Magic Numbers

How to succeed in commercial value-based risk contracts

Featuring Ashish D. Parikh, M.D., and Jamie L. Reedy, M.D., M.P.H.

AMGA held a fully virtual Annual Conference in April 2021, bringing its members a variety of roundtable discussions, lectures, and topical keynote addresses all through one's computer screen. Among the remote gathering's highly rated presentations was the peer-to-peer breakout session, "How to Succeed in Commercial Value-Based Risk Contracts," presented by Summit Health Chief Quality Officer Ashish Parikh, M.D., and Chief Population Health Officer Jamie Reedy, M.D., M.P.H.

Often, a medical group's initial foray into risk contracts is through a Medicare or Medicaid alternative payment model. Unfortunately, the strategies that work for Medicare or Medicaid value-based programs frequently face shortcomings in the commercial space, either because the agreements are not structured to help the group succeed or the health plan falls short in supporting the patient population and providers.

"Commercially insured populations have a broader age range, resulting in the need to be prepared to manage utilization and cost across the lifespan," explained Reedy. "A population health management program built only for elderly Medicare patients will not suffice to meet the clinical service needs of a commercial population. Patient expectations also vary, and in our experience, we find the commercially insured patients have different expectations about how they will access care and utilize services. We're certainly seeing this now more than ever where the demand for virtual care continues to be high. The patient populations, their socio-demographics, and their overall health needs are all highly variable, which results in different clinical program needs and opportunities for cost reduction. For the most part, government programs have standard payment models that are non-negotiable and are created as a one-size-fits-all approach. In commercial risk, a wide variety of advanced payment models exist, and they vary by market across the U.S. Provider groups can have significant impact on the evolution of these models, and there's more latitude for health plans and provider groups to be creative and define the terms of a contract and how performance will be assessed."

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—Jamie L. Reedy, M.D., M.P.H.

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Which Comes First: Investment or Revenue?

Naturally, one of the biggest dilemmas medical groups face when venturing into risk-based contracts is the question of how to best invest in the population health infrastructure needed to be successful, while also planning for possible lower fee-for-service revenue as the group focuses on reducing total medical expense, especially since bonuses and increased revenue from risk contracts are not an early guarantee. As Parikh explained, the key is to make value-based investments that also benefit a group's fee-for-service revenue.

"Whether you're contemplating going into risk or you're already on the journey, you should use your track record for delivering cost-effective care to bolster your fee-for-service negotiations and protect yourself from the ongoing rate cuts that the payers are pushing upon us. And if you don't have this data, ask your payers for it. Often, they know much more about how well we're doing compared to what we know."

Other things Parikh said are important to identify are areas of focus that can help maintain or even grow fee-for-service revenue, while managing cost and quality. Such things are not mutually exclusive. Summit, for example, targeted inpatient care, dramatically reducing inpatient total cost of care without losing revenue by growing its number of primary care physicians (PCPs) and medical specialists and improving access for acute and chronic condition management. It also developed high-acuity urgent care centers to help reduce emergency department utilization, built out hospitalist teams to efficiently manage patients when they got admitted, and bolstered its ambulatory surgery and infusion centers to move care from expensive outpatient hospital settings to capture additional revenue. Finally, Summit emphasized growth in high-value, preventive care and condition maintenance services that improved outcomes while offsetting revenue from reducing unnecessary and low-value care.

"With all of these implementations, we saw reductions in cost of care, better outcomes, and maintenance of our fee-for-service revenue, all the while succeeding in building loyalty and a reputation for being a one-stop shop for comprehensive care," said Parikh. "It's a win, win, win."

Let's Make a Deal

When it comes to the inevitable contract negotiations, Reedy and Parikh emphasize the importance of knowing the organizational priorities of your group. Summit, for instance, focused on protecting its fee-for-service revenues so it could continue to invest in its value infrastructure and insisted that its payers provide the right data—including medical and pharmacy claims data—in order to assess the biggest opportunities for cost reductions. Summit also focused on its patient experience, as well as the tenets of comprehensive care and loyalty, in order to help reduce attribution churn. It partners more closely with health plans willing to invest in its success as a medical group and strategically built its network of providers to ensure the right balance of PCPs and specialists to provide coordinated care across its geographic footprint.

"We use these organizational priorities to inform our collaborations with all of our health plan partners, regardless of the level of financial risk in a particular contract or the upside opportunity for value revenue," said Reedy.

Utilizing a standard approach in how the group operationalizes its working relationship with plan partners—a "we do, you do" approach—Summit capitalizes on each partners' strengths. Oftentimes, for example, aspects of care delivery and contract management are better handled by medical groups, and others by the health plan. With this in mind, it is important to build the accountability for these aspects into the contracting process.

"We base our collaborations on the premise that results move at the speed of relationships," explained Reedy. "At Summit, we forge strong personal and professional relationships with our commercial health plan partners in order to effectively manage the collaborative activities and the results that we achieve together. We also structure our commercial collaborations in a fashion that facilitates holding each other accountable. If one partner doesn't uphold their end of the 'we do, you do model' then there are consequences built into our contracts that account for this. We have regular touchpoints with our health plan leadership to monitor these collaborations and ensure accountability on both sides."

Details in the Data

Once the moment arrives for negotiating a commercial contract, the key is to go in with data-driven knowledge of the organization's performance, not only of its strengths, but weaknesses as well. This means excavating internal data, information you can compile and analyze without payer or provider data, that showcase current clinical programs, quality outcomes, and technologies that support your ability to manage patients, oversee data, and monitor performance.

