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How providers can best confront the reality of value-based care

Value-based care models are becoming increasingly important for health systems. Implemented well, they can improve system economics, enhance care quality and outcomes, and strengthen physician alignment.

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In most parts of the United States, the use of value-based care (VBC) arrangements is growing, and health systems today typically participate in a diverse VBC portfolio. Nevertheless, the proportion of total net patient revenue derived from these programs is usually small. As a result, many senior executives do not yet realize that VBC arrangements, when designed and implemented well, can have a significant positive impact on EBI(T)DA—and deliver other benefits as well.

Design and implementation can be challenging, however. Among the factors that can limit the potential benefits of VBC arrangements are poor transparency into value-based formulas and metrics, inconsistent alignment with physicians, lack of actionable insights for motivating behavioral change at the point of care, and suboptimal coordination between clinical, financial, contracting, and operational stakeholders. In addition, several misperceptions about the arrangements themselves or difficulties in their implementation hinder what the programs can achieve. (See "Barriers to success in VBC arrangements" on p. 2 for details.) For example, providers may be hesitant to enter VBC arrangements because they can lead to a near-term decline in inpatient volume. These arrangements also require providers to transition their footprint away from acute-care, asset-heavy "bricks and mortar" facilities to ambulatory and virtual sites of care.

Despite these challenges, when design and implementation are done well, VBC arrangements can also enable earnings growth, reduce the total cost of care, improve clinical quality and outcomes, and increase physician alignment. In addition, the arrangements can strengthen a system's competitive advantage by helping it deliver greater value (quality, outcomes, experience) at a lower total cost, which ultimately strengthens its negotiating position with payers. Given the value at stake—and potential risks—health system executives should carefully consider the pace and path they want to take, which should vary depending on their organizations' capabilities and local market conditions.

After working with many provider organizations on this topic, we have developed five core beliefs:

— Taking greater advantage of existing VBC programs can improve most providers' EBI(T)DA—often, by at least 20 percent and sometimes up to 50 percent in low-margin systems.

— Market factors and structure influence health system adoption rates.

— Value can be created in three major ways: better alignment of VBC arrangements with health system operations, more effective network performance management to drive physician engagement and clinical alignment, and ongoing care delivery transformation.

— Health systems need targeted and tailored action plans to put these three strategies into operation.

— Payers can play an essential role in helping providers make the shift to VBC by simplifying and aligning quality and process metrics so the providers can be rewarded for clinical and operational changes.

We discuss each of these insights below.

VBC can increase EBI(T)DA

Although the rate of VBC adoption varies in different markets, the arrangements are becoming increasingly common throughout the United States. A new report from the Health Care Payment Learning and Action Network, a public-private partnership launched by the Department of Health and Human Services, found that the percentage of total healthcare payments tied to a value-based payment methodology (e.g., shared savings, shared risk, bundled payment, population-based payments) reached 34 percent of total dollars paid to providers in 2017, up 23 percent from 2015.[1]

[1] Health Care Payment Learning and Action Network. Measuring progress: Adoption of alternative payment models in commercial, Medicaid, Medicare Advantage, and fee-for-service Medicare programs. October 22, 2018. In this report, pay-for-performance contracts were not included in the calculations about VBC arrangements.

At most health systems, VBC arrangements can now be found in multiple lines of business. Examples include commercial pay-for-performance (P4P) contracts, various Medicare fee-for-service (FFS) models,[2] programs offered through Medicare Advantage or managed Medicaid plans, and other financial risk-sharing arrangements (e.g., direct-to-employer bundles, shared-savings models, accountable care organizations).

We often hear from health system executives that VBC arrangements affect only a small proportion of overall revenue—yet in our experience, many health systems could earn significant incremental revenue by optimizing VBC programs. Few executives have a clear picture of the scope and nature of these arrangements, given difficulties in accessing data and the relatively small amount of revenue at stake.

Despite their relatively small effect on overall revenue, VBC arrangements often have disproportionate margin impact—often, larger than the contribution of even the most profitable service lines. In our experience, the potential margin improvement for a typical health system ranges between 20 and 50 percent. (Given a 5-percent operating margin, a system would

[2] Includes programs such as Hospital Value-Based Purchasing, Bundled Payments for Care Improvement–Advanced, and the Medicare Shared Savings Programs, among others.

