# The Unfulfilled Cost-Control Promise of Provider Risk Sharing

**Richard Kipp**, MAAA
**Lisa Mattie**, RN

While healthcare reform does not provide many immediate mechanisms for limiting increases in the underlying cost of care,[1] it does call for the creation of pilot programs that build off of an old concept: provider risk sharing. The concept makes sense: Decisions at the point of care determine utilization, and utilization is a major determinant of healthcare costs.[2] Provider risk sharing creates an incentive for increased managed care—and the accompanying improved quality and efficiency that come with improved utilization—and thereby offers an alternative to a fee-for-service payment system.

The problem is that provider risk sharing was pursued in the 1990s and largely failed as an agent of systemic change. There are many reasons to account for this: a lack of valid quality measures that a majority of providers could agree on and support,[3] few documentation and coding procedures that providers were prepared to use,[4] best practices often not in place (or even understood well) to maximize the use of non-physician support staff,[5] insufficient information technology, and risk assessment techniques that were relatively unsophisticated by today's standards.

Many of these factors have improved, but the first question to address nevertheless remains: If it failed before, will it work this time?

If so, the difference will most likely be the newfound precision and interconnectivity of the tools available, along with the advanced refinements in risk assessment that will become increasingly important in the coming era in which risk dumping is no longer allowed. Several considerations and questions are key:

- Incentives need to be aligned. Can providers, payors, and patients work together to make this happen?
- Evidence-based medicine can provide a roadmap for higher-quality and more efficient care.[6] Are providers ready and are the infrastructures in place to enable more providers to follow that roadmap?
- Electronic health records (EHR) can deliver evidence-based guidelines and consolidate essential data.[7] But how can they be made viable when many providers are reluctant to realize EHR implementation due to past failures or resistance to change?
- Data sharing has been validated as a path to better information in certain communities where stakeholders buy into the idea of centralized data warehousing.[8] Can data sharing become the norm?
- Risk adjustment is essential and sophisticated tools are available. Will they be properly implemented?

These questions will have to be addressed in order for the American health system to realize this potential for cost control. The reform law provides for the creation of accountable care organizations (ACOs)[9]—the new provider risk-sharing model—and Medicare is pursuing this approach. The participation of Medicare in particular, with its mix of *carrots and sticks*—that is, rewards for meeting both cost containment and carefully defined patient outcome goals, and comparable penalties for failing to meet them—may well move provider risk sharing onto the front burner of cost control efforts.

Will it work? This paper will reframe provider risk sharing as a cost-control strategy and examine the key considerations for actualizing the potential of this strategy, with a particular focus on how providers

1 2010 Milliman Medical Index. May 2010. http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2010.pdf
2 Harris, Ronald G., Rifkin, William & Snook, Thomas D. (March 2010). Healthcare cost: Manage the causes, not the effects. Milliman Healthcare Reform Briefing Paper. Retrieved April 8, 2010, from http://www.milliman.com/perspective/healthreform/pdfs/healthcare-cost-manage-causes.pdf.
3 Gold, Marsha (Jan. 2010). Accountable care organizations: Will they deliver? Policy Brief, Mathematica Policy Research, Inc.
4 Devers, K. & Berenson, R. (Oct. 2009). Can accountable care organizations improve the value of health care by solving the cost and quality quandaries? Timely Analysis of Immediate Health Policy Issues, Urban Institute, Robert Wood Johnson Foundation.
5 Fisher, Elliott S., Staiger, Douglas O., Bynum, Julie P.W., & Gottlieb, Daniel J. (2007). Creating accountable care organizations: The extended hospital medical staff. *Health Aff (Millwood)* 26(1): w44–w57.
6 Blumen, Helen E. & Nemiccolo, Lynn D. (June 2009). The convergence of quality and efficiency and the role of information technology in healthcare reform. Milliman Research Report. Retrieved April 8, 2010, from http://www.milliman.com/perspective/healthreform/pdfs/convergence-quality-efficiency-role-RR06-01-09.pdf.
7 Moyer, Rich & Leonardo, Paul (February 2010). Building an accountable care system. Milliman Marketing Brief. Retrieved April 8, 2010, from http://www.milliman.com/expertise/healthcare/products-tools/medinsight/pdfs/building-an-accountable-care.pdf.
8 Moyer, Rich & Leonardo, Paul. Regional data exchanges unlock potential of electronic health records. Milliman Insight. Retrieved June 4, 2010, from http://publications.milliman.com/publications/healthreform/pdfs/regional-data-exchanges-unlock.pdf.
9 Parke, R. & Fitch, K. (Oct. 13, 2009). Accountable care organizations: The new provider model? Milliman on Healthcare. Retrieved April 8, 2010, from http://www.milliman.com/perspective/healthreform/accountable-care-organizations-new.php.

