Creating a Sustainable Future for Value-Based Care

Exploring Best Practices for VBC Payment Arrangements

Purpose

AHIP, AMA, and NAACOS seek to advance the voluntary adoption of Value-based Care (VBC).

By sharing what works, health plans, clinicians, and VBC entities will have access to best practices that are informed by real-world experiences to voluntarily consider during the future design, implementation, and evaluation of their own VBC participation.

Approach

The Playbook represents findings from:

- An advisory workgroup comprised of members from each partner association,
- A managing committee of association leaders,
- A literature review,
- An environmental scan, and
- Interviews with subject matter experts.

Workgroup members and subject matter experts were selected through an intentional process to ensure diverse representation; they include national and regional health plans; large, small, rural, integrated, and independent physician practices; and VBC entities, such as accountable care organizations (ACOs), including those with substantial experience and those that are newer to VBC arrangements.

Playbook Domains for Voluntary VBC Payment Arrangements

1. **Patient Attribution**
   The process by which patients and their associated medical costs are assigned to a physician or entity.
2. **Benchmarking**
   The financial target in a VBC payment arrangement with which performance year expenditures are compared.
3. **Risk Adjustment**
   A statistical method that converts the health status of a person into a relative number.
4. **Quality Performance Impact on Payment**
   Reward VBC entities for strong performance on quality of care as measured by a set of predetermined quality metrics.
5. **Levels of Financial Risk**
   Assume some level of accountability for improving the care outcomes and costs of managing their patient populations.
6. **Payment Timing & Accuracy**
   Structure how and when funds flow in VBC payment arrangements.
7. **Incentivizing for VBC Practice Participant Performance**
   Consider if and how each individual participant will be engaged to cascade the goals, objectives, and advantages .of the VBC payment arrangement.

Common Themes Across Best Practices

- **Collaboration & Flexibility:** By working together to create VBC payment arrangements, participants can take differences in readiness, capabilities, patient populations, and resources into consideration.
- **Transparency:** Clear advance documentation, and regular feedback around methodologies and performance can address the sheer complexity of VBC payment arrangements and (at times) unpredictability of payment.

Considerations Across Best Practices

- **Rural Geographies:** Rural health care organizations typically have smaller margins and higher relative fixed costs than their urban counterparts, making it more difficult to invest in the necessary tools and resources for managing total cost of care. When combined with staffing challenges, it can be difficult to take on financial risk or participate in VBC payment arrangements that require additional administrative or logistical capacity.
- **Multi-payer alignment:** Participating practices and VBC entities can be better incentivized to implement changes in care management and clinical workflows, invest in necessary infrastructure, and deploy population health interventions at scale when VBC payment arrangements are aligned both within and across health plans.
- **Health Equity:** Before integrating health equity data into aspects of a VBC payment methodology, there are a number of important pre-steps, including physician education, piloting, evaluation, and recognition of the additional resources this type of training, outreach, and data collection require of VBC entities, physicians, and participating practices.

Payer-Provider Forum

Optimizing Your Payer-Provider Engagements

Wednesday, **October 16 from 1:00 – 5:00 pm ET**

NAACOS Fall Conference: October 16-18, 2024
Marriott Marquis Washington, D.C.
Registration now open

Description: Providers in value-based care have been innovating care delivery across lines of business through partnerships with payers. This session will provide a forum for providers and payers to engage in solutions-focused discussions on building rapport, successful contract experiences, and collaborative partnerships. Providers and payers will have an opportunity to deep dive into the principles of value-based care contracting through panel discussions, live Q&A, and table discussions.

- Engage with ACOs and payers to discuss best practices, challenges and solutions for building optimal engagements.
- Attendees will gain an understanding of the perspectives and challenges both providers and payers experience in deploying VBC programs across lines of business.
- Learn from industry experts as we explore strategies and best practices focused on strengthening provider and payer relationships.

Benchmarking

Goal: Establish an agreed upon cost target that incentivizes care transformation activities by rewarding a VBC entity for efficiency as well as improvement in the total cost of care; predictably, accurately, and transparently set an achievable spending target; and create a path toward sustainable savings over the life of the VBC payment arrangement.

Voluntary Best Practices	
Setting the baseline	• Use multiple years of historical data. • Avoid frequent rebasing of the baseline years when using a VBC entity's own historical costs and consider moving to regional baselines over time. • Collaborate on an achievable percent of premium target. • Include pharmaceutical costs, where feasible.