Sidebar 1

Barriers to success in VBC arrangements

Despite the potential benefits of VBC arrangements, most health systems are not entering them in a coordinated way or adequately tracking performance against them. In some cases, misperceptions about the programs help explain why health system executives pay insufficient attention to them. The rationales cited most often are that the value at stake today is not sufficient to justify senior leaders' involvement, and that success in VBC arrangements could have a knock-on effect that might then reduce utilization and FFS revenues. As we discuss in the main article, neither of these rationales is true.

In other cases, executives cite legitimate problems that can hinder implementation but overstate the difficulty these barriers present:

- Clinical and operational leaders do not know what is needed to take advantage of value opportunities in existing programs.
- Lack of coordination and transparency between contracting and operational leaders leads to misalignment of contract/program incentives and operational priorities.
- Program economics are complex and rarely generate positive near-term effects (e.g., a readmission avoided today may not affect payments or penalties for up to two years).
- Health systems must participate in multiple programs, each with its own complex structure. Typically, each payer has numerous benchmarks and methodologies for its VBC arrangements, often with variations between lines of business. In some cases, we have seen the same facility track more than 200 different metrics connected to incentive payments for its commercial contracts alone.
- Physician alignment is critical but difficult to achieve, given operational and regulatory restrictions and the proliferation and complexity of metrics.

Although these barriers are real, they can be overcome. Health systems can surmount these barriers through a deliberate VBC arrangement strategy and operational follow-through.

need to have only 1 to 2.5 percent of revenue at risk from VBC payments for upside or downside revenue potential to equal 20 to 50 percent of system EBI(T)DA.) In many cases, the potential upside and downside from VBC payments could dwarf the entire system margin.

To confirm our experience, we looked at over 4,000 health systems with publicly available financial information. In nearly 20 percent of them, the upside potential in VBC arrangements from Medicare FFS programs alone was greater than their total reported margin.[3] Furthermore, several states now require downside-risk arrangements for Medicaid members, as do many managed Medicaid and Medicare plans. Most commercial contracts also have at least 1 or 2 percent of price or growth tied to quality and efficiency incentives.

Another statement we have often heard is that VBC arrangements can decrease utilization, ultimately reducing provider revenues. While many of them do focus on reducing total medical costs, a large portion—including those offered by the Centers for Medicare & Medicaid Services (CMS) and private payers—are P4P programs.[4] Furthermore, most of the programs include goals (e.g., adherence to preventive care) that, in many cases, could increase some types of utilization in the shorter term.

To the extent that VBC arrangements provide financial and performance-analytic tools that help raise physician awareness about patient referral patterns, they can be a powerful catalyst to improve system care continuity (improving the share of patients receiving follow-up care within the health system). For example, improving system referral retention from 60 to 70 percent in volume would be tantamount to a 10-percent growth in volume, which could offset a 10-percent reduction in volume that might result from cutbacks in unnecessary utilization.

Market factors influence adoption

Several factors influence the speed at which VBC arrangements are adopted in a given market:

High ratio of government volume to commercial volume. The potential revenue at stake in VBC arrangements is often larger in government-payer segments than in other segments. CMS currently has multiple VBC models (in addition to several pilot programs being run by its Center for Medicare and Medicaid Innovation):

- End-stage Renal Disease Quality Incentive Program
- Hospital Value-based Purchasing (HVBP) Program
- Hospital Readmission Reduction Program
- Value Modifier Program (also called the Physician Value-based Modifier Program)
- Hospital-acquired Conditions Reduction Program
- Skilled Nursing Facility Value-based Purchasing Program
- Medicare Access and CHIP Reauthorization Act of 2015

Two factors magnify the impact of government VBC arrangements. First, participation is mandatory in some cases (e.g., HVBP; Medicaid programs in Ohio, Tennessee, and Arkansas). Second, patients covered by government programs are becoming an increasingly large contributor to providers' volume. Between 2011 and 2017, the percentage of the total US population covered by Medicaid or some type of Medicare increased from 31 to 37 percent because of population aging and Medicaid expansion.[5] By 2022, these programs are expected to cover about 40 percent of total lives

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3 To compare VBC potential with health system margins, we began with a 2012 report in the *New England Journal of Medicine*, which found that a typical health system has at least 8 percent of Medicare FFS revenues at stake through various CMS value-based programs. (See: VanLare J, Conway C. Value-based purchasing—national programs to move from volume to value. *New England Journal of Medicine*. 2012;367:292–5.) We then used the 2016 American Hospital Association Database to determine Medicare FFS revenues for each health system, calculated what 8 percent of the revenues would be in each care, and then compared that number to the reported EBI(T)DA for each system.

