KEY CONSIDERATIONS FOR VALUE-BASED PAYMENT (VBP) ARRANGEMENTS

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DHCF
Department of Health Care Finance

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AGENDA

I. Background on Value-Based Payment Arrangements
II. Health Care Learning and Action Network HCP-LAN Category 2 Arrangements
I. LAN Category 3 Arrangements
II. LAN Category 4 Arrangements
III. Additional VBP Contracting Considerations

Learning Objectives

1. Assess opportunities and risks in VBP contract terms
2. Understand key legal considerations in evaluating VBP contract terms
3. Negotiate more favorable VBP contract terms

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BACKGROUND

SHIFT TO VALUE-BASED PAYMENT

The traditional fee-for-service (FFS) payment system is based on the number and units of service provided, without linkages to, or adjustments for, provider reporting of quality data, or performance on cost or quality data.

FFS's price per unit of service system is viewed to incentivize providers to produce revenue by increasing volume, which can encourage unnecessary and even harmful care.

Value-Based Payment (VBP) generally refers to activities that move away from the traditional fee-for-service (FFS) payment system to alternative payment models that reward high-quality, cost-effective care.

Population-based payments may enable providers to develop more innovative approaches to person-centered health care delivery because such payments reward providers that successfully manage all or much of an individual's care.

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"RISK" BY PAYMENT METHODOLOGY

- The risk under any payment methodology is whether a provider is guaranteed payment to fully cover the provider's costs.
- Spectrum of risk:
  - **Cost-Reimbursement:** Provider is at risk only to the extent that certain costs will be disallowed (e.g., administrative/medical cost caps, non-reimbursed costs).
  - **FFS:** Provider is at risk that the cost of furnishing a service exceeds a pre-established fee schedule for each service (i.e., "fee for service").
  - **Case Rate or PPS:** Provider is at risk that the cost of furnishing a bundle of services exceeds its case rate or prospective payment system (PPS) rate.
  - **Capitation:** Provider is at risk that the cost of furnishing a defined scope of services exceeds its monthly lump sum per patient (i.e., "capitation" payment).

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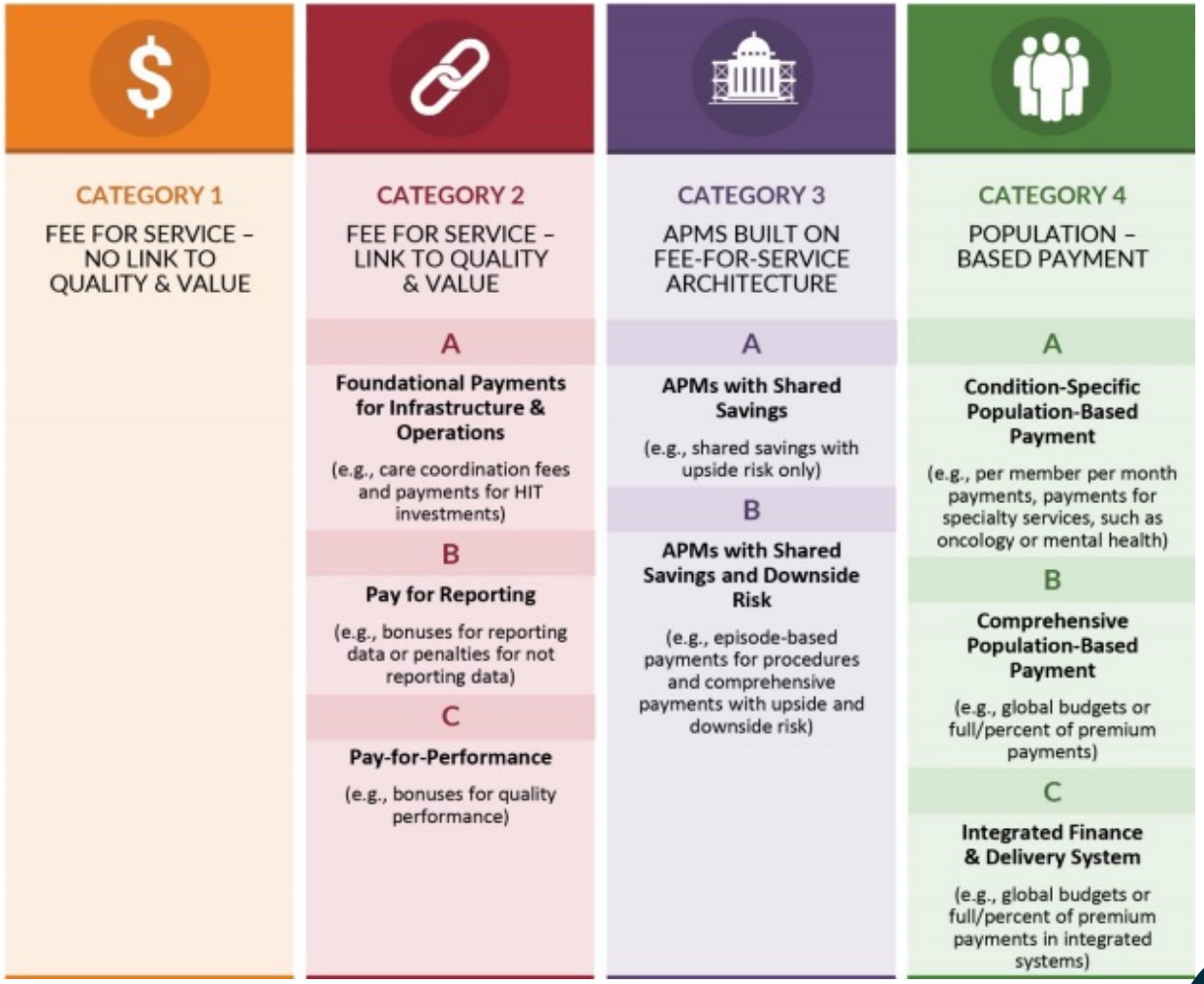
VALUE-BASED PAYMENT MODELS

