CHAPTER 8

Contract and Risk Management

Although virtually all healthcare organizations have experience in negotiating traditional fee-for-service contracts with commercial health plans, few organizations today have experience in negotiating value-based contracts that could potentially expose the organization to substantial financial risk. The willingness and ability to enter into such contracts depends in large part upon the success an organization has had in mastering the other value-driving capabilities (people and culture, business intelligence, and performance improvement), because risk-based contracts require that an organization be able to:

- Respond quickly and agilely to issues that might increase the organization's exposure to financial loss
- Collect, evaluate, and act upon business intelligence regarding cost or utilization trends, in as close to "real time" as possible
- Understand its opportunities for performance improvement, based on a demonstrated ability to identify, target, and reach defined performance improvement goals

As the transition to a more value-based payment and care delivery system accelerates, few healthcare organizations will be able to avoid exposure to some form of risk. But organizations will also have the option to take on different forms of risk, and not all forms of risk will be appropriate for all organizations. The degree of risk and integration required will depend on an organization's value-based future state strategy.

This chapter:

- Describes the main categories of risk healthcare organizations are likely to encounter in the transition to value-based payment
- Discusses various strategies for modeling and managing exposure to risk in value-based payment contracts
- Highlights examples of how healthcare organizations are mitigating their exposure to risk as they pursue value-based payment opportunities

RISK CATEGORIES

Main categories of risk include transition risk, performance risk, and insurance risk. The first will be to some degree unavoidable, the second will be an option many organizations will want to pursue (in varying degrees), and the third is an option that most organizations will want to approach cautiously.

Transition risk. Over the course of research for the Value Project, the dilemma of "a foot on the dock and a foot in the boat" has been mentioned frequently. Although most signs indicate that a transition to a more value-focused healthcare system is under way, that transition is likely to unfold over many years. The complexities and incentives of the existing system must be unraveled while a new system that better aligns hospitals, physicians, and other providers to render better coordinated, higher quality, lower cost care is fashioned.

Putting both feet in the "new system" boat too early can have serious financial consequences if, for example, reduced utilization from better coordinated care reduces revenue under the current payment system. But staying on the "old system" dock too long risks missing the boat altogether if other providers have developed the capabilities they need to take advantage of value-based opportunities as they arise. Transition risk refers to the potential costs inherent in either of these scenarios.

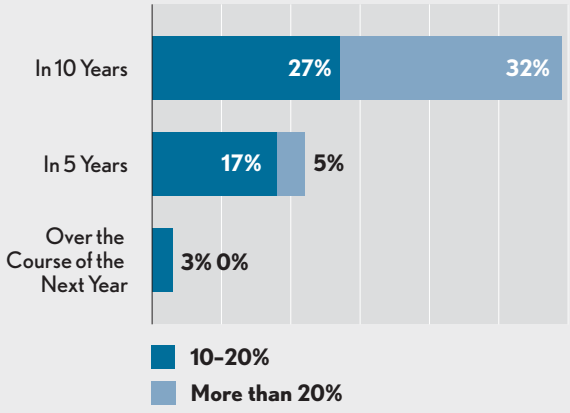
Performance risk. Performance risk encompasses a wide range of payment strategies in which a healthcare provider may face lowered payments or financial penalties for failure to meet quality targets, manage utilization or costs, achieve patient satisfaction goals, or meet other performance-related targets. Prospective payment system hospitals and health systems will be facing some level of performance risk with the Medicare value-based purchasing program, the Hospital Readmissions Reduction Program, potential penalties for failure to achieve "meaningful use" of EHRs under the HITECH Act, and failure to control hospital-acquired infections. At the same time, hospitals will be facing additional revenue pressures from the Medicare market basket productivity adjustments. Although cumulative percentages of Medicare payments at risk under these programs start at relatively low levels (2 percent in federal fiscal year [FFY] 2013), up to 12 percent of hospital Medicare payments could be at risk by 2018.

