Successful Models to Educate Physicians and Providers about Value-Based Care (VBC)

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May 27, 2021

NATIONAL RURAL HEALTH RESOURCE CENTER

Delta Region Community Health Systems Development (DRCHSD) Program

Delta Regional Authority

U.S. Department of Health & Human Services

HRSA

Federal Office of Rural Health Policy

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DRCHSD Value-Based Care Series

Final Session:

June 3, 2021 - Best Practices to Work with Community Partners on Population Health Initiatives

Pre –Polling Questions

1. I am ___ in my understanding of key strategies that support the hospital's transition from the current payment and care delivery models to a population-based health system.

2. I am ___ in my understanding of various tools to gain physician buy-in for value-based care.

Introduction

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Population Health Transformation Framework: Gaining Physician Buy-in

Delta Regional Community Health System Development (DRCHSD) Program

Value Based Care Webinar Series

May 27, 2021

Eric K. Shell, MBA

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New CMMI Director Dr. Liz Fowler on "Strategic Refresh" (4/25/21)

"WE NEED TO FIND A WAY TO BRING EVERYONE ALONG. WE CAN'T HAVE FEE-FOR-SERVICE REMAIN A COMFORTABLE PLACE TO STAY."

"We need to have a clear path for the innovators who are ready and willing and able to take on…risk, but I think we also need to push the laggards and then we need to reach those who have challenges participating….It may not be one-size-fits-all."

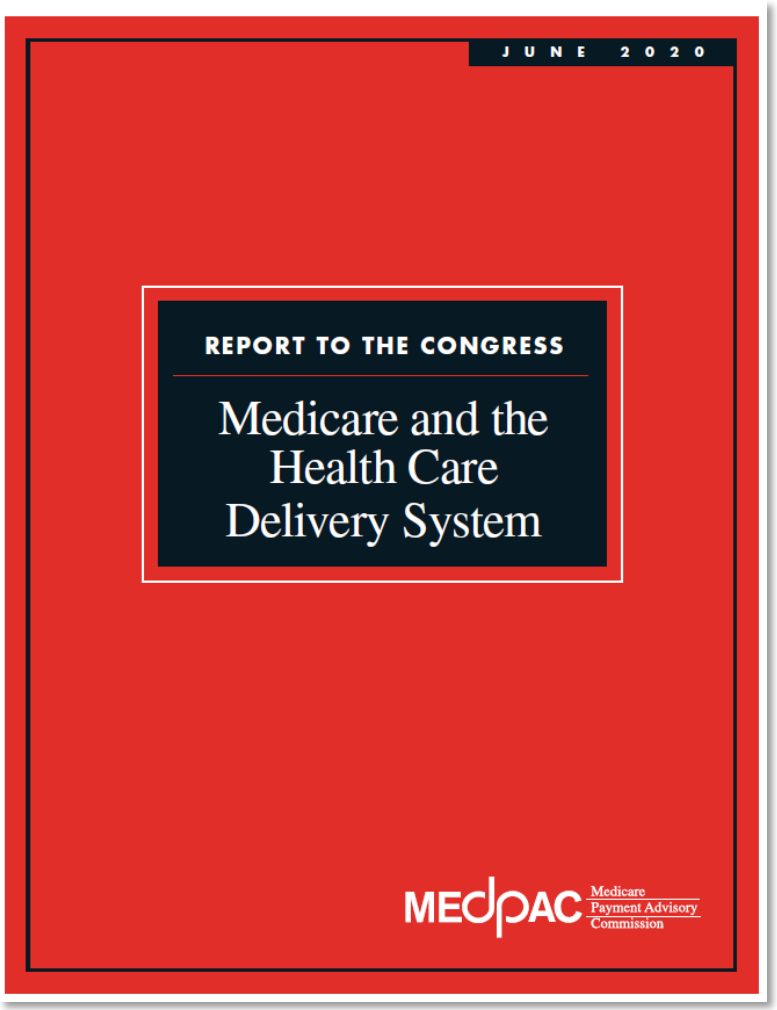
On CMMI innovation models: "A lot of what we've done has been aimed toward certification of models to become a permanent part of Medicare….In trying to get a model certified, it really does suggest a very specific model and a very specific way of thinking about evaluations and the assessment by actuaries. I wonder if we can instead think about the overall goal being transformation of the system instead of certification, or both."

Center for Medicare & Medicaid INNOVATION

Fowler asked for patience **"as we take time to review the portfolio of models, make adjustments where necessary and make sure that our path forward is sustainable and meaningful."**

June 2020 MedPAC Annual Report: Major Considerations

- **Realizing the promise of value-based payment in Medicare: An agenda for change.** The Commission outlines a multiyear effort to lay out a strategic direction for Medicare payment policy and delivery system design that broaden the use of value-based payment.
- **Challenges in maintaining and increasing savings from accountable care organizations (ACOs).** The Commission evaluates past savings, examines strategies to increase savings, and recommends a technical change that will reduce the risk that program vulnerabilities might result in unwarranted shared savings payments to ACOs.
- **Replacing the Medicare Advantage quality bonus program.** Medicare's quality bonus program (QBP) for assessing and rewarding quality performance in the Medicare Advantage (MA) program is flawed and not consistent with the Commission's principles for quality incentive programs. In this report, the Commission recommends that the Congress replace the QBP with an MA–VIP that includes five key design elements.



