# Accelerating Value with Two-Sided Risk

## A Toolbook for Healthcare Boards and Executives

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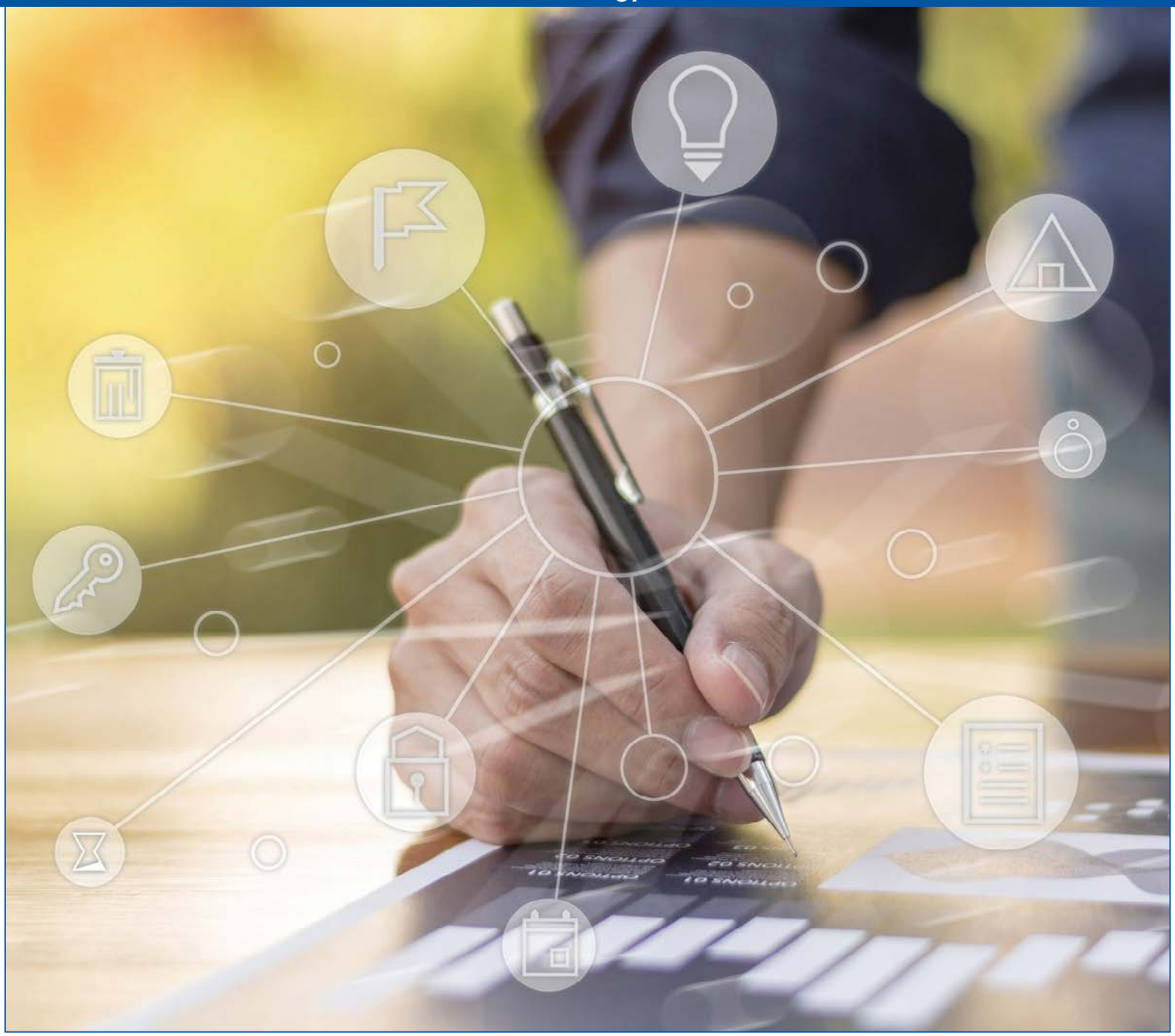
**A Governance Institute Strategy Toolbook** **Fall 2018**

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# Table of Contents


**1 Introduction**
1 How to Use this Toolbook

**3 Step 1: Begin Preparing Now**
3 Understand Revenue Implications (But Be Willing to Accept Modest Initial Losses)
4 Educate Key Stakeholders (and Make Sure They Are on Board)

**5 Step 2: Invest in the (Substantial) Infrastructure Required to Manage Enrollee Health**
5 Robust, Multidisciplinary Approach to Contracting and Contract Management
7 Large, Integrated Primary Care Network, with Appropriate Financial Incentives
7 Effective Network of High-Value, Post-Acute Partners
8 Robust Care Coordination and Management Across Settings
8 Cross-Platform Data Warehouse and Analytics to Support Performance Measurement and Feedback

**11 Step 3: Set Up Appropriate Governance Structures and Relationships**
11 Lesson 1: Create Opportunities for Physicians to be Front and Center in Governance
12 Lesson 2: Review and Discuss Performance Reports at Every Board Meeting
13 Lesson 3: Charge Subcommittees with Ongoing Monitoring

**15 Step 4: Consider a Quick Scale-Up**
15 Reason 1: Accelerating Movement Down the Experience Curve
15 Reason 2: Reducing the Element of Chance in Payout Calculations
15 Reason 3: Leveraging Economies of Scale on Fixed-Cost Infrastructure

# Introduction

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. In fact, the number of Medicare ACOs has grown 15-fold over the past half-dozen years, from 61 in 2011 to 923 in 2017. (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]) Collectively, these ACOs cover 32 million lives, including 10 million Medicare beneficiaries (roughly a third of the program's fee-for-service enrollees).[2] In addition to ACOs, many other kinds of risk arrangements continue to proliferate, particularly with commercial insurers.

