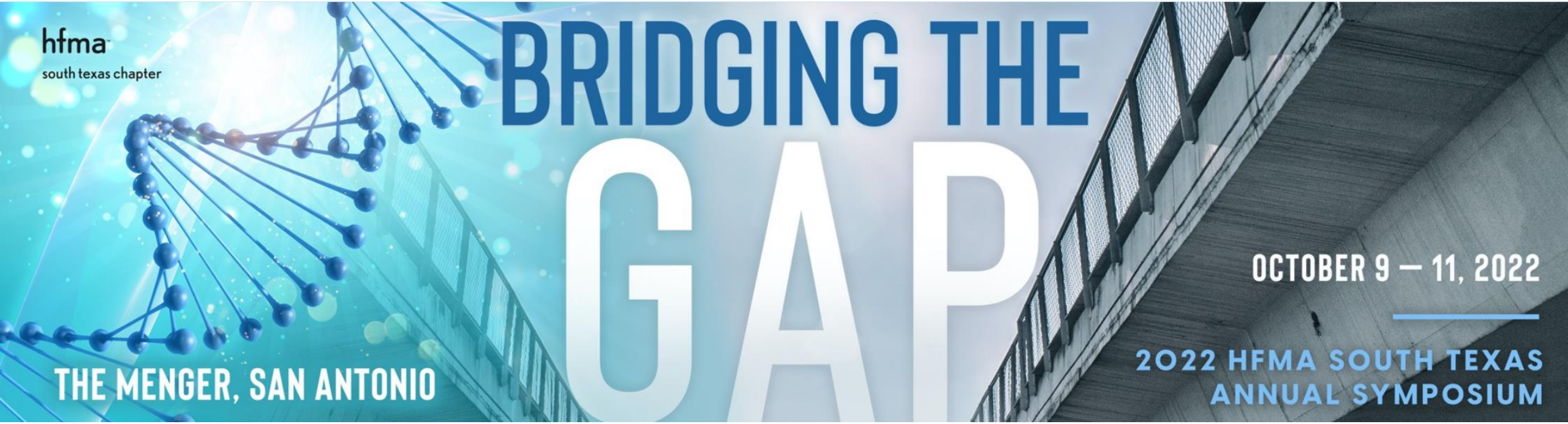
THE RACE TO VALUE: PREPARING YOUR STRATEGY FOR TRANSFORMATION



ERIC WEAVER, DHA, MHA, FACHE

OCTOBER 10, 2022

Modern Healthcare

THE ONLY HEALTHCARE BUSINESS NEWS WEEKLY | FEBRUARY 8, 2016

ACHE AWARDS | Honoring exemplary healthcare leadership

He helped build successful ACOs—with a few tips from Cuba

ACHE **Robert S. Hudgens Memorial Award for Young Healthcare Executive of the Year**

Eric Weaver

WHO AM I?

INSTITUTE FOR ADVANCING HEALTH VALUE
AT WESTERN GOVERNORS UNIVERSITY

RACE TO VALUE
A health care podcast focused on value.

MAJOR DRIVERS OF VALUE

Macroeconomic Forces

Rising gross national debt, rising general inflation, increasing federal and state deficits all amplify urgency for cost savings

Shifting Demographics

Aging and increasingly diverse population, added financial and system pressures of the Baby Boomers along with workforce shortages

Technological Advancements

Advancements in technology drive higher costs but promising future savings; changes enabled by new abilities to collect, share, and analyze data

Policy & Politics

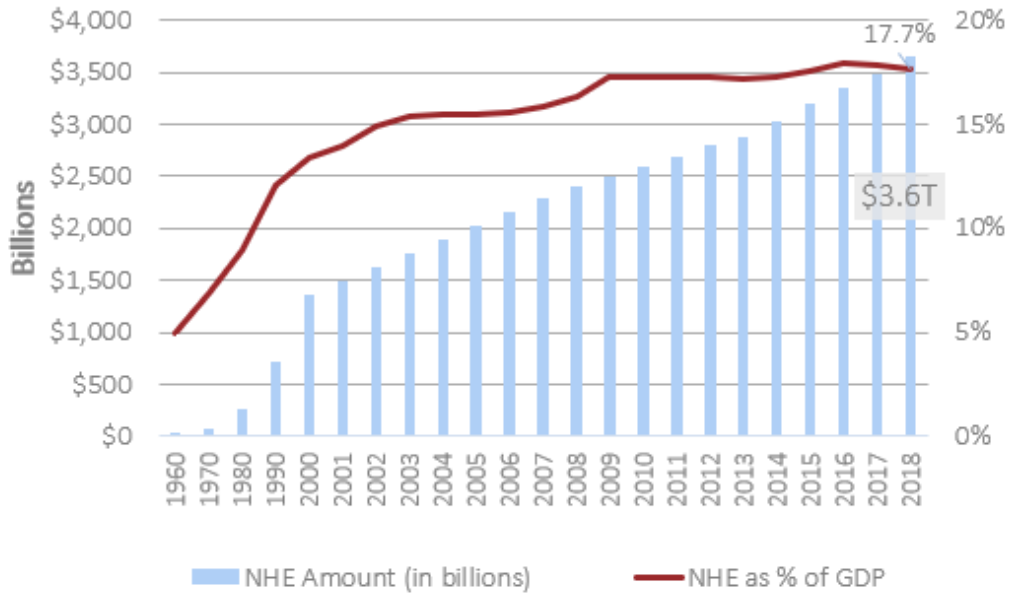
Mounting budgetary pressures for federal and state leaders, along with increasing constituency demand/appetite for change

COVID-19 - Consumerism & Equity

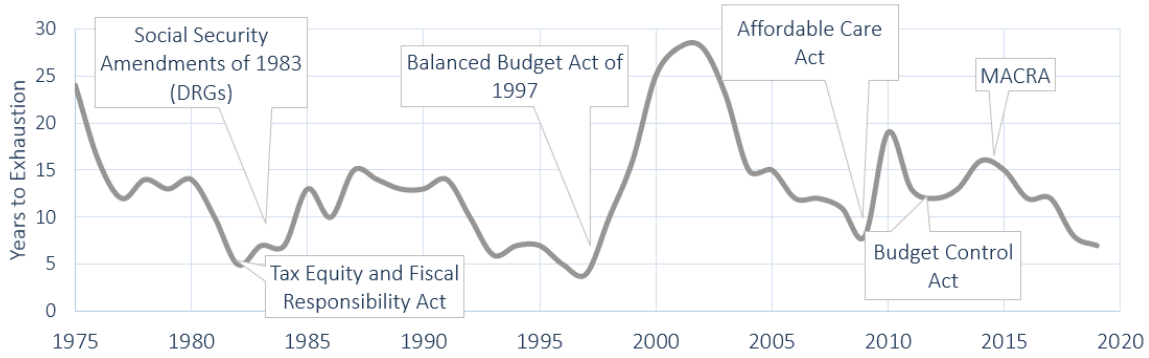
The long-term economic effects of COVID-19 are not yet known, but the increased societal awareness of the need for system reform and elimination of inequities.

ECONOMIC IMPERATIVE FOR VALUE IN HEALTHCARE

National Health Expenditures



Medicare Trust Fund Projected Years to Exhaustion 1975-2019



Note: Prior to 1975, no exhaustion of the trust fund was predicted

Source: Leavitt Partners Analysis of Annual Medicare Trustees Reports

UNSUSTAINABILITY OF FFS

Human Compassion

- Social Security
- Medicare
- Medicaid
- CHIP
- Medicare Part D
- PPACA

Economic Dispassion

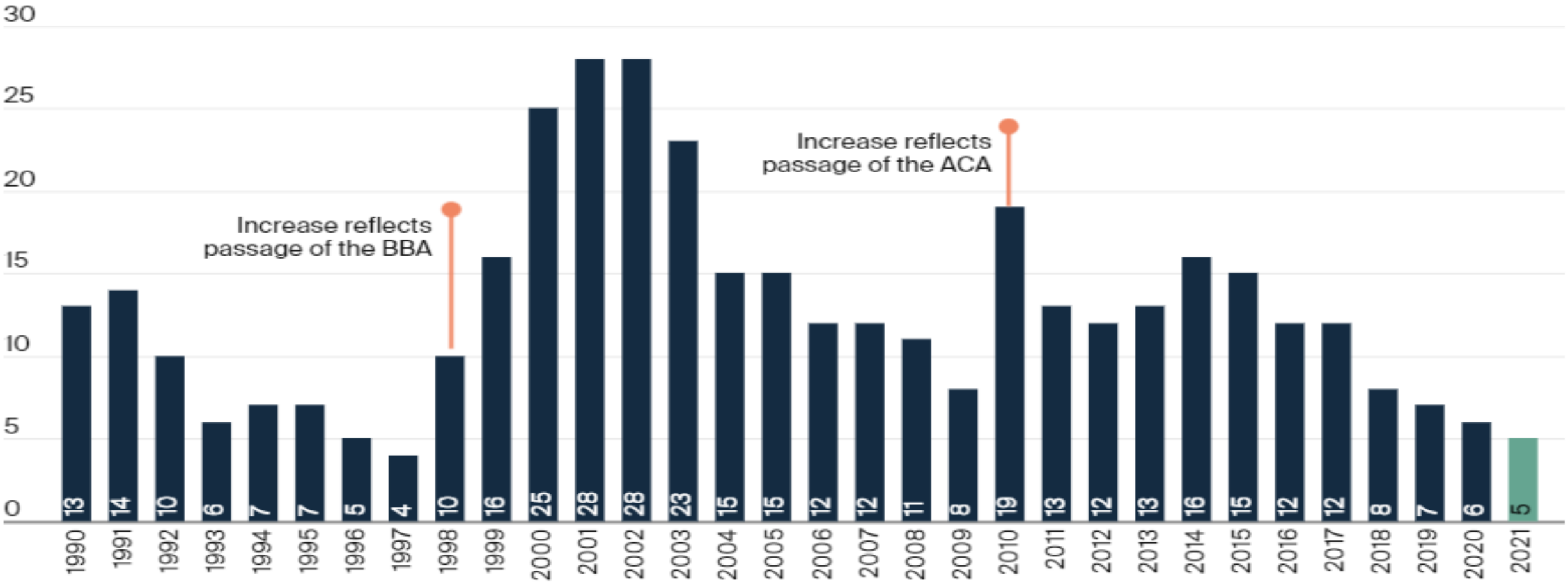
- National Debt = $31.1T
- Federal Deficit = $0.9B ($2.7T in ’21)
- Unfunded Liabilities $162T
- Current Inflation Rate = 8%
- Medicare HI Trust Fund Insolvency - 2026

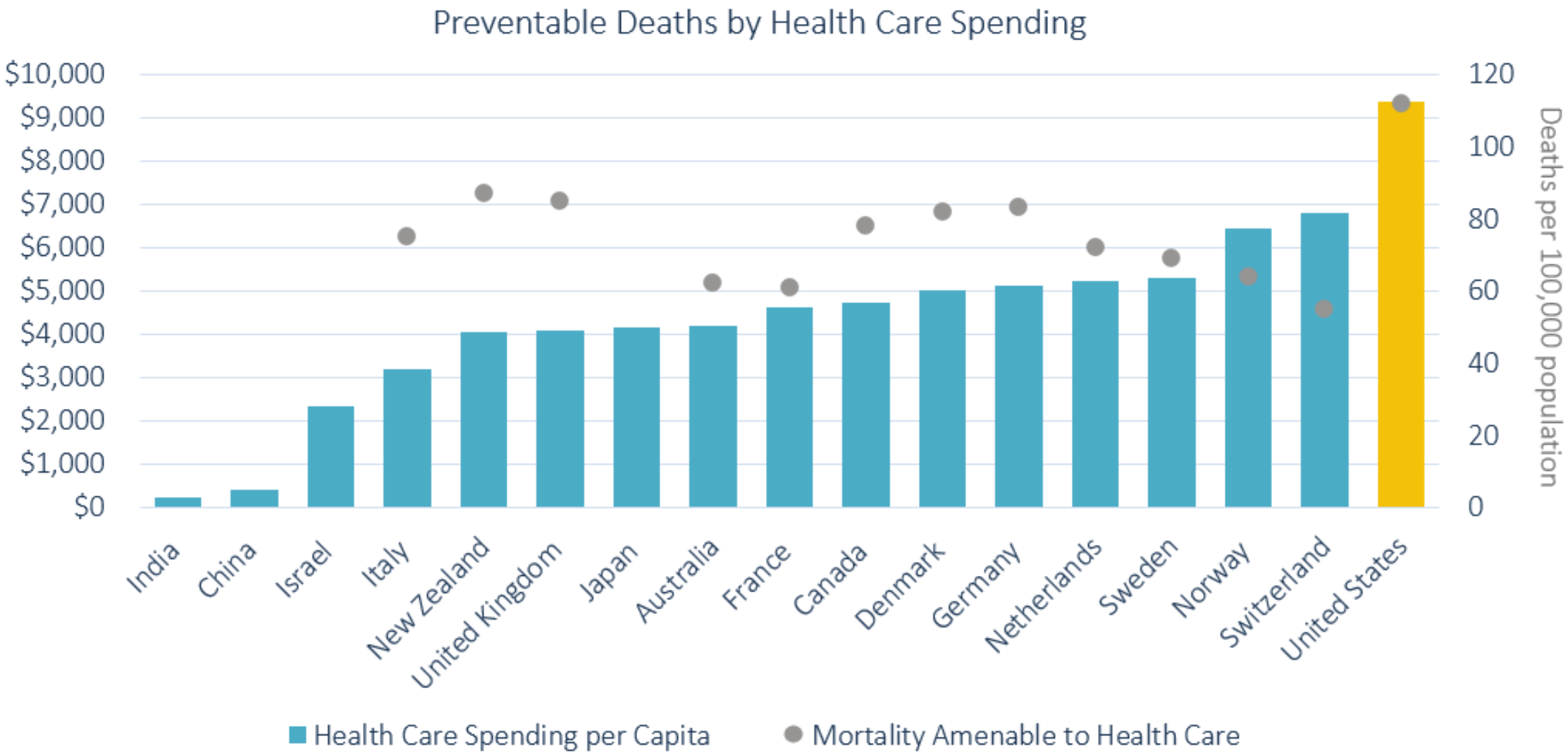
<u>Niagara Falls and Healthcare</u>:

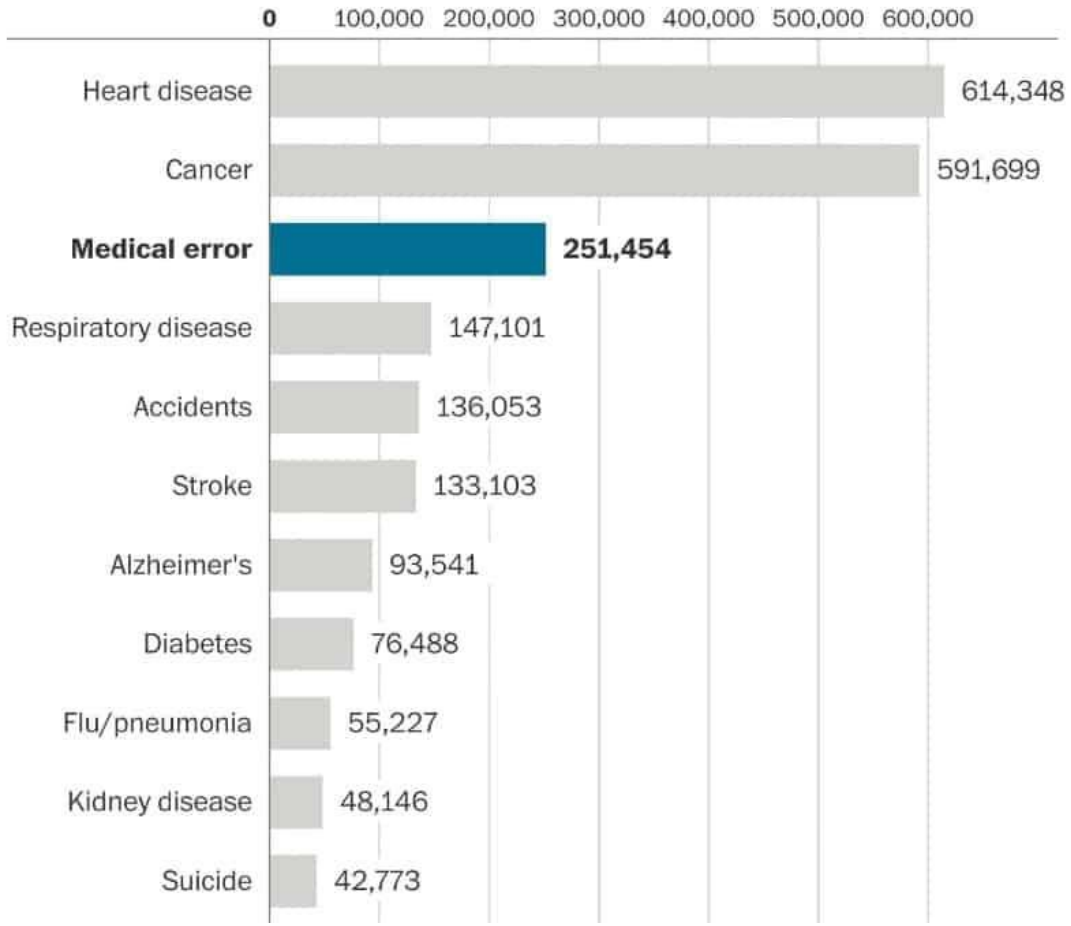
- The torrent of water that goes over the crest of the falls every minute is six million cubic feet.
- Compare this to healthcare spending in our country at $6M per minute on healthcare, with that flow of funding is specifically in tune with sickness (not health).

Insolvency projections for the Medicare Hospital Insurance Trust Fund have varied over the years, with current estimates projecting insolvency in 2026.

