NATIONAL RURAL HEALTH RESOURCE CENTER

Value-Based Care Workshop 101

First Steps to Assessing and Building Value-Based Capacity in Rural Health Care Organizations

Panelists:

- Ashley Anthony, CEO Delta Memorial Hospital
- Liz Snodgrass, CEO Livingston Hospital and Healthcare Services Inc.

Facilitators:

- Terry Hill, NRHRC
- Eric Rogers, BKD

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U65RH31261, Delta Region Health Systems Development, $8,000,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

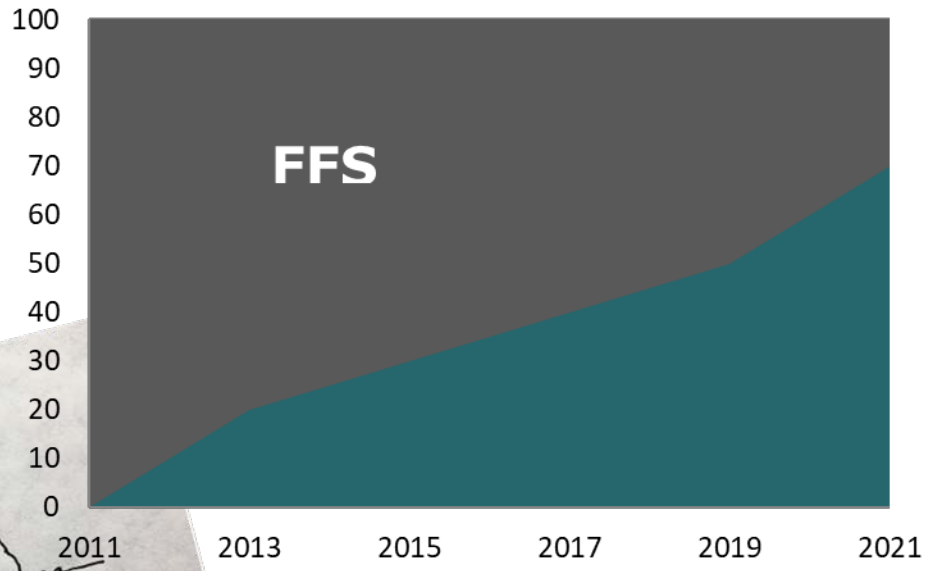
NATIONAL RURAL HEALTH RESOURCE CENTER

Topics for Today's Discussion

- Overview of Value-Based Care (VBC)
- Why participate in a VBC program?
- What are the options?
- Case Studies and Discussion
  - Livingston Hospital and Healthcare Services Inc.
  - Delta Memorial Hospital
- Keys to Success
- Q&A

Overview of Value-Based Care

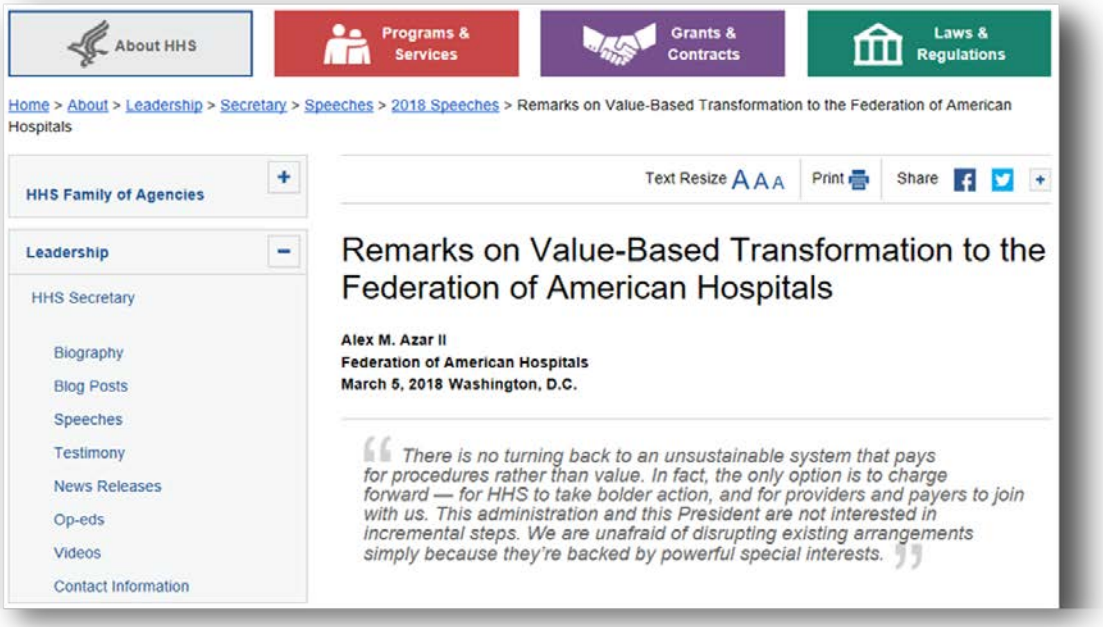
- 2009 “The Cost Conundrum”
- 2010 Affordable Care Act
  - Access vs delivery model
  - Goal of transitioning 30% FFS Medicare payments to through VBC models by end of 2016 and 50% by 2018



NATIONAL RURAL HEALTH RESOURCE CENTER

Value-Based Care Updates

- Political landscape may have changed, but emphasis on outcomes is still bipartisan and central theme at CMS

