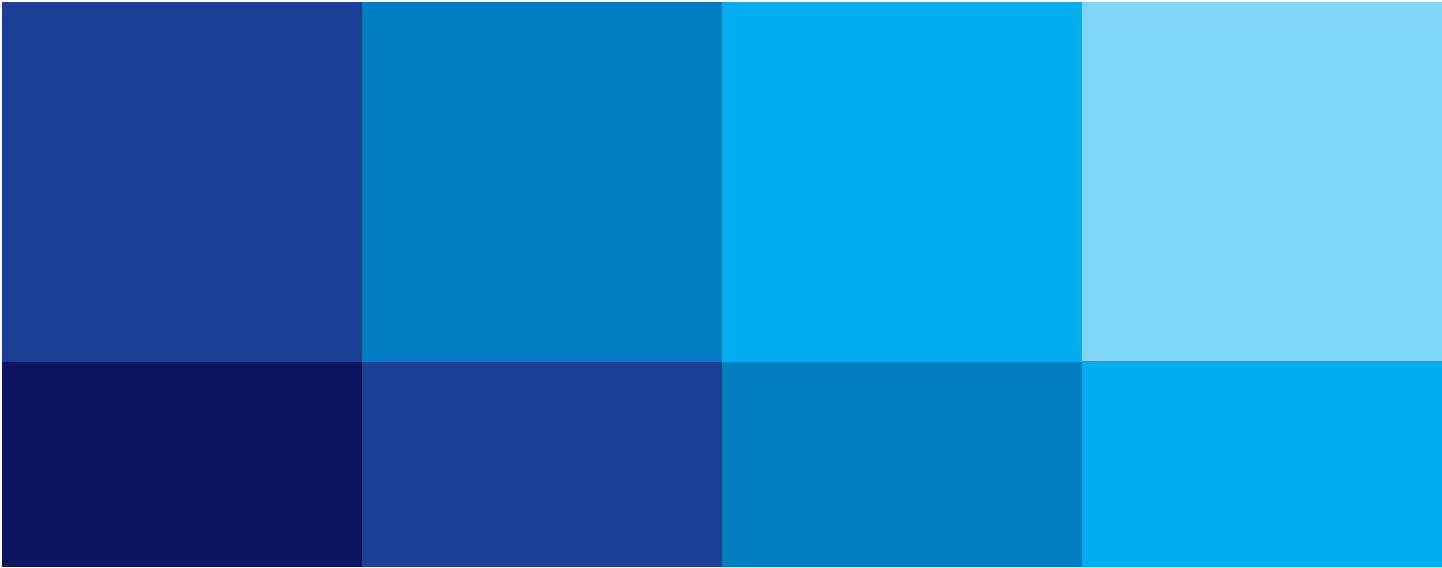
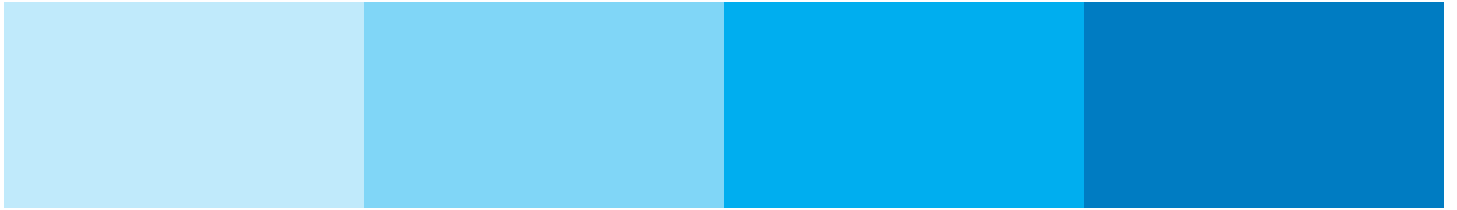


**Accessing More of the Health Premium:  
The Transition into Population Health and  
Value-based Payment**





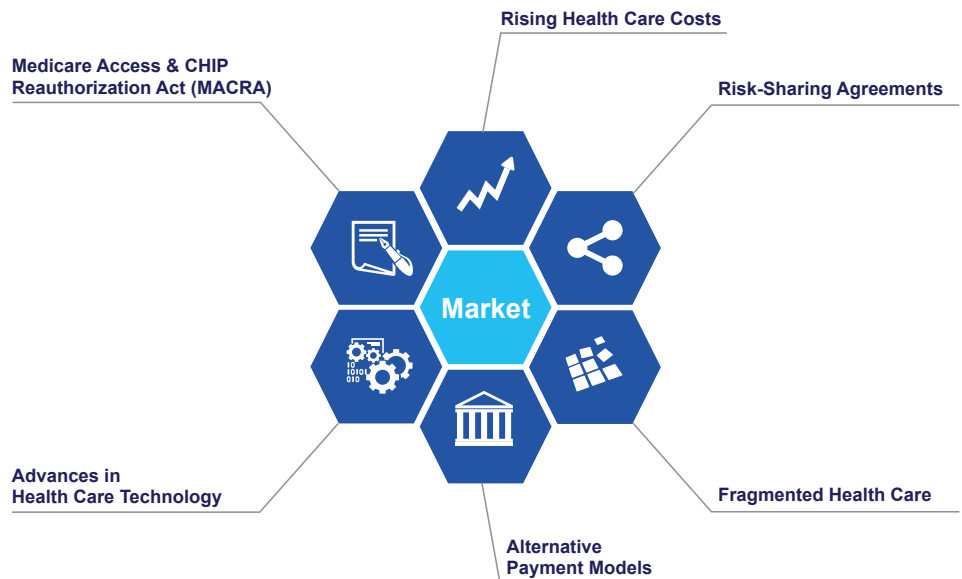
# Accessing More of the Health Premium: The Transition into Population Health and Value-based Payment