can efficiently transition toward this new model even as utilization declines and incentives change.

## WHY THE FOCUS ON PROVIDERS? AND WHY NOW?

The reasons for focusing effort on providers are fairly clear. First, it makes sense to leverage the position of providers on the front lines of care. Providers are in the position to understand their patients best—their particular needs, their specific conditions. In their one-on-one contacts with patients, providers occupy the important role of helping patients best understand the ramifications of all their choices for treatment, including early options for preventive steps, tradeoffs in costs, and basic understandings of all the risks, financial as well as medical, that will be involved in their choices.

Providers also work and operate within a community. They are expected as a matter of routine to remain current on the latest developments in their fields and frequently communicate with their peers to help facilitate ongoing, career-long learning efforts. With so many developments in medical research happening so quickly, often simultaneously, providers need all the help they can get to stay on top of them.

Which is where payors enter the conversation. Commercial health plans, as well as the Centers for Medicare and Medicaid Services (CMS), can offer an invaluable source of information to providers, making available the data and reports they need as well as acting as a reinsurer to help finance treatments for the most severely affected patients. The cumulative effect of entering into risk-sharing agreements with multiple health plans is that providers would enjoy a sharpened ability to manage care, because most of their patients would be covered by plans under such agreements.

Shared risk, in turn, leads to even more unified efforts between providers and payors. Like anyone, providers are more likely to act on the need to manage cost when they have something at stake—if they share in any savings that are realized and bear the burden of any extra costs that are incurred.

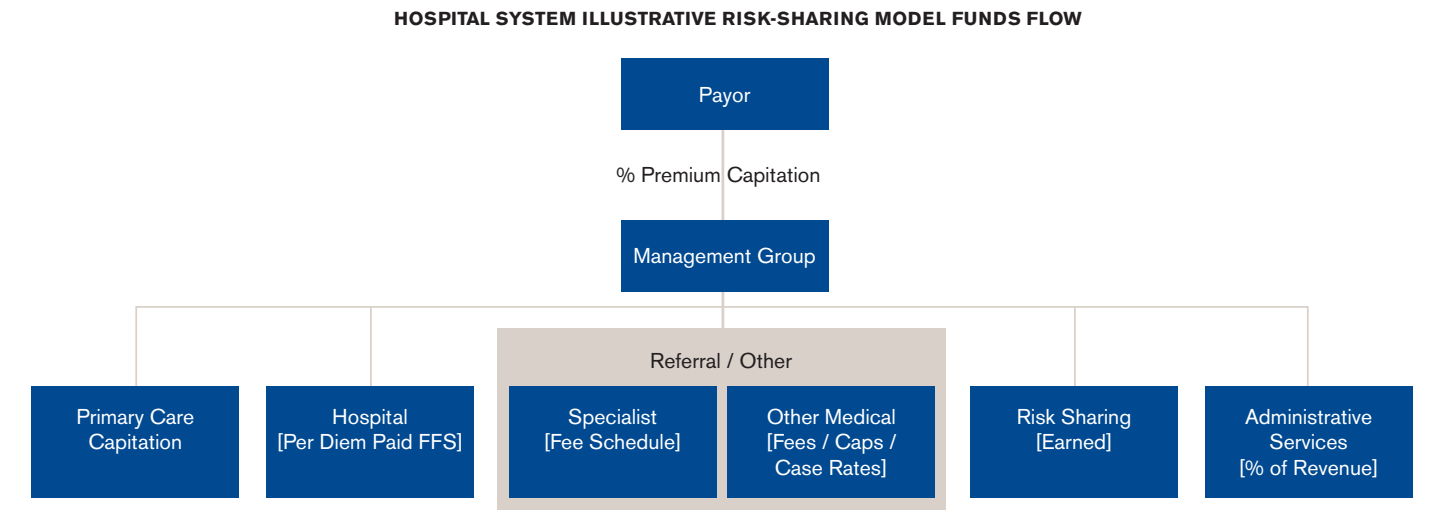
An example of how this approach would work in a practical implementation is shown in Figure 1. This diagram illustrates the necessarily collaborative nature of the work that must be established between providers and payors. Providers are in the best position to know what their patients need on a case-by-case basis, with primary care providers making referrals as necessary to hospitals or specialists, each of which in turn work directly with patients to make the best assessments and recommendations for treatment and care.

