Cost, Capitation, and Care Accountability: Leveraging Cohesive Payment Strategies that Align Meaningful Incentives

Chair: Natalie McGann, Tandigm Health

Cost, Capitation, and Care Accountability: Leveraging Cohesive Payment Strategies that Align Meaningful Measures

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Family Physician|Practice Owner, **Primary Care Partners Lincoln, NE**

President-Elect, **Nebraska Medical Association**

OneHealth NEBRASKA

OneHealth NEBRASKA

Partnering with 470+ Physicians Across Nebraska

470+
Participating Physicians

95 Provider Groups
10 Ambulatory Surgery Centers
1 Surgical Hospital

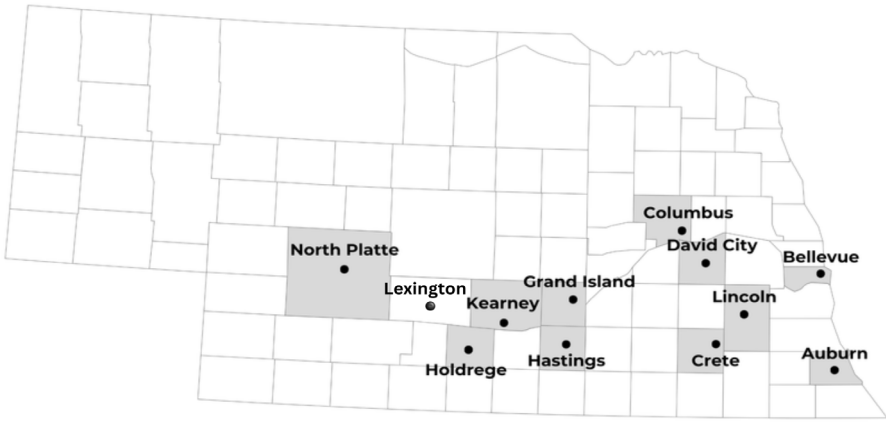
$ 65M
Total ACO Shared Savings

62K
Value-based lives

5
Value-based/incentive program contracts

MSSP Enhanced Track

$ 80M**
Achieved in Value payments



Provider Engagement/Incentives

OneHealth Nebraska is owned by its independent physicians and governed by a board of the same

The board's objective in owning the ACO/IPA is to keep independent practices independent and grow independent medicine in Nebraska

That objective informs the way performance is viewed and incented and how money from value-based programs is paid

Short version: 90% of shared savings distributed to clinics based on "weighted attribution"

Quality performance of each clinic monitored but no monetary penalties/rewards for that performance; win and lose together

OneHealth
NEBRASKA

Lessons Learned: A Clear WHY

- Stay Independent
- Deliver Best Care
- Keep Care Affordable
- Protect Physician-Patient Relationship
- True ownership in the organization (cost and quality)

OneHealth NEBRASKA

Challenges

- Risk Literacy Gaps
- Pharmacy Exposure
- Data Lag
- Incentives Not Reaching Front Line Promptly

OneHealth NEBRASKA

Jefferson Health

Jefferson Health

Population Health

Thomas Jefferson University

200+ Graduate and undergraduate programs

77,000+ Alumni

17 NCAA Division II teams

8,300+ Students (full/part time)

Over **$200 million** In applied, basic, clinical and scholarly research

1,000+ Patents for new drugs, software innovations, medical devices and diagnostic tools

Data is FY24 - updated January 2025

Jefferson Health

4,350 Employed physicians

32 Hospital campuses

13,600+ Nurses (full/part time)

4 Magnet® designated locations

700+ Sites of care

4 Pathway to Excellence® designations

8.8+ million Outpatient visits (hospital and physician)

Data is FY24 - updated January 2025

Jefferson Health Plans

362,000+ Total members

40+ Years of service

316,000+ Medicaid members

750 Employees

13,000+ Medicare members

20,000+ CHIP members

13,000+ Individual and family plans

Data is 12/24 - updated January 2025

Jefferson Footprint

- Serving a rural and urban population across Pennsylvania and New Jersey
- 700+ Total sites of care
- 150+ Primary care sites
- NCI-designated Sidney Kimmel Comprehensive Cancer Center is one of 57 comprehensive cancer centers nationwide
- Level 1 trauma centers

