



BUYER'S GUIDE

Value-Based Care: The Path to Scaling Contract and Performance Management

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Introduction

Value-based financial relationships between payers and providers continue to be one of the most dramatically effective methods for increasing both financial efficiency and quality in U.S. healthcare. In the past five years, there has been a seven-fold increase in the number of states implementing value-based contracts.

In response to the success of initial value-based arrangements, payers and purchasers will continue to rapidly expand the volume and types of value-based contracts and payment models. The next generation of value-based arrangements will be considerably more sophisticated than prior alternative payment programs. Emerging models are expected to:

- a. Increase adoption of upside-downside risk, or “shared accountability”
- b. Put a greater share of provider revenue at risk, including holding fee-for-service unit prices flat over time
- c. Introduce more naturalistic outcome measurement in the value equation, like use of clinical versus claims data for outcome measurement, and use of consumer-reported satisfaction and outcomes—supplementing or even replacing the use of ubiquitous Healthcare Effectiveness Data and Information Set (“HEDIS”) quality constructs in these contracts

For example, in the last twelve months, The Centers for Medicare and Medicaid Services (CMS) has continued to add tailwinds to the evolution of value-based models with actions such as creating the new Primary Care First (PCF) and Direct Contracting (DC) payment models which began in January 2021.¹



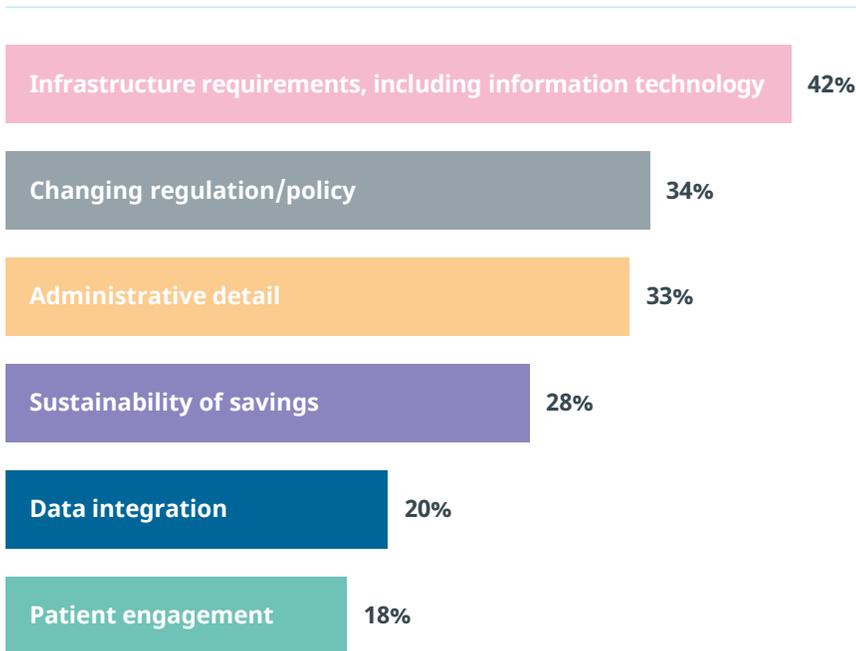
1. (2019, April 22). Retrieved from <https://www.cms.gov/newsroom/press-releases/hhs-news-hhs-deliver-value-based-transformation-primary-care>

For commercial payers, a market survey suggested that 91% believe risk-based payment will increase and that 10.6% of all commercial payments are already tied to some form of risk.² By 2025, adoption of “shared accountability” downside-risk models is expected to penetrate 50% of commercial and Medicaid medical expense and almost 100% of Medicare expenditure.³

Payers typically accommodate two dominant families of value-based risk models—population-based and episode-based models—and may implement only one type or run them in parallel. Population models prospectively create a per member per year budget, where the total cost of care is managed by an accountable provider entity, typically the organization that employs a member’s primary care clinician. Episode models generally create flat rates for an episode of care, typically deployed for specific procedures or conditions. There are infinite variations and hybrids within and in addition to these two families of value-based models, including various styles of prospective and retrospective payment, partial and full capitation, and further combinations of these models.

In addition to widespread adoption of common value-based models, many payers and providers will also inevitably partner to develop non-standard value-based arrangements, including unique benefit plans and “micro-networks” built around specific consumer geographies and best-in-class provider organizations.

