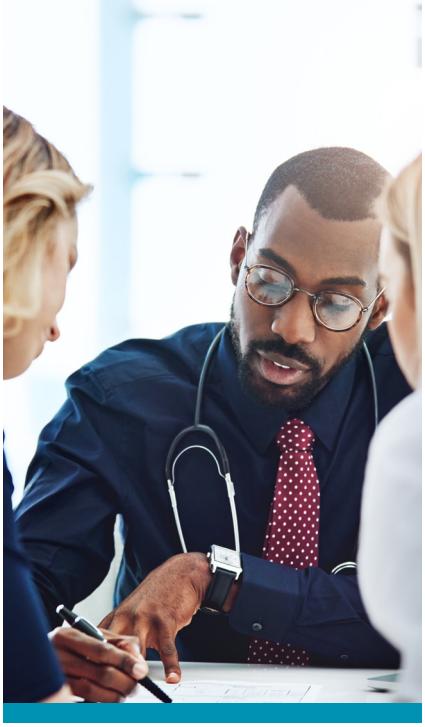


Ready, Risk, Reward:

Building Successful Two-Sided Risk Models

Curious about how evolving risk-based alternative payment models will affect your organization? This in-depth white paper probes the impact of risk-based payment models and uncovers insights around the capabilities health systems need to achieve success in today's healthcare environment.

Executive Summary

Fee-for-service pressures are pushing health systems to pursue alternative payment options for economic survival, as payment penalties and reimbursements are increasingly tied to measures of quality, satisfaction and cost performance. Continuing the movement away from fee-for-service and toward value-based, alternative payment models (APMs) creates new opportunities for healthcare providers and payers to work together on improving health for patients and better managing costs. It is essential for health systems to understand what is driving the continuum-wide cost and quality outcomes included in their risk arrangements, continuously identify and prioritize gaps in care, and build and implement the core capabilities needed to succeed in rapidly evolving APMs.

With nationwide growth in accountable care organizations (ACOs) and other APMs, such as bundled payment models, the continued development and expansion of APMs that support value-based care is inevitable. Today there are more than 900 active public and private ACOs in the U.S., covering more than 32 million people. While Medicare contracts represent about 30 percent of the covered lives in ACOs, commercial contracts represent nearly 60 percent and Medicaid covers about another 12 percent[1]. The enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), which was passed by a Republican Congress, also creates positive incentives for clinicians to move away from fee-for-service in favor of APMs. In addition, APMs are starting to see success, as Medicare ACOs have documented a savings of approximately $2 billion and reported measureable improvements in quality.

As value-based APMs succeed and progress, government and commercial payers are driving providers toward contracts that require them to take

1 David Muhlestein, Robert Saunders, and Mark McClellan, "Growth Of ACOs And Alternative Payment Models In 2017," *Health Affairs*, June 28, 2017, http://healthaffairs.org/blog/2017/06/28/growth-of-acos-and-alternative-payment-models-in-2017/

more accountability for outcomes that are increasingly tied to varying levels of financial risk. This has left the healthcare industry at a critical junction in time, as two-sided risk arrangements for providers are becoming more prevalent. Now more than ever, providers have a financial stake.

The Medicare Shared Savings Program (MSSP) requires ACOs that have participated in the program since its inception nearly six years ago to either move to a two-sided risk model or drop from the program altogether after 2018. MACRA also reinforces two-sided risk models by rewarding clinicians for participating in Advanced APMs to earn even more financial rewards in exchange for taking on risk related to patient outcomes. Additionally, a recent survey of ACOs suggests that nearly half have at least one contract that requires downside risk today and nearly half of ACOs are planning to participate in future at-risk arrangements[2].

While the Centers for Medicare & Medicaid Services (CMS) was the early leader in this area, commercial payers now make up the majority of covered lives for alternative payment arrangements and they, too, see the benefits of engaging in two-sided risk contracts with providers to drive cost and quality improvements. In fact, more than half of ACOs report bearing the same levels of financial risk in their commercial and Medicaid contracts as their accountable care contracts with Medicare[3]. In Premier discussions with the five largest commercial insurers, each payer stated that they are aggressively transitioning to value-based arrangements that include provider downside risk, which they have begun to implement in select markets. Furthermore, major employers are adopting two-sided risk models to control healthcare costs by removing intermediaries and aligning incentives to share savings between employees, providers and the company.

