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VBC Transformation for Providers

Tipping Point Where VBC Investments Pay Off

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Summary

As pressures of moving to value-based care (VBC) continue to rise, many providers have, or are beginning to, enter VBC arrangements. Through this transition, organizations are often unsure of how far to go—how many VBC contracts should they accept? How much risk should they take on? How will this impact their fee-for-service (FFS) business? This brings up an important topic, that will be referred to as the "tipping point"—the point at which an organization's VBC financial opportunities start to outweigh FFS revenue reductions. Success within value-based care arrangements necessitates alignment of payer contracting and payment reform with care model transformation. This article will focus on the financial side of the equation.

Based on our experience working with providers, organizations need to reach a tipping point of 40% of their care delivery/clinical revenue managed under VBC contracts in order to be financially and operationally incentivized to manage total cost of care versus the volume of services provided. Within this article we will outline how the tipping point is defined and calculated, why 40% is considered the tipping point, risks of being above or below the tipping point, and how provider organizations can increase the amount of revenue they have tied to VBC.

To maximize population health financial performance and align incentives to deliver both well and sick care, provider organizations should push to have 40% of their revenue managed under VBC contracts. But how does one measure 40% and what does that even mean? Creating a consistent and measurable process is the key to aligning financials with an organization's care model delivery transformation as they move toward value-based care.

Introduction to value-based care and the tipping point

The transition from FFS to VBC is not a new concept for most health care systems. Over the last couple of years, the pandemic, rising health care costs, disparities in health outcomes, and payer pressures have caused most organizations to re-evaluate the pace and scale of their VBC journey. Health care spending in the United States has continued to increase at an unsustainable rate, which leads to concerns around long-term affordability. It has been reported that over 25% of health care spending in the US is considered unnecessary or waste [1]. More recently, providers in FFS arrangements have been hurt financially due to deferred care from the COVID-19 pandemic. Taking all of this into account, it has become evident that the FFS model is no longer sustainable, and many providers are looking to VBC as a means for future financial security.

Providers in VBC arrangements are financially incented to act differently than those in FFS arrangements. In FFS, providers are reimbursed based on the volume of services performed, whereas in VBC, providers typically earn more reimbursement by improving quality, shifting sites of services, and managing utilization and overall total cost of care. These conflicting business models create uncertainty for providers on where they should focus and prioritize their efforts. Knowing when the financial tipping point is reached is critical. Providers need to mitigate the period of time they have a "foot in both canoes" where actions to improve one business model have greater negative consequences than the positive value of the other business model.

Understanding the calculation

Before we can justify 40% as the tipping point, one has to understand where this number came from and how exactly it is measured. There are two ways to measure the tipping point: attributed lives or patient service revenue in VBC. For the purposes of this exercise, we'll be considering the tipping point in terms of revenue, as it tends to be a more precise indicator. While many attempt to use attributed lives as the measurement, we have found that attributed lives have multiple variables, making it an inconsistent comparison (e.g., variation in claim costs across lines of business and the associated impact on provider revenues). For example, a commercial member will have lower utilization and claims costs than a Medicare member, on average. Provider revenue, as a result, is more precise since it accounts for differences in utilization, claims costs, and care patterns across lines of business.

An additional point of clarification that is often needed is that this calculation is not how much financial risk an organization has. Calculating the total dollars at risk via VBC contracts is a useful measure; however, it is often times misleading because an organization would have to perform incredibly poorly to ever incur that level of loss.

The tipping point is reflected as a ratio—so it is important to understand what goes into both the numerator and denominator of this ratio. These details are outlined as follows:

Revenue In Value Based Care (VBC)

FFS Revenue
(i.e., net patient service revenue)

Medical Spend from Non-Attributed Lives	Medical Spend from Attributed Lives *at Health Care Organization*	VBC Payments

Revenue in VBC

$$\text{\% Revenue in VBC} = \frac{\text{Revenue In VBC}}{\text{FFS Revenue} + \text{VBC Payments}}$$

Term	Definition
Revenue in VBC	Revenue in VBC has two components. The first component is the total FFS revenue (i.e., net patient service revenue) received by a healthcare organization for care delivery services provided to an attributed population where the healthcare organization is responsible for managing total cost of care. This represents the healthcare organization's portion of total cost of care that it is responsible for managing across its entire VBC portfolio in order to achieve shared savings (and avoid losses). In addition, this also includes any VBC related payments received by the healthcare organization such as capitation payments, shared savings, pay-for-performance dollars (P4P), care coordination fees, etc.
% of Revenue in VBC	This is calculated by dividing the revenue in VBC by the total FFS Revenue for both attributed and non-attributed lives plus VBC payments. This can be calculated for a single contract, within a line of business, or across a healthcare organization's entire book of business.

