



# Value-Based Contracting

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# Value-Based Contracting

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**Resources:** For more information related to value-based contracting, visit [www.hpoe.org](http://www.hpoe.org) and [www.kaufmanhall.com](http://www.kaufmanhall.com)

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## Table of Contents

EXECUTIVE SUMMARY	3
INTRODUCTION	4
FOUNDATIONAL REQUIREMENTS	5
Shared Goals and Incentives	5
Strong Leadership and Governance	5
The Unified Persistence of a Value Mindset	5
ASSESSMENT AND PREPARATION	6
Desired Future Position	7
Delivery Service Area and System Infrastructure, Resources, and Contract Scope	8
Types of Arrangements	9
Capacity to Carry Risk	11
Types of Risk	12
Strategy and Contracting Plan	13
Time Frame for Transitioning and How to “Mind the Gap”	15
FINANCIAL AND OPERATIONAL CONSIDERATIONS	16
Capital Requirements	16
Unit Costing and Tracking	17
Financial/Actuarial Assessment and Planning	18
Contracting Capabilities	19
Data Infrastructure and IT	19
EVALUATING A CONTRACT	20
Initial Questions	21
Responsibilities and Risk	21
Financial Impact	22
Credit Risk	24
IMPLEMENTATION SUCCESS FACTORS	24
Physician Engagement	24
Transparency and Accountability	25
Performance Measurement and Improvement	25
CONCLUSION	27
RESOURCES	28
ENDNOTES	29
ABOUT THE AUTHORS	31

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## Executive Summary

Health care is experiencing dramatic change as the nation's delivery system transitions to a value-based system from the fee-for-service approach that has been in place for the past half century. In the evolving business model, hospitals, health care systems, physician groups, and other health care providers<sup>1</sup> will take on more risk, and be responsible for delivering defined services to a specific population at a predetermined price and quality level. New care delivery networks and value-based arrangements are emerging in communities nationwide. While the pace of change varies in different communities, health care organizations must be proactive or risk being left behind.

The transformation in how providers deliver and are paid for services is, and will continue to be, challenging. The terms of value-based contracts are significantly different than the fee-for-service arrangements. *Value-Based Contracting* provides a primer for hospitals and health care systems as they begin the move to value-based contracting arrangements.

The guide commences with an examination of the foundational requirements for success with value-based arrangements: shared goals and incentives, strong leadership and governance, and a value mindset organization-wide. These factors ensure that organizations are able to learn how to operate in a value-based environment, and maintain strategic flexibility as markets and stakeholders change.

In assessing and preparing for value-based contracting, health care organizations must evaluate the feasibility of their desired position in the new delivery environment, and their preparedness to assume risk under value-based arrangements. Some vital questions hospitals and health care system leaders must ask of their organizations include: What is our desired service area and what infrastructure, resources, and contracting scope are required to meet the population health needs in that service area? What types of arrangements can we or should we participate in? How much risk and what types of risk can we carry? What is our plan for risk contracting and how do we develop this plan? How quickly should we move to value-based contracts and how do we "mind the gap" during the transition?

There are numerous financial and operational considerations for health care providers entering into value-based care. These include capital requirements, unit costing and tracking (which will drive the evaluation of performance under a value-based contract), financial/actuarial assessment and planning, and contracting capabilities (expertise and strength of contracting relationships). A strong data infrastructure and expertise also will be required in order for providers to meet quality targets and proactively, effectively, and efficiently manage the care of a specific patient population under a value-based contract.

Evaluating a specific value-based contract requires weighing the potential benefits and risks related to the organization's capabilities and resources, the financial impact, and credit risk. Three factors that are absolute "must haves" for successful implementation of value-based contracting are: physician engagement, transparency and accountability, and performance measurement and improvement.

The transition to the new care delivery model will vary by market, and likely will extend over a period of 10 years or more. As hospitals, health care systems, and other providers evaluate their changing roles, they must recognize that preparing for value-based contracts will require planning, new skills, and a new approach to health care delivery. Taking measured, incremental steps will increase the chances of success for organizations in the face of a shifting health care environment. At the same time, it is important not to wait too long. Participation is essential to realizing the goal of improving quality and efficiency through value-based arrangements, which ultimately will benefit providers, employers, payers, and patients alike.

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## Introduction

*Value-Based Contracting* provides guidance for hospitals and health care systems that are considering value-based contracting arrangements.

“Value” is generally understood to be defined as the result of quality divided by cost, or the health outcomes achieved per dollar spent.<sup>2</sup> Value-based contracting involves payment or reimbursement based on indicators of value, such as patient health outcomes, efficiency, and quality. This is distinct from volume or fee-for-service based contracting, which involves payment for every unit of service delivered, often without terms related to outcomes, quality, or cost performance.

In the emerging new care delivery model, under the terms of a value-based arrangement, hospitals, health care systems, physicians groups, and other health care providers will be responsible for delivering defined services to a specific population at a predetermined price and quality level. This development has significant strategic and financial implications for health care organizations, as described in this guide.

Managing a population’s health, or “population health management,” involves proactively identifying and assessing those at risk of developing disease, preemptively managing those with chronic disease, and implementing broad-based interventions in early stages of disease to avoid or reduce cost and improve health. This approach requires broadening the scope, environments, and capabilities in which health care organizations must operate in order to be a successful “population health manager.” It also involves developing the right strategies for specific population segments to maximize wellness and minimize illness.

The transformation in how hospitals, health care systems, and other health care providers deliver and are paid for services is, and will continue to be, challenging. The terms of value-based contracts are significantly different than the fee-for-service arrangements in place for the past half century in the United States.

Challenges notwithstanding, progressive health care leaders who understand the value imperative are moving their organizations forward, shifting their business from fee-for-service to performance-based risk arrangements. The anticipated benefits to all stakeholders—patients, health care providers, payers, employers, and the community—include alignment of compensation with quality and outcomes, improved administrative and care-delivery efficiencies, and better quality, outcomes, and access to care.

Value-based contracting will be critical to the ability of health care organizations to establish themselves as essential in their markets. The current level of their involvement in such contracting varies widely. But non-participation is no longer an option anywhere for health care organizations wishing to preserve clinical and financial integrity in their communities. Achieving the Triple Aim objectives of better health, improved care, and lower cost—as described by the Institute for Healthcare Improvement—is a national imperative.

By providing specific guidance related to assessment, and financial, operational, and implementation issues, this guide aims to speed the process for providers. While the primary audience is hospitals and health care systems, much of the information provided is applicable to other types of health care providers, such as physicians, physician groups, and nursing facilities. Its scope is introductory, purposefully focusing on readiness issues, while leaving specific implementation elements or legal issues (for which qualified legal advice should be sought) to other sources.

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## Foundational Requirements

For value-based contracting, a good starting place is foundational requirements. To be successful with the transition to value-based arrangements, hospitals and health care systems must have underpinning from three sources:

- Shared goals and incentives
- Strong leadership and governance
- The unified persistence of a value mindset

### Shared Goals and Incentives

Stakeholders participating in value-based contracting should share goals and incentives for effective health care payment and delivery. Sidebar 1 outlines one expert's definition of necessary goals. Although it may be difficult and take significant time to do, achieving these goals and establishing aligned incentive systems could remedy many of the problems and concerns about current payment systems.

### Strong Leadership and Governance

Strong executive, physician, and board leadership call for a unified vision and focus, as well as transparent accountability for the quality and efficiency of delivered care. Such leadership can:

- Clearly articulate the organization's strategy and direction
- Align physician and hospital goals and objectives
- Proactively guide the organization through the delivery and payment-model transformation
- Establish a shared culture with effective multidisciplinary teams

### The Unified Persistence of a Value Mindset

A value mindset recognizes the following:

- In risk arrangements, utilization creates expense, not revenue, and hospitals and health care systems become viewed as cost centers.
- Improving outcomes and costs under value-based contracts requires a different incentive system, as well as new management and reporting structures.

## Sidebar 1. Goals for Effective Value-Based Health Care Payment Systems

### Payment systems should:

1. Enable and encourage hospitals and health care systems to deliver accepted procedures of care to patients in a high-quality, efficient, and patient-centered manner.
2. Support and encourage hospitals and health care systems to invest, innovate, and take other actions that lead to improvements in efficiency, quality, and patient outcomes and/or reduced costs.
3. Make hospitals and health care systems responsible for quality and costs within their control, but not for quality or costs outside of their control.
4. Support and encourage coordination of care among multiple health care organizations, and discourage hospitals and health care systems from shifting costs to other organizations without explicit agreements to do so.
5. Encourage patient choices that improve adherence to recommended care processes and improve outcomes, thus reducing the costs of care.
6. Minimize the administrative costs for hospitals and health care systems in complying with payment system requirements.
7. Align different payers' standards and methods of payment to avoid unnecessary differences in incentives for hospitals and health care systems.

