HATA Value Based Care Fact Sheets

Key questions to ask prior to moving into a Value Based Care Program

A gradual transition to increased value based care payment models provides your practice with an opportunity to move from fee for service to a more engaged, coordinated and high-performing practice through benchmarking. Whether regulations and/or market forces are driving your practice to value based care contracts, the following facts sheets were created to provide you with key questions to ask and better understand what your practices needs to consider to be successful.

What you should know prior to moving into a Value Base Care program?

1. What measures should be considered?
   - What cost, quality, advancing care and improvement activity (i.e., patient satisfaction) measures do I currently track?
   - What measures are important to my practice for my patient population?
   - What is my current measure baseline of the measures currently being tracked or considered?
   - What measures can I influence to ultimately improve?

2. What measures will I be incented on?
   - How can I identify and align to the measures that will provide my practice with an opportunity for the most successful outcomes?
   - How can I manage the differences in the various measurement incentives for multiple payers?
   - Is the proposed assigned membership appropriate for the contractual provisions being offered by the payer?

3. How am I performing?
   - Throughout the year, how will I identify how I am performing against contracted incentives?
   - Based on tracking results, what type of action plan (i.e., phone call campaign), will need to be developed to close gaps prior to the end of the measurement period?

4. How can I align performance to my payment?
   - How do I distribute payments to downstream providers that I am responsible for?
   - Does my attributed membership align to members that I had the ability to influence outcomes?

5. Analysis & Reporting
   - How can I use the data collected from the chosen measures to fine tune the Value Based Care program to further improve performance?

What questions should you ask your vendor/administrative systems in preparation for Value Based Contracting?

1. Value Based Contracting Capabilities
   - What Value Based Contracting Methodologies are supported? (Pay for Performance, Pay for Quality, Gain Share, Shared Savings, Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program (QPP), etc.)

- What administrative/clinical metrics can be supported within the system?
    - Cost
    - Quality (Preventative Care, Disease State, Total Care Management, etc.)
    - Advancing care (Avoidable Emergency Room visits, Readmission Rates, etc.)
    - and
    - Improvement Activity (i.e., Patient Satisfaction)
- What payment methodologies can be supported within the system?

2. Attribution of member population
    - Can the solution support multiple payer attribution methodologies?
      Attribution methodologies can be assigned by Payer, Line of Business, Products, etc.? Each may have a different attribution rule set for defining applicable members.
    - Does the solution freeze attribution so that no new members can be added during the contractual period? Recalculating attribution each period may not provide the time for the physician to manage the newly attributed member to all metrics.
    - How do I determine if the assigned membership in the system meets contractual provisions?
    - What payer format does the solution support to receive and upload the attributed members, i.e., ASC X12 834, Excel to determine assigned member population meets contractual provisions?

3. Modeling: Payment Calculation
    - Can I perform: "what if" scenarios using both historical and current claims data? Does this allow for modeling of 1) new Value Based Contracting proposed contracts and 2) help fine tune metric calculation and reporting during contract renewal process?

4. Analysis & Reporting
    - Does the solution have reporting that allows my practice to see how it is performing according to the contract provisions? Timely reporting is essential to help a practice continuously monitor and manage the program participation throughout the term of the contract.

What questions should you ask payers prior to Value Based Contracting?

1. Value Based Care Capabilities
    - Evidenced Based Measures: What is the exact rules/methodology that is used to calculate metrics? Are they based on administrative or clinical data? Example: Do immunization "combos" count the same as individual immunizations?
    - Are members risk adjusted for more complex measurement provisions? If yes, how?
    - If an attributed member crosses age categories, how is the member counted toward the measurement? (Infants age moves from 18 months to 19 months during contract period. Does this count towards compliance?)

2. Attribution of Member Population
    - What are the rules of the attribution methodology? What are the rules for tie breaker definitions? (Most recent member is selected over historical member)
    - How often is the attribution re-calculated? Annually, quarterly, monthly
    - Am I responsible for new members who enter the program mid-year? How are attributed members who leave the plan evaluated per contractual provisions?
    - Is my assigned membership aligned to the contractual provisions and my practice? How can I evaluate and validate my assigned roster? Is there a certification process?

3. Payment
    - What is the payment and bonus payment methodology, if applicable to track appropriate receipt of payment?
    - How and when will I receive payment for services rendered? Fee for service and a one-time bonus payment after stated time period or other process.

4. Analysis and Reporting
    - How often, and in what format, do you provide trend reporting on my compliance? Monthly or more frequently is often desired.
    - Do you provide detailed reporting that includes drill down capabilities for each membership to show who is compliant and non-compliant?
    - Who do I contact if I have questions and have not received a timely report?

Additional resources:

ADD YOUR OWN VENDOR RESOURCE LINKS HERE

Payer programs

Center for Medicare & Medicaid Services –
Quality Payment Program fact sheet
Quality Payment Program

Aetna
Anthem
Cigna
Humana
UnitedHealthcare

Value Based Contracting Methodologies

Accountable Care Financial Arrangements: Options and Considerations WHITE PAPER INSIGHTS FROM THE HEALTH CARE TRANSFORMATION TASK FORCE, June 2016

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