The Academy
The Health Management Academy

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Strategic Survey Q1 2019: Defining Risk

March 2019

Defining Risk

INTRODUCTION

In 2019, the U.S. healthcare market is poised to continue its march towards value-based care. In the context of increasing financial pressure and the prioritization of quality improvement, risk contracting provides health systems an opportunity to manage the total cost of patient care. Through risk assumption, clinically integrated networks are able to align quality and care coordination with cost containment and thereby deliver value to their communities.

In this special topic report, The Health Management Academy (The Academy) seeks to quantify participation in risk-bearing arrangements and understand the strategic prioritization of risk among Leading Health Systems (LHS).

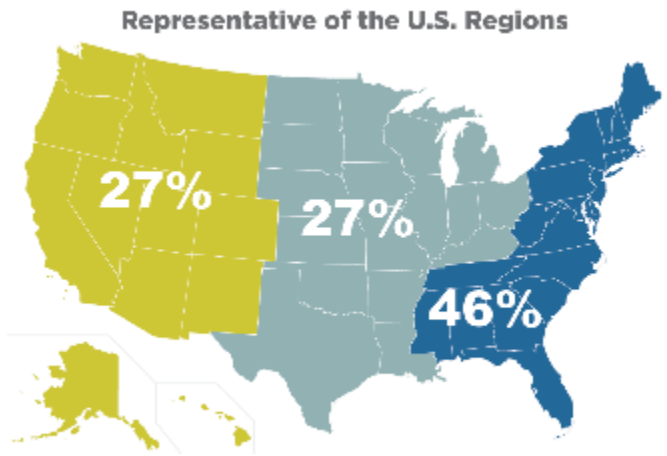
METHODOLOGY

In February 2019, The Academy conducted the eighteenth round of phone interviews for its quarterly strategic survey among LHS executives, including: CEOs, COOs, CFOs, CMOs, CNOs, and CSOs.

The survey for the interview consisted of:

1. A tracking section that provides insight into trends around primary strategic areas; and
2. A special topic area that allows for an in-depth look into a timely developing issue.

PROFILE OF PARTICIPATING HEALTH SYSTEMS



MEDIAN TOTAL OPERATING REVENUE

$3.1 BILLION

OWN OR OPERATE 168 HOSPITALS WITH 38,055 BEDS

SINGLE-STATE SYSTEMS: 67%

MULTI-STATE SYSTEMS: 33%

Key Findings

1

Definition

Health systems view risk and value-based care as separate but complementary. Risk is a construct for managing the premium dollar and a key mechanism by which they can deliver value to their communities.

2

Prioritization

Despite any limitations posed by regional market dynamics, 54% of health systems place a high priority on growing their risk portfolio. Moreover, 64% anticipate that the number of lives covered under such arrangements will grow in 2019.

3

Preparedness

Health systems' participation in risk arrangements is generally proportional to their preparedness for taking on risk. While 86% of health systems report having centralized oversight of these arrangements, the robustness of operational support seems to increase along with participation.

Risk and Value-Based Care are Separate but Complementary

In addressing health systems' participation in risk arrangements, it is necessary to first understand how they define risk and how they distinguish risk from value-based care. The general consensus is that risk and value-based care are separate but complementary concepts. Risk is a construct for managing the premium dollar and the overall cost of managing the health of the population allocated to the health system. As such, it provides a mechanism to focus on value, which seeks to address the core tenets of quality, cost, and access. The goal of value-based care is to improve outcomes and promote the overall health of the community. Health systems can avoid taking on additional risk while still developing programs that seek to increase value to their patients.