### Payment systems should not:

1. Encourage or reward overtreatment, use of unnecessarily expensive services, unnecessary hospitalization or readmission, provision of services with poor patient outcomes, inefficient service delivery, or choices about preference-sensitive services that are not compatible with patient desires.
2. Reward hospitals and health care systems for undertreatment of patients, or for the exclusion of patients with serious conditions or multiple risk factors.
3. Reward hospital and health care system errors or adverse events.
4. Reward short-term cost reductions at the expense of long-term cost reductions, or increase indirect costs (such as the cost of lost time from work or other activities by an individual while receiving health care services) in order to reduce direct costs (the spending by a hospital or health care system for immediate services).
5. Encourage hospitals and health care systems to reduce costs for one payer by increasing costs for other payers, unless the changes bring payments more in line with costs for both payers.

*Source: Miller, H.D.: Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. The Commonwealth Fund, Sept. 2007. Used with permission.*

**Sidebar 2. Moving Up the Risk Continuum: Challenges for Hospitals and Health Care Systems**

- Health care networks and distribution of care are fragmented, siloed, and inefficient.
- Clinical outcomes often are unmanaged; poorly performing health care providers are not held accountable.
- Compensation is not aligned with quality of care.
- The regulatory environment is not conducive to integrated delivery models.
- Facility infrastructure does not align with the new era of health care delivery.
- Many health care organizations have not been successful in past pursuit of risk; lessons learned should be applied to avoid repeat use of models proven unsustainable in the past.

Source: Kaufman, Hall & Associates, Inc.

- Hospitals, health care systems, physicians, and other health care providers must work collaboratively to develop new systems to track and manage the care of patients, particularly those with chronic illness.
- Health care organizations must operate as efficiently as possible in providing evidence-based services.
- Evidence-based services should be provided to all patients, regardless of the payer or payer agreements.

Health care organizations that learn how to operate in a value-based environment will gain critical experience that provides strategic flexibility over time as markets and stakeholders change. The process will be neither quick nor easy, so commitment to the long haul is vital. Initial investments in value-based care and risk contracts will be significant, and efficiencies will not be immediate. But it is far better to lead change than to await its impact.

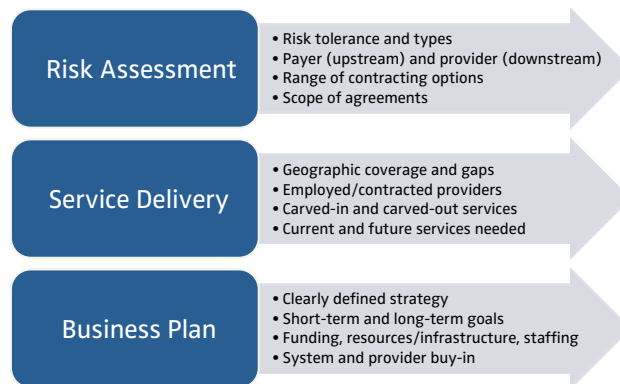
Moving up the risk continuum presents hospitals and health care systems with significant challenges related to changing the “sick care” model to a true “health care” model (see Sidebar 2). Organizational assessment and preparation, covered in the next section, facilitate the structural and behavioral changes needed for success as the “next generation” of payment arrangements emerge.

**Assessment and Preparation**

To assess and prepare for value-based contracts, hospitals and health care systems should conduct an iterative evaluation of risk and strategic financial performance. Factors organizations should consider in evaluating performance within the context of their desired position in the new delivery environment include the population covered, services to be offered, capabilities, existing delivery model, relationships of other providers in the community (i.e., non-acute or continuum-of-care providers), and alternative payment arrangements (as described later). The end result of this iterative process is a solid business plan that presents a clear strategy for value-based contracting and the key financial and operational considerations going forward (see Figure 1). Such considerations are covered in separate sections that follow.

In developing a contracting strategy and plan, hospitals and health care systems must have meaningful and collaborative dialogue with the desired payers. Overcoming past differences and working together will facilitate a win-win for both parties moving forward with a new contract.

**Figure 1. What Is Needed to Assess and Prepare**



Source: Kaufman, Hall and Associates, Inc.



Hospitals and health care systems can proactively develop a value-based contracting plan and start implementing this plan.

### Desired Future Position

To assess the organization’s ability to participate in value-based care delivery and build a viable plan, hospitals and health care systems should ask, “What role do we want to play in a care delivery network?” As risk contracting and providing care that is “accountable” across value dimensions increase nationwide, different categories of providers are emerging and likely will continue to emerge. The categories will reflect the health care organizations’ ability to incur risk in managing a population’s health, extending from no risk to the ability to assume full capitated, or “cap” risk.

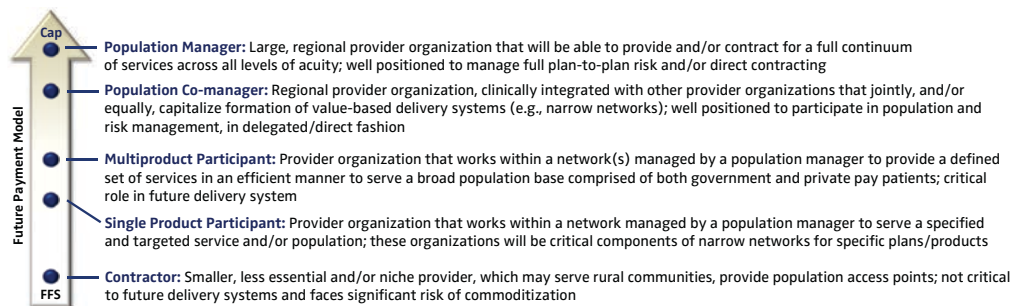
Some large health care systems will be functioning as regional “population health managers,” defined as organizations providing and/or contracting for a full continuum of services across all acuity levels for regional populations. At the other end of the spectrum, some hospitals—such as critical access hospitals, small and rural hospitals, and post-acute care facilities—will provide specified services to target populations under contract, working within networks that are managed by larger entities functioning as population health managers. Other roles in between will be assumed by other organizations as outlined in Figure 2.

The health care organization’s desired position within this framework must be firmly grounded on its strategic financial condition, and its organizational and leadership competencies. Only a small proportion of health care organizations today have the geographic reach, scope of services, scale, and risk-management expertise to truly manage the care of a large population. However, many providers—including large physician practices, hospitals and health care systems—are working aggressively to reposition themselves to do so through virtual affiliations or more formalized, integrated delivery structures.

Boards and management teams of every hospital and health care system need to determine which category of provider they are seeking to become under the value-based model. Success factors are different for each organization type, and resource issues are significant.

For example, health care providers working under contract (“contracted providers” or “contractors”) with another provider to deliver specified services will need high quality, predictable outcomes, low cost, and efficient information exchange with the contracting population health manager. Population health managers will need to offer an integrated delivery system, with health care providers accessible across the delivery continuum (from preventive services to hospice). This will require a sophisticated care management infrastructure, advanced information technology and analytics, network development and management expertise, and interface and connectivity to all stakeholders, as appropriate.

**Figure 2. Categories of Hospitals and Health Care Systems Under a Value-Based Model**



Source: Kaufman, Hall & Associates, Inc.



### Delivery Service Area and System Infrastructure, Resources, and Contract Scope

Hospital and health care system leaders must define the desired service area and assess whether they currently have, or can build or purchase, the delivery infrastructure required to participate in value-based contracts for the covered population. Critical considerations include identifying the target population, the services used, and services needed in the future. The question is, "Given our resources, which service area and how large a population do we believe we can effectively manage?"

Health care organizations must accurately assess their geographic coverage capabilities, defining the "right" population and the organization's ability to meet that population's health needs under a contracting arrangement (Figure 3). Contracting will differ by location and by the presence or absence of participating payers. Many different payers exist in most markets, with broad categories including: Medicare; Medicaid; county and other public programs; commercial insurers (operating nationally, regionally, or locally, and including Medicare Advantage programs); self-insured employers (often working through a third-party administrator); and self-pay individuals.

To participate in contracts in some regions, organizations will need considerable scale and geographic coverage with a range of care-continuum providers, either through ownership or partnerships. In other areas, more limited service delivery may be possible. Scale will be required to diversify risk in many areas of the country. Many small and mid-size organizations—including critical access or rural hospitals—may need to pursue risk-contracting strategies through strategic partnership arrangements with other organizations.

**Figure 3. Defining and Managing the Optimal Populations Are Key**



Source: Kaufman, Hall & Associates, Inc.

Additional questions to be answered include:

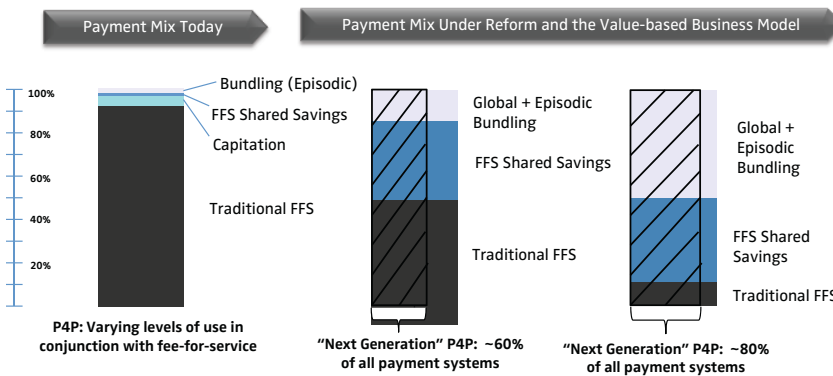
- How strong are our relationships with payers and employers? What defensible value proposition can we proactively bring to them in contracting arrangements?
- How strong are our relationships with primary care physicians, specialists, and other health care providers? Do we have a physician network with contractual arrangements that provide incentives to effectively and efficiently manage the care of a defined population?
- Do we need to employ or own the providers (for example, physician practices, home care) or can we contract or make partnership arrangements for their services?
- Which clinical services would we want included ("carved in") or excluded ("carved out") in contracts?
- How can the number of patients who seek out-of-network and out-of-area services be minimized, when allowed by state and federal regulations?

