Navigating Value-Based and Risk Sharing Agreements: Payors and Providers Partnering to Improve Care

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Transforming Healthcare Together

**Leading a provider-led transformation of healthcare that consistently delivers high quality, high value care**

**Scale**
- Alliance of more than 4,000 hospitals – 83% of U.S. community hospitals, hundreds of thousands of clinicians and approximately 165,000 other providers and organizations
- Integrated clinical, financial, operational data – insights into ~45% of U.S. health system discharges
- Approximately $60 billion in supply chain spend

**Alignment**
- Members own ~60% of equity
- 10 health system board members

**Co-innovation**
- Co-develop solutions with members
- Committees composed of ~140 member hospitals
- ~1,450 hospitals in performance improvement collaboratives

Note: Data as of June 30, 2018.
Real Results on the Journey to Value-Based Care

Value-based purchasing: HACs, quality, efficiency, cuts

Bundled payment

Global payment

HAC & readmissions penalties

Shared savings

FEE-FOR-SERVICE MOVING TO INTEGRATED CARE, NEW PAYMENT MODELS & RISK

QUEST (≈350 hospitals, 2008-2018)

- 210,190 deaths avoided
- $18.4 billion saved
- 48,922 fewer readmissions
- Performing 45% better on VBP

Partnership for patients (450 hospitals, 4 years)

- 74,693 readmissions avoided
- 28,214 harms prevented
- $1.03 billion cost avoided
- Work with thousands of physicians

High-value episodes

- Outperformed peers by 35%+ to 100% depending on the model
- 75% achieved savings
- > half achieved at least 10% savings
- 80% achieved good or excellent quality scores

Population management

- Performed 2X better than all other ACOs
- 6% of ACOs each yr. since 2012, yet generated 20% of savings to Medicare
- Performed 57% better in achieving shared savings than all other ACOs
- Superior quality performance
Medicare Advantage plan’s common contracting models

1). Star score and HEDIS incentives
- **Star score incentives**: 5-10 measures – PMPM (e.g. breast and colorectal screening, diabetes care, medication adherence)
- **HEDIS**: Patient experience and quality – Additional bonus or incentives (e.g. readmissions, ED visits, AWVs, patient experience)

2). Medical Home payment / rewards
- **Patient Centered Medical Home (PCMH)** – Incentive payments for certification
- **Care coordination** – PMPM to help cover care management cost

3). Shared Savings
- **Share savings** – Provider organization can share in the savings created if total cost of care is below designated target
- **Levels of savings** – Greater accountability / more measures and performance requirements, results in a greater savings potential

4). Two-sided risk / accountability
- **Two sided risk** – Provider organizations take full accountability to manage a population based on a global expenditure target
- **Payer requirement** – Provider organizations must demonstrate high level of population health capabilities to qualify / delegation of services
Success factor #1 – Clinical documentation and coding accuracy (risk score)

Example proforma for a practice or health system’s gain share deal with an MA Payor

ASSUMPTIONS:
2000 MA lives attributed to a group.
Average Group risk score of .90
Average PMPM cap payment from CMS to plan of $800 (average)
$60 pmpm increase in cap payment for each 0.10 move up in group risk score
85% Medical Loss Ratio (MLR) target to produce shared savings
50/50 split of shared savings under 85% MLR

GAIN SHARE EXHIBIT 1 (0.90 average patient risk score)
2,000 MA lives x $800 pmpm x 12 months: $19,200,000
85% MLR target = 15% Health Plan Retention / 85% into Gain share ($19,200,000 x 85%): $16,320,000
Group runs a 87% MLR ($19,200,000 x 87%): $16,704,000
Gain share calculation ($16,320,000 – $16,704,000): -$384,000
Result – no shared savings payment from payor to provider: $0

GAIN SHARE EXHIBIT 2 (1.10 average patient risk score)
0.20 rise in average group risk score produces $120 pmpm in additional pmpm from CMS to the plan
2,000 MA lives x $920 pmpm x 12 months: ($2,880,000 increase) $22,080,000
85% MLR target = 15% Health Plan Retention / 85% into Gain share ($22,080,000 x 85%): $18,768,000
Group runs same utilization ratio as in Exhibit 1 ($19,200,000 x 87%): $16,704,000
Gain share calculation ($18,704,000 - $16,704,000): $2,064,000
Result – shared (50/50) savings payment from payor to provider: $1,032,000
Success factor #2 – Star score

A study by Oliver Wyman indicates a strong correlation between Provider-driven measures and overall Part C Star Ratings.

Even though provider-driven measures only make up about 74 percent of the total Part C scoring weight, they essentially determine the score by themselves.