Benchmarking (continued)

Voluntary Best Practices	
Trending the baseline forward to establish a benchmark	• Exclude the VBC entity from the reference population when their experience is large enough to drive the regional trend. • Prioritize regional over national trend factors, as appropriate. • Combine prospective administrative trend factors with retrospective adjustment to balance predictability and accuracy. • Establish guardrails when using an administrative trend to help manage risk. • Ensure attributed and reference populations are comparable.
Making specialized adjustments to the benchmark	• Include benchmark adjustments to incentivize continued VBC entity efficiency. • Test adjustments to the benchmark to encourage inclusion of historically marginalized populations in VBC.

Speaker

Andrea Osborne is the Senior Vice President of ACO Operations and Delegated Services at VillageMD. Andrea graduated with a master's of science in therapeutic recreation from Indiana University. She spent the next 16 years working in long term care and has been a licensed nursing home administrator since 2004. Through her career, Andrea has had responsibility for managing performance within Payer contracts and CMMI models. She has managed value-based contracts for multiple entities including hospital systems, employed providers and affiliates.

VillageMD

Access

Primary Care[1]

- ~750 total providers
- Approximately 600,000 primary care patients
- ~1 in 6 patients require specialist care

Urgent Care

- 150 urgent care locations
- ~6.7 million urgent care visits annually, with Aftercare managing ~50K patient calls per month
- Average patient visits CityMD ~1.8 times per year
- >80% cost reduction vs. comparable ER visit
- ER send rate of ~2%
- Post-visit care management for monitoring, review, and outreach

Specialty Care

Multispecialty Care[2]

- ~550 specialist physicians and ~1,200 total providers
- Nearly every medical specialty covered within provider network
  - 140+ Urologists
  - 100+ Orthopedists
  - 50+ Gastroenterologists
  - 30+ ENTs, Endocrinologists, Dermatologists, and Pathologists

Ancillary Services

Ancillary Services

- ~90 physicians and ~170 providers
- Four ambulatory surgery centers ("ASCs") with 20+ operating rooms
- Full-service centralized lab and pathology services processing over 3 million annual tests
- Advanced imaging and interventional radiology capabilities

Support Infrastructure

Managed Services Organization

- MSO provides back-office infrastructure for VillageMD physicians
- Key services provided include:
  - Billing / RCM / IT / Analytics
  - Provider recruiting, onboarding and training
  - Payor contracting and regulatory reporting
- Shared infrastructure provides operating leverage and allows VillageMD to increasingly enter risk-based arrangements with payors

2,700+ Total Providers Offering Holistic Connected Care and Services Across Nearly Every Medical Specialty

(1) Includes physicians and visit volume from following specialties: family medicine, internal medicine, OBGYN, Pediatrics, and Geriatric Medicine.
(2) Specialists include physicians across Surgery, Medicine, Oncology and Post Acute Care.

Benchmarking is a complex process that varies from Payer to Payer

- Historical Spend
- National Trend
- Risk Acuity
- ADI
- Carve-Outs
- Retro Trend Adjustment
- Regional Trend
- Efficiency
- Discounts

