FLAACOS 2021 VBC PANEL SURVEY

=SUMMARY OF ACOEXHIBITHALL.COM ADVISORY BOARD RESPONSES=

November 4, 2021

On November 4, 2021, the Executive VP of the ACO ExhibitHall.com (ACOEH), John Schmitt, Ph.D., MBA, will participate as Panel Moderator of the session titled “How to successfully transition from fee-for-service medicine to value-based care”. He will be joined on the panel by Dr. Brent Staton, CEO of CCHI (ACO), as well as Rachel Corbitt, Executive Director, Primary Care Alliance (ACO) and Phyllis Wojtusik, EVP Health Systems Solutions, Real Time Medical Systems. In preparation for the session, the Panel Moderator has proposed the five questions below to be addressed by the panelists.

Realizing the valuable resource available within the ACOEH Advisory Board (AB) membership, Dr. Schmitt invited the AB members to provide their input to one or all of the panel’s questions. AB member responses to the survey are not identified with specific contributors.

Below are the five panel questions and the responses received from the AB member respondents:

1.Physician and clinician engagement has proven time and again to be the secret sauce for value-based success, regardless of the complexity of the contract. However, it takes more than physician and clinician champions to enable value-based care; it requires infrastructure. What infrastructure resources do ACOs need to enable successful value-based contracting?

Respondent 1:

In order to effectively engage physicians and other clinicians, ACOs need an entire medical economics team that gathers data from many disparate healthcare data streams into an enterprise data warehouse. This data includes your own electronic health records, the records of health information exchanges, and other behavioral, psychosocial, and biometric data sources that you can procure. This clearinghouse of actionable data provides the critical foundation for proprietary data modeling and rules engines that can be leveraged to build sophisticated AI/ML algorithms to identify risk and drive care interventions. In addition to the data infrastructure, success in value-based contracting will require provider engagement personnel and an interdisciplinary clinical team practicing at the top of their scope and licensure to provide comprehensive, integrated care to the population under management in the value-based contract.

Respondent 2:

Vendors offer a myriad of infrastructure resource nuts and bolts required for ACO success. The VP of Clinical Operations for Intermountain’s ACO hit the nail on the head when he said "This is a team-based sport; you can’t do this by yourself. The level of analytics needed, of bringing together care coordinators, pharmacy managers, house calls, care management—it’s not just the provider and MA [Medicare Advantage] trying to see 25 patients a day and trying to do value-based care as well—that doesn’t work. You’ve got to surround the teams with the right tools and resources and be in the workflow.”

Respondent 3:

ACOs must lay the groundwork to create the proper infrastructure to manage populations. Key infrastructure components must support Annual Wellness Visits, Disease Management, Transitional Care Management, High-Risk Care Management, Risk Coding, and Applied Analytics. Each of these requires having sound data and a mechanism to aggregate claims and other payer data across value-based contracts. From there, it takes the ability to turn the numbers into insights which forms your population health strategies. And, as previously mentioned, yes, provider engagement is at the crux of all this. Successful ACO's will need a dedicated provider engagement team who educate, equip, and empower providers with the reports and support needed to facilitate behavior change.

Respondent 4:

Three basic infrastructure resources are needed:

a. ACOs need meaningful and actionable reports from the data. It's OK if the reports are a little late or incomplete due to claims lag.
b. ACOs need to measure engagement, set goals and hold providers accountable to goals. Many ACOs are far too vague in this area.
c. Tools that are actionable, allow prompt performance measurement, and as close to the point of care as possible are best.

Respondent 5:

A. Credible analytics and the ability to know your market dynamic, a local phenomenon.
B. Building an informed and aligned network of providers dedicated to your mission.
C. Talented process engineers and critical problem solvers from clinical and administrative backgrounds.
D. Lots of breaking down of barriers, economic conflicts and relationships that don't serve the main agenda. Get rid of the dead wood.
E. An incubator to test and fail ideas.
F. Communication and buy-in from champions, if you have them. Otherwise proselytize until you do.
G. A learning care management team who is learning how to stratify populations, identify rising indicators and can respond to measured outcomes.
H. Money and time

2. How has COVID-19 advanced or inhibited the value-based care movement? In that regard, how can providers and payers improve upon their pre-COVID value-based care models?