Source: *Report to the Congress: Medicare and the Health Care Delivery System,* MedPAC, June 2020 http://www.medpac.gov/docs/default-source/reports/jun20_reporttocongress_sec.pdf?sfvrsn=0

Call to Action

- Traditional fee-for-service payment will continue to transition to value-based payment
- Pressure for operational efficiencies and human and capital resources will continue to accelerate
- Clinical integration will create advantages to systems of accountable care (Value based payment, re-admission rates and preventable re-admissions, bundled payments, accountable care organizations, etc.)
- Flexibility must be ingrained into any short to medium term strategies as a direct result of increased regulatory and environmental uncertainty

Future Hospital Financial Value Equation

- Definitions
  - Patient Value

$$\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}} \text{ X Population}$$

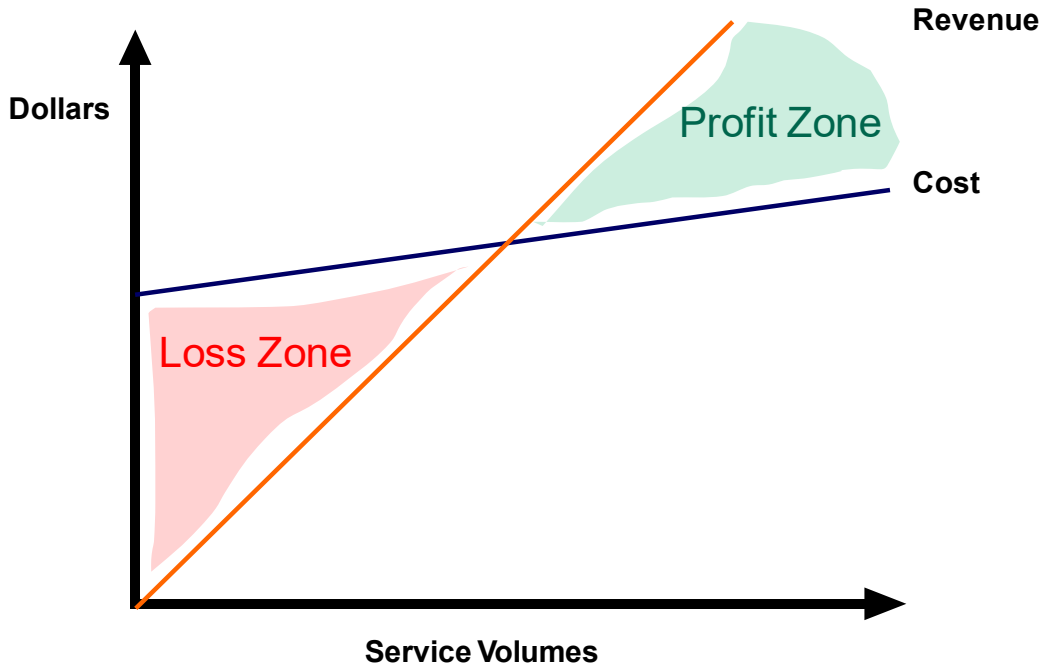
  - Accountable Care:
    - A mechanism for ***providers to monetize the value derived from increasing quality and reducing costs***
      - Accountable care includes many models including bundled payments, value-based payment program, provider self-insured health plans, Medicare defined ACO, capitated provider sponsored healthcare, etc.
    - Different “this time”
      - Providers monetize value
      - Government “All In”
      - New information systems to manage costs and quality
      - Agreed upon evidence-based protocols
      - Going back is not an option

Future Hospital Financial Value Equation (once more)

- ACO Relationship to Small and Rural Hospitals
  - Revenue stream of future tied to Primary Care Physicians (PCP) and their patients
  - Small and rural hospitals bring value / negotiating power to affiliation relationships as generally PCP based
    - Smaller community hospitals and rural hospitals have value through alignment with revenue drivers (PCPs) rather than cost drivers but must position themselves for new market:
      - Alignment with PCPs in local service area
      - Develop a position of strength by becoming highly efficient
      - Demonstrate high quality through monitoring and actively pursuing quality goals

Future Hospital Financial Value Equation (continued)

- Economics
  - As payment systems transition away from volume-based payment, the current economic model of increasing volume to reduce unit costs and generate profit is no longer relevant
    - New economic models based on patient value must be developed by hospitals, but not before the payment systems have converted
  - Economic model: FFS Rev and Exp VS. Budget Based Payment Rev and Exp



Future Hospital Financial Value Equation (final)

- Value in Rural Hospitals
  - Lower Per Beneficiary Costs
  - Revenue centers of the future
    - PCP based delivery system
  - CAH cost-based reimbursement
    - Step towards ***budget-based*** reimbursement
    - Incremental volume drives down unit costs
    - Once commitment to community Emergency Room, system incentives to drive low acuity volume to CAH

The Challenge: Crossing the Shaky Bridge

Payment Transition – CMMI (Dr. Rajkumar 3/2016)

The Premise

Macro-economic Payment System

- Government Payers
  - Changing from F-F-S to PBPS
- Private Payers
  - Follow Government payers
  - Steerage to lower cost providers

