WHERE THE BEST MINDS COME TOGETHER ON HEALTH CARE RISK

- INDUSTRY ARTICLES
- VIDEOS
- PROVIDER INTERVIEWS
- UPCOMING EVENTS
- LIVE BLOG

PLUS, all past issues:

optum.com/riskmatters

SPRING 2015

RISK MATTERS

DATA RICH INSIGHT STRONG

HOW VANTAGE CANCER CARE NETWORK IS TAKING ON RISK IN SPECIALTY CARE

Ben Slocum, President Vantage Cancer Care Network

John Iacuone, MD, Chief Clinical Officer Vantage Cancer Care Network

PAYERS & PROVIDERS
Making big data work

TREND WATCH
Increasing the demand for price transparency

INFOGRAPHIC
Spotting opportunity in disparate data

POPULATION HEALTH
Adapting your business model

PLUS: The value of actuaries in risk-based contracting
We all saw the tidal wave of data rising. Providers and payers improved their ability to collect information, and governance around data management and planning to extract and apply the potential insights is just beginning.

Optum collaborates with organizations across the health care industry, while building and implementing new strategies and solutions that can make their data actionable.

**DATA RICH INSIGHT STRONG**

1. **Find Opportunities for Intervention**
   - Utilizing advanced analytics, find the populations that are not only the highest-risk but also the most likely to be helped through clinical intervention. For example, take a look at your patients with diabetes.

2. **Plan Your Interventions**
   - Create a plan for targeted outreach and care coordination for high-risk patients with the highest likelihood for improving.

3. **Opportunity for Targeted Intervention**
   - Identify the most valuable opportunities for intervention.
   - Prioritize patients to appropriate programs.
   - Address barriers to care.
   - Improve care transitions.

4. **Measure Intervention Success**
   - Use a scientific approach to determine which interventions make the biggest difference in your high-risk population.

5. **Refine**
   - Improve your population analysis.
   - Find new opportunities for intervention.

References:
TREND WATCH
Value-based care increases demand for cost transparency

PAYERS & PROVIDERS
Opportunities to make big data work

EXECUTIVE INTERVIEW
Vantage Cancer Care Network innovates an approach to risk for specialty care

POPULATION HEALTH
Innovative providers adapting approach to local markets and populations

RISK PERSPECTIVE
The value of actuaries in your risk-contracting efforts

DATA RICH, INSIGHT POOR
Uncovering the value hidden in providers’ disparate data

optum.com/riskmatters
The future of meaningful health care competition lies in ensuring full transparency on pricing, quality and outcomes so that all participants in the health care marketplace have the information they need to make informed choices.

Merrill Goozner, editor, Modern Healthcare
Financial transparency is on the rise due to consumer and regulatory demand. Access to quality of care data, coupled with an emphasis on consumer accountability, will make it essential for providers to demonstrate their value. Patients enrolled in high-deductible plans are already beginning to demand transparency as they decide how to spend their health care dollars. And quality is becoming an increasingly important differentiator. Beginning in 2015, every physician participating in Medicare will be subject to a value-based modifier (VBM), with results impacting 2017 reimbursement. Penalties tied to the Physician Quality Reporting System (PQRS) are also increasing.

Online tools are emerging that will empower consumers to make informed decisions. The Centers for Medicare and Medicaid Services (CMS) Hospital Compare website allows consumers to review hospital performance measures. The CMS Physician Compare website includes information about insurance and hospital affiliations, among other things, as well as performance data reported through PQRS. CMS explicitly states that the goals of both sites are to help patients make more informed decisions and encourage providers to improve quality. Private companies are also moving to meet consumer demand for quality and cost information.

High-deductible health plans (HDHPs) are on the rise among the newly insured. Up to 80 percent of the Healthcare.gov plans had high deductibles, and only 5 percent of the plans had no deductible. Enrollment in HDHPs has more than doubled since 2009 and more than a quarter of employers now offer HDHPs, and those consumers want financial clarity. Organizations that are transparent in their pricing can help patients better understand their treatment options and costs and be more active participants in their care.

Wide variations in cost and quality confuse consumers. An appendectomy can cost anywhere from $1,529 to $186,990, and a hip replacement can run anywhere between $11,100 and $125,798. Spending more, however, doesn’t guarantee better care. Without demonstrated value, many patients in HDHPs may simply delay or forego more expensive care, leading to more expensive complications later on.

CMS incentivizing value-based care. The Centers for Medicare and Medicaid Services has started implementing value-based payment modifier rules that reward providers who give high-quality, efficient care and adjusts reimbursements downward for providers who underperform.

- The modifier will be applied beginning in 2017, but will be based on care data collected in 2015.
- The downward adjustment for providers failing to meet the reporting requirements and those who classify as low quality/average cost or average quality/high cost will increase from 2 percent to 4 percent in 2017.
- The upward adjustment for providers classified as high quality/low cost will increase from 2 percent to 4 percent.
- Solo practitioners or groups of fewer than 10 physicians will not be subject to penalties until 2018 at the earliest. They can receive upward adjustments if they qualify.
TREND WATCH

BUSINESS IMPACT

Determining the true cost of care could make it easier for health systems to embrace price transparency.

The shift toward value-based reimbursements makes it imperative that organizations determine the true cost of care. To do so, they must collect, analyze and leverage data from throughout their system and from all of their physicians. Providers such as UPMC and University of Utah Health Care are making strides in this area. UPMC has developed what they call an “activity-based costing system,” helping them correlate the relationship between cost and outcomes. The University of Utah’s “value-driven outcomes” system helps the organization “find greater value, not just eliminate costs.”

Quality is becoming a more important competitive advantage.

In years past, reputations were made by word of mouth and longevity. In the new health care economy, reputations will be made by outcomes. Well-known health systems, such as Cleveland Clinic and Dartmouth-Hitchcock Medical Center, are beginning to make quality data easily available to consumers. Health insurers are also making moves toward transparency. For example, Aetna, Assurant Health, Humana and UnitedHealthcare all contributed data to a new website, Guroo.com, that helps consumers make informed cost decisions. Another insurer, Blue Cross Blue Shield of North Carolina, has posted reimbursement rates by procedure and provider. UnitedHealthcare and other commercial insurers are also beginning to integrate quality and cost ratings into network provider search engines leveraged by consumers under their health plans.

REFERENCES

The Kaiser Family Foundation (KFF) found that 20 percent of those insured by employer-sponsored plans in 2013 chose HDHPs. That number has increased from 8 percent in 2009.

The average yearly deductible for Healthcare.gov Bronze Plans was $5,181 for an individual, and Silver Plans averaged a deductible of $2,927 for individuals.13

Nearly 13 percent of Americans spend at least 10 percent of their income on out-of-pocket health care expenses, and nearly 50 percent of middle-income earners consider their deductibles “difficult or impossible to afford.”14

The larger the employer, the higher the likelihood that it will offer HDHPs. In KFF’s analysis, 45 percent of employers with 1,000 or more employees offered HDHPs, compared to 27 percent for employers with fewer than 200 employees.12

The people who are attracted to lower premiums tend to be the ones who are going to have the most trouble coming up with all the cost-sharing if in fact they want to use their health insurance.

Katherine Hempstead, health insurance research director for the Robert Wood Johnson Foundation15

TAKEAWAYS

To prepare for an escalating demand for price transparency, consider the following steps:

1. Organize around your patients. Focus on clarity for cost, especially when it comes to their out-of-pocket expenses. Doing so can improve consumer loyalty.