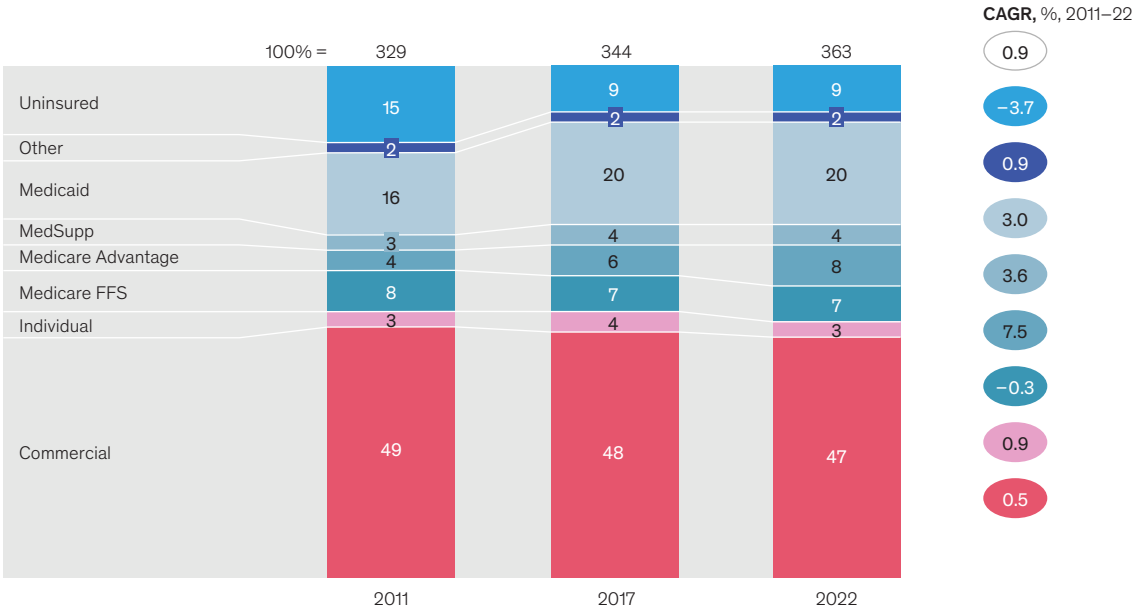
4 We define P4P programs as those in which provider compensation can be increased because of good performance against one or more quality metrics assessing outcomes or costs.

5 McKinsey MPACT 8.1 model, based on underlying data from the US Census Bureau, Small Area Health Insurance Estimates Program, ACS, CPS, MEPS, Behavioral Risk Factor Surveillance System, Pew Hispanic Center, Office of the Assistant Secretary for Planning and Evaluation, and CMS.

Exhibit 1

Number of lives insured by government payers will likely grow 40% from 2011 to 2022

Number of lives, % of total



CAGR, compound annual growth rate; FFS, fee-for-service; MedSupp, Medical Supplemental.

Source: McKinsey MPACT 8.1 model, based on underlying data from US Census Bureau's American Community Survey, Current Population Survey, and Small Area Health Insurance Estimates; Behavioral Risk Factor Surveillance System; Centers for Medicare & Medicaid Services; Medical Expenditure Panel Survey; Office of the Assistant Secretary for Planning and Evaluation; Pew Hispanic Center. Note that the total number of lives is greater than the US population because of overlapping coverage.

(Exhibit 1). As the programs grow, so will the significance and magnitude of VBC arrangements.

Fragmented provider landscape. In more fragmented and competitive provider markets, VBC arrangements can help establish competitive differentiation. Health systems can demonstrate their commitment to providing high-value care—in terms of lower total cost of care and better outcomes—as a way to build preferred relationships with payers and thereby increase share and profitability.

