

Listening Session 1: Vision for Developing Successful Population-Based Total Cost of Care Models

Presenters:

Subject Matter Experts

- [Mark E. Miller, PhD](#), Executive Vice President, Health Care, Arnold Ventures
- [J. Michael McWilliams, MD, PhD](#), Warren Alpert Foundation Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School
- [Michael E. Chernew, PhD](#), Leonard D. Schaeffer Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Director, Healthcare Markets and Regulation Lab, Harvard Medical School

Population-Based Total Cost of Care Payment Models

Physician-Focused Payment Model
Technical Advisory Committee Meeting

Mark E. Miller, PhD

Executive Vice President of Health Care, Arnold Ventures

September 19, 2022

Conflicts of Interest

- 1 I have no financial conflicts of interest.
- 2 Opinions expressed are solely my own and do not necessarily reflect the views or opinions of my current or previous employers.

Arnold Ventures Health Care

Arnold Ventures is a philanthropy dedicated to addressing some of the most pressing problems in the United States.

Health Care Objective > Reduce health care spending for patients, employers, and taxpayers while maintaining access to needed, high-quality care and supporting health care delivery system reform.

Tactics > Research, policy development, technical assistance and education, visibility and communications, advocacy.

Commercial sector
prices

Drug prices/ FDA
clinical trials

Provider payment
incentives &
Medicare
sustainability

Care for complex
populations

Constraining Unnecessary Utilization

Objective > Achieve reductions in unnecessary utilization throughout the system by using policy tools and leveraging public purchasers to drive broader change.

1.	Increase share of spending and enrollees in effective population-based payment models.
2.	Hold providers accountable for low-value care within payment models by incorporating measures into payment and performance systems.
3.	Reduce FFS payment for low-value care and make FFS less profitable.
4.	Align consumer incentives and steer toward high-value providers.

Our Vision: Population-Based Payment

- > Emphasize shift to population-based payment models; streamline and align payment models.
- > Define a parsimonious set of tracks that accommodates different providers; creates longer-term, low-risk options for eligible (smaller) organizations; moves most providers to two-sided risk.
- > Strengthen and simplify incentives for participation in population-based payment models.

Our Vision: Population-Based Payment (cont'd)

- > Improve performance benchmarks.
- > Improve the risk adjustment systems to improve fairness and accuracy and to limit profits from coding.
- > Improve primary care by adopting partially/fully capitated models and reallocating spending to primary care.

Thank you

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Population-based Payment Models

PROMISE, PROGRESS, & DESIGN

J. Michael McWilliams, MD, PhD

September 19, 2022

Disclosures

- Senior Advisor to CMMI; consultant to RTI, BCBSNC, Abt Associates; board of directors, Institute for Accountable Care
- Views expressed here solely my own and do not necessarily reflect those of any organization with which I am affiliated

What can and can't we achieve through TCOC payment models?

- Realistic:
 - Control spending growth, discourage overuse, smooth revenue
 - Give providers more flexibility to select right services for patients by limiting interfering FFS incentives (pre-condition for care delivery transformation)
- Not so much:
 - Make prevention/health improvement profitable (cost offsets generally partial)
 - Successfully contract for quality via incentives linked to performance measures

Evidence - ACOs

- Savings
 - Modest but incentives weak
 - Larger where incentives stronger (physician groups, higher initial spending, PAC)
 - Driven more by apparent waste reduction, less by integration/coordination/prevention
 - Minimal patient-level risk selection but benchmark regionalization → costly selective participation at provider level favoring ACOs/TINs with already lower spending
 - Recent savings overstated by comparisons of spending vs. benchmarks
- Quality
 - Rigorous evidence largely limited to claims-based measures
 - No evidence of deterioration, but improvements small and scattered
 - Patient experiences a bright spot but not clearly attributable to P4P incentives

Design Considerations

- Multi-track
- Downside risk – benefits depend on participation incentives
- Prospectivity of TCOC payment not critical
- Risk adjustment – tradeoff between predictive accuracy (fit) and other objectives
- Primary care capitation
- Benchmarks:
 - Incentives compromised by ratchet effects
 - Need to decouple from observed/realized spending

October 2021

From Vision to Design in Advancing Medicare Payment Reform: A Blueprint for Population-based Payments

J. Michael McWilliams, MD, PhD; Alice Chen, PhD; and Michael E. Chernew, PhD

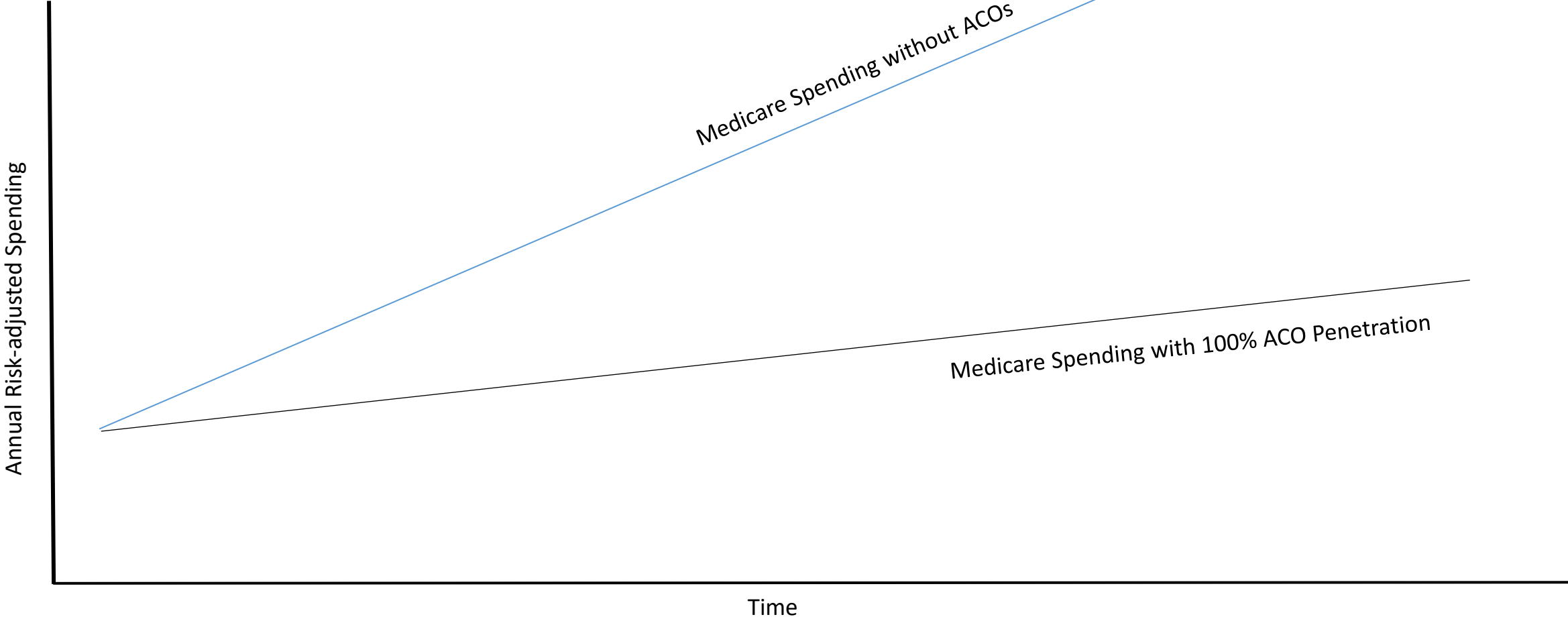
USC-Brookings Schaeffer Initiative for Health Policy

