Best Value-Based Care Strategies for A Cost-Focused Future

Part 1: Strategically Manage Your VBC Payment Models

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VBCExhibitHall.com
Educational Webinar Series

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The health care landscape is changing

Image: Library of Congress

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Does Value-Based Care create the opportunity to rebuild a better Health Care System?

A. Yes. We're all in.

Image: Hiroko Yoshii on Unsplash

B. No. Not enough resources

Image: David Baker on Unsplash

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Health Care Providers Will Lose Resources

Image by Birger Strahl on Unsplash

- Research grants
- Reimbursement formula revenues
- Support for medical education
- Payments for uncompensated care
- Medicaid cuts?

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Cuts Aimed at Hospitals, Eligibility – But Will Affect Entire System

Providers

- Hospital staff
- Employed Physicians and Practices
- Residency slots
- Specialty physician researchers
- Support staff of providers
- Clinics, including FQHCs
- Rural and Urban

Patients

- Access to primary & specialty MDs
- Wait times
- Treatments available
- Clinical trial availability
- Cost share of care
- Vaccines
- Routine and preventive care

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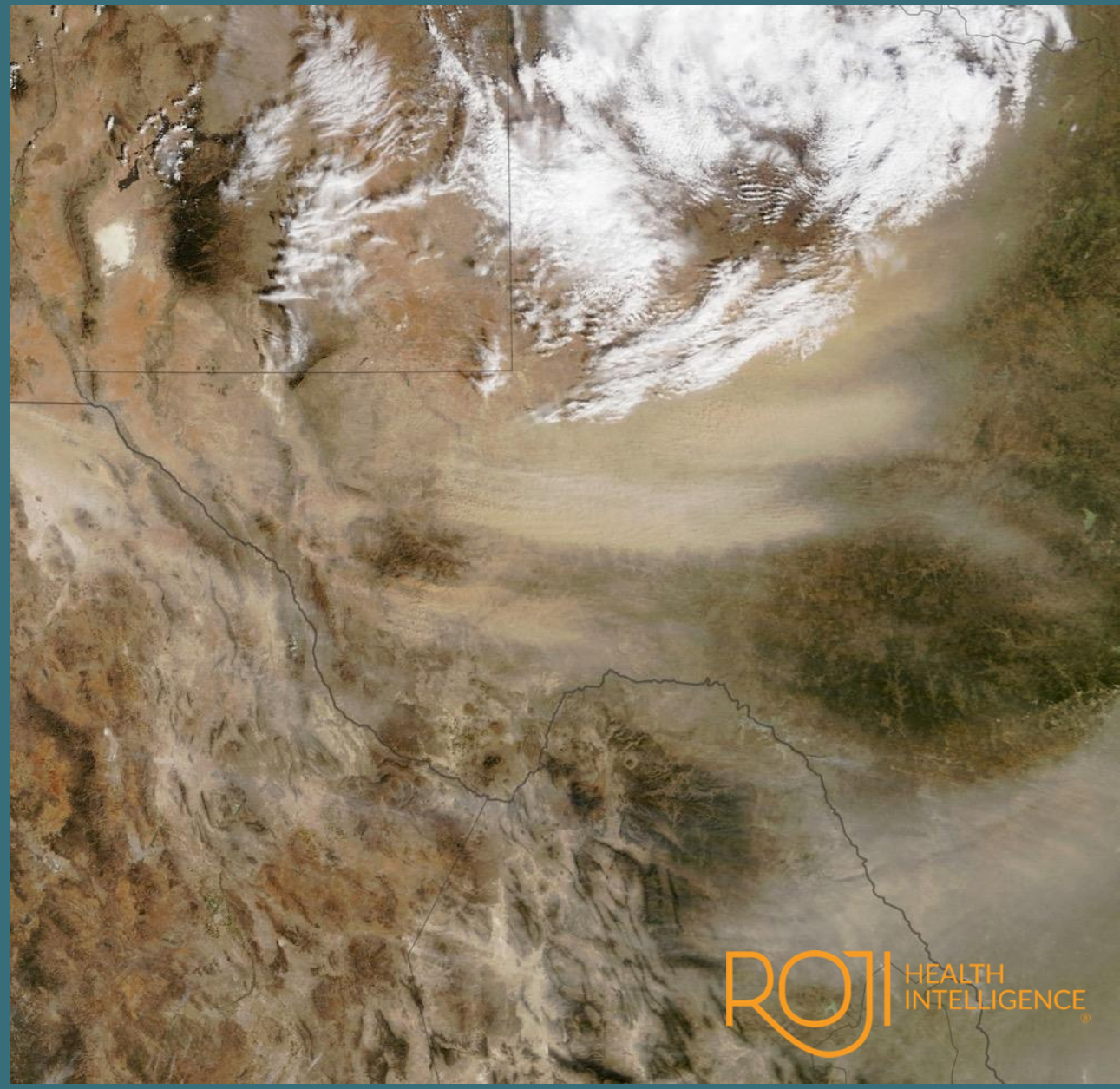
Medicare Advantage: The Future of Medicare?

What Government Gets:

- Fixed Cost through capitated payments
- Popular with beneficiaries
- Privatize the problems of Medicare
- Looks like smaller government



Can Value-Based Care Save Enough?

- One-time cuts won't fix it.
- Reductions in the Total Cost of Care can continue to drive savings.
- To generate TCoC reduction, need to improve patients at highest cost risk.

