

Becoming risk-capable: A group's transformation story

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Medical practices are at a tipping point today when it comes to preparing for value-based payments. Most practices have a significant portion of their revenue tied to fee-for-service (FFS) arrangements and are struggling to navigate new risk-based contract methodologies. The Centers for Medicare & Medicaid Services (CMS) is accelerating the percentage of payments tied to high-quality/low-cost metrics, and commercial payers are quickly following suit. The transformation in payment methodologies has created a heightened level of urgency for providers to understand how they can successfully migrate from a volume-driven business model to a value-driven platform.

To successfully transition to this value platform, practices must prepare to assume greater risk associated with payment for services and understand how this change will affect them financially and operationally. This is the core of the concept “risk capability,” a term that refers to an organization’s ability to be able to thrive and succeed in a risk-based environment.

To increase its risk capability, an organization must focus on three critical areas:

- Enterprise intelligence
- Revenue transformation
- Clinical enterprise maturity

Risk capability can be assessed by understanding your practice’s capabilities around enterprise intelligence (the ability to understand internal/external data and use it to identify opportunities for strategic development, effectively manage



new payment models and influence the practice's value proposition), revenue transformation and clinical enterprise maturity. Once a practice assesses its capabilities in these areas, it can begin to align strategies and goals that optimize those capabilities and create a roadmap for future success. Here's how one medical practice became risk-capable.

A practice journey

Blue Ridge Bone & Joint (BRBJ), Asheville, N.C., embraced risk after acknowledging changes in the marketplace. The independent orthopedic surgery practice has 21 fellowship-trained physicians in the following specialties: orthopedic surgery, physiatry, family practice, sports medicine, occupational therapy and physical therapy. Five locations accommodate approximately 85,000 visits annually. After passage of the Patient Protection and Affordable Care Act, distinctive exclusion conversations with payers and self-insured employers about inclusion in narrow networks, and recent hospital integration and bundled payment activities, practice leaders wanted to assess the group's position and capabilities to prepare for the future.

BRBJ conducted a market assessment, assessed its data analytic capabilities and created a payer view scorecard to assess enterprise intelligence. Practice leaders reviewed clinical documentation and coding routines, care management capabilities and outcomes to address the clinical enterprise component. The revenue transformation step focused on provider compensation methodology and cost and efficiency from a collections cycle perspective.

Enterprise intelligence

An examination of population data and internal system information demonstrated that BRBJ had a strong position in terms of access and accolades but needed to become more transparent about

sharing information with partners to illustrate its value proposition. The value proposition statement was developed with key marketing materials for payers, hospitals, accountable care organizations, independent physician associations and other existing and potential partners. This process confirmed that BRBJ did not have a deep understanding of its referral sources. The leadership began a comprehensive review of referral patterns so the practice could anticipate market shifts and meet patient expectations.

Next, practice leaders developed a deeper understanding of payer perspectives. BRBJ identified key managed care payers, obtained ratings by provider and organized the information in a matrix. The process uncovered several important findings, including a high-quality/efficiency rating from payers, but there were some inconsistencies. The immediate takeaway was to correct panel listings and initiate conversations with payers to better understand inconsistencies and, in some cases, appeal ratings. BRBJ then leveraged this information during managed care contract negotiations with a written, well-articulated value proposition — a document that outlined practice service offerings, outcome measures, quality ratings and patient satisfaction scores and then integrated the value proposition with the payer's goals. The exercise demonstrated the ways in which the practice aligned with payers and its interest in acting as a true partner, which proved to be a very successful strategy.

By showing that BRBJ is pursuing the Triple Aim, payers were more open to exploring how the two groups could work together and rewarding BRBJ with an increase in its FFS rates to share the savings that resulted from BRBJ's efforts. For example, one payer that denied any increases in the last renegotiation provided a 5% increase after BRBJ discussed its value proposition, which demonstrated high-quality healthcare at affordable



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prices and high patient satisfaction. BRBJ has also successfully explored performance-based contracts with payers instead of asking for percentage increases based on volume.

Transparency

In January 2015, Blue Cross Blue Shield of North Carolina published 1,200 nonemergency and elective procedures to help consumers make more informed decisions about the cost of healthcare expenditures. BRBJ leaders recognized the importance of assessing how their group compared with peers and understanding the information that was available to patients. Table 1 summarizes some of the comparative information that was helpful to BRBJ. The Blue Cross Blue Shield of North Carolina tiered network uses administrative claims data to identify high-quality, low-cost providers and help consumers make more informed choices for their medical care. Transparent methodology provides physicians with access to information on how their performance compares with their peers on nationally accepted quality measures as well as local cost efficiency benchmarks. Comparison is based on geographical region and across like specialty groups. Practices were aligned and segmented by their area of specialty, and were first measured against a quality rating and then subsequently against cost. Practices that exceed both the quality and cost thresholds were designated as Tier 1 practices, and all other practices were designated as Tier 2, as noted in Table 1.

