

Issue Brief

Risk-Sharing Arrangements Across a Continuum

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The key to successful development of a chronic care network is the integration of care, finance, information, and management—this integration is also critical to the development of an integrated delivery system.

“Form follows financing” is a phrase often heard in this kind of discussion. If we pay for service, we get more of it; if we pay for comprehensive care, we hope to get comprehensive care. One of the first questions that arises when beginning to develop a chronic care network is, how will members of the network share risk? In this *Issue Brief on Risk-Sharing Arrangements Across a Continuum*, we present ideas regarding the goals and issues affecting risk sharing to stimulate discussion of an organization’s philosophical approach to risk sharing. We also offer six models of risk sharing to illustrate how these issues are affected by different financial risk-sharing approaches. So far no single answer for risk sharing has emerged, but these examples and discussions will help your organization find the best approach for your network given the capabilities of your provider network and the reimbursement trends in your community.

Goals of Risk Sharing

The following goals set the stage for provider networks facing the challenge of how a diverse set of providers will share risk in a manner that reinforces the success of a chronic care network. Risk sharing should:

1. Support integration of care

Individual providers are likely to deny that payment methods influence clinical practice. However, the fee-for-service payment system and the rules that go with it create incentives that result in unnecessary and fragmented services. Fee-for-service rules also prevent payment for lower-cost substitute services that could replace higher-cost “approved” services. On the other hand, integration of reimbursement and care encourages care providers to modify services, shift resources to other levels of care, and otherwise coordinate care delivery for greater efficiency.

2. Create a provider-based delivery system with provider-held risk

The quality of care and accountability for it have long been the responsibility of healthcare providers. But when financial risk is held by an insurance company, health maintenance organization, or government agency, it means that an external entity has the final decision on the provision of care. Shifting financial risk to the provider network makes the same people accountable for both the care and the costs of care. This creates incentives to find ways to change the delivery of care for the best clinical outcomes and the greatest efficiencies. It stimulates creative and collective thinking within the network in ways that cannot happen when the control of care and of finances rests with an external payer.

3. Reinforce common mission and vision for the provider network

Sharing financial risk brings together the members of a provider network around the common goal of financial success, which reinforces the shared commitment to the service values usually identified in the mission of a provider network. This shared financial goal provides the incentive for diverse providers to find ways to work together for greater coordination, efficiency, and market strength. Financial success not only minimizes the risk of each provider but also brings new revenue when savings are achieved. Including all (or most) of the provider organizations and programs in the delivery network fosters a commitment to coordinate across a continuum of care.

4. Align Economic Incentives

The toughest challenge, once financial risk is accepted, is how to align economic incentives between providers. Most providers in an evolving integrated delivery system will jump on this train quickly and easily. But when the details are put on the table the concept of risk sharing takes on a whole new complexity. Getting beyond the theoretical discussion to work out the details of how providers will get paid, who is at risk, how risk is shared, and who benefits from success brings to the surface the individual agendas and financial goals of each provider. Success in a capitated system often means changing existing practice patterns, for example, substituting lower-cost facilities and services for high-cost facilities and services when similar care and outcomes can result. This generally means more services are provided in outpatient settings, at home, and in skilled nursing facilities. Financial incentives have to be established to support this change.

5. Maximize Clinical Outcomes by Maintaining Flexibility of Resources

The dual goal of protecting the financial future of the various providers in the network and integrating care delivery for the best outcomes for clients is a balance important to success. While the fastest way to achieve clinical practice change is through capitation, it is not necessarily the best way to maximize clinical outcomes. Clinical outcomes can be positively or negatively affected by subcapitation because there is an incentive to shift care to other providers and thereby maximize financial return. As the provider network struggles with the financial implications of risk sharing—as difficult as these discussions are—it is important to consider the implications for clinical care caused by incentives created by various approaches to risk sharing. Short-term financial gains (e.g., in one year) must be balanced against long-term (e.g., within three to four years) effects on clients' health status. Maintaining flexibility of resources will not only support better clinical integration but also will result in better clinical outcomes over the long term.