Many providers are also contemplating—or have entered into—value-based payment initiatives with both government and private payers that involve some potential for performance risk. Indeed, nearly 60 percent of respondents to an HFMA Value Project survey indicated that they believe more than 10 percent of their total payments will be exposed to performance risk within the next 10 years (see the exhibit below).

Performance risks under various types of value-based payment contracts can range from relatively minimal (failure, for example, to receive an incentive payment for meeting quality metrics under a pay-for-performance contract) to substantial (repeated failure to keep costs below the negotiated price for a bundled episode of care). Modeling and accounting for performance risk will be a critical consideration for provider organizations in negotiations for value-based payment contracts.

EXPOSURE TO RISK

How much of your payment do you predict will be exposed to performance risk (e.g., value-based reimbursement based on bundled payment, capitated payment, or shared savings with penalty contract):



Source: HFMA Value Project Survey, March 2011.

Insurance risk. Insurance risk refers to the risk that a possible—but uncertain and typically uncontrollable—event might occur. In health care, insurance risks might include the risk of being involved in an accident that causes traumatic harm or the risk of contracting a serious disease. The degree of insurance risk is a combination of several factors, including the probability of an event occurring and the likely magnitude of harm if the event does occur. From the perspective of a healthcare provider, insurance risk differs from performance risk in that, for performance risk, the patient's condition is known in advance—the element of risk centers on how well the provider performs in treating the known condition. Insurance risk would come into play if, for example, a provider organization had agreed to provide all necessary healthcare services for a defined population of patients, including patients who may at some future date be involved in an accident or contract a serious disease.

Insurance risks can be managed, but healthcare organizations should be wary about assuming risk without access to population data with enough historical depth and population breadth to allow statistically valid modeling of risk exposure.

MODELING AND MANAGING EXPOSURE TO RISK

As provider organizations face new exposure to different forms of risk, it is imperative that they work to model the extent of their exposure and put processes into place to manage their risk.

The capabilities grid below illustrates particular skills within the four capabilities of people and culture, business intelligence, performance improvement, and contract and risk management that providers will need to develop to accommodate the demands of different payment methodologies requiring varying levels of provider integration and assumption of risk.

As payment methodologies shift to the right side of the grid, the need to create integrated networks of providers (formal or informal) to coordinate care across the continuum intensifies. Providers also assume more risk as payment methodologies shift to the right. Performance risk emerges almost immediately under a pay-for-performance methodology. Population risk and the attendant need to manage utilization effectively become critical considerations under disease and chronic care management and total health management methodologies.

CAPABILITIES GRID

Lower — **Degree of Risk and Integration Required** — Higher

Organizational Capabilities	Focus Area	Fee for Service	Pay for Performance	Penalties for Adverse/ Preventable Events	Episodic Bundling	Disease/Chronic Care Management	Total Health Management
People & Culture	Cultural Emphasis	Establishing Learning Organization	Leading with Quality			Managing Long-Term Conditions	Engaging the Community
	Management and Governance	Informal Physician Leadership	Formal Acute-Care Physician Leadership		Communities of Practice		
	Operating Model	Department Structure		Episode-Focused Service Lines		Cross-Continuum Product Lines	Community Collaboratives
	Performance and Compensation	Productivity-Based		Outcomes-Based			
Business Intelligence	Financial Reporting and Costing	Procedure-Level		Activity-Level	Longitudinal	PMPM	
	Quality Reporting	Core Measures	Process Measures	Outcome Measures		Condition Measures	Population Indicators
	Business Case	Supply/Drug and Productivity		Medical/Surgical Interventions		Lifestyle Interventions	
	Decisions Support Systems	Financial Data	Acute Quality Data	Ambulatory Indicators	Claims and Prescription Info	Health Risk Assessment, Biometrics, and Predictive Modeling	
Performance Improvement	Process Engineering	Identifying Service Variability	Increasing Reliability within Clinical Value Bundles		Optimizing Care Pathways Across the Continuum		
	Evidence-Based Medicine	Increasing Patient Safety	Developing Clinical Value Bundles			Managing Conditions	Improving Wellness
	Stakeholder Engagement	Creating Transparency		Informing Patient Alternatives		Developing Accountability	
Contract and Risk Management	Contract Management	Negotiating Pricing	Balancing Cost and Quality Aims		Network Development Funds Distribution		
	Risk Modeling and Management	Profit/Loss Analysis	Estimating Exposure			Predicting Outcomes	

