# Is there Value in Value-Based Care?

*Or is Value-Based Care a side-hustle?*


**Don Calcagno**

SVP, Chief Population Health Officer | Advocate Health
President | Advocate Physician Partners


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# Population Health Platform

Managing Health, Quality, and Total Cost of 2.2M+ Lives and $1.6B in capitated risk

**13K+**
Participating Physicians

**12**
ACOs / CINs
*+4 Owned entities*

**2.3M**
Managed Lives

**2 of 7**
CMS ACO REACH Health System Participants in the Nation

**108**
Value-Based Contracts

**$656M**
Total CMS/CMMI Taxpayer Savings

**$1.4B**
Total Value Savings Paid Out

**73**
Participating Hospitals

Value-Based Care success built-on capabilities fine-tuned over decades of experience managing shared savings, shared risk, professional and global capitation across CMS, commercial and Medicaid contracts.

- Network Management
- Advanced Analytics
- Value Innovation
- Clinical Programs
- Data Management Infrastructure
- TPA/MSO

TPA/MSO: Third Party Administrator/Medical Service Organization

# Balancing Volume and Value

## *The Transition to Value Based Care*


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**“…things take longer to happen than you think they will, and then they happen faster than you thought they could.”**

~ Rudiger Dornbusch

# Behavioral Economics

## 10 behavioral economics principles are most applicable to physician and hospital incentives

| Principle | Description |
|---|---|
| Limitations of information | Information is necessary but is rarely sufficient to induce behavior change on its own |
| Choice overload | Too many options or too much complexity can induce paralysis |
| Limits of willpower | Requiring active decision-making is likely to be less effective than creating default pathways |
| Goal gradients | People try harder when they know what a goal is and that they are close to achieving it |
| Relative social ranking | People are influenced by their perception of how their performance compares with their peers |

| Principle | Description |
|---|---|
| Status quo bias | People tend to favor the status quo |
| Loss framing | People react more strongly when incentives are framed in terms of losses |
| Shared goals | Social pressure to achieve a shared goal can motivate individual performance |
| Immediacy | Incentives are stronger if given immediately |
| Mental accounting | Incentives are stronger if given distinctly and explicitly |

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# Health Care Value Chain


***Fragmented***

***Disrupters***

***Sub-Optimized***

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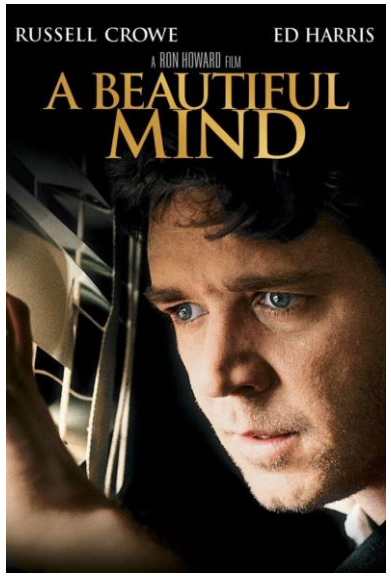
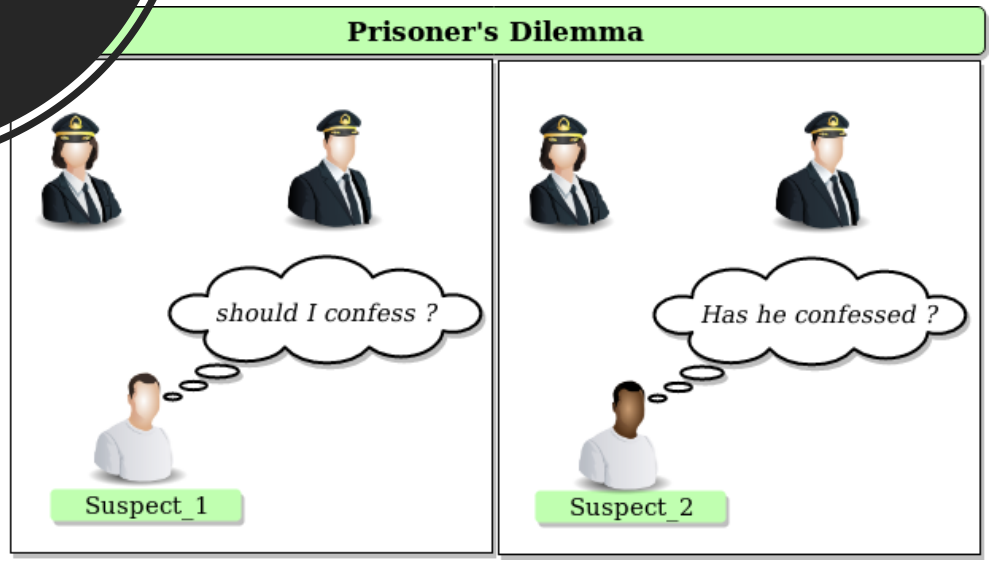
# Game Theory?