Provider Imperatives

- F-F-S
  - Management of price, utilization, and costs
- PBPS
  - Management of care for defined population
  - Providers assume insurance risk

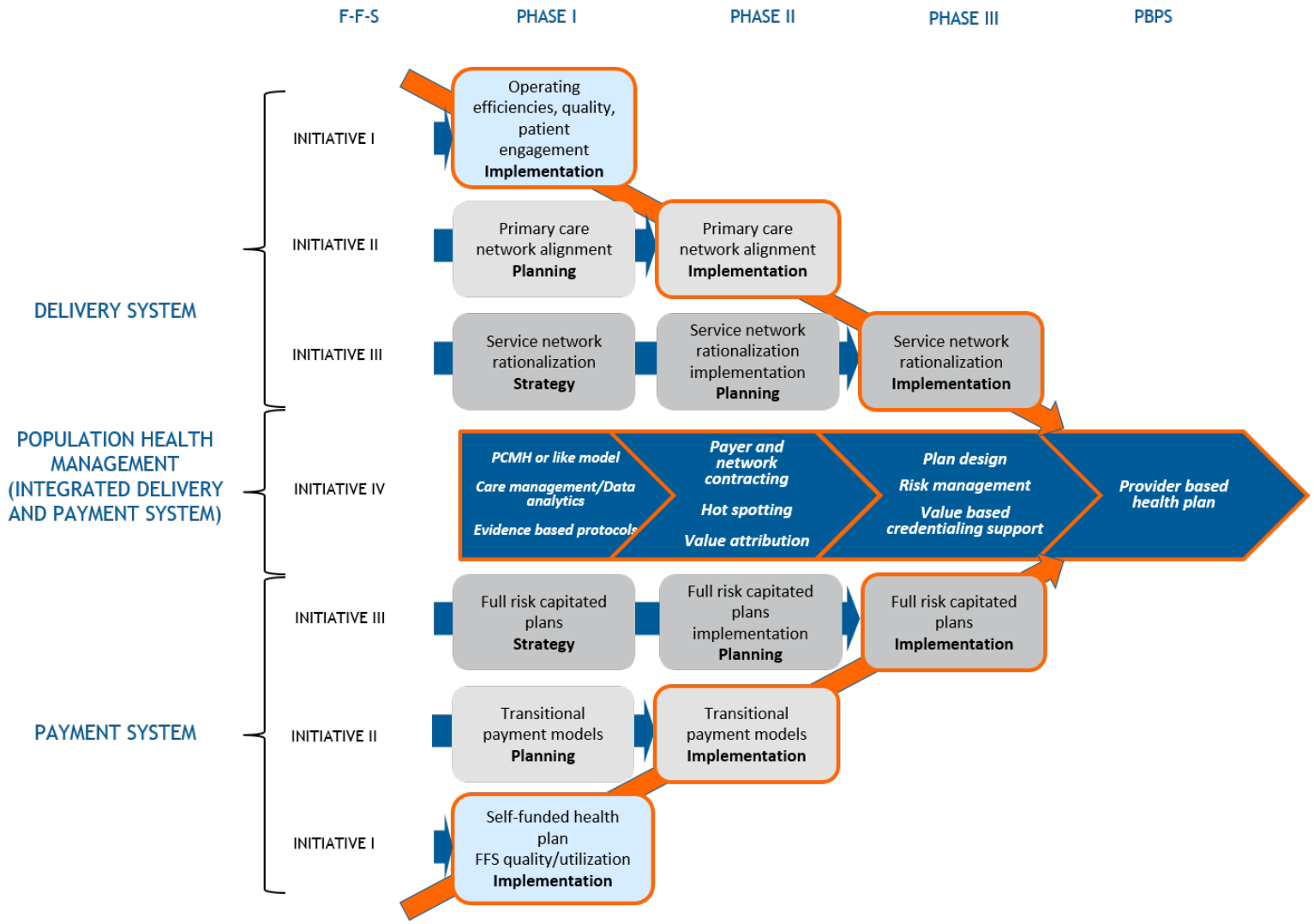
Provider organization

- Evolution from
  - Independent organizations competing with each other for market share based on volume to
  - Aligned organizations competing with other aligned organizations for covered lives based on quality and value

Network and care management organization

- New competencies required
  - Network development
  - Care management
  - Risk contracting
  - Risk management

Transition Framework – What Is It?



Initiative I – Operating Efficiencies, Patient Safety and Quality

- Hospitals not operating at efficient levels are currently, or will be, struggling financially

- "Efficient" is defined as
  - Appropriate patient volumes meeting needs of their service area
  - Revenue cycle practices operating with best practice processes
  - Expenses managed aggressively
  - Physician practices managed effectively
  - Effective organizational design

Graphic: National Patient Safety Foundation

Operating Efficiencies, Patient Safety and Quality

- Focus on Quality and Patient Safety
  - As a strategic imperative
  - As a competitive advantage