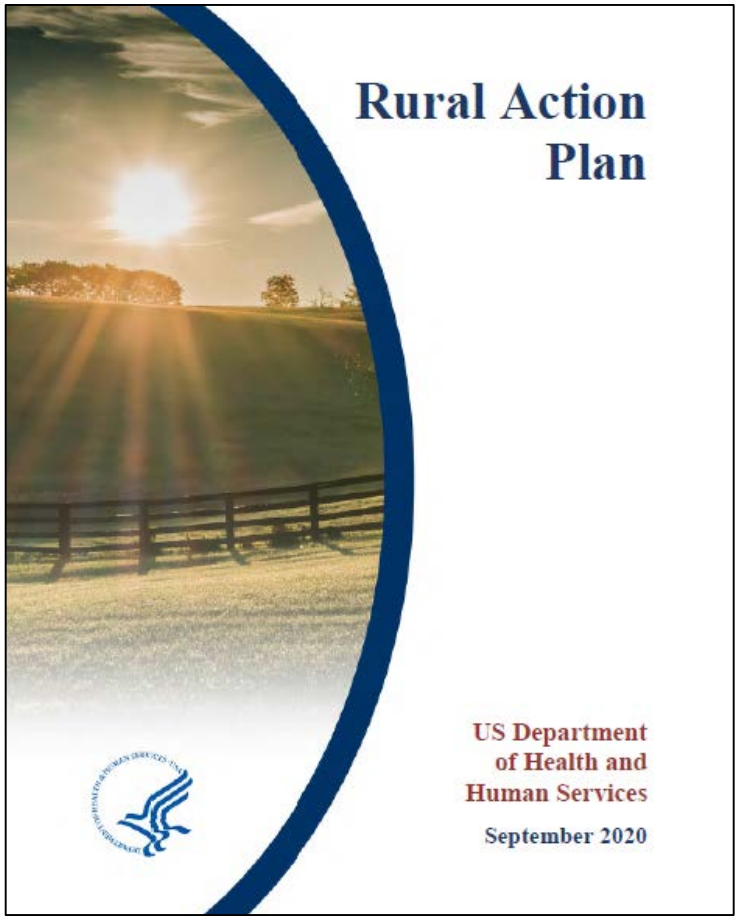


"Value-based payment under the Trump administration is the future," said Verma. "So, make no mistake — if your business model is focused merely on increasing volume rather than improving health outcomes, coordinating care and cutting waste, you will not succeed under the new paradigm." Seema Verma 9/9/2019

NATIONAL RURAL HEALTH RESOURCE CENTER

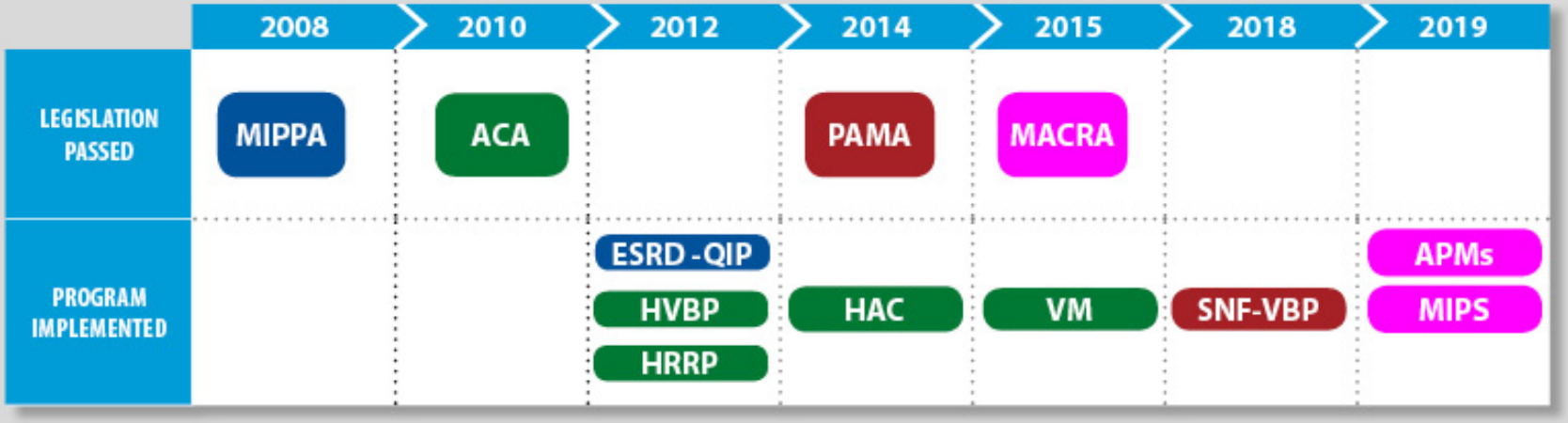
Value-Based Care Updates, Continued

- Roadmap for HHS to strengthen departmental coordination and better serve rural Americans through 4 key strategies
  1. Building a sustainable HHS model for rural communities
  2. Leveraging technology and innovation
  3. Focusing on preventing disease and mortality
  4. Increasing rural access to care
- Includes funding the Rural Healthcare Providers Transition Project, a new program in conjunction with FORHP & HRSA to provide support for hospitals and rural health clinics transitioning to value-based models.



NATIONAL RURAL HEALTH RESOURCE CENTER

CMS VBC Programs



LEGISLATION

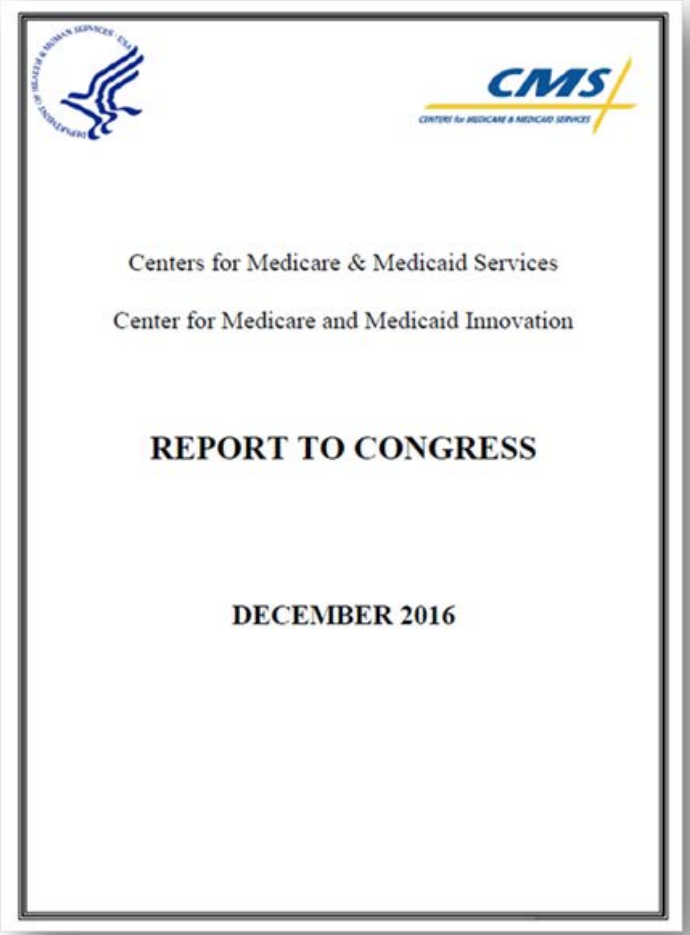
ACA: Affordable Care Act
MACRA: the Medicare Access & CHIP Reauthorization Act of 2015
MIPPA: Medicare Improvements for Patients & Providers Act
PAMA: Protecting Access to Medicare Act

