

Lumeris



Building and Operating a Provider-Driven Population Health Services Organization

Lumeris Authors:

Greg Scrine
Principal
Lumeris Advisory Solutions
gscrine@lumeris.com

Ricky Garcia
Senior Manager
Lumeris Advisory Solutions
rgarcia@lumeris.com

INTRODUCTION

The march toward value-based care delivery and financing will continue despite deep industry structural inertia, business self-preservation motives, and the shift in national politics. As we head toward 20 percent of US gross domestic product (GDP) being spent on healthcare, economic forces and federal budget math will demand the long-term transition to value-based healthcare delivery and financing. As health systems and physician organizations face this inevitability, they have two choices:

- Resist for as long as possible by clinging to fee-for-service (FFS) models and focusing on volume preservation; or
- Embrace the new reality and transform for competitive benefit by creating new competencies and accepting performance risk.

The Affordable Care Act's (ACA) passage in 2010 created a new impetus to shift from volume-based to value-based care and to dedicate new resources to that end. Since that time, we have seen many examples of failures and, more commonly, examples of mediocre performance falling short of success. It's clear that the required business and clinical transformation will not be easy. It's also clear that should the ACA be repealed in full or in part, the motivation for transition to value will not abate. Compelling examples of success exist, and the lessons from those experiences suggest the following:

- **Providers must steer the way:** Providers are the only ones in a position to lead the journey toward value-based care delivery—from setting an initial organization vision for population health management (PHM) to acting as the quarterback for care teams on a daily basis.
- **Underpin PHM with primary care:** Success requires deep integration and collaboration with primary care physicians (PCPs) and their surrounding care teams. The core of a successful PHM effort is a PCP, supported by care teams, care management programs and an informatics infrastructure that takes responsibility for each patient's health status and resource use.
- **Think all payers, all populations:** Providers cannot act differently for different populations. This is true both ethically and from a clinical operations standpoint. PHM programs and infrastructure must have a vision to serve all payers and all populations over time.
- **Aim for Scale:** The required investment of financial and management resources in PHM is considerable and, therefore, requires scale to achieve economic viability. Empirical experience and financial modeling suggest that over the long term, PHM organizations will need to serve 100,000 or more covered lives to be financially sustainable.
- **Redesign physician economics:** Transformational behavior change and resulting outcome improvements require transformational economics. This requires that physicians, particularly PCPs, be paid very

What is Population Health Management?

Population health management (PHM) is a care delivery framework to improve the health of a group of people. By delivering the right care at the right time to the right person, PHM targets care management to high risk patients and encourages preventive care for the healthy, thereby improving outcomes for the whole population.

differently. Compensation models must move toward payment based on quality, patient satisfaction, and efficient resource utilization. In our experience, successful value-based PCP arrangements should garner closer to 8% of the premium dollar, compared with a typical 4% provided under FFS structures¹. Not only does the provider win, but this investment yields significant positive return to those paying for care—governments, employers, insurers, and ultimately premium- and tax-paying individuals.

- **Don't dabble:** Small scale or incomplete initiatives typically do not lead to meaningful change. In fact, this might be counterproductive as unremarkable results can extinguish organizational energy and momentum.

With much having been written about “why” health systems and physician organizations need to pursue PHM, this paper is intended to address the “how.”

RECALIBRATING WHAT IS POSSIBLE

This much is certain: the healthcare industry's cost-saving opportunity remains high and business models—for both provider organizations and payers—have been slow to evolve. The solution is to rethink health spending allocation and to reengineer how provider organizations are paid and compete in the marketplace.

Sizing the Industry's Cost Opportunity

It is widely accepted that approximately one-third or more of all US healthcare spending is unnecessary, wasteful, or inappropriate² and does not lead to better health outcomes. In 2017, US healthcare spending is projected to be \$3.5 trillion³. This means as much as a colossal \$1.2 trillion in spending may be avoidable.

With such an enormous dollar amount in play, it's not surprising that industry observers view reducing annual cost growth by just a few percentage points as a significant win. For even a modest size population, that alone can represent millions of dollars in cost savings and avoidance. While any cost improvement is certainly welcome, it's possible to move well beyond the incremental. True leaps in performance have and can be achieved.

It is widely accepted that approximately one-third or more of all US healthcare spending is unnecessary, wasteful, or inappropriate and does not lead to better health outcomes.

¹ Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med.* 2007; 22(3):410-415.

² Health Affairs, Health Policy Brief: Reducing Waste in Health Care, December 13, 2012.

³ Centers for Medicare & Medicaid Services, Office of the Actuary.

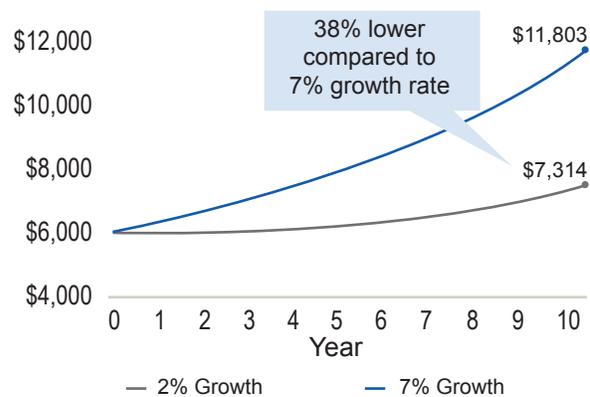
Medical Trend: Why is it Important?

The long-term goal for most PHM organizations is to reduce the year-over-year rate of growth in spending. This is commonly referred to as the “medical trend.”

Since 2008, US healthcare spending has been growing at an annual rate of between 3 percent and 5 percent⁴. However, employers routinely see spending and related premiums in commercial populations growing at 7 percent or more on a sustained basis. If that 7 percent could be reduced to 2 percent, which is still more than the current US Consumer Price Index, the resulting cumulative difference would be dramatic (see **Figure 1** example).

