

RIGHT-SIZING RISK

Lessons Learned From Industry Leaders

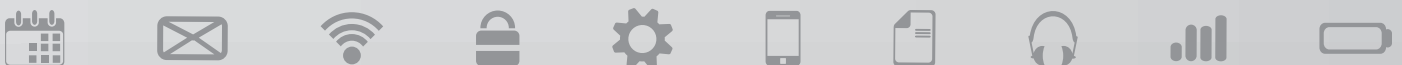
By Laura Ramos Hegwer

To succeed under value-based payment models, healthcare organizations need to develop risk capability, says Craig Tolbert, principal, DHG Healthcare, Birmingham, Ala. One component of risk capability is having a mature clinical enterprise that aligns providers across the care continuum to improve quality and manage costs. “Clinical enterprise maturity hinges on having systems in place to implement quality improvement strategy such as initiatives to reduce hospital-acquired conditions and readmissions,” Tolbert says. “Having physician leadership involved in these strategies also promotes maturity and helps create alignment across the organization.”

For organizations to become risk capable, business intelligence and analytics tools that have the capability to be leveraged across the enterprise are becoming increasingly vital as executives depend on both clinical and financial metrics to influence a profound shift in culture and meaningfully impact patient care across the care continuum, Tolbert says.

Building an organization’s risk capability can seem daunting, but the cost of inaction is great, Tolbert warns. “Whatever you do, don’t wait—you can develop risk capability in a way that fits your market and your organization’s mission and culture,” he says.

Following are examples of providers that are developing their risk capabilities to fit their market and culture—and key lessons learned that could help your organization succeed under value-based payment models.



RIGHT-SIZING RISK

Lessons Learned From Industry Leaders

Bringing Bundles to the Market

“One of the key challenges for providers is determining how to share risk across the continuum,” Tolbert says. Some entities are using physician-led organizations to help them administer gainsharing programs and build greater alignment.

Texas Health Resources, Arlington, Texas.

Amy C. Schornick, vice president of payer relations and contracting, THR, and an ACHE Member, believes one of the keys to right-sizing risk is understanding local market forces and whether physicians are well-organized in the market. “These are physician-driven arrangements, and it takes organized physicians to execute them successfully,” she says. In addition, an organization’s risk level should match the system’s culture for risk tolerance and be well-communicated to the board. All parties involved must be educated on the changing healthcare landscape to promote an understanding across the various stakeholder groups as to the financial and operational implications of entering into risk.

THR started testing value-based contracting nearly seven years ago by entering pay-for-performance contracts

in which a portion of their facilities’ and physicians’ rate increase was put at risk based on quality outcomes. Then, four years ago, the 25-hospital system began piloting gainsharing arrangements to manage population health. Today, THR has some type of value-based arrangement with each of the four major payers in its market.

During the past year, leaders at THR have developed several value-based bundles they plan to sell to national payers and through brokers for coverage beginning Jan. 1, 2017. The bundles cover common episodes of care, including lumbar laminectomy, coronary artery bypass graft surgery, joint replacement, and pregnancy and delivery. The risk-adjusted bundles are prospectively priced rather than retrospectively billed. They are designed around a care model to improve the patient experience of care, both clinically and financially.

“A big promise of the bundles is that patients get one bill, make one co-pay and have a warranted, top-of-line process of care that is completely transparent,” says Daniel W. Varga, MD, senior executive vice president and chief clinical officer.

Prior to designing the bundles, THR had developed physician-led, specialty-specific corporations, called 162.001(b) corporations, for cardiovascular services, orthopedics, spine care and women’s health. Under Texas law, such structures are required to allow physicians and hospitals to receive bundled payments. The 162.001(b) corporation administers the bundle, including all payments to the hospital and any providers. The corporation also adjudicates any performance incentives. “Having the care model and the dollars come through the physician organization has given us a high level of clinician engagement in this process,” Varga says.

Physicians who participate in the bundles can receive two types of incentives. One is a prepaid incentive for complying with the evidence-based process of care that is built into each specific care model. The other is a gainsharing payment, based on the total pool available and how much risk the physicians decide to take. Depending on the amount of downside risk they are willing to accept, physicians have access to varying amounts of upside opportunity. The prepaid incentives are applied to any potential gainsharing the physician may earn later on.

