Revenue Risk Management Group

RISK-BASED CONTRACTING FRAMEWORK

Entering into a risk-based model [although taking what the payer offers is certainly a form of risk!] isn't as simple as taking what the payer offers. There is a best balance answer for medical groups to maximize revenue while delivering efficient, high-quality care. Finding that balance and reaping measurable value from it requires changing the organization's approach to Business and Clinical Processes, Skillsets, and Analytics in order to be successful. Achieving that value is probable when done with the right framework and approach. The purpose of this whitepaper is to provide medical groups with a checklist for the skills, analyses, and data structures needed at different phases of the contracting lifecycle.

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CONTEXT / UTILITY

During the 1990s, CMS experimented with simple capitation-based reimbursement models for primary care physicians, primarily under Medicaid statutes. During that period, many (perhaps most) providers experienced financial hardship, unless practices implemented systems and processes designed to change the manner in which they delivered care.

Today's models are far more sophisticated than the 1990-style primary care capitation. Provider-level systems and staffing will seldom match the predictive and management capabilities of CMS and other large payers. A payer's goal with a new contract is seldom to put more money into a doctor's pocket. Government and commercial payers are increasingly shifting to risk-based models that reduce fee-for-service reimbursement in exchange for additional, non-visit-based payments. Overall momentum has been established with ACOs, CPC+, Medicare Advantage, and a variety of commercial payer variations. Providers commonly enter into risk-based contracts either directly with a payer or indirectly by joining an ACO. While the concept of non-visit payments may seem appealing, each of these models are built with the goal of reducing overall healthcare costs.

Because risk-based contracts between providers and payers can vary considerably, there is value in defining a common set of terms and concepts that can facilitate sophisticated discussion and analysis of risk-based contracts. Relevant concepts include:

1. **Lifecycle of risk-based contracting** that will aid in planning the timing and deploying of specific skills, analyses, data structures and organization structures.
2. **The components** that define risk-based contracts.
3. **The skillsets** necessary to plan, negotiate and execute.
4. **Business analyses and reports** associated with each contractual variable, at each stage.
5. **Data structures** needed to drive new analyses.
6. **Practice structure** - provider groups may need to analyze their internal delivery capacity, internal compensation philsopy and structure, specialty coverage and referral patterns to determine the effect of a risk-based contract.

The purpose of this whitepaper is to define these concepts for physicians as a preface to outlining future in-depth analyses. The management of active contracts, and negotiation of new agreements in this document are all from the perspective of a physician group. See Appendix A for information on the collection of whitepapers we are considering for elaboration on future topics as follow up to this whitepaper.

LIFECYCLE OF RISK-BASED CONTRACTING

Each component of our material (elements of contracts, analytical processes, skillsets and data constructs, and even practice structure) may vary in usage or level of involvement, depending on lifecycle stage for a given contract. In the following lifecycle framework, we differentiate between lifecycle scenarios, under each of which unique analytical activities and tools will be applicable:

1. **Creation of a pre-emptive strategy for risk-based contracting** – even before the first contract is presented, clinic administrators should formally contemplate their payer environment, and document guidelines for reacting to a move by payers away from fee-for-service. The strategy will differ based on objectives:

    a. Offensively seeking to acquire new patients

    b. Defensively seeking to protect existing patients as other providers move into attribution-based agreements

    c. Basic regulatory compliance (including antitrust compliance)

Depending on those objectives, a clinic will evaluate investments, network expansion, or staffing changes, as well as assess what data is readily available to support contractual decisions. Strategies may evaluate whether to seek out and pursue new, risk-based payer contracts, or simply respond to contract opportunities as presented by commercial or governmental payers. Funding and sharing of downside risk should be an element of any plan, including gaining an understanding of how non-member providers within the same geographic market can impact the "network's" performance.

