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Mastering Value-Based Care Contracting: A Guide for Healthcare Leaders

Overview

There is no one short answer to help providers negotiate value-based care (VBC) contracts with payers. However, a checklist with some guidance is definitely a worthy attempt. This quick guide provides a few pointers to use while negotiating or reviewing a contract's exposure to the provider organization.

We have attempted to make this guide simple and digestible, covering what matters most—the factors to address while negotiating a value-based contract. Use the table of contents to navigate more quickly to sections of interest, as each section is designed to stand on its own.

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Benchmark and Shared Savings Calculation

Benchmark

The **benchmark** is a key component of any shared savings contract, as the benchmark methodology will often dictate what target will be assigned to compute expected expenditure in a shared savings value-based arrangement.

How is the benchmark expenditure calculated? There are three standard ways payers compute benchmark expenditure:

Risk Adjusted: The benchmark expenditure is computed based on the risk adjustment of members. Risk adjustment is usually carried out on demographics and existing disease conditions. Risk-adjusted models help to ensure the expenditure is rightfully adjusted if the provider organization has more sick members in the portfolio. Although, over time this model can result in diminishing returns as the provider can only do so much cost of care reduction on an annual basis on members with the same or diminishing risk.

Market Adjusted: In this model, benchmark expenditure is not provided upfront by the payer. Although savings are computed by the efficiency created in expenditure compared to the market, (i.e. if the cost of care increase for the provider organization members was lower than the market) then that delta is assumed to be savings. This model is more sustainable than a risk model as long as the provider continues to outperform the competition. However, the risk is that the provider organization lacks a specific goal to work towards and only finds out where they stand at the end of the year.

Hybrid: This model incorporates the positive attributes of both aforementioned models. Both the market and a healthcare organization's patient populations are risk-adjusted and then the cost growth rate delta between the population and the market provides savings.

Make sure the **risk model** used to compute a risk-adjusted benchmark **is clearly spelled out in the contract.**

Ensure that **benchmarking is not based on a comparison with a random cohort selected from the market** (e.g., Blues in many states choose random cohorts for risk adjustment, which can lead to trust issues for provider groups).

Shared Savings

The next question to ask is how shared savings are computed.

It is common for shared savings percentages to be negotiated upfront between providers and payers as part of value-based contract negotiations. 50% is a standard percentage as this represents an equal share between provider and payer (equal share of success).

However, from a financial standpoint, when the share rate is set at 50%, this often represents a maximum that can be impacted by performance on agreed-upon quality measures. It is becoming commonplace for quality measures to serve as a "gatekeeper" or "lightswitch" to create eligibility for financial shared savings incentives to be applied, or "in play." The quality component of shared savings calculations is often derived from an overall composite score based on the performance of many measures.

To arrive at a composite quality score that can be used as part of the shared savings calculation, the quality multiplier is either based on percentile or absolute quality performance of quality measures, and scores for quality measures are averaged or weighted to arrive at a composite score.

Applying a quality multiplier on shared savings is acceptable, but ensure the **percentile-based quality multiplier is not too sensitive.** This can cause **undesirable returns at mid-market level performance.**

Don't negotiate and agree to quality measures which are inherently more difficult for providers to document and/or it is hard to generate data to demonstrate performance. *Read more on this topic in the quality measures section.*

Shared Savings Calculator

Measurement Period			
Key	Field	Amount	Formula
a)	Member Months	25,000	
b)	Allowed Spend	$5,000,000	
c)	ACO Customer Expenses	$1,000,000	
d)	Excess Medical Claims	$500,000	
e)	Risk Score	1.12	
f)	Measurement Period Adjusted Net Spend	$3,500,000	= b - c - d
g)	Measurement Period Adjusted Net PMPM	$140.00	= f / a

Baseline Period			
Key	Field	Amount	Formula
h)	Member Months	24,000	
i)	Allowed Spend	$5,500,000	
j)	ACO Customer Expenses	$900,000	
k)	Excess Medical Claims	$600,000	
l)	Risk Score	1.15	
m)	Baseline Period Adjusted Net Spend	$4,000,000	= i - j - k
n)	Baseline Period Adjusted Net PMPM	$166.67	= m / h

Trend Adjustments			
Key	Field	Amount	Formula
o)	Budgeted Trend	1.20%	
p)	Actual Trend	1.10%	
q)	Adjusted Trend	1.15%	= o - 0.5 (p - o)
r)	Net to Allowed Change	-3.75%	=((f/b)/(m/i))-1
s)	Risk Score Change	-2.61%	=l-e

Target Adjustments			
Key	Field	Amount	Formula
t)	Adjustment Factor	95%	=(1+q)(1+r)(1+s)
u)	Target Spend PMPM	$158.03	=n*t
v)	Target Spend	$3,950,714	=v*a

Shared Savings			
Key	Field	Amount	Formula
w)	Total Shared Savings Amount	$450,714	= v - f

Downside Risk /Upside Risk /Two-Sided Risk Models

There are three different value-based contract risk models: upside risk, downside risk, or a combination of the two (a two-sided model).

