ROUNDTABLE

# Provider Strategies for Risk-Based Contracting

Despite—or perhaps because of—the uncertain timing of the shift from fee-for-service to value-based payment, most healthcare providers are eager to prepare for risk-based reimbursement. They are trying different arrangements with and without payers. But providers are leery of taking on higher levels of risk exposure, such as shared profit and loss with insurers or opening their own payer business units. The mixed results of early ACOs are worrisome, and providers fear drawing the competitive ire of big payers. This report includes how providers are determining the right level of risk, redesigning care to deliver value, and using data to support risk-based contracting.

## PANELIST PROFILES

**MICHAEL BROWNING**
Executive vice president and CFO, WakeMed, Raleigh, North Carolina

**ANDREW DEVOE**
Senior vice president and CFO, Aria Health System, Philadelphia

**TOM LOWRY**
Vice president of finance and physician integration, Dignity Health, San Francisco

**KERRI SCHROEDER**
National credit products executive, Bank of America Merrill Lynch Specialized Industries Group, Seattle

**CHRISTOPHER CHENEY (MODERATOR)**
Senior finance editor, HealthLeaders Media, Danvers, Massachusetts



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# Roundtable Highlights

**HEALTHLEADERS:** *What are the main factors that healthcare providers should account for when assessing financial exposure to risk associated with delivery of medical services?*

**ANDREW DEVOE:** The largest factor is making sure you have the population to do it. So it's all about the population that you're inheriting. If you're taking the inner-city population, and it's a Medicaid population, then that's quite a different exposure than it is for a community-based system that has different demographics. Then you've just got to have the right number. You don't want to take risk on 500 lives.

**HEALTHLEADERS:** *Is there a minimum critical mass?*

**DEVOE:** If you're in some type of risk model where you're only seeing the upside, or you're doing bundled payments, or you're doing Medicare Shared Savings, you're not doing anything downside, then why not take 500 lives or 200 lives or whatever you can get?

**TOM LOWRY:** The ability to measure what you're doing financially and statistically—that's critical. Do you have the systems? Do you have the talent to do a good job of measuring where you are in the baseline and what it's going to take to move the needle?

The second factor in this is management. Do you really have management that's going to be committed to actually moving the needle? As finance guys will tell you, we can push out metrics all day long, but if we don't have managers who can actually manage those numbers, it's nothing but frustration and, ultimately, potential failure.

**MICHAEL BROWNING:** For us, the most important part is physician engagement and ownership because physicians drive so much of how we deliver care. It's really physician commitment and how we can assist them in this area. Financially, we typically do it through incentives, but it helps to get them engaged if they can share the risk. Once engaged, you have to support their commitment with good data.

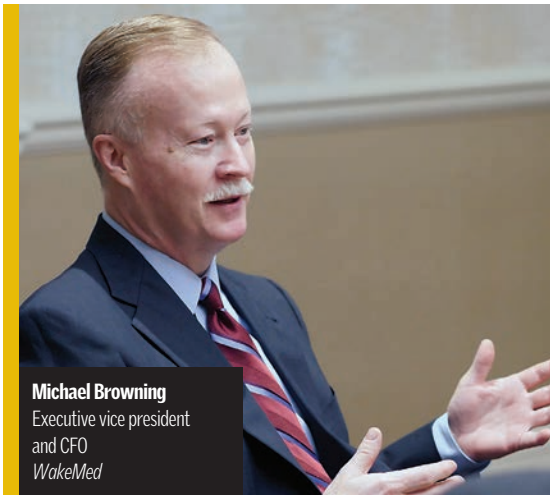
**HEALTHLEADERS:** *What are the main challenges of assessing risk?*

**BROWNING:** We're running into an issue with the Medicare Next Generation ACO product with changing populations. We had 39,000 lives that were in our Medicare Shared Savings Program product, and now that's been trimmed down to 22,000 for Next Gen. The challenge is patients are moving around—they're passing away or switching to a Medicare Advantage plan. You are trying to identify that population, then assess whether you want to take risk.

