Roadmap to Successful Risk Contracting for Providers

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April 27, 2017

Overview

- Risk contracting basics for provider organizations
- The characteristics of provider organizations that have successfully transitioned to risk contracting from FFS
- Roadmap to Successful Risk Contracting for Providers
- Q&A

Risk Contracting Basics for Provider Organizations

Risk Contracting Basics for Provider Organizations

- What is risk contracting?
  - Risk contracting is a reimbursement arrangement under which the provider assumes or shares a non-trivial amount of the financial risk associated with providing contracted health care services to a specific population
  - The idea is not new, but has received a renewed focus in recent years
- Traditional contracting arrangements reward quantity not quality and efficiency
- Risk contracting exists on a spectrum
  - At one end is FFS (i.e., 0% financial risk assumed by provider)
  - At the other end is Global Capitation (i.e., 100% financial risk assumed by the provider)
- Risk contracting is, well, risky
  - Providers could receive less pay
  - Quality of care could decline
  - Very few people really understand how to make it work

Risk Contracting Basics for Provider Organizations

- Why is risk contracting becoming more popular?
  - For the country in general, and for many individuals and families in particular, the cost of health care is becoming unbearable
  - Increase in the National Health Expenditures (i.e., NHE) as a Percentage of the GDP
    - 13.3% in 2000
    - 17.8% in 2015
    - Projected by Office of the Actuary in CMS to be 18.7% in 2020 and 20.1% in 2025
  - NHE have grown at a rate far greater than general price inflation, private sector wages, and the GDP
  - More and more payers want providers to have a financial stake in the cost of care delivery because they believe it could lead to lower overall health care costs and higher quality

Characteristics of Provider Organizations That Succeed in Risk Contracting

Characteristics of Provider Organizations That Succeed in Risk Contracting

- Effective Care Management
  - Under risk contracting, a provider organization's revenue will be capped in some fashion
  - Opportunities for increased margins are directly tied to how much potentially avoidable care exists within the system and how quickly it can be eliminated
  - Successful provider organizations will be those that effectively and efficiently deliver care
- Revenue sources aligned with risk contracting opportunities
  - If majority of revenue comes from a payer with no inclination to enter into risk contracting arrangements, then risk contracting is probably not a workable proposition
- Demonstrable competitive cost structure versus similar provider organizations in the market
  - The provider organization cannot be seen as expensive versus competitors

Characteristics of Provider Organizations That Succeed in Risk Contracting

- Effective budget development and management process
  - Detailed and rigorous estimate of projected costs for the target people (Actuarial)
  - Reporting package that monitors actual results versus budget and provides actionable data to determine root cause of unfavorable performance (IT/Analytics)
  - Organization structure to easily implement corrective actions (Management)
- Internal reimbursement model that correctly aligns the risks and rewards of the whole organization to provide effective and cost-efficient care
- Appropriate staffing and resource allocation to be a risk contracting provider organization
  - Correct number and type of healthcare professionals to service targeted population
  - Management team with expertise in risk contracting and managed care
  - Readily available expertise in cost of care modeling, reporting and analytics, change management, communication, etc.
- The appropriate behavioral mindset to succeed in risk contracting
  - Can not be held back by the “we have always done it this way” thinking

Roadmap to Successful Risk Contracting For Provider

Overview of Roadmap to Successful Risk Contracting Steps

- How does a provider organization that has been successful with FFS reimbursement transform so that it becomes successful under a risk contracting?
- Successful transformation requires a plan (i.e., roadmap) based on a review of the organization's current risk contracting-related readiness and a listing of the items/actions necessary to fill the organization's gaps
- Roadmap steps:
  1. Care management effectiveness assessment
  2. Financial and risk assessment
  3. Development of budgetary framework
  4. Development of internal provider reimbursement framework
  5. Market opportunity assessment and professional resource planning
  6. Organizational readiness assessment
  7. Shopping list of needed items to fill identified gaps

