FUNDS FLOW METHODOLOGY FOR RISK-BASED CONTRACTS

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INTRODUCTION

As the healthcare industry evolves, adoption of risk-based contracts is becoming increasingly common and important. The urgency to develop risk-based competency accelerated when Health and Human Services (HHS) established the following goals as part of their January 2015 announcement:

- Ensure 30% of traditional Medicare (FFS) payments are tied to alternative models such as Accountable Care Organizations (ACOs) or bundled payments by the end of 2016, and 50% of these payments by 2018.
- Ensure 85% of traditional Medicare (FFS) payments will be tied to quality or value by 2016 and 90% by 2018.
- Launch a Health Care Learning and Action Network that will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs.

Every provider should assess the transformational pace of change in their market that will lead to risk-based contracting. Each market will have a unique tipping point, commonly defined as the point when risk-based contracting increases to a level where Fee-for-Service payment strategies are no longer sufficient to sustain operational performance and in some cases to survive. Experience demonstrates that markets are aggressively moving toward their unique tipping points as providers accelerate risk-based contracting relationships. This will be further accelerated by the new HHS rules and the expectation that other payers will quickly follow with their own risk-based programs. The following figure highlights the tipping point consideration.

FIGURE 1: TIPPING POINT CONSIDERATIONS

Hospitals and provider groups across the country have responded to this announcement with a sense of urgency focused on a number of key decisions. Many of those decisions include proactively negotiating risk-based contracts which offer health systems, physicians and other providers incentive-based opportunities that promote alignment, collaboration and increased transparency across a defined population. Changes in the flow of funds among stakeholders involved in these incentive-based strategies will serve as either a significant opportunity to strengthen alignment or become a significant point of contention and distrust. There are six critical guidelines that every provider should consider as they develop their unique funds flow strategy:

1. Keep the funds flow methodology simple;
2. Confirm that performance against targets can be reported in a timely fashion to help change behavior;
3. Incentivize behavior to prepare providers for current and future risk contracts;
4. Allow providers to define quality and monitor improvement;
5. Enhance communication and buy-in among the provider community; and
6. Recognize that variations to each model may be necessary based on your portfolio of contracts.
SCOPE OF FUNDS FLOW

As providers consider their markets’ unique tipping point and its impact on timing and magnitude of risk-based contracting strategy, it is equally important to understand funds flow fundamentals and opportunities to reward providers for changes in behavior. The funds flow methodology and considerations outlined in this document are primarily applicable to value-based contract methodologies outlined below in Figure 2. These methodologies allow for equitable distribution of funds that can incentivize and reward changes in provider behavior to support enhanced value delivered throughout the healthcare ecosystem.

