Are You Sabotaging Your ACO Viability?

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January 28, 2025

VBCExhibitHall.com
Educational Webinar Series

National Geographic Photo

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About Roji Health Intelligence

- We provide Value-Based Care technology and services to providers.
- Our powerful tools identify patients at risk and target health interventions.
- Roji Health Intelligence is a CMS-qualified ONC-certified registry for QPP reporting, and we report eCQMs and CQMs.
- Roji Episodes reveal cost variations and drivers to generate strategies to address Total Cost of Care.

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HEALTH CARE VERS. 2025:

The pendulum swings to cost control.

The road ahead will be hard to navigate.

Image by Malachi Brooks on Unsplash

How Prepared Are You For Change?

A. You're exaggerating. We're fine.

Image by Martie Bloem on Unsplash

B. We may be buried, but we're planning our cost strategies.

Image by Richard Pennystan on Unsplash

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Methods of Managing Health Care Costs
Part 1: Traditional

- Reimbursement strategies (payers and government)
  - Changes in reimbursement formulas
  - Cuts in eligibility
  - Prior authorization for services
  - Benefit reductions
- Reimbursement negotiations
- Tiered provider networks
- Tiered coverage vehicles (e.g. catastrophic insurance plans)

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Traditional Health Care Cost Proposals on the Table

Changes in Reimbursement and Cost Formulas	• Site-neutral payments to hospitals • Phase out Medicare payments for bad debt • Modify uncompensated care pymts and remove Medicare funding • Adopt block grants for GME and change distribution • Remove 50% floor on Medicaid cost sharing • Per capita caps on Medicaid funding • Eliminate tax-exempt status for non-profits
Change eligibility (Medicaid)	• Change eligibility requirements • Eliminate expansion programs
Cut Medicaid services	• Repeal Medicaid home- & Community-based Services

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In 2024, there were 72 Health System / hospital mergers.

30% involved one distressed partner.

Methods of Managing Health Care Costs
Part 2: Value-Based Care

- Payment models with per capita or episodic reimbursement
  - ACO REACH
  - TEAM
  - Enhancing Oncology Model
  - ACO PC FLEX
- Medicare Advantage expansion with reimbursement changes
- MSSP ACO Changes in risk, savings formulas
- Mandatory participation in payment models

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Magical Thinking (def.): A persistent belief in positive outcomes without the need for change.

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Realistic Options for the Future

- Providers' best avenue for financial sustainability are in VBC payments
  - More ways to live within levels
  - Opportunities to excel on cost accountability and outcomes
  - Long term strategy for clinical excellence / maintaining workforce
  - Best competitive positioning if TCoC control is serious

- Reimbursement formula & other traditional changes will happen, but can be reduced under controlled TCoC

- Resisting all change is equivalent to adopting top-down cuts.

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Review of Current Payment Models with Risk

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Primary Care Payment Models Tested by CMMI

- Primary Care First
- Making Care Primary
- ACO Primary Care FLEX (begins 2025)

Other payment models with emphasis on Primary Care

- MSSP ACO
- ACO REACH
- Maryland Total Cost of Care Model
- Pennsylvania Rural Health Model
- Vermont All-Payer ACO Model

