ECG MANAGEMENT CONSULTANTS

Risk Share Development and Valuation

ECG Provider Financial Services Division

September 17, 2018

Discussion Objective

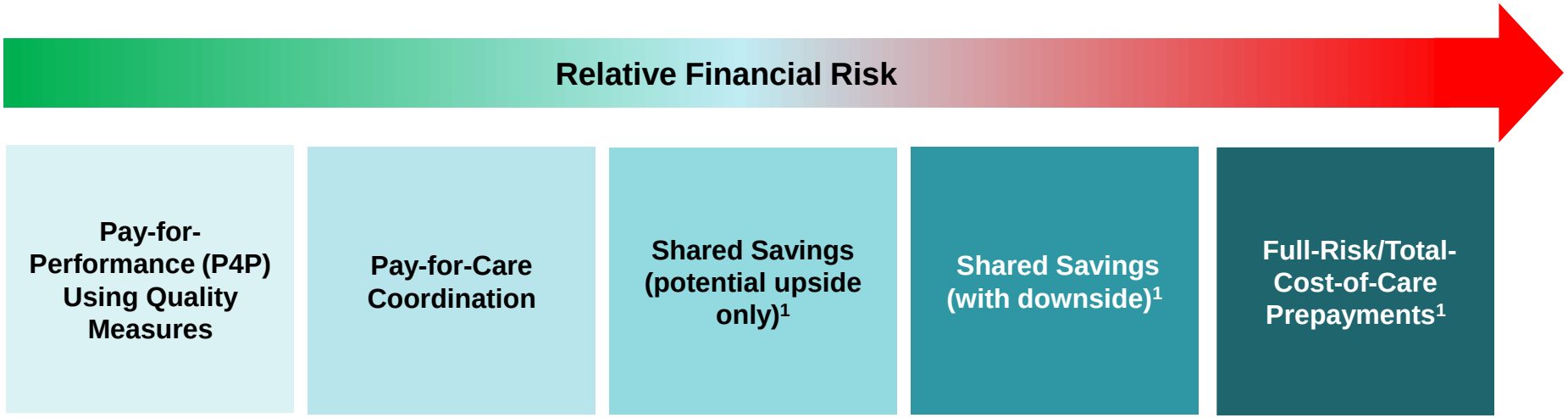
Be Prepared

Despite the high prevalence of managed care value-based and risk contracts, many of our colleagues are not prepared to manage the financial, performance, and regulatory risk associated with these models.

The objective of today's discussion is to highlight some of the best practices associated with risk contract performance and share strategies for evaluating/ appraising these arrangements.

Risk-Sharing Arrangements

There is a broad spectrum of risk-sharing arrangements in the market. For simplicity, they can be categorized as follows:



[1] Bundled payments could fall under this model, depending on the level of financial risk assumed by the provider.

