Making the Transition into Risk-Based Payment
Why Children’s Hospitals Need to Accept Value-Based Care Strategies

Substantial changes within the Medicaid marketplace are driving U.S. children’s hospitals to reevaluate how they approach billing, payment, physician alignment, care delivery and care quality measurements. These changes include the significant, albeit optional, expansion of Medicaid within the context of the Patient Protection and Affordable Care Act of 2010 (ACA). Additionally, there is a continuing trend among states to transition their Medicaid programs to managed care or accountable care models. These programs demand greater provider coordination of care and clinical integration in order to demonstrate quality achievement and to replace fee-for-service payments with prospective payment or risk-based models.

Considering that on average more than half of the revenue of children’s hospitals comes from providing care to Medicaid populations, these changes will significantly alter the business landscape — rewarding the provider organizations that deliver value, and penalizing those that depend on patient volume to drive revenue. To survive in this environment, children’s hospitals will be pressured through economic incentives to focus on managing population health, preventing avoidable readmissions, and reducing costs to elevate the value of the care they deliver. Furthermore, states will increasingly require that children’s hospitals accept additional financial risk in order to have more control over marketplace variables that impact their performance.

Essentially, children’s hospitals have a range of options. They can:

• Maintain their current business models as long as possible before market forces dictate change, and hope for the best.
• Develop new contracting approaches based on risk-sharing strategies, financial incentives that reward hospitals for quality, prevention and the appropriate management of chronic conditions. Within this option, the pediatric health system must decide whether it should be a Pediatric Accountable Care Organization (ACO) that contracts a) with Medicaid Managed Care Organizations (MCOs), or b) contracts directly with the State Medicaid Agency for medical management.
• Become a provider-sponsored Medicaid health plan to gain greater control over finances and incentives while adding revenue streams.

Deciding on which option to pursue is highly dependent upon variables that are specific to the hospital’s marketplace, as well as state laws. However, the trend is unmistakable – children’s hospitals must eventually align their stakeholders using financial incentives and integrated care management to achieve their long-term mission of providing high-quality care to children. With the proper strategy, hospitals can better coordinate care for children through integrated delivery networks that align the
community’s primary care physicians to manage the health of entire populations, typically starting with Medicaid but also moving toward commercial populations with adult health system partners.

This white paper explores the current market drivers dictating the need for change, and the eight key components that organizations need to address before entering into risk-sharing arrangements.

**Current Market Factors Dictating the Need for Change**

A number of factors are driving changes within the children’s hospital marketplace. Most recently, the transition of state Medicaid programs to managed care contracting has opened the door for accountable care organizations (ACOs) to further penetrate the marketplace. Currently, about 40 percent of Americans live within the service area of one or more ACOs, which are primarily in larger populated regions. These entities create the infrastructure and mechanisms that allow for the rapid adoption of leading risk-sharing practices, which will drive market competition on price and quality to usher in the next generation of value-based care.

Although children’s hospitals possess some experience with risk-based contracting, many lack strong relationships with the primary care providers who are essential for population health management, and who are also the font of all downstream revenue through referrals for specialty and inpatient services.

*Figure 1: More than 40% of Americans live in primary care service areas with at least one ACO*
Other factors increasing the financial vulnerability of children’s hospitals and dictating the need for change include:

- **Medicaid Expansion**
  New populations became eligible in 2013, and further expansion in 2014 due to ACA optional state expansion may create downward pressure on rates and utilization. In total, approximately 16 to 18 million more Americans will be covered under ACA with full Medicaid expansion. The majority of states have elected to expand Medicaid. Even in non-expansion states, Medicaid programs could see additional enrollment due to increased awareness.

- **Managed Care Plans Reducing Costs/Government Payment Reduction**
  Increasing trends to reexamine use of the emergency department (ED) and shift inpatient utilization to observation status and outpatient service are resulting in care that is provided at the lowest cost option. At the same time, government payers are reducing or eliminating payments for avoidable readmissions, hospital-acquired conditions and so-called “never events.”

