

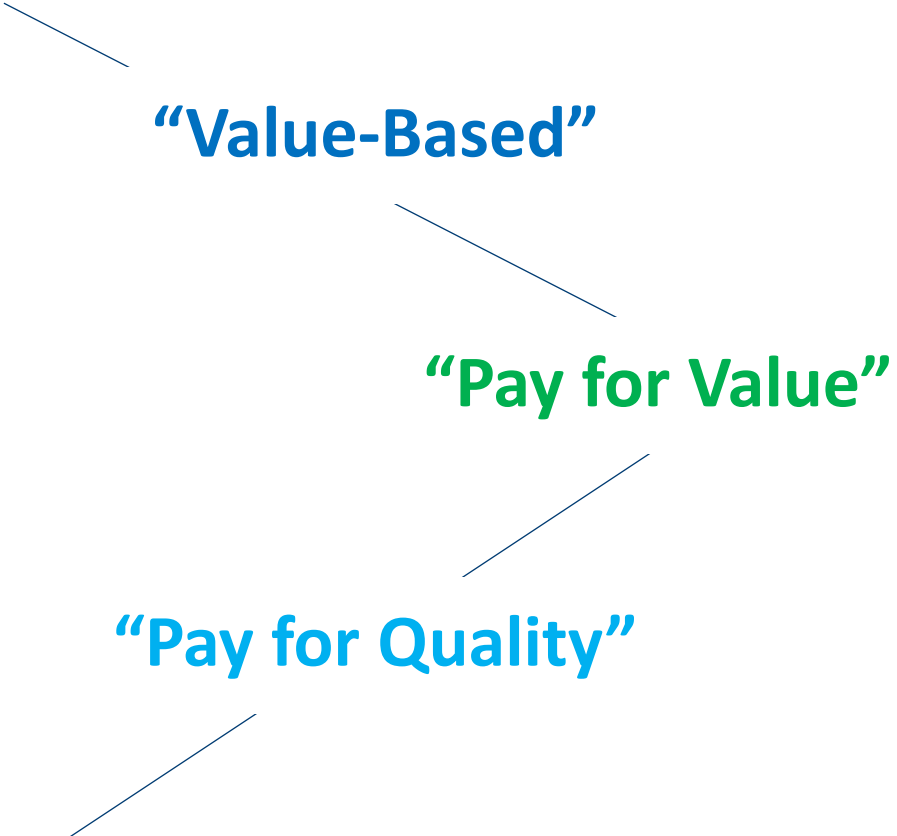


Balancing Fee-for-Service and Risk-Based Contracts in a Changing Reimbursement Landscape

Presenter:

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An agreement by many names





For-for-Service and Value-Based Care

Each foot in a different canoe

Financial aspects of various contracting approaches can differ significantly and sometimes conflict with each other