## Nash Equilibrium

**Dominant strategy:** where one did not care about the strategies of others in a given setting

**Nash Equilibrium strategy:** one could have better outcomes if strategy formulated while anticipating the behavior of others




1. Two prisoners are accused of a crime
2. Each prisoner is in solitary confinement with no means of speaking to the other
3. If only 1 confesses, they are released and the other receives 20 years in prison
4. If both confess each receives 5 years in jail
5. If both remain silent each receive 1 year in jail

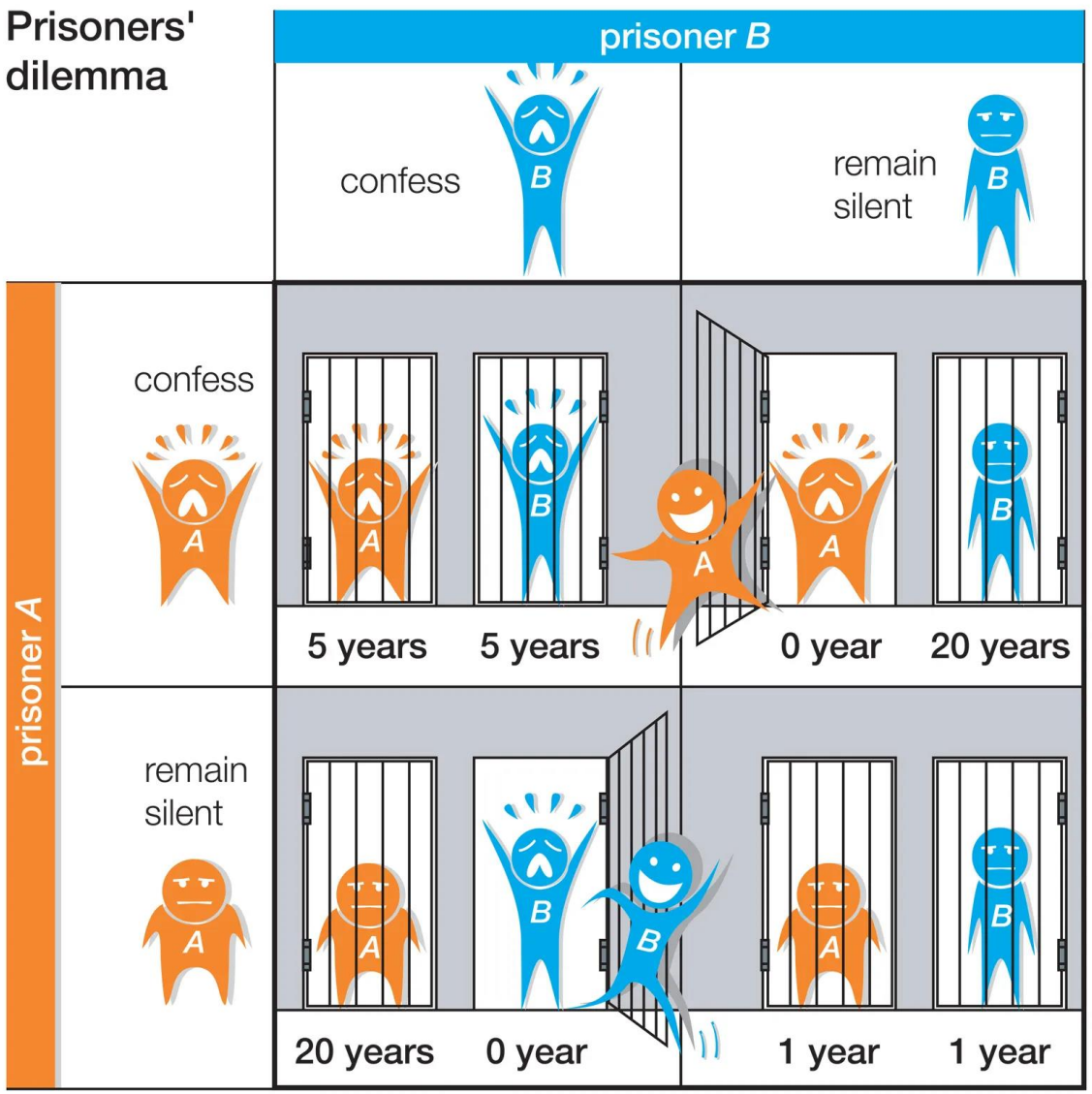
# Prisoners Dilemma

- They cannot communicate with one another

- If 1 confesses, the other gets 20 years
- If neither confesses, each will be held 1 year
- If both confess, they will each be jailed 5 years

- Given that neither prisoner knows whether the other has confessed, it is in the self-interest of each to confess himself.

**When each prisoner pursues his self-interest, both end up worse off than they would have been had they acted otherwise**



# What about financial risk?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# Aren’t you already at financial risk?

| | | |
|---|---|---|
| Capitation? | Down-side Risk? | DRGs? |
| Medicare or medical admits? | CMS Policy? | Cost Structure? |

