Contracting for Success in Value Based Care

AR HFMA

April 14, 2023

Agenda

1	**Introductions**
2	What is Value-Based Care
3	Medicare Advantage: Business Model Overview
4	Success in Value-Based Care
5	Case Study: Baxter Health

Introductions

Debbie Henry, CFO Baxter Health

- Over 17 years of hospital financial management experience
- Helped establish an accountable care organization (ACO) and a Clinically Integrated Network for a multi-hospital and physician group organization
- Started her financial career in public accounting with KPMG

Kim Fleming, Regional President Main Street Health

- Over 10 years of financial and operational healthcare experience
- Experienced working with both providers and payors
- Prior to healthcare, worked with marketing and service organizations, and also started her career with KPMG

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Why Value-Based Care?

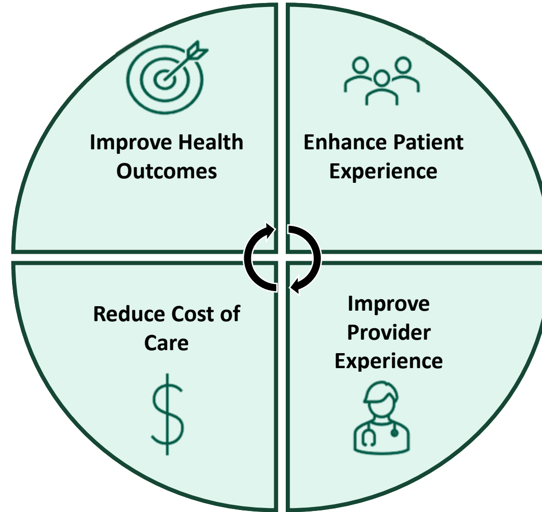
US Healthcare is Expensive	**2.0x spend per capita** *Health consumption expenditures vs. other developed nations*	**17% of GDP** *Compared to ~9% of GDP at other developed nations*	
US Healthcare has Poor Outcomes	**6+ year gap** *US life expectancy vs. other developed nations*	**5x+ gap** *Maternal mortality rate vs. other developed nations*	**5.0 HAQ gap** *Healthcare access and quality index vs. other developed nations*
Poor Experiences are prevalent in the US Healthcare system	**>40%** *Physician Burnout Rate*	**23M in Debt** *Americans owe > $195B in medical debt*	

Potential Solution: Value-Based Care

CMS Goals for Healthcare Paradigm Change

- In October 2021, CMMI announced a goal of having every Medicare beneficiary and the majority of Medicaid beneficiaries covered by some type of alterative payment model (APM) by 2023
- CMMI considers an alternative payment model to be any arrangement whereby providers are held accountable for the quality and costs of care, not just paid based on the volume of services they deliver

Value-Based Care Focused on the Quadruple Aim



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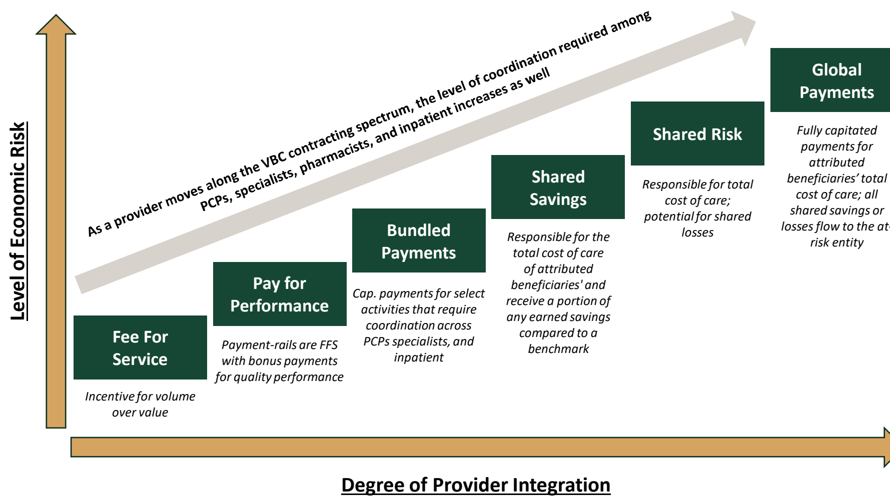
Value-Based Care Can Take a Variety of Forms

Spectrum of Risk Participation Across Contracting Types



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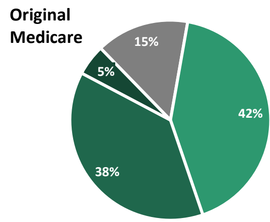
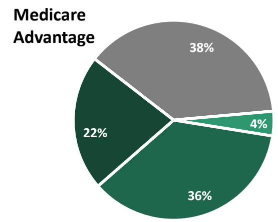
Value-Based Care Is Already Present All Patient Populations

