Value Based Care and Reimbursement

Aaron D. Clark, DO
Medical Director of Value Based Care
Division of Post-Acute & Home Based Care
Office of Population Health
The Ohio State University Wexner Medical Center

MedNet21
Center for Continuing Medical Education

The Ohio State University
Wexner Medical Center

Agenda

- Learning Objectives
- Disclosures
- Emerging Models and Expansion of Retail Primary Care
- Importance of Value Based Care and Population Health
- Keys to Success
- Future Directions
- Discussion

Learning Objectives

- Understand emerging models and future competitive landscape in primary care
- Review background and basic tenets of population health and value-based care
- Understand key elements to succeeding in VBC arrangements
- Understand prominent shifts in the industry that will drive the future healthcare landscape

Disclosures

- Dr. Palakodeti is co-founder and Chief Product Officer for mishe.co, an online marketplace for direct cash-pay clinical services
- Dr Clark – No disclosures to report

Emerging Models and Competitive Landscape

Sandeep Palakodeti, MD, MPH
Co-Founder, Chief Product Officer - Mishe.co
(Former Chief Population Health Officer - University Hospitals)

MedNet21
Center for Continuing Medical Education

The Ohio State University
Wexner Medical Center

CVS buys Oak Street Health for $10.6B

The deal is a major development in the strategic positioning of large retailers in the primary care space, according to analysts.

CVS finally makes primary care play, scooping up Oak Street Health in $10.6B deal

AMAZON / TECH / HEALTH

Amazon closes $3.9 billion buy of membership-based healthcare provider One Medical / The FTC hasn't stepped in so far, and now Amazon's latest acquisition is temporarily offering new subscribers a discounted rate to try its Netflix-for-primary-care service.

Amazon Acquisition of One Medical

AMAZON'S ACQUISITION OF ONE MEDICAL

In 2022, Amazon acquired One Medical, a primary care provider, for $3.9 billion

VALUE-BASED HEALTHCARE

One Medical is a leader in value-based healthcare, which focuses on providing quality care at a lower cost

IMPACT ON THE SPACE

The acquisition has had a significant impact on the healthcare space, as it has opened up new opportunities for value-based healthcare acquisitions

AMAZON'S ACQUISITION OF ONE MEDICAL HAS BEEN A MAJOR MILESTONE IN UNLOCKING VALUE-BASED HEALTHCARE ACQUISITIONS IN THE SPACE.

CVS Acquisition of Oak Street Health

CVS ACQUIRES OAK STREET HEALTH

CVS acquired Oak Street Health, a provider of value-based healthcare services, in 2023 for $10b

STRATEGIC BENEFITS

The acquisition provides CVS with access to a larger network of primary care providers and a greater presence in the value-based healthcare space

FINANCIAL IMPACT

The acquisition is expected to generate $300 million in annual cost savings for CVS

THE ACQUISITION OF OAK STREET HEALTH BY CVS DEMONSTRATES THE POTENTIAL FOR UNLOCKING VALUE-BASED HEALTHCARE ACQUISITIONS IN THE SPACE.

The Impact of CVS Acquisition on the Marketplace

NOVEMBER 2018
CVS announces acquisition of Aetna

DECEMBER 2018
CVS and Aetna complete merger

JANUARY 2019
CVS launches new value-based healthcare services

MARCH 2019
CVS begins offering new pharmacy services

JUNE 2019
CVS expands value-based healthcare services to more markets

AUGUST 2019
CVS launches new digital health platform

OCTOBER 2019
CVS begins offering telehealth services

The premier Medicare Value-Based Care platform

making healthier happen together

~159K at-risk patients

~600 care providers

169 medical centers

with significant ***opportunity to scale***

Advanced Primary Care
Oak St. Health

Foundational Businesses
CVS caremark · CVS pharmacy · aetna

Home Health / Provider Enablement
signifyhealth

10K in-field clinicians nationwide

~2.5M patient home visits (1)