The strength of the organization's value proposition will hinge on the strength of the proposed primary care network and its geographic and service line coverage. It also will depend on whether the organization has the requisite infrastructure to allow for data sharing with patients, payers, and other providers (more on this later). Payers must be convinced that the organization's care delivery platform will lead to lower costs and better outcomes.

### Types of Arrangements

As payment transitions to a value-based system, a hybrid of payment mechanisms is emerging, incrementally shifting the mix from fee-for-service to value-based (Figure 4).

**Figure 4. Expected Shift in Payment Mix**



Note: Projections are "in the aggregate" and not market-specific  
 Sources: Payment system "mix" extrapolated from *Managed Care Digest Series*, *HMO-PPO Digest* (23rd edition) and review of for-profit, publicly traded managed care 2009 10Ks.

One size will not fit all. A wide range of value-based payment alternatives already are in operation nationwide and are expected to increase as payers, purchasers, hospitals, health care systems, and other types of providers gain experience.

Although payer initiative is more common, providers or employers may be the parties proposing the contracts. Some organizations and companies are establishing their own health plans, or entering into existing plans and assuming insurance risk. Contract opportunities are regional or localized in nature. Regional or national insurers are not and likely will not offer arrangements in all communities or to all providers.

National payers have begun to take a position that shared-risk arrangements are the only way to drive results. Such arrangements have upside potential, but they also have downside potential if performance doesn't meet expectations. In early-stage value-based arrangements, both upside gains and downside risks are usually "bracketed" to give reasonable protection to both sides. Risk-based contracting involves some expansion of potential downside financial risk for the cost of care, through bundling of payments, varying degrees of capitation, or full assumption of both administrative and clinical costs (e.g., a system-owned health plan).

Variations in possible payment arrangements abound, and organizations need to assess which types of contracts are appropriate. For example, a multi-provider bundling of payment for an episode of care might or might not extend beyond hospital discharge. A hospital or home health bundled payment would provide one fee for the combined inpatient and home health services for an episode of care, as well as related physician services. Organizations would need contracts with those providers and expertise in administering those contracts.

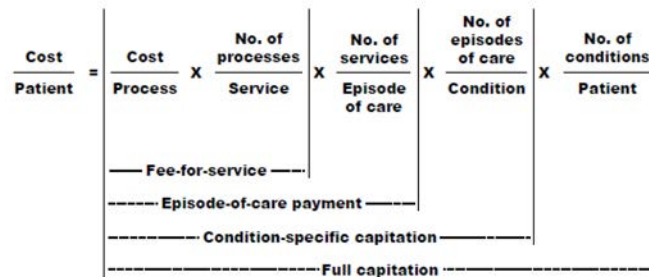
Under "health condition-specific capitation," one fee would be paid to cover all services rendered by all providers for a defined condition, either on a one-time basis for short-term conditions, or on a regular, periodic basis for longer-term conditions,

such as chronic diseases. In this case, the hospital or health care system should determine the scope of services that the organization can provide and with whom it will need to partner if pursuing a capitated contract.

As noted by one expert, “Any given provider may face significantly different incentives and disincentives for the care of patients with similar conditions, depending on which payer is paying for a patient’s care.”<sup>3</sup> Figure 5 shows the variables contributing to care cost and which of these variables the provider could be at risk for under alternative payment systems.

Each of the payment systems inherently creates incentives and disincentives for the provider and payer, with systems on the left side of Figure 5 having risks of higher costs for the payer and overtreatment of patients, while those on the right side shift the risks of costs to health care providers, thereby creating risks of undertreatment of patients, as described by Harold Miller.<sup>4</sup> Various contractual controls and incentives can be developed to counteract the risks, but the organization must be cognizant of its risk tolerance, as described later in this guide.

**Figure 5. Variables for Provider Risk Under Alternative Payment Systems**

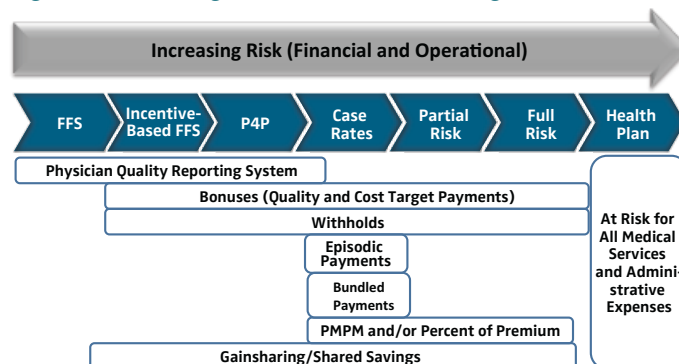


Source: Miller, H.D.: *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*. The Commonwealth Fund, Sept. 2007. Used with permission.

Risk-sharing arrangements may not be available in all regions, but most areas will have a variety of incentive options. It is possible to get into value-based contracting under the current fee-for-service model through pay-for-performance and other upside incentive-enhanced arrangements.

If sufficient time and payer willingness exist for an incremental transition, hospitals and health care systems can start with programs with upside risk only, or those heavily weighted to upside risk, and then move up the risk continuum as they gain experience and build infrastructure (see Figure 6). Sidebar 3 includes definitions of basic types of value-based arrangements.

**Figure 6. The Range of Value-Based Arrangements on the Risk Continuum**



Source: Kaufman, Hall & Associates, Inc.

### Capacity to Carry Risk

Leaders of health care organizations should assess the organizational tolerance for risk. In the value contracting context, risk is incurred through acceptance of a fixed dollar amount in exchange for the partial or total care of an identified patient population at a specified quality level, as defined through a contract. Risk represents the uncertainty about whether, after incurring the care-provision costs, the organization will have a net gain or net loss from this arrangement. Tolerance reflects the organization's capacity to "carry" the risk without endangering its strategic, operational, or financial performance, or a combination thereof, to an extent defined by the organization. Different organizations will have varying capacity and tolerance for risk.

Value-based models are designed to shift "performance risk" for care quality and costs to health care providers, who ultimately control the costs and quality of care, and away from insurers or payers, who have limited control over these factors. Insurers or payers traditionally assume "insurance risk," namely the risk that a patient will need services or a greater level of services than projected.

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.

Upside-only risk models may carry downside risk too if the agreed-upon fixed-payment amount (the base rate) is lower than the provider received or receives under other payment arrangements. Upside incentives will be paid if the provider meets or exceeds goals, as defined, but uncertainty exists related to whether the provider can accomplish this. If not, the result will be lower overall payments than experienced under other arrangements. Payments might come from a commercial or government payer, a self-insured employer, or another health care organization. If the latter, this organization would be accepting and managing risk as a partial or full-spectrum delivery network under population care arrangements with payers.

Research-based quantification of the amount of risk assumed by hospitals and health care systems at this point in time is lacking. But in early 2013, Moody's Investors Service introduced new indicators to capture the changing payment and care models.<sup>5</sup> One of the indicators asks organizations to report

### Sidebar 3. In-Brief Definitions: Types of Value-Based Arrangements

**Pay-for-performance**—Hospitals, health care systems, physicians, or other providers receive bonus payments or have a portion of their pay withheld based on whether they meet preset performance targets. Targets may relate to quality, cost effectiveness, efficiency of care, or other factors.

**Physician Quality Reporting System**—PQRS involves a Medicare payment bonus paid once a year based on previous time period completion and submission of PQRS initiative measures.

**Case rates (also known as episode-of-care payment or bundled payments)**—Under these arrangements, providers are paid a fixed amount for services required by a patient during an entire care episode. For example, a provider may be paid a set amount for all care associated with treating a stroke patient. Payments are based on the estimated costs of care associated with a specific condition and determined annually or within a set time frame, such as from the time a stroke patient is admitted to the hospital to when he or she is discharged, or 30 days after hospital discharge.

**Gainsharing**—Gainsharing is a management system or approach that promotes a higher level of performance through the involvement and participation of physicians or other providers. As performance improves, financial gains are shared. Improved performance yields greater compensation, in turn promoting continuous improvement through a reinforcing cycle.

**Shared savings**—Shared savings is a payment strategy that offers incentives for providers to reduce health care spending for a defined patient population by offering them a percentage of net savings realized as a result of their efforts.

**Capitation contracts**—Under capitation contracts, providers administer the contract and assume risk for contractually defined services. These contracts can be structured in many ways. Providers can receive a set amount per patient per month, or periodically receive a predetermined percentage of the premiums that patients pay to insurers. Providers are able to keep any savings if costs are below the capitated amounts, but are responsible for any cost overruns. Global capitation payments cover all patient services, while partial global capitation payments cover only a specified portion of services. The entity contracting with the payer must have downstream network contracts. Cost savings, after administrative fees, can be distributed per contract agreement.

