

# Lessons from Higher Performing Networks

## A Guide for Employers

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### INTRODUCTION

Large public and private purchasers have a long standing commitment to the “triple aim” of better care, improved health and cost moderation. As health costs continue to rise much faster than the overall cost of living, alternative networks with aligned financial incentives are being tested more broadly. Employers seek new options to deliver affordable, quality health programs.

Increasingly, employers are looking at alternative provider networks, integrating the best of health plan-based networks and expanded versions of accountable care organizations, primary-care medical home-designated networks, and episode payments to support and encourage providers. Provider-based care, through responsible providers – whether physicians, hospitals, or provider organizations, has the potential to deliver high value. In fact, some show higher performance already.

Ongoing national discussions on system and payment reform create an opportunity to accelerate the dissemination of effective initiatives across the country. Leading organizations have formed the Health Care Transformation Task Force<sup>1</sup> and committed to having 75 percent of their respective businesses operating under value-based payment arrangements by 2020. The U.S. Department

of Health and Human Services (HHS) launched the Health Care Payment Learning and Action Network to speed adoption of alternative payment models. Major employers are directly contracting and working through their health plans to access strong provider-based networks with the goal of improving care for their members and overall performance of their health programs. Through the Purchaser Value Network, best practices and lessons learned will be disseminated through employer coalitions and public and private purchasers.

Published early results for the recent programs has been variable. Many programs have seen quality improvements. However, financial performance is uneven and limited. Some networks have delivered higher performance on cost and quality while others are struggling. This paper focuses on the programs with better financial performance by distilling key elements of higher performing networks (HPNs):

- Pilots and initiatives,
- Care coordination and quality measurement,
- Alternative payment models,
- Management, and
- Infrastructure.

This paper examined dozens of HPNs that reported strong financial results. Many of these HPNs had previous experience with

managing populations as well as with taking more responsibility and risk; others are new. These HPNs cross the entire industry including Accountable Care Organizations (ACOs), Primary Care Medical Homes (PCMH), health plan-based alternative networks, and condition-specific initiatives such as episodes/bundled payments for a group of providers. This paper reflects lessons from these HPNs:

- What are networks with higher financial performance doing differently?
- Can techniques and initiatives be applied more widely across the system?
- What should public and public purchasers and health plans expect over time?

These are extraordinary times. Many providers are investing significant time and energy to improve the health system. Employers need to identify and support potential allies. This is the time for purchasers to support responsible providers and monitor these programs.

## DEFINITIONS

HPNs are not new. Often employers offer a broad network paid under traditional fee-for-service arrangements along with other options with a more narrow network of providers. Some of these narrow networks can be classified as HPNs (see sidebar) but they have only been partially successful: moderated rate increases though still higher than the overall costs of living. Furthermore, the geographic growth of these programs has been slow.

The word “network” has historically been used by employers to refer to health plan-based networks. The paper extends this definition to include new approaches to providers and payment. For example, an HPN may use

an episode-based program on maternity internally. For this report, a regional initiative that successfully improves condition-specific performance is a HPN, even though this has not been the traditional definition of “network”. The statewide Arkansas global budget model<sup>2</sup> based on defined episodes of care is such an example.

### CORE CONCEPT

A critical mass of responsible providers with the right support, authority, and aligned financial incentives will perform significantly better than the typical health program.

These experts take actions that health plans, employers, and members cannot.

### CORE CONCEPT FOR HIGHER PERFORMANCE

This core concept is based on a basic business principle. Effective decisions are made when the right individual with the right information has the authority to act at the right time.

The HPNs are real-life examples of how this concept works. HPNs, when done well, achieve:

- Measurable quality improvement;
- Much less waste in the system with cost savings passed along to purchasers;
- Lower administrative costs and ultimately fewer after-the-fact disagreements;
- Greater membership growth with financial and operational support from purchasers.

Health plans and employers think in terms of populations. Hospitals and physicians think in terms of illnesses. HPNs think about both. Shifting from a clinically oriented model to a consumer-centric model that prioritizes patient experience, supports momentum for more

**DEFINITIONS: PROVIDER-BASED CARE**

This paper focuses on performance, not the official name of the network. A higher performing network (HPN) can be an Accountable Care Organization (ACO), Primary Care Medical Home (PCMH), health plan-based network, hospital-owned insurer, on-site clinic, or stand-alone initiative that is intensely focused on a specific condition. The following definitions apply:

**Network:** a selected group of providers

**Higher performing network (HPN):** a network that shows better quality and financial performance.

**HPN for a defined population:** a network responsible on most services for a defined population (for example, an ACO and some PCMH programs).

