Accelerating Value with Two-Sided Risk

A Toolbook for Healthcare Boards and Executives

THE GOVERNANCE INSTITUTE

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A Governance Institute Strategy Toolbook Fall 2018

Discussion Guide

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Discussion Guide: Accelerating Value with Two-Sided Risk

Two-sided risk arrangements represent a timely topic for most hospital and health system boards and CEOs. Growth in such arrangements continues and likely will for the foreseeable future. While the majority of ACOs to date are in one-sided risk/shared savings programs, CMS has proposed a new rule that will require ACOs to enter into a two-sided risk contract after only two years in the program.[1] Over time, The Governance Institute expects that upside-only arrangements will be replaced with those that include some form of downside risk, as evidence shows that such arrangements provide more opportunity to attain meaningful cost control. While there may be a learning-curve period where costs increase, providers will learn to manage two-sided risk and thus help to bend the cost curve over time. Organizations will be better-positioned to succeed in two-sided risk contracts by taking several steps now to prepare.

This discussion guide serves as an at-a-glance reference to accompany the *Strategy Toolbook: Accelerating Value with Two-Sided Risk*. Please refer to the toolbook for in-depth background and foundational information to better understand the action items listed in this guide.

Step 1: Begin Preparing Now

Not every health system or hospital should immediately launch into two-sided risk arrangements, either through Medicare ACOs or other payer contracts. The decision on whether and when to embark on such arrangements depends on factors that vary by both market and organization, including the "maturity" of the local market in terms of the penetration of risk arrangements versus traditional fee-for-service (FFS), and the organization's internal capabilities, resources, and overall readiness to manage risk.

Two key activities should take place during this phase:

Understand the revenue implications of downside risk (but be willing to accept modest initial losses).

To Dos:

1. Develop financial planning/revenue cycle models, including estimations of upside or downside from the contracts themselves and any lost FFS revenues that will accompany reductions in inpatient and ED use. (Who: CFO, other members of the finance team)
2. Create estimates based on the above of losses on initial two-sided risk contracts in the first several years as capabilities are developing, and integrate into budget. (Who: CFO)

Educate and get buy-in from key stakeholders.

To Dos:

1. Educate the full board on ACOs and related downside risk issues (one way is to create an *ad hoc* board committee or team of board members to do the research and present to the full board).
2. Provide education to physicians about how ACOs and other risk-based contracts are structured, including an understanding of the organization's specific risk contracts and the need to manage population health. (Who: CEO and physician leaders.)
3. Develop a collaborative process to facilitate a deep understanding across stakeholders of the key differences in value-based care delivery/two-sided risk and decide together what quality-improving/cost-reducing changes to the care delivery model need to be implemented. (Who: the board, CEO, other senior management such as CFO, CMO, CNO, and CQO, and other physician leaders.)

Step 2: Invest in the (Substantial) Infrastructure Required to Manage Enrollee Health

Without question, success in managing ACOs and other two-sided risk contracts requires significant investment in a variety of infrastructure necessary to effectively manage the health of enrollees. Critical pieces of infrastructure include:

- Robust, multidisciplinary approach to contracting and contract management
- A large, integrated primary care network, with financial incentives for physicians to improve performance
- Effective network of high-value, post-acute care providers
- Robust care coordination and care management across care settings
- Evidence-based protocols and guidelines, along with physician profiling on adherence to them
- Cross-platform data warehouse and analytics to support performance measurement and feedback

Robust, multidisciplinary approach to contracting and contract management

To Dos:

The board should task senior management with establishing a multidisciplinary contract team of individuals from

1 Virgil Dickson, "CMS plans to 'retire' some ACOs," *Modern Healthcare,* August 9, 2018; Seema Verma, "Pathways to Success: A New Start for Medicare's Accountable Care Organizations," *Health Affairs* Blog, August 9, 2018.

information technology (IT), finance, and clinical departments to do the following:

1. Review each proposed contract, including the specific cost and quality metrics that will be used to evaluate performance.
2. Avoid having too many metrics across the various contracts; work with payers to encourage consolidation around a limited number of measures.
3. Understand how the metrics are defined, the sources of data for each metric, and how that data will be used.
4. Put systems in place to capture the information without manual input, using standardized codes so that there is little or no variation.
5. Educate providers and others on the requirements related to coding, making sure they understand them, feel comfortable with how to code accurately, and understand how to influence performance on cost and quality metrics tied to payments.
6. Assign an accurate risk profile to patients newly attributed to an ACO or risk contract.
7. Work with payers and other stakeholders to be sure that the health system has access to paid claims data (including from outside laboratories, pharmacies, and other entities) and can calculate its performance in the same manner used by its payer partners.