FIGURE 2: ALTERNATIVE VALUE BASED METHODOLOGIES

<table>
<thead>
<tr>
<th>NAME</th>
<th>PAY-FOR-PERFORMANCE</th>
<th>INTERNAL COST SAVINGS</th>
<th>SHARED SAVINGS</th>
<th>BUNDLED PAYMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITION</td>
<td>Designed to create subsidies for the reduction in reimbursement for providers, while also creating incentives for demonstrated improvement in quality and efficiency. Defined by selecting evidence-based metrics directly aligned to per member per month (PMPM) rewards based on compliance.</td>
<td>Formally aligned cost containment, standardization and operational efficiency efforts across the health system and network providers.</td>
<td>A regularly scheduled FFS payment in addition to opportunities for bonus payments based on the achievement of quality targets or decreased 3rd party payments for not attaining said targets; drivers of success are reduced readmissions and appropriate discharge behavior (e.g. caring for patients in home health at cost of $2,500 vs. SNF at cost of $16,000).</td>
<td>Reimburse a set of healthcare providers for the completion of a defined episode of healthcare services; price of episode is based on the cost of care to Medicare for that provider over a recent 3-year baseline period; participating provider must manage to a baseline and target price and have the ability to distribute savings to key stakeholders.</td>
</tr>
<tr>
<td>HEALTH SYSTEM</td>
<td>Generates bonuses for assisting with care coordination across the continuum.</td>
<td>Aligns providers around improving operational efficiencies within the hospital setting. Furthermore, it allows the health system to improve inpatient performance metrics.</td>
<td>Creates shared accountability across the continuum of care and provides economic incentive for improving efficiencies within defined populations.</td>
<td>Assists in managing resources and overutilization and creates shared accountability across the care continuum.</td>
</tr>
<tr>
<td>PROVIDERS</td>
<td>Acts as an add on to negotiated contracts (does not require a transition away from physician fee schedules).</td>
<td>Provides opportunity to share in savings gained from increased efficiencies, reduced duplication of services, and eliminated waste within a hospital setting.</td>
<td>Provides opportunity to share in savings gained from increased efficiencies, reduced duplication of services, and eliminated waste throughout a defined population.</td>
<td>Provides financial gain when episodes of care are managed effectively and coordinated with other providers.</td>
</tr>
<tr>
<td>EXAMPLES</td>
<td>1. HEDIS Measures</td>
<td>1. Supply Cost</td>
<td>1. One-sided (upside-bonus only)</td>
<td>1. Total Joint Replacement</td>
</tr>
<tr>
<td></td>
<td>2. PQRS</td>
<td>2. Pharmacy Cost</td>
<td>2. Two-sided (upside-bonus or downside-risk)</td>
<td>2. Heart Valve Replacement</td>
</tr>
<tr>
<td></td>
<td>3. SCIP</td>
<td>3. Employee Health Cost</td>
<td></td>
<td>3. Asthma Care</td>
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</tbody>
</table>
COMPONENTS OF FUNDS FLOW METHODOLOGIES

While each methodology will likely have unique components that align with organizational philosophy, contract type or network maturity, most methodologies will be built around the following components:

FIGURE 3: STRUCTURE FOR FUNDS FLOW METHODOLOGY

**Integrated Legal Entity:** Generally, contract revenue flows into an integrated legal entity, which could be a hospital subsidiary, provider-owned joint venture or independent physician association (i.e., Clinically Integrated Network, ACO, Joint Venture, etc.). Funds flow into the Integrated Legal Entity based on executed contract terms. It should be noted that contract terms do not typically dictate a specific funds flow methodology. Additionally, this methodology does not assume a change in traditional FFS revenue which typically flows directly to the accountable provider and not through an intermediary.

**Hospital/System:** The Hospital or Health System can contract with the separate legal entity to create a Hospital Efficiency Program (or an entire hospital internal cost savings program). The terms of the agreement would allow the hospital or health system to share savings with the integrated legal entity.

**Eligible Provider Members:** Providers who meet the necessary participation and performance criteria will be eligible for a distribution.

**Payers/Employers:** Once an integrated legal entity can demonstrate improved performance, payer and employers can contract with the integrated legal entity to improve quality and reduce costs across defined populations.

**Local Network Performance:** A component that is typically defined by service line, hospital location or department to create groups of providers that materially impact performance in line with the agreement.

**Global Network Performance:** A component that distributes rewards to all participating provider members that are eligible for a distribution either through attribution to a specific contract or participation in the program

**Individual Activity/Outcomes:** A component that distributes rewards based on individual criteria and performance (i.e., committee involvement, individual cost metrics, quality metrics and compliance with program expectations).
CRITICAL DECISION POINTS WHEN ASSESSING A FUNDS FLOW METHODOLOGY

Prior to entering into risk-based contracts, the health system, providers and other healthcare professionals must demonstrate the Risk Capable competencies to accept, manage and succeed under value-based contracts. Risk-based competencies include enterprise intelligence capabilities around analytics, a clinical enterprise maturity model in the form of an integrated legal entity and revenue transformation skillsets. Without each of these capabilities, the integrated legal entity may struggle to succeed in risk-based contracts and potentially fail to achieve rewards for distribution.

Developing a funds flow methodology requires engagement from all key stakeholder groups involved in the integrated legal entity and contracting arrangement. It is vital to define a methodology for equitable distribution. There are several important decision points – and key considerations for each – that require input and agreement from all stakeholders in order to align around a common methodology. Critical decision points when assessing a funds flow methodology include:

1. Determine the amount to be retained by the legal entity to recover infrastructure and development costs and/or ongoing administrative fees;
2. Define the eligibility criteria to participate in distributions from the rewards pool;
3. Determine the percentage of total rewards available for distribution to each stakeholder group; and
4. Determine equitable distribution to all provider members.