BRBJ practice leaders then reviewed internal data analytics competencies and identified gaps in data mining capabilities that would be necessary for new payment methodologies. For example, a methodology to develop bundled pricing was developed and grounded in data analytics. BRBJ needed to understand its costs in order to

provide prompt, accurate feedback internally and externally. This foundational competency is key for the group as it ramps up for the CMS Bundled Payments for Care Improvement (BPCI) initiative.

Using the practice’s technology platform, BRBJ leaders identified trend reporting opportunities to better integrate clinical and financial data, which allowed them to assess risk-taking ability at an episodic level and to establish a baseline for comparing future methodologies. For example, when it comes to bundled payment for hip and knee procedures, BRBJ needed to understand cost per episode of care, which included post-acute providers, to ensure profitability.

Clinical enterprise maturity

This assessment included an evaluation of governance and care management activities. The practice had an inclusive committee structure with finance, clinical excellence, marketing and operations committees that included the chief executive officer (CEO). These committees empowered selected physicians to work with the CEO to complete the assessment and determine next steps. During this phase of the assessment, leaders identified an opportunity to code co-morbid conditions, which is important in risk environments (contracts that reward value-based outcomes versus volume) because they could have a financial effect on dollar attribution. For example, Hierarchical Condition Category (HCC) protocols are associated with payment methodologies that attribute additional dollars to providers for more complex patients based on diagnosis coding. Focusing on specificity in terms of coding is healthy preparation for ICD-10.

Care management and clinical capabilities were critical components of this portion of the assessment. BRBJ took a closer look at the PQRS and meaningful use measures

Table 1. Sample payer ratings summary

Payer/Provider	UnitedHealthcare Quality	UnitedHealthcare Efficiency	Cigna Care Designation	BCBS Tier 2013	BCBS Tier 2014
Provider A	Quality and cost efficiency criteria met	Quality and cost efficiency criteria met	Effective Jan. 1, 2014	Not listed on website	Not listed
Provider B	Quality and cost efficiency criteria met	Quality and cost efficiency criteria met	Not enough information to evaluate	Tier 2	Tier 2
Provider C	Quality criteria met	Not met	Effective Jan. 1, 2014	Tier 2	Tier 2
Provider D	Not enough data to evaluate	Cost efficiency criteria met	Not enough information to evaluate	Tier 1	Tier 1

Sources: UnitedHealthcare: mgma.org/bcbs-tiered-network. Quality initiatives, Cigna, 2015. Available at: mgma.org/Cigna-initiatives.

it was reporting, and leadership identified existing and potential measurement opportunities based on service line significance. For example, the practice began to focus on patient satisfaction surveys and completed a patient satisfaction survey for its same-day clinic this year.

BRBJ also initiated discussions about standardizing and documenting protocols and care pathways relative to how the group works with its partners on these initiatives. Care management staff was hired to support efforts required for care coordination activities associated with the BPCI program as well as imminent pay-for-performance contracts with commercial payers. Physician champions identified a primary goal for the group to become the leader in musculoskeletal care in western North Carolina, which is when it became clear that focusing on care management was key. BRBJ is developing protocols to manage patients based on level of need, as outlined in Figure 1.

The primary focus in the outcomes assessment was patient satisfaction and those metrics that BRBJ constantly measures and monitors. BRBJ asked focused questions about how to describe its value proposition with data in ways that would be of interest. BRBJ asked its hospital and payer partners for the scorecard they use to assess BRBJ services with its peers in terms of cost and efficiency, readmission rates, infection rates and length of stay. Executives used this data to quantify the financial savings (e.g., readmissions) the practice provided.

Feedback from these partner scorecards confirmed that BRBJ was outperforming its peers on length of stay, infection rates and readmission rates. This finding has strengthened relationships with partners and has moved BRBJ forward in discussions about exploring volume-to-value initiatives. With the value proposition in hand, BRBJ executives sat down with payers to discuss attributes and ask for feedback. The dialogue was focused on how the

two could work together since similar goals had been identified.

