Value-Based Contracts: Ten Traps to Avoid

Harnessing Physician Partnerships

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Value-Based Contracts & Alternative Payment Models

- Last best hope
- 75% of all payments by 2020
- Recognizes that health care value is created by physicians
- Success demands true collaboration between payer & provider

Ten Ways to Kill the Value

1. Fail to have a well-defined Value-Based Care – Alternative Payment Model strategy that includes new products, benefit design and pricing. (i.e. set up gainsharing on top of a legacy PPO product and call it good.)
2. Hope for primary care focus without benefit changes or elements of friction
3. Fail to have a well-defined provider strategy, including mechanisms of partnership, investment, even preferred groups
4. Fail to be thoughtful about selection of provider partners, how to nurture them on the journey, and fail to be best friends with independent PCP-weighted groups
5. Set up harsh targets, or contracts in which you doubt MDs will succeed. Get stuck in fights with the overconfident, expensive system/group.

Ten Ways to Kill the Value

6. Keep activities to support value contracts dispersed throughout the organization, no defined services team with accountability
7. Approach providers as opponents in the chess game of health care, a zero-sum game
8. Beat the providers at actuarial poker game; be stingy with risk share and incentives – "they already get paid plenty"
9. Don't freely and skillfully share data
10. Stay out of the providers' business – "they are on the hook, they can figure it out". Don't worry about provider tools, or let them shop in the wrong places, or force narrow proprietary solutions on them. Don't understand their business.

Two Critical New Strategies

- Value-based care strategy (AKA accountable care strategy)
- Provider engagement / provider alignment strategy

Value-Based Care Strategy

- Competitive market landscape
- Value-based products and benefit design
  - "Mall product" with separate storefronts, or unique provider-branded products
- Market segmentation for price-vs-choice trade-offs
- Retail individual products (MA and HIX) vs. group insured, group ASO
- MACRA – a gift from the Feds

Provider Alignment Strategy

- Love all children equally or pick favorites?
- Strategy for picking partners
- Starting the partnerships
- Collaborative engagement activities

Principles of Engagement / Partnership

- Give share of value, but don't dump risk on providers not ready
- Incentive targets are always Total Cost of Care (TCC), including pharmacy
- Goal is 100% of your primary care providers in some form of risk contracting
- Specialists & hospitals in VBC as well, but priority is PCPs

Fairness & Transparency

- Open books concerning value, total cost of care
  - i.e. if you get a rebate on Rx, put that in the settlement (put part D in the contract)
  - If you get a reconciliation payment from CMS (or payer) in the future, look back & share it with groups
  - Groups may need an audit for trust
- Share up-to-date financial performance all through the year. No surprises.
- Transparency on quality measures
- Understand that sharing value with MDs gives some $$ away in short term, but long-term creates even more value, leads to win-win.

Payers: Who Are Our Partners?

- Integrated hospital systems
- Community vs academic systems
- Big physician groups
- Smaller independent PCP groups
- Single PCPs: aggregate or eliminate?
  - Group performance not credible unless 1,500 MA patients, 3,000 commercial
- Full analysis – performance on total cost of care, with detail by unit price, utilization, and episodes
- Sophistication of care model not as important as readiness to partner

How Do We Partner?

- Contractual only: spectrum from loose availability of P4P or gainshare clause in PPO product contracts for any willing provider
- To partnerships for specific products
- To JVs and other entities
- To outright acquisition & ownership
- **Goal:** PCPs in full risk, Total Cost of Care, transparent contracts
  - Regardless of legal structure of partnership

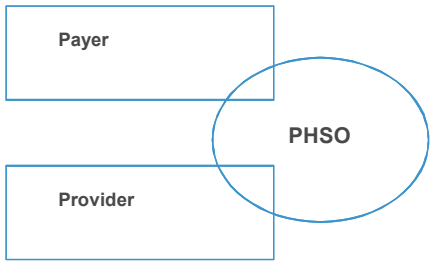
Examples of vehicles IBC, Regence, Premera, Highmark – Many Others VERIFY THIS PUBLIC

- Regence (Cambia)
  - New product ActiveCare – one product, 4 ACOs with 4 narrow networks. Support ACOs with data/analytics, benefit design. Network partnerships specifically chosen.
- Large Blue Cross
  - Global Outcomes Contracts – contracts with delivery systems on existing PPO products. Evolutionary step, shares upside against target. Support groups with data/analytics.