Number of years until insolvency of the Medicare Hospital Insurance (Part A) Trust Fund



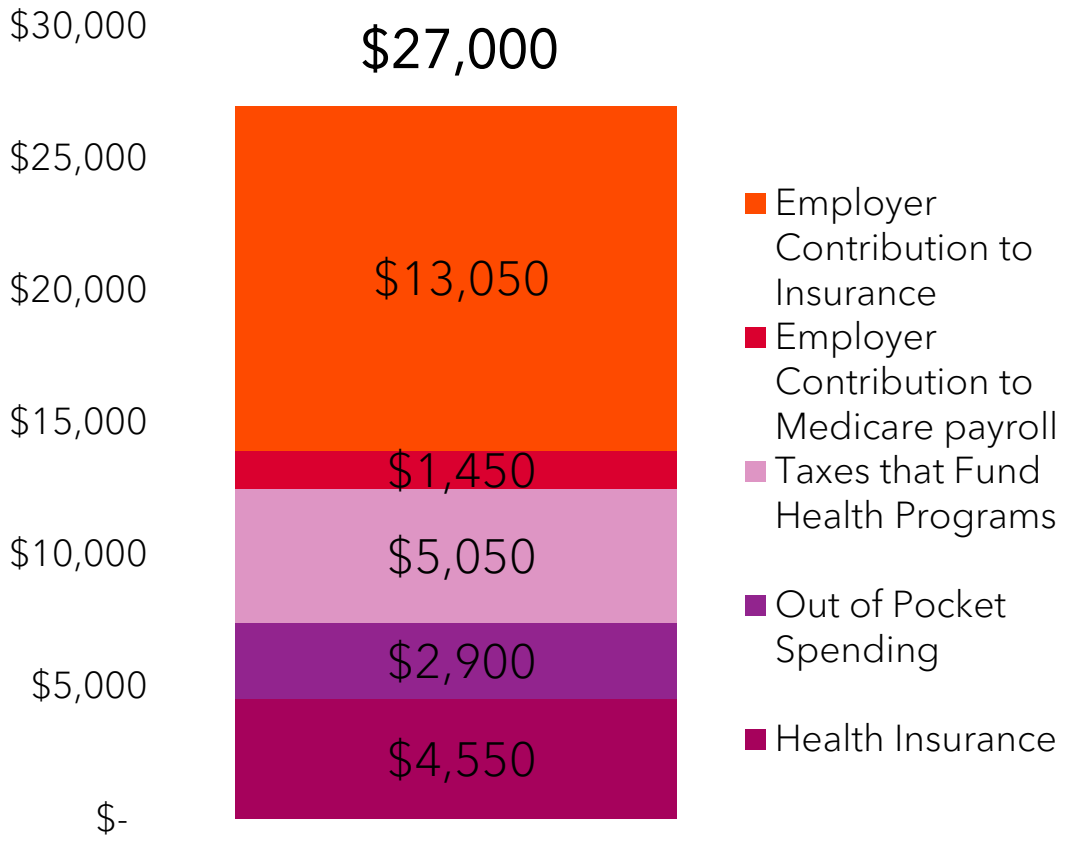

Preventable Deaths by Health Care Spending
$10,000
$9,000
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
120
100
80
60
40
20
0
Deaths per 100,000 population
India
China
Israel
Italy
New Zealand
United Kingdom
Japan
Australia
France
Canada
Denmark
Germany
Netherlands
Sweden
Norway
Switzerland
United States
Health Care Spending per Capita
Mortality Amenable to Health Care



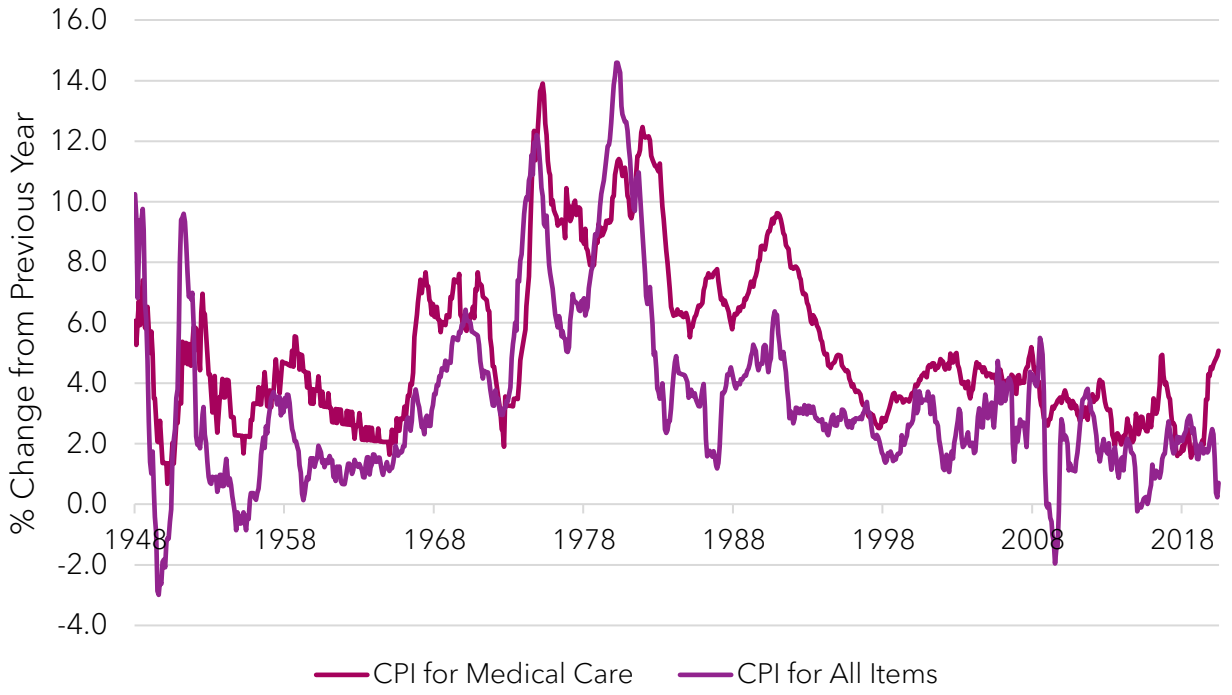
HEALTHCARE IS 3RD LEADING CAUSE OF DEATH

HEALTHCARE'S IMPACT ON INCOME

Family of Four with Employer-Based Insurance, $100k Income



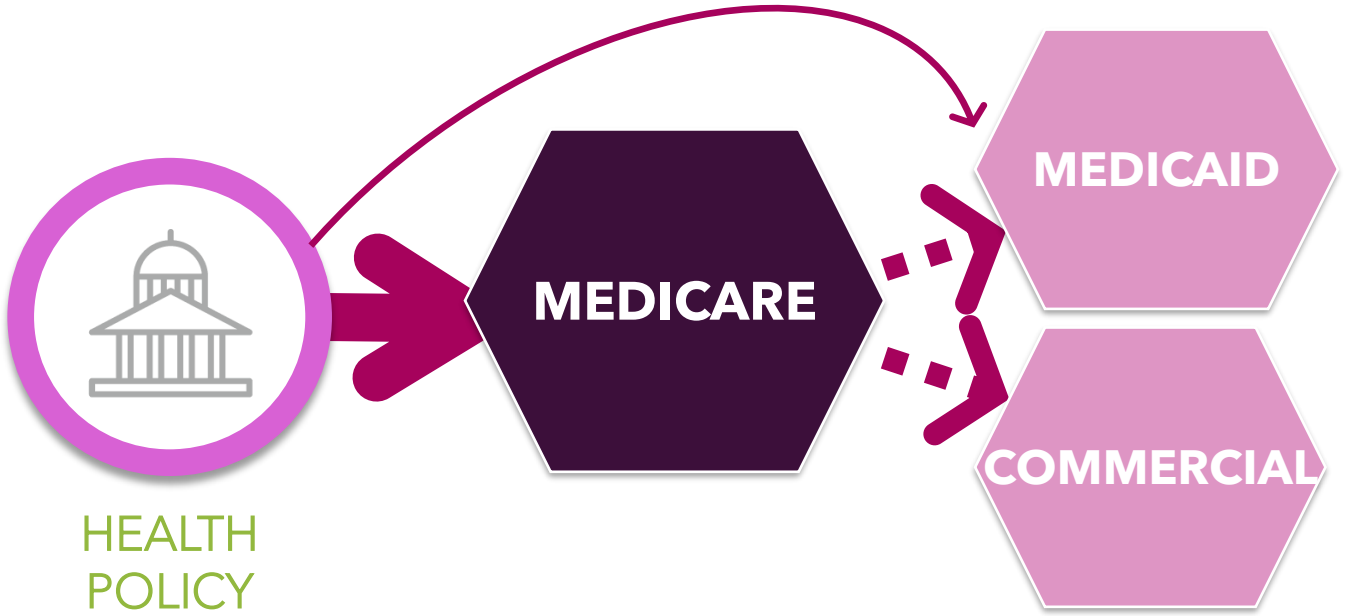
Change in General CPI Compared to CPI for Medical Care Over Time



Kaiser Family Foundation. Household Health Spending Calculator, Peterson-Kaiser Health System Tracker, St. Louis Reserve, "Inflation in the healthcare industry vs. general CPI" [1]

MEDICARE'S ROLE IN INFORMING & ACCELERATING VALUE

Medicare policy (often the way CMS pays for care) is almost always mirrored in the broader health industry.



CMS' Value-Based Program Portfolio*

ACO Models:

- Pioneer ACO Model
- Medicare Shared Savings Model (MSSP)
- Next Generation ACO Model (NGACO)
- Comprehensive ESRD Care Model (CEC)
- Vermont All-Payer ACO Model
- Direct Contracting (DC)
- Kidney Care Choices (KCC)

Bundled Payment Models:

- Bundled Payments for Care Improvement Initiative (BPCI)
- Comprehensive Care for Joint Replacement Model (CJR)
- Oncology Care Model (OCM)
- BPCI Advanced (BPCI-A)
- Radiation Oncology (RO)
- Oncology Care First (OCF)

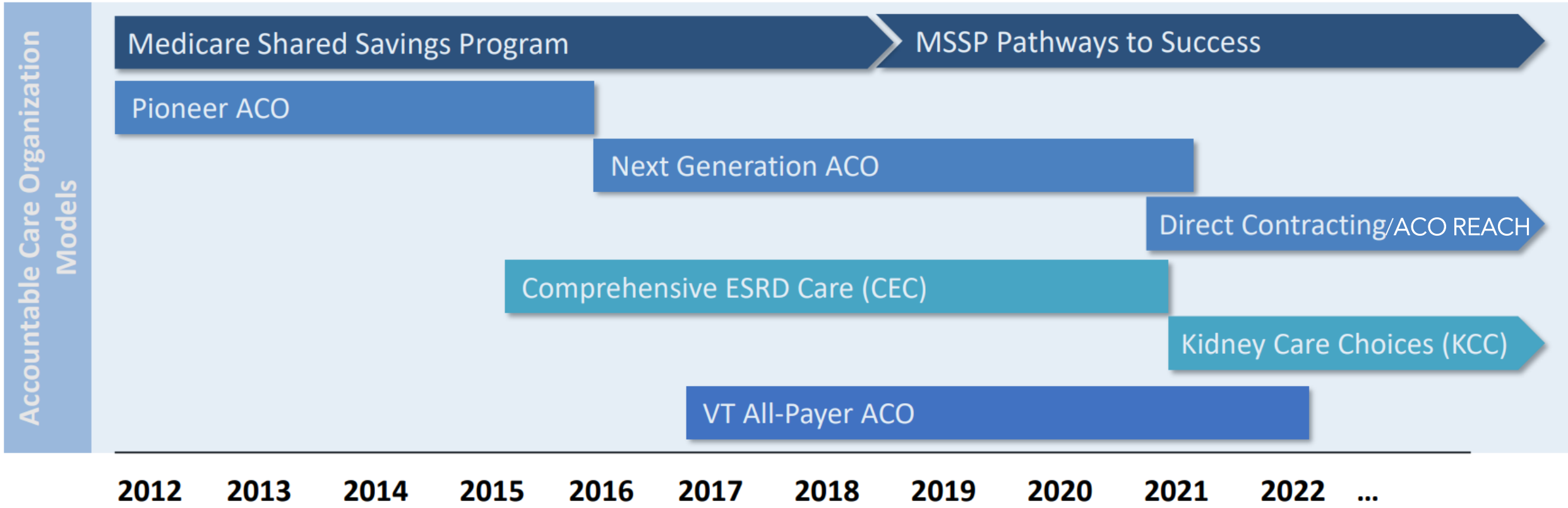
Advanced Primary Care Models:

- Comprehensive Primary Care (CPC)
- Comprehensive Primary Care Plus (CPC+)
- Transforming Clinical Practice Initiative
- Primary Care First (PCF)

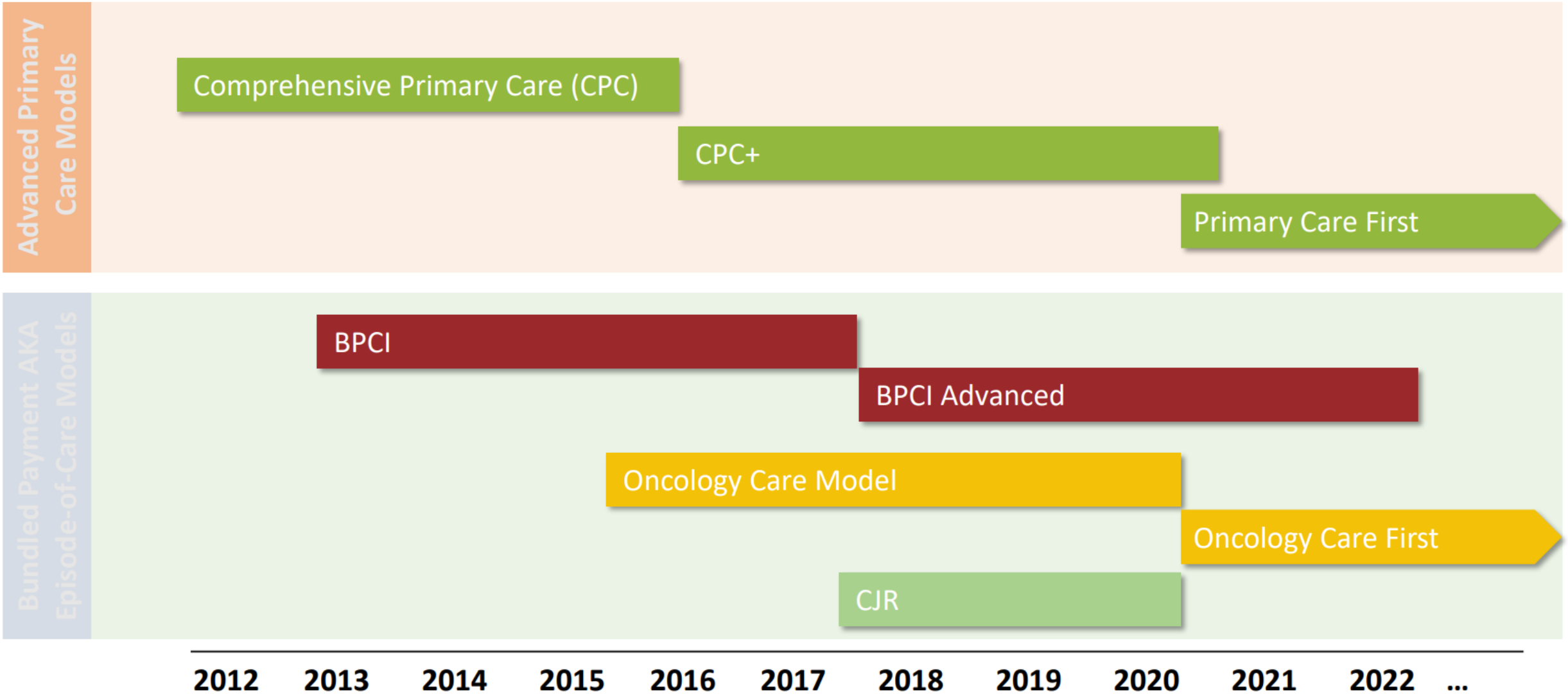
- *Comprehensive list found at https://innovation.cms.gov/initiatives/index.html#views=models

THE EVOLUTION OF MEDICARE ACO MODELS

- While the MSSP is Medicare's cornerstone ACO program, the agency continues to test new and advanced accountable care approaches via the CMS Innovation Center (CMMI)
- Each iteration applies lessons from its predecessor model, industry input, and often MA



CMMI PORTFOLIO SHOWS EVOLUTION OF OTHER MODELS

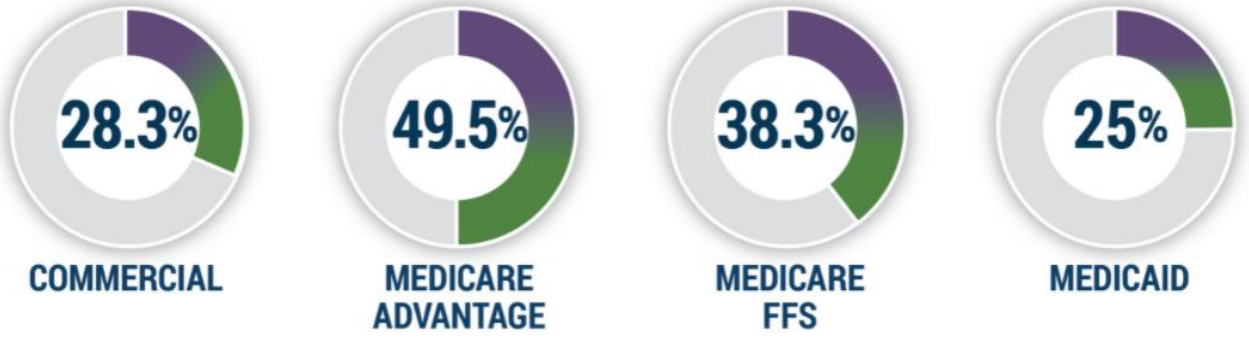


HCPLAN

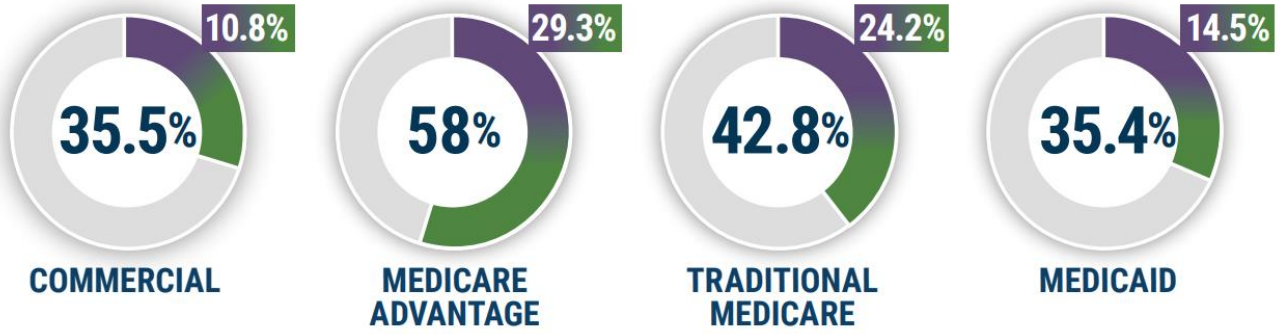
APM MEASUREMENT EFFORT

In **2017**/**2020**, **34%**/**40.9%** of U.S. health care payments, representing approximately **226.3**/**238.8** million Americans and **77%**/**80.2%** of the covered population, flowed through Categories 3&4 models. In each market, Categories 3&4 payments accounted for:

2017



2020



*Top right % (purple) notes payments in models that have partial or full shift to person-based advance payment (i.e., downside/ 2-sided financial risk)