Source: Kaufman, Hall & Associates, Inc.

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the percentage of net patient revenue that is “risk-based,” which will include the traditional forms of risk-based payment, such as per-member, per-month capitation, and emerging models, such as bundled payment and pay-for-performance. These data will help capture how quickly hospitals and health care systems whose debt is rated by Moody’s are moving into value-based arrangements.

### Types of Risk

Assessment of risk tolerance needs to be based on an understanding of how much and what type of risk the organization can and should incur. Four sources of risk are inherent in value-based contracting: strategic and operating; actuarial or insurance; financial/asset and liability; and comprehensive.

*Strategic and operating risk* involves the organization’s ability to successfully execute its contracting plan into the future. 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. The ability to generate sufficient capital and to effectively manage the allocation of risk will be critically important to all organizations participating in a care delivery network.

Risk related to potential care-continuum partners should be considered as part of strategic and operating risk. The contracting entity usually assumes risk for its network partners and out-of-area services. Robust data are needed prior to contracting to ensure that the amount paid will cover these services. Risk incurred by potential partners will impact the contracting provider. For example, hospitals and health care systems that contract with physicians or laboratories will assume their downside risk unless the arrangements involve subcapitation, with contracted physicians and labs also at risk.

*Actuarial or “insurance” risk* involves the organization’s ability to properly estimate use rates and costs for serving a defined population, and to mitigate risk of inaccurate projections through specific initiatives. Also important is the ability to meet capital reserve requirements for assuming risk, as described later in this guide. Only a limited number of organizations currently have the scale and resources to absorb this level of risk, so any organization considering taking on actuarial risk should seek expert advice.

*Financial/asset and liability risk* is incurred due to the significant capital that is required to build physician networks, enhance technology, develop care-management infrastructure, and maintain minimum cash reserves. All of these uses divert capital capacity from supporting the “traditional” business or funding other strategic initiatives. Health care organizations will be at risk for capital allocation decision-making that does not enhance long-term competitive or financial performance. This impact is capable of altering—perhaps profoundly—the organization’s financial risk profile.

Capital commitments to population health arrangements also restrict the organization’s flexibility with capital structure decision-making, i.e., asset and liability management. Because the health care 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 current credit rating or outlook, as provided by the rating agencies.

*Comprehensive risk* represents vertical risk, or how the component risks described here might combine in ways that create substantially more risk than the parts might suggest. Such total risk can undermine the health care organization’s strategies, market position, financial performance, and ultimately, its ability to serve its communities. If the three risks are not properly balanced, 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.



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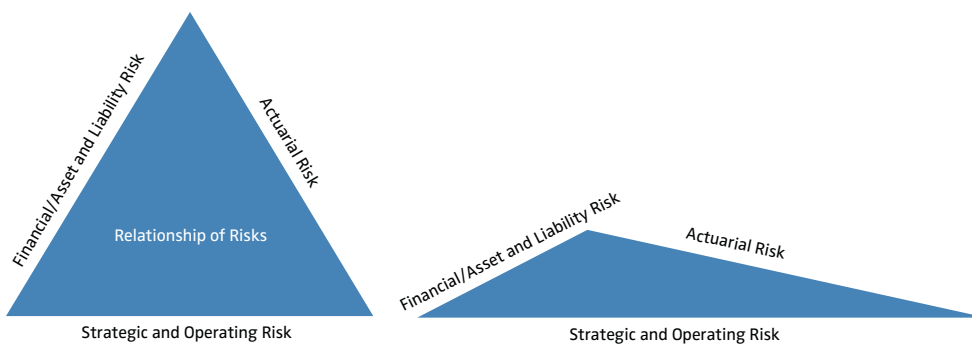
Health care executives and board members must understand how their organizations' single and comprehensive risk profiles are matched—or not—with the ability to handle that risk. The key to success becomes finding the balance point.<sup>6</sup>

Like the sides of a triangle, all risks are linked and interdependent. The total comprehensive risk that reasonably can be assumed by an organization 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 (single type of risk) will and should proportionately reduce the length of other sides. Unless the organization wishes to increase its total risk by increasing the triangle's perimeter, total risk thus remains constant and balanced.

The left triangle in Figure 7 depicts a situation in which all major risk components are equal. The right triangle depicts a scenario in which there has been a significant increase in the organization's strategic and operating risk. In this instance, to keep its total risk profile constant, the organization has had to significantly decrease its financial/asset and liability risks.

The risks involved in implementing a health care organization's strategies will be high during the next decade. When, with whom, and how to start managing population health and assuming performance-based risk contracts are important questions with critical implications to the total risk assumed by hospitals and health care systems. Top-down management of risk, with executive buy-in and commitment at all levels, is required.

**Figure 7. Comprehensive Risk: The Relationship of Risks**



Source: Kaufman, Hall & Associates, Inc.

### Strategy and Contracting Plan

A fact-based, corporate-finance approach is recommended for answering the questions in each of the previous sections. Answers to these questions will identify the feasibility of the organization's desired future state, and also identify strategies that might be needed to achieve it.

The corporate financing approach, well-documented in a number of publications,<sup>7</sup> involves the following steps:

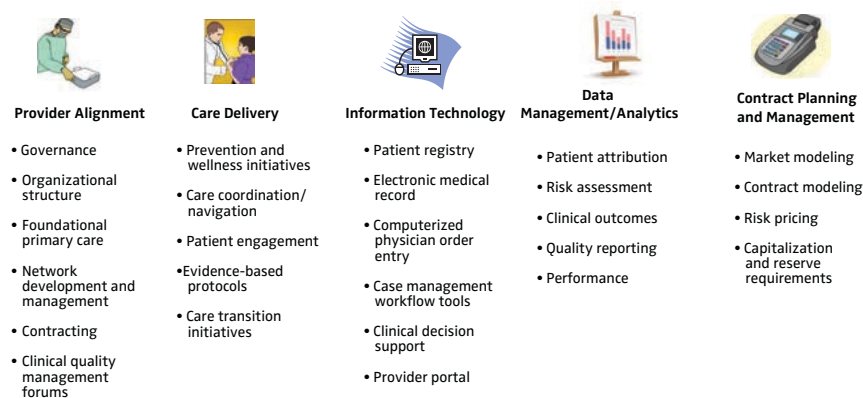
- Quantify the organization's capital position through an analyses of risk position, and sources and uses of capital, as described earlier.
- Determine its capital constraint (i.e., the net capital available for spending within a designated period of time) and risk constraint (i.e., the level of total risk the organization can carry, given organizational risk tolerance).
- Identify available debt capacity (i.e., the amount of debt an organization is capable of supporting within a particular desired credit profile).
- Assess the risk profile and available hedging resources, such as working capital and contingent payments.
- Conduct sensitivity analyses around the magnitude of possible financial impacts of defined risks, occurring singly and in combination.

In short, the objective is to build a comprehensive catalogue of the health care organization's risk-bearing capacity, and identify how that capacity can best be deployed against the array of risks the organization would assume by pursuing financial, strategic, or operating returns. These analyses will indicate the organization's ability to assume risk, including risk related to contracting arrangements. If that ability is limited, partnership arrangements may be needed and appropriate.

A health care organization's risk-contracting strategy should be a part of its comprehensive business plan. This provides the documentation and analysis necessary for valid capital decision-making related to risk contracting and the scope of feasible population health management.

Hospitals and health care systems need to be thoughtful and realistic about the skills and infrastructure needed to manage different types of payment arrangements under population health management. Figure 8 outlines critical elements of readiness for organizations assuming full risk as population health managers.

**Figure 8. Organizational Abilities Required for Population Health Management**



Source: Kaufman, Hall & Associates, Inc.

Relationships are changing rapidly. Value-driven contracts will fundamentally transform how many hospitals conduct their business with physicians, other health care organizations, and payers. Many health care organizations have no prior experience with risk-based contracting. External advisors can help ensure organizations consider all important factors in developing a plan, and evaluate their capabilities in a broader context of the regional and national markets. The assessment and planning process can take between two to six months, depending on the complexity of contracting arrangements in the specific region, and the organization assuming performance or risk-based agreements.

Hospitals' or other providers' entry into new agreements and how they position themselves on the risk contracting and population health management continuum depend on two key elements:

- What the hospital, health care system or other provider brings to the table in terms of current clinical capabilities, culture, IT infrastructure, and financial capability to understand and manage the future risk involved with a population's health management. This includes the degree to which the organization has a population health management or total continuum of care viewpoint rather than a singular viewpoint (i.e., hospital or ambulatory), and its fortitude to make quality of care and financial decisions independently of their impact on a singular network component.
- The payers present in the market, which will affect the speed of movement and the options available to hospitals, health care systems, and other providers. In some



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markets, risk contracting is limited. In other markets, payers are actively negotiating value-based arrangements that allow hospitals and health care systems to assume increased risk, and give them greater control or influence over benefit design and administration when they do so. This depends on specific state- or employer-defined benefit levels and scopes. When insurers offer risk contracts, the provider entering into the contract must administer the benefits per defined scopes in the state, or as defined by self-insured or fully insured employers (it cannot change the benefits).

