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the great risk shift

a strategic road map for providers

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When assuming financial risk for healthcare delivery, a provider has many options to choose from and a broad range of internal and market-based factors to consider to be able to choose the right option for its specific circumstances.

AT A GLANCE

- > Healthcare providers that are assessing their readiness to assume financial risk for care delivery should understand the full range of risk options available to them.
- > Available options fall into two broad categories: episode-based risk (e.g., the Medicare BPCI initiative and CJR model, commercial insurance models, and direct-to-employer models) and population-based risk (e.g., shared savings models and professional or institutional capitation models).
- > Providers also require a deep understanding of both internal and market-based factors that are essential for success under any risk option being contemplated.

An unprecedented shift of financial risk from payers to providers is occurring within the healthcare delivery system as a result of reform efforts. Healthcare providers have many important strategic decisions to make in preparation for this shift that will have a profound impact on their future success. Foremost among these decisions is choosing from the broad range of risk options available to providers, including quality incentive and penalty programs, Medicare accountable care organization (ACO) models with various degrees of risk and requirements, commercial shared savings, bundled payments, cobranding, and partial/full capitation or percentage-of-premium models. It is clear that government and private payers, as well as employers and the general public, are pushing to improve overall healthcare value by increasing providers' degree of risk.

Market nuances, resources, partnerships, and past experiences, among other factors, will help each provider organization determine which models and programs are the best fit based on its unique characteristics. Understanding the benefits and drawbacks of various risk models, effectively weighing considerations on when and how to formulate the best strategy, and knowing how to advance to higher levels of risk while maintaining

success will be instrumental to a provider's transition to the new care delivery system.

Risk-Based Models: A Primer

There is a wide array of risk arrangements, some having existed for many years and others that are evolving as part of the value-based system. It is important to understand that risk models differ depending on the population and payer source, with certain models reflecting core approaches used by government payers and others being developed by private payers to adapt to today's healthcare environment.

Some of the more prominent models are described below. These models do not represent an exhaustive list of all risk-bearing programs, but they are anticipated to be the most widely adopted by providers as they assume increased risk.

Episode-Based Risk Models

Risk models based on episodes of care present a great opportunity for providers that have performed well in pay-for-performance contracts but that may not yet feel ready to move into population-based risk models such as shared savings or capitation.

Perhaps the most popular approach using episode-based risk is bundled payment. At its core, bundled payment is essentially a pricing strategy where a fixed supply-side price is assigned to a set of predefined procedures and services. This definition may call to mind another familiar term: DRG.

DRGs and case-rate payment both fall under the episode-based risk umbrella, albeit in a more limited form, and they therefore share similarities with bundled payment. The latter aim to reduce cost and improve quality by reducing clinical variation and aligning incentives among the hospital, physicians, post-acute providers, and various other stakeholders involved in treating an episode. This evidence- and team-based approach is one of the main reasons the Congressional Budget Office has estimated that bundling payments for inpatient and post-acute

care for Medicare patients alone could save nearly \$47 billion by 2023.^a

The following list represents some of the episode-based risk programs available to certain providers.

Bundled Payments for Care Improvement (BPCI)

initiative. Created by the Centers for Medicare & Medicaid Services (CMS) after success with the Medicare Acute Care Episode demonstration, the BPCI program consists of four unique models, each offering a varying degree of payment arrangements (retrospective versus prospective), episode definitions, and provider stakeholders.

Comprehensive Care for Joint Replacement (CJR)

model. Following its success with the BPCI program, CMS developed the CJR model along similar lines but limited it to two MS-DRGs: 469 (major joint replacement or reattachment of lower extremity with major complication or comorbidity [MCC]) and 470 (major joint replacement or reattachment of lower extremity without MCC). The CJR model also is mandatory for certain hospitals residing in one of 67 predetermined metropolitan statistical areas (MSAs) across the country.

Commercial insurance models. Many commercial insurers across the country are moving full throttle into bundled or episode-of-care payments. Commercial bundles often allow greater flexibility in setting incentive structures and risk levels than is possible with CMS programs. Many commercial insurers also are piloting programs for nontraditional episodes, such as colonoscopies or oncology-related services.

