The Essentials of Risk-Based Contracting

Avoiding Financial Missteps in Structuring Contracts
Financial Leadership Council

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Available Within Your Financial Leadership Council Membership

Over the past several years, the Financial Leadership Council has developed numerous resources to help program leaders evaluate the transition to risk-based contracting. All of these resources are available in unlimited quantities to members.

Managing Financial Performance Under Risk
*Emerging Imperatives for Finance Departments in the Transition to Accountable Payment*

Explore how finance leaders preparing for accountable payment can project financial performance, prepare for cash flow disruptions, and negotiate favorable payer terms. By reading this white paper, members will learn:

- The accounting challenges under total cost of care contracts and the impact on margin projections
- The cash flow implications of delayed shared savings bonuses
- Considerations for successful contract negotiations and evolving payer-provider relationships

Next-Generation Revenue Cycle
*Accelerating Cash Flow Under Risk-Based Contracts*

Learn eight ways to optimize revenue cycle performance by refocusing documentation efforts to capture quality, preparing the front office to manage more complex processes, and updating billing operations to handle risk and exchange products. By reading this white paper, members will learn how to:

- Adapt revenue cycle functions to new incentives
- Structure clinical documentation improvement to support care management
- Retool the front office to manage more complex collections, verification, and enrollment processes
- Handle new exchange products and greater risk with new capabilities

The Future of Uncompensated Care
*Addressing the Impact of Changing Coverage on Patient Revenue*

The nature of uncompensated care is drastically changing. These changes have dramatic implications for uncompensated care and hospitals’ approach to collections. To fully understand the impact of these dynamics, we developed a complex financial model capable of projecting levels of bad debt, charity care, and net patient revenue—among other financial metrics—under a variety of potential future scenarios.

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Beyond the Financial Leadership Council

In addition to the resources available through the Financial Leadership Council membership, The Advisory Board Company offers performance technologies to assist its members with unique revenue cycle challenges.

**Payment Integrity Compass**

Payment Integrity Compass is a unified solution for pinpointing all payment discrepancies, streamlining denials and underpayment workflow, and maximizing yield from all payers and contracts.

**Benefits of Payment Integrity Compass**

- Calculates expected reimbursement on existing contracts and rate schedules
- Boosts collector agility to overturn denials and recover underpayments
- Arms staff with data and scenario analysis to improve payer negotiations

**For More Information**

For additional information on Payment Integrity Compass, please visit our website: advisory.com/technology/payment-integrity-compass

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**Payment Integrity Compass — Forecaster**

Payment Integrity Compass—Forecaster helps organizations solve challenges in understanding, evaluating, and transitioning to new risk-based payment models.

**Benefits of Payment Integrity Compass—Forecaster**

- Determines areas of opportunity and targets contracts
- Monetizes clinical improvements through effective risk-based contracting
- Models risk-based contracts, including bundled payments, shared savings, capitated (ACO) and pay-for-performance contracts

**For More Information**

For additional information on Payment Integrity Compass Forecaster, please visit our website: advisory.com/technology/payment-integrity-compass-forecaster
Executive Summary

Many providers are currently entering into shared savings contracts with both public and commercial payers. But even with the savings potential, in the near term revenue rarely reaches the level accrued under fee-for-service due to the demand destruction required to meet cost targets.

As such, some finance executives question the sustainability of the model and are looking to quickly progress into capitated contracts. Yet the extensive population health management and actuarial capabilities necessary to succeed under these global contracts preclude a rapid move; many providers will need to gain experience with agreements that contain less risk and gradually gain the competencies necessary to accept full risk for a population of patients.

As shared savings arrangements are often a part of this evolution, providers must try to optimize contractual terms minimize potential losses. This white paper examines five financial missteps in this process, as well as strategies for avoiding each to ensure sustainable risk-based contracts.

Observations on the Risk Environment

1. The competitive landscape dictates whether or not payers and providers are willing to enter into risk arrangements.
2. Most commercial risk-based contracts in place currently are limited to upside-only shared savings; only a few contracts include downside risk.
3. Providers that have successfully managed the cost and quality of care for their own employee population are well positioned to demonstrate proof of concept to payers.

Five Financial Missteps in Risk-Based Contracting

1. Imprecise Attribution of Patients
   - Seek contracts that contain patient financial incentives to seek care in network (p. 15)
   - Advocate for prospective assignment of open access network patients (p. 15)

2. Detrimental Structure of Incentive Payments
   - Understand how shared savings contracts impact revenue targets (p. 18)
   - Ensure cost rewards are contingent upon quality performance (p. 18)
   - Create separate cost targets according to service type (p. 19)
   - Request use of medical loss ratio as cost target (p. 20)
   - Agree upon cost and quality targets prospectively (p. 20)
   - Advocate for prepayment of quality incentives (p. 21)

3. Inadequate Focus on Quality
   - Standardize quality measures and targets across contracts (p. 22)
   - Ensure quality measures are applicable and actionable (p. 22)
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4. **Ambiguous Breakdown of Responsibility**
   • Create an infrastructure for collaboration (p. 24)
   • Utilize existing data sources to monitor ongoing performance (p. 25)
   • Request claims data from payers to prevent network leakage (p. 26)
   • Determine responsibility for care management programs (p. 27)

5. **Unequal Distribution of Risk Across the Provider Network**
   • Structure physician compensation models to encourage focus on quality and cost of care (p. 28)
   • Create opportunities to align with other members of the care continuum through incentives (p. 31)
Discussion of risk-based payment—accountable care organizations (ACOs), bundled payments, value-based purchasing, or capitation—has dominated much of the health care reimbursement landscape the past few years. Looking to lower health care expenditures, many policymakers and providers have advocated for this particular category of payment reform, placing a certain amount of risk for cost and outcomes onto providers.