Low Degree Medium Degree High Degree

Managing transition risk. The pace of the transition to a more value-based payment and care delivery system varies widely among states and more local markets across the country. In Massachusetts, for example, commercial carriers and healthcare organizations are moving rapidly toward risk-based contracting and population health management strategies. Other markets have encountered few value-based payment mechanisms beyond pay-for-performance in contract negotiations. But even in markets where no "burning platform" for change exists today, forward-looking healthcare organizations are seeing a "burning horizon" and are taking advantage of a slower pace of change to prepare their organizations for what they see as an inevitable acceleration in that pace.

Healthcare organizations can manage transition risk by balancing experiments in value-based care delivery with the need to remain financially viable. For example:

- *In markets where there is unmet demand for services,* a focus on reducing per-patient utilization of an in-demand service can help develop value-driving performance improvement capabilities while opening up capacity for additional volume that offsets per-patient revenue reductions.
- *For organizations with self-funded employee health plans,* an effort to better coordinate the care of high-frequency users or to better manage the conditions of employees or their family members with chronic diseases can provide experience with value-based care delivery while producing cost savings for the organization. For example, Adventist HealthCare's patient-centered medical home pilot program resulted in a 48 percent reduction in its high-risk patient population and a 35 percent reduction in per-member-per-month costs (Lee, James G., et al., "Medical Home Leads to Healthier Patients—and Savings—for AHC," *hfm*, June 2011). For an innovative twist on this strategy, see the sidebar "Managing Transition Risk: Value-Based Charity Care at Shands Jacksonville Medical Center" on page 76.
- *For all markets,* a focus on lowering costs while maintaining the quality of services provided is critical. As noted in a report from Standard & Poor's, "an almost universal response [to transition risk] among providers is lowering costs"[27]—an imperative for all providers in a healthcare system that must find a way to bend the cost curve, no matter which direction reform takes.

Managing performance risk. As noted earlier, most healthcare providers will have to assume some level of performance risk in the coming years as programs such as Medicare's value-based purchasing and hospital readmissions reduction programs take effect. Many providers are considering taking on additional performance risk through bundled payment programs, either through the Centers for Medicare & Medicaid Services (CMS) and Center for Medicare & Medicaid Innovation (CMMI) programs or with commercial carriers or large employers.

Value-based purchasing. At a minimum, all hospitals and health systems should have modeled their potential financial exposure under the Medicare value-based purchasing program. The amounts at risk under value-based purchasing are relatively straightforward: One percent of each hospital's base operating DRG amounts were at risk in FY13, increasing to 2 percent in FY17. Hospitals will be subject to risk-adjusted comparisons with other hospitals, as well as to hospital-specific benchmarks for improvement, and there will be clear winners and losers in terms of penalties and rewards.

Through CMS, hospitals have access to simulated, hospital-specific reports that flag areas of strength and weakness in the value-based purchasing scoring domains that should help hospitals identify areas for improvement in both clinical quality of care (which accounts for 70 percent of a hospital's value-based purchasing score in FFY13) and patient satisfaction (which accounts for the remaining 30 percent). Hospitals should, of course, be actively working to improve areas of weakness.

Readmissions reduction. Managing risk under CMS's hospital readmissions reductions program is slightly more complicated, as the penalty for excess readmissions must be weighed, in the short-term, against revenue forgone as readmissions are reduced. In the first year of the program (FY13, beginning Oct. 1, 2012), CMS applied an adjustment factor capped at 1 percent of all DRG payments for hospitals with excess readmissions. The adjustment factor rises quickly, however, to 3 percent of all DRG payments by FY15 and beyond. A tool to model the financial implications of the readmissions reduction program is available at hfma.org/reform.

[27] Standard & Poor's, *U.S. Not-For-Profit Health Care Providers Hone Their Strategies To Manage Transition Risk*, May 16, 2012.