**HPN for a targeted illness:** a stand-alone network for specific illnesses or services. This major innovation bridges the gap between purchasers focused on overall performance and hospitals and physicians with special expertise. This concept goes beyond traditional Centers of Excellence designated by volume or contract discounts.

**Narrow network:** a network that only includes a subset of available providers, often established based on negotiated contract discounts and which may or may not include quality or performance criteria for inclusion. The general narrow network is not the focus of this paper.

innovation and pilot initiatives that achieve higher levels of patient engagement in their implementation.

Providers who are moving towards successful provider-based care have more resources. Major system-wide challenges have been identified. Improved technology, a developed, deeper support system, and broader expertise in quality improvement and patient support are available).<sup>3</sup> There is widespread awareness about initial approaches to help providers work together (Accountable Care, Primary Care Medical Homes, bundled payment, etc.) Providers and health plans are running major pilots throughout the country. In some markets, provider organizations leveraged early success to form provider-sponsored health plans.

As mentioned earlier, HPNs are new in many parts of the country, so performance varies widely. There are many implementation challenges for providers and purchasers when these programs are introduced and built, but these challenges can be handled over time. Implementation and challenges are not the focus of this paper although key issues are outlined in papers from organizations such as the Academy of Actuaries.<sup>4</sup>

A summary of key elements for financial performance follows on the next page.

## SUMMARY OF KEY ELEMENTS FOR FINANCIAL PERFORMANCE

Many essential elements of provider-based care are already well known in the industry. Executive leadership, quality improvement, as well as actions to reduce readmissions and support for members with chronic diseases are widespread. However, financial performance for employers requires additional actions that often work behind-the-scenes. As we examined what Higher Performing Networks did differently, the following twelve elements stood out:

### Pilots and Initiatives

1. Implement multiple initiatives aimed at financial results (supported by new payment systems on some initiatives). Initiatives extend beyond quality improvement and are targeted to the line of business (such as Medicare, Medicaid, employer, or individual).

### Care Coordination & Quality Measurement

2. Improve care coordination and member engagement
3. Manage future high-risk members - not past illnesses.
4. Use outcomes-focused and value-differentiating measures

### Alternative Payment Models

5. Develop strong ongoing financial agreements on overall costs (with purchasers).
6. Implement selective “aligned incentives” over time (with individual providers).

### Management, Roles and Responsibilities

7. Use the full resources and unique capabilities of responsible, informed providers – from the executives to individual providers.
8. Reduce waste and related internal operating expenses across the system – demonstrated by multiple initiatives and a responsible executive.
9. Communicate with allies in deep blunt discussions (cost drivers, responsibilities, duplicate tasks, etc.).

### Infrastructure

10. Use multiple data sources to create useful reports to prioritize, create initiatives, and support the individual taking action.
11. Develop infrastructure to support informed action at the right time by the right individual.
12. Monitor economies of scale - particularly for smaller organizations (as they buy, rent, collaborate with other providers, or use allies).

#### DEFINING THE PROBLEM

What can be done?

Who is the right person to fix it?

- Physician
- Hospital
- Health plan
- Staff
- Member
- Employer

What resources are needed to create a solution?

## PILOTS AND INITIATIVES

**1) Implement multiple initiatives aimed at financial results (supported by new payment systems on some initiatives). Initiatives are targeted to the line of business (such as Medicare, Medicaid, employer, or individual).**

Major purchasers have implemented initiatives, including centers of excellence for very complex acute care like transplants. More condition-specific initiatives are underway such as the Pacific Business Group on Health's Employers Centers of Excellence Network<sup>5</sup> focusing on elective hip and knee surgery and spine surgery. Such programs reduce variation in care and cost, while advancing measurement to include patient-reported outcomes.

The industry has developed more resources and expertise to focus on specific conditions given improvements such as bundled payments alternatives, next generation Pay-for-Performance programs, and local market pilots. Condition-specific HPNs are now scalable.