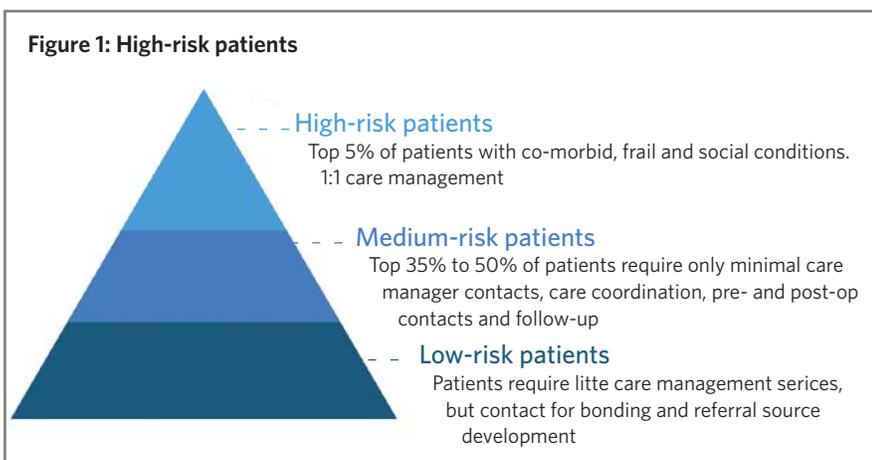
Revenue transformation

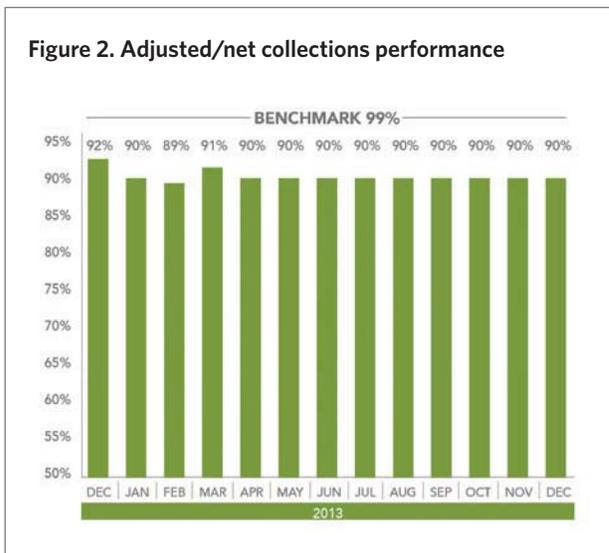
Defining the implications of changing revenue streams was a key focus in this assessment. The group confirmed that it is highly efficient based on operating cost as a percentage of medical revenue (42% at the time of publication), which compares favorably to MGMA results reported in *MGMA Performance and Practices of Successful Medical Groups: 2014 Report Based on 2013 Data* (mgma.org/store, Item 8774).

Recognizing that the professional side of the cost question is only part of what is necessary to gauge and influence cost and efficiency, BRBJ began to develop a better understanding of total cost for place of service (hospital compared to an ambulatory surgery center), provider (BRBJ providers compared with peers) and ancillary services (pharmacy costs compared with peers) to manage cost and risk. After reviewing the data, BRBJ learned that the practice is efficient from an operational perspective and recognized areas for improvement with time of service collections. Ever-increasing deductibles create a higher cost to collect and necessitate an elevated skill set at the front end of the collections process. Optimizing these routines will increase the likelihood of collections, which helps maintain the financial health of the practice. Figure 2 demonstrates BRBJ's adjusted/net collections performance, which is directly affected by the amount collected at the time of service. The group is focusing on improving adjusted collections by implementing more rigorous insurance verification processes and instituting more formal time of service collections protocols.

It makes sense that incentives must evolve with revenue streams. However, only 7.3% of compensation for specialists is tied to quality metrics (including accountable care organizations and patient-centered medical homes), according to the *MGMA DataDive™ Provider Compensation 2015* (mgma.org/store, Item 8847).

Productivity is a primary driver for compensation in an FFS environment. But as the shift from volume to value continues, it will be necessary to restructure incentives to maintain alignment in market shifts and compensation. For BRBJ and its peers, this might be one of the more challenging areas





it is perceived by payers, employers, hospitals, patients and referring providers. They are more interested in healthy discussions about collaboration and ways to provide the practice with timely information for its strategic plan. Understanding what is required to get from here to there will allow organizations to determine what they need to focus on to become risk-capable.

BRBJ's experience illustrates a call to action for medical practices to examine their current state and determine where they want to be positioned. Walk through each category and identify strengths and weaknesses as your team begins to craft a strategy for progressing along the risk capability continuum. The key is to understand what steps are required to become or remain a leader in your market. ■

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to address, but it is critical in order to survive and thrive in a risk-based environment.

Table 2 summarizes the data gathered during these assessments, which BRBJ has used to develop a strategy to move from FFS to risk-based payments.

As a result of this experience, practice leaders have learned to compare the group to others and to consider how

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Table 2. BRBJ risk-capability assessment

	Category	Before	After
Clinical enterprise maturity	Outcomes	Little understanding of measured outcomes compared with market peers	Length of stay, readmission, infection rates validated and quantified; superior to peers
	Clinical capabilities and care management	Market standard capabilities	Care management team hired and currently being deployed
	Clinical documentation and coding	Co-morbid conditions not always captured	Efforts toward creating more robust clinical documentation and coding
Enterprise intelligence	Market position	Clearly defined goals	Goals incorporated into value proposition
	Data analytics	Market standard capabilities	Improved capabilities work in progress
	Payers' perspective	Strictly FFS negotiation posture	Value-based negotiation posture
Revenue transformation	Cost and efficiency	Superior cost and efficiency performance compared with peers	Superior cost and efficiency metrics but closer eye on costs in terms of episodes of care
	Compensation model	Productivity-driven	Productivity-driven; considering potential future evolution