Jefferson- Value-Based Care Landscape

2 Billion
Managed Premium Dollars

50+
Value Based Arrangements

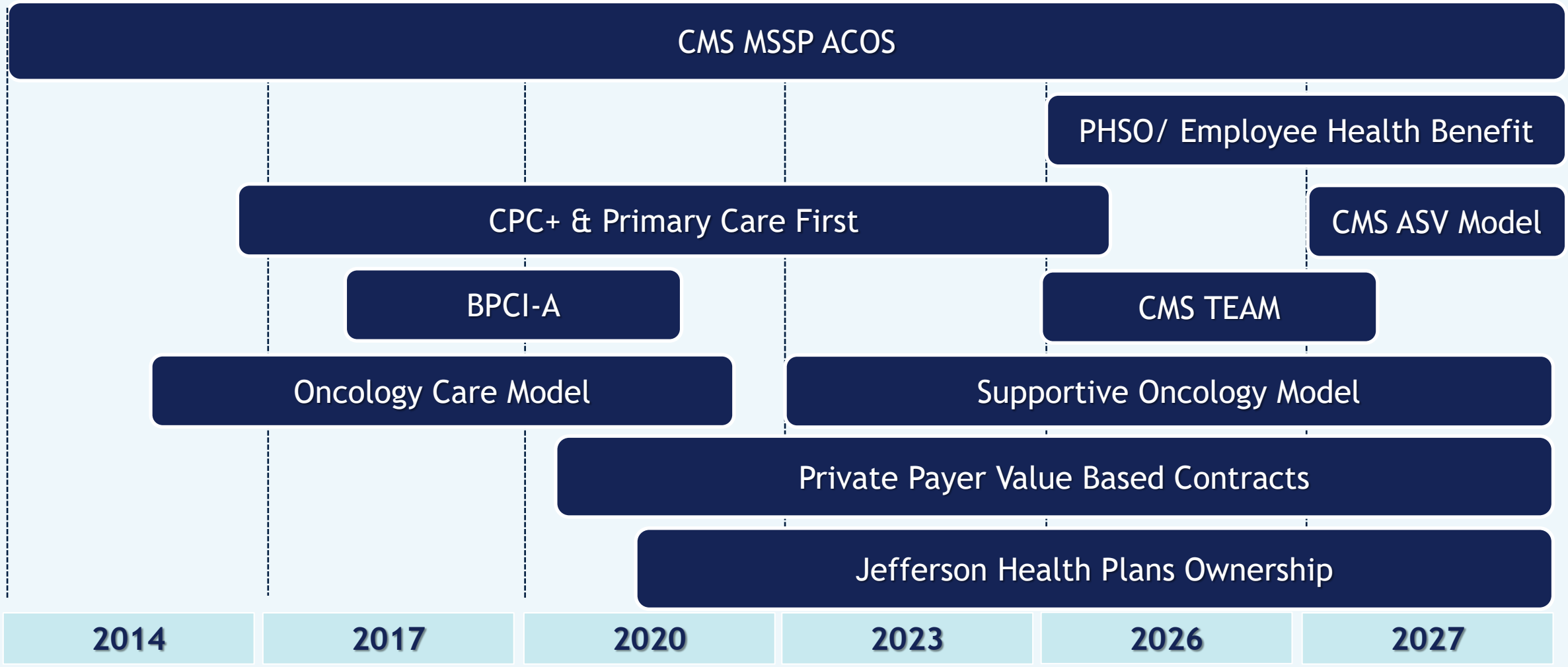
760,000
Lives in Value Based Arrangements

Lines of Business

- Commercial (371K)
- Medicaid (224K)
- Medicare FFS/ACO (87K)
- Medicare Advantage (78K)

3
MSSP ACOs

Resilient Structure Regardless of Program

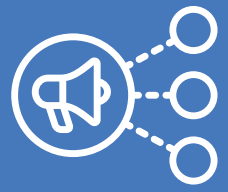


Population Health Operational Units

Care Management, Social Needs, Ambulatory Pharmacy

Quality/Wellness

CIN/ACO Operations



Outreach

Actuarial Analytics

Practice Transformation

Incentive and Capability Alignment

High Performing Medical Group/Acute Care

- *Measurement across all populations*
- *Incentives tied to value based metrics*
- *Ability to break out value funding from FFS in P&L*

Population Health Capabilities

- *Important to supplement core performance*
- *May need to fund programs in a hybrid model*
  (Palliative, social services examples)
- *High efficiency operations (3 or 4 to 1 ROI)*
- *Can assist beyond value based contracts*
  (acute throughput, direct to employer)