By [Cindy Ehnes](#), Executive Vice President, COPE Health Solutions and [Allen Miller](#), Chief Executive Officer, COPE Health Solutions

## INTRODUCTION

Health systems and providers must strengthen their ability to manage population health and costs through risk based contracting. It is critical to shift towards global financial risk through capitated arrangements between managed care organizations (MCOs) and providers. Despite the ever-shifting winds of federal and state health policy, traditional fee-for-service payment is insufficient in today's marketplace. Innovative health system leadership in network development, population health management and contracting negotiations is vital to remain competitive, as well to address rising costs and poor health outcomes. There is simply no new money flowing into the funding of healthcare for any line of business. Macro-economic forces, such as the growing penetration of government reimbursement and value-based payment methodologies, lingering uncompensated care and limited progress on affordability of coverage, are shaping the need for closer alignment and integration of health systems. While shifting risk to providers is increasingly a cost control strategy, it may empower providers to elevate population health and gain more control of the premium dollar.

## MARKET DRIVERS



The failure to repeal and replace the Affordable Care Act (ACA) masks the continuing threat of a squeeze in Medicaid dollars on both the federal and state level. Federal proposals and tight state budgets aim to drive down dollars available for Medicare and Medicaid funding through increasingly blunt instruments. In light of these challenges, the current administration continues to signal that “value over volume” will remain a central tenet of federal policy. Despite the recent retreat from the federal bundled payment initiative, the U.S. Department of Health and Human Services (HHS) remains charged with enforcing the Medicare Access and CHIP Reauthorization Act (MACRA) and has issued a draft regulation for quality payment programs that maintains a value orientation. On the state level, in particular in those states that did not expand Medicaid under the ACA, there are likely changes in Medicaid eligibility requirements and benefit limits that may, in the near term, advantage health care providers with deeper partnerships with payors.

While the crippling black cloud of uncertainty regarding Exchange markets hovers over the industry, a sobering fact shows that 80 million people, or one in five Americans, are on Medicaid<sup>1</sup>. As tight state budgets drive Medicaid and Medicare dually eligible individuals into Medicaid, managed care organizations are increasingly charged to execute this critical public policy. These fragile, at-risk populations, many with behavioral health issues, require high touch, collaborative, patient centered care delivered in a community setting. This has major implications for patient-centered, population-based care, considering both the health care needs of Baby-Boomers and the reliance on performance measures that focus on member experience.

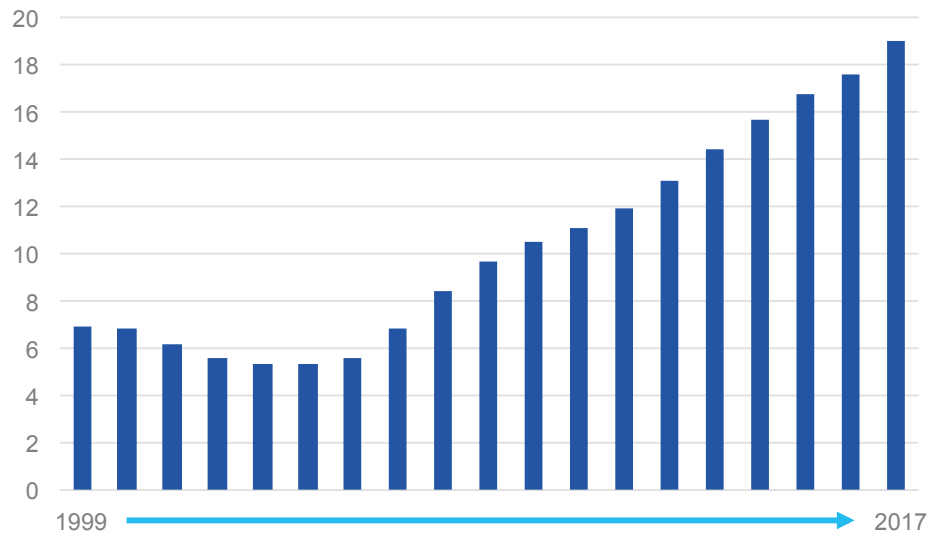
<sup>1</sup> *Oliver Wyman New Analysis: Trends in Payer-Provider Partnerships*, February 09, 2017

## Quick Facts about Medicare and Medicaid

- 80 million people, or 1 in 5 Americans, are on Medicaid
- Since the ACA passed in 2010, Medicare Advantage enrollment has increased by 71%
- 1 in 3 people with Medicare have selected Medicare Advantage and value-based compensation products (19 million beneficiaries)

## ENROLLMENT IN MEDICARE ADVANTAGE PLANS

Total Medicare Private Health Plan Enrollment (in millions)



Marked growth in off Exchange products continues, particularly in Medicare Advantage and value-based compensation products. Since the ACA passed in 2010, Medicare Advantage enrollment has increased 71% and as of 2017, one in three people with Medicare have selected Medicare Advantage (MA) and value-based compensation products (33% or 19 million beneficiaries). Further evidence of this growth was apparent in 2016, as nearly 40% of partnered products entering the market were Medicare Advantage plans<sup>2</sup>. In the commercial sector, payors are recognizing that collaborative relationships with providers expand contracting opportunities to improve health status and quality of care while holding down premium increases. The prevalent “skinny network” strategy partnered with traditional fee-for-service is being reimaged as commercial Accountable Care Organizations (ACOs) gain traction to address fragmentation and poor population health outcomes. Success in a commercial ACO requires all parties to address patient care across the entire continuum, in and out of the hospital setting.

