

At the crossroads of health care financial risk

New regulations, soaring medical costs and the shift to value-based care models are driving health care providers to assume more financial risk and better address the entire continuum of care. This is leading to a shift in how providers maximize risk-adjusted revenue and minimize risk-adjusted total cost-of-care within new innovative organizational structures that focus on greater efficiency and better care quality.

Value based care — the new normal

Government payers are phasing out the age-old fee-for-service payment model. The U.S. Department of Health and Human Services has set a goal of tying 90 percent of traditional Medicare payments to quality or value by 2018¹ and expects to eliminate fee-for-service totally by 2020. Commercial health insurance companies are likely to follow suit.

Opportunities for increased growth and value

Care management

Payer provider convergence

Demographics

Emerging technologies

Strong focus
on growth
and value

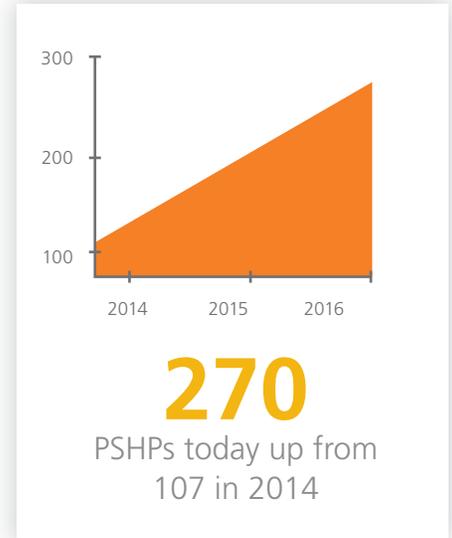
This new normal is leading health care providers and health plans to consider alternative payment models that assume more risk, such as shared savings or bundled payment arrangements, in which reimbursements are linked to the quality of care and the value delivered within an episode of care. Due to this shift, many provider organizations are looking to become risk-bearing entities (RBEs). An RBE is an organization that assumes financial responsibility for the provision of a defined set of benefits by accepting a fixed payment for some or all of the cost of care. Providers and provider organizations, if payments are capitated, bear risk.² Bottom line, risk-bearing entities are the means to value-based care.

Figure 1: Value-based reimbursement models enable integrated care. As you move from left to right, the reimbursement model requires a greater degree of provider sophistication, collaboration and managed risk.

Fee-for-service	Bundled payments	Shared savings	Shared risk	Global patient management and risk (PSHP)
Payment for service or activity	Attain measure targets	Manage event/condition	Manage event/condition	Manage a population

One RBE option that’s rapidly becoming more common in the U.S. is the provider-sponsored health plan (PSHP). A PSHP is defined as a health plan owned by a health system, physicians group or hospital. It takes on global risk and management of a patient, including acquisition, retention, total cost management and care delivery. There are 270 PSHPs in operation today in the U.S., up from 107 in 2014, and 50 percent of health systems have applied or intend to apply for an insurance license.³ According to a recent survey of health system executives, 66.7 percent of hospital C-suite leaders are considering starting or working with a provider-owned health plan rather than partnering with private insurers.⁴

Whichever option an organization chooses to provide and pay for care, one thing is clear: care quality and the cost to achieve that quality are now front and center and creating a patient-centered healthcare system that promotes choice, quality and affordability remains a central focus. What’s unsustainable today and needs to change is the rising cost of care per patient. The Department of Health and Human Services (HHS) recently reported that the U.S. spends on average \$10,345 per patient per year and projects that health care spending will grow at a faster rate than the national economy over the next decade.⁵ Value-based models can lessen these rising health care costs by driving out inefficiencies while improving quality and increasing patient satisfaction.



Regulatory and consumer driven transformation

Federal regulatory changes and programs are creating a direct-to-consumer channel and spurring the shift from volume to value. The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) is playing a key role in transforming the U.S. health care system, Connecting these key groups, founded to support connections between innovation models, stakeholders, providers and others, at both national and regional levels is an essential part of supporting efforts towards driving greater quality and better value.

One of CMMI’s main initiatives that is bound to have an impact on value-based care models is MACRA – the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), a landmark payment system for Medicare physician reimbursement. MACRA’s Quality Payment Program will create a catalyst and a framework for physicians so they can transition from the current fee-for-service world to a value-based care model. Characterized as “delivery system reform/Medicare payment reform” by the CMS, MACRA is a “new framework for rewarding health care providers for giving better care, not just more care.”⁶ MACRA provides new incentives in how providers are paid, however the changes to these payment models require that the provider take on additional financial risks.