*"When I think of value, I think at a higher level around **the magic triumvirate of quality, cost, and access**. So to provide value to a community or population, you need to address all three. When I think about risk, I think about that more in terms of a component of value." (CFO)*

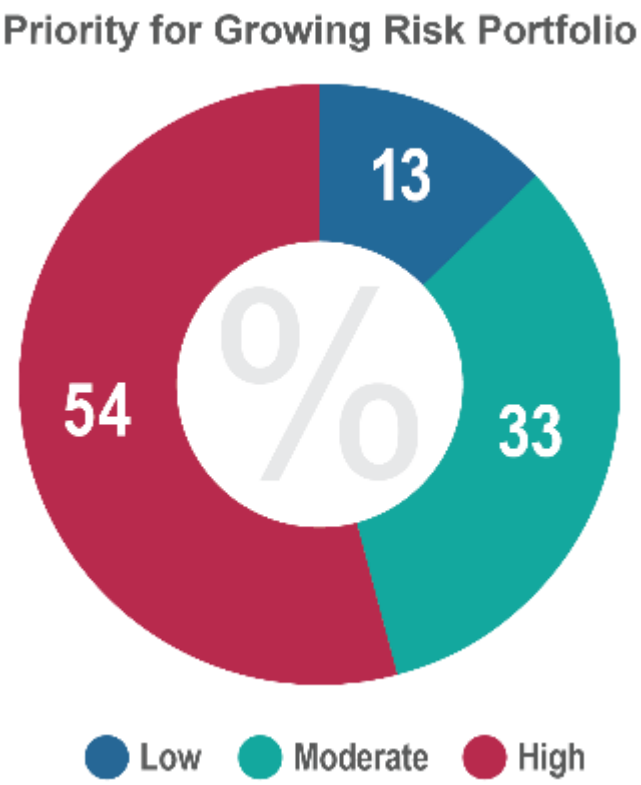
*"Risk and value-based care often get lumped together. They're not the same but connected. **Taking on more risk gives you an opportunity to approach value** in ways that you may not otherwise have had. Value is about what you are giving the community for what they're paying. The at-risk dollar gives you more options and a greater ability to provide value." (COO)*

*"A lot of these risk-based products talk a big game around quality, but they're really driven around unit cost and tied to a number. But **it's not just cost; it's proper utilization and outcomes**. That's why value is more important to us. It's beyond just the unit cost – it goes back to the numerator piece of the equation." (CFO)*

Priority Level for Growing Risk Portfolio is High

“Growing risk is a major factor for us. We think that the adoption of risk is the fuel that drives the transformation of healthcare and we’re all about that transformation. We want the way we’re being paid to be able to change both provider and consumer behavior.” (CSO)

Half of the health systems surveyed (54%) indicate a high priority for growing their risk portfolio. For these health systems, they see healthcare is moving toward value, especially as CMS continues to create new alternative payment models. They also report that it is preferable for them and the patients they serve to evaluate the success of their organization based on quality metrics rather than by volume, and risk-based contracting allows them to more easily tie quality to cost.



“Market forces aren’t pushing it too quickly. It takes time, and we don’t want to get too far ahead of it.” (CEO)

For health systems that place a moderate or low priority on growing their risk portfolio, it is generally because they are limited by market forces in their geography. In many areas, particularly on the East coast, payers are resistant to moving towards risk-based contracting.

