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 UNIVERSITY

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

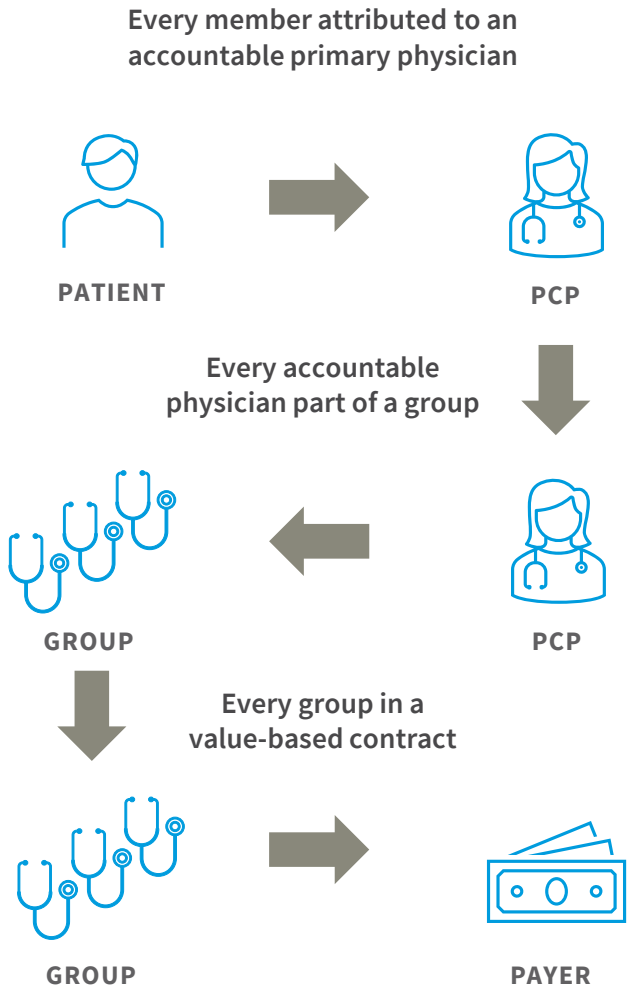
Powered by deep expertise, enabling technology, analytics, playbooks, workflows, and continuous improvement.

DRIVERS	OUTCOMES – Triple Aim Plus One	
Aligned Incentive Payer/ Employer Contracting	**Reduced Per Capita Costs of Care**	26% lower costs vs. FFS Medicare
Effective Compensation & Incentives	**Improving the Health of Populations**	Average of 4.5 Stars for the past twelve years, 5 Stars for 2022
Care Delivery Transformation & Delivery of Accountable Primary Care (Nine C's®)	**Increasing Physician Engagement**	89% of providers rate they are satisfied w/collaborative payer
Enterprise Engagement	**Improving the Consumer Experience of Care**	Highest consumer satisfaction
Ideal Leadership & Organizational Structure		
Powerful Technology & Information		

**Health System, Facility, Others…*

Sources: 2016 AON Actuarial Study, 2019 Provider Satisfaction Summary, CMS Star Ratings

Essence Healthcare - A Collaborative Payer

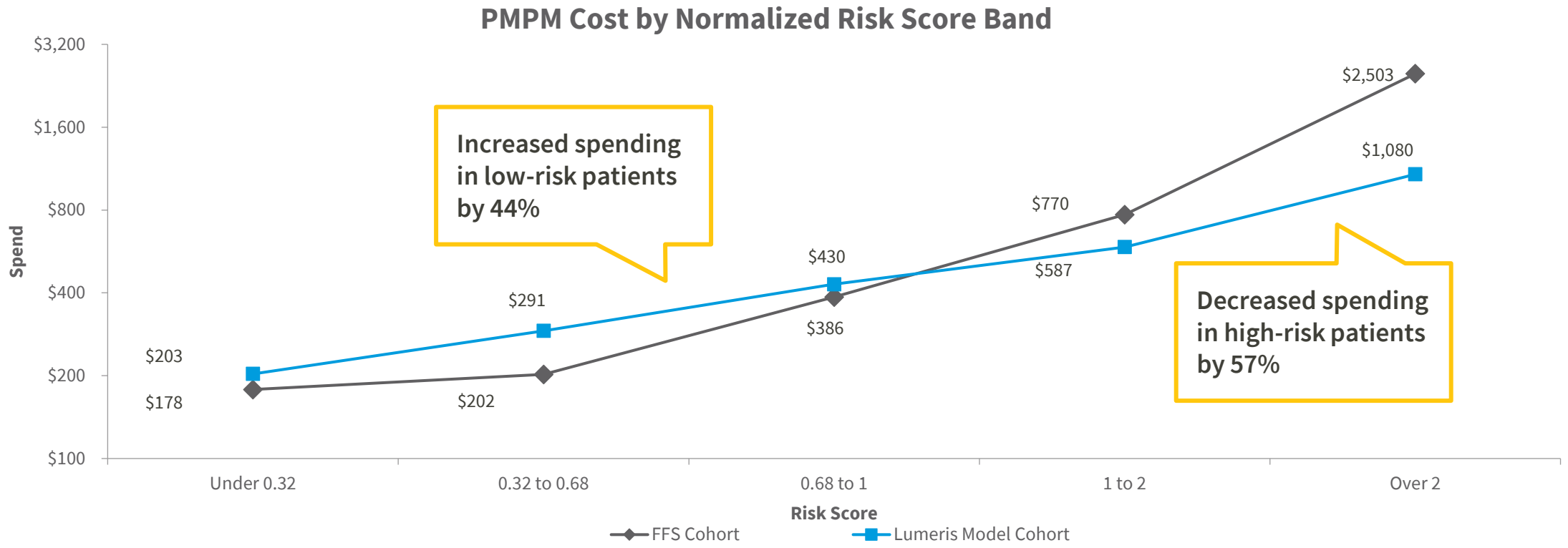


Best Practices in TCOC Alignment

- 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.*



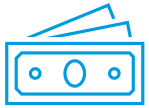
*Source: 2016 AON Actuarial Study

Reducing Unnecessary Costs & Utilization

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

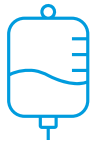
48% Reduced specialist spending

18% Fewer readmissions



26% lower costs

SNF costs **52%** lower



Outpatient facility surgery spending **1.5x** higher

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

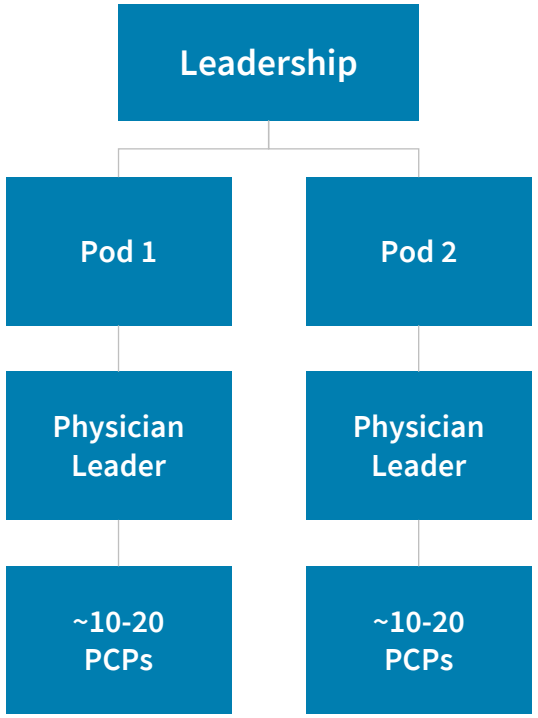
What is a POD?

- 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



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

Powerful Technology and Information

maestro

KNOW

DO

myPCP

Population Health Executives

Clinicians & Care Team

Clinicians & Care Team

Patient / Beneficiary

aws

Business Intelligence

Clinical Intelligence

Machine Learning Insights Engine – Risk and Predictions

Lumeris Measures Calculations

Population Health Analytics

Appointment

Text Messaging

Referral

Email

Voice Call

Patient Message Portal

Data Ingestion and Transformation

ELLKAY

Hart

Smartlink Health

Data Sources

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

United Healthcare

athenahealth

eClinicalWorks

aetna

Anthem

Epic

Cigna

EVENTS

- High risk discharges
- Overdue visits
- No-shows
- Open gaps in care
- Medication adherence issues
- Rising risk
- Inappropriate ED use
- Patient questions
- Etc.

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

MyHealth ACCESS NETWORK

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

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Experience with CMMI Models

Model	Roles	Timing
Comprehensive Primary Care Initiative (CPC Classic)	• Convener • National Faculty • Data Aggregator	2012-2016
CPC+	• Data Aggregator • National Faculty • Convener	2017-2021
Accountable Health Communities	• Principle Investigator • Bridging Organization	2016-2022

Primary Care First	• Event Alerting
	• Proposed:
	  • Data Aggregator
	  • Social Determinants of Health Screening
	  • Convener
		2022-?

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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
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   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

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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

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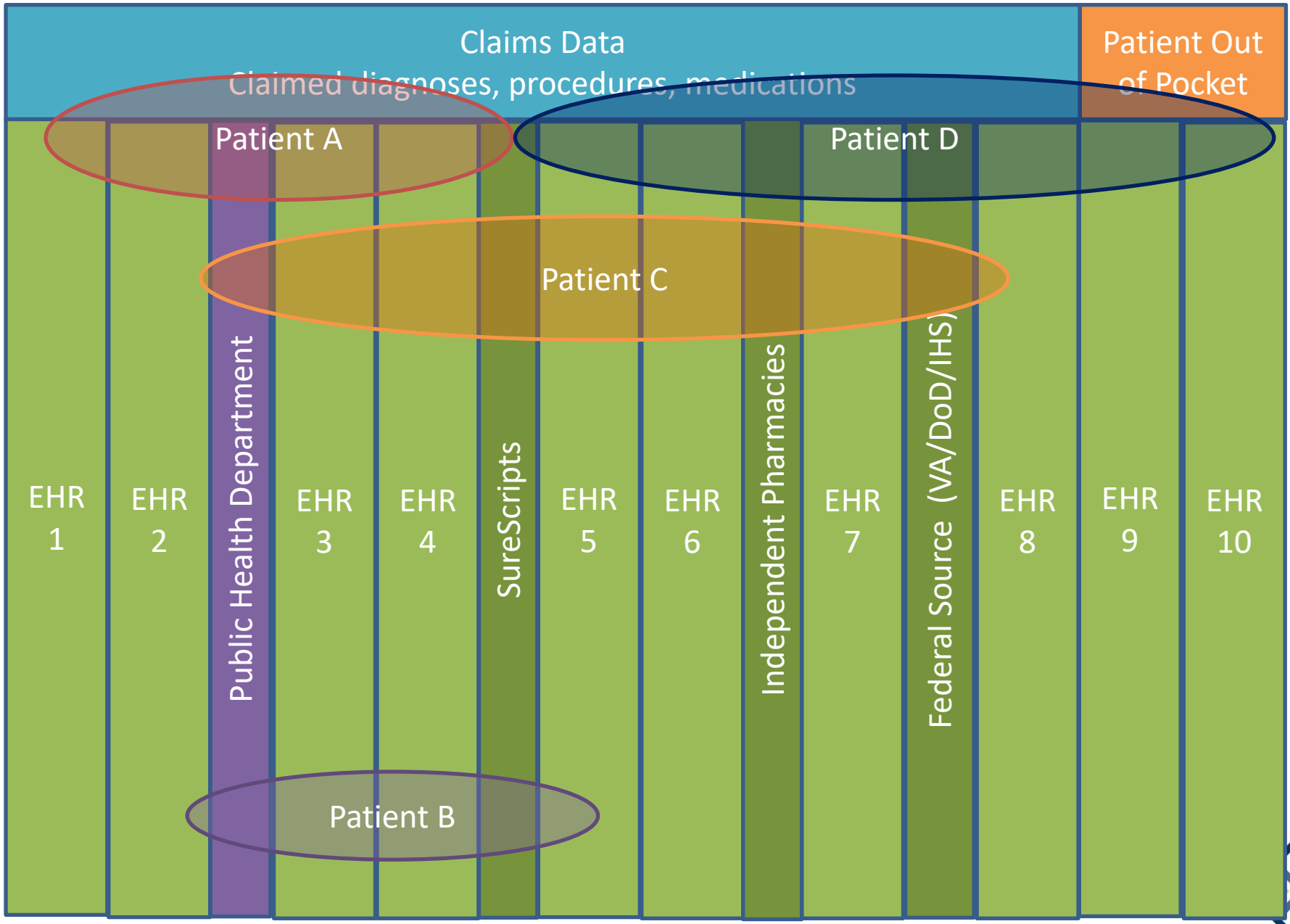

