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TOPIC OF THE WEEK
Why commercial risk will decide the fate of value-based care

featuring
Rae Woods, Clare Wirth, and Alex Tallian

with ADVISORY BOARD

Thursdays at 3 p.m. ET

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Questions for today

May 19, 2022

1. What is the state of Commercial risk today and how does it compare to what we see in Medicare risk?
2. How do you answer the question “is commercial risk possible”?
3. What are the top opportunities for savings?
4. What does this mean for the future of commercial risk?
5. Your questions, answered
Participants keep moving, but overall still sitting at 60%

Payments made in CY 2020 and percentage point change from payments made in CY 2018

<table>
<thead>
<tr>
<th></th>
<th>Traditional fee-for-service</th>
<th>Fee-for-service linked to quality and value(^1)</th>
<th>Shared savings and bundles(^2)</th>
<th>Population-based payment(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage</td>
<td>38.0%</td>
<td>4.0%</td>
<td>36.2%</td>
<td>21.8%</td>
</tr>
<tr>
<td></td>
<td>-1.5 pts</td>
<td>-2.9 pts</td>
<td>-0.2 pts</td>
<td>+4.6 pts</td>
</tr>
<tr>
<td>Original Medicare</td>
<td>15.0%</td>
<td>42.2%</td>
<td>37.8%</td>
<td>5.0%</td>
</tr>
<tr>
<td></td>
<td>+4.8 pts</td>
<td>-6.7 pts</td>
<td>+1.3 pts</td>
<td>+0.6 pts</td>
</tr>
<tr>
<td>Medicaid</td>
<td>59.0%</td>
<td>5.5%</td>
<td>29.1%</td>
<td>6.4%</td>
</tr>
<tr>
<td></td>
<td>-7.1 pts</td>
<td>-5.1 pts</td>
<td>+11.7 pts</td>
<td>+0.5 pts</td>
</tr>
<tr>
<td>Commercial</td>
<td>51.5%</td>
<td>13.0%</td>
<td>32.1%</td>
<td>3.4%</td>
</tr>
<tr>
<td></td>
<td>-4.2 pts</td>
<td>-1.2 pts</td>
<td>+4.5 pts</td>
<td>+0.9 pts</td>
</tr>
<tr>
<td>All-payer</td>
<td>39.3%</td>
<td>19.8%</td>
<td>34.2%</td>
<td>6.7%</td>
</tr>
<tr>
<td></td>
<td>+0.2 pts</td>
<td>-5.3 pts</td>
<td>+3.5 pts</td>
<td>+1.6 pts</td>
</tr>
</tbody>
</table>

1. Includes foundational payments for infrastructure and operations (e.g., care coordination fees) and fee-for-service plus pay-for-reporting payments and pay-for-performance payments.
2. Includes alternative payment models with shared savings with upside risk only and shared savings with downside risk. These are built on FFS architecture.
3. Includes condition-specific payments (e.g., PMPM for oncology or mental health), comprehensive population-based payment (e.g., global payments), and integrated finance and delivery systems (e.g., global budgets).

A mix of wins and losses in commercial risk

Sample value-based payment models in the commercial sector

**Providence-Swedish Health Alliance** (2014–2018)

PROVIDENCE ST. JOSEPH HEALTH, BOEING

- Providence St. Joseph Health’s ACO created a direct contract with Boeing
- Deal ended because of financial unsustainability

**Blue Premier** (2019–present)

BLUE CROSS NC

- Agreements with 11 health systems and 870+ practices
- $350 million in cost savings in first two years
- Covers over 857,000 lives statewide, (+60% from first year)

**Cigna Collaborative Care** (2008–present)

CIGNA

- Agreements with over 230 primary and specialty physician groups in 32 states
- Has encompassed over 2.65 million members and over 144,000 physicians

**Haven** (2018–2021)

JP MORGAN CHASE, AMAZON, BERKSHIRE HATHAWAY

- Aimed to find solutions for high, rising costs for employee health care
- Disbanded in 2021 because of poor timing, perverse incentives, insufficient market power, and a lack of true collaboration

Are the barriers to commercial risk insurmountable?

