



The Physicians Advocacy Institute's  
Physician Education Initiative:  
**Helping Physicians Navigate Value-Based Arrangements**  
**Guide to Value-Based Contracting**



## PHYSICIAN EDUCATION INITIATIVE: HELPING PHYSICIANS NAVIGATE VALUE-BASED ARRANGEMENTS

# Guide to Value-Based Contracting

The foundation of value-based revenue models (VBRs), often referred to as alternative payment models (APMs), are the underlying contractual arrangements that dictate the terms and conditions by which a physician or practice and a contracting entity (i.e., payers, ACOs, or employers) base their reimbursement relationship. Value-based contracts (VBCs) are based on clinical performance and set pre-determined, mutually agreed upon quality, financial, and patient experience targets that must be met to achieve value-based rewards (e.g., shared savings or quality performance bonuses). Furthermore, VBCs will often, though not always, include a monthly per member per month (PMPM) or bundled service rate as the base of the contractual arrangement. These contracts are central to the shift in reimbursement from traditional fee-for-service approaches to methods based on quality and efficiency of care provided to a specified group of patients.

**This resource guide provides an overview on how physicians and practices can decide on which types of value-based contracting efforts to engage in based on their practice structure and capabilities. This guide will also highlight areas of potential negotiation for practices to be aware of and consider when going through the contracting process.**

### Background on Value-Based Contracting

The transition to value-based contracting from traditional FFS contracting is unfolding rapidly across the American health care system. While traditional FFS contracts have historically occurred between physicians, practices, or health systems and payers (i.e., commercial health plans, Medicare, Medicaid), new players (i.e., large national employers like Walmart) have entered the VBC environment. This presents opportunities for physicians to capture additional market share and reimbursement if they are willing to take on the associated financial risks, as these new arrangements are increasingly focused on shifting both the cost-of-care and quality of patient care to physicians and practices, and away from payers and employers. The push to change physician reimbursement comes from government entities aiming to reduce the costs of health care—namely the Department of Health and Human Services (HHS), their colleagues at the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (CMMI)—and private-sector entities similarly concerned about health care spending, including the Health Care Transformation Task Force and large national employers.

The extent of risk incorporated into value-based contracting can vary significantly based on the organization a physician or practice is contracting with and the type of contract being negotiated. At a minimum, VBCs provide incentive payments based on provider performance relative to a defined set of efficiency and quality measures, with limited risk to the physician or practice. However, VBCs are beginning to transition away from these limited risk contracts and move toward full risk revenue-models for a defined population through either two-sided (i.e., downside or repayment) risk arrangements, direct-to-employer contracts, capitated models, or bundled payments. Prior to entering a VBC, physicians and practices should

understand the network adequacy requirements (i.e., ability to deliver contracted health care services) associated with the agreement and ensure they can satisfy these requirements. In general, there are three core components to a VBC as displayed in **Figure 1**.

**Figure 1: The basics of a Value-Based Contract**



For more information on the different types of revenue models, please see PAI’s [Types of Value-Based Revenue Models](#).

### Network Adequacy Requirements and Tiered Networks

Network adequacy requirements ensure that payers, physicians, and practices can deliver contractually agreed upon health care services in VBCs. Payers are responsible for ensuring their members have access to the agreed upon continuum of health care services provided through their plans. Physicians and practices similarly must have the ability to provide all agreed upon services with their contracted entity. However, payers often take creative approaches to satisfy network adequacy requirements, including the use of tiered networks. Tiered networks are created by designating groups of physicians into levels (i.e., tiers) based on the value (i.e., cost efficiency, quality) of care they provide. Physicians deemed to provide high value care—high quality and low cost—are in the highest tier, while physicians providing care deemed low value—low quality and high cost—are in the lowest tier. **The main objective of tiered networks is to channel patients to “preferred physicians” that are high value—offering high-quality care at a relatively low cost.**

Payers use several different levers to direct patients seeking care to preferred, “high-value”, physicians, including lower out-of-pocket costs. As an example, a patient may have a lower co-pay, coinsurance, and deductible for a tier 1 physician and a higher co-pay, co-insurance, and deductible for a tier 2 physician. Tiered networks give payers the opportunity to sort physicians by their perceived value in competitive markets, and direct patients to higher tiered physicians. Being placed in a lower tier can have an impact on a physician’s patient volumes, and as such, to remain competitive, some physicians renegotiate their prices with a payer to adjust their tiered placement short term and improve their quality performance in the long term. However, tiered networks may not be viable in markets with dominant physician groups that capture a majority of patient services, as these physician groups use their leverage to secure placement in the tier of their choice or may even prevent tiering from being instituted.