Examples of vehicles IBC, Regence, Premera, Highmark - Many Others

- Highmark
  - Ownership of Allegheny Health Network
- Independence Blue Cross
  - Tandigm – legal Joint Venture LLC with DaVita HCP
    - Provides tools & extensive Pop Health support. Supports multiple independent groups
  - "Virtual JV" with Aria, Abbington, Einstein, others (VBC programs with health systems)
- Anthem
  - Vivity JV with seven health system partners

Population Health Services Organization



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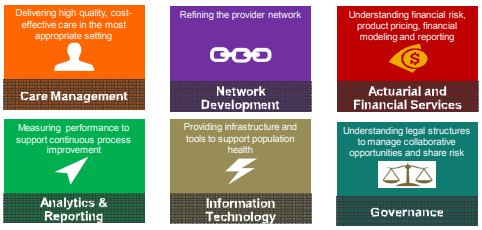


Enabling And Empowering Accountable Providers

1. Assess Organization and Identify Population Opportunities
2. Design Care Delivery Model and Align Incentive Structure
3. Implement Care Delivery and Business Model
4. Deploy Technology and Information for Providers and Consumers
5. Develop Accountable Care Teams, Transform Provider Workflow, and Support Continuous Improvement

1 Assess Provider Organization and Identify Population Opportunities

The assessment helps determine the culture of the organization and the governance structures needed to support increasing risk.

Provider Organization Assessment	Analyze components	Physician makeup
		Internal physician compensation
		Gaps in delivery
		Leakage – amount and types of care
	Readiness for Population Health Management	Technology readiness
		Organization and practice objectives
		Quality and care management programs
		Leadership and culture

1 Assess Provider Organization and Identify Population Opportunities

Identify improvement areas within a population.

- Focus areas
  - Access to Care
  - Documentation and coding
  - Cost and utilization
  - Transitions of Care
  - Evidence-based care
  - Operational processes
- Conversation educates leadership
- Program development for identified areas

2 Collaborate on Care Delivery Model and Aligned Incentive Structure

Population-based care most effective when guided by physicians, supported by payers.

Define Accountable Primary Care

- PCP model
- Extensivist model
- Direct primary care
- Virtual Care
- Nurse Triage

Develop population-specific programs

- Hospitalist programs
- Transition
- ER diversion
- Radiology management
- NICU management
- Oncology drugs
- High cost disease

Define Provider Care Management programs

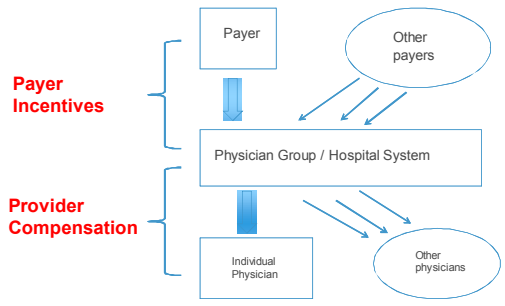
- Degree / nature of payer support determined by the capabilities of the provider
- Strict avoidance of duplication or contradiction of effort
- Likely places to start
  - High risk patient management
  - Inpatient management
  - Transition management
  - Medication management
  - End of life care

2 Collaborate on Care Delivery Model and Aligned Incentive Structure

Create a "we do – you do" grid

Physician Engagement Level	Utilization Management		Complex CM	Transition Management	Quality Outreach	
	Prior Auth.	Concurrent Review			Ongoing	4th Quarter
High	Health Plan	Medical Group	Medical Group	Medical Group	Medical Group	Health Plan
Midrange	Health Plan	Health Plan	Health Plan	Medical Group + Health Plan	Medical Group	Health Plan
Low	Health Plan	Health Plan	Health Plan	Health Plan	Medical Group	Health Plan

2 Create Aligned Incentive Structure



2 Create Aligned Incentive Structure

Design contracts to evolve incentives and capabilities over time.

FFS	FFS + P4P	Upside Only + P4P	Limited Risk + P4P	Full Risk w/Balanced Incentives
Level 1	Level 2	Level 3	Level 4	Level 5
Traditional Fee-for-Service (FFS)	Traditional FFS + Incentivize activities that support maturation to Level 3	Pay based on draw or cap + Surplus + P4P incentives that provider can hit regardless of surplus/ deficit	Shared risk + Additional portion of upside share when incentive targets are met	Pay based on draw or cap + Upside and downside risk + Greater share of upside if incentive targets are met

2 Create Aligned Incentive Structure

Determine incentives that will support appropriate behavior change.

