Hospitals on the Brink: An Rx for Population Health

Steve Hyde, Principal
Value-Based Health Care Practice Leader
Stroudwater Associates
Revised 3/5/13

AN EXISTENTIAL THREAT

The third-party fee-for-service (FFS) reimbursement system has outlived its usefulness as the revenue model for America's hospitals. By driving volume at the expense of value, FFS has yielded mediocre quality while escalating costs to levels that neither governments, insurers, employers, nor consumers can continue to pay. Yet most payers continue to cling to FFS, offering increasingly unsustainable rates and only half-hearted attempts at new payment models that reward value.

This leaves only one viable solution. Hospitals themselves must take the initiative to implement sustainable revenue models. Otherwise, they risk finding themselves among the estimated one-third of all American hospitals that will cease to exist by 2020, dwarfing the one-sixth that disappeared in the 1980s and '90s for failing to respond to that era's massively disruptive managed-care revolution.

Fortunately, there is abundant evidence (e.g., Duke University Hospital) that provider-driven quality improvements can—by their nature—deliver greatly reduced costs. The problem for hospitals is that these savings now go to payers instead of the providers that produce them. Even worse, they result directly from reduced demand (and revenues) for hospitals' most expensive and profitable services. Unless hospitals adopt new value-based revenue models that capture these savings, they can put themselves out of business by delivering only too well on their population and quality initiatives.

THE NEW REVENUE MODEL: CAPITATION WITHOUT DECAPITATION

All successful value-based revenue models share two characteristics: (1) they financially reward providers for quality-improvement efforts that reduce per-capita patient costs, and (2) they penalize providers that don't. The most successful models have all been variations on population-based per-capita payments—commonly (and often notoriously) known as "capitation." Today, successful capitation models require hospitals to do three things:

1. **Focused commitment on quality and cost:** For savings-capture revenue models to work, hospitals must, obviously, produce the savings. That means committing to a permanent quality-improvement and PCP-care-coordination culture. Otherwise, they may as well stay with the declining FFS system and hope to find a deep-pocket consolidation partner before time runs out.
2. **Actuarial confidence:** During the 1990s, many capitation-based revenue models failed because providers accepted rates they hadn't actuarially verified as adequate. This inevitably led to provider losses that soon drove them back to FFS. For capitation to work, providers must negotiate sound rates supported by their own experts.
3. **Cost measurement and management:** Another reason capitation failed was that too many providers treated patient utilization and cost as Acts of God beyond their influence or control. As a result, they failed to adopt the budgeting, reporting, and management systems necessary to successfully measure and manage utilization rates, unit costs, and per-capita costs.

WHERE TO START AND HOW TO PROCEED

The key to implementing a value-based revenue model is first to establish a comprehensive strategy that will, in time, convert your hospital system's patients (and payers) to capitation-based payment models. Here's a synopsis of the key components of this strategy:

1. **A narrow provider network:** Start now (if you haven't already) to develop your own selectively narrow, quality-focused provider network with your primary care physicians at the center. Design it exclusively to engage your payers in population contracting and capitation payment models (including your own self-funded health plan). Be serious about quality-credentialing, quality management, value-based provider compensation, and, of course, capitation management.
2. **Organize for population health.** Your current organizational structure is designed for FFS. It won't work in an operating population-health environment in which your current profit centers become cost centers. Change it in three, multi-year phases: (a) Without disturbing your current structure, establish a multi-disciplinary developmental tiger team with a designated leader who either is or reports to the CEO or CFO; (b) As its initiatives move from development to active operations, the team (with shifting personnel and functions) will morph into a new Department of Population Health profit center operating in parallel with the rest of your organization; (c) As population health becomes your dominant business and revenue model, reorganize your entire structure accordingly.
3. **Prioritize and segment your markets:** Opportunities will vary from system to system, but these savings-capture opportunities are common to most:
    a. **Optimize your self-funded employee health plan:** Unless you're experienced in population-health and capitation management, your first target should be your own employees. Restructure—not cut—benefits, implement patient-management programs, and target 12% first-year plan savings. This will both accelerate your learning curve and generate meaningful bottom-line results. Start now for 1/1/14 implementation.
    b. **Take the initiative with your private payers:** If you haven't been approached by your insurers with population-health proposals, you will be. But the ideas they put on the table will most likely prove untested and provide you with little (if any) of the savings you must capture to justify your efforts. Develop your own contracting strategy alongside your new network, establishing a minimum set of payer-participation standards (see below). Unless you start your own health plan, your approach should be either to work with one or two preferred payers, or to establish an any-willing-payer model. Approach your payers before they call you. The savvy ones (or the ones that need you most) will work with you. The others will either come around or (as during the managed care revolution) won't matter. Exclude non-participating FFS payers from your new value network, leaving them to continue with their non-value-added PPOs.
    c. **Medicare Advantage:** Medicare Advantage is one of the fastest growing and highest per-capita savings-capture opportunities now available to hospital-based systems (Medicare ACOs are not). Yet most providers still accept FFS payments from their MA plans, assuring the savings they produce will benefit the payers rather than themselves. Effectively negotiated and managed capitation contracts can reap large rewards.
    d. **Medicaid managed care:** Many states either have, or are adopting, capitation-based Medicaid contracts with private insurers and medical providers. These can offer significant opportunities to convert your FFS losses into a profitable market segment.
    e. **Insurance exchanges:** State-based exchanges have the potential to transform American healthcare. But those mandated by the Affordable Care Act are virtual invitations for adverse selection that create major risks for participating payers and providers. While it can be beneficial for you to participate in well-crafted exchange offerings, negotiate initial payment structures that minimize your actuarial and selection risk.
    f. **Self-funded employers:** Seemingly attractive for hospital population-health programs, large employers can be a very challenging market to penetrate, especially for systems

that haven't demonstrated their effectiveness with their own employees. Approached properly, however, this can be a lucrative market.

4. **Capitation implementation and phase-in:** At the outset, few of your newly-contracted payer populations are likely to be large or actuarially predictable enough to justify full-risk capitation—even with reinsurance. Until such populations are achieved, phase in capitation, starting with FFS benchmarked against per-capita targets with shared savings. However, avoid agreeing to mere patient-management fees or PCMH support payments in lieu of true savings capture.
5. **Start your own health plan?** During the last 25 years of the 20th century, 500 startup HMOs—mostly provider-sponsored—overturned American health insurance. The plans that thrived all shared a common set of characteristics that apply now to the growing number of new hospital-based health plans. Don't reject this option without giving it serious, informed thought.
6. **Positive patient attribution:** Your participating payer contracts must require or incentivize their members to select one of your value network's PCPs or medical homes to coordinate their care. This is essential for patient coordination, provider responsibility, and revenue recognition.
7. **Joint decision making:** While some elements of benefit design (e.g., patient attribution) are essential for population management, your most successful payer partners will be those that collaborate with you on numerous product design issues to optimize your joint competitiveness.
8. **Data sharing:** You must track and manage your costs under capitation payer contracts. Initially, you need only a few, remarkably simple reporting tools (see Exhibit 1: The Stroudwater Capitation Management Dashboard™). In time, you'll want a full data warehouse to drill down on opportunities, problems, causes, and solutions. Few, if any, payers have or offer adequate reporting systems for this. To feed yours, you must get their claims and membership data.
9. **Operational efficiency improvement:** Regardless of revenue model, improving your operational efficiency through fine-grained cost accounting, waste reduction, operational improvement, LEAN, Six Sigma, and other techniques is now a baseline requirement for any provider.
10. **Learn from others.** Don't try to invent everything yourself. Connect with experts and experienced organizations to accelerate your learning curve and to minimize mistakes, startup costs, and lead times.

CONCLUSION

Hospitals face an existential threat. They also face an unparalleled opportunity to secure a solid future by transforming an inefficient, mediocre-quality healthcare system into a sustainable world-class model. Navigating the circuitous route to this goal will require you to embrace change and to take prudent risks. Fortunately, there are some pretty good road maps—and navigators—to help.

To learn more, call Steve Hyde at 719-338-9500 or email at shyde@stroudwater.com.

Exhibit 1
The Stroudwater Capitation Management Dashboard™
Summary View