A large, integrated primary care network, with financial incentives for physicians to improve performance

To Dos:

1. Build large, geographically diverse PCP networks. (Who: management and physician leaders)
2. Make sure that affiliated PCPs have the capabilities and financial incentives to perform well on contract performance measures. (Who: management and physician leaders)
3. Put in place specific provider financial incentives that tie to performance metrics in two-sided risk contracts. (Who: management and physician leaders, with board input)

Effective network of high-value, post-acute care providers

To Dos:

1. Develop a framework and screening criteria to evaluate potential post-acute partners based on their ability to provide high-quality and low-cost services. (Who: management, with board input)
2. This framework should include partners' ability to communicate and share information.

Cross-platform data warehouse and analytics to support performance measurement and feedback

To Dos:

1. Build a data warehouse that brings together claims from primary care practices and specialists, outside pharmacies, laboratories, and other entities that provide services to enrolled patients. (Who: IT staff under leadership of the CIO, with input from QI staff)
2. Use the warehouse to provide regular one-page dashboards on physician performance relative to their peers on contract measures, including adherence to guidelines, protocols, and pathways. (Who: QI staff under CMO/CQO leadership.)
3. Use this information to identify and reduce variation across physicians by sharing best practices across the organization. (Who: CMO/CQO, other physician leaders.)

Step 3: Set Up Appropriate Governance Structures and Relationships

Along with infrastructure, hospitals and health systems need to put in place governance structures and relationships to help manage and monitor two-sided risk contracts. In most cases, this step will involve partnering with other key stakeholders—especially physicians¾to set up an ACO or ACO-like contracting organization. These separate organizations must have their own governing boards, and hospitals and health system boards must establish explicit reporting and communication relationships with them. Key lessons related to this process are:

Create opportunities for physicians to be front and center in governance.

To Dos:

1. Structure the ACO/CIN board (if applicable) to encourage physician engagement and buy-in (and within the guidelines as outlined by CMS for Medicare ACOs). (Who: ACO owners.)
2. Determine which board positions, if any, should be held by the health system and why. (Who: ACO owners.)
3. Determine how and when the ACO/CIN board will report to/communicate with the health system board. (Who: ACO owners.)
4. If you are working with value-based contracts that don't involve an ACO-type structure with a separate board, determine the type of leadership structure needed to succeed and assign clear roles and reporting responsibilities. (Who: health system board, with CEO input.)

Review and discuss performance reports at every board meeting.

To Dos:

1. The ACO or other contracting organization should send monthly reports and report in person at least twice a year to the hospital/health system board about its performance relative to goals and expectations.
2. Monitor whether the ACO's performance and practices remain consistent with health system mission and values. (Who: hospital/health system board)
3. Make discussions about ACO and other two-sided risk contract agreements a standing agenda item for every board meeting. (Who: hospital/health system board chair)

Charge subcommittees with ongoing monitoring.

Risk contracts need to be monitored on a monthly basis by the ACO/contracting organization board or a subcommittee of that board, so that performance targets remain on track to being met. Quarterly monitoring (or anything less frequently than monthly) does not allow enough time to get back on track.

Reports should provide a snapshot of how the downside risk contracts are performing, with information on key trends and progress versus established goals related to enrollee volume (e.g., number of individuals attributed to the organization, number of primary care doctors involved) and quality and cost metrics that affect payments. Each short report should highlight specific, critical issues, such as whether the contracts are on budget, whether they are on track to receive upside risk (or likely to suffer a financial penalty), and whether they are making a difference in terms of high-level, triple-aim measures.

Step 4: Consider a Quick Scale-Up

Consider a quick scale-up once the move to downside risk contracting begins. Organizations involved in downside risk on a small scale (e.g., with just one or two small contracts) run a significant risk of incurring meaningful financial losses. Those that scale up reduce that risk for a variety of reasons:

Accelerating movement down the experience curve
Reducing the element of chance in payout calculations
Leveraging economies of scale on fixed-cost infrastructure

	BASIC Track's Glide Path				ENHANCED Track Years 1-5 (two-sided)
	Years 1 and 2 (upside only model)	**Year 3 (two-sided)**	**Year 4 (two-sided)**	**Year 5 (two-sided)**	
Shared Savings (once minimum savings rate met or exceeded)	1st dollar savings at a rate up to 25% based on quality performance; not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 30% based on quality performance; not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 40% based on quality performance; not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance; not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 75% based on quality performance; not to exceed 20% of updated benchmark
Shared Losses (once minimum loss rate met or exceeded)	N/A	1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program, capped at a percentage of updated benchmark that is 1 percentage point higher than the expenditure-based nominal amount standard	1st dollar losses at a rate of 1 minus final sharing rate, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark

Source: Proposed Rule: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success, August 2018.