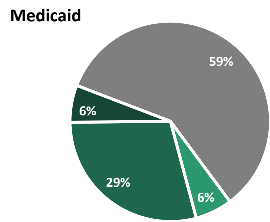
Original Medicare



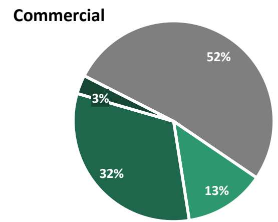
Medicare Advantage



Medicaid



Commercial



- APM penetration is the highest in Medicare beneficiaries
- However, global capitated arrangements still represent a small portion of lives
- For Commercial and Medicaid populations, significant penetration remains in shifting FFS payments to APM models and global capitated models

Key:
- Fee-for-service
- Pay-for-performance & reporting
- Shared savings & bundles
- Full population-based risk & global capitation

CMS Expects 100% of Medicare Beneficiaries to be in VBC Arrangements by 2030

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Medicare Advantage (MA) Overview

Original Medicare	Medicare Advantage
Administered by CMS, funded through taxes	**Administered by CMS, funded through taxes**
• Covers part A and B • Providers submit claims to CMS for payment; Medicare sets reimbursement rates • CMS takes responsibility for all original Medicare claims	• Combines Part A, B, and D (pharmacy); also include supplemental benefits • Providers submit claims to insurance companies • MA plans receive a fixed amount per member from CMS; MA plans use this to pay for member's care • MA plans make money if the total cost of care for all their members is less than amount CMS paid them
	Medicare Advantage plans take full risk from CMS for the patients that enroll. **It is a capitated financial payment.**

How is the amount CMS pays to MA plans determined?

Medicare Advantage plans take full risk from the government.

Each year, MA plans submit their "Bid" to CMS.

- Bids are determined based on historical actuarial analysis, benefit design, competitive dynamics, sales and margin goals, and several other factors
- Bids are determined by state and county, and submitted to CMS for review

CMS must approve each bid and benefit plan annually.

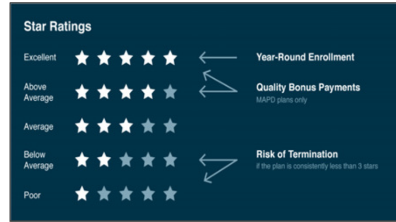
Medicare Advantage Bid and Payment Considerations

- ➢ Payment to Medicare Advantage plans are made based on bids at or below the average cost of FFS Medicare beneficiaries by county.
- ➢ CMS adjusts Medicare Advantage plan payments to reflect the health of each beneficiary, along with considering other factors such as demographics.
- ➢ Plans that "bid below" the benchmark receive rebates to provide enrollees extra benefits. Enrollees in plans that "bid above" the benchmark pay the difference in the form of a premium.
- ➢ **Plans with higher Star Ratings receive quality bonus payments**. If a plan is not a 4 star or higher, they receive 95% of Medicare.

Star Ratings: "Quality" for Medicare Advantage

How MA Defines "Quality":

- Improving healthcare quality is a core pillar of value-based care and the "quadruple aim"
- CMS rates MA plans on quality using the Star rating system (up to 5 Stars)
- Plans that achieve high Star scores (4-5) are eligible for 100% of Medicare reimbursement and other special benefits
- Other government segments like original Medicare and Medicaid measure quality in similar ways, though specific measures vary



Calculating MA Star Scores

Star Ratings Calculations:

- MA plans' Star ratings are composed of 9 performance domains and ~40 individual measures
- Providers can impact a <u>subset</u> of MA plans' quality measures
- MA plans are increasingly embedding quality incentives in value-based care provider contracts
- CMS adjusts measures, thresholds, and weighting annually, and health plans adjust provider measures accordingly
- Some of the most important measures for providers are **medication adherence measures** (triple-weighted) and **patient experience measures** (quadruple-weighted)

Black text = Measures providers can impact *Gray text = Measures providers <u>cannot</u> impact*

