Provider risk-contracting: Opportunities and pitfalls

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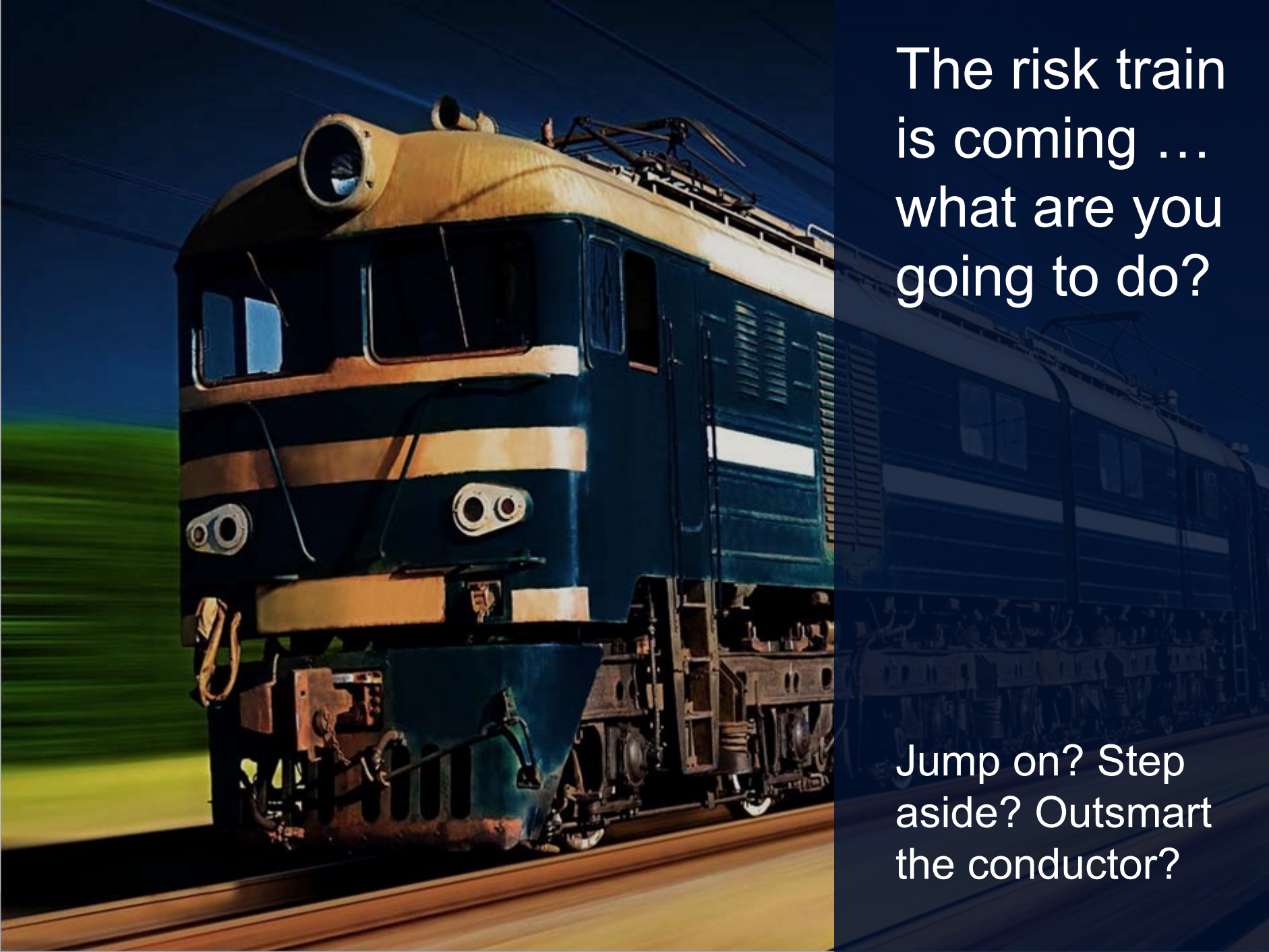
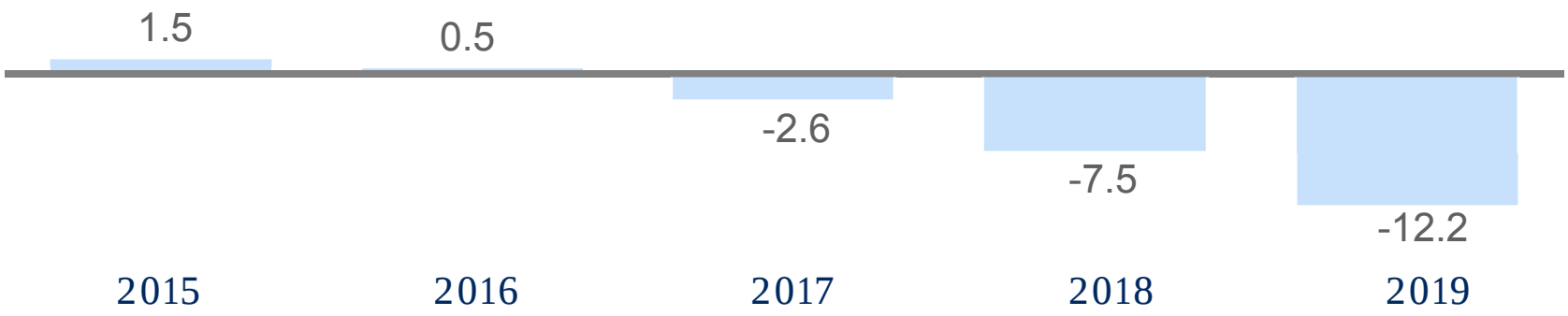
McKinsey&Company


The risk train is coming … what are you going to do?
Jump on? Step aside? Outsmart the conductor?

