



Creating a Sustainable Future
for Value-Based Care

A Playbook of Voluntary Best Practices for VBC Payment Arrangements

2024

This playbook was prepared by Aurrera Health Group and Coral Health Advisors on behalf of the following organizations:



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Introduction

America's Health Insurance Plans (AHIP), the American Medical Association (AMA), and the National Association of Accountable Care Organizations (NAACOS) have undertaken a significant collaboration to engage their members in helping identify and refine voluntary best practices to advance a sustainable future for value-based care (VBC). This initiative, known as the Future of Value, is committed to enhancing patient experience, improving population health, and reducing costs by sharing voluntary best practices validated in real-world experience.

Previously, this collaboration produced an in-depth [playbook to advance data sharing](#) to support VBC. Now, the collaboration is focused on voluntary best practices related to the underlying payment arrangements. VBC payment arrangements seek to align payment with performance on quality, cost, and patient experience. The economic incentives are intended to motivate changes in care delivery to further goals such as evidence-based, preventive, equitable, and coordinated whole person care.

Physicians, hospitals, VBC entities, and health plans have made great strides over the last decade adopting various VBC payment arrangements and improving quality and cost. The 2023 Health Care Payment Learning and Action Network (HCP-LAN) report found that 24.5% of all payment for medical care is now in two-sided financial risk arrangements. This reflects a five percentage point increase from 2022.¹ Another recent study from the Institute for Accountable Care found that 75% of organizations participating in Traditional Medicare ACO VBC payment arrangements in 2022 also had VBC payment arrangements with Medicare Advantage (MA) or commercial plans and more than 30% had such arrangements in Medicaid.² Compared with earlier surveys dating back to 2018, this represents a two-fold increase in those reporting VBC payment arrangements with MA plans and a 50% increase with commercial plans. These numbers demonstrate the continued growth of VBC payment arrangements overall and further, that those who participate expand VBC to serve additional patient populations.

Increased participation has led to a wide variety of VBC payment arrangements. By exploring the lessons learned from implementation, AHIP, AMA, and NAACOS intend these voluntary best practices to support continued growth and new participation by improving awareness for what works well and by providing information that can reduce unnecessary variation and administrative burden that might hinder participation. This playbook provides insights into key domains within payment arrangements that can support alignment and allow stakeholders participating in VBC to focus their time and attention on the work of improving health outcomes, equity, patient experience, and overall health care spending.

AHIP, AMA, and NAACOS commissioned a thorough literature review, an environmental scan, and interviews with subject matter experts. They formed an advisory workgroup composed of members of each association, which met throughout the fall of 2023. Workgroup members and subject matter experts were selected to ensure diverse representation including national and regional health plans; large, small, rural, integrated, and independent physician practices; and VBC entities, such as accountable care organizations (ACOs), with substantial experience and those newer to VBC.



Throughout the initiative, AHIP, AMA, and NAACOS elevated common aims to guide the workgroup in considering potential best practices, including ensuring equitable, timely access to high-quality care and advancing health equity. Sufficient flexibility is needed within model parameters to meet the unique needs of both current and prospective VBC participants, such as whether risk is appropriate, at what levels, and when. It was also important to identify best practices in mechanisms to reward participants for both improvement and achievement to encourage broader VBC

payment arrangement participation, and to align payment arrangements across payers and populations where appropriate to reduce administrative burden and increase incentives for VBC transformation. To support a sustainable future for value-based care, VBC entities must have a viable long-term business case to support continued investment. Additionally, assurances of accuracy, predictability, and transparency within the underlying payment arrangement are critical to continued growth in VBC payment arrangements.

Several key themes emerged during the working sessions. The first of these is the importance of collaboration and flexibility in developing VBC payment arrangements. By working together to create these arrangements, participants can take differences in readiness, capabilities, patient populations, and resources into consideration. In addition to collaboration, transparency was also identified as a priority. The sheer complexity of VBC payment arrangements and at times, the unpredictability of payment can be addressed with clear advance documentation and regular feedback around methodologies and performance.

While this playbook recognizes there is no single recommendation for the best VBC payment arrangement, it identifies several voluntary best practices sourced from the direct experience of physicians, VBC entities, and health plans focused on alleviating pain points where possible to deliver better health and smarter spending for patients and communities.

Scope and Use

In an effort to manage consideration of the many elements of VBC payment arrangements, the workgroup focused its examination and discussion on total cost of care (TCOC) models. The sponsors acknowledge there are other types of payment structures within VBC that drive accountable care, and many of the considerations and voluntary best practices identified in the playbook may apply to those models (e.g., bundled and episodic payment, and primary care specific models). The central themes of transparency and engaging health plans, physicians, practices, and VBC entities in co-design of VBC payment arrangements are broadly applicable. Other voluntary best practices, including considerations for managing the level of financial risk and trade-offs between various types of attribution, can also inform VBC payment arrangements beyond TCOC.

What is Total Cost of Care (TCOC) Arrangement?

A Total Cost of Care (TCOC) Arrangement refers to a contract, often between three and five years in length, between a health plan and a VBC entity where the VBC entity takes responsibility for the total cost and quality of care for an attributed patient population that is calculated for a defined performance period, usually one year, and in exchange can receive or retain a portion of achieved savings or pay back any losses based on predetermined spending and quality targets or benchmarks.

Finally, this is an action-oriented playbook intended for physicians, participating practices, VBC entities, health plans, purchasers and employers seeking to participate in VBC arrangements. It is not meant to advocate, advance, or otherwise influence public policy.

Payment Domains

This playbook includes seven domains, each discussed in their own chapter:

1. Patient Attribution
2. Benchmarking
3. Risk Adjustment
4. Quality Performance Impact on Payment
5. Levels of Financial Risk
6. Payment Timing & Accuracy
7. Incentivizing for VBC Practice Participant Performance

While each domain is discussed distinctly, it is important to note many of the features of payment models are interdependent. For instance, making choices related to attribution influences benchmarking and quality measurement. Wherever possible, these considerations are called out.

Each domain is laid out similarly to include: a definition, a statement of the goals for that domain as it relates to sustainable VBC payment arrangements, a table summarizing the best practices, a discussion of key challenges, and more in-depth detail around the voluntary best practices for consideration, including the ways VBC participants have implemented them to achieve the goals. In addition, the playbook includes numerous examples to illustrate how these approaches are put into practice by VBC participants today.

1. Patient Attribution

Under TCOC arrangements, physicians, advanced practice practitioners (APPs) including physician's assistants (PAs) and nurse practitioners (NPs), practices, and/or VBC entities take accountability for a defined population of patients including their medical costs and health outcomes for a specified performance period. The process of matching a particular patient with a physician, APP, practice, or VBC entity is known as "attribution." There are numerous terms used to describe this process (e.g., assignment, alignment, enrollment, empanelment) that differ somewhat, but we will use attribution as a generic term throughout the playbook.

VBC participants have a variety of decisions to make on how to attribute patients. Attribution methodologies can be based on where a patient receives the greatest number of attributable services, often primary care services, who the patient selected as primarily responsible for their care, empanelment based on geographic proximity, or a combination of these and other factors. Additionally, VBC participants must agree on a time period to assess attribution and which specialty types and services are considered for identifying the physician or other health professional or VBC entity primarily responsible for the patient’s care for the purposes of attribution.

The goals of attribution within VBC payment arrangements are to accurately identify the population for which a VBC entity or participating practice will be held accountable during a performance period; honor patient preference wherever possible; and include only those patients where the VBC entity or practice has a reasonable ability to coordinate and improve their care.

Voluntary Best Practices at a Glance

The following is a summary of voluntary best practices identified as effective approaches to promote accurate and efficient attribution under VBC payment arrangements. Each is discussed in greater detail in the section that follows.

Patient Attribution	Voluntary Best Practices for Consideration:
<p>Voluntary patient selection</p>	<ul style="list-style-type: none"> • Prioritize and facilitate voluntary patient selection. • Validate voluntary patient selection with claims data, especially annual physical or preventive visits. • Proactively provide opportunities to update voluntary patient selection, especially if claims indicate a change in physician.
<p>Claims-based attribution</p>	<ul style="list-style-type: none"> • Use a multi-year attribution window. • For prospective attribution, apply appropriate exclusions at the end of the performance period to enhance accuracy. • For retrospective attribution, deploy strategies to enhance predictability, including: <ul style="list-style-type: none"> ◦ Providing provisional attribution reports during the performance period. ◦ Adjusting financial performance reports based on the most recent attribution lists. ◦ Limiting quality performance measurement to those who attribute in the first three quarters of the performance year.

Patient Attribution	Voluntary Best Practices for Consideration:
<p>Automatic new member attribution</p>	<ul style="list-style-type: none"> • Attribute patient to VBC entity once either a voluntary patient selection has been made or claims data is available to verify, such as a visit with a PCP in the VBC entity. • In the absence of voluntary patient selection and claims history to verify, rely on data such as geography, language preference, and physician capacity to take on new patients.
<p>Clinician types used for attribution</p>	<ul style="list-style-type: none"> • Include Advanced Practice Providers (APPs) in attribution methodology. • Deploy strategies to correctly identify the clinician principally responsible for managing a patient’s care, including attribution to a non-primary care specialist in circumstances where they are providing comprehensive care to the patient.

Challenges

The first notable challenge with attribution is accuracy, particularly with missing, inaccurate, or delayed data, which can lead to misattribution. Without accurate information on patient preference in provider directories or on submitted on claims, it is more difficult to link patients to the clinician that is most appropriate for managing their care. For example, with voluntary patient selection, if a patient selects a physician who has retired, moved locations, or is no longer accepting new patients, based on information in the provider directory, the patient could be “attributed” to a physician that is not likely to be able to deliver their care. If a patient does not update their selection when they change their physician, it can lead to holding the wrong physician or VBC entity accountable for the cost and quality of their care. Alternatively, with claims-based attribution, if specialty designations of physicians or APPs are not accurate in claims data, the methodology may attribute a patient to a clinician that is not primarily responsible for their care. Physician practices, VBC entities, health plans, and patients each have a responsibility and opportunity to support accurate attribution data.

The second challenge is building an attribution methodology that correctly identifies the accountable physician, which can be complicated by several factors including care setting, specialty, and provider type. Most attribution methodologies rely on Current Procedural Terminology (CPT®) codes in claims data. While the primary services reported for VBC payment arrangements center on the Evaluation and Management (E&M) codes, CPT® codes describe all medical procedures and services, and are critical to identifying the services performed, as

well as to attribute patients to the physician, care team, or entity who is most likely to be responsible for coordinating a patient's care. Healthier patients who require fewer visits or seek care via other non-affiliated, non-attributable settings such as urgent care are more difficult to capture in an attribution methodology, especially when attribution windows are limited to a single year. If the attribution methodology does not capture these patients, physicians could be attributed a disproportionately sicker population, creating an adverse selection issue that may unfairly hinder performance in the VBC payment arrangement if not addressed in the benchmark calculations. Alternatively, a patient who had a stay in an acute care hospital may see a particular hospitalist more than the PCP during a defined attribution window, or a patient who lives in a nursing home may be attributed to a physician that does rounds there even if they have another physician they identify as their PCP. The services and the sites in which those services are delivered can demonstrably alter attribution results and diverge from what both the physician and patient consider to be the accountable clinician.

The final challenge involves tradeoffs between accuracy and predictability. Prospective attribution delivers predictability but can be less accurate than retrospective attribution. Knowing which patients are attributed in advance helps VBC entities proactively manage patients' care, however it can compromise accuracy when care delivery patterns shift during the performance period. In contrast, retrospective attribution may lead to more accurate patient panels as it is based on actual utilization during the performance period, but VBC entities are less able to predict which patients will or will not be attributed to them. However, allowing for growth in the attributed panel over the year or removing patients who move away can also be beneficial and is more likely to ensure that a VBC entity is accountable for a patient population that is actively receiving care from the participating practice or VBC entity.

Exploring Best Practices in Depth

There are multiple approaches to constructing an attribution methodology that achieves the goals identified above. See below for further detail on the best practices associated with key elements of attribution.

Voluntary patient selection

Voluntary best practices for voluntary patient selection:

- Prioritize and facilitate voluntary patient selection.
- Validate voluntary patient selection with claims data, especially annual physical or preventive visits.
- Proactively provide opportunities to update voluntary patient selection, especially if claims indicate a change in physician.

With optimal information, patient preference could be considered the gold standard to determine attribution. It is important for VBC payment arrangements to honor who an individual patient believes is the physician most accountable for their care. However, in many cases, patients either do not have a PCP or other physician primarily responsible for managing their care, choose not to select, or struggle to keep their selection up to date after moving or switching physicians. To address these challenges, it is often helpful to affirm patient selection with claims data, especially using annual physicals or preventive visits, if available. It is also important to provide ample opportunity for patients to update their information via multiple methods (e.g., via internet-based forms, phone calls, or at the point of care), particularly if and when claims data indicate a change in PCP has occurred. However, issues common to populations who travel between multiple locations, such as retirees or “snowbirds,” also require consideration. It may not always be appropriate to automatically switch attribution due to changing care patterns and geography, which underscores the importance and utility of engaging with the patient to update or confirm their selection.

Claims-based attribution

Voluntary best practices for claims-based attribution:

- Use a multi-year attribution window.
- For prospective attribution, apply appropriate exclusions at the end of the performance period to ensure accuracy.
- For retrospective attribution, deploy strategies to enhance predictability, including:
 - Providing provisional attribution reports during the performance period.
 - Adjusting financial performance reports based on most recent attribution lists.
 - Limiting quality performance measurement to those who attribute in the first three quarters of the performance year.

Using claims data is the most common way VBC payment arrangements attribute individuals to VBC entities. Using claims-based attribution is often referred to as allowing patients to “vote with their feet” as claims indicate from which physicians the patient has received care. Claims-based attribution can also be used to confirm voluntary patient selection. See [“Spotlight: Attribution in MSSP” on page 17](#) for an example.

For enhanced accuracy of attribution to properly identify the physician and care team responsible for managing the patient’s care, claims-based methodologies often consider the type of claim, codes billed, rendering physician or specialty, dollar amount or number of services delivered, and the time period used as the attribution window. It is important to

consider when building these claims-based attribution algorithms that care utilization can vary based on factors such as patient age and health status. For example, older adults and those living with chronic conditions may have more frequent visits with their care team over a given period compared to a younger population with fewer health concerns. Tailoring attribution windows by patient population is one way to account for utilization differences due to age or illness. In addition, using multiple years of claims data can help identify clear and consistent patterns of care and identify the appropriate physician, APP, practice, or VBC entity for attribution, thus preventing unnecessary churn in the attributed population for patients who may not receive annual visits.

Another consideration within claims-based attribution is the timing when the attribution occurs. A VBC entity may receive a list of attributed patients for which they are accountable at the start of a performance year, typically referred to as prospective attribution, or a list may be finalized at or after the end of the performance year, referred to as retrospective attribution. This playbook does not identify one approach as preferable over the other as a best practice but does offer voluntary best practices to consider within each approach.

To attribute prospectively, a health plan may use patient preference information and claims data during an attribution window before the start of the performance year. With a prospective model, a VBC entity has the advantage of knowing from the beginning who they are accountable for but may also be responsible for individuals who did not see physicians or APPs participating in the VBC entity during the performance year. When using prospective attribution, a voluntary best practice would be to apply appropriate exclusion criteria at the end of the year to account for patients who should no longer be attributed to the VBC entity based on performance year data (e.g., they have moved out of the service area). While use of exclusionary criteria does not eliminate the tradeoffs of using prospective attribution, it can mitigate them, including the financial impact of being held accountable for patients the VBC entity did not care for during the year.