- Multiple condition-specific initiatives are done within HPNs.
- A few statewide condition-specific HPNs involve collaboration by state governments, key providers, and the private sector.
- Other initiatives are local, with providers that choose particular illnesses, collect financial and quality data, analyze variation, and improve performance.
- Hospitals and physician organizations work to reduce variation in practice patterns.

In summary, initiatives offer a practical way for purchasers to monitor any network and anticipate their potential as an HPN. As more initiatives are focused on employer objectives, the more likely the network is to create higher performance.

There is also widespread adoption of initiatives to keep members healthy, including quality improvement, readmissions, member support for chronic patients. Requirements are clear, with published literature and training materials. In general, these initiatives are important but not distinguishing elements among HPNs, and hence, are not the primary focus of this paper.<sup>6</sup>

HPNs use financial initiatives and connect the right initiative to the right provider. A bundled payment program to reduce complications can be done with one set of surgeons. A program to use appropriate resources may focus on primary care physicians, and so on. Responsible physicians play a key role in HPNs. Many initiatives build on their expertise and are illustrated on the next page.

HPNs closely match financial initiatives to the type of purchaser (Medicare, Medicaid, and employer programs), since each purchaser has very different demographics and condition prevalence, payment methods, and members. Length of stay, pharmacy and price variations are key levers for employers and their members. Other purchasers have different financial levers.

## CARE COORDINATION AND QUALITY MEASUREMENT

**2) Improve Care Coordination and Member Engagement.**

HPNs focus on provider-based programs to coordinate care by professionals across multiple disciplines. Over time, the responsible providers work as an integrated team. A significant focus on patient engagement supports self-care and risk reduction. The team encourages behavior change that reduces avoidable risk, and ultimately use of high-cost services directed

### EXAMPLES OF MAJOR INITIATIVES AND PILOTS UNDERTAKEN BY MANY HPNs

- Real member engagement on health (beyond just the top chronic illnesses)
- Reduction in practice variation and wasted services across the system
- Effective referrals (inpatient, outpatient, other physicians, etc.)
- Condition-specific initiatives
- Patient channeling (for all services, not just inpatient)
- Advanced pharmacy management imbedded in physicians
- Reduce wasted services within the provider system
- Deep physician/hospital working relationships to reduce in-hospital expenses
- Health Information Technology usable by providers and staff (such as disease registries)
- Reduce fraud
- Reduce complication rates
- Reduce re-work and duplicative administrative expenses across the system

at acute exacerbations such as emergency department visits as well as duplication of services. Using tools like enhanced primary care access, centralized support staff education material, and customizes support material, patients get the right support at the right time.

Many HPNs use a “whole-person” approach to care management beyond traditional condition-specific disease management programs. While there is still a place for condition management such as diabetes education, reducing the total cost of care depends on understanding what’s in the patient’s way: lack of knowledge for self-care, psychosocial, home, family and environmental issues. HPNs also have targeted programs for high-cost and high-risk patients that follow patients over time and across settings. Care coordination and case management address gaps in care and care transitions that result in reduced readmissions and other high-cost, avoidable care.

### 3) Manage future high-risk members – not past illnesses.

The vast majority of health costs come from a small group of people, especially for older

populations. However, this basic observation vastly understates the challenge; in most cases, future high-risk members are hard to find. Many members with high costs in one year do not have high costs in subsequent years, particularly in employer programs. For example, a complicated pregnancy in one year rarely repeats in the next year.

HPNs spend significant effort to identify future high-risk members, determine whether action is possible, and develop targeted support programs. HPNs use a variety of sources to identify future high risk actionable patients: chronic illnesses, disease registries, case manager suggestions, provider references, and prospective risk scores from claims data. Support for high-risk patients requires a major commitment of resources that are not normally paid, so HPNs continually refine their process to identify the right subset of patients. Management of these patients has become its own industry. There are in-depth programs that are highly customized to the circumstances of the member.

- A face-to-face meeting elicits greater member engagement and behavior change

affecting overuse of services.

