

Analyzing the Expanded Landscape of Value-Based Entities

HCP-LAN Framework











QUALITY & VALUE

FEE FOR SERVICE -LINK TO QUALITY & VALUE

CATEGORY 2

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A

APMs with Shared

Savings

(e.g., shared savings with

upside risk only)

В

CATEGORY 3

CATEGORY 4 POPULATION -BASED PAYMENT

Foundational Payments for Infrastructure & Operations

(e.g., care coordination fees and payments for HIT investments)

В

Pay for Reporting

(e.g., bonuses for reporting

data or penalties for not

reporting data)

C

Pay-for-Performance

(e.g., bonuses for quality performance)

APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

A

Condition-Specific Population-Based Payment

(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

Comprehensive Population-Based Payment

(e.g., global budgets or full/percent of premium payments)

C

Integrated Finance & Delivery System

(e.g., global budgets or full/percent of premium payments in integrated systems)

3N Risk Based Payments

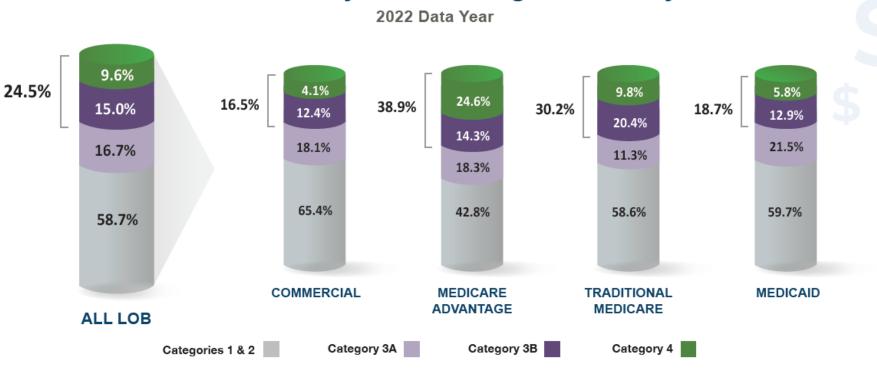
NOT Linked to Quality

4N Capitated Payments NOT Linked to Quality

APM Landscape



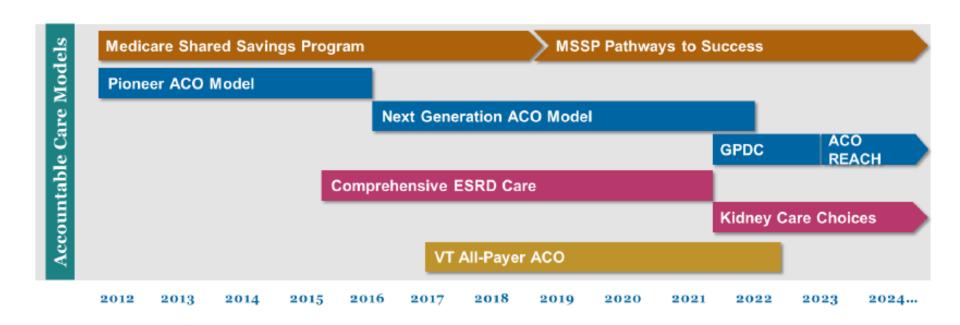
Percent of APM Payments in Categories 3B-4 by LOB



CMS Innovation Center (CMMI)



- Leading the shift from fee-for-service (FFS) to Value Based Payment
- 2030 goal All Medicare & *vast majority* of Medicaid Enrollees



