Managing Risk Arrangements: Getting From Here to There

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The Current Market Environment: Key Characteristics

- Healthcare expenditures continue to rise at unsustainable levels
- Every stakeholder group is feeling the squeeze – employers, payers, patients, and providers
- Provider revenues will be under severe pressure as payment mechanisms migrate toward value-based approaches – need to do less with less
- Inpatient and outpatient use rates will decline
- Continuing to compete on volumes and rate will be a riskier strategy than shifting to value-based reimbursement – being a rate taker in a shrinking market is not a viable strategy
- Regardless of what happens at any regulatory level, improving quality and efficiency is the right thing to do
- Value-based care payment and delivery are here to stay
- Providers will need to answer the fundamental question: At what level of risk are we able to participate now and at what level do we want to participate in the future?
Payer Response

- CMS is requiring hospitals to begin competing on value
  - Penalty for readmissions
  - Incentives for Medicare Shared Savings Program and accountable care organization (ACO) development
  - Hospital value-based purchasing (VBP) program roll out
- Commercial payers are independently seeking significant reductions in provider reimbursement
  - Many payers are tightening networks and terminating contracts with many small providers
  - Shift to tiered and narrow networks is gaining momentum
  - Benefit design is being used to shift gatekeeper role to members
  - Payers prefer to contract through larger networks to cover the spectrum of providers
- The gap between government and commercial payer reimbursement is narrowing
Healthcare Exchanges Are Coming

• Several types of exchanges will exist:
  
  - Public Individual
  - Public SHOP
  - Private

• Each exchange will impact hospital revenue differently
• Separate contracting strategies may be required
• Timing and adoption rates will be market specific

Providers will need to develop a specific strategy and plan for the exchanges
More Exchange Enrollment Is Projected to Originate From Commercial Lives than the Uninsured in 2014

Example: Projected 2014 Colorado Public Exchange Enrollment by Source

Society of Actuaries

2014 Exchange Lives: 616K

Currently Uninsured

228K (37%)

Commercial (Group)

262K (42%)

Commercial (Non-Group)

127K (20%)

Note: Figures do not total 100% due to rounding. 5K enrollees from Medicaid excluded for simplicity. High risk pool classified as individual. ESI shift includes SHOP (189K) and individual exchange (72K) lives.

A Broad Range of Public Exchange Contract Rates Is Emerging

- Reimbursement rates will be driven by a variety of factors including provider competition, payer competition, and current contract rates
- Payers are carefully evaluating and selecting a limited number of markets for exchange participation (i.e., UnitedHealthcare selecting between 10-25, BC/BS: 15-25)
- Initial contracts will mirror current commercial contracts but may shift to value-based reimbursement over time

Private Exchanges Will Break Apart Employee Populations, Leading to New Contracting and Strategic Considerations

Lives will be broken up across multiple carriers and networks, resulting in increased fragmentation of the market, risk of share and revenue loss.
Value / Risk Arrangements
A Wide Range of Reimbursement Alternatives

- Markets will likely offer a variety of choices based on payers, providers, costs, and sophistication
- Upon determination of the appropriate value-based model, specific skills and capabilities must be in place to produce optimal results

Notes: FFS = fee for service; P4P = pay for performance; PMPM = per member, per month; PQRS = Physician Quality and Reporting System.
Use of Contract Models by Provider Type

**Hospitals**
- FFS, MSDRG, Case Rates, Episodes, Per Diem, Ambulatory Payment Classifications (APC)

**Physicians**
- FFS, Capitation, P4P, Bonus, Withholds

**Ancillaries**
- FFS, Case Rates*, Bundled*
  (*Depending on position)

**Health Systems**
- Variable

**Physicians IPAs, PHOs, ACOs**
- Capitation, % Premium, Bonus, Case Rates
Moving Up the Risk Continuum Won’t Be Easy

• Many providers have not been successful in past pursuit of risk
• Provider networks and distribution of care are fragmented and inefficient
• Clinical outcomes are unmanaged; poorly performing providers are not held accountable
• Alignment of compensation with quality of care has not occurred
• Legacy costs and infrastructure do not align with the “new era” of healthcare change

Value-based contract success will depend heavily on physician leadership and participation. An alignment of all stakeholders will be required on a variety of levels.
Question

- What type(s) of value-based arrangements does your organization currently have?
  - Upside only – shared savings
  - Downside and upside risk / shared savings
  - Global payments under FFS
  - Partial capitation
  - Full capitation
  - Other
Strategic Options: Compete on Value or Compete on Price

• Anyone who doesn’t compete on value will have to compete on price and will contract through payers or other providers who will manage the risk