To achieve such a dramatic improvement in the rate of cost growth requires structuring health spending very differently and apportioning the healthcare dollar in a previously inconceivable manner.

Figure 1: Annual Growth Rate Scenarios. This figure illustrates the drastic difference in per person spend for a 10-year, straight-line forecast for growth at 2% and 7%. The result: spending by the 10th year at a 2% growth rate is a mere 62% of what it is using a 7% growth rate.



Rethinking Health Spending

Over the 50 years of the modern US healthcare insurance experience, insurers have structured themselves and operated in much the same way, borrowing the long-tested model of the property and casualty insurer.

This model assumes that healthcare utilization and related spending is an insurable event and is infrequent, unpredictable, and results in a large enough financial loss to merit the spreading of risk. However, one study showed that the treatment for unpredictable, catastrophic events accounted for only 31 percent of total US health spending⁵. In short, there is a significant portion of health spending that is frequent and predictable, and, therefore, unsuited for the existing health insurance model.

The traditional management of healthcare premiums can be described in two categories: plan administration and medical spending. Almost by design, there’s an adversarial construct between the claimant and the administrator because spending on the former eats into the budget and profit of the latter. As shown in **Figure 2**, approximately 15 percent of the healthcare dollar goes to health plan administration and profit. The other 85 percent goes to paying claims, typically in a FFS model.

Processes for effective population health management must be engineered in a way such that the incentives of all stakeholders are aligned for value.

⁴ Centers for Medicare & Medicaid Services, Office of the Actuary.

⁵ McKinsey & Company, Why Understanding Medical Risk is Key to US Health Reform, June 2009.

Figure 2: Current Distribution of the Healthcare Dollar



It's this oppositional relationship that has given us utilization review, medical necessity testing, insurer case management, prior authorization, denials, appeals and grievance processes, and countless cases of contract termination, litigation, and arbitration. Though these processes can be useful for effective cost management, they must be engineered in a way such that the incentives of all stakeholders are aligned for value. Until then, the fundamental market failures of the current insurance model will continue to yield unsustainable rates of annual cost growth.

Introducing the Population Health Services Organization

To move beyond the current structural trap requires a new construct, one that includes a previously unheard of level of collaboration and reflects the market reality of what drives health spending. The new collaborative model redefines historic roles and introduces a new role that assumes some of the functions of traditional players but also adds new capabilities.

This new role is the Population Health Services Organization (PHSO). The PHSO creates a bridge across the traditional payer-provider divide, while adding capabilities that enable providers to successfully take on performance risk and materially change physician behaviors. The PHSO radically improves utilization, quality, patient satisfaction, and provider satisfaction based on rational market behaviors.

The incentive for this radical shift is unlocked by the new model. Known as the “value surplus,” these are dollars previously locked into inefficient health plan administration and needless medical spending. As **Figure 3** shows, the value surplus can be as much as 14 percent of the healthcare dollar or premium in the near term, depending upon the population.

The PHSO creates a bridge across the traditional payer-provider divide, while adding capabilities that enable providers to successfully take on performance risk and materially change physician behaviors.

Figure 3: Future Distribution of the Healthcare Dollar in a PHSO



This new construct, built around performance risk transfer and enabled by the PHSO, fundamentally changes incentives and the basis for competition. Market players compete around surplus optimization, which is dependent upon medical cost management, quality, and patient satisfaction. As the players organize around the new model, market forces will drive medical spend and surplus efficiencies, thereby reducing the rate of health spend growth and creating a virtuous cycle and cost stability.

The construct described above is not a fantasy. Several million patients are cared for under these constructs today. Given the overwhelming economic, political, and demographic forces at hand, there are certainly many millions more who will be cared for under this model in the future.

HOW TO BUILD AND OPERATE A PROVIDER-DRIVEN PHSO

Within this report, we seek to articulate the “how” with regard to creating and operating a high-performing, provider-driven PHSO. In particular, we draw on Lumeris’ more than 10 years of experience in partnering with providers, operating a health plan, and building information systems solutions. As any operator will tell you, knowing what to do and creating a good plan is the easy part. It’s the execution—and most importantly repeatable execution—that creates value.

Five components are essential to a successful PHM model that is reproducible for provider organizations seeking to transform their own business. The balance of this document outlines key design, deployment, and operational considerations; action steps; and critical success factors in developing each of these components.

Five Essential Components of a Provider-Driven PHSO

- I. Clear vision, leadership, and organizational infrastructure
- II. An engaged and high-performing physician network
- III. A robust and adaptive care management program
- IV. Meaningful value-based contracts serving covered lives at scale
- V. A comprehensive and functional PHM information system

Many provider organizations have invested millions of dollars in building out a subset of these components only to find they can’t make it work operationally or create a financial return. This results from a failure to recognize the interdependence between the five components and the necessity of each to overall success.

Each of these components must exist simultaneously and be operationally persistent for a true PHSO to work and to achieve care improvement and financial objectives.

I. Developing Vision, Leadership, and Infrastructure

A strong sense of direction and a supporting organizational model are key prerequisites for building and operating a PHSO. This section identifies key considerations for setting a vision, establishing an organizational infrastructure, and fostering buy-in and success by communicating with stakeholders.

PHM Vision: Be Ambitious

“Make no small plans for they have no power to stir the soul.” Machiavelli is not often quoted in healthcare circles, but in this case his advice applies. To achieve transformational performance leaps, leaders must in fact stir the soul of their physician community.

The vision for a successful PHSO must be one that encompasses the core business of the organization.

The vision for a successful PHSO must be one that encompasses the core business of the organization. If the vision lacks ambition, the entire initiative risks quickly being relegated to science project status. It will only get the time, energy, and capital that a science project merits. As a result, the endeavor won't achieve the necessary scale and will be doomed to failure from the beginning. While ambition is a relative term, experience suggests a viable, five-year vision is one in which the PHSO serves at least 100,000 members representing \$500 million or more in health spend.

