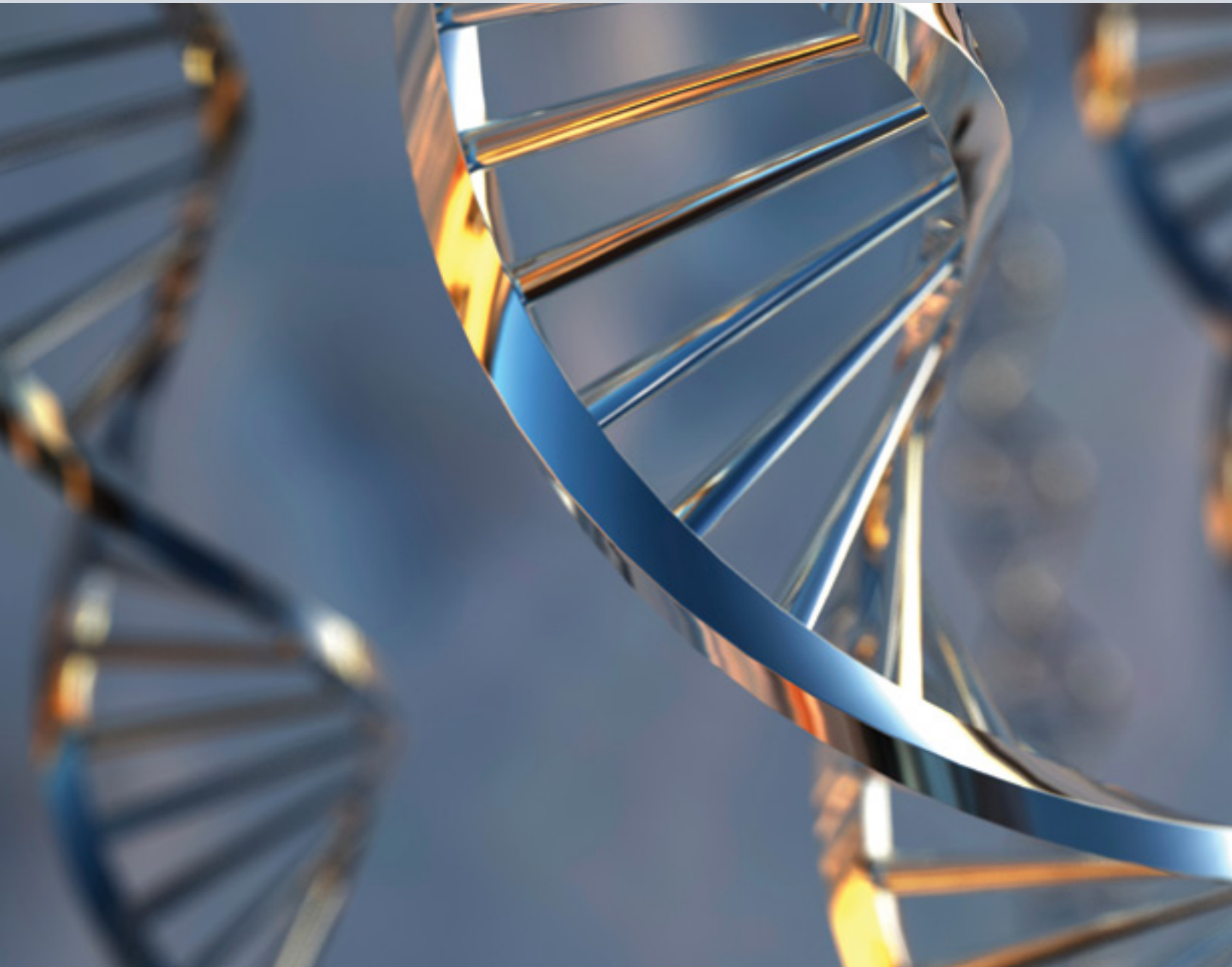
Wharton
University of Pennsylvania

THE WHARTON HEALTHCARE QUARTERLY

SUMMER 2017
VOLUME 6, NUMBER 3



FEE-FOR-SERVICE TO VALUE-BASED PAYMENT TRANSFORMATION: PROVIDER READINESS – PART 1

This article is part of a series about value-based payment and its applications in the healthcare landscape. Part 1 provided an overview of the landscape. This second article in the series begins the review of provider readiness through a discussion of risk-bearing options for physicians, hospitals, and health systems

Value-based payments reward physicians, hospitals, and health systems for achieving positive health outcomes while decreasing or maintaining costs. As discussed in our first article, value-based payment models continue to increase at an escalated rate in prevalence and variety, giving providers an increasing number and mix of options for entering into arrangements ranging from simple to complex and from low to high risk, all based on value rather than volume.

Knowing how to begin assuming risk is complex – there is no one-size-fits-all approach. For example, while a mature health system may have the employed and/or contracted provider network in place to both establish a health plan and take on global risk, another less developed physician group may want to first test the waters with perhaps an independent physician association (IPA). Why? The ability to manage a population's health depends on multiple factors, including (but not limited to):

1. existing care management structures
2. capital resources
3. provider network maturity
4. population make-up/payer mix (Commercial, Medicaid, Medicare)

We will delve more in-depth into the necessary building blocks for value-based payment in a later installment of this series. We're reviewing the different risk-bearing options for providers, including relative merits and reach considerations. The appropriate required entity (physician, hospital, health system) for taking on well-managed risk will depend on the structural makeup of the particular option.