More large employers willing to enter value-oriented partnerships. VBC arrangements are often more common in markets with large and influential employers willing to place restrictions on their members' healthcare options (or create tiered systems with strong incentives). While many employers still remain reluctant to contract directly with providers, there is evidence that this is beginning to change. Several large employers launched bundled products for surgical procedures and are gaining valuable experience more actively managing cost and outcomes for their employees. At the same time, recent high-profile announcements (e.g., GM/Henry Ford Health System partnership, Amazon/Berkshire Hathaway/JP Morgan joint venture) suggest deeper relationships between employers and providers are coming.

Payer market behavior. In some circumstances, payers can independently promote VBC adoption. The key variable is not necessarily the degree of market consolidation. In fragmented payer markets, we have observed both relatively high (e.g., St. Louis) and low (e.g., New York City, Hartford) adoption levels. Similarly, both high (e.g., Southern California, Las Vegas) and low (e.g., Detroit) VBC penetration exists in more consolidated payer markets. However,

in markets where a prominent payer makes a clear strategic choice to move forward with VBC (e.g., Massachusetts), it becomes more difficult for providers to choose not to participate.

Physician market structure. The presence of well-organized, independent primary-care groups is a major factor influencing a market's transition to a delegated-risk model in which providers take on more risk (e.g., Monarch HealthCare in Long Beach and Orange County). Experience in the Medicare Shared Savings Program shows that physician-led accountable care organizations are the most successful in generating shared savings. However, some specialty groups (e.g., OrthoCarolina) and physician-contract-staffing organizations (e.g., Sound Physicians, which operates in most states) have also shown their ability to capture value through VBC arrangements. In markets where physician practices are largely owned by health systems, adoption of these arrangements is less common.

Of course, health systems have a choice in how they respond to these market factors, ranging from launching their own provider-led health plan (e.g., HAP), to partnering with a payer to jointly launch a product (e.g., Ascension, Centene) or contracting to share risk (shared savings, pay-for-value, etc.). The "value posture" each system adopts influences its competitive conduct and the pace at which it participates in new payment and care delivery models (see "Value postures" below for more details).

Sidebar 2

Value postures

Several factors should influence a provider's "value posture" (its strategic approach to VBC arrangements), including:

Relative price and market position. In competitive markets, second- and third-place health systems may lack the scale to effectively achieve favorable pricing from payers, yet they can be more efficient from a total-cost-of-care standpoint. These systems can use VBC arrangements to improve their value proposition to payers and attract a greater share of volume in the market; in some cases, they may eventually be able to justify higher unit rates and network inclusion in other health insurance products. At the other end of the spectrum, leading higher-priced systems often adopt VBC models to ensure participation in narrow networks, achieve further unit rate increases, or advance joint payer/provider goals for improved quality, experience, and outcomes.

Degree of physician alignment and clinical care model maturity. Most health systems are increasingly working to align physicians through formal and informal mechanisms to reduce clinical variability, advance quality and experience goals, and maintain greater continuity of care. Systems that have had success aligning physicians possess many of the building blocks needed to effectively coordinate and manage care in VBC programs (e.g., evidence-based care pathways, care-management capabilities, lower-cost ambulatory and virtual footprints).

Advanced technology infrastructure and care-delivery capabilities. Many health systems have invested heavily in population health capabilities but to date have received only limited returns. We have found that there are specific capability areas that are most critical to invest in depending on the starting point and type of VBC arrangement. Examples of these capabilities include integration of claims and clinical data, provider-performance management, member/patient attribution to VBC agreements, care management, network management, and continuity of care.

Creating value

We have found that most health systems can achieve short- and long-term performance gains by focusing on three key strategies: better aligning VBC programs with health system operations, managing network performance more effectively, and continuing to transform care delivery. The relative weight given to each of these approaches should vary by market and system—but each can generate significant performance improvement. Furthermore, these strategies deliver benefits that can strengthen provider performance under FFS contracts.

Aligning VBC programs with operations

Health systems should regularly evaluate their portfolio of commercial and government VBC contracts to identify improvement opportunities. Because the VBC component of overall contracts is often small, many systems agree to contract terms without getting input from clinical and operational leaders. This approach can lead to a mosaic of competing VBC arrangements with payments tied to dozens (and possibly hundreds) of metrics. As a result, clinical and operational leaders are often unaware of the breadth of these programs and do not have access to performance data. Furthermore, in poorly designed VBC programs, high-performing clinical organizations may not achieve positive results due to unfavorable benchmarks, reinsurance costs, or asymmetric shared-savings arrangements.