**KERRI SCHROEDER:** One of the biggest challenges is the asymmetry of data. The payers have a lot of data about utilization and claims patterns that providers don't have equal access to. A second challenge is making sure that you've got all of the services in-house or the right partnerships established to provide all the services that a patient population needs and prevent leakage out of the system. If you can't control the leakage, it is very difficult to control costs under a population health model.

> **"For us, the most important part is physician engagement** and ownership because physicians drive so much of how we deliver care."

**BROWNING:** We see the payers being vastly different, where one of the largest payers in North Carolina has trouble getting timely and accurate data. Another national payer that's in our market gets you things right away. They really know what they are doing, and how they are doing it. The payers are extremely important with how they can get the data to you the right way, but it's all over the board.



**Michael Browning**
Executive vice president and CFO
*WakeMed*

**HEALTHLEADERS:** *When taking on risk, how do you manage shifts in the patient population?*

**BROWNING:** The insurance companies have a lot of data. They are able to do a better job with managing it, but they are not always open to sharing the data. At this point, there is not a really good answer to how you manage the people who are changing plans.

**LOWRY:** In the capitation world, essentially what we get every month is a file that tells us who our members are and which primary care physicians they're enrolled with. So we have a good grasp of who the population is, whether it's Medicare Advantage or commercial capitation through HMOs or whether it's even Medicaid capitation.

That's the capitated population. Flip over to Dignity Health in Arizona, where it's in an ACO, and it's got all the problems with trying to track the population, and who's in and who's out, especially in markets where the patient can move.

**HEALTHLEADERS:** *Are there ways to be tighter partners with your commercial payers and get the data you need to track patients more effectively?*

**DEVOE:** Generally speaking, we have a very good relationship with our largest payer in the market. We get all of the data that we need. ... It's more difficult with some of the other payers that are nationally based.

**LOWRY:** In California, you're going to have to separate the HMO industry, both Medicare Advantage and commercial, and Medicaid for that matter, from the PPO industry. It's actually two different agencies that manage those in California. There's the Department of Managed Health Care that manages the HMO business and the Department of Insurance for everything else. On the HMO side, data sharing is very good, largely driven by the pay-for-performance program. Flip it over to the PPO business, and we're right where everybody else is: trying to get the data out of the payers. They want to cooperate, but it's still a relatively new game and we're nowhere near where we are with the HMO business.

**Andrew DeVoe**
Senior vice president and CFO
*Aria Health System*

**SCHROEDER:** The lines have become increasingly blurred between payers and providers. We have providers creating their own health plans that compete with the payers, or establishing direct-to-employer plans that take the payers out of the middle. Shared savings plans are beginning to incent much more collaboration between the two. The evolution of it is all over the map. I have heard many CFOs say that they would like to take more risk. They want to receive risk-based payments, but it's been difficult to get there. The reality is, insurers are as addicted to fee-for-service as the providers have been.

> "... somewhere between 2% and 5% of the population is going to make up **70% to 80% of the total cost of care."**

**BROWNING:** We all set our healthcare delivery systems up as ways to provide patients access to care. At WakeMed, we have six ERs in Wake County—three with hospitals and three freestanding. We all know ERs are one of the most expensive places you can get primary care, but that was a model that was established years ago. The payers are now asking, "Do you change those to urgent care? What are you going to do to lower the cost?"

The three ERs that are affiliated with hospitals won't change, but what about the other three ERs? We treat 260,000 ER patients per year. I do not believe that providing low-acuity primary care in the ER is the best use of these resources, especially in the value world. So we will likely need to change our delivery model, which will hopefully build trust with the payers. And over time, as we build that trust, hopefully they will do the same with us and we will develop a more collaborative relationship.

**HEALTHLEADERS:** *What is the role of data analytics in assessing the risk associated with medical services? How are your organizations using data analytics to help manage risk-based contracts?*

**BROWNING:** We're starting something pretty cool. One of our physicians coined this the "rack and stack." We have good Medicare data that we have received, and our analytics team organizes the information. They "rack" the data, and they "stack" the physicians based upon performance.

Our physicians made the decision not to blind the data for each practice. They want to show each group how they are doing as compared to each other. Then, within each group, they open it up so that each group can see how each physician in that group compares on quality and cost. This was a huge step forward for our organization. Our physicians are saying, "We all want to know how each other is doing, because if we are going to be at risk for this population, then we need to manage it."

