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The Essentials of Risk-Based Contracting

Avoiding Financial Missteps in Structuring Contracts

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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)

- Collaborate with clinical leadership to ensure alignment of cost and quality initiatives (p. 22)

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)