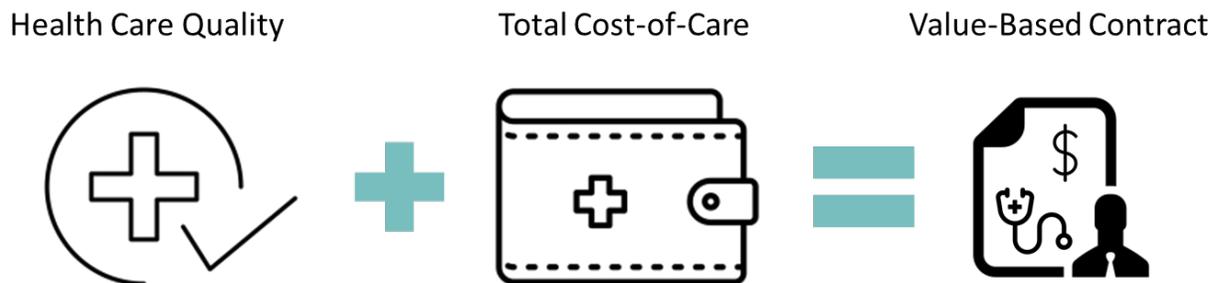
Few physician groups have similar levels of quality across their service lines, even if considered a high or low value physician group by a payer. This determination makes it difficult for payers to maintain adequate network adequacy requirements across tiers and leads to creative approaches to meet network adequacy requirements in VBCs. Some Payers will place physicians in a high value tier, even if they do not have high

value services across all their service lines, to meet these network adequacy requirements. Physicians should ensure that all physicians in a VBC are properly tiered so that payers are appropriately maintaining their network adequacy requirements across tiers. Physicians should also ensure they are placed in the proper tier for each service to avoid any negative impacts on their patient volume and revenue.

### Value-Based Contract (VBC) Structure and Design

Despite the range of contracting approaches in the market, each type of VBC shares a common set of structural characteristics, which allow physicians and practices to engage in multiple agreements, if their practice is set up in a way that allows them to thrive in a value-based environment. While there can be significant variation in each contractual arrangement based on the health plan, employer group, or covered region, generally each contract involves a quality component and a cost component, as illustrated by **Figure 2**.

Figure 2: Basic Structure of a Value-Based Contract



### Establishing & Negotiating Quality Measures

When negotiating a VBC, physicians and practices should be aware of the methodologies used to establish quality and efficiency measures. Quality measures are usually based on targeted clinical and efficiency metrics (i.e., medication adherence, control of chronic conditions) or on heavily weighted metrics that could lead to improved reimbursement from CMS (i.e., patient experience scores for MA payers). Before agreeing to a set of quality measures in a VBC contract, physicians should ensure they understand their practice’s baseline quality performance for the proposed performance measures over the past several years. Additionally, physicians should request the previous two to three years of regionally appropriate quality performance data from a contracting entity, to understand the potential baseline and performance of a population they may be inheriting. With this data in hand, physicians and practices can select from an available set of quality measures and should be able to negotiate fair and achievable quality performance targets. **It is critical to have all available historical and trending quality data before agreeing to terms with a contracting entity.**

### Understanding Baseline Financial Benchmarks

Financial benchmarks for VBCs are generally calculated by taking a physician’s base period of claims, on a PMPM basis, multiplying amounts by the rate at which the cost-of-care in their regional market is growing, on average, and then applying the aggregate adjustment factor (including risk-score adjustments for a

beneficiary panel) to come up with a basic benchmark total cost of care (TCOC), as seen in **Figure 3**. Understanding this calculation, even at a base level, allows physicians and practices to know how payers will hold them accountable and can serve as a basis for projecting growth in future costs of care.