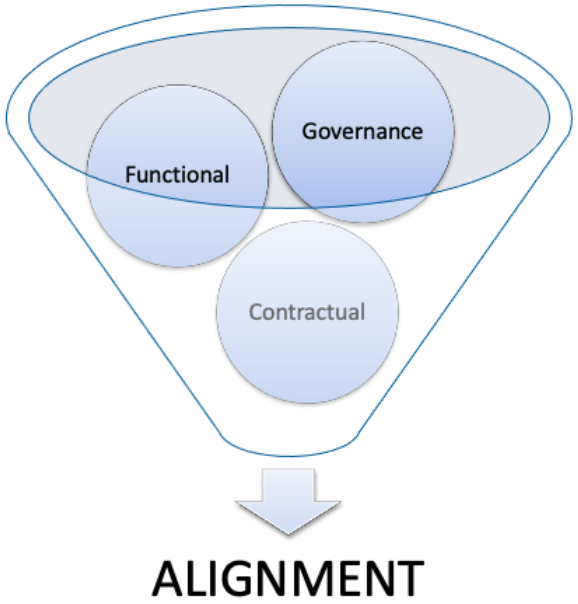
Highest Score
Above State Avg.
Below State Avg.
Lowest Score

U.S. HHS Hospital Compare Measures	National Avg.	MA Average	Fairview Hospital	Berkshire Medical Center	Baystate Medical Center	Columbia Memorial Hospital	Sharon Hospital	Saint Peter's Hospital	Bringham and Women's Hospital	Mass General Hospital	Albany Medical Center	Charlotte Hungerford Hospital
Patient Survey Summary Star Rating:			**5**	**3**	**3**	**2**	**4**	**3**	**3**	**4**	**2**	**3**
Patient Satisfaction (HCAHPS) Average:	**71%**	**70%**	**84%**	**68%**	**66%**	**61%**	**73%**	**67%**	**71%**	**74%**	**64%**	**65%**
Nurses "Always" communicated well:	80%	80%	92%	81%	75%	73%	84%	77%	80%	83%	75%	77%
Doctors "Always" communicated well:	82%	81%	90%	78%	77%	74%	84%	76%	80%	82%	70%	75%
"Always" received help when wanted:	68%	66%	88%	64%	59%	58%	71%	59%	69%	65%	62%	60%
Pain "Always" well controlled:	71%	71%	83%	73%	68%	70%	72%	70%	69%	72%	65%	69%
Staff "Always" explained med's before administering:	65%	64%	78%	64%	61%	56%	69%	59%	61%	66%	58%	58%
Room and bathroom "Always" clean:	74%	72%	86%	73%	67%	63%	78%	63%	66%	72%	66%	72%
Area around room "Always" quiet at night:	62%	53%	68%	46%	48%	45%	60%	47%	56%	54%	43%	40%
YES, given at home recovery information:	87%	89%	94%	89%	88%	83%	85%	87%	89%	90%	83%	91%
"Strongly Agree" they understood care after discharge:	52%	53%	70%	50%	49%	41%	51%	49%	51%	59%	46%	47%
Gave hospital rating of 9 or 10 (0-10 scale):	72%	70%	88%	65%	65%	53%	73%	69%	80%	82%	65%	60%
YES, definitely recommend the hospital:	71%	74%	91%	65%	73%	50%	72%	76%	84%	90%	70%	61%