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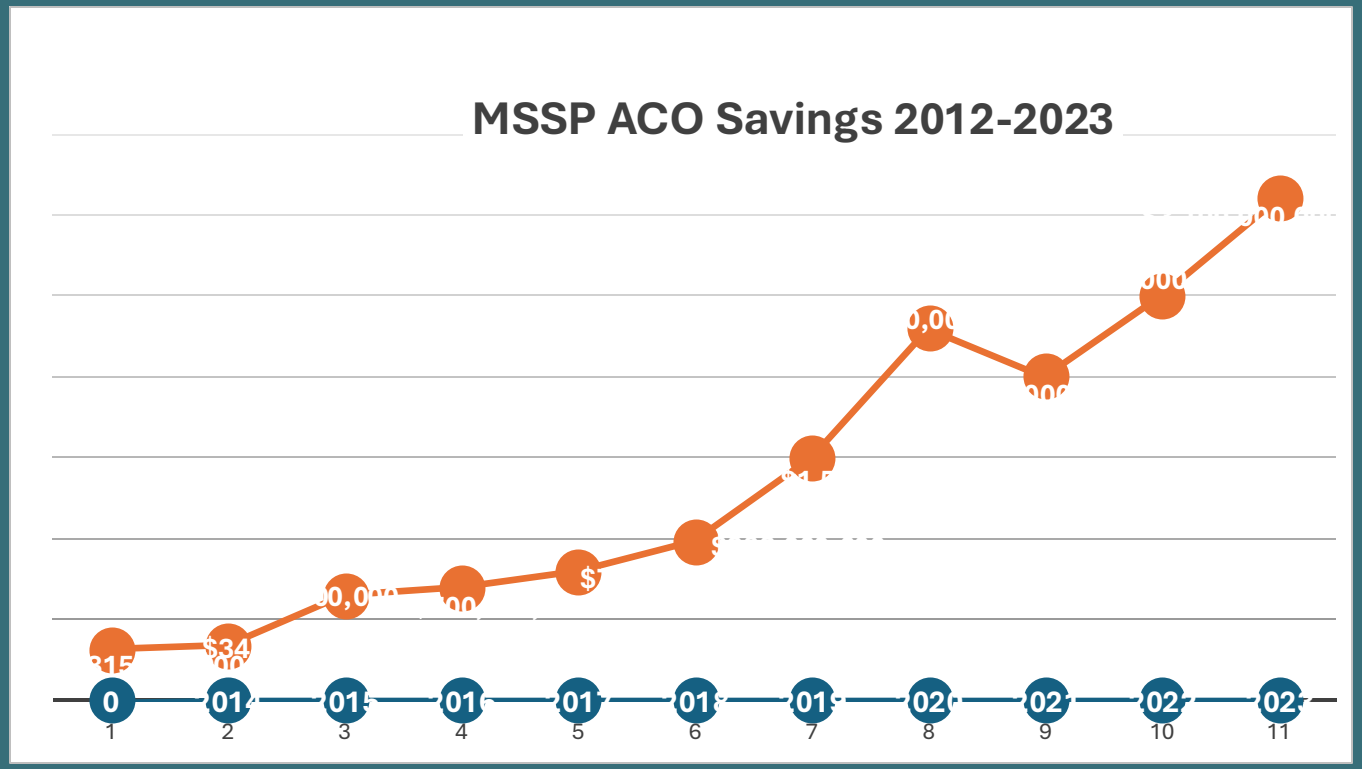
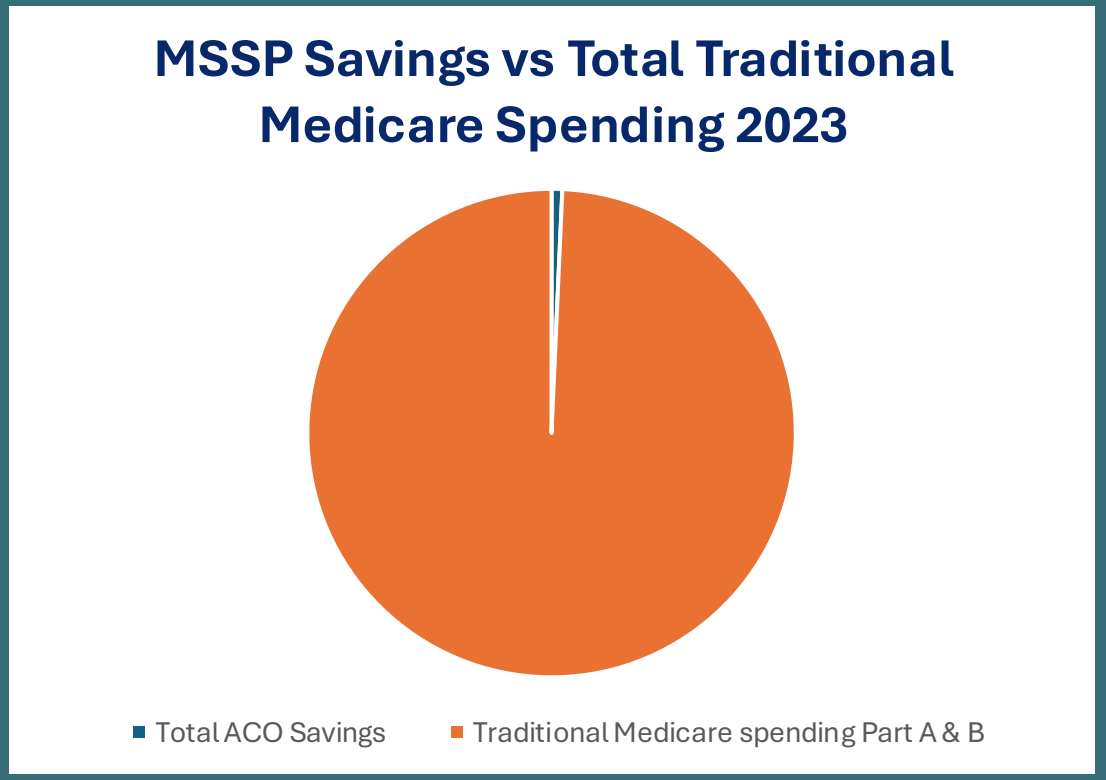
Problem: Our Largest VBC Program Has Not Generated Enough

ACO View: MSSP ACO Savings Have Progressed



Gov Budget View: Is it Enough?



Source: CMS Data

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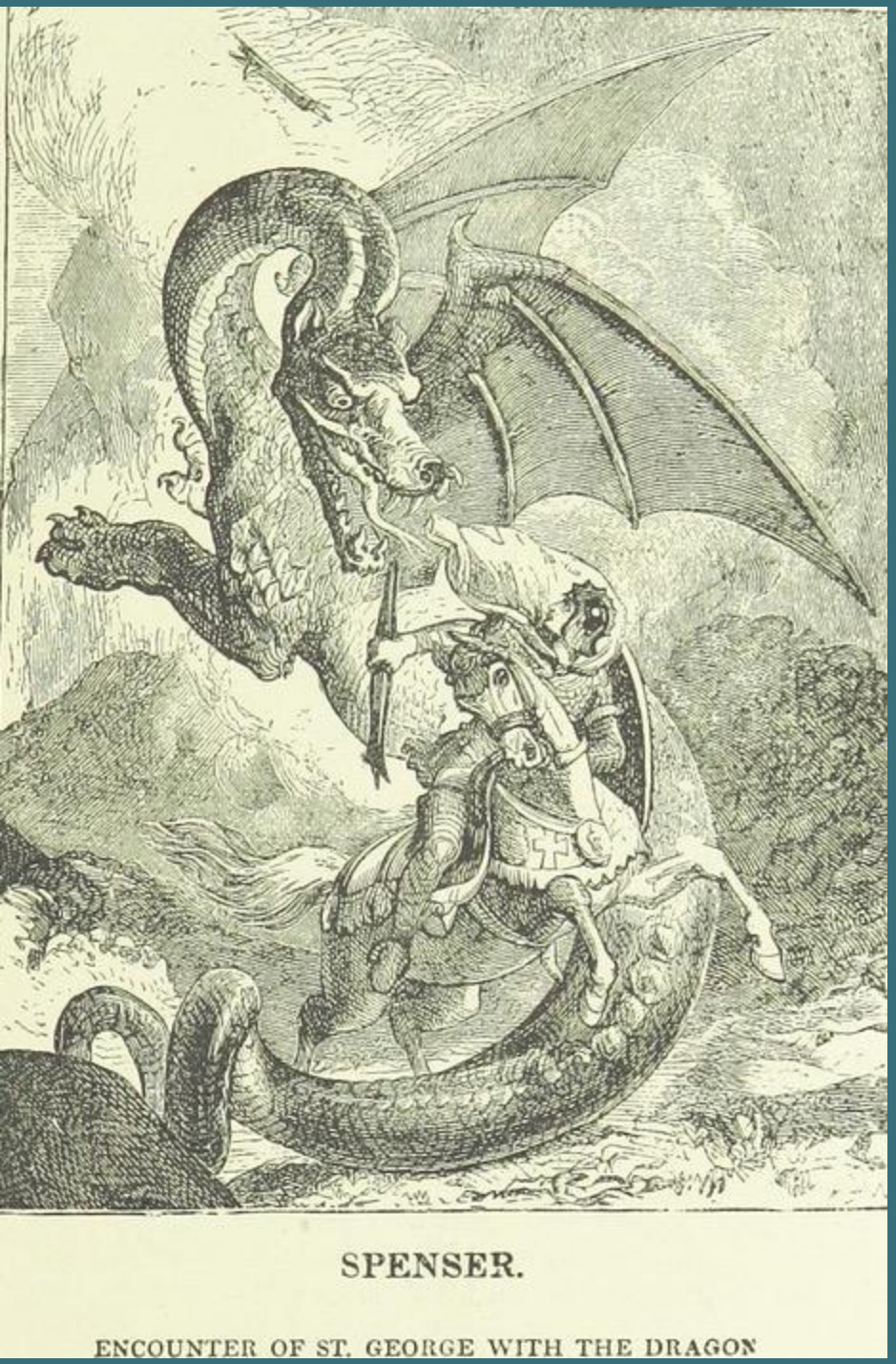

