Provider Networks and Risk: Network Curation via Direct Contracting

Increasing Competition for Access to Healthcare Dollars and "Risk"

Mike Padilla, Vice President, Advisory Solutions
John Fryer, Senior Vice President, Head of Market

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Introduction

For the last decade+ the healthcare industry has been on a journey toward "population health." Healthcare providers have talked about the panacea of moving their business model toward value-based care and away from the activity-driven fee-for-service model that has propagated the healthcare ecosystem over the last half century. It is a clear message that the right thing to do for consumers and patients is to align the aggregate incentives to encourage more proactive management and care for an individual's holistic health and wellness. The reality is, for most providers this language and pragmatic thinking is window dressing. Progress toward true alignment of incentives across the delivery spectrum (and toward value-based care) has been extremely slow, hampered by the ongoing and tenuous relationship between payers and providers. In some cases, better alignment is actively blocked by leadership teams in all segments of the industry (e.g., payers, providers) to protect the status quo which has been rather profitable for healthcare delivery providers and payers alike. While finger-pointing remains between stakeholders as to who is harvesting the most profits, recent history demonstrates that the tectonic plates of the status quo are shifting as consumers, employers, and ultimately the government demand more accountability for the "value" provided in our complex healthcare equation. The increasing costs may finally be untenable and unsustainable.

This plate shifting has not gone unnoticed, with new and well capitalized private businesses aiming to disrupt the incumbents. Several of these businesses have even become publicly traded in the last several years at multi-billion-dollar valuations. It appears everyone wants a piece of the "risk" in the value stream (and a share of the premiums). From hospitals, physicians, post-acute providers, to dialysis, prescription drug, and consumer-oriented companies, everyone is starting to clamor for their piece of the share of the healthcare dollars. Beyond the common talk track of value-based care, going "at-risk" for outcomes means everyone is competing for "control" of the members within their contracts, or more broadly, the population at-large. This race toward more "risk" and "control" of populations has created a near-term necessity for existing healthcare delivery networks to focus on their current and planned assets to understand where they can proactively accelerate their confidence in performing in true at-risk contracts. Without hardened capabilities, comprehensive data sets, and deep actuarial modeling, moving to risk can be akin to flipping a coin: Heads you lose millions of dollars, tails you create positive savings.

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A Step Forward for Medicare Risk

For over a decade now, the Centers for Medicare and Medicaid Innovations (CMMI) has advanced their risk-based Medicare programs to delegate more financial accountability to providers. Many would argue that these programs did encourage the "right" type of behaviors including clinical documentation, quality reporting, and utilization/readmission monitoring. Though appeal of these programs seems to have dwindled over time, or at the very least plateaued – the number of participating Medicare Shared Savings Program Accountable Care Organizations (MSSP ACOs) peaked in 2017* – due in large part to the uncertainty and commitment level required for these programs. Given that participation in both MSSP and Next Generation ACOs is organized at the tax identification numbers (TIN) level, financial performance can vary dramatically across and within physician practices. In the board room, ACO leaders find themselves saying "we have no idea what our MSSP benchmark is going to be this year." So, with these challenges it is no wonder the Centers for Medicare and Medicaid Services (CMS) saw the need to develop a more flexible and transparent model that would encourage applications from new entrants.

The promise of the Global and Professional Direct Contracting Model (GPDC) lies in the lessons learned from both Next Generation ACOs and Medicare Advantage. Of all the new elements in the GPDC model, Lumeris sees the growth and viability of the model linked to three key areas:

- Provider and Beneficiary Engagement: As the name suggests, Direct Contracting does allow networks to create direct and custom financial arrangements with providers to accommodate things like quality-based payment carve outs. To support cash flow, CMS offers prospective capitation payments which can be paid for primary care only or for total cost of care. When it comes to beneficiary engagement, Medicare rule waivers and benefit enhancements are encouraging timely and appropriate care in a similar vein to Medicare Advantage.
- Benchmark Transparency: Benchmarks are based on a blending of 1) historical 2017-2019 medical expenditures and hierarchical condition categories (HCCs) for the participant network and 2) a county-based rate book for the service area, similar to the rate book used for Medicare Advantage. This does away with "black box" inflationary and regional adjustments that MSSP leaders find so frustrating.
- Participation at the National Provider Identifier (NPI) Level: Participating providers are submitted at the NPI-TIN combination level, meaning a practice can be split up if needed. The non-participating providers can still be a part of the network, but their attribution would not be considered at-risk in the economic model and not included in the calculation of shared savings.

