5 Tips

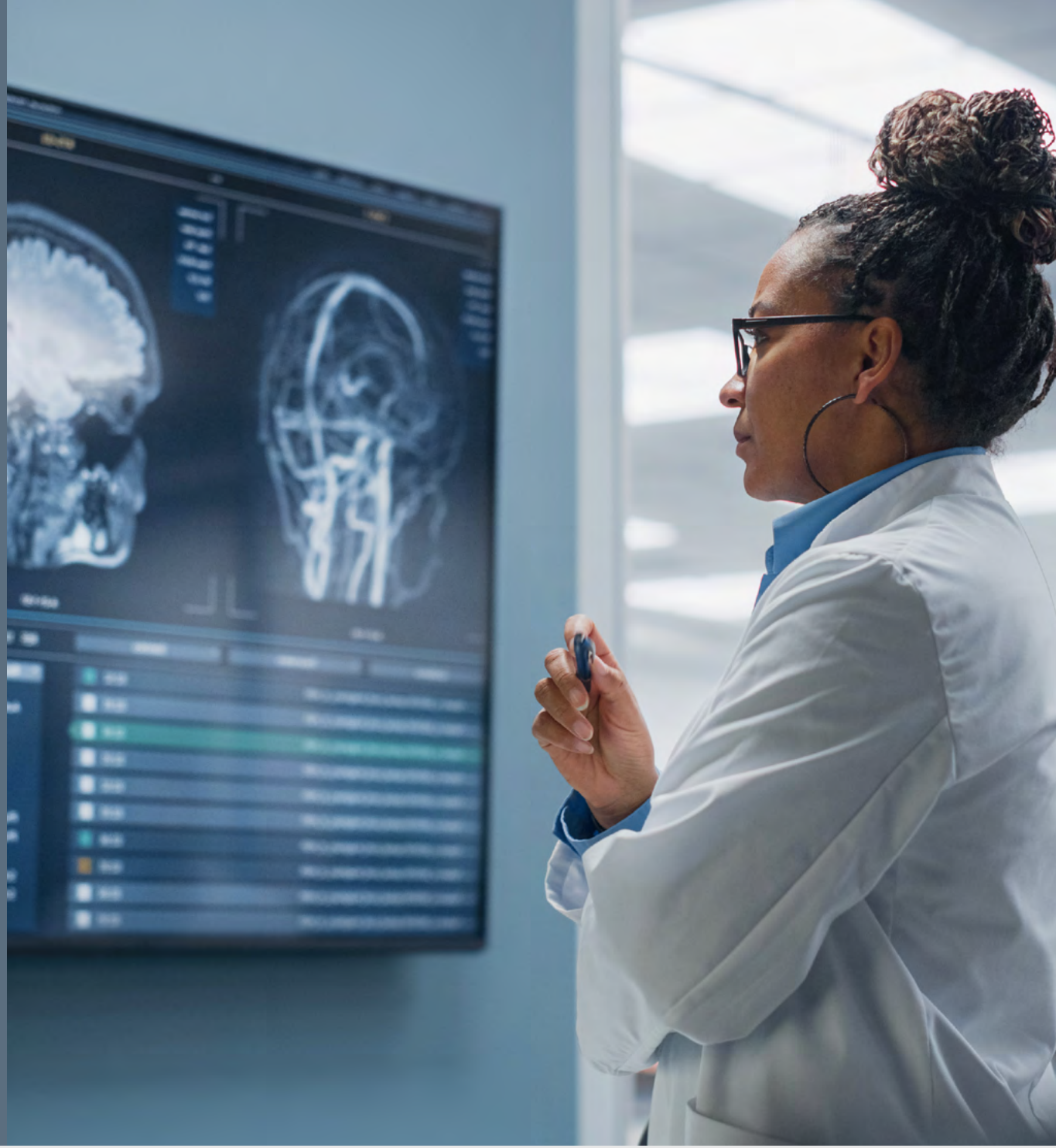
for Renegotiating Your Value-Based Care Contracts

Over the past 20 years, we've seen an evolution in payer contracts from Fee-for-Service to Value-Based Care (VBC).

This evolution is occurring across payer types: commercial, Medicare, and Medicaid. In recent years, many providers have signed VBC contracts, which often provide better reimbursement rates as a reward for improvements in care delivery and care outcomes.

