hfma greater heartland

THE FUTURE OF VALUE-BASED CARE (VBC) AND MANAGED CARE CONTRACT STRATEGIES

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HFMA Greater Heartland
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Kansas City, MO

BDO

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- **30+ years experience** at senior levels (Maxicare, FHP, United Healthcare, CIGNA, Advocate Healthcare, Rush Health, PBC Advisors)
- **Focused experience in:** Payor/Provider Contracting, Value-Based Care Models, Provider Sponsored Health Plans, Medicaid Reform, Expert Witness Work
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Agenda for Today

Introduction & Learning Objectives

Current State of Affairs What's Happening in the Industry

Evolving & Emerging Value-Based Care (VBC) & Managed Care Contracting Models

Drivers in Next Generation VBC

A Case Study Integrating Value-Based Care (VBC) & Population Health Management (PHM)

The Path Forward

Session Summary & Learning Objectives

The US healthcare system has been dramatically impacted by the COVID-19 pandemic. Going into the pandemic, managed care contracting strategies were focused transitioning to innovative Value- Based Care (VBC) models embraced by payers, providers and patients. As a result of the pandemic, there are significant impacts to existing VBC models and the payer/provider contracts that frame these programs.

Additionally, as a result of the rapidly changing U.S. healthcare system, there are additional core issues and objectives to consider in VBC strategies going forward, especially Patient Engagement. Our session will detail the implications of the COVID-19 pandemic on VBC models and Managed Care Contracts and provide foresight into future direction of VBC models and new challenges and opportunities in payer/provider managed care contract models.

1	Understand the implications the COVID-19 pandemic has had on Value-Based Care (VBC) models and the managed care contracts that detail these programs.
2	Review the economic areas of managed care contracts requiring most consideration in assessing impact and setting the path forward.
3	Exploring the short term and longer-term opportunities and challenges in post-pandemic VBC and managed care contracting transformation.
4	Glean practical tactics and ideas to implement in your organization.

CURRENT STATE OF AFFAIRS

What's Happening in the Industry

Key Transformative Forces in U.S. Healthcare Today

- Stabilizing and Moving Forward from Pandemic to Endemic
- Staffing & Talent: Labor Shortages
- Supply Chain Challenges
- Cost Increases at a time we are focused on Total Cost of Care
- Changes in Reimbursement
- Changes in Healthcare Delivery models
- Revenue Cycle and EMR Integrations and Transformations
- Advancing Health Equity: Discontinuing a healthcare system of “haves” and “have nots”
- Site Of Service Differentials and Steerage
- Impact of M&A Transactions and Private Equity
- Impact of mega-payers and mega health systems
- State-level Medicaid Reform

Resilience Through Distress

The pandemic brought a financial cliff to many healthcare organizations. It also created new clarity on the importance of liquidity and what are truly essential services and operational costs.

CASH

44% say liquidity will be a challenge in 2021

COSTS

34% will pursue a strategic cost reduction

CAPITAL

90% plan to seek outside capital

CONSOLIDATION

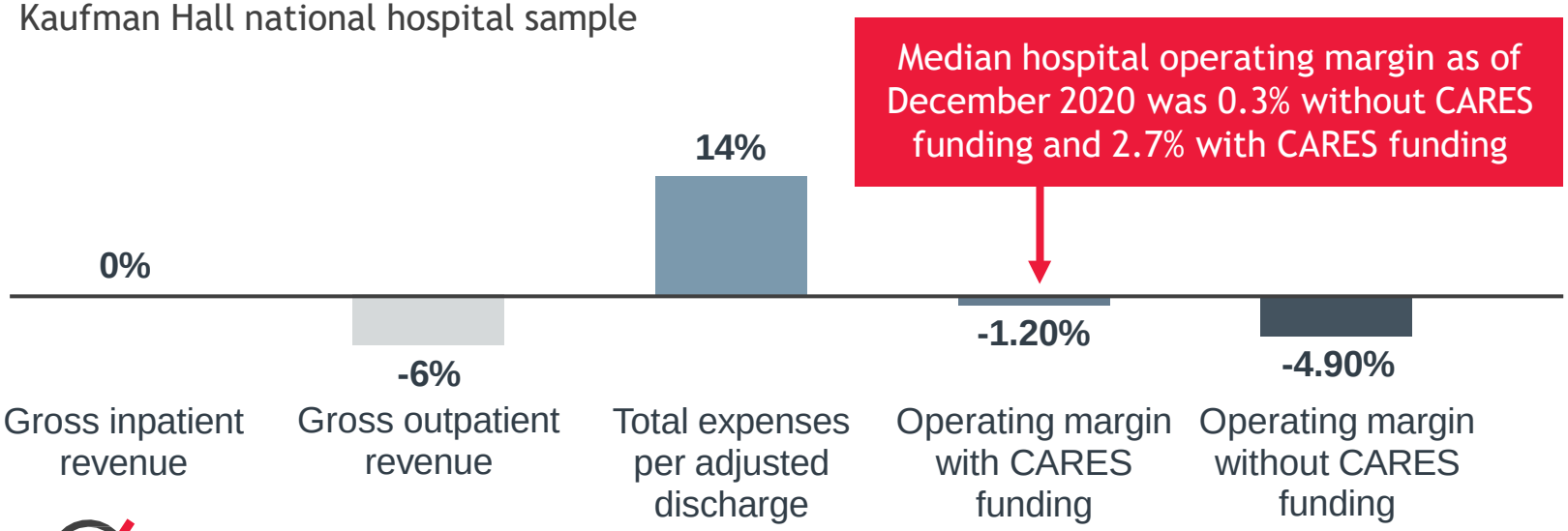
34% will look to optimize their real estate footprint

While the pandemic exacerbated some areas of distress, it's important to look critically at issues that may continue to present problems when the crisis abates. Unwieldy administrative structures, high reliance on Medicaid funding and lack of affiliation with a healthcare system should be addressed as part of any reorganization strategy.

2021 Margin Pressures Expanding in 2022-2023

Median percentage change in 2020 from 2019 in hospital revenue, expenses, and margins

- Kaufman Hall national hospital sample



DATA SPOTLIGHT

$22.3B Estimated loss of revenue from cancelling elective surgical cases from March-May 2020 alone

2021-2022 PRESSURES

- Repayment of 2020 loans, Medicare accelerated payments
- Continued suppression of volumes
- Higher supply expenses with longer length of stay, higher patient acuity
- Higher staffing costs
- Stock market and investment income volatility

Source: "National Hospital Flash Report: January 2021," KaufmanHall, January 2021; Bose S et al., "The Cost of Quarantine: Projecting the Financial Impact of Canceled Elective Surgery on the Nation's Hospitals," Annals of Surgery, January 22, 2021.

Foundational Thoughts on Moving from Current State to Future State

Sustained Strain on the Healthcare System

Healthcare needs a financial checkup amid workforce and supply chain struggles.

Big Bets to Build the Future of Care

Healthcare is transforming and partnering to build the future of care.

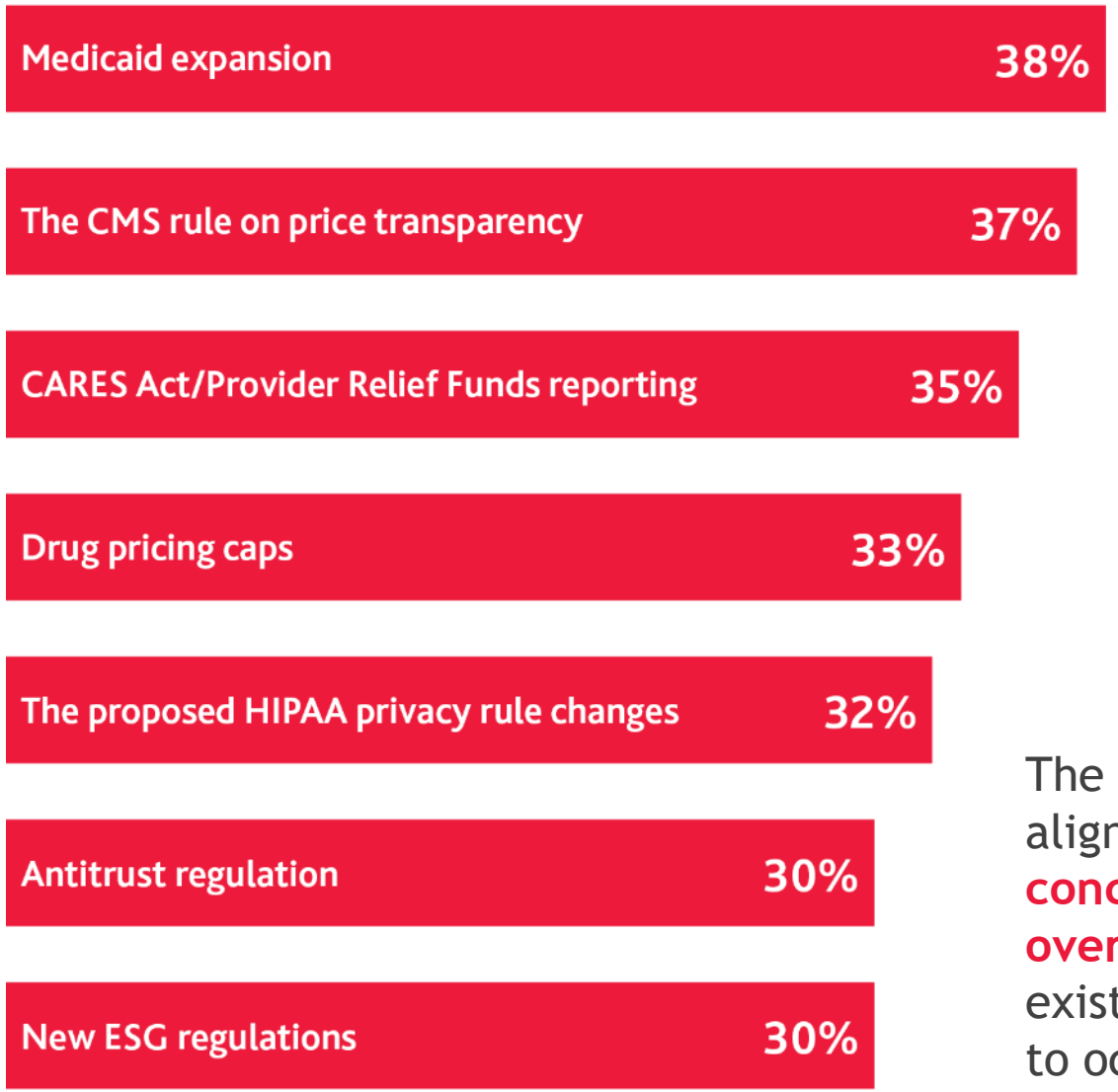
Regulation and Reporting for What's Next

From the Provider Relief Fund to pricing to ESG, reporting requirements are changing.

The Political and Regulatory Framework

- Pandemic has proven an accelerant for
  - Site of Service for care
  - Telemedicine services
  - Focus on Healthcare disparities
- Price Transparency measure
- No Surprise Billing
- Anti-trust actions are increasing – Does consolidation lead to higher costs for consumers?
- Coverage expansion including new Public Option, permanent tax credit increases

Regulatory Change Concerns



The healthcare industry is not aligned on one major risk; rather **concerns are spread nearly equally over several regulatory issues** that exist or are expected to occur in the near future.

