Creating a Sustainable Future for Value-Based Care

Exploring Best Practices for Levels of Financial Risk

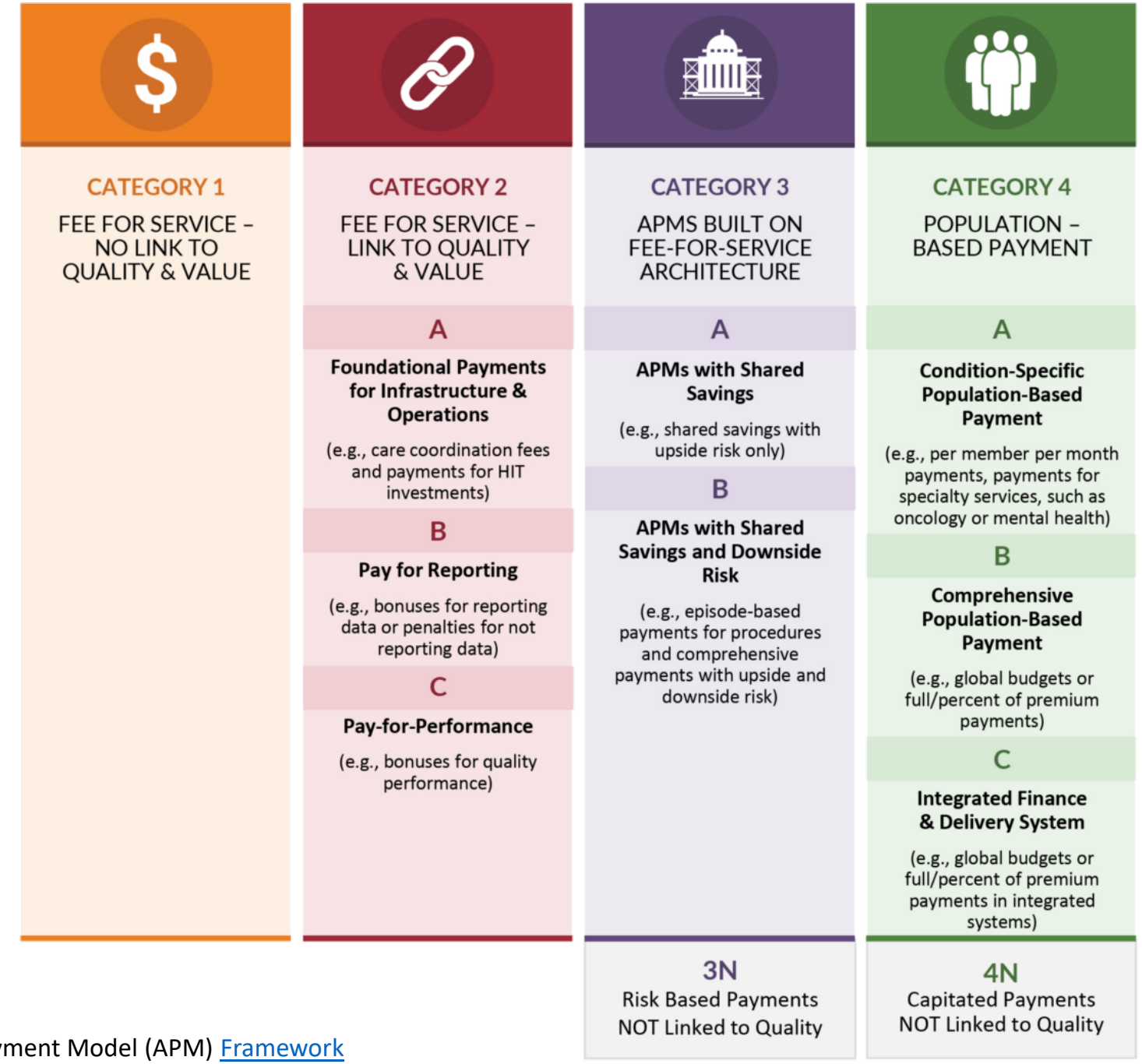
Purpose

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.

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.



Source: HCPLAN: Alternative Payment Model (APM) Framework

5. Levels of Financial Risk

Goal: Further align incentives for total cost of care management, and improvement of quality and patient outcomes –it is important to balance the level of financial risk against both the goal of driving increased opportunity for participation in VBC and ensuring that VBC entities only take on risk that they are able to effectively manage.