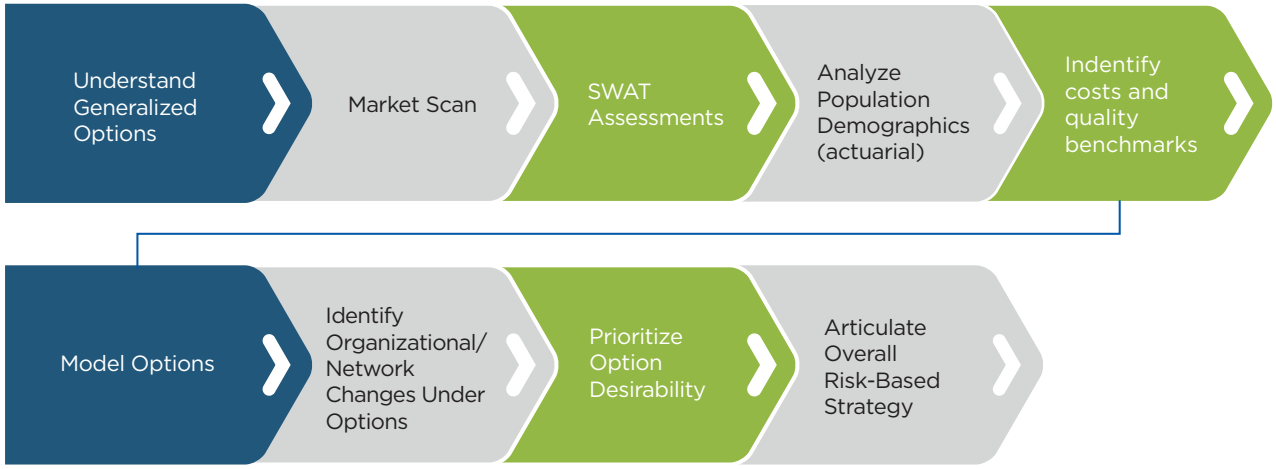
The primary input to a strategy is a market scan, both locally and nationally into what payers and options exist (after all, a clinic can't create one out of thin air). Then, given an understanding on market forces, a clinic strategy should articulate the techniques targeted to make more money (via more patients and/or more profitable patients).

2. **Contract negotiations** – The selection of analyses and data structures to deploy will be driven by a payer's proposal for components of a risk-based arrangement, and the variables associated with each. Having a pre-emptive strategy and legal check list will shorten the contract negotiation cycle, and improve the resulting agreement.

3. **Ongoing Operations** – A new contract will probably incur new costs (both startup and ongoing), and should be envisioned in separate states for implementation and steady state. Early phase activity could include clinical and operational organizational change, implementation of new systems, and personnel training. Post-implementation, a risk management team should engage clinical and operational leadership to drive decisions based on contractual performance.

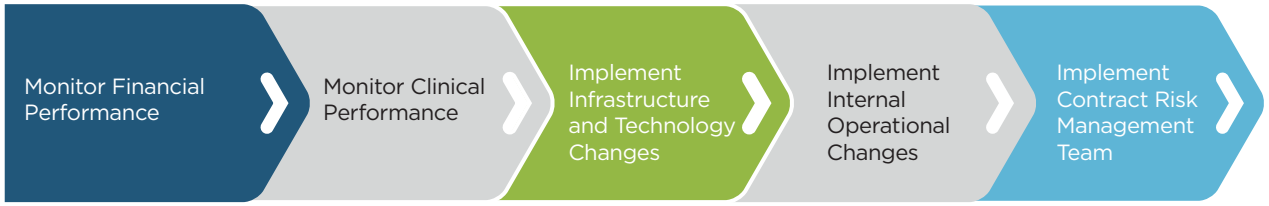
4. **Renewal decisions** – In the renewal cycle, we anticipate decisions to "stay the course", advance to more aggressive risk arrangements, or exit the contracts altogether.

CREATION OF A PRE-EMPTIVE STRATEGY

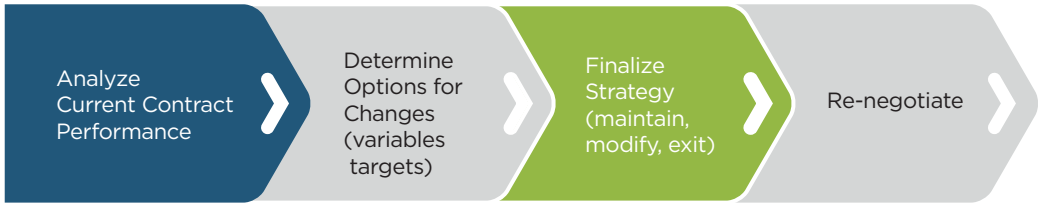


CONTRACT NEGOTIATIONS

ONGOING OPERATIONS



RENEWAL DECISIONS



COMPONENTS OF RISK-BASED CONTRACTING

Because contracts between payer and provider can vary quite a bit, our framework identifies a series of contractual elements. Risk factors are defined differently for different types of contracts. Our definition of risk includes any contract with one or more of the following elements:

1. **Fee-for-service (FFS) modifications:** Entering into a risk-based contract doesn't mean the FFS goes away. The amount of downside risk taken is a function of the balance you placed between FFS (i.e., something close to guaranteed allowable amount) vs. alternative reimbursements. Reducing, eliminating, or even increasing the reimbursement associated with specific CPT codes (i.e., HCC coding or managing E&M improvement) is almost by definition the foundational element of provider risk. Cannibalization effect / Fee reductions tied to other payments / FFS can be risky if contracts drive utilization down far enough. Movement to DRG or Ambulatory Payment Classifications (APC) can also introduces risk in fee for service arrangements.

