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Accountable Care NEWS

Understanding the Four Stages of Risk-Based Contracting

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It's no secret that the healthcare system is in the midst of a fundamental change. Fee-for-service (FFS) reimbursement is being replaced by payments tied to quality metrics, defined health outcomes and associated patient cost.

The Centers for Medicare & Medicaid Services (CMS) and commercial payers are implementing bundled payments, shared savings models and capitation arrangements. Under these new models, physicians are accountable for the quality of care they deliver and effective stewardship of healthcare resources.

For many providers, these new payment models have already resulted in meaningful changes in how they practice. Physicians are embracing team-based care, hospitals are collaborating more closely with outpatient providers to reduce readmissions and skilled nursing facilities are focusing on length of patient stay.

To maximize revenue in a value-based care environment, healthcare organizations must develop a strategy that aligns data analytics with effective population health management. Providers need to understand risk, utilization and cost trends, and align targeted care based on patient needs.

However, organizations are in varying stages of readiness to manage data, apply analytics and deploy programs. Understanding the four stages of risk associated with value-based contracting can help any organization build an infrastructure that drives successful clinical and financial outcomes.

Stage One: Pre-Risk

Healthcare organizations in the pre-risk stage are still operating exclusively under FFS payment models. Given that CMS has now tied many payments to quality or value, each year there are fewer organizations that can truly fit into this category. Independent specialty providers, as well as some primary care groups, could fall within this segment.

The passage of the Medicare Access and CHIP Reauthorization Act (MACRA) and the coming of the Merit-Based Incentive Payment System (MIPS) payment adjustments will require the majority of provider groups operating exclusively in FFS models to start measuring performance metrics to ensure that they do not receive significant reimbursement cuts from CMS and other payers.

Pre-risk organizations are typically smaller in size and likely do not have extensive experience working with data. An investment in an analytics platform can jump start the process of tracking provider performance metrics. Alternatively, given the small size of many of these organizations and the potential lack of capital for technology investment, partnership with larger organizations may be a more appropriate first step. An investment in a commercial risk adjustment and predictive modeling solution may also be a more practical start.

Pre-risk organizations can review their local healthcare landscape and identify organizations that are already taking on risk through participation in accountable care organization (ACO) programs, such as the Medicare Shared Savings Program (MSSP). Partnership with an ACO can allow a pre-risk organization to gain entry into the risk-based ecosystem without the need for any large up-front investments. Through data sharing arrangements, access to analytics and focused quality improvement activities, a pre-risk organization will transition into the next stage of risk-based contracting.

Stage Two: At-Risk, Emerging

Organizations in stage two are typically receiving some payments that are linked to quality or other performance measures, whether through CMS programs or commercial payers. These organizations are often small clinical groups, including provider-owned practices. They may also include standalone, single hospital organizations.

They often are exploring opportunities to take on more financial and clinical risk yet may be wary of the potential downside consequences. Many choose to focus on their own employee population first, or engage in one-sided risk contracts such as MSSP Track 1, which offers gain sharing without the risk of financial loss.

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Emerging risk organizations generally have a minority of their patient panels in risk-bearing contracts. They are eager to engage in population health analytics but might only have one or two people within the organization with the data management and analytical skills needed to run detailed reports and manage databases. At the same time, they are building their capabilities based on lessons learned with their smaller populations, such as their employees.

These organizations are often looking for guidance in population health management strategy—especially on the best ways to engage responsibly in more risk-based contracts. Emerging risk organizations will benefit greatly from participation in learning collaboratives such as those run by CMS.

To address core analytical needs, these organizations can also work with an analytical vendor partner who can help organize data; identify population risk, utilization and cost trends; and develop a population health management strategy for the strongest outcomes possible.

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Stage Three: At-Risk, Mid-State

Stage three organizations typically have larger numbers of attributed lives in risk contracts. They often have a higher percentage of revenue at risk, 25% or more, including one-sided contracts and some two-sided arrangements.

Because they are taking more risk, including two-sided contracts with dollars at stake, these organizations have an incentive to build internal analytical expertise to effectively aggregate healthcare data and produce meaningful reports for providers, clinicians and finance directors.

Mid-state, risk organizations are often more sophisticated in their approach to population health and care management, and many have relationships with vendors who can assist with building data warehouses and translating data into actionable reports.

With greater risk comes greater reward so that mid-stage organizations have an opportunity to expand on their existing contracts to drive stronger financial success. However, to be successful, they need to ensure effective contracting coupled with a strong population health management strategy. Mid-stage organizations must push to get the most out of their population health tools to effectively translate data into action. These include identification of high risk, cost and/or utilization areas informed through advanced data analytics.

Armed with this information, these organizations can develop and deploy targeted programs to reduce negative trends. One example is post-acute care and assessing utilization patterns that are resulting in inefficient or ineffective care delivery and rehospitalizations.

Mid-stage organizations need aligned leadership, integrated medical management and a clear strategy to transform clinical care through a strong analytical platform. Effective workflow management and getting patient data into the hands of front-line caregivers are also essential.

Stage Four: At-Risk, Market Leaders

Stage four organizations are at the highest end of the risk spectrum, and are taking on significant financial risk across their patient populations. There are only a small number of such organizations in the United States today that fit into this category. Generally, they fall into two categories: large integrated delivery networks (IDNs) with hundreds of physicians and more than 100,000 attributed patients and physician-led, multispecialty groups.

Most market leader organizations have participated in major CMS programs, such as the Pioneer ACO Program. They have population health management departments and teams of internal analysts to help build databases and develop reports for providers, care managers and financial leaders.

These organizations are experienced in managing risk and are best positioned to share knowledge and expertise with others, such as speaking at conferences or writing in medical journals, to share best practices.

Market leading organizations have an opportunity to further engage in risk-based, capitation arrangements, potentially removing themselves from FFS payment entirely. By moving into full-risk, payment models, these organizations can focus all energy on patient outcomes without the constraints of a volume-based, payment system. Their patients will also benefit from receiving the best care in the right place at the right time.

Regardless of where an organization falls on the risk spectrum, there are opportunities to better prepare for a rapidly changing, healthcare payment system. Although FFS still accounts for the majority of payments today, ongoing legislation changes have altered the healthcare payment landscape, driving toward risk contracts with aggressive timelines.

Every organization has an opportunity to review programs, explore technology investments and prepare for risk contracting. By understanding the stages of risk and reviewing best practices from organizations that have paved the way, healthcare providers across the country can achieve success in a value-based, care world.

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