Voluntary Best Practices	
Structuring levels of risk	• Use multi-year arrangements with a glidepath to increasing risk and reward over time based upon a clear long-term strategy. • Allow VBC entities to elect to move back to upside-only arrangements when substantive changes in population or payment arrangement occur. • Evaluate capacity, readiness, and local market dynamics when designing downside risk options.

5. Levels of Financial Risk (continued)

Voluntary Best Practices	
Accounting for unexpected events, outliers, and random variation	• Offer a menu of options for mitigating risk including risk corridors, capping savings and losses, and stop-loss. • Waive downside risk for significant unforeseen events (e.g., global pandemic, or the sudden introduction of an extremely high-cost drug or technology).

Speaker Introductions

	James Grana, PhD is currently the VP, Value Based Care Programs, Innovations, and Contracting in the Healthcare Innovation and Improvement Division of BlueCross BlueShield of South Carolina. His team develops and implements innovative VBC programs that benefit patients, providers, and plan sponsors. On the provider side of the health system, James has served at the Rush Health Clinically Integrated Network, where he served as the Interim President, the Chief Analytics Officer, and the Chief of the Contracting and Network Development Division, focusing on value-based care, provider incentive systems, population health, and creative partnerships. James was the Divisional Vice President for Health Services and Outcomes Research at the Walgreens Corporate Office. Prior to joining Walgreens, James served as the Vice President of Enterprise Analytics at Health Care Service Corporation (HCSC / Blue Cross Blue Shield). Previous to his health care career, James was a Captain in the U.S. Army Medical Service Corps, the president of a consulting company, and taught health services research and management courses at Penn State University and The University of Scranton.
	David S. Louder, M.D., MBA is currently the System Chief, Population Health, Medical University of South Carolina (MUSC) and the Executive Director, MUSC Health Alliance, a clinically-integrated network and accountable care organization with 70,000 attributed beneficiaries across commercial, Medicare, and Medicaid contracts, including a joint venture in an insurance exchange product. Dr. Louder joined MUSC Health in 2016 to start these endeavors and to accelerate MUSC Health's operational flexibility in value-based reimbursement and population health. He is responsible for both day-to-day management of the Health Alliance and, as a member of its executive team, provides strategic vision to the larger health system. Dr. Louder's first career was in the US Air Force as a physician leader and neonatologist. Prior to his military retirement in 2009 as a Colonel, he served In Texas, Germany, Oklahoma, and Washington, D.C. Dr. Louder is board certified in neonatal medicine and licensed to practice in South Carolina. He has been a national examiner for the Baldrige Performance Excellence Program since 2018. Dr. Louder earned his bachelor's degree in physics and his medical degree from the University of Virginia and earned his master's in business administration from the University of Massachusetts.

Who is BlueCross® BlueShield® of South Carolina?

- We’re the only South Carolina owned and operated health insurance carrier.
- We’ve been serving South Carolinians for more than 75 years.
- We’re the largest health insurer in South Carolina.

Making a Difference for Our Members

- We are the only insurance company in South Carolina offering health insurance products in every consumer segment.
- We offer the largest provider networks in the state, giving members the greatest choice in doctors, hospitals and other health care providers.
- We have award-winning customer service.

2023 Value Based Payments and Lives

2023 Value Based Payments by Program					
2023 Value-Based Program	**Approximate Lives**	**Shared Savings Amount**	**CMFs Amount**	**Quality Incentive Amount**	**Total**
Healthy Blue Midlands ACO	28,000				
Healthy Blue Upstate ACO	21,300				
HIX Midlands ACO	41,000				
HIX Reedy ACO	8,200				
HIX Cooper ACO	7,000				
PCMH+	520,138				
PCMH Kids	135,131				
SEHP Novel ACO	350				
RA	336				
OCM	1,283				
CKD	2,285				
Site of Service	3,000				
Colonoscopy	700				
Total					***$70,747,381***

MUSC BY THE NUMBERS 2025

The Only Comprehensive Academic Health System in South Carolina

201 Years of service

1824 — 2025

2.78 MILLION Patient encounters annually

200,000 Patients in value-based care contract

16* Hospitals (4 in development)

2,744 Licensed beds

830+ Care locations

*Includes owned and governing interest

Statewide health system

Serving all **46** counties

1 of 2 National Telehealth Centers of Excellence

350 Telehealth sites

50,000+ Jobs supported annually

10 = 12

For every 10 jobs MUSC creates, 12 more South Carolina jobs are generated*

*Average

32,693 Total people

Faculty, physicians, researchers, employees, care team members, contract employees and affiliates