Many organizations, at least initially, have elected to participate exclusively in upside-only arrangements that provide a share in any savings generated, but no penalty if costs and quality performance do not meet targets. For example, over 550 ACOs participate in the Medicare Shared Savings Program (MSSP), which provides this type of one-sided risk arrangement.[3] Of the 561 MSSP ACOs, 18 percent (101) participate in a two-sided risk model.[4]

But one-sided, upside-only arrangements may not be around forever. The goal of any payer—public or private—is ultimately to curb their own costs and to improve quality for their customers. Upside-only arrangements may result in reduced savings or slower progress towards goals, particularly with respect to costs. MedPAC (the Medicare Payment Advisory Commission) believes that increased risk will provide greater focus and potentially more savings. In its most recent report to Congress, MedPAC stated that ACOs have saved Medicare 1–2 percent more than indicated by their performance relative to benchmarks and that two-sided models appear to save more than one-sided models. Further, ACOs can be "the low-cost option in some areas of the country, and their advantage of lower administrative costs could keep them as a long-term option, if benchmarks are set equitably."[5] An August 2018 report from CMS found that Next Generation (two-sided risk) ACOs reduced Medicare spending by 1.7 percent in their first year, or about $100 million.[6]

However, there is some concern in the industry that CMS's push towards two-sided risk sooner will result in fewer ACOs participating in their program, and that the savings from one-sided or "traditional" ACOs should not be discounted. As such, the number of risk arrangements may not grow at the rate they have historically. CMS is working to combat this possibility by providing more flexibility to those organizations willing to take on more risk.[7]

Over time, The Governance Institute expects that upside-only arrangements will be replaced with those that include some form of downside risk. Already today, roughly 15 to 20 percent of value-based payment arrangements include downside risk, although most include a mechanism to cap potential losses. This figure continues to increase steadily in many parts of the country,[8] and likely will continue to do so as payers increasingly realize that meaningful cost control is more attainable with two-sided risk. 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.

## How to Use this Toolbook

This Governance Institute Strategy Toolbook is intended to help boards and senior executives of member health systems and hospitals prepare for and successfully manage second-generation ACOs and other "two-sided" risk contracts (i.e., those that give the organization both an upside and downside financial risk, generally through bonuses or penalties tied to how the organization performs against established cost and quality benchmarks). To that end, it provides a "checklist" of needed steps and capabilities, supported by background information to enable better understanding of why organizations need to be taking such steps and building capabilities. It also includes, where applicable, case examples of what leading organizations are doing.

Each section in this toolbook contains a list of "to dos" along with who is responsible for each task. Download the accompanying discussion guide to use as a quick at-a-glance reference, and refer to this in-depth toolbook for background and foundational information to help exercise due care when making strategic decisions about entering into two-sided risk.

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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.

2 Lynn Barr, Anna Loengard, LeeAnn Hastings, and Tim Gronniger, "Payment Reform in Transition—Scaling ACOs for Success," *Health Affairs* Blog, May 11, 2018.

3 *Ibid.*

4 CMS, Medicare Shared Savings Program Fact Sheet, January 2018 (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SSP-2018-Fast-Facts.pdf).

5 MedPAC, "Chapter 8: Medicare Accountable Care Organization Models: Recent Performance and Long-Term Issues," *Report to the Congress: Medicare and the Health Care Delivery System,* June 2018. (http://www.medpac.gov/docs/default-source/reports/jun18_ch8_medpacreport_sec.pdf?sfvrsn=0).

6 Steven Porter, "Next Gen ACO Model Saves $62M in First Year," *Health Leaders Media,* August 27, 2018.

7 *Ibid.*; Robert Mechanic and Clifton Gaus, "Medicare Shared Savings Program Produces Substantial Savings; New Policies Should Promote ACO Growth," *Health Affairs* Blog, September 11, 2018.

8 Joe Damore, Seth Edwards, and Guy Masters, *Accountable Care Organizations: Past, Present, and Future* (white paper), The Governance Institute, Spring 2018.

# 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. Moving too early could result in significant financial losses. For example, an organization in a heavily FFS market that successfully manages utilization and costs under risk contracts may find that FFS revenue declines significantly outweigh upside gains on the contracts. Conversely, an organization without risk management experience operating in a more mature market could quickly experience substantial losses on the contracts themselves. The leaders of every organization will need to evaluate the external and internal environment and make the decision on when and how to begin embracing downside risk in earnest.