Best Practices

- Strong financial ownership (roll up P&Ls and visibility)
- Strong actuarial review for any downside risk
- Diverse portfolio across multiple lines of business
- Ongoing contract planning and evaluation for focus
- Funding creativity for certain programs
- Think about applying population health skill set versus only value based contracts
- Master education decks at the ready (School house rock style)
- Organizational positioning of population health

Appendix

VB Contracting Elements for Consideration

- Type of contract(Premium basis, shared savings, P4P)
- How much will you need to move the medical loss ratio to receive a payout?
- What is the ability of the payer to provide the timely data and reporting you need and your ability to ingest it?
- What is included in the plan expenses?
- Are you taking risk on drugs? Consider your ability to impact change.
- What is the risk adjustment model being using and your ability to internally project it?
- Are you modeled against your self or the region?

Clinical and Operational Elements for Consideration

- How is attribution completed? Do you have the ability to operate multiple models?
- How are quality metrics and benchmarks determined? Do they align with your overall strategy?
- Do you have enough run way to stand up the clinical programs you would need and hit performance time frames?
- Do you have a sense of your operational PMPM expense to operate the contract, clinical programs, compliance, EMR builds and other elements?
- What analytical and actuarial capability do you need? In house or purchased service?
- Do you have the right clinical leadership to operate on a larger scale across multiple contracts?
- Are there other technology builds and software needed for multiple payers and models?
- Do you know the internal performance KPIs for your operational units and expense to operate?

Medicaid Considerations

- Specific state considerations, changes in rates and other operating environment impacts
- Items like shift care, DME, dental, behavioral health and health replated social needs may have a far greater impact on performance.
- Is behavioral health carved out or in?
- What is the benefit design? Drug coverage?
- What is your ability to provide pediatric services?
- What is the Medicaid plans capability to provide sophisticated data, reporting and other services?
- Can you co design clinical programs with the MCO?
- Do you have special clinical programs you need to consider? (example sickle cell)
- Are members auto assigned? How hard/easy is it for them to change their provider?

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NAACOS Spring 2026

Natalie McGann, D. O.

Medical Director

Tandigm Value Partners ACO

TriValley Primary Care: Family Physician, Shareholder, and Clinical Co-Chair

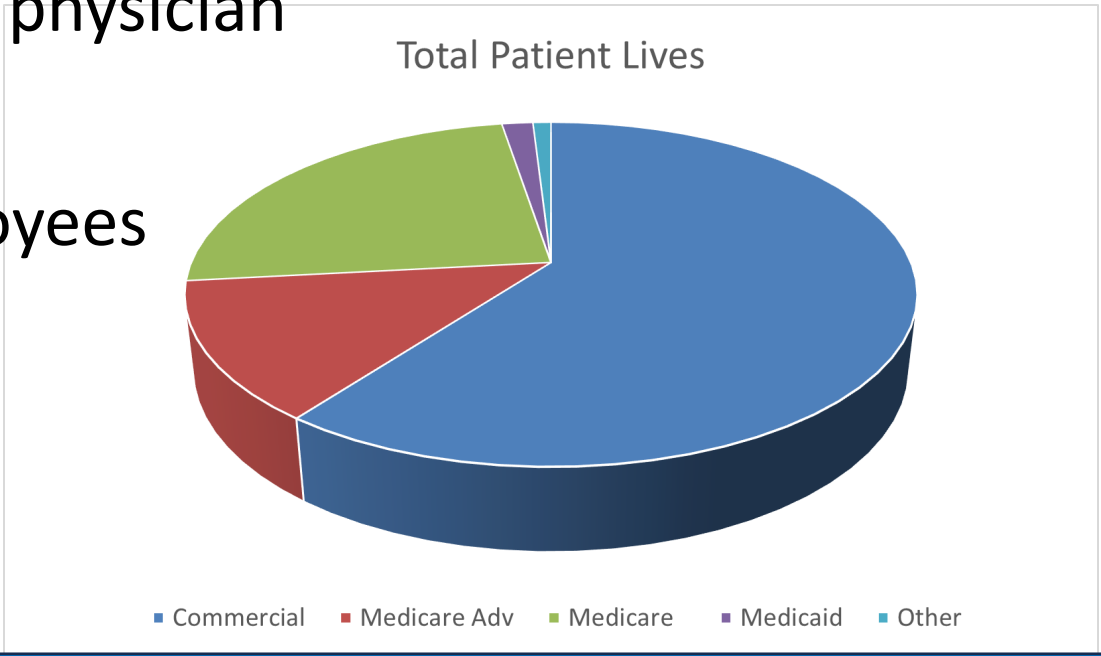
Tandigm Value Partners ACO

- ACO Greater Philadelphia Area
  - TriValley Primary Care
  - Honig Family Practice
  - King of Prussia Medicine
- MSSP Enhanced Track
- Retrospective attribution
- Performance by Year:

Performance Year	Attribution	Savings Rate
2022	11,150	6.37%
2023	11,402	8.42%
2024	11,596	13.39%

TriValley Primary Care

- Independent Primary Care Practice
- 28 Physician shareholders & 1 employed physician
- 19 CRNPs
- 180 Employees



- Value Based Contracts
  - Medicare
    - MSSP
  - Commercial Contracts
    - Aetna
    - Independence Blue Cross
  - Medicare Advantage Contracts
    - Aetna
    - Independence Blue Cross
    - Humana
    - United Healthcare

Approach to Value-Based Care

- All patients, all payors
- Population Health Specialist
- Care Manager
- Clinical Site Lead (Physician)
- Clinical Committee (Physicians)
- Certified coder
- AI Coding software overlay on EMR
- Tech-enabled Care Coordination
- Keep your moral compass pointing true north

GENERATING SHARED SAVINGS

EARN

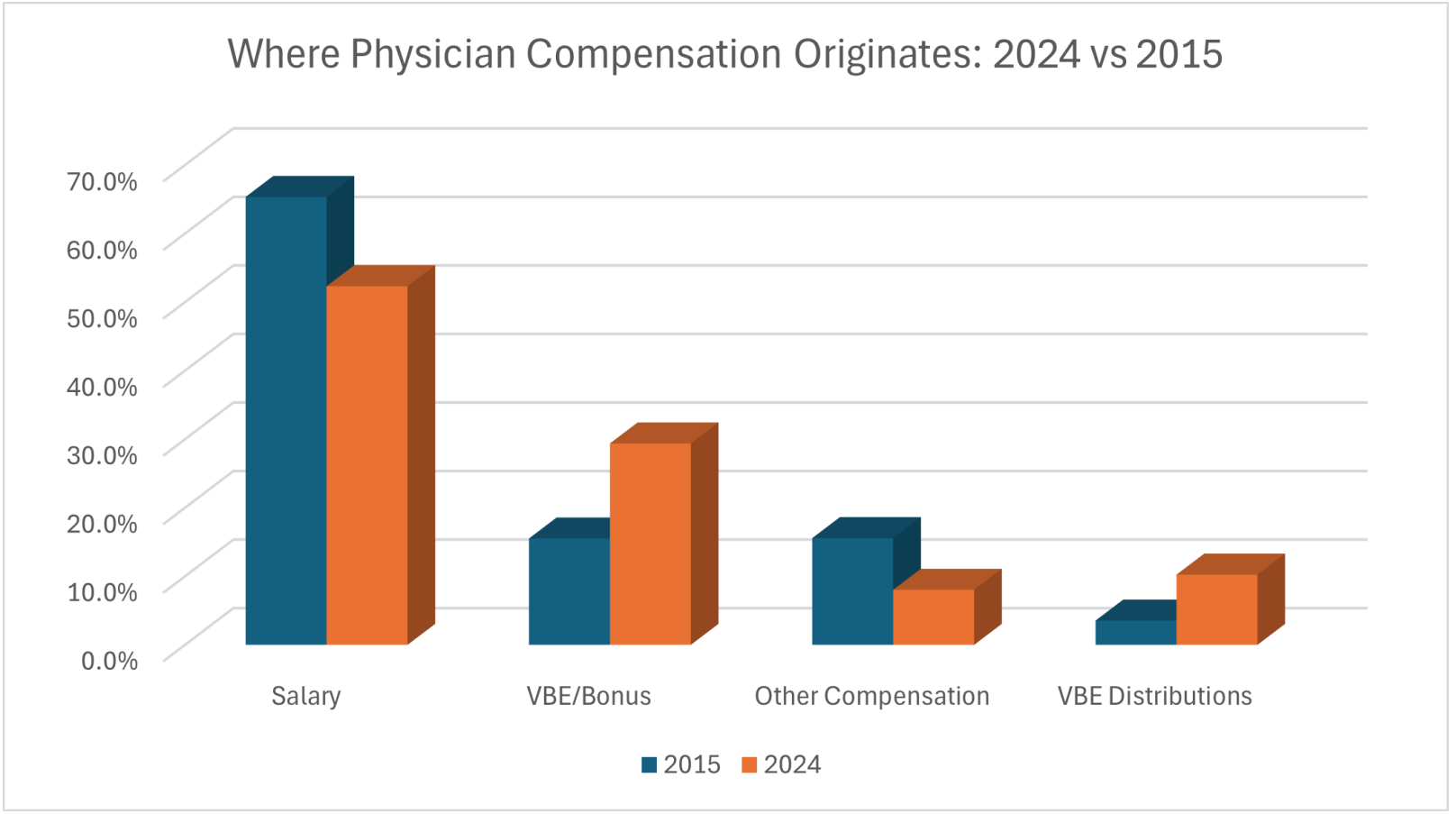
- Accurate coding and education
  - Use more than 1 tool
  - AI software
  - Coder support
  - PHYSICIAN leadership
  - Quality STATs
  - Quality Benchmarks

