Population-Based Healthcare: Structural Models and Options

George Choriatis, Esq.
Rivkin Radler LLP

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Indemnity HMO

Population-based healthcare first promoted by federal policy in 1970s

In HMO Act of 1973, the “prepaid group practice” model, which originated decades earlier, goes mainstream as a health maintenance organization (“HMO”), and is promoted by federal health policies as a cost saving alternative to indemnity insurance plans.

- **Indemnity**
  - Insurance and provider functions are separate
    - Patients have free choice of provider
    - Physicians have unrestricted choice of therapy, subject to medical necessity
    - Physicians paid FFS

- **HMO**
  - Insurance and provider functions are integrated
    - Insurer vertically or virtually integrated with provider networks based on primary care, coordinated with specialists
    - Financial accountability for total costs of care of a defined patient population

Increasing integration of provider and insurer functions
In the 1980s, carrier-HMOs grow and outnumber delivery system HMOs

Increasing integration of provider and insurer functions

Indemnity

Insurance and provider functions are separate

If integrated medical groups are not available in local community
- Insurer contracts with providers unaffiliated with the insurer and with each other.
- Providers paid discounted FFS on a “selective contracting” basis
- Insurer alone seeks to control costs through variety of methods, including utilization review, discounted FFS, risk sharing, etc.

Carrier HMO

HMO built on an insurance company foundation
- HMO product sold by multi-product insurance company
- Insurer contracts with a wide network of physicians

Delivery system HMO

HMO built on a delivery system foundation
- Staff Model
- Group Model

If integrated medical groups are available in local community
- Insurer may share risk with the medical group
- Insurer may delegate cost/ care management functions to the medical group
1990s to 2000s: The rise and fall of population health management led by carrier HMOs not integrated with care delivery

Increasing integration of provider and insurer functions

Indemnity

- Medicare evolves to fee schedule/DRGs

Commercial indemnity evolves to PPO (and, less commonly, EPO)

Carrier HMO

- By mid-1990s, carrier HMO becomes widely prevalent

Delivery system HMO

- Limited development/success of multispecialty groups, IDSs, and clinically integrated networks

FFS/fragmentation prevalent throughout

- By mid to late 1990s, carrier HMOs succeed in slowing growth of health spending.
- But such success is followed by provider/patient “backlash” –
  - Patients demand greater freedom of choice of provider
  - Providers consolidate to increase bargaining power and secure more volume
  - As consolidation increases, costs become less “managed” and more “unmanaged”
2009: Increasing calls for population-based care led by providers (not carrier HMOs) and done through care delivery transformation.

Increasing integration of provider and insurer functions.

Indemnity: No population-based care, unmanaged costs.

Carrier HMO: By 2009, carrier HMO-led pop. based care, not integrated with care delivery, was rendered by the "provider backlash" ineffective in reining in health spending.

Delivery system HMO: Provider-led pop. based care, done through restructuring of care delivery, promoted as preferred way to rein in health spending.

“If we could actually get our health-care system across the board to hit the efficiency levels of a Kaiser Permanente or a Cleveland Clinic or a Mayo or a Geisinger, we actually would have solved our problems.” President Obama, 2009.
2010: Support for provider-led, population-based care across the nation under the banners of Accountable Care, Triple Aim, etc.

Accountable Care Organization (ACO)

An ACO is a group of providers who assume accountability for the outcomes and total health costs of a defined patient population.

Volume to Value

IHI Triple Aim

Better Care for Individuals
Better Health for Populations
Lower Costs Through Improvement
The key innovations in population-based healthcare during the era of “accountable care”

<table>
<thead>
<tr>
<th>Linking patients to provider organizations</th>
<th>Conventional HMO</th>
<th>2010 innovation in ACO model</th>
<th>Consequence of the innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment/Gatekeeper</td>
<td>Attribution</td>
<td></td>
<td>Allows for pop. based care in indemnity plans (i.e. Medicare FFS, commercial PPO)</td>
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<tr>
<td>Cost control methods</td>
<td></td>
<td></td>
<td>Allows for lower costs through improvements in population health</td>
</tr>
<tr>
<td>• Utilization review</td>
<td></td>
<td>• Population-based care</td>
<td></td>
</tr>
<tr>
<td>• Lower FFS prices</td>
<td></td>
<td>• Risk contracting</td>
<td></td>
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<tr>
<td>Provider payment</td>
<td>FFS or capitation</td>
<td>Blended methods, utilizing various combinations of FFS and capitation</td>
<td>Allows for providers to gradually take on more risk</td>
</tr>
<tr>
<td>Support for development of provider PHM capabilities</td>
<td>Minimal</td>
<td>Subsidies, EMRs, regulatory reform, etc.</td>
<td>Facilitates the development of provider organizations capable of engaging in population based healthcare in every community</td>
</tr>
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</table>
The “accountable care” era’s modifications to the system that was developed previously during the “managed care” era:

