Performing With a Net

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With the pivot from fee-for-service to fee-for-value underway, hospitals must learn how to accept risk-based contracts

By T.J. Redington, MD, MBA, FACP

Today's healthcare systems live in a fee-for-service world—the familiar payment model in which hospitals and doctors are compensated depending on the services performed. Under this model, hospitals are more invested in quantity than quality of care, potentially resulting in patients receiving more treatments than they may need and inflated healthcare costs. The United States spends almost 20% of its Gross Domestic Product on healthcare and related health services, making our per capita spending almost twice as high as the next closest-priced country.

A solution to growing and avoidable costs is fee-for-value, or value-based care, a compensation model contingent upon care quality and patient outcomes. Fee-for-value brings several benefits that fee-for-service cannot provide; specifically, it allows health systems to save money, helps patients receive better care, and rewards healthcare providers by paying out a portion of the savings to them. This is a win-win for everyone involved.

However, one aspect of value-based care has stopped hospitals dead in their tracks: risk-based contracts. A risk-based contract is a contract between providers (hospitals) and payers (health insurance companies) that makes the provider group responsible for the costs of the population they cover, whether it is commercial/employer-provided healthcare or a government payer like Medicare or Medicaid. This arrangement creates the crux of value-based care: each patient has entirely different risks, but providers are incentivized to provide value by giving each member of the population the care they need without excess costs. One person may be completely healthy and only see their primary care physician once a year, while another may have a complicated pregnancy resulting in a premature birth. Every population follows the Pareto Principle (the 80/20 rule)—20% of patients require 80% of the care.

With payers interested in moving away from fee-for-service to fee-for-value, especially with the potential improved payout and better patient outcomes, hospital systems will have to shoulder more risk. Therein lies one of the primary objections to moving to value-based care with a risk-based contract; a poorly managed risk-based contract can be catastrophic, especially if a hospital is unfamiliar with its nuances.

For example, 25 years ago, during my time as Ohio Medicaid Director, hospitals that engaged with a risk-based contract had a "fatality rate" of 100%, and many hospitals closed, primarily in the northern part of the state. This was mainly due to a misunderstanding of the requirements laid out in the contract and what a hospital needs in order to prevail in a risk-based environment.

There are a few steps health systems can take when preparing to pivot from fee-for-service to fee-for-value. These steps will ensure that everyone—the hospital, the physicians, and the C-suite—is aligned, educated, and ready to manage a risk-based contract confidently, making the risk feel less terrifying and more likely to succeed financially.

Step 1: Strategic Alignment of Shareholders

The first step entails ensuring everyone in the hospital is on board with a risk-based contract. But who, exactly, are "the shareholders"?

In my view, it's everybody, from patients, payers, and physicians to C-suite members and the board. In a risk-based contract, everyone is involved because of the wide-reaching effects. It's important to communicate that it's not an easy transition—it's like the hospital is an airplane in flight, and you want to change the engines while the plane is still in the air. You don't want to go from 100% fee-for-service to 100% risk-based contracts in one fell swoop; however, everyone should know that your hospital is making the transition in a way that makes sense for everybody and does not incur undue risk.

One great way to align shareholders is a simple one—"never eat lunch by yourself." You don't need to be a salesman, but if you want to garner interest and familiarity in a risk-based contract, physician leaders always need to be talking about it, especially with other clinicians. Of course, some groups will not be convinced as easily as others. It's important to be relentless, especially when bringing naysayers along for the ride.

Communication also becomes more manageable if you persuade each stakeholder group with different variations of the same strategy. For example, providers are a group you want to align early with a risk-based contract. Physicians are interested in improving patient care and seeing a payout from the money saved. Furthermore, physicians aren't great at taking orders—I can confidently say this, because I am one! Implementing a risk-based contract isn't about leadership ordering providers to do this and that; it's about physicians asking, "How can you help me take better care of my patients? If I can share in the savings, all the better."