Additionally, physicians must understand if the financial benchmark will be adjusted based on a regional or national basis. If the benchmark is regionally comparative, physicians should understand if their patient population is included or excluded from the calculated regional growth rate they will be compared against. Furthermore, regional growth rates are typically capped in comparison to a regional or national growth rate benchmark, meaning that the growth in cost-of-care for a physician or practice cannot exceed the average cost-of-care growth rate by more than a set percentage each year. **This cap protects payers from excessive growth in costs but can result in underpayment of physicians with a higher acuity patient panel than the average for their region.**

**Figure 3: Example of a Benchmark TCOC calculation**

Benchmark TCOC Variables	Metrics	Formula Key
Base Period Claims PMPM	\$1,000.00	A
Cost-of-Care Trend	7.0%	B
Adjusted Cost-of-Care PMPM	\$1,070.00	$C = A \times (1+B)$
Aggregate Adjustment Factor	1.050	D
Performance Year Target PMPM	\$1123.50	$E = C \times D$

### Key Considerations for Physicians & Practices

Attention to contractual details as physicians and practices engage in negotiations can enhance opportunities for success. These contracts involve far more complexity than the average fee-for-service contract, as they shift added responsibility onto physicians and practices.

Enhanced focus should be placed on three essential areas when negotiating a VBC:

- **Legal assistance.** Secure expert legal assistance to understand and negotiate the terms, conditions, and definitions contained within a contract. While this is admittedly, the least “fun” part of contracting, it is arguably the most important, as the terms, conditions, and definitions can have a significant impact on the viability of a VBC.
- **Claims data.** Ensure that you have access to appropriate historical claims data for any rate-setting or benchmark calculations and analysts on your team who can help you identify opportunities and risks.
- **Actuarial analysis.** Ensure that you have adequate actuarial analysis at your disposal to make sure that the model is sound and fair and that you understand the implications of different scenarios on your reimbursement.

Additionally, pay attention to the following contractual areas when reviewing a VBC:

- **Attribution and Assignment language:** The methodology for how patients are attributed or assigned to a physician or practice in a VBC.
- **Network Adequacy Requirements:** Ensures physicians or practices can deliver the contractually agreed upon health care services in a VBC.

- **Opt-Out Clause:** Determines the circumstances whereby either party can opt-out of the contract or provisions of the contract and the amount of advanced notice they must provide.
- **Stop-loss Provision:** A provision that sets a pre-determined cost threshold for a patient whereby any costs over the threshold are removed from the physician or practice's TCOC.
- **Force Majeure Clause:** Protects both parties from liability in case of unforeseen and unavoidable catastrophic events.

## Contracting with Health Plans or Payers

Traditionally, most FFS contracts have been between a health plan or payer (i.e., Aetna, Humana, traditional Medicare) and a physician, practice, or health system. While these contracts still make up most of the reimbursement relationships in the U.S. health care system, entities are rapidly adopting VBCs and their presence is growing.<sup>1</sup> When contracting with a payer, there are four main types of contracts to be aware of, including, pay-for-performance contracts, shared-savings contracts, capitation models, and episodic-payment models.

### Pay-For-Performance Contracts

Pay-For-Performance contracts (P4P) are often a stepping-stone for physicians and practices not yet ready for a full shared-savings arrangement. P4P contracts can be structured in variety of ways, but often provide a minimal PMPM to the physician or practice for care management services as well as performance-based quality and efficiency metrics paid out on a quarterly or yearly basis. Typically, these metrics are focused on variables like readmission rates, medication adherence, and patient experience scores. As physicians meet these measures, they are rewarded on a pre-determined PMPM or a per-opportunity-per-member (POPM) dollar basis. P4P contracts can also focus on total cost-of-care (TCOC), and reward providers if they are able to lower their TCOC by a set percentage below their pre-determined baseline cost-of-care. Importantly, there are no penalties for failing to lower TCOC. Furthermore, P4P contracts typically require physicians meet a set number of quality measures before any financial incentives are realized. In these arrangements, payers modulate their risk based on the proportion of revenue subject to performance measures.

### Shared Savings Contracts

Shared Savings models are contractual arrangements where a physician's performance year (PY) TCOC for their beneficiary population (on a PMPM basis) is compared to a contractually agreed upon baseline, or benchmark for those costs (i.e., financial target). Under shared savings arrangements, physicians are paid a percentage of any generated savings when their actual costs are lower than their benchmark costs. Furthermore, these shared savings payments can be affected by quality scores, which act to increase or decrease the percentage of shared savings a physician can achieve. Shared savings arrangements are also affected by the level of risk a physician or practice takes on. The more risk a physician is willing to take on as it relates to total costs, the higher the percentage of shared savings they will share with a payer. Additionally, some of these arrangements have a corridor in place whereby a physician must lower their TCOC for the period by a specific percentage below the benchmark TCOC before shared savings can be

---

<sup>1</sup> <https://hcp-lan.org/2018-apm-measurement/2018-infographic/>



achieved. When this corridor is not included in a contractual arrangement and physicians share on any savings below the benchmark, this is known as “first-dollar savings”.

