Listening Session 2: *Supporting Primary and Specialty Care Transformation*

Presenters:

Subject Matter Experts

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  (Previous submitter – *The ACS-Brandeis Advanced APM* proposal)

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Elizabeth Mitchell

President and Chief Executive Officer,
Purchaser Business Group on Health (PBGH)

March 3, 2025

PTAC Supporting Primary Care and Specialty Transformation

Elizabeth Mitchell

President and CEO, PBGH

Purchaser Business Group on Health

Purchaser Business Group on Health

- 40 members
- Private employers & public agencies
- $350B spend
- 21 Million Americans

Advancing Quality

Driving Affordability

Fostering Health Equity

EXPERTISE APPLIED ACROSS ALL STRATEGIES:

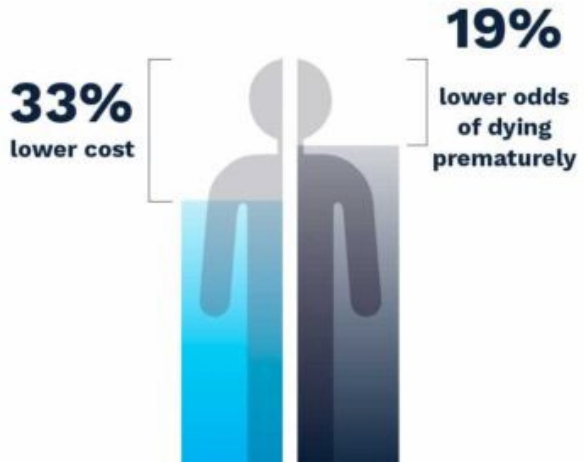
Measuring What Matters | Policy and Advocacy | Payment Reform | Care Redesign | Health Equity

A Clear Primary Care Strategy is Foundational

Primary care lowers costs, decreases premature death and increases productivity.

Despite its benefits:

- Primary care accounts for only 35% of ALL health care visits yet influences 90% of total health care spending.
- Roughly 4% of U.S. health care dollars are spent on primary care.



$13 in savings for every $1 spent

Fixing primary care: https://www.medicaleconomics.com/view/fixing-primary-care
Advanced Primary Care can Steer to Quality, Cost-Effective Providers: https://www.mercer.us/our-thinking/healthcare/advanced-primary-care-can-steer-to-quality-cost-effective-providers.html
Delivering value in healthcare starts with increased primary care investment: https://www.medicaleconomics.com/view/delivering-value-healthcare-starts-increased-primary-care-investment

Impact of poor primary care

The average primary care experience leaves families without timely or quality care, and employers footing larger bills.

20.6 Days

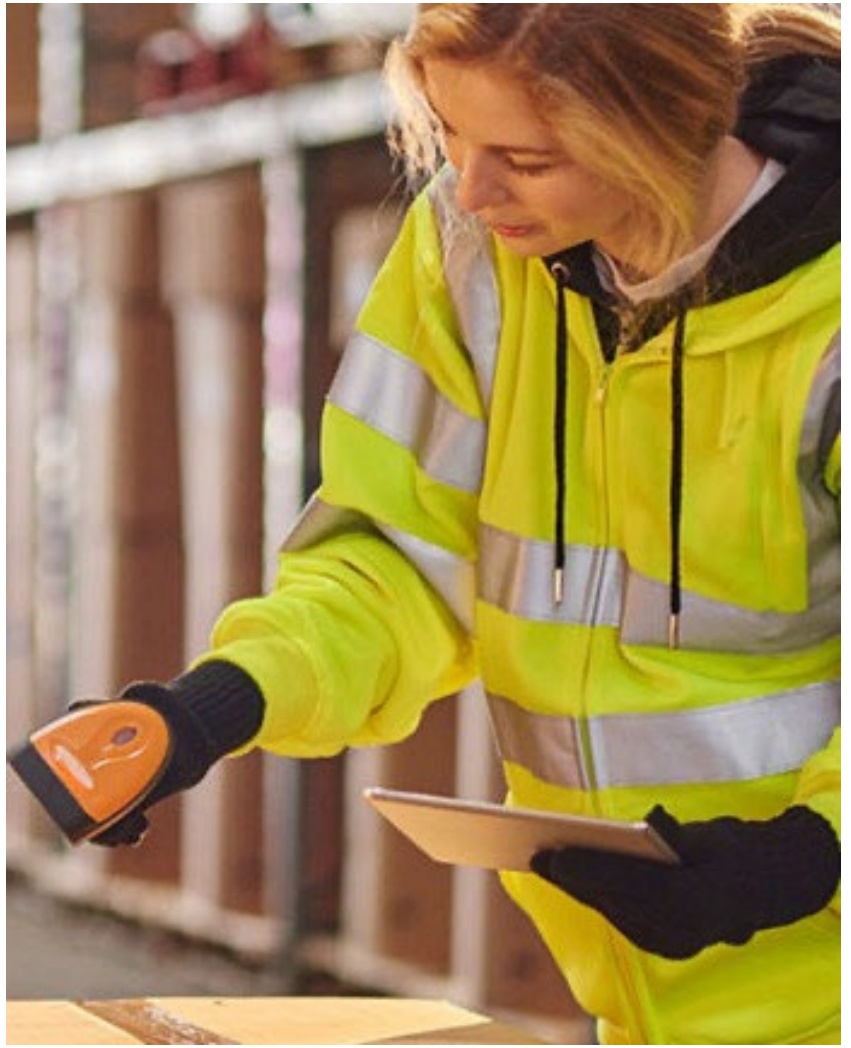
Average family medicine wait time[1]

$3,300

Additional cost of employee when they don't have PCP[2]

7.2%

Higher total cost of care if NOT using employer-sponsored clinics



1. Medical Economics: https://www.medicaleconomics.com/view/appointment-wait-times-drop-for-family-physicians-indicating-shift-in-care
2. Chartbook on Care Coordination: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html ; The High Cost of Avoidable Hospital Emergency Department Visits: https://www.unitedhealthgroup.com/newsroom/posts/2019-07-22-high-cost-emergency-department-visits.html
3. Journal of Internal Medicine. https://doi.org/10.1007/s11606-022-07724-w

Advanced Primary Care Overview

The difference: Primary care that treats the whole patient and cares for the patient throughout their healthcare journey, not just in office visits.

Required Components:

1. **Access the way a patient prefers**, expanded hours, various forms of communication E.g. virtual visits, asynchronous messaging
2. **Interdisciplinary care**. Coordination with at least the following disciplines: nutritionist, exercise, mental health, health navigators, and community health workers.
3. **Integrated mental health.**
4. **The patient beyond the chart,** consider: SDOH, family and community relationships, lifestyle and health access.
5. **Integrate** with other parts of the health system (informed referrals)

Common APC Measure Set

This measure set is used in:

- California Advanced Primary Care Initiative payment model demonstration project.
- Advanced Primary Care Measurement Pilot results
- Listed in Covered California and CalPERS contracts
- PBGH purchaser APC standards and toolkits (Common Purchaser Agreement)

				Industry Alignment			
Quality Domain	Measure	NQF ID	Population	Commercial[1]	Medi-Cal[2]	CMS[3]	DMHC[4]
Health Outcomes & Prevention	Asthma Medication Ratio (AMR)	1800	Pediatric/Adult	●	●	●	●
	Breast Cancer Screening (BSC-E)			●	●	●	●
	Childhood Immunization Status Combo 10 (CIS-E)*	0038	Pediatric	●	●	●	●
	Colorectal Cancer Screening (COL-E)*	0034	Adult	●	●	●	●
	Controlling High Blood Pressure (CBP)*	0018	Adult	●	●	●	●
	Glycemic Status Assessment HbA1C Control*	0059/ 0575	Adult	●	●	●	●
	Immunizations for Adolescents (IMA-E)	1407	Pediatric	●	●	●	●
Patient Reported Outcomes	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	–	Pediatric/Adult	●	●	●	●
	Depression Remission or Response for Adolescents and Adults (DRR-E) *phased approach*	–	Pediatric/Adult		●		
Patient Safety	New measures being tested.						
Experience	New measures being tested.						
High Value Care	Emergency Department Visits	–	Pediatric/Adult	●			
	Inpatient/Acute Hospital Utilization	–	Pediatric/Adult	●			
	Total Cost of Care	1604	Pediatric/Adult	●			

* Equity sensitive measures have higher payouts and are tied to quality initiatives lead by Covered California, CalPERS, NCQA and others. GSD HbA1c (>9%) and (<8%) are both included in to support payer tracking needs with goal of shifting to poor control.

1. Integrated Healthcare Association. Align. Measure.Perform. Commercial HMO (Measurement Year 2025)
2. California Department of Health Care Services. Medi Cal Managed Care Accountability Set (Measurement Year 2025)
3. CMS Universal Foundation Measure Set (2023)
4. DMHC Health Equity and Quality Measure Set (2025)

Lessons Learned

A key barrier is payment.

Primary Care is foundational and requires a new payment model:

– Prospective Population-based Payment

Specialty Care needs to be linked to Primary Care with robust quality measures

You have to:

- pay for a team to manage care
- pay for data and analytics
- hire community extenders
- Integrate mental health,
- pay for physical therapy

Why the health care industry isn't solving this…

Employers

Health Plans

Providers

Employers work via health plans to provide health care benefits to employees.

Our Members aren't waiting. They are direct contracting.

Anchor Employer in a Region

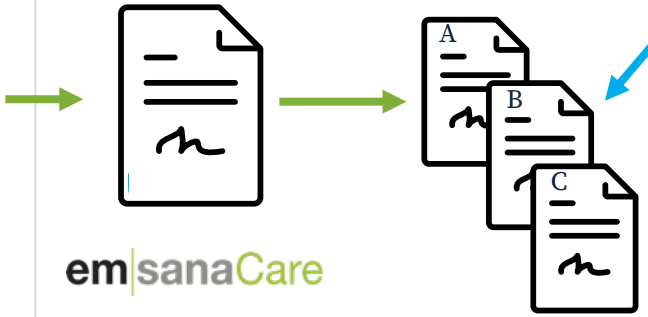
Other Employers

Employers Sign Just Two Documents

1. One Administrative Contract regardless of how many regions they join
2. One Market Addenda for each region joined

Employer Contracts with EmsanaCare for Services

Regional Market Addenda

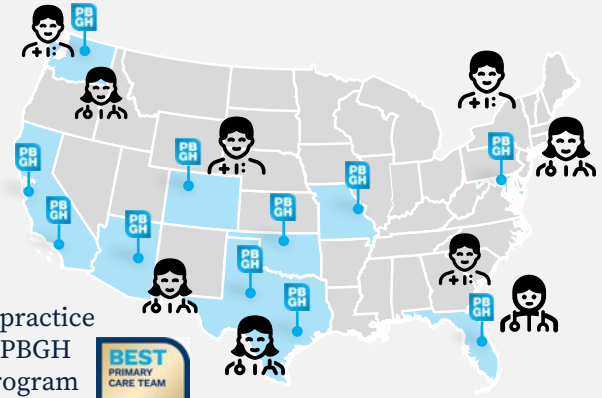


emsanaCare

PBGH System of Excellence

A National Network of Regional Advanced Primary Care Clinics and Top-Quality Specialists

emsanaCare



EmsanaCare holds contract with APC practice awardees through PBGH Care Excellence Program