> "In some markets, entering into two-sided risk arrangements is critical for survival. In other markets, it's still a slower pathway. What is the supply and demand of providers in your marketplace? If there is a shortage, such as in many rural communities, there is less of a pressing need to hurry into risk. Areas with provider surpluses drive a cost-reduction competition strategy."
>
> *—Brian J. Silverstein, M.D.*

Over the long term, however, The Governance Institute believes that effectively managing two-sided risk will be critical to survival. Those organizations that do not do so will find themselves losing contracts to others that do, and/or they will face huge financial losses on at-risk contracts they are not prepared to manage. Given this reality, organizations today should be embracing Medicare and other payers' "upside-only" arrangements, using this experience and time to prepare for taking on downside risk. Indeed, the primary "risk" involved in taking on two-sided contracts is not being able to perform to expectations. Organizations need to be prepared to deliver on their risk contracts.

Two key activities should take place during this phase and described in detail below:

1. Understand the revenue implications of downside risk.
2. Educate and get buy-in from key stakeholders.

## Understand Revenue Implications (But Be Willing to Accept Modest Initial Losses)

Downside risk contracts tend to perform well financially only when there are reductions in utilization on the hospital side of the equation. Consequently, before embracing downside risk on a meaningful scale, senior leaders need to understand what these declines could mean for the organization. To that end, the CFO and other members of the finance team need to acquire or develop good financial planning and revenue cycle modeling capabilities, including the ability to estimate both the potential upside or downside from the contracts themselves and any lost FFS revenues that will accompany reductions in inpatient (both admissions and readmissions) and emergency department (ED) use.[9,10,11]

At the same time, senior leaders must recognize that there will never be an ideal time to "flip the switch" with respect to downside risk contracting. Some loss in FFS revenues is likely inevitable. In addition, no organization can be fully prepared to manage utilization and per-capita costs without some experience in doing so, as evidenced by the fact that ACOs tend to improve their ability to control costs as they gain experience with risk contracting. As a result, leaders should be willing to accept several years of modest losses on these initial contracts, as well as develop strategies to target non-health system related cost-reduction opportunities. In many cases, the largest area of decline will be hospital admissions, but there is also a lot of opportunity to reduce costs in post-acute care, durable medical equipment, drugs, and other cost areas that are not FFS revenue. So rather than "flipping a switch," consider the process to be a gradual build-up of competencies, more like a "dimmer function."

**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)**

9 Interview with Guy Masters, Principal, Strategic Advisory Services, Premier, Inc., conducted on May 7, 2018.
10 Interview with Seth Edwards, Principal, Population Health Management Collaborative, Premier, Inc., conducted on May 30, 2018.
11 Interview with Debra Ryan, Vice President, Strategy Practice, Kaufman Hall, conducted on May 16, 2018.

## Educate Key Stakeholders (and Make Sure They Are on Board)

Once the decision has been made to embrace downside risk, the board and senior leaders must quickly educate other key stakeholders on the rationale for that decision. In fact, without their buy-in, it makes little sense to move forward with the plan.[12,13,14] Stakeholders such as the CNO, CMO, CFO, and physician leaders should be involved early in the process, with the goal of communicating a clear message to them on the need to learn to manage downside risk. In addition, the board and senior leaders should create committees and workgroups to define key stakeholder roles and responsibilities related to the transition.[15] For example, Genesys Health's board created an *ad hoc* team of board members to educate the full board on ACOs and related downside risk issues. Armed with this information, the board approached another key stakeholder—the system's physician-hospital organization (PHO)—to make sure that affiliated primary care physicians (PCPs) and specialists were "on the same page" with respect to the need to manage population health by keeping people healthy and reducing utilization.[16] Genesys also sent out a letter describing the downside risk model to all key stakeholders. After reading the letter, specialists held multiple meetings over a several-week period with PHO leaders and the hospital board to discuss the need for a collaborative process and to educate themselves on how ACOs are structured.[17]

It is important during this process to draw a distinction between the roles of the board, management team, and physicians, and when each group should be brought into the decision making. The board sets the direction and management implements that direction, so it becomes a matter of determining how these initiatives get cascaded in such a fashion throughout the organization. The board needs to decide what the organization's position is regarding this (with input from management and physician leaders). Then, management develops a plan demonstrating how the organization will stay consistent with this position, and then management will engage physicians to ensure the organization has the right clinical partnerships to deliver on a given contract.

**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.)**

12 Interview with Guy Masters, May 7, 2018.
13 Interview with Seth Edwards, May 30, 2018.
14 Interview with Debra Ryan, May 16, 2018.
15 Paul Tuten, "Building an ERM Framework for Value-Focused Health Care," *hfm,* Healthcare Financial Management Association, April 1, 2018.
16 Elaine Zablocki, *Genesys Health System Tackles Pioneer ACO Challenge (Part Two)* (case study), The Governance Institute, December 2013.
17 *Ibid.*

# 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:[18,19,20,21]

- 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

Each of these pieces are explained in further detail below. The most successful organizations have a substantial portion of this infrastructure in place before embarking on two-sided risk contracts. For example, Genesys Health already had a primary care-driven PHO, specialist co-management companies, and an integrated continuum of care in place before its leaders began considering becoming involved in an ACO with some level of downside risk. In addition, specialists already knew how to work together on quality improvement (QI) issues, including with PCPs on ways to improve processes outside the hospital.[22] Similarly, prior to launching a Medicaid ACO, Memorial/Broward Health had a primary care service model in place for several decades. In fact, the South Broward Hospital District began focusing on managing the health of uninsured and low-income populations in the early 1990s.[23]