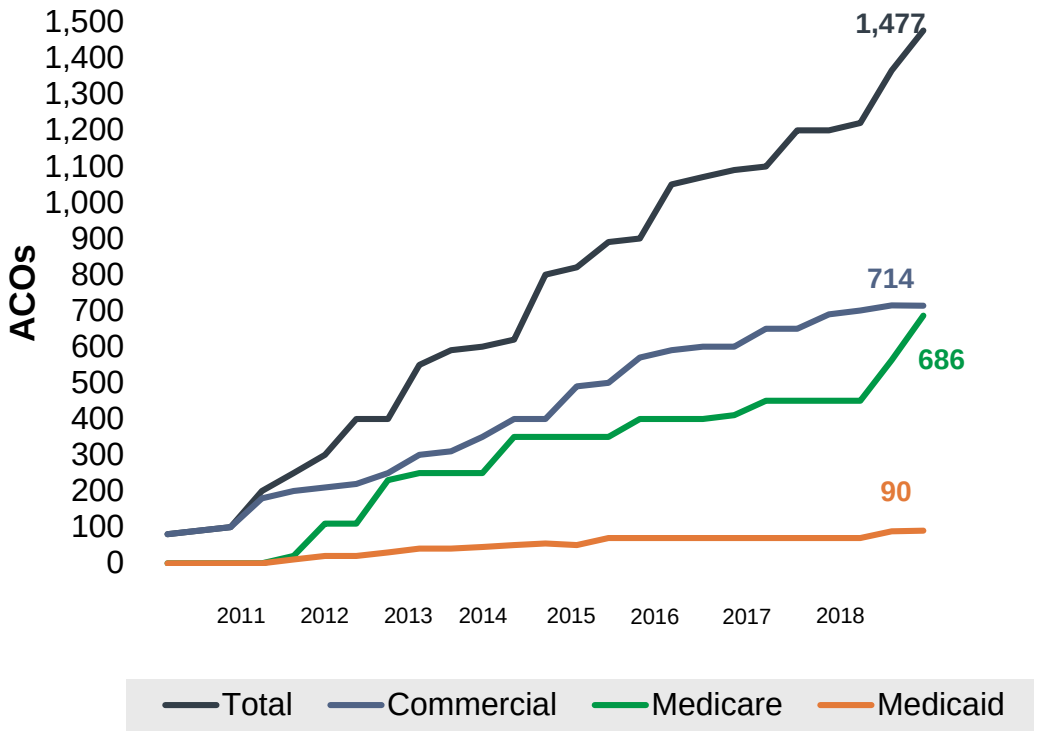
Examples

P4P Metrics	Bundles/BPCI		ACOs
Care Management Fees	MSSP Track 1	MSSP Tracks 2 and 3	Provider-Owned Health Plan

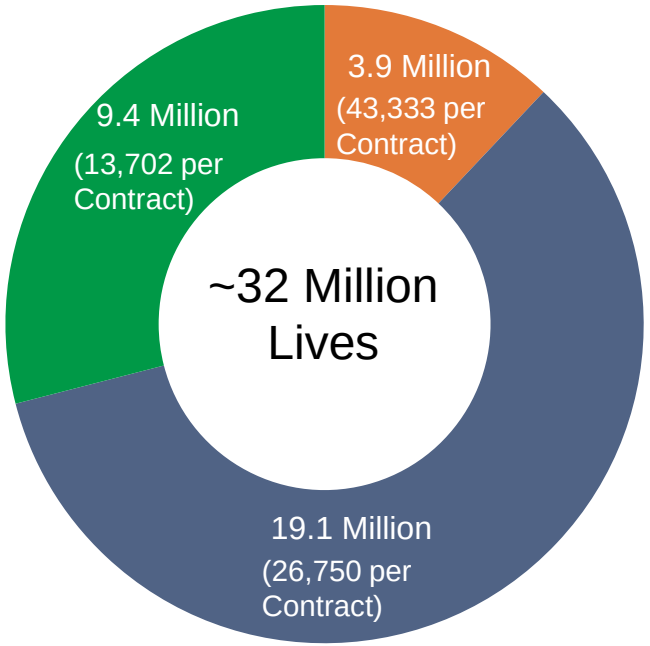
Growth of ACO Contracts

Approximately 10% of the country's population is attributed to some type of ACO structure.