Many APMs require providers to assume a small level of risk, known as upside models, where a provider can share in savings with a payer but will not be responsible for losses if they do not meet their goals. The only economic risk is not recovering the investment costs to build the APM through shared savings. Two-sided risk models take APMs to the next level, engaging providers to take accountability for both upside and downside financial risk, providing stronger incentives to better manage overall costs to avoid losses, and the ability to earn greater shared savings splits with success. However, because these arrangements are attractive to physicians participating in Advanced APMs, providers that are not considering or preparing for two-sided risk models could lose market share to competitor organizations, payers and venture capitalists. These organizations are taking advantage of today's market dynamics by building their own relationships with high-value physician networks in order to pursue potentially more lucrative two-sided risk arrangements.

Effective two-sided risk arrangements offer access to powerful bonus rewards and freedom from regulations that undermine innovation, representing a smart business choice for providers to ensure continued economic viability in today's risk-based healthcare environment. The challenge for providers is determining their readiness for assuming greater levels of risk and prudently managing that risk. Some ACOs report that they will not be ready to assume two-sided risk for a number of years, and other ACOs are concerned about ever being ready to assume downside risk[4].

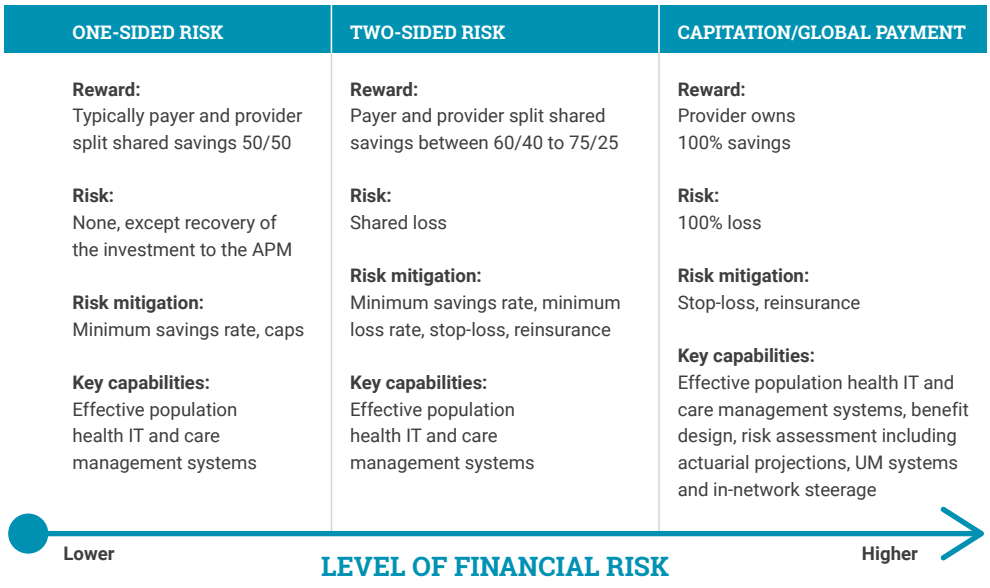
While two-sided risk arrangements are more challenging and require very specific clinical, technical and administrative capabilities across the continuum, if executed properly, they create opportunities for providers and clinicians to leverage greater financial incentives to improve care delivery practices. At the same time, payers and employers reduce expenses by paying for less unnecessary services, fewer healthcare complications and better patient outcomes. As two-sided risk arrangements continue to take hold, providers must be well-

2 Kate de Lisle, Teresa Litton, Allison Brennan, and David Muhlestein, "The 2017 ACO Survey: What Do Current Trends Tell Us About The Future Of Accountable Care?," *Health Affairs*, October 4, 2017, http://healthaffairs.org/blog/2017/10/04/the-2017-aco-survey-what-do-current-trends-tell-us-about-the-future-of-accountable-care/

3 Ibid.

4 Ibid.

FIGURE 1: RISK CONTINUUM



prepared and skilled at assessing and managing risk before diving into these contracts with public and/or private payers. Just as the reward is greater, so is the financial risk. Even though most two-sided risk arrangements can limit the downside risk, accurately assessing readiness is key to success.