With retrospective attribution, health plans may use the claims and patient preference data from the performance year. By definition, this information will be more up to date. While retrospective attribution is a more accurate reflection of which patients received care during the performance year, accountable physicians and VBC entities do not know in advance which patients they are responsible for under the payment arrangement, which can make it more difficult to proactively manage a patient's care, particularly when the payment arrangement only covers a subset of a practice's total patient panel. Several voluntary best practices can be considered to help improve predictability when using retrospective attribution. Because the final patient population is unknown during the performance year, it is difficult to project financial performance. The provision by health plans of provisional attribution lists regularly (at least quarterly) during the performance year, and adjustment of financial reporting to match the updated provisional

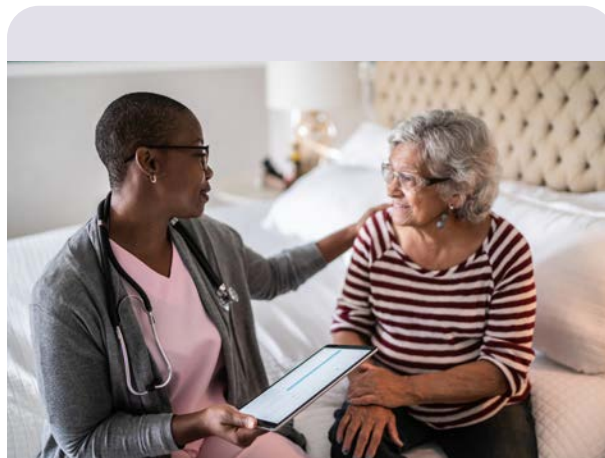
attribution, including supplying a rolling 12 months of data on that population, can better support VBC entities in proactively managing the attributed population and monitoring their performance in the payment arrangement. With retrospective attribution, another voluntary best practice for consideration is the limitation of quality performance measurement to those patients who are included on provisional attribution lists in the first three quarters of the performance year because there is not sufficient time to manage care for a patient who is provisionally attributed in the fourth quarter.

Automatic new member attribution

Voluntary best practices for automatic new member attribution:

- Attribute patient to VBC entity once either a voluntary patient selection has been made or claims data is available to verify, such as a visit with a PCP in the VBC entity.
- In the absence of voluntary patient selection and claims history to verify, rely on data such as geography, language preference, and physician capacity to take on new patients.

Another form of attribution is to automatically assign a patient to a PCP's panel upon enrollment in a health plan. This is most common in Medicaid where patients are typically assigned to a PCP when enrolled in a Medicaid managed care organization (also called empanelment). In some circumstances, attribution occurs before the health plan has any claims data on the patient's care. In this scenario, a voluntary best practice for consideration is the use of other relevant information like the patient's address, PCP capacity, and language preference to increase the likelihood that the patient will be assigned



Health Equity Considerations when requiring PCP visits for attribution

When using an attribution methodology that requires a visit with a PCP before a VBC entity is held accountable, patients who encounter barriers in accessing primary care may be excluded from VBC initiatives perpetuating disparities in access to care and health outcomes. Proactive outreach coupled with initiatives to address barriers to seeking care, may encourage PCP visits for historically marginalized populations and increase attribution of these patients to VBC entities.

to a PCP that meets their needs. With automatic new member attribution, it is important to check claims data regularly and switch attribution when more information becomes available about the patient's preference for care. In some cases, even when patients are assigned to a PCP during enrollment in a health plan, assignment may not always be used for VBC payment arrangement attribution. VBC participants may find it appropriate to wait at least six months to attribute the patient for purposes of financial calculations in a VBC payment arrangement.

Clinician types used for attribution

Voluntary best practices for determining clinician types eligible for attribution:

- Include APPs in attribution methodology.
- Deploy strategies to correctly identify the clinician principally responsible for managing a patient's care, including attribution to a non-primary care specialist in circumstances where they are providing comprehensive care to the patient.

Most attribution methodologies are designed to identify a patient's PCP or the physician most appropriately accountable for managing an individual's care. Part of that process is defining the clinician types eligible for attribution. Most commonly, VBC payment arrangements consider specialties such as family medicine, internal medicine, pediatrics, and geriatrics to be primary care, though this list could change depending on the line of business, patient population, or goals of the VBC payment arrangement. APPs, typically NPs or PAs, can also be important members of the patient's primary care team, and their inclusion as eligible clinician types in an attribution methodology can serve to capture additional patients as part of the attributed population. However, due to the way APPs are identified in claims data, it can be challenging to discern whether an APP is practicing in a primary care or specialty setting. Additional checks are needed to ensure the patient is not unintentionally attributed to a specialty practice due to E&M CPT® codes on claims billed by an APP who is not acting in a primary care capacity.

Circumstances may exist where it makes sense to attribute patients to a non-primary care specialist, for example, an endocrinology or cardiology practice, based on their management of a complex chronic condition. It is not always clear from claims when a non-primary care specialist is managing a patient longitudinally versus when they are managing an acute episode. Attribution methodologies attempt to discern this difference in a variety of ways (e.g., discussion with the patient, looking only at certain specialty or service types, using a longer time period for attribution, and requiring two or more attributable services to establish a pattern of care). See ["Spotlight: Attribution in MSSP" on page 17](#) for one example of how to attribute patients based on non-primary care specialists as part of its overarching approach to attribution.

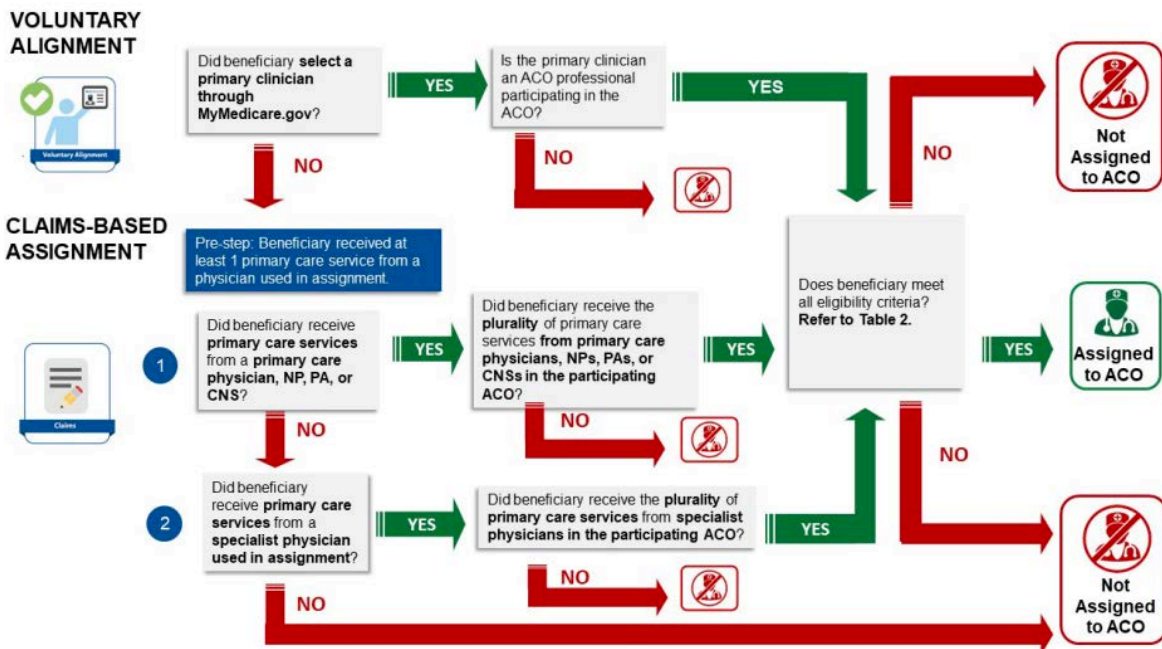
SPOTLIGHT: Attribution in MSSP



The Medicare Shared Savings Program (MSSP) was created by CMS in 2012 as the permanent TCOC program in traditional Medicare. A number of features of the MSSP methodology represent voluntary best practices in addition to the high level of transparency and documentation and the ability to choose between prospective and retrospective attribution on an annual basis.

The Medicare Shared Savings Program (MSSP) uses a combination of patient selection and claims-based attribution. MSSP allows beneficiaries to use the Medicare.gov website to identify their primary clinician. If that clinician is a participant in MSSP, the beneficiary is attributed to the ACO the following year if not already attributed. Patient selection or “voluntary alignment,” is given priority over claims-based attribution.

If a beneficiary does not select a clinician on Medicare.gov, they are attributed to an ACO if they receive a plurality of their primary care services, defined by E&M CPT® codes on claims, from participants in that VBC entity. Within claims-based attribution, claims from a primary care physician are given priority over non-primary care specialist claims. MSSP only attributes Medicare beneficiaries to an ACO based on care provided by non-primary care specialties if the patient received no care by a PCP during the attribution window. If no PCP visits are identified in claims, then the patient is attributed to the ACO if the total dollar value of E&M CPT® codes on claims by certain specialists in the ACO is larger than any other ACO or practice. The diagram below represents this process flow:³



2. Benchmarking

In a typical VBC payment arrangement, the actual cost of care for an attributed population during the performance period is compared to a target amount that is commonly an estimate of the expected cost of care. If the actual cost of care in the performance period is lower than the expected costs, the VBC entity may earn a share of the difference, otherwise known as shared savings. If the cost of care in the performance period is higher than the expected costs, the VBC entity may be responsible for a share of the difference, otherwise known as shared losses.

Benchmarking within VBC payment arrangements is complex and involves a multitude of steps and decisions. The first major component is to calculate a baseline spending amount, including whether and to what extent to use the VBC entity's own historical costs or a market comparison, such as regional or national costs, how many years of data to use, and whether any costs are excluded. There are multiple ways that VBC participants can estimate expected costs as part of establishing a benchmark. Expected costs can be calculated using the VBC entity's own historical costs, a national or regional reference population, or a combination. In many managed care payment arrangements, the VBC entity is held to a percent of premium target. Whether based on the premium, the VBC entity's own experience, or some other reference group, the VBC entity is responsible for the total cost of care for an attributed population.

The second major component is to establish a trending methodology to update the baseline with projected or observed changes in costs during the performance period to estimate the expected costs of the VBC entity's attributed population. The third major component is how to apply any additional adjustments to advance the goals of the VBC payment arrangement, including adjustments to the benchmark over the course of a contract period. For instance, to encourage experienced VBC entities to continue to participate, the benchmark may be adjusted to reflect their efficiency compared to regional costs. Benchmarks may also include adjustments to encourage expanding access to historically marginalized communities. In addition to these steps, VBC participants must decide when during a contract period, if ever, to update ("rebase") the baseline, apply an updated trend, and/or recalculate the benchmark.

The goals of a benchmarking methodology in VBC payment arrangements are: to establish an agreed upon cost target that incentivizes care transformation activities by rewarding a VBC entity for efficiency as well as improvement in the total cost of care; to predictably, accurately, and transparently setting an achievable spending target; and, to create a path toward sustainable savings over the life of the VBC payment arrangement.

Percent of Premium Target



A percent of premium target (sometimes referred to as a minimum loss ratio or MLR target) refers to a TCOC arrangement where the VBC entity’s benchmark is set as a percentage of spend relative to the agreed upon premium between the health plan and the employer or government payer (depending on the line of business). When a VBC payment arrangement benchmark is set as a percent of premium, it means the VBC entity’s financial target is calculated using the health plan premium, but how that premium is set varies. The way a premium is set can depend on a variety of factors including the line of business (Medicaid, MA, or commercial), and includes costs in addition to medical care like claims processing and other types of administrative overhead. Percent of premium targets are commonly used for VBC payment arrangements between VBC entities and MA plans. For example, if an MA plan received \$100 dollars per patient per month (as determined by their MA bid to CMS), the MA plan may then choose to provide a VBC entity with a percent of premium target of 85%, meaning that the VBC entity must spend less than \$85 per patient per month to receive any shared savings.

Voluntary Best Practices at a Glance

The following is a summary of voluntary best practices identified as effective approaches to promote sustainable VBC payment arrangements through benchmarking. Each is discussed in greater detail in the section that follows.

Benchmarking	Voluntary Best Practices for Consideration:
<p>Setting the baseline</p>	<ul style="list-style-type: none"> • Use multiple years of historical data. • Avoid frequent rebasing of the baseline years when using a VBC entity’s own historical costs and consider moving to regional baselines over time. • Collaborate on an achievable percent of premium target. • Include pharmaceutical costs, where feasible.

Benchmarking	Voluntary Best Practices for Consideration:
<p>Trending the baseline forward to establish a benchmark</p>	<ul style="list-style-type: none"> • Exclude the VBC entity from the reference population when their experience is large enough to drive the regional trend. • Prioritize regional over national trend factors, as appropriate. • Combine prospective administrative trend factors with retrospective adjustment to balance predictability and accuracy. • Establish guardrails when using an administrative trend to help manage risk. • Ensure attributed and reference populations are comparable.
<p>Making specialized adjustments to the benchmark</p>	<ul style="list-style-type: none"> • Include benchmark adjustments to incentivize continued VBC entity efficiency • Test adjustments to the benchmark to encourage inclusion of historically marginalized populations in VBC.

Challenges

When establishing a benchmark for a VBC payment arrangement, there is an inherent challenge in estimating what costs would have been for a patient population had the VBC payment arrangement not existed. Because developing a precise and timely counterfactual is not feasible, the goal becomes reasonably forecasting future spending and aligning the VBC payment arrangement in a manner that will encourage and reward better health outcomes and lower cost growth. Variability in a VBC entity’s population over time, and changes in utilization from events like a pandemic or new high-cost drugs, can make this type of forecasting even more difficult. Just as there are trade-offs between accuracy and predictability with prospective and retrospective approaches to attribution, developing a trend factor in advance provides predictability, but updating the trend at the end of the performance period ensures accuracy.

Value-based care requires significant time and resources to invest in transforming models of care, and at the same time, a VBC entity may agree to lower payments over time. For this reason, participating practices and VBC entities need a long-term, sustainable business case for participation that takes into account their circumstances, local market dynamics, and the considerable time and resources it takes to transform care delivery. When benchmarks are established using solely a VBC entity’s own historical costs, organizations must compete against their own past performance. For historically high-performing organizations, and those who have been in VBC payment arrangements for longer periods of time, this can lessen the potential

to achieve success and continue supporting the care model over time. When benchmarks are calculated using regional costs or based on a percentage of premium target, they may not always incentivize improvement if a VBC entity is already less expensive than others in their market and may discourage those who are much higher cost from entering into VBC payment arrangements altogether. VBC participants must consider each of these factors when designing a benchmarking approach to ensure sustainability over multiple agreement periods and encourage organizations at different levels of readiness to participate.

Finally, due to historical inequities including a lack of access to care for historically marginalized communities, historical health care costs can reflect that lack of access and fail to account for the appropriate level of health services needed for all patient populations. In these situations, setting benchmarks based on historical costs can exacerbate existing disparities and play a role in preventing necessary health care resources from reaching these communities.

Exploring Best Practices in Depth

Each decision within a benchmark methodology has implications for others due to their interactive nature and many of these choices depend on factors unique to a given population, line of business, or market. These various complexities make arriving at a single best approach for benchmarking not only difficult, but inadvisable. Retaining some degree of flexibility in designing benchmarks helps to attract and retain a more diverse slate of participants, thereby allowing more patients to benefit from VBC payment arrangements.

Below are voluntary best practices and key considerations for establishing sustainable benchmarks in VBC payment arrangements that should be considered depending on the circumstances of the particular arrangement.

