optimity ADVISORS

Scaling Value-Based Contracting Programs

A Guide for Payers to Drive Long-Term Transformation

optimityadvisors.com

ORANGE PAPER

The Challenge and the Opportunity

Despite recent deceleration, the growth rate of national healthcare expenditures in the US continues to be unsustainable, draining families, employers, and governments and diverting resources from other critical priorities. In 2018, the cost of healthcare for a typical American family rose 4.5%, well above the rate of inflation[1]. A myriad of factors contribute to the continued rise in costs; however, it is uncontroversial that a key driver of escalating costs is fee-for-service reimbursement – the prevailing approach to paying for healthcare based on individual services – which encourages waste and inefficiency.

As a consequence, **the US healthcare system is steadily shifting from a fee-for-service reimbursement model that rewards volume to value-based payments, with incentives aligned to cost and quality outcomes.** With increasing pressure from government and employer groups to shift the focus of the healthcare system to improving outcomes and lowering costs while increasing overall access to care, payers have accelerated their efforts to transition away from fee-for-service and increase provider adoption of various forms of value-based contracts.

For payers, the opportunity is clear. **Value-based contracting (VBC) models are designed to align incentives with providers to improve clinical outcomes, patient experience, and cost efficiency to the benefit of all parties.** Payers that build robust and effective VBC programs will not only achieve improvements in these key areas but will also experience growth and remain competitive as employers, governments, and consumers increasingly demand affordable healthcare solutions.

The Barriers to Scaling

However, payers are encountering substantial challenges in building VBC programs that are both effective in improving outcomes and responsive to rapidly shifting markets. Most payers are using systems and operating models designed for a fee-for-service environment and not easily adapted without significant time and investment. Since payers are often responding to external pressures to implement VBC, they often proceed with a reactive mindset rather than a thoughtful, strategic approach. Additionally, since providers differ substantially in their capabilities to participate in VBC there are no "one-size-fits-all" contracting approaches, which results in complexity and lack of standardization across payment models. As a result of these factors, **payers often need highly manual processes to operationalize these models, creating severe inefficiency which impedes scale and agility.**

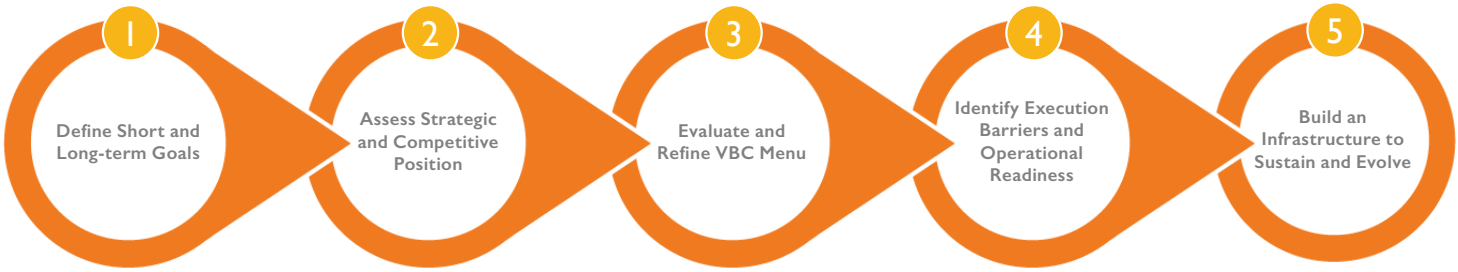
Indeed, according to a recent Change Healthcare survey, more than a third of payers said they need up to a year to launch a new episode-of-care program, 21% need up to 18 months, and 13% need 24 months or longer[2]. At the same time, conditions on the ground are changing rapidly, with providers consolidating, new "pay-vider" models and startups challenging market incumbents, as well as new VBC models and episode bundles constantly being tested, implemented, and modified by the CMS Innovation Center (CMMI). Payers are also challenged in delivering on existing VBC commitments, as provider support tools - such as claims data and risk analytics - are often limited, lagging, or lacking sophistication.