- Payers should reinforce enterprise goals (e.g., Stars/HEDIS)
- Ensure that incentives are meaningful
- Drive adoption of applications
- Incentivize behavior to help provider evolve to next level of risk assumption

2 Create Aligned Incentive Structure

Design internal compensation model that aligns with payer contracts and transitions over time.

Significant portion of compensation tied to value-based incentives

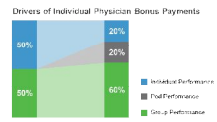
- Cost of care
- Quality metrics
- Access
- Patient Satisfaction
- Participation

Model should encourage team accountability

- Combine group & individual performance
- Pool dollars for high risk coverage

Payer ability to impact internal compensation

- Contractual: 30% - 50% surplus to PCP, payment for MA assessment
- Educate and incentivize



2 Internal Compensation

Guiding Principles

1. Make Incentives Meaningful	• Ensure adequate compensation for level of effort and degree of risk assumed • Target 25-30% of total compensation minimally be tied to value at steady state
2. Use Balanced Incentives	• Cost of care balanced with quality, access to care, citizenship, and outcomes measures • Processes to monitor for underutilization
3. Use Clear & Credible Metrics	• Ensure physicians understand what is required and set attainable goals • Use standard metrics whenever possible (HEDIS, ACO, PQRS) • Minimize the potential impact of low panel penetration
4. Promote Transformation	• Tie to value-based contracts and organizational goals • Reward behaviors that will make it possible to assume greater risk • Strive for consistency across payer contracts
5. Include Only Metrics That Can Be Tracked	• Tools and information that support performance management are key • Regular monitoring of individual and comparative performance • Include only when required data available
6. Foster Mutual Accountability	• Combination of group wide and individual metrics • Encourage information and best-practice sharing • Supported by governance structure
7. Emphasize Fairness	• Use measures physicians can actually impact • Protect individual physicians in full-risk agreements from catastrophic cases • Involve physicians in the design process

2 Internal Compensation

Creating Provider Engagement

- Transitioning health system physicians to value in parallel presents significant challenges
- Start small with groups of physicians that have a high likely of success, create proof of concept, then roll out more broadly
- Look for physicians / groups that:
  - Believe in the vision for value transformation
  - Have a high panel density of patients with meaningful contracts
  - May not have to undergo radical transformation to their existing compensation model

2,000 Patient Panel

Fee-for-Service Contracts	Meaningful Value-Based Contracts
70% - 80% of panel	20-30% Value-based patients in practice
1,600 – 1,400 patients	

Behavior Change

3 Implement Care Delivery and New Business Model

Develop and deploy the necessary programs to support the care delivery and business model goals.

Medical Care Management Program	• Complex Case Management/Transition Management
	  • Develop care manager job description / deployment strategy
	  • Design workflows for pre-screen and post-visit planning

Quality Improvement Program	• Gaps in care campaign
	  • Design campaign and outreach processes
	• Closing suspected diagnosis campaign
	  • Identify necessary data feeds to target additional suspected gaps in diagnosis coding
	• Focus on efficient resource allocation (central vs. local)

Practice Transformation	• Develop centralized source of information for continued education and improvement
Governance	• Collaborative provider and payer governance is critical to sharing comparative performance and best practices.

3 Implement Care Delivery and New Business Model

Collaborative provider and payer governance is critical to sharing comparative performance, best practices, and finding barriers to success.

Sample Governance Schedule – Payer Level

Structure	Purpose	Frequency
Executive Steering Group	Alignment of strategic initiatives and ongoing programs with leadership	Monthly
PHSO Operating Committee	Review operational status of ongoing programs	Bi-weekly
Joint Operating Committees	Review provider groups' financial and operational performance	Quarterly
Medical Director Calls	Share comparative performance, best practices, identify barriers to success	Monthly
Medical Expense Management Program	Review provider groups' medical management goals	Bi-weekly
(MA) Star Executive Committee	Oversight of Star initiatives	Weekly
Health Plan Risk Documentation Team	Oversight of Documentation & Coding (RAF score) program	Weekly

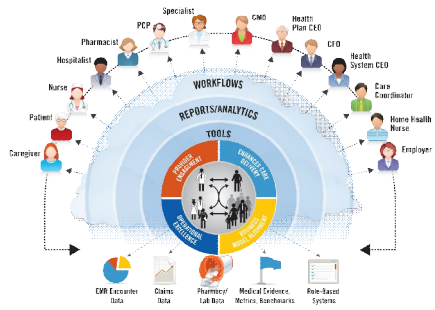
3 Implement Care Delivery and New Business Model

Collaborative provider and payer governance is critical to sharing comparative performance, best practices, and finding barriers to success.

