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finding the 'sweet spot' in value-based contracts

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With the transition to fee for value accelerating in healthcare markets across the nation, the time is at hand for providers to develop and implement value-based contracts.

AT A GLANCE

Health systems pursuing value-based contracts should address six important considerations:

- > The definition of *value*
- > Contracting goals
- > Cost of implementation
- > Risk exposure
- > Contract structure and design
- > Essential contractual protections

Although the transition from fee-for-service to value-based payment is likely to unfold over some time, health systems, employers, and payers are increasingly committed to value-based models, developing necessary infrastructure and actively seeking value-based contracts. Both the U.S. Department of Health and Human Services (HHS) and the newly formed, private-sector Health Care Transformation Task Force recently announced plans to support the rapid expansion of value-based contracts.^a

HHS Secretary Sylvia Mathews Burwell announced in January a goal of having 50 percent of all Medicare provider payments made through alternative, value-based payment models by 2018. The Transformation Task Force was launched on Jan. 18 with the announcement of its commitment to move 75 percent of its members' business into value-based payment arrangements by 2020.

Trinity Health in Livonia, Mich.—a founding member of the Task Force—has about 20 percent of its revenues in value-based contracts. Another Task Force member, Renton, Wash.-based Providence Health & Services, which participates in value-based arrangements in five states and owns a 500,000-member health plan in Oregon, has about 27 percent of its facility and medical group net revenue tied to payment models in which some level of incentive or risk is associated with managing total cost of care or achieving specified quality measures.

The pace of transition from fee-for-service to value-based models varies by geography, but in most markets, once the shift has begun, it tends to accelerate rapidly. Health systems that are slow to respond with a risk-based value proposition for employers, payers, and other purchasers risk losing market share to competitors that are more actively seeking alternative payment models.

a. The Health Care Transformation Task Force comprises 28 industry leaders, with 16 large provider systems, including Trinity Health, Providence Health & Services, Ascension, Partners Health, Dartmouth Hitchcock Health, Montefiore, and SSM Health; four commercial payers; several industry payer groups; and selected industry thought leaders.

With the market evolving rapidly, health systems should address the following key considerations as they embrace value-based contracting.

The Definition of Value

Value-based contracting starts with understanding the customer's view of *value*. In the emerging

retail healthcare market for many healthcare services and insurance products, value equates with price, which is becoming a primary factor in consumer decisions (i.e., purchase decisions made directly by consumers, rather than on their behalf by employers, payers, or providers).

The Boeing Company ACO 'Preferred Partnership' Option

The Boeing Company, the global aerospace company, has 500,000 lives covered in 48 states and a \$2.5 billion annual healthcare spend.

To improve its employees' healthcare experiences and to control their healthcare costs, Boeing has signed direct, multiyear, value-based accountable care organization (ACO) contracts with the Providence-Swedish Health Alliance and the University of Washington Medicine Accountable Care Network. Some 27,000 employees (approximately a third of the active Boeing workforce in Washington) and 3,000 retirees were offered the "preferred partnership" option during the first enrollment period in 2014 (with coverage starting in 2015). The goal of the partnership is "to provide extraordinary customer services drawn from contemporary retail methods."

Boeing aims to expand the partnership to other markets as part of an effort to improve member healthcare experiences and save money. Each contract sets goals for total employee health and medical costs. If costs are higher, Providence-Swedish and UW Medicine foot the bill; if costs are lower, they reap the value saved.

The preferred partnership deal includes benefit differentials and incentives (e.g., lower paycheck deductions, larger company contributions to health savings accounts, no copays for primary care visits) to encourage members to sign up and stay within partner networks. The employee's

choice of plans is voluntary, fitting in with trends in the new retail market where consumers shop among plans on the various health insurance exchanges. Boeing created a website with cost models for different care options, a provider search function, and FAQs to help employees decide whether the preferred partnership option is right for them. A provider website offers access to electronic health records, Epic's My Chart, and "concierge service" call centers for scheduling and resolving issues.

In addition to these features, the Boeing ACO contract stipulates the following requirements:

- > Guaranteed access to primary, specialty, and after-hours care
- > Access to intensive outpatient care for managing medically complex patients
- > Adherence to best-practice standards for all ACO participants
- > Level III NCQA patient-centered medical home accreditation for larger clinics and practices
- > Adoption of specific quality/performance metrics and policies and procedures to ensure discharges and emergency department visits are well-managed
- > Shared decision making for procedures that involve sensitivities with respect to patient preference

Along with these requirements, financial penalties are imposed if the ACO does not meet service-level targets for primary care and specialty access.

