OPTUM®

What we talk about when we talk about value-based care

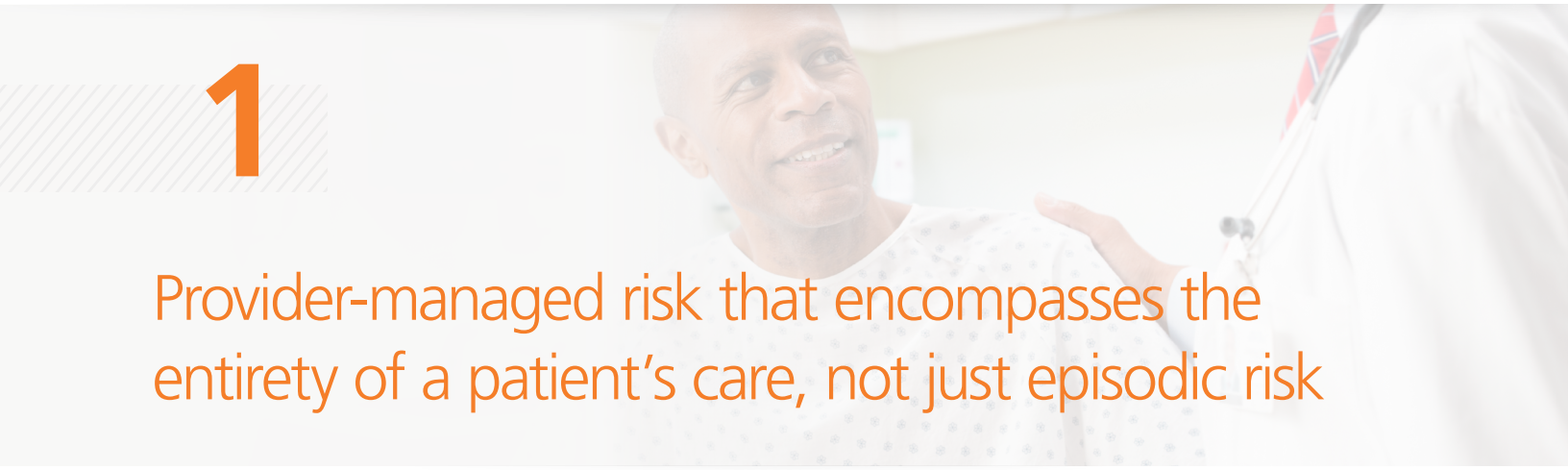
There is near-universal consensus that "value-based care" is a good and worthy objective for all health care stakeholders.

That includes providers, payers, employers and consumers. But in any instance when all agree about an idea, a thoughtful person might ask whether everyone shares a precise definition of the idea. Or is it only vaguely defined, a concept that appeals to more ambiguous, aspirational ideals?

In this instance, it may be the latter. The Quadruple Aim identifies categories of objectives that include various useful and worthy measures. Value-based care (VBC), on the other hand, is a strategy that includes five major elements.

1. Provider-managed risk that encompasses the entirety of a patient's care, not just episodic risk
2. Deploying targeted population health programs through expanded networks
3. Integrating data and consistently reporting it across stakeholders in financing and health care delivery
4. Payer-provider collaboration
5. A focus on growth

Other programs — such as pay-for-performance regimes, bundled payment initiatives — can support and reinforce various elements of value-based care. But in and of themselves, these do not comprise a full strategy. So let's take each element in turn.



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Provider-managed risk that encompasses the entirety of a patient's care, not just episodic risk

Provider-managed risk

In this context, "risk" refers to insurance risk. And it is the most significant difference in this era of provider-led value-based care. Accountable care organizations models now include both significant upside and downside risk. This is particularly true as the Centers for Medicare and Medicaid Services moves the Medicare Shared Savings Program in that direction. This shift requires participating providers to take responsibility for the lives of individuals, rather than just episodes of care. Under VBC, providers are seeking to move toward first-dollar premium risk. This is shown in Chart 1 as the movement from left to right. In the most ambitious scenario, health systems are bringing new products to market for which they either own the premium or are delegated full risk from a partner.

The shift to VBC

This shift requires participating providers to take responsibility for the lives of individuals, rather than just episodes of care.

