

What Is the Financial ‘Tipping Point’ for Provider Groups to Implement Person-Centered Care?

Key Issues and Considerations

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Introduction

Since the passage of the *Affordable Care Act*, there have been shifts in policy that are striving to achieve better care at lower costs. The health care sector is testing a number of models and approaches, particularly for the high-need, high-cost (HNHC) population—those with multiple chronic conditions and functional limitations. Person-centered care programs are being implemented with varying outcomes. They focus on providing care based on what is important to the person. Given that they are implemented at the point of care, provider groups (medical and physician groups) are best positioned to capitalize on improving care and lowering costs.

For a provider group that treats individuals through a mix of risk arrangements, one might reasonably inquire: What is the tipping point when it becomes financially advantageous to offer person-centered care to the entirety of its HNHC population, regardless of whether it is a financial risk for all of them? This brief, based on research conducted with provider groups in California, seeks to answer this question and provide insights. It explores the reasons why provider groups may choose to provide this intrinsically valuable care, or consider it outside of their capacity. It also suggests the conditions under which a liberal and uniform policy of “person-centered care for all who could benefit” is preferred to a more restrictive one.

METHODS

The ideas expressed in this paper are based on interviews conducted in late 2019 with 15 physician leaders of health plans and medical groups in California. The medical groups were selected from California members of America’s Physician Groups (APG). The selection criteria for those to be interviewed were two-fold:

- (1) the group takes substantial risk with its Medicare population; and
- (2) the group has demonstrated noted capability in complex care programs.

The health plans interviewed were chosen based on their presence among the top five plans with Medicare Advantage (MA) enrollment in California.

What Is Person-Centered Care?

While person-centered care for older populations has a clear definition in the literature ([American Geriatric Society](#)), the term nevertheless is not universally employed by provider groups. When the core components of person-centered care are named, those in provider groups included in this research will often say that person-centered care conforms precisely to the care model they offer because it embodies those components. Even if their care approach has a different label. Commonly used terms considered as having comparable meaning include “patient-centered care,” “whole-person care,” “complex care,” and “coordinated care” approaches. The core elements of person-centered care that are widely perceived as also being characteristic of these approaches are:

- (1) A care plan developed based on person’s preferences;
- (2) Care delivered by an integrated and coordinated interdisciplinary team, often with the involvement of care managers and social workers; and
- (3) Education, collaboration, and engagement with the person being cared for, and their network of support.

These person-centered features are expressed in a variety of programs such as [Intensive Outpatient Case Management](#), [Hospital at Home](#), [Care Transitions](#), [Advanced Illness Management](#), [Palliative Care](#), [Disease Management](#), and others.

STUDY LIMITATIONS

The analysis did not account for any revenue that health plans passed on to provider groups who delivered coordinated care for HNHC populations. Undoubtedly, were such subsidies to be forthcoming, the willingness to provide person-centered care for all would be heightened.

Nor did the analysis account for the possibility of Medicare shared savings accruing to groups as a result of providing person-centered care. Groups gave only slight mention to the Accountable Care Organization (ACO) Shared Savings Model as a motivator to offer person-centered care, and no group cited provider engagement as a major positive factor in deciding to deliver a different care model. In fact, in some instances, the added time required for physicians to more fully understand and address the whole person was cited as an impediment. And while a person’s experience should be expected to be enhanced by person-centered care, it was the health plans rather than the groups that highlighted its potential importance.

Although financial factors are critical, we found that a provider group’s decision on whether to offer person centered care is not solely financial.

Who Should Receive Person-Centered Care?

The business case for a provider group, assuming the group carries some financial risk exposure, is that implementing a person-centered care program is built upon its potential to reduce future medical utilization (and therefore costs). Consequently, the business case is stronger when enrollment in a person-centered care model is limited just to people in a segment variously classified as HNHC; high risk; or complex. Henceforth, we will refer to this segment as “high risk,” suggesting that it is the risk of excessive costs – and where a group’s cost liability is concentrated – that defines the targeted population. The provision of such care to a limited portion of its patient population can result in an attractive return on investment (ROI).

However, while all patients in a person-centered care program will tend to be high risk, not all high risk patients will receive person-centered care. Groups may sometimes exclude individuals for whom such care is clinically appropriate because the payment system governing them fails to supply a sufficient financial incentive. To understand that point, we need to explore the possible payment systems under which a provider group might operate.