- **Health Insurance Exchanges and ACA Economic Incentives**
  Also called health insurance marketplaces, the exchanges will shift commercial enrollment into new products with potentially different or lower reimbursement. Costly new mandates could cause large group employers in selected low wage industries to limit weekly work hours to avoid ACA coverage obligations and small group employers may drop coverage altogether. The loss of employer coverage will send new enrollees to the exchanges to purchase health insurance.

- **Increased Provider Competition and Consolidation**
  The consolidation of health systems, which is taking place on a local, regional and national level, has become a means of survival in order to achieve operating efficiencies, accumulate capital for investment, and provide the necessary scale to achieve return on investment (“ROI”) in the face of stiff price competition. Additionally, health system acquisition of physician practices is making it more difficult for children’s hospitals to align with community physicians.

- **Price Competition – Consumer Sensitivity and Transparency**
  ACA establishes plan offerings based on the second lowest cost Silver Plan (“SLCSP”) in a Rating Area. If a health plan’s premium exceeds the SLCSP, then consumers must pay 100% of that difference in premiums. This will force insurers to drive premiums down, which can be achieved through lower provider pricing accounting for at least 80% of premium cost in the individual and small group markets. At the same time, the ACA mandates increased price transparency for insurers and providers. The combination is forcing physicians to direct care to lower-price alternatives. In addition, many state Medicaid programs are substantially changing reimbursement strategies by shifting payments toward prospective payment models.

**Approaches to Take on Risk**

The children’s hospitals that are willing to take additional risk are the ones that will thrive in this new environment. Yet the question remains: how much risk is a hospital willing to take and when? There is a relationship between risk and reward, so organizations must weigh their potential opportunities against perceived downside risks, including cost of capital to implement systems to more effectively manage care.
Fortunately, hospitals have some advantages over payers when taking risk. Up to 75 to 80 percent of pediatric hospital costs are fixed, meaning that costs remain fairly steady whether the hospital is at capacity or nearly vacant. Incremental services cost a hospital only the remaining 20 percent. In contrast, payers assume 100 percent of costs for each incremental patient who is hospitalized.

There are also mechanisms to mitigate risk for provider organizations that take the plunge into becoming a qualified health plan (QHP) under the ACA. Three safety net features built into ACA provisions are reinsurance, risk corridors and risk adjustment.

- Reinsurance aggregates high cost members into a shared risk pool to smooth actuarial risk during the first three years of the individual mandate (2014 – 2016), during which providers gain greater experience with the new risk pool.
- Risk corridors limit losses to insurers, and are also available for three years, 2014 – 2016.

Risk adjustment is performed on the state or federal level, and creates a mechanism to transfer funds from plans with relatively low-risk members to plans with higher-risk members based on comprehensive diagnosis-based risk adjustment.

**Strategy Development**

There are a variety of scenarios that children’s hospitals can employ in their risk-based strategies. These range from continuing on the current path, preparing by creating a clinically integrated pediatric network, engaging in capitated agreements with MCOs, or becoming a provider-sponsored health plan. With value-based care, financial opportunities increase as incentives are aligned.
Eight Key Components for Risk-Based Strategies

1. **Provider Network**
   Having or being able to create strong provider relationships is the cornerstone to a hospital’s risk-based strategy. Provider networks must support the strategy and actively be the first line of defense in population health management that reduces costs. Pursuing *clinical integration*, as opposed to full physician employment, is an option for all hospitals, especially those without the ability to purchase existing medical groups. Clinical integration ties physicians more closely to the hospital, provides a vehicle to collectively negotiate contracts with payers, and focuses on quantifying quality and efficiency. Incentives are initially structured without financial risk and form a solid foundation for eventual ACO participation.