Hospitals and health care systems that are contracting with a payer will want to ensure that, as they move to the right on the risk continuum, they are responsible for managing medical services risk, including claims payment, and referral management and authorization, but not premium collection or bad debt. This should remain under the insurer's purview until the hospital or health care system assumes full risk with a health plan of its own.

Health care organizations that currently have strong population health management capabilities and infrastructure will bring to the table a solid value proposition for contractual arrangements with payers and self-insured employers. Hospitals and health care systems that don't yet have the requirements outlined in the first bullet point above (and illustrated in Figure 8) can begin building these processes and infrastructure, and developing new collaborative partnerships with payers.

Hospitals and health care systems should explore all available options, whether that means developing the required capabilities alone, or seeking partners to achieve the goal of increased risk management, reward, and the delivery of higher-quality, cost-effective care.

Assuming risk will have other implications that will need to be explored. From a financial reporting perspective, assuming risk contracts will require changes to the way the organization recognizes revenue and accrues liabilities over time. The cash and financial impact of these accruals could significantly impact the organization's financial performance and should be incorporated into planning activities.

### **Time Frame for Transitioning and How to "Mind the Gap"**

The current macroeconomic environment, including federal and state budget pressures, presents significant challenges for hospitals and health care systems. Health care organization revenues will be under considerable pressure as payment mechanisms migrate toward value-based approaches. Use rates for inpatient and certain hospital outpatient services are declining already in many areas of the United States, and this trend is expected to continue.<sup>8</sup>

In this environment, a key issue in front of every hospital and health care system is how quickly to move to value-based arrangements. Current trends will reshape health care's business model from a volume- to a value-based one, with the transition extending over a period of 10 years or more. Hospitals and health care systems should understand the impact and start the move to value-based arrangements now, if they haven't already done so. Improving quality and efficiency through value-based arrangements is the right thing to do. As the market for health care services continues to shrink, continuing to compete on volumes and rate will be a riskier strategy than shifting to value-based arrangements.

The speed of the shift will vary by market. Variables affecting the rate of change include payers, employers, health care organizations, physicians, and other providers (and their degree of integration). The demographics, health needs, and other characteristics of the population also will have an impact. The transition in payment rates and structures to pursue value-based care will affect hospital and health care system performance, decreasing margins in the short term.

Robust, disciplined financial planning is required to quantify the health care organization's

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path to optimize performance as it transitions payment from volume to value. The foundation for best practice financial planning is the corporate finance-based approach outlined in the previous section. Components of this approach include analyses related to:

- Credit position
- Overall capital position that defines profitability targets to meet the organization's needs for long-term strategic positioning
- Capital requirements (both routine capital committed into the next 5 to 10 years, and capital required to accomplish strategic goals)
- Debt capacity
- Minimum cash position required given future reimbursement challenges, competitive threats, and capital demand

In all, these analyses will provide a comprehensive view of the organization's current capital position and the performance levels required to support its strategic requirements.

Based on these analyses, the hospital or health care system should develop baseline financial projections using assumptions related to volumes, reimbursement (Medicare, Medicaid, and commercial payers), salary expense, non-salary expense, capital spending, and investment income. From that base, scenario analyses are essential to quantify the effect on margin and liquidity of changing assumptions and new initiatives that represent key variables. These variables may include expense reduction efforts, increased physician alignment (to enhance primary care and/or specialist base), and restructuring of reimbursement arrangements from fee-for-service to value-based.

The resulting plan can be used to identify the strategic and financial implications of these key variables singly or in combination. As the health care organization moves forward with its new initiatives, the plan should be revisited regularly to measure success or lack thereof, adjust to changing market realities, and ensure that the organization maintains its desired level of financial performance.

## Financial and Operational Considerations

Financial and operational considerations should be inexorably linked. Each of the topics covered in this section is critical to achieving sustainable financial performance in value-based arrangements.

One operational consideration that should be addressed here first is that organizations seeking to develop their own health plans will need to be licensed and, possibly, accredited. Accreditation bodies include the National Committee for Quality Assurance, Accreditation Association for Ambulatory Health Care, and URAC (formerly known as the Utilization Review Accreditation Commission).

### Capital Requirements

Significant investment of capital—both financial and human—is required for entering into risk-based arrangements. As mentioned earlier, the health care organization's capital and financial performance is greatly affected by the cost of building physician networks, enhancing technology, developing care-management infrastructure, and maintaining cash reserves. Hospitals and health care systems must maintain enough capital to fund their strategic needs, while meeting operating costs and maintaining the liquidity required for financial performance targets.

Capital reserve requirements, which will vary by contract, include regulatory reserves and financial reserves.

- *Regulatory reserves* may be required by states or the federal government. Their size will depend on the specific health insurance contract and the level of risk involved.

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- *Financial reserves* offset an organization's future operating exposure to contract-based risk, such as higher-than-anticipated costs. These reserves generally need to be in place to meet the terms of the contract. Hospitals, health care systems, and other providers that make global contracting arrangements, for example, must meet minimum "statutory" capital requirements. These are defined as the organization's liquid assets that can be converted to cash quickly, thus ensuring sufficient capital to pay ongoing claims.<sup>9</sup> Payers that make partial risk arrangements with health care organizations also may require access to financial reserves, a line of credit, or both.

Organizations also may have debt covenants that require excess reserves and specific audit requirements to book those reserves. Reserves can significantly affect access to capital and its cost due to implications relative to debt covenants (e.g., liquidity requirements). If an organization's use of capital reserves diminishes its liquidity to the point of triggering debt covenants, its credit rating may be at risk. A lower credit rating increases the cost of capital for the organization going forward.

As part of statutory reporting requirements, organizations must be calculating, monitoring, and recording a new class of liability known as Incurred But Not Recognized (IBNR). IBNR exists under fixed or capitated payments and is a claim against the organization's payment streams when services have been provided but the contracting entity has not yet received the claims information.

State commissioners or departments of insurance also typically promulgate state statutory requirements. Many states require statutory reserves only if providers are taking on insurance risk, but providers still should maintain IBNR records. Depending upon the timing of the fixed payments to the health care organization, the organization's auditor may require reserves and accruals to recognize the fixed payments due to the organization.

The American Academy of Actuaries<sup>10</sup> and the National Association of Insurance Commissioners<sup>11</sup> publish reserve standards for health plans. Organizations should seek expert advice in this area as regulations and requirements are complex.

### **Unit Costing and Tracking**

Data on unit and case cost for all services for which the hospital or health care system will be at risk will drive the evaluation of the health care organization's performance under a value-based contract. The availability and accuracy of such data are of utmost importance. Tracking ensures that costs are managed, given quality and outcome targets.

Hospitals and health care systems must know their current cost of care, as well as the care costs of partners that will be sharing risk. A quick response to high-cost "outlier activity" will be required to meet expected financial targets. But hospitals and health care systems currently may not have their own cost data, as actual per-unit or per-case costs have not been tracked under the existing diagnosis-related group-based payment system. Additionally, hospitals and health care systems typically have had difficulty capturing and accessing data on outpatient costs.

Payers currently have the most complete cost picture. While this information traditionally has not been shared, the situation is changing for the better. As of June 2013, 16 states have established or are establishing all-payer claims databases, with the purpose of promoting the uniformity and availability of health care data.<sup>12</sup>

Many hospitals and health care systems will need to acquire more robust, cost-accounting systems that allocate costs—either directly or through a proven and established formula—to the products and services provided. This will require many decisions about what data to capture and how to capture them.

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#### Sidebar 4. Actuarial Considerations with Risk Contracting

##### Contractual payment model:

- Model types, such as global capitation, shared savings, and incentive plans
- Model considerations, such as period of time, benchmarks/targets, one- or two-sided risk, phase-in of payment model
- Enterprisewide management of contractual arrangements

##### Cost-measurement considerations:

- Define costs
- Define members, such as minimum enrollment and attribution logic
- Risk adjustment, including model choice, calibration to other contractual parameters, provider coding patterns

##### Savings calculation considerations:

- Where is the health care organization today? (Consider level of current medical management/care coordination, availability of comparative analytics, IT infrastructure, culture for change)
- Where does the health care organization want to go? (What changes are included in the plan? Has the organization set targets or goals?)
- How long will the health care organization take to get there? (What are the upfront costs? When will savings from the initiatives materialize? Will there be savings offsets?)

Source: Presentation by David A. Neiman, FSA, MAAA: *Actuarial Implications of Accountable Care Organizations & Patient-Centered Medical Homes*. Society of Actuaries, Oct. 2012. Used with permission.

Hospitals and health care systems will want to establish a baseline of cost and utilization data for the organization itself and any of its partnering providers participating in a risk contract. Developing financial scenarios for a risk contract and ongoing cost and volume tracking will be critical. For example, with bundled payment arrangements for episodes of care, different types of defined episodes will have different distributions of costs by service type. An American Hospital Association<sup>13</sup> publication notes that the 30-day fixed costs of a “major joint” episode (DRG 471) was comprised of initial hospital costs of approximately 51 percent, physician services of 12 percent, post-acute care of 32.6 percent, readmission-related expenses of 3 percent, and “other” costs of 1.5 percent. These data suggest possible savings opportunities through initiatives designed to reduce post-acute care for major joint replacement patients.