PRIVATE EQUITY (PE)

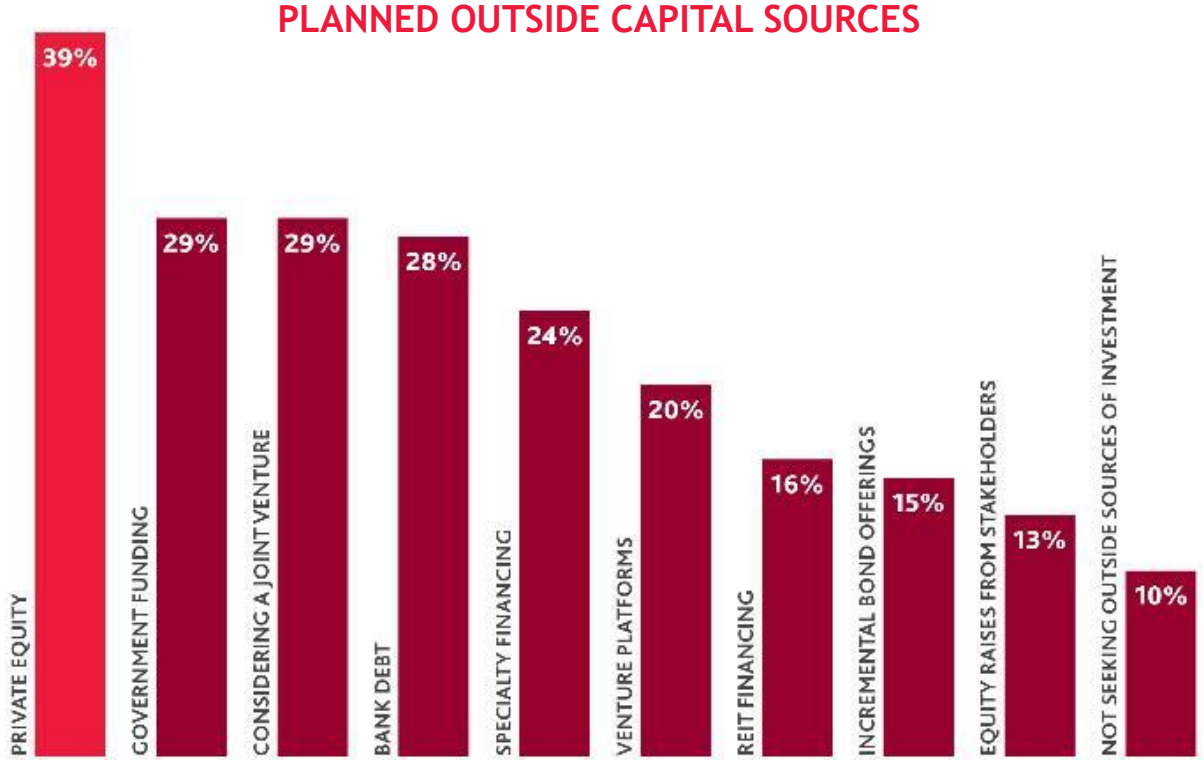
Sees Robust Markets in Healthcare

- Despite coming to a screeching halt at the onset of the pandemic, deal flow rebounded in late Q2 and is **now back in full swing, reflecting a "perfect storm" of pent-up deal demand**.
- Both strategic and private equity backed-companies are looking for inorganic growth opportunities. This is being driven in part by the prominence of healthcare solutions and innovations in the face of COVID-19 and a fear of a potential increase in capital gains tax rates.
- When deal activity resumed in late spring, investors focused on business models that performed well during lockdowns, including **behavioral health, home health, telehealth, women's health and health information technology (HIT)**.
- Companies that provide services for VBC arrangements, especially **Medicaid managed home care companies and autism services companies** that have incorporated telehealth, are expected to see growth.
- Payer services with a VBC component, such as providing **data analytics for population health managemen**t, are expected to thrive.
- Telehealth providers saw their market share grow to around 20-25% of outpatient providers. In 20222 and beyond, growth will come from adding **remote patient monitoring, self-collection testing, and other asynchronous services**.
- Institutional investors will continue to provide historical, if not increased, levels of allocations to healthcare private equity funds.
- The healthcare private equity investment and deal market will remain robust across numerous subsectors and remain "the place to be" for many investors in 2022-2023.

PE

Preferred Source of Capital

Healthcare CFOs give an edge to private equity as a preferred source of capital, followed by government funding.



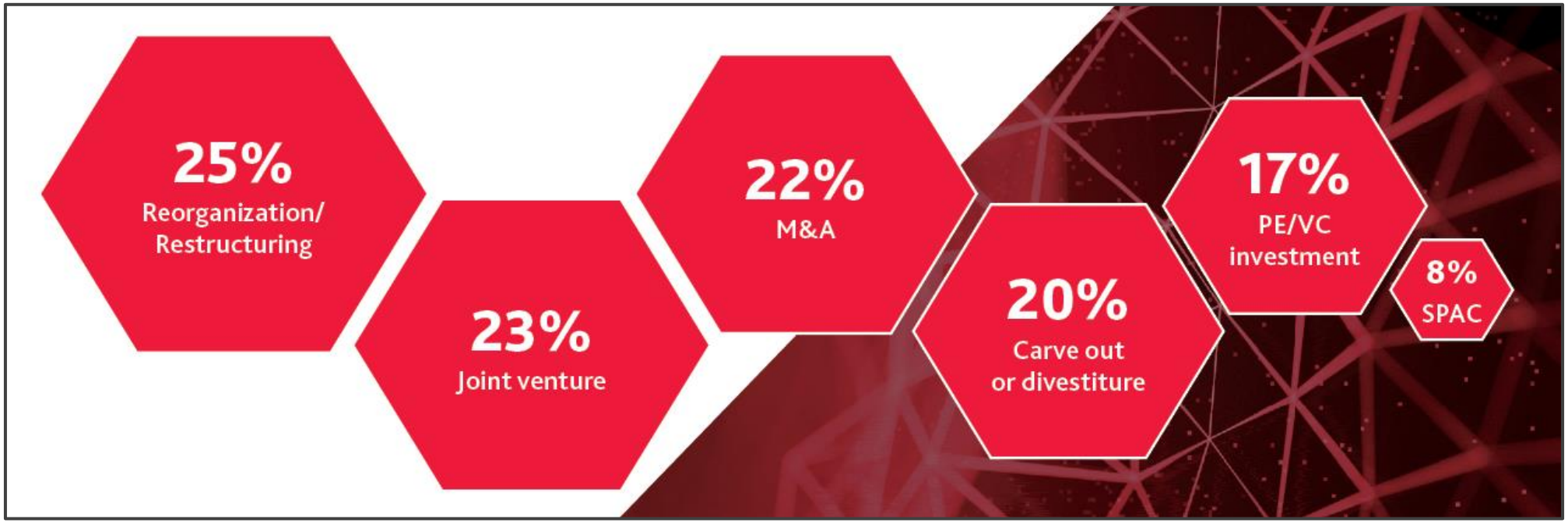
65%

Secured **government funding** in response to the pandemic.*

*As of September 2020

Source: BDO 2021 Healthcare CFO Outlook Survey

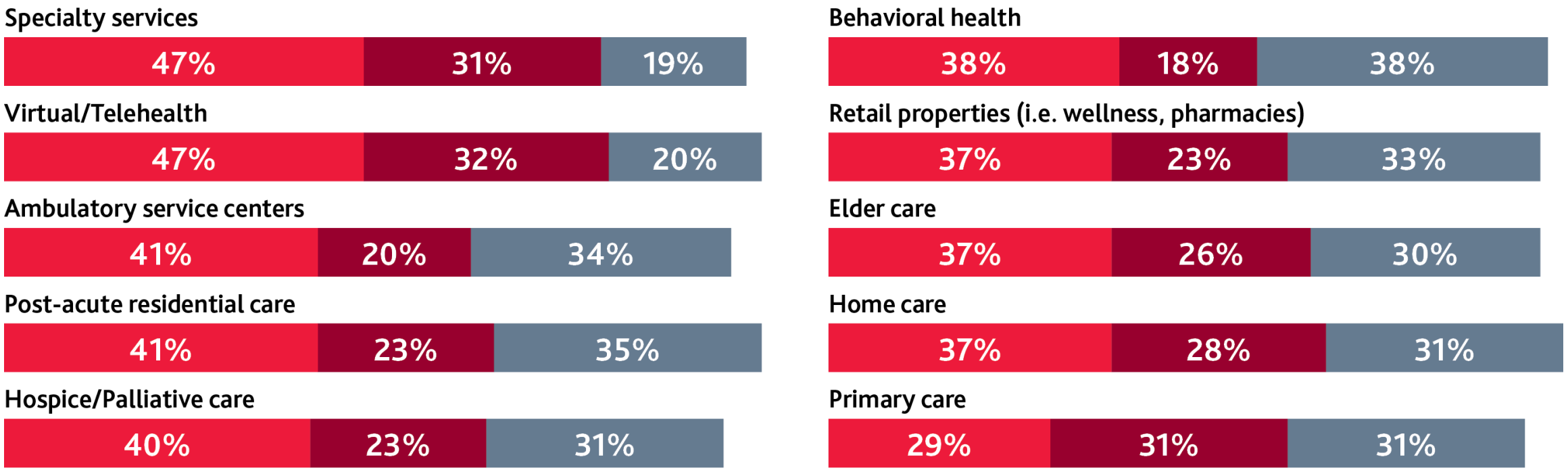
Tracking Transaction Outcomes



62% of healthcare organizations **plan to pursue a transaction** in the next year.
Of those 62%, here's the type of transaction they plan to pursue.