700K+ Medicare ACO beneficiaries expected by 2023

More than 100M Caremark & Aetna members

85% of Americans live within 10 miles of a CVS Store

Nearly **5M customers** visit CVS locations every day

>47M unique **digital customers**

>1,100 MinuteClinics delivering **5.5M+** acute care visits annually

Carbon investment and pilots to help **transform our Retail Health experience**

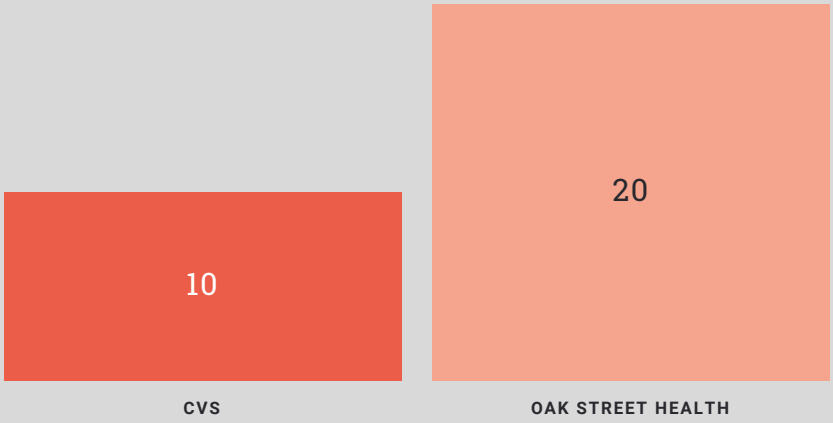
10

1. In-home and virtual visits expected in 2022

Please note that the Signify Health transaction is pending and remains subject to customary closing conditions.

CVSHealth

Financial Analysis of CVS and Oak Street Health



OAK STREET HEALTH HAS A HIGHER FINANCIAL ANALYSIS SCORE THAN CVS.

*Data sourced from Forbes.com

All major insurers now vertically integrated

PAYERS

	UHC	Aetna	Cigna	Anthem	Humana	BlueCross BlueShield	Walmart
Insurer							
PBM	OptumRx	CVS Caremark	Express Scripts	IngenioRx	Humana Pharmacy Solutions	Prime Therapeutics[2]	Capital Rx
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

Competitive Landscape

Focus and Plans:
- Palliative Care: Top 1% sickest (All plan types & at-risk providers)
- Complex Care: Top 5-10% highest risk (All plan types)
- Full Population Solutions: General enrollment (MA Only)

Panel Sizes:
- 61.4 patients per Aspire APP

Satisfaction & Engagement
- Aspire NPS: 88%
- CareMore NPS: 91-92%

Focus: Low-income chronically ill seniors; 50% duals
Plans: Medicare and Medicare Advantage
Panel Size: 500 patients per Oak Street PCP
BD Strategy: Clinics strategically located in dense urban areas near bus stops and target underserved populations with limited access
Clinics have retail feel and community centers to host events
Satisfaction & Engagement
- 95% of patients that complete a first visit stay with Oak Street
- 94% patient retention rate
- >90% NPS

Focus: Average age 72 with 4-5 chronic conditions; low-to-moderate income seniors, 90% within 300% of FPL; 30% dual-eligible
Plans: Medicare Advantage only
Panel Size: 450 patients per ChenMed PCP
Services: Door-to-doctor transportation, on-site prescriptions, on-site health and lifestyle education classes
Satisfaction & Engagement
- Avg. ChenMed patient sees their doctor 13.2x per year versus Nat'l average of 9.6 for similar high-need populations
- 97.4% of ChenMed centers beat the US Top Box average for "Provider – Overall Rating"
- 84.6% of ChenMed centers beat the US Top Box average for "Timeliness of appointment for check-up or routine care"
- 90% NPS

Focus: Low-income seniors
Plans: Medicare Advantage and FFS (intention to convert to MA)
Panel Size: 1,000 patients per Iora PCP
BD Strategy: Focus on large MSAs with patient/urban density, 10-12 practices in a market with 3-4 physicians in a practice
Care Model: Relationship based model of care; leverage proprietary EMR that integrates pop health workflows with clinical documentation to engage patients and their families in care planning
Satisfaction & Engagement:
- 80% patient engagement in primary care vs. national average of 8%
- 90% patient retention rate
- 90% NPS

Value-based Care and Population Health

Aaron D. Clark, DO
Medical Director of Value Based Care
Division of Post-Acute & Home Based Care
Office of Population Health
The Ohio State University Wexner Medical Center

MedNet21
Center for Continuing Medical Education

The Ohio State University
Wexner Medical Center

What is Value-Based Care?

