Value Based Contracting

DIAGNOSTIC COVERAGE AND REIMBURSEMENT CONFERENCE

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GREG RICHARD

INTERPACE™ DIAGNOSTICS

GUIDING TREATMENT. DELIVERING INNOVATION.

Agenda

- Value Based Contracting
  - Definition
  - Market Dynamics
  - Features
- 3rd Party Influencers
- Lab Opportunities
- Network Management
- Pricing

Definition

- Rewarding providers for the quality of care provided vs. number and type of procedures
- Promotes ways to change clinician behavior by rewarding value over volume
- The right service, right time, right place

Market Dynamics

- Increasing pressure from Government and employers to shift to improving outcomes, lowering costs, and increasing access vs. FFS
- Shift toward increased collaboration, outcome-based payment and new benefit plan design is driving innovation in how we pay for and deliver healthcare
- Value-based contracting programs largely driven by self-funded customers (comprise > 60 percent of commercial membership)

Market Dynamics

- >50% of UHC commercial lives under value based contracts
  - New United contract with Quest and LabCorp
- Evolution in clinical care and payment methods
- Model being used in ACO's
- Foster greater accountability
- Take advantage of medical innovation
- Alignment of incentives across providers, members, employers, and payers to improve clinical outcomes, patient experience, and cost

Features

- Physicians know that payers will not pay incentives unless savings are realized
- Cost efficiency performance measures include non par lab utilization, others
- A portion of the provider's total potential payment is tied to cost-efficiency and quality performance measures
- Providers may still be paid fee-for-service for a portion of their payments, a bonus, or have payments withheld
- Bonus not paid unless the provider meets cost efficiency and/or quality targets

Contract Features

- Contract considerations:
  - Financial risk
  - Patient/member component
  - Data sharing arrangements
  - Quality measures
  - Minimum savings thresholds
  - Leakage
  - Carve-outs
  - Pre-determined baselines and clear targets for improvement
  - Organizational alignment around performance & risks

Value Based Contracting

- Some Core Elements
  - Predictive Pricing
  - Shared Opportunity
  - Fee for Service Alternative
  - Outcomes Focused

Defining "Value-Based Contracting" Requires More Than a Few Words

coventry
returning people
to work, to play, to life

Value-based contracting (VBC) is one of the most talked-about topics at conferences, in stewardship meetings, and in workers' compensation requests for proposal (RFPs). But for all the discussion around the term, one thing seems missing: a common definition. VBC seems fairly straight-forward to most observers and that might be part of the problem. Indeed, ask a half dozen people what value-based contracting means and you'll get as many answers.

In conversations with clients and providers during the past six months or so, I've heard value-based contracting variously described as relating to case rates, pay-for-performance, risk-based payments, risk-reward, bundled payments, and an outcomes-based payment model. To some degree, each is correct. Think of value-based contracting, or VBC, as a new name applied to several well-established concepts used in group health provider contracting on a risk-reward basis.

In its most basic sense, VBC focuses on paying for positive results, not process or fee-for-service. Value-based contracts would be more appropriately thought of as an umbrella term rather than a single idea. And there are several critical components to VBC.

Value-based contracting (VBC) is one of the most talked-about topics

Four elements form a meaningful workers' comp VBC model

The variety of definitions industry watchers apply to VBC share the same objective: Each involves moving away from volume-based contracting or fee-for-service contracting by removing the financial incentive to treat more. A VBC model strips out the payment structures that reward activity over outcome.

There are several critical principles for constructing a sound VBC arrangement:

- **Predictive pricing for providers and payors:** This requires reaching agreement with providers on what it takes to treat an overall illness or injury and deliver the injured worker to the condition he or she was in prior to the injury.
- **Alternative to fee-for-service:** When a payment is rendered for each service there is a perverse incentive to do more in order to get paid more. Value-based payment models are designed to pay for better outcomes regardless of the services required to reach that outcome. That's best for injured workers and for payors.
- **Shared opportunity for the provider and the payor:** This concept centers on risk-reward and underscores the goals that provider and payor share. There is an upside and downside for both if the value isn't delivered.
- **Outcomes focus:** The model should be calibrated to deliver the correct mix of services so that an individual can achieve the best outcome.