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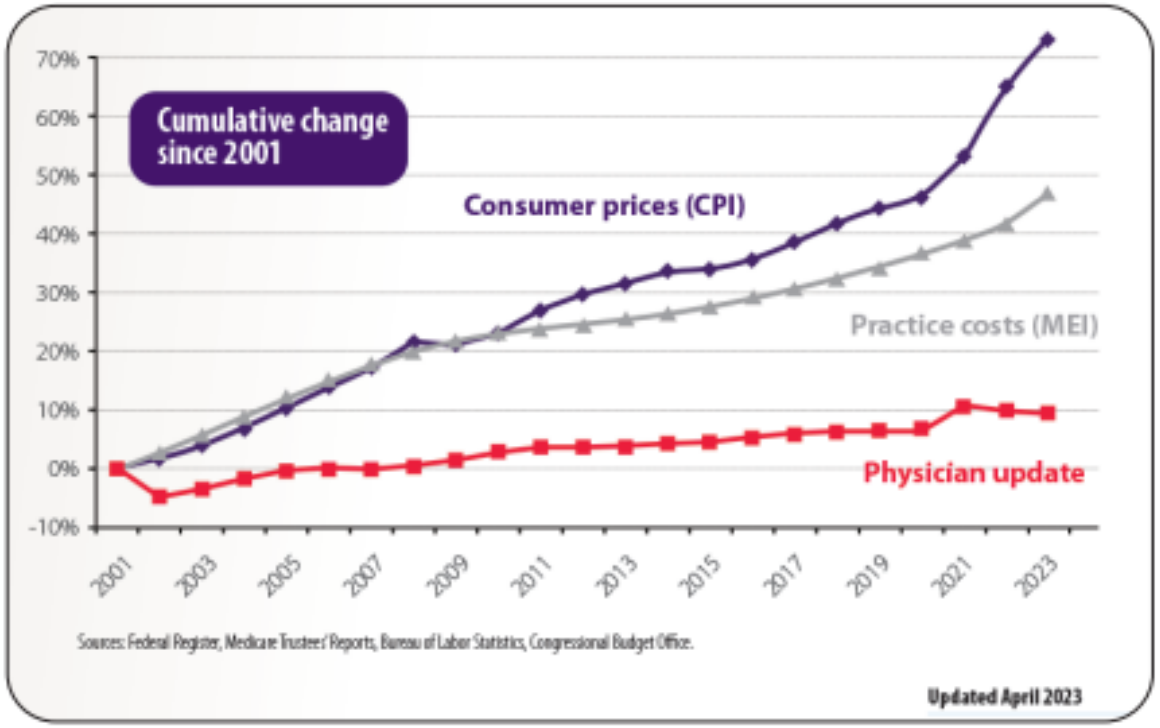
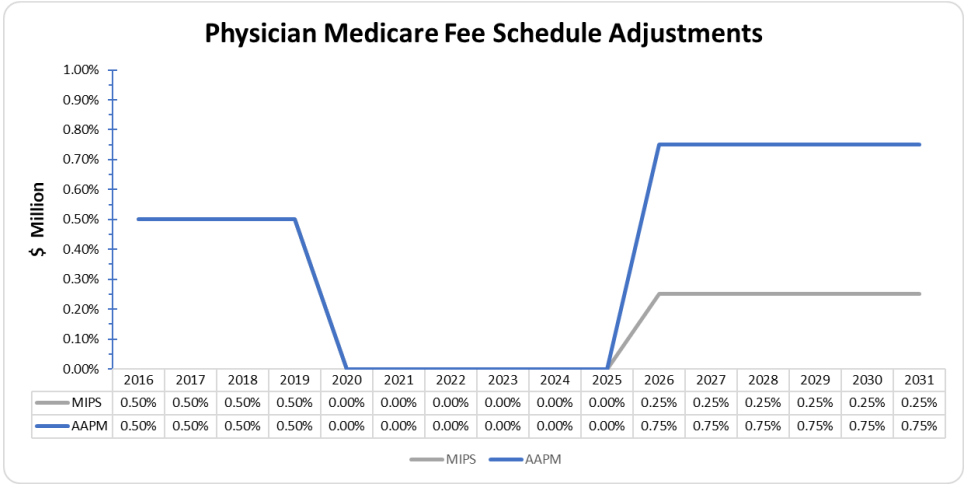
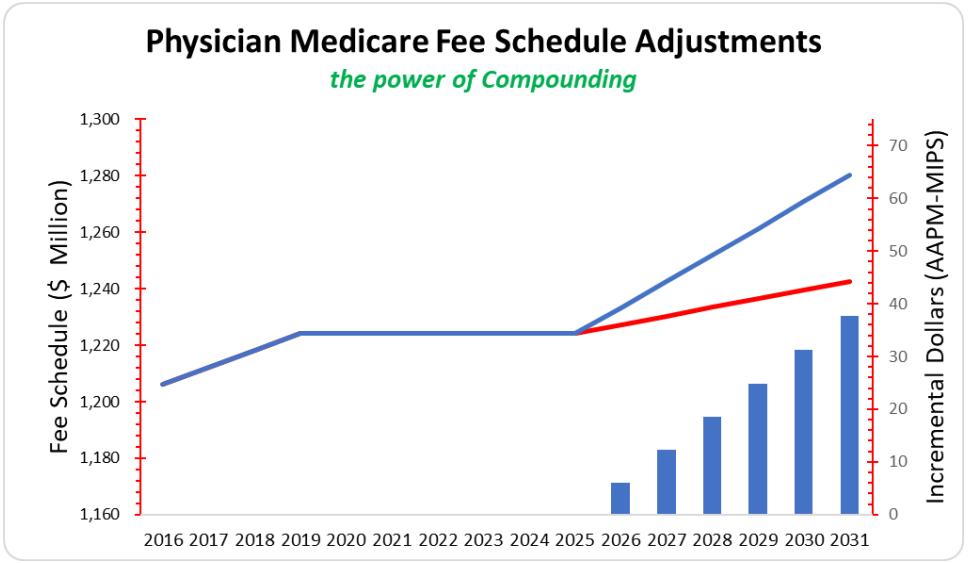
# Conversion Factor lags Inflation




| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MIPS | 0.50% | 0.50% | 0.50% | 0.50% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.25% | 0.25% | 0.25% | 0.25% | 0.25% | 0.25% |
| AAPM | 0.50% | 0.50% | 0.50% | 0.50% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.75% | 0.75% | 0.75% | 0.75% | 0.75% | 0.75% |