Risk-Sharing Terms

Usual, Customary, and Reasonable (UCR)

Charges for services based on a fee schedule. For example, pays up to amount of 90 percent of physician bill for procedure.

Discounted fee-for-service (FFS)

Lowers UCR, e.g., 80 or 75 percent of UCR.

Relative Value Scale (RVS)

Converts services into units rather than dollars using a conversion index.

Balance billing

Allows billing of difference between reimbursed amount and charge, shifting costs to patients.

Bundling and unbundling

Allows maximizing of reimbursement, e.g., upcoding to a similar, more intensive procedure.

Carve-in or carve-out

The separation of special groups of services or patients for financial and payment purposes. A carve-in focuses on the special group, and a carve-out excludes the group.

Salary payments

Annual professional wages. Providers on salary do not benefit from unbundling, upcoding or balance billing and have no incentive to change clinical practice for financial gain. (Some salary plus incentive plans attempt to incent practice pattern changes.)

Capitation

Prepays providers on a per-person, per-month payment for all defined services needed by a group of assigned people. The transfer of risk to providers creates control of resources as well as responsibility to control utilization.

Withhold reserves

Used as an incentive to control cost and utilization. For example, a withhold reserve might range between 5 and 15 percent of a rate schedule. The provider receives the withhold if budgets are met.

Risk reserve

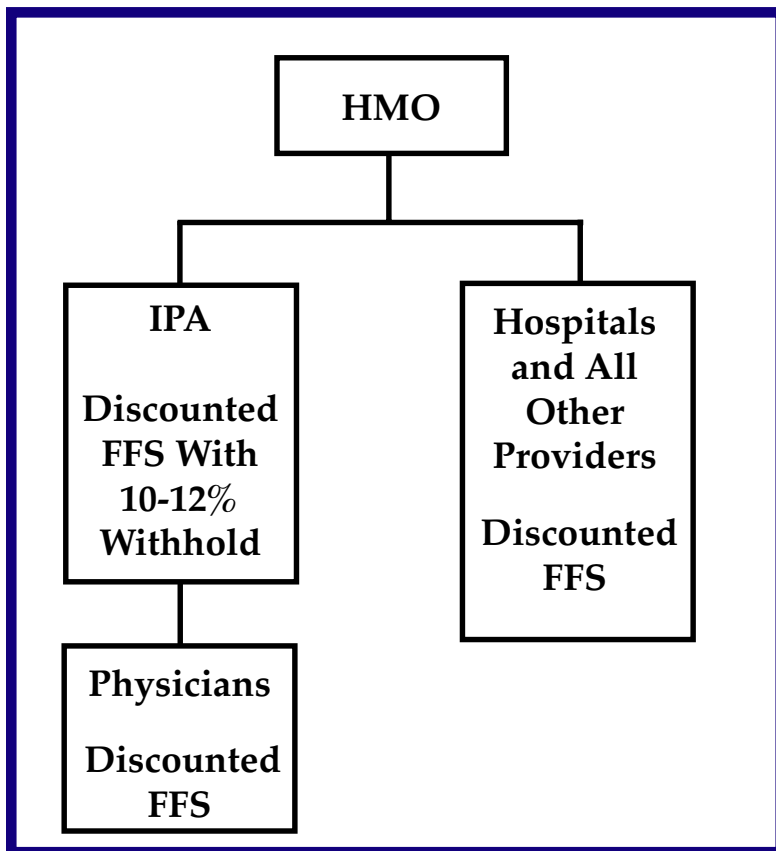
An account set aside to cover unexpected losses for individual catastrophic cases or aggregate loss. Risk reserve accounts range between 5 and 10 percent of total revenue.

Models of Risk Sharing

For purposes of illustration, we are presenting six models of risk sharing. These models highlight alternatives available under Medicare risk plans where health plans receive a per-person, per-month capitated payment from the Health Care Financing Administration for each Medicare enrollee in the plan. This rate, specific to the county of residence, is adjusted for age, sex, nursing home residence, and Medicaid status.

Model A: No Entities Directly Receive Capitation

The HMO in this scenario pays providers on discounted fee-for-service. The usual means of controlling costs will be strong utilization management at the HMO. Withholds may be used to add incentive for changing care delivery and controlling costs. Savings or losses beyond the withhold amounts are totally within the HMO.



