Elements and Progression of Provider Risk Contracting

by

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Depending on the type of Health Plan (HMO vs High Deductible FFS) the payor organizes patient flow by transferring elements of risk to the provider. In HMO provider contracting, as the member/case volume increases, one or more elements of risk are transferred to the provider (Primary Care or Specialist) by utilizing the following types of contracts: Fee-for-Service (FFS), Discounted Fee-for-Service (DFFS), Case Rates (CR), and finally, Capitation (CAP). Each type of contract attempts to transfer one or more of the three principle elements of risk namely: frequency of the type of cases, the cost magnitude of those cases, or the cost variability (acuity). As a provider progresses through the spectrum of risks, each type of contract requires the provider to be more integral in the process of delivering care and ultimately be responsible for the cost of care. See table below.

Provider's Risk Progression

Risk Elements	FFS	DFFS	CR	CAP
Frequency	None	None	Some	All
Cost Magnitude	None	Some	All	All
Cost Variability (Acuity)	None	Some	All	All

Payor's Risk Progression

Risk Elements	FFS	DFFS	CR	CAP
Frequency	All	All	Most	Transferred
Cost Magnitude	All	Most	Transferred	Transferred
Cost Variability (Acuity)	All	Most	Transferred	Transferred

As mentioned, the type of Health Plan limits the ability for the payor to organize and direct care by provider contracting. However, even in markets saturated by High Deductible FFS plans, providers are seeing the "writing on the wall" and are working together to meet the market demand of Case Rates, the first steps in entering the risk progression. The largest payors including the government are moving rather quickly to introduce risk contracts. The world of FFS medicine is shrinking as the payors and members can no longer afford to pay for unnecessary procedures. In the FFS market, it has been documented that **unnecessary procedures average around 30%,**

fulfilling the premise, the more I do, the more I make. In the provider's defense, the FFS reimbursement scheme almost always guarantees over-utilization because the provider doesn't get paid unless they do "something". However, in a risk contract, the paradigm changes to optimization. The what, where, when, how, and by whom, now become integral to the care process.

As a payor has more concentrated membership in a local area, the need to reduce price and outcome variability becomes paramount. As a result of the payors' need, a payor will offer to send their members to an efficient provider or group in exchange for a price discount. It seems an obvious "Win/Win", the provider gets a steady flow of patients/cases in exchange for a price discount. The payor Wins by reducing its' risk profile which results in lower annual premiums. However, what works out well for a payor, creates a new financial risk as well as operational concerns for the individual provider or group. In each step of the risk progression, the provider's ability to manage and direct healthcare costs becomes paramount.

For a risk contract to be successful over time, there needs to be **balance** between the level of volume of members/cases and acuity of those cases against payment received. Provider Groups that understand their cost structure, control their utilization of services, and use efficient case protocols can succeed and thrive over time in a risk contract. It should be noted here, that a risk contract is not a *panacea* for over utilization, nor will it fix a broken provider organization and inefficient practice patterns. In fact, it will almost guarantee their financial failure, unless appropriate changes are made.

The very first question that needs to be addressed is, **What type of procedures are a good fit for a risk contract?** Is the frequency, cost magnitude, and cost variability of a type of procedure make financial sense for a payor or provider to enter into a risk contract? What is the *most appropriate type of risk contract* that transfers the right amount and type of risk? What are the provider issues that need to be address to be successful long-term?

Below is a very short check list of items that are negotiated in a risk contract:

1. Division of Financial Responsibility (**DOFR**)
    a. Who pays for follow up visits, for how long?
    b. Who is responsible for labs, drugs, institutional care, radiology, et.?
    c. What additional providers are included in the contract? (Example, Anesthesiologists, Rehab)
    d. Who controls the distribution of payments to providers?
2. In a long-term agreement, given low volume or high acuity, is there a **stop-loss available**? At what level?

3. Can the provider demonstrate they have operational controls and contracts in place to handle the risk?
4. Is this contract with an individual provider or group? What are the "hold harmless" criterion for the member?
5. How will this contract change with various types of payors? (Medicare, Commercial, Government, Self-Funded Payor)

How does a good payor help the provider to deal with these issues? If you are a provider are you asking the right types of questions to the payor? While most provider contracts are annual in nature, good risk contracts need constant attention to make them successful over the long term. **Are you prepared to enter a risk contract?**