Keys to Success: Build a coalition of individuals who understand and share the ambition. In this case, the disciples are more important than the visionary. Clearly articulate the PHM strategy and how it fits with the larger enterprise strategy. Paint a credible picture of what is possible from a care delivery improvement and financial reward perspective.

PHM Vision: Think Provider Driven for All Payers, All Populations

Many examples exist of PHM initiatives that are either narrowly focused around a small subpopulation, driven by a specific payer, or both. While it's possible and occasionally preferred to start with a narrow population and a single payer, achieving practice density (a meaningful number of lives covered in value-based models within a given PCP practice) almost always necessitates a vision that includes all payers and all populations.

It's this need that best positions providers to be the builders and operators of the PHSO. Development of a singular care management organization, common performance measures, unified contracting structures, and coherent and compelling provider incentive structures is only possible when driven by the provider organization itself. Scale can only be achieved when these structures are singular in nature as enabled by a PHSO.

Keys to Success: Design a PHSO with an expectation of serving all payers and all populations (e.g., commercial, Medicare Advantage, Medicare ACO, health insurance exchange, managed Medicaid). Consider the full range of potential payer partners who are able to transfer performance risk through value-based contracts.

Governance Design: Make Physicians the Focal Point

PHM success is contingent on fundamentally changing physician thought processes and choices. This is only possible through deep engagement with the physician community built on a foundation of trust, transparency,

fairness, and, of course, evidence-based care.

These requirements necessitate a PHSO that is physician governed and led. Only physicians have the standing to ask other physicians to change how they practice medicine. Physicians will only respond if those asking are trusted, respected, and viewed as having the best interest of patients and providers at heart. The goal is to create an unassailable governing body that is transparent, balanced, unbiased, and trusted.

The PHSO board should be structured in a way that is credible, representative, and maintains real accountability and decision-making authority. This board should have a physician majority and be chaired by a physician. In addition, a majority of physician members should be PCPs with active practices in the community. Experience suggests a governing body of at least nine members but not more than 21. It's reasonable and preferred that health system executives, including the system chief medical officer, have representation.

Characteristics of a Strong Board

Getting the board composition and personal chemistry right is critically important to the PHSO board's credibility and sustainability. Look for board members who are:

- Progressive thought leaders
- Embracers of value-based care delivery
- Persuasive and respected by colleagues
- Able to commit significant time to the initiative
- Energetic and passionate
- Outstanding in their interpersonal and leadership skills

Keys to Success: Resist the urge to put the usual emeritus or senior physician leaders on the board. Physicians in early- or mid-career are more likely to part with the past and chart a material transformation that they and their peers are willing to embrace over the balance of their careers.

Leadership Design: Consider a Dyad Leadership Model

Excellence in leadership is essential when moving from vision to operationalization. While it's possible to find all the aforementioned characteristics and expertise in one executive, it's typically very difficult to source such a leader.

The preferred solution is often a dyad model that pairs an accomplished physician executive with a non-physician management executive. The dyad model offers distinct advantages as it enables a PHSO to benefit from a diverse and complementary set of leadership competencies. The physician executive brings clinical leadership, clinical knowledge, and influence, while the management executive brings operations, finance, and contracting expertise.

The dyad model also creates more leadership capacity by allowing two people to share the workload. More importantly, this approach creates partners for collaboration in what is a complex, ambiguous, and evolving clinical and financial organization.

The specific roles and domains of responsibility for each leader should be clear from the beginning. This explicit definition will help mitigate conflicts and, in areas where there is true overlap, facilitate more efficient and effective resolution.

Keys to Success: Make sure the decision to use the dyad model is made at the outset, so the organization can recruit to the expectation of a dyad leadership model. The dyad partners must respect each other's skill set and acumen and trust in their commitment to standing together. The relationship must be such that the two leaders can privately resolve disagreements and project a singular direction to the board and other stakeholders.

Organization Design: Decide on a Risk-Bearing Entity

PHSO leaders should determine early on where the performance risk in a value-based contract is going to be held. While there are many possibilities, the risk is generally either held directly by the provider organization or placed with a new entity, developed for that purpose, that could include multiple owners.

If a health system is the primary organizer and source of capital behind the PHSO, it makes sense that the health system holds the risk directly or through a subsidiary. In instances where there is a desire to create a syndicate of participating partners to share in risk, capitalization, and alignment of incentives, it will be necessary to create a special entity—either taxable or non-taxable—that can accommodate multiple owners.

Keys to Success: Select a corporate structure and tax status that anticipates the requirements of future partners. Engage counsel early in these discussions. States have differing regulations with regard to healthcare organizations maintaining risk-bearing entities. Be sure to understand state regulatory requirements at the outset as they may impact capitalization, capital reserve requirements, risk contracting structures with third parties, and distributions and payments made to provider partners.

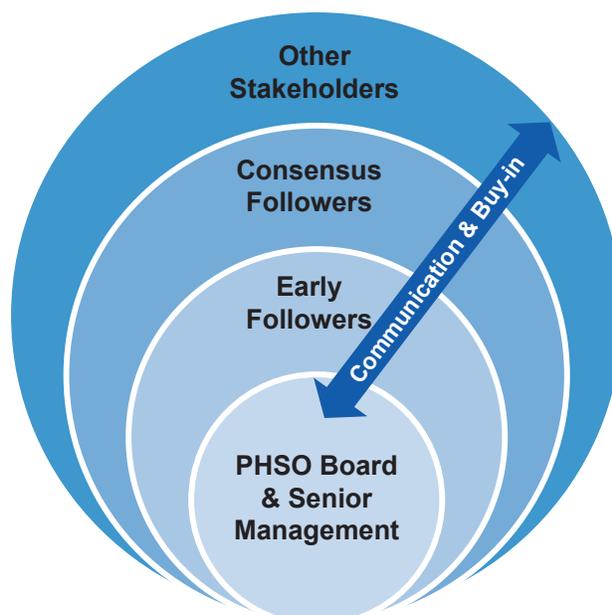
Communication Strategy: Foster Buy-In

PHM transformation is not a business strategy to be closely guarded. Rather, it's a broad social movement that achieves competitive advantage through exceptional execution. It is not necessary or desirable to keep this strategy confidential. In fact, the movement toward PHM requires broad understanding and community buy-in.

