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WHITE PAPER

Best practices: Is your point solution on point?

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As the cost of healthcare continues to increase, employers, plan sponsors, and health plans are looking for cost containment strategies.

At the same time, venture capital firms are investing billions of dollars in new health and well-being vendors offering point solutions that promise to reduce overall healthcare costs, increase access to healthcare, and improve health outcomes. This white paper is intended to support decision-making processes for evaluating and implementing point solutions. It includes a discussion of the various financial arrangements common to point solutions, and the advantages, disadvantages, and customer considerations for each type of arrangement.

What are healthcare point solutions?

A point solution is one that targets a particular business problem. Often, point solutions try to add value to a benefits program by offering enhanced services to help manage concerns related to cost, access, and quality of care. Point solutions may target specific medical conditions and their interventions. Examples include diabetes, musculoskeletal (MSK), hypertension, cancer, or weight management programs. Many of these programs also leverage telehealth benefits with virtual counseling options.

Engaging a healthcare point solutions vendor: Contract options

There are many ways that point solution vendors contract with plan sponsors or health plans, and vendors are frequently open to offering their services through a variety of reimbursement models. Before making a choice about how to contract with a vendor, it is important to consider your program goals as well as the advantages and disadvantages of each contract type (discussed in more detail in the table in Figure 1 below).

Contracting options include the following:

Fee-for-service

This approach resembles the common fee-for-service (FFS) arrangement with physicians, in which every encounter between a member and vendor is reimbursed according to a fee schedule, with different rates applying to different services. This is a common model for telemedicine, where a member interacts with a primary care or behavioral health provider through a virtual point solution vendor, as opposed to an in-person visit. Patient navigators, care management, and referral services might also be reimbursed through this model.

Per program period or per case

The vendor receives a flat fee for each member during a defined program period or a defined case. For example, a behavioral health vendor might offer a fixed number of virtual visits and unlimited text-based support for three months. All services provided during that time period are covered by a single fee. Service ends after that predefined program duration. Similar models can be used for general care management or centers of excellence programs.

Flat monthly payments

In some cases, it may be preferable to pay a monthly rate that covers all or certain members, as in the following arrangements:

- *Per member per month:* The vendor receives a monthly payment for each eligible plan member but no additional payment when members use the vendor's services. Lower-intensity member navigation services applying to a wide range of members might be reimbursed using this method.
- *Per engaged member per month:* This model is commonly used when plan sponsors and health plans partner with condition-specific medical management solutions. In this case, the vendor is paid a fee for each member who is defined as "engaged" with its programs or services. This arrangement is also called "Per Patient Per Month."
- *Per attributed member per month:* These arrangements are another common method by which vendors focusing on condition-specific management partner with health plans and plan sponsors. In this case, the vendor is paid a fee for each member who meets certain criteria. For example, with diabetes management, the health plan or plan sponsor might pay the vendor a monthly fee for any member diagnosed with diabetes within the previous year, regardless of whether the member engages with the program.

Performance guarantees

Performance guarantees are a common feature in contracts with point solution vendors. Performance guarantees define a desired clinical outcome or a minimum savings from the contract. They often mitigate some of the financial risk of using a point solution and can provide incentives for a vendor to achieve metrics the customer deems to be of value. While the computation of guarantees will vary, they typically amount to a discount on underlying program fees.

Contract option overview

The table in Figure 1 summarizes some of the key advantages, disadvantages, and other factors to consider with each contracting methodology. The advantages and disadvantages are from the perspective of a health plan or plan sponsor.

Figure 1: Analysis of common contracting methodologies between point solution vendors and plan sponsor groups or health plans

Contract Type	Advantages	Disadvantages	Considerations
Fee-for-service	Payment based only on services provided.	Incentivizes the provision of more services, regardless of improvement in outcomes.	Consider applying a cap on the services provided to a single member over a specified time period. Define how to identify services.
Per program period/Per case	One fixed cost covers all interactions over the course of a program.	Because fees do not rise with number of interactions, vendors may provide fewer services per program.	Contractually define minimum expectations for payment of full program fees, such as duration of engagement, or number/nature of outreaches. Under this approach, the vendor may accept risk for the volume of services for a particular case.
Per member per month	Simple model with predictable costs.	Vendors are paid for all eligible members, even those who do not use their services.	Contractually define: • Expectations for vendors' member outreach. • Minimum member participation for vendor to receive payment.
Per engaged member per month	Simple model; client pays only for members who engage with services.	It can be difficult to define an engaged member and track engagement, potentially leading to ongoing payments for members no longer receiving services.	Contractually define engagement expectations, such as: • What defines the beginning and end of a member's engagement. • Number of interactions per participant in a specific timeframe. • Whether engagement necessarily includes contact with a physician or may apply to intervention from other clinician types and/or health coaches. • Whether a member can be engaged indefinitely, or for a finite program period.
Per attributed member per month	Simple financial model with predictable costs.	Fees may be paid for low-risk members if the attributed population is not carefully defined.	Define the program's desired outcome and the members requiring intervention, and only allow vendor to manage these members.
Performance guarantees	Guaranteed savings mitigate some financial risk when intervention fails to meet desired outcomes.	Calculating, tracking, and predicting performance across vendors can be difficult because guarantee calculations can take many forms.	Final financial settlements might occur long after benefit year when interventions occur. Promotional claims can make financial losses sound impossible. Though minimum performance guarantees typically ensure some shared savings, the guaranteed amount generally does not exceed the program's underlying cost (i.e., a 1:1 ROI may not be guaranteed). Saving more than program costs requires a vendor to achieve substantial cost reductions for enrolled members.