1. http://www.milliman.com/mmi/
2. https://www.changehealthcare.com/press-room/press-releases/detail/change-healthcare-study-finds-value-based-care-bending-the-cost-curve

While these challenges are substantial, through our work with national and regional payers across Medicare, Medicaid, and Commercial lines of business, Optimity has identified 5 key steps to guide payers through their journey to expanding and scaling value-based contracting programs.

5 Steps to Scaling Value-based Contracting Programs

To effectively scale value-based contracting models, payers need to engage in 5 steps:



1. Define Short and Long-term Goals Across and Within Markets

In our experience, many payers lack a well-defined set of both tactical and strategic goals that their VBC programs are designed to achieve. Tactical goals may include savings to stabilize medical cost trend, quality improvement to enhance revenue, meeting state-mandated requirements for Medicaid contracts, and gaining data for analytics purposes. More strategic goals include bolstering relationships with key providers, promoting independent physician practice, and improving the member experience. Payers are increasingly setting adoption goals intended as a signal to demonstrate their commitment to transformation, such as Blue Cross and Blue Shield of North Carolina's recent announcement[3] that they would seek to have 100% of members covered under value-based contracts within five years. Whatever the goals may be, they need to be thoughtfully envisioned and aligned to the payer's positioning and growth strategy.

While many VBC programs are formulated and owned by a centralized Clinical or Population Health department, payers should leverage a wide set of perspectives from across their organization including local market business units and supporting functional stakeholders to collaboratively create a well-defined agenda for the VBC program aligned to the firm's broader strategic goals as well as near-term market and competitive imperatives. Additionally, payers should instill accountability for meeting these goals by selecting key performance metrics and targets for each goal.

Optimity has supported payers to define and address many different strategic goals through their VBC programs. In one example, a client was seeking to address a core market where large, consolidating health systems were increasingly absorbing private physician practices, resulting in higher payment rates and increased referrals to high-cost facilities. As a result, the client identified promoting independent physician practices, in addition to cost savings, as a strategic goal for their VBC program and aligned their program to support this objective by enabling and empowering virtual panels of primary care physicians to obviate the need for health system employment.

3. http://mediacenter.bcbsnc.com/news/blue-cross-nc-and-five-major-health-systems-announce-unprecedented-move-to-value-based-care

2. Assess Market and Competitive Positioning

After clearly defining goals, the next step is to holistically assess your positioning in each market to identify and prioritize opportunities. Consider factors such as consumer demographics, payer market share by product type and line of business, provider market composition and geographic considerations, demand for VBC from employers and/or providers, relative cost of care, as well as regulatory considerations. Develop a thorough understanding of provider adoption, readiness, and maturity in VBC models in the market across payers and lines of business. A careful analysis of these considerations will enable you to identify opportunities to meet program goals and to define a customized approach towards each market.

The market analysis requires a baseline understanding of the payer's competitive positioning in the relevant markets. The payer's membership and market share relative to competitors is a key driver of VBC approaches, for both tactical and strategic reasons. For example, a large or concentrated membership enables the payer to establish more VBC models that require a large population base for actuarial significance, and to more quickly gain interest and adoption from providers in the market. Alternatively, a smaller or startup health plan may be unencumbered by legacy relationships and have more flexibility to structure their network around a health system in a strategic, value-based partnership including co-branding, for example.

Incorporating a detailed analysis of the local provider market is critical to addressing two distinct but related questions – which providers are ready for VBC and which should you partner with. This analysis should begin with provider market share by facility/service type, ownership and organizational structures, and affiliation and consolidation trends. Payers should understand which providers are currently under VBCs, the level and scope of the risk assumed, and the payers involved. In addition to current VBC status, the payer should assess readiness for VBC based on a number of factors including leadership, quality improvement, and technology infrastructure.

