

Managing Financial Risk Through a Value-Based Clinical Care Delivery System

White Paper



Business Advisors for the Healthcare Industry

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Abstract: In days past, hospitals, healthcare systems, and their medical staffs could afford to exist in separate but parallel tracks, intersecting only when necessary to deliver clinical care. As value-based reimbursements, especially those involving both upside and downside risk, become more the norm and providers realize that, like it or not, risk is being shifted onto them, they will need to learn how to manage risk more effectively. In today's healthcare industry, providers of all types face the overarching challenge of improving value (quality per unit of cost) for the consumer of healthcare services, an integrated approach is not only preferred but necessary for success.

Key Words: Managing Financial Risk, Financial Risk Management, Risk Management, Value-Based Care Delivery, Value-Based Care, Clinical Care Delivery System, Clinical Integration

INTRODUCTION

Healthcare organizations, such as hospitals or healthcare systems, traditionally have been averse to assuming financial risk. As value-based reimbursements, especially those involving both upside and downside risk, become more the norm, and providers realize that, like it or not, risk is being shifted onto them, they will need to learn how to manage risk more effectively.

Interestingly, one of the most effective ways to manage financial risk is to align and integrate more completely with front-line clinical caregivers, e.g., physicians and advanced practice providers (APPs). This arrangement may seem counterintuitive in that most providers, while usually adept and quite comfortable with managing clinical risk, have had minimal experience in managing financial risk. Nevertheless, these individuals are best positioned to control clinical outcomes and clinical costs, which comprise the bulk of spending in the healthcare industry. Put simply, clinical caregivers, especially physicians, hold *the power of the pen*, or in today's parlance, they control *the power of the computer mouse*. Therefore, they are best able to determine how to lower costs without sacrificing quality or patient safety. This control over the purse can then be leveraged by hospitals or healthcare systems and used to mitigate their exposure as they voluntarily or involuntarily take on more risk in the marketplace.

Consider the following examples:

1. The Medicare Access and CHIP Reauthorization Act (MACRA) and its quality payment programs (QPPs), i.e., the Merit Incentive Payment System (MIPS) and the various alternative payment models (APMs), is a risk-based, pay-for-performance reimbursement model that the Centers for Medicare and Medicaid System (CMS) soon will deploy. In fact, MACRA can be viewed as the largest of all such payment models in the country, as it is mandatory for those Medicare providers who care for more than 200 patients a year or bill Medicare for more than \$70K a year. In a hypothetical system that employs 100 Medicare providers, all of whom are planning to participate in MIPS in 2019, if each provider bills Medicare \$100K a year in professional fees (not that far above the lower limit threshold where providers are mandated to participate in MACRA), then the total dollars at risk for payment adjustments in 2019 would be 4% of \$100K x

100 (\$10M) or \$400K. This number will then increase between 2019 and 2022, ultimately topping out at 9% of \$10M or \$900K once the legislation is fully in place. Since most hospitals and healthcare systems have single-digit operating margins, these numbers on the downside, i.e., allowing the system's Medicare professional service reimbursements to be cut by this much because their employed physicians did not perform well, could take a considerable bite out of an organization's profit.

2. Healthcare organizations, beyond contracting for value-based reimbursements, should also consider ways that clinicians can help them manage financial risk by changing practice patterns that directly affect the expenses of the system. For example, a hospital that engages its providers in gainsharing arrangements, where savings for cutting down on the utilization of certain items, such as blood products, name-brand antibiotics, and operating room supplies or equipment, are shared back with the providers can achieve dramatic expense reductions. One healthcare system in the southeastern US achieved savings of nearly \$2M in blood product purchasing fees and over \$3M in OR supply costs through just such a program. Interestingly, for the blood product initiative, the quality of care also improved in that blood transfusions can have serious short- and long-term consequences for patients and the hospital was able to avoid many transfusions, thus creating a proverbial "win-win" scenario, i.e., higher quality of care and lower costs. Finally, these types of gainsharing arrangements can undoubtedly be considered financial risk-management endeavors since they are usually geared toward expenses that are not associated with much if any accompanied reimbursements or profit margins. Therefore, the system is at-risk for the utilization of things like high-priced antibiotics, blood products, or the supplies used in the OR by its providers.