BEST PRIMARY CARE TEAM 2024 PBGH

Negotiation Expertise: We handle the complexities

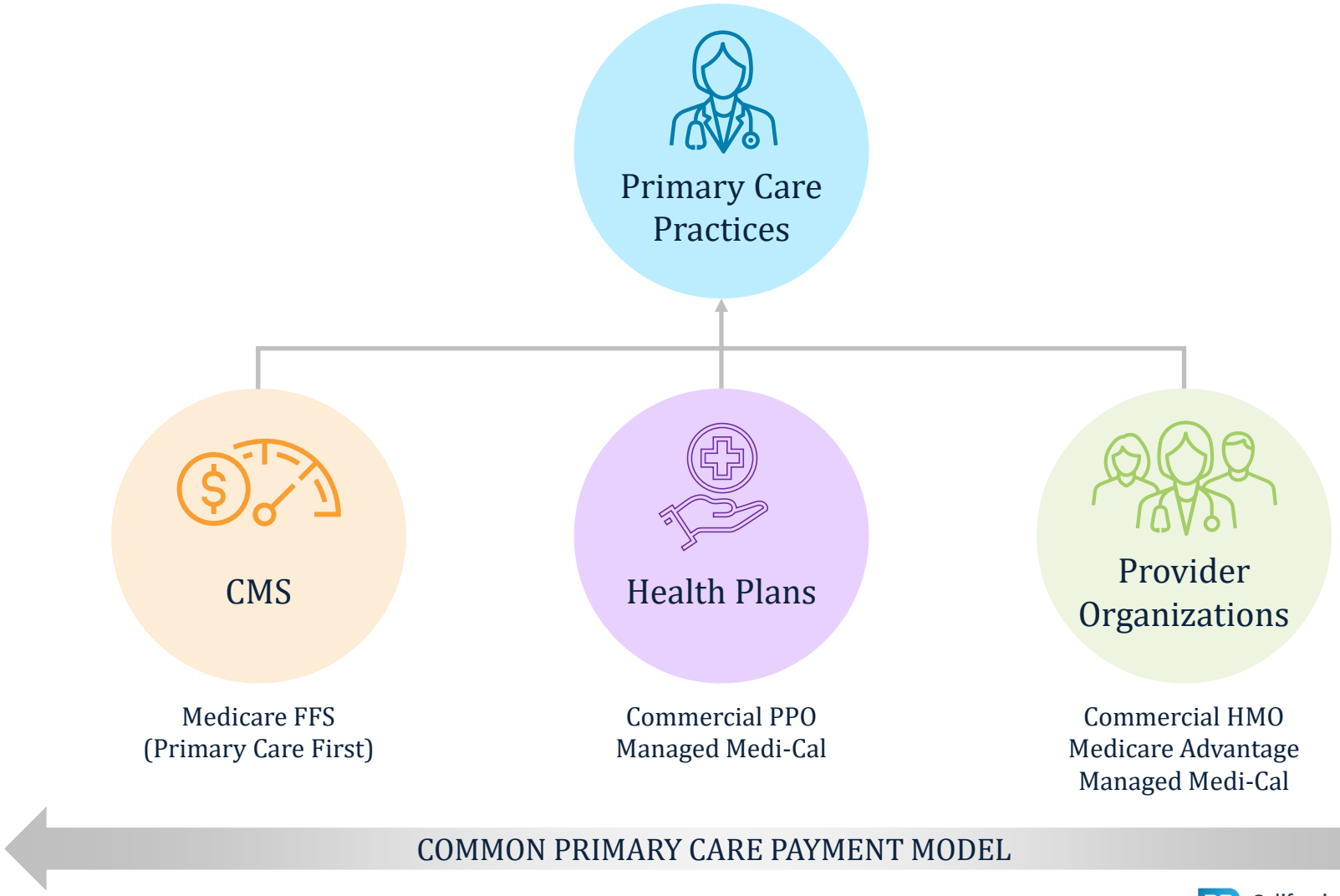
Contract Management: We hold the contract

Scale Benefits: Enables Advanced Primary Care for smaller workforces

Best Practices: Always at the forefront

Provider Ease: Aligning with purchaser needs seamlessly

Alignment for primary care practices across California payers and products



A Novel Concept for Primary Care Transformation

Transparency

Report primary care investment, adoption of value-based payment models and performance on the APC measure set

Investment

Increase primary care investment without increasing the total cost of care

Multi-Payer Alignment

Value-Based Payment

Adopt a common value-based payment model for primary care that pays more, offers flexibility and supports team-based care

Practice Transformation

Provide practices with technical assistance to support: shift to value-based payment, behavioral health integration and demographic data collection

Payers signed a memorandum of understanding (MOU) committing to this effort through 2025.

- Quality Measures
- Technical Assistance
- Performance Incentives
- Increased Investment
- Provider Manual
- Performance Insights via a common platform

blue california

health net

aetna

Common Value-Based Payment Model

1

Payment for direct patient care using a mix of capitation and FFS*

2

PMPM payment to support population health management (+ 15%)

3

Performance-based payment based on standard APC measure set (+ up to 15%)

*Fee for Service Plus option will be offered

Call to Action

- **Plans:**
  - With PPO direct contracts: Join by aligning with the payment model
  - With HMO: Convince one or several of your IPAs to align
  - Align your P4P incentive program with APC measure set
- **IPAs:**
  - Align with payment model
  - Take a step before a big leap: Align your P4P incentive program with this design, as LA Medi-Cal MCPs are considering
- **Purchasers:**
  - Engage in regular, collaborative dialogue with health plans for:
    - awareness of what health plans are planning/implementing
    - identification of and formal support for multi-payer collaboration
    - understanding of operational hurdles and potential partnership to overcome barriers
    - recognition of and support for the time, resources and adaptations needed to commit to real collaboration
    - realistically assess feasibility and pace of change to accompany ambitious goals, particularly with financial penalties, that will require collaboration to be impactful
  - Incentivize collaboration or, at very least, remove dis-incentives to collaboration.
    - Use investments from penalties to invest in this collective action in partnership and dialogue and shared decision-making with payers to nurture these efforts directly impacting your enrollees

Purchaser Business Group on Health

Thank You

Purchaser Business Group on Health

Appendix

July 1, 2024 – December 31, 2025

Common Value-Based Payment Model Guide for Primary Care Physicians & Payers

Payment Model Demonstration Project
California Advanced Primary Care Initiative

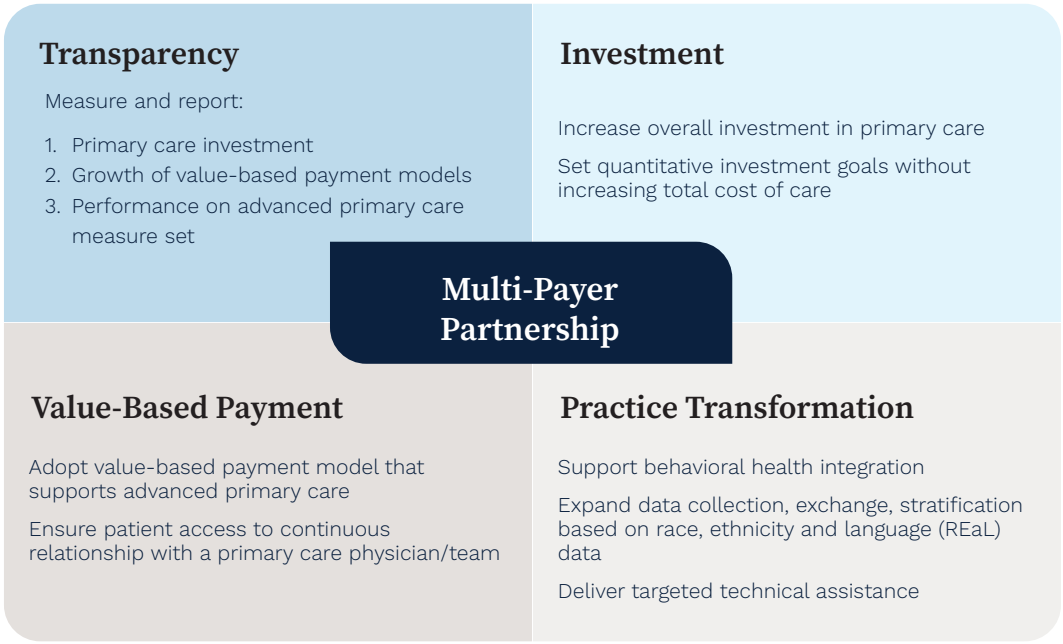
PBGH California Quality Collaborative | Integrated Healthcare Association

Table of Contents

What is the California Advanced Primary Care Initiative?

Convened by the California Quality Collaborative (CQC) and the Integrated Healthcare Association (IHA), the California Advanced Primary Care Initiative is an effort comprised of a group of California-based health care payers — predominantly health plans — who have voluntarily partnered to support providers in strengthening primary care delivery. The group shares a common definition for Advanced Primary Care based on attributes and measures that was collaboratively built by care providers, health plans and other health system partners.

The initiative is working towards increasing adoption of payment models that provide increased resources, more flexibility, and rewards for quality to primary care practices piloting value-based payment models that invests more into primary care. Due to the range of payers that practices contract with, implementing payment changes collectively has the potential to yield greater positive impact compared to individual plan-driven efforts.



Value-Based Payment

What is Value-Based Payment?

Value-based payments tie health care provider payments to the quality of care delivered. Better outcomes will yield higher payment. These payments are generally designed to be flexible, as they are not tied to delivering specific services. Value-based payment generally holds providers more accountable for improving patient outcomes while also giving them greater flexibility to deliver the right care at the right time.

How is Value-Based Payment Beneficial to Primary Care Physicians?

Providers receiving payment through a fee-for-service (FFS) model are often not compensated for all the work they do. Running a practice and managing the health of a population involves more than interacting directly with patients. Shifting to value-based payment creates flexible revenue for all the additional work clinicians and their team do when not directly engaging with patients, such as hiring and training new staff, chart review, referral research, patient calls, care coordination, process improvement and business administration. Value-based payment also pays more for high-quality outcomes.

Why Are Multiple Plans Paying This Way Together?

There is general agreement on the concept of value-based payment, but what counts as "value" or "high quality" varies. When multiple payers work together to pay primary care providers more using similar criteria, providers can focus on what is most important — providing high-quality patient care — and confusion and administrative burden are reduced. When a larger portion of the patient panel is paid under an aligned value-based model, it enhances value to the provider by increasing the opportunity to earn more based on performance while supporting sustainability.

What is the Impact on Patients?

The overarching goal of value-based payment is to incentivize providers for high-quality performance and equip them with the resources necessary to deliver better patient care — leading to improved outcomes for patients.

Payment Model Demonstration Project Overview

The California Advanced Primary Care Initiative is conducting an 18-month demonstration project of the common value-based payment model. The demonstration project will partner with up to 30 independent primary care practices in the southern California and Central Valley regions, with the following goals:

- Test the payment model (for more details about all tracks of the payment model, see pages 6-13).
- Build advanced primary care capabilities within participating practices through payment and direct technical assistance, enabling care team success in value-based payment models (for more details about the support for practices, see pages 18-19).
- Improve outcomes for people served by the participating practices.

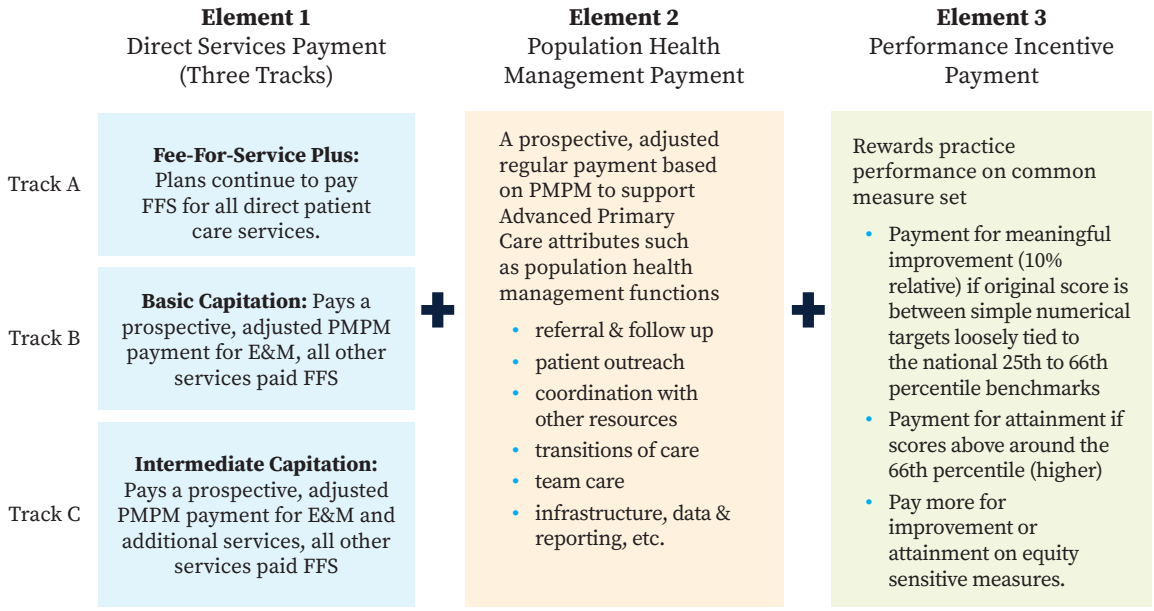
Four health plans — Aetna, Anthem Blue Cross, Blue Shield of California and Health Net —collaborated to build a framework for a common value-based payment model that enables prospective Population Health payments, provides flexibility in how prospective payments are invested, rewards improvement and high performance, and potentially increases total payment. To demonstrate the impact of value based primary care, these health plans are jointly conducting a demonstration project with practices that contract for commercial PPO with at least one of the plans, and ideally multiple plans, that account for a significant portion of the practice's panel. This will enable business and clinical transformation across the whole practice.

By coordinating this demonstration project among shared practices and aggregating resources and technical assistance to practices in one collective approach, the project can demonstrate that collective impact is greater than individual efforts and needed change can be accelerated.

Payment Model Overview

The initiative's payment model aims to increase pay for primary care providers and do so differently, in a manner that invests in primary care in California and promotes value-based care. The payment model includes three elements of payment to participating practices. Together, these three elements of payment are intended to increase revenue to practices, support patient relationships and care coordination, and improve provider satisfaction.

For participating practices under the common payment model, there is a potential to earn up to an additional 30% above base payments across the three elements listed below. While the distribution of the increased payment allocation amongst the three elements may differ from plan to plan, the initiative aligns on the unified target of 30% potential increase in payment.



Payment Element 1 tracks B and C and Element 2 will be adjusted for clinical risk and social risk

It is important to note that exact payment amounts may vary by payer, however the structure and measures in the incentive payment will remain the same.