Value-Based Care is a healthcare delivery model that focuses on providing quality care to patients while controlling costs.

It is based on the idea that healthcare providers should be rewarded for providing better outcomes for patients, rather than for the number of services they provide.

It is a shift away from traditional fee-for-service models.

In this model, providers are paid based on the quality of care they provide, rather than the quantity of services they offer.

It encourages collaboration between providers and patients.

Value-based care emphasizes patient engagement and shared decision making between providers and patients.

Value-based care is a healthcare delivery model that focuses on providing quality care to patients while controlling costs, shifting away from traditional fee-for-service models, and encouraging collaboration between providers and patients.

History of Value-Based Care

1980s
The Balanced Budget Act of 1997 introduced the concept of value-based care, which focused on improving quality and reducing costs.

2000s
The Medicare Modernization Act of 2003 established the Medicare Part D prescription drug benefit and the Medicare Advantage program.

2010s
The Affordable Care Act of 2010 introduced the Medicare Shared Savings Program, which incentivized providers to reduce costs while maintaining quality of care.

2015
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the Quality Payment Program, which replaced the Sustainable Growth Rate formula for physician reimbursement.

2018
The Centers for Medicare & Medicaid Services (CMS) launched the Comprehensive Primary Care Plus (CPC+) program, which incentivizes primary care physicians to provide comprehensive, coordinated care to their patients.

The Trillion Dollar Problem

NEJM Catalyst | Innovations in Care Delivery

IN DEPTH

Making a Dent in the Trillion-Dollar Problem: Toward Zero Defects

Peter J. Pronovost, MD, PhD, John W. Unwin, MD, Eric Beck, DO, MPH, Justin J. Coran, PhD, MPH, Abirammy Sundaramoorthy, MD, MBA, Mark E. Schario, MS, RN, FACHE, James M. Muisyo, MSc, Jonathan Sague, MSN, RN, Susan Shea, FAA, MAA, Patrick Runnels, MD, MBA, Todd Zeiger, MD, George Topalsky, MD, Andrew Wilhelm, PhD, Sandeep Palakodeti, MD, MPH, Amol S. Navathe, MD, PhD

Vol. 2 No. 1 | January 2021

DOI: 10.1056/CAT.19.1064

Health care harms too many patients, costs too much, and improves too slowly. Progress in improving value has been slow. Most efforts to eliminate defects in value have been piecemeal rather than systematic. In this article, the authors describe a framework for identifying defects in value and provide estimates for cost savings if these defects were to be eliminated. The authors then provide a framework for how health systems may work to systematically eliminate these defects in value. Finally, they provide an example of one academic health system that embarked on a journey to implement this framework and the initial results and lessons learned. In the current study, the authors found that: (1) the U.S. health system spends in excess of $1.3 trillion per year on suboptimal behavior; and (2) their organization was able to reduce the annual per-member-per-year cost by 9% over the course of 12 months by reducing specific defects in care. Although it is early in the journey and the framework is only 25% deployed, the authors believe that this model offers a hopeful path forward for improving value.

"**Quality** is the foundation of **value-based care**, and **value-based care** is the foundation of **quality**."

Goals of VBC: Improving Quality & Efficiency of Care

Defining Quality & Efficiency of Care
Identifying and measuring the quality and efficiency of care to ensure value-based care is achieved

Improving Care Delivery
Implementing strategies to improve the delivery of care, such as team-based care and patient engagement

Reducing Costs
Reducing costs through the use of evidence-based practices and technology

Value-based care requires a focus on improving quality and efficiency of care, which can be achieved through defining quality metrics, improving care delivery, and reducing costs.

