Listening Session on Issues Related to Population-Based TCOC Models

Presenters:

Subject Matter Experts

- **Sherry Glied, PhD**, Dean, Robert F. Wagner Graduate School of Public Service, New York University
- **Karen E. Holt**, Vice President, South Region, Collaborative Health Systems
- **Valinda Rutledge, MBA, MSN**, Chief Corporate Affairs Officer, UpStream
- **Christina Severin, MPH**, President and CEO, Community Care Cooperative

Previous Submitter

- **Jon Broyles, MSc**, Chief Executive Officer, Coalition to Transform Advanced Care (C-TAC);
  Gary Bacher, JD, MPA, Chief of Strategy, Policy, & Legal Affairs, Capital Caring Health; and
  Torrie Fields, MPH, Chief Executive Officer, Votive Health
  - *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model* proposal

Presentation:
Reducing Cost of Care While Maintaining or Improving Health Outcomes

Sherry Glied, PhD
Dean, Robert F. Wagner Graduate School of Public Service, New York University

PTAC Public Meeting

Sherry Glied, PhD
Dean and Professor of Public Service
NYU Wagner

Goals

- Reduce cost of care while maintaining or improving health outcomes
- How?
  - reduce duplication, unnecessary care
  - monitor and connect people to care more effectively to avoid increases in severity
  - increase prevention efforts to avoid future care
- (Note: discussion is focused on Medicare program where prices are set – this would look different in a setting where prices are negotiated)

FFS as the Problem

- All of these actions are disincentivized under FFS payment
- The more you do, the more you are paid – whether the care is necessary or could have been avoided
  - Rationale for APM
    - A capitated/bundled/flat payment structure creates incentives to reduce costs

But…

FFS payment has many very useful properties

– easily monitor performance
  - payment clearly tied to a patient and process

– allows maximal choice of provider by patients
  - highly valued by patients

– automatically risk adjusts
  - patients who use more services generate greater payments

– in normal times (except in once in a hundred years pandemics), provider faces little risk
  - output generates payment

How many of these 9 countries use primarily fee-for-service to pay outpatient providers?

- Canada
- France
- Germany
- Italy
- Netherlands
- Sweden
- Switzerland
- UK

How many of these 9 countries use primarily global budgets to pay hospitals?

- Australia
- Canada
- France
- Germany
- Italy
- Netherlands
- Sweden
- Switzerland
- UK

APM Challenges (I)

- Shifts away from FFS toward APMs that include a capitated/bundled/flat payment component generate new sets of problems
  - Higher burden of monitoring
    - theoretically better to measure value than volume – but a lot harder to do!
  - Must assign patients to providers somehow
    - creates incentive for providers to offload work and costs to others
      - for example, behavioral health carve-outs shift from talk therapy (covered under capitation) to pharmacotherapy (drugs not in the contract)
      - bundled payment for post-acute care may shift burden of care to families, informal care

APM Challenges (II)

- Need some way to risk adjust so providers are not incentivized to avoid the sickest patients
  - risk adjustment systems can create perverse incentives to over-diagnose
  - pervasive across the system
- Need to address provider risk (even with risk adjustment)
  - voluntary participation
  - multiplicity of models
    - given inherent variability in costs and structures of provider organizations, each organization can select the model that brings it the most revenue relative to cost
    - organization can capture savings that would otherwise accrue to Medicare
- It is really hard to accurately assess performance of many APMs because of these selection problems at the patient and program level

The Underlying Problem is Tough!

- Research suggests the level of “inefficiency” in healthcare is comparable to that across the economy and probably smaller in the US than elsewhere.
  - lots of reasons to improve processes (as everywhere)
  - but these problems are not more pervasive in health care
- This means that it is easier to generate positive financial results by manipulating incentives etc. than by doing the hard work that might improve care

Total Cost of Care

- Key feature: unit of analysis is very broad
  - best-established is Maryland
  - other models at employer level
  - Population is not discretionary/assigned/etc.
  - Very crude risk adjustment (age/sex) is enough – and hard to manipulate
  - Ideally – measure all aspects of the cost of care
    - including all services paid for by Medicare
    - and all beneficiary out-of-pocket payments
    - and all informal care etc.

Examples

- Maryland – Medicare beneficiaries
- States – cost-growth benchmarks
  - Massachusetts
  - Connecticut
  - Oregon
    - Nevada
    - New Jersey
    - Washington

TCOC is a Management Tool

- TCOC avoids:
  - Selection of patients
  - Risk adjustment
  - Assignment of patients
- But it is not an incentive program – it is a monitoring and management tool
  - Incentives sit within TCOC monitoring

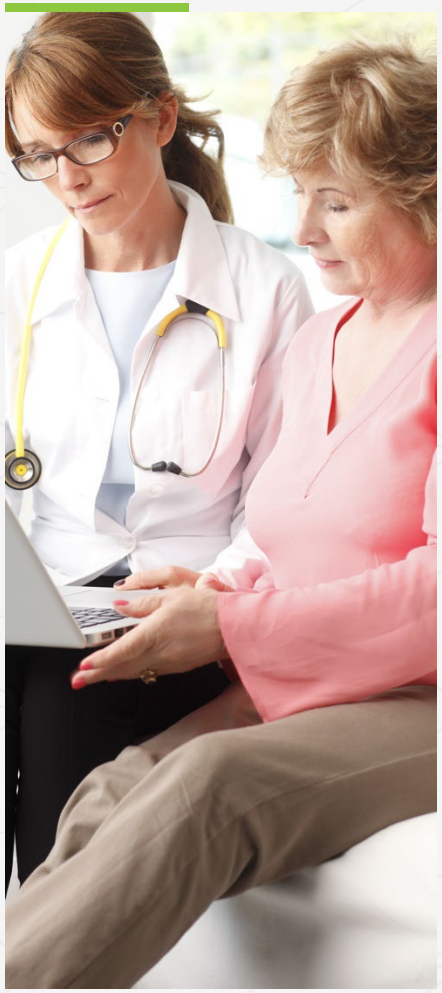
Presentation:
Making Care Primary Again: Partnering on the Path to Value Based Care

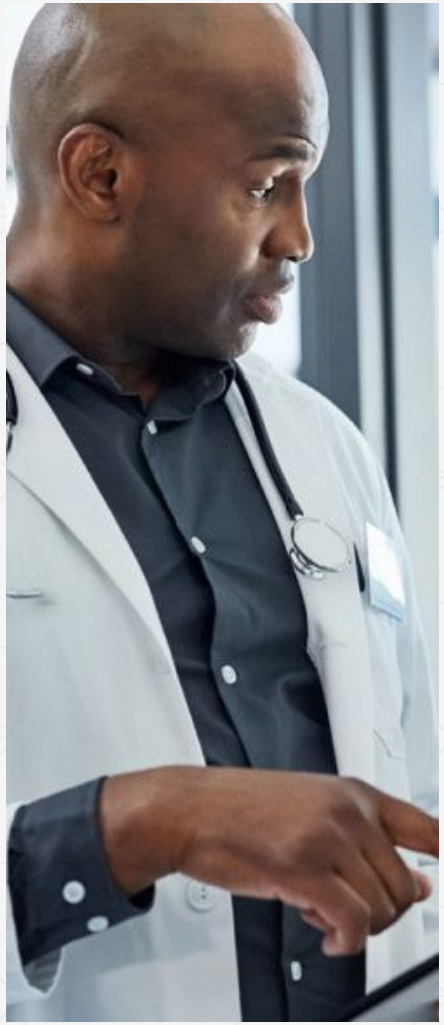
Karen E. Holt
Vice President, South Region,
Collaborative Health Systems

MAKING CARE PRIMARY AGAIN

Partnering on the Path to Value Based Care

Opportunities for Improving PCP Care Coordination





COLLABORATIVE HEALTH SYSTEMS®

Proven Performance & Outcomes

In PY2020, 160K Medicare beneficiaries cared for across the country by CHS partner providers

Since 2012*

$475M Total net savings to Medicare Trust Fund

$300M Total earned shared savings

Patient Impact in PY20

✓**97%** Average quality score

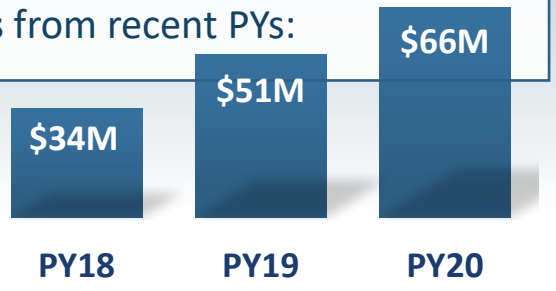
✓**19%** Reduction in Hospitalization

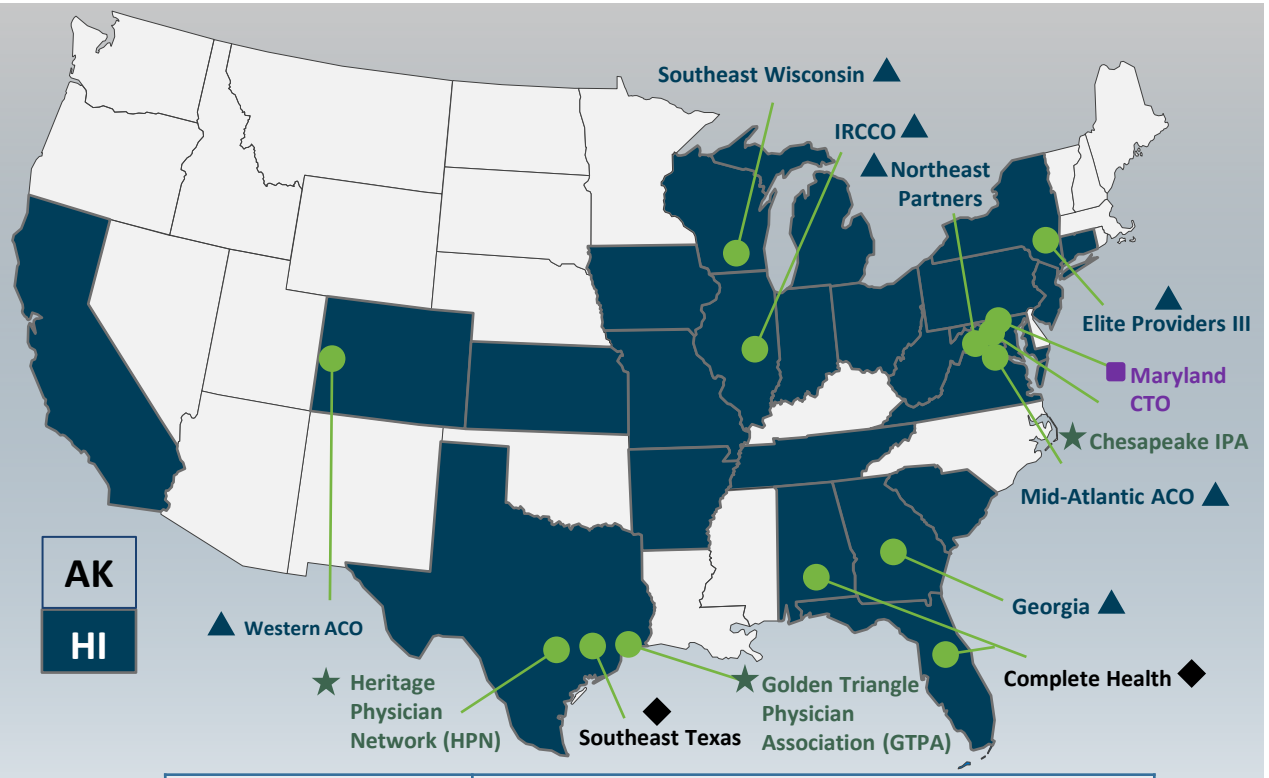
✓**26%** Reduction in SNF utilization

Financial Impact

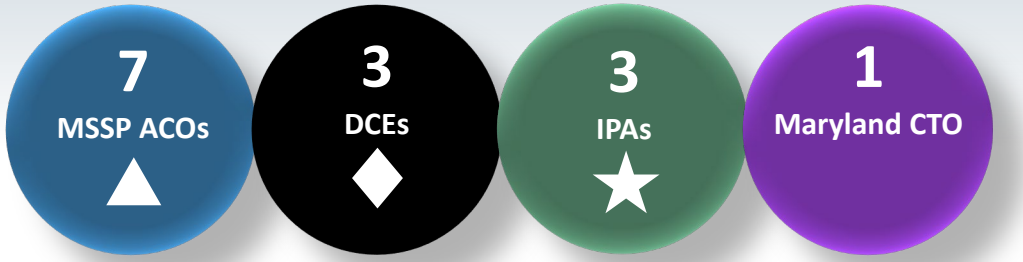
$91M Total new savings to the Medicare Trust Fund in PY20

Total Earned Shared Savings from recent PYs:





ACC of Direct Contracting	AR, CA, CT, FL, GA, HI, IA, IL, IN, KS, MI, MO, NJ, NY, OH, SC, TN, TX



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*2012 is the first year of the program, generated by CHS Partner Shared Savings Program(MSSP) ACOs

Navigating An Evolving Industry

Administrative and clinical activities are overwhelming providers

Industry Trends

- **Migration from Fee-for-Service to Risk**
- **Shift to PCP, SDOH & Prevention**
- **Exploding Tech and Admin Requirements**
- **Increasing Vertical and Horizontal Integration**

Implications for Providers

Increasing Financial Pressure

- Margin compression across value chain
- Reimbursement tied to quality
- Cash flow problems due to slow/under/non-payments
- Rising operating costs and investment in new technology
- Federal budget uncertainty

Disparate Technology and Data Systems

- Multi-platform data integration
- Implementing EMR/analytics tools
- Ability to keep current and deploy new technology
- Patient/beneficiary mobile health platforms

Declining Autonomy

- Increasing administrative burden/reporting requirements
- Pressure on balance sheet & community needs
- Maintaining independence

CHS Value Proposition

Empower Providers to Run Efficiently

- Provide state-of-the-art tools which focus efforts on critical actions and eliminate waste

Preserve Independence

- Reduce the financial and administrative burdens which force acquisition from outside

Enhance Transition to Value-Based Care

- Collaborate with providers to deploy critical infrastructure for success in VBC and risk programs

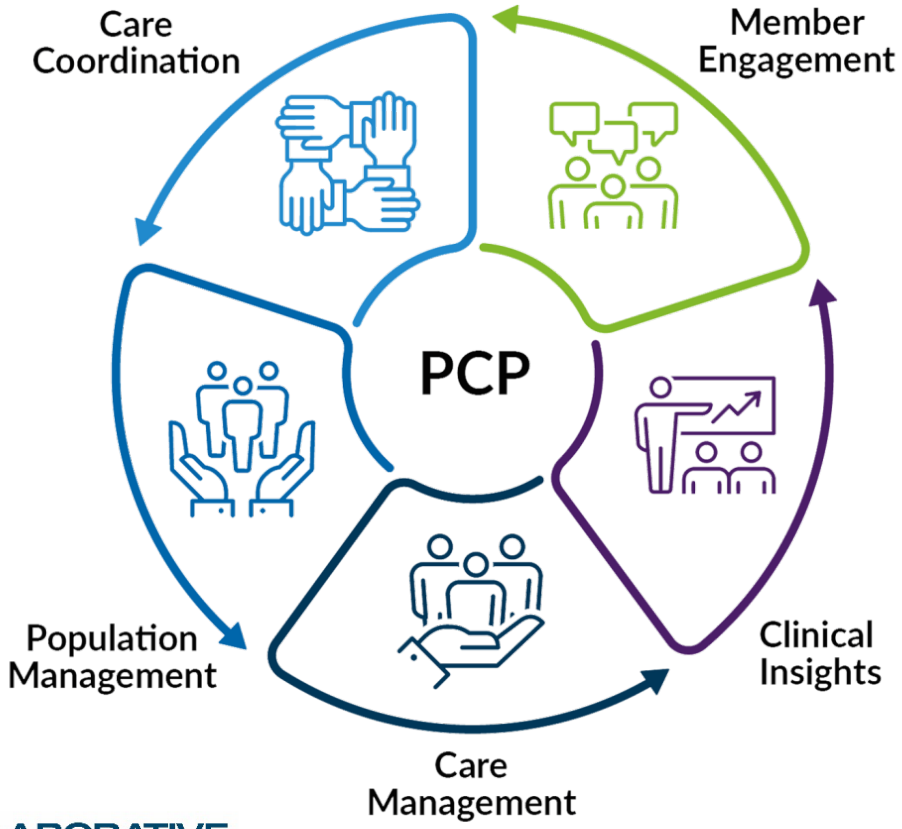
Clinical Program Implementation

- ADT messaging at the point of care
- Health Systems and Emergency Departments
  - Readmission and Discharge Placement
- Community Based Organizations
- Community Health Worker
- Transitional Care Management

COLLABORATIVE HEALTH SYSTEMS®

Population Health Management

Population health management requires timely data for care coordination and beneficiaries to collaborate more effectively for improved care and lower costs



Care Coordination and Connectivity

- Timely data for all patients and all health plans
- Stronger regulations to support ACOs, and IPAs ADT feeds

Care Settings

- Post Acute Facilities (SNFS, LTAC, IRFs, etc.)
- Home Health Providers
- Hospitals
- Specialty care providers
- Diagnostic services
- Transportation services

Care Management

- Health risk assessments and stratification
- Transitions of care and follow-up
- Care plan definition, management, tracking

Patient Engagement

- Timely outreach to patients for education and support

COLLABORATIVE HEALTH SYSTEMS®

CHS Core Care Model

- ✓ Educates providers around risk adjustment practices and reviews for accuracy

Risk Adjustment Educator

Coding Accuracy

Practice Transformation Coach

Provider Facing

- ✓ Monthly programs review: Home Health, Skilled Nursing Facilities, Transitions of Care and ER Utilization
- ✓ Monthly practice scorecard and gap review
- ✓ Review of accurate diagnosis documentation education

- ✓ Develop partnerships with providers, facilities and ancillary services to collaborate and coordinate beneficiary care
- ✓ Review Utilization reports to identify actionable opportunities

Market Manager

Development

Community Health Worker

Patient Centric

- ✓ Collaboration/Coordination of community resources to meet beneficiary needs
- ✓ Communicates care needs with Primary Care Physician and coordinates care based on provider direction
- ✓ Beneficiary education to entitlements

Social Worker & Care Coordinator

Care Navigator

- ✓ Referrals for behavioral health and social issues
- ✓ Beneficiary education: Annual Wellness Visits, age/gender/disease specific preventive services, and appropriate care
- ✓ Assist in access to care

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QUESTIONS?

Let’s Collaborate

COLLABORATIVE HEALTH SYSTEMS®

For general questions & to determine if you qualify to participate, **call 877-808-5643** Or visit our website to schedule a time for a representative to call you

For contract or model specific questions, reach out to our team:

Karen E. Holt, *Regional Vice President*
Karen.Holt@collaborativehs.com

Michael Barrett, *Vice President, Strategy & Business Development*
Michael.Barrett@collaborativehs.com

Presentation:
Healthcare is a State of Independence

Valinda Rutledge, MBA, MSN
Chief Corporate Affairs Officer,
UpStream

UPSTREAM

Healthcare is a state of independence

PTAC

Valinda Rutledge
March 8, 2022

UpStream

UPSTREAM

UpStream's Innovations

A Global Value-based Risk Organization

Physically embedded clinical care teams

Highly trained prescribing pharmacists and coordination nurses physically in the office working with patients

Systematic resolution of quality and care gaps with consistent follow-up over time to therapeutic goals

Extended services such as fully integrated pharmacy dispensing with home delivery

Risk-free physician participation in value-based care

Upfront, irrevocable guaranteed advance payments for quality (GAP-Q™) during the performance year

Elimination of uncertainty for physicians with greatly improved cash flow

Based on underlying full-risk contracts with traditional Medicare and Medicare Advantage insurers

UpStream takes all contract risk through substantial capital investment

Most powerful technology platform in primary care

Industry-leading population analytics and data science capabilities to proactively identify risk

Combined with embedded teams, delivers dramatic reductions in downstream utilization within months

Significant improvements in patient outcomes and satisfaction

UpStream

BARRIERS TO PHYSICIAN ADOPTION IN TCOC

1. Financial Risk – Risk averse to “betting farm”

2. FFS reimbursement is main stay for clinical encounters but ill-designed for integrated team delivery

3. Inability to connect the dots between coordination of care (CCM) *codes* for integrated team *care*

4. Difficulty in independently applying technology and clinical resources at point of care including home

UpStream

SOLUTIONS

Increase Incentives

- Support development of more provider groups (tax or financial provisions)
- Engage patients as partners – a develop compacts with patients
- Reduce regulatory requirements
- Funds to address SDOH

Minimize Risk

- Benchmark modified for high performers (less discount, more geographic weight)
- Education and Technical Assistance programs to help groups including central repository.
- Financial support to develop/buy analytics tools

Overcome Inertia

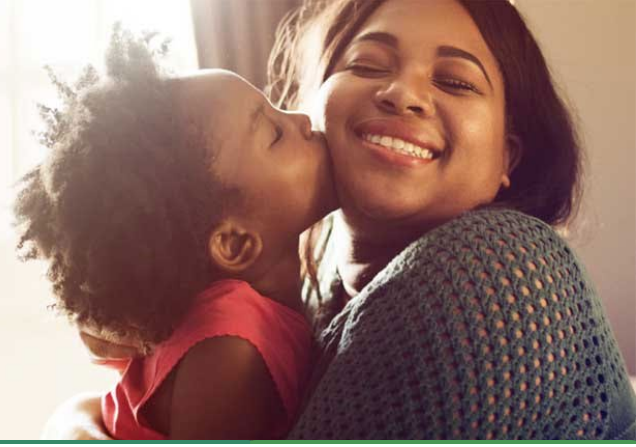
- Lower FFS schedule
- Strengthen architecture of MIPS – i.e. Minimize ability to use “uncontrollable” circumstances, maintain 5% AAPM bonus

UpStream

Presentation:
Community Care Cooperative: Moving FQHCs to VBC

Christina Severin, MPH
President and CEO,
Community Care Cooperative

COMMUNITY CARE COOPERATIVE



Community Care Cooperative: Moving FQHCs to VBC

PTAC Public Meeting on Population-Based Total Cost of Care

March 8, 2022

Christina Severin

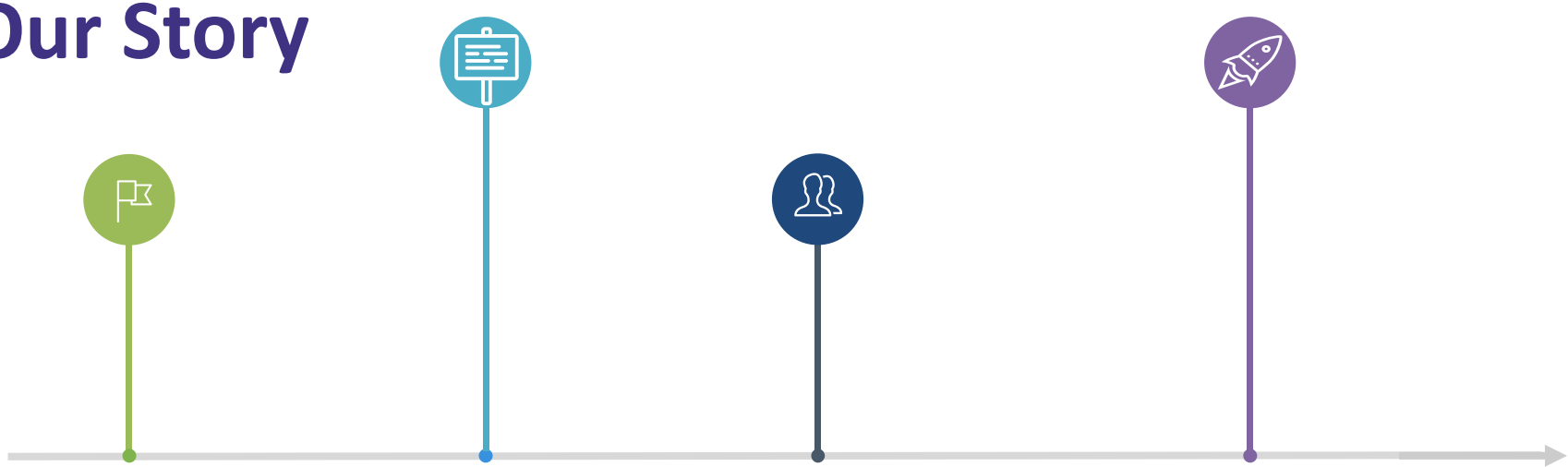
President and CEO of Community Care Cooperative

COMMUNITY CARE COOPERATIVE

Background on Health Centers & on C3

COMMUNITY CARE COOPERATIVE

Our Story



Early 2016

Nine health center leaders created Community Care Cooperative to play a leading role in a redesigned Medicaid program, facing stiff opposition

2018

We launched our MassHealth ACO with 15 health centers and 110,000 members following a one-year ACO Pilot

2019

We grew to 17 health centers serving 125,000 Medicaid members in the largest ACO in Massachusetts

2022

We are 18 FQHCs serving 170,000 members in 3 risk contracts; our BCBS and Medicare DC contracts have a primary care capitation

We have launched pharmacy and IT (Epic) services subsidiaries

We will welcome 2+ new FQHCs in 2023

Current Vision, Mission and Strategy

- Vision
  - Transforming the health of underserved communities
- Mission
  - To leverage the collective strengths of federally qualified health centers to improve the health and wellness of the people we serve
- Strategy
  - We unite federally qualified health centers at scale to advance primary care, improve financial performance, and advance racial justice
- Core values


Social Justice

Integrity


Learning


Respect

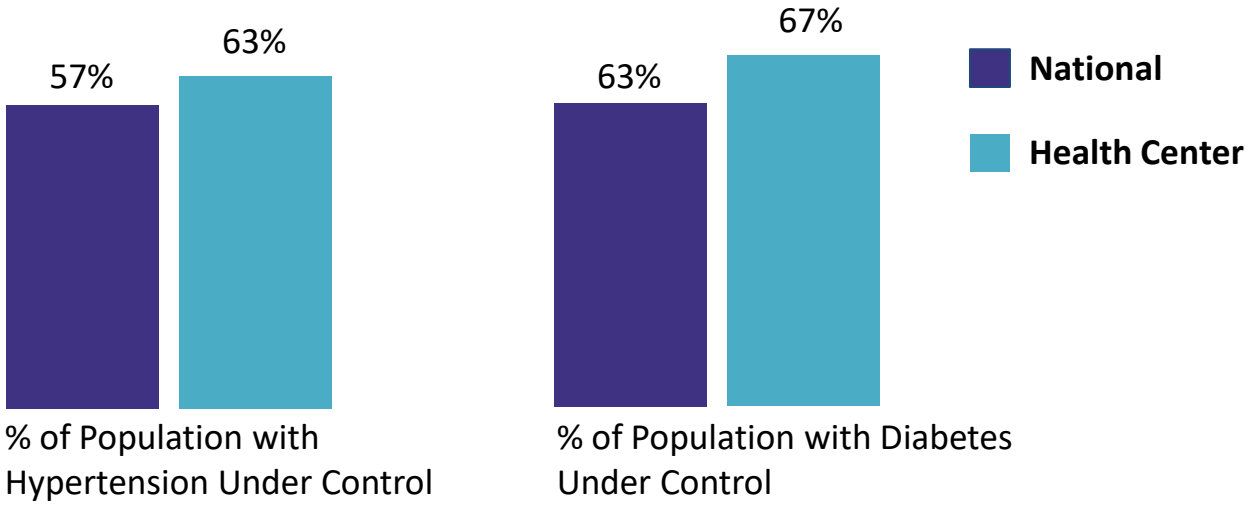

Optimism


Results

COMMUNITY CARE COOPERATIVE

Health Centers Provide *Better* Care for Patients Than Other Forms of Primary Care

Health Centers Achieve Higher Rates of Hypertension and Diabetes Control than the National Average, Despite Serving Higher Need Population



- Health centers provide more accessible and satisfying care
  - 96% of low-income patients satisfied with FQHC hours vs. 37% nationally
  - 98% of low-income patients satisfied with FQHC care vs. 87% nationally

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Source: NACHC Community Health Center Chartbook, January 2019

Health Centers Provide More *Economic Value* Than Other Forms of Primary Care

Health centers deliver ***24% lower*** total health care spending than non-health center based care…

TABLE 2—Use and Expense for Health Center Patients Compared With Matched Non–Health Center Patients: United States, 2009

Variable	Non–Health Center (n = 144 075), Estimate (95% CI)	Health Center (n = 144 075), Estimate (95% CI)	Difference,[a] % (95% CI)
Primary care			
Visits, no.	8.2 (8.2, 8.3)	7.6 (7.6, 7.7)	−7 (−8, −7)
Spending, $	1845 (1815, 1876)	1430 (1418, 1442)	−23 (−24, −21)
Other outpatient care[b]			
Visits, no.	15.7 (15.5, 15.9)	12.2 (12.0, 12.4)	−22 (−24, −21)
Spending, $	2948 (2900, 2996)	1964 (1930, 2000)	−33 (−35, −32)
Prescription drug spending, $	2704 (2664, 2744)	2324 (2296, 2352)	−14 (−16, −12)
Emergency department			
Visits, no.	1.3 (1.3, 1.4)	1.2 (1.2, 1.2)	−11 (−13, −10)
Spending, $	244 (240, 247)	216 (213, 219)	−11 (−13, −10)
Inpatient			
Admissions, no.	0.25 (0.25, 0.26)	0.19 (0.19, 0.20)	−25 (−27, −22)
Length of stay,[c] d	1.1 (1.1, 1.2)	0.8 (0.8, 0.9)	−26 (−29, −23)
Spending, $	2047 (1987, 2114)	1496 (1446, 1548)	−27 (−30, −24)
Total spending, $	9889 (9784, 9996)	7518 (7440, 7597)	−24 (−25, −23)

Source: Nocon et al, Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings, Am J Public Health 2016

COMMUNITY CARE COOPERATIVE

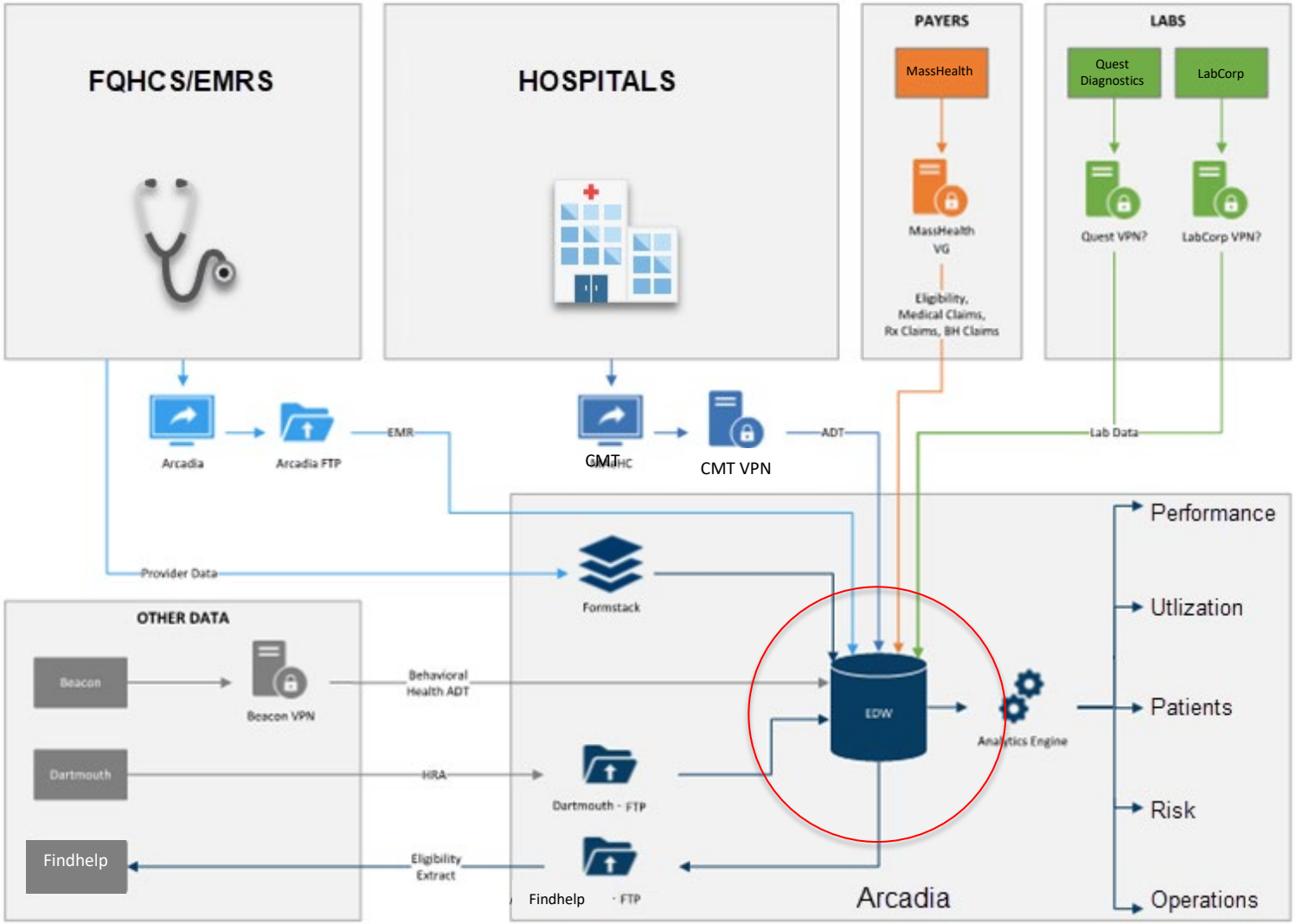
How We Started the Company

COMMUNITY
CARE COOPERATIVE

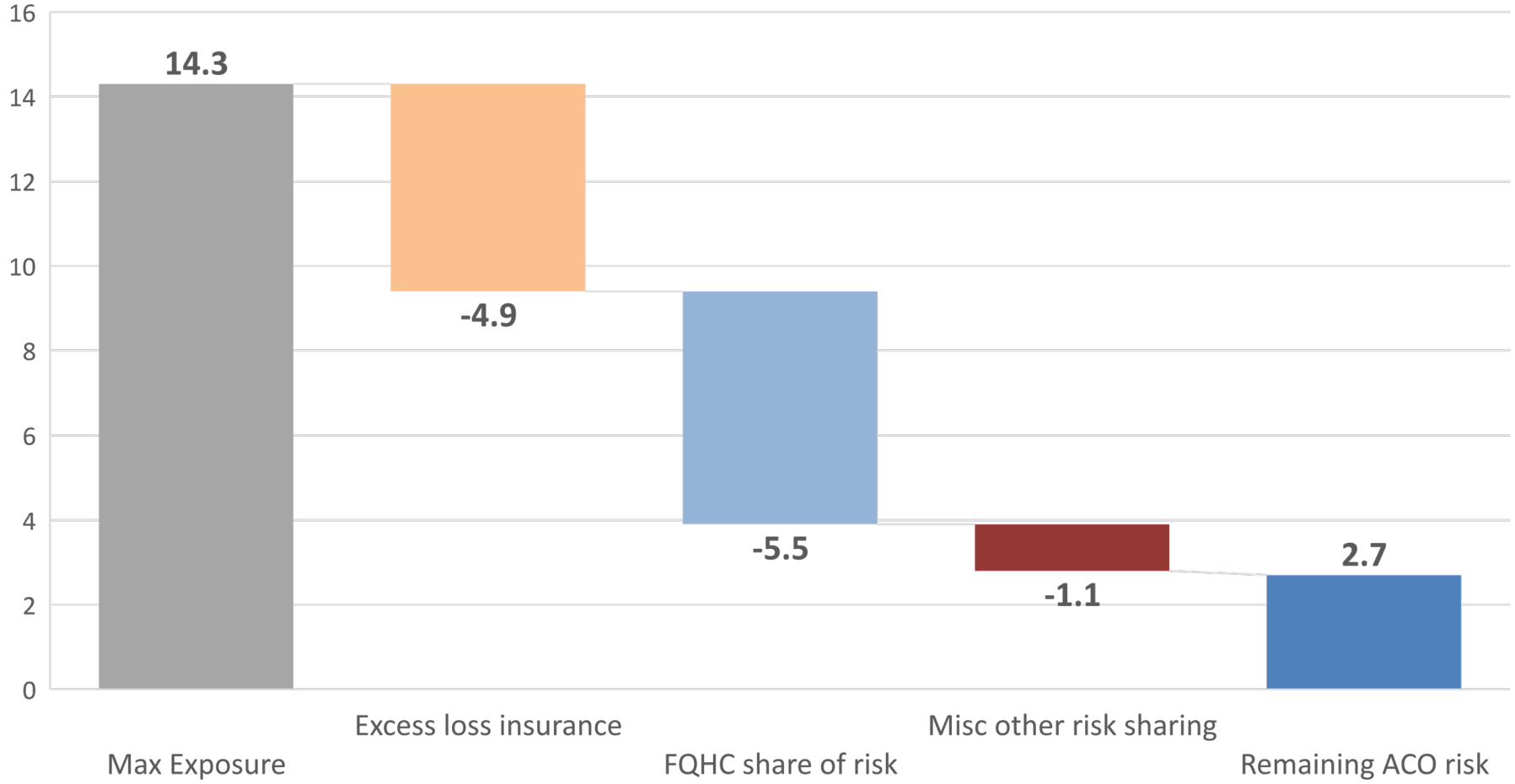
Developing and Executing a Strategy for an ACO: Operating Platform

- To take on TCOC two-sided risk, an ACO must have a strategy to harvest multiple data streams into a harmonized enterprise data warehouse (EDW)
- The EDW becomes the engine of virtually all aspects of the operating model, including:
  - Rules-based approach to workflow automation
  - Universe for performance analysis, actuarial, financial reporting, KPIs
  - Research database

Systems and Data Flows



Developing and Executing a Strategy for an ACO: How We Used a Portfolio Strategy for Risk Distribution



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The C3 Model of Care

Our Model of Care:

- ➔ Builds on existing capabilities and strengths at our Health Centers
- ➔ Integrates new MoC programs at the provider level (Health Center or Hospital)
- ➔ Improves quality of care for patients
- ➔ Brings targeted and tailored care to the entire population

How It's Been Going

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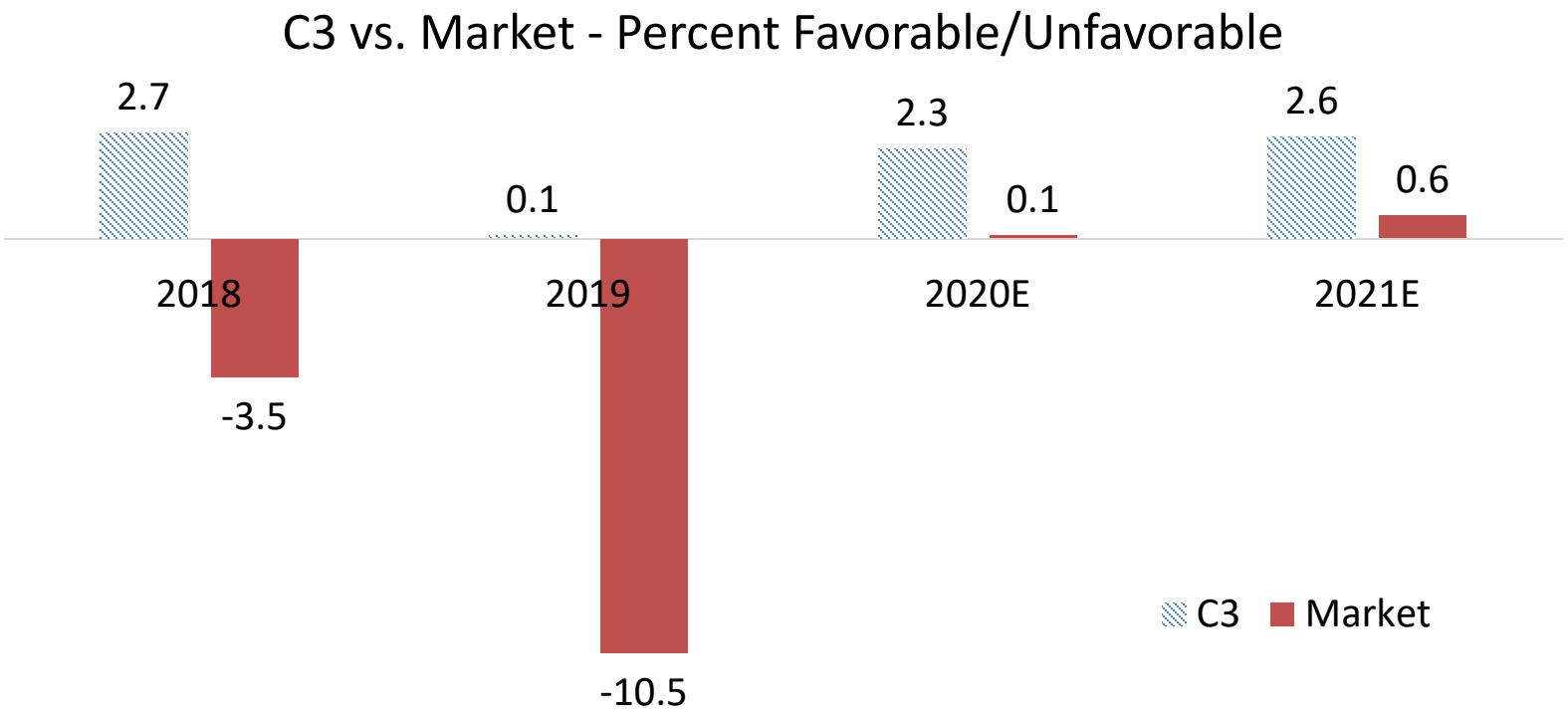
Our Total Cost of Care Performance Has Been Favorable Every Year and Market Leading



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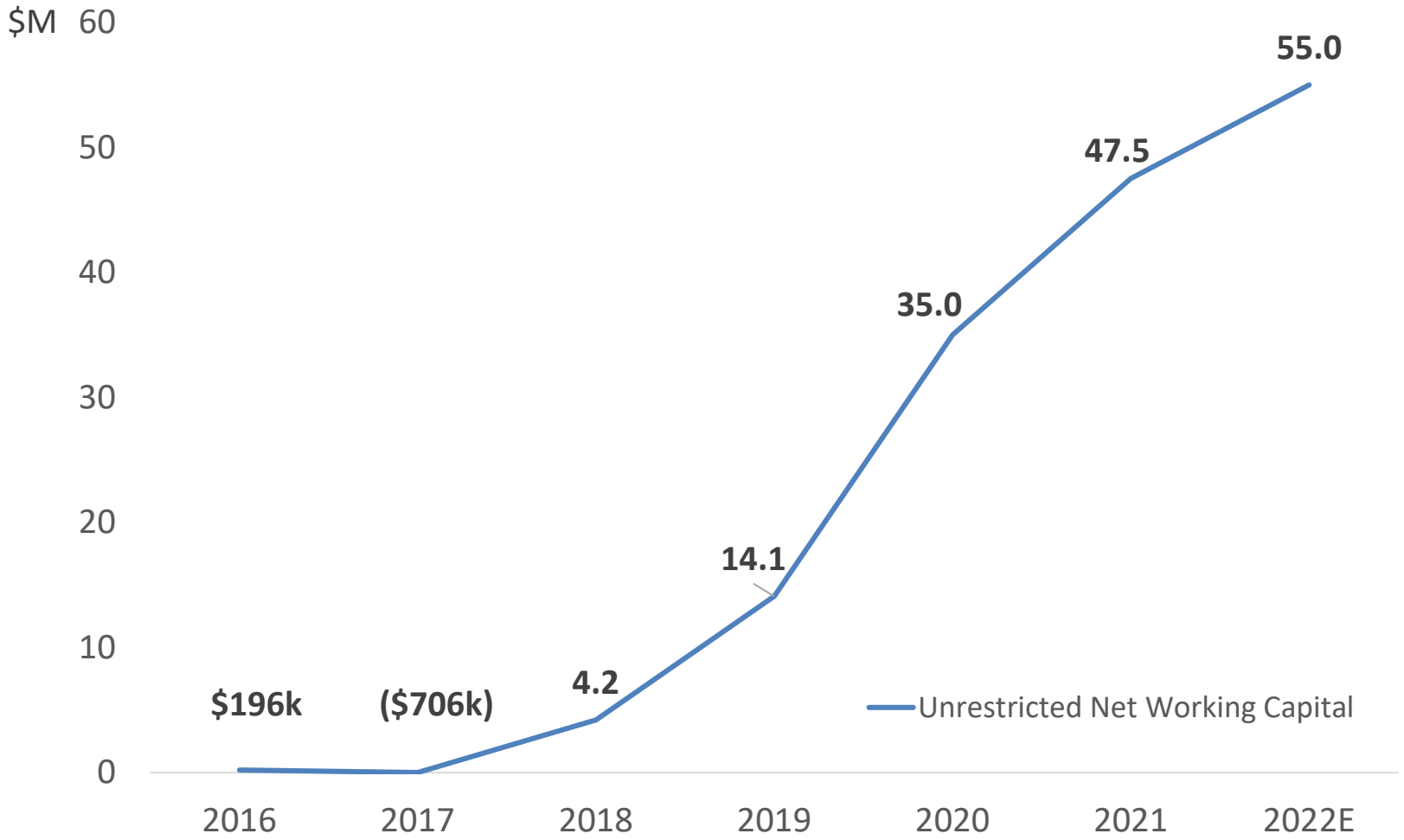
Note: Market is the sum of the largest 10 ACOs required to report to the state on their performance
Source: "4B" regulatory reporting obtained under FOIA; MassHealth/Mercer rate setting and performance reports

Growth in Balance Sheet Strength



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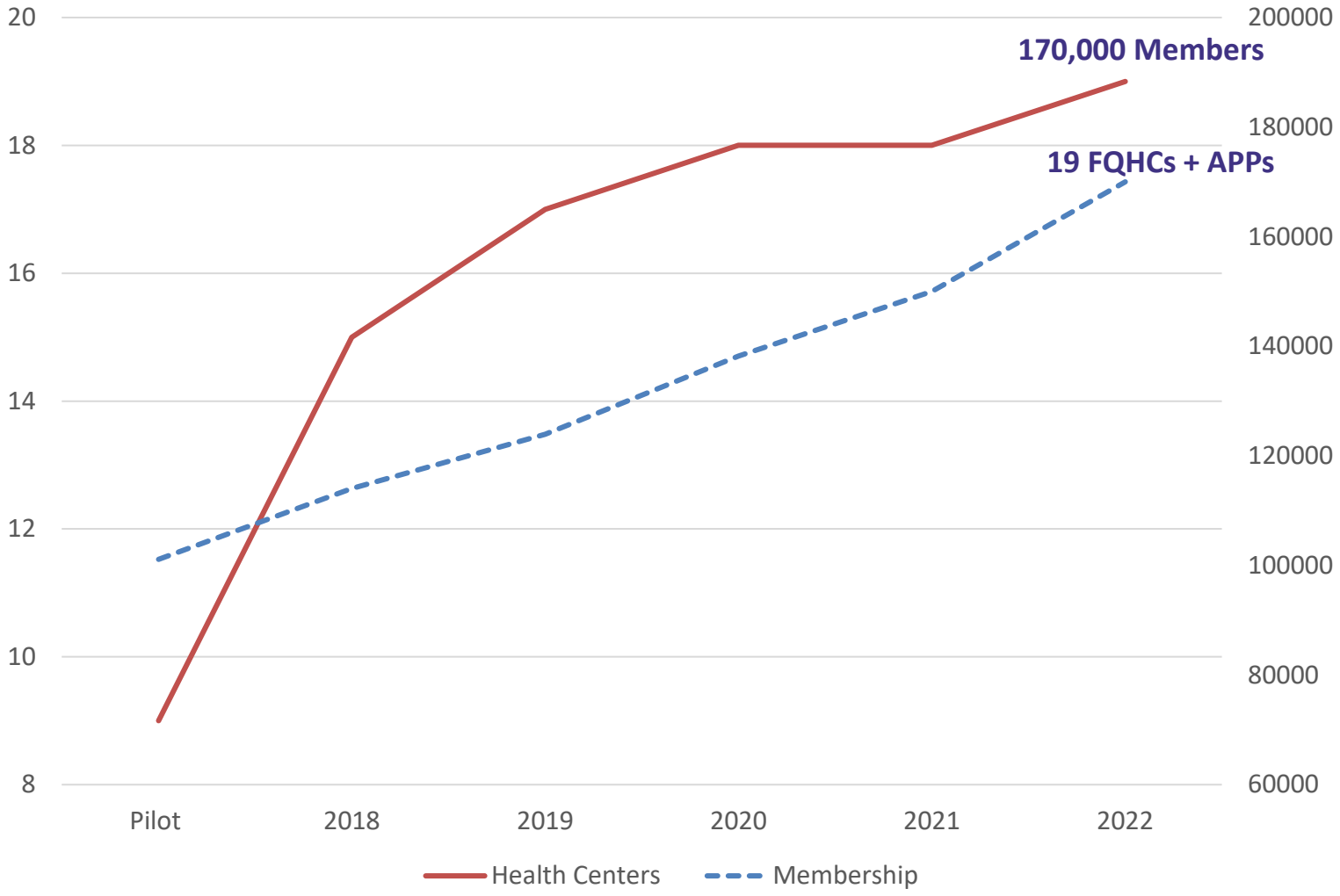
Growth



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Business Diversification: 2 New Subsidiaries

- Community Technology Cooperative (CTC)
  - Licensed Epic and converting 12 FQHCs to this EHR
- Community Pharmacy Cooperative (CPC)
  - Working with FQHCs to have them regain ownership of 340B and retail pharmacy licenses and supporting them with MSO services to run the business

What's Coming Next

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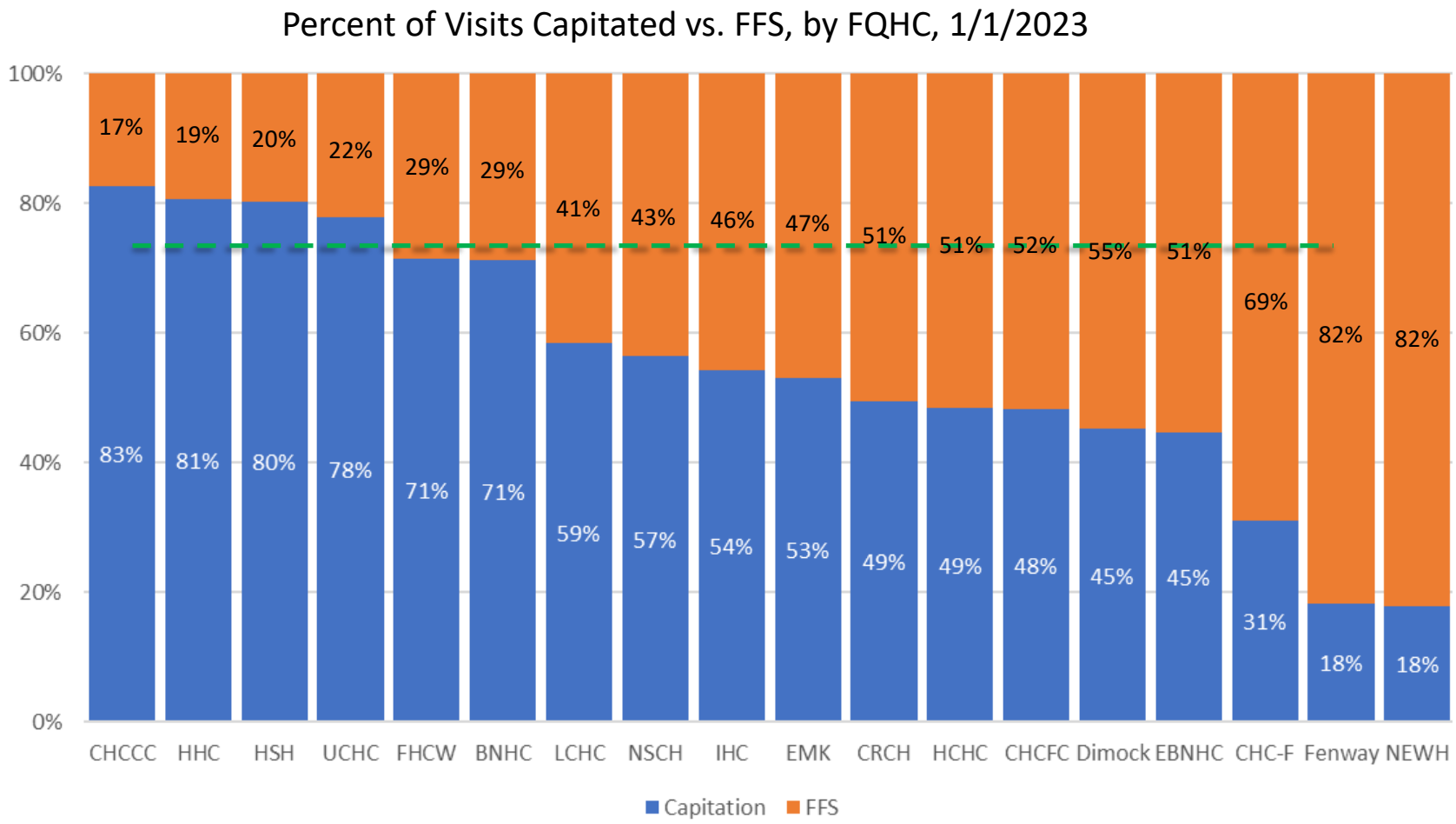
Move to Primary Care Capitation

Primary Care Capitation

- For the last several years, we have had a policy agenda of getting off of the Fee-for-Service chassis and into prospective, enhanced primary care capitation
- Primary Care Capitation will be included in the next 1115 MassHealth Medicaid Waiver
- By moving away from the need to focus on volume-driven health care, we have re-tooled our model of care based on this system of prospective payment

Goal is >70% in Primary Care Capitation



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In Summary

- We believe that the opportunity to transform primary care that health centers have been waiting for, is upon us – and this is very exciting!
- We think it is critical for FQHCs across the country to figure out how to get the support that is needed to enable them to responsibly move into Advanced Payment Models because they are THE BEST positioned to get it right from a quality, outcomes, equity and cost perspective

Thank You

Questions?

@C3aco

Community Care Cooperative

www.communitycarecooperative.org

COMMUNITY CARE COOPERATIVE

Previous PTAC Proposal Submitter Presentation:

Coalition to Transform Advanced Care (C-TAC): Voice of the Patient and Family

Jon Broyles, MSc
Chief Executive Officer, Coalition to Transform Advanced Care (C-TAC)

Gary Bacher, JD, MPA
Chief of Strategy, Policy, & Legal Affairs, Capital Caring Health

Torrie Fields, MPH
Chief Executive Officer, Votive Health

Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model proposal

Coalition to Transform Advanced Care (C-TAC) | Voice of the Patient and Family

- **Vision:** All Americans experiencing serious illness, especially those who are underserved and under-resourced, have a high quality of life – on their own terms.

- **Our Approach:** Convene and Advocate based on Core Principles for Care

- **Our Members:** Alliance of all sectors of healthcare (170+ organizations), including:

    - Health systems (Kaiser Permanente, Optum, Health Partners), health plans (Humana, Cigna, etc), Area Agencies on Aging, Hospice and Palliative Care Providers, Home-Based Primary Care Providers, etc

    - 14+ State Coalitions developing / implementing care models (e.g., Arizona - see Appendix)

    - 100+ faith leaders developing new models (Alameda Co Care Alliance – see Appendix)

TheCTAC.org

Background

- C-TAC submitted the “Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model” proposal to PTAC in 2017.

- The ACM focused on using a population health management approach for delivery of palliative care services to Medicare beneficiaries who are in the last 12 months of life.

- The proposal was recommended to the Secretary of HHS for Limited-Scale Testing.

Shirley Roberson lived with serious illness for over 14 years

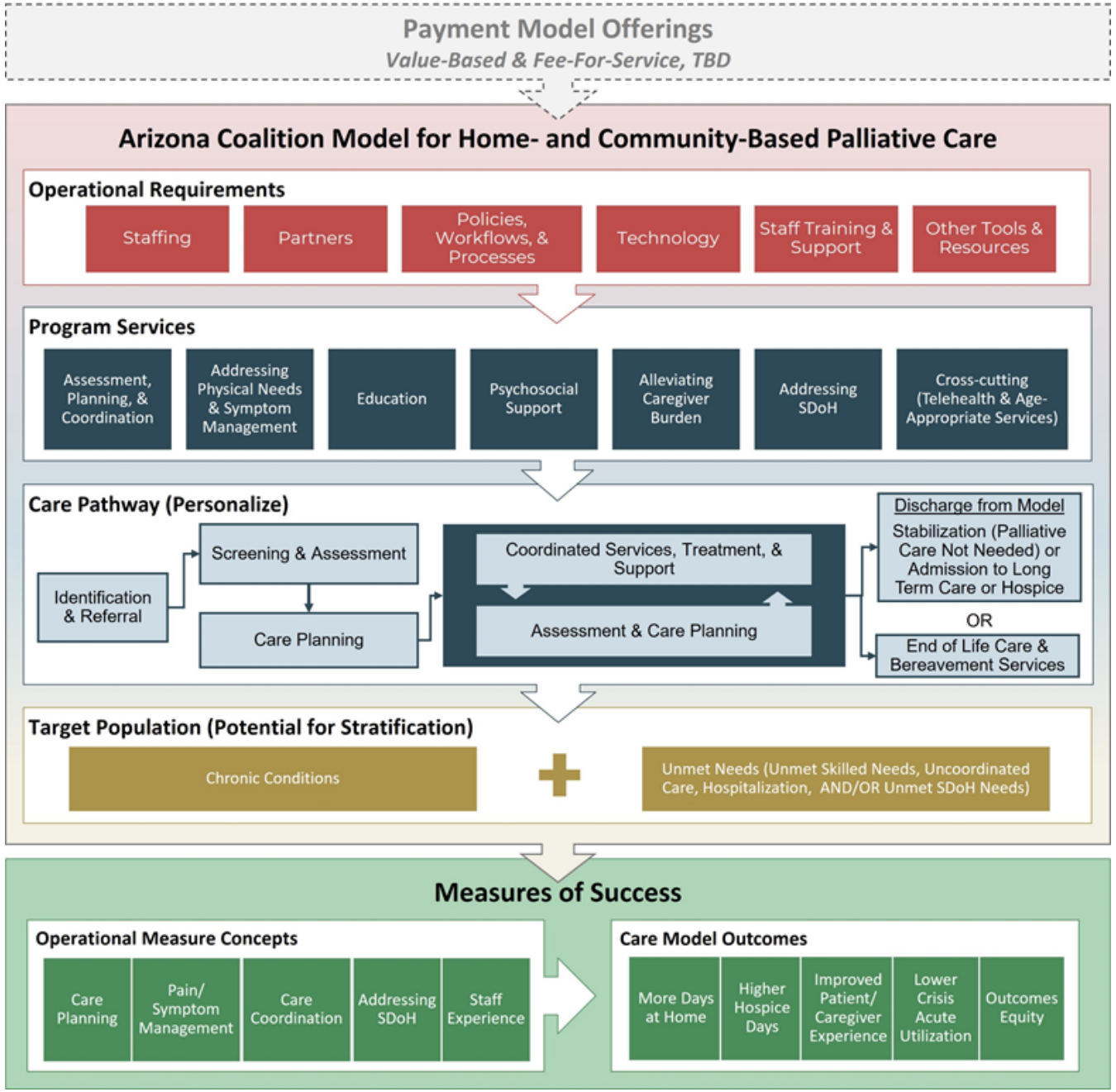
Priorities to Explore Today

1. **Systematically identify and assess** populations with serious illnesses and their caregivers
2. Support CBO Infrastructure
3. **Explore payment options and support for high-value CBO services** that could be adopted across payer contexts

Appendix –Innovative CBO Models (examples from our membership)

- Arizona Coalition model
  - Care Model developed after 18 months of coalition building w/ 40+ orgs
  - Needs: Payment model design and pilot

- Alameda County Care Alliance (ACCA) Advanced Illness Care Program
  - Pilot underway with Kaiser Permanente serving 400 people
  - Needs: Capacity Building



The Arizona Coalition Model

azhha.org/az_model

AzHHA Arizona Hospital and Healthcare Association

C-TAC COALITION TO TRANSFORM ADVANCED CARE

DISCERN HEALTH

Arizona END OF LIFE CARE PARTNERSHIP

Anchored at United Way of Tucson and Southern Arizona

ACCA Advanced Illness Care Program™
Five Cornerstones

Series of 5-12 meetings between the Care Navigator and Person Needing Care or Caregiver over approximately 6 months

Program is personalized to individual participants' needs

Spiritual Needs

Prayer, meditation, and faith community support

Health Needs

provider communication, physical and emotional support

Planning for Advance Care

Understanding, choosing and documenting advance care choices

Social Needs

Transportation, meals, housing, socialization, financial/legal

Caregiving Needs

Respite care, support groups, support for caregivers

➢ ***Identify needs, provide trusted referrals/resources, empower individuals with tools & training***