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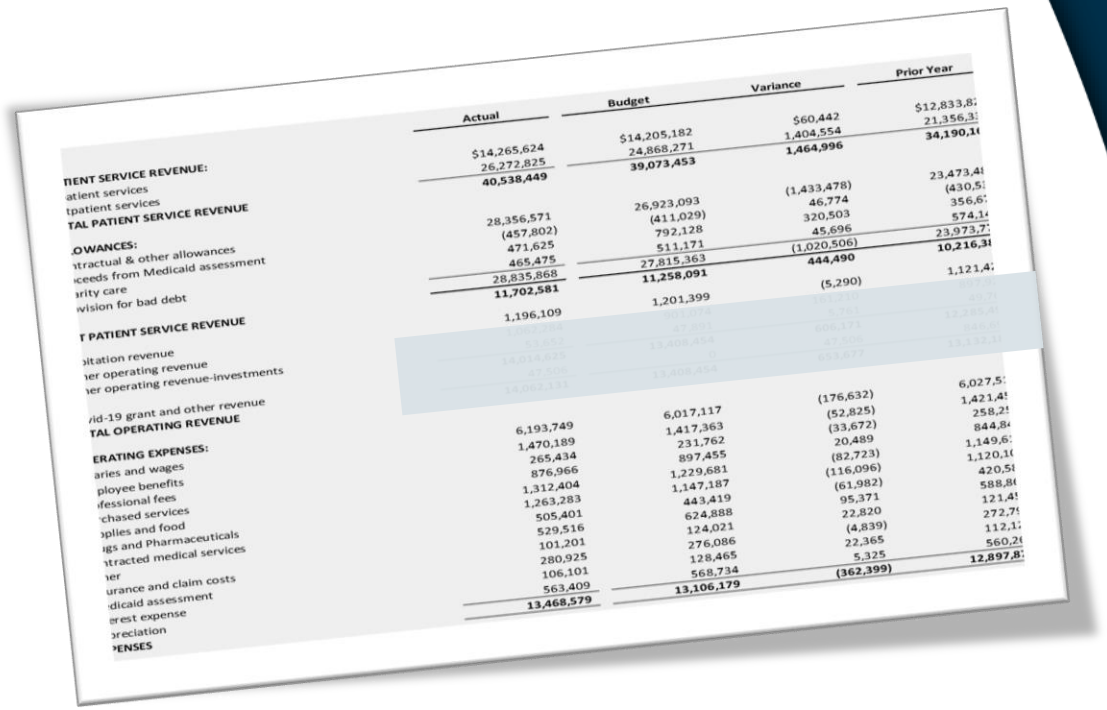
# Funds Flow

## How does shared savings, shared risk and capitation flow through the financials?

- ✓ Net patient service revenue (provider)
- ✓ Medical Expense (payor)
- ✓ Medical Benefit Expense (purchaser)
- ✓ Cost-share (patient)



| | Actual | Budget | Variance | Prior Year |
|---|---|---|---|---|
| TIENT SERVICE REVENUE: | | | | |
| atient services | $14,265,624 | $14,205,182 | $60,442 | $12,833,8 |
| tpatient services | 26,272,825 | 24,868,271 | 1,404,554 | 21,356,3 |
| TAL PATIENT SERVICE REVENUE | 40,538,449 | 39,073,453 | 1,464,996 | 34,190,1 |
| OWANCES: | | | | |
| ntractual & other allowances | 28,356,571 | 26,923,093 | (1,433,478) | 23,473,4 |
| ceeds from Medicaid assessment | (457,802) | (411,029) | 46,774 | (430,5 |
| arity care | 471,625 | 792,128 | 320,503 | 356,6 |
| vision for bad debt | 465,475 | 511,171 | 45,696 | 574,1 |
| | 28,835,868 | 27,815,363 | (1,020,506) | 23,973,7 |
| T PATIENT SERVICE REVENUE | 11,702,581 | 11,258,091 | 444,490 | 10,216,3 |
| pitation revenue | 1,196,109 | 1,201,399 | (5,290) | 1,121,4 |
| her operating revenue | | | | |
| her operating revenue-investments | | | | |
| vid-19 grant and other revenue | | | | |
| TAL OPERATING REVENUE | | 6,017,117 | (176,632) | 6,027,5 |
| ERATING EXPENSES: | 6,193,749 | 1,417,363 | (52,825) | 1,421,4 |
| aries and wages | 1,470,189 | 231,762 | (33,672) | 258,2 |
| ployee benefits | 265,434 | 897,455 | 20,489 | 844,8 |
| fessional fees | 876,966 | 1,229,681 | (82,723) | 1,149,6 |
| chased services | 1,312,404 | 1,147,187 | (116,096) | 1,120,1 |
| plies and food | 1,263,283 | 443,419 | (61,982) | 420,5 |
| gs and Pharmaceuticals | 505,401 | 624,888 | 95,371 | 588,8 |
| tracted medical services | 529,516 | 124,021 | 22,820 | 121,4 |
| her | 101,201 | 276,086 | (4,839) | 272,7 |
| urance and claim costs | 280,925 | 128,465 | 22,365 | 112,1 |
| dicaid assessment | 106,101 | 568,734 | 5,325 | 560,2 |
| erest expense | 563,409 | 13,106,179 | (362,399) | 12,897,8 |
| preciation | 13,468,579 | | | |
| PENSES | | | | |

**Depends on your vantage point**

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# Consolidated Financial Statements

Receive capitation funds (1)

Pay yourself (2)


Revenue & Expenses eliminate (3)

**RBE** = Risk Bearing Entity

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# Can you manage risk?