Figure 1. Infrastructure Is Top Barrier to Value-Based Contracting Adoption



However, with all the political, regulatory, market, and social pressures, there are still significant barriers to adoption and challenges to aligning incentives and outcomes. Chief among these barriers is the underlying infrastructure for supporting value-based contracts. Given that the current set of healthcare IT solutions were developed over a 30-year period to support a claims-based fee-for-service transactional economic model, it shouldn’t come as a surprise that those same systems don’t support capitation, risk corridors, upside/downside or even shared savings models with the same robustness and efficiency that is required to manage more than \$385.5 billion in various forms of risk-based contracts.⁴

Payers who have experienced a value-based contract implementation, especially those on the “deeper end” of risk transfer, are keenly aware of the infrastructure challenges that come along with the administration of the well-intended contract. With the increasing sophistication and variation in value-based models comes increased administrative complexity for payer and provider back-office operations—typically deploying expensive and time-consuming manual processes, spreadsheets and home-grown IT to tackle their value-based contracts—and these stakeholders are not prepared for today’s initial value-based arrangements, or the evolution of the more complex and unique models.

Base: 552 (multiple responses)
NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

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Solutions Can Help Value-Based Models Succeed

Recognizing the inherent lack of support and transparency of existing data infrastructure and IT systems, payers are beginning to actively seek out solutions to accommodate the value-based risk models they have developed in complexity. As they look for next-generation support, payers are recognizing that there are different system and support needs for the variety of models; various shades of prospective and retrospective payments, partial and full capitation, models for population-based, episode-based, unique benefit plans, micro-networks and combinations of all of the above.

As payers look to procure value optimization solutions, they'll find that vendors are still developing and refining their offerings, with high levels of variability in solution scope and functionality from vendor to vendor. Full automation is preferred but given the variability and complexity of value-based models, vendors may combine professional services and automated software-as-a-service.

Maximum flexibility in the solution is essential, given the high likelihood that risk model designs will continue to evolve every year.

This Buyer's Guide is focused on value optimization solutions that enable payers to operate population-based value payment models. The intent of this Buyer's Guide is to:

1. Review the high-level business functions that comprise the value-based contract administration process inside a payer
2. Provide a framework that payers can use for specifying their needs; creating RFIs or RFPs and evaluating vendor offerings



A Unified Value Solution

Clarify has developed an end-to-end software solution for value-based care to help both payers and providers meet the infrastructure challenges of value-based arrangements and truly realize the potential of these aligned incentive models. This solution is purpose-built to support value-based contracts, not fee-for-service transactions. As a result, payers no longer have to try to repurpose old software or FFS platforms for a new use but can easily and efficiently meet the complex needs of payers and providers in value-based contracts.

Although solutions can vary in the core functions that they seek to support and automate, the best are designed to support the entire life cycle of a value-based arrangement. The typical life cycle of any given value-based contract program at a payer can be characterized by a set of chronological functions during the contract period.

Clarify has defined the annual life cycle of a value-based contract as a set of eight key chronological phases, which include key capabilities that payers should look for in a vendor. Careful consideration of these key vendor capabilities will allow payers to effectively source a solution that meets their specific needs.

Figure 2. Life Cycle of a Payer’s Value-Based Contract Program

Figure 2 illustrates the core functional activities that make up the annual life cycle of a typical population-based contract model value optimization solution ideally support one or more of these functions with SaaS tools, automation and/or packaged BPO services.



1. Program Planning & Design

- Set enterprise VBC program goals
- Design & test enterprise VBC contract modeling
- Create VBC contract templates
- Baseline provider performance

2. Contract Modeling & Negotiation

- Perform “what if” modeling
- Negotiate individual contracts

3. Management of Contract Terms

- Manage contract terms, provider roster, attribution, benchmarks, algorithms, etc.

4. Capture & Management of Key Data

- Capture & manage key data—financial, administrative, clinical, outcome quality measures & scores

5. Calculation & Reporting of Performance, Insight & “Calls to Action”

- Calculate performance against targets
- Share performance reports, dashboards & raw data
- Create & share actionable insight and “calls-to-action”
- Make any applicable adjustments

6. Performance Improvement Collaboration

- Convene & collaborate with providers for performance improvement
- Trend and report on provider performance

7. Settlement

- Evaluate & improve enterprise VBC design & program operations

8. Program Evaluation & Improvement

- Set enterprise program goals
- Design & test enterprise contract modeling
- Create contract templates

