Building Better Partnerships: A Facilitation Guide for Successful VBP Arrangements

Background

Research on how value-based payment (VBP) arrangements perform often focuses on aspects of technical design (e.g., benchmarking methodologies, risk corridors/stop loss, quality measurement). VBP designers cannot account for every eventuality and stakeholders will inevitably encounter unexpected challenges when operating a model. These may come in the form of unanticipated operational challenges with legacy systems, insufficient experience with care delivery change, or external forces impacting the broader market (such as a global pandemic). While design elements are important, strong working relationships based on mutual trust between organizations are a critical – but often underappreciated – driver of success. It is these relationships that allow organizations to adapt and improve VBP arrangements in response to challenges.

Purpose

The Health Care Transformation Task Force (HCTTF or Task Force) has developed a reference guide intended to support organizations interested in building new or improving existing value-based payment arrangements. The guide highlights existing HCTTF resources and covers new ground regarding topic areas that organizations should consider when negotiating and operating VBP arrangements. This resource is intended to compliment earlier HCTTF products by exploring the inter-organizational factors that experienced VBP stakeholders have identified as key to successful operations.

Value Based Contracting Guide

Successful value based contracting arrangements rely on payers and providers accurately assessing needs, identifying resources, negotiating contracts, and building relationships. The Task Force has developed a host of resources designed to support organizations in implementing successful VBP arrangements. This document compiles existing Task Force resources as well as fresh insights from our membership into a useful reference guide for organizations seeking to create new or improve existing value-based arrangements. This guide offers concrete resources like partnership evaluation templates and explainers that break down common payment arrangements as well as advice on less tangible – but equally important – aspects of successful partnerships like trust building and relationship management.

Section 1: Understanding the Options

There are many types of VBP concepts ranging from pay-for-performance to total cost of care and medical expense ratio-based models. These payment strategies generally fit into two categories: Accountable Care Organization models focused on improving population health, and episode-based payment models focused on improving care for specific conditions or service areas. HCTTF has created the following resources to educate those new to this area on these strategies.

- Accountable Care Financial Arrangements – Options and Considerations: This report offers a comprehensive look at the seven predominant payment models currently used by accountable care organizations. It describes each type of payment arrangement, notes which payers and provider organizations use it, and outlines the level of risk transfer, as well as the opportunities and challenges unique to each arrangement.
- Episode Groupers – Key Considerations for Implementing Clinical Episode Models: This paper examines episode groupers and clinical episode payments and provides key insights within context of the following four categories: (1) defining the focus and duration of the episode, (2) differentiation across patient groups, (3) differentiation between subgroups within similar diagnosis groups, and (4) attributing services and costs to the episode.

Section 2: Preparing for Value-Based Contracting

Is your organization – or the organization you are considering for partnership – prepared to implement a VBP model? Before entering a new value-based contract or renegotiating an existing contract, organizations should conduct an honest assessment of their readiness to operate a VBP model, an assessment of any potential partner organization(s), and an evaluation of the strategic alignment between each organization. These assessments should focus on identifying each organization's strengths, weaknesses, and opportunities for development. Highlighting potential areas for collaboration and capacity building will allow for the early identification of partnerships that are more likely benefit both parties and create a basis for ongoing success. The Task Force has produced the following resources intended to assist organizations in these assessments.

- Transformation to Value Guide - A Leadership Guide: Transitioning away from fee-for-service reimbursement often requires substantial changes to a health care organizations strategic direction and operating structures. This guide compiles the collective feedback of experienced value-based care organizations into a framework focused on key issues across four dimensions: 1) strategy and culture, 2) structures and investments, 3) operations and accountability, and 4) performance measurement.
- Value Partnership Evaluation Tool: The partnership evaluation tool is an open-source resource built in Excel that is designed to support organizations in evaluating potential partner organizations for readiness to engage in successful value-based partnerships. This interactive Tool is designed around a set of core competencies determined to be necessary for successful partnerships; it can also serve as a self-assessment tool for organizations to benchmark their own readiness to enter risk arrangements and track areas for improvement.

Section 3: Coming to the Negotiating Table

Successful value-based payment arrangements are built on strong partnerships. While the focus is often on partnerships between payers and providers, the partnerships between different provider types and community-based organizations are also critical, especially for models focusing on improving population health. Strong partnerships rely on organizations understanding their needs, building trust, and coming to agreements that can offer benefits to both parties. Organizations should consider the following factors in preparation for contract negotiations.