Respondent 1:

We certainly saw the impact on preventive screenings drastically declining during COVID. In addition, practices were seeing a dramatic reduction in the volume of patients, establishing an urgency for physicians to look at alternative payment opportunities. More than ever before we

could see the vulnerability in relying entirely on a fee-for-service model and realized the need for diversification. Seeking prospective payment opportunities is the first step in moving the agenda forward from a fee-for-service to a model that ensures practice viability during unpredictable times. PCPs receive a fixed monthly amount for each patient linked to them covering most basic clinical services. Payment is made whether a patient is seen or not that month. Upfront monthly payments provide shelter from unpredictable events and promotes practice/cost efficiencies.

Respondent 2

In my opinion COVID-19 advanced value-based care as providers started to see that value-based agreements continued to be a successful resource when fee for service patient volume dropped off (which included the associated revenue they were used to as well). I think the COVID pandemic brought the realization one step closer for providers to understand the ability of value-based care to bring in more revenue than just seeing their patients under the fee for service model.

Respondent 3:

We are in this “iPhone moment in healthcare” where the COVID-19 pandemic has put a spotlight on the lack of resilience in healthcare and how technology can fix this issue. It’s a moment, like the introduction of Apple’s iPhone when a new universe of possibilities opens up. I envision a future where innovation ascends and displaces parts of the old system, where it took something like COVID-19 to catalyze digital, mobile consumerism into the healthcare mainstream. The scalability of telehealth during the pandemic was just the beginning, as consumer orientation toward technological innovation and convenience will necessitate changes to how care will be delivered in the future. COVID has also served as a flashpoint for revolutionary change by moving us towards health equity in our society. The pandemic illustrated the vast inequities in our healthcare system and raised awareness for the need of value-based care to address disparities in outcomes between populations. I anticipate value-based care models and benchmarking methodologies will begin to incorporate measures of health equity as a key performance indicator.

Respondent 4:

A win-win for payors and providers would be for payors to reimburse providers to continue providing newly adopted models to include but not be limited to tele-health and hospital-at-home; i.e., models that provide less costly care and places the patient (not the doc’s office) at the core of the patient centered medical home. Another lesson learned is to prioritize preventive services because delays lead to escalating costs for treating diseases (Cancer, etc) that have advanced in severity.

Here is a must-read article on the subject:

https://medcitynews.com/2021/10/who-is-generation-c-and-how-will-healthcare-adapt-to-meet-their-expectations/

Respondent 5:

The biggest impact of COVID-19 has been the scarcity of employees. Providers have taken at least one step back on what they are able to accomplish in their office, directly related to

provider performance, due to staffing challenges. We recommend that providers consider their staff to be an investment and therefore spend more in the short term (overtime, higher offers, bonuses) so that their staffs' end of year performance payments don't decrease. That consequence will likely cost providers far more than their investment.

Respondent 6:

The cost of human life for those on the front lines has been more than can be comprehended by most. It is tragic our doctors and nurses have not been more significantly honored as heroes. Their families should be compensated for their immeasurable service and sacrifice. Our folks are worn to the bone. It is amazing they keep on doing their jobs. It is truly, a privilege to work alongside our providers. So proud! (I know my response is somewhat emotional, but I know that if we can survive COVID we certainly have the "right stuff" to make needed reforms happen given time.)

3.As practitioners participate in more value-based care arrangements, their patients benefit. One reason is because doctors have more time to discuss their patients' conditions along with other contributing factors, such as social determinants of health. Given the inherent benefits of value-based care, what could accelerate the movement to healthcare models that pay providers for value rather than volume?

Respondent 1:

VBC has come a long way. It keeps some of us up at night thinking about the market threat of retail and other direct to consumer (DTC) healthcare companies (e.g. Walmart, Walgreens, Teledoc) and their lack of VBC vision. Increased access to healthcare is great, but we need to think through who will take responsibility/accountability for patient populations. If DTC companies provide services that PCPs formerly provided with no responsibility/accountability, health plans are going to need to increase compensation to PCPs for taking on the higher risk patients that are out of the scope of DTC companies. Another approach for payers would be to advocate for VBC providers by creating small incentives for patients to maintain relationships with VBC providers vs. DTC companies who have limited scope and don't manage higher risk patients.

