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All Roads Lead to Value Part II:
Positioning Physicians to Manage Care Risk

Market Corner Commentary
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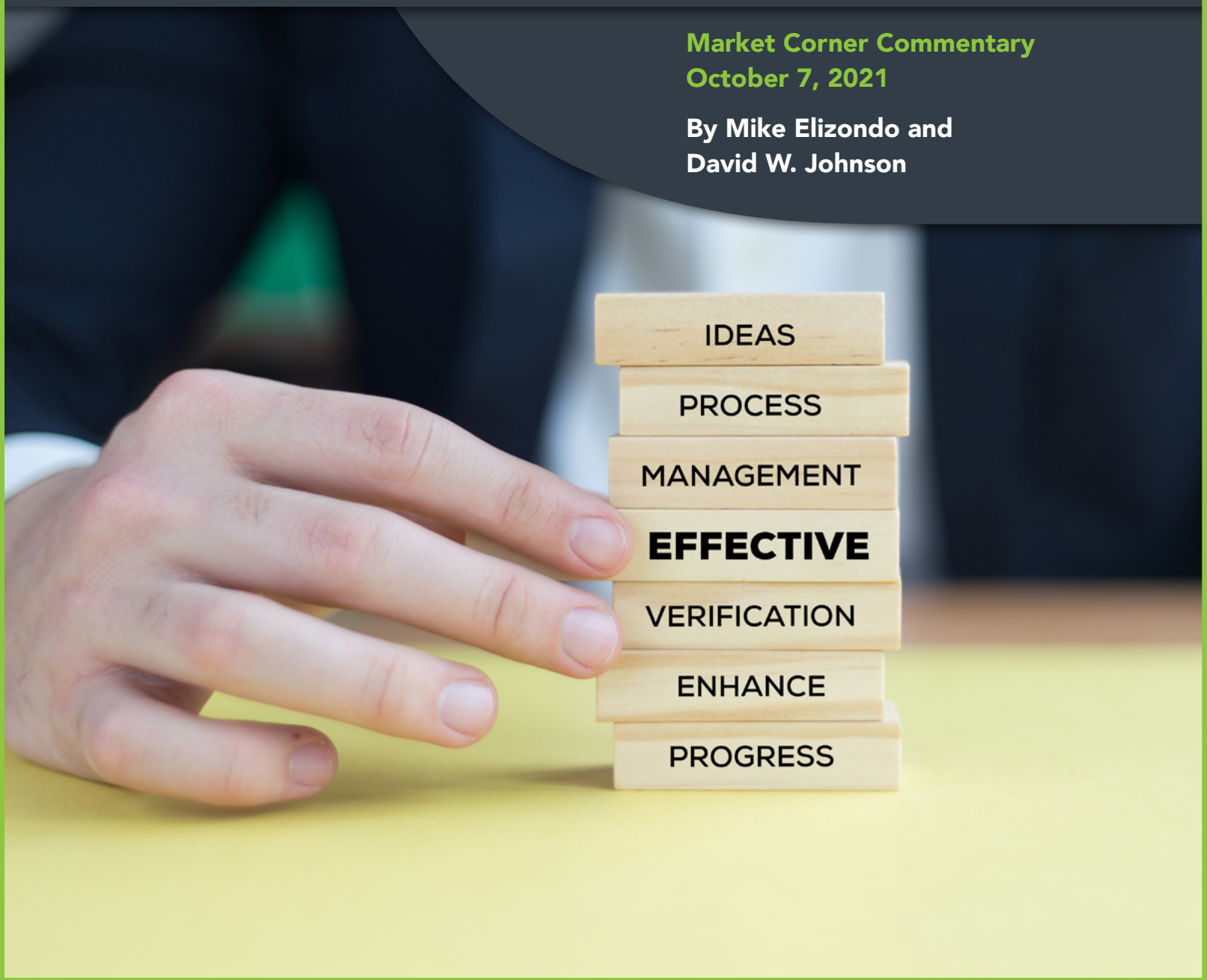

[Readers' Note: This is the second of four articles on the transition to value-based care models for providers. Risk-based (also known as value-based) payment models, pro-market regulations, new competitors, technology advances and rising consumerism are combining to place enormous pressure on the healthcare industry to deliver better outcomes at lower costs with better customer experience. This article examines the platforms that new service companies have built to enable physician groups to take full risk.]

Resistance to healthcare's volume-based, fee-for-service (FFS) payment paradigm is growing at an accelerating pace. In response, innovative providers are exploring and implementing various roads to value. These include shared-savings payment schemes, bundled payments and capitation. Whichever path providers take, they must have the capabilities and tools necessary to accept and manage financial risk for the care services they provide.