Setting the baseline

Best practices for setting the baseline:

- Use multiple years of historical data.
- Avoid frequent rebasing of the baseline years when using a VBC entity's own historical costs and consider moving to regional baselines over time.
- Collaborate on an achievable percent of premium target.
- Include pharmaceutical costs, where feasible.

The baseline is the foundation of the benchmarking methodology. It is trended forward and adjusted to create the benchmark that the VBC entity's performance year expenditures will be measured against. As noted above, there are a number of decision points when designing a baseline, each with different considerations.

Using multiple years of historical data to set a baseline helps create a reliable and predictable target by minimizing the effect of a single year of potential unusual spend (e.g., an especially bad flu season). Some VBC payment arrangements weigh the most recent years more heavily because it is easier to make adjustments and more recent spending data tends to be more predictive of performance year costs.



When a VBC entity's own historical costs are used to establish a baseline, frequent updating of the baseline years, known as "rebasings", can discourage continued participation because it reduces predictability, and if the VBC entity is successful, then the new benchmark will be lower and require the VBC entity to continually lower its own spending, sometimes referred to as the "benchmark ratchet effect." Many VBC payment arrangements annually rebase financial targets because changes to payment schedules make comparing years further in the past to the performance year too

incongruous. Regular rebasing can make it difficult for experienced VBC entities to continue to achieve the savings needed to maintain care management staff and population health capabilities that require investment year over year. Prolonging the period of time between rebasing can help address this issue.

Incorporating current regional or national spending into the baseline can also make benchmarks more sustainable as VBC entities improve on their past performance. In percent of premium VBC payment arrangements, the VBC entity's own historical costs are not typically used to set a baseline. A VBC entity's historical performance is considered when setting a percent of premium target but the target itself tends to depend on market dynamics. Since a percent of premium target is less related to a VBC entity's own costs, there is risk the target

can be too high or too low. When setting a percent of premium target in a VBC payment arrangement, VBC entities and health plans can work together to identify an achievable target to ensure that it rewards VBC entities for both improvement and achieved efficiency.

While VBC payment arrangements often include all professional and institutional medical expenses, many do not include pharmaceutical costs. For example, not all pharmaceutical costs are included in traditional Medicare ACO programs because prescription drugs are paid through separate private Part D prescription drug plans. Including pharmaceutical costs can be challenging administratively, and certain drug costs may be outside of a physician’s or VBC entity’s ability to control unless there is a medically appropriate alternative that is covered by the plan. However, when a health plan covers both medical and prescription drugs for patients, as is often the case in MA or commercial plans, it is worth considering the inclusion of pharmaceutical expense in the VBC payment arrangement. Evidence-based prescribing and medication adherence are integral to whole person care. By adding pharmaceutical costs to VBC payment arrangements, VBC entities and participating practices have incentives to improve health outcomes through better medication adherence and prescribing lower cost options when equally as clinically effective.

Evidence-Based Cost Targets



While not currently in use, defining a baseline using evidence-based standards of care could be an alternative approach to creating a sustainable future for VBC payment arrangements. This approach is used in some episodic models, such as capitated payment for labor and delivery where the clinically indicated use of ultrasound, prenatal visits, routine labs and testing, as well as events such as hospitalization, are used to determine the cost target instead of historical spend. Complexity increases when applying this method to the total cost of care for a population. Nevertheless, this type of pricing structure holds promise as a strategy to base future VBC payment arrangements on optimizing patient care, rather than being tied to previous payment structures.

Trending the baseline forward to establish the benchmark

Voluntary best practices for trending the baseline forward to establish a benchmark:

- Exclude the VBC entity from the reference population when their experience is large enough to drive the regional trend.
- Prioritize regional over national trend factors, as appropriate.
- Combine prospective administrative trend factors with retrospective adjustment to balance predictability and accuracy.
- Establish guardrails when using an administrative trend to help manage risk.
- Ensure attributed and reference populations are comparable.

The trend factor is used to update the baseline expenditures to the benchmark for the performance period. VBC payment arrangements may use an administrative (or prospective) trend that is an actuarial projection, apply a trend factor at the end of the performance period that reflects actual costs, or apply a blended approach. VBC participants must decide which trend factor(s) to apply and who to include in the reference population.

Trend factors can be based on regional spending, national spending, a subset of specific covered services or patient populations, or a combination. More localized trend factors can best capture nuances of market dynamics, like pricing changes of a large academic medical center, or a cold season that causes spikes in respiratory viruses in a particular area. However, in certain cases, smaller health plans may not have a large enough network in a geographic area to establish a local trend and need to broaden the region for statistical accuracy. If the VBC entity is large enough to affect the regional trend, it is most effective to exclude them from the reference population. This is more often the case in rural areas, or in markets with a single, large health system. If the VBC entity is not excluded, by definition, the trend would in part reflect the VBC entity's own performance, essentially competing against itself and lessening its ability to beat the benchmark and earn incentives to effectively manage costs. Once the large VBC entity is excluded, it may be necessary to find an alternative method for defining the reference population to reach a minimum sample size. For example, VBC participants can use a larger region, a comparable region where the VBC entity is not operating, or supplement with a national or other administratively set trend factor.

There are tradeoffs between using prospective or retrospective trend factors. Prospective trends give VBC entities the advantage of better estimating their final benchmark at the start of the performance year and allowing them to track their financial performance throughout the

year. However, trends are notoriously hard to forecast, especially in recent years with COVID-19, and an inaccurate trend that does not reflect current costs is commensurate with taking on added financial risk. Retrospective trends, while reflective of actual changes to expenditures, are not available until after the end of the performance period, creating uncertainty in the expenditure target for the VBC entity. It can be an effective strategy to use a mix of a projected administratively set trend and a retrospective regional trend to balance predictability with accuracy. The ratio may vary based on the stability of costs in the local market.

When using a prospective trend, it is useful to establish guardrails to mitigate risk for significant spending changes that are beyond the VBC entity's control. One approach is to establish that any changes above or below a certain percentage will require closer examination and may be subject to a retrospective adjustment. When using a trend adjustment, it may also be helpful to limit the amount of negative adjustment that can be applied retrospectively. The combination of a retrospective trend adjustment and a cap on the level of downward retrospective adjustments can address substantial changes in spending beyond the control of a VBC entity (e.g., a pandemic, or significant climate event that displaces communities and shifts care patterns) and provide assurance to VBC entities that they are being held accountable for costs and risk they have the ability to affect through better care, boosting confidence and willingness to participate in VBC payment arrangements.

Lastly, when calculating a trend, it is essential for the reference population to match the attributed population as closely as possible. For instance, when eligibility criteria for attribution in a VBC payment arrangement requires at least one E&M CPT® code reported by a PCP on a claim within the last 12 months, it is best practice for the reference population to include the same eligibility criteria. Even small differences between the reference population can have a significant impact on financial performance.

Making specialized adjustments to the benchmark

Voluntary best practices for making specialized adjustments to the benchmark:

- Include benchmark adjustments to incentivize continued VBC entity efficiency.
- Test adjustments to the benchmark to encourage inclusion of historically marginalized populations in VBC.

VBC participants may want to use specific adjustments to further particular aims of the arrangement. For example, the VBC participants may seek to incentivize continued participation in care transformation by experienced VBC entities or the expansion of VBC to new physicians or historically marginalized communities.

When a health plan updates baseline costs annually, it may want to consider alternative methods to create a sustainable business case for an experienced VBC entity to remain in the payment arrangement. One possible approach is to factor in the VBC entity's cost efficiency compared to their region or market. Another would be to add a portion of demonstrated savings from previous years of the arrangement back into the benchmark. Integrating regional spending into baseline calculations is another common solution, all of which can also be used in concert with one another. Whatever the approach, offering a certain range of flexible adjustments to the benchmark can help ensure continued participation as well as drive continued cost mitigation and improved outcomes over time.

To recognize historical inequities in care and the need to encourage greater safety-net participation in these arrangements, benchmarks can be adjusted to allow for additional funds to be invested in historically marginalized populations and communities. Many health plans are in the early stages of exploring how to adjust VBC payment arrangements to reflect the higher acuity of populations with significant health-related social needs (HRSNs) that have not historically had equal access to health care.



One approach to address these concerns would be to make an adjustment to the benchmark to acknowledge the limitations of traditional methods of risk adjustment and historical claims to accurately reflect the cost of caring for population, with HRSNs and allow for participating VBC entities to expand access to and manage care for these historically marginalized communities without it negatively impacting their performance under the model. Another recommended approach would be to provide separate spending targets for historically marginalized populations along with dedicated resources or funding opportunities.

Adjusting benchmarks to account for health disparities between communities and populations is still new, and there is not yet an approach that VBC participants have found to be most effective. At this point, many health plans are at the stage of incentivizing demographic and HRSN data collection to determine areas of improvement and implementing pilot programs in select communities. Continued testing of both the tools for measuring disparities and the appropriate adjustments needed to advance health equity without it adversely impacting

financial or quality performance under TCOC models will hopefully help to further refine TCOC methodologies so VBC arrangements can be successfully inclusive of historically marginalized communities.

3. Risk Adjustment

VBC payment arrangements compare the risk profile of the baseline patient population with the risk profile of attributed patients during the performance period and then adjust the benchmark up or down to reflect the difference in clinical acuity and demographic factors. This process is referred to as “risk adjustment.”

The goals of risk adjustment in a VBC payment arrangement are to adjust payment in a clear and understandable way for all VBC participants (health plans, physicians, and VBC entities); accurately reflect the intensity and acuity of the attributed population; avoid resource-intensive processes and practices; and mitigate for the potential of over or under payment due to differences in coding capabilities.

Voluntary Best Practices at a Glance

The following is a summary of voluntary best practices identified as effective approaches to risk adjustment in VBC payment arrangements. Each is discussed in greater detail in the section that follows.

Risk Adjustment	Voluntary Best Practices for Consideration:
<p>Selecting a risk adjustment model</p>	<ul style="list-style-type: none"> • Use standard known risk categories like Hierarchical condition categories (HCCs) or other independently verified models. • Use concurrent models or update the risk scores within the performance year.
<p>Physician education and support</p>	<ul style="list-style-type: none"> • Provide targeted physician education and supports for clear and complete documentation of the extent of illness while minimizing administrative burden.
<p>Incorporating demographic and Social Determinants of Health (SDOH) data</p>	<ul style="list-style-type: none"> • Support efforts of physicians, practices, or VBC entities to report demographic data and SDOH data to allow for future efforts to incorporate socioeconomic data into risk adjustment models. • Pilot and monitor health equity adjustments in risk models before scaling.

Challenges

Significant resources are spent by most VBC participants to ensure that the full extent of illness of their population is documented, typically based on diagnosis codes on claims. However, not all entities have equal abilities to invest the same amount of time, attention, and resources into risk adjustment. This variability in resources and solutions for accurate diagnosis coding can lead to higher benchmarks for well capitalized VBC entities that are not based on true differences in the health of the population, but rather, a difference in coding capabilities.

Health plans rely on a variety of risk adjustment models when implementing VBC payment arrangements. When these models are designed by the individual health plan, they may contain proprietary information and therefore are not publicly available to examine, understand, and replicate. Since risk adjustment can be a determinative factor in whether savings or losses are achieved, the inability to replicate risk models may discourage participation by some VBC entities. Additionally, managing different risk adjustment methodologies across payers can be administratively burdensome.

Exploring Best Practices in Depth

There are a number of ways VBC participants can avoid the potential pitfalls of risk adjustment and ensure the adjustment appropriately reflects the health of the population. Below are voluntary best practices and key considerations for establishing effective risk adjustment in VBC payment arrangements.

Selecting a risk adjustment model

Voluntary best practices for selecting a risk adjustment model:

- Use standard known risk categories like HCCs or other independently verified models.
- Use concurrent models or update the risk scores within the performance year.

Differences in the health of an attributed population compared to a baseline reference population can materially affect the cost of care. Thus, VBC entities seek to understand how targets will be adjusted, what documentation is required, where they are starting from, and how relative health risk of the population is changing throughout the year. Many VBC entities indicate a preference for HCCs used in Medicare because the categories and methodology are publicly available and replicable, which promotes transparency and gives participants a greater ability to track risk adjustment for continuously evolving populations. Using fewer risk adjustment models across all patients and lines of business (LOBs) also makes clinical documentation less burdensome for physicians, practices, and VBC entities.

In certain cases, health plans may select other more targeted risk adjustment models to better measure risk for select populations (e.g., pregnant people and children). When using a model that is not publicly available, health plans may consider models created and validated by a trusted third party such as Milliman Advanced Risk Adjusters (MARA), 3M Clinical Risk Groups (CRGs), Chronic Illness and Disability Payment System (CDPS), and Johns Hopkins Adjusted Clinical Groups (ACGs) based on the unique characteristics of the attributed population. In designing VBC payment arrangements, it is important to find the appropriate balance between transparency for VBC entities and the reliability of the model in predicting costs. See table of [“Common Risk Adjustment Models” on page 66](#) in the Appendix for more information on available models and how they compare.

Another important feature of a risk adjustment model is how and when risk scores are updated. Concurrent models are the timeliest in that they rely on diagnoses identified during the performance year to calculate risk scores used for payment. Prospective models rely on diagnoses from a base period (usually the prior year) to predict costs during the performance period. The CMS-HCC model used in MA is an example of a prospective risk adjustment model. The advantage of prospective models is the incentive they provide to manage patient health and chronic conditions, thereby reducing costs that would be expected based on the risk score. However, this approach is not well-suited for real-time fluctuations in a patient’s acuity. Concurrent models tend to be better at capturing acute illnesses or events, and by definition, will more quickly adjust for a change in the health of the patient.

Physician education and support

Voluntary best practices for physician education and support:

- Provide targeted physician education and supports for clear and complete documentation of the extent of illness while minimizing administrative burden.

Risk adjustment models are meant to measure illness in a population and predict expenditures based on that acuity. The current models available rely on physician documentation to capture their patients’ illness, which means that how physicians, practices, and VBC entities implement clinical documentation efforts can have significant effects on financial performance. To support physicians, practices, and VBC entities that may not have the time or capital to invest, health plans can provide physician education and resources around appropriate documentation practices. For rural, safety-net, and small group practices, these additional resources can “level the playing field” with other participants and support their participation in VBC.

Incorporating demographic and SDOH data

Voluntary best practices for incorporating SDOH data:

- Support efforts of physicians, practices, or VBC entities to report demographic data and SDOH data to allow for future efforts to incorporate socioeconomic data into risk adjustment models.
- Pilot and monitor health equity adjustments in risk models before scaling.

Current risk adjustment methodologies likely do not fully predict expenditures for historically marginalized populations because they are largely based on historical spending from diagnoses reported on claims, which may be distorted by racial bias or access issues, and do not include other factors that affect utilization like HRSNs.⁴ Currently, health plans have reported using more targeted pilots to pay physicians, practices, and VBC entities for collection of demographic and SDOH data that identify social, economic, and environmental conditions that may impact health.⁵ Collection efforts may focus on gathering data related to social needs and services such as unemployment, homelessness, and food insecurity via Logical Observation Identifiers Names and Codes (LOINC®) codes or ICD-10 “z codes” as well as demographic data (e.g., race, ethnicity, and language). These are positive steps towards gathering the data necessary to fully understand the differences in the prevalence of illness across populations and the needs of certain populations. These data can be used to develop better predictive risk adjustment methodologies that take into account how health disparities and HRSNs impact patient health and the intensity of care needed. However, collecting these types of data can be resource-intensive. Therefore, incorporating this expectation and investment to support data collection into VBC payment arrangements can help to accelerate and sustain these efforts. It is important to fully vet, monitor, and iterate on any new risk adjustment methodologies that integrate health equity data to evaluate efficacy and identify possible unintended consequences before these methodologies are scaled to avoid potentially exacerbating existing inequities even further.