This report is available online at:
<https://www.brookings.edu/research/from-vision-to-design-in-advancing-medicare-payment-reform-a-blueprint-for-population-based-payment>

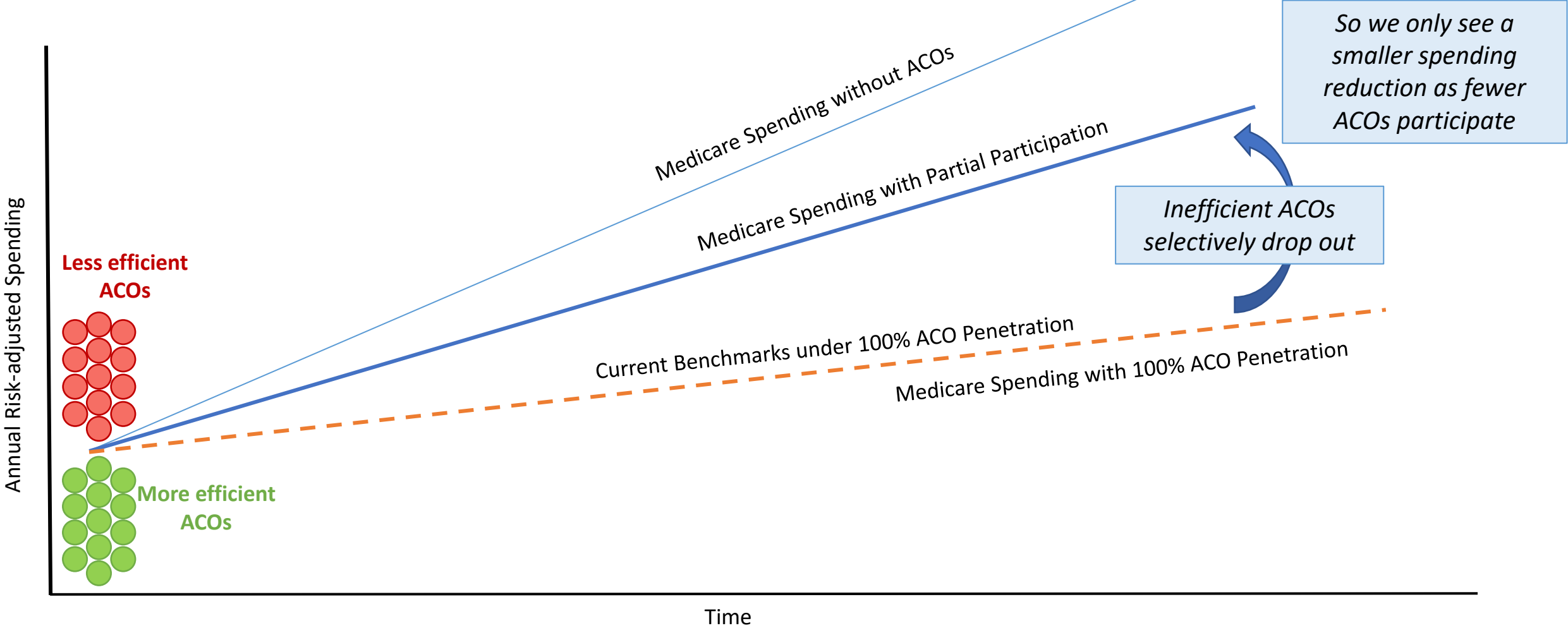
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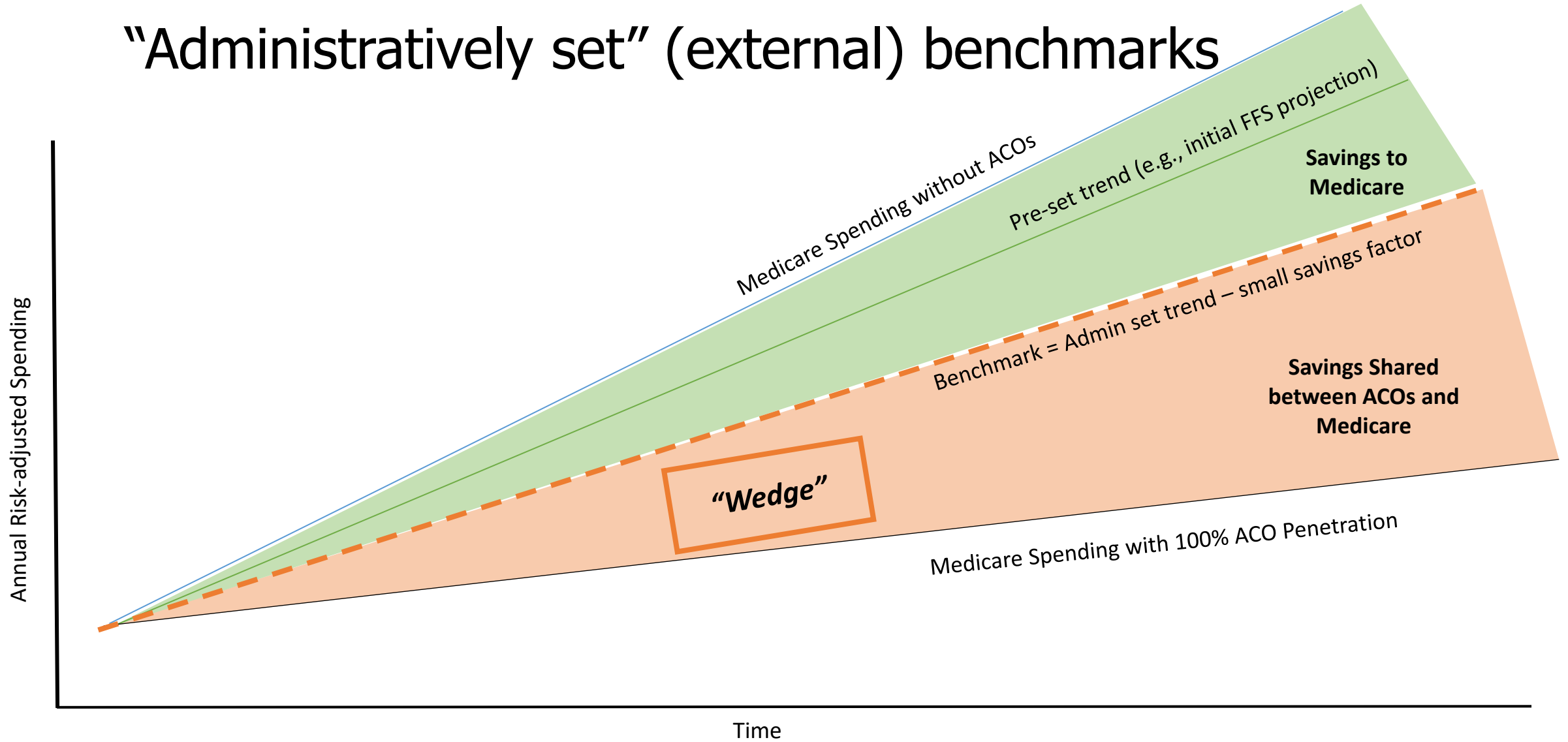
Current Benchmarking Approach



