What's Broken in Health Care: Instituting True Risk-Based Payments

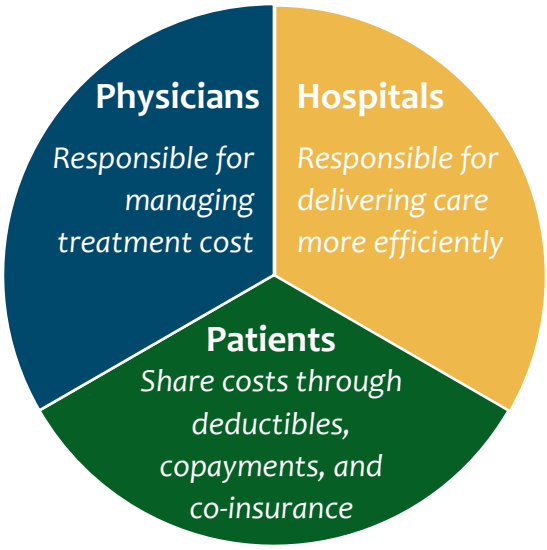
Introduction

In a time where many in this nation are confused about the direction of Health Care we look toward the future. Regardless of the design one thing is clear, we need more accountability in health care. There still isn't a clear understanding of risk-based contracting in the healthcare industry. This value-based payment model is inevitable and will ultimately shape the future of healthcare in a way that will be mutually beneficial to patients, providers, and payers. So why are the details still so murky and where does all the trepidation come from? As with many visionary endeavors, risk sharing can require heavy collaboration, strategic planning, complex contracts, a slow return on investment, and uncertainty in the near term. In a word, risk.

Understanding the Problem

Risk Sharing 101

Risk-based payments are meant to provide more accountability in health care by requiring providers and hospitals to share in the risk of treating the entire spectrum of a population. Physicians are required to lower costs by providing quality care to reduce utilization, while hospitals must learn to deliver care more efficiently and coordinate with others.



Medicare Leads the Way

Over the last 50 years, we have seen Medicare take the lead on reforming the delivery of healthcare. Some of their initiatives have already succeeded and others are still a work in progress. Medicare introduced DRGs to control costs and better manage the episode of care in a hospital by paying a set amount per diagnosis, thereby reducing the hospital's incentive to extend stays and encouraging them to provide care more efficiently. More recently, Medicare introduced bundled payments to manage the cost of a case from preadmission to discharge to follow up.

Partial Risk

Both DRGs and bundled payments are examples of partial risk. If the cost of care is higher than the set payment, the hospital and/or provider will take a loss. This arrangement encourages innovation, quality care, and efficiency in order to drive down medical costs and turn a profit. This is in direct contradiction to the fee-for-service (FFS) model, which incentivizes a high quantity of care rather than quality. Many believe that FFS withholds and discounts are risk, but they are not. These models are shared savings, not shared risk. However, even these forms of risk are not true risk because they do not account for the total cost of care for a population.

Shared Risk Pools

The first step for many health plans has been to set up shared risk pools, wherein groups of physicians with a payment incentive arrangement work with health plans and other providers in the community to manage costs. When they are successful, they have a reserve in the pool attributed to those members. These reserves allow for the group to invest in additional services to prevent diseases and better manage chronic conditions.

This limited shared risk arrangement will evolve into taking global risk where the entity is responsible for physician, hospital and other provider costs for the population. Some of the investments that are put forth with these savings are home based services, chronic care centers, dedicated nurses for case management and coverage of items needed to ensure a healthy population that often require unique services are not covered by their insurance.

True Risk

True risk is accountability for the total cost of care for the lifetime of a population. Some members are healthy and rarely access care, while others require intense services provided by multiple professionals. We must get to a point where we as collective providers are responsible for the cost of care for an entire population. This can be done through working with a community and taking on the payment and administration of services.

One successful true risk model is Medicare Advantage, wherein a plan is paid a monthly capitated fee to provide care for its assigned members. This is most often delivered through a network of physicians and providers that are responsible for some or all of the prepaid amount. They must keep the cost of care less than the payment in order to make a margin so they can continue to reinvest in the lifetime care of their patients.

Drawbacks

Commercial Plans are beginning to implement risk-based payments, but a major drawback of following the Medicare Advantage model is that membership changes often in today's transient society. When the health plan invests heavily in their member's treatment and the newly healthy patient changes their insurance,

this significantly inhibits the plan's ability to realize an ROI on that treatment. Why invest in the health of a member that will change plans? Without limiting the patient's choice in health plans, perhaps there could be a risk-sharing arrangement among commercial plans, wherein a small tax is imposed on all commercial premiums that would fund an incentive pool. This would provide value-based payments to health plans when their member leaves after receiving care that substantially improves their health.

Next Steps

Sharing risk can be complicated and intimidating, but it's a step in the right direction for the healthcare industry as a whole. As Medicare and Medicaid push to shift from fee-for-service to value-based care, we should embrace the change and be proactive in taking on this new responsibility.

If you need help with risk-based contracting, contact us at 949-503-8578 or mark@athenagroup1.com.

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