Levels of Risk and Types of Alternative Payment Models

As seen in Figure 1, one-sided risk models provide the ability for providers to share any savings they achieve with a payer, relative to a spending target, without accepting downside risk. Healthcare providers that are new to value-based payment should first engage in a one-sided risk APM to build their core capabilities and learn how to manage the health of a population. For those still eligible to do so, participation in a no-downside Medicare APM is a perfect opportunity to learn how to manage care, use un-blinded claims data as an important tool for success, and acclimate physicians to risk arrangements.

After gaining experience and developing capabilities to manage populations under a one-sided APM, many organizations decide to implement "two-sided risk with guardrails." This model places limitations on an organization's downside risk. For example, an organization with a 5 percent cap on downside risk and a per capita expenditure of $10,000 per beneficiary could lose a maximum of $500 per beneficiary if they exceed the targeted spend. An example of this is MSSP Track 1+, as listed in Figure 2. Two-sided risk models start with limited risk sharing and move to greater levels of risk depending on provider readiness. With additional risk comes additional opportunities for reward. While Medicare has several two-sided risk models with a variety of risk-sharing options, on the commercial side, providers and payers negotiate specific terms. Structured appropriately, two-sided risk arrangements can limit downside risk and provide even more upside potential than is available in one-sided arrangements.

Capitation or global payment models, advanced APMs which most providers are not yet prepared for, are the end goal on the risk spectrum for providers and payers. In most cases, full capitation or global payment models put the organization at risk to meet financial and clinical thresholds for all of the services it provides.

While understanding financial risk is important, there is more to risk than just the pay back. Providers increasingly

FIGURE 2: EXAMPLES OF ALTERNATIVE PAYMENT MODELS RELATIVE TO LEVEL OF FINANCIAL RISK

PAYER	One-Sided Risk	Two-Sided Risk*	Capitation/Global Payment	Other
Medicare Fee-For-Service	**MSSP Track 1** Comprehensive ESRD Care (CEC) One-Sided Risk Oncology Care Model One-Sided Risk	**MSSP Track 1+** **MSSP Track 2** **MSSP Track 3** Next Generation ACO Model CEC 2-Sided Risk Oncology Care Model 2-Sided Risk Comprehensive Care for Joint Replacement Track 1	Next Generation ACO Model (option)*	Bundled Payments for Care Improvement CPC+ Track 1* CPC+ Track 2*
Medicare Advantage	Negotiated between MA plan and providers			Joint venture Provider Sponsored Health Plan
Commercial Health Plan	Negotiated between plan and providers			
Medicaid			Massachusetts Oregon Maryland Global Budget	Arkansas Bundled Payment

Blue: *Anticipated to have an open application period in 2018 for 2019 start.*

** Advanced APM, which allow clinicians and providers to earn even more rewards in the Quality Payment Program in exchange for taking on risk related to patient outcomes.*

taking on downside risk through more sophisticated APMs also need to factor in other levels of risk, including the impact of changes in utilization on provider volume and profitability; quality and cost performance targets; and ensuring the technical elements of a contract match the population and circumstances[5].

Market Dynamics and Opportunities for Two-Sided Risk Arrangements

Market dynamics and new payment policies in today's healthcare industry are driving providers toward two-sided risk arrangements, presenting greater savings splits, the ability to retain high-value physicians as part of MACRA, and the opportunity to achieve higher payments in markets with high utilization and cost rates. However, providers that aren't preparing to take advantage of these opportunities risk losing market share to competitor organizations, payers that are organizing narrow networks, and savvier consumers with increasing involvement in their care decisions.