4. Quality Performance Impact on Payment

Most VBC payment arrangements reward VBC entities for strong performance on quality of care as measured by a set of predetermined quality metrics. VBC payment arrangements adjust payment in a variety of ways based on quality performance, including: adjusting shared savings and losses up or down based on a quality score; creating a performance threshold that a VBC entity must surpass to receive any incentive payment; establishing quality withholds where a certain amount of a prospective payment is held back by the health plan and only offered when quality performance

is achieved; creating high-performance bonus pools; and, calibrating other future model payments (e.g., care coordination fees) based on quality performance; or a combination of the aforementioned.

The goal of incorporating quality performance in a VBC payment arrangement is to incentivize quality improvement and sustain long-term high-quality care, especially in areas where there may not be an immediate return on investment. Additionally, incorporating quality performance can serve to counterbalance competing financial disincentives related to lowering avoidable or unnecessary costs or to promote expanded patient access to more historically marginalized or clinically complex populations.

Voluntary Best Practices at a Glance

The following is a summary of voluntary best practices identified as effective approaches to integrating quality performance into sustainable VBC payment arrangements. Each is discussed in greater detail in the section that follows.

Quality Performance Impact on Payment	Voluntary Best Practices for Consideration:
<p>Structuring the quality component of VBC payment</p>	<ul style="list-style-type: none"> • Set achievable quality performance targets. • Establish a minimum performance threshold with sliding scale to reward higher quality improvement. • Allow bonus dollars for quality improvement regardless of whether cost target is achieved. • Adjust both savings and losses based on quality performance. • Take historically marginalized populations into account when establishing quality targets and incentives.
<p>Implementation</p>	<ul style="list-style-type: none"> • Provide transparent quality measures, methodologies, and performance targets at the start of the performance period and regular feedback on progress towards these targets.

Challenges

The proliferation and variability of quality metrics is the most frequently expressed frustration and administratively intensive feature of VBC arrangements. Concerns include the quantity of measures, varying measures and measure specifications used across payers, and challenges reporting the necessary data. While the future of sustainable VBC would benefit from greater clarity around voluntary best practices in quality measurement and performance, such as

adoption of the measure sets created by the [Core Quality Measures Collaborative](#), this playbook focuses specifically on the ways in which performance on quality is used to adjust VBC payment.

It is difficult to create quality thresholds that are both achievable and contain adequate incentive to improve for a diverse range of practices with varying quality performance without over-tailoring them to specific practices and VBC entities. Establishing thresholds that a VBC entity must meet to earn savings sets minimum standards for high-quality care, but if the measure thresholds are set too high, a VBC entity may disengage from both the cost and quality elements of the arrangement entirely if they determine early in the performance period that the target is not achievable. Conversely, setting quality targets too low could fail to incentivize continued improvement or the highest quality performers.



When determining how quality performance should impact model payments, it is important to take certain considerations into account. For example, VBC entities providing care to historically marginalized populations may have lower quality scores, especially to start, because they need to overcome known challenges with access and the impact of HRSNs. Failure to account for historically marginalized communities and patients in quality scoring may lead to further disparities in care by reducing resources provided to safety-net entities.

Another challenge includes how to structure quality incentives within a VBC payment arrangement, namely to what extent the total dollars at risk should be impacted by quality performance (and vice versa: to what extent quality incentives should be contingent on achieving financial savings). When the total dollars at risk for quality performance are small, and especially if the efforts are administratively burdensome or the measures are not viewed as clinically meaningful, the incentive to focus limited resources (human and capital) on quality performance activities may be insufficient. Quality performance monitoring is also an important counterbalance to incentives to manage cost as they can ensure patient safety and quality of care are maintained. For this reason, many VBC payment arrangements make financial incentives contingent on achieving some quality standard. However, few current VBC payment

arrangements offer separate incentives purely for improving or achieving high quality care regardless of achieving financial savings. Making quality performance incentives contingent on achieving any cost savings could underrecognize important strides in quality, such as improved access for historically marginalized populations, that may not reduce savings in the short term but are critical to meeting long term quality and spending goals.

Exploring Best Practices in Depth

Voluntary best practices include a combination of methods to set achievable targets and support incentives designed to encourage physicians, practices, and VBC entities to strive for continuous, strong quality performance. Below are voluntary best practices and key considerations for integrating quality performance into VBC payment arrangements.

Structuring the quality component of VBC payment

Voluntary best practices for structuring the quality component of VBC payment:

- Set achievable quality performance targets.
- Establish a minimum performance threshold with sliding scale to reward higher quality improvement.
- Allow bonus dollars for quality improvement regardless of whether cost target is achieved.
- Adjust both savings and losses based on quality performance.
- Take historically marginalized populations into account when establishing quality targets and incentives.

A sustainable framework for quality performance in VBC payment arrangements is based on rewarding both quality improvement and high achievement. Achievable quality performance targets encourage VBC entities to invest resources in transforming care and improving quality, in addition to appropriately managing costs. Unattainably high thresholds in quality performance to earn shared savings can discourage engagement and participation. If not appropriately designed, such gates can also disproportionately negatively impact VBC entities with higher acuity or higher risk patient populations, reducing resources for patients that need them the most.

Instead of setting a universal threshold for quality performance, it may be more effective to establish a minimum performance threshold accompanied by a sliding scale of additional incentives to improve quality. By introducing a sliding scale of incentives above and beyond a minimum performance threshold, the VBC payment arrangement can consider varying levels

of quality achievement and promote continuous improvement in quality of care delivered to patients. It is also important that quality benchmarks are appropriately adjusted for clinical and social risk factors. See “Spotlight: Setting Minimum Quality Performance with a Sliding Scale” for an example of this practice in action.

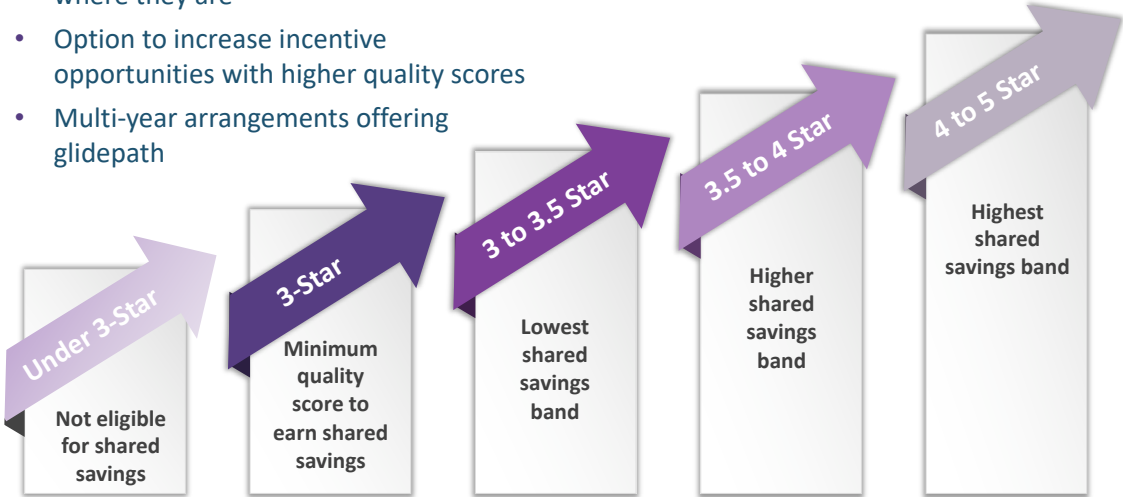
SPOTLIGHT: Setting Minimum Quality Performance with a Sliding Scale

Aetna, a CVS Health company, offers health insurance products covering approximately 39 million individuals nationally. Aetna offers physicians across the country a wide variety of VBC contract arrangements to incentivize advanced care delivery, improve quality, enhance patient and physician experience, and manage the total cost of care. Aetna believes quality is a core element to any VBC arrangement. The following example describes Aetna’s approach to quality measurement in its VBC payment arrangements for Medicare Advantage.



Aetna VBC Quality Payment Structure

- Designed to meet provider partners where they are
- Option to increase incentive opportunities with higher quality scores
- Multi-year arrangements offering glidepath



Aetna’s VBC approach establishes a collaborative process with network participants to mutually agree on the inclusion of specific quality measures within the VBC payment arrangement. These measures, drawn from a core set of evidence-based criteria aligned with the Healthcare Effectiveness Data and Information Set (HEDIS) and the CMS Star

Performance Measurement Program, serve as the foundation for evaluating performance in VBC payment arrangements for Medicare Advantage.



In many of Aetna’s Medicare shared savings and shared risk models (across most of the country), VBC participants are required to achieve a minimum quality score to qualify for any shared savings. Once this threshold (i.e., floor) is met, VBC entities have the opportunity to earn a greater percentage of savings on the predetermined sliding scale, contingent upon their quality score. The incremental sliding scale allows for participants with higher quality scores to receive a proportionately greater share of the savings, reinforcing the linkage between quality performance and financial incentives.

It is not uncommon for costs to remain flat, or perhaps even increase, in the initial years of a VBC payment arrangement as practices are making initial investments, including in IT and data to support quality measurement improvement and reporting, to achieve long-term population health management. Accordingly, it can be beneficial for VBC payments arrangements to encourage better health outcomes and higher quality care even in situations where VBC entities are not likely to meet a cost target, particularly in the early years of implementation. In some cases, and for those newest to being accountable for quality, entities may also wish to consider arrangements where participants are paid for reporting quality prior to being accountable for quality outcomes.

Layering separate, targeted performance goals and incentives on top of a VBC payment arrangement and adjusting losses (or lessening the total penalty) based on quality scores are two methods entities might consider for continuing to incentivize quality performance when VBC entities are not projected to meet overall cost targets. See “Spotlight: Creating Targeted Quality Incentives” for an example of how and why VBC participants may want to consider targeted quality performance incentives even when cost targets may not be met.

SPOTLIGHT: Creating Targeted Quality Incentives

Medicare Advantage Star ratings are linked to increased funding for high-performing health plans. The increased funding is used to provide additional benefits and reduce beneficiary cost-sharing. In a VBC payment arrangement, if a VBC entity is forecasting that they will not meet their financial target, health plans still have reasons to incentivize the organization to focus on quality metrics related to Star ratings. By layering additional pay-for-performance incentives for meeting Stars quality metrics on top of a VBC payment arrangement, VBC entities and MA plans can effectively focus resources. These types of pay-for-performance incentives may also be offered more broadly to those network physicians not participating in VBC payment arrangements.



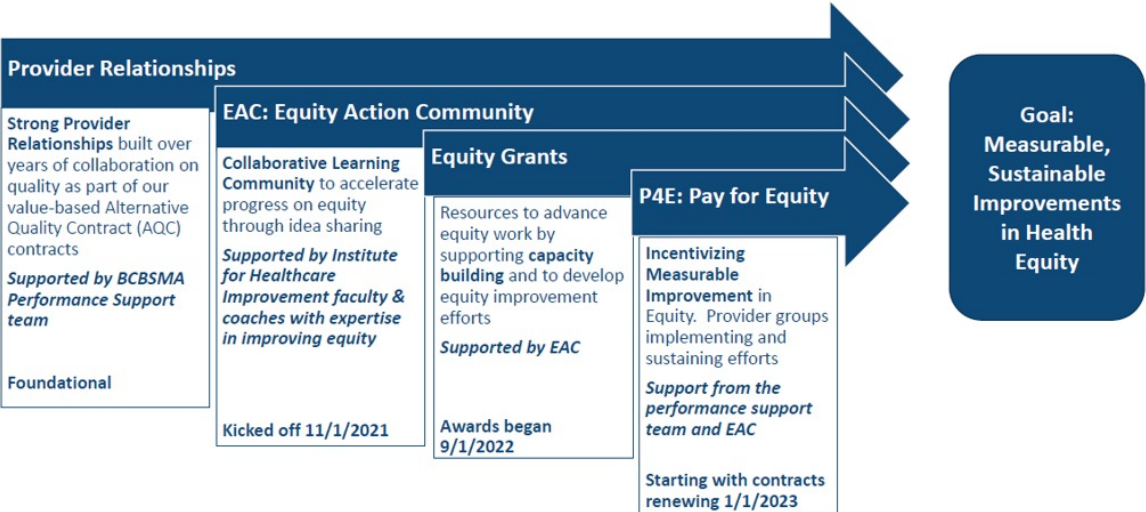
An emerging but important part of integrating quality performance into VBC payment arrangements is the recognition of the additional resources required to improve the quality of care for those populations that are historically marginalized, and a recognition of how HRSNs can affect health and health care outcomes, and thus, performance on quality measures. Some health plans have reported using sociodemographic factors to stratify an attributed population to understand the baseline performance for historically marginalized populations and providing additional credit for quality performance for those entities that treat a higher-than-average share of historically marginalized populations. Demographic and SDOH data can be used to adjust quality measures to ensure providers are not negatively impacted based on the fact that HRSNs may affect patient health and the intensity of care needed.

See “Spotlight: Piloting Approach for Health Equity Incentives” for more on how Blue Cross Blue Shield of Massachusetts is moving from data collection to paying for improvements in health equity as it relates to quality measurement.

SPOTLIGHT: Piloting Approach for Health Equity Incentives



Blue Cross Blue Shield of Massachusetts (BCBSMA) is a nonprofit health plan serving approximately three million patients. As an organization, they have publicly declared racism as a public health crisis and health care as a racial and social justice issue. In 2023, BCBSMA added Pay for Equity incentives to their Alternative Quality Contract (AQC) payment program, their VBC payment arrangement. Before paying for improvement of health disparities on certain quality metrics, they first began a process of building the infrastructure for data collection, physician education, and data sharing.



BCBSMA first created a user-friendly report to share differences in race and ethnicity across certain quality and outcomes measures. Initially, the race and ethnicity data were determined using the Bayesian Improved First Name Surname Geocoding approach,⁶ which imputes race and ethnicity using first name, surname, and geography using a 2010 census reference table. They began sharing these confidential reports annually in the summer of 2021. Each year, BCBSMA has upgraded the accuracy of the underlying race and ethnicity data; in 2023 these reports were based on self-reported data, supplemented by imputed data based on new methods that leverage data from additional sources (e.g., state immunization registry). BCBSMA then asked AQC participant practices to participate in an equity action community (EAC) in the fall of 2021, which provided guidance in topics such as race and ethnicity data standards, data collection methods, and interventions to close measured inequities in care. In recognition of the effort and resources required, BCBSMA offered \$25 million in grants for participating practices in 2022-2024 to cover the costs of participating in the EAC, developing data and equity performance tracking capabilities, and beginning improvement efforts. Only after these steps did BCBSMA kick off its Pay for Equity program in 2023, where it rewards practices for reducing racial and ethnic health disparities on a set of quality metrics.

Implementation

Voluntary best practices for implementation of the quality component into VBC payment arrangements:

- Provide transparent quality measures, methodologies, and performance targets at the start of the performance period and regular feedback on progress towards targets.

Clear and achievable targets help VBC entities improve quality performance. Providing quality measure performance targets at the start of a performance year allows physicians, practices, and VBC entities to best understand what is required to succeed, and how succeeding at quality will impact payment. Establishing quality benchmarks upfront and presenting the data and context for how targets are set helps foster trust in the measurement process and can be an important component for a VBC entity's strategic planning and resource prioritization. Additionally, providing regular feedback on progress towards quality targets throughout the performance period ensures VBC entities are better able to monitor performance throughout the year, make more accurate financial projections, and adjust strategies and resources accordingly.