Example: Risk Plan, No Providers Capitated

Incentives/Obstacles

The operational incentive of this model is “cheaper is better.” Both the provider and the HMO are working to lower costs of care but the relationship between the two is generally adversarial. The strong utilization management of the HMO, usually following published standards of practice, results in micromanagement of medical practice. Providers need to ask for permission through precertification and authorization policies before providing service. The accountability for change is external to the provider network.

This model allows the HMO to present a broader network to the consumer and, therefore, generally, offers more consumer choice in terms of primary care physician choice.

Model B: All Entities/Services Are Cost Centers

Two good examples of this model are staff model HMOs and the Program of All Inclusive Care for the Elderly (PACE). In this model the provider (or network) receives a single pooling of capitation for all services. Individual facilities are considered cost centers and operate according to budgets. Individual providers and professional staff are usually salaried and experience no personal gain or loss dependent upon performance. The care delivery network is closed with most of the costs within the system and few services provided outside the network. Strong central management and collaboration in budget development are necessary in this model. Savings or losses are shared by the whole through budget variations in current or future years. The complete assumption of risk by the provider system creates the need for stop-loss and reinsurance to protect against catastrophic expenses.

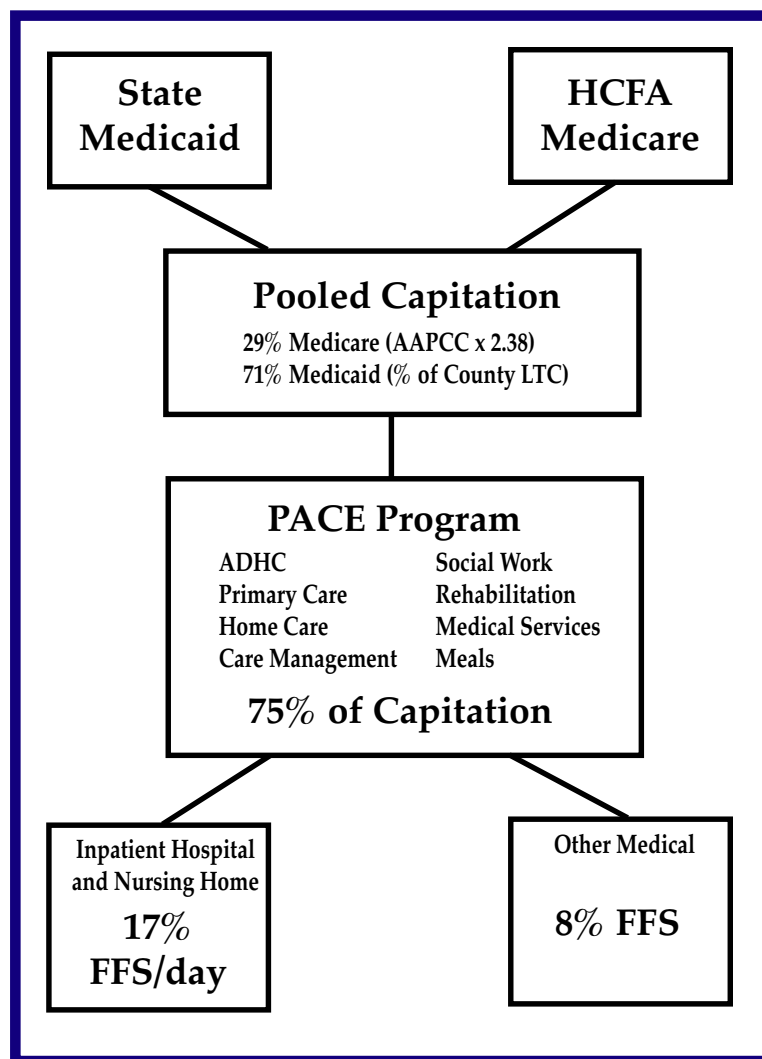
Incentives/ Obstacles

The system has the incentive to manage care over all levels of care. This integrated effort will result in easy use by the patients. Services that are within budgets are used first and the system will tend to avoid use of services outside the network. Using budgets will mean that services within the network are provided at cost while services outside will be paid for at usual and customary rates.