Why Value-Based Care Matters

We should aim to deliver care that we would want for ourselves and our families

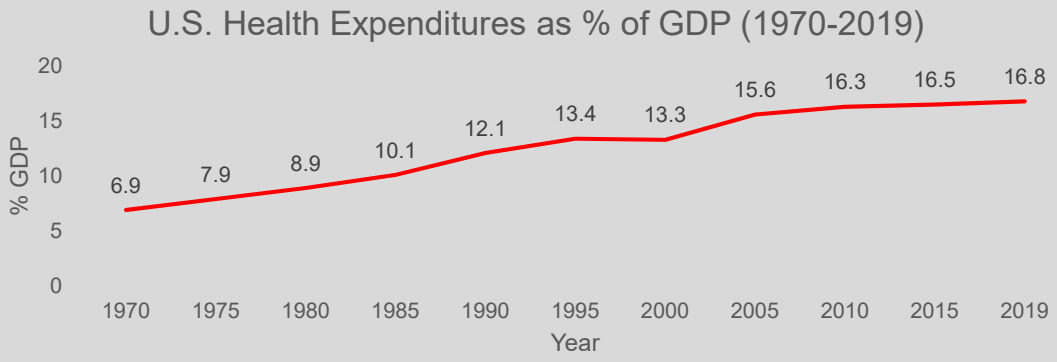
- **Achieve the quadruple aim**
- Provide the full **spectrum of care** for those we serve:
  - Preventative care and **thorough risk assessment**
  - **Chronic disease management**
  - **Gap closure** and **high quality/STARs scores**
  - **Complex longitudinal** care
  - **Transitional and acute** care
  - **Palliative and end-of-life** care
- **Improvement** in quality outcomes
- **Improvement** in hospital admissions
- **Improvement** in ED utilization
- **Improvement** in pharmacy spend
- More **time spent with loved ones, doing things we enjoy, and contributing meaningfully**

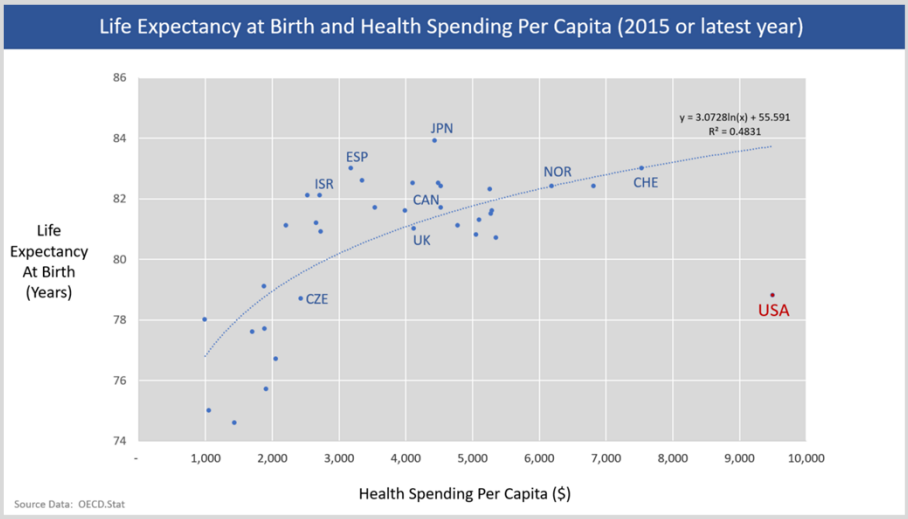
"**Value** is the **equation** that determines the success of any endeavor."

The Value Equation

By 2030, the Centers for Medicare and Medicaid Services (CMS) expects that **all** Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care. This is driven by the exponential, and unsustainable, growth in health care spending.