5. Levels of Financial Risk

While VBC arrangements, by their nature, require participating practices and VBC entities to have some level of accountability for improving the care outcomes and costs of managing their patient populations, there is no single approach to determining if, when, and what level of downside risk is appropriate. Readiness for downside risk often requires experience in VBC and making investments in clinical and administrative staff, tools, and technology to support managing patient care across care settings, and data and analysis to support continuous improvement. Without these capabilities, VBC entities lack the foundation necessary to be accountable for downside risk on the total cost of care of a population. Even without formal downside risk in a payment arrangement, physicians, practices, and VBC entities take a form of risk when making upfront and ongoing investments to make care delivery, financial, and operational transformations, and in some cases may be taking actions that reduce their own fee-for-service revenue at the same time.

Health plans have recognized that participating practices and VBC entities have varying levels of readiness for and ability to take on risk. Factors including the amount of financial reserves, patient panel characteristics, the type of organization, and experience managing total cost of care are often considered in the creation of VBC payment arrangements and the determination of

whether a given physician group or VBC entity should ever be expected to take on downside risk. In some cases, VBC payment arrangements may move towards partial or full risk over time with a corresponding increased opportunity for savings, colloquially referred to as a “glidepath.”

The goal of having a VBC entity take on any level of financial risk is to further align incentives for total cost of care management and improvement of quality and patient outcomes. It is important to balance the level of financial risk against both the goal of driving increased opportunity for participation in VBC and ensuring that VBC entities only take on risk that they are able to effectively manage. VBC payment arrangements with a set of customizable options can meet physicians, practices, and VBC entities at their level of readiness while allowing health plans efficiency of administration.

Voluntary Best Practices at a Glance

The following is a summary of voluntary best practices identified as effective approaches to offering varying levels of financial risk under VBC payment arrangements. Each is discussed in greater detail in the section that follows.

Levels of Financial Risk	Voluntary Best Practices for Consideration:
<p>Structuring levels of risk</p>	<ul style="list-style-type: none"> • Use multi-year arrangements with a glidepath to increasing risk and reward over time based upon a clear long-term strategy. • Allow VBC entities to elect to move back to upside-only arrangements when substantive changes in population or payment arrangement occur. • Evaluate capacity, readiness, and local market dynamics when designing downside risk options.
<p>Accounting for unexpected events, outliers, and random variation</p>	<ul style="list-style-type: none"> • Offer a menu of options for mitigating risk including risk corridors, capping savings and losses, and stop-loss. • Waive downside risk for significant unforeseen events (e.g., global pandemic or the sudden introduction of an extremely high-cost drug or technology).

Challenges

There are challenges with designing VBC payment arrangements that both encourage flexibility across the spectrum of physician’s, practice’s, or VBC entity’s readiness and capacity to take on risk and standardize terms to promote operational efficiency. Even within a single VBC

entity, readiness for risk varies across populations, practice location, and line of business. The capabilities required to manage a population with a high percentage of chronic conditions differ from one with lower acuity but for which there is significant price variation for the same service across physicians or facilities. In the former, a VBC entity must have capabilities for advanced care management while in the latter, referral strategies for high-value specialists and acute care take priority. Importantly, different practices also have varying levels of infrastructure and resources and may require different levels of support, particularly at the outset. Safety-net, rural, and other types of practices that serve historically marginalized patient communities may have a desire to participate in VBC arrangements, but often lack the financial resources and infrastructure required to participate and be successful.

Often, VBC payment arrangements do not deliver success immediately. Some VBC participants engage in VBC for several years before they are able to realize a return on initial capital investments in care transformation.⁷ Health plans, practices, and VBC entities are all invested in seeing care and cost for patients improve, but determining who bears the cost and how much during the initial VBC capacity-building phase is often challenging and will likely need to vary based on the VBC entity and its available resources, amongst other factors.

Exploring Best Practices in Depth

There are multiple ways for VBC participants to set appropriately calibrated levels of risk and allow for risk mitigation through payment arrangement features (e.g., stop-loss or risk corridors). Below are voluntary best practices and key considerations for offering varying levels of risk within VBC payment arrangements.

Structuring levels of risk

Best practices for structuring levels of risk for VBC payment arrangements:

- Use multi-year arrangements with a glidepath to increasing risk and reward over time based upon a clear long-term strategy.
- Allow VBC entities to elect to move back to upside-only arrangements when substantive changes in population or payment arrangement occur.
- Evaluate capacity, readiness, and local market dynamics when designing downside risk options.

The decision of whether to use a VBC payment arrangement with downside risk involves weighing several factors. Understanding local market and participating entity characteristics is important to setting risk expectations based on what is within control of the VBC entity. While the most effective and preferred approaches vary across entities, flexibility is paramount

to ensure that a VBC entity does not take on more risk than it is equipped to manage. One of the most crucial factors is the VBC entity's experience managing total cost of care, and more specifically, managing total cost of care for that patient population or line of business. Different populations may require different capabilities and resources. The type and size of practice or VBC entity also plays a role in its ability to take on risk. Small practices that are not well-capitalized may not be in a strong position to take downside risk but may be successful in downside risk arrangements if provided support from an aggregating organization or provided upfront resources to fund infrastructure investments.

Rural and safety-net physicians and facilities with tight margins and high fixed costs may also not be in a position to take on downside risk. It is important to the success of value-based care that VBC entities that enter into these higher-risk, higher-reward arrangements are prepared to sustain potential losses. Offering additional supports or a glidepath to risk can be effective strategies to gradually build experience and confidence with small, rural, safety-net, and other types of practices that have so far been slower to adopt value-based care payment arrangements, and thus expand value-based care's reach to more patients, including historically marginalized communities who stand to benefit greatly. Additionally, inability to sustain downside risk should not prevent a practice or VBC entity from participating in other VBC payment arrangements that do not require downside financial risk within the terms of the arrangement.

In VBC payment arrangements, downside risk is not always necessary. Offering the ability to earn more of the overall savings and allowing time in one-sided risk can also incentivize VBC entities to take on risk and help them gain confidence in moving to downside risk after they have experience in a payment arrangement and better understand what is required to be successful. The use of customizable risk levels, based on a VBC entity's unique characteristics (such as being a small or independent practice) and local market dynamics (such as being in a rural market or having a high density of uninsured or underinsured patients), has the benefit of allowing VBC entities to take on more manageable levels of risk as they progress along a risk glidepath.

VBC participants may also wish to make the glidepath bidirectional in certain circumstances, i.e., allow VBC entities to move to lower risk or an upside-only arrangement following major changes to the terms of the VBC payment arrangement or when changes occur at the VBC entity. For example, if a large group in the VBC entity's market negotiates an increase in rates or an employer switches insurers for its employees thus changing the demographics and health needs of the population for which the VBC entity is accountable, it may be appropriate to revisit the terms of the VBC payment arrangement, including the level of downside risk.

Accounting for unexpected events, outliers, and random variation

Voluntary best practices to account for unexpected events, outliers, and random variation in a VBC payment arrangement:

- Offer a menu of options for mitigating risk including risk corridors, capping savings and losses, and stop-loss.
- Waive downside risk for significant unforeseen events (e.g., global pandemic or the sudden introduction of an extremely high-cost drug or technology).

In addition to adjusting the maximum percentage of losses for which a VBC entity is responsible, there are several other ways to calibrate the VBC payment arrangement terms to find an appropriate level of risk for the VBC entity.

Risk corridors protect against payment of savings or recoupment of losses due to random variation by statistically determining a minimum value needed to measure a true difference between the benchmark and performance year costs. Otherwise, arrangements can unduly penalize (or reward) VBC entities and participating practices for market dynamics which are out of their control. Based on the size and natural churn of a patient population and the typical variance in costs, risk corridors can vary by line of business and VBC entity. Within a VBC payment arrangement, the risk corridor percentage may also be a customizable term as a way to further mitigate risk. A larger risk corridor means savings and losses must be more significant before any savings or losses are paid.

Another possibility to adjust the level of financial risk is by capping the total amount of savings or losses a VBC entity can receive or pay out. This can be done as a percentage of the benchmark or relative to the size or revenue of the VBC entity or its participating practices. Capping can provide more certainty around the maximum losses a VBC entity could be accountable for and allows the entity to plan for a possible worst-case scenario.

Stop-loss applies to outlier events or costs of individual patients. In certain extreme circumstances, the total cost of care for a patient may substantially exceed typical costs due to catastrophic events. Some VBC entities may prefer to include outlier costs because reducing these catastrophic events or their costs can lead to shared savings. Others prefer to use stop-loss as the costs may be too unpredictable. MSSP is an example of a simple approach to stop-loss. In the MSSP, costs for patients are truncated at the national 99th percentile of cost in each patient enrollment group and all costs above that threshold are excluded from performance year calculations. Importantly, this is done both the expenditures in the baseline years as well as the performance year to ensure a fair comparison. Workgroup members indicated

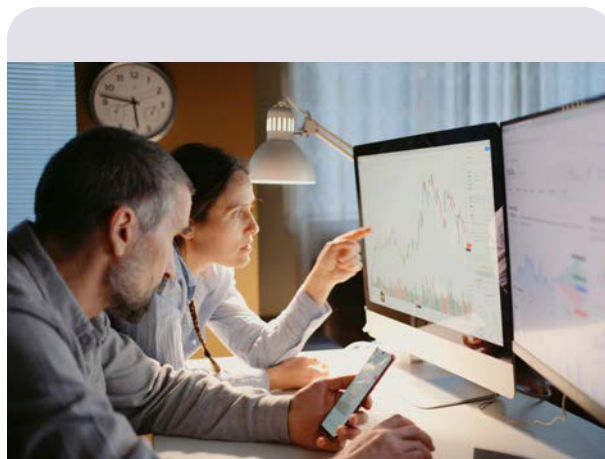
that the simplicity of the methodology as well as making the application of stop-loss optional were preferable approaches to incorporating stop-loss into VBC payment arrangements.

Calibrating risk by using corridors, savings or loss caps, and choosing whether to leverage stop-loss, are ways to tailor the level of risk without making sizable changes to the underlying financial methodology.

Lastly, VBC payment arrangements need to consider the possibility of unforeseen events like a pandemic or the introduction of a new high-cost drug or technology. While the details of the individual circumstance will vary and affect the exact updates or changes to the financial methodology, signaling that there will be an approach to handling such trigger events (e.g., waiving downside risk or adjusting or excluding certain types of expenditures) allows VBC entities to trust that payments will be based on expenditures within their locus of control.

6. Payment Timing & Accuracy

VBC participants have choices when structuring how and when funds flow in VBC payment arrangements. In shared savings arrangements, final calculation of performance and payment of savings or losses typically occurs after the end of the performance period allowing for processing of claims. This is not the only option, however, for type and timing of payment in VBC payment arrangements. In some cases, participating physicians, practices, and VBC entities receive prospective payments before a performance period concludes, which can take many forms.



Balancing Flexibility with Consistency Around Levels of Risk in VBC Payment

Working from a “menu” of options regarding elements of the payment arrangement—especially around the levels of risk—can help simplify the process and balance the need VBC participants have for flexibility with the goal of standardizing to reduce administrative burden. For example, a health plan could establish standards for certain elements of VBC payment arrangements (e.g., patient attribution or quality measure selection), while leaving others customizable within bounds (e.g., level of risk), and other design features entirely optional (e.g., stop-loss).

One common example, capitation payments, are risk-adjusted per patient payments made on a monthly or quarterly basis (or some other regular interval), based on the VBC entity’s historical spend, percent of premium, or some other agreed-upon amount. Capitation payments are typically for more experienced VBC entities and can cover total expenses, or focus on a smaller subset of services, such as primary care spend.

In any case, providing payments earlier in the contract period is important to supporting the care coordination activities and advanced infrastructure that are necessary to improving care and can also help remove barriers for small, rural, safety-net, and other types of under-resourced practices to successfully participate in VBC payment arrangements.

VBC payment arrangements are most effective when VBC payments are provided to VBC entities as close to the behavior change in managing cost and quality as possible, while also attempting to achieve the greatest accuracy possible. Since these are often in direct tension, the tradeoffs are best made when taking into account the needs of the participating physicians, practices, and VBC entities and larger goals of the payment arrangement.

Voluntary Best Practices at a Glance

The following is a summary of voluntary best practices identified as effective approaches to offering varying levels of financial risk under VBC payment arrangements. Each is discussed in greater detail in the section that follows.

Payment Timing and Accuracy	Voluntary Best Practices for Consideration:
Prospective payments	<ul style="list-style-type: none"> • Structure the timing and method of payment to address the specific goals of the payment arrangement and VBC participants. • Include prospective payments especially when entities are new to VBC or face resource challenges. • Adjust payments to account for complexity of the patient population. • Evaluate high-value service areas that may require additional investment when establishing capitation rates.
Reconciliation	<ul style="list-style-type: none"> • Conduct optional preliminary reconciliation. • Share complete data on reconciliation and offer technical assistance. • Provide an appeals process.

Challenges

Waiting until after the performance year to make any VBC-related payment can create a long lag between actions and investments made to improve care and payment related to those improvements. Savings (or losses) are reconciled typically at least six months after the end of a performance year. Delayed payment can be especially challenging for organizations in the initial stages of a VBC payment arrangement as savings may not be realized initially while building infrastructure, increasing capabilities, and hiring staff require upfront funding. Early, regular payments in VBC payment arrangements can help to overcome these hurdles and facilitate more rapid achievement of VBC goals, but there are tradeoffs to take into consideration. Prioritizing early, predictable payment may rely on calculations that require reconciliation later, which increases the unpredictability of VBC participants' financial bottom line, particularly when combined with shared losses that may be owed. Having finely-tuned prospective payment methodologies mitigates the impact of retrospective reconciliation, but with so many variables and unknowns particularly at the start of a payment arrangement, this can be difficult to accomplish.

Exploring Best Practices in Depth

Below are voluntary best practices and key considerations for timely and accurate payment within VBC payment arrangements.

Prospective payments

Best practices for making prospective payments:

- Structure the timing and method of payment to address the specific goals of the payment arrangement and VBC participants.
- Include prospective payments especially when entities are new to VBC or face resource challenges.
- Adjust payments to account for complexity of the patient population.
- Evaluate high-value service areas that may require additional investment when establishing capitation rates.

The approach to prospective payments within a VBC payment arrangement can support different goals for VBC participation. When VBC participants have an ability to select from certain design features of the payment arrangement, they can more effectively structure funds flow to reflect the mutual goals of physicians, practices, VBC entity, and health plan. For more on various types of prospective payments see the "Spotlight: Examples of Prospective Payments."

SPOTLIGHT: Examples of Prospective Payments



Upfront infrastructure investment – For entities newer to VBC payment arrangements who need to build capacity, upfront infrastructure investment (similar to the advance investment payments in the MSSP) or in-kind infrastructure support can mitigate upfront infrastructure costs. Upfront support can make it easier for undercapitalized organizations to make the initial investments in human resources or technology necessary to overcome initial barriers to participation and may be netted out of eventual shared savings.

Care coordination payments - Predictable, monthly or quarterly care coordination fees can help organizations make investments in care managers and other members of the interdisciplinary care teams to provide advanced primary care. Care coordination payments may or may not be included in performance year expenditures.