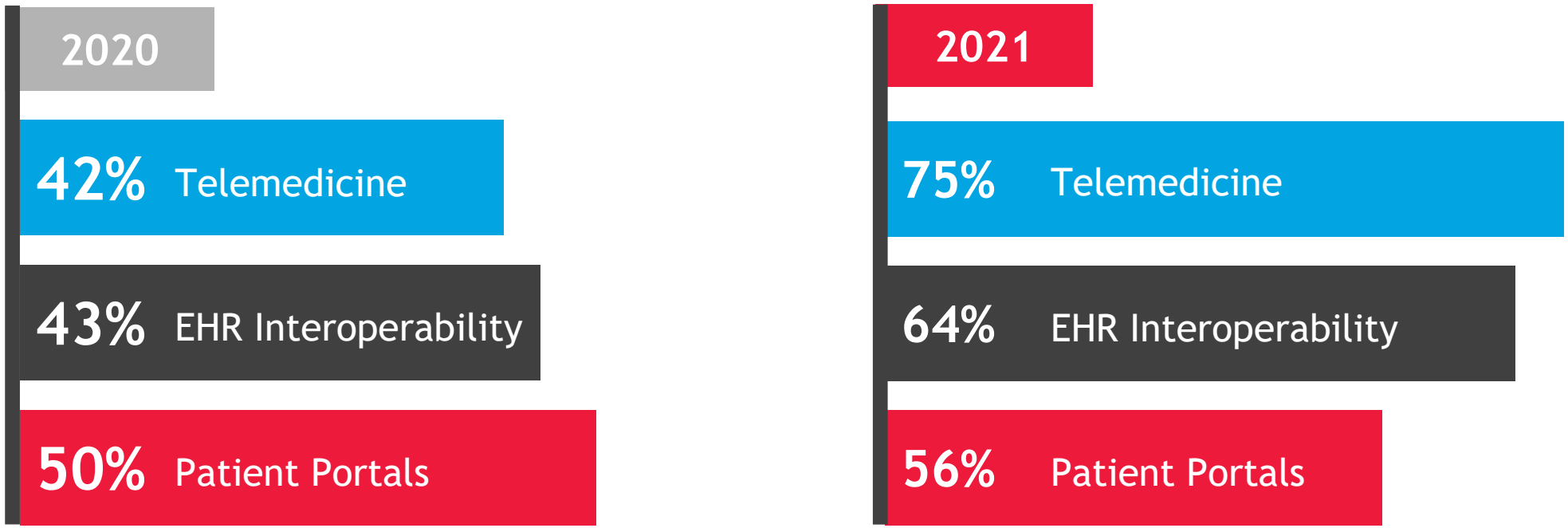
Healthcare Industry Investment Plans in 2022

CARE INVESTMENT PLANS



DIGITAL & DATA

Patient Experience Takes Priority



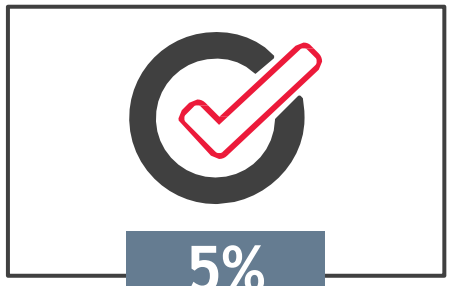
SOURCE: BDO 2021 Healthcare Digital Transformation Survey

Patients are pushing for digital enhancements to the care experience. Telemedicine, remote monitoring and patient portals have gone from “desired” to “expected.” Just like some patients need help adjusting to digital health, healthcare clinicians also need support and training to get the most out of new technologies. Make sure you’re getting input from your clinicians before integrating new technology. Without their insights and usage, your digital solutions could quickly become digital problems.

DIGITAL & DATA

Healthcare's Data Analytics Capabilities Fall Short

Healthcare organizations are collecting massive amounts of data. Now, they need to learn how to make the most of it.

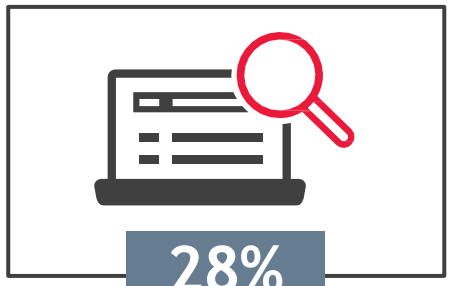


5%

Use analytics on ad hoc basis for specific needs

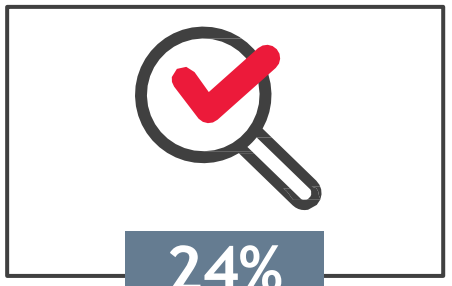
39%

Primarily use analytics for real-time reporting



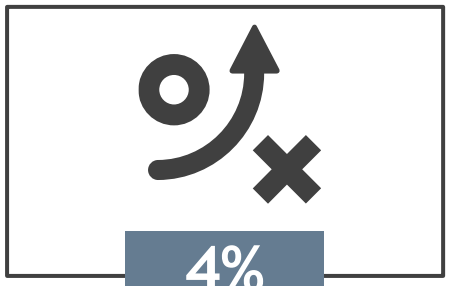
28%

Have insights from data existing in dashboards that few can access



24%

Use advanced analytics, including forecasting and predictive models



4%

Adopted machine learning and deep learning algorithms*

MATURITY LEVEL: Healthcare organizations collect large amounts of data every day, but it's what you do with the data that matters. Turning data into actionable insights is key to building an information-first organization. Focus on harvesting insights related to financial and operational health in order to grow and thrive. The future of healthcare is data driven.

SOURCE: BDO 2021 Healthcare Digital Transformation Survey

PAYERS

Engaging Patients and Employers in Site of Service Incentives

1 Inpatient Setting

- Completely **eliminates the inpatient only (IPO) list** by 2024 (1,700 total services)
- 300 services (primarily musculoskeletal) removed in 2021

Hospital outpatient department (HOPD)

2 Hospital Outpatient

- Adds eleven procedures to the ASC covered list in 2021, including total hip arthroplasty (THA)1
- Revises ASC covered service exclusion criteria, which adds additional 267 procedures in 2021

Ambulatory surgical centers (ASC)

3 Outpatient Setting

- Permanently covers 9 additional telehealth services (geographic, originating site, and other restrictions apply after public health emergency PHE)
- 138 telehealth services covered on a temporary basis
- Increases reimbursement for home infusions

Home

CPT codes: 0266T, 0268T, 0404T, 21365, 27130, 27412, 57282, 57283, 57425, C9764, C9766.

Source: "Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021," CMS, December 1, 2020; "CY 2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1736-FC)," CMS, December 2, 2020; "List of Telehealth Services," CMS, January 2021.

PAYERS

Expanding Steerage Strategies with Employers and Members

Virtual Primary Care Plans

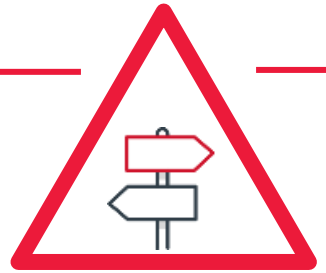
Digital-first health plans that aim to lower costs by requiring patients to consult with virtual providers first before receiving specialty care.

Humana

- Members assigned PCP from Doctor On Demand and can see the same physician over time
- Members given digital blood pressure cuff, thermometer, and log for submitting data to virtual providers
- Out-of-pocket costs include a $0 copay for video visits and a $5 copay for lab tests and prescriptions
- All referrals remain in Humana's high-value provider network

EXISTING OR PLANNED VIRTUAL-FIRST PLANS

- Premera Blue Cross
- Kaiser Permanente
- Oscar Health
- UnitedHealthcare1
- Community Health Choice
- Harvard Pilgrim



Centers of Excellence Programs

Hyper-narrow networks that incentivize consumers to travel to preferred providers for high-complexity surgeries by lowering out-of-pocket obligations and by offering concierge navigation services.

Carrum Health

- Custom-built provider network
- Surgeons meet pre-determined quality performance thresholds selected for each surgery
- Negotiates discounted bundled rates with providers up to 35% lower than industry standards
- User-friendly technology platform enables consumers to select surgeon; care concierge assists with navigation

Source: "Humana and Doctor on Demand launch virtual primary care plan to bring more services with lower costs to patients, insurers, and employers," Business Wire, April 24, 2019; Livingston S, "Humana announces virtual primary care plan," Modern Healthcare, April 24, 2019.

PAYERS

All Major Insurers Now Vertically Integrated

PAYERS							
Insurer	**UHC[1]**	**Aetna**	**Cigna**	**Anthem**	**Humana**	**BlueCross BlueShield**	**Walmart?**
PBM	OptumRx	CVS Caremark	Express Scripts	IngenioRx	Humana Pharmacy Solutions	Prime Therapeutics[2]	Capital Rx[2]
Specialty Pharmacy	BriovaRx	CVS Specialty	Accredo	CVS Specialty	Humana Pharmacy	AllianceRx[2]	Walmart Specialty Pharmacy
Provider Services	OptumCare	Minute Clinic Health Hub	Cigna Collective Care	CareMore Health; Aspire Health	Partners in Primary Care; Conviva Care Center; Kindred at Home	Various Blues physician practices	Walmart Health

Source: Fein, "Insurers + PBMs + Specialty Pharmacies + Providers: Will Vertical Consolidation Disrupt Drug Channels in 2020?" Drug Channels, December 2020.

PAYERS

Align with Physicians to Expand Outpatient Coverage

PAYER DRIVERS OF FREESTANDING SHIFT

MEDICARE

- THA added to ASC-payable list, joining TKA
- Number of ASC-payable spine procedures has risen from 56 in 2014 to 107 in 2021
- Pre-authorization required for cervical fusion with disc removal and spinal neurostimulators

Payers driving freestanding shift

COMMERCIAL

- UHC1 to require pre-authorization for hospital-based arthroscopy, foot surgery
- BCBS2 of Minnesota ends coverage of hospital-based arthroscopy, foot surgery if an ASC within 25 miles offers the service at a lower cost

39% Cost savings of ASC total joint replacement, compared to inpatient

Source: The Advisory Board 2021

PHYSICIANS

New Wave of Physician Employment Likely

POTENTIAL STRATEGIC PARTNERS FOR ESTABLISHED PHYSICIAN PRACTICES

Potential Partner	Attractive Factors	Deterring Factors	Common Target Specialties
Other Physician Practices	Like-minded, similar to status quo	Likely only large groups with enough capital to acquire	Single and multispecialty groups
Enablement Partner	Remain independent, long- term sustainability, burnout mitigation	Partial business model change, limited short term cash support	Small independent primary care practices
Health Plan	Long term sustainability, burnout mitigation	Lose independence, partial business model change	Independent primary care practices
Private Equity Investor	Rapid cash infusion, remain independent	Aggressive growth targets, limited control over future owners, range of business model change	Orthopedics, gastroenterology, women's health, urology
Health System	Stability with employment, existing delivery infrastructure	Lose independence, uncertain revenue stability due to Covid-19	Primary care practices, new physician graduates

DATA SPOTLIGHT

8%

Of physicians have closed their practices because of Covid-19

10%

Of physicians plan to move to a new employment situation or practice in 2021

Source: "2020 Survey of America's Physicians: Covid-19 Impact Edition," The Physician Foundation, August 2020.

Evolving & Emerging Value-Based Care (VBC) & Managed Care Contracting Models

The “Contractualization” of Our Entire Patient Base and Payer Mix

THE MOVEMENT TO “VALUE-BASED CARE” (VBC) VIA PAYER CONTRACTS AND “ACCOUNTABLE CARE” MODELS

Risk Transfer Based on Actuarial Assumptions and Provider Ability to Manage Risk and Delegated Functions

Fee for Service

Pay for Performance

Medical Home Models

Clinically Integrated Networks (CINs, ACOs)

Shared Risk

Global Payment or % Premium

Different Metrics, Initiatives and Contract Models Across Commercial and Governmental Product Spectrum

Value-Based Care (VBC) Payment Models: What Are They?