• Population health management will be a key factor for risk taking and success

• Not all payers will seek providers to manage risk; if payers delegate all risk management, they have effectively become a marketing and administrative services company

• The level of risk will evolve to match the market readiness
Strategic Options

• Understand that there are two basic strategies (will drive assessment approach):
  • Align with current payer models offered
  • Sell an alternative model to the payers
• Regardless of approach, the same basic exercises must occur!
Steps for Successful Risk Arrangements

- Assess and Prepare
- Financial Implications
- Operational Implications
- Legal and Human Capital
- Implementation Success Factors
- Ongoing Management, Tracking & Reporting
Assess and Prepare:
Key Questions to Ask / Answer

• What is our desired future position?
• What is our desired service area and what delivery system infrastructure, resources, and contracting scope are appropriate?
• What types of arrangements can / should we participate in?
• How much risk can we carry?
• What types of risk can we carry?
• What’s our plan for risk contracting?
Assess and Prepare: What’s Our Desired Future Position?

**Population Manager:** Large, regional provider organization that will be able to provide and/or contract for a full continuum of services across all levels of acuity; well positioned to manage full plan-to-plan risk and/or direct contracting.

**Population Co-Manager:** Regional provider organization, clinically integrated with other provider organizations that jointly, and/or equally, capitalize formation of value-based delivery systems (e.g., narrow networks); well positioned to participate in population and risk management, in delegated/direct fashion.

**Multiproduct Participant:** Provider organization that works within a network(s) managed by a population manager to provide a defined set of services in an efficient manner to serve a broad population base comprised of both government and private pay patients; critical role in future delivery system.

**Single Product Participant:** Provider organization that works within a network managed by a population manager to serve a specified and targeted service and/or population; these organizations will be critical components of narrow networks for specific plans/products.

**Contractor:** Smaller, less essential and/or niche provider, which may serve rural communities, provide population access points; not critical to future delivery systems and faces significant risk of commoditization.
Assess and Prepare: What’s Our Desired Service Area and Scope?

The right risk balance requires finding the appropriate population size – to what extent is population health management in your future?
Population Health Management – A Different Approach

A radically different and iterative approach to providing healthcare, and implies broadening the scope, environments, and capabilities in which healthcare organizations must operate to be successful in the role of a population health manager.

Identification: Who are the populations?
Those who are at risk of or who have chronic disease

Stratification: Where do they fall on the risk continuum?

Intervention: Opportunities and prioritization for early and continuous intervention
Assess and Prepare: What Types of Arrangements Should We Pursue?

Payment Mix Today

- Bundling (Episodic)
- FFS Shared Savings
- Capitation
- Traditional FFS

P4P: Varying levels of use in conjunction with fee-for-service

“Next Generation” P4P: ~60% of all payment systems

Payment Mix Under Reform and the Value-based Business Model

- Global + Episodic Bundling
- FFS Shared Savings
- Traditional FFS

Global + Episodic Bundling

“Next Generation” P4P: ~80% of all payment systems
Assess and Prepare: How Much Risk Can We Carry and What Types?

- Assess organizational capacity to carry risk
  - Strategic and operating risk
  - Actuarial or “insurance” risk
  - Financial / asset and liability risk
  - Comprehensive risk
Assess and Prepare: What Is Our Strategy and Contracting Plan?

Planning Is Essential

**Strategic Plan**
- Clearly defined strategy
- Short-term and long-term goals
- Defensive/offensive
- System and provider buy-in

**Tactical Plan**
- Service delivery - employed/contracted
- Geographic coverage and gaps
- Carved-in versus carved-out services
- Support services - current and future

**Financial Plan**
- Payer risk level (upstream)
- Provider risk tolerance (downstream)
- Reserves, stop loss, risk limits, corridors
- Impact on current and future revenue
Financial Consideration

- A clear understanding of capital resources and requirements along with timely unit cost and volume tracking are critical to long-term success

**Capital Requirements**
- Financial reserves
- Regulatory reserves
- Access to capital
- Implications for reporting

**Unit Costing and Tracking**
- Inpatient and outpatient
- Hospital and community services
- Baseline, ongoing unit cost and volume
- Timely unit costing and tracking critical to response to high-cost and outlier activity

**Actuarial Assessment & Planning**
- Risk versus panel size
- Not all panels are the same – employees first may not be the best course
- Analysis of up/down stream reimbursement necessary
- Benefit design
- Stop loss / reinsurance
- Pricing must be competitive for long-term success
Operational Considerations

- New skills and capabilities will most likely be needed to succeed with value-based reimbursement arrangements