PROGRAM

APMs: Alternative Payment Models
ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
HACRP: Hospital-Acquired Condition Reduction Program
HRRP: Hospital Readmissions Reduction Program
HVBP: Hospital Value-Based Purchasing Program
MIPS: Merit-Based Incentive Payment System
VM: Value Modifier or Physician Value-Based Modifier (PVBM)
SNFVBP: Skilled Nursing Facility Value-Based Purchasing Program

Centers for Medicare and Medicaid Innovation (CMMI)

- Launched over 50 new payment models in ten years
- Estimated 20 million patients impacted/received care through new payment models in first 6 years
- Invested in EMR and data analytics infrastructure
- State Innovation Models and global payment arrangements: Maryland, Vermont, PA
- Develop MACRA proposed/final rule
- $34 Billion spending reduction per CBO in first 6 years
- **Partnered with Medicare, Medicaid and commercial payors to develop value-based models of care**

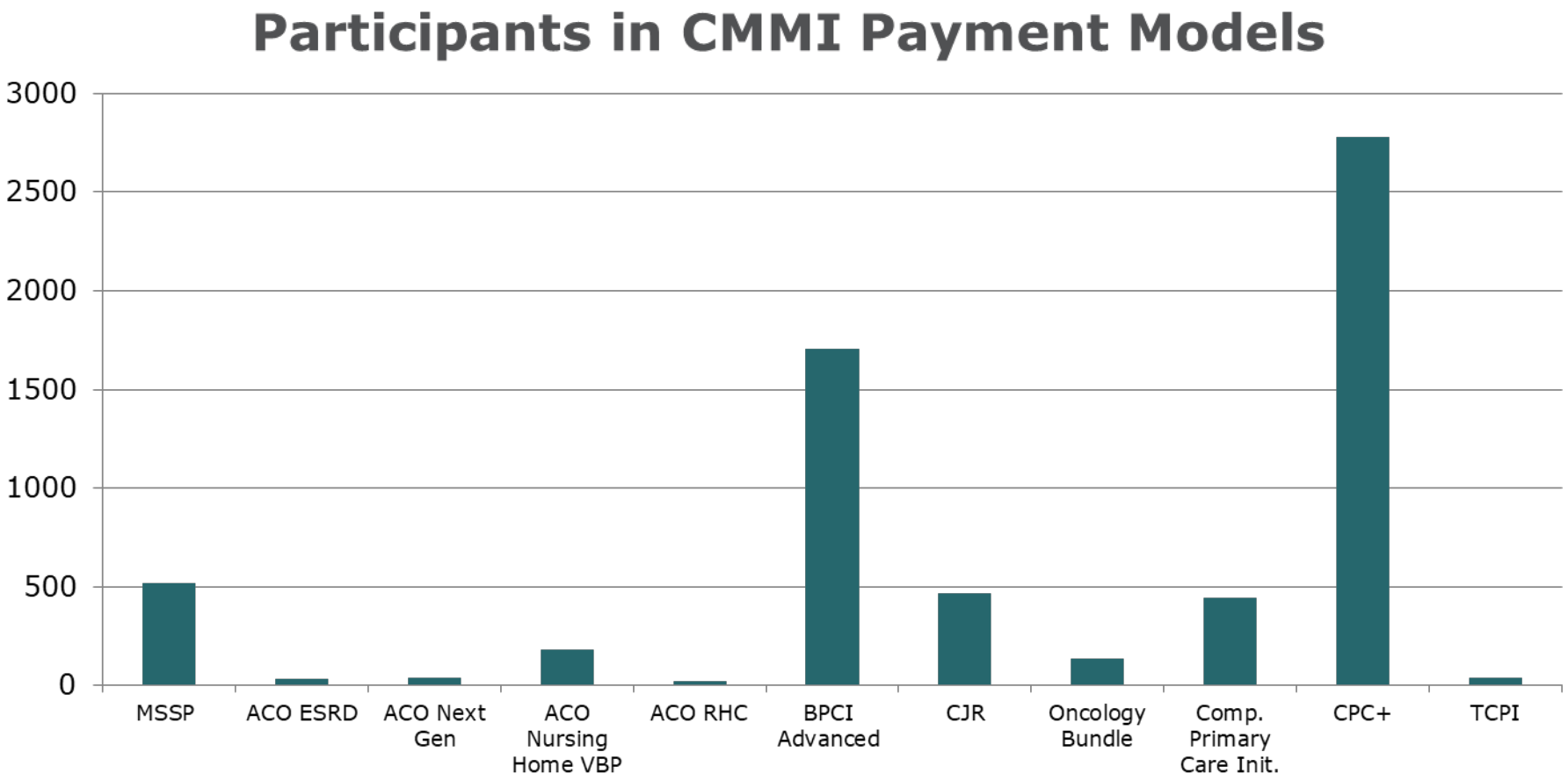


NATIONAL RURAL HEALTH RESOURCE CENTER

CMMI APM Models

Accountable Care	Episode Based Payments	Primary Care Transformation	Medicaid and CHIP	Acceleration Models	Speed Adoption of Best Practices
Track 1-3	Model 1	Advanced Primary Care Initiative	Reduce Avoidable Hospitalizations	State Innovation Models	Beneficiary Engagement Model
Pioneer & Advanced Payment ACOs	Model 2	Comprehensive Primary Care Initiative & +	Financial Alignment Incentive for Medicare and Medicaid	Frontier Community Health Integration	Community Based Care Transitions
ACO Investment Model	Model 3	FQHC Advanced Primary Care Practice	Strong Start for Mothers and Newborns	Health Care Innovation Rounds	Health Care Action and Learning Network
Next Generation ACO	Model 4	Transforming Clinical Practice	Medicaid Prevention of Chronic Diseases	Health Plan Innovation Initiative	Innovative Advisors Program
Pathways to Success	**CJR Mandatory Voluntary 3 yr extension**	Direct Contracting	Medicaid Emergency Psychiatric Demonstration	Direct provider contracting	Million Hearts
	BPCI-Advanced	Primary Care First	Ped Alt. Payment Model	**CHART Model**	Medicare Diabetes Prevention

Overview of Value-Based Care, Continued



NATIONAL RURAL HEALTH RESOURCE CENTER

Commercial Payers

Anthem Blue Cross Nears 60% Value-Based Care Spend

Bruce Japsen, CONTRIBUTOR

I write about healthcare business and policy **FULL BIO**

Opinions expressed by Forbes Contributors are their own.

