ARTICLE

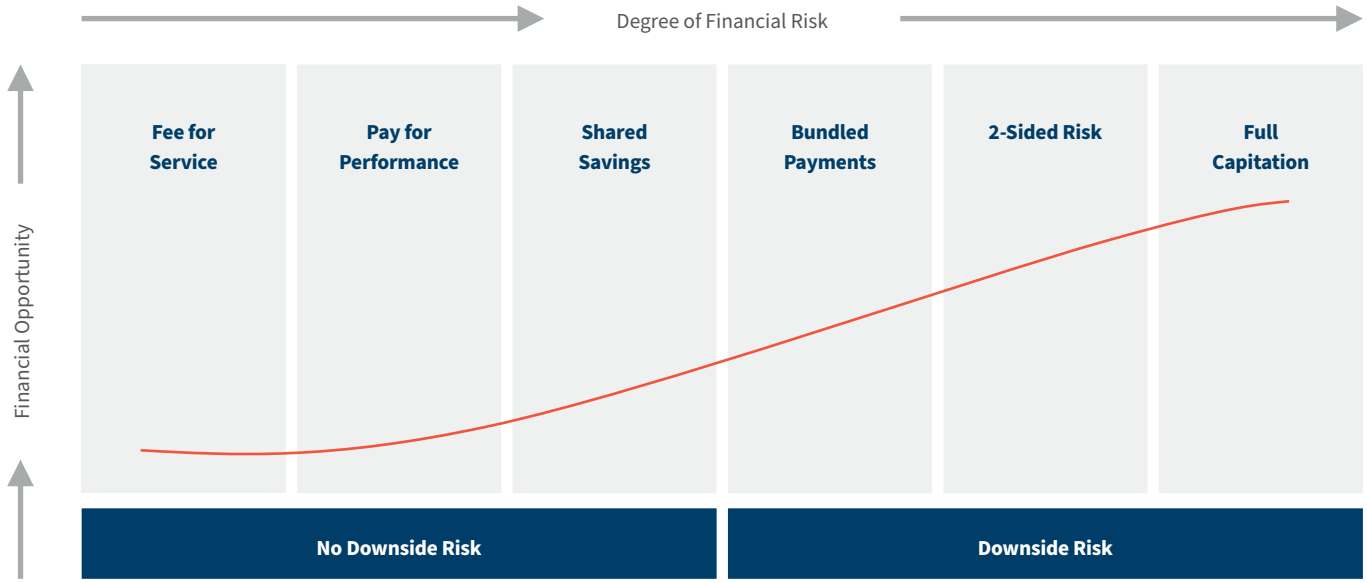
Introducing FTI Consulting's Market Maturity Model for a Risk-Based Ecosystem

Healthcare payers have evolved and become highly sophisticated in their Enterprise Risk Management capabilities, enabling them "to use a cross-functional approach to assess, evaluate, and measure risks, and help guide decision-making within the organization's tolerance for risk."[1] Risk management is central to the payer business model and entails product design and pricing, contracting and network creation, and medical expense management — the last including managing demand, limiting the volume of services, and steering and managing care. Actuaries set the price for a product and determine risk and model variations, while underwriters are responsible for determining what risk the company will take on and under what conditions on a case-by-case basis.

The advent of value-based care, based on the Institute for Healthcare Improvement's "Triple AIM" framework (improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care), has pressured providers to shift their focus from volume to value.[2] And, as providers shift to value-based activities, their reimbursement model is also more in alignment with payers. Like payers, providers now benefit from a fundamental understanding of and ability to manage risk.

Taking risk presents multiple financial opportunities for provider groups. As providers take on more accountability for patient care in exchange for greater reimbursement, they should understand the degree of risk-sharing associated with alternative business models. For example, the transition into risk-sharing can be gradual, beginning with pay-for-performance or one-sided shared savings opportunities and, with increasing experience, extend to a full risk commitment consisting of global capitation.

Continuum of financial risk to providers



Value-based initiatives are here to stay

Value-based initiatives are being driven by Medicare. In 2020, there were 61.7 million Medicare beneficiaries and total expenditures were $856.5 billion; spending per enrollee is $14,536. Due to a rapidly aging population, Medicare expenditures are forecast to reach $1,559.4 billion in 2028, with spending per enrollee reaching $20,751.[3] Medicare's focus on value-based reimbursement will gain urgency as the population ages and costs rise.

