

ALERT

The Return of Risk Sharing

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The Healthcare practice of Navigant Consulting is dedicated to exploring business issues of relevance to senior level executives. Our Navigant Consulting Alert series is intended to offer new perspectives and insight as you consider the strategic direction of your organization.

Recent announcements from Washington all point toward a reduced dependence on fee-for-service payment in favor of systems that “would pay for care that spans across provider types and time (encompassing multiple visits and procedures) and would hold providers accountable for the quality of care and the resources used to provide it.”¹ It’s not capitation, but it is transferring risk to providers.

We are seeing renewed interest in hospital-physician integration. In addition to the significant increase in physician employment by health systems, these announcements have opened at least four new corridors of hospital-physician integration that are further explored in the remainder of this document.

#1: Stark Exempt Quality Improvement and Cost Savings Incentive Programs

Although the current Medicare physician self-referral law (the “Stark Law”) is potentially invoked by any payment made to a physician under pay-for-performance (P4P), gainsharing and other similar quality improvement and cost savings incentive programs, the Centers for Medicare and Medicaid Services (CMS) recognizes that these programs can be beneficial to providers, payers and patients. Therefore, in order to stimulate their development, the proposed 2009 Medicare Physician Fee Schedule creates an exception to the Stark Law for these programs.

What should you do to prepare to participate?

1. Review in detail the proposed regulation in the 2009 Medicare Physician Fee Schedule, 73 FR 38502, or consult your legal counsel for a summary.²
2. Assess your quality improvement and cost savings opportunities in cardiology and orthopedics – two areas with the greatest gainsharing opportunity and experience.
3. Meet with your physicians to discuss these programs, assess their interest in and commitment to them, and explore potential opportunities to develop and implement them at your organization.
4. Review with your physicians the CMS “Specifications Manual for National Hospital Quality Measures” to begin the process of selecting performance measures – as presently written the proposed rule requires that hospitals select measures from the CMS Manual.³
5. Begin calculating baseline performance levels for use in determining quality/performance improvement payments to physicians – draft regulations require hospitals to use actual acquisition costs for items and supplies or the costs of delivering specified services, for all patients during the one-year period prior to initiating the program.

We observe that the industry has had just enough exposure to P4P and gainsharing to have developed some cynicism around them. Hospitals may believe: (a) that this is just a new way for payers to pay less; and (b) that physician behavior will “relapse” the moment financial incentives diminish and will end up costing more in the long run. On the other hand, with increasing cost pressures can hospitals afford to pass up any legal opportunities to capture savings and quality improvements connected to physician discretion?

#2: Clinically Integrated Contracting Vehicles

“Clinical integration” is used to describe certain types of collaboration among otherwise independent healthcare providers to improve quality and contain costs. Hospitals and physicians which form a collaborative entity to integrate and coordinate the provision of medical services to patients typically utilize best practices and evidenced based medicine in treating patients. Patients’ treatment and physicians’ individual and aggregate performance are monitored and measured against benchmarks for improved patient outcomes and reduced costs and resource use. The Federal Trade Commission has indicated that clinical integration efforts that involve substantial integration and that have the potential to result in significant efficiencies that benefit consumers may be allowed to jointly contract with health plans.

In the past, this activity would have invited anti-trust review. Today the FTC’s Bureau of Competition has issued advisory opinions, most recently to Greater Rochester Independent Practice Association,⁴ commenting on the merits of such a program.

What should you do to prepare to participate?

1. Assess the current PHO/IPA landscape within your organization/market and determine whether your existing PHO/IPA can facilitate clinical integration or whether you need to revise or reconstitute it, or perhaps develop a new one.
 - ▶ Risk bearing PHOs/IPAs may have experience with information management/sharing that may be repurposed for this level of risk sharing
2. Evaluate the contracting infrastructure within the PHO/IPA and/or the hospital organization (e.g., systems, care management, use of evidence-based protocols) and the interest of payers in your community.