2. Emphasize the value of routine visits, along with preventive care for patients that are often fully covered by their health plan under an HDHP. Helping consumers keep their care affordable will contribute to your organization’s sustainability within a value-based system.

3. Be strategic about opening your organizational reporting on quality and cost to private companies, insurers and employers—not just to Medicare. This will allow your organization to compete on value instead of simply focusing on price.

4. Leverage organizational resources and IT solutions to collect and analyze data. Collaborate across the organization to improve the inputs by increasing attention to data governance and formalizing a strategy around making it actionable for your organization.
MAKING BIG DATA WORK:

PAYERS & PROVIDERS
So why hasn’t more been done with that data to slow the rapid climb in health care spending and begin competing on outcomes rather than expenditures?

The answer is that, despite the promise of electronic medical records, much of the data that reveals what works in health care has been inadequate and unusable—or is missing altogether. What’s more, organizational silos have made it difficult to link together pieces of information to show health-related patterns for any given patient group.

Policy makers and industry leaders in most countries are trying to shift to newer reimbursement and delivery models, such as payment by results, episode-based payment, and value- and population-based health care. These models demand much more detailed insights into what drives outcomes than previous ones did. They also require significantly different data sources in order to tease out the impact of a current treatment and its associated expenditures from other variables, such as treatments already performed, genetics, risk factors, patient behaviors, and the environment. (See Competing on Outcomes: Winning Strategies for Value-Based Health Care, BCG Focus, January 2014.)

Big data and advanced analytics, used intelligently, provide an opportunity to bring together diverse data sources—including patient records, clinical trials, insurance claims, government records, registries, wearable devices, and even social media—to understand health in a truly value-oriented way. Payers and providers—and, by extension, all health-care consumers—can now discern the extent to which each intervention, as well as its associated expenditures, contributes to better health.

Three High-Potential Opportunities:

Data can transform health care in seemingly endless ways. But are these future scenarios real?

Most areas of health care are in the early stages of using big data and advanced analytics; many more sources of data and ways to combine and analyze information will emerge. Still, based on our work with payers and providers across many countries, we see three particular opportunities among many that offer high potential right now. Exploiting them could measurably improve outcomes as well as generate significant additional revenues and profits.

Optimizing Care for Patient Populations.

Governments and other integrated payers and providers often lack a comprehensive view of complex usage, needs, and outcomes trends at the local, regional, or national level. This is particularly true for chronic diseases, which consume most health-care resources in the developed world.

To achieve the greatest improvement in outcomes, payers and providers need to proactively allocate resources before patients seek care and then track their impact. But to do this well, data needs to be comprehensively aggregated and analyzed at the level of large populations. The data can be used to target services more directly to the area of need, reduce waste, and redirect spending to effective interventions.

Consider the case of the department of health for the state of Victoria in Australia, which undertook a major effort to analyze health care spending on citizens. Federal and state governments, along with
private insurers, each pay for about one-third of third-party health-care spending for every individual in Australia. But they have little visibility—and no control over—one another’s expenditures, which allows for the possibility of duplication and gaps in services. With overlapping responsibilities, governments and insurers cannot link together the need for services, the level of care being delivered, and the outcomes of those services. Not surprisingly, no payer or provider is prepared to be accountable for outcomes, and data for comparing outcomes among citizens is not available.

The health department wanted to create an integrated picture of health care across the state of Victoria by combining data about health needs from population surveys with information about services paid for by each of the responsible payers and with outcomes data from patient, population, and clinical sources. Even though this data had been collected for some time, the complexities of aggregating and interpreting it had discouraged earlier efforts.

The health department developed a seven-step model of the natural progression of chronic diseases in order to organize the more than 400 health-related measures gathered. This was done at the city and neighborhood levels to pinpoint specific needs while still maintaining individual privacy. The department compiled a picture of health needs, service usage, and outcomes across 200 areas—each with a population of around 25,000—to identify areas of over- and undersupply and to assess the effectiveness of the health services they received.

The state learned, for example, that while primary-care providers are quite effective in managing chronic diseases in more affluent communities, they are relatively ineffective in low-income communities, resulting in high costs, hospitalization rates, and mortality levels in those areas. The results of the analysis highlighted a number of neighborhoods with particularly poor chronic-disease outcomes, despite adequate access to and use of services, suggesting opportunities for quality improvements. (See Exhibit 1.)

The analysis looked at the rate of hospitalizations for ambulatory-care-sensitive conditions—which include illnesses such as diabetes, asthma, and chronic obstructive pulmonary disease—because hospitalization serves as an important barometer of patient access to primary care in these cases. The department discovered that even a modest reduction in avoidable hospital admissions through better primary care would save health care payers an estimated A$60 million per year. In addition, it found that rates of screening colonoscopy in areas with high levels of private insurance were six to seven times the expected rates given the demographics, and outcomes were no better than in areas with low rates of screening, suggesting a significant opportunity to redirect resources and improve patients’ quality of life without adversely affecting population health.

Exhibit 1. A Big-Data Analysis Revealed Large Geographic Variations in Avoidable Admissions in Victoria, Australia
Reducing the Cost of Care. Payers, whether governments or private insurers, face a huge hurdle in bending the cost curve downward to slow the pace of growth in health care expenses. One area ripe for improvement lies in reducing the cost of care. Since the cost of care generally accounts for 90 to 95 percent of total costs for an efficient payer, every 1 percent reduction in the cost of care has the same effect as a 10 to 20 percent reduction in operational costs. Still, many payers consider the cost of care to be unchangeable. They routinely enter into contracts with hospitals based on historical budgets plus a small percentage increase for inflation growth. Frequently, they do not differentiate their negotiations by hospital. And they conduct only limited benchmarking about differences in costs or quality across hospitals and providers. In the area of procuring care alone, we see enormous potential to drive down costs through the use of big data. A leader in this area is VGZ, one of the largest payers in the Netherlands, with about 4 million clients and a cost of care of nearly $10.9 billion per year. As a result of major investments in data-driven health-care procurement, the company has identified significant potential for improving quality while producing estimated savings of over $544 million by 2016. One target was prescription drugs, which accounted for about 15 percent of costs. The company focused on prescriptions for generic drugs when they first became available off patent as a substitute for brand-name drugs. Often, generics cost less than 10 percent of branded medicines. An analysis showed that switching almost entirely to generics for just one cholesterol-controlling drug, Lipitor, would save nearly $32.7 million. In most countries, pharmacies are obliged to deliver a generic drug instead of a branded drug. But prescribers can state that medical necessity requires the patient to receive the expensive branded drug instead. Since the active ingredient in generics is the same as in branded drugs, prescriptions for a branded drug on the grounds of medical necessity should be rare—for example, less than 5 percent of prescriptions, according to calculations based on best practices. In practice, however, VGZ found that for a number of important drugs, the expensive branded version accounted for approximately 30 percent of prescriptions. In an effort to bring up the rate of generic adoption among doctors much more quickly, the payer decided to use its own records to pinpoint exactly who appeared to be overprescribing branded drugs. First, VGZ brought order to millions of rows of chaotic, raw claims data by using advanced analytical techniques to unravel the prescription patterns of every doctor and specialist by drug. The company looked in particular for anomalies and outliers that indicated overprescribing behavior by specific doctors and groups and unusual combinations of prescribers and prescriptions. The analysis focused on the top 25 medicines with the greatest potential for reducing prescription drug costs. A compelling visualization showed the prescribing behavior of groups of doctors and, when required, the prescribing behavior of individual doctors as well. For the first time, the payer could show groups of doctors how the behavior of their members compared with best practices. Extreme outliers were highly visible. (See Exhibit 2.)
This visual tool created an opportunity for the payer to have constructive discussions with providers and to improve their prescribing behavior. The focus on costs helped bring down the rate of branded-drug prescriptions to below 5 percent for nearly all the drugs studied, saving the payer more than 10 percent of total pharmaceutical costs. Similar benchmark analyses are now being used in other areas, such as diagnostics, hospital contracting, and claims verification. For instance, VGZ has developed advanced analytic algorithms to automatically analyze millions of lines of data across different areas of care in order to highlight suspicious combinations of treatments and instances in which medical specialists seem to choose the most complex or expensive treatments.