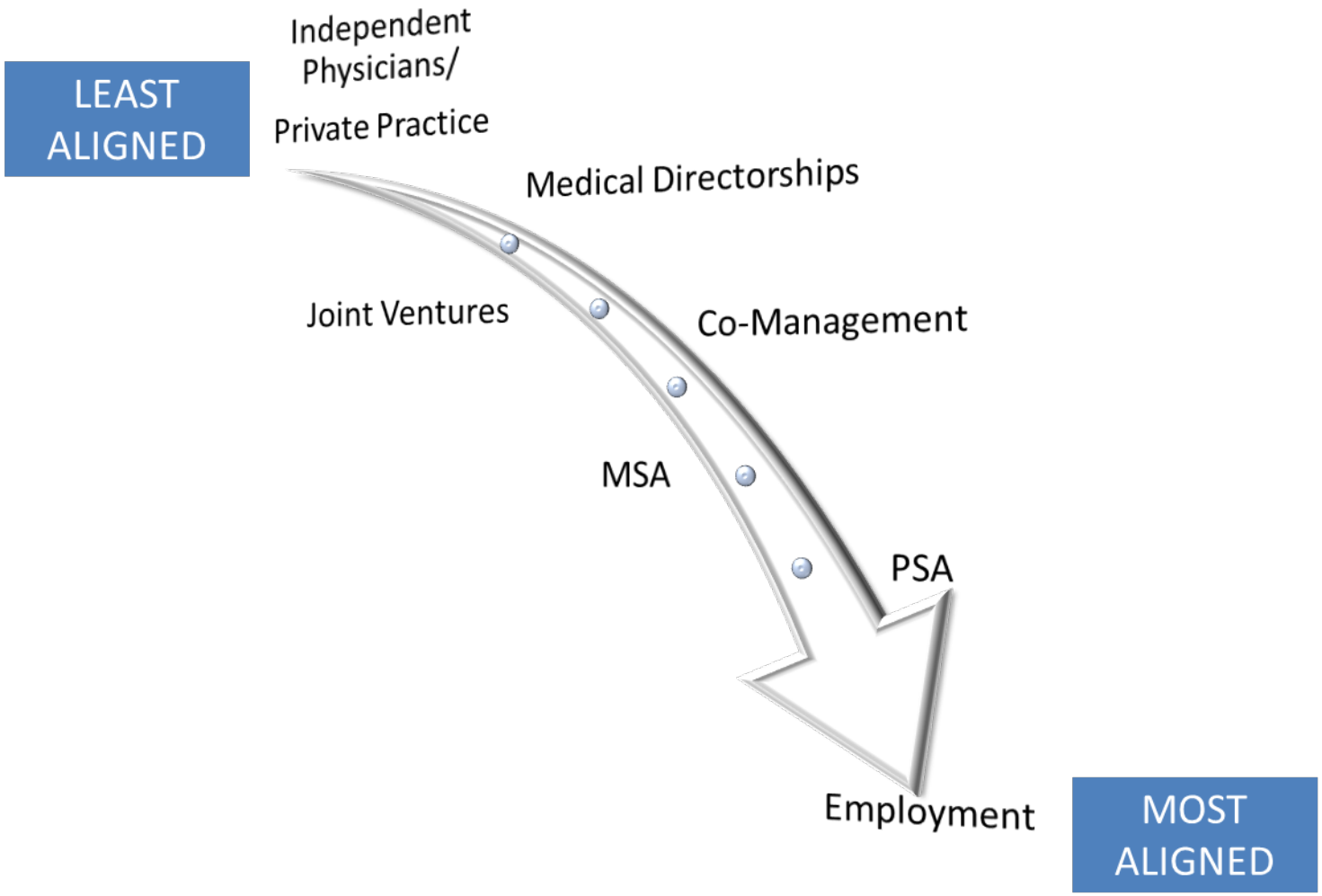
Source: www.hospitalcompare.hhs.gov

Initiative II – Primary Care Alignment

- Understand that revenue streams of the future will be tied to primary care physicians, which often comprise a majority of the rural and small hospital healthcare delivery network
  - Thus, small and rural hospitals, through alignment with PCPs, will have extraordinary value relative to costs
- Physician Relationships – Alignment to Buy-in!
  - Hospital align with employed and independent providers to enable interdependence with medical staff and support clinical integration efforts
    - Contract (e.g., employ, management agreements)
    - Functional (share medical records, joint development of evidence-based protocols)
    - Governance (Board, executive leadership, planning committees, etc.)
  - *Potential Model for Rural:*
    - *New PHO/CIN/IHN*



The Alignment Spectrum



The Transition to Value-Based

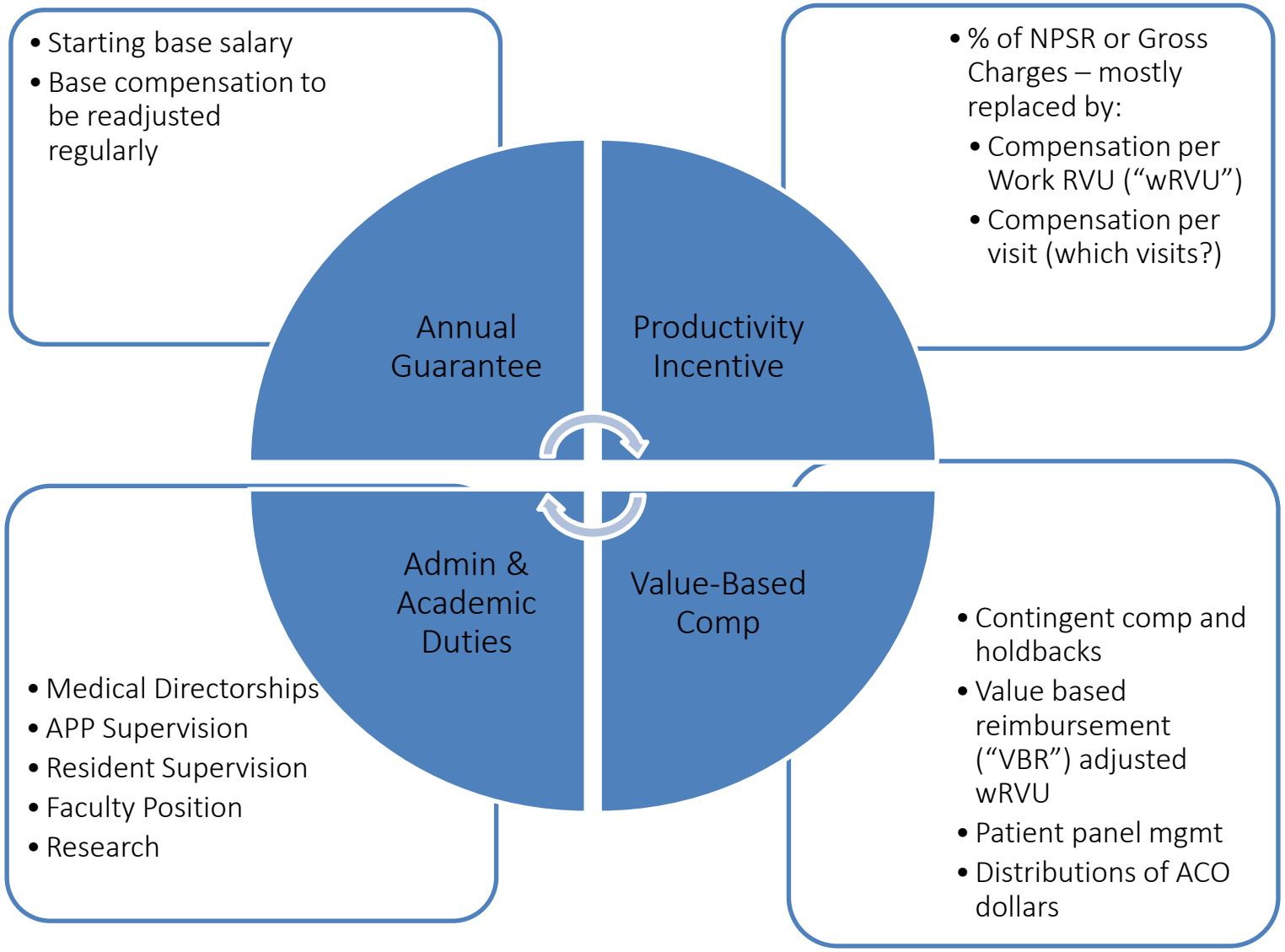
Value-Based Reimbursement ("VBR") will have a direct impact on how we compensate physicians and APPs

