Value-Based Care:
Where we are and where we're headed

when

Today's Sponsoring Organizations

Agenda

- Welcome and Introductions
- Overview of value-based care and ACOs
- Value in Health Care Act of 2021
- Congressional remarks
- ACO speaker presentations
- Q & A

Value Overview

- Shifting healthcare payment and delivery from focusing on volume of services to value of care has been an ongoing effort across payers for over a decade
- History of bipartisan support
- Medicare has played a central role in this transformation, implementing over 50 alternative payment models (APMs)
- ACOs have played a prominent role with the Medicare Shared Savings Program (MSSP) as the largest APM, covering nearly 11 million beneficiaries with nearly 500,000 participating clinicians
- ACOs focus on population health, quality improvement and bending the cost curve – meaningful transformations that take time, hard work, and resources.

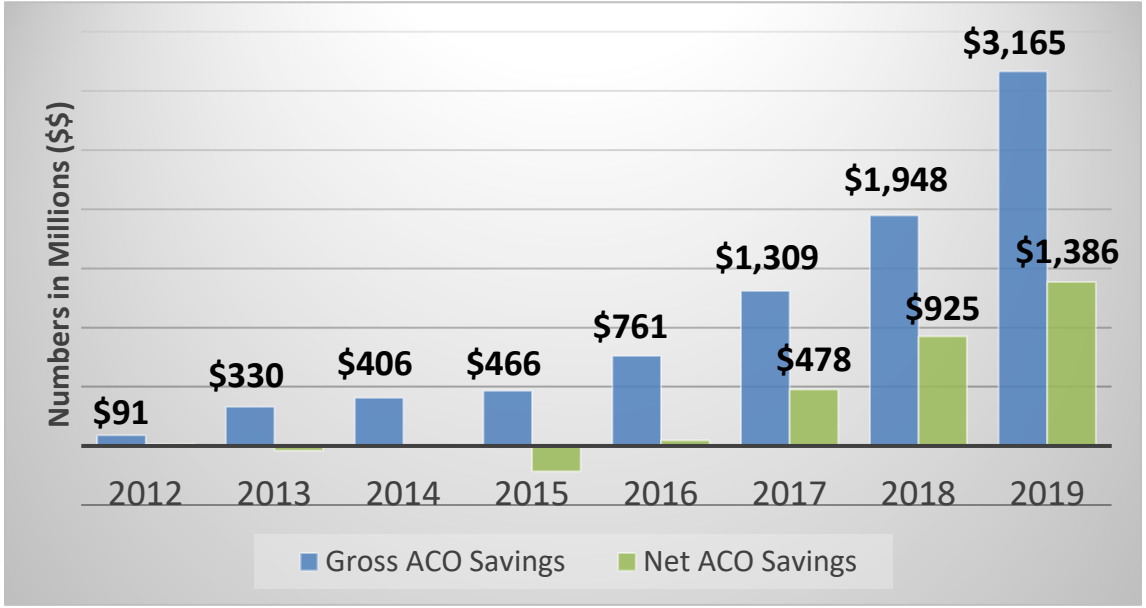
Background

Accountable Care Organization (ACO) = A group of doctors, hospitals, and/or other health care providers working together to provide better care at a lower cost

When ACOs improve the quality of patient care while lowering the costs, they keep a portion of savings.

