



Navigating The Economics Of Value-Based Contracting

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Unknown Speaker 0:00

Thank you for participating in today's webinar navigating the economics of value based contracting. I'm Rick Gutierrez, senior associate for open minds, and will be facilitating today's session. A few housekeeping items before we begin. Today's webinar is being recorded. You'll receive an email in a few days with a link to the recording along with the materials that we present today. Should you have any questions during the webinar, please enter those in the question box and we will address them at the end of our session. This webinar is brought to you by One Care Population Health Academy and alira health. One Care Population Health Academy is a premier educational program created for behavioral health executives, managers and clinicians, covering key areas such as population health management, value based contracting and the elements of integrative systems of care.

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Unknown Speaker 1:03

And now I'd like to introduce our presenter, Lizzie Baum, serves as the executive director of payer contracting at allera Health. She has extensive leadership experience across the healthcare continuum, including inpatient, outpatient payer relations, value based contracting and network management settings. Lizzie joined a lira in 2022 and is part of the allira team that negotiates and executes value based contracts as well as other complex reimbursement models. She has a master's in business administration from North Carolina State University, and a Bachelors of Arts in Psychology from North Carolina State University. Recently, in her role, she led the launch of an affiliate clinically integrated network of pediatric

primary care providers serving over 50,000 Medicaid lives. Today, we will define the various types and structures of value based contracts. Understand the core economic principles of these incentive structures and their ROI identify the key revenue and risk drivers of different contract terms and evaluate opportunities to assess how behavioral health organizations can leverage clinical outcomes and cost effectiveness to maximize incentives. With that, let's jump into today's session. Thank you, Rick for such a warm introduction, and I also want to take a moment to thank open minds for being such a valuable partner and resource to allera health and all of the organizations that you support. The insights that you provide have proven invaluable, and we are thankful for your continued intentional collaboration with providers in a similar desire. Alera health wanted to share all that we've learned over the years supporting behavioral health providers in moving into the value based care space through all of our work building our one care networks across the country, which now include nine networks in six different markets. And

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I also want to take a moment to thank all of you as well for taking the time out of what I'm sure are your very busy days to spend an hour with me talking about something that I'm really passionate about, and I humbly recognize that once the words economics and financial modeling start to get thrown around, many people's eyes may glaze over, but I aim to make this discussion as engaging and digestible as possible, and if you take anything away from Our next hour together, I really hope that these concepts I'm going to share with you, though maybe not always very glamorous, are foundational to health care sustainability. I firmly believe that innovative value based contracting and financial modeling is the future of a more equitable and quality focused health care delivery system, and as providers are empowered to understand and innovate on these models, the closer we as an industry get to that reality. So I know Rick touched on some of this in his introduction as well, but what you see here is going to be our roadmap for our discussion this afternoon. I'm excited to share today some of what Alera health has learned from negotiating these agreements so that other organizations can realize an increase in the benefits to their value based care journey, whether that is providers doing this on their own with Alera health and one of our one care networks or other networks we want to contribute To the concept of rising tide lifts all boats. And as part of The One Care Population Health Academy, which Rick spoke to earlier, there have been some previous webinars pertaining to different aspects of value based contracting, covering some of the similar concepts and models. And though attending those sessions definitely were not prerequisites to this talk. I really do see them as companions to this presentation and the information provided today. I really do see expanding and diving deeper into some of those specifics around the economic levers in some of these models to again empower you all as providers and leaders with the ability.

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To deeply understand not just the theoretical structures of how value based contracts can work, but also the financial considerations organizations really must make when stepping into these agreements to determine the operational realities of taking the terms that we see on paper into daily practice, workflows and outcomes,

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I fundamentally want you to be able to walk away from this presentation with tools in your tool belt, to be able to look at contract opportunities as they arise and as you analyze these various opportunities, be able to answer the questions, is this model realistic for us To implement at this time? Is success for your organization, achievable? Is the program meaningful? And finally, is the model financially sustainable? I know that's a really hefty order to fit all in just under an hour, but I'm going to try to do my best to fulfill that central goal and hopefully a little bit more on top of that, while leaving some time for questions at the end. So let's start our discussion today with the why. I always like to, you know, answer all of the w's in every presentation, but we want to discuss the why behind this topic and what makes it so timely and important, while also explaining some of the driving forces behind the industry's movement towards value based care, value based care and value based contracting is not a new concept in the industry, but there has been mass movement, especially in recent years, towards these types of reimbursement models for Medicare, Medicaid and even commercial payers. You know, CMS has established the goal of having 100% of traditional Medicare beneficiaries and the vast majority of Medicaid beneficiaries in some form of accountable care or VBC type, relationship with their providers, by 2030 and that may sound like a long way off, but we are inching ever closer to 2026

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as We speak on the Medicare side, Medicare shared savings programs in 2022 saved Medicare more than \$1.8 billion with a B and show evidence of continuing to provide and deliver high quality care. And then on the Medicaid side of the house, more than half of the responding Medicaid managed care organizations identified specific targets in their contracts for a percentage of payments or members that the MCO must cover under some type of APM or value based arrangement.