*Zhu, Michael, et al. "The Medicare Shared Savings Program in 2020: Positive Movement (And Uncertainty) During A Pandemic." Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20211008.785640/full/

Shaping Your Network to Succeed in Risk

The ability to curate a network to fit the financial parameters of this program makes the evaluation of this opportunity different than anything we have seen in the past. For the first time, networks can use historical provider data to not only predict future medical expenditures, but also estimate the projected benchmark based on the selected provider participants. At Lumeris we leverage our strategic partnerships to analyze the complete 2017-2019 CMS dataset, pulling NPI-level activity for beneficiary alignment, medical spend, and HCCs. Our networks need only provide a listing of NPIs to evaluate complete historical performance. The result is an NPI-level analysis that shows the impact of every provider combination on the bottom line. Table 1 below shows the distribution of a network across two important variables: The x-axis has 2019 attribution for each individual provider while the y-axis shows 2019 risk-adjusted spend (i.e., spend relative to total HCCs).

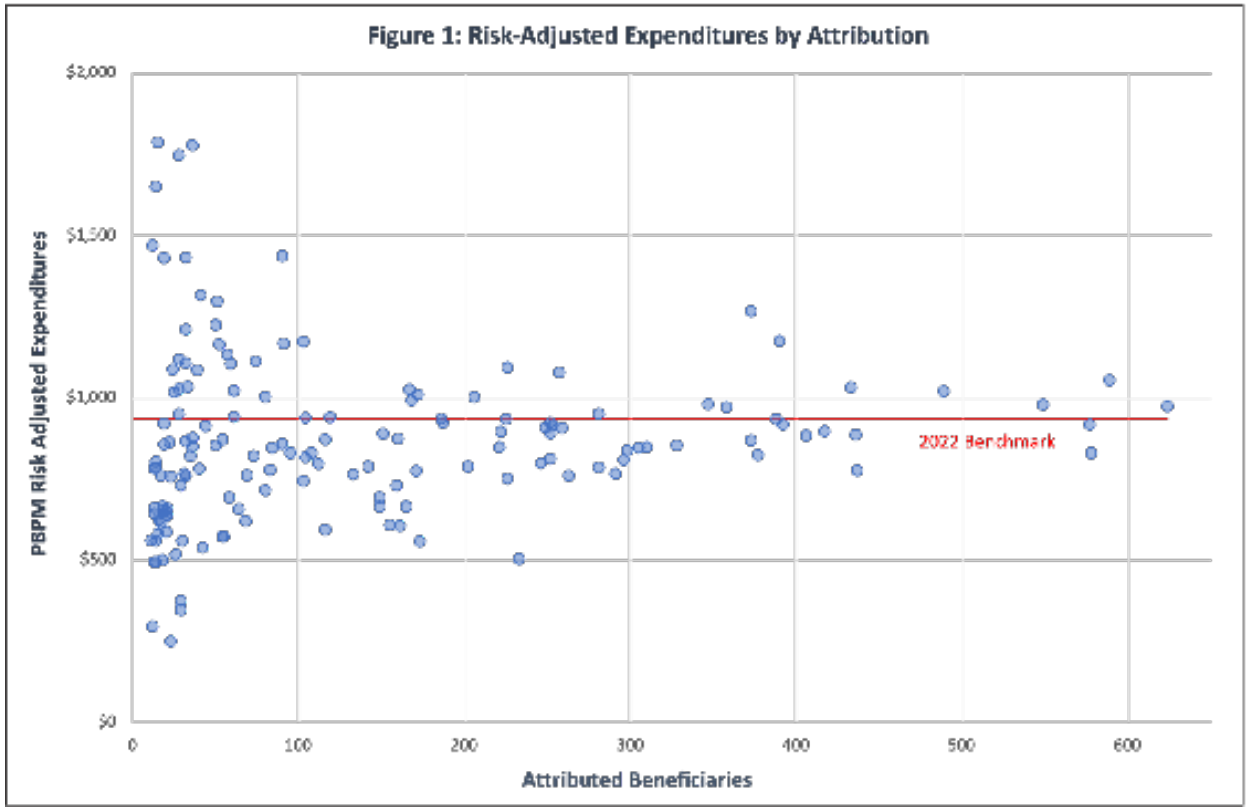

Figure 1: Risk adjusted expenditures plotted against beneficiary count; 2019 data aged to 2022. Analysis and projections proprietary to Lumeris.

