

## EXECUTIVE BRIEFING

# Value-Based Contracting: How to Think Like a Payer

It is widely recognized that the rate of healthcare spending in the U.S. is unsustainable. In recent years, experts of all types, from academia to policy makers, agree that the traditional fee-for-service (FFS) approach is a major contributor to our country's outlier status in cost-to-quality performance.

In response, both commercial payers and the government have been working to shift the mechanism for provider reimbursement from volume-based to value-based incentives predicated on quality and efficiency. Many view this shift with skepticism, or even disdain; however, when compared with alternative models, which depend on governmental pricing controls and / or care rationing, the value-based transition is clearly more palatable.

**Many health systems and providers find themselves at an inflection point.**

Given the level of investment in capabilities, human capital, and other infrastructure for value-based payment, it is apparent that greater assumption of risk will be needed to realize a return on these investments. However, financial success for health systems in downside risk contracts oftentimes directly conflicts with the traditional metrics that drive FFS model financial success. This inherent conflict has made it difficult for health systems and physician groups to make the requisite change in their financial, clinical, and operating model to achieve financial success under contracts and programs involving downside risk.

*"But there is no turning back to an unsustainable system that pays for procedures rather than value."*

*- Alex Azar, HHS Secretary  
March 6, 2018*

**Providers face two barriers in the shift to risk-based contracts:**

**1** Providers must operate in parallel worlds of both value-based and volume-based models. This period of parallel existence requires health systems to **assume risk in a measured, phased approach to allow their organizations and clinicians to adapt to the risk-based world** in which they will operate over the long term. Which leads us to the second equally important, but less apparent, barrier.

**2** Health systems and providers entering into risk arrangements normally allow health plans to drive the structure and approach for the contract. This passive approach creates a host of issues, the most important of which is that **the organization cannot create one unified risk-based operating model that achieves the critical mass** needed to overcome the competing interests of the entrenched FFS operating model.

To overcome these barriers to success, health systems should take a proactive approach to value-based contracting, which requires health systems to **think like a payer** in their communication and approach to these contract structures and operating models.

**Without a proactive approach, providers risk having their options limited to widely varying, payer-centric models that may not be to their maximum benefit while also making the organizational transition operationally challenging.**

Through our work supporting both plans and providers in the migration to value-based payment, we have found the following methodology to be successful in the development of a **proactive approach to value-based contracting**.

## Value-Based Contracting Approach



### Market / Organizational Assessment

The first step is to conduct an expedited assessment that looks both internally at the organization's readiness to assume risk and externally at the critical factors in the payer landscape that could influence the system's value-based contracting approach. Everyone knows that healthcare is local, and the transition to value and risk is no different.

### Organizational Assessment

It is important for all stakeholders in the organization to align on the system's capabilities and organizational readiness for value-based payment models, especially those that will require downside risk assumption. **It is equally important for all constituents to gain more in-depth knowledge of what it takes to successfully assume risk and how that will compete with traditional FFS success factors during the transition period.** Assumption of risk requires everyone to buy-in with their eyes wide open. Critical domains to be considered in this assessment include:

- + **Enterprise governance:** What experience does the organization have with value-based payment? Is the organization aligned with the change management needed to move to value-based payment?
- + **Care delivery:** Will the current care delivery model support success in value-based contracting? Does the organization understand the structural utilization controls that are needed to thread efficiency into the organizational fabric to achieve downside risk success?
- + **Health technology and infrastructure:** What tools and processes are used and applicable to value-based payment?
- + **Operational performance:** Is the organization financially stable enough to implement new processes and assume risk? What operational changes are needed to assume risk? How is current quality performance, and would it support success under value-based contracts?

## External Market Assessment

Every market is unique and it is important that the health system understands the dynamics of the payer and competing provider landscape that could impact value-based contracting. **A payer landscape that has led to successful contract negotiations under the FFS model will require a different approach for value-based contracting.** Critical market factors include:

- + **Payer enrollment and market share trends:** Who are the dominant payers? How has their market share trended over time?
- + **Line of business implications:** Are there variations in enrollment and market share trend by line of business (e.g., group fully insured vs. self-insured vs. individual)?
- + **Access to membership:** Are there health plans for which the health system cannot currently access members (but could represent new patient opportunity)?
- + **Value-based maturity:** What is the value-based payment participation by payer and maturity of the transition to downside risk arrangements in the market?
- + **Macroeconomic trends:** What is the local rate of healthcare spending/premium increases? What is the health of the labor market? What is the state of data sharing/connectivity in the market?
- + **Regulatory trends:** What national and state regulatory forces are impacting value-based payments?

### External Market Situation Impacts Value-Based Contracting

#### Fragmented Market



- Advantageous for historical FFS contracting, but difficult to create critical mass for value-based contracts
- + Creates optionality to bring value-based contract to multiple payers; not reliant on interest from one payer

#### Consolidated Market



- Reliant on payer interest in value-based contracting and acceptance of the provider's preferred model
- + Easier identification of value-based contracting partner for critical mass



#### Value-Based Payment Strategy & Structure Development

The results of the organizational readiness and external market assessment will inform the development of preferred value-based contracting strategies and structures for the health system. Recognizing that there is a continuum of strategies available, the health system should start by identifying a set of potential value-based contracting structures, considering the following factors:

- + Risk profile / level of risk assumption required and how this risk could be phased in over time
- + Lines of business best suited to the contracting strategy (e.g., commercial vs. Medicare Advantage vs. Medicaid)
- + Critical success factors compared to current state capabilities
- + Data / interoperability requirements with the payer
- + Market / competitive response

Objectively assessing various models under a set of common evaluation criteria will allow the organization to focus on a narrow set of strategies that best fit the organization. It is also likely that strategies will need to evolve over a three- to five-year period to allow the health system or provider organization to work through the change management needed to take on risk.