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Even more recently, we've seen growing interest from CMS and various payers in value based contracting for behavioral health, specifically stemming from the response in ever rising health care costs, many of which are tied to primary or secondary or CO occurring behavioral health conditions. Medicaid payers in particular, are showing increased interest in behavioral health value based contracting due to the prevalence of these conditions in the populations that they serve, and some of the driving factors for these heightened costs you can see here on the slide. You know, those with primary or secondary behavioral health diagnoses are eight times more likely to use the emergency department and spend four times more days in the hospital when they do get admitted for behavioral health or physical health related needs, and this focus on driving down acute behavioral health and medical spend will become even more evident as a result of some of the recent redetermination and eligibility changes that are happening at the federal level, meaning that a larger portion of, you know, the covered population, will fall into more acute, severe mental illness or disability eligible cohorts. As it's projected, that many of those who will lose Medicaid coverage will be those who are, you know, the relatively healthy, young and a little bit less acute. So there's lots of movement, lots of financial pressures, but all of which are emphasizing the need for innovative opportunities and value based contracting solutions. So with all of that industry movement in mind, behavioral health providers are uniquely positioned to be well suited for value based care, if approached correctly, behavioral health providers have a relatively definable, clearly attributable and relatively stable population, and I don't mean stable as in the form of their clinical presentations per se, but more so that behavioral health conditions require long term interventions, allowing behavioral health

homes to be an ideal fit for continuous attribution and attribution, and this will come up quite a few times throughout the rest of this conversation, but attribution is critical in the development and success of advanced value based contract structures, and it's not ideal for a member who would be rolling on, rolling off, and.

Unknown Speaker 10:00

Attribution rapidly.

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First and foremost specialty populations like behavioral health requires robust diagnostic history based on available encounter or claims data. There is a caveat as well that I want to call out in the behavioral health space regarding members with undiagnosed behavioral health needs. ALARA has identified these undiagnosed and unengaged members as what we call silent sufferers. Being able to identify and attribute these members to a behavioral health home can expand your attributed population pretty drastically, but it is a bit more nuanced, as many behavioral health attribution models currently require both a diagnosis of behavioral health and evidence of engagement in outpatient services. And many of these silent sufferers, as we call them, are not engaged in any form of outpatient care. And that also includes, you know, primary care as well.

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You know, secondly, around kind of the attributable population considerations is wrestling attribute. Attribution from primary care has historically been relatively difficult. This has presented the opportunity, actually, for behavioral health providers to move more towards adding physical health services or even becoming a behavioral health integrated health home, like an FQHC or a CCBHC, or even just adding PCP services. This helps to drastically mitigate some of the conflict between identifying if a member would be best served by a physical health home or a behavioral health home, and

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then also those with primary or secondary behavioral health diagnoses show a relatively durable spend, similar to the benefit of being a stable and attributable population. The utilization and spend profile of this cohort is often consistent over time without intervention, meaning behavioral health conditions take time to treat, and this durable spend makes financial projections a little bit more reliable.

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And then the last bullet point really highlights that behavioral health providers have a unique ability to impact this population, and the associated cost drivers are tied to interventions with clear impact to decreases in spend. So for example, you know, for a lot of these cohorts, you know behavioral health inpatient spend and inpatient physical health spend or nursing facilities account for 60 to 70% of their total spend profile. So by reducing inpatient admissions and limiting exacerbation of behavioral health or

substance use disorder symptoms, behavioral health providers are able to have a direct impact on population costs, directly generating savings that providers can have the opportunity to share in via alternative payment models and value based contracting.

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Behavioral Health is also simultaneously positioned to address underlying cost drivers with SDOH needs as well, and value based contracting and value based care can provide alternative funding methodologies for providers to be able to invest in these types of wraparound services and solutions that have traditionally not been billable in many markets, perfect. So some of this may look very familiar to you all, but I find it's helpful to level set a bit as value based care, value based contracting, alternative payment models are often buzz words we hear a lot, and each of you may be in various stages in your VBC journey and have varying levels of knowledge and familiarity with these structures. So with that in mind, I want to share a layers perspective on what constitutes value based care, starting with the conceptual definitions on the left, then moving to more concrete descriptions on the right. This will help to set the stage for the financial modeling examples we'll walk through later on.