Once a PHM vision has been articulated and agreed to by senior leaders, they should begin communicating that vision and describing the path forward to key sets of constituencies in a cascade approach. This cascade can be envisioned as concentric circles of support and buy-in (Figure 4). The PHSO board and senior management are its core.

The first ring around the core contains the early followers or evangelizers. This group should consist of at least 25 to 50 key physicians, the majority of

Figure 4: Communicating the PHSO Vision. Alignment across stakeholders is critical for success of the PHSO.



whom should be PCPs. In many ways, garnering this group's support and conceptual buy-in is the most important of all. It is this group that others will look to as the measure of the PHSO's credibility.

The second ring contains the group of physicians who are consensus followers. The evangelizers drive the message out to this group of peers. This approach positions the shift toward PHM as a provider-driven movement, rather than a directive from a central authority or the health system. Only after it appears that the risks of not joining are greater than the risk of participating will follower physicians lend their support to the effort. Ideally, this group will include a super majority of targeted physicians and will be the core of the PHSO's physician network.

The third ring consists of other interested parties, including employees, partners, associates, and the community. Communication efforts here will largely be focused on information sharing and education.

The PSHO should create an explicit communication plan based on this concentric circle cascade. The communication plan is intended to not only build an understanding of the PHSO and garner support, but also to generate stakeholder enthusiasm about the changes that lie ahead and potential opportunities to get involved. Target audiences, audience owners, and the frequency and method of communication must be identified.

What should be done about the naysayers? PHSO leaders shouldn't worry about converting their thinking. It's better to spend time and energy elsewhere.

Keys to Success: Create momentum by carefully constructing stakeholder messaging. Be ready to comfortably answer questions regarding how the PHSO will operate, even if it's still in development, and what's in it for relevant parties.

II. Building an Engaged, High-Performing Physician Network

This section describes common vehicles for organizing providers into a network to which lives can be attributed and offers essential considerations when identifying and selecting provider partners.

Choosing a Physician Organization Structure

A successful PHSO requires scale in terms of the number of lives managed under a value-based contract. The population that falls under a value-based contract is a direct function of the physicians in a PHSO's network. That is, payers will attribute lives to a contract based upon patient utilization of providers within a defined network.

This means that a scaled—and scalable—physician network is an essential element for success. There are three ways to aggregate a physician organization under the current regulatory environment.

A scaled—and scalable—physician network is an essential element for success.

The first and most traditional approach is the creation of a single corporate entity in which physicians are employed or contracted through a professional services agreement (PSA). While this model has its advantages, most health systems find it is not economically practical to employ all the physicians necessary to achieve scale in a PHSO. They also typically find that a sizable portion of independent physicians are not interested in an employment relationship or PSA.

The second approach requires a network of physicians who are financially integrated with meaningful shared risk to be compliant with antitrust regulation. This approach creates a risk intermediary that accepts allocated risk from a payer on behalf of a network of physicians. The best examples of these organizations are the West Coast independent practice associations (IPAs) that have accepted capitation from payers and are operating performance programs with contracted physicians.

While the IPA model has its place within the healthcare system, most health systems will find that establishing a shared-risk IPA looks much like developing a health plan—complete with capital requirements and significant regulatory and competitive hurdles. As a result, few health systems pursue this approach.

This leaves Clinical Integration as the final option. This is the most practical and attractive model for most health systems that are seeking to enable PHM capabilities and create an organization that can legally negotiate on behalf of its members. The relative investment requirement and flexibility offered by Clinical Integration make it the preferred physician network structure for many health systems.

The legal construct of the Clinical Integration program consists of a legal entity, which may be the risk bearing entity, and a connection to its network physicians through a participation agreement.

Antitrust laws forbid collective negotiations by economically independent entities. However, the Department of Justice has said it will not prosecute provider networks that are genuinely Clinically Integrated and do not exercise market power.

Clinical Integration Defined

The Department of Justice and the Federal Trade Commission (FTC) define clinical integration as “. . . an active and ongoing program to evaluate and modify practice patterns by the networks’ physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. Such programs may include:

1. Establishing mechanisms to monitor and control utilization of healthcare services that are designed to control costs and ensure quality of care;
2. Selectively choosing network physicians who are likely to further these efficiency objectives; and
3. The significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.”

The FTC has said it will not pursue action against clinical integration arrangements if they meet a three-part test:

1. The network’s program of clinical integration is likely to achieve “real” integration of providers.
2. The initiatives of the program are designed to achieve likely improvements in healthcare cost, quality and efficiency; and
3. Joint contracting with health plans is “reasonably necessary” to achieve the efficiencies of the clinical integration program.

Keys to Success: Clinical Integration has specific requirements and significant legal implications if set up improperly. Start by engaging an advisor and legal counsel with experience in setting up a Clinical Integration program early in the process.

Selecting Physician Partners

What is the single most important ingredient for PHSO success? Having the right physician partners in the network. After all, this group will directly drive the bulk of utilization decisions and influence health outcomes the most.

Unlike the typical health plan network that seeks to be broad and inclusive, the objective of the PHSO network is to be first and foremost composed of high-performing practitioners who share a common vision for better care at a lower cost.

Identifying and selecting the right group practices or physicians is market specific, but PHSOs should prioritize providers based upon practice characteristics and service area considerations.