For physician groups, the willingness and ability to take financial risk can be harrowing. They often lack the tools for delivering and monitoring care across multiple settings. Most lack the capital, resources and scale required to develop in-house solutions. Old FFS practice habits die hard. Absent properly aligned incentives and protections, transitioning to value-based payment models can be prohibitively costly for providers.

At the highest level, physician groups can develop risk-taking capabilities by either becoming part of larger, vertically integrated networks or by contracting with risk-services companies (including health plans) that offer wraparound tools, technologies and services.

Many physician groups have sold their practices or linked themselves to health systems and/or health plans. In 2020, 49% of physicians worked in a private practice wholly owned by physicians, a decline from 54% in 2018[1], while almost 40% of physicians worked for practices at least partially owned by a hospital or health system[2].

Not all physician groups, however, see that path as desirable. Some resist losing control, value their independent relationships with patients and/or want autonomy to make care decisions. Post-acquisition dissatisfaction among their physicians is rampant. There also can be antitrust concerns in consolidating markets.

Other physician groups have effectively chosen the status quo by refusing to sell or to adapt to changing market dynamics. Failure to evolve, however, comes with significant strategic risk as FFS payment recedes. As a consequence, increasing numbers of groups that wish to remain independent are choosing to work with partners or vendors to enhance their risk-taking capabilities.

Risk services organizations (RSOs) have emerged to meet the risk management needs of independent physician practices. Like management services organizations (MSOs) that offer providers efficient administrative solutions, RSOs give physician groups the technological, administrative and financial supports necessary to undertake risk-based payment contracts.

This commentary explores the increasing market demand for RSOs, describes the services they offer, and highlights several notable companies that are helping physician groups stay independent.

UNHEALTHY PAYER-PROVIDER RISK-SHARING DYNAMICS

In the U.S. healthcare system, insurance companies largely manage the financial risk associated with healthcare expenditures either for themselves or as administrators for self-insured employers. Control of healthcare premiums often accrues to their financial benefit. As such, it was not surprising that health plans experienced a profit windfall and providers a significant financial downturn during COVID with the steep decline in elective surgeries.

Payers manage the risk associated with healthcare costs via two approaches. For consumers, they can offer plan members incentives (through benefit design) to influence consumer behavior, curb utilization or promote lower cost venues for care. For providers, they may employ network design, rate negotiation, pre-authorization and utilization limits to manage expenditure outflows.

Neither approach is foolproof. Member incentives have limits tied to co-pay and deductible provisions. Wellness programs are notoriously fickle in their ability to promote healthier behaviors. Most importantly, it's exceedingly difficult for members to price shop without knowing procedure costs in advance, let alone evaluate quality in relation to price.

Providers can direct consumers to lower-cost procedures and treatment venues without compromising quality, but have little incentive to do so. Under FFS medicine, providers financially benefit from delivering more care at higher per-unit costs. Managing utilization and care costs generally goes against their financial interests. Fragmentation, overutilization and underutilization, as well as overpricing for service provision, result.

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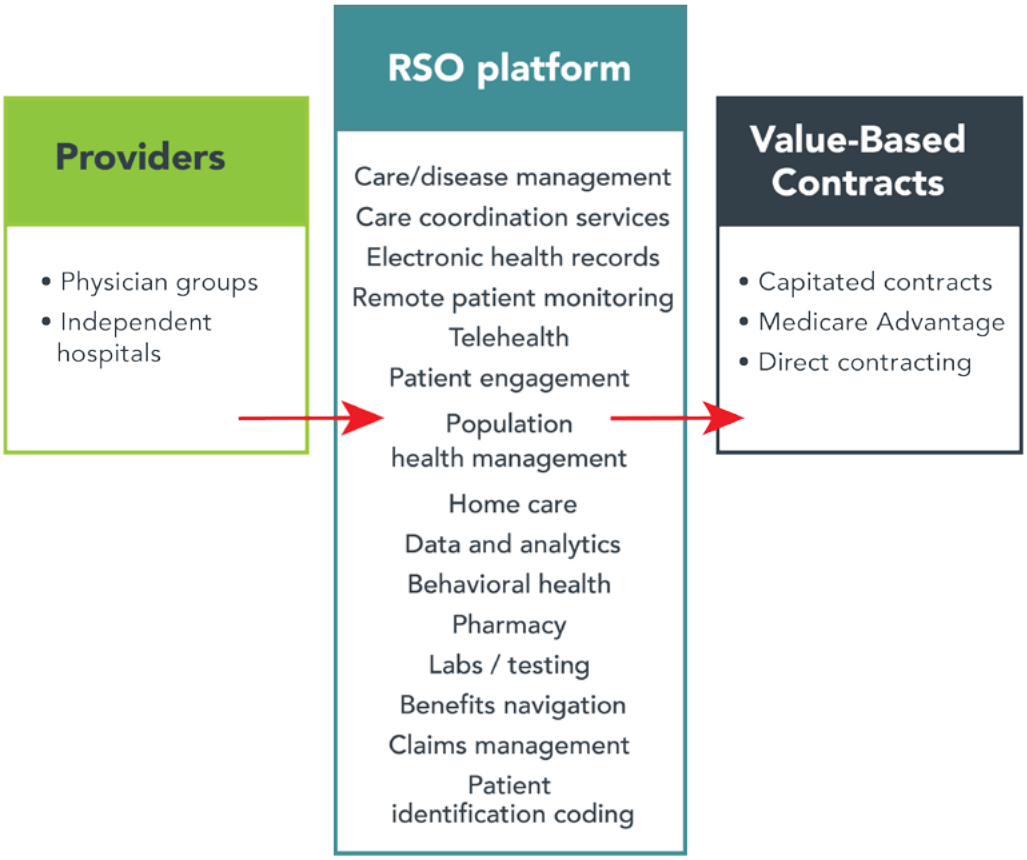
Closer financial alignment between payers and providers mitigates against the perverse incentives embedded within FFS medicine. Risk-based contracts are the principal mechanism that payers and providers employ to better manage utilization and costs. These arrangements reward providers for delivering appropriate care in the right settings.

