

 **OUR TAKE**

for health plans and payers

How Health Plans Can Support Providers in Risk

Findings from our 2021 Path to Value provider survey

Published – May 2021 • 30-min read

In early 2021, Advisory Board surveyed a randomized sample of 225 providers and 26 health plan executives from across the country. The survey asked about their readiness for risk and their most effective support resources.

The survey found that plans are still operating on outdated strategies that were formed when value-based payment was in its infancy. On the current trajectory, providers stall in upside risk and remain ill-prepared for downside risk. Plans must adapt their strategies to break through this plateau.

Furthering the urgency for plans, the Covid-19 pandemic has increased providers' interest in participating in value-based payment models but not necessarily their ability to succeed under those models.



Table of contents

Overview pg. 3

What we found pg. 4

1. Prevent providers in downside risk from backsliding. pg. 11

2. Convert providers in upside risk to downside. pg. 16

3. Focus providers not in risk on the end goal. pg. 23

What this means for you. pg. 26

Methodology. pg. 37

Related content. pg. 29

Overview

Research question

How should health plans support providers on the path to value?

Problem

Years into the transition to risk-based payment models, health plans are still nowhere near their downside risk goals. Of provider organizations in risk-based contracts, a handful participate in downside risk only, and even fewer are successful. It is difficult for plans to identify how they can be helpful for providers to encourage them to take on additional risk.

On the current trajectory, providers stall in upside risk—and they're ill-prepared for downside risk. We are still operating on strategies formed when value-based payment (VBP) was in its infancy. Health plan strategies to support providers in risk must change and adapt to the current situation, especially now, given that the Covid-19 pandemic has increased some providers' interest in value-based payment.

What we did

In early 2021, Advisory Board surveyed a randomized sample of 225 providers and 26 health plan executives from across the country. The survey asked about their readiness for risk and their most effective support resources.

What we found

The state of VBP following Covid-19 is not set in stone. Health plans must take an active role in advancing risk-based payments using the three new strategies:

1. Prevent providers in downside risk from backsliding
2. Convert providers in upside risk to downside
3. Focus providers not in risk on the end goal

Source: Advisory Board 2021 Path to Value survey and analysis.

What we found

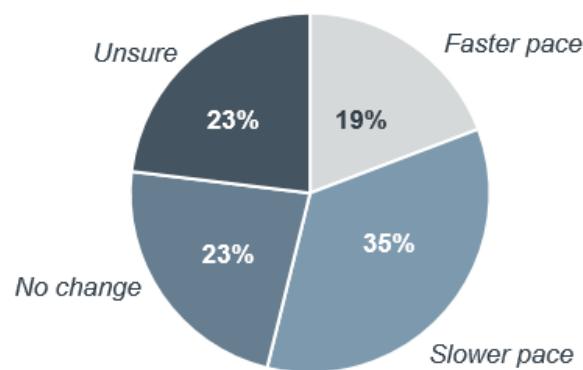
The state of value-based payment during Covid-19

The Covid-19 pandemic has once again placed a spotlight on value-based payments. Many news headlines suggest providers are more interested in VBP now because they desire a more stable financial model than they experienced during the pandemic.

In contrast, health plans are less bullish in their predictions. More plan executives think Covid-19 will slow down the pace of risk adoption rather than speed it up. Driving that belief is a recognition that risk adoption is a costly proposition and provider financials are “inconsistent” as a result of the pandemic.

Do you think the Covid-19 pandemic will change the pace of risk adoption by providers?

n=26 plan executives



“

Making the transition from volume to value requires a tremendous investment in capital, time, and other resources. The interruption Covid-19 has caused to the money supply would likely be an impediment to the introduction of value-based care.

Michael D. Robertson MD
CEO, Covenant Health Partners in Texas

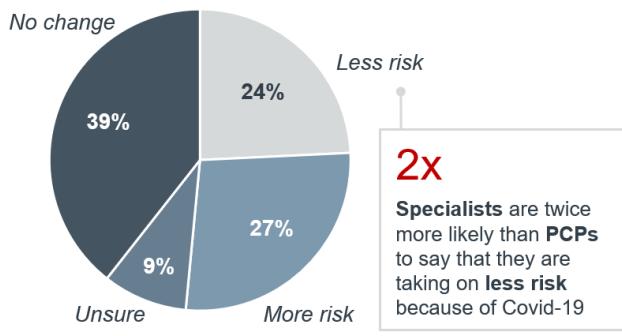
Source: Gittlen S. "Time, Not Covid-19, Will Be Value-Based Care's Tipping Point." *NEJM Catalyst Innovations in Care Delivery*, 2, no.1 (2021), DOI: <https://doi.org/10.1056/CAT.20.0662>; Advisory Board 2021 Path to Value survey and analysis.

THE STATE OF VALUE-BASED PAYMENT DURING COVID-19

Within this landscape, providers are split on how they think Covid-19 will impact risk adoption. As the data below indicates, a quarter of providers say Covid-19 has caused them to take on less risk, but another quarter say Covid-19 has caused them to take on more risk. Similarly, 28% of providers think Covid-19 will *slow down* risk adoption while a similar percentage, 26%, of providers think Covid-19 will *speed up* risk adoption.

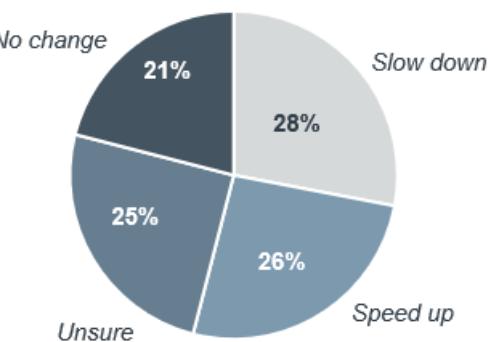
How has Covid-19 impacted the level of risk you are taking on?

n=225 providers



How do you think Covid-19 will change the pace of risk adoption?

n=225 providers

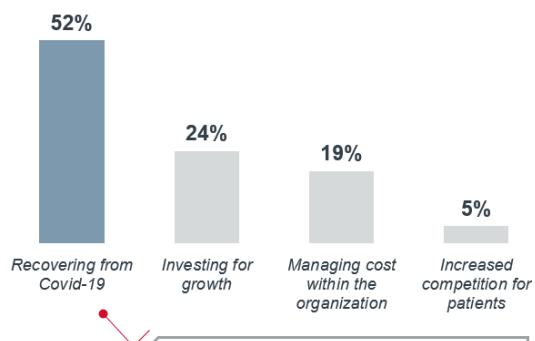


The future is not set in stone. Health plans *can* influence how fast providers adopt risk post-pandemic, but providers will require support. Plans will need to prioritize who they support, and which types of supports they offer.

THE STATE OF VALUE-BASED PAYMENT DURING COVID-19

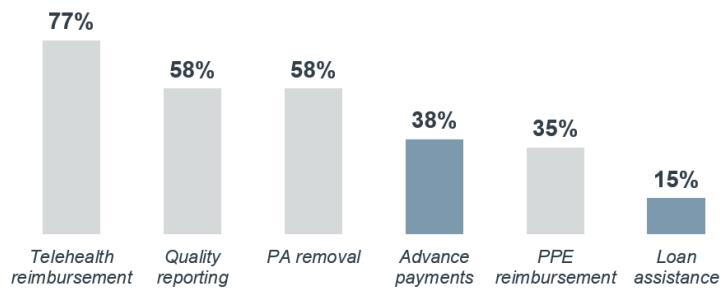
Covid-19 hasn't made life easier for providers. In fact, providers say that recovering from Covid-19 will be their biggest challenge in 2021 with plans offering limited support during the pandemic. The most common additional supports given by plans were telehealth reimbursement and quality reporting exemptions. Only 38% of plans offered providers support through advance payments and even fewer (15%) offered loan assistance during the pandemic.

Providers' biggest challenge going into 2021



63% of providers from **rural areas** said this was their biggest challenge compared to **46%** from **urban areas**

Percent of plans offering additional support for providers during the Covid-19 pandemic



35% of plans anticipate provider reimbursement to increase

As providers work toward their Covid-19 recovery goals, they especially value the financial support plans can offer that give time and flexibility to pay shareholders back when patient volumes fully recover.

Although plans are seeing more losses in 2021 than in 2020 (when decreased utilization had lowered plan MLRs across the board), provider financial struggles are arguably more pronounced. The American Medical Association (AMA) announced that medical practices have seen a 32% average drop in revenue because of Covid-19. Providers are still recovering from lost volumes, and interviews show that even the most progressive independent physician groups lack capital to push forward new risk initiatives.