Reducing Hospital Readmissions.
Health care organizations frequently struggle to capture, integrate, and share valuable information among internal departments and external partners. But organizational and technological barriers often prevent payers and providers from seeing the big picture, which would enable them to transform the cost and quality of care.

Many people hoped that electronic medical records (EMRs) would solve these problems. But traditional EMR systems do not provide much of the data required to assess outcomes and behaviors, such as socioeconomic status and health patterns within populations—obesity and smoking rates, for example. Another problem is that 80 percent of hospital data is unstructured, often taking the form of patient interviews and paper-based records, which may be stored in incompatible systems by different organizations. Claims data may be readily available but is typically poorly structured and inconsistent. Privacy regulations also limit how data is combined and used.

Integrating disparate data sources, as is done with big data, can overcome these hurdles. A large government-run hospital trust in the UK, for example, achieved powerful results with this approach. The trust wanted to decrease readmissions by 5 percent within a year and thereby reduce the length of hospital stays, the number of preventable deaths, and the incidence of hospital-acquired infections. The move would also help hospitals avoid the significant financial penalties imposed by regulators for high rates of readmission.

The hospital trust first combined existing internal data about patients and locations with publicly available data. This enabled the trust to identify factors such as specific diagnoses, wards, and times of discharge—that were associated with higher-than-expected readmission rates.

Next, the trust developed a predictive algorithm that could identify—at the time of admission—the groups of patients who were most at risk of readmission. Identifying those patients at such an early stage meant that providers could do the most to lower the odds of readmission by adjusting staffing levels, planning for medical reviews on discharge, and arranging training for patients about their drug regimens after discharge. For instance, the provider learned that information such as the age of the patient, the length of any previous stays, the time of admission, the reason for the hospital visit (such as an elective procedure or an emergency), and whether there were any previous emergency admissions could be combined to create a highly predictive profile of patient risk. The profile was then converted to a color-coded system that was easy to understand so the staff could quickly set in motion the right approaches upon admission.

The trust also identified four groups of patients with high numbers of avoidable readmissions and devised tailored interventions to address their needs. For example, when the trust found that 50 percent of urology readmissions occurred within one day of discharge, it established a program for educating patients on proper catheter use, supported by rapid-response community nursing.

As a result of the hospital trust’s use of these tactics and others, preventable readmissions have fallen, and the approach is now being rolled out across the trust.
How to begin
As payers and providers explore the opportunities enabled by big data, they should take the following initial steps.

Start where there is tangible value.
Small steps combining existing data in new ways to solve specific issues can have more immediate impact than big-bang solutions that try to do everything. EMR systems and data warehouses are not always the best places to start, either because they do not have the most relevant information about outcomes or because a more iterative and agile approach could capture value more quickly. Some of the most interesting initial insights can be gleaned from creating segmentations and population-level analyses of existing information, such as the age of patients and referral patterns.

Focus on the patient—not on the institution. Care delivery is a complex, multidimensional process involving many providers. For chronic diseases, it can span a lifetime. Providers spend considerable time and energy reducing budgets and optimizing processes. The patient perspective is often missing, however. To generate new insights, organizations need to understand the novel sources of data that offer insights into groups of patients. Often that data lies beyond the four walls of the hospital, such as with patients themselves.

Ensure trust.
Health information is often quite sensitive and involves important legal and regulatory constraints about its management and use. Health care providers cannot afford to lose the trust of regulators and patients. To earn trust and gain access to even greater amounts of personal data for big-data applications, payers and providers must communicate transparently how they use and secure confidential data across multiple organizations and demonstrate the important benefits to patients from emerging big-data approaches. (See The Trust Advantage: How to Win with Big Data, BCG Focus, November 2013.)

Develop analytic capabilities to improve costs, value, and the coordination of care. Most payers and providers have pockets of expertise in clinical processes and IT but require additional capabilities to generate integrated insight and improvements in practice. They must bring together a combination of skills in order to find related internal and external sources of population-level data and to work with emerging tools. They may need to create new partnerships or work within new ecosystems to source, combine, and explore data across multiple organizations and locations.

Big data and advanced analytics offer tremendous potential to solve some of health care’s thorniest problems—if the industry can overcome significant barriers to improving its efficiency and effectiveness. Today’s data-rich world offers vast new potential. The key to success lies in focusing on pragmatic steps that drive real value instead of chasing the latest fads.

Reprinted with permission from The Boston Consulting Group
By Karalee Close, Stefan Larsson, John Luijs, Neil Soderlund, and Anna Vichniakova

optum.com/riskmatters
EXECUTIVE

John Iacuone, MD, Chief Clinical Officer
Vantage Cancer Care Network

Vantage Cancer Care Network addresses risk in specialty care
Cancer is on the precipice of a massive shift in cost with few, if any, knowing how to keep care quality high while still managing financial impact on the provider, the payer and the patient. The predicted number of new cases of cancer in the United States is expected to increase by as much as 45 percent by 2030. Additionally, by 2020 cancer costs will increase to over $207 billion, a nearly 50 percent increase from 2012.¹ And it’s not just cost that will be impacted, it is quality of care and patient experience that suffers with it.

Ben Slocum, President
Vantage Cancer Care Network
Vantage Oncology is a front-runner in treating cancer through their comprehensive approach across a national network of over 50 affiliated cancer centers in 14 states. In this interview, Vantage Cancer Care Network’s president, Ben Slocum, and Chief Clinical Officer, Dr. John Iacuone, discuss how Vantage Oncology is pioneering the development of Vantage Cancer Care Network (VCCN). It is an organization that partners with clinics in their network to improve patient care through an integrated, multi-specialty approach where identifying the most appropriate and effective treatment regimens allows for more personalized patient care while also combating rising oncology costs. VCCN takes on oncology-specific risk contracts through strong relationships with payers, improved provider coordination, and by finding ways that allow their specialty physicians to maintain their focus on providing high-value clinical functions. How Mr. Slocum and Dr. Iacuone describe VCCN reveals a new vision of care, finance and approach to attaining the long-term results for physician specialists that match the market and its shift to value-based care.

We wanted to start by asking you to tell us a little bit about VCCN. How did it get started?

Dr. Iacuone: Certainly. Vantage Oncology’s mission is patient-centered, integrated oncology care. However, cancer costs are rising two times faster than health care costs. And with the predicted increase in oncology cases, payers are beginning to face a serious financial crisis regarding providing the right kind of care. This creates an issue that we [Vantage Oncology] clearly work against. At the same time, cancer care has been consolidating into more centralized, hospital-based systems, and the problem grows further there. It becomes hospital-based services over community-based services, and this approach can drive up costs even further. We wanted to find a solution that took on costs, but still led to the most effective outcomes.

Mr. Slocum: Exactly, and the current shift further hurts a field that is built to grow on pay for service, not a quality of care model. Right now, oncology pays on what is done, not how good the care is performed. And payers do not have a method to change this yet, but hospitals and physicians still have to cover their costs. Right now, no one is in a good place and no one has a solution.