★★☆ Where is your organization on its transition to value?

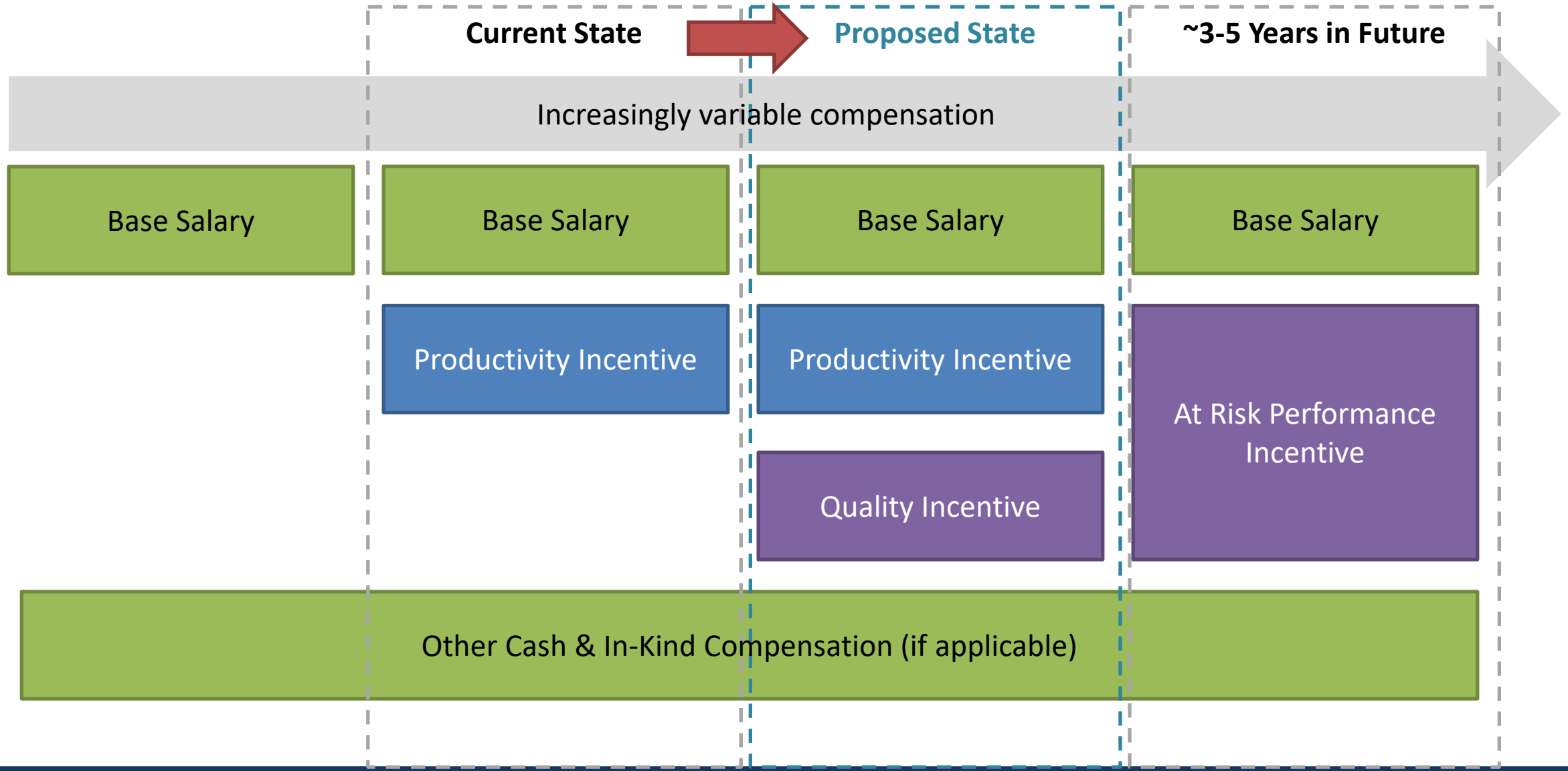
Where is your organization in its compensation model?