Direct-to-employer models. For employers and their employees, bundled payment introduces reference pricing in which the employer can set a price for a specified service, choose a set of providers that are willing to accept the reference price, and build incentives for employees through benefit design to seek care from these providers

a. CBO, "Bundle Medicare's Payments to Health Care Providers," Options for Reducing the Deficit: 2014 to 2023, Nov. 13, 2013.

consistently throughout the episode. Lowe's and Walmart are two large employers that have teamed up with the coalition Pacific Business Group on Health Negotiating Alliance to form the Employers Centers of Excellence Network, whose participating providers will offer bundled knee and hip replacement surgeries for coalition member's employees.^b

Population-Based Risk Models

This type of risk model takes the underpinnings of episodic models and expands them to cover an entire population of healthcare services beneficiaries. It therefore represents a higher overall level of risk. Population-based risk models come in many forms, such as ACOs or shared savings, professional or institutional capitation, and global capitation. The following are the population-based risk bearing models that are likely to be most widely adopted as financial risk is shifted from payers to providers.

ACOs or shared savings. Used by both CMS and private payers, shared savings models are perhaps the most common of population-based risk models used today. Many providers favor shared savings because the agreements tend to be built on a fee-for-service chassis.

Shared savings and deficits are determined by comparing actual medical spending during a performance period with a budget. If the actual claim experience is lower than the budget, a portion of the savings may be shared with the participating provider, whereas if the actual claim experience is higher than the budget, the participating provider may be liable for a portion of the deficit. The calculation of the budget usually is based either on a percentage of the payer's performance-year premium or on trending of historical claim costs.

With the the first of these approaches, the payer determines the budget as a percentage of its performance period premium for the attributed

beneficiaries. The premium is based on average contractual rates and utilization for providers in the same geographic region. This approach is particularly popular among Medicare Advantage products.

The second approach involves trending forward the historical claim cost experience, or baseline performance, of the attributed beneficiaries to the current performance period. In multiperiod shared savings agreements, the baseline budget may be calculated once and then trended forward at a contractually agreed-upon rate, or it may be recalculated every period based on the new historical baseline. CMS uses the historical baseline approach in its Medicare Shared Savings Program (MSSP), and it also is commonly used in commercial ACO models.

Whichever approach is used to determine the budget, it is imperative that the contracting organization fully understand the methodology and key considerations of the approach and—if the shared savings contract is with a private insurer—what elements of the approach used may be negotiable.

As with most population-based risk models, shared savings models include an attribution process in which beneficiaries are assigned to a specific provider based upon a predetermined methodology. Attribution methodologies can range from primary care provider selection (where the product is an HMO), to prospective, retrospective, or a hybrid of assignment types based on the beneficiary utilization patterns. In a prospective model, the attributed beneficiaries are determined prior to the performance period, so the provider has a clear sense of who it is responsible for. Conversely, in a retrospective model, the attributed members are determined after the performance period based upon utilization during the performance period, and therefore the provider cannot distinguish between its attributed patients and nonattributed patients.

The budget calculation and attribution are just two of many important contractual parameters in

b. Gamble, M., "Lowe's, Wal-Mart Strike Deal With 4 Hospitals for Hip, Knee Replacements," *Becker's Hospital CFO*, Oct. 9, 2013.

shared savings arrangements that providers should carefully evaluate and weigh against their risks when contemplating entering such an arrangement.

Professional or institutional capitation. This type of population-based risk could be considered half way between shared savings and full risk because, typically, only a certain provider receives capitated payments while others in the system continue to receive fee-for-service payments.

Professional capitation is an arrangement in which an organized physician group is paid a per-member-per-month (PMPM) or other form of payment to cover a set of services for an attributed population, regardless of the actual number of services provided to each member.

With institutional capitation, the payer provides a PMPM payment or other form of payment to a hospital or other provider institution in exchange for delivery of agreed-upon services to the attributed population.

In both of these types of arrangements, where there is a PMPM payment, the payment rate is adjusted for age and gender. Other forms of payment include a monthly percentage of the premium received by the payer for each contracted member. And in some cases, the payment also may be risk-adjusted.

Percentage-of-premium payment holds more risk for the provider than does PMPM payment because—although both put the provider at risk for overutilization of attributed members—the former involves an added risk that the payer might have underpriced its premium. With either payment approach, it is important to identify the division of financial responsibility in the contract. This consideration is particularly important under the PMPM approach because the pricing of the PMPM rate for either the institutional or provider risk is subject to how costs will be allocated among the plan, the physicians, and the hospital provider.

Full or global risk. Full- and global-risk contracts represent the population-based risk models with the highest degree of risk. Under a full-risk contract, a provider agrees to receive capitated payment for both institutional and professional services, whereas under a global-risk arrangement, a single entity receives all funding and pays all claims. The benefits of such arrangements include strong cost control elements, reduced managed care and revenue cycle administration costs, and aligned economic interests of institutional and professional providers. In most instances, full- or global-risk payments are based on a percentage of premium.