Individual providers usually do not have incentives with personal gain or risk for utilization variations. This lack of incentive means that productivity is not rewarded, which may impact the effort needed for creative care management of difficult and high-cost cases.

With complete financial responsibility, this model creates incentives to support health promotion and illness prevention. A central pool of resources allows for variations according to patients' needs. If budgets are firmly adhered to, there is the potential for competition between cost centers for resources.

Because this model is a closed system offering fewer primary care providers, potential members may be required to change physicians upon enrollment.



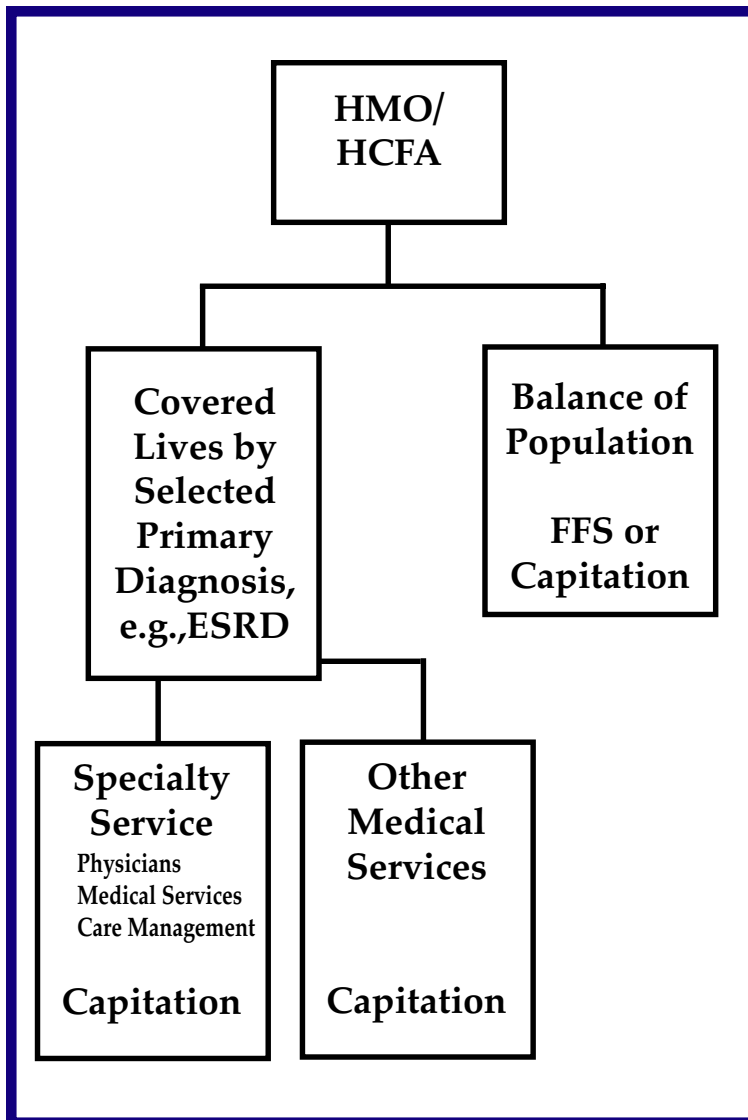
Example: PACE

Model C: Partial Capitation

Partial capitation means capitation of some services or some patients. This can mean focusing on a special group of homogeneous patients or carving out high-risk, high-cost patients. Partial capitation can also refer to capitation of a segment of services.

Selecting a similar group of patients to start a risk relationship can be helpful because it produces an easier-to-predict financial risk and supports common care protocols. As a transitional step, partial capitation can be used to stimulate system development and learning about the incentives of capitation.

Risks and savings for the covered services or patients are held by the provider network.



Example: Carve-Out

Incentives/Obstacles

Partial capitation provides a step into capitation and can be incrementally increased with more services and/or population covered as the provider network is better able to handle risk.