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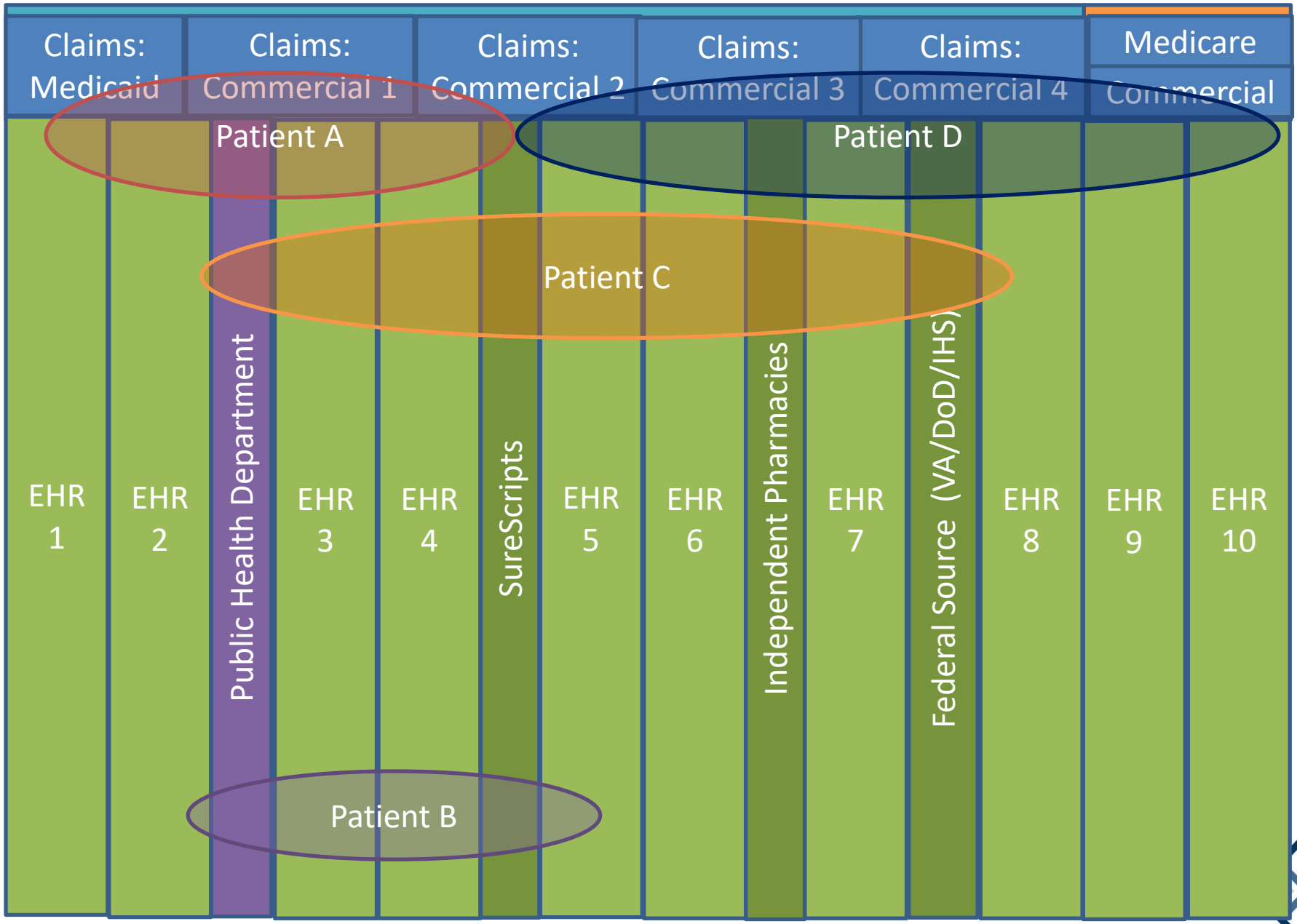

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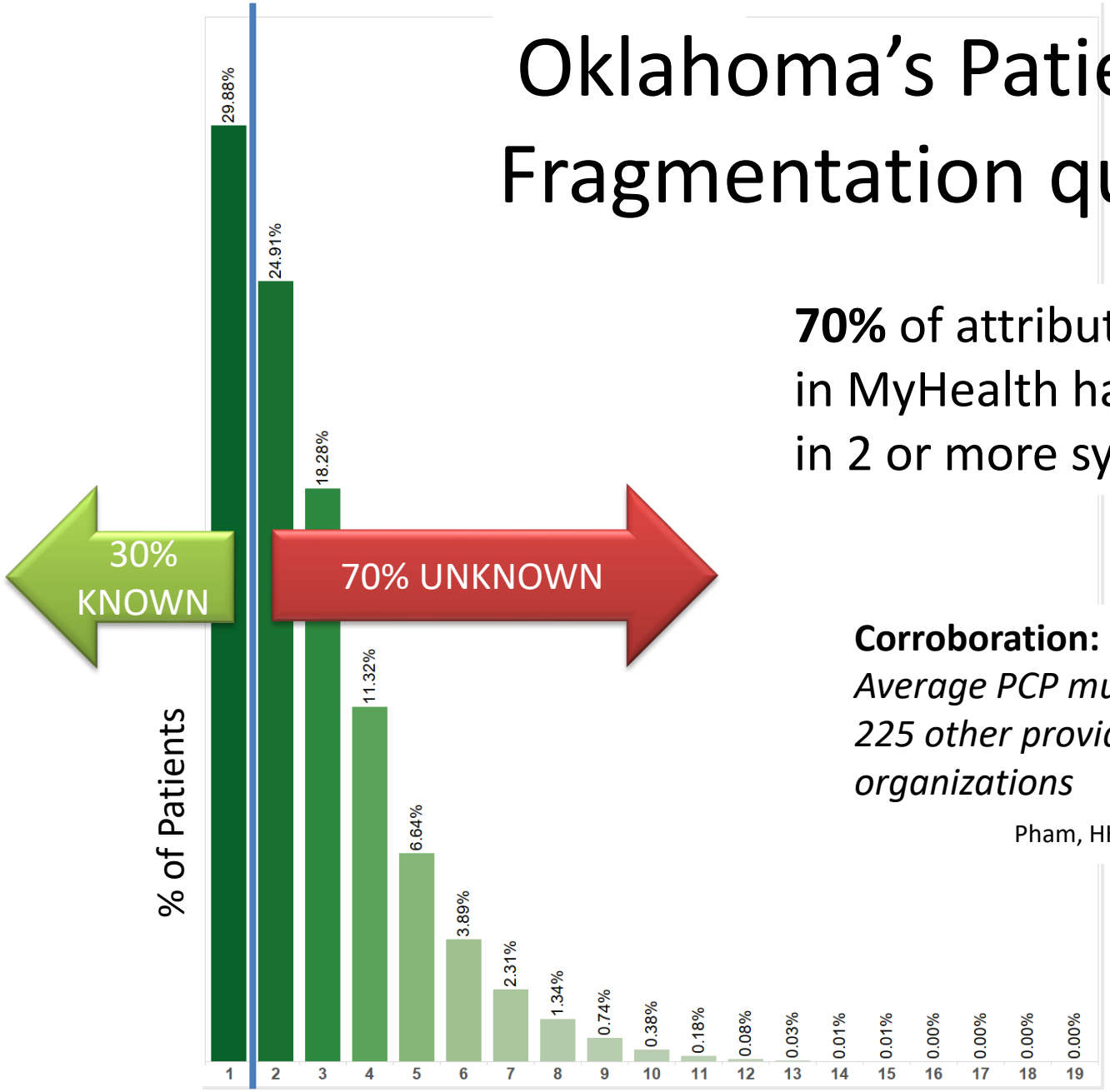
Oklahoma's Patient Data Fragmentation quantified



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

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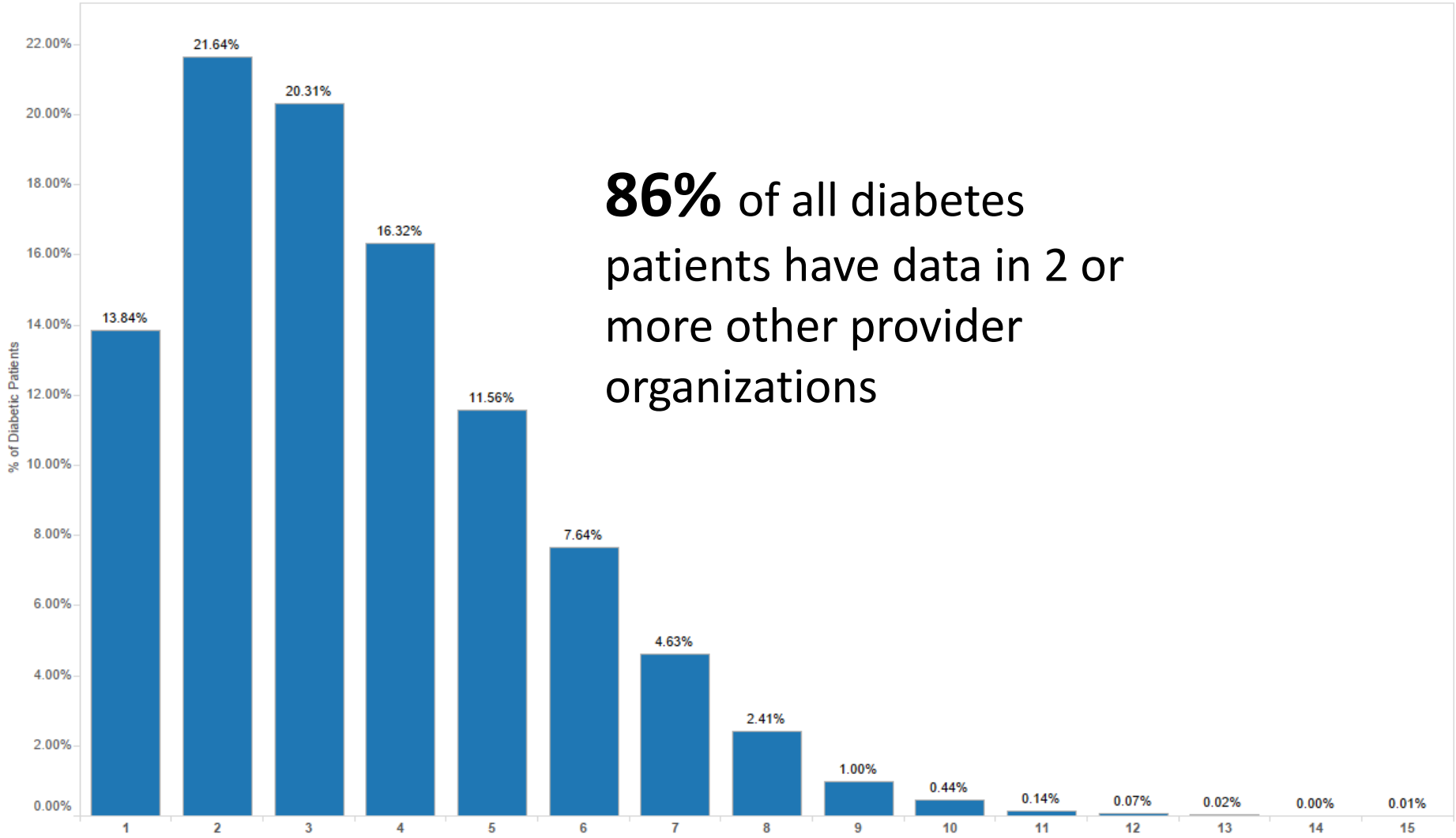
Diabetes patients with records elsewhere



86% of all diabetes patients have data in 2 or more other provider organizations

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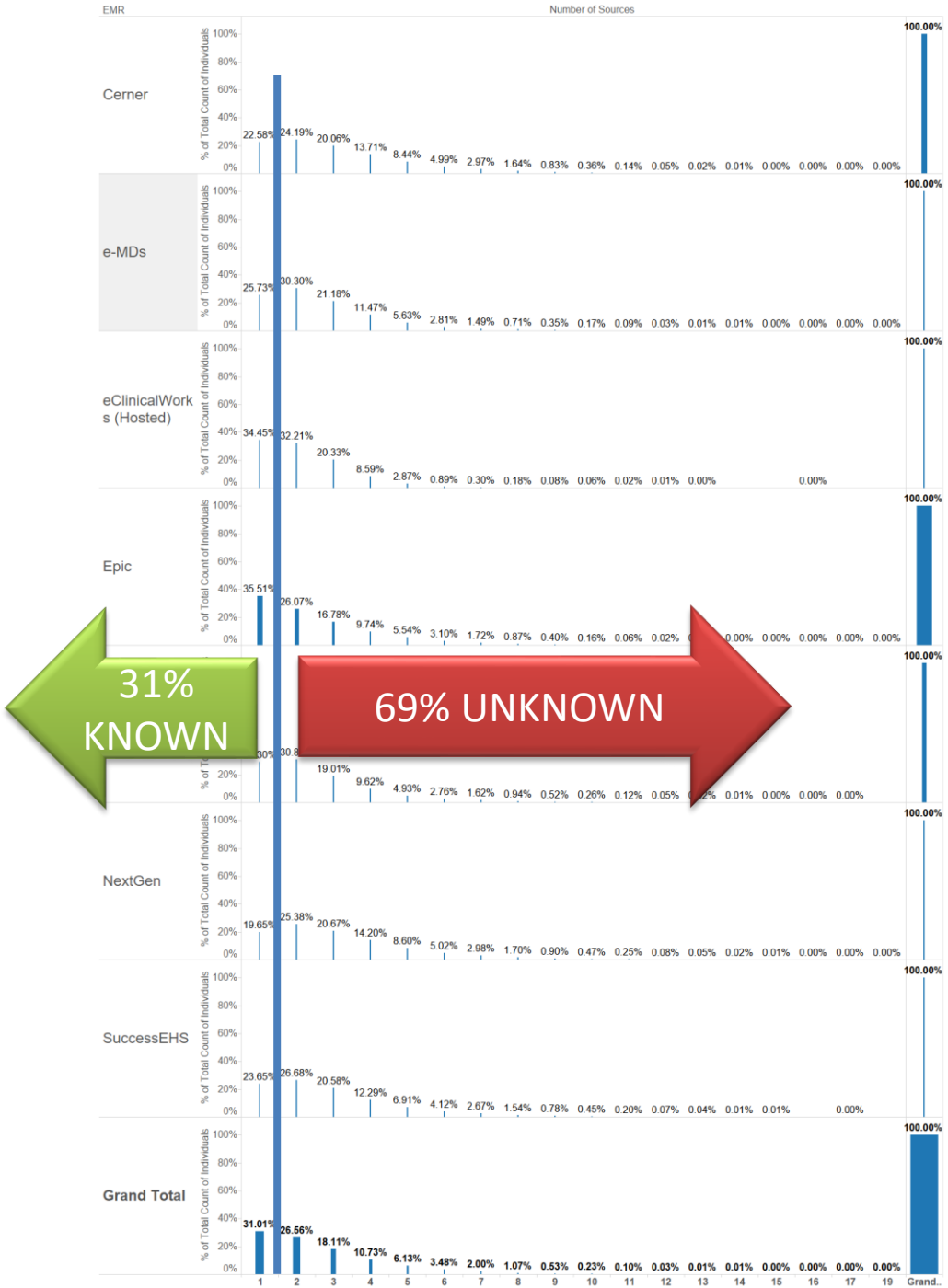