- The Health Care Payment Learning & Action Network (HCP-LAN) was created to **drive alignment** in payment approaches across the public and private sectors of the U.S. health care system.
- The HCP-LAN created a **common framework** for adoption and measurement of VBP across all payer types (Medicare, Medicaid, and Commercial).



Source: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

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LAN CATEGORY 2

HCP-LAN CATEGORY 2

- Category 2: FFS payments linked to quality and value.
- FFS payments are adjusted based on other factors, such as infrastructure investments, whether providers report quality data (pay-for-reporting), and/or performance on cost and quality metrics (pay-for-performance).
  - **Category 2A (Foundational Payments):** Payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics.
  - **Category 2B (Pay for Reporting):** Positive or negative payment incentives to report quality data.
  - **Category 2C (Pay-for-Performance):** Payments that reward providers that perform well on quality metrics and/or penalize providers that do not perform well thus providing a significant linkage between payment and quality.

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PAY-FOR-PERFORMANCE PROGRAMS

Advantages of performance-based payment incentives:

- Earned by a provider in addition to reimbursement for services
- No penalty if performance incentives have not been met

Disadvantages of performance-based payment incentives:

- Staff time and process investments to track and report data to MCOs.
- Multiple and inconsistent measurement sets across MCOs.

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PAY-FOR-PERFORMANCE PROGRAMS

P4P Programs: A provider is not usually placed at any financial risk to participate in APM Category 2C (P4P) VBP incentive arrangements.

- Even if the provider does not qualify for incentive payments, participation in those arrangements may "kick-start" internal delivery changes and partnerships with other providers to qualify for future payments.

Practice Pointer: During negotiation of contracts (and contract amendments!) with MCOs, providers should affirmatively request participation in an MCO's P4P programs to maximize overall reimbursement.

- If an MCO is not willing to permit participation in P4P programs at the point of contracting, a provider should seek language that entitles the provider to participation at a future date, upon meeting eligibility requirements, or otherwise.

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VBP PERFORMANCE MEASURES

- To facilitate participation in multiple VBP arrangements, providers should seek performance measures that have standard definitions and methodologies for calculating scores (*e.g.*, HEDIS measures).
  - Ideally, the Medicaid measure sets, and incentives would align with those used by Medicare and commercial payers.
- Providers should:
  - Be familiar with the performance measures applicable to MCOs (particularly Medicaid MCOs)
  - Understand the financial rewards available to MCOs (if any)
  - Prioritize internal operations to score high on those performance measures; and
  - Leverage those results for favorable VBP arrangements with MCOs.