Supported by Arnold Ventures

Source: https://hcp-lan.org/apm-measurement-effort/

MEDPAC'S KEY VALUE INITIATIVES

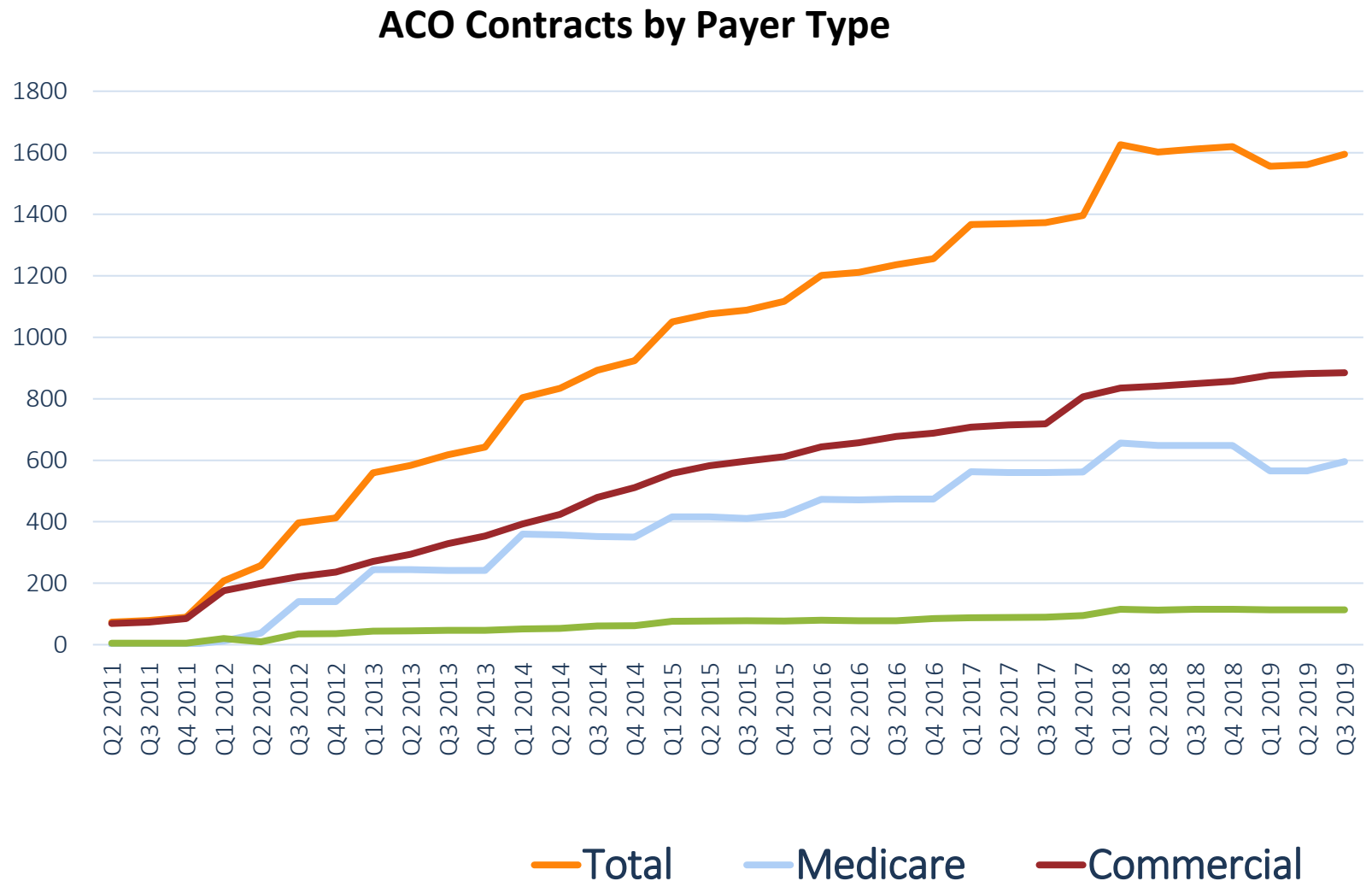
Longstanding MedPAC recommendations that previously went unheeded are now gaining traction. Notable examples include:

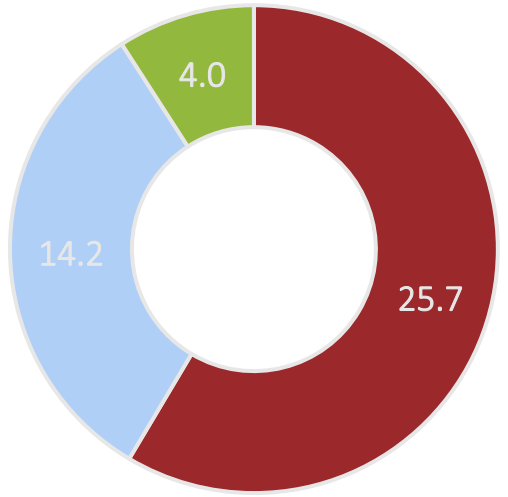
UNIFYING POST-ACUTE CARE PAYMENTS

MIPS VALUE PATHWAY

SITE NEUTRALITY

ACO GROWTH BY PAYER TYPE





Leavitt Partners Center for Accountable Care Intelligence

MSSP PERFORMANCE

"The Medicare Shared Savings Program is the foremost payment model driving value-based care. It must endure, it must grow, and it must be enhanced. We have an imperative to advance health value, and the continued positive trajectory of MSSP Performance Results shows us that this program is the largest and most effective means of accomplishing that objective. With Medicare insolvency looming, the MSSP provides an important lever to reshape healthcare delivery for improved population health equity at a much more affordable and sustainable spending level."

- Dr. Eric Weaver, DHA, MHA, Executive Director, Institute for Advancing Health Value

TABLE 1: NET PROGRAM SAVINGS/LOSSES OVER TIME

PY	2013	2014	2015	2016	2017
Net Loss/ Gain to CMS (Millions)	-$82.3	-$49.8	-$216.0	-$39.3	$313.7

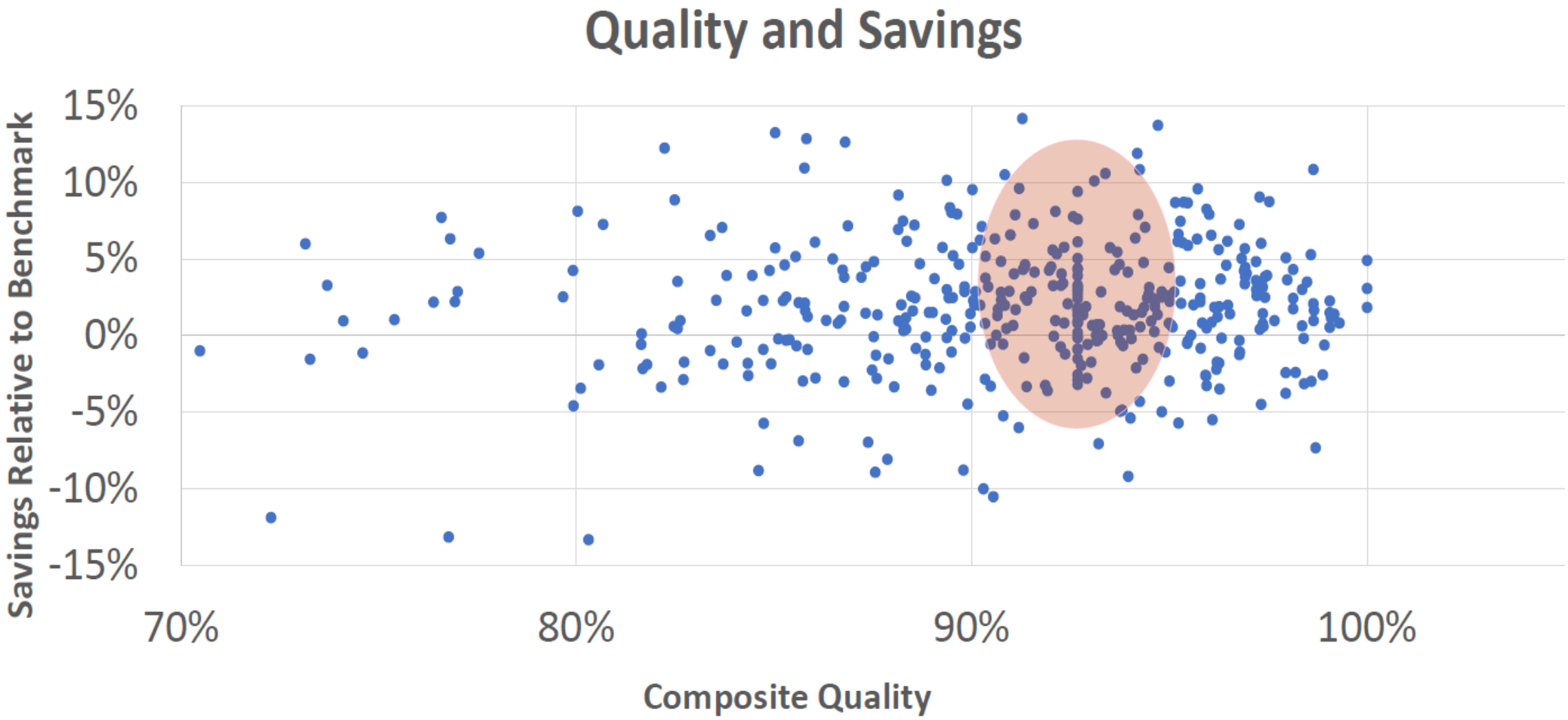
PY	2018	2019	2020	2021
Net Loss/ Gain to CMS (Millions)	$739.4	$1,200.0	$1,860.0	$1,660.0

$5.4B

TABLE 7: NET PER BENEFICIARY SAVINGS BY ACO PROVIDER TYPE

ACO Provider Type	2021 Results	2020 Results
Physician Group-Led	$224	$218
Hospital System-Led	$147	$168
Both	$156	$145

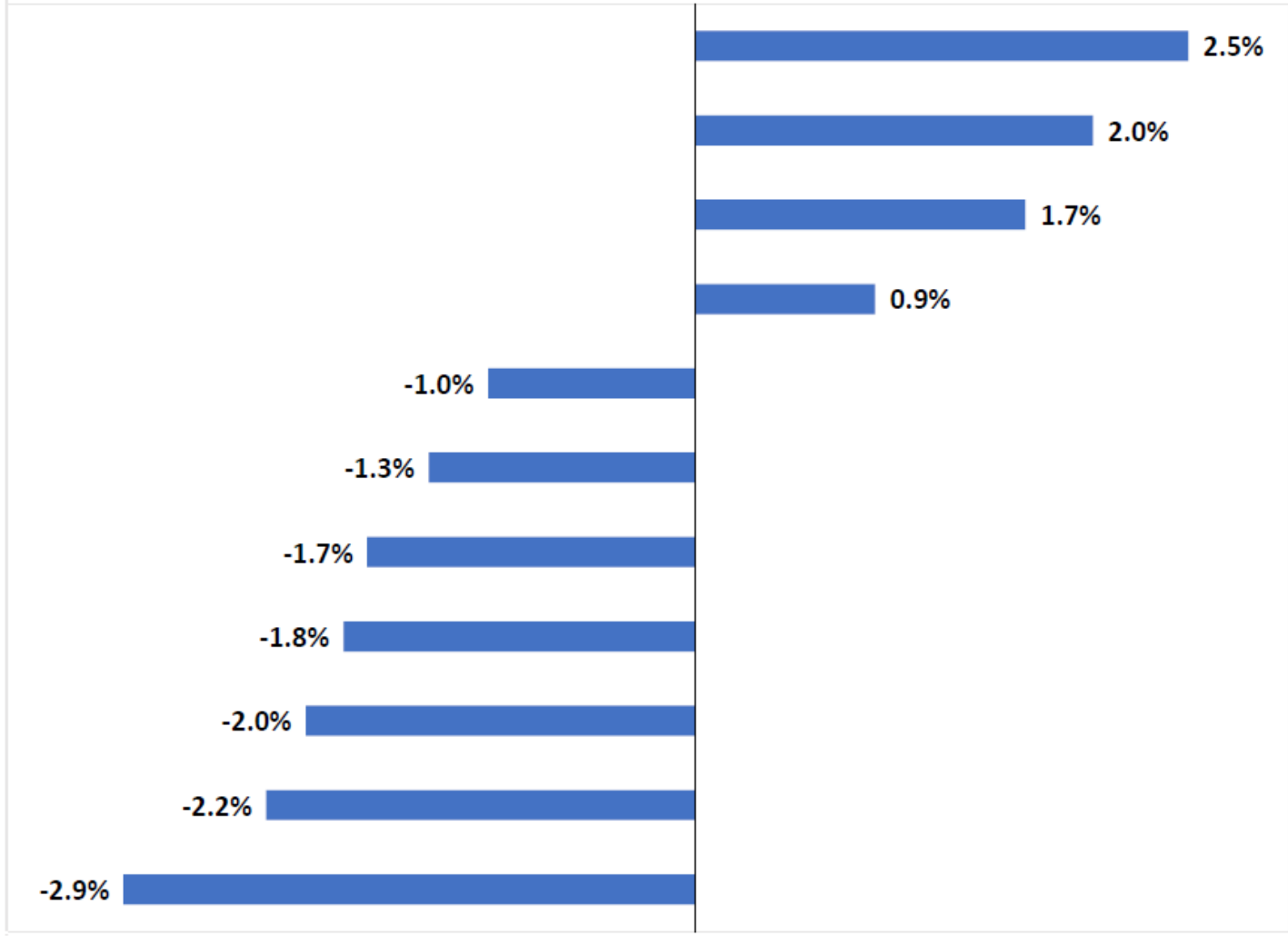
MSSP QUALITY AND SAVINGS



UTILIZATION IMPACT ON SAVINGS

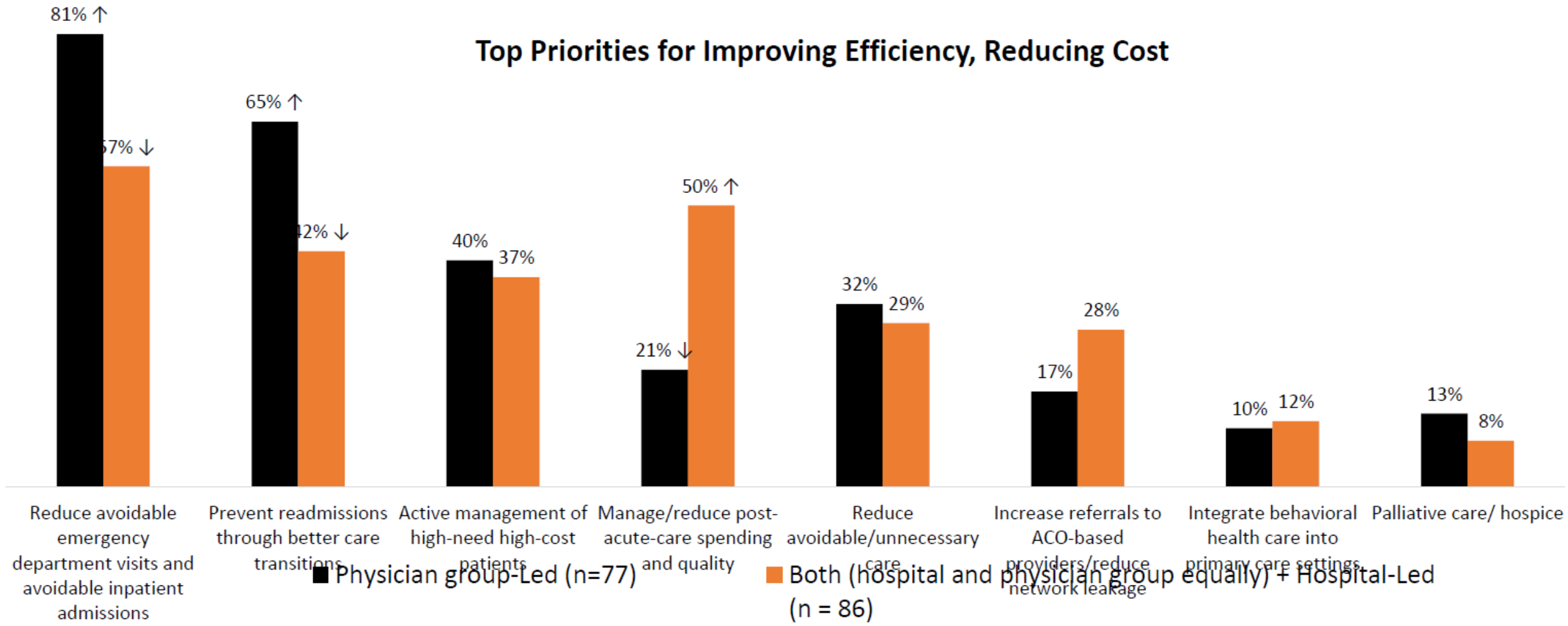
	Services per 1,000 person-years	
	25th Percentile	75th Percentile
Primary Care Services from Primary Care Provider	3,488	4,800
Primary Care Service	9,117	11,246
Primary Care Services from Specialist	3,743	5,399
MRI Visit	248	331
Primary Care Services from FQHC/ RH	9	141
Provider Visits within 30 Days of Discharg	767	819
Inpatient Discharge	282	359
Primary Care Services from NP	703	1,416
Outpatient ED Visit	615	822
Short-term Hospital Discharge	260	328
SNF Discharge	47	86

Marginal effect on savings rate when moving from low to high on specified activities



Percentages shown are the marginal effect of moving from the bottom quartile to the top quartile of the specified activities, controlling for aligned beneficiaries, total benchmark expenditures, year, and patient risk scores. For percentiles, values are services per 1,000 person-years. Source; Leavitt Partners Analysis of 2017 MSSP Data

DIFFERENT ACOS FOCUS ON DIFFERENT THINGS



Arrows (↑↓) indicate statistically meaningful differences from the mean; Filter: answered_priority; Unweighted; base n = 182; 12% filtered out

2018 Annual ACO Survey, Leavitt Partners and National Association of ACOs

HOW ARE ACOS CHANGING CARE DELIVERY?

6. BEHAVIORAL HEALTH INTEGRATION

- Expand the care team to include behavioral health providers, either embedded in the primary care practice or ED, or accessible via telehealth.
- Ensure behavioral health experts are available for patients' direct access and to consult physicians on mental health- and/or substance use-related issues.

5. PHARMACEUTICAL MANAGEMENT

Implement medication therapy management programs to:

- Increase patient adherence to treatment protocols by removing barriers (e.g., financial, cognitive, practical)
- Mitigate harmful drug interactions via medication reconciliation,
- Ensure chronic conditions with medication dependence (e.g., diabetes) are effectively managed.
- While most VBP contracts do not currently incorporate drug costs (Part D) in the total cost of care calculations, medications play an indirect, yet important, role in VBP success.

4. SUB-SPECIALIST OPTIMIZATION

Analyze subspecialist referral patterns to understand utilization trends, quality outcomes, and patient/PCP satisfaction among key high-cost subspecialties (e.g., orthopedics, cardiology, etc.). Prevent low-value behaviors (e.g., excessive/unnecessary imaging) by:

- Increasing transparency,
- Prioritizing high-value subspecialists in referral recommendations,
- Designing protocols to help encourage best practices.

3. POST-ACUTE CARE OPTIMIZATION

Evaluate post-acute care (PAC) referral patterns and costs to inform a high-value PAC strategy. PAC optimization could include:

- Identifying a preferred SNF network,
- Educating/training PAC providers,
- Establishing protocols to prioritize high-value care settings (e.g., home health vs SNF) as clinically appropriate.

2. TARGETED CHRONIC CARE MANAGEMENT

- Analyze population to identify chronic conditions with significant short-term 'impact potential' through improved management/oversight (e.g., diabetes, COPD, CHF, etc.).
- Develop targeted care management programs to proactively monitor, support/engage, and intervene prior to preventable utilization.

