determining your organization’s ‘risk capability’

To be successful in a healthcare reform environment, providers must develop key capabilities for managing financial and performance-based risk.

The healthcare industry is in a time of profound change. Passage of the Affordable Care Act (ACA), while politically controversial, has created unique opportunities for the healthcare industry to examine and change both how care is delivered and how delivery is financed. An important dialogue is unfolding among industry thought leaders and stakeholders regarding how providers will shift from fee-for-service payments to risk-based, patient-centered payment models.

Risk is defined by Merriam-Webster as “the possibility that something unpleasant (such as an injury or a loss) will happen.” Capable means “able to do something; having the qualities or abilities that are needed.” Risk capable, then, could be defined as having the ability to prevent something unpleasant from happening. As the healthcare industry continues to transform and evolve, the future survival and success of providers will depend on the extent to which they can become risk capable by developing the capabilities to manage new financial and performance-based risk.

Accepting—and Managing—the Risk of Population Health

Traditional fee-for-service revenue streams are beginning to shift to patient-centered and risk-based payments. The combination of unsustainable growth in national healthcare costs and passage of the ACA brought a new level of urgency to the dialogue related to the lack of sustainability in the healthcare economy. These two factors have accelerated the shift of risk from payers to providers.

Current literature suggests that the future of risk-based contracting is bright—and some recent advisory opinions offer insight into this perspective. The Advisory Board Company reported this past summer that risk-based, total-cost-of-care contracts with large multihospital systems had more

AT A GLANCE

An assessment of a provider’s level of risk capability should focus on three key elements:

> Business intelligence, including sophisticated analytical models that can offer insight into the expected cost and quality of care for a given population
> Clinical enterprise maturity, marked by the ability to improve health outcomes and to manage utilization and costs to drive change
> Revenue transformation, emphasizing the need for a revenue cycle platform that allows for risk acceptance and management and that provides incentives for performance against defined objectives
than doubled since 2011, from 14 percent to 35 percent (Survey Results: Percentage of Providers Taking on Risk Doubled Since 2011, June 5, 2013). Similar results for bundled payments have occurred with commercial payers around the country. United Healthcare, the nation’s largest health insurer, announced that it will double its accountable care contracts by 2017. In 2013, $20 billion of United Healthcare’s 2013 payments were tied to quality and cost-efficiency measures.

Successful voluntary projects (e.g., bundled payments, comprehensive care initiatives, accountable care organizations) are giving rise to new payment models where participants share risk and have the opportunity to share savings from achieving defined financial and clinical outcomes. Such risk-sharing arrangements often create new levels of anxiety for governance and executive management as payers proactively approach providers to enter into these agreements. Providers frequently feel unprepared to analyze the impact of risk-sharing agreements, but feel a sense of urgency to participate to keep pace with changing payment models.

One of the critical issues for any provider to understand is the pace of internal change required to prepare the organization to be fully risk-capable in a risk-sharing environment. The risk hierarchy diagram located below demonstrates a typical progression away from fee-for-service toward acceptance of risk for total population health. How quickly a market moves will depend on factors such as the extent that competitors are looking to shift market share and payers and employers are creating new contracting or private-label health plan options.

As the mandatory elements of reform progress, it is important to recognize that some providers are already dealing with and learning to manage the ongoing transformation that ties payment to clinical outcomes. What was called pay-for-performance under the previous administration has transformed into value-based purchasing, readmission penalties, and other performance-based risk-sharing payment models. As governmental innovation models (e.g., Medicare Shared Savings Program, bundled payments) expand, we can expect wider application in years to come as other commercial payers drive these types of payment mechanisms through their managed care contracts.

The most important question for both governance and healthcare executives is, How quickly will payers and competitors in their market move up the risk hierarchy toward population health cost-risk contracting? Each level of the risk hierarchy requires increasing levels of clinical alignment among physicians, hospitals, ambulatory

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Each successive level of financial risk emphasizes the need for organizational redesign and profound management, regardless of the specific market.

