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Elements of value-based payment contracting: a guide for health care plans and health care providers

VBP toolkit overview

The Value-based Payment (VBP) Toolkit for Coordinated Care Organizations (CCOs) is intended to support CCOs and contracted providers in achieving the objectives of the VBP Roadmap for Coordinated Care Organizations, including:

- Rewarding providers' delivery of patient-centered, high-quality care
- Rewarding health plan and system performance
- Aligning payment reforms with other state and federal efforts
- Ensuring consideration of health disparities and members with complex needs
- Supporting the triple aim of better care, better health and lower health care costs

Access the full toolkit here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx

Purpose and contents of this document

This document identifies key elements that should be incorporated into value-based contracts between a provider and a CCO. Not all elements apply to all forms of value-based payment arrangements, and not all elements in a contract are covered in this brief. For example, episode-based payment terms have some distinctive characteristics not found in population-based arrangements. Still, this document can serve as a general reference guide for providers and CCOs entering new types of arrangements. This document includes information on the contractual elements listed below; a set of resources, including sample contract language; and a compilation of all elements in the form of a checklist (Appendix A: VBP contracting elements checklist).

Covered services

The goal of VBP programs is to create provider accountability around the cost and quality of care that is within the provider's control to coordinate and deliver. Key to the success of a VBP arrangement is defining the payment in a way that includes services that are appropriate to the population or treatment, and within reasonable control of the contracted provider.

The contract should specify which services are included in the value-based payment arrangement to ensure providers are clear on what services they need to deliver to qualify for payment. The definitions need to be detailed, and include procedure codes as well as who should be able to bill for services (for example, physician vs. non-physician and ancillary staff, or providers across multiple settings). The contract should also be clear on the services that are excluded from the payment, such as in the case of mental health or pharmacy services that may be carved out to a specialty vendor. The services that are encompassed in the payment will depend on the value-based payment arrangement:

- √ Does the contract specify the services, including CPT codes, included in the payment?
- √ Does the contract specify the services, including CPT codes, that are excluded from the payment?
- √ Does the contract outline which type of providers may submit claims for the services included in the payment?
- √ For episode-based payments, does the contract specify what triggers the payment and the time period covered by the payment?

- Services do not need to be specified in **pay-for-performance contracts** since unlike other value-based payments, pay-for-performance programs do not change the underlying fee-for-service arrangement. Bonuses or penalties are determined based on achievement of certain quality benchmarks at the end of the performance period.
- In **episode-based payment arrangements**, the services generally included are those for a given or typical course of treatment for a condition or procedure. This involves not only specifying the services included, but also defining the beginning and end of an episode or condition, including what "triggers" the beginning of what is paid for within the episode and what establishes the end of what is included in the payment arrangement for that episode or condition. This is particularly important where multiple providers deliver services in multiple settings. The episode may be triggered by the delivery of one or more of the services included in the episode, or by the diagnosis of a health condition. In terms of time period covered by the payment, this may be defined by the length of time to deliver a service or achieve an outcome. For example, a maternity care episode may include all covered services for prenatal care, labor and birth, postpartum care, and newborn care. This includes imaging, testing and other services typically provided to pregnant women. In this case, the trigger would be the birth, but the episode would encompass prenatal care 40 weeks prior, postpartum care 60 days after the birth for the mother, and newborn care 30 days after the birth.[1]
- In **shared-savings and risk and global capitation arrangements** that are typically based on total cost of care, payments tend to include the whole spectrum of covered services for the patient population. For

[1] The Clinical Episode Payment Work Group. "Accelerating and Aligning Clinical Episode Payment Models: Maternity Care." Draft White Paper, April 22, 2016.

example, Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract pays accountable care organizations a total cost of care target, within which they are supposed to manage the full continuum of care for their attributed populations.[2] Similarly, in UnitedHealthcare's Global Capitation Program, providers receive a risk-adjusted per member per month payment that covers the majority of services for an attributed member.[3] Risk-sharing and global capitation arrangements typically exclude payments that are not related to direct provision of services, such as bonus or incentive payments, management fees, vendor-capitated payments (for example, behavioral health and laboratory services), and risk-contract settlements. They also typically exclude costs from high-cost, outlier patients.[4]

Data and reporting responsibilities

Accurate performance data are essential to success in a value-based payment program. The contract should clearly outline obligations of both the CCO and the provider regarding the submission and reporting of data.