¹MedPac, Report To Congress: Reforming the Delivery System, June 2008

²www.cms.hhs.gov/center/physician.asp

³www.cms.hhs.gov/hospitalqualityinits/10_hospitalqualitymeasures.asp

⁴<http://www.ftc.gov/bc/adops/gripa.pdf>

3. Profile the current state of independent physician practices in the market and forecast the likely future of independent practice in the market.

Generally speaking, we believe a clinical integration strategy is more relevant with independent physicians than in those markets that are aggressively moving towards health system employment as this opportunity addresses the class of payer which hospitals and physicians believe yields the greatest financial return. Therefore, any innovation which promises to deliver more good paying patients is likely to be embraced.

#3: Acute Care Episode (ACE) or Health System-Physician “Bundling” Demonstration Projects

In an effort to “align financial incentives” between hospitals and physicians, on May 18, 2008, CMS announced plans for an Acute Care Episode (ACE) demonstration project that will feature bundled payments. For purposes of the demonstration, a bundled payment is a single payment for both Part A and Part B Medicare services furnished during an inpatient stay.

CMS argues that bundling, compared to paying for inpatient services on an individual basis, may incentivize physicians to provide the most efficient and cost-effective care. CMS Acting Administrator Kerry Weems states, “CMS expects to demonstrate how to not only better coordinate inpatient care, but to also achieve savings in the delivery of that care that can ultimately be shared between providers, beneficiaries, and Medicare.”

The demonstration project, open to applicants in Texas, Oklahoma, New Mexico, and Colorado, will competitively award only **one** ACE demonstration site per market area during the first year of the demonstration. Each demonstration site, or “Value-Based Care Center,” will be selected and actively marketed by CMS to both beneficiaries and referring physicians. The clinical focus of the demonstration project is on orthopedic (9 procedures) and cardiac (28 procedures) inpatient surgical services.

What should you do to prepare to participate?

1. Share the demonstration project proposal with your cardiac surgery and orthopedics medical staff members.
 - › For organizations in one of the four states, hopefully you’ve been on top of this as applications were due August 15 (sites are to be selected in October with the demonstration sites up and running as of January 1, 2009).
2. For organizations not in the four states, conduct a hypothetical review of your “bundled” performance based on current volume, quality and cost indicators.
3. Monitor the demonstration projects’ progress⁵ and be prepared to mobilize assuming the demonstration project is rolled out to other markets. Test any major investment in cardiology and orthopedics to ensure it makes economic sense under a “bundled” reimbursement scenario.

We expect many organizations will conclude they are better off financially under the current system and will not pursue a demonstration project. While that may be true for most organizations, a key longer-term strategic question is whether a “market maker” will emerge in your market who will embrace a “budget neutral” option as an opportunity to build volume and align proceduralists. As a result, you should look not only at whether it would be financially beneficial to your organization to participate in a demonstration project but also at the potential downside risks if some other organization does and uses it to move market share.

#4: Medical Home Primary Care Models

The medical home model is an approach to providing comprehensive care in which each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care. The personal physician leads a team of care givers who collectively take responsibility for providing for all of the patient’s healthcare needs or appropriately arranging care with other professionals for all stages of life (acute care, chronic care, preventive services, and end of life care). In the medical home concept, care is coordinated and integrated across all elements of the healthcare system (subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (family, public and private community-based services). Access to care is enhanced through systems such as open scheduling, expanded hours, and new communications options. In addition, care is facilitated by registries, IT, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.⁶

What should you do to prepare to participate?

1. Assess the current supply, demographics and organization of primary care physicians in your market and on your medical staff.
 - › Are you right-sized relative to the market supply/demand?
 - › Is the practice structure/organization of primary care physicians adequate to participate in the medical home concept (i.e., solos or groups of primary care physicians)?

⁵www.cms.hhs.gov/DemonstrProjectsEvalRepts/