Capitation – For more experienced VBC entities, fully capitated payments reflect the VBC payment arrangement cost target and allow VBC entities to create innovative payment arrangements with their own downstream partners. Capitation creates an opportunity for physicians, practices, and VBC entities to focus on otherwise non-reimbursable services that lead to better patient outcomes, such as integration of community supports or closer coordination of physical and behavioral health. Partially capitated payments like with primary care capitation can be leveraged within VBC payment arrangements to create stable predictable payments to PCPs that may then be included as performance year expenditures for purposes of determining shared savings or losses in the VBC payment arrangement.

Capitation with reconciliation – Capitation payments of any structure or size can be reconciled with the amount that would have been billed in fee-for-service, with the effect of transforming the capitation payment into an upfront cashflow mechanism with retrospective reconciliation. With this approach, it is the amount that would have been billed in fee-for-service that is used as performance year expenditures for the purposes of calculating any shared savings or losses in the VBC payment arrangement.

Flexible payment options ensure the way funds flow through the VBC payment arrangement best supports the goals of that model of care and meets the needs of the individual practice or VBC entity. See “Spotlight: Prepayment to Enter and Sustain VBC Participation” for more on how early ongoing payments can help support population health management infrastructure in VBC arrangements.

SPOTLIGHT: Prepayment to Enter and Sustain VBC Participation

For independent physician Dr. Karen Smith, serving patients in private practice in North Carolina, upfront funding was incredibly important to building her population health infrastructure and practice transformation. In 2021, she began contracting value-based payment with Carolina Complete Health as part of a pilot for a segment of her patient population eligible for Medicaid. Carolina Complete Health is a physician-led health plan established as a joint venture between North Carolina Medical Society and Centene Corporation working in conjunction with the North Carolina Community Health Center Association.



As North Carolina moved into managed Medicaid, Carolina Complete Health created a pilot grant program to support practices in developing the capabilities for Tier III Advanced Medical Homes that would be a goal of North Carolina's Medicaid Transformation. The focus of the pilot was to assess population health capabilities and develop initiatives addressing quality measure goals where the practice was underperforming in comparison to peer practices in the region.

Based on review of clinical data, blood pressure control was identified as the focus for Dr. Smith's practice. The upfront payments allowed them to hire an RN care coordinator and designate a portion of time from a population health administrator to interface with patients around social drivers of health such as transportation, enhanced health literacy, appropriate ER utilization, comprehensive advanced care planning, and several other areas which proved to be barriers toward achieving high quality, lower cost care. Dr. Smith's practice also invested in population health software and immunization services. Prior to this payment arrangement that provided upfront payment, the cost to invest in added staff and infrastructure and delayed payment reconciliation were barriers to enter VBC payment arrangements. Now Dr. Smith's practice is in the third year of VBC arrangements with multiple payers and her practice has realized shared savings in the first two years. These savings have been used to support the continued infrastructure and salary costs of the RN care coordinator and allowed her practice to satisfy requirements for advanced medical home status in North Carolina and deliver improved outcomes for patients.

When making prospective payments, even for a small care coordination fee, it may be beneficial to consider the increased time and resources required for managing patients with complex conditions or social needs. Risk adjusting payments, including prospective payments, in some form to address the level of patient complexity ensures that physicians, practices, and VBC entities are not disincentivized to care for patients with greater needs.

Similarly, when building a capitation methodology, it is important to consider whether historical spending reflects appropriate payment for the needed services to care for the attributed

population. For example, a primary care capitation rate that is based solely on prior experience may be insufficient to encourage improved access for historically marginalized populations or appropriate utilization of primary care services. Adjusting supplemental payments upward may empower practices to expand access and drive utilization of high-value services in the short-term to deliver improvements in overall outcomes and reduce the total cost of care in the longer term.

Reconciliation

Voluntary best practices for reconciling VBC payments arrangements:

- Conduct optional preliminary reconciliation.
- Share complete data on reconciliation and offer technical assistance.
- Provide an appeals process.

Final reconciliation of TCOC VBC payments typically occurs at least six months after the end of a performance year to allow ample time for claims to be submitted and paid and for the full expenditures of the performance year to be accurately accounted. If shared savings during final reconciliation is the only form of payment in a VBC payment arrangement, it can be a hinderance to participation given investments made in the people, processes, and technology to support VBC. One potential way to address this lag is to offer preliminary reconciliation in advance of the final payment, including prepayment if savings are projected. The purpose of preliminary reconciliation is to provide an avenue for cash flow and to be able to compensate participating physicians and practices in closer proximity to their care improvement activities. This could be done closer to the end of the performance year using a claims completion factor to estimate the additional costs of claims incurred but not yet reported. Alternatively, six months of claims data could be annualized and used to perform preliminary reconciliation approximately nine months after the start of the performance year. However, the earlier preliminary reconciliation is performed, the less accurate it is likely to be which will require further true-up during a final reconciliation. “See Spotlight: Preliminary Reconciliation” for an example of the ACO REACH Model offers participants the option for provisional settlement.

With all payment and reconciliation, it is important for health plans to provide information to VBC entities and participating practices to validate calculations were performed as agreed to in the VBC payment arrangement. Technical assistance to participating VBC entities to better understand financial reporting and calculations also offers value. This type of transparency is helpful for sustaining multi-year VBC payment arrangements by establishing trust in the data and the working relationship between health plan and VBC entity. Providing a formal appeals process to challenge calculations that may be in error is also an important way to ensure calculations are accurate, maintain credibility in the process, and promote continued participation in VBC payment arrangements.

SPOTLIGHT: Preliminary Reconciliation



The CMS ACO Realizing Equity, Access, and Community Health (REACH) Model, a traditional Medicare VBC payment arrangement, offers VBC entities the option for a “provisional” financial settlement. To allow for sufficient runout of claims, quality performance calculations, and final risk scores, CMS typically issues final settlement reports to participants in late summer following a calendar year performance year, but under provisional settlement, CMS provides a provisional financial settlement report to the VBC entity by late February, as shown in the table below.⁸ This optional feature of the ACO REACH Model, helps mitigate some of the cashflow challenges VBC entities or participating physicians may experience when waiting six months or more following a performance year to see financial returns on investments they made much earlier.

Settlement Details	Provisional Financial Settlement	Final Financial Settlement
Date for Settlement	February 28 of the calendar year following the performance year	July/August of the calendar year following the performance year
Claims Included in Settlement	Performance Year Expenditure incurred through December 31	Performance Year Expenditure incurred through December 31
Claim Run-out	Through December 31 of the performance year	Through March 31 of the calendar year following the performance year
Risk Scores	Interim risk scores for January through December	Final risk scores

7. Incentivizing for VBC Practice Participant Performance

VBC is a “team sport” that can benefit from engagement at all levels of a VBC entity. Each participant has a different role to play, whether in providing enhanced care management, or helping to connect patients to community-based services. When thinking about VBC payment arrangements, it is important to consider if and how each individual participant will be engaged to cascade the goals, objectives, and advantages of the VBC payment arrangement to maximize the potential for success. Up to this point, the playbook has focused on the elements of VBC payment arrangements between the health plan and the participating practice or VBC entity assuming accountability for the total cost of care. In this section, the focus is on considerations for achieving the goals of the VBC payment arrangement through engagement of individual physicians and care teams using education, communication, and incentives.

Knowledge and incentives can be impactful tools in encouraging the care delivery transformation necessary to achieve the goals of VBC arrangements. Financial incentives alone are not sufficient. Moreover, non-financial incentives including access to pertinent and timely data, reducing administrative burden (e.g., prior authorization requirements), and increasing transparency around performance metrics are all critically important to incentivizing broad participation and achieving the goals of the VBC payment arrangement.

Today, the amount of education and information that physicians and other health professionals receive about the intricacies of the VBC payment arrangement in which they participate and their role within them varies. This variation can occur both across and within VBC entities and may be due to the way the VBC entity communicates with and incentivizes individual physicians and other health professionals for their participation. To the extent that individual physicians and other health professionals are unaware of the goals and incentives of a VBC payment arrangement, this could diminish its ultimate success.

The structure and goals of the VBC entity can shape information flow and how any financial benefits achieved by the VBC entity may be distributed. While some VBC entities limit savings distribution to only those practices that contribute to patient attribution, which are often primary care, others include additional non-primary care specialists, other health professionals, and community-based organizations (CBOs). Clinically integrated networks (CINs), or other similarly structured entities, may have different approaches for employed versus affiliated physicians. VBC aggregator entities that enter into VBC payment arrangements may also choose to partially insulate practice participants from downside risk, and compensate them using a different financial incentive model, for example by paying directly for activities that drive value.

The most effective design of participant incentives in VBC payment arrangements is still evolving, including determining whether and at which level to apply them. When well-designed, financial and non-financial incentives can more fully engage physicians, other health professionals, and additional individuals contributing to the ultimate success of the VBC payment arrangement. Well-designed incentives must be significant and predictable enough to drive behavior change but also simple to understand, achievable, and connected to the actions within a VBC practice participant's ability to control.

Voluntary Best Practices at a Glance

The following is a summary of voluntary best practices identified as effective approaches to offering varying levels of financial risk under VBC payment arrangements. Each is discussed in greater detail in the section that follows.

Incentives for VBC Practice Participant Performance	Voluntary Best Practices for Consideration:
<p>Education and communication related to incentivizing VBC participant performance</p>	<ul style="list-style-type: none"> • Provide education on VBC payment arrangement goals. • Develop clear, objective criteria for distributing incentives among participants appropriately focused on pursuing goals of value-based care. • Provide feedback at least quarterly on performance related to incentives. • Combine incentives across health plans and LOBs.
<p>Structuring VBC practice participant incentives</p>	<ul style="list-style-type: none"> • Use a combination of factors (e.g., panel size and outcomes measures) that are determined in advance of the performance period when allocating practice participant incentives. • Where appropriate, calculate incentives at the Taxpayer Identification Number (TIN) level and allow practice participants to determine how to share internally including with office staff.

Challenges

In addition to their own fixed costs and anticipated care management responsibilities, VBC entities must also consider how to most efficiently tailor incentives to encourage participation amongst a range of downstream participants. Effectively delivering value-based care requires engagement from many parts of the health care delivery and administrative team (e.g., medical assistants, front desk staff, etc.) and it is often difficult to identify the most effective way to educate all involved staff on the VBC payment arrangement goals without overburdening them and to appropriately align incentives across all individuals contributing to the success of the VBC payment arrangement. It can also be challenging to find the right balance between involving practice participants, including individual physicians, in manageable amounts of financial risk while creating sufficient incentives to drive the behaviors and outcomes that all parties want to see in value-based care.

Meanwhile, participating practices, physicians, and other health professionals find themselves in increasingly competitive environments where they can choose to align with an ever-expanding list of VBC entities, which can be mutually exclusive depending on the rules of each payment arrangement. To make an informed choice, practice participants may need to perform financial modeling and understand the investments in infrastructure and staff that will be needed to be successful, as well as their own share of any risk. At the same time, physicians, practices, and other health professionals are overburdened and understaffed following the pandemic – and do not always possess the resources required to navigate the complexity of the choices they face.

The majority of health care revenue is still largely driven by fee-for-service payment, and most physician compensation models are tied to service-based utilization and other metrics that drive that revenue. To change practice behavior, education around VBC payment arrangement goals as well as changes to physician compensation must be meaningful enough to counteract current incentives to make up for potential lost revenue due to service-based reductions and from enhanced care management responsibilities.

Exploring Best Practices in Depth

Below are voluntary best practices and key considerations for VBC entities to effectively engage VBC practice participants within VBC payment arrangements.

Education and communication related to incentivizing VBC participant performance

Best practices for implementation of VBC practice participant incentives:

- Provide education on VBC payment arrangement goals.
- Develop clear, objective criteria for distributing incentives among participants appropriately focused on pursuing goals of value-based care.
- Provide feedback at least quarterly on performance related to incentives.
- Combine incentives across health plans and LOBs.

If physicians, other health professionals, and practice participants do not understand the goals of the VBC payment arrangement, they are unlikely to be as effective in making the changes needed to deliver better quality and cost. For this reason, targeted practice participant education on the overarching VBC payment arrangement goals, how they themselves will be contributing (including any enhanced care management or data reporting responsibilities), and a clear breakdown of how any incentives are tied to those activities or

goals, is essential. This can be done through site visits, practice manager educational sessions, webinars, or virtual office hours. Regardless of the approach, devoting resources to participant education efforts is important to achieving care transformation and meeting program goals. See “Spotlight: Physician Education on VBC Payment Incentives” for an approach to physician education on payments for quality gap closure at Virginia Mason Franciscan Health.

SPOTLIGHT: Physician Education on VBC Payment Incentives

Virginia Mason Franciscan Health is a leading health system in Washington state with nearly 5,000 employed physicians and affiliated providers delivering medical care through ten hospitals and close to 300 care sites throughout the Puget Sound region.



At Virginia Mason Franciscan Health, physicians are educated on the organization’s VBC payment arrangements with health plans including expected quality activities and the reasons behind them. To align physician incentives with VBC goals, physicians receive payment for completing a quality-based attestation form and a percentage of compensation is also tied to quality performance and access initiatives. Dr. Francis Mercado, Ambulatory Associate Chief Medical Officer of Medical Specialties at Franciscan Medical Group, emphasizes that tying the broader VBC payment arrangement terms to specific physician and care team activities helps highlight the importance of delivering high quality care and patient experience and gives physicians clarity about what they need to do to receive payment and support the organization’s VBC efforts.

In addition to education, timely feedback (at least quarterly) in the form of actionable reports and dashboards containing data on performance (for the VBC entity, individual physicians, and practice participants) is critical to sustaining engagement and allows individual team members to monitor progress towards both individual and collective goals and deploy changes, as necessary. For more on voluntary best practices related to data sharing in VBC arrangements, please see our [data sharing playbook](#).

Finally, VBC payment arrangements can be complex with a range of metrics measured at aggregate levels, so it is often most effective when physicians and practice participants are given a manageable set of metrics and goals on which to focus, rather than potentially having dozens of unique metrics and varying incentives for each VBC payment arrangement. Having the VBC entity standardize performance metrics and corresponding incentives across VBC payment arrangements, can create easier to understand, and more consistent goals to drive performance and can provide greater reliability in assessing performance by increasing the

number of patients included in the calculations. See “Spotlight: Aligning Physician VBC Incentives across Health Plans and Lines of Business” for an example of how Mount Sinai Health System, a large integrated delivery system with multiple VBC payment arrangements, created a unified scorecard and physician VBC incentive program.

SPOTLIGHT: Aligning Physician VBC Incentives Across Health Plans and Lines of Business

Mount Sinai Health System is an integrated delivery system made up of eight hospitals and over 400 ambulatory practices located across all five boroughs of New York, Long Island, and Westchester. Mount Sinai operates a clinically integrated network (CIN), “Mount Sinai Health Partners” composed of employed physicians as well as independent practices. Mount Sinai participates in VBC payment arrangements with multiple health plans across Medicare Advantage, traditional Medicare, commercial, and Medicaid lines of business. Mount Sinai’s physician incentive program aggregates performance across lines of business. The program has four domains: Quality – a mixture of process and outcomes measures (40%), Cost – emergency department, inpatient, and total cost of care metrics (30%), Accurate Coding and Documentation (20%), and Patient Satisfaction (10%). Physicians receive a score based on performance under these domains which determines their additional compensation for VBC participation. Aligning across all lines of business makes it easier for physicians and practices to focus on the targeted set of measures rather than getting a separate set of measures and performance rates for each VBC payment arrangement.