- VBC payment models are reimbursement structures that incentivize provider organizations to improve the cost and quality of care
  - VBC payment models create performance risk and utilization risk
  - The VBC and bundled payment models create performance risk by holding organizations financially accountable for clinical outcomes and avoidable costs.
  - Models incentivize coordination and efficiency, not reduction of the overall volume of care
  - Shared savings models and capitation create utilization risk
  - Model incentivize organizations to reduce the overall volume of services delivered to achieve greater cost savings

- Value-Based Care (VBC) is next generation of Pay-for-performance (P4P); a/k/a also referred to as Value-Based Purchasing (VBP). Differing in scope, design, and complexity, these models include:
  - Medicare Shared Savings Programs (MSSPs)
  - Accountable Care Organizations (ACOs)
  - Clinically Integrated Networks (CINs)
  - Medicaid MCOs
  - Medicare Advantage plans and networks
  - CMS Direct Contracting Entities (DCEs)
  - Bundled Payment and Center of Excellence Programs (Commercial, Governmental)

Latest Data on VBC Models in U.S. Healthcare System

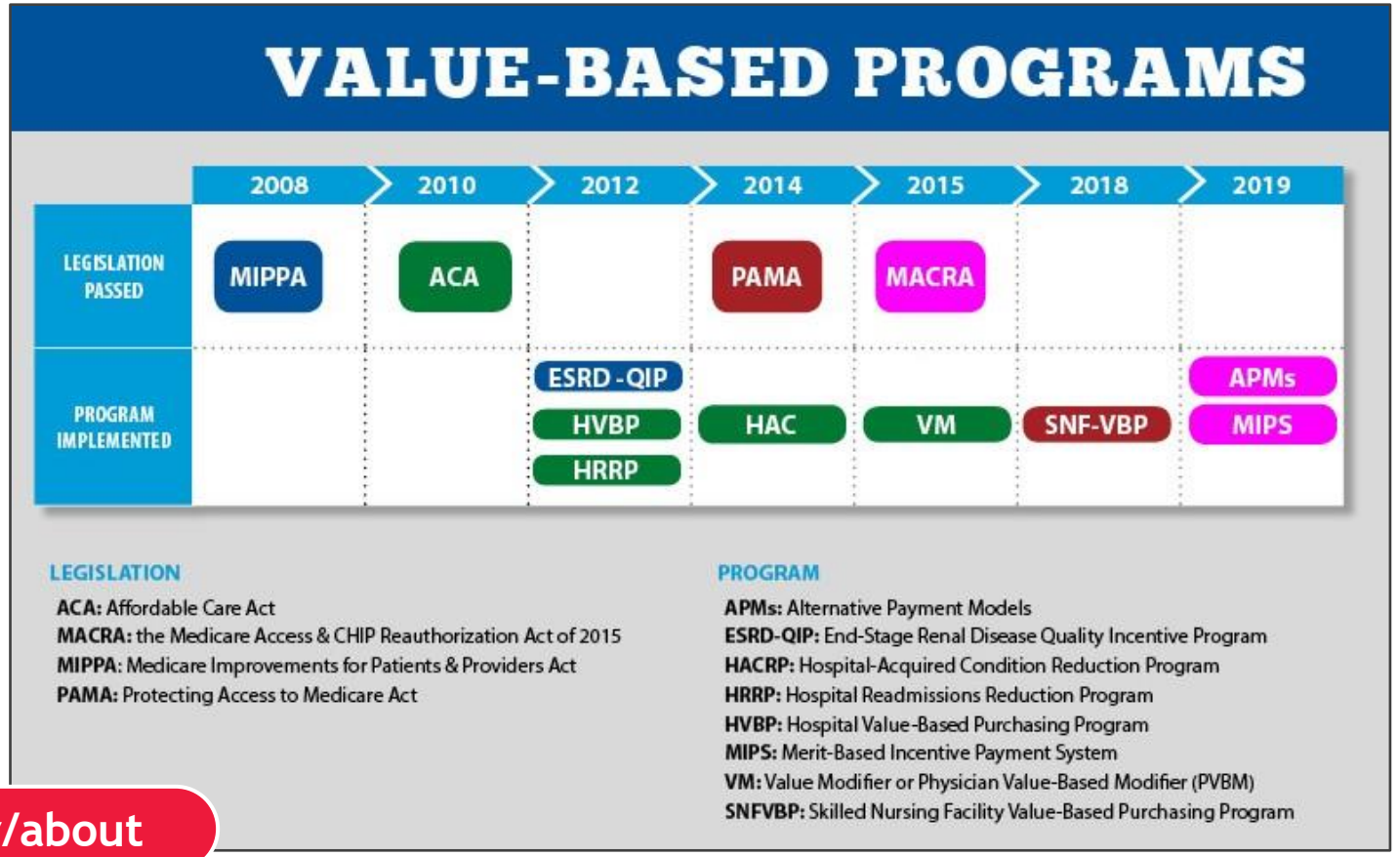
- VBC reimbursement represents 40.9% of US healthcare payments in 2020
- 80% of the US population is covered under a VBC model
- VBC models growing rapidly in Governmental Segments (Medicare, Medicaid)

- VBC models seeing rapid innovation in Commercial Segments
- CMS ACOs as of 1/1/22: 66 new ACOs joined the program and 140 existing ACOs renewed their participation for a new agreement period starting January 1, 2022. This brings the total number of ACOs in the Shared Savings Program to 483 in 2022. As of January 1, 2022, over 11 million people with Medicare receive care from a health care provider in a Shared Savings Program ACO, up 324,000 (3%) from the previous year.

- What makes a good VBC model? According to the American Medical Association (AMA), there are six components to an "ideal" high-value healthcare system. Those primary features include
  - A patient-centered model in which the medical team has a clear, shared vision
  - Healthcare workers possessing professionalism and leadership
  - A functional and robust IT system
  - Payment models that reward quality improvement over quantity
  - Wide-spanning access to care

The Brief History of CMS VBC Models

- The Center for Medicare and Medicaid Innovation (CMMI)
  - Accountable Care Organizations (ACOs)
  - Bundled Payment Programs (BPCI)
  - Community-Based Care Transitions
  - Care Model Demonstrations & Projects
  - 1115 Waivers
  - Dual Eligible Coordination



https://innovation.cms.gov/about

Metrics and Measures in VBC

Quality & Cost	Intangibles/SDOHs	Sustainability
▶ HEDIS measures	▶ Stabilization	▶ Scalable and adaptable
▶ HCAHPS measures	▶ Support	▶ Shared Savings funding to create sustainability strategies
▶ Hospitalization reduction	▶ Individual and Family	▶ MCO partnerships and JVs
▶ ER reduction	▶ Connections for the long term	▶ State-funded Transformation Grants
▶ Recidivisms and readmissions	▶ Behavioral change for the long term	▶ Other funding available
▶ Pharmacy Compliance		
▶ Total Cost of Care		
▶ Episodic Cost of Care		

What's Happening in VBC Contracting Across the USA

MEDICARE	MEDICAID	COMMERCIAL
Medicare Advantage models (MCO-based, Provider Owned, Hybrids)	Medicaid MCOs	Physician Network-Based (CINs, ACOs, IPAs/PHOs)
Direct Contracting with CMS	State level initiatives (i.e., Illinois HFS Medicaid Transformation)	Hospital-Network Based (CINs, ACOs, IPAs/PHOs)
Senior-Focused Integrated (Oak Street Health, Village MD, Cano Health, etc.)	Various MCO, HFS, Community- Based Models	Site of Service migrations can cause IDNs heartburn Challenges with SI v FI; Attribution v. Enrollment for PHM/VBC metrics

Core Issues in Contract Portfolios Today

- Underlying Actuarial Assumptions and Financial Modeling in Existing payer Contract Portfolios: Disrupted by Pandemic
- Adequacy of agreed to unit prices
- Increased Retroactive Disenrollment Among Patients
- Cost of care under capitated/risk contracts
- Ability to perform administrative requirements that subsequently created financial/incentive problems or compliance problems
- Impact to Publicly Reported Metrics and CMS Star Ratings

- These significant trends are impacting payer-provider relationships
- But its not just about payer contracts
- Moreover, the entire U.S. healthcare system is strained beyond capacity, inequitable in its access, and financially unsustainable in nearly 50% of hospitals

COVID-19 Pandemic Potential Impact on Payor Contract Portfolios

1. **Underlying Actuarial Assumptions and Financial Modeling in Existing payer Contract Portfolios Not Valid:** Premiums, Reimbursements, and VBC Incentives are based off Actuarial Assumptions on utilization and unit price. Those assumptions are essentially invalid at this point, for this period, and for comparative purpose. Everyone from payers, to employers, to providers to consumers will be looking to be "made whole."
2. **Adequacy of agreed to unit prices:** Providers will be dealing with dramatic drops in volumes, and for some providers, a dramatic shift in patient and service mix. Negotiated unit prices may no longer be sufficient for the "new world" budget needs.
3. **Increased Retroactive Disenrollment Among Patients:** As more people lose their jobs, health insurance coverages will change, and for some patients it will change multiple times with 1–2-year timeframe. Subsequently there will be significant Retroactive Adjustments to claims, eligibility, capitation, incentive earnings.
4. **Cost of care under capitated/risk contracts:** Simply stated, less people accessing elective services equates to low claims expense which leads to higher margin. On the other hand, we've had to pay the costs of Telehealth, and costs of Waived Copays. How are we tracking that and getting made whole?
5. **Ability to perform administrative requirements that subsequently created financial/incentive problems or compliance problems:** There may be relevant language that provides relief to the provider with respect to administrative denials during this period.
6. **Impact to Publicly Reported Metrics and CMS Star Ratings:** There are other implications like CMS Star Ratings, and downstream implications (i.e., an organization's ability to market/enroll Medicare Advantage year-round once 5-Star level is achieved), and other payer profiles.

Pandemic Impact on VBC Contracts

Here is an example of a 2020 Income Statement of a Commercial ACO, buoyed by both a drop in expenses and an increase in premium/capitation.

	Budgeted	Actual	Variance
Covered Lives	1000	1000	0
Premium/Capitation-MA	$18,000,000	$21,000,000	$3,000,000
Expense-MA	$17,100,000	$14,700,000	$2,400,000
Medical Loss Ratio (MLR)	$15,300,000	$12,600,000	$2,700,000
Profit-Medicare Advantage	$900,000	$6,300,000	$5,400,000
Covered Lives	1000	1000	0
Premium/Capitation- Comm	$7,200,000	$7,200,000	$0.00
Expense- Comm	$6,120,000	$5,400,000	$720,000
Medical Loss Ratio (MLR)	$5,400,000	$4,320,000	$1,080,000
Profit-Commercial	$1,080,000	$1,800,000	$720,000
Covered Lives	1000	1000	0
Premium/Capitation-PA	$8,400,000	$9,240,000	$840,000
Expense-PA	$7,980,000	$8,778,000	$798,000
Medical Loss Ratio (MLR)	$7,140,000	$5,544,000	$-1,596,000
Profit-Public Aid	$420,000	$462,000	$42,000

Pandemic Impact on VBC Contracts

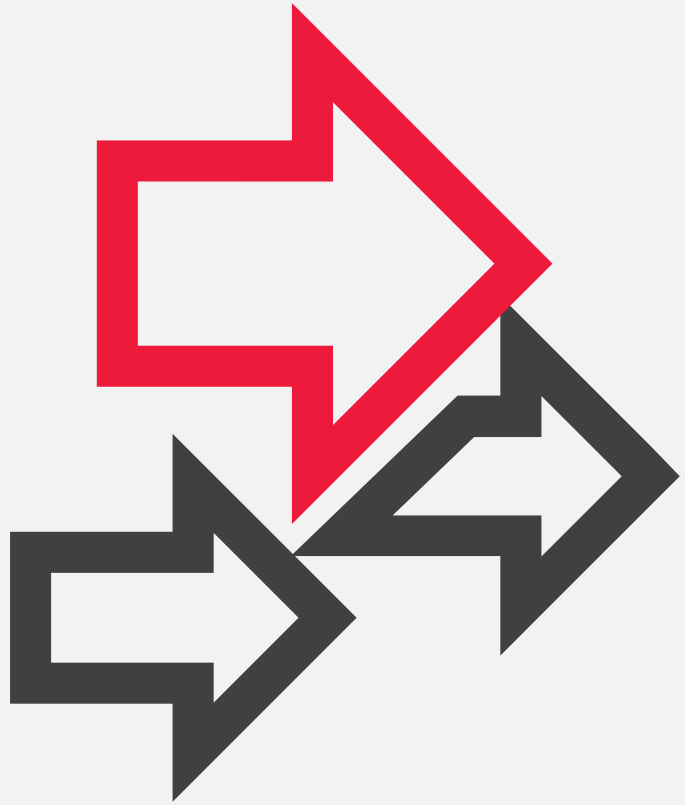
The impact of COVID-19 on this hospital's Commercial Managed Care Contract Portfolio