Potential low risk and low return
Low integration/Alignment

High integration/Alignment
Potential high risk and high return

No-risk VBC arrangements		Shared risk without partnership		Shared risk with partnership	
Pay for performance	Upside-only shared savings	2-sided shared savings	Capitation/Global budget	Co-branded, white-label product partnership	Ownership/ Provider-sponsored health plan (PSHP)
No Total cost of care (TCOC) opportunity/risk	Built on FFS chassis with quality metrics	Built on FFS chassis with quality metrics	Delegated risk with negotiated carve-outs	Joint governance on product and network design	Merger/acquisition or develop own plan

Chart 1: VBC program overview

But not all risk is created equal. There is no "right" or "wrong" type of risk if the populations for which a system is taking risk are large enough to create a sustainable pool of lives. However, selecting which population(s) for whom a provider is willing to take risk should lead to different investments, growth trajectories and population health interventions. Here are a few examples.

- Managing ***Medicare risk*** requires a greater emphasis on:
  - Developing post-acute care networks
  - Establishing greater rigor in physician coding
  - An over-rotation on palliative care
  - Maintaining a healthy Star rating for Medicare Advantage plans

  Moreover, growth in Medicare Advantage requires a more deliberate, individualized strategy.
- ***Medicaid risk*** presents an entirely different challenge. Medicaid patients demonstrate a disproportionately high incidence of behavioral health conditions relative to other populations. This requires significant investment in establishing an adequate and effective network. Moreover, the effective management of risk for this population demands a greater focus on gathering useful data on social determinants of health (SDOH). Transportation, diet, relationships and environment represent significant non-clinical barriers to quality clinical care for many Medicaid enrollees. Risk-bearing entities for such populations are well-served by a systematic approach to meeting these populations within their communities. They need to determine effective strategies that address SDOH challenges.
- Finally, ***commercial risk*** asks risk-bearing entities to:
  - Build broad networks
  - Engage in aggressive contracting on fee-for-service rates
  - Establish close relationships with brokers to grow aggressively in the employer-sponsored markets

Aspiring and ambitious risk-bearing entities can choose more than one type of population for value-based risk models. Investments in managing risk in one type of population can certainly serve others. But each type of population will require its own unique investments and risk models to account for its different characteristics and demands.

Not all risk is created equal

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2

Deploying targeted population health programs through expanded networks

Rethinking networks

Health systems have deep experience in deploying patient-centered medical homes, care transition programs and disease management protocols. Value-based care places an even greater premium on targeting such programs to chronic care populations and vulnerable populations. The increasing appreciation for and sophistication in addressing SDOH is slowly pushing health systems to engage even more aggressively in the community to mitigate such health risks. Moreover, the increasing integration of SDOH in population health approaches creates the need for risk-bearing providers to rethink their networks. Strong, broad foundations of primary care physicians and specialists are now both necessary and insufficient. Risk-bearing providers must integrate post-acute, social work and community-based resources.

Effective population health interventions focus on reducing unnecessary utilization and improving the health of the targeted individuals. Such interventions also should strive to keep providers practicing at the top of their professional licenses.

Initial population health efforts often focus on easily measured, high-cost events such as reducing hospital readmissions for certain conditions and preventing unnecessary ER visits. Each of these examples reveals opportunities that many health systems new to VBC did not see. That is, the opportunity to engage in communities with a focus on keeping patients healthy — and reducing their demand on expensive sites of care.

When focusing on readmission or ER prevention, risk-bearing health systems often find themselves short-staffed in critical roles. These are the roles that focus on the transition to and maintenance within the patients' communities. Persistent staffing shortages make it difficult enough to maintain a sufficient workforce in inpatient and clinic settings. Extending the reach of the VBC entity to the community can strain a health system even further, if it relies on the existing workforce.

Value-oriented health systems are ramping up their investment in community health workers (CHWs) and clinical social workers (CSWs) to manage community-based risk needs. CHWs and CSWs use a blended approach that combines both SDOH and clinical interventions. Increasingly, they play a critical role in designing and implementing high-impact population health interventions in the community.

Effective population health interventions focus on

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and

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3

Integrating data and consistently reporting it across stakeholders in financing and health care delivery

Data integration and stakeholder reporting

Health systems have made significant investments in their own clinical and financial systems. Their ongoing efforts to integrate and add data sources to these systems generate greater insight into their own performance and reveal opportunities to improve population health.