ACO Savings and Quality

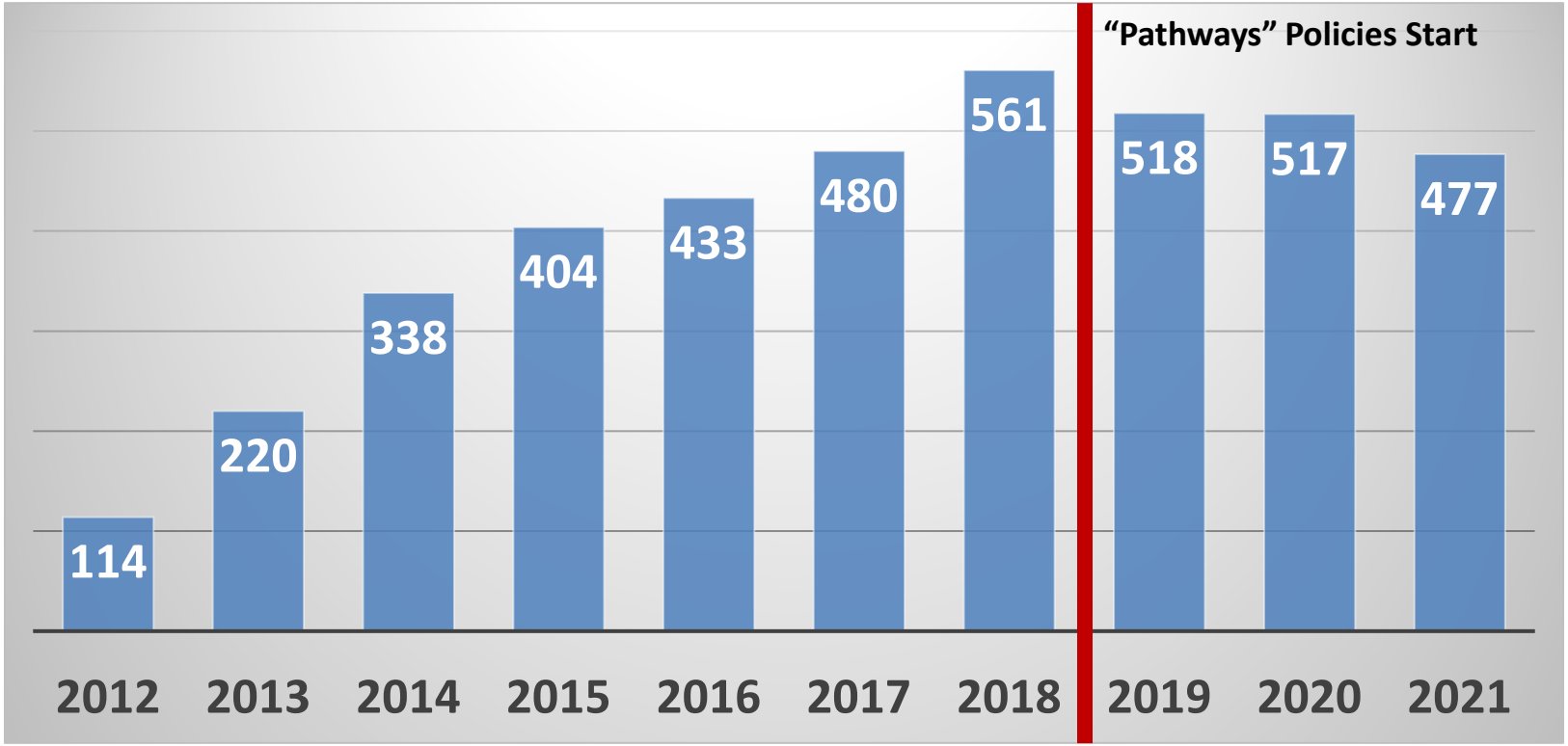
Since 2012, ACOs have saved Medicare $8.5 billion in gross savings and $2.5 billion in net savings