1. REDUCE AVOIDABLE ED VISITS/INPATIENT ADMISSIONS

Drive care from high-cost settings to more cost-effective, appropriate settings by:

- Increasing access to primary care and other alternative sites for unscheduled care (e.g., urgent care, telehealth)
- Expanding care coordination from the ED,
- Improving discharge/ care transitions protocols, etc.

TOP 10 MEDICARE ACOS IN 2021

1. PALM BEACH ACCOUNTABLE CARE ORGANIZATION — $61.9 MILLION
2. BAYLOR SCOTT & WHITE QUALITY ALLIANCE (TX-ONLY ACO) — $61 MILLION
3. PRIVIA QUALITY NETWORK (VA, MD, DC) — $41.6 MILLION
4. CARAVAN HEALTH COLLABORATIVE ACO — $35.3 MILLION
5. STEWARD NATIONAL CARE NETWORK — $34.4 MILLION
6. ADVOCATE PHYSICIAN PARTNERS ACCOUNTABLE CARE — $27.8 MILLION
7. USMM ACCOUNTABLE CARE PARTNERS — $25.8 MILLION
8. KEYSTONE ACO (GEISINGER) — $25.6 MILLION
9. BANNER HEALTH NETWORK — $25.5 MILLION
10. MERCY HEALTH SELECT — $25.3 MILLION

TABLE 8: NET SAVINGS PER BENEFICIARY BY ACO SIZE

Size Percentile	Range of Assigned Beneficiaries	Average Net Savings Per Beneficiary
Largest 20% of ACOs	30,877 – 220,365	$139
60th – 80th percentile	15,866 – 30,795	$151
Middle 20% of ACOs	10,666 – 15,859	$214
20th – 40th percentile	7,711 – 10,619	$206
Smallest 20% of ACOs	3,014 – 7,664	$213

ACO REACH Model

Accountable Care Organization Realizing Equity, Access, and Community Health

Promote **health equity** and address healthcare disparities for underserved communities

Continue the **momentum of provider-led organizations** participating in risk-based models

Protect beneficiaries and the model with more participant vetting and monitoring and greater transparency

Capitation Payment Mechanisms

ACOs must select one of the two Capitation Payment Mechanisms. The available Capitation Payment Mechanisms vary based on the Risk Option selected by the ACO.

1	**Primary Care Capitation (PCC)**	Monthly capitation payments for primary care services furnished to aligned beneficiaries.	*Available for Global and Professional*
2	**Total Care Capitation (TCC)**	Monthly capitation payments for all services furnished to aligned beneficiaries.	*Available for Global Only*

Capitation payments (and associated claims reductions) apply only for Participant Providers, and Preferred Providers that opt in to fee reductions.

*In PY2021, the average capitation payment represented **2.5% of TCOC***

New Focus on Health Equity

To promote Health Equity and expand the availability of accountable care to underserved communities, ACO REACH includes the following provisions:

Health Equity Provision	Description
Health Equity Plan	REACH ACOs will be required to develop and implement a Health Equity Plan starting in 2023 to identify underserved patients within their beneficiary population and implement initiatives to measurably reduce health disparities
Health Equity Benchmark Adjustment	A beneficiary-level adjustment will be applied to increase the benchmark for those REACH ACOs serving higher proportions of underserved beneficiaries in order to mitigate the disincentive for ACOs to serve underserved patients by accounting for historically suppressed spending levels for these populations

ALIGNMENT OF ACO REACH WITH MA PRINCIPLES

- ► **More predictable spending targets** - Benchmarking methodology calculates historical spend blended with MA rate book
- ► **Prospective payments** - Smooths cash flow and enables flexibility in downstream contracts
- ► **The ability to "enroll" beneficiaries via voluntary attribution** - Direct Contracting Entities (DCEs) can conduct outreach and market themselves to beneficiaries
- ► **Pass through of benefits to "preferred providers"**
- ► **Beneficiary Engagement Incentives**
- ► **Supplemental benefit enhancements** - DCEs can provide supplemental benefits not available in Medicare FFS (e.g., transportation, hearing aids, eyeglasses)

Sharing and Loss Rates Across Programs and Tracks Show Different Options With Various Levels of Risk and Reward That Must be Considered

All programs and tracks have a quality component. Applicability of MSR/MLR, risk corridors, caps and other financial mechanisms vary by program and track.

EPISODE-BASED MODELS (BUNDLED PAYMENTS)

Providers receive a single payment that covers defined services to treat a given clinical condition.

Characteristics:

- Specific episode length (30, 60, 90-day most common)
- Responsible for limited or total cost of care; performance measured against a target price for the episode
- Prospective vs. retrospective payment
- Voluntary and mandatory models

Advanced APMs of this type:

- **BPCI Advanced**
- **Oncology Care Model** (Two-Sided Risk track)
- **Comprehensive Care for Joint Replacement (CJR)** (Track 1-CEHRT)

SOWING SEEDS

- *"Sometimes, in the enthusiasm of sowing a thousand seeds, we forget that the overabundance of a crop is as much of a problem as no crop at all. That's especially true when the seeds from different crops become entangled - an analogy applicable to what has happened with the proliferating and unmanageable set of alternative payment models supervised by CMMI."*

The CFO's Dilemma: Achieving Margin with Risk-Based Payment, with François de Brantes and Joe Fifer

POSTED ON MAY 24, 2021 BY THERACETOVALUEPODCAST

08:00 01:13:45

Podcast: Play in new window | Download

signifyhealth

hfma healthcare financial management association

VALUE-BASED ONCOLOGY CARE

- Oncology is the 3rd most expensive specialty in the senior population, but it is growing 3X faster than the top 3 specialties. It will soon be the #1 most expensive specialty.
- From state-to-state, there can be a 2-3X multiple difference in oncology care costs, and there is no correlation between the cost and the quality.
- 34% of all cancer deaths could be prevented if disparities in access were eliminated
- The financial toxicity of cancer care (1 in 4 cancer patients go bankrupt within 2 years of diagnosis, 1 in 3 cancer patients go bankrupt within 5 years of diagnosis)
- **Exemplar (The Oncology Institute of Hope & Innovation)**
  - TOI is the first specialty value-based care company to go public (November 2021) and has become one of the largest oncology practices in the US
  - TOI has achieved 25% lower costs in oncology care. This practice has

  40% fewer admissions, 75% fewer ED visits, with patient satisfaction scores

  14% higher than traditional oncology care

The Oncology Institute of Hope & Innovation

VALUE-BASED KIDNEY CARE

- 37 million people in the US (15% of adults) are affected by CKD
- Medicare pays $100B for people with all stages of renal disease (20% of all spending)
- While just 1% of Medicare beneficiaries have kidney failure, it accounts for 7% of spending
- The reimbursement system is designed to fail patients with CKD since high margin reimbursement kicks in during ESRD stage
- Black Americans are 3.5X more likely than White Americans to experience kidney failure. And Black Americans are less likely to do home dialysis or get a kidney transplant than whites.
- **Exemplar (Cricket Health):**
  - More than 50 percent fewer hospital admissions than the status quo;
  - 77 percent of those starting dialysis do so in an outpatient setting (compared to the status quo of 40 percent);
  - 45 percent who need dialysis are initiating at home (compared to the status quo of 11 percent); and
  - 60 percent of those starting dialysis do so with a permanent access placed (compared to the status quo of 45 percent).

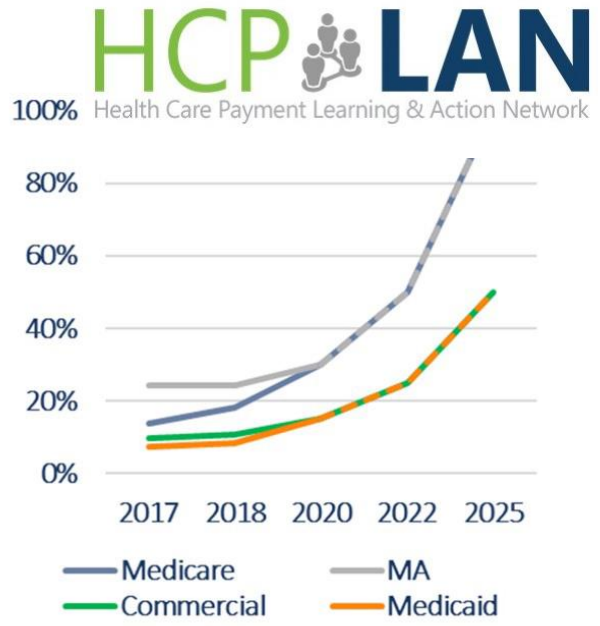
FUTURE OF SPECIALTY MODELS?

- Is there an appetite for mandatory episodic models and TCOC APMs? (Yes, if concerns with benchmarking and health equity are addressed.)
- CMS will not design specialty payment models for every type of episode of care (ex: diabetes)
- Continued focus on Oncology and Kidney Care APMs
- Incentives for ACOs to integrate specialists
- Updates from CMMI forthcoming later this year

HCP-LAN GOAL FOR APM ADOPTION

By 2025, shift 100% of Medicare payments (Traditional and Medicare Advantage) and 50% of Medicaid and commercial health care payments to downside-risk models

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%



CMMI GOAL FOR APM ADOPTION

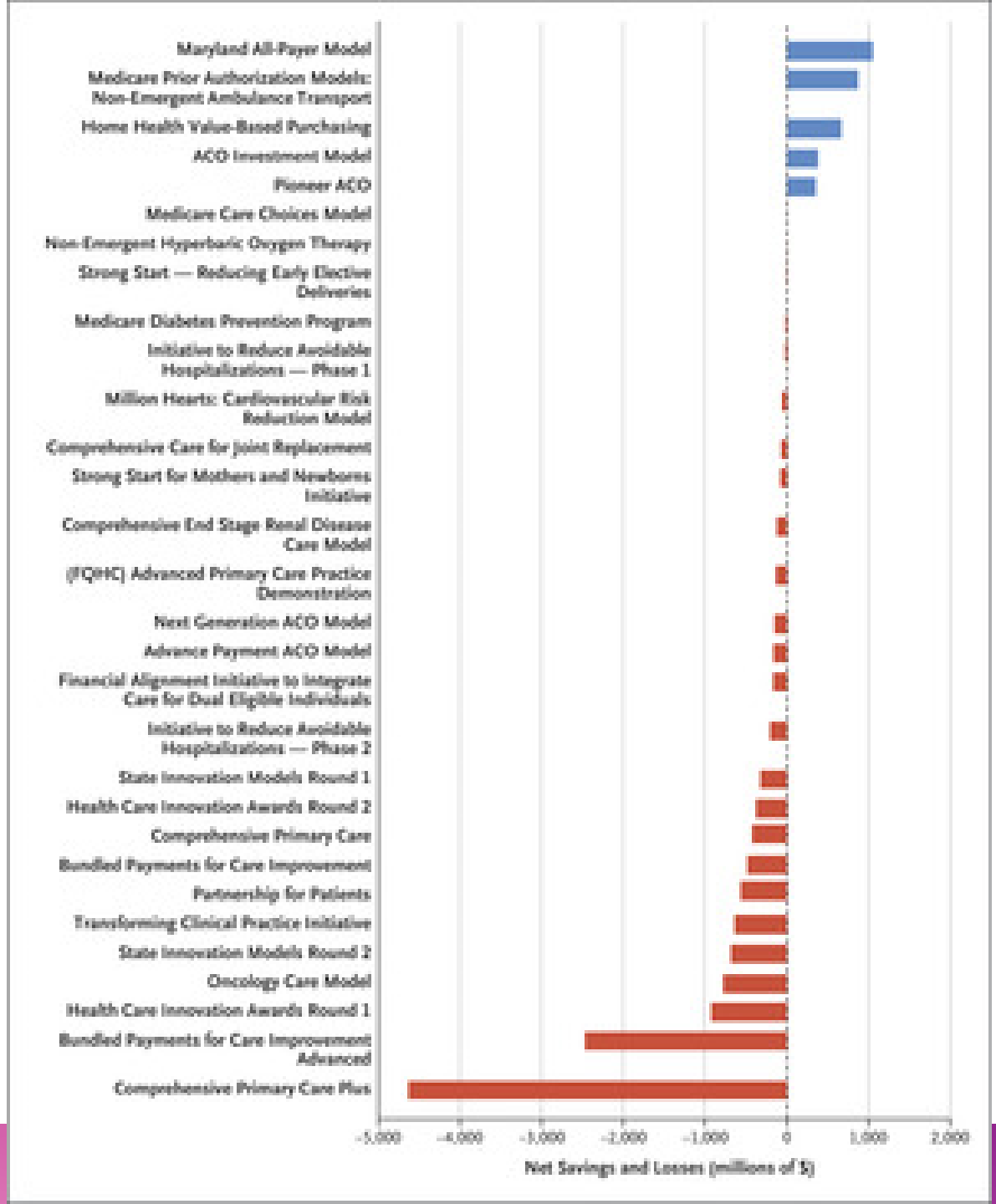
By 2030, all Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care.

CMMI PAYMENT MODEL PORTFOLIO

- While its reach is impressive – with models serving over 26 million patients – CMMI APMs are not producing the necessary financial and quality impacts to justify expanding most of the pilots.
- Of CMMI's 54 total models, only five have ever produced statistically significant savings.

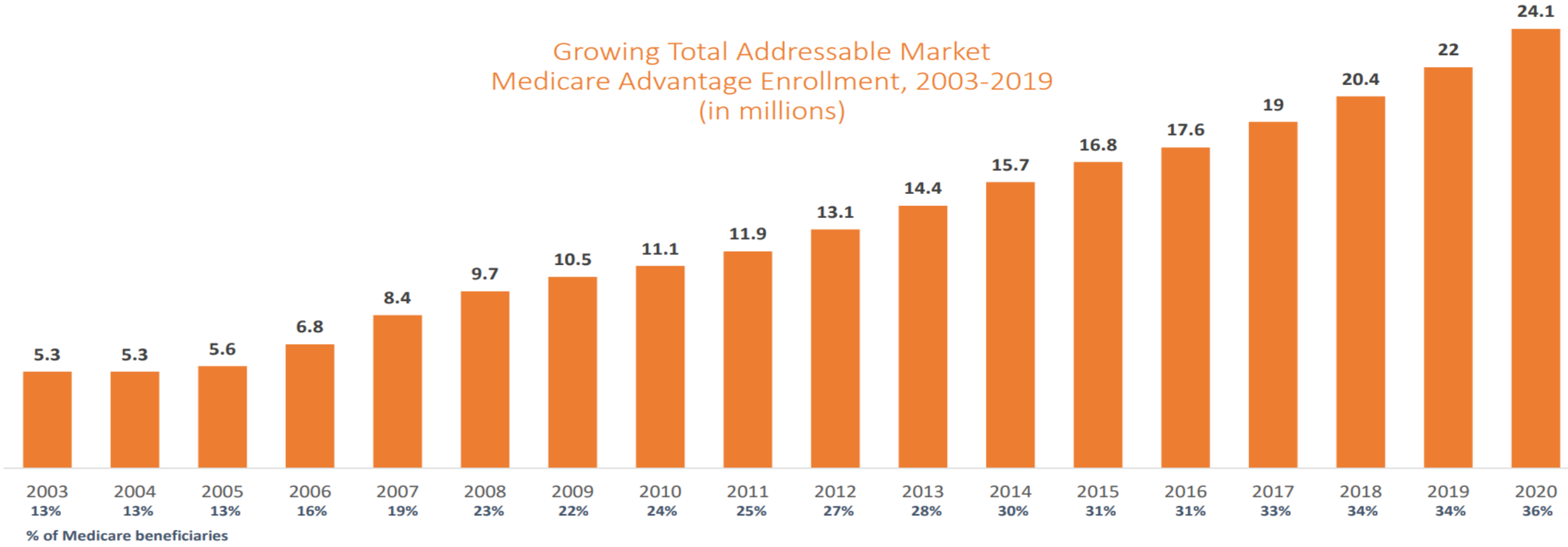
CMS SIGNALS

- To improve performance, future CMMI models:
  - will be reduced and streamlined
  - will require participants to bear downside risk,
  - include regulatory flexibilities to incent participation,
  - use improved benchmarks,
  - provide participants with more data and support
  - will have equity embedded as a core performance measurement



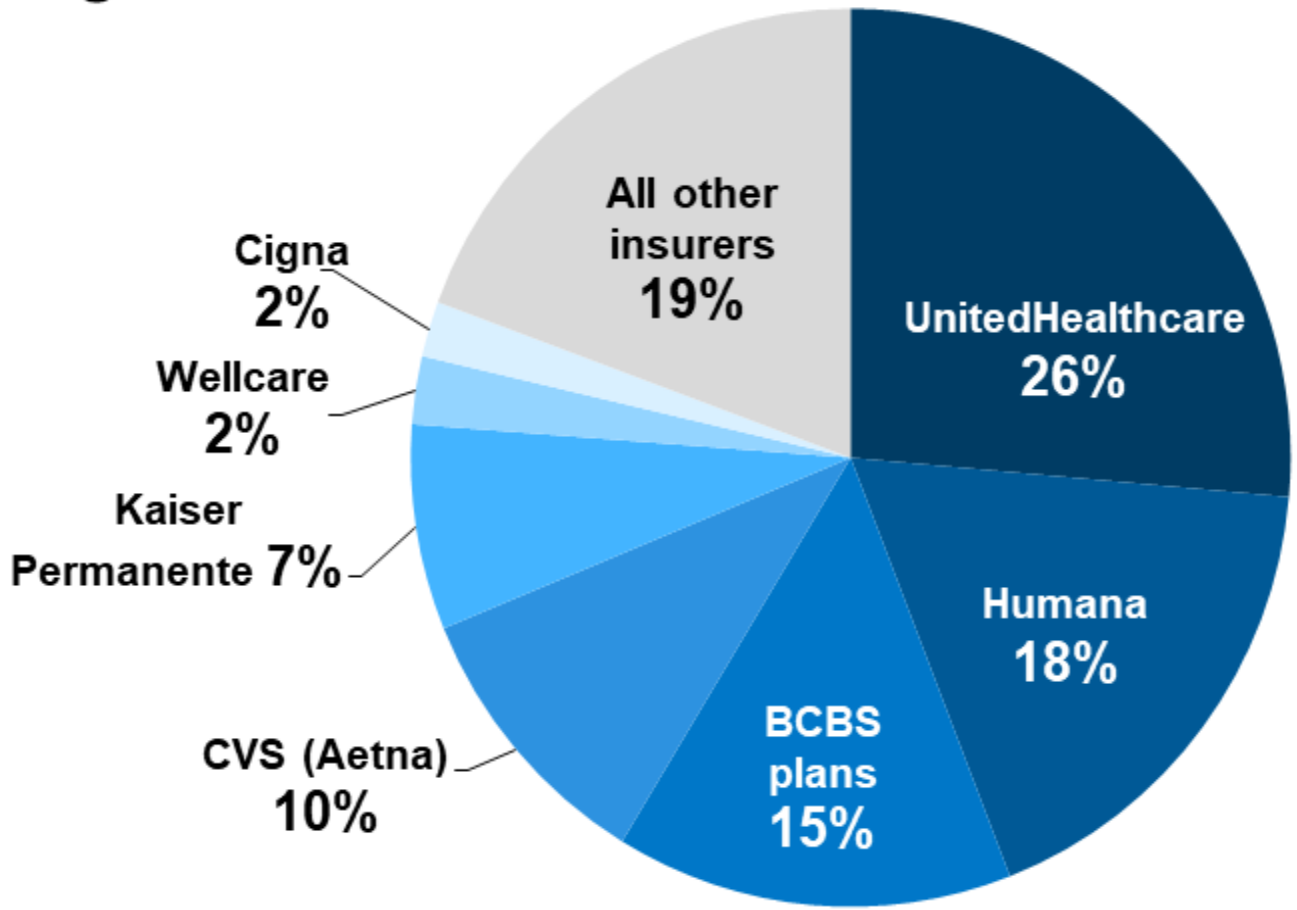
MEDICARE ADVANTAGE GROWTH

- MA is 35% of the Medicare program today at 22 million, and it will reach 50% by 2025 with over 34 million people enrolled.
- MA has almost doubled its penetration over the last 14 years -- from 10 million (of 45 million) in 2008 to 28 million (of 64 million) in 2021



Source: KFF analysis of CMS MA Enrollment files, 2008-2020, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

Medicare Advantage enrollment is highly concentrated among a small number of firms.

