# Value Based Care and Reimbursement

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MedNet21
Center for Continuing Medical Education

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## 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)*

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**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.

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**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.**

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**CVS** Acquisition of Oak Street Health

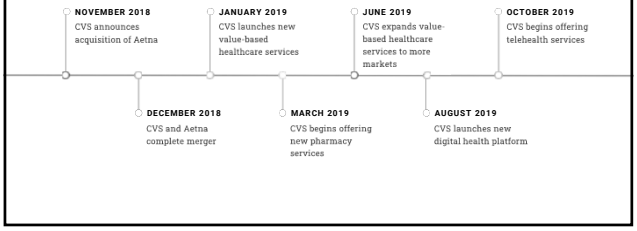
**CVS ACQUIRES OAK STREET HEALTH**
CVS acquired Oak Street Health, a provider of value-based healthcare services, in 2023 for $10b

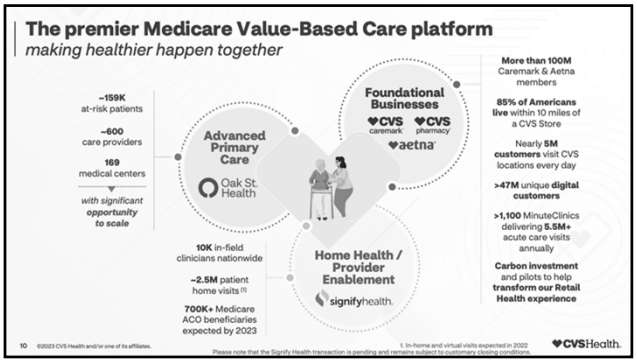
**STRATEGIC BENEFITS**
The acquisition provides CVS with access to a larger network of primary care providers and a greater presence in the value-based healthcare space

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

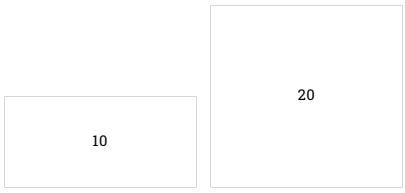
**THE ACQUISITION OF OAK STREET HEALTH BY CVS DEMONSTRATES THE POTENTIAL FOR UNLOCKING VALUE-BASED HEALTHCARE ACQUISITIONS IN THE SPACE.**

## The **Impact** of CVS Acquisition on the Marketplace




## 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 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Insurer | UHC | Aetna | Cigna | Anthem | Humana | BlueCross BlueShield | Walmart | |
| 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; Comviva Care Center; Kindred at Home | Various Blues physician practices | Walmart Health | |

## Competitive Landscape

CareMore Health · Aspire Health

**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%

Oak Street Health

**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

ChenMed

**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

iorahealth

**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

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## 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


"**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

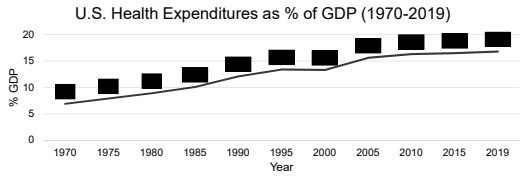
- **Achieve the quadruple aim**
- Provide the full **spectrum of care** for those we serve:
  - Preventative care and **thorough risk assessment**
  - **Chronic disease management**
  - **Gap closure** and **high quality/STARs scores**
  - **Complex longitudinal** care
  - **Transitional and acute** 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."

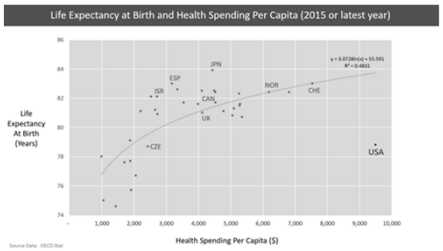
## The Value Equation


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.

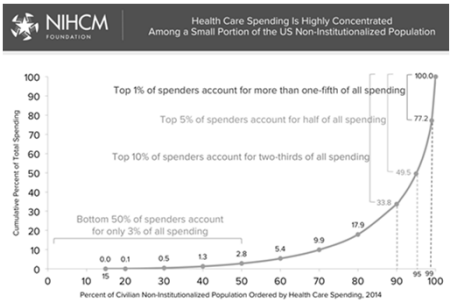
***U.S. health care spending grew 9.7 percent in 2020, reaching $4.1 trillion or $12,530 per person. As a share of the nation's Gross Domestic Product, health spending accounted for 19.7 percent.***






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




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

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**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

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Payment models that reward
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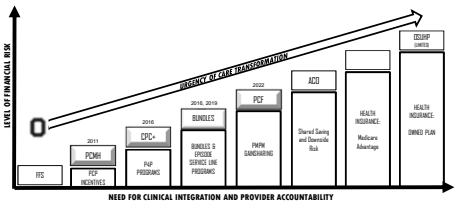
Quantity/Volume ← Lower $ Risk / Fee for service — Higher $ Risk / Full Capitation → Quality/Outcomes

**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

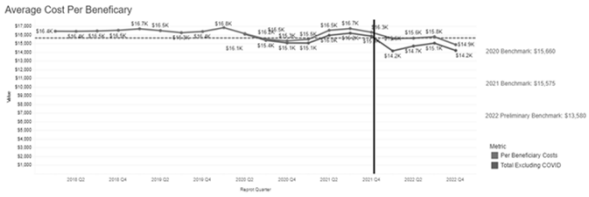



## The Ohio State Health ACO

- 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<br>• Primary-Oncology Care<br>• High Cost Imaging<br>• Reduced Readmissions | • Reduced High ED Utilization<br>• Ambulatory Sensitive Admissions<br>• Home Enabled Care | • Home Enabled Care<br>• Post-Acute Care Options<br>• Length of Stay<br>• Disease Management<br>• SDoH Screenings | • Public Policy Advocacy<br>• Health Outreach<br>• Community Engagement<br>• Bias Training | • Annual Wellness Visits<br>• Risk Adjustment Factor optimization<br>• 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)*

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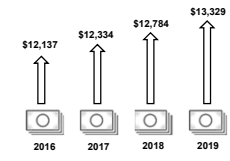
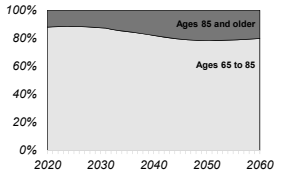
## Medicare population is getting older, and more costly

**Medicare spending per capita continues to grow…**

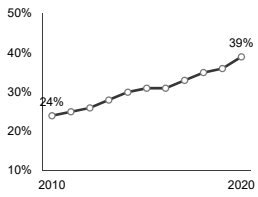



**…and patients will become older, sicker over time**




## 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

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## 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
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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