- **Upside risk,** or a one-sided risk model, allows those who participate to share in the savings if they meet all criteria. Providers are eligible to earn a percentage of the shared savings that their care has produced. If they do not exceed the agreed-upon benchmark, then there is no payment to them, but there is also no financial penalty. This is the model most providers prefer, as they are not liable for losses.
- The **downside risk** option is designed to mitigate losses in the situation where a provider's care (medical services and treatment) exceeds agreed-upon financial and clinical thresholds. In the case that the provider has a cost that exceeds the agreed-upon benchmark, they must refund the payer for a portion of the losses.
- A **two-sided risk** model combines both the upside and downside portions of the aforementioned models. The maximum and minimum of this model tend to be lower than the minimum of the downside or the maximum of the upside model. Thus, this model will typically yield less savings than the other models as it is a blend of the risk from the other models.

In 2017, CMS announced that **438 out of the 480** total Medicare Shared Savings Program (MSSP) ACOs are in Track 1, an **upside risk-only model.**[1]

Min/Max Savings/Loss Ratio

Having a floor and ceiling on loss or savings is a good idea to ensure the provider organization understands its limit and risk exposure. Having a maximum loss percentage of benchmark expenditure is important to include in the contract, and it is likely the payer will, in return, ask for a maximum savings percentage to be outlined in the contract.

In addition to establishing maximum savings and loss percentages, most payers ensure provider groups are eligible for shared savings only when they hit minimum savings as a percentage of benchmark expenditure.

25% of ACOs fail to achieve shared savings despite reducing the cost of care below the benchmark expenditure because they **don't meet their negotiated minimum savings rate**. While negotiating this aspect of a contract can be challenging, they should aim for a **minimum savings rate as low as 2%**.

Truncation/Stop Loss

To eliminate the outlier effect from cost savings generated, **truncation**, or limiting an amount, is usually applied. For example, if truncation is $100,000, the cost of care towards per member per month (PMPM)

[1]Source: https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/2017-mssp-fact-sheet.pdf

model for members where the cost of care beyond $100,000 is capped at $100,000. Having a truncation clause in the contract is important to eliminate outlier sensitivity from cost savings as it can skew results.

Cost Carve Outs

The primary intent of a value-based contract is to reduce the cost of care. It is the delta between the expected and actual cost of caring for populations where savings, and subsequently shared savings, can be generated. In order to accurately measure the difference between expected and actual cost of care for a population, it is important to call out which service lines in cost of care are included, and more specifically, not included in the management of a population in a value-based contract. Usually, in commercial VBC contracts, medication costs are excluded, as typically they are not something the provider has a large amount of direct control in terms of spend.

Most **provider groups** try to **carve out medication costs** from the total cost of care to manage under the VBC contract in the Commercial Line of Business. This is because **rising medication costs are not in their control** and it is the highest rising service line which could impact them if included.

Quality Measures

In many contracts, quality measure performance is linked directly to shared savings. In many other contracts, payouts are provided for every measure met, such as payouts for **pay for performance (P4P)**. Thus, it is important to ensure providers meet their quality measures. In many cases, quality measures involve the physician having to do more work and/or documentation without payouts, which are tougher to meet, such as “depression screening with follow-up” or “screening for fall risk.” They should try to avoid such measures in the contract, especially if its performance is linked directly to shared savings more so than pay for performance.

Some payers try to complicate pay-for-performance (P4P) payouts with relative percentile ranking, weights, and point systems which can be a challenge to operationalize and predict. Providers should **try to structure P4P payouts as simply as possible. Payout per member for each measure closed** or PMPM payout if a measure performs beyond a set benchmark are the two simpler structures to operationalize.

