



# Insights on Reimbursement Risk From a True Industry Insider

**Financial stability is top of mind** for every healthcare organization. Recent industry activity, such as announcements from the Centers for Medicare & Medicaid Services (CMS) and large payer organizations earlier this year, show a definite shift away from traditional fee-for-service reimbursement models. Provider organizations looking to position themselves to thrive in the emerging value-based healthcare system must make decisions around taking on risk, and the extent of that risk, in their reimbursement arrangements. Here, Elena White, Optum's vice president of risk, quality, and network solutions, discusses how providers are approaching decisions around risk-based contracts in the new healthcare economy.

## Where does the industry stand in the transition from fee-for-service to a value-based payment system?

There is a wide spectrum of activity in this arena, ranging from providers that are just now dipping their toes into the waters to gauge their threshold for risk to those that have become quite adept at managing risk-based contracts—namely organizations in markets such as California that have been operating under a capitated system for many years. Most providers lie somewhere between the two extremes, making investments in people, processes, and technologies that will help them succeed in the evolving payment system. Activity in this space will likely accelerate across the board in response to initiatives such as those from CMS, which is aiming to tie 90% of Medicare payments to clinical and operational performance by 2018.



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Payers, many of which have been hesitant to enter risk-sharing arrangements, are also fanning the flames by pursuing strategic provider alliances and rolling out innovative new benefit designs within ACO networks that include sharing financial risk and gain for provider members.

## Shared-risk contracts will likely test the limits of providers' comfort zones. What are their greatest trepidations about accepting risk for their diverse populations?

Risk-based contracts represent a significant cultural shift for providers. Hospital systems, whose focus traditionally has been around volume, must now be thinking more about population management, which will have a significant impact on their fee-for-service business. They have also expressed concern over their ability to manage many different risk-based contracts, each with their own set of metrics and rules governing standards for performance and cost efficiency. For example, payers will often require practices to conduct annual assessments. While the assessments may be the same across health plans, providers will need to complete multiple different forms to satisfy their many payers' diverse requirements.

Providers are evaluating their internal infrastructures and capabilities to determine if it is sufficient to manage to the quality and cost-efficiency goals for each of their payer agreements. Without a comprehensive analytics solution and diverse data, they will find it very difficult, if not impossible,

to deliver measurable improved outcomes throughout their networks for their risk-based populations as well as their remaining fee-for-service patients.

### **Data has emerged as the engine to help providers survive and hopefully thrive in the market. Talk about how solutions have evolved to impact care quality while maintaining a healthy balance sheet.**

Whether talking about quality reporting systems, electronic medical records, or other enabling technologies, providers are utilizing technology to improve population management and clinical outcomes. Yet to achieve optimal success, they need to gain a true understanding of the value of having clinical and claims data available at their fingertips. Aggregated and harmonized, this information becomes a significant resource that provides unique insights on population cohort analysis, risk stratification, predictive analytics, and longitudinal outcomes tracking. Providing data when and where it's needed gives providers the ability to continuously track performance improvement activities throughout the organization. When providers are armed with the necessary tools and effective patient care processes, they can achieve enhancements in patient access, medical cost management, quality and preventive care, and satisfaction scores.

Furthermore, organizations are increasingly focused on how they can use the analytics to understand the nuances of their risk contracts, including the types of services they will be responsible for delivering and which quality and cost metrics they will be measured upon. As health plans are developing their target for reaching medical cost savings, providers are evaluating historical claims data to ensure that targets under risk agreements are set at achievable levels. Providers are also evaluating their internal costs to identify areas for process and medical cost improvement that they can use to drive increased efficiency and quality. Utilizing both claims and clinical data will help them better understand their targets for shared savings and performance improvement—valuable information not only to help support day-to-day operations but also to assist when negotiating reimbursement rates.

### **So data-infused analytics is the answer for ensuring providers will succeed under a risk-based payment model?**

In reality, it's only one part. There is often a disconnect between the wealth of data providers now have at their fingertips and a deep understanding of how to turn that information into the results they expect to achieve from their investments. A leader from a very large health system I recently spoke with summed up providers' need for a coordinated approach to addressing the complex reimbursement issues. His message was that technology has matured into an effective tool that can help providers better manage their populations, identify and control costs, and consistently maintain high levels of quality. However, providers still need a solutions partner that can marry a deep knowledge base of the workflows and processes of greatest importance to internal clinical and administrative teams with the infrastructure and advanced analytics if they are to succeed with shared-risk arrangements.

Providers that take advantage of this full complement are more desirable affiliates for other provider organizations, offering them the opportunity to leverage the efficiencies and stature enjoyed by larger networks and ACOs. It also makes them more attractive to payers looking for partners in new opportunities. Payers make these decisions based on organizations that are optimally performing from a quality and patient satisfaction perspective.

### **If you were to develop a to-do list for organizations pursuing a risk-based strategy, what would their priorities be?**

Topping the list would be the need to evaluate their market and competitive position within the space, as well as gaining an understanding of their competition and commercial, employer, and government payer partnership opportunities.

Provider network optimization would also be a priority. Evaluating historical claim and clinical data, organizations have the ability to compare provider performance and select those that have the greatest potential to improve care quality, reduce medical costs, and increase patient satisfaction for the needs of their patient populations—all of which can lead to bottom-line improvements.

No organization will succeed without a deep understanding of its patient population. Providers require the ability to stratify and segment their patients in order to gain an understanding of how certain groups (high-risk members, for instance) will impact medical cost performance.

Engage the consumer! Health outcomes are determined by whether or not patients adhere to therapies, participate in follow-up appointments, and engage in healthy behaviors. Patients who are able to improve their own health will assist providers in achieving their operational goals.

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Also on the list would be acquiring in-depth knowledge of their payer contract terms; developing and implementing processes to successfully drive care management, clinical initiatives, and network and payer optimization; monitoring performance with analytics and modeling; and deploying subject-matter experts who can accelerate performance under risk agreements, allowing organizations to navigate the market more quickly and with greater precision.

### **What are the near-term realities and long-term expectations for providers going down the risk-sharing path?**

Near term, providers shouldn't expect to perform flawlessly in a risk-based delivery system. There are still many technology and process kinks that must be worked out before providers can claim they are achieving all the benefits that this model offers. With thoroughly conceived goals and a well-planned yet flexible road map of how to achieve those goals, I believe there is a bright future in the long term for providers to achieve great success in the new value-based payment era.

For more information about how providers are succeeding under risk-based contracts, visit [www.optum.com/riskmatters](http://www.optum.com/riskmatters).