An effective value-based analytic strategy, however, should establish a cadence toward ever-more sophisticated reporting while starting with clear and simple metrics today. This includes:

- Whole-person chronic and acute care episodes
- Provider panel management and performance
- Integration of medical, behavioral, clinical notes and SDOH information for predictive and stratification applications

A data and reporting infrastructure is an organism evolving toward greater complexity and strategic value. It's not a static model that will one day reach final development. At whatever stage of maturity, the data and reporting infrastructure is only as good as the decisions it can inform, the performance it can improve, and the action it can drive. In guiding the evolution of the system, value-oriented health systems are well-advised to maintain a steady focus on which group of stakeholders (and which decisions they make) can be improved through greater data sophistication.

CASE IN BRIEF

CareFirst BlueCross BlueShield Patient-Centered Medical Home Model

The CareFirst BlueCross BlueShield Patient-Centered Medical Home demonstrates how highly coordinated care can:

- Lower expected total cost of care
- Improve quality for patients
- Increase annual income for primary care physicians

The program of 4,400 physicians who work across several thousands of practices organizes primary care physicians into panels. These groups of 5 to 15 physicians earn financial incentives based on the quality and savings they deliver. An essential component of the program's success has been driving provider behavior by providing them with better data with which to make decisions, particularly around referral patterns. The PCPs share a list of their favorite specialists, ranked by color-coding based on risk-adjusted PMPM costs.

From the program's inception until 2017, CareFirst members had:

21.3% fewer hospital admissions

22.5% fewer emergency department visits

.8% fewer days in the hospital

In addition, CareFirst's overall medical trend **averaged 3.5% from 2013 to 2017.** This compares to a baseline in the **five years prior to launch of 7.5%.**[1]

Mature VBC arrangements call for even more ambitious data sharing and acquisition efforts. Payers have also made substantial investments in their ability to aggregate and report on patient and provider activities. They aim to improve patient outreach and engagement. VBC models are beginning to align these efforts between payers and providers. Now, it's up to both payers and providers to recognize such alignment and begin to collaborate on data sharing, data aggregation and reporting.

1. Finnegan J. Patient-centered medical home program saves CareFirst $1.2B, pays off for doctors. *FierceHealthcare.* June 28, 2018. Accessed July 16, 2019. fiercehealthcare.com/patient-centered-medical-home-carefirst-chet-burrell.

4

Payer-provider collaboration

Partners in value-based care

That brings us to possibly the biggest challenge stakeholders confront in this shift. Past efforts at provider-led value-based models include the physician hospital organization (PHO) movement of the '90s. These were narrow-network managed care approaches that have largely been efforts to "go it alone." They have rarely proven successful, repeatable or scalable. Similarly, payers' efforts at VBC are hampered by their arms-length relationships with enrollees' clinical needs, which providers address most effectively and sustainably. Clearly, past efforts at sustainable VBC have been broken. They were fundamentally flawed by the build-it-from-scratch approach by individual stakeholders.

What has emerged is a gradual realization that effective, sustainable and scalable value-based models are, at their heart, based on partnerships. Health systems do not have to own every skilled nursing facility or gerontology practice to take better whole-person care of Medicare enrollees. Payers do not need to own their provider network to manage risk. Both approaches are expensive. They are also outside the core capabilities of most health systems and payers. Perhaps most important, such approaches are unnecessary and, if not done appropriately, result in additional costs to the overall delivery of care.

We grant that the cultural and business elements of the payer-provider relationship have long been fraught. A reliance on the traditional focus of negotiating reimbursement rates and percentage of charges only reinforces the fee-for-service dynamic that value-based contracting means to upend. At times, such a focus can have the exact opposite effect of what VBC aims to accomplish.