**Fee-for-Service
Financial Drivers**



More is better

Higher the better

Not always necessary

Rich and abundant

**Value-based Care
Financial Drivers**



Less in some areas; more in others

Generally lower

Needed to spread risk and gain more of the premium

Occasionally missing for out-of-network spend

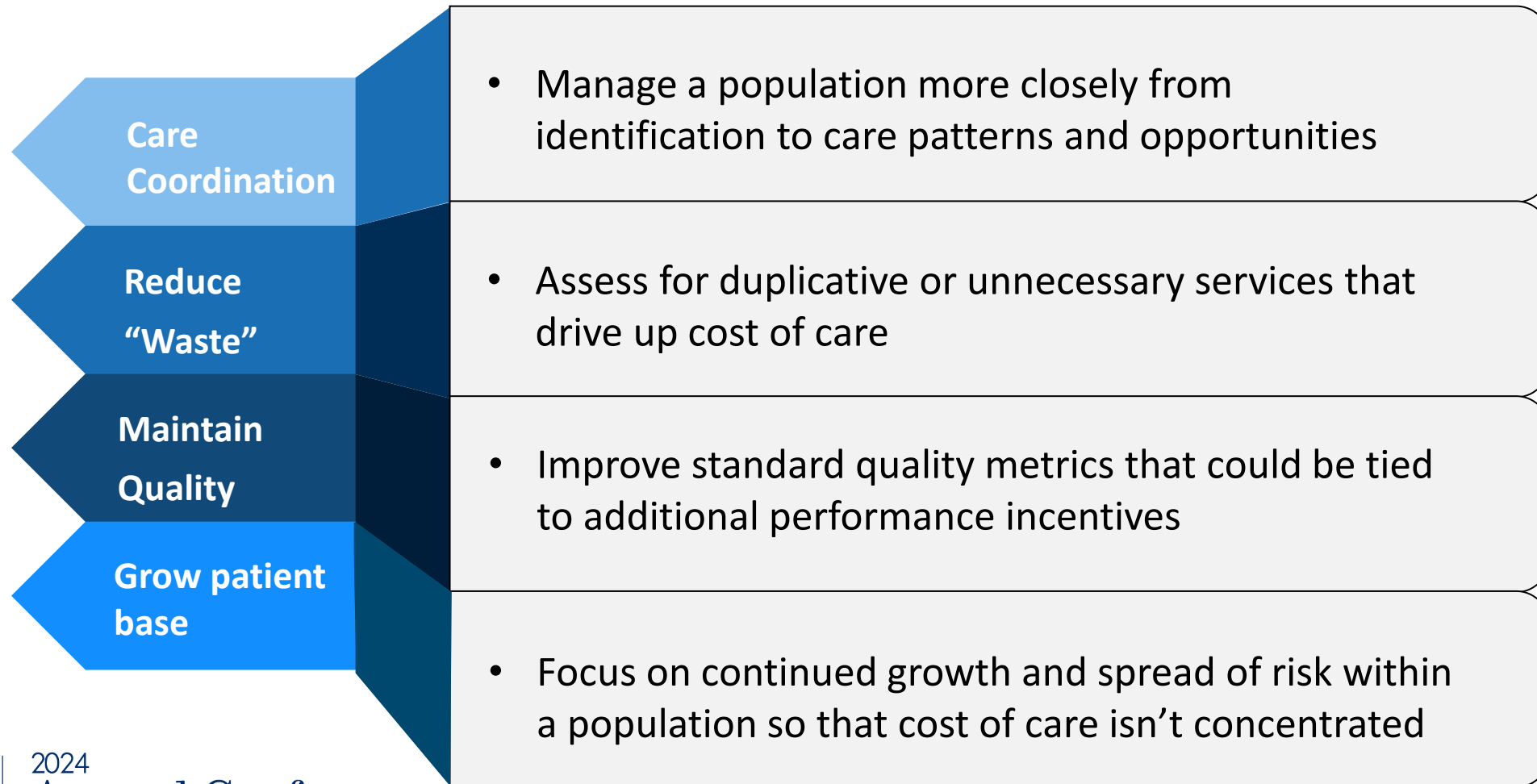
Utilization

Rates

Patient Growth

Data Availability

Adopting value-based contracts requires more operational resources and enhanced cooperation with the finance department

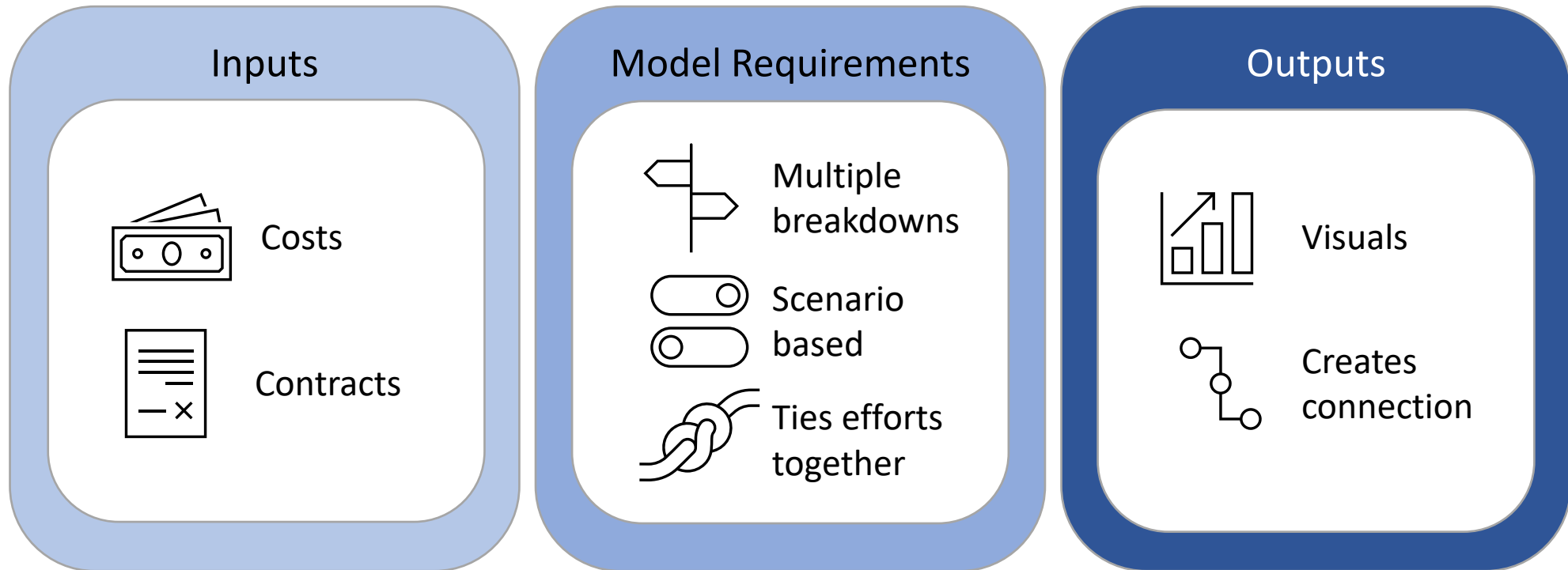




How do you tie it all together?