## Incremental Approach to Investment for Those Starting from Scratch

Not surprisingly, the infrastructure required to succeed with two-sided risk contracts is not cheap. While some organizations may already have much of it in place, others may not and hence may be dissuaded by the need for a large upfront investment that can take years to pay off. In these situations, an alternative strategy may be to take a more incremental approach to infrastructure investment, with an eye toward generating some quick savings that can be used for future investment. For example, Hackensack Health System in New Jersey (now Hackensack Meridian Health) loaned its ACO the money to build infrastructure needed to manage the health of enrollees. However, Hackensack did not initially focus on costly new technologies, but instead invested incrementally, beginning with low-tech interventions that could generate quick cost savings and payback to the health system and physicians. The first year-goal focused on "quick-hits" that could reduce ED visits, while the second-year goal focused on reducing 30-day readmissions. By the end of the first year, the ACO generated enough savings to distribute a significant amount of money to its primary care doctors and to begin paying back the start-up loan.[24]

## Robust, Multidisciplinary Approach to Contracting and Contract Management

Hospitals and health systems that succeed with ACOs and other downside risk contracts have a systematic approach to the administration of that risk. Many of them put in place a multidisciplinary contract team—that is, unlike the traditional approach where contracting resides in a separate department, these organizations bring together a team of individuals from information technology (IT), finance, and clinical departments. (Some organizations hire an individual with a financial background to "own" the issue and head the multidisciplinary team.) The team reviews each proposed contract, including the specific cost and quality metrics that will be used to evaluate performance. To the extent possible, the team seeks to avoid having too many metrics across the various contracts, but rather works with payers to encourage consolidation around a limited number of measures. Without such an approach, health systems can end up tying their financial fortunes to 200 or more different metrics, way too many for any organization to pay attention to at once. Payers

18 Damore, Edward, and Masters, Spring 2018.
19 Joseph J. Fifer, "Taking on the Risk of Accountable Care: Five Questions to Assess Organizational Readiness," *BoardRoom Press,* The Governance Institute, February 2013.
20 Interview with Seth Edwards, May 30, 2018.
21 Interview with Debra Ryan, May 16, 2018.
22 Zablocki, December 2013.
23 Damore, Edward, and Masters, Spring 2018.
24 *Ibid.*

have begun to recognize this problem and generally show a willingness to work with providers to create more narrow sets of standardized measures.[25,26,27]

> "In too many health systems and hospitals, contracts are signed, put in a drawer, and worried about later when contract results are surprising or disappointing."
>
> —*Debra Ryan*

The contracting team also must understand how the metrics are defined, the sources of data for each metric, and how that data will be used. The team ensures that the health system has the systems in place to capture the information without manual input. Wherever possible, data should be driven off standardized codes so that there is little or no variation.[28,29,30] Once contracts have been signed, the team educates 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.[31] One issue of particular concern is assigning an accurate risk profile to patients newly attributed to an ACO or risk contract. Often rules prohibit the initial risk profile assignment from being changed, meaning that providers are penalized when an enrollee ends up being more ill than initially thought.[32,33,34]

Finally, the contract team must 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. Too often providers use billing data rather than claims data, which generally leads to different calculations and unwelcome "surprises" when payers send performance reports to providers.[35]

The failure to have a strong contracting and contract management function in place can lead to disagreements with payers about performance measurement and payouts. In March 2018, for example, seven of 58 risk-bearing Medicare ACOs left the program, primarily due to concerns or disagreements about the accuracy of performance measurement.[36] The lynchpin is the benchmark—the line at which cost expectations are set in advance in the risk contract, based on historic data. MedPAC believes that current benchmarks are not necessarily the best measure of what spending would have been in the absence of the ACO and thus may not be a good measure of true or total program savings. In some models, benchmarks are being rebased using a blend of regional and historic spending, but there remain concerns about current benchmark methodology for CMS ACOs, which CMS is working to address.[37]

Benchmark adjusters have a significant impact on the contract. Insurers will propose the benchmark and it is up to the provider to agree upon it. Questions providers should take into consideration include:

- Are we using a regional benchmark, actual patient data, a state database, data from our market or a larger region?
- How are we defining the benchmark?
- For adjusters, what are we expecting to happen without this contract from a cost/growth standpoint, depending on our position in the market?
- Are we using last year's number, or the last two years, and then how does it roll forward?

In most risk-based contracts, it is very difficult to perform in a single year; usually progress is seen within three to five years. But insurers generally work on a single-year contract. There is movement among payers towards longer contracts for two-sided risk; providers will be better off working with the insurer to develop a longer contract that will have improved results for both sides.

Another tactic is to seek out payers that will be "strategically aligned" with the organization with common goals. For example, Jefferson Health, Main Line Health, and other providers in the Delaware Valley Accountable Care Association recently put out a request for a proposal for a strategically aligned payer that will share data and risk. It got seven responses, according to Jefferson CEO Dr. Stephen Klasko.

*Source:* Alex Kacik, "Disrupters Dominate Modern Healthcare's 100 Most Influential People in Healthcare," *Modern Healthcare,* August 18, 2018.