Decision #1: Determine the amount to be retained by the legal entity to recover infrastructure and development costs and/or ongoing administrative fees

In the creation of risk-based contracts, the integrated legal entity that takes on risk needs to be an entity that executes the contract on behalf of its participants. This integrated legal entity is typically a clinically integrated network with participating providers across the continuum of care. As with any other business, the legal entity will incur start-up expense to develop the entity and ongoing expense to operate the entity (Figure 4). The legal entity should recover all or a portion of the development and ongoing expenses prior to distributing funds to participants. However, recovering these costs comes out of the reward pool, offering a potentially tense and difficult decision point based on participant expectations.

For example, a four-hospital integrated legal entity in the southeast spent approximately $1.6 million on information technology, care management resources, provider leadership fees and other expenditures. Due to the large amount of operating expenses, the legal entity engaged their Finance Subcommittee (chaired by provider members) to develop a reasonable administrative fee. The subcommittee ultimately adopted an administrative fee of 17% of the rewards pool to fund the internal investment and ongoing network operating infrastructure.

IMAGE 4: TYPICAL ADMINISTRATIVE FEES AND INFRASTRUCTURE COSTS

<table>
<thead>
<tr>
<th>THE LEGAL ENTITY SHOULD RECAPTURE ALL OR A PORTION OF DEVELOPMENT AND/OR ONGOING EXPENSES. EXAMPLES MAY INCLUDE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Salaries and Wages</td>
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<tr>
<td>• Information Technology</td>
</tr>
<tr>
<td>• Legal and Consulting Fees</td>
</tr>
<tr>
<td>• Fair Market Valuation</td>
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<tr>
<td>• Office Expenses (Rent, Utilities)</td>
</tr>
<tr>
<td>• Board and Committee Meeting Attendance Fees</td>
</tr>
</tbody>
</table>

Decision #2: Define the eligibility criteria to participate in the distributions from the rewards pool

After repaying the administrative fees and infrastructure costs, funds flow into the rewards pool. Prior to distribution, participants must demonstrate eligibility to share in these rewards. The integrated legal entity may require their members to attend subcommittee meetings, achieve process/outcome-based metrics or help the health system partners achieve their goals.
An integrated network located in the southwest created aligned eligibility criteria focused on health system and provider goals. They mandated achievement of Meaningful Use prior to any distribution of funds. This example shows the positive impact a funds flow methodology can have as a mechanism to achieve objectives and strengthen alignment between health system and provider goals.

**Decision #3: Determine the percentage of total rewards available for distribution to each stakeholder group**

Once each participant has achieved eligibility, funds are distributed. In most cases, this includes a distribution to:

1. The hospital/health system for management and operations and to subsidize lost volume;
2. Providers for their direct interaction with patients and ability to impact the care provided; and
3. Other stakeholders, such as post-acute providers and urgent care providers for providing services or capabilities to the entity that allow for enhanced levels of performance.

**FIGURE 5: INDUSTRY BENCHMARKS ON DISTRIBUTION OF FUNDS**

<table>
<thead>
<tr>
<th>STAKEHOLDERS</th>
<th>% OF REWARDS DISTRIBUTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Legal Entity (i.e., Admin. Fee)</td>
<td>10% - 15%</td>
</tr>
<tr>
<td>Health System</td>
<td>20% - 35%</td>
</tr>
<tr>
<td>Providers and other stakeholders</td>
<td>50% - 70%</td>
</tr>
</tbody>
</table>

To develop a fair and equitable distribution, it is important to consider each stakeholder’s impact on performance. Providers within the integrated legal entity are likely to have the most significant opportunity to drive entire network performance and thus, generally deserve a majority of the reward pool. However, in certain circumstances other providers, such as post-acute providers in a network with bundled payment contracts, may deserve a portion of rewards for their ability to reduce readmissions.

**Decision #4: Determine equitable distribution to all provider members**

The distributions of funds are typically allocated based on activity in three performance opportunity categories: Global, Network and Individual.