Ultimately, a health plan’s Star rating is defined primarily by the behavior of its providers.

Interestingly, clinical quality may even affect scores on the member experience measures—the metrics traditionally viewed as payer-driven.

Source: WINNING ON STARS (T. Abott, M. Durr and M. Graf, Oliver Wyman Health & Life Sciences Group), October 2015
Effective care management is vital for managing patients that are complex (most costly) and rising risk/cost

Successful Medicare ACOs have already developed impactful care management programs

Payer/Provider collaboration can occur

Optimizing annual wellness visits is an important step in coding and identifying patients that could benefit from Care Management
Success factor #4 – Sales and marketing (market share)

- Which plans to work with? (Thinning the herd)
- Provider-sponsored plan?
- Member growth, onboarding and retention
  - Hitting a critical mass is important for mitigating risk, whether you take risk by owning a plan or simply taking risk with a plan
  - Growing market share in successful MA VBP deals grows financial success
  - Partner with your preferred MA payers to market the plan – Most payers are motivated and willing to fund marketing strategies
Other Drivers of Success

Claims analytics

• Utilize claims data to calculate realistic expenditure or MLR targets for risk and upside only agreements
• Utilize MA health plan reports to drive performance improvement (i.e. members not seen report)
• Identify opportunities to align data and reporting systems with health plans (i.e. Bi-lateral reporting tool with Humana)
• Spread learnings from Medicare ACO analytics to Medicare Advantage populations

Medicare Advantage plan design elements to leverage

• Engage with health plans around plan design
• Benefit structures that reduce out of network utilization (higher out of network co-pays, narrow networks)
• Replicate CMS bundled payment programs for MA lives
• Establish engaged relationships with high-value providers

Risk stratify MA populations and align with plan goals

• Align contract metrics with top priority population segments
Provider considerations for the strategic path forward

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Coding Accuracy</th>
<th>Star Score</th>
<th>Care Management</th>
<th>Sales and Marketing</th>
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<td>Health plan ownership with a TPA</td>
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<td>Health plan ownership and management</td>
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Development and Implementation of Any VB Contracting Strategy. Primary Outputs Include:

1. Coherent, vetted strategy to approach payer discussions
2. Clear understanding of financial considerations and population risks
3. Analysis of claims data and contract implications
4. Clear path for capability development to manage contracts
5. Contracts with payers to align incentives for successfully assuming risk
General Timeline, Alignment, and Direction Setting for any VB Negotiation – Can be a 5 to 10 month Process

1-3 Months
- Strategic Discussions & Assessment

1 Week
- Attribution or Assignment

2 Weeks
- Total Cost Of Care & Quality Benchmarking

2-4 Months
- Negotiation

2-3 Months
- Implementation

- Create awareness with C level and plan/product admin and clinical leadership with P&L responsibility
- Form interdisciplinary teams between plan & provider
- Shape framework and alignments & tenants of expectations and success

- Understand
  - Product Strategies
  - Scope

- Establish common goals
- Stratify market for planning and analysis
- Outline network and contracting models and adjust according to market conditions

- Finalize market discoveries and pro-forma analyses
- Incorporate appropriate performance guarantees and data requirements into contract
- Finalize Provider Delivery, Service, and Funding Model
- Final assignment of network providers to contract
- Testing
- Joint Communications – Providers/Members
## Key Business Drivers

### Product/Growth
- Higher degree of joint innovation, planning, and response times around product opportunities.
- End to end alignment that allows for better response times to CMS model and regulatory year to year moves.
- Better alignment of MCO distribution and channel strategy with network growth strategy.
- Mutual top line motivation for risk-adjusted membership.

### Affordability
- Unit cost becomes a joint total of cost of care discussion, strategy, and shared outcome.
- Data and financial alignment better facilitate aggregation of claims and clinical, lab, and pharmacy data, allowing for earlier intervention and greater cost predictability.
- Focus on inpatient and post acute management.
- Allows emphasis on respective area of competencies (e.g., care management).
- Full alignment on payment accuracy and integrity.

### Network
- Optimized identification of highest performing providers and direct volume where appropriate.
  - Optimize coding and documentation for applicable risk adjustment, and potential kick payments, and revenue accuracy for all stakeholders.
  - Superior quality performance metrics (e.g., HEDIS).
- Bottom up vs. top down network optimization and adequacy initiatives.
- Allows emphasis on respective area of competencies (e.g., credentialing, network development/management).
- Faster response times with ad hoc and CMS-driven compliance initiatives.
- Establishment of a “Accountable Care” communities with patient-centered care.