Imperative for Provider-led VBC Options to Stay:

Significant Win over Costs

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Value-Based Care Does Require Resources

Data aggregation	Analytics	Technology	Physician Communications
Improvement programs	Patient information, communication	Interventions	Community Development

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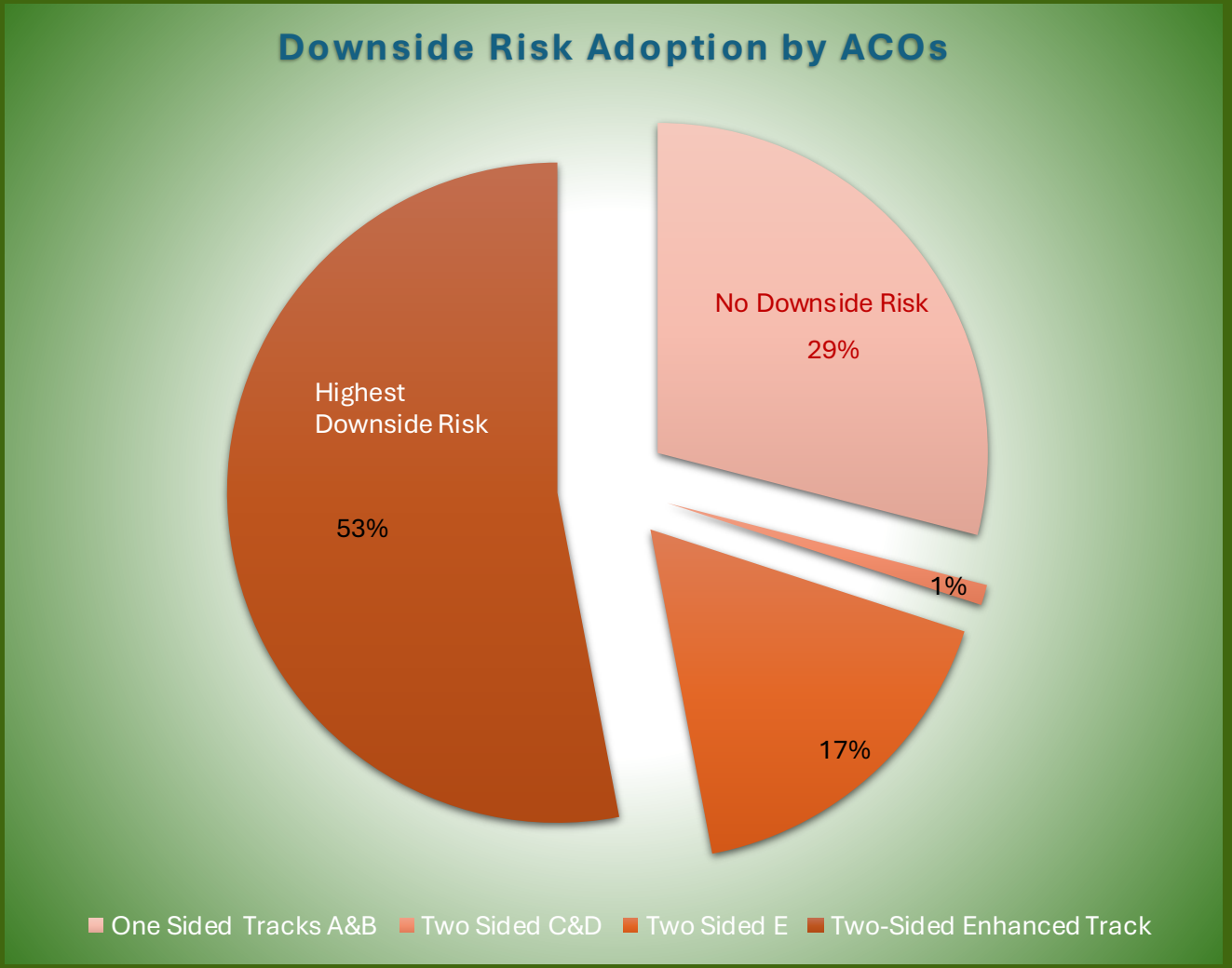
Primary Care Models Intended for Broad Impact

Image designed by freepik

Shared Savings ACOs (MSSPs)

- Biggest Model – 476 ACOs
- FFS, 50-75% shared savings
- 29% ACOs have 0 downside risk
- 71% have some downside risk
- Downside risk is capped at 8%-15%



MSSP ACO Savings Have Progressed

- 69% of MSSPs achieved savings
- Slow start; exponential growth
- Experience and selection bias generate savings
- One-time fixes could not produce continued savings

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ACO REACH

- Evolution of Global and Direct Contracting Models
- Capitation, either for primary care only, or total cost capitation
- Scores total costs, in addition to claims-based outcome-driven quality measures
- Voluntary, intended to increase new ACO formation
- Original pool is shrinking; no new applicants until the model concludes
- References to Realizing Equity, Access and Community Health (REACH) have been expunged—including the Health Equity Benchmark

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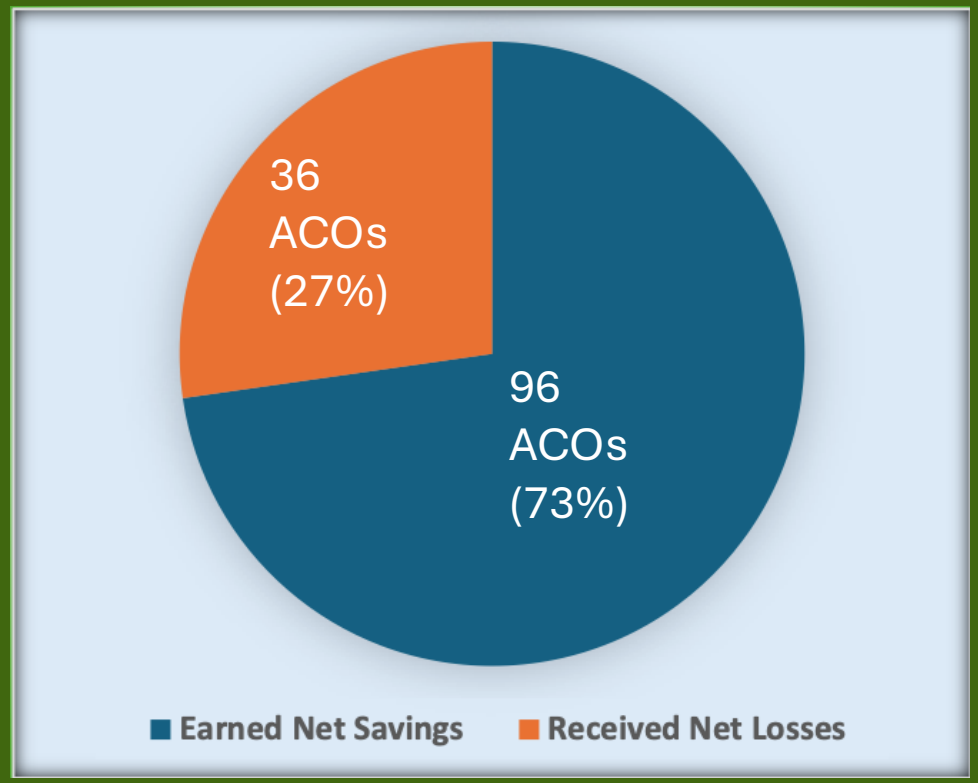
2023 ACO REACH Results

2023 ACO REACH Savings and Losses



Numbers at a Glance

- 2.6% net saving to CMS when compared to benchmark
- Higher rate of Global Risk ACOs earned Shared Savings
- PBPM gross savings increased 72% from 2022 levels
- Improved performance attributed to performance improvement and experience

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ACO PC Flex

5-year voluntary model test, occurring *within an existing, Low-Revenue* ACO

Prospective payment option for primary care and an advanced shared savings payment

Limit FFS payments, directly fund primary care to facilitate increased care coordination

Equity strategy including Rural Health Clinics and FQHCs and Incentivizes the creation of new ACOs in underserved communities

MSSP ACO quality reporting, cost and utilization metrics

Applicant pool is heavily comprised of ACO Enablers

Question: Will CMS continue to provide up-front investment?

