RISK-BASED CONTRACTS: HOW TO MAKE THE VALUABLE TRANSITION

CMS Webinar
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Innovation Center Primary Care Models

Presenter**:** Michael J. Lipp, Chief Medical Officer, Center for Medicare and Medicaid Innovation (CMMI), Centers for Medicare & Medicaid Services (CMS)

When organizations are able to get more lives under risk arrangement:

- They are able to focus their organization more on value-based care and improved outcomes
- They are able to make the necessary investments to allow them to be successful

5 (4 Newly Announced) CMMI Models That Influence Primary Care

Each model fits along a risk spectrum

- Discussed/listed in order of lowest to highest risk/reward
- Necessary because different organizations are starting at different places and are comfortable at different levels of risk

1. Comprehensive Primary Care Plus: Not new — not discussed

2. Primary Care First

- Payments moving away from fee-for-service (FFS)
  - Goal of improving patient access and patients under primary care
- Accomplished through two payment types:
  - Population-based payment type to compensate for professional services
  - A simple flat business fee for each face-to-face primary care visit
- Performance-based adjustment:
  - Rewards practices that meet quality standards and reduce avoidable hospitalizations
  - Practices have an opportunity to increase their payments by up to 50%
  - Professional population-based payments will be adjusted based on the medical complexity of a population
    - Practices will be placed in one of the five risk groups based on the average APG (America's Physician Groups) score of their population

        - Physicians that specialize in the care of more complex patient populations will receive higher population-based payment, which corresponds to the amount of resources needed to successfully manage that specific population
    - In addition, CMS will offer participants actionable data to inform their efforts on utilization, clinical quality, and patient experience
        - Within Primary Care First, there is an opportunity for practitioners to care for new beneficiaries that have serious illness

3. Direct Contracting — Professional

- Direct contracting — An evolution of the Next Generation Accountable Care Organization (NGACO) model
    - Offers new forms of capitative payment, enhanced payment options, and flexibility that give providers the tools to meet beneficiaries' medical and nonmedical needs (social determinants of health)
    - Model features:
        - Expanded emphasis on voluntary alignment, while also retaining the claim-space alignment approaches
        - Benefits enhancements and payment role waivers that improve care coordination
        - Access to actual data to care for aligned beneficiaries
        - A more predictable prospective spending target that more closely resembles Medicare Advantage rate calculations
        - A focus on dually eligible and complex chronic and seriously ill populations
        - Opportunities for organizations that are new to Medicare FFS as well as Medicaid managed-care organizations that are interested in accountability for cost by quality
    - Expected to be Advanced Alternative Payment Models (APMs) in 2021
- Professionals will have an ACO (Accountable Care Organization)-like structure with participants and preferred providers defined at the 10-NPI level (10-digit National Provider Identifier)
    - Participants will be used to align beneficiaries to the Direct Contracting Entity (DCE)
    - Preferred providers may participate in downstream arrangements, receiving certain advancements toward payment role waivers and overall improving care to beneficiaries
    - DCEs receive a primary care capitation equal to 7% of total cost of care (TCOC) to cover enhanced primary care services
        - They will share in 50% of the shared savings or losses with CMS

4. Direct Contracting — Global

- Organizations have the same ACO structure as the professional option with participants and preferred providers defined at the 10-NPI level
    - However, they will be able to choose between primary care and total care capitation, and they will assume 100% of both savings and losses

5. Direct Contracting — Geographic

- Entities can take on regional risk and enter into arrangements with clinicians in that region
    - Organizations would assume 100% of savings or losses and can choose between total care capitation and full financial risk with FFS claims reconciliation
- To participate in the direct contracting model, must have 5,000 beneficiaries
    - However, there will be an on-ramp for Medicare organizations that are new to FFS as well as added flexibility for organizations that serve dually eligible and/or chronically ill populations
- Must submit application for direct contracting by August 2, 2019

Success in Risk-Based Contracts (I)

Presenter**:** Narayana S. Murali, Executive Director, Marshfield Clinic; EVP Care Delivery and Chief Strategy Officer, Marshfield Clinic Health System (MCHS)

About Marshfield Clinic

Over time, participating in upside-only value contracts

- 2006–2010: PGP (Physician Group Practice) demonstration:
    - Results: Across 10 different organizations, the Marshfield account system was responsible for generating the highest savings for CMS (about $112 million)
- 2011–2012: CMS transition demonstration
- 2013–2018: CMS Track 1 ACO
    - Medicare Shared Savings Program (MSSP) Round 1 and MSSP Round 2
    - Results: Marshfield account system is 15% less costly than the average of ACOs participating in MSSP

Strategy is to bring informatics and analytics together

- If you have strong informatics alone, a lot is spent on resources (technology) for good workflow, but cost isn't managed well and there isn't much quality reporting
- If you have strong analytics alone, the analytics teams aren't linked with the physician/provider group — clinical efficiency, but no one sees the reports or information

Analytics Center of Excellence

- Interfaces with the information systems department along with the furbished line departments that exist across the organization
    - IS (Information Systems) provides technical support to the analytics team
    - Analytics team builds the analytics to support the MCHS application
    - Each of these centers (the IS center and analytics centers) works with the respective department

- In order to have a value-based system, you need to have dashboards and reports
  - Dashboards extend into important hard outcomes (e.g., 5-year cancer survival rates)
  - Reports should most importantly take information from your electronic medical records (EMRs), information from your provider, and tools required for day-to-day appointments, and tie them to the financial reports of the organization
    - You need one source of truth to help identify what the total cost of care is and how to go about managing it