Much focus has been on ACOs, specifically CMS’s pilots and programs, including both the Pioneer ACO program as well as the Medicare Shared Savings Program (MSSP). Following quickly has been the proliferation of commercial ACOs and shared savings contracts which we now estimate to be 207. Financial Leadership Council survey data also shows that a large portion of providers without these types of contracts in place currently plan to have one in place by 2015.

But these types of shared savings arrangements rarely result in positive margins in the near term. The demand destruction necessary to achieve cost targets almost always outsizes the bonus potential stipulated within these contracts. Early results from the MSSP show that only a quarter of participants reduced expenditures enough to qualify for shared savings bonuses.

<table>
<thead>
<tr>
<th>Total Cost of Care Implementation Timeline</th>
<th>Providers without Total Cost of Care Contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely by 2013</td>
<td>8%</td>
</tr>
<tr>
<td>Likely by 2014</td>
<td>15%</td>
</tr>
<tr>
<td>Likely by 2015</td>
<td>31%</td>
</tr>
<tr>
<td>Likely by 2016</td>
<td>15%</td>
</tr>
<tr>
<td>Likely by 2017</td>
<td>6%</td>
</tr>
<tr>
<td>Not Likely Within 5 Years</td>
<td>25%</td>
</tr>
</tbody>
</table>

Savings Earned by MSSP ACOs

- 53% Did Not Reduce Spending
- 25% Earned Shared Savings
- 22% Reduced Spending, but Did Not Earn Shared Savings
**Skipping Ahead to Capitation?**

Most providers, therefore, do not see shared savings as a sustainable model; many CFOs and finance executives have voiced the desire to move quickly toward capitation. Financial Leadership Council modeling reveals why: while margins are usually negative under shared savings, capitation can create a positive ROI.

**Margin Impact of 10% Reduction in Inpatient Utilization**

Despite the greater financial sustainability this model offers, the complexity of successful execution of capitated contracts contains a number of financial pitfalls. Our research has shown that contemporary risk contracting tends to evolve along a common path, beginning with pay-for-performance and care coordination incentives before progressing into shared savings, and finally capitation. Each stage of this evolution requires ever more sophisticated capabilities on the part of the provider.

**Progression of Risk-Based Contracts and Capabilities Required**

<table>
<thead>
<tr>
<th></th>
<th>0-3 years</th>
<th>3-5 years</th>
<th>5-10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay for Performance</td>
<td>Metric tracking, reporting</td>
<td>Metric tracking, reporting</td>
<td>Metric tracking, reporting</td>
</tr>
<tr>
<td>Care Coordination Fee/PMPM</td>
<td>Disease management, patient activation infrastructure</td>
<td>Disease management, patient activation infrastructure</td>
<td>Disease management, patient activation infrastructure</td>
</tr>
<tr>
<td>Upside Shared Savings</td>
<td>Metric tracking, reporting</td>
<td>Physician, other provider alignment</td>
<td>Physician, other provider alignment</td>
</tr>
<tr>
<td>Downside Shared Savings</td>
<td>Ability to share risk with other providers</td>
<td>Ability to share risk with other providers</td>
<td>Ability to share risk with other providers</td>
</tr>
<tr>
<td>Capitation</td>
<td>Utilization management</td>
<td>Utilization management</td>
<td>Total cost-of-care measurement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Stop-loss insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Actuarial expertise</td>
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</table>
Optimizing Shared Savings Contracts

Although shared savings contracts are not financial boons, they are often an initial step in the evolutionary process. While the contractual elements of MSSP are nonnegotiable, providers have more flexibility under commercial contracts. If structured optimally, these commercial contracts will:

- Result in minimal financial loss
- Prepare the provider and payer for more extensive risk arrangements, including capitation

But structuring these contracts is difficult. Our research has revealed five financial missteps that providers should avoid:

1. Imprecise Attribution of Patients
2. Detrimental Structure of Incentive Payments
3. Inadequate Focus on Quality
4. Ambiguous Breakdown of Responsibility
5. Unequal Distribution of Risk Across the Provider Network

The remainder of this briefing will discuss the implications of these pitfalls and suggest strategies for avoiding them in the design of commercial shared savings contracts.¹ While the case studies are from actual provider organizations, due to the proprietary nature of contractual terms the majority of institutions are given a pseudonym.

¹) Not including capitated contracts.
Observations on the Current Risk Environment

**Observation 1: The competitive landscape dictates whether payers and providers are willing to enter into risk arrangements.**

There is significant variation in the proliferation of risk-based contracts from market to market. Generally, both payers and providers enter into contracts to differentiate themselves from or keep up with other competitors in the market, with the hope of capturing patient lives.

Within highly consolidated markets lacking in competition at both the payer and provider level, risk-based contracting is typically—but not uniformly—either in very early stages, or nonexistent.

Take the example of one market in the South. The market has six highly competitive health systems, each with fairly equal market share, and has seen risk-based contracting advance rapidly, with each provider jockeying for a greater number of captive lives. One VP of managed care in the market admitted that his system was not interested in risk at all—until a competing provider signed a shared savings agreement. Since then, the VP’s system has quickly invested in the necessary care management infrastructure and currently has 30% of its revenue tied to total cost of care contracts.

A similar scenario is true for payers: if one begins to enter into risk-based contracts with providers, others feel they must follow suit to defend market share. One midsized metropolitan area is dominated by two payers, which both currently participate in risk-based contracts with providers. The larger payer first began deploying these types of arrangements; scared of losing even greater share to its competitor, the smaller payer quickly developed risk-based arrangements to offer providers.