At the same time, payors—who may be working most closely with various designated management groups (MG), such as an ACO—have perspective on the larger picture of treatment and care, based on their access to today's increasingly sophisticated data sources, which are becoming more refined and sensitive practically by the week to patient outcomes and best practices. The key is for payors and providers to be in a position where they can share this information—granular patient profiles and immediate needs on the one hand, and practical information about what is and is not working on the other. And just as important, if not more so, they must be able to do so in circumstances that require on-demand and real-time information to make decisions and take action.

## INCENTIVES NEED TO BE ALIGNED

Early efforts at provider risk sharing in many cases were too crude in their essential design, dropping too much of the risk on providers without properly balancing patient and payor considerations. Many of the provider organizations' medical management structures were not sophisticated, lacking evidence-based medicine clinical decision support tools or non-physician staff to coordinate patient continuity of care and clinical integration efforts. Nor were most provider organizations in a position to collect and analyze the data required to enable ongoing implementation of high-performance best practices. For their part, payors were not effective at plugging these gaps for

**FIGURE 1: RISK SHARING MODEL FUNDS FLOW**



### PROVIDER RISK SHARING AS AN ALTERNATIVE TO FEE-FOR-SERVICE REIMBURSEMENT

A recent Milliman report, *Healthcare Cost: Manage the Causes, Not the Effects,* shows how the foundation of spiraling healthcare costs is simply a function of the costs for health services, or unit costs, along with the number and types of services used, or utilization.[10] Thus, the ever-multiplying impact to overall costs of the healthcare system can be expressed as $C \times U \times M$ where $C$ represents fee-for-sevice charges, $U$ the number of services delivered, and $M$ a factor that acknowledges the ever-changing mix of services available to providers for their patients.

Fee-for-service charges are negotiated with providers as a group in order to obtain the best price for patients. Utilization is managed by incentivizing primary care doctors and other healthcare professionals to monitor best practices in their fields and choose carefully the number and types of services and treatments that they order for their patients, based on their demonstrated effectiveness in addressing the conditions of their patients.

Managed care has frequently been viewed as an effective way of addressing the spiraling costs—in some of the best managed examples of its use it has been shown to reduce costs by 10%–20%. The model is familiar and simple: Large management organizations take advantage of economies of scale to negotiate the best prices with providers for patients and payors. One of the ways used to create incentives for providers to *manage* patient care from a cost perspective was to institutionalize sharing financial risk with them. That is, based on best practices and evidence from the latest literature, providers were expected to hold costs within formal guidelines while maintaining a certain level of patient outcomes. When they were able to do so, they were rewarded with bonuses; when they were not, they were penalized. The hope of such provider risk sharing was that patients would be treated in an effective but realistic and efficient fashion.

providers, even though they were more likely to have access to the necessary information.