Specifically, a significant number of providers signed incentive-laden 5-10-year VBC contracts in 2020 moving away from traditional fee-for-service models, which helped improve their financial positioning throughout the pandemic. However, recent economic shifts have changed the landscape in which these contracts exist. Current contracts fail to take into account the rate of inflation and heightened financial distress we are seeing in the industry today. They also do not take into consideration the fact that many COVID-19-era government relief options — such as the CARES Act, Provider Relief Fund, and American Rescue Plan of 2021 — are sunsetting.

Simply stated, VBC contracts negotiated pre-pandemic are not only obsolete but likely contain pricing provisions that do not consider either unprecedented cost increases or difficulty in meeting performance incentives due to changes in patient behaviors. The result is an urgent need to reassess payer contracts of all types across all payer types.



Considerations before you start renegotiating

Preparing to renegotiate your organization's contracts is just as important as the negotiation itself. Before getting started, it's crucial to examine the following considerations:

Fee-for-service vs. risk-based

Fee-for-service-based models should assess their steerage. Risk-based models should identify actuarially sound allocations, percentage of premium reconciliations, and risk adjustments/risk scores.

IT infrastructure

Evaluate your IT infrastructure. For example, is your EHR system set up for data analysis and able to benchmark KPIs? It's important that your systems are designed to provide this information for negotiations and to ensure you have a complete picture of your patient population.

Business structure

Some provider organizations benefit from VBC models more than others. For example, a primary care provider (PCP) is more likely to coordinate along the continuum of care than a specialist. This enables the PCP to potentially have more control over the cost of care and revenue streams than a specialist, making them a better candidate for a risk-based contract.

Market position

Having greater market share often leads to better-negotiated rates. Your organization should understand its market position before renegotiating its VBC contracts to understand what advantages you may have.

Current yield

Determine the percentage of total cost and the value of your denials and write-offs.

Total reimbursement & total value

Assess your total reimbursement rates, base reimbursement, and incentive reimbursement opportunity.

Once you have taken the time to evaluate these considerations, you are ready to begin renegotiating your VBC contracts.

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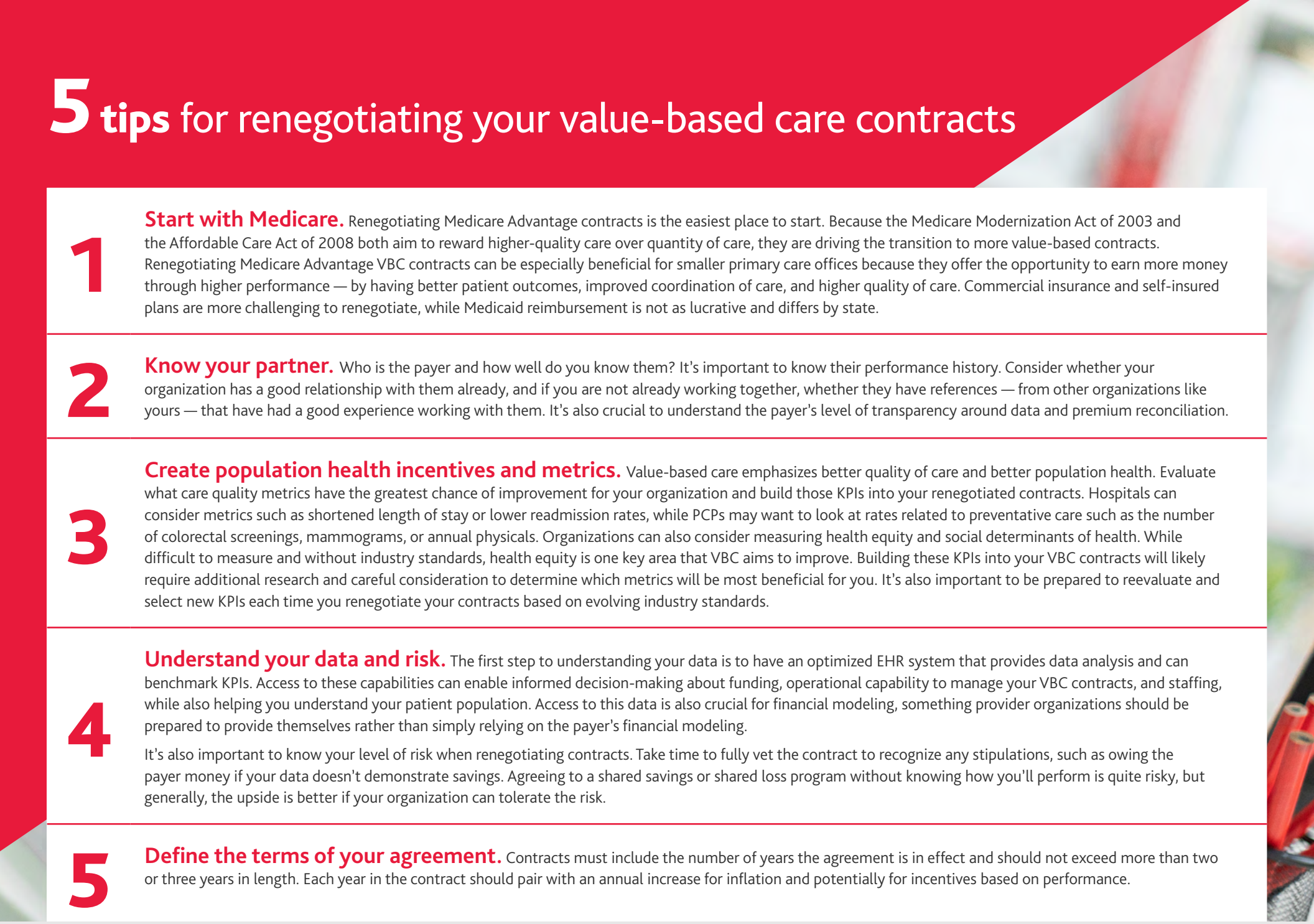


