Value Based Care – How we got here and where is it going? Methodist's journey

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SVP Contract Strategy and Population Health

Methodist Health System

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Trust. Methodist.

Bio

Shannon C. Huggins, M.S.

Shannon began with Methodist in 2002 and has responsibilities for non-governmental payor contracting and relations on behalf of Methodist facilities, joint venture organizations, Accountable Care Organization / CIN and physician groups. Additionally she has operational responsibilities for the population health services. Shannon has designed and implemented contracting and pricing strategies for Methodist. She leads Methodist discussions in value based care arrangements. MPCACO has successfully achieved for Medicare savings for the 9 years in participating in this program – an achievement only 10 other ACOs across the nation also have.

Shannon has over 30 years of experience in contracting, payor relations, population health, value based care, financial analysis and decision support. Prior to Methodist, Shannon served in several roles at Baylor All Saints (formerly All Saints Health System) in Ft. Worth and various roles in a profit hospital organization.

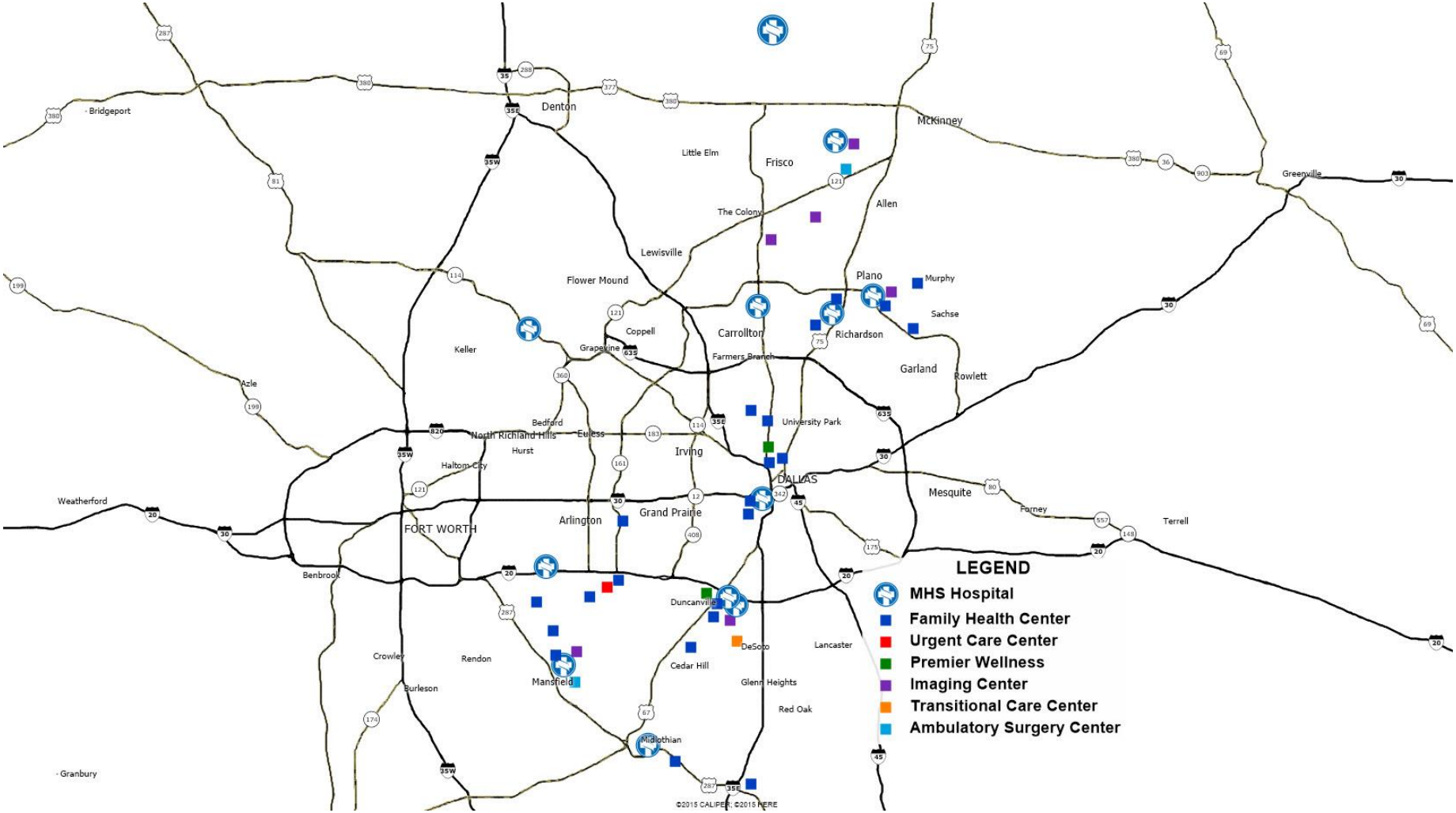
She has served on various civic boards and is currently finishing a term as President of the Alumni Association for her alma mater the University of the Ozarks and has recently began a term on the University's Board of Trustees. Civically, she has been on some local committees and was selected to be in Leadership Dallas class of 2014. Also, Shannon currently serves on several Board of Directors as a representative for Methodist Health System.

