COPE HEALTH SOLUTIONS

Learning From Kaiser and Optum

A recent headline, "***With 8k more physicians than Kaiser, Optum is 'scaring the crap out of hospitals'***[1] is resonating within the hospital sector, as it reinforces what many hospital system executives are facing: either becoming a partner - or fearing becoming a "cost center." The article's premise - that two behemoths are battling it out for control of the physician employment market – fails to illuminate the underlying war waged in small and large communities as health care sector acquisitions, consolidations and alliances have greatly accelerated.

Hospital and health system executives are divided into two camps strategically, those primarily focused on market consolidation to increase pricing leverage and those primarily focused on building scalable population health management infrastructure and ambulatory, post-acute and community care networks in order to increase their value to payors and members. Most hospital leaders acknowledge that they are at a crossroads and that their fee-for-service reimbursement days are numbered.

The extremely tough questions that linger are when to initiate change and how to calibrate this shift to value-based payments for both their government and commercially insured patients. Besides grappling with capital budget decisions related to buildings and equipment, hospital executives must also consider how to patch together the required managed care infrastructure to succeed in bearing the financial risk inherent in value-based payment contracting.

While a closer look at Kaiser Permanente ("Kaiser") and Optum/United Health Group reveals different strategies to dominate their relevant markets, they share certain characteristics of success, as well as the goal to move care out of the hospital. Hospitals and health systems that will successfully overcome the image as a commodity or cost center understand the need to bring benefit, as well as strong strategy, scale and aligned financial incentives to payers.

Optum, founded in 1997, has advanced a model nationally using a "hopscotch" approach, identifying large physician practice acquisitions across a broad geography[2]. Kaiser's growth on behalf of its exclusive membership has been a more accretive spread within relevant market regions.

The value-based, often delegated approach to care delivery advanced by Optum was spurred by cost, quality, care delivery and physician satisfaction pressures from Kaiser Permanente in the California market in the 1980s. Kaiser's model created market pressures from their inherent cost controls: an exclusive physician group practice, strong primary care and care management practices, combined with ownership of hospitals and ancillary facilities.

Kaiser grounds its success in leading-edge HIT capabilities that enable data mining to identify evidence-based best practices that produce more optimal outcomes at a lower cost. Kaiser's care management strengths buttress a patient's medical record that is fully accessible to clinically integrated systems that span patients, physicians, hospitals and outpatient services. This is a key differentiator that affords actionable patient information at the point of care and has been a big boost in achieving a 5-Star rating in a number of regions.

Further, robust patient telemedicine applications position Kaiser with "next generation concierge health care services." Today in many markets, Kaiser provides online scheduling

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of appointments; email communication with doctors; tele-visits, convenient phone appointments, phone app visits; online reorder of medications, viewing of lab results and history, all of which integrate into patients' medical records.

Until recently, what has impeded Kaiser's growth, beyond its needed cultural buy-in, is the fact that any venture has had to provide winning opportunities in each of its three inextricable corporate domains: Health plan, Hospitals and Medical Groups. This is changing and Kaiser is both experimenting and learning to succeed in markets in which it has no hospital infrastructure.

PacifiCare of California, now part of the United Health Group, of which Optum is a member, was one of the pioneer health plans that advanced the delegated model outside of Kaiser. The California PacifiCare-contracted IPA networks provided a number of features that allowed these delegated networks to compete with Kaiser:

- Contracted provider networks, which could replicate faster than the Kaiser model, which is a distinct cultural model.
- Reduction of the capital burden of building hospitals and other medical facilities.
- Contracts for the major components of the provider network, physicians and support staff, that reduced the minimum operating capital required by the health plan to replicate the best features of the Kaiser model.
- Mitigation of health plan exposure to the cost of the delegated services, network development and contracting, provider credentialing, utilization management and claims adjudication.
- Capitated physician groups and capitated hospitals are often assuming these costs.

Currently, all major California health plans contract with at least some physician organizations using this delegated approach. Optum advances this model nationally on the chassis of PPO products, buying physician practices that also contract with health plans competitive with United. In part, Optum's success builds on sophisticated HIT capabilities, administrative simplification, employed physician base and contracted physician networks to create narrow aligned networks. OptumCare provides population health management expertise and front office administrative services that help physicians efficiently operate their practices in a value-based context.

By controlling a greater number of physicians, Optum not only buffers itself from competitors, but also may steer patients toward lower-priced care outside of the hospital. In some cases, despite claims of a wall between Optum and UnitedHealth, UnitedHealth may be directing members toward its Optum-acquired physicians.[3]

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As medical groups and IPAs assume financial risk for patient care through risk-based arrangements, Optum aids the development of infrastructure and expertise to proactively manage utilization. Reduction in inpatient utilization is emphasized. Tactics such as proactive patient management to divert patients from the ED and inpatient care to lower cost services, such as skilled nursing, home health, management of inpatient specialists impact shorter hospital stays. They focus on building IT-informed process/work flows, care guidelines that enhance both the provider and patient experience.