Accountable Care Contracts



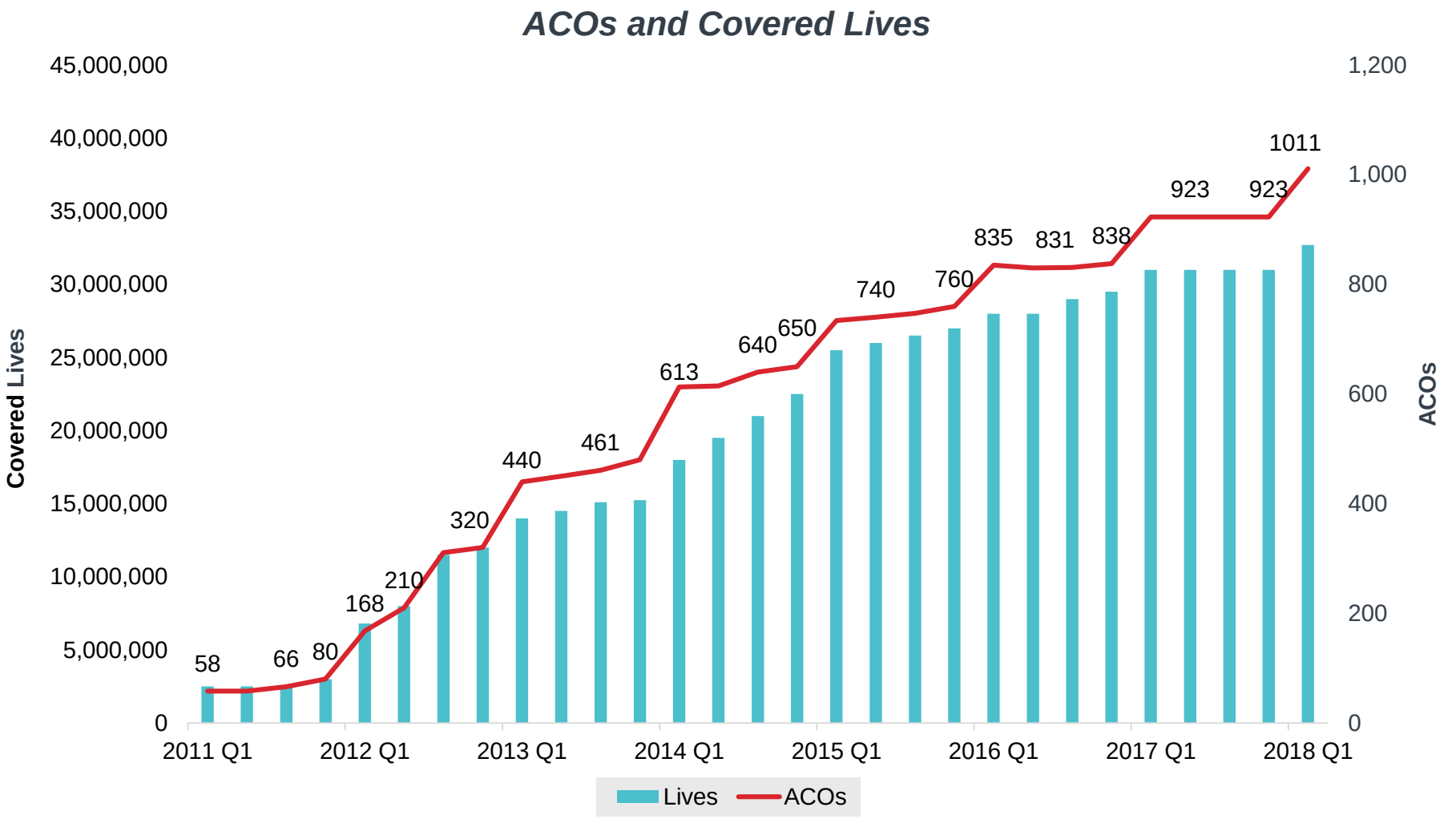
ACO Lives



Source: Muhlestein, Sunders, Richards, McClellan. "Recent Progress In the Value Journey: Growth of ACOs and Value-Based Payment Models in 2018" Health Affairs Blog. August 14, 2018. Leavitt Partners' ACO database analysis.

The growth of commercial ACOs has outpaced Medicare and Medicaid, and most ACOs are located in populous states.

Growth of ACOs



Source: Muhlestein, Sunders, Richards, McClellan. "Recent Progress In the Value Journey: Growth of ACOs and Value-Based Payment Models in 2018" Health Affairs Blog. August 14, 2018. Leavitt Partners' ACO database analysis.

Example Risk-Sharing Arrangements

Risk arrangements offer considerable leeway in achieving physician incentives related to improving quality/outcomes and reducing unnecessary costs.

Global Risk

- **Entity:** Medicaid Care Coordination Organization
- **Description:** Risk is held by JV between IPA and hospitals.
- **Goal:** Ensure access to specialists for Medicaid patients.
- **Issue:** Can the organization pay above Medicaid rates to specialists who are not at risk?

Shared Savings

- **Entity:** Health system self-insured employee health benefit plan
- **Description:** Health system is fully at risk for all health benefit costs.
- **Goal:** Control rising benefit expenses and develop population health management expertise.
- **Issue:** Can the system pay care management fees, quality incentives, and shared savings in addition to fees that are already at the high end of the market range?