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At its nucleus, value based contracting is a collaboration between payers and providers. It's moving away from the traditional fee for service reimbursements we're all so used to when you know providers reimbursement is based on solely the volume of services provided, and moving more into models that are focused on member outcomes and quality of services provider provided over quantity, this focus on outcomes really allows for better alignment of incentives and reduction in costs that also improve the Quality of care delivered

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and depending upon the specific type of model that you're looking at, these incentives can either act as a complement to fee for service or can be provided in place of fee for service reimbursement, which is highly dependent upon the level of sophistication of the arrangement. And then on the right you.

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See a table outlining those specific VBC structures, which has become sort of the foundation that the industry has accepted to define the different categories and types of arrangements we commonly see throughout various markets. As you move from the left to the right. On these categories, there is an increasing level of sophistication required of the model this sophistication is not just of the operational clinical and, you know, reporting requirements, but also the sophistication required of the predictive financial models used to make arrangement, feasibility decisions.

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And so starting on the right category to be is what we typically see as the starting point for value based care arrangements for those that are brand new to the concept, so this is really an entry point that's called Pay for reporting. Payers and or government agencies will often offer a very small incentive to begin reporting on certain data elements. This data is often very important in supporting the promotion of quality and quality improvement, and helps in measuring costs. These types of models are helpful in diagnosing a markets readiness to take on enhanced value based care arrangements. So for specific markets, populations or payers where value based care is brand spanking new. This would be the starting point, but typically, where we see the first opportunity for providers to engage in BBC is going to be category 2c pay for performance. What this looks like in the simplest term in practice, is when there's an incentive or bonus structure tied to quality measures, and most commonly, we will see that these quality measures are, you know, NCQA, HEDIS measures, essentially a payer will incentivize on either a per opportunity basis or per gap closure, or in a per member per month or PM, PM, incentive that can be earned proportional to meeting certain quality benchmarks over the course of a measurement period, which can be, you know, a quarter or biannually, or for a full

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calendar year

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later, we will walk through economic modelings of category 2c so both A gap closure, example, and a quality performance, PMPM structure, so more there as well, and then as it will be a central part of the remainder of our discussion, and really kind of the central point that we want to make at the end of all of this, I wanted to call out for Category three A which is shared savings. These models are, you know, tied to shared savings, which means that as providers drive down medical costs and expenses through, you know, preventative care and so on and so forth, they're able to share in a portion of the savings that they help generate with the payer in an equitable fashion.

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Category 3b with downside risk is still something more common in the physical health space. And even then, taking on risk is something that many smaller providers are pretty wary of. Alera has also seen an increase in interest from payers in certain markets, in you know, category for a which is, you know, highly advanced, but around some condition specific bundled payments for behavioral health or substance use disorders services, some payers are exploring partial capitation for specific clinical presentations and treatment protocols. You know, in the physical health space, this would look like, you know, some you know, prenatal care,

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kidney disease management, and, you know, cancer reimbursement, as well as something that you'd see common in the physical health space for this. But we're also seeing partial capitation considerations for the provision of health, home type services that behavioral health providers are already, you know, conducting things like care coordination, health promotion and other wraparound supports that may not

be directly billable in certain markets. So in summary, pay for performance, both gap closure and per member per month, incentive structures and shared savings with upside only are really the three most common types of arrangements. A layer is currently seeing behavioral health providers entering into though there is ongoing and rapidly developing innovations happening far beyond these three All right now into the fun stuff, ROI, everyone's three letter acronym that is everyone's favorite so in line with the fundamentals of financial and economic principles. There are risk, reward, investment, return, trade offs in value based care and value based contracting. The various VBC structures can be seen here as following these principles on the continuum that you see here. And as one would.

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SPECT the more advanced the contract structure, the more complex the financial modeling associated. And with this increased complexity, there are enhanced opportunities for more innovative negotiations and provider leverage and even higher ROIs. But in order to negotiate and engage in these kind of advanced contracting models, organizations must have a foundational understanding of the various economic levers and impacts of the different arrangement structures and specific contract terms. These impacts really need to be understood at both a micro so within a specific agreement or contract and a macro level, so in relation to all contracts that you hold, all services that you provide, and all various revenue streams and organization may be engaged in,

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in general, the industry understanding of the financial risks of the different BBC models sees the shared risk arrangements as being the first in the continuum that requires like true financial investment. But in reality, all VBC arrangements require investments of one form or another, whether that investment is in enhanced technology solutions, personnel or other resources. All of these models have some form of investment, and all of these investments can be quantified and should be, you know, intentionally considered,

Unknown Speaker 21:33

as we view value based contracts from the financial modeling perspective. I think there's also another axis that could be considered in this ROI graph, and I would, I would call that, you know, risk. So as you see, along the x and y axis, is, the higher the investment, the higher the return. But providers also need to take into consideration their own sensitivity to risk. This may not be a direct correlation to return per se, but like any investment, financial modeling decisions, the investor, and in this case, that investor, would be the organization engaging in value based contracting, needs to fully understand and quantify their ability and or willingness to take on risk, both in the short term and the long term.