- Reducing unneeded utilization relies on understanding what's in the patient's way: lack of self-care, psychosocial issues etc. Disease management (DM) is secondary. In a high-cost population, HEDIS scores can be misconstrued as DM program quality. Patients saw the physician frequently, but that did not necessarily reduce overutilization.
- “Transitional Care” is an important element, for instance, but insufficient as the focus is usually only the 30 days following hospitalization. “Care coordination” and “care management” are critical for this population because they track patients over time--6 to 9 months or longer, and across all care settings.

Many major employers have their own stand-alone programs aimed at chronic high-risk employees and dependents. There is potential for major duplication of effort and/or member confusion unless provider-based and employer-based programs are coordinated to leverage the strength of each. In some instances, employers have suppressed outreach based on zip code or geographic overlap with contracted HPNs.

#### **4) Choose a limited set of measures that demonstrate value, linking financial results to utilization and quality outcomes.**

For reporting to purchasers, HPNs consistently use quality metrics. This is often applied to hold individual providers accountable for key measures and evidence-based care that improves health outcomes. This can be reinforced by payment policies to recognize high performers (as discussed in other elements).

However, other reporting is almost entirely internal rather than external. Most HPNs use

a measurement dashboard. For some HPNs, this is becoming more robust to expand into measures that includes appropriateness, care coordination, and patient experience, and increasingly, outcomes-focused. This leverages investments in health information technology and infrastructure. HPNs also advance quality reporting from clinical registries and electronic health records.<sup>7</sup> Beyond readmissions and avoidable emergency department services, HPNs look at access-related measures such as ambulatory care sensitive admissions.

A few HPNs are beginning distinguish themselves through their external reporting to major employers. A couple of others collect and publish outcomes data on key population segments, such as patients undergoing elective surgery and patient-reported outcomes captured in clinical registries. However, the reporting to major employers remains a challenge given the internal management focus of many HPNs.

## **ALTERNATIVE PAYMENT MODELS**

### **5) Develop strong ongoing financial agreements on overall costs (with purchasers).**

There is extensive literature about contracts between purchasers and provider organizations for programs with higher financial performance.<sup>8,9</sup> HPN contracts have common components for both overall populations and condition-specific programs that include clear quality standards.<sup>10</sup> Financial targets must include both upside and downside risk. Incentive payments can be built around specific goals. Virtually all costs and services are included inside the network (carve-outs of services, if any, are limited). Most of these contracts are currently between provider organizations and health plans.

Other elements vary based on contractual negotiations between providers and purchasers.

- Risk adjustment may or may not be included.
- Cost targets can either be specific numbers or a specified methodology.
- Trend factors are a major point of discussion.
- The population can be defined based on enrollment or attribution, which increases the complexity of measurement due to the impact on cost targets and trend factors.
- The program can be offered as a stand-alone option to members.
- Payments for out-of-network services are limited.

*Agreement on total costs with a single organization is essential, but does not produce ongoing higher performance by itself.*

Some issues are particularly complicated.

1. The most sophisticated purchasers and providers have extensive discussions about large claims and outliers. This goes past the discussion of unit costs. It focuses on joint identification of high risk patients, how to use providers as ongoing managers of large claims, and how to pay for the management.

2. Dollar caps on upside and downside risk are used by some HPNs; particularly smaller, up-and-coming, or physician-based networks. This provides financial incentives to the provider while avoiding massive windfalls or penalties.

3. The most complex issue is how to craft an overall agreement that matches the responsibility for costs to the real-life strengths of the provider organization. Many attempts

at network place too much responsibility on the providers too quickly. A highly-experienced HPNs with experience in all twelve elements can take responsibility for the full cost of care. Other networks need focus.

In the private sector, the financial agreement is tailored to the size, experience, and type of provider organization. As one example, responsibility for the total cost of care is split between the health plan, hospitals, and multiple physician organizations. Each organization identifies its capabilities and what it can impact. The hospitals takes responsibility for acute and facility care. The physician organizations take responsibility for all outpatient services, sometimes with pharmacy. This directly aligns the provider financial responsibility with their capabilities and potential authority.<sup>11</sup>

Condition-specific HPNs generally have contracts that focus on the cost of specified services. Often the split is two-way, with the health plan and provider organization sharing the financial impact of the programs.<sup>12</sup> Condition-based initiatives can be powerful for the HPNs since it offers the opportunity for actions that mimic how they work and can be applied to other lines of business. However, this makes client-specific measurement more complicated.

