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Moving to Value with a Population Health Services Organization

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AN INDUSTRY IN FLUX



The healthcare marketplace is steadily shifting from volume-based payment to value-based payment. Why? Simply put, the nation cannot afford ever-increasing spending on healthcare services, which now consumes nearly 20 percent of the US gross domestic product.

That realization spurred government and private sector efforts to test methods of paying for value other than traditional fee-for-service reimbursement. These new reimbursement models switch healthcare organizations' and professionals' incentives from volume-driven payment to providing high-quality care, constraining costs and sharing in the savings.

Now, widespread agreement exists across the healthcare industry that value-based payment is the way to go, even if there isn't yet consensus on how to get there. The payment transformation is unlikely to stop despite congressional efforts to repeal the Affordable Care Act (ACA) — a major

force behind the growth of value-based payment — because support for value-based payment crosses party lines and the issue is separate from the law's disputed health insurance marketplace provisions.

Momentum is on the side of value-based payment. The Centers for Medicare & Medicaid Services reached its goal of tying 30 percent of traditional fee-for-service Medicare payments to quality or value through alternative payment models in January 2016 — 11 months earlier than anticipated. The agency wants 50 percent of payments to be tied to these models by the end of 2018. Meanwhile, although it varies significantly by geography, 58 percent of payers' business has shifted to value-based reimbursement, and hospitals' business is split 50-50 between value-based and fee-for-service payment, according to a 2016 survey of 465 payers and hospitals conducted by ORC International.

However, value-based payment comes in many forms with varying degrees of risk, from pay-for-performance on up to full-risk contracts in which providers share both upside and downside risk. Currently, most providers have experimented with models that carry only upside risk.

Though there is disagreement about how to calculate the proportion of true value-based reimbursement, one thing is clear: Moving to value is here to stay.

What is value-based care?

Value-based care can be defined as healthcare delivery that is accountable for both clinical and financial outcomes. It encompasses a wide spectrum of risk levels and programs, such as ACOs (MSSP, Next Gen), bundled payments, shared savings and partial capitation, all the way to full risk models.

With all the market dynamics and policy reforms in play in the healthcare industry today, one thing is clear: Moving to value is here to stay.

Public Policy Promoting Value-Based Payment

Several federal laws have encouraged healthcare to shift away from volume-based payment toward value-based payment.

HITECH Act and Meaningful Use

The Health Information Technology for Economic and Clinical Health Act of 2009 provided financial incentives to healthcare providers to accelerate their adoption of electronic health records (EHRs). The Meaningful Use rules aim to make sure providers use EHRs in ways that control costs and improve care.

ACA

The Affordable Care Act of 2010 included many provision directly or indirectly encouraging value-based payment, including:

- **Medicare Payment Incentives** Through its Hospital Value-Based Purchasing Program, the ACA provides incentive payments to hospitals that perform well on select quality of care and patient experience measures.
- **Medicare Payment Reductions** The law imposes financial penalties on hospitals with high rates of certain hospital-acquired conditions and high readmission rates for certain conditions.
- **New Care Models** The ACA enabled many programs testing several new care models, such as a variety of accountable care organization types, bundled hospital-physician payment, and primary care medical homes.
- **Insurance access** The law vastly expanded access to health insurance coverage through creation of state health insurance exchanges and the expansion of Medicaid. The influx of newly insured people seeking care heightens pressure to control costs without harming quality.

MACRA

The Medicare Access and CHIP Reauthorization Act of 2015 created a new physician payment system aimed at rewarding doctors for providing higher quality care. It established two tracks for payment — the Merit-based Incentive Payment System and Advanced Alternative Payment Models.

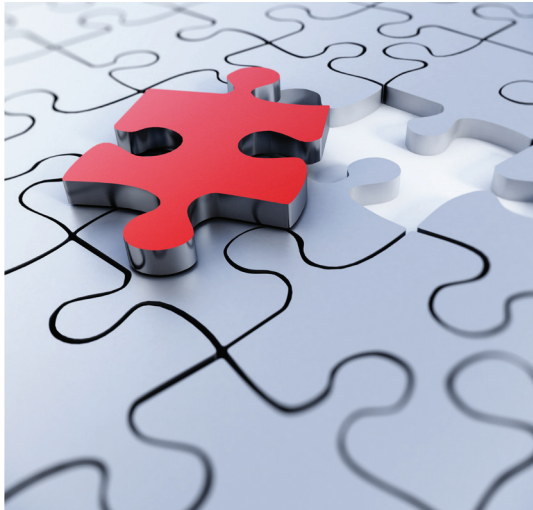
Medicaid

Ten states have created Medicaid accountable care organizations, and at least eleven more are exploring them.