Across all lines of business, patchworking a disconnected network of providers requires organization and integration to coordinate the pieces that add true return on investment in which quality, value, and joint efforts successfully control total cost of care. The shifting of risk to providers is a government cost control strategy, but one that can empower providers to elevate population health and gain more control of the premium dollar.

<sup>2</sup> *Who's on Medicaid Might Surprise You* - Consumer Reports, Jun 21, 2017

**Transition toward risk is necessary for retention, market share growth and long-term profitability of health systems. However, a disconnected network of well-intentioned providers requires organization and integration to add true return of value in which quality, value and joint efforts control the total cost of care.**

## **ADDRESSING PROVIDER SKEPTICISM OF RISK-BASED CONTRACTS**

Health system leaders diverge greatly in their attitudes towards taking additional financial risk. While the Centers for Medicare and Medicaid (CMS) report 30 percent of its reimbursement to hospitals ties to some level of risk-based contracting, health systems are still largely reliant on the fee-for-service model. In the 2017 Modern Healthcare Hospital Systems Survey<sup>3</sup>, only nine of 60 respondents derived 10 percent or more of their net patient revenue in 2016 from risk-based contracts, with the majority generating four percent or less of their net patient revenue from risk-based contracts. Critical to developing successful risk contracts is acknowledging and addressing this deep provider skepticism.

A broad spectrum in provider risk models is evident. At one end are those systems skeptical of taking on risk beyond modest bonuses for reaching quality and patient satisfaction benchmarks or avoiding penalties for hospital readmissions. Those reluctant physicians and hospitals do not feel they have the resources or geographic range necessary to create the infrastructure needed to succeed at risk. That may be true. In the middle of the spectrum, many health system administrators have matured past dabbling in risk and are creating clinically integrated systems of care. These systems are aligning and integrating with physicians, as well as embracing clinical performance improvements with an integrated medical staff. The market-leading health systems are actively engaged in Medicare Shared Savings programs, Next Generation ACOs and Bundled Payments for conditions such as spinal surgery. Finally, systems such as DaVita Healthcare Partners in California, Montefiore Health System in New York and Geisinger Health System in Pennsylvania have fully embraced value-based care, population health and contracts that delegate substantial accountability and financial risk to providers.

Transition toward risk is necessary for retention, market share growth and long-term profitability of health systems. However, a disconnected network of well-intentioned providers requires organization and integration to add true return of value in which quality, value and joint efforts control the total cost of care. The shift towards a successful, all-payor, value-based environment is rooted in seven essential characteristics that enable health systems to align payment with high-quality care.

<sup>3</sup> Modern Healthcare, Hospital Systems Survey, 2017

## ALIGNING PAYMENT WITH HIGH QUALITY CARE: 7 ESSENTIAL CHARACTERISTICS



### I. Phased Roadmap for Success

Moving into global risk is critical for longer-term sustainability; however, it is perilous if approached with a muddled strategy. Health systems must develop a clear, phased roadmap to global risk. This road map must combine a sound strategy for assessment, evaluation and implementation at the health system level, along with well-negotiated managed care contracts. These payor arrangements must ensure that successful utilization management will lead to pass through revenue savings to physicians and dollars to reinvest in core population health infrastructure.

The first step in developing a phased, articulated strategy is to understand in great depth the flow of dollars into and out of the health system. Significant structural changes in care delivery and payment systems necessitate all hospitals to undertake transformation to participate in value-based payment arrangement. Hospitals vary significantly in terms of geography, services and patient population. There is no single model that will work for all systems. Deficiencies in operational, clinical information technology (IT) infrastructure can jeopardize value-based contracts if not readily addressed. Therefore, it is essential that a population health infrastructure build, such as in new data systems and integration of health records with community care partners, be phased in to ease system transition. The ultimate goal of the strategy must be sustainable success in managing the global risk dollar for defined populations.

The movement to risk is a delicate balance, best approached as a gradual phase out of traditional revenue streams based on volume of services. Today, health systems and providers navigate a complex mix of discounted FFS, diagnostic related groups (DRGs), per case payments, bundled payments, supplemental payments (such as disproportionate share hospital dollars) and other payment methodologies. Each of these has its own administrative burden and incentives that will require modification. Safety net systems, in particular, face competing demands and tight margins. There is little room for error when addressing the realities of declining inpatient FFS revenue and the new costs associated with infrastructure building for value-based care.