A common structure used to manage value-based initiatives is an Accountable Care Organization (ACO), which is composed of "groups of doctors, hospitals, and other health care providers and suppliers who come together voluntarily to provide coordinated, high-quality care at lower costs to their original Medicare patients."[4] Most ACOs have multiple participating providers, with an average of 37 participants comprising hospitals, health systems, physician groups and solo practitioners.

In 2021, approximately 11.9 million Medicare beneficiaries were enrolled in 518 ACOs; 10.7 million (90 percent) in Medicare Shared Savings Program (MSSP) and 1.2 million (10 percent) in Next Generation ACOs.[5,6] The MSSP requires ACOs to meet a number of quality and performance benchmarks, and then offers shared savings when the ACOs achieve their goals. The majority of MSSP participants, 59 percent, were enrolled with one-sided, upside-only risk, and the remaining 41 percent were enrolled with two-sided, upside/downside risk. Next Generation ACOs allow participants to assume higher levels of risk and, potentially, higher rewards. The average size of an ACO is 22,973 members.

New value-based initiatives are continuously being developed. For example, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 altered the physician payment model; its two-track Quality Payment Program focuses on value. The Medicare Incentive Payment System (MIPS) track adjusts payment based on costs, quality, promoting interoperability, and improvement opportunities. Payment lags reporting by two years; thus, performance reporting in 2020 results in payment adjustments for 2022. The maximum MIPS payment adjustment for 2021 is 7%, and for 2022 it is 9%.[7]

The Advanced Alternative Payment Model (AAPM) track includes the Comprehensive Primary Care Plus (CPC+) model, Medicare Shared Savings Program (Basic Track Level E and Enhanced Track, Track 1+, Track 2), Medicare ACO (Track 1) and the Next Generation ACO Model.[8]

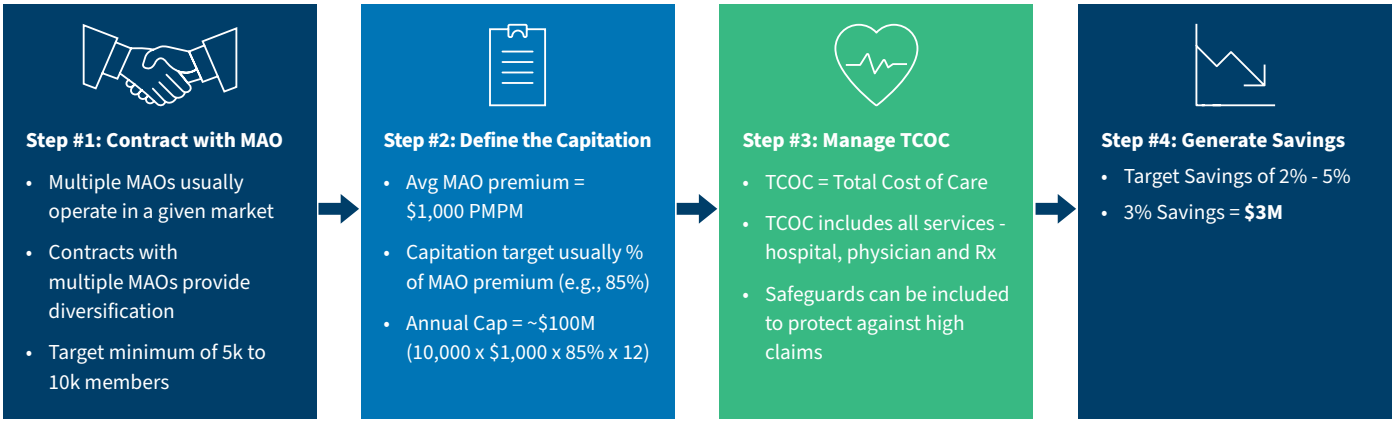
Direct Contracting and Primary Care First (PCF) are the most recent CMS payment models, effective in 2021. Direct Contracting entities will have two risk options: the Professional option, with 50% shared savings/losses with CMS and the entities receive a primary care capitation payment; and the Global option, with 100% shared savings/losses with CMS and an opportunity to choose between primary care or total care capitation. Discounts (to ensure CMS gain) and quality withholds (which can be earned back) to historical benchmarks are applied.[9]

Primary Care First is "oriented around five comprehensive primary care functions: (1) access and continuity; (2) care management; (3) comprehensiveness and coordination; (4) patient and caregiver engagement; and (5) planned care and population health."[10] Flat and population-based payments, and an incentive-based adjustment, are included in the model.