The capitated providers have incentives to shift services to other providers, especially fee-for-service providers. Coding of services can become an art in the attempt to shift costs to maximize billing. For example, if primary care services are capitated and specialty services are fee-for-service, the primary care physician has the incentive to refer more patients to specialists for care that may be within the scope of primary care.

Continuity of care is not supported by partial capitation except in the cases where a subset of special-needs people are covered by the capitation (e.g., ESRD). If the partial capitation is a carve-out of high cost procedures, the management of complex cases is fragmented by this model.

Model D: One Entity Receives Capitation For All Care

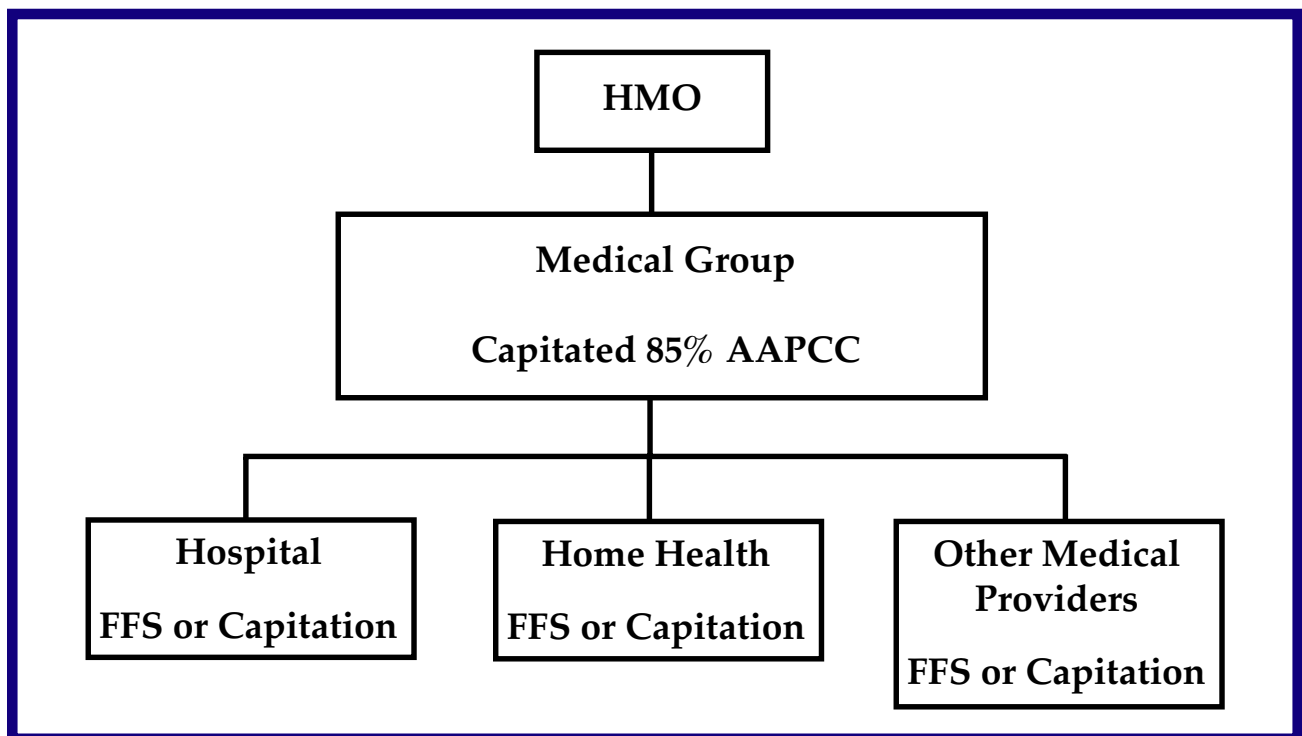
In some cases provider networks choose to have one provider accept the capitation for all services. This often occurs in a multispecialty group practice but may also occur in a hospital or long-term care facility. The provider accepting capitation then creates subcontracted reimbursement arrangements with other providers ranging from fee-for-service to subcapitation. The single entity carries the financial responsibility in savings or losses.

Incentives/Obstacles

A physician group must be quite large in order to have the capital and administrative structure to accept risk. Few groups are prepared to arrange and manage this risk.