ACOs

- **Entity:** Provider networks that take on risk from the payor
- **Description:** The contractual relationship is between the health system–owned ACO and the physicians (independent and employed).
- **Goal:** Use health system to shield physicians from downside risk.
- **Issue:** Does the Shared Savings Distribution Waiver require any restriction in physician incentives? Are other gainsharing arrangements allowed?

If the hospitals bear the risk, it is important to understand how the payments to physicians are structured.

Practical Considerations to Risk Sharing

The development of risk arrangements requires an organization to consider multiple perspectives in ways that fee-for-service (FFS) contracts do not.

Strategy

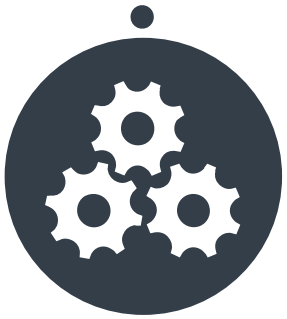
- Risk contracts align the interests of facilities, physicians, patients, and payors.
- Tactics should mitigate the impact of declining facility utilization (inpatient and outpatient).

Finance

- The increase in health benefit dollars to manage requires the appropriate infrastructure.
- More opportunities are available to develop direct arrangements with employers (cut out the middle man).

Operations

- The care management infrastructure is vital to managing the population.
- Management of provider “leakage” is critical to improve performance.



Contract Development

Reaching agreement with a health plan on a risk contract can seem straightforward, but there are a few key touchstones to remember.

- Member benefit structures in competitive markets need sufficient incentives for patients to help direct utilization.
- Care management services, whether internal or provided by the health plan, must have proven effectiveness (e.g., utilization or spend impact). Don't overpay for or undervalue this function.
- Exposure to out-of-network costs should be limited through agreements with high-volume providers where possible (e.g., local trauma centers).
- Discounts offered under directed volume agreements/narrow networks should be balanced with revenue minimums guaranteed by the health plan, if possible.
- Revenue discussions should be based on a percentage of premium versus a percentage of historical reimbursement, if possible.

Physician Compensation Development

Funding the risk pool and distributing dollars to physicians can be challenging. Iterate the metrics and measures used to distribute the risk pool over time to focus on the best ones.

Structure

- People (including physicians) respond to incentives; therefore, make sure they align with the contract.
- While the actual percentage split with physicians is not important, the financial implications are critical.
- When determining risk surplus/shared savings amounts, calculate the value of clinical utilization at market rates.

Distribution Method

- Group culture should be considered when crafting the model.
- Overengineering the model can lead to unintended consequences (e.g., dilution of incentives).
- Risk bonuses should reimburse the physicians and APPs for the value they add.

Risk Share Distribution Model

- Primary care physicians
  - Compensation is usually capitation payments (draw or actual) with risk pool sharing.
  - Alternative models could use discounted FFS payments.
- Specialists compensation
  - Compensation commonly remains FFS based with no risk pool sharing.
  - Alternative models could use discounted FFS payments with risk pool sharing for specialists.
- Risk pool
  - Maximum shared savings amount can be indexed to total patient revenue.
  - Minimum shared savings floor (i.e., maximum amount owed by physicians) can be established if dollars are truly at risk.
  - Metrics and triggers can be applied to the risk pool to unlock payment.

Regulatory Requirements

Depending on the risk factors, as determined by legal counsel, even risk-sharing arrangements may need a fair market value (FMV) analysis in addition to a commercial reasonableness (CR) assessment.

FMV

- Is required for compliance with the IRS, Stark law, and the Anti-Kickback Statute (AKS)
- Is generally assessed through a quantitative approach using market data
- Is based on a hypothetical buyer and seller