In light of the risks to profitability and the realities of change management complexity, those facing infrastructure build must coordinate with areas currently at risk. Health systems may need a comprehensive understanding of how they are already in the risk business, even if not directly labeled as such. For instance, safety and quality of care performance metrics, readmission penalties, CMS initiatives and bundled payments are all common examples of simple risk arrangements in which most health systems are participants. It is essential to understand that the infrastructure required to perform well on these initiatives can coordinate with opportunities to negotiate rewards for reducing cost and utilization and managed care contracts. Through partnerships with IPAs, medical groups and other local provider organizations, health systems must ensure that their providers and support staff understand the requirements of risk contracts in place. They must fully grasp how this will affect their day-to-day work, payments and experience with patients and other providers in order to make incremental shifts towards higher value care.

Further, it is crucial to gain buy-in from employed and affiliated providers in compliance with MACRA. MACRA is in effect for eligible clinicians who participate in Medicare Part B. MACRA, in alignment with the Sustainable Growth Rate (SGR) “fix” in 2015, appears to be deepening its roots, despite all of the uncertainty of larger health reform. Either individually or in groups, physicians will participate in the quality payment program through one of two tracks: (1) the Merit-based Incentive Payment System (MIPS) or (2) Advanced Alternative Payment models (APMs). Both tracks will prepare providers in a health system to recognize the changes required in infrastructure and practice standards in order to excel in a value-based environment.

For some organizations, a desire to participate in Advanced APMs under MACRA may lead their long-term strategy for maturing their clinical practice and population risk. Participating in an Advanced APM requires systems or IPAs to have moved beyond the requirements of MIPS to deliver efficient, high-quality care, while taking on downside risk. Overall,

**A framework of managed care contracts that support aligned incentives and population health infrastructure underpins a successful move to risk.**

Advanced APMs offer more potential rewards for clinicians than the MIPS track. Advancing to this level of care delivery and risk requires strong, consistent leadership, physician buy-in, IT capabilities and redefined risk contracts. While daunting, organizations who participate and perform well under Advanced APM's will lead the healthcare community as those elite few who have truly mastered value-based payment and care delivery.

Finally, while MACRA is currently only a Medicare program, it is likely that Medicaid and private payors will adapt similar reimbursement strategies in the near future. New York State's *Value Based Payment Roadmap*<sup>4</sup> details the state's vision to drive the transition of its provider system to sustainable population health management and clinical integration.

## **II. Infrastructure Build to Support Risk-Sharing**

A framework of managed care contracts that support aligned incentives and population health infrastructure underpins a successful move to risk. Payment systems from MCOs within a given market must expeditiously reach a 'tipping point' of concentrated revenue that reward aggressive waste reduction and improved quality of care. Aligning disparate payment streams from multiple payors allows a concentration of resources. If this does not happen, the costs of assembling care management and data infrastructure will overpower small separate pockets of prospective risk revenue. In spite of much industry "buzz," full capitated payment made directly to care delivery systems or practices remains relatively rare, as noted in the previously cited Modern Healthcare *Hospital System Survey* for 2017 and in product "pockets," such as Medicare Advantage and Medicaid managed care. Increasingly, it is likely to encompass care for the Medicare and Medicaid dually eligible populations as they transition into managed care, but has not yet amassed a presence in the commercial market.

While negotiating a risk contract is markedly different than negotiating a FFS contract, certain fundamentals should be considered. First, every market is local, defined by the players and opportunities in geographic boundaries. The kinds of arrangements health plans and providers are willing to enter into depend on traditional supply-demand analysis of the local market. However, it also depends on the underlying concerns that each player has with value-based arrangements, often related to readiness from an administrative, population health management and network adequacy perspective further emphasizing the need to quickly reinvest in infrastructure.

<sup>4</sup> New York Department of Health, *A Path toward Value Based Payment for Medicaid Payment Reform: New York State Roadmap*, June 2015



For risk-based agreements to successfully raise revenue for reinvestment, payors must also see the opportunity for tangible savings to incent creating capitated arrangements. They often report that many hospitals and health systems, particularly safety-net systems, simply do not have the expertise and do not bring the “value equation” for prospective payment. In fairness, however, ‘late-to-the-value-game’ health plans can often demonstrate growing system efficiencies, such as reduced admissions, without paying to build the infrastructure immediately.

Health plans are also concerned that value-based arrangements will not lead to better care platforms that result in cost savings and quality improvements, but instead will give providers market-power advantages that lead to higher costs for payors or even the dreaded ‘disintermediation’ of the health insurer’s role. Health plans, such as Aetna, Blue Cross and Blue Shield and others have collaborated with dominant health systems in arrangements ranging from value-based contracts to joint venture to co-branded products in certain product sectors. Nevertheless, these highly touted partnerships remain scatter-shot across the country. Whether they create the ‘rising tide that raises all boats’ is highly debatable.

Many initial risk arrangements are upside-only shared savings to allow providers time to invest and build the infrastructure and skills to transition to upside and downside and eventually capitated risk. However, the conundrum with shared savings arrangements is that as providers become more efficient, the opportunity to share savings erodes. If contracts do not evolve to full capitation from initial shared savings agreements as efficiencies increase, rewards will decline. When that happens, the current costs and ‘hassle factors’ of the care infrastructure overwhelm those future achievable rewards and become unsustainable. For this reason, shared savings contracts must be an articulated starting place intended to shift expeditiously to capitation in both private and public arrangements.