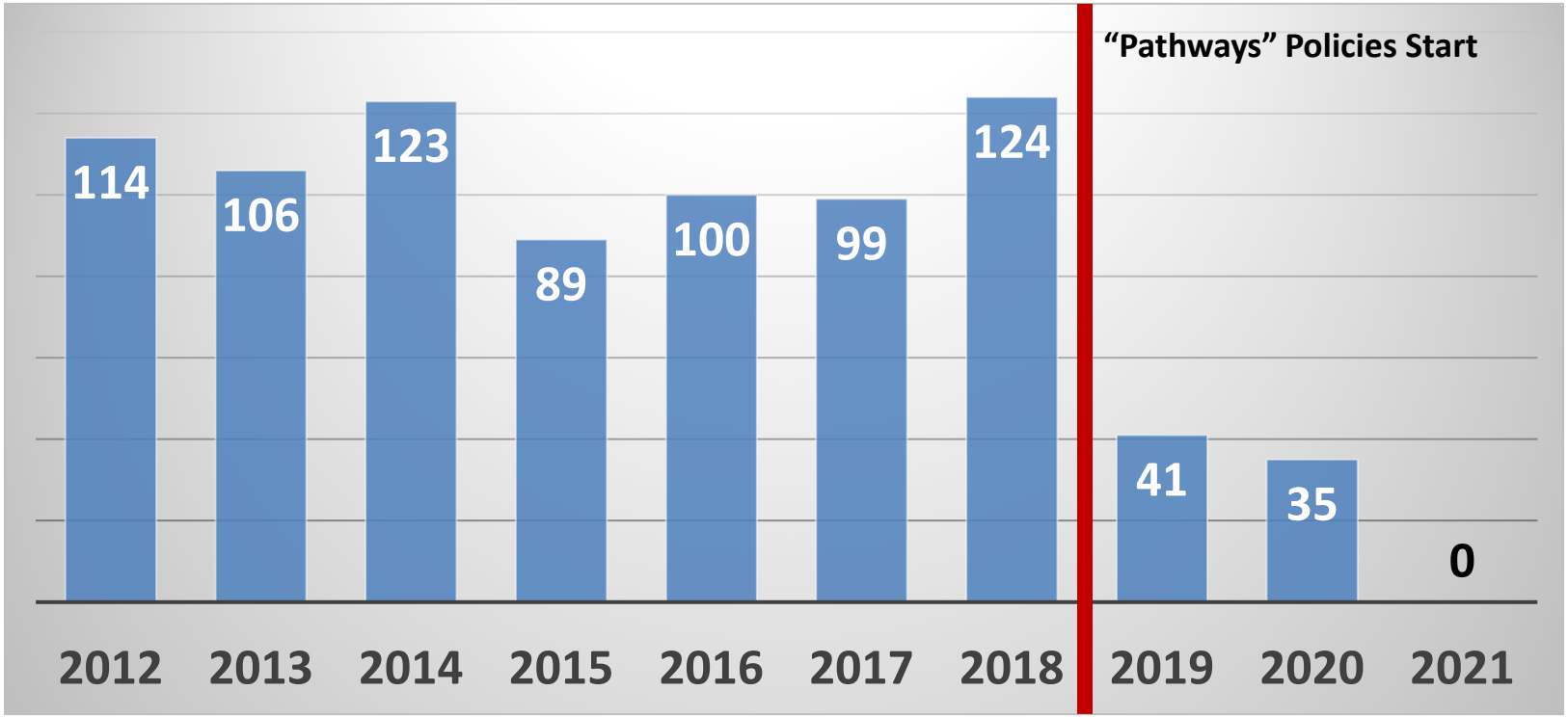
Includes Savings for Pioneer ACOs, Next Gen ACOs, and MSSP ACOs

ACOs and Quality
2019: MSSP ACOs received an average quality score of 94.77%

Total MSSP ACOs



New MSSP ACOs



Value in Health Care Act of 2021

- "Value Act" was introduced in the House of Representatives on July 20
- Bill text is available here, summary available here.
- The bill supports ACOs and the shift to value-based care and payment
- Thank you to the bill sponsors: Reps. Peter Welch (D-Vt.), Suzan DelBene (D-Wash.), Darin LaHood (R-Ill.), and Brad Wenstrup (R-Ohio).
- 14 leading national healthcare stakeholder organizations sent a letter and issued a press release in support of the bill