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# Population Health Capabilities

## Population Health Services

### Network Management

- Contract Consulting & Negotiation
- Contract Management
- Field Operations
- Governance
- Network Steerage
- Network Curation
- Physician Engagement
- Risk-based Capital Reserves & Strategy

### Clinical Programs

- Integrated Care Management & Navigation
  - Social Determinant Screening & Resolution
  - Care Transitions Program
  - Chronic Care Management
  - Disease Management
- Quality Improvement
- High Cost Claimant Assessment
- Condition Management & Documentation
- Palliative & Advance Care Planning
- Pharmacy Programs
- Integrated Behavioral health
- Continuing Post-acute care
- Clinical Transformation/Care Model Design
- Care Team Enablement (Actionable Data)

### Value Innovation

- Deploy and test VBC innovation initiatives at scale across enterprise/diverse populations (equity) and geographies (rural vs. urban)
- Place emphasis on ensuring the aLHS and real world applicability/operations to new models of care, risk prediction and episodes of care to inform VBC operations, policy and payment.

### Infrastructure

- Sophisticated Interfaces to Ingest Payer, Employer, HIE Data
- Web-based Provider Tools
- Data Extracts & Mapping Multi-Systems
- Data Warehouse
- Licensed, Trained Staff Source
- Legal, Regulatory & Compliance Expertise
- Plug/Play API's for System-to-System Ease of Use
- Systematic Support for EMR Integration
- E-commerce

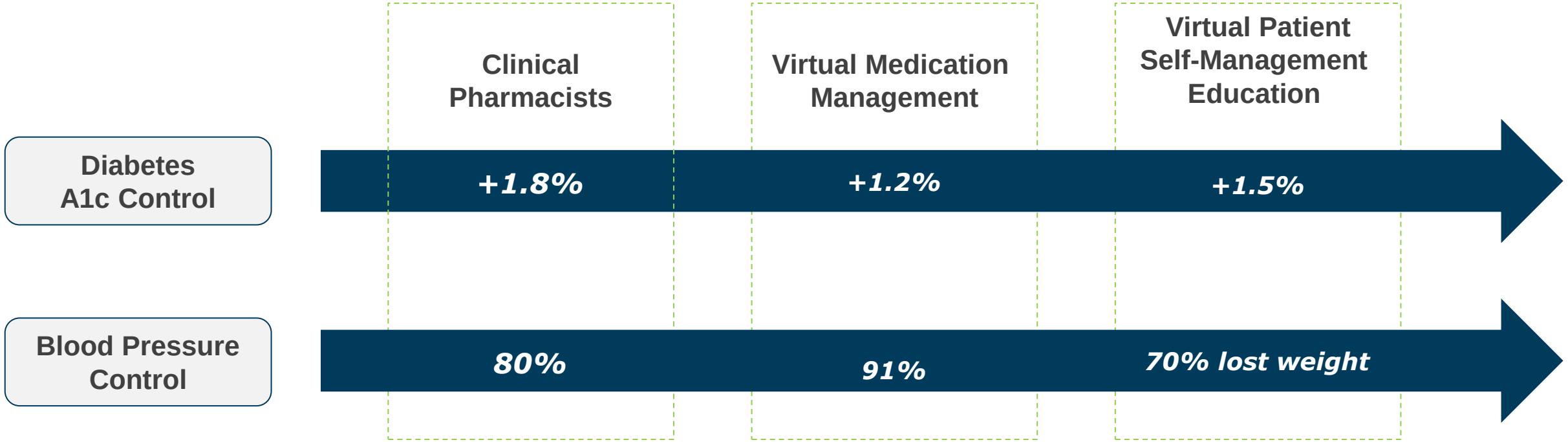
### Analytics

- Gap Analysis
- Business Intelligence, Data Science & Analytics
- Performance Program Management
- Predictive/prescriptive analytics
- Scorecard/ feedback loop
- Risk Stratification

### TPA/MSO

- Enrollment, Attribution, Benefits
- Credentialing
- Claims Administration
- Referrals Management
- Utilization Management
- Financial Reporting & Solutioning
- Member-Provider Resolution Call Center
- Government Program Management

# Point Solutions vs Care Platform

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# Center for Medicaid and Medicare Services Innovation (CMMI)

## Strategic or side-hustle?

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# Opportunity to be strategic - Advocate

- Medicare Shared Savings Program (MSSP)
- Bundled Payments for Care Improvement- Advanced (BPCIA)
- Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH)

- Proof of Concept?
- Capability development?
- Economic reward - budgeted?
- Care Model Transformation?
- Prepare for CMS Health Equity?
- Create Centers of Excellence (COE)?