Source: Robeznieks A, "Physician Survey Details Depth of Pandemic's Financial Impact." American Medical Association, Oct 2020. <https://www.ama-assn.org/practice-management/sustainability/physician-survey-details-depth-pandemic-s-financial-impact>. Advisory Board 2021 Path to Value survey and analysis.

WHAT WE FOUND

There are two equations providers face when considering risk

adoption. When providers do the math on strategy and market forces, it makes sense for them to take on VBP. But when providers consider the resources and time investment necessary to operationalize VBP and succeed under risk, the math starts to fall apart.

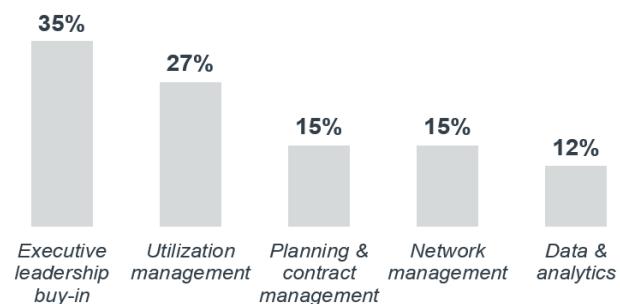
This doesn't mean health plans must fund a provider's path to risk, but plans should be prepared to help provider partners analyze *how* they could source funding or justify investments.

Beyond financial supports, plans told us that very few providers in their network have the utilization management, contract management, network management, and data & analytics skills that are required for success in risk—despite buy-in from executive leadership at health systems.

Data below show that provider executives feel more prepared to take on risk than physicians.

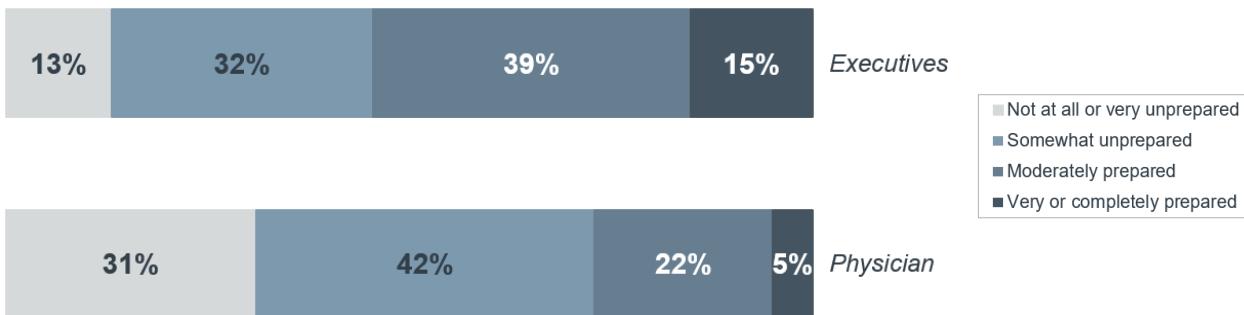
Percent of plans that think 50% or more of their network have the following capabilities for managing downside risk

n=26 plan executives



Physicians feel less prepared to take on risk than provider executives

n=169 physicians, 59 executives



Source: Advisory Board 2021 Path to Value survey and analysis.

2. INVEST IN RESOURCES TO PUSH PROVIDERS IN UPSIDE RISK

This discrepancy is worrisome because it indicates executives must be able to change physician thoughts and behavior to succeed under risk. Further, physician burnout was already high pre-Covid-19 and has only worsened during the pandemic. Executives are, therefore, rightfully concerned that pushing a new way of practicing on physicians will further exacerbate physician burnout.

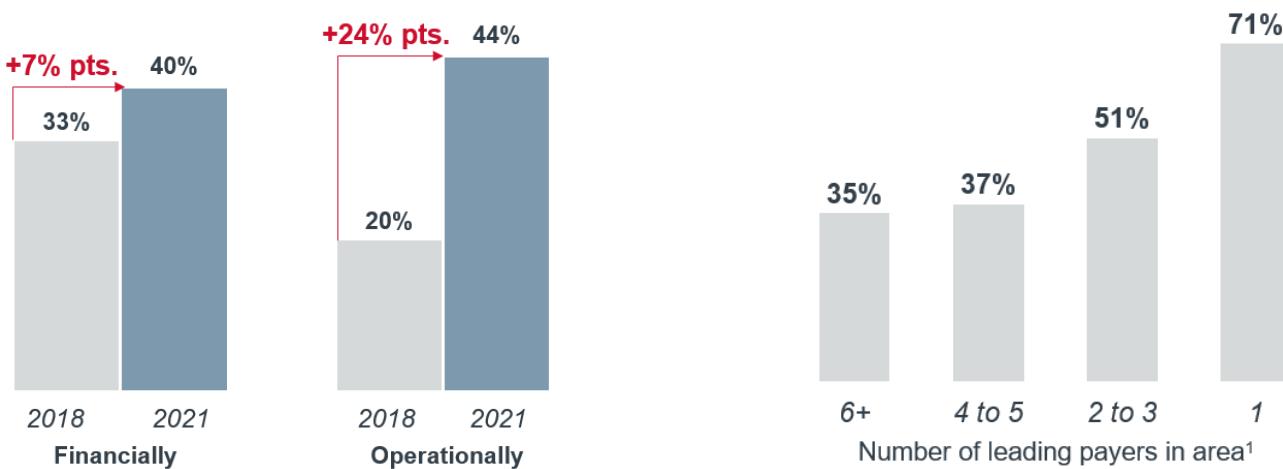
The silver lining in this story is that providers *do* appreciate plan resources offered as part of risk-based contracts. When we conducted this survey in 2018, few providers thought plan financial or operational supports were effective. However, as the data below shows, since then, the percent of providers who find plan financial supports effective has risen by 7 percentage points and the percent of providers who find plan operational supports effective has risen by 24 percentage points.

How effective are health plans at supporting frontline clinicians to take on downside risk?

Percent of providers selecting “very effective” or “somewhat effective”

n=86 in 2018, 226 in 2021

n=40 for 6+, 79 for 4 to 5, 84 for 2 to 3, 14 for 1



Give yourselves a pat on the back... but don't rest on your laurels. Providers need both financial and operational support to succeed under VBP—and increasingly they recognize the value of the supports you are offering. The next phase is evolving those supports to prioritize the right help for the right physicians.

1. Provider reported

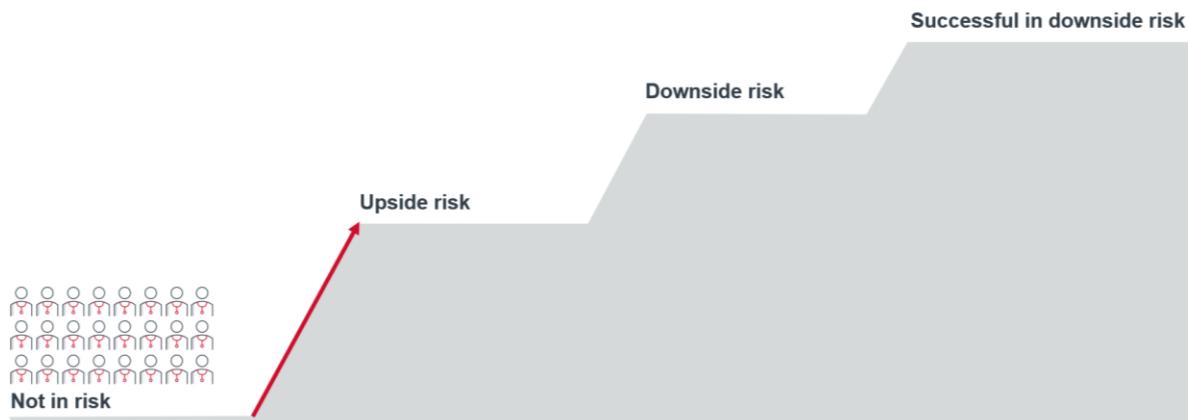
Source: Advisory Board 2021 Path to Value survey and analysis.

THE STATE OF VALUE-BASED PAYMENT DURING COVID-19

Plans and providers initially formulated their strategy on pursuing risk when few providers participated in these models. At the time, these strategies made sense. First, move providers from no risk into some risk. To do this, front-load resources to entice providers to make the jump from fee-for-service to risk. Then make sure to maintain support so that eventually providers move into downside risk when they are comfortable with upside risk.

Encouraging providers to climb up risk mountain **circa 2012-2020**

2012-2020



But the world has changed a lot since risk adoption started, and especially as the U.S. starts to emerge from the pandemic. These strategies made sense back in 2012 when CMS launched the ACO model, and even earlier, but not now.

