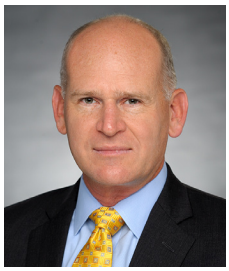
COPE HEALTH SOLUTIONS

Preparing Your Health System for Risk-Based Contracts



Allen Miller
Principal & CEO

Stephanie King
Manager

As health systems seek or are forced into risk-based contracts, aligning stakeholders and developing a comprehensive strategy to create a culture ready for change is key. Regardless of your system's current level of maturity with risk contracts or its ability to manage care for a population, moving from fee-for-service payments to global risk or capitated agreements requires a thorough plan and successful execution of internal and external strategies. Although not all external elements are within the organization's direct control, preparing the internal organization by building the operational capacity to align financial incentives that drive improvements to the health of an attributed population can begin immediately. This includes completing a checklist of network adequacy, care model and administrative readiness requirements that is functional and managed by experienced leaders, prior to taking complete financial responsibility for the health of a population.

Key Elements for a Successful Transition

The transition to risk requires deep stakeholder alignment to establish a set of key structures, processes and functions not required in traditional models. These include network development or optimization, the build or buy of management service organization (MSO) functions and redesign of the care model to focus on managing attributed members in order to impact their health and total cost of care. At a high level, organizations can focus their strategy on three key steps, each described below in the subsequent paragraphs:

1. Strategic Alignment of Stakeholders
2. Business Practice Changes
3. Data Analytics and Care Redesign

Strategic Alignment – Physician and Staff Engagement

Key to the success of any strategy is a deeply aligned group of executive and physician leaders who can over time engage and bring along middle management and the entirety of the health system's providers, including contracted physicians, providers and staff all in alignment towards the same goal. For successful alignment, executive and physician leaders, and eventually all stakeholders, should have a unified understanding of the risk business and the structure and processes required for success. Leaders should be aligned not only on what are the proven best practices, but on the local political, financial, geographic and competitive landscape that may shape the organization's risk-based strategy.

Upon establishing a common base of knowledge and assumptions around market and regulatory current state and best practices for success in risk contracts, organizations should develop a clear vision for areas to manage and take financial accountability for from an administrative and medical perspective. Use a division of financial responsibility (DOFR) approach to identify specific medical expenses, based on the targeted network and expertise, as well as administrative functions for which MLR risk and delegation will be sought. Define the high-level value proposition for providers, members and payors based on the provider network and the medical, social support and administrative services to be offered. This should be measurable in terms of access, quality and total cost of care.

With a common base of knowledge, administrative and clinical leaders must work collaboratively to translate the value of the population health strategy and efforts to physician leaders and clinical teams, in relation to the impact on their practice, members and overall business. Without this connection and strong value proposition, buy-in will be limited and conducted more out of obligations to governance as opposed to a clear line of sight regarding success to the system and success of the provider.

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Upon this foundation, leadership can create an educational and alignment pathway for the overall health system and network to ensure each provider and staff member gains an understanding of their daily work impacts on customer satisfaction, attributed member retention, premium dollar optimization and total cost of care.

Business Practice Changes

As the strategic alignment work ramps down and leaders are aligned with how the business will change, a timeline and operational work plan should be developed to build some of the initial foundational requirements.

The high-level business practices that need to be decided on initially include but are not limited to:

1. The managed care contracting strategy for upstream (health plan) and downstream (provider) contracts based on the DOFR approach previously discussed. During this process, the organization should conduct a current state assessment of population health management capabilities to determine the initial and future MSO services that can be internally managed or created as opposed to those that can be bought. The organization should also assess current and proposed health plan as well as provider contracts against goals to determine that require the most change.

2. The creation or modification of a network development strategy to ensure network adequacy and optimization across various lines of business and traditional and nontraditional providers (e.g., home and community health programs). The network development strategy should be data-driven to identify and proactively address member needs for care to support a population health approach and therefore address clinical, ancillary and community-based services.

3. Development of a financial pro forma and, if appropriate, reinsurance approach that ties together the medical and administrative divisions of financial responsibility (DOFR) with the contracted network, attributed characteristics and projected cost for the attributed (or to be attributed) population, MSO services provided and the terms of the upstream and downstream contracts.

4. Development of a master metric overlap tool to document, understand and translate performance metrics across the continuum of care to accountable operational and clinical owners or stakeholders. There should be transparency, mutual understanding and consistency with relation to performance metrics in upstream contracts, funds flow and incentives to downstream providers and agreed upon measures to track progress throughout the year. Metrics across risk-based agreements should translate to measureable initiatives, bottom line impact and carry through consistently across health system agreements (e.g. medical foundation or IPA professional services agreements, MSO service level agreements, administrative bonuses and provider risk sharing arrangements).

Data Analytics, Network and Care Model Redesign

Accessing and using the best available claims data for current or potential attributed populations whenever possible is required for planning and budgeting to succeed in risk. Analysis of claims data will inform the required provider and community based organization (CBO) network to achieve “network adequacy” by line of business and sub-populations such as HIV, ESRD, care model staffing and member journeys and focal points for utilization review and utilization management activities.

With data analytics completed, a gap assessment should be undertaken of the following key areas:

1. Member Identification – understand the population and for whom a health system will take on risk
2. Risk Stratification – use data and logic to determine which members are most likely to be impacted by care management interventions and wellness/prevention initiatives

3. Member Attribution and Empanelment – systematic assignment of members attributed to primary care panels and care teams accountable for member outcomes
4. Network Development and Optimization – ensure geographic access to the required provider types, CBO and care management services with alignment of financial incentives and provider contracts to key performance indicators that will improve quality and reduce total cost of care
5. Care Management Delivery – design evidence-based care management interventions and wellness/prevention initiatives that meet the needs of both the member and the organization
6. Care Management Workforce – staff the care management interventions with an adequate number of resources and skillsets to meet member volume and needs
7. Evaluation and Reporting – identify key performance indicators that will support care model and outcome evaluation without unnecessary overhead
8. Enabling Infrastructure – integrate other core infrastructure to support population health management programs including IT solutions, scheduling and call center and member and provider engagement platforms and apps

Through gap analysis and identification of best practices, implementation plans and key milestones can be developed for each redesign initiative.

The transition to risk-based care contracts should not be one that organizations fall or rush into. Without an appropriate and thought-out strategy, organizations can risk entering risk-based arrangements that are not in their best interest or require infrastructure that is not available, which may cause confusion across the organization. COPE Health Solutions has over 20 years of experience in supporting organizations to succeed in value-based care models. To find out more about our expertise and how we can support your organization, please visit www.copehealthsolutions.com.

For more information, please contact Allen Miller, Chief Executive Officer, COPE Health Solutions at amiller@copehealthsolutions.com or call (213) 259-0245.