**Observation 2: Most commercial risk-based contracts in place currently are limited to upside-only shared savings; only a few contracts include downside risk.**

While different markets are at various stages of risk, very few contracts are structured as shared savings with downside risk; most providers are avoiding any agreement that requires them to cover costs when they rise above predetermined targets.

This reticence is understandable. The downside risk stage of contracting adds another layer of risk onto providers (beyond the risk of lost revenue from demand destruction) and may require building cash reserves or even stop-loss insurance, depending upon the parameters of the contract.

**Observation 3: Providers that have successfully managed the cost and quality of care for their own employee population are well positioned to demonstrate proof of concept to payers.**

A provider’s own employee population serves as a logical first place to begin managing risk and lowering the cost of care for a captive population. With employees, providers avoid the risk of destroying their own demand with the resulting reduction in revenue. Tulip Medical Center, a hospital system in the Midwest, formed an ACO for its own employee population, building the care infrastructure and utilization management necessary to control costs of caring for that cohort. Tulip succeeded, holding premiums flat for three years. Armed with this data, the system approached commercial payers,
highlighting its ability to manage a population and succeed under risk. Tulip is currently in two commercial contracts, and cites their experience with their own population as a strong argument for its ability to manage under shared savings arrangements.

Shared savings arrangements are still in early stages in most markets, and our research revealed that this relative inexperience with risk-contracting has led many providers to make grievous missteps. The remainder of this briefing outlines the five most common missteps organizations have made with upside shared savings contracts, along with strategies that may be deployed to avoid these pitfalls.
Misstep 1: Imprecise Attribution of Patients

A foundational component of a successful risk-based contract is a clear understanding of which patients are covered under the arrangement—the patients that, for the purposes of the contract, are attributed to the provider. Providers must be certain that they are monitoring quality and cost measures for the correct cohort of patients and, more importantly, that the organization is delivering the appropriate care and interventions to inflect those measures. While this may seem to be an obvious point, accurate attribution presents a sizeable challenge for many providers participating in risk contracts.

Two Primary Patient Attribution Methodologies

**Assignment**

- Patient assigned to provider based on retrospective review of historical utilization, charge data
- Assigned to provider at which patient received majority or plurality of care over certain time period
- Generally used for patients participating in open access plans
- Patients may be assigned following performance period (retrospectively) or prior to performance period (prospectively)

**Patient Choice of Product**

- By virtue of patient enrollment in insurance product, patient required to choose PCP within provider network
- Based on PCP choice, patient assigned to provider with which PCP is affiliated
- Generally used for patients participating in narrow network plans
- May only be used prospectively

**Patient assignment**

A patient is assigned to a provider based on where that patient has received the majority (or plurality) of care in the last year or two years. The correct assignment is determined by reviewing the patient’s historical claims or charge data. This methodology is generally used for patients enrolled in open-access insurance plans, including Medicare's Shared Savings Program, and others that place few restrictions or penalties on patients seeking care outside a certain network.

Patients may be assigned following the performance period—*retrospective assignment*—which ensures that the provider is held accountable only for the patients that it saw during the performance period.

The drawback of retrospective assignment is that the provider may not be aware of what patients it is accountable for during the performance period—when it could potentially inflect outcomes by targeting specific attributed patients for intervention.

Assignment can also be *prospective*. In these cases the provider is notified it is responsible for a certain cohort of assigned patients, which allows the provider to undertake targeted interventions and may increase the likelihood of success.
Patient choice of product

The other methodology of patient attribution is patient choice of product. This is when a patient chooses to enroll in a plan that is linked to a certain provider network. This methodology is generally used for patients enrolling in narrow network plans, as well as HMOs and Medicare Advantage plans, and can only occur prospectively because the patient is attributed at the point of enrollment.

Neither methodology is without complications. Both patient assignment and patient choice of product present challenges for providers.

Factors Complicating Patient Attribution

<table>
<thead>
<tr>
<th>Complicating Factor</th>
<th>Description</th>
<th>Assignment Methodology</th>
<th>Patient Choice Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage churn</td>
<td>• During performance period, patients may change between coverage, becoming eligible for attribution or losing attributed status</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
| Non-recognized PCPs | • Patients receive majority of care from nurse practitioners or physician assistants, who aren’t recognized as primary care providers by contract terms  
  • Attributed to providers from whom patients only receive tertiary care because true "PCP" not recognized for attribution purposes | ✓                       | ✓                         |
| Patient Leakage     | • Attributed patients unaware of, or unwilling to use, in-network providers | ✓                       | ✓                         |

Coverage churn

Coverage churn can pose challenges to both methodologies and occurs when an attributed patient jumps between sources of coverage during a provider’s performance period. For example, a patient attributed to a provider through a commercial risk contract may lose coverage and become eligible for another source of coverage, causing that patient to be outside the attributed population.

Non-recognized PCPs

The complication of non-recognized PCPs is primarily an issue with the patient assignment methodology. A patient may receive the majority of his or her primary care from a nurse practitioner or physician assistant, two providers who are frequently not recognized as primary care providers by risk-based contracts. As a result, the patient could be attributed to a provider who sees the patient only for tertiary care, placing the provider at risk with limited ability to inflect that patient’s care.