When sophisticated providers contract with major health plans or sophisticated employers, the discussions can be very deep. Purchasers conduct due diligence on the structure of affiliated provider contracts and the organization of hospital contracts. The length of health plan-provider contract terms is discussed.

Within shared risk arrangements, issues include how negotiated increases in provider payments are reflected in gainsharing. Parties

agree to assumed trend increases relative to management of the targeted total cost of care. If accessing an HPN through a health plan, the contract addresses topics such as clauses which limit price transparency or “most-favored nation” treatment that requires preferential treatment in tiered products.

**6) Implement selective “aligned incentives” over time (with individual providers).**

An overall agreement between purchaser and provider is not enough; real improvement depends on new methods of paying individual providers. Aligned provider financial incentives are essential for long term sustainability and affordability. HPNs often start by identifying their key initiatives and then target incentives to support them. Powerful approaches are:

- A broader role for primary care physicians and office staff in exchange for higher compensation. This can be a mix of capitation, incentive payments, reduced administration, or additional support in the physician’s office.
- Reduction in complicated care in hospitals with new payment approaches for hospitals and key specialists.
- Alternative payment for hospitals to incent management of the length of stay, including payment per admission, global payments, gainsharing, capitation, or alternative approaches to large claims.

For HPNs, aligned incentives are not a theoretical discussion, this is a practical business decision. They make highly targeted adjustments to fee-for-service payment to key individual providers. This becomes more customized and complex over time.

Aligned incentives at the provider level are targeted. For example, physician payment is a

compensation discussion. Base compensation may be capitated for primary care services. Specialists are paid on with fee-for-service or case rates. Gainsharing programs can be developed between physician groups and hospitals to improve quality or control underlying expense. There is often a moderate bonus program based on each provider’s performance on quality, efficiency, and service metrics.

In some HPNs, there are sensitive discussions about hospital marginal income and high cost claims, since high unit prices distort the real internal costs and create very poor financial incentives. For example, the hospital margins are far higher for complicated surgeries than uncomplicated surgeries.<sup>13</sup> Unless this is changed, it creates a financial barrier to improved patient care.

*Is the current payment system a major obstacle to the action we want? If so, change it. If not a major obstacle, leave it alone in the short term.*

HPNs that focus on specific illnesses use many options. There can be bonuses for quality and efficiency, as well as gain-sharing for savings from reduced internal expenses. For example, if the initiative consolidates to a single device manufacturer for certain surgeries offers lower supplier expenses, eases internal training, and improves quality, but requires some cardiologists to change devices. HPNs use highly targeted one-time approaches to this type of business situation.

## MANAGEMENT, ROLES, AND RESPONSIBILITIES

### 7) Use the full resources and unique capabilities of responsible informed providers – from the executives to individual providers.

The existing fragmented delivery system has disconnected providers. As a result management is often limited and retroactive. Even with the new energy around performance, newly developed networks primarily use their own existing expertise. A health plan refines its claim-based networks, a hospital system focuses on acute care, and so on.

HPNs understand and leverage the existing capabilities of each part of the system. They go beyond their own personal training and instincts. Initiatives are assigned to the individual with the right strengths and experience. Each part of the system has major strengths. For example, health plans and employers have strong member programs, primary care physicians guide to the right resources within the system, specialists reduce complications, and hospitals provide acute care management. These strengths are often unknown outside of their part of the system.

As one example, the traditional health plan approach to physicians is far different from that of a physician organization or an HPN.

- Health plans with large data bases have data on historic financial performance and build networks around historic performance enhanced by other data sources. However, health plan actions happen after the fact, from afar. Most of the energy is focused on difficult, non-compliant providers.
- A physician-based HPN builds around responsible physicians. It treats physicians as a resource and creates training and system

support to improve future performance. As mentioned earlier, physician based systems enhance the unique capabilities of physicians and create initiatives that maximize their impact.

HPNs that blend the strengths of the health plans, physicians and hospitals have stronger performance.

For HPNs, this commitment to having balanced roles for each part of the system starts with the executive team and overall system manager. Some other networks still struggle to reach a practical balance or react almost entirely within their historic role.

### 8) Reduce waste and related internal operating expenses across the system – demonstrated by multiple initiatives and a responsible executive.