Peak of reform volume and financial "sugar high" is ending

EBITDA – difference between projected "no-reform" and "reform" scenario

$ Billions per year



2015	2016 – 2017	2017 – 2019	2019
▪ Medicare growth rate reduction ▪ Exchanges launch ▪ Medicaid expansion ▪ DSH reductions begin	▪ Consumer uptake on exchanges at steady state	▪ DSH reductions accelerate ▪ Medicare growth rate declines accelerate	▪ Employer opt-out hits steady state

SOURCE: McKinsey Provider Reform Impact and Stress-test Model (PRISM)

Rapid adoption of new payment models

Last 5 years

- Fee for service
- Some pay for performance on quality or cost

Evidence of a tipping point

- **Healthcare spending** on risk-based models has increased from **10-15% in 2013** to **>20% in 2014**
- **CMS has set a goal to tie 50% of Medicare payments** to quality or value through alternative payment models by 2018
- Hundreds of private payors and provider organizations have set goals **to achieve 50-80% adoption** over coming 3-5 years
- **More than 20 Governors are sponsoring public-private initiatives** to support adoption in a more coordinated manner

Next 5 years

- Meaningful transfer of risk
  - Nested population-based and episode-based payment
  - Capitation / delegation

Momentum but with mixed emotions

Leaders see the need for change...

"Recognizing that we will increasingly be measured and reimbursed based on the quality and value of our services, improvement in patient outcomes and patient service will be our top priority in 2015"

– Provider CEO

"We're changing the way providers and insurers interact with one another to lower medical costs"

– Payor CEO

"We're not going to sit here and let the change be upon us. We want to be part of the change."

– Provider system CFO

...but don't have a clear direction moving forward

"Our biggest challenge is managing all the change …"

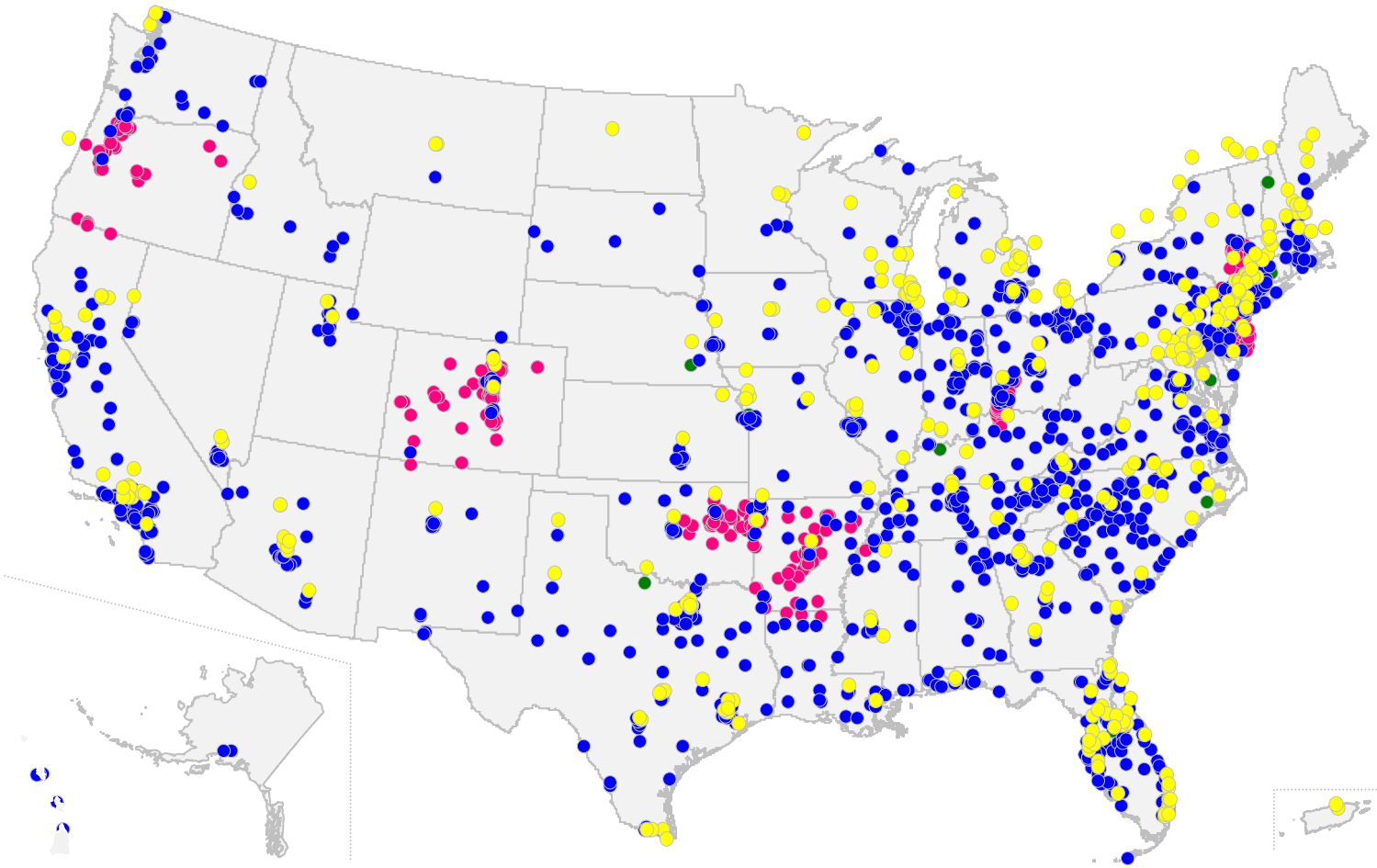
– Provider CFO

"It's a tough transition. But when you look at the industries that have gone through the transition, those industries have ended up strengthened. And we're going to have to change business models,"