**DEVOE:** Depending on who you talk to, somewhere between 2% and 5% of the population is going to make up 70% to 80% of the total cost of care. Using data analytics is really to drill down into who are those 2% to 5% consuming all of the vast majority of those expenses. We've used the data to identify that 2% to 5%.

**LOWRY:** You really need to find out where you're going to spend your money and start tracking that. Medicare Advantage makes it easy because you've got the [Hierarchical Condition Category] coding—hierarchical conditions that pay you more under a Medicare Advantage plan. Then you have your overall [Risk Adjustment Factor] score. That causes you to go

out and identify those patients. The better you are at capturing that diagnostic data, the more the Medicare Advantage plan is going to get paid, and if you're getting a percentage of that dollar, then you're going to get paid more.

Bundled payments is a whole new learning curve. Bundled payment is a whole new game because we don't have the same data access that we have with the capitated population, where we pay the claims.

**SCHROEDER:** Most of our clients are looking for ways to identify those high-fliers who are going to be the most costly patients in the system, to identify them early and try to get them into a lower-cost intervention before they arrive at the acute care setting.

With bundled payments, thinking about the postacute care also becomes really important. Many providers are working to identify those postacute providers that have the best outcomes and are successful in accelerating recoveries and keeping patients out of the hospital.

**BROWNING:** As you think about the payer arrangements, if we start taking on risk, there is going to be an incentive to move patients into an environment that's lower cost. The next 5 to 10 years will be significant for organizations in smaller communities. I don't think the hospital will go away, but there may be more outpatient centers. We've seen at least one hospital in our area close because there wasn't enough volume to support it.

## Risk-based contracting helping drive care redesign

**HEALTHLEADERS:** *How are risk-based contracts changing the way care is designed and delivered?*

**LOWRY:** We have 26 hospitals in 38 of the 48 possible Medicare bundles. Now we have five more hospitals that are going to be in [the Comprehensive Care for Joint Replacement (CJR) model]. So we're looking at a lot of data. Most hospitals have not been looking at longitudinal data 90 days post-discharge to see what's happening in that period to their Medicare fee-for-service patients.

So bundles are a whole new ballgame that we're being pushed into in terms of care redesign and managing those patients in a way that we haven't before. It's quite a learning curve. I won't pick any specific hospital, but you can see that for some bundles, the readmit rate within 90 days is over 50%. They're just coming back and back and back. It's frankly financially lucrative for the hospital. There's the 30-day readmit penalty, but that's relatively small. The fact is you're going to basically drive down your own revenue stream by managing that readmit rate down.

**DEVOE:** The documentation, especially in the primary care practices, can drive the top line, which is the premium dollar coming into the practice. So the better you document, the more comorbidities that you document, the more frequently you see patients in the primary care office, and the more mammograms and preventive screenings you do, all of those things help drive additional revenue into the premium. That's a direct result of this risk-based contracting. You've got to do other things to drive more top-line revenue.

**SCHROEDER:** The reduction in revenue is coming regardless, isn't it? There's so much movement to reduce payment for readmissions that you have to be focused on that. It's not a matter of just simply choosing not to bill for it. One of the things that I hear consistently is if you're going to accept risk-based payments, one of the first things you have to do is reduce

**Tom Lowry**
Vice president
*Dignity Health*

variation in terms of care protocols, cost per physician, and cost per facility. Getting to that level of cost analysis has proven to be really difficult.

**DEVOE:** Doctors are very smart people, probably the smartest people on Earth, and if you can create incentives and compensation in a way that gets you the outcomes you want, they'll do it. Once they figure it out, they can manage it the right way; then you've got some of the brightest people helping you manage the care. It's how you create those models, and each model's a little bit different.

> "You just have to be able to **feed them good data,** and data integrity is everything."

**LOWRY:** You just have to be able to feed them good data, and data integrity is everything. The first time you have to go back and say, "Oops, we made a big mistake with this report or this analysis," your credibility starts to go down. But to the extent that you can build trust and feed them data, they'll manage the metrics that you give them, whether it's patient satisfaction or virtually anything else. ... No physician wants to be an outlier.