Provider VBC Readiness Factors

Example Capabilities

Organizational Profile

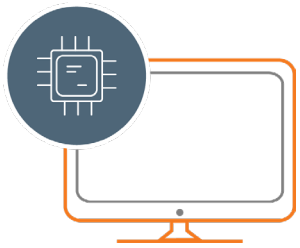
- History of participation in CMS, commercial value-based payment initiatives
- Quality improvement programs with payers
- Facility affiliations, physician specialty composition
- Financial ability to assume risk

Leadership & Governance

- Engaged leadership committed to accountability, improved outcomes, with ability to drive provider alignment
- Governance structure promotes broad participation including physician leadership
- Physician performance-based incentive sharing programs

Quality Improvement & Population Health

- Demonstrated ability or potential to impact and improve quality and cost outcomes
- Structured programs to engage and incentivize providers on quality improvement
- Population health programs to identify and engage high-risk patients
- Comprehensive care coordination programs for select populations, including behavioral health/social service supports
- Practice transformation programs and support, e.g. PCMH



Technology

- IT Systems - EHR, Patient Portals, Care Management Platform, Analytics
- Participation in regional HIEs to promote integrated care delivery
- Systems and processes to collect and report data on quality measures
- Tools to identify referral patterns, benchmark performance, and provide transparency to physicians

Finally, the payer must evaluate which providers are the best fit for their VBC program. Success in an aligned payment model is ultimately contingent on mutual cooperation, support, and trust necessitating a long-term partnership between parties. The payer should consider its existing provider relationships including any prior collaborations on quality improvement initiatives, as well as competitive dynamics between providers, and other payer-provider relationships in the market. Look beyond existing contractual relationships and consider whether any IPAs may form the basis of a partnership. Alternatively, if there is limited provider capacity or investment capability in the market, consider opportunities to partner in an MSO vehicle or other joint venture constructs.

3. Evaluate and Refine VBC Offerings

Once the payer has a thorough understanding of the opportunities in its markets, the next step is to evaluate its catalogue of VBC options, or "menu", and determine current and future gaps. The payer should evaluate its offerings relative to a "full menu", meaning a range of models covering a variety of populations, clinical episodes, and risk levels, which may be suitable for different provider types. Since providers have substantially different levels of experience with VBP, risk tolerance, and organizational resources to support transitioning to VBC, a broad menu of options with flexibility to support different risk arrangements is ideal for the ability to engage a wide range of providers and achieve scale within a market.

Types of Value-Based Arrangements

Population-Based	Episode-Based
Encompassing comprehensive services for defined patient populations over time and across settings.	*Encompassing services for specific conditions or procedures that occur across settings within a defined window of time.*
• Medicare Shared Savings Program (MSSP) • Next Generation ACO Model • ACO Investment Model • Comprehensive Primary Care Plus (CPC+) • Independence at Home • Pediatric Alternative Payment Models • Total Care for Special Needs Subpopulations	• Bundled Payment for Care Improvement (BPCI) Models 2-4 and Advanced (episodes include Joint & Spine, Cardiology, Pulmonary, Nephrology, Stroke, etc) • Comprehensive Care for Joint Replacement (CJR) • Oncology Care Model (OCM) • Altarum/PROMETHEUS Episodes • Maternity & Prenatal Care Models

In addition to scope and flexibility, payers need to consider if their VBC models effectively address the most impactful clinical areas and needs for their member populations in each market. Ideally, the payer should leverage analytics tools to evaluate claims and member data to identify variation in quality and cost outcomes, using common episode groupers or provider attribution and profiling models. Once these clinical areas and needs are identified, consider what VBC models have demonstrated results impacting these outcomes. For example, diabetes and other chronic conditions are often best addressed through an ACO-like population-based model, whereas common procedure-based episodic models such as orthopedic bundles can significantly impact post-acute utilization. Finally, consider other models in development or in the pilot stage from CMMI or other payers in less-mature spaces of VBC such as cardiac and oncology.