If the medical group accepting the capitation is a primary care group, conflicts may result between primary care and subspecialists because primary care physicians will have incentives to reduce referrals to specialists.

Like the HMO, the single provider has the incentive to reduce the utilization of any services by other entities in the provider network. This can result in underutilization of high-cost services. The provider has the long-term incentive to prevent illness and disability and to focus on quality and member satisfaction to retain the patient base.



Example: One Provider Capitated for All Services

Model E: All Entities Are At Risk and Receive Subcapitation

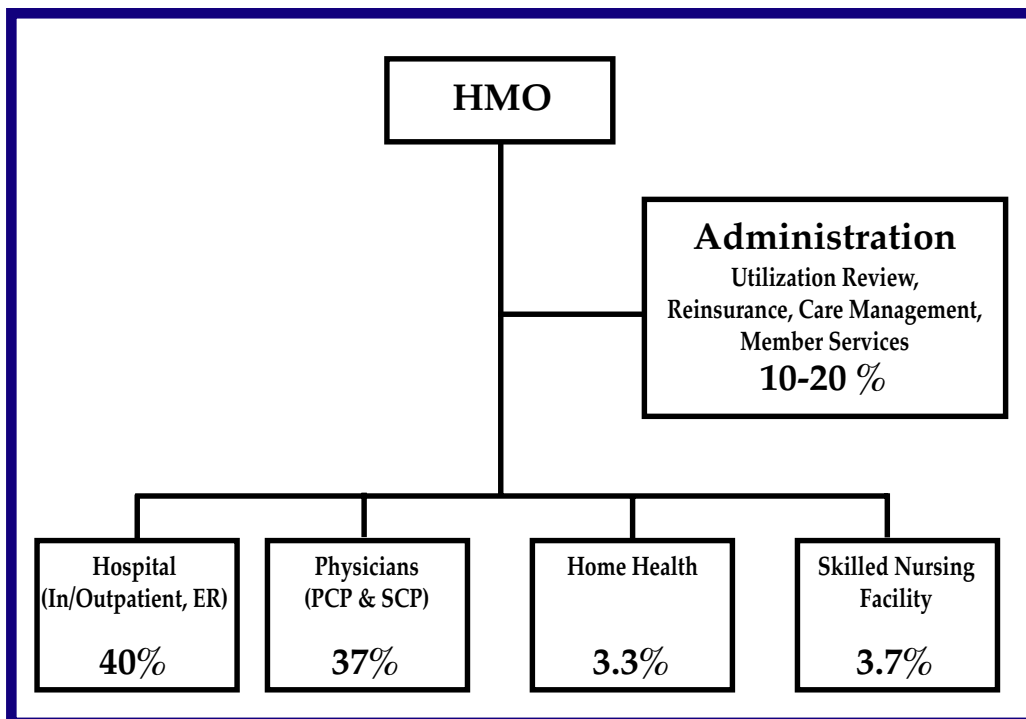
This is a common model used in health systems. The provider network receives a capitation which it disperses to each entity as a subcapitation. Each entity is then responsible for managing services within its assigned scope of services. Generally, reserves are maintained for risk pool and reinsurance at the system level. Some sharing of these risk pools may occur. Each entity holds full financial responsibility for use of its capitation both in terms of savings and losses.

Incentives/Obstacles

This model creates shared incentives giving all parties responsibility for cost control, however, each entity has the incentive to enhance their own bottom line. Division of the resources prospectively results in a loss of flexibility to substitute, when appropriate, less intensive, less expensive care. For example, if the hospital and home health have each received a subcapitation, home health does not have the incentive to help the hospital discharge a high-cost patient.

Subcapitation may be based on past or projected utilization. Individual providers will not have resources beyond the projection to invest in changing patterns of care. For example, a subcapitated skilled nursing facility does not have resources to invest in enhanced services for a higher-acuity patientload.

Sophisticated information and accounting systems are needed to adjust capitation



payments to account for varied acuity levels of different providers' case loads.

Each provider has the incentive to create separate care management systems to maximize the efficiency of services within their responsibility. The overall provider network also has the incentive to provide system-wide care management resulting in potential conflicts and duplicated services.