Data fragmentation by EHR Vendor

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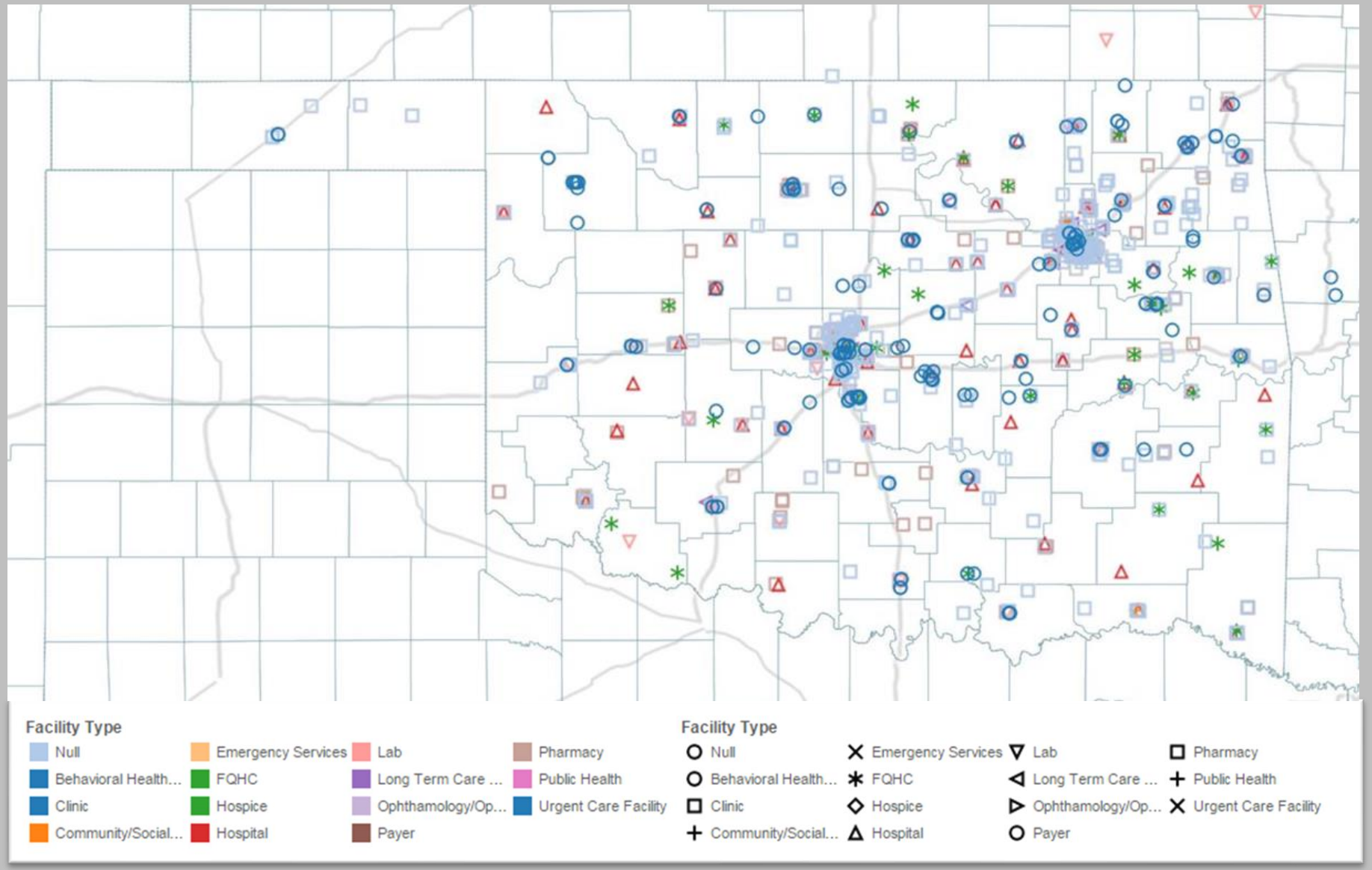
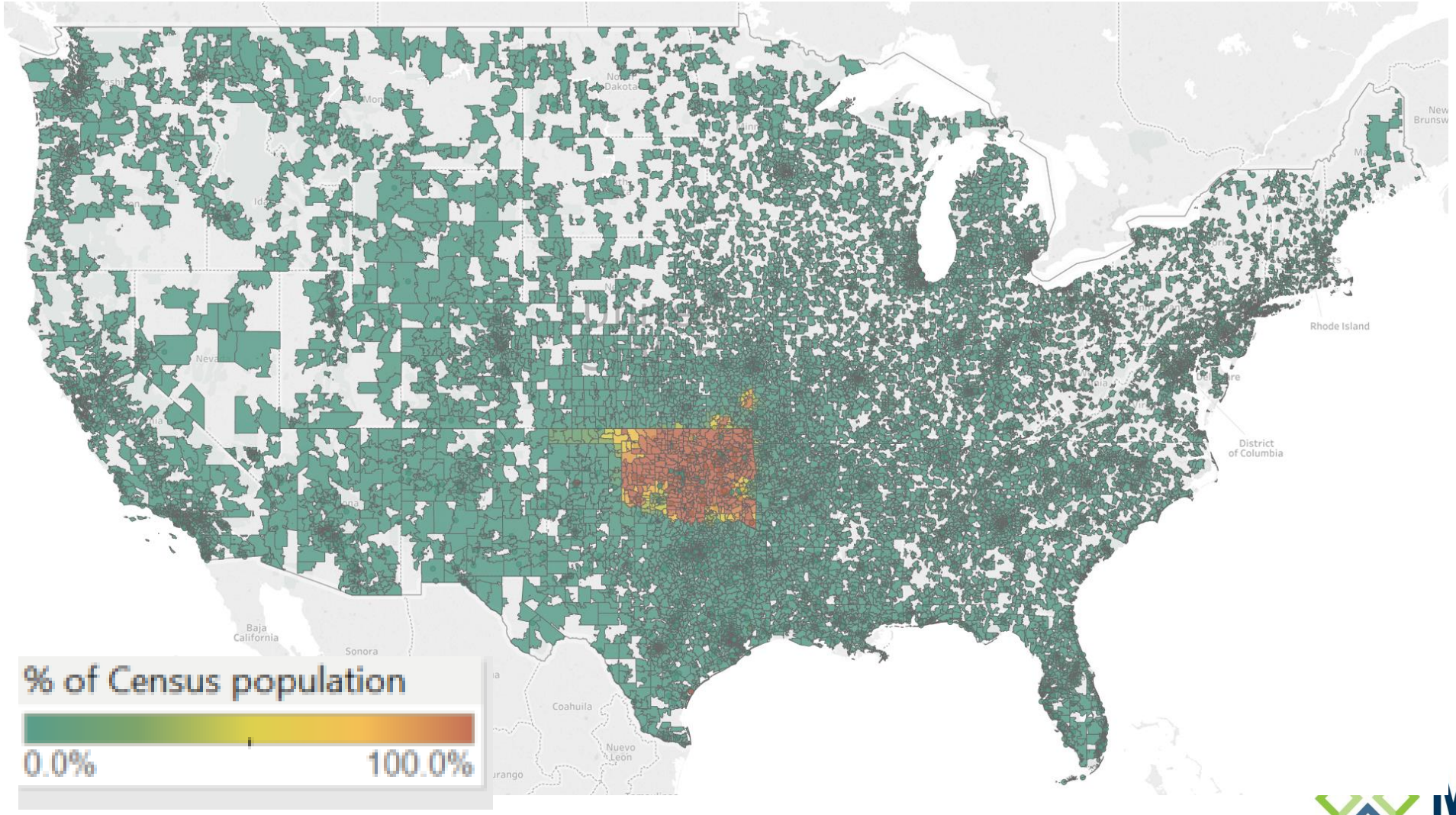
>1400 locations serving >110,000 patients daily



MyHealth Patient Population



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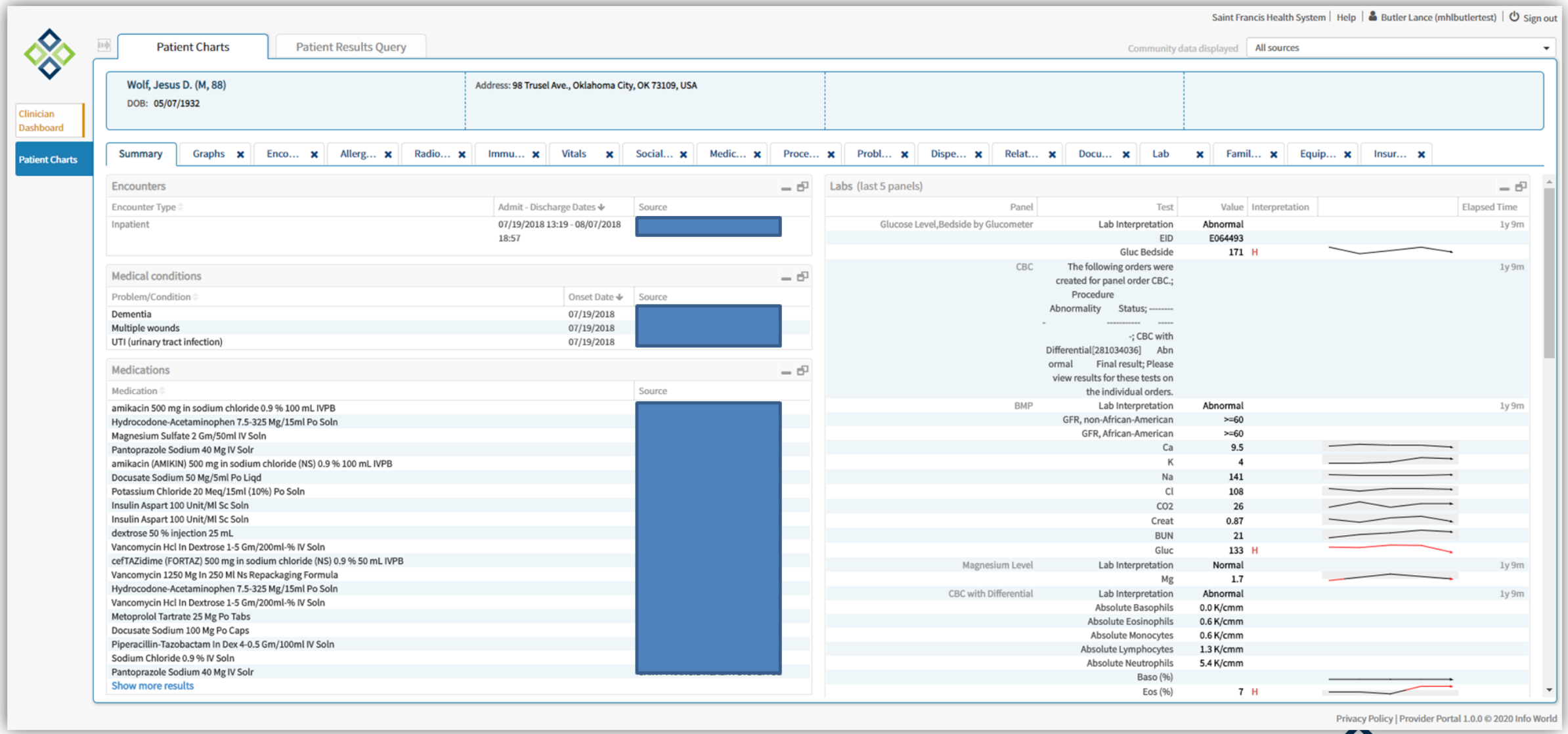
MyHealth Provider Portal + FHIR API



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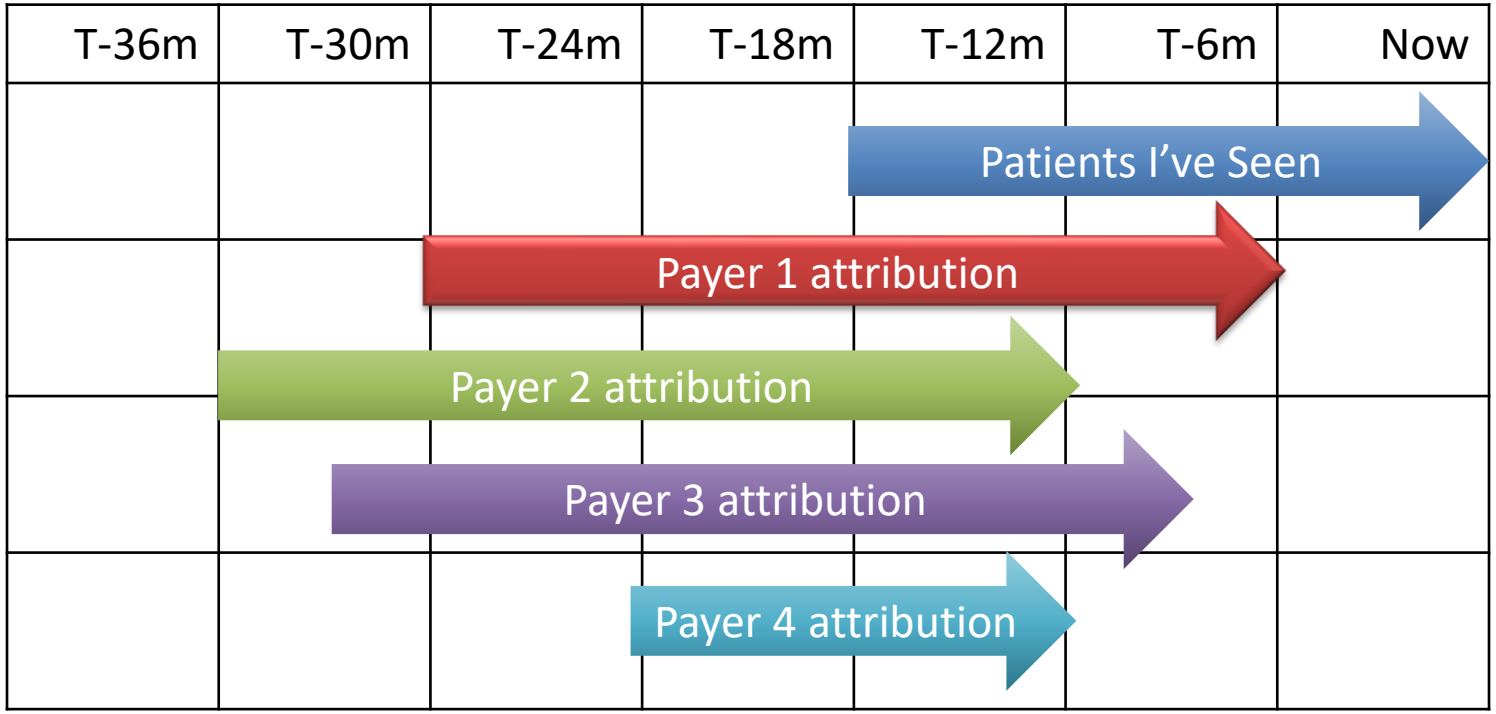
Who are my patients?