Another key aspect to examine whether looking at new or prospective models is alignment to CMS and other payer models. Since providers typically don't differentiate patients by their payer, they need common rules across payer programs to effectively implement care models and protocols while avoiding unnecessary administrative work. At the same time, providers vary substantially in their ability to manage risk and take accountability for different aspects of patient care. **To account for this dichotomy, the ideal VBC model will have streamlined contract templates with design elements substantially similar to other models in the market, but with variable negotiation levers such as risk and incentive amounts, enabling the payer to meet providers where they are while allowing appropriate customization.**

As a result, the payer should analyze its models against CMMI and private payer models in its markets, then assess and align key differences in model parameters including:

- Scope such as total cost or clinical episodes
- Risk arrangements including outlier protections such as risk adjustment, stop-loss, etc
- Infrastructure investment, e.g. care management or practice transformation funding or resources
- Service carve-outs and episode definitions
- Quality requirements and measure definitions
- Benchmarking and target rate setting and rebasing methodologies
- Analytics and technology support
- Utilization Management requirement waivers or delegation authority

4. Identify Execution Barriers and Operational Readiness

A well-crafted menu of VBC options is necessary, but insufficient to building a robust VBC program. Implementing and administering VBC is a major challenge for payers due to legacy systems and processes designed for a fee-for-service payment environment. Additionally, VBC success requires a new level of collaboration with providers, requiring new capabilities to share meaningful and actionable data to improve outcomes. As a result, payers need to assess their capabilities to ensure they can operationalize VBC including their ability to engage and support providers, to measure performance and outcomes, and to share rewards accurately and efficiently.

The inherent complexity of VBC contracts poses a challenge to administering these contracts within a legacy business architecture resulting in **manual workarounds and downstream operational challenges.** These arrangements are often cumbersome to manage with existing claims adjudication systems resulting in significant inefficiencies including:

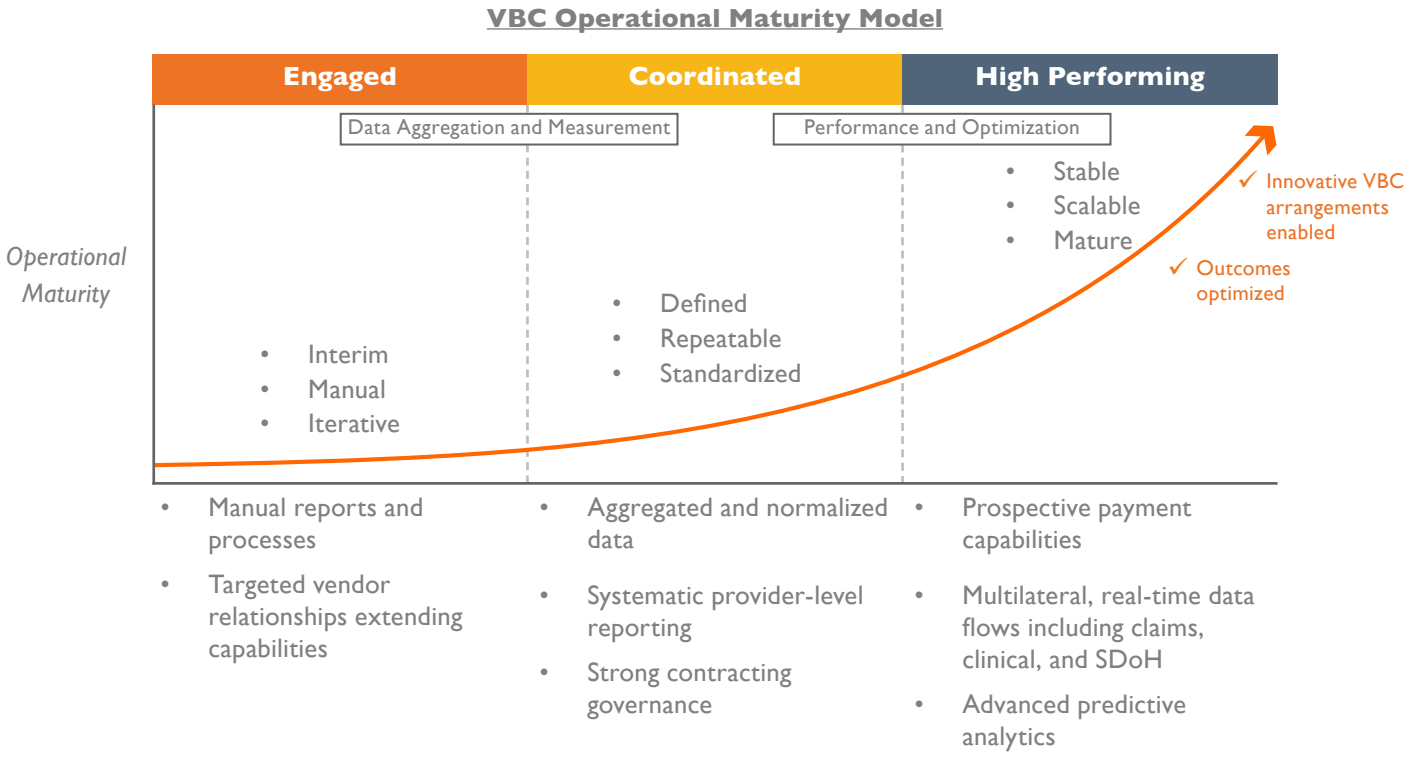
- Inconsistent payment accuracy that hinders the ability to accurately calculate costs, attribute members and costs appropriately to a provider, and adjudicate payments.
- Financial settlement to determine savings and rewards often entails significant manual processes that vary from contract to contract.
- Ingesting clinical quality data and measuring performance outside of core systems
- Critical reporting needs are often addressed in an ad-hoc fashion, with duplicative processes across programs and markets creating additional inconsistency.