For payers, data and reporting obligations typically involve giving providers tools to help them monitor progress. These may include the following:

- For shared savings and shared risk arrangements, data to reconcile financial results and validate any adjustments made to either the target or financial results
- Timely membership reports
- Dashboards and reports comparing provider performance with benchmarks, including the format and frequency of the reports
- Claim files that providers can manipulate and analyze, should the provider organization have the resources to accept and use such files
- Access to web-based or database tools that offer standard reports and allow for customized inquiries
- Ad hoc analyses requested by providers

√ Does the contract clearly specify the CCO's responsibilities with respect to furnishing data and reports to help providers manage their clinical and financial risk?

√ Does the contract outline providers' responsibilities to submit quality and encounter data?

For providers, requirements around data may include:

- Type of data for quality measurement
- Required format for submitting data
- Frequency and procedure for submitting data

In addition to the above data responsibilities, the contract should include requirements for submitting claims, including the process, frequency and timeframe for doing so if they are different from procedures used for services that are outside of the value-based payment program.

[2] More information about the payment model is available at https://aboutus.bluecrossma.com/affordability-quality/alternative-quality-contract-aqc, last accessed January 3, 2020.
[3] Bailit Health, "Categorizing Value-Based Payment Models According to the LAN Alternative Payment Model Framework: Examples of Payment Models by Category," State Health and Value Strategies, February 2018.
[4] Bailit M and Hughes C. "Key Design Elements of Shared-Savings Payment Arrangements," The Commonwealth Fund, August 2011.

Patient attribution

- √ Is the process for attributing patients to a provider clearly articulated?
- √ Does the contract state whether attribution will be prospective or retrospective?
- √ Is it specified whether attribution will be to a single provider or multiple providers?
- √ Is the algorithm for determining patient assignment clearly articulated?

Patient attribution is the method for defining the patients for whose care a provider or provider group is accountable. Patient attribution is relevant for population-based VBP contracts for which a provider entity has responsibility for the quality and/or cost of care for a defined patient population. For contracts involving shared financial risk, it is a critical component of a value-based contract, as it essentially defines a provider's risk pool. The outcomes and costs associated with the care provided to the attributed population determines whether a provider will realize financial savings or losses in a value-based payment arrangement. Aspects of patient attribution that should be in the contract include:

- **Whether attribution will be prospective or retrospective**. When attribution is made prospectively, the payer informs the provider organization before the performance period begins about the patients for which it will have responsibility. Prospective attribution can be conducted based on an enrollee's geographic location, past utilization patterns, specified health condition, or other factors. It has most commonly been used by Medicare, but it is sometimes used in other applications, including in Vermont's Medicaid ACO program.

  With retrospective attribution, the payer determines the at-risk population at the end of the performance period. Retrospective attribution is most commonly used in total cost of care contracts,[5] and it ensures patients actually received care from their attributed provider. However, the approach makes it difficult for providers to proactively identify and coordinate care for attributed patients, and it could lead to some providers focusing only on low-cost patients.[6]

- **Assignment to a single provider or multiple providers.** In single attribution, a patient is assigned to one provider or provider group. Multiple attribution assigns a patient to more than one provider or provider group. Attribution often, but not always, requires a minimum threshold for assigning patients to a provider to ensure the provider can be accountable for the care, and/or that the payment incentive will be large enough to motivate behavior change. Multiple attribution methods may be used when the minimum threshold cannot be met using the single attribution method.[7]

- **Attribution methodology**. This includes the algorithm for determining patient assignment, such as whether it will be to the provider who provided the majority (50%) or the plurality of the patient's care, and the service codes that will be used to define patient care. It should also detail the data used to make the attribution and the time period (for example, claims from the 24-month period preceding the performance period).

[5] Total cost of care contracts include payment for the comprehensive basket of health care services utilized by a patient or population.
[6] Houston R and McGinnis T. "Program Design Considerations for Medicaid Accountable Care Organizations," Center for Health Care Strategies, February 2016.
[7] Pantely, SE. "Whose Patient Is It? Patient Attribution in ACOs," Milliman Healthcare Reform Briefing Paper, January 2011.

Payment terms

Financial risk arrangement details

The financial risk arrangement between the payer and the provider determines the financial rewards or penalties associated with the value-based payment. These may involve:

- Bonus payments for meeting quality benchmarks
- Withholds or penalties for failing to meet quality benchmarks
- A lower/higher percentage of shared savings/losses being paid for meeting/exceeding/failing to meet quality benchmarks

All value-based contracts should clearly describe these financial arrangement details, including the process for determining and distributing or recouping financial rewards/penalties and shared-savings/losses associated with the payment arrangement. For episode-based payments, if payment is not prospective, language should address timing of reconciliation of completed episodes, and how reconciliations are to be performed if multiple provider entities are involved (for example, medical group and hospital).