Practice Selection Considerations

1. Willingness to embrace PHM
2. Number of PCPs in the practice
3. Patient panel size
4. Clinical leadership
5. Density of attributed patients under value-based contracts
6. Intangibles, such as participation likelihood, reputation, and influence
7. Market indispensability

Geographic Selection Considerations

1. Number of lives available for management
2. Disposition of market participants toward the PHSO
3. Competitive dynamics

Keys to Success: Use a robust analytical approach to identify physician member targets and set recruitment priorities. Remember that the first several groups of physicians in the network are key to setting the tone. They must embody the desired cultural standards—an appetite to innovate, experiment, and share ideas, as well as an eagerness to help build and shape the network.

Building the Network

As with many strategic initiatives, sequence and timing are important. Building a physician network is in many respects like throwing a party. People's interest in going to the party is partially dependent on who else is likely to attend. Providers will ask themselves: Are the others joining the network relevant? Do I want to be associated with them? And, like a party, no one wants to be the first to arrive. At the same time, no one wants to be late and miss the fun or get left out when the venue is full.

The art of building the network—getting physicians to commit to coming to your party—really resides in the answers to these questions:

- ✓ Who is delivering the message?
- ✓ What is the message?
- ✓ How is that message delivered over time?

Having a small, dedicated field team delivering the message to the provider community at the outset is critical to trust building and continuity of the message. This team must include at least one physician who is well-versed in the overall initiative and is responsible for leading the conversation. Ideally this is the chief medical officer or network chair if possible.

The actual message and how it is delivered must be deliberately planned. The team should stage discussions with recruiting targets in a series of three conversations, each with its own objectives.

The first conversation is largely an educational one. The team should share the vision and value proposition. It should communicate to providers what's in it for them from a physician's perspective, and give an overview of the planned network design and composition, and new care delivery programs.

The second conversation should dive into specifics regarding how the PHSO will impact the physician and physician practice. This conversation should be structured around a set of frequently asked questions:

- In “real life,” what will the PHSO look like?
- Are physicians involved in its development and leadership?
- What clinical initiatives will the PHSO undertake?
- Who is paying the start-up costs?
- What will physicians need to participate in the network?
- Will physicians have to abandon current payer contracts to participate?
- Is an ambulatory electronic medical record (EMR) required to participate?
- Will participation require physicians to change the way they practice medicine?
- What does it cost a physician to participate?

The final conversation must set expectations around implementation and outline contractual obligations. The field team should describe the expectations of a participating provider. It should discuss practice transformation efforts and what physicians should expect during the first 90 days of network membership.

Perhaps most importantly, the team should introduce the key elements and provisions of the network's participation agreement. The participation agreement is the legal document that formalizes physicians' membership in the network, includes their commitment to participate in PHSO programs, and grants the Clinically Integrated network the authority to negotiate on their behalf. Transparency and a trust building orientation is essential.

Keys to Success: Appreciate that the recruitment process will require more than just a handful of conversations with each provider target. Expect that some audiences will get it quickly and others will need more time to digest concepts. Remember that the network will be attractive to providers based upon its ability to obtain incentive-based payer contracts and provide value to members that they would not be able to achieve on their own.

Creating Physician Engagement and Practice Transformation

Fundamental to PHM success is changing the way physicians interact with patients and the care choices they make along the way. PHSOs need to provide primary care physicians and their surrounding care teams with a framework to make those changes and to know when they've succeeded in transforming their practices. This

framework can be thought of as a package of nine characteristics for accountable primary care physicians from the Accountable Primary Care Model—The Nine C's®.

A PHSO must engage physicians and their teams in adapting their daily routines to realize the Nine C's competencies. A proven approach is to assign dedicated resources, known as accountable care team (ACT) specialists, to each practice. ACT specialists are experts at integrating accountable primary care delivery models into provider practices.

These specialists are much more than just a traditional practice liaison. They are responsible for transforming a practice's care delivery model in a way that is as seamless as possible. ACT specialists conduct practice workflow analysis, reinforce utilization of technology and clinical tools, manage change initiatives, coach physicians and their team members, evaluate practice performance, and support continuous improvement.

ACT specialists typically are non-clinical personnel with three to five years of experience working with physician practices in the areas of provider relations, provider education, and/or practice management. ACT specialists should be deployed based on the number of physician offices that require support (typically beginning with primary care locations) and adjusted for their geographic dispersion.

Other elements that are essential for physician engagement include creating the right internal governance structures to share best practices, mentoring clinical leadership, and developing the appropriate physician compensation structures to support change.

Keys to Success: Start practice transformation efforts with groups that are positioned to succeed. While the number of lives attributed to a practice is an important consideration, what may be more important is that a practice has the right culture. The physicians should be progressive thinkers, comfortable with change, and able to serve as change agents for the PHSO.

What are the Nine C's?

Content, programs, and methodologies built for physicians and care teams to deliver the Triple Aim *plus* One (quality, cost, and patient and physician satisfaction)

- C1 First Contact
- C2 Comprehensive Care
- C3 Continuous Care
- C4 Coordinated Care
- C5 Credibility and Trust
- C6 Collaborative Learning
- C7 Cost Effective
- C8 Capacity Expansion
- C9 Career Satisfaction

III. Designing a Robust, Adaptive Care Management Program

Employing an effective care management capability is an essential element in driving a PHSO's success. This section describes key functions within a care management program, staffing considerations, and how to refine and evolve a portfolio of care management capabilities over time.

Providing Program and Staffing Essentials

The primary objective of care management efforts should be to build a singular programmatic function and portfolio that will serve all populations and payers. These activities are more effective when performed closer to the delivery of care, but providers need the appropriate resourcing

The primary objective of care management efforts should be to build a singular programmatic function and portfolio that will serve all populations and payers.

and funding to manage these programs successfully. The care management program should become more sophisticated over time in order to position the PHSO to succeed as more lives are covered under two-sided or full-risk contracts.

At the outset, it's important to understand and codify all existing care management services provided by payers, third-party administrators, and other parties to prevent duplication of services. Moreover, aligning care management programs with existing health system initiatives creates a more efficient strategy. The PHSO should challenge any existing population health management vendors to provide evidence of a return on investment. Most systems have found opportunities to rationalize care management services and bring mission-critical activities in-house.