MANAGING TRANSITION RISK: VALUE-BASED CHARITY CARE AT SHANDS JACKSONVILLE MEDICAL CENTER

Shands Jacksonville Medical Center in Jacksonville, Fla., is gaining the skills needed to help manage the risk of transition to a value-based healthcare system with a focus on better coordinating the care provided to uninsured and charity care patients. Shands Jacksonville's efforts include reducing the risk of readmission following inpatient care and, more broadly, developing a patient-centered medical home to better serve the healthcare needs of indigent patients in Duval County.

Shands Jacksonville's focus on reducing readmissions for uninsured and charity care patients allows the organization to develop protocols for coordinated postdischarge care that benefit both the patients and the organization. From a financial standpoint, misaligned incentives within the current payment system mean that reducing readmissions for the general population can also reduce volumes—and revenue—for the admitting organization, unless sufficient demand exists within the market to "backfill" reduced volumes. But for the charity care population, there is no positive financial impact from either an initial admission or a readmission. The mission of virtually all hospitals and health systems includes a commitment to providing care to these patients. By ensuring that inpatient care is supported by effective postdischarge care, Shands Jacksonville can improve both the quality of outcomes for charity care patients and the financial impacts of serving the charity care population.

Shands Jacksonville is establishing a postdischarge clinic for its uninsured and charity care patients and ensuring that, upon discharge, a visit to the clinic has been scheduled for within 72 hours postdischarge. An additional follow-up visit with a primary care physician is also scheduled for within two weeks postdischarge. Postdischarge care is further supported by a telehealth component through the hospital's home health agency to help monitor the patient's recovery, vital signs, and compliance with their prescribed medication regimen.

As the Centers for Medicare & Medicaid Services and commercial carriers strengthen penalties for readmissions within the general patient population, Shands Jacksonville will be able to draw upon the protocols developed for its charity care patients to further reduce readmissions for the organization as a whole.

Shands Jacksonville's commitment to improving the effectiveness of charity care extends well beyond its focus on reducing inpatient readmissions. It is also developing a consolidated, multipurpose clinic for serving Duval County's indigent population, using a patient-centered medical home model.

The use of a single clinic for the city contract patients helps address another dilemma of the current payment system, says Michael Gleason, Shands Jacksonville's CFO: "Physicians have to change their care strategy based upon payer and payment method." The traditional fee-for-service system, for example, promotes a "more is better" approach, while new payment methods emphasizing population health management emphasize both the quality and cost-effectiveness of care. Primary care providers and specialists who staff the clinic will know that their focus should be on effective population health management.

Specialists who rotate through the clinic will not simply be seeing patients. Shands Jacksonville envisions that specialists will spend one hour in each four-hour block reviewing cases with primary care physicians, mid-level providers, and case managers, using a team approach. One purpose of these meetings is for the specialists to educate the other clinic providers on the type of patients who truly warrant specialty care. Over time, Shands Jacksonville believes this approach will help avoid unnecessary specialty referrals, while increasing the ability of mid-level providers to treat and address various medical needs directly.

The clinic site has been chosen to ensure accessibility via major bus lines. It will also be staffed to provide a range of behavioral health and other social services tailored to the needs of the county's indigent population. Shands Jacksonville is also considering inclusion of a pharmacy at the clinic site to make it a truly one-stop site for patient needs. The clinic will offer expanded evening and weekend hours to enhance patient access, particularly for those patients who cannot leave work during normal business hours, and to further reduce the need to seek services in the ED.

Shands Jacksonville believes the costs of maintaining the clinic will be offset by a reduced need for more expensive emergency and inpatient charity care services. It will also gain skills in population health management that can be transferred to other populations as payment methods change; in fact, Shands Jacksonville is already working with area employers to develop on-site workplace clinics. At the same time, charity care patients will benefit from better health management and better coordinated care.