Photo by whitedaemon on pixaby

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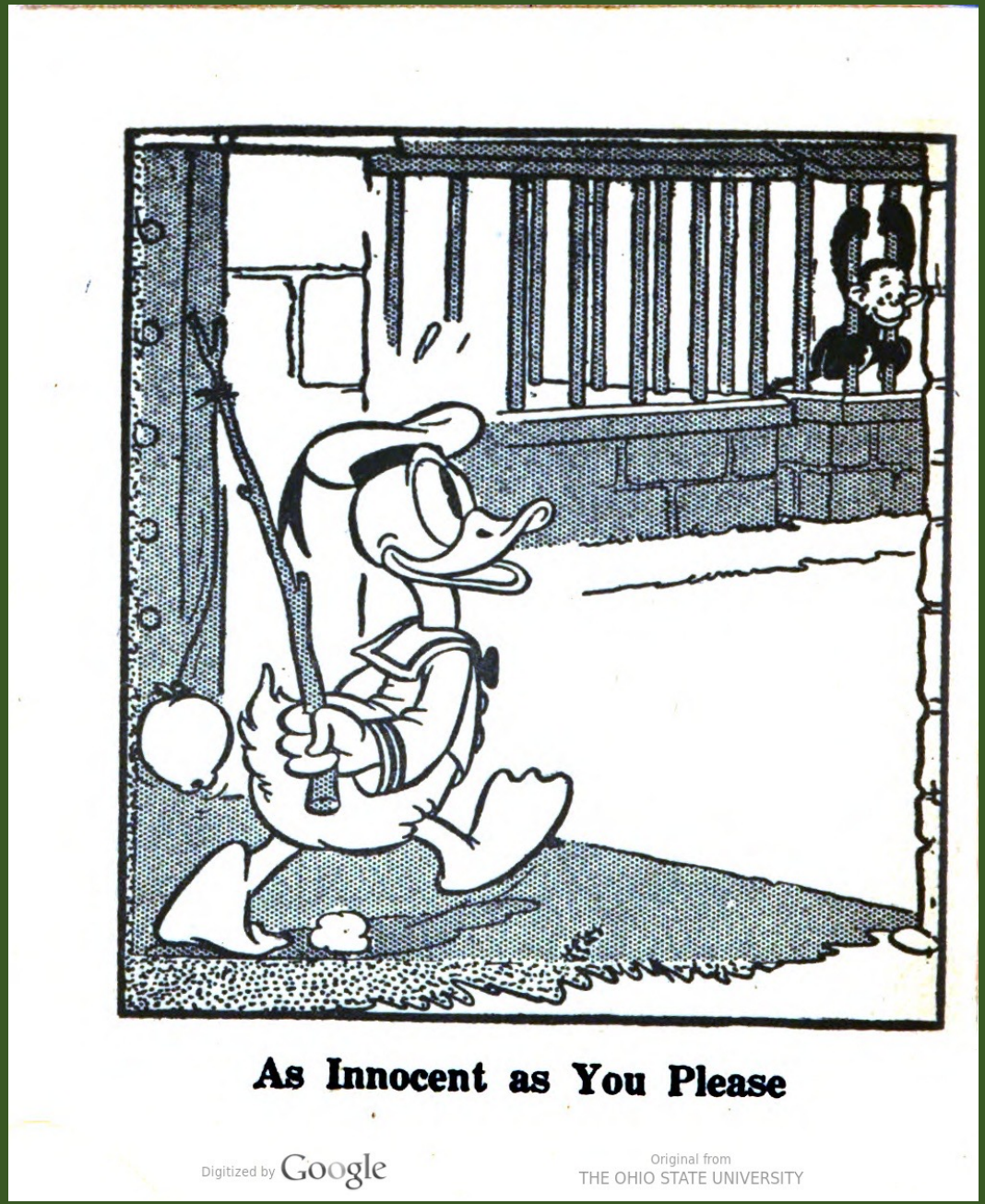
Key Point of Payment Models

- Cap total cost of care
- Change incentives away from volume and toward efficient / effective care
- Divide and conquer change strategy
- Address high cost clinical areas



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Primary Care First

5-Year Model starting 2021/2022

Image by Alek Olson on Unsplash

Features

- Prospective, risk-adjustment population-based payment + flat fee
- Practices experienced in care management
- HaveCEHRT Systems, aggregate data
- Longitudinal care management
- Behavioral health integration

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Latest Evaluation of PCF (Year 2)

- PCF payments higher than FFS
- Minimal effect on hospitalizations and Medicare expenditures
- Participating practices did not believe money enough to support transformation

