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Building a successful value-based payer contracting strategy

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Healthcare providers are finding it increasingly difficult to achieve strong financial performance as the popularity and complexity of value-based payer contracts continue to rise. Healthcare providers that implement an effective contracting strategy can improve financial performance under value-based contracts. While payer contracts are complex, providers may gain insight by prioritizing and measuring operational and contractual elements against three core pillars: transparency, stability, and control.

Two years ago, the Centers for Medicare and Medicaid Services (CMS) announced its goal to tie 50% of traditional fee-for-service (FFS) Medicare payments to quality or value by 2018.[1] Commercial payers are also pursuing value-based contracts.[2] A single provider may manage several value-based contracts with varying degrees of risk and complexity. Value-based provider contracts rely on a wide range of approaches from bundled payments to accepting downside risk. It is easy to lose track of what is important and where to best focus limited resources.

In this paper, we introduce three pillars to optimize a provider's performance with value-based contracts. In this simplified example, we apply the pillars to the contract, the payer's reporting, and data sharing between the payer and provider to show how prioritizing and managing these broad attributes increases the likelihood of a positive return on investment. Figure 1 summarizes important considerations for each pillar and element.

Providers prioritize each pillar and attribute to create weights for each cell. Contractual elements are then evaluated against those pillars to produce a score for each cell. This can be either a subjective evaluation or a more rigorous analytic evaluation depending on the nature of the element. The weighted scores can be used to prioritize areas of administrative concentration and to compare payer contracts on a similar basis. This prioritization is a critical step to a successful contracting evaluation process.

Transparency

Value-based contracts are becoming increasingly more complex than traditional FFS contracts as they introduce additional financial risks. Transparency ensures that complex contractual provisions and their associated reporting metrics can be independently verified. At a minimum, the provider should be able to reproduce the base medical costs and historical trends that match key metrics specified in the contract, using data provided by the payer. The provider's ability to manage its risk is diminished if the payer fails to provide the necessary data to complete this exercise.

1 CMS.gov (March 3, 2016). Better Care. Smarter Spending. Healthier People: Improving Quality and Paying for What Works. Fact Sheet. Retrieved January 29, 2016, from https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html.

2 Muhlestein, D. & McClellan, M. (April 21, 2016). Accountable care organizations in 2016: Private and public-sector growth and dispersion. Health Affairs Blog. Retrieved January 29, 2016, from http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/.

FIGURE 1: THREE PILLARS OF A SUCCESSFUL VALUE-BASED PAYER CONTRACTING STRATEGY

ELEMENT	TRANSPARENCY	STABILITY	CONTROL
Contract	Are all items clearly defined? Can the payer verify all elements?	Is the contract structured to create a stable outcome?	Is the contract negotiable or dictated? How is trend determined?
Reporting	Are the report calculation methods clear? Can they be replicated?	Are calculations consistent over time?	Are requested changes to calculation methods implemented?
Data	Are all the needed data elements provided to effectively manage the population?	Are there frequent changes in the data formatting or content?	Are additional data elements available upon request?

Examples of non-transparent contract provisions include trend targets that do not reconcile to the payer's portfolio trends, proprietary risk scoring methods, undocumented completion factors, and paid-to-allowed ratios based on confidential contracts outside the provider's right to know.

Stability

Contractual instability creates unpredictable financial results and does not tie financial incentives to a provider's performance under a value-based contract. Successful contracts mitigate random fluctuation in payments by ensuring the proper number of lives are considered, removing certain high-cost claims, and incorporating verifiable risk adjustment.

Value-based models and reporting should be reflections of the provider's initiatives. A payer changing contract terms, reporting, and models can create undue disruption to a provider's operations and revenues, which could cause more harm than good for the provider.

Other considerations that could destabilize a contract include continual changes in the provider's physician network, lack of referral management processes, inaccurate coding tied to risk scores, lack of prescribing tools, and unskilled use of data provided.

Evaluating each element through the lens of stability highlights areas where providers can wproductively focus their efforts or, if needed, eliminate unneeded complexities that may destabilize the contract's outcome.

Control

Providers often enter into value-based contracts to gain more control over managing their healthcare delivery, not realizing the complexity of the contract. Examples include profit sharing and eliminating medical management documentation requirements by agreeing to meet certain quality measures.

Medical trend is a frequently contested contractual provision. Trend is also a key variable in the financial reporting and should be verifiable through the raw data obtained by the provider. Providers should feel empowered to:

- Negotiate the contracted definition of trend
- Request detailed reports on trend
- Request additional data to fully evaluate the provider's ability to generate a positive financial outcome

A similar evaluation could be made on other contract provisions such as attribution, quality measures, and risk adjustment.

Some elements of a value-based contract will likely remain outside the provider's control. For example, changes in the payer's enrollment base, payer contracting with hospitals and physicians outside the provider's network, and regulatory changes are not within the provider's control. Contracts should be structured such that these uncontrollable elements do not affect a provider's financial results.

Putting it together

The exercise of scoring the grid identifies high-risk elements and compares contract structures from different payers that require revisions. When performed rigorously, this process brings focus that allows management to spend more time on contracts with the greatest risk and potential for improvement. Applying each pillar to specific payer contract elements identifies specific risks and creates areas of focus for providers during negotiation. However, this analysis alone does not enable providers to easily compare value-based contracts in their entirety.

The complex evaluation process is illustrated below in a simplified form. The intent of this illustration is to highlight important aspects of the decision-making process required to effectively manage complex payer relationships.

First, the contract is scored for each pillar and element cell in the scoring grid. Each contract is evaluated separately and may contain different elements. The provider may require independent help.

Second, the provider weights each cell in the grid based on priorities. These weights would likely be consistent across contracts. The provider may counsel with outside help to prioritize, but ultimately will be responsible for the focus of their efforts.

Finally, the total score is calculated by applying weights in each cell based on prioritization of the contracting elements. Figure 2 illustrates this contract-scoring approach.

While the sample *contract* scores 60% on the control pillar, its overall score is 110 of 270, or 41%, which is due to lower *transparency* and *stability* scores. This provider may conclude that its primary focus should be on either the transparency of reports from the payer or on improvement of the data it receives so it can produce its own reports.

FIGURE 2: SAMPLE VALUE-BASED PAYER CONTRACT PRIORITIZATION GRID

	TRANSPARENCY		STABILITY		CONTROL		
ELEMENT	SCORE	WEIGHT	SCORE	WEIGHT	SCORE	WEIGHT	TOTAL POINTS
Contract	6	3	4	5	6	3	56
Reporting	3	5	2	2	5	1	24
Data	2	4	5	3	7	1	30
Total points	**41**		**39**		**30**		**110**
Possible points	*120*		*100*		*50*		*270*
Score %	**34%**		**39%**		**60%**		**41%**

This contract evaluation framework as described requires careful consideration when selecting elements. Each element must be tailored to the client's specific situation and be detailed enough to perform a complete evaluation according to enterprise risk management principles. For example, the high-level contract element could expand into a hierarchy of other elements such as definitions, multi-year considerations, auditability, and risk model math. The risk model further expands into base costs, risk adjustment, trend calculations, attribution, quality measures, etc. Depending on the nature of the evaluation, the number of elements may range from six to over 200.

The three pillars of successful value-based payer contracting strategy puts healthcare providers in a position to work effectively with payers in a value-based world. This contract evaluation framework sharpens focus on areas that are critical to manage. The result of this approach is an execution strategy that empowers providers to achieve strong financial performance.

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