Patient Leakage

Patients may also leave their attributed network for care, a scenario commonly called leakage. This is particularly an issue for patients attributed under the patient assignment methodology who are enrolled in open access plans. These patients may have selected coverage unaware of network restrictions and may continue to seek care from other providers. While this scenario is fairly rare, it still poses a threat.
Strategies for Avoiding Imprecise Attribution of Patients

Seek contracts that contain patient financial incentives to seek care in network

Patients who are encouraged to receive care from the provider under risk will be more likely to stay within network. This can be achieved by creating either a narrow or tiered network, both of which will result in financial penalties if the patient seeks care elsewhere.

For example, Daisy Physician Group, a small IPA in the East, has risk contracts with Medicare Advantage plans and traditional commercial HMO plans, while also participating in the Pioneer ACO program. Data analysis has shown that while the leakage rate for care delivered locally under its Medicare Advantage contracts is about 5%, the leakage rate is about 50% under the Pioneer ACO contract. Daisy attributes the widely varying rates to the choice patients make to enroll in Medicare Advantage plans, whereas patients in the Pioneer program most likely have no idea they are attributed to the physician group and are allowed to seek care outside the network without repercussion.

While providers may have limited power to mandate this approach, having a frank conversation with payers as to how these products can be structured will assist in attribution efforts.

Advocate for prospective assignment of open access network patients

Providers will not be able to benefit from plan incentives that encourage patients to stay in network in every scenario. Many commercial risk contracts include patients enrolled in PPOs and other types of coverage that offer patient choice. In these scenarios, prospective patient attribution is optimal. Although prospective assignment does not guarantee that the attributed patients will actually be seen by that provider during the performance period, it does allow providers to proactively work to activate attributed patients and encourage them to stay within the network throughout the contract period.

Under one provider’s shared savings arrangement, the payer prospectively assigns its PPO patients based on historical utilization patterns. While patients do not face the financial penalties for going out of network, the provider knows its attributed patient population at the start of the contract and works to activate and motivate that cohort to stay within the system.

3) Pseudonym.

4) Source: “Promising Payment Reform: Risk-Sharing with Accountable Care Organizations,” The Commonwealth Fund, July 2011. Research completed by: Suzanne Delbanco (Catalyst for Payment Reform); Kristine M. Anderson, Catherine E. Major, Mary B. Kiser, Brynnan W. Toner (Booz Allen Hamilton).
Misstep 2: Detrimental Structure of Incentive Payments

Carefully crafting incentive payments can be the difference between a slight loss and complete disaster. Orchid Health\(^5\) entered into an upside-only shared savings arrangement, accepting the payer’s terms without much alteration. After the first year, Orchid saw a negative 1.5% margin on the contract. Resolving to improve margins over time, Orchid has restructured the terms and has seen fortunes begin to improve, increasing its margin to a smaller 1.1% loss.

<table>
<thead>
<tr>
<th>2011 Incentive Structure</th>
<th>2012 Incentive Structure</th>
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</thead>
<tbody>
<tr>
<td>Quality bonus dependent upon cost performance</td>
<td>Cost bonus dependent upon meeting quality metrics</td>
</tr>
<tr>
<td>One cost target for all care delivered</td>
<td>Multiple cost targets for each type of care provided</td>
</tr>
<tr>
<td>Quality targets decided after contract signed</td>
<td>Quality targets agreed upon prospectively</td>
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Orchid’s Losses on Risk-Based Contract

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<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>(1.1%)</td>
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(1.5%)

Case in Brief: Orchid Health
- 650-bed hospital in the West
- Entered into upside shared savings contract with payer in 2011, agreeing to payer’s standard terms
- Saw greater losses than anticipated, restructured certain incentive terms for 2012 contract
- Saw smaller loss in 2012, continue to work with payer to refine terms

Our research has revealed that upside shared savings arrangements share four common attributes:

1. **Separate cost and quality bonus payouts**

   Upside shared savings contracts include cost and quality performance goals, as well as accompanying payouts. This structure allows providers two opportunities for earning a bonus and a greater likelihood of some financial reward.

2. **Cost rewards take the form of shared savings**

   In these contracts, providers have the opportunity to earn cost bonuses in the form of shared savings; while the percentage of savings that providers may earn varies quite a bit from contract to contract, cost targets are typically determined in one of two ways:

   * **Medical loss ratio (MLR)**

     A medical loss ratio of 85% is used as a cost target in some contracts. When costs remain under that limit, the provider shares some of the savings with the payer. The 85% limit is in direct response to the Affordable Care Act, which states that payers must spend 85 cents of each premium dollar on patient care.

5) Pseudonym.
Historical cost trends

The other common methodology is using historical cost trends to set targets. Payers either look to past provider spend or look to the expenditures of a similar provider; then they set a goal of staying flat against those targets or remain under a target that includes minimal growth.

3. Lack of robust risk-adjustment

Risk-adjusting the patient population to determine an appropriate cost target is rare in current upside shared savings contracts. Most arrangements depend solely on the MLR or historical spend. When risk-adjustment does occur, it remains relatively simple and straightforward—factors beyond sex and age are not typically used to price risk.

4. Quality incentives paid as PMPMs

Where cost bonuses take the form of shared savings, quality rewards are often distributed as PMPMs or care coordination fees. While the amount per quality metric ranges, rarely are current metrics outcomes-based but instead focus on process measures. For example, several providers reported receiving anywhere from $1 to $3 for testing a certain percentage of diabetic patients’ LDL levels.
Strategies for Avoiding the Detrimental Structure of Incentive Payments

Understand how shared savings contracts impact revenue targets

Providers should have a firm understanding of how incentive payment structure will impact overall revenue goals and margin. Far too frequently, these arrangements are viewed independently, without thought as to how other contracts should be structured to minimize margin loss.