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



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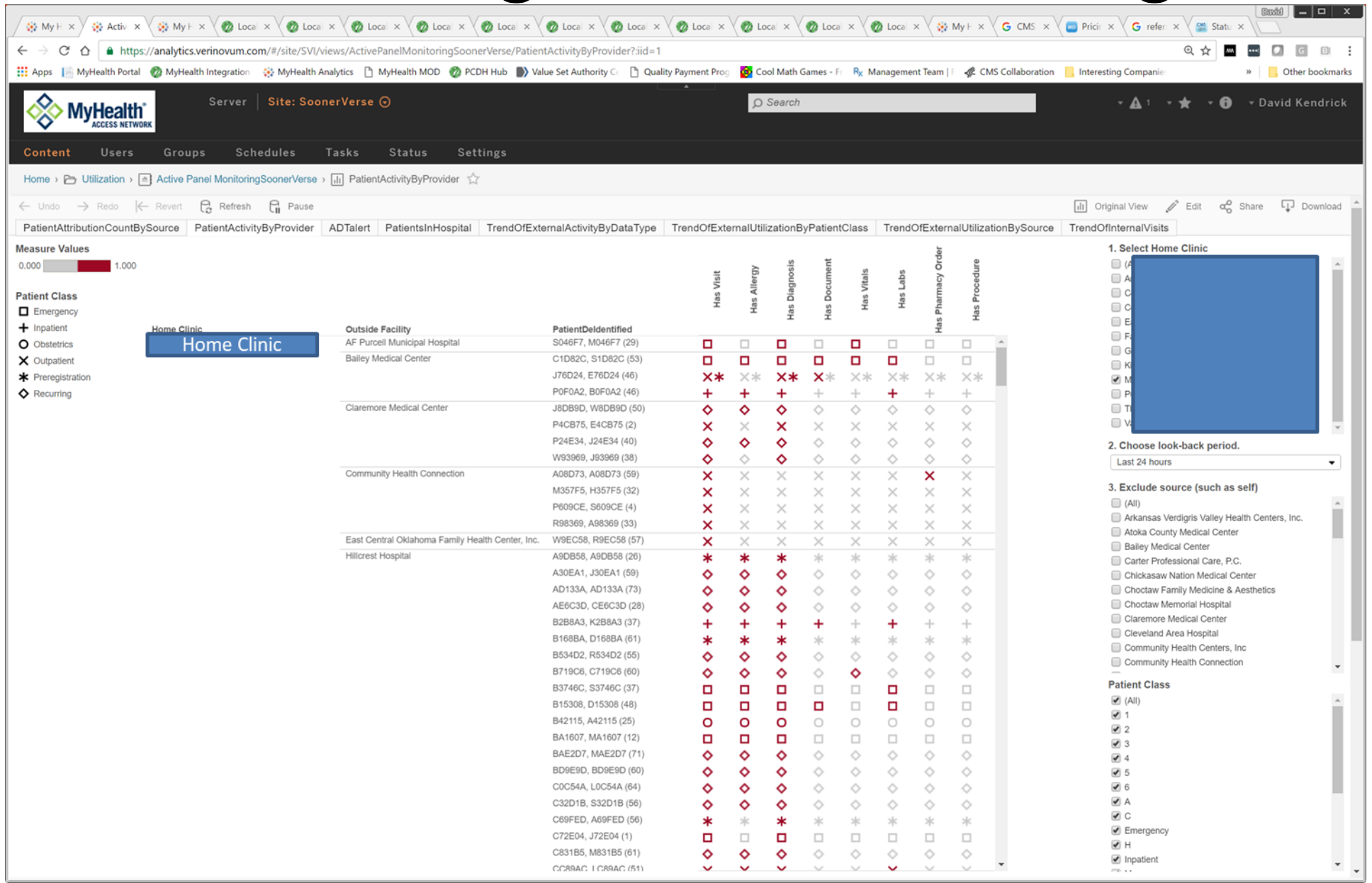
Care Fragmentation Alerting



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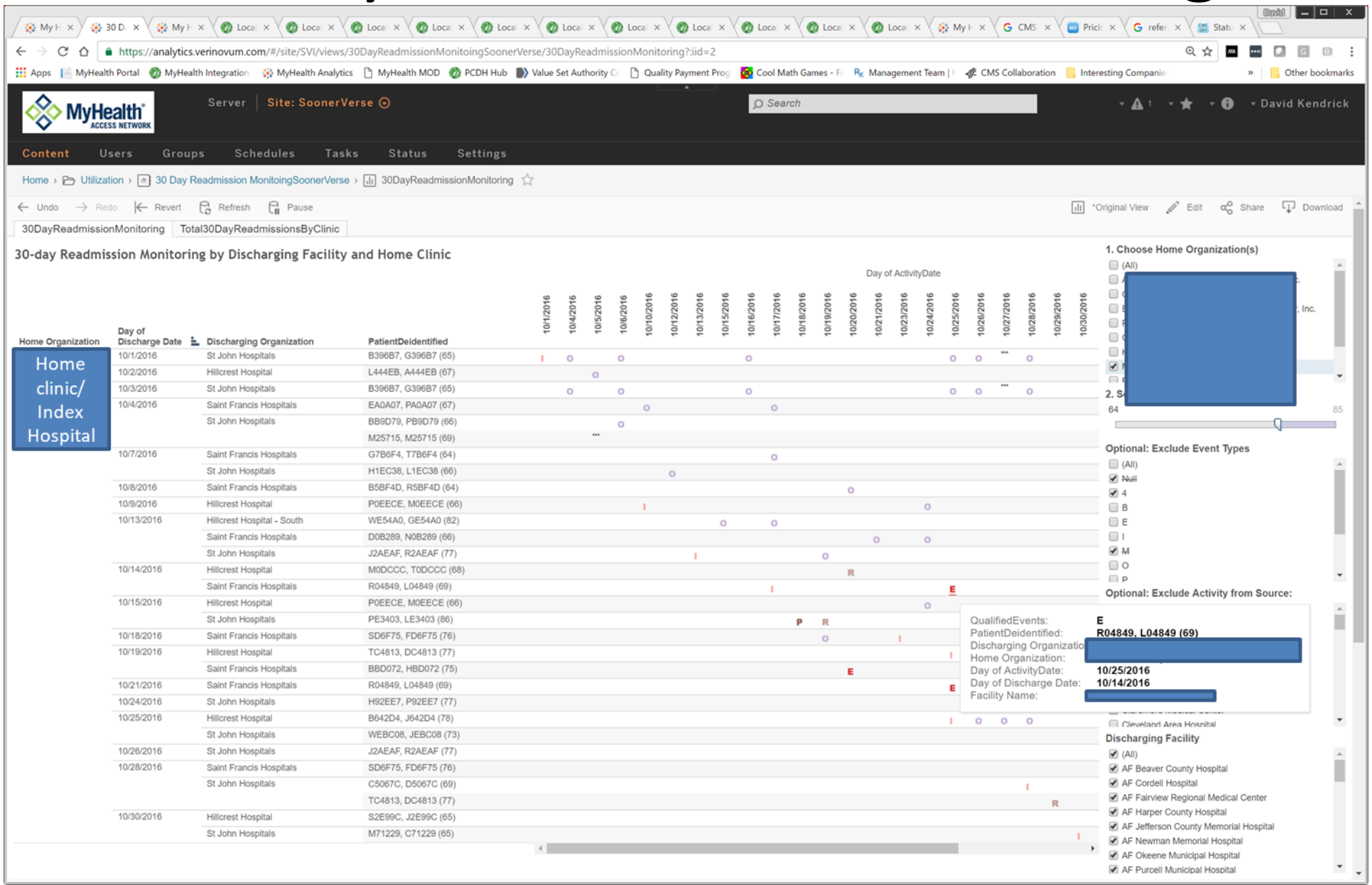
30-day readmission monitoring



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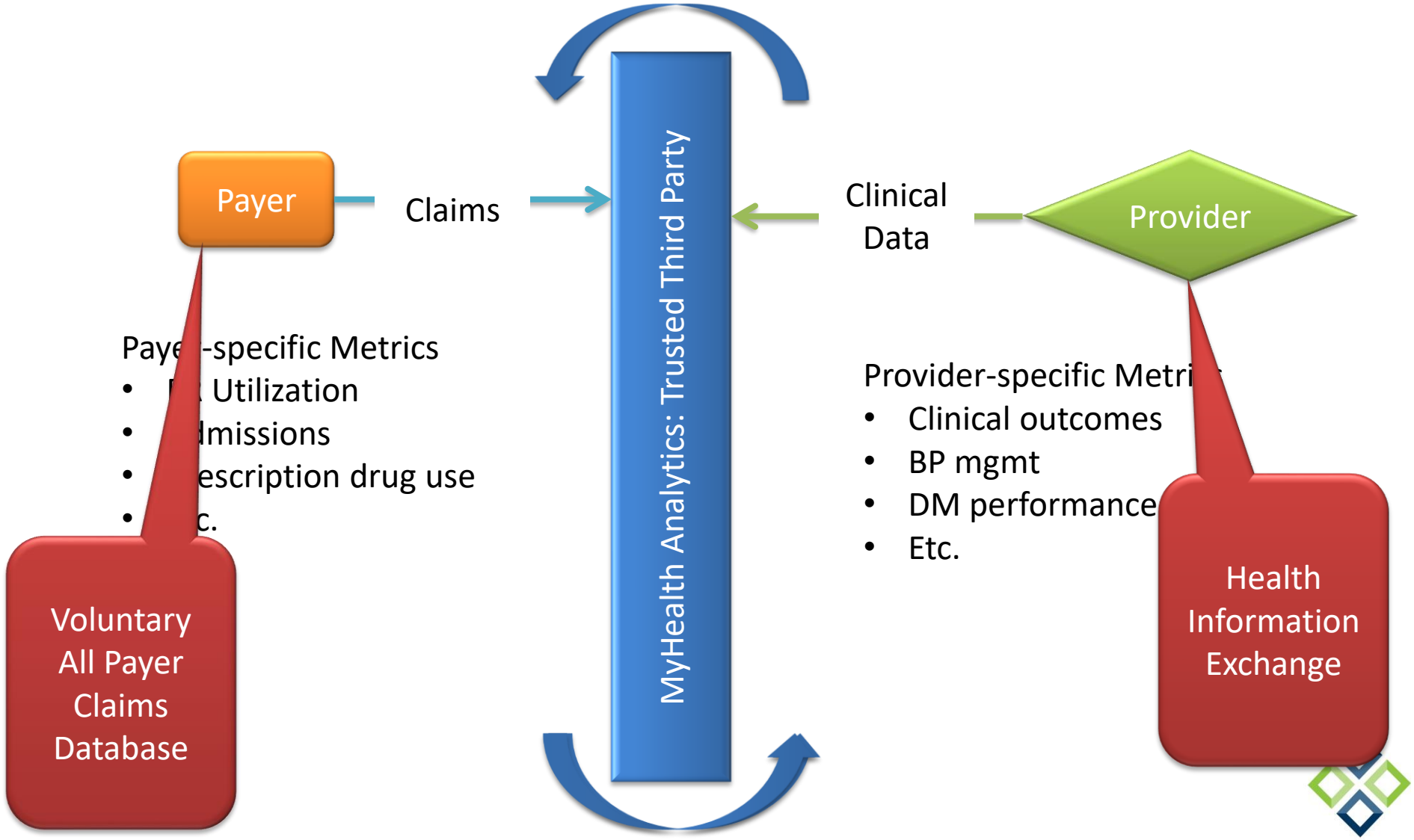
Trusted 3rd Party for Measurement