25 Interview with Guy Masters, May 7, 2018.
26 Interview with Seth Edwards, May 30, 2018.
27 Interview with Debra Ryan, May 16, 2018.
28 Interview with Guy Masters, May 7, 2018.
29 Interview with Seth Edwards, May 30, 2018.
30 Interview with Debra Ryan, May 16, 2018.
31 Interview with Seth Edwards, May 30, 2018.
32 Interview with Guy Masters, May 7, 2018.
33 Interview with Seth Edwards, May 30, 2018.
34 Interview with Debra Ryan, May 16, 2018.
35 *Ibid.*
36 Barr, Loengard, Hastings, and Gronniger, May 11, 2018.
37 MedPAC, June 2018.

**To Dos:**
**The board should task senior management with establishing a multidisciplinary contract team of individuals from 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.**

## Large, Integrated Primary Care Network, with Appropriate Financial Incentives

A robust primary care network is likely the single-biggest factor that drives the success of an ACO or other risk-based contracts. PCPs are critical both for attracting enrollees (since consumers get assigned to an organization based on PCP choice) and for managing their care once enrolled.[38] To attract enrollees to ACOs and other two-sided risk contracts, health systems need to build large, geographically diverse PCP networks. That said, organizations are wise not to accept any PCP who may be interested. Rather, they must make sure that affiliated PCPs have the capabilities and financial incentives to provide high-quality, low-cost care (and hence perform well on contract performance measures). Some health systems put in place specific requirements to become part of their ACO networks. For example, Hackensack Health System mandated that every primary care practice participating in its ACO (known as HackensackAlliance) become certified as a patient-centered medical home (PCMH) within one year. The ACO provided consultants to assist with this transformation.[39] The most successful health systems also recognize that the biggest obstacle to diffusion of innovative care delivery models is a lack of aligned financial incentives and fragmented payment systems across providers.[40] To address this issue, they put in place specific financial incentives that tie to performance metrics included in two-sided risk contracts. For example, at Genesys Health, physicians and the health system negotiate anywhere from eight to 12 indicators on which to focus, including those related to patient safety, quality, and patient satisfaction. Physicians receive at-risk income each quarter based on performance on these indicators.[41] Similarly, physicians in the Broward Health and Memorial Healthcare System Medicaid ACO have the at-risk portion of their income tied to their performance on 37 quality measures, including adherence to evidence-based care protocols and guidelines.[42]

**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 Partners

Depending on the type of downside risk contract being signed, health systems could find themselves dependent on the quality and cost of services delivered by post-acute care providers. These organizations are critical to keeping patients from experiencing expensive post-acute care episodes that could land them back in the hospital or ED. As a result, health systems involved in ACOs and other two-sided risk contracts should create partnerships that aid in managing populations effectively. To do that, they need a framework and good screening criteria to evaluate potential partners' ability to help achieve their goals by providing high-quality, cost-effective services.[43]

38 Interview with Guy Masters, May 7, 2018.
39 Damore, Edwards, and Masters, Spring 2018.
40 K. Davis, C. Buttorff, and B. Leff, et al., "Innovative Care Models for High-Cost Medicare Beneficiaries: Delivery System and Payment Reform to Accelerate Adoption," *American Journal of Managed Care*, June 5, 2015.
41 Zablocki, December 2013.
42 Damore, Edwards, and Masters, Spring 2018.
43 Interview with Seth Edwards, May 30, 2018.

Effective partners must be able to communicate and share information and provide appropriate interventions that reduce costs and improve quality.[44] In particular, health systems need closer relationships with post-acute care providers that offer skilled nursing, home health, rehabilitation, behavioral health, pharmacy, and hospice services.[45]

**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.**

## Robust Care Coordination and Management Across Settings

Organizations that are successful in managing two-sided risk contracts invest heavily in care coordination and care management, with a focus on case management for high-risk enrollees who use care frequently.[46] This infrastructure may include chronic disease managers, care coordinators, health educators, social workers, pharmacists, nutritionists, and others.[47] Organizations must have the ability to share care plans across the continuum of care so that everyone is aware of the patient's goals and needs.[48]

In some cases, contract partners such as employers and health plans may be willing to share in the costs of this piece of infrastructure, but even if they are not, health systems would be wise to put robust systems and resources in place. Typically, the focus is on providing services to the top 5 percent of costliest enrollees, along with support services to those who are at risk of joining the 5 percent without additional attention. Some models choose instead to focus resources on the highest-cost diagnoses or procedures rather than patients.[49,50] Regardless of approach, the largest savings generally comes from better management of high-risk patients in their homes and nursing homes to avoid ED use and hospitalization.[51]

Examples of organizations that have invested heavily in care coordination and management include the following:

- The Broward/Memorial Medicaid ACO places dedicated care managers in every primary care practice with over 400 members. The care manager uses IT-based tools to identify high-risk patients through evaluation of disease/case mix, pharmacy use, physician and ED visits, and hospitalizations. For those identified, care managers work to close gaps in care, develop an annual care roadmap, and conduct home visits to anyone with three or more ED visits in a calendar year and those who have not seen their primary care doctor in 18 months.[52]
- HackensackAlliance ACO pays for nurses to be trained and certified in care coordination and then embeds a care coordinator within each PCMH in its network. Care coordinators see patients in person and follow up by phone. In the ACO's first year, patients were given the ability to reach their care coordinator's cell phone after hours, a tactic that led to reductions in unnecessary ED visits. In year two, the focus expanded to reducing 30-day readmissions through investments in medication reconciliation and promoting PCP follow-up appointments within 72 hours of discharge. Patients now leave the hospital with an appointment in hand and with a 30-day supply of all needed medications. They are advised to stop taking what they had at home until the physician can verify medications and dosages at the follow-up visit.[53] In addition, after realizing that post-acute costs represented a third of total ACO costs, HackensackAlliance developed a checklist of discharged patients at high-risk of needing post-acute care and then mandated that an ACO physician monitor all patients who go to sub-acute or post-acute care after discharge. Care coordinators visit post-acute facilities and work with this physician to minimize lengths of stay.[54]

## Cross-Platform Data Warehouse and Analytics to Support Performance Measurement and Feedback

In an ideal world, every stakeholder will be on the same data platform and able to share information seamlessly. Realistically, however, that will not generally be the case. Consequently, participating entities will need a data warehouse that can amass critical data from various platforms, along with analytic capabilities that can turn that data into useful information.[55,56] The data warehouse brings together claims data not only from primary care practices and specialists, but also from outside

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44 D. Muhlestein, K. de Lisle, and T. Merrill, "Assessing Provider Partnerships for Accountable Care Organizations," *American Journal of Managed Care,* March 2018.
45 Patrick M. Allen and Mark E. Grube, "Three Leadership Imperatives for Success with Value-Based Care," *BoardRoom Press,* The Governance Institute, August 2016.
46 Tuten, April 1, 2018.
47 Ellis Knight, "Clinical Integration: What Hospital Board Members Need to Know," *E-Briefings,* The Governance Institute, March 2017.
48 Interview with Seth Edwards, May 30, 2018.
49 Interview with Debra Ryan, May 16, 2018
50 Interview with Seth Edwards, May 30, 2018.
51 K. Davis, C. Buttorff, B. Leff, et al., June 5, 2015.
52 Damore, Edwards, and Masters, Spring 2018.
53 *Ibid.*
54 *Ibid.*
55 Interview with Guy Masters, May 7, 2018.
56 Interview with Seth Edwards, May 30, 2018.

pharmacies, laboratories, and other entities that provide services to enrolled patients.[57] Examples of organizations that have built such a system include the following:

- Genesys Health developed a "data integrator" that allows access to the complete health record regardless of site, along with a tool that captures patient-specific data in an extensive database to identify groups of at-risk patients with special needs. Genesys is also working with others to develop a community-wide public health information exchange so that information such as advance directives can be shared across health systems.[58]
- Broward Health and Memorial Healthcare System invested $5 million each over five years to build the infrastructure and IT to support its 45,000-member Medicaid ACO, including a data warehouse that provides a full picture of every ACO members' health status, disease profile, and risk factors.[59]

As noted, having a warehouse that captures lots of data is of limited value without analytic capabilities that turn that data into useful information. Organizations involved in two-sided risk need timely information related to performance on the specific metrics included in the contracts. For example, many health systems involved in two-sided risk contracts need to monitor patient safety indicators such as medication errors, infections, bed sores, post-operative blood clots, and hospital-acquired conditions.[60] They also need to monitor a bevy of other performance measures that are embedded in contracts, many of which relate to the provision of evidence-based care as defined in protocols, guidelines, and pathways. (As noted earlier, providers should work with payers to limit the number of measures included in such contracts.) Analytic and tracking tools are available and should be part of hospital and health system infrastructure.

For example, to stimulate improvement, successful organizations will provide timely "profiling" information to physicians on their performance relative to peers on these measures, including adherence to the guidelines, protocols, and pathways. Many physicians respond to such information by improving their performance.[61,62,63] These reports should be designed as one-page "dashboards" that clearly show where the physician stands versus peers and established protocols. Physicians should also be able to use the reports to easily identify which patients have care gaps that need to be addressed.[64] At the macro level, hospitals and health systems should use the same kind of information to identify and reduce variation across physicians by sharing best practices and lessons learned across the organization.[65] Ideally, the protocols should extend beyond the hospital's walls and link with the care management infrastructure.

**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.)**

57 Interview with Debra Ryan, May 16, 2018.
58 Zablocki, December 2013.
59 Damore, Edwards, and Masters, Spring 2018.
60 Tuten, April 1, 2018.
61 Interview with Guy Masters, May 7, 2018.
62 Interview with Seth Edwards, May 30, 2018.
63 Interview with Debra Ryan, May 16, 2018.
64 *Ibid.*
65 Danielle Sreenivasan and Peggy Crabtree, "From Legacy to Relevance: Leveraging Service Lines to Effectively Compete in the Value-Based Care Environment," *E-Briefings,* The Governance Institute, September 2017.

# 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 physicians—to 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 described below.