- Early termination of the Making Care Primary program
- Anticipated HHS spending cuts

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Primary Care Payment Models: Common Structure with Unique Features

Similarities	Differences
Payment for advanced care management process	Population Focus
Financial Risk, either on the front or back end	Underlying payment structure (FFS or Capitation)
Arc towards capitated payments	Scope
Attempt to correct for under-resourced care	Inclusion of payers besides Medicare

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Specialty Care Models: Targeting Specific Outcomes

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BPCI Advanced

- Move responsibility for communication from patients to the BPCI participant
- Goals: Successful recovery, reduced readmissions and complications
- Measures: Total Cost of Care + Quality Measures within the window
- Buyer Beware! TCOC includes all costs in the episode window
- Different procedures bundled together – loses clinical integrity

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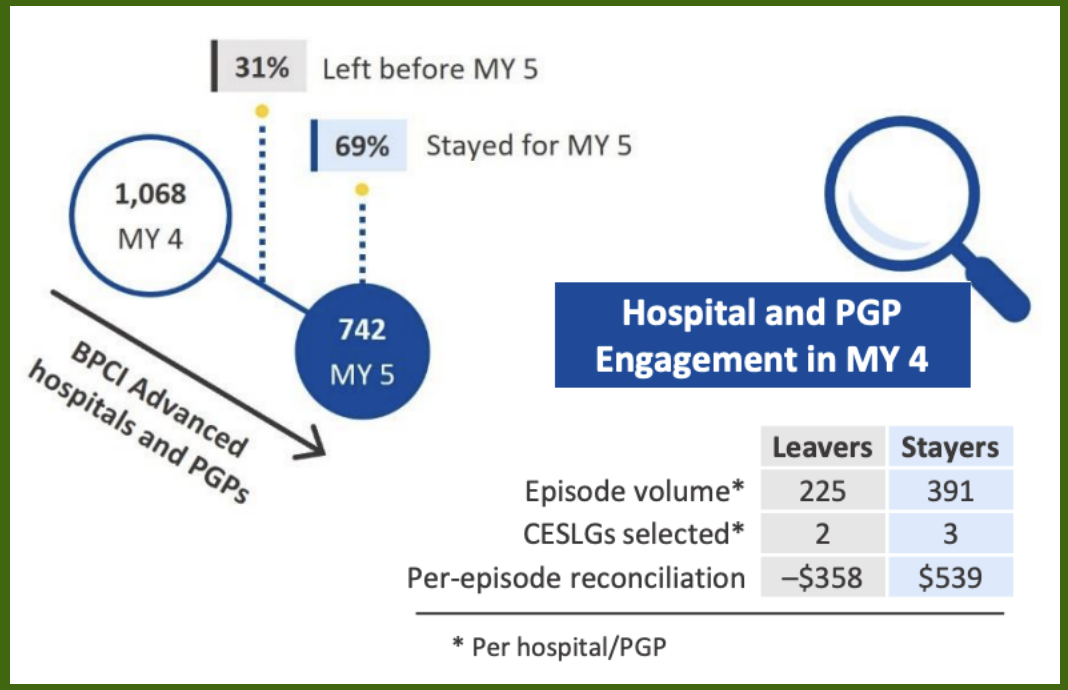
BPCI Advanced: Results and Trends

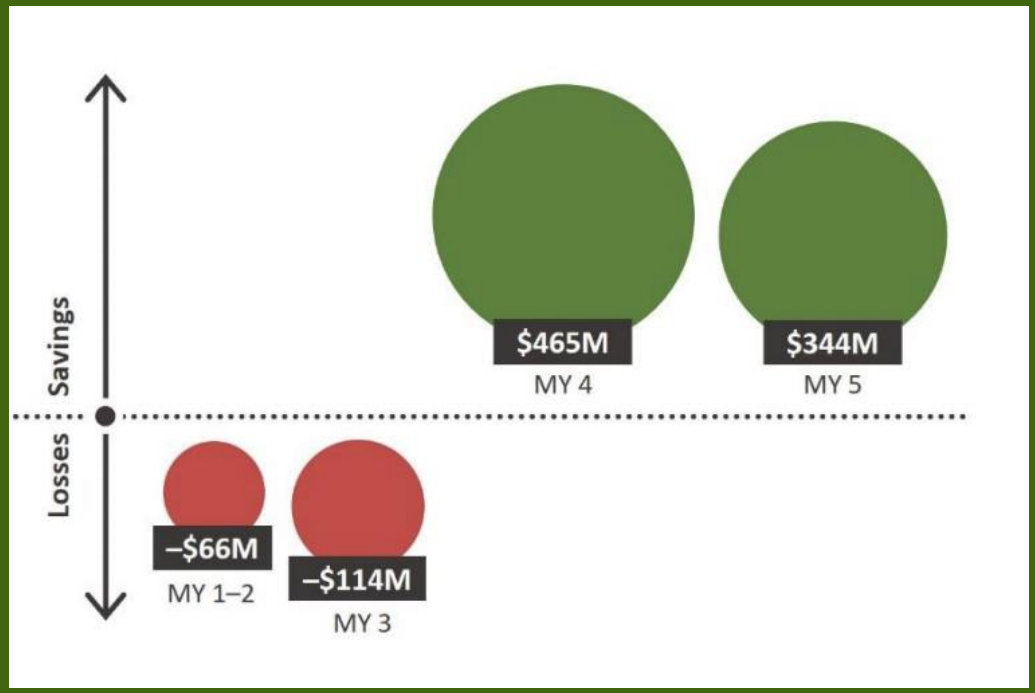
Improvement, but selection bias is inherent in voluntary models



	Leavers	Stayers
Episode volume*	225	391
CESLGs selected*	2	3
Per-episode reconciliation	–$358	$539

* Per hospital/PGP

Those who stayed generated savings compared to benchmarks



Source: https://www.cms.gov/priorities/innovation/data-and-reports/2025/bpci-adv-ar6-aag

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Enhancing Oncology Model

- Goals:
  - Improve coordination– decrease patient burden
  - Enhance the quality of care for patients in chemo
  - Focus on patients with comorbidities to ensure care continuity
  - Reduce Total Cost of Care associated with treatment

- Financial Structure for each 6-month episode
  - Financial and Performance Accountability for TCoC of chemo episodes
  - Performance Based Payment (PBP) or Recoupment (PBR)
  - 2 Commercial Payers are participating

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Image design by freepik

Transforming Episode Accountability Model

- For LEJR, Surgical Hip/Femur Treatment, Spinal Fusion, CABG, and Major Bowel Procedure:
  - Avoid ED and IP visits (or shorten stays)
  - Faster recoveries after procedures
  - Transition back to primary care
  - Create equitable health outcomes
- TEAM procedures dovetail with MIPS Cost Measures

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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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Pillars of Specialty Payment Models