Value in Health Care Act of 2021

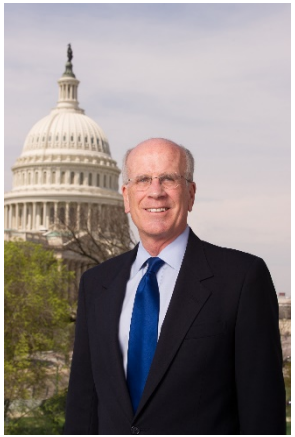
- Encourages participation in the Medicare Shared Savings Program by:
  - Increasing shared savings rates
  - Modifying risk adjustment
  - Eliminating high-low revenue distinction
  - Providing more time before risk is required; Enhanced track voluntary
  - Removing ACO patients from regional population in benchmarks
- Provides advanced funding to ACOs
- Improves Advanced APM incentives and fixes “QP” thresholds
  - Extends the Advanced APM bonus for six additional years
  - Maintains the QP payment threshold at 50 percent through performance year 2022 (payment year 2024) with small annual increases thereafter
- Requires study on overlap in value-based care programs
- Calls for GAO study on racial health disparities for ACOs compared to FFS

Value Act Supporters

Congressional Remarks

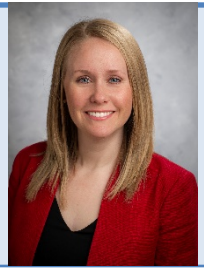
Rep. Suzan DelBene
Democrat
Representing Washington's
1st Congressional District

Rep. Darin LaHood
Republican
Representing Illinois's
18th Congressional District



Rep. Peter Welch
Democrat
Representing Vermont

ACO Speakers

	**Melanie Matthews** *CEO, Physicians of Southwest Washington* *President, MultiCare Connected Care*
	**Megan Reyna** *Vice President, Government & Value Based Programs* *Advocate Aurora Health*
	***Vicki Loner*** *CEO* *OneCare Vermont*

PSW

Managing lives across multiple ACOs

NW Momentum Health Partners ACO

Next Generation ACO Model

- 1st Next Generation ACO in Pacific NW
- Participation since 2017
- Growth from **7,000** Medicare Beneficiaries to **33,000**
- 95.68% Average Quality Score
- $7M Total Shared Savings

MultiCare Connected Care

Medicare Shared Savings Program

- Track 1+
- Participation since 2018
- Growth from **25,000** Medicare Beneficiaries to **38,000**
- $8.1M Total Shared Savings

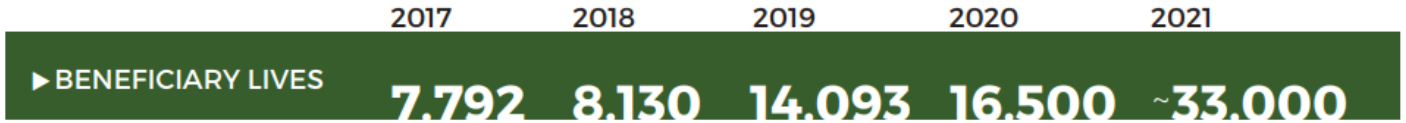
GEOGRAPHIC REACH ACROSS WASHINGTON AND WESTERN IDAHO

COMBINED **71,000** MEDICARE BENEFICIARIES

INDEPENDENT PHYSICIAN OWNED

NWMHP RECOGNIZED AS LOWEST IN POST – ACUTE CARE SPEND

NextGen ACO Growth



2019 NETWORK

970 PROVIDERS

- Thurston County, WA
- Nez Perce County, ID

2020 NETWORK

735 PROVIDERS*

- Kitsap County, WA
- Lewis County, WA
- Pierce County, WA
- Thurston County, WA
- Nez Perce County, ID
- Lane County, OR

2021 NETWORK

1,458 PROVIDERS

- Clark County, WA
- Grays Harbor County, WA
- King County WA
- Kitsap County WA
- Kilickitat County, WA
- Lewis County, WA
- Pacific County, WA
- Pend Oreille County, WA
- Thurston County, WA
- Nez Perce County, ID

The Value in Health Care Act

The evolution of value-based care

Over time, CMS/CMMI is increasing the number of value-based programs available for participation. Addressing the concern of model overlap allows:

- Increased opportunity to take risk
- ACOs to diversify their network to participate in a model where their providers can be successful
- Allow organizations to build competencies in pursuit of their move to value-based care

Advanced funding and support to ACOs to help them start down the path to value

- Rural providers especially benefit due to the lack of resources in rural areas
- Give organizations the ability to develop their programs without falling behind

Accurate benchmarking methodology

- Fair opportunity for all ACOs to be successful
- Address disadvantage for rural ACOs (Rural Glitch Bill)

The “Rural Glitch” Bill

Helping ACOs support rural providers in their participation in APMs

The move to value-based care is happening everywhere and rural ACOs have a great opportunity to rapidly change healthcare in rural areas.