SAVE

- Control utilization
  - Integrated Delivery Network (IDN)
  - Communication
    - ADT feeds, Interfaces, Consults, Provider to provider
  - Reports
  - Relationship building and networking

TriValley Physician Compensation Over Time

- Over the past 10 years, physician compensation has evolved
  - From standard salary + a little in bonus earnings and owner distributions
  - To less originating from standard salary, and much more dependent upon value-based earnings and owner distributions



TRIVALLEY PRIMARY CARE

FOOD FOR THOUGHT

- What types of downstream provider compensation models—PMPM, capitation tiers, gainshare, episode bundles—have most effectively aligned incentives for cost, quality, and accountability?
- Where do downstream models fall apart? Is it attribution instability, coding gaps, referral leakage, specialty variation, or something else?
- What structures help maintain continuity through policy changes, market shifts, or financial downturns?

TriValley's Secret Sauce for MSSP Earnings Distribution

- 10% PMPM advance
- 10% Operational withholding
- 15% Employee bonus/Leadership compensation
- 65% RESERVED FOR PHYSICIAN COMPENSATION
  - 20% Even split per shareholder
  - 80% Allocated to offices based on member lives

TRIVALLEY PRIMARY CARE

LOOKING TO THE FUTURE

- SIMPLIFIED ATTRIBUTION
  - AWV
- UNIFIED QUALITY METRICS
  - Single-stream workflows
- BETTER CONTRACT ALIGNMENT
  - CMS, MA and Commercial
- IMPROVED PAYOR CAPITATION RATES
  - Maintain cashflow

FOOD FOR THOUGHT

- What are the minimum requirements VBC entities need to sustain capitated agreements or enter into downside risk arrangements?
- What questions should decision-makers be asking before entering into risk arrangements?
  - Provider mentoring
  - Cultural transformation: both business and clinical leaders at the table
  - Valuing sustainability through legacy and preserving institutional knowledge
  - Transformative growth mindsets
  - Asking the right questions of payer audiences (across LOBs), such as what's going into expenses? What are the network coverage expectations?

FOOD FOR THOUGHT

- How do you reconcile competing incentives between various entities in a health system or within an ACO with providers that participate to varying degrees?
- What factors help determine whether a partnership should continue, evolve, or unwind?
- Where do you see the most promising innovation in cohesive payment strategies—aligned PMPMs, specialty bundles, global capitation, hybrid models?

FOOD FOR THOUGHT

- How are you calibrating downstream PMPMs or episode-based payments alongside your specialists so that they hold real accountability without inheriting population risk they cannot manage?
- How do you navigate infrastructure costs such as shared resources (care management, platform/tech, etc.) when building out comprehensive programs for high-needs, complex patients?
- LEAD presents many capitation options, how do you weigh these options against other program offerings with capitated or partnership arrangements, waivers, gainsharing, etc.? What parameters do you use to evaluate fit and appropriateness entering into these options?

FOR WHAT IT'S WORTH: LESSONS LEARNED

- It's all about PERSPECTIVE
  - You can't please everyone
- Transparency can be a blessing and a curse
- Leaders are NEEDED to shape the mindset
  - Value-Based Earnings, monies available for distribution
- Be willing to CHANGE
  - Our formula evolves year over year
- You need to invest to earn
  - Figure out what generated your share savings and earmark $ for investment