# Optimizing Contracting and Performance Assessments for Health Plans, Care Management Providers, and Benefit Vendors

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## Strategies to Eliminate Ambiguity, Accelerate Assessment, and Manage Risks

In the evolving landscape of healthcare, care management organizations (CMOs) and benefit solution vendors play a critical role in delivering value-based care and high-quality health outcomes. Assessing savings and financial performance is essential, both to ensure that they are providing value to beneficiaries and to garner support from the health plans and other risk-bearing entities with which they partner.

Innovative healthcare solutions rely on clear and concise contracting language to ensure singular interpretation and alignment with business goals. Unfortunately, many contracts are plagued by vague terms and misaligned timing, leading to disputes and inefficiencies. Additionally, modeling and estimating medical cost savings, especially at an individual client level, can take more than two years, depending on billing models, the number of patients treated, and claim runout patterns.

This paper delves into contracting strategies to eliminate ambiguity, methods to accelerate the assessment timeline, and techniques to better understand the risks facing all parties involved in value-based care management programs. Through detailed examples and practical solutions, we aim to provide a roadmap for more effective and efficient contract negotiations and value demonstration exercises.

### Avoiding Contracting Ambiguity

When establishing alternative payment methods (including shared savings/loss agreements, utilization targets, or claims-based metrics) between servicing organizations and risk-bearing entities, several contracting terms rise to the surface as critically important to the success of the relationship. Clear and easy to understand language within these topics is key when drafting a contract to avoid disputes upon contract execution.

#### Attribution Methodology

Attribution is the process that determines which members are eligible to receive benefits and when services occur. Even when the triggering events resulting in attribution are clearly defined in the contract, it is still important to understand timing differences and how they will impact the assessment of performance.

For example, a patient may be diagnosed with a given condition during a costly inpatient admission on January 12th (the Service Date). The payer may receive the claim from the provider for that service on January 26th (the Claim Received Date). Based on the attribution logic, the patient may then be attributed to the servicing organization on the first day of the month after the triggering event, February 1st (the Attributed Date). Matching baseline and performance period assumptions is important in not only the analysis of ROI, but in setting targets that will determine successful performance in the agreement.

## Member and Condition Exclusions

In addition to clearly articulating the methodology by which members are attributed to the servicing organization, the parties to the agreement should be thoughtful about the types of members that may not be appropriate for inclusion. Often, member exclusions are straightforward based on the nature of servicing organization, but it is worth thoughtfully considering other population segments or clinical conditions that might not be so obvious for exclusion. Common exclusions may be:

- Excluding dual eligible members from a Medicare Advantage population due to differing performance of the vendor's benefit.
- Excluding high-cost members, such as cancer patients, due to high volatility of cost.
- Excluding members with specified chronic conditions based on expert clinical advice.
- Excluding specific service or service category, such as biologics or total pharmacy, where an intervention may not be capable of controlling the cost.

When thinking about conditions that might warrant inclusion or exclusion, assessing historical data can help servicing organizations understand both the magnitude and the likelihood of various approaches to including and excluding members based on conditions.

One example would be consideration of COVID-19 costs in the baseline and in the performance period. Consider how inclusion or exclusion of the diagnosis would impact a fair and accurate assessment of the program. Condition duration may also play a role when contracting.

When analyzing condition specific solutions, it is key to define how a claim record should determine whether a patient has the treated condition. Drafting language for using principal or secondary diagnosis positions, a minimum number of visits, or a minimum amount spent will help to better define patients targeted for the intervention.

## Member-Specific Participation Thresholds

Consideration should be given to the member-specific activity level of a vendor's solution. The purpose of this is to clearly define what level of participation a member needs to be included in any type of outcome analytics or performance-based reporting. Many solutions require a minimum usage across a duration of time to achieve results. Any activity level threshold in the contract should be clearly defined with an appropriate time for claims run-out to see results.

Another key consideration would be to define the total number of enrollees required to trigger bonus payments or other incentives. Having too few members analyzed would make any analysis or contractual terms susceptible to outliers and volatility. Power analysis, discussed later in this paper, details how to calculate various thresholds to ensure that results are not a fluke and repeatable.