- Tight connected communities
- High engagement
- Collaborative approach to health care

Increasing the number of rural providers in an ACO can help mitigate their risk.

Leverage a current ACO’s knowledge and resources to help rural providers:

- Strengthen current competencies to optimize performance
- Build along the path to risk
- Participate and thrive in value-based care

The “Rural Glitch” Bill helps to offset benchmarking challenges that impact performance.

NW MOMENTUM HEALTH PARTNERS

Population Health

Maturity Index

	Payment Models	Provider Network	Org Foundation	Care Delivery	Clinical Business Informatics
Highly Evolved	Capitation payer collaboration	Fully contracted network, direct to employer	Formal and active PHM structure with specific (FTE) PHM Leadership	Coordination across all patient populations	Longitudinal record of care; centralized value analytics
Transitional	Upside/downside risk bundles	Inclusion of specialists and Contractors; Performance requirements	Org engaged in opportunities in PHM and willing to make investments	Coordination across larger patient populations	Enterprise EHR (POP) risk adjustment; some data and CM functionality
Developing	P4P upside-only shared savings PMPM (most)	Open network PCP – Driven	Existing but not prolific PHM structure	Coordination across certain pops or service lines	Deployed EHR; claims-based analytics: EHR use
No Development	Fee-for-service (FFS)	No provider alignment	No quality committees; no defined business strategies for PHM	No integration or care coordination	Substantial paper – based and EHR tools

Transforming the Organization – Population Health and Connectivity

The level of organizational maturity in transforming to a value-based entity will be how technology can be used to drive population health management.

How we partner

Delivering the value of innovative models

Our Approach

- Meet partners where they are
- Create value-based ACO opportunities
- Share PSW's experience and best practices

Partnership

- Active engagement
- Commitment to improving care, reducing cost, rewarding network
- Performance monitoring cadence

Continuation of Success

- Support in navigating the Quality Payment Program
- Increasing risk experience and performance competencies
- Maintaining quality standards year over year

NWMOMENTUM
HEALTH PARTNERS

Thank You

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Advocate Aurora Health

Megan Reyna, MSN, RN
Vice President, Government & Value Based Programs
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AdvocateAuroraHealth®

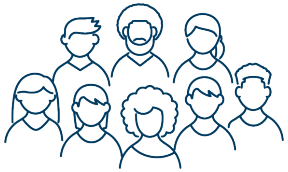
OUR PURPOSE

We help people **live well.**

Guided by

Our Values

Excellence
Compassion
Respect



Focused on

Our Patients
Our People
Our Communities

Committed to

Diversity
Equity
Inclusion

AdvocateAuroraHealth

BY THE NUMBERS

28 HOSPITALS

500+ SITES OF CARE

Top 12

NOT-FOR-PROFIT HEALTH SYSTEM

Top 10

IN QUALITY AMONG NATIONAL HEALTH SYSTEMS

70,000+

TEAM MEMBERS

22,000+ NURSES

10,000+ PHYSICIANS

10,000+

VOLUNTEERS

3M UNIQUE PATIENTS

1.3M VALUE-BASED LIVES

53

INTEGRATED HEALTH & SAFETY MEASURES TRACKED

NEARLY

$2.2B

COMMUNITY BENEFITS IN 2019

1M+

LIVEWELL APP DOWNLOADS

AdvocateAuroraHealth

Value

Fee-for-service to fee-for-value drives health care transformation and accountability in managing the care of a population.

In value-based contracts, our physicians are rewarded for achieving better outcomes and lowering the total cost of care.

Over 30
Value-based contracts

More than **$131.5 million** saved in 2019 to reinvest in patient care*

LEARN MORE!
Read *"This is Population Health"* by Carrie Nelson, MD

** In Illinois*

Low-Risk: Jane

Who: Jane is a 25-year-old who is overall healthy

Her health care journey: While she hasn't needed care for her physical health in a while, Jane has noticed some changes with her mood that she can't seem to shake. She decides to research providers she can meet with to learn more about her feelings.

