The essential eight: Keys to successful ACO contracting

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Accountable care organizations (ACOs), now a common fixture in the healthcare landscape, will likely face significant growing pains. Unfortunately, an ACO could incur substantial financial losses and face an uncertain future if the ACO doesn't appropriately manage its financial risk and variability.

As ACOs negotiate contracts with shared risk and population-based payments, numerous subtle but important contract nuances could substantially curtail their chances of success. ACOs that best identify and manage their financial risks, particularly by understanding the variability and potential risk around important contracting terms, should realize a much improved likelihood of success. Such ACOs identify, quantify, and manage their risks prior to entering into a shared risk or population-based payment arrangement. Specifically, these ACOs understand their potential financial risks and rewards under various performance outcomes.

Even a straightforward payment arrangement has risk. Thus, a risk analysis that includes an analytical review of proposed contract terms and, in many situations, financial modeling under various operational outcomes is crucial. Such an analysis positions ACOs to take one of the key steps to financial sustainability by helping them understand their relative risks under existing and proposed contracts. Below, based on my experience reviewing payer contract proposals to ACOs over the last several years, I identify eight common elements critical to analyzing and understanding shared risk and population-based arrangements.

1. Understanding the attribution model. Attribution models and their administration vary widely. A deep understanding of how and when members will be attributed under a proposed contract is necessary. The attribution method impacts the potential population size, the ability of the ACO to manage those members, and the risks the ACO may face if members use providers outside the ACO.

2. Projecting population size and contract volume. Once the attribution model is understood, a preliminary estimate of population size can be developed. Deals with insurers might not be worth the effort if the population is small and yields relatively little volume for the ACO. Often, an insurer might be large in a particular geographic area but the ACO's projected population might be low. Developing and maintaining an ACO is a significant investment, from care management practices to infrastructure investments such as information technology (IT). If there won't be enough members in the deal, then it may not be worth the time and investment on the part of the ACO to engage with the insurer. Of course, if the ACO has multiple shared risk contracts covering a large population, there may be some "economies of scale" that make the infrastructure cost more palatable for a deal covering a smaller number of members.

3. Modeling the impact of random variation. Actuaries often deal with the impact of random variation in health claims and can help demonstrate to ACOs how usual variation alone might influence costs. For various population sizes and types (e.g., Medicare, commercial exchange, other commercial, or Medicaid), an ACO should understand the relative likelihood of results occurring above or below the expected value average, simply because of random variation. Some populations reach a size where the impact of random variation moderates more quickly than for other populations (e.g., a Medicare population's results are relatively more stable than a typical commercial population of the same size due to higher utilization of services per member). Actuaries often refer to this concept as credibility. Keep in mind credibility varies widely by population, and random variability should be a consideration when evaluating proposed contracts.

4. Analyzing data. Thorough analysis of experience data can help ACOs get a sense of their population health cost centers and opportunities for improvement. While insurers might question providers on their billing, comparing them with the billing of competing providers, much can get overlooked and an ACO must be prepared to sift through the data to deeply understand what is going on and, possibly, correct some previous impressions. This requires digging into the data, ensuring the comparison is on an "apples to apples" basis, questioning anomalies, getting restated data, and often repeating the process. In one example, after an initial data pull, an ACO's average payment per admission for a C-section was nearly $12,000, compared with a competitor's reported average of less than $5,000. When I inquired about it, the insurer indicated it had gone on for years. A more rigorous analysis of the data, however, revealed, among other smaller issues, the cost for the mother and baby had been combined for the ACO but was separated for the competitor. The detective work revealed the combined cost for the competitor (comparable with the ACO) was actually over $14,000, more than $2,000 higher than that of the ACO. This saved the ACO from making an enormous concession to remain competitive when, indeed, it already was. Bottom line: if something seems unreasonable, it likely is. ACOs need to understand the data and its intended use for each analysis. The implications vary for each situation, but with an appropriate apples-to-apples comparison, the results can be dramatically different from initial impressions.

Data analysis can also help identify where costs are centralized and guide the ACO in considering what types of clinical procedures can help drive down those costs. This insight can be used to project the resulting financial implications from ACO investments in delivering care more efficiently.