3,327 Students

The Medical University

6 Colleges

1,061 Residents & Fellows

40 Degree programs

University Hospital

#1 rated in S.C. by U.S. News & World Report

7.1 BILLION Total enterprise operating budget

10.1 BILLION Current estimated economic impact

$360 MILLION Research funding

1,369 Clinical trials

33 Products in market

62 Active faculty startups

618 U.S. and international patents

NCI-designated cancer center

South Carolina's NIH-funded Clinical and Translational Science Awards institution

1,325 Awards received

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Our Strategy for the Future

ONEMUSC

INNOVATION | IMPACT | INFLUENCE

Aspirational Goals

Within 20 years ...

- MUSC will be a top 20 academic health system in the nation.
- South Carolina will be top 20 in the nation for health outcomes.

Empower Healthy Communities

- Exceed patient and family expectations
- Collaborate to expand access to education, research, and patient care
- Improve outcomes and eliminate health disparities

Drive Innovation and Health Transformation

- Accelerate preeminence in key areas of strength (cancer, digestive health, heart and vascular, neurosciences, and precision health)
- Double funding to create new knowledge and scientific discoveries
- Embrace transformative changes in health care, clinical trial enrollment, and learning
- Stimulate South Carolina's economy through innovation

MUSC Value Based Care Programs (recent: BCBS EOM)

Payment Type	Program	VBC Contract Entities	2023		2024	
			Revenue *	Beneficiaries	Revenue [Projected]	Beneficiaries
	CMS QPP: aAPM and MIPS	5 MUSCH entities				
	CMS Medicare ACOs **	Health Alliance		24,997		2,526
	BCBS PCMH+	5 MUSCH entities		56,445		54,061
	BCBS PCMH+ Care Management Fees	5 MUSCH entities		*Same as line above*		*Same as line above*
	BCBS PCMH Kids CMFs	5 MUSCH entities		13,962		13,978
	MUSC Health Plan	MUHA + University		29,298		31,288
	BCBS Cooper Exchange Insurance	Health Alliance		7,300		7,728
	Centene Medicaid MCO	Health Alliance		7,047		7,812
	Select Health Medicaid MCO	Health Alliance		9,846		25,111
	CMS Kidney Disease ETC	UMA		155		155
	SC Medicaid Quality Achievement Program	MUHA		Go Live		24,030
	CMS Enhancing Oncology	UMA + MCP		Go Live		431
	CMS Spine Bundle *[ended 2023]*	MUHA CHS		183		-
	CMS GUIDE *[implemented 7/24, operational 7/25]*	UMA		N/A		N/A
	CMS TEAM *[scheduled go live 1/26]*	MUHA Florence		N/A		N/A
	Total		**$45.66M**	**149,233**	**$30.19M**	**167,120**