Key Considerations for Developing a Glide Path

A provider's choice of which of the many episode-based or population-based risk models to adopt will be determined by a broad range of factors, including not only the degree of risk involved but also the type of population under consideration and the specific provider characteristics that will be necessary for success with the model. For every provider organization that is preparing to assume risk, careful analysis and consideration of both internal and market-based factors are required to develop a glide path, which includes knowing where to start and how to design an effective risk strategy for the future.

Clearly, for example, if an organization is located in one of the 67 MSAs where the CJR program is mandated, bundled payments for joint replacement and the associated relationships with supply vendors, orthopedists, and post-acute facilities will be one of the priorities.

As another example, if a health system is just getting started in accepting risk and its market is much more highly concentrated in traditional fee-for-service Medicare than in Medicare Advantage, participation in the MSSP may be a solid starting point. The MSSP has its benefits and drawbacks, but one of the benefits is the multiplicity of options that allow organizations to enter at varying degrees of risk.

Another starting point for a organization seeking to start with lower risk is in the management of the organization's own self-funded employee health plan. Self-funded employee health plans offer organizations that are new to risk the opportunity to gain the benefits from piloting new care management efforts, controlled networks, and creative benefit designs to reduce healthcare costs and improve overall value.

In most markets, commercial payers have established shared savings programs, some with upside risk only (i.e., where the provider shares in a portion of savings only if they occur and does not share in any losses should the medical spend exceed the budgeted amount) and others with progression to upside and downside risk (i.e., where if medical spend exceeds the budget, the provider is also responsible for a percentage of the difference). For those organizations still

"testing the waters" of risk arrangements, these shared savings programs can serve as a beginning or even intermediate step.

However, care should be taken to support the organization's success in these models by ensuring that proper reporting, care management, and network structure are in place. A robust reporting platform will allow a provider to monitor results and respond quickly should problem areas arise. A strong care management structure will allow a provider to successfully implement desired care model redesign aimed at reducing medical spend while boosting quality measurements. And a provider's network structure and adequacy are critical to being able to serve the attributed population efficiently while simultaneously ensuring the growth of domestic utilization.

RISK MODELS AND CRITICAL SUCCESS FACTORS

Degree of Risk ↑	Fee for Service	Episode of Care	Population Risk
	Pay for Performance Plus Cost Management Incentive	Prospective Payment	Full or Global Risk
	Pay for Performance	Bundled Payment 90 Days	ACO or Shared Savings—Upside or Downside
	Pay for Reporting	Bundled Payment 30/60 Days	Professional or Institutional Capitation
	Discounted Fee Schedule	Retrospective Payment	ACO or Shared Savings—Upside Only
	Percentage of Charges	Shared Savings	Case Management Fee Plus Incentive (e.g., PCMH)
	Full Charges	Per Episode (e.g., Oncology) Case Rate or DRG	
Breadth of Risk →			
Critical Success Factors			
	Fee for Service	Episode of Care	Population Risk
	<ul style="list-style-type: none">> Cost per unit> Market price sensitivity> Volume> Billing/coding> Patient satisfaction	<ul style="list-style-type: none">> Per episode per unit cost> Case volume> Volume> Care coordination across continuum> Physician engagement> Adherence to protocols> Quality/experience outcomes	<ul style="list-style-type: none">> Covered population size> Patient attribution> Total cost of care and risk adjusters> Care redesign across continuum> Patient and physician engagement> Quality/experience outcomes> Multiyear agreements plus reserves

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Shared savings programs also often are rigid in their structure and leave little room for negotiation. Moreover, if an organization has shared savings programs with multiple payers in the market, the structures could differ significantly, making management of the programs and achievement of shared savings more challenging. At a minimum, providers should seek to establish similar quality metrics across programs to eliminate the need to treat patients differently based on payer source.

As with most initiatives, the greater the risk, the greater the potential reward. Thus, those organizations that are less risk averse, have greater experience in population health management, and enjoy strong relationships across the continuum of care may wish to enter the risk arena at the high end of the spectrum by starting their own health plan or partnering with an existing health plan on a cobranded product, the latter helping to minimize the learning curve and resource requirements of operating a health plan.

The specific characteristics of the provider organization and its market also represent important considerations that will have a major bearing on the organization's risk strategy. A prudent initial step, therefore, is to define these characteristics to inform the organization's considerations of its risk tolerance and the glide paths it will use to gradually increase participation in risk-based programs.

To help guide this effort, we list below the primary characteristics that are unique to providers and that are unique to markets, with key questions that providers should be asking with respect to these characteristics. Careful consideration of these characteristics, with thoughtful attention to each question, can help a provider thoroughly evaluate its risk participation options and obtain critical insight into what direction will be best for it to take for future success.