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VBP PERFORMANCE MEASURES

Practice Pointers:

- A provider's terms of participation in VBP arrangements should contain clear language regarding the population of patients subject to the performance measures, the definitions and methodology for calculating scores, and the financial rewards available.

- The MCO should not be permitted to change the performance measures (or methodology) after they have been established for any given performance year, at least without the provider's consent.

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LAN CATEGORY 3

HCP-LAN CATEGORY 3

Category 3: Alternative payment models based on FFS.

- Payments are based on FFS but provide mechanisms to more effectively manage services. Providers must meet quality metrics to share in cost savings, and payments are based on cost performance against a target.
  - **Category 3A (Shared Savings):** Providers must meet a total-cost-of-care target for some/all services for an attributed set of patients. If actual costs are below projections, providers may keep some savings if quality measures are met.
  - **Category 3B:**
    - **Shared Savings and Downside Risk.** Providers must meet a total-cost-of-care target for some/all services for an attributed set of patients. If actual costs are below projections, providers may keep some savings if quality measures are met, or if actual costs are above projections, providers must compensate MCOs for a share of the losses.
    - **Bundled or episode-based payments.** A single payment to providers for all services needed to treat a given condition or to provide a given treatment. Providers receive an inclusive payment for a specific scope of services to treat an "episode of care" with a defined start and endpoint.
- Note: Must include link to quality to qualify as a Category 3 arrangement!

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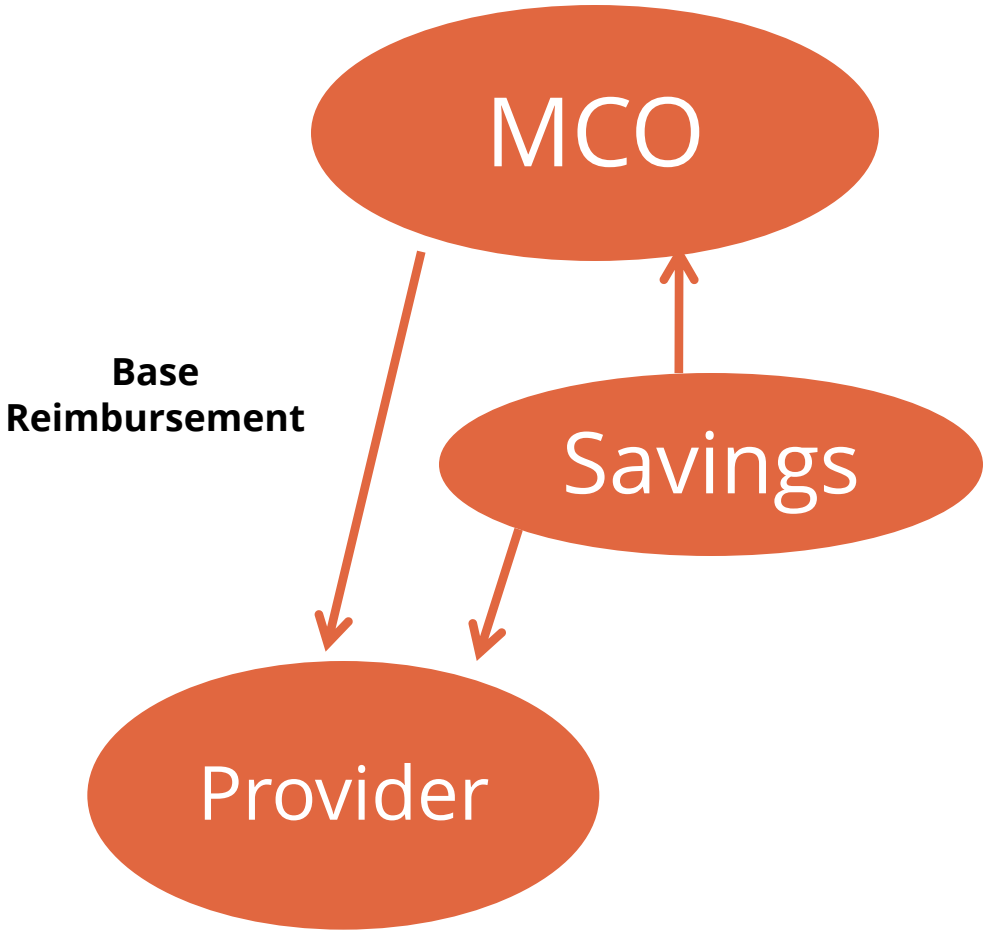
EXAMPLE: SHARED SAVINGS (SINGLE PROVIDER)

- Benchmark established at targeted level of expenditures for attributed population of patients.
- Actual expenditures measured against benchmark for attributed population of patients.
- Difference is “shared” between MCO and provider.