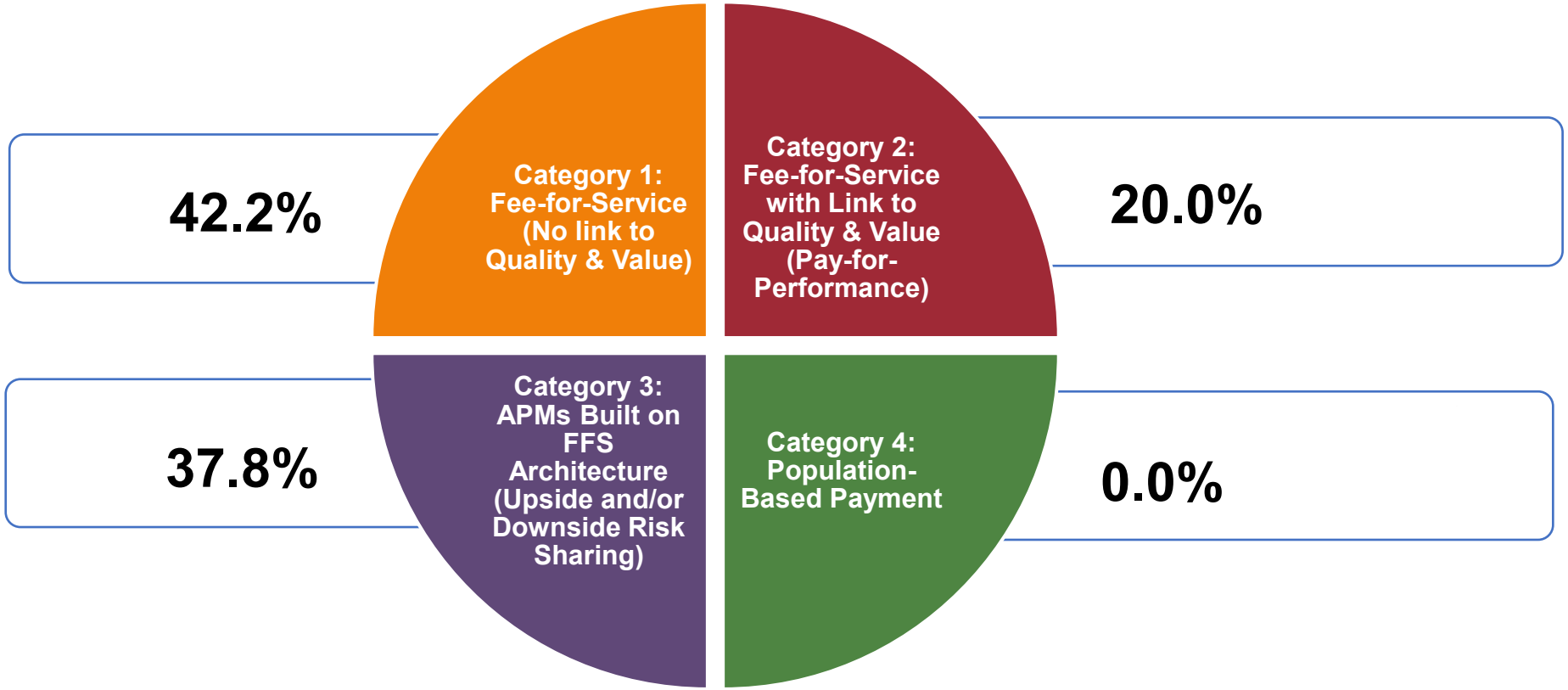
Contract Types & Associated Revenue

Pay for Performance	Medicaid SCQAP	Bundle Payment	Shared Savings	Shared Risk	Global Payment / Capitation

* *Revenue reflects annual amount, but VBC contracts are typically on a CY basis while SCQAP is on FY basis*

** *Medicare ACOs - Shared Savings contracts in 2023 and 2024 but transitioned to Shared Risk in 2025 [and were SR historically]*

BlueCross Alternative Payment Framework in 2023



*Health Care Payment Learning Action Network The MITRE Corporation

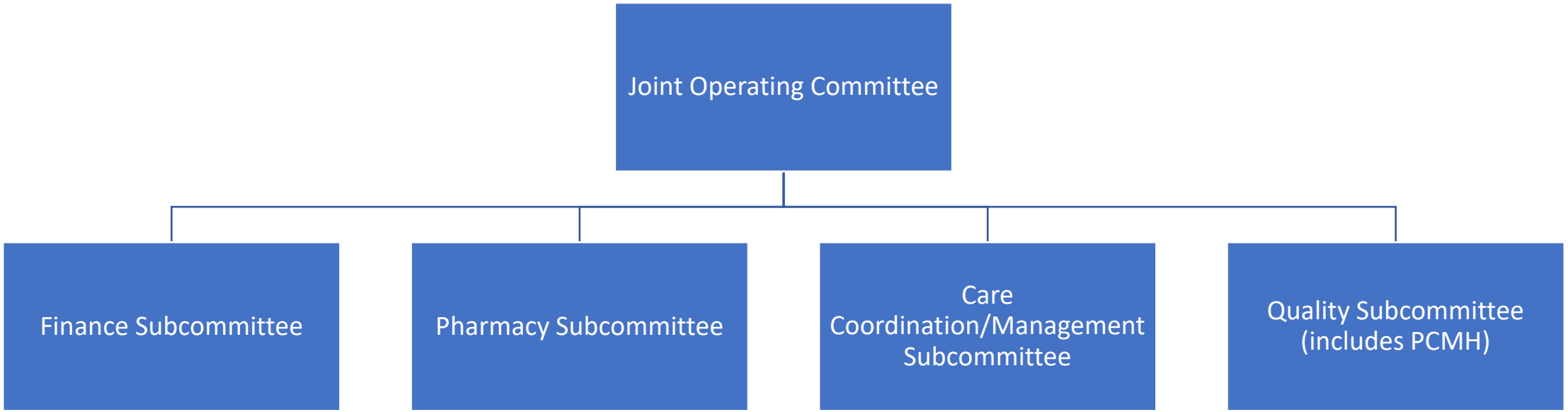
Accountable Care Organizations (ACO)