TWEET THIS

Anthem now 159 ACO agreements.

over 64,000 providers now engaged in ACOs and patient-centered medical homes

Anthem's top executive says the health insurer is paying out 58% of its reimbursements via value-based care models that are quickly dominating the U.S. medical system.

Anthem ANTM -0.23%, which operates Blue Cross and Blue Shield plans in 14 states, this week opened a window into the health insurance industry's shift away from the traditional fee-for-service approach that is based on volume of care delivered and can lead to overtreatment and unnecessary medical tests and procedures. Rival insurers, including Aetna AET +0.07% and UnitedHealth Group UNH +0.14%, are also moving aggressively away from fee-for-service

Modern Healthcare Feb 2018

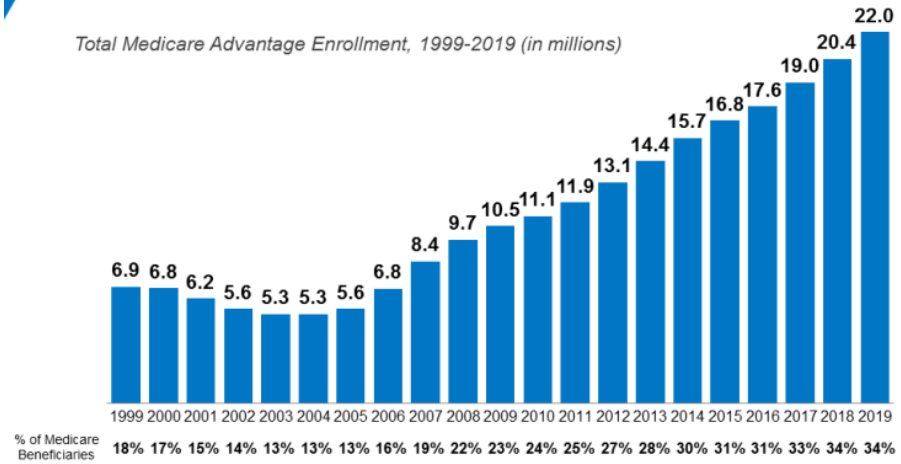
MH: To what extent did the Trump administration taking over and the future of the Innovation Center drive the decision?

Conway: I worked on value-based care in Republican and Democratic administrations. I believe the Innovation Center and the work on value-based care will continue. It's driven in both the public and private sectors. **Private insurers are driving value-based care models like accountable care organizations and bundled payment. We've got over 80% of payments tied to quality and value in some way** in Blue Cross North Carolina and now it's taking it to the next step of really scaling these ACO models and bundled payments across the state.

Medicare Advantage

Figure 1

Enrollment in Medicare Advantage has nearly doubled over the past decade

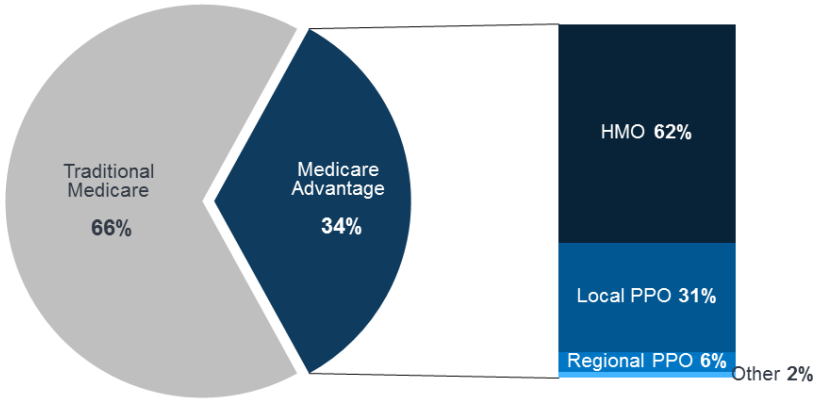


NOTE: Includes cost plans as well as Medicare Advantage plans. About 64 million people are enrolled in Medicare in 2019.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2008-2019, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

KFF HENRY J KAISER FAMILY FOUNDATION

Figure 3

Almost two in three people enrolled in Medicare Advantage plans are in HMOs in 2019



NOTE: PPOs are preferred provider organizations and HMOs are Health Maintenance Organizations. Other includes Private Fee-for-Service plans, MSAs, cost plans, and demonstration plans. Includes enrollees in Special Needs Plans as well as other Medicare Advantage plans. Numbers may not sum due to rounding.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2019.