– Payor CEO

SOURCE: Press search

Some information on pace of adoption, but limited insight into significance to payor/provider economics



SOURCE: CMS

Hesitation among many leaders to commit to change without more meaningful insight into what is working

"Pioneer ACOs save $385M in first 2 years"

- Pioneer ACOs demonstrated **improved quality with decreased growth in spending**
- Of original 32 ACOs, **11 (34%) received shared savings and 13 (41%) dropped out**
- Of 220 ACOs in the MSSP, **<25% received shared savings and >50% had higher costs** than their benchmarks in 2013

"CMMI bundled payment models improve care"

- **Early signs of success** (e.g., reductions in readmission, LOS)
- Of original 450 providers, **108 (24%) dropped out** in the first year
- In second round, over 6,000 organizations joined, but so far **only 243 providers (4%) are assuming any financial risk**

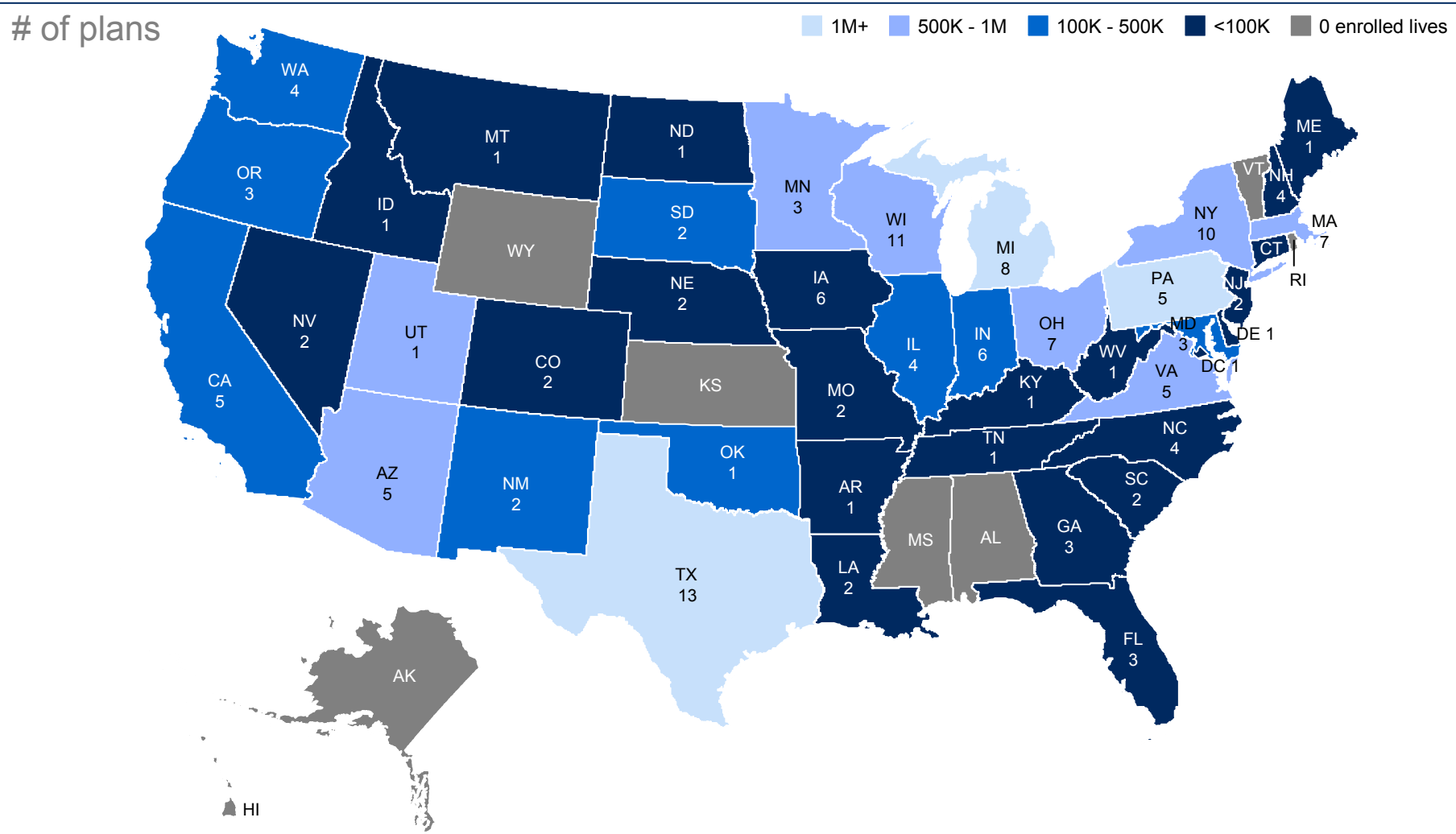
Businesses face may types of risk

Focus of today

	Description	Examples
Strategic risk	▪ Risk that the strategy becomes less effective and the company struggles to reach its goals as a result	▪ Risk of **retaliatory action from existing payers** ▪ Shift of the system's focus system away from core priorities (e.g., focusing on a small population covered by risk arrangements)
Operational risk	▪ Risk that the company cannot deliver on its strategy	▪ Difficulty in **effectively managing care coordination efforts across the continuum** if the system does not have full ownership of provider assets ▪ **Slow ramp up of capabilities** necessary for execution (e.g., technology infrastructure, compliance capabilities)
Financial risk	▪ Risk of financial downside by pursuing the strategy	▪ High risk from **investments required in capability and infrastructure** development as well as **risk-based capital** (~1k per insured commercial life) ▪ **May result in underperformance** (e.g., higher than expected total cost of care) given **lack of adequate experience data**
Regulatory / compliance risk	▪ Risk of failing to comply with all the necessary laws and regulations that apply to the business, resulting in serious consequences	▪ **Medicare Advantage plans are highly regulated by CMS**, and non-compliance in day-to-day operations can result in significant risks, including federal fines, sanctions, or civil monetary penalties

