Aligning Value-Based Contracts for Better Performance

With the increase in value-based payment arrangements across commercial and public payers, how is your health system fairing in managing multiple contracts?

**Ann Paul:** Ascension St. John, Oklahoma shares ownership in a provider-sponsored health plan and has a long history of participating in value-based arrangements. Our providers tend to think in terms of overall care delivery rather than specific contract arrangements. We have evolved through different variations of care delivery models with a focus now on integrated advanced primary care practices and team-based care.

**Aditi Kumar:** At UChicago Medicine, we have numerous private and public payer contracts, and some of them overlap. What we try to do is make sure that we are consistent across all contracts in how we manage them, although it has been a journey. We are currently working toward consolidating vendor support for the various contracts, and we already have a centralized care management platform for our network. As we leverage our mixture of internal and external resources, we are striving to be more normalized across the system regardless of who the contracting entity might be. We have made many positive changes as we integrate the core competencies needed to succeed in value-based care contracts.

**Robin Jensen:** At Baycare Health Partners, we embrace having multiple value-based contracts for two reasons. First, we think that participating providers—whether physicians or hospitals—need to have a critical mass of patients in these contracts for it to make sense to redesign care models and workflows around patient-centered and team-based care. The payment and care models should evolve in parallel and having more patients in value-based contracts facilitates this. Second, having many of these contracts is a risk mitigation strategy—the theory being that having multiple contracts minimizes the peaks and valleys from year to year because it’s not likely that every contract will be in deficit in the same year. We pool the performance of all the agreements before distributing surpluses to the providers, so strong performance in some contracts is a ready source of funding for deficits in others.

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Is it a challenge for you to get visibility across contracts? How do you address this hurdle?

John McLean: Gaining visibility across contracts can be difficult for a lot of organizations. For example, one of our members located in the Southwest—a multi-state, multi-region integrated delivery network—has numerous value-based and fee-for-service contracts within each state, coming from commercial and public payers. Getting together everyone in the organization who “owns” one of those contracts to create greater collaboration and coordination is tough—and it isn’t happening consistently, although they are working toward that.

Paul: It is also hard to know exactly how we are performing, because health data remain dependent upon claims data. In certain models, we have access to data outside our health system, which helps, but it is still a retrospective review. As we gain access to more real-time data, such as through our regional health information exchange, I expect that we will have greater capabilities in closing data gaps, which will then improve the quality of care for our patients and community.

Jensen: Since beginning our risk contracting journey in 2010, we have conducted periodic performance meetings with the primary care practices that participate in our risk programs. At these events, we share unblinded quality, efficiency, and utilization data—reporting to the practice site and individual physician level to the extent we can. This allows practices to compare their performance to others. Our standard reporting packages have always included all value-based payers. That’s how we’ve kept the contracts visible and transparent. Increasingly, we are starting to generate payer-blind reports that show key performance metrics across an entire population—either the entire commercial population or the entire Medicare population. By pooling information in this manner, we can give providers a clearer idea of how they’re doing in aggregate.

How does your organization connect contract metrics and goals with care delivery improvement efforts and new care delivery models?

Jensen: Our primary tactic is conducting the performance meetings I just mentioned. These offer a good venue for sharing best practices and discussing progress on quality improvement efforts. A mix of small, medium, and large practices participate in our risk contracts. For the small practices, all the providers plus the lead clinical staff and practice administrator attend the performance meetings to hear from us in person. For the larger practices, we meet with organization leadership and rely on them to communicate with the frontlines. In addition to the reports mentioned above, we also give meeting attendees a report later in the year—around October—that shows them how many more patients they would need to see to reach the lower and/or higher benchmark of a measure. We even provide them with patient names and contact information to help them achieve their goals.

Kumar: About a year ago, we created a new department, the Center for Transformative Care, to deploy concentrated resources to patient care coordination across our network. This group holds meetings with physicians by site and department and disseminates performance metrics and what is needed in terms of care management. They’ve even started some pilot programs to zero in on certain conditions—such as high-risk sickle cell anemia, congestive heart failure, and oncology patients—and how to better manage them. There are dashboards in place that let providers see their quality and performance gaps at a glance and how to improve it to better meet their targets.