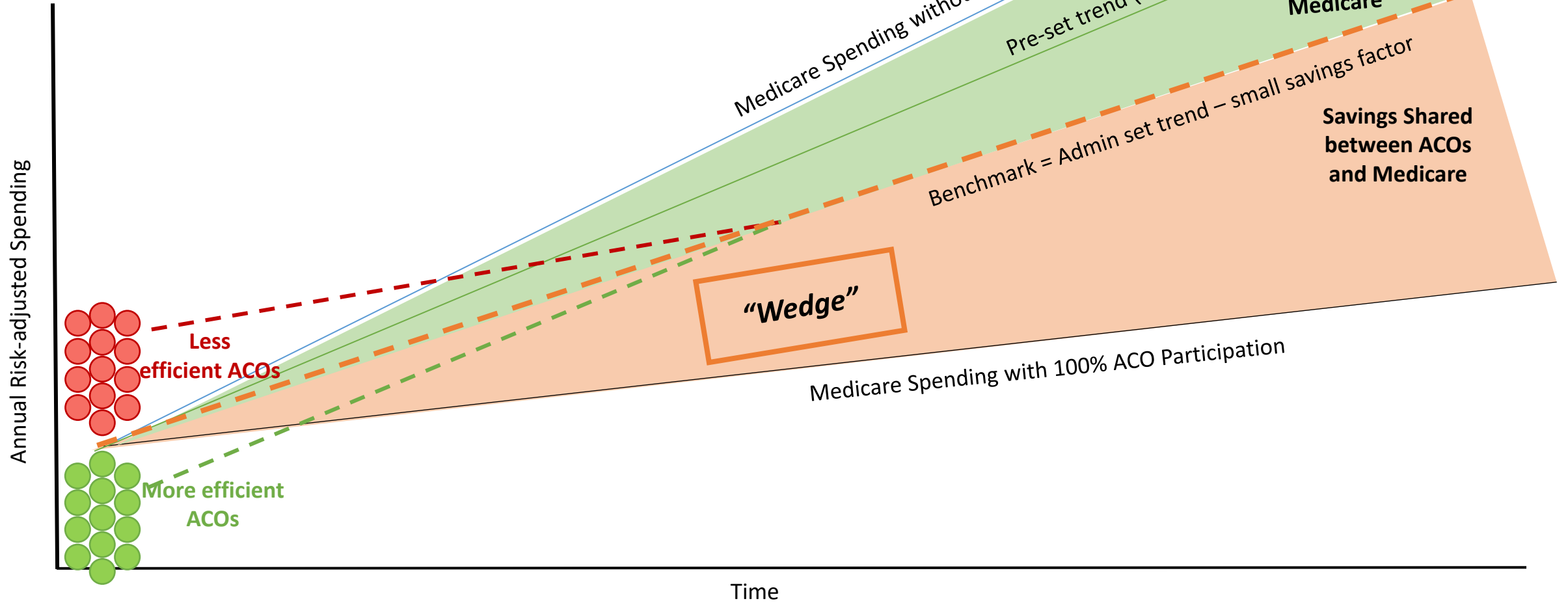
Current Benchmarking Approach



“Administratively set” (external) benchmarks



"Administratively set" (external) benchmarks



Group-level Incentives

- Purpose of risk contracting with groups: pool risk, encourage orgs to do what individuals cannot
 - Devolving risk from group to clinician level based on clinician performance defeats that purpose
 - Sharing risk with clinicians based on collective performance affects clinician incentives minimally (free rider problem)
- Beyond shifting internal clinician compensation from FFS toward salary, changing clinician behavior largely a matter of non-financial incentives (a management challenge)

ACO and episode-based payment (EBP) models

- 2 basic models for interacting with downstream external providers:
 1. ACO + FFS chassis → ACOs shop for efficiency
 2. ACO + EBPs → risk for episode spending borne by EI (e.g., IPPS)
- Issues w/ CMS inserting EBPs within ACO-like payment system:
 - Benchmarking, attribution, and risk adjustment more complex
 - Can undermine ACO incentives to save/shop and natural subcontracting
 - Potential volume effects (adds to tension with ACOs)
 - Implications for market structure (picking winners)
- Role clearest where: market consolidated or ACOs otherwise cannot exert influence, less concern for induced demand

Recent progress and areas in need

- Recent progress:
 - ACO REACH health equity benchmark adjustments (paradigm shift)
 - Proposed SSP changes in CY 2023 PFS proposed rule
- Areas in need:
 - Risk adjustment
 - Participation incentives
 - Primary care capitation
 - Beneficiaries sharing in the savings
 - Multi-payer alignment (though getting it right in Medicare is BIG step)