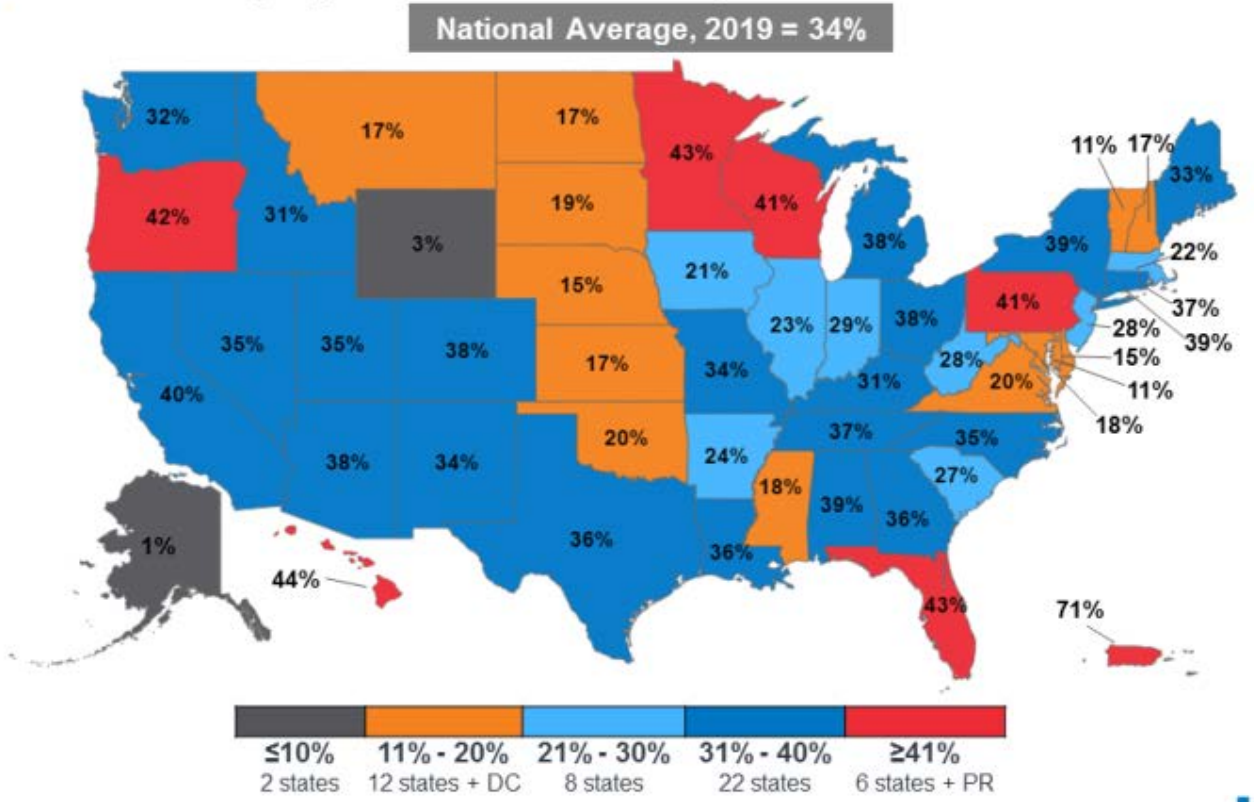
KFF HENRY J KAISER FAMILY FOUNDATION

NATIONAL RURAL HEALTH RESOURCE CENTER

Medicare Advantage, Continued

Figure 2

The share of Medicare beneficiaries enrolled in Medicare Advantage plans varies widely across states



NOTE: Includes cost plans, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2019.

KFF
HENRY J. KAISER FAMILY FOUNDATION

NATIONAL RURAL HEALTH RESOURCE CENTER

Why Participate?

- Improve quality
- Improve network /decrease leakage
- Access to data
- Prepare for future

NATIONAL
RURAL HEALTH
RESOURCE CENTER

What Are My Options?

- Do nothing
- Rip off the FFS Band-Aid
- ✓ Crawl, walk, run
  - Focus on FFS & VBC win-win scenarios: quality bonuses, readmissions, etc.
  - Improved care management/transitions of care
  - Coding and documentation
  - Upside arrangements and PMPMs
  - Physician compensation redesign
  - Starting or improving a provider owned/sponsored health plan
  - Procuring high-value post-acute network
  - Strategic affiliations with other providers and health systems
  - Leverage data to understand risk management
  - Think like an insurance company in terms of managing risk

What are My Options, Continued

ACO

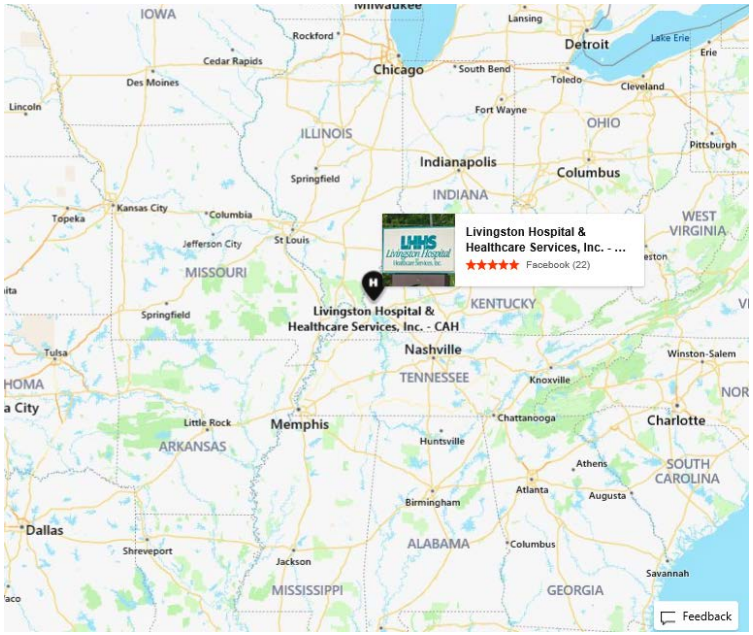
Bundled Payments

Targeted Programs

Self-insured & Direct to Employer

NATIONAL RURAL HEALTH RESOURCE CENTER

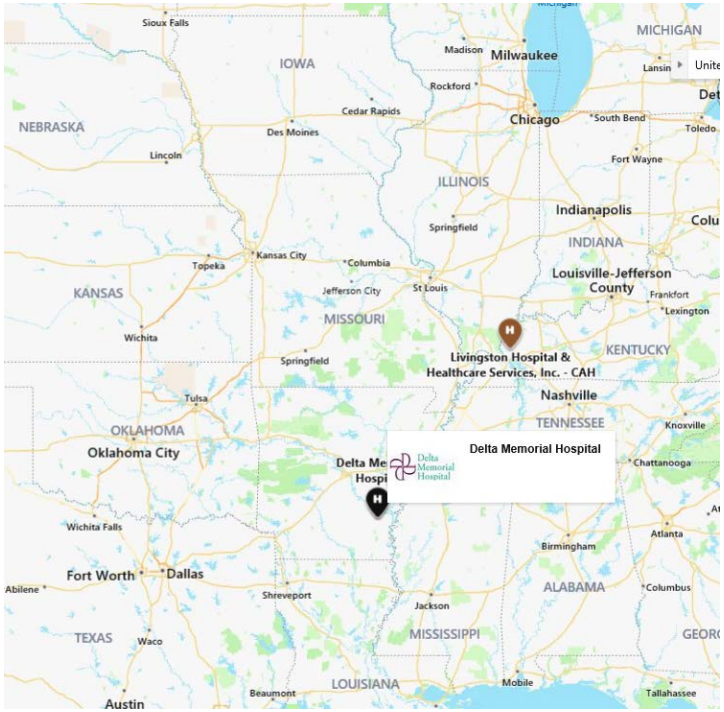
Livingston Hospital and Healthcare Services