She earned her BS in Marketing/Finance from University of the Ozarks and her MS in HealthCare Administration from Texas Woman's University.

Who We Are

- 1,859 Licensed Beds
- 2,543 physicians
- 9 Acute Care Hospitals
- 2 Rehabilitation Hospitals
- 2 Ambulatory Surgery Centers
- 24 Family Health Centers
- 6 imaging centers
- 1 urgent care center
- Skilled Nursing Facility
- Home Health Agency
- 4 Residency & 5 Fellowship Programs

Locations


Bridgeport
Denton
Little Elm
Frisco
McKinney
Greenville
The Colony
Allen
Lewisville
Flower Mound
Plano
Murphy
Sachse
Coppell
Carrollton
Richardson
Keller
Grapevine
Farmers Branch
Garland
Rowlett
Azle
Bedford
North Richland Hills
Euless
University Park
Hurst
Irving
Haltom City
DALLAS
Mesquite
Forney
Terrell
Weatherford
FORT WORTH
Arlington
Grand Prairie
Benbrook
Duncanville
DeSoto
Lancaster
Crowley
Rendon
Cedar Hill
Glenn Heights
Mansfield
Burleson
Red Oak
Midlothian
Granbury
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LEGEND
MHS Hospital
Family Health Center
Urgent Care Center
Premier Wellness
Imaging Center
Transitional Care Center
Ambulatory Surgery Center

Definitions

What is Population Health?

The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

These groups can be defined in may different ways

What is Value Based Care?

A healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes.

What is an ACO? CIN?

Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their patients.

United States Healthcare is Transforming at Unprecedented Pace and Scope To Value