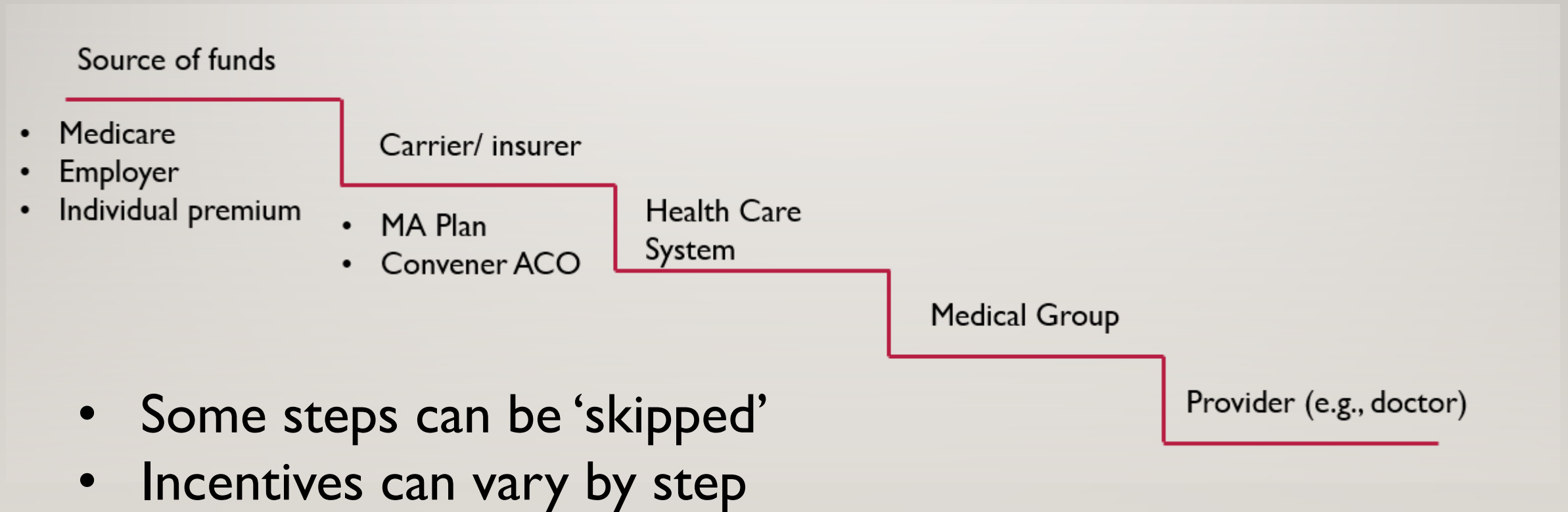
Thank you

INCENTIVES VS CASH FLOW IN POPULATION BASED PAYMENT MODELS

MICHAEL CHERNEW

SEPT. 19, 2022

THE HEALTH CARE SYSTEM OPERATES AT MANY LEVELS



SOME STEPS CAN BE SKIPPED

Source of funds

- Medicare
- Employer
- Individual premium

Carrier/ insurer

- MA Plan
- Convener ACO

Health Care System

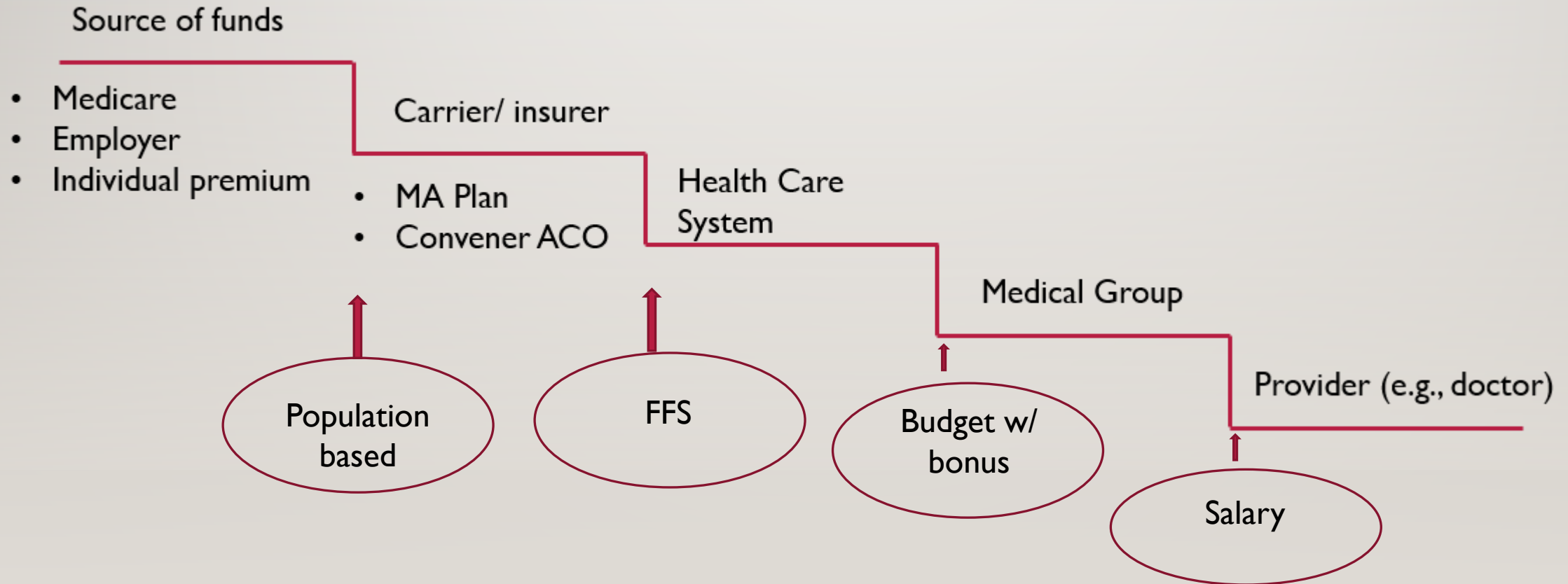
Medical Group

Provider (e.g., doctor)

Provider system based ACO

FFS to independent medical group

INCENTIVES CAN VARY BY STEP (EXAMPLE)



NON-FINANCIAL INCENTIVES CAN VARY BY STEP, BUT TOOLS VARY BY PROGRAM

FFS	ACOs	MA
Patient cost sharing • Supplemental coverage can undo	Managerial initiatives • Education • Information • Financial bonuses • Administrative hurdles • Investments in care infrastructure	<ul style="list-style-type: none">• Network design• Prior auth• Benefit design• APMs