Elizabeth (Liz) Snodgrass
Chief Executive Officer

NATIONAL RURAL HEALTH RESOURCE CENTER

Delta Memorial Hospital



Ashley Anthony

Chief Executive Officer

NATIONAL RURAL HEALTH RESOURCE CENTER

Keys To Success

- Governance and Oversight
- Physician Engagement
- Care Management
- Data Analytics
- Coding and Documentation
- Partnerships

NATIONAL
RURAL HEALTH
RESOURCE CENTER

Value-Based Care Workshop 201

Next Steps for Assessing and Building Value-Based Capacity in Rural Health Care Organizations

Panelists:

- Gene Burge, CEO Savoy Medical Center
- Randy Dauby, CEO Pinckneyville Community Hospital District

Facilitators:

- Terry Hill, NRHRC
- Eric Rogers, BKD

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U65RH31261, Delta Region Health Systems Development, $8,000,000 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

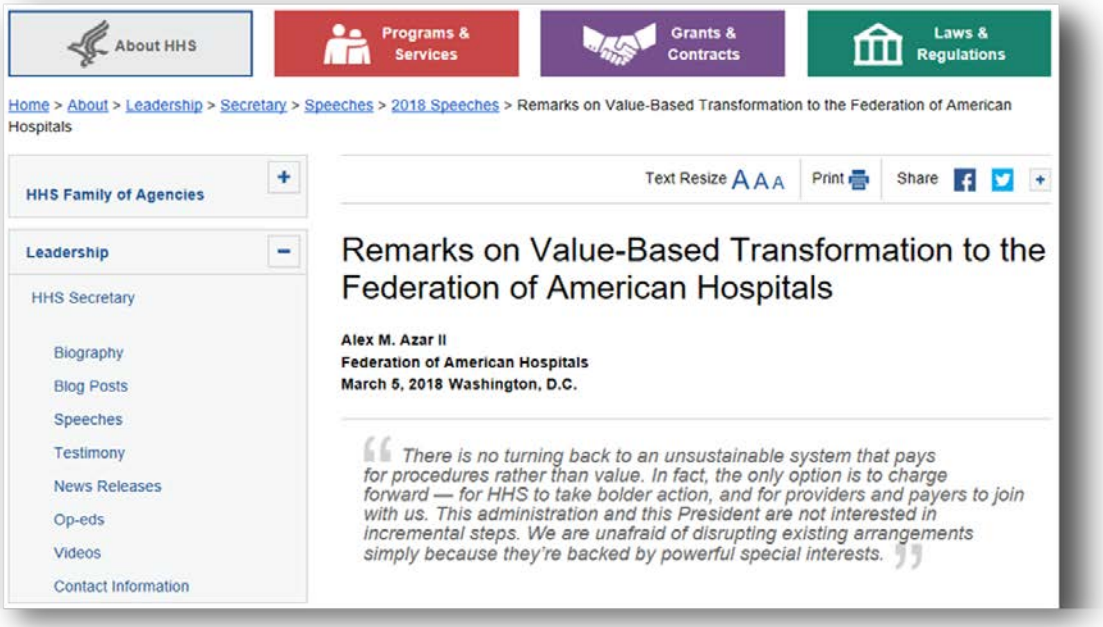
NATIONAL
RURAL HEALTH
RESOURCE CENTER

Topics for Today's Discussion

- Value-Based Care (VBC) Program Updates
- Case Studies and Discussion
  - Savoy Medical Center
  - Pinckneyville Community Hospital District
- Strategies for Success
  - Physician engagement
  - Data analytics
  - Financial modeling and settlement estimation
  - Patient risk stratification
  - Care coordination
- Partnerships
- Q&A

Value-Based Care Updates

- Political landscape may have changed, but emphasis on outcomes is still bipartisan and central theme at CMS



"Value-based payment under the Trump administration is the future," said Verma. "So, make no mistake — if your business model is focused merely on increasing volume rather than improving health outcomes, coordinating care and cutting waste, you will not succeed under the new paradigm." Seema Verma 9/9/2019