Organizations without accurate information about costs across the episode are “at risk of either overpricing the bundle, making it less attractive to purchasers, or underpricing the bundle, exposing the organization to financial risk,” according to the Healthcare Financial Management Association.<sup>14</sup>

##### Financial/Actuarial Assessment and Planning

Actuaries use mathematics, statistics, and financial theory to study the risk of uncertain future events, such as hurricanes or health care utilization. They evaluate the likelihood of those events, and design creative ways to reduce such likelihood and decrease the impact of adverse events that do occur.<sup>15</sup> Most actuaries work in the insurance industry and determine how much an insurer should charge for insurance, taking into account the specific region’s demographics, costs, utilization patterns and expectations, and other factors.

Although hospitals and health care systems have financial planning staff, they typically do not have actuaries on staff. Depending on their level of involvement in risk contracting, hospitals and health care systems may need to contract for these services or recruit the talent to complete the financial statements at the chief financial officer and audit level. Relevant actuarial issues for health care organizations considering risk contracts are numerous, including the number of patients covered by the contract, risk adjustment, cost, pricing, benefit design, the required upside and downside payment, and stop-loss insurance and reinsurance. All of these issues are interrelated, so they must be assessed together to ensure that the total cost of the services provided does not exceed the payment offered for those services.

For example, the risk inherent in providing care to a specific population depends on its size, with larger panels generally representing lower risk. But even large populations, such as Medicare beneficiaries and commercially insured patients, will have very different utilization patterns, representing significantly different risk to contracting organizations.

If contracting in a competitive market, payer pricing may be constrained, and richer benefits (which cost more to provide) may be necessary. A close look at the cost of each benefit—who will be providing it, the appropriate infrastructure, and the expected payment—is important. Every variable in the equation must be accounted for, as closely as possible. Pricing and payment must be competitive to enter and survive in a market.

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To mitigate risk, hospitals and health care systems should ensure that they do not enter full-risk arrangements until they have the capabilities to do so. Risk mitigation strategies include purchasing stop-loss insurance, which provides financial coverage for care delivery costs that exceed a maximum threshold amount, and incorporating maximum cost structures into contracts. Sidebar 4 outlines actuarial assessment and planning considerations.

### Contracting Capabilities

Organizations should consider two important issues related to contracting capabilities: contracting expertise and strength of relationships. The current know-how within many hospitals and health care systems for contracting under risk arrangements and administering contracts may not be sufficient. Health care organizations will most likely need new skills and capabilities due to both the overall complexity of contracts, and the critical nature of financial and operational considerations (see Sidebar 5).

On the front end, individuals negotiating risk contracts will need solid financial and analytic skills to know what constitutes the right contract and the right terms, and whether the organization has the resources and infrastructure in place to deliver on those terms. Analytic expertise exists across health care, but an executive of a major health care system notes, “It’s hiding in silos,” including payer organizations, care-management organizations, traditional hospital-system organizations, and physician enterprises.<sup>16</sup> To be successful, hospitals and health care systems will need to obtain contracting expertise from other areas. Employment or advisory arrangements may be appropriate.

Individuals with leadership, analytic, and performance-management expertise will be needed for “governance” of contractual arrangements. Such governance includes high-quality program management and administration, which are achieved through a clear delineation of roles and responsibilities across all stakeholders. Program governance answers questions about who will provide which services and the specific targets under which each hospital or health care system will operate. During the life of a contract, the contract must be managed proactively, with routine tracking of progress related to benchmarks and targets, and developing and implementing course corrections as necessary.

Governance also includes strong “upstream” relationships with payers and “downstream” relationships with physicians and other providers covered under the contract or subcontracting arrangements. The quality of these relationships will largely determine contracting capabilities. If relationships are weak, the health care organization’s leaders should figure out why and what they can do to remedy the situation. Relationships will need to be collaborative under the value-based model.

### Data Infrastructure and IT

Data sharing between payer and provider is essential to tracking organizational performance of key measures under value-based contracts. Multiple types of data will be needed, including claims data, transactional information, and data available through the electronic medical record system.

Payers have robust actuarial, benefit, and contract departments, as well as the ability to provide claims data independent of where the patient receives care. But payers’ use of multiple processes and systems to validate, route, and report on their transaction activity still can result in “a spaghetti-like environment that is plagued with inconsistent

### Sidebar 5. Skills Required for Risk Contracting

- Actuarial expertise/insurance risk management
- Networking and contracting strategies
- Predictive modeling
- Aggregation and analysis of claims and EHR data for population-level intelligence
- Advanced data management capabilities
- Physician-level reward systems
- Operation of analytic software for performance measurement
- Analysis of disease registries for practice variation reduction opportunities

Sources: Mechanic, R., and Zinner, D.E.: “Many Large Medical Groups Will Need to Acquire New Skills and Tools to be Ready for Payment Reform.” *Health Affairs* 31(9): 1984-1992, Sept. 2012; Morrissey, J.: “Data Driven.” *Hospitals & Health Networks*, Feb. 2013.

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processing and fragmented visibility into transaction activity.”<sup>17</sup> More insurance companies share data now, and technology capabilities to enable that sharing are improving rapidly.

Hospitals and physician practices historically have had access only to data on their own patients, with no broader view of what is happening in their communities. But the ability to proactively manage the care of a specific patient population requires a much more expansive level of data. All risk-based contracts secured by hospitals and health care systems should grant access to data from payers and other health care providers on the populations to be served. Ready access to timely data from all care providers and payers helps providers to measure and track performance, and to frame their clinical programs and protocols. Data sources include inpatient and outpatient claims, medical records, pharmacy, and lab and test results.

Moreover, to effectively and efficiently manage the care of a patient population, hospitals and health care systems must have sophisticated analytics, informatics, and predictive modeling capabilities related to overall population health and high-risk subsets. Modeling enables organizations to more accurately identify and target specific populations for health-related interventions. Health care organizations can initiate pilot programs, track results, and revise programs, as needed.

Additionally, with drill-down analytics by clinician, location, and date, health care organizations can quickly respond to any variance below targeted performance standards. Real-time data that are patient-centric and available at the point of care facilitate quick remedies to non-optimal performance.

Health care organizations that subcontract with other providers must routinely share data and analyses with partnering entities to ensure transparency in measuring subcontractor performance. Reports generated by the entity's IT system and related to specific performance metrics should be submitted on a regular basis to the leadership team and other appropriate internal departments or program supervisors.

Many hospitals and health care systems are finding ways to collect and use more data to manage population health risk. For example, Advocate Health Care in Illinois is developing data-driven predictive models to enhance patient care across the care continuum. The health care system is partnering with an IT vendor to build a cloud-based platform that will integrate all of Advocate's data silos, including claims, and inpatient, outpatient, and home care EMR-based information.<sup>18</sup>

“We're aligning all data so that the index of analysis is not the episode of care but the patient and his or her entire longitudinal history,” notes Advocate's vice president of clinical transformation.<sup>19</sup> The goal is to use advanced analytics and models to predict when a patient is likely to develop a complication, or be admitted or readmitted. Advocate then aims to embed tools in the organization's workflow at the point of care so that information is actionable and improves care delivery.

Other data infrastructure and IT considerations include billing and coding capabilities. Billing and coding capabilities must be robust, with systemwide consistency and timeliness. New contracts may bring new coding requirements, with payers or providers at risk if the coding is done incorrectly, so education in proper coding techniques may be needed.

## Evaluating a Contract

Big-picture evaluation of value-based contracts involves identifying and weighing the potential pros and cons based on the health care organization's current capabilities and resources. This is true whether the organization is evaluating a contract proposed by a payer, or developing contractual elements to propose to a payer or employer. Potential benefits should include: effective population health management through coordination of care, with improved care quality at the lowest-possible cost; a bottom-line impact that is



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sustainable into the future; facilitation of a closer partnership with physicians in the community; lower administrative and operating expenses; and a model to use for contractual arrangements with other payers.

### Initial Questions

To evaluate a specific contract, initial questions to answer include:

- What population will be covered by this contract?
  - If an existing contract covers this population, what level of profitability does it achieve?
- What infrastructure elements are required for successful management of this population (primary care and specialty physicians, allied health professionals, facilities, staff, technology support, and more)? Clarifying questions that can help in this evaluation include:
  - What are the inpatient and outpatient utilization patterns for this population?
  - What employer groups are included in the enrolled population?
  - What is the population’s expected distribution by age and sex? (key to usage rates)
  - What has been the historical growth of the proposed population? (slow growth rates offer more predictability, which helps to reduce risk)
  - What other demographic factors should be considered? (e.g., income, ethnicity, crime rates)
- What utilization do we project for this population going forward under our management?
- What expenses do we project for this population going forward under our management?
- Will accepting this contract in any way interfere with the organization’s ability to work with other providers, payers, and employers in the market?