Step #1: Care Management Effectiveness Assessment

- Basic purpose of CME assessment is to determine how well a provider organization manages care and to determine the amount of potentially avoidable care.
- Two parts: actuarial assessment and clinical assessment
- Actuarial assessment (see Appendix A for a sample output):
  - Statistical comparison of organization's CME versus an ideal CME benchmark
  - Example: Inpatient length of stay (i.e., LOS)
    - Compare actual LOS with ideal LOS benchmark
    - Group data by APR-DRG so results can be normalized by severity of illness
    - Remove outliers from analysis
    - Total potentially avoidable days (i.e., PAD) is the difference between aggregate actual LOS and CME benchmark LOS
    - Potential cost savings can be estimated by multiply the aggregate PAD by the average cost per day and then applying the 65% rule
      - Most avoidable care is at end of stay and should be least costly days

Step #1: Care Management Effectiveness Assessment

- Clinical assessment (see Appendix B for a sample output):
  - Primarily a review of patient charts to identify possible inefficiencies of care.
  - Reviews done by healthcare professionals (typically physicians) with the appropriate experience and knowledge to conduct the specific review
  - Example: Inpatient LOS (continued)
    - A sample of patient records for cases included in the actuarial assessment are reviewed
    - Charts chosen randomly for most frequently occurring APR-DRGs and perceived areas of inefficiency
    - Remove extreme outliers from review sample to clearly identify operational inefficiencies
    - Each record reviewed for possible inefficiencies
    - Each review is peer reviewed by at least one additional clinician
    - Results are compared with results of actuarial analysis for consistency
    - Identified inefficiencies are group into pre-defined categories to accommodate amelioration (e.g., understaffing, lack of weekend or nighttime services, etc.)
    - Resulting potential savings opportunity from clinical assessment will be a subset of savings from actuarial assessment

Step #2: Financial and Risk Assessment

Financial assessment

- Review source of payments by payer to determine near-term viability of risk contracting
  - If major payers in the provider's market have no known interest in risk contracting, then it is not the time to make the transition
- Determine competitiveness of service costs compared with the market and similar organizations
  - Being seen as high cost relative to competitors can be an issue when entering into risk contracting arrangements with payers
  - Need to be able to explain higher necessary reimbursement levels are not due to inefficiency but other factors beyond the organization's control

Step #2: Financial and Risk Assessment

Risk assessment

- Purpose is to identify level of risk that the organization currently assumes or is willing to assume
  - Also tells organization how much they know and don't know about risk assumption
  - Also helpful to identify what types and levels of risk are associated with different contracting arrangements
- Types of risks associated with risk contracting
  - Clinical Risk (or procedural risk)
    - Defined as the uncertainty of how much a particular medical event will cost (i.e., severity)
    - Example of high-clinical risk event is a serious heart condition, low is annual physical
  - Population (or insurance risk)
    - Defined as the uncertainty of how many medical events will occur for a given population (i.e., frequency)
    - A higher risk would occur in a population with a relatively small and variable frequency of event and a higher than average cost of event.
- Level of each type of risk by contracting arrangement
  - See Appendix C

Step #3: Development of Budget Framework

- For a provider organization to accept some or all risk for specific population, then the organization must understand the cost of care so that it can effectively manage it from a financial perspective. This is done using budget based reimbursement
- A typical budget framework uses the following standard set of categories:

Primary Care	Specialty Care	Ancillaries	Hospital Inpatient	Hospital Outpatient	Admin Overhead & Risk Ret

- Categories are clearly defined so there is no potential for confusion
  - E.g., how primary care is differentiated from specialty care
- Budgets need to be tailored to specific reimbursement models proposed when determining whether the model is reasonable

Step #3: Development of Budget Framework

- The following items should be considered when tailoring a health care budget to a specific reimbursement proposal:
  - **Population:** who is being covered? Need to review population's prior claims experience
  - **Demographic and/or Risk Adjustment:** provider should be protected from demographic and/or risk mix when comparing actual results to budget
  - **Reimbursement/Care Management Levels:** historical data is based on specific reimbursement and Care Management levels, and needs to be adjusted if different from proposed level
  - **Trend and Inflationary Adjustments:** Reflects general increases in mix and utilization
  - **Division of Financial Responsibility (DOFR):** Used to identify what is included in the budget and who is responsible for it
  - **Potential Incentive Payments:** The budget assessment requires a good understanding of what potential incentive payments exist and how they would work