- √ Does the contract clearly specify the financial risk arrangement, such as the bonus payment or risk-sharing structure?
- √ Does the contract specify whether payment will be prospective or retrospective?
- √ Does the contract include a timetable for receipt of bonuses or risk-shares, or in downside risk arrangements, the payment of monies due?
- √ If payment involves retrospective reconciliation, does the contract outline the timeframe for reconciliation?
- √ What is the method of reconciliation, if multiple provider entities are involved?

Payment Schedule

Depending on the design of the payment model, payments could be prospective or retrospective with reconciliation. In a prospective payment model, providers receive a lump sum payment for a defined category or set of services. This could be for total cost of care, for all care associated with a specific condition, or all care provided by a certain provider type. In the retrospective reconciliation method, providers receive traditional fee-for-service payments for services they render, then reconcile actual expenditures against a target price for an episode of care. The contract should be clear on the payment and reconciliation terms, including remittance timeframes (for example, monthly, quarterly or annually) and the process for appealing the payments.

Performance measures and benchmarks

Performance measurement is central to value-based payment's goals of achieving better care, better health and lower cost. All value-based programs collect and analyze provider performance on a set of agreed-upon measures to determine whether the value-based payment and associated delivery system reforms are resulting in higher quality, cost-efficient care, and to determine whether providers qualify for incentive payments or shared savings. Requirements around performance measures and benchmarks that should be included in the contract include the following:

- **Measures used**. Measures should be selected based on shared CCO and provider goals, the medical conditions and services included in the value-based payment, and the provider and CCO's capacity to

support the collection and analysis of the data. The specific measures could include standard measure sets endorsed by the Centers for Medicare & Medicaid Services and national measurement bodies such as the National Committee for Quality Assurance and the National Quality Forum, measures endorsed by local measurement committees, such as the Health Plan Quality Metrics Committee and Metrics and Scoring Committee, or on occasion, homegrown measures, such as those developed by CCOs and providers.

- **Performance benchmarks or thresholds**. In value-based payment arrangements, providers must meet certain performance benchmarks in order to be eligible for bonuses, or shared savings. These benchmarks may be absolute to incentivize providers to achieve a goal (for example, providers must score above 75th percentile in a measure). Benchmarks could also be relative, or a percentage change from baseline (for example, providers' performance on a measure must increase by 5 percent from previous year) to reward progress. Incentives could also be based on a combination of meeting threshold and improvement targets, which is commonly used when baseline performance of participating providers vary widely.

- **Methodology for determining provider performance on selected measures**. The agreement should lay out how provider performance on the quality benchmarks will be calculated, including the relative weight or importance of specific measures. This section of the contract should reference other provisions related to the methodology as necessary, such as patient attribution, the performance period, and risk adjustment (when applicable).

- √ Does the contract include measures selected based on shared CCO and provider goals, the medical conditions and services included in the value-based payment, and the provider and CCO's capacity to support the collection and analysis of the data?
- √ Does the contract include performance benchmarks or thresholds?
- √ Does the contract lay out how provider performance on the quality benchmarks will be calculated, including the relative weight or importance of specific measures?

Performance period and phase-in

The contract should be clear on the performance period start and end dates. The performance period is the time period during the term of the contract agreement in which the provider's performance is measured. The agreement term and performance period may sometimes align, but in some cases, multi-year agreements may include several performance periods within the agreement term, usually on an annual basis. Some contracts may include a ramp-up period prior to the first performance period to allow providers to put in place administrative systems and protocols needed under the value-based payment initiative. For episode-based payments, the performance period will include many "sub-periods" that are defined

- √ Is the performance period clearly specified as distinct from the agreement term?
- √ If there is a ramp-up period prior to starting the performance period, is this clearly articulated?
- √ For episode-based payments, does the performance period include sub-periods defined by when care episodes begin and end?

by when patient-specific care episodes begin and ends (for example, 90 days prenatal and postpartum for a maternity episode).

Provider participation requirements

- √ Does the contract include the requirements providers must meet to participate in the value-based payment arrangement?
- √ For arrangements involving downside risk, does the contract include requirements for risk mitigation?

Different value-based payment arrangements often have specific requirements that providers must meet to be able to participate. These requirements can range from participation in practice transformation activities, to having a minimum panel, to having certain state licensure or certification. For example, to participate in the Medicare Shared Savings Program, accountable care organizations must have at least 5,000 assigned beneficiaries, meet certain organizational and management requirements, and have certain care management functions, among others.[8] Contractual agreements should specify these requirements and the consequences for failing to meet them. Payment arrangements involving downside risk should also include requirements for risk mitigation to protect against insolvency, such as obtaining reinsurance for high-cost patients or receiving certification from the state insurance agency as a risk-bearing entity.