Care Management Program Components

The starting point for any care management program should include:

- Complex Care Management
- Transitions of Care
- Pharmacy Management
- Quality Management

Resource requirements vary for each care management component. Having a five-year roadmap of covered lives by line of business and contract type (i.e., shared versus full risk) helps to determine the appropriate staffing levels for complex care management, pharmacy management, and quality management.

Case management for patients with complex needs is the most resource-intensive component but also the most important one. Personnel include nurses, social workers, behavioral health, medical directors, clinical pharmacists, and administrative support staff. A number of variables must be considered when estimating resource needs. They include:

- Number of lives in shared-risk versus full-risk value-based contracts
- Targeted percent of high-risk lives under management
- Patient engagement model—opt-in versus opt-out
- Average panel size and average panel turnover
- Balance of nurses, social workers, and administrative support
- Centralized care management versus embedded care management

With regard to quality management, resources typically are a function of the number and type of quality measures included in the organization's value-based contracts. This applies across all lines of business and contract types.

Pharmacy management resources—clinical pharmacist and pharmacy technician positions—also are a function of covered lives. Another consideration is the types of pharmacy campaigns the PHSO plans to deploy. It may focus on generic fill rates, medication adherence, or specialty drug spend. The scope of these programs will be driven by examining pharmacy cost and utilization patterns.

Transitions-of-care staffing is based on discharges. Some organizations prefer to apply transition management services to all discharges, while others prefer to focus only on those deemed to be high risk. The decision

should be driven by the contracts the PHSO has in place, the personnel resources it either has or plans to have, any existing initiatives, and other variables, such a high readmission rate. Positions included in transition management resource forecasting include nurses, health coaches, and administrative support staff.

Each of the care management program components should have its own “playbook.” These playbooks define the program vision and its supporting activities. They also typically include, but are not limited to, the following sections:

- Purpose and objectives
- Targeted patient population and patient risk stratification
- Enrollment criteria and program enrollment process
- Care planning, monitoring, and workflows
- Program operational performance metrics

Beyond the playbooks, a robust care management program needs standardized assessments, care plans, intervention descriptions, call scripts, and provider and patient education materials.

Keys to Success: Develop robust training and onboarding capability, and expect the hiring of experienced care managers to be difficult. The supply of talented care managers nationwide is small. In some markets moving quickly toward population health, health system and payer demand has fueled a competitive job market for care managers, and recruitment lead times can be six months or more.

Calibrating to the Opportunity

While care management programs share common foundational elements, each program must be tailored for the specific populations under management and their supporting contractual arrangements. It's important to identify opportunities to enhance the organization's care delivery model by payer and line of business using a quantitative approach or an opportunity analysis at the population level.

Generating this analysis involves a clinical analytics team using claims, EMR, lab, pharmacy, and other data sources to craft insights that focus on such opportunity areas as:

- Capturing out-of-system spending
- Offering care in lower-cost settings
- Avoiding unnecessary utilization
- Enhancing care coordination
- Reducing duplication of services

The clinical analytics team also quantifies the value of improvement opportunities relative to industry benchmarks and identifies requirements needed to achieve such improvements. These insights help shape how a PHSO's core care management programs must be refined and/or identify new programs that must be deployed, such as behavioral health and post-acute care management.

Pulling this off is not easy. A PHSO can't just rely on its data warehouse and decision support staff. And making care management program decisions based on discharges and emergency department visits will not get the organization very far.

Keys to Success: Start with the essential care management programs. As with most change management initiatives, don't try to take on too much. Begin with the populations with the greatest need. Remember, typically 1 percent of the population drives over 20 percent of spending and 5 percent drives half of all spending.⁶

IV. Structuring Meaningful Value-Based Contracts

A PHSO only works when changes to payment structures enable providers to share in the value generated by utilization, cost, and quality improvements. This requires payer partners or, in some case, the creation of a provider-sponsored health plan. In all cases, value-based contracts must provide adequate incentives to attract and retain physicians, as well as support ongoing investment in the PHSO.

Value-based contracts must provide adequate incentives to attract and retain physicians, as well as support ongoing investment in the PHSO.

This section describes how to assess the payer market's readiness to move into value-based contracts and design a roadmap for the populations that will be managed by the PHSO. It offers advice on deal strategy, contracting parameters, and execution.

Assessing the Payer Market

In many markets, payers still are reluctant to move toward value-based contracts, or they simply lack the creativity to move on from generic upside-only deals. To be fair, pockets exist where payers have made tremendous progress in value-based contract design and implementation. But despite the industry's move toward value-based care, payers have not, in general, been that progressive.

To determine where the payers in the PHSO's market stand, the organization's contracting or marketing team should gather intelligence on the value-based contracts payers have struck in the market. Fact-finding goals include discovering the types of risk-bearing arrangements payers have, the number of lives under these contracts, and whether any performance results have been published. The team should hold exploratory conversations with the payers to gauge their interest.

The objective is to be able to ascertain which payers offer the PHSO the most potential. Each payer should be plotted on a matrix with the following two dimensions—willingness to partner and strategic value to the organization. Payer market share is important in achieving scale for the PHSO, but equally important is finding a payer that is willing to innovate, experiment, and craft mutually beneficial value-based contracts.

Evaluating Payers

Gather market intelligence on value-based contract opportunities:

- Types of value-based contracts available
- Number of lives
- Available performance results
- Likelihood of payer collaboration (organizational dynamics)
- Payer market share

⁶National Institute for Health Care Management (NIHCM) Foundation, 2014.

Keys to Success: Appreciate that many payers are figuring this out as they go along, too. Try to find a payer that will work shoulder-to-shoulder with the PHSO to design mutually beneficial contracts and share and evaluate performance data.