When it comes to right-sizing risk, leaders at THR have been unwilling to dive into retrospective, nonrisk-adjusted bundles, Varga says. “You have to do more for a 59-year-old



Amy C. Schornick, vice president of payer relations and contracting, THR, and an ACHE Member, says it is critical to understand local market forces when taking on risk.

RIGHT-SIZING RISK

Lessons Learned From Industry Leaders

Ann Peterson (left), vice president, provider network services, and Margie Zeglen, FACHE, administrative director, network development and analytics, Palos Community Hospital, Palos Heights, Ill., say the BPCI program has helped their organization gain experience in managing risk.



joint patient who is a smoker with multiple conditions to make sure they have the same chance at an exceptional outcome as a 40-year-old marathon runner. If we cannot risk adjust so we can match a high-risk patient to a high-risk care model, we would rather not do the bundle. There is much less risk if you can risk adjust and get high-risk patients into the hands of providers who know how to handle high-risk patients.”

Building Capabilities Through BPCI

Many providers have viewed the Centers for Medicare & Medicaid Services’ Bundled Payments for Care Improvement model as a way to experiment with managing risk and building risk capability, DHG Healthcare’s Tolbert says.

Palos Community Hospital, Palos Heights, Ill. Since April 1, 2015, the 425-bed hospital has participated in the BPCI Model 2 90-day bundle for major joint replacement of the lower extremity. In late 2015, the hospital began participating in bundles for congestive heart failure and stroke.

“Participating in the bundle program was our approach to preparing for

anticipated changes in care delivery,” says Terrence Moisan, MD, president and CEO. “It’s helping us develop a coordinated system of care for treating these conditions in a way where the entire spectrum of health can be addressed from primary prevention, to care for seriously ill patients and support for their families.”

Margie Zeglen, FACHE, administrative director, network development and analytics, agrees. “We look at the bundles as a way to increase our agility and preparedness for future value-based care models,” she says.

For example, having monthly access to 90-day, episode-of-care data gives leaders insights on where dollars are spent across the continuum so they can target appropriate savings opportunities. So far, the hospital has reduced total 90-day, episode-of-care costs by 6 percent, which is above CMS’ target of 2 percent. The hospital also has increased the percentage of patients who have met the target pricing, primarily by focusing on coordinating care and working with providers and patients on reviewing the appropriateness of the post-discharge setting.

“We initiate a discharge planning process with patients before surgery that looks at the best and safest place for them to go after surgery,” Zeglen says. “Generally, if patients can go home after surgery, that is a better option for them.” These patients are able to participate in a rapid-start rehabilitation program as part of their home care. With an emphasis on patient care coordination and communication, the hospital has reduced costs and has decreased joint replacement readmission rates by 23 percent.

Zeglen says joint replacement is a good bundle to pilot because patients can be easily attributed to one surgeon or group for gainsharing. Looking at a 90-day episode also provides a longitudinal view of the patient’s care and health. “Reviewing and sharing information with providers helps prepare our system for managing population health,” she says.

Physician and hospital leaders are actively launching a clinically integrated network called Chicago Health Colleagues. It is governed by a board that is mostly comprised of community physicians. “Having the [clinically integrated network] led by community physicians

is so critical to getting them involved in the hospital's improvement efforts," says Ann Peterson, vice president, provider network services. "Showing them the success we've had so far with the bundles also helps get them engaged."

Although Palos has not yet entered into any risk-based contracts with commercial payers, Peterson believes Palos will in the future as its market continues to evolve rapidly. "Based on our experience, I feel comfortable we will be agile enough to adapt to the changes headed our way," she says.

Preparing for the Joint Replacement Model

In April, CMS designated 67 markets to participate in the mandatory Comprehensive Care for Joint Replacement model for MS-DRG 469 and 470. "By making this mandatory, CMS hopes to reduce the wide variability in spend that has existed across providers in these two DRGs," Tolbert says.

One of the designated markets in the CJR model is Nebraska's capital.

Bryan Health, Lincoln, Neb. The nonprofit, 640-bed health system has

not had as much experience with value-based models as hospitals and health systems on the coasts, but the organization is still taking note of what is occurring, says Kimberly A. Russel, FACHE, president and CEO.

"Even though it has been a slow evolution in Nebraska, we have been closely monitoring what is happening in other places and preparing our health system for value-based contracting," Russel says.

In fact, on April 1, the health system piloted bundled payments for hip and knee replacements as part of the CJR model. The alternative payment model covers care episodes that begin with the hospital admission and end 90 days post-discharge. It also includes all services paid under Medicare Parts A and B.