Payment Model Elements

1. Element 1: Direct Services Payment (Three Tracks)
    a. FFS+
    b. Basic Capitation
    c. Hybrid Capitation
2. Element 2: Population Health Management Payment
3. Element 3: Performance Incentive Payment

Element 1: Direct Services Payment

Direct services is all patient care that is billable. The direct services payment includes payment for eligible direct care services for patients. There are three voluntary tracks for direct services payment: A) Fee For Service +, B) Basic Level Capitation Hybrid Model and C) Intermediate Level Capitation Hybrid Model that practices may be able to choose from, depending on health plan offerings and provider preference. It is possible for a practice to participate in more than one track if the practice contracts with multiple health plans, but practices will only participate in one track per health plan.

Figure 1: Three Potential Tracks for Element One- Direct Services Payment

A. FFS+ Model
Direct Services: All direct services are reimbursed Fee For Service (FFS)

B. Basic Level Capitation Hybrid Model
Direct Services: Evaluation and management services are capitated Per Member Per Month (PMPM), all other services remain FFS

C. Intemediate Level Capitation Hybrid Model
Direct Services: Evaluation and management services and additional services (transitional care management, advance care planning, non-oral drugs, certain small surgeries, some ultrasounds) are capitated PMPM, all other services FFS

Table 1: Capitated Services and CPT Codes – Basic Level Capitation Hybrid Model (B)

Services Covered Under Capitation	Services to be Paid Fee for Service
E&M 992xx	Immunizations 90281–90756, G0008–G0010
Other E&M 99300-99499	Annual well visits 99381–99387, 99391–99397 Home visits Rest home visits SNF
	All other direct, billable services rendered by primary care practice

Table 2: Capitated Services and CPT Codes – Intermediate Level Capitation Hybrid Model (C)

Services Covered Under Capitation	Services to be Paid Fee for Service
E&M 992xx	None
Other E&M 99300-99499	Home Visits, Rest Home Visits, Skilled Nursing Facility (SNF)
Medicine Services 90757-99756, HCPCS – S & Q codes	Echocardiograms, Specimen handling, Inhalation treatment, Filing of inflatable pump, COVID testing, Flu Vaccines, IV tubing, IV infusion, Pap smear, IUDs, Abortion
Temporary HCPCS – G & C Codes	COVID testing
Drugs, non-oral and chemo – HCPCS – J Codes	Ceftriaxone, Progesterone, Asthma-related, Nausea-related, IV Fluid, IUDs, Estradiol, Cortisone, Chemo
Category III – Codes ending in T	None
	All other direct, billable services rendered by primary care practice

This Guide outlines the model's recommended metrics and methodology. Each participating plan will determine whether they will adopt the recommendations or modify them to meet their business needs and any regulatory requirements.

Element 2: Population Health Management Payment

Population health management payment supports population health and care coordination activities and will be paid either monthly or quarterly to the practice. The payments are based on a PMPM calculation. The population health management payment is additive to payment for direct care services (Element One). The monthly PMPM calculated amount may be adjusted for clinical and social risk based on the methods outlined in this section.

As stated above, the Initiative recommends a potential 30% increase to base payment amongst the three elements, with flexibility for plans to allocate a higher share of the increase in payment to one or more of the elements as they see fit. As a result, the Population Health Management amount may vary slightly from plan to plan while commitment to an overall increase of up to 30% in payment remains aligned.

The initiative recognizes the activities for investment may vary from practice to practice but will require that dollars are put toward strengthening the advanced primary care attributes. Technical assistance coaches will work one-on-one with practices, at no cost to the practice, to assess where these additional funds may be best utilized depending on each unique situation and will be tracking progress via surveys and regular collection tools. See pages 18-19 for additional information on technical assistance.

Element 3: Performance Incentive Payment

Background

In developing the model for performance incentive payment, the initiative convened a physician workgroup to help create an incentive design that is simple, meaningful, and that reinforces the message that every practice that excels will be rewarded. The initiative is working to move beyond longstanding incentive models based on percentiles within a cohort that force competition among participating practices and instead will put forth numerically simple target scores drawn loosely from national percentiles. This will ensure each practice has the opportunity to succeed for performance on each measure compared to a benchmark that is simple to understand and remember and will not change during the demonstration project. The initiative understands that quality measurement can be a significant undertaking and one of many competing priorities providers must juggle, and it incentivizes improvement on the path to quality performance excellence.

Methodology

Similar to the Population Health Management payment, there is flexibility for plans to allocate a higher share of the overall increase in primary care payment to Element 3: the Performance Incentive than the other two elements. This allows for flexibility while remaining aligned to the overall target of the potential 30% increase in overall payment to the participating practices. As a result, the maximum performance incentive amount may vary from plan to plan. The Performance incentive will evaluate Quality, Efficiency, Cost and Patient Experience and incentivize practices that achieve improvement or attainment.

The initiative's performance incentive payment will reward both attainment and improvement, with increasing payment for better performance. There will be a smaller incentive for practices that do not reach the Attainment Threshold (as described below) but demonstrate meaningful improvement.

- The initiative intends to use clinically meaningful levels of performance based on national percentiles as benchmarks, and targets will remain steady for the duration of the demonstration project and ideally going forward.
- The performance incentive will be paid based on performance on the standard primary care measure set listed below. Measure payouts are determined individually by each measure where practice data is available.

Table 3: Advanced Primary Care Measure Set

Standard California Primary Care Standard Measure Set	Measure Type	Source/ Benchmark Source	Population
Depression PROMs (DSF-E) Phased approach: screening → monitoring → remission	Quality	NCQA	Adult/pediatric
Breast Cancer Screening (BCS)	Quality	NCQA	Adult
Controlling High Blood Pressure* (CBP)	Quality	NCQA	Adult
Colorectal Cancer Screening* (COL)	Quality	NCQA	Adult
Glycemic Status Assessment for Patients with Diabetes <8.0%* (GSD)	Quality	NCQA	Adult
Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD) Info only for demonstration, not eligible for incentive	Quality	NCQA	Adult
Asthma Medication Ratio (AMR)	Quality	NCQA	Adult/pediatric
Childhood Immunization Status: Combination 10* (CIS)	Quality	NCQA	Pediatric
Immunizations for Adolescents: Combination 2 (IMA)	Quality	NCQA	Pediatric
Emergency Department Utilization (EDU)	Utilization	NCQA/IHA Atlas	Adult
Acute Hospital Utilization (AHU)	Utilization	NCQA/IHA Atlas	Adult
Total Cost of Care using standardized pricing (TCOC)	Cost	HealthPartners	Adult/pediatric
Patient Experience (CG-CAHPS) Addressed through technical assistance only, not eligible for incentive	Patient Experience	AHRQ	Adult/pediatric

* The National Committee for Quality Assurance (NCQA) and Covered California are requiring these measures to be reported stratified by race and ethnicity, because they tend to be equity sensitive. This means they exhibit a greater range of performance when stratified across demographic variables. Additionally, these measures are emphasized in Covered California's Quality Transformation Initiative. This version of the payment model demonstration project will not be evaluating based on stratified scores for race and ethnicity.
** All utilization and cost measures will be risk adjusted

As the table above illustrates, there are eleven total measures included in the Advanced Primary Care measure set and eligible for the performance incentive. Variance on the number of measures applicable at each practice depends on the type of practice and the population for which each measure applies. For Mixed Practices, or practices that

serve both adult and pediatric population with neither making up a strong majority, all measures apply. For Adult practices, there are nine measures and for Pediatric practices, there are five measures.

Along with guidelines for both attainment and improvement in this section, there is a table included in both the attainment and improvement sections that models out the proportion of the maximum total incentive amount for each of the applicable measures for the three types of practice (Mixed/Adult/Pediatric). For example, for a pediatric practice that has five applicable measures, each measure will be worth a larger proportion of the total incentive amount than a mixed practice where there are eleven measures. The intention is that each practice, regardless of the type of population they serve, is eligible for the maximum incentive amount set by each payer. It is also important to note that Non-QTI measures are consistently worth about two-thirds of QTI measures in an effort to emphasize the importance of equity sensitive measurement.

A practice's performance on each measure will fall into one of three categories: 1. score is ineligible for an incentive as it does not meet the minimum threshold score, 2. score meets the minimum performance threshold but does not meet or exceed the attainment threshold and is eligible for an improvement incentive, or 3. score meets the attainment threshold and is eligible for an attainment incentive.

Performance incentive payments are recommended to be paid at least bi-annually, with an initial payout from health plans based on projected amount earned and another payout to reconcile the difference.

Element 3: Performance Incentive Payment: Improvement Incentive

The performance-based incentive payment will reward improvement within the Improvement Range from the Minimum Performance Threshold which loosely aligns with the national 25th percentile (from the National Committee for Quality Assurance) for all lines of business up to the Attainment Threshold which aligns loosely with the national 66.7th percentile.

Improvement Incentive Guidelines

- If a practice's performance is within the Improvement Range, it is recommended the practice receive a payment if their performance closes at least 10% of the gap between baseline performance and the Attainment Gold Standard (roughly the national 90th percentile).

Table 4: Performance-Based Improvement Incentive Model

					Mixed Practice	Pediatric Practice	Adult Practice
Measure	**Adult/ Pediatric**	**Improvement Range**	**Attainment Gold Standard**	**Improvement Needed to Earn Incentive**	**% of Total Incentive**	**% of Total Incentive**	**% of Total Incentive**
Childhood Immunization Immunization Status Combo 10 (CIS)	Pediatric	45-61	70	10% gap closure	5.0%	11.0%	NA
Immunizations for Adolescents Combo 2 (IMA)	Pediatric	26-35	46	10% gap closure	3.5%	7.5%	NA
Asthma Medication Ratio (AMR)	Both	81-87	91	10% gap closure	3.5%	7.5%	4.0%
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	Both	TBD	TBD	10% gap closure	3.5%	7.5%	4.0%
Total Cost of Care (TCOC)	Both	TBD	TBD	10% gap closure	3.5%	7.5%	4.0%
Breast Cancer Screening (BCS)	Adult	70-76	80	10% gap closure	3.5%	NA	4.0%
Colorectal Cancer Screening (COL)	Adult	52-63	67	10% gap closure	5.0%	NA	6.0%
Controlling High Blood Pressure (CBP)	Adult	56-67	74	10% gap closure	5.0%	NA	6.0%
Glycemic Status Assessment for Patients with Diabetes <8.0% (GSD)	Adult	55-64	69	10% gap closure	5.0%	NA	6.0%
Acute Hospital Utilization – Total Acute (AHU)	Adult	26-21	18	10% gap closure	3.5%	NA	4.0%
Emergency Department Utilization (EDU)	Adult	146-121	107	10% gap closure	3.5%	NA	4.0%

It is important to note that exact payment amounts may vary by payer, however the structure and measures in the incentive payment will remain the same.

Element 3: Performance Incentive Payment: Attainment Incentive

If the practice's performance reaches the Attainment Threshold for a measure, the practice is eligible for an attainment incentive and is no longer eligible for an improvement incentive.

Attainment Incentive Guidelines

- If the practice's performance meets the Attainment Threshold for the measure, the practice will receive a recommended base, depending on whether it is a QTI measure, and incrementally more the closer they are to the Attainment Gold Standard.
- If the practice's performance meets the Attainment Gold Standard for a measure, the initiative recommended incentive amount increases with higher amounts given to equity sensitive measures.
- The recommended total maximum PMPM across all measures and including both attainment and improvement is as much as 15% increase to base payment.

Table 5: Performance-Based Improvement Incentive Model

				Mixed Practice		Pediatric Practice		Adult practice	
Measure	**Adult/ Pediatric**	**Attainment Threshold**	**Attainment Gold Standard**	**Threshold % of Total Incentive**	**Gold Standard % of Total Incentive**	**Thresh-old % of Total Incentive**	**Gold Standard % of Total Incentive**	**Thresh-old % of Total Incentive**	**Gold Standard % of Total Incentive**
Childhood Immunization Immunization Status Combo 10 (CIS)	Pediatric	61	70	7.5%	12.0%	16.5%	27.0%	NA	NA
Immunizations for Adolescents Combo 2 (IMA)	Pediatric	35	46	5.0%	8.0%	11.0%	18.0%	NA	NA
Asthma Medication Ratio (AMR)	Both	87	91	5.0%	8.0%	11.0%	18.0%	6.0%	10.0%
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	Both	TBD	TBD	5.0%	8.0%	11.0%	18.0%	6.0%	10.0%
Total Cost of Care (TCOC)	Both	TBD	TBD	5.0%	8.0%	11.0%	18.0%	6.0%	10.0%
Breast Cancer Screening (BCS)	Adult	76	80	5.0%	8.0%	NA	NA	6.0%	10.0%
Colorectal Cancer Screening (COL)	Adult	63	67	7.5%	12.0%	NA	NA	9.0%	14.0%
Controlling High Blood Pressure (CBP)	Adult	67	74	7.5%	12.0%	NA	NA	9.0%	14.0%
Glycemic Status Assessment for Patients with Diabetes <8.0% (GSD)	Adult	64	69	7.5%	12.0%	NA	NA	9.0%	14.0%
Acute Hospital Utilization – Total Acute (AHU)	Adult	21	18	5.0%	8.0%	NA	NA	6.0%	10.0%
Emergency Department Utilization (EDU)	Adult	121	107	5.0%	8.0%	NA	NA	6.0%	10.0%

It is important to note that exact payment amounts may vary by payer, however the structure and measures in the incentive payment will remain the same.