- **Increasing integration of provider and insurer functions**

**Indemnity**

- Shared savings ACOs allow providers to engage in population-based care in Medicare FFS and Commercial PPOs.

**Carrier HMO**

- Opportunities for providers to partner with the carrier HMOs in total cost of care partnerships, moving away from an adversarial and toward a partnership relationship between them.

**Delivery system HMO**

- Blended payment methods allow integrated provider organizations to move into capitation one step at a time, taking on progressively broader financial responsibilities as they build their competencies in evaluating and managing risk.

- Shared savings ACO programs also are intended to spur the development of medical groups and other integrated provider organizations who then also seek to contact with HMOs.
At the core of the provider-led, population-based healthcare business model is “population health”

Population health is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.” Kindig (2003).
Population health is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.”

Two perspectives on the relevant population group

Public health perspective
- Relevant “group” typically is all the people in a given geographical area

Healthcare delivery system perspective
- Relevant “group” typically is a panel of patients for whom the system is accountable
To address outcomes, new partnerships needed

Population health is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.”

Health Outcomes

- Personal Behaviors (30%)
- Medical Care (10%-20%)
- Social and Economic Factors (40%-50%)
- Physical Environment (10%)

Healthcare System

- Primary Care and Prevention
- Behavioral Health
- Extended Care
- Post-Acute Care
- Ongoing Disease Management
- Acute Episode Care $$$
To maintain the health of a population, providers engage in population health management

1. Select patient subpopulation

2. Segment the population by health risk
   - Assess distribution of outcomes within the population
   - Segment the population by health risk
   - Identify health determinants for each population segment

3. Develop interventions appropriate for each segment
   - Redesign care/ implement interventions across continuum for each population segment

4. Evaluate outcomes
   - Improved health/ reduced costs

- Healthy (Low Cost)
  - Prevention and health promotion to maintain health
  - Improved health outcomes
  - Reduced per capita total health costs

- At-Risk/ Rising Risk (Potentially High Cost)
  - Care coordination to manage the risk

- Advanced/ Complex Illness (High Cost)
  - Case management to reduce avoidable complications
**Business model for provider-led, population-based healthcare (i.e. ACO business model)**

<table>
<thead>
<tr>
<th>Mission –</th>
<th>To engage in population health management</th>
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<tbody>
<tr>
<td></td>
<td>• Identification of patient population</td>
</tr>
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<td></td>
<td>• Assessment of health status and needs</td>
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<td></td>
<td>• Interventions for improving health outcomes to reduce total per capita costs</td>
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<thead>
<tr>
<th>Organizational –</th>
<th>Assemble a network across the continuum</th>
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<tbody>
<tr>
<td></td>
<td>• Organizational structure includes participants from across care continuum, as necessary to improve the population’s outcomes</td>
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<td></td>
<td>• Value-driven governance and leadership</td>
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<thead>
<tr>
<th>Clinical –</th>
<th>Redesign care to improve coordination</th>
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<tr>
<td></td>
<td>• Patient-centered primary care</td>
</tr>
<tr>
<td></td>
<td>• Care coordinated across clinicians, facilities, functions, and time</td>
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<td></td>
<td>• Performance measurement/ accountability</td>
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<table>
<thead>
<tr>
<th>Administrative –</th>
<th>Invest in tools to support pop. health mgmt.</th>
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<tr>
<td></td>
<td>• HIT/ HIE Infrastructure supporting care coordination</td>
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<td></td>
<td>• Data analytics and predictive modeling</td>
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<td>• Quality and process improvement methods</td>
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<tr>
<th>Financial –</th>
<th>Contract for value-based payments</th>
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<tr>
<td></td>
<td>• Value-based/ outcome-based reimbursement</td>
</tr>
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<td></td>
<td>• Alignment of provider compensation/ incentives to patient outcomes</td>
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Structural components of the provider-led, population-based healthcare business model

