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Succeeding in Value-Based Payment: Success with Providers "Outside Your Walls"

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Public hospitals and health systems have a commitment to provide access to care for the most vulnerable populations, including the uninsured and underinsured. They also have a unique opportunity to become leaders of a network of choice for the care of Medicaid, Medicare Advantage, dual-eligible, subsidized exchange, and other populations by overcoming the traditional siloes of public versus private providers and community-based organizations (CBOs). This can be done through engagement of private providers and CBOs in value-based payment arrangements that add value to health plans.

However, public hospitals and health systems have often struggled to become a provider of choice, exacerbated by the Medicaid expansion and subsidized exchange implementation post the Affordable Care Act (ACA) and the increasingly rapid enrollment of Medicare members into narrow network Medicare Advantage plans across the nation.

Key Board Takeaways

- Develop a public-private provider network to ensure access to care and system sustainability.
- Take a systematic look at providers "outside your walls"; value-based arrangements for Medicaid and Medicare (among others) are requiring this.
- Clearly identify the populations for whom you wish to provide care. This is a vital first step to frame the private provider roles and scope within your network.

Developing the Optimal Network

It is particularly important for the long-term financial viability of public hospitals and health systems to create competitive networks with access to "the right care at the right time at the right place—and at the right cost" for Medicaid and Medicare managed care members. This has become more vital as CMS and state governments continue to grapple with ballooning Medicaid and Medicare costs and as payers turn to high-quality narrow networks.

In developing the right public-private network, public hospitals and health systems need to take a systematic approach to understanding their target population and network needs:

1. Determine the population(s) for which they want to take financial responsibility.
2. Identify the unique medical, behavioral, wellness, and social determinant-driven needs of that population.
3. Determine what an optimal network would look like for this population in terms of geographic access to the right medical and non-medical services.
4. Complete an honest self-assessment in order to recognize and leverage existing infrastructure and expertise and identify remaining geographic and provider or CBO service gaps.

Engaging Providers and CBOs

Once the gap assessment is completed, it is important to strategically engage potential providers and CBOs outside the walls of the public hospital or health system that will add necessary services and value to the network.

The following are key steps to consider when engaging these providers and CBOs:

1. Develop specific roles, service definitions, and key performance indicators (KPIs) for each medical provider and CBO type.

2. Lay the groundwork with health plans to transition existing contracts and/or gain access to new contracts that allow for value-based payment and funds flow for population health management infrastructure for an attributed population.
3. Identify and engage with the right community providers, including federally qualified health centers, home care agencies, independent primary care and specialist physicians and medical groups, skilled nursing facilities, behavioral health providers, and various community-based organizations to develop a value-add network with defined roles, services, and KPIs by type.
4. Develop a "top of license," data-driven care management model that leverages both clinical and non-clinical resources to meet the needs of the population, address social determinants of health, and reduce costly and avoidable emergency department visits, inpatient admissions, and post-acute institutionalization.
5. Engage primary care physicians, specialists, and other key providers to standardize care flows, referral guidelines, and access to specialty care to enable appropriate utilization of lower-cost points of care.
6. Create a financial pro forma and funds flow that charts a financial sustainability roadmap through shifts in high-cost acute care and other institutional utilization to lower-cost, safer interventions through ambulatory, home, and community care interventions and wellness promotion tightly coordinated with emergency department, inpatient, and post-acute institutional facilities.
7. Create provider and CBO value-based payment contracts that leverage the funds flow model to demonstrate how they can be more successful financially by hitting their KPIs for quality and total cost of care.

Discussion Questions

- Do we want to be a provider of choice or only of last resort?
- When our safety net patients age into Medicare or gain access to commercial coverage do they stay with us? Do we want them to?
- Do we need to expand our employed/owned or contracted network to accommodate access for our target population?

Public hospitals and health systems are the ultimate safety net for many U.S. communities. By employing a value-based payment and population health strategy that adds value to private providers and CBOs, public hospitals and health systems can chart a course to financial sustainability as a network of choice for payers and consumers.

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