

Optimizing an ACO Network to Succeed in Downside Risk Arrangements

Recent announcements from the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) indicate that the current administration sees cost savings opportunities when providers, including hospitals, take downside financial risk. HHS Secretary Alex Azar commented, "There is no turning back to an unsustainable system that pays for procedures rather than value..." and CMS Administrator Seema Verma remarked, "Two-sided ACOs have shown significant savings to the Medicare program while advancing quality. ACOs [that] have yet to move to any downside risk...are actually increasing Medicare spending."^{1,2} As a result, physician groups, hospitals and health systems are contemplating the many different options for taking and succeeding in downside risk, from the Track 1+ Medicare Shared Savings Program (MSSP) ACO, to entering into various types of health plan capitation contracts for Medicare Advantage and other lines of business.



Carla D'Angelo
Vice President

Preparing for downside risk in any arrangement requires a strong, high-quality network of providers to care for the defined member population. Once a high-performing network is in place, ensuring the right incentives for all practitioners is crucial to help achieve the desired quality, experience and financial outcomes. ACOs that started in the MSSP Track 1 in 2012 or 2013 may be at this juncture if they decide to move to a risk-based model, a decision that gives them until 2019 to align their networks. Even if your organization is not tied to a particular timeline, you should consider the following four questions about optimizing your network to succeed in a downside risk arrangement.

How do I identify the right providers for my network?

The first step is to assess your current provider network, with regard to the needs of your defined member population, and identify key gaps. At the organizational level, develop a provider chase list based on the gaps between the needs of the member population and your organization's current service offerings. A "population needs assessment" (or community needs assessment) is a starting point to understand how your organization can address endemic diseases or chronic conditions. It will also help identify key demographic insights that can be used to ensure your network of providers can effectively address the unique needs of your market. Creating a chase list of target providers to include in your network means understanding the providers who serve in your market. Does your current network cover all of the identified needs of your member population? How are you planning to address any service gaps?

How are your network providers performing on quality and cost targets?

Next, consider your market - the supply and demand of both the patient population as well as providers. An aging population indicates a growing Medicare population, and prevalence of chronic conditions, behavioral health or substance use disorders may indicate a need for increased capacity and coordination/integration of behavioral health, medical care and community support services. Meanwhile, competition with other networks for specific providers may impact physician compensation and conflicting loyalty to one network or another. A vital activity is going out and speaking to community physicians and understanding what they want and need. Simply asking the question will help you focus your strategy and will also lead to an increased likelihood of higher provider satisfaction. There is no one-size fits all approach to developing a network, but market trends will inform the boundaries, especially provider rates and service offerings, which you may begin to draw around your target providers.

Fine tune your target provider list by gathering and reviewing data to identify the highest value providers, measured by cost of care and quality of care measures. Compare providers across the same service line and target those who provide the right care for the lowest cost while achieving the best outcomes. Leverage clinical and claims data to make a comprehensive assessment on performance and use the data to help set achievable and reasonable targets. A critical success factor in performing well in downside risk models is

"The right providers will look to partner with organizations that have the right culture of clinical excellence; in other words, those that share the goal of the Institute for Healthcare Improvement's Quadruple Aim - improved population health, patient experience, provider experience and reduced costs."

regularly reviewing and sharing claims data with providers to promote transparency and behavior change.

How do I determine my network's value proposition?

After identifying the right providers, you will need to define the benefits of your organization, considering your providers will bear the risk for delivering the right care to their attributed members. Before you can recruit these physicians, you'll want to define a value proposition that can be easily understood by all stakeholders including your board of directors. A defined value proposition will enable your network to maintain and attract high-performing practitioners, even in a competitive market. How do you manage quality and cost? Success in a downside risk arrangement hinges upon an organization's infrastructure. The right providers will look for operational value - an organization that can get them the right information at the right time. Their ability to make decisions that impact patient experience, clinical outcomes, network utilization, and financial performance is dependent on access and integration of clinical and claims data.

Providers will want to access their members' data whether they are seeing a patient in the hospital or at a clinic five miles away. Beyond providing information at their fingertips, providers will look for reduced administrative burden, access to care coordination resources, and alignment of quality incentives. When setting budgets and strategic goals for the year, an important consideration to make is the level of investment you are willing to make for your network. Will you provide access to a common electronic health record (EHR) for all network providers? How are providers going to receive monthly reports on performance? Has provider productivity improved over time and how has technology enabled this?