With better understanding of VBC program performance (e.g., dollars at risk, performance compared with achievable amount), providers can more thoroughly negotiate future VBC payments and prioritize clinical and operational tactics to gain value in both the near and long terms.

We recommend four steps for optimizing a portfolio:

- Review and quantify all current VBC arrangements and others that are common in the local market or proposed for future managed care contracts
- Develop greater performance transparency to understand both the value currently being captured and the additional upside potential
- Ruthlessly prioritize which metrics to focus on
- Use this information to refine existing and develop new clinical and operational initiatives to improve performance on metrics

In parallel, the health system should assess its care-delivery capabilities and work to ensure that VBC arrangements reflect its areas of strength but do not extend beyond its competency to deliver. Clinical and operational leaders should work closely with the contracting department to ensure that the arrangements are aligned with the system's clinical and operational goals.

Case example

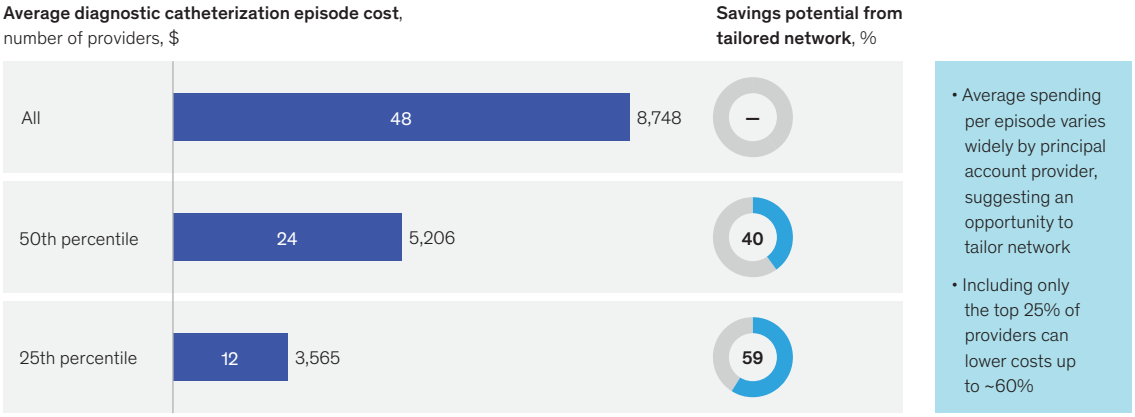
Health systems can now apply for the Bundled Payments for Care Improvement (BPCI)-Advanced program, a new voluntary bundled payment initiative. This program has greater complexity and puts more financial value at stake than the original BPCI program did, but it also offers opportunities for more financial upside (an additional revenue bonus of up to 50 percent) and several nonfinancial benefits. To effectively evaluate these opportunities, health systems should consider their performance not only on standard BPCI metrics (e.g., post-acute care optimization, physician preference items) but also on new BPCI-Advanced specific measures (e.g., anesthesia, imaging, testing, procedure selection). This approach should enable systems to build a business case for investing in new capabilities or strengthening existing ones, including alignment with other care providers (e.g., post-acute care facilities), optimized care delivery and analytics, and performance management proficiency.

Managing network performance to increase physician engagement and clinical alignment

Taking a strategic, data-driven approach to assess the performance of a health system's network of providers can enable the system to create significant near-term value, even in a predominantly FFS environment, while building the capabilities needed for long-term, strong VBC performance. This approach can help health systems better understand and communicate the attractiveness of their services to consumers

Exhibit 2

Reducing provider variability can help build a high-value network



Source: Disguised provider example

and payers, identify performance gaps, and design initiatives to optimize the network's performance.

In a high-performing network, all providers recommend referrals to other in-network providers whenever appropriate, resulting in excellent continuity of care across inpatient and ambulatory sites, and also improved patient experience. To design such a network, a health system must be able to understand the quality, outcome, and cost performance of both facilities and individual practitioners and to manage both types of providers as needed. Performance transparency is also crucial, since it can help the system earn appropriate VBC payments, meet the needs of local employers and payers, and deliver good outcomes and a distinctive patient experience.

Some health systems have started to build high-performing networks by evaluating the risk-adjusted total cost of care for specific episodes of care[6] and then including only a subset of providers in certain VBC contracts (Exhibit 2). This type of transparency also encourages best-practice sharing among clinicians and stronger performance management, raising the performance level even within high-performing providers.