ORGANIZATION

EMPLOYMENT

Unfortunately, many employers of physicians and other providers are not aligned or integrated in a way that facilitates provider engagement in clinical initiatives that lower financial risks for the sponsoring system. Employment contracts do not necessarily drive provider engagement in these efforts. However, carving out some of an employed provider's compensation and putting it at risk for achieving certain cost control metrics can help.

Compensation models that do incentivize providers to engage in financial risk management should be carefully structured and the following considerations incorporated into the compensation plan.

1. Financial incentives to reward clinicians who change practice patterns enough to control expenses significantly should be:

- a. Paid for from the savings achieved by the clinicians either through shared savings agreements between the hospital or healthcare system employer and its employed providers or gainsharing agreements between the same two parties.
 - b. Paid for via agreements that have been reviewed by a qualified and knowledgeable healthcare attorney to avoid Stark or Anti-kickback compliance issues.
 - c. Paid for via agreements that are felt to result in equitable shares for the employer and the provider employees to prevent contention between the employer and its provider employees.
 - d. Paid for with dollars that have been carved out of the provider's total compensation package and not merely added onto the compensation to avoid issues around fair-market value and possible claims of excessive inurement of providers, in that compensation add-ons might exceed the boundaries of what is considered commercially reasonable.
 - e. Set at a level high enough to drive behavior change, but not so high that providers are tempted to lower costs in a way that might jeopardize the quality of patient care.
 - f. Combined with a set of carefully selected quality metrics that can be monitored to ensure that quality is not compromised as costs are selectively removed.
 - g. Directed to those providers who contributed the most to the cost savings. This arrangement can be memorialized in a well-constructed income distribution plan (IDP) and occur up-front to avoid contention between the different clinical providers once income is available to distribute.
2. Financial incentives to change provider behavior should be combined with non-financial methods to achieve similar aims. These might include:
- a. Initiating clinical co-management agreements where providers have an opportunity to co-manage operations, particularly at the service line level.
 - b. Making sure that provider compensation models are aligned with payer contracts. For instance, a contract that pays for production, i.e., a fee-for-service agreement, will be at odds with a comp model that pays for value, i.e., achieving certain quality and cost outcomes.
 - c. Utilizing peer pressure and the competitive nature of most providers to drive behavior change. This stimulation can occur by sending out frequent reports where an individual's performance is benchmarked against their peers.

Clinically integrating providers with a hospital and then using the clinically integrated network (CIN) to focus on improving quality and lowering costs. Note in these types of arrangements, i.e., clinically integrated networks that meet the Federal Trade Commission's and others' definition, can bargain with payers or self-insured employers for service contracts if indeed the financial rewards (reimbursements, shared savings, pay for performance bonuses, gainsharing payments, etc.) are necessary to achieve quality and cost efficiency results that would not be achievable without these incentives.

EMPLOYMENT LITE (E.G., PROFESSIONAL SERVICES AGREEMENT)

As with employment agreements and their associated compensation models, contractual agreements between hospitals and providers can be structured in a way that also incentivizes professional caregivers to focus on cost efficiency and cost-effectiveness in their clinical practices.

Professional service agreements, for example, are often used to contract for hospital-based providers (radiologists, pathologists, hospitalists, anesthesiologists, emergency medicine) or specialists needed to ensure adequate staffing of a service line, e.g., cardiac, orthopedics, or oncology. These agreements can also incorporate financial incentives to control costs and should be constructed with the same degree of care as to compliance with relevant regulatory and statutory requirements as that outlined above regarding employment agreements.