Global distribution of funds is intended to share a portion of the reward among all members of the organization. The global reward incentivizes all providers to act as a network and ensure that peers are meeting performance standards. A hospital network in Arkansas with 100+ provider members agreed to distribute all rewards equally in the first year. The intent of the program was to reduce fragmentation within the provider community. As long as all members met minimum eligibility criteria, all members received the same distribution. In year two of the program, their distribution shifted toward network or group performance.

Network and individual criteria ensure each provider or group of providers are accountable for defined performance. It is important to consider contract targets and performance goals when selecting performance metrics. Providers are typically held accountable for performance based on leadership activities, quality targets, financial performance, and/or attribution methodology. In some cases, performance against these metrics determines the percentage of available rewards earned by each qualified participant (e.g., 65% performance results in earning 65% of available rewards). The only limitation to this approach is linked to the granular nature and timely reporting of available information.

Organizational philosophy and strategy will also have a significant influence on the percentage split between local network, global network and individual performance. By allocating a larger portion of rewards to the global pool, the organization is effectively asking its providers to hold each other accountable for performance and behavior changes. Conversely, allocating a larger portion of rewards to the individual pool supports a philosophical perspective of individual accountability leading to overall improvement.
In all cases, it is important to consider entity/network maturity. Younger, less mature entities typically have fewer covered lives, lower infrastructure costs and are focused on provider engagement through process-based metrics. Furthermore, these networks are not as sophisticated, so they will have to rely on basic leadership metrics, such as participation on committees. Also, the administrative fee will likely be relatively low. Mature, more complex networks generally have more covered lives, higher infrastructure costs, and can reward for outcomes and performance more comfortably at an individual level. These networks may also have more innovative types of contracts that require more sophisticated decisions. For instance, a bundled payment contract requires reconciliation on a periodic basis. In this case, annual reconciliation reduces the variability of quarterly reconciliation, preventing a gain share one period and a downside payment the next.

TAX CONSIDERATIONS

The risk-based contracting strategies discussed in this whitepaper will undoubtedly involve entities and individuals from any variety and combination of tax structures: provider practices organized as S Corporations or partnerships; hospitals as nonprofits or for-profits; individual providers, etc. The value of each stakeholder’s contribution in a risk-based contract will have diverse, yet profound tax implications to each of those parties.

At a foundational level, each respective party would report and be responsible for tax on their share of allocable income. As examples, a physician practice organized as an LLC would recognize the share of income and allocate the income to each LLC member/partner pursuant to the partnership agreement, whereas, income earned by a nonprofit hospital may be considered non-taxable (or exempt income). Determining the value of each individual stakeholders’ contribution (and resulting share of the income) is crucial; however once decided, income tax implications follow each participants’ tax structure.

Another consideration corresponds to Stark and anti-kickback rules. While violations do not directly affect tax status, severe infractions call into question the tax-exempt status of nonprofit providers. As discussed, reasonableness rules and referral rules must be considered.

SUMMARY

The first step in a funds flow methodology must be to create an integrated legal entity that can be used as the vehicle to implement change in one’s community. With that said, it is important to maintain open communication with legal and compliance experts, as well as Fair Market Valuation firms to ensure the defined funds flow methodology falls within certain guidelines. However, as the industry continues to evolve, certain circumstances may require re-evaluation of and exceptions to long-standing legal funds flow parameters as discussed earlier in the gainsharing example.

Although some organizations do not currently participate in any risk-based contracting arrangements that allow for funds to flow among key stakeholders, all executives should begin thinking about how their organizational philosophy could guide a funds flow methodology and strengthen alignment with key partners. Healthcare institutions and leaders who have remained on the sidelines observing the recent pilot programs and initiatives will no longer have this luxury. In the very near future traditional FFS programs will shift toward payment based on delivered value as stated by the recent announcement and goals set forth by the HHS in January 2015.

As an integrated network prepares to enter into risk-based contracts that could lead to a distribution pool, they should consider the following questions:

1. When and where is the tipping point for my local market?
2. Do I have a mature integrated legal entity to manage the change of payment models?
3. Is my organization Risk Capable?