Risks and Incentives to Provide Person-Centered Care

When a group is considering if person-centered care should be provided, it will inevitably consider the risk arrangement with the payer. A comparison among alternative payment models governing Medicare patients will demonstrate the differing incentives for groups to invest in person-centered care.

Fee-for-Service Model

A provider group may accept traditional Medicare, billing Medicare on a fee-for-service basis for the services rendered. Here, unless the provider is part of a Next Generation ACO with beneficiaries attributed to the ACO, there is no financial risk for the provider group related to utilization. It will be challenging, if not impossible, to make a business case for providing person-centered care to their beneficiaries. Any lessened utilization will not reduce the group’s cost and may, in fact, reduce revenues.

Risk Delegation

MA plans, unlike traditional Medicare, create powerful incentives for cost containment. Plans recognize it is the provider group that is in the better position to manage cost risk. Consequently, payers will often choose to “flip” the risk to those best-positioned to control medical costs and maintain quality. This is achieved

through delegating risk to contracted providers. There are two entirely distinct risk-bearing models in the MA context, each creating a different level of motivation for groups to extend person-centered care to its beneficiaries.

Global Risk Model

The first model is called global risk contracting. Global risk, also known as full risk, is a pure capitated model under which 100 percent of the risk has been assigned to the plan's delegated group. This entails a health care entity, such as provider group or integrated health system, taking full risk for all professional and institutional services. The former category includes primary and specialty care, whereas the latter refers to inpatient services, i.e., hospitals and skilled nursing facilities. With exposure to the total costs of care, a provider group will find the highest ROI by applying person-centered care to those where there is global risk.

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Partial Risk Model

Another system in which a provider group may accept risk is to collect capitation payments from the MA plan, but only to cover the services of health care professionals. Under this partial risk contract, the plan can either retain the institutional risk or else delegate it to a hospital group. The contracted physician group takes partial risk—by sharing, rather than solely absorbing, the risk for institutional services. Here, the incentive for the group to contain costs is muted relative to global risk, because it is only reductions in professional service costs that contribute directly to its bottom line. Since person-centered care is successful in reducing inpatient stays and emergency room visits, and further – since the institutional cost constitutes the larger component of overall costs – one can understand why provider groups may be reluctant to extend this care to those under partial risk arrangements.

The Concept of a Tipping Point

The tipping point is when an idea, behavior, or trend reaches and crosses a point where it begins to spread. For a provider group or independent physician association (IPA) that treats people under a mix of risk arrangements, one might reasonably inquire: What is the tipping point when a provider group or IPA finds it advantageous to offer person-centered care to all of its high-risk beneficiaries, regardless of whether it is at financial risk? A tipping point is conceptual.

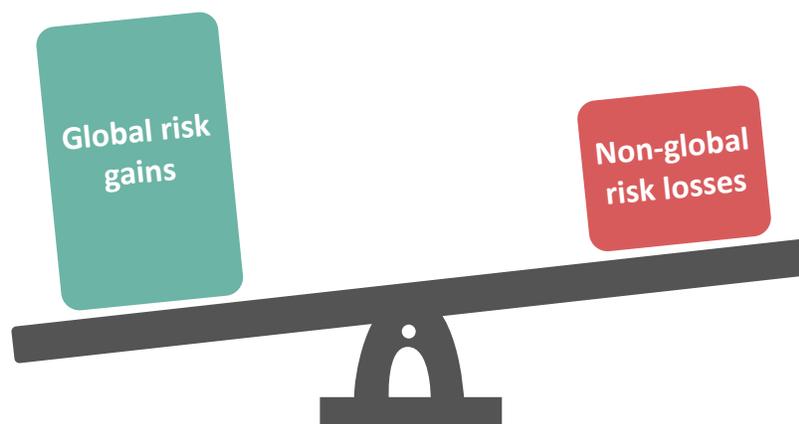
The tipping point occurs when that proportion of a provider group's overall Medicare population for which it assumes global (full) risk reaches a critical minimum. At that point, the financial benefits from extending person-centered care to all high-risk beneficiaries exceeds the costs by an acceptable margin. At this point, the financial benefits from providing person-centered care to capitated individuals is just sufficient to cover any losses from providing such care to those covered under partial or no-risk arrangements.