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Financial modeling for value based contracting, I like to say, is a bit like predicting the weather. We don't have a crystal ball, but we do have patterns, data and really reliable models to help us to anticipate what is likely to happen, just like meteorologists, blend science and judgment to say it looks like rain next week, we use financial modeling to project what patient care, costs, of care and outcomes might look like under

various contract structures, really taking the contract from paper to real world practice implications, it's not perfect. It's part science, part art, but it gives us a reliable roadmap of possible futures so that organizations can prepare, adjust and make informed decisions. All right, so let's take a bit of time to, you know, lay the groundwork of some key considerations when aiming to maximize incentive opportunities while negotiating value based contracts. These considerations are central to the decisions around what type of model your organization prepares to participate in, and is critical in determining the arrangements forecasted return on investment. Successfully maximizing incentives requires a cross functional understanding of financial modeling, clinical operations, market movements and quality improvement

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at a high level, if you learn absolutely nothing else from the rest of this presentation, these three areas are key elements within the structures of value based contracts to consider when negotiating and entering into new arrangements. First and foremost, total cost of care, while a more complex and nuanced model type, total cost of care gives organizations the ability to impact whole person health and implement creative strategies to drive down cost. It allows for the recognition of, you know, a whole person and their care, and provides organizations a bit more flexibility in the how they impact quality of care and in how they invest in interventions like, you know, SDOH, mitigation, collaboration, care navigation support, and, you know, enhanced referral technology and so on.

Unknown Speaker 24:46

Secondly, attribution. You will hear this word a lot through the rest of my presentation. We've already touched on it once, but I want you to think about attribution, just how real estate thinks about location attribution at.

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Distribution, attribution, it's the most critical part of a layers negotiations and often where we spend the most time in our contract negotiations and discussions with payers. Attribution is really how we determine who the best quarterback of care is, and providers want to be attributed, members that make sense and ones that they have meaningful impact on and have ability to impact

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these conversations around attribution require organizations to have a really strong understanding and line of sight into the populations that they serve and be able to identify whether or not they are positioned best to be the quarterback of care.

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For example, you know, in some of the negotiations that we've done, you know, we look at total population profiles and diagnostic makeup and so on and so forth ahead of the execution of value based contracts. And you know, in a recent example, you know, we identified a high prevalence of members

with dementia diagnoses, which is by a lot of definitions, still considered a behavioral health diagnosis. But then we also saw that coupled with a high level of long term skilled nursing facility utilization. And so with that consideration, though, that member may have a, you know, anxiety diagnosis or depression. Diagnosis on top of that, dementia, you know, a outpatient behavioral health provider may not be best suited to impact that members outcomes, as well as the, you know, skilled nursing facility or a geriatrician, maybe.

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And then last targets. Targets really are what maximize the slice of the pie for providers, while aligning measures and targets to make arrangements meaningful and achievable, target setting and benchmarking can make or break an arrangement. Oftentimes, we see that managed care organizations will, you know, default to benchmarks around Medicaid targets or NCQA percentiles

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in order to strategically position yourself for meaningful and sustainable alternative payment models. Understanding these economic levers at play and developing robust financial models is integral to your enterprise strategy and decision making, and although the nitty gritty of these models we're going to walk through is not the most glamorous part of contract negotiations, it's vital to support all of our ultimate goals, which is ensuring that as providers, we can deliver the highest quality of care to the vulnerable populations that we serve. Okay, so now we are entering Act Two of our discussion today. So now that we've covered the why surrounding value based contracting, we're going to walk through some of the examples to better understand the how. For the remainder of our time together, we're going to take a look at a couple of theoretical examples of three different value based contract arrangements and discuss the various financial impacts and negotiation considerations to understand an organization's ability to maximize their opportunity for impact and earned incentives. We'll take the time with each of these models to discuss the key points of negotiation, areas of financial modeling complexities and any upward or downward pressures that some of these terms may place on the return on investment. And these three models I selected, you know, for our discussion today, as these are ones that Alera has implemented in some form or fashion in the various markets across the country with our one care networks. Okay, perfect. So, like with any good financial modeling, for comparison purposes, we're going to utilize a couple of outlined assumptions across three examples to really make sure that as we kind of get to our closing statements, that we identify that, you know, the population is the same, the population size is the same. We're looking at the same measurement period and so on and so forth for a good comparison. So we're looking at a Medicaid only population of adults

Unknown Speaker 29:13

with SMI or SCD population, and the hard part's already done with full attribution to behavioral health homes. And we're looking at a population size of about 4500 members. And like I mentioned, for comparison purposes, of these models, the measurement period will be assumed to be one calendar year. All right, perfect. So we're going to get into a little bit of math today, but it's very simple. I promise. First up in our example is going to be a one of our pay for performance models. This one's typically

termed, you know, a gap closure, incentive gap closure, or pay for pay per opportunity models are the most linear when financially modeling out these models offer provider a set dollar amount in.