### Responsibilities and Risk

Under value-based contracts, hospitals, health care systems, and other providers typically will receive a set sum from the payer, and then they distribute that money to partnering or participating providers both inside and outside the organization. This arrangement requires a clear delineation of services covered under the agreements and of entities responsible for risk for each service. Distribution methodologies should be outlined in advance for agreements with the payer and partnering providers.

Sidebar 6 provides principles to guide the equitable and effective distribution of risk among collaborating organizations during this process.

With sound payment methodologies, hospital or health care system payments from payers are aligned with partnering providers, meaning that each benefit financially as they achieve common value-based goals. The parameters, terms, and conditions of the contract should be flexible and negotiable.

The Integrated Healthcare Association, a California-based nonprofit representing health plans, physician groups, and hospitals, developed a coded version of the Division of Financial Responsibility framework. The DOFR defines which party is financially responsible for services rendered, and is used as a reference document to support contract administration and claims payment. The DOFR gives providers and payers a starting point for negotiating capitated payment arrangements with Medicaid managed care plans,

### Sidebar 6. Three Guiding Principles of Risk Distribution

- Establish a structure that rewards providers who are successful in efficiently managing the provision of quality care; incentivize cost-efficient and high-quality care across all collaborating health care organizations.
- Distribute risk equitably and transparently across participating health care organizations, to the extent possible.
- Although payment methodologies often have multiple structures, as much as possible, ensure that payments to physicians and other collaborating health care organizations are consistent with the overall payment structure of the contract.

*Source: Kaufman, Hall & Associates, Inc.*



commercial Health Maintenance Organizations/Point-of-Service plans and Medicare Advantage populations. It offers a standard set of service categories with associated codes to help “manage” any redefinition of the DOFR, commonly called “DOFR creep.”

The initial assessment of organizational capabilities should guide the hospital or health care system to potential services and the assumption of risk related to them. The scope of risk contracts can include:

- Primary care services only
- All professional services
- All organizational services
- Both professional and organizational services (global or full risk)

Items commonly negotiated in risk contracts include how to handle out-of-area care and high-cost, high-risk items, such as transplants, which may be “carved in” or “carved out” according to different arrangements between contracting entities.

The proposed payment arrangements with both the payer and partnering providers must be sound. Financial expertise is required to determine soundness, by taking a full look at the level of risk involved given the elements outlined in Sidebar 4. Individuals with financial expertise will advise on whether stop-loss, risk limits, and “risk corridors” might be needed to protect the organization’s financial position.

### Financial Impact

Evaluating the bottom-line impact of any individual contract is an iterative process that starts by calculating the percentage of the health care organization’s inpatient and outpatient revenues associated with the proposed contract by service line. This is based on identification of the services included in the agreement. Revenue calculations vary by type of contract, with “new math” involved with each.

For *shared savings contracts with upside only* arrangements, hospitals and health care systems are incentivized to decrease service units while meeting quality requirements. Revenues include a “savings” payment for efficiencies and the agreed-upon price multiplied by the service units provided. Savings depend on the providers’ ability to control volume and mix. To achieve a net gain, providers must lower variable expenses and service units, and the share of savings generated must offset the lower revenues from the decreased number of service units.



For *shared savings contracts with upside and downside* arrangements, which introduce risk, providers again are incentivized to decrease service units while meeting quality requirements. Revenues include a savings payment for efficiencies, or a deduction for a lack thereof, and the agreed-upon price multiplied by the service units provided. Savings or losses depend on the providers’ ability to control volume and mix. To achieve a net gain, providers must lower variable expenses and service units, and the share of savings generated must offset the lower revenues from the decreased number of service units. Providers unable to lower the cost of providing care will experience loss of revenue.



For *capitation contracts*, providers receive fixed revenues on a per-member, per-month basis to pay all costs of providing specified care. Higher utilization by the covered population results in lower profits and higher losses. To achieve a gain, providers must keep expenses and utilization at the targeted levels.



*Scenario modeling* is essential to evaluate how a contract would work under various operating assumptions or various levels of risk. Many health care organizations can start the modeling by comparing current contracts to proposed shared-savings or risk-based contracts, adding scenarios to evaluate the financial results, as required. Sidebar 7 provides an example of scenario modeling for a hospital considering a full capitation contract.

### Sidebar 7. Scenario Modeling Example

A hospital evaluated a capitated contract for inpatient and outpatient facility services for a large Medicaid population in its primary and secondary service area. The following options were compared to continuing with the current fee-for-service contract under a rate reduction:

- A. Assuming capitated risk for outpatient services only
- B. Assuming full capitated risk for inpatient and outpatient services for a small member pool
- C. Assuming full capitated risk for inpatient and outpatient services for the proposed larger patient population

Scenario modeling was conducted, using a number of variables related to operating assumptions, including enrollment growth, expenses, and capital funding for inpatient and outpatient facilities. Also included were adjustments to utilization patterns and cost structure, contract and risk assumptions (such as downside limits), and projected annual revenue funding and expenses for the risk pools.

Figure 9 presents the overall results for the “best” contract scenario. This was identified as Scenario A, taking full risk for outpatient facility services only. The “worst” contract arrangement is Scenario B, assuming full risk for a small member pool. The projected potential losses under Scenarios B and C are significant, so key lessons learned from the modeling are:

- Incorporate as many internal and external data in the analyses as possible
- Make the decision to move forward, or not, based on a detailed financial analysis

**Figure 9. Sample Financial Scenario Analysis Results**

	Current Fiscal Year	Projected Year 1		
		Scenario A	Scenario B	Scenario C
TOTAL – I/P and O/P Expenses - PMPM	\$88.36	\$26.61	\$79.52	\$79.52
TOTAL – I/P and O/P Risk Expenses	\$53,018,029	\$18,623,912	\$57,651,653	\$57,651,653
TOTAL RISK POOL SURPLUS / (LOSS)	\$(7,518,029)	\$1,376,088	\$(7,051,653)	\$(7,051,653)
TOTAL RISK POOL SURPLUS / (LOSS) PMPM	\$(12.53)	\$1.97	\$(9.73)	\$(9.73)
Full Risk Pool Margin	\$(16.5%)	6.9%	(13.9%)	(13.9%)
Profit/(Loss) Summary – Full Risk		\$(13,092,087)	\$(21,519,828)	\$(21,519,828)
Profit/(Loss) Summary – Fee-for-Service	\$(10,404,774)	\$(14,468,174)	\$(14,468,174)	\$(14,468,174)
Variance		\$1,376,088	\$(7,051,653)	\$(7,051,653)
Downside Risk Projection Provisions				
Risk Pool Up/Downside Split (Health Plan / Primary Hospital)		\$688,044	\$(7,051,653)	\$(3,525,827)
Risk Pool – Downside Limit Threshold – Only if Negative		\$-	\$(5,060,000)	\$(2,530,000)
Profit / (Loss) – Full Risk		\$(13,780,130)	\$(19,528,174)	\$(16,998,174)
Variance		\$688,044	\$(5,060,000)	\$(2,530,000)



Source: Kaufman, Hall & Associates, Inc.

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### Credit Risk

Based on such modeling, health care organizations should assess how the expected financial performance of a contract affects the organization's current credit rating. Maintaining a solid credit rating is critical as it ensures the organization's ability to access affordable capital in the debt markets.

Doing so requires a close look at the balance sheet, including operating margins, and days-cash-on-hand and cash-to-debt ratios. Because payment arrangements are expected to put continuing pressure on hospital and health care system balance sheets, Moody's Investors Service is beginning to closely examine how hospitals and health care systems are reimbursed and how payer mix is changing. For example, the agency now is asking for data on reimbursement methods, including traditional capitation, DRG, percent of charges, fee schedule, per diem, and risk-based or other.<sup>20</sup>

Moving incrementally toward managing risk is recommended, and gainsharing options can be a good way to start improvement efforts. But at the same time, the proportion of revenue affected has to be enough to motivate behavior change. Stephen M. Shortell, PhD, MPH, dean of the University of California, Berkeley, School of Public Health, observes: "When 30 percent of your business is in a non-fee-for-service model, your structure starts to change."<sup>21</sup> This change will vary by organization and area of the country, but significant progress is still needed in moving toward value-based arrangements.

### Implementation Success Factors

Three factors are absolute "musts" for implementation success with value-based contracting:

- Physician engagement
- Transparency and accountability
- Performance measurement and improvement

#### Physician Engagement

Fully engaging physicians by offering alternatives that align their clinical and financial interests with those of the hospital or health care system is required for success with value-based contracts.

Most hospitals and health care systems will need to support a pluralistic integration or alignment model that addresses the different interests of physician groups. Not all physicians will want to be employed, and most hospitals and health care systems likely will not have the capital to employ all the physicians they need. Options available for engaging physicians who wish to remain independent include offering support for business systems, management, or IT. Examples of contracting options are joint ventures, physician-hospital organizations, and management service organizations.

Depending on the population to be covered under an agreement, many hospitals and health care systems are likely to need to invest in primary care practices, midlevel providers, and IT support for such providers. This investment will enable the practices to become patient-centered medical homes or similar models, as care delivery shifts in emphasis from inpatient care to primary care.