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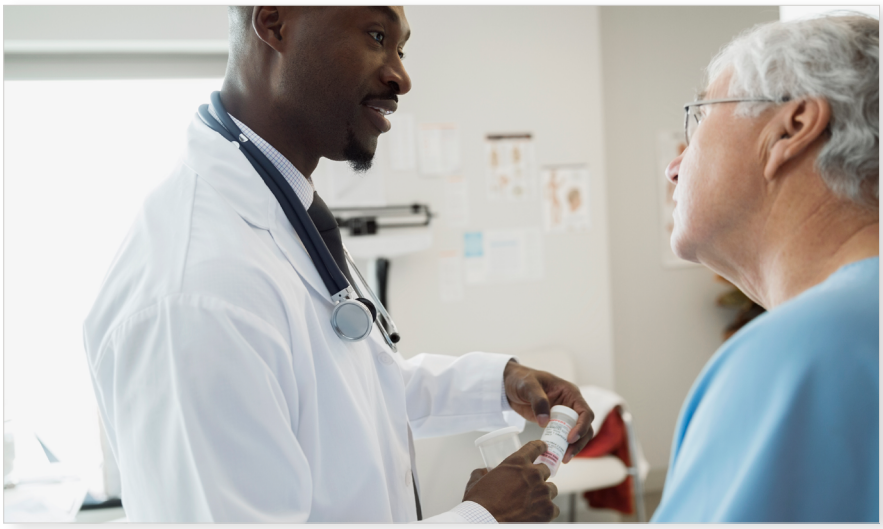
What has emerged is a gradual realization that effective, sustainable, and scalable value-based models are, at their heart, based on partnership.

Successful VBC arrangements require the primary stakeholders to move past this historical baggage. Rate negotiations may not disappear. But in a collaborative relationship, they can be put in the context of a more ambitious approach (see "A focus on growth" section on the following page). Ultimately, these successful partnerships have the opportunity to disrupt markets with innovative, competitively priced insurance products that seek not just to bend, but to break the cost curve.

Health systems and providers benefit from the licensing, risk-based capital, credentialing and even the back-office capabilities of payers. Likewise, payers require the frontline clinical presence and patient engagement that providers excel at. Collaboration around the design of a fully formed network that can serve both clinical as well as geographic needs enables the partnership to focus on a broad-based growth agenda.

Sharing the risk between payers and providers frees the provider from focusing solely on fee-for-service volume. It provides them the freedom to experiment with community-based and more innovative clinical interventions that may or may not be attached to a fee schedule. As the population served by these products grows, providers can maximize the return on their population health investments.



Hitting "reset" on the payer-provider relationship takes time and in-depth involvement from both sets of leadership. But absent such a reset, providers will lack sufficient exposure to risk and will be unable to scale their population health efforts successfully. And payers will miss the opportunities to engage more fully with patients.

Sharing the risk between payers and providers frees the provider from focusing solely on fee-for-service volume.

5

A focus on growth

Managing the network population

Finally, value-based care can be an enabler of growth. However, the system must focus on growing the number of lives covered, as well increasing share of wallet for these lives. They must also limit spending on unnecessary health care services and manage per-capita utilization efficiently to maintain volumes over a broader population.

You can't simply grow the size of the population covered by the new product without new engagement models and product design features. That would be insufficient to sustain the economics of this type of partnership. Through applying these new models and design features, this new collaborative must also focus on managing the enrolled population effectively.

Building a network that ensures that a patient's health care spending remains domestic to the network can drive substantial growth in revenue for the participating providers. This is illustrated in Chart 2. In this simplified example, we assume a patient incurs an average of $4,000 a year in total facility services, and $3,000 of this care is provided in the domestic network under an HMO product (that is, share of wallet). Using the $3,000 as the assumed share-of-wallet capture level then suggests that the annual share-of-wallet opportunity for a PPO life is $2,000 ($3,000 minus $1,000) and a life attributed to another provider is $2,500 ($3,000 minus $500).

Profitability. Sustainability. Then Scalability.

Each collaboration will have different mutual goals based on a payer and provider's individual needs.

- How many lives does a payer want to grow?
- What level of sustainability can a provider achieve?
- How scalable are both to each organization?
- Who are the competitors we face?