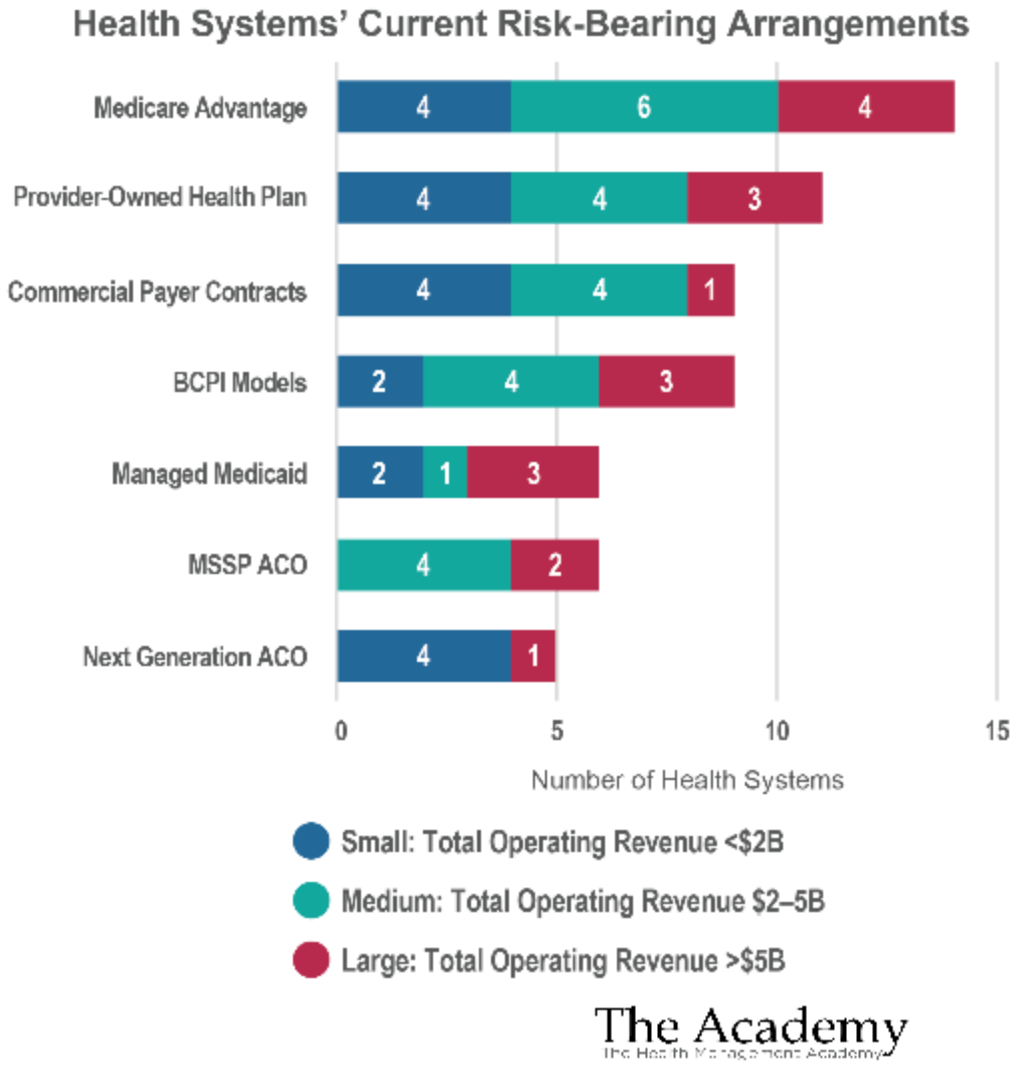
Aside from market dynamics, other limiting factors for growing risk-bearing arrangements are a lack of provider capacity, limiting the ability to take on additional lives, and a lack of IT capabilities, making it difficult to manage the population of attributed lives. Notably, some health systems averse to assuming additional risk are still prioritizing quality improvement and the overall value of care delivery. They do not view the concepts of risk and value-based care as mutually exclusive.

Medicare Advantage is the Most Common Risk Arrangement

Nearly all health systems (93%) are participating in the Medicare Advantage (MA) program, making this the most popular risk-bearing arrangement among the health systems surveyed. Other common arrangements among LHS are provider-owned health plans (73%), commercial payer contracts (60%), and Bundled Payment for Care Improvement (BPCI) models (60%). Less frequent arrangements include Managed Medicaid (40%), Medicare Shared Savings Plan (MSSP) ACOs (40%), and Next Generation ACOs (33%). While there is no apparent association between health system size and participation in risk-bearing arrangements, large health systems (total operating revenue >$5 billion) participate in an average of five different programs while small (total operating revenue <$2 billion) and medium (total operating revenue $2-5 billion) health systems participate in an average of four.

In 2019, most health systems are focused on increasing the number of covered lives within their existing risk programs, as opposed to joining new programs. Health systems most commonly expect the highest growth of covered lives in their commercial payer contracts over the next year, but this is primarily subject to local market dynamics specific to each health system. Others expect the most growth among their MA, ACO, or Managed Medicaid populations.