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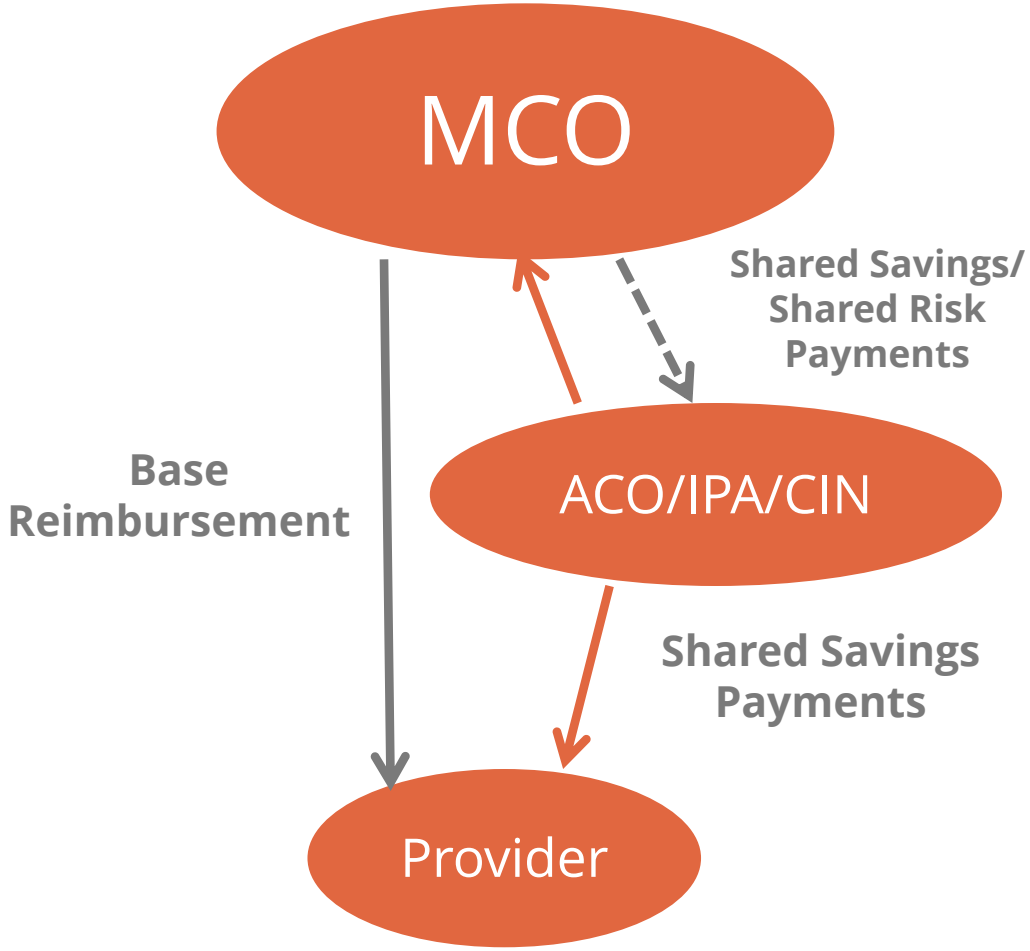
EXAMPLE: SHARED SAVINGS / DOWNSIDE RISK (MULTIPLE PROVIDERS)

- Benchmark established at targeted level of expenditures for attributed population of patients.
- Actual expenditures measured against benchmark for attributed patients.
- Difference is “shared” between MCO and ACO/IPA/CIN.
- ACO/IPA/CIN shares savings with providers participating in ACO.



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SHARED RISK AND SHARED SAVINGS

Understand How the Benchmark (aka MLR) is Set

- Generally, the benchmark is a Medical Loss Ratio (MLR) that reflects the percent of the MCO's premium spent on medical services and quality improvement activities.
- If the benchmark is set too low, it will be impossible to generate savings (or you will more quickly incur downside losses under shared risk arrangements).

