Population Health 360
A COMPREHENSIVE LOOK

Round Table Discussion Notes

Financial Perspective on Value-Based Payments

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Bluethorn 7

Round Table Facilitators

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Topic/Question	Groups Comments/Discussion
Background	• Our organization looks at risk in 4 buckets: capitation, bundled payments, care transformation (admission penalties, infections) then ACOs and CINs. In early 90s, company went into capitation full fledged but didn't succeed. It is interesting to see the market going back into it 20-30 years later. Back then, we went to contract with secure horizon for Medicare and lost 2M in one year and discovered very quickly that you cannot have a very small pool and be able to absorb risk because one case can wipe you. The reinsurance industry wasn't as lean, they charged a lot. Learned that key to success was the need to know the data, have infrastructure in place and not be wiped out with one bad case. • Today, they have 50K capitated lives, half are employed physicians and the other with independents. • Can have 200K lives at risk. The business is there but you have to know the data and know what to take and what not to take.
Infrastructure: takes tools and skills to successfully manage risk	• IPA as a delegated model. To manage capitation, a full time care manager was hired to look at capitated patients. This person calls the IPA to find the members and reroute them in-network.
Approach 40+ years worth of experience in managing risk?	• In 1979 our CEO asked the plan to pay fixed money and he can manage the dollar himself. He then went on to turn it into a clinic, hired all the right people and built a network doing that. • Don't delegate, do it yourself, look at internal benchmark. He built IT systems internally, policies and procedures and are looking to take that to market • In Palm Springs, FFS was still fully fledged but they understood that if the financial partnership is more robust, they can do better and be effective for patients. Whatever was least costly, regardless of whether within the four walls of the hospitals, it was the right place to go. Has 9 urgent care centers in Coachella valley as close as across the street from the hospital. Part of the journey is for everyone to have the view of the future. • New York market has a lot of inertia, rhetoric around collaboration. It is also heavily fortified union market. A lot of drag around unionized

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	labor. Is a hospital still measuring bed days, length of stay, traditional hospital KPIs? All that may not be how revenue is generated, what the cultural shift around what everyone sees? • Still measures those metrics but it helps identify who gets accepted in as compared to FFS business. • You still want your hospital full but at a reasonable utilization coefficient, as a lower % of a higher volume. Hospital is not the profit center. More and more hospitals are going to operators to partner with them as physician aggregators. They're a primary choice for health plans because they can do it faster, cheaper, better. Profitability is at the risk pool level. The plan offloads its risk, and that's the budget the multiple parties begin to work. The world needs to change: in order to be successful. • To further elaborate on FQHC's role, capitation breeds more membership not more utilization. You buy more physician practices, you take on the capacity and now that you have the top line revenue. A provider with more lives has more leverage over the health plan. • FQHC pays the hospital on a cost basis – year end reconciliation • Takes capitation on all LOBs for liquidity reasons, doesn't want rev cycle management. Don't get every dollar back in cost but there's a ceiling and doesn't get most of that cost back. FQHCs should feel comfortable because they have automatic reinsurance without paying for it. Question from hospital: is FQHC better at high cost high acuity patients than community-based docs. Its probably true 9 out of 10 times. • Sophisticated health system should be in FQHC business? • Cannot be in FQHC business legally. Primary care pool needs to be north of 10% and the hospitals struggle with that. • Our organization has to subsidize GME regularly but the FQHC doesn't need to do that as much because of higher rates. • Our organization has 120K Medicaid lives. Taking that annual per capita spend somewhere $5000 range. We can bring a billion dollars in proposition you'll make the FQHCs angry. The opportunity is there but takes progressive leadership at the hospital level.
When you go to risk agreement, do you assume providers will make money on the deal?	• We work with IPAs with their physicians and we make distributions quite significantly (last one was $3M with an IPA). • If, as a hospital partner you take it upon yourself, you can run utilization, do you take it upon yourself to estimate whether the end result will be ok for them? There's a whole lot of discussion about the draw rates, risk pool and incentives in the risk pool.
Policy changes: CMMI is allowing direct capitated contracting with individual PCPs. There's an LOI process with some comments and various levels of risk a PCP group can undertake. The goal is to take the health plans and hospitals down a notch.	• There are various levels, haven't worked out how deep the cap can go but doesn't hurt the dialogue • The fed regulation doesn't allow direct contracting with an FQHC tax ID • We are in CHIPA IPA with 250K lives

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	• We have no footprint in VBP. Want to move in this direction beacuse they're in discussion with us to understand how they can move in this direction. • Have significant market share in certain technologies but not all of them. • We have seen a pioneer on current run rates and environments. What technologies can be deployed at the home that may help utilization for various ancillary services. How can we keep patient connectivity with such a degree that alexa is monitoring the health. • In the short term will raise costs astronomically. It used to be that they were charging 1-2 dollars per member per month. Other products have a low as $.25 pmpm. The data scientists are the value proposition.
Action Items/Next Steps	• Know your data, have a management infrastructure you can take on