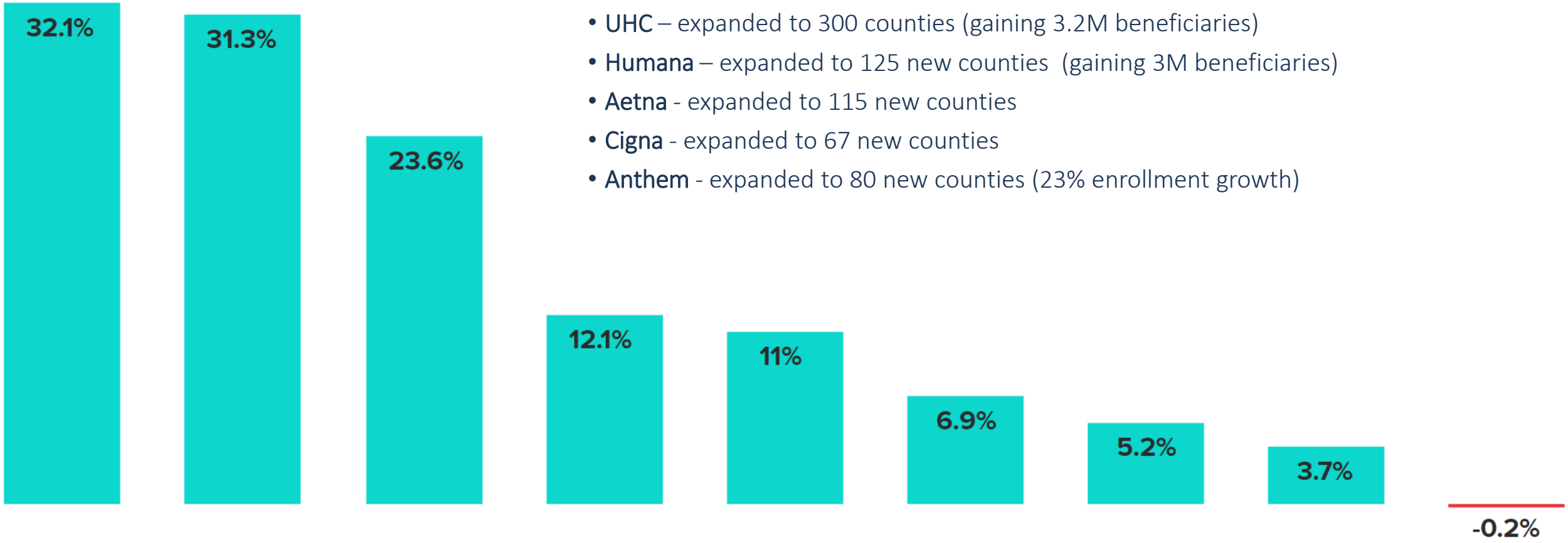


Total Medicare Advantage Enrollment, 2019 = 22 Million

NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans. Anthem non-BCBS plans is less than 2% of total enrollment.
Percentages may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2019.

KFF
HENRY J KAISER FAMILY FOUNDATION

MA Payer Expansion (2021)



- **Centene** acquisition of WellCare attributable to 30% growth in MA portfolio
- **UHC** – expanded to 300 counties (gaining 3.2M beneficiaries)
- **Humana** – expanded to 125 new counties (gaining 3M beneficiaries)
- **Aetna** - expanded to 115 new counties
- **Cigna** - expanded to 67 new counties
- **Anthem** - expanded to 80 new counties (23% enrollment growth)

MEDICARE ADVANTAGE UPSTARTS

- **Devoted Health** is a start-up exclusively offering MA plans that is backed by $369 million in investor capital.
- **Bright HealthCare** has raised nearly $1.6 billion in funding and offers MA plans in 12 of the 13 states in which it operates after a 2020 expansion into six new states.
- **Oscar Health**, an insurance company built around a technology platform, raised $1.6 billion in nine years before going public in 2021 and launched its first MA plans in 2020. The company has an innovative strategy to pursue co-branded health plans with provider organizations, combining Oscar's technology capabilities with provider organizations' value-driven approaches.
- **Clover Health** also leverages technology to manage patients enrolled in its MA plans. Clover uses a cloud-based system to share the data that they collect as an insurer with providers at the time of care, creating a closed-loop data sharing system between the insurer and provider.
- **Alignment Healthcare**, another MA insurer with a data focus, is currently working to expand their geography and serve a greater number of seniors. Since 2014, Alignment has experienced a 33 percent compound annual growth rate in its membership. Raj Shrestha, newly appointed president and new markets and chief business officer of Alignment, has experience in value-based payment that is likely to accelerate the company's growth and increase the value they provide to consumers.

STAR RATINGS IN MEDICARE ADVANTAGE

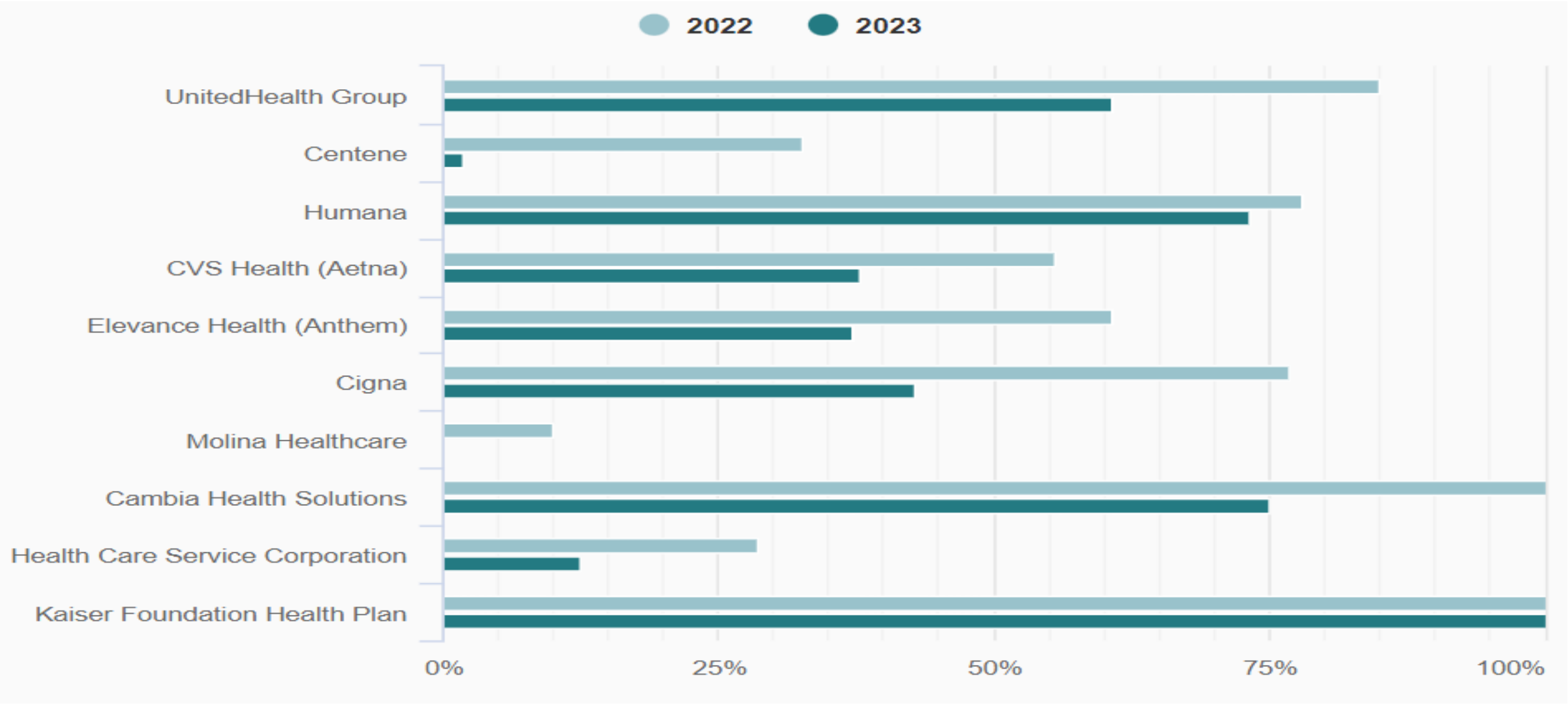
- For every Star a Medicare Advantage plan gets, it receives an **additional 8% more revenue** between the increased bonuses it receives and the increased enrollment.
- On a scale of 1-5 Stars, you have to hit the all-important 4th Star to get the bonus and the rebates that the program funds. These bonuses have dramatically changed the behavior of health plans and the providers that are contracted with them to provide services that improve of quality care.
- For providers that share risk with the MA plan (capitated or have a percent of premium deal), when the plan scores that all-important 4th Star and receives the bonuses and rebates, they get a portion of that as well in what gets paid out downstream.

Modern Healthcare

Nearly 20% of Medicare Advantage plans lose star revenue for 2023

NONA TEPPER

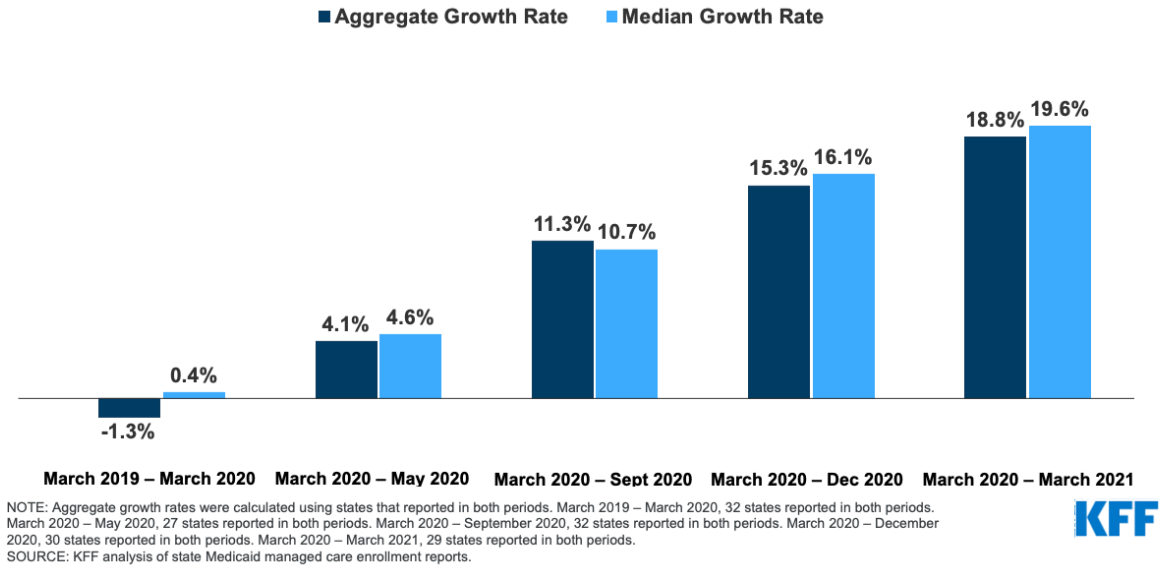
THE % OF MA PLANS THAT RECEIVED 4+STARS DECLINED FOR MOST OF THE TOP 10 LARGEST PLANS



SURGING MEDICAID ENROLLMENT

- We currently have 75 million Americans covered by Medicaid (approximately 1 in 5 Americans).
- Overall, we spend over $600B annually on the Medicaid program! That equates to 15% of all healthcare but will continue to grow exponentially if unabated by economic recovery.
- Given that Medicaid enrollment and the strength of the economy are countercyclical, some forecasts have even projected that Medicaid beneficiaries may even approach 100M in the next five years if we experience a persistent economic downturn with ever-widening economic inequality in the post-COVID era.

Figure 1



NOTE: Aggregate growth rates were calculated using states that reported in both periods. March 2019 – March 2020, 32 states reported in both periods. March 2020 – May 2020, 27 states reported in both periods. March 2020 – September 2020, 32 states reported in both periods. March 2020 – December 2020, 30 states reported in both periods. March 2020 – March 2021, 29 states reported in both periods.
SOURCE: KFF analysis of state Medicaid managed care enrollment reports.

KFF

DYSFUNCTION OF EMPLOYER-SPONSORED MARKETPLACE

- 'Poor health' costing employers $530B on top of the $880B they already spend in premium dollars annually.
- Employers (and their employees) continued to get fleeced by unsustainable double-digit premium increases every year, with hospitals using that excess spend in commercial insurance to their subsidize losses on the public pay side.
- Employers are the sleeping giants in the health value movement and will no longer tolerate the current fee-for-service model.

PRIVATE SECTOR ADOPTION

Nation's largest health insurers are now paying roughly half of their reimbursements via value-based contracts

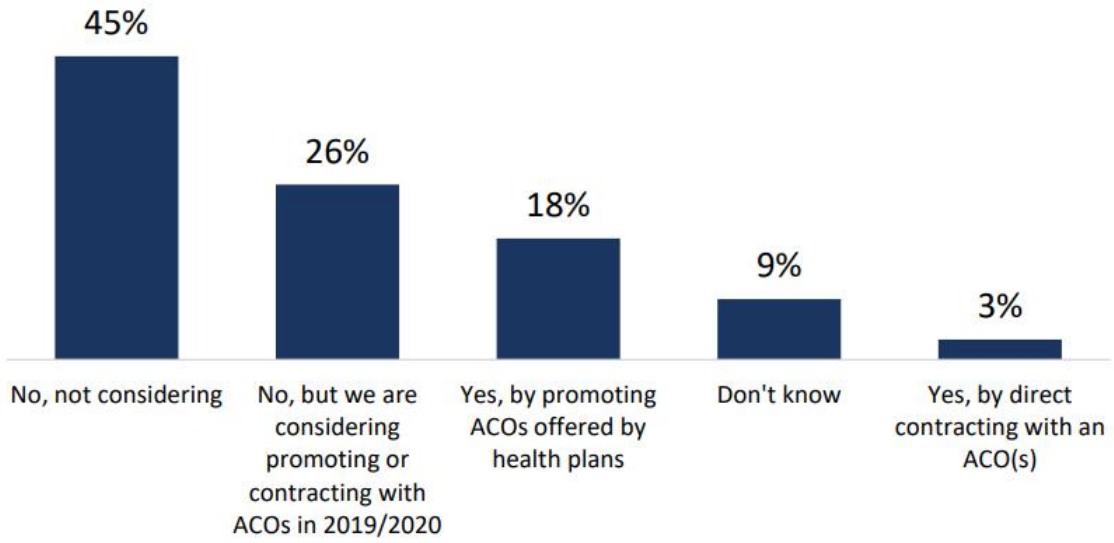
UnitedHealth Group℠ **60%**

Cigna **51%**

Anthem **58%**

aetna℠ **45%**

Large employers are increasingly engaging in innovative payment and delivery models, directly contracting with providers



PEPSICO LOWE'S Walmart BOEING GE

Sources: Forbes, Cigna Newsroom, NBGH Large Employers' 2020 Health Care Strategy and Plan Design Survey

ROSEN HOTELS & RESORTS

EMPLOYER VBC EXEMPLAR

Improving Lives (and Saving $450M) with an Employer-Led Health Ecosystem, with Harris Rosen, Kenneth Aldridge, and Ashley Bacot

POSTED ON NOVEMBER 1, 2021 BY THERACETOVALUEPODCAST

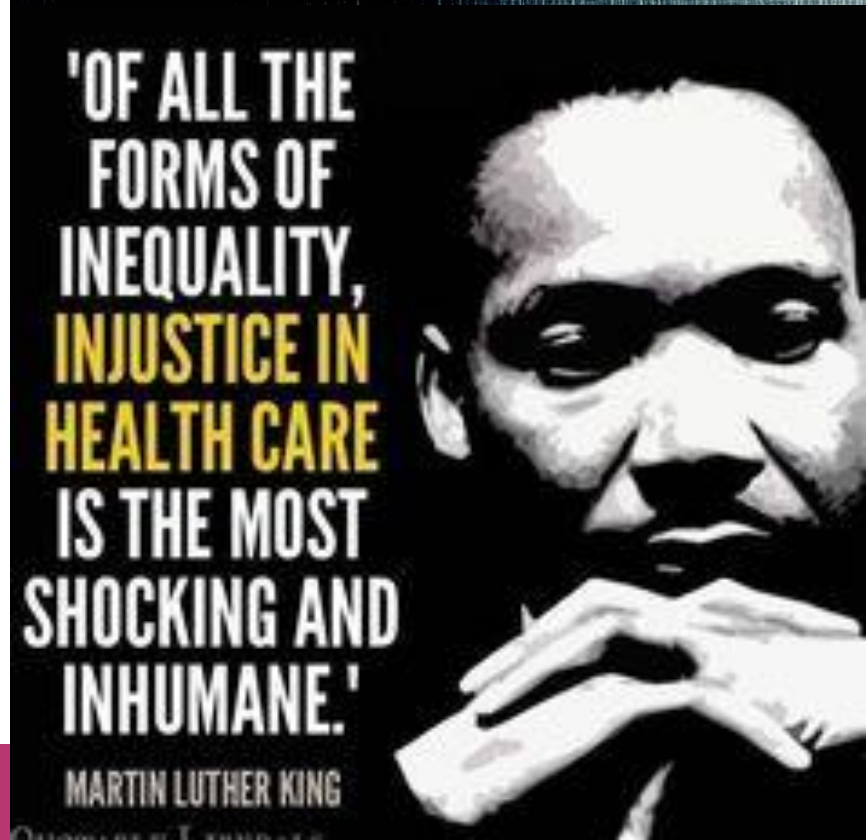
00:00 00:00

Podcast: Play in new window | Download

You are about to be inspired and challenged about how you think about value-based care. Since 1991, Rosen Hotels & Resorts has offered an innovative in-house healthcare program called RosenCare that has been improving lives for employees and the community, as well as saved the company approximately $450 million since its inception.