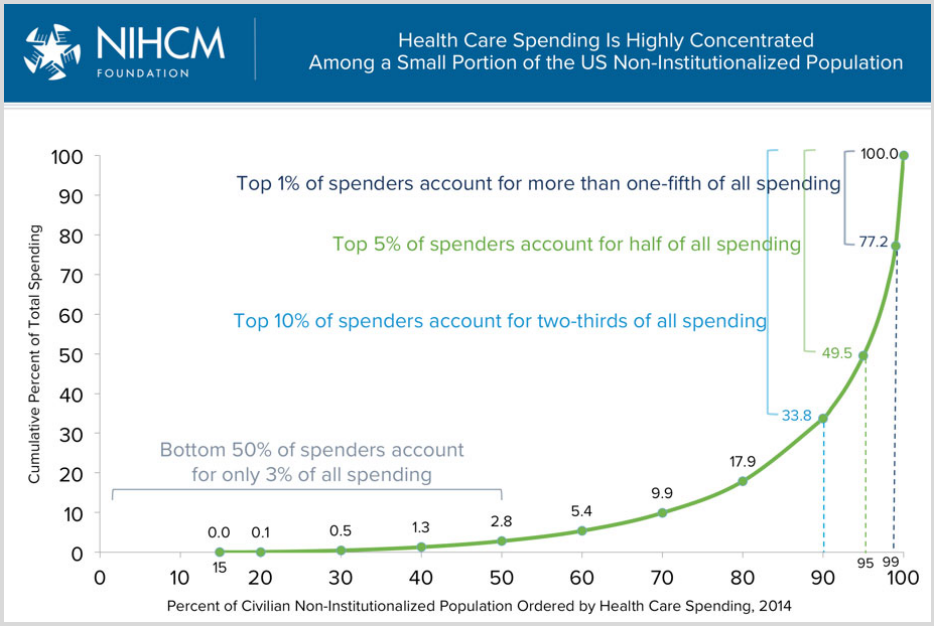
U.S. health care spending grew 9.7 percent in 2020, reaching $4.1 trillion or $12,530 per person. As a share of the nation's Gross Domestic Product, health spending accounted for 19.7 percent.





OECD life expectacy and health spending per capita 2013 v1 - Health care finance in the United States - Wikipedia

Author: Farcaster (CC BY-SA 4.0)



Source: NIHCM Foundation analysis data from 2014 Medical Expenditure Panel Survey

Volume vs. Value Based Revenue Models

Managing against predictable inputs
Payment models that reward:
Visits/procedures/RVUs

Managing against outcomes
Payment models that reward:
quality outcomes over volume

Quantity/Volume ← Lower $ Risk — Fee for service … Higher $ Risk — Full Capitation → Quality/Outcomes

ACOs
OCPC
CPC+
BPCI-A

Acronyms:

ACO: Accountable Care Organization
OCPC: Ohio (Medicaid) Comprehensive Primary Care
Comprehensive (CMS/Multi-payer) Primary Care Plus (evolution from PCMH – Patient Centered Medical Home)
Bundled Payments for Care Improvement- Advanced

Source: OSUWMC

Volume vs. Value Based Revenue Models

Managing against predictable inputs
Payment models that reward
Visits/procedures/RVUs

Managing against outcomes
Payment models that reward
quality outcomes over volume

Quantity/Volume — Lower $ Risk / Fee for service ⟷ Higher $ Risk / Full Capitation — Quality/Outcomes

Traditional medical care in US is the Fee for Service model

- Payment is tied to providing a service, not to the health outcome
- No payment for work done outside context of a visit/episode of care
- Incentivizes system utilization = increased costs with variable outcomes

Source: OSUWMC

Volume vs. Value Based Revenue Models

Managing against predictable inputs
Payment models that reward
Visits/procedures/RVUs

Managing against outcomes
Payment models that reward
quality outcomes over volume