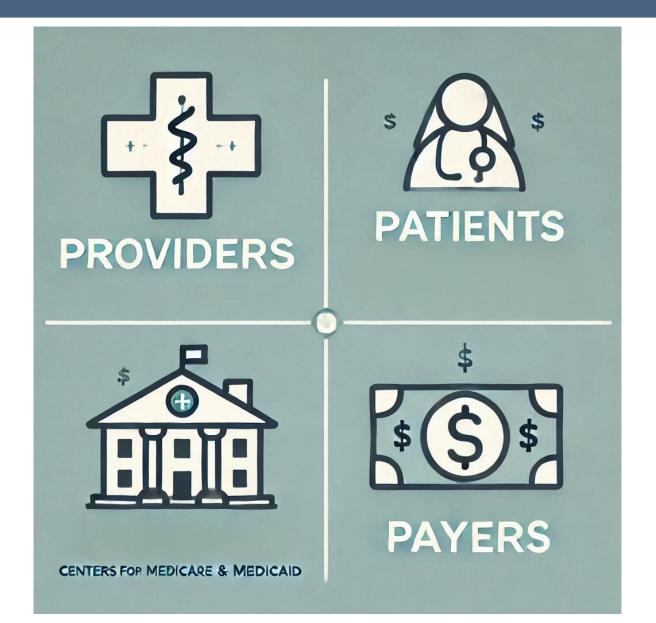
CMMI Participation Criteria



| Model | Enablers/ Hybrids Allowed to Participate | Eligibility |
|---|---|---|
| Medicare Shared Savings Program (MSSP) | Yes | Eligible participants are Medicare-enrolled providers and/or suppliers who form or join an ACO and have at least 5,000 Medicare fee-for-service beneficiaries assigned to their ACO. |
| ACO Realizing Equity, Access, and Community Health (<u>ACO REACH</u>) | Yes | The ACO is not required to be a Medicare-enrolled provider or supplier, but all participating providers must be. |
| Kidney Care Choices (KCC) | Yes (for CKCC) | Comprehensive Kidney Care Contracting (CKCC) Option: The Kidney Contracting Entity (KCE) itself is not required to be a Medicare-enrolled provider or supplier, KCE participants must be. Kidney Care First (KCF) Option: The applicant must be a Medicare-enrolled entity (i.e., physician practice or professional corporation) that bills Medicare for physician services rendered by one or more nephrologists by the start of the performance period. |
| Enhancing Oncology Model (EOM) | Yes | Participants must be a Medicare-enrolled physician group practice (PGP). |
| Making Care Primary (MCP) | No | Eligible participants are Medicare-enrolled organizations that provide primary care services to a minimum of 125 Medicare beneficiaries. |
| Primary Care First (<u>PCF</u>) | No | Eligible participants are <i>practices</i> with primary care practitioners, at least 125 attributed Medicare beneficiaries, experience in value-based care, and other requirements. |

Stakeholders – Benefits & Risks





Barriers to Entry





Small physician groups and safety net organizations

- Lack of access to capital to invest in needed infrastructure.
- Difficulty navigating the operational complexity of transformation.



Specialists

- Fewer available/willing partners or model options, relative to PCPs.
- Less financial or competitive pressure to leave FFS.
- Greater reliance on partnerships along the continuum to manage patients' holistic care needs.



Hospitals/Health Systems

- · Powerful inertia of status quo.
- High fixed costs and debt obligations further reinforcing a reliance on FFS revenues from services that are intentionally reduced under VBP (e.g., ED visits, admissions, and select high-paying service lines).
- Dilemma of shared performance with unaffiliated providers who have unequal capabilities and capital, requiring added investment while ensuring all partners "pull their weight."

Segmenting the Expanded Value Ecosystem



Value-Based Payment Enablers

Entities that <u>partner</u> with providers to help them in the transition from FFS to value and share responsibility for the cost and quality outcomes of the VBP contracts they support.

Offer a range of services including technology, contracting expertise, performance monitoring, and financial support; variety of partnership approaches from contractual relationships to JVs (but enabler does not acquire provider).

Hybrids

Entities that own risk-bearing providers and also offer VBP enablement services to external providers.

Risk-Bearing Delivery Organizations

Entities designed to <u>deliver</u>
value-based care from the outset
and assume accountability for
the cost and quality outcomes
of patient populations.

Offer high-touch clinical models with interdisciplinary care teams, smaller panel sizes, and salaried physicians; Represent an all-inclusive alternative to traditional FFS-based care delivery system.