### Lesson 1: Create Opportunities for Physicians to be Front and Center in Governance

When it comes to Medicare ACOs, CMS has specific requirements related to the composition of the governing body, including that three-quarters of the governing board be representatives of the entities participating in the ACO. These requirements help to ensure participant buy-in and collaboration on potentially contentious issues such as distribution of shared savings and development and use of care pathways and protocols.[66] Hospitals and health systems would be wise to follow this guidance when it comes to governance structures for any two-sided risk contracting organization, including clinically integrated networks (CINs) or other entities. The reason is fairly straightforward—engaged, motivated physicians and strong physician leaders are critical to success with downside risk. Physicians have the most direct control over quality and costs, and hence the financial success of the enterprise. Consequently, experts recommend that they hold the majority on the board and any of its subcommittees.[67]

Physicians who sit on the health system board are excellent candidates to serve on the ACO board, to provide clinical expertise, serve as a bi-lateral communication vehicle between the ACO and the health system, and help the health system expand ACO care transformations to other areas of the system.

> "Make sure physicians are leading the committees and that they are highly involved and engaged. As they develop more skills and competencies at the governance level, let them loose in a smart way so that, rather than a fight over board seats, it becomes an evolution of developing physician leaders towards having roles in governance over time."
>
> *—Brian J. Silverstein, M.D.*

Second, the boards of ACOs and similar organizations need to focus on very specific "in-the-weeds" issues, particularly related to revamping care delivery systems to manage costs and quality. In particular, the ACO board will spend a lot of time on operational issues such as IT, clinical pathways and protocols, management of post-acute care, and others. Health system and hospital board members and CEOs probably are not the right people for this job. Instead, their job is to make sure that the right people are in these positions. For example, Genesys Health's CEO brought together people with the right expertise and knowledge in specific areas and let them take the lead in governing the ACO. These individuals conducted research into best practices being used by others and came up with their own ideas for how best to redesign the care delivery system. For example, ACO workgroups led by physicians developed new care pathways and best practices. Not only did this approach lead to better quality, lower-cost care, but it also generated greater buy-in by all key stakeholders.[68]

The bottom line is that hospital and health system leaders should think carefully about whether they or other organizational representatives (apart from physicians) should be a part of the ACO governing board.[69] Often the answer will be no, although in some circumstances it may make sense for one or two senior clinical, financial, and/or operational leaders from the health system (e.g., CEO, CFO, or CMO) to be part of the ACO board and/or its subcommittees (e.g., quality, finance, network development), perhaps as an *ex officio* (non-voting) member.[70,71,72]

Regardless of the exact composition of the ACO/CIN governing board, the goal should be to structure the board to

66 Interview with Seth Edwards, May 30, 2018.
67 Knight, March 2017.
68 Zablocki, December 2013.
69 Damore, Edwards, and Masters, Spring 2018.
70 Interview with Guy Masters, May 7, 2018.
71 Interview with Seth Edwards, May 30, 2018.
72 Interview with Debra Ryan, May 16, 2018.

encourage engagement and buy-in. To that end, Baycare Health Partners ACO (which focuses exclusively on commercial contracts) decided to set up its board with nearly even representation across its three key stakeholders—primary care physicians (seven members), specialists (nine members), and the sponsoring health system, Baystate Health (seven members, including a community advocate independent of the system). To foster buy-in and consensus, the three parties decided to require a supermajority quorum on all key votes, thus giving any of the three key stakeholder groups veto power.[73]

**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.)**

## Lesson 2: Review and Discuss Performance Reports at Every Board Meeting

While health systems and hospitals should not expect to have significant representation on the boards of affiliated ACOs and other risk-contracting organizations, they should expect to receive regular updates on how these contracts are performing. Hence, they need to pay close attention to reporting relationships and the degree of control exercised with respect to these organizations.[74] An ACO or other contracting organization should send monthly reports to the health system board about its performance relative to initial goals and expectations; then, a representative from the ACO should report in person at least twice a year to the system board. In addition to reviewing performance against targets, the health system board should monitor whether the organization's performance and practices remain consistent with health system mission and values.[75] For some organizations, in-person reports may come more frequently. For example, the CEO of the Broward/Memorial ACO reports on financial and quality performance on a quarterly basis to the system boards and CEOs of both sponsoring organizations.[76]

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.[77,78]

While in-depth discussion might naturally occur only at board meetings when a new report has been provided, discussions about ACOs and other two-sided risk contract agreements should be a standing agenda item for every health system/hospital board meeting. The item can always be taken off the agenda if there is nothing pertinent to discuss. Whenever issues do arise, however, a qualified representative from the ACO or contracting organization should be present to discuss them.[79,80]

It should be emphasized here that risk contracts need to be monitored on a monthly basis by the ACO/contracting organization board or a subcommittee of that board. While the health system board may not choose to look at reports as frequently, it needs to ensure/assign responsibility to the proper committee for ongoing, regular monitoring of performance targets so they remain on track to being met. Quarterly monitoring does not allow enough time to get back on track, so the ACO/contracting organization board has a more rigorous role to play in frequent monitoring of performance (described below). The health system board needs to remain aware of how the ACO is performing and immediately informed of any problems or issues.

**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)**

73 Damore, Edwards, and Masters, Spring 2018.
74 *Ibid.*
75 *Ibid.*
76 *Ibid.*
77 Interview with Guy Masters, May 7, 2018.
78 Interview with Debra Ryan, May 16, 2018.
79 Interview with Guy Masters, May 7, 2018.
80 Interview with Debra Ryan, May 16, 2018.