Risk Adjustment

Element 1 (Track B and C) capitation payments and Element 2 population health management payments will be adjusted for clinical severity and social risk. The initiative seeks to align with the National Academies report on primary care and recognizes that different patients will need different levels of primary care based on their unique medical situation, demographic area and other variables.

Clinical Risk

The initiative seeks to align with the Office of Health Care Affordability (OHCA) and will adjust for age and gender in the payment demonstration project. For potential future use, the initiative will continue to explore the value of developing a more nuanced approach to adjustment that includes clinical diagnoses.

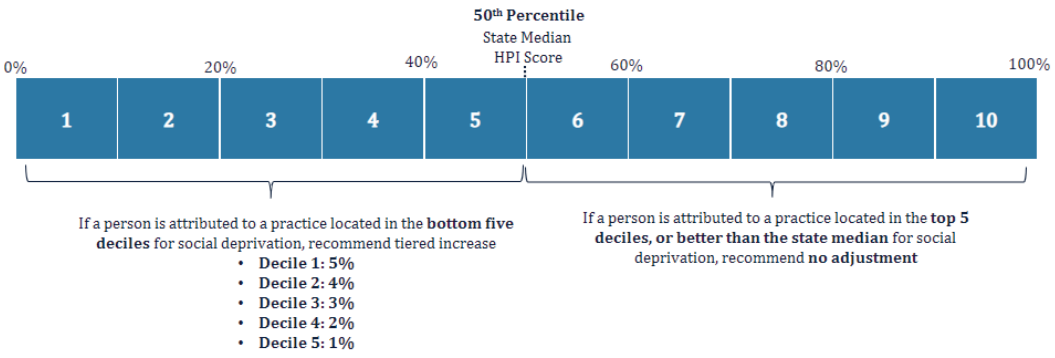
Social Risk

The initiative will use the California Healthy Places Index (HPI) to adjust payments for both direct service capitation and population health management payment. HPI was selected as the superior index, as it is a California-specific index and includes additional data sources on top of the American Community Survey commonly used in other indices.

Direct service capitation and population health management payments will be adjusted upwards only for populations lower than the California state median HPI score. HPI scores will be calculated based on practice location and every practice will be attributed to a decile. If the practice is located in the bottom five deciles for social deprivation, the recommended tiered increase is 5% upwards adjustment for the lowest decile, 4% for the second lowest decile, 3% for the third decile, 2% for the fourth decile, and 1% for the fifth decile. If the practice is located in the top five deciles, or better than the state median for social deprivation, the Initiative recommends no adjustment.

Although the additional payment for social risk is expected to increase a small amount overall, the initiative believes that incorporating a person's social environment into the primary care payment model through social risk adjustment is a step toward whole-person, integrated care.

Figure 2: Recommended HPI Adjustment Index



Attribution

Attribution will either be performed at the plan level according to a plan's own attribution methodology and provided to the common reporting platform each month or alternatively, the common reporting platform will run a common methodology for plans who choose this route.

If the common reporting platform is chosen, membership attribution will be done utilizing claims data and will map each member to one practice and then one primary care provider. Each participating practice of the initiative will have a panel of attributed members that will be updated monthly.

Common Methodology

Members will be attributed to a single primary care practice and then to a provider in that practice. Preference will be give to a primary care provider selected by a member or matched by a plan. If a member has selected or been matched to a PCP they will be attributed to their selected/matched PCP. In the absence of a selected/matched PCP, attribution will be established based on the primary care practice and provider that has been seen most frequently and recently over the past 12-month period, with a further six-month lookback period considered, if necessary.

Primary care is defined as all services provided by Family Practice, General Practice, Internal Medicine, Pediatrics and primary care-focused Nurse Practitioners and Physician Assistants and includes subspecialties related to adolescent, adult and geriatric medicine, hospice and palliative medicine* and school* and community health*.

* service restrictions apply

Incentive Payouts

The initiative recommends incentive payouts occur every six months during the payment demonstration project, approximately a quarter after each six-month period has closed, with reconciliations as needed. The rationale for every six months (instead of a year) is to help invest more into primary care practices sooner to fuel their improvement. There would be three incentive payouts for the demonstration project. The first payout would occur in approximately March 2025 based on performance through December 2024. The next payout would be in approximately September 2025 for performance through June 2025. And the last incentive payout would be made in approximately March 2026 based on performance through December 2025. Details are displayed in the table below.

	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Q1 2026
Demonstration project starts July 1, 2024		First incentive payout: March 2025 (for performance through December 2024		Second incentive payout: Sept 2025 (for performance through June 2025)		Third incentive payout: March 2026 (for performance through December 2025)

Common Reporting Platform

The initiative will use a common reporting platform for the payment model demonstration project that requires only one login to view data on patients across plans. The intention is to create a seamless experience for practices and provide them with actionable information related to performance on the measures used for incentive payments. A common reporting platform will provide aggregated results reporting for practices, as well as tools such as member-specific care gap analysis, identification of high-risk members and attribution flagging for members who are likely to fall off a practice's attribution list. Practices will receive training and ongoing support on the platform through the technical assistance described below.

Technical Assistance

Providers contracting for any version of the initiative's common value-based payment model will engage in technical assistance to support performance improvement. Technical assistance services are provided by the California Quality Collaborative (CQC), a nonprofit regional health care improvement program of the Purchaser Business Group on Health. CQC has been serving ambulatory care practices across California for more than twenty years.

Technical assistance will include evidence-based support through a combination of on-demand virtual learning resources and personalized guidance from an improvement coach who interacts with practices in bi-monthly virtual coaching sessions and remain available to address questions and offer support throughout the duration of the initiative. The improvement coach will partner with the practice to understand needs and opportunities, set goals, guide improvement efforts and track progress. In addition, participating practices will meet together each quarter to exchange learnings, provide peer support for overcoming challenges and celebrate achievements.

Curriculum

The foundation of the technical assistance program will focus on concepts from evidence-based frameworks and best practices, including:

- Model for Improvement
  A widely used framework from the Institute for Healthcare Improvement for developing, testing and implementing changes leading to improvement.
- 10 Building Blocks of High-Performing Primary Care
  A roadmap to identify foundational capabilities and implement these 'building blocks,' which include practice-level advanced primary care capabilities like engaged leadership, data-driven improvement, team-based care and population management. CQC has developed webinars on the 10 Building Blocks of Primary Care.
- Practice Transformation Initiative
  An assessment, change package and curriculum developed by CQC and used across more than 2,000 California primary care practices to guide transformation efforts and improve care and health outcomes.

Support and Resources

In addition to learning practice-level change concepts, participants will have access to skill-building trainings such as improvement coaching, motivational interviewing and patient and family engagement techniques.

Participating practices will receive a range of technical assistance from CQC to support quality improvement and advanced primary care capabilities. In turn, each practice will work directly with their assigned improvement coach to tailor, test, implement and scale the quality improvement recommendations.

The technical assistance will focus on strategies that build upon and enhance existing practice capabilities and relationships with participating practices. Practices will leave the program with deeper insight into their practices and an improved ability to support their quality improvement work

About the California Quality Collaborative (CQC)

California Quality Collaborative (CQC), a program of PBGH, is a health care improvement program dedicated to helping care teams gain the expertise, infrastructure and tools they need to advance care quality, be patient-centered, improve efficiency and thrive in today's rapidly changing environment. The program is dedicated to advancing the quality and efficiency of the health care delivery system across all payers, and its multiple initiatives bring together providers, health plans, the state and purchasers to align goals and take action to improve the value of health care for Californians.

Visit pbgh.org/program/california-quality-collaborative to learn more.

Integrated Healthcare Association

At Integrated Healthcare Association (IHA), we bring the healthcare community together to solve industry-wide challenges that stand in the way of high-value, equitable care. As a non-profit industry association, we use objective data, our decades of expertise, and our unique role as a trusted facilitator to make the healthcare system work better for everyone. We provide insights that help the healthcare system continuously improve. We build new tools that simplify how the industry works together. And we provide a forum for cross-industry leaders—through our board and our programs—to have honest conversations that guide the future of healthcare. Because we envision a future where people get the best possible care at an affordable price. Where providers can focus on delivering care, health plans can focus on serving their customers, and purchasers
feel confident they're getting value for their money. A future where the healthcare system works.

Visit iha.gov/who-we-are to learn more.

Contact us to learn how you can get involved: lpetersen@pbgh.org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GH
California Quality
Collaborative


Integrated
Healthcare
ASSOCIATION

Listening Session 2: *Supporting Primary and Specialty Care Transformation*

Joe Kimura, MD, MPH

Chief Medical Officer,
Somatus

SOMATUS
More Lives, Better Lived.®

Cascading Accountability: Developing Team-Based Attribution Methods and Aligning Specialty Payment Mechanisms and Performance Measures

PTAC Public Meeting - March 3, 2025

Joe Kimura, MD, MPH

Chief Medical Officer, Somatus

somatus.com

National Leader in Value Based Kidney and Cardiovascular Care

Revenue
$3B+

VBC Providers
4,800+

Medical Cost Under Management
$6B+

Members Served
275,000+
In 50 States

Total Physician Partnerships
22,000+

Strategic Partners
110

Lines of Business Served

Medicare Advantage | MA SNP | Medicaid | CKCC
Commercial Fully Insured | Commercial Self Insured

CORE VALUES

AUTHENTICITY | COLLABORATION | EMPOWERMENT | INNOVATION | TENACITY

SŌ - MAT' - US

Derived from the Latin word, somata, plural of soma, meaning "our bodies, free of 'germs'."

Somatus is our healthy bodies.

INVESTORS

INOVA | BLUE VENTURE FUND | Elevance Health | United Healthcare | OPTUM VENTURES | Longitude CAPITAL | FLARE CAPITAL PARTNERS | HealthQuest CAPITAL | DEERFIELD Advancing Healthcare | WELLINGTON MANAGEMENT | Fidelity INVESTMENTS | RACAPITAL | GIC

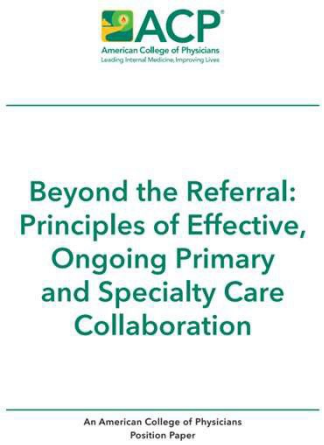
Speaker Background

- Current: Chief Medical Officer for Somatus, Inc since 2022

- Prior: Chief Medical Officer for Atrius Health / Harvard Vanguard Medical Associates
  - Independent ambulatory group practice in Boston with ~750,000 patients with 1100 providers in 32 specialties
  - > 80% of annual revenue generated through full risk contracts across Medicare, Medicaid, and Commercial
  - Robust VBC infrastructure including delegated model for Medicare Advantage
  - Inaugural cohort participant in BCBSMA Alternative Quality Contract and CMMI Pioneer ACO program
  - Managed IM/FM, Pediatrics, ObGyn, Medical/Surgical Specialties, Radiology/Lab Service Lines
  - Managed Quality/Safety, Clinical Informatics & Analytics, Medical Management, Provider Wellness programs

- Served as PCP and Co-Physician Lead of Complete Care Program at SCPMG Orange County
- Active Board Certification in Internal Medicine and Clinical Informatics
- 20+ years of experience working both as a clinician and an executive in value-based care
- Co-Chaired ONC Federal Workgroup on Advanced Care Models and Meaningful Use

Core Principles of Effective Primary and Specialty Care Collaboration



Outland BE et.al. for the Council of Subspecialty Societies of the American College of Physicians, 2022

Principle 1: Patient and Family Partnering

Clinical care teams should work collaboratively with patients, family, and caregivers to empower them to be active partners in all aspects of their care.

Principle 2: Defined Clinical Roles and Responsibilities

Roles, responsibilities, and mutual expectations of PC and SC team members should be clear and acceptable to all parties including the patient and family.