MORAL IMPERATIVE FOR VALUE IN HEALTHCARE

"Health equity means that <u>everyone</u> has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." - RWJ Foundation



Likelihood of Having A Bad Outcome Compared to Whites in the U.S. Goes Beyond Health Disparities

Wealth gap

- White households hold **86.8% of overall wealth**
- Black and Hispanic households hold **only 2.9% and 2.8% of wealth**, respectively

Federal Reserve (2019)

- In 2016, the median net worth of non-Hispanic White households was **$143,600**.
- The median net worth of Black households was **$12,920**.

Census Bureau. "Wealth, Asset Ownership, & Debt of Households Detailed Tables: 2016," Download "Wealth and Asset Ownership for Households, by Type of Asset and Selected Characteristics: 2016.

Between 1983 and 2013, White households saw their wealth **increased *by* 14%.**

But during the same period, Black household wealth **declined 75%.** Median Hispanic household wealth **declined 50%.**

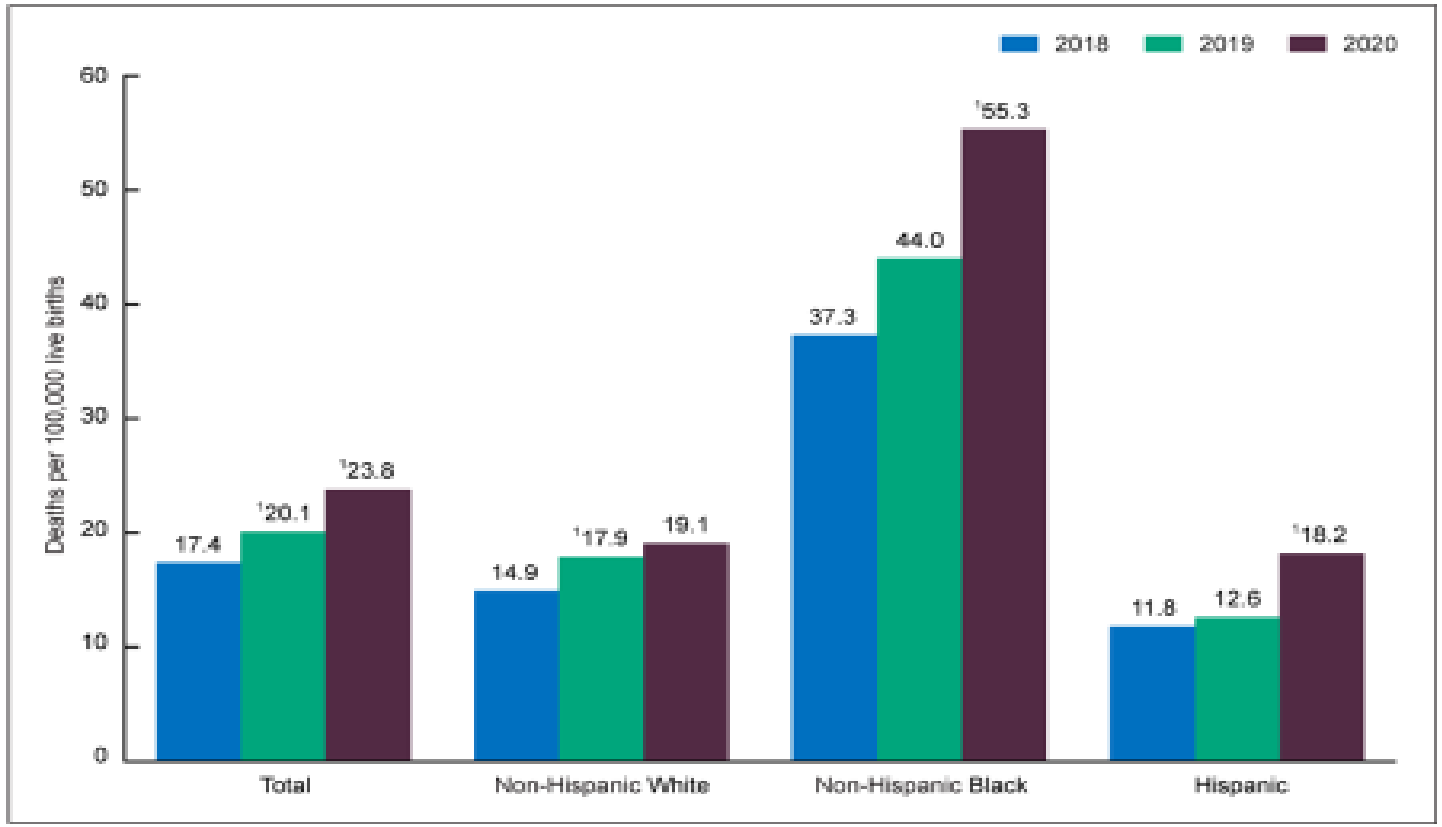
Prosperity Now. "The Road to Zero Wealth: How the Racial Wealth Divide Is Hollowing Out America's Middle Class," Page 5.

THE PREVALENCE AND SEVERITY OF CHRONIC DISEASES IN POPULATIONS OF COLOR

African-American patients tend to receive lower-quality health care, including treatments for cancer, HIV, prenatal care, diabetes, and preventive care.

Maternal Death rates by Race

Black women – 2.9 times higher than non-Hispanic White women

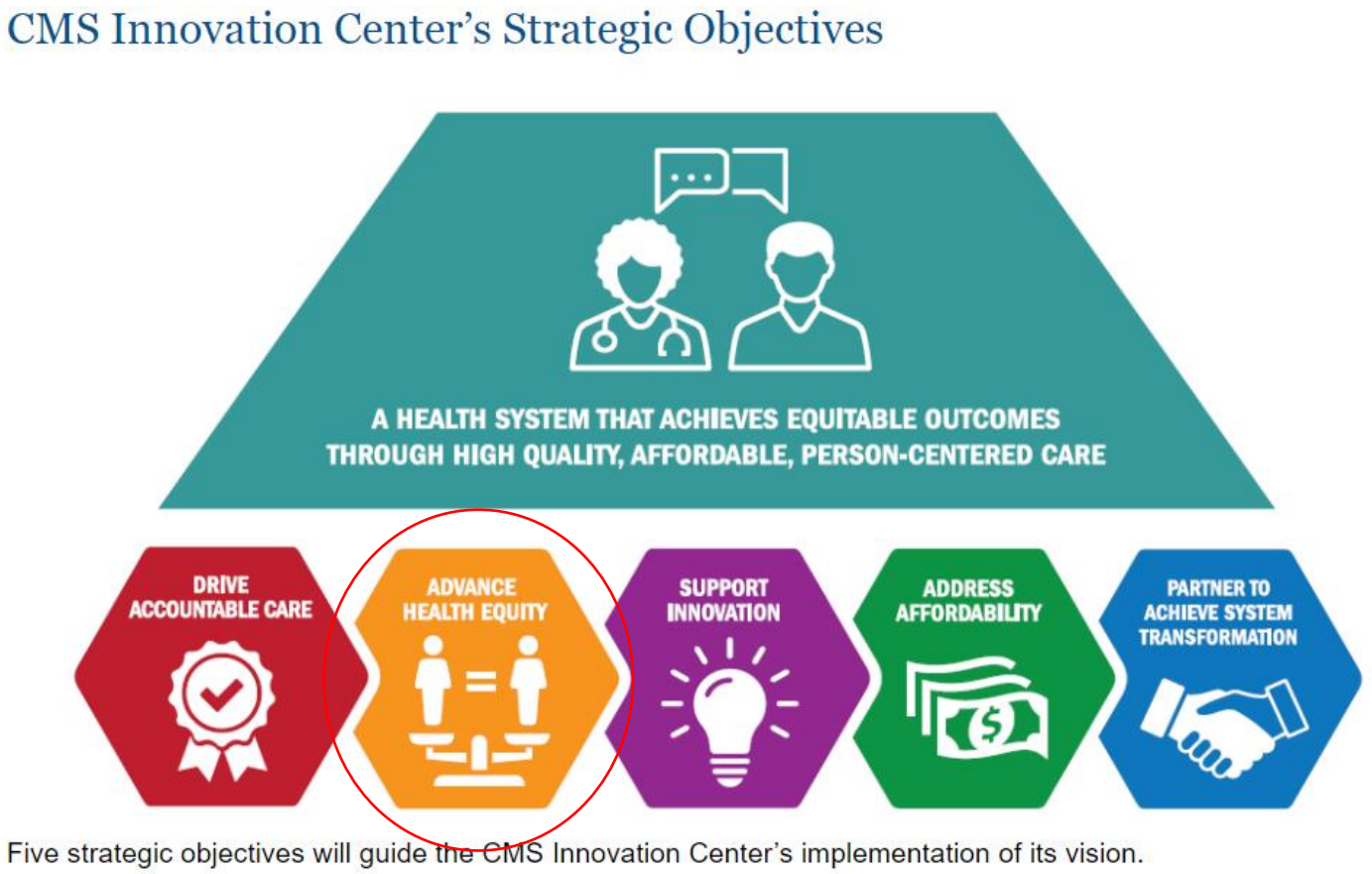


†Statistically significant increase in rate from previous year ($p < 0.05$).
NOTE: Race groups are single race.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

VALUE-BASED PAYMENT WILL BE THE VEHICLE FOR IMPROVING EQUITY

Equity in health cannot be attained without models for value-based payment.

A solution to health inequity is the value-based care movement, as future payment models will require that all healthcare organizations demonstrate health equity outcomes.



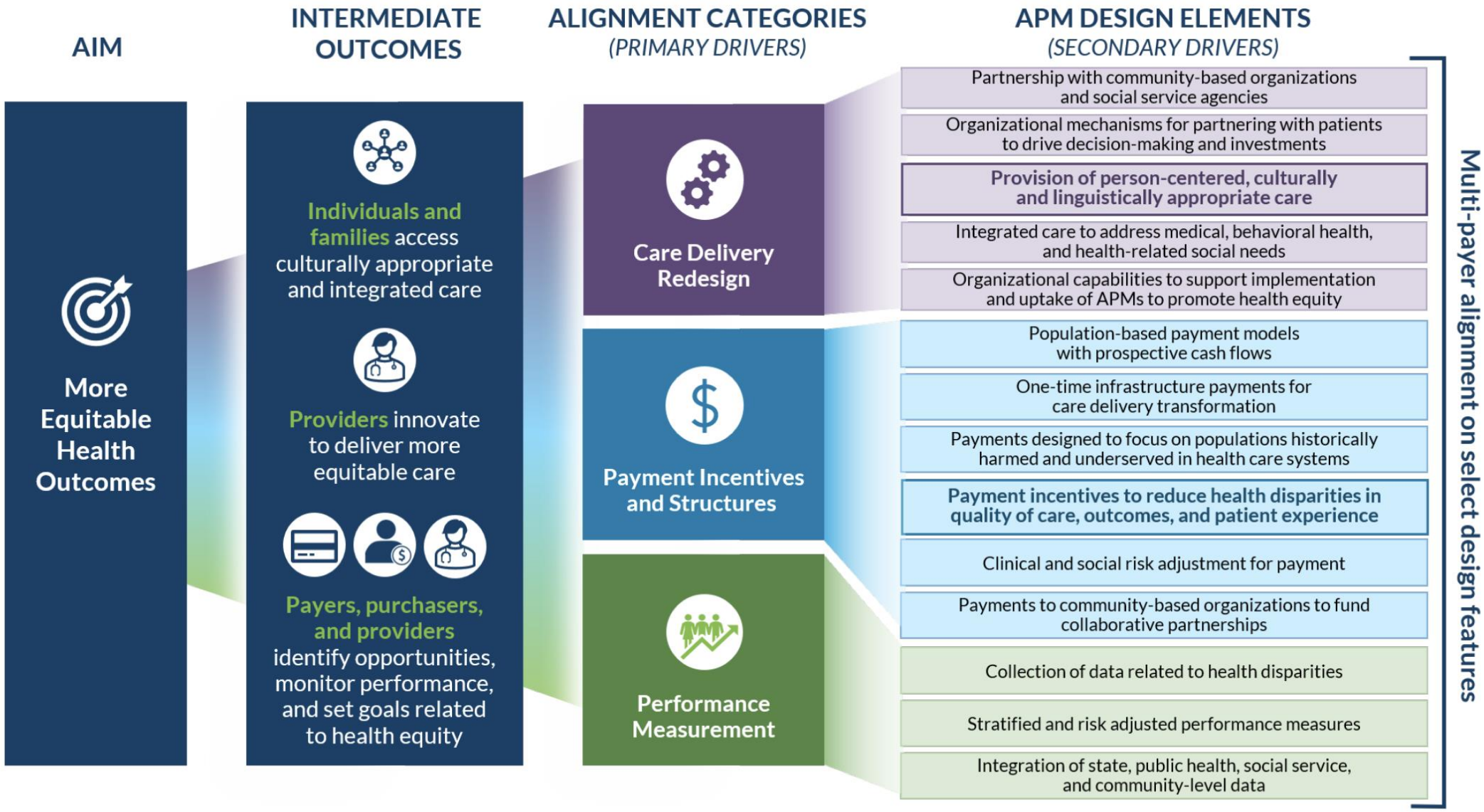


Figure 4: Theory of Change for How APMs Advance Health Equity

CMMI GOAL: ADVANCE HEALTH EQUITY

Goal 2: Advance Health Equity

Embed health equity in all CMS models & increase focus on underserved populations.

Progress Measured by:

- Participants are required to collect & report the data for their beneficiaries' demographic, social determinants of health, social needs
- All new models will include patients from historically underserved populations and safety-net providers

- The CMS Innovation Center has stated definitively over these last few months that it plans to embed health equity within the performance measurement of alternative payment models to increase focus on underserved populations.

- Address the lack of self-reported data on race, ethnicity, sexual orientation, gender identity, disability status, and veteran status

- There will be a longer-term return horizon on investments in Health Equity reporting infrastructure and SDOH interventions

OPPORTUNITIES FOR VALUE-BASED CARE

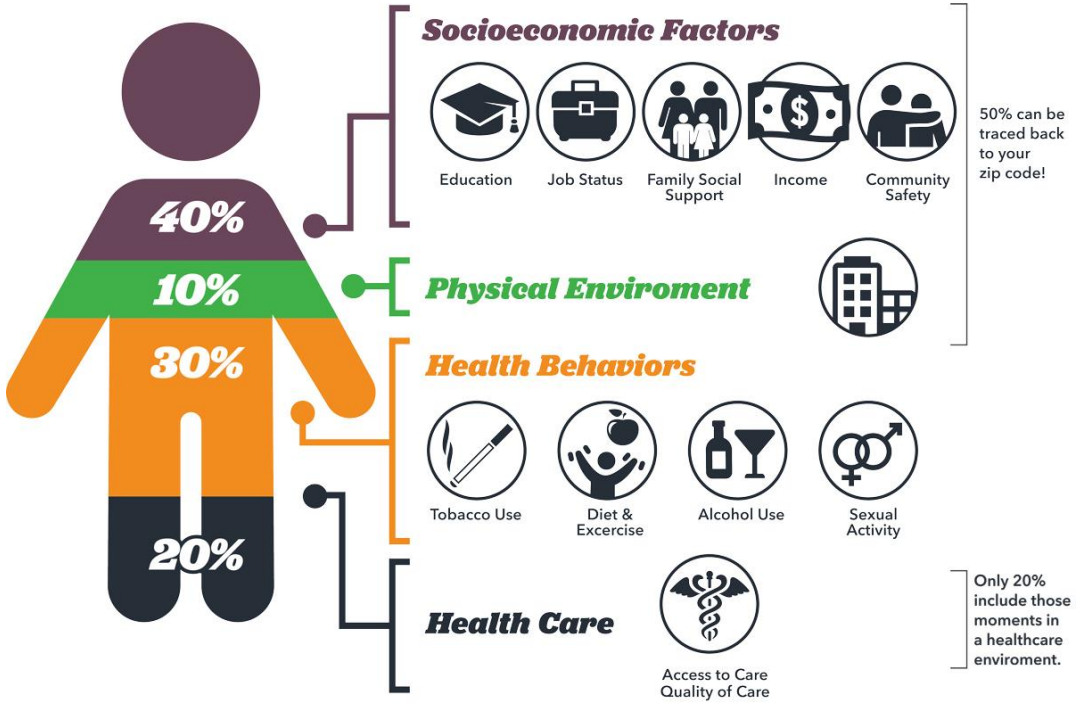
- Social Determinants of Health (SDOH) Interventions
- Asset-Light Models of Care Delivery
- Lessons Learned from COVID-19

SOCIAL DETERMINANTS OF HEALTH

There is so much to address in the SDOH space -- access to quality education, employment, housing, transportation, and nutritious foods all can influence the well-being of a community more than the delivery of healthcare services in and of itself.

The health value movement will lead to a convergence of the traditional healthcare sector and communities where traditional lines of demarcation will soon become blended.

Programs for reskilling the healthcare workforce for the future of value-based health care will focus on the effective deployment of community-based SDOH interventions to improve population health outcomes.



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
HENRY J KAISER FAMILY FOUNDATION

- Premature deaths (up to a 20-25-year life expectancy difference)
- Every 7 minutes a Black person dies prematurely
- At every level of education Whites live longer than Blacks
- Black females with college degrees are more likely to see their babies die than White females that have not finished high-school

PRIMARY FACULTY

David Williams

Florence Sprague Norman and Laura Smart Norman Professor of Public Health

Social and Behavioral Sciences

dwilliam@hsph.harvard.edu

ACO EXEMPLARS IN HEALTH EQUITY

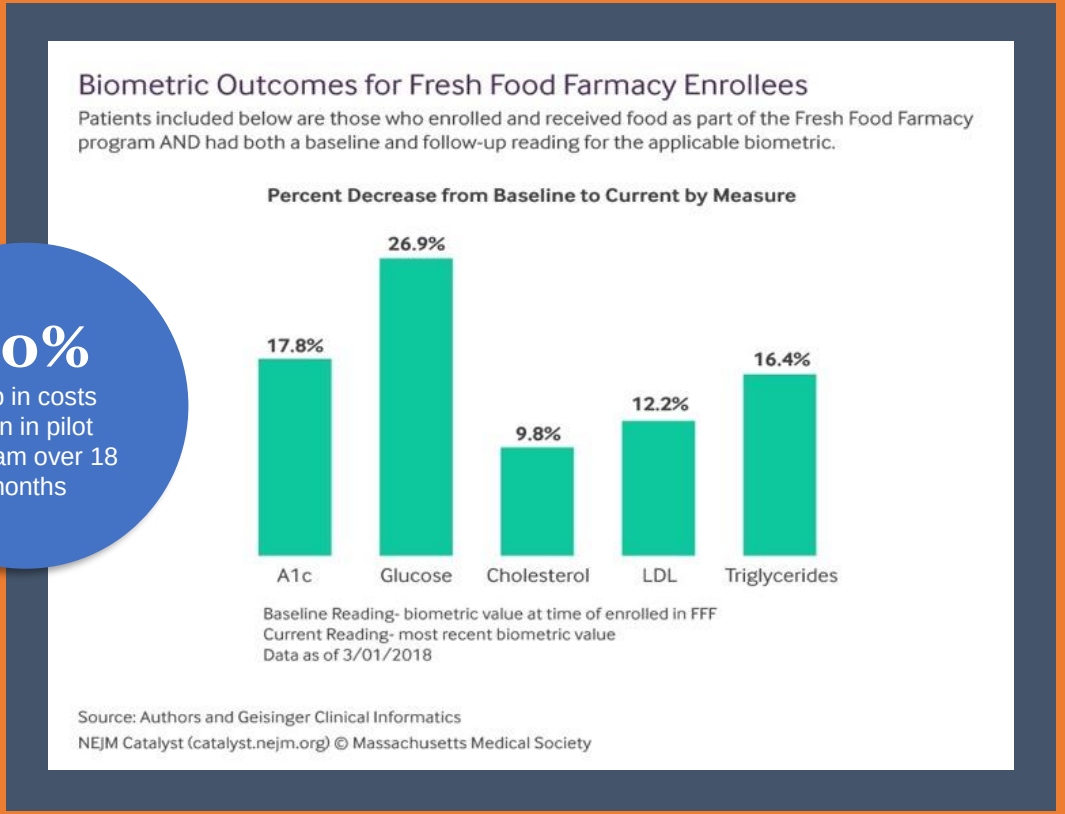
- RGV ACO: Physician-led ACO in McAllen, TX has achieved $74M in aggregate Shared Savings for 9-year period by adopted patient-centered diabetes and SDOH playbook to manage care for supermajority Hispanic population
- CV-CHIP ACO: African-American ACO in Central Virginia has achieved $7.5M in Shared Savings over 4 years
- Aledade: $50M in Shared Savings since 2014, focus on reducing racial disparities in care for patients with sever hypertension

Healthcare Leaders are Implementing Food as Medicine Programs

Geisinger Health System – Fresh Food Farmacy

Patients who are identified as having HBA1C levels greater than 8 and as being food insecure are given a referral by their primary care physician for the Fresh Food Farmacy. Once enrolled, they have access to at least 10 fresh and healthy meals per week and are provided with diabetes education and consultations with dietitians and pharmacists.