Now, some providers are in upside risk, others participate in downside risk, and others are showing interest in risk for the first time (following the impact of Covid-19). This means strategies to encourage further risk adoption must become multifaceted as well.

THE STATE OF VALUE-BASED PAYMENT DURING COVID-19

First, overinvest in providers already taking on downside risk to prevent backslide. Second, providers in upside risk will naturally pursue more upside opportunities. Your job is to convert them to downside risk. And lastly, save the hardest (providers not in risk) for last. When you approach them, focus them on the end goal.

In the rest of this brief, we will present data that show why it is time to adapt our path-to-value strategies and how not doing so will render plan efforts useless.

New path-to-value strategies **post-pandemic**



01 Prevent providers in **downside risk** from backsliding

02 Convert providers in **upside risk** to downside

03 Focus providers **not in risk** on the end goal

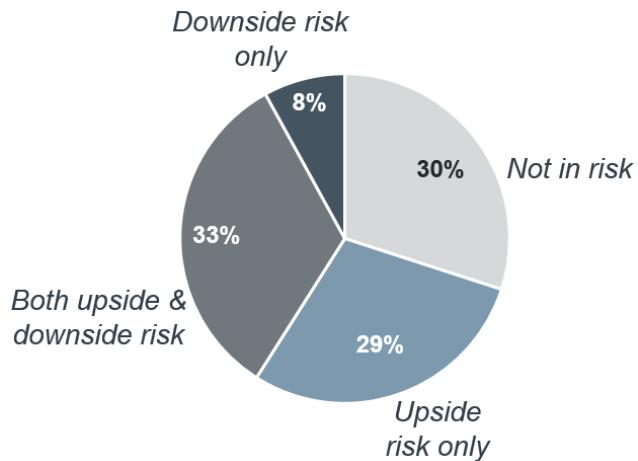
01 Prevent providers in downside risk from backslicing

Roughly a third of providers say their organization does not participate in risk, a third say they participate in upside risk only, and another third say they participate in both upside and downside risk.

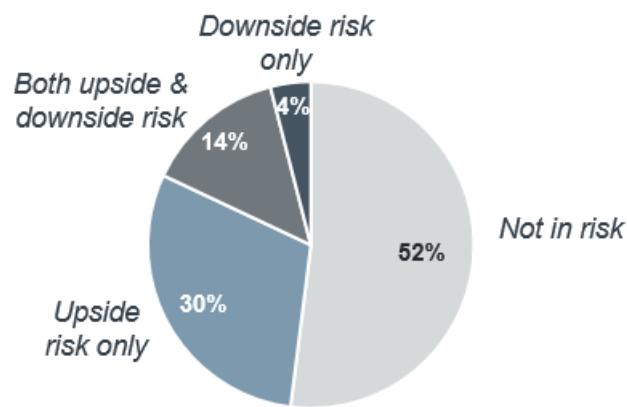
In contrast, when we asked physicians about their *personal* participation in risk, over half said they don't participate in risk and only 18% said they participate in downside risk. The discrepancy between physician participation and organization participation reflects a gap in understanding and awareness—likely driven by physicians whose payment structures did not change after their organization adopted risk-based payment contracts.

Overall, the story is that participation in risk, especially downside risk, is low even after years of investing in providers to take on risk.

Provider organization participation in risk
 n=227 providers



Physicians' personal participation in risk
 n=173 physicians



PREVENT PROVIDERS IN DOWNSIDE RISK FROM BACKSLIDING

From the plan side, the news is good when looking at upside risk adoption and goals. Plans are relatively close to their upside risk goals. On average, 63% of their provider networks are in upside risk compared to an average plan goal of 78%.

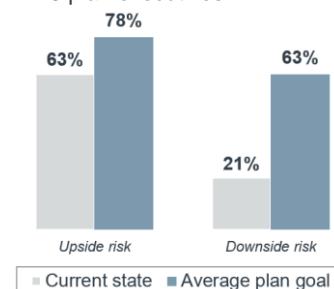
On the flip side, plans are a ways off from their downside risk goals. Plans report only 21% of their provider networks are in downside risk even though they would like 63% of their provider networks in downside risk models.

Also, providers in downside risk only have a small portion of their patient panel in risk. Room exists to push further by increasing the potential financial risk or bringing more of their patient panel into risk.

Thankfully, providers in downside risk are optimistic about their ability to move further into risk when compared to other providers. 67% of providers in downside risk say they feel prepared to take on more risk, compared to only 49% of providers in upside risk and 40% of providers not already in risk.

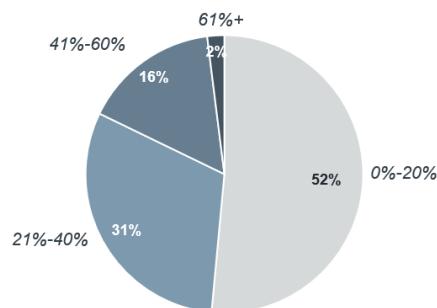
Percentage of plans' provider network in risk currently vs. plan goals

n=26 plan executives



Most physicians in downside risk have less than 20% of their patient panel in downside risk

n=62 physicians



How prepared do you anticipate you will be to take on more risk in 2 years from now?

Percent of providers selecting one of the following preparedness options

n= 99 providers not in risk; 58 providers in upside risk; 62 providers in downside risk



- Not at all prepared or very unprepared
- Somewhat unprepared
- Moderately prepared
- Very or completely prepared

Source: Advisory Board 2021 Path to Value survey and analysis.

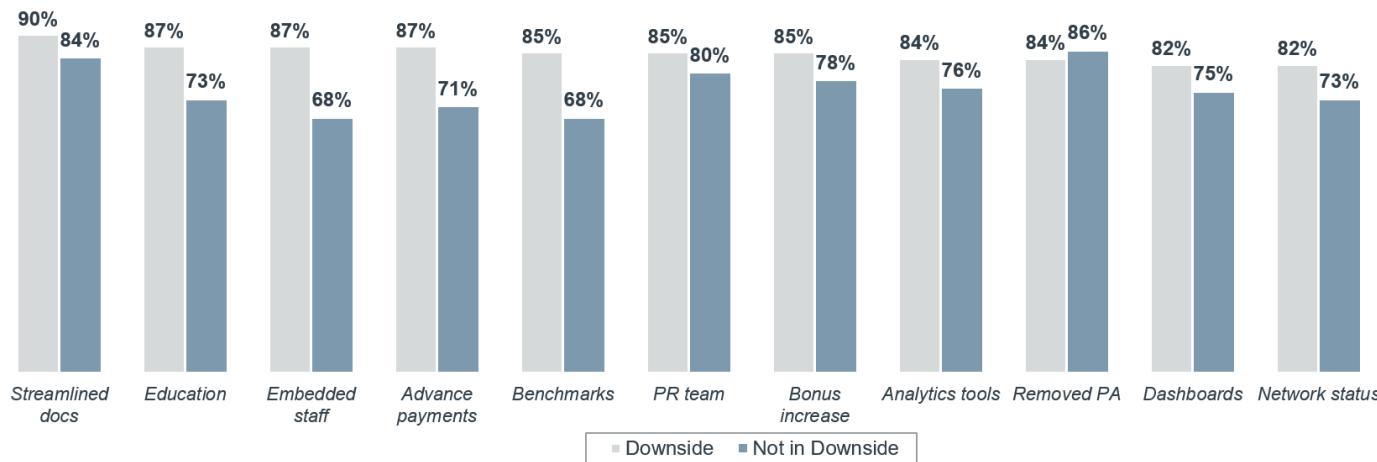
PREVENT PROVIDERS IN DOWNSIDE RISK FROM BACKSLIDING

Providers in downside risk appreciate the supports that plans offer. They are more likely than other providers to say that they are receiving these supports and to say that they are effective. Further, once they start receiving these resources, they find them more effective than expected.

How effective is each support resource in helping you improve your performance?

Percent of providers who have these resources and answered somewhat or very effective

n=65 providers in downside risk, 160 providers not in downside risk

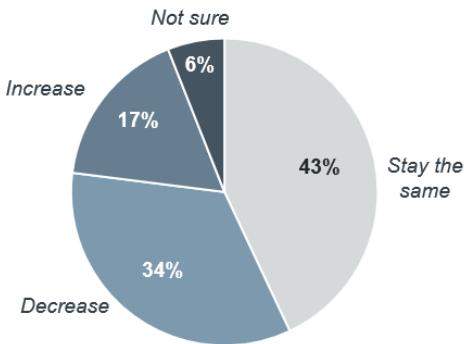


But ability does not equate to desire. 43% of providers in downside risk want to keep their involvement in downside risk the same and 34% of providers in downside risk want to *decrease* their involvement.