Additionally, to ensure care continuity, health systems should enhance their care-delivery processes and their systems for connecting practitioners and sites of care throughout the delivery continuum. Accomplishing this requires health systems to understand patients' initial attachment points, including unplanned care channels—especially emergency departments (EDs) and urgent care clinics—and ambulatory referral patterns. Such a data-driven approach can help systems identify where opportunities exist to improve patient access, experience, and care continuity, as well as to develop processes to enhance in-network utilization and better serve patients. To support these changes, health systems should optimize their digital channels, customer care support (e.g., call centers), and clinic operations to ensure that patients receive appropriate, high-quality care in a timely manner and can move easily through the network.

Rigorous network performance management can deliver significant near-term value. We have seen health systems achieve 8 to 15 percent in organic revenue growth by implementing ED attachment and ambulatory continuity-of-care programs. Such measures are crucial for success in VBC models—up to 75 percent of costs in

6 Episodes of care are patient-centered clinical scenarios that have defined start and end points (e.g., planned procedures, pregnancy, management of some acute conditions).

some episodes (e.g., maternity, total joint replacement) are often controlled by providers other than the principal accountable provider, which suggests that coordination across sites of care is crucial for removing waste from the system.

Case example

A large regional health system was able to achieve a roughly 2-percent improvement in its contribution margin by identifying and addressing problems with ED attachment and retention. The system found that roughly three-quarters of the patients visiting one of its EDs did not follow up as recommended with an in-network primary care provider or specialist. Because of the missed opportunities for appropriate future utilization, the health system was losing $3,000 to $5,000 of revenue per patient, depending on each patient's chief complaint. To address this issue, the system identified the reasons many patients failed to follow up, which included poor understanding of the need for additional care, procedural difficulties (e.g., no phone number listed online), and lack of appointment availability. By implementing process improvements, such as using a patient navigator to book future appointments before patients left the ED, the system was able to nearly triple its in-network follow-up rate.

Transforming care delivery

In addition to improving network performance through conventional management approaches, providers can improve FFS and VBC performance by reducing clinical variability through the use of patient-journey or episode-of-care analytics. This approach can identify opportunities for health systems to improve performance in a variety of ways, including:

- Delivering appropriate care throughout the care continuum
- Involving patients in important decisions
- Identifying practitioners who can deliver superior clinical outcomes while reducing health system variable costs
- Managing the total cost of care

One example of how patient-journey analytics can be used within the FFS environment is referral management. Primary care physicians (PCPs) can use a real-time digital application to access information on the network status, outcomes, service, and cost performance of potential providers (e.g., specialists, hospitals, post-acute facilities). Through increased awareness of referral-physician performance, PCPs can make more value-informed choices and improve system retention.

Providers need tailored execution plans

Regardless of how well a given provider is able to create value through VBC arrangements, there are several "no regrets" near-term actions it can take to refine its VBC strategy. Taking these steps should enable a health system to become a performance leader within its own market, regardless of the pace of payment-model change.

Evaluate all existing VBC arrangements. Establish an inventory of all current and upcoming VBC arrangements. For each one, quantify its potential upside (with focus, targeted interventions, capability building) compared with current performance. Prioritize for improvement the performance areas likely to deliver near-term value (including a positive return on investment), then develop action plans for those areas.

Strengthen care delivery transformation capabilities. Identify the system's current ability to deliver value in VBC programs with upside or downside risk, then compare them against best-in-class capabilities. Prioritize for investment those capabilities that are most important for VBC (Exhibit 3). Remember: managing population health well requires many skills, several of which are "table stakes" for VBC arrangements (e.g., the ability to track and measure performance across the care continuum). Ensure that efforts designed to address the prioritized improvement areas are coordinated and can be extended to other current arrangements and contracts; this will enhance the efforts' clinical focus and improve the chances of success.

Define clear goals, link them to operational targets, and establish performance accountability. Once an opportunity is identified, set targets for how much of the value at stake the

system could potentially capture. Translate those targets into meaningful, measurable goals. (For example, a target 5-percent decrease in the total cost of care for knee replacements could become a goal of 0-percent discharges to in-patient rehabilitation facilities and a 30-percent decrease in discharges to skilled nursing facilities.) Communicate these goals to all those who will be accountable for meeting them, including the front-line staff.