Dr. Iacuone: It’s not a model that will last. Oncology care is something that doesn’t, right now, fit the shifting volume to value model and because of that, we had to create a solution, the Vantage Cancer Care Network. 

Q: So how is this impacting your relationship with payers?

Mr. Slocum: Payers currently hold most of the valuable financial data. So as VCCN came off the ground, we understood the value in partnering with them immediately. Their data, when run through our network, can begin to increase the predictability on cancer costs based on several factors. And this is extremely valuable to payers. But it’s not just cost predictability; VCCN can run that information against quality oncology performance indicators to pinpoint metrics…

Dr. Iacuone: Our “Metrics that Matter.”

Mr. Slocum: Right, these metrics that matter can demonstrate to a payer that patients are getting value at a lower cost, as well as getting quality outcomes.

Dr. Iacuone: Let me expand on that. It really allows for clinical integration of a network, which you need if you’re going to go at risk. If we are going to move to a capitated model from a gain-share model, I think integration would be the desire in many markets. This benefits the payer because it provides great predictability in the upcoming year for what their cancer spend is going to be. We’re saying “what is your total spend for cancer on a cancer patient?” It’s not for a specific treatment or drug, it’s total spend, and VCCN can take risks that are based on our data. And the comprehensive nature of that is very appealing to the payer. Because now we are taking a very delicate problem that’s inflating at a really big rate, and we’re offering to take it off of their hands in a value-based, contractual way.

---

**PROJECTED AVERAGE CANCER CARE SPEND PER PATIENT**

![Graph showing projected average cancer care spend per patient from 2010 to 2018.](optum.com/riskmatters)

1 Health Industry - Behind the Numbers, PWC (2014)
2 Drug Costs Become Bigger Issue in Cancer Care, Reuters (June 2012)
3 Benefit Designs for High Cost Medical Conditions, Milliman (April 2011)
**Q** And what about providers in your network? How do they benefit from VCCN?

**Mr. Slocum:** That’s a good question. It impacts them in several ways, as well as their patients. Right now, there is not much, if anything, out there in the specialty care world where they get paid to manage the health of a patient population. And oncology is a great fit for this. The oncology providers are finding themselves experiencing a pretty significant squeeze on reimbursement. You’ve particularly seen this around radiation oncology. They’re not as sustainable as they once were as an independent practice.

And we’re trying to recognize that in cancer, such a unique disease state, different from diabetes or COPD, asthma and other things that the payers all have a pretty good program for, and you can actually have a patient manage themselves at some level with the right education. Oncology is not a disease state like that. And it really is one where that medical oncologist becomes the point person. They become the primary care physician and should get rewarded for providing the care that the patient needs.

So institutions want to have a broader reach and presence into the community. Historically, what they’ve done is buy doctors in order to command that presence. But with VCCN, we can actually create a clinically integrated network of doctors that have become part of the institution’s cancer service line through the integration, without the institution having to actually buy the doctors. But the institution gets a broader network, integrated with the doctors that they do own, without the need to continue to go out and invest in buying practices and having the challenges associated with managing a group of doctors as employees.

So VCCN helps them move away from care options being managed by payers, and instead it is a patient-centered oncology home where the medical oncologist acts like the primary doctor in a specialty situation and can be rewarded for it.

**Q** And patients?

**Dr. Iacuone:** This one is simple. With payers able to pay for quality of care and providers being rewarded for good care, the patients begin to benefit. Additionally, using the network can make the care more community-based, so it is easier for patients to access as needed, which can be a difficult task if they have to travel across town to find a hospital in other situations.

For example, a patient often prefers to come to my clinic or office, or knows that she could do something as simple as getting some Gatorade to be hydrated appropriately and come see me in the morning, rather than have her daughter drive her to the emergency room at 8 o’clock at night, and have her sit for two hours in a highly infectious environment while her immune system is crashing all around her because of her cancer.
So this clearly can benefit all parties, but can you highlight where risk, structure and relationships come into play?

**Mr. Slocum:** Right now, there are no collaborative, peer-oriented provider-driven oncology solutions you can find in the market. And we believe that we can facilitate the elimination of any kind of distrust that might exist between the payers and providers, and really create that kind of collaborative relationship. So we hope that payer-provider relationships significantly improve.

**Dr. Iacuone:** And then ultimately, what we want to have over the next couple of years is a continuous trend toward improved patient experience, improved quality and improved outcomes. One of the comments that we want to dispel or diffuse out of the industry is that if you pay the doctors more, you’ll get quality.

And in our model, it’s not about paying the doctors more to get quality. It’s about paying the doctors the right way and paying them in a way that helps them cover the additional costs of running their practice in a quality, medical home-type model. Because it does cost you a bit more money, and it’s a bit more complicated to learn a medical home-type model than it is to run a fee-for-service practice.

So what we’re trying to do is just make sure that we use appropriately placed capital to allow the doctors to run the business the right way. And that will definitely end up with a much higher quality model for the patient, and hopefully happier patients in all of this.
Q | And you see this developing into a long-term solution?

Dr. Iacuone: We do.

Q | And what other plans do you have?

Dr. Iacuone: We want to keep building the market. And to keep building the market in appropriate areas in partnership with payers, and to turn the tide on the absorption of health care delivery in the hospital-based, hospital-owned practices. We want to swing that pendulum back to the community-based neighborhood and environment where the people really get better access, closer to home, and get the same quality care and outcomes that they would get traveling great distances and sitting for long times in other, current scenarios.
So how are you doing that?

We bring really a blue-ribbon panel of oncology-based leaders together to advise and direct our company from a strategy standpoint.

John Iacuone, MD, Chief Clinical Officer
Vantage Cancer Care Network

Dr. Iacuone: We are establishing three things. We have a medical advisory committee for radiation therapy. We have a medical advisory committee for medical oncology. And we’re going to have national oncology thought leaders including provider, payer and patient advocates advising us on this journey—and Ben can probably expand on that a little bit more—where we bring really a blue-ribbon panel of oncology-based leaders together to advise and direct our company from a strategy standpoint. We’re looking at that group from different pockets around the country, so that we can blend some of the key markets in with the behavioral patterns as they’re shifting, and as we constantly look at all the different pathways that are out there. We’re not simply focused on care pathways around drugs. We’re going to be looking at the radiation side of the equation, the surgical side of the equation, and then the reapplication of that. Because that’s really where so much cost is just lost. And people kind of lose focus on the fact that it isn’t just cost that’s lost. It’s quality, and it’s patient experience that’s lost.

Mr. Slocum: John hit it on the head. I think we’re getting traction with providers and payers, because we can demonstrate that we have built and have tools to manage risk. In other words, we have demonstrated that we’ve got the infrastructure. We’ve got proprietary pathways that we can implement. We’ve already demonstrated that over 20 years with our radiation company. I also think that just getting payers to stop for a second and recognize that if they take a thoughtful approach, supporting the development of a network in their marketplaces where a network can be developed. Once the payers and the providers see that we really have built that infrastructure, a lot of their anxiety about getting into a shared savings or risk venture will go away.

To learn more about the Vantage Cancer Care Network, visit www.vantageoncology.com

VCCN engaged Optum as a strategic partner in enabling the operation of a risk-based business model for their specialty network. Their organization currently leverages a custom suite of Optum solutions that includes network analytics and actuarial services supporting payer strategy, market and operational analytics tools to manage cost and care guidelines, along with cancer support and helpline programs to further support cancer patients during this difficult time.

optum.com/riskmatters
Negotiating the inevitable transition to value-based care requires local market savvy and knowledge of population risks.
ADAPT TO POPULATION HEALTH?