At-risk contracting can be profitable

Provider groups have been very successful in at-risk contracts with Medicare Advantage Organizations (MAOs) for managing the overall health care of their patients. A hypothetical global capitation arrangement between a primary care group comprising 20 physicians with an average panel size of 500 Medicare patients (10,000 patients total) and a MAO can result in significant savings opportunities that drop to the bottom line, as illustrated below:

Case study



Managing the total cost of care — an outcome measure — is essential. This includes investment in information technology, analytics and select personnel, e.g., care coordinators. The chronic disease life cycle is typically progressive and subject to acute, intermittent events. The key to effective chronic care management is risk stratification, proactive intervention, transition management, and ensuring that provider organizations have the tools and processes to manage the enterprise risk with the same sophistication as a payer.

FTI consulting market maturity model

A team at FTI Consulting developed a market maturity model highlighting six critical success factors essential to the value-based evolution of providers. These factors include contracting and physician engagement, operations and analytics, member engagement, care models, compliance and financial acumen. Each of these factors has three to five focus areas across the continuum.

- Contracting affects the level of physician engagement. The alignment of incentives and risk drives physician behaviors.
- Analytics are essential to operations. Risk stratification identifies patients with chronic conditions requiring case management. Panel size will be determined by the clinical needs of the patient and not efficiency (i.e., throughput). The reporting of population health metrics such as gaps in care highlights an increased focus on prevention. Lastly, coding practices will focus on diagnosis rather than solely on procedures.
- Member engagement requires two-way communication that focuses on health-related issues, such as changing lifestyle to promote health, adhering to a treatment plan (including medication regimens), making office visits for lab tests, physical exams and clinical consultations, closely monitoring signs and symptoms and responding with appropriate actions, e.g., contacting a provider. Patients with multiple chronic conditions require close monitoring. Providing ready access and enabling tools facilitates member engagement.
- Successful delivery system redesign (i.e., care models) requires a focus on secondary prevention (early detection and intervention), tertiary prevention (treating established disease to prevent deterioration), closing gaps in care, managing care transitions (e.g., from hospital to home), treating behavioral health issues, facilitating self-management and, if appropriate, offering palliative care. Preemptive "whole person" care across the continuum, supported by analytics and, if necessary, case management, is required.
- Compliance requires design of a framework with well-documented policies and procedures, supported by a strong training program and detailed controls reporting.
- Financial acumen is associated with an organization's ability to ingest new sources of data from payers and CMS, and to translate this data into financial projections that enable the organization to accurately predict cash flows, manage capital investments and maintain strong relationships with investors.

Moving to maturity – 6 key factors

	Initial	Matured	Optimized
Contracting and Physician Engagement	• **INCENTIVES:** Fee for service with physician incentive enhancements (mainly quality-based) • **RISK LEVEL:** Low levels of risk sharing • **ALIGNMENT:** Minimal alignment between payor contracts and provider compensation	• **INCENTIVES:** Physician incentives based off practice performance • **RISK LEVEL:** One-sided risk model; • **ALIGNMENT:** Some alignment between payor contracts and provider compensation; shared savings pool with distributions to providers	• **INCENTIVES:** Provider compensation and incentives is completely aligned with payor contracts and practice performance • **RISK LEVEL:** Two-sided risk models (mainly global capitation) • **ALIGNMENT:** Shared savings pool with distributions to providers
Operations and Analytics	• **PATIENT PRIORITIZATION:** Few changes to patient scheduling/intake • **CODING:** Practices focused on optimization of revenue cycle (Procedure vs Diagnosis) • **PANEL SIZE:** Emphasis on efficiency rather than completeness of visit • **REPORTING:** Monthly reporting based on productivity-based measures	• **PATIENT PRIORITIZATION:** Start prioritizing patient scheduling using chronic conditions and gaps in care • **CODING:** Practice is mostly focused on full documentation of procedures and diagnosis (largely retrospective) • **PANEL SIZE:** Beginning to make investments care management • **REPORTING:** Changing reporting to focus on measures showing gaps in care	• **PATIENT PRIORITIZATION:** Scheduling incorporates regular outreach to high-priority patients • **CODING:** Practices are fully focused on full documentation of procedures and diagnosis (real-time and interactive) • **PANEL SIZE:** Emphasis on completeness of visits rather than efficiency • **REPORTING:** Reporting on individual patient care gaps and other reporting on demand
Member Engagement	• **ACCESS:** Driven by the practice and provider • **VOICE OF THE CUSTOMER:** Low level of patient feedback. Limited to required surveys by CMS • **FOCUS ON WELLNESS:** Lack of tools and clinical focus on proactive health and wellness leading to low member engagement	• **ACCESS:** Multiple options available for patients • **VOICE OF THE CUSTOMER:** Begin to invest in member engagement platforms and technologies leading to: — Greater level of patient feedback — Greater level of active member engagement • **FOCUS ON WELLNESS:** Begin to invest in practice approaches to health and wellness	• **ACCESS:** Full consumer preference (i.e., at home visits, remote patient monitoring, etc.) • **VOICE OF THE CUSTOMER:** Customize surveys delivered through multiple channels with real-time feedback • **FOCUS ON WELLNESS:** Multichannel, proactive approach to management in health and wellness with tools and technologies to enable