“Consumer demand and expectations are going to lead to the transformation of the care delivery system,” says Zahoor Elahi, Senior Vice President, Optum. “Organizations that find innovative ways to improve quality and reduce costs are likely to succeed. Whether it’s creating an RBE, a PSHP or some other non-traditional arrangement that pulls all the pieces together, integrated value-based offerings and new financing models are going to win the day.”

Evolve or decline

Collaboration between health plans and health systems is required, or survival could be in question. “We started the Vanderbilt Health Affiliated Network several years ago as a risk-bearing entity,” says David Posch, Senior Vice President, Population Health, Vanderbilt University Medical Center. “It really began by, first of all, looking at the trends: there was consolidation in the market, and the amount of money available for health care was going to be restricted if not shrunk. It was clear that the risk was going to be transferred from payers to providers. And quite frankly, in that kind of environment, either you will be consolidated or you will be a consolidator. And we chose the latter.”

Many factors are driving the need for consolidation, including shrinking margins, increasing cost of care and the shift toward consumer-centric health care. In addition, the changing demographics of an aging population will mean an increasing number of Medicare patients and adherence to MACRA-driven value-based payment models. Finally, more than 40 percent of the U.S. population has at least one chronic health condition, and that number is rapidly increasing.⁷ Chronic conditions account for the majority of health spending, and a cost-effective integrated care continuum with a patient-centered approach offers the best opportunity to manage chronic conditions.

Selecting the right model

One thing is for certain: providers can’t maintain the status quo. They must evolve their operating models to assume greater risk and structure themselves into risk-bearing entities that both provide and pay for care. Potential models include:

- **Bundled payments:** Physicians and hospitals bill insurance for services using capitated rate or bundled payments.
- **Shared savings:** Physicians are capitated by the health plan for professional services, and the physician and the health plan share a percent of upside and downside for medical expense.
- **Shared risk:** Physicians and hospitals are capitated per patient by the health plan for professional and institutional services. The health plan keeps a percentage of premiums for profit, marketing, underwriting, etc., while the remainder goes to the provider groups responsible for care.
- **Global patient management and risk:** This is the PSHP model; the health plan and the provider system are one and the same, and control all functions around both insurance coverage and care delivery.

Which model an organization chooses will depend on its unique circumstances and the dynamics of the market in which it operates. In the case of the global risk model, either the provider or a health plan could be the catalyst for change. If the health plan remains the RBE, it still needs to integrate with the provider to deliver coordinated services across the continuum of care in order to effectively manage costs. “The biggest piece was just understanding what it takes to run a health plan,” says Jamie Reynoso, Chief Operations Officer, Memorial Hermann Health Plan. “You need to appreciate the type of assets and skill sets that you need to run a successful health plan, and understand that just because you have a successful ACO doesn’t necessarily mean you’re going to succeed in population health and managing a health plan population.”

Figure 2: There are several potential risk models to choose from as providers and payers adapt to the new normal. As you move from left to right on the chart below, you are increasing integration, coordination and commitment to financial risk.

	Fee-for-service (FFS)	Bundled payments	Shared savings	Shared risk	Global patient management and risk (PSHP)
Patient or population attributions	No — patients are not attributed to any one physician or system	Patients are attributed to a provider/system, however patients rarely know about the association	Patients are knowingly assigned to a primary physician within a network	Patients are knowingly assigned to a primary physician within a network	Patient chooses provider group with plan choice (not necessarily directly assigned a physician — depends on plan design)
Provider payment method	Paid for each service that is billed by patient’s insurer	Paid for each service provided, however, there is a budget set (between payer and provider) for care	Payment from insurer to provider(s) is capitated per patient or incident/condition based on contract rates and risk-assignments (DOFR)	Payer keeps a percentage of the premium (for underwriting population), remainder goes to provider to cover care costs	Physician group retains full medical premium as they are both the payer and provider
Provider risk	None	Upside risk — if providers come in under set budgets, they have an opportunity to share in the savings	Both upside and downside risk — due to rate capitation	All care/medical risk*	All care/medical risk*



*There is likely some risk, for high-dollar procedures, like transplant, that might still be borne by out of network providers or payers. But most risk will be borne by the primary physician and system.

Sponsoring a health plan is a complex undertaking and requires adding new competencies not typical to provider services including: sales, marketing, product development, enrollment, billing, claims, care management and servicing. “I think one of the biggest challenges is that hospital people are really good at running hospitals and health plan folks are really good at running health plans,” says Reynoso. “When you put the two together, sometimes there’s conflict.”