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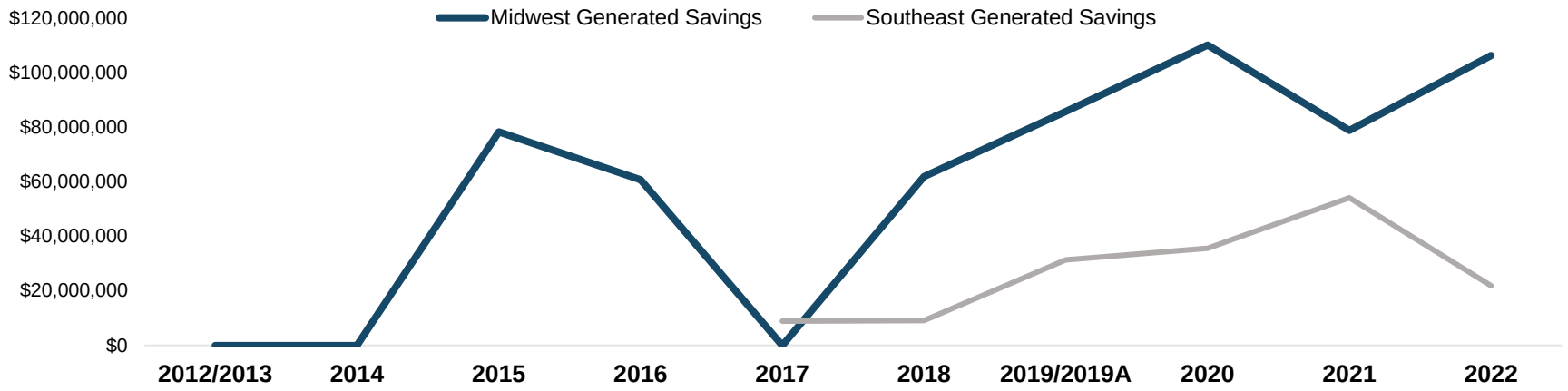
# MSSP Accountable Care

## Financial Results




| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Midwest Generated** | $0 | $0 | $78.2M | $60.7M | $0 | $61.9M | $85.7M | $110.0M | $78.8M | $106.3M |
| ***Quality Score*** | 100.0 % | 90.9% | 94.2% | 97.3% | 86.5% | 91.0% | 96.9% | 97.8% | 92.8% | 82.2% |
| **Southeast Generated** | $0 | $0 | $0 | $0 | $8.9M | $9.1M | $31.4M | $35.6M | $54.1M | $21.9M |
| ***Quality Score*** | - | - | - | 100.0% | 96.6% | 99.0% | 95.9% | 97.6% | 95.6% | 83.0% |

- Nine MSSP and Next Gen ACOs have generated **$761.5M** since 2012
- ACOs have achieved an **89.8% quality score** overall

**Top 2 Lessons Learned:**
- Benchmark years are critical to success
- Network management is key

**Top 2 Success Factors:**
- MWV to close care gaps and capture chronic conditions
- Chronic condition management

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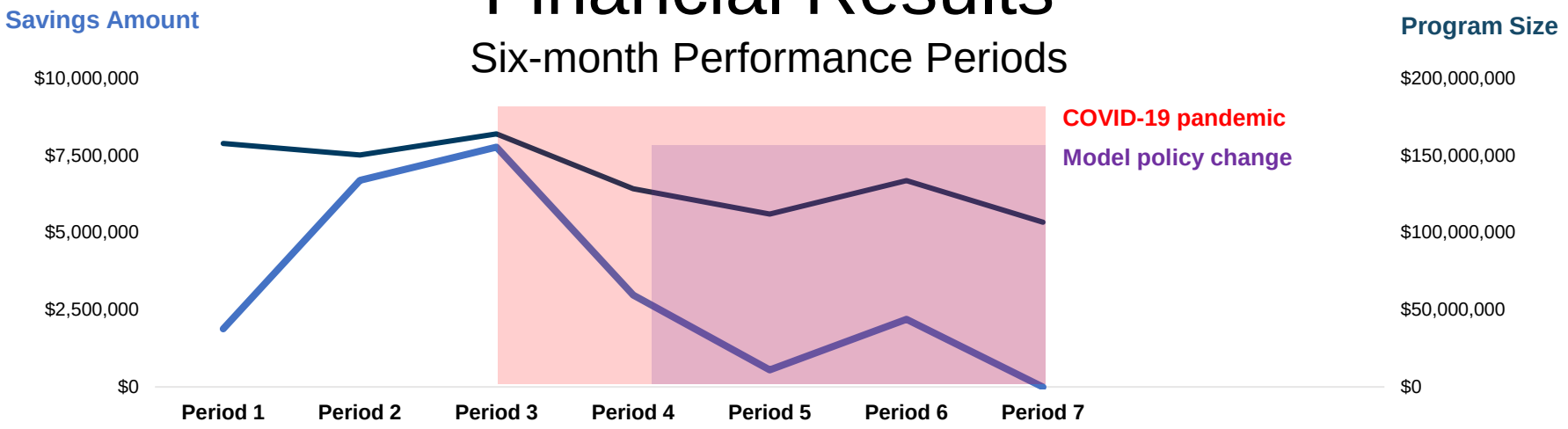
*Source: CMS Public Use Files*

# BPCI Advanced

## Financial Results

### Six-month Performance Periods




| | Period 1 | Period 2 | Period 3 | Period 4 | Period 5 | Period 6 | Period 7 |
|---|---|---|---|---|---|---|---|
| **Program Size** | $158M | $150M | $164M | $129M | $112M | $134M | $107M |
| **Savings Amount** | $1.9M | $6.7M | $7.8M | $3.0M | $0.5M | $2.1M | $0 |
| **Quality Score** | 56% | 56% | 56% | 49% | 49% | 61% | 61% |