Across the country, providers are already offering health plans

Provider-led health plans: covered lives by state – 2014

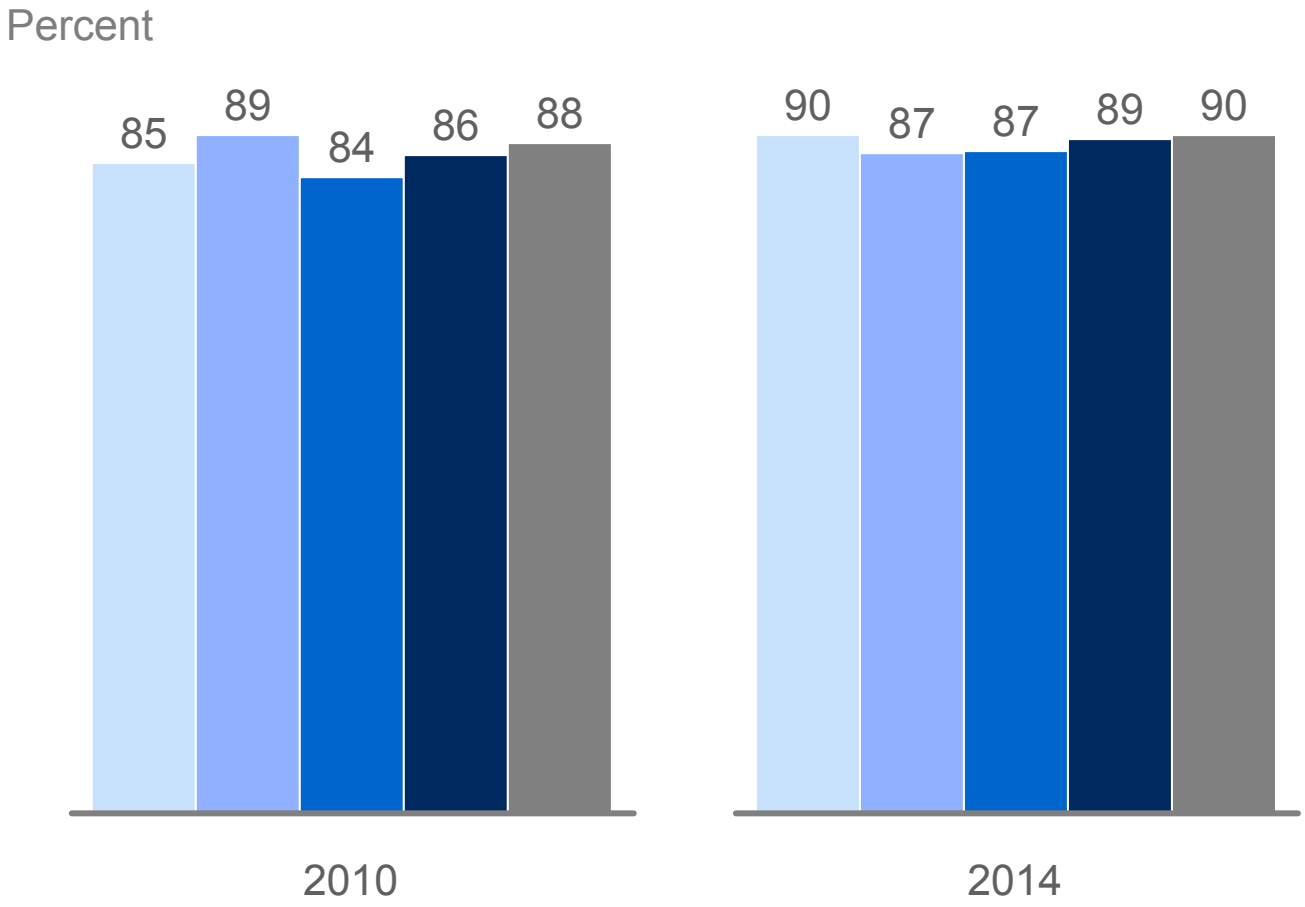


SOURCE: CMS, Supplementary healthcare exhibits

Provider-led plans have seen consistent increase in MLR across most LOB's

Individual[1] Small group[1] Medicare[2,3] Large group Medicaid[4]

Medical loss ratio for provider-led plans by segment, 2010-2014



1 MLR reflects payments and receivables from ACA risk programs; 2 Financials include claims and premiums from cost products; 3 Financials cover ~80% of the Medicare LOB; 4 Medicaid does not include all data due to financial reporting constraints