*For effective contracting strategy &
enterprise-wide planning*

Our teams aimed to evaluate the interactions and compromises between Fee-For-Service (FFS) and Value-Based Contracting (VBC)



Our goal was to create a model to guide our strategy in establishing relationships with payers in our market

The construction of the model necessitated the inclusion of four primary components

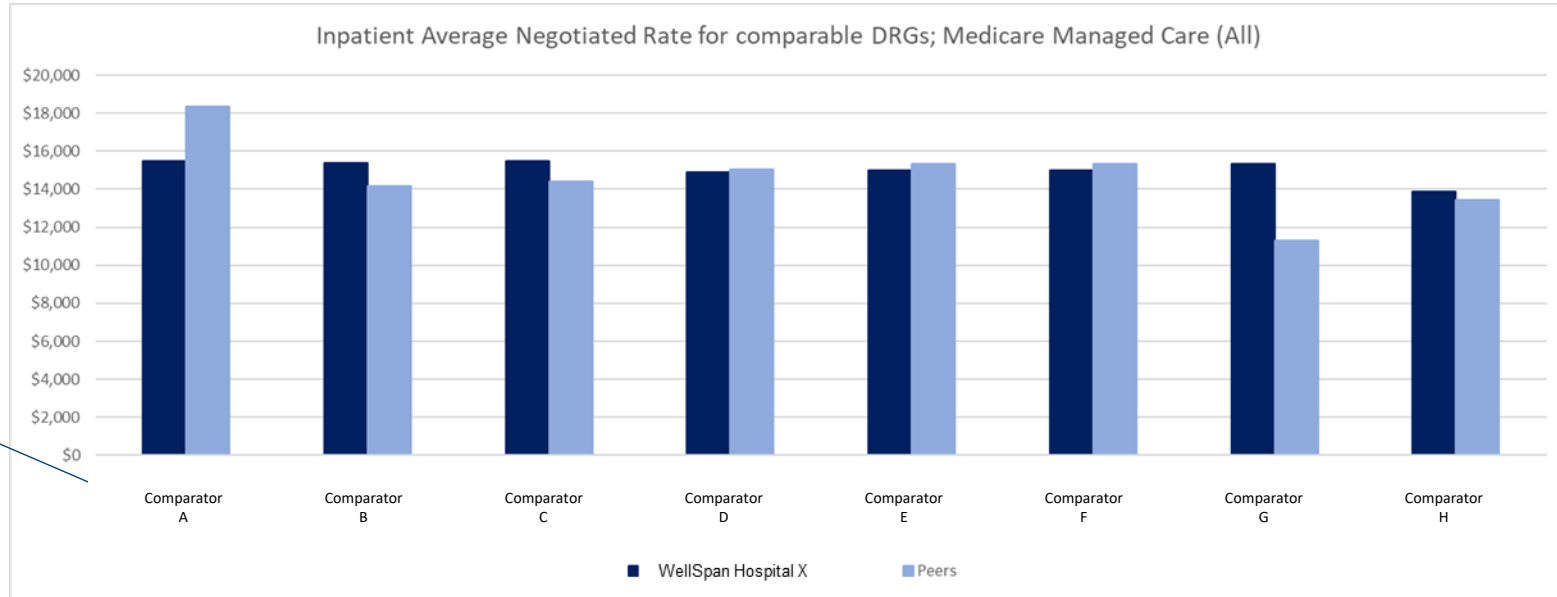
Modeling objectives:





Analyze the competitive rate landscape at a micro-level

Results can be assessed by inpatient, outpatient and professional levels on a by hospital and competitor basis