For instance, CMS is pushing approximately 200 MSSP Track 1 ACO participants that have reached their six-year mark and are entering the final year of their second Track 1 agreements to move into two-sided risk or leave the program. Further, MACRA's QPP incents providers to take on two-sided risk by offering clinicians who participate in Advanced APMs the opportunity to earn lump sum bonuses of 5 percent on their Medicare payments if at least 25 percent of their Part B payments and 20 percent of all Medicare patients are from an Advanced APM in 2019, as well as avoid the downside risk of the Merit-based Incentive Payment System (MIPS). Therefore, healthcare organizations engaging in two-sided risk models, such as an Advanced APM like MSSP Track 1+, are appealing to clinicians, making talent easier to retain. Organizations that are not in Advanced APMs risk losing clinicians to competitors that are engaging in these models. This can be a particular issue in markets where competition for qualified medical talent is fierce and health systems

5 Juliet Spector, Brian Studebaker, Ethan Menges, "Provider Payment Arrangements, Provider Risk, and Their Relationship with the Cost of Health Care," *Society of Actuaries*, October 2015, https://www.soa.org/Files/Research/Projects/research-2015-10-provider-payment-report.pdf

may need to offer a range of highly-competitive salaries, relocation dollars, signing bonuses and the opportunity for a wide range of APM incentives in order to attract and retain top talent[6].

While providers must possess specific capabilities to be successful in two-sided risk models, they must also operate in markets where the macro dynamics are favorable. Providers in high-utilization, high-cost markets stand to gain the most under two-sided risk models. For example, in South Florida, annual Medicare per capita costs range between $16,000 and $17,000 per Medicare beneficiary, compared to the national average of about $9,700 per beneficiary, per year. Thus, there is more opportunity to better manage care in these markets with more bandwidth to lower costs, translating into the potential for greater shared savings payments. But as healthcare providers better manage these populations' health, per capita dollar amounts are beginning to drop significantly, primarily due to reductions in the unnecessary utilization of healthcare services. Therefore, the cost reduction targets will continue to be lowered over time, which means providers, even in these initially high-cost markets, will need to work harder to achieve their objectives.

Timing for taking advantage of these macro dynamics is essential. Many providers have lost market share to local competitors that have created risk-bearing entities in high-use, high-cost markets before they were able to do so. Venture capital-based companies are taking advantage of these market dynamics and organizing primary care physicians into independent practice associations, clinically integrated networks or ACOs, and contracting with payers to capitalize on shared savings opportunities. These companies are building ACOs without hospitals and simply view hospitals as cost centers. Health systems need to be aware of this happening in their markets and start preparing now by considering the competitive risks of a local venture capital-backed physician network entering their market. The greater number of independent physicians, the greater the risk in a market. Hospitals and health systems that aren't benefitting from these models are losing revenue without the benefit of financial offsets (i.e. shared savings arrangements with payers), if provider competitors are engaged in APMs in their market with commercial and/or government payers. This is because of the utilization reductions that will happen to rather than with these health systems by APM-engaged competitors and their payer partners.

Additionally, many payer organizations have adopted narrowed networks of health system partners based on cost and quality outcomes, forcing health systems to compete for payer contracts that require mission alignment and expect improved population health outcomes[7]. This movement is supported by the primary care attribution process that is required in most APM arrangements. In other words, as payers increasingly turn to

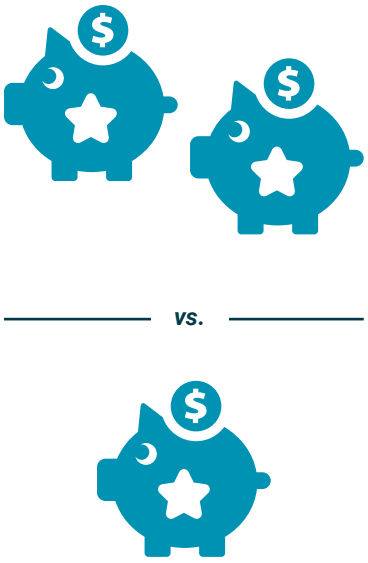
Results from performance year 2016 of the CMS Next Generation and Pioneer ACO Models show that more than half of the ACOs generated savings for Medicare, grossing nearly $140 million in savings, as well as earning a total gross share of the savings of approximately $95 million.