Further, the benefit design must lend itself to capitation. Medicare Advantage, MACRA APMs and Medicaid Managed Care are the federal and federal/state programs that have contributed the most to advancing Value-Based Purchasing arrangements, including ACOs. However, a decline in commercial Health Maintenance Organizations (HMOs) across the country, including in California, eliminates the health product with the most natural framework for provider capitation. Of course, in many parts of the country, the HMO and associated capitation contracting never caught on in the first place.

What this means is that risk-sharing, value-based arrangements have often been constructed on ill-fitting PPO (Preferred Provider Organization) or FFS platforms that tend to advantage payors. Historical

## Factors Influencing Impact of Capitation

- Size of the group of patients at risk
- Patient “risk groups” as defined by diagnoses
- Scope of capitated service
- Provider incentives already in place (both financial and nonfinancial)
- Adequacy of the capitated payments
- Risk-adjusted for disease type and/or severity
- Proportion of practice revenue derived from capitation
- Availability of savings (if any) from cost efficiency for use to improve services

discounted fee-for-service with back-end utilization review (and an often-lengthy claims approval process) affords numerous opportunities to defer or deny payment. Further, some fee-for-service payors derive advantage from opportunities to “free ride” off hospital value-based payment infrastructure investments that reduce utilization across all lines of business.

Moving deliberately—and not immediately including downside risk in contracts—allows providers and payors time to negotiate the delegation of both responsibility and adequate dollars associated with specific services. Providers must understand fully how their contract works in multiple scenarios, favorable and unfavorable. The Division of Financial Responsibility (DOFR) is the most critical underpinning of risk contracting, detailing which party is financially responsible for the purchase of supplies and medications and the costs of provision of services. Only experienced experts should lead negotiations on the DOFR, one familiar with the many nuances of drafting to address issues of adverse contract interpretation by a sophisticated payor.

### III. Data Analytics and Modeling Capabilities

Knowing how to begin taking risk is complex – there is no one-size-fits-all approach. Moving deliberately but not immediately to downside risk in contracts allows providers and payors time to negotiate delegation of responsibility and adequate dollars to make the agreement attractive for both parties. Providers must understand fully how their contract works in multiple scenarios, favorable and unfavorable. Future success lies at the intersection of optimal division of responsibility between payors and providers and the appropriate infrastructure in place. It is vital that leadership understand various revenue and spend impacts at the level of individual physicians, hospitals and other key providers.

A validated forecast of the actual impacts of key initiatives will gain buy-in from stakeholders. A pro forma based on validated claims and cost data is crucial to demonstrating the actual impact of key initiatives. A rigorous funds flow model evaluates the costs, risks and revenues, taking into account the proposed population characteristics, associated cost, savings opportunities and threats to profitability. Funds flow modeling also highlights short-term opportunities to fine-tune current FFS payments to incentivize reductions and utilization. It is critical to model costs based on the population makeup of the proposed risk initiative (commercial versus Medicaid versus Medicare). Additionally, network leakage statistics provide the indicators of gaps in provider access and highlight referral patterns that can bleed finances with out-of-network hospitalizations and specialty care.

Factors influencing the impact of capitation on a health system or physician practice and its patients may include:

- Size of the group of patients at risk
- Patient “risk groups” as defined by diagnoses
- Scope of capitated service
- Provider incentives already in place (both financial and nonfinancial)
- Adequacy of the capitated payments
- Risk-adjusted for disease type and/or severity
- Proportion of practice revenue derived from capitation
- Availability of savings (if any) from cost efficiency for use to improve services

Further, to get the right care to the right people at the right time, actionable data is indispensable to identify where the highest costs of care reside. In all populations, low, medium and high-risk patients require continuous predictive analytics in order to manage risk effectively. Claims and other data sources, such as pharmacy utilization, are essential to provide meaningful performance feedback on these opportunities under value-based contracts. For example, reconciling information by individual patient is a challenge but it is necessary to establish a “bundled” price and to assess physician performance.

However, obtaining robust and timely data from payors remains a challenge, requiring dogged pursuit. Transparency of data and consistency of data submission and reports across providers remains problematic. Health plans and CMS transmit data in different formats with distinct elements and reporting periods. Comprehensive data sets must be accessible and encompass both payor and provider sides of business.

#### **IV. Managed Services Organization (MSO) Competencies**

As risk begins to shift from health plans to providers, many of the functions and services traditionally operated by health plans, such as quality outcomes and provider education, are widely considered more appropriately owned by the health system. Managed services organizations provide a wide range of these administrative and management services to providers through delegation agreements in order to standardize and reduce duplicative services in multi-hospitals. The health system typically owns and operates the MSO as a division of the system.

Available claims or expense data are necessary ingredients in detailed cost modeling to estimate implementation costs, the potential to restructure, scale and redeploy resources and profit and loss estimates. Ultimately, an MSO is an engine for effective population health and success on risk-based contracts.

MSOs enable coordination of employed and community practices to improve accessibility of primary and specialty care. Additionally, they provide centralized reporting for physicians to monitor their performance on quality metrics, total cost of care and efficiency measures that are more focused and effective than health plans alone can offer. This reporting capability allows providers to track their progress in real time and compare their performance relative to other providers in the region. The governance, structure and functionality of an MSO is unique to the health system it serves. Typical MSO services group into three main categories with multiple subservices within each group: strategic and administrative services, clinical or operational program design and clinical decision support, and technology enablement services. Due to the variety of MSO services, it is critical to understand the network need, scope and costs of services prior to building or purchasing MSO services.

