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FEE-FOR-SERVICE TO VALUE-BASED PAYMENT TRANSFORMATION, PART 5: SUCCESSFUL POPULATION HEALTH MANAGEMENT - INSTALLMENT 1

This article is part of a series about value-based payments and their applications in the healthcare landscape. This is the fifth article in the series and will be part of a two-part installment on population health management.

Introduction

The complexity of pluralistic payment environments represents a new wave of challenges providers and health systems face in managing business within each of their markets. Previous articles in this series examined the foundation of new payment models, including structure and characteristics of unique value-based payment (VBP) arrangements, expectations around provider readiness, as well as how high-performing networks are constructed. Installment 1 of this two-part article will explore and address critical business functions required for successfully managing a defined population under a VBP arrangement.

Population Health Management Defined

Healthcare in the United States has historically been dominated by an episodic system-of-care model. Typically, patients are treated for their health event, leading to decisions dictated by presentation of disease and ending at their last related medical follow-up. Treating episodes provides only a narrow scope into the health of a patient and misses the opportunity to leverage data that could reduce the overall cost of each episode and the frequency of occurrence. In a fee-for-service (FFS) environment, there rarely exists a financial incentive to explore opportunities outside of episodic systems, driven unfortunately by the direct causal link between increased quantity leading to increased revenue. As the healthcare industry continues to shift its focus to VBP, changes in the way care is conceived and delivered must change and be managed appropriately as well.

Population health management shifts the focus from individual episodes to caring for complete (sometimes very large and diverse) populations. While striving to achieve the Triple Aim™ of decreased cost, improved quality, and increased access, selected healthcare systems have enabled themselves to successfully meet the new wave of VBP reimbursement.

Population health management converges the following:

- data for decision-making;
- matched financial incentives between the payment and delivery systems and;
- patient-centered care models.

By harnessing the power of detailed analytics, providers can leverage longitudinal data to support clinical decision-making for individual patients, while health systems can assess their populations to meet the needs of their patients as a whole. This could mean opening a new access point in an underserved area, building out a specialty practice for a disease with higher prevalence in a defined geographic area, or finding systematic ways to improve care delivery by targeting unique characteristics of the population.

Centering care on the needs of each patient aligns very well with VBP models because incentives are more closely tied to health, well-being, and outcomes. Allowing providers to focus on the

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needs of the patient does not function well in an exclusively FFS payment environment because of the misalignment between a physician's motivation to proactively maintain the health of their patients and the motivation to maximize payment. In adopting an alternative payment model, a framework emerges that drives all stakeholders towards a common goal of better health.

Data for Decision-Making

From small to large, population health management program success depends on maximizing the benefit of appropriate useful information being utilized during decision-making. The most successful programs have managed to present results in a meaningful way through simple and contextually relevant reports. Analyses should highlight recommendations for action-oriented behaviors within the appropriate scope of practice for the provider. In addition, there needs to be sufficient political support (e.g., from leadership) and autonomy among those responsible for implementing change.

Providers can utilize an array of analytical tools and reports for practical application of data to empower better decision-making. Examples of these are outlined below:

Example Report	Data Source	Variables of Interest	Strategic Impact
Disease Cohort – Gaps in Care Report	Electronic Medical Record (EMR)	screening rate by patient for certain diseases	Proactive screening leads to early detection and treatment, reducing chances of expensive acute care episodes.
Rising Risk Patients Report	Health Plan Claims	continually enrolled patients with at least one or more chronic condition in the current calendar year vs. the last calendar year	Proactive outreach to rising risk patients to enroll them into care management and/or disease management programs reduces the likelihood of future hospitalizations and drug expenditures.
Medication Fill Rate	Health Plan Claims and/or Electronic Medical Record (EMR)	patients prescribed certain prescription medications who did not fill the prescription within a specified period	Patients who do not fill their prescriptions have increased risk for emergency department use. Further, they may have social barriers (e.g., financial, cultural, physical) prohibiting them from filling prescriptions. Removing those barriers helps improve medication compliance and reduces the risk of ED use.

Financial Incentives

Finding financial alignment between payors and providers has been a challenge that continues to complicate care delivery. Further adding to the complexity are the various degrees of involvement for incentives ranging from individual-level to large network and systems-level motivations.

In an effort to reconcile alignment between healthy patients and greater utilization of services, incentive systems were developed to reward improved quality under an effort-driven payment model. This major push to pay-for-performance (P4P) was aimed at dealing with the discordance between providers being paid for quantity of services rendered versus payments based on quality of care provided. Research on P4P impact produced mixed results, and plenty of critics will point to the fact that providers are motivated to perform well on what is measured, often missing or neglecting other variables that still may decrease the overall health of the patient. Providers may also argue that constant quality oversight limits their autonomy as physicians, while interrupting and producing increased burden to providing care.

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The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act, known as MACRA, was aimed at advancing alignment of financial incentives for providers with major payment sources. Population health management programs that have aligned financial incentives are the most successful, even if there is fragmentation of these arrangements across different insurance offerings or lines of business. Finding universal alignment that spans Medicare, Medicaid, and commercial payor offerings will take time, but as providers phase slowly into VBP arrangements, acknowledgement of these differences will be addressed. The market is starting to understand how helpful standardizing quality measures will be for reporting and payment.

Conclusion
Providers have been managing both spheres, straddling a line between FFS and some risk transfer or capitation arrangements with payors. After decades of FFS, this transition is perhaps appropriately slow. Providers need time to adjust to new climates, to systems of incentives, and to realize material success, before moving to total and complete alternative payment models. As healthcare in the U.S. approaches 20% of the gross domestic product (GDP), it is likely the emphasis on value is a shift that is here to stay.

Part 2 of this VBP installment will include a deeper look at patients and how they stand to benefit from these new payment models.

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