- Adverse impact on return of 42.5%, or $5.7M in profit margin
- Decrease in Surgical Admissions of 80% for the Observed Period
- Increase in high-cost Medical Admissions by 75% for the Observed Period
- Decrease in profitable Elective Outpatient Services
- Decreased/no earnings Value-Based Contracts/Pay-For-Performance arrangements (VBC/P4P)

Fee-For-Service Illustration										
Commercial Payor	Service Line	Budgeted Volume	Budgeted Total Cost	Budgeted Payment	Budgeted Profit	Actual Volume	Actual Costs	Actual Payment	Actual Profit	Total Budget Variance
Inpatient	Medical	500	$15,000,000.00	$17,250,000.00	$2,250,000.00	900	$36,000,000.00	$41,400,000.00	$5,400,000.00	$3,150,000.00
Inpatient	Surgical	500	$37,500,000.00	$45,000,000.00	$7,500,000.00	100	$7,500,000.00	$9,000,000.00	$1,500,000.00	-$6,000,000.00
Inpatient Stoploss	Catastrophic	25	$2,500,000.00	$3,375,000.00	$875,000.00	10	$1,000,000.00	$1,350,000.00	$350,000.00	-$525,000.00
Inpatient	VBC P4P Incentive	Full Earn	$0.00	$0.00	$0.00	1010	$0.00		$0.00	
Inpatient Total			$55,000,000.00	$65,625,000.00	**$10,625,000.00**		$44,500,000.00		**$7,250,000.00**	-$3,375,000.00
Outpatient	ER	1,000	$1,000,000.00	$1,500,000.00	$500,000.00	300	$300,000.00	$450,000.00	$150,000.00	
Outpatient	Surgery	700	$3,500,000.00	$5,250,000.00	$1,750,000.00	200	$500,000.00	$750,000.00	$250,000.00	
Outpatient	Imaging	2,000	$600,000.00	$900,000.00	$300,000.00	500	$75,000.00	$112,500.00	$37,500.00	
Outpatient	Lab	5,000	$500,000.00	$750,000.00	$250,000.00	1000	$50,000.00	$75,000.00	$25,000.00	
Outpatient	VBC P4P Incentive	Full Earn		$0.00	$0.00					
Outpatient Total			$5,600,000.00	$8,400,000.00	**$2,800,000.00**	2000	$925,000.00	$1,387,500.00	**$462,500.00**	-$2,337,500.00
Grand Total					**$13,425,000.00**				**$7,712,500.00**	-$5,712,500.00
										-0.425512104

Drivers in Next Generation VBC

- Coding
- Patient Engagement
- Health Equity



Today's Top Ten: The Future Trajectory of Value-Based Care and Value-Based Contracting (VBC)

- Attributed Product Models (PPOs, Claims-Based, PCP Concierge, Limited Referrals – more for care coordination than unit cost management)
- Enrolled Product Models (HMOs, PCPs, Referrals, Capitation with high focus on utilization, post-acute care management, case management)
- Total Cost of Care
- Increasing Downside Risk
- Incorporating Social Determinants of Health (SDOH) in Patient Engagement Strategies
- Advancing Health Equity
- Alignment of "Quality Metrics" and Incentives
- Precision Coding
- Real Time Data Sharing/Exchange, Access to EMRs, BlockChain Adjudication
- Joint Ventures and Joint Governance

Health Equity

While the term health equity is used widely, a common understanding of what it means is lacking. What is health equity?

- In a report designed to increase consensus around meaning of health equity, the Robert Wood Johnson Foundation (RWJF) provides the following definition
  - Health equity means that everyone 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.
  - Consensus around definitions for an issue such as health equity can help bridge divides and foster productive dialogue among diverse stakeholder groups. Conversely, a lack of clarity can lead to detours, and pose a barrier to effective engagement and action.

Health Equity Work

COULD INVOLVE

- Hiring an Executive leader for the hospital system of Diversity Equity Inclusion
- Hiring a Vice President Diversity Inclusion for Graduate Medical Education, if applicable

- Working with MCOs on overall approach
  - Patient Focus
    - Patient Registration info
    - Education of registration personnel
  - Hospital Focus
    - Commitment to long-term improvement in the numbers and retention of **URiM, if applicable**
    - Make **unconscious bias training** a core component of requirements for clinical department chairs, residency selection committee members, and medical school admissions committee members

Health Equity Work

COULD INVOLVE

- Actively participate in the DEI programming with the ACGME Office of Diversity and Inclusion, AAMC Diversity Initiatives
- Develop a robust holistic review process in GME

- Residents: Increase the number of URiM resident candidates that are ranked in each program's "top" (however many spots you have) by 10%.
- New Attendings: Increase the URiM clinical faculty composition by 5%, the second year is 10%, the third year is 20%.
- Existing Attendings: Submit a comprehensive evaluation of clinical faculty promotion trends identifying opportunities for improvement and implement an improvement plan, where necessary. The second year is to increase promotion of URiM by 10% and the third year is by 10%.

REAL LIFE EXAMPLE

Environmental, Social, Governance (ESG)

SUSTAINABILITY DIMENSIONS

ENVIRONMENTAL

- Climate change
- Biodiversity
- Fresh water availability
- Water pollution
- Air pollution
- Circular economy
- Waste management
- Resource availability

SOCIAL

- **Health and safety**
- **Diversity and equality**
- Work-life balance
- Sustainable innovation
- Corporate citizenship
- Consumers' awareness
- Products and services innovation
- Sustainable consumption
- Community involvement

GOVERNANCE

- Corporate Governance
- Stakeholder engagement
- Anti-corruption
- Fair operating practices
- Risk and opportunity oversight
- Ethical behavior
- Responsible lobbying

Coding

OVERVIEW OF THE REVENUE CYCLE

No Longer Just About The Front Office and Business Office

Mid-Cycle is Increasingly More and More Important for Driving Financial Stability and Improvements in Quality Performance

Patient Registration & Scheduling	Care Coordination & Utilization Management	Clinical Documentation Improvement	Coding & Revenue Integrity	Billing, Collections & Denials/Appeals

Coding

Importance of Coding: Value Based vs Fee For Service

- **Fee for Service**: Coding to “get paid” or to “meet medical necessity”
- **Value Based Care**: Coding for Value Based Care began in 2004 with HCC coding and is the cornerstone of most Value Based Care arrangements. A Risk Adjustment (RA) model is where patient care is paid based on a prospective payment model
- **VBC coding is used to determine Risk Scores for patients.**
  - The Patient Demographics + diagnoses + Rx = Risk Scores
  - The sicker the patient, the higher the Risk Score Uri.
  - The higher the Risk Score, the more dollars it will take to care for this patient.
  - The higher the Risk Score, the higher the payment to the organization.

CODING

Medicare Wellness Visit: Critical To MCOs/VBC MA Agreements

Initial Preventive Physical Exam (IPPE)	Annual Wellness Visit (AWV)
Review of medical and social health history and preventive services education ▶ **Covered** only once within 12 months of first Part B enrollment ▶ Patient pays nothing (if provider accepts assignment)	Visit to develop or update a Personalized Prevention Plan (PPP) and perform a Health Risk Assessment (HRA) ▶ **Covered** once every 12 months ▶ Patient pays nothing (if provider accepts assignment)

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410#410.16

https://www.cms.gov/Outreach-andEducation/Medicare-LearningNetworkMLN/MLNProducts/preventiveservices/medicarewellness-visits.html

CODING

Coding for Medicare Wellness Visits

Initial Preventive Physical Exam (IPPE) Physician or NPP (PA, NP, CCNS)	Annual Wellness Visit (AWV) Physician or NPP (PA, NP, CCNS), medical professional or team of medical professionals supervised by a physician
▶ **G0402** Initial preventive physical examination	▶ **G0438** Annual wellness visit;, initial visit
▶ **G0403** Electrocardiogram, global	▶ **G0439** Annual wellness visit, subsequent visit
▶ **G0404** Electrocardiogram, technical only	▶ **G0468***Federally qualified health center (fqhc) visit
▶ **G0405** Electrocardiogram, professional only	
▶ **G0468***Federally qualified health center (fqhc) visit	

No specific ICD-10 Codes, can use any appropriate diagnosis codes from exam

USE SOCIAL DETERMINANTS OF HEALTH Z CODES

CODING

Social Determinants of Health (SDOH)

- SDOHs are conditions in the **environments in which people live, learn, work, play, worship and age**

SDoH	
Food Insecurities	Physical Inactivity
Loneliness & Social Isolation	Income
Housing Quality & Instability	Social Status
Transportation	Employment & Working Conditions

- **60% of a person's health is impacted by behavioral, environmental and social conditions**
- **Your patients' lifestyle choices often can put them at higher risks for health challenges**
- **Identifying/Coding + Addressing SDoH = Comprehensive Approach to Patient Care**

CODING

SDOH Coding Examples (Z-Codes)

Food insecurity

- Z59.4 Lack of adequate food/drinking water

Loneliness/lack of primary support group

- Z60.2 Problems related to living Alone
- Z60.4 Social Exclusion and Rejection
- Z63.8 Other specified problems related to primary support group
- Z63.9 Problems related to Primary Support Group, unspecified

Housing instability and problems with economic circumstances

- Z59.0 Homelessness
- Z59.1 Housing, Inadequate
- Z59.8 Other Problems related to housing and economic circumstances
- Z59.9 Problems related to housing and economic circumstances, unspecified