Example: All Entities Capitated, At Risk

Model F: Integrated System Receives Capitation

In this final model, an integrated delivery system receives a single capitation payment and agrees to align incentives between all providers within the network. Resources are kept flexible to permit proactive adaptations to changing patterns and variations in the needs of covered members. Risks and rewards are shared within the provider network. Risk pools and reserves are centrally managed.

Incentives/Obstacles

Care delivery at the lowest cost setting for the individual patient is achievable because care management is systemwide and resources are centrally maintained for flexibility in resource allocation.

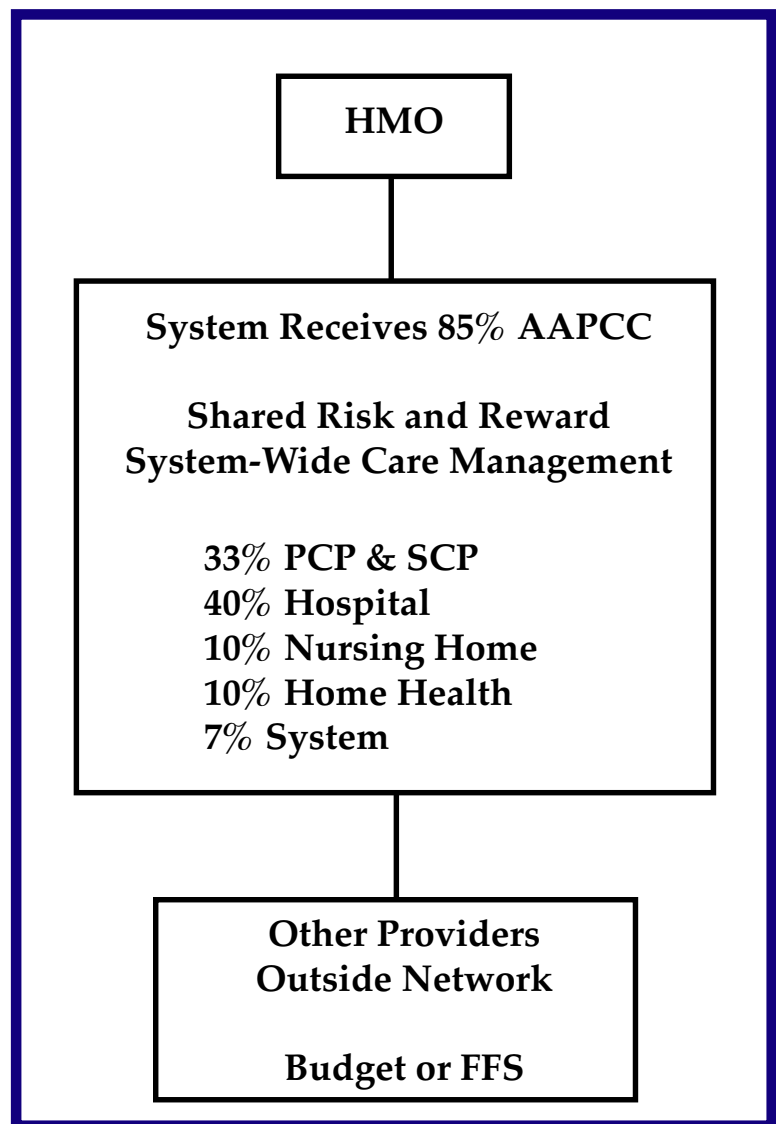
All providers within the network share incentives to maximize clinical outcomes at the lowest cost and to identify and manage problems early to prevent unnecessary use of high-cost clinical services.

Complex financial and information systems are needed to manage the data for both clinical as well as financial management.

Establishing an equitable procedure for cash flow is complex and difficult. Compensation must cover costs of services, and there must be incentives to make acceptable changes in practice patterns to reduce the inappropriate use of high-cost services, and to prevent illness and disability when possible. Without incentives to change clinical practice, this model risks a return to the cost-based reimbursement pattern of practice.

The provider network has the incentive to support the health status of the covered members through early detection and health promotion.