Revenue in VBC is the FFS Revenue for the organization's **Attributed Lives** plus **payments received from VBC contracts.**

It is calculated as the % of **Total Revenue** tied to healthcare organization's **Attributed Lives** plus **payments received from VBC contracts** divided by total revenue from FFS and VBC payments.

Revenue In Value Based Care (VBC) – Illustrative Example

Contract Overview

Health Care Organization has 4 payer contracts, 2 of which are downside risk VBC contracts with Payer C and D → **For Payer C and D, Health Care Organization has NPSR that is associated with both attributed and non-attributed lives** → **Attributed Lives –** patients that receive the plurality of their primary care at the Health Care Organization. **Non-Attributed Lives –** patients that only receive select care at Health Care Organization (e.g., specialty care), but are attributed elsewhere

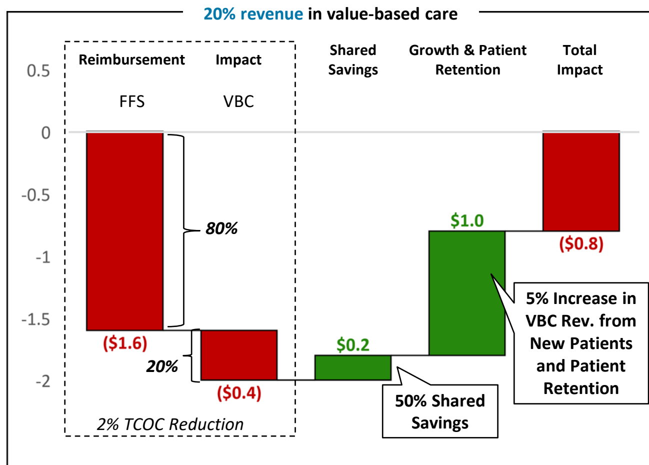
Illustrative Calculation

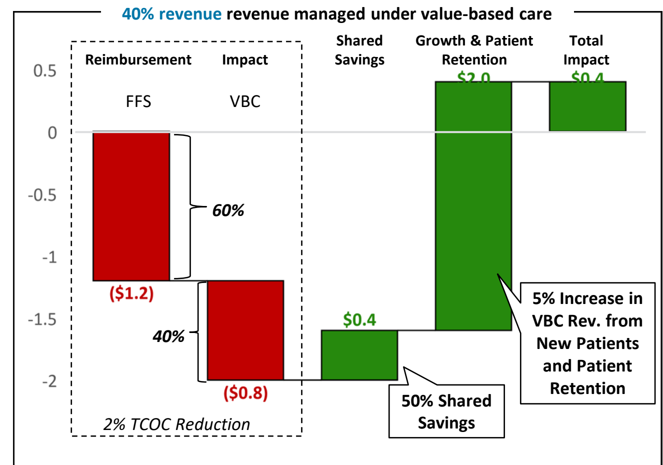
FFS Revenue *(i.e., net patient service revenue)*

Medical Spend from Non-Attributed Lives				Medical Spend from Attributed Lives *at Health Care Organization*		VBC Payments	
$500M				$250M		$10M	
Payer A *FFS Contract* *$200M NPSR*	**Payer B** *FFS Contract* *$150M NPSR*	**Payer C** *Non-Attributed Lives FFS* *$100M NPSR*	**Payer D** *Non-Attributed Lives FFS* *$50M NPSR*	**Payer C** *VBC Contract Attributed Lives* *$150M NPSR*	**Payer D** *VBC Contract Attributed Lives* *$100M NPSR*	**Payer C** *VBC Contract* *$8M shared savings & P4P*	**Payer D** *VBC Contract* *$2M shared savings*

$$\text{\% Revenue in VBC} = \frac{\text{Revenue In VBC}}{\text{FFS Revenue} + \text{VBC Payments}} = \frac{\$250M + \$10M}{\$250M + \$500M + \$10M} = \textbf{34\% of revenue in VBC}$$