What do physicians in your area expect?

Types of Compensation Models



Transition of Compensation Structure



Value Attribution Model – Initial Concepts

Health System ACO Provider Scorecard

Reporting for Employed Primary Care Providers

Dr. NAME HERE Sample ACO Scorecard

Metrics focused on the provider's panel size, utilization, prevention and health status; Data come from EMR and PQRS reporting program.

In-In-Network	In-Network	Out-of-Network

Metrics focused on the site of service for all care provided to PHS attributed patients divided into three major network-type categories; Data come from Medicare claims data, Employer Health Plan claims data, PHS billing systems and PHS Financial Statements.

Metrics focused on the provider's panel related to clinical processes, outcomes and a subset of meaningful use indicators; Data come from EMR and PQRS reporting program.

Metrics focused on patient experience in the primary care setting; Data come from Healthstream (CG-CAHPS program).

Health

To what extent are providers managing full panels and what efforts are being made to reduce utilization?

PMPM

When patients require care, where are they receiving it, are they being referred by system providers, and what are the cost implications for medical decision making?

Quality

For the providers' attributed patients, to what extent are they receiving evidence-based care resulting in positive clinical outcomes?

Satisfaction

To what extent is the provider offering services that meet their patients' expectations?

Initiative III – Rationalize Service Network

- Develop system integration strategy
  - Evaluate wide range of affiliation options ranging from network relationships, to interdependence models, to full asset ownership models
    - Interdependence models through alignment on contractual, functional, and governance levels, may be option for rural hospitals that want to remain "independent"
  - Explore / Seek to establish interdependent relationships among small and rural hospitals understanding their unique value relative to future revenue streams
- Identify the number of providers needed in the service area based on population and the impact of an integrated regional healthcare system
- Conduct focused analysis of procedures leaving the market
  - Understand real value to hospitals
    - Under F-F-S
    - Under PBPS (Cost of out of network claims)

Payment System Strategy – Initiative I

- **Develop self-funded employer health plan**
  - Hospital is already 100% at risk for medical claims thus no risk for improving health of employee "population"
  - Change benefits to encourage greater "consumerism"
    - Differential premium for elective "risky" behavior
  - "Enroll" employee population in health programs – health coaches, chronic disease programs, etc.
- **FFS Quality and Utilization Incentives**
  - Maximize FFS incentives for improving quality or reducing inappropriate utilization (e.g., inappropriate ER visits, re-admissions, etc.)
  - Annual Well visits, Chronic Care Management (CCM) and Transitional Care Management (TCM) FFS payments
  - Maximize MIPS incentive payments
    - MIPS ACO

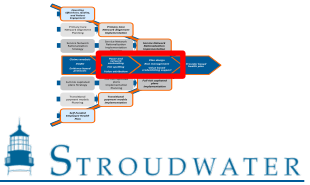
Payment System Strategy – Initiatives II and III

- **Initiative II: Implementation planning for transitional payment models**
  - Transitional payment models include:
    - FFS against capitation benchmark w/ shared savings
    - Shared savings model Medicare ACOs
    - Shared savings models with other governmental and commercial insurers
    - Partial capitation and sub-capitation options with shared savings
  - Prioritize insurance market opportunities
  - Take the initiative with insurers to gauge interest and opportunities for collaborating on transitional payment models
  - Explore direct contracting opportunities with self-funded employers
- **Initiative III: Develop strategy for full risk capitated plans**

