Accessing More of the Health Premium:

The Transition into Population Health and Value-based Payment*

By Cindy Ehnes and Allen Miller

Health systems and providers must strengthen their ability to manage population health and costs through risk-based contracting. A shift to global financial risk through capitated arrangements between managed care organizations (MCOs) and providers is critical. Despite the ever-shifting winds of federal and state health policy, traditional fee-for-service (FFS) 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 as 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. Macroeconomic 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. Although 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.

ADDRESSING PROVIDER SKEPTICISM OF RISK-BASED CONTRACTS

Health system leaders diverge greatly in their attitudes toward taking on additional financial risk. While the Health Care Payment Learning & Action Network (LAN) reported in October 2017 that almost 30 percent of all healthcare payments in the United States are linked to alternative payment models,[1] clearly most health systems still rely largely on the fee-for-service model. A 2017 survey of physician groups by the American Medical Group Association found that, while "it is reasonable to say the move to value is prevalent among a large majority of survey respondents," significant impediments remain in transitioning to value. The most critical obstacles cited involve lack of access to value-based contracts, lack of access to administrative claims data, health plan data that is not actionable, and the need to develop and finance the infrastructure necessary to take risk. While physicians and health systems understand the rationale to move to risk-based arrangements and away from FFS payments, there remain deep undercurrents of doubt and concern. Critical to developing successful risk contracts is acknowledging and addressing this deep provider skepticism and negative experience.

A broad spectrum in provider risk models is evident. At one end are systems skeptical about 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

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Medicare Shared Savings Programs, next generation accountable care organizations (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.

Transitioning to 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 to a successful, all-payor, value-based environment is rooted in seven essential characteristics that enable health systems to align payment with high-quality care.

ALIGNING PAYMENT WITH HIGH-QUALITY CARE: SEVEN ESSENTIAL CHARACTERISTICS

I. PHASED ROADMAP FOR SUCCESS

Moving into global risk is critical for longer-term sustainability; however, global risk is perilous if approached with a muddled strategy. Health systems must develop a clear, phased roadmap to global risk. This roadmap 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 require all hospitals undertake a transformation to participate in value-based payment arrangement. Hospitals vary considerably 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 goal of the strategy must be sustainable success in managing the global risk dollar for defined populations.

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 rewards aggressive waste reduction and improved quality of care. Aligning disparate payment streams from multiple payors concentrates 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 2017 Modern Healthcare Hospital Systems Survey 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.

Although negotiating a risk contract is markedly different from negotiating an 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 that health plans and providers are willing to enter into depend on traditional supply-and-demand analysis of the local market. However, the choice also depends on the underlying concerns that each player has about value-based arrangements, often related to readiness from an administrative, population health management and network adequacy perspective, further emphasizing the need to reinvest quickly in infrastructure.

III. DATA ANALYTICS AND MODELING CAPABILITIES

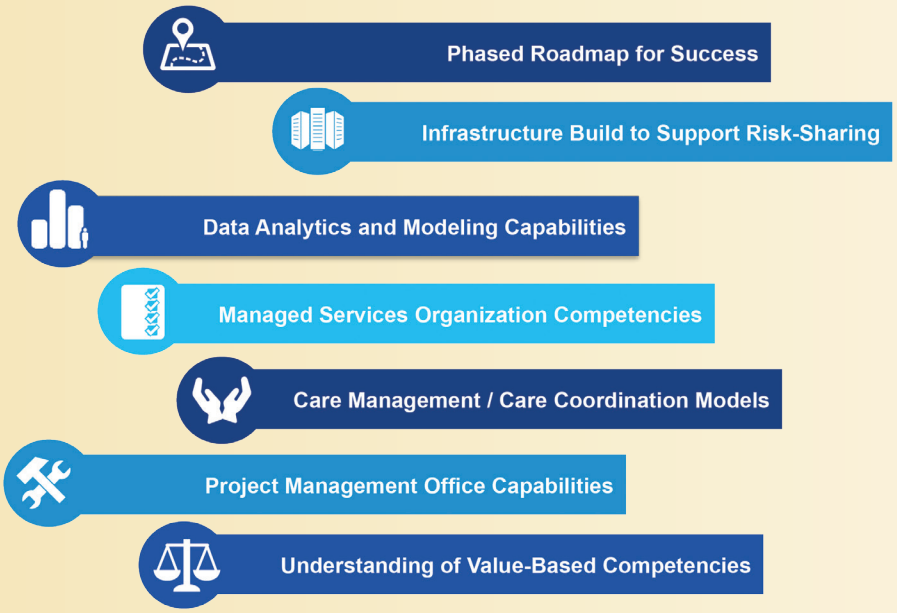
Knowing how to begin taking risk is complex. There is no one-size-fits-all approach. Moving deliberately but not immediately to downside risk in contracts allows providers and payors time to negotiate delegation of responsibility and adequate dollars to make the agreement attractive for both parties.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