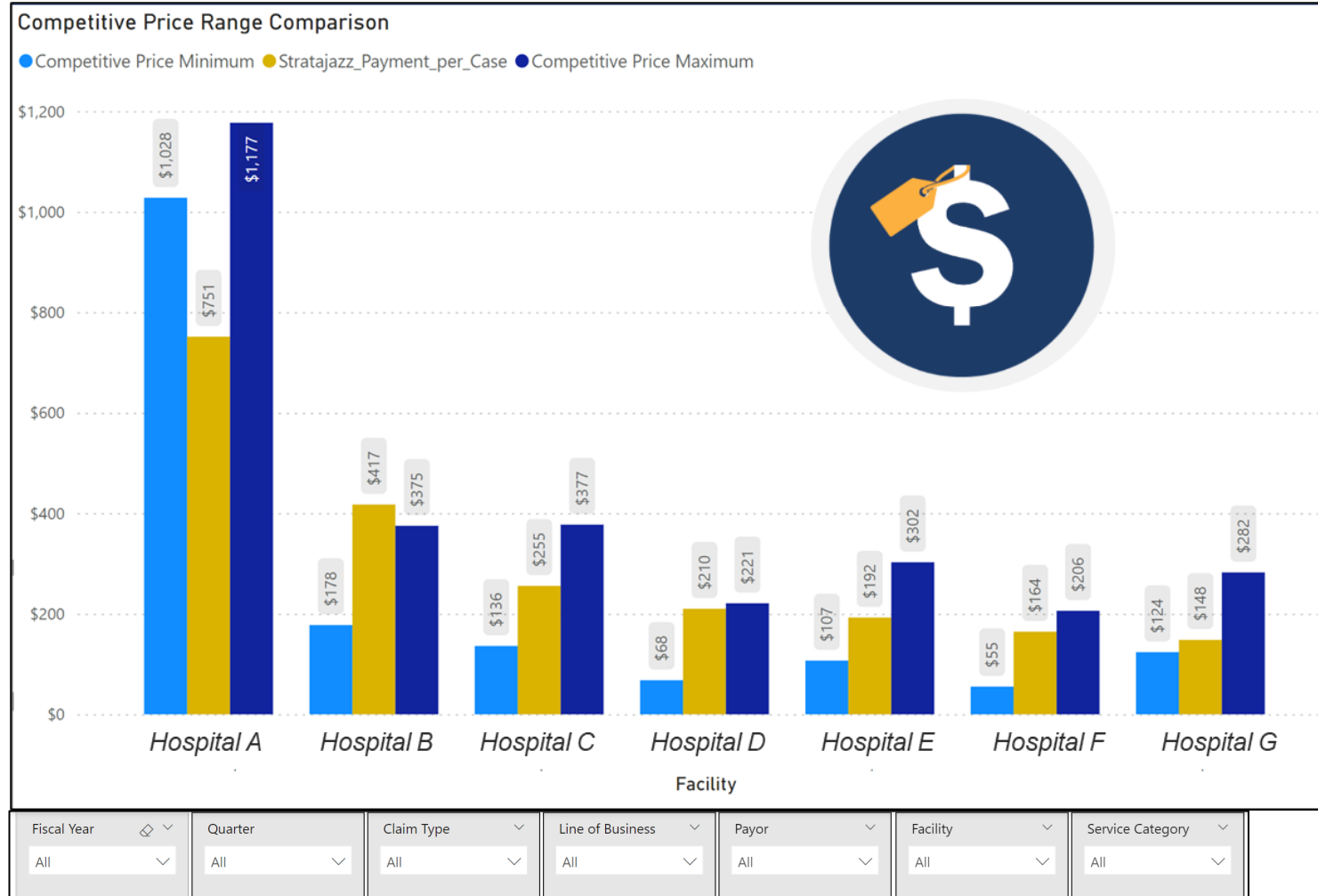


Even further assessment down to the DRG specific level is also attainable

DRG	Description	WellSpan Hospital X	Comparator A	Comparator B	Comparator C	Comparator D	Comparator E	Comparator F	Comparator G
All	(All)		0.85	1.07	0.99	0.98	0.98	1.36	1.03
177	RESPIRATORY INFECTIC	15%	0.96	1.22	1.25	1.20	1.20	2.02	
871	SEPTICEMIA OR SEVER	14%	0.82	1.04	0.91	0.96	0.96	1.18	1.23
853	INFECTIOUS AND PAR	10%	0.81	1.03	0.96	0.81	0.81	1.50	0.73
870	SEPTICEMIA OR SEVER	8%	0.95	1.23	1.00	1.07	1.07	1.80	
207	RESPIRATORY SYSTEM	5%	0.96	1.23					
291	HEART FAILURE AND SI	4%	0.87	1.09	1.05	0.95	0.95	0.65	1.01
247	PERCUTANEOUS CARD	3%	0.82	1.05	0.94	0.91	0.91		1.19
270	OTHER MAJOR CARDIC	2%	0.81	1.04	1.02				
280	ACUTE MYOCARDIAL II	2%	0.83	1.05	1.00	0.76	0.76	1.15	
246	PERCUTANEOUS CARD	2%	0.81	1.04	1.09	0.68	0.68		



Analyze the competitive rate landscape at a macro-level



Transparency data, when appropriately cleaned, can provide vital insights for understanding if your rates are commensurate with market positioning

Results of the assessment supported where pricing on the fee-for-service side could help or hurt a risk-based contract