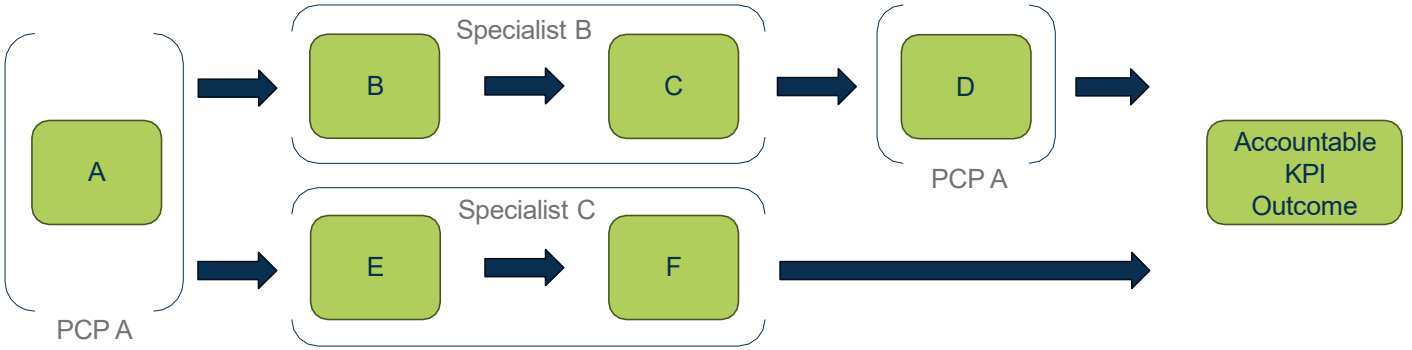
Principle 3: Timely Productive Communication

All parties should engage in timely, informative, and focused communication with one another that highlights critical issues and/or items needing attention

Principle 4: Effective Data Sharing

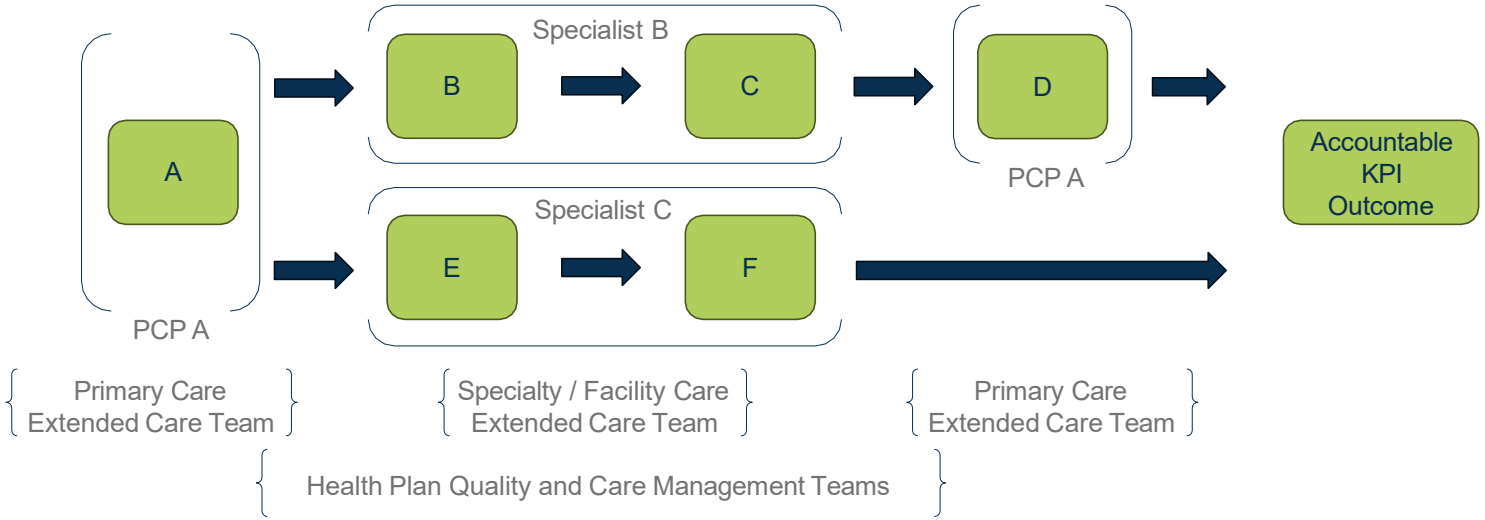
Patient data should be shared in a timely, thorough, actionable, and well-organized manner.

How do organizations effectively apply team-based attribution methods? How is accountability achieved?



- Aligned Clinical Culture – General Agreement on Clinical Best Practices
- Aligned Clinical Operational Systems – Point of Care Decision Support + EHR configuration
- Clinical Informational Continuity - Robust, Timely, Meaningful Clinical Communications
- Transparent Performance Management – Process + Outcomes at Accountability Level
- Aligned Financial Incentives – Both Core Compensation Model + Incentive Structures

How do organizations operationalize team-based attribution in different kinds of settings (more integrated vs. less integrated)? How effective is team-based attribution in less integrated settings?



Model	Example	Cultural Alignment	Operational Alignment	Informational Continuity	Shared Performance Management	Incentives
Fully Integrated	**Kaiser Permanente**	**+++**	**+++**	**+++**	**+++**	**+++**
Partially Integrated	**Atrius Health**	**++**	**++**	**++**	**+++**	**++**
Provider Partnership	**Somatus**	**++**	**+**	**+**	**++**	**+**

What are evidence-based practices to incentivize primary and specialty providers to integrate care/provide team-based care?

METHODS

Changing Physician Behavior: What Works?

Fargol Mostofian, BHSc; Cynthiya Ruban, BSc; Nicole Simunovic, MSc; and Mohit Bhandari, MD, PhD, FRCSC

ABSTRACT

Objectives
There are various interventions for guideline implementation in clinical practice, but the effects of these interventions are generally unclear. We conducted a systematic review to identify effective methods of implementing clinical research findings and clinical guidelines to change physician practice patterns, in surgical and general practice.

Study Design
Systematic review of reviews.

Methods
We searched electronic databases (MEDLINE, EMBASE, and PubMed) for systematic reviews published in English that evaluated the effectiveness of different implementation methods. Two reviewers independently assessed eligibility for inclusion and methodological quality, and extracted relevant data.

Results
Fourteen reviews covering a wide range of interventions were identified. The intervention methods used include: audit and feedback, computerized decision support systems, continuing medical education, financial incentives, local opinion leaders, marketing, passive dissemination of information, patient-mediated interventions, reminders, and multifaceted interventions. Active approaches, such as academic detailing, led to greater effects than traditional passive approaches. According to the findings of 3 reviews, 71% of studies included in these reviews showed positive change in physician behavior when exposed to active educational methods and multifaceted interventions.

Conclusions
Active forms of continuing medical education and multifaceted interventions were found to be the most effective methods for implementing guidelines into general practice. Additionally, active approaches to changing physician performance were shown to improve practice to a greater extent than traditional passive methods. Further primary research is necessary to evaluate the effectiveness of these methods in a surgical setting.

Am J Manag Care. 2015;21(1):75-84

There is increasing recognition of the difficulty in translating research evidence and clinical guidelines into practice, which has resulted in the development of many active dissemination and implementation strategies.[1] Although there is a substantial amount of primary research evidence concerning the effectiveness of various implementation methods, it is extensively dispersed amongst medical specialties.[1]

Research evidence should ideally inform the development of clinical practice guidelines (CPGs).[2] CPGs are systematically developed and updated, and are evidence-based.[3] They provide physicians with a framework for diagnosing, assessing, and treating clinical conditions commonly encountered in practice, and are developed to promote best practices for patient populations. The implementation of these guidelines is important to help improve the quality and consistency of care in clinical situations by changing physician practice patterns.[3]

The Figure demonstrates the steps involved in implementing research findings into medical practice. After dissemination of CPGs, there are 6 main factors specific to healthcare providers that effect guideline adoption into practice and physician behavior: guideline implementation, characteristics of practice, laws and incentives, patient characteristics/problems, social norms, and knowledge and skills.[4,5] Understanding the relative effectiveness of guideline implementation methods is necessary to changing physician behavior for the better and improving patient outcomes.[3]

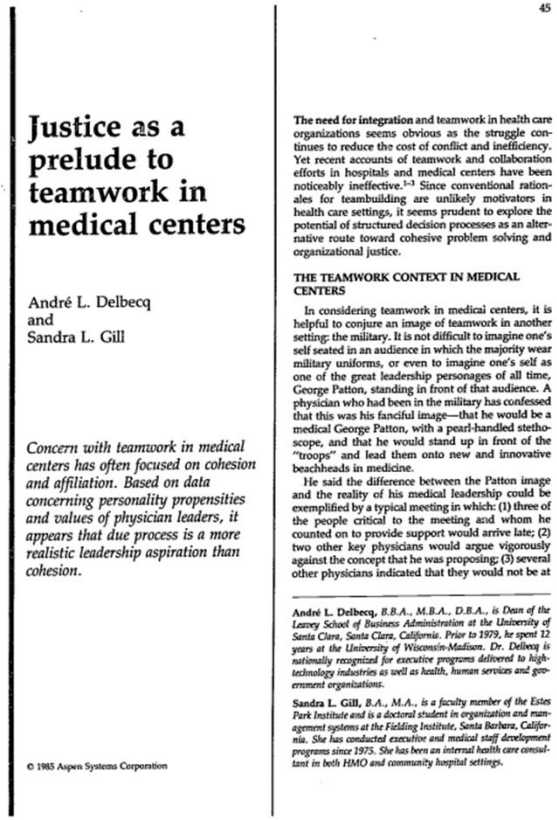
Overall, just a small number of reviews unify different methods and evaluate the implementation methods proven most successful in changing physician behavior.[2] Moreover, there is a lack of research on intervention methods specific to surgery.[1] We have undertaken a systematic review to inform changing physician practice patterns by evaluating methods for implementing clinical research and guidelines. More specifically, we addressed the following research question: in surgical and general practice, through what methods are clinical research results, as well as guidelines, best implemented to change physician practice patterns? A second-

Am J Managed Care. 2015;21(1):75-84

In this review, the authors identify effective methods of implementing clinical research findings and clinical guidelines to change physician practice patterns, in surgical and general practice.

1. Academic Detailing
2. Audit and Feedback
3. Continuing Medical Education
4. Decision Support Systems
5. Economic Incentives
6. Local Opinion Leaders
7. Patient-Mediated Interventions
8. Printed Educational Materials (Passive)
9. Reminders (Computerized Prompts)
10. Multi-faceted (2 or more intervention methods)

Leading to Alignment: Foundations of Teaming



45

Justice as a prelude to teamwork in medical centers

André L. Delbecq
and
Sandra L. Gill

Concern with teamwork in medical centers has often focused on cohesion and affiliation. Based on data concerning personality propensities and values of physician leaders, it appears that due process is a more realistic leadership aspiration than cohesion.

The need for integration and teamwork in health care organizations seems obvious as the struggle continues to reduce the cost of conflict and inefficiency. Yet recent accounts of teamwork and collaboration efforts in hospitals and medical centers have been noticeably ineffective.[1-3] Since conventional rationales for teambuilding are unlikely motivators in health care settings, it seems prudent to explore the potential of structured decision processes as an alternative route toward cohesive problem solving and organizational justice.

THE TEAMWORK CONTEXT IN MEDICAL CENTERS

In considering teamwork in medical centers, it is helpful to conjure an image of teamwork in another setting: the military. It is not difficult to imagine one's self seated in an audience in which the majority wear military uniforms, or even to imagine one's self as one of the great leadership personages of all time, George Patton, standing in front of that audience. A physician who had been in the military has confessed that this was his fanciful image—that he would be a medical George Patton, with a pearl-handled stethoscope, and that he would stand up in front of the "troops" and lead them onto new and innovative beachheads in medicine.

He said the difference between the Patton image and the reality of his medical leadership could be exemplified by a typical meeting in which: (1) three of the people critical to the meeting and whom he counted on to provide support would arrive late; (2) two other key physicians would argue vigorously against the concept that he was proposing; (3) several other physicians indicated that they would not be at

André L. Delbecq, *B.B.A., M.B.A., D.B.A., is Dean of the Leavey School of Business Administration at the University of Santa Clara, Santa Clara, California. Prior to 1979, he spent 12 years at the University of Wisconsin-Madison. Dr. Delbecq is nationally recognized for executive programs delivered to high-technology industries as well as health, human services and government organizations.*

Sandra L. Gill, *B.A., M.A., is a faculty member of the Estes Park Institute and is a doctoral student in organization and management systems at the Fielding Institute, Santa Barbara, California. She has conducted executive and medical staff development programs since 1975. She has been an internal health care consultant in both HMO and community hospital settings.*

Approaches to teamwork that focus on high norms for affiliation are doomed to failure…medical organizations must acknowledge that medical centers are made up of very independent professionals with high needs for power and control.

The mechanisms for enacting leadership must include:

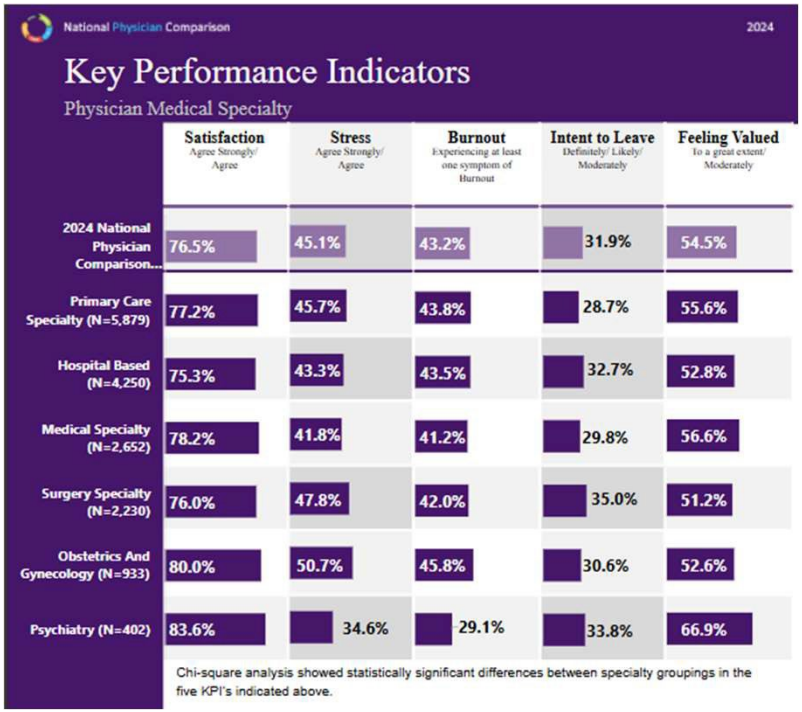
1) Clearly perceived representative structures
2) Visible processing of decisions
3) Clear decision roles

In a sense, justice is substituted for cohesion.