Despite the short-term risks to revenue, hospitals should begin developing and implementing strategies to reduce readmissions before the higher penalties for excessive readmissions take effect. There are several obstacles to these efforts within the program as currently structured, which HFMA has highlighted in a comment letter to CMS.[28] For example, hospitals may not have access to timely, cross-continuum data that will allow them to accurately identify and mitigate the impact of readmission drivers. Incentives for physicians and skilled nursing facilities—both key providers of postdischarge care that can affect readmission rates—are not yet sufficiently aligned to ensure coordination of care with hospitals. And the risk adjustment mechanism used in the program fails to account for key patient socioeconomic factors—such as the presence of Supplemental Social Security Income or presence of Medicaid as a secondary payer—that can have significant predictive power to improve risk adjustment (a factor that could especially affect safety-net hospitals). Tactics outlined in the sidebar "Readmissions Reduction Strategies" at right can help hospitals work around some of these limitations.

Bundled payments. Bundled payments are typically anchored on a procedure—a knee replacement, for example, or coronary artery bypass graft—but also include payment for all inpatient services and, in some instances, postacute services related to a defined episode of care associated with the procedure. Bundled payments can also be structured around chronic diseases; in these cases, the payment might be for a yearlong "episode" of care that is renewed annually to cover chronic disease management services and the costs of treating any disease-related complications that arise during the year. Because healthcare organizations are paid under bundled payment programs for each episode of care, or for the care of patients with a known chronic condition, these programs involve performance risk only; there is no assumption of insurance risk.

Hospitals, health systems, and other provider organizations are pursuing bundled payment opportunities through CMMI's Bundled Payment for Care Improvement initiative and through contracts with commercial carriers and large employers. Organizations considering such opportunities should be aware of the following risks:

Administrative costs. Participants in CMS's Acute Care Episode (ACE) bundled payment demonstration project estimated $350,000 in annual ongoing costs associated with the participation in the demonstration. These costs included hiring of patient navigators or case managers to screen lists of patients for eligibility to participate in the ACE demonstration and dedicated patient financial services staff to resolve claims with the Medicare Administrative Contractor (MAC). Participants in the CMMI bundled payment initiative will also need to dedicate staff time for collection and reporting of quality measures. Depending on contract terms, administrative cost risks may be lower in the private sector.

READMISSIONS REDUCTION STRATEGIES

A wide range of tactics is available to hospitals seeking to reduce readmissions. Some of the most commonly cited include:

- Patient risk-screening upon admission to better understand patient needs during the hospital stay and to identify services that may be needed to support the patient postdischarge
- Review of medications and instructions with patients at discharge. To ensure patient understanding of instructions, hospitals employ both multiple reviews of instructions with the patient (e.g., first a physician, then a nurse) and repetition (the patient repeats the instructions to ensure understanding)
- Postdischarge follow-up with the patient, often a phone call from a nurse within three days of discharge to ensure the patient is taking medications regularly, etc.
- Scheduling a primary care physician visit at discharge, to take place within 72 hours of discharge—and following up to ensure the visit occurred.

For patients with more intense needs and a higher risk of readmission, some hospitals are also employing case managers who actively work with the patients and postacute providers following discharge.

[28] HFMA letter on the hospital readmissions reduction program, addressed to Marilyn Tavenner, acting administrator of CMS, Jan. 30, 2012.

Downside financial risk. For bundled payments focused on inpatient procedures, the hospital or health system will often find itself assuming full downside risk, at least initially, to engage physicians and postacute providers in the project and build a relationship of trust with them. Hospitals then need to focus on incentives to encourage other providers to identify cost-savings opportunities and work on reducing complication rates and readmissions, which reduce the amount of cost savings left for the hospital.

Lack of control over patient. HFMA has expressed to CMS its concern that Medicare beneficiaries will not be encouraged to receive their care from providers in the beneficiaries' region who have contracted for conditions bundled under models two and three of the CMMI initiative.[29] This poses obvious obstacles to bundles that require coordination of care among multiple providers.

Outlier risk. The risk of outlier cases—those involving significantly higher costs and more intensive services than contemplated for the bundle—is of particular concern to hospitals with lower volumes of a bundled procedure, and thus lower capacity to absorb outlier costs.