Strategy

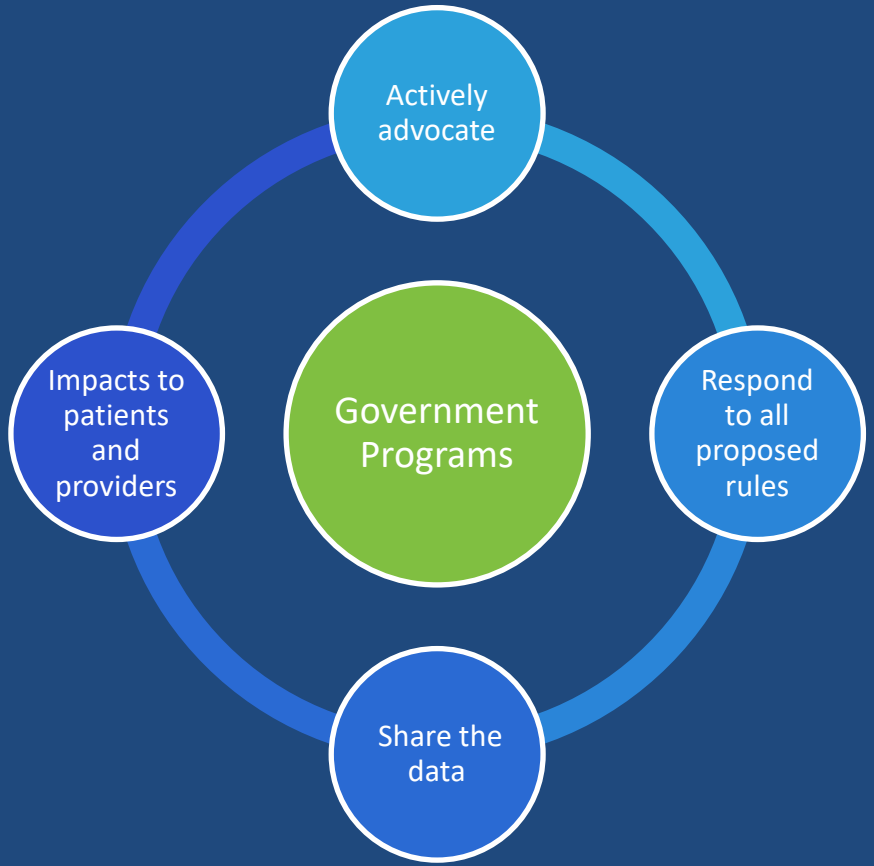
An appropriate and agreed upon baseline calculation must be set in advance of the performance year

- Use multiple years of data that are representative of your population
    - May change as a practice or group grows/losses staff
    - New geographic areas
- Know your past success and how they compare to those in the region
- Add guardrails around variable factors
    - This protects both parties
    - Set prior to performance period
- Collaborate on an MLR - Challenging but achievable
- Connect at multiple layers of the organization
- Plan for future initiatives in the benchmark

Analytical Projections

Benchmark Prediction

State and Federal Programs



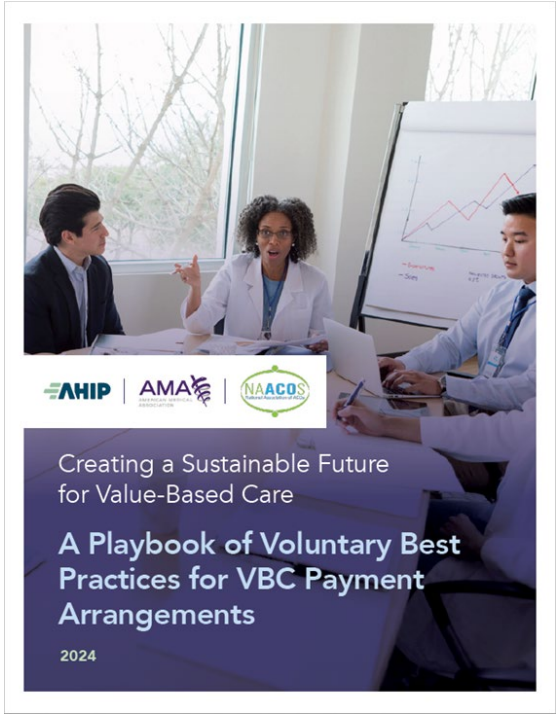
Thinking Beyond an MLR

- Negotiate payments for the extra work your team is doing
- How will their network contracting structure impact your success
- Agree on quality
- Engagement in alternative support

Future of Value Playbook Link

For the complete list of voluntary best practices and considerations, see:

Creating a Sustainable Future for Value-Based Care: A Playbook of Voluntary Best Practices for VBC Payment Arrangements



Patient Attribution

Goal: Accurately identify the population for which a VBC entity or participating practice will be held accountable during a performance period; honor patient preference wherever possible; and include only those patients where the VBC entity or practice has a reasonable ability to coordinate and improve their care.

Voluntary Best Practices	
Voluntary patient selection	• Prioritize and facilitate voluntary patient selection. • Validate voluntary patient selection with claims data, especially annual physical or preventive visits. • Proactively provide opportunities to update voluntary patient selection, especially if claims indicate a change in physician.