Key Provider Characteristics

Clearly, having prior experience with risk-based arrangements gives a provider a strong basis for assessing its own ability to assume risk. If a provider has such experience, it should start by asking how successful the arrangements were. The answers to this question provide a basis for addressing the next fundamental question: What is the organization's tolerance for risk—including potential financial losses? In answering this question, providers should assess the extent to which the following characteristics describe their organizations.

Strong physician alignment. Alignment with independent physicians in the community is especially important. Key question: What is the size of our affiliated primary care base?

Robust health IT infrastructure in place. This infrastructure should include referral tracking, utilization tracking, risk stratification, data sharing, and aggregation. Key question: Do we have an integrated electronic health record and appropriate tools to support care management and high-level data sharing?

High domestic utilization. Organizations that strongly exhibit this characteristic will be in a good position to assume population-based risk. Key question: Do we adequately track and manage services performed within our network as well as patients who leave our system?

Option value of services and provider network adequacy. The *option value* of a provider's various services refers to the extent that those services are seen as essential to consumers and may have limited exposure to the substitution effect. Key questions: Is our provider network adequate to meet demand? Are we seen as irreplaceable for certain services? How does access measure up? Can patients access services in a timely manner?

Relationships with post-acute care providers and others across the continuum. Risk arrangements often require that an organization either own or be affiliated with post-acute providers such as

long-term acute care facilities, skilled nursing facilities, home care agencies, and hospice organizations. Key questions: Do we have a clearly defined post-acute care strategy? Have we identified “high performing” post-acute providers?

Current care management and care model capabilities. Most providers must redesign their care models in preparation for assuming risk, so it will be important for each organization to assess whether it has actively undertaken such an effort. Key questions: Are risk stratification processes in place? Do we have an effective disease management program embedded within care management?

Cost and quality of care. A provider’s performance in terms of cost and quality compared with that of its competitors is important to consider. Key questions: Is our organization a low- or high-cost provider? How is it performing on key quality metrics?

Market Characteristics

A provider should not assume any type of risk that will not be supported by the specific characteristics of the provider’s market. Here are some primary categories of market characteristics that providers should consider to assess whether their markets will support risk arrangements and, if so, what types of arrangements.

Data sharing. A hallmark of a risk-ready market is the presence of health information exchanges (HIEs) and regional health information organization (RHIOs). Key questions: Do HIEs and RHIOs exist within the market, and if so, are we participating? Is there a need within our organization for an HIE to allow communication with other providers?

Community resources and socioeconomic factors. In this category, providers in urban markets may face greater challenges than those in suburban markets. Key question: Do we have established relationships with community resources, and do we actively refer patients to these organizations?

Community demographics. Demographic indicators such as total population growth, aging population (55 years old and over) growth, average household income, and others can help determine future medical needs of the community. Key question: What changes in the demographic makeup of the communities served by the organization can be expected over time?

Provider market concentration. A highly concentrated market may provide stronger opportunities for collaboration in risk arrangement among providers. Key question: Are there adequate provider partners to support clinical integration across the continuum and assumption of risk?

Employer landscape. Organizations should identify the employer groups in their markets, both large and small-mid size. Direct contracting arrangements are most feasible in markets that have large employers, which tend to be receptive to narrow networks. By contrast, markets with only small employers may signal higher exchange participation or collaboration for self-funding. Key question: Are pre-existing direct-to-employer contracts already in place?

Payer mix. An in-depth analysis of the organization’s payer mix will be essential in determining which risk option will be best for the organization. Key questions: On what payer base are we most dependent? What is our strategy moving forward to alter or maintain the payer base? Is there high managed care penetration? Is the payer market highly consolidated? Is there a concentration of traditional fee-for-service Medicare, or is Medicare Advantage dominant? Does the region have mandatory managed Medicaid?

Extent of risk-assumption among providers in the market. It is important to understand the extent to which other organizations in the market have assumed risk. Key questions: Have other organizations in the market established successful risk strategies? If so, how, and what are their areas of focus?

The Keys to Perpetual Success

Executing a carefully planned strategy of transitioning into risk is the most critical step for any organization that is embarking on a risk arrangement. Episode-based and population-based risk models require different capabilities and infrastructure, yet they also require many features in common that will become core capabilities of successful organizations of the future.

Each new provider entrant into risk-based models should capitalize on its current infrastructure by selecting the models complementary to its capabilities and level of comfort with risk. For providers that already have experience with risk and that have mastered some of the attributes of population-based programs, however, spending too much time in lower-risk models essentially amounts to leaving money on the table. It also is important to keep in mind that

health systems often can embrace a blend of risk-based models across payers and services within their organizations. Finding the right balance during this time of transition is key. ■

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