Formulating a Covered Life Strategy

All PHSOs should develop a roadmap outlining the populations—by payer and line of business—that will be managed over a five-year period. This is an essential planning tool as it feeds financial projections and helps set and communicate expectations. Moreover, the target populations will shape the care management resources and programs the PHSO installs. For example, a single transition management nurse can manage a commercial population that is more than four times the size of a Medicare Advantage population.

For most PHSOs, self-insured employees and dependents, as well as lives under a provider-sponsored health plan, are almost always the best starting points because organizations already bear risk for these populations.

PHSOs should try not to jump right into managing Medicaid populations. They are notoriously difficult to manage because so many patients in this population have multiple medical conditions, behavioral health issues, and limited access to care. Instead, the PHSO should bring in these populations once it has matured—perhaps two years after initial ramp up—and the care management program is operating efficiently and effectively.

For most PHSOs, Medicare Advantage and commercial populations will be the first set of covered lives. To determine the size of these populations, the PHSO should give potential payer partners a list of tax identification numbers for physicians in its network and ask them to do a preliminary attribution.

As for Medicare populations, Medicare ACOs are complementary to the PHSO's overall efforts. The upside of a Medicare ACO—whether it's the Medicare Shared Savings Program or the Next Generation ACO program—is that it quickly adds scale. The downside is that these programs require significant organizational time and energy. Although most Medicare ACOs have shown quality improvements, a vast majority of them have not demonstrated an ability to share in their savings.

Keys to Success: Think crawl, walk, and then run. Move toward value-based contracting at a deliberate pace, but also recognize that it is advantageous to accelerate the organization's development of risk acceptance capabilities. Of course, the staging and sequencing of populations is critical, and a PHSO should always look to bring collaborative payer partners in the fold first—not necessarily the payer that will do a deal first.

Executing Deals

The task of designing and evaluating all value-based contracts should fall to a deal team created by the PHSO. A subset of this team also will be involved in payer discussions and negotiations and lead internal discussions with senior executives. The deal team should develop a value proposition for payers and delineate standards for what the PHSO will provide participating payers.

The deal team should also outline preferred contracting structures and parameters in advance of entering into payer conversations. For example, does the PHSO want deals that are upside-only savings in the first year and then transition to downside risk in subsequent years? Does the PHSO need a care management per-member, per-month payment to fund initiatives and attract physician interest? The team should create a list of negotiation areas and the PHSO's preferences, and then rank their relative importance.

Many major commercial payers have a baseline shared savings contract, and they exhibit varying degrees of willingness to customize these standard deals. The deal team should ask for a copy of these standard contracts and work to understand them inside and out.

In addition, the team should ask payers to build a financial model based upon preliminary attribution. The team must conduct due diligence to understand payers' assumptions and methodologies, particularly around patients' risk scores and calculation of healthcare expense trends. It's important to understand how the PHSO network's medical and pharmacy per-member, per-month payments compare to the market. Even some of the most sophisticated payer contracting shops need outside financial and actuarial expertise.

Before entering a contract, the deal team should hold one or two reference calls with organizations that have partnered with the payer even if it's in another market.

The PHSO must strive to establish similar contracting structures across contracts in order to drive operational efficiencies. This is particularly true for quality metrics. The PHSO should avoid metric proliferation by standardizing metrics as much as possible across its value-based contracts.

Keys to Success: Don't underestimate the time this stage can take. An executed agreement takes at least six to nine months. Don't expect to see anything more than summary level cost data before a deal is signed. It will require a leap of faith, so pick partners wisely.

V. Creating a Comprehensive, Functional Information System

The PHSO and its staff must be supported by robust technology that aggregates data from disparate sources into a single source of truth about a patient—a 360-degree view of a patient. But the information system has to be more than that. It also has to streamline workflows and bring clinical decision support to the point of care. It is impossible to achieve operational scale without such a system.

Bringing necessary clinical data and insights to the point of care and eliminating burdens to addressing gaps in care and clinical quality metrics are essential for the PHSO.

This section describes the mission-critical components of a PHSO information system and offers guidance when selecting such a system.

Required Functions and Data

As it relates to an information system, a PHSO's end game must be to establish a core system of record for an individual—a single source of truth about a patient's entire consumption of healthcare and their medical condition as well as population-level insights (**Figure 5**). Armed with this information, care teams can more effectively close gaps in care, manage cost and utilization, conduct care management outreach, share best

practices, and conduct comparative performance reviews.

Perhaps the most underrated aspect of a PHSO information system is the ability to automate workflow. Part of this has to do with automating and centralizing care management assessments and care plans. But another part is bringing necessary clinical data and insights to the point of care and eliminating any burdens to addressing gaps in care and clinical quality metrics. Access to data in real-time—or as close to real time as possible—is needed to support the best care decisions.

The ideal is to have consolidated administrative and clinical data from the following sources:

- Payers and third-party administrators (TPAs)
- Pharmacy benefits managers
- Laboratories and pharmacy systems
- Electronic medical records
- Health information exchanges

“Data discovery” sessions with external data partners facilitate this consolidation. The primary goals of the initial meetings are to discuss contact points; legal hurdles, such as non-disclosure agreements; data requirements; relative ease of data extraction; and expected turnaround time. The data discovery sessions can then evolve into solution design workshops to align PHSO needs with system capabilities and design the data exchange processes.

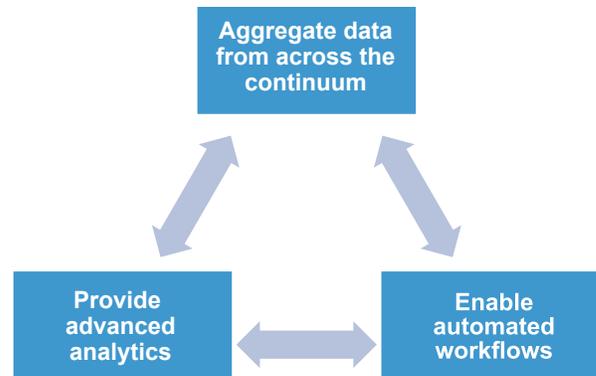
It’s worth noting that most payers and TPAs have a “standard claims” file. It’s a description of the fields that they include in their standard claims-level data extracts when sharing data with partners. The PHSO should ask for it. In most cases, the standard claims file will provide the organization with the necessary data, and it typically requires less lead time compared with a custom data extraction.