Momentum alone is not going to spur further downside risk adoption among providers. In fact, left alone, many providers would choose to revert into upside risk only models, reaping the benefits without the potential losses. Plans must, therefore, provide the necessary supports to push providers further into downside risk if they don't want providers to backslide.

Most providers in downside risk don't want to increase their organization's involvement in downside risk

n=65 providers in downside risk



Start with providers in downside risk first. This group can increase their risk, are more willing than other groups, and could backslide if not prioritized for financial success.

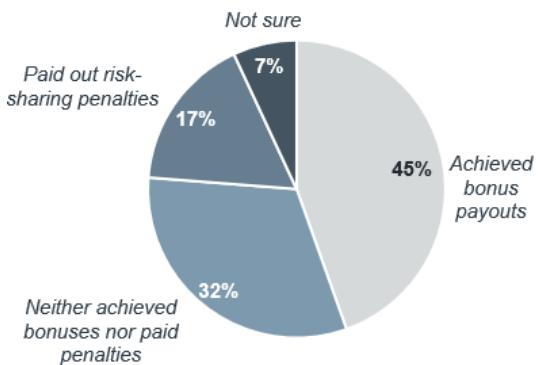
Source: Advisory Board 2021 Path to Value survey and analysis.

PREVENT PROVIDERS IN DOWNSIDE RISK FROM BACKSLIDING

The main reason providers in downside risk models don't want to continue is because they don't see a meaningful financial benefit for participating in downside risk models. Only 45% of providers in downside risk said that they achieved a bonus payout in the last year and of those providers, 48% achieved a bonus of 1% to 5%.

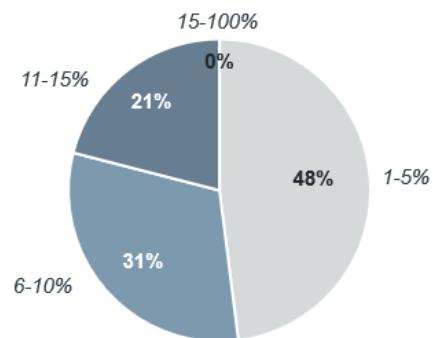
Even providers who achieve bonus payouts, don't receive a significant amount

n=65 providers in downside risk



Of those who achieved bonuses, no one got more than 15%

n=65 providers in downside risk



Providers face a catch-22. Help stop the cycle. Providers won't take on more risk if they don't think they will be successful financially. Then again, they also won't make the investments to be successful if they are not on the hook for a larger potential loss or bonus.

Plans can help this catch-22 by partnering closely with providers new to downside risk so that success in the first year is not only realistic, but likely and financially meaningful. The goal is to encourage providers to make further investments that will lead to success under downside risk in subsequent years.

FOCUS PROVIDERS NOT IN RISK ON THE END GOAL

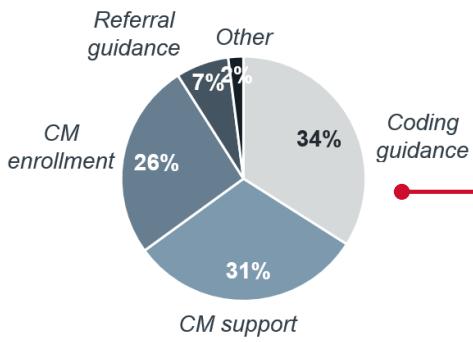
Differences exist in what providers in downside risk find effective versus providers not yet in downside risk. For example, while the average provider wants embedded staff support for coding guidance, providers in downside risk want embedded staff support for care management guidance as shown on the next page.

This aligns with a provider's traditional path to risk. In the beginning, when providers are taking on upside risk, they may struggle with functional questions—such as HCC coding—but by the time they are progressive enough to take on downside risk, they are focused on care delivery transformation.

Additionally, providers in downside risk are more likely than the average provider to want educational and informational resources. Specifically, they like the idea of having peer-led summits to learn from other provider organizations trying to adapt to downside risk.

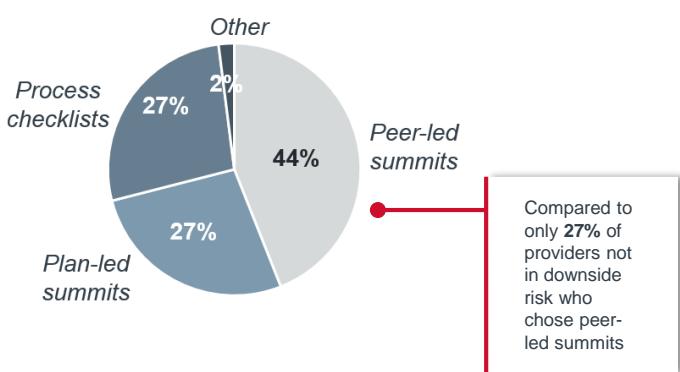
Which type of **embedded staff support** would be most helpful to you?

n=225 providers



Which type of **informational resource** would be most helpful to you?

n=62 providers in downside risk



Offer embedded care managers and peer-led summits. Providers in downside risk appreciate (relative to other providers) embedded staff support for care management and peer-led summits for education.

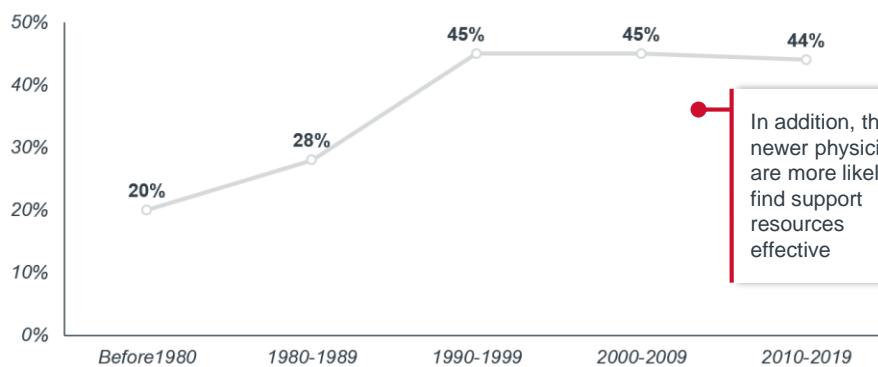
02 Convert providers in upside risk to downside

Providers *want* to be in upside risk with 44% of providers already in upside risk saying they want to increase their upside risk and another 37% want to maintain their current level of upside risk.

This desire is distributed across providers regardless of age. Providers who graduated medical school in 1990 or later are all equally willing to participate in upside risk (~45%)—it is not just the newest generation of doctors thinking about payment differently. The only subgroup that may not be willing to take on upside risk are those who graduated medical school before 1980 and may be up for retirement soon.

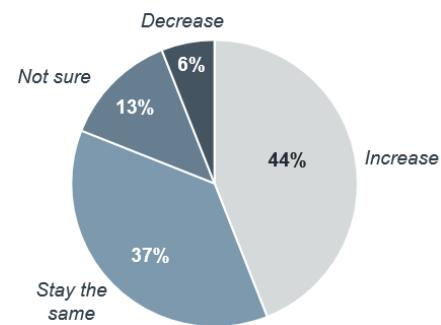
Physicians who want to increase upside risk by medical school graduation year

n=173 physicians



Most physicians in upside risk want to take on more upside risk

n=52 physicians in upside risk



Sources: Advisory Board 2021 Path to Value survey and analysis.

CONVERT PROVIDERS IN UPSIDE RISK TO DOWNSIDE

Let momentum take over. Don't over-focus on moving providers in upside risk further into upside risk. This will happen naturally, and on average, plans are already close to meeting their goals in upside risk.

Instead, plans should focus on moving providers in upside risk into downside risk. Although plans report only 21% of their provider networks are in downside risk, they say that 35% of their provider networks are capable to take on downside risk. This is a gap that plans can and must close.

Providers in upside risk are more willing to take on downside risk than those not in risk. In fact, most providers in upside risk models say that they would need less than 40% of their patient panel in risk before they are motivated to take on downside risk. This indicates an earlier threshold for when plans should start conversations on downside risk.

The interest is there. Some providers in upside risk are willing to move to downside risk, but they need support. This is made most evident by this survey finding: when plans negotiate a new risk-based contract, their top priority is looking for providers who have made investments in TCOC¹ infrastructure (as shown on the graph on the next page).

In contrast, providers in upside risk believe the most important attribute to demonstrate is experience managing risk with other payers—yet, only 27% of plans indicated that as a priority. Providers in upside risk don't even know what is most important in risk-based contracts to plans.