Eight questions to ask before implementing a healthcare point solution

1. Why are you implementing a point solution?

Point solutions are usually implemented to mitigate areas of excessive cost, provide additional care options, improve health outcomes, or assist in attracting and retaining employees or health plan members. Understanding the primary business goal(s) before engaging with vendors will assist in determining the best point solution for your needs at the outset of the process and will help guide the choice of metrics to measure success down the road.

2. How much can you expect to save, and how will those savings be realized?

There has been a significant increase in the number of new healthcare management vendors entering the market over the past few years, including many start-ups with significant venture capital backing. Although many vendors make considerable claims about their effectiveness and corresponding cost savings, the reality is that credible studies of cost-effectiveness are often lacking. Clients should be wary of vendors' claims regarding effectiveness or return on investment (ROI). It will take time for the industry to agree on the long-term benefits and any associated savings. In addition, the efficacy of some interventions could vary depending on a population's location, social determinants of health, and other variables.

It is always advisable to ask vendors to be as specific as possible in explaining the mechanisms within their programs that produce clinical and/or financial results along with the effect of each mechanism. Each program is unique and should be thoughtfully evaluated. Considerations include:

- Are savings achieved by reducing hospital admissions or readmissions, emergency department use, or something else? What is the source of the cost assumptions?
- Would reductions occur in the absence of the program, potentially stemming from regression to the mean or other existing programs?
- Were savings calculated net of the program costs?
- What are the estimated savings from each care setting and visit type?
- Does the vendor expect care to be redirected to a lower-cost setting or avoided altogether?
- Are drug costs reduced through lower-cost alternatives or by recommending changes in the underlying treatment regimen?
- Will the intervention cause an increase in the use of some services? Is this a desired consequence of the program?
- Are primary care providers and specialists receptive to the types of changes that members make as part of this program?
- To realize the program's full potential, will the plan sponsor or third-party administrator (TPA) need to make any operational changes?

Asking specific questions provides two benefits:

1. A more detailed understanding lets you assess the reasonableness of purported cost savings and facilitates better measurement of actual results once the program is active.
2. A better understanding of each program will help you evaluate how each additional point solution fits within the larger strategic landscape.

3. Should you narrow your target group of members?

For interventions that do not apply to all members, consider adding a methodology that defines which specific members you are targeting with each engagement and allow vendors to engage only with them, not the entire population. For example, to maximize revenue, a diabetes management vendor will likely want to engage any member who has diabetes. However, savings are likely to come from members whose diabetes is not managed effectively. You can direct the vendor to focus specifically on those members who need it the most.

4. Will any services overlap?

Some members are likely to qualify for multiple, potentially overlapping services or interventions offered through the various point solutions you are reviewing. To reduce member confusion and potentially redundant expenses, consider allowing individuals to participate in only one engagement program at a time—what's known as "deduplication." This requires developing and managing a system to coordinate business rules and program prioritization logic at the member level.

In addition, plan to communicate with members about their available options and provide clear information about eligibility and where they can find answers to any questions.

5. How will you monitor a vendor's cost and quality of care?

Throughout the vendor's contract, it is vital to monitor each program. For example, the following are some high-level metrics to potentially define during the procurement process and continue measuring on an ongoing basis:

Operational program metrics for each vendor:

- The number of targeted members.
- The number of members engaged. What is the average engagement period?
- Who are the members engaging? Based on who is engaged, are there any identifiable gaps?
- With those who are engaging, what services are they receiving? How frequently are they receiving services?
- When is a member's case considered "closed" by the program and intervention is no longer necessary?

Aggregate cost-of-care metrics:

- Are the cost trends for the members covered by the point solutions more favorable than for comparable populations?
- When measuring cost savings, be thoughtful about your comparison group. Members who opt in to a program versus those who are eligible but choose not to participate may have meaningful attitudinal differences that could impact results. Additionally, members who have exceedingly high costs in one year, on average tend to have lower costs in the following year even without intervention (regression to the mean). Make sure your measurements do not give full credit to a single source, if multiple factors may reasonably explain some of the observed change in costs or behavior between periods.