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Incentive for closing a particular open care back care gap most commonly tied to various HEDIS measures. In the example here, this program includes three common behavioral health related follow up measures, and these are ones that we see quite commonly across various markets.

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Fundamentally, the incentive earned is calculated simply by multiplying the number of gaps you were able to close during that measurement period by the per opportunity rate. And depending upon the program and per particular measure, the rate can vary. As you can see here, for the seven day measures, it's \$100 reimbursement. And the 30 day measures, it's a \$50 reimbursement. So in this example, the provider earned almost \$28,000 for the measurement period, with a max opportunity, should all of the gaps be have been closed of about \$75,400

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and though this type of program is one that's relatively simple in modeling, I want to take a moment to highlight and address what elements of the program may be negotiable, and by how much we often find that these types of arrangements are the least negotiable of the VBC structures. The selected measures are usually chosen based on specific payer or market needs. We often see these arrangements in the Medicaid space tied to withhold measures that payers are held to, or particular measures a payer has identified an opportunity for improvement in, and although there's not a lot of room for negotiation in these types of arrangement around the margins, these types of models, there is a benefit that they're usually easy to operationalize. Require limited financial and resource investment, and depending upon the payout structure or the revenue cycle, it may provide a more frequent revenue cycle. We've typically seen, you know, quarterly payouts, when a lot of vbcs may be annual,

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the one key consideration when determining the impact and financial projections of this type of model is going to be the different measures can present different ease and reliability when forecasting than others. So, for example, some measures a provider has an entire measurement period, or entire year to close to earn that incentive. So take, you know, PCP, annual wellness visits for an example. So as long as the provider is able to close that gap within that measurement period, the incentive can be earned. While, on the other hand, for measures like these, follow up measures you see here, if that gap is not closed within the seven or 30 day window, that opportunity is lost. So an open gap is going to be an open gap forever.

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Also, measures like well visits are much easier to model out the financial opportunity in a you know future measurement period, because the eligibility for those measures is easily defined and the opportunity pool is as stable as your attribution is for that period, while using follow up and hospitalization as an example, again, there are some assumptions one will need to make and how many of your attributed Members may have a qualifying event during that period. Being able to forecast that fiscal opportunity for those types of measures will require strong historical claims analysis to calculate a projected per 1000 members that may have a qualifying event. If that information isn't readily available, there are market standards that can be reverted to as assumptions as well. All right, so the second common paper performance structure that we see is a tiered per member per month incentive. This model requires some form of true attribution as to calculate your incentives earned, you have to, you know, multiply your rates by your total attribution and then, of course, by the number of months in your measurement period, which for this one is 12 months. And even though the earning calculations are relatively straightforward, there are more inputs to consider when modeling out incentive opportunities for this type of pay for performance structure, there are a couple of more assumptions required of the model, not just for the max opportunity, but a reliable performance incentive earns for any given given measurement period requires a couple of assumptions as well. So, for instance, you need a relatively stable attribution, and then you'll need clear historical performance and benchmark information

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that's very you know, necessary in preparation and negotiation of this type of reimbursement model, there is some more room for negotiation in these types of arrangements to help maximize in.

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Incentive and impact ability to providers, as you see in the comparison to the gap closure model, the enhanced complexity of this model lens to higher earning potential. So while the max opportunity for gap closure was about \$75,000

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we're now up to, you know, almost \$130,000

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for Max opportunity. So some of the things that are going to be more negotiable, as you know, that tiered incentive reimbursement amount, so you see the 40 cents, 50 cents and 80 cents, along with the specific measures for selection

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baselines are going to really impact financial modeling for a pay for improvement. So there could be two realities happening here on this example when looking at the benchmark. So you see these benchmarks are already kind of entered in here. But when setting baselines, it could be, you know, that 30% 40% and