Sample Governance Schedule – Provider Level

Meeting	Purpose	Participants	Frequency
JOCs	Review provider groups' financial and operational performance Share initiatives, contract and benefit changes	Payer representatives Clinical leadership Administrative leadership Physicians	Quarterly
Administrative meetings	Strategic planning and budget Contract review Review financial performance Evaluate and review Internal compensation model Staffing and program funding	CEO CFO Medical Director	Monthly
Clinical Management meetings	Discuss detailed clinical performance, trends, and outliers Develop campaigns and monitor performance	Medical Director (s) Quality Management Staff Care Management Staff	Monthly
Medical Director	Review comparative performance Provide leadership training Share best practices	Medical Director POD Leaders	Monthly
Practice POD	Review comparative practice-level performance, initiatives and plans for remediation Share updates about the broader group, leadership and training	POD Leader Practice POD Physicians Office Managers	Monthly
Office Manager	Review comparative performance Provide leadership training Share best practices	Office Managers Medical Director	Monthly

4 Deploy Technology and Information for Providers and Consumers



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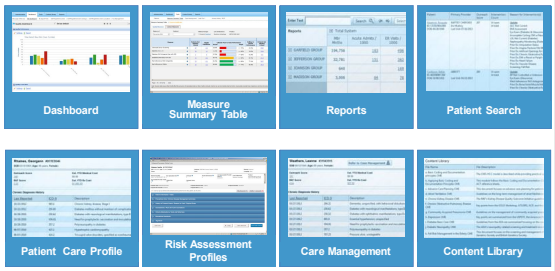
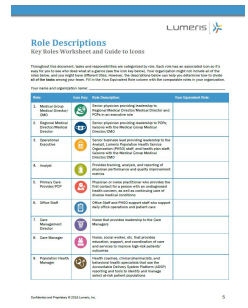


5 Transform Provider Workflow and Support Continuous Improvement

Accountable Primary Care Goals

1. Reduce Readmissions for High-Risk Patients
2. Reduce ER Utilization
3. Increase Generic Dispense Rate
4. Improve Quality Metrics/Close Gaps in Care
5. Optimize High Value Specialty Care
6. Monitor and Manage High-Risk Patients
7. Accurate and Complete Documentation and Coding
8. Improve Network Optimization
9. Improve Access to Care
10. Improve Communication and Shared Learning
11. Improve Specialty Drug Management and Medication Adherence
12. Encourage Continuous Improvement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Role Descriptions

Key Roles Worksheet and Guide to Icons

5 Transform Provider Workflow and Support Continuous Improvement

Provider Engagement Teams support physicians in market as they transition to a new model of care delivery.

Practice Coaching

Approx. 1 Practice Coach per 20 practices
- Intro Meetings
- Understanding the contract/model
- Workflow analysis
- Introduction to the data platform
- Evaluate status

Workflow Transformation

- Clinical nurse specialists focused on workflow transformation
- In-person observation of practice operations
- Recommendations tailored to capabilities, resources

Physician Boot Camp

- One-day accountable physician training
- Transform into an Accountable Practice
- Understand how to evaluate your performance
- Identify opportunities for improvement

5 Transform Provider Workflow and Support Continuous Improvement

- Collaborative Payer-Provider Meetings
- Medical Director calls
- Regional physician meetings
- Leadership development
- Ongoing opportunity analyses
- Mentoring program for new physicians

Roadmap to Profitability

1. Transition to value-based payment models for healthcare required for success
2. Delivery of value requires engagement of physicians
3. Engagement of physicians requires intentional development work by collaborative payers
   a. Clear provider strategy and value-based care strategy
   b. Willingness to invest and create new roles, new payer organizational design
   c. Intentional decisions about best provider partners
   d. Creation of a population health service organization (PHSO)
   e. Commitment to share data & technology
   f. Roll up sleeves to work deeply with chosen providers
4. Harder than it looks! Classic fixer-upper remodel project…

Thank you!

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