- Cap total cost of care
- Change incentives away from volume and toward efficient / effective care
- Address highest cost clinical areas

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Benefits of Specialty Models

- For Specialists:
  - Predictable revenues
  - Market excellence to patients & health plans
- For Healthcare Networks / ACOs
  - Reduce cost variation and identify overruns
  - Tools for narrow network development
  - Negotiations with health plans
- Assumptions:
  - Clinical episodes to identify variation and cost drivers
  - Transparent data for collaboration

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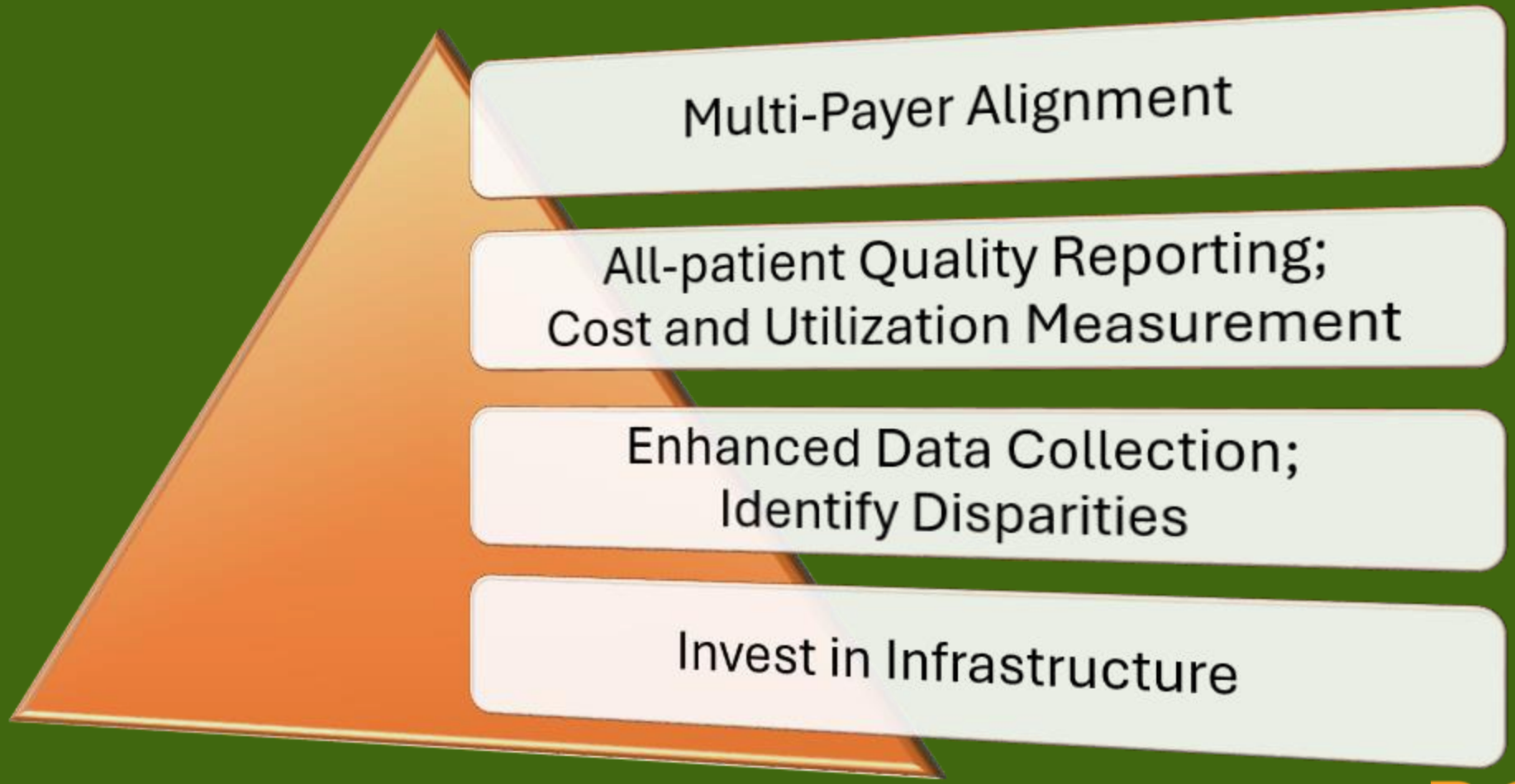
Pan-Program Features: Your “How To” Guide



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Original Medicare vs. Medicare Advantage

	Original/Traditional Medicare	Medicare Advantage
Coverage Area	Nationwide	Geographically limited (excluding emergencies)
Doctors and Hospitals	All who accept Medicare	Within network
Referrals to Specialists	No referral required	HMO plans typically require PCP referral
Prescription Drugs	Part D plan available for purchase	Nearly 9 out of 10 plans provide cost sharing (Medicare, AARP, KFF)
Supplemental Insurance Option	Medigap policy available for purchase	Not available
Out-Of-Pocket Limit	No (but Medigap policy may offset)	Yes