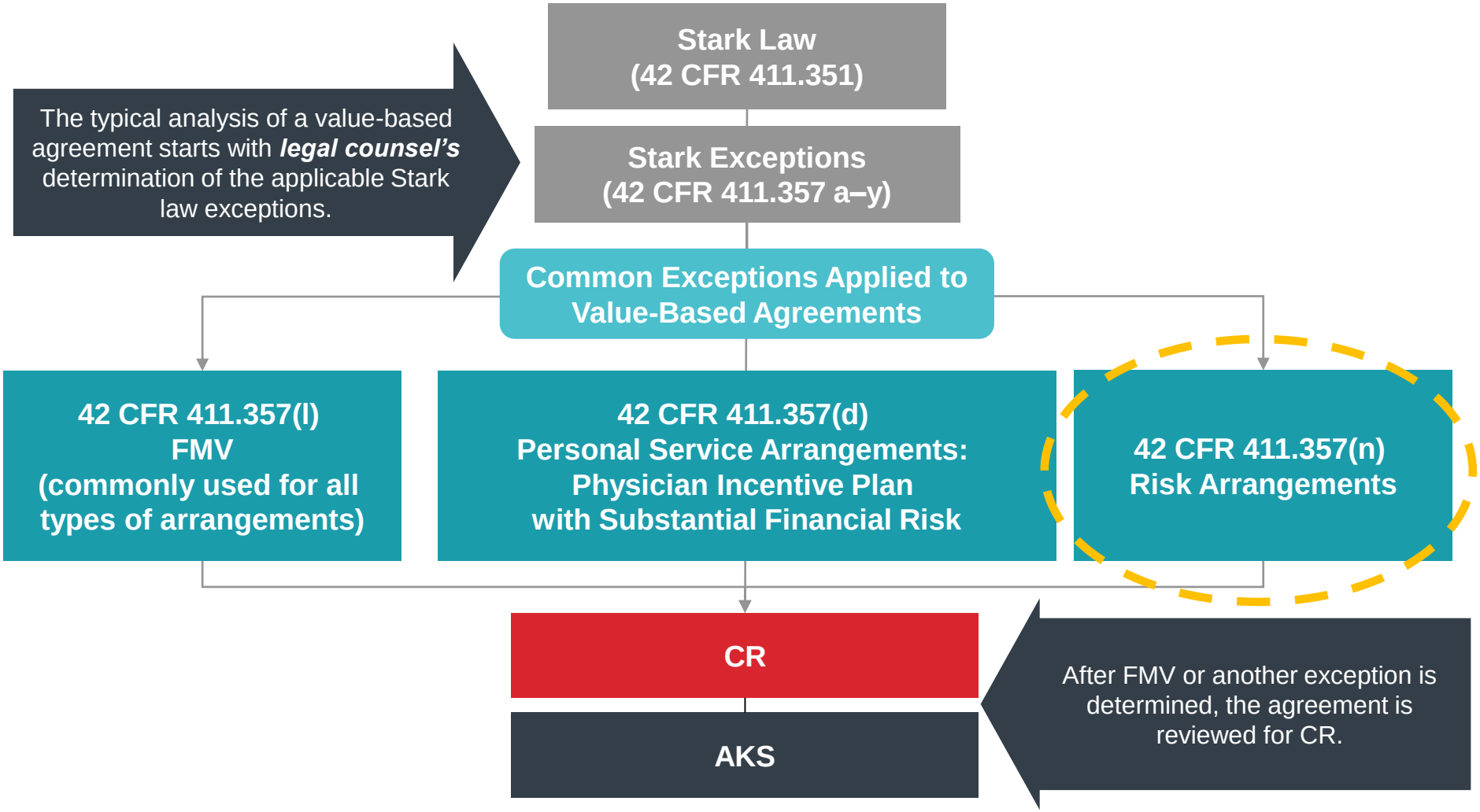
CR

- Is required for compliance with Stark law and AKS
- Is highly subjective, with limited guidance on how to meet it
- Requires systems to have a rationale for transacting that does not hinge on referral considerations

Reasonable Compensation

- Is a term derived from the IRS
- Is based on a large set of qualitative factors relevant to a specific physician and employer
- Is commonly invoked when evaluating both FMV and CR

Regulatory Compliance



ECG provides FMV and CR analyses but does not provide legal analysis.

Managed Care–Related Exceptions

Physician payments under managed care value-based arrangements should be reviewed by legal counsel. The text provided below is for informational purposes only.