“We’re hopeful the joint venture we have with a commercial payer for our Medicare Advantage plan will continue to grow. That’s the largest we have right now.” (CMO)



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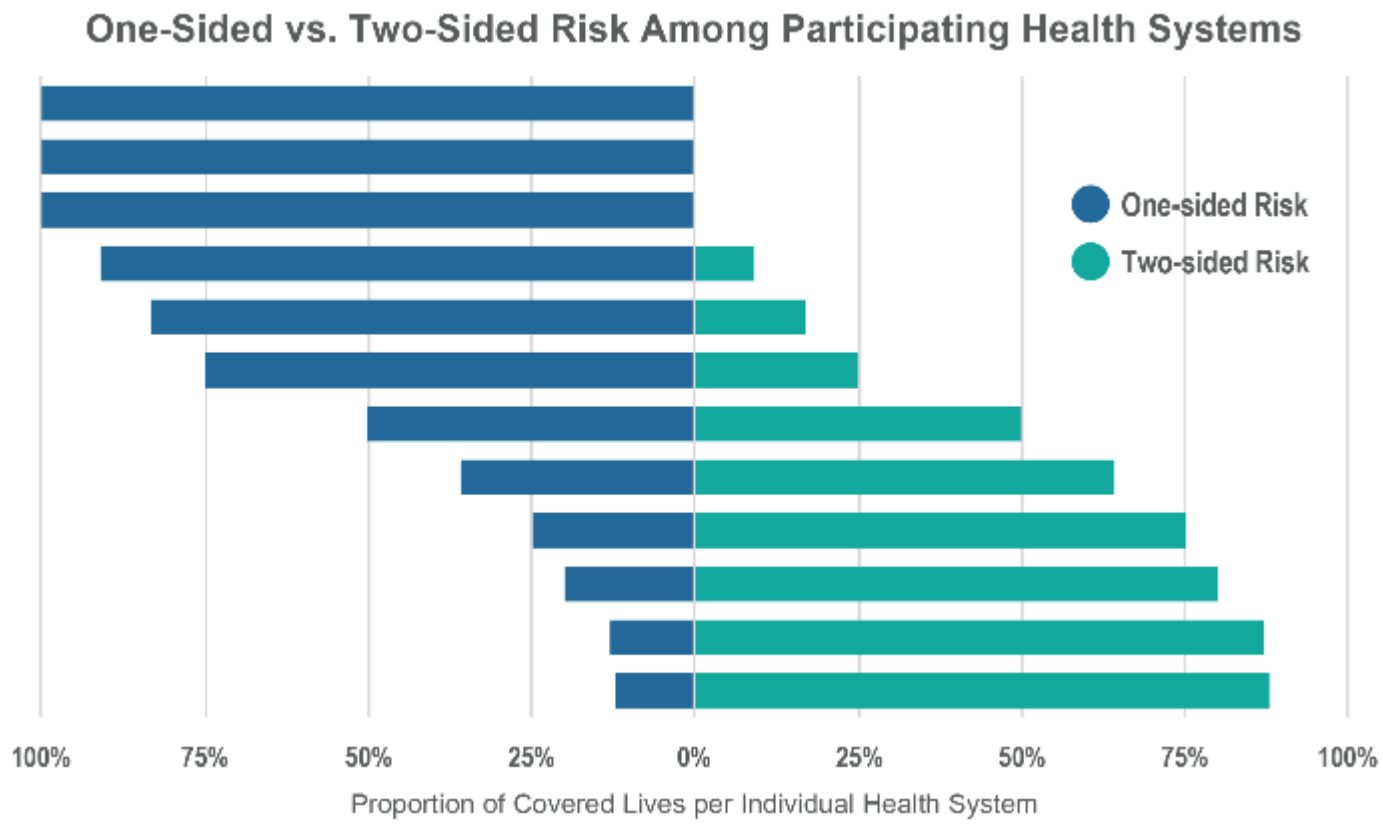
Lives Covered Under Risk Contracts Expected to Increase



"Almost everything right now is one-sided. We are acquiring another health system, which already has a NextGen ACO and this will bring in some two-sided risk." (CMO)

Reflective of health systems' diverse risk portfolios, there is notable variation between the proportion of lives covered under one-sided and two-sided risk. Some health systems exclusively participate in one-sided risk arrangements, while others lean more towards two-sided risk. This variation is predominantly due to each health system's geographical region and unique payer mix in its market. These market dynamics strongly affect the types of risk contracts in which health systems are able to participate. Despite this variation, all participating health systems have at least some population covered under upside-only risk contracts.