Key Considerations in Selecting a Vendor

Core Activities of the Life Cycle Phase

1. Program Planning & Design

- Payer’s management team and executive board set the enterprise-wide VBC program goals, including savings targets, transformation in payer-provider relationships, next-generation benefit products, risk model type, etc.
- Design & test the enterprise VBC contract model: Pressure-test the financial forecasts using historical data; actuarial modeling; gather feedback and input from network provider organizations
- Create value-based contract templates: These templates will form the basis for starter negotiations and help maintain consistency across the program

2. Contract Modeling & Negotiation

- Payer performs “what-if” modeling regarding individual risk-bearing entities (RBE), including a focus on the participating organizations within the RBE, a focus on higher-performing providers, etc. Payers ideally also perform modeling in real-time with potential participating providers in order to illustrate the “art of the possible”
- Individual contracts are negotiated, locking in specific contract terms and target budgets/thresholds that will apply to each participating RBE
- Negotiated terms typically vary from the enterprise template and these differences must be captured for accurate reporting

3. Management of Contract Terms

- Payer management of all specific terms and component algorithms for each negotiated, in-force contract
- Other essential components for managing and executing the contract include the applicable provider roster, attribution, methodology, benchmarks, stop-loss, exclusions, and special terms, etc. Terms and algorithms must be captured clearly and accurately in order to ensure accuracy of downstream calculations and settlement
- Contract terms, values, and inputs may change over the multi-year contract period, including provider rosters, trend adjustments, target values, and other expected ordinary and extraordinary adjustments

Key Considerations in Selecting a Vendor

- Direct hands-on, end-to-end experience managing value-based contract operations, including access to third-party actuarial expertise
- Expertise in evaluating and enhancing payers’ organizational readiness
- Vendor creation of or access to off-the-shelf models, templates, and best practice policies and procedures
- Hands-on experience in value-based contract negotiations
- Configurable “what-if” modeling and budget-setting tool that uses historical data and forecast metrics
- Hands-on experience capturing contract terms in detail for accurate downstream calculation of performance
- Ideally the solution includes a self-serve configurable contract set-up tool that captures all terms and algorithms in a secure cloud format that:
 - a. allows ongoing adjustments,
 - b. is accessible and transparent to both payer and provider, and
 - c. directly drives all downstream calculations on an automated basis

4. Capture & Management of Key Data

- Payer must coordinate the acquisition and capture of the data needed to adjudicate value according to the value-based contract model in operation. Typical data sources include:
 - a. financial, administrative, paid claims
 - b. provider roster,
 - c. membership,
 - d. quality measures and scores, potentially derived from HEDIS or for EHR-derived clinical data, patient reported outcome information, and
 - e. other data sources such as local/national benchmarks and guidelines
- Data must be initially mapped and tested for accuracy and refreshed regularly. Refresh of financial data (claims) should occur on a regular cadence, ideally monthly

5. Calculation & Reporting of Performance, Insight & “Calls to Action”

This activity area is the most complex, burdensome, and longest-running activity in the value-based contracting workflow. The activity commences at the moment of the contract go-live and runs through the entire contract measurement period. There are multiple discrete sub-areas:

- Calculation of performance against financial targets and all contract algorithms. Payers must supply providers rolling calculation of applicable contract algorithms, including application of up-to-date financial results, risk adjustment, attribution, etc. This calculation capability should serve as the system of record for determining value-based payments
- Sharing of performance reports, dashboards, and raw data with providers: Calculations resulting from the prior step must be shared promptly in order to let their provider partners know how they are doing against contractual goals. Payers typically supply standard reports and a “raw data” file representing the underlying data
- Creation & sharing of actionable insight and “calls to action”: Beyond accurate reporting of up-to-date performance, payers ideally also calculate, predict and share guidance that helps providers identify and capture specific clinical and financial interventions. This guidance may take the form of file, alert or “call to action” that is “pushed” to the provider
- Interim payments/adjustments (if applicable): Some VBC programs may provide interim bonus/deficit adjustments on a monthly or quarterly basis
- Optional extensions: The payer may seek automated outbound links or interfaces such that “calls to action” can be exported to care management systems, EHRs, provider-facing alerts, and even consumer-facing alerts

- Hands-on experience in high-volume capture of payer-derived data, including ETL automation and experience in identifying and troubleshooting data quality issues. Where EHR-derived clinical data is utilized, solution should have expertise in acquisition of clinical data from multiple source systems typically found in the payer’s provider network