For example, Peony Healthcare\(^7\) approaches negotiations with payers keeping in mind an overall “yield rate,” which informs the contractual terms to which they are willing to agree. Understanding that they may miss the bonus opportunity, Peony tries to negotiate higher rates from fee-for-service contracts, which serve as a potential cross-subsidizer to ensure they meet their goal “yield rate.”

Ensure cost rewards are contingent upon quality performance

Though all upside shared savings contracts contain both cost and quality goals, they tend to be interconnected, with payment of one type of reward contingent upon the other. While there is variation, payment for cost performance should only be paid if quality goals are met. When quality payments are contingent upon financial performance, a few outlier patients may prevent a provider from earning a bonus at all. Providers and payers would also run the risk of appearing to prioritize financial sustainability over patient outcomes.

Cost and quality payments may also be completely separate, with no relationship between the two rewards. While not financially detrimental to the provider, this arrangement can also give the appearance of not placing enough of a priority on quality.

Some contracts use performance on quality measures to dictate not only whether providers earn the cost reward, but how much of the cost reward they receive. Tulip Medical Center\(^8\), which we discussed earlier, participates in upside-only shared savings contracts through which it is typically eligible for 50% of the savings generated. To receive that bonus in its entirety, Tulip must reach certain quality targets. Therefore, the...
The actual amount of the shared savings bonus rewarded depends upon the level of performance Tulip reaches on quality metrics. For example, if Tulip reaches 30% of its quality targets, the organization will earn 30% of its cost bonus pool. Meeting each quality metric individually earns the organization a separate PMPM.

The Medicare Shared Savings Program has a similar cost bonus structure. The amount a provider may earn of cost savings generated is determined by the provider’s performance on the 33 quality measures across the 4 different quality domains—the provider receives a higher sharing rate when its quality performance improves. The amount of any losses that a provider must cover is also determined by performance on quality measures—the better a provider does on the measures, the less of the loss it has to cover.\(^9\)

Create separate cost targets according to service type

Progressive contracts not only create separate bonuses for cost and quality performance (though payout of the two should be interdependent) but also divide cost targets into separate buckets, according to the type of service provided or the setting within which care is provided.

There are three primary benefits of creating separate cost targets:

1. Improves the accuracy of individual targets because of the wide variation in cost structures and performance between settings and services
2. Ensures that low-performing areas do not preclude all shared savings
3. Pinpoints any areas of opportunity in terms of cost performance

Violet Health\(^10\), a three-hospital system in the Midwest, is in an upside-only, shared savings contract that separates cost targets into the following categories:

- Hospital inpatient
- Outpatient/ambulatory
- Pharmacy
- Post-acute care

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10) Pseudonym.
Calla Clinic’s\textsuperscript{11} contract has taken a different approach. With its Medicare Advantage contract, cost target buckets correspond with Medicare parts A, B, and D. During its contract period, Part A expenditures exceeded targets while Part B spend remained below the goal. After earning the bonus connected to Part B, Calla closely scrutinized inpatient expenditures and feels it has identified several areas to focus on so it will meet the target under the current contract.

**Request the use of medical loss ratio as a cost target**

In the absence of robust risk-adjustment, the medical loss ratio method of determining cost targets may be preferable to those based on historical costs. For payers, this methodology is obviously appealing, as the ACA requires them to spend 85 cents of every premium dollar on patient care. The payer must refund any savings generated below the 85% MLR ratio, which makes this a natural cost benchmark.

The methodology also assumes that payers have already risk-adjusted for the population and priced the premium accordingly. As a result, the MLR would likely be the most accurate and appropriate strategy for determining costs for a population of patients. This may become even more important when entering into downside risk arrangements.

Jonquil Health System\textsuperscript{12} is in the process of negotiating an upside and downside shared savings arrangement with a payer, through which it will either receive a set amount of savings generated or cover the cost of expenditures over the target—according to the MLR.

<table>
<thead>
<tr>
<th>Percentage of MLR</th>
<th>Shared Savings Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% or more</td>
<td>Payer: 75%</td>
</tr>
<tr>
<td></td>
<td>Jonquil Health System: 25%</td>
</tr>
<tr>
<td>&gt;85.5% - 99%</td>
<td>Payer: 65%</td>
</tr>
<tr>
<td></td>
<td>Jonquil Health System: 35%</td>
</tr>
<tr>
<td>71% - ≤85.5%</td>
<td>Payer: 50%</td>
</tr>
<tr>
<td></td>
<td>Jonquil Health System: 50%</td>
</tr>
<tr>
<td>70% or below</td>
<td>Payer: 25%</td>
</tr>
<tr>
<td></td>
<td>Jonquil Health System: 75%</td>
</tr>
</tbody>
</table>

Jonquil Health System feels that the use of MLR incorporates the risk posed by the population of patients and relies upon the actuarial work already performed by the payer.

**Agree upon cost and quality targets prospectively**

While this strategy may seem simplistic, many providers interviewed for this research have lost money in the first year of a contract because of lack of agreement on targets prior to signing the contract. Daffodil Healthcare,\textsuperscript{13} for example, was not informed prior to the start of its performance period what its cost target would be. While Daffodil knew it would be based on historical spend, the actual number wasn’t included in the contract. Due to different cost methodologies, the payer’s cost target was much different from Daffodil’s own.

\textsuperscript{11} Pseudonym.
\textsuperscript{12} Pseudonym.
\textsuperscript{13} Pseudonym.
In the second year of the contract, Daffodil insisted that targets be agreed upon prospectively. Now, the contract includes the actual target Daffodil must reach to garner savings.