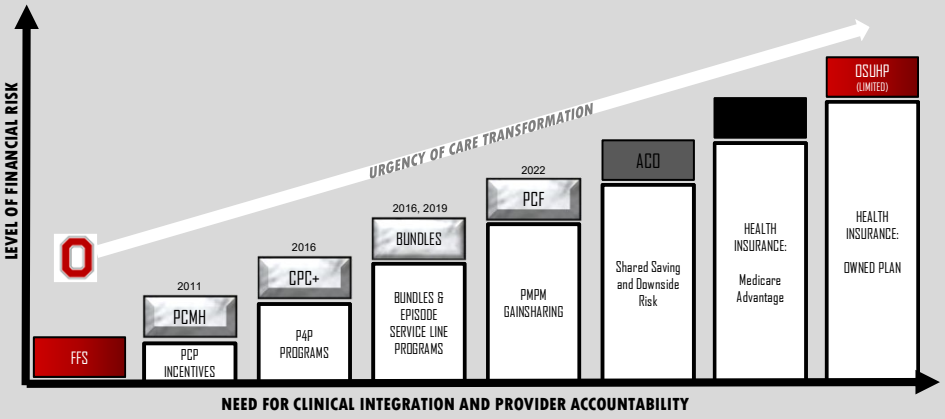
Quantity/Volume — Lower $ Risk / Fee for service ⟷ Higher $ Risk / Full Capitation — Quality/Outcomes

Value Base Care Models:

- Share financial 'risk' of providing care for populations of people
- Reward quality outcomes
- Focus on prevention and care coordination
- Revenues not entirely connected to 'visits' (examples)

Source: OSUWMC

OSU's Population Health Journey

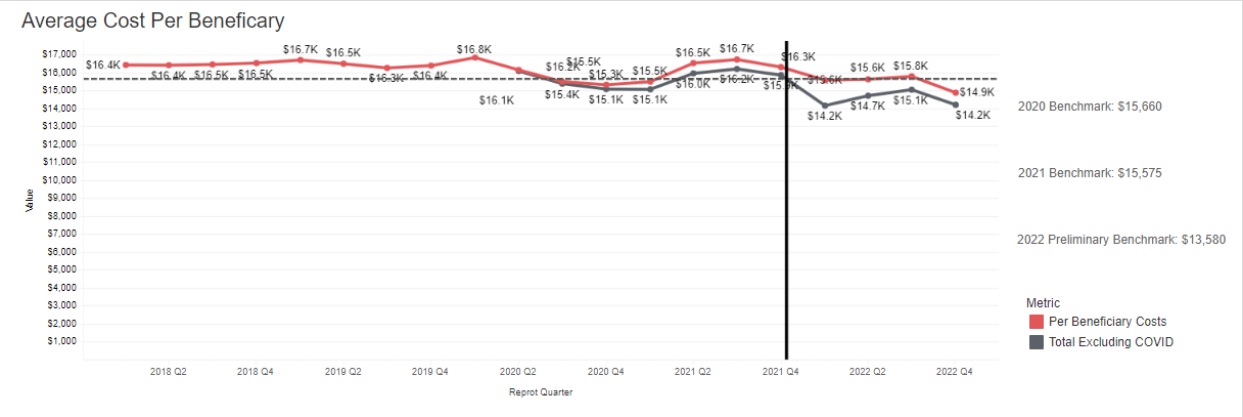


The Ohio State Health ACO

- Medicare Shared Savings Program (**MSSP**)Track 1 – No downside risk model. If costs are less than expected, there is potential shared savings modified by quality metric goals. Currently about 13,000 beneficiaries (90% overlap with PCF cohort).
- The ***strategic goal*** of the ACO is to reduce the total cost of care, while enhancing the quality of care, for a risk-stratified, high cost/high need patient population
- Progression to downside risk. In 2023, the Ohio State Health ACO will be moving to MSSP Track C which carries downside risk

Source: OSUWMC

Expenditures and Benchmark since inception



	Q1	Q2	Q3	Q4	$ Change Q1 – Q4
Total Expenditures / beneficiary	$15,582	$15,628	$15,794	$14,883	$745.00
Total Expenditures / beneficiary w/o COVID	$14,163	$14,714	$15,051	$14,209	$505.00