80%
drop in costs seen in pilot program over 18 months

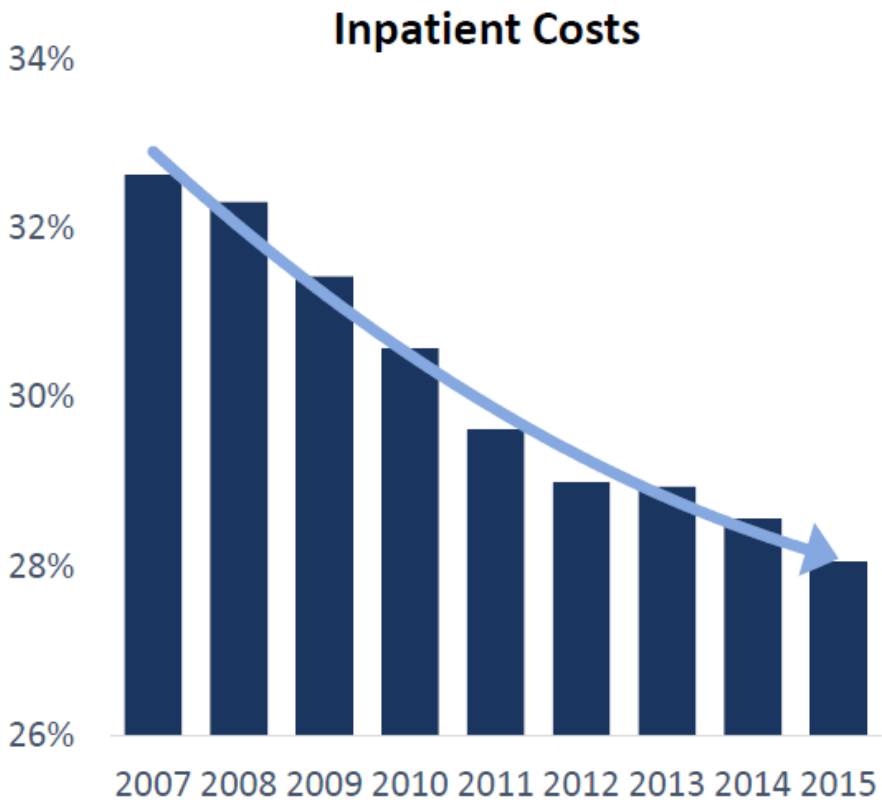


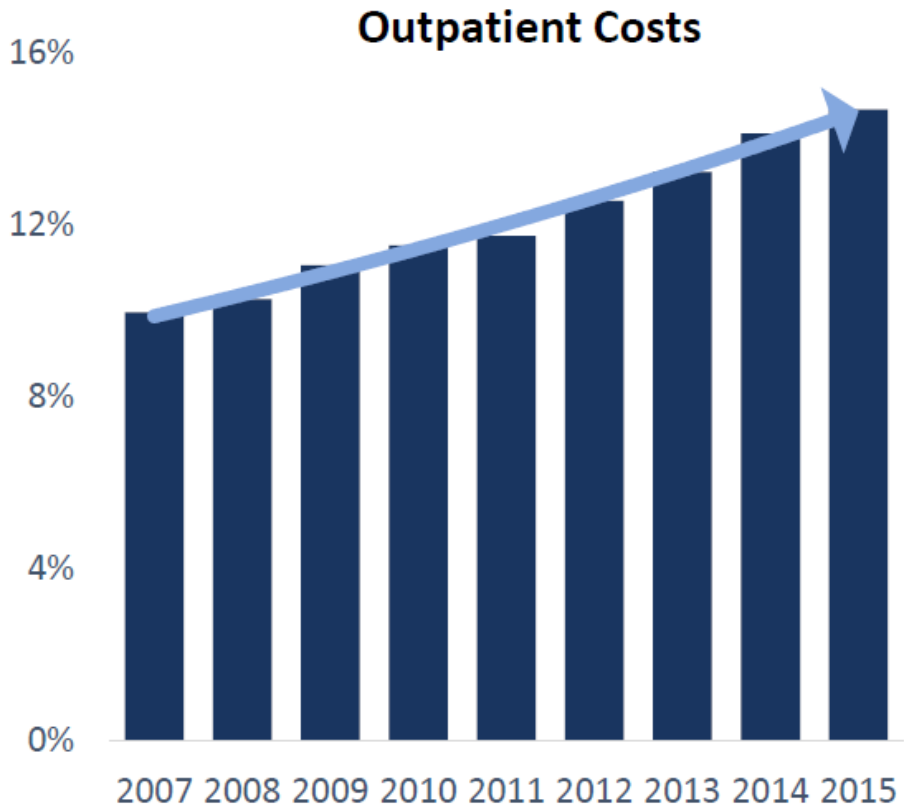
THE MOVE TO ASSET-LIGHT MODELS OF CARE DELIVERY

- The workforce will require new skills to provide more care virtually or in the patient's home as institutional care moves to alternative settings.
- The aging Baby Boomer population will overwhelm hospitals with admissions for chronic disease exacerbations in the next few years, their care reimbursed at public-payer rates. Additionally, we will see an inevitable shift of various higher margin procedures to the ambulatory care setting.
- These factors, coupled with the constraints of current cost and labor structures, will force hospitals to pursue asset-light care models that can capitalize on alternative care settings and value-based payment.

CARE IS SHIFTING AND WILL CONTINUE TO SHIFT

Health systems will continue to become more dependent on outpatient revenue.





Standardized Costs as a % of Total Standardized Costs

What's driving changes in utilization patterns?

- Advances in technology
- Regulatory changes allowing/encouraging outpatient surgeries
- Alternative payment models involving total cost of care

MOVING TO ASSET-LIGHT CARE

- Ochsner Health – investment in care capabilities and realignment of incentives within large employed physician group are keys to success.
- SoNE Health – Clinical integration with recognition that the future state of hospitals will be the inevitable shift of care to ambulatory settings
- Jefferson Health – Costly sick care will give way to affordable, personalized, and preemptive care with genomic sensors and AI-based digital therapies
- Mary Washington Healthcare – created an in-home assessment opportunity in their own Medicare Advantage Plan (40% patient engagement level) and continued progression to virtualized, asset-light care delivery models
- Geisinger Health: Geisinger-At-Home is a national example of home-based care delivery, and their MyCode Community Health Initiative is an innovation for precision health and genomic-driven care

LESSONS LEARNED FROM COVID-19

- Expands opportunities to leverage telehealth
- Makes plain that FFS is not conducive to population health
- Spotlights the need to address more directly, and holistically, chronic conditions
- Inspires a renewed commitment to strategic partnerships and investment in public health
- Emphasizes the importance of prevention (and not just the treatment) of chronic and underlying conditions

BURNOUT AND MORAL INJURY

<u>Provider and Nurse Burnout will create a value-based revival in medicine</u>:

- Nearly half of US doctors suffer from extreme burnout, leading to emotional exhaustion, cynicism, loss of enthusiasm and joy in in their work, as well as increasing detachment from their patients and their patient's needs.
- Essentially, in FFS with our quest for economies of scale and process standardization, healthcare organizations have largely become monolithic, rigid and impersonal, and provider empathy has been sapped. And now we're seeing severe results – physician burnout and moral injury have led to the highest suicide rates among all professions.
- A move to value-based care can ameliorate moral injury in the medical profession.

WORKFORCE RESILIENCE TO IMPROVE PATIENT OUTCOMES

- Healthcare workforce burnout impacts patient outcomes; studies demonstrate poor wellbeing and moderate to high levels of burnout are associated with poor patient safety outcomes such as medical errors
- Creating resources and mechanisms to support the workforce experiencing burnout and assisting providers in developing skills to promote personal well-being and resiliency is critical for the health and safety of the populations of patients served across the nation.

TEAM-BASED CARE AND THE VALUE WORKFORCE

- Physicians
- Nurse Practitioners
- Physician Assistants
- Nurses
- Medical assistants
- Pharmacists
- Behavioral health specialists
- Peer Counselors
- Social workers
- Physical therapists
- Dieticians
- Care coordinators
- Data Analysts

THE PATH TO EQUITY WILL REQUIRE NEW WORKFORCE SKILLS

Figure 1. CMS Path to Equity

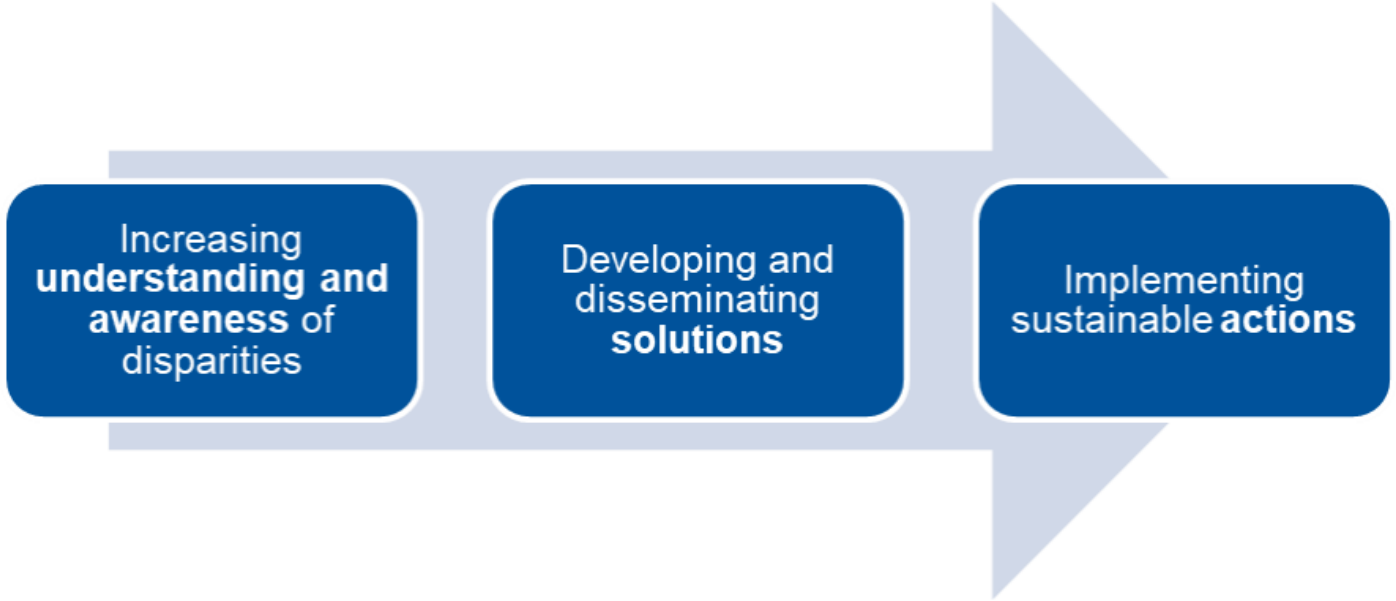


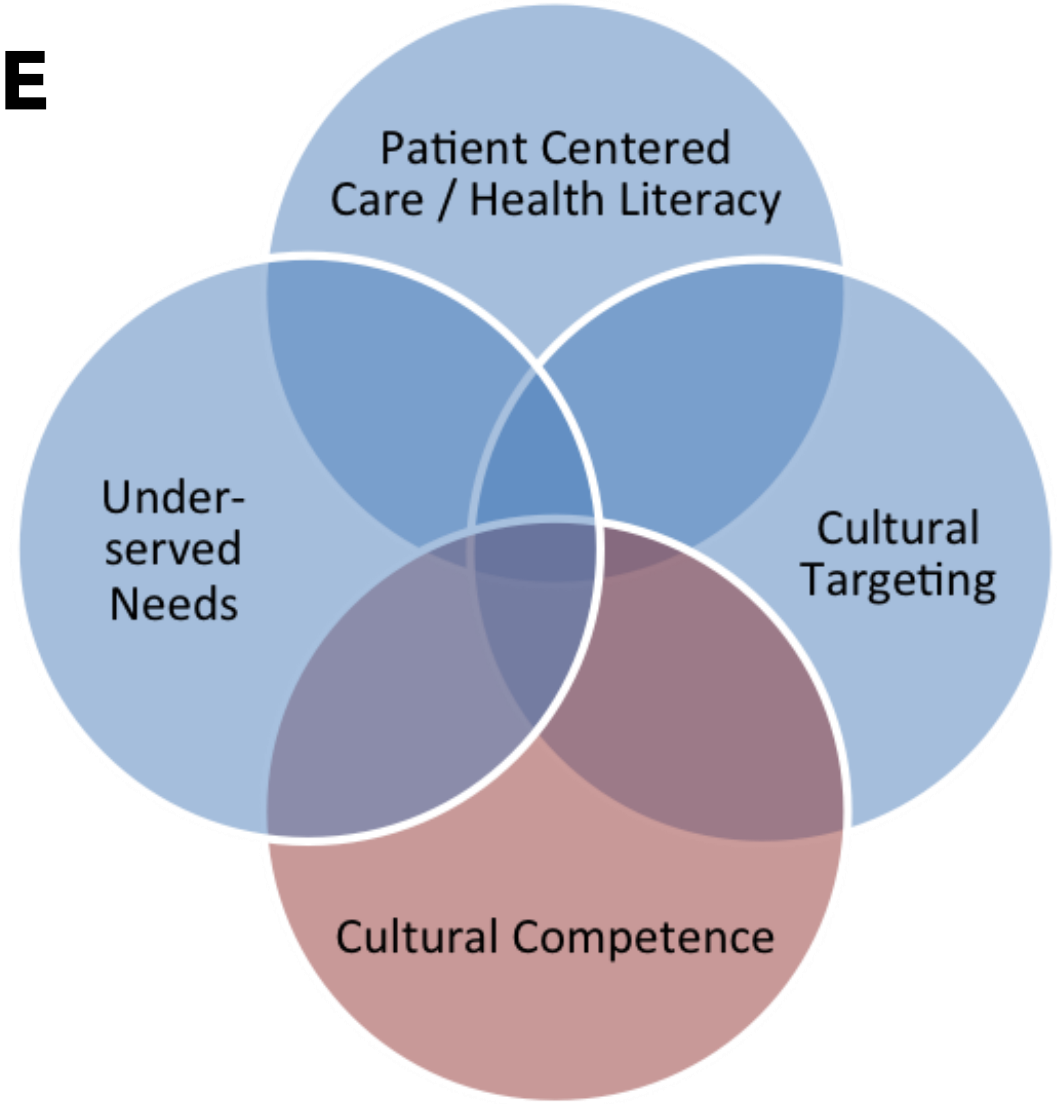
Figure 2. CMS Equity Plan for Medicare: Priority Areas

- **Priority 1:** Expand the Collection, Reporting, and Analysis of Standardized Data
- **Priority 2:** Evaluate Disparities Impacts and Integrate Equity Solutions across CMS Programs
- **Priority 3:** Develop and Disseminate Promising Approaches to Reduce Health Disparities
- **Priority 4:** Increase the Ability of the Health Care Workforce to Meet the Needs of Vulnerable Populations
- **Priority 5:** Improve Communication and Language Access for Individuals with Limited English Proficiency and Persons with Disabilities
- **Priority 6:** Increase Physical Accessibility of Health Care Facilities

THE NEED FOR CULTURAL COMPETENCE IN THE WORKFORCE

Equity in health cannot happen without equity in access and attainment of education for underserved learner populations in the health professions.

A solution to health inequity is a well-trained, qualified, culturally-competent workforce that mirrors the diverse population it serves.



THE NEED FOR RESKILLING AND UPSKILLING AT SCALE

Equity in health cannot happen without reskilling and upskilling the workforce at scale.

A solution to health inequity is reskilling and upskilling of the workforce through scalable educational and training programs that can provide pathways to establishing competency in population health and health equity.

VALUE-BASED CARE COMPETENCIES

The Health Value Atlas is a collection of over 160 competencies organized into a logical sequence to aide providers in their transformation to value-based care.

Representatives from across the industry were convened by the Institute to identify the competencies needed for provider organizations to successfully navigate value-based care.