Consumers with large deductibles are selecting outpatient imaging services based on price, for example. Price also is the basis for consumers' choice of individual health plan coverage on the health insurance exchanges established by the Affordable Care Act. And employers are including price considerations in the selection of network providers for high-cost surgical procedures. In response, health systems are lowering prices at the unit-of-service level and focusing on lowering costs by improving care management—and by lowering the cost of care, they are enabling health plans to reduce premiums.

Price, however, is not the only criterion for describing value. Other important factors are access, choice, patient experience, pricing transparency, and premium cost predictability—all of which are key considerations in the design of value-based contracts. For example, although value-based contracts are increasingly relying on narrow networks to provide more control over unit price and utilization management, they also must meet the expectations of not only consumers but also regulators for access and network adequacy. Many such contracts go to significant lengths to specify value-based elements such as guaranteed after-hours access, consumer call centers and concierge services, and patient portals with transparent service price and patient satisfaction data.

With high stakes, providers do not have time to experiment—they should adopt the motto, “Do it right the first time.” Given the growing transparency of both quality and cost data, providers that cannot demonstrate early quality improvement or cost savings will encounter obstacles in negotiating successful future contracts.

Value-Based Contracting Goals

Having a clear organizational consensus on strategic and business objectives is necessary to

achieve hospital and physician alignment on the care and operating model changes that are essential to success in value-based contracts.

A recent survey of 18 successful accountable care organizations (ACOs) and clinically integrated networks (CINs) across the nation, each with multiple commercial and Medicare Shared Savings Program (MSSP) contracts, found that for 70 percent of these organizations, the decision to pursue value-based contracting was the result of a conscious internal strategy to move to full-risk contracting or health plan partnership.^b The remainder of the organizations reported their decision to engage in value-based contracting was motivated more opportunistically by the strong interest of local employers in such contracts or by pressure from or opportunities created by commercial payers to develop ACO business partnerships.

Most value-based contracting is based on three premises:

- > Reducing cost by eliminating inappropriate utilization and lowering prices
- > Sharing savings or capturing a portion of the value created through lower costs
- > Increasing volume through market share gains resulting from enhanced value to the customer

Joseph Gifford, MD, former CEO of the Seattle-based Providence-Swedish Health Alliance, stresses the necessity of being realistic about the impact of shared savings and value-based contracts.^c “You need to get your head around the fact that value-based arrangements are fundamentally about reducing someone’s revenues,”

b. Collaborative Care Colloquium, ACO/CIN Survey, BDC Advisors, LLC, Miami, April 2015.

c. Comments by Gifford and other executives quoted in this article are from telephone interviews conducted in May and June for this article, or from prior interviews conducted for an article by Eggbeer, B., and Bowers, K., “Healthcare’s Game Changer: Thinking Like a Health Plan,” *hfm*, October 2014.

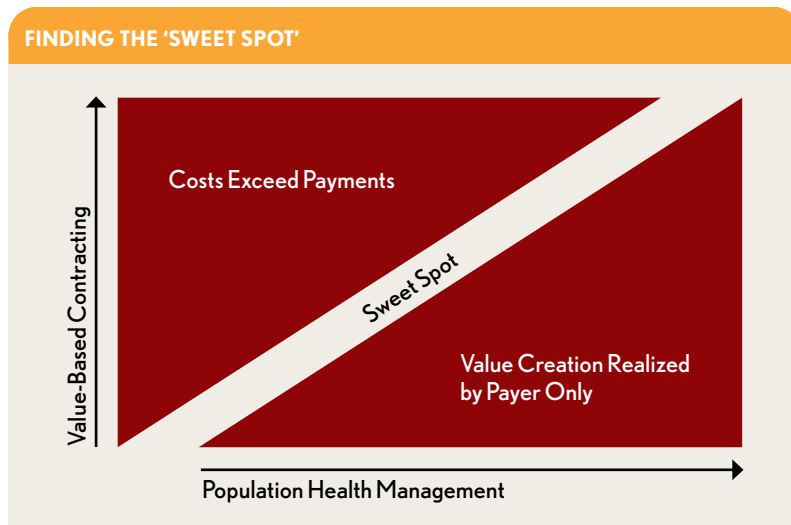
Gifford says. “That is part of the rules of the game if you are going to play in the value-based market. You have to have a talk with yourself and say, ‘Here comes the future.’”

Gifford stresses the need for health system leaders to act quickly. “There is an obvious ethical issue for physicians,” he says. “If they are going to start managing care for one group of patients, it is impossible for them to behave in the old way of just maximizing revenue and not managing care for all the rest.”