All Next Generation and Pioneer ACO Members of Premier's Population Health Management Collaborative Achieved Shared Savings

- ***Banner Health of Phoenix*** *(42K beneficiaries): ~$10.9 million in shared savings (3.04% of benchmark)*
- ***Baystate Health of Springfield, Massachusetts*** *(33.8K beneficiaries): ~$4.7 million in shared savings (1.6% of benchmark)*
- ***Fairview Health Services of Minneapolis*** *(12.9K beneficiaries): ~$1 million in shared savings (5.82% of benchmark)*
- ***Henry Ford Health System of Detroit*** *(20.3K beneficiaries): ~$3.9 million in shared savings (2% of benchmark)*
- ***Triad Health Network/Cone Health of Greensboro, NC*** *(27.8K beneficiaries): ~$10.7 million in shared savings (4.1% of benchmark)*

6 Rich Daly, "Physician Recruitment Competition Spreads to Urban Areas: Analysis," *HFMA*, February 25, 2016, https://www.hfma.org/Content.aspx?id=46934

7 Sandhya Somashekhar and Ariana Eunjung Cha, "Insurers Restricting Choice of Doctors and Hospitals to Keep Costs Down," *The Washington Post*, November 20, 2013, https://www.washingtonpost.com/national/health-science/insurers-restricting-choice-of-doctors-and-hospitals-to-keep-costs-down/2013/11/20/98c84e20-4bb4-11e3-ac54-aa84301ced81_story.html?utm_term=.da5251884817



Premier Population Health Management Collaborative ACOs Outperform Peers in Achieving Shared Savings and Quality Improvements by Nearly 2:1

Making up just six percent of all program participants, Premier Population Health Management Collaborative Medicare ACOs have contributed to approximately 20 percent of total Medicare savings since 2012.

two-sided risk contracts to better manage costs, they may opt to leave providers that are not prepared to meet financial challenges out of the network in order to offer lower premiums, improve quality performance, increase operating margin and achieve medical loss ratio targets.

It is imperative for providers to prepare for and address these competitive pressures by thoroughly assessing their market and entering into prudent risk arrangements now to take advantage of high per capita costs before they decline, as well as retain high-value clinicians. For two-sided risk models, the cost savings opportunities are even greater, especially for those in high-cost, high-utilization markets.

Five Capabilities Needed to Succeed in Two-Sided Risk Arrangements

In Premier's work with health systems in more than 200 markets across 40 states, we have identified critical factors for planning and implementing a successful transition to value-based payment, and increasingly taking on risk.

To create an effective two-sided risk arrangement, providers first need to assess their readiness and ability to manage risk, define success and strategically map the operational capabilities needed to achieve it. It is important that an organization engaged in APM arrangements carefully scales up the level of risk they take on. This includes making sure that before taking on two-sided risk, the health system has already established a risk-bearing entity so that participating providers have experience and the organization has implemented the foundational capabilities needed to assume greater accountability for a defined population. Foundational capabilities include having highly-engaged C-Suite and physician leadership, systematic assessment and administration of risk arrangements, measurement and reporting systems to track and drive improvement, a highly engaged network of high-value primary care providers, and a demonstrated ability to coordinate care across the continuum.

It is also important that a provider organization considering greater financial risk with a payer conducts an internal and external risk assessment to determine the potential upside and downside from a financial perspective. This is central to determining the likelihood of success in two-sided risk arrangements. It must also be recognized that more advanced capabilities will be required to expand into and succeed at effective two-sided risk APMs.

Health systems pursuing two-sided risk models in partnership with Premier are focusing on the following five key capabilities to achieve success.

1. ALIGNED STRATEGY, LEADERSHIP AND INFRASTRUCTURE

A successful two-sided risk arrangement requires aligned and effective C-Suite, administrative and physician leadership, and compensation incentives, from the governance entity that oversees the entire enterprise to the physician groups that participate. This means strategic planning to ensure that clinicians and providers are rewarded for efficient and high-quality care, but also for access. C-Suite leaders and physicians should both be at the table to discuss payment options to ensure alignment and determine an agreed-upon, shared infrastructure across risk contracts. In addition, the organization must define who oversees leadership and management of the arrangement, and who has ownership and accountability for assessing, implementing, monitoring and improving APM operations. This includes involving primary and specialty care leaders to ensure they are committed to invest in the success of the two-sided risk arrangement.