Respondent 2:

Allow the provider to be at the top of the food chain and control every dollar spent in a beneficiary's total cost of care. Engage and educate the providers to understand that every service rendered has a cost (expense) that comes out of their own pocket, and "X"% of every dollar not spent is theirs to keep, they will endorse and support the concept that a stitch in time saves nine.

Respondent 3:

A. Change the attribution model to include a broader definition of providers. Voluntary alignment is complex and difficult for most seniors. We do not want the vulnerable to fall prey to marketing gimmicks and "free handouts". Midlevel primary care providers who predominantly see a panel of chronic comorbid patients should be allowed to count their

patients without an MD consult. In a value-based model, the MD is only one of many caregivers involved. Using claims data, it should be fairly clear which NPI is the rendering longitudinal caregiver regardless of licensure.
B. Prohibit third party chronic care or RPM companies from contracting with non-primary care providers. It is very confusing to the patient and results in significant overlap in the AWV and ensuing care management process when multiple parties, not tied to their primary care provider are fighting to generate revenue for specialists who are just trying to offset declining elective activity.
C. Legislation which changes the hospital COPs to allow for coordinated case management which aligns with ACO COPs. Make the language very clear that for beneficiaries assigned to ACOs, a blended COP can replace the hospital COP and stay in compliance. This will significantly ease the pressure of hospital administrators and allow them to be fully involved in value based integrated post-acute care management initiatives.

Respondent 4:

More health plans going to more value-based agreements. There are still too many fee for service agreements with health plans to be able to have providers go all in. They get stuck in what they know (fee for service) and its harder to get them to go all in when the majority of their contracts are still using fee for service pay models.

Respondent 5:

Groups that were fully capitated were financially stable during the pandemic when fee-for-service revenues dried up. That raised awareness that one's revenue portfolio should be more centered towards capitated risk. Additionally, the continued success stories of groups taking risk and the velocity of capital driving provider aggregation in risk-based payment is a trend moving the industry towards value. Despite the success of the Medicare ACO program, however, CMMI payment models continue to struggle. In the coming years, the CMMI APM portfolios will consolidate (and perhaps require mandated participation) which will drive up the adoption of value-based payment arrangements.

4. Despite tailwinds coming from COVID-19 in terms of cost pressures and heightened awareness of health inequities, CMMI has delayed the second application cycle for the Global and Professional Direct Contracting Models. Additionally, the actual results of the CMMI's APM portfolio show that, out of 54 total models, only five have produced statistically significant savings. Therefore, will value-based care policies move healthcare fast enough to secure the movement? How could Medicare Advantage play a role in advancing value-based care in the future?

Respondent 1:

"Medicare Advantage for All" is certainly a possible solution to health reform. It seems to me that Medicare Advantage for All could be a good starting point for a bipartisan discussion on creating a new framework for the US health system. Unlike the higher-profile Medicare-for-all approach, a Medicare Advantage–for-all approach would have several advantages such as broad political support, a capitation system that allows for a variety of benefits, greater efficiency and patient satisfaction, and a better emphasis on social determinants of health. Currently, one-third of all Medicare beneficiaries – 22 million people – are enrolled in Medicare Advantage plans, and the CBO projects that the share of beneficiaries enrolled in Medicare Advantage

plans will be about 50% percent in the next 5-10 years. This enrollment growth trajectory, coupled with the silver tsunami of the aging baby boomer population, certainly makes MA an attractive business to get into for primary care physicians. If they can do it well, it's really a remarkable opportunity to have an impact in population health with rewarding economics. MA plans also seem to be an area for consumer-centric innovation, where certain health plans can offer members greater flexibility, inventive care models, an increased emphasis on economic value and unique benefits options—often while still being more affordable than traditional fee-for-service coverage.

Respondent 2:

Government policy has its limitations and speed is one of those. The CMMI's goal is to try different models to see if they work, it is not a one and done methodology. Value based care is broad and can vary throughout each state. Medicare Advantage could play a role in advancing value-based care in the future, but it has to be more consistent throughout the US. There are states that have very low Medicare advantage penetration rates while other states have larger conversions to Medicare Advantage. If Medicare advantage plans were more consistent in their value-based contracting initiatives it could help providers move more quickly to value-based care.