Source: Mathmatica

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Making Care Primary (2024)

- 3-Track approach to fortify advance primary care management in conjunction with payment type:
  - Phase 1, Build infrastructure – Payment FFS
  - Phase 2, Advanced Care Management – Payment PCPM
  - Phase 3, Optimize care & Build Partnerships

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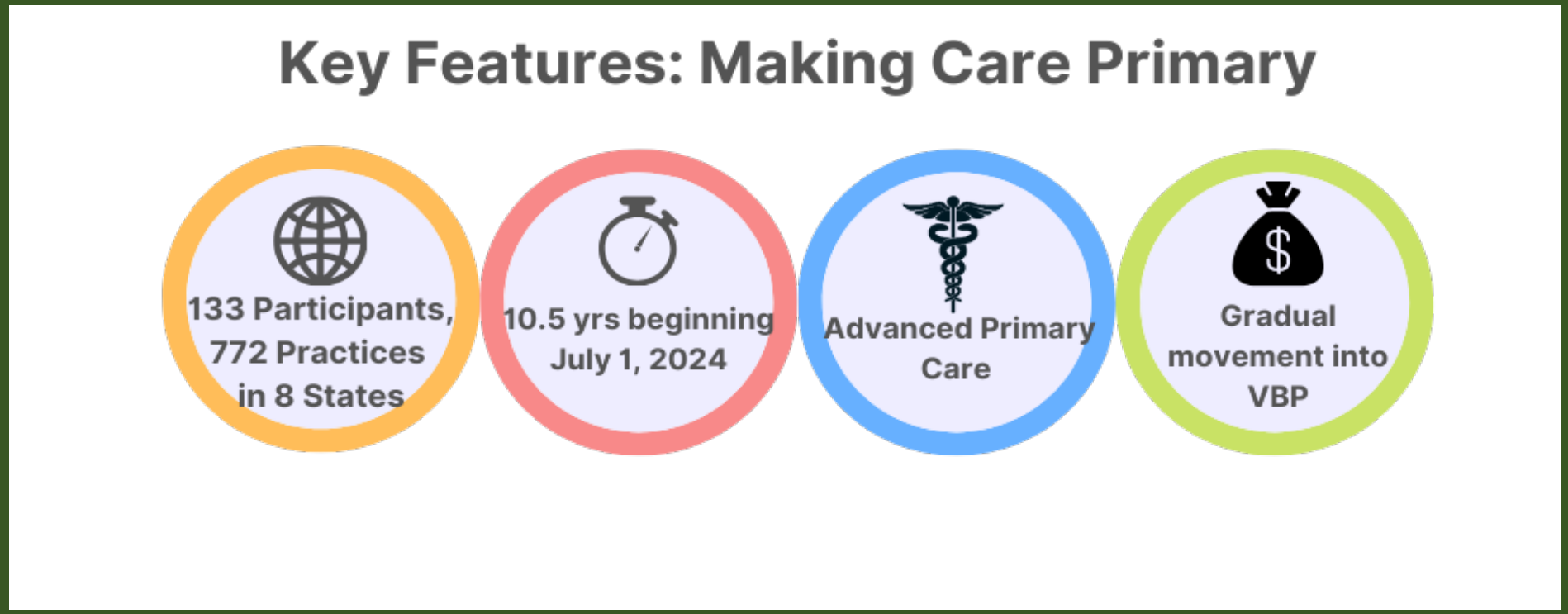
Features of Making Care Primary

- Responds to lessons learned in previous models
- MCP allows longer time for transformation and testing



ACO Primary Care Flex (2025)

- For the first time, focus on the group perceiving to be core of successful physician-based ACOs
- Recognizes bootstrapped ACOs need money to be data-driven
- Introduces capitated payments to a core of ACOs
- Multi-payer

