Listening Session Part 1 on Assessing Best Practices in Care Delivery for Population-Based TCOC Models

Presenters:

Subject Matter Experts
- Debbie Zimmerman, MD, Corporate Chief Medical Officer, Lumeris
- David Kendrick, MD, MPH, Principal Investigator and CEO, MyHealth Access Network
- Yi-Ling Lin, Healthcare Actuary & Financial Strategist, Terry Group

Previous Submitter
- Shari M. Erickson, MPH, Chief Advocacy Officer and Senior Vice President, Governmental Affairs and Public Policy, American College of Physicians; The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version) proposal
Presentation: 

*Lumeris Model and Total Cost of Care*

Debbie Zimmerman, MD

Corporate Chief Executive Officer, Lumeris
Lumeris Model and Total Cost of Care

EHI MO / IL

Dr. Deborah Zimmerman
Corporate Chief Medical Officer
Lumeris Drivers and Outcomes

Essence Healthcare
64,000 Member MAPD Plan in MO/IL

**DRIVERS**

- Aligned Incentive Payer/Employer Contracting
- Effective Compensation & Incentives
- Care Delivery Transformation & Delivery of Accountable Primary Care (Nine C’s®)
- Enterprise Engagement
- Ideal Leadership & Organizational Structure
- Powerful Technology & Information

**OUTCOMES – Triple Aim Plus One**

- **Reduced Per Capita Costs of Care**
  - 26% lower costs vs. FFS Medicare

- **Improving the Health of Populations**
  - Average of 4.5 Stars for the past twelve years, 5 Stars for 2022

- **Increasing Physician Engagement**
  - 89% of providers rate they are satisfied w/collaborative payer

- **Improving the Consumer Experience of Care**
  - Highest consumer satisfaction

*Health System, Facility, Others…
Sources: 2016 AON Actuarial Study, 2019 Provider Satisfaction Summary, CMS Star Ratings
Essence Healthcare - A Collaborative Payer

Every member attributed to an accountable primary physician

PATIENT

Every accountable physician part of a group

GROUP

Every group in a value-based contract

GROUP

Best Practices in TCOC Alignment

- Primary Care providers must be aggregated into groups
- 100% of Primary care groups have TCOC incentives
- TCOC includes all costs – Medical and Pharmacy, Capitated services, Reinsurance, Rebates
- TCOC incentives balanced with Quality and Access
- Complete transparency into cost of care
- EHI and Medical groups share in surplus for total alignment
- Level of risk varies depending on Medical group capabilities
- EHI invests in service to assist groups in managing population
  - Care Management
  - Physician Engagement staff
  - Medical Group Collaboration
  - Data and Analytics
Delivering Total Population Management

**Decreased** spend in high-risk patients through effective management of complex patients and **increased** spend in low-risk patients for preventive care to promote health and wellness.*

### PMPM Cost by Normalized Risk Score Band

**Increased spending in low-risk patients by 44%**

**Decreased spending in high-risk patients by 57%**

*Source: 2016 AON Actuarial Study*
Reducing Unnecessary Costs & Utilization

New care model shifts utilization to more appropriate sites of service compared to FFS Medicare.*

- **48%** Reduced specialist spending
- **18%** Fewer readmissions
- **26%** lower costs
- Outpatient facility surgery spending **1.5x** higher
- SNF costs **52%** lower
- Lowered inpatient costs by **23%**
- Maintained **1.2% cost trend** vs. 4-5% national average*
- Spending for primary care **34%** higher

*Source: 2016 AON Actuarial Study
Aligned Incentive Payer / Employer Contracting
Effective Compensation and Incentives

Aligning value-based incentives at the group and individual levels is essential for transforming the business model.

**Value-Based Contract Incentives**

Evaluate organization’s maturity along risk spectrum:

- Early incentives around behaviors necessary to manage populations
- Move to TCOC balanced with Quality and Access
- Collaborate on goal setting
- Evolve incentives to advance risk
- Complete transparency in performance and cost of care
- Leverage physician leadership as plan advisors

**Value-Based Compensation**

Align physician compensation with payer contract:

- Tie payment to measurable incentives
- Cost, quality, access, patient satisfaction, involve physicians
- Encourage team accountability with combination of group and individual incentives
- Differentiate high performance
- Advance over time
- Foster transparency and comparative performance
- Goal of 30-50% of compensation tied to value

**OUTCOMES**

- Upside only
- Upside + downside risk with quality incentives

*Lumeris client data

Advanced provider groups along risk tiers
Care Delivery Transformation / Delivery of Accountable Primary Care

Population-based care is most effective when guided by physicians, supported by payers.