Lack of readiness to participate at a level equal to or ahead of the competition could be a failed market strategy. A new set of leadership skills is required to design and implement the organizational transformation processes, technology, and people requirements to successfully provide services in a risk-based environment. Clearly, not everyone is going to survive this transformation.

Becoming risk capable and embracing population risk-based payment models are steps that require organizations to first understand and address the fundamentals. A provider that has not mastered the basics in the mandatory elements of the Centers for Medicare & Medicaid Services (CMS) programs (e.g., Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, hospital-acquired conditions penalties for acute care) will have difficulty responding quickly to the increased complexity of adding commercial programs, state-sponsored efforts, or voluntary elements associated with the ACA. These mandatory elements represent the lower levels of risk for providers on the widest base of patients: Medicare beneficiaries. Standardizing clinical processes that produce positive financial results—which is a simple, but not easily accomplished goal and can take time—will benefit providers interested in increasing their risk tolerance and moving up the risk hierarchy ladder. Progressive cultures that seek continuous improvement at every step of the delivery process will stand the best chance of reacting to increasing performance levels as the bar is raised in subsequent years.

Consider, for example, one element of value-based purchasing. For FY15, Medicare introduced a single item worth a staggering 20 percent of the entire payment of the at-risk pool: the Medicare spend per beneficiary. The performance period for this component has passed, and at this time, we are preparing for the 2016 performance period, where the percentage for this item increases to 25 percent of the 1.75 percent of inpatient Medicare payments to a facility or health system. Providers working on this component of value-based purchasing should be focusing on all discharge readmissions, hospital-acquired conditions, and the post-acute cost components of the continuum. They should continue to focus on clinical integration to enhance their ability to provide the right care at the right location at the right time. These are the same fundamentals that drive success for the voluntary Medicare Shared Savings Program.

Key Elements of Risk Capability
To assess how risk capable they are to meet each advancing level of risk, providers should evaluate three core organizational competencies required for success in a fully capitated environment:

> Business intelligence
> Clinical enterprise maturity
> Revenue transformation

Business intelligence. The traditional market-assessment processes and financial/clinical analytics that view each component of the delivery system independently will be insufficient to meet the business intelligence needs in a full-risk environment. Advancing levels of risk require more sophisticated analytical models with potential payer partnerships that can access data sets offering insight into the expected cost and quality of care for a given population.
A simple process model, as illustrated in the exhibit below, will require interdependent systems, tools, and resources. Negotiating risk contracts may mean new partnerships for improving the chance of success—including outsourcing components that enhance accuracy and enable quicker measurement and evaluation of outcomes. For some organizations, a build strategy is an option, but costs of this endeavor require detailed planning in the “buy versus build” decision process.

A provider might consider collaborating with a commercial or government payer in defining the population of individuals in the risk group, assuming the appropriate trust can be developed to ensure the relationship will be successful for both parties. The ability to derive and evaluate longitudinal, continuum-based data on the medical spending profile of the members in the population will be critical. The provider’s ability to understand the information provided and combine it with valuable episodic financial and clinical data is the first variable in solving the risk equation. Understanding the nature of the risk rates is pivotal as insights come from the data and are likely to already be, in part, established up front.

Comprehensive answers to the following questions will be a “rite of passage” for an organization’s future success in this new payment environment:

- Is the model an incremental per-member-per-month payment program given for participation in care management models sponsored by the payer?
- Is the model a “shared savings” program that rewards both parties for eliminating unnecessary utilization, resulting in lower-than-expected costs?
- Conversely, is the relationship full capitation, where all risk falls on the provider to manage within a capped annual payment for each patient?
- Should a global budgeting model be considered, such as is emerging in some states, where revenues are capped based on all care provided for anyone living in certain geographic regions?
- Given that effectively managing within any of these risk models requires an in-depth understanding of utilization and costs and awareness of the responsibility-versus-accountability equation, how much control will the provider actually have in influencing or mandating the care patterns of individuals within the risk population?