**Advocate for prepayment of quality incentives**

Creating a care management infrastructure capable of taking on risk is an expensive undertaking; payers acknowledge that success under shared savings requires a care delivery redesign and a significant amount of capital on the part of the provider.

Acknowledging the large investment, some payers have shown willingness to pay quality incentives prospectively, with providers returning the incentive if they are unable to meet performance goals. This limits the initial outlay providers are required to make and allows a “fund-as-we-go” approach to building an infrastructure necessary for risk.

Clover Healthcare\(^{14}\) receives quality payments (in the form of a PMPM care coordination fee) prospectively each quarter. The care coordination fee ranges from $1 to $8; depending upon the contract, a portion of the fee may be at risk based on Clover’s performance on certain quality and/or cost performance metrics. Clover communicates with its payers that the fee is an investment in the infrastructure required to succeed under risk and prepayment helps to minimize the burden of the costs already incurred to support aligned and collaborative behaviors between all stakeholders.

If payers are unwilling to prepay quality incentives, providers should ask for quarterly or biannual retrospective payments as opposed to annual payments, to help smooth cash flow and minimize the amount of upfront capital providers must invest independently.
Misstep 3: Inadequate Focus on Quality

Because of the widely held view that a lack of quality incentives led to stunting of care during the last wave of managed care in the mid-1990s, they are now routinely included in risk contracts. But even today finance executives seem to focus a disproportionate share of their time on meeting cost targets. While this isn’t entirely surprising given the CFO and broader finance department’s responsibilities, quality metrics (and the accompanying quality bonus) offer an opportunity that shouldn’t be relegated to an afterthought.

Based upon the way most shared savings contracts are structured, when finance does not pay sufficient attention to quality metrics and targets, the opportunity to earn both cost and quality rewards may be at risk.

Strategies for Avoiding an Inadequate Focus on Quality

Standardize quality measures and targets across contracts

Though quality measures included in contracts are typically combinations of common sets of measures such as HEDIS, CMS’s MSSP quality metrics, or, in the case of Medicare Advantage plans Star measures, contract to contract, the measures vary in three ways:

1. The type of metrics being tracked within each contract
2. The number of metrics being tracked within each contract
3. The performance targets for each metric

Across contracts, providers should push to have quality performance (and any associated rewards) contingent upon the same set of measures with, perhaps most importantly, identical performance targets, ideally rooted in evidence-based medicine.

Most interviewed providers agree that early risk contracts should include no more than eight to ten measures. As the provider gains experience with risk, more metrics can be added, with the quality bonus opportunity increasing proportionally.

Ensure quality measures are applicable and actionable

While the use of many publicly reported sets of quality metrics may assist in standardization between contracts, this can also lead to the inclusion of metrics that providers are unable to inflect.

Hibiscus Physicians is in an upside-only, shared savings contract that includes the metrics used by the CMS Pioneer ACO Program. Among those, Hibiscus has struggled especially with flu shot coverage for its attributed patient population. These patients have overwhelmingly received vaccines from urgent care/retail clinics and one-off clinics offered by their employers, making tracking—and inflecting—this metric particularly difficult. Hibiscus reports that it will advocate removal of this metric from the next contract as it has missed the target, and the associated PMPM, two years in a row.

Collaborate with clinical leadership to ensure alignment of cost and quality initiatives

Finance executives should communicate with clinical leaders to not only understand the likelihood of achieving quality goals, but also ensure that clinical leadership’s current performance initiatives do not undermine risk-based contracts.

15) Healthcare Effectiveness Data and Information Set.
16) Pseudonym.
In the case of Hyacinth Health, the goals of utilization management under an upside-only shared savings contract ran counter to the volume goals of a new clinical offering. The contract included imaging utilization as one component of quality, requiring Hyacinth to keep imaging utilization per 1,000 patients to historical levels. Yet during the same contractual period, the organization’s imaging and oncology service lines launched a lung cancer screening program, which, though financially successful, increased utilization and caused Hyacinth to miss out on that portion of its bonus opportunity.

**Contract Runs Counter to Current Initiatives**

- Quality metrics include measure of imaging utilization
- New lung cancer screening program runs counter to metric goal
Misstep 4: Ambiguous Breakdown of Responsibility

Many services and infrastructural components are necessary to effectively manage a patient population under a risk contract. Historically, there has been overlap in the provision of these elements between payers and providers—specifically with care management programs, patient activation initiatives, and data analyses. As payers and providers move beyond traditional contracting relationships into risk, this area of overlap offers a ripe opportunity for collaboration and necessitates the clear delineation of responsibility to avoid redundancy and wasted efforts.

Strategies for Avoiding Ambiguous Breakdown of Responsibility

Create an infrastructure for collaboration

Payers and providers must first establish an appropriate forum for collaboration, which provides the opportunity to communicate regularly, and identify new ways to work together.

Tulip Medical Center\textsuperscript{18}, mentioned previously, is currently in shared savings arrangements with payers that stipulate the creation of a joint operating committee. With representatives from both the payer and the provider, the committee meets regularly to review the ACO’s performance reports and identify opportunities for further improvement. The committee is also responsible for determining whether Tulip or the payer is responsible for leading decided-upon initiatives.

\textsuperscript{18) Pseudonym.}
Clear delineation of responsibility is most important when it comes to capital investments. Carnation Insurer\(^{19}\) addresses this issue up-front by defining an administrative budget—separate from reimbursement—at the beginning of the contract period. The budget is meant to provide for some of the necessary infrastructure investments and the costs of ongoing administration of the arrangement. Providers clearly understand how much assistance they will receive from Carnation in financing the components necessary to be successful under risk.