1 **Start with Medicare.** Renegotiating Medicare Advantage contracts is the easiest place to start. Because the Medicare Modernization Act of 2003 and the Affordable Care Act of 2008 both aim to reward higher-quality care over quantity of care, they are driving the transition to more value-based contracts. Renegotiating Medicare Advantage VBC contracts can be especially beneficial for smaller primary care offices because they offer the opportunity to earn more money through higher performance — by having better patient outcomes, improved coordination of care, and higher quality of care. Commercial insurance and self-insured plans are more challenging to renegotiate, while Medicaid reimbursement is not as lucrative and differs by state.

2 **Know your partner.** Who is the payer and how well do you know them? It's important to know their performance history. Consider whether your organization has a good relationship with them already, and if you are not already working together, whether they have references — from other organizations like yours — that have had a good experience working with them. It's also crucial to understand the payer's level of transparency around data and premium reconciliation.

3 **Create population health incentives and metrics.** Value-based care emphasizes better quality of care and better population health. Evaluate what care quality metrics have the greatest chance of improvement for your organization and build those KPIs into your renegotiated contracts. Hospitals can consider metrics such as shortened length of stay or lower readmission rates, while PCPs may want to look at rates related to preventative care such as the number of colorectal screenings, mammograms, or annual physicals. Organizations can also consider measuring health equity and social determinants of health. While difficult to measure and without industry standards, health equity is one key area that VBC aims to improve. Building these KPIs into your VBC contracts will likely require additional research and careful consideration to determine which metrics will be most beneficial for you. It's also important to be prepared to reevaluate and select new KPIs each time you renegotiate your contracts based on evolving industry standards.

4 **Understand your data and risk.** The first step to understanding your data is to have an optimized EHR system that provides data analysis and can benchmark KPIs. Access to these capabilities can enable informed decision-making about funding, operational capability to manage your VBC contracts, and staffing, while also helping you understand your patient population. Access to this data is also crucial for financial modeling, something provider organizations should be prepared to provide themselves rather than simply relying on the payer's financial modeling.