VBE Market Segmentation Players



Figure 5. Entity Segmentation Matrix with Sampling of Organizations



Market Subsegments



- Payer/Program Focus. Is the entity focused on a single payer/program or multiple? If the latter, what was their entry point and expansion path?
- Patient Breadth. Does the entity assume cost and quality accountability for all patients in a given population, or do they carve out a specific cohort (e.g., high-needs patients)?
- Investor Interest. Is the entity publicly listed or private? What sources of funding have been used?
- **Independence.** Is the entity independently owned or is it a subsidiary of a larger entity such as a payer, retailer, health system?
- Asset Ownership. Does the entity own all of the assets used to enable/provide high-value care, or does it subcontract or partner with other vendors/enablers to deliver these services?
- **Diversification.** Is value-based care enablement or delivery the sole focus of the entity or is it simply one offering among a suite of services/divisions?
- Clinical Staff Employment. Does the entity employ "core" clinical staff (e.g., MDs/DOs, APPs, etc.) or "supplemental" clinical staff (e.g., care coordinators, medical assistants, etc.)?
- Offering Focus. Does the entity differentiate itself with its clinical offerings, technological offerings, or administrative offerings? Does it offer similar services in FFS/transactional context as well as VBP partnerships? (Enablement only)
- Ownership of Risk. Does the entity or the provider group directly hold the insurance risk? (Enablement only)
- **Preferred Partners.** Does the entity primarily partner with one provider type (e.g., independent primary care practices, FQHCs, etc.), or does it partner with multiple types of providers and various practice configurations? (*Enablement only*)
- Practice Growth Strategy. Does the entity build de novo practices or acquire existing FFS practices with the intent of transitioning them to VBP? (Care delivery only)

VBE Market Growth



Figure 1. Growth of New Entities Over Time (2011-2023)

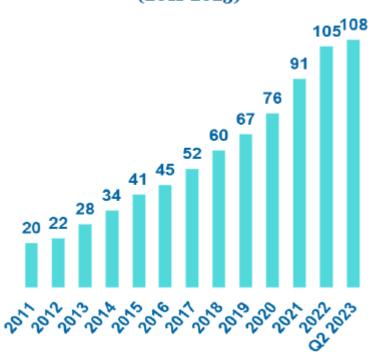
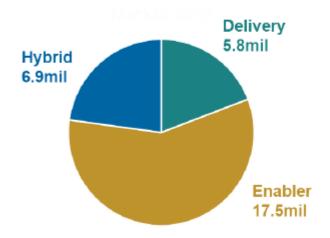


Figure 2. Estimated Number of Value-Based Covered lives by Entity Type



VBE Growth Drivers



- State and Federal Government Focus
- Increase in Capital Investment
- Growth of the Medicare Market
- Demand for Transformation
- VBC Market Evolution