Relationship Between Quality and Shared Savings

In most value-based contracts, quality measure performance acts as either a gatekeeper or a direct correlation to shared savings. Quality measure as a gatekeeper is potentially limiting to a provider, i.e. if quality measure performance hits a particular threshold, the provider is eligible for shared savings. If the quality performance does not cross the threshold established, no shared savings payment would be made to a provider, even when the total cost of care is below the benchmark negotiated.

A better approach than using quality as a gatekeeper is to have quality measure performance as a

multiplier of shared savings. The table below shows an example of shared savings incentives when quality is used as a multiplier.

Scenario: 50% Maximum Savings Rate

Quality Performance	Maximum Shared Savings Rate	Shared Savings Rate Paid to Provider
80% of target achieved	50%	(80% x 50%) = 40% savings rate
90% of target achieved	50%	(90% x 50%) = 45% savings rate

It is important to understand how composite quality performance is computed. Is it based on relative or absolute performance, or is it based on a point system for each measure wherein one measure has more weight than the other? Answers to these questions can help providers negotiate attainable targets so as not to dilute the shared savings rate as illustrated above.

Pay For Performance

Beyond the quality performance relationship with shared savings, provider groups can also be incentivized to meet quality measures in isolation. Pay for performance can be paid on different models:

Per gap closure:

$40 for breast cancer screening done

$10 for A1C under control — essentially a separate dollar amount for every gap on every patient closed

Per measure performance:

A measure for performance that meets target criteria, PMPM for all members or members in denominator paid

Overall measure performance:

A number of measures that meet performance criteria based on a point system, a PMPM payout is scheduled depending on the performance brackets

Supplemental Reporting

Most payers give some leeway to provider groups in how they access a list of members with care gaps for all quality measures. Also, provider groups can send evidence of gap closures using clinical data sent back to the payer to close open gaps.

The methodology and format for back-and-forth data communication between payer and provider groups should be clearly documented in the contract and should include verbiage on frequency and data samples. This process ensures providers will be able to take advantage of submitting additional information necessary to maximize performance on negotiated quality measures.

Data Sharing

Both payer and provider groups need to understand how, how often, and what data will be shared between them. Usually, these data exchanges are:

Claim and eligibility:

On a regular basis (weekly/monthly), the payer must send these files for attributed and sometimes assignable members to the provider group.

Cost & utilization reports:

The payer must send monthly / quarterly on cost and utilization break-up, at least high-level metrics such as:

- PMPM is split into inpatient, outpatient, professional, DME, and Rx
- Utilization per 1000: IP discharges, ED visits, SNF admits, primary care visits
- LoS (Length of stay): Inpatient admit days / 1000 and inpatient average. LoS for short-term, rehab, physc, SNF

High cost members:

Sometimes, the payer also gives out a list of members with the cost of care. Having costs from the payer on high-cost members is an added value.

Quality reports:

Ideally, the payer should provide a monthly report on which members have not qualified quality measures in this performance year (for the provider group to give evidence back in supplemental reporting).

Supplemental reporting:

The provider group and payer should pre-define a format on how the provider group will share clinical evidence back to the payer to meet criteria for qualifying quality measures for its managed members.

ADT and Pre-Auth:

Payers have access to **ADT** and **pre-auth** feeds for all members with a slight lag. Although provider groups might want to connect to a more real-time ADT feed to better manage transitions in care, having a daily file from the payer on ADTs and pre-auths is not a bad idea to run some care management activities, especially **transition-in-care Management (TCM).**

Claims Data

The following attributes should be included in claims data sent over at least on a monthly basis:

Claim Header	Claim Line	Pharmacy Claim	Additional Diagnosis	Additional Procedures
member ID*	member ID*	member ID*	member ID*	member ID*
member name*	claim ID*	claim ID*	claim ID*	claim ID*
birth date*	claim ID*	claim ID*	claim ID*	claim ID*
gender*	first date of service*	birth date*	diagnosis coding system	procedure coding system