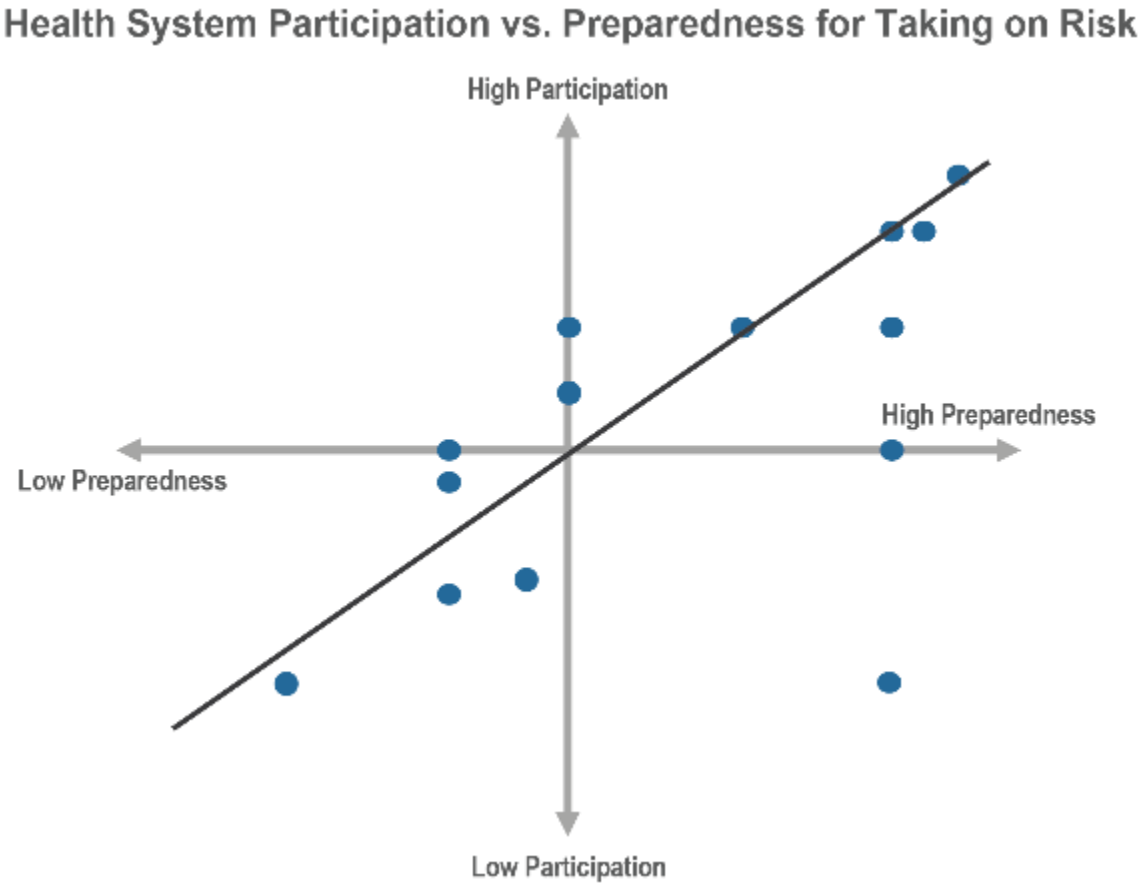
Most health systems (64%) expect that the number of lives covered under these risk arrangements will increase over the course of 2019. Reflective of their preference to continue growing their current risk arrangements rather than entering into new programs in 2019, health systems primarily involved in one-sided risk will continue to focus on one-sided risk, and vice versa.