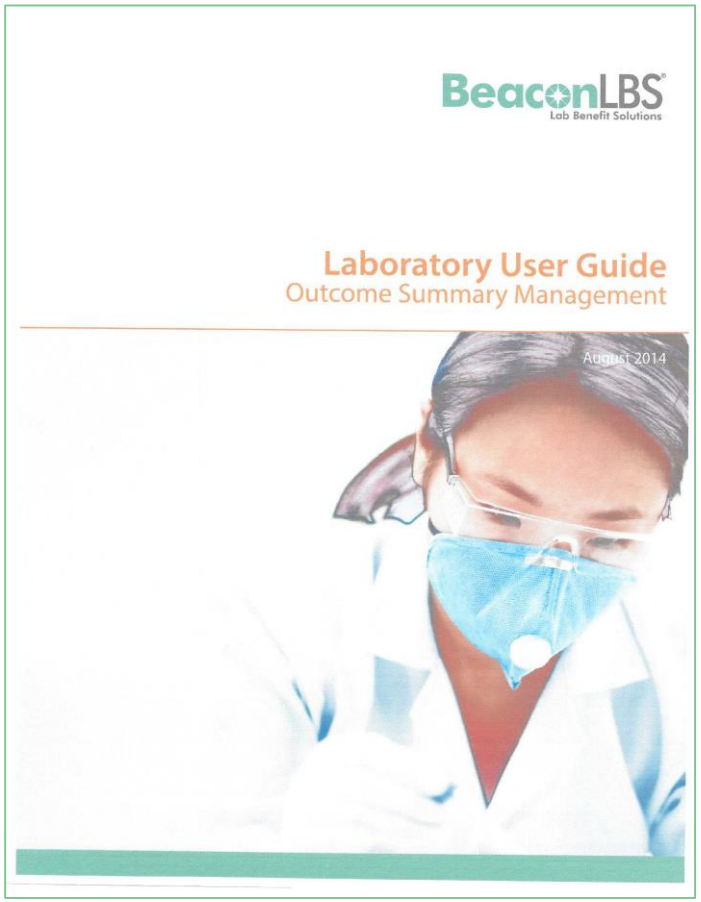
If these core principles are intact, it is fair to consider the approach value based.

The 4 elements of VBC Models

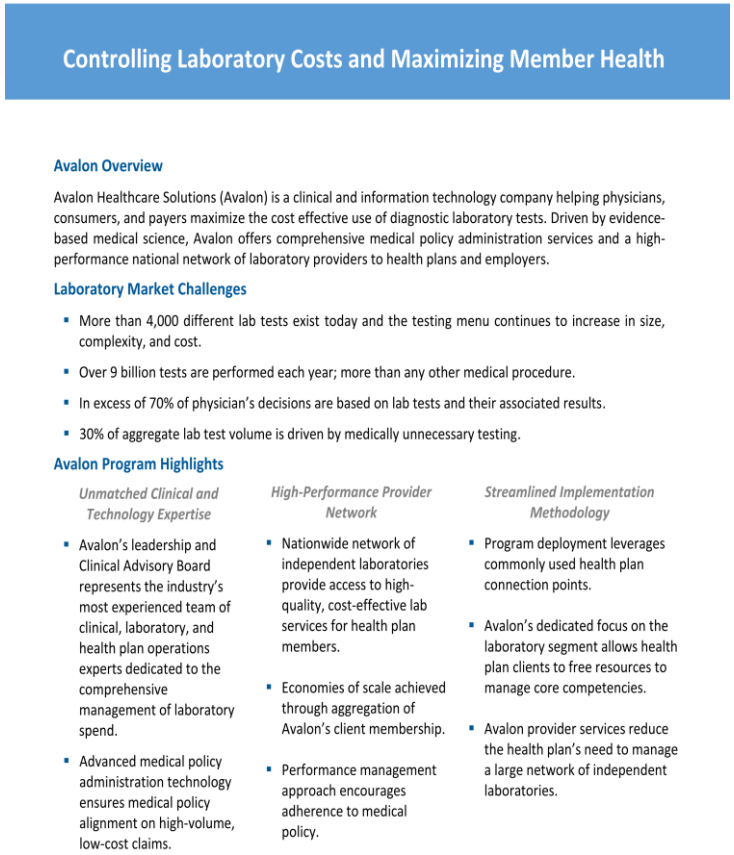
Beacon/LBS

- "We assist health plans **in lowering test costs while improving test selection in a value-based economic model"**

- Physician decision support
- Labs of Choice® program
- Test ID & Mapping
- Claims Editing & Pricing
- Prior Authorization
- Policy Development & Maintenance



AVALON HEALTHCARE SOLUTIONS



Controlling Laboratory Costs and Maximizing Member Health

Avalon Overview

Avalon Healthcare Solutions (Avalon) is a clinical and information technology company helping physicians, consumers, and payers maximize the cost effective use of diagnostic laboratory tests. Driven by evidence-based medical science, Avalon offers comprehensive medical policy administration services and a high-performance national network of laboratory providers to health plans and employers.

Laboratory Market Challenges

- More than 4,000 different lab tests exist today and the testing menu continues to increase in size, complexity, and cost.
- Over 9 billion tests are performed each year; more than any other medical procedure.
- In excess of 70% of physician's decisions are based on lab tests and their associated results.
- 30% of aggregate lab test volume is driven by medically unnecessary testing.

Avalon Program Highlights

Unmatched Clinical and Technology Expertise

- Avalon's leadership and Clinical Advisory Board represents the industry's most experienced team of clinical, laboratory, and health plan operations experts dedicated to the comprehensive management of laboratory spend.
- Advanced medical policy administration technology ensures medical policy alignment on high-volume, low-cost claims.