- **Do you know what you want?** Payers, providers, and purchasers can have a host of reasons for seeking out VBP opportunities. Identifying the specific goals of each organization and any goals held in common across organizations creates opportunities for creative problem-solving during negotiations and provides a focal point for ongoing cooperation. Common goals may include increasing efficiency/reducing low-value care, improving measures of community/population health, increasing patient satisfaction and organization reputation, increasing predictability in costs or revenue streams, improving care quality, eliminating prior authorization requirements, supporting care delivery transformation.
- **Do you have the right team?** Many health care organizations have internal silos that can make communications challenging across departments. When preparing for a contract negotiation, it is critical to assess whether you have the right people at the table to review all aspects of the model and identify potential pitfalls. Specifically, organizations should consider including representatives from areas responsible for the model design, strategy, legal, operations (business and clinical), data analytics, revenue cycle management, provider and patient engagement, and any other areas of particular importance to the success of the model being considered. Consider the following questions:
    - Have I built a multidisciplinary team of people from the areas that will be key to the model's operational success at the negotiating table?
    - Are the people that need to work together within and across organizations when implementation challenges arise adequately represented?
    - Do I have the decision makers I need at the table with the authority to discuss and act on any changes in contract terms?
- **Do you have the data?** Value-based payment arrangements require complete, accurate, and actionable data to be successful (e.g., patient level claims, enrollment, and risk adjustment data). Data is key to managing patient populations, measuring quality and costs, setting benchmarks, and a host of other activities. Organizations interested in these partnerships need to have a clear strategy for managing data. Providers should be able to demonstrate how they will use data to deliver on quality, patient experience. Payers should be able to demonstrate how they will get providers the data needed to manage risk (i.e., data elements, frequency of data feeds, file formats) commit to transparency in how performance under the contract is measured so that providers can replicate performance calculations.

- **Are you building trust?** Do other organizations believe your organization can be trusted? While a payer or provider may be technically capable of implementing a model, if the organizations do not trust each other the likelihood of long-term success is low. While there are no shortcuts for building trust, there are common best practices that can contribute to developing positive rapport.

- Invest in the relationship. While it is tempting save time by diving into the details of a negotiation the time saved on the front may result in more miscommunications in the long term. As with any partnership it is important to get to know the people and organization you will be working with. Taking the time to get to know the people around the table, presenting an overview of each organization's APM strategy, and understanding each organizations goals and approach to measuring value is a worthwhile investment in building rapport. This is true even for organizations that have a prior history of working together under fee-for-service arrangements since value-based arrangements require a deeper relationship to operate.
- For payment model designers, consider hosting brainstorming sessions with potential partner organizations to fully understand their perspective on potential models. Work to include partner organizations in the design and decision-making process including holding regular meetings to leverage the perspectives and experience of those ultimately tasked with implementing the model.
- All parties should develop a clear understanding of your organizational strengths, needs and goals prior to starting negotiations and be prepared to be transparent about what you can offer and the benefits you want to get from a value-based contract.
- Be up front regarding what aspects of a contract may be negotiable and what aspects are fixed (and explain why). *For example, is there room for changes in terms around payment rates, the pace of transition to risk, benchmarking methodologies, quality measure strategy, utilization management, potential for practice investments or supports, etc.*
- Offer leadership level commitments to participate in joint operations and contracting performance review meetings – ideally at least on a quarterly basis – to demonstrate ongoing organizational commitment to working through operational challenges.

- **Do you understand the issues?** As with any contract negotiation, organizations considering value-based partnerships will have concerns about the risks associated with the arrangement. Having a clear understanding these concerns is a prerequisite for productive negotiations and eventual partnerships. While there is no universal list of concerns some common issues include:
  - Payer concerns about increasing costs or creating opportunities for double payments, failing to achieve expected quality improvement, incentivizing providers to practice at the tops of their licenses, improving member experience and ability to navigate the care continuum, and marketability of coverage options to purchasers and members.
  - Providers may want to take on increased accountability for managing medical expenses but be wary of inadvertently taking on insurance risk. Additionally, providers may worry about the ability of a payer to provide actionable data to manage patient population risk, or that a payer is primarily interested in reducing payments without a focus on increasing value or sustaining practice transformation.
  - Purchasers are often focused on balancing costs increases, contracting for care within a high performing network, and responding to employee preferences which often include a desire for broad, open network health plan options. Furthermore, purchasers often seek out plan options that offer specific clinical and cost benefits and can be skeptical about the ability of VBP arrangements to deliver results. This

can make issues like network adequacy, infrastructure investments, and utilization management practices difficult to align with VBP.