The timing of CMS' announcement requiring hospitals that were not participating in the BPCI initiative for joint replacements to join the CJR model was fortuitous, Russel says. Just prior to the CMS announcement in 2015, Bryan Health entered into a co-management agreement with a large, private group practice of orthopedic

surgeons for its entire orthopedic service line. "We already had a structure in place to work collaboratively with this key group of physicians to help us plan for this," she says. For example, the surgeons had identified key quality metrics the hospital and private practice would work on together.

As a rural state, Nebraska is home to many critical access hospitals, which often provide skilled care or rehabilitation services for joint patients after they have been discharged from tertiary care centers. However, under the CJR model, more patients may be discharged home. "This could represent a major operational change for a number of critical access hospitals in Nebraska, so we have been collaborating with them to determine how best to provide care for total joint patients, from prior to surgery through home healthcare," Russel says.

Looking ahead, leaders at Bryan Health also are trying to help community physicians prepare for value-based payment initiatives. The health system is one of nine founding members of the Enhance Health Network, a regional provider network of independent hospitals and health systems working together on clinical integration, payer contracting and shared services. Through a partnership with the Iowa Healthcare Collaborative, Enhance Health Network recently was awarded a Transforming Clinical Practices Initiative award from CMS. The grant will fund at least one full-time employee at Bryan Health to



Kimberly A. Russel, FACHE, president and CEO, Bryan Health, Lincoln, Neb., is leading her organization as it prepares to enter CMS's Comprehensive Care for Joint Replacement model.

RIGHT-SIZING RISK

Lessons Learned From Industry Leaders

assist community physicians in the move toward value-based payment.

Lessons Learned

When taking on greater levels of risk, healthcare leaders should consider the following lessons learned from industry experts and provider organizations.

Create internal alignment. “It’s not uncommon for the strategic planning department, the finance department and the quality department to work toward differing goals that create an unintentional division among leadership in these critical departments,” says Tolbert of DHG Healthcare. Gaining alignment among internal stakeholders is a critical factor in the successful management of new alternative payment models, which require institutional alignment across the care continuum.

Involve physicians. “To be successful in managing risk, you need to solidify your relationships with physicians,” says Russel of Bryan Health. “Ideally, that kind of collaboration should be ingrained in your culture.”

Keep employees informed. “We are continually communicating with employees to explain how the national trends impact us here at home,” Russel says.

Step up your presurgical patient education. As part of its BPCI pilot, Palos Community Hospital has increased patient participation in its presurgical joint care classes from 25 percent to 90 percent, thanks to



Craig Tolbert, principal, DHG Healthcare, Birmingham, Ala., believes organizations need to become risk capable to succeed under value-based payment models.

greater enrollment efforts by surgeons and care coordinators. Empowering patients to manage their care at home can prevent unwanted readmissions that compromise quality and increase costs.

Apply best practices to the entire patient population. “Clinicians say it is challenging to apply best practices to just the segment of the population that is at risk,” says Peterson of Palos Community Hospital. That’s why her hospital is now rolling out the joint care protocol to all joint patients, not just attributed Medicare patients.

Leverage outside expertise. THR used a consultant to determine which type of episode of care product would sell with national payers. In addition, the consultant helped THR price the model and internally allocate costs using its cost accounting system. THR also used another consultant to perform the predictive risk modeling. “Having an external consultant do the risk adjustment and be directly engaged with the 162.001(b) was a real advantage because no one could claim that our physician group was gaming the risk modeling,” Varga says. “It also helped to reassure the physician corporation that it is leading this effort.”

Make bundles easy to administer.

One of the challenges of selling bundles for episodes of care is that employers and payers have a difficult time understanding how to administer the bundles, Varga says. “If you want to get these embedded in a payer’s portfolio offering, you need to make the administration aspects as easy as possible,” he says. For this reason, THR’s bundles include a third-party administrator, utilization review/utilization management, care management, preauthorization and claims administration.

Determine whether payers in your market have the human capital in place to execute their contracts effectively. “You need to ensure payers have committed the necessary creative and collaborative leaders in their organizations to manage value-based contracts,” says THR’s Schornick. It also helps if both the payer and provider recognize the importance of humility when partnering on these arrangements. As Schornick puts it, “There are no experts in value-based contracting—we are all learning.”

Laura Ramos Hegwer is a freelance writer and editor based in Lake Bluff, Ill.