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

- 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

ALIGNING PAYMENT WITH HIGH QUALITY CARE:

7 ESSENTIAL CHARACTERISTICS



- Proportion of practice revenue derived from capitation
- Availability of savings (if any) from cost efficiency for use to improve services

IV. MANAGED SERVICES ORGANIZATION COMPETENCIES

As risk shifts 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 (MSOs) 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.

With MSOs, employed and community practices are coordinated to improve the accessibility of primary and specialty care. Additionally, MSOs 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. 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 are unique to the health system the organization serves. Typical MSO services are grouped 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, understanding the network need, scope and costs of services before building or purchasing MSO services is critical.

V. CARE MANAGEMENT AND COORDINATION MODEL

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

- Demonstrates improved clinical performance. Success is demonstrated by improved disease management measures, patient engagement in care, reduced hospitalizations, decreased emergency room visits and avoidable readmissions.
- Moves moderate risk patients from costly episodic care. Success is demonstrated by avoiding a patient moving into the high-risk category by becoming self-sufficient in managing his or her 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), participating in preventive screenings and avoiding unnecessary hospitalizations and emergency department visits.
- Improves 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 and post-acute relationships and affiliations, including home health services and wellness initiatives.

VI. PROJECT MANAGEMENT OFFICE CAPABILITIES

A robust project management office (PMO) is essential to move a system through the complexities of a phased approach to global capitation. A strong PMO team can aid an organization in navigating change in a complex environment where patient care, financing and the workforce are all critical to operations. Many health systems have utilized PMOs to execute strategic initiatives as the systems 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.

VII. UNDERSTANDING OF VALUE-BASED COMPETENCIES

Perhaps the most critical component of a shift to 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 specific time. For instance, in alignment with federal and state programs, Medicare Advantage and Medicaid contracts are likely to have more risk imposed than commercial contracts. Healthcare leaders must understand the various negotiation points tied to varying levels of risk in order to execute effective contracts.

It is also imperative that physicians 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.

CONCLUSION

Healthcare must become an integrated experience that encompasses 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 healthcare is delivered. Patients can expect to spend less time in the hospital and to have an improved experience that is delivered across multiple settings. Providers can expect to benefit from shared savings tied to performance improvements, to gain more control over how their dollars are spent and to realize the increased administrative and technological support of MSOs.

For this model to be successful in delivering care, improving the patient experience and sharing risk between the health plans and providers, a significant investment must be made up front. Although substantial capital investments (such as building an MSO) may bring quick wins, there are initial steps that are arguably equally important for a fraction of the cost.

First, for any transformative initiative to succeed, complete buy-in from all stakeholders is imperative. Health systems must understand that there is success in numbers, and fragmented leadership or competing priorities can derail strategic decisions and implementation if not approached as a united front.

Second, once buy-in from key stakeholders is achieved, this education and strategy must waterfall down to providers, administrative support and care managers. To succeed, the full continuum of care providers must understand and support the decision to choose value over volume.

Finally, a comprehensive plan must be realistic and address the necessary infrastructure to support the achievement of strategic goals. Central to this plan is acknowledging and developing solutions for management services, population health, data analytics and care management as these services are the basis for providing the whole-person, patient-centered approach that is the crux of risk-based payments.

As value-based payments have rapidly gained 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 the Medicare Access and CHIP Reauthorization Act (MACRA) to ACOs, Medicaid and Medicare programs are leading the charge in the transition to value-based arrangements and physician incentives. These programs may serve as training wheels for organizations wishing to take steps toward a capitated model and can 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.

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

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1. Health Care Payment Learning & Action Network. (2017, October 30). *Measuring progress: Adoption of alternative payment models in commercial, M*edicaid, Medicare Advantage, and Fee-for-Service Medicare Programs report.
2. Speed, J. D., & Graziano, A. (2017, December). Taking risk, 3.0: Medical groups are moving to risk … Is anyone else? *White Paper: Third Annual Survey on Taking Risk*. http://www.amga.org/wcm/PI/Risk/MA/EI/wpTakingRisk3.pdf.