To help mitigate these risks, healthcare organizations have several options. For those organizations considering participation in the CMMI bundled payment initiative, the Health Care Incentives Improvement Institute (HCI3), which also runs the PROMETHEUS Payment program, has assembled a set of resources, including "freeware" analysis and reporting tools to select potential bundled episodes and determine episode price based on Medicare Parts A and B claims data (available at www.hci3.org). For organizations pursuing bundled payment opportunities in the private sector, risk-mitigation considerations when contracting for the bundle include:

- *Clear definition of the episode.* Ensure that the contract clearly defines the start and end dates for the bundled episode, which defines the period for which the provider organization is at risk. Similarly, for organizations that are considering offering a "warranty" or guarantee for the care provided in the bundle, the guarantee should have a clear end date.
- *Coverage of outlier cases.* Provider organizations may want to set a threshold (expressed, for example, as a certain percentage above the contracted price for the bundle) above which they will not be at risk for costs.
- *Incentives for patients to stay "in network."* The commercial carrier, employer, or benefits consultant with which the provider organization is contracting should consider creating strong financial incentives for patients to receive all care covered by the bundle from the provider organization and, if applicable, its contracted provider network.
- *Data sharing.* The provider organization should receive historic claims data for the population that will be covered by the bundled arrangement during the negotiation process to assess any health risks that might complicate or raise the cost of services covered by the bundle, as well as ongoing current claims data on, ideally, a monthly basis once the bundled payment agreement begins.
- *Subcontracts with other providers.* Subcontracts can offer the opportunity for risk-sharing among providers. If a hospital or health system is organizing the bundle, it may encounter initial resistance in convincing physicians to

HFMA RESOURCES ON BUNDLED PAYMENTS

HFMA has produced several reports and resources examining the issues, impacts, risks, and opportunities of bundled payment programs, including:

- *Transitioning to Value: PROMETHEUS Payment Pilot Lessons*, based on interviews with providers working to implement bundled payment pilots with the PROMETHEUS Payment program. Available at hfma.org/Prometheus.
- *Pursuing Bundled Payments: Lessons from the ACE Demonstration*, presenting lessons learned from provider organizations participating in CMS's Acute Care Episode (ACE) demonstration project for orthopedic and cardiology bundled payments. Available at hfma.org/ACEDemonstrationReport.
- *Bundled Payments: An Opportunity Worth Pursuing?*, a compendium of resources from HFMA publications exploring the potential benefits and risks of bundled payments. Available at hfma.org/BundledPaymentCompendium.

[29] HFMA comment letter re the CMMI Bundled Payment Pilot, addressed to Marilyn Tavenner, acting administrator of CMS, May 10, 2012.

assume a portion of downside risk. But if physicians or other contracted providers stand to enjoy a potentially significant "upside" for strong performance, they should also be willing to assume some portion of downside risk if costs cannot be contained within the negotiated bundled payment price.

Managing insurance risk. Responses to an HFMA Value Project survey indicate that many hospitals and health systems are planning to invest in population health management capabilities (see the exhibit at bottom right), although the number that have made a significant investment to date is low. As shared savings programs gain traction as well as—potentially—a move toward capitated or "global payment" contracts, these numbers are likely to grow. In many instances, however, healthcare organizations assuming responsibility for the care of a defined population will want to limit their exposure to insurance risk.

Payment structures typically differ between shared savings and capitated payment arrangements. Shared savings are often built on a fee-for-service chassis, with savings or losses calculated through reconciliation of actual fee-for-service costs against a budgeted cost of care for the attributed population. Capitated payments are typically made in a lump, "per-member-per month" sum for the attributed population. But insurance risk considerations for the two payment arrangements are largely the same. Absent limitations on this risk, provider organizations are on the line for both known and unforeseen costs of care within the attributed population.