Seek the highest benchmark possible from the MCO

- Historically, some provider contracts:
  - Define MLR in a way that is inconsistent with federal Medicaid rules or definitions or the state Medicaid-MCO contract.
  - Set a more aggressive MLR target than the one imposed by the state on the MCO.
  - Understate an MCO's total, aggregate payments from the State Medicaid agen

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SHARED RISK AND SHARED SAVINGS

Understand Which MCO Expenditures Count Against the Benchmark

- If too many expenses (e.g., incurred claims) count against the benchmark, it will be impossible to generate savings (or you will more quickly incur downside losses under shared risk arrangements).

Minimize the "allowed spend" against the benchmark

- Do allowed expenses include any non-medical administrative costs?
- Is there an exclusion of outlier claims for enrollees who have an excessive amount of claims (often referred to as "stop-loss coverage)?

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SHARED RISK AND SHARED SAVINGS

"Real-Life" Example:

- Allowed Spend: The sum of
  - All expenses, services, and other amounts paid relative to Covered Services rendered to [Plan Members] regardless of whether the professional rendering the Covered Services was reimbursed on fee-for-service basis, a capitated amount, a case rate or pursuant to any other reimbursement methodology; plus
  - All administrative capitation payments and any other payments made to an applicable vendor for services provided in connection with [Plan Members] plus
  - Any additional payments or adjustments (up or down) for offering or providing Covered Services to Plan Members; and
  - An estimate of [Incurred But Not Reported (IBNR) claims].

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SHARED RISK AND SHARED SAVINGS

Contracting Pointers:

- Review definitions of key terms defining benchmark and allowed expenses against similar terms in the Medicaid/state contract with the MCO.
  - Ensure that benchmark's premium includes any one-time payments by a state Medicaid agency for certain life events (*e.g.*, labor & deliveries) and additional payments to cover GME and, if applicable, FQHC wrap-around payments; fraud recoveries, prescription drug rebates, etc.
  - Exclude all claims for enrollees that hit re-insurance threshold (including those claims below the threshold).
- Request that the MCO run a report using a prior year's data to determine how you would have performed against the proposed benchmark.
- Negotiate a provision that requires the MCO to provide monthly or quarterly reports during the performance year on how expenditures for the attributed population compares against the benchmark.
- Negotiate audit rights for MCO's calculations of any key benchmarks or performance against those benchmarks.

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SHARED RISK/SHARED SAVINGS PROGRAMS

- **Attribution Methodology.** The basis by which the MCO attributes patients to a population under a shared savings or shared risk arrangement. Possible attribution methods might include populations based on an enrollee's:
  - Geographic area (e.g., counties)
  - Specific health diagnoses
  - Receipt of services from a particular provider (*e.g.,* patient/clients)
  - Receipt of health home services
  - Receipt of primary care services
  - PCP Assignment

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SHARED RISK/SHARED SAVINGS PROGRAMS

Attribution Issues:

- Attributed patients do not always match patients who have received services from provider during the performance year, i.e., attribution based on patient's PCP selection or MCO's default assignment.
- The attribution methodology can result in a provider held accountable for the cost and quality of services for patients who actually receive services from other providers.

Prospective Attribution: If attribution of patients is prospective (i.e., done in advance of the performance year), providers should recognize that the population of patients attributed to the provider may:

- Include patients who have not visited the provider during the current performance year and
- May exclude patients who have received services from the provider in current performance year but who have been assigned to a different provider.

"Real-Life" Example:

- [Attributed Plan Member]: A [Plan Member] who has selected or has been assigned to [a] PCP and is eligible for and enrolled in the following Benefit Plans…

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SHARED RISK/SHARED SAVINGS PROGRAMS

Contracting Pointers:

- Avoid attribution of “disengaged” patients who have been assigned to the provider but who have not actually received any services from the provider during the performance year.
- If contract requires you to accept attribution of disengaged patients, consider cost of staff and other resources (e.g., CHWs, patient incentives, transportation) that may be necessary to re-engage such patients.
- Request that the MCO generate a list of attributed patients based on prior year’s data.
- If MCO prospectively attributes patients, negotiate a provision that requires the MCO to provide a list of the attributed patient population at least 90 days prior to the start of the performance period for the VBP arrangement.
- Negotiate a provision that requires the MCO to provide monthly or quarterly patient rosters of attributed patients for the current performance year.