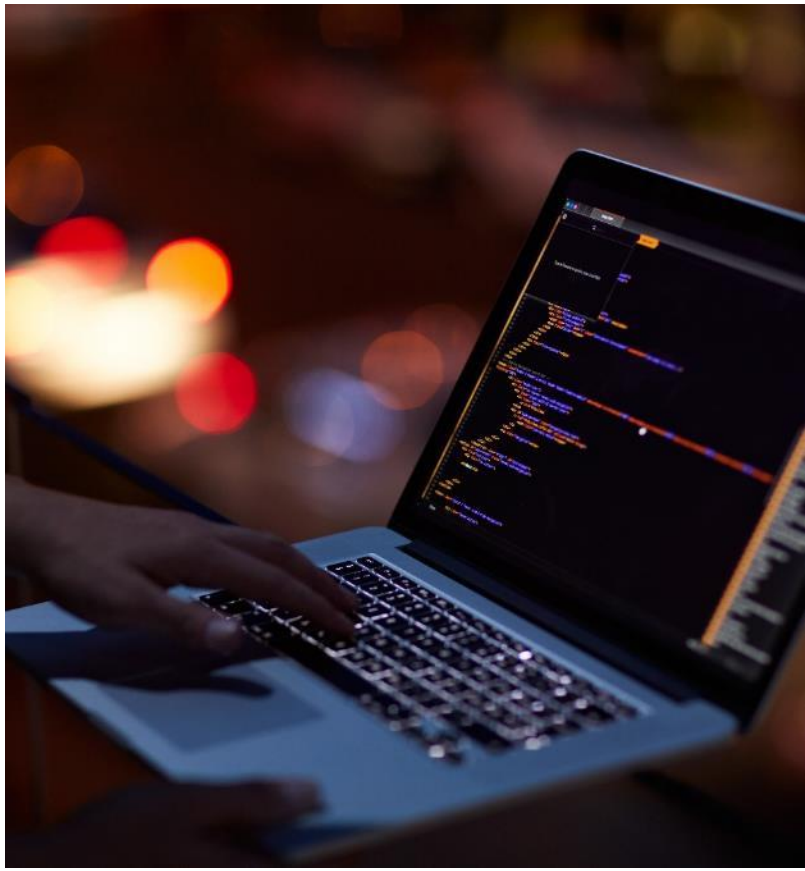
Coding

RISK ADJUSTMENT & RISK SCORE (RA, RS)

- Provider's Documentation Directly affects the Patient's Risk Score
- Patients Risk Profiles are determined by their diagnoses
- Higher severity and complex patients have higher weighted risk scores
- The more complete and accurate the provider's documentation and coding, the more accurately the patient's risk score

DOCUMENTATION AND CODING TELL THE STORY FOR THE PATIENT

- The More Accurate The Story
- The More Accurate The Risk Score
- The More Accurate The Health Care Funding



CODING

Specificity Matters in Risk Scoring

ICD-10 Unspecified or Condition	Risk Score
75 yr old Male	0.8608
E11.9 MD Type 2 unspecified	0.8129
N18.9 CKD unspecified	1.8073
I10 Hypertension	0.2236
Total	**3.7046**

ICD- Specified	Risk Score
75 yr old Male	0.8608
E11.22 DM type 2 with CKD	2.0399
N18.5 CKD Stage 5	1.8073
E20.0 Idiopathic Hypoparathyroidism	.7240
K21.9 GERD	0.2411
J45.909 Asthma, unspecified	0.4848
Total	**6.1278**

Risk scores for each condition reflect anticipated future cost of care for the patient and drive premium funding from payers.

CODING ERRORS LEAD TO

Denials, Underpayments, Under-Reporting, Lost VBC Revenue

COMMON ERRORS IN FFS CODING

- Not Enough Data to support claims – improper linking of CPT and ICD-10 codes, incomplete ICD-10 information
- Over coding/Under coding – documentation does not support the CPT code
- Telemedicine Coding Errors – incorrect use of modifiers, missing time documentation
- Missing or Incorrect Information – Missing Chief Complaint, missing attestation Statement
- ICD-10 coding “unspecified” vs. coding to specificity

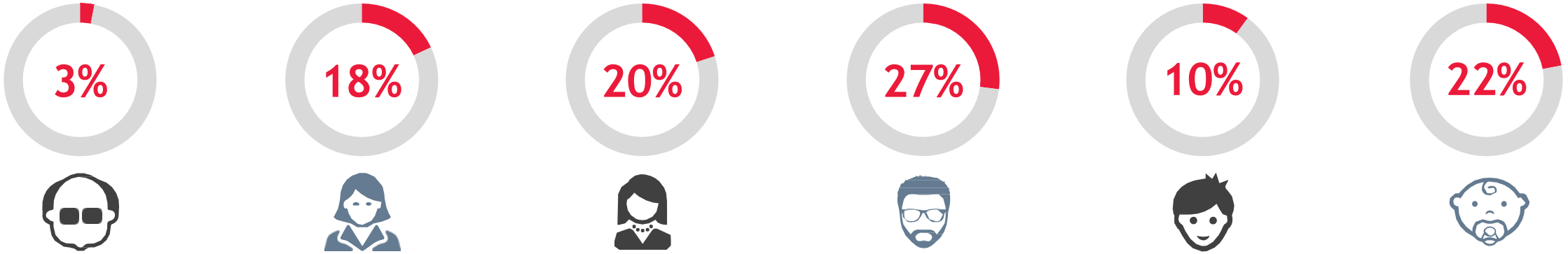
COMMON ERRORS IN RISK ADJUSTMENT CODING

- The highest degree of specificity was not assigned
- A discrepancy was found between the diagnosis codes being billed versus the actual written description
- Documentation does not indicate the diagnoses are being monitored, evaluated, assessed/addressed, or treated (MEAT)
- Status of a cancer is unclear. Treatment is not documented
- Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic
- Chronic conditions or status codes aren’t documented in the medical record at least once per year

PATIENT ENGAGEMENT

Six Generations, Six Sets of Expectations

% OF 2028 POPULATION



THE SILENTS	BABY BOOMERS	GEN X	MILLENNIALS	GEN Z	GEN ALPHA
Born 1928 - 1945	Born 1946 - 1964	Born 1965 - 1980	Born 1981 - 1997	Born Late 1990s - 2000s	Born 2014 - Present
AGE 83-100 IN 2028	**AGE 63-82 IN 2028**	**AGE 48-63 IN 2028**	**AGE 31-47 IN 2028**	**AGE 14-33 IN 2028**	**<14 YEARS IN 2028**
▶ 83% Have A PCP ▶ Rely on word of mouth ▶ Technology averse	▶ 83% Have a PCP ▶ Rely on MD rec ▶ One of the unhealthiest generations than any previous at same age	▶ 56% Have PCMD ▶ Feel less comfortable opening up to MD ▶ 1 in 4 say they've lost trust in doctor or hospital	▶ 33% Have A PCP ▶ 1 In 4 use other care sites ▶ More likely than any generation to say they can tell their doctor anything	▶ Generation "Now" ▶ Time is a premium ▶ Need more info	▶ Complete immersion in tech ▶ Less human contact ▶ Long life expectancy ▶ Smaller family size with older parents

PATIENT ENGAGEMENT

Telehealth's New Relevancy

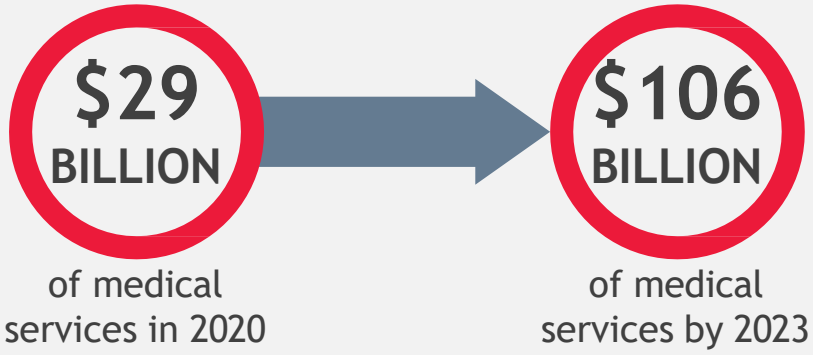
"The rapid explosion in the number of telehealth visits has transformed the health care delivery system, raising the question of whether returning to the status quo turns back the clock on innovation."

Seema Verma, Centers for Medicare and Medicaid Services

Utilization and outcomes data, and physician and patient experiences will be crucial to showing the long-term value of telehealth.

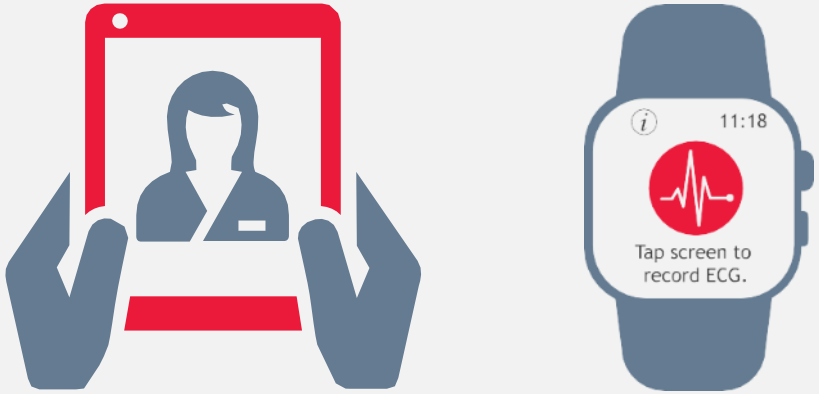
Source: Becker Hospital Review

BY THE NUMBERS



of medical services in 2020

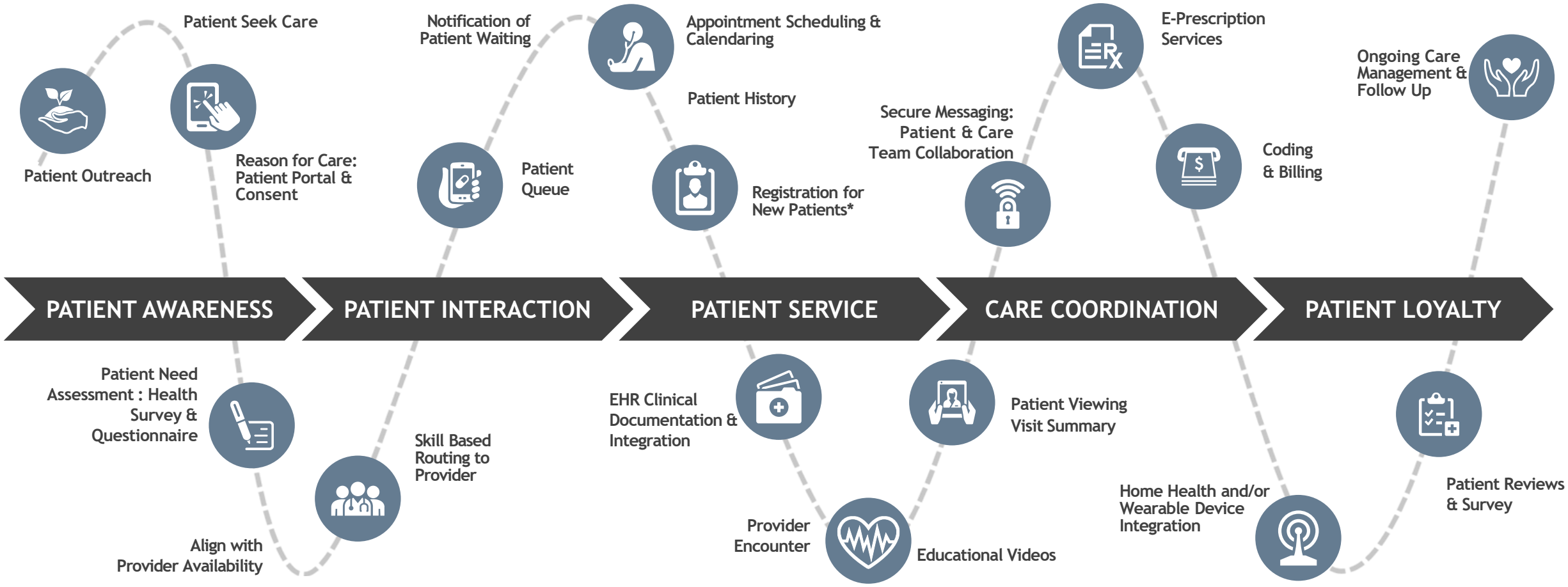
of medical services by 2023



Source: Healthcare Finance News

PATIENT ENGAGEMENT

The “Stickiness” of Telehealth, Patient Portals and EMRs



PATIENT ENGAGEMENT

Telehealth and Remote Patient Monitoring (RPM)