Care Delivery Model Design
- Define delivery of accountable primary care
- Leverage existing programs and resources
- Evaluate care team capabilities
- Use next generation analytics to define opportunities
- Develop population-specific programs

Care Management Programs
- Structure programs and support based on maturity
- Avoid duplication and redundancy
- E.g., Transition, Complex Case, Quality Campaigns
- Multidisciplinary team as needed
- Review program impact and adapt operations

OUTCOMES*

- 6-8% improvement in medication adherence
- 18% fewer readmissions compared to FFS Medicare
Deep Dive: Practice Transformation in Market

EHI provider engagement teams support physicians as they transition to a new care delivery model.

1. Nine C’s & Act Visits
   - Approx. 1 Population Health Manager per 20 practices
   - Intro Meetings
   - Understanding the contract/model
   - Workflow analysis
   - Introduction to the platform and Nine C’s
   - Performance reviews

2. Workflow Transformation
   - Clinical nurse specialists focused on workflow transformation
   - In-person observation of practice operations
   - Recommendations tailored to capabilities, resources, Nine C’s
   - Leverage technology to reduce administrative burden

3. Physician Boot Camp
   - One-day accountable physician training
   - Transform into an Accountable practice
   - Understand how to evaluate your performance
   - Identify opportunities for improvement
   - CME credit
Enterprise Engagement
Ideal Leadership and Organization

The right network and governance structure help drive physician mind share and accountability—for new and existing provider groups.

Leadership and Network development
- Strategic commitment to value-based care
- Identify and mentor clinical leaders
- Ensure panel density and network adequacy
- High performing network or create “network within network”
- Identify variation and work to reduce over time

Organization
- Enact collaborative governance structure
- Leverage existing forums
- Set cadence for ongoing meetings and communication
- Review performance regularly, sharing best practices, shared accountability
- Align strategy and operations

OUTCOMES*

800+ physicians recruited to clinically integrated network including specialty and primary care, independent and employed physicians

Effective governance established medical director, POD, and JOC meetings to drive physician alignment

*Lumeris client data
Defining the POD Governance and Leadership Structure

What is a POD?
• A Pod is a group of physician practices that share similarities around geographic region and/or patient panels
• All providers within the Pod will share a physician lead and population health manager
• Medical leadership aligned to Pods to provide oversight

Participation in a POD will:
• Promote best practice sharing amongst similarly structured provider groups
• Assess quality and cost performance among the group
• Identify operational success, opportunities, and barriers
• Drive data transparency and information usage

Example Physician Engagement Pod Structure

Leadership

Pod 1
Physician Leader
~10-20 PCPs

Pod 2
Physician Leader
~10-20 PCPs

Pod Leader Attributes
• Well respected by peers
• Have the ability to influence behavior
• Early adopter of technology and processes
• Open and accepting to change
• Understanding and support for Value Based Care physician incentive models

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Powerful Technology and Information

Population Health Executives  Clinicians & Care Team

Business Intelligence  Clinical Intelligence

Machine Learning Insights Engine – Risk and Predictions

Lumeris Measures Calculations  Population Health Analytics

Data Ingestion and Transformation

Data Sources

EHR | Payor | HIE | Pharmacy | SDoH | Open Data | Devices | Consumer | Patient Communications

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Presentation: *Infrastructure for Innovation: Lessons from the Front Lines*

David C. Kendrick, MD, MPH

Principal Investigator and CEO,
MyHealth Access Network
Infrastructure for Innovation: Lessons from the Front Lines

Health Information Exchange
Health Data Utility

David C. Kendrick, MD, MPH
Disclosures

David C. Kendrick, MD, MPH
• CEO, MyHealth Access Network
  – Oklahoma’s Statewide Health Information Exchange
• Chair, Department of Informatics, OU School of Community Medicine
• Assistant Provost for Strategic Planning, OU Health Sciences Center
• Founder of MedUnison, LLC and developer of Doc2Doc
• Immediate Past Chair, Board of National Committee for Quality Assurance
• Board, Patient Centered Data Home, nationwide interoperability model
# Experience with CMMI Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Roles</th>
<th>Timing</th>
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</table>
| Comprehensive Primary Care Initiative (CPC Classic) | • Convener  
• National Faculty  
• Data Aggregator                        | 2012-2016  |
| CPC+                                        | • Data Aggregator  
• National Faculty  
• Convener                                     | 2017-2021  |
| Accountable Health Communities             | • Principal Investigator  
• Bridging Organization                       | 2016-2022  |
| Primary Care First                         | • Event Alerting  
• Proposed:  
  • Data Aggregator  
  • Social Determinants of Health Screening  
• Convener                                     | 2022-?     |
Lessons Learned