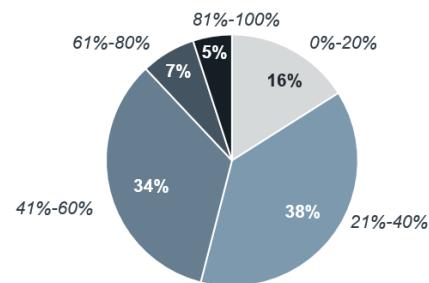
Plans say **21%** of their provider networks are in downside risk but

35%

Of their provider networks are capable of taking on downside risk

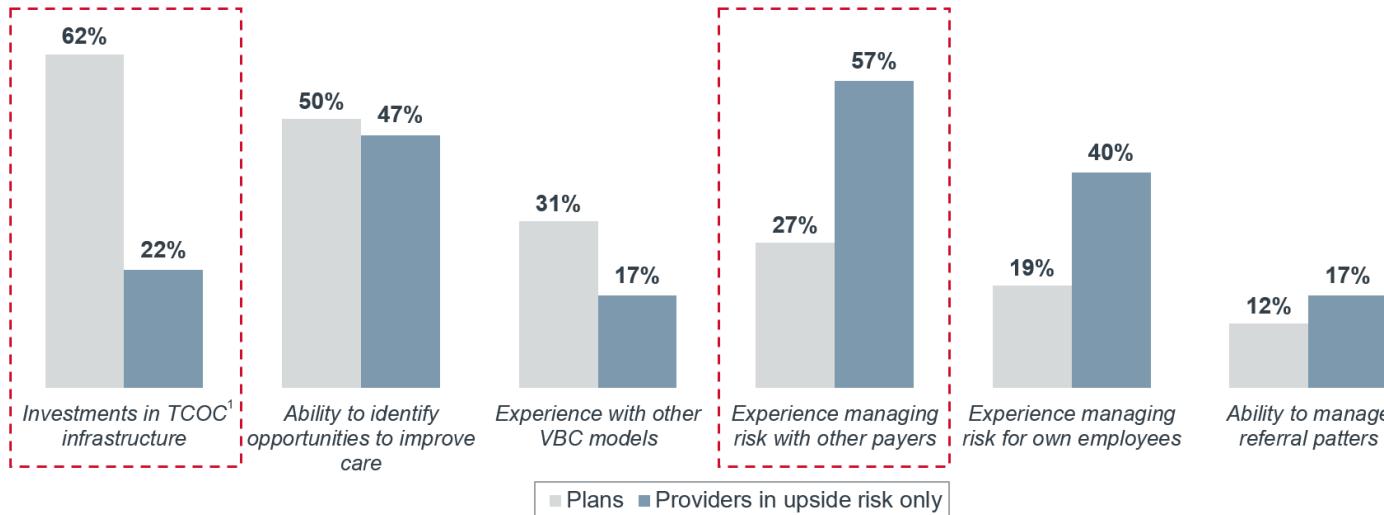
What percentage of your patient panel would need to be under risk-based arrangements to motivate you to take on downside risk?

n=58 providers in upside risk



CONVERT PROVIDERS IN UPSIDE RISK TO DOWNSIDE

What plans look for vs. what providers highlight when negotiating a new risk-based contract



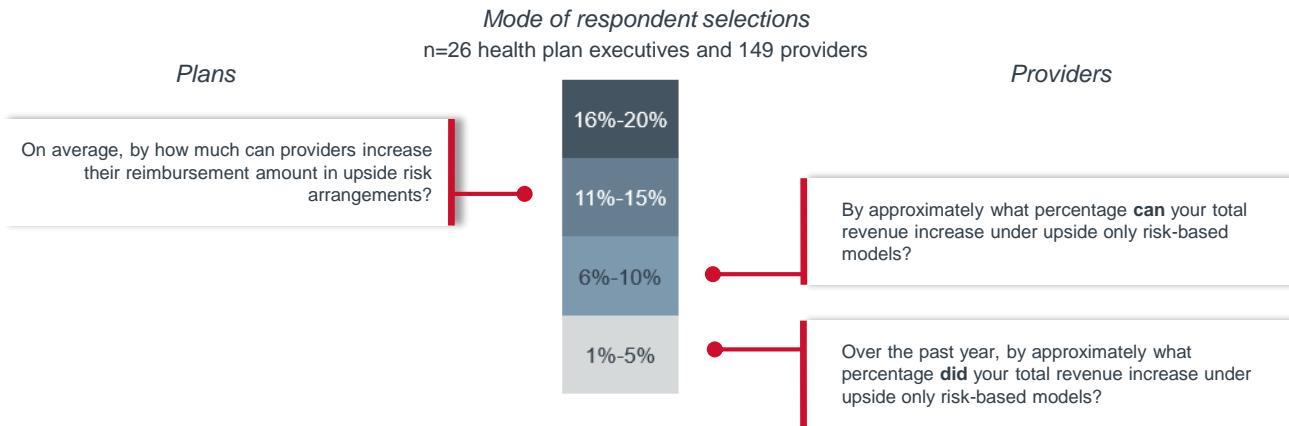
Make providers in upside risk confident about entering downside risk.

Focus on bringing providers in upside risk to downside risk and make those efforts early. Said differently, don't discount providers who only have a limited portion of their patient panel in risk and don't sell short providers in upside risk who may not appear ready for downside risk. Rather, engage them in lessons learned from other practices and help them prioritize investments in what's necessary for success.

Not surprisingly, the main challenge preventing providers from moving from upside to downside risk is financial uncertainty. Making this challenge even more problematic is the disconnect between plans and providers on potential bonus increases from upside risk. Plans say that the average potential reimbursement increase is around 11% to 15%. Meanwhile, the most common range from providers is a potential bonus increase between 6% to 10%. That gap widens even further when asking about actual bonus increases, where provider reports a mere 1% to 5% boost.

CONVERT PROVIDERS IN UPSIDE RISK TO DOWNSIDE

Plans and providers differ on how much they think providers can earn in upside risk



The disconnect should be taken seriously. Plans are overpromising and underdelivering on their financial promises in upside risk models, which makes providers less likely to enter downside risk.

Overpromising and underdelivering. Providers are less likely to take the next step and enter downside risk because even their financials in upside risk are lower than they expected (or were promised). Plans must be more transparent about what provider revenues will look like in upside and downside risk to set expectations appropriately.

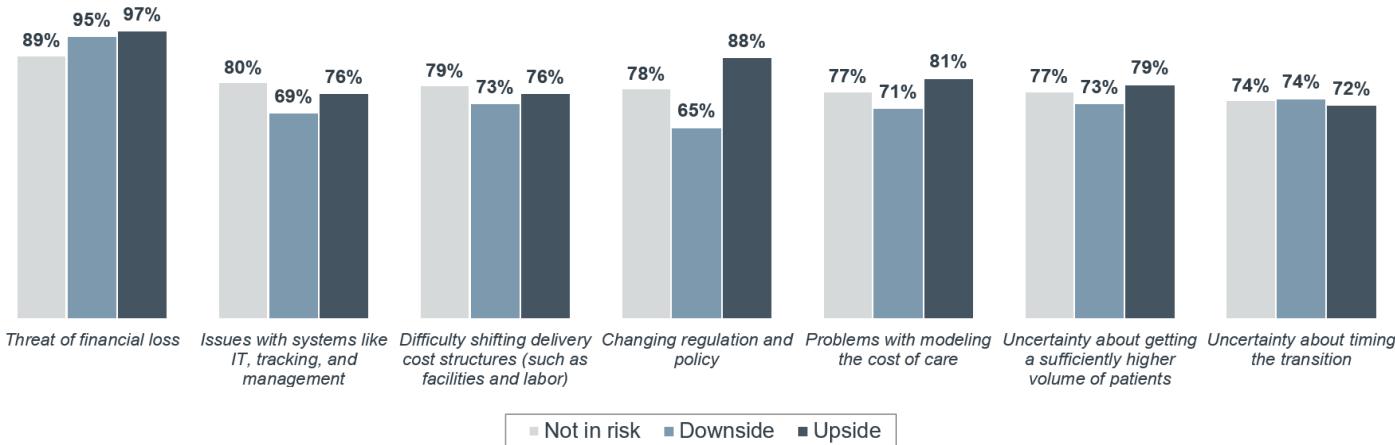
For providers in upside risk, threat of financial loss is the #1 barrier to take on more risk and accordingly, they prioritize supports related to finances. The top three resources that would make providers in upside risk participate in downside risk all relate to finances: bonus increases, advance payments, and preferred network status (as shown on the next page).