These common inefficiencies represent a barrier to scaling VBC programs and need to be addressed in order to expand and innovate. Perhaps more importantly, inefficient and inaccurate processes also represent significant barriers to meeting the needs of providers and building crucial trust through transparency, accuracy, and consistency.

The ability to effectively engage and support providers is perhaps the ultimate key to VBC success. Among the most critical success factors for providers is the ability to receive timely, accurate, and actionable data in order to engage the right patients at the right time to improve quality, lower preventable utilization, and steer patients to lower cost treatment settings. However, many payers lack standardized analytics and automation to create this reporting in a timely manner and often rely on overburdened internal reporting teams to provide reporting on financial performance, utilization and claims data, and gaps in care. These data sets are critical for providers to identify opportunities and evaluate their performance. Flexibility in delivering this data is also important, as more advanced providers may maintain a data warehouse containing data sets from numerous sources and payers that ultimately feeds into a common workflow. Finally, payers should consider their capabilities to deploy trained personnel to engage providers directly to educate, guide, and collaborate on opportunities to improve performance.

5. Build an Infrastructure to Sustain and Evolve

The path to VBC is a long and iterative journey and requires infrastructure to adapt and evolve the program over time. In the short term, ad-hoc solutions and narrowly focused vendor supports may be sufficient for payers to advance their VBC strategy. However, planning and building an enterprise foundation is necessary for long-term success. Payers need to envision and design a future state business architecture with administrative capabilities robust and flexible enough to support a variety of future VBC arrangement types (e.g. shared savings/risk, capitation, bundled payments) across multiple lines of business. In addition to claims adjudication, core systems will need the capability to automatically combine claims with quality data and provider contract terms to produce real-time reporting of provider progress against VBC thresholds and rewards calculations, while also factoring in risk scores and other risk management parameters. Additional capabilities include the ability to integrate these measurements with provider portals to share performance data, as well as payer population health management, analytics, and quality reporting applications. While end-end VBC administration solutions are still emerging, many focused solutions are available from a variety of vendors to support data analytics, claims adjudication, episode management, benchmarking and target rate setting, and financial settlement.