Provider organizations are rightly cautious in assuming unlimited insurance risk for a population, and before they consider taking on any significant amount of insurance risk, they should consider their capabilities in terms of:

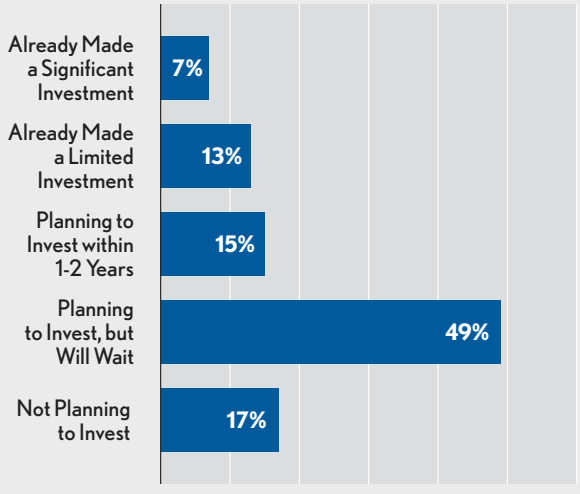
- *Integration of care delivery network.* Population management strategies rely on increased utilization of primary and preventive care services to reduce utilization of more expensive specialist services and inpatient and outpatient procedures. They also rely on coordination of care. From a hospital or health system's perspective, an integrated primary care network is essential to provide primary care, maintain a referral base when more intensive services are required, and coordinate postacute care needs to reduce complications and readmissions.
- *Process improvement.* Success under a value-based population management strategy will require an ability to maintain the quality of patient outcomes while enhancing the cost-effectiveness of care. Organizations should be comfortable with their ability to successfully plan and implement process improvements across the organization.
- *Data access and analytics.* Population management also requires access to historical as well as timely current claims data for the attributed population, combined with clinical data from patient medical records and data on costs of care across the network. Often, access to claims data will require the cooperation of a partner on the payer/purchaser side that is willing to work closely with the provider organization on identifying and fulfilling data needs (see the sidebar "Bellin Health: Finding the Right Partners to Improve Health and Reduce Cost" on page 80). The provider organization also needs the skills of data analysts and actuaries—either in-house or contracted—to mine the data for actionable information and identify cost and utilization trends.

Even with these capabilities in place, provider organizations should consider the following options to limit insurance risk in a shared savings or capitated payment system:

- *Open versus closed network.* The more control the provider organization has over managing the attributed population's

POPULATION HEALTH MANAGEMENT PLANS

What are your plans related to investing in population health management capabilities?



Source: HFMA Value Project Survey, March 2011.

BELLIN HEALTH: FINDING THE RIGHT PARTNERS TO IMPROVE HEALTH AND REDUCE COST

Bellin Health, based in Green Bay, Wis., is offering a full-spectrum of products to both self-funded and fully insured employers in its community, ranging from pay-for-performance based on traditional quality and efficiency metrics to shared savings and loss contracts. Bellin realizes it is not in a "one-size-fits-all" environment. At the farthest end of the spectrum, it will enter into shared savings agreements as a strategic partner in situations where certain requirements are met:

- A long-term contract is in place.
- A willing partner will look at and respond to the data (e.g., claims, health-risk assessment results, and workers' compensation).
- A willing partner will innovate with Bellin on plan design and health and healthcare solutions.

Bellin's willingness to enter into shared savings agreements for bending cost trends downward and achieving quality metrics is unique in its market in that it does not require employer exclusivity. "This is where innovative benefit design and employer willingness to work in partnership come into play," says Peter Knox, executive vice president at Bellin. "We recognize that not requiring exclusivity is what our customers truly want. We can capitalize on our primary care network, business intelligence, and performance improvement capabilities to be successful managing entire populations in an open network environment."

As an example, Bellin worked with one strategic partner to develop a requirement that employees must earn a "wellness certificate" to access the benefit design with the lowest employee cost sharing. The certificate requires that employees meet with a primary care physician, complete basic screenings and a health-risk assessment, and be working on a personal health improvement plan. These requirements help Bellin manage population health and reduce risk, and also help to increase access for patients.

Bellin recognizes that necessary competencies and transitions will be required as the organization moves forward with its payer strategies. In particular, shared savings plans will reach a point at which it is difficult to wring out any additional savings. Bellin believes that if it has managed the relationship with its strategic partners appropriately up to this point, it will be able to work out an arrangement that will continue to be mutually beneficial.