Categorize the payer relationship(s) for total Cost to Serve

Measures (Service Categories)	Best in Class	Overall Cost to Serve (HB+PB)					Total for Top 5 Payors
		Payor 1	Payor 2	Payor 3	Payor 4	Payor 5	
Annual NPSR	N/A	\$196.3M	\$545.5M	\$127.M	\$568.9M	\$146.7M	\$1584.5M
<i>DRG downgrades</i>	\$0.02M	\$0.08M	\$0.02M	\$0.M	\$1.19M	\$0.06M	\$1.34M
<i>Inpatient to observation downgrades</i>	\$0.02M	\$0.08M	\$0.15M	\$0.02M	\$0.12M	\$0.1M	\$0.47M
<i>Itemized bill requests</i>	\$0.02M	\$0.23M	\$0.02M	\$0.07M	\$0.02M	\$0.13M	\$0.46M
<i>Medical records requests</i>	\$0.03M	\$0.18M	\$0.36M	\$0.03M	\$0.29M	\$0.08M	\$0.94M
<i>Hospital audits</i>	\$0.M	\$0.02M	\$0.18M	\$0.M	\$0.48M	\$0.1M	\$0.78M
<i>Denials</i>	\$0.11M	\$0.45M	\$0.57M	\$0.11M	\$0.64M	\$0.25M	\$2.02M
<i>Payor contracting effort</i>	\$0.M	\$0.5M	\$0.54M	\$0.76M	\$0.49M	\$0.23M	\$2.52M
<i>Aged A/R effort cost</i>	\$0.15M	\$0.24M	\$0.47M	\$0.15M	\$0.44M	\$0.18M	\$1.49M
<i>Aged A/R carrying cost</i>	\$0.1M	\$0.16M	\$0.3M	\$0.1M	\$0.29M	\$0.12M	\$0.97M
<i>Denial write-offs</i>	\$1.96M	\$3.99M	\$6.25M	\$1.96M	\$5.28M	\$2.62M	\$20.09M
Total Cost to Serve	\$2.41M	\$5.92M	\$8.85M	\$3.21M	\$9.24M	\$3.87M	\$31.08M
Cost to Serve as % of NPSR	0.76%	3.01%	1.62%	2.52%	1.62%	2.64%	

The “Total Cost to Serve” or sum of administrative service and revenue impact costs by payor is an important measure of the relationship.

Assessed by account type (hospital, professional) and line of business both as an overall impact (total dollar)



Categorize the payer relationship(s) for Cost to Serve per Encounter

Measures (Service Categories)	Best in Class	Overall Cost to Serve (HB+PB)					Average for Top 5 Payors
		Payor 1	Payor 2	Payor 3	Payor 4	Payor 5	
Annual Encounter Volume	N/A	464,457	1,127,256	252,519	1,295,852	325,517	693,120
<i>DRG downgrades</i>	\$0.02	\$0.17	\$0.02	\$0.00	\$0.92	\$0.17	\$0.25
<i>Inpatient to observation downgrades</i>	\$0.09	\$0.18	\$0.13	\$0.09	\$0.09	\$0.30	\$0.16
<i>Itemized bill requests</i>	\$0.01	\$0.49	\$0.01	\$0.27	\$0.02	\$0.39	\$0.24
<i>Medical records requests</i>	\$0.14	\$0.38	\$0.32	\$0.14	\$0.22	\$0.26	\$0.26
<i>Hospital audits</i>	\$0.00	\$0.04	\$0.16	\$0.00	\$0.37	\$0.30	\$0.17
<i>Denials</i>	\$0.45	\$0.96	\$0.51	\$0.45	\$0.50	\$0.77	\$0.64
<i>Payor contracting effort</i>	\$0.00	\$1.07	\$0.48	\$3.02	\$0.37	\$0.71	\$1.13
<i>Aged A/R effort cost</i>	\$0.34	\$0.53	\$0.41	\$0.59	\$0.34	\$0.56	\$0.49
<i>Aged A/R carrying cost</i>	\$0.22	\$0.34	\$0.27	\$0.39	\$0.22	\$0.37	\$0.32
<i>Denial write-offs</i>	\$4.07	\$8.58	\$5.55	\$7.75	\$4.07	\$8.05	\$6.80
Total Cost to Serve per Encounter	\$5.35	\$12.74	\$7.85	\$12.70	\$7.13	\$11.89	\$9.61

We analyzed the per-encounter amount to facilitate comparison among various payors

Results of the scorecard helped identify which payers were candidates for true partnership and a potential for value-based agreements

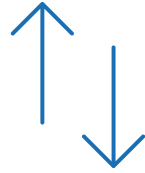
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Consider mechanics of value-agreements



Base Period

When the contract “rebases” and what is considered the performance payment can influence your ability to meet targets



Risk Share

The share (or changing share) of upside and downside risk can affect your overall opportunities



Care Coordination

Care coordination fees collected can be substantial. They may or may not be tied to quality incentives



Attribution

The more patients you can get attributed, the more risk you can spread across the population. However, understanding attribution logic is key



In-network Spend

The more quality, and coordinated care services inside your system, the more opportunity to further collect your upside risk savings

Modeling effort included the ability to assess each component of the value-based agreements to evaluate opportunities and financial implications



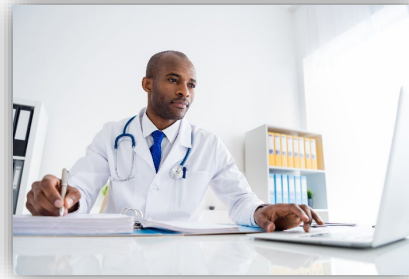
Connect it to the operational execution

Operational strategy meets financial modeling:

Keeping services within the system



Bringing down the cost of care



Growing the patient base



Assessing site of service



Others?