This model is time intensive to create and administer because it requires communication between care delivery components and a complete understanding of incentives and operational issues for the components to best work together.



Example: Integrated Delivery System

Issues to Consider in Risk Sharing

1. What are the options for sharing risk and which fit the current organization, community preparedness, and climate?

There are many models and variations of risk sharing. Only a few of them will be appropriate for any organization at a given time. A look at a variety of approaches will help your organization find those options that best fit your current situation. You may also find that a model that is best for one situation may not be the best one for another.

2. Will arrangements be different for providers inside and outside the formal provider network, e.g., community care services, tertiary care?

Before deciding how to share risk, you have to decide with whom to share it. You may consider a difference between the definition of the provider network as it relates to the provision of care and the network as it relates to risk sharing. Most organizations only want to share risk and reward with formal affiliates of their system. Other organizations outside the formal network may play an important role in completing the continuum of care, but sharing of risk and reward is another matter.

3. How does the model of risk sharing affect provider incentives for the care provided to patients? Is disability prevention enhanced?

Differences in risk sharing can affect service utilization by either increasing or decreasing specific services. Risk sharing and compensation will also affect access to certain services and can cause under- or over-referral to other providers. The impact of these service incentives can affect both the coordination of care and the quality of the clinical outcome.

4. How will the routine cash flow needs of the network members be met within the risk sharing model selected?

Once your provider network has decided how to share risk, the next decision involves cash flow. Several decisions must be made, including subcapitation, frequency of payments, use of budget accounts, prepayment versus retro payments, discounted fee-for-service with withholds, or some balance of fee-for-service and capitation. In addition, the network may choose to use periodic reconciliation to adjust cash flow based on results of changing care patterns or as a means to reinforce desired changes in care patterns.

5. Who will share risk with whom? What size will the risk pools be, and who will share risk together?

Risk pools can be complicated or they can be simple. The most complicated arrangements may include smaller groups of providers who share groups of patients with interrelated referral patterns. Larger pools of providers, such as the entire medical staff of a hospital or all the hospitals in the network, could also be a risk pool. Smaller pools are riskier for providers, but they offer clear feedback regarding performance and create strong incentives to change practice patterns. While larger pools give more risk control, they reduce the impact of individual provider behavior on the end result.

6. Assuming there are savings at the end of a given time period, how will these savings be shared based solely on financial performance within the network?

The first decision regarding shared savings requires a look at the financial return and performance. Without good financial performance there are no savings. However, to reinforce the practice pattern changes that your network is working toward, other kinds of rewards may be justified, such as reward for utilization of specific types of services, reward for increasing patient access to services, or reward for reaching quality indicators for clinical outcomes and/or patient satisfaction.

7. Does the provider network have the information system capability to handle the risk sharing model and to track care and cost outcomes?

Most information systems were designed to handle the day-to-day operational needs of individual facilities. The dramatic changes required to integrate multiple systems and create management information for use in monitoring and implementing risk sharing will likely take years to evolve. In the meantime, cost accounting and common data definitions will help support risk sharing.

Conclusion

The models presented here represent an illustrative, not exhaustive, set of risk-sharing models. Each of these models is in operation somewhere and any one of them may be appropriate in a given situation at a given time. Application of any of these models can result in incentives as diverse as those caused by fee-for-service. Selection should be made following consideration of the incentives created and the impact these incentives have on the goals of the provider network.

These models have been used in several NCCC Working Sessions to generate discussion of the issues raised by the models. In each discussion, group members have identified the last two models (Model E and Model F) as the goal for an integrated delivery system. These models are best for systems seeking to align the incentives to maximize coordination of care and to support the development of a provider-based delivery system. The last model—Model F, which aligns incentives of the providers and protects the flexibility of resources—is usually the preferred model. However, it creates the challenge of designing a cash flow plan with incentives to maximize the efficiency that naturally occurs in the subcapitation model.

About the Author

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The National Chronic Care Consortium (NCCC) is a mission-driven organization of 27 leading-edge health networks dedicated to transforming the delivery of chronic care services.

The NCCC's mission is to serve as an operational laboratory for enabling innovative health networks to establish prototype systems for better serving persons with chronic conditions.

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