- Scalable calculation skills—either automated or manual—where a very high volume of updated data and contract terms are blended and adjudicated at a high level of accuracy
- Ideally the solution can serve as the payer’s system of record for determining valuebased payments and reconciliation
- The solution should ideally offer:
 - a. payer- and provider-facing secure reporting portals, accessible via single sign-on (SSO), with easy-to-use static reports and dashboards,
 - b. standalone, guided data mining, reporting, and visualization,
 - c. ad-hoc data mining, deploying data science tools or a “data science workbench” for advanced users, and supporting the payer’s preferred visualization tools,
 - d. APIs that feed the payer’s EDW and
 - e. ability for the dynamic reports to be downloaded, exported to other file formats like PDF or CSV, and printed
- Automated tools for creation of actionable insights, ideally on a prioritized basis, and derived at the individual consumer and clinician level of detail
- Optionally, vendors may offer provider facing alerts and “playbooks”, EHR-integration, application interfaces that connect the solution to care management software or workflow, and consumer facing alerts

6. Performance Improvement Collaboration

- Payer-provider collaboration is essential for the success of the value-based relationship. Ongoing performance improvement collaboration throughout the contract measurement period may take many forms:
 - Pre-go-live “what to expect” educational sessions that cover risk model design, data-sharing, operational details
 - Payer may convene multiple provider organizations for best-practice knowledge-sharing
 - Monthly or quarterly face-to-face meetings between payer and individual risk-bearing provider entities. The payer is in a unique position to share comparative performance across provider peers in the network, and to support the provider in targeting and developing joint “campaigns” in specific areas of opportunity for cost and quality improvement
- Knowledgeable, experienced staff to support the payer’s provider performance improvement activities, including initial and ongoing network-wide training on use of the solution, participating in individual face-to-face meetings and regional knowledge-sharing conferences, help-desk to support provider staff in use of the payer-supplied tools (where applicable)

7. Settlement

- Most value-based payment models are prospectively budgeted and retrospectively reconciled (there are important exceptions such as prospectively paid bundles and others)
- During the contract period, the payer may make non-claims payments, prepaid capitation, and /or interim financial or quality performance payments. At the close of the measurement period, these interim payments are tallied, the final surplus/deficit calculations are made, and the parties “settle” their financial arrangement per the contract terms. Ideally, the settlement calculations are transparent and can be validated by both parties. Both payer and provider will require sufficient detail to reconcile to their enterprise financial statements and accommodate third-party audit
- Experience in successful settlements, including maintaining accurate data management and reporting throughout the contract period as well as troubleshooting any issues that may arise in final settlement
- Value optimization solutions should provide prompt reporting throughout the period and at the end of the period to reduce the lag-time for settlement. Ideally the solution provides fully transparent and audit-worthy calculations, versus a “black box” with opaque results

8. Program Evaluation & Improvement

- Although value-based contract and payment innovation has been around for over a decade, best practices are still evolving
- Payers will benefit from a formal evaluation of its enterprise value-based contract program, focused on improving the program design as well as driving efficiency in program operations
- Experience in data-driven strategic assessment of VBC contract design and operations, creation of recommendations for program improvement, and consulting support for implementing program and operational improvements

Integration With Existing Technologies

These solutions must interact with multiple other distinct vendor-supplied or internally built enterprise technologies. These technologies must be utilized across multiple functional domains inside the payer’s legacy IT and operational environment. Together, the value optimization and legacy ecosystem play a coordinated role in the success of the payer’s enterprise value-based contract programs.

Ideally the payer’s selected solution also interacts directly or indirectly with the enterprise technologies used by providers in supporting their financial risk. Consistent with the core tenets of payer-provider collaboration in value-based relationships, the solution must support timely data-sharing across the payer and provider ecosystems and do so with industry-standard interfaces, such as Fast Healthcare Interoperability Resources (FHIR).

It’s also helpful to consider the core minimum “functional footprint” of a contract performance solution: the boundary where the expected functionality ends, and other functional systems begin. For example, should a solution provide care management workflow or even replace existing care management or population health software? Perhaps, but likely more important for a payer, is to make sure the solution covers the core value-based contract and payment functions, providing an informational “hand-off” to dedicated care management solutions supplied by vendors specializing in that solution domain.

Figure 3. Value-Based Care Contracting Ecosystem

Figure 3. Solutions interact with multiple other distinct vendor-supplied or home-grown solutions across multiple functional domains inside both payers and providers. Together they form an ecosystem across which data is ideally shared in a timely manner through deployments of industry standards such as FHIR.