Variation in Participation and Preparedness for Risk

In evaluating the risk landscape among LHS, it is helpful to compare health system participation in risk-bearing arrangements to their preparedness for assuming risk. A majority of health systems (86%) indicate there is centralized leadership and governance that oversees participation in all of their risk-bearing arrangements. However, these organizational structures are relatively new for many health systems, so the comprehensiveness of operational support capabilities within this domain varies substantially among systems.

In general, health systems' participation in risk is proportional to their preparedness. For some health systems in markets that aren't ready to move towards risk yet, their preparedness greatly outweighs their participation. And for others, they have begun participating more substantially in risk programs without having developed robust internal support and oversight that health systems with more mature risk portfolios have.

"Fragmentation and duplication led us to centralize the management of all our arrangements. Our data analytics journey showed us that we were touching some people multiple times, and others were falling through the cracks. We were completely disjointed for prior-authorization and what we should be taking from the EHR versus claims data. Conflicts began to expose themselves, and so we centralized these operations over the last 18 months." (COO)



Note: Participation refers to the number of different risk-bearing arrangements and the number of lives covered under risk contracts. Preparedness refers to the organizational infrastructure and support capabilities for managing risk populations, as well as the overall priority for growing risk.

Success Measures Focus on Quality, Access, and Cost

A majority of health systems (92%) indicate that they have developed a robust IT infrastructure and data analytics that allow them to track measures of success across their various risk arrangements. In general, these success metrics fall into three broad categories: quality, access, and cost. While there are some metrics that are consistent across programs, there are also success metrics that are idiosyncratic to the objectives of each specific program.

Health systems have invested in a variety of technology platforms to support the aggregation and analysis of data across programs. Some platforms that have been implemented include Epic Healthy Planet, McKesson Risk Manager, Jiva, MedeAnalytics, Evolent Health Identifi, MIDAS, Apache Spark, and other homegrown tools.

Quality

- Clinical continuity/variation
- Patient outcomes
- Patient satisfaction
- Length of stay
- Preventive screenings
- Admissions/readmissions

Access

- Response times (time from initial call until appointment)
- Volume per 1,000 members
- Ambulatory clinic wait time
- Surgery wait time
- Other procedure wait time

Cost

- Margin on risk-bearing lives
- Cost per case
- Cost per member per month (PMPM)
- Prescription spend PMPM
- In-network vs. Out-of-network spend PMPM
- Actual vs. expected spend PMPM

“That’s the biggest issue we have. When we talk about managing a population, not having all of the data makes it difficult. That’s why we’re pushing for clinical continuity – trying to refer only within our health system. That way we will have all the information we need without relying on claims data. It will already be in our EMR.” (CFO)

About The Academy

The Health Management Academy, "The Academy"

The Health Management Academy (The Academy) is a membership organization exclusively for executives from the country's Top-100 Health Systems and most innovative healthcare companies. The Academy's learning model identifies top priorities of health system leaders; develops rich content based on those priorities; and addresses them by convening members to exchange ideas, best practices, and information. The Academy is the definitive trusted source for peer-to-peer learning in healthcare delivery with a material record of research and policy analysis. Offerings include C-suite executive peer forums, issues-based collaboratives, leadership development programs, research, advisory, and media services. The Academy is an accredited CE provider. More information is available at www.academynet.com.

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About Lumeris

Lumeris is a value-based care managed services operator for health systems and providers seeking extraordinary clinical and financial outcomes. Lumeris aligns providers and payers across populations with technologies, processes, behaviors and information to achieve high-quality, cost-effective care with satisfied consumers — and engaged physicians. For the past eight years, Essence Healthcare, Lumeris' inaugural client and learning laboratory with more than 65,000 Medicare members in Missouri and Illinois, has received 4.5- to 5-Star Ratings from the CMS and produced the highest consumer and physician satisfaction scores in the industry along with significantly better clinical outcomes and lower costs. For more information, go to www.lumeris.com.

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