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### Lesson 3: Charge Subcommittees with Ongoing Monitoring

In addition to reviewing and discussing regular performance reports, hospitals and health systems engaged in downside risk contracting should charge various board subcommittees with more in-depth ongoing monitoring of the contracts. For example, the Genesys board and senior leaders worked together to develop a detailed list of each board committee's responsibilities in monitoring the ACO, including setting specific objectives with associated timelines and delineating how progress toward those objectives will be measured. For example, the audit committee takes responsibility for budget review and internal controls of data transfer; the finance committee reviews service agreements, financial targets, and the adequacy of the provider network; and the quality committee monitors quality-related targets. For its part, the full board reviews continuing engagement and satisfaction of key stakeholders, including physician and network partners.[81]

### Not Everything Can Be Shared

As noted, the governing body of an ACO or other risk-contracting organization will likely be made up of representatives from other organizations—i.e., those sponsoring the venture. In some cases, these sponsors may collaborate on the ACO/risk contract at the same time they compete in other areas. Even though members of the ACO/risk-contracting governing body may well have "dual" allegiances, they must recognize that their fiduciary responsibility lies with the ACO/risk-contracting organization. From a practical perspective, this means that not all information can be shared with the sponsoring organizations.[82]

81 Zablocki, December 2013.
82 Damore, Edwards, and Masters, Spring 2018.

# 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, as outlined below.

### Reason 1: Accelerating Movement Down the Experience Curve

As noted earlier, organizations new to downside risk contracting tend to perform less well than those that have been engaging in it for several years or more. It stands to reason, therefore, that an organization can gain valuable experience by increasing the scope of its involvement in downside risk contracting by embarking on more and/or larger contracts.

### Reason 2: Reducing the Element of Chance in Payout Calculations

Scaling up the number of lives has the very valuable benefit of reducing the role of chance from the calculations that determine payouts or losses from the contracts. When downside risk contracts are small, there is a reasonable probability that calculations of cost and quality performance versus established benchmarks will be the result of statistical variation rather than true underlying performance. When more lives are involved, this diminishes significantly. For example, an ACO with 5,000 lives has a 10-percent chance of earning "random" winnings, compared to just a 1-percent chance for a 50,000-life ACO. Conversely, a 10,000-life Medicare ACO that achieves 4 percent savings (well above the 3-percent target needed to receive a payout) still faces a 25-percent chance that statistical variation will reduce that measured savings rate and hence take away the payout. Even at 30,000 lives, a significant risk remains. Today, however, 73 percent of ACOs in the MSSP program have fewer than 20,000 lives; even when these ACOs perform well they face a significant risk of not receiving a payout due to statistical variation.[83] Given that an ACO's success hinges on thin margins (with one study showing average savings of just 0.7 percent), it is highly likely that some small ACOs will fall outside the minimum loss rate of 2 percent simply due to statistical variation and hence be forced to write a check to CMS simply due to bad luck. Conversely, others will receive bonuses because of good luck.[84]

### Reason 3: Leveraging Economies of Scale on Fixed-Cost Infrastructure

As described earlier, successful management of downside risk requires substantial investment in various types of infrastructure, including IT, contract management, care management, and partnership/network-building activities. Many of the costs related to these investments are at least partially fixed in nature, meaning that unit costs will decline as enrollment in two-sided risk contracts grows. ■

### Consider Expansion to All Patient Populations

The benefits of a quick scale-up give rise to the question of the degree to which hospitals and health systems should consider expanding the care models used with ACO/risk enrollees to all patients, even those covered by FFS contracts. Assuming that these care models are producing lower costs and higher quality, using them on all patients would seemingly be the "right" thing to do. At the same time, under today's perverse payment systems, doing so could lead to financial distress. For example, use of intensive care management on high-risk FFS patients could save lives while also significantly cutting revenues due to reductions in ED visits and inpatient utilization.

The Governance Institute believes that organizations should do everything possible to expand cost-lowering, quality-enhancing care models to all patients as quickly as practical. To that end, health system and ACO boards should work together to expand quality and cost improvements across other parts of the health system.[85] While certainly the short-term focus should be on targeting those covered by risk contracts, the long-term goal should be to move toward a single standard of high-quality, low-cost care for all. To guard against the financial downside on FFS patients, boards should consider setting aggressive targets for the proportion of overall business covered by value-based payment contracts over the next five to 10 years, including the proportion that entails downside risk.[86] The faster the transition to a time when risk-based contracting is the dominant model, the less time that hospitals and health systems face the issue of conflicting and perverse financial incentives.

Some organizations have already adopted this aggressive mindset. For example, the HackensackAlliance ACO set an aggressive goal of increasing the number of physicians in its CIN from roughly 3,000 to 5,000 over a period of several years.[87] In addition, the goal at Hackensack from the outset was to translate its ACO successes into standards of practice throughout the organization. To that end, the hospital began having PharmDs perform medication reconciliation on every discharged patient, regardless of insurance status. This decision came after Hackensack's ACO had significant success using a similar approach with hospitalized ACO enrollees that features a mandatory PCP visit within 72 hours of discharge (as described earlier).[88]

83 Barr, Loengard, Hastings, and Gronniger, May 11, 2018.
84 *Ibid.*
85 Damore, Edwards, and Masters, Spring 2018.
86 *Ibid.*
87 *Ibid.*
88 *Ibid.*