**Provider Integration**

- Integrator/convener for population-based healthcare
  - Primary
  - Specialty
  - Hospital
  - Long Term
  - Other

**Value-Based Payment Arrangement**

- Payer
- Defined Patient Population
Provider Integration and its Many Meanings

<table>
<thead>
<tr>
<th>Mission</th>
<th>Organizational</th>
<th>Clinical</th>
<th>Administrative</th>
<th>Financial</th>
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</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Specialty</td>
<td>Hospital</td>
<td>Skilled Nursing</td>
<td>Ancillary Providers</td>
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<tr>
<td>Mission</td>
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<td>Clinical</td>
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Provider Integration and its Many Meanings

- Primary Care
- Specialty Mission
- Hospital
- Skilled Nursing
- Ancillary Providers

- Mission
- Organizational
- Clinical
- Administrative
- Financial
Provider Integration and its Many Meanings

- Primary Care
- Specialty Mission
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**Mission**

**Organizational**

**Clinical**

**Administrative**

**Financial**
Provider Integration and its Many Meanings

- **Primary Care**
- **Specialty**
- **Hospital**
- **Skilled Nursing**
- **Ancillary Providers**

**Mission**

**Organizational**

**Clinical**

**Administrative**

**Financial**
Provider Integration and its Many Meanings

- Primary Care
- Specialty
- Hospital
- Skilled Nursing
- Ancillary Providers

- Mission
- Organizational
- Clinical
- Administrative
- Financial
Provider integration – can be “vertical” or “virtual”

**Vertical Integration**

The integrator brings the participating providers under a common ownership arrangements

**Virtual Integration**

The integrator develops arms length relationships among the participating providers through joint ventures, alliances, and other collaborative arrangements
Provider Integration
Organizational Archetypes

- **Vertical integration**
  - Hospital and Physicians
  - Physicians
  - Community and Public Health

- **Virtual integration**
  - Insurer
  - Hospital
  - Physicians

- **Integration of delivery system and insurer functions**
  - Integrated Delivery System
  - Physician Hospital Organization
  - Multispecialty Group
  - Network of Physician Practices

- **Integration of delivery and public health**
The multispecialty group is well situated to prosper under population-based healthcare

**Increasing integration of provider and insurer functions**

- **Indemnity**
  - Shared savings arrangements in Medicare and PPO plans are particularly appealing to medical groups due to opportunity to share in savings from reductions in hospital admissions

- **Carrier HMO**
  - Multispecialty medical group is the natural partner of the carrier HMO
  - Innovations in value-based payments allow groups to progressively take on more risk as they build their competencies

- **Delivery system HMO**
  - Some multispecialty groups establishing own HMO plans and contracting for the premium directly with insureds
Network of Independent Physician Practices

- Permits member physicians to retain ownership and control of their individual practices but still pursue economies of scale and coordination by centralizing resources and functions necessary for them to engage in accountable care.

- Independence is a key element of physician identity. The network of independent physician practices emphasizes shared identity of physicians as independent practitioners within collaborative model working toward common aim.
Integrated Delivery System

- Integrated delivery system is a hospital or health system with employed physicians.

- Under population-based healthcare, hospitals and health systems espousing population-based healthcare are re-conceptualizing themselves from being facilities of acute inpatient care to being hubs for population-based healthcare.

- Advantages
  - IDS has access to the capital necessary to bring together individual practices into a unified medical group and to create a supportive administrative infrastructure
  - Greater opportunities to coordinate care and seek savings across the entire continuum and therefore succeed under global capitation.

- Disadvantages
  - Conflicting incentives
Physician Hospital Organization (PHO)

- A physician hospital organization (PHO) is a clinically integrated network comprised of a hospital and independent physician practices.
- Typically, a PHO is a component of an IDS’s strategy for engaging in population-based healthcare, allowing the IDS to extend its population-based healthcare operations to independent physicians.
## Value-Based Payment (VBP)