CLINICAL INTEGRATION

As mentioned, the newest model for the alignment and integration of all types of healthcare providers (hospitals, physicians, advanced professional providers, post-acute care providers, ancillary service providers, and others) is the clinically integrated organization (CIO) or clinically integrated network (CIN). These organizations provide some advantages compared to more traditional alignment and integration models, e.g., employment or contracting. These include:

1. Less stress on a hospital or health system's balance sheet in that the providers can be fully integrated into the system's clinical operations without resorting to expensive employment models. Further, the entire clinically-integrated organization can jointly contract with payers or employers even though all participants in the CIO do not share a common tax ID number (TIN).
2. Flexibility, in that the well-constructed CIO can function as an ACO under one of the Medicare Shared Savings Programs or as an APM under MACRA. Also, subcomponents of the CIO can function within specialty-specific payment programs, such as the Comprehensive Primary Care Plus (CPC+) model for primary care providers and the Oncology Medical Home (OMH) Program or End-Stage Renal Disease Program for oncologists or nephrologists respectively.

A well-designed clinical integration program, network, or organization can provide a venue wherein coordination of care around specific chronic disease entities (e.g., diabetes or heart failure) or procedures (e.g., total joint replacement or STEMI care) can occur, and bundled payments for these services can be used to facilitate efficacy and efficiency. In fact, it is hard to imagine how providers who are not legally integrated could coordinate and choreograph care effectively in bundled payment programs if they weren't first clinically integrated.

OPERATIONALIZATION

Once providers are aligned and integrated with a sponsoring system, e.g., a hospital or health system, through one of the mechanisms outlined above, what specific actions should they then take to manage effectively both clinical and financial risk?

CONTRACTING

Provider groups should look to contract with those payers (government or commercial) or self-insured entities (e.g., large employers) who are offering at-risk, value-based reimbursement (VBR) models. As mentioned, these types of agreements are quickly becoming the norm in the healthcare industry, and a distinct advantage will accrue to those service providers who can be first to market and capture the greatest market share of these contracts. There will likely be plenty of at-risk VBR models to choose from. Here is a short list of those now active in the market or soon to be so...

1. **MACRA.** Several of the APMs under MACRA, so-called advanced APMs, include a risk element, where at least 8% of reimbursement is at risk for performance within four categories – Quality, Cost, Care Process Improvement Activities (CPIA), and Advancing Care Information (ACI) through electronic health record systems.
2. **Medicare Shared Savings Programs.** These programs include the Medicare accountable care organization programs to include ACO Levels 1, 1+, 2, 3, and the Next Generation ACO program. All these programs except for ACO Level 1 are considered advanced APMs under MACRA in that they incorporate the requisite level of risk, i.e., 8%.
3. **Commercial ACO Plans.** Many commercial payers, e.g., Aetna, are marketing plans that work similarly to the Medicare ACO model. Characteristics of these plans include:
 - a. Narrow networks made up of providers that the health plans feel will be able to produce high value, i.e., high quality and low cost, for the health plan members. This model is dissimilar to most PPO health plan networks that tend to favor breadth and depth of network coverage over network provider performance.
 - b. Fee-for-service payments with an additional shared savings bonus or penalty depending on whether the projected spend for the provider's attributed population is higher or lower than anticipated.
 - c. Attribution of patients to providers, usually done according to which clinicians provided the most care (billed the most services) to the member over the course of the year.
 - d. Quality, cost efficiency, and patient experience performance measurements down to the individual provider level that are then used to trigger payment of any shared savings. This analysis is done to ensure that withholding care and cutting costs are not at the expense of quality, patient satisfaction, and safety.

