Defining a Contracting Strategy to Support PHM Opportunities

The seven-level framework for pursuit of population health management (PHM) opportunities provides detailed guidance on developing a financially sustainable role in PHM through critical interrelated analyses and decisions (Figure 1). Numerous activities described within this framework may occur simultaneously as an organization pursues value-based PHM opportunities. This Snapshot describes Level 6 – Defining a Contracting Strategy to Support PHM Opportunities. Other Snapshots address specific levels in greater depth.

**FIGURE 1. The Framework for Pursuit of PHM Opportunities**

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**Level 6 – Define a Contracting Strategy to Support PHM Opportunities**

The movement toward value-based care under a PHM construct is not a one-size-fits-all mandate. Organizations can take and are taking incremental steps toward managing the total cost of care (i.e., assuming full provider risk) in a “budgeted care” or “prepaid” contracting environment.

The spectrum of provider risk contracting options should be closely evaluated to ensure that the risk model appropriately aligns with an organization’s size, sophistication, PHM readiness, start and desired endpoint along the risk continuum, and the stage of transition toward value in its market. Leadership teams must start moving their contracts to risk-based arrangements to gain critical experience in meeting PHM objectives. Inaction or inadequate action could impair the organization’s ability to meet such objectives longer term.
Arrangements along the risk continuum (Figure 2) extend from no risk to full risk as follows:¹

- **Fee for Service (FFS):** The predominant model historically, under FFS arrangements providers are paid for the quantity and intensity of care delivered. Because payment is not dependent upon the quality or cost of care delivered, the provider has neither performance risk nor financial risk. Providers benefit from increases in the number of patients seen and in the number of tests and treatments provided to each patient.

- **Pay for Performance (P4P):** Hospitals, physicians or other providers receive bonus payments to their FFS reimbursement 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.

- **Shared Savings:** The shared savings model offers incentives to reduce health care spending for a defined patient population by giving providers a percentage of net savings realized as a result of their efforts to decrease care costs. Over the long run, shared savings models are difficult to sustain because the savings pool is finite and extracting incremental savings as care improves is challenging.

- **Case Rate (Episode-of-Care or Bundled):** Providers are paid a fixed amount for services required by a patient for a specific procedure or condition, such as a total knee or hip replacement. Providers benefit from the savings they generate through improved efficiencies in care delivery, but payers are likely to provide lower upfront payments for each care episode as efficiencies improve. Providers are at risk for the cost of care delivered if it exceeds the predetermined payment amount, but continue to benefit from seeing a greater volume of patients.

- **Partial Risk:** Under partial capitation or partial risk, a provider typically takes on full financial and clinical risk for a specified set of services (for example, acute care services, but not professional services), receiving a single fixed payment for those services.

- **Shared Risk:** Providers share with the payer both positive and negative financial risk depending on whether the cost of care exceeds the pre-specified payment amount. The level of savings (or losses) depends on the negotiated arrangement between the provider and the payer, and typically is a percentage of the total premium dollar or a proportion of the cost overruns. Because providers take on more downside risk in this model, various contracting mechanisms are often used to limit the provider’s financial exposure. These include stop-loss insurance (provider pays a fixed fee to another insurer to accept the risk beyond a specified amount), risk corridors that limit upside and downside risk, and carve-outs for patient populations where the clinical risk may be more difficult for the provider to manage.

- **Full Risk:** Under full-risk “capitation” arrangements, providers receive a single fixed 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 capitation payments cover only a specified portion of services. The entity contracting with the payer must have downstream network contracts covering the specified continuum of care. Cost savings, after administrative fees, can be distributed per contract agreement.

**Provider-Sponsored Insurance:** With provider-sponsored insurance, the provider manages not only the total cost of care (full provider risk), but 100 percent of the financial risk for insuring the patient and controlling the full premium dollar. Provider-sponsored insurance represents the greatest level of financial and clinical control because the provider organization controls the clinical aspects of care and care financing, and administration.

Hospitals and health systems need to be thoughtful and realistic about the skills and infrastructure needed to manage different types of payment arrangements under PHM. An organization’s risk-contracting strategy should be part of its comprehensive business plan, which provides the documentation and analysis necessary to validate capital decision making related to risk contracting and PHM scope.

**FIGURE 2. The Range of Contracting Arrangements on the Risk Continuum**

![Diagram of Risk Continuum]

Snapshot 1.12 will discuss how to identify the appropriate PHM path for an organization when determining whether to build, buy or partner.