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The concept of a tipping point relies on an assumption that the financial margin from providing person-centered care is larger when provided to those for whom greater risk of medical utilization is undertaken. A realistic assumption used in this analysis is that the financial margin accruing to a provider group from delivering person-centered care to global risk (capitated) individuals is higher than for those at partial risk, and, further, there is no material net margin whatsoever for fee-for-service (no-risk) individuals. While the benefits depend on the nature of the payment system, the cost of providing the same person-centered care service should not; the expense is expected to be identical. That means person-centered care services extended to partial risk individuals are more likely to lose money for the provider group and will certainly do so when extended to no-risk individuals.

WHAT'S THE TIPPING POINT?

When does it make business sense to offer person-centered care to all high-need, high-cost Medicare beneficiaries?



An acceptable margin for a group might be \$0, meaning that it would be satisfied if person-centered care for all resulted in breaking even. Alternatively, a provider group may require a positive margin – a higher threshold of acceptability – in order to offer a program that embraces all high-risk Medicare beneficiaries, irrespective of payer method.

The tipping point analogy assumes a willingness to take gains from one population segment and use them to offset losses elsewhere.

There is a crucial assumption underlying the tipping point concept. If a person-centered care program generates a sufficiently large ROI when providing for global-risk beneficiaries, the group then can both afford and is willing to provide it to all beneficiaries who are medically appropriate. The tipping point analogy assumes a willingness to take gains from one segment and use them to offset losses elsewhere. However, there is no assurance under these conditions that the provider group will deliver a person-centered care program to people for whom the ROI is negative. Groups will be aware that an “acceptable ROI” can be enhanced further via a segmented strategy. In a segmented strategy, the enhanced and more costly level of care would not be provided to all beneficiaries but only to those for whom sufficient financial risk is assumed.

The Tipping Point as Viewed by Provider Groups

The question then presents itself: How do provider groups behave? Do they abide by a tipping point such that when the requisite proportion of global risk is reached, they then offer person-centered care to 100 percent of its high-risk population? The answer from our interviews with provider groups revealed that there is no uniformity regarding how a tipping point is viewed.

Provider groups spoke of their willingness to provide the same level of care to those under partial risk as under global-risk arrangements once the latter proportion reached a threshold level.

Instead, there were four broad categories of reactions to the tipping point concept. The tipping point was actually deemed as a major consideration as the basis for decisions in the first three categories. Here, provider groups spoke of their willingness to provide the same level of care to those under partial risk as under global-risk arrangements once the latter proportion reached a threshold level. But in these three categories, the reasons for recognizing and acting upon the tipping point when reached were different. And the fourth type of response indicated that the concept may be irrelevant for at least some groups.

PROVIDER GROUPS' FOUR RATIONALES ON THE TIPPING POINT

Person-Centered Care for All: The Ethical View	Person-Centered Care for All: Because It Costs Nothing	Person-Centered Care for All: Because Uniformity Is Simpler	Person-Centered Care Just Isn't for All: ROI is Higher When Restricted
<p>“People are people” and irrespective of the underlying payment system, the highest standard of care should be offered to all. In deciding who is to receive person-centered care, a provider group regards the payment system as irrelevant. This view that person-centered care should be payer-agnostic was voiced by a limited number of groups.</p> <p>The ethical view might not be enough if the proportion of global risk individuals is not high enough. It wouldn't make sense financially.</p> <p>Hence, even here financial considerations and the tipping point concept will underlie the decision whether to offer person-centered care to all. One group cited the range of 60 percent to 75 percent as the proportion of global risk individuals needed before the ethical goal of providing a uniformly enhanced level of care became affordable.</p>	<p>The tipping point makes sense when the provider groups regard the incremental expense person-centered care for those under partial risk as being insignificant. Essentially costs are fixed. Therefore, as long as the segment is small, the policy will be to provide enhanced care to all.</p> <p>On the other hand, if this segment becomes so large such that more staff and other resources are needed, it would no longer make sense financially. In short, costs may be fixed, but only within a narrow range. As long as demand does exceed fixed costs, care can be provided to all.</p> <p>In the case where global-risk individuals are the overwhelming majority and incremental costs are inconsequential, the notion of a tipping point is highly relevant to the decision to generalize the person-centered care offering.</p>	<p>The tipping point makes sense as a result of the operational inefficiencies of having different modes of care. When the proportion of global-risk individuals are the overwhelming majority, a care delivery model that emphasizes person-centered elements is appropriately designed for that segment.</p> <p>Having a smaller, parallel system designed for other segments that strips away some of these elements complicates decision making. It requires time for nurses, providers, and social workers to assess whether a person is eligible for specific services. Having disparate and parallel care tracks creates complication and confusion.</p> <p>Unless each is of critical mass, it is better to offer uniform care. A one-size-fits-all approach to care delivery makes sense when one segment – the global risk – is dominant.</p>	<p>The tipping point is considered not relevant. Here, the provider groups evaluate the program ROI for each beneficiary segment independently. In this instance, when the ROI for segments not covered under global risk contracting is inadequate, such care will not be provided to them. This is despite the fact that the ROI from those at global-risk possibly more than cover these losses.</p> <p>Provider groups that do not evaluate ROI based on the “entire book of business,” but instead assess each segment separately, are not going to regard a tipping point as having relevance. For these groups, the tipping would be 100 percent. Under these circumstances, only when all individuals are at global risk would person-centered care be provided across the board.</p>