There are a variety of current payer and provider enterprise systems and domains that the payer’s solution will interact with, whether directly or indirectly. However, it is not necessary, and often preferred, that the solution also try to solve for these existing capabilities. Other distinct vendor-supplied or home-grown enterprise technologies may interact with or complement the solution, but do not have to be in the scope of the solution. Some of these domains include:

- FFS Claims Adjudication
- EDW, Analytics & Reporting
- Care/Case Management and Population Health Programs
- Risk Adjustment Optimization
- FFS Network Modeling
- ACO Risk Enablement, Clinician Practice Support
- EHR and Clinical Data Aggregator

Clarify can work with your organization in an advisory role to further discuss the connections and handoffs between an end-to-end value solution vendor and these other distinct, often existing payer and provider domains and systems.

Conclusion

When value-based care is implemented at scale, it can transform the whole healthcare system by incentivizing stakeholders to focus on health outcomes first. However, successful VBC models require alignment and trust between health plans and providers. For health plans to prosper in value-based arrangements, there must be a scalable, simplified, and transparent approach to building trusted partnerships. This trust comes from sharing the way provider performance is measured, delivering financial performance insights early and often, reconciling contracts without surprises, and supporting providers with assessing the needs of their populations and matching patients to the right intervention. With mutually beneficial incentives and the right analytics and technology, VBC programs will reduce the cost of care and improve health outcomes.

Clarify's Value Solution

Clarify's Value Solution for health plans is the only end-to-end, unified software solution to connect the dots between clinical performance and financial impact. It boosts payer-provider collaboration and transparency, simplifies contract design, and digitizes contract management and settlements.

Clarify Care

Find unwarranted clinical variation

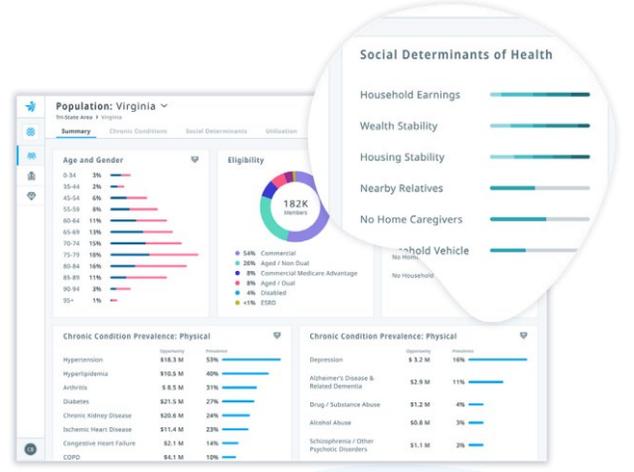
An analytics software that precisely scores and benchmarks provider performance to show opportunities to improve the quality and efficiency of care delivery and optimize utilization management interventions.



Clarify Populations

Manage population risk

A predictive analytics software that identifies member risk using clinical and SDoH data and matches individuals to programs that are best suited to meet their needs.



Clarify Contracts

Digitize value-based contracting

By digitizing the key terms, methods, and metrics used to determine contract performance, this product is the simplest way to design better contracts, managing ongoing financial performance, and digitize settlements.



Glossary

Affiliation

Like member-PCP attribution, provider-RBE affiliation is used to determine a relationship between the clinician participating in the value-based model with the risk-bearing entity. This is necessary to assign member's costs to the appropriate at-risk clinician to the appropriate risk bearing entity, at a given point in time, in the value-based contract model.

Alternative Payment Models (APMs)

Alternative payment models deviate from traditional fee-for-service (FFS) payment. APM is sometimes used interchangeably with value-based payment, however, all value-based payment models are APMs and not all APMs are value-based. For example, under various capitation-based APM models a payer might "prepay" a physician group rather than pay FFS on a retrospective basis. The example is considered value-based if it accounts for performance on some external metric or activity, like a cost benchmark, budget, value or quality.

ASC, ASO, Administrative Services Contract

An arrangement in which a licensed insurer provides administrative services to an employer's or plan sponsor's health benefits plan (such as processing claims) but doesn't ensure the risk of paying benefits to employees. The employer or plan sponsor is typically self-insured.