What makes commercial risk challenging

• The patient population is younger and healthier so there’s less avoidable cost
• There is significant patient “churn,” which means less time to generate meaningful savings
• Cost savings opportunities are harder to capture given the number of commercial plans
• Employers may be the most important stakeholder in determining success— and it is unclear how much they’re willing to drive transformation

What makes commercial risk possible

• Everyone wants lower-cost care (while maintaining or improving quality)
• There are obvious cost-saving opportunities today
• And, there are less obvious opportunities that can have a tremendous impact
• Commercial payers follow CMS’s lead on alternate payment models—and CMS is bullish on risk
• We’re betting on change—VBC is just one option
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Analyzing top cost opportunities in the commercial population

Top professional (non-facility) commercial medical spend areas for a national payer, CY 2019¹

<table>
<thead>
<tr>
<th>Rank</th>
<th>Sub-service line</th>
<th>Relative cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Office/outpatient E&amp;M</td>
<td>$$$$$$$$$$$</td>
</tr>
<tr>
<td>2</td>
<td>Therapeutic procedures</td>
<td>$$$</td>
</tr>
<tr>
<td>3</td>
<td>Supplies/DME</td>
<td>$$$</td>
</tr>
<tr>
<td>4</td>
<td>Other E&amp;M</td>
<td>$$</td>
</tr>
<tr>
<td>5</td>
<td>Chemotherapy</td>
<td>$$</td>
</tr>
<tr>
<td>6</td>
<td>Psychiatry</td>
<td>$$</td>
</tr>
<tr>
<td>7</td>
<td>Immunizations</td>
<td>$</td>
</tr>
<tr>
<td>8</td>
<td>Emergency department E&amp;M</td>
<td>$</td>
</tr>
<tr>
<td>9</td>
<td>Ultrasound</td>
<td>$</td>
</tr>
<tr>
<td>10</td>
<td>Home health/hospice</td>
<td>$</td>
</tr>
<tr>
<td>11</td>
<td>Infusions, transfusions, injections</td>
<td>$</td>
</tr>
<tr>
<td>12</td>
<td>X-Ray</td>
<td>$</td>
</tr>
<tr>
<td>13</td>
<td>Labor &amp; delivery</td>
<td>$</td>
</tr>
<tr>
<td>14</td>
<td>Medical cardiology</td>
<td>$</td>
</tr>
<tr>
<td>15</td>
<td>MRI</td>
<td>$</td>
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Methodology overview

- Analyzed cost to payer for commercial patients under age 65 in CY 2019
- Focused on professional (non-facility) commercial claims with nationwide coverage
- Attributed costs to outpatient and ambulatory sub-service lines based on the primary procedure or service performed on each claim
- Cost represents average, price-normalized commercial rates reported at the claim level; a good proxy for cost and spending.

¹. Based on Advisory Board analysis of Optum’s commercial claims databases; includes commercially covered lives from major national insurance carriers and plans.
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But “Opportunities” in commercial risk not what they seem

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<td>1</td>
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<td>$$$$$$$</td>
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- Frequency of visits is a core benefit feature for generally healthy employees
- Cancer care is extremely sensitive, but site-of-care shifts enable opportunities to improve experience
- Increased uptake is needed to improve prevention effectiveness
- Emergency care use by infrequent, incident-based patients is difficult behavior change to accomplish
- Plannable, frequently bundled episode with wide cost variation and key quality components
- Plannable, commoditized service with wide cost variation frequently targeted by incentive programs
All in on risk still requires a tailored provider response

Risk-based population health management strategies by patient segment

### Age 65+
- Emphasis on screening
- Annual visit recommended
- Chronic care management (especially comorbidities)

### Age 0-64
- Emphasis on prevention
- Some early screening habits started
- Annual visit NOT recommended for everyone

### Primary Care
- Trading hospital stays for low-cost management
- Shifting disconnected specialist management into comprehensive care management

### Shift Utilization
- Shifting visits to more cost-effective sites and sources
- Identifying “missing” patients (and likely increasing appropriate primary care utilization)

### Engage Consumers
- Consumers prefer consistent clinicians and extra benefits
- Influence from caregivers and federal government

- Consumers prefer low costs and provider options
- Influence from dependents and employer
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Commercial risk options have tradeoffs on both sides

Follow the public sector risk footsteps:
A “glide path” to population-wide models

- Efficiencies from standardized incentives and infrastructure for providers
- Overly broad emphasis on multiple chronic condition management

Options for pursuing commercial risk:

- Split focus required across multiple processes and capability needs
- Tailored to commercial population’s clinical needs and savings opportunities

Take distinct approach for commercial risk:
A focus on high-spend episodic models

Industry players collaborate to develop uniform care model

Strategic position in ecosystem for success

Industry players compete for savings opportunities and strategic partners
Value-based payment demands efficiency tradeoffs

Industry-wide reimbursement standard
Both public and private payers funnel most of their payments through true downside risk models at the population level. Payments include physicians and hospitals across a wide range of specialties. Most patient care is reimbursed under value-based models, and acute care businesses adapt to fit into the model.

Public and private payers split on risk
Population-wide, risk-based contracting marches forward in public programs only. Commercial payers and employers focus on models that target the specific needs of the employer-insured population, most often via bundles and with physician groups. All industry players operate in a hybrid world with split incentives and processes.

What tradeoffs will maximize sector-wide savings?
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Value-based care should be more than a buzzword.

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