So, you think you're ready for risk…

There is little doubt that the healthcare payer environment is slowly moving toward risk. While this is certainly episodic and regional, there is clearly a push toward more accountability at the provider level. This includes the potential of new bundling pilots coming out in 2019, the new ACO rules limiting the time that an ACO can "squat" on "upside only" risk, and the push toward Medicare advantage.

Certainly, it is easy to get attracted by the large upside financial and emotional value of accepting risk. You are now in charge, but also accountable. Let's not forget the lessons of the 90's where many groups lost millions of dollars in jumping into what is still a very difficult process. It is easy to look at insurance companies, see their profits, and be tempted on how easy it looks. It is not. Understanding provider risk and actuarial risk is complex and challenging.

The biggest change that has made accepting risk viable now is the better understanding and availability of data and information. Another factor contributing on both sides of being successful with risk is the advent of new technologies. On one hand new technologies help us share information, help patients get needed information (smart phones, wearables) and help deliver more efficient care. On the other hand, these new innovations are extremely expensive in many cases and are driving the cost curve exponentially and in the case of disruptive technologies, unpredictably. So, let's start with data.

I would arbitrarily divide the successful solutions to accepting risk into three categories. These include data, culture, and infrastructure.

Clearly, the most important aspect of being successful in managing risk is having access to data and being able turn it into actionable information. This includes administrative and claims data, EMR level data from the physician's practice, and hospital EMR data. From each of these different sources a different snapshot is obtained. It is also important to get this information as real-time as possible knowing that claims run out will always be a challenge. Even after getting this data, it is important that there be strong analytics and reporting with clear transparency and a communication plan that gets this information to the appropriate stakeholders. This would include getting financial, utilization, clinical, and patient experience information to the appropriate sources including leadership and practicing physicians. This also includes understanding patient flow and having a good grasp on leakage out of the system (or keepage in the system).

The second aspect is making sure the culture is correct. This includes a culture of engaged physicians, clear transparency, and aligned partnerships. There must be a strong governance structure with associated committees to lead change. There should be a quality and patient centric focus and a willingness to have the difficult discussions that will align individuals and resources. There must be a commitment to use high-quality/efficient physician specialists and primary care. Difficult decisions will sometimes have to be made. Aligned incentives cannot be overstated. Incentives and alignment must trickle down to all areas of the organization including at the point of care. I watched many systems fail when they accepted capitation at the group level but paid the physician's fee-for-service on the delivery side. The model needs to be transparent and aligned to be successful, and the culture must support this.

Infrastructure is the last item needed to be successful. This is clearly a catchall category that includes many separate items. This includes the above-noted governance and committees, data sharing policies and profiles but adds to it the care management processes from the patient's perspective, the physician's point of view and procedure/location of service.

Most successful managed-care plans have traditionally focused on the hospital setting. Since this is the most expensive care, it has always garnered the most attention. This includes focusing on admission and/or length of stay, depending on the payment model. If the hospital is paid by DRG or case rates, then focusing on precertification and an aggressive hospitalist ER program and other processes will help control the admission process. There can also be an outpatient focus on high hospital utilizers, high ER utilizers and ambulatory sensitive medical conditions. In a per diem world, the focus is on length of stay including early discharge, transitions of care, and home health/SNF utilization. The use of hospitalists

and SNF's is also crucial. In the same context is the challenge of readmissions and an understanding and linkage with post-acute care.

Other areas under this location of service are the issues of managing out-of-network and out of area costs. These, as well as transplant patients, are always a focus.

Specific procedures and resource use cases will also need to be tracked and trended. This includes things such as high-end radiology, i.e. CTs and MRIs, specialty pharmacy usage including oncology drugs, and a focus on special high usage surgeries through a pre-authorization process. There are certain surgical procedures that have very high variation in the care process and these need to be focused on as well. I would be remiss if I didn't also mention the large opportunity with end-of-life care and the effectiveness of an efficient use of palliative care.

An additional approach to controlling costs and improving quality is with a patient focused approach. This includes case or care management for highly complex patients that need assistance in navigating through our difficult healthcare system. There is also a place for navigators in areas such as oncology. It has been shown in some of the literature that simply concentrating on these high-risk patients is not adequate. It is imperative that you identify the "rising risk" patients as well. These are the patients that may not have high expenditures of healthcare but are at high risk because of their underlying healthcare factors. Working with these patients can significantly mitigate high-risk events and improve quality for these patients.

Also, in this category is looking at some of the social determinants of health. This is a relatively new area, although things such as weight control and smoking cessation have been around for a while. Focusing on environmental factors and behavioral factors can have significant downstream benefit to the patient and the healthcare system.

It is also important that you share information with physicians that includes appropriate profiling data which is clear and concise and helps them provide better and more efficient care to their patient. This may include the appropriate use of wellness visits (especially important for Medicare advantage and Medicare ACO's). Appropriate coding both at the CPT and ICD 10 level is also important to capture the right billing as well as the correct illness burden of the patient population.

You must also make sure that the access to primary care and specialists in your panel is correct and that you thought about the attribution process (if there is one).

While the above is only a quick snapshot, it does lay bare some of the complexities of understanding and managing risk. Remembering some of the failures of the past and how expensive these failures can be being important. On the other hand, with the right infrastructure and risk understanding this can be a

highly successful model and take much of the waste out of the healthcare system while structuring the reimbursement model to support providing the right care, at the right place, to the right patient, in the right way.