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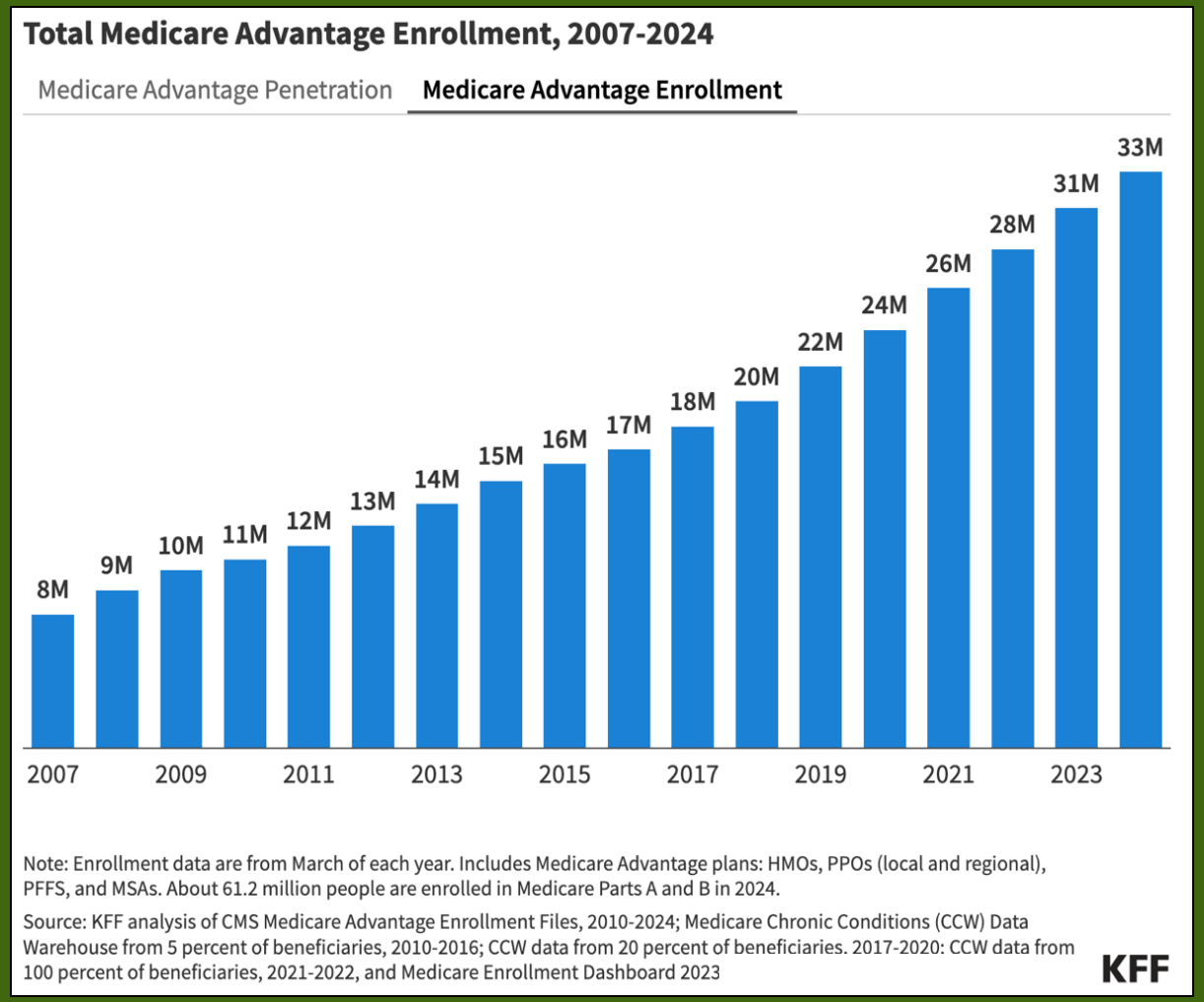
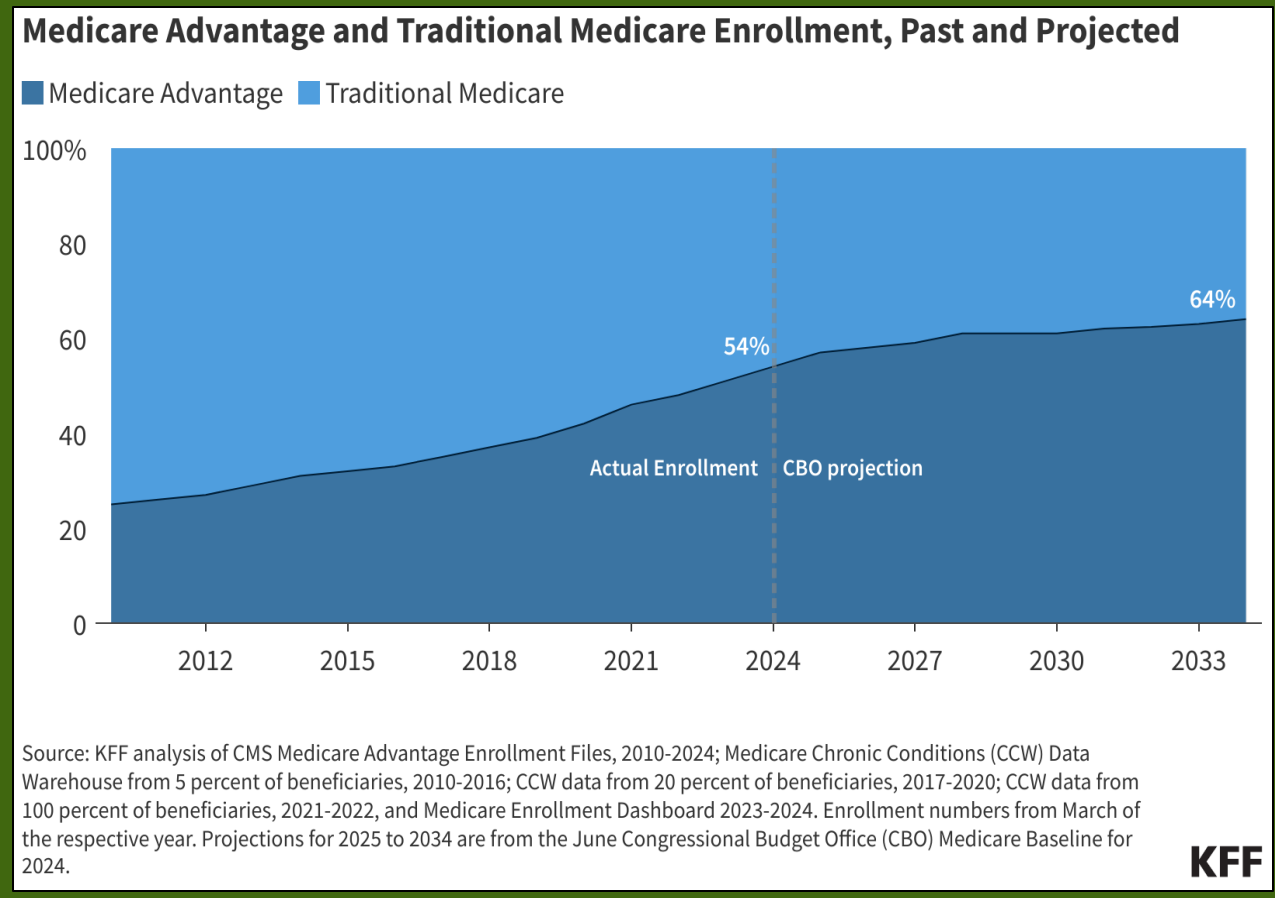
Medicare Advantage Enrollment Trend:

Steady increases in both volume and proportion of enrollment





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Elephant in the Room

- 2024 MA payments were 22% above traditional Medicare (MedPAC)
- Additional payments benefit the plans, not the patients. Why?
  - Capitation: A fixed per-patient payment regardless of services delivered
  - Creates a financial incentive to restrict care