- BPCI Advanced has achieved **$19.3M in reconciliation** since 2018

**Top 2 Lessons Learned:**

- Established patients often fare better over 90 days often due to better post-acute management
- Many care designs do not generalize to multiple bundles

**Top 2 Success Drivers:**

- Continuity of specialty care, including hospital clinics and home-based programs
- Maximal days at home through post-acute reduction and efficiency

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*Source: BPCI-A Reconciliation Workbooks (Oct 2018 – Mar 2022)*

# Lets Talk about Medicare Advantage

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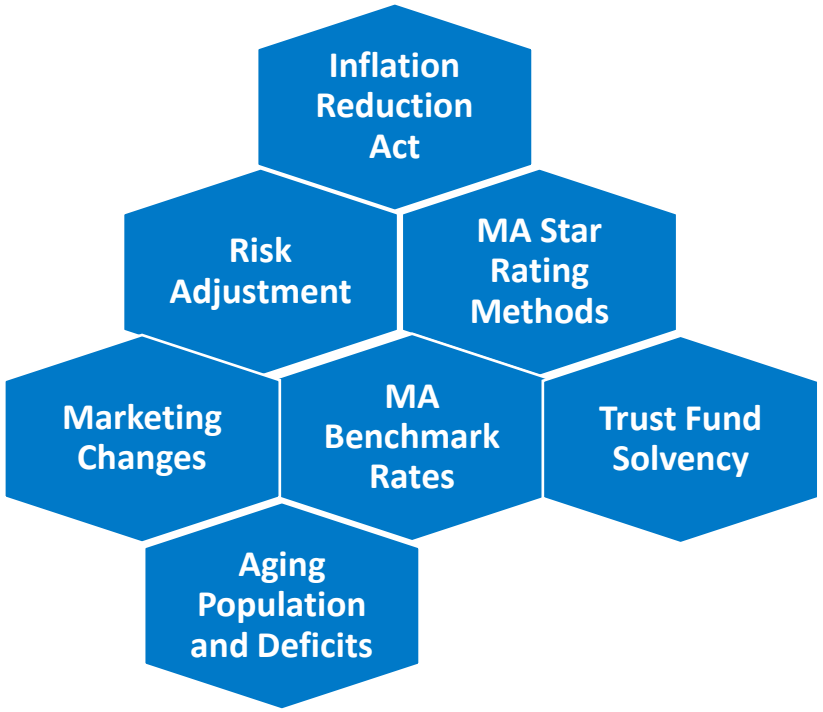
# Medicare – Death by a thousand cuts?

## Government




## Effect on Plan

- Higher Costs
- Lower Revenue
- Increased Financial Risk

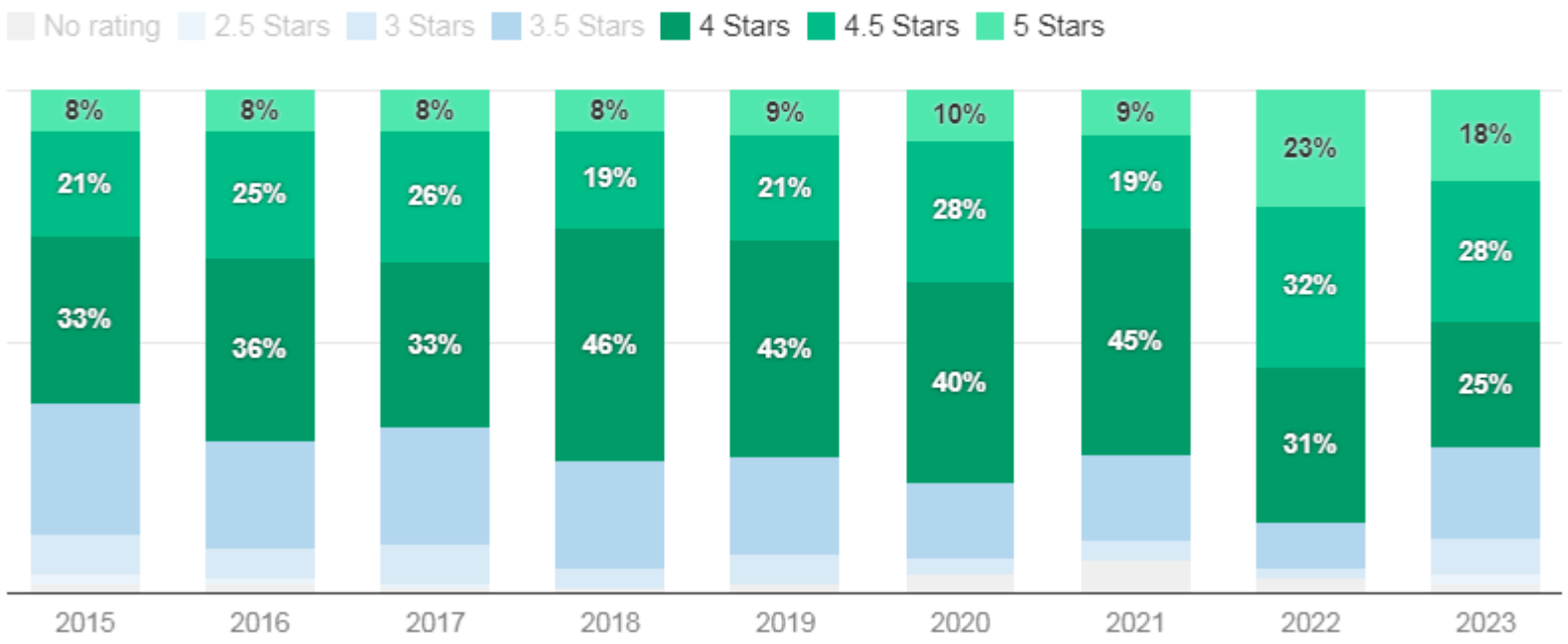
## Payor Actions

- Cut Benefits
- Higher Costs
- Raise Premiums
- Deny Care
- Tighten Networks
- Shift Risk