Most networks, whether HPN or not, work to improve the health of their population. However, this is just the starting point for HPNs. HPNs manage the health system, not just their member population. Long term sustainable and affordable programs require an effective system after the member is ill. Waste within the system needs to be managed over time.

Waste reduction and efficient delivery of care is challenging given the complexity of health care, but, it also faces a unique historical problem. The poor design of the existing payment system encourages high use of resources. Quality improvement and waste reduction may reduce expenses, but often reduce revenue under a fee-for-service environment. Some initiatives are stopped due to the revenue loss before they even get started. Executive support is therefore essential.

Most networks, whether HPN or not, have executives committed to quality improvement with extensive quality metrics and widespread goals to improve patient health. However, HPNs have executives committed to reducing waste across the system. The executive commitment can come in many forms, such as a standing financial committee of executives across multiple organizations or an IPA medical director meeting with individual physicians to review referral decisions.

### **9) Communicate with allies in deep and blunt discussions (cost drivers, responsibilities, duplicate tasks, etc.).**

Historically communication across the system has been weak, proprietary, and often counterproductive. HPNs overcome these historic barriers. This works at multiple levels.

- Many HPNs involve alliances across different parts of the industry. A hospital owns an insurer or a health plan builds relationships with responsible physicians, with executive-level discussions for sensitive issues. Allies share key information including claims. Each ally gets its own set of assigned tasks.
- Providers typically know only about their own encounters with patients. HPNs share more complete information--not just raw data but actionable information. For some initiatives, detailed claim data is included. For other initiatives, management shares analytic results and implications.
- This communication is reinforced by aligned financial incentives to individual providers. This is often connected to element #6, most HPNs pay incentives to providers and key staff for better performance.

## INFRASTRUCTURE

### **10) Use multiple data sources to create useful reports to prioritize, create initiatives, and support the individual taking action.**

The ongoing goal of provider-based care is effective and informed decisions at the right time. So, HPNs continually improve their data analytics and reporting. HPNs use a variety of data sources and analytic techniques for their programs. The goal is not just mining a database or EMR, but useful, timely reporting to the right person.

Targeted analysis of claims is more widely available to all networks, whether HPNs or not. Developments such as bundled payments, illness-specific physician variation, and hospital analysis of claims have become available, but data reporting for employers remains a challenge due to smaller volumes in each location.

Some HPNs report using more than one hundred reports to manage their programs. Each report has its own audience. Some reports are used by management, others by hospitals, or individual physicians. Useful data and reporting remain a challenge given the complexity of health care. While financial analytics are often extensive and conducted individually, there can be benefits to collaboration on analysis for benchmarking and shared insights. Data and resource limitations have not stopped HPN from higher financial performance, leveraging homegrown systems like disease registries or jointly contracted data vendors.

### **11) Develop infrastructure to support informed action at the right time by the right individual.**

HPNs get information to the people making decisions. This requires a strong infrastructure with key functions done on a centralized basis to let physicians and other providers focus on

their core job. This works at multiple levels: support staff for high-risk members at the physician's office, health professionals working at the "top of their license," centralized systems that deliver key information to providers, and extensive professional training.

HPNs reflect many different organization structures. Some are single organizations, such as Kaiser or hospital-owned insurers. Others programs split responsibility between an insurance health plan and hospital, or delegate management to multiple physician organizations. Some health plans select networks of individual physicians and hospitals. Moderate-sized IPAs develop "critical mass" in their local community for a particular line of business. There are also statewide condition-specific initiatives for episode-based payment, and other regional performance improvement programs to support primary care physicians.

The scope of healthcare and range of potential initiatives can be overwhelming to newer or less experienced organizations, especially if they try to do everything themselves. Rather than focus on overall financial targets, it may be easier to get their operation up and running through targeted quality initiatives.

### **12) Monitor economies of scale – particularly for smaller organizations and individual providers.**

Critical mass, administration and economies of scale are a major obstacle to growth of provider-based care. This is even a problem for some HPNs. It is even more challenging for smaller, physician-based, and up-and-coming networks, which are essential for geographic expansion of high performance programs. Problems include lack of expertise, bureaucracy,

competition for scarce talent, duplicative resources, and high operating costs. Resulting costs eventually are passed along to purchasers.