- Telehealth and RPM will continue to provide value in VBC models and expand its footprint in care delivery. Capitalize on that now
- Continual and expanded used of Telehealth necessitates strong revenue cycle knowledge to ensure billing is performed correctly. You don't want to lose your patient to a provider that has better Telehealth and RPM capabilities.
- Organized networks (PHOs, IPAs, CINs, ACOs, etc.) must go the extra step to educate private/independent MDs on Telehealth and RPM billing practices and patient Outreach and Engagement (OAE) strategies
  - Consider educational seminars as part of the value prop of the organization
  - Consider alternate partners to assist with additional revenue capture
    - Chronic Care Management firms
    - Gap Closure firms
- Although you may want to "make" this internally, it might be faster to "buy" service
- Accelerates goal achievement
- Accretive to provider and to value-based contracts

A CASE STUDY

Integrating Value-Based Care (VBC) & Population Health Management (PHM)

MOUNT SINAI HOSPITAL

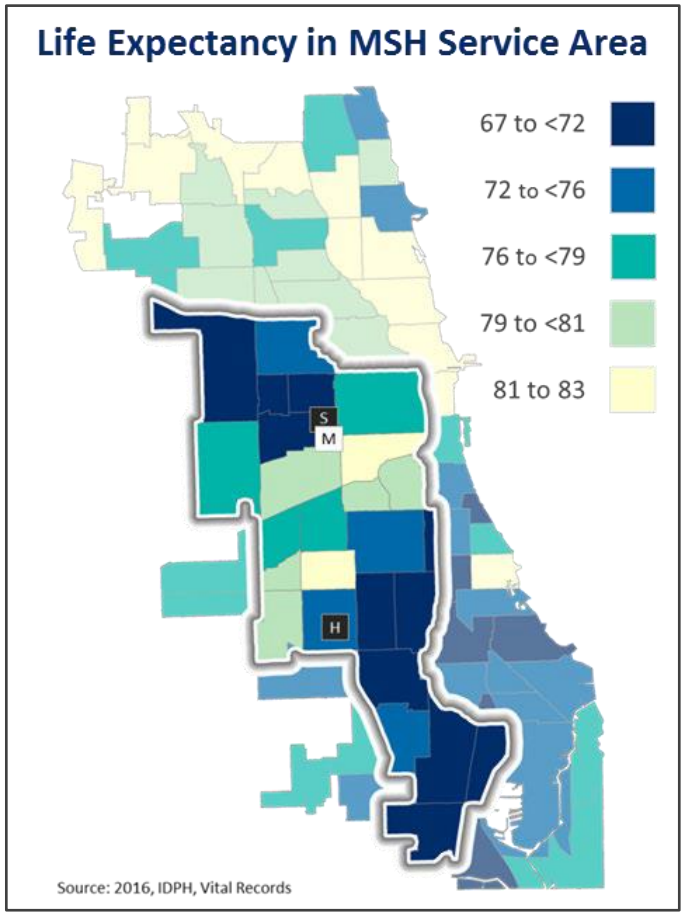
2019 Community Health Needs Assessment Findings

DEMOGRAPHIC PROFILE

- 26 communities – 36% of Chicago's population (980,000).
- 12 communities are predominantly Non-Hispanic Black and 12 are predominantly Latinx, with a large foreign-born population.
- 27% children (<18yo) and 10% seniors (>65yo).

SOCIAL DETERMINANTS OF HEALTH

- Financial Insecurity: All 26 MSH communities had higher unemployment rates than Chicago and 25 had lower median household incomes (ranging from $21,437 to $50,884).
- Education: 21 MSH communities had lower high school graduation rates than Chicago (ranging from 50% to 83%).
- Food Access: The percent of residents with easy access to fruits and vegetables was lower in 18 MSH communities than Chicago.
- "I have to go out of my neighborhood to do anything. I don't shop in my neighborhood. I don't eat in my neighborhood."



MOUNT SINAI HOSPITAL

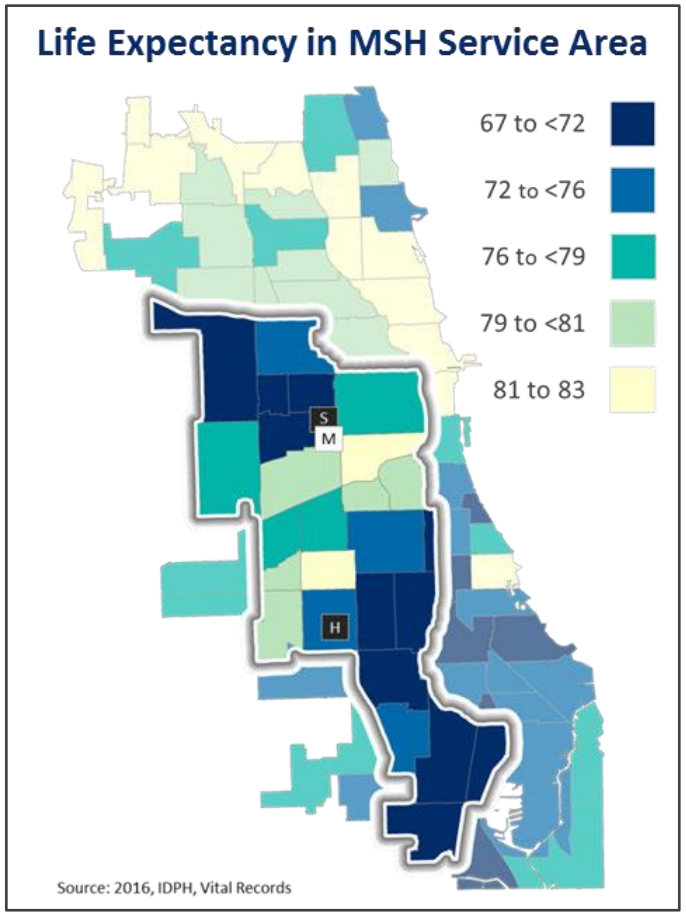
2019 Community Health Needs Assessment Findings

COMMUNITY SAFETY

- 16 communities had higher violent crime rates than Chicago and the proportion of adults who felt safe in their neighborhood was lower in 19 MSH communities.
- **"It's not just violence, it's the lack of money in the area. If people had money, there would be less violence."**

HEALTH CARE ACCESS AND USE

- Residents and Sinai caregivers highlighted various barriers to accessing needed appointments and medications, challenges with being un- or under-insured, and the need for culturally sensitive care.
- 24 MSH communities had higher uninsured rates than Chicago and 14 had a higher proportion of adults that did not receive needed medical care in the past year, such as tests or treatments.
- **"Most of us don't have health insurance. You can't get a mammogram or go to the doctor for checkups. If we had health insurance, we would go more often, not just when we are sick."**



MOUNT SINAI HOSPITAL

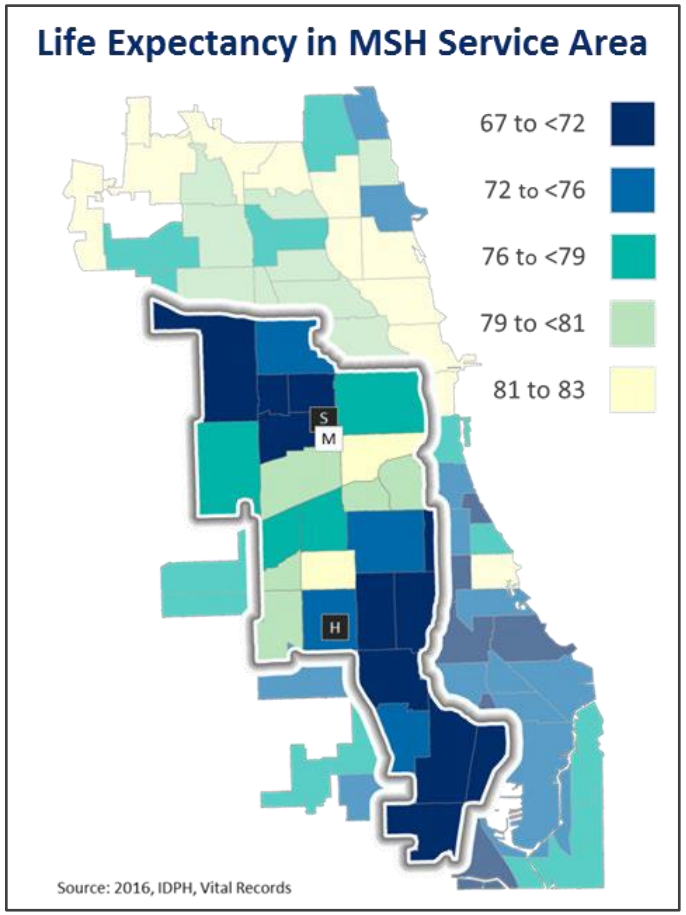
2019 Community Health Needs Assessment Findings

CHRONIC AND INFECTIOUS DISEASE

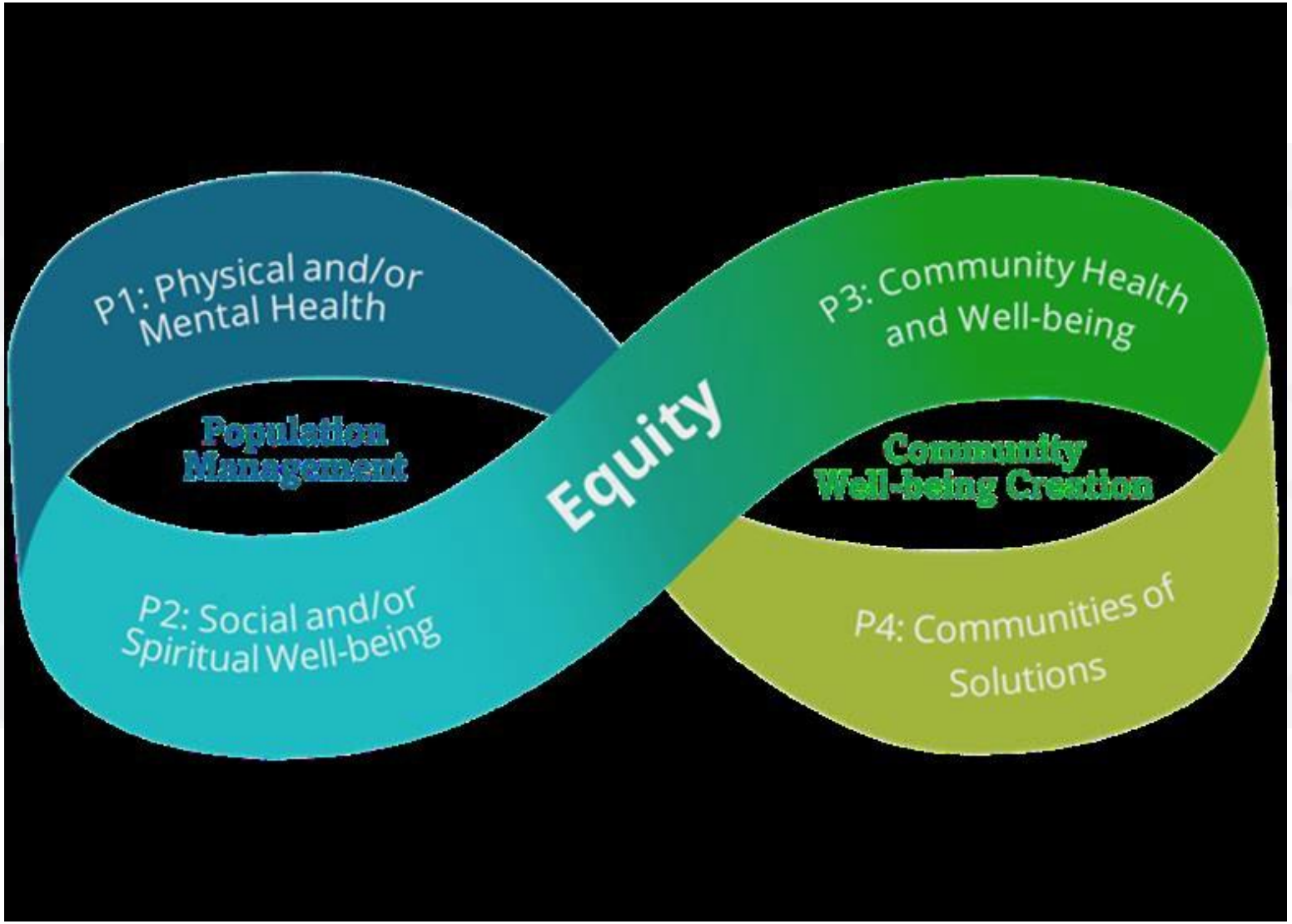
- Diabetes was selected by residents as the #1 community health issue.
- More than half of MSH communities had higher rates of chlamydia and gonorrhea than Chicago.
- Data highlight the disproportionate burden of cardiovascular disease (including high blood pressure and heart disease), stroke, kidney disease, cancer, and asthma on community health.

