Trustee
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Performance-based Contracting: Emerging Issues and Considerations

A new business model is emerging to transform the care delivery and payment systems. The transition is underway in many communities — moving health care delivery from emphasizing sick care to addressing population health management.

Managing a population's health involves proactively identifying and assessing those at risk of developing disease, pre-emptively managing those with chronic disease and implementing broad-based interventions in early stages of disease to avoid or reduce cost and improve health. This approach requires broadening the scope, environments and capabilities in which health care organizations must operate. It also involves developing the right strategies for specific population segments to maximize wellness and minimize illness.

New payment models are evolving to align with the new care models. Typically, under the terms of performance-based payment arrangements, hospitals, systems, physician groups and other providers will be responsible for delivering defined services to a specific population at a predetermined price and quality level. This development has significant strategic and financial implications.

Change is occurring at different speeds in different markets. But, due to the unsustainable costs of health care under a fee-for-service system, a value-based system is expected to evolve nationwide, replacing the current volume-based system. Ensuring success in this new environment is critically important to boards and executive leaders because change is driven organizationwide from the top. Just as boards must ensure that patients receive safe, quality care, they also will help to move the hospital toward a system of care that delivers greater value while protecting the organization's financial resources.

Understanding performance-based contracting — the mechanism fostering change from a volume- to a value-payment model — will be essential for boards and executive leadership. This Workbook highlights current contracting issues and offers eight strategies for addressing those issues. Trustees will need an understanding of them to be able to provide financial stewardship in the changing payment environment.

CONTRACTING RISK

Performance-based contracting generally requires an organization to assume some level of financial risk for providing care. Risk is incurred when providers accept a fixed dollar amount in exchange for partial or total care of an identified patient population, at a specified quality level, as defined through a contract. Risk represents the uncertainty about whether the organization will have a positive margin from this arrangement after incurring the expenses to provide care.

When an organization and a payer begin collaboration through a performance-based arrangement, both upside gains and downside risks usually are delineated to protect both parties. With such arrangements, risk is assumed through different mechanisms depending on the contract terms. For example, under bundled arrangements, providers get paid a fixed amount for providing defined services required by a patient during an entire episode of care. Global capitation payments cover all services to a defined patient grouping. Partial capitated payments cover only a specified portion of services; providers administer the contract and assume risk for defined services.

Strategy 1: Understand the Requirements for Success

Hospitals and systems will need new infrastructure and competencies to

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manage a population's health under different types of payment arrangements. Trustees need to understand and allocate resources to support requirements needed for success in the new environment, which include:

- **The physician enterprise:** Performance-based contracts will transform how hospitals and physicians work together to achieve care delivery and payment. Employed, affiliated and independent physicians should be involved in redesigning care delivery to increase efficiency. Improving outcomes, costs and service levels under performance-based contracts requires a different incentive system, as well as new management and reporting structures that integrate physicians as leaders.
- **Care coordination infrastructure and clinical pathway redesign:** Hospitals, systems, physicians and other providers must collaborate to develop new systems to track and manage the care of patients, particularly those with chronic illness.
- **Sophisticated IT and data management:** Information systems must be able to analyze and turn data into information that supports decision-making and action. For example, predictive modeling capabilities enable organizations to more accurately identify and target specific populations for health-related interventions.
- **Contract planning and management:** Planning evaluates the potential benefits and risks of specific contracts given the organization's capabilities and resources; management ensures that the targeted benefits are achieved.
- **Financial capability:** Significant investment of capital — both financial and human — is required for entering into performance-based arrangements.

Organizations that can provide care under new payment arrangements are leveraging performance-based contracts as a growth strategy to access new markets, patient populations and service offerings. Additionally, health care organizations that can demonstrate both quality outcomes and cost-effectiveness are participating in narrow networks developed by payers.

Strategy 2: Ask and Answer the Big Strategic Questions

In preparing for performance-based contracting, health care organizations and their boards must evaluate the feasibility of their desired position in the new delivery environment. They also need to determine how prepared they are to assume risk under performance-based arrangements. Vital questions include:

1. What role do we want to play in a coordinated care delivery network?
2. How strong are our relationships with payers and employers? What value can we bring to them in contracting arrangements?
3. How strong are our relationships with primary care physicians, specialists and other providers? Do we have a network of physicians working under arrangements that provide them with incentives to manage the care of a defined population effectively and efficiently?
4. Do we need to employ or own providers — for example, physician practices, home care entities and others — and/or contract or partner with them for their services?
5. Given our resources, which service areas and what size population do we believe we can manage effectively? Can we do this alone or do we need a partner?
6. Do we have the capabilities to manage and report our performance in real time?