CONVERT PROVIDERS IN UPSIDE RISK TO DOWNSIDE

Providers' biggest barriers from taking on risk

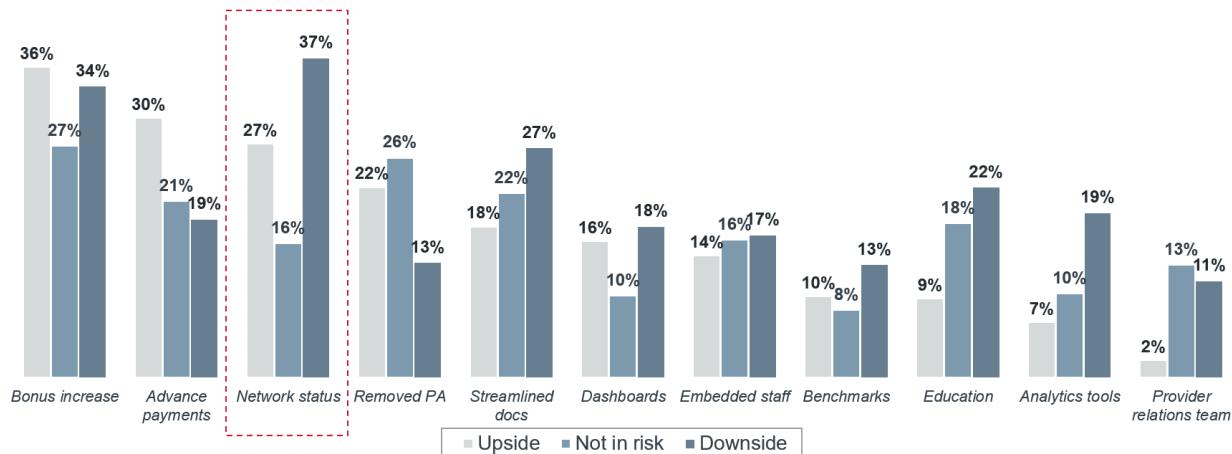
Percent of providers who said the following barrier is somewhat of or a very large barrier

n=99 providers not in risk, 62 providers in downside risk, 58 providers in upside risk



Which of these resources would make you more willing to participate in downside risk with private payers?

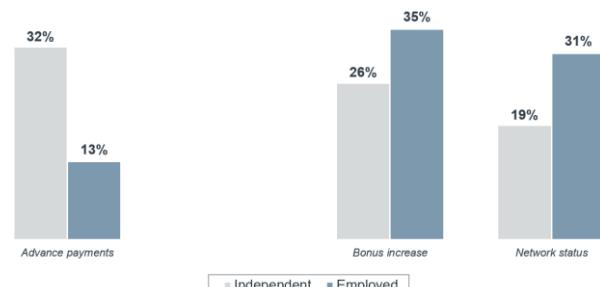
n=176 providers in total, 46 providers in upside risk only



Specifically, independent physicians prefer advance payments while employed physicians prefer bonus increases. This discrepancy potentially speaks to the challenge independent physicians face in investing upfront capital to succeed in VBP.

Which of these resources would make you more willing to participate in downside risk with private payers?

n=78 independent physicians, 98 employed physicians



Source: Advisory Board 2021 Path to Value survey and analysis.

CONVERT PROVIDERS IN UPSIDE RISK TO DOWNSIDE

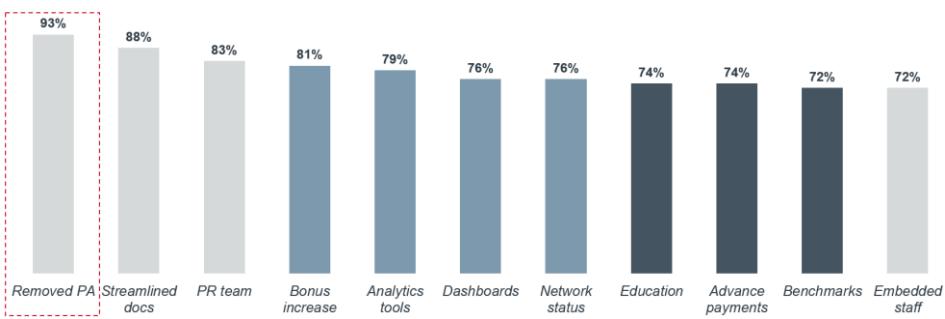
Interestingly, preferred network status is the top choice for providers already in downside risk although it falls behind bonus increases and advance payments for providers in upside risk. Providers in downside risk realize that a successful risk relationship can not be built on bonus increases and advance payments alone. Said differently, they likely recognize that if a plan must make outsize financial investments for VBP model to succeed, it defeats the purpose. By comparison, preferred network status helps high-quality providers succeed financially while still reducing TCOC under VBP arrangements.

Convey the full financial picture. Providers in upside risk need financial support to move into downside risk and gravitate toward bonus increases and advance payments. Plans must acknowledge this reality but should also expand the view of these providers, so they value network status like those already participating in downside models.

Beyond financial supports, prior authorization (PA) removal is the next resource that providers in upside risk value, and they are looking for significant relief from PA requirements. The majority want >40% of PAs removed and nearly a fifth of providers are looking for 81%-100% removal as an incentive for taking on downside risk.

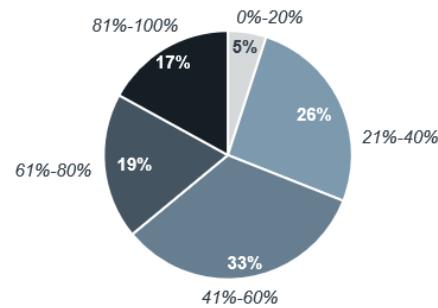
Resources that providers in upside risk think are effective at improving their performance in risk

n=58 providers in upside risk



What percentage of PAs would have to be removed to motivate you to take on downside risk?

n=58 providers in upside risk



CONVERT PROVIDERS IN UPSIDE RISK TO DOWNSIDE

Set up processes to remove more PAs as providers hit certain milestones.

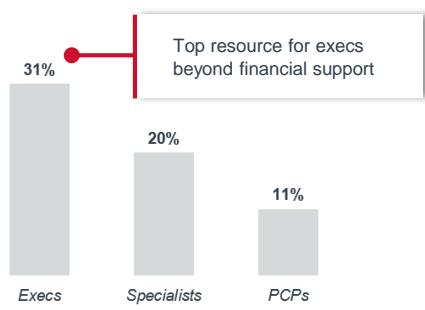
As providers demonstrate success under risk-based models, they expect plans to ease administrative burdens such as PAs. Adopting a principled structure for PA removal is one of the simplest ways plans can convey trust to providers and show providers the benefits of being in risk.

Lastly, education can be one way to entice providers from upside to downside risk. Prior to receiving any form of education, provider executives are more intrigued by education (than PCPs or specialists). In fact, executives indicate education as the top, non-financial resource to encourage participation in downside risk. But the story flips when a provider organization is in downside risk and has begun receiving educational resources. In those cases, physicians find education more valuable than executives.

Education would make me more willing to participate in downside risk

Percent of respondents who said yes

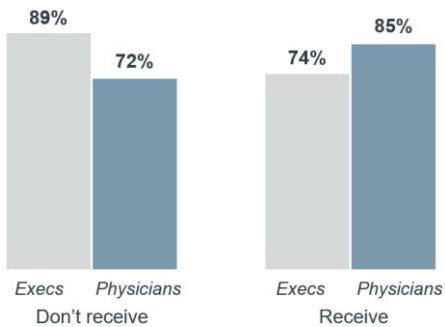
n=48 execs, 36 specialists, 92 PCPs



Once you provide education, physicians find it more effective than execs

Percent of respondents who find education somewhat or very effective

n=59 execs, 166 physicians



Showcase education to get your foot in the door. Education can entice provider executives to participate in downside risk and impress frontline physicians once they have direct experience with these sessions.

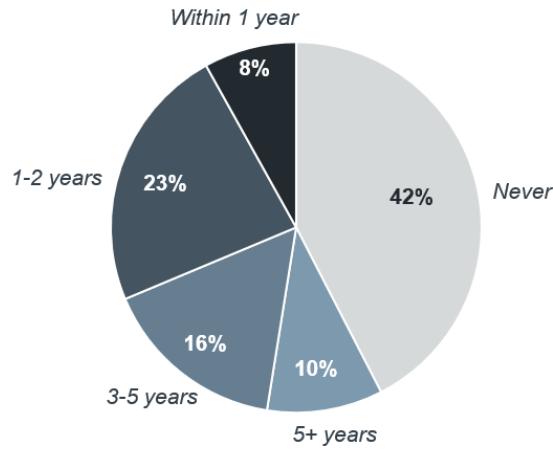
03 Focus providers not in risk on the end goal

Contrary to the conventional wisdom of many, the *last* group to focus on is providers not yet in risk.