Barry Arbuckle, CEO of MemorialCare Health System, a large integrated delivery system in Los Angeles and Orange County, has also emphasized the need for action in discussing his organization’s preparation for the future: “We are moving as fast as possible to embrace population health management—developing processes and data systems and rapidly expanding our ambulatory networks—while not abandoning what got us here in the first place: the acute care hospital.”

As illustrated in the exhibit above, a well-designed contract establishes a “sweet spot” where a provider can create value through lower costs and capture an appropriate portion of the value created, through shared savings and market share gains. Poor contract design can lead either to unprofitable marginal operations, where unit costs exceed payments, or to a failure to capture a sufficient share of the value through steerage and market share gains.

A successful transition to value-based payments requires management buy-in and commitment across all levels of the organization. As an example, one health system that was preparing to initiate its first value-based contract sought to build support for the initiative by formally surveying its board. The survey was designed to determine the board’s “risk tolerance” under



various population health scenarios, which the health system noted would lead to decreased utilization if managed effectively. The board was persuaded of the health system’s need to move to a value-based business model given market trends and the demands of large national employers in the market.

Substantial capital is required to get started with any value-based contracting initiative, particularly one that involves risk at the population level. Based on findings from the previously cited survey, the three-year cost of building and sustaining the care management and clinical analytics infrastructure required to support value-based contracting can range from \$2.5 million to \$15 million.

Risk Exposure

The extent of risk that can be incorporated in value-based contracts covers a broad spectrum. At the low end, contracts can provide for modest incentive payments based on provider performance relative to a defined set of efficiency and quality measures. At the other end, health systems can assume full risk for a defined population through a capitated arrangement or

ownership of a health plan. (See the exhibit below).

Before entering into a contract to assume risk, health system leaders should conduct an organizational analysis that includes the following key questions:

- > Did we go through an organized process to align all constituencies around our value proposition?
- > Do we have a clear plan for organic growth to replace the utilization losses if value-based contracting takes hold?
- > Have we budgeted for appropriate care management, data processing, and clinical analytics infrastructure?

Primary options for pursuing value-based contracts include the following.

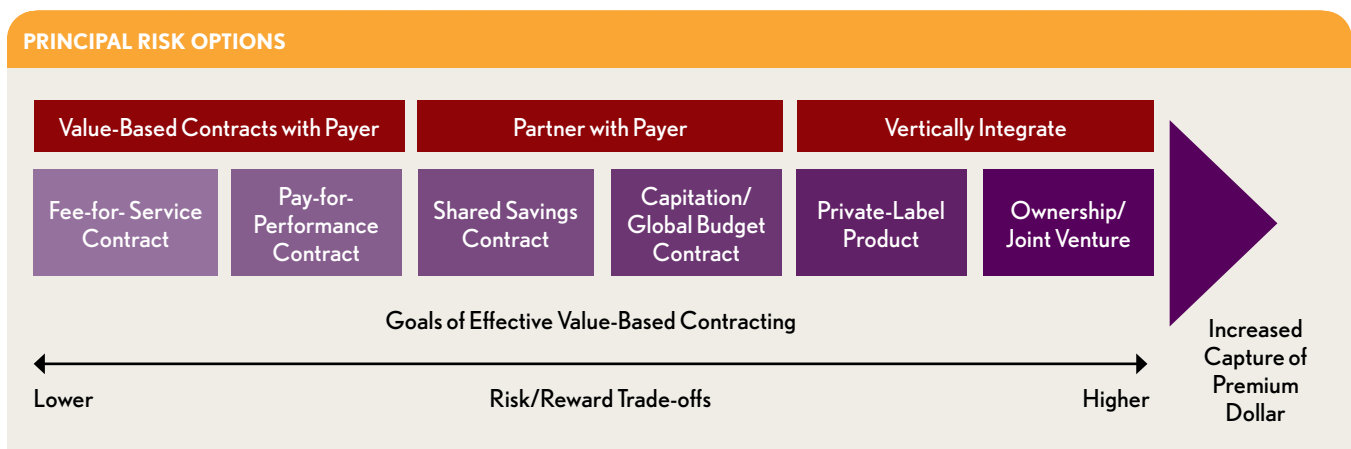
Hospital and physician pay-for-performance contracts. Such contracts can provide training wheels for larger shared savings agreements. Pay-for-performance incentives can be used with a variety of payment models, from fee-for-service to bundled payments. They can incorporate efficiency metrics (e.g., total cost of care,

readmission rates) but typically use quality measures that must be met before financial incentives are paid. Risk is modulated based on the proportion of total revenue subject to performance measures.

Hospital and physician shared savings contracts.