Structuring VBC practice participant incentives

Voluntary best practices for structuring VBC practice participant incentives:

- Use a combination of factors (e.g., panel size and outcomes measures) that are determined in advance of the performance period when allocating practice participant incentives.
- Where appropriate, calculate incentives at the TIN level and allow practice participants to determine how to share internally including with office staff.

Savings and losses in VBC payment arrangements are typically determined at the VBC entity level. To drive success in VBC payment arrangements, when a VBC entity performs well in a payment arrangement and receives payment, downstream practice participants may receive a portion of

those savings. However, financial methodologies do not easily account for the varying contributions of each individual physician or practice participant. There are a multitude of factors VBC entities may consider when determining how to most effectively allocate shared savings across individual participating practices, or other downstream entities including the role within the VBC entity and its larger goals, the physician specialty, proportion of attributed patients, and cost and quality outcomes.

For example, a TCOC arrangement (that is based around primary care with additional consultation from other non-primary care specialists) may reward primary care practices with a larger amount of the shared savings as they play a central care coordination role, and partnering non-primary care specialty practices a smaller portion of shared savings. Alternatively, they could pay a flat rate for other specialty consultations, or a combination. Similarly, VBC entities may choose to pay CBOs in a different way than practice participants, such as a flat monthly rate plus a per-patient fee for services rendered.

Using only panel size or number of attributed patients does not account for variance in practice participant performance and contribution towards the overall performance of the VBC entity in the payment arrangement. To avoid this, the voluntary best practice suggests a combination of process and outcome metrics in conjunction with panel size to determine the amount of shared savings a practice participant receives.

If VBC entities attempt to drive performance by incentivizing individual physicians, they may encounter challenges due to small patient panel size and difficulties attributing patients and performance to a single physician. Depending on the structure of the VBC entity and its participating physicians and practices, it is often more effective and accurate for VBC entities to distribute incentives at the TIN or practice level and allow those organizations flexibility around how to use those funds including compensation to other clinical and administrative staff who have contributed to care management and improvement activities in the VBC payment arrangement. Using this approach still requires that the VBC entity create a methodology for distributing savings or incentive payments across its participants but reduces some of the challenges of individual physician incentives, allowing each VBC participant practice to distribute incentives in the most efficient manner according to its own unique structure, while promoting team-based care.

Additionally, arrangements must comply with relevant laws and regulations including the Physician Self-Referral (“Stark”) Law and Anti-Kickback Statute (AKS) and include training and education for practice participants, so they are able to understand how to operate effectively within the boundaries of these laws. Arrangements should be agreed upon with each downstream partner in advance to ensure not only that expectations are clear and awarded based on predefined, objective criteria, but also that the incentive structure operates as intended.

Additional Considerations

Multi-payer Alignment

It is generally acknowledged that participating practices and VBC entities can be better incentivized to implement changes in care management and clinical workflows, invest in necessary infrastructure, and deploy population health interventions at scale when VBC payment arrangements are aligned both within and across health plans. VBC payment arrangements for a single patient population, or in one line of business (e.g., only for traditional Medicare), may not provide sufficient incentive or resources to invest in the people, processes, infrastructure, and other changes needed. Ranges of VBC payment arrangements and programs, each with varying performance metrics, goals, and payment methodologies increase the administrative burden of administering and participating in multiple VBC arrangements. It can make participation especially difficult for small, independent, rural, and safety-net practices lacking the infrastructure, bandwidth, and other necessary resources, which has likely contributed to slower adoption of VBC by these types of practices. CMS has introduced a number of multi-payer models specifically aimed at aligning VBC payment arrangements for these types of entities like the series of primary care medical home models including the recently introduced Making Care Primary Model targeting smaller independent primary care practices and the Pennsylvania Rural Health Model testing whether hospital global budgets across payers could improve access to care for rural Pennsylvanians.

There is a tension, however, between having elements of payment arrangements standardized enough to align incentives across patient populations and reduce administrative burden for all involved, while at the same time incorporating the flexibility needed to account for ability to take risk, varying patient demographics, and other unique participant characteristics. For example, lines of business can have different rates of turnover among enrolled patients and different population characteristics (e.g., unmet social needs, disabilities, ages) which can necessitate appropriate variation in VBC payment arrangement design. Regulatory and



programmatic requirements can prevent large multi-payer VBC payment arrangements from emerging. The design of the MA program results in many VBC payment arrangements using a percent of premium target and a quality component based on Stars metrics. Commercial products do not use Stars metrics and many commercial health plans function as third-party administrators for large employers who self-insure, where percent of premium is not as applicable, making it difficult for commercial and MA payment arrangements to align benchmarking and quality measures. This is compounded by the fact that the specifics of private payer VBC payment arrangements are often not public (due to antitrust laws and the protection of proprietary business information), further limiting the ability to align on specific payment methodologies.

While achieving total alignment across plans can be challenging given these current barriers, certain aspects of payment, including risk adjustment and attribution, hold promise as areas for potential alignment. For example, the use of HCCs in all traditional Medicare and MA VBC payment arrangements has led to increased understanding by physicians and a willingness to invest in tools and enabling technology that make clinical documentation easier. Within patient attribution, alignment around clinician eligibility for patient attribution could offer physicians more assurance of when patients would be attributed even as they switch between health plans.

Aligning certain elements of VBC payment arrangements within health plans that contract across multiple lines of business is also considered an area that may be within reach. Reconciliation timelines, agreeing to report and share data on financial performance throughout the year, and general approaches to integrating payment for quality performance (e.g., using a sliding scale to adjust savings) could be explored as ways to improve efficiency while allowing for the necessary differences between patient populations and unique product features.

Altering existing approaches to VBC payment arrangements requires large investments from health plans, participating practices, and VBC entities to devise new contracts and reconfigure data and payment systems. Therefore, alignment must be approached thoughtfully, prioritizing areas that are most feasible (both legally and operationally) and that will lead to the greatest improvements in care.

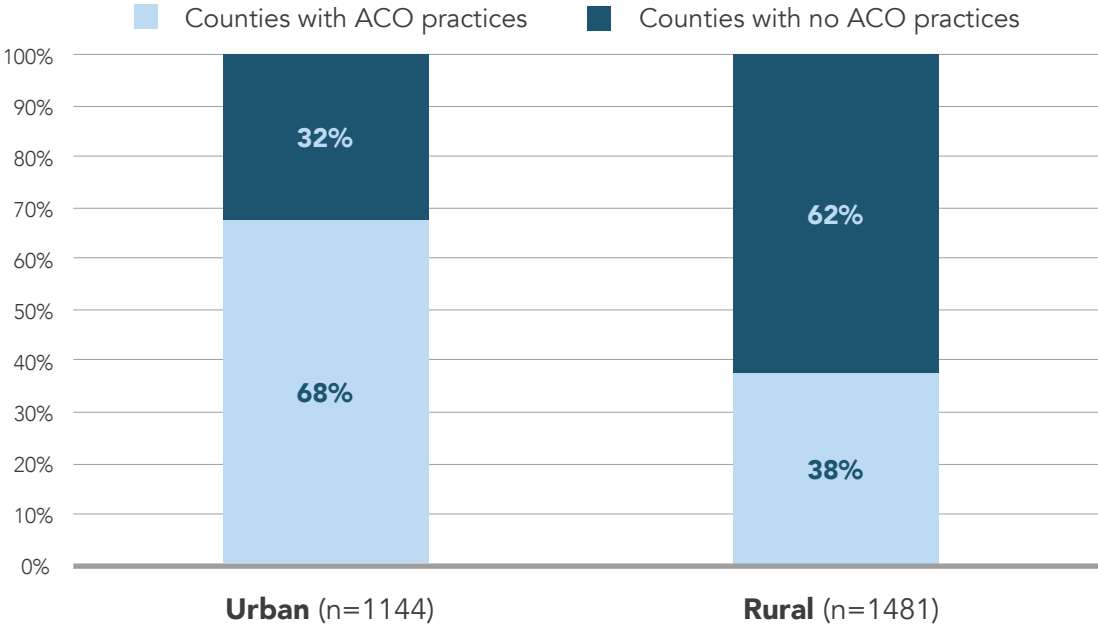
Rural Health

VBC payment arrangements have been somewhat slower to spread in rural areas of the United States due to unique elements of these local markets. Rural health care organizations typically have smaller margins and higher relative fixed costs than their urban counterparts, making it more difficult to invest in the necessary tools and resources for managing total cost

ADDITIONAL CONSIDERATIONS

of care. When combined with staffing challenges, it can be difficult to take on financial risk or participate in VBC payment arrangements that require additional administrative or logistical capacity. VBC payment arrangement operations usually involve time and resources for program compliance, quality improvement and reporting, and clinical documentation in addition to other care transformation activities intended to improve patient outcomes and lower costs. Rural areas often experience more physician shortages, particularly in certain non-primary care specialties, presenting unique challenges when it comes to building integrated networks of care, particularly when payment arrangements have exclusivity requirements.

Financial methodologies in VBC payment arrangements also may not have been designed with rural health care delivery in mind. Basic requirements around minimum patient counts, risk adjustment, or the levels of financial risk may keep rural health organizations from participating. Smaller patient populations create more inherent cost volatility, making it more challenging to take on financial risk. More complex elements, like the trend methodology can also pose a barrier. For example, if trends are calculated on local geography, there is a high chance the participating rural entity is a significant contributor to any trend factor, thus potentially creating a financial target that may not be meaningful. All of these factors likely contribute to the lower percentage of VBC entities in rural areas. The chart below is from a National Rural Health Association Policy brief in February of 2023 noting that 62% of rural counties had no Medicare ACO penetration compared to 32% of urban counties.⁹



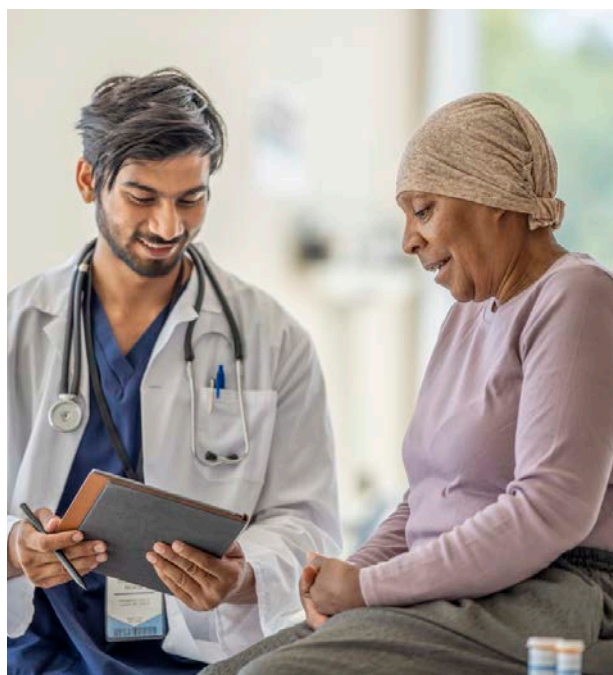
Some VBC payment arrangements have found a way to provide rural health care organizations with the types of dedicated support and design flexibilities they have needed to be innovative and participate in VBC while continuing to meet the needs of their patients. VBC payment arrangements that provide dedicated financial support and incentives for the use of interdisciplinary care teams, community health workers, and CBOs to address SDOH, or infrastructure payments and technical assistance particularly at the start of VBC payment arrangements can combat issues with staffing shortages and access to capital. If an arrangement requires investments in people and technology for data analysis, quality reporting, or care management, upfront payment can eliminate some of the barriers to entry. Flexibility in the amount of financial risk can also create pathways for more rural physicians, practices, and organizations to participate. Accounting for specific aspects of rural health needs in dedicated payment methodologies, as opposed to making modest adjustments to more generally applied methodologies, can help to proactively take into account the right geographic adjustment factors, issues with trend, and smaller reference populations, to help set realistic expectations around benchmarks. For value-based care to be successful across rural America entities will need to find approaches that include a focus on long-term investment in these communities to deliver care focused on sustainable population health.

Health Equity

To improve health care in America, health plans, physicians, practices, VBC entities, and other health care organizations are increasingly acknowledging the importance of eliminating health disparities to improve population health. Health equity is also emerging as a top public health policy priority. In October 2023, CMS leaders published an article in JAMA to articulate the CMS Strategy for Rewarding Excellence for Underserved Populations (REUP).¹⁰ The article noted approaches already being tested. The ACO REACH Model and MSSP adjust benchmarking and quality performance scores respectively by leveraging the Area Deprivation Index (ADI), Low Income Subsidy (LIS), and dual eligibility status, to encourage VBC participating practices and VBC entities to provide care to historically marginalized populations. CMS has also created a health equity index (HEI) effective for 2027 Medicare Advantage Star Ratings that is intended to boost Star ratings for plans that perform well on select quality measures for certain vulnerable populations. In the Calendar Year 2024 Medicare Physician Fee Schedule, CMS finalized proposals to pay for SDOH risk assessments as part of Annual Wellness Visits as well as new care management codes focused on community health integration services to address unmet social needs.¹¹ Health plans are actively exploring ways to address health disparities and integrate health equity into VBC payment arrangements.

Similar to CMS, they are early in their efforts. The 2023 LAN survey indicated 44% of responding health plans are incenting health equity data collection within VBC payment arrangements,¹² a first step before integrating this information into risk adjustment, quality measurement, and other aspects of the financial methodology.

Several earlier sections of this playbook include voluntary best practices for VBC payment arrangements to help eliminate health disparities and avoid contributing to worsening disparities. The discussions reflect limitations of current approaches and the importance of avoiding unintended consequences such as challenges with tools like the ADI being tested by CMS to adjust quality scores in MSSP and the financial benchmark in ACO REACH. The



ADI includes variables like real estate prices and home value, which may under-identify disparities and poor health outcomes that exist for certain populations living in high-cost urban centers. Another challenge to advancing health equity is the wide variation in approaches to collecting data, measuring disparities, and reporting on the health equity of populations – alignment across these areas could advance health equity across various industries.¹³

Before integrating health equity data into aspects of a VBC payment methodology like risk adjustment or benchmarking, there are a number of important pre-steps, including physician education, piloting, evaluation, and recognition of the additional resources this type of training, outreach, and data collection require of VBC entities, physicians, and participating practices, all of which will take time. For this reason, initial reported approaches by health plans have largely focused on payment for data collection and more targeted interventions to address specific HRSNs. This approach promotes building the capabilities for more targeted measurement and iterating on the right models for adjustment while not waiting to address known deficiencies in the resourcing needed to improve health disparities and patient outcomes.

VBC arrangements can support these efforts by creating dedicated funding streams for the infrastructure, education, and investment needed for robust and complete HRSN data

collection and coordination with CBOs to provide services that focus on addressing known disparities while more advanced tools and methodological adjustments are in development. Focusing funds on more targeted initiatives can sometimes prove more effective than spreading limited funding across broad populations, diluting the effect. [“Spotlight: Piloting Approach for Health Equity Incentives” on page 46](#) provides an example of a multi-step process for working toward gradually tying payment to health equity-specific objectives.

While VBC payment arrangements offer one important path to addressing chronic underinvestment in historically marginalized communities, eliminating health disparities will require a collaborative, multi-faceted industry approach. Health plans, physicians, practices, VBC entities, and other health care organizations must focus resources on training, education and infrastructure including coordination with CBOs and other service providers that respond to HRSNs. Communities must ensure that CBOs themselves are sufficiently funded and have the capacity to serve the needs of their local populations. Technology companies must ensure that racial bias is not unintentionally included in their risk forecasting algorithms. While not in scope for this playbook, it is important to acknowledge that addressing health disparities goes well beyond incentives and adjustments within VBC payment arrangements.