45% could be a benchmark. So set to Medicaid standards or NCQA percentiles, or it could be an expectation of baseline improvement for that provider. So it could say 30% required a 2% 4% or 8% improvement upon previous year's performance. And this is really critical, because baselining impact for financial modeling is more critical for these pay for improvement types of models. So for instance, you know, if a provider is already performing an NCQA 90th percentile, they're top of the herd for a particular measure, their ability to improve year over year becomes significantly less over time. So year over year, exceptionally high performers, you know, the ability to squeeze juice out of the lemon will become less and less and start to fall into the law of diminishing returns. It's critical, as you're assessing and considering possible incentive opportunities, measures for inclusion and so on, to understand fully your current performance and how you stack up against the market and those percentiles as well. All right, so our last of the three models is going to be our shared savings with upside only and equality gate. So we're going to walk through the model and how the incentive is going to be calculated. And I like to use the analogy of a pie when conceptualizing shared savings. And I'll expand upon that in just a moment. So we're going to start at the top with our premium. Can either be total cost of care or shared savings. Your premium will determine the size of your pie,

Unknown Speaker 37:40

and so total cost of care would cover all healthcare expenditures for members, both physical and behavioral health, whether they go to a hospital visit or they have, you know, pharmacy, it includes any and all service, billable services for those members

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in Medicaid managed care. Oftentimes, this premium is tied to the capitation rates that payers receive from the state for rating within while shared savings. On the other hand, you know, not all total cost of not all shared savings is total cost of care, but all total cost of care is shared savings. But with shared savings can be a specific spend sub category. You know, for instance, if a program is interested in, you know, minimizing inpatient behavioral health and residential spend, the premium could include just the spend for those two cost categories.

Unknown Speaker 38:34

And as you see here, our math for this though thought exercise is going to start at the top and work our way down. And I want to call out before we walk through all of our steps, that the root math on all of these models isn't complicated. We're at the end of the day, we're adding, we're subtracting, we're multiplying and we're dividing, but where the complexity comes is when and how we calculate those various pieces. So like I mentioned, starting at the top with your premium, which is going to be, you know, the projected or expected expenditures per member per month, and subtracting the actual spend for that measurement period, you get the savings generated for that measurement Year per member. So you'll see savings generated PMPM, as our third line, the almost \$90 that you see here calculated is the savings that a provider generated via all of their interventions throughout the measurement year to drive down costs. And that's really critical to understand, because this is your slice of the pie. So the pie analogy continues, and all of the rest of the calculations following that, \$87.75

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of generated savings are putting downward pressure and decreasing the earnings recognized for a provider, so making your slice of the pie smaller and smaller.

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Next, you'll see the line item for risk.

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Corridor. And this is in this example set at 2%

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this means, this terminology means that the risk corridor is the percent of premium that the provider needs to generate savings for before they're able to recognize earnings on that shared savings. So that means, you know, if a provider, let's say, generates 10% of savings on the premium. They will be eligible for an opportunity pool of only 8% because it's everything past that 2% of the savings are generated.

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Risk corridors are still very important in these more complex models to ensure that provider reductions in cost during a measurement period aren't, you know, by happenstance or and making sure that they stem from true quality improvement efforts. So, you know, for example, if there was a population that had, let's say, \$200 million in spend,

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and you know, spend went down by, you know, point 5%

Unknown Speaker 41:04

if a provider makes, you know, even minimal quality improvement or no improvement efforts at all, they would still reap a reward of \$1 million so Bill risk corridors add a layer of quality assurance and program integrity for these types of arrangements for payers in this particular scenario, this provision is whittling away at the realized earnings, even though the savings generated was that \$87.75

Unknown Speaker 41:33

so next you would, you know, multiply that shared savings opportunity pool, which is the \$60.75

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after your risk corridor is taken into consideration, this portion of savings is going to be multiplied by your Shared Savings percentage. This is also another point of negotiation. This is the portion of savings generated after that risk corridor that provider shares in with the payers. So it could be a 4060, split, a 5050, split. And as an aside, you know models that take on risks. So those downside risk arrangements, you'll often see a much higher split than the you know, 4060, 5050, split. You may see more like an 8020, split instead. And

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then last but not least, how we get down to that \$12.15

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we take into consideration our quality gateway. So although another methodology for payers to promote quality assurance, quality gateways also put downward pressure on the calculated earnings for providers earn shared savings, making our slice of the pie again a little bit smaller. So that's why you see the earned PMPM not being \$30 being half of the 60 you'd expect for the 50% split. I've seen these quality gateways and performance expectations slash earnings in a given measurement Year, and that's why it's really important for providers to analyze, consider and negotiate these measures and benchmarks intentionally to set yourself up for success. Similar economic considerations need to be kind of taken and taken under advisement. When looking at quality gateway projections to what we saw in the pay for performance structures and resource allocation for those quality gateways

Unknown Speaker 43:27

as a portion of shared savings is going to be very similar to how you would operationalize a pay for performance especially when you're able to have and include measures that are already aligned across multiple contracts and programs. It allows for your investment of resources to be distributed across multiple agreements.