This is because many providers not yet in risk say they will *never* be ready to take on downside risk—partly as a result of being ill-prepared. Out of providers not yet in risk, 59% feel unprepared to do so. Additionally, 10% of providers not yet in risk do not say they will *never* be ready but anticipate it will take a significant amount of time (over five years).

When will you be ready to take on downside risk?

n=69 physicians not in risk



59% Of providers not yet in risk feel unprepared¹ to take on risk

Save the hardest for last. Almost half of providers not yet in risk say they will never be ready for risk. Unless most of your providers are still in this category, only move to this group once you have already made all the progress you can with providers already in risk. Once these providers are ready for risk, you will already have support resources set up from investing in providers in risk.

However, by understanding what these providers value, plans can begin to make incremental progress in this final group of providers.

Source: Advisory Board 2021 Path to Value survey and analysis.

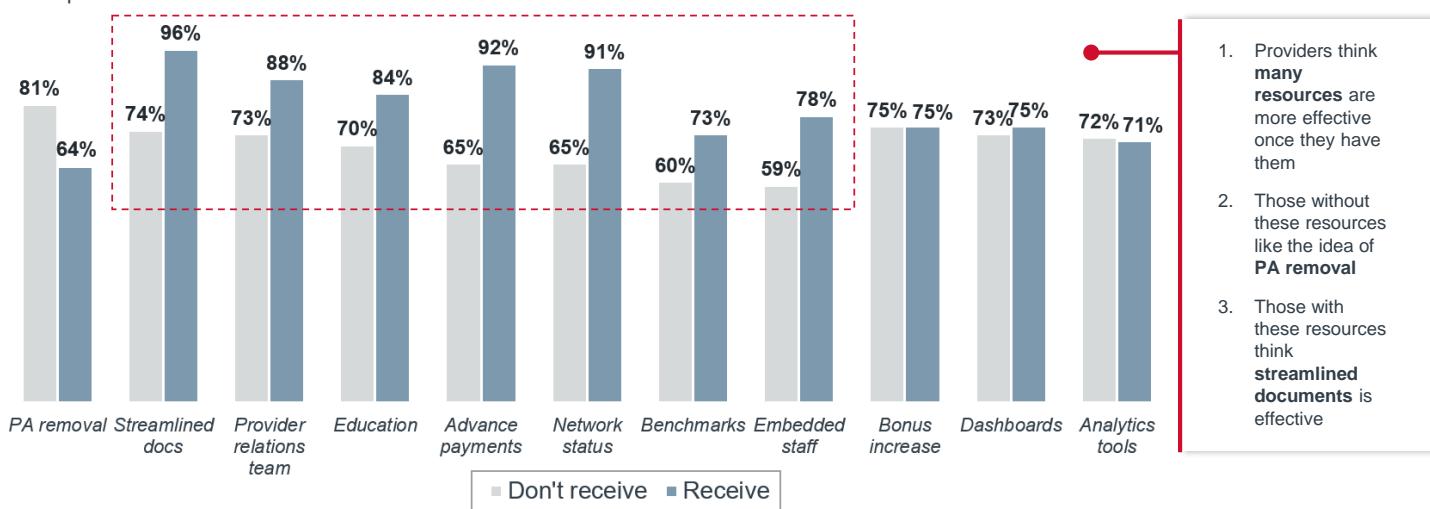
FOCUS PROVIDERS NOT IN RISK ON THE END GOAL

Providers not participating in risk-based models envision PA removal as the most valuable support resource, but once they start receiving these supports, streamlined documents become the most valuable. And, in general, these providers find resources more effective once they receive them.

How effective is each support resource in helping you improve your performance?

Percent of providers who answered somewhat or very effective

n=99 providers not in risk



Carrots, not sticks. When plans initiate risk conversations with providers not yet in risk, they must clearly articulate the available reward(s)—starting by reducing administrative burden. In some cases, plans may have to offer select supports before providers enter risk so they can experience being in upside risk. Or in other words, taste how good the carrot *can* be.

Providers not yet in risk are unlikely to jump straight into downside risk. They'll need to transition to upside risk as a way of appeasing their concerns.

Unfortunately, in many instances, providers are not seriously evaluating a future transition to downside risk even as they enter upside risk.

To overcome this challenge (and ultimately ease the transition for both parties), plans must keep the transition to downside risk top of mind for providers early in the process. The next chart outlines the resources that providers not yet in risk would find effective—segmented by whether they would ultimately consider adopting risk-based payment models.

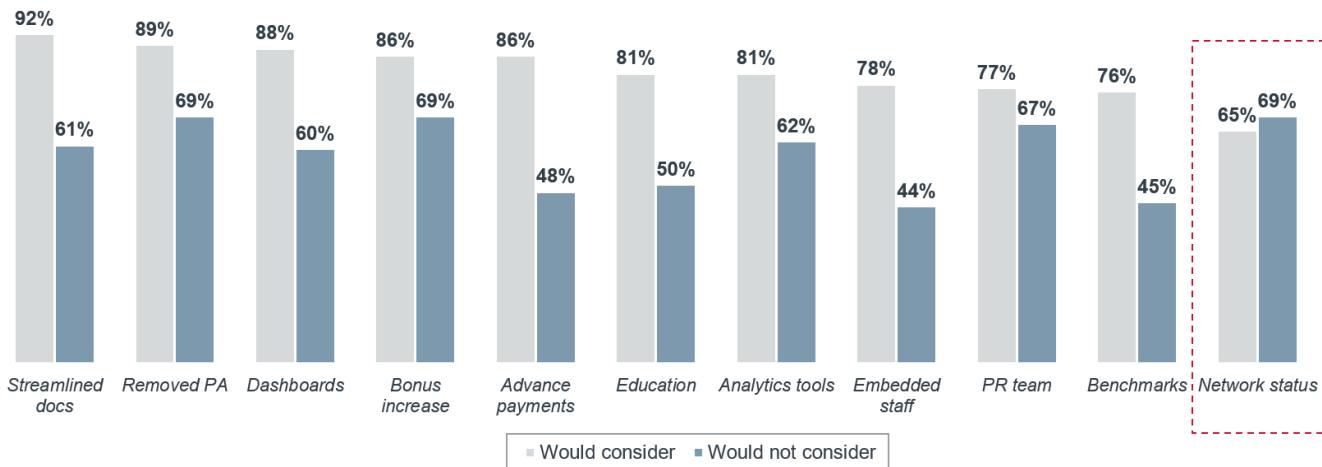
Source: Advisory Board 2021 Path to Value survey and analysis.

FOCUS PROVIDERS NOT IN RISK ON THE END GOAL

How effective is each support resource in helping you improve your performance?

Percent of providers who answered somewhat or very effective

n=28 physicians not in risk but would consider being in risk, 26 physicians not in risk and wouldn't consider being in risk



Notably, providers who are willing to enter risk in the future are more likely to find all of these supports effective *except* preferred network status. Even though providers in downside risk have learned that preferred network status is critical for success under downside risk.

Additionally, while providers not in risk may prefer supports such as removed PA and streamlined docs, providers in downside risk prefer supports such as benchmarks, embedded staff, and education. Plans should leverage these differences when transitioning providers (who are not currently participating in risk) into risk-based payment models.

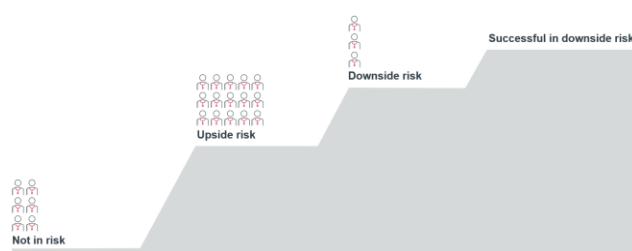
Keep the entire timeline in mind for providers from the beginning. Providers not in risk will want reduced administrative burden and increased bonuses as incentive to enter upside risk, but they eventually need to value preferred network status, benchmarks, embedded staff, and education to be successful in downside risk. Conceptually, it would be preferable for providers to stay in FFS while building up their capabilities for upside *and* downside risk—as opposed to having providers jump into upside risk without the ability to take on downside risk in the future.

What this means for you

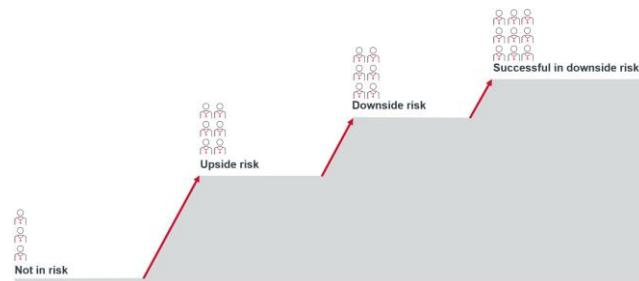
Don't formulate one risk strategy, but three.