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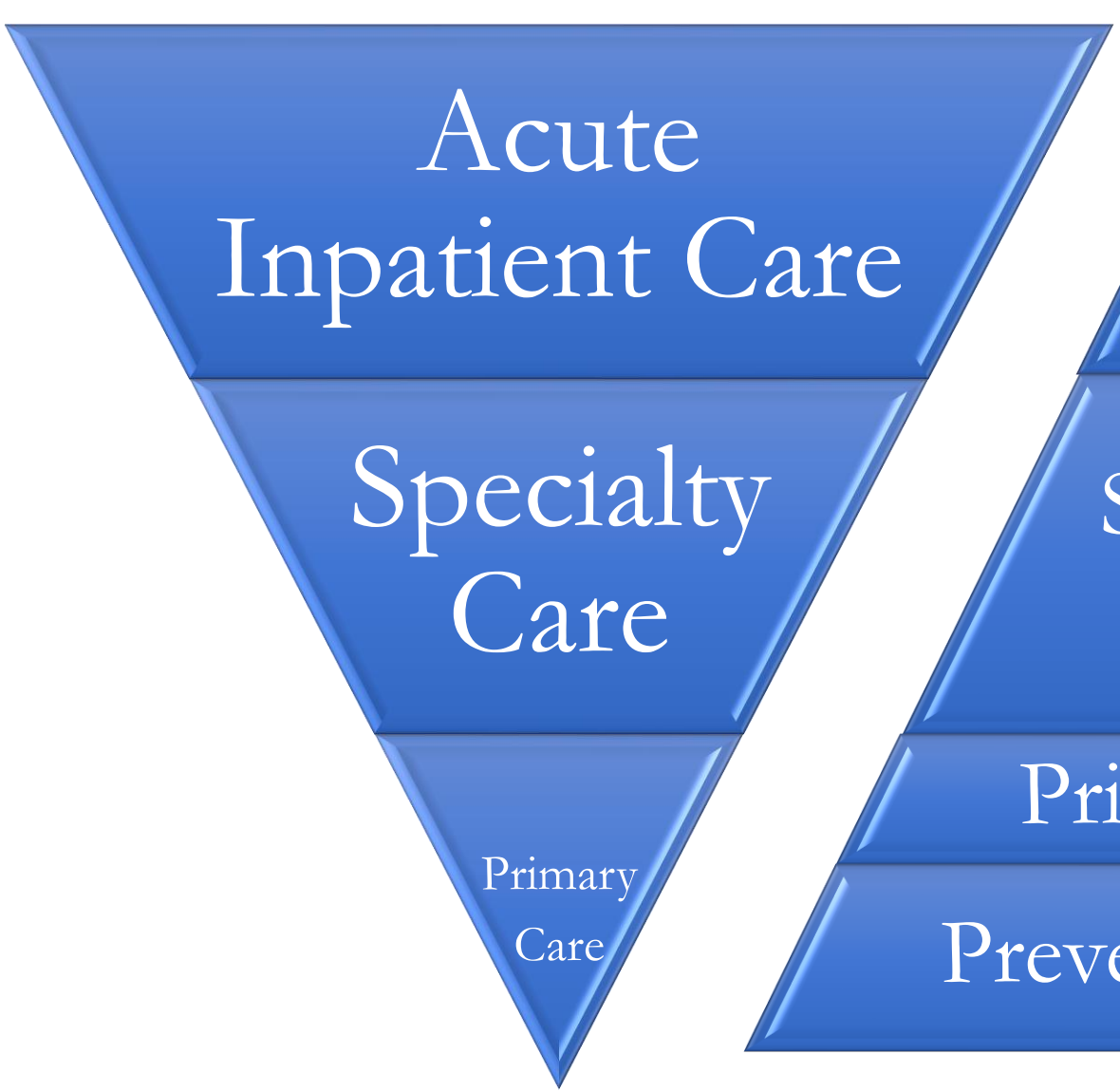