Claims-based attribution	• Use a multi-year attribution window.
	• For prospective attribution, apply appropriate exclusions at the end of the performance period to enhance accuracy.
	• For retrospective attribution, deploy strategies to enhance predictability, including:
	  o Providing provisional attribution reports during the performance period.
	  o Adjusting financial performance reports based on the most recent attribution lists.
	  o Limiting quality performance measurement to those who attribute in the first three quarters of the performance year.

Patient Attribution (continued)

Voluntary Best Practices	
Automatic new member attribution	• Attribute patient to VBC entity once either a voluntary patient selection has been made or claims data is available to verify, such as a visit with a PCP in the VBC entity. • In the absence of voluntary patient selection and claims history to verify, rely on data such as geography, language preference, and physician capacity to take on new patients.
Clinician types used for attribution	• Include Advanced Practice Providers (APPs) in attribution methodology. • Deploy strategies to correctly identify the clinician principally responsible for managing a patient's care, including attribution to a non-primary care specialist in circumstances where they are providing comprehensive care to the patient.

Speakers

	Jeff VandenBoom is the Director, Direct-to-Employer Relationships, at Henry Ford Physician Network based in Detroit, Michigan. Jeff graduated from Wayne State University with a master's in industrial engineering and joined Henry Ford Health in 2005 and subsequently held roles Transformation Consulting, General Internal Medicine, and Performance Analytics. In 2014 Jeff took a position at a healthcare consulting firm based in Rochester, MI where his role involved client management, consulting, analytics, and software development in support of projects for the Department of Defense. Jeff returned to Henry Ford Health in 2021 as Director, Direct-to-Employer Relationships overseeing the execution of key D2E contracts and helping design the organization's direct-to-employer strategy.
	Sharon Thomas, MHSA is the Director of Network Performance for the Henry Ford Physician Network (HFPN). The HFPN is Henry Ford Health's clinically integrated network (CIN) with over 2,800 providers. In this role, Sharon supports network development, network performance, and clinical integration efforts across the CIN. Sharon works closely with payors, employers, physician organizations, independent physicians, and other internal/external stakeholders on improving our quality, cost, and utilization performance. Sharon is also involved in several initiatives relating to interoperability, advancing clinical transformation initiatives, and helping foster collaboration and clinical best practice sharing across the HFPN.

HENRY FORD HEALTH®

Patient Attribution Models in Direct-to-Employer Contracts

Henry Ford Physician Network

August 2024

Henry Ford Health

Integrated Health System (est. 1915)

- Among Michigan's largest and most diverse employers, with more than 33,000 valued team members, including nearly 6,000 physicians and researchers
- 250+ locations throughout Michigan:
  - Primary care and urgent care centers
  - 5 acute care hospitals
  - 3 behavioral health facilities
  - 2 destination facilities for complex cancer and orthopedics and sports medicine care
- Full complement of ancillary services:
  - Pharmacy services, virtual care, DME, Optometry, dialysis, home health
- Health Alliance Plan (HAP) integrated in 1986

Academic Medical Center

- Training more than 4,000 medical students, residents and fellows annually across 50+ accredited programs
- $100M in annual research funding

Clinically integrated network (HFPN) launched 2010

- Clinically Integrated Network with 2,800+ physicians (employed, independent)

Attribution Models used in D2E Contracts

D2E Contract #1

- Plan design does not require PCP attribution
  - TPA sends full eligibility (membership) file monthly
  - Members cannot self-select PCP
- Network **aligns** members to PCP to support network operations
  - Claims-based
  - Alignment to PCPs only

D2E Contract #2

- Plan design does require PCP attribution
  - TPA auto-**assigns** beneficiaries to a PCP based on 1) geographic proximity, 2) provider panel status
  - Patients can self-select PCP through TPA portal
- Assignment to PCPs only

D2E Contract #2
Assignment vs. Alignment

TPA PCP **Assignment**

- Defines the population used for contractual requirements
  - –Total Cost of Care (PMPM)
  - –Quality reporting
  - –Care Management and Administrative fee invoicing

HFPN PCP **Alignment**

- Drives network operations
  - –Performance Reporting
  - –Care Management
    - Gaps in Care
  - –Shared Savings distributions to providers

Henry Ford Alignment Model

- Network Provider Roster (PCP/SPC flags)
  - *Any provider with SPC flag will not have attributed lives*
- Paid claims (rolling 24 months)

