Value-Based Contracting: Selected Case Studies

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1. **What are Value- Based Programs ("VBPs")?**
    a. CMS defines "value-based programs as those programs that reward health care providers with incentive payments for the quality of care they give to people".
    b. CMS indicates that "value-based programs are important because they're helping us move toward paying providers based on the quality, rather than the quantity of care they give patients".

2. **Goals of VBPs: Payer Perspective**
    a. Goals
        i. Increased quality & efficiency
        ii. Increased care coordination
        iii. Lower costs
        iv. Higher premium
        v. Potential risk sharing
        vi. Greater accountability
        vii. Data analysis
    b. Potential negative impact
        i. Potential increased administrative costs
        ii. Provider relations difficulties
    c. Potential positive impact
        i. Higher premium
        ii. Decreased spend on provider reimbursement
        iii. Increased revenue

3. **Goals of VBPs: Provider Perspective**
    a. Goals
        i. Increased quality & efficiency
        ii. Increased care coordination
        iii. Lower costs
        iv. Increased patient experience and engagement

v. Secure patient population
vi. Increase population health
vii. Increased access to healthcare for vulnerable communities

b. Potential negative impact
    i. Cannibalization of Provider revenue
    ii. Decreased in Provider revenue through risk sharing
    iii. Decreased utilization

c. Potential positive impact
    i. Reimbursement for previously non-covered care coordination services
    ii. Incremental revenue through shared savings
    iii. Funding for data analytics and other support services

4. Payer v. Provider Perspective – Inherent Conflict

a. Terms of proposal: Payer seeks to lower the Medical Loss Ratio ("MLR")

b. Economics
    i. Variance between Net Premium and Allowable Spend
        1. Allowable Spend = Provider Revenue
        2. Net Premium = Payer Revenue
        3. Shared savings split

c. Conflict:
    i. Provider increases spend to manage population resulting in decreased utilization and decreased Provider revenue
        1. Increased spend is due to increased FTEs for care management, patient tracking, greater number of quality mandates,
    ii. Lack of creativity and flexibility in payer structured VBC

5. Goal of VBPs: Patient Perspective

a. Goals
    i. Proactive care
    ii. Preventative care
    iii. Management of chronic conditions
    iv. Greater accountability
    v. Decreased morbidity

b. Potential negative impact

i. Decreased privacy
ii. Infantilization of patient
iii. Steered towards fewer choices

c. Potential positive impact
i. Lower employer contribution for health insurance coverage
ii. Lower patient co-payments & deductibles

6. Goal of VBPs: Employers

a. Goals
i. Healthier work force
ii. Higher quality and efficiency
iii. Lower costs

b. Potential negative impact
i. Potential short term higher costs (increase primary care and other services)
ii. Potential privacy issues

c. Potential positive impact
i. Lower costs for employer and employee
ii. Control healthcare spend
iii. Better care

7. **Goal of VBPs: Public Interest**

a. Goals
i. Healthier populations
ii. Higher quality and efficiency
iii. Lower costs that may be passed on to employers/employees and government funded plans which are ultimately supported by tax payer dollars
iv. Greater accountability

b. Potential negative impact
i. Reduction in medically necessary services

c. Potential positive impact
i. Lower costs
ii. Control healthcare spend
iii. Better care

8. **Issue Spotting in the Structuring of Value- Based Payments through Case Studies**
    a. Pay for Performance (Case Study 1)
        i. Terms of proposal: A portion of Provider's reimbursement from Payer is contingent upon meeting performance metrics
        ii. Issue spotting
            1. Payment
                a. PMPM basis
                b. Fixed dollar amount
                c. % of rate trend
            2. Metrics
                a. Healthcare Effectiveness Data and Information Set (HEDIS) measures, which focus on patient outcomes
                b. Hospital readmissions
                c. Hospital acquired conditions
                d. Potentially avoidable hospitalization rates
                e. Out-of-network provider use
            3. Baseline
                a. % increase over prior year's performance
                b. Exceeding a mutually agreed upon baseline
            4. Data and data access
                a. Which party provides the data?
                b. How is data accessed/shared between the parties?
            5. Reconciliation
                a. Reconciliation methodology
                b. Timing of payment
            6. Termination
                a. Limitations on Payer termination
                b. Limitations on Provider termination
    b. Pay for Performance (Case Study 2)
        i. Terms of proposal: Reimbursement by Payer to Provider for closing gaps in care
        ii. Issue spotting
            1. How are the gaps in care identified?
            2. Reimbursement by Payer to Provider

a. Is reimbursement paid only when the Provider determines the suspect medical condition is present?
b. Is reimbursement paid regardless of whether the suspected medical condition is diagnosed?