SOURCE: McKinsey Healthcare reform center , financial supplements data

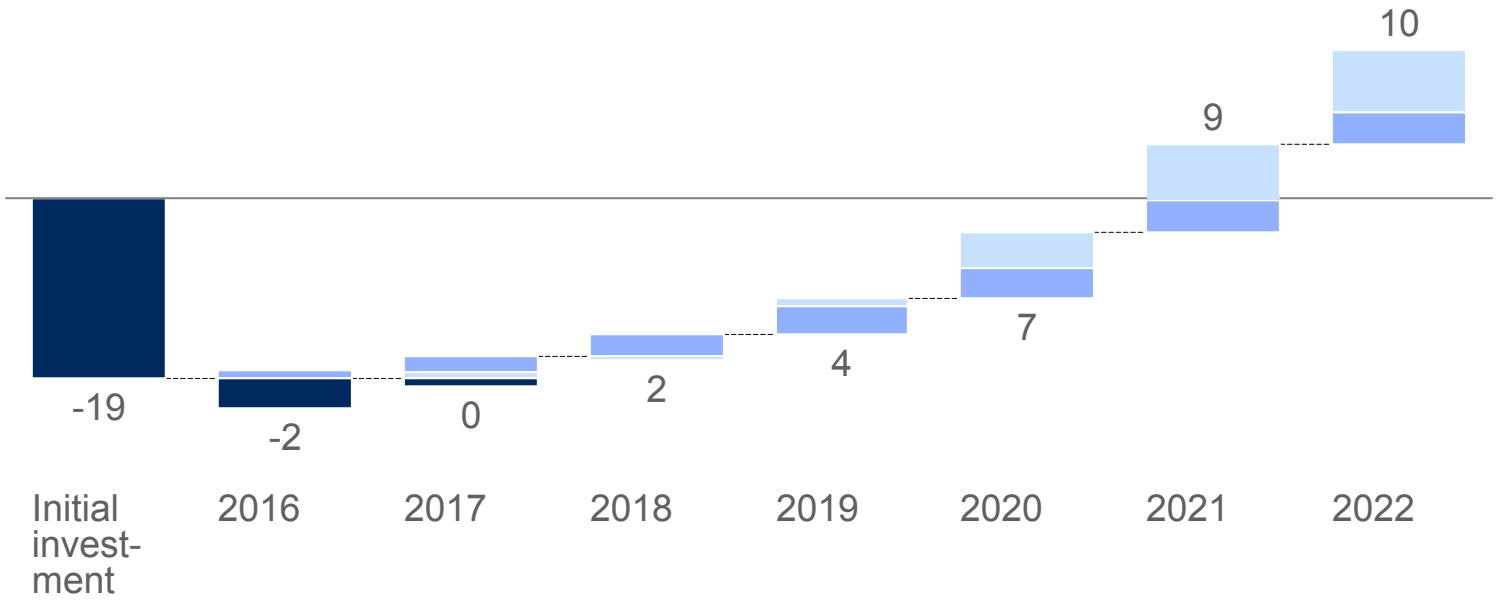
The impact of combined provider led health plan economics can take time, even with reasonable market capture and integration

ILLUSTRATIVE

Payor Provider Investments

Net cash flow by year for organic growth scenario

$ Millions, from an Integrated Delivery Network perspective

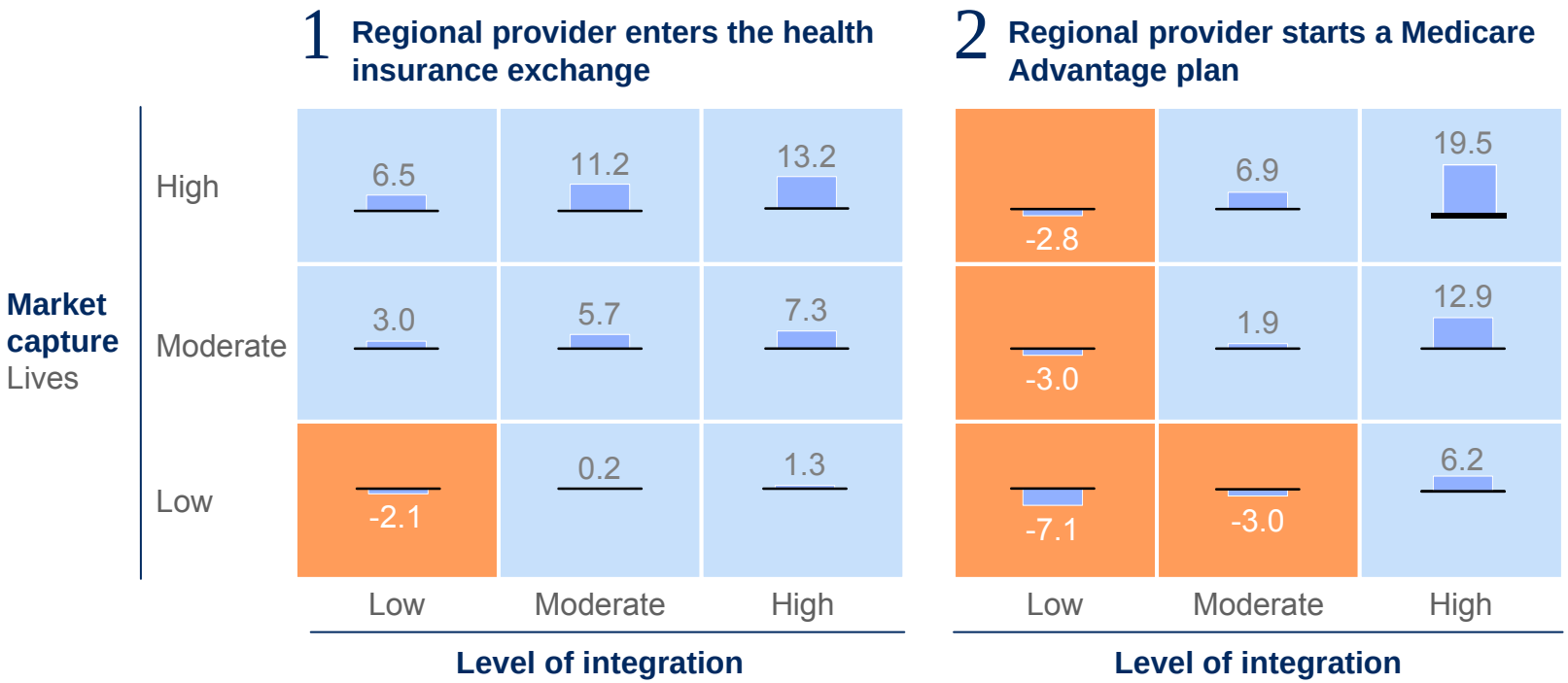


With risk-based capital of 15-20% of premiums for a new plan, investment can be substantial

