Providers, are you ready for employer-led accountable care?

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Employers are becoming increasingly involved in the movement toward value-based reimbursement, particularly employers that self-fund the healthcare needs of their employees.

Two common strategies currently used by providers to reach the employer market segment are:

1. Aligning with a health plan to develop an accountable care product, which steers employees to participating providers in the accountable care network.
2. Direct contracting with employers. Typically, an employer offers its employees a narrow or tiered network plan alongside a broader network product offering.

A full economic impact analysis is necessary for a provider to make an informed decision about entering a direct contract with an employer. Specifically, a provider should consider the three main drivers of the contract:

1. Potential revenue changes
2. Opportunity to reduce cost
3. Range of potential outcomes

INCREMENTAL VOLUME SHOULD BE MEANINGFUL ENOUGH TO OFFSET ANY REDUCED REVENUE FROM THE CONTRACT

In our experience, financial arrangements proposed by employers can be aggressive and often unrealistic. For example, the employer is often seeking flat or negative trend and/or steeper discounts. Also, many shared risk arrangements are structured such that the provider receives a maximum 50% share of savings, often with reduced payouts if quality measures are not met. In many cases the shared savings received by the provider are insufficient to offset reduced revenue from lower levels of utilization. This has a detrimental impact on the provider's contribution margin. Thus, the provider will want to model the economic impact on contribution margin of each proposed agreement.

Key Questions for Providers

What are you currently doing with your own employee health plan?

What opportunities exist to more effectively manage the utilization of the likely attributed population?

What change and investment is required to implement initiatives that manage care more effectively?

To what extent will you need to reduce reimbursement rates in the arrangement to achieve the employer's required cost targets?

Will the potential incremental volume and/or shared savings sufficiently offset any reimbursement rate reductions?

What portion of services do you provide for the likely attributed population?

Is it likely you will capture some leakage of services outside of your current patients?

Specifically, a provider should:

1. **Evaluate additional volume:** Will the potential additional volume offset any revenue reductions (e.g., utilization management, reduced reimbursement rates)? The effect of lower reimbursement rates is amplified if the provider also reduces its reimbursement rates for members outside of the accountable care arrangement (e.g., revenue for non-attributed members).
2. **Consider the non-attributed population:** Will any reimbursement rate reductions offered by the provider also apply to the non-attributed population? Discounting existing services can have a material financial impact on the provider's revenue and contribution margin, depending on the magnitude of the reimbursement change and volume of services.
3. **Estimate the opportunity to capture leakage:** Is there sufficient opportunity to capture leakage based on an analysis of services and total dollars incurred by the likely attributed population in recent years? Capturing or preventing leakage for the attributed population has the additional benefit of enabling the provider to better manage and control costs and quality. This optimizes the likelihood of receiving a payout from the arrangement, and the size of that payout.

UNDERSTANDING THE MAGNITUDE OF THE POTENTIAL SAVINGS OPPORTUNITY IS CRUCIAL

In a typical employer-led shared risk agreement, a per member per month (PMPM) cost target is developed as a target benchmark. The actual PMPM cost of the attributed members in the performance year is compared against the target to determine overall cost savings or losses. Understanding the opportunity to reduce cost is a critical consideration for a provider prior to entering into an agreement with an employer. Specifically, the provider will want to understand if it is feasible to bend the cost curve enough to generate savings.

The historical claims experience of the likely attributed members, when available and complete, can help address the questions the provider needs to consider. Specifically, the historical claims can be benchmarked against industry targets and used to develop potential savings opportunity analysis. For a valid comparison, the benchmarks must reflect the same demographic and population health mix. The benchmarks should also reflect the employer's plan design, provider discounts, and the geographic location of the attributed population. Figure 1 shows an illustrative example of output from such a benchmarking analysis.