2. **Capitation and Attribution:** Per beneficiary per month (PBPM) as a component of overall reimbursement, deternining which beneficiaries for which a PBPM payment received is a function of attribution. Attribution is typically based on some method by which the payer determines which primary care provider bears responsibility for, and receives compensation for, which beneficiaries. Patient-level risk, as quantified under HCC guidelines, has become an integral part of basic Medicare reimbursement, and forms one (but not the only) method for adjusting reimbursement at both capitated and fee-for-service levels.

3. **Quality and Operational Adjustments:** There is a fair amount of variety in how quality bonuses are configured across contracts. We define "Quality Adjustments" as reimbursement tied to achievement of (or improvement in) a series of Clinical Quality Measures (CQMs), or other operational metrics such as ER, or SNF usage, or readmission rates. This reimbursement can take the form of either adjustments to the Fee Schedule, or lump-sum payments based on CQM scores, or even formulae defining sharing of deficit and surplus pools.

   Under risk-based contracting, quality measurement can no longer be an end-of-year process and must migrate to a real-time population health discipline. When quality scores directly impact reimbursement, providers need to manage quality reporting from two perspectives. First, do our tools accurately and adequately capture clinical events as a natural by-product of documenting the medical record? Second, does our population health discipline identify actions and interventions that will continuously improve those quality scores most relevant to our practice?

4. **Total Cost of Care (TCC):** For purposes of this document, we define TCC as the cost of all healthcare services rendered to a population of patients / beneficiaries from within and outside the domain of the contracting provider group.

5. **Bundled Payments:** Analogous to modified FFS / capitation with its own version of episode/awardee-based version of attribution, except that it usually includes all care provided by **all** providers for the entire episode of care.

SKILL SETS INVOLVED IN MANAGING RISK-BASED CONTRACTS

Medical groups have experience with these skills in differing capacities and sourcing options. Later in this whitepaper, we'll explore the role these skillsets play in the business processes involved in successful implementation of a risk-based contract.

Skillset	Description
Financial	Forecast and assess financial performance and risks under a contract
Executive Management	Big rock decisions
Clinical Management	Analysis and decisions on clinical workflows, tied to quality measures; analysis and management of referral patterns; implementation of evidence-based practices (cost and quality)
Analytics	Transform data into actionable information
Actuarial	Contrast current state against modeled alternatives
Legal	Beyond contracting, counsel on the right contract type and configuration
Training	Educate the organization on how to actualize contract-instigated change
PI/QI	Process and Quality Improvement – measure baseline, identify change, create change plan, measure progress against baseline

BUSINESS ANALYSES INVOLVED IN MANAGING RISK-BASED CONTRACTS

Some of these analyses exist as a standard form of operations for medical groups, and others will be new. We align these analyses into our components of risk-based contracting, and risk management life cycle, to help focus on any given contract, based on its unique characteristics. The elements active an any given contract will determine which processes pertain to a specific risk-based model.

1. FFS modifications

a. Comparison of FFS vs risk contract for a population of patients
b. Improvement in reimbursement due to HCC coding
c. Changes to allowed amount due to contract
d. Patient write-off / charge off under contract

2. Capitation and Attribution

a. Plan and analyze financial reserve position
b. Attribution - getting what we should / were promised
c. Attribution - are we getting inappropriate patients (adverse selection)
d. Analyze attribution retention (add / change / delete)
e. Analyze capitation amount tied to contract variables (primary / specialty)
f. Point to areas where someone else will improve clinical activity
g. Analysis of reinsurance needs and triggers
h. Identifying, measuring and managing leakage

3. Quality and Operational Adjustments

a. Identify Clinical Quality Measurers (CQM) changes that would benefit from implementation of evidence-based guidelines and EHR workflow design
b. Measure impact in Total Cost of Care (TCC) of changes in protocol compliance (i.e., CQM improvement over time)
c. Analysis of “non-patient” beneficiaries under capitation
d. Which specific CQMs will have the most relevant impact?
e. Reconcile up-front payment with true-up

BUSINESS ANALYSES INVOLVED IN MANAGING RISK-BASED CONTRACTS

4. Total Cost of Care (TCC)

a. How do our costs compare (full scope) to actuarial model?

b. How have changes we made impacted TCC over time?

c. Cannibalization assessment.