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SHARED RISK AND SHARED SAVINGS

Do not assume too much risk, too soon

Historically, some MCO contracts:

- Require providers to move from shared savings to shared risk in a specific time frame without regard to provider's readiness to assume downside risk.
- Require providers to establish reserves and replenish those reserves (or arrange for a letter of credit or line of credit) and allows MCO to draw funds from such reserves.
- Contain no ceiling on the amount of downside risk incurred by provider.

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SHARED RISK AND SHARED SAVINGS

Contracting Pointers:

- If the contract requires the provider to move from shared savings to shared risk in a performance year under the agreement, negotiate language that would permit the provider to delay that move if it has not generated savings over the last two performance years.
- If the contract involves a shared risk arrangement, the provider should negotiate language that limits financial losses to a percentage of total payments or the benchmark or has a risk corridor that caps financial risk.
- If the contract involves a shared risk arrangement, the provider might negotiate a provision that allows financial losses incurred in one year to be paid back to the MCO by financial gains earned in subsequent years.
- If the MCO fails to meet its data sharing obligations, the provider should negotiate language to be held harmless from any obligation to compensate the MCO for downside losses.

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LAN CATEGORY 4

HCP-LAN CATEGORY 4

Category 4: Population-based payments.

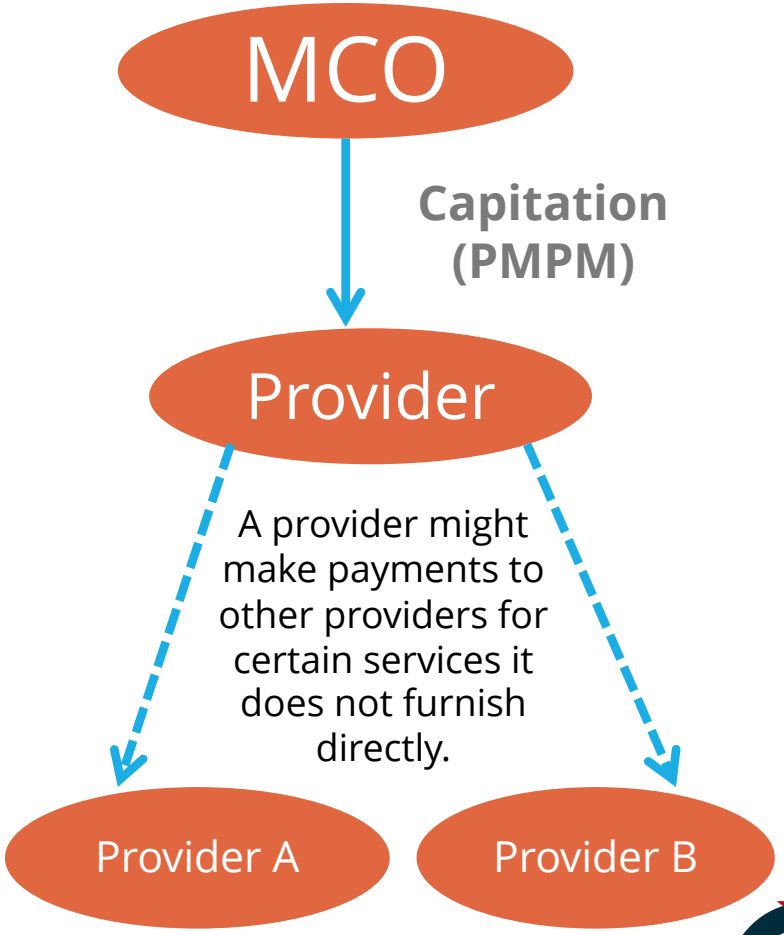
Payments are structured to encourage providers to deliver coordinated, high-quality care within a defined budget.

- Category 4A (Condition-Specific Population-Based Payments): Providers are accountable for quality and cost, receiving per-member per-month payments for a specific condition or defined scope of practice.
- Category 4B (Comprehensive Population-Based Payments): Providers are accountable for quality and cost, receiving per-member per-month (or percent of premium) payments for all of the individual's health care needs.
- Category 4C (Integrated Finance & Delivery Systems): Also involve comprehensive population-based payments but involve organizations that integrate financial and care delivery systems.