One of the most significant oversights in managing risk deals is that the providers are often not brought into the negotiations, and more often, are not told of the deal structure. This oversight can leave millions of dollars on the table. According to one study, providers who went at risk for a majority of their patients and had a thorough knowledge of their advanced risk contracting structure were able to

reduce their average cost of care in 95 percent of all patient visits. Those with no real risk obligation and no knowledge of two-sided risk generated financial losses of approximately $42,000 per physician, per year[8] - big dollars that can quickly add up to ruin in a two-sided model.

A key consideration for two-sided risk is ensuring providers are aware of the drivers for return on investment (ROI) and making sure those metrics are included in the arrangement and individual incentives. When payment options are understood and agreed to by leadership, administrative staff and clinicians, participants involved with contributing to the APM contract are more apt to make meaningful changes to their practice, including better coordination of care across the continuum, as well as implementing patient risk stratification, rising risk identification and care management capabilities that need to be scaled, integrated and coordinated across populations for two-sided risk models to be successful.

2. OPTIMIZED EXECUTION OF RISK ARRANGEMENTS

To do well in two-sided risk arrangements, the network should have a managed care department (or consultative assistance) that is well-versed in negotiating two-sided risk contracts. Keys to successful negotiations include effectively sharing accurate and timely claims data across the continuum with all stakeholders, realistic and attainable financial targets, tasking providers with meeting specific metrics that have clear definitions, and ensuring terms and conditions are standardized across the network.

Two-sided risk contracts must also consider market factors, such as whether the population at risk is large enough and if the benchmark expenditure rate is high enough based upon actuarial review. It is important for two-sided risk models to have at least 20,000 covered lives to properly spread the risk and balance out high-cost outlier cases. Provider factors, such as patient panel size are also important, as at least 30 percent of the panel should be in the risk arrangement in order to influence behavior.

Lastly, the health system must be prepared to deal with the impact of lower volume as a result of fewer emergency room visits and fewer inpatient admissions from the population covered by the at-risk contract. There are some levers that can be pushed and pulled to help ameliorate the downside, such as using data to help increase in-network utilization and therefore, improve market share; small increases in commercial rates; and reduced overhead expenses.

3. ESTABLISHMENT OF A NARROWED, HIGH-VALUE PROVIDER NETWORK

High-value, narrowed provider networks that reach beyond primary and preventive care must be developed to include all the other medical services that may be needed to provide high-quality, cost-effective outcomes. The key here is to bring hospitals, specialists, rehabilitation centers, behavioral health providers, hospice and post-acute care providers into the network, together. With the success of current APMs and future QPP requirements, these providers are already being driven toward Advanced APMs, creating an opportunity to bring more clinicians on board with aggressive care management efforts that steer patients toward their in-network services.

Heath systems taking on two-sided risk must establish provider participation criteria to evaluate performance across the continuum, determine action plans and share results with referring providers. Without dependable post-acute providers collaborating with an ACO, acting as an extension of the health system with shared goals, for example, the inconsistency and unpredictability in care can result in increased readmissions, unnecessary or misuse of care and unfavorable patient outcomes[9]. For instance, a New England Journal of Medicine study found that for patients hospitalized with congestive heart failure, Medicare paid about $2,500 in the 30 days after discharge for each patient who received home healthcare, as compared with $10,700 for those admitted to a skilled nursing facility and $15,000 for those cared for in a rehabilitation hospital[10]. With cost differentials such as these at stake, two-sided risk contracts

8 Sanjay Basu, Russell Phillips, Zirui Song, Asaf Bitton and Bruce Landon, "High Levels Of Capitation Payments Needed To Shift Primary Care Toward Proactive Team And Nonvisit Care," *Health Affairs*, September 2017, http://content.healthaffairs.org/content/36/9/1599.abstract

9 "The Post-Acute Care Guidebook," Premier Inc., December 2016, https://learn.premierinc.com/population-health/inpatient-beyond-the-post-acute-care-conundrum

demand networks of aligned providers to enable steering to the most cost-effective care setting, and also to the most effective providers within that setting.

This requires a renewed emphasis on narrowing the network by analyzing claims and clinical data to identify appropriate utilization/high-quality providers. Lower performers should be asked to move into a separate network that is not taking on downside risk, if possible. Community partners, social services and behavioral health providers should also be included to help address social determinants of health.