VBE Offerings



Types of Offerings of VBP Enablers



Financial Support



Strategic & Administrative



Population Health Infrastructure & Technology



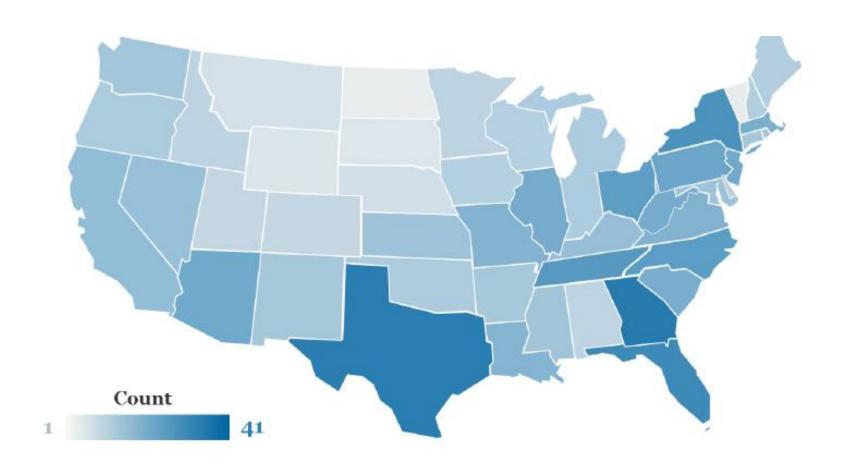
VBE Offerings



- Financial Support
 - Access to capital for infrastructure investments
 - Protection from downside risk
- Strategic and Administrative Support
 - MSO-like functions and strategic partnerships
 - Contract negotiation and scaling value-based lives
- Population Health Infrastructure and Technology
 - Importance of data and HIT solutions
 - Proprietary and third-party technologies
- Clinical Support
 - High-touch clinical models and care team support
 - Expanded access points and virtual care

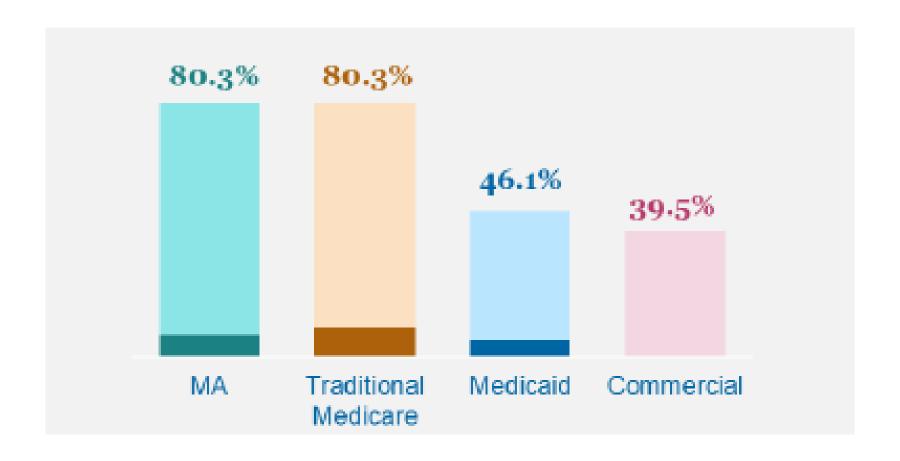
Trends: Provider and Geographic Prioritization





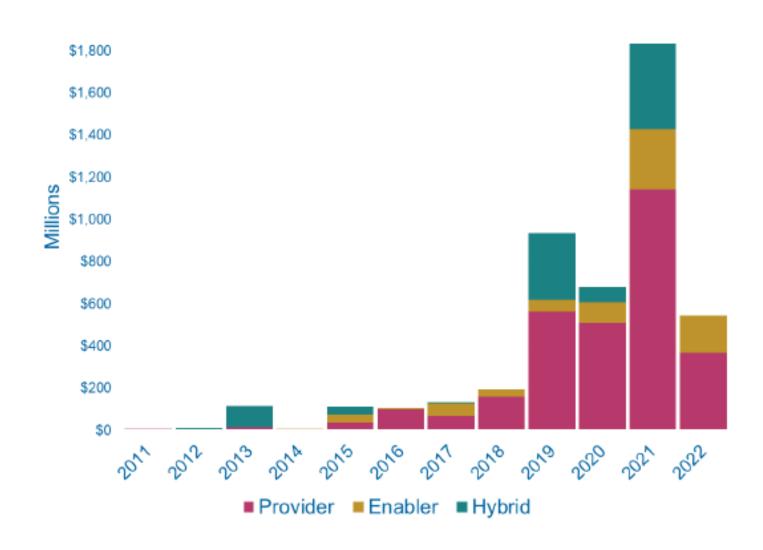
Trends: Populations of Focus





Trends: Funding





Future Expectations



- Continued Growth
- Market Fluidity
- Multi-specialty Market Growth
- Sub-capitation and Risk-Based Growth
- Rapid VBE Entity Growth followed by Consolidation