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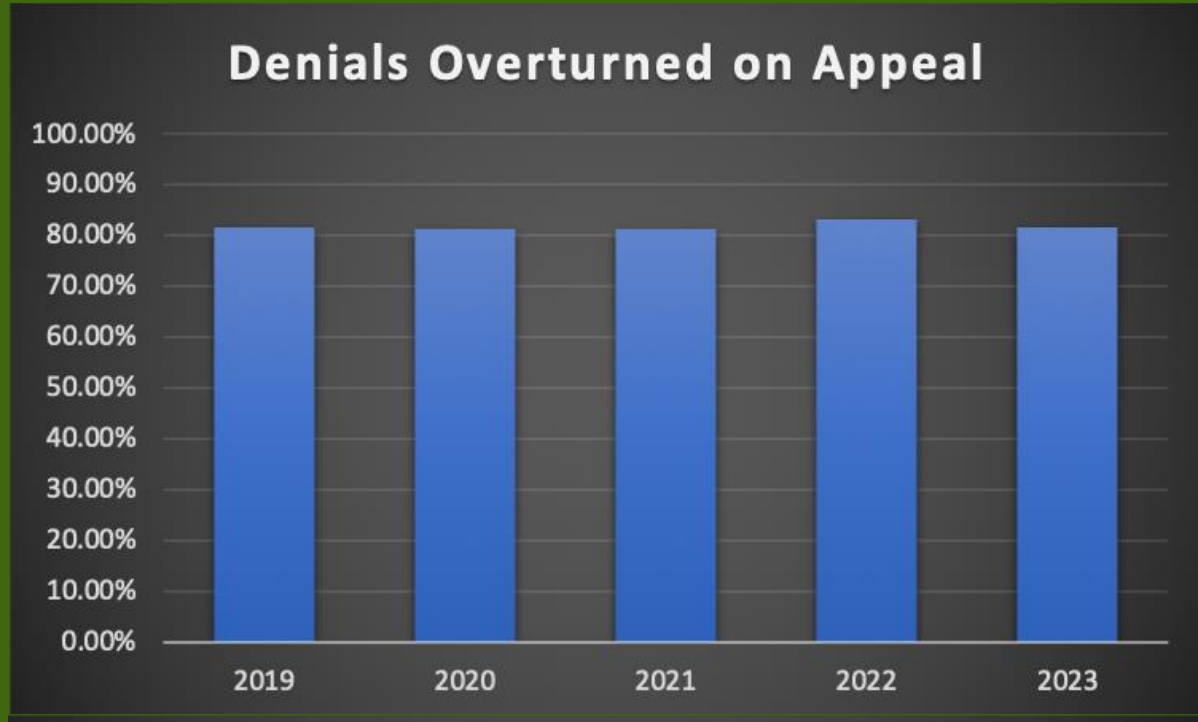
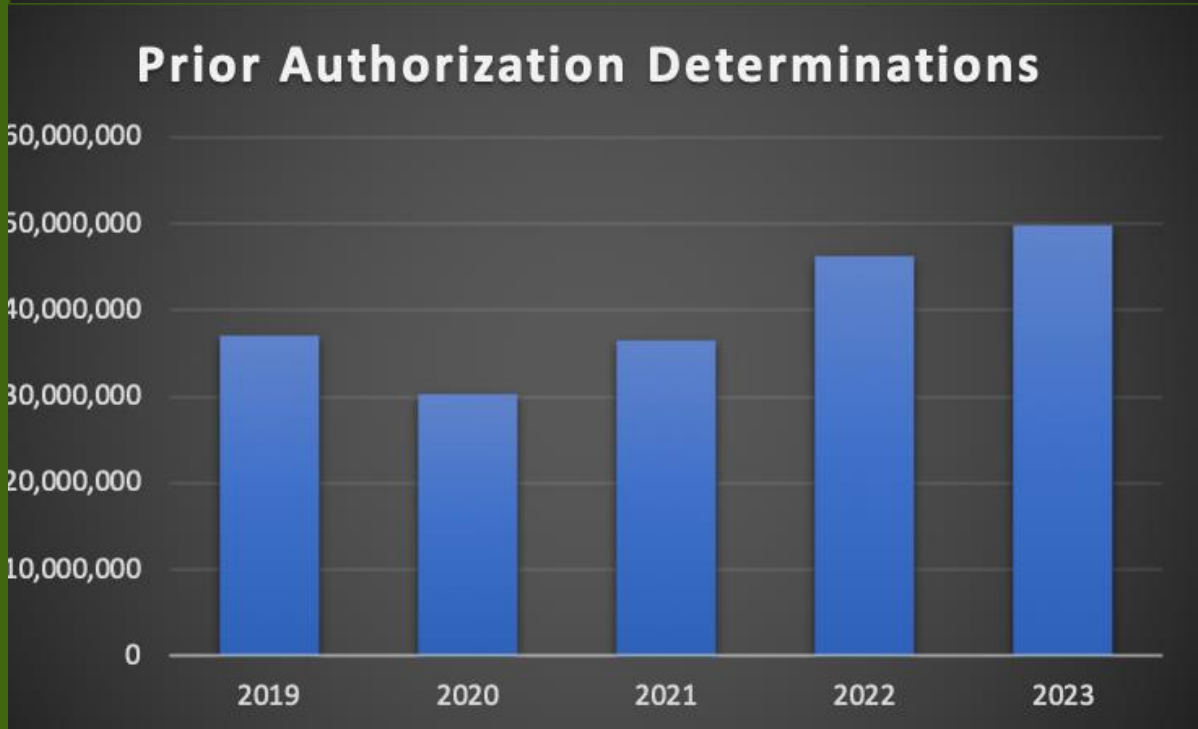
Image by Geranimo on Unsplash

Impact on Patient Care

- 3.2 m prior auth denials in 2023*; most appeals were successful – net result is delayed care
- Limited networks further restrict care, esp for complex patients, e.g. lower access to high-volume hospitals and higher post-surgical mortality rates+





*https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

+https://ascopubs.org/doi/full/10.1200/JCO.21.01359

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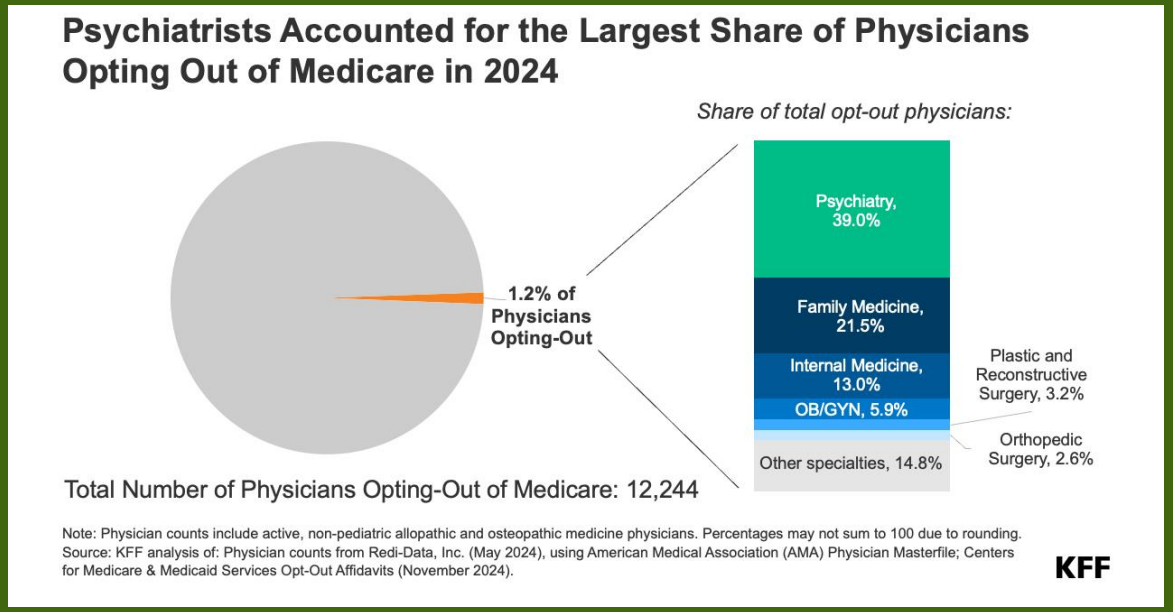
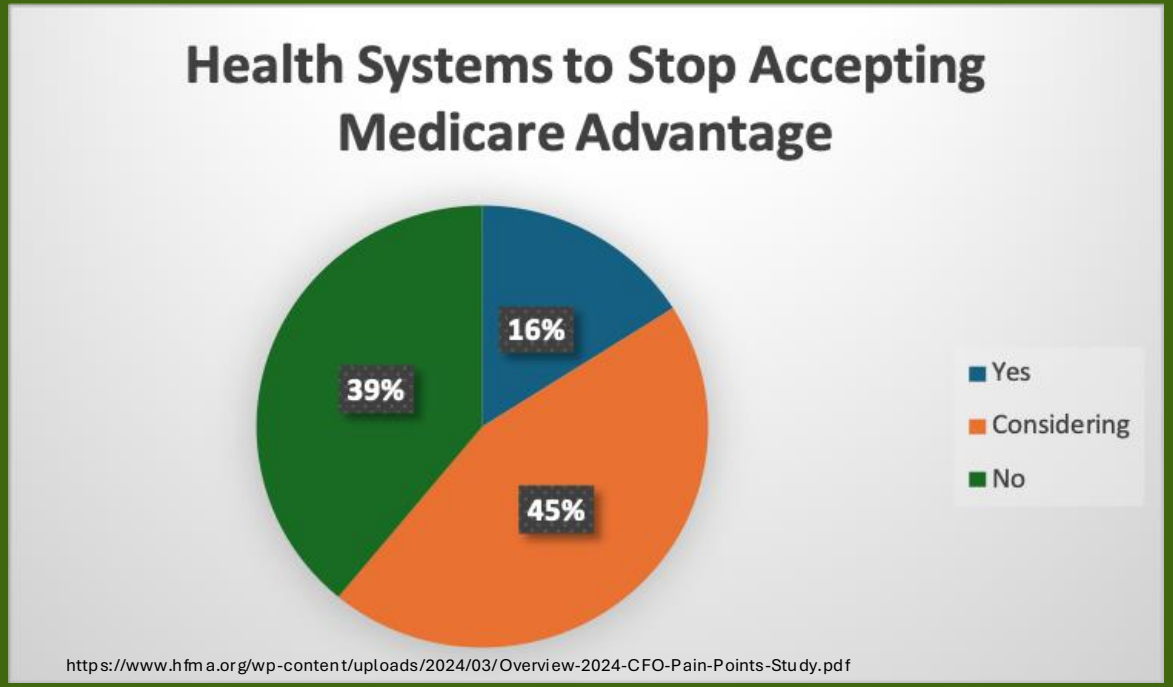
Impact on Providers