Note: Must include link to quality to qualify as a Category 4 arrangement!

EXAMPLE: CAPITATION PAYMENTS

- Under capitation, providers receive a prospective flat payment for each enrollee per month ("per member per month," or PMPM, payment).
  - **PCP or BH capitation**: Pays for primary care or behavioral health services covered under the contract.
  - **Professional capitation**: Pays for a defined portion of physician services (*e.g.*, primary and specialty services).
  - **Full capitation**: Pays for broad scope of services covered under the contract (*e.g.*, hospital and physician services).
- Under partial capitation, providers receive a combination of capitation and fee for service payments.



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CAPITATION

Advantages of capitation:

- Disputes over payment less likely to arise under capitation than under fee-for-service.
- Maintains stable source of revenue during a pandemic if the number of patient encounters suddenly drops.
- Payment amount may cover non-clinical and enabling services, such as case management, translation, and transportation.

Disadvantages of capitation:

- Unpredictability of actual utilization.
- Some MCOs believe that capitation encourages fewer patient encounters.

CAPITATION ARRANGEMENTS

Capitation Issues

- Capitation is not risk adjusted

Contracting Pointers

- Ensure the scope of services subject to the benchmark are appropriately and accurately defined (see next slide).
- Consider whether the capitation amounts should be risk-adjusted (e.g., aged/gender, health risk), specific to particular subpopulations (e.g., SSI), or social determinants of health (e.g., housing instability, food insecurity, employment).
- Consider whether the MCO should make any adjustments to the capitation amount for retroactive changes in eligibility, payments for services furnished by other providers (e.g., leakage), or state adjustments to premiums.

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REAL-LIFE EXAMPLE: DEFINITION OF PRIMARY CARE SERVICES UNDER CAPITATION ARRANGEMENT

TYPE	DESCRIPTION
Office visits	New and established patients
Hospital Inpatient	Observation, initial hospital care, subsequent hospital care / discharge
Consultation	Outpatient and inpatient
Emergency Department	Between hours of 5pm and 8am
Critical Care / Neonatal Intensive Care	
Intermediate Care Facility / Skilled Nursing Facility	
Preventive Medical Services; Immunizations	New Patients – Initial history and examination; Established Patients – Interval History and Examination
Newborn Care	
Administrative Services	Arterial Puncture, withdrawal of blood; Initial (new patient) visit for surgical procedure; services after office hours; services between 10pm and 8am; Hem – Phlebotomy; Therapeutic; prolonged services; case management services; case plan oversight services
Injections	IV Fluids; Allergy
Special Services	Burn treatment; anoscopy; catheterization, urethra; irrigation, endocervical polyp removal; removal of foreign body (eye); EKG and interpretation; pulmonary function; urinalysis; pregnancy test; occult blood; hematocrit; hemoglobin; strep screen; cocci skin test; TB skin test
Miscellaneous	Treadmill; Holter monitoring; ambulatory BP monitoring (including interpretation)
Minor surgical and other miscellaneous procedures	Surgical procedures; debridement; biopsy; excision; evacuation; repair; cryotherapy; arthrocentesis; minor casting; sigmoidoscopy; circumcision; vasectomy; proctosigmoidoscopy; IUD removal
Auditory System	Removal of foreign body; removal of cerumen impaction
Radiology	

ADDITIONAL VBP CONTRACTING CONSIDERATIONS

ACCESS TO DATA

Access to Claims Data and Reports:

- Providers need timely, accurate, and usable data to be successful in VBP arrangements
- Timely receipt of patient health information related to emergency room visits, hospitalizations, and physical health care is essential for performing well on P4P incentives and managing the total costs of care of the attributed population

Many VBP contracts are silent on furnishing data to a provider or allow the MCO to decide which reports it will share with a provider

"Real-Life" Example

- *Reports. [Health Plan] will provide [Network] with monthly standard reports. [Health Plan] reserves the right to revise, replace and discontinue reports from time to time. [Health Plan] will not provide to [Network] any reports or data which would cause [Health Plan] to be out of compliance with any obligations, contractual or otherwise, regarding confidentiality of information.*