Yet, full risk-bearing arrangements between providers and payers remain rare. Providers, especially physician groups, often lack the scale, tools and/or capabilities to engage in risk-based contracts. At the same time, payers are reluctant to spend incremental premium dollars on utilization controls absent offsetting gains in margins and revenue growth.

MOVING TO MORE ROBUST RISK CONTRACTING

Market and regulatory pressures to deliver more transparent, higher-value care for both payers and providers are increasing. As the population of chronically ill and aged member populations grows, it is becoming more difficult to manage care costs without payer-provider partnerships. More preventive care, for example, can lower costs and improved outcomes.

"Upside-only" or "limited downside" risk arrangements have largely failed to move the cost curve in a meaningful way, however. These modified FFS arrangements lack sufficient financial incentives to induce material changes in utilization and care delivery practices. More robust risk-based arrangements offer the potential to align interests, reduce costs and improve margins and outcomes, but they must reward and punish desired and undesired outcomes more substantially.



To undertake full-risk contracting, providers must develop their capacity for effective care management. This requires them to do the following:

- Achieve quality outcomes that improve health status for individuals and populations.
- Routinely provide appropriate care in appropriate settings.
- Understand population health needs at the individual level through robust analytics
- Enhance member/patient engagement through more holistic care, an expanded array of touchpoints, and better technology and customer service.
- Coordinate care among a continuum of service providers, including social service organizations.

In response to this growing market need, a number of risk-services organizations have emerged to help physician groups enhance their care management capabilities.

RSOs facilitate risk-based contracts between physician groups and payers. For payers, RSO solutions offer the resources, tools and confidence necessary to engage in full-risk contracting with providers. For providers, RSOs offer an integrated platform of technology and services that enable risk contracting.

RSO solutions go beyond achieving MSO-style administrative and back-office efficiencies. They include tools and services that enhance care coordination, care management, patient data management, data analytics, virtual care, payment mechanics, and financial risk management.

Examples of successful RSOs include Agilon Health, Privia Health, Aledade Health, NeueHealth and Altais. Let's explore each of these innovative RSOs individually.

Agilon Health

Long Beach, California-based Agilon Health[3] works with primary care physician groups to manage Medicare Advantage patients. Founded in 2016, Agilon completed its initial public offering in 2021[4]. The firm provides services to physician groups in 17 geographies for over 230,000 Medicare Advantage members[5].

Agilon contracts with insurers in each region it serves, making Agilon the primary risk-taking entity responsible for the care its physician networks provide to Medicare Advantage patients. On the provider side, Agilon's platform enables regional networks of physicians to take risk under an HMO-style capitated cost model.

Agilon secures these relationships under a 20-year contract and simplifies multiple value-based payment models to a single line of risk. It also shares best practices and data analytics with its providers to drive clinical innovation and improve patient engagement. Agilon's Total Care Model is supported by a platform that enables physicians to manage patient health holistically through EMR data integration, clinical playbooks and tools for patient engagement and performance management/analysis[6].

Privia Health

Arlington, Virginia-based Privia Health[7] owns and partners with primary care and other physician groups and health systems to undertake value-based contracting arrangements with payers and employers. Founded in 2007, the company went public in May 2021, and operates in six states and Washington, D.C. serving 739,000 lives. The company organizes its physicians into single-TIN medical groups in each market, leveraging economies of scale while enabling physician groups to respond to local needs.