2. **Market Position**
   Organizations can choose between being a “first mover”, or a “fast follower”. With the current physician practice acquisition trend, aligning physicians may prove difficult, unless the hospital is a dominant force within its marketplace. Hospitals with minimal market share should opt to focus on bundled payments and very narrowly defined risk arrangements to limit their financial downside risk. There is a wide variety of techniques to gain access to primary care physicians, including:

   - **Clinical Integration Checklist**
     - Collect clinical data from all members
     - Incorporate agreed upon care guidelines in care delivery
     - Ability to measure compliance to guidelines
     - Enforcement process for compliance
     - Evidence of actual operations and use of clinical integration

   *The FTC defines clinical integration as “an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.”*

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**Table 2: Range of Risk-Based Scenarios**

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<th>Scenario</th>
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| **Current Path**       | • Continue to contract with MCOs  
                         • Expect tighter utilization management, downward pressure on rates, decreasing volume and new lower-priced competitors  
                         • Explore smaller scale pilots to build capabilities: medical home, care coordination, and pay-for-performance (P4P) with commercial payers |
| **Pediatric ACO**      | • Opportunity exists in some states; this can be full or partial medical risk  
                         • Capitation payment  
                         • Need to create infrastructure to distribute payment to providers  
                         • Develop care management / clinical integration and financial management tools to succeed within capitation budget  
                         • Care management of high-risk medically complex children |
| **Capitation from MCOs** | • Capitation from all Medicaid MCOs for all kids in your service area; this is typically a full medical risk model  
                           • MCOs pay claims and reconcile out-of-network claims against your capitation  
                           • Develop care management and financial management tools to succeed within capitation budget |
| **Medicaid Health Plan** | • Form a licensed health plan  
                           • Accept premium for all members who select your plan  
                           • Build or outsource health plan operations  
                           • Contract with a network of providers including adult providers  
                           • Determine how to pay your own providers and other contracted providers out of premium |
• Providing management services organization (MSO) offerings
• Employing physicians other than medical school faculty
• Organizing physicians as an independent physician association (IPA) or as a physician-hospital organization (PHO)
• Providing Stark-compliant clinical technology
• Employing physicians as medical school faculty

3. Payer Mix and Relationships
Forty-four percent of hospitals view payers as their biggest barrier or challenge in taking on financial risk, according to February 2013 survey conducted by the Children’s Hospital Association, Valence Health, and Goldman Sachs. Clearly, payer relations and mix within a market impact provider decisions. However, there are typically opportunities to improve the situation. First, relationships with payers should be about more than just rate negotiations. There should be an open discussion about opportunities for physician engagement and patient engagement to drive improved quality of care. Second, commercial payers and Medicaid managed care payers may be open to pilot projects that align with a hospital’s strategy. The more evenly spread out the payer mix is, the more opportunities exist for hospitals. Managing children’s health is largely accomplished through Medicaid/CHIP, and this gives children’s hospitals a huge advantage in low cost market entry due to ability to use their brand to attract large market share. Portfolio diversity may be achieved by expanding to QHPs and enrolling parents of children who don’t qualify for Medicaid into QHPs.

4. Organization and Leadership
Key to a successful risk-based strategy is having leadership that is willing to begin change on a proactive, instead of reactive, basis. There needs to be a culture of learning, continuous improvement, and an acceptance, if not a thirst for, change. Most importantly, there must be a governance model for data and operations across all care settings, and physicians must be a part of the decision-making process.

5. Population and Care Management
Engaging in value-based care requires the monitoring and management of population health to prevent illness and manage chronic conditions to minimize costs. Currently, hospitals and physician practices are engaging in some baseline management of conditions such as asthma, immunizations, diabetes and others. However, few are managing these conditions under risk-sharing scenarios. Expanding the number of conditions managed and increasing the number of risk-sharing scenarios creates the potential for substantial opportunities to reduce costs and improve population health.

