Reprinted from hfm

EXPERT REVIEWED

6 actions for physician practices on signing **risk-based contracts**

Physician practices are continuing to make the move into value-based payment, and for many, such contracts will present a substantial learning curve.

CLIFFORD FRANK, MHSA
cfrank@luminahp.com

GEORGE MAYZELL, MD, MBA
gmayzell@luminahp.com

Medical practice leaders, whether their practice is independent or part of a health system, have different motivations for taking the plunge into risk-based contracting. Some are eager to embrace the challenge of turning better care into stronger revenue. Others just want to protect themselves from the coming reductions in fee-for-service (FFS) payment.

Whatever the motivation, once the ink is dry on the new contract, the question is often, "What comes next?" It's a reasonable question, given that risk-based payment is a different world compared with traditional FFS payment. Practice leaders and physicians alike must adopt new processes, new tools and a new way of looking at healthcare delivery if they are to succeed in this new world.

Whether a medical practice is brand-new to risk-based payment or has some experience with these contracts, its physicians and administrators immediately should focus on six actions.

1 ADOPT A NEW MENTALITY FOR PATIENT MANAGEMENT

Under FFS payment, the most important driver of revenue is what happens *inside* the practice. The more services physicians deliver (assuming medical necessity and correct coding), the more income they generate.

Under risk-based contracts, however, the most significant revenue driver is what happens *outside* the practice. Even if a primary care practice provides economically efficient care, visits to the emergency department (ED), specialist consults and other outside services can easily lead to unnecessary patient spending.

Success under risk-based contracts therefore depends on ensuring every physician in the practice internalizes this shift and embraces a new care mindset: "In addition to delivering efficient, high-quality care to our patients, we also must make sure their outside utilization is appropriate."

This mindset is especially important under newer risk-based contracts that limit narrow-network protections and allow physicians much less leeway to deny authorization for services. In addition, risk-based contracts with a population health component create a special challenge, because the practice will typically be responsible for a list of attributed members its physicians have never seen. Practice leaders must attempt to engage these patients to optimize services and manage outside utilization.

Practices also should keep in mind that controlling outside utilization does not always mean *reducing* utilization. For example, if a patient visiting a primary care practice has borderline asthma and has never seen a pulmonologist, a referral to a specialist to fine-tune medications and assess respiratory therapy options could help reduce long-term spending for the patient.

2 DEVELOP RISK, UTILIZATION AND QUALITY REPORTS

Physician groups with risk-based contracts require reports that list all the services patients are receiving, both inside and outside the practice. Groups also require reports identifying patients most at risk for high utilization.

To develop useful risk and utilization reports, the practice should begin by obtaining claims data for patients covered by the risk-based contract. (Again, data should cover claims for *all* services, not just services provided by the practice.) Next, the practice should use the claims data to generate a risk score for each covered patient. Medicare provides hierarchical condition category scores for these beneficiaries. For non-Medicare contracts, practices can work with a risk score vendor or use commercial software to generate scores.

Finally, claims data and risk scores should be linked with patient care data in the electronic health record (EHR) to enable practice leaders to generate various standard and custom risk reports. These reports complement the limited information available in most EHRs, because they meld available data sets for a true view of population health. Examples of reports include the following:

Patients with a rising risk score. Early identification of patients who are undergoing a significant shift in health status can enable primary care physicians to positively affect patient outcomes.

Risk-based contracting requires a new mindset

Old Model	New Model
Focus on what happens ***inside*** the practice.	Focus on what happens ***outside*** the practice.
Maximize billable services while minimizing non-billable costs.	Maximize overall efficiency and quality.
Outside utilization has no financial impact.	Manage outside utilization — but know when to ***spend to save.***

Climbing the ladder of risk

Once physician practice leaders have gained experience with risk-based payment, their next step should be to use what they have learned to pursue more rewarding opportunities. Here are three guiding principles.