************ FRAMING THE ISSUE ************

Population-based accountable care arrangements reward innovators who can cut costs and improve outcomes.

The rewards mostly flow from revenues previously budgeted for hospital services—often funding services that directly reduce inpatient volume.

Optimizing operational effectiveness and efficiency, and better integrating hospital and other services are prerequisites to delivering value-based care.

Population health management also exposes hospitals to new risks, including defining and tracking populations and patient compliance.

Successfully negotiating the transition to value-based care requires careful assessment and management of local market conditions and population risks.

If you haven’t already met someone like Mike Pykosz...
If you haven’t already met someone like Mike Pykosz, chief executive officer of Chicago-based Oak Street Health, chances are you will soon.

After graduating from Harvard Law and a stint at the Boston Consulting Group, Pykosz returned to his native Chicago last year as a health care entrepreneur. Backed by a group of investors “excited about the model,” he opened four primary care clinics exclusively serving Medicare and Medicare-Medicaid dual-eligible patients mostly from underserved, low-income communities—with plans for more.

“\nWe looked at the risks and opportunities for reducing costs and improving health in this population and built a doctor’s office around it.\n\nWe looked at the risks and opportunities for reducing costs and improving health in this population and built a doctor’s office around it.”

The clinic model Oak Street’s well-informed backers find so attractive meets social service as well as medical needs. Patients are served by a team including a geriatric-trained primary care physician, a nurse and a medical assistant, with support from care coordinators. Panels are limited to 500 patients, or 750 with the addition of a physician’s assistant or nurse practitioner—about one-quarter the typical primary care size. This allows half-hour visits as well as quick and comprehensive follow-ups to ensure that chronically ill patients comply with care plans and are seen within 48 hours of a hospital visit. And, Oak Street’s physicians earn more than average for their specialties.

Oak Street also provides transportation for patients to clinics and other services, and each clinic hosts a community gathering place where patients can come for frequent special programs or just to pass the time. Clinics include on-site dental and pharmacy services, which patient surveys found are common care gaps—all without charging deductibles or co-payments.

How is this possible? Shared savings.

In its first nine months, Oak Street significantly reduced hospital admissions and emergency department use, cutting costs for its population by more than 10 percent below projections. This nets bonuses that more than cover the extra services. “The biggest levers to improve performance are primary care and social services,” Pykosz says. “If you do both, you can save a lot.”

Traditional fee for service simply wouldn’t produce enough income to pay for it all. For that matter, a low-risk patient population with less total savings potential also might not support the model, Pykosz says. “We looked at the risks and opportunities for reducing costs and improving health in this population and built a doctor’s office around it.”

It remains to be seen whether Oak Street Health continues to clear its financial hurdles as it rapidly scales up. But as Pykosz sees it, there’s plenty of opportunity to improve on the cost and performance of the current system. “As long as we are the best, we will be OK. And our performance is very much above average now.”

Lead or get out of the way

That entrepreneurs are betting on comprehensive primary care for high-risk Medicare patients demonstrates the disruptive potential of population health-based risk-contracting. The potentially huge rewards created by shared savings, bundled payments and capitation are sure to entice competition for the traditional physician-hospital delivery model.
And since the rewards mostly come from funds previously budgeted for hospital services, it’s critical for health systems to recapture a share, even if it won’t make them whole. “The truth about health care is that no matter what happens, we are going to spend less money on it,” says Bruce Muma, M.D., chief medical officer of the 1,200 member Henry Ford Physician Network, part of the five-hospital Henry Ford Health System based in Detroit. Doing more with less is not optional, he adds.

So the question for hospitals is not whether to participate. It is how, when, where, with which partners and for which target populations they can do so—without going under.

Many systems are developing capabilities to address new risks presented by population-based accountable care. These include reorganizing, integrating and streamlining clinical services; aggregating and tracking risk pools; and building patient outreach and counseling services. Many find that these capabilities help them fulfill their community service mission, including better serving uninsured and underinsured patients.

“Our hospitals are in many different places in terms of where they are on the spectrum of taking risk and how they are engaging in population health,” says Ashley Thompson, director of policy at the American Hospital Association. “As part of the Triple Aim, we are committed to improving population health.”

Bulking up carefully

For Juan Serrano, senior vice president of payer strategy and operations for Englewood, Colo.-based Catholic Health Initiatives, the issues around population health management are complex, but the solution, at least generally, is clear. “All the answers lead in the direction of being the best we can be in serving the needs of our community and serving our fair share of the community,” he says.

That means aggressively developing population-based services, even if it means temporarily taking a loss, Serrano says. For example, CHI, which operates 93 hospitals in 18 states, accepts risk for more than 200,000 lives through Medicare shared savings programs—despite rules that make it hard to keep patients within its network, or even know all the patients for which it is responsible.

The AHA anticipates changes in federal shared savings programs that will clarify attribution and simplify quality reporting, Thomson says. However, it’s not clear if these and any changes to the formula for sharing savings will be enough to keep most hospitals in once the upside-only option expires.

Regardless, Serrano believes participating provides valuable experience that will pay off as CHI expands its Medicare Advantage plans, which currently enroll 17,000. It’s simpler to predict and manage risks in Advantage plans because enrollees join voluntarily and accept incentives to stay in-network.

CHI also will expand its commercial plans, which now include 70,000 members, some at full risk and others in self-funded programs. In addition, about 12 to 15 percent of CHI’s commercial contracts include some kind of value-based purchasing component, but that’s rising fast, Serrano adds.
“It is anyone’s guess how much of our revenue will be at risk five years from now, but it will be more than it is today,” Serrano says. “To be paid for value, we have to be adept at creating and maintaining value—that is a requirement. We don’t believe we have the choice but to invest in population health programs.”

Indeed, CHI is restructuring itself around the task. At the system level, it has added technical resources that include actuarial analysis, underwriting and health plan management on the insurance side, and clinical network development and care coordination on the provider side, with IT support for it all. The system also provides financial backing, including a $1 billion investment in health plans serving the Little Rock, Arkansas, and Louisville, Kentucky, markets. The goal is three-pronged: own and operate health plans partner with payer health plans, and provide managed health services directly to employers, Serrano says.

That’s not to say CHI enters risk-bearing arrangements blindly. To the contrary, the system launched this strategic initiative by systematically assessing its capabilities and opportunities in each market.

Insurance products and services for both commercial and Medicare patients were examined along with the cost of care relative to national and regional norms. From this, the financial potential for specific risk products was projected, as well as the potential for improving care quality and access. “In some markets the total cost represents an opportunity we can work toward reducing outright,” Serrano says, “but more important is rationalizing health care consumption, which makes it more affordable in the community.”

Markets also were assessed in terms of readiness for risk-contracting. Those already served by HMOs, PPOs and Medicare Advantage plans, or by narrow provider networks, are good candidates for value-based contracting, Serrano says. Building capacity quickly makes sense under these conditions. But where employers have little experience or interest in risk contracts, a slower approach may be better. Willingness of commercial insurers to partner in shared risk products also influences how quickly and with which products CHI moves forward.