Delbecq AL, Gill SL. Justice as a Prelude to Teamwork in Medical Centers. Health Care Manage Rev. 1985 Winter; 10(1):45-51.

Applied Example: Atrius Physician Compensation Committee

Change Challenge of Teaming and Communication



Source: Personal Communication
Jane Fogg MD MPH – Director of Organizational Transformation, Professional Satisfaction, American Medical Association

- High Levels of Burnout and Intention to Leave
  - Physicians, APCs, Nurses, Staff
  - High Turnover and Long Recruitment Cycles
- Higher Incentives Needed to Nudge Change
- Growing Tradeoff of $$ for Time/Lifestyle
- Recognized Need to Improve Systems of Care
  - AMIA 25 x 5 effort to reduce documentation burden to 25% of Current State in Five Years
  - Make it easier and quicker to do the right thing

Successful Examples of Collaboration for Patient Care Improvement

- Complete Care Program[1]
  - Implemented evidence-based person focused protocols for 26 chronic conditions across ALL care settings and specialties
  - Idea was to leverage every patient encounter across the entire health system and maximizing scope of practice of the team
  - Outpaced HEDIS performance improvement 13% vs 5.5% nationally over six years

- SureNet Program[2]
  - SureNet (Patient Safety Net System) Centralized Surveillance System
  - Identifies patients with abnormal kidney function on lab test and automates FU if no action in 90d
  - Of those patients who followed up, 50.4% were confirmed to have CKD3 and 2.1% at CKD4 or higher.

- Ask-A-Doc Program[3]
  - Geisinger Ask-a-Doc e-consultation program
  - 14% reduction in TCOC in 1st month, 20% reduction during second month
  - Due to reductions in ED visits and unnecessary physician office visits

1. Kanter MH. et.al. Complete Care at Kaiser Permanente: Transforming Chronic and Preventive Care. The Joint Commission Journal on Quality and Safety. 2013; 39(11): 484-494.
2. Sim JJ.et.al. Kaiser Permanente Creatinine Safety Program: A Mechanism to Ensure Widespread Detection and Care for Chronic Kidney Disease. The American Journal of Medicine. 2015; 128: 1204-1211
3. Newman ED et.al. Impact of Primary and Specialty Care Integration via Asynchronous Communication. American Journal of Managed Care. 2019; 25 (1): 26-31.

Listening Session 2: *Supporting Primary and Specialty Care Transformation*

Robert E. Mechanic, MBA

Senior Fellow, Heller School of Social Policy and Management,
Brandeis University,
Executive Director, Institute for Accountable Care

Strategies for Improving Alignment Between PCPs and Specialists in ACOs

Prepared for ASPE/PTAC

Robert Mechanic, MBA

March 3, 2025

Overview

- What does it mean to nest episodes in total cost of care models?
- Episode of care opportunities and challenges
- ACO characteristics that affect the feasibility of nested episodes
- Considerations moving forward

How Would CMS Nest Episodes in ACOs?

- Provide data and encourage ACOs to develop episode-based protocols and incentives?
- Require ACO and their providers to join bundled payment models?
- Set condition-specific benchmarks?
- Structure medical home approaches with incentives for longitudinal specialty care management?
- How would bundle and shared savings payments be reconciled?

Episode Challenges

- Episode volume and random variation
- Risk adjustment
- Provider attribution
- Defining longitudinal episodes given co-occurring conditions

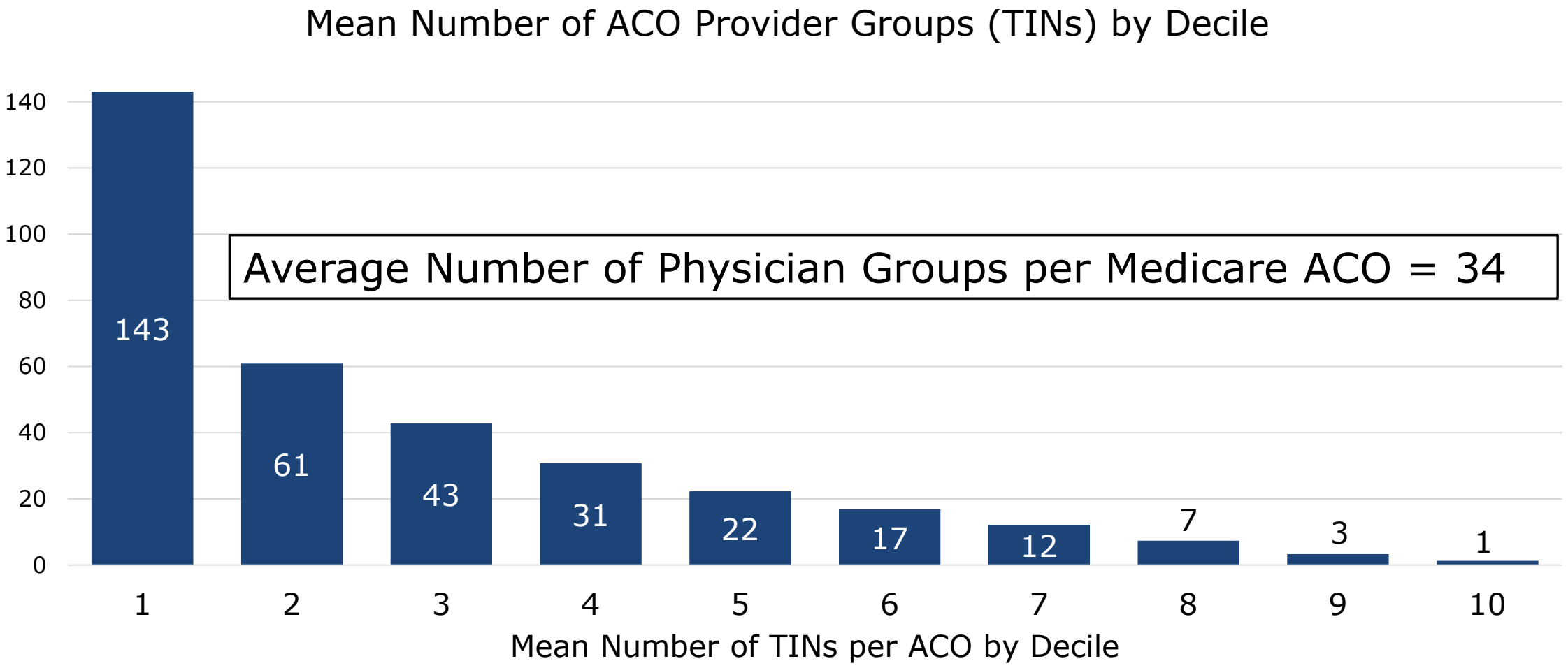
Opportunities for ACOs to Use Episodes of Care

1. Help PCPs make better specialist referrals
2. Engage specialists in value-based care
3. Facilitate effective PCP-specialist collaboration

Tools for Improvement

1. Data
2. Culture
3. Systems/workflows
4. Incentives

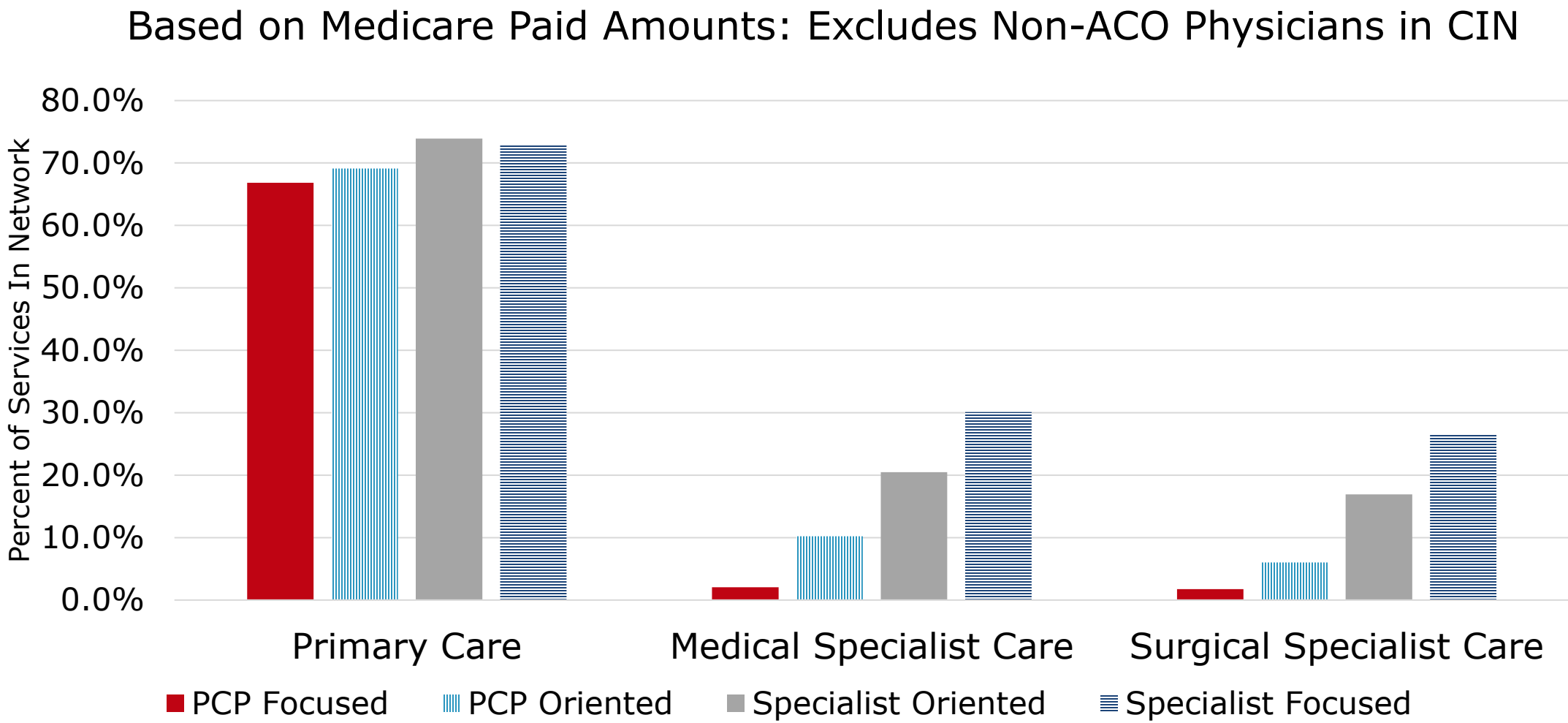
ACOs Combine Multiple Independent Provider Groups



Source: MSSP 2020 Public Use File.