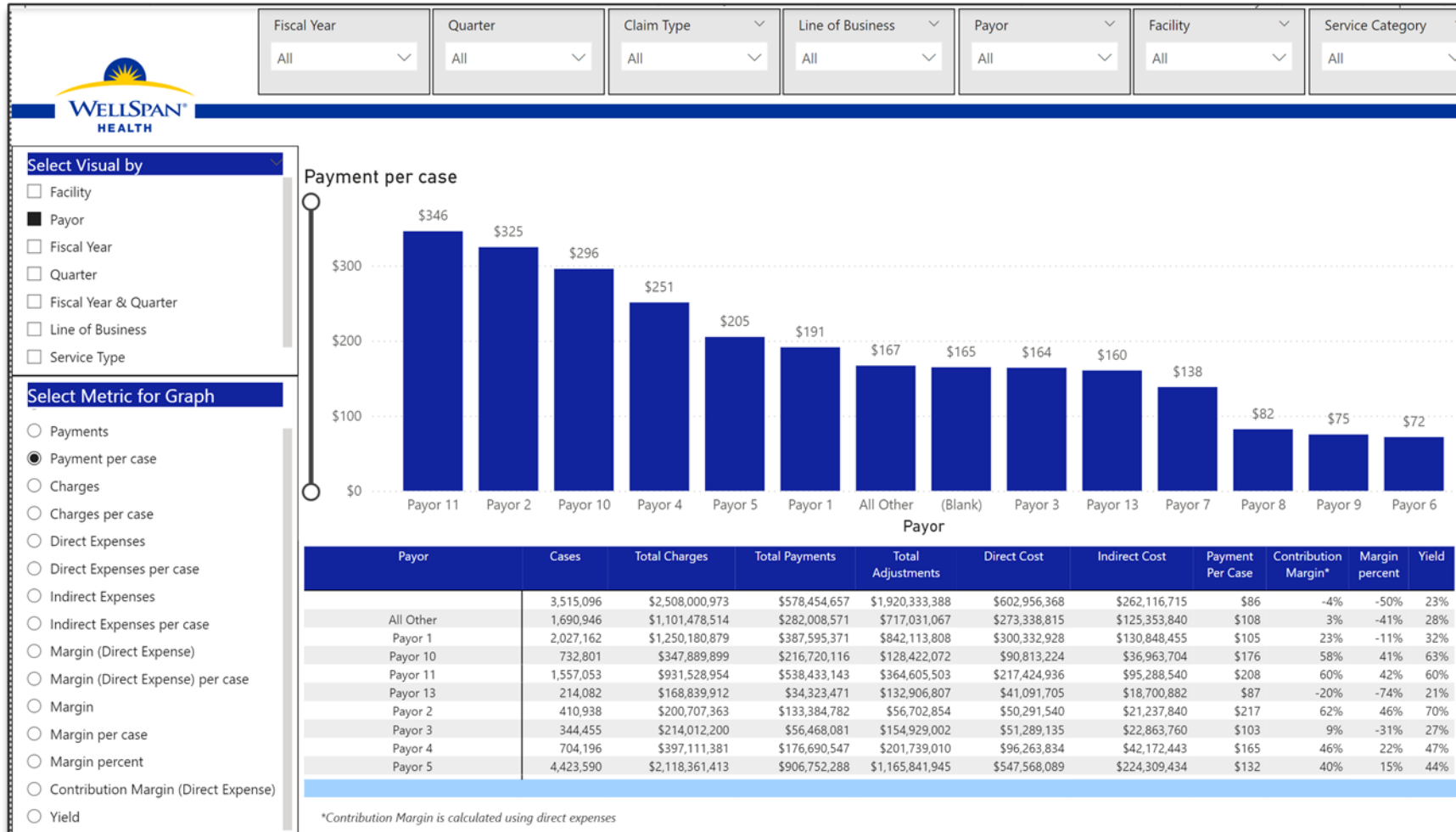


Modeling the projected strategic tradeoffs

For a coordinated enterprise strategy



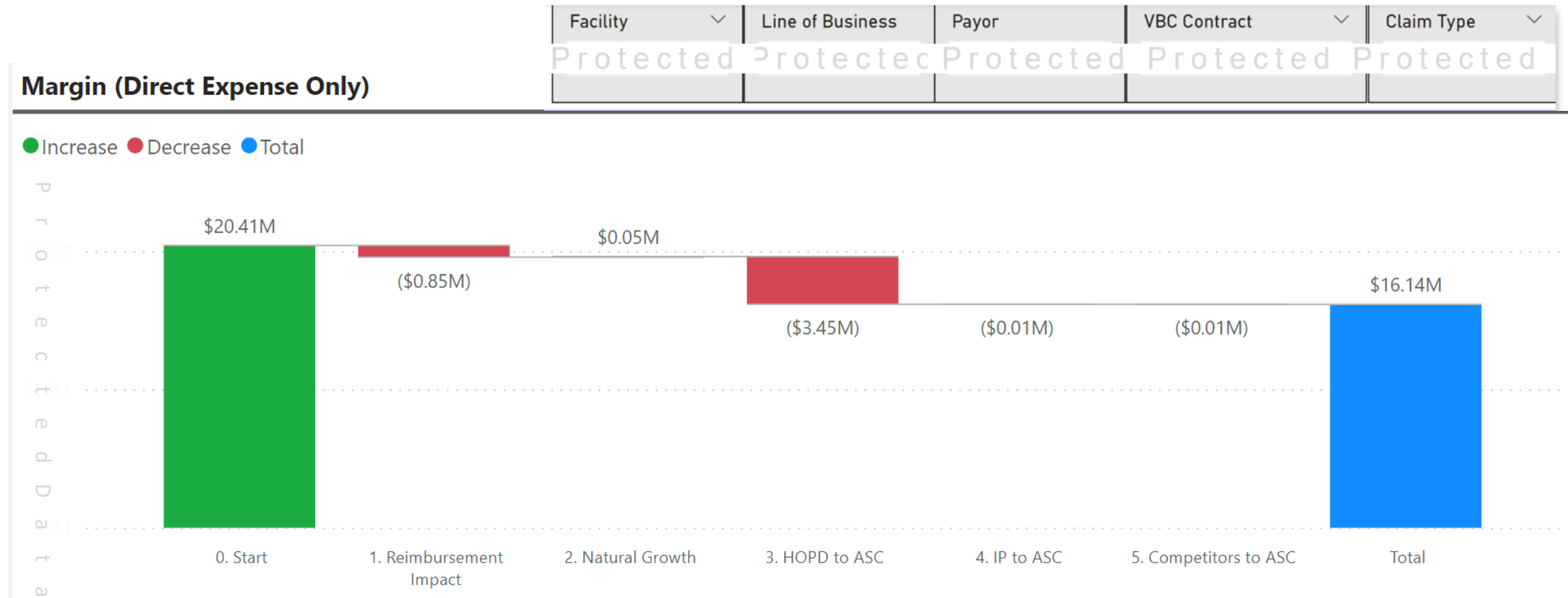
The model includes the ability to assess both the Fee-for-Service