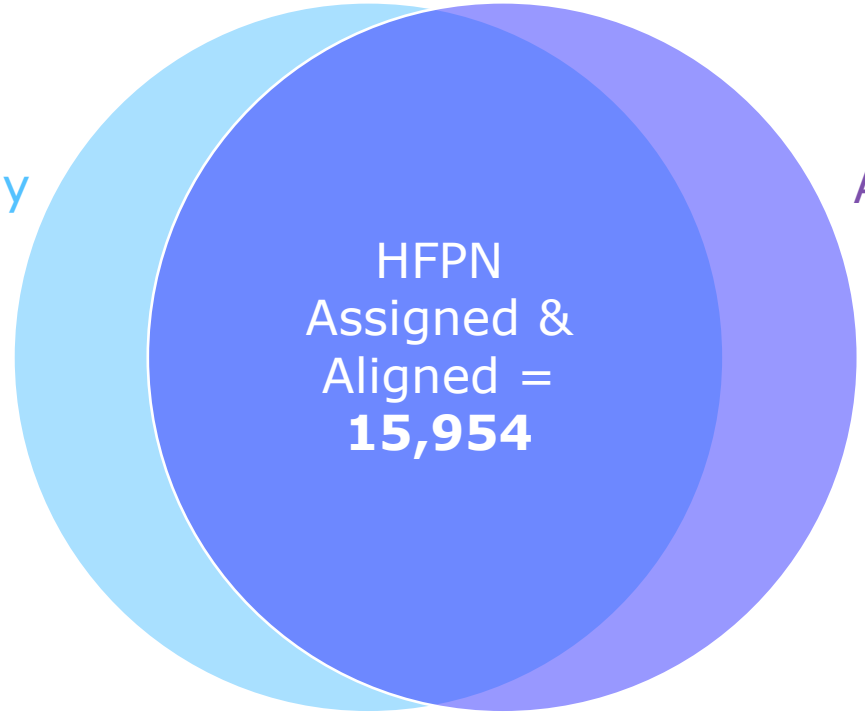
Practice & Provider Level

1. Frequency
2. Recency
3. Claim(s) amount ($)
4. Random

- Member with claims history or PCP election in EMR is *attributed*
- If no claims AND no PCP in EMR, remains *unattributed*

HFH-SF Assignment and Alignment

HFPN Assigned Only = **3,734**



HFPN Aligned Only = **4,524**

Attribution Model Comparison

Geo-based Auto-Assignment

Pros

- Immediate upon enrollment
- Small unaligned population
- Does not require claims history

Cons

- Erodes HFPN relationship with providers – trust & validity of data reporting (i.e. gaps in care reports)
- Member burden to re-assign themselves and any dependents to preferred PCP