Conclusion

VBC payment arrangement adoption has grown considerably over the past decade despite anticipated challenges associated with such a notable change in payment strategy, as well as unexpected events, like a prolonged pandemic. Over this time, the early and middle adopters of VBC payment arrangements have learned many valuable lessons in terms of what works well, and what would benefit from further experimentation and testing (e.g., health equity adjustments in payment methodologies). One clear lesson was that while there is potential for alignment and best practices for voluntary adoption across several areas that could promote economies of scale and reduce administrative burden, flexibility is equally necessary to attract a wide range of participating practices, physicians, health plans, and patient populations and create a sustainable path forward for value-based care. Alignment does not mean uniformity. Experience from our workgroup participants from across the industry reinforces that achieving this delicate balance between what can be aligned and where to be flexible is best supported by shared learning, flexible features, and clear communication and shared expectations. When VBC payment arrangements have been designed in collaboration with all participating, and health plans, VBC entities, and physicians understand each other's goals and operational considerations, it is more likely for the arrangement to be sustainable and successful for all parties.

As was the case in the first phase of the Future of Value initiative (see the [playbook on Voluntary Best Practices to Advance Data Sharing](#)), while lessons have indeed been learned through this collaborative effort, it is also inherently hindered by the models and concepts that have been tested to date, leaving several areas standing out as ripe for continued experimentation and improvement. For example, for the most part, benchmarks in TCOC VBC payment arrangements have been tied to historical costs. This works well if historical costs reflect necessary and sufficient access and appropriate utilization, but more and more we are learning about the structural inequities that may underrepresent the care needed for historically marginalized populations. Moving to evidence-based cost targets is called out as a concept that is daunting, but a worthy endeavor that warrants further exploration. Secondly, approaches to incorporating health equity into payment, quality, or risk adjustment are relatively nascent and there will continue to be lessons learned. Third, risk adjustment models today largely depend on clinical documentation that can require substantial resources from VBC participants. Identifying methods to ensure that payment reflects the illness burden of a population while requiring fewer resources, could support progress toward VBC goals. Finally, more discovery and research is needed to help understand what incentive frameworks

CONCLUSION

effectively and efficiently engage all key partners, including primary care physicians, non-primary care specialty physicians, acute care providers, and community support partners to work collaboratively at achieving the quadruple aim—better quality care, lower cost, and higher patient and physician satisfaction.

AHIP, AMA, and NAACOS hope this discussion of voluntary best practices adds meaningful insights to start and sustain VBC payment arrangements and that physicians, VBC entities, health plans, employers and purchasers can make use of these practical examples and considerations to accelerate and spread VBC—whether in TCOC arrangements or VBC payment more broadly while continuing to experiment, innovate, and improve.

Appendix

Definitions

Accountable Care: A person-centered care team takes responsibility for improving quality of care, care coordination, and health outcomes for a defined group of individuals, to reduce care fragmentation and avoid unnecessary costs for individuals and the health system.

Attribution: The process by which patients and their associated medical costs are assigned to a physician or entity.

Baseline period: The time period during which data on expenditures is collected for the purpose of creating a benchmark.

Benchmark: The financial target in a VBC payment arrangement with which performance year expenditures are compared.

Capitation: A fixed sum of money, per patient per period of time, for providing services.

Community-Based Organizations (CBOs): public or private not-for-profit resource hubs that provide specific services to the community or targeted population within the community. CBOs include but are not limited to aging and disability networks, home visiting programs, homeless services providers, and food banks that work to address the health and social needs of populations.

Health equity: "Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."¹⁴

Health-Related Social Needs (HRSN): include the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. Examples include housing instability, housing quality, food insecurity, employment, personal safety, and lack of transportation and affordable utilities.

Line of Business (LOB): A category of health insurance which includes commercial (employer sponsored and individual exchanges), Medicare Advantage, traditional Medicare, and Medicaid.

Percent of Premium Target (sometimes referred to as a minimum loss ratio or MLR target): An arrangement where the VBC entity's benchmark is set relative to the agreed upon premium between the health plan and the employer or government payer (depending on the line of business).

Risk adjustment: A statistical method that converts the health status of a person into a relative number.

Safety-net provider: Individuals or organizations that deliver a significant level of health care and other needed services to uninsured, Medicaid, and other vulnerable patients.

Social Determinants of Health (SDOH): The conditions in which people are born, grow, work, live, and age that are shaped by wealth distribution, power, and resources, and are impacted by factors such as institutional bias, discrimination, and racism. These are often associated with health-related social needs (HRSNs).

Total Cost of Care (TCOC) arrangement: refers to a contract, often between 3 and 5 years in length, between a health plan and a VBC entity where the VBC entity takes responsibility for the total cost and quality of care for an attributed patient population that is calculated for a defined performance period, usually one year, and in exchange can receive or retain a portion of achieved savings or pay back any losses based on predetermined spending and quality targets or benchmarks.

VBC payment arrangement: refers to the contracted terms between a health plan and VBC entity and/or participating practice(s) that links payment to performance on cost, quality, patient experience, or other defined metrics to encourage delivery changes that are expected to result in better patient outcomes, greater patient experiences, and/or cost efficiency. Payment to participating VBC entities and/or participating practice(s) is increased when quality of care increases and/or costs decrease, while payment is reduced when quality of care decreases and/or costs increase.

VBC entity: An organization that may be composed of clinician groups, hospitals, service organizations, or health systems that collectively take accountability for a population's quality of care and spending such as, but not limited to, an Accountable Care Organization (ACO). Such entities can leverage in-house resources or partner with third party organizations that provide clinical care teams with the tools and technology to participate in VBC arrangements.

VBC participants: The individuals and organizations, including health plans, participating practices, and VBC entities, which work together under a contractual arrangement to tie payment to patient outcomes.

VBC participating practices: The physicians and other members of the clinical team, such as physician assistants or social workers, responsible for providing care to patients in addition to the individuals supporting the administrative operations of a medical practice, which in some instances include VBC performance improvement and financial benchmarking functions.

Common Risk Adjustment Models

<i>Model</i>	<i>Methodology At-a-glance</i>	<i>Popular Uses</i>
CMS Hierarchical Condition Category (CMS-HCC)¹⁵	<ul style="list-style-type: none"> Prospective model that uses current-year (base year) to predict future (next year's) costs. Combines demographic risk score (age, gender, place of residence (community or SNF) and Medicare and/or Medicaid enrollment) with diagnosis-based risk score using HCCs mapped to ICD-10 codes to create a Risk Adjustment Factor (RAF) score. Does not factor in drug costs. Integrates with many software solutions/ Electronic Health Records 	Used by CMS to calculate payment rates for Medicare Advantage; primarily used in Medicare Advantage plans and traditional Medicare ACOs.
HHS Hierarchical Conditional Category (HHS-HCC)¹⁶	<ul style="list-style-type: none"> Concurrent model that uses current-year diagnoses to predict costs for current year. Combines demographic risk score (age, gender, place of residence (community or SNF) and Medicare and/or Medicaid enrollment) with diagnosis-based risk score using HCCs mapped to ICD-10 codes to create a Risk Adjustment Factor (RAF) score. Diagnosis list covers a wider population than CMS-HCCs including categories for infants, children and obstetrics. Factors in drug costs 	Primarily used by CMS to pay commercial payers on ACA marketplace. Used by all states except Massachusetts.

Model	Methodology At-a-glance	Popular Uses
<p>Milliman Advanced Risk Adjusters (MARA)¹⁷</p>	<ul style="list-style-type: none"> Options for concurrent and prospective models Used to develop more granular risk scores and customize to unique populations. Accounts for medical and social conditions that influence risk. Scores explain risk by various health service categories (i.e., inpatient, outpatient, emergency, physician, retail Rx, other, and a total risk score). 	<p>Used by over 300 organizations, including government programs, plans and clinicians in commercial, Medicaid, and Medicare/Medicare Advantage.</p>
<p>3M Clinical Risk Groups (CRGs)¹⁸</p>	<ul style="list-style-type: none"> Can be used either prospectively or retrospectively. Clinical and categorical model which classify patient based on most salient health condition(s) versus HCC model's regression-based approach which measures relationships between variables. Uses inpatient and ambulatory diagnosis and procedure codes, pharmaceutical data, functional health status to assign each individual to severity-adjusted group. V2.1 has 392 base CRG groups and 1,470 risk groups including severity levels. Indicates typical health care costs for CRG relative to an average individual 	<p>Used predominantly by commercial plans.</p>

Model	Methodology At-a-glance	Popular Uses
Chronic Illness and Disability Payment System (CDPS)¹⁹	<ul style="list-style-type: none"> • Concurrent and prospective specifications of expenditures are used in the CDPS model. • Uses ICD codes to assign CDPS Categories that indicate illness burden related to major body systems or types of chronic disease. • Each category has a hierarchy that considers both the clinical severity of the condition and assigns a weight (additive across major categories). • Individual risk score includes the sum of the intercept (baseline), demographic (i.e., age and gender) weights, and weights for all indicated CDPS categories. 	<p>Used by 33 of 38 Medicaid managed care states to adjust payments to MCOs for Temporary Assistance for Needy Families program (TANF) and disabled Medicaid beneficiaries.</p>
Johns Hopkins Adjusted Clinical Groups (ACGs)²⁰	<ul style="list-style-type: none"> • Can be applied both concurrently and prospectively. • Based on the premise that clustering of morbidity is a better predictor of resource use than the presence of specific diseases/disease hierarchies. • Assigns ICD codes to one or more of 32 aggregated diagnosis groups (ADGs). • Diseases or conditions are placed into ADGs based on five clinical dimensions: duration of the condition; severity of the condition; diagnostic certainty; etiology of the condition; and specialty care involvement. • Designed to allow customization of model to organization's needs. 	<p>Used primarily by commercial health plans and health systems.</p>

Summary Table of Voluntary Best Practices

Domain	Voluntary Best Practices for Consideration
1. Patient Attribution	
Voluntary patient selection	<ul style="list-style-type: none"> • Prioritize and facilitate voluntary patient selection. • Validate voluntary patient selection with claims data, especially annual physical or preventive visits. • Proactively provide opportunities to update voluntary patient selection, especially if claims indicate a change in physician.
Claims-based attribution	<ul style="list-style-type: none"> • Use a multi-year attribution window. • For prospective attribution, apply appropriate exclusions at the end of the performance period to enhance accuracy. • For retrospective attribution, deploy strategies to enhance predictability, including: <ul style="list-style-type: none"> ◦ Providing provisional attribution reports during the performance period. ◦ Adjusting financial performance reports based on the most recent attribution lists. ◦ Limiting quality performance measurement to those who attribute in the first three quarters of the performance year.
Automatic new member attribution	<ul style="list-style-type: none"> • Attribute patient to VBC entity once either a voluntary patient selection has been made or claims data is available to verify, such as a visit with a PCP in the VBC entity. • In the absence of voluntary patient selection and claims history to verify, rely on data such as geography, language preference, and physician capacity to take on new patients.
Clinician types used for attribution	<ul style="list-style-type: none"> • Include Advanced Practice Providers (APPs) in attribution methodology. • Deploy strategies to correctly identify the clinician principally responsible for managing a patient's care, including attribution to a non-primary care specialist in circumstances where they are providing comprehensive care to the patient.
2. Benchmarking	
Setting the baseline	<ul style="list-style-type: none"> • Use multiple years of historical data. • Avoid frequent rebasing of the baseline years when using a VBC entity's own historical costs and consider moving to regional baselines over time. • Collaborate on an achievable percent of premium target. • Include pharmaceutical costs, where feasible.
Trending the baseline forward to establish a benchmark	<ul style="list-style-type: none"> • Exclude the VBC entity from the reference population when their experience is large enough to drive the regional trend. • Prioritize regional over national trend factors, as appropriate. • Combine prospective administrative trend factors with retrospective adjustment to balance predictability and accuracy. • Establish guardrails when using an administrative trend to help manage risk. • Ensure attributed and reference populations are comparable.

Domain	Voluntary Best Practices for Consideration
<p>Making specialized adjustments to the benchmark</p>	<ul style="list-style-type: none"> • Include benchmark adjustments to incentivize continued VBC entity efficiency • Test adjustments to the benchmark to encourage inclusion of historically marginalized populations in VBC.
<p>3. Risk Adjustment</p>	
<p>Selecting a risk adjustment model</p>	<ul style="list-style-type: none"> • Use standard known risk categories like Hierarchical condition categories (HCCs) or other independently verified models. • Use concurrent models or update the risk scores within the performance year.
<p>Physician education and support</p>	<ul style="list-style-type: none"> • Provide targeted physician education and supports for clear and complete documentation of the extent of illness while minimizing administrative burden.
<p>Incorporating Social Determinants of Health (SDOH) data</p>	<ul style="list-style-type: none"> • Support efforts of physicians, practices, or VBC entities to report demographic data and SDOH data to allow for future efforts to incorporate socioeconomic data into risk adjustment models. • Pilot and monitor health equity adjustments in risk models before scaling.
<p>4. Quality Performance Impact on Payment</p>	
<p>Structuring the quality component of VBC payment</p>	<ul style="list-style-type: none"> • Set achievable quality performance targets. • Establish a minimum performance threshold with sliding scale to reward higher quality improvement. • Allow bonus dollars for quality improvement regardless of whether cost target is achieved. • Adjust both savings and losses based on quality performance. • Take historically marginalized populations into account when establishing quality targets and incentives.
<p>Implementation</p>	<ul style="list-style-type: none"> • Provide transparent quality measures, methodologies, and performance targets at the start of the performance period and regular feedback on progress towards these targets.
<p>5. Levels of Financial Risk</p>	
<p>Structuring levels of risk</p>	<ul style="list-style-type: none"> • Use multi-year arrangements with a glidepath to increasing risk and reward over time based upon a clear long-term strategy. • Allow VBC entities to elect to move back to upside-only arrangements when substantive changes in population or payment arrangement occur. • Evaluate capacity, readiness, and local market dynamics when designing downside risk options.
<p>Accounting for unexpected events, outliers, and random variation</p>	<ul style="list-style-type: none"> • Offer a menu of options for mitigating risk including risk corridors, capping savings and losses, and stop-loss. • Waive downside risk for significant unforeseen events (e.g., global pandemic or the sudden introduction of an extremely high-cost drug or technology).

Domain	Voluntary Best Practices for Consideration
6. Payment Timing and Accuracy	
Prospective payments	<ul style="list-style-type: none"> • Structure the timing and method of payment to address the specific goals of the payment arrangement and VBC participants. • Include prospective payments especially when entities are new to VBC or face resource challenges. • Adjust payments to account for complexity of the patient population. • Evaluate high-value service areas that may require additional investment when establishing capitation rates.
Reconciliation	<ul style="list-style-type: none"> • Conduct optional preliminary reconciliation. • Share complete data on reconciliation and offer technical assistance. • Provide an appeals process.
7. Incentives for VBC Practice Participant Performance	
Education and communication related to incentivizing VBC participant performance	<ul style="list-style-type: none"> • Provide education on VBC payment arrangement goals. • Develop clear, objective criteria for distributing incentives among participants appropriately focused on pursuing goals of value-based care. • Provide feedback at least quarterly on performance related to incentives. • Combine incentives across health plans and LOBs.
Structuring VBC practice participant incentives	<ul style="list-style-type: none"> • Use a combination of factors (e.g., panel size and outcomes measures) that are determined in advance of the performance period when allocating practice participant incentives. • Where appropriate, calculate incentives at the Taxpayer Identification Number (TIN) level and allow practice participants to determine how to share internally including with office staff.

Endnotes

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