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   b. Consider including potential model participants in the model design process, piloting any complex process elements

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   a. Scope of data available to providers is critical
   b. Patient attribution is a difficult concept for providers and is not accounted for in their internal analytics
   c. Provide Alerting services for Sentinel Events

3. Performance measurement and reporting:
   a. Community-wide quality measurement required for true performance results
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   a. CPC/CPC+: Effective care coordination requires HIE, electronic referral and consultation technology
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   c. AHC: SDoH screening and intervention can be done at scale and actually reduce provider burden
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Comprehensive Primary Care “Classic”

>$100M in Care Management and Practice Transformation fees to PCPs

- 68 practices, 265 docs
- OK Payers require MyHealth Participation
- >30 hospitals affiliated

- Four payers (BCBS, CCOK, Medicaid, Medicare)
- >90% of covered lives
- Shared savings Y3-4
Lessons Learned

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Claims Data
Claimed diagnoses, procedures, medications

EHR 1
EHR 2
EHR 3
EHR 4
EHR 5
EHR 6
EHR 7
EHR 8
EHR 9
EHR 10

Patient A
Patient B
Patient C
Patient D

Independent Pharmacies
SureScripts
Public Health Department
Federal Source (VA/DoD/IHS)

Patient Out of Pocket
Oklahoma’s Patient Data Fragmentation quantified

70% of attributed patients in MyHealth have records in 2 or more systems

Corroboration: Average PCP must coordinate care with 225 other providers in 117 other organizations

Pham, HH, NEJM 2007; 356: 1130-1139
Diabetes patients with records elsewhere

86% of all diabetes patients have data in 2 or more other provider organizations
Data fragmentation by EHR Vendor
>1400 locations serving >110,000 patients daily
MyHealth Patient Population
Lessons Learned

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Who are my patients?

Attribution can be confusing, but is critical to understand . . .

<table>
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<tr>
<th>T-36m</th>
<th>T-30m</th>
<th>T-24m</th>
<th>T-18m</th>
<th>T-12m</th>
<th>T-6m</th>
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- Patients I’ve Seen
- Payer 1 attribution
- Payer 2 attribution
- Payer 3 attribution
- Payer 4 attribution
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Care Fragmentation Alerting
30-day readmission monitoring

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Trusted 3rd Party for Measurement

- MyHealth Analytics: Trusted Third Party
  - Clinical Data
  - Payer
    - Claims
  - Provider
    - Claims
  - Voluntary All Payer Claims Database
  - Payer-specific Metrics
    - ER Utilization
    - Admissions
    - Prescription drug use
    - Etc.
  - Provider-specific Metrics
    - Clinical outcomes
    - BP mgmt
    - DM performance
    - Etc.
  - Health Information Exchange
Example: HbA1c control– what is the correct answer for each provider? Patient? Payer?

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<th>Claims: Medicaid</th>
<th>Claims: Commercial 1</th>
<th>Claims: Commercial 2</th>
<th>Claims: Commercial 3</th>
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</tbody>
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Patient A: 12.1% 9%

Patient B: 6.9% 7.5%

Patient C: 9.8% 10.5%

Patient D: 7.6% 8.5% 10% 8%

SureScripts

Independent Pharmacies

Federal Source (VA/DoD/IHS)

Claims: Medicare

1.12

7.5%

6.9%

9.8%

10.5%

8.5%

10%

8%

7%

8.6%
Take 3 diabetes measures: 1) Appropriate Testing, 2) Control <8, 3) Out of Control >9

