly gathering support; however, in markets where there is limited hospital/physician integration, legal issues create obstacles and essential market maker functions have yet to be widely developed.

#### **Focused Transformation**

A less complex model that might serve as a good starting point for capturing lost medical value is focused transformation. This model relies on targeted collaboration among healthcare partners to reduce specific high-cost, frequently recurring, or clearly redundant activities, such as hospital readmissions or duplicate testing.

In a focused transformation model, care delivery is based on clinically established guidelines and pathways.

Physicians rely on real-time access to the latest medical information, with frequent feedback on how their patients are doing, as they make decisions about the proper approach to treatment ranging from diagnostics to surgery to managing intensive care.

The focused transformation model uses payment to establish links between compensation and medical outcomes, but it also includes mechanisms for reducing unnecessary and costly overuse of medical services. Payment incentives reward improvements in medical value, such as fewer medical complications, hospital readmissions, and repeated services, and reductions in the amount of redundant or ineffective care such as duplicative testing. While previous models have utilized pay-for-performance incentives, focused transformation entails more comprehensive change by linking compensation not only to medical outcomes but also to reductions in avoidable overuse of medical resources. To be effective, focused transformation payment systems need to enhance compensation, provide sufficient resources, and alter delivery costs sufficiently to incentivize behavior change.

To get patient buy-in, focused transformation requires consistent

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and coordinated education efforts, as well as increased involvement by patients in their own health, to improve safety and cut back on wasteful overuse of the medical system. Partners in this model offer support for patient decisions that emphasize appropriate, evidence-based care and manage patient expectations about how much care is necessary. For example, partners can improve instructions to make sure patients know they must fast before a blood test in order to avoid costly repetitions of the test. Compliance incentives, such as lower co-pays for using less expensive medical facilities or doctors, can also be built in. Finally, next-generation medical information portals can give patients the most up-to-date information about appropriate clinical care.

This model can be used even in fragmented markets where few physicians work for an integrated provider. Because of its single focus, the model is also a good place to start for payors and providers with little history of collaboration.

A joint effort by Kaiser Permanente, Intermountain Healthcare, and Mayo Clinic, launched in late 2008, used focused transformation to design pilots for care delivery that revolve around individual patients.<sup>9</sup> Provider payment is based on better-than-average health results, patient satisfaction, and reduced costs. Also, Intermountain Healthcare, Kaiser Permanente, Mayo Clinic, Geisinger Health System, and Group Health Cooperative in Washington announced the formation of the Care Connectivity Consortium to share patient data in a secure, interoperable electronic system that will make it easier for physicians to treat patients who come to them from outside their primary networks.<sup>10</sup>

A key lesson learned from previous pay-for-performance models is that practices need to be focused on the needs of a particular marketplace rather than universally applied. Collaborative efforts between payors and providers to determine the strengths and weaknesses in the particular market will allow focused transformations to have a significant impact without incurring unnecessary and wasteful costs.

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## CONCLUSION

Though each of these models has the power to transform care delivery and create sustainable medical value, the population care and healthcare products models represent deeper change and provide a greater opportunity to gain ground in affordability, medical quality, and overall patient experience. In large systems, one model might work better than others in a given market, so individual partnerships need to take all three into consideration to build their own tailored approach to providing affordable, high-quality care in an increasingly consumer-focused environment.

Once health plans, hospitals, and physicians define their overarching vision for innovative collaboration and identify an approach to creating medical value, they can pursue the essential work of investing strategically in capabilities, technology, and processes specific to their chosen model. These capabilities become the flesh on the framework of these three models. Selecting the right capabilities and putting them to work effectively is the final step in generating new medical value throughout the healthcare system.

## Endnotes

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<sup>2</sup> "Massachusetts Blues' Alternative Quality Contracts Signal Hospitals' Risk-Based Future," by Caralyn Davis (FierceHealthFinance, July 28, 2010). [www.fiercehealthfinance.com/story/mass-blues-alternative-quality-contracts-signal-hospitals-risk-based-future/2010-07-28](http://www.fiercehealthfinance.com/story/mass-blues-alternative-quality-contracts-signal-hospitals-risk-based-future/2010-07-28)

<sup>3</sup> "ACO via Care Model Innovation & Comp Model Redesign," presentation to World Congress by Barry Bershow, February 26, 2010.

<sup>4</sup> CalPERS press release, April 12, 2011. [www.calpers.ca.gov/index.jsp?bc=/about/press/pr-2011/april/integrated-health.xml](http://www.calpers.ca.gov/index.jsp?bc=/about/press/pr-2011/april/integrated-health.xml)

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<sup>6</sup> "Healthcare of the Future Model: A Response to the Reform Challenge," by Gary D. Ahlquist, Mino Javanmardian, E. Blake Wilkerson, and Sanjay B. Saxena (Booz & Company, 2009). [www.booz.com/media/uploads/Healthcare\\_of\\_the\\_Future\\_Model.pdf](http://www.booz.com/media/uploads/Healthcare_of_the_Future_Model.pdf)

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<sup>9</sup> "Delivery System Reform: Action Steps and Pay-for-Value Approaches" (Intermountain Healthcare, Kaiser Permanente, and Mayo Clinic, November 4, 2008). [www.mayoclinic.org/healthpolicycenter/pdfs/delivery-system-reform.pdf](http://www.mayoclinic.org/healthpolicycenter/pdfs/delivery-system-reform.pdf)

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