Step #4: Development of Internal Provider Reimbursement Framework

- Big Question: who assumes what risk?
  - The level of risk assumed by different types of providers can vary
  - E.g., a primary care medical group might assume a different level of risk than a multi-specialty medical group.
- General reimbursement framework

Providers Assuming Risk	HARP	Admin Overhead & Risk Ret

- The Hospital and Referral Pool (i.e., HARP)
  - The budget for services not directly assumed by the provider assuming risk are grouped together in a separate budget or fund known as the Hospital and Referral Pool or HARP Fund.
  - As a larger number of providers in a provider organization assume risk, the size of the HARP will decrease
- Three potential reimbursement models
  - Note: size of overall budget does not change

Step #4: Development of Internal Provider Reimbursement Framework

- Model I: Primary Care Model

Primary Care	HARP	Admin Overhead & Risk Ret

  - Attributed primary care provider held directly accountable for:
    - Primary care services
    - The services part of the HARP in the form of an incentive arrangement
  - Incentive payment to primary care providers based on performance of the HARP budget with the actual cost of services on behalf of patients attributed to her
  - Incentive arrangement could be via shared savings model (i.e., upside-only) or a risk sharing model (upside and downside)
  - In this model, it is assumed that the primary care provider would take the full risk for primary care services provided to attributed members, most likely in the form of a capitated payment

Step #4: Development of Internal Provider Reimbursement Framework

- Model II: Medical Group Model

Professional	HARP	Admin Overhead & Risk Ret

  - Attributed professional provider held directly accountable for:
    - All professional services provided (most likely in the form of a capitated payment)
    - The remaining services that are part of the HARP (in the form of an incentive arrangement)
  - Incentive payment to professional providers based on performance of the HARP budget with the actual cost of services on behalf of patients attributed to her (can be an upside-only or an upside and downside incentive)

- Model III: Global Payment Model

Global Payment	Admin Overhead & Risk Ret

  - Attributed provider held directly accountable for all services provided
  - The provider (i.e., most likely a health system) often sets up an internal budget management system similar to Model I or Model II to effectively manage program

Step #4: Development of Internal Provider Reimbursement Framework

- Important considerations:
  - Incentive payments must be understood by providers in advance
  - Primary care providers need sufficient patient attribution to avoid statistical risk fluctuations (i.e., results do not correlate well to actual primary care performance)
  - Catastrophic claims can effect a PCP's performance; include stop-loss reinsurance
  - Definitively and properly define PCPs and primary care services to avoid PCP self-referrals
  - Any incentive payments associated with a reimbursement model should always be adjusted by quality performance (assuming actual costs favorable to budget)
    - One possible approach:
      - Quality measures: 25%
      - Customer satisfaction measures: 25%
      - Cost measures: 50%
    - Separate measures would be developed for each type of provider with actual payments based upon provider specific scoring in each of these areas.
    - Pay 100% of the allocated risk incentive amount for excellent performance across the above metrics. 50% payment for average performance. 0% for below-average.

Step #5: Market Assessment and Professional Resource Planning

Market Assessment

- Determine the provider organization's current market share and potential for growth
- Use resource planning process to understand how many providers need to be recruited by provider organization engaging in risk contracting
  - Can use Actuarial Cost Model and population estimates to estimate demand
  - Determine number and type of providers needed to meet estimated demand
- Complete market assessment
  - Understand external provider community as far as risk readiness and risk willingness
  - Complete market surveillance of competitor plan programs
  - Survey providers to gain information regarding health plan's positioning vs. competitors