- Strong informatics and analytics don't necessarily have to be built in-house — there are public tools you can contract with:
  - WHIO (The Wisconsin Health Information Organization)
    - Breaks information from claims database based on resource utilization to help identify areas where you can address care
  - Med Markers (Care Consulting)
    - Med Insight — a health waste calculator
    - Utilization management is a key aspect of this entire process, and it has to be a team effort of physicians, clinicians, and the entire team to figure out what the waste is and how you drive it out of the system
  - Clear feedback mechanism (population health dashboards)
    - Enabling physicians and providers to see performance in real time requires:
      - Quality of care (outcome metrics and process metrics)
      - Patient experience
      - Utilization

Having the Right Pieces to Move to Full Risk

- Need to have a Model for the Continuum of Care: ambulatory care, acute care, and financial strategy are all intertwined
  - Need to have congruent access to:
    - Data — claims, EMR
    - Analytics — focused on baseline cost trends, risk corridors, and how to attribute a patient
      - For example, using the NPI-10 as a way of attributing patients to the preferred providers and physicians
  - Control of ambulatory and acute-care facilities in key markets
  - Contracts — must have business rules that work for all payers in terms of the contracting strategy
  - Development of care management programs to lower TCOC
    - Medicare — risk satisfaction tools, socioeconomic factors, and post-acute spending
    - Commercial — must understand the pharma and procedure space spend to actually create the necessary programs
  - Innovation or programs — reduce the reliance on acute-care beds

What Matters Most in Care Management?

- On the infrastructure element, the focus has to be on:
    - A strong primary care base with Patient-Centered Medical Homes
    - Care management capabilities
        - Identify the key chronic diseases and create the necessary interdisciplinary teams to address them
    - Care coordination — reduce redundant services
    - Integrated EMR
- Medical ethics: When there are mortality benefits of 50% or higher, it becomes unethical not to perform that practice
- The power of integration (of a health plan and care facility system) — financial benefits are shared by:
    - Patient, in the form of lower out-of-pocket costs for services and lower premium
    - Security health plan supporting stable earnings
    - The clinic primary care providers and staff, through value-based reimbursement programs designed to improve quality and resource efficiency plus address gaps in care

Results: Increased the Percent of Hypertension Patients at Our Goal

What did this require:
- Education
- Identifying the practice guidelines
- Updating the providers in terms of the tools required
- Replacement of equipment
- Measuring the quality of equipment

Lessons Learned

- Concern for the high performing “penalty”
    - High-performing organizations that adopt the new policy cannot compare their success to themselves, because it is so easy to receive a penalty, such as if a bad flu season occurs, as opposed to receiving a bonus

        - These organizations will drop off if they are only compared to themselves; they need to look more broadly at their place of success in comparison to other organizations
- Long-term investment vs. short-term measurement
    - To effect long-term goals, you might have to raise the costs now
- Bookmarking cycle
    - Use the model they suggested, but there are exceptions when an organization should be rewarded, not penalized, when it surpasses the goals of others, but does not meet its own

Success in Risk-Based Contracts (II)

Presenter: Kelly A. Robinson, Chief Executive Officer, Brown and Toland Physicians

Understanding the Risk Model Continuum

FFS

- Group level FFS contracts
- MD bills and collects
- No claims or UM (utilization management)
- Division of Financial Responsibilities (DOFR) not necessary
    - Providers are billed and paid based on what they're billed

Shared Savings Programs

- Group level contract vs. individual
- PPO (preferred provider organization) patients attributed vs. assigned
    - Some ability to drive and direct clinical decisions and referrals, but the patients aren't required to participate in that structure
- FFS + incentives for quality/cost management
    - Only upside and benefit awarded for performance
- Can be handled within multiple products

Shared Risk Model

- Typically, a medical group or independent physician association (IPA), either independent or integrated with a hospital system
- Group capitated for professional services
    - Start to see capitation, or a percentage premium, paid at the group level, and that group takes all of the financial risk (upside and downside) for services provided in the ambulatory setting
- DOFR sets risk for group, hospital, and health plan
- Start to see groups that are capitated
    - They often pair with hospitals so that there's close coordination to determine how care is going to be managed
- To enter into the realm of risk and downside risk, you need to start entering the processing of claims, UM, care management, credentialing, and those types of services
    - Usually delegated to group

Full Risk

- Similar to shared risk model — physicians and providers are taking the financial risk
- Group capitated for professional services
- Hospital capitated for all facility and hospital-based services
    - Providers are doing all that they do in the shared-risk model alongside this
- Plan retains premium dollars/assumes risk for out-of-area emergencies/special instances

Global Risk

- Risk-bearing entity capitated globally (professional and hospital)
- Group is at 100% risk for all medical services with a few exceptions
- Claims and UM delegated to IPA for all risk services
- Brown and Toland (IPA) serves the full risk continuum (global since 2014)
- These models look at the physician and patient at the center of care

Managing the Total Cost of Care

- Inpatient
  - Daily rounds, transitions of care program, care management
- Ambulatory CM
  - SNP, case identification, CCM, high need/high utilization
- Referral services
  - Auto-authorization, embedded contractual rules
- Population health
  - Clinical quality promotion across network, quality programs