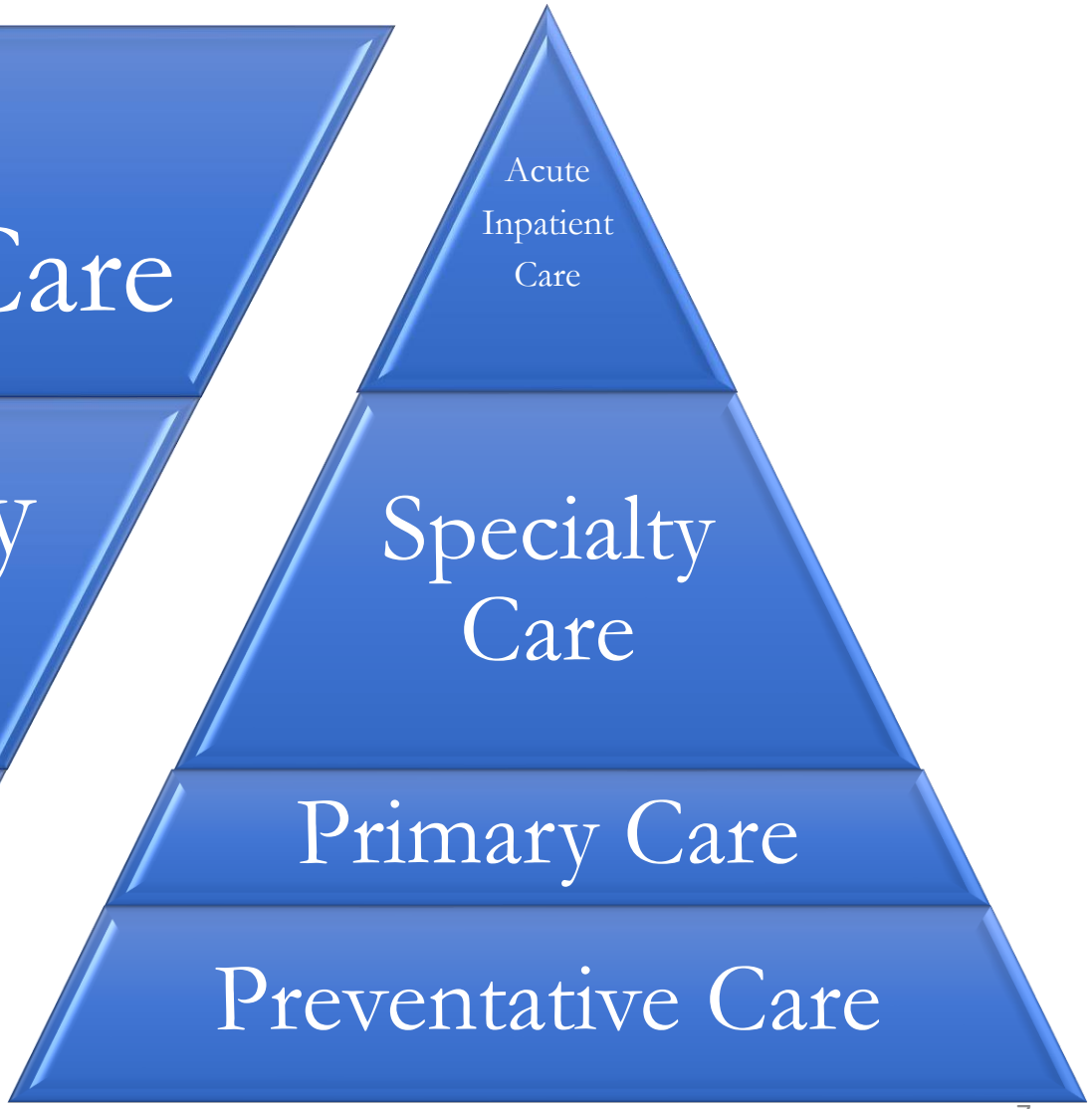
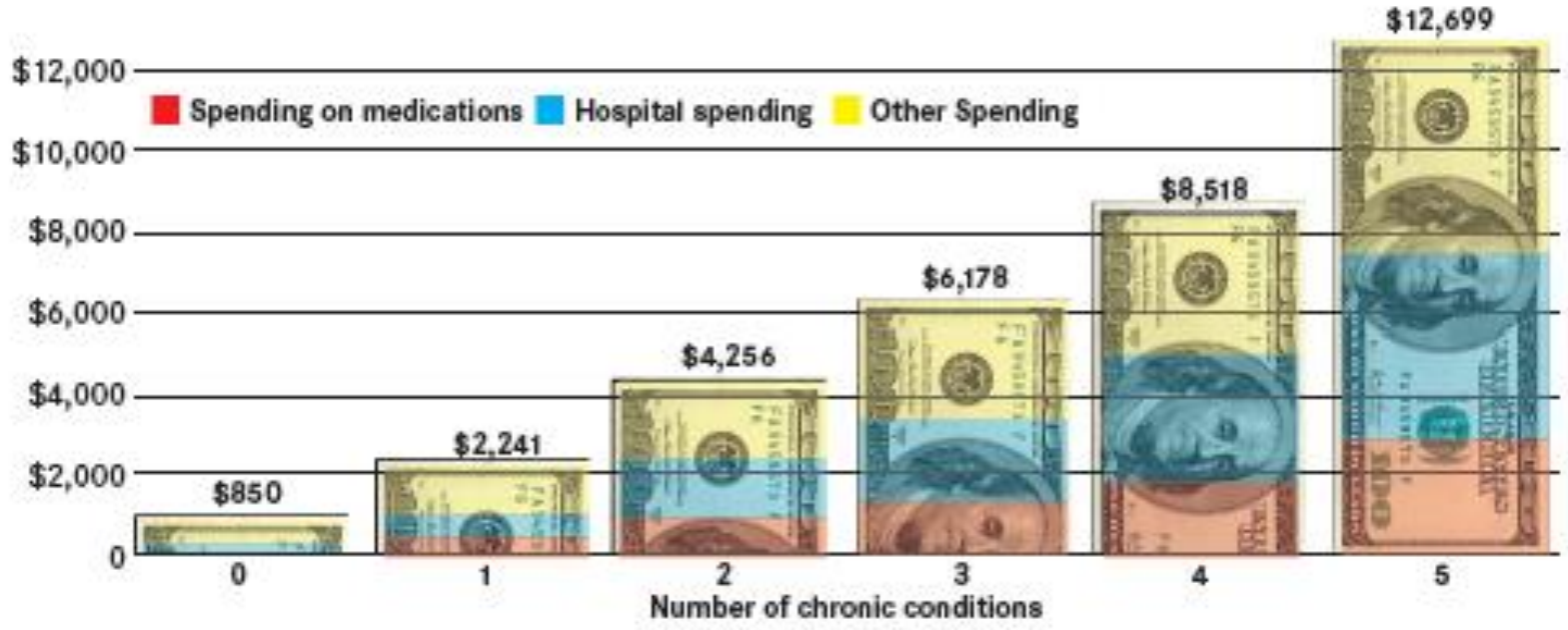
Moving from FFS to Value Based