Organizations engaged with payers under a two-sided APM must then work with selected providers on joint care redesign efforts, such as sharing care plans and clinical notes to ensure follow-up appointments with primary care physicians, monitoring provider performance, pharmacy compliance, and sharing and analyzing performance data and referral patterns to ensure continuous improvement.

4. CLINICAL INTEGRATION ACROSS PROVIDERS AND RISK CONTRACTS

Of critical importance is the need for clinicians to have access to information about their patients and the care their patients may have accessed outside their network so that they can develop, share and keep track of each patient's care plan. In addition, it is imperative for providers to participate in the development of and abide by established care delivery models. This requires a commitment to care standardization, as well as a coordinated care management structure that integrates all populations that are at risk, thereby developing economies of scale necessary for both capital and operating costs.

An effective care management structure is enabled by a technology platform that identifies high-risk and emerging-risk populations, provides access to patient information and supports the flow of patient services across care management teams. The care management system must also manage the utilization of high-cost services across the continuum to avoid taking a loss in a two-sided risk arrangement. This is more difficult in a Medicare ACO where steerage must be limited to sharing provider performance information with patients so that patients retain provider choice. In two-sided risk arrangements with Medicare Advantage plans, providers can work with the payer to build in much stronger in-network utilization incentives for patients, such as through benefit design.

5. ROBUST INFORMATION MANAGEMENT AND ANALYTICS

Robust population health data management entails the use of strategically selected actionable, predictable and comparable health information technology capabilities to support the clinical and administrative aspects of care, with the goal of improving health outcomes. It requires resources to integrate measures across contracts to focus efforts; evaluate and benchmark the effectiveness and return on investment (ROI) of clinical interventions; establish interoperability between providers to exchange clinical data and to manage and prevent leakage; and integrate electronic health record (EHR) clinical data with payer claims information.

Two-sided risk arrangements provide opportunities to negotiate with payers to ensure the payer shares robust adjudicated claims data for the population attributed in a risk arrangement in a timely manner. Claims data is typically held by payers, but it can help at-risk providers tremendously to understand hidden areas of inefficiency, such as unfilled prescriptions or a provider with a propensity for ordering too many inappropriate imaging tests, which may not be obvious from the EHR alone[11].

Integrating claims data with clinical information also allows the at-risk health system to tap into more mature predictive analytics capabilities to risk stratify patients and intervene appropriately, as well as support workflows that can direct providers participating in risk arrangements toward standardized, appropriate, evidence-based care pathways. Additionally,

10 Robert Mechanic, "Post-Acute Care — The Next Frontier for Controlling Medicare Spending," *The New England Journal of Medicine*, February 20, 2014, http://www.nejm.org/doi/full/10.1056/NEJMp1315607#t=article

11 Joel Weissman, Michael Millenson, and R. Sterling Haring, "Patient-Centered Care: Turning the Rhetoric Into Reality," *The American Journal of Managed Care*, December 21, 2016, http://www.ajmc.com/journals/issue/2017/2017-vol23-n1/patient-centered-care-turning-the-rhetoric-into-reality

provider organizations can use this information to identify high-performing clinicians to partner with, which is vital for developing narrow networks specific for two-sided contracts, and ensuring the greatest opportunity for success under these arrangements.

Conclusion

It is key for providers to build effective core capabilities, gain experience and achieve success with a one-sided risk APM model before pursuing and engaging in a two-sided risk model with a government or commercial payer. However, providers must take a methodical approach to assessing readiness for risk to avoid jumping into a two-sided risk model too soon and ensure their organizations are well-prepared for the risks in order to attain the rewards. Additionally, clinicians and providers that do not take on two-sided risk may miss out on valuable opportunities for greater savings from current lower utilization and per capita costs; better quality and outcomes; attracting and maintaining top clinician talent; and more satisfied patients. The keys to success with two-sided risk are ensuring incentives are aligned, including compensation; that performance and processes are standardized and being optimized; market conditions are ripe; a narrow and committed network is developed; robust population health data and analytics are implemented; and effective new care delivery models are well-established.

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