Ready for Risk Contracting?

Value-based models of care will expose hospitals to new financial stress

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Health care’s new value proposition — best-possible quality, outcomes and access at the lowest-possible price — heralds a different care delivery and payment system. Whether the model driving the transformation in local communities takes the form of an accountable care organization or other forms developed by public or private payers, all value-based models are designed to shift risk for costs of care to providers. This is accomplished through alternative reimbursement mechanisms.

Under the terms of a value-based contract, hospitals, systems and other providers will be responsible for delivering defined services at a predetermined price and quality level to a specific population within a limited delivery network. Providers will assume downside financial risk for not meeting targeted population health measures, for costs above expenditure benchmarks, and for not meeting quality thresholds. Conversely, upside financial incentives will accrue when providers exceed the population health measures, achieve a lower cost of care than target levels and exceed quality thresholds.

As performance-based arrangements increase, boards should be asking and answering critical questions, including: What will it take to move our organization from a fee-for-service to a value-based system? How fast will the payment system transition away from fee for service? What does future utilization look like given trends and movement to the new business model? What steps do we need to take to assume risk contracts with payers? How much capital capacity do we need to make these transitions? How will these transitions impact the volatility of forecasted capital capacity and our ability to carry risk in other parts of our business? Should we be a first mover in our service area? Do we need a partner or can we go it alone?

Risk-based contracting is already present in many locations and likely will be more common across the nation. Organization leaders will have a choice about how and when to enter risk-based contracting models.
They can decide to:
- establish and operate their own health plan and manage a population’s health through a branded health insurance offering;
- establish an owned or managed network of providers across the continuum of care and assume risk contracts with commercial and governmental payers on behalf of the network; or
- participate, through contractual arrangements, with a managed network to provide a specific service or portfolio of services within a portion of the care continuum, assuming risk within such arrangements.

A sit-it-out strategy that avoids value-based contracts and value network participation is risky in a competitive market. Only a limited number of participants will be able to establish themselves in each market as the value-based providers. To leverage their position with payers, employers and the community, organizations must differentiate themselves on the front end of the curve.

To aid the decision-making process, examine the four sources of risk inherent in value-based contracting: strategic, actuarial, financial and comprehensive. Then, consider strategies that executives and trustees can implement to mitigate and manage their organization’s total risk.

**Strategic Risk**
The central strategic issue is whether the organization has access to the human and financial capital required to make the transition to a new environment and successfully execute the organization’s plan into the future. Answering the questions outlined previously will provide a foundation for identifying the organization’s desired position in the new environment. It will be critical for leaders to select the right role because the capital commitment required to pursue each path is significant.

To build or participate in a care-delivery network, hospitals will need to invest in physician and ancillary provider integration, technology and care-management infrastructure, not to mention intellectual capital. The level of investment will depend upon the level of desired network ownership or participation. Few organizations have the resources for midstream course corrections, so strategic risk will be significant during the transformation process.

At the highest level, organizations wishing to provide — either directly or through managed relationships — a full continuum of services across all service lines and levels of acuity will need deep financial resources and a robust risk-management infrastructure. These population health managers must have the system leadership, vision and scale required to build and maintain an integrated network, effective data management and reporting, advanced clinical intellectual property (such as protocols and best practices), appropriate care management knowledge and tools, strong reputation and brand recognition, and other critical attributes.

At the other end of the spectrum, contracted providers will offer best-available-in-class services in their communities, appropriately supported by capital investment in facilities and local care delivery.

Midspectrum, major participant organizations will provide a specific portfolio of services, under contract to a population health manager. This portfolio will be supported by a capital investment level that ensures cost-effective, high-quality care to patients. A new way of thinking and delivering care will be required.

The ability to generate sufficient capital and to manage the allocation of risk will be vitally important to all organizations participating in a care-delivery network. Service areas are changing overnight as providers align to form delivery networks. The hospital’s strategic choices about network participation are critical, as are the responses of competitors, payers, employers and other stakeholders. All of these issues create a high level of strategic risk.

**Actuarial Risk**
Managing population health will be a new venture for most organizations. Actuarial risk will be involved, so the availability of actuarial expertise will be critical. Skills include evaluating the level of risk assumed for a defined population as specified in contract terms and benefit plan design, understanding the sources and reliability of data used to make key risk decisions, modeling the financial impact of such risks based on the likelihood of future scenarios, and managing or mitigating risk through specific initiatives. Such expertise is a core competency of health plans, but must be acquired in most hospitals and systems.

Other insurance-related competencies, such as claims, premium management (pricing) and membership management, also will be required of organizations that develop and offer their own branded health plans.

During the 1990s, many of the hospitals that experimented with risk-based contracts under capitated arrangements experienced significant losses because their actuarial expertise was limited and they underestimated use rates and costs for serving a defined population. Clearly, this history must inform current planning and highlight the importance of actuarial expertise as a foundational competency for the acceptance of risk.

Because start-up losses may be considerable, significant capital capacity also will be required to effectively assume actuarial risk under population health-based contracts. In addition, the potential call on unrestricted cash and investments to meet “insurance company” reserve requirements could create considerable barriers to entry for many organizations with competing capital needs and existing debt requirements (for example, minimum liquidity covenants).