Unknown Speaker 43:50

Providers will also need to take into consideration if the percentage of shared savings earned, so the 40% here that you see for you know, meeting three measures is based on a proportion of quality benchmarks met, or an absolute earned quality gateway percentage. So proportional focuses on, you know, number of opportunities over the number of measures met. And in that instance, you'll want to focus on measures that you're more confident you will meet

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or improve upon so that you're not negatively impacting your performance if you don't meet one of the selected measures, while on the other end of the spectrum for absolute calculations, the more measures, the more opportunity for Earning a higher shared savings percentage. So with the addition of the quality gateway percentage you get your earnings, you then, you know, multiply that per member per month

earnings by your attributed member count, and then you'd multiply it by the months in that, you know, measurement period, which this is a calendar year to get your annual earnings.

Unknown Speaker 45:00

Payment. Last thing I want to call out is that last 3% so that shared savings cap, many of these shared savings invest arrangements will have kind of a cap on how much decrease in spend you can earn from so you have your risk corridor kind of decreasing from the top, and you have your Shared Savings cap, kind of decreasing from the top to give you a window of your earning potentials. And so to get the max opportunity, you know, you just multiply your premium by that cap, and then, you know, multiply it by your members and your annual number of months as well to get your \$2.19

Unknown Speaker 45:36

million but as you see these downward pressures of your risk corridor, of your Shared Savings percentage and your quality gateway took a max of \$2.19 million

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down to \$656,000

Unknown Speaker 45:50

so, you know, really critical to take into account all of those elements, because the risk corridor is putting a downward pressure on earned savings dollars, shared savings percentage putting a downward pressure on shared savings opportunity. And of course, those quality gateways putting downward pressure as well. All of these items are going to be vital in negotiating those value based contracts. So since I did kind of a little bit of a simplified shared savings you know, structure, there are some other considerations on various other types of model types you want to consider. I won't go through all of these, because I think each one of these could constitute its own webinar in and of itself, as you get into the complexity and nuances as well. But I did want to take a moment to highlight that first dollar versus second dollar, especially since we covered in our example that 3% risk corridor. So the concept of a first dollar versus second dollar is that in this example, we were sitting under a second dollar. And what that means is that you know any savings beyond that 2% risk corridor you're eligible to earn, while first dollar means there's an expectation to reduce by 2% spend, but every dollar is available for that opportunity pool, so it's a way to still include that quality assurance of you need to drive down costs by a certain amount to be eligible for shared savings. But the provider is, you know, open to earning back all of the savings that they generated. So really wanted to take a moment to call that out as well. You know, we talked about the premium calculations of the variations between what is included in this cost bucket, and then, of course, the caps on shared savings, the quality performance and the proportional versus absolute, alrighty. So this is kind of going to bring us home. So from the comparison across the models, shared savings show an exponentially higher maximum opportunity as we're increasing complexity of the model, we're increasing the possibility for ROI. So you may be asking yourself, well, Lizzie, this sounds great. Why aren't all behavioral health providers in a shared savings arrangement? And there are a couple of barriers that you know Alera has identified and managed to address and overcome, to make

these models successful in multiple markets. First and foremost, I think we touched on this is attribution to a behavioral health home provider is still difficult to get buy in from payers, and there's still a heavy reliance on primary care attribution, but also integrated behavioral health homes are helping to overcome this as well. Secondly, operational readiness for non integrated behavioral health providers to take on impacts to medical spend in total cost of care arrangements can be daunting. And then also, you know, shared savings models, as the complexity increases, shared savings models require the highest level of analytical and data maturity to implement, which can be difficult for independent providers. And in the simplest terms, change is hard. So some of those key decisions in contract terms and your actuarial consideration is

Unknown Speaker 48:57

entering into the VBC space can be overwhelming if providers try to solve all problems at once, or if we try to financially model for every possible eventuality, and there's only so much that you can predict and so much you can achieve in one measurement period, and trends are going to be critical in decision making and implementation of value based contracts. This requires robust and actionable data, and you must know what the market is doing and how your performance compares to that. And then lastly, I want to touch on diversification. Diversifying out risk is a terminology and concept that's very widely used in financial modeling and investing modeling as well. But diversification isn't just about protection. It's a strategic tool. Engaging in a mix of value based models across populations, across various payers and products and across various VBC structures, helps to balance. You know your financial.

Unknown Speaker 50:00

Performance and mitigate some of that investment risks. To some degree, it allows your organization to test innovations, identify what works in different settings, and scale successful models. A diversified portfolio will give you the agility and resilience as the value based landscape continues to change and evolve.