CHI also examined its own readiness. The system is building clinically integrated networks in each of its markets and adding technology, informatics and care coordination capabilities, as well as developing provider reimbursement and legal structures that support risk sharing. Physicians from key specialties are brought in to help identify specific population health needs and structure programs to meet them. This helps to improve care efficiency and shift caregiver culture
toward managing populations, Serrano says. Consumer preferences also are examined. “We conduct sensitivity analysis to find out how aggressively we can transform our culture from a patient perspective without undermining the economic stability of the system,” Serrano says. For example, moving to restrictive networks before patients accept them can undermine loyalty.

The program already has delivered some notable successes. In Des Moines, a shared savings partnership with the Blues improved compliance with national standards for blood pressure, diabetes and cholesterol control, from about 50 to 85 percent by adopting a medical home model, says Stephen Moore, M.D., CHI’s CMO. Health plans acquired in Washington state and Arkansas have expanded operations into Kentucky, Nebraska, Ohio and Tennessee. Products include commercial plans, third-party administration services and Medicare Advantage and supplemental plans. Services offered directly to employers include wellness education, preventive screenings, personal health coaching, disease-management support and on-site health services.

“We have to trust that putting the value proposition in the marketplace will result in a favorable economic response from employees and consumers,” Serrano says.

Pinpointing different populations Identifying and tracking patient populations are crucial for managing risk. It’s also a challenge, both technically and economically.

“Markets also were assessed in terms of readiness for risk-contracting. Those already served by HMOs, PPOs and Medicare Advantage plans, or by narrow provider networks, are good candidates for value-based contracting.”
Consider Fairview Health Services, which includes seven hospitals and about 3,350 physicians in Minneapolis and surrounding areas. Located in one of the most active managed care markets in the nation, Fairview launched its population health program five years ago. It participates in the Pioneer ACO program, has risk-sharing contracts with all local commercial payers and has developed network products to appeal to targeted consumer segments. Extensive as the offerings are, they still mostly focus on about 5 percent of the population—those with high-cost conditions, including chronic obstructive pulmonary disease and congestive heart failure. The potential savings from aggressively managing these patients justifies the expense of frequent checkups, monitoring equipment, calls from care managers and even home care visits, says Dan Anderson, chief operating officer and president of community hospitals. Another 20 percent or so are at elevated risk for future problems, but identifying and engaging them is less immediately rewarding. “Our next challenge in preparing for alternative models of capitation or global payment is extending them to a less-complex population,” Anderson says. “The impact on total costs is less for an individual, but the size of the population in less critical categories is quite large.” Better automated tracking of care received inside and outside the network as well as expanded care networks are needed to effectively manage these patients.

This is where many global risk arrangements fall down, particularly taking risk for the total cost of care for a large population—with potentially catastrophic consequences for providers, says Lynn Carroll, senior vice president of provider economics for PaySpan, which automates and coordinates payments among providers, patients, payers, health plans and financial institutions across a wide variety of reimbursement models. Risks in relatively small populations with known high-cost conditions treatable through well-defined protocols can be controlled because they are identifiable and the value of specific interventions is clear, Carroll explains. But as the population expands and unknown conditions multiply, that value relationship breaks down. “We are a long way from universally being able to assess fee-for-value across every concatenation of patient need and service provided.”

Real-time tracking of patient encounters is the only way to keep up, but that’s not easy, Carroll points out. “There are plenty of horror stories of providers that take risk and then six or nine months later they get a reconciliation report and they owe a couple of hundred thousand dollars, and it’s too late to do anything about it,” he says. Needless to say, this dampens enthusiasm for risk-contracting.

Since tracking claims and costs historically has been a payer rather than provider function, it may make sense to partner with a payer for those services, Carroll says. Better yet, contract fee for service with bonuses for recommended preventive care. “It’s not about ACOs, shared savings or fee for service, it is about achieving the most value for what you are paying. As long as there is a quality component that is measurable and makes sense, we are going in the right direction,” Carroll says.

Indeed, risk-contracting can deliver value only if providers understand—and are able to meaningfully address— exactly the risks they’re taking, he adds.
Rationalizing operations

As value-based purchasing squeezes hospital revenues, optimizing operational efficiency and effectiveness will be essential not just to maintain margins. With hospitals viewed as cost centers, they’ll need to show evidence that a certain level of spending is necessary to maintain quality—and deliver value—to keep payer rates reasonable.

“If you reduce fees without understanding the cost structure, you make cuts based on what you’re paying rather than what is needed to do the job,” says Henry Ford’s Muma. “It becomes a downward spiral, a race to the bottom.”

Understanding costs mostly comes down to good old-fashioned cost accounting—something hospitals historically haven’t done well. “It involves getting out a stopwatch and figuring out how many nurse hours, how many pharmacy hours, how many tech hours it takes to do a hip replacement—figuring out what is needed and what is not,” Muma says. “It involves figuring out actual supply costs and joint prosthesis costs. That is where the learning needs to be, and it needs to be more broadly applied across all hospital services.” Henry Ford is participating with 24 other organizations in a bundled joint replacement initiative through the Institute for Healthcare Improvement aimed in part at developing such standards.

And just as hospital responsibility for care now extends beyond the hospital walls, so must operational analysis, says Andrew Ziskind, M.D., managing director, clinical solutions, at Huron Consulting Group. Employing physicians gives systems much greater ability to coordinate care across a much broader continuum. But it’s also new territory for systems that previously focused on inpatient care. Many need help connecting care processes so readmissions are reduced and care is delivered in the lowest-cost appropriate setting. In what has become a health mantra, the goal is providing the right care to the right patient in the right setting at the right time.

This often requires rethinking the delivery system. “We focus heavily on optimizing assets,” Ziskind says. “Do you have redundant services? Too many beds? The right mix of primary care and specialty physicians? The right clinical programs? With efficient operations and infrastructure you are well-positioned from a delivery and cost structure perspective to build the core competencies to successfully manage population health and the risk that goes with it.”

But truly managing population health goes further, says Rob Schreiner, M.D., also a Huron managing director. “It’s one thing to construct coordinated care that consumes fewer dollars than uncoordinated care. It’s even better to have some kind of upstream intervention that avoids acute episodes altogether.”

This is done by analyzing records to identify patients at risk for specific illnesses and intervening early. For example, out of 100,000 patients, a handful might be obese adults with a history of diverticulitis not requiring surgery, putting them at significant risk of severe diverticulitis. Reaching out to these patients with diet and lifestyle support could head off a repeat episode requiring colostomy, Schreiner says. “That
can be replicated for heart attack, asthma, obstructive lung disease and a multitude of conditions if you have the right analytics, reporting and outreach.”

Still, systems must avoid financially crippling themselves as they transition to population health. “The tipping point comes when you move beyond your initial self-insured or small-risk contract,” Ziskind says. “When it gets to the point where you truly shift the way care is delivered, we often see dramatic decreases in inpatient volume.”

Managing mission risk

While population health discussions mostly focus on making it pay for insured patients, many systems also find it useful for managing another risk—caring for underserved, uninsured and underinsured community members.

“As we plan to take more risk in the Medicare and commercial markets, we want to tap that expertise to give our most vulnerable populations care that mirrors what is available to populations that can afford better coverage and access,” CHI’s Moore says. He estimates system cost for charity care and self-pay shortfalls run $500 million to $600 million annually.

In a study of high-utilizing uninsured patients in Louisville, CHI found that most were impoverished, with multiple chronic illnesses requiring active management; many were homeless or itinerant; and most had a comorbid psychiatric diagnosis. The patients were identified primarily from the system’s own medical records and about 500 accounted for nearly a quarter of the system’s uncompensated care in the region.