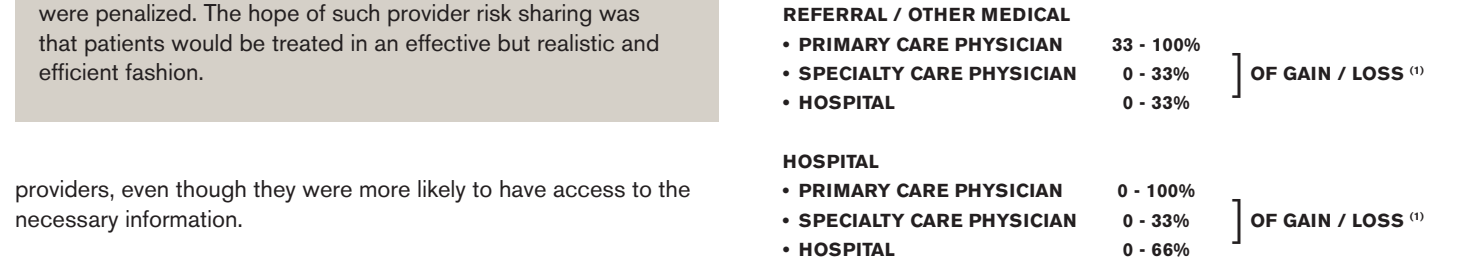
In the latest move toward provider risk sharing, payors and providers will enjoy enhanced opportunities to change the bases of compensation, opening the possibilities for more equitable, efficient, and effective strategies. Fee-for-service models, which have been demonstrated in many studies to contribute a troubling degree of the sources of medical costs inflation (see the sidebar, *Provider risk sharing as an alternative to fee-for-service reimbursement*), may well be used less and less in the future.

Compensation instead may come in the form of a per-member basis, with bonuses paid depending on the provider's achievement of specified targets and goals. Savings will be shared between providers and payors according to their effectiveness and efficiency. Pay-for-performance components within this overall approach will reward improved patient outcomes as well as straightforward savings.

One new wrinkle that has developed in these latest iterations of provider organization models is that Medicare may allow some of them to be voluntary. In this scheme, provider organizations would be defined by Medicare specifically as ACOs consisting of a hospital, primary care physicians, and specialists. These ACOs would be eligible for bonuses based on their performances, but they would not be open to sanctions if they did not meet performance goals.

The diagram in Figure 2 illustrates some of the ways that savings may be shared among payors, primary care providers, specialists, and hospitals. In some cases, these schemes may offer very little or no downside risk to physicians, although more often the shared risk will be symmetrical. As always, the devil will be in the details, and the specifics of the potential shared percentages of bonuses and penalties will depend on negotiations between the various parties involved and how the contracts are ultimately finalized. With the new and more robust provider organizations that are likely to emerge under this paradigm, it's probably prudent to anticipate as well some difficulties in negotiations with them. Some parts of the new law are already indicating directions in which a new generation of provider organizations may be likely to go. For example, there are provisions for a demonstration project for a pediatric ACO that will begin in 2012. These pediatric ACOs will be required to meet certain performance guidelines and those that do so, providing services at a lower cost, will share in a proportion of the savings.

**FIGURE 2: TYPICAL SHIFTS**




(1) Sometimes no downside risk to physicians; often it is symmetrical.

### EVIDENCE-BASED MEDICINE CAN PROVIDE A ROADMAP

Milliman clinicians Helen Blumen and Lynn Nemiccolo published a healthcare reform research report last year, *The Convergence of Quality and Efficiency and the Role of Information Technology in Healthcare Reform*, which discusses the importance of evidence-

[10] Ibid Harris, Rifkin, Snook.

based quality measures in improving healthcare quality and uncovering new efficiencies in the delivery of care.

Numerous studies, including the Milliman Medical Index, have shown significant geographic variations in healthcare costs and utilization in the United States. In many cases, these variations are the result of cultural or style influences that can go unquestioned and simply become habit. It is important to note, however, that higher costs do not necessarily equate to improved outcomes. Recognition in physician compensation of adherence to best practices and of the outcomes produced is often missing but clearly needed in order to simultaneously pursue quality and efficiency.

In a reformed system, evidence-based guidelines could be expected to offer physicians a safe harbor to insulate them from liability uncertainties and associated risks. Rather than simply looking to excess lab work to prove the appropriateness of treatment, for example, physicians could be incentivized to turn to guidelines for a scientifically-proven approach to diagnosis and treatment.