Visits **aah.org** to easily compare providers based on ratings, reviews, video and more

Sets up a video visit with her provider from the comfort of home

Provider connects her with a Behavior Health Coordinator

Schedules therapy appointment 5 min from her home (with video visit options)

Uses LiveWell for meditation and wellness tips as another avenue for her mental health

Improved health outcomes

AdvocateAuroraHealth

Rising-Risk: Mary

Who: Mary is an active 47-year-old who has Diabetes

Her health care journey: Mary has an established PCP and but has not had a visit in over a year. Given her busy schedule, keeping her health on track is not always top of mind.

Receives email that her care is overdue

Makes appointment with her PCP to get her A1C tested

PCP identifies her condition worsened and she hasn't been filling relevant prescriptions due to cost

PCP asks care manager and pharmacy team to create action plan including low-cost generic alternatives

Pharmacist enrolls patient in metformin dose titration program to stabilize A1C

Uses LiveWell to access diabetes-friendly recipes and meal plans

Lowered total cost of care

Improved health outcomes

High-Risk: Carl

Who: Carl is a 67-year-old who suffers from multiple chronic conditions, including COPD, and a recent heart attack.

His health care journey: Carl has a PCP and sees several specialists to manage his multiple chronic conditions. However, he has trouble keeping his health on track in between his visits and most recently was seen for complications with his COPD at his local Advocate Aurora hospital ED.

Visits his local Advocate Aurora ED and is admitted

Care Transitions RN creates a plan for his transition home

Receives calls from an RN 48 hours post-discharge to help with follow up care and assess for SDOH needs

Scheduled for a Transitional Care Management post-discharge visit with his PCP

Hospital readmission avoided

PCP leverages multiple specialty consultation plans in coordination with care management

Care management arranges for transportation to specialty visits

Improved health outcomes

Social Determinants

*"Medical care accounts for **only about 10 to 20 percent** of the modifiable contributors to healthy outcomes of a population, with the other **80 to 90 percent being the SDoH."** – **Alvia Siddiqi, MD.***

Social Determinants of Health (SDoH) play a critical role in overall health outcomes and total cost of care. Patients with SDoH barriers disproportionately have:

- Higher utilization and unnecessary emergency room visits
- Avoidable hospital admissions and readmissions
- Lack of engagement with their primary care medical home

job security **education** **transportation**

safe shelter **access to healthy food**

social isolation

SDoH is an Equity Issue

- Transformation based on a medical-social construct
- Data needs to drive improvement & solutions
- Clinicians need access to resources in order to screen for SDOH
- ACOs are well positioned to address health equity

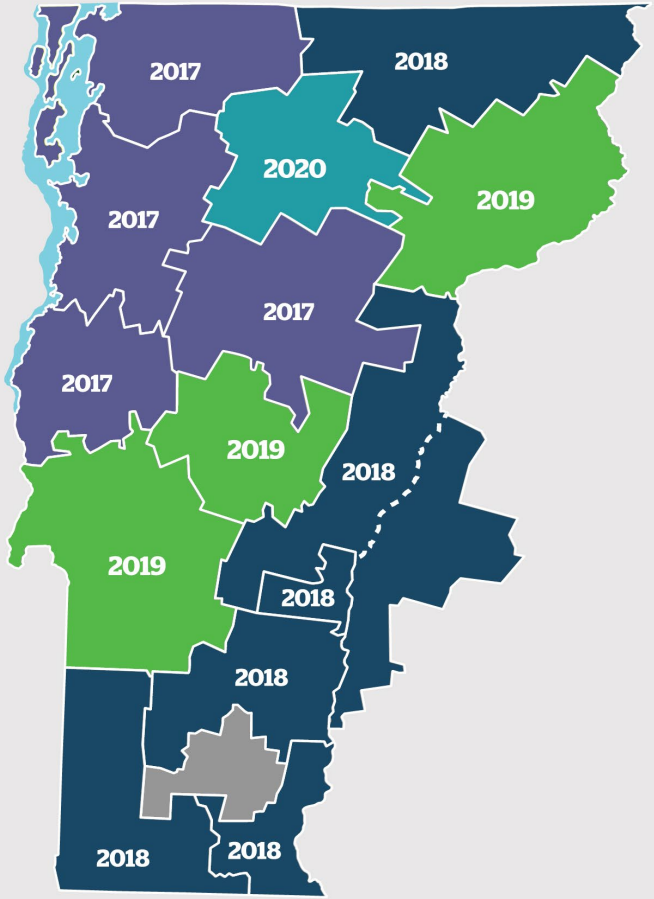
LEARN MORE!
Read *"SDoH and the ComEd HEAL program"* and *"Tackling the SDoH"*