Putting patients in the middle

In addition to adding health plan capabilities, value-based health care demands innovative new clinical care models in order to be effective. Health care in the U.S. has evolved into a system of silos. From the macro perspective, this includes hospitals, insurance companies, government agencies, pharmacies and employers — all bound by contracting agreements. At the micro level, silos have proliferated within provider organizations and are standing in the way of efficient and effective care. We need to move from silos to enterprise data management and clinical integration to create a more value-based system.

To meet these challenges, a successful RBE must:

- Innovate across the continuum of care for every patient over time, which could include financial incentives for better care management and better quality-of-care reporting
- Do a better job based on evidence-based medicine—for example, using analytics to proactively identify high-risk patients for care interventions
- Engage the patient, including providing more care management and cost oversight, and begin anticipating care needs

“We start with the patient in the middle,” says Mary Jo Williamson, Chair for Practice Administration, Mayo Clinic. “We figure out how we can bring the best resources to bear and provide the most efficient and high-quality care. That works really well, regardless of in what direction the market tends to move with new products or the reinvention of old products.”

Data: catalyst for innovation

In addition to the financial considerations, merging health plan and provider capabilities will uncover a hidden store of clinical, financial and customer data. Maximizing this treasure trove of comprehensive and diverse data on outcomes, costs, and patient satisfaction will require collaboration and vision. “As you move into either a PSHP or an RBE model, you are now in a deep partnership with your provider or your payer, and you need to work out how data sets are shared to drive better outcomes, both clinically and financially,” says Optum’s Elahi.

In order to take full advantage of integrated provider and health plan data, next-generation provider organizations need to:

- Bring together large volumes of data across many silos to create an actionable data set
- Take advantage of the latest data analytic tools and techniques to uncover new relationships and drive strategy and performance
- Continually evolve to take advantage of new data and digital business opportunities

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Data-driven evolution

The transition to value-based health care in conjunction with the increasing consumerization of health care, presents new opportunities to drive innovation. Provider-payer partnerships will provide full actuarial and patient utilization data that can be vital to success. “By focusing on next-generation informatics, analytics and business intelligence, you get a complete and comprehensive knowledge of the customer,” says Virginia McFerran, President, Optum Analytics.

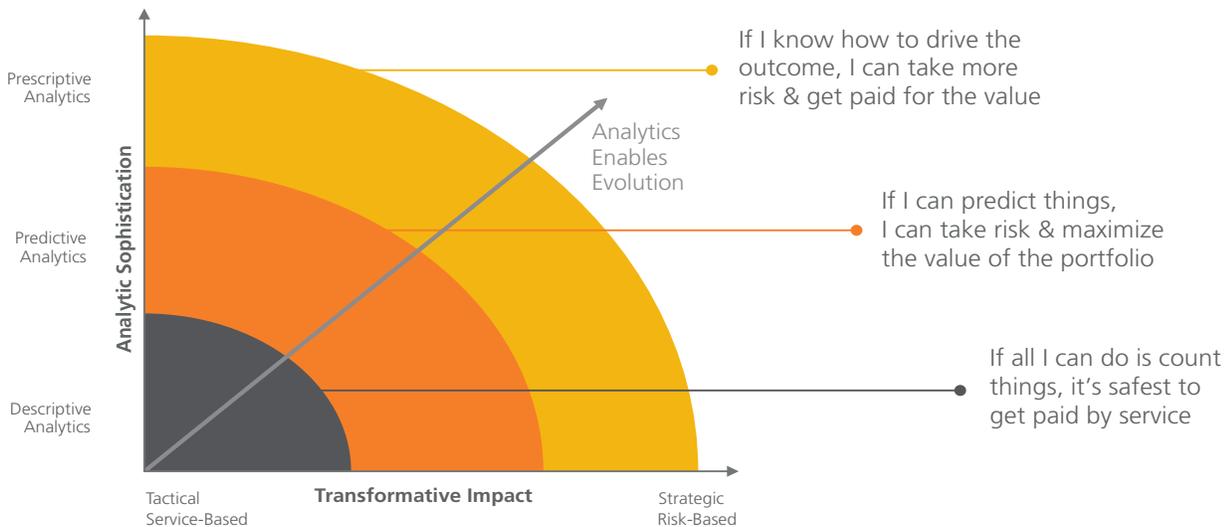
In an organization that is optimized to deliver value-based care, there will be not only an abundance of claims and clinical data, but also the opportunity to combine that information with social, economic, geographic, -omics, care coordination and behavioral data, as well as data from remote patient and medical devices and the Internet of Things (IoT).

“By 2020, there will be 50 billion devices and data sets connected to the Internet, and they can provide invaluable information by patient cohort, by disease and by therapeutic area,” says McFerran. “Whether it’s a continuous glucose monitor tracking blood sugar trends for a diabetes patient or a scale reporting rapid weight changes for a patient with congestive heart failure, this information can go directly to a care coordinator to circumvent an event before it happens.”