Personal Service Arrangements	Risk Arrangements
» 42 CFR 411.357 (d)2 Personal Service Arrangements, Physician Incentive Plan Exception	» 42 CFR 411.357 (n): Risk-Sharing Arrangements
» In the case of a physician incentive plan between a physician and an entity, the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan (iii) places the physician or group at substantial financial risk as defined at § 422.208.	» Compensation pursuant to a risk-sharing arrangement (including, but not limited to, withholds, bonuses, and risk pools) between a MCO or an IPA and a physician (either directly or indirectly through a subcontractor) for services provided to enrollees of a health plan, provided that the arrangement does not violate the anti-kickback statue, or any Federal or State law or regulation governing billing or claims submission.

- As more information and examples of risk arrangements become available, an FMV standard could be developed, similar to physician employment arrangements.
- ***Even risk arrangements that are not subject to FMV evaluation commonly require a CR review.***

Typical CR Testing

Criterion	Description
Business Rationale	The services must not exceed those necessary to accomplish the business purpose of the transaction.
Expected Financial Impact of the Transaction	The hospital must be financially, operationally, and/or strategically better off as a result of completing the transaction, even if there were no actual or potential referrals.
Evaluation of Alternatives	The hospital has no readily available alternative that would be materially more beneficial.
Risk versus Return	Any risks assumed by the hospital are balanced by the benefit the hospital expects to receive from the arrangement (again, excluding any consideration of referrals).
Terms of the Transaction or Arrangement	The business terms of the transaction are typical and do not provide an unbalanced advantage to one party, unless there is a business purpose for establishing unbalanced terms.

FMV is only one component of the CR assessment, meaning an arrangement can be within FMV but not commercially reasonable.

CR Framework: Key Questions

ECG additionally tests five key areas when specifically assessing the CR of a risk-sharing agreement.

Financial Risk

Do the physicians bear financial risk under the arrangement?

Funding Alignment

- Is the risk pool from which distributions are calculated based on actual savings/loss using accurate allocations?
- If not, is the proxy calculation highly likely to coincide with the true savings/loss?

Windfall Protection

Is there reasonable protection against windfalls to the doctors, particularly when financial downside is limited?

Performance Driven

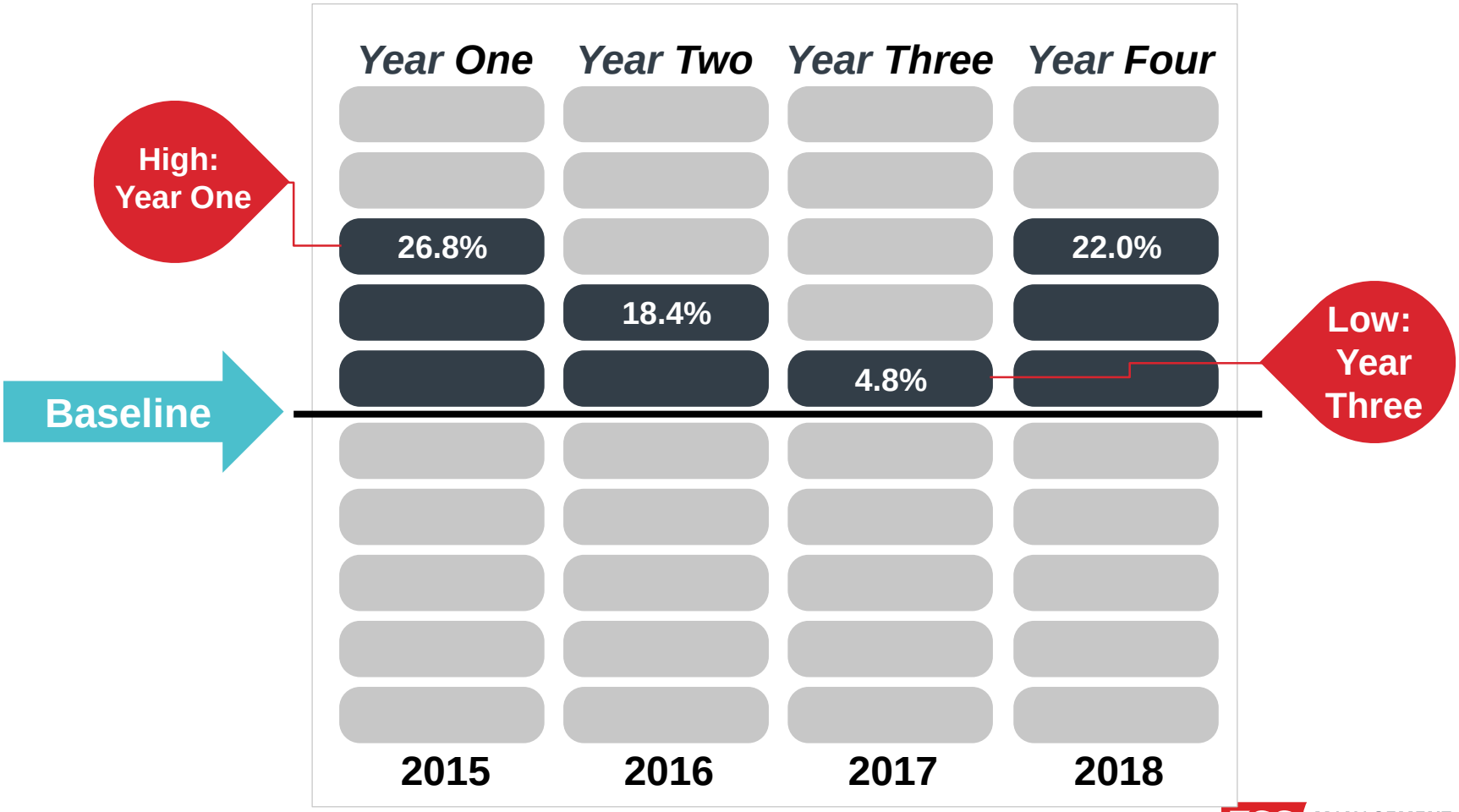
Is the physician distribution contingent on meaningful measures of effective population health management?