MSOs are built or may evolve from existing health systems or practices already providing many standard services found in these categories. The decision to build an MSO can be part of a larger strategy to gain market share or increase revenue and/or fill a need for central infrastructure to manage administrative services or population health. Available claims or expense data are necessary ingredients in detailed cost modeling to estimate implementation costs, the potential to restructure, scale and redeploy resources and profit and loss estimates. Ultimately, an MSO is an engine for effective population health and success on risk-based contracts.

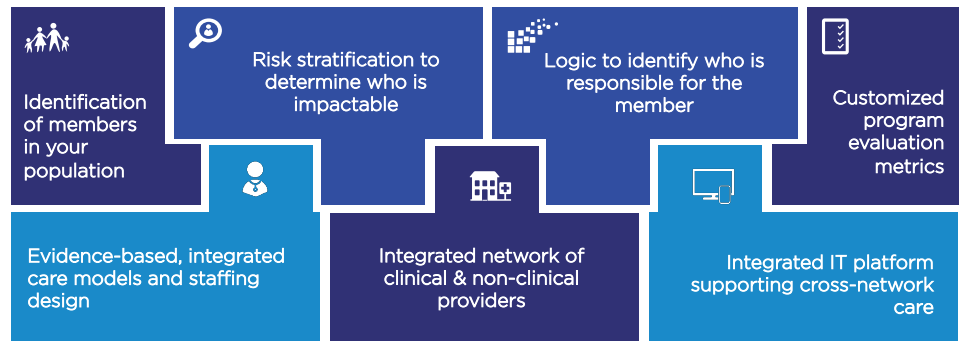
## V. Care Management and Coordination Model

Success under risk contracts and capitation requires a defined care management and care coordination model that accomplishes the following:

- **Demonstration of improved clinical performance.** Success is demonstrated by improved disease management measures, patient engagement in care, reduced hospitalizations, emergency room visits and avoidable readmissions.
- **Moves moderate-risk patients from costly episodic care.** Success is demonstrated by avoiding a patient's movement into the high-risk category by becoming self-sufficient in the management of their care.
- **Maintains a healthy status in those patients identified as low-risk.** A strong primary care system is required, evidenced by pairing patients with a primary care provider (PCP), participation in preventive screenings and avoiding unnecessary hospitalizations and emergency department visits.

- **Improve ambulatory care networks outside the hospital.** Success requires collaboration with independent physician associations (IPAs) or ancillary providers to build wrap-around support services such as care navigation centers, care coordination, post-acute relationships/affiliations including home health services and wellness initiatives.

## KEY COMPONENTS OF FUTURE STATE CARE MANAGEMENT



Treating an illness is often far more expensive than providing the preventive care that would deter its onset. In response, health care providers have developed programs aimed at addressing patient care needs before those become critical. The programs vary widely in structure and style, but all have the goal of improving health outcomes while decreasing overall cost. When the term care management is used, it generally describes the overarching structure of care<sup>5</sup>.

Care management models often fail to address factors outside of the health care system that impact an individual’s overall health status. It is thus imperative to developing long-term solutions for population health management. While care teams may evaluate external factors, they often function in silos within the health care setting, with little information on how to engage the resources available such as social workers or community based organizations. Care coordination involves the deliberate organization of patient care activities and the sharing of robust, actionable information across the continuum of care to achieve optimal patient outcomes and includes all appropriate providers and resources needed.

<sup>5</sup> *The New England Journal of Medicine*, Bodenheimer and Berry-Millett, Sept. 30, 2009

A robust approach to care coordination should consider:

### **Care Coordination Across the Full Care Continuum**

All providers must communicate and work together as a patient moves across care settings. This includes nonclinical providers such as community-based organizations that address social and environmental factors that influence a patient's ability to thrive.

### **Care Coordination Enabled by Information Exchange**

A robust information technology (IT) infrastructure. Integration of data and exchange is essential to ensure that providers are able to access information. Selection of the appropriate tool for your organization is essential as providers will never incorporate a care management technology that is not relatively easy to learn and utilize in the care visit.

### **Patient Enrollment and Outreach**

A consistent, formalized approach to preventing and managing disease has always been a central tenet of supporting a patient's health and wellness. Care coordination programs should establish this approach, by proactively ensuring that they have the means to not only enroll patients in care coordination but to consistently engage with patients at any point across the continuum of care.

### **Provider Engagement**

To successfully execute on care coordination programs, inpatient, primary and specialty providers must be engaged. Developing the necessary level of engagement means involving the providers in all stages of program development. Engaged providers are well versed in the composition of their patient populations, the programs available to the patients, how to document patient care so that systems flag care coordination opportunities and how to encourage or reinforce participation in programs during patient encounters. Achieving this level of engagement may require additional training as well as feedback and support from the care management team.

### **Care Coordination Infrastructure**

The foundational elements, as well as additional and advanced capabilities in care coordination, require infrastructure to be successful. Although not all organizations are prepared to make significant IT investments, an electronic medical record that supports discrete data fields and has native reporting capabilities is a necessary baseline system. Such a system will allow the organization to identify patients before migrating them to a manual or third party system to manage program enrollment and subsequent care management workflows. A more robust infrastructure will consist of a system that provides an

**A strong PMO team can aid an organization through the navigation of initiating change in a complex environment where patient-care, financing and workforce are all critical to operations.**

analytics platform that supports an end-user defined and applied risk stratification methodology. Additionally, systems that are more robust will support the end-to-end care coordination workflow, including alerts and triggers for patient enrollment in programs, task management, reporting at the patient and program level and program “graduation” indicators.