Shared risk arrangements with health systems for management of group, Medicaid, ACA Exchange and Medicare populations

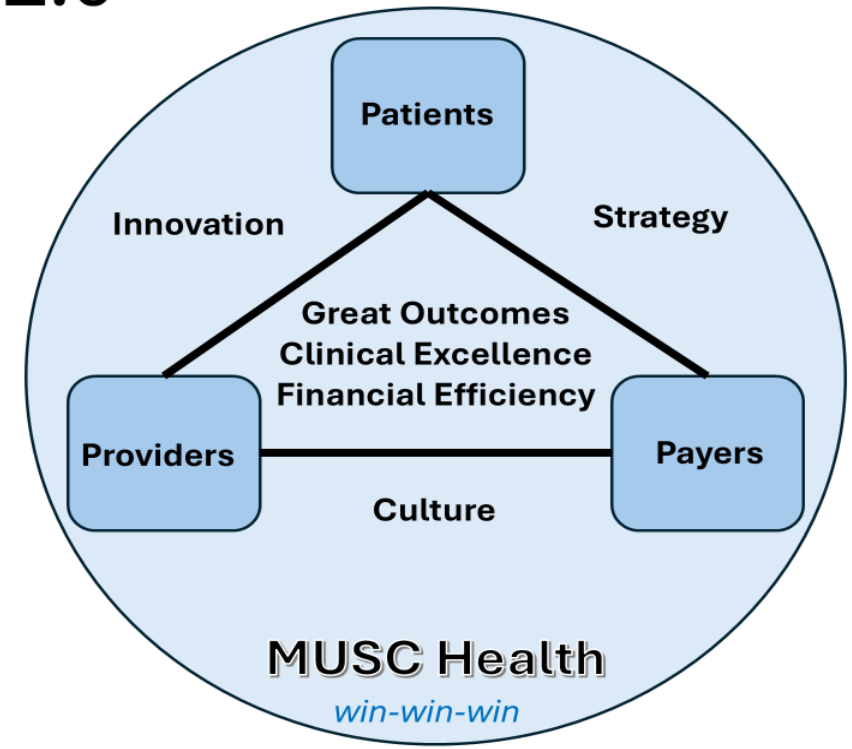
Health systems are responsible for managing total cost of care while maintaining or improving quality

BlueCross supports and collaborates with health systems by sharing eligibility and claim data as well as working together to identify areas for improvement

Communication Structure Between MUSC & BlueCross



MUSC Population Health v2.0



Alignment to Mission

Purpose:
- To preserve and optimize human life in South Carolina and beyond

Aspirational Goals:
- Top 20 academic health system in the nation
- South Carolina will be top 20 in the nation for health outcomes

Uniquely Addresses:
- Population Health Transformation

Our State (our patients and not ours)
Health Outcomes Ranking
- A quilt of partners and initiatives
- Equity/Access, SDoH, Outreach

Our Patients (in and out of VBC)
Demonstratable high quality care
- Prevention; chronic disease mgmt
- Connected, safe, effective, satisfying

Our Programs
Value-Based Care (VBC)
- Leading and Prepared for the Transformation
- Care Management; clinical decision support

Purpose, Aspiration, Innovation

Our Affiliates as Clients
Support for their Population Health efforts
- VBC management and consultation
- PH Services delivery and management

PCMH+ Program Overview

Key Points

Plans Included	BlueCross BlueShield of SC (S. Carolina residents, including National Alliance), BlueChoice HealthPlan, State Health Plan, ACA Exchange, FEP
Member Population	**All members** attributed to a practice (not only those with chronic disease). Risk stratified into 4 Risk Tiers.
Member Coverage Requirements	Primary coverage only
Member Attribution Model	**Claim-based.** Members attributed to practice visited most often during prior 18 months.
Performance Measurement	**Quality Measures** and **Total Cost of Care**
Performance Incentives	**Monthly Care Management Fees (CMFs)** - adjusted annually based on practice's quality measure performance **Annual Shared Savings** - based on total cost of care
Clinical Data Submission	Practice electronically submits clinical data from their EHR system to BlueCross