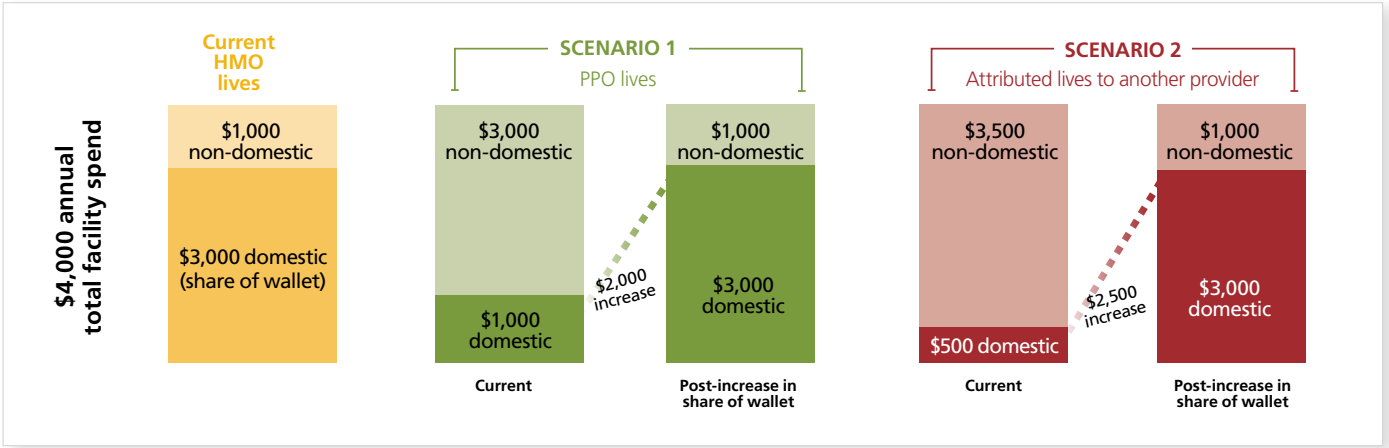


Chart 2: Share-of-wallet opportunity

The impact to topline revenue growth can be substantial through increasing the lives and the share of wallet. The model in Chart 3 illustrates the potential relative revenue impact of maximizing share of wallet and typical VBC incentive revenues for a commercial population. Although the VBC incentives will be important to the construct of the arrangement, the share of wallet will typically be the largest driver of revenue.