5. Quantifying risk through specific modeling. Ultimately, an ACO needs to identify and manage its financial risk. Many years of experience taught me a strong understanding of the underlying experience data together with actuarial modeling will help an ACO understand the financial implications of key contracting terms under a variety of scenarios. Key contracting terms such as the minimum savings rate, service inclusions/exclusions, quality measure definitions and performance terms, and the setting of initial and subsequent financial targets substantially impact the financial outcome. An analysis demonstrating the variability of operational results related to key contracting features under various scenarios greatly improves an ACO's ability to truly understand its risks. Further, such an analysis allows an ACO to identify which risks can be managed through contractual provisions and which should simply be avoided. Each contract is typically unique and, as such, should be analyzed independently. However, in a more general sense, it is also important to have a "holistic" understanding of an ACO's risk across contracts and understand dynamics that could cause potential financial distress.

6. Setting utilization or financial targets. From an ACO's perspective, cost targets would, ideally, be based on experience from a period before any significant new cost-reduction initiatives were implemented. The target should reflect the ACO's actual population and be consistent with the trend that would have occurred without the improvements under the agreement. This allows the ACO an opportunity to achieve savings (which can be used to realize a return on often substantial investments) before the target reflects the ACO's initiatives. It is important to look at multiple years of experience and work with the underlying data to help determine if there are underlying initiatives directly linked to cost savings. This may help an ACO get credit for initiatives already underway. For example, say an ACO's commercial per member per month (PMPM) cost was $440 on average for its attributed population a year ago. Today, the PMPM dropped to $420, and the ACO seeks to move into a shared risk arrangement with an insurer. The historical cost data should be "mined" to sort out the "noise" from real trends and patterns, and to project the impact of future incentives. This insight can be invaluable to an ACO when developing a shared risk arrangement. Also, it is key for the ACO to avoid resetting targets to immediately incorporate any savings in the next target, which gives the ACO the opportunity to capture savings for a modest period before the revised targets reflect all of those savings.

7. Forward thinking contracts. Through all the detail of a specific proposal, it is also key for an ACO to think ahead. The ACO should explicitly consider what could happen down the road when the contract will be administered. ACOs can be disappointed with results when contracts do not have well-defined calculations, precise definitions, and appropriate rules that discuss how things will work. With well-defined calculations, the contract specifies the source of data, time frame, and exactly what will be calculated by whom and how. To determine precise definitions, ACOs need to think about what they will be doing over a performance period. Baselines for quality measurements may need to be based on a different time period from cost targets. Rules in the contract should state how the agreement will evolve year to year, whether targets will be reset, and what data sources will be used in case the current one in use is no longer available. All calculations by an insurer should be subject to audit largely because the staff doing the calculations is usually in a different department and several layers removed from those directly involved in developing the understanding as the contract was negotiated with the ACO.

8. Building trust. The best arrangements occur when the insurer and ACO collaborate. When they do not see eye to eye, explaining the other's perspective sometimes helps bridge the gap. Often the two parties can come together faster when robust data and analyses are used to support contracting discussions. Understanding the data and results and discussing the underlying circumstances may provide a neutral ground to start contracting conversations. Further, trust is important when something turns out to be substantially different from what either party expected during negotiations. If trust is built, the parties can work through reasonable adjustments to keep the arrangement reasonable for both sides.

There are certainly other equally important considerations (e.g. trend). However, I believe the essential eight keys discussed above, while not necessarily comprehensive, are critical to effective ACO contracting, an early step toward long-run success.

ACO contracts are complex and require data-driven decisions

In this era of healthcare reform, the rise of ACOs means healthcare providers must adapt to increasingly complex deal structures, which can make the word "accountable" a potentially perilous responsibility. These deals take time to put in place, with lots of details in the background. Without attention to detail and data-driven decisions, deals can turn sour overnight because of oversights on the smallest details, ranging from contract language to attribution to target setting. ACO decision makers need to think through all the details, as complex and intertwined as they may be, and make sure they are as explicit as reasonably possible in the contracts. ACOs need to navigate all of the nuances of this evolving world to ensure that what could be a costly endeavor is instead a cost-effective and sustainable operation.

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