Master the art of shadow capping. Never take on a new level of risk without making sure the practice is ready. *Shadow capitation* is using current data, including data on costs, utilization and quality, to model performance under a potential contract and verify profitability.

Climb one rung at a time. Do not jump straight from simple pay-for-performance incentives to global-risk contracts. Protect the practice by moving deliberately from upside to downside risk opportunities, leveraging risk corridors and carve-outs, and building a solid foundation of contracting expertise.

Work toward scale. A contract covering 5,000 patients (the starting point for Medicare ACOs) does not offer much statistical heft. Aim for agreements covering at least 10,000 patients, which will allow the practice to use statistical tools effectively to identify and manage risk. Similar issues are at play with regard to terms. If a risk-based contract covers only two years, investments in patient health will not pay off before the term is up. Five-year contracts offer a real incentive to manage longer-term risks.

Patients with a high risk score who have not received preventive services. This report can guide targeted patient outreach. Ensuring patients receive appropriate monitoring can help prevent high-cost episodes of care.

Patients with a low risk score and high costs. If a patient has a risk score of 1 and annual claims of $40,000, one can assume there is something wrong with the data. The practice should reach out to these patients and schedule them for a reassessment. Updating their diagnoses can set the stage for better patient management while securing additional capitated payment.

Practice leaders who want to implement risk reports should be aware of the following operational implications:

- Because risk scores are driven by diagnoses, physicians must learn and use ICD-10 and DRG codes.
- Because patient risk is dynamic, practices need to obtain fresh claims data and update risk scores every month.

Risk and utilization analytics should be reviewed on a regular basis, and all physicians — not just practice leaders — should be integrally involved with the process.

Quality reports should track not only standard quality metrics (which are often tied to increased gainsharing) but also physician compliance with the group's agreed-upon clinical practice standards (for example, standard medications, tests and follow-up for hypertension). Reducing clinical variation for common diagnoses ensures optimal care and lowers overall spending.

3 ESTABLISH SYSTEMS FOR AFTER-HOURS COVERAGE

ED visits and other after-hours services will escalate patient costs. The key to controlling this utilization is to establish relationships with preferred after-hours providers for urgent care and telehealth services.

Preferred urgent care provider. Criteria for an urgent care partner include the capability to deliver high-quality care, accessibility to the practice's patient base and the ability to offer reciprocal access to EHR data. The EHR link helps ensure patients receiving urgent care are not prescribed medications that

conflict with their current medications and facilitates post-visit follow-up by the patient's regular physician.

Preferred after-hours telehealth coverage provider. High-quality telehealth can help ensure evening medical needs do not progress to an ED visit. However, some telehealth companies do little more than funnel patients to the ED, and the hospital providers usually can easily tell the difference between these companies and high-quality telehealth providers. Therefore, when assessing potential telehealth partners, it is helpful to talk to the director of the local ED and ask which telehealth vendors provide the best patient workup.

4 TAKE STEPS TO CONTROL SPECIALIST UTILIZATION

Primary care physicians are generally reluctant to confront specialists over utilization decisions. Yet overutilization of specialty services can precipitate significant financial losses under risk-based payment. Primary care groups should actively seek specialists who are willing to collaborate on a coordinated patient management approach.

Practices' preferences and expectations should be made clear from the start. At a minimum, specialist consultants should report all patient findings, and they should agree to readily return all patients to the primary care practice at the point where they can be managed by the practice.

It can be helpful to have frank discussions with specialists who tend to treat aggressively, letting the specialist know that the group is now in a risk-based contract — for every patient that exceeds the spending cap, the group will have to write a check back to the payer. The message: "We are depending on you to help us keep utilization appropriate."

Practice leaders should regularly reassess referral relationships based on access, cost, patient outcomes and communication, and they should be prepared to find new referral partners. If a specialist never sends back findings for patients, it's time to find another who will help in delivering more coordinated care. If a cardiologist's negative angiogram rate is 65%, primary care physicians owe it to their patients to find a heart care partner who will do better.