4. **Commercial Pay for Performance Plans.** Like MACRA, these plans provide for adjustments to reimbursement rates, up or down, depending on a provider's performance over time, usually a year, on certain quality or cost metrics. Many state Blue Cross Blue Shield (BCBS) programs, for instance, have had programs like this in place for diabetes care for many years.
5. **Bundled Payment Programs and Plans.** Although CMS has slowed down the roll-out of bundled payments for certain conditions, such as the treatment of acute MI, and done away with mandating participation in the comprehensive joint replacement (CJR) program, CMS is studying (field testing of cost models) bundled payment models for many conditions and procedures in the future. In addition, several commercial bundled payment plans are in place, e.g., Blue Cross Blue Shield's bundled payment program for total joint replacement which is operative in many states. As described earlier, bundled payments should be especially appealing to clinically-integrated organizations who can bring together diverse providers, who are otherwise not part of the same legal structure, and go to market collectively with bundled service offerings that reliably deliver high quality at low cost, i.e., high value.
6. **Partial Capitation.** Several commercial payers have provided small per-member-per-month capitation payments to those organizations who can achieve recognition as patient-centered medical homes (PCMH), where team-based care and the expanded sharing of information between providers or providers and patients via electronic health records is emphasized. These payments, however, have not usually been at-risk and have been paid when the facility is recognized by an accrediting body (usually the National Committee for Quality Assurance or NCQA) as meeting the criteria to be recognized as a PCMH. A new all-payer model, i.e., one that involves both CMS and several commercial payers, known as the comprehensive primary care plus (CPC+) program, will however, offer more substantial capitation payments to those primary care practices that can demonstrate that they are incorporating novel, patient-centered, care delivery and care management services to their patients. These payments can be viewed as being at-risk in that they are contingent upon meeting the criteria set by the CPC+ program, and there are performance metrics that must be met before the capitated payments are made.

CARE PROCESS DESIGN AND CONTINUOUS IMPROVEMENT

The next step an integrated provider group should consider as they go about the business of managing both clinical and financial risk is to incorporate a systematic approach to re-tooling clinical care processes and procedures so that they reliably deliver high-quality outcomes in a cost-efficient manner.

Unfortunately, the care delivery system we have now has been primarily designed to deliver high-volume care on an acute, episodic basis to individual patients and is not well suited to the delivery of high-value care to patient populations. These two production models, while not mutually exclusive, (there will always be a need to address access to care, especially as the citizens of this country grow older and develop more chronic disease) will have to transition slowly from a primarily volume-based to

a more value-based system over time. This change will require a careful, well-thought-out approach to care process design and delivery that includes the following steps:

- 1. Care Process Mapping.** Incredibly, many frequently used care processes and procedures in healthcare today are not well understood or well designed. This weakness leads to a significant amount of waste and inefficiency in the delivery system and places many patients at risk of receiving sub-standard care and being exposed to medical errors or mishaps. Therefore, the first step in the care process design system (CPDS) described here includes mapping of common care processes or procedures (diabetic care by a primary care physician, total joint replacement by an orthopedic surgeon, heart failure management by a cardiologist) as to how they are currently being performed. We recommend doing this using a simple modified Lean process mapping method where individual steps (those that are done more than 10% of the time) are identified with square blocks in the care map and decision points (if this, then that) in the care map are identified by diamond figures. It is often surprising how little providers know about the various steps in the care delivery pathways that they utilize every day. This mapping step can better allow them to visualize their current processes and recognize steps in the process that may be unnecessary, inefficient, or even dangerous.
- 2. Best Practice Care Design.** Once the current state of a care process has been mapped then the next step is to assemble a care process design team made up of front-line caregivers (clinical and non-clinical) who work within the care process under study on a regular basis. This team is then given the responsibility of scrutinizing the current state care map as to steps that can be modified so that the process conforms more with what they consider *best practice*. Note, ideally these best practice recommendations would all be evidence-based, but most would agree that the majority of what is done in the healthcare delivery system has not been subjected to scientific study via methods such as randomized, controlled clinical trials and, therefore, there is no evidence for how best to do many of the steps in most care process maps. Nevertheless, the care process design team should take advantage of their collective knowledge and experience and use this information to design the care map in ways that they think will improve both quality and cost efficiency. They should realize that the care process maps they are creating will only serve as a starting point, and an integral part of the CPDS will be to revise and refine these maps via an iterative process over time.
- 3. Outcome Measurement Selection and Capture.** Once the care maps are in place and serving as initial guidelines of care, each care process or procedure should then be subjected to continuous monitoring via carefully selected quality and cost metrics. These metrics should be relevant to the process/procedure, easy to measure (preferably in an automated fashion), geared to outcome measures as opposed to process measures, and inclusive of measures for which there are national benchmarks to use for comparative purposes. In addition, the measures need to be captured in as real-time a manner as possible, so that they can be fed back to the front-line providers for use in the data-driven continuous process improvement step described below before they grow too stale to be of value. To keep things as simple as possible, each care