SOURCE: McKinsey financial modeling

Success is largely driven by membership capture and level of payor and provider integration

Variation in Net Present Value (NPV) based on scenario, market capture and level of integration
$ Millions



1 Integration in this analysis is varied according to upfront costs to integrate physicians, Star rating and reimbursement changes, change in utilization, level of profitability, and degree of market capture

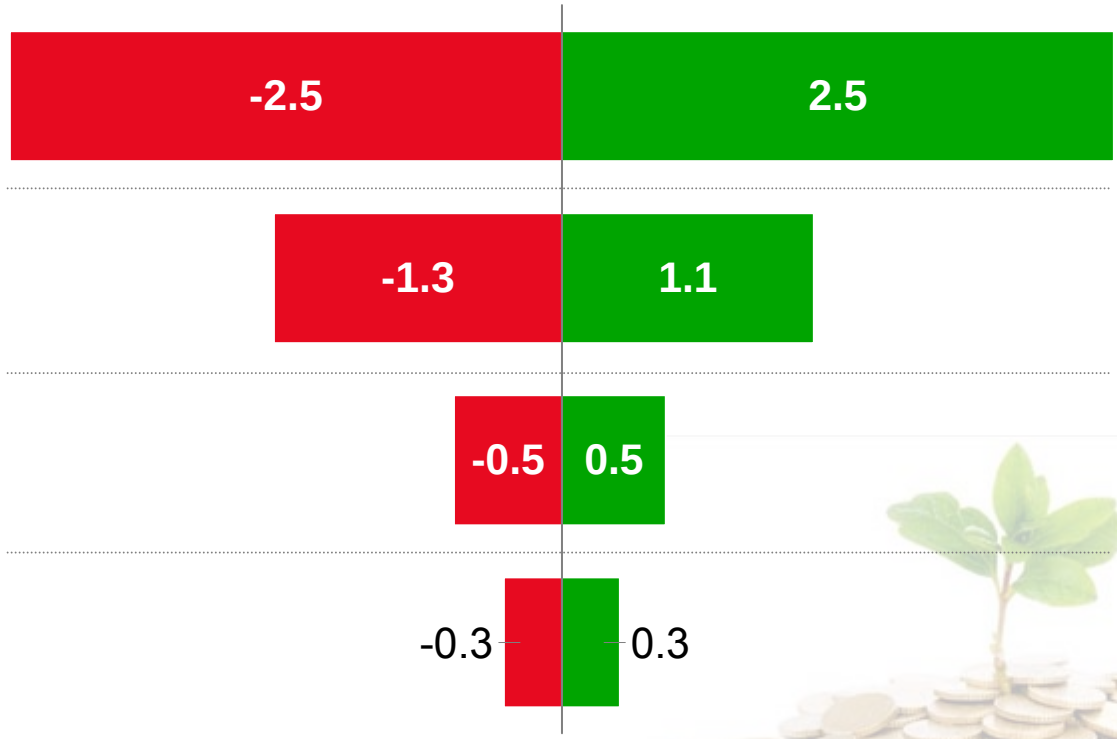
SOURCE: McKinsey Care Delivery and Payment Model Innovation Toolkit v2.0

How sensitive is value creation to various drivers?

Organic market entry, moderate market capture, moderate system integration

MEDICARE ADVANTAGE EXAMPLE

Change in NPV of provider-led MA plan based on 1% change in key driver, $ Millions



1 Assumes +/- 1 percentage point change;
2 Baseline is 6%; reflects +/- 1 percentage point change;
3 Medicare Advantage members who change health plans each year; represents +/- 1 percentage point change;
4 Indicates +/- 1% change in Medicare Advantage capitation rates

SOURCE: McKinsey Care Delivery and Payment Model Innovation Toolkit v2.0

In general, new volume and shared savings are critical to outweigh reduced utilization and investments required for risk-based models

Desirable
Undesirable
Depends on specific partnership

Category	Provider EBITDA impact	Payor PMPM impact
Volume growth	↑	—
Reduce avoidable utilization via prevention and care coordination	↓	↓
Decide on the lowest cost on modality and care setting	↓	↓
Optimize encounter performance	↑	↓
Price, bonuses, shared savings, and capitation premium	↑	↑
Partnership operational expenses[1]	↓	↑

Favorable conditions for risk-based contracting include:

- High out-of-hospital footprint
- Low fixed cost structure
- Medicare-heavy payer mix

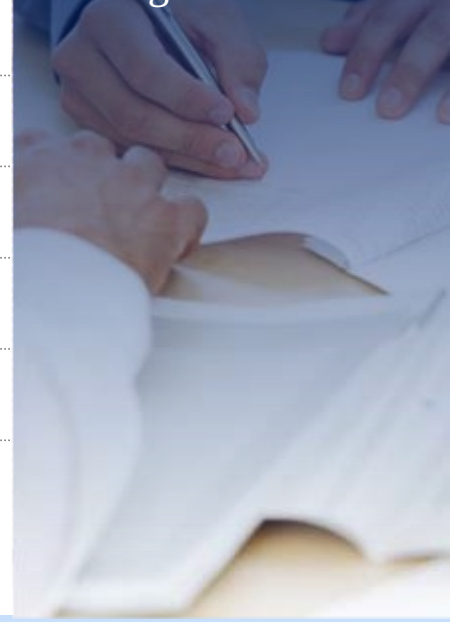
SOURCE: McKinsey population health management impact assessment

Favorable contracts show elements of shared savings, volume steerage, and payor opex contribution