CASH FLOW VS. INCENTIVES

- Incentives refer to how profits are affected by use.
 - Incentives are holistic
 - In simple settings, FFS with end of year reconciliation will have incentives similar to capitation depending on design (FFS profits offset by penalties)
 - Cash flow facilitates daily operation and avoids need for complex contracting between risk holders and non-affiliated providers
- ➔ The FFS chassis problem is a red herring

POLICING VS PARTNERING

- MA plans control beneficiaries
 - This gives plans leverage over providers
 - ACOs are either providers, or must recruit providers, to get patients
 - This gives providers leverage over convening ACOs.
- ➔ The cash flow (payer to provider to convener vs payer to convener to provider) is not central to incentives

Listening Session 2: Payment Model Features Contributing to Successful Population-Based Total Cost of Care Models

Presenters:

Subject Matter Experts

- [Kristen Krzyzewski, MBA](#), Chief Strategy & Program Development Officer, LTC ACO
- [Jeff Micklos, JD](#), Executive Director, Health Care Transformation Task Force
- [Clare Wirth](#), Director, Value-Based Care Research, Advisory Board



PAYMENT MODEL FEATURES CONTRIBUTING TO SUCCESSFUL POPULATION-BASED TOTAL COST OF CARE MODELS

Kristen Krzyzewski
Chief Strategy & Program Development Officer, LTC ACO

Prepared for the Physician-Focused Payment Model Technical Advisory
Committee (PTAC), Listening Session #2, September 19, 2022

About LTC ACO



- LTC ACO is an Enhanced Track MSSP ACO that was the first to serve the Medicare FFS population that resides in long-term care nursing facilities
- Started in 2016 in Track 1, serving eligibles residing in Genesis HealthCare nursing facilities
- Migrated to Enhanced Track in 2019, and expanded to include providers outside the Genesis facility chain
- Now serving (PY 2022) approximately 20,000 beneficiaries in 39 states through over 1,800 participating practitioners

Results Summary	2019	COVID PHE 2020	COVID PHE 2021
Assigned Beneficiaries	5,798	6,186	8,018
Benchmark/Beneficiary	\$31,327	\$30,104*	\$30,771*
Total Benchmark	\$161m	\$157m*	\$221m*
Total Savings	\$32m	\$0*	\$28m*
Savings/Beneficiary	\$5,500	\$0*	\$3,500*
Quality Adjusted Final Sharing Rate	70.9%	72.7%	75.0%

** Methodology to exclude COVID PHE Costs did not exclude SNF-only COVID admissions, disproportionately increased costs for the Nursing Facility population during the PHE. Meanwhile negative trends, which excluded certain COVID, caused the benchmark to fall.*

LTC ACO Serves a Unique, Underserved, High-Needs Population



Population Characteristic	LTC ACO	All MSSP ACOs
Long-Term Institutionalized Status	96%	1%
% of Dual Eligibles (Aged, Disabled, and ESRD)	88%	9%
Age 85+	37%	11%
Race:		
White	84%	88%
Black	11%	5%
Hispanic	2%	1%
Utilization of Primary Care Services (per 1,000 person years)	28,017	7,572
Highest Disease Rates per 10,000 Beneficiaries (CMS-HCC):		
Vascular Disease*	4,751	1,538
Major Depressive, Bipolar, and Paranoid Disorders	3,858	1,043
Dementia Without Complications	3,310	376
Diabetes With Complications*	3,178	1,866
Congestive Heart Failure*	3,115	1,278
Hospice	18%	2%
Beneficiary Deaths	23%	3%
COVID (PY 2020)		
Percent with COVID-diagnosis	46%	4%
Percent with COVID-episode, as defined by CMS for cost exclusion during PHE	7%	1%
Ratio of COVID episodes/COVID-diagnosis	15%	25%

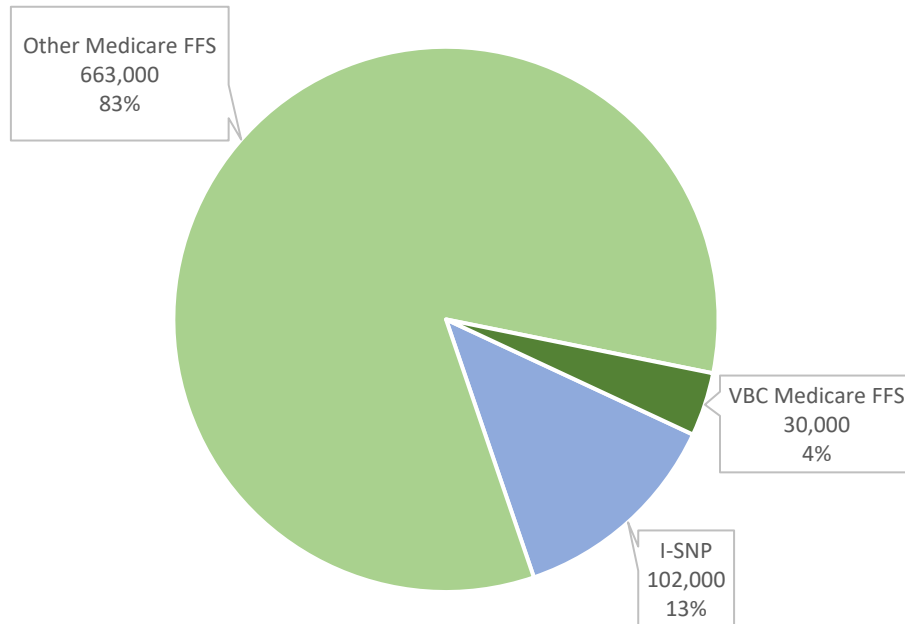
* In top 5 for all ACOs

A well defined, unique population with specific delivery patterns warrants a population-specific approach