While different models for success, both Kaiser and Optum carry a strong message: *hospitals and health systems must become excellent partners to their aligned physicians and relevant health plans.* Three important characteristics - strategy, scale and financial alignment - will increasingly define success in local markets:

Strategy: It all starts with strategy – what is your local market? Is Optum and/or Kaiser a factor? Where are the opportunities? Are health plans offering risk contracts? Are self-insured employers interested in direct risk contracting? What are your growth strategies? What will keep your organization from becoming a commodity over the next five years? What are the assets and value proposition you can bring to payers?

Scale: Hospital leaders recognize that such fundamental changes to the payment system require them to integrate both *vertically*, with other types of providers such as physicians and post-acute care providers, and *horizontally*, with other hospitals. Smaller hospitals and systems, in particular, see the need to become part of a larger system to gain bargaining leverage and to enter into downside risk. For many hospital services, additional member/ patient volume enables the delivery of higher quality at lower cost.

Consolidation of clinical services across merging hospitals can allow them to take advantage of these benefits. Health system integration can influence cost and improve quality of care when the merging hospitals are geographically proximate and can combine clinical service teams. However, these same combinations are precisely those that are most likely to raise competitive concerns with regulators.

Hospitals must also make substantial investments in the clinical and administrative information technology (IT) infrastructure necessary to provide the type of integrated care envisioned in both private and public health care reform initiatives. Infrastructure investments, such as construction of a robust and productive IT system, benefit from substantial economies of scale: they are expensive to develop and operate but are highly scalable. These systems require more than the installation of an electronic health record (EHR) system, which itself can be a costly undertaking.[4]

Moreover, new payment initiatives that require providers to become financially responsible for the outcomes of the services they provide and the general health status of the population they treat also demand scale in order to mitigate the risk of unavoidable high cost patients.

Financial and Clinical Alignment

Preparing for downside risk in any arrangement requires an aligned, robust network of providers to care for the defined member population. Besides channeling utilization to the system's providers and facilities, aligned physicians recognize that another key to success in a value-based payment is to be accountable for all utilized services, as they recognize that utilization is the most important determinant of total cost of care.

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An adequate network outside of the hospital(s) will include Primary Care Physicians, high quality and efficient specialists, as well as providers of post-acute, home and community care services. Before recruitment of these physicians, a value proposition must be defined that will enable the network to maintain and attract high-performing practitioners, even in a competitive market.

How is quality and cost managed? Success in a downside risk arrangement hinges upon an organization's infrastructure. The right providers will look for an organization that can get them the right information at the right time. Decisions that affect patient experience, clinical outcomes, network utilization, and financial performance depend on access to and integration of clinical and claims data. Further, a high-performing network must ensure the right incentives for all practitioners to facilitate the desired quality, experience and financial outcomes.

In a strongly aligned culture, physicians often value the freedom from utilization management by health plans. They also appreciate financial rewards for sufficient care delivery, particularly for high quality practices such as actively managing chronic disease and avoiding unnecessary utilization. Health plans, for their part, support the model in recognition that physician organizations are able to manage care more efficiently because they are closer to and understand their local markets.

One critique of Optum's model is that Optum has done a lot of acquisition but not as much consolidation and "true" mergers that create a shared physician practice culture. Optum is creating narrow networks that add access and capacity; however, has it engendered the major cultural change that anchors sustainable value-based care strategy? While short-

term success comes from market plays, long-term success will be more attributable to physician culture - a physician-led culture of quality care at the right place and right time.

Conclusion

Hospitals and health systems will continue to face relentless pressure to reduce healthcare costs, whether to compete with lower cost “care models,” to save money for government payers or to reward shareholders. Commitment to a value-based payment/population health strategy is essential for both physician practices and health systems. By improving communication and collaboration among patients, physicians, hospitals and health plans, hospitals and health systems can succeed both at profitably managing the costs of care, while improving the quality and efficiency of health care in local communities. The smartest players in the system are the ones who get there first. Get in the game to win!

Endnotes

[1] *Morgan Haefner, Beckers Hospital Review, April 09, 2018*

[2] OptumCare hopes to expand its 30-market operation to 75 markets, including the nation’s most populous states: California, Texas, Florida and New York.

[3] For example, UnitedHealth lists New West Physicians, a Denver-area group of 120 physicians that the insurer purchased last year, as a favored narrow-network plan for commercial members. Some members can see the physicians for 20 percent to 30 percent less in out-of-pocket expenses compared to physicians outside the network.

[4] Examples of essential capabilities include a sophisticated cost accounting system, training of staff to input data, development and production of informative reports from the data to measure and monitor performance, usage of the reports to provide feedback to system participants, and development of reward systems that hold participants accountable to certain standards based on quality and cost.

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