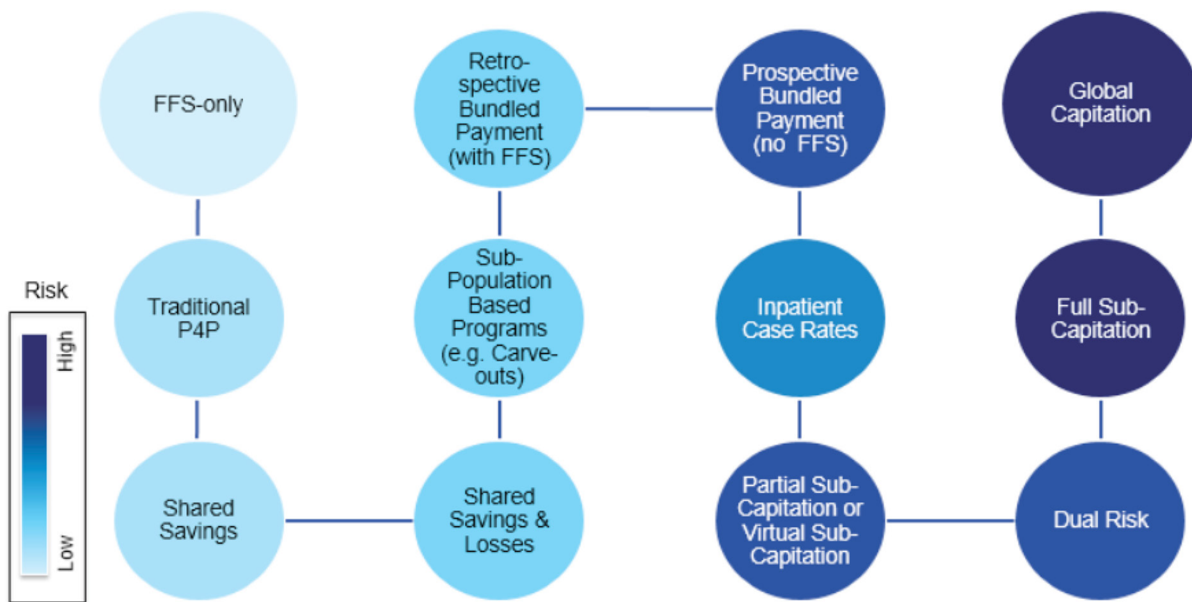
Robust Data Analytics: The Backbone for Success in Our Emerging Pluralistic Payment Environment

By Carla D'Angelo, Vice President and Cindy Ehnes, Executive Vice President

2018 has been a year of uncertainty in federal and state health policy, particularly with respect to population health. Despite increasing complexity and ambiguity, most markets continue to move toward various forms of value-based payment (VBP). However, most health systems and physicians continue to operate in pluralistic payment environments, defined by having a portion of their revenue in dual risk, some in shared savings, some in bundled payments and some in fee-for-service (FFS) – concurrently straddling several points along the payment system spectrum.

Figure 1: Payment System Spectrum



Knowing how to be successful in this pluralistic payment environment necessitates an evidence-based, "clear-eyed" look at strategy, payment contracts and systems, delivery system structure and programs, care management capabilities and workforce requirements. Undoubtedly, health systems and physicians are navigating the delicate move to value-based payment. At the same time, however, health plans are increasingly deemphasizing shared savings programs, the starter VBP arrangements, which plans perceive to be less successful at changing behavior, in favor of both up and downside risk contracts. Downside risk leaves little room for error when managing loss of traditional inpatient revenue for hospitals and the new costs associated with infrastructure building for value-based care.

For health systems, moving a significant portion of their book of business into dual risk and capitation arrangements can present a difficult situation because the revenue loss generated by reduced volume on traditional admissions must be made up elsewhere within the system. It becomes critical for providers to develop a roadmap to success, characterized by a gradual shift from traditional revenue streams

based on volume of services, to profitable capitated lines of business. In order for health systems and physicians to excel in the current payment environment, they must address three key value drivers:

- Quality Management
- Revenue Optimization
- Utilization Management

Success in addressing these drivers requires a new level of collaboration with other providers across the care continuum and robust data and analytics to help focus providers on the right efforts to ensure a positive margin. It is also essential to understand that the infrastructure required to perform well on these initiatives can coordinate with opportunities to negotiate rewards for reducing cost and utilization and managed care contracts. Well-negotiated managed care contracts must then ensure that successful performance and utilization management will lead to pass-through revenue savings to physicians and dollars to reinvest in core infrastructure.