**Utilize existing data sources to monitor ongoing performance**

Providers often insist that receiving payer claims data is a prerequisite to signing a contract. Although claims data is valuable and offers distinct insights for providers engaging in population health management, it is not absolutely necessary for success under shared savings contracts.

Data systems already in use by providers, such as EMRs, lab, and e-prescribing systems, as well as health information exchanges where they are available, provide a trove of information that helps track cost and quality performance.

Montefiore Medical Center has a long history with risk-based contracting. Each month, nurses mine the organization’s disease registry to identify diabetic patients whose HbA1c levels have risen. These patients are then contacted by nurses who can manage the patient via phone or schedule a follow-up visit. Targeted intervention programs help providers manage the population’s overall health and maintain cost and quality.

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19) Pseudonym.
Request claims data from payers to prevent network leakage

Though providers can engage in the necessary cost and quality tracking with current systems, receiving data support from payers—claims data and data analysis assistance—can be beneficial.

Complementary Functions of Clinical and Claims Data

**Clinical Data**

*Provides Accuracy in Detail*

*Strengths:*
- Close to real-time availability
- Rich clinical detail not available in claims

*Weaknesses:*
- May reside in multiple EMRs and other systems; integration required
- Most useful when limited to a specific disease state (e.g., diabetes, CHF, COPD)

**Claims Data**

*Enables Broad View*

*Strengths:*
- Spans care delivery settings
- Provides out-of-system view of patient utilization

*Weaknesses:*
- Difficult to attain without signing risk-based contract
- Delayed availability (months)
- Limited granularity on clinical condition
- Out-of-pocket expenses not captured

Claims data in particular can help with patient leakage efforts and gives providers insight into four things:

1. What particular services patients are seeking outside the network
2. The cost of the services for which the provider will be accountable
3. Which patients regularly go outside the network for certain services
4. Which physicians are regularly referring patients outside the network

But claims data is not the panacea that many providers view it as. Reports are rarely real-time; in best case scenarios payers distribute these reports monthly. While this allows a provider to intervene to prevent leakage in the future and address historical patterns, it will not prevent leakage as it occurs.
Determine responsibility for care management programs

Many risk-based arrangements are stymied by a lack of delineation of responsibility when it comes to care management. Frequently, both the payer and the provider have disease or care management programs in place; to avoid redundancy, each party must agree upon the components that will continue and which should cease.

**Redundancy Neutralizes Partnership Effectiveness**

<table>
<thead>
<tr>
<th>Payer</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Historically offered care management services</td>
<td>• Implements care management program to target attributed patients</td>
</tr>
<tr>
<td>• Continues providing services</td>
<td></td>
</tr>
</tbody>
</table>

Care managers follow up with recently discharged patients

![Diagram](image)

![Table]

<table>
<thead>
<tr>
<th>Cost</th>
<th>Patient Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both organizations incur cost to provide care management services</td>
<td>Patients receive twice the necessary follow-up</td>
</tr>
<tr>
<td></td>
<td>Generates confusion, frustration</td>
</tr>
</tbody>
</table>

In the case example above, a payer and provider engage in a risk contract, but do not determine what each organization will provide to the partnership. As a result, both continue to offer telephonic care management programs that target the same cohort of patients. The duplication not only increases costs, but also decreases patient satisfaction because the patient receives twice the necessary follow-up. The redundancy is inconvenient but also potentially confusing—even detrimental—if differing guidance is offered.
Misstep 5: Unequal Risk Distribution Across the Provider Network

To succeed under a risk contract, all providers across the care continuum must be dedicated to managing the cost and quality of care delivered to a patient population. Though providers are often in different settings and are engaged in widely varying types of care, the structure of these payments models requires alignment.

A major step toward securing alignment is extending the potential rewards—as well as the risk and accountability—to the other members of the care continuum. Without distribution of risk across all providers, there is little incentive to change behavior.

In the case of a physician-based risk contract (as are the majority in the MSSP), physician groups are forced to find ways to align with the hospital, sharing in any potential savings—and risk—with acute care providers. While this structure presents a variety of potential challenges, for the purposes of this section, the focus is on hospital-based risk contracts. We will be publishing research in the future that will investigate the distribution of risk across physician-led ACOs.

**Strategies for Avoiding Unequal Risk Distribution Across the Provider Network**

Structure physician compensation models to encourage focus on quality and cost of care

While all providers should be aligned with the goals of the organization, it is particularly critical for physicians due to their direct involvement in key components of population health: bridging gaps in care coordination, developing effective care plans, and delivering high-quality, low-cost care.

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20) While the MSSP allows physicians to share in savings without employment or clinical integration, it is still unclear whether the same holds true for commercial shared savings contracts.
For hospitals participating in risk contracts, linking physician financial rewards with cost and quality targets aligns goals and ensures that risk for outcomes—as well as the opportunity for reward—is shared by all providers. Our research has identified three key elements of physician bonuses under risk:

- **Perception of fairness**: Risk and bonus distribution mechanisms must be perceived as fair by both PCPs and specialists—permitting all physicians the opportunity to receive a bonus is a key starting point.

- **Avoidance of individual cost goals**: Attributing patient costs back to specific physicians is quite difficult and perhaps unfair; cost goals should be shared by a group of physicians.

- **Internal quality metrics**: Unrelated to the contract’s external quality metrics, organizations with strong degrees of alignment create metrics specific to the physicians.

**Perception of fairness**

The incentives associated with extending risk to physicians must be perceived as fair by both PCPs and specialists. Although PCPs are generally understood to have a greater influence over total cost of care through utilization reduction and referral management, specialists are critical to controlling the unit costs of care. Providing an opportunity for specialists to earn financial incentives by controlling cost and improving quality both rewards them for those efforts and helps maintain engagement.