### Capitation Models

Capitation is a health care payment system in which a physician or practice is paid a fixed amount per patient over a defined period-of-time (e.g., monthly) by a payer. The payment amount received is based on the average expected health care utilization and cost of each beneficiary in a defined group for a set period-of-time (e.g., a performance year). This PMPM is usually calculated in advance of a performance year and is based on historical, local, regional, and/or national cost and utilization data. Furthermore, higher utilization and costs are assigned to groups with greater medical needs or higher acuity. Many capitation models establish risk pools as a percentage of the capitation payment. Money in this risk pool is withheld from physicians until the end of the performance year. If a physician or practice is successful in reducing their TCOC below their pre-determined capitated amount, they will receive these funds back. However, if their total costs are over the set capitated amount, the funds will be used to pay deficit expenses.

### Episodic Payment Models

Episodic payment models (EPMs), often referred to as bundled payments, are VBCs where a physician or practice assumes the risk for all services provided for a defined episode of care (e.g., joint replacement). These models can be set up to be prospective (i.e., paid before an episode occurs) or retrospective (i.e., paid after an episode through reconciliation). In both models, the costs are defined for an episode of care, and consider all services included in that care (e.g., inpatient, outpatient, specialty, PT/OT), over a defined period. The physician is responsible for all care provided under this model. Due to this structure, the physician’s ability to coordinate care is an important element of success. With EPMs, physicians share in any losses or savings that result from the difference between the model’s target TCOC and the actual TCOC. **An episode of care involves the entire care continuum for a single condition or medical event (e.g., labor and delivery) during a fixed period.**

## **Contracting with Accountable Care Organizations**

Accountable Care Organizations (ACOs) are a collaborative group of physicians and other providers that agree to share cost-of-care and quality responsibility for a defined patient population through enhanced coordination of services and care management. More generally, ACOs are based upon the broader concept of “patient-centered care”, which delegates the responsibility of care coordination to their entire care team (i.e., primary care physicians, specialist physicians, laboratory). Furthermore, primary care physicians and their teams generally take on a lead role as it relates to care management and coordination, acting as a hub in this “hub-and-spoke” model of care.

### Available Types of ACOs

Multiple types of ACOs are available to physicians and not all are focused on primary care services. Specifically, there are specialty and multi-specialty ACOs, a fact which has different implications for practices considering entering a VBC.

The types of ACOs available for participation include:

- **Integrated Delivery Systems:** These ACOs tend to include health systems, physician practices, and sometimes a vertically integrated payer. These systems generally include integrated electronic medical records, team-based care, and resources to support cost-efficient care coordination and care management.
- **Multispecialty Group Practices:** These ACOs tend to have strong affiliations with health systems. They do not usually include a vertically integrated payer but do tend to have contracts with multiple payers.
- **Physician-Hospital Organizations:** These ACOs are generally a subset of a health system's medical staff, including primary care physicians and multi-specialists.
- **Independent Practice Associations:** These ACOs are usually comprised of individual physician practices that join to contract as a single entity with a payer.
- **Virtual Physician Organizations:** This type of ACO is comprised of physicians providing care in rural focused regions.

### Key Considerations when Negotiating with an ACO

When considering contracting with an ACO in a VBC, physicians should evaluate relevant opportunities by querying publicly available quality and financial data for the ACO as part of a larger due diligence process. Specifically, physicians should utilize CMS "[public use file](#)" ("PUF") data to analyze potential organizational partners. Private ACOs may use their own savings and losses methodology, and physicians should understand how savings and losses are calculated as well as the ACO's track record of performance. Furthermore, physicians should understand that these entities need them to succeed and should ensure that any arrangement strikes an appropriate balance between ACO benefits (like opportunities for shared savings, quality performance rewards, and reporting capabilities), clinical autonomy, quality of care, and administrative burden (e.g., gaps-in-care quality reporting initiatives).