Population Health Strategies – Phase I

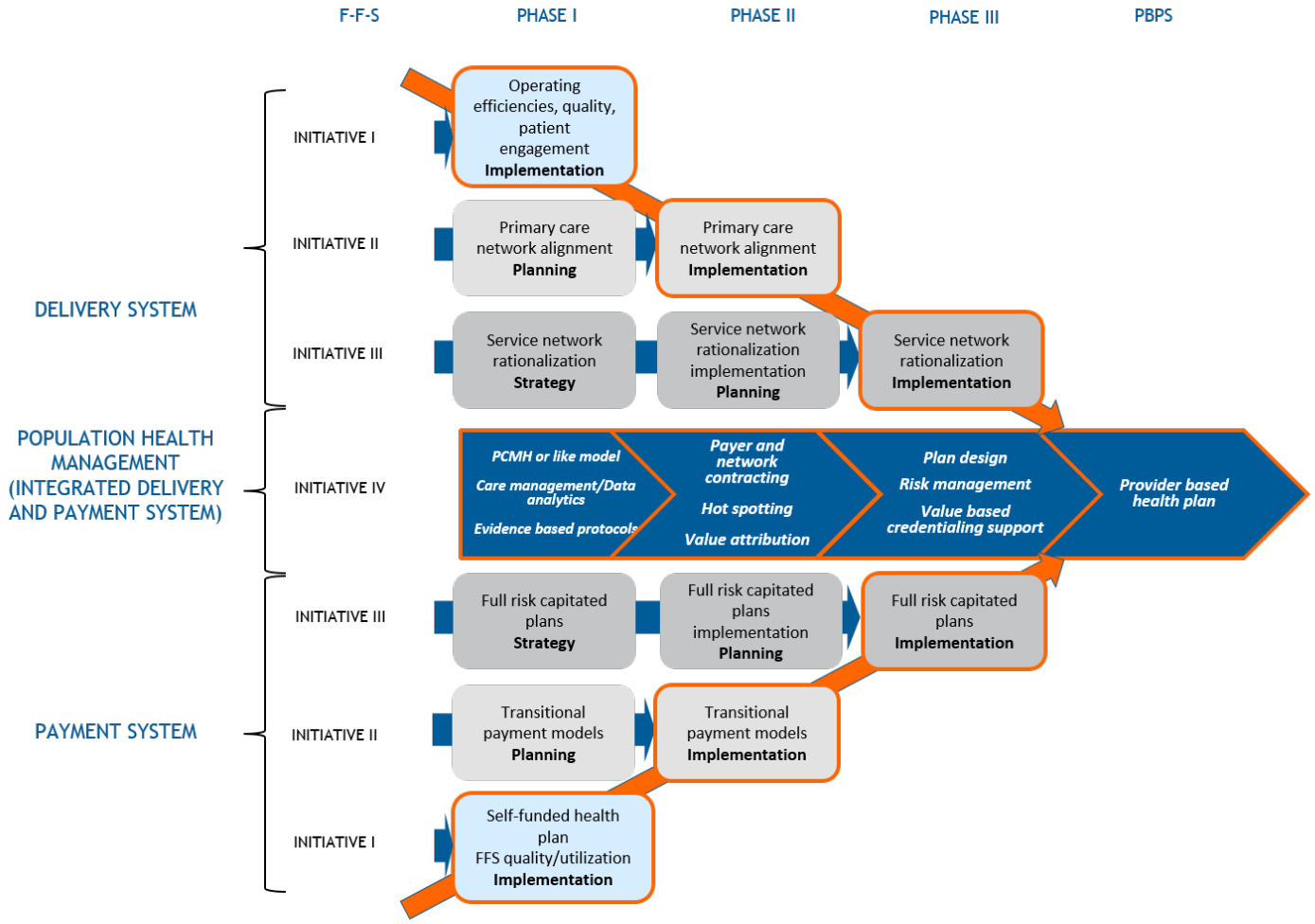
- Phase I: Develop Population Health building blocks
  - Goal: Infrastructure to manage self insured lives and maximize FFS Utilization and quality incentives
  - Initiatives:
    - PCMH or like structure
    - Care management
      - Discharge planning across the continuum
        - Transportation, PCP, meds, home support, etc.
      - Transitions of care (checking in on treatment plan)
        - Medication reconciliation
        - Post discharge follow-up calls (instructions, teach back, medication check-in)
        - Identifying community resources
        - Maintain patient contact for 30 days
    - Develop claims analysis capabilities/infrastructure
    - Develop evidenced based protocols

Population Health Strategies – Phase II and III



- Develop Strategy for population health management
  - Phase II Goal: Infrastructure to manage transitional payment models
  - Initiatives:
    - Develop capability to contract with third party payers including actuarial expertise
    - Acquire and analyze third party payer claims targeting high cost users
    - ***Develop payment/measurement system to attribute value and distribute shared savings***
    - PCMHs are provided tools to better manage patient care to improve outcomes and patient health
  - Phase III Goal: Infrastructure to manage care for a defined population within a budget
  - Initiatives:
    - Risk management capability (e.g., re-insurance)
    - Enhanced third-party payer "partnerships" (e.g., plan design, joint marketing, etc.)
    - Capability to support value-based credentialing

Implementation Framework – In Review



Conclusions/Recommendations

- For decades, rural hospitals have dealt with many challenges including low volumes, declining populations, difficulties with provider recruitment, limited capital constraining necessary investments, etc.
  - The current environment driven by healthcare reform and market realities now offers a new set of challenges. Many rural healthcare providers have not yet considered either the magnitude of the changes or the required strategies to appropriately address the changes

- Locally delivered healthcare (including rural and small community hospitals) has high value in the emerging delivery system

- “Shaky Bridge” crossing will require planned, proactive approach
  - Maintain alignment between delivery system models and payment systems building flexibility into the delivery system model for the changing payment system

Conclusions/Recommendations (continued)

- Important strategies for providers to consider include:
  - Increase leadership awareness of new environment realities
  - Strategic plan to incorporate new strategic imperatives – “Bridge Strategy”
  - Improve operational efficiency of provider organizations
  - Adapt effective quality measurement and improvement systems as a strategic priority
  - ***Align/partner with medical staff members contractually, functionally, and through governance where appropriate***
  - Seek interdependent relationships with developing regional systems
  - Develop strategies to proactively move towards value-based payment

Post-Polling Questions

1. I am ___ in my understanding of key strategies that support the hospital's transition from the current payment and care delivery models to a population-based health system.

2. I am ___ in my understanding of various tools to gain physician buy-in for value-based care.

3. I am ___ that I will apply the knowledge gained from this educational training to assume risk and participate (or continue to participate) in value-based payment models to prepare for population health.

Questions, Discussion, and Next Steps…

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DRCHSD Value-Based Care Series

Final Session:

June 3, 2021 – Best Practices to Work with Community Partners on Population Health Initiatives, Toniann Richard, Health Care Collaborative of Rural Missouri

https://www.ruralcenter.org/drchsd/events

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