### **Social Determinants of Health**

Addressing patient health from a broader perspective includes addressing the social determinants that influence health outcomes, and engaging patients as a collaborative partner in their own wellness. Health systems across the nation are beginning to recognize this dynamic interplay between an individual’s social needs, healthy lifestyles and behaviors, and their corresponding health status. Frequently, health systems cite unmet needs related to behavioral health, substance abuse, housing, access to food and unemployment as significant contributors to poor outcomes and cost. This holistic approach to patient care has been difficult for health systems to execute on due to the lack of aligned incentives and reimbursement models.

### **Workforce Planning**

The final foundational element of a care coordination strategy is the development of a workforce. The title “care coordinator” has become more common in the changing health care landscape; however, each organization must define the appropriate level of licensure to meet the needs of the patient population, as well as create a roadmap to achieve a care coordination team with clear workflows, roles and responsibilities for care coordination. Although some systems are more successful in seeing the clinical and financial benefits across patient populations, many programs only see improvement in outcomes for severely ill patients at high risk for hospitalization or re-admission.

## **VI. Project Management Office Capabilities**

A robust project management office (PMO) is essential to move a system through the complexities of a phased approach towards global capitation. A strong PMO team can aid an organization through the navigation of initiating change in a complex environment where patient-care, financing and workforce are all critical to operations. Many health systems have utilized PMOs in an effort to improve the execution of strategic initiatives as they face intense competitive pressures. There is widespread consensus that PMOs can help organizations deliver their projects on time and on budget. The PMO should operate independently from the day-to-day management responsibilities of the system to define the project, train key managers, manage information flow, allocate resources, schedule projects and track budgets.

Establishing an effective project management team keeps focus on timelines, ensures a structure for accountability, and engages key influencers in the system. Key influencers are those individuals who routinely get things done, who have the respect and buy-in from essential staff. When a PMO engages these and other key leaders throughout the system from the start, establishing relationships, earning trust and building credibility will ultimately lead to smoother approvals and consensus. It is important for the PMO to understand the system's readiness and pace at which it can make change happen and to find the right balance of new initiatives for the system's executive and physician leaders to move toward their future state. For these reasons, project leadership capabilities must be robust and integrated into the organization.

## VII. Understanding of Value-Based Competencies

Perhaps the most critical component of a shift towards value-based payment is a thorough understanding of the various “transition states” it will take to reach a strategic goal for risk-based arrangements. Most health systems will gradually transition through several stages of risk, and will likely have contracts in different stages of risk at any one time. For instance, in alignment with federal and state programs, Medicare Advantage and Medicaid contracts are likely to have higher risk imposed than their commercial contracts. Health care leaders must understand the various negotiation points tied to varying levels of risk in order to execute effective contracts. It is also imperative for physicians to understand the stages at which their risk shifts from being upside-only with less to lose, to including highly consequential downside risk. At this point, providers should be fully prepared to succeed in a risk-based arrangement. The table provided below may serve as a guide for navigating the various levels of risk that a health system and/or provider may encounter on the transition into the value-based market.

### LOW RISK

- Use clinical guidelines
- Refer to preferred specialists, facilities, ancillary services
- Develop bonus structure for providers
- Work on quality metrics
- Develop CM team to manage episodic care
- Report on quality measures, patient attribution, and cost of care

Examples: MSSP Tracks 1-3; CPC+ Tracks 1-2



## MODERATE RISK

- Develop strategies to manage high cost items
- Develop a disease registry
- Develop care management team work flows to manage late stages of disease
- Report on disease-specific cost of care
- Develop education around proper documentation and coding
- Develop shared saving structure for other key stakeholders

**Examples: Next Gen ACO-FFS; Medicare Advantage-FFS; Advanced Payment ACO; Next Gen ACO - all inclusive; Bundled payments**

## HIGH RISK

- Determine DOFR after rigorous cost modeling
- Contract directly with facility, ancillary, durable medical equipment (DME), provider services
- Establish tiered network of providers, facilities, services
- Manage utilization process-authorizations, denials, appeals
- Develop repatriation process for out-of-network transfers
- Utilize predictive models for care management team to manage all levels of disease state
- Develop claims process with audits of claims and payments
- Add stop-loss insurance
- Develop quality, appropriate utilization, citizenship dashboards for provider, facility, ancillary services
- Develop bonus structure based on the dashboard

**Examples: Medicare Advantage - capitation with Professional risk and/or Institutional risk**

## HIGHEST RISK

- Manage credentialing process
- Develop value-based contracting
- Develop process to accept Part D pharmacy risk
- Obtain state licensure as appropriate, (e.g., limited Knox-Keene license)

**Examples: Global Risk or Provider-Sponsored Plan**

Central to the transition to risk is acknowledging and developing solutions for management services, population health, data analytics and care management as these services are foundational for the ability to provide the whole-person, patient-centered approach that is the crux of risk-based payments.