**Contracting**
- Current contracting resources may not be sufficient
- Existing and new payer relationships are critical
- Administration of value-based contracts will take additional skills and capabilities
- Who does what – Division of Financial Responsibilities (“DOFR”)

**Governance**
- Program management and administration
- Downstream provider management (physicians, hospitals, ancillaries, owned-vs-subcontracted
- Clear delineation of roles and responsibilities across all stakeholders

**Data Infrastructure, IT and Billing**
- Bidirectional (payer/provider) data flow necessary
- Business intelligence capabilities and reporting requirements
- Billing and coding - consistency and timeliness
- Accreditation, permits and licensing (what, when and how)
Additional Considerations

• Value-based arrangements will most likely be complex and challenging, requiring significant upfront investments and analysis prior to entering

Legal

• Does acceptance of risk contradict your charitable cause?
• Physician incentive plan regulations related to risk
• State and Federal regulatory considerations, such as anti-kickback statutes and Stark laws
• Legal entity structure and risk mitigation

Human Capital

• Existing staff expertise and availability
• New skills acquisition and dedicated staff/ resources

Pre-Contracting Investments

• Comprehensive gap analysis and corresponding business and capital plan development
Implementation Success Factors

- Clear delineation of risk and responsibly across all stakeholders, supported with timely and accurate data flow are necessary

**Physician Engagement**
- Aligned incentives
- Investment in primary care
- Physician leadership in redesigning the delivery system to meet value objectives

**Transparency and Accountability**
- Well-defined process for clearly delineating and communicating responsibilities
- Transparency of quality and pricing data

**Performance Measurement and Reporting**
- Data collection, ownership, flow, timing, analysis, communication and response
- Clear policies and procedures for risk and performance measurement and management
“Minding the Gap” During the Transition

“When 30 percent of your business is in a non-fee-for-service model, your structure starts to change.”

*Stephen M. Shortell, Ph.D., M.P.H.*

- How quickly should we move to value / risk-based contracts?
  - If you haven’t already started, start now
  - Speed of change will vary by market
  - Expect margins to decline in the short term
- Quantify the organization’s path using robust financial planning
  - Credit position, capital position, capital requirements, debt capacity, minimum cash position
  - Baseline financial projections, layering on scenario analyses for key variables related to value contracts, for example:
    - Expenses related to primary care or physician alignment
    - Restructuring of payment arrangements
- Revisit the projections regularly
ABC Health System Assumptions – “Risk Profile”

Volumes
- IP volume declines FY14-15: 2.3%, FY16-17: 1.6%
- OP weighted average annual growth of .8%

Reimbursement – Medicare
- Annual inflation averages 1.1%

Reimbursement – Medicaid
- Annual inflation averages -2%

Reimbursement - Commercial Payers
- +3-+5% annual growth

Salary Expense
- Grown at +3.0% annually

Non-Salary Expenses
- Grown at an average of ~+3.0% annually

Capital Spending
- $751M over 5-years

Investment Income
- +4.0% annual return
Sensitivity Analysis:
Impact of Key Variables on Projected FY2017\(^{(A)}\) Results

**FY2017 Days Cash on Hand:**
- FY17 Final Plan: 179.5
- 1% Lower Annual Medicaid Increase: 177.6
- 1% Lower Annual Commercial Increase: 164.5
- Salary Inflation Remains at 3%: 144.5
- Flat Market Share: 137.6
- 50% Planned Capital Spending: 214.0

Note\(^{(A)}\): All sensitivities are calculated independent of each other.
Achieving Success in Managing Risk Takes Time

- Initial start-up investments will likely be significant
- Behavior change and experience will take time
- Efficiencies will not be immediate
- Organizations must be prepared to sustain initial losses for three to five years

![Graph showing revenue and expenses over different years](image)
Concluding Comments

• The healthcare marketplace is experiencing dramatic change
• A paradigm shift is occurring in the payer space
• Every stakeholder will be impacted
• Providers must respond proactively to meet the challenges of a changing market
• Competing on value will be required
• Preparing for value-/risk-based contracts will require planning, new skills, and a different and possibly phased approach
• Physician involvement and leadership will be an essential component
Andrew Cohen, Vice President

Andrew Cohen is a Vice President at Kaufman Hall and a member of the firm’s Strategy practice. He provides strategic planning advisory services for a wide range of clients, including healthcare systems, academic medical centers, and community hospitals. Mr. Cohen’s responsibilities focus on value-based contracting, payer relations, market and product development, growth strategy, population-driven demand, and physician and hospital/health system integration.

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