process unit (CPU), a care process or procedure that has a well-defined stop and start point and can be easily described in a care map should have at least two metrics monitored on a regular basis. The first metric should reflect the numerator of the value equation, where value = quality/cost, i.e., it should be a well-accepted quality metric (note that patient self-reported outcome measures are often of great value and much easier to obtain than true quality outcome measures) and the second metric should reflect the denominator of this equation, i.e., the cost of care (either the cost to the payer as reflected by claims data or the cost to the provider as measured by a legitimate cost accounting method, such as time-driven, activity-based, cost accounting or TDABC).

4. **Continuous Process Improvement.** Once the process guidelines (via the mapping) are in place and being utilized and the quality and cost measurements are being collected, the care process design team should meet regularly and use this data to drive continuous process improvements in the CPU, i.e., iterative changes in the care map that are expected to produce higher quality, lower costs or ideally both higher quality and lower costs simultaneously. Note, changes in the care maps/guidelines should not be made without communicating such changes to the rest of the care team and once made the effect of such changes should be monitored closely via the quality and cost metrics used for each CPU. If, as hoped, the changes in the care process result in better outcome metrics, then these changes should be made permanent and shared across the organization. If, however, changes result in a worsening of the outcome metrics, then the care team needs to be ready to revert to the original guidelines and jettison the changes that were put in place. Over time, the above approach can lead to significant bedside learning and augment or even fill in gaps in the evidence base that as mentioned previously is often far from complete for many steps in the care delivery system.

SUMMARY

Hospitals, healthcare systems, and their medical staffs in days past could afford to exist in separate but parallel tracks, intersecting only when necessary to deliver clinical care. In today's healthcare industry, as providers of all types face the overarching challenge of improving value (quality per unit of cost) for the consumer of healthcare services an integrated approach is not only preferred but necessary for success.

For some time, provider organizations, such as hospitals, have looked to their organized medical staffs to help them manage risk in the clinical space. They have done so by engaging physicians and other providers in quality improvement initiatives, many of which are led by clinical professionals. Now, that the simultaneous improvement of both quality and cost has become the imperative, organizations realize that financial risk management is also something that can be and should be done by clinical care providers, in that they are best-positioned and knowledgeable about how to selectively identify and remove costs without compromising quality or safety.

Engaging front-line providers in this enterprise involves both organization and then operationalization of clinicians around this significant task.

Traditional organizations, such as a hospital's organized medical staff structure, are not well-suited to this function and, therefore, newer structures, e.g., employed physician networks, contractual agreements like PSAs, and clinically integrated organizations, are rapidly emerging in almost all markets.

Once formed, however, these new organizational models must then have an operating system that serves to guide clinicians on how to systematically re-tool processes or procedures at the bedside, exam room, or operating room level so that they reliably deliver measurably high-clinical and cost-efficient outcomes. This transformation of the front-line delivery system is not easy and often flies in the face of well-entrenched practice patterns that are difficult to change. Many healthcare administrators are also loath to expend the resources needed to produce this kind of dramatic transition from a volume-based business model to a value-based business model. Some believe that the market demand from government and commercial payers is still not strong enough to warrant the shift and others just do not know how to make it happen relatively smoothly and seamlessly.

As payment models such as MACRA (MIPS and APMs), Bundled Payments, Shared Savings, Gainsharing, Full or Partial Capitation, and other at-risk, value-based plans are rolled out by payers and self-insured employers, this resistance to change will inevitably lessen. However, individual markets, organizations, and even providers will transition at a varied pace, which may differ considerably even in geographically close locations.

Have no doubt; the change will occur. The current system's costs and relatively poor quality of care performance as compared to other economically developed countries is not sustainable. Therefore, those organizations that successfully engage their clinical providers in helping them to manage both clinical and financial risk will be at an advantage as they face the changes and challenges ahead.