Quality-of-care metrics:

- Are members with a particular disease profile better able to manage their underlying symptoms? For example, do a greater portion of members with diabetes have controlled A1c levels?
- Are more members able to access critical services? For example, are more members, or members with different demographic profiles, receiving mental healthcare services for the first time? Are members more adherent to their chronic disease medications?

6. What are your data requirements?

To measure the benefits provided by each service, you will need to receive data feeds from each point solution vendor detailing the dates and nature of their engagement with your members. As a best practice, your contract should define these data requirements and your timing expectations surrounding data delivery. If services are billed and paid through the current claims system, much of the data might already exist. For services that are not accounted for through claims, you might want to incorporate some or all of these data feeds into your data warehouse, for example.

7. Should you expect to see savings in the short or long term?

Each type of point solution will have a different timeline for realizing savings. For example, a surgical center of excellence program may generate savings in the near term by avoiding unnecessary procedures or offering more favorable reimbursement models when procedures do occur. In contrast, a diabetes management program may result in higher short-term costs because it encourages more consistent provider visits and more medication adherence. In this scenario, your goal might be longer-term health improvements that could lead to savings over several years.

8. How will you measure the vendor's impact?

All point solutions come at an additional cost, some more substantial than others. It is important to periodically perform a detailed review of each vendor's performance to determine whether the engagement is yielding the desired results. Ideally, performance targets and measurement methodology would be defined in advance, agreed to in the contract, and measured by an independent third party.

Know your population

Understanding the member population impacted by point solutions is as important as the point solution itself. If your population is unwilling to accept disruption, the point solution may have low utilization, resulting in a less effective implementation. The success of many interventions hinges on behavior change by members and employees, which is only possible if members engage. Reviewing current utilization measures for voluntary benefits can give direction into future point solution utilization.

Keep it simple

While the point solutions market continues to grow, health insurance remains a confusing and hard-to-understand topic for most members. Implementing a wide array of point solutions can easily overwhelm them. This can further evolve into organizational deadlock as management tries to prioritize competing interests, known as decision paralysis. Two ways to avoid decision paralysis in implementing multiple point solutions are: (1) limit the point solutions to the most impactful for your population, and (2) engage members through clear communication, using whichever channels work best for your population—digital mailers, physical mailers, texts, call centers, local health fairs, or even posters.

Factoring in Third Party Administrator (TPA) arrangements

For self-funded plan sponsors and health plans that outsource operations, consider the capabilities of your other partners. When developing a point solution implementation strategy, make an honest assessment of your third-party administrator (TPA) and its track record. If you have one point solution vendor or TPA that manages your insurance benefits and another that modifies insurance benefits, the two will need to communicate and synchronize.

In some instances, point solutions may only realize their maximum potential if the TPA integrates condition-specific or procedure-specific utilization management criteria into its existing process. It is important to keep in mind that some TPAs might already be engaged with vendors or have developed internal programs to provide services comparable to the point solutions you have identified. In these situations, the TPAs might be reluctant to carve those services out of their contracts or unwilling to coordinate with the point solution vendors you independently select through a modular benefits approach.

On the other hand, if the TPA you select is already engaged with one of the point solution vendors on your radar, you might be able to benefit from those services without a separate contract to manage. The existing relationship might also streamline the integration of benefits and, therefore, their engagement and adoption by members. Some services such as virtual primary care, virtual mental healthcare, and diabetes programs might be payable through their standard claims process.

Tell your TPA about any point solutions you select so it can address any questions asked about these programs through its customer service lines. The quality of these interactions may be diminished if your TPA staff is unfamiliar with the point solution's specifics.

Next steps for plan sponsors and health plans

As the number of point solution options continues to increase, it is important to carefully consider your choices and plan your implementation strategy before you commit to an outside program or vendor. To test your program, the gold standard for measuring effectiveness in interventions is experimental design, where some people are randomly assigned to receive an intervention and others are held out as a control. However, this approach is generally not accepted in the health management space due to ethical concerns about holding back potentially beneficial care and related operational issues arising from the potential for inconsistent benefits. As an alternative, you may wish to use geographically limited pilot programs to test a solution's effectiveness.

An independent consultant can support your decision-making process by evaluating any documents that quote specific program impacts, including the assumptions used to develop those expectations. Incorporating an independent party will give an assessment of the reasonableness of the results. A consultant can also assist with assessing the number of engaged members necessary to reliably calculate savings from an actuarial perspective and provide input on quantitative metrics that can be implemented to monitor program effectiveness.

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