Advancing these capabilities holds tremendous promise to make VBC more effective. Achieving automation, improving accuracy, and speed will enable more advanced attribution models, better reporting, and more timely financial reconciliation that may have significant effects. For example, transitioning from retrospective to prospective payment and/or more frequent reconciliation may substantially impact provider performance, given that behavioral economics indicates long delays between action and rewards (the norm under most models today) blunts the effectiveness of these incentives. Improving payment processes using real-time, transparent data may also aid provider relationships and build trust which is ultimately necessary for any aligned payment arrangement.

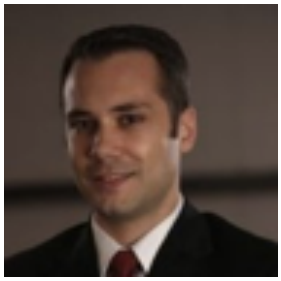
Building a VBC infrastructure goes beyond technology and process, it requires an organizational model that guides the enterprise to deploy VBC in an effective, strategic manner. Most payers VBC programs have varied departmental ownership, interactions, and activities creating challenges with coordination, issue resolution, and accountability. Often lacking is structured governance to ensure strategic and operational alignment of key functions across all LOBs and markets as well as to align, prioritize, and sequence competing investments and initiatives. To address this need, Optimity has worked with payers to implement cross-functional Center of Excellence models to develop, leverage, and maintain VBC expertise across the enterprise and create integrated teams to provide program management, ensure adequate resourcing, support evaluation of new and existing models, and to oversee training and education to bolster local market expertise and provider engagement. Developing this organizational infrastructure is a key ingredient for payers to institutionalize their commitment to VBC and ensure their ability to evolve and adapt to a constantly and rapidly shifting marketplace.

Conclusion

To move beyond narrow programs and targeted pilots and truly achieve scale in VBC, payers need to develop a long-term strategic plan supported by investments in people, process, and technology infrastructure. While these investments are significant, the potential payoff is transformational and the risks to not acting swiftly are higher, as the shift to value-based payment will continue and leave behind those not prepared. Payers that carefully undertake this planning process are the most likely to realize the ultimate goal of linking cost and quality performance to payment, better serving members, and competing in a value-based world.

Optimity Advisors is committed to supporting payers, providers, employers and government agencies through their journey to value-based care. We have guided payer organizations in planning and implementing their transformation initiatives in all regions of the US and all lines of commercial and government business. Our team of experts has deep domain expertise and over 25 years of experience in supporting healthcare organizations to achieve results in value-based models. We leverage our experience with strategy, design, implementation, and evaluation of new models in healthcare financing and delivery systems across the US, Europe, and Middle East to achieve the triple aim of lower costs, better quality, and improved patient experience.

Meet the Author



***Vince Volpe**, based in Optimity's New York City office, Vince has experience across the healthcare payer, provider, and managed care sector, including Medicare, Commercial health plans, Medicaid managed care, physician organizations, and health systems. His focus lies in engaging diverse organizations across the continuum to drive solutions for improving value in the healthcare system. Vince has significant expertise in value-based contracting, population health, care management, and consumer/patient engagement. He has led the design and execution of numerous value-based care initiatives including the formation and launch of a multi-payer ACO, assessment of value-based contracting strategies for Medicaid MCOs, readiness support for a behavioral health and substance abuse IPA preparing for state-driven DSRIP value-based contracting initiatives, and future-state operating model design and roadmapping of value-based contracting capabilities for a national managed care organization. Vince is a graduate of the Health and Pharmaceutical Management program at Columbia Business School, where he received his MBA.*

THANK YOU

Thank you for your valuable time. For further information, please contact:

Vince Volpe, MBA | Senior Manager
Direct: (917) 828.6418
Vincent.Volpe@optimityadvisors.com

optimity®
ADVISORS

EUROPE, MIDDLE EAST, UNITED STATES – HERE TO HELP

LET'S WORK TOGETHER

Together, we create better experiences—experiences that drive profitable and sustainable growth in a hyper-connected world.

Optimity Advisors is a global management consulting firm that helps organizations architect, build and launch human-centered strategies and solutions that embrace the complexities of our digital world.