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HEALTH

+ A FIELD GUIDE FOR HEALTH PLAN LEADERS

The Value-Based Care *Brief*

A five-step blueprint for value-based care strategies that actually move the needle, year after year.

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+ INTRODUCTION

Why value-based care *stalls*

Every health plan is somewhere on the value-based care journey: piloting pay for performance, measuring providers on total cost of care, or running full-risk arrangements across lines of business. Too often, momentum stalls.

+ Plans enter risk models they can't operationalize.
+ Contracts look attractive on paper but unravel at settlement.
+ Models are copied across lines of business without accounting for each segment's economics.

The common thread is a missing or underperforming operational backbone. This brief lays out a disciplined process, grounded in your current reality, tailored to each market segment, and backed by governance, so value-based care delivers results year after year.

01 Assess your current portfolio
Build a factual baseline of what's in place and how it performs.

02 Define goals by line of business
Medicare Advantage, Commercial, and Medicaid each need their own approach.

03 Match models to provider capabilities
Fit the contract to the provider's readiness, not the other way around.

04 Build the data and operational infrastructure
Attribution, insight, and one source of truth.

05 Govern and evolve the strategy
Steady oversight and a glide path for risk.

01 + STEP 1 Assess your current portfolio

Effective strategies start with a clear picture of what's in place today. Without it, you risk designing a future your systems, providers, and contracts can't support.

Catalog your arrangements

+ **Line of business:** Medicare Advantage, Commercial, Medicaid
+ **Attribution method:** prospective or retrospective, claims-based, PCP assignment, or member choice
+ **Metrics and incentives** tied to each model
+ **Financial structure:** pay for performance, shared savings or losses, full risk
+ **Provider type:** primary care, specialist, vendor

Overlay actual performance

+ Which providers exceed, meet, or miss their targets
+ Which models drive impact, and which create disputes or drag
+ Where attribution delays or mismatched data sources caused friction

> + THE POINT
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> This is more than a list of contracts. Build a factual baseline that combines contract terms, performance, and operational readiness. Without it, every decision downstream is guesswork.

02 + STEP 2 Define goals by line of business

Value-based care is not one size fits all. Each segment has its own economics, operational realities, and levers.

Medicare Advantage

Medical loss ratio (MLR) rules require Medicare Advantage plans to spend at least 85% of premium revenue on medical costs. That creates a clear opportunity to delegate financial performance to providers and align incentives.

Delegating MLR performance to a provider organization lets the plan lock in financial results for that part of the population for the year. It can also align incentives on Stars performance and accurate risk coding, and free capital the plan would otherwise hold in reserve.

Experienced plans start small and increase risk as providers build the capabilities to carry it. Move too much risk too quickly and some providers won't survive financially, leaving the plan to manage the fallout.

Commercial

Commercial has no MLR requirement like Medicare Advantage's, and lacks levers such as risk adjustment and Stars. Risk-based models here rely largely on managing total cost of care.

The biggest cost drivers (surgery, specialty drugs, cancer care) sit outside primary care's direct control. Partner with specialists who deliver high-quality care at lower cost, through bundled payments with fixed prices for specific procedures or by directing members to lower-cost sites for the same service. Primary care still matters: reward PCPs for the referrals and care decisions they directly influence, rather than asking them to own total cost.

+ STEP 2, CONTINUED

Medicaid

Medicaid populations often have more complex needs and higher membership turnover, which makes it hard to move providers quickly into deep financial risk.

Start with targeted pay-for-performance programs or care management initiatives that reward better outcomes. Design them so providers, especially safety-net and rural clinics, can sustain them without reducing access to care.

When risk-based models are used, they usually focus on discrete, high-cost segments of the population and are often delivered through purpose-built vendor partners.

+ DON'T COPY AND PASTE

Don't carry a Medicare Advantage model into Commercial or Medicaid. The financial levers, member needs, and care patterns differ. What works in Medicare Advantage rarely succeeds elsewhere without meaningful adaptation.

	MEDICARE ADVANTAGE	COMMERCIAL	MEDICAID
Main levers	MLR delegation, Stars, risk coding	Total cost of care, specialist and site-of-care steerage	Outcomes-based incentives, care management
Typical starting model	Shared savings, growing toward delegated risk	Bundles and PCP referral incentives	Pay for performance
Watch out for	Moving risk faster than providers can carry it	Asking PCPs to own costs they can't influence	Models that strain safety-net access

+ STEP 3

03 Match models to provider capabilities

A value-based arrangement is only as strong as the provider's ability to succeed in it.