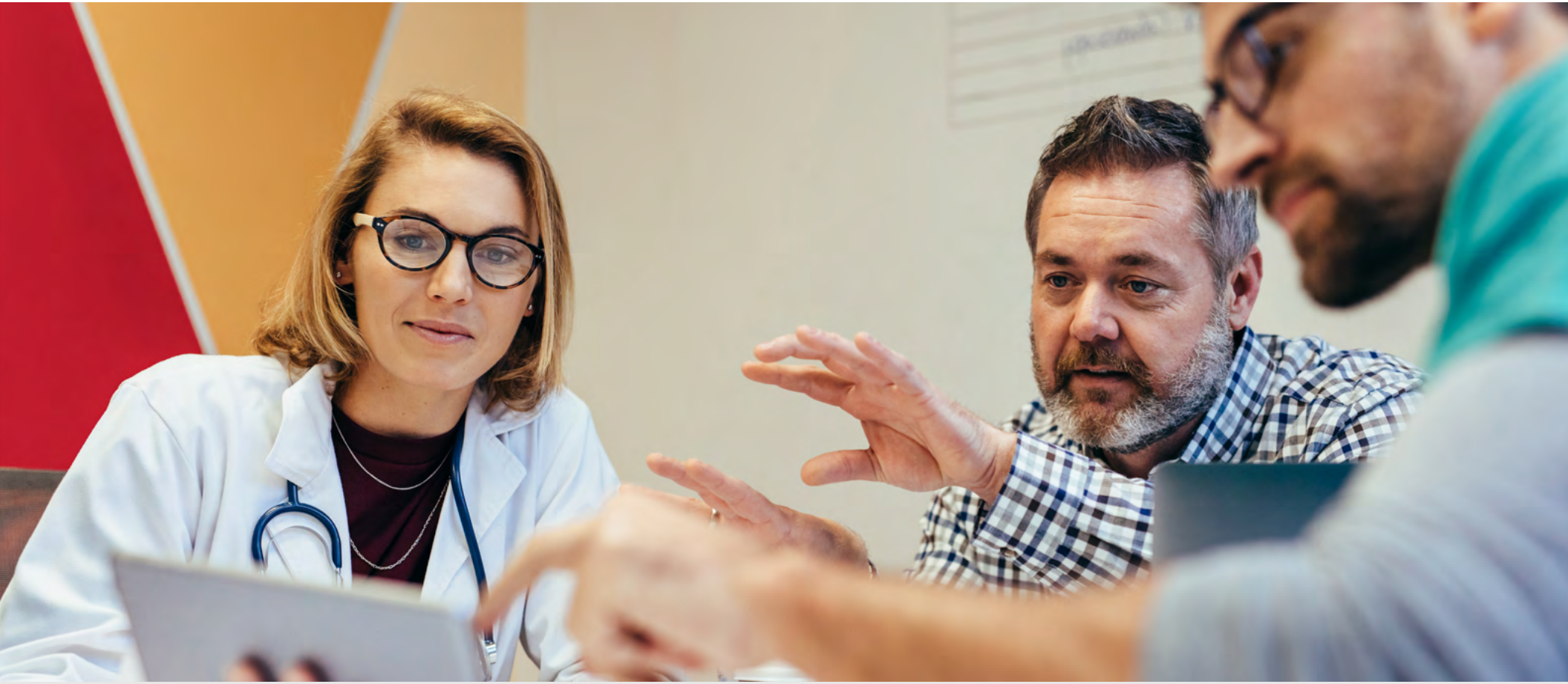
It's also important to know your level of risk when renegotiating contracts. Take time to fully vet the contract to recognize any stipulations, such as owing the payer money if your data doesn't demonstrate savings. Agreeing to a shared savings or shared loss program without knowing how you'll perform is quite risky, but generally, the upside is better if your organization can tolerate the risk.

5 **Define the terms of your agreement.** Contracts must include the number of years the agreement is in effect and should not exceed more than two or three years in length. Each year in the contract should pair with an annual increase for inflation and potentially for incentives based on performance.

Renegotiating: An Ongoing Process

The events of the past several years have shown that organizations should be renegotiating VBC contracts every two to three years — not five or 10 years. Profitability and line items are based on a certain service mix and volume, which has changed significantly since 2020, and each has different margins. During the pandemic, patients were forgoing elective procedures and skipping regular appointments and preventative care, which also has an impact on VBC performance and reimbursement. That's why establishing built-in opportunities for your organization to thrive is crucial, as the industry and economy continually evolve.

Throughout your contract term, you should monitor your performance. If you're not meeting the agreed-upon benchmarks, you should work with the payer to try modifying them. Monthly Joint Operating Committee (JOC) meetings are an excellent opportunity to work through expectations and performance. In addition to monitoring care performance, you should also implement regular check-ups of your managed care portfolio. This enables your organization to determine whether volume and yield are performing as expected and whether there are new contracts to add, or others you should remove.