Respondent 3:

Having been entertained by several Public and PE aggregators, the consistent theme driving valuation is based on current benchmarks, enhancing benchmarks mostly via RAF/HCC modifications and scaling up with aggressive growth or conversion of lives into a controlled utilization business model. Very little of the discussion is about expending capital and the progress towards reforming care at the provider community level, creating integrated care streams, and tying service providers into one homogeneous delivery system. The quick opportunity to enter a market via a DCE or GeoDCE path (excluding the provider or at least controlling the provider via long term lock down agreements and leveraged operating agreements) is reason to pause and rightly so. We are getting away from the original intent of VBC reform of using converging data, EMRS, enhanced documentation, enriched analytics, provider engagement, integrated networks and other well-placed initiatives which will eventually create the accountability originally visualized. We are making the assumption of "risk" the main objective, a game MA and MA-like DCEs know very well. I seriously doubt the current administration wants to return to an old insurance model which uses leverage to guide price inflation and manage margins. DCE proponents are already claiming they are "advanced ACOs" and nothing else. If that is the case, then the provider should be put back into control of the delivery model and financiers or insurers should return to MA. Then we will have the private and public options back in equilibrium and let the public choose.

Since COVID, I believe healthcare policy is much more sensitive to solutions which grant an equitable distribution of care and give the population deliverables which are local and immediate. This bodes well for traditional ACOs who entered the space for the right reasons. For these reasons, I believe MSSP Enhanced will continue to gain traction with the possibility of a global capitation option but within the confines of MSSP. DCE will be either closed out or redefined to exclude "gamers" however that's defined. MAs will continue to grow aggressively until rate book and benchmark methodologies are adjusted more in line with the latest spending national and regional trends to create an equal playing field. We will see how

the current administration reacts to the recent MEDPAC evaluations suggesting a 2-4% downward adjustment to the MA rate book.

Respondent 4:

MA has and will continue to play a major role in the near term … and is currently used as the template for commercial payor contracting. The insurance business of marketing, customer relations, claims adjudication, etc is a whole new business in which few provider organizations have knowledge or capability. Insurance models should not be internalized until the provider organization has mastered clinical integration and risk management.

Respondent 5:

Medicare Advantage is widely considered to be the most expensive VBC option that offers patients/voters the least amount of choice. We advocate that it should be considered as a last resort for policy makers who seek public buy in. We support the efforts of CMMI to include a variety of stakeholders/providers to VBC. While certain models may have had limited savings results, the principles of inclusion and increased performance awareness to a variety of provider types are commendable. Direct Contracting attracts managed care stakeholders whose strengths may not benefit all stakeholders. Organizations with contractual discount and risk adjustment expertise certainly have more of a winner/loser stakeholder effect than organizations with quality and UM expertise. We advocate that CMMI should be thoughtful about the pace of adding new programs, how those programs will overlap with existing programs, the types of stakeholders they attract/effect and vigilantly evaluate any adverse incentives.

5. What information resources have you found helpful for advancing your field knowledge about value-based care?

Respondent 1:

The Accountable Care Learning Collaborative (ACLC) and the Race to Value podcast are great resources to advance knowledge about value-based care.

Respondent 2:

Every situation is so different. We reach out for answers when we need the help. So much of the learn is internal. But on occasion we find someone who meets a specific niche knowledge that is a catalyst or helps us get unstuck. But for the most part, our field of knowledge is home spun.

It is important to stay up on policy changes. CMMI, NAACOs, FLACOs, and internet reports or opinion pieces are great for testing your policy strategy.

Respondent 3:

I personally find myself to be in the weeds with day-to-day VBC management, although vast, and request advice from others on how to keep up on national trends/advocacy.

Respondent 4:

Active participation in healthcare professional organizations such as ACHE and National Association of Health Services Executives (NAHSE). Subscriptions to value-based resource materials such as ACO Exhibit Hall (ACOEH) Newsstand, Modern Healthcare, and my ACOEH Advisory Board colleagues.

Respondent 5:

The ACO Exhibit Hall (ACOEH), *Health Affairs*, Becker newsletters & podcasts, CMS/CMMI news releases & webinars, meetings/demos w/vendors.

Respondent 6:

This is a hard question. Experience and time are two things that I can't get away from stating. I think it comes with jumping in and doing. Listening to people at conferences to see what they did right and wrong has been helpful as well.

Our sincere thanks to the following ACO Exhibit Hall (ACOEH) Advisory Board respondents:

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