IU Health Physicians has recognized the importance of extending both risk and rewards to PCPs and specialists. The organization manages 100,000 patients under total cost of care contracts. Due to the amount of risk within the arrangement, the provider’s steering committee opted to alter the physician compensation model to better align goals.

PCPs are eligible for shared savings bonuses (up to 25% of the compensation) for managing total costs under the set budget. The budget also includes downstream care, which encourages PCPs to refer to low-cost, high-quality specialists. Specialists are rewarded for controlling costs via co-management arrangements, which also include small quality incentives.

**Encouraging Physicians to Focus on Cost, Quality**

**Leveraging New Data**

- Steering committee uses Medicare ACO, health plan data to drive cost, utilization management
- Physician-specific cost data shared with all providers

**Case in Brief: Indiana University Health Physicians**

- 1,100+ physician group employed by Indiana University Health, based in Indianapolis, Indiana
- Manages 100,000 full-risk patients, cared for by 70%-75% of employed PCPs

**New PCP Incentive Model**

- PCP pod managing 2,500 risk patients assigned budget for total cost of care, including downstream
- PCPs eligible for shared savings bonus of up to 25% of compensation for managing total costs under budget

**New Specialist Incentives**

- Quality-based incentives small but significant portion of salary, set to grow
- Co-management agreements tie shared savings benefits to better hospital performance
At the same time, PCPs—because they do have a greater influence over downstream costs—are usually favored in some way by the bonus distribution mechanism. For example, some ACOs interviewed for this research make a stark distinction between PCPs and specialists, create separate payout categories, and then tier payouts to each category with PCPs receiving a larger reward.

**Avoidance of individual cost goals**

But holding both PCPs and specialists accountable for total cost of care presents some difficulties. Organizations seem split as to whether they hold individual physicians accountable for cost performance—those that do generally do so only for PCPs, to whom patients can be directly attributed. The problem arises from the size of the population one physician cares for. The cohort is not big enough to properly distribute risk; one or two extremely sick outlier patients can prevent a physician from earning the reward.

Dahlia Healthcare, a large integrated delivery system in the West, is evaluating a physician compensation model that assigns a patient population—as well as a total cost of care budget—to the physicians and clinics (both employed and independent, and PCPs and specialists) in a particular region. The patients in the population are Dahlia employees and are insured through Dahlia’s insurance company.

Under the model, 12.5% of each clinic’s payment for the assigned population is tied to successfully managing patient care within the assigned budget. If the physicians hit the target, they would receive the full 12.5%. If they come in below the total cost of care target, the physicians would receive their full reimbursement, as well as one-third of the savings on total cost of care. However, if physicians exceed the budget, a third of the cost overrun will be deducted from the physicians’ income. It is estimated that the outer boundaries of the impact on physician income for the assigned population would be +/−6%.

Dahlia has also set targets for quality and service, and has linked the physicians’ compensation to performance against those targets. There are both potential financial upsides and downsides for these measures as well, which are paid independently.

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**Physician Income at Risk for Total Cost Performance**

*Illustrative Example*

<table>
<thead>
<tr>
<th>Total Cost of Care Target for Population</th>
<th>Costs Exceed Target</th>
<th>Costs Hit Target</th>
<th>Costs Less Than Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>The clinics’ 12.5% of payment tied to budget</td>
<td>Clinics receive full payment</td>
<td>Clinics receive full payment plus one-third of savings generated</td>
<td></td>
</tr>
<tr>
<td>reduced by one-third of cost overrun</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20) Pseudonym.
Internal quality metrics

Although external quality metrics may vary across contracts, using a small number of internally identified quality metrics to adjust potential physician incentives keeps the process simple and consistent. Many of these internal quality metrics are more focused on physician citizenship and patient experience than they are on measurement of actual patient outcomes, though they clearly should still align with the goals of the contract. A few examples of these metrics include patient satisfaction, Meaningful Use attestation, and participation in institutional committees.

Create opportunities to align with other members of the care continuum through incentives

Each provider must also recognize that other providers play a crucial role in managing cost and quality. Extending financial incentives to these stakeholders ensures that they are aligned with the goals of the risk contract and encourages providers to change behavior in beneficial ways.

MMC Physician-Hospital Organization includes non-owned ancillary providers in the PHO’s shared savings contract. Leaders identified partners in four key areas: home health, lab, SNF, and behavioral health, and has worked with each group of providers to identify performance metrics they will be held accountable to. These partners will share in upside risk if the entire organization earns shared savings. Although this example comes from the Medicare Shared Savings Program, it provides an example of how to extend the risk beyond the hospital and physicians to other types of providers.

Bringing Ancillary Providers to the Table Through Shared Savings

**Home Health**
- Included because of high Medicare utilization

**Lab**
- Included due to relevance for any population

**SNF**
- Included because of high Medicare utilization

**Behavioral Health**
- Included in case of expansion to Medicaid

PHO has worked with each provider to identify relevant performance metrics, focusing specifically on 33 metrics from MSSP to promote performance against value-based metrics across sites

Case in Brief: MMC Physician-Hospital Organization

- PHO with 1,100 physicians from the Community Physicians of Maine and the seven MaineHealth hospitals; based in southern and coastal Maine
- As part of participation in the Medicare Shared Savings Program, will be sharing savings with ancillary providers based on value performance measures

“In the end, it’s not even about the magnitude of the savings. It’s about the contract bringing everyone to the same table.”

Peter W. Wood
Executive Director, MMC-PHO