Conclusion

VBC contracts can be incredibly advantageous, but it's important to be strategic about what areas you're renegotiating in your contracts. Over the next several years, we expect to see the industry continue to transition to risk-based models as opposed to fee-for-service, because of the emphasis that risk-based models place on patient-centered care. That means now is the right time for provider organizations to begin trying to participate in, and to get comfortable with VBC contracts if they haven't started already. At the same time, organizations that already have risk-based contracts must continually reevaluate their portfolios and contracts to drive the most value for their organization.

Ready to unlock more value from your value-based contracts?

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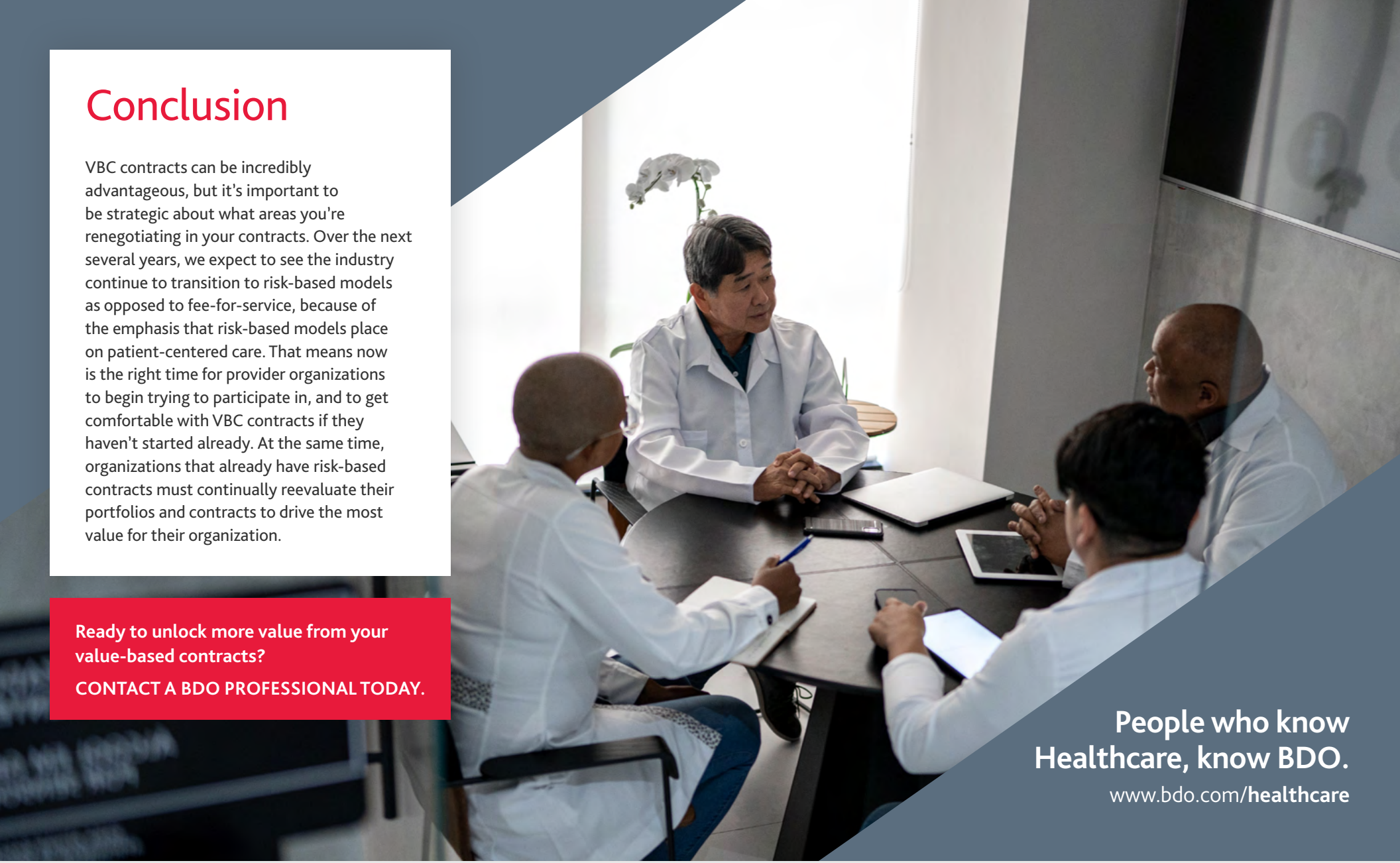

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