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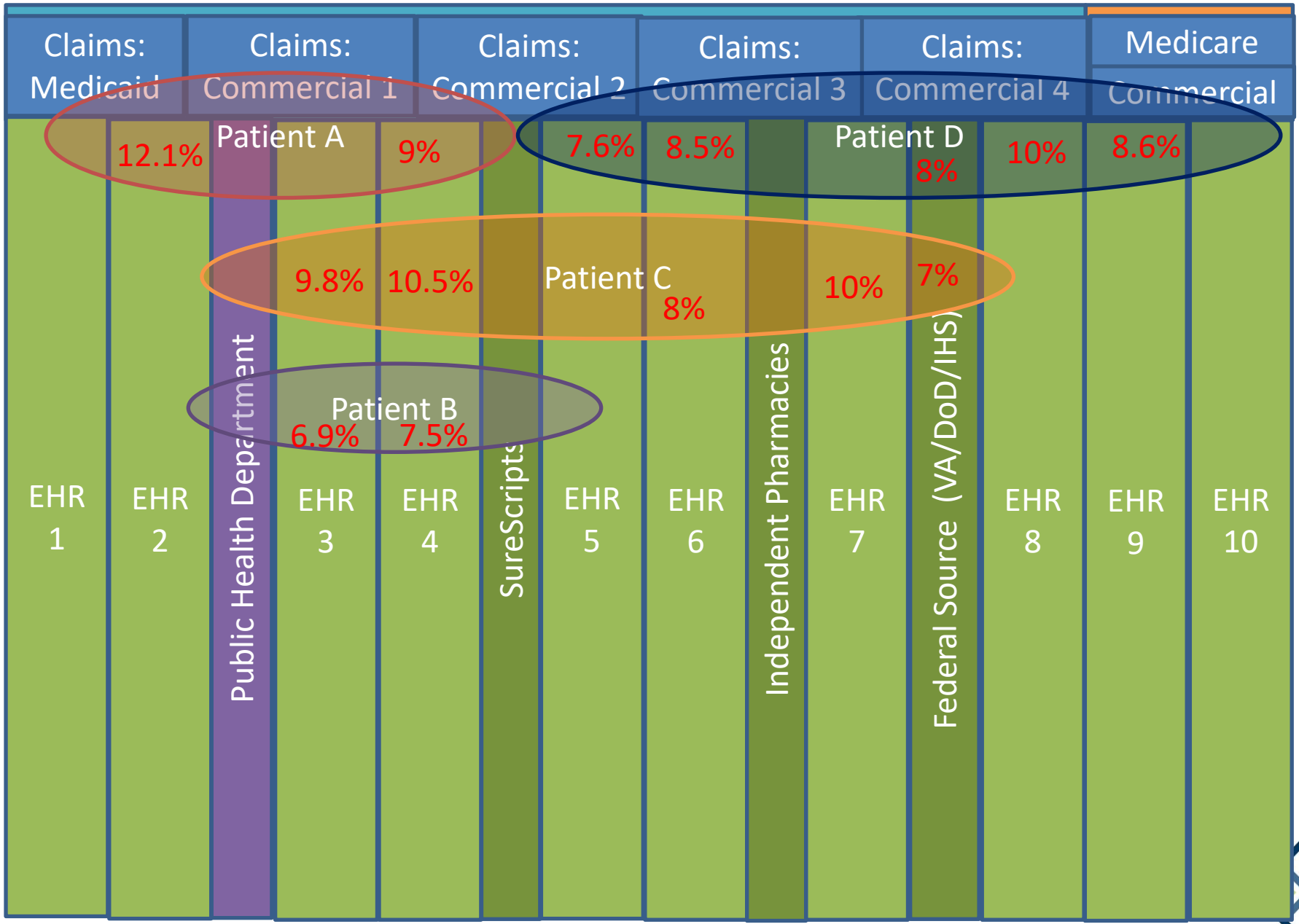
Example: HbA1c control– what is the correct answer for each provider? Patient? Payer?



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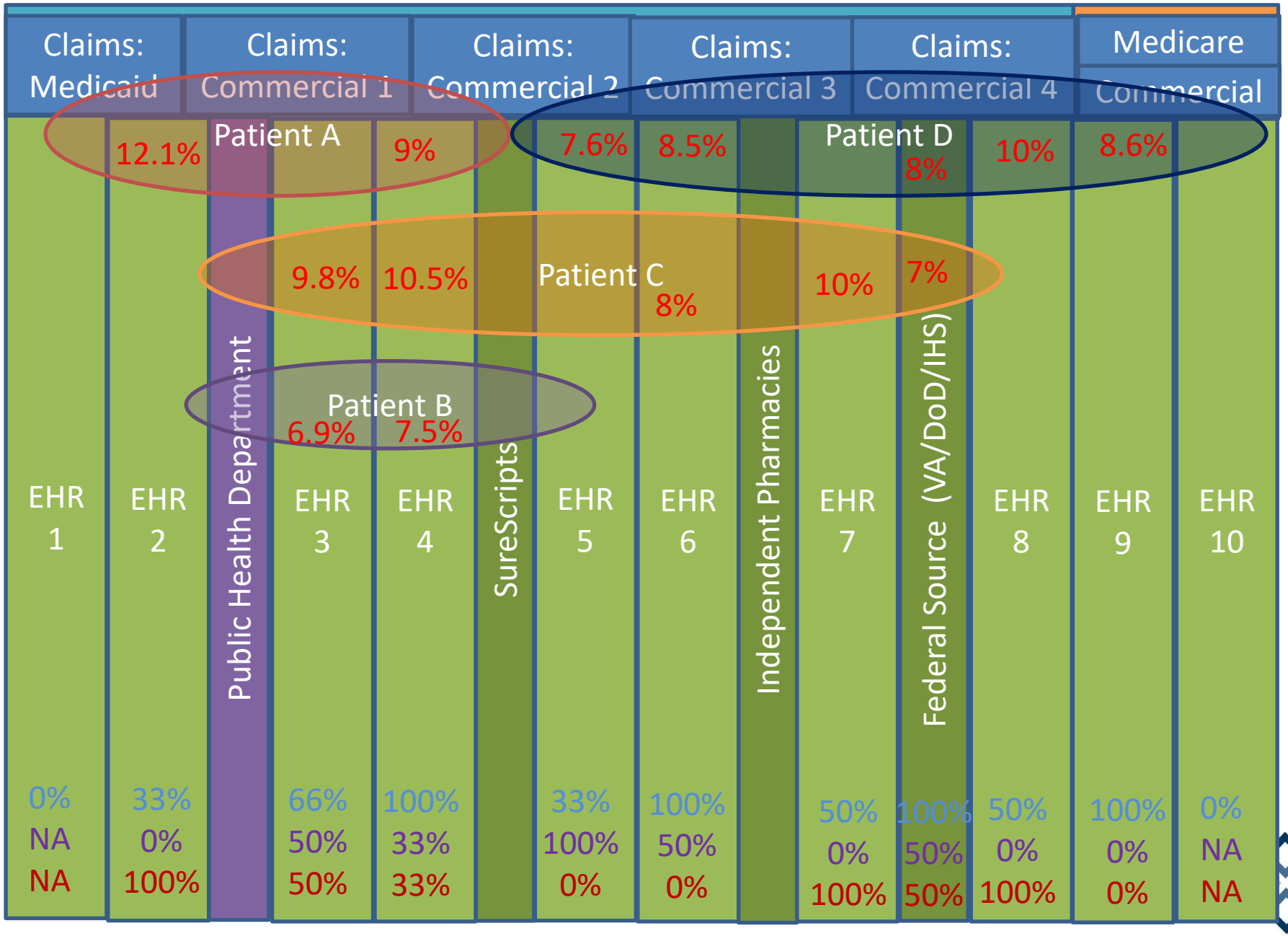
Take 3 diabetes measures: 1) Appropriate Testing, 2) Control <8, 3) Out of Control >9



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Take 3 Diabetes Measures:

Source	Appropriate HbA1c Testing	DM in control (A1c<8)	DM out of control (A1c>9)
EHR 1	0%	NA	NA
EHR 2	100%	0%	100%
EHR 3	66%	50%	50%
EHR 4	100%	33%	33%
EHR 5	33%	100%	0%
EHR 6	100%	50%	0%
EHR 7	50%	0%	100%
EHR 8	50%	0%	100%
EHR 9	100%	0%	0%
EHR 10	0%	NA	NA
VA/DoD/IHS	100%	50%	50%
Population:	?	?	?

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

Looking at populations, we cannot roll these up . . .

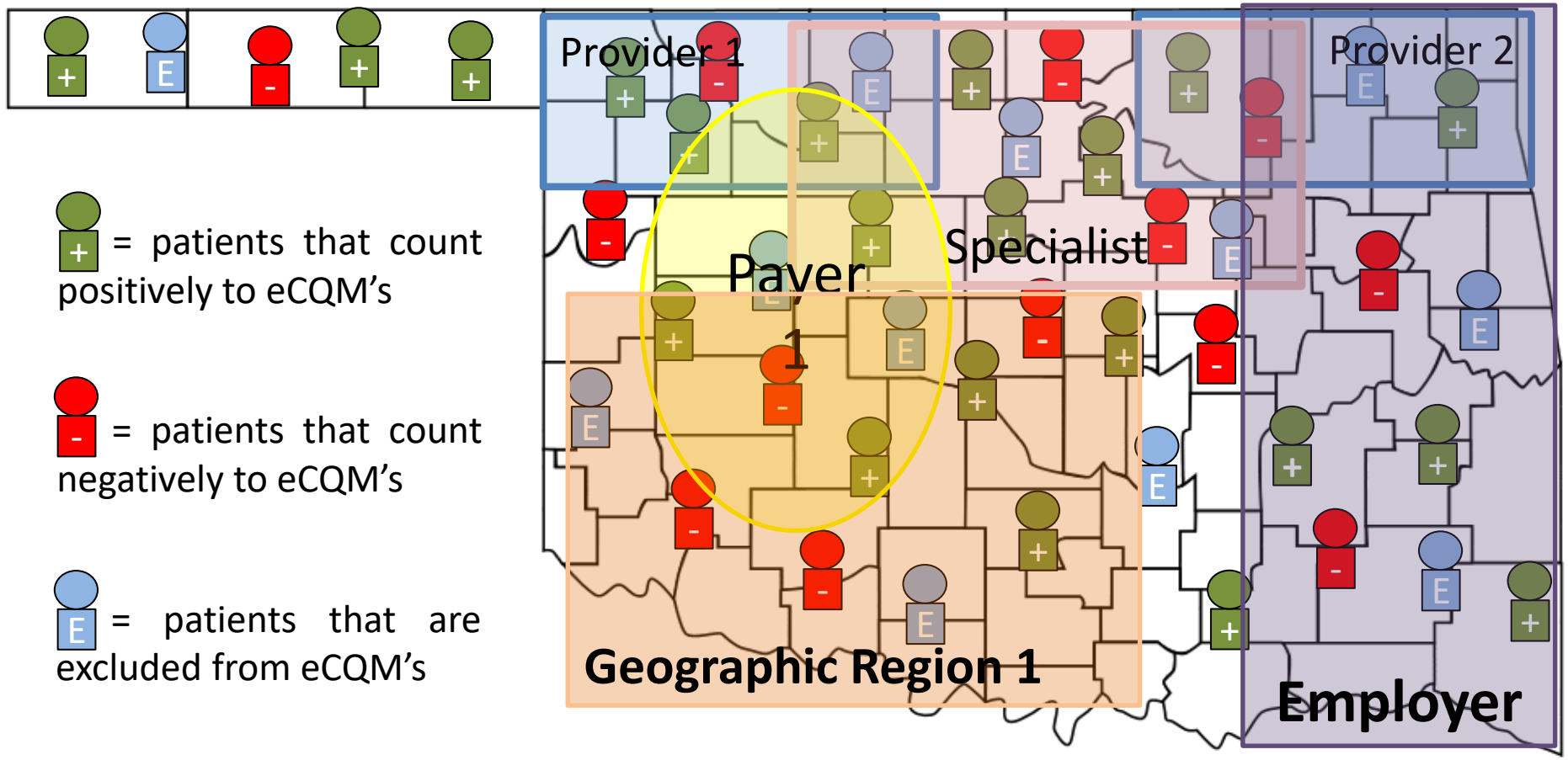
Isn't this what we *really* want to know?

Patient	Appropriate HbA1c Testing	DM in control (A1c<8)	DM out of control (A1c>9)
Patient A:	100%	0%	0%
Patient B:	100%	100%	0%
Patient C:	100%	100%	0%
Patient D:	100%	0%	0%
Population:	**100%**	**50%**	**0%**

MyHealth ACCESS NETWORK

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

3+, 1-, 1E = ¾ = 75%

2+, 1-, 1E = 2/3 = 67%

6+, 3-, 3E = 6/9 = 67%

4+, 1-, 2E = 4/5 = 80%

5+, 4-, 3E = 5/9 = 56%

4+, 3-, 3E = 4/7 = 57%

eCQM's calculated in real time based on changes in a patients cross-community data by placing a box around any portion of a population.

MyHealth ACCESS NETWORK

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
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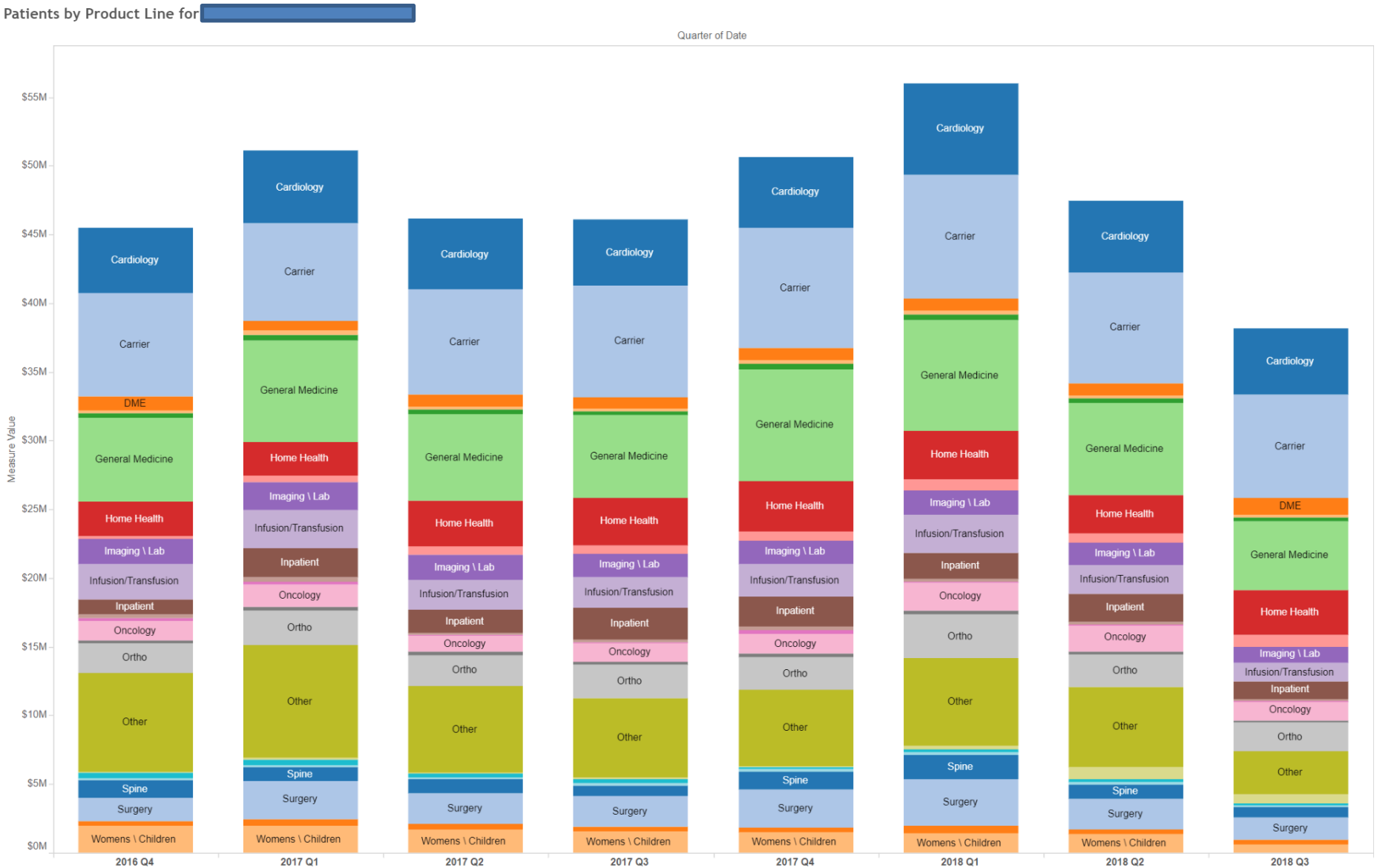
   a. Community-wide quality measurement required for true performance results
   b. Incent providers to take on the sickest patients by measuring and rewarding *improvement* at the individual patient level rather than achievement of an arbitrary numerical goal on average.
   c. Use at least some common 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