Commercial population, 30,000 lives

Price reduction Percent	Volume steerage Percent	Shared savings Percent	Payer opex contribution Dollars	Change in PHM EBITDA[1] Percent
				(7)
5% ↓				(19)
10% ↓				(31)
10% ↓	5% ↑			(25)
10% ↓	10% ↑			(15)
10% ↓	10% ↑	50% ↑		(7)
10% ↓	10% ↑	75% ↑		(4)
10% ↓	10% ↑	75% ↑	$2 ↑	0
10% ↓	10% ↑	75% ↑	$5 ↑	4

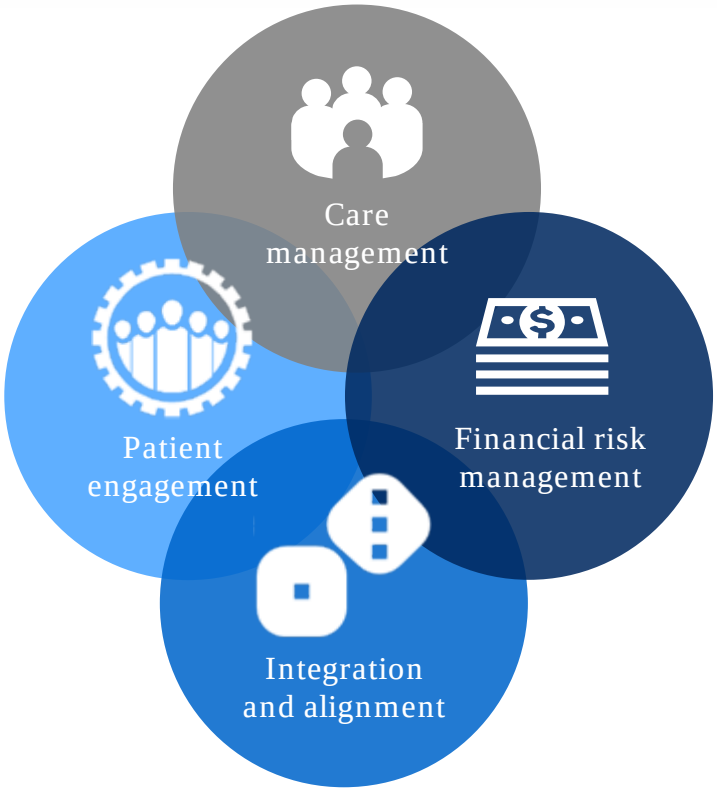
Ensuring value requires careful estimation and negotiation across a range of criteria



1 Stated 5-year EBITDA impact includes incremental operational expenses

SOURCE: McKinsey population health management scenario modeling

In order to succeed in population health, it is critical to perform across several dimensions



- Data aggregation, collection and provider reporting
- Clinical analytics
- Care coordination including post-acute and supportive care, across medical neighborhood
- Chronic disease management
- Wellness and Prevention
- Pharmacy programs

- Cost and utilization analytics
- Diversity of gain and risk sharing models
- Financial risk accounting/ and reinsurance
- Contract management
- Documentation and accurate coding

- Governance, strategy and alignment across the network
- Clinical quality and best practice dissemination, clinical pathways
- Clinical operations improvement to optimize quality and cost
- Practice transformation
- IT tools that enable integration
- Provider engagement

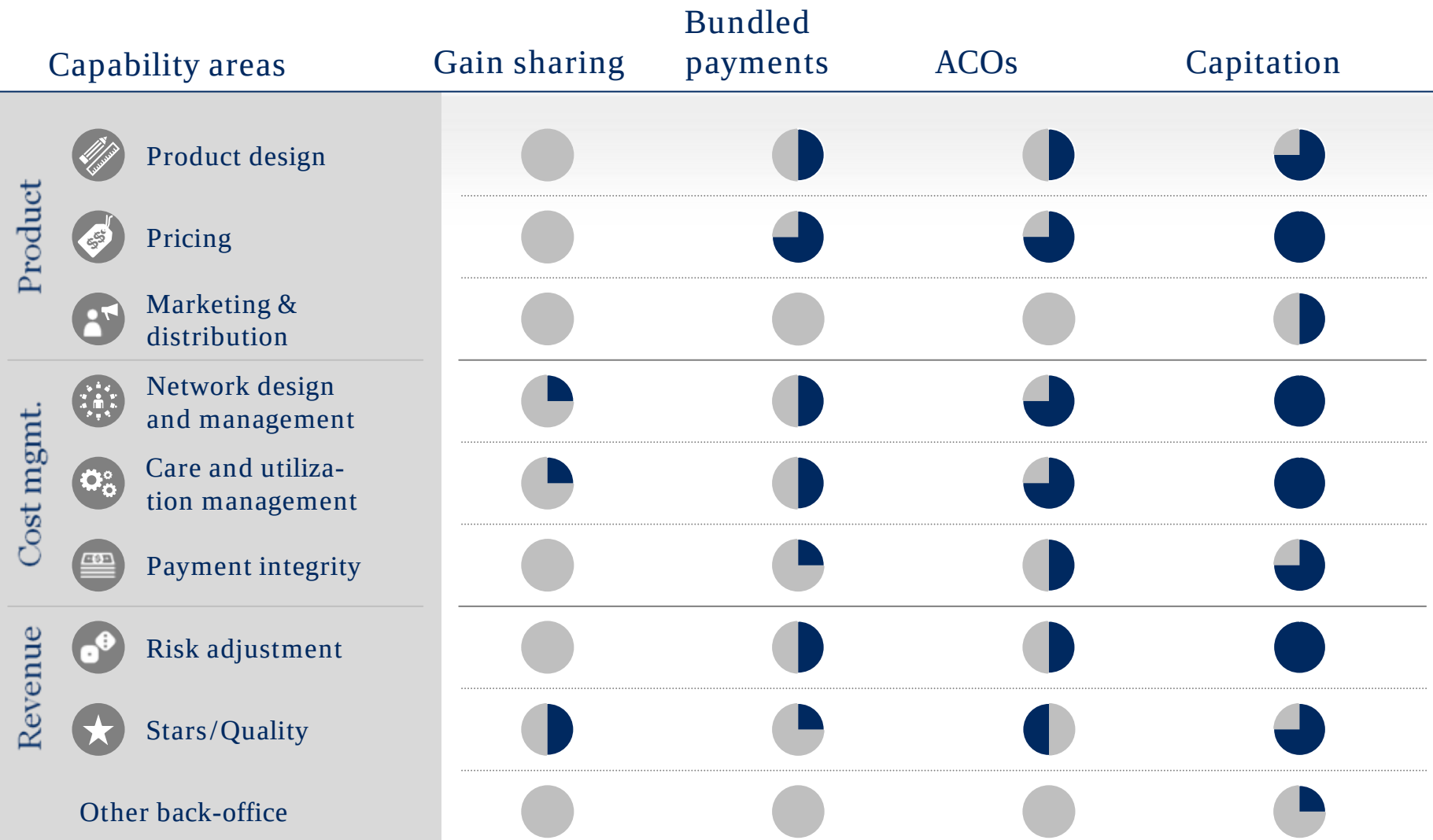
- Patient navigation tools including transparency
- Tools and education programs for patient self-management
- Patient experience and customer service