This initial analysis can be telling on its own. Are the low performers in the network limited to only a handful of providers or is it a sizable portion of the network? If we used a minimum beneficiary count as a threshold to tier the network, would that improve average performance? What if we only look at primary care providers? While this sets the stage for a conversation around curating a high-performing network, Lumeris recommends taking this one step further with a financial analysis at the NPI level.

The Impact of Network Curation on the Bottom Line

The idea of network curation can be administratively and politically fraught, making one of the more difficult questions for leadership: Is this worth it? The idea of tiering a network drives many immediately to remember feelings of the 90s when Health Maintenance Organization (HMO) networks and gate-keeper models left many providers on the outside looking in and then ultimately imploded. Why does one provider get to be a part of this exclusive program and one does not? To get to an answer we need financial projections for our network. In other words, if we assume 2019 activity is an accurate representation of each provider's performance and we know that provider's individual benchmark, let us measure their projected contribution to earned shared savings in Direct Contracting.

Figure 2 below shows the same sample network where we can now see the financial impact of each provider. When viewing performance on a Per Beneficiary Per Month (PBPM) basis, significant losses may suggest a provider isn't ready for participation in a full-risk program, whereas aggregate losses with a lower PBPM loss suggest this provider is important to the network if they could only improve certain care management activities. For those that fall below a select performance requirement, whether that be projected losses, risk-adjusted spend, or beneficiary count, it may be best to exclude them from the participant list for the first year.

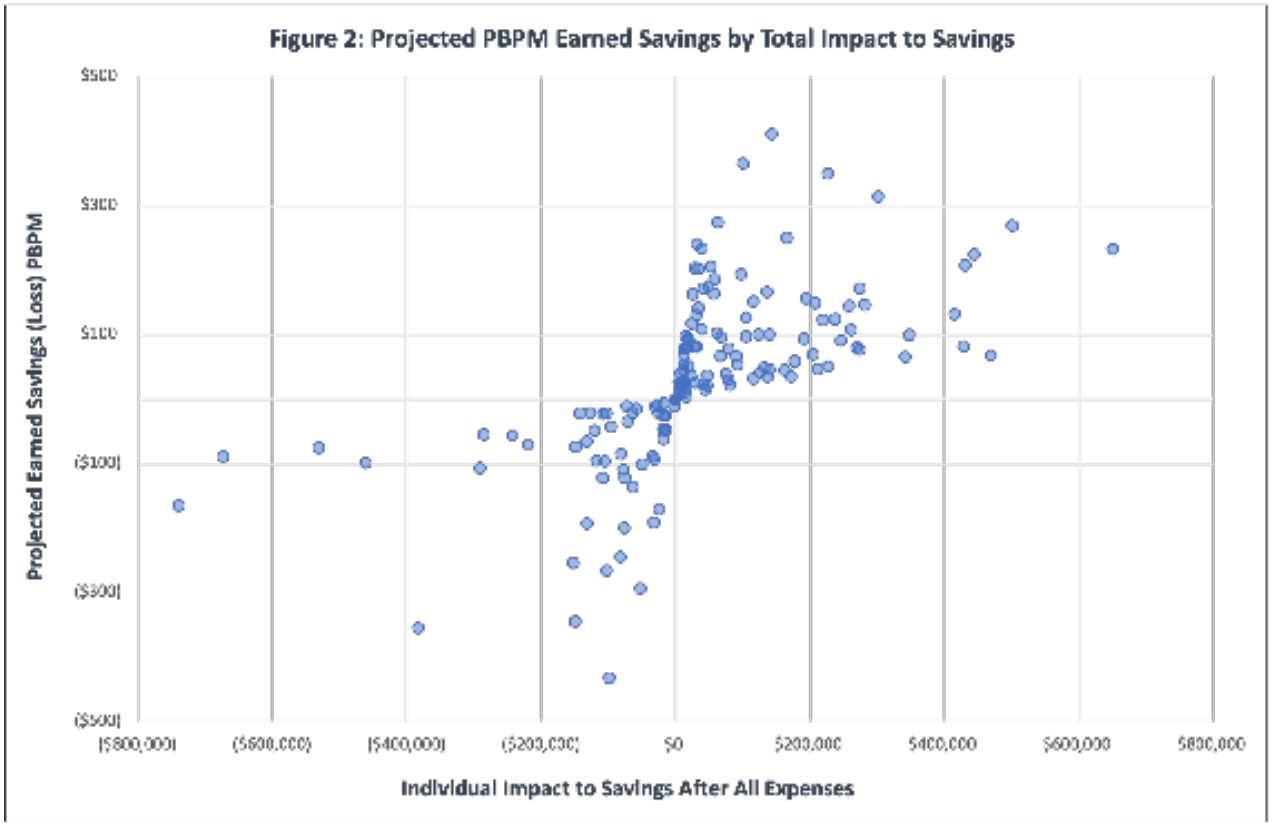

Figure 2: Impact to total earned savings by provider based on individual benchmark calculation and projected expenditures; performance year 2022. Analysis and projections proprietary to Lumeris.