Large, Untapped Opportunity to Implement VBC

Long-Stay Nursing Facility Residents

794,000 total long-stay nursing facility residents, 2016*

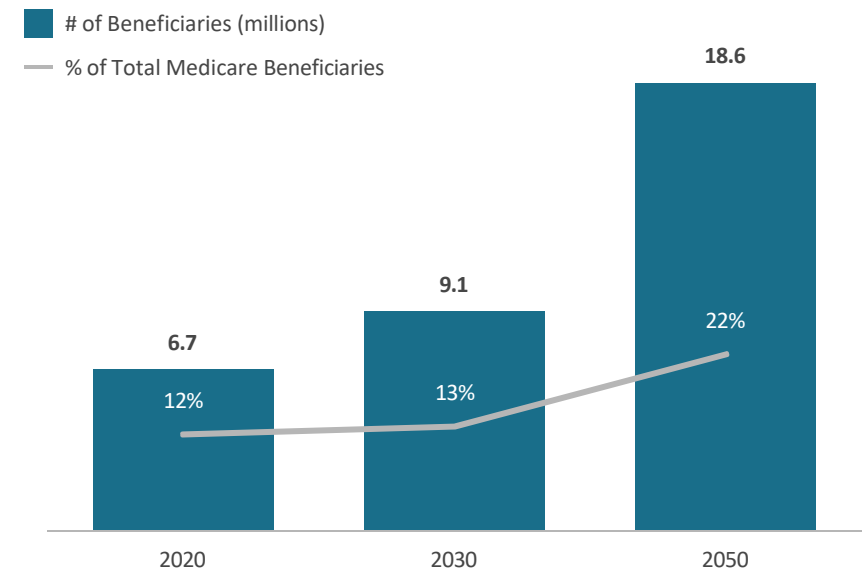


- I-SNP MA is a slow growth model that has achieved low penetration of Medicare beneficiaries over decades
- 13% I-SNP MA penetration of long-stay nursing facility beneficiaries/beds compares to 46% MA penetration in the overall Medicare population
- Annual Medicare spend for those in FFS is estimated to be \$20-25 billion per year, representing a significant isolated opportunity for improvement

The long-stay nursing facility population will become higher cost and higher risk over time

- Aging population will increase the number and percent of Medicare beneficiaries that are aged 85+
- As Medicaid increases the use HCBS to drive Medicaid long-term care program cost savings, the population utilizing nursing facility care will increasingly become older, higher risk, and higher cost

Medicare Beneficiaries Aged 85 and Older



Key Considerations for Population-Based Program Design



- Tailor the program to population/delivery system, if they are well defined, distinct from the “average” Medicare population, and of significant size
 - Identify these populations, similar to the Kidney Care Choices (KCC) Model
 - Drive participation among providers serving populations that are disproportionately higher cost

Program Feature	Challenge	Solution
TIN Exclusivity	Provider TINs typically serve mixed populations that have widely varying characteristics/ benchmarks/primary POS	Isolate and measure population within participating NPIs and TINs for participation in VBC (e.g. LTI status); TIN exclusivity should occur at the population subset level
Attribution	Physician visit required for attribution in MSSP, although bulk of primary care is often provided by NP/PAs ACO REACH does not allow retrospective alignment	Eliminate required physician visit for attribution. Rely on plurality of primary care services provided NPs, PAs or physicians (similar to ACO REACH) Allow retrospective alignment for populations with high death rate
Minimum Participation Levels	LTC providers are fragmented . 5k is too high to meet in MSSP for most; 500 in High Needs ACO REACH is difficult because many LTC beneficiaries won't meet clinical eligibility criteria	Lower participation thresholds for MSSP ACOs serving high needs populations LTI status should qualify beneficiaries for attribution to population-specific initiatives

Key Considerations for Population-Based Program Design



Program Feature	Challenge	Solution
Benchmark Development	Ratcheting down of benchmark between agreement periods discourages participation; Proposed fixes don't adjust sufficiently for high risk/high cost/high benchmark populations	Risk-adjust caps on prior savings adjustments (rather than use a % of national FFS expenditures for assignable population) Ensure prospective administrative growth rates adjustments or benchmarks adequately address differences in population cost/risk relative to "average" populations
Quality Measurement	Some measures don't apply to specific populations (CAHPS, some preventive measures, health equity)	Ensure scoring doesn't penalize entities serving specific subsets of the population Choose measures meaningful to population under management
Costs	COVID episode methodology didn't exclude bulk of COVID costs for LTC population, therefore these providers were penalized during PHE relative to other community-based providers	Ensure PHE/Extreme & Uncontrollable policies consider impact on high risk populations and ACOs and providers that serve them
Telehealth	Outside of the PHE, telehealth in NFs is not allowed except in certain geographies	Allow all populations to access telehealth services
Data Sharing	Collecting relevant data from Nursing Facilities	Require Nursing Facilities receiving Medicare FFS payments to share real-time EMR data with MSSP ACOs/third-party clearing house to improve care coordination for LTI population

■ Key Drivers of Participation

- Amount of shared savings
- 5% MACRA AAPM participation bonus on Part B allowed charges
- No downside risk
- Physician-centric, unlike I-SNPs that are nursing facility-centric
- Primary care-centric, recognizing and rewarding them for their important role
- Multi-year period to improve performance (vs. overnight efficiency improvement)
- Data sharing/support/opportunity identification

■ Obstacles

- Entire TIN exclusivity/mixed population history
- Benchmark ratcheting in future agreement period
- No 100% upside path in MSSP
- No capitation or advanced shared savings opportunities (cash flow)
- Might lose 5% MACRA AAPM bonus

Other Considerations



- Primary care providers delivering care in this setting “get it” and are highly motivated to participate; they move much faster than nursing facilities (requiring nursing facility participation will only slow progress)
- Eliminate programmatic overlap/confusion – VBC Medicare FFS programs, dual demonstration initiatives, other demonstrations, managed Medicaid, etc.
 - The institutionalized long-term care Medicare population is a distinct subset of dual eligibles and they should be excluded from other dual eligible initiatives (which focus on maintaining independence in the home through the use of lower cost Medicaid-covered HCBS).
 - Once a beneficiary needs long-term nursing facility care, Medicaid custodial care costs are fixed and cannot be made more efficient (daily custodial cost of care rate)
 - MA I-SNPs will never enroll all (or even a majority) of available long-term care lives, so VBC Medicare FFS program must make up the difference
 - VBC Medicare FFS programs and MA can exist side-by-side in nursing facilities
- Increase the speed of adoption by these providers
 - Participation among long-term care nursing facility providers is negligible
 - Next participation opportunity is PY 2024 (2023 application deadline has passed), meaning only 6 more years to get all of these providers and their beneficiaries into the program
 - No time to waste – create focus and solutions for this population

Health Care Transformation Task Force

Patients, Payers, Providers
and Purchasers Partnering
to Promote Value



Established in 2014, the **Health Care Transformation Task Force** is a multi-sector industry consortium comprised of

Providers



Payers



Purchasers



Patients



committed to advancing delivery system transformation that drives rapid, measurable change for ourselves and our country.