CPC+ Expenditures by Product Line



MyHealth ACCESS NETWORK

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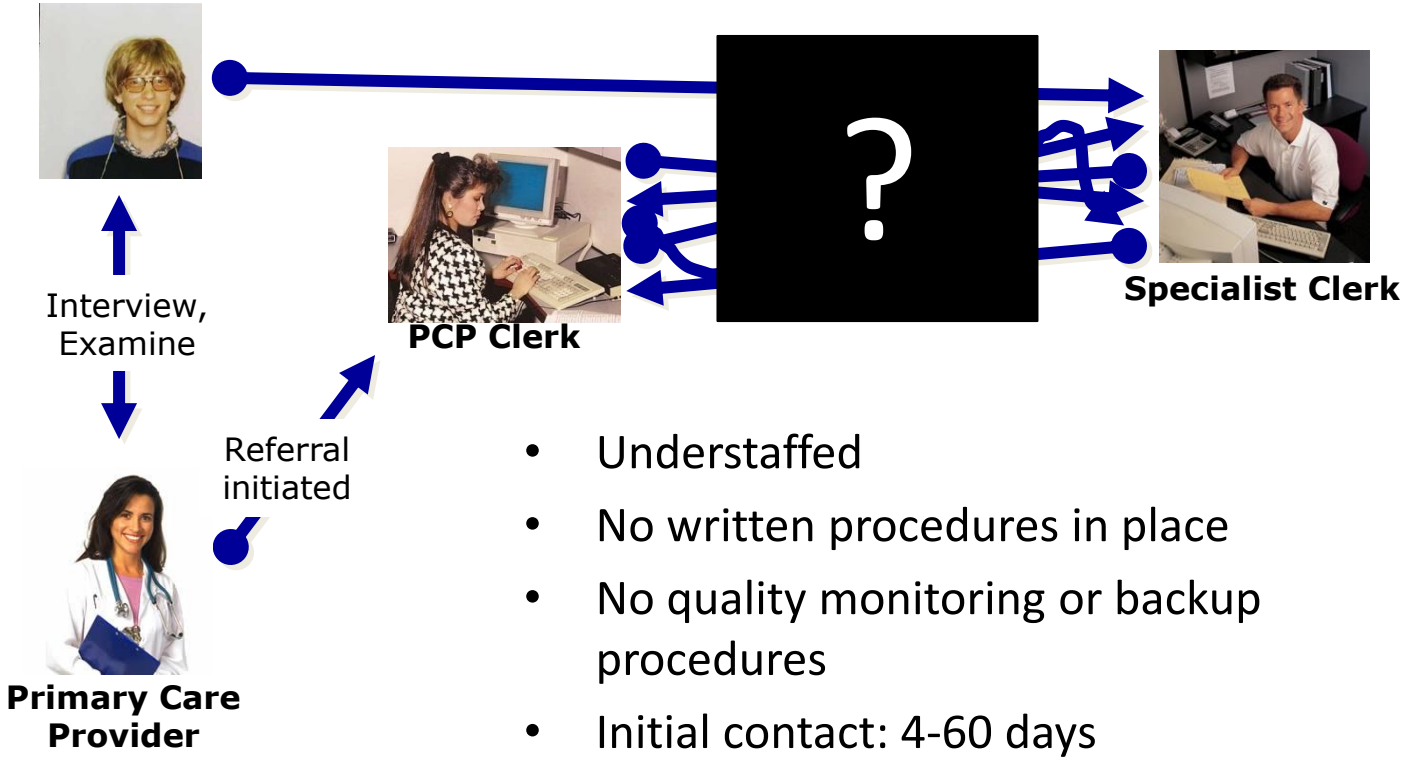
Pre-Community-Wide Care Transition Management

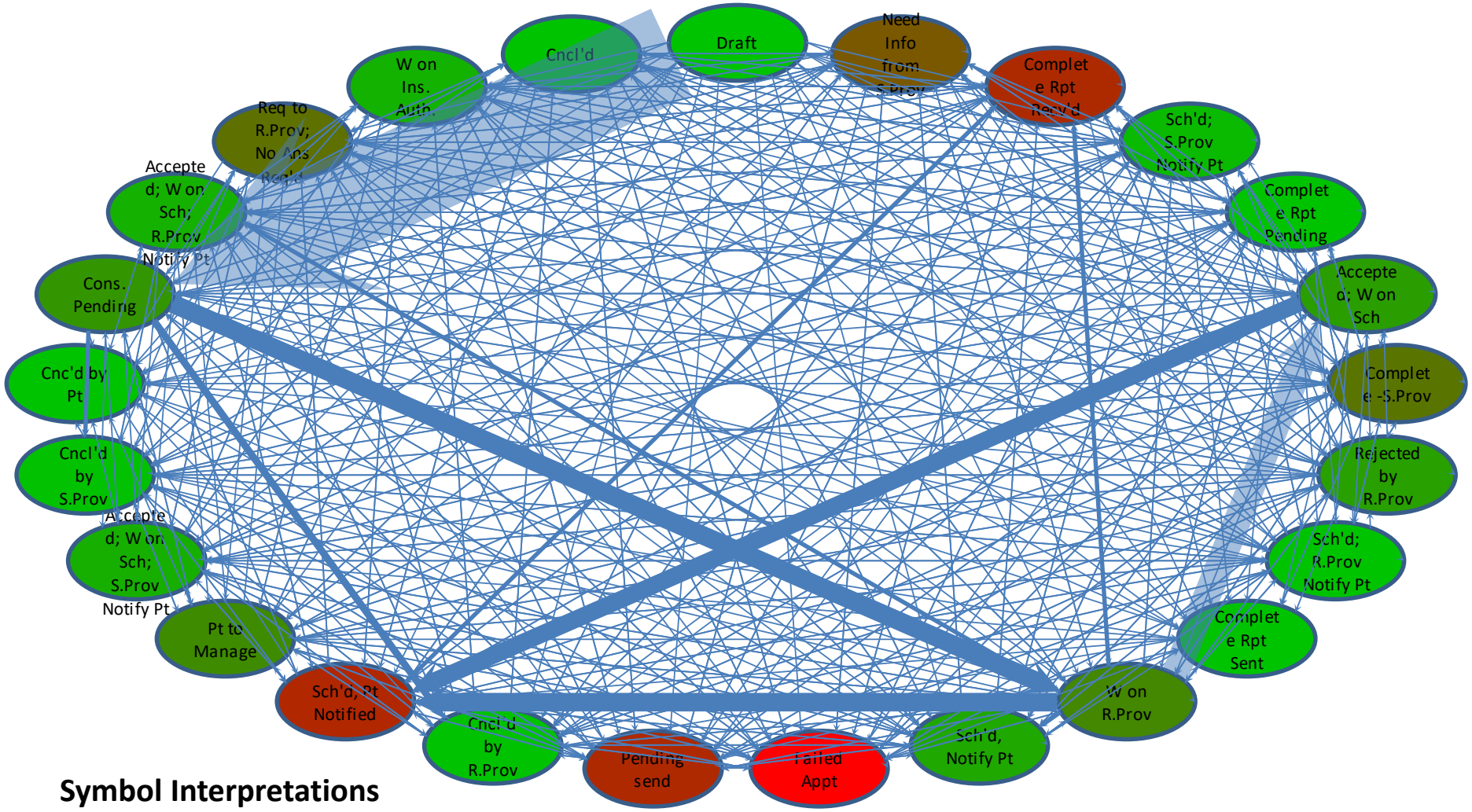


- Understaffed
- No written procedures in place
- No quality monitoring or backup procedures
- Initial contact: 4-60 days
- 50 to 3,000 referrals behind
- Many simply dropped

Consultant

MyHealth ACCESS NETWORK

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

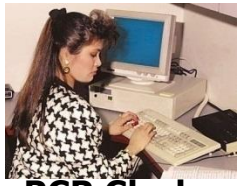
MyHealth ACCESS NETWORK

Community-wide Care Transitions Process

Interview, Examine

Primary Care Provider

Referral initiated



PCP Clerk

Schedule Patient

Specialist Clerk

- 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

Specialist Physician

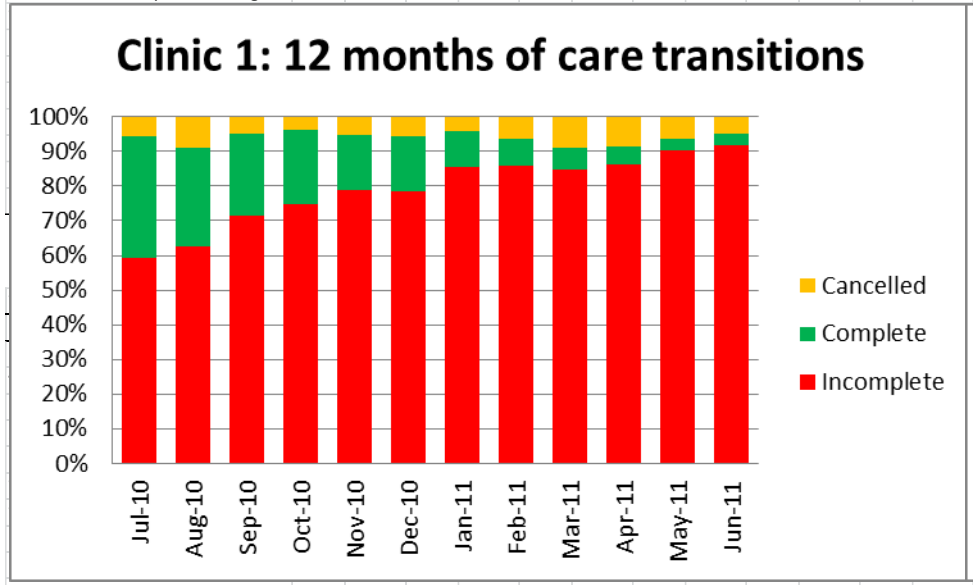
MyHealth ACCESS NETWORK

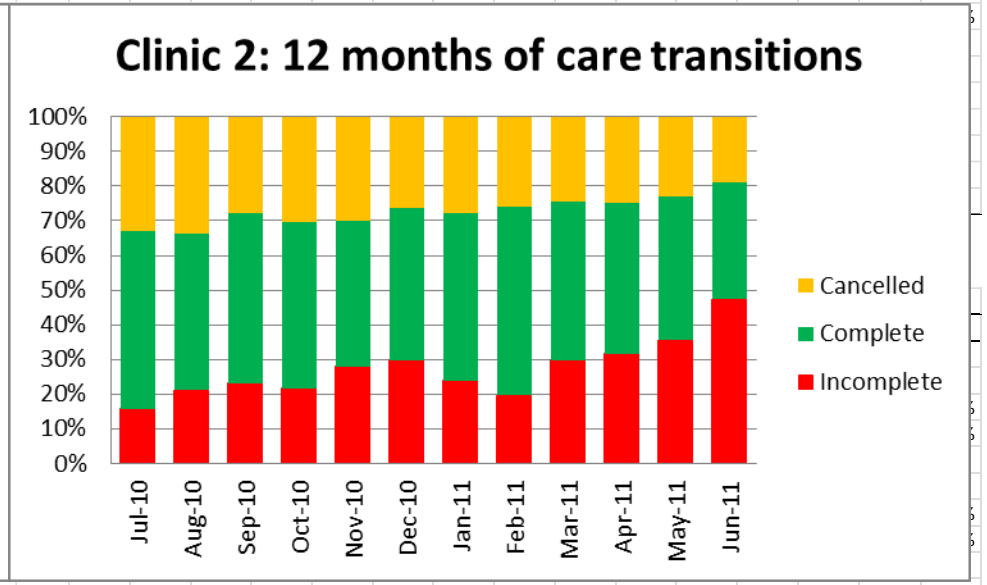
Results: A Tale of Two Clinics

Clinic 1:

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

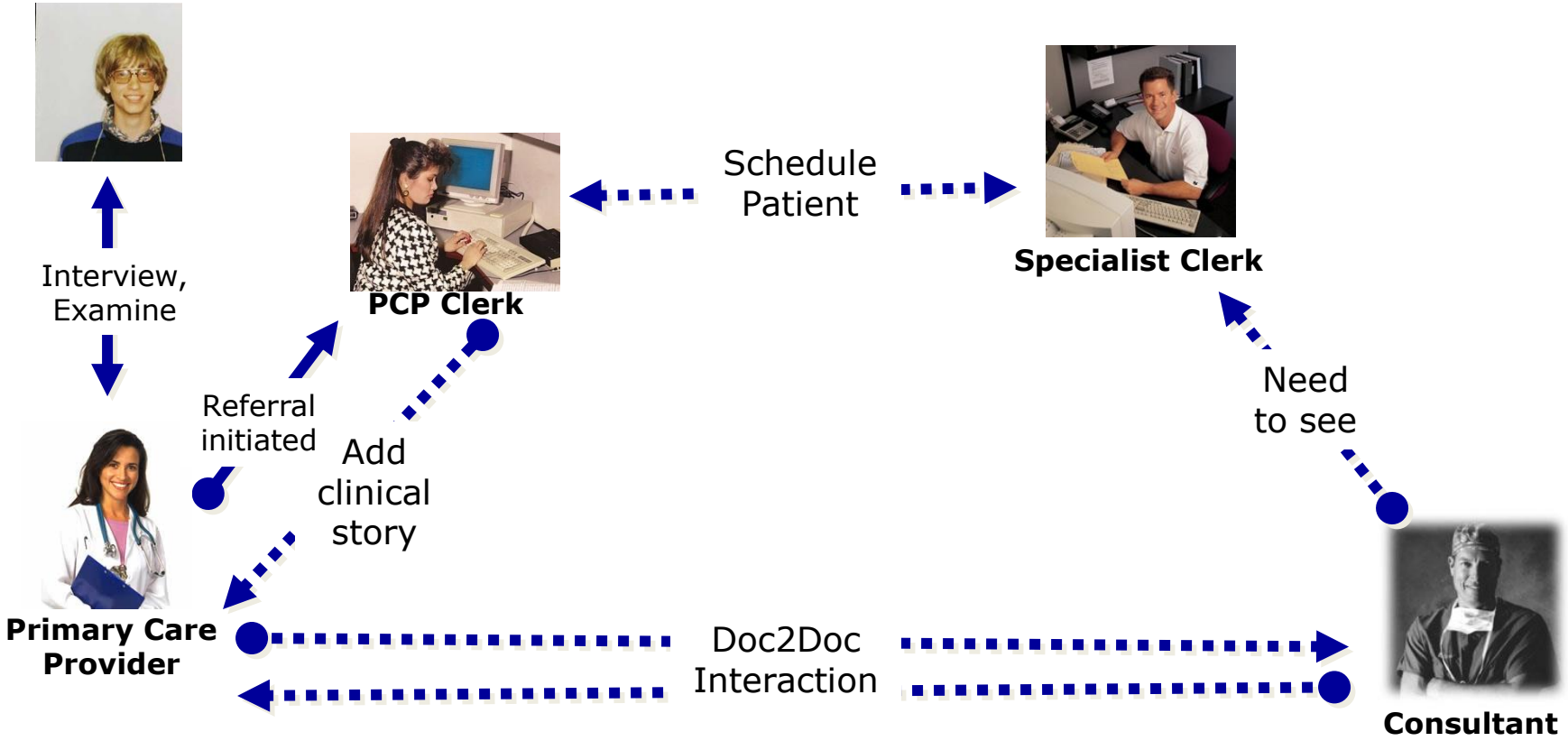
	JUL 2010		AUG 2010		SEP 2010		OCT 2010		NOV 2010		DEC 2010		JAN 2011		FEB 2011		MAR 2011		APR 2011		MAY 2011		JUN 2011		JUL 2011		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total Number Initiated	**409**		**361**		**442**		**363**		**362**		**324**		**325**		**285**		**438**		**426**		**433**		**457**		**392**		**5,017**	
Pending Appointment	154	37.7%	172	47.6%	227	51.4%	210	57.9%	165	45.6%	171	52.8%	211	64.9%	199	69.8%	296	67.6%	272	63.8%	306	70.7%	314	68.7%	280	71.4%	2,977	59.3%
Scheduled	79	19.3%	49	13.6%	71	16.1%	55	15.2%	99	27.3%	65	20.1%	57	17.5%	37	13.0%	61	13.9%	75	17.6%	67	15.5%	90	19.7%	71	18.1%	876	17.5%
Consult in Progress	4	1.0%	2	0.6%	3	0.7%	3	0.8%	4	1.1%	4	1.2%	2	0.6%	0	0.0%	2	0.5%	8	1.9%	9	2.1%	10	2.2%	6	1.5%	57	1.1%
Visit Occurred: Report Pending	5	1.2%	3	0.8%	14	3.2%	4	1.1%	18	5.0%	14	4.3%	8	2.5%	9	3.2%	12	2.7%	13	3.1%	9	2.1%	5	1.1%	9	2.3%	123	2.5%
Cancelled by Receiving Provider	31	3.8%	49	5.6%	34	3.7%	34	4.7%	30	3.6%	22	3.3%	18	3.0%	14	2.6%	32	3.4%	25	2.8%	42	5.1%	26	3.5%	14	1.6%	371	3.6%
Cancelled by Sending Provider	77	9.5%	77	8.7%	58	6.3%	44	6.1%	37	4.5%	32	4.9%	54	8.9%	46	8.7%	50	5.3%	56	6.3%	43	5.3%	36	4.8%	25	2.9%	635	6.2%
Failed Appointment	93	11.4%	96	10.9%	92	9.9%	82	11.4%	90	10.9%	70	10.7%	51	8.4%	28	5.3%	84	9.0%	76	8.5%	51	6.2%	37	4.9%	29	3.4%	879	8.6%
Rejected by Receiving Provider	10	1.2%	22	2.5%	24	2.6%	14	1.9%	23	2.8%	8	1.2%	11	1.8%	10	1.9%	9	1.0%	13	1.5%	15	1.8%	20	2.7%	33	3.9%	212	2.1%
Not Specified	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%





MyHealth ACCESS NETWORK

eConsultations to optimize care transitions



MyHealth ACCESS NETWORK

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:

Cost Type	Mean PMPM Cost Change	Mean Percentage Change
Facility Costs (UB92)	-$13.00	-20%
Professional Costs (HCFA 1500)	-$108.04	-34%
Pharmacy Costs (PBM)	-$9.14	-14%
Total Costs	-$130.18	

MyHealth ACCESS NETWORK

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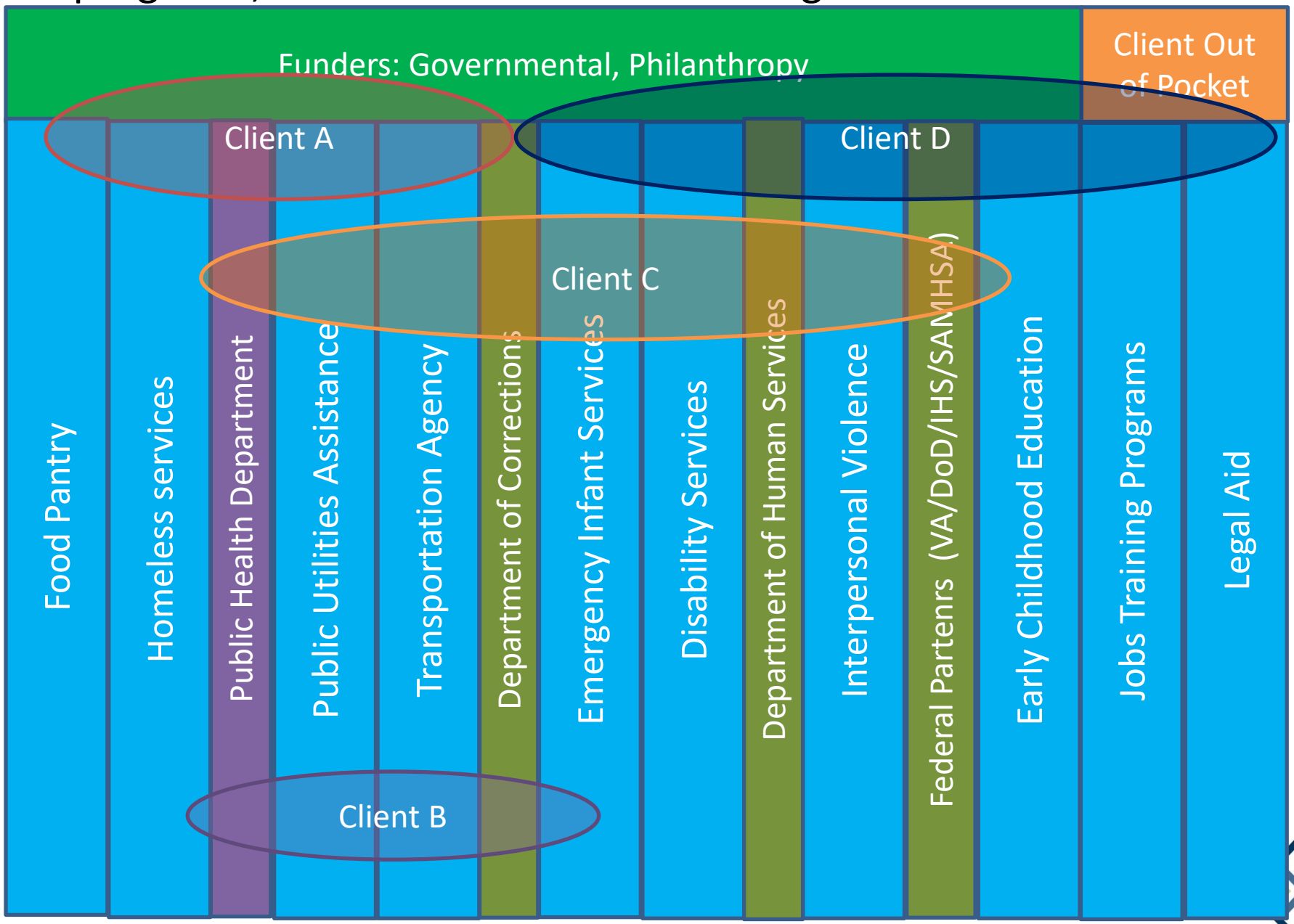
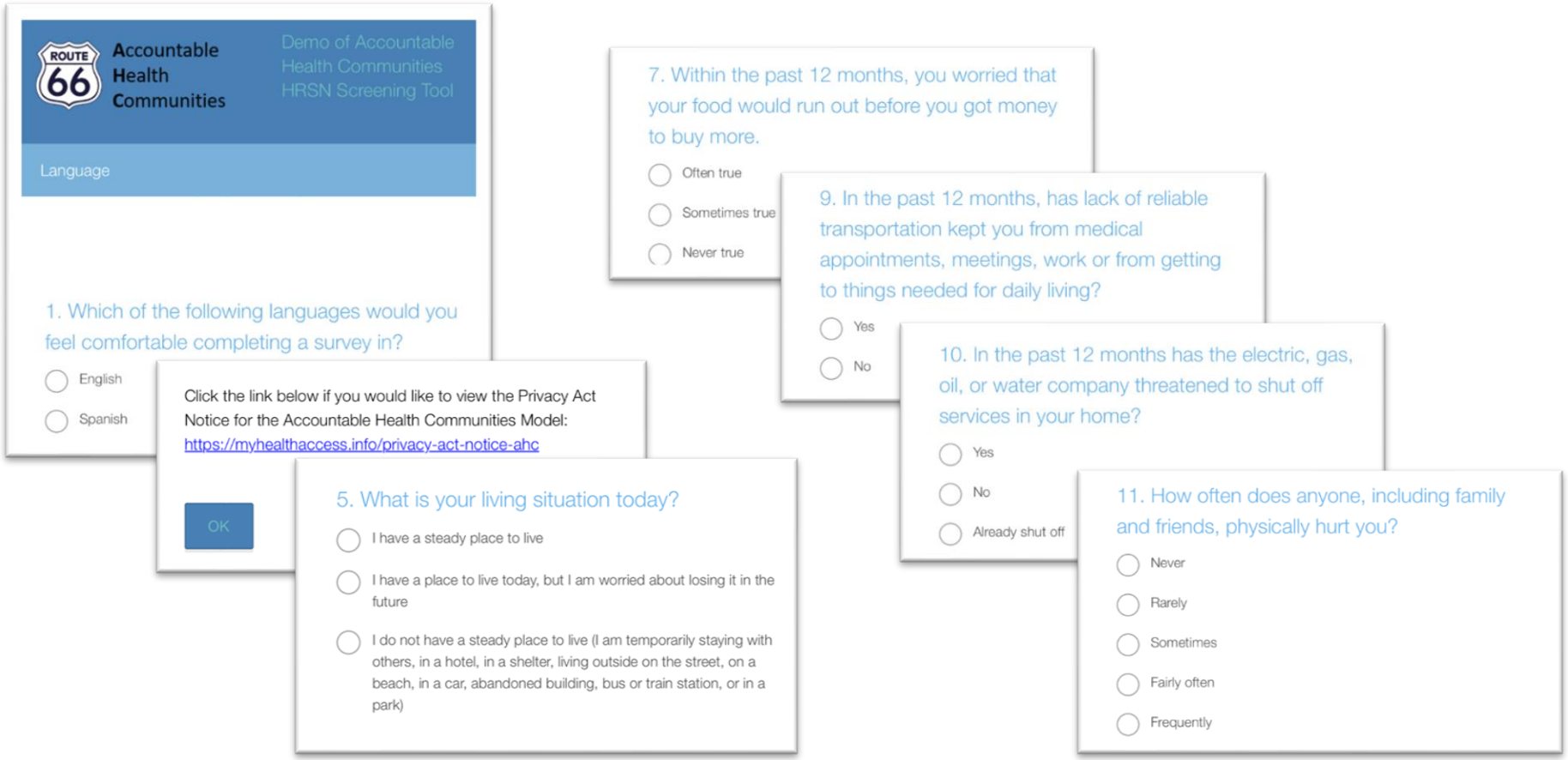
MyHealth now working with social needs and early childhood programs, where data is even more fragmented . . .



