

Trust but verify: Best practices for third party validation in provider risk-sharing contracts

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“A lack of transparency results in distrust and a deep sense of insecurity”
- Dalai Lama

Shared-risk contracts between health plans and healthcare providers are becoming increasingly common and sophisticated. As these arrangements become more prevalent, there is an increasing amount of money at stake between health plans and providers. Transparency and verification are best practices in any relationship between parties that involves money, and this includes provider risk-sharing arrangements. A settlement audit prepared by an independent third party is a recommended best practice for any organization considering entering into or already participating in one of these arrangements.

The underlying principle in these agreements is straightforward: healthcare providers are in the best position to identify and reduce unnecessary, duplicative, or inefficient care, and shared-risk arrangements provide a financial incentive for providers to do just that. Much attention has been focused on the clinical and operational changes needed to implement collaborative programs to generate cost savings and “bend the cost curve.” And while shared-risk contracts may be conceptually simple, the actual real-world financial adjudication of these contracts is usually complex.

Furthermore, these contracts almost always involve information asymmetry between the insurer/payer and the healthcare provider:

- While health plans often share claims data with providers, the claims data may have certain data elements censored, or the provider organization may not have the capacity to analyze the data to understand drivers of claim costs.
- Many key elements of the financial settlement may be set by the health plan, and partially subjective and/or driven by marketing or other business considerations. This may include trend or the actual premium charged for a product.
- Providers are not in a position to independently validate any risk adjustment, outlier, or claim cap provisions.
- Health plans may not have access to the detailed knowledge of clinical data for covered lives.

In this paper we discuss proposed best practices for an independent audit of provider risk-sharing settlements, and discuss the value of this review for all parties involved.

Overview of shared-risk arrangements

Shared-risk arrangements can have a variety of structures, ranging from full capitation and bundled payments to simplified primary care incentive payments. While this paper is focused on the shared savings¹ model of shared risk, the techniques and approaches described here can be applied to other types of shared risk arrangements.

Shared savings contracts typically take on one of two broad forms:

- A target based on prior experience, trended and risk adjusted to the measurement period
- A target based on a percent of premium or revenue approach, often risk adjusted to be on the same morbidity basis as the population attributed to the provider group

Aggregate savings (or losses) are established by taking the difference between the target costs and actual performance year costs. After aggregate savings or losses are calculated, the specific parameters of the arrangement are applied to arrive at a shared savings or loss payment.

The determination of the appropriate target is typically an actuarial exercise which can rely heavily on proprietary health plan and professional judgment. This is a key source of complexity and lack of transparency in a shared-risk arrangement.

Issues in shared-risk contracts

TARGET BASED ON PRIOR EXPERIENCE

A target based on a prior “baseline” period is a common feature of commercial risk-sharing contracts. In these arrangements, the target cost is generally set as follows:

BASELINE PERIOD COST

- x Risk adjustment
- x Benefit adjustment
- x Trend

= TARGET COSTS

¹ Broadly, we use the term “shared savings model” to refer to a contract in which the provider stands to share in savings (or losses) if costs come in below (or above) a defined target.

In the table below, we describe the importance of each of these elements as well as key transparency difficulties faced by the providers engaged in shared-risk contracts. These are broad general themes -- in practice, there will be detailed and nuanced considerations specific to the agreement being evaluated.