Proportionality

Is each party's share of the risk pool reasonably related to its respective downside risks and/or efforts and investments toward the generation of a surplus?

Physician Performance Example

Consider a risk-sharing arrangement with the following utilization performance results compared to the baseline:



Risk Share Distribution Example

The group's performance on total costs and the risk share payout is outlined below. Note a typical agreement will also provide a ceiling for the payout as a risk mitigation factor for the system.

Description	Year One	Year Two	Year Three	Year Four
Utilization Performance	26.8%	18.4%	4.8%	22.0%
Capitation Revenue	$98.00M	$99.00M	$100.00M	$101.00M
Total Costs: Loosely Managed Population	$113.93M	$114.75M	$115.57M	$116.39M
Total Costs: Actual Performance	$93.44M	$95.08M	$94.26M	$96.72M
Variance in Total Costs	*$(20.49)M*	*$(19.67)M*	*$(21.31)M*	*$(19.67)M*
Risk Share Paid to the Group	$3.00M	$3.75M	$3.60M	$2.50M
Risk Share Ceiling 5% of Revenue	$4.90M	$4.95M	$5.00M	$5.05M

The estimate of total costs under a loosely managed population standard is based on utilization ratios (e.g., bed days, ED, readmissions, post-acute care) applied to the known population activity.

Risk Share Analysis Example

The financial analysis of a group's performance centers on a few key factors, including the payment as a percentage of the total premium and the variance between the actual performance and a loosely managed population.

Description	Year One	Year Two	Year Three	Year Four
Risk Share Payment as a Percentage of Total Capitation	4.1%	3.8%	3.6%	2.5%
Risk Share Payment as a Percentage of Total Cost Variance versus a Loosely Managed Population	19.5%	19.1%	16.9%	12.7%
Risk Share Ceiling as a Percentage of Total Cost Variance versus a Loosely Managed Population	23.9%	25.2%	23.5%	25.7%

Additional Factors to Consider

There are a host of other financial and nonfinancial factors to consider when evaluating a risk-sharing agreement.