McLean: Realizing improvement in this area requires a commitment at the most senior level. Otherwise, various stakeholders may only try to figure out how to manage performance relative to their own contracts, and reach out to care managers directly to create success for those separate initiatives. Engaging someone at the regional or corporate level—say the CEO, CFO or chief strategy officer—will improve accountability and alignment across contracts.

Is it important to align the various value-based contracts you have in place? How does this impact costs and quality overall?

Jensen: I think we can all agree that it is essential for risk agreements to be as similar as possible. The rationale is that for us to succeed in risk and be able to effectively support providers, we need agreements to have a consistent design and message. Physicians can focus on only so many priorities at one time—they can’t have 10 quality measures in one contract and 50 different ones in another.

McLean: Although we’re seeing our members invest in and build capabilities around value-based care—such as through patient-centered medical homes or developing programs to enable cost-effective joint replacement—it is much more challenging for them to successfully tie together and align contracts to take advantage of the broader improvement opportunities. We support members in looking at the commonalities between the different programs and see where to improve performance in those areas. This results in a broader-based improvement rather than just a one-off advancement, which is not as cost effective or efficient.

What are some best practices for evaluating value-based contracts across an enterprise?

Paul: At the most basic level, it is a good idea to keep a matrix of the various measures versus the different programs—including Medicare, Medicaid, and commercial offerings. As technology improves, we will be able to increase our capabilities for reviewing metrics systemwide...
and at the hospital or practice level. A major challenge for our organization—and we are not alone in this—is the cost associated with updating electronic health records and other software platforms to enable such analytics. We fortunately have the power of a national health system—Ascension—to pool the necessary resources to develop these capabilities.

**Kumar:** We aim to organize our processes and metrics around the patient as opposed to the contract. Our job as the contracting department is to figure out what’s going to be in the contract and get it heading—more or less—in the same direction as our other initiatives. You can’t have too many projects; if you do, you’re just going to be chasing down actions and not succeeding.

To further align our work, we’ve been consolidating the annual health assessment form because every contract seems to have a slightly different version. Our department researched all the requirements and put a comprehensive form together that goes a long way in meeting everyone’s conditions. Staff across the organization use our form, which brings some consistency and standardization to the effort.

**Jensen:** We look for a wide variety of features before entering a contract, which helps us adopt initiatives that are focused in the same direction. For example, we make sure there are infrastructure payments to help fund our population health program. That includes support for analytics and care management, which are very expensive. Another characteristic we seek is a budget that doesn’t reset every year. If it resets, then it makes it almost impossible to realize savings.

Ideally, we want to see a link between the efficiency settlement and quality performance, so better quality performance opens a bigger share of the efficiency settlement, and it also gives the providers a lower share of any deficit. We have that in two of our agreements right now. This type of reciprocal relationship resonates with our providers because they often feel they have more control over quality.

We look for asymmetrical risk corridors, where we get a bigger upside and a lower downside risk, although we don’t usually get that. We also seek to have risk mitigation mechanisms in the contract whether it’s through reinsurance provisions, pooling within the agreement, or expense exclusions like when pharmacy or behavioral health is excluded.

One of the most important things we request is timely claims data with a consistent file layout across payers. This is much more difficult to get than you would expect. However, we won’t accept downside risk from any payer that won’t give us paid claims data because you can’t manage your efficiency without that.

Of course, we don’t get all these components in every agreement, but this is how we judge each opportunity. When we’re presenting a summary about contracting opportunities to our contracting committees and board, we show this analysis to compare the given proposal against others that we have. This lets us funnel opportunities into a more consistent format.

**McLean:** When it comes to evaluating value-based contracts, it’s important to look broadly at all arrangements to incorporate fee-for-service contracts into the discussion. There is this misperception that health systems can’t live in both worlds simultaneously. However, there is an opportunity to generate upside revenue through value-based contracts by improving the cost-per-DRG, for example. By analyzing resource use across acute care settings, organizations can pinpoint opportunities to limit unwanted variations or excessive utilization, such as excess testing that occurs late in a patient’s stay. This will allow organizations to realize upside value-based revenue while simultaneously enabling more solid fee-for-service contribution margins.

**Are there revenue opportunities being missed when leaders do not have a strategic plan governing existing and future value-based contracts? What does a plan look like?**

**Paul:** Without a strategy, organizations are in danger of entering into certain value-based arrangements before they are ready. They need to determine what gaps exist in the organization before taking the leap. Any plan should include an assessment of the mission/vision/values and purpose of the organization; an internal and external environmental scan of strengths, weaknesses, opportunities, and threats; identification of key result areas (and metrics); and then goals, objectives, and tactics for each of the key result areas.