SOURCE: McKinsey population health management capability assessment

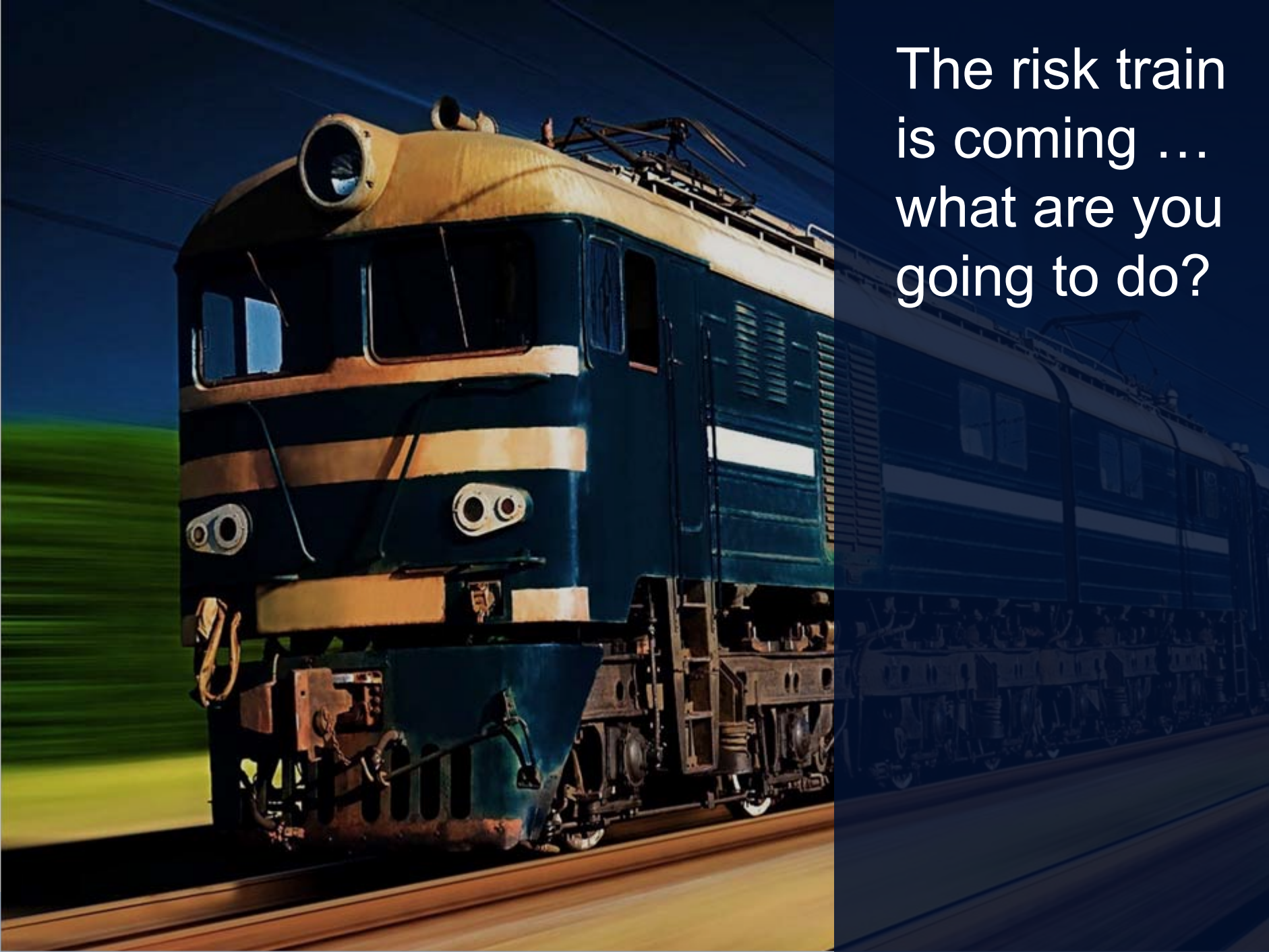
In particular, providers will need to build payor like capabilities

Importance of capability for taking on risk

Most important · Least important



SOURCE: McKinsey analysis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