Making physicians aware of the new environment and what you're trying to do can often make it easier to get the approval of the CEO or the board. If your team is ready and has a play planned out, the pieces should fall into place. Even if the CEO or board oppose it, it's not insurmountable. Physician enthusiasm will generally carry the day if the providers are interested and ready to make that move.

Hospitals should also consider a monthly meeting among all stakeholders to ensure everyone is on the same page. Communication is critical. A consistent and ongoing meeting of the minds is a great way to keep everyone updated and reiterate the point of a risk-based contract.

Step 2: Care Redesign

This step involves bringing together the risk-based contract with your preferred method of care redesign, which takes several steps to complete.

First, hospitals must decide what care redesign will work best for them and their contract. A relatively popular option today is an accountable care organization (ACO). In an ACO, physicians, hospitals, and other healthcare providers join voluntarily to provide better care for Medicare patients, and it is excellent for covering the entire continuum of care. However, ACOs are bound by the Centers for Medicare and Medicaid Services rules, making them more expensive and cumbersome to get up and running. There is also the issue of reconciliation—oftentimes, the insurance companies will allege the savings weren't what the hospital system had expected.

Another popular choice is a clinically integrated network (CIN). In a CIN, a group of independent physicians identifies and improves their patient offerings. It exists as a separate legal entity set up by a hospital or system, allowing savings to be distributed to participating physicians. Once implemented, a CIN can save millions of dollars, lower turnover, provide better patient outcomes, and—most importantly—make your hospital confident in a risk-based contract and help transition to a business environment that makes sense for you. With the populations' financials relatively current and obtainable, CINs can also remove the reconciliation problem prevalent with ACOs.

Although the risk may feel terrifying, these steps can help your hospital develop a plan, transition to value-based care, and get on the road to success.

Step 3: Analytics

While setting up one of these care redesign systems can seem daunting, many hospitals don't realize they already have what they need to get started. In fact, it can be easier, cheaper, and more efficient to go down this path.

There are two main items any organization needs: data and infrastructure. The most critical data in the process are historical patient health data from payers that show claims and health conditions. These data can help identify the most prominent medical issues, such as diabetes or cancer, and the population needing the most care. As for infrastructure, many hospitals have IT and analytic systems that can be reconfigured into something they can use. In our experience, we use the existing hospital systems to integrate the data into something actionable.

Once the plan is in place, it's time for the providers to step up and work with targeted patients. This plan can include phone calls, online messages, or emails to keep in touch and ensure patients get medications refilled and see doctors during appointment times. You may consider a small monetary incentive pool for the office staff—it takes a team to do the work, and your organization will be more likely to succeed if you recognize the front office staff and medical assistants.

Some hospitals think outside the box when contacting patients. For example, Cleveland Metro has many uninsured and at-risk patients who may need consistent ways of reaching their doctors. Their solution: provide burner phones to patients who have been in the hospital more than three times in the last year. The phones contain one phone number that will connect the patient to someone at the hospital in both English and Spanish.

Hospitals should next think about how they want to define and measure success and goals for the program. Money saved is an obvious place to start. Other potential options include clinical improvements (e.g., HEDIS measures, A1Cs, blood pressure), patient satisfaction, how often providers contact patients, and how often a patient refills medication and attends or misses appointments. Consistent targeted case management will make savings dramatic and durable.

It's also vital to consider how to approach the distribution payout for providers. After all other operational costs—the hospital system, the health plan, the sponsor, and any debt—are paid, the focus should turn to making prompt payments to the providers. It's up to leadership to determine who gets paid and how much of the fund gets paid out. A third party must be engaged to conduct fair market value tests and parsing the data provided by the physicians to determine who had the most robust results to ensure appropriate and fair distributions to the providers. Anticipate a large sum left over for the providers and get a feel for how much the organization is willing to distribute. This is a good problem to have! In my experience, we saved so much money that we were worried about exceeding fair market value and put millions into a "rainy day" reserve fund.

Conclusion

While fee-for-service will be around for many years, hospitals should be prepared to move into the value-based care space. Although the risk may feel terrifying, these steps can help your hospital develop a plan, transition to value-based care, and get on the road to success. GPJ

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