6. Data, Information Technology, and Analytics
Population and care management require massive amounts of data and an infrastructure to collect, aggregate, and analyze the data, and then to convert it to actionable information. The major asset for a pediatric risk organization is data. Infrastructure must be in place to share comprehensive patient data across providers, as well as distribute and monitor adherence to evidence-based medicine guidelines. Benchmarking physician performance against peers and external benchmarks will enable hospitals to identify areas needing improvement, best practices, and new opportunities for cost reduction and improved outcomes. With the right technology, organizations will be able to effectively track cost per population, physician, provider type, disease state, and patient.
Financial Position
Both operating performance reflecting disciplined performance and accumulated balance sheet capital are essential to create a full risk ACO or health plan with sufficient risk-based capital for licensure. The children’s hospital market is in a state of flux, with about a quarter of provider organizations fully transitioned to managed care, almost 60 percent partially transitioned, and about 16 percent still under state-run plans, according to February 2013 survey conducted by the Children’s Hospital Association, Valence Health, and Goldman Sachs. The transition to prospective payment is also having an impact on revenues. With these factors still in transition and other components of the ACA being enacted in 2014, children’s hospitals have a great number of variables impacting their future.

Therefore, it is essential that organizations have a cost control plan that is timed appropriately with their migration to risk-based strategies. Move too soon, and providers risk not having the ability to control costs quickly enough to impact results during a transition period. Move after all the costs are under control, and all the value has accrued to payers. Often a winning strategy is to have a cost control plan fully analyzed and developed but not yet executed, and then execute once risk-based strategies are in place. Additionally, some risk-based models have capital reserve requirements which must be budgeted for in advance. Yet timing is everything, as risk is also involved in waiting too long for all components to align before taking the plunge. The first and early movers typically gain a higher share of the rewards. Organizations that move too early accept additional risk with the potential of greater rewards, while late movers reduce their risk but gain fewer rewards.

Expertise and Bandwidth
Entering into a risk-based scenario or creating a provider-sponsored Medicaid health plan requires special expertise that few organizations possess internally. Organizations can choose to build their expertise internally, or gain access to it by:
- Partnering with an established local, state or national health plan
- Outsourcing to a third party
- Acquiring a plan with the required expertise

Charting a Path — Crawl, Walk, Run
The world is changing for most if not all children’s hospitals. To avoid getting left behind, pediatric organizations should perform a tailored market and capabilities analysis as soon as possible. Free-standing children’s hospitals and adult health systems with pediatric organizations should gain access to experts, non-competitive colleagues and associations with vital expertise, such as the Children’s Hospital Association. The knowledge gained through these interactions should be shared with board members to begin educating them about the changing dynamics within the marketplace and how they can be approached as responsible fiduciaries.
Summary
With Medicaid expansion and health insurance exchanges already underway, pediatric organizations need to undertake strategic plan development and timetables to take action sooner, rather than later. It frequently requires time to fully establish a clinically integrated pediatric network, often the foundation for taking financial risk. Modeling an organization’s crossover from a predominantly fee-for-service payment system to one incorporating risk is paramount to most children’s hospitals long-range strategic and financial planning.

About Valence Health
Valence Health provides healthcare organization solutions for value-based care, helping them better manage their patient populations and accept financial responsibility for the quality of the care they provide. With unique data collection and analysis solutions, Valence Health has emerged as a leader in population management and clinical integration, serving dozens of clients from physician groups to standalone hospitals to large IDNs such as Cleveland Clinic. In-depth actuarial analysis combined with operational excellence allows Valence to not only advise but also provide ongoing services to provider organizations operating under various value-based reimbursement models. From risk-based contracting to accountable care organizations (ACOs) to administering provider-sponsored health plans, Valence has been helping providers appropriately accept and manage financial responsibility while improving clinical quality since 1996. Headquartered in Chicago, with three other office locations, Valence Health serves more than 30,000 physicians and 100 hospitals, helping them manage the health of over 15 million patients nationwide.

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