## Material Adverse Change

Material Adverse Change ("MAC") clauses are included in risk agreements to protect both parties from significant, unforeseen changes that materially impact the ability of either or both parties to perform under the terms of the agreement. For example, a change in the mix of members from the baseline to the performance period may have a material impact on the baseline upon which the target was established. Creating a materiality threshold allows the parties to agree in advance to a magnitude of change that exceeds normal variation and justifies a remedy. MAC clauses are notoriously difficult to implement given that parties often dispute what rises to the level of a material adverse change. A well-drafted MAC clause is key to avoiding ambiguity and potential litigation.

There are many components of a value-based agreement that can contribute to a material adverse change. It is critically important to identify the elements of the value-based agreement that have the greatest likelihood of changing in a way that may materially impact performance. If the material adverse change language is overly specific, an element that is not contemplated in the language might reasonably be assumed to be outside the scope of the clause. Conversely, language that is overly broad may open the door for any element impacting performance to be pointed to as a material adverse change. Accordingly, the parties should ensure that the MAC clause is crafted in a way that accounts for all appropriate factors, which may necessitate engaging experts with relevant experience in value-based contract negotiation and analytics.

Ultimately, the goal of the material adverse change clause is to ensure that neither party receives a windfall due to changes that, had they existed when the contract was being executed, would have been accounted for in the targets that were established. In this way, remedies afforded by the MAC clause should seek to mitigate the impact of any changes that are contemplated by the clause.

Target Setting / Funding

Determining the appropriate target or the appropriate amount of funding for the services contemplated in the agreement can be challenging. Not only is this one area of value-based care where the incentives of the parties are not aligned, but also servicing organizations may lack adequate experience to understand their own funding requirements. In such situations, engaging actuaries with experience pricing the services being contemplated within the risk arrangement can ensure a fair and adequate target setting approach that increases the likelihood that both parties can benefit from the relationship. Failure to set appropriate targets or funding amounts will inevitably result in conflict between the parties, which jeopardizes not only the risk arrangement, but also the benefits available to the patient/member through the relationship.

## Improving Reporting Timeliness through Proxy Development

For shared savings/loss assessments or bonus arrangements, it may take multiple years to reconcile the first 12 months of a contract depending on the terms. This is due to needing a minimum number of patients who enrolled in the intervention, necessitating that each patient has 12 months of data before and after the intervention, and waiting an appropriate amount of time for claims run-out to adjudicate. Health plans, large employers, and other purchasers of these services find it unacceptable to wait for 24 months to determine whether cost savings occurred.

Proxies for claims-based savings may be used in these situations where relevant data can be collected and analyzed. While it will not replace a full and robust healthcare economic analysis, a highly correlated proxy can provide valuable directional insight to aid in population management and contract reconciliation. Proxy analysis will not be able to detail the cost drivers and underlying reasons for generating healthcare economic savings. Oftentimes, payers may not provide consistent data needed for a full claims analysis. In such situations, proxy analysis is recommended to determine whether or not a relationship exists between easy to access internal data and claim amounts.

Data internal to the CMO or benefit vendor may be combined with eligibility and claims information from health plans. Care management organizations and benefit vendors should be collecting survey and other data which are relevant to their business including but not limited to the following:

- Member enrollment and engagement
- Patient usage metrics
- Clinical information, such as medication adherence or GAD-7 scores
- Patient satisfaction
- Induced utilization questionnaires

Correlation analysis, regression methods, and other statistical techniques can be used to determine whether easy to collect data are predictive of future medical savings. Correlation analysis is used to quantify if two variables are associated with each other. Regression analysis would be used to infer a formula that quantifies the relationship between the variables. Using an example, correlation analysis would answer the question: Does improved medication adherence lead to fewer inpatient admissions? Regression methods would seek to answer a question like: How many inpatient admissions could be avoided for each additional person adhering to their medication?

The supplemental data elements and the relationships to outcomes can be turned into valuable business intelligence. If two variables are shown to be correlated and statistically significant, a claims-based proxy can be developed for uses in contracting and reporting. The proxy would allow CMOs and benefit vendors to provide outcomes based reporting and medical cost savings estimates on a timelier basis. Rather than requiring 24 or more months, the reporting cycle could conclude in under 15 months. Additionally, these insights could also be turned into key performance indicators which would result in faster decision-making and greater insight into the interventions themselves. If a correlation is proven between medical spend and vendor program data, cost savings can be estimated based on the changes in the clinical data. This allows for a faster contract reconciliation cycle while providing CMOs and vendors with more immediate feedback about the results of their interventions.