Vermont's Transition to Value-Based Care

NAACOS Briefing
July 21, 2021

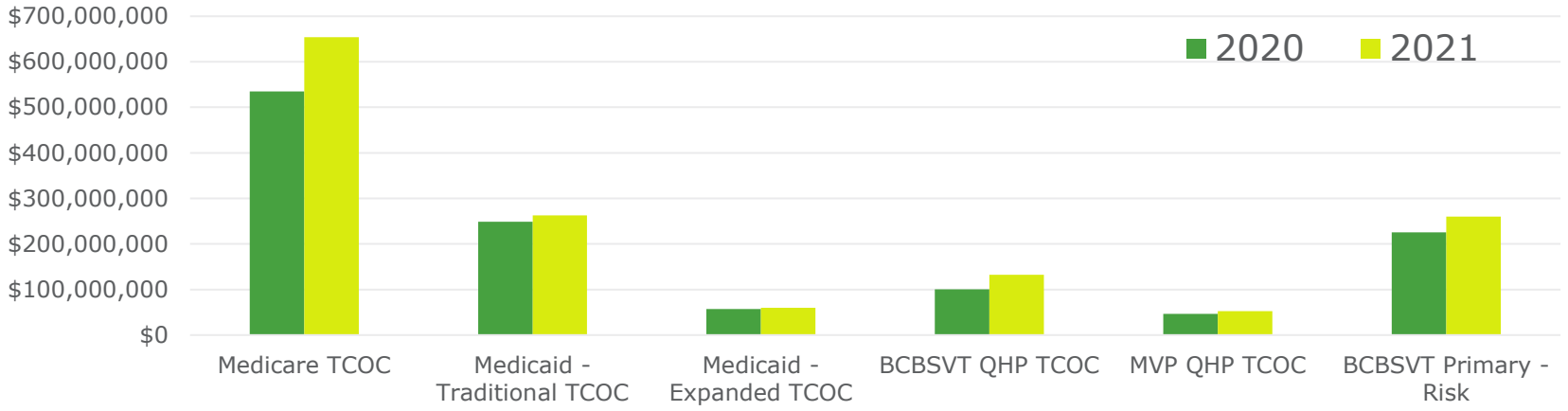
OneCare Vermont
onecarevt.org

OneCare Growth Supporting All Payer Model



Year	Attribution	Payers	Health Service Area That Joined OneCare
2017 YEAR 0	29,100 Vermonters	MEDICAID	Burlington, Berlin, Middlebury, St. Albans
2018 YEAR 1	112,000 Vermonters	MEDICAID MEDICARE BCBSQHP UVMMC (self-funded)	Bennington, Brattleboro, Lebanon, Newport, Springfield, Windsor
2019 YEAR 2	160,000 Vermonters	MEDICAID MEDICARE BCBSQHP UVMMC (self-funded)	Randolph, Rutland, St. Johnsbury
2020 YEAR 3	250,000 Vermonters	MEDICAID MEDICARE BCBSQHP MVPQHP BCBS-ASO	Morrisville
2021 YEAR 4	270,000 Vermonters attributed	Payers and Health Service Areas same as 2020	

17.1% Growth in Health Care Accountability



$1.42B of Health Care Costs in Value-Based Contracts

- Estimated 22.2% increase in Medicare accountability (largely driven by Rutland)
- Other accountability growth follows insurance rate increases and other payer reimbursement modifications

***TCOC**: Total Cost of Care*

OneCare Core Capability
Payment Reform

Fixed Payment Transformation

Health care providers have historically been paid on a fee-for-service basis for each visit or procedure. OneCare sought to change this by paying certain providers monthly fixed payments to care for their patients. This helps shift the focus to delivering the best care, not the most care.