Step #5: Market Assessment and Professional Resource Planning

Professional Resource Planning

- If additional providers are needed, develop prioritized list of providers
  - Identify historical risk adjusted performance of prospective providers in terms of an actuarial cost model with comparison to best practice norm
  - Assess care management readiness of prospective providers
  - Identify current high performers
  - Focus on material middle performance providers who can be trained to immediately improve profitability
- Match prioritized list of target providers with list of providers with greatest health plan influence to expedite enrollment into program
  - These providers can help recruit other needed providers into delivery system

Step #6: Organizational Readiness Assessment

- Administrative functions
  - Risk management (i.e., actuarial) capabilities
  - Accounting systems (move to member-based from user-based)
  - Claims and capitation payment processing for internal payments to providers
  - Provider reimbursement negotiation
- Care management
  - Care management different in a risk contracting environment than in a FFS environment.
  - Probably need to develop new and different care management initiatives
- Regulatory compliance
  - May be additional licensing and reporting requirements for risk bearing organizations
  - May need to hire additional legal and compliance capabilities

Step #6: Organizational Readiness Assessment

- Leadership commitment
  - Commitment to risk contracting at the highest levels of management team
  - Recommend creation of "Transformation Team" to facilitate move to risk contracting
    - Team should include senior management and staff from various departments in organization
    - Team would focus on the cultural, process and structural changes necessary to effect the broad organizational change
- Managed care experience
  - Needed to lead transformation process and to educate staff on managed care practices
- IT/Reporting infrastructure
  - Develop provider-facing and management reporting packages to measure performance (and key drivers of results), manage risk, and communicate best practices
  - Reports must be streamlined and contain actionable data (i.e., leads to an action that can positively impact results and identifies the true drivers of higher level problems)
  - See Appendix D for an example of a report with actionable data

Step #7: Shopping List of Needed Items to Fill Identified Gaps

- Previous steps are assessments of needed capabilities, resources, and processes
- The results of the multiple assessments is the identification of “gaps” in an organization’s risk contracting-readiness
- We suggest prioritizing list items using scores of 1, 2, and 3, with 1 signifying the highest priority. Additionally we also suggest including an indicator of how much time a specific item would likely take to complete as follows:
  - Short: less than 3 months
  - Medium: 3 - 6 months
  - Long: more than 6 months
- The “shopping list” is a listing of the recommended steps and activities to fill identified gaps in an organization’s risk contracting readiness
- Appendix E provides an illustrative sample of a shopping list

Q&A and Wrap-Up

Appendices

Appendix A: Actuarial Care Management Effectiveness Assessment Output

- Example: Inpatient Length of Stay (i.e., LOS)

MDC	Admits	Days	Cost	ALOS	PAD/Stay	Potential Savings**
Newborns & Other Neonates - Perinatal	1,349	25,123	$87,071,146	18.6	5.8	$17,697,281
Respiratory System	2,337	11,957	$32,770,179	5.1	1.2	$5,064,085
Circulatory System	239	2,654	$15,755,108	11.1	5.0	$4,615,315
Nervous System	1,086	5,155	$18,617,612	4.7	1.4	$3,688,418
Infectious & Parasitic	491	3,741	$10,503,410	7.6	3.1	$2,794,943
Digestive System	1,945	7,134	$20,947,562	3.7	0.9	$3,221,708
Pre-MDC (Transplants)	22	1,774	$5,902,070	80.6	44.2	$2,104,584
Myelproliferative, Neoplasms	522	3,547	$11,523,419	6.8	1.9	$2,088,900
Ear, Nose, Mouth, Throat	821	2,251	$6,733,460	2.7	0.8	$1,343,746
Hepatobiliary System & Pancreas	191	1,187	$3,133,277	6.2	2.8	$922,403

*PAD = Potentially Avoidable Days

Potential Savings = Average Cost/Day × PAD/Stay × Admits × 0.65*

***65% rule assumes avoidable days occur at end of stay and are less costly on average

Appendix B: Clinical Care Management Effectiveness Assessment Output

- Clinical Care Management Effectiveness Assessment Output:

Category	Description	Counts	AD/PAD
1	AD-Understaffed for patient census	0	0
2	AD-Lack of weekend or night time services	0	0
3	AD- Delays in carrying out orders	4	5
4	AD-Physician decision making	15	18
5	AD-Patient does not meet admission criteria and could be treated in an alternative setting such as observation, or home if pt has a medically safe home	11	37
6	AD-Delay in writing orders for appropriate recovery stage of the illness in the hospital	1	1
7	AD-Patient not discharged to next level of care when clinically stable and a medically safe level of care is available	17	27
8	AD-No adequate Respiratory therapy	0	0
9	AD-No Home Health availability	0	0
10	PAD-Lack of adequate payer contracted vendor i.e. pharmacy, home care, SNF, Hospice	1	1
11	PAD-No medically safe home or alternative setting to discharge to.	3	10
12	PAD-CPS issues. No alternative setting to discharge to until CPS issues resolved	1	2
13	PAD-No medically safe home	2	8
14	PAD-No alternative or step-down care	2	21
15	PAD-Social – Family not comfortable with discharge plan, transportation issues, etc.	5	17
16	PAD-Teaching – delay in patient/family education (may be due to family availability or ability to learn or staff delay)	2	4
	Total	**64**	**151**
	Total LOS	**2,799**	
	Percentage of Avoidable Days (PAD/AD divided by LOS)	**5.39%**	

Appendix C: Level of Each Type of Risk by Contracting Arrangement

- Purpose is to identify level of risk that the organization currently assumes
  - Provides the organization with another metric on the degree to which it will need to change to successfully transition to risk contracting
  - Also helpful to identify the types of risk currently assumed, what types of risk are associated with different contracting arrangements, and what expertise gaps an organization might have to overcome to enter into certain risk contracting arrangements

Payment Method	Level of Risk to Provider		
	Clinical Risk	Population Risk	Total Risk
% of Billed Charges	Very Low	Very Low	Very Low
Fixed Fee Schedule (no bundling)	Very Low	Very Low	Very Low
Per Diem	Low	Very Low	Low
Case rate by DRG	Med	Very Low	Low
Episode Bundled Payment	Med to Very High	Very Low	Low to Med
Partial Capitation	Med	Low	Low to Med
Total Capitation	Very High	High	High to Very High

Appendix D: Example of a Report with Actionable Data

- Example: ER costs
- Without actionable data

Year	PMPM Cost	Cost/Visit	Visits/1,000
2015	$24.62	$1,048.60	281.8
2016	$28.31	$1,143.53	297.0
Trend	15.0%	9.1%	5.4%

- With actionable data

2016 ER	PMPM Cost	Cost/Visit	Visits/1,000
Emergent/ER Appropropiate	$14.15	$1,633.80	104.0
Emergent/Other Appropropiate	$9.91	$1,334.30	89.1
Emergent/Avoidable	$2.83	$571.80	59.4
Not Emergent	$1.42	$381.20	44.6
Total Emergency Room	$28.31	$1,143.53	297.0

  - Potential actions
    - Increase Urgent Care and after hours PCP access
    - Member education and economic incentives to reduce inappropriate ER utilization
    - Care management initiatives to lower cost/visit for ER appropriate visits

Appendix E: Example of Shopping List of Needed Items to Fill Identified Gaps

- Illustrative sample from a hypothetical organization's "shopping list"

Recommended Activity	Priority
CARE MANAGEMENT EFFECTIVENESS ASSESSMENT	
Include length of stay targets in pathways	1 - medium
Ensure that clinical judgment overrides pathways	1 - medium
Address potential for earlier discharges, including: • Earlier rounding • Orders to discharge in the morning if criteria are met • Earlier discharge orders • PM rounding to address patients whose conditions change very quickly • Encourage case management to become more proactive and assertive in earlier discharge planning	 1 - short 1 - short 1 - short 1 - short 1 - medium
Identify procedures which should typically be performed on an outpatient basis	1 - medium
Clarify role of hospitalist in managing progression of care orders for cardiac patients	1 - medium
Define guidelines clearly for cardiac patients for early extubation, chest tube removal, and pacer wire removal	1 - medium to long
Increase activity of mid-level providers in the ED	2 - medium
Recruit two weekend case managers	1 - short