MyHealth ACCESS NETWORK

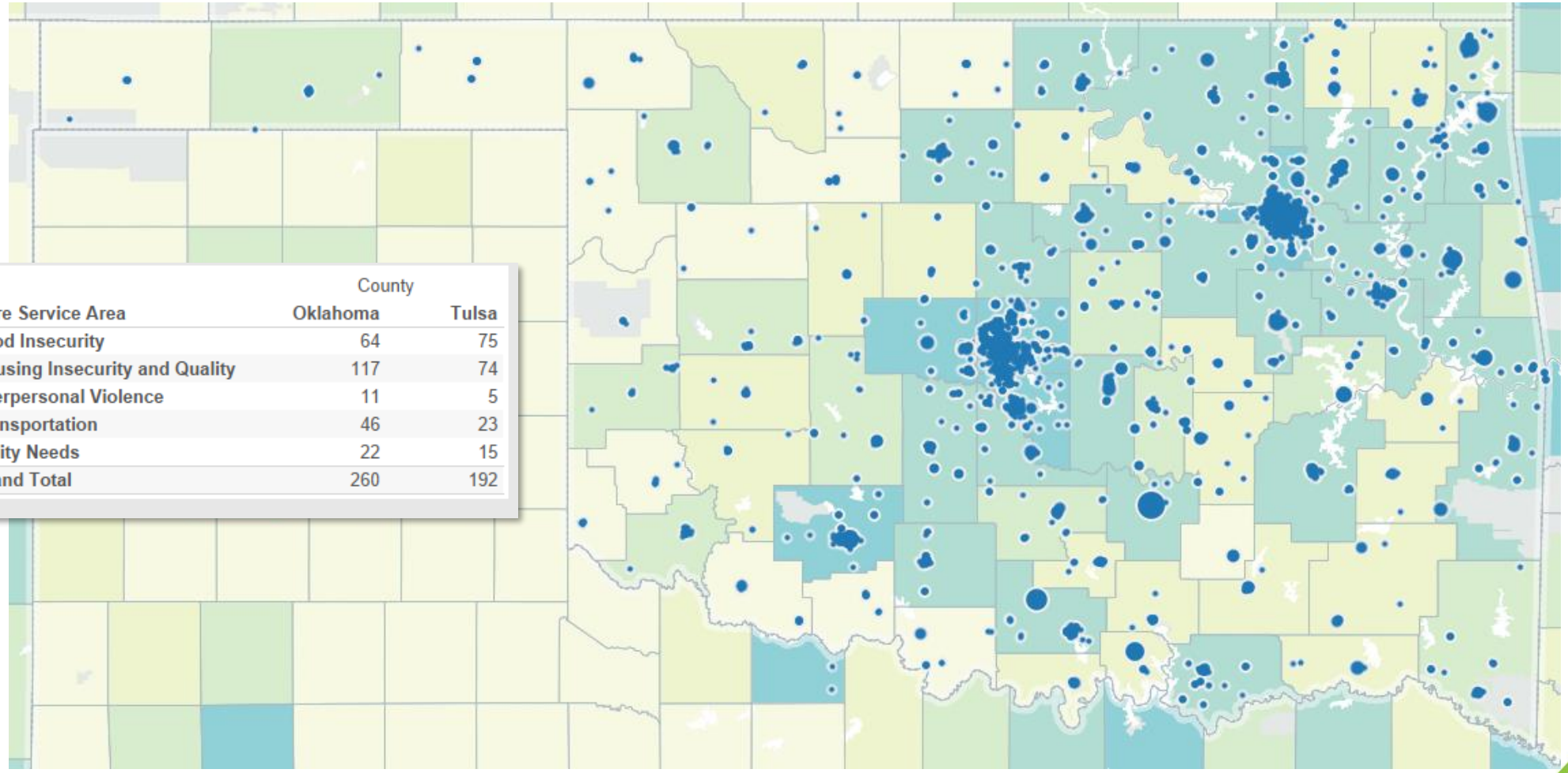
Accountable Health Communities: Statewide Screening for Social Needs



MyHealth ACCESS NETWORK

Accountable Health Communities: CRS

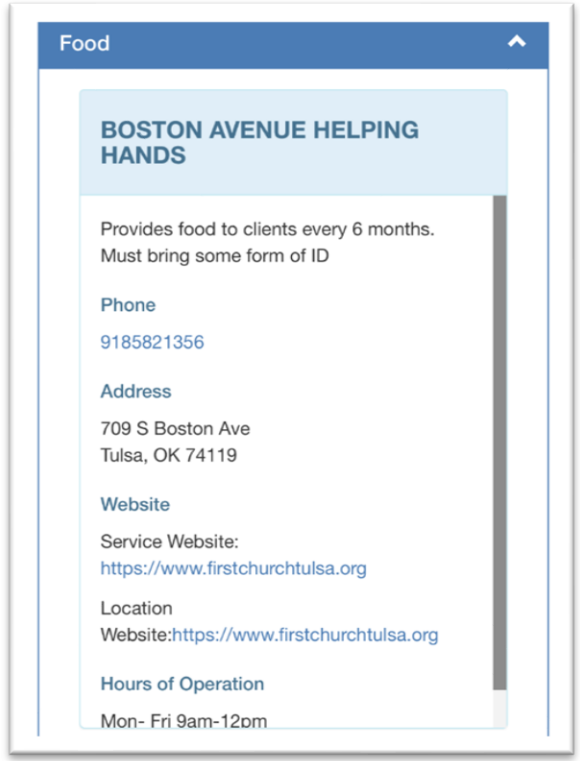
4,857 Resources in CRS Database, All 77 Counties in OK Covered by CRS Database

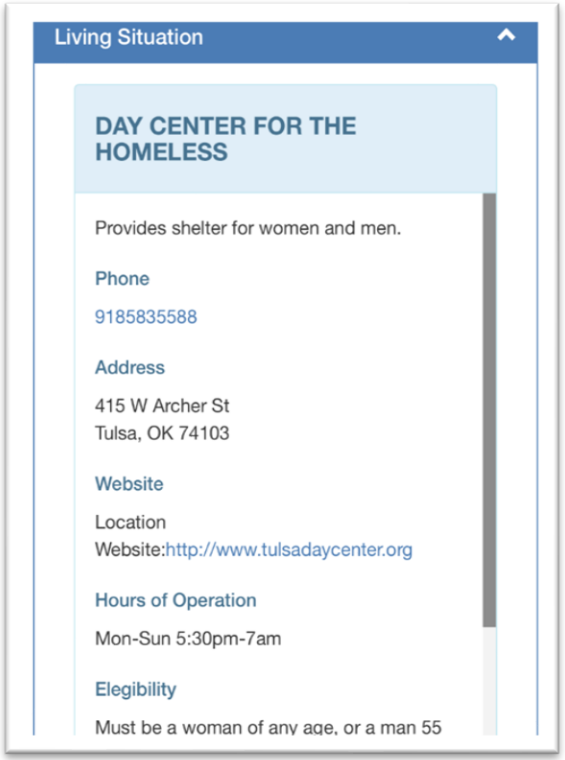


	County	
Core Service Area	Oklahoma	Tulsa
Food Insecurity	64	75
Housing Insecurity and Quality	117	74
Interpersonal Violence	11	5
Transportation	46	23
Utility Needs	22	15
Grand Total	260	192

MyHealth ACCESS NETWORK

Accountable Health Communities: CRS

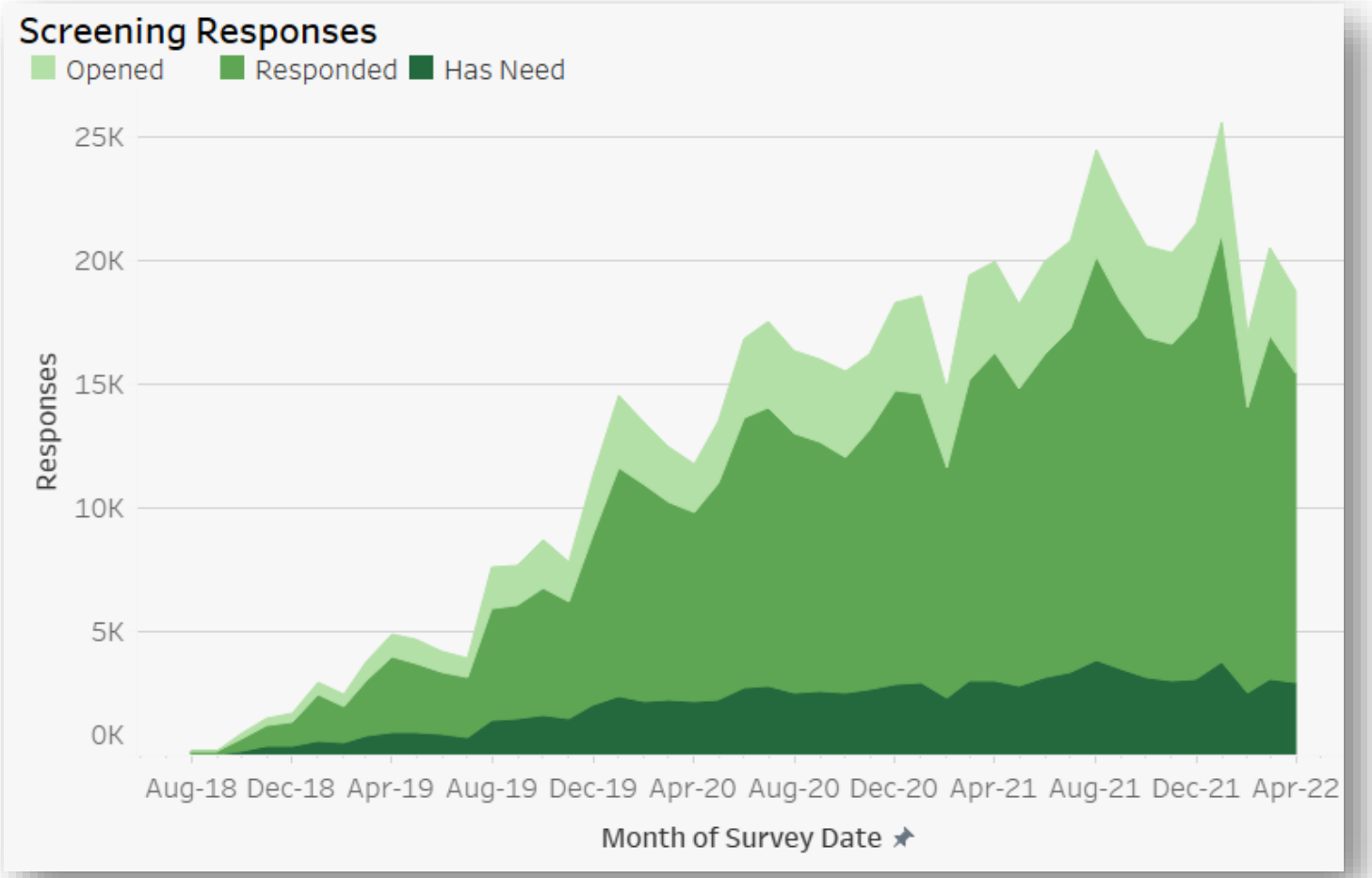




MyHealth ACCESS NETWORK

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

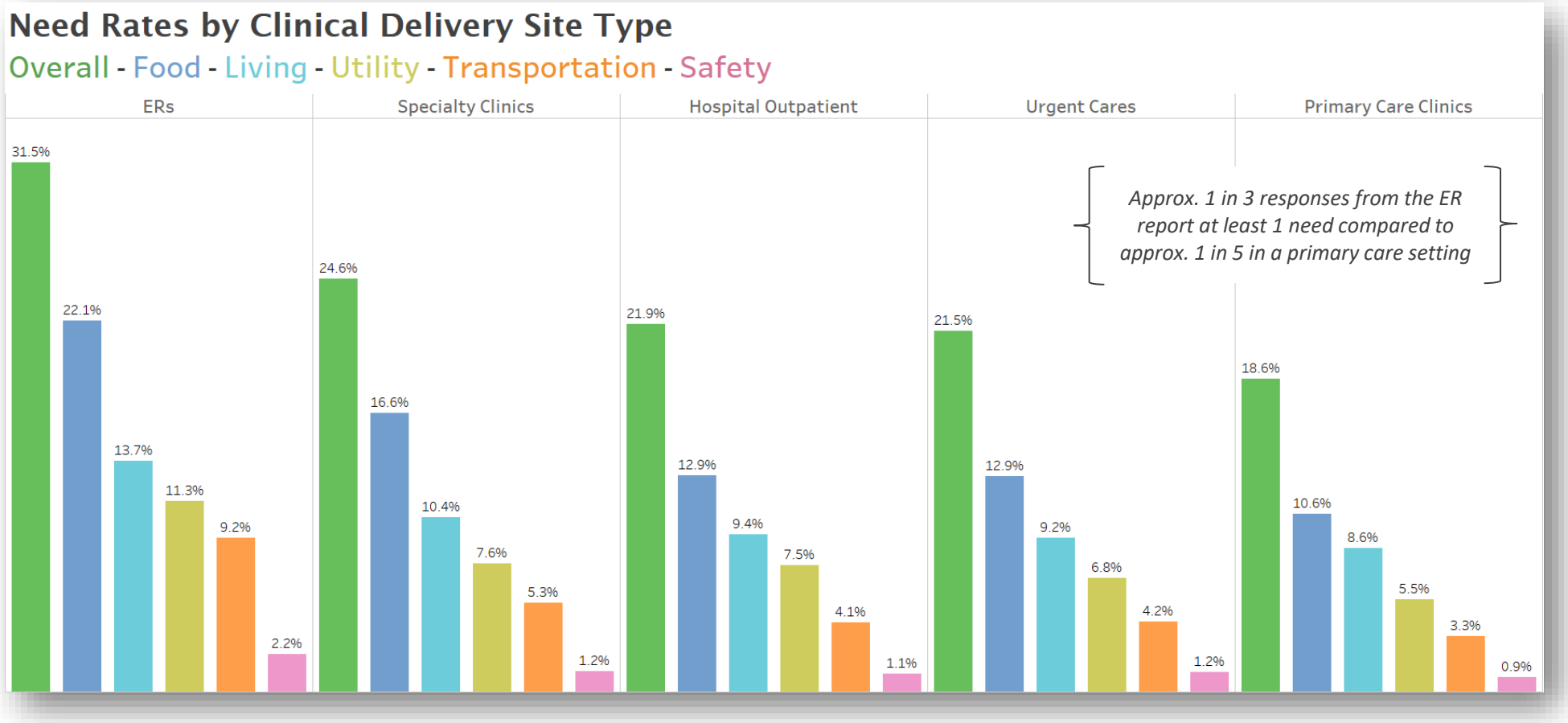
11,200+ Eligible Navigation Cases

Medicare and Medicaid Only

13,400+ Navigation Needs Resolved