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Risk-Bearing Options
The following table shows some of the more common risk-bearing vehicles, along with the initial level of risk ranging from low to high.

			Low Risk → → → → High Risk		
Options	Applicable Provider Type	Shared Savings and Losses	Professional Risk	Institutional Risk	Global Risk
Establish/Join an Independent Physician Association (IPA)	Physicians	X	X		
Develop/Join a Medicare Accountable Care Organization (ACO)	Physicians, Hospitals	X	X	X	
Create a Federally Qualified Health Center (FQHC)	Clinic		X	X	
Establish a Health Plan or Plan-to-Plan Arrangement	Varies – typically hospital or health system				X

Independent Physician Associations, Physician Groups
Independent Physician Associations (IPAs) are groups of physicians who come together (individually or collectively) to share in operational efficiencies afforded to them because they are now part of the larger whole. Under this structure, IPAs can potentially manage patient populations. IPAs typically share a managed services organization (MSO) or a third-party administrator (TPA) that manages the administrative aspects of physician practice, allowing the physicians as a group to participate in delivery system innovations, such as centralized care management and quality improvement programs.

- **Pros:** As a general rule, the IPA structure allows physicians to share administrative efficiencies, approach health plans to partner as a network, provide access to a larger range of services/ provider types (e.g., physician assistants, nurse practitioners) for its patients, access to group purchasing, and begin to bear professional risk.
- **Cons:** There is little/limited ability for an IPA to take on institutional or global risk because it is composed of physicians. IPAs will need to partner with other organizations to do so, or broaden to include hospitals in-network.

Medicare Accountable Care Organizations (ACOs)
ACOs are CMS pilot innovations designed to allow groups of doctors, hospitals, and other providers

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to share savings if they can manage to lower the total cost of care and increase quality for Medicare beneficiaries. Currently, CMS awards ACOs for eligible Medicare populations and have begun to explore demonstrations for Medicare/Medicaid eligible populations, also known as dual-eligible beneficiaries.

- **Pros:** This is generally a CMS-driven program, with the support of the agency to lower the cost of care for a defined population. There are many options for providers regarding level of risk, from shared savings to more advanced payment models, as ACOs progress in their ability to manage downside risk.
- **Cons:** The process for becoming an ACO can be cumbersome, and CMS approval is not guaranteed. In addition, the population eligible for this innovation model is still limited to Medicare, which makes this a good option for groups that want to serve that population but may not be a good option for providers who provide care in significant numbers to other populations (e.g., Commercial, Medicaid).

Federally Qualified Health Centers (FQHC)
FQHCs are community clinics that have been designated by the Health Resources and Services Administration (HRSA) as serving large populations of underserved, Medicaid, or indigent populations. As a result, they are eligible for increased payment rates under a prospective payment system.

- **Pros:** FQHC designation is advantageous for existing primary care clinics that already serve large Medicaid and indigent populations or systems looking to expand their primary care (and designated specialty) capacity for their specific populations. The elevated (cost-based) payment rates allow the organization to care for this population when they may have been losing money previously. The risk comes under the prospective payment system, which holds the FQHC financially accountable for the totality of primary care (and designated specialty) services.
- **Cons:** Similar to an ACO, any federally regulated program can be intensive to apply for and administer. This can be a capital-heavy/time-intensive investment if the system is starting from the ground-up to build a new primary care clinic/FQHC. In addition, an FQHC requirement for significant community presence on the board can greatly complicate governance.

Establishing a Health Plan or Entering Into a Plan-to-Plan Arrangement
Many large health systems with at least one full-service hospital and specialty and primary care networks can and have begun to explore becoming fully established and licensed health plans, capable of managing insurance risk through selling products or partnering with another plan under a global capitation contract (called a plan-to-plan arrangement). This is an advanced step for provider organizations, or groups of provider organizations, confident in their ability to manage utilization and cost, have experience with managing populations, and have the care management history/ demonstrated ability in place.

- **Pros:** This is an opportunity for a very experienced system already managing overall population health to take on the full responsibility (and eventually reap rewards) of ensuring that patients have access to quality care.
- **Cons:** Establishing and operating a health plan is a significantly different endeavor than running a healthcare system. An organization that cannot adequately manage its population's health and the utilization of its members stands to lose money in taking full financial risk for enrolled members.

In conclusion, before even considering assuming additional financial risk, each provider (e.g., solo,

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independent, affiliated, or system) needs to accurately and objectively pinpoint where it falls on the low to high risk continuum in order to determine its next course of action in the uncertain world of value-based reimbursement. Each entity needs to understand if it has all the necessary components and the capability to manage them to be able to deliver high-quality care and effective care management in a cost-efficient manner. Failure to do so could result in irreparable financial and reputational harm. The next article in the series will further the review of provider readiness through a continued discussion of risk-bearing options for physicians, hospitals, and health systems.

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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 focus on all aspects of strategy, population health management, managed care contracting, CMS demonstrations, Medicaid redesign, and workforce development for clients across the healthcare continuum, including hospitals, health systems, physician organizations, health plans, and community based organizations.

Our multidisciplinary team of healthcare experts provides our clients with the tools, services, and advice they need to plan for, design, implement, and support successful operations in a challenging and rapidly evolving healthcare environment.

We are currently working with multiple health systems across the country to develop a clear roadmap to success under value-based payment. Please contact any of our leadership team members if you have questions and would like to discuss how to ensure success amidst the coming changes.