Improve care continuity and access. Make targeted operational investments to provide greater care continuity for patients. These could include:

- Using advanced analytics to stratify ED patients and then targeting those with the greatest need through a high-touch navigator interaction to make sure these patients receive appropriate follow-up care from in-system PCPs or specialists
- Setting new access standards (e.g., all new patients seen within 24 hours) by deploying consumer-facing tools and redefining scheduling templates for both employed and affiliated physicians
- Creating transparency around referral patterns for both referring and receiving physicians
- Using journey analytics to quantify where and when patients with a specific need seek care and to make changes in network or access based on patient behavior

Exhibit 3

Health systems need core capabilities to succeed in value-based care

	Capabilities	Descriptions
Governance	1 Governance	Organizational support and accountability structure
Data and analytics	2 Data aggregation and exchange	Processes to assemble, standardize, and share data across multiple sources
	3 Population health analytics	Analytical capabilities and processes to attribute patients to care programs based on risk profiles and clinical needs
	4 Performance tracking	Performance data utilized to identify sources of variability in cost, utilization, and quality and to develop solutions
Care coordination	5 Program structure and comprehensiveness	Effective coordination of care across inpatient and outpatient settings
	6 Chronic disease management	Customized outreach to patients based on needs and preferences; coordinated care across continuum
	7 Patient access	Network adequacy and availability of timely access to care and healthcare decision information
	8 Supportive care, wellness, and prevention	Access to nonclinical care and tools and programs to maintain health and prevent acute events
Clinical practices	9 Evidence-based guidelines and protocols	Evidence-based guidelines that are embedded in systems at point of care (for both primary and specialty care) and are refreshed regularly
	10 Clinical cost, utilization, and quality reporting and improvement initiatives	Performance tracked and shared to enable focused improvement initiatives that create measurable behavior change
	11 Documentation and accurate coding	Training, reports, and reviews to support accurate documentation and coding
	12 Network performance	Sufficiency of network and performance across all providers and physicians outside the health system

These types of interventions can typically generate near-term value and lay the foundation for more effective network management as systems take on more financial risk in VBC arrangements.

Develop effective leadership models and accountability for value-based arrangements. Make sure that the clinical and operational leaders involved with VBC arrangements understand and support the health system's strategy for VBC program participation, are measured and incentivized in part based on program performance, and have the authority to drive change.

Payers can help

Both payers and providers are trying to deliver greater value by lowering the total cost of care and improving outcomes. Increased adoption of VBC arrangements can help both groups achieve these aims. Furthermore, both sides can benefit if payers play an active but targeted role in helping providers transition to VBC.

Many health systems are eager to make the transition but lack the knowledge, resources, and capabilities needed to succeed in VBC arrangements. Also, the proliferation of contracts, arrangements, and metrics to improve value may seem overwhelming to some providers and leave them with the impression they are working very hard to achieve relatively small payouts. As another example from our experience, a recent review of the commercial VBC arrangements undertaken by a large integrated delivery network found over 100 different quality and process metrics, with limited overlap across contracts or visibility to those on the front line.

Reducing the complexity of VBC arrangements increases the likelihood that providers will succeed. Among the steps that could be taken by payers:

- Apply advanced analytics to claims data as a step toward identifying the metrics that best reflect outcomes. Other metrics could then be dropped, which would reduce the reporting burden.
- Define a set of metrics to be used in all contracts and lines of business, which would further lower the reporting burden. Some customization of metrics may be appropriate because of the population(s) being covered or a payer's strategy, but most of the metrics should be common to all VBC arrangements.
- More closely align the financial incentives being offered (e.g., through use of a consistent set of metrics) and clarify how those incentives are linked to performance. As we discussed, VBC arrangements already have a substantial impact on many providers' margins, but changes such as these would make it easier for providers to grasp that fact.

Case example

The state of Ohio implemented a multi-payer VBC program, working with Medicaid and commercial payers to ensure that it was aligned with existing programs. The VBC program included primary care medical homes and episodes of care. All payers in the state, 161 primary care providers, and more than one million patients are now participating in the program. The metrics in the program were almost fully aligned with Medicare's Comprehensive Primary Care Plus Program, with limited modifications (e.g., using metrics appropriate for pediatricians, excluding those that are primarily applied to the Medicare population). Early roll-out results indicate that the program is achieving run-rate savings of at least $250 million annually.

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