- Prior authorizations and denials choke revenue streams
- Some (1.2%) providers have opted out of Medicare
- Original Medicare payments do not keep up with inflation
- Higher MA reimbursements are offset by delays and denials





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Benefits to Federal Government Gain from MA

- Fixed Costs per person – easy to manage
- Fits into privatization strategy
- Decreases fed staffing needs
- Gets government out of claims adjudication
- Gets government out of insurance business

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Options for Your VBC Program

- PCP Models
  - ACO MSSP
  - ACO REACH ?
  - ACO PC FLEX ?
  - MA Plan
- Specialty Models
  - BPCI Advanced ?
  - EOM
  - TEAM
  - MA Plan

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Not All Models
Will Survive
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Models Voted “Most Likely” to Survive & Regenerate

- ACO MSSP - Proven model, likely to have payment features of ACO REACH
- Medicare Advantage – Fixed cost per patient
- Enhancing Oncology Care Model – specialty condition episodic payment
- TEAM – procedural episodic payment

Probable Future

- ACOs will continue but:
  - Risk required/dominate
  - Global / PCP Population-based pymt
- If ACO REACH saves money, will survive
- Specialists – Mandatory episodic payments
- Medicare Advantage growth
- Payment Models not all voluntary

Image by Nick Fewings on Unsplash

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Building Strategies for a Cost-Focused Future

1. Choose payment models likely to survive
2. Accept that more risk will be required - structure your network / ACO accordingly
3. Focus on your core strengths – primary or specialty
4. Organize tools needed to do well under risk

What You Need to Make VB Payments Effective at Cost Control: Providers

- Align internal incentives to cost control
- Aggregate sources of data to get the full picture: EHR, Cost, Claims
- Curate data and analytics to match payment models
  - Population-based payments: chronic disease episodes of care
  - Episodic payments: procedural and treatment episodes of care
- Build a pipeline of improvements and interventions for patients
- Share data with providers, involve them in solutions

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Major Ways to Pivot Organizationally to VBC

National Gallery, Rogier van der Weyden, 1432

- Align with VBC patient-centric approach with clinical teams, led by physician.
- Respond to patient-expressed needs, convenience and price transparency.
- Build the support for physicians to provide patient information, management programs
- Share data with physicians!

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Make VB Payments Effective at Cost Control
What Providers Must Ask of Payers

- Collaboration to experiment with cost control payment models
- Digital patient-identified claims data!!!
- Ability to choose, collaborate (and negotiate rates with specialists under global payments)
- Consistency of quality and cost measures across payers

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Reality: Revenues Will Shift from FFS Over Time

FFS, incl with incentives: 92%

Population-Based Pymts: <8%

Source: MGMA Practice Operations 2024, data from 2022

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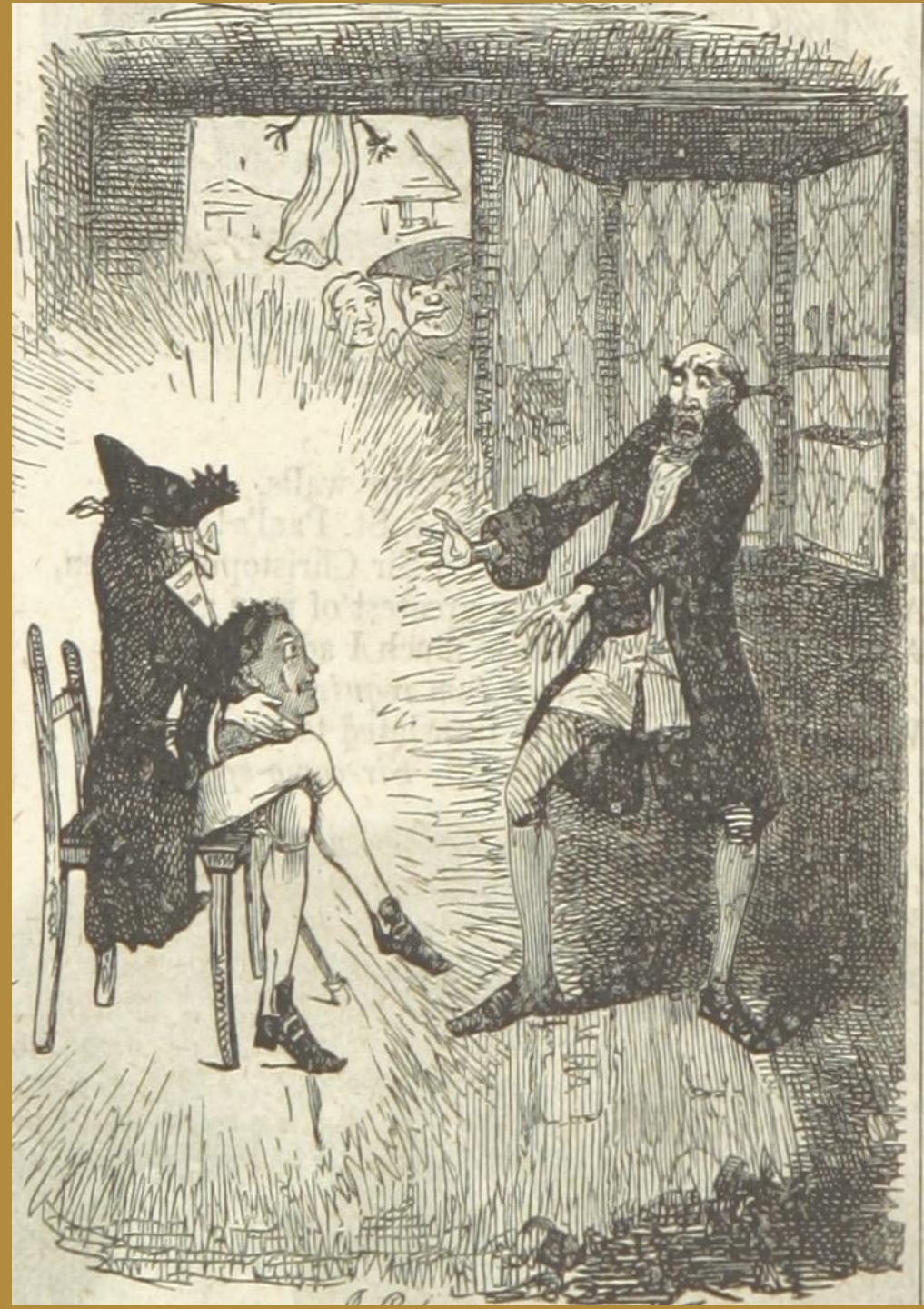
Providers: Don't Lose Your Head, Anticipate the Future

- Use data-driven strategies to achieve success under population-based & episodic payments
- Collaborate with specialists
- Involve clinicians in performance improvement
- Negotiate with payers based on ability to control costs (i.e. get claims data)



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Questions and Answers

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