Keys to Success: Engage an appropriate advisor with the knowledge and expertise to assist in specifying system requirements and needs.

Selecting and Deploying a System

Incredibly, it’s not unusual to find PHSOs that are on their second or third information system. What’s going on here? At the beginning of the population health management movement, around 2010 to 2011, many organizations acquired and deployed relatively narrow solutions related to tracking quality measures, gaps in care, data aggregation and reporting. Unfortunately, these solutions were frequently fragmented and lacked integration to simultaneously aggregate, analyze and translate information into workflows. Like most technology solutions, it’s more about having a functional, comprehensive system than one

Figure 5: Three Functions of a PHSO Information System. Information from across the continuum of care (including claims data) must be actionable to enable effective patient and population management.



Questions to Ask for Planning an Information System

- What data is necessary?
- Who uses the data?
- Where does the data come from?
- How frequently is data refreshed?

that is really good at one dimension but lacks capability to perform the whole task.

So where should PHSOs start? The organization should establish a data governance function and have a core group of business and information technology leaders who are empowered to evaluate and make system selection decisions. It also should assign dedicated resources—an executive, project manager, and data steward—to lead and manage implementation activities.

The data governance team should begin by conducting an environmental scan of all the existing data sources and platforms that are relevant to population health management efforts. That means mapping out the ecosystem of existing data sources, data partners, and interfaces. Surprisingly, manual processes and spreadsheets still are pervasive.

Another task is to delineate how individuals may be accessing and using relevant data. For example, if the PHSO has an existing care management solution, it's important to understand who is accessing the platform. Is it only the care managers? Do providers also access the system? If so, at what point in the care delivery process do they access the tool? What are the essential data points they are using?

Understanding of the current information systems environment should then set up a conversation with your data governance team on the overall technology strategy. Is this a green field project for the organization? Should the PHSO consolidate to a smaller universe of vendors and fill gaps as needed? Or does the organization need to do a full rip and replace? The organization shouldn't necessarily look to its EMR vendor. It's well-documented that they often haven't been able to bring the right tools into the marketplace, despite their best efforts.

While the deployment process can be complex, the technology professionals and independent advisors should be comfortable with the tools underpinning good system selection and planning.

Keys to Success: Engage an appropriate advisor with the knowledge and expertise to assist in evaluating and selecting an appropriate PHM information system. Obtaining accurate, complete, and timely data from external data partners is perhaps the single most resource-intensive activity in building a PHSO. Start working on data acquisition on day one and plan for a long lead time.

CONCLUSION

Concerns about unsustainable increases in US healthcare spending and the inefficiencies inherent in at least one-third of that spending means that the drive toward value-based care delivery and financing isn't going to wane. Given this reality, health systems and physicians must adapt or be left behind. The best course is to embrace the new reality and transform healthcare delivery into a new, collaborative model that endeavors to manage population health—via the PHSO.

Adopting the PHSO model allows physicians and health systems to bridge the traditional payer-provider divide and build the capacity to take on performance risk and transform the practice of medicine in a way that improves care quality and keeps cost growth in line.

Compelling examples of success using the PHSO model exist. Healthcare organizations can replicate that success and transform their own businesses by using the five essential components of a PHSO laid out in this document as a roadmap. By putting in place each of these components simultaneously and embedding them operationally, healthcare organizations can create a true PHSO that achieves both care improvement and financial objectives.

For more information about how to create a high functioning population health management capability for your organization, please contact any one of the following:

Greg Scrine

Senior Vice President, Lumeris Advisory Services
312-888-0335
gscrine@lumeris.com

Ricky Garcia

Vice President, Lumeris Advisory Services
281-701-0908
rgarcia@lumeris.com

ABOUT THE AUTHORS

Greg Scrine is a senior vice president with the Lumeris Advisory Services group within Lumeris. Greg leads client advisory teams that work with a broad array of health system, physician, and payer organizations that seek to transform their business and clinical models to excel under population health management value-based arrangements. Greg has pioneered the strategy, design, and creation of population health service organizations for notable provider and payer organizations across the country. With more than 20 years of healthcare experience, he brings a deep understanding of healthcare organizations and a practical perspective to rapidly advance clients on their value-based journey.

Ricky Garcia is a vice president with the Lumeris Advisory Services group within Lumeris. Ricky is a healthcare strategy professional with more than a decade of experience delivering advisory services to hospitals, health systems, and physician groups. His areas of expertise include all aspects of developing a population health service organization, including deploying clinically integrated networks, operationalizing care management programs, and designing value-based contracts.

ABOUT LUMERIS

Lumeris brings common sense to healthcare. We provide strategic advising and technology to help providers and payers get back to the way healthcare should be—and share in the rewards. We guide health systems and providers through seamless transitions from volume to value, enabling them to deliver improved and more affordable care across populations—with better outcomes. And, we work collaboratively with payers to align contracts and engage physicians in programs that drive high-quality, cost-effective care with satisfied consumers—and engaged physicians.

An industry recognized leader, Lumeris was awarded 2017 Best in KLAS for value-based care managed services for helping clients deliver improved clinical and financial outcomes. This was the second year we received this distinguished award. For the past six years, Essence Healthcare, Lumeris' premier client with more than 63,000 members in Missouri and Illinois, has received 4.5 to 5 Stars from the Centers for Medicare and Medicaid Services. We enjoy working with all of our clients, delivering these same results, and aligning our proven multi-payer, multi-population model with their value-based care vision.