Transition to managing care versus responding





Annual Health Care Costs by number of Chronic Conditions



Adapted from *When I'm 64: How Boomers Will Change Health Care*, American Hospital Association, 2007.

- By 2030, it is projected that **more than 60%** of this generation will be managing more than 1 chronic condition.
- Managing these chronic conditions, along with a patient's level of disability, will **increase the financial demands** on our health care system.
- The cost increases with the number of chronic conditions being treated, taking into account the **expected twice as many** hospital admissions and physician visits for Baby Boomers by 2030

Value Based Care models provide a path to full accountability

(Accountability to transform healthcare payment and delivery)

Fee For Service

Pay as service is provided

Pay for Performance (P4P)

Bonus payments for meeting metrics (e.g., quality, process)

- Potential for "boxchecking" vs. improving population health/cost of care

Upside gainsharing

Provider shares savings created if total of care is below target

- Creates accountability for population health management, even if provider cannot take on full accountability

Downside loss sharing

Provider shares upside savings, but pays back some costs above target

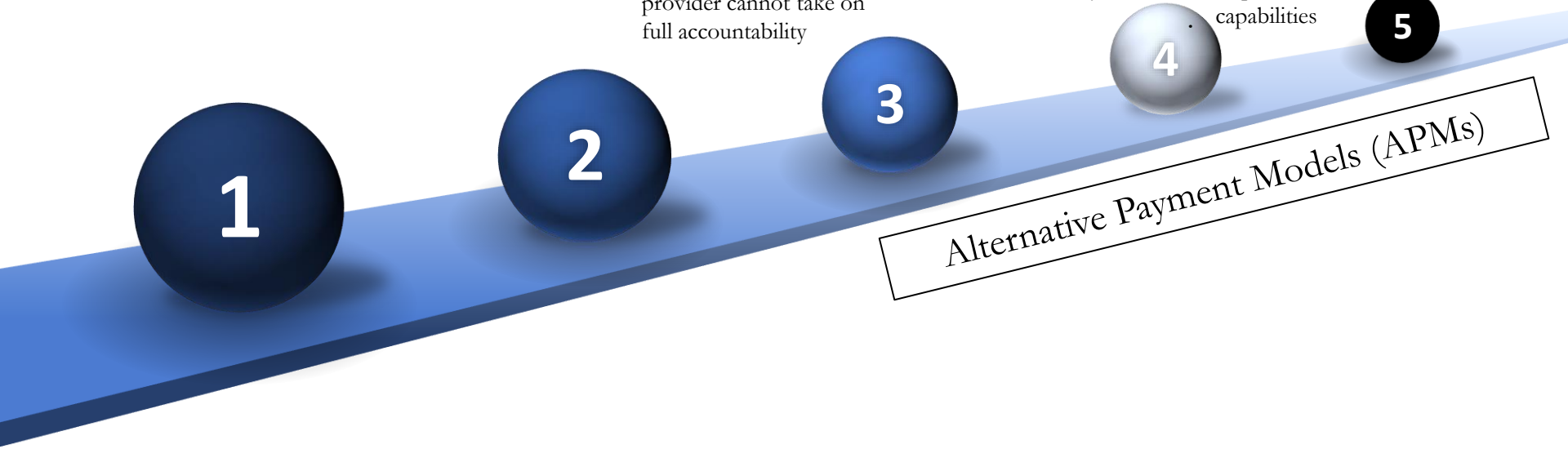
- Higher reward potential

*Accompanies taking on full accountability

Global payment

Providers take on full risk and manage patients' costs with a set global budget

- Requires broad set of provider capabilities



The Aim is Expanding

TRIPLE AIM 2007

1. Improved Patient Experience
2. Better Outcomes
3. Lower Costs

QUADRUPLE AIM 2014

4. Clinician Well Being

QUINTUPLE AIM 2021

5. Health Equity

Defining Social Drivers of Health

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What are social determinants of health?

Social Determinants of Health (SDOH) are defined by Healthy People 2030 as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."

Why are SDOH important?

SDOH are important because they affect patient health. It is estimated that between 70-90% of health is determined by SDOH. **This does not mean that the clinical encounter does not matter** – rather, that health and health outcomes are strongly influenced by the context of a person's place and space in society.

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.
https://health.gov/healthypeople/objectives-and-data/social-determinants-health

CMS

Economic Stability	Neighborhood and Built Environment	Education Access and Quality	Food	Social and Community Context	Health Care Access and Quality
Employment	Housing	Literacy	Hunger	Social Integration	Health Coverage
Income	Transportation	Language	Access to healthy options	Support Systems	Provider ability
Expenses	Safety	Early childhood Education		Community Engagement	Provider linguistic and cultural competency
Debt / Medical Bills	Parks / Playgrounds	Vocational Training		Discrimination	Quality of care
Support	Zip code / Geography	Higher Education			

Patient Centered ACO

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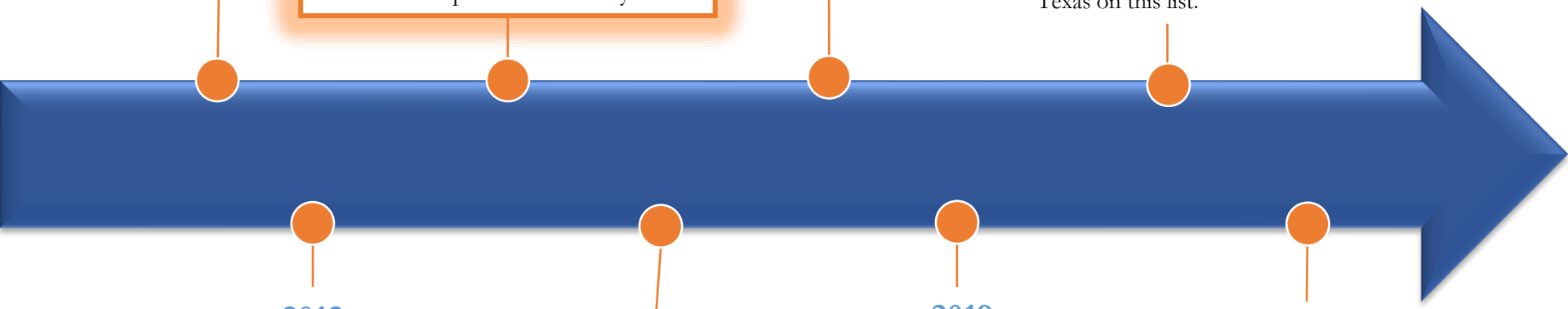


2012
Methodist Patient Centered ACO Established.

2012
Accepted into MSSP track 1

2014
Developed and Published a quality list for post acute services. Continues to be updated biannually.

2015
Affiliation participation with several local CINs to expand participation.

2017
1st Medicare Advantage agreement with risk.

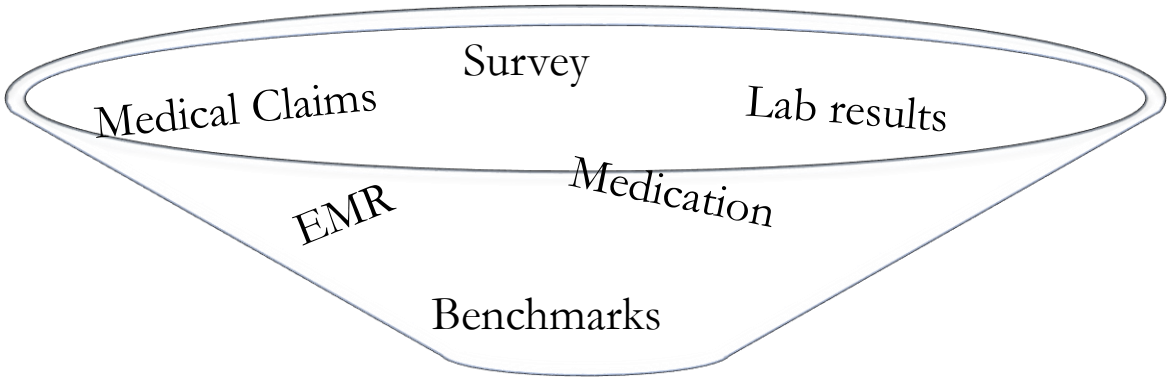
2019
Moved to the enhanced track in MSSP

