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FEE-FOR-SERVICE TO VALUE-BASED PAYMENT TRANSFORMATION PART 3: BEARING FINANCIAL RISK IN A CHANGING LANDSCAPE: ARE YOU READY? PART A

Introduction

This article is part of a series about value-based payments and their application in the healthcare landscape. This is the third article in the series.

Ideally, value-based payment (VBP) arrangements are designed to financially reward physicians, hospitals, and health systems for achieving positive health outcomes while simultaneously decreasing or, at minimum, maintaining costs. In this installment of our value-based payment series, we will look at various characteristics of evaluation readiness to move away from traditional fee-for-service (FFS) payments and toward an alternative payment mechanism or some risk-bearing arrangement(s). In Part 2, we outlined several different approaches to risk-based payments, from low risk to high risk. We believe organizational readiness characteristics fall into several domains, including but not limited to these six:

- Clinical Care Model and Provider Culture
- Care Management Programs
- Provider Network Makeup
- Previous Experience with VBP and/or Bearing Financial Risk
- Administrative and Contracting Infrastructure
- Financial Standing and Capital Investment Capacity

In this article, we will outline key considerations within the first three of these broad domains, including readiness indicators and characteristics of "ready" organizations. In our next installment, we will look at considerations for the last three.

Clinical Care Delivery Model and Provider Culture

Central to success in any risk-bearing payment arrangement and/or VBP program is clinical care providers' ability to appropriately manage healthcare services utilization, potentially resulting in decreasing total cost of care for a defined population. We believe this is most commonly achieved through improving the overall health of the population, including managing chronic diseases and increasing access to (and appropriate use of) primary care services. Very commonly, process and clinical outcome metrics and measures are used to track population health. Positive changes in overall population health should result in favorable financial measures, such as fewer admissions per thousand members and generate lower cost of care. In order to move metrics and measures in positive favorable directions, physician/provider culture and willingness to change care delivery models are paramount.

Physicians/providers are often offered financial incentives (e.g., bonuses) to improve key performance indicators (KPIs), but are not concurrently provided care delivery models to employ to help ensure success. An effective clinical care delivery model is the sum of many parts, including: proven evidence-based care pathways, effective metrics and/or tracking measures, appropriate decision support tools to choose the best clinical journey through the care pathway, willingness to utilize

Contributors:

Lisa Soroka, and Wren Keber

To learn more about Lisa, and Wren, click here.

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external resource support such as care navigation, care management and/or case management, and lastly, frequent/detailed reports showing individual, group, and/or network performance on the tracked KPIs. Clinical care models vary in detail and complexity and may be set at any level of the healthcare enterprise, from as broadly as at the system level, or all the way down to individual provider specialty and subspecialty levels.

> **Indicators of Readiness for Risk-bearing Arrangements:** An integrated physician/provider enterprise with a current culture of individual accountability, strong respected clinical governance and leadership, wide-spread cultural willingness to develop and adopt new ways of delivering clinical care, and hospital/facility (inpatient and ambulatory) leadership willing to disrupt "traditional" FFS-based referral patterns to promote population health.

Care Management Programs

As described above, one component of a progressive clinical care model is a strong care management program that supplements site-based and/or physician-provided care delivery. Care management has a complex care model of its own, with distinct resource needs (both human and technology) separate and apart from the core needs of the practice or facility. That said, when designed and deployed, an effective care management program plays a critical role in success under VBP and risk-bearing payment arrangements.

Many patients need significant resources and help with managing their complex chronic diseases and/or non-clinical/social situations, all of which can adversely impact overall health. These include: consistent access to nutritious food, stable and supportive relationships, affordable, reliable transportation and child care services, information and reminders about prescription medication and/or supplements, advice and guidance on minor/major symptoms and symptom management, to name a few. While care management programs vary in size and complexity, they should focus on creating a trusting connection between the care manager and the program enrollee, which encourages the program enrollee to actually use the program services and be receptive to advice and guidance.

> **Indicators of Readiness for Risk-bearing Arrangements:** A care management program with a focus on providing access to high-quality services across the continuum of care, information technology care management tools for tracking information about program enrollees, and key indicators (metrics and/or measures) useful in optimizing and managing program performance and facilitating appropriate referrals from the physician/provider community.

Provider Network Makeup

Provider networks take many sizes and shapes and have different levels of impact on success in value-based payment arrangements and financial risk. From a health system perspective, the provider network is where the day-to-day population health management takes place. In order for various programs involved in managing population health to be successful, the provider network should have the right mix of providers interdependent in some positive way, such as through clinical integration. A robust provider network will include a balanced ratio of primary care providers, specialists, and

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subspecialists aligned to collectively manage chronic conditions and conduct/order timely and appropriate testing, referrals, therapies, and procedures for the entire population. Location is important: for the population to utilize primary care, having key access points (clinics, practices, retail care, etc.) is critical, as well as ensuring they are more convenient to use than expensive settings (such as emergency departments and urgent care centers).

For certain populations, easy referral to non-clinical services is a critical factor in managing total cost of care. Many non-clinical/social services are rendered by community-based organizations (CBOs) or agencies; understanding what services are offered and service capacity are essential. Ensuring these organizations (and thus their services) are in-network will allow for shared accountability for population health management and outcomes among clinical and non-clinical provider organizations, as well as sharing in financial rewards.

> **Indicators of Readiness for Risk-bearing Arrangements:** A broad, comprehensive network of physicians/providers, including behavioral health and specialists/sub-specialists with shared accountability for population health outcomes, integration with non-clinical services offered by nontraditional community-based providers, and easy convenient access to primary care services.

Conclusion

These are just some of the key domains to consider when evaluating readiness for entering into value-based payment arrangements and/or bearing financial risk. In our next installment, we will look at other domains, including:

- Previous Experience with VBP and/or Bearing Financial Risk
- Administrative and Contracting Infrastructure
- Financial Standing and Capital Investment Capacity

Contact Lisa at: lisasoroka@themarbleheadgroup.com
Contact Wren at: wkeber@copehealthsolutions.com