### ***Elements to Consider in Value-Based Contracts***



#### **Product**

- + PCP attribution
- + Value-based benefit design, both positive and negative incentives



#### **Network**

- + Encourage utilization within the health system
- + Improved coordination, patient experience, quality and cost management



#### **Financial Model**

- + Transition to downside risk
- + Inclusions / exclusions from the cost target
- + Varying structures by market (commercial vs. MA, risk adjusted vs. non-risk-adjusted)



#### **Roles & Responsibilities**

- + Data needed from the payer, both content and frequency
- + Plan vs. provider responsibility for medical management, marketing, member engagement, etc.

For each of the targeted structures (over both the short and long term), the health system should then prepare a contract business case, which can be used as a framework to guide future discussions and negotiations with targeted health plans.

Historically, value-based contracts have been payer-driven, causing the health system to react to terms set forth by the health plan and adapt to contracts that may not reflect the unique capabilities and market dynamics of the health system. **This business case will allow for more accelerated contracting discussions, and will ensure that the structure of the ultimate contract is driven by the health system, not the health plan.** Elements of the value-based contract business case should include:

- + Value proposition to the health plan and health system
- + Criticality given market specific trends
- + Network requirements
- + Product requirements
- + Proof points / lessons learned from existing value-based contracts
- + Financial model and high-level financial opportunity
- + Roles and responsibilities for the value-based arrangement
- + Data requirements / request for claims data to support further value-based contract development

In addition, many health systems are exploring opportunities to contract directly with employers. This option is increasingly used by large, self-insured employers, as it can give employers more control over benefit design and create more direct incentives to lower the cost of care. Health systems derive value by capturing more of the healthcare premium dollar (as the role of the health plan is eliminated) and receiving greater reward for their role in cost and quality outcomes.

Direct-to-employer contracting is a largely market dependent decision. Health systems may achieve greater speed to market and scale by partnering with existing health plans to access self-insured groups. It is also dependent on the availability of an employer with sufficient size and employee concentration in the health system's service area. Health systems must also develop or partner / acquire capabilities to administer these contracts and be willing to accept the downside risk exposure inherent in these models.



### Roadmap to Risk

The last step involves the creation of a detailed transition "road map" to guide the organization to a future state that will allow for success in preferred value-based contracts. This execution plan must incorporate critical elements in the roadmap to risk, including:

- + Contract business case development and negotiations
- + Network evaluation
- + Provider outreach and communication
- + Clinical care model evolution
- + Analytic / information technology needs
- + Program and performance management

## Lessons Learned

1

**Communicate, communicate, communicate (and then communicate some more):** Gaining buy-in and concurrence on new value-based contracts is **not a one-time communication**. This ongoing message includes everything from educating all constituents in the early stages to cementing comprehensive buy-in before risk is assumed. Deliver frequent communication to providers on the process, including the case for change and / or market dynamics driving the need for value-based contracts, as well as the structure and contract details, and finally, **a financial impact analysis**. Education to the Board on what is required of the health system and the change management required from providers is also important.

2

**What's in it for me:** Assuming understanding and support for value-based contracts, organizations must **model the impact of these contracts on specific stakeholders to gain final buy-in and approval**. This step is especially important to show how the financial model will change based on the value-based contract parameters (e.g., changes in reimbursement rates, impact of utilization declines needed to meet cost targets, etc.).

3

**Look beyond chronic care management:** Given the need for risk assumption, health systems must ensure they have **medical management needs across the entire continuum of services, reflecting the needs of both government and commercial markets.** For example, many health systems / providers have strong chronic care management capabilities, but have not yet developed programs needed to succeed in downside risk models, including utilization management and referral management for specialists or lower cost sites of care.

4

**Practice what you preach:** Health systems can **use their large employee base as a testing ground** for critical elements of a value-based contract, including product design, value-based benefits, and clinical care model redesign. Success with this employee population creates compelling proof for the payer business case.

5

**Value-based contract 2.0:** Many health systems have tacked their initial value-based contracts onto existing PPO and FFS arrangements. Given this structure, these contracts have limited downside risk, which impacts the financial return for these contracts. Moving forward, and with increased downside risk assumption, **value-based contracts will need to be structured differently and incorporate elements such as value networks, product design, and primary care physician (PCP) enrollment.**

6

**Phased approach to risk:** Recognizing the business reality that health systems will be operating simultaneously in FFS and value-based environments, the **approach to risk assumption should be phased.** This approach will also allow for the capability / infrastructure development and change management needed to ensure the health system can succeed in these types of contracts. The value-based contract must allow for this migration to risk and have **contract terms that protect the health system's risk exposure.**

7

**Executive support and alignment of incentives:** The shift to value-based contracting represents a fundamental change for providers and health systems, from the clinical and operating model to underlying financial incentives. While most recognize the imperative to shift from FFS, it is **critical to have full transparency on how value-based contracts will impact the organization** and build executive support for needed changes. Executive leadership must then rally that support down the organizational model to all levels of management that have spent their careers operating under the FFS model.

### **HealthScape can help.**

*The migration to value-based payment is very market dependent and must be tailored to these unique market dynamics, as well as a health system's organizational capabilities and readiness. We have experience working with both payers and providers through the transition to value-based payment.*

**Contact Alexis Levy for more information.**



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