The Transformation of
OneCare's health care spending to fixed payments and value-based care over time

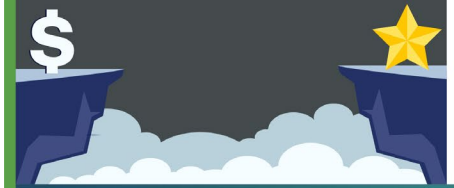
OneCare is currently in this stage*

Stage 1

* 100% fee-for-service (FFS)

* Volume-based: health care providers bill for each test, office visit, procedure, etc.

* No link to quality and value



Stage 2

* OneCare forms and participates in Medicare, Medicaid, and Commercial Shared Savings Programs

* PMPM paid for Medicaid and Commercical Care Management

* Shared savings earned and tied to quality, distributed to network providers

Stage 3

* Fixed payment infrastructure launched with Vermont Medicaid Next Generation Program

* Followed with Medicare Next Generation AIPBP payments

* Providers still recieve PMPM payments for care management and earn in shared savings.

Stage 4

* Full integration of fixed flat payments to providers across all payers for a majority of Vermonters

* Reaching scale for both payments made and number of lives is critical so providers do not need to rely on FFS reimbursement

* FFS should be the second or even third type of payment methodology utilized

100% Fee-For-Service → 100% Value-Based Payments

* OneCare works with/oversees multiple programs (e.g., Medicare, Medicaid), some of which are at the end of stage 3, and some of which are in stage 4; this placement represents an approximate combined average of of where these programs currently are in this transition to value-based care. *CHART SOURCE: Health Care Payment Learning Action Network Updated All Payer Model Framework*

Why Value-Based Care Is Important

> Today, the most important objective for our state is to meet the health care needs of our residents and to ensure capacity to provide quality care for all persons, including persons with COVID-19. To this end, the predictable payments that are a part of our state's innovation model are proving an important line of defense in battling the pandemic.

Governor Phil Scott, AHS Secretary Mike Smith, and GMCB Chair Kevin Mullin
(Letter to CMMI April 27th 2020)

> Had we not been in the CPR Program (Comprehensive Payment Reform) and relied solely on fee-for-service, we would have seen greater losses during the state of emergency given the reduction in the number of in-person office visits. The fixed payments helped provide a safety net during [those] extraordinarily difficult times.

Jon Asselin
Primary Care Health Partners - IPA

> The pandemic ... made it clear that fee-for-service is unsustainable, and we're fully committed to value-based care as the solution to stabilizing Vermont's increasing health care costs.

Claudio Fort
President and CEO of Rutland Regional Medical Center

Strengths, Challenges, and Opportunities

Program Strengths

1. Broad accountability across providers via expanded community network
2. Model that takes a population approach to care, cost, and quality
3. Payments linked to outcomes
4. Fixed predictable payments, potential for revenue stabilization
5. Benefit enhancement Waivers for better patient care
6. QPP Incentive to reward quality
7. MACRA/MIPS exemption and Aligned/simplified Quality Measures across Payers to reduce burden

Program Challenges

1. Lack of Unreconciled fixed payments with all payers to deliver the "stability" promised under the APM
2. Inconsistent/weak investment opportunities for the delivery system reform efforts
3. Payer Operational challenges (claims and payments)
4. Unclear reporting for Critical Access Hospitals
5. Lack of variable risk levels for rural participants

Future Opportunities

1. **Move away from FFS lookback as the basis for target setting**
2. **Maximizing risk/reward in alterative advanced payment models**
3. **Models that support rural high value/low cost providers**

Q&A

Thank you!