Historically, large organizations were needed to operate HPNs, but the success of less-structured HPNs has contributed to more diversification. Some strong federal Medicare ACOs are multi-provider collaborations. Critical mass and economies of scale are continuing challenges, but resources and technology have greatly improved. Various efforts are underway to achieve high performance using more virtual and less formal structures.

### **Lessons from Smaller Existing HPNs**

In some parts of the country, smaller, local networks are already HPNs and offer comparable performance to their larger counterparts. In fact, these smaller HPNs can drive major improvement even if larger organizations resist engagement by obtaining support from allies, educational collaboratives, or relying on joint purchasing. Such HPNs may not control the total cost of care, resulting in a more narrowly focused contract. For example, a physician-based HPN may limit financial risk by being paid for outcomes of specific initiatives or accepting responsibility for outpatient and physician services. Smaller organizations can build powerful relationships with the local provider network, members, and selected purchasers. This commitment to the local community offsets many challenges of size.

## STAKEHOLDER PERSPECTIVES ON PAYMENT INCENTIVES AND REFORM

As discussed earlier, the issue of payment structures and incentive alignment is a key element and warrants further discussion. There is widespread agreement about weaknesses of fee-for-service payment, a need to shift from “volume to value,” and the importance of alternative payment methods. Various words are used: “value-based payment,” “aligned incentives,” “payment reform,” and “fee-for-results.”

These words are used at two very different levels. One refers to the agreement between the network and purchaser. The other is the payment system used for each individual provider. Each is distinct within HPNs.

- The agreement between purchaser and the provider network focuses on comprehensive measures, such as the total cost of care with additional performance incentives for specific initiatives.
- Agreements between the network and individual providers uses a targeted mix of fee-for-service and aligned provider incentives. The agreements link payment to the role and performance of the provider.
- The purchaser and provider payments are aligned. For example, incentive payments for quality from the purchaser are allocated to responsible providers.
- HPNs precisely match the payment to the task the individual provider can influence or control. For example, an individual physician is not held accountable for the total cost of care. They are paid for key quality metrics, or specific tasks to reduce waste.

## PURCHASER PERSPECTIVE

Purchasers are responsible for all costs for their members – expensive patients, low cost patients, regardless of quality metrics, etc. This is how individuals pay for insurance. This is how larger employers measure financial results. So, as purchasers work with large provider organizations, an agreement to be responsible for most costs is fundamental.

*We can't rely on the carriers to fix our health care system... It's up to employers to get engaged to fix our health care system.<sup>14</sup>*

Sally Welborn, Senior Vice President of Benefits, Walmart Stores, Inc.

Major employers use an extensive bid process to select their health plan (or third party administrator). This includes extensive questions about operations, finance and network management. There are also ongoing standards for quality, access, and member satisfaction. Similar operational and management questions are being asked of HPNs with opportunities and challenges to provider-based care and use of alternative payment models. Provider-based care must distinguish itself through new and/or improved initiatives.

One new concept for employers and health plans is the impact of “waste reduction” on their costs. The first instinct of purchaser is that internal expense management and waste reduction in the overall health system is not their business. However, HPNs that reduce waste across the system can offer lower unit costs than other providers in each market. Waste reduction is essential to sustainable, affordable programs.

## HOSPITAL PERSPECTIVE

For a large provider, such as a hospital, healthcare is their core business. So, any change in their strategic direction is a major, complex decision. Many hospitals see declining employer coverage (and fewer high profit members) which create declining margins.<sup>15</sup> So, they are evaluating major changes in their business models.<sup>16</sup> Hospitals-based HPNs have moved past evaluation and taken action on the elements discussed in this paper. These includes the commitment to waste reduction outlined in Element #4. Actions often starts with Medicare, the employees of the hospital, and/or members of hospital-owned insurers.

Hospitals financial decisions are complicated given high fixed costs. So, they make financial decisions based on marginal income (revenue less internal expenses) not just revenue from claims. Health plans and employers typically only see the claims. Purchasers who effectively deal with hospitals understand the implications of marginal income on hospitals.

Some hospital-based HPNs have taken a very active role. This includes implementing many improvement projects across all lines of business care coordination in their local markets, and in some cases, offering a standalone product to purchasers through a hospital-owned insurer or a joint business arrangement with a carrier.