An effectively reformed system could help roll back much of the litigiousness that has crept into our culture as it pertains to the practice of medicine, and contribute to restoring trust between physicians and patients. The problem is that, despite theoretical agreement, evidence-based medicine still face various implementation hurdles.[11] These hurdles will need to be cleared in order for this evidence-based thinking to be widely incorporated into physician practice patterns.

## ELECTRONIC HEALTH RECORDS CAN DELIVER EVIDENCE-BASED MEDICINE AND CONSOLIDATE DATA

Electronic health records (EHRs) can provide immediate access by attending physicians to comprehensive patient information and to evidence-based guidelines—thereby improving the input for physician decision making and enabling the real-time application of important evidence-based guidelines. EHRs are uniquely portable—they afford the potential for bringing up-to-date information and decision support to physicians on the phone, in the office, and at the bedside. In addition, they are invaluable in helping to cut back on unnecessary redundancy—multiple providers ordering the same lab tests, for example—and thus contribute to controlling costs too. This means that they can both help encourage more efficient care *and* reduce quality deficiencies.

The ongoing effort toward a common, standardized language to use with EHRs, known as Systematized Nomenclature of Medicine-Clinical Terms (SNOMED CT), looks promising as a strategy to enable standard reporting similar to administrative data that will be able to report on actual health outcomes.

Because EHRs can capture clinical data, they can also be used to gather information with significant research potential, empowering a kind of evidence-based feedback loop. But once again, the implementation has been slow and reluctant. The American Recovery and Reinvestment Act offered incentives for providers to implement EHRs, though it remains early in that process and the majority of providers are still not using EHRs.

## DATA SHARING HAS BEEN VALIDATED AS A PATH TO BETTER INFORMATION

Since the late 1990s, when efforts toward provider risk sharing first began to fade, the ability of the key stakeholders—patients, providers, and payors—to communicate with one another has continued to improve. Meanwhile, much more data has become available to use for various purposes—data related not only to medical conditions, treatments, and procedures, but also to effective quality measures and how to gather and understand them. Analysis of medical best practices and patient outcomes has also grown increasingly sophisticated, at exponential levels, in the intervening years. Efforts to pool data and conduct population-level analysis are an important part of this effort.[12]

This data has been used collectively to improve the following key aspects of managing care:

- Research and development of best practices.
- Early identification of people at risk for serious conditions.
- Quantification of that risk, which can be used to properly adjust provider reimbursement.
- Medical records for patients can now be digitally captured and shared quickly and efficiently among treating providers.
- Quality has been identified as a key factor in patient care and a great deal of work has been done to create meaningful measures for which data exist and that can be tracked by treating providers.
- Health plans are making cost data transparent so that patients and providers understand and compare the possible costs and the various tradeoffs for their choices of treatments.

## RISK ADJUSTMENT IS ESSENTIAL

Risk adjustment was a hallmark of the prior move toward provider risk sharing. These early efforts evolved to become today's risk-based performance measures and have been integral in developing new incentive systems.

The role for risk adjustment, however, is broader than this. In addition to calibrating the payments under the new incentive systems, risk adjustment can also refine the measurement of provider performance and utilization of resources. Risk adjustment can identify opportunities for improving quality and utilization, serving as a way of recognizing and enacting opportunities for improvement.

[11] Merola, Patty & Hopkins, Rodger. How hospitals can successfully implement evidence-based guidelines. Milliman Insight. Retrieved June 4, 2010, from http://publications.milliman.com/publications/healthreform/pdfs/how-hospitals-can-successfully.pdf.

[12] Studebaker, Brian & Leonardo, Paul. Healthcare data pooling: Coming soon to a community near you? Milliman Insight. Retrieved June 4, 2010, from http://publications.milliman.com/publications/health-published/pdfs/Healthcare-data-pooling-coming-PA02-06-08.pdf.