High-Performance Provider Network

- Nationwide network of independent laboratories provide access to high-quality, cost-effective lab services for health plan members.
- Economies of scale achieved through aggregation of Avalon's client membership.
- Performance management approach encourages adherence to medical policy.

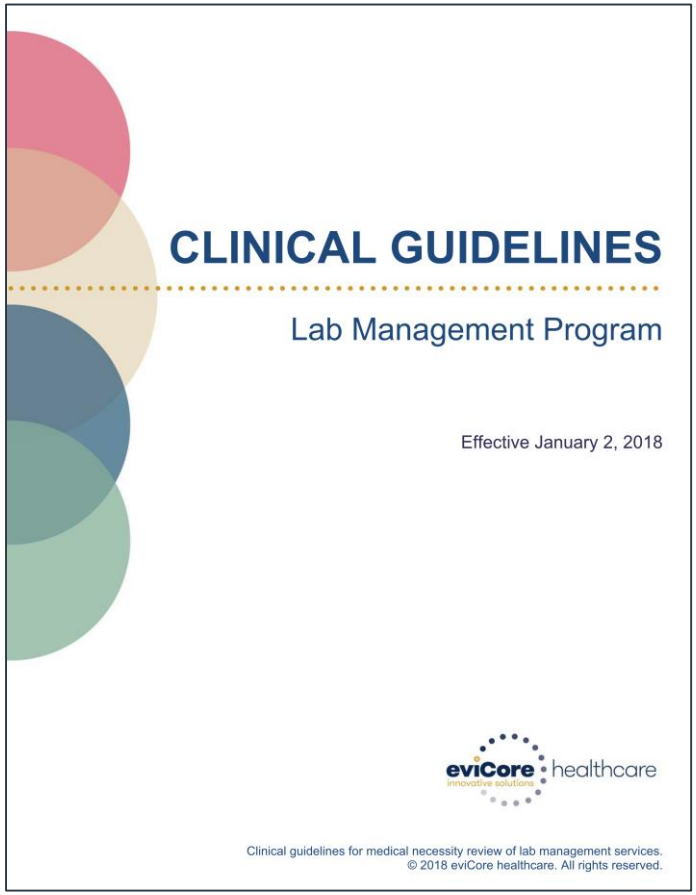
Streamlined Implementation Methodology

- Program deployment leverages commonly used health plan connection points.
- Avalon's dedicated focus on the laboratory segment allows health plan clients to free resources to manage core competencies.
- Avalon provider services reduce the health plan's need to manage a large network of independent laboratories.

- >4,000 tests exist and menu increasing
- 9 billion tests performed each yr; exceeds all other procedures
- >70% physician decisions based on test results
- 30% of aggregate lab test volume is "unnecessary"

eviCore

- eviCore applies **44,000 lab-specific claim rules** to ensure **appropriate reimbursement for medically necessary tests**
- Funding models include capitation and shared savings
- Reviews **each gene in a panel** and prior authorizes and **reimburses genes that are "medically necessary"**



Lab Opportunities

- Quest and LabCorp/United
  - Shared savings
  - “Appropriate utilization”
  - Beacon LBS
  - Data sharing
- Other large labs
  - Understand requirements/performance
  - Similar or more aggressive terms with other National/large Regional payers
  - Emphasize key differentiators (menu, specialty)

Small/Specialty Lab

- Distinct Challenge – Coverage
  - Example: Priority Health (MI)
  - New Technology Coverage - Contract
    - MDx Test for Pancreatic Cancer
    - Claim re: reduction in unnecessary surgeries & costs
    - Contract provisions
      - Coverage and payment during initial term
      - Limited use to applicable specialty physicians
      - Achieve savings over baseline costs

PANCRAGEN®
PANCREATIC CANCER RISK CLASSIFIER

Small/Specialty Lab

- Results
  - Test was used by appropriate specialists (GI's) >80% of the time (achieved metric)
  - Reduction in surgery rate vs. baseline not achieved
  - Test covered with prior authorization and only orderable by Gastroenterologists
  - Value based metrics incorporated in to ongoing contract

PANCRAGEN®
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Networks

- Limited Networks
  - Patient incentives
    - High OON ded./co-ins.
    - Plan design options for patients
  - Pricing negotiation leverage
- Network re-balancing
  - National contracts
    - United, Aetna, Quest, LabCorp
  - Head to head in-network lab performance on
    - Total utilization
    - “Inappropriate utilization”
    - Leakage management

Pricing

- Fee schedules based on
  - Total spend reduction
  - Specific test/class savings
  - “Appropriate spend”
    - Covered tests
    - Correct “indication”
    - Physician type
    - Leakage success
    - Who can squeeze the balloon the most?

Summary

- Proving value is paramount to contracting
- Labs need to decide what risk parameters are acceptable (financial, quality)
- Labs should interact with 3rd parties making decisions re: appropriate testing, utilization, etc.
- Data is critical to monitoring and monetizing contracts
- All parties should be aligned and feel like they have a fair shot at benefitting

“However beautiful the strategy, you should occasionally look at the results.”

Winston Churchill