ELEMENT	PURPOSE	CONSIDERATIONS FOR PROVIDERS
Prior period costs	In this approach to setting the target, the prior period costs are used as the baseline for measuring performance. In theory, this allows providers to compete against their past performance.	<p>If a provider was previously participating in a shared risk contract or was otherwise providing efficient care, use of past experience can set an unrealistic standard against which the provider can expect to improve.</p> <p>Furthermore, there is typically little transparency into the specific claims detail that is used to set the prior period costs.</p>
Risk adjustment	For cost targets to be meaningful, they must be calibrated to reflect the underlying morbidity of the attributed population during the performance period. "Risk adjustment" is a tool designed to perform that calibration. This is often important because without risk adjustment, there may be "savings" or "losses" created merely out of differences in morbidity levels between the baseline and performance period populations.	<p>Typically there is little transparency into the specifics of the risk adjustment calculation by the payer. This is particularly true for commercial contracts, where (unlike Medicare) there is not one widely accepted risk adjustment methodology.</p> <p>Each risk adjustment model has its own pros and cons which makes it essential that the parties appropriately understand and vet the options. Carefully chosen risk adjustment means that savings/losses can be more accurately determined to the benefit of both parties.</p>
Benefit adjustment	Benefit adjustment is designed to account for changes in patient cost sharing or covered benefits between the baseline period and the performance period.	There is typically little or no transparency surrounding how benefit adjustments are developed. Development of these adjustments typically involve actuarial calculations by the insurer.
Trend	Trend accounts for changes in utilization, unit cost, and service intensity between the baseline period and the performance period.	<p>There are a number of factors to consider with trend. In many instances, trend is informed by data but then ultimately set using judgment. Judgment can be subjective and influenced by competing needs, such as the plan's desire to become more or less competitive.</p> <p>Providers should also consider if trend is set prospectively based upon assumptions about the future, or retrospectively based on actual cost trend data for a block of business or other defined cohort.</p> <p>For payers with a high concentration of providers participating in shared-risk arrangements, trend may be depressed, leading to more difficult-to-achieve targets. Instead of being measured against a baseline meant to represent a true counterfactual, the baseline is indexed to the performance of other high-achieving providers.</p> <p>Finally, trend can be driven by a "service intensity" component-- namely the introduction of new high cost medical technologies and prescription drugs between the baseline and performance periods. For providers that treat a disproportionately high share of patients seeking these newer treatments, the combination of trend and risk adjustment may fail to track the cost of care.</p>
Contractual changes	A mid-year contractual change with any provider could cause a shift in the total cost of care.	<p>Often shared-risk agreements are vague regarding how this situation would be handled and lack a transparent mechanism to account for it.</p> <p>Retrospective trend may partially address this issue, although it needs to be carefully considered by all parties. Contracts indexed to a percent of revenue will need an explicit mechanism to address this possibility.</p>

TARGET BASED ON A PERCENT OF PREMIUM OR REVENUE

Setting a target based on a percent of premium or revenue dominates risk-sharing contracts in Medicare and Medicaid, and is common in commercial contracts as well. In these arrangements, the target cost is usually set as follows:

PREMIUM/REVENUE

x Change in mix and/or risk adjustment

x Percent of premium

= TARGET COSTS

In these arrangements, trend and benefit adjustments are assumed to be already incorporated into the premium/revenue rate. The same conceptual issues highlighted in the table above and associated with prior period cost, risk adjustment, benefit adjustment, and trend apply to targets based on percent of premium. However, there are some unique features associated with this approach:

- **Subjectivity of the pricing process:** When developing premium rates, trends and risk adjustment factors are chosen based both on assumptions about what will happen in the future and pricing goals of the insurer. This implies that the premiums may not fully reflect the conditions faced by providers during the plan year including shifts in utilization, new technologies, etc.

For example, the insurer may choose a lower profit margin if necessary to be more competitive in a market. This assumption in particular can create challenges for the provider, especially if insurers assume that providers will generate savings offsetting the reduction in profit margin. However, lower margin will lower the provider's target cost level if there is not an offsetting adjustment to the percent of premium used in the target formula.

- **Care management/care coordination allocation:** Insurers may introduce a "care coordination" adjustment intended to reflect the anticipated savings associated with the health plan's own care management activities. This has the effect of reducing the target for assumed savings generated by health plan (as opposed to provider) activities. This number is highly subjective, difficult to measure, and heavily dependent on the health plan being successful in meeting its cost savings program goals.
- **Timing and assumptions surrounding reimbursement rates:** Because pricing is done prospectively (approximately six to nine months prior to the plan year), the rates are based on assumptions about unit cost reimbursement for medical services and prescription drugs.
- **Mix of membership:** In Medicaid particularly, the mix of attributed membership by eligibility category will affect not only overall claim costs but also the distribution of costs and the medical loss ratio. This can be material for contracts where the target is set across the Medicaid book of business rather than separately for each eligibility category if the actual enrollment mix is materially different from that assumed.

QUALITY ADJUSTMENT TO SHARED SAVINGS RATE

Many shared savings contracts include a provision that introduces a measurement of quality into the settlement formula:

- The shared savings rate is often tied to a quality score and/or
- The availability of achieving shared savings is contingent on the provider meeting certain quality standards.