Confirming 40%





Two illustrative examples will be used to demonstrate the validity of the 40% tipping point. First, let's assume an organization has 20% of its revenue in VBC, and the other 80% fee-for-service and has aggregate revenues of $100 million. Let us also assume that whatever care model redesign and transformation undertaken by the provider effectively applies across their entire population and not just the VBC population. In this example, the provider effectively reduces the total cost of care (TCOC) across its entire patient population by 2%. This results in a positive impact on the provider's VBC business because the reduction in TCOC triggers a shared savings payment. If the sharing percentage is 50%, the provider will receive $0.2 million back in the form of a shared savings payment (2%*$20M*50%). On the other hand, reducing TCOC negatively impacts FFS revenue, reducing the provider's revenue by $1.6 million (2%*$80M). After netting out these two transactions, the provider has experienced a revenue reduction of $1.8 million (-$2M reduction in TCOC, offset by $0.2M savings). However, there are additional levers that can be pulled to improve overall financial performance. Most of these levers focus on growing volumes by leveraging a health system's unique market position by being heavily in VBC. For example, the provider can increase in-network utilization for attributed lives and/or gain access to new patients due to product benefit design or attracting new patients through the providers' differentiated population health capabilities. This would likely result in a revenue lift. In this scenario, they could theoretically increase it's VBC revenue by $1 million ($20M*5% revenue lift on VBC revenues). In this scenario, though, the provider is still operating at a loss, thus displaying why creating care model efficiencies is actually a net loss financially to the provider system when there are not enough VBC contracts in place.

Next, we'll look at a scenario where an organization has 40% of its revenue in VBC and the other 60% in fee-for-service. Similar to the first scenario, the provider effectively reduces the total cost of care (TCOC) across its entire patient population by 2%. However, this impacts revenue differently since there is a different mix of VBC versus FFS revenue. The impact on the provider's VBC revenue, under the 50% shared savings assumption, is a $0.4 million ($40M*2%*50%) shared savings payment, which is double what was earned in the previous scenario. Additionally, the reduction in FFS revenue is less significant because the provider has a lower proportion of its business in FFS. Ultimately, the 2% reduction in TCOC results in a $1.2 million reduction in FFS revenue. After netting out these two transactions, the provider has experienced a revenue reduction of $1.6 million (-$2M reduction in TCOC, offset by $0.4M savings). But now, once again assuming the provider system could net an additional 5% increase on VBC revenues through in-network utilization and new attributed lives, the net revenue impact is a $0.4 million gain. You can see that as an organization has an increasing amount of its revenue in VBC, it allows for increased financial success.

Organizations that have less than 40% of revenue in VBC can try to increase their shared savings percentage (i.e., by taking on more risk) to help close the gap created by any reductions in TCOC. However, many organizations may not be comfortable taking on additional risk unless they have the capabilities and population health initiatives to perform well.

Risk of not meeting 40% tipping point

Often when an organization has both FFS and VBC arrangements, it will ideally try to maximize performance in both at the same time. We refer to this concept as having a "foot in both canoes."

There is an assumption that an organization's population health activities will impact its entire book of business, and that it is very difficult to tailor care delivery programs and initiatives that only impact attributed lives. Particularly, from an individual provider standpoint, all patients will be treated the same, regardless of if they are a VBC attributed life or not. Therefore, since population health initiatives may impact the TCOC on all lives, having a "foot in both canoes" (i.e., FFS and VBC) becomes problematic. As demonstrated in the example above, when an organization has a larger proportion of business in FFS, it is unable to maximize VBC financial performance because any progress on population health initiatives is also impacting the large percent of business that is still in FFS. Eventually, an organization will have to choose whether it will operate as an FFS- or VBC-minded company, or the market may dictate that decision for them. At 40% of the organization's patient services revenue under value-based care contracts, it will still receive FFS payments for some care; however, the organization is more financially incentivized to behave as a population health/value-based organization than an FFS organization.

How to get there

Organizations can increase their percent of revenue in VBC by pulling two levers: (1) increasing attributed lives, and/or (2) increasing in-network utilization. Increasing attributed lives can be accomplished by either entering new VBC contracts with payers and/or growing your attributed life base in existing VBC contracts. There are several operational and contracting strategies to both increase attributed lives and in-system spend in existing contracts.

These could include:

- Establishing initiatives around outreach and stratification designed for non-attributed patients to bring those patients to in-network PCPs
- Ensuring primary care footprint can adequately serve the attributed population and appropriate geographic areas for capturing new attributed lives
- Adding new contracts with attributed lives with beneficial attribution methodology
- Working with payer partners to design products that increase attribution

Closing

As the health care industry and corresponding regulatory environment continue to evolve, it is to the advantage of providers to push toward the tipping point to both improve patient population health and revenue financial outlooks. Organizations can pull various levers to accomplish this goal, and which levers are pulled will likely depend on the provider's construct, including, but not limited to, the structure of their provider network, facility asset footprints, risk appetite, and general health system size. While there are numerous stakeholders in the health care space that grapple with how much to pursue with regard to VBC, the 40% tipping point goal is intended to be a guideline for integrated delivery networks that have a shared goal among their providers to capture payments aligned with delivering more integrated and coordinated care. Ultimately, understanding the rationale and risks associated with not working toward that 40% contract goal will be key in order to best balance providing patient care with financial stability.

Endnotes

1. Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. *JAMA*. 2019;322(15):1501–1509. doi:10.1001/jama.2019.13978

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