IAC
Institute for Accountable Care

Proportion of ACO Beneficiary Care Provided by ACO Physicians



Source: Institute for Accountable Care analysis of 2019 Medicare Claims (100% file)

Institute for Accountable Care

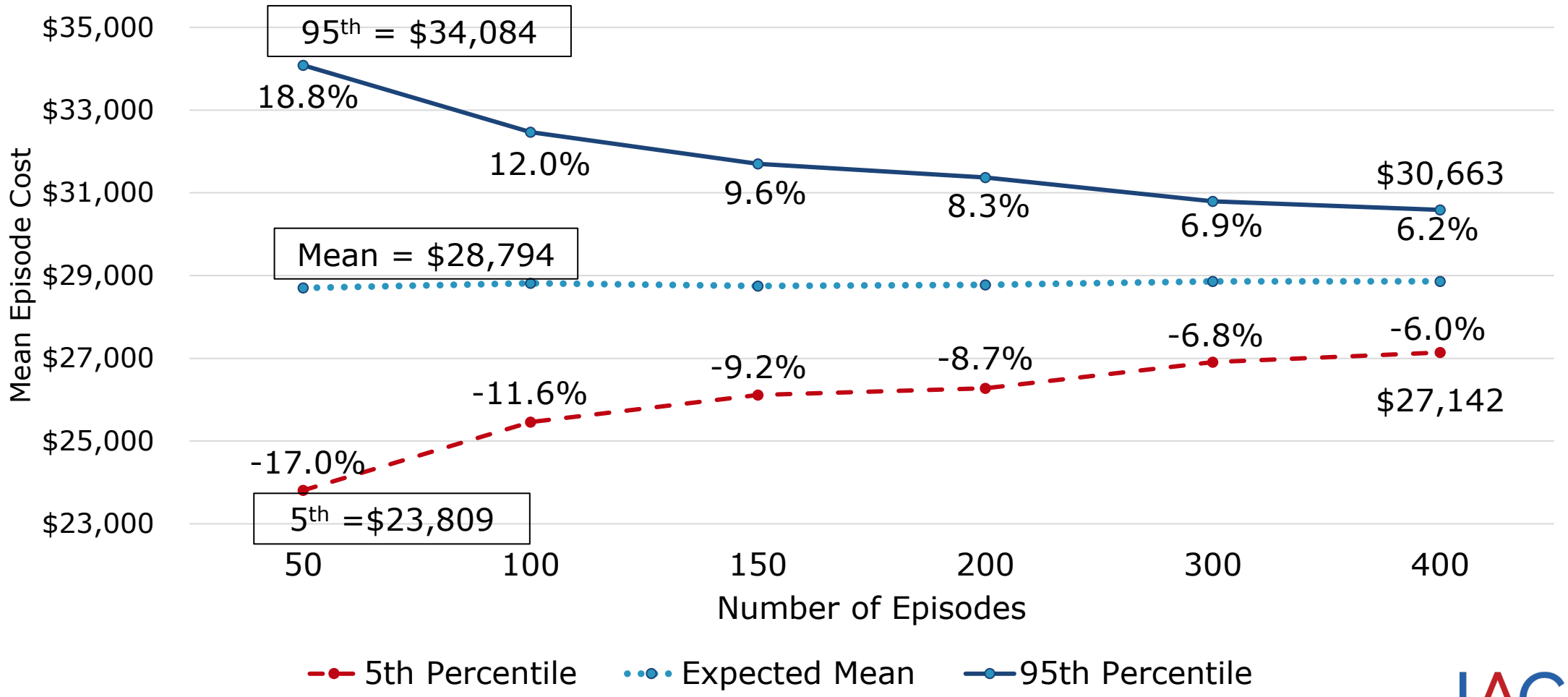
Number of ACOs with 100+ BPCI Cases in 2021

BPCI-Advanced Episode	Number of ACOs	Percent of ACOs
Pneumonia and respiratory infections	391	82.3%
Major joint replacement (lower)	386	81.3%
Sepsis	363	76.4%
Congestive heart failure	225	47.4%
Stroke	141	29.7%
Cardiac arrhythmia	130	27.4%
PCI (Outpatient)	114	24.0%
Gastrointestinal hemorrhage	112	23.6%
Urinary tract infection	117	24.6%
Renal failure	109	22.9%
Spinal fusion	87	18.3%
Hip & femur except major joint	94	19.8%
Acute myocardial infarction	84	17.7%
PCI (Inpatient)	89	18.7%
Major bowel procedure	69	14.5%
COPD, bronchitis, asthma	72	15.2%

Source: Institute for Accountable Care analysis of 2021 Medicare claims data using BPCI-Advanced episodes.

Variation of Risk-Adjusted BPCI Episode Costs Sample Size

90-Day Medicare Episodes: **Heart Failure (HF) Hospitalization**



Source: Institute for Accountable Care analysis of 2021 Medicare claims data using BPCI-Advanced episodes. Bootstrap simulation uses 1,000 random draws of episodes for each case volume group.

Institute for Accountable Care

Reported Barriers to Specialist Alignment in ACOs

1. Lack of data or metrics to evaluate specialist performance (especially quality)
2. Dominant fee-for-service incentives driving specialist behavior
3. Insufficient bandwidth in ACO and among specialist groups to take on engagement efforts
4. Specialist interest in engagement
5. Uncertainty about financial incentives given lack of data and concern about diluting shared savings for PCPs

Conclusions

- CMS should share more episode data with ACOs – ideally 100% of Medicare data including MA
- Incentives needed for specialists to engage with ACOs – not just for ACOs to engage specialists
- Mechanics of nesting episode payment models inside ACOs may be challenging
- Nested medical home approaches with incentives for longitudinal specialty care management worth exploring

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Listening Session 2: *Supporting Primary and Specialty Care Transformation*

Frank Opelka, MD, FACS

Principal Consultant,
Episodes of Care Solutions

(Previous submitter – *The ACS-Brandeis Advanced APM* proposal)

PRIMARY AND SPECIALTY CARE TRANSFORMATION

Frank G Opelka, MD FACS
George Washington University, Professor

DISCLOSURES:

EPISODES OF CARE™ SOLUTIONS, LLC
Founder & Principal

Consultant:

American College of Surgeons
KPMG / State of Colorado

Boards and Advisory Services:

PACES Center
Gemini Health
Metadiagnostics

HOW CAN A PCP, AN ACO, OR MA HELP A PATIENT FIND THE CARE THEY SEEK?

What are specific best practices for integrating primary and specialty team-based care?

How can organizations best facilitate data sharing between primary care and specialty providers in less integrated settings?

What are some specific approaches that have been particularly effective?

PCPS STRUGGLE TO HELP PATIENTS FIND THE SPECIALTY CARE THEY SEEK.

Despite hundreds of payer metrics, still patients ask the same questions.

“I’ve got this condition and need a specialist. What if I need an operation? Do I know all my options?”

“What does good look like and where can I find safe, effective, efficient care?”

“What is the cost?” (out-of-pocket)

Lack of meaningful transparency.

PCPS STRUGGLE TO HELP PATIENTS FIND THE SPECIALTY CARE THEY SEEK.

Meaningful transparency:

- Clinical Outcomes
- Patient Goal Attainment
- IOM's STEEEP (Safe, Timely, Effective, Efficient, Equitable, Patient Centered)
- Certified/Verified to a Clinical Care Standard

VALUE BASED HEALTHCARE

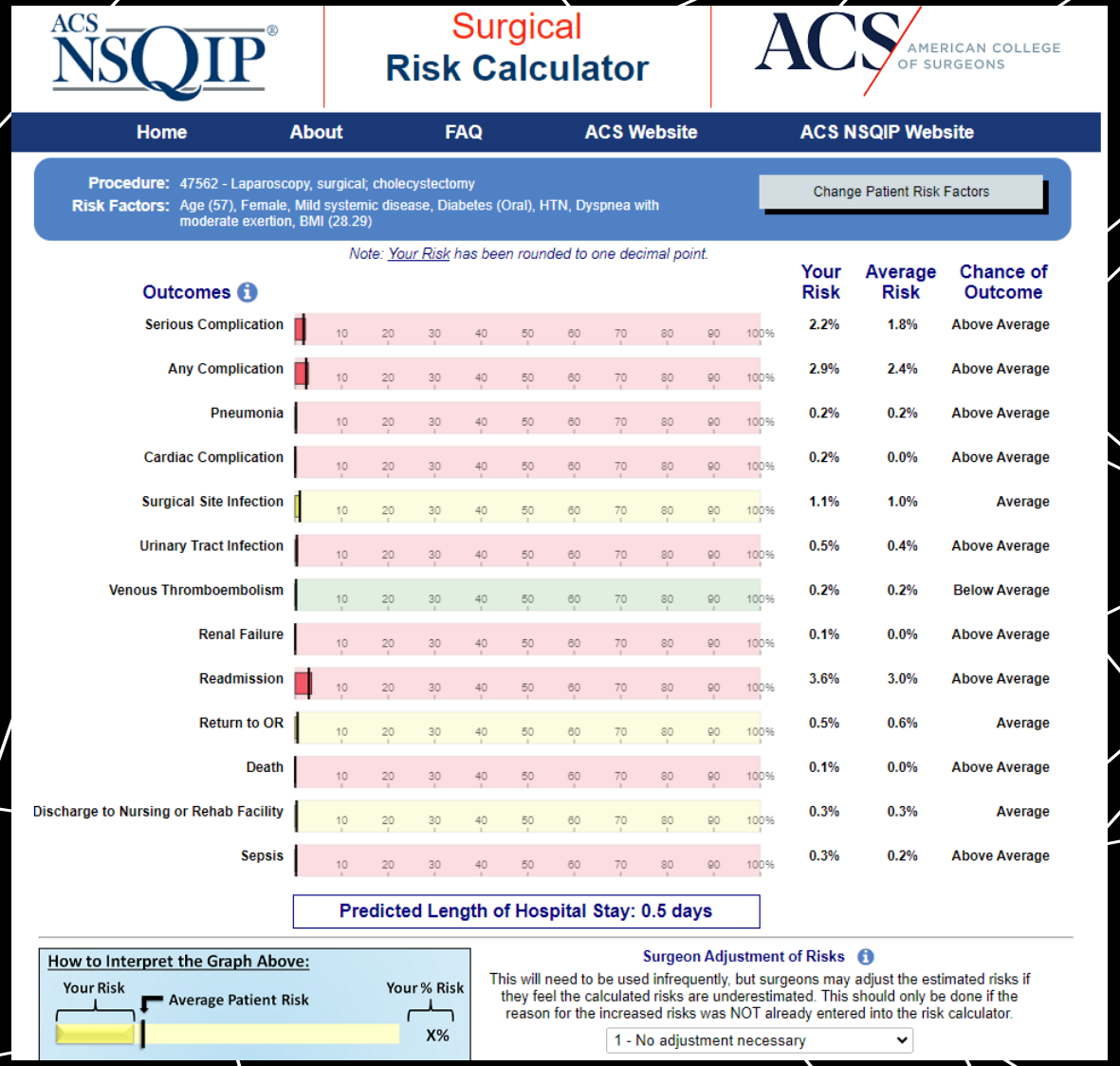
- VBHC is a ***judgment*** defined by the 'end user' reaching a patient's **goals of care**.
- Goals of care should be highly personalized, representing a patient's wishes, with guidance advised by their PCP and specialists.
- It is the **clinical outcome and the patient's goal attainment** that binds the patient, PCP and specialist.
- Too much time and effort is spent on tracking purchaser/payer adverse event metrics and not enough on actual outcomes and levels of patient goal attainment.
- **To achieve value, PCPs, specialists, and patients must have openly shared goals, the true outcomes of care and transparent level goal attainment.**

REFERRALS RELY TOO OFTEN BASED ON RARE ADVERSE EVENTS.

THEY ARE NOT GOAL ORIENTED. IMPERSONAL. TECHNICAL. **NO SHARED OBJECTIVES.**

TRACKING ADVERSE EVENTS IS NOT DISTINCTIVE. MOST AVOIDABLE HARMS ARE RARE. WE TRACK THEM BECAUSE THEY ARE COSTLY.

DEFINE PATIENT GOALS AND EXPECTATIONS OF THE REFERRING PCP.



VALUE BASED HEALTHCARE

- **Patient Goals of Care:** meeting the unique needs of patients, considers care based on various factors such as severity of their illness, their underlying co-morbidities, patient affordability, resource availability, patient preferences and goals, socio-economic circumstances and more.
- **Certified / Verified Care Teams:** Healthcare relies on the right structure for the available resources, the ability for a team to be reliant and execute the processes of care, tracking outcomes, manage patient risk variability and so forth.

THE UNIT OF ANALYSIS FOR OPTIMAL VALUE IS FOUND IN THE KPIs WITHIN AN EPISODE OF CARE:

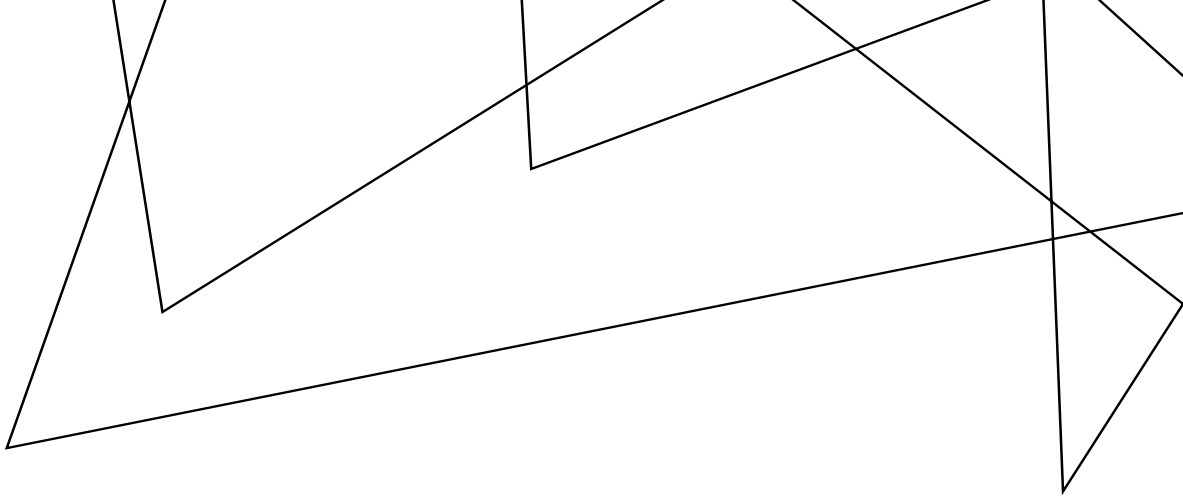
A) DEFINE *EPISODE OF CARE*

B) EPISODE CARE TEAM & FACILITY

C) EPISODES IN VERIFIED FACILITY FOR CLINICAL DOMAIN

D) OPEN & TRANSPARENT KPIs

SAFETY PROFILE
GOAL ATTAINMENT SCORES
CLINICAL OUTCOMES
ACCESS
AFFORDABILITY
PATIENT RISK PROFILES



Patient Defined Goals of Care

- Patients and purchasers are asking for **one episode price**
- Inclusive of **all clinical services**
- **One team** to deliver the total episode
- **Patient's goals:** safe, affordable, satisfactory outcome, & equitable