CHI developed a program that included regular primary care focusing on managing chronic conditions. Other services included transportation to clinics and providing telephones for those who didn’t have them. All were offered services, and about 80 percent enrolled, Moore says.

At nine months, the enrolled group saw a 30 percent reduction in emergency department use and a 50 percent reduction in inpatient use. More important, both physical and mental health status improved markedly, Moore reports. If expanded systemwide, the program could cut uncompensated care 10 to 15 percent while providing better service. A similar approach might reduce Medicaid losses, he adds.

Heartland Regional Medical Center in St. Joseph, Mo., sees a population health approach as essential to maximize the benefit of its free clinic, in operation for more than 100 years, says Linda Bahrke, R.N., who administers Heartland’s community health improvement program and the system’s ACO. The uninsured population in the area is still large, in part because Missouri declined to expand Medicaid under the Affordable Care Act.

The clinic has added care managers to help patients with chronic conditions. It also intercepts and steers low-acuity patients who seek care at the ED to other venues, and helps them to connect with primary care and clinic providers. But managing or even
**READMISSION READINESS**

| Does the hospital have the ability to detect readmissions even when the patient is readmitted to a different hospital? |
|---|---|---|---|---|
| Yes we can detect virtually ALL readmissions | Yes we can detect MOST readmissions | Yes we can detect readmissions to OUR HOSPITAL ONLY | No |
| 7% | 15% | 51% | 27% |

**SAFE TRANSITIONS**

Describe your hospital’s processes for facilitating safe transitions. Is the process standard?

- Identifying patients who transition between settings of care: 33% Yes, 67% No
- Sharing clinical information between settings of care: 30% Yes, 70% No
- Providing patient discharge summaries to primary care providers: 31% Yes, 69% No
- Providing patient discharge summaries to other providers (e.g., rehabilitation hospitals): 34% Yes, 66% No
- Tracking the status of transitions, including the timing of information exchange: 34% Yes, 66% No

**RISKY BUSINESS**

Does your organization have a state approved health insurance license to provide health insurance services to defined populations such as employers, Medicaid or Medicare?

- No: 27%
- Yes: 73%

Source: AHA Survey of Care Systems and Payment, May 2014, Data Release
finding uninsured patients is challenging because many move often or are homeless. “It’s hard to get your arms around this population,” Bahrke says.

The ACA mandate that nonprofit hospitals do annual community needs assessments is helping many to identify and respond to local needs, Thompson adds. “It has been extremely valuable to members to address voids in local health services. We hear a lot about dental and mental health needs. Hospitals can fill the void themselves or contract with others in the community to fill the need. It’s amazing.”

Another challenge for organizations taking population-based risks is conflicting patient incentives, notably high-deductible health plans. Out-of-pocket costs not only increase self-pay balances and bad debt, they also discourage patients from seeking the regular care that is the cornerstone of population health management, says Kris Kurtz, controller at Metro Health, a 208-bed osteopathic teaching hospital with 204 employed and independent physicians affiliated through a physician-hospital organization in Wyoming, Mich.

National data suggest the problem is growing, says Ann Garnier, chief operating officer for CarePayment, an Oswego, Ore.-based finance firm that partners with providers to fund patient out-of-pocket charges. As of 2012, 41 percent of U.S. residents reported carrying or having trouble paying medical debt, up from 31 percent in 2005, according to surveys by the Commonwealth Fund. Over the same period, those reporting deductibles of $1,000 or more rose to 25 percent from 10 percent. That contributed to a 12 percent rise in uncompensated care reported by hospitals to $46 billion in 2012, according to the latest available data from the American Hospital Association. Even modest deductibles and co-payments financially strain patients, particularly when they recur, as with chronic conditions. According to a 2014 study of medical debt by the Kaiser Family Foundation, the average 2013 single-coverage deductible of $1,135 was nearly double the average liquid assets of households earning up to 100 to 250 percent of the poverty level. Add typical co-payments and coinsurance, and the total for a major medical case exceeds the $2,740 average cash on hand for households up to 400
percent of poverty. Over two years, it even comes close to depleting the $12,000 in average liquid assets of households above 400 percent of poverty.

Given that family deductibles for Bronze plans on insurance exchanges, which are chosen by about 20 percent of buyers, average more than $10,000, and for Silver plans, chosen by about 60 percent, average more than $6,000, providers everywhere likely will see patient balances explode, Garnier says. Many already have.

At Metro Health, uncollected patient balances rose from about $500,000 monthly in late 2013 to $800,000 in the first quarter this year, driven mostly by higher deductibles and co-payments, Kurtz says. “Self-insured balances did not change; the upward trend is on the underinsured side.”

More insidious, out-of-pocket costs create disincentives to seek regular preventive and maintenance care. While cost sharing is supposed to prompt more prudent health care buying, it instead drives many patients to avoid treatment altogether until their conditions are too serious to ignore. In a recent Gallup poll, nearly one-third said they put off care because of cost last year.

That undercuts providers’ ability to reduce costs by providing continuing care. “If you have most people choosing high-deductible plans, it creates risk for an ACO, which is tied to patient outcomes,” Garnier says.

Metro Health has taken several steps to manage high deductibles, including beefing up its charity care and outreach programs, such as free screening for vascular disease. The system also publishes average prices paid for services on its website and offers zero percent financing through CarePayment, Kurtz says. He credits the program, which is co-branded with the system and integrated into its patient intake processes, with keeping total bad debt stable despite rising patient account balances. Typically, such a plan can double self-pay collections over internal collection efforts, Garnier says.

Kurtz also thinks it gives Metro Health a competitive edge as out-of-pocket costs loom larger in patients’

“More insidious, out-of-pocket costs create disincentives to seek regular preventive and maintenance care. While cost sharing is supposed to prompt more prudent health care buying.”
decision-making. “People in this community like to pay their bills, and this gives them an opportunity to do it in an affordable way.”

Patient financial counseling also may help hospitals to reduce self-pay risks. “Consumers need to make fundamental changes in spending habits to budget in health care,” says Garnier. “They haven’t been used to being asked for money up front. It’s a sea change and it will take a few years to adjust to the new world, but it has to become more retail.”

Counseling should extend to choosing plans that make care more accessible, Garnier adds. “Patients need to know the difference among a Bronze, Silver and Gold plan. They need to know they are getting good providers, good quality and how much it will cost, and how to pay for it. We need to support patients as consumers.”

Prevalence of high-deductible plans also may create opportunities for systems to offer their own plans with patient incentives more aligned to population health management, says Juan Serrano, senior vice president of payer strategy and operations for Englewood, Colo.-based Catholic Health Initiatives.

A related risk is if patients reject the narrow networks required to make it work, much as they did restrictive managed care models in the 1990s. But, Serrano notes, consumers now have data on how well networks deliver both clinical care and patient satisfaction.

The movement to health exchanges also gives the choice of networks to consumers rather than employers. People are more likely to commit to a network they freely choose based on reliable quality and cost data.

— Howard Larkin is an H&HN contributing writer.