In 2015, The Task Force began its journey with the goal of members having 75% of their business in value-based payment models by the end of 2020. Our members more than doubled their progress during those six years.



Our updated goal - **75% by 2025** - reflects the significant progress to date, and our members continued commitment to advance adoption of value-based care delivery and payment models.

We look forward to continuing the journey.



Task Force Members

The image displays a variety of logos for member organizations, including:

- MHA** (Mental Health America)
- KAISER PERMANENTE**
- national partnership for women & families**
- Mass General Brigham**
- CAMBIA** (HEALTH SOLUTIONS)
- innovaccer**
- COMMUNITY CATALYST**
- Atrius Health**
- blue california**
- FAMILIESUSA** (THE VOICE FOR HEALTH CARE CONSUMERS)
- BlueCross BlueShield of North Carolina**
- Blue Cross Blue Shield Blue Care Network of Michigan**
- PREMIER**
- aetna**
- Sun River Health**
- apollomed**
- PSW** (a population health company)
- Elevance Health**
- Aledade**
- Included HEALTH**
- Mark McClellan, Duke-Robert J. Margolis, MD, Center for Health Policy**
- agilon health**
- CURANA HEALTH**
- HEALTH [at] SCALE TECHNOLOGIES**
- MASSACHUSETTS**
- MedStar Health**
- OPN HEALTHCARE ONCOLOGY PHYSICIANS NETWORK**
- evolent HEALTH**
- Washington State Health Care Authority**
- CommonSpirit**
- connections HEALTH SOLUTIONS**
- AAFP**
- Clarify**
- Trinity Health**
- UAW RETIREE Medical Benefits Trust**
- HERITAGE PROVIDER NETWORK**
- Cleveland Clinic**
- South Carolina**
- SENTARA**
- signifyhealth**



Before Designing a TCOC Payment Model

- Cultural commitment/serious governance buy-in remain critical first steps.
- Conduct a readiness assessment and internal benchmarking. Know your own capabilities and limitations before choosing a payment model.
- What APM opportunities are available to sustain change and how do they align with the population(s) you are seeking to serve?
 - Medicare fee-for-service and some state-based models are set by government payers without much choice/flexibility available to participants.
 - Commercial models, Medicare Advantage, and Medicaid managed care provide more flexibility for private parties to collaborate/partner.
- Conduct a “partnership evaluation:” What are the strengths and weaknesses of a potential partner? What are they ready for now and capable of over time?



Choosing an Accountable Care Payment Model

- On Ramps/Low Risk Models
 - One-sided risk on total cost of care
 - At-risk care management payments
- Moderate Risk Models
 - Two-sided risk on total cost of care
 - Capitation on a limited cost of care
 - Capitation on limited cost of care with one-sided risk on total cost of care
- Full Risk Models
 - Capitation on limited cost of care with two-sided risk on total cost of care
 - Capitation (or global budgets) for total cost of care.



On Ramps/Transformation Supports

- Addressing investment risk/business risk: financing of start up costs and infrastructure needs to overcome any barriers to entry
 - Costs \$1million + to set up an ACO and begin operations
 - CMMI's successful AIM model reflected importance of financing start up
 - MSSP's newly proposed ACO Investment program (AIP) will help widen the “on ramp” for new participants, attracting safety net and rural providers
- At risk care management payments also help with provider capacity building
- Private partnerships design capital allocations and resource contributions impacted by form of arrangement (e.g., direct contracting, joint venture, clinically integrated network).



Ongoing Participation Protections/Incentives

- Properly calibrated financial incentives and rewards related to provider performance on cost and quality goals that grow over time.
 - Arrangements revisited periodically and adjusted as appropriate.
 - Ensure proper flow through of incentive payments to individual providers.
- Eliminate the “ratcheting” effect of current benchmark policies to drive sustained provider participation.
 - Creating more reliable and predictable benchmarks; heading toward administrative benchmarks in Medicare is a good idea.
- Progression to incentivizing advanced risk arrangement adoption.
 - Implement reinsurance and stop loss protections against outsized downside risk.



Engaging Specialists in Accountable Care Arrangements

- Engaging specialists in PB TCOC models remains a challenge for many performance-based providers.
- MACRA's Advanced APM bonus payment incentive program has contributed to the problem, with policies about who constitutes a "qualifying practitioner" often discouraging ACOs from including specialists in order to qualify for bonus payments.
 - MSSP's new CY 2023 Proposed Rule seeks to change this.
- The future of CMMI clinical episode models is uncertain. More models addressing specialist engagement strategies are desirable across all model types.



Value-Based Payment Model Overlap/Alignment Generally

- Alternate Payment Models are becoming ubiquitous and making it difficult to manage patient attribution, measure model impacts, and appropriately credit providers for cost and quality improvements.
- ACOs and clinical episode models often overlap, particularly for health system participants who may be operating both models simultaneously.
 - Precedence determinations are important to drive desirable outcomes.
 - “Nesting” of clinical episode models inside ACOs is being experimented with for some populations; CMS has not yet tested a “nesting” model.
 - HCTTF recommends that CMS pursue a hierarchical model alignment strategy that sets a consistent and predictable beneficiary attribution policy that shows preference to higher-risk arrangements.



Opportunities for Multi-Payer Alignment

- The greatest opportunity for broad-based adoption of PB TCOC models is to make them as consistent as possible across payers/populations.
- This alignment does not come easy in an industry built on FFS competition. Success will require payers and providers to agree on a shared vision for transformation in their respective markets.
- APM alignment does not mean a lack of competitive differentiation. It does require payers to reassess what elements of their operations should or should not be proprietary in a market dominated by value-based payment models.
 - Key alignment areas to consider include quality measurement, risk adjustment, and patient attribution methodologies.





Value-based care's path forward: Commercial risk

Clare Wirth

Director of Value-Based Care Research

Advisory Board

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Commercial risk will decide the fate of value-based care

POSSIBLE SCENARIOS

CENTRAL TENSION

1

Industry-wide reimbursement standard

Both public and private payers funnel most of their payments through true downside risk models at the population level. Payments include physicians and hospitals across a wide range of specialties. Most patient care is reimbursed under value-based models, and acute care businesses adapt to fit into the model.

2

Public and private payers split on risk

Population-wide, risk-based contracting marches forward in public programs only. Commercial payers and employers focus on models that target the specific needs of the employer-insured population, most often via bundles and with physician groups. All industry players operate in a hybrid world with split incentives and processes.