Summary and Conclusions

This analysis found that the tipping point rationale is understood by all provider groups. Although some groups regard beneficiary segments separately and do not apply cross-subsidization, most base their decisions on the tipping point. Groups arrive to those tipping point decisions in different ways, either:

- The gains from the global risk segment make it affordable;
- The costs of serving a decreasing segment of no, or low-risk beneficiaries becomes insignificant; or
- Multiple approaches to care based on payment type become unduly complex when one segment begins to dominate all others.

The exact tipping point will vary by provider group, and not all provider groups that we interviewed were able to estimate its precise level. However, based on what we learned, the tipping point is dependent on two factors, the total number of Medicare beneficiaries and the percent to which the group has global risk. Beneficiaries include members in partial and global risk arrangements and those who are fee-for-service. Thus, the tipping point occurs when a group has 10,000 plus Medicare beneficiaries, of which 60 percent to 75 percent are part of a global risk contract. Provider groups can assume that 2 percent to 5 percent of their beneficiaries may meet the criteria of HNHC and benefit from the person-centered care model.

Factors Influencing the Position of the Tipping Point

The analysis included the development of an algorithm that calculates the tipping point position. While that position will vary depending on the unique circumstances of the particular provider, the algorithm revealed that of the approximately 30 variables, four took on outsized significance that contribute to the tipping point for providing person-centered care. Unsurprisingly, the most crucial factor in shaping the ROI is the percentage of all beneficiaries for whom the group is assuming full risk. Next is the cost of operating a person-centered care program. The cost consists mainly of the staffing expenses of nurses, nurse practitioners, medical assistants, pharmacists, physicians, and social workers that deliver the care. The cost depends on the variant of person-centered care considered, but \$300-\$500 per member per month and higher might be expected for care coordination and other person-centered activities.

The third and fourth factors which are of equal weight relate to institutional care.

- The baseline level of hospitalization expense of the segment – both admissions and readmissions – that is targeted for person-centered care is critical. Groups that successfully identify and then restrict person-centered care to only those who would otherwise exhibit significant inpatient utilization under usual care will display a higher ROI (and lower tipping point). That requires looking beyond just tracking prior utilization as a measure of future utilization. Some individuals that were high cost in the past may revert to more usual expenses in the future; and some that were low cost in the past may have rising risks and incur high costs in the future. Using the past as a guide to the future is a poor

predicting method. Thus, some groups are currently benefiting from predictive modeling techniques, which, when refined further, will lead to more accurate cost forecasting and risk stratification.

- The last factor is the impact that person-centered care has on inpatient utilization. Person-centered care programs are most effective when they target populations, who as a result of the intervention, will reduce utilization or benefit from lower levels of care. New methods to further define impact beyond diagnosis and functional limitations to impact on utilization could yield two or three times the savings.¹

Attribution

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Victor is an Adjunct Professor Emeritus at the UCLA Anderson School of Management. He has served as Senior Associate Dean and Director of the UCLA Anderson School's Executive Education programs and of its professional MBA programs.

He has collaborated with [The SCAN Foundation](#) and the [American Geriatrics Society](#) to conduct research on the subject of the business case for person-centered care older adults with multiple chronic conditions and for those living with functional limitations. With [Collaborative Consulting](#), he is the developer of the Linkage Lab, a program to build the business acumen of community-based organizations to enable hyphenate cross-sector partnering. He was funded by [The Commonwealth Fund](#) to investigate payment models that will allow social service organizations to profitably offer their services to the medical sector for HHNC populations. As part of this effort, he created a now widely used [calculator](#) to assess the ROI from cross-sector partnerships.

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¹ *It's All about Impactability! Optimizing Targeting for Care Management of Complex Patients*
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