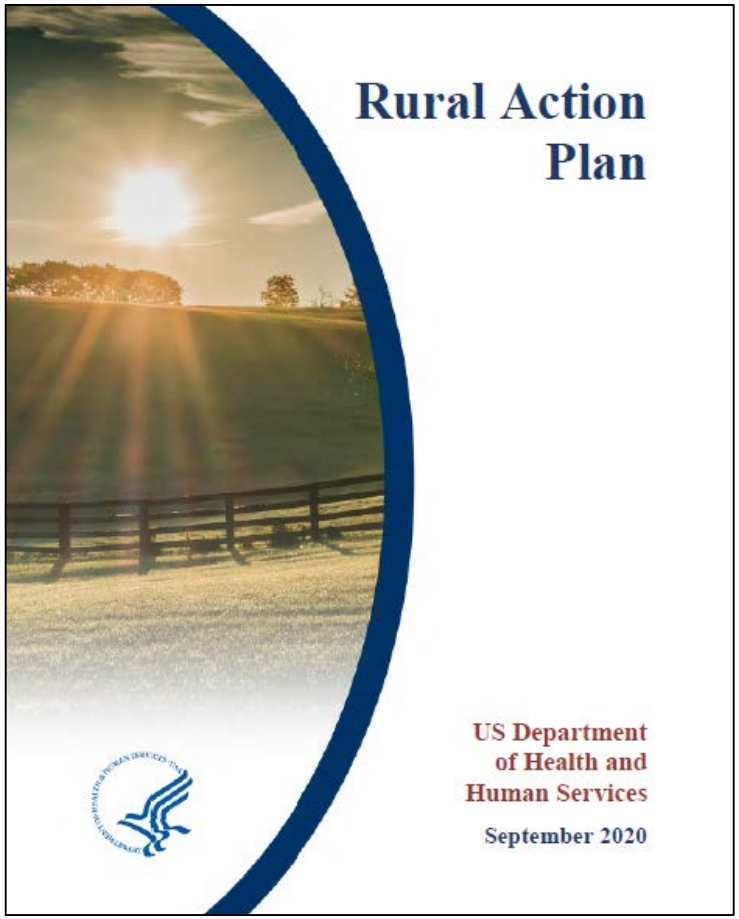
NATIONAL RURAL HEALTH RESOURCE CENTER

Pathways to Success

Tracks and Levels	Highlights
BASIC Track	*ACOs in the BASIC Track automatically advance to the next level (as presented below) annually, unless the ACO elects to advance to a higher level of risk. Certain ACOs will have the option of remaining at Level B for one extra year.*
BASIC - Level A	→ Upside-only model, shared savings rate up to 40% → Comparable to *Track 1* from former program rules
BASIC - Level B	→ Upside-only model, shared savings rate up to 50% → Comparable to *Track 1* from former program rules
BASIC - Level C	→ Two-sided risk, shared savings rate up to 50%, shared loss rate 30% → Lesser of revenue-based or benchmark-based loss sharing limit → Lowest loss-sharing limit of any two-sided model
BASIC - Level D	→ Two-sided risk, shared savings rate up to 50%, shared loss rate 30% → Lesser of revenue-based or benchmark-based loss sharing limit → Greater loss-sharing limit compared to Level C
BASIC - Level E	→ Two-sided risk, shared savings rate up to 50%, shared loss rate 30% → Lesser of revenue-based or benchmark-based loss sharing limit → Greater loss-sharing limit compared to Level D
ENHANCED Track	→ Two-sided risk, comparable to *Track 3* from former program rules → Can share up to 75% of savings, but 40-75% shared loss rate → Maximum downside risk equal to 15% of benchmark expenditures

Value-Based Care Updates, Continued

- Roadmap for HHS to strengthen departmental coordination and better serve rural Americans through 4 key strategies
  1. Building a sustainable HHS model for rural communities
  2. Leveraging technology and innovation
  3. Focusing on preventing disease and mortality
  4. Increasing rural access to care
- Includes funding the Rural Healthcare Providers Transition Project, a new program in conjunction with FORHP & HRSA to provide support for hospitals and rural health clinics transitioning to value-based models.



NATIONAL RURAL HEALTH RESOURCE CENTER

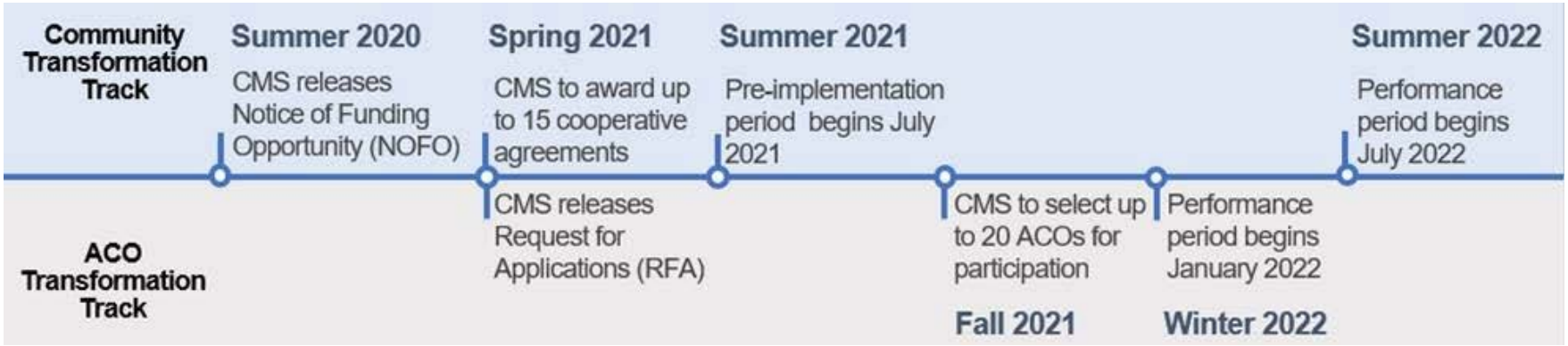
CHART Model

"CMS remains focused on the transformation of rural health care delivery and enabling local community collaboration to redesign their systems of care and align across providers and payers based on their unique needs. As part of that rural transformation, including transforming a system built on fee-for-service and volume to one based on value, CMS is testing the CHART Model."

"Through the Model, CMS is directly providing a pool of $75M in upfront, seed funding, with 15 rural communities applying for up to $5M to develop local transformation plans. With this upfront seed funding, CMS is also providing regulatory and operational flexibility for updated service delivery models as well as changing how participating hospitals in these communities are paid, from a system based on volume to stable, monthly payments. In addition, CMS is also looking for 20 rural Accountable Care Organizations to participate in the model, paying shared savings upfront."

CHART Model, Continued

- Two Tracks and Timelines



NATIONAL RURAL HEALTH RESOURCE CENTER

Warning:
Mandatory Bundled Payments are Coming

CB

Thu 9/10/2020 3:27 PM

CMS BPCIAdvanced <BPCIAdvanced@cms.hhs.gov>

BPCI Advanced – Message from Brad Smith, Deputy Administrator and Director, Centers for Medicare and Medicaid Innovation

To

Retention Policy 180 Day Retention (6 months) Expires 3/9/2021

Follow up. Start by Thursday, September 10, 2020. Due by Thursday, September 10, 2020.
You forwarded this message on 9/10/2020 4:36 PM.

CAUTION External email from (BPCIAdvanced@cms.hhs.gov). Do not open attachments or click links from sources you do not know and trust.

Greetings,

Today, the Centers for Medicare & Medicaid Services (CMS) Innovation Center announced changes to the existing Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model beginning in Model Year 4 (MY4), which begins on January 1, 2021. As we completed the reconciliations for Model Years 1 and 2 this spring, we discovered the model was resulting in significant net losses. We provided participants with a memo from Acumen (our payment contractor) through the Participant Portal on June 29, 2020 sharing our observations.