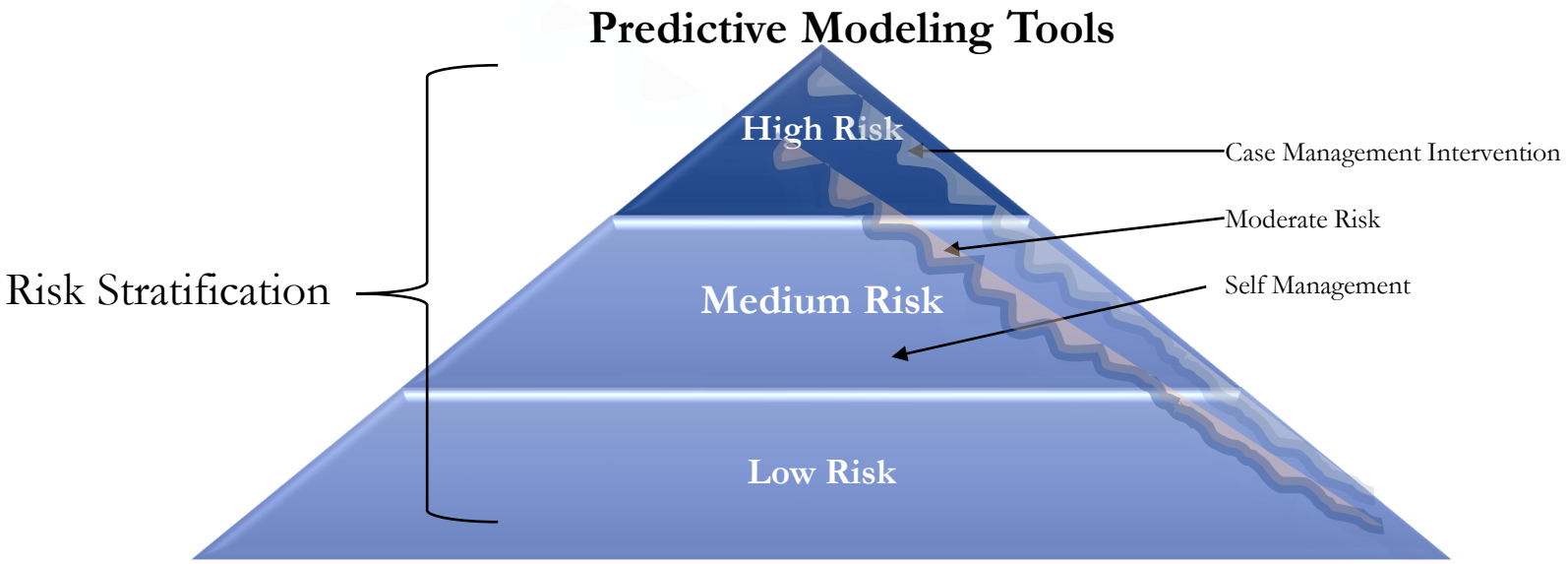
2021
Methodist is one of only 10 ACOs (~2.3%) who have earned shared savings every year since the start of the MSSP program in 2012. Methodist is the only ACO in Texas on this list.