Privia's business model enables physician groups to participate in commercial, Medicare Advantage, Medicare and Medicaid programs while moving patients into full-risk arrangements over time. Its platform offers providers MSO and ACO capabilities through tools that enable practice management, performance management, data analytics, virtual health, risk-adjustment, referral management and total-cost-of-care monitoring. These applications are integrated into a single interface and workflow within Privia's cloud-based technology solution.

Aledade Health

Founded in 2014, Bethesda, Maryland-based Aledade Health[8] works with over 800 primary care physician groups across 31 states. The company's platform enables physician practices, health centers and clinics to participate in ACO and other value-based programs. The company's focus is on partnering with physicians rather than owning or managing them.

Aledade supports primary-care practices with coaching and data-based insights that help them identify and engage high-risk patients, improve access and prevention, and close quality gaps. The company's technology platform integrates EHR, hospital discharge, claims and lab/pharmacy data to improve care and quality. The company also provides practice support through workflow optimization and enhanced contracting.

NeueHealth

Minnesota-based Bright Health, a growing health insurance company which completed an IPO in June 2021, launched its risk-enablement services entity NeueHealth[9] in 2020. While other insurance companies offer risk-enablement platforms as services to providers, Bright established NeueHealth as a separate business unit that can serve clients independently from Bright.

NeueHealth currenty works with over 235,000 providers through Bright's 44 owned primary care clinics and 87 additional affiliated clinics.

NeueHealth's technology platform combines payer, provider and patient data-analytic insights with virtual and concierge care services. Other features include care/population/utilization management models and services, administrative services and contracting.

Altais

Blue Shield of California launched Altais in 2017 as an independent business offering platform technologies and services to relieve physician groups of administrative and care-delivery burdens and to enable clinicians to spend more time with patients. It also supports those physician groups in transitioning to value-based care models. The company offers both partnership and ownership options as part of its model.

In 2019, Altais joined Aledade and the California Medical Association in the Health Reimagined initiative. The program aims to facilitate primary care physicians in building their care management capabilities through telehealth and nonmedical services to improve housing, food insecurity and other social determinants of health.

The company's eNable platform integrates patient data from disparate sources, allowing clinicians to review meaningful patient data and connect with patients through virtual services. Blue Shield of California and Altais have partnered to coadminister Primary Care Reimagined and support physicians in value-based care.

CONCLUSION: THE FUTURE OF RISK-ENABLEMENT

Care management is not new, but today's technology and data-analytics capabilities give independent physician groups the ability to engage patients more efficiently and effectively. With the help of RSOs, physician groups now can provide holistic and individuated care services, monitor that care across multiple providers and settings, measure outcomes and account for total costs.

These are the essential elements of risk-based contracts. RSOs are keeping independent physician practices relevant. Risk-based contracting places physician groups on their own "roads to value" where they control the factors of production.

Risk-services organizations occupy the essential middle ground between payers and providers. They facilitate risk-enablement by providing these essential functions:

- Contracting with payers (including the government) for risk-based arrangements with providers.
- Administering these contracts for providers while sometimes serving as the de facto "risk-bearing entity" for payers.
- Providing the infrastructure of services, technologies, insights and expertise necessary to operate efficiently while meeting cost and quality measures.

After a decade of experiments in value, the formula for risk-enablement is now well established. Developing these capabilities, however, requires deep pockets and sophisticated technology systems. RSOs remove barriers to payers and providers that want to engage in risk-based contracting. As more RSOs enter the market, competition among them will drive innovations and insights that will benefit providers and patients alike. In the process, they are helping to pave the road to value-based healthcare.

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David Johnson is the CEO of 4sight Health, a thought leadership and advisory company working at the intersection of strategy, economics, innovation and capital formation. Dave wakes up every morning trying to fix America's broken healthcare system. Prior to founding 4sight Health in 2014, Dave had a long and successful career in healthcare investment banking. He is a graduate of Colgate University and earned a Masters in Public Policy from Harvard Kennedy School. Employing his knowledge and experience in health policy, economics, statistics, behavioral finance, disruptive innovation, organizational change and complexity theory, Dave writes and speaks on pro-market healthcare reform. His first book ***Market vs. Medicine: America's Epic Fight for Better, Affordable Healthcare***, and his second book, ***The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All*** (McGraw-Hill 2019), are available for purchase on www.4sighthealth.com.

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Prior to joining Cain Brothers, Mike was at Financial Technology Partners, where he focused on supporting M&A advisory and that company's business development efforts.

Mike graduated from Loyola Marymount University with a Bachelor of Business Administration (Finance) and a Bachelor of Arts in Economics.

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