## PHYSICIAN PERSPECTIVE

Physicians direct much of health care spending, but traditionally have limited information outside of their direct patient contact and no support system. Fee-for-service payment within the current cottage industry does not support or reward responsibility and good decisions.<sup>17</sup> As a result, there is wide

variation in performance of and support staff (primary care, specialists, nurses, etc.). Responsible physicians with strong support become part of the solution: they treat wasted resources as if it was their own money.<sup>18</sup>

Higher performance depends on HPNs creating a better working environment:

- Primary care physicians have a broad role - beyond typical PCMH criteria.
- Aligned incentives between primary care and specialty physicians.
- Managing the scope of physician responsibility. Too many initiatives can be overwhelming.
- Payment reflect the scope of the provider responsibility and their performance.

For some physicians, more responsibility comes with much higher compensation. Responsible physicians are important assets, so physician payment is an ongoing compensation issue, not a once-a-year contracting decision.

Many HPNs connect members to primary care physicians (or certain specialists) at the time of enrollment, enabling better integration of care and management. Responsible physicians in HPNs can work through an expanded version of a PCMH, an Accountable Care Organization, or an on-site clinic run by a major employer. Some HPNs work directly with individual physicians, for example, state governments run condition-specific initiatives. Some strong physician-based ACOs actually consider themselves as a blend between a high-end PCMH and an ACO.

Given the wide variety of alternative networks, many leading health plans are testing multiple options to engage physicians, physician-based ACO in one market and a hospital-based program in another. In a third

market, physicians may prefer to stay in small practices, so the same health plan gives direct support in an expanded version of a PCMH working with individual primary care physicians (most infrastructure and management stays within the health plan.)

### SUMMARY

Provider-based care, through responsible providers, can deliver high value if done well. But, historically, higher performing networks (built around responsible providers) have only existed in a few locations. And, even these do not reach full potential. There is an opportunity to create widespread performance improvement for major purchasers and your employees.

There is widespread agreement on member engagement and quality. Improvement is already happening. The situation is different for financial performance, it has been weak and uneven. Strong financial performance does not happen by itself – it is time for purchasers to drive financial performance to the next level – more affordable care for your employers in many more locations. The current national direction offers a solid starting point, but it is just the first stage.

Provider-based care is being used successfully in the real-world already, you need the health plans and providers working for you to move this to more locations.

Purchasers can drive strong programs through actions including:

1. Distinguish between HPNs and boilerplate typical networks
2. Assess how your health plans and allied providers are performing on the twelve elements in this paper.
3. Understand the health plan's plan to improve your key markets.
4. Build key initiatives into on-site clinics.
5. Conduct due diligence on the structure of affiliated provider contracts and the organization of hospital contracts.
6. Identify and encourage innovation and implementation of stronger initiatives.
7. Continue to communicate your goal to improve financial performance within the triple aim.
8. Incent members to utilize responsible providers through communication, plan design, and stand-alone network choices.
9. Leverage employer coalitions to drive local improvement even on the most complex issues.
10. Monitor and encourage provider efforts to reduce waste across all purchasers.

**It is time for employers to act.**

**Improved financial performance for purchasers and their employees will not happen without their voices.**

## LESSONS FROM HIGHER PERFORMING NETWORKS – ISSUE BRIEF

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### About the Pacific Business Group on Health

PBGH’s Member organizations -- private employers and public agencies -- are the most powerful voice for consumers and patients in the U.S. Ultimately, the profound concern of purchasers about the high cost and poor quality of healthcare puts them on the same side as the American public when it comes to driving improvement throughout the healthcare system. PBGH’s approach is to use the clout and concentrated power of our Member organizations to test innovative healthcare methods in specific markets, and then to take successful approaches to scale across the U.S. PBGH also uses educational forums, user groups, and networking events to maximize our Members’ impact. Since its inception, PBGH has made some of the most notable improvements to U.S. healthcare since, including launching the first public website displaying health plan, hospital and medical group quality and patient experience data, influencing the drafting of the Affordable Care Act to emphasize federal value purchasing and accountability, representing purchasers in the Meaningful Use Health IT roll-out, and implementing the Intensive Outpatient Care Program (IOCP) for Americans with serious chronic illness in five states. To learn more please visit [www.pbgh.org](http://www.pbgh.org).