2022
Over 800 physicians in the ACO

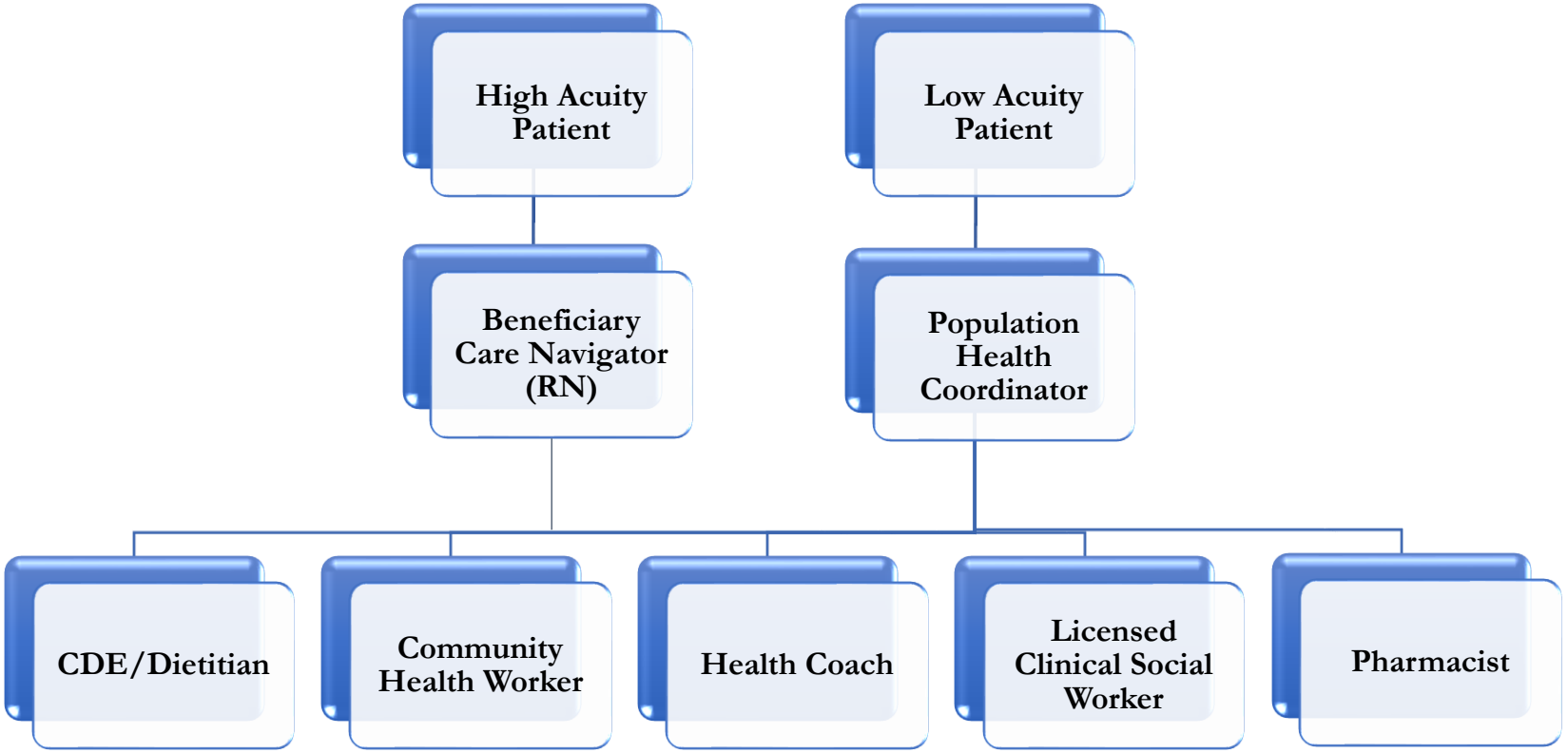
77,000+ attributed lives being managed

Converting data to actionable information





What Does Navigation Mean?



Additional Resources:

- Medication Therapy Management
- Clinical Education
- Gap Closures Support
- Office Assessment / Education

Medicare Shared Savings Program Results

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MPCACO Cumulative MSSP Distribution - $53,818,420						
Year	Benchmark	Expenditures	Savings	Medicare % Saved	Quality	MPCACO Distribution
2013	$214,790,906	$202,073,625	$12,717,280	6%	78%	$6,231,468
2014	$161,544,535	$148,941,538	$12,612,997	7.8%	85%	$5,260,901
2015	$161,942,966	$143,224,521	$18,718,445	12%	91%	$8,328,054
2016	$173,325,994	$162,698,883	$10,627,110	6%	95%	$4,936,071
2017	$158,516,381	$143,616,541	$14,899,840	9%	92%	$6,747,649
2018	$159,915,254	$146,037,106	$13,878,148	9%	94%	$6,402,707
2019	$170,053,316	$152,597,029	$17,456,287	10.3%	92%	$4,022,284
	$151,059,946	$148,710,191	$2,349,755	1.6%		$0
2020	$141,716,818	$133,500,062	$8,213,756	5.8%	97.5%	$6,006,309
2021	$140,941,584	$132,937,535	$8,004,050	5.7%	90.99%*	$5,882,977

Beneficiary Profiles

Ms. A

74 years old

7 ER/Admissions Prior year

5 ER/Admissions current year through April

COPD, DM, CHF, CKD

No meds in the home, apartment extremely dusty

No PCP, specialists follow up scheduled

Had not picked up medications

Care Navigator Interaction:

- Coordinated home needs with Home health nurse, Oxygen Company and family.
- Medication reconciliation with Home health agency, PCP, and beneficiary
- Work with family to coordinate thorough cleaning of apartment
- Made several physician appointments

Met 30 day mark of no re-hospitalizations since intervention began.

Ms. B.

- 49 years old
- 15 Admissions in prior year
- 6 ER in 2012
- ESRD with H/D, COPD, CHF, DM, HIV, HTN