FIGURE 1:ILLUSTRATIVE BENCHMARKING ANALYSIS UTILIZATION PER 1,000 MEMBERS

SERVICE CATEGORY	UTILIZATION TYPE	ACTUAL UTILIZATION	WELL-MANAGED BENCHMARK	POTENTIAL UTILIZATION OPPORTUNITY
Inpatient Surgical	Days	40.2	36.6	9%
Emergency Department	Visits	148.6	110.2	26%
Office Visits	Visits	4,687.1	3,034.6	35%
Physical Therapy	Visits	422.3	311.6	26%
Outpatient - Psych	Units	339.8	268.4	21%

In Figure 1, the actual utilization of the attributed population is compared to Milliman's Health Cost Guidelines™ "well-managed" benchmarks (see the sidebar "What Are Well-Managed Targets?"), calibrated to the provider's specific situation. This analysis can help determine the potential opportunity to generate utilization savings. Specifically, this analysis highlights areas of opportunity for more exploration and can be used in conjunction with clinicians' own assessments of practice patterns to understand what is driving the results and what might be changed.

Finally, it is important the provider's economic modeling also consider other similar value-based payment arrangements it may have with other carriers. For example, if the employer's narrow network product is offered side-by-side with a broad network product, it is possible the provider already has a shared risk arrangement with the carrier providing the broad network option. This becomes a particularly important consideration if the narrow network arrangement has a cost target based on bettering the trend of the non-attributed population (i.e., the trend observed for the population choosing the broad network option, which the provider also has an incentive to reduce).

EVEN WHEN THE SAVINGS POTENTIAL APPEARS ATTRACTIVE, VARIATION RISK CAN DESTABILIZE THE RESULTS

Random claims fluctuation will occur from year to year so understanding and mitigating the variation risk can help a provider withstand claims fluctuation. To help providers understand the potential claims fluctuation, we suggest a simulation of claims experience using a claims probability distribution appropriately calibrated to the expected risk profile of the attributed population. The output of this analysis provides the provider with an estimate of the likely variation around the PMPM cost target. This insight can help a provider make an informed decision about the level of stop-loss (if any) to include in the contract.

What Are Well-Managed Targets?

Well-managed targets are intended to represent integrated utilization levels that are attainable in practice by a well-managed delivery system. Such delivery systems typically have active use of:

- Evidence-based treatment guidelines
- Programs to educate physicians on ways to provide care more efficiently
- On-site utilization management of inpatient services
- Availability and coordinated use of appropriate alternative levels of care
- The use of a primary care manager
- Active use of physician assistants, nurse practitioners, and other physician extenders
- Demand management programs that teach members when to seek medical assistance
- Disease management programs targeting persons with particular disease states
- Information systems that support utilization monitoring efforts and provider incentive programs, including physician profiling and predictive modeling
- Case managers to facilitate treatment of acute and chronically ill patients

At the other extreme, no-cost and low-cost members can also present a potential risk to the provider. Under shared risk agreements it is very difficult for providers to generate savings for low-cost or no-cost patients. These members could materially impact a provider in a shared savings agreement, depending on the attribution methodology (i.e., the way members are assigned to the provider). For example, narrow network products often include direct financial incentives for employees who select them over broader network products. Such incentives are particularly popular for members who expect to have low or no claims. The provider should understand how many of these members are in the population relative to typical expectations. If significantly more members with no or low claims opt for the narrow network product than expected, or if these members represent a large proportion of the attributed population, the potential savings opportunity is considerably reduced.

EMPLOYER-LED ACCOUNTABLE CARE MAY BE A GOOD OPPORTUNITY BUT SHOULD BE THOROUGHLY ANALYZED

An increasing number of employers are seeking accountable care-style solutions. This type of arrangement is still evolving, but will likely continue to proliferate, because it aligns the financial incentives of employers and providers. In our experience, performing financial due diligence on an agreement's proposed terms allows the provider to obtain a deep understanding of the opportunity for savings and to capture leakage. The provider will need high-quality, detailed, historical claims data from the employer to perform a thorough due diligence on the proposed contract and to support its negotiation. Without this analysis, the provider may be navigating uncharted territory without key information, and may find it difficult to measure, manage, and mitigate potential risks in these contracts.

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