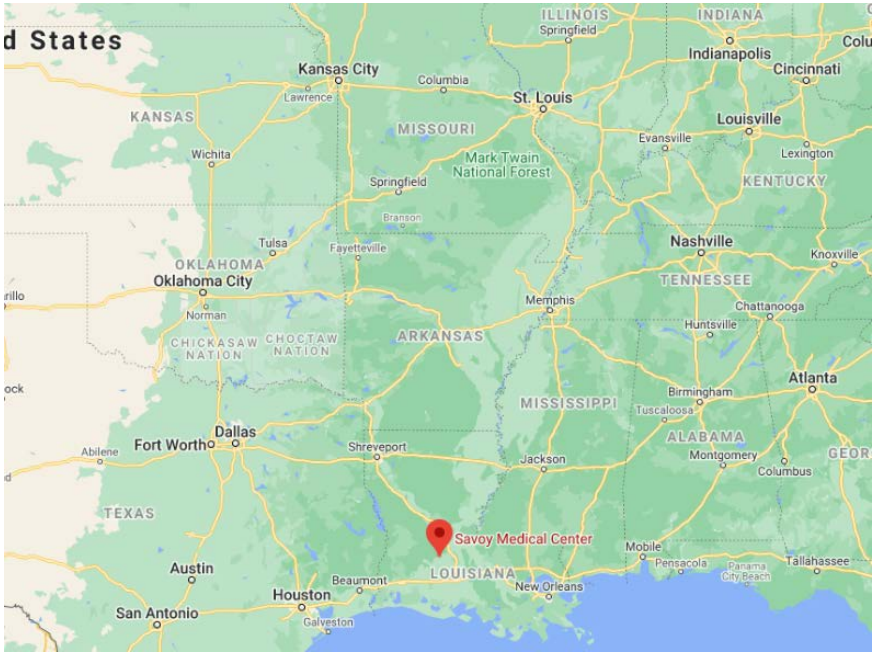
Specifically, the prospective trend in the model has proven to be particularly challenging, as we distributed $567 million in reconciliation payments using the model's prospective trend that would not have been paid had the BPCI Advanced model design adopted the actual trend that occurred during the first two performance periods. We estimate that without changes, the model is on pace to lose close to $2 billion over the model's ten performance periods. This amount of loss is unsustainable, especially in a second generation model such as BPCI Advanced. As most know, the Innovation Center has the authority to test models expected to reduce costs while maintaining or increasing quality. We also have a statutory obligation to modify or terminate models unless the model is expected to improve quality without increasing spending, reduce spending without reducing quality, or improve quality and reduce spending after testing has begun. Given BPCI Advanced's current performance, we feel it is necessary to modify the model to achieve these objectives.

Because this voluntary model relies on the ongoing support of our Participants, we requested your comments on how best to move forward with model revisions. We carefully reviewed the written and oral feedback we received from the stakeholder community and are now adopting several revisions for MY4 and beyond. All of these revisions, with the exception of how we allocate overlapping clinical episodes among participants, were recommended in some form by at least one, if not multiple, model participants. In totality, these changes are designed to improve target price accuracy for both CMS and model participants.

The Innovation Center remains strongly committed to moving forward with testing bundled payments. As a next step, **we plan to accelerate our work on a new bundled payment model that we anticipate launching as a mandatory model at the completion of BPCI Advanced**. By being mandatory, we are optimistic this future model will mitigate many of the selection effects we have seen in both BPCI and BPCI Advanced. Given the lessons we have learned from bundled payments over the past eight years, we view a mandatory model as the logical next step on our journey towards value-based care. We hope that many of you will remain deeply engaged and invested in this very important work as we enter MY4.

NATIONAL RURAL HEALTH RESOURCE CENTER

Savoy Medical Center



Gene Burge

CEO Savoy Medical Center

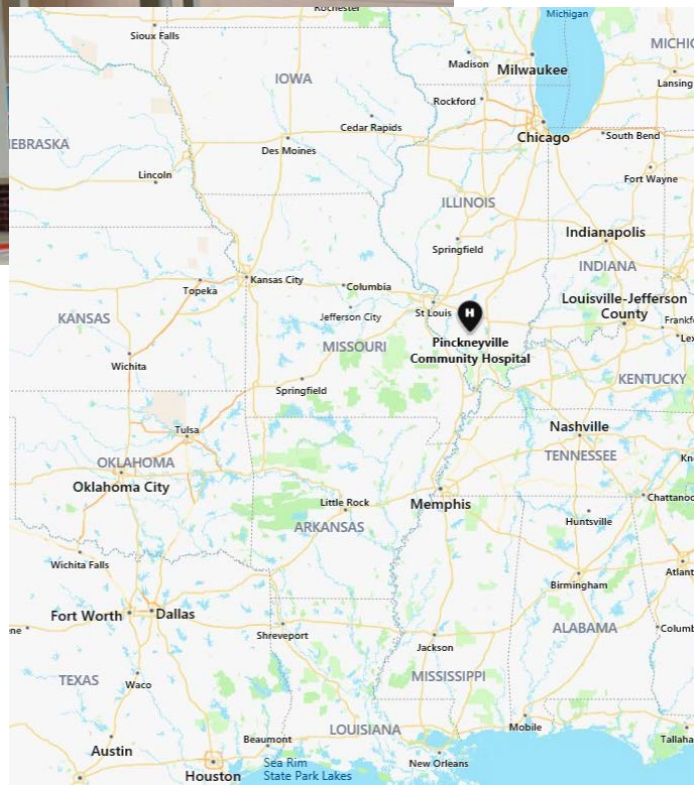
NATIONAL RURAL HEALTH RESOURCE CENTER

Pinckneyville Community Hospital District

Randy Dauby

CEO Pinckneyville

Community Hospital District



NATIONAL RURAL HEALTH RESOURCE CENTER

Strategies for Success

- Physician engagement
- EHR systems and data analytics
- Financial modeling, FFS impact and settlement estimation
- Patient risk stratification
- Coding and Documentation (HCCs)
- Care coordination
- Partnerships