- **How will you balance competing needs?** Similar but distinct from identifying common goals, balancing needs focuses on what each organization has identified as the "must have" aspects of an VBP arrangement and seeks to balance those needs in a way that benefits both parties and allows for a collaborative approach to achieving an objective. While payers or purchasers may be pursuing a value-based arrangement with the goal of reducing health care expenditures, this goal must be balanced with the need for the providers they partner with to sustain and invest their business.

- **Do you know what is expected of you?** Too many cooks can ruin a meal. Under value-based arrangements the roles of payers and providers can often become blurred as financial risks and responsibilities shift from one party to another. Agreement regarding the roles (often called Division of Functional Responsibility or DOFR) that each party is expected to play within these arrangements is an important factor for long term success. Under FFS payers, providers, and purchasers have developed a host of duplicative systems for activities such as utilization management, care coordination, data analytics, and credentialing. The incentive structures built into value-based arrangements should incentivize partner organizations to streamline or eliminate many of these processes to deliver the greatest net value for all parties. This simplification is a key benefit to participating in VBP arrangements and should be a focal point of discussion during contracting and ongoing operations. The Task Force has developed the following resource to support these efforts:
    - APM Roles & Responsibilities Matrix : This tool supports payer, provider, and purchaser efforts to clearly identify and assign roles and responsibilities for common VBP workstreams by identifying the relationships between the parties implementing the VBP, recognizing caps or overlaps in responsibilities, improving efficiencies and communication, and promoting successful operations. The resource guide and Excel-based matrix cover the most common VBP activities and can be customized to reflect a user's specific VBP model or integrated into existing organizational project management plans.

In addition to the factors discussed above, the Task Force has created the following model specific resources to support contracting efforts:

- Key Elements to Consider in ACO Agreements: This guidance is an educational resource for the health care community and focuses on contracting strategies in three main areas: (1) patient experience and access; (2) cost; and (3) quality of care.
- Clinical Episode Contracting Guidance for Commercial Payers: This guidance provides an objective tool for payers and providers to work together to make key program and contract design decisions in a logical, stepwise way. It also includes links to key resources that can assist organizations in pursuing specific design elements.
- Care Management Contracting for High Need High-Cost Populations: This resource is designed to help provider and payer organizations effectively contract for high-need, high-cost populations. The resource includes a whitepaper that shares information and recommendations regarding a range of different care models and contracting approaches; and a practical set of guidelines to providers and payers develop contracts that incorporate reimbursement for high-need, high-cost individuals. This resource was

developed in collaboration with the Pacific Business Group on Health with financial support from the Commonwealth Fund and the SCAN Foundation.

Section 4: Sustaining Change

A successful contract negotiation is the beginning not the end. Once a contract has been signed the hard work of implementing the value-based arrangement starts. While there are numerous guides on the technical components of running a VBP arrangement (*i.e.*, risk adjustment, case management, provider and patient engagement, clinical workflow changes), one of the most important factors for success are an organization's ability to adapt to unanticipated changes. Adaptable partnerships require ongoing engagement between organizations to govern the model and continuously evaluate whether the responsible parties are able to fulfill a risk contract to its full expectations, performance, and outcomes.

- **Adapting to Change:** Demonstrating a commitment to success requires that organizations in a VBP arrangement recognize the need for ongoing adjustments to models as specific organization or market factors change. There are several strategies for adapting VBP arrangements. These can include incorporating or modifying glide paths for the acceptance of risk tolerance, establishing specific triggers for reopening a contract, modifying aspects of the financial methodology, offering multi-year contracts designed to avoid "race to the bottom" incentives, and committing to long term quality and population heath management goals. The COVID-19 pandemic highlighted both the value of VBP arrangements and the need for flexibility in their implementation and operations. The Task Force has compiled a collection of case studies examining how different organizations used their VBP arrangements to adapt to the pandemic.
    - Value-Based Care Amid COVID-19 - Stories from the Frontlines: This resource compiles 25 stories highlighting how HCTTF members have leveraged their value-based payment arrangements during the pandemic. These stories support the notion that participation in value-based payment arrangements offered an advantage in emergency response and that existing investments in population health infrastructure were a critical asset, allowing systems to rapidly adapt and meet patient needs.
- **Ongoing Governance and Provider/Payer Engagement:** Defining roles and reaching agreement on a value-based contract is just the first step in successful operations. Payers and providers must focus on ongoing relationship development at the leadership and staff levels with an emphasis on continued engagement between multidisciplinary teams responsible for the implementation and operation of VBP arrangements. Organizations should develop a clear leadership and staff level meeting cadence with clear agendas that create regular opportunity to discuss financial and quality performance and identify opportunities to close gaps and reduce administrative burden. Ideally these meetings should occur at least quarterly, and organizations may want to consider monthly meetings in the early implementation phase.