What tradeoffs will maximize sector-wide savings?



A mix of wins and losses in commercial risk

Sample value-based payment models in the commercial sector

Providence-Swedish Health Alliance (2014–2018)

PROVIDENCE ST. JOSEPH HEALTH, BOEING

- Providence St. Joseph Health’s ACO created a direct contract with Boeing
- Deal ended because of financial unsustainability

Blue Premier (2019–present)

BLUE CROSS NC

- Agreements with 11 health systems and 870+ practices
- \$350 million in cost savings in first two years
- Covers over 857,000 lives statewide, (+60% from first year)



Cigna Collaborative Care (2008–present)

CIGNA

- Agreements with over 230 primary and specialty physician groups in 32 states
- Has encompassed over 2.65 million members and over 144,000 physicians

Haven (2018–2021)

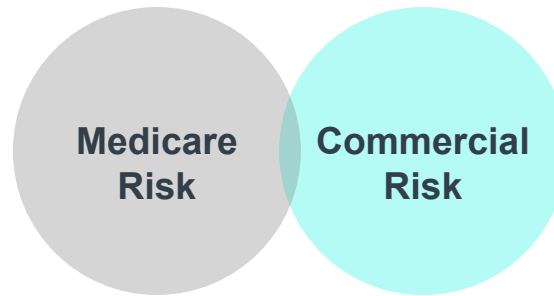
JP MORGAN CHASE, AMAZON, BERKSHIRE HATHAWAY

- Aimed to find solutions for high, rising costs for employee health care
- Disbanded in 2021 because of poor timing, perverse incentives, insufficient market power, and a lack of true collaboration

Source: “BCBS of North Carolina’s value-based model saves \$197M,” Becker’s Healthcare, August 2021; “Blue Cross NC’s Industry-Leading Blue Premier Program Saves \$197 Million in 2020 Health Costs, Expands Value-Based Care Across State,” BCBSNC, August 2021; “Cigna Collaborative Care for Specialists,” Cigna, February 2021; “Haven, the Amazon-Berkshire-JPMorgan venture to disrupt health care, is disbanding after 3 years,” CNBC, January 2021; “Left out of the game: Health systems offer direct-to-employer contracting to eliminate insurers,” Modern Healthcare, January 2018.

All in on risk still requires a tailored provider response

Risk-based population health management strategies by patient segment



Age 65+

Age 0-64

- Emphasis on screening
- Annual visit recommended
- Chronic care management (especially comorbidities)

Primary Care

- Trading hospital stays for low-cost management
- Shifting disconnected specialist management into comprehensive care management

Shift Utilization

- Consumers prefer consistent clinicians and extra benefits
- Influence from caregivers and federal government

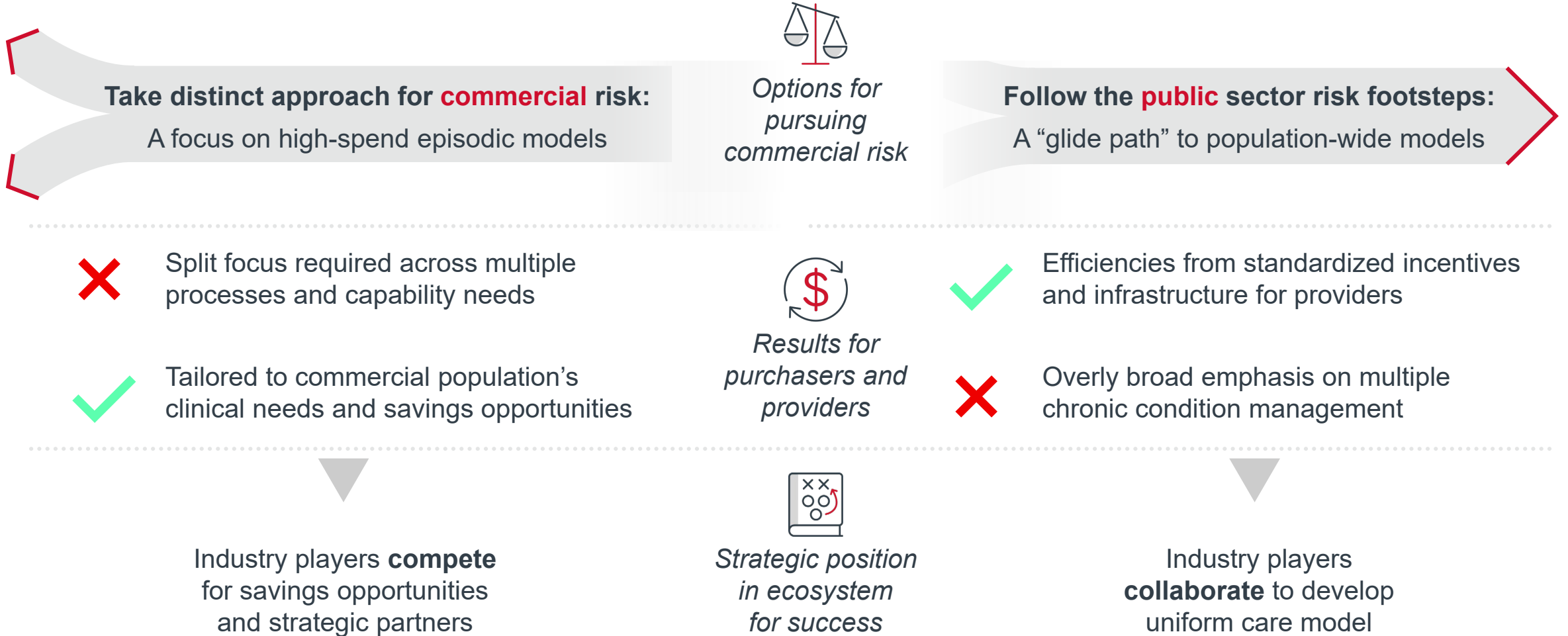
Engage Consumers

- Emphasis on prevention
- Some early screening habits started
- Annual visit NOT recommended for everyone

- Shifting visits to more cost-effective sites and sources
- Identifying “missing” patients (and likely increasing appropriate primary care utilization)

- Consumers prefer low costs and provider options
- Influence from dependents and employer

Commercial risk options have tradeoffs on both sides





Value-based care should be more than a buzzword.

Find out what will tip the
industry toward risk at

[advisory.com/VBC](https://www.advisory.com/VBC)