- Care Management Costs:
  - How much are these costs?
  - Who is responsible for providing these services?
- Risk Mitigation:
  - Is reinsurance being purchased, and if so, by whom?
  - How will payment ceilings and floors be applied or adjusted by performance?
  - How many baseline thresholds should be used for the performance metrics, and what should they be?
- Local Factors: Are there other organizations offering similar arrangements and terms?
- Market Value:
  - What are the market reimbursement rates that the hospital should expect when evaluating savings?
  - How does this impact the expected savings and the physicians' share?

Value-Based Arrangement Challenges

Value-based arrangements have several aspects that make them challenging to appraise, and organizations can be placed under greater risk if arrangements are valued improperly.

- *Detailed Understanding Required:* Unlike a standard physician compensation arrangement, evaluation of managed care or capitation contracts requires a knowledge of the terms of service. This includes the typical service mix and any carve-outs in the agreement.
- *Lack of Benchmark Information:* Capitation arrangements and other value-based incentives do not have a long history of benchmarking in the market.
- *Limited Information Regarding Risk-Sharing Arrangements in the Market:*
  - Agreement terms are inconsistent and often unavailable.
  - Physician disbursements are often unavailable or only represent a small portion of a physician's total compensation.
- *System Organization and IPA Inequality:* IPAs that may be competing with system-aligned organizations are not subject to the same level of regulatory scrutiny.

Recent Value-Based Agreement Examples

Risk-Sharing Agreement	» Global spend risk-sharing arrangement with independent physicians » Risk-sharing arrangement for utilization management with employed physicians » Assessment of CR for the arrangement, including the expected physician distributions
Provider Professional Fee Contract	» System-owned IPA contracting with independent physicians » FMV and CR evaluation of the rates offered, by specialty, for the expected mix of services
Care Management Fee Arrangement	» Risk-sharing arrangement with a care management company » Reasonable compensation assessment of the fees charged to the system
Provider Capitation Contract	» System-owned IPA offering primary care capitation rates to both independent and employed physicians » FMV and CR evaluation of the rates and terms of the agreement

Questions and Answers

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About ECG

Areas of Expertise: Valuation

SINCE 2005:
>300 Clients
>1,000 Projects
37 States

ECG provides independent valuation services and transaction consulting to healthcare providers and the organizations that support them. Clients rely on us to provide accurate, reliable work products that are easy to understand and hold up to rigorous scrutiny.

Valuation Team's Areas of Expertise	
Service Category	**Common Engagements**
Provider Compensation	Clinical, administrative, tracking, research, call coverage, comanagement, risk pool distributions
Business Services	Management, technology, staffing, leasing
Business Enterprises	Hospitals, clinics, surgery centers, imaging centers, labs, payor organizations, support services
Tangible and Intangible Assets	Capital assets, purchase price allocations, contractual terms, trade names, technology
Transaction Support	Negotiations, due diligence, appraisal review, JV planning
Litigation Support	Reports, testifying or non-testifying expert
Managed Care Contracts	Managed care contracts, risk-based arrangements
Value-Based Provider Compensation	Capitation payments, provider incentives, shared savings distributions

ECG's Core Competencies

- Opinions of FMV and CR
- Development and Implementation of FMV Compliance Programs
- Analysis of Local Variation in Compensation and Reimbursement
- Transaction and Negotiations Support
- Risk Assessments

Risk Share Structural Elements

Attribute	FFS	P4P	Shared Savings (upside)	Shared Savings (up and downside)	Global Risk with Corridors
Payment	FFS	FFS with incentives	FFS May include quality and care management fees Shared Savings	FFS May include quality and care management fees Shared savings and losses	Prepaid capitation or percentage of premium
Plan Type	PPO	PPO	PPO/MSSP track 1	PPO/MSSP track 1+, 2, or 3	HMO
Contracting Entity	Medical group	Medical group	ACO	ACO	Integrated delivery network/ IPA
Patient Assignment	None	None	Attributed	Attributed	Assigned or selected
Network	Broad	Some tiering	Tiered (commercial) or open (MSSP)	Tiered (commercial) or open (MSSP)	Restricted
Incentives	Rare	$ Quality or other metrics	$$	$$$/($$$)	$$$$/($$$$)
Considerations			MSSP waiver	MSSP waiver	May require insurance license (e.g., Knox Keene in California)

While this is not a definitive list, it does show typical attributes across the risk spectrum.