Milliman

### WHAT IS RISK ADJUSTMENT?

"Risk adjustment is defined as the process of adjusting health plan payments, healthcare provider payments, and individual or group premiums to reflect the health status of plan members. Risk adjustment is commonly described as a two-step process. The first step involves risk assessment, which refers to the method used to assess the relative risk of each person in a group. The relative risk reflects the predicted overall medical claim dollars for each person relative to the claim dollars for an average risk person. The second step in the risk-adjustment process is payment or rate adjustment, which refers to the method used to adjust payments or premium rates in order to reflect differences in risk, as measured by the risk assessment step. It is common to refer to a particular risk assessment method as a risk adjuster."[13]

## THE MODEL OF THE MOMENT: ACCOUNTABLE CARE ORGANIZATIONS

The fundamentals of provider risk sharing in the future will not look very different from what was phased out in the early 2000s. The key difference is that now many of the tools necessary to support them will be readily available.

Another effort, also set to start in 2012 and focus on ACOs, will again be based on shared savings. Each ACO in these Medicare programs will be responsible for the quality, cost, and overall care provided to traditional Medicare beneficiaries, and will participate in the program for at least three years. The Department of Health and Human Services (HHS) will periodically measure each ACO based on quality of care measures, such as clinical processes and outcomes, patient and caregiver experiences, and utilization rates.

Providers participating in certain ACOs in these programs will continue to be paid based on the Medicare fee schedule, but ACOs that meet quality performance standards will be eligible to receive additional payments based on a share of the savings the ACO achieves. ACOs that see program savings but do not meet quality performance standards will not be eligible to receive additional payments, and ACOs found to have avoided high-risk (high-cost) patients may be sanctioned.

Another provision in the new law that will have an impact here establishes a nonprofit corporation, the Patient-Centered Outcomes Research Institute. This organization is intended to provide support for patients in making informed health decisions by advancing the quality and relevance of evidence for strategies that can effectively and appropriately prevent, diagnose, treat, monitor, and manage various health conditions by synthesizing research and other evidence as it becomes available. This could contribute greatly to effective cost controls if it is done well and quickly.

Efforts by health plans to address rising costs have already been under way for several years now, and have established a foundation on which the new models of provider organizations will likely be based. Some of these efforts include a move by BlueCross BlueShield of Massachusetts toward a refined version of capitation[14] and another by Highmark Inc., which is based in Pittsburgh, Pa.,[15] as well as the shift by Medicare toward ACOs. Having Medicare on board promises to give a good deal of momentum to the effort, if previous reimbursement mechanisms such as diagnosis-related groups (DRGs), resource-based relative values (RBRVs), or ambulatory payment classifications (APCs) are any indication.

## THE RIGHT OPERATIONAL SUPPORT

In order to succeed with the new generation of provider risk-sharing models, providers will need to be sure that they have several key processes and systems in place:

- Data availability, tracking, and reporting capability for patient tests and referrals, practice performance reporting, and other electronic data
- Ability to identify patient illness
- Systems to connect with other providers
- Assistance in managing patient care such as evidence-based clinical decision support tools
- Adequate processes and non-physician staff to assist with care coordination, such as coordinating follow-up care post-discharge, coordinating with external disease or case management organizations, or contacting patients post-discharge

Efforts that pair these operational components with the new tools and a clear strategy and proper buy-in from all parties may succeed where past efforts have failed. It will not be easy—systemic change never is—but the tools needed are now available and the system may have learned enough from the previous failed attempt to actualize the potential of provider risk sharing.

Richard Kipp is a principal and consulting actuary with the Philadelphia office of Milliman. Lisa Mattie is a healthcare management consultant with the Philadelphia office of Milliman. Contact them at richard.kipp@milliman.com, lisa.mattie@milliman.com, or at 610.687.5644.



13 Ross Winkelman and Syed Mehmud, *A Comparative Analysis of Claims-Based Tools for Health Risk Assessment*, Society of Actuaries, April 20, 2007, available online at http://www.soa.org/files/pdf/risk-assessmentc.pdf.

14 Berry, Emily (Feb. 11, 2008). Can the Massachusetts Blues revive capitation? New twist includes quality bonus. American Medical News. Retrieved April 16, 2010, from http://www.ama-assn.org/amednews/2008/02/11/bil10211.htm.

15 Berry, Emily (Feb. 8, 2010). Pa. Blues plan may pursue capitation. American Medical News. Retrieved April 16, 2010, from http://www.ama-assn.org/amednews/2010/02/08/bisb0208.htm.