## CONCLUSION

Health care must become an integrated experience that will encompass services from the hospital setting, ambulatory clinics, social services, community organizations and beyond. No overnight solution or “easy-fix” will prepare a health system to succeed sustainably in the world of capitated payments. The transition to value-based care is a complex shift in reimbursement and a foundational shift in how health care is delivered. Patients can expect to spend less time in the hospital and an improved experience that is delivered across multiple settings. Providers can expect to benefit from shared savings tied to performance improvements, gain more control over how their dollars are spent, and realize increased administrative and technological support as MSOs are built.

For this model to be successful in delivering care, improving the patient experience and sharing risk between the health plans and providers, there must be a significant investment made up front. While substantial capital investments such as building an MSO may bring quick wins, there are initial steps that are arguably of equal importance for a fraction of the cost. First, in order for any transformative initiative to succeed it is imperative to have complete buy-in from all stakeholders. Health systems must understand that there is success in numbers and fragmented leadership or competing priorities have the ability to derail strategic decisions and implementation if not approached as a united front. Second, once buy-in is achieved from key stakeholders, this education and strategy must waterfall down to providers, administrative support, and care managers – the full continuum of care must understand and support the decision to choose value over volume in order to succeed. Finally, a comprehensive plan must be developed that is realistic, and addresses the necessary infrastructure to support achievement of strategic goals. As discussed in detail above, central to this plan is acknowledging and developing solutions for management services, population health, data analytics and care management as these services are foundational for the ability to provide the whole-person, patient-centered approach that is the crux of risk-based payments.

As value-based payments are rapidly gaining traction in the market in recent years, there are many models for health systems to consider when transforming their organization. The federal and state governments are an excellent source of such models. From MACRA to ACOs, Medicaid and Medicare programs are leading the charge on transition to value-based arrangements and physician incentives. These programs may serve as training wheels for organizations wishing to take steps towards a capitated model and can be used to guide the development of arrangements in different lines of business. Additionally, several independent organizations may serve as models for success in different

areas such as Montefiore’s ACO or Geisinger Health System’s physician-led success in population health. Models such as an ACO or IPA offer the infrastructure that is geared towards success in this type of environment and can be replicated across many settings in the market.

The continued underlying government budget “squeeze,” as well as the broad range of services needed by patients for care in their community create continued right conditions for value-based care. The shifting dynamics of federal and state health policy and an understanding of the need to emphasize volume over value is a notion that will not be leaving the market anytime soon – despite the uncertainty in health care policy.

## ABOUT THE AUTHORS



### Cindy Ehnes

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Cindy Ehnes, Executive Vice President, is an attorney licensed in California and Colorado who served as Gov. Schwarzenegger’s Director of the CA Department of Managed Health Care for seven years.

As Director, overseeing health insurance services for 21 million Californians, Mrs. Ehnes regulated the operations, clinical and financial performance for 105 health plans and 220 delegated medical groups. She launched the quality improvement program, the Right Care Initiative, involving 10 health plans and more than 50 delegated medical groups and IPAs, a ten-year program focused on improving HEDIS scores for several million HMO enrollees.

She also provided leadership to the California Quality Care Collaborative, leading initiatives to improve standards of care and EMR adoption for medical groups in the Inland Empire. As a 12-year board member of the Integrated Healthcare Association, Mrs. Ehnes has assisted in developing pay-for-performance programs and total cost of care measurement for California Medicaid managed care organizations.

In her role in consulting, Mrs. Ehnes brings her deep expertise in “what works and what doesn’t work” in regulatory, financial, risk contracting and operational mechanics to health plans and delegated providers. Cindy also provides interim health plan CEO capabilities, executive coaching, compliance reviews, as well as strategic consulting for health plans and medical groups.

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## Allen Miller

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Allen Miller is the CEO of COPE Health Solutions. He has over 20 years of experience providing strategic planning, business development, managed care/value based payment, network development and care management consulting services. Allen has lead assessments, planning, development and implementation of integrated delivery networks, Independent Physician Associations and Accountable Care Organizations throughout the US. Under Allen's leadership, COPE Health Solutions has become the pre-eminent go-to solutions company for health systems and health plans looking to take on a leadership role in population health for all lines of business.

COPE Health Solutions complements its consulting services with the largest health care talent pipeline in the country, known as COPE Health Scholars providing a unique health care training experience to over 4500 students annually in over 20 hospital and ambulatory sites throughout California and Washington State. Allen and his team are consistently on the cutting edge of work to implement new health care policy, including federal demonstrations and state waivers across the country, by partnering with providers and payers to transform fragmented, acute care "un-systems" of delivery into coordinated systems of care focused on improving the health of populations, while enhancing efficiency and aligning financial incentives.

A graduate of UCLA, both for his Bachelors of Science and his Masters of Public Health in Health Services, Mr. Miller also completed an intensive on International Business at Oxford University in England.

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## ABOUT COPE HEALTH SOLUTIONS

COPE Health Solutions partners with our clients to help them achieve visionary, market relevant health solutions. We have deep expertise in all aspects of strategy, clinical integration, population health management, managed care solutions, financial modeling, care coordination, behavioral health integration, CMS demonstrations, technology assessment and implementation and workforce development. Our firm is known for working hand-in-hand with our clients on successful large-scale implementations of managed care and population health management strategies. We are the partner of choice for providers and payors across the United States who are committed to success in the evolving value-based payment environment and developing the diverse talent needed to fill future health care roles.

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