According to McFerran, the key is building the next-generation analytics that can harness information from the growing number of data sources. “From an analytics perspective, the more you know, the more risk you can accept and the more you can drive value.”

Figure 3: As we move from descriptive analytics to predictive and prescriptive analytics, this information and insight can be used to reengineer the system across the continuum of care.

Build the analytics



The integration of data and analytics will also provide the opportunity to create powerful new tools for providers and other caregivers. Using the latest technology, these tools will reinforce value-based care and ensure the best clinical outcomes by supporting integrated care coordination and monitoring across the new digital health care ecosystem.

To be most effective, next-generation provider tools should:

- Present information in an easy-to-consume format
- Take advantage of predictive/prescriptive analytics
- Use health population management data to create insights into the individual patients you are trying to serve
- Support patient-entered symptoms and direct feeds from personal monitoring devices
- Provide tailored views for doctors, nurses and other caregivers
- Incorporate the latest devices as they emerge

Big data plus

In order to take advantage of the data available to a provider-payer, most organizations will require substantially more computing power than they have today. Initially, you need an infrastructure that can support the integration of the combined clinical-health plan data. Later, your infrastructure will need massive computing power to support the advanced analytics required not just for your own patient population but also for comparisons to patients throughout the entire U.S. Finally, big data gets even bigger when data from social media, personal devices and the IoT has to be managed as part of the digital health care ecosystem. This will become even more important as data and recommendations will be provided to patients and consumers on a real-time basis.

Staying current with accelerating data requirements demands a high-performing computing environment that is secure and scalable. Provider-payer organizations must develop a big data computing infrastructure strategy that is both right for today and ready for a tomorrow that could include data loads that reach petabytes and beyond.

Consider these five best practices

Based on third-party research and insights from health care executives, we identified five best practices for provider organizations considering a PSHP or RBE solution.

1. Develop an agile infrastructure that can quickly leverage new opportunities.

With changing regulations, shared risk arrangements, increased consumer engagement and ongoing digital business transformations, your organization needs the agility to quickly leverage “business moments” as they occur. This requires a transition to IT and business processes delivered as a service (aaS) in order to gain the flexibility and scalability to act quickly.

2. Consider strategic partnerships that add core competencies that your organization does not possess. Health systems have the leadership and technology to run hospitals, but typically don’t have the expertise required to manage an insurance plan. A partner or an outside service provider with knowledge, experience and an administrative infrastructure can fill the holes and minimize your investment and exposure during this evolution.

3. Be proactive instead of reactive. Provider organizations need to develop work processes and tools that improve efficiency, accountability and care management. With comprehensive data on outcomes, costs and population health, you can deliver proactive care management and disease prevention that generate superior patient engagement and results.

4. Develop a culture of collaboration. Providers and payers have traditionally had different outlooks. One understands risk from the viewpoint of health and physiology; the other understands financial and actuarial risk. To succeed, leaders of a combined provider and payer organization must create a culture of collaboration across the enterprise that includes more transparent sharing of information and a joint accountability for patient outcomes.

5. Focus on a single market segment to start. Providers can differentiate themselves by focusing on a specific line of business such as Medicare Advantage or managed Medicaid. According to Ross Erlebacher and Warren Suh of Top Tier Consulting, being focused enables organizations “to optimize operations around a market segment, which enables them to compete with traditional plans.”⁸

Conclusion

New government regulations are causing seismic changes in the way health care services will be provided and paid. The shift from volume to value has created new incentives for alternative payment models that require taking on more financial risk. This is leading to collaboration between health care providers and health plans as each tries to find the right formula to navigate the new normal.

Many providers are changing their operating model and structuring themselves as provider-payer risk bearing entities that take on some level of risk for the cost of care and the and quality of patient outcomes. This requires addressing significant challenges such as increased risk, substantial capital investment, and building or acquiring health plan competencies. The winners will be the organizations that embrace these challenges and find innovative ways to drive out inefficiencies and improve quality.

The primary catalyst for innovation could very well be the wealth of clinical, financial and customer data that resides within an integrated provider-payer entity. By taking advantage of next-generation informatics, advanced analytics and business intelligence — as well as tapping evolving new data sources such as remote patient monitoring, biosensors and social media — your organization can gain the insight needed to reengineer the system across the continuum of care.

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For more information, contact an Optum representative at:

Email: empower@optum.com

Phone: 1-800-765-6807

Visit: optum.com



11000 Optum Circle, Eden Prairie, MN 55344

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