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ACCESS TO DATA

Contracting Pointers:

- The contract should contain clear language that requires the MCO to furnish all information necessary for the provider to do well under the VBP arrangement, on a real-time basis
- Contracts should specify the type of data that the provider is entitled to receive, the timeliness of such data, and the frequency in which the MCO must provide the data to the provider (See next slide)
- If the MCO fails to meet its data sharing obligations, the provider should be held harmless from any loss of revenue arising from unearned payment withholds or downside financial risk

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EXAMPLE: SAMPLE REPORTS

REPORT NAME	DATA	FREQUENCY
Attribution	Attributed Medicaid Members with demographic and contact Information.	Monthly
Emergency Department Utilization Overview	Overview of emergent and non-emergent utilization that will include a Summary Report and Member Level Detail Report for members with 3+ non-emergent ED visits.	Monthly
Inpatient Utilization Overview	Overview of inpatient utilization that will include a Summary Report and Member Detail Report for members with the greatest number of inpatient admissions, and a Readmission Report.	Monthly
Quality Threshold Targets	A report that tracks the quality threshold targets.	Monthly
Performance Measures	A report that tracks performance measures; includes current rate (numerator and denominator) as compared to benchmark and previous time period.	Quarterly
Budget Tracking Report (Financial Reporting)	Shows at service category level, budget, actual performance and variance to the budget.	Quarterly - by the 15th of the second month following the end of the quarter
Claims Data	Member-level claims data.	Monthly
IBNR	IBNR for Attributed Members.	Monthly

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VBP CONTRACT TERM

Providers should be aware that there may be a separate contract term that applies to VBP arrangements.

In practical terms, the contract term reflects the amount of time that the provider is committing to participate in the VBP arrangement.

Practice Pointer: When initially contracting with an MCO, it may be desirable for the term of the VBP arrangement to be shorter (e.g., one year) – possibly without automatic renewal – so that the provider can re-negotiate any problematic terms of participation in VBP arrangements.

- In any VBP arrangement, providers should seek contract language that permits them to receive payment of any earned payment incentives for completed performance periods prior to termination of the participation agreement, even if the payment incentives have not been distributed prior to termination.

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VBP CONTRACT TERMINATION

- If participation in a VBP arrangement involves financial risk, the provider may wish to include contract language that permits the provider to terminate its participation in the VBP arrangement if the provider is incurring (or is likely to incur) financial penalties under the arrangement.
- Contracts can typically be terminated “for cause” or “without cause”
  - For cause: The situations that constitute cause will be listed in the contract, e.g., breaches of material terms of the contract
    - **Practice Pointer: The provider may want to add other circumstances that would permit participation in the VBP arrangement to be terminated for cause, e.g., the MCO modifies the performance measures or methodologies.**
  - Without cause: In some contracts, a party may also terminate without cause after providing written notice to the other party
    - **Practice Pointer: Contracts that contain termination without cause provisions mean that, from a practical perspective, the term of the contract is the notice period. This may be a desirable mechanism to exit the VBP arrangement if necessary.**

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VBP CONTRACT AMENDMENTS

- Amendment provisions are particularly crucial in VBP arrangements because the clinical, operational, and financial environments in which the parties operate are subject to constant change.
  - **Practice Pointer: Determine whether there is a specific amendments clause that applies to participation in VBP arrangements.**
- Any amendments clause to VBP arrangements should offer the right to the provider to opt-out but if the amendments clause permits the MCO to amend unilaterally the terms of participation in a VBP arrangement, then the provider should negotiate language that permits the provider to terminate its participation in the VBP arrangement.

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QUESTIONS / COMMENTS/ IDEAS

Source: iStock

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WRAP-UP/NEXT STEPS

BRIEF EVALUATION

1. Overall rating:

1. Poor 2. Fair 3. Average 4. Good 5. Excellent

2. Content Level:

1. Too Easy 2. Just Right 3. Too Advanced

3. Which TA modalities are you interested in for additional TA? *(Select all that apply)*

1. Webinars 2. Individual Coaching 3. Group Coaching

4. Which domains are you interested in receiving additional TA in? *(Select all that apply)*

1. Financial 2. Clinical 3. Legal 4. Business

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September 21st

VBP Virtual Learning Collaborative

HMA

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