Private Sector Factors Driving the Trend to Value

- Commercial insurers adopting value-based contracts.
- High-deductible health plans prompting consumers to shop for value.
- Consumer demand for quality ratings and other tools expanding to healthcare.
- Healthcare providers launching their own health plans.
- Commercial accountable care organizations and other models spreading outside of Medicare.

NEW CHALLENGES REQUIRE NEW CAPABILITIES



Although the structure of today's healthcare industry has not historically supported value-based models, the impetus for change is strong. Most health systems want to position their organizations to succeed in the emerging value-based ecosystem. But to truly achieve total population health management — better managing the sick and keeping the healthy well — requires new skills for all stakeholders, and each will have to navigate its own journey. As healthcare shifts to this new paradigm, the roles of providers, payers and consumers are changing. The lines that once strictly defined their positions in the marketplace are blurring.

To truly achieve total population health management—better managing the sick and keeping the healthy well—requires new skills for all stakeholders, and each will have to navigate its own journey.

Payers Move Closer to Providers

Value-based payment models turn the sometimes adversarial role between payers and providers on its head. The emphasis on improving healthcare quality while containing costs translates into efforts to accomplish such goals as preventing illness, reducing unnecessary utilization, preventing duplication of services, avoiding hospital-acquired conditions and readmissions, and improving hospital lengths of stay.

Payers cannot succeed in these endeavors without closely collaborating with providers. Some insurers are employing physician groups, but more are partnering with them. The underlying capabilities are to engage providers and work with them in a mutually beneficial way.

If value-based payment truly works, the result is a patient population that is healthy enough to need fewer services. This goal is accomplished through such means as aggressive management of chronic disease, early identification of disease exacerbation, avoidance of unnecessary care, creation of interdisciplinary care teams, support of care management and medical management resources, and engaged providers and care teams.

Payers will have to work closely with provider partners to adjust to this new way of thinking and to create contracts that, instead of paying solely for services rendered, move beyond just quality improvement incentives. The most advanced contracts will enable providers to share performance risk and the value derived from care improvements that generate savings.

Payers also will have to be more open with their data and resources. Providers can't be true partners in value without having the cost, utilization and quality data needed to identify improvement opportunities and track results. Resource sharing, and resource rationalization in particular with respect to care coordination, will enable payers and their provider partners to deliver better care without wasteful duplication.

Providers Behave More Like Payers

As providers assume accountability and even risk in value-based payment models, they will need a new skill set that includes capabilities more familiar to payers. Providers will have to understand what it means to manage patients at the population level before they can successfully take on risk sharing. That means shifting their focus from only the patient in front of them to the patients in their panel, in their practice and ultimately the entire population.

To achieve that wider perspective, providers must learn how to evaluate population health data to find opportunities to improve quality and efficiency and to track their performance. They'll have to think outside the four walls of the hospital to build care coordination and care management programs to support quality and efficiency improvement goals. Moreover, providers will need the right resources and tools to help support these programs.

Contracts must foster this vision of value. This means providers will need the know-how to build agreements with incentives designed to create the behavior change capable of improving quality while constraining costs and enhancing the patient experience.

Consumers Become More Engaged

To slow rising healthcare expenditures, many employers and insurers are asking consumers to pay more out of pocket for care. This trend is reflected in the increased prevalence of high-deductible health plans.

The rise in out-of-pocket costs puts pressure on consumers to learn to shop for value in healthcare services. And as they pay for more of the cost of care, consumers are becoming more engaged in making actual care decisions.

This means that consumers will be asking providers more frequently for information about their pricing and quality performance. Consumers won't succeed as value shoppers, however, unless providers are able to provide that information. Again, providers have a crucial role — that of a trusted advisor who lays out care options and helps to guide patients in their decision-making.

Providing Value with a Population Health Services Organization

Though many health systems are moving toward value-based models, few have completed the journey. Some systems have invested in strategy development but are unsure of how to implement the resulting plans. Others have invested in the technology and analytics solutions that have become synonymous with population health, but need support in how to use that data to transform their operations and drive outcomes in a sustainable way.

Furthermore, many health systems don't have experience with many of the complex functions necessary to take on full risk. These include aligning the leadership and organizational



structure, building the right physician network, negotiating payer contracts for value-based risk arrangements, developing care management programs and capabilities, deploying an advanced analytics infrastructure, and operating a health plan.

The way to get to the pinnacle of taking on full risk is to create a population health services organization (PHSO) — an entity that establishes population health management infrastructure and resourcing, enabling physicians to deliver improved clinical and financial outcomes.

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Transformation Through Partnership

But building a PHSO is easier said than done. Health systems that have little or no experience with value-based contracts face a steep learning curve likely marked by much trial and error. A faster, more effective option is to create an operating partnership with an entity that has a track record of building population health management infrastructure — beyond technology — using proven methodologies. An experienced operating partner helps newcomers transform their business without the bumps and missteps that cause disruption and slow the process.

