ever before has there been a greater call to action for physician organizations experienced in managing care under capitation: managing populations of patients, measuring quality, and coordinating diverse providers are characteristics that many healthcare organizations now aspire to achieve. Yet it is also a time in which the model is threatened by the market’s desperate need to reduce health insurance premiums. We have already seen the rapid rise in high-deductible PPO products over the past few years, and the requirements set forth in the Affordable Care Act and executed in health insurance exchanges such as Covered California, are driving the expanded proliferation of fee-for-service, narrow network products. The increase in self-insured employers, now spreading to mid-size employers, is further fuel to the flames lapping around the delegated model.

Many medical groups, IPAs, and integrated delivery systems are taking a hard look at either developing their own health plan, or pursuing the necessary regulatory approvals (Knox-Keene license in California) to accept global risk from commercial or Medicare Advantage health plans as a way to combat the potential disaggregation of delegated networks. Some larger systems are establishing plans to compete in the Exchange. There is even new terminology to describe what used to be called a “limited license:” now labeled “plan to plan” arrangements which essentially create private-label health plans centered around the organization’s provider network. Some of the major health plans are encouraging these structures and are eager to partner with qualified organizations.

What are the considerations, risks and criteria for contemplating such a strategy? Here are a few of the most critical:

- Network size, geographic coverage, and experience in managing risk of the targeted population
- Financial stability and balance sheet strength
- Physician group and hospital partners willing to collaborate to manage care effectively
- Analytics and comprehensive data capture to conduct predictive modeling, care models that are responsive to the population’s health risks, and actionable reports and information for providers
- Objective assessment of the ability to attract an adequate enrollment base, consideration of market and competitive payer reactions, and overall organizational “stamina” to take on additional risk.

After assessing the situation, the organizational and operational options must be considered. Today, we see a variety of structures and joint ventures being utilized, to spread business, clinical, and insurance risk across more than one entity. Listed below are a sample of some of these combinations that are emerging:

- Large physician organizations or integrated delivery systems. Those organizations that are already managing the professional or shared risk for hundreds of thousands of enrollees are pursuing global capitation or health plan licenses as the “final step” in assuring their leading position in the marketplace.
- Physician groups partnering with other physician groups. Groups are creating

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So the confusion, threats, and opportunities in this healthcare reform era continue to mount. Just as the marketplace demands greater accountability for outcomes and cost control, the products being sold are based on an old chassis of fee-for-service payment. At the same time that payers consolidate to grow and gather market strength, they are also showing willingness to partner with providers to introduce new products to new markets. Simultaneously, providers that have historically considered each other competitors are evaluating opportunities to share risk and present themselves to the marketplace as a unified system of care.

Is global cap in your future? It’s not for the meek, but it may be the key to achieving the promise of integrated, coordinated, patient-focused care and the quality, patient satisfaction, and cost efficiencies expected by the market.

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continued from page 20

joint ventures as a way to cover a larger population and geography in order to be more relevant for self-insured employers, or simply to spread the risk across a broader base.

• Physician groups creating joint ventures with hospitals. Some of these ventures are outgrowths of initial conversations about creating ACOs for shared savings models. As the structure is developed, opportunities may emerge for leveraging this structure to take on full risk as a private label product with an established health plan.

• Multiple integrated health systems. In some parts of the country, disparate health systems are establishing statewide alliances for purposes first of developing and sharing the cost of population health management infrastructures, and second to enable full risk or health plan development.

• Payers or technology vendors as partners. With United, Aetna, and Anthem all deploying population health-enabling functions and technology solutions, some provider organizations are evaluating ventures which include a payer or technology company as both an administrative services provider and/or as a partner in the venture.

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continued from page 20