Shared Savings

- The shared savings component of the PCMH+ program is designed to reward practices for managing member cost of care
- **Two Performance Tracks** to accommodate a practice's capacity for taking on risk (practice decides which Track they want to start in):

Track 1: Upside-only (no downside risk)
- Provider share of savings up to 5%

Track 2: Bi-directional risk
- Provider share of savings up to 20%
- Provider share of losses up to 20%

Practice Reporting to BlueCross

- Practices are required to electronically submit clinical quality data to BlueCross
- Monthly files preferred
- Typical files include:
  - ✓ Patient demographics
  - ✓ Procedure and Diagnosis codes
  - ✓ Immunizations
  - ✓ Medications
  - ✓ Diagnostic results

PCMH+ Program Overview

Enhanced provider reporting developed by BlueCross to help practices:

- Target appropriate members for intervention
- Identify/address areas of high cost

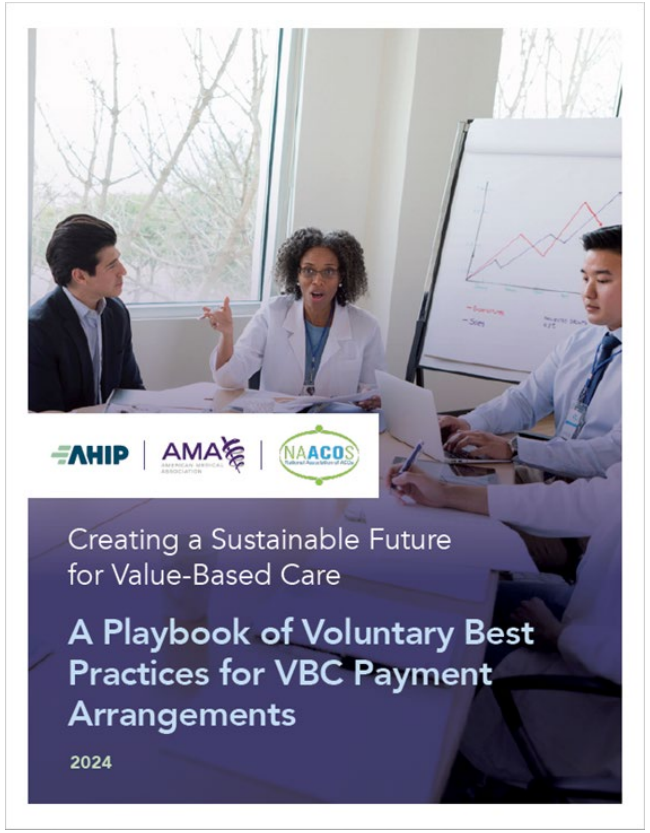
PCMH+ Provider Reporting Package:

- Member Attribution Report
- Member Risk Report
- Inpatient Authorization Report
- ER Utilization Reports
- Medical and Pharmacy Claims Files
- High-Cost Member Report
- Quality Reports

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



NAACOS Spring Pre-Conference

Driving Innovation in Value-Based Relationships through Specialty Care Engagement

Tuesday, April 22 **from 1:00 – 5:00 pm ET**

NAACOS Spring Conference: April 22-24, 2025
Hilton Baltimore Inner Harbor
Pre-Conference Registration

Description: As the goal of Value-Based Care (VBC) is to coordinate and integrate care across the full continuum of care, VBC providers and entities are exploring ways to more deeply engage specialists in accountable care. This session will also bring together providers, payers, and health care purchasers to explore approaches that engage specialists in accountable care, identifying operational and policy challenges – and solutions – for advancing specialty-specific models and involving specialists within total cost of care models.

- Define pathways for driving adoption and implementation of accountable care in specialty care.
- Understand market trends, challenges, and opportunities to engage specialists in value-based arrangements.
- Learn from industry experts on approaches for implementing various specialty care models, including performance incentives/P4P, episode-based payments, and specialty sub-capitation models.
- Understand payer and purchaser priorities and approaches for driving innovation in specialty care and network optimization.

Registration Now Open

Spring 2025 Conference

April 22–24, 2025

Hilton Baltimore Inner Harbor

Register here!

Thank you!


AHIP
AMA
AMERICAN MEDICAL ASSOCIATION
NAACOS
National Association of ACOs