Risk adjustment

- √ Does the contract specify the components of the value-based payment arrangement that are subject to risk adjustment?
- √ When risk-adjustment is applied, does the contract indicate the methodology for adjusting risk?

Risk adjustment is the process of modifying payments to providers to account for patients' underlying health status and expected costs. It is widely used in establishing payments under different value-based payment approaches and in calculating provider performance on cost. It is employed less often with quality process and outcome metrics, primarily due to a lack of means to make such adjustments. Risk adjustment is critical to ensuring providers aren't disadvantaged for serving patients with complex needs. Contracts should specify the components of the value-based payment arrangement to which risk adjustment applies, such as the amount of payment and the calculation of the quality scores or savings targets.

[8] See https://assets.hcca-info.org/Portals/0/PDFs/Resources/Conference_Handouts/Compliance_Institute/2014/mon/101handout1.pdf, last accessed January 1, 2020.

Resources

Tools to support the development of value-based payment contracts

Arkansas Health Care Payment Improvement Initiative Episodes of Care Provider Manuals
http://paymentinitiative.publishpath.com/Websites/paymentinitiative/images/PCMH_II%202019%20Manual.pdf

Harold D Miller, "How to Create an Alternative Payment Model: Designing Value-Based Payments that Support Affordable, High-quality Healthcare Services," Center for Healthcare Quality & Payment Reform, December 2018
http://www.chqpr.org/downloads/How_to_Create_an_Alternative_Payment_Model.pdf

Sample value-based payment contracts

Integrated Healthcare Association Bundled Episode Payment Contract Template: Health Plan (PPO) and Hospital Agreement
https://www.iha.org/sites/default/files/resources/contract-template-health-plan-and-hospital.pdf

Massachusetts Executive Office of Health and Human Services Primary Care Accountable Care Organization
https://www.mass.gov/files/documents/2017/11/17/primary-care-aco-model-contract.pdf

Massachusetts Executive Office of Health and Human Services Primary Care Clinician Plan Provider Contract
https://www.mass.gov/files/documents/2016/07/tk/pcc-contract-fourth-amended.pdf

Minnesota Department of Human Services Integrated Health Partnerships Contract
https://mn.gov/dhs/assets/2018-ihp-track-2-contract-template_tcm1053-327867.pdf

Pacific Business Group on Health and Catalyst for Payment Reform Model ACO Contract Language
http://www.pbgh.org/storage/documents/CPR_PBGH_Model_ACO_Contract_FINAL.pdf

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VBP contracting elements checklist

This checklist identifies key elements that should be incorporated into value-based contracts between a provider and a CCO. Not all elements apply to all forms of value-based payment arrangements.

Covered services

- ☐ Specific services, including CPT codes, included in and excluded from the payment
- ☐ Which type of providers may submit claims for the services included in the payment
- ☐ For episode-based payments, what triggers the payment and the time period covered by the payment

Data and reporting responsibilities

- ☐ CCO's responsibilities to furnish data and reports to help providers manage their clinical and financial risk
- ☐ Providers' responsibilities to submit quality and encounter data

Patient attribution

- ☐ Clear process for attributing patients, including:
  - ☐ Whether attribution will be prospective or retrospective
  - ☐ Whether attribution will be to a single provider or multiple providers
  - ☐ Clear algorithm for determining patient assignment

Payment terms

- ☐ Financial risk arrangement, such as the bonus payment or risk-sharing structure
- ☐ Whether payment will be prospective or retrospective
- ☐ Timetable for receiving bonuses or risk-shares, or in downside risk arrangements, payment of monies due
- ☐ Timeframe for reconciliation, if payment involves retrospective reconciliation
  - ☐ Method of reconciliation, if multiple provider entities are involved

Performance measures and benchmarks

- ☐ Measures selected (should consider shared goals, conditions and services included, and capacity to collect/share data)
- ☐ Performance benchmarks or thresholds
- ☐ How provider performance on the quality benchmarks will be calculated, including the relative weight or importance of specific measures

Performance period and phase-in

- ☐ Performance period (which may be distinct from the agreement term)
- ☐ If there is a ramp-up period prior to starting the performance period, it is clearly articulated
- ☐ If an episode-based arrangement, the performance period clearly defines "sub-periods" for specific episodes

Provider participation requirements

- ☐ Explicit requirements providers must meet to participate in the value-based payment arrangement
- ☐ For arrangements involving downside risk, requirements for risk mitigation (for example, obtaining reinsurance for high-cost patients)

Risk adjustment

- ☐ Components of the value-based payment arrangement that are subject to risk adjustment
- ☐ Methodology for adjusting risk when risk-adjustment is applied