...and Value-Based contracts simultaneously

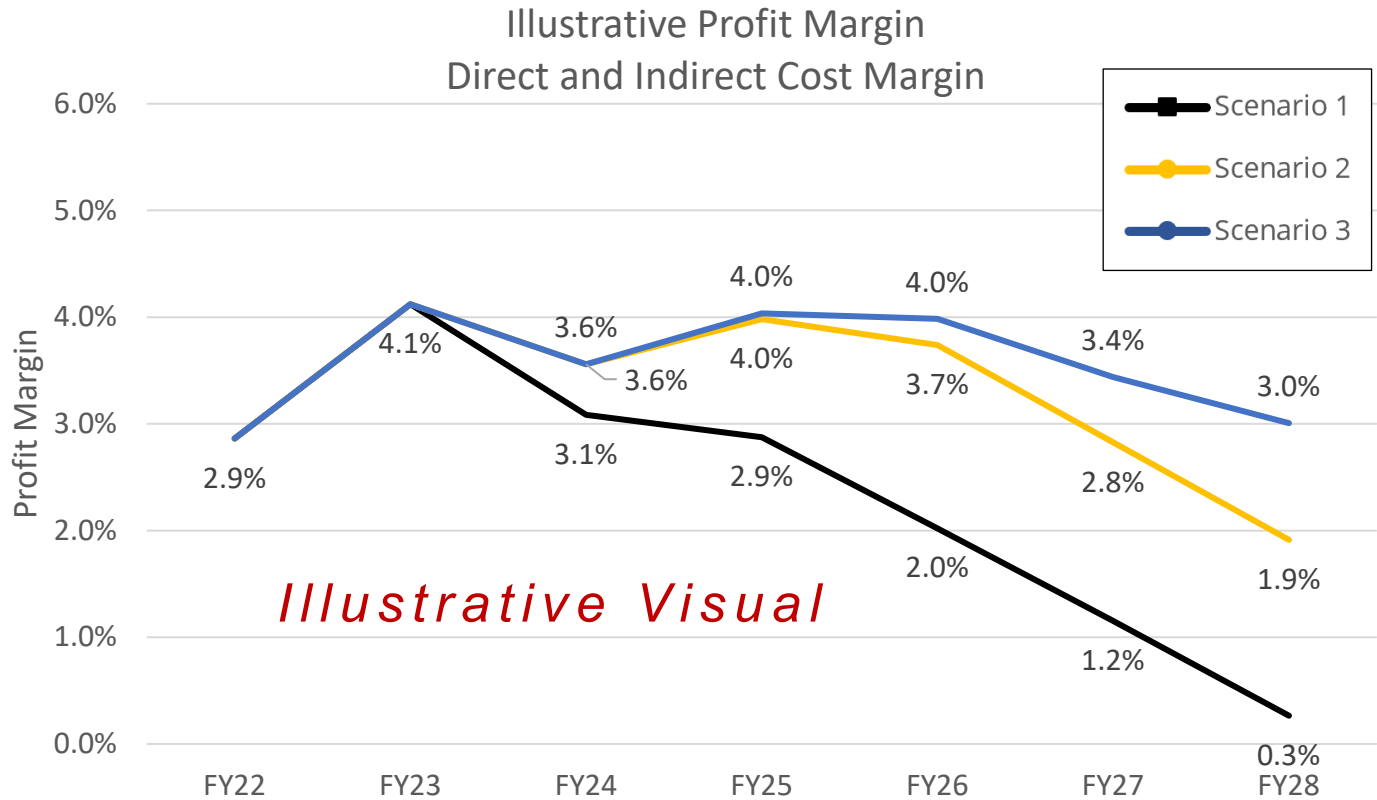
Payor	Payor 1		
Financial Class	Product 1		
CMS Revenue Increase	3.00%	3.00%	3.00%
Market Paid Claims PMPM % Increase	3.00%	3.00%	3.00%
WellSpan PMPM Growth	0.0%	3.3%	
Contract Year	CY21	CY22	CY23
Paid in	FY22	FY23	FY24
Shared Savings Rate	50%	50%	50%
Max Savings Rate	100%	100%	100%
Shared Loss Rate	0%	50%	50%
Max Loss Rate	-100%	-100%	-100%
Admin PMPM	N/A	\$133.00	\$133.00
Risk Corridor (Shared Savings)	1%	0%	0%
Risk Corridor (Risk Share)	-1%	0%	0%
Care Coordination Fees	\$3.00	\$0.00	\$0
Average Attributed Members	3,583	3,801	9,604
Member Months	24,284	40,722	110,519
Member Risk Score	0.913	0.898	0.909
<i>Premium Revenue</i>	<i>\$23,808,140</i>	<i>\$35,971,000</i>	<i>\$103,071,000</i>
Total Revenue PMPM	\$980.40	\$883.33	\$909.83
<i>Claims Expense</i>	<i>\$23,173,390</i>	<i>\$37,231,000</i>	<i>\$93,281,000</i>
Total Claim PMPM	\$954.27	\$914.27	\$844.03
Actual MLR	97.33%	103.50%	92.77%
Target MLR	85.00%	85.00%	85.38%
Operating Gain / (Loss)	N/A	-\$1,676,026	\$4,909,027
Gross Gain	12.33%		
Corridor Met?	Y	Y	Y
In-Network Spend	58.2%	58.2%	58.2%
WellSpan FFS Revenue	\$23,879,234	\$24,270,443	\$56,612,538
Shared Savings	\$0	-\$3,338,013	-\$2,454,514
Approx. Total Care Coordination Fees	\$72,852	Protected Data	\$0
Total VBC Performance Payments	\$72,852	-\$3,338,013	-\$2,454,514
Net Revenue (FFS + VBC)	\$23,952,086	\$20,932,430	\$54,158,025

Modeling results created easy to read visuals that can be toggled by several system dimensions



The visuals effectively demonstrated the financial consequences, particularly on profit margins, of strategic and payer partnership decisions

The results of modeling can be used to measure the return on investment for strategic opportunities



- **Scenario 1:** A fundamental projection of financial outcomes influenced by market dynamics and escalating cost pressures.
- **Scenario 2:** A projection following the evaluation of opportunities for rate enhancement and improvements in value-based care performance.
- **Scenario 3:** A projection under intensified attention on attribution and in-network expenditure for value-based contracts

The financial results, influenced by specific operational and contracting actions, guide the setting of overall business performance targets.

The model's operation mirrors the complexity and capability of a **Harrier jet**

- *Intricate computations, mathematical models, and underlying assumptions*
- *An innovative tool for the payor contracting team, BUT*
- *Still learning to fly the plane!*





Final Value-Based Considerations