Healthcare providers and CMOs should work together in the contracting phase to determine what proxy analyses may be relevant to do an early assessment of the program efficacy.

## Considering Credibility and Conducting Power Analysis

One of the key elements when contracting for shared savings/loss or bonus payments with a payer organization is determining when and how these contract terms should take effect. CMOs and benefit vendors should provide services to enough members so that a material impact can be calculated and deemed statistically significant. When contracting, this can be summarized as the need to calculate how many patients must use the intervention to prove an impact of a mutually agreed upon level of savings. Savings may vary and number of treated patients may differ when calculating savings for total cost of care versus a condition specific treatment. By knowing the number of patients needed to detect various impacts, appropriate contracting strategies can be deployed to mitigate risks of alternative payment models and to provide unique offerings to payers.

Performing a power analysis can answer those questions. At its core, a power analysis is calculating the probability of detecting an effect, given that effect truly exists. In statistical jargon, this means that a power analysis calculates the likelihood that the null hypothesis should be rejected when it is actually false. In layman’s terms, the power analysis measures the likelihood that differences in populations and results is caused by more than simply random variation. There are four key concepts to a power analysis:

- Power

  A range between 0 and 1. A power of 0.6 means that a statistically significant difference would be detected 60% of the time between the two analyzed components[1]. Power levels should be negotiated, where needed, and will depend on the characteristics of the study being performed.

- Effect Size

  This represents the change between the two groups being analyzed. It is also the most subjective piece during contract negotiations. A $1 PMPM reduction in medical claims expense could be deemed statistically significant, but materiality will be dependent on the business.

  Effect size is typically represented as the difference in means between the two analyzed groups divided by the standard deviation of one of the groups. A ratio greater than 0.5 is evidence of a large effect.

- Alpha

  This is the level of risk that an organization is willing to accept that results are driven by randomness in sampling rather than the intervention.

  As an example, consider a study with an alpha <= 0.05. This means that there is less than a 5% chance that the differences between the analyzed groups are driven by random sampling rather than the intervention itself.

- Sample Size

  This element is the total number of participants measured in a statistical test. In general, more participants means a greater likelihood of achieving statistical power.

  Sample size can be calculated by knowing the statistical test used, the alpha value, and the anticipated effect size.

By conducting power analysis, CMOs and benefit vendors can gain valuable insights into their business. Knowing the number of patients required to drive statistically significant and material cost savings will allow a servicing organization to better manage the risks of their business while understanding the scale needed for an intervention to be measured. When contracting, this analysis can provide a baseline to determine when risk should be shared and at what level results will stabilize.

## Conclusion

Contracting for health services, particularly those involving risk-based and performance components, is inherently complex. By addressing key elements such as clear attribution methodologies, thoughtful member and condition exclusions, precise participation thresholds, well-crafted MAC clauses, and appropriate target setting, CMOs and benefit vendors can navigate these complexities more effectively. Moreover, employing proxies for claims-based savings and conducting power analysis can significantly enhance the timeliness and reliability of performance assessments. By incorporating these considerations during contract negotiations, parties can reduce ambiguity, better understand their risk profiles, and ensure mutually beneficial agreements. Wakely is committed to supporting vendors, providers, and payers in achieving these goals, offering expertise in all aspects of value-based contracting. As the healthcare landscape continues to evolve, embracing these strategies will be crucial for delivering impactful and sustainable value-based care solutions.

Please refer to our care management page for more details.
https://www.wakely.com/services/consulting/care-management-analyses

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**References**

[1]Myors & Murphy, Statistical Power AnalysisA Simple and General Model for Traditional and Modern Hypothesis Tests, Fifth Edition

## OUR STORY

**Five decades.** Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

**Wakely is now a subsidiary of Health Management Associates.** HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

**Broad healthcare knowledge.** Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

**Your advocate.** Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

**Our Vision:** To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

**Our Mission:** We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

Learn more about Wakely Consulting Group at www.wakely.com