<table>
<thead>
<tr>
<th>ACO Level</th>
<th>VBP funds investments in PHM</th>
<th>VBP holds providers accountable for PHM outcomes, but is built on FFS foundation</th>
<th>VBP with no FFS</th>
<th>ACO owns health plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>No VBP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced ACO</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Intermediate ACO</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Beginner ACO</td>
<td>X</td>
<td>X</td>
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- **FFS (Value-enhanced)**
- **FFS plus PCMH payment**
- **FFS plus care coordination payment**
- **Bundled**
- **Shared Savings (one-sided)**
- **Shared Savings (two-sided)**
- **Partial Capitation**
- **Capitation (limited scope or full scope of services)**
Opportunities for VBPs in Medicare

Increasing integration of provider and insurer functions

Indemnity

Medicare FFS

No attribution to ACO
Medicare FFS for Medicare populations not in an ACO

Attribution to ACO
MSSP
• Track 1
• Track 2
CMMI Programs
• ACO Investment Model
• Pioneer ACO
• Bundled Payment

Carrier HMO

Medicare Advantage

Example of shared savings with carrier HMO:
Aetna Collaborative Care Compact

Example of delivery system HMO:
Healthfirst Mt. Sinai Select

Delivery system HMO
VBPs in Commercial Sector

Increasing integration of provider and insurer functions

Indemnity
- PPO/ EPO

Carrier HMO
- HMO
- P4P, PCMH/ shared savings programs
- Innovations in global payment

Delivery system
- HMO
Template for a common combination of FFS and shared savings in current marketplace

1. Payor continues to pay the providers the FFS rates that would have been paid otherwise.

2. Payor pays monthly fee paid to the ACO (or other such entity), not the individual providers, to cover the costs of the organization’s care management activities.

3. PHM integrator (i.e. ACO or other such entity, not the individual providers) is entitled to shared savings (one-sided or two-sided shared savings models)

FFS component
Care coordination PMPM component
Shared savings component
Example of innovations in capitation: The patient-centered global payment

• Alternative Quality Contract, created in Jan. 2009 by BCBS of Mass
• Long term (5 year) contract that pays two types of payments:
  • Baseline global payment:
    • based on historical FFS expenditures of provider group;
    • health status adjusted;
    • increases annually with inflation;
    • opportunity for provider to keep profits derived from efficiency savings
  • Additional financial incentives to improve access, quality, and patient satisfaction (up to 10% upside)

In 2014, 40% of in-network payments are tied to value, compared to 11% last year.

<table>
<thead>
<tr>
<th>Payment Reform Program</th>
<th>National Results</th>
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<tr>
<td><strong>Payment poses financial risk for providers</strong></td>
<td></td>
</tr>
<tr>
<td>Bundled payment with quality</td>
<td>0.1%</td>
</tr>
<tr>
<td>Partial or condition-specific capitation with quality</td>
<td>1.6%</td>
</tr>
<tr>
<td>Full capitation with quality</td>
<td>15%</td>
</tr>
<tr>
<td>Shared risk with quality</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>Payment does not pose financial risk for providers</strong></td>
<td></td>
</tr>
<tr>
<td>FFS with shared savings</td>
<td>2%</td>
</tr>
<tr>
<td>FFS base pay plus P4P</td>
<td>12.8%</td>
</tr>
<tr>
<td>Non FFS payments (e.g. care coordination payment, PCMH)</td>
<td>0.6%</td>
</tr>
<tr>
<td>No-FFS shared savings</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other</td>
<td>6.7%</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>40%</td>
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15% of all commercial plan members are attributed to a provider participating in a VBP.

53% of the VBPs pose risk

47% of the VBPs do not pose risk
Population-based healthcare in NYS Medicaid

- Move to Medicaid managed care for all: HARP, MLTC, FIDA, DISCO, etc.
- NYS Health Innovation Plan contemplates that, in 5 years, vast majority of payments made by Medicaid MCOs to providers will be VBPs
- Who, on the provider side, will seek to contract for VBPs?
  - State is supporting formation of PPSs over next 5 years
606 Total ACOs
Formed in 2011-2013

Source: Leavitt Partners Center for Accountable Care Intelligence
Prevalence of ACOs by Type of Composition

Source: Leavitt Partners Center for Accountable Care Intelligence
Extent of Physician Participation in ACOs

Physician Practice Participation in ACOs in 2012-2013
(based on nationally representative sample of 1,183 practices)

- 60% Participating in an ACO
- 24% Planning to participate in an ACO within next 12 months
- 16% Not part of an ACO and not planning to be at this time

Thank You!