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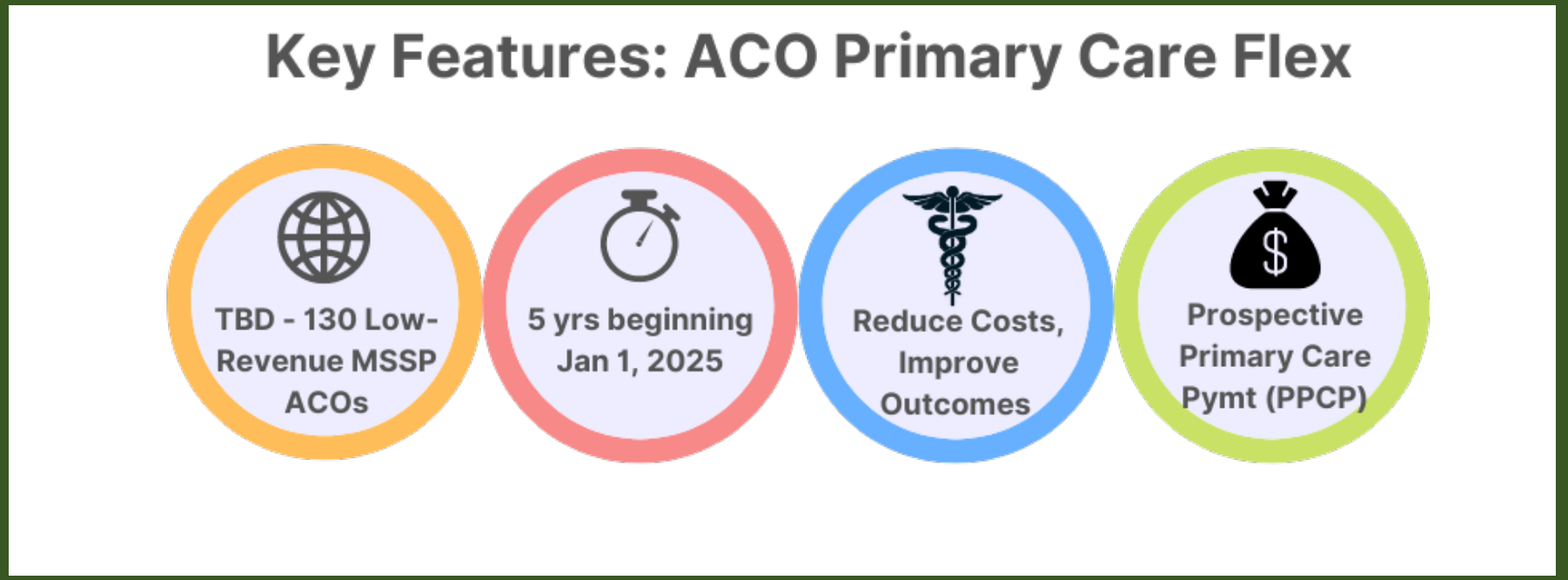
ACO Primary Care Flex

- Responds to risk-averse MSSPs
- One-time advanced Shared Savings Payment to participants
- Participants just announced January 1, 2025



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Vulnerabilities of Primary Care Models in a Cost-Focused Environment

- Timeline for results is very long
- More focused on transformation and less on $$
- In cost-focused environment, patience is limited for long term savings – they don't fund tax cuts next year, nor lower government spending

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Primary Care Models

In a cost-focused environment, what is tolerance level for long-term testing / results?

For payment models, in general?

"Can this dog hunt?"