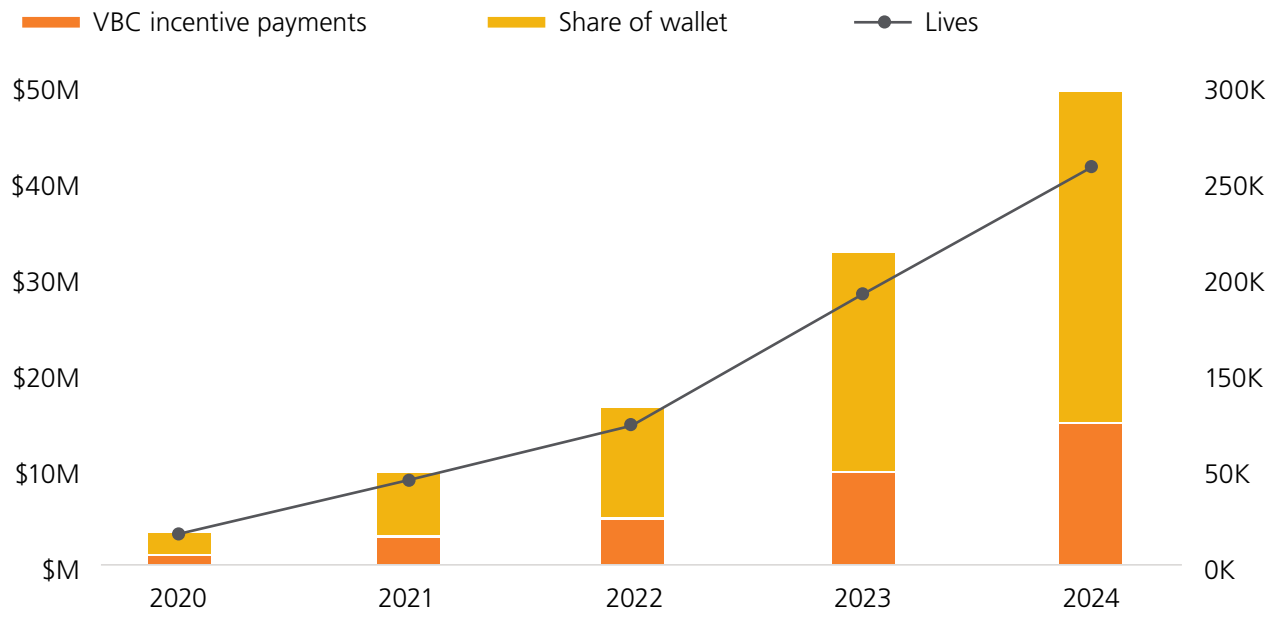


Chart 3: Share-of-wallet topline revenue growth model

The growth from increased share-of-wallet capture from existing and new lives buffers the negative fee-for-service revenue impact health systems might otherwise face. These negative impacts come from reductions in utilization (through effective population health interventions) and payer reimbursement rate discounting (in order to offer a competitively priced premium). Each of the previously mentioned components (i.e., share of wallet, payer reimbursements, utilization levels and VBC incentive payments) will either have a positive or negative impact to the overall revenues and margins of a health system. Thorough analyses are required to understand the impacts from each independently and in combination with one another. However, when designed correctly, the positive impacts should outweigh the negative. Below, in Chart 4, we highlight some of the key drivers to address how each contributes to the ultimate margin impact.

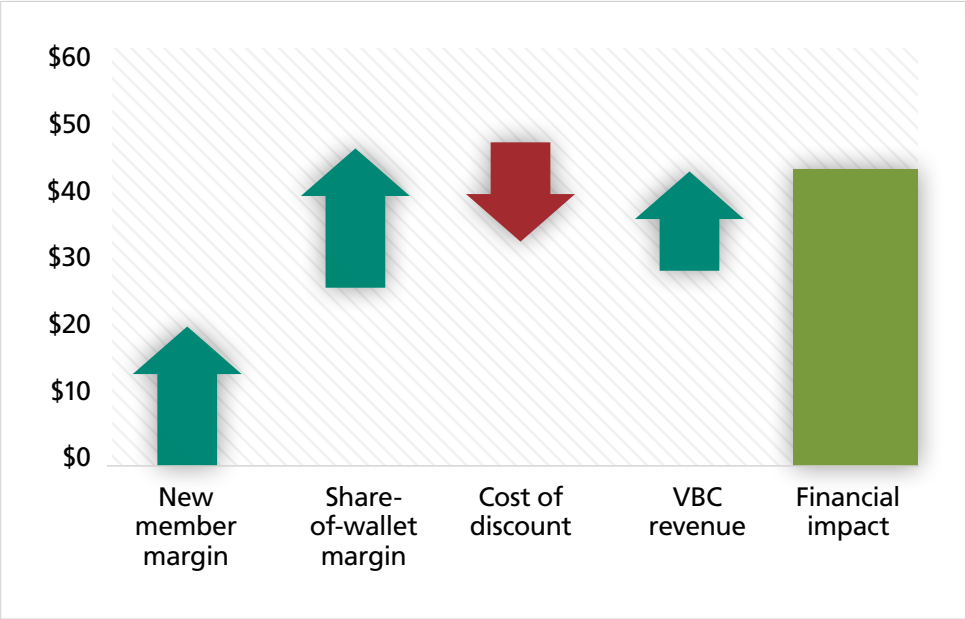


Chart 4: Illustrative margin impact (in M$)

There are certainly other ways to hedge the risks inherent in this approach. Payer-provider collaborations can establish risk-sharing corridors and reinsurance mechanisms. But we believe the focus should be on growth as the most effective hedge against the upside-downside risk of VBC. Growth provides the strongest platform and clearest focus for providers as they pursue market disruption.

Taking the leap to VBC is not simple and cannot be executed hastily.

There are many challenges:

- Massive investments required in data infrastructure
- Increasing sophistication of population health programs
- Increasingly urgent demands of employers and patients for better, cheaper care

These challenges leave primary stakeholders with little choice but to engage with each other on a sustained journey toward a shared vision. The alternative is an increasingly unsustainable and unsatisfactory fee-for-service system. Transformation will not happen overnight. Yet VBC will help all stakeholders realize the Quadruple Aim rather than remain mired in the status quo. One win at a time, transformation will happen.

An abridged version of this topic first appeared in *Managed Care* as "What We Talk About When We Talk About Value-Based Care."

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