<table>
<thead>
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<td>50%</td>
<td>100%</td>
<td>50%</td>
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<td>7.6%</td>
<td>8.5%</td>
<td>10%</td>
<td>8%</td>
<td>Patient D</td>
<td>8%</td>
<td>10%</td>
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<tr>
<td>Patient B</td>
<td>6.9%</td>
<td>10.5%</td>
<td>9.8%</td>
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<td>7%</td>
<td>9.8%</td>
<td>Patient C</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
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<td>7.5%</td>
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<td>Independent Pharmacies</td>
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<td>SureScripts</td>
<td>6.9%</td>
<td>10.5%</td>
<td>9.8%</td>
<td>10%</td>
<td>7%</td>
<td>7%</td>
<td>Federal Source (VA/DoD/IHS)</td>
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<tr>
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Claims: Claims: Claims: Claims: Claims: Claims: Medicare

Patient A: 12.1%
Patient B: 9%
Patient C: 8%
Patient D: 8%

NA: Not available
100%: Data present
0%: Data not available
Take 3 Diabetes Measures:

Isn’t this what we really want to know?

Payers will get multiple scores on the same patient—what do they do with that?

Looking at populations, we cannot roll these up . . .
Patient-centric measurement
Measure once, reuse many times for many perspectives...

+ = patients that count positively to eCQM’s
- = patients that count negatively to eCQM’s
E = patients that are excluded from eCQM’s

eCQM’s calculated in real time based on changes in a patient’s cross-community data by placing a box around any portion of a population.
Lessons Learned

1. Model design:
   a. Multi-payer models produce scale and reduce provider burden, but must be self-governed for commercial payers to trust them
   b. Consider including potential model participants in the model design process, piloting any complex process elements

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   c. Provide Alerting services for Sentinel Events

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   d. All: Transformation takes time- progress appears to be proportional to dwell time

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   a. Common infrastructure required for most innovation models
   b. Starting up and winding down is expensive and wastes model time and resources
   c. The roles of convening and training matter, especially where multiple organizations are working together
   d. Using subcontractors can disintermediate the community from CMMI- consider regular direct meetings
CPC+ Expenditures by Product Line
Lessons Learned

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Pre-Community-Wide Care Transition Management

- Understaffed
- No written procedures in place
- No quality monitoring or backup procedures
- Initial contact: 4-60 days
- 50 to 3,000 referrals behind
- Many simply dropped
ALL Observed Transitions Between Visit Request Statuses

Symbol Interpretations
- Arrows represent transition from one referral status to another
- Arrow thickness is proportional to # of transitions
- Status color represents relative length of time consults remain in each status (compared to others in this subset): red = longest; green = shortest
- Status states are abbreviated
Community-wide Care Transitions Process

- All communications electronic and logged
- Status of referral events clear to all involved parties
- No faxes, no printing: All records sent electronically to receiving provider
- Sending providers given the software, trained in 0.5 days
- Enables sending and receiving provider to meet meaningful use for care coordination, with or without an HIE
Results: A Tale of Two Clinics

Clinic 1:

Visit Request Status as of August 31, 2011 by Month Initiated:

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number Initiated</td>
<td>409</td>
<td>361</td>
<td>442</td>
<td>363</td>
<td>362</td>
<td>324</td>
<td>325</td>
<td>285</td>
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<td>426</td>
<td>433</td>
<td>457</td>
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<tr>
<td>Pending Appointment</td>
<td>154</td>
<td>172</td>
<td>277</td>
<td>211</td>
<td>165</td>
<td>160</td>
<td>211</td>
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<tr>
<td>Consult in Progress</td>
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<td>4</td>
<td>2</td>
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<td>8</td>
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<td>Visit Occurred: Report Pending</td>
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<td>Cancelled by Receiving Provider</td>
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<tr>
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Clinic 2:

Visit Request Status as of August 31, 2011 by Month Initiated:

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<td>0</td>
<td>6</td>
</tr>
</tbody>
</table>

Clinic 1: 12 months of care transitions

- Cancelled
- Complete
- Incomplete

Clinic 2: 12 months of care transitions

- Cancelled
- Complete
- Incomplete

My Health Access Network
eConsultations to optimize care transitions
Results: eConsultations in Medicaid

• Patients receiving an online consult had a significant reduction in PMPM cost of care when compared with themselves as historical controls:
  – $140.53 Pre Consult vs. $78.16 Post Consult
  – Net savings of $62.37, p=0.021

• Compared with patients who received a referral but NOT a consult:

<table>
<thead>
<tr>
<th>Cost Type</th>
<th>Mean PMPM Cost Change</th>
<th>Mean Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Costs (UB92)</td>
<td>-$13.00</td>
<td>-20%</td>
</tr>
<tr>
<td>Professional Costs (HCFA 1500)</td>
<td>-$108.04</td>
<td>-34%</td>
</tr>
<tr>
<td>Pharmacy Costs (PBM)</td>
<td>-$9.14</td>
<td>-14%</td>
</tr>
<tr>
<td>Total Costs</td>
<td>-$130.18</td>
<td></td>
</tr>
</tbody>
</table>
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MyHealth now working with social needs and early childhood programs, where data is even more fragmented . . .
Accountable Health Communities: Statewide Screening for Social Needs
Accountable Health Communities: CRS

4,857 Resources in CRS Database, All 77 Counties in OK Covered by CRS Database
Accountable Health Communities: CRS

Thank you for completing the Accountable Health Communities Survey!

Listed below are free or reduced cost resources that could help meet your needs. We strongly encourage you to call ahead before you visit any service or program! It is important to confirm the hours the program is open, the qualifications for the program and how they can help before you visit any location.

For additional resources, you can text your zip code to 898-211, call 2-1-1 or visit www.211ok.org

---

Food

**BOSTON AVENUE HELPING HANDS**

Provides food to clients every 6 months. Must bring some form of ID

- **Phone**: 918-562-1300
- **Address**: 709 S Boston Ave
  Tulsa, OK 74119
- **Website**: https://www.firstchurchtulsa.org

---

Living Situation

**DAY CENTER FOR THE HOMELESS**

Provides shelter for women and men.

- **Phone**: 918-583-5568
- **Address**: 415 W Archer St
  Tulsa, OK 74103
- **Website**: https://www.firstchurchtulsa.org

---
AHC by the Numbers
(August 2018 – May 15, 2021)

2,792,000+ Offers to Screen

477,000+ Responses

94,000+ Responses with a Need

152,000+ Individual Needs Reported

11,200+ Eligible Navigation Cases

Medicare and Medicaid Only

13,400+ Navigation Needs Resolved

Medicare and Medicaid Only

Accountable Health Communities
Approx. 1 in 3 responses from the ER report at least 1 need compared to approx. 1 in 5 in a primary care setting.
MyHealth AHC Need Rates by Insurance Type

![Chart showing need rates by insurance type](chart.png)
Cycle of Improvement

CMMI CPC+ DA ended in 2021!

Total Cost of Care and Utilization

Social Needs Screening & Intervention

Alerting to Sentinel Events

CMMI AHC ends in 2022!

All three together will maximize the impact
Preliminary Results!
Preliminary Results!
Putting it all together

Clinical

Claims/Cost

Sweet Spot

SDoH
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Preliminary Results!

Note: CommunityCare of Oklahoma data is still under review and validation at this time; we will update this note once it is finalized and ready for use.
Preliminary Results!
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   d. Using subcontractors can disintermediate the community from CMMI- consider regular direct meetings
Common Infrastructure Ingredients needed for Most Models

- Governance/Trust
- Clinical Data
- Claims Data
- Analytics & Measures
- Alerting on Sentinel Events
- Actionable Results
>1400 locations serving >110,000 patients daily

Oklahoma Non-Profit, 501c3
Established in 2009:
more than... 
- 4M individuals with
- 12 years of clinical history
- 8 years of claims data
- 4 years of SDoH data
Potential innovation labs nationwide
Lessons Learned

1. Model design:
   a. Multi-payer models produce scale and reduce provider burden, but must be self-governed for commercial payers to trust them
   b. Consider including potential model participants in the model design process, piloting any complex process elements

2. Model execution:
   a. Scope of data available to providers is critical
   b. Patient attribution is a difficult concept for providers and is not accounted for in their internal analytics
   c. Provide Alerting services for Sentinel Events

3. Performance measurement and reporting:
   a. Community-wide quality measurement required for true performance results
   b. Incent providers to take on the sickest patients by measuring and rewarding *improvement* at the individual patient level rather than achievement of an arbitrary numerical goal on average.
   c. Use at least some common metrics across all models to facilitate comparisons
   d. More rapid interim and final results to avoid ending models and losing the investment in process and infrastructure

4. Model-specific feedback:
   a. CPC/CPC+: Effective care coordination requires HIE, electronic referral and consultation technology
   b. CPC/CPC+: Chronic Care Management codes may have blunted the impact of primary care transformation models
   c. AHC: SDoH screening and intervention can be done at scale and actually reduce provider burden
   d. All: Transformation takes time- progress appears to be proportional to dwell time