Additional considerations for physicians prior to contracting with an ACO include:

- The ACO's strategy for moving to downside risk
- Composition and stability of participants
- Physician satisfaction and governance structure
- Transparency of past quality and financial performance
- Disbursement model for rewards and savings
- Data collection and reporting processes (and the administrative time required)
- Participation fee structure (e.g., flat yearly or monthly fee)

### **Direct Contracting with Employers**

As yearly health care costs continue to climb for employers and contribute to a significant percentage of overhead costs, large, well-resourced companies have begun engaging in direct contracting agreements with physicians, practices, and health systems of their choice. Beginning in the 2010's, large employers (e.g., Boeing and Walmart) began engaging in direct contracts for their employees and their families. The goal for these employers was, and is, to reduce their health care costs by cutting out middlemen (i.e., Health



Plans, PBMs) and using their significant employee populations to negotiate their own VBCs with health systems and physician practices.

Rather than pay premiums to traditional health insurance companies to accept unknown carrier network pricing, employers' contract directly with physicians to be their preferred points of service for employees' health care needs. Employers generally prioritize contracts for their highest-cost and most frequent health care needs. Beyond the financially advantageous nature of direct-to-employer VBCs, large corporate populations are also likely healthier and more financially secure than the average beneficiary contained in a payer's risk pool. Because of this factor, large employers are attempting to lower their health care costs by separating their likely lower risk employees from the broader commercial insurance risk pool, and thus create a lower cost risk pool of their own.

In general, large employers are focused on providing their employees and their families comprehensive primary care services for acute and chronic conditions, and specialty care services across the care continuum. Furthermore, direct-to-employer contracts provide numerous other benefits to employers, including increased employee satisfaction, decreased employee absences or sick days, and a competitive advantage due to enhanced benefit packages.

Physician payment in direct contracting may be based on a combination of factors including:

- A negotiated Per Employee Per Month (PEPM) payment
- A negotiated flat fee that covers the total cost-of-care, including for physician and other providers involved in patient care.
- Co-payments or cost-shares paid by the employee

For physicians and practices, direct contracting can be advantageous by:

- Providing relief from administrative burden typically faced by traditional contracting arrangements with health plans or payers; and
- Enabling physicians to spend more time with their patients, both in face-to-face visits, and through telephonic or electronic communications mediums since they are not bound by insurance reimbursement restrictions.

### Direct Primary Care

Direct Primary Care is a VBC agreement used by large employers to cover the total costs of care for their employee population over the course of a financial year. This arrangement generally includes a monthly PMPM, often billed as a subscription, based on the average annual health care costs of the employer's covered employee population. The benefits of this model include reduced administrative burden, improved patient interactions, and recurring, guaranteed monthly revenue paid directly to the practice or physician by the employer. In this arrangement, there are no bills to insurance and no insurance claims to be processed, which can result in significant administrative cost savings. Furthermore, this model removes the need to schedule multiple in-office visits due to health plan or payer billing regulations and allows physicians and practices to manage and care for their patients based on their needs. Physicians can also use various mediums to interact with patients as is clinically appropriate, including telehealth, audio-only telehealth, and text or email-based messaging. Engagement in this type of VBC requires investment in financial and business analytics capabilities and staff to ensure the physician or practice can stay within the budgeted PMPM amount.

### Benefits of Direct Contracting for Employers

Large employers favor direct contracting agreements because they can directly discuss and control cost and quality of care, rather than relying on a third-party entity, like a traditional health plan or payer. As a result of these arrangements employers believe they will be able to achieve long term cost-of-care savings that will be directly removed from their overhead costs and thus increase their profitability. In general, employers are interested in direct contracting because they believe it:

- Reduces complex and often obscure health plan or payer processes.
- Can establish a financially advantageous relationship with physician practices.
- Allows them to shop around for the highest quality, most cost-efficient care.
- Improves transparency of health care costs and services being utilized.
- Keeps employees healthy, happy, and productive.
- Ensures better access to care for employees, which is viewed as a competitive advantage.