**Jensen:** You must have a plan, so you can make the contracts as manageable as possible. For hospitals, for instance, our top priorities are managing post-acute care and acute care. For acute care, that means decreasing unnecessary emergency room visits, inpatient admissions, and readmissions. To the extent that we’re successful, we’re taking volumes out of our hospital participants that are also half owners of our endeavor, so those objectives are not aligned.

But, at the same time, if we’re taking out unnecessary utilization, and the hospitals can backfill with more appropriate, potentially better-paying utilization, that’s a win-win. Basically, they should focus on increasing their market share to replace the lost volume and corresponding revenue.

I think this mentality holds true for specialists as well. Even though specialists participate in our agreements, they share in a small percent of any surplus. They are doing it mainly because they need the referrals from the primary care physicians, and they want to be good citizens and participate. But if our strategies are succeeding, we’re decreasing unnecessary specialty utilization as well, so again, these providers must pay attention to market share just like the hospitals do.

The other thing to look at is HCC [hierarchical condition category] and diagnosis coding because depending on the agreement, if you zero in on accurate and complete diagnosis coding, it allows you to better
identify complex patients, who need more care. Moreover, it ensures that you have an appropriate budget to care for these expensive patients. It’s also a revenue strategy because—particularly for the hospitals—if they do more specific and accurate coding, it’s going to improve their reimbursement.

Kumar: Yes, the lack of a strategic plan and culture will derail or slow efforts to succeed in these contracts. There are a few overarching elements which organizations need to incorporate (at some level) into their strategic plan, including primary care attribution, scale to maximize the number of lives, care coordination and utilization management, and partners (e.g., offsite locations, other provider groups). The strategic plan needs to hold the network—providers included—accountable with competitive incentives and funds that flow across the care continuum.

McLean: Every health system needs a broad-based, coordinated, and long-term value-based contracting strategy, and it needs to be set at a pace that is based on the health system’s specific market conditions. It is a continuous process that includes having the right data and information to inventory and evaluate performance, metrics and contract structures, as well as align care models. Each contract needs data-driven parameters and decision-making mechanisms. Health systems also must form a cross-functional team of leaders and staff with plans and resources that allow them to easily communicate. Moreover, improvement efforts must be managed, measured, tracked and reevaluated on a regular basis.

What role does data play in building an effective value-based contract strategy?

Jensen: A robust data and analytics program is a fundamental building block for effectively navigating risk-based contracts. Note that it doesn’t have to be an expensive program, but it does need to deliver the broad scope of information required for managing these agreements. We couldn’t execute any of our strategies, whether it’s managing post-acute utilization or improving quality, without a comprehensive analytics program.

Data can also help you establish priorities and see where you have actionable opportunities to make a meaningful difference. Once you implement interventions, you also need data to evaluate what’s working, so that you can rapidly redirect your resources if you need to. In that sense, the data is informing where and when to change your strategies and tactics.

Our philosophy has always been to share data transparently. All our dashboards have been unblinded with the participating providers consent since day one. The physicians in particular are competitive—not one of them wants to be in the lowest percentile on any given report. This competitiveness can motivate performance improvement. It also helps those who are performing well to share with those who are performing less well. If one practice is struggling with ED utilization, for example, and it sees another practice is doing well, then the data can reveal best practices.

Kumar: Data is critical, although if it is not used in the right way, it is not a benefit. External and internal claims data helps us know how we perform. We have found there is a learning curve on how to make it user-friendly and actionable for providers, care coordinators, administration, and others. As we participate in more value-based contracts, we have become savvier in how to present and use the data in a way that allows the organization to work toward our targets.

McLean: Unfortunately, the ability to connect all data across the continuum does not fully exist yet. This is an essential capability that organizations need to be able to fully determine the cost of a patient’s care or revenue implications associated with all the interventions. It’s about connecting all the data points around the patient’s journey and the entities that care for them—from the hospital to the physician enterprise. We’re working with our members to find ways to connect that data and figure out how to do the right thing for patients, while managing value-based contracts more effectively to improve their margins at the same time.