Although a quality standard is designed to promote patient safety and high quality care, there is often a lack of transparency regarding how the adjustment is set. Often, quality scores are based on a provider's performance relative to a peer group as determined by the health plan. Typically, there is no avenue for providers to audit the underlying information and determine if the standards were set appropriately.

Best practice: Auditing provider risk-sharing contract settlements

It is reasonable and common practice, in a contract with a future settlement payment that is dependent on certain results or outcomes, for the contract to include a provision for an audit of the financial settlement. Moreover, as a means to further the partnership aspect of shared-risk agreements, both payer and provider will want to seek information symmetry in the financial adjudication of the contract. Ultimate settlements must be reasonable, equitable, and accurate, or else the shared-risk model will not be sustainable in the long term.

As noted in the introduction, transparency and verification are best practices in any relationship between parties that involves money. To that end, we propose the following best practice for provider shared-risk contracts: Every piece of data and information that affects the bottom line settlement of a shared risk contract should be made available to both parties and be subject to verification. In other words, there should be an audit trail of settlement amounts and a right to conduct that audit. This includes an audit of the actuarial calculations, assumptions, and judgments that determine the target costs, and thus the final settlement amounts. Provision for both the audit, sufficient time to complete the audit, and supporting documentation to make the audit possible should be standard language in provider risk-sharing contracts.

There are benefits to this level of transparency beyond the verification of the shared savings calculation. For providers, often the biggest question after receiving shared savings or losses is why? Often, the answer is far from obvious. Through an audit process, an independent third party can provide more insight into what exactly is driving savings or losses without revealing proprietary information. This information can be useful for all parties, helping the provider understand what it needs to do and in helping the payer achieve its objective.

EXISTING CHALLENGES

To date, there have been several challenges that prevent insurers from sharing the full data with providers that would allow for full transparency:

- There are contractual limitations to the claims data that can be shared with provider groups. This is particularly true regarding the reimbursement rates paid per claim because this information could be used to reverse engineer payment rates to competing healthcare providers.
- Much of the information required to fully verify the appropriateness of the settlement calculation is proprietary, and perhaps even highly sensitive, for the health plan.
- The volume of data is a challenge for provider systems. In addition, many healthcare providers may not have the tools or actuarial expertise to conduct such an analysis.

These hurdles are significant and have made it such that providers are left to fully rely on insurers/payers for the adjudication of shared savings.

AUDIT TRAIL

Actuarial audits should be negotiated into shared-risk contracts from the outset, and such audits should be performed annually.

In many cases, however, the challenges listed above may inhibit the ability to conduct a meaningful audit. However, the use of a third party entity, mutually acceptable to both payer and provider, and subject to appropriate nondisclosure and other agreements, may provide a useful way around those limitations.

Information and analyses that would be subject to audit could include:

- **Evaluation of attribution methodology:** Attribution links patients to providers. Inaccurate or imprecise attribution limits the ability of providers to manage patient care and expenditures.

- **Evaluation of underlying data:** The underlying data may be used to develop a target directly or used to develop premium rates that inform a target. In either case, this evaluation would serve to evaluate the baseline as well as explore any factors that might be causing an unexpectedly low or high baseline.
- **Evaluation and validation of the risk adjustment calculation:** A comprehensive audit would evaluate the risk adjustment calculation for reasonableness, at a minimum.
- **Evaluation of benefit adjustment:** A comprehensive audit should evaluate the effect of changes in benefit design and coverage. If payer tools are not directly available, the auditor should be able to do a reasonableness check using a separate tool (such as the Milliman Health Cost Guidelines™).
- **Evaluation of trend:** Evaluation of trend is complex but also of critical importance. A thorough audit would review the underlying information used to select trend, seek to understand what judgment was used to set a final trend factor, and share this information with all parties.
- **Percent of premium target:** For targets set on a percent of premium basis, a complete audit would probe the appropriateness of this percentage as well as any care coordination adjustment to savings.
- **Pricing projections:** For shared risk arrangements based on a percent of premium, a complete audit should review the pricing process. The goal of this audit is not to direct or influence the pricing process, but to provide full transparency to all parties regarding how rates were set and how those decisions affect participating providers.

The long-term success of the current push to shared risk is dependent on trust, collaboration, and transparency between payers and providers. However, there are current structural challenges to this level of data sharing and transparency. Third parties without a financial interest in the outcomes are well positioned to either adjudicate shared risk contracts directly or to audit the shared-risk calculation made by the payer.



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