Source: CMS Quarterly Expenditure Report

PY22 Clinical Strategy Outcomes

Reduce Unnecessary Utilization

- 275+ BH Counseling sessions completed
- CHW meets F2F with 5 – 10 high risk patients / wk
- Move after-hours clinic from Gahanna to OSU East to divert necessary ED utilization

Maintain Quality Performance

- 9% decrease in patients with uncontrolled diabetes
- Increased number of CRC Screening for AA patients
- Decrease in flu vaccination rate disparity

Risk Capture

- At the end of the Q1 2022, HCC Overall capture rate was 33.8% (15.6% higher than previous year)

Active Panel Management

- 200 beneficiaries have been linked to a PCP
- 300+ PCP fields have been updated in IHIS

Leverage data analytics and appropriate technology solutions

Keys to Succeeding in Value-Based Care

How to Succeed In VBC - AAFP

https://www.aafp.org/dam/brand/aafp/pubs/fpm/issues/2021/1100/p25.pdf

- Empanelment
- Risk Stratification
- Panel Management
- Team-Based Care
- Pitfalls
  - Paltry payments
  - Clunky data reporting
  - Poor change management
  - Lack of incentives
  - Coding missteps

Maximizing probability for success in downside risk environment

Driving success in a value-based reimbursement model requires attention to four key drivers:

- 1.1. Reducing unnecessary costs & utilization
- 1.2. Maintenance and enhancement of quality outcomes
- 1.3. Capture of accurate risk adjustment
- 1.4. Active management of panel attribution

Active solutions

- ❑ Enhanced, Risk Focused Care Management
  - Integrated Care Management Team
- ❑ Advanced Analytic Insights
  - Innovaccer/IHIS
- ❑ Primary Care Alignment
  - HCC Risk Capture (Curation)
  - AWVs
- ❑ Cost Control/Awareness
  - CT scans
  - Facility fees
  - LOS, Post-Acute Care

Population Health Key Cost Saving Strategies

Strategic Goal

Reduce Total Cost of Care for Risk Stratified Populations and Enhance Capture of Risk Scores

Domains

Cost Control Activities	Right Place of Care	Patient Centric Care	Health Equity	Risk Adjustment
Engage key stakeholders to identify and act on opportunities around controllable costs	*Transform care delivery model To encourage patient centered cost effective locations of care*	*Patient engagement to provide meaningful patient centered*	*To lead, in awareness of, and in addressing inherent inequities*	*Optimize Risk Scoring to Capture Reimbursement*
• PCP Attribution • Primary-Oncology Care • High Cost Imaging • Reduced Readmissions	• Reduced High ED Utilization • Ambulatory Sensitive Admissions • Home Enabled Care	• Home Enabled Care • Post-Acute Care Options • Length of Stay • Disease Management • SDoH Screenings	• Public Policy Advocacy • Health Outreach • Community Engagement • Bias Training	• Annual Wellness Visits • Risk Adjustment Factor optimization • Maximize Accuracy of HCC capture

Source: OSUWMC

Importance of AWVs and HCC accuracy

- Role AWVs play
  - Attribution!!
  - Closing care gaps
  - HCC accuracy
- Role HCCs play
  - Sets RAF
  - Benchmark for cost on ACO and MA patient cohorts
  - PMPM risk-tier for PCF

Source: OSUWMC

Future Directions in Value-Based Care

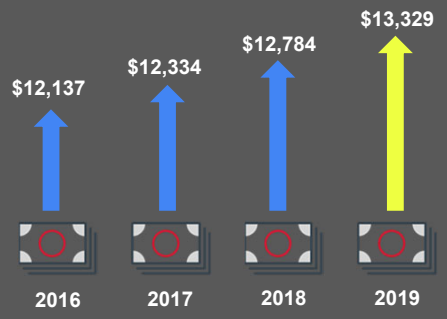
Sandeep Palakodeti, MD, MPH
Co-Founder, Chief Product Officer - Mishe.co
(Former Chief Population Health Officer - University Hospitals)