Moving to maturity – 6 key factors

	Initial	Matured	Optimized
Care Models	• **PROVIDERS:** Mostly physician driven with little reliance on APPs to treat conditions • **DATA & ANALYTICS:** No capabilities • **CASE MANAGEMENT:** No care management • **CONTINUITY OF CARE:** Not considered • **WELLNESS:** Not considered	• **PROVIDERS:** Relying on alignment of complexity of care with degree of expertise and licensure • **DATA & ANALYTICS:** Investing in data and analytical capabilities • **CASE MANAGEMENT:** Investing in care management • **CONTINUITY OF CARE:** Begin to consider transitional care management • **WELLNESS:** Begin to consider "pre-emptive, whole person" care	• **PROVIDERS:** Use of integrated care teams to maximizing level of licensure • **DATA & ANALYTICS:** Use of predictive analytics to identify patients likely to experience adverse events • **CASE MANAGEMENT:** Deployment of care managers to at-risk patients • **CONTINUITY OF CARE:** Focus on transitional care management • **WELLNESS:** Fully implemented provision of pre-emptive, "whole person" care
Compliance	• **DESIGN:** Focus on fee-for-service and revenue cycle • **FRAMEWORK:** Lack of policies and procedures with respect to managed care; Limited auditing and testing • **TRAINING:** Limited training for the organization with respect to risk adjustment	• **DESIGN:** Basic physician training and education programs initiated • **FRAMEWORK:** Well documented policies and procedures with a focus HCC coding and RADV audits • **TRAINING:** Active training and refreshers for the organizations coding team	• **DESIGN:** Robust compliance program with a focus on accuracy of member reimbursement • **FRAMEWORK:** Well documented policies tested by external and independent reviews • **TRAINING:** Specialty specific education programs for physicians based on individual physician needs
Financial Acumen	• **MODELING:** Little to no financial modeling and forecasting (based on prior year plus growth) • **ANALYTICS:** Revenue driven by quantity and severity of visits rather than member population and outcomes; basic budgeting process with no tie to analytics and operational results • **REPORTING:** Heavy reliance on payor-based reports	• **MODELING:** Beginning to introduce financial modeling and forecasting (based on membership and patient health status) • **ANALYTICS:** Beginning to rely on in-house analytic platforms and modeling • **REPORTING:** Active financial reconciliation between operational results and payor reporting	• **MODELING:** Proactive financial models and forecasting that tie to the analytics and operational results that allow for real-time changes; Establishment of financial reserves • **ANALYTICS:** Leveraging financial models as a form of checks and balances within operations • **REPORTING:** Managed care models help drive cash flow forecasting and balance sheet initiatives

Bottom line

Organizations can optimize performance by redesigning incentives for payers, providers and patients alike. Providing patients with tools to proactively care for their health and wellness creates incentives for patients to engage in their health. Redesigning the relationships between payers and providers to incentivize more frequent assessments with patients in order to help them stay well, and to assess and treat chronic conditions can focus care on high-value activities, eliminate waste and overtreatment in the system, and allow both payers and providers to benefit from keeping patients healthier.

However, realigning and redesigning a provider group to incorporate more sophisticated tools that payers employ means more than modifying compensation contracts. Investments in analytics and operational changes are required to ensure provider groups have better visibility into what is happening within the entire team — with patient health, within their provider operations, and within their financials – their bottom line. And to achieve excellence some organizations might choose to add experienced staff to ensure organizational functions are aligned and prepared for a great performance.

Citations

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