### TYPE OF CARE COORDINATION

| Chronic care management processes or programs to manage patients with high-volume, high-cost chronic diseases | 39% | 33% | 28% |
| Use of predictive analytic tools to identify individual patients at high risk for poor outcomes or extraordinary resource use | 57% | 24% | 19% |
| Prospective management of patients at high risk for poor outcomes or extraordinary resource use by experienced case managers | 44% | 27% | 28% |
| Assignment of case managers to patients at risk for hospital admission or readmission for outpatient follow-up | 43% | 21% | 36% |
| Post-hospital discharge continuity-of-care program with scaled intensiveness based upon a severity or risk profile for adult medical-surgical patients defined diagnostic categories or severity profiles | 54% | 24% | 22% |
| Nurse case managers whose primary job is to improve the quality of outpatient care for patients with chronic diseases (e.g., asthma, CHF, depression, diabetes) | 56% | 20% | 23% |
| Disease management programs for one or more chronic care conditions (e.g., asthma, diabetes, COPD) | 44% | 28% | 28% |
Risk-contracting factors to consider

**MARKET OPPORTUNITY**

- **Revenue vs. cost trends** — Do historical and projected revenues exceed costs for a given population cohort?

- **Opportunity for lowering costs** — Can costs be reduced while maintaining or improving quality by “rationalizing” service delivery (for example, keeping chronically ill patients out of the hospital through better integrating services)?

**MARKET CONDITIONS**

- **Are employers ready** to move from fee for service to pay for performance? If so, what measures are they likely to embrace (for example, FFS plus quality bonuses, FFS plus gain-sharing, accountable care with FFS plus gain-sharing plus outcome bonuses, bundled payment for episodes of care, partial capitation, full capitation)?

- **Will payers support** or partner in risk-contracting, or view provider-sponsored plans as threats?

- **How willing are patients** to accept narrow networks, care coordination or preventive medicine and lifestyle coaching?

**PROVIDER CAPABILITIES**

- **Does your system** have the ability to coordinate services across the care spectrum?

- **Do you have** quality improvement and quality reporting systems in place?

- **Are your clinical services** operating at optimal efficiency?

- **Are your physicians** on board with specific types of risk-contracting?

- **Do you have** in place or can you buy or contract for all services required for a particular type of risk-contracting (such as control of inpatient and outpatient costs for gain-sharing, or all elements of a service line for episodes of care)?

- **Have you established** or can you establish care management protocols among all network members?

- **Can you track** and report clinical and financial utilization data in real time?

- **Do you have historical** clinical and financial information sufficient to assess the risks of a given population segment?

- **Do you have the financial** expertise to price bundled or capitated services, or global costs for a given population?

- **Do you have the contracting** expertise and infrastructure to clearly assign risk to network providers, track contract performance and distribute payments accordingly?
Why actuaries count for health care providers in the new world of risk

“Who is your actuary?” is my first question to health care providers looking to engage in risk-based contracts with payers.

My reasoning, payers have teams of actuaries that are constructing “fair and equitable” provider contracts while at the same time maximizing their own benefit potential. Actuaries attend college and then continue about nine years, on average, of post-college education to learn, identify and be certified to manage organizational risk and its financial consequences. Actuaries are asked to predict future events along with their associated costs based on analyzing historical experience in the context of current and/or future environments. As the health care industry shifts more toward provider risk contracts, you potentially expose your organization to large levels of risk without actuarial insights, with consequences ranging from poor cash flows, non-competitive “rates” resulting in decreasing market share, strained capital or worse-case scenario insolvency.

It goes without saying; historically insurance companies and providers viewed the health care market through very different lenses. Many times insurance companies ask their actuaries to focus on a product line in order to create benefit plans that attract members while also balancing the companies’ need for positive margins. For the provider, historically it’s not about a specific product line but more about managing their portfolio of fee-for-service contracts and margins with multiple payers, and how each of these contracts come together to support the overall organization as a whole. As these two lenses blur -- and make no doubt about it they are rapidly blurring -- it will be important to garner favorable risk reimbursement contract terms to position your organization in the most advantageous market position possible. That could be anything
from growth in market share due to care retention, to narrow network products, etc., or the ability to develop and capitalize on health care delivery efficiencies both inside and outside the health systems walls.

In addition to evaluating the reimbursement risk of contracts, actuaries identify operational risk items based on reviewing and/or modeling the key program characteristics. For example, attribution of patients within risk contracts on the surface is a fairly straightforward concept; however, we have seen time and time again how a poorly designed attribution model can introduce selection to the program and extend undue risk to the provider risk bearing entity such as an ACO. Careful consideration and/or modeling of the program terms will likely uncover the operational risk, along with other risks, prior to entering into an unsatisfactory contract. I believe the old real estate investment adage that “you make money when you buy the property, not when you sell it” holds true for risk contracts. In other words, the contract needs to be written to allow you to be successful from the very beginning; a poorly contrived contract will undermine your best outcomes for achieving high quality and efficient care.

Other areas where actuaries contribute to provider risk-bearing organizations involves working alongside the chief medical officer and medical directors to quantify the clinical opportunities into financial terms and risks, which can then assist management with prioritizing high-value initiatives. Without applying the financial rigor to quantify the financial impact of these opportunities, the provider risk bearing organization runs the possibility of deploying its capital in an inefficient manner. Although done today but not as common, actuaries in the near future will assist providers with product design development, placement of excess loss contracts for risk mitigation purposes, downstream provider contracting and network optimization and capital and surplus regulatory requirements.

As mentioned previously, the historic two distinct lenses of providers and payers are merging. With this merger providers are absorbing more risk and with more risk comes opportunity. Providers need to be acutely aware of how to capture this upside opportunity while minimizing the downside risk. This has been the role of actuaries within health plans. We encourage providers to make sure they level the playing field as well. If anything, double-check your numbers with an experienced actuary. Before signing a contract be sure to confirm the terms are fair, equitable and that you are set up for success.
Apply your data to understand your populations through all available lenses and act on the data to improve health.

Utilizing advanced analytics, find the populations that are not only the highest-risk but also the most likely to be helped through clinical intervention. For example, take a look at your patients with diabetes.

Measure Intervention Success
Use a scientific approach to determine which interventions make the biggest difference in your high-risk population.

Now that you have gained insights from your data, use those insights to continuously improve.

SOCIO-DEMOGRAPHIC LENS
Assess barriers to care
- No transportation to obtain care
- Depression (PHQ score of 9)
- Lack of help at home

FINANCIAL LENS
Which patients cost the most by chronic condition?

PATIENT POPULATION LENS
5% of population drives nearly 50% of health care spending. Who are my sickest patients? Which patients are at greatest risk for hospitalization?

1. See Data Through Multiple Lenses
Apply your data to understand your populations through all available lenses and act on the data to improve health.

SOCIO-DEMOGRAPHIC LENS
Assess barriers to care
- No transportation to obtain care
- Depression (PHQ score of 9)
- Lack of help at home

FINANCIAL LENS
Which patients cost the most by chronic condition?

PATIENT POPULATION LENS
5% of population drives nearly 50% of health care spending. Who are my sickest patients? Which patients are at greatest risk for hospitalization?

4. Measure Intervention Success
Use a scientific approach to determine which interventions make the biggest difference in your high-risk population.

Your organization stores disparate data—electronic health records (EHR), claims, socio-demographic, administrative—but how are you using it?

> 80% of doctors have EHR

94% of U.S. hospitals have EHR

30% of U.S. hospitals use a data warehousing/mining tool

80% of EHR data is unstructured

References:


We all saw the tidal wave of data rising. Providers and payers improved their ability to collect information, and governance around data management and planning to extract and apply the potential insights is just beginning.

Optum collaborates with organizations across the health care industry, while building and implementing new strategies and solutions that can make their data actionable.

References:


WHERE THE BEST MINDS COME TOGETHER ON HEALTH CARE RISK

- INDUSTRY ARTICLES
- VIDEOS
- PROVIDER INTERVIEWS
- UPCOMING EVENTS
- LIVE BLOG

PLUS, all past issues:

optum.com/riskmatters