Strategy 3: Assess the Organization's Risk Tolerance

Risk tolerance reflects the organization's capacity to assume risk without endangering its strategic, operational or financial performance. Risk types include strategic and operating, actuarial or "insurance," financial/asset and liability, and comprehensive risk. Different organizations have varying capacity and tolerance for risk. And, just because an organization can enter into specific risk arrangements doesn't mean it should; downstream effects on strategic financial performance can be significant. Key questions include:

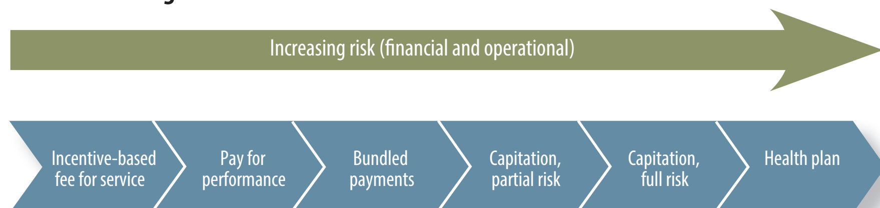
1. How much and what types of risk can our organization carry?
2. Will our organization need to access capital for investments, contractually required reserves or ongoing operations and how will this affect its tolerance for risk?
3. Is the local service area ready for risk, and are key stakeholders aligned?

The risks involved in implementing a health care organization's strategies will be high during the next decade. When, with whom and how to start managing population health and assuming risk contracts are important questions with critical implications for the total risk that hospitals and health systems can assume. Top-down management of risk, with board and executive buy-in and commitment at all levels, are required.

EMERGING PAYMENT ARRANGEMENTS

As payment transitions to a value-based system, different arrangements are emerging based on the

The Contracting Risk Continuum



Source: Kaufman, Hall & Associates Inc., 2014

level of sophistication and alignment of payers, employers, hospitals and other providers in various markets. Markets are transforming at different speeds.

Strategy 4: Gain Familiarity with Basic Contract Types

A wide range of contracting alternatives already are being used nationwide and are expected to increase as stakeholders gain experience. Trustees likely will have discussions about many of these and should be familiar with basic types, including:

- **Incentive-based fee-for-service:** Providers receive bonus payments for achieving quality and cost targets.
- **Pay-for-performance:** Providers receive bonus payments or have a portion of their pay withheld based on whether they meet preset performance targets related to quality, cost-effectiveness, efficiency of care or other factors.
- **Bundled payments** (also known as episode-of-care payments or case rates): Providers are paid a fixed amount for services required by a patient during an entire care episode. Payments are based on the estimated costs of care associated with a specific condition and determined annually or within a set time frame, such as from the time a stroke patient is admitted to the hospital to when he or she is discharged, or 30 days after hospital discharge.
- **Capitated contracts:** Providers administer the contract and assume risk for contractually defined medical, and possibly certain administrative, services. These contracts can be structured in many ways. Providers can receive a fixed amount per patient member per month that varies by age and benefit plan, or receive a contractually set percentage of premiums each month. Providers are able to keep any savings if costs are below the capitated amounts, but are responsible for any cost overruns.

Partial global capitated payments cover only a specified portion of services. Global capitated payments cover all patient services. The entity contracting with the payer must have contracts with other service providers, such as home care or skilled nursing care facilities, to cover services that are the providers' responsibility under the contract.

The Contracting Risk Continuum, Page 18, displays various contracting arrangements based on the level of risk associated with each arrangement. In today's environment, fee-for-service contracts are still the dominant form of payment arrangement for hospitals and health systems. Payment under these contracts is typically driven by the volume of services delivered and may include some shared savings opportunities and risk of loss based on performance against specific cost and quality metrics. Pay-for-performance programs are in place in most areas of the country, with incentives offered for meeting performance targets.

Health care payment is expected to move toward increased risk arrangements, likely involving capitation or percent-of-premium methodologies. An incremental transition up the risk continuum is desirable for hospitals and systems, enabling them to gain experience and build infrastructure as they assume more risk.