"The goal here is to use data to profile your organization as an

entity that is truly prepared to succeed in value and showcase your successes," said Reedy. "This could include HEDIS quality scores, current risk scores reflecting your clinical documentation improvement, or data related to clinical programs that your organization has developed, such as specialty pharmacy management programs or hospitalist program operations."

In addition to this internal data, organizations should also consider accessing any external data from publicly available sources or from vendors who use such data to create comparisons and benchmarks for your market.

"We always request the health plan provide us with comparison to our market, to their broader book of business and/or their other value-based partners," said Reedy. "It's really critical to know where your group measures up against other groups in the same market, as well as against the overall performance goals of the health plan. Ultimately, the question really is, 'Are your utilization and cost outcomes where the health plan needs them to be, and does this give you any negotiating leverage?'"

Reedy continued that as an organization prepares to negotiate a contract, it is important to have a complete list of all the key elements required for a successful implementation and collaboration. Often, commercial contracts offer substantial flexibility to design mutually beneficial value-based care arrangements. However, it is vital that the contract language be clear and hold both parties accountable across a wide range of elements—data nuances targeting patient attribution, which benchmarks and measures will be applied, how data will be shared, the depth of that data, sharing of savings or losses, and provisions that allow for conflict resolution.

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Comparison Shopping

In addition to attribution and quality metrics, setting the benchmark for cost comparisons is one of the most important aspects of contract structure and negotiation.

Reedy emphasizes just how many considerations have the ability to influence this benchmark: "You will need to agree on a comparison population that will be used to set your benchmark. For instance, will you compare to the health plan's broader market or to a segment of the market that more closely resembles your population with respect to counties of residence or product mix? Or will the health plan create a matched cohort comparison group or compare you to yourself year over year? There are significant pros and cons to each of these approaches. You also need to determine whether the comparison will be based on actual cost of care or based on cost trends. If you're a group that enjoys a higher fee schedule than others in your area, then you may want to compare yourself to market trend rather than actual cost target. If you're not efficient and may be new to commercial risk, then comparison to yourself may work well, as there may be lots of room for improvement.

"Another important consideration is the application of catastrophic caps on individual patient spend. You'll definitely want to have a cap on medical spend. However, in a commercial risk contract where you may be at risk for pharmacy spend, you could also consider separate caps for pharmacy-related expenses, given our general lack of control on drug pricing. With respect to timelines for final reconciliation, we prefer six months for claims to run out. But every health plan is a bit different. In order to measure and monitor success against benchmarks and anticipate performance, you will need access to claims data and timely reporting from the payers. You should ensure that your commercial risk contracts include standard language about provision of data and actionable reports and that there are consequences when that data is not provided."

As managing attribution is a key competency, organizations should ensure that their contracts have language supporting a process for validation and the removal of patients, and that the organization has processes in place for avoiding churn. When thinking about quality measures, it is crucial to think not only about which measures will be in the contract, but also how you're measured against benchmarks and how your performance will impact your overall contract performance. This means aligning metrics across payers so that you can minimize the number of measures you have to focus on, you know your baseline performance and are able to select measures where you have the greatest ability for success, and you choose measures that are going to be clinically relevant.

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For Reedy, another important item to address in contract negotiation is how any surplus or deficit will be shared. If given the opportunity, Reedy explained that it is wise to keep quality payments and any other incentive revenue separate from shared savings, and that these payments are not included as medical expenses. There are also internal considerations to take into account with shared savings, particularly whether the group will simply accrue the bottom line to support expenses and physician salary, or the savings should be placed into a pool that can be distributed to providers based on their performance.

Building Data and Clinical Infrastructure

Parallel to contracting, medical groups taking on commercial contracts will need to build out both the data infrastructure, as well as the clinical services needed to manage the unique patient population. Achieving this requires the commitment that everyone in the organization believes in value-based care from the get-go. At Summit, for example, Parikh said, "We know that we give quality care, but we have to prove it by making sure that we satisfy our quality measures and by giving superior patient experience. We know that we give great care to very complex patients, but we need to make sure we get credit for that work and our complex decision making by capturing the appropriate disease burden. We also need to make sure that we manage cost of care by keeping people healthy, by keeping them out of expensive clinical settings like the hospital and SNFs to make sure that we reduce avoidable utilization of unnecessary or potentially harmful services. And lastly, by keeping people within Summit Health, we make sure that they're getting the best care from the best providers."

It all goes back to using the data to identify and address key challenges that can impact an organization's population health management and developing the clinical resources to manage different challenges. This can involve identifying high utilizers of urgent care services and emergency rooms and engaging them with high-quality, ready-access alternatives in the office to manage their conditions cost-effectively, determining the development of a possible internal behavioral health service or building a partnership with strong community providers, or in the pharmacy, measuring generic medication utilization. You prove what needs to change by tracking and continuously improving on quality measure performance through transparent reporting, workflow optimization, and aligning incentives for clinical teams.

Concluding the pair's presentation, Parikh underscored the undeniable benefits of commercial contracts. "This inevitable shift toward value-based contracts is actually a way to protect yourself from this slowing of fee-for-service rates," he said. "And interestingly, over the last year, we have learned that value-based contracts may actually be a way to protect medical groups from unexpected, cataclysmic shifts in utilization from things like global pandemics, major technology advances, and other unknowns that may come toward us in the future.

"The key takeaways about commercial value-based contracts are that they are different from Medicare and Medicare Advantage contracts and that the populations require a very different population health management infrastructure, and that almost everything in the contracts is negotiable. And data is the key to success. As you go into commercial risk, use all available data sources to understand your performance, negotiate favorable contract terms, identify areas of opportunity, and invest in clinical strategies that will lead to success and increased revenue, as well as better outcomes for all of our patients." GPJ

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