# MA Stars Under Pressure

Figure 7

Most Medicare Advantage Enrollees Are In Plans With At Least 4 Stars, 2015-2023




**CMS Actions**

1. (2022) Eliminate disaster provision
2. (2023) Cut point guardrails
3. (2023) Quadruple weight CAHPS
4. (2024) Remove Outliers
5. (2027) HE Index Reward Factor

**Timing**

2023 Dates of Service → 2025 Star Ratings → 2026 Reimbursement Rates

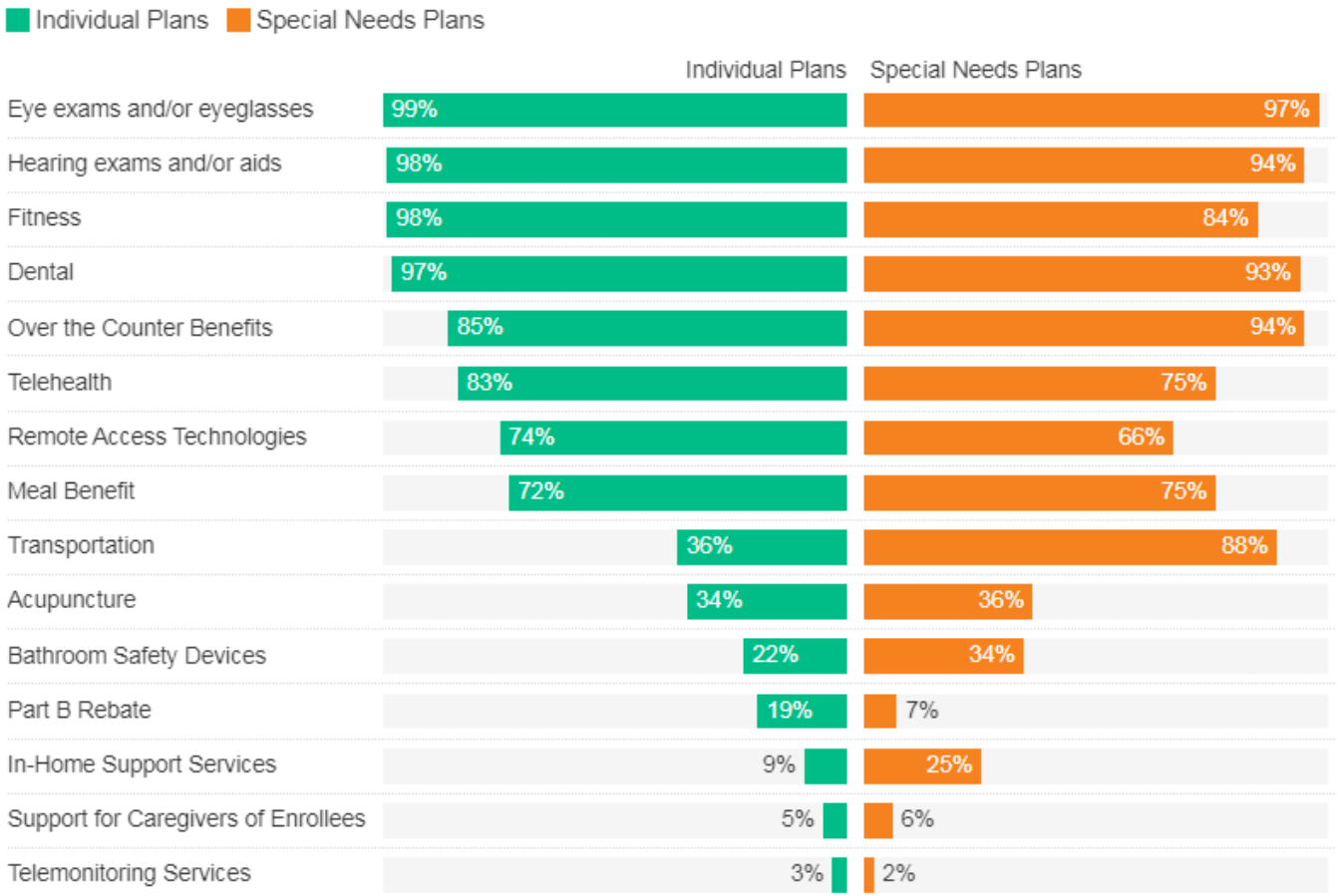
Medicare Advantage in 2023: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings | KFF

# MA Supplementary Benefits

Figure 9

## 97% or more of individual Medicare Advantage plans offer vision, fitness, hearing, or dental benefits in 2024

*Share of Individual and SNP Medicare Advantage Plans offering extra benefits by benefit and plan type, 2024*




Medicare Advantage 2024 Spotlight: First Look | KFF

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# Q&A

TOGETHER WE ARE ADVOCATE HEALTH