Note: KPIs = Key Performance Indicators

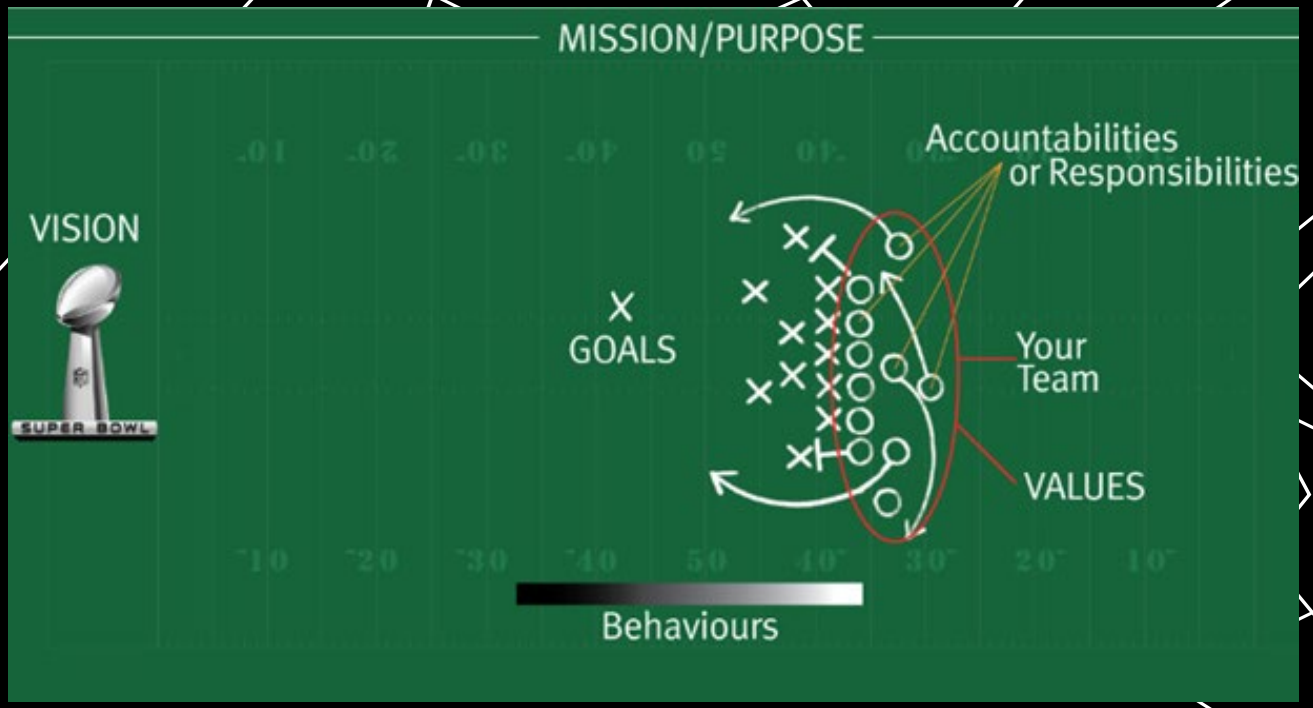
AN ORGANIZED TEAM IS ESSENTIAL TO SUCCEED IN EPISODE

Time for a thought exercise:

Imagine your favorite sports team.

Team Role players: (I'll use an NFL football team)

- Top line quarterback
- Upper tier running backs and wide receivers
- Hall of Fame tight ends
- Down lineman pro-bowlers



Despite raw talent, this is not a *team* until they come together, test themselves, push beyond, self accountability, etc.

Healthcare Teams are measurably distinctive!

(Verification)

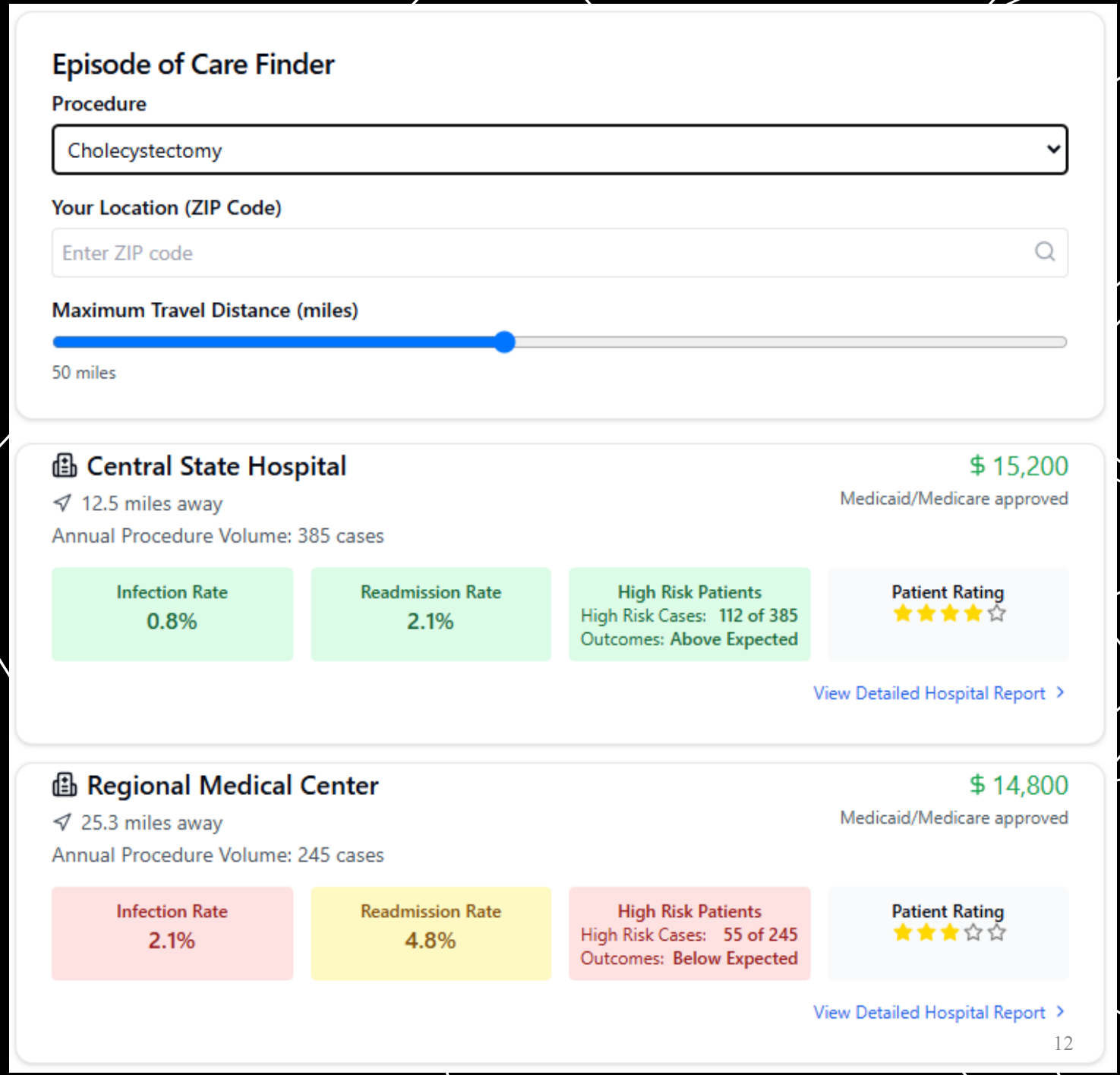
DIGITAL CLINICAL REFERRAL PLATFORMS

A patient and PCP need a digital platform for shared knowledge.

PCP – Specialty Integration is about Share Knowledge.

To provide everyone with openly available information for the episode of care they seek. The platform must contain the information about all the STEEEP factors.

EPISODE COMPARE



EPISODE COMPARE

Memorial Regional Hospital

☆ Center of Distinction

← Back to Episode Hospital Comparison

2420 W 26th Ave, Denver, CO 80211

✓ Medicare Participating Hospital

✓ Medicaid Certified

Episode of Care

Total Knee Replacement

Typical Duration: 8-12 weeks

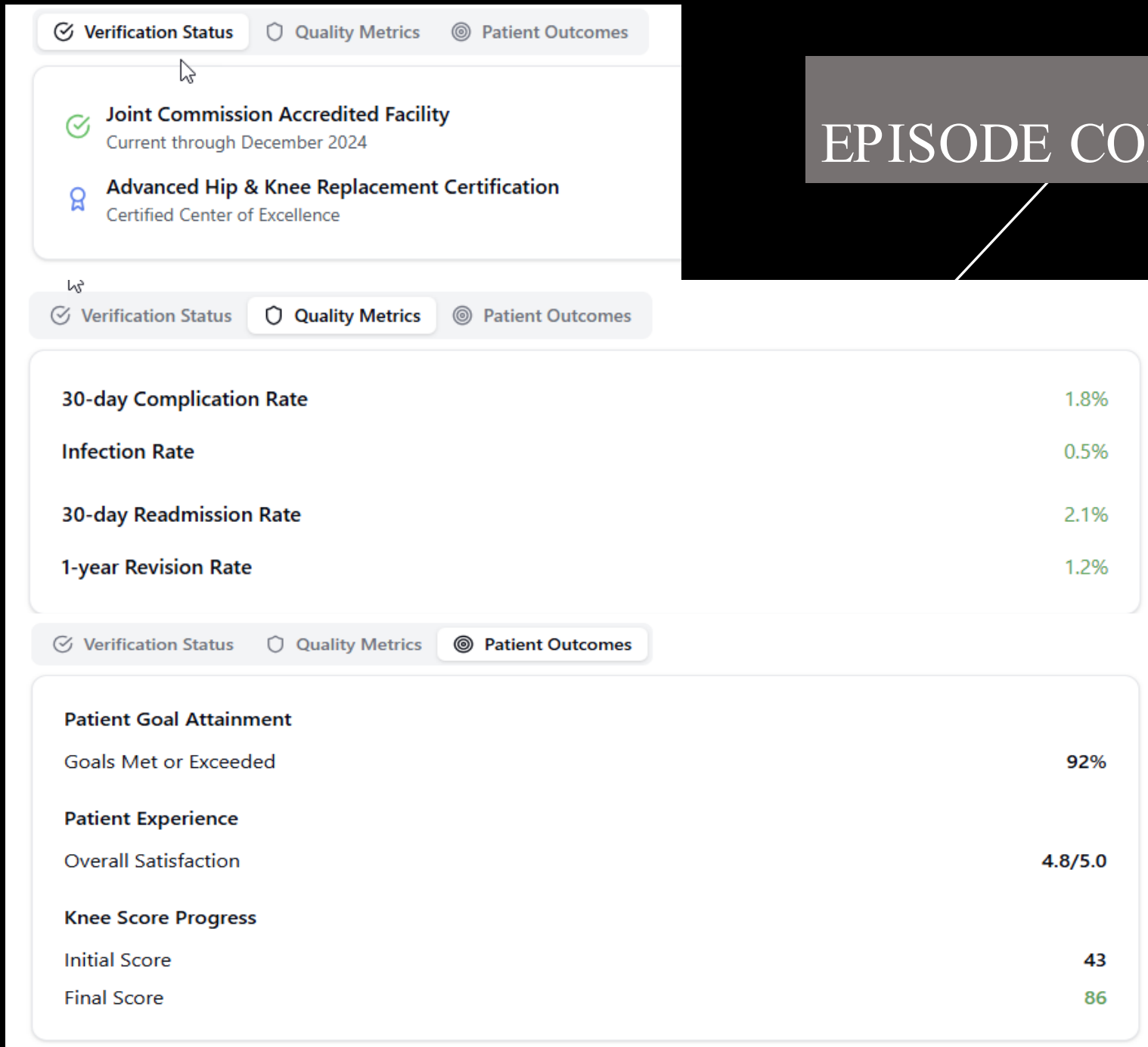
Care Pathway:

- Pre-op: Education & Physical Therapy
- Day 0: Surgery
- Days 1-3: Hospital Recovery
- Weeks 1-3: Home Recovery & PT
- Weeks 4-8: Outpatient Rehabilitation
- Week 12: Final Assessment

Volume & Cost Metrics

Annual Volume	**847 cases**
Expected Cost (risk-adjusted)	**$32,500**
Observed Cost	**$29,800**
High Risk Patients	**168 (19.8%)**

EPISODE COMPARE



Highlight patient-centered care.

Reduce emphasis on the hospital or individual physicians.

Help patients and PCPs to focus on the outcomes and not on who received payment incentives.

THANK YOU

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Episodes of Care Solutions, LLC