BEHAVIORAL HEALTH (INCLUDES MENTAL HEALTH AND SUBSTANCE USE)

- Sinai caregivers emphasized behavioral health as an underlying factor across health issues.
- Access to behavioral health services remains a challenge across communities. The age-adjusted ED visit rate per 10,000 ranged from 60 to 262 for mental health and from 14 to 197 for substance use.
- According to residents, substance-use and mental health are the #3 and #4 top community health issues, ranking just behind diabetes (#1) and violence (#2).
- **"A lot of the facilities that cater to people with mental illness have been closed. You have to go to Oak Park or to the North Side to get care."**



Pathways to Population Health



PATH #1

Physical and/or Mental Health

ACTIVITIES

- Patient empanelment and care management
- BH integration
- Access, evidence-based practice and risk stratification
- Partnering with patients and families
- Engaging in performance improvement

PROVIDER OR PAYOR RESPONSE

- MCO Participation
- ACO - Participation
- BPCIA – CMS Bundles Program – Participation
- Chronic Care Management – Participation
- Direct Contracting Entity - Participation
- MSSP Participation
- Health Equity Program – Participation

PATH #2

Social and/or Spiritual Well Being

ACTIVITIES

- Screening and addressing the SDOH
- Developing key partnership to improve social and spiritual wellbeing
- Tracking improvement in the activities to establish the value proposition

PROVIDER OR PAYOR RESPONSE

- Utilization of Community Health works in multitude of settings
  - Ambulatory
  - Emergency Department
  - MD Offices
- Research and Intervention Driven

PATH #3

Community Health & Wellbeing

ACTIVITIES

- Cross sector partnerships
- Collaborative CHNAs
- Setting goals and developing improvement projects
- Establishing a learning and improvement system
- Facilitate collaboration around the sharing of data, improvement methods, learning and resources

PROVIDER OR PAYOR RESPONSE

- WIC
- Adult Protective Services
- Family Case Management
- Better Birth Outcomes
- Health Works of Illinois
- Senior Centers
- Early Childhood Development Learn Together – Afterschool Program
- Once Summer Chicago Plus Program
- The Leadership Academy
- RISE
- Health Ministry Program
- Community Relations
- Volunteer
- Workforce Development
- Technology Center

PATH #4

Community of Solutions

ACTIVITIES

- Anchor organization roles such as a purchaser, employer and investor working together for the long term well being of the community as part of their mission and responsibility
- In community coalitions, mapping assets, creating vision for the community and identifying leaders at multiple levels
- Address policy and system changes

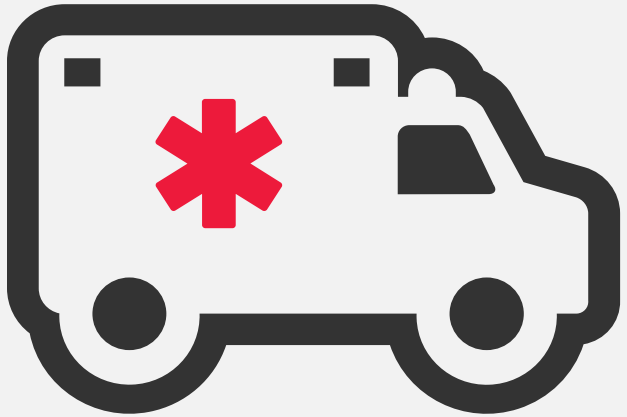
PROVIDER OR PAYOR RESPONSE

- Healthcare Transformation Collaboratives
- Program Goals
  - Community Needs
  - Health Wellness
  - Specialized Approaches
  - Sustainable Investment

Healthcare Transformation (noun) 'health-care trans-for-ma-tion' a person-centered, integrated, equitable, and thorough or dramatic change in the delivery of healthcare at a community level. www2.illinois.gov/hfs/Pages/HealthcareTransformation

Healthcare Transformation Collaboratives

The Path Forward



STRATEGIES FOR MOVING FORWARD

The Future of Managed Care Contracting

COLLABORATE WITH PAYERS ON FINANCIAL RELIEF SOLUTIONS AND ADDITIONAL FUNDING SOURCES

RESTRUCTURE PAYER CONTRACTS AND APPROACHES

EVALUATE AND INNOVATE: VBC, PHM AND OTHER TRANSFORMATIONAL MODELS

GET AHEAD OF THE NEW VBC DRIVERS

- Coding, SDOH
- Patient Engagement
- Data Exchange
- Health Equity

SUMMARY & CONCLUSION

Defining Your VBC/Managed Care Strategy

It's not so much about the VBC Model but whether or not your workflows are prepared for the change that the models necessitate

- Define your "glide path to risk" with end goal in mind ("get as close to the premium as you can")
- Conduct an internal readiness review
- Understand The Market and Your Market Position: (Offensive and Defensive Strategies)
- Define your VBC/MC Strategy Vertically and Horizontally
  - Vertically: By Payer (i.e., United, BCBS, AETNA, etc.;) for all products within a Payer
  - Horizontally: Defining Product Strategy: Government Product Strategy (Medicare/Medicare Advantage; Medicaid MCOs, Marketplace Plans), Commercial Strategy (HMO, PPO, Self Insured v Fully Insured, Narrow Networks)
  - Other Models: CMS Bundled Payment Models, CMS Direct Contracting, State Level Direct Contracting, CMS ACOs, Commercial CINs/ACOs
- Ensure you have the Operations Management to take on VBC models
  - Delegated models vs. Non-Delegated Models (pursue Delegation and Data Exchanges)
  - Build or Buy MSO Services (Credentialing, Contracting, Data Management/Reporting, Patient Registry, Claims Payment, Incentive Fund Tracking/Reporting, Payer Contract Compliance). Most Buy to start up and insource over time.

BDO

SUMMARY & CONCLUSION

Evaluating VBC Models: Are You Ready?

- Alignment with Strategic Plan (Pop Health Management, Value Based Care, Payer Contracting, Migration to Risk-Based Reimbursement)
- Provider Network Adequacy (quantity and quality; employed and independent)

- Talent
  - Clinical (Physician Champions, Quality Champions, Care Navigation Champions)
  - Administrative (Payer Contracting, Operations Management, Finance)

- Technology Platforms
  - Platforms: EMRs, MSO/Claims/Data, payer Interfaces, Other
  - Interoperability
  - Inputs & Outputs: Data Management & Reporting (up and down)

- Finance Support
  - Lines of Business Review (Proforma Modeling, Prospective/ Retrospective, Risk Adjustments)
  - Economic Review (retain an actuary to assist with review)

Other Key Takeaways

- Provider consolidation activities will continue to increase but with Private Equity as a more active participant, impacting large hospitals/health systems
- The goal of payers and PE: Acquire physician practices and shift sites of care away from hospitals
- We'll continue to see investment in ancillaries and Ambulatory Surgery Centers (ASCs) as a way to grow profitably by shifting volumes from hospitals to lower-cost settings
- Employers will not accept historic levels of cost shifting taking place
- Demarcation lines between payers and providers will continue to blur and with new entrants/competition (AETNA/CVS, Amazon, Wal-Mart, Epic/Cerner, etc.)

Moving to Post-Pandemic Strategies

IMPROVING PERFORMANCE ACROSS THREE CRITICAL AREAS

FINANCIAL IMPROVEMENT

- Operating Cost Reduction
- Revenue Enhancement
- Corporate Development
- Restructuring & Turnaround
- Assurance
- Tax

CLINICAL INNOVATION

- Workforce & Productivity
- Growth & Development
- Population Health Strategies
- Compliance & Risk Management
- Consumer Experience

DIGITAL TRANSFORMATION

- Develop a Digital Strategy
- Manage Risk
- Modernize Technology
- Manage Opportunity
- Lead Change
- Unlock the Power of Data

Jim Watson

PRINCIPAL, BDO HEALTHCARE ADVISORY

Thank you!

hfma greater heartland

Stay strong, be safe,
and keep up the great work!

Visit us at
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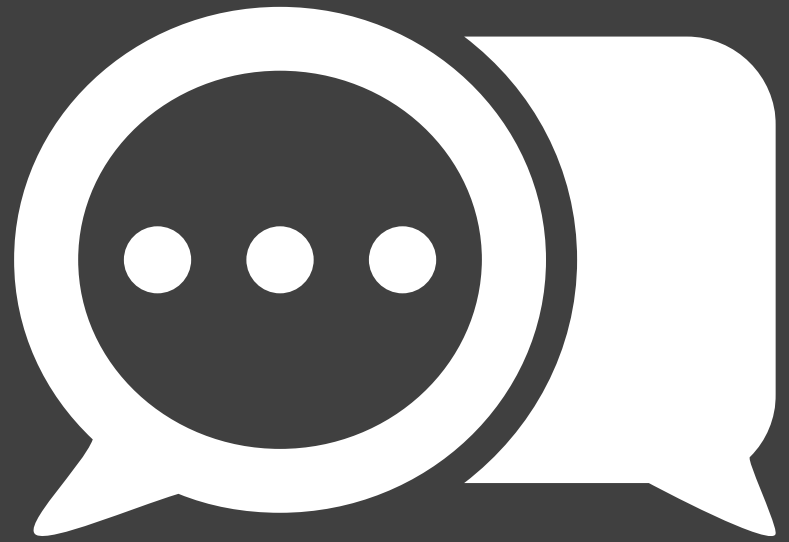
Q&A



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