The criteria used to set minimum performance requirements and select participating providers will need to be customized to the goals and circumstances of each individual network. If there is a level of losses, or minimum gains, that the network is willing to tolerate then that can be included as part of the analysis. If there are practices or specialties that are more difficult to exclude from the program, then that needs to be considered as well. The most important takeaway for any network curation/tiering exercise is that this is a data driven selection model. This is not kickball teams on the playground with "favorites" getting in and others getting left out for non-quantitative reasons. It's also not an effort to ostracize clinicians that may be the "under-performing" segment of the network. In most cases these clinicians have never seen data to show them their performance with this level of detail. What is great about Medicare Direct Contracting is that everyone can actually participate (even high-cost providers can be preferred providers) and the goal is to move clinicians as fast as possible into the participant provider bucket (the "high-value network").

A Path to Transformation

The reason an evaluation like this works is because Direct Contracting is more transparent in its benchmark calculation. There will always be a margin of error in performance measurement as well as an opportunity for shifts in year-to-year performance. After all, no network would want to limit an individual's potential based solely on what they did in 2019. What is novel in Direct Contracting though, is that with the program rules, a provider that improves performance can be added to the participant list on a quarterly basis and eligible for shared savings on an annual basis. Imagine being able to say to your doctors:

"These are the three measures you need to perform on, and if you do that this year then we can add you to the program the following year."

When Lumeris partners with health systems and physician groups, we not only look to accelerate value creation in high performers, but we also look to coach and educate those providers that have a clear opportunity for improvement. The Direct Contracting program offers a mechanism to start to organize these resources and move providers to full risk over time, as performance improves. In the meantime, there may be more foundational investments that can help support transformation across the network. Objectives such as adding new Medicare Advantage contracts, improving clinical documentation, and enrolling patients in disease-specific programs, are only a few examples within a comprehensive population health strategy. While "tiering" models of the past may have left providers feeling like they were on the outside looking in, on the contrary this curation approach focuses on surfacing the data and information, and working with all providers to move toward the high-value network.

How Can We Participate in Direct Contracting?

To the disappointment of many provider organizations, with an administration change in 2021, CMS closed applications to the GPDC model in April of 2021, leaving the program open to only those organizations that had already submitted applications with intent to participate in either 2021 (PY1) or 2022 (PY2). While some on the outside are awaiting a reboot from the Biden administration, Lumeris believes a likely outcome is for CMS to rely on the MSSP Pathways model developed under the Obama administration, and maintain the GPDC model for participants through 2026 (PY6) as originally planned. At that point, the success of the program may dictate how the next phase evolves.

For 2022, we expect there to be upwards of 100+ Direct Contracting entities operating across the country. Lumeris is well positioned to facilitate opportunities within the Direct Contracting program and assist in driving your overall value-based care performance. If developing a pragmatic roadmap to strengthen your clinical provider network's capabilities is of interest, or your organization desires to participate in Medicare Direct Contracting as a vehicle to enhance network performance improvement and alignment, we encourage you to reach out and begin evaluating this opportunity.

About Lumeris

Lumeris is empowering health systems to successfully deliver exceptional value-based care through a comprehensive suite of capabilities developed over a decade of building, testing, and proving the path to value. A joint-operating partner in both value and risk, Lumeris provides the complete continuum of value-based care competences via the deployment of its Population Health Services Organization (PHSO). The PHSO includes not only market-leading value-based enablement capabilities, but also access to provider-centric, tech-enabled Medicare Advantage and Direct Contracting plans. In partnership with many of the nation's leading health systems, Lumeris has deployed its PHSO to more than 1 million patients and 7,000 physicians nationwide and successfully build 4.5+ star health plans that consistently deliver better clinical and financial outcomes for Medicare, Medicaid, Commercial, and Individual populations. To learn more about Lumeris, please visit www.lumeris.com.

13900 Riverport Dr.
St. Louis, MO 63043
T: 1.888.586.3747
www.lumeris.com