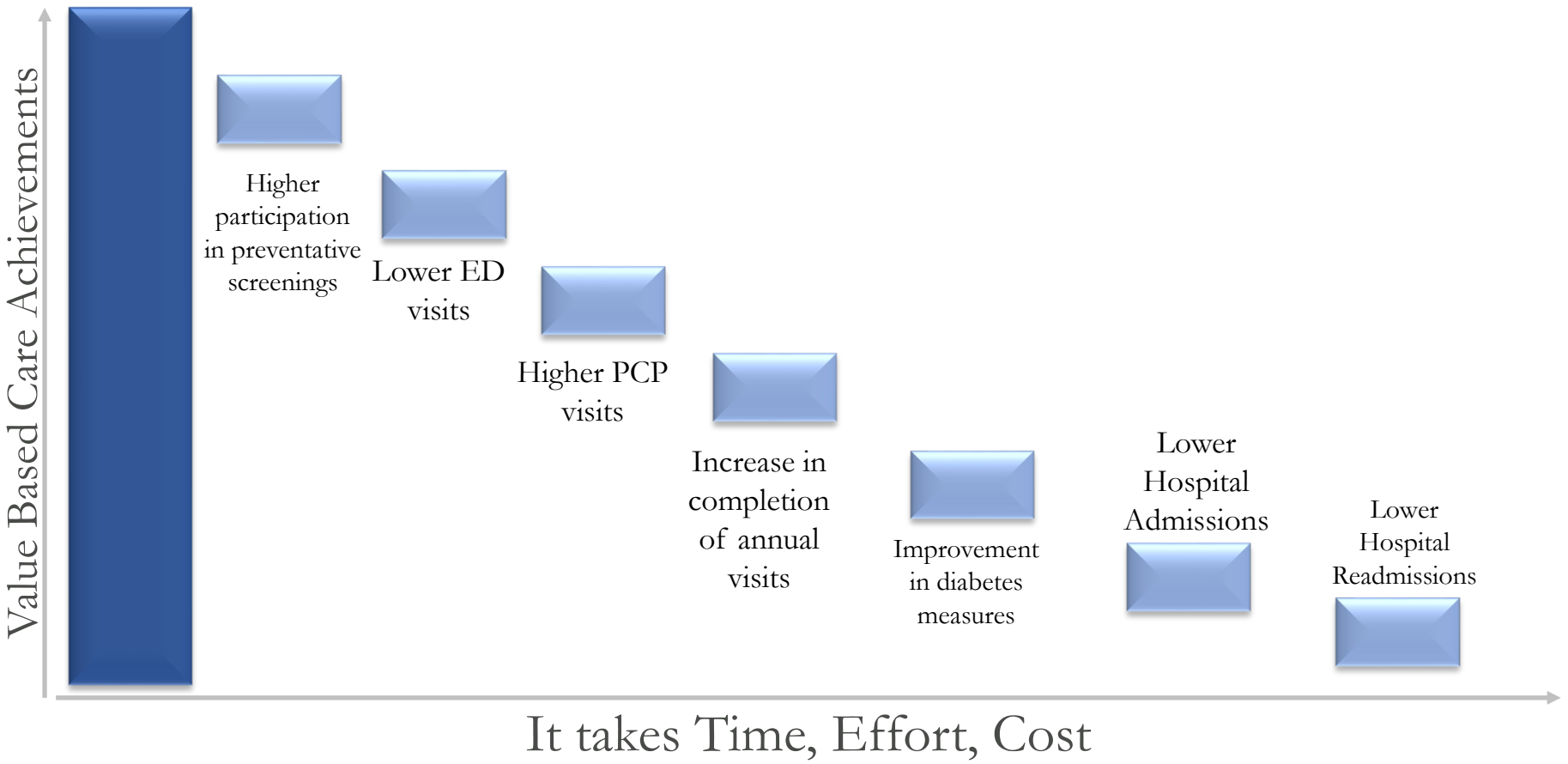
- No meds in the home, no food (1 meal/day)
- Caregiver crisis, lack of self -management,
- 4 generations living in one home with one mentally challenged caregiver
- Care Navigator Interaction:
  - Caregiver education
  - Immediate Long term placement in a NH
  - Medication reconciliation with Home health agency, PCP, NH and beneficiary
  - Care coordination appointment meeting with beneficiary's PCP
  - Continue biweekly calls to NH
- **No admissions to Inpatient or ER visits since intervention began.**

The Shift in Reimbursement

- In 2021, almost 20% of US Healthcare payments were in APMs
- Change from 2015 – 2021 % of payments in APM increased over 30%
- Largest area - 35% of Medicare Advantage spending was tied to an APM
- 83% of survey Health Plans think APM activity will increase
- Biggest barriers to additional risk = provider willingness, ability and readiness
  Biggest facilitators to additional risk = payor interest, govt influence, provider readiness.

https://hcp-lan.org/workproducts/apm-infographic-2022.pdf

Value Based Care Delivers



Consumer and Provider Access to Data

The Future of Value Based Care

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- Technology, Big Data is changing how we manage care delivery for populations
- Market pressures to reduce costs are increasing
- Payors are experimenting with different models, working with providers and consumers
- Consumers are more informed and aware of healthcare costs and value
- Healthcare is local so competition in the payor space is defined locally in each market
- Market Disruptors will alter the landscape, focus on value and quality

Where Do We Go From Here: The Evolving Value Based Care Market

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Commercial:

- More Commercial plans are seeking to engage with high quality providers in value based contracts
  - In-network utilization
  - High cost imaging
  - Avoidable ED
  - Avoidable admissions
- Gain share arrangements
- Care navigation payments
- Moving metrics is a challenge (market analysis)

Medicare Advantage:

- Continued growth from current approx. 15,000
- Working with Subcontracted groups
- MA poised to grow in our market
- Potential higher reimbursement than in Traditional Medicare model
- Navigation similar to MSSP

Direct to Employer:

- DFW has a large mid sized employer market
- Health care costs are an increasing share of employer expense
- Gain share arrangements
- Care navigation payments
- Challenges
  - Developing brand loyalty
  - Competing with other systems
  - Workforce preferences

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Thank you

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