Shared savings arrangements call for a distribution of savings that reflect the difference between the actual costs for an attributed population and an agreed-upon target for that population. Most shared saving programs begin with upside-only contracts (such as the initial MSSP program), but these programs are increasingly migrating to two-sided agreements, in which providers assume risk exposure based on the possibility that actual costs might exceed the agreed-upon target with the payer. Many shared savings agreements split savings evenly between the payer and provider, which can translate into a net loss for the provider when the cost of infrastructure investment and the reduction in utilization due to improved care management are considered.

Agreements also typically call for “resetting the bar”—i.e., the baseline target that must be met is



As providers and payers come together to embrace value-based contracting and improve quality, there is a continuum of shared risk they should consider.

Trinity Health's CIN

Trinity Health's Holy Cross Physician Partners (HCPP), a clinically integrated network (CIN) in Fort Lauderdale, Fla., started in 2013 with one contract covering more than 4,000 lives. In January 2015, the number of value-based contracts grew to five (including a Medicare Shared Savings Program contract), and attributed lives to just over 37,000.

HCPP has met "quality gates," opening the door to shared savings, through the use of a real-time disease registry in physician offices and of population care managers working with primary care physicians on quality metrics and helping high-risk patients maneuver through the healthcare system. By meeting or exceeding efficiency and quality metrics, HCPP physicians have earned shared savings in both 2014 and 2015, based on the previous year's successes. The shared savings distributions are based on each individual physician's attributed population volume (physicians with more patients receive a larger share), but only when the physician's quality metrics meet a standard set by the network.

adjusted every contract period to account for prior-year savings—as total cost of care declines. A substantial decline in utilization, therefore, could make a shared savings model problematic for long-term contracting if the health system does not also experience market-share gains to replace the lost business.

Upside-only shared savings programs may be the best place to start perfecting care management techniques for the first few years. When providers feel comfortable that they have a sufficient infrastructure to manage the care of the attributed patients effectively—and that the costs of care are accurate and payments will surpass these costs—they will be ready to move to deeper risk initiatives, such as bundled payment, capitation, and health plan ownership.

Bundled pricing models. These models involve an all-inclusive set price covering all services associated with a specific procedure or episode of care, including physician and hospital costs and pre- and post-procedural care. Bundled pricing is a growing part of the transition to value-based payments; for example, CMS announced in mid-2014 the expansion of its Bundled Payments

for Care Improvement initiative from roughly 2,400 to about 6,500 providers. Bundled pricing contracts are increasingly popular with provider systems that are hesitant to assume utilization risk, but confident in their ability to create value through better-managed episodes of care. They often are included alongside other population health risk initiatives. Bundled pricing contracts are more effective than are primary care-focused population health initiatives as a means of aligning with procedural specialists.

Capitation, global budgets, and percentage-of-premium arrangements. Capitation agreements set a flat per-member-per-month budget for all or selected services. Global budget arrangements set an inclusive medical cost budget for all services provided to an attributed population. And percentage-of-premium contracts pass a defined percentage of a health plan's premium to the provider. All such arrangements can take a wide variety of forms and can be defined to encompass either the full cost of care or specified components of the care continuum (e.g., professional services, hospital services). Payments often are subject to quality gates, such as clinical outcomes (e.g., blood pressure, statin use, diabetes

measures) and preventive screening to identify high-risk or medically complex patients. Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract is an example of such an arrangement in which success at reducing medical cost inflation and improving quality is well-documented. In all such arrangements, health systems have both upside and downside risk, with stop-loss insurance a contract requirement.

Private-label health plans with a commercial partner.

Private-label health plans are narrow or tiered network products designed around one or more provider systems. Contractually, a private-label plan can look like a shared savings or capitated arrangement, or the provider system can participate in the economics of the health plan itself. Private-label plans can enable health systems to improve value capture and grow market share by leveraging their high-performing networks and brand positions.

The advantages for health systems in going to market with a commercial partner include access to competencies in health plan product design, pricing, marketing, customer relations, and plan operations, which most health systems lack. Typically, the payer partner brings a license, risk-based capital reserves, and infrastructure to the arrangement. Depending on terms, health systems can have significant reward opportunities as well as downside risks.

Contract Structure and Design

Although value-based contracts are designed to meet specific market and customer needs, they have common structural characteristics. Many are structured as *shadow capitation* agreements, meaning there are no prepayments and billings continue as they have under fee for service, depending on what contracts are in place.

Accountability is measured, and the incentive payments reconciled after the contract period.