By answering these questions (among others), a provider can forecast volumes and staffing levels in the optimal building of the budget and understand what emerges as lower per-patient utilization. As a result, the provider can reduce unnecessary and redundant care and increase volume as more patients are managed within the network.

**Clinical enterprise maturity.** Success in mitigating and managing risk depends on developing a high-performing, clinically integrated network (CIN) of care that aligns incentives toward population health management. The first steps to this goal may be to align providers within the CIN and then to proactively seek out payer partners and employers to develop new value-based contracts in a more comprehensive high-performance network. Developing a mature clinical enterprise will require the abilities to improve health

**A PROCESS MODEL FOR EVALUATING RISK**

- Define Population
- Understand Capitation Rates
- Analyze Utilization and Cost
- Build the Budget
- Sensitivity Test the Budget
- Ongoing Monitoring of Expected vs. Actual
Outcomes of individuals and populations and to manage utilization and costs to drive change in the care model delivered in the marketplace.

The objective of an integrated clinical enterprise is to organize, design, build, and operate a network that allows sets of providers to be financially successful for delivering outcomes envisioned in the Institute for Healthcare Improvement “Triple Aim” framework. The exhibit above identifies the process components needed to successfully establish a network that can assume accountability for the health of populations and aggressively pursue risk-based contracting.

The gold standard for clinical integration is a well-conceived and codified program that can be routinely tracked for all participating providers to assure compliance and adherence. Organizational requirements for a CIN have been clearly documented. The Federal Trade Commission no longer requires an individual application-and-approval process to proceed with such a network. The clinical enterprise should be set up broadly enough to coordinate care for various groups of patients and narrow enough to accomplish the protocols and measures required to achieve a status of care accountability for a defined population. In the future, competitive walls regarding care coordination need to be bridged for improved patient outcomes, as network effectiveness is critical to creating the ultimate care-coordination entity.

**Revenue transformation.** Managing revenue transformation emphasizes the need for a revenue cycle platform that can accept risk, manage risk, optimize payment, process claims, distribute funds, and incentivize performance against defined objectives. Providers should understand not only the impact of revenue transformation on its legacy systems, but also what new processes need to be implemented to build and model new revenue streams.

What are the gaps in the organization’s infrastructure, and what is the plan of attack to start filling those gaps, internally or externally? Answering this question requires an assessment of the creative financial experience and ability of
staff and leadership. The static financial models of the past will no longer be sophisticated enough to satisfy the need for information as payment models continue to change. Providers should develop and nurture dynamic financial modeling capabilities to monitor and measure the impact of reform and to strategically allocate capital, people, and other scarce resources. The exhibit at the bottom of page 5 illustrates the steps necessary to understand revenue transformation and evaluate risk-based contracting opportunities.

Providers should ensure that traditional revenue cycle components continue to operate optimally while the new processes are built and implemented. A full financial capability assessment at each level of the risk hierarchy should be completed to ensure timely processing of claims, distribution of funds, tracking of performance, and optimization of contracts.

An increasingly important component of revenue transformation is price transparency. The rollout of the health insurance marketplaces will raise awareness of pricing to a new level, as potentially millions of Americans will be covered under high-deductible health plans for the first time.

Making the Transition
Providers must somehow learn to operate in this time of transformation. Every provider acknowledges this reality. But many are wondering what to do next. The challenge is that providers are in different stages of risk capability. Solutions and strategies are not one-size-fits-all.

By performing a readiness assessment that focuses on the three key elements of risk capability, a provider can develop a plan for addressing gaps with respect to each element that can help guide the organization to success in a payment reform environment. Transformation into a fully risk-capable organization will not happen overnight. Having a game plan specific to your organization and your market is essential for survival.

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