**HEALTHLEADERS:** *How do you harness physician leadership to help put risk-based contracts into place?*

**DEVOE:** What we know is that physicians are scientists. They're very factually based, and if you put the data in front of them, then it's amazing how they usually will follow the data. So you show them the data, then you give them the right incentive, whether it be positive or negative. I think it needs to be both. It can't just be upside. You've got to suffer some repercussions if you don't do what you need to do.

**HEALTHLEADERS:** *What level of your business is presently tied to risk-bearing contracts, and where do you see that moving in three to five years?*

**LOWRY:** It varies market to market, whether we're a fully integrated delivery system in a market or whether we're just a hospital company. But I think all of us are basically in the same boat, in the sense that we all look down the road and see that our reimbursement rates are not going to rise at the rate of our costs. So if we don't have a better scheme for how we're going to manage cost of care within the reimbursement that's available to us, that's where we're going to be put in an untenable situation.

**Kerri Schroeder**
National credit products executive
*Bank of America Merrill Lynch*

For Dignity Health as a whole, exposure to risk is still relatively low. In markets like Sacramento or Phoenix, where there's severe competition that's driving us, we're probably at 50% in risk right now.

**DEVOE:** We probably have about 65,000 lives that we are, in some form or fashion, taking some degree of risk. Maybe it's upside. Maybe it's whole. Maybe it's because we own part of the health plan, so we share in the profitability. Our Medicare Advantage business now outpaces our Medicare fee-for-service business. So if you look at all that, then you're talking 40% or so of our business is at risk.

But Medicare Advantage really has two components. It has a fee-for-service component depending on how the contract is negotiated. Then you've got the medical loss ratio risk-sharing, whether you're bringing down the cost or increasing the cost, where you have to pay back or you have to take some off the table.

**BROWNING:** WakeMed is a little different than the other two organizations. We have about 40,000 lives at risk, including Next Generation ACO and our employees. We're a little different because we have a high self-pay population that uses our organization for primary care. Approximately 10% of the patients who access our system are uninsured. Since we receive little to no reimbursement for the services that are provided, we are also at risk for this population. Currently, we are identifying and attempting to manage the high-risk uninsured patients that are accessing our system. So when you aggregate all those patients, we are at risk for approximately 20% of our patient population, and we also have shared savings arrangements on another 30% of our patients.

**SCHROEDER:** The level of risk providers assume depends on the market. There's a full spectrum, from small community providers that are primarily still fee-for-service, to large integrated systems that have dominant market share and see risk as a significant opportunity to enhance the operation.

**HEALTHLEADERS:** *Is the healthcare industry's shift away from volume toward value permanent, or is this just a passing phase like the first HMO boom and bust a couple decades ago?*

**DEVOE:** Some health systems are betting that they've got such a unique mousetrap that they're going to get the business anyway and they're not going to have to take on risk. There are some academic medical center CEOs out there who are following that suit. They're all AA or AAA. They're just phenomenally endowed, and they've had huge margins for so long.

**BROWNING:** It doesn't matter whether it sticks or not. Assuming risk is the right thing to do, we all know that we have a significant amount of waste in our healthcare delivery system. We are spending other people's money, whether it's a payer, an employer, or a patient. We have a responsibility to create value.

**LOWRY:** The big difference this time is technology and data. If you dial it back to the 1990s, you really didn't have the stats that you have today about sepsis rates, mortality, readmissions. Now, quality drivers are out there. You're going to be ranked and graded every step of the way, and that's not going away. The intensity of those ratings is just going to keep picking up, and you're going to be driven by your ability to produce quality. This time around, it's going to stick.

**SCHROEDER:** One of the things that's different this time is we're at a point, looking at Social Security and Medicare funding, where there is a real concern that these programs are in jeopardy in the not-too-distant future. If you look at the demographics and you look at the math, you have to agree that something has to change.

Outside of that, employers are paying a significant amount to cover employee healthcare and retiree healthcare, and they are looking for ways to keep those costs down. These are drivers that are influencing what's going on and creating the need to bend the healthcare cost curve over time.

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