INSTITUTE FOR ADVANCING HEALTH VALUE
AT WESTERN GOVERNORS UNIVERSITY

PERSON-FOCUSED CAPABILITIES NEEDED FOR SUCCESS IN VALUE-BASED CARE

Leadership and Structure

- Leadership, staff focus on patient value goals – mission and culture
- Organizational structure, staffing, and networks/partnerships aligned with mission and culture

IT/ Data and Analytics

- Aligned IT infrastructure including clinical, financial, and patient data
- Key data sharing including patients
- Analytics to track progress on key care reform goals (dashboard)
- Capacity to simulate and assess effects of reforms on patient care, net revenues

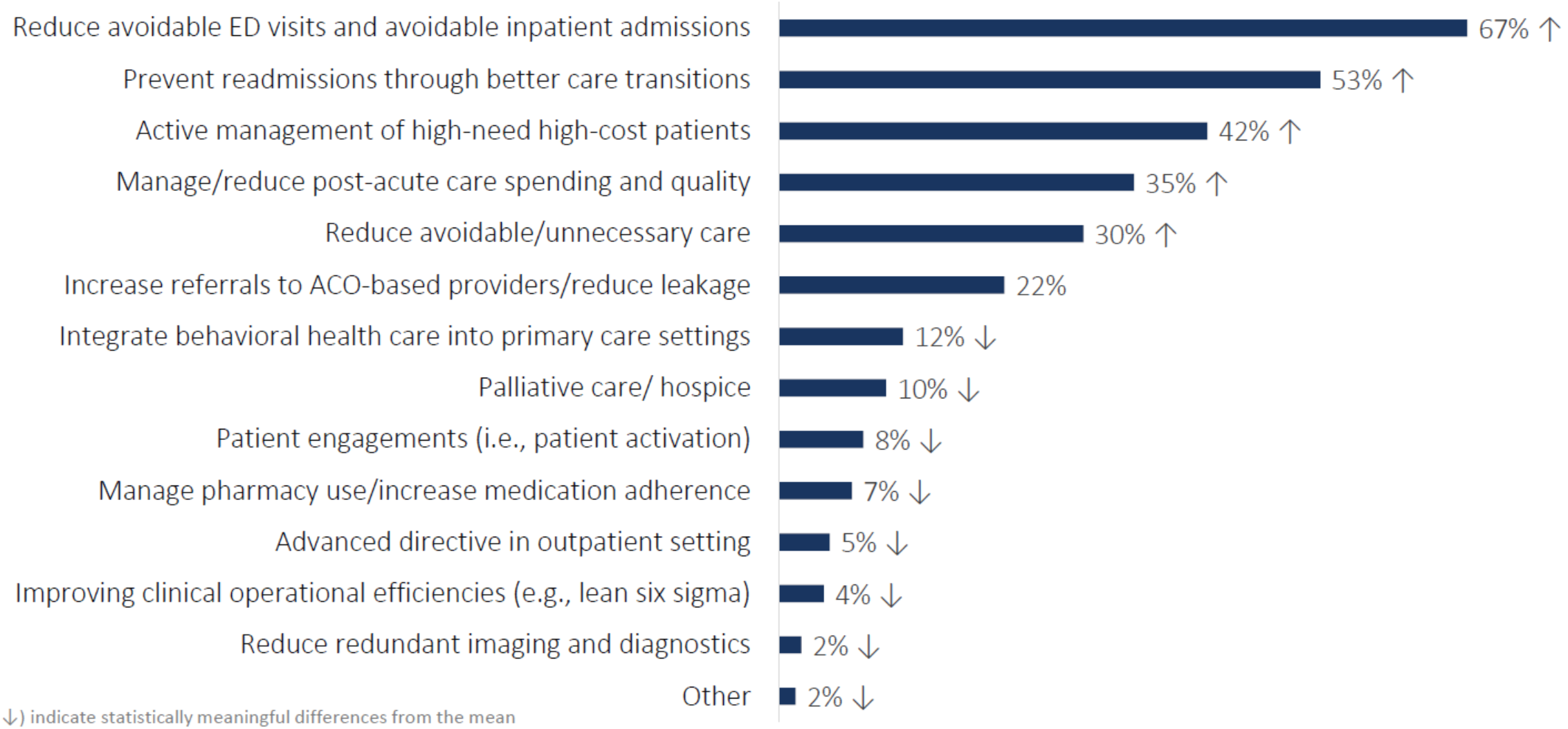
Care Delivery

- Person centered care support, pathways, engagement – more convenient and efficient "shift left"
- Longitudinal care coordination and teams
- Continuous quality and safety improvement

Finance

- Adequate capital to support new care models, risk
- Financial tracking and reform modeling
- Clinician/staff compensation and risk/savings distribution
- Payments for costly medical technologies aligned with value
- Network contracting to support effective care coordination

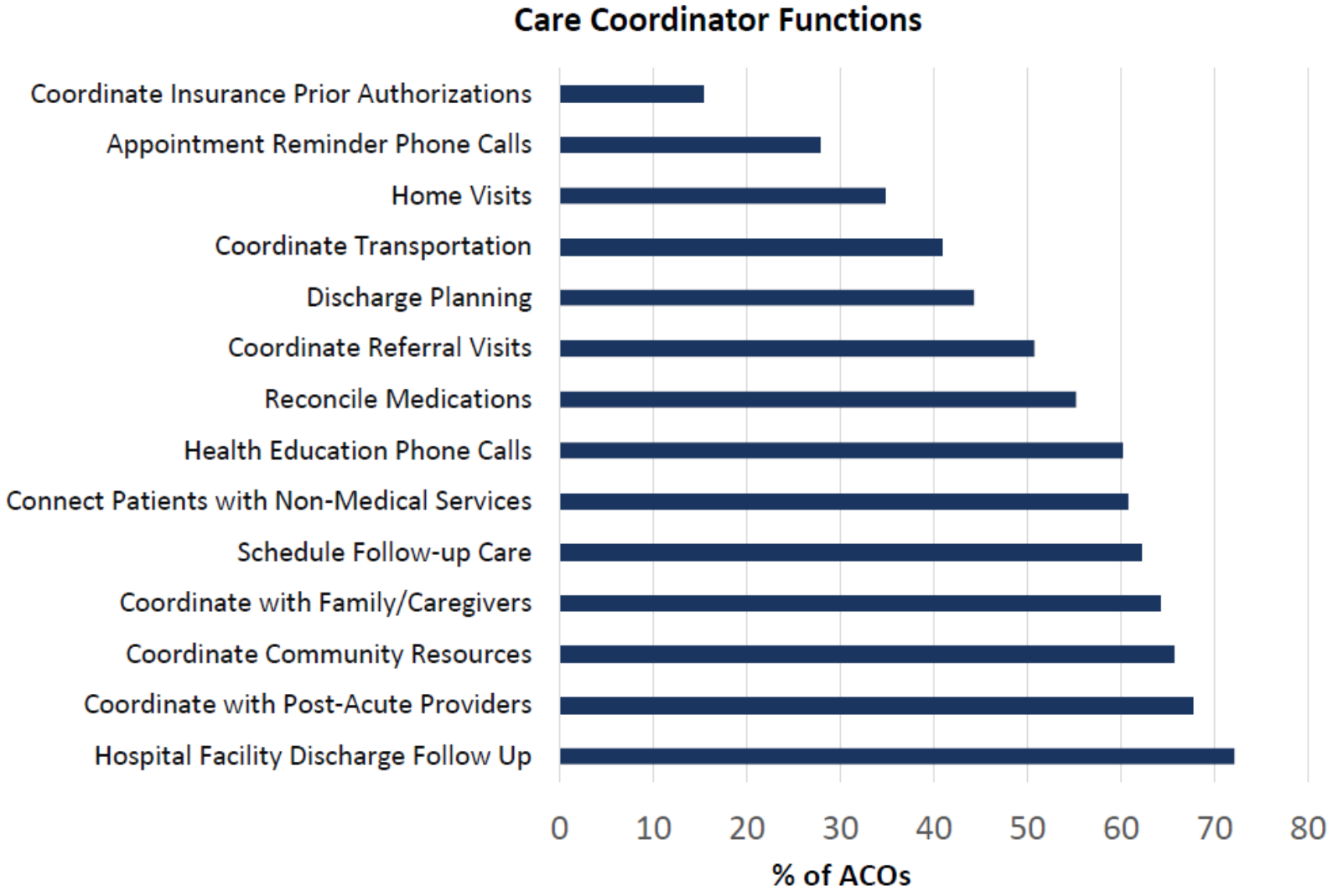
TOP PRIORITIES FOR IMPROVING EFFICIENCY AND REDUCING TOTAL COSTS

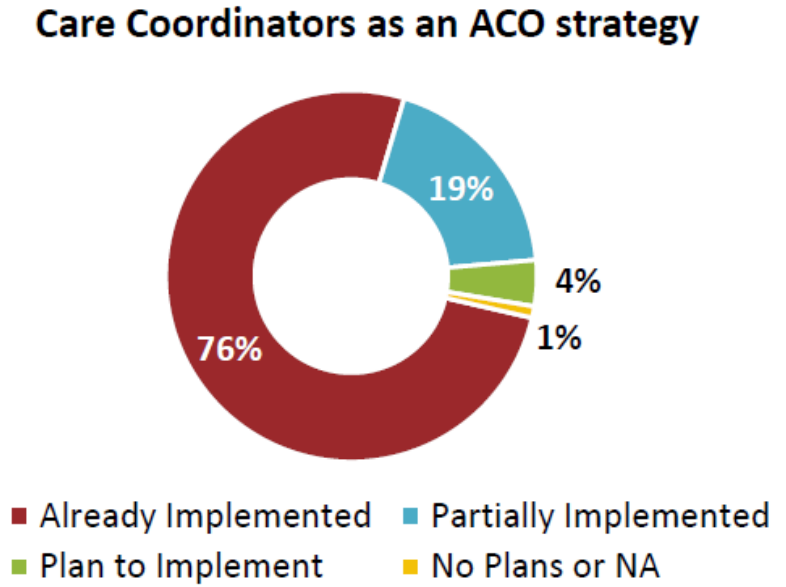


Arrows (↑↓) indicate statistically meaningful differences from the mean

2018 Annual ACO Survey, Leavitt Partners and National Association of ACOs

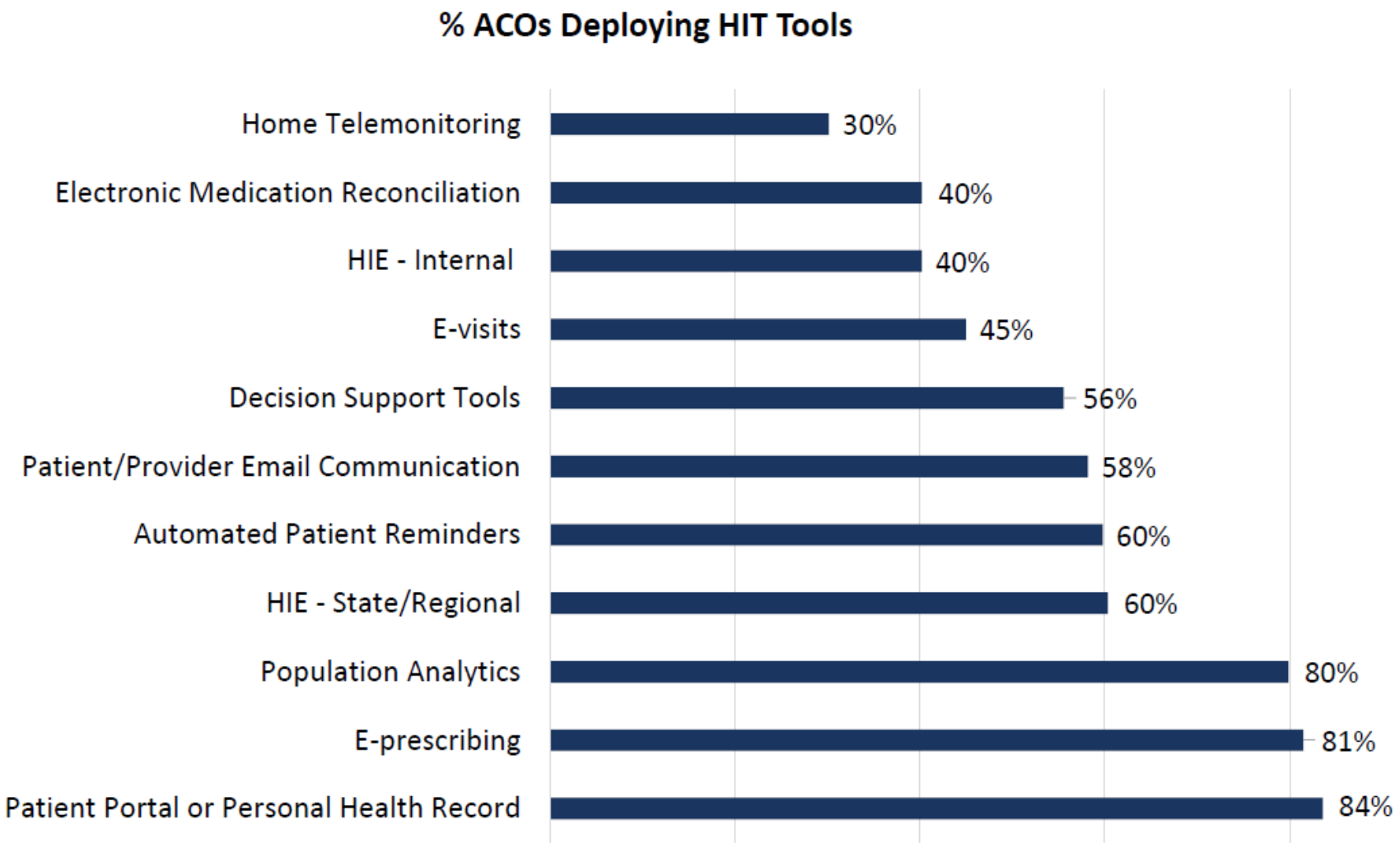
THOUGH ALMOST ALL ACOS UTILIZE AND VALUE CARE COORDINATORS





87% of ACOs say care coordinators are very important or extremely important to the success of the ACO

WHAT TECHNOLOGIES ARE ACOS PURCHASING?



13

Average number of EMR platforms per ACO

$600,000

Average operating expenses for health IT

Find the complete Case Study Brief library at: www.accountablecarelc.org/case-study-briefs

PATIENT ENGAGEMENT & CONSUMERISM

Consumerism will continue to drive and shape health care delivery – accountability to and engagement with the consumer is key.

Providers are responding to patients' increasing consumeristic behavior in a variety of ways, with mixed results. Many digital tools have been created to improve the patient experience, but relatively few are utilized.

Relatedly, retail clinics are gaining popularity as more consumers favor convenient, low-cost alternatives to traditional primary care.

Walmart care clinic
quality healthcare at an everyday low price

CVS minute clinic

Walgreens

NOVANT HEALTH

Allina Health

CAPITAL INVESTMENT TRENDS

- **The valuation of private equity deals in the US health care sector is nearly $100 billion dollars**—a twentyfold increase from 2000 (when it was less than $5 billion). Before COVID-19, we were already seeing mass provider consolidation, expansive funding in digital health, and significant M&A activity…and the appetite for capital investment in healthcare has only increased in recent years.
- The number of healthcare services deals among institutional investors has more than doubled in the last six years, with 356 deals in 2015 and a whopping 733 deals in 2021. Investor interest continues to grow along with healthcare spending itself, with national spending on health services jumping 9.7% last year, topping $4.1 trillion.
- ***One in five physician transactions involved primary care practices—a signal that investors are banking on profits to be made in the shift to value-based care models.*** A big driver of this is groups taking full-risk Medicare Advantage where practices are getting acquired by investors paying anywhere from $5k - $10k per MA life!

IMPACT OF M&A ON VALUE TRANSFORMATION

Large employers, payers, and even tech companies are forming unique partnerships to enable the delivery of higher-value health care.

HIGH-TOUCH PRIMARY CARE

Value-based contracts – particularly capitated arrangements with MA plans – have proven to be an effective business model for advanced primary care startups.

These organizations prioritize high-touch engagement with patients and caregivers, coordinating their medical and non-medical needs while assuming full risk for patients' total cost of care.

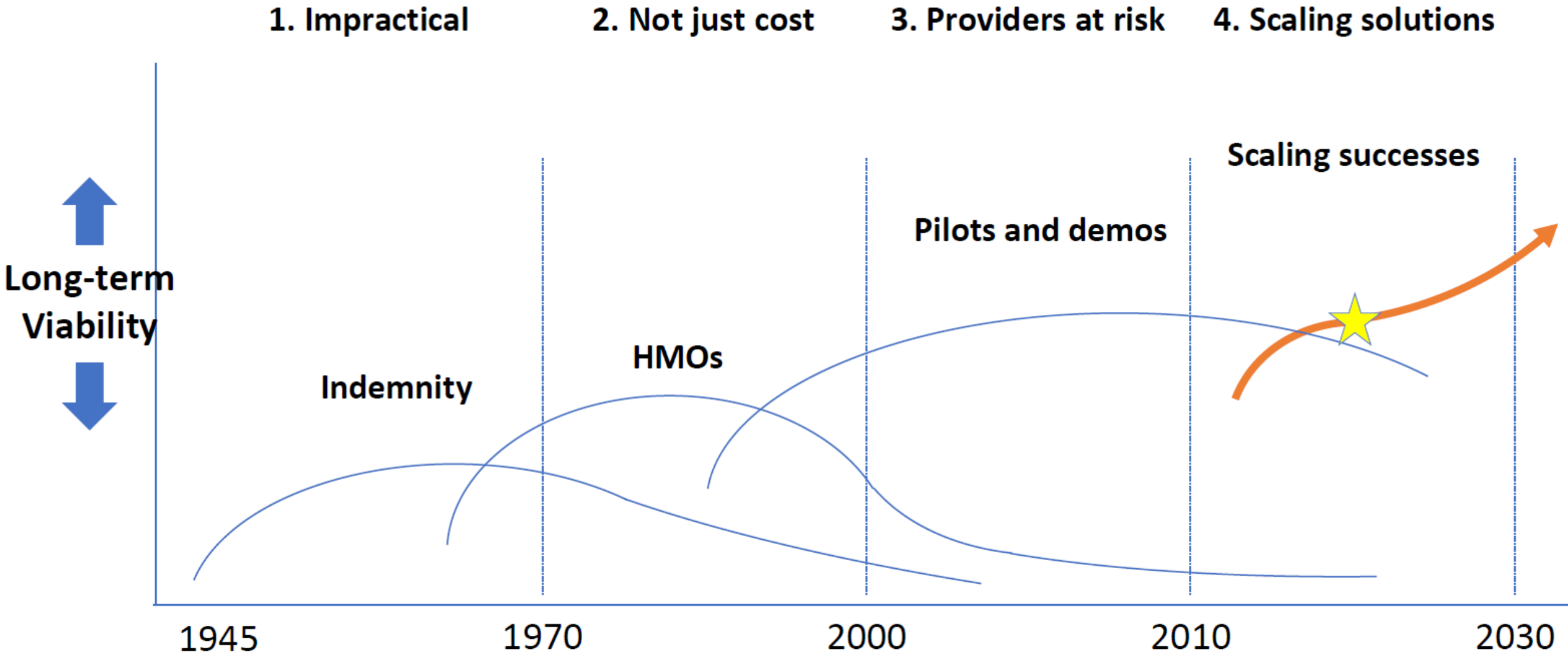
ChenMed

OAK STREET HEALTH

iorahealth

Aledade

WHERE ARE WE GOING? THE ERAS OF ACCOUNTABLE CARE



EXPECTATIONS FOR THE FUTURE

- Mandated APMs from the federal government
- Consumerism will drive and shape care delivery
- New technologies will scale (e.g. telehealth, AI, wearables, RPM)
- Clinical workforce deficits will create supply/demand imbalances
- Improved interoperability to enable data liquidity to improve population health outcomes
- Upstream SDOH will become the new frontier
- Delivery system and Employer purchasing power will continue to aggregate horizontally
- Industry-wide vertical integration
- Supply chain disrupters will seek to provide greater transparency
- Equity focus will be top priority for federal government

Join the **Value Movement!**

INSTITUTE FOR ADVANCING HEALTH VALUE
AT WESTERN GOVERNORS UNIVERSITY

Eric Weaver

eric.weaver@wgu.edu