Image by Charles Deluvio
On Unsplash

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Key Active Specialty Models

- Single-Specialty Focused Payment Models
  - Enhancing Oncology Care Model
  - Kidney Care Choices

- Bundled Payments for Care Improvements (BPCI)
- Cost Measures
- Transforming Episode Accountability Model (TEAM) (Announced 8/2024)

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Enhancing Oncology Care Model

NASA Image

Enhancing Oncology Care Model

- Goals:
  - Transform and improve care coordination in oncology care
  - Enhance the quality of care furnished to beneficiaries undergoing chemo
  - Reduce Total Cost of Care associated with treatment

- Transform: Patient care plan, communication, evidence-based care
- Enhance: Screen SDOH, coordinate patient needs
- Financial Structure for each 6-month episode
  - Financial and Performance Accountability for TCoC of chemo episodes
  - Performance Based Payment (PBP) or Recoupment (PBR) based on quality

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Enhancing Oncology Model (EOM)

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What's Important about EOM?

- Specialty focused episode-based payment model that focuses on coordination of patient needs beyond cancer treatment
- Practices get claims data, so allows building of clinical episodes beyond the 6 months for comparative analysis of costs
- Practices at financial risk with episode-based payment

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Kidney Care Choices

- Two structural options:
  - Nephrology practice
  - Multi-provider contracting entity
- Two key goals
  - Promote transplants
  - Reduce dialysis
- Capitation and population-based payments

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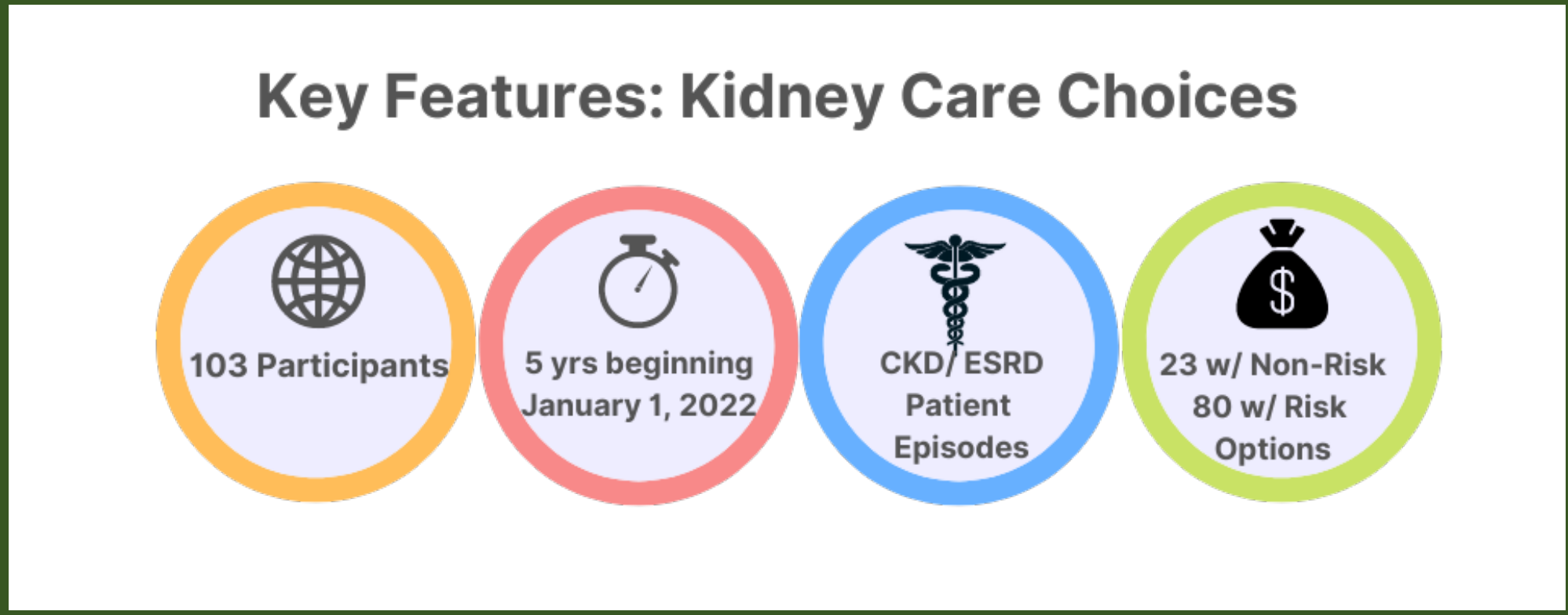
Kidney Care Choices Model (KCC)