5. Practice Demographics

a. Analysis of referrals and TCC.

b. Coordination of care analysis.

c. Analysis of specialty referral leakage.

6. Bundled Payments

a. Determine episode / awardee expectations.

b. Determine scope of services included, and evaluate participation by other providers.

c. Measurement and management of post-acute care.

d. Comparison of current vs bundled activities.

e. Measure efficacy and optimize configurations.

f. Probably specialty rather than primary care.

7. Contract types

a. Which contract variables are most / least attractive to our physician / beneficiary mix?

b. Create operational and financial metrics against which to measure performance.

i. Create benchmarks, change targets.

ii. Contract = strategy to realize change.

c. Create rubric for periodic meetings to determine contract compliance to vet necessary modifications, or to invoke early termination provisions if necessary.

8. Actuarial assessment

a. How do overall costs compare to model? (within our scope)

b. How does utilization (CPT/ICD) of our population measure against actuarial standard?

c. How does our cost profile measure against actuarial standard for each utilization category?

DATA STRUCTURES

We believe that risk-based contracting will require data beyond what is managed in most EHR and Practice Management software. Even sophisticated providers who invest in leading-edge population health software, or advanced HCC coding tools, could find gaps in analytical capabilities, based on features in a specific risk-based payer contract.

New data structures in support of a comprehensive set of analytical use cases are likely to include Actuarial benchmarks, Total Cost of Care (from outside the contracting organization), and Capitation / Attribution content from payers.

Even for data traditionally offered within EHR / Practice Management, new analyses are likely to require that data be structured in ways unique to the needs of a specific risk-based contract. Based on the volume and sources of data, and the complexity of the mathematics, these analyses will frequently exceed the capabilities of spreadsheet-based methods with the volume of data, as well as with complexity of relationships between data aggregates.

PRACTICE STRUCTURE

While we present no model as part of this discussion, we believe that the administrative and clinical organization and capacity of a clinic will differ in risk-based contracting (as opposed to pure fee-for-service arrangements). Clinics will likely migrate to increasingly integrated models involving cohesion between hospitals, private practice, specialists, tertiary care, long term care, or therapists, specifically around high value care episodes. Another model of care might include Patient Centered Medical Home (PCMH), where the primary care provider is the hub of clinical care. While these models may be informal cross-organizational care management teams, additional contractual structures, such as ACO membership, is also likely to create opportunities for cost sharing in the infrastructure that will facilitate communication across entities.

Managing Total Cost of Care, for example, requires extensive transitional care and data sharing across unrelated providers to provide seamless patient care. Data exchanges will require sharing of clinical, cost, and care plan information. Defining primary care providers as a clinical and information hub will necessitate not only information exchange, but information sharing strategies and agreements that enable financial and clinical analyses of individual patients, and patient populations.

Successful organizations will be those that can successfully make and sustain changes in their organization. Success will also require a continuous learning culture, one that consistently makes changes to improve care and studies how these changes impact clinical and financial outcomes. Many organizations make a commitment to formalized change management practices, stepping up to “Lean”, Six Sigma, or other formal methodologies, as well as communicating executive and clinical leadership messages that initiate and sustain a culture of change.

NEXT STEPS

A. Configure the risk-based approach for your clinic. We have created useful online matrices to help clinics actualize the concepts identified in this paper. The matrices align required skills, processes and data tools with contract features and risk management life cycle.
   To access these matrices, visit our association website at:
   https://revenueriskmanagementgroup.com/contract-configurator

B. Subscribe to future publications. Those communications will provide you with increased granularity and work instructions for taking action. Potential future publications:

   1. Creating a risk-based contract strategy
   2. Legal checklist for risk-based contracting
   3. Actuarial checklist for risk-based contracting
   4. Practice transformation under risk contracting
   5. Deep dive on technologies and data for risk-based contracting success
   6. Deep dive on skillsets: org model options and process triggers
   7. Deep dive on specific risk-based analyses
   8. Coordination of care across independent organizations
   9. Risk-based coverage under an ACO
   10. Hospital / inpatient risk-based contracting

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