first date of service*	procedure code*	start date*	modifier code 1
last date of service*	procedure coding system	end data*	modifier code 2
plan ID	modifier code 1	plan ID	modifier code 3
plan name	modifier code 2	plan name	modifier code 4
DRG Name	modifier code 3	medication code*	modifier code 5
DRG code*	modifier code 4	medication name	
discharge disposition code	modifier code 5	days of supply*	
primary diagnosis code*	service unit quantity	unit quantity	
diagnosis coding system	revenue center code*	dosage per unit	
claim submission date	servicing provider npi*	refill no*	
claim processing date	servicing provider	route of administration	
claim adjudication date	attending provider npi	charge amount	
claim approval date	attending provider	allowed amount	
admission type	other provider npi	amount paid by insurance*	
present at admis-sion indicator	other provider	co pay	
claim type*	line - charge amount	pharmacy id	
type of bill*	line - amount paid by insurance*	pharmacy npi*	
place of service*	out of network flag*	pharmacy name	
servicing provider npi*	place of service	pharmacy street add1	
servicing provider name		pharmacy street add2	
attending provider npi		pharmacy city	
attending provider name		pharmacy zip	
other provider npi		pharmacy state	
other provider name		pharmacy country	
facility npi		pharmacy fax	
facility name		pharmacy phone	
tax id*		formulary id	

CCN	formulary name
billing tax organi-zation name	adjustment status*
charge amount	pharmacy service type code
allowed amount	drug enforcement agency
amount paid by insurance*	dispense as written
co pay	
deductible	
adjustment status*	
referral source code	
out network flag*	

*Minimum required fields

Eligibility Data

It should contain demographics, attributed provider, eligibility indicators (dental, eye, etc.), and clarity on when this member is part of the plan or is inactive.

Cost and Utilization Reports

At least the following attributes should be reported on at least a quarterly basis:


PMPM


IP Admits and $s


All Cause 30-Day Readmits


Risk Scores


ED Visits and $s


CT & MRI Events and $s


Person Years / Member Months


SNF Admits and $s


Split of $s & Utilization By Cost Centers

High Cost Members

List of top 5% members by total cost of care with costs, comorbidities, and changes from last year.

Quality Reports

The following attributes are required in quality reports on at least quarterly basis:

- Members who met what measures with evidence of
- Members who did not meet the measure

Supplemental Reporting

Consensus on the format to submit supplemental data back.

ADT

Daily feed on admit discharge transfer with at least member identification, demographics, diagnosis, facility, date and time, and discharge disposition details.

Glossary

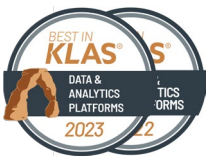
- **ADT** - Admission, discharge, and transfer. The ADT process is one of the most important parts of hospital workflows. An ADT system is a part of a hospital information system (HIS).
- **Benchmark** - The goal set in the upcoming year, typically based on historical data and performance that the group must exceed to be eligible for savings.
- **Benefit Cost Ratio (BCR)** - An indicator that shows the relationship between the relative costs and revenue for a proposed population or project.
- **Ceiling** - This is the highest possible rate at which the shared savings or losses can be earned.
- **Floor** - This describes the lowest possible rate at which the shared savings or losses can be earned.
- **Gatekeeper** - It controls access to the created shared savings where certain standards must be met to become eligible for the next step.
- **Maximum savings %** - The maximum amount a provider can earn from the creation of their shared savings.
- **Minimum savings %** - The minimum amount of financial savings a provider must exceed in order to be eligible for shared savings.
- **Medical Loss Ratio (MLR)** - The ratio between the premium revenues spent on clinical services and quality improvement.
- **Pay For Performance (P4P)** - Also known as "value-based purchasing," is a payment model that offers financial incentives to physicians, hospitals, medical groups, and other healthcare providers to meet certain performance measures.
- **Pre-Auth** - Pre-authorization is the process used by health insurance companies to determine if a prescribed procedure, service, or medication will be covered.
- **Transition-in-Care Management (TCM)** - Addresses the hand-off period between the inpatient and community setting after a hospitalization or other inpatient facility stay (e.g., in a skilled nursing facility).
- **Truncation/Stop Loss** - Occurs when the limit is set and whatever exceeds the limit amount is removed.

About Innovaccer

Innovaccer is the data platform that accelerates care innovation. The Innovaccer platform unifies patient data across systems and care settings, and empowers healthcare organizations with scalable, modern applications that improve clinical, financial, operational, and experiential outcomes. Innovaccer's EHR-agnostic solutions have been deployed across more than 1,600 hospitals and clinics in the US, enabling care delivery transformation for more than 96,000 clinicians, and helping providers work collaboratively with payers and life sciences companies. Innovaccer has helped its customers unify health records for more than 54 million people and generate over $1.5 billion in cumulative cost savings. The Innovaccer platform is an industry-leading data and analytics platform and the #1 rated population health technology platform by Black Book.

For more information, please visit innovaccer.com.

Awards & Recognition



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