The first step in developing a phased, articulated strategy is to understand in great depth the flow of current dollars into and out of the health system using existing available claims data. Today, health systems and providers navigate a complex mix of reimbursements, including discounted FFS, diagnostic related groups (DRGs), per case payments, bundled payments, supplemental payments (such as disproportionate share hospital dollars) and other payment methodologies. Safety and quality of care performance metrics, readmission penalties, CMS initiatives and bundled payments are other common examples of simple risk and quality payment arrangements. Each of these has its own infrastructure implications, system burdens and positive and negative incentives.

From this baseline information, it is critical to assess reliably the opportunity to enhance performance under current risk contract configuration and the opportunity to improve that performance at the individual provider level. Providers must fully understand their financial and nonfinancial incentives already in place, both favorable and unfavorable. It is equally vital that executive leadership understand various current revenue and spend impacts at the level of individual physicians, hospitals and other key providers.

By using claims data, a health system can see where their patients are utilizing services both within and outside of their system. Drilling down to practitioner-level detail for all providers within the health system as well as for those practitioners caring for their patients outside of the health system is a critical success factor to effectively managing the population and performing well in value-based arrangements. A validated forecast of the actual impacts of key initiatives will gain buy-in from key stakeholders. Setting target benchmarks using peer performance is an important initial step when trying to culturally shift a health system and its practitioners. The most successful health systems are able to navigate the myriad of upside opportunities and downside risk measures they are engaged in by identifying a common set of key initiatives that will drive success across the various metrics.

Quality Management

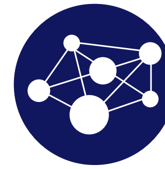
Effectively manage total cost of care through appropriate medical use

- PCP and Specialist Co-Management
- Chronic Condition Management

Revenue Optimization

Increase premium revenue through additional services, member enrollment and documentation

- MCO STAR Rating
- Appropriate Member Enrollment



Utilization Management

Optimize appropriate utilization through improved care coordination

- Reduce avoidable admissions
- Referral Management

The development of a multi-year pro forma based on validated claims and cost data that demonstrates the actual impact of key initiatives will assess:

- Appropriate enrollment of current and prospective patients and members in the product optimally designed for their needs (e.g. Medicare Advantage vs. traditional Medicare; Medicaid or the other Affordable Care Act products)

- Optimal opportunities for high-risk member management, initially determining “impactable” members and high-risk member density mapping against available providers

- Contracting opportunities to measurably improve payor STAR ratings based on improved quality and reporting, as well as provider aligned incentive programs; fee schedule and risk-adjusted capitated payment negotiation and reinsurance thresholds

- Revenue enhancement initiatives, such as correct coding optimization, call management, formulary development and UM optimization

- Facilitated member access to the most appropriate site of care, including initial empanelment to high-performing PCPs and specialty providers, reducing network leakage to non-system specialists, as well as e-consult availability for PCPs

Hospitals and health systems vary significantly in terms of geography, services and patient population, which creates the need for understanding the data at a local level. Rigorous data analytics evaluates the costs, risks and revenues based on proposed population characteristics, associated cost, savings opportunities and threats to profitability. Analytics will highlight short-term opportunities to fine-tune current FFS payments to incentivize reductions and utilization. Additionally, network leakage statistics provide the indicators of gaps in provider access and highlight referral patterns that can bleed finances with out-of-network hospitalizations, specialty care and home or community-based care.

The ultimate goal must be sustainable success in managing the dollars at-risk for defined populations. Deficiencies in operational, utilization and referral management, claims administration and clinical information technology will jeopardize well-intentioned population health strategies. Therefore, current management services organization (MSO) capabilities must be assessed against what is necessary to profitably manage and administer a capitated population. Population health infrastructure build, such as in MSO services, new data systems and integration of health records with community care partners, must be phased in gradually to ease system transition.

Taking financial risk is complex – there is no one-size-fits-all approach. Moving deliberately but not immediately to downside risk in contracts allows providers and payors time to negotiate delegation of responsibility and adequate dollars to make the agreement attractive for both parties. That deliberate path is a robust roadmap based on rigorous data analytics and a cultural discipline around leveraging payor claims data to inform strategies is indispensable for long-term success.

Carla D’Angelo, a Vice President, can be reached at cdangelo@copehealthsolutions.com or (213) 542-2266. Cindy Ehnes, an Executive Vice President, can be reached at cehnes@copehealthsolutions.com or (916) 599-5490.