### Benefits of Direct Contracting for Physicians and Practices

Direct contracting has many benefits for physicians and practices engaging in DCs with large employer groups. While a DC may result in slightly lower rates than traditional FFS, there are benefits that offset these rates including an established, guaranteed revenue stream in the form of a per-member-per-month (PMPM) paid by the employer. Additionally, other benefits physicians and practices may receive include:

- Additional PMPM for added services like establishing an employee health help line, onsite vision screenings, and onsite health screenings.
- Establishment of clinic hours at site(s) of employers.
- Contract to provide educational videos to employees on workplace safety.
- Placement of practice marketing collateral at employer work sites.
- Employer health coordinator that streamlines coordination of visits for staff in need.
- Provision of additional patient data and comparison of practice and physician performance across an employer's total geographic population (i.e., how do physician's compare to competitors across cost and quality metrics)

### Direct Contracting Vendor Considerations

While direct contracting is a feasible and attractive solution for large employers, the contractual agreements must make financial sense for both parties to move forward. When considering engaging in a direct contract with an employer, many physicians and practices will rely on outside consultants and counsel to ensure the contractual arrangement is favorable. When selecting these vendors to help negotiate, consider the following areas:

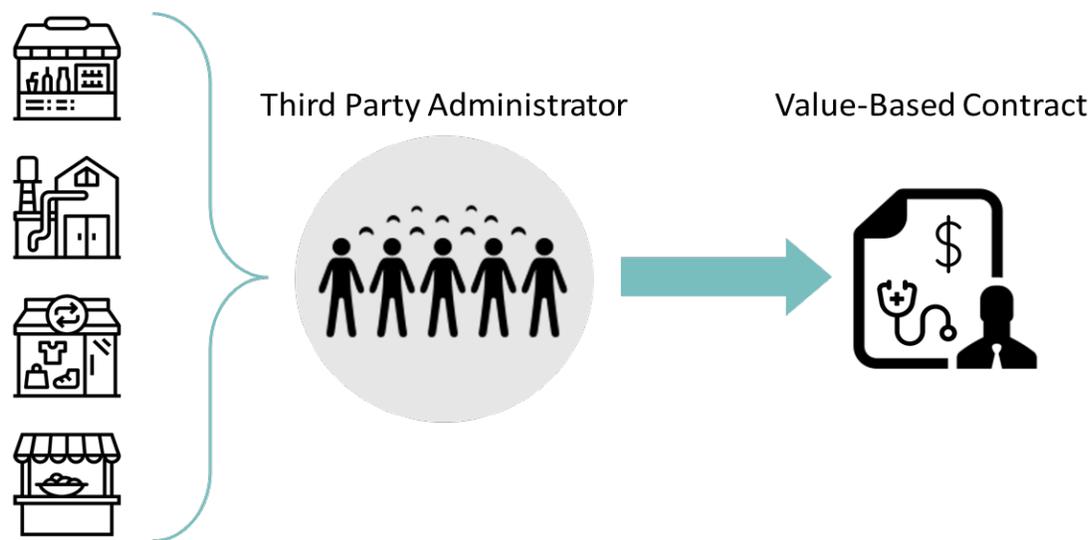
- Does the vendor or consultant have direct contracting negotiation and implementation experience, and can they provide you with examples?
- Do they have analytics capabilities to help determine the financial and operational viability of the proposed arrangement compared to traditional FFS?

- What does their payment structure look like? Will they bill based on an ongoing percentage of claims, the PMPM rate, or a one-time fee?

## Custom Physician Networks & Third-Party Administrators

Most employers are too small to engage in direct contracting with physicians, practices, or health systems on their own and are unable to engage in a full-scale, risk-based agreement that sets a capitated PMPM for the health care services and care management of their employee pool. However, when partnered with a third-party administrator, small employers can pool their collective resources and employment numbers to derive market power in negotiations with physicians, practices, and health systems. In this arrangement, a third-party administrator maintains, manages, and pays the established network of physicians and practices on behalf of their employer members, as seen in **Figure 4**. Small employers in these arrangements still play an influential role in the shaping of these custom physician network arrangements and the VBCs resulting from them.

Figure 4: Custom Physician Network Via a Third-Party Administrator



For physicians considering engaging in a VBC with a third-party administrator, the criteria employers and their third-party administrators use in developing custom physician networks is important to understand before engaging in negotiations. These VBCs develop their own unique criteria, often focused on cost, quality, and patient experience, but sometimes have additional terms and criteria not found in typical payer-associated contracts (i.e., specific value metrics to an employer). As a result, physicians that are unable to meet performance standards may be excluded from a custom physician network. While there are risks to participating in such an arrangement, the potential benefits of participation may be worthwhile, as physicians and practices could see higher guaranteed patient volumes via contractual steerage and predictable base revenue streams over the course of the contractual arrangement.