START WITH READINESS

Large primary care groups with strong infrastructure may be ready for full total-cost-of-care risk, particularly with an enablement partner that can backstop downside exposure. Specialists and niche vendors may do better in episode-based or case-rate arrangements. Match the contract to operational maturity, analytic capability, and clinical model.

SETTLE THE MATH FIRST

Many models fail not on care delivery but because the plan and provider can't agree on the math. Align on attribution, metrics, calculation methods, and reporting cadence before launch, and build them into daily operations.

RISK ISN'T REQUIRED

Not every high-impact partnership needs full insurance risk. A well-structured pay-for-performance model with meaningful incentives can drive real change and financial impact without overwhelming the provider or the plan.

+ THE POINT

Fit the contract to the provider you have today, with a clear path to the one you want next year.

+ STEP 4

04 Build the data and operational infrastructure

Even the most elegant contract fails if providers can't see who they're accountable for, what's happening with those members, and how they're tracking against goals.

ACCURATE ATTRIBUTION

Attribution is the foundation. Providers need their member panel early in the performance year, with no surprises midstream. The logic must be clear, consistent, and executable.

ACTIONABLE INSIGHT

Go beyond performance dashboards and point providers to the members who matter most:

+ High utilizers
+ Multiple chronic conditions
+ Frequent ED visitors
+ At-risk post-acute patients
+ High-impact care gaps

Include care received outside the provider's network so they see each member's full journey.

ONE SOURCE OF TRUTH

Agree on data sources, definitions, and methods so the plan and provider track the same numbers. Make reporting continuous: monthly or quarterly updates give providers the chance to intervene, not just reflect after year-end.

> + THE POINT
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> Annual scorecards arrive too late. A continuous flow of data turns insight into action.

05 + STEP 5 Govern and evolve the strategy

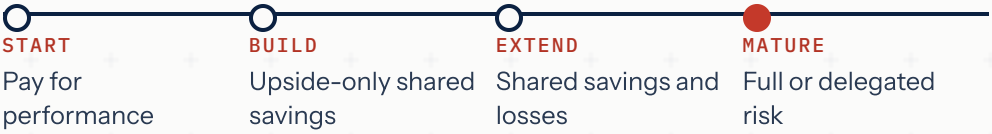
Sustainable value-based care needs steady, disciplined oversight to keep models working as intended, providers engaged, and performance moving in the right direction.

NAME AN OWNER

Appoint a leader, or one per line of business, with a complete view of every value-based arrangement. Their job is to make programs work together, avoid duplication, and keep financial, clinical, and operational priorities aligned.

MAP A GLIDE PATH

Begin with models providers can succeed in today and move toward higher risk as capabilities grow.



STAY ENGAGED

Collaboration continues after the contract is signed. Share data regularly, address bottlenecks early, and adjust before small problems become big ones.

REVIEW THE PORTFOLIO

On a regular schedule, retire models that no longer deliver, refresh incentives so they keep motivating, and keep administrative complexity in check so running a program never costs more than the value it creates.

+ CLOSING

From pilots to *lasting* advantage

Launching a value-based care pilot is straightforward. Making value-based care a core strategic capability is hard. Health plans that succeed:

01 Start with a clear baseline

02 Tailor models to each market segment

03 Match contracts to provider readiness

04 Build the data and operational backbone

05 Govern actively and keep evolving

+ THE RESULT

Done consistently, value-based care stops being a collection of disconnected projects. It becomes a durable advantage: better outcomes, predictable costs, and lasting provider partnerships, year after year.

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+ ABOUT THE AUTHOR

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Aaron is the founder of Perspectiv Health. He trained as a physician and a computer scientist, and has worked in nearly every seat that shapes a health plan's results, from product and sales to analytics and medical cost management.

He advises health plan CEOs and their executive teams on operating model, affordability, products, and provider partnerships: first a clear direction, then hands-on help until the team can carry it forward.

Talk with Aaron

Facing a value-based care decision? Start with a conversation about your situation.

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