, *, **** = Typically double, triple, or quadruple weighted measures

Part C Performance Domains	
D1: Staying Healthy	D3: Member Experience with Health Plan
Breast Cancer Screening	Getting Needed Care****
Colorectal Cancer Screening	Getting Appointments and Care Quickly****
Annual Flu Vaccine	*Customer Service*
Monitoring Physical Activity**	*Rating of Health Care Quality*
D2: Managing Chronic Conditions	*Rating of Health Plan*
Special Needs Plan Care Management	Care Coordination****
Care of Older Adults – Medication Review	D4: Member Complaints about Health Plan
Care of Older Adults – Pain Assessment	*Complaints about Health Plan*
Osteoporosis Mgmt. in Women with a Fracture	*Members Choosing to Leave the Plan*
Diabetes Care – Eye Exam	*Health Plan Quality Improvement*
Diabetes Care – Kidney Disease Monitoring	D5: Health Plan Customer Service
Diabetes Care – Blood Sugar Controlled***	*Plan Makes Timely Decisions about Appeals*
Controlling Blood Pressure***	*Reviewing Appeals Decisions*
Reducing Risk of Falling**	*Call Center – Foreign Language, TTY Availability*
Improving Bladder Control**	
Medication Reconciliation Post-Discharge	
Statin Therapy for Cardiovascular Disease	

Part D Performance Domains	
D1: Drug Plan Customer Service	D4: Drug Safety and Accuracy of Drug Pricing
Call Center – Foreign Language, TTY Availability	*MPF Price Accuracy*
D2: Member Complaints about Drug Plan	Medication Adherence – Diabetes***
Complaints about Drug Plan	Medication Adherence – Hypertension***
Members Choosing to Leave the Plan	Medication Adherence – Cholesterol***
Drug Plan Quality Improvement	MTM Program Completion Rate for CMR
D3: Member Experience with Drug Plan	Statin Use in Patients with Diabetes
Rating of Drug Plan	
Getting Needed Prescription Drugs	

The Medicare Advantage Business Model

1. Medicare Advantage plans get paid a fixed amount from CMS each month.
2. Top line revenue is impacted by their Star Rating, or quality.
3. MA plans will embed quality metrics into their value-based contracting with providers, along with other incentives to go with FFS contracts.

- Incentives for completing patient assessment forms (PAFs) or annual wellness visits (AWVs)
- Incentives for closing gaps in care
- Criteria for a provider to be at a certain star rating to participate in shared savings programs
- Star ratings and quality metrics will an important consideration of any full risk deals (MA plan is still responsible for Star ratings from the perspective of CMS)

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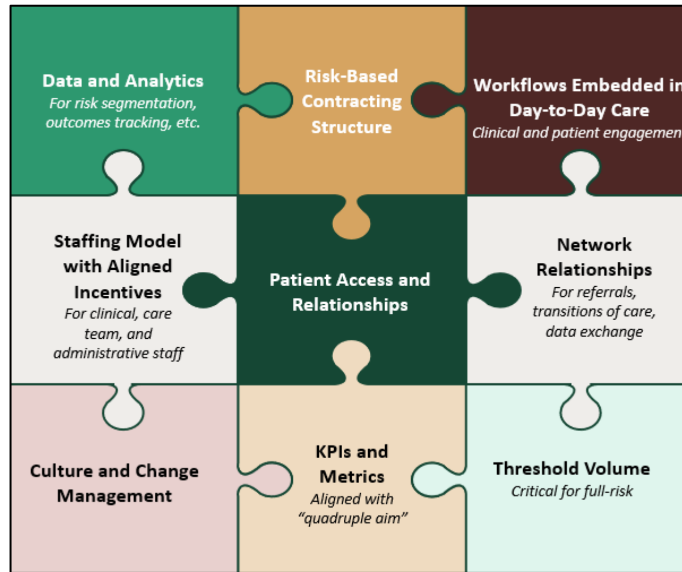
Success in VBC Requires a Variety of Capabilities



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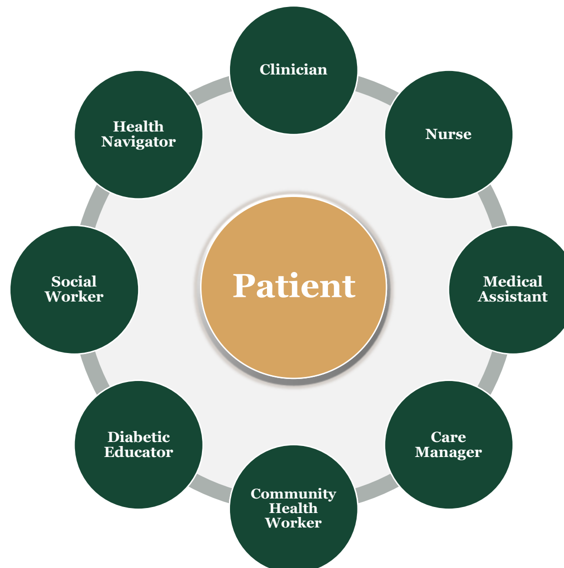
Collaborative Care Model Drives Success



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Baxter Health Case Studies