Providers will seek financial value, in the form of access to a broader portfolio of payor contracts, shared savings opportunities and bonus incentives. Finally, they will seek value for their attributed members; in particular, increased access to primary and specialty care, outpatient services, care transition services, integrated care delivery, and a centralized care coordination model.

It almost goes without saying that the right providers will look to partner with organizations that have the right culture of clinical excellence; in other words, those that share the goal of the Institute for Healthcare Improvement's (IHI) Quadruple Aim - improved population health, patient experience, provider experience and reduced costs. For that reason, your organization's mission and vision statement will indicate your dedication to population health and anchor your value proposition. Use this mission statement and value proposition to bring in the best set of providers for your member population.

How do I recruit providers into my network?

Provider affiliation is more competitive than ever and there are no signs this trend will slow. Signing the right providers means having an effective provider recruitment strategy - one that includes significant support from your board. This includes a robust communication strategy to first educate your existing providers, board and internal staff on the goals of your organization and the value you bring to members and payors. To do this, identify a clinical executive champion to lead the way and model desired behaviors. Your board will need education and access to dashboards and reports so you can gain their buy-in and work collaboratively on the path to downside risk. In all materials distributed both internally and externally, highlighting the "What's in it for me?" will have a profound impact on every discussion.

Once your "board is on board" and your clinical champion is identified, it is time to assemble a provider recruitment team. Prepare a set of deal points in advance for your recruitment team, which will delineate what is negotiable -such as compensation, benefits package, and student loan repayment -from what is non-negotiable, such as provider accountability to clinical guidelines and network referral guidelines. Seek the assistance of your board of directors in the recruitment process - providers want to know they have support and consensus at all levels of an organization and this is a great way to commence the relationship. Outline the financial incentives that will be included within your network and have that discussion as soon as possible with your providers.

How do I incentivize my providers?

Your provider incentive structure will be a key selling point to your recruitment strategy so thoroughly understanding what you are willing to give must happen right away. Once you have recruited and contracted with your target providers, the next consideration is to develop and maintain strong loyalty. As with your network's value proposition, incentives are two-fold: financial and non-financial. Some of your target providers may be transitioning from fee-for-service (FFS) or upside-only shared savings arrangements, which will require attention to the key terms of your incentive package and highlighting of the benefits of the fee-for-service terms negotiated as a part of a potential risk deal. Alignment of financial incentives to at-risk quality metrics is key for a downside risk arrangement. Further prioritization of clinical and operational guidelines may provide some targets for alignment bonus incentives, such as referring to high performing sub-networks or following up with members within 48 hours of discharge.

Ensuring that your providers become engaged with your network will ensure success in achieving the same goals. It will be important to create "stickiness" for members to their providers in order to help coordinate and manage care. Engage your providers by empowering them to be leaders; encourage several clinical champions to demonstrate the change and give them the tools and resources to be successful. Establish a foundational base of knowledge about value-based care, quality, and risk sharing across the network, from physician leaders to technicians. By creating this culture of excellence, you are closer to achieving high-reliability, which facilitates efficiency and predictability for your providers to do their job well.

Empower your providers further with transparency into performance metrics and outcomes relative to their peers within the network as well as nationally. Data drives actions and no physician wants to be at the bottom of the rankings. Sharing performance transparently will ignite discussion and will highlight both high and lower performing providers. Consider offering your high-performing providers incentives to help your lower performing providers through education and best practice sharing.

Next Steps

Armed with empowered providers who share the same goal of the Quadruple Aim, drive towards high-performance by gathering and analyzing your network's performance data. Conduct frequent analysis of utilization and quality metrics, and use these reports to practice continuous quality improvement. Engage your clinical champions and board of directors in helping to demonstrate a culture of risk-taking and innovating. Regularly survey your patients and providers to understand the high and low points and use that information to enhance your network and further prepare you for downside risk. Your network providers will follow suit in this charge of optimizing quality and cost. Taking downside risk doesn't have to be "risky" – plan well, measure regularly and be nimble with making network changes and your organization can improve profit margin and enhance the quality of care.

Endnotes

¹ Alex Azar. Value-Based Transformation of America's Healthcare System (America's Health Insurance Plans, Washington, D.C., March 8, 2018)

² Seema Verma. Remarks by CMS Administrator Seema Verma at the American Hospital Association Annual Membership Meeting (American Hospital Association Annual Membership Meeting, Washington, D.C., May 7, 2018).

COPE Health Solutions is a national leader in helping health care organizations succeed amid complexity and uncertainty

For more information, please contact **Carla D'Angelo, Vice President, COPE Health Solutions** at cdangelo@copehealthsolutions.com or call **(213) 259-0245**.