A faster, more effective option to successfully move to value is to create an operating partnership with an entity that has a track record of building population health management infrastructure — beyond technology — using proven methodologies.

An operating partner must do more than create an implementation plan. It should work on the ground to help implement the strategy, technology and care management solutions. It should help to create the PHSO organizational structure and train leadership, physicians and staff in skills necessary for population health management.

Health systems that decide to form an operational partnership should look for an organization with capabilities in strategy development and execution, proven outcomes in areas of strategic interest, a deep operating bench, technology solutions, provider engagement playbooks, and a willingness to align incentives that drive continuous improvement.

Key Capabilities for an Operational Partner

Strategy Development & Execution

- Assess existing population health capabilities and detect any gaps.
- Identify populations with actionable opportunities to target for management across payers and lines of business.
- Create a physician-led organizational structure able to take on risk.
- Identify and negotiate win-win value-based contracts with sufficient value to share.

Technology Solutions

- Offer a platform integrating claims, EMR, lab, pharmacy and other data from across the care continuum to provide actionable insights that drive interventions by various stakeholders.
- Assemble data and analytic teams able to implement and oversee technology strategy that enables accountable care teams (ACTs).
- Employ tools that streamline workflows and bring clinical decision support to the point of care.
- Train physicians in the data skills necessary to manage patient populations.

Provider Engagement

- Align incentives across the continuum to encourage behavior change and practice transformation.
- Establish a primary care delivery model that engages physicians, and promotes accountability and care coordination across the ACT (including the patient).
- Offer a robust menu of care management programs that can be deployed across the care continuum.
- Deploy multidisciplinary teams adept at helping physicians transform their care delivery models, anchored on playbooks that can drive significant improvement in outcomes.

Aligned Incentives for Continuous Improvement

- Commit to a care model and business transformation over the long haul with a partner that will add value to existing infrastructure and simultaneously tailor its solutions and pricing to align with strategic interests.
- Leverage data, programs and knowledge resources to identify future improvement opportunities and move quickly to capitalize on these opportunities. Change management is at the heart of this effort that impacts a significant number of stakeholders.
- Create a long-term vision and roadmap — with flexibility to review and refine over time.
- Adapt to changes in the marketplace and organizational priorities.

THE WAY FORWARD

Healthcare is a complex industry in the midst of fundamental change. The shift to value — with its inherent focus on improving quality and containing costs — requires new systems for care delivery and payment. The PHSO is a proven model that provides both. It bridges the traditional payer-provider divide by enabling providers to manage populations under value-based arrangements by implementing programs and tools necessary for sustained clinical and financial outcomes improvement.

Building a population health management infrastructure from scratch, however, is a difficult undertaking. Entering an operational partnership with an entity experienced in PHSO development and implementation can ease the transition to this new model.

PHSO establishment is not a set-it-and-forget-it endeavor. Long-term change takes time, and value delivery doesn't materialize overnight. Any operating partner should commit to seeing the journey through and aligning incentives. The end result should be a self-sufficient organization that has internalized population health precepts in its infrastructure, incentives, programs, tools, operations and culture.

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Jeff Smith is an established health care executive with 20 years of health care technology and pharmaceutical services experience in sales and account management, operations, product development and management, business development and corporate strategy. Earlier in his career, Jeff started a point-of-care software business that grew to a market leader. Immediately before joining Lumeris, he was vice president of Strategy, Acquisitions, and Population Health Management at CVS Caremark, one of the nation's leading integrated pharmacy services companies. Jeff also served six years on the board of directors of RxHub and Surescripts. In his current role, Jeff is responsible for the national oversight of Lumeris' sales, marketing, and advisory solutions. He can be reached at jsmith@lumeris.com.

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Dr. Shah, based out of Chicago, is one of the key leaders within the Lumeris Advisory Services team. He is a physician by training and also has 15+ years of healthcare consulting and investment banking experience. Prior to joining Lumeris, Dr. Shah spent three years at GE Healthcare and xG Health Solutions, where he provided strategic advisory solutions to clients transitioning from a volume to value based payment environment. Prior to that, he spent 7 years at J.P. Morgan as a Vice President within its not-for-profit investment-banking group. At J.P. Morgan, he led various teams responsible for execution of several on and off-balance sheet transactions totaling more than \$5 billion aimed at providing short and long term financing solutions for several hospitals and health systems throughout the country. Prior to joining J.P. Morgan, he was at Booz Allen and Hamilton where he was involved in a wide variety of strategy engagements providing market assessment, acquisition related advisory services, and strategic planning to a large number of clients across multiple healthcare settings including pharmaceutical companies, managed care organizations and provider facilities. Prior to Booz Allen, he worked as a physician in both India and the United States. He has his Bachelor of Medicine and Bachelor of Surgery degree from Seth G. S. Medical College and King Edward Memorial Hospital, Bombay, India and his Masters of Business Administration from Fuqua School of Business, Duke University.