Learning from MA Care Models

Tori Bratcher, Trinity Health
Henish Bhansali, Medical Home Network
Eric Cragun, Castell
Jennifer Houlihan, Advocate Health
Wilson Gabbard, Advocate Health

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Learning Objectives Outline

a. Overview of Medicare Advantage
    a. The growth trend of MA – its appeal and drawbacks
        a. KFF statistics and detractors
b. Review the changes differences between MA and MSSP
    a. Where do you focus?
c. Understand what is needed to succeed
    a. People
    b. Processes
    c. Technology
d. Tying it all together

Learning from MA Care Models

Leaders from Trinity Health, Intermountain Health, Advocate Health and Medical Home Network will review how they are translating care models from Medicare Advantage (MA) to MSSP, REACH, ACA and beyond. The panel will review the growth trend of MA, some of the challenges that have faced the program, and how they have seen payer and provider partnerships help transform care delivery.

Eric Cragun, Executive Director of Government Programs

Eric Cragun is the Executive Director of Government Programs for Castell, an Intermountain Health company. In his role, Eric leads Castell's efforts to succeed in risk-based contracts with government payers. This includes guiding Castell's strategy in Medicare and Medicaid programs, managing participation, and collaborating with operations teams to drive performance. Eric and his team have experience participating in a range of models including ACO REACH, the Medicare Shared Savings Program, Bundled Payments for Care Improvement – Advanced, and Idaho Medicaid Value Care Organization.

In addition, Eric helps Castell support Medicare Advantage and Medicaid products operated by SelectHealth, Intermountain Health's insurance company. Eric also contributes to Castell's work advancing national and state health policy discussions.

Prior to joining Intermountain, Eric led health policy consulting for Advisory Board, serving as an advisor to executives at health systems around the country. Eric earned an MBA from Northwestern's Kellogg School of Management.

Henish Bhansali, MD, Chief Medical Officer, Medical Home Network

Dr. Henish Bhansali is a leader and executive in value-based care, with expertise in care model design and delivery, data and analytics, and population health management. He serves as the Chief Medical Officer of Medical Home Network (MHN), caring for 300,000+ Medicaid and Medicare patients served by FQHCs across eight states.

Prior to MHN, Dr. Bhansali served as the SVP of Medicare Advantage at Duly Health and Care where he was responsible for leading care model design and delivery, TCC management, HEDIS, payor relationships, and MA expansion. Previously he also served as Oak Street's Senior Medical Director and VP of Care Navigation nationally. Prior to Oak Street, he led primary care education of over 50 internal medicine residents annually as an Associate Program Director with the University of Chicago.

Dr. Bhansali trained in internal medicine and was Chief Resident at Washington University (WU)-Barnes Jewish Hospital (BJH). Post-residency, he directed BJH's readmission reduction program and WU's Global Health Program. His current focus is moving FQHCs into VBC and he is currently a Presidential Leadership Scholar. Dr. Bhansali serves on the NAACOs Education Committee, and he is a Fellow of the American College of Physicians, a member of the AOA Medical Honor Society and is board certified in both internal and obesity medicine.

Tori Bratcher, System Director Alternative Payment Models, President Trinity Health ACO, Trinity Health

Tori is responsible for the strategy and operations of Trinity's National alternative payment models including being the ACO executive for the Trinity Integrated Care MSSP, one of the nation's largest ACOs. Within the ACO, she is accountable for performance quality reporting, network management, and ACO governance. Ms. Bratcher works collaboratively with system and local physician and business unit leaders to drive population health and clinical integration success with the providers and practices across the system.

Prior to her role at Trinity, she was the executive director of population health operations at Indiana University Health where she managed a portfolio of risk contracts and the teams that drove population health success. Ms. Bratcher graduated with a master's in health administration from University of Illinois Chicago and bachelor's in biology & pre-med from Indiana Wesleyan University. She is a former NAACOs Education Committee member and currently serves on the Policy Committee.

Jennifer Houlihan, VP of Aplied Research & Innovation, Advocate Health

Jennifer serves as a vice president for enterprise population health focused on the value service organization (VSO) platform integration with the academic core of Advocate Health. Specifically executing on aligned learning health system priorities including serving as a key liaison with Wake Forest School of Medicine Center for Healthcare Innovation to test, implement, and scale initiatives that currently include new risk segmentation models and care model innovation focused on complex care, brain health and chronic kidney disease.

She also supports the academic core of Advocate Health- Atrium Health Wake Forest Baptist Health providing administrative leadership for market ACO and value based contracts as well as providing leadership and oversight for faith health, chaplaincy, and community based behavioral health/ CareNet.

Jennifer also teaches at Wake Forest University and is a graduate of Florida State University and Thomas Jefferson University with degrees in Healthy Policy and Planning and Population Health.

Wilson Gabbard, VP of Condition Management & Documentation and Quality, Advocate Health

Wilson joined Advocate in 2020 where he is responsible for population health quality and health outreach across over 2.3M value based members and revenue accuracy for over $5 billion in system risk-based revenue. This includes responsibility for operationalizing programs for a portfolio of joint-ventures, fully delegated capitation, upside/downside risk, shared savings and pay-for-performance contracts.

Previously, he spent seven years leading population health operations for UNC Health Care where he was responsible for strategy and operations during its transition from fee-for-service to value-based reimbursement. The UNC population health services team grew from two to over 200 team members during his seven-year tenure.

Prior to joining UNC, he led regional operations for primary and specialty care practices and regional emergency and hospitalist service lines for Vidant Medical Group. Mr. Gabbard received his Bachelor and Master of Business Administration degrees from Morehead State University and is a Fellow of the American College of Healthcare Executives (FACHE). He also serves on the NAACOs Quality Committee.

Question #1

How would you rate your knowledge of drivers of success in Medicare Advantage?

a. Just learning about it

b. Understand the basics

c. Beyond the basics but less than expert

d. Significant understanding

Question #2

What types of contracts do you participate in?

a. Medicare Shared Savings

b. Medicare Advantage

c. Commercial risk

d. All of the above

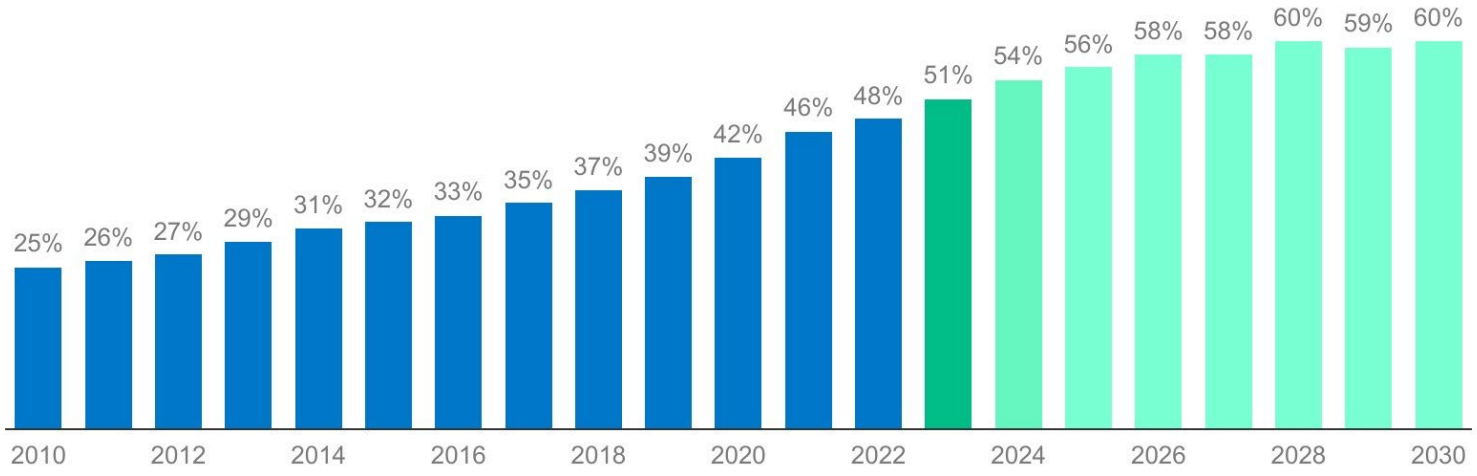
Overview of Medicare Advantage

Medicare Advantage Growth

Figure 1

Medicare Advantage Enrollment and Projections

Medicare Advantage Enrollment 2010-2023 & Projected Enrollment 2024-2030
(As a share of the eligible Medicare population)



NOTE: Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.0 million people are enrolled in Medicare Parts A and B in 2023. Using the CBO baseline, Medicare enrollment is based on individuals who are enrolled in Part B, which is designed to include only individuals who are eligible for Medicare Advantage and exclude those who have Part A only and cannot enroll in Medicare Advantage. However, it may include some individuals who have Part B only and also are not eligible for Medicare Advantage.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023. Enrollment numbers from March of the respective year. Projections for 2024 to 2030 are from the May CBO Medicare Baseline for 2023.

KFF

2024 CBO Reports:

- Two million new MA enrollees
- A decrease of one million fee-for-service enrollees
- U.S. will see a $65 billion increase in Medicare spending in 2024, largely caused by increased Medicare Advantage (MA) and Part D payments

Medicare Advantage Growth

Figure 6

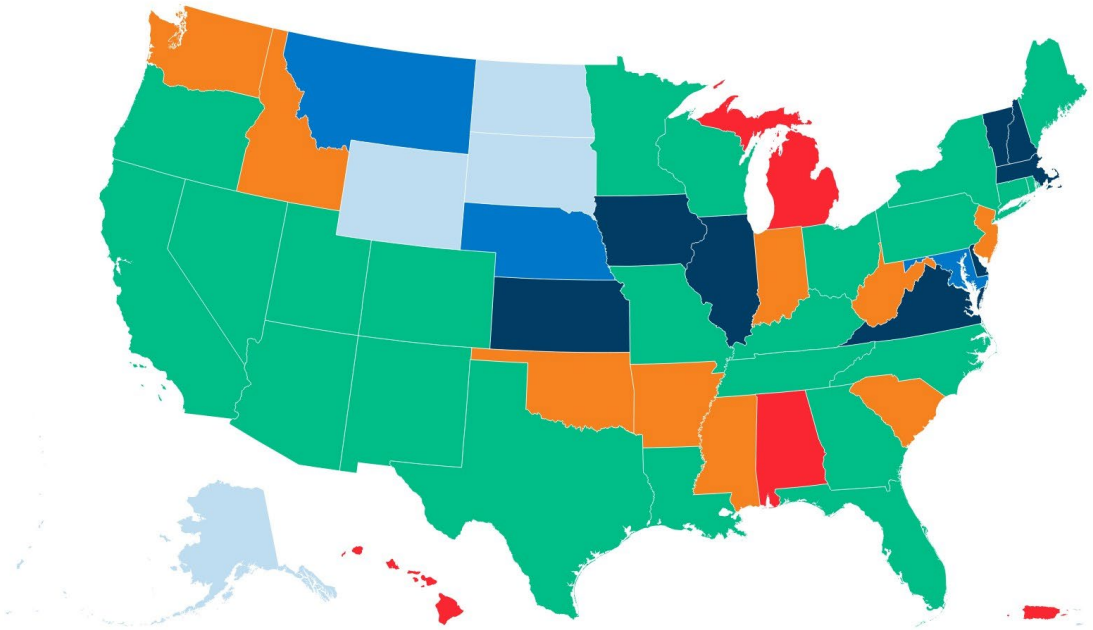
Share of Beneficiaries Enrolled in Medicare Advantage in 2023, by State

Click on the buttons below to see enrollment data for 2013 and 2023:

2013 2023

2023 National Average = 51%

< 20% 20%–30% 30%–40% 40%–50% 50%–60% ≥ 60%

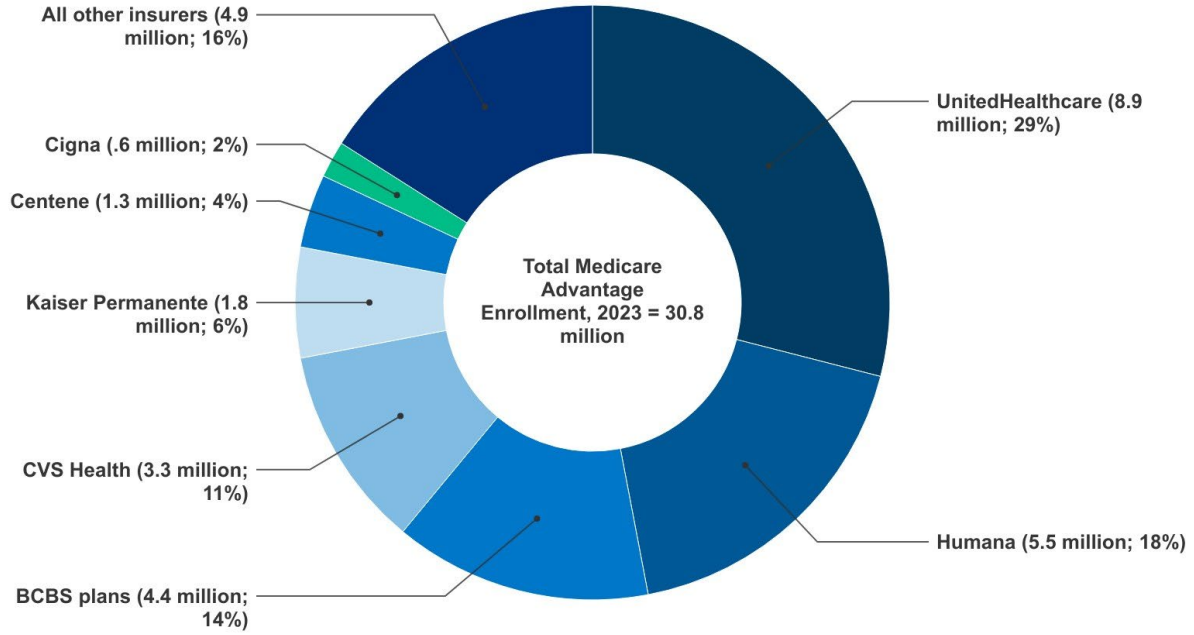


NOTE: Includes only Medicare beneficiaries with Part A and B coverage.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files and March Medicare Enrollment Dashboard, 2013 and 2023.

KFF

Figure 8

Medicare Advantage Enrollment by Firm or Affiliate, 2023



NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans (Elevance). Non-BCBS Elevance plans are 2% of total enrollment.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2023.

KFF

Medicare Advantage Challenges

The New York Times

'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions Oct. 8, 2022

By next year, half of Medicare beneficiaries will have a private Medicare Advantage plan. Most large insurers in the program have been accused in court of fraud.

Top 10 Medicare Advantage Providers	Accused of fraud by whistle-blower	Accused of fraud by U.S. government	Overbilled, according to Inspector General
UnitedHealth Group 27.1% of market	✓	✓	✓
Humana 17.4%	✓		✓
CVS Health 10.7%			✓
Elevance Health 6.5%		✓	✓
Kaiser Permanente 6.1%	✓	✓	
Centene 5.0%			
Blue Cross Blue Shield of Mich. 2.2%			✓
Cigna 1.9%	✓	✓	✓
Highmark 1.3%			✓
Scan Group 0.9%	✓	✓	✓

Note: The lawsuit against Scan was settled in 2012, and the lawsuit against Humana was settled in 2018. Lawsuits against other insurers are ongoing, and the insurers have disputed the claims. The government has joined the lawsuit against Cigna, but will not file detailed allegations until later this month. • Source: Market share data from Mark Farrah Associates • The New York Times

POLICY-ISH

Older Americans say they feel trapped in Medicare Advantage plans

JANUARY 3, 2024 · 2:21 PM ET

FROM KFF Health News

HEARD ON ALL THINGS CONSIDERED

By Sarah Jane T

HEALTH AFFAIRS FOREFRONT | CONSIDERING HEALTH SPENDING

RELATED TOPICS:
MEDICARE ADVANTAGE | ACCOUNTABLE CARE ORGANIZATIONS | MEDICARE SAVINGS PROGRAMS | TRADITIONAL MEDICARE | CAPITATION | PAYMENT | ACCESS TO CARE | FEE-FOR-SERVICE

Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 2: Building On The ACO Model

Richard Gilfillan, Dona

HEALTH INC.

How Medicare Advantage plans dodged auditors and overcharged taxpayers by millions

DECEMBER 12, 2022 · 5:00 AM ET

By Fred Schulte, Holly K. Hacker

Medicare Advantage Fundamentals

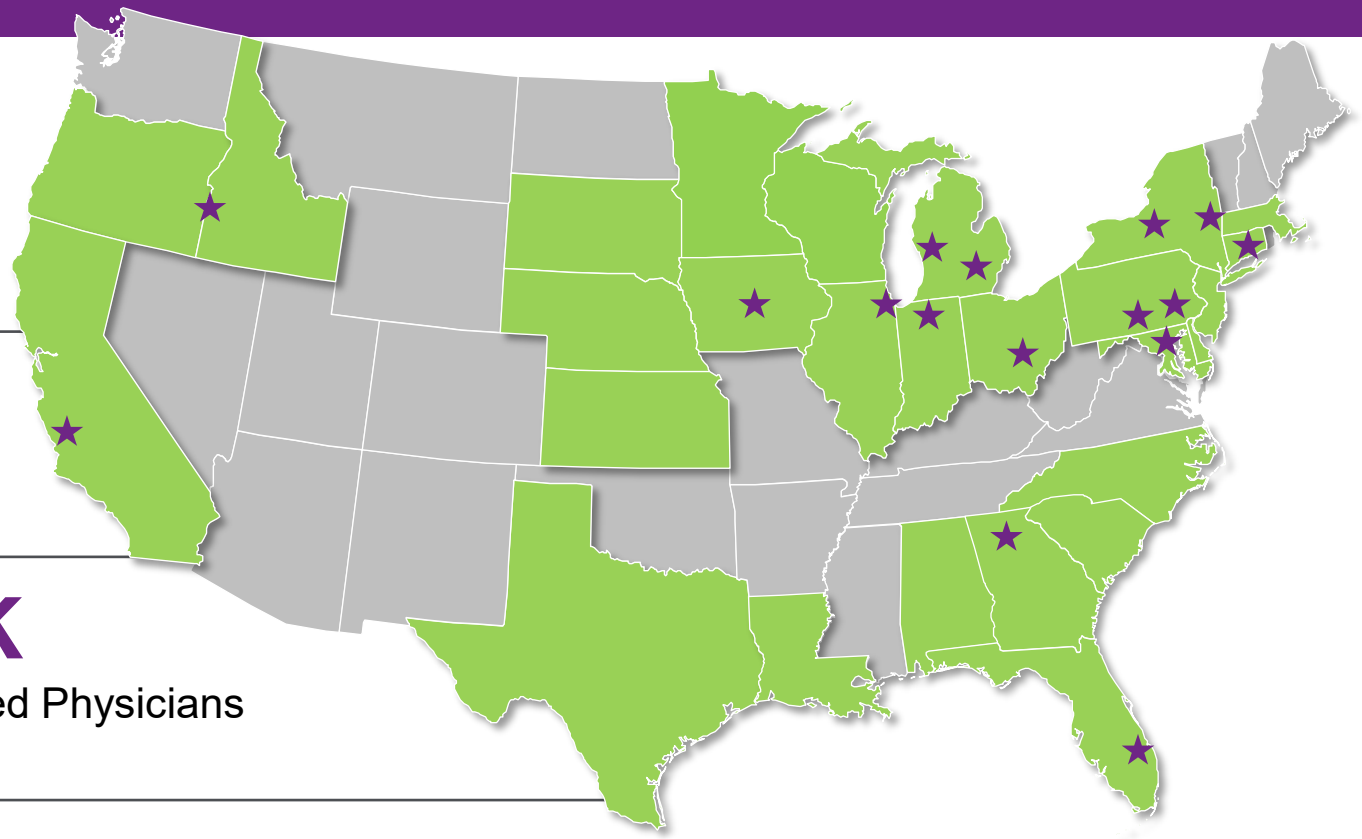
1. Medicare Advantage can be a key strategy to help align value based efforts with other programs
2. The payment model for Medicare Advantage has driven a significant shift in the focus of payments from fee-for-service to value-based care models.
3. To succeed in Medicare Advantage you need to ensure you can execute on Population Health fundamentals.
4. The goal is not for clinicians to be gatekeepers or expert coders but rather to support them being expert caregivers; shifting the payment model from one that rewards providing more services to one that rewards providing preventative care at lower cost.
5. All programs should be focused on compliance and improving member outcomes

MA Care Model Overview

Trinity Health is one of the largest Catholic health care systems in the nation

$21.6B
In Revenue

27
States



1.6M
Attributed Lives

$1.5B
Community Benefit Ministry

121K
Colleagues

8.2K
Medical Group Physicians and Providers

28K
Affiliated Physicians

101
Hospitals*

17
Clinically Integrated Networks

126
Continuing Care Locations*

23
PACE Center Locations*

136
Urgent Care Locations*

FY23 data unless noted, *Owned, managed or in JOAs or JVs.

We currently hold $11.5B in cost of care accountability for 2.1M people

	Annual Medical Cost	Attributed Lives
Medicare ACOs	$2.9 Billion	236,000
Medicare Advantage	$2.2 Billion	239,000
PACE / LIFE	$350 Million	3,300
Bundled Payment for Care Improvement Advanced	$210 Million	12,700
Colleague Health Plan*	$1.1 Billion	159,000
Commercial & Medicaid	$4.1 Billion	939,000
Maryland All-Payer Global Budget	$620 Million	488,000

*Colleague health plan is total medical and Rx cost, not adjusted for domestic or colleague payroll contributions. Data as of 6/30/2023.

Aligning care models reduces the disruption and improves the likelihood of success in Medicare APMs

- HEDIS and Stars Quality measure alignment
- Care management
- Accuracy of risk score
- Focus on Duals

Our Trinity Health MA Plan (MediGold) has taught us important "Payvider" skills and allowed for operational alignment

Castell At A Glance

CASTELL

Intermountain Health's Population Health Platform Company

5 states

~1.2 Million
lives under management

~$5 Billion
in value-based care arrangements

~550
employees

Advanced data & analytics platform

860
employed providers

840
affiliate providers

Multi payer value-based relationships

Full spectrum of valuebased care arrangements

Medicare Shared Savings	Medicare Direct Contracting	Medicare Advantage	Managed Medicaid	Individual ACA	Commercial

MA Brings a Different Set of Considerations

Program Element	MSSP/REACH	Medicare Advantage
Attribution	Provider relationship	Plan relationship
Cash flow/savings	Retrospective	Prospective
Benchmark	Own historical spend plus actual trend	Regional plus prospective trend
Risk Adjustment	Capped	Uncapped
Network/Prior Auth/Cost Sharing/UM	No (or few) tools	Many tools
Quality	Fewer measures	Many more measures
Pharmaceutical Management	Part B drugs only	Part B and Part D drugs

ADVOCATE HEALTH

NEARLY	NEARLY	MORE THAN	NEARLY	NEARLY	MORE THAN		
6M	**150K**	**21K**	**42K**	**$5B**	**1K**	**67**	**$27B+**
UNIQUE PATIENTS	TEAMMATES	PHYSICIANS	NURSES	COMMUNITY BENEFIT	SITES OF CARE	HOSPITALS	REVENUE

AdvocateAuroraHealth

- **2.9M** unique patients
- **77K** teammates
- **10K** physicians
- **22K** nurses
- **$2.4B** in community benefit
- **500+** sites of care
- **27** hospitals
- **$14B+** in annual revenue

Atrium Health

- **2.9M** unique patients
- **73K** teammates
- **11K** physicians
- **20K** nurses
- **$2.46B** in community benefi
- **500+** sites of care
- **40** hospitals
- **$13B+** in annual revenue

MAGNET RECOGNIZED · 2018-20 TOP HOSPITAL FOR DIVERSITY · LGBTQ+ HEALTHCARE EQUALITY LEADER · Modern Healthcare Best Places to Work 2021 · 2022 Practice Greenhealth SYSTEM FOR CHANGE AWARD · American Hospital Association Quest for Quality Prize · Forbes 2022 AMERICA'S BEST-IN-STATE EMPLOYERS · 100 Top Hospitals · AMERICA'S MOST LOVED WORKPLACES · Equity of Care AWARD

Advocate Health has a long history with value-based care, and partners with 13,000+ physicians in 12 ACOs & CINs

13,000+
Participating Physicians in our CINs

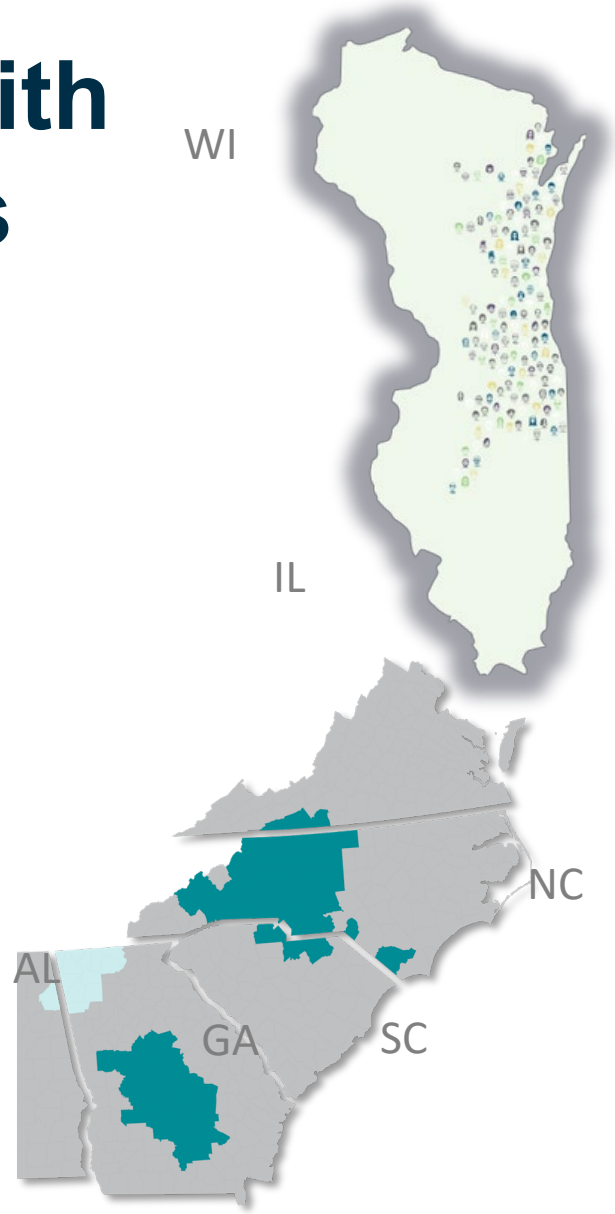
2.2 M
Total Managed Lives

73
Hospital Organizations Part of our CINs

108
Unique Value Contracts Across All ACOs/CINs

$1.2 B
Annual managed Capitation revenue

$1.4 B
Paid Out in Value payments



Advocate Health Population Health Platform

Managing Health, Quality, and Total Cost of 2.3M 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

$761.5M
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

The Vision

The Center for Healthcare Innovation is a preeminent leader in the innovative transformation and improvement of human health.

The Mission

To collaboratively leverage the unique talents and capabilities of our innovators, digital health tools, scientific discoveries and clinical care delivery system.

…to improve population health, enhance patient experience, reduce costs and improve care provider work life.

*NNGN™ (I**NN**ovation En**G**i**N**e, a.k.a. the Center for Healthcare Innovation)*

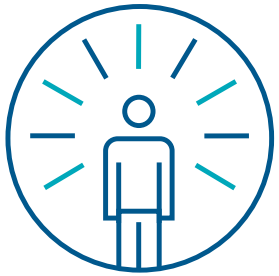
MHN's Unique Offering for CHCs

CHCs need different care delivery and payment models to sustain their mission and compete for patients

MHNConnect
Practice-level Care Management

+

Health Centers/Providers
Care Management & Practice Transformation Across the Continuum



Patients

MHN Unique Value Proposition

Practice-based Care Management Model & Programming

MHN blueprint builds patient engagement & trust; supports training & coaching by MHN Clinical Staff

Sustained funding for staffing

FQHCs to hire community-based, culturally-competent staff

MHNConnect ™ Proprietary Care Management Platform

Structured assessments, workflows, AI-based risk stratification

Provides a 360° view of patients with real-time alerts & connectivity

Localized Governance & Data Transparency

Drives practice transformation provider engagement, accountability & clinical innovation

Protect FQHCS From Downside Risk

Offers a glide path to two-sided risk & primary care capitation

Care model and level of risk

1. Medicare Advantage
2. ACO REACH
3. Medicaid
4. Delegated functions – CM and UM

Enablement

1. Contracting directly with a payor – do you engage the provider (vs. patient only), and if so, how?

2. Contracting directly with a provider(s) – how do you curate a longitudinal partnership?

3. A little bit of both – how can you navigate a combined approach?

Provider vs. Payor

Build or buy?

1. Opportunity – how big is it?
2. Timeline – how much runway do you have to solve the problem?
3. Market – how saturated is the market with competitors?
4. Resources – where does this initiative fall in the 2 x 2 (x 2) framework – important x urgent (x lift)

Learning from MA Care Models

Jennifer Houlihan, Vice President
Enterprise Population Health

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Wake Forest University
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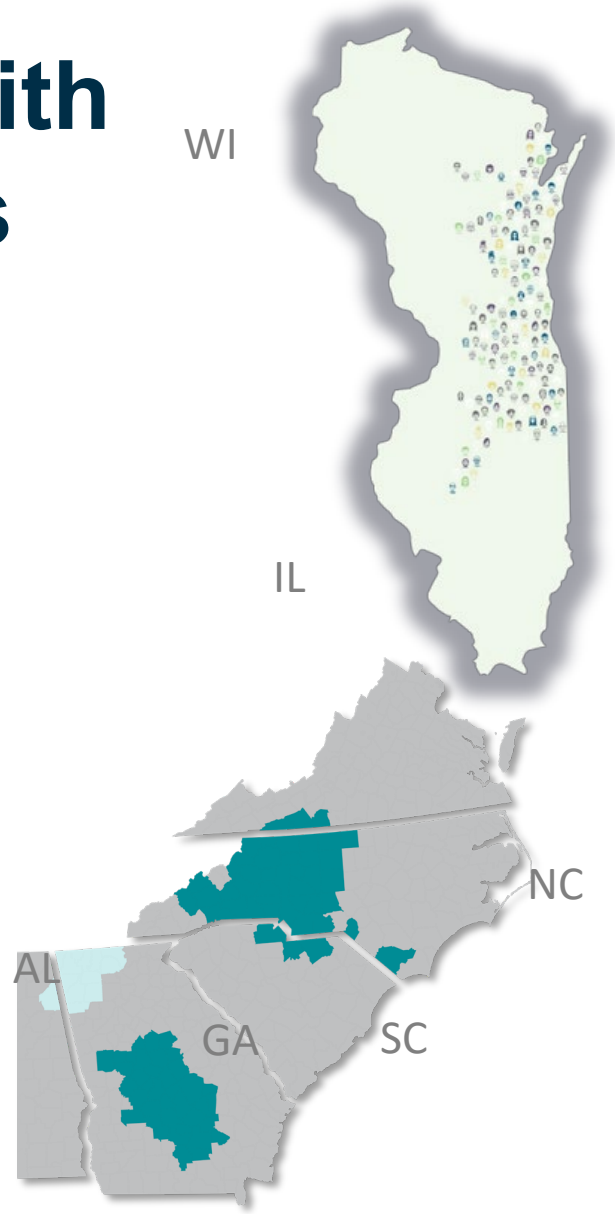

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Focus on Equity - Quality & Outcomes for MA

Equity in Quality and Outcomes: providing patients with consistent and equitable care across all demographics by:

• Collecting better demographic data by increasing options for ethnicities, races, languages, gender identity, sex assigned at birth and legal sex

• Using the Demographic data to identify gaps in clinical quality and outcomes across populations

- Progressive SDOH screening- screened over 140,000 unique patients in 2023
- Exploring use of new G codes and Z codes in MA populations
- Positioning to prepare for new MA health equity index (HEI) reward for the Star Ratings system.

Care plus- primary care model for reaching the underserved

A primary care based medical home model located in high ADI geography for frequent inpatient and ED utilizers serving high numbers of Medicaid and Dually eligible patients- implement in 2015

Services provided:

- ✓ Comprehensive SDOH screening- linkage with mental health
- ✓ Weekly multidisciplinary care coordination meetings
- ✓ Longer, more frequent visits
- ✓ Providers exempt from wRVUs/production compensation
- ✓ Home visits
- ✓ CHW resources to assist with medication, transportation, food pantry
- ✓ Population management including outreach to patients who miss primary care and subspecialty appointments
- ✓ **Focuses on high risk ACO and MA dual eligible patients**
- ✓ **Consistent reductions in ED (10%+) and IP (15%+) utilization**

Right door. Right time. Ready to be treated & not alone. Community outreach partnerships with the Faith Community.

Our focus areas are:

- ✓ Places: vulnerable and rural areas with lower income
- ✓ People: targeting the most vulnerable, uninsured and socially isolated.
- ✓ Process: identifying opportunities for transportation, medications, social/emotional support, resource navigation, housing, etc.

Programs that improve outcomes:

- ✓ Right Door: Promoting care upstream – reduction in ED visits and cost of care by targeted zip code and CHW caseload
- ✓ Right Time: Encourage people to seek care sooner and do not delay treatment
- ✓ Ready to be Treated/Healed: Ensure people and patients are prepared when arriving to receive healthcare or community-based services
- ✓ Not Alone: Aligning social networks with patients who are alone in their health care journeys

New risk models to inform MA population health management priorities and resources

Frailty is a decreased reserve in both physiology and day-to-day function, leading to a vulnerability to acute stressors. This predicts worse health outcomes, including falls, burdensome healthcare utilization, and mortality.

Why eFI? Most frailty tools are time consuming and laborious. The eFI mobilizes routine data that already exists in the electronic health record (EHR), in a single, automated, objective score.

- Frailty predicts a number of outcomes, utilization among them
- Zero additional work to "screen" – it's computed in EMR
- Identify high utilizers before they become high utilizers
- Not disease-specific

eFI and Healthcare Utilization

	Mean Cumulative Count (per 100 individuals aged 65+) Over 1 Year		Multiplier
Health Outcome:	"Fit" (eFI<0.1)	"Frail" (eFI>0.21)	
-Healthcare Visits	125.5	449.9	3.6
-Emergency Department Visits	2.4	19.3	8.0
-Hospitalizations	5.1	41.5	8.2
-Injurious Falls	0.8	5.1	6.2

The Association of Frailty and Neighborhood Disadvantage with Emergency Department Visits and Hospitalizations in Older Adults

- ***BACKGROUND:*** Risk stratification and population management strategies are critical for providing effective and equitable care for the growing population of older adults in the USA. Both frailty and neighborhood disadvantage are constructs that independently identify populations with higher healthcare utilization and risk of adverse outcomes.
- ***OBJECTIVE:*** To examine the joint association of these factors on acute healthcare utilization using two pragmatic measures based on structured data available in the electronic health record (EHR).
- ***DESIGN:*** In this retrospective observational study, we used EHR data to identify patients aged ≥ 65 years. Frailty was categorized through an EHR-derived electronic Frailty Index (eFI), while neighborhood disadvantage was quantified through linkage to the area deprivation index (ADI). We used a recurrent time-to-event model within a Cox proportional hazards framework to examine the joint association of eFI and ADI categories with healthcare utilization comprising emergency visits, observation stays, and inpatient hospitalizations over one year of follow-up.

The Association of Frailty and Neighborhood Disadvantage with Emergency Department Visits and Hospitalizations in Older Adults

- ***KEY RESULTS:*** We identified a cohort of 47,566 older adults (median age = 73, 60% female, 12% Black). There was an interaction between frailty and area disadvantage ($P = 0.023$). Each factor was associated with utilization across categories of the other. The magnitude of frailty's association was larger than living in a disadvantaged area. The highest-risk group comprised frail adults living in areas of high disadvantage (HR 3.23, 95%CI 2.99–3.49; $P < 0.001$).

- ***CONCLUSIONS****:* Considering both frailty and neighborhood disadvantage may assist healthcare organizations in effectively risk-stratifying vulnerable older adults and informing population management strategies. These constructs can be readily assessed at-scale using routinely collected structured EHR data.

• Lenoir KM, Paul R, Wright E, Palakshappa D, Pajewski NM, Hanchate A, Hughes JM, Gabbard J, Wallston BJ, Dulin M, Houston J, Callahan KE. The Association of Frailty and Neighborhood Disadvantage with Emergency Department Visits and Hospitalizations in