Unknown Speaker 50:24

So I will leave you with this. As we've seen today, the path to shared savings and true value based care is, you know, filled with real challenges, but with also incredible opportunity. The barriers are not insurmountable. In fact, they are being overcome every day by organizations willing to think differently, act boldly and lean into collaboration. If you're feeling overwhelmed, you're not alone. Change is hard, but it's also where growth happens. Whether you're an independent provider just starting to explore value based contracting, or part of a larger, well established network, refining your approach. Remember this, you don't have to solve everything at once, pick your priorities, build your MVP and make a move one intentional and well financially modeled step at a time. And my call to action for you is this, take all that you've learned today back to your teams, start asking intentional questions about your data and intentional questions to your payer partners, and find your next best move, whether that's partnering through a clinically integrated network like our one care networks, diversifying your current value based contracts, or sharpening your operational efficiencies in preparation for your very first value based contract. Just get moving. Value based contracting isn't just the future, it's already here. So you have to ask yourself, are you ready?

Unknown Speaker 51:58

So I really appreciate all the time. I was hoping to not run this close to give you extra time for questions, but so I will pass it on to Rick to take a look at some of the questions in the chat. Thank you very much. Lizzie, what a wonderful presentation again. Please use the question box on your GoToWebinar platform to submit any questions you might have. Our first question has two parts, who is determining what is a value, and then the second part of it is, how are the needs of all stakeholders solicited and considered?

Unknown Speaker 52:30

Yeah, that is a very good two part.

Unknown Speaker 52:33

I'm not sure exactly, you know, who decides value, and that what the intent of that was. So I'd love to, you know, take that back, but I will intentionally address that second portion of you know, how do you engage all stakeholders? And it depends, so one, it depends on the structure. It depends on your operational structure, whether you're a multi location provider, whether you are participating within a clinically integrated network, and so on and so forth. So getting stakeholder buy in is going to be really critical, but what that looks like is going to be wildly buried. And I think that that is really dependent upon one the products that you already are engaged in, what payer partners you have, and then, of course, you know what your internal operational structures look like, all right. Another question is, what are the key pieces of data providers slash organizations need to have in hand or available to start negotiating BBCs? Yeah, great question. I think the starting point is getting access and understanding NCQA, you know, historical benchmarks. That's really going to be your kind of start in the market. So that's kind of a starting point, and that's your measuring stick for your own performance. Secondly, some form of EMR data aggregation is going to be really critical. And then the ability to ingest large claims files, you know, in something like Power BI or so on and so forth, some of those things like the EMR data is going to be available within your own technology suites. But you know, historical claims data, and historically, we usually request 24 months of look back data to, you know, really identify trends and true, you know seasonality as well

Unknown Speaker 54:16

from the payer partners. So usually that data would be coming from your payer partners as it pertains to cost and claims information, and prior to executing contract, that data is usually de identified as well. So those are kind of the starting data pieces. I mean, you can as as complicated as you make your financial model will be as complicated as how many data points you need to be able to aggregate and ingest, all right, and we'll do one more. How do we know if we are ready as a provider to engage in an alternative payment model arrangement?

Unknown Speaker 54:52

Yeah, so it's Interestingly enough, the last question really kind of helps to answer that question is, do you have the data of.

Unknown Speaker 55:00

Available to at least make reliable, maybe not perfect, projections and preparations. So do you know the general makeup of who you're serving? Do you know what the diagnostic profiles of your members are? Do you know how engaged your members are things like that? So you have a population understanding, and then you have to have to have a really strong understanding of your current operational workflow. So do you have

Unknown Speaker 55:25

gap closure work already happening? Do you have staff to do that gap closure work? Some of those types of preparatory things help you to really diagnose and understand where your operational efficiencies are in preparation for engaging in these types of models. And I often say, if you don't have that information readily available, lean on your payer partners because they want these models to work too. You know, this isn't the adversarial of we're going to blind copy you and not tell you anything about your members and just spray and pray and hope you do well. So really, lean on your payer partners as you're exploring these opportunities because they have line of sight into, you know, much longer histories of data and much more rich and robust data through claims that may happen outside of your four walls. So even if you're not sure you're ready, you know, ask the question and prepare, and especially in the upside only types of arrangements, your risks are minimal. So you know your opportunities are more vast, and your you know financial and operational risks are lower, so you might as well at least ask the question.

Unknown Speaker 56:31

All right. Well, that about wraps it up for today. I'd like to once again, thank our speaker, Lizzie bomb, for her wonderful presentation, and I'd also like to thank our audience for attending and listening in this presentation and recording will be available in the next few days on The One Care Population Health Academy. So make sure to enroll and not miss out on this exclusive resource, and don't forget to check out The One Care Cafe happening at the Open Minds technology and analytics Institute in Philadelphia on October 21 space is filling up fast, so if you want to attend, please visit [technology. Dot open minds.com](https://technology.dotopenminds.com) to register. Thank you everyone and have a great day. Thank you so much.

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