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Kidney Care Choices Model

- Goals:
  - Delay onset of dialysis for patients in Chronic Kidney Disease Stage 4 and 5, and ESRD
  - Provide incentives for kidney transplantation

- Transform: Integrate care through Kidney Care Team including nephrologists, dialysis centers and others in patient care team
- Reduce patients with kidney failure, in dialysis centers, and increase transplants
- Financials Structure: 4 Options with graduated risk

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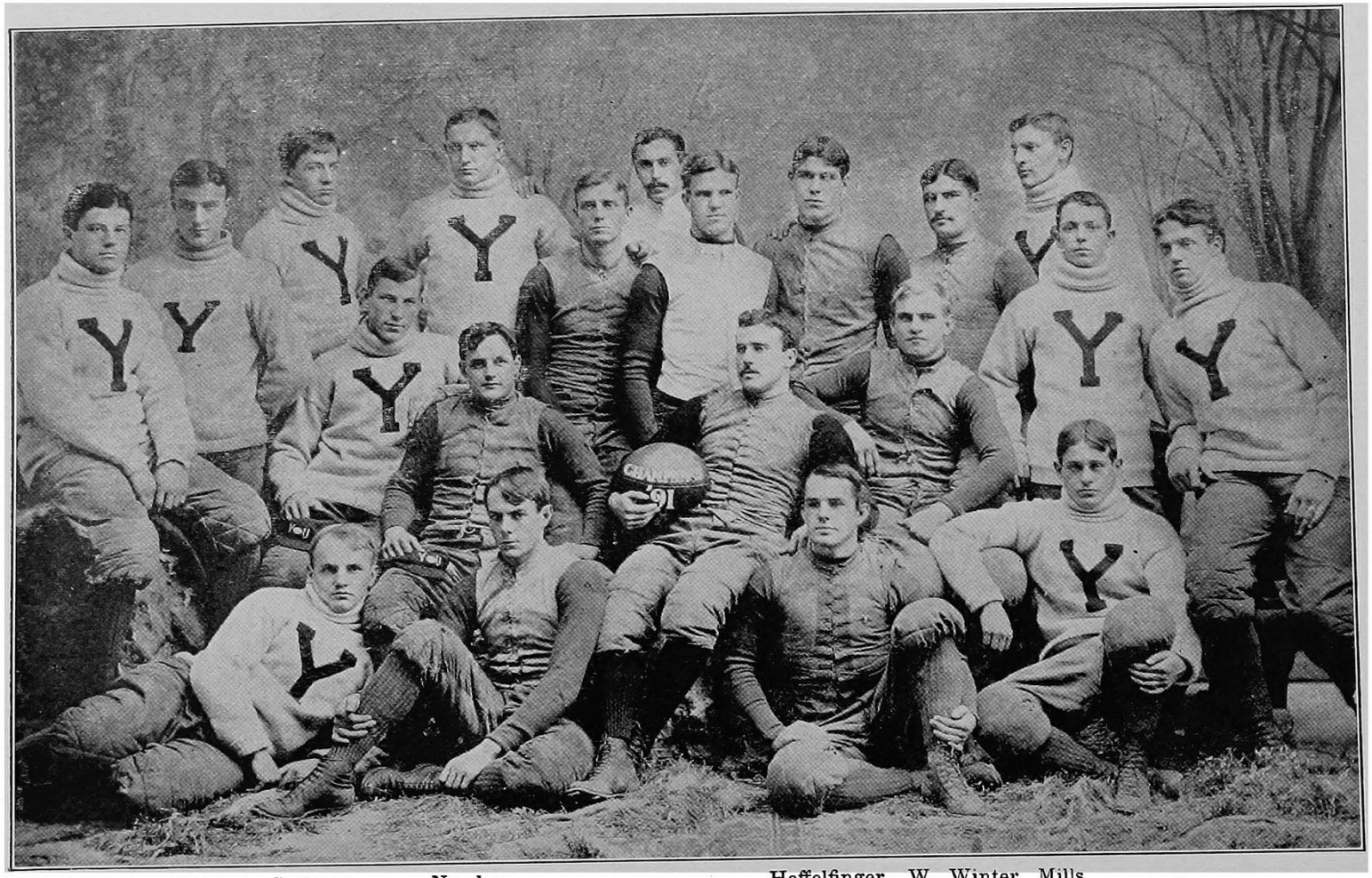
TEAM: First Mandatory Episodic Payments