Shared savings and/or global budgets can be expressed contractually in a variety of ways:

- > Based on the health system's total costs of care compared with a peer group's total costs of care over a defined measurement period, usually inflation-adjusted
- > As a cost trend, where the health system agrees to hold the trend to a certain inflation measure
- > As a trend relative to the market, where the health system agrees to beat the market medical cost trend by a certain percentage

Health systems also can agree to cost guarantees, where their performance for attributed beneficiaries is compared with the experiences of a reference group of unassigned beneficiaries.

Various incentives or guarantees can either be upside-only or involve bilateral risk. The health system can have full exposure to upside and downside risk or can mitigate risk exposure through the use of defined corridors.

Guarantees and benchmarks can be approached in many different ways, with an organization's specific circumstances determining which approach will work best. Typically, a combination of approaches is negotiated into the contracts, with an emphasis on fairness to both the payers and providers and on alignment of all parties to improve patient care.

Two essential requirements should be addressed in establishing targets and capitation rates. First, it is necessary to have access to appropriate claims data for start-up planning, including a minimum of two years of actual claims data for any rate-setting or benchmark calculation. Second, it is necessary to have adequate professional actuarial assistance. Agreeing to

KEY CAPABILITIES REQUIRED FOR EFFECTIVE CONTRACTING

Superior Care Management	Rigorous Physician Alignment	Proficient Financial Management	Enhanced Consumer Experience
<ul style="list-style-type: none"> • Prevention/wellness • Utilization • Case management • Chronic disease management • Segmented analytics 	<ul style="list-style-type: none"> • Network design • Governance • Best practices • Operational excellence • System support 	<ul style="list-style-type: none"> • Segmented analytics • Predictive modeling • Contracting • CMS compliance • Capital/reserves 	<ul style="list-style-type: none"> • Customized communication • Tools and transparency • Self management • Service excellence

To learn to swim upstream against the currents of healthcare reform, health systems require the right set of skills.

performance targets without such assistance is “leading lambs to slaughter,” notes one ACO executive.

Key Contractual Protections

Attention to contract details also is important. Value-based contracts involve far more complexity than fee-for-service contracts, needing to cover a wide range of issues, including product design, patient attribution, steerage, and quality and cost data exchange and analytics. One of the frustrating—and perhaps unintended—consequences of value-based contracts is that a health system can go 18 months (one-year target period, three-month claims rollout, three-month final reporting by payer) before it finds out whether it met quality targets and generated any shared savings. The health system can expend a lot of money, time, and effort on infrastructure while remaining in the dark on actual quality and cost performance.

Notwithstanding this challenge, value-based contracts should address a number of specific issues, reflected in the following important questions:

> What is the scope of any proposed unit price reductions? Do they encompass only a specific value-based arrangement or product, or do they affect all patients covered by a particular payer?

- > For shared savings and other population risk arrangements, what is the patient attribution methodology?
- > Does the contract contain specific anti-steerage language to restrict payers from using benefit design to shift volume from high-revenue service lines to lower-cost settings?
- > How should disputes with payers and physicians be managed and settled?
- > Does the payer’s product have adequate benefit incentives to steer members to products covered by the contract, and protect against network “leakage” and out-of-area utilization?
- > How are network tiers defined, and what incentives exist to steer patients between tiers?
- > What incentives does the payer have to steer members covered by other products and/or contracts to the health system?
- > What commitments has the payer made to market the products encompassed in the contract?
- > Has the payer agreed to guarantees or contractual protections if committed steerage/volume increases don’t occur?
- > Will the payer help fund infrastructure (network development, care management, clinical informatics) required to support the contract?
- > What are the payer’s commitments with respect to data sharing, and what protections are built into the arrangement if expected reporting is inadequate or untimely?

- > Does the contract adequately address Stark and antitrust issues?
- > What are the termination provisions? Is there an “out” if the agreement goes south?

A Value-Focused Strategy

A value-based contract should be the culmination of a set of strategic and operational business model changes required to be successful in the new healthcare environment. Successful value-based contracting starts with aligning organizational leadership around a new definition of value and a new business model that—as summarized in the exhibit on page 9—touches virtually every aspect of a health system’s operations. Next comes a strategic evaluation of risk posture, defining how much risk the value-based contract itself will involve. The contract presents a host of terms and considerations typically not at play in a traditional fee-for-service payer-provider contract, such as attribution models, network access standards, quality metrics, shared savings methodologies, risk-sharing and reinsurance provisions, and compensation for a variety of elements not included in most fee-for-service arrangements. As a result, a well-executed value-based contract has the potential to create a

material impact on all major drivers of healthcare value—enhanced patient experience, improved outcomes, reduced costs, and extended reach of care. ■

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