Payment Reform Measures

Rand Corp. recommends the following measure types for development and refinement:

- Health outcome measures that can be used to assess care for populations:
  - Health status measures (functional status and quality of life)
  - Safety outcomes (preventable harm attributable to health care)
- Care coordination measures, including measures that assess care transitions
- Measures of patient and caregiver engagement in their care
- Measures of structure, particularly management and information technology utilization measures, that address new organizational types
- Composite measures that combine outcome, process, structure, patient experience, cost and other measures
- Efficiency measures that combine quality and resource use measures

To minimize the risk that new payment models will increase disparities in care, additional measure development may be useful in two specific areas:

- Clinical and sociodemographic risk profiles of providers' patient populations
- Measures of access to care and provider avoidance of high-risk patients

Source: Schneider, E.C., Hussey, P.S., Schnyer, C.: Payment Reform: Analysis of Models and Performance Measurement Implications. Santa Monica, Calif.: The Rand Corp., 2011.

Strategy 5: Assess the Contracting Strategy

A risk-contracting strategy should be part of an organization's comprehensive business plan to provide a foundation for capital decision-making and determining the scope and feasibility of population health management. Trustees should be familiar with how the executive team is setting the organization's contracting strategy and evaluating specific contracts.

How revenue projections are calculated will vary by type of contract. Revenue also will vary by the level of risk in various contracting arrangements. For example, higher-than-expected service utilization by the covered population results in lower profits and higher losses under capitation contracts. Sophisticated financial planning and business management tools must be used to project and assess the impact of changing risk profiles on expected revenue.

Strategy 6: Understand New Payment Arrangements

Hospitals and systems will need new skills and resources to negotiate and administer performance-based contracts. Individuals who negotiate contracts need solid financial and

analytic skills to determine what contracts and terms are right for their organizations. Individuals with leadership, analytic and performance-management expertise will be required to manage and administer performance-based contracts.

BOARD OVERSIGHT

Boards and executive teams should be focused now on what it takes to ensure their organizations' success under a value-based payment and care delivery system. Financial and quality oversight has never been more important.

Strategy 7: Determine the Pace and Cost of Change

The transition to managing population health under performance-based payment arrangements will not occur overnight, and timing is uncertain. In the near term, hospitals and health systems will manage under the old and new systems concurrently. Boards and executive teams should be evaluating what it will take to move their organizations toward the new system. Important considerations include how fast the organization wants to move, how fast it can move and how much the transition might cost.

Minimizing risk while moving toward performance-based payment depends on the readiness of the organization and its market. For example, if the market evolves quickly, the organization may not have in place the appropriate talent or infrastructure to deliver on new contract terms. If the market evolves slowly, the organization may find itself ready to accept risk before payers are ready to offer risk-based arrangements.

Sophisticated, market-based scenario planning and analyses will be required to manage the risk of entering into performance-based contracts. The results of these analyses will enable leadership to identify the right population, contracting model, contract terms and payers at the right time for the organization. On the other hand, the impact of poor projections can be significant. For example, if use of services within a shared savings model declines more than projected due to effective population health management, capitated rates in the future likely will be set at a level at which it will be difficult to achieve further savings.

Strategy 8: Ensure the Use of Key Performance Metrics

As the organization makes the transition from volume to value, boards and executive teams must monitor contracting and population health management metrics to ensure the organization is meeting targets. However, the answer to the question, "What metrics are most relevant?" is not necessarily simple or straightforward. A 2012 survey of hospital chief financial officers conducted by the Healthcare Financial Management Association indicated a high degree of variation in quality and value indicators used by commercial insurers.

A 2011 report from Rand Corp. indicates that key performance-based reform measures include those outlined in the sidebar on Page 19.

Trustees should be able to understand whether their organizations are successful; however, the measurement quandary often precludes a clear answer.

Focusing on a finite set of metrics that improve performance related to Triple Aim objectives (better health, better care and lower costs) is a place to start. Contracts typically have targets for access to care and overall population health to address the goal of better health, and measures of effective treatment practices and making care safe to address better care. Increased efficiencies typically are determined by measuring spending per beneficiary and cost per episode of care. Boards also should be monitoring patient engagement, access and service metrics and the success of interventions to improve organizational performance.

As payment models evolve, health care organizations likely will develop specific measurement programs based on their patients' demographics. Success will be determined by reviewing target achievement against contract requirements and by the financial impact of the contracts over the near (one to three years) and longer term.

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ONGOING EDUCATION

This is a remarkable period for the governance and management of hospitals and systems. Challenges and opportunities abound. The key issues related to performance-based contracting — contracting risk, emerging payment mechanisms and the oversight required by boards — are complex. Boards will need ongoing education as contracting arrangements mature. Beyond attending conferences and regularly reviewing relevant publications, board members can benefit from specific education on performance-based contracting during meetings and retreats.

Excellence in financial oversight is vital to organizational success. Proactive boards and management teams, well-versed in what it will take to succeed, can sustain the financial and competitive performance of their organizations into the value-based era. **T**

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