1. Overinvest in providers already taking on downside risk to prevent backslide.
2. Providers in upside risk will naturally pursue more upside opportunities. Your job is to convert them to downside risk.
3. Save the hardest (providers not in risk) for last. When you approach them, focus them on the end goal

The future on our **current** trajectory



The future with **new** path-to-value strategies



How we do it

Preventing providers in downside risk from backsliding

- Don't think of downside risk as the finish line
- Overinvest in the first year to show providers financial success early on
- Offer embedded care managers and educational peer-led summits

Converting providers in upside risk to downside

- Be transparent about expected financials
- Showcase education to get your foot in the door
- Set up processes to remove PAs as providers hit VBP milestones

Focusing providers not yet in risk on the end goal

- Don't blindly invest in this group first
- Offer streamlined documents as a taste of the carrot
- Highlight the value of preferred network status

Methodology

In early 2021, Advisory Board surveyed a randomized sample of 225 providers and 26 health plan executives from around the country. The survey asked about their readiness for risk-based contracting and the most effective support resources.

How we defined each provider type for survey respondents:

- *Executives*: Clinical executive (such as chief medical officer, director of nursing, chief nursing officer, cardiologist department head, director of emergency, pharmacy director, medical director) or administrative executive (such as CFO, CIO, COO, business office director, and more)
- *Physicians*: Respondent identified themselves as a physician and not an advance practice provider (APP)
- *Providers*: Both provider executives and physicians as defined above

The support resources the survey asked about are below. They are referred to as their shorthand in italics throughout this brief.

- *Education* from payers on how to create and execute value-based payment arrangements (e.g., plan-led educational series, peer-led learning summits)
- *Patient dashboards* from payers showing clinical and financial data
- *Benchmarking* data from payers illustrating performance against peers
- *Analytics tools* from payers to plan and execute VBP arrangements (e.g., risk segmentation, predictive analytics)
- *Provider relations team* support from payers to quickly answer questions on data and service
- *Embedded staff* from payers to see patients in the office, support coding, and fill care gaps (e.g., care managers)
- *Streamlined documentation* and reporting requirements (e.g., standardized metrics set, embedded EHR insights)
- Removal of select *prior authorization* requirements in VBP arrangements
- Preferred health plan *network status* resulting in additional patient volumes
- *Increase in bonus* potential under risk-based contracts
- *Advanced/up-front (lump sum) payment*

Source: Advisory Board 2021 Path to Value survey and analysis.

METHODOLOGY

Below are how we defined providers in risk in this brief:

Providers in downside risk: The physician (for physicians) or the organization (for executives) already participates in at least one of the following:

- Bundled or episode-based payments
- Global budget or capitation
- Shared risk

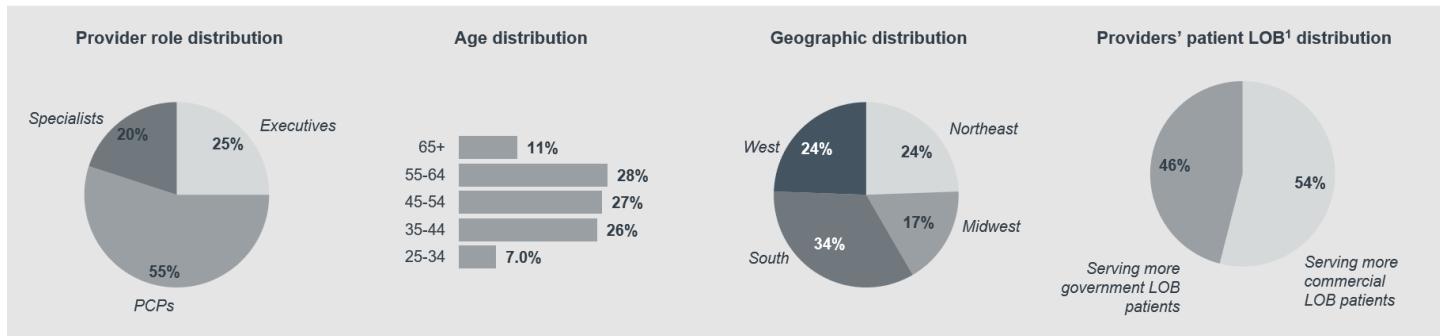
Providers in upside risk: The physician (for physicians) or the organization (for executives) already participates in at least one of the following and does not participate in downside risk:

- Shared savings
- Quality bonuses
- Add-on payments

Providers not in risk: The physician (for physicians) or the organization (for executives) already participates in at least one of the following and does not participate in either upside nor downside risk:

- Productivity-based
- Fee-for-service
- Salary-based

Descriptive statistics



1. Line of business.

Source: Advisory Board 2021 Path to Value survey and analysis.

Related content

WEBINAR

How to Help Providers Prosper with
Downside Risk

[Watch now](#)

RESEARCH REPORT

Value-Based Payment
Models

[Read now](#)

OUR TAKE

Value-based care is back in the
spotlight—what should health care
leaders learn from their past experience?

[Read now](#)

BLOG POST

Covid-19 threatens provider finances.
Here's how plans can amend value-
based care contracts.

[Read now](#)

RESEARCH REPORT

Path to Value Survey

[Read now](#)



Project director

Sally Kim

kimsal@advisory.com

Research team

Max Hakanson

Yasmine Hussein

Daniel Kuzmanovich

Natalie Trebes

Clare Wirth

Program leadership

Jared Landis

Natalie Trebes

LEGAL CAVEAT

Advisory Board has made efforts to verify the accuracy of the information it provides to members. This report relies on data obtained from many sources, however, and Advisory Board cannot guarantee the accuracy of the information provided or any analysis based thereon. In addition, Advisory Board is not in the business of giving legal, medical, accounting, or other professional advice, and its reports should not be construed as professional advice. In particular, members should not rely on any legal commentary in this report as a basis for action, or assume that any tactics described herein would be permitted by applicable law or appropriate for a given member's situation. Members are advised to consult with appropriate professionals concerning legal, medical, tax, or accounting issues, before implementing any of these tactics. Neither Advisory Board nor its officers, directors, trustees, employees, and agents shall be liable for any claims, liabilities, or expenses relating to (a) any errors or omissions in this report, whether caused by Advisory Board or any of its employees or agents, or sources or other third parties, (b) any recommendation or graded ranking by Advisory Board, or (c) failure of member and its employees and agents to abide by the terms set forth herein.

Advisory Board and the "A" logo are registered trademarks of The Advisory Board Company in the United States and other countries. Members are not permitted to use these trademarks, or any other trademark, product name, service name, trade name, and logo of Advisory Board without prior written consent of Advisory Board. All other trademarks, product names, service names, trade names, and logos used within these pages are the property of their respective holders. Use of other company trademarks, product names, service names, trade names, and logos or images of the same does not necessarily constitute (a) an endorsement by such company of Advisory Board and its products and services, or (b) an endorsement of the company or its products or services by Advisory Board. Advisory Board is not affiliated with any such company.

IMPORTANT: Please read the following.

Advisory Board has prepared this report for the exclusive use of its members. Each member acknowledges and agrees that this report and the information contained herein (collectively, the "Report") are confidential and proprietary to Advisory Board. By accepting delivery of this Report, each member agrees to abide by the terms as stated herein, including the following:

1. Advisory Board owns all right, title, and interest in and to this Report. Except as stated herein, no right, license, permission, or interest of any kind in this Report is intended to be given, transferred to, or acquired by a member. Each member is authorized to use this Report only to the extent expressly authorized herein.
2. Each member shall not sell, license, republish, or post online or otherwise this Report, in part or in whole. Each member shall not disseminate or permit the use of, and shall take reasonable precautions to prevent such dissemination or use of, this Report by (a) any of its employees and agents (except as stated below), or (b) any third party.
3. Each member may make this Report available solely to those of its employees and agents who (a) are registered for the workshop membership program of which this Report is a part, (b) require access to this Report in order to learn from the information described herein, and (c) agree not to disclose this Report to other employees or agents or any third party. Each member shall use, and shall ensure that its employees and agents use, this Report for its internal use only. Each member may make a limited number of copies, solely as adequate for use by its employees and agents in accordance with the terms herein.
4. Each member shall not remove from this Report any confidential markings, copyright notices, and/or other similar indicia herein.
5. Each member is responsible for any breach of its obligations as stated herein by any of its employees or agents.
6. If a member is unwilling to abide by any of the foregoing obligations, then such member shall promptly return this Report and all copies thereof to Advisory Board.



655 New York Avenue NW, Washington DC 20001
202-266-5600 | advisory.com