3. Process for reporting a positive assessment of a suspected medical condition versus a negative assessment of a suspected medical condition
4. Payer access to Provider medical records
    a. Provider administrative burden in providing medical records
    b. Payer access to Provider EHR
5. Payer training of Provider physicians

c. Shared Savings Arrangements (Case Study 3)
    i. Terms of proposal: Shared savings payment if actual MLR is lower than target MLR
    ii. Issue spotting
        1. Attribution
            a. Attribution criteria per population
            b. Minimum attribution
        2. Target calculation
            a. Different targets for different populations
            b. Weighted average for different populations if using one target
        3. Conditions precedent to Provider receiving shared savings payment
            a. Data
            b. Quality
        4. Adjustments to shared savings payment
        5. Timing of payment
d. Bundled Payments (Case Study 4)
    i. Terms of proposal: Payer reimburses Provider to manage the overall course of treatment for bone marrow/solid organ transplant (i.e. episode of care) equal to the lesser of (A) the case rate plus outlier per diems, or (B) % of billed charges
    ii. Issue spotting
        1. Defining the episode of care

a. Pre-transplant period
b. Transplant period
c. Post-transplant period

2. Delineation of services included in the case rate and excluded from the case rate
    a. Pre-transplant services
        i. Preparative therapies for patient
        ii. Bone marrow/solid organ acquisition, manipulation, transportation, storage
        iii. Living donor services
    b. Inpatient services
        i. Technical and professional transplant services
        ii. Professional hospital based services such as professional radiology, anesthesiology and pain management services
        iii. Pharmaceuticals, DME
    c. Outpatient services
        i. Pharmaceuticals, DME
    d. Ancillary services
        i. SNF, home health, inpatient/outpatient rehab
        ii. Complications
        iii. Will readmission within certain time period for certain known complications be included in the case rate?
        iv. Complications that are excluded from the case rate
3. Premature closure of cases
4. Outlier per diems
5. Subsequent transplants
6. Payment
    a. Timing
    b. Lump sum v. installment
    c. Late payment penalty
    d. Charge cap
    e. Stop loss (taking risk)
7. Authorization process

8. Carve out vendors
9. Steerage

iii. Other potential bundled payments
1. Joints – CMS Comprehensive Care for Joint Replacement Model and CMS Bundled Payments for Care Improvement
2. Cancer – CMS Oncology Care Model
3. Behavioral health
4. Substance abuse

e. Shared Risk Arrangements (Case Study 5)
i. Terms of proposal:
1. Care Management Fee on a PMPM ("CM Fees") from Payer to Provider for Provider's care management services for certain Payer members enrolled in the Program
2. Incentive payments to Payer if spending for the Payer members enrolled in the Program is lower than the mutually agreed upon target expenditure
3. CM Fees are at risk for repayment back to Payer in the event that:
a. Provider does not achieve mutually agreed upon quality metrics, and
b. Spending for the Payer members enrolled in the Programs is higher than the mutually agreed upon target expenditure

ii. Issue spotting
1. Delineation of what care management services are reimbursed through the CM fees
2. Delineation of eligibility criteria for enrollment in the program
3. Disenrollment process
4. Payment of CM fees
5. Target expenditure calculation
a. Risk adjustment
b. Geographic adjustment
c. Trend adjustment
6. Actual expenditure calculation

            a. Delineation of included expenditures
            b. Delineation of excluded expenditures
            c. Outlier cap
        7. Minimum savings requirement
        8. Quality thresholds
        9. Reconciliation
            a. Claims run out period
            b. Timing of payments
            c. Data validation

f. Full Risk Arrangements (Case Study 6)
    i. Terms of proposal: % of Premium
    ii. Issue spotting
        1. Attribution
        2. Definition of premium
            a. What is included in premium
            b. What is excluded in premium
        3. Definition of services
        4. Leakage – gatekeeper v. no gatekeeper
        5. Re-insurance
        6. Reconciliation
            a. PMPM
            b. Payer pays FFS but reconciles yearly based on total premium and attributed members