5 BUILD STRONG RELATIONSHIPS WITH PATIENTS

It is essential under risk-based contracts to manage the dynamics of patient consumerism. Consider this common scenario: A patient with back pain sees a television ad for a local orthopedic surgeon. Before the primary care physician knows it, the patient has had spine surgery. There was never a chance for conservative management.

Many newer risk-based contracts do not allow physicians to keep patients within a narrow network. The only solution is to build a stronger relationship with all patients, so that whenever patients have a health problem, they think of their primary care providers first.

Relationship-building strategies include the following.

Committing to same-day access. Patients who call with an urgent problem by 10 a.m. should be assured of being seen by 5 p.m.

Maintaining consistent contact. Telehealth options should be used to see patients more often. Under risk-based contracts, lower payment for telehealth visits can be offset by the benefits of higher patient compliance.

Providing cell phone access to patients at highest risk. For the sickest patients, being able to contact a provider instantly can have a huge impact on utilization.

These strategies require a commitment of time and resources. Practice leaders should see them as an investment in preventing high-cost utilization.

60%

Approximate percentage of healthcare payments in primary care in the United States that had some linkage to quality and value, as of 2021 (although less than 20% involved two-sided risk)

Source: Fry, S., et al., "Value-based care: Opportunities expand," Bain & Company, April 10, 2023

6 MAKE JUDICIOUS CHANGES TO PRACTICE OPERATIONS

Practices transitioning into risk-based contracts should reassess operating expenses. Some expenditures such as the following, which are hard to justify under FFS, may make sense within a risk framework.

Convert some office visits to phone calls. For example, reviewing test results over the phone instead of via an office visit can be more efficient for both the patient and the physician. It also creates the opportunity for more consistent patient contact and greater patient satisfaction.

Perform more frequent medication reconciliations. About 25% of Medicare hospital admissions are due to drug-drug interactions. For patients with multiple diagnoses and specialists, performing medication reconciliation during every primary care visit (where feasible) can reduce admission rates.

Make strategic hires. Practices can lower costs, for example, by hiring a care manager to coordinate care of patients with chronic disease. Or given the rising cost of specialty drugs, practices might benefit from hiring a full- or part-time pharmacist to manage their highest-risk patients.

Target social determinants of health. For example, if a major heat wave is forecast, office staff could reach out to elderly patients to make sure they have adequate air conditioning and, if necessary, help link them to community organizations that can assist them.

All these ideas cost money. Under risk-based payment, however, reductions in downstream spending can affect the cost-benefit analysis.

TRANSPARENCY IS CRITICAL

When practice leaders take the plunge into risk-based contracting, many believe that they can lower aggregate spending through management interventions alone. They may establish new referral policies. They may attempt to tighten up direct costs. But it also is critical that they inform and educate staff physicians about the new contract and begin to make necessary changes to physician incentives so the physicians will not continue doing what they are used to doing: *generating volume*.

To succeed under a risk-based contract, practice leaders must commit to full transparency by taking three steps:

- Ensure all physicians are aware of the new contract and understand the implications of risk-based payment.
- Align physician incentives with contractual risk by building utilization, quality and patient satisfaction metrics into the compensation formula.
- Provide physicians with the tools they need to succeed, including data reports (typically in graphic form) that encapsulate their performance against contract goals.

The key to full transparency is to create a governance structure that addresses every aspect of risk-based contracting. Key steps the governance group should take in building a risk management infrastructure include:

- Establishing guidelines for specialist referrals
- Identifying preferred referral partners
- Monitoring individual referral utilization
- Establishing principles for sharing bonuses

When the entire practice understands the contract and knows the plan, the practice can reach short-term goals and build for long-term success in risk-based contracting. ▮

About the authors

Clifford Frank, MHSA, is a principal, Lumina Health Partners, Chicago.
George Mayzell, MD, MBA, is a managing principal, Lumina Health Partners, Chicago.