**Financial Risk**
The assumption of strategic and actuarial risk through risk contracts will alter — perhaps profoundly — the organization’s financial risk profile. The significant capital required to
build physician networks, enhance and maintain technology, develop care-management infrastructure, and maintain minimum cash reserves all divert capital capacity from supporting the traditional business or funding other strategic initiatives. Organizations will be at risk for capital allocation decision-making that does not enhance long-term competitive or financial performance.

Capital commitment to population health arrangements also restricts the organization’s flexibility with capital structure decision-making, that is, asset and liability management. Because the organization is assuming considerable new market and operating risks, it may be unable to tolerate capital structure-related risks that would lower the cost of capital and enhance earnings under other circumstances. Over time, this may stress the organization’s rating or outlook from the credit rating agencies. Additionally, the capital required to fund initial operating losses from risk contracts and to create reserves to offset future operating exposure to contract-based risk, such as higher-than-anticipated care costs, cannot be financed through traditional tax-exempt debt offerings. As such, an organization considering assuming the risk of population health should first determine if its balance sheet is strong enough to handle reserve requirements, considerable changes to working capital and potential operating losses. Alternate forms of outside capital (particularly taxable debt) likely will become more important funding sources for some providers.

**Comprehensive Risk**

All of this discussion leads to the concept of comprehensive risk. Many health care leaders likely have a solid understanding of the various component risks embedded in the business lines comprising their organizations. What leaders may need to gain is a comprehensive understanding of the vertical risk or how the component risks might combine in ways that create substantially more risk than the parts might suggest.

Such total risk can undermine the organization’s strategies, market position, financial performance, and ultimately, its ability to serve its communities. Long-term success will be linked to how well its leaders ensure the application of total, organization-wide risk management. An illustration helps to show the challenge (see The Relationship of Risks, above).

Like the sides of a triangle, all risks are linked and interdependent. The total risk that can be reasonably assumed by any organization, comprising various risk types, is finite at any moment in time, but variable as internal and external circumstances change. Once an organization quantifies the level of total risk it is able to support, an increase in any side of the triangle will and should proportionately reduce the length of other sides (amount of other risks). Unless the organization wishes to increase its total risk by increasing the triangle’s perimeter, total risk thus remains constant and balanced.

The triangle on the left depicts a situation in which all major risk components are equal. The triangle on the right depicts a scenario in which there has been a significant increase in the organization’s strategic and operating risk. To keep its total risk profile constant, the organization has had to significantly decrease its capital structure risks.

Total risk for some hospitals, as they reposition themselves in the new environment, may very well exceed the organizations’ risk-bearing capacity. This imbalance may represent a short-term disequilibrium or a more permanent state driven by an intentional risk-assumption strategy. Regardless, during the period of imbalance, the organization is strategically vulnerable due to the resulting limits on its financial flexibility and, potentially, its inability to respond to realized risk or to provide financial support for its strategic needs.

An organization that is not achieving sufficiently strong financial performance to warrant the current level of its incurred risk is highly risk-leveraged and in a potentially precarious situation. As is the case with most any form of leverage, when things stay stable or go well, risk leverage is extremely accretive to success. But when things go wrong, the leverage accelerates deterioration, especially when different risks are paired.

Given this observation, risk management will be an incredibly important function in the new health care environment. It is a role that cannot be fragmented, as has been the
case frequently in the fee-for-service world. Risk management should rightly reside within finance and treasury so that all of the organization’s risk-bearing resources and risk exposures can be monitored and managed on a total portfolio basis.

Perhaps the most significant risk confronting organizations is that they will fail to build the right internal risk infrastructure. Leaders who see contracting risk as somehow separate or disconnected from interest rate or equity risk are opening their organizations to carrying an inappropriate level of comprehensive risk.

Further, these organizations will miss the opportunity to begin to understand the returns on risk that they incur in different activities across the organization. Does the assumption of contracting risk exceed the return potential of some type of change of interest-rate spread? Does the answer change when capital (or risk-bearing capacity) is allocated to different risk transactions? To answer these and other questions, it is clear that the ability to build and manage a well-diversified risk portfolio is a key leadership competency.

Executives and board members must have the information needed to understand their organizations’ comprehensive risk profile matched against a thorough assessment of the ability to handle that risk. The key to success becomes finding the balance point whereby the hospital or system is operating within the corridor of effective risk management (see Effective Risk Management this page).

**Going Forward**

The risks involved in implementing an organization’s strategies will be very high during the next decade. When and how to start managing population health and assuming performance-based risk contracts are important questions with critical implications to an organization’s total assumed risk.

A fact-based, corporate-finance approach to answering these questions is recommended. That involves quantifying the organization’s capital and risk position, determining its capital and risk constraint, identifying debt capacity, assessing the organization’s risk profile and hedging resources, and conducting sensitivity analyses around the magnitude of possible financial impact of defined risks, occurring singly and in combination. In short, the objective is to build a comprehensive catalogue of the organization’s risk-bearing capacity and how that capacity can be deployed best against the risks the organization can assume in pursuit of financial, strategic or operating returns.

Based on results of these analyses, the organization’s management team and board will be equipped to identify its current and projected ability to assume risk, including those related to risk contracts. If that ability is limited or nonexistent, strategies based on partnership arrangements may be needed and appropriate.

Relationships are changing rapidly. Value-driven contracts fundamentally will change how many hospitals and health systems conduct their business with physicians, other provider organizations and payers. Is your organization ready? T

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