Attribution

Method used to determine which provider or risk-bearing provider entity (RBE) is "responsible" for expense and value related to a given member/patient. The attributed clinician is typically a PCP but could be a specialist. In HMO benefit products, a consumer typically actively selects a PCP. In benefit products where a consumer does not select a PCP (such as in a PPO benefit), this methodology includes statistically analyzing prior claims to assign members to providers (in general, identifying PCPs seen most regularly).

There are a variety of attribution models, prospective, concurrent, retrospective, or network or product specific, that can be applied to the value-based models as well as many components within each model that can vary the outcome, such as eligible clinicians, scope of services included, and look back periods.

Benchmark

In value-based payment models, a financial benchmark is a population-based spending target or budget. Financial benchmarks may be based on a provider organization's spending in the previous year, on regional or national spending levels, negotiated forecast, or peer or provider network averages. Benchmarks are risk-adjusted to take into account relative patient acuity. Additionally, financial benchmarks can also be adjusted to account for geographic variation in input costs if variations exist across the covered region.

Capitation

A payment method for healthcare services. This term has widely disparate definitions. Capitation means "per head" and usually refers to an allocation of medical spending for a single person for a year. The physician, hospital or other healthcare provider is typically paid a "per-member-per-month" (PMPM) rate, for each attributed member for a class of services regardless of the number or nature of services provided in that class. The class or "market basket" of services that are capitated may be limited to primary care or professional services only, or may include all services, often described as total cost of care (TCOC). Capitation contract rates are usually adjusted for age, gender, illness and regional differences. Capitation may be partial (limited class) or full and may be prepaid or "virtual" (as in the case of a capitation budget built on top of FFS payments and reconciled later).

Episode-Based Payment Model or Bundled Payment Model

An episode payment is a negotiated bundled payment for a set of services that occur over time and across settings. This payment model can be focused on a setting (such as a hospital or a hospital stay), procedure (such as elective surgery), or condition (such as diabetes). Episode payment models typically take into consideration the quality, costs, and outcomes for a patient-centered course of care over a set period of time and across multiple settings. Episodes may be prepaid or, more commonly, "virtual" (based on FFS and retrospectively reconciled).

Episode Treatment Groups

Episode treatment groups is a "grouper" model used to combine related medical and pharmacy claims into clinically relevant episodes that allow for focus to be placed on a patient's underlying medical condition.

Fee-for-Service (FFS)

Traditional U.S. healthcare payment method where payers pay providers based on unit-priced fee schedules for each unit of service or “procedure” that is rendered to a covered/eligible member. Unit prices may be negotiated (commercial healthcare) or set by a government regulatory or cost-based process (Medicare, Medicaid).

MA

Medicare Advantage Plan.

Network

Collective term for healthcare providers under contract with a payer within a specific geographical area.

Payers

Payers are entities paying for healthcare in the U.S. Payers are distinguished from providers (the deliverers). Payers include licensed health plans that sell insurance products; health plans and administrative contractors that provide ASC or administrative services act, acting as the payer for self-insured purchasers like employers and governments; third-party administrators.

PCP (Primary Care Physician)

A PCP is a medical provider (e.g., doctor, nurse practitioner, or physician assistant) who acts both as the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause or diagnosis. The attributed PCP is the primary care physician responsible for a member, whether selected by the member or statistically assigned by a defined attribution methodology.

Percent of Premium

An APM, widely used in Medicare Advantage, where payer and provider agree to a budget based on percentage of the premium that CMS pays the payer for each member across a population. This may be a predetermined capitation amount that is prepaid or “virtual”, for professional fees only or overall performance against TCOC, and other variations.

Performance Measurement

Performance measurement encompasses the development and implementation of metrics that assess the clinical quality, health outcomes, patient care experience, and cost of care provided to patients. Performance measurement can be used both for accountability and improvement purposes. Performance measurement makes it possible to monitor and quantify how well payment models achieve and reward the Triple Aim of better care, better health and lower costs.

Population

A group of people who are cared for by a particular provider, live in a particular community, share the same benefit plan, or share a similar characteristic (e.g., condition, age, gender, race, or ethnicity).

Population-Based Payment (PBP) Model

Payment model in which a risk-bearing provider organization (RBE) is given a population-based “global” budget or payment and accepts accountability for managing the total cost of care (TCOC) or total medical expense (TME), quality, and outcomes for a defined population across the full continuum of care (or full continuum with certain expense types excluded, like behavioral health, pharmacy, or enhanced benefit plans). Population-based payment models offer providers the incentives and flexibility to strategically invest delivery system resources, treat patients holistically, and coordinate care. Populations under PBPs typically need to contain 3,000 or more consumers to maintain statistical integrity.