Physician leadership in redesigning the delivery system to meet value objectives will be critical. Most health care organizations today don't have a high proportion of physicians in executive leadership roles or in key positions on board committees. This will have to change. Creating a leadership structure that is responsible for coordinating the many affiliated independent physician practices is recommended.

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### Transparency and Accountability

Transparency and accountability are essential components of any contracting arrangement. The goal should be to align financial interests of contracting parties with quality, efficiency, and other performance targets.

Transparency in engaging physicians under contracting arrangements can make or break efforts to secure their participation. As noted by the American Medical Association in contracting guidance to physicians,<sup>22</sup> physicians need to be given complete, accurate, and transparent information concerning all important contract items, such as the assigning of responsibilities and timing of payments.

A well-defined process for clearly delineating and communicating responsibilities keeps all stakeholders accountable. Organizations should communicate with participating providers about what information they are collecting and when and how they will report that information back to stakeholders. Participating providers must know how they are performing and where to make improvements to meet performance targets and incentivized goals.

Spurred by consumers who want information on their smart phones 24/7/365, health care pricing and quality data are moving to transparency with lightning speed. Resources like the Joint Commission's Quality Check website,<sup>23</sup> Medicare's "Hospital Compare" website,<sup>24</sup> The LeapFrog Group,<sup>25</sup> and the Dartmouth Atlas of Health Care,<sup>26</sup> as well as tools developed by payers and employers, enable consumers to do organization-specific searches that aid their decision making about health care providers.

### Performance Measurement and Improvement

Value is measured through a combination of quality, cost efficiency, and patient satisfaction indicators. To achieve sustainable performance improvement with value-based care under new payment arrangements, hospitals and health care systems will be required to measure, report, and improve care processes. To determine whether performance has improved across Triple Aim dimensions, health care stakeholders nationwide are wrestling with the questions:

- How do we measure value?
- What measures of value should be linked to payment and other contractual incentives to improve population health, experience of care, and costs?

So far, the array of answers is confounding. Payers are using different measures, even with a particular patient population or contract type, such as bundled payment.

Multiple entities disseminate measures. Commonly used indicators include Medicare quality measures,<sup>27</sup> Healthcare Effectiveness Data and Information Set (HEDIS) measures from the National Committee for Quality Assurance, and National Quality Forum measures.<sup>28</sup> NQF has endorsed approximately 700 measures that are included in its Quality Positioning System database.<sup>29</sup>

As health care delivery moves toward a value-based approach, hospitals will need to provide data on numerous care measures to federal and state agencies, private payers, and a variety of accrediting bodies. Sidebar 8 provides the American Hospital Association's guidance related to measures.

### Sidebar 8. Selection and Use of Measures with Value-Based Contracts

It is important that the measures selected for reporting programs and value-based contracting meet rigorous standards. The National Quality Forum is a consensus standards organization for health care that convenes multistakeholder committees to review measures, and decide whether those measures are suitable for endorsement. NQF's endorsement criteria are intended to determine whether measures are important, feasible to collect, usable for improvement, and reliably generate accurate performance results.

The American Hospital Association, in general, believes that measures selected for public reporting programs, and for value-based contracts, should be NQF endorsed. However, it is important that such measures are applied in a manner consistent with how the measures are specified and tested. For example, a measure specified for use in nursing homes may not be well-suited for a hospital value-based contract and program. Similarly, if a measure is specified for use with an all-payer data source, it may not generate accurate performance scores with Medicare-only data.

*Source: The American Hospital Association*

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The state of performance measurement and its role in moving payment from volume to value are of interest to numerous policy experts. Robert Berenson, MD, of the Urban Institute, cites the following challenges:<sup>30</sup>

- Current measurement approaches must rely on existing data sources, which for the most part have been administrative claims rather than true clinical information.
- Major gaps exist in the current clinical measurement sets; few measures address accuracy of diagnosis, surgical success rates, appropriateness of diagnostic and procedural interventions, or skill in managing patients with complex care needs.
- Most of the focus has been on the quality numerator; there is controversy about whether costs (the denominator) can be accurately measured and how to incorporate cost assessment into any value index.
- Current value-based payment with pay-for-reporting and pay-for-performance initiatives do not recognize that value can be improved not only by enhancing how well particular services are provided, but also by improving the kind and mix of services that beneficiaries are receiving.

Advancing performance measurement, and assisting providers and payers in selecting and implementing effective measures, must be national priorities. A report from the RAND Corporation,<sup>31</sup> which was based on the review of 90 different payment models, indicates that the following measures are key to value-based reform:

- Outcome measures
- Care coordination measures
- Patient engagement measures
- Organizational capability measures
- Composite measures
- Efficiency measures
- Disparity measures

The Institute for Healthcare Improvement's *A Guide to Measuring the Triple Aim* provides a menu of suggested measures for the Triple Aim dimensions and outlines key measurement principles including:<sup>32</sup>

- The need for a defined population (as the denominator of population health)
- The need for data over time, which distinguishes between common cause variation (always present and inherent in all processes) and special cause variation (intermittently present, arising from causes that are not part of the system, as designed)<sup>33</sup>
- The need to distinguish between outcome and process measures, and between population and project measures
- The value of benchmark or comparison data

Identifying the right measures and then linking them to the right payment involve difficult processes, such as attributing a patient's health outcomes to a specific provider and adjusting risk to account for patient populations with different risk factors, demographics, and health conditions.<sup>34</sup> According to Miller, "Since different payment systems create different kinds of incentives and disincentives, no single set of quality measures and payment adjustments will be appropriate for all payment (systems)."<sup>35</sup>

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The measures used and the extent of their use will vary depending on the contract. Hospitals and health care systems must have knowledge of and confidence in their ability to meet the required standards of selected measures. In negotiating contracts, providers should remember that measures often are negotiable and should be regularly reviewed and updated. Detailed analyses of which measures should be linked to what type of payment, and to what extent incentives and disincentives should be put in place, are beyond this publication's scope but are important issues for hospitals and health care systems.

## **Conclusion**

Health care delivery is experiencing dramatic change. Roles and lines for hospitals and health care systems, payers, employers, and other stakeholders are blurring. Every stakeholder is or will be affected. Payers and providers will learn to work together in developing and implementing value-based contracts. If they are not proactive, providers may be forced into an unfavorable contract, or be excluded from the narrow and tiered networks that are being formed nationwide. Inaction is not an option.

Preparing for value-based contracts will require planning, new skills, and a new approach to health care delivery. Without a true partnership between hospitals and health care systems, physicians, other providers, and payers, the likelihood of long-term success with risk contracts will be limited. Achieving the right timing in the volume-to-value transition will involve a delicate but critical balancing act. Strong health care leaders with a value mindset will help their organizations make a successful transformation.

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## Resources

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## Endnotes

- <sup>1</sup> The terms “providers” or “other providers” include a variety of health care organizations and professionals, such as acute, non-acute, and specialty facilities, physicians, physician groups, independent physician associations (IPAs), physician-hospital organizations (PHOs), and other entities.
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- <sup>12</sup> All-Payer Claims Database Council at [www.apcdouncil.org](http://www.apcdouncil.org)
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- <sup>16</sup> Stephen Moore, M.D., as quoted in Morrissey, J.: “Data Driven.” *Hospitals & Health Networks*, Feb. 2013.
- <sup>17</sup> Edifecs: *Modernizing IT for the Next Era of Healthcare*. Seattle, WA: Edifecs, 2012. [www.edifecs.com](http://www.edifecs.com)
- <sup>18</sup> Cerner press release, “Cerner and Advocate Health Care Take Bold Steps to Improve Patient Health Outcomes and Safety,” April 18, 2012. [www.cerner.com/about\\_cerner/newsroom/cerner\\_advocate\\_health\\_care\\_take\\_bold\\_steps\\_to\\_improve\\_patient\\_health\\_outcomes/](http://www.cerner.com/about_cerner/newsroom/cerner_advocate_health_care_take_bold_steps_to_improve_patient_health_outcomes/)

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- <sup>19</sup> Private interview with Rishi Sikka, M.D., May 29, 2012.
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- <sup>25</sup> The Leapfrog Group hospital comparison tool: [www.leapfroggroup.org/cp](http://www.leapfroggroup.org/cp)
- <sup>26</sup> The Dartmouth Atlas of Health Care: [www.dartmouthatlas.org/](http://www.dartmouthatlas.org/)
- <sup>27</sup> Centers for Medicare and Medicaid Measures Inventory: [www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html)
- <sup>28</sup> HEDIS 2013 Measures: [www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013.aspx](http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013.aspx)
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## **About Kaufman, Hall & Associates, Inc.**

Founded in 1985, Kaufman, Hall & Associates, Inc. is an independent management consulting firm, providing services and software to hospitals, health care systems, and other health care organizations nationwide.

The firm provides strategic advisory services; physician advisory services; financial advisory services to debt transactions; strategic, financial and capital planning services; capital allocation design and implementation services; and merger, acquisition, joint venture, real estate and divestiture advisory services.

In addition, Kaufman Hall developed and markets the ENUFF Software Suite® of strategic and financial management products. Kaufman Hall serves its clients from offices in Chicago, Atlanta, Boston, Los Angeles, and New York. For more information, visit [kaufmanhall.com](http://kaufmanhall.com).

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