MedNet21
Center for Continuing Medical Education

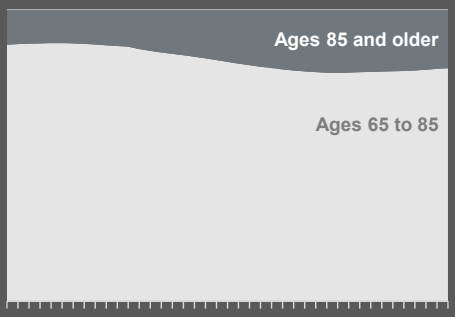
The Ohio State University
Wexner Medical Center

Medicare population is getting older, and more costly

Medicare spending per capita continues to grow…

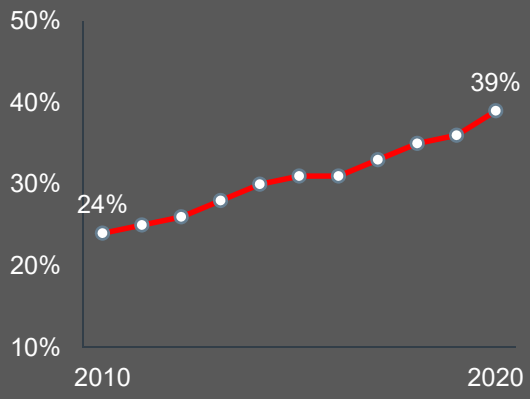


…and patients will become older, sicker over time



Shift to Medicare Advantage continues upward trend

Medicare Advantage (MA) penetration, 2010-2020



- **Why is MA growing?**
  - Supplemental benefits (vision, dental, transportation, meals) and lower costs continue to appeal to beneficiaries
  - Health plans continue to offer more MA plans due to favorable economics, increasing consumer choice
- **What is the impact to providers?**
  - Medicare Advantage plans are more likely to have narrow network and managed care designs, making provider selection and steerage more prominent
  - Those with affiliated MA plans may face stiffer competition and may need to pursue options to enhance plan appeal

Shift to Alternative Payment Models

Progression to alternative payment methodology

	Traditional fee-for-service	Pay-for-performance	Shared savings and bundles	Population-based payments
Medicare Advantage	39.5%	6.9%	36.4%	17.2%
Original Medicare	10.2%	48.9%	36.5%	4.4%
Medicaid	66.1%	10.6%	17.4%	5.9%
Commercial	55.7%	14.2%	27.6%	2.5%
All-payer	**39.1%**	**25.1%**	**30.7%**	**5.1%**

Price Differential Pressures Shifting Site of Care

Price differential for THA across sites of care

Inpatient	HOPD	ASC
$12,320	**$12,101**	**$8,923**

Future of ASCs

More services?

- CMS continues to evaluate other interventions to add to ASC list in future, e.g.,
  - Coronary atherectomy
  - Revascularization of CTO
- ASCs allowed to perform more services during COVID-19 crisis, may set future precedent

More scrutiny?

- Poor quality outcomes would cause CMS to reconsider procedures already shifted to ASCs
- History of inappropriate use in freestanding labs may increase attention on procedural shift

More steerage?

- Some payers initiating site-of-care reviews for HOPD procedures that could be performed in ASCs
- CMS price comparison tool available for HOPD vs. ASC

42

CMS Final rules propel three site of care shifts:

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

To Be Sure…

CMS Innovation Center at 10 Years — Progress and Lessons Learned

Brad Smith, M.Phil.

The federal CMMI was created to assess new payment and service delivery models for improving health care nationwide. This review reports that during the agency's first decade of operation, some of the value-based models saved money and improved quality but most did not. The lessons learned and future directions are discussed.

February 25, 2021
N Engl J Med 2021; 384:759-764
DOI: 10.1056/NEJMsb2031138

Print Subscriber? Activate your online access.

Viewpoint ONLINE FIRST FREE

January 30, 2023

Salve Lucrum: The Existential Threat of Greed in US Health Care

Donald M. Berwick, MD, MPP[1]

Author Affiliations | Article Information

JAMA. Published online January 30, 2023. doi:10.1001/jama.2023.0846

“Discussion is an essential part of the learning process.”

JOHN DEWEY