Claims-based Alignment

Pros

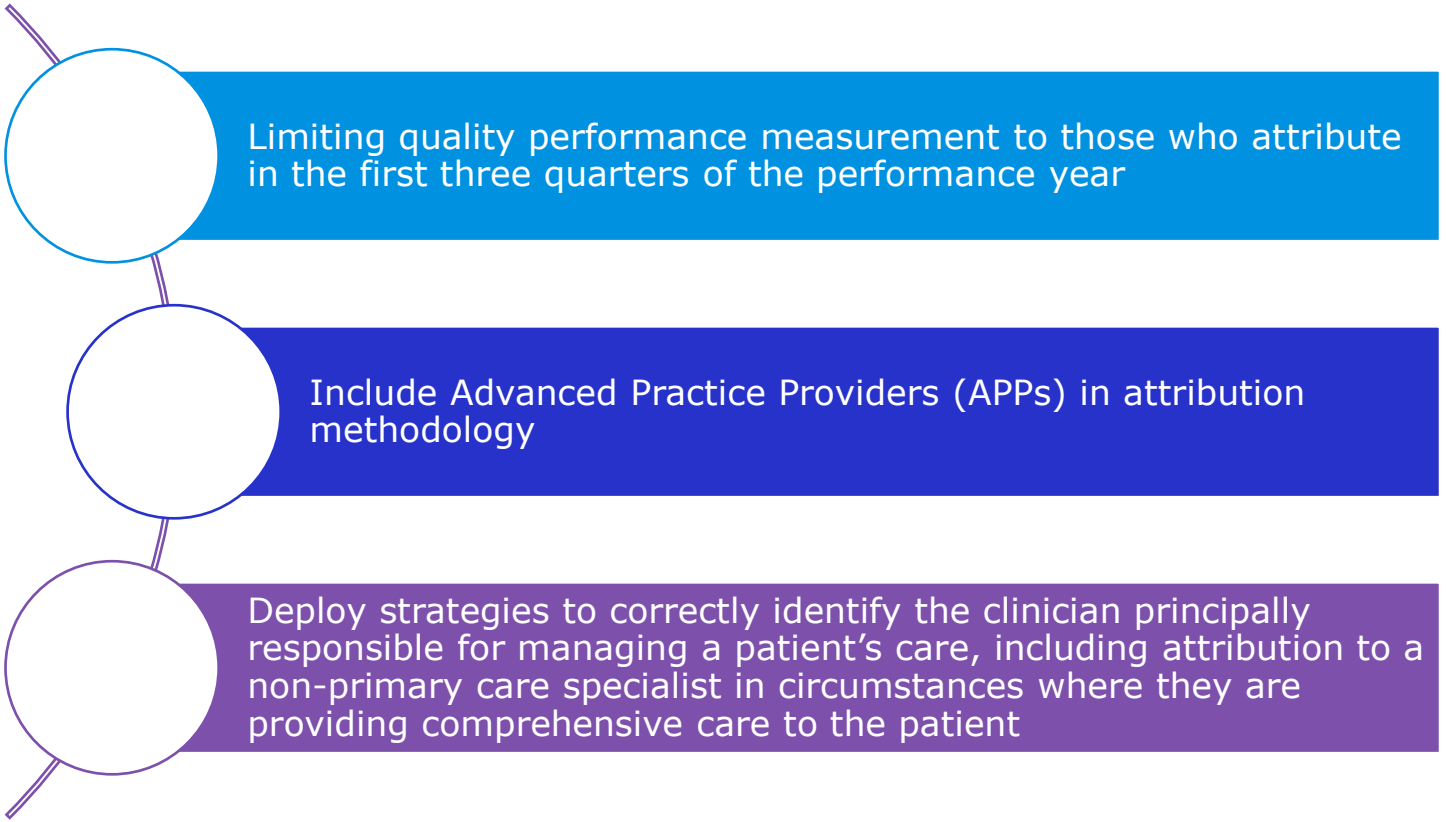
- Alignment driven by actual patient activity
- No burden to member
- Provider Satisfaction with "accurate" patient panels

Cons

- Initially larger unaligned population, shrinks over time
- Alignment will take 6 months - 1 year as patients generate claims

Attribution, Reporting, and Outreach

Future Considerations



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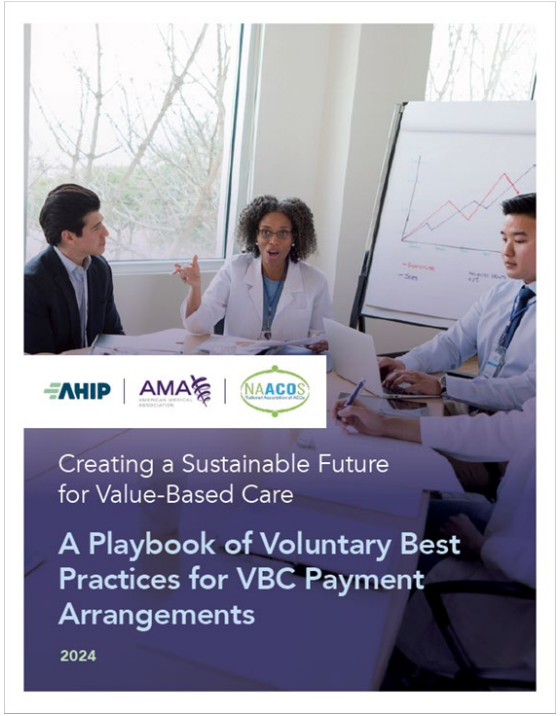

Upcoming Events

- NAACOS Fall Conference:
  - October 16-18, 2024
    Marriott Marquis Washington, D.C.
    Registration now open!
- Payer-Provider Forum will be held on Wednesday, **October 16 from 1:00 – 5:00 pm ET.**
- This forum is part of the NAACOS Fall Pre-Conference event and separate registration is required from the main meeting.

Thank you!