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OLD YALE HEROES—LEE McCLUNG'S TEAM

Who's on the TEAM?

You are, and you don't need to try out.

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Transforming Episode Accountability (TEAM) Model

- 5-year Mandatory Model in selected CBSAs
- Hospitals in prospective payment must also participate
- Includes 3 risk tracks, one year glide path
- Track 1: Zero downside risk for 1 year, up to 3 years for safety net hospitals
- Track 2: Lower levels of risk for safety net and rural hospitals
- Track 3: Higher levels of risk

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Image by Clement Falize on Unsplash

What's New About TEAM?

- First episode-based mandatory specialty payment model
- Moves 5 procedure types to new model
  - Lower Extremity Joint Replacements
  - Spinal fusion
  - Surgical Hip Femur Fracture Treatment
  - Coronary Artery Bypass Graft
  - Major Bowel Procedure

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Key Sustainable Feature to Specialty Models: Cost Control

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Equip Your Organization for Cost Control

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5 Tools You Need. Yes, You Really Do.

- Agreement on Total Cost of Care and driving factors requires Trust in data.
- Physicians will feel threatened:
  - If the data is incomplete
  - If it pinpoints providers without feedback
- Solutions to cost of care will involve clinician and practice changes.

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Must Have #1: Aggregated Data from EHRs

- Why?
- Cost Control must go way beyond cost trimming, and address efficiencies behind Total Cost of Care and Per Patient Cost
- Elements of care and variations require clinical analysis and engagement of clinicians

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Must-Have #2: Claims Data

- Typically provided within a payment model
- Commercial insurers hesitant to provide this data
- Essential for creating the holistic view of patient costs and services

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Must-Have #3: Method of Revealing Cost Variation and Cost Drivers

- Clinical Episodes of Care for procedures and treatment – defined timeframes, inclusive of diagnostics and treatment
- Compare variations across clinicians, patients, regimens
- Must segue to review mechanism for physicians to respond

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Must-Have #4: Technology to Share Data, Get Feedback

- Physician review and change is essential to specialty case reviews
- For primary care, must orient to highest risk cases to address obstacles to patient progress, overutilization, and care-on-autopilot because of patient, SDOH, or other issues
- Primary-specialty collaborations will require evaluation of cases between the two

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Must-Have #5: Interventions

- Make it easy to perform referrals, queue patient for pop health or return visits, review medication plan

- Identify the levers of change for every inflection point in cost

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Must-Have #6: Stakeholder Involvement

- CFO must believe and validate savings potential
- Clinical Leadership cannot sit out the cost discussions, but understand the connection between orders/referrals and total costs
- Rank and file physicians must see cost data
- Support for clinicians to manage costs is essential – physician-oriented tools to optimize episodes

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Wrap-Up

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Value-Based Care is Pivoting to Cost

- ACOs and health systems are vulnerable to meat-ax cuts
- Acceptance of cost responsibility can ameliorate cuts through acceptance of risk-based payment models
- Time is limited to ramp up organizational capacity to handle cost control
- ACOs especially must facilitate changes in systems and practices among disparate practices

Questions and Answers

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