Knox also shares some considerations that provider organizations should be aware of if they are thinking about shared savings plans with employers.

- **Listen to the market and develop a product it wants.** In Bellin's market, for example, there was little employer appetite for exclusivity.
- **Prepare for a significant time commitment, including lots of meetings to review data, plan, and set goals for the program.** A fully engaged partner that understands this at the outset is essential.
- **Listen to the data.** One employer in Bellin's market, for example, had low per-employee spending but troubling health-risk assessment scores. There was little opportunity for savings, but Bellin was able to develop a pay-for-performance contract focused on improving employee health-risk assessment scores.
- **Design benefit packages to create the desired results.** Incentives for employees to complete screenings and health-risk assessments, for example, help manage population health and mitigate risk.
- **Understand organizational strengths, capabilities, and competencies.** Bellin cites its primary care network, business intelligence, and data-mining capabilities as prerequisites to the work it is doing on shared savings plans.
- **Prepare to step outside the traditional comfort zone.** Business models for hospitals and health systems are changing. If your organization is not able to respond to the needs of employers, another organization will.

health, the better able it is to control the quality and cost-effectiveness of the services and care provided. Closed networks can still be a difficult sell, however, given the failures of managed care in many areas of the country in the 1980s and 1990s. Bellin Health, based in Green Bay, Wis., found little appetite for closed networks among employers within its service area, and has constructed open network shared savings programs, balanced with incentives that give it an opportunity to increase market share (see the sidebar "Bellin Health: Finding the Right Partners to Improve Health and Reduce Cost" on page 80). Where greater willingness to consider closed networks exists, copays can be lowered or waived to promote in-network care or significantly increased to discourage out-of-network care.

- *Limitations on downside financial risk.* High-cost individual outlier cases, inaccurate cost or utilization projections, or unforeseen events, such as a disease outbreak, that significantly elevate costs across the population can all pose significant financial risks to the provider organization. Outlier payments similar to those discussed with respect to performance risk earlier in this chapter is an option, but it can be difficult to identify and establish threshold costs in advance for all the procedures and conditions that could affect a managed population. Strategies more appropriate to a population management situation include provider-carried reinsurance to compensate the provider organization for total costs incurred above a certain threshold, or the establishment of "risk corridors," in which the provider is responsible for losses up to a certain percentage threshold above the budgeted or capitated total cost of care for the population, and the payer assumes responsibility for losses above that threshold. Corridors can also be established on the savings side, where the provider retains savings up to a certain percentage threshold below the budgeted/capitated total cost of care and the payer receives any additional savings beyond that threshold.[30]
- *Exceptions and carve-outs.* This consideration applies particularly to provider organizations that offer a more limited range of services. The provider organization takes on accountability for services it provides or controls and receives a capitated payment for those services, but is not accountable for the costs of excluded (or "carved out") services. Provider organizations negotiating carve-outs can anticipate that the payer will in turn seek provisions protecting itself against efforts to shift high-cost patients to excluded services.

[30] For additional information on risk corridors, see Miller, Harold D., *Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care,* Center for Healthcare Quality & Payment Reform and the Commonwealth Fund, January 2011, pp. 22-24.

CONCLUSION

Risk will be an inevitable factor in the transition to a more value-based healthcare system. But organizations will have many opportunities to control and manage the risks they face—or decide to pursue. Going forward, key strategies will include the following.

Develop the capabilities needed to create value. Effective contract and risk management will require organizations to draw upon the full range of value-driving capabilities.

Experiment with payment and care delivery transformation in a risk-controlled environment. Take advantage of opportunities to gain experience with value-based reforms today to prepare for an almost certain intensification of purchaser demands for greater healthcare value.

Develop relationships of trust across the provider continuum and with the payer and purchaser community. These relationships should support the coordination of care, sharing of data, innovation of benefit design, and appropriate division of risk. Such efforts should will improve population health while maintaining the financial sustainability of the healthcare delivery system.