Providers

Licensed or certified entities that get paid for a healthcare service that is rendered.

Risk Adjustment

The TCOC attributed to an RBE in a value-based contract is often adjusted for the health status or severity of the patient population of each RBE. The risk adjustment ensures the severity of the patient and thus the resources that may be required are normalized for the patient populations being compared at each RBE, and those with a more severe health status are not penalized for requiring more resource use leading to higher costs. There are a variety of risk adjustment methodologies that can be utilized, and a payer may adjust the “actual” TCOC for each RBE or instead adjust only the targets or benchmarks for the comparable population.

Risk Bearing Entity (RBE)

Provider organization bearing financial risk in a value-based contract arrangement with a payer. The RBE may be comprised of one provider organization or many component entities, such as combinations of hospitals, physician groups, accountable care organizations, home care organizations, nursing homes, etc., as well as downstream individual clinicians and caregivers.

Run-Out or Claim Lag

Amount of time necessary to complete a reporting period following the incurred period. Run-out for an annual contract may be 4-months, e.g., January through April of the year following a calendar year contract. The reporting period for a given year may include the incurred-year plus run-out. This time period allows for more claims from the incurred year to process, thus depicting a more complete picture of the incurred year.

Sensitivity Masking

Some reports and extracts have specific masking applied to de-identify personal information in the output. As an example, quality reports for behavioral health may mask first and last name, set the birth date to 1/1, and scramble the subscriber ID.

Settlement

The annual financial activity that reviews final results for a performance period against the terms and expectations of a value-based contract, at a minimum this often includes the cost and quality performance compared to predetermined target values. In population-based models, final reconciliation settlements typically take place annually, interim settlements may be calculated quarterly or semi-annually to depict estimated performance or provide interim payments then reconciled in the annual settlement. Many contractual variables may be adjusted at settlement.

Stop Loss

Stop loss is often included in the value-based contract terms, to protect the RBE against unexpected, large financial costs for the patients attributed to its organization. Often this is calculated as a member specific threshold, if claims for a specific member exceed the predetermined dollar amount, they are excluded from the value-based equation, protecting the RBE from significant financial risk.

Total Medical Expense (TME) or Total Cost of Care (TCOC)

A broad indicator of spending for a given population (i.e., payments from payer to provider organizations). In the context of population-based payment models, in which provider accountability spans the full continuum of care, TCOC is the “market basket” of healthcare services that include all spending associated with caring for a defined population, including provider and facility fees, inpatient and ambulatory care, pharmacy, behavioral health, laboratory, imaging, and other ancillary services.

Upside Risk, Downside Risk

Risk exposure terms. Upside-only value-based payment models allow providers to share in savings or surplus against a pre-negotiated target or benchmark but do not hold the provider accountable for losses. Up-downside risk typically puts provider and payer at symmetrically equal risk of loss or gain. Most up-down models blend financial gain/loss with quality and outcomes. Downside risk is also called “shared accountability”.

Value-Based Contract (VBC)

Also, value-based “arrangement” and “relationship”, the contract addendum to an existing FFS contract, or agreed-upon terms, between payer and provider that describes how value is measured, calculated and paid. The VBC may include hundreds of algorithms and calculation features. Note: many providers use VBC to describe value-based care, which is the type of accountable care sought under a value payment arrangement.

Value-Based Payment (VBP)

Payment model where calculation of “value” is a component of the amount paid. “Value” in a B2B context is usually a factor of price, efficiency and quality. Quality may include outcomes and stakeholder/consumer satisfaction.

About Clarify Health

Clarify Health is an enterprise analytics company that empowers payers, providers, and life sciences companies to deliver better care, therapies, and outcomes with actionable patient journey insights. Clarify's cloud-based business applications are built on the Clarify Atlas Platform, which maps 300M+ patient journeys to deliver 18B+ AI-powered predictions and surface insights with speed and precision. Clarify's platform and products illuminate actionable opportunities to drive growth, optimize networks, improve care delivery, manage population health, maximize value-based care performance, and commercialize pharmaceutical and biotechnology products. With Clarify, healthcare organizations can leapfrog from point-solution and manual analytics to self-service, rapid generation of enterprise insights that light the path to better care and outcomes.

Learn more at clarifyhealth.com.