5. Infrastructure for Innovation:
   a. Common infrastructure required for most innovation models
   b. Starting up and winding down is expensive and wastes model time and resources
   c. The roles of convening and training matter, especially where multiple organizations are working together
   d. Using subcontractors can disintermediate the community from CMMI- consider regular direct meetings
Discussion

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Presentation: *Population-Based Total Cost of Care Models – An Actuarial Perspective*

Yi-Ling Lin
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Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Population-Based Total Cost of Care Models – An Actuarial Perspective

June 7, 2022
Beyond the Numbers: Three Structural Change Imperatives

1. Use of Historical Data
2. One-Year Time Horizon
3. Use of Risk Scoring

There are many other imperatives — incentive alignment, data sharing, true cost vs. price analysis (via fee schedule), health equity, etc.

These 3 are the most foundational elements to move the needle in the right direction.
Using Historical Data

• Over-reliance on historical data perpetuates what’s been done in the past

• Trend is a measure that anchors to the past
  – No anchor to the desired future state

• Organizations that manage well compared to last year are essentially punished with lower targets next year
  – Encouraged to just barely achieve targets
The One-Year Time Horizon

• Health is a long-term issue

• One-year measures encourage management to that timeline
  – What’s the ROI?
  – Lack of planning for “non-normal” years
    – Management of reserves
    – Supply chain
    – Inflation and Inverted Medical CPI
    – Endemic, Mental Health and Social Trauma
Use of Risk Scoring

• Risk scores are a predictor of cost, not a reflection of need, and thus a tool for allocating cost, not a tool for personalizing healthcare

• Incorporating SDOH is a step in the right direction, but often SDOH are proxies
  – Income, zip code, race, etc. are not data about actual need
  – Mixing a cost predictor with a tool for allocating resources

• Investment should
  – Support deployment to all patients not just those covered under APMs
  – Tailor treatment appropriately to match the need for all patients
Contact

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Presentation:

*The Medical Neighborhood Advanced Alternative Payment Model*

Shari M. Erickson, MPH

Chief Advocacy Officer and
Senior Vice President,
Governmental Affairs and Public Policy,
American College of Physicians

*The "Medical Neighborhood" Advanced Alternative Payment Model (AAPM) (Revised Version) proposal*
Listening Session on Assessing Best Practices in Care Delivery for Population-Based Total Cost of Care (PB-TCOC) Models

PTAC Public Meeting, June 7, 2022

Shari M. Erickson, MPH
Chief Advocacy Officer and Senior Vice President, Governmental Affairs and Public Policy
The Medical Neighborhood Advanced Alternative Payment Model

- Patient-Physician collaboration – agree that a specialty referral is appropriate
- Referral to a specialty practice
- Specialty practice pre-screens referral and accompanying documentation
- Visit – triggers and “active phase” of attribution
- Specialty practice role may vary – could co-manage the patient’s treatment or be the primary manager
Best Practices for Overall Clinician Engagement in Accountable Care Arrangements

• Focus on the development and implementation of a more limited set of measures that are patient-centered, actionable, appropriately attributed, and evidence-based measures for public reporting and payment purposes, while also supporting the use of additional clinically meaningful measures for internal quality improvement.
  • Incentivizing the use of QI measures will allow for greater innovation opportunities and will engender trust; establish “safe harbors”
  • Move toward measurement at the practice level rather than at the level of the individual clinician.
  • ACP has reviewed internal medicine-relevant measures for validity – prioritize use of these
  • Also prioritize measures focused on prevention – e.g., cancer screening; SBIRT for tobacco, alcohol, and drug use

• Performance targets must be provided to physicians and their clinical care teams in a prospective and transparent manner and that all performance feedback be accurate, actionable, and timely (provided at least quarterly). Appropriate attribution and benchmarking are critical!
  • Voluntary patient attribution is the gold standard
  • Patient-relationship codes are promising form of attribution
  • Absent these, robust case minimums should be used
  • Benchmarks should be fixed across all participants; relative benchmarks create arbitrary winners and losers
  • Prospective benchmarks should be set using the most current data available (perhaps via shorter performance periods)
• PC and/or SC work collaboratively with the patient to establish a care plan.
  • Customized to account for individual patient and family circumstances and preferences

• Utilize care coordination agreements between primary care and specialty care practices that allow for all involved in the patient’s care to understand their role and expectations
  • Clarify when the specialty clinician is acting as the patient’s primary clinician, or the PC and specialty clinician agree to co-manage a patient’s care
  • Communication and data-sharing protocols should be clearly established within these agreements, including mechanisms that ensure notifications are prioritized based on urgency
  • Ensure clarity when the handoff needs to occur back to PC, including templates for these transitions of care (allowing for patient preferences)
  • Each practice should establish an internal plan that defines team members for all clinical and care coordination tasks
How to Encourage Specialty Engagement?

• Models must be scalable to different types of specialties while being built on a fundamentally similar framework, which allows it to be understandable and predictable to both the PC practices and the specialty practices – the Medical Neighborhood Model allows for this.

• Communication and information sharing is critical – specialty clinician (SC)/practice should be involved in pre-screening all referrals and accompanying documentation.

• Care coordination agreements!

• Reimbursement structure must support SC engagement and unnecessary and duplicative work/administrative burden must be reduced.
  • Critical to triage all referrals!

• TCOC models should incorporate incentives for patients to engage participating specialists – transportation, copay waivers, etc.

• TCOC can be reviewed and aggregated at each practice and across both the PC and SC practices (excluding any cost attributed to specialists outside the model).
How to operationalize this?

Critical Elements of the Referral

- **Prepared Patient**
- **Patient Demographics and Scheduling Information**
  - Include any special considerations such as language needs, vision/hearing/cognitive impairments, need for caregiver assistance, etc.
- **Referral Information**
  - *Clinical Question / Detailed Reason for Referral*
    - Summary of pertinent details
    - Patient goals
    - Urgency (referral priority status)
  - *Supporting Pertinent data*
  - *Referral type (role for specialty care)*

Patient’s Core Data Set

- Active problem list
- Past medical and surgical history
- Medication list
- Medical allergies
- Preventive care (e.g. vaccines and diagnostic test)
- Family history
- Habits / social history
- List of providers (care team) (other specialists caring for patient)
- Advance directive
- Overall current care plan and goals of care
- Any pain agreement, Care Management and /or Behavioral Health contacts

Core Coordination / Referral Tracking

Referral request sent, logged and tracked and acted on

https://www.acponline.org/acp_policy/policies/beyond_the_referral_position_paper_2022.pdf
How to operationalize this?

A High Value Referral Response

- **Answer the clinical question / address the reason for referral**
  - Summary (include some thought process)
- **Agree with or Recommend type of referral / role of specialty care**
- **Confirm new, existing, or changed diagnoses**
  - Include “ruled out”
- **Medication / Equipment changes**
- **Testing** results, testing pending, scheduled or recommended
  - including how / who to order
- **Procedures** completed, scheduled or recommended
- **Education** completed, scheduled or recommended

- **Any “secondary” referrals made**
  - Confer with and/or copy PCP on all
- **Any recommended services or actions to be done by the PCP/PCMH**
- **Follow up** scheduled or recommended
- **Clear indication of**
  - What specialty care is going to do
  - What the patient is instructed to do
  - What the referring physician needs to do and when
- **Easy to find and refer to in the response note**

https://www.acponline.org/acp_policy/policies/beyond_the_referral_position_paper_2022.pdf
Integration of Behavioral Health with Primary Care (and Specialty Care)

• Collaborative Care Model (CCM)
  • Allows patient to be seen by PC and evaluated for behavioral health issues, consultation with psychiatry, and referred if needed

• CCM is a good start, but...
  • Cost of implementation for PC must be supported, including covering upfront costs to build infrastructure
  • Overall payment for the services is insufficient

• Consider integration of CCM with the Medical Neighborhood Model – would also allow SC to engage more fully in the care of patients with complex needs that include behavioral care
Addressing Health Equity and Social Drivers of Health

• Payers must prioritize inclusion of underserved patient populations in all value-based payment models.

• We must work to create a validated way to measure the cost of caring for patients who are experiencing health care disparities and inequities based on personal characteristics and/or are disproportionately impacted by social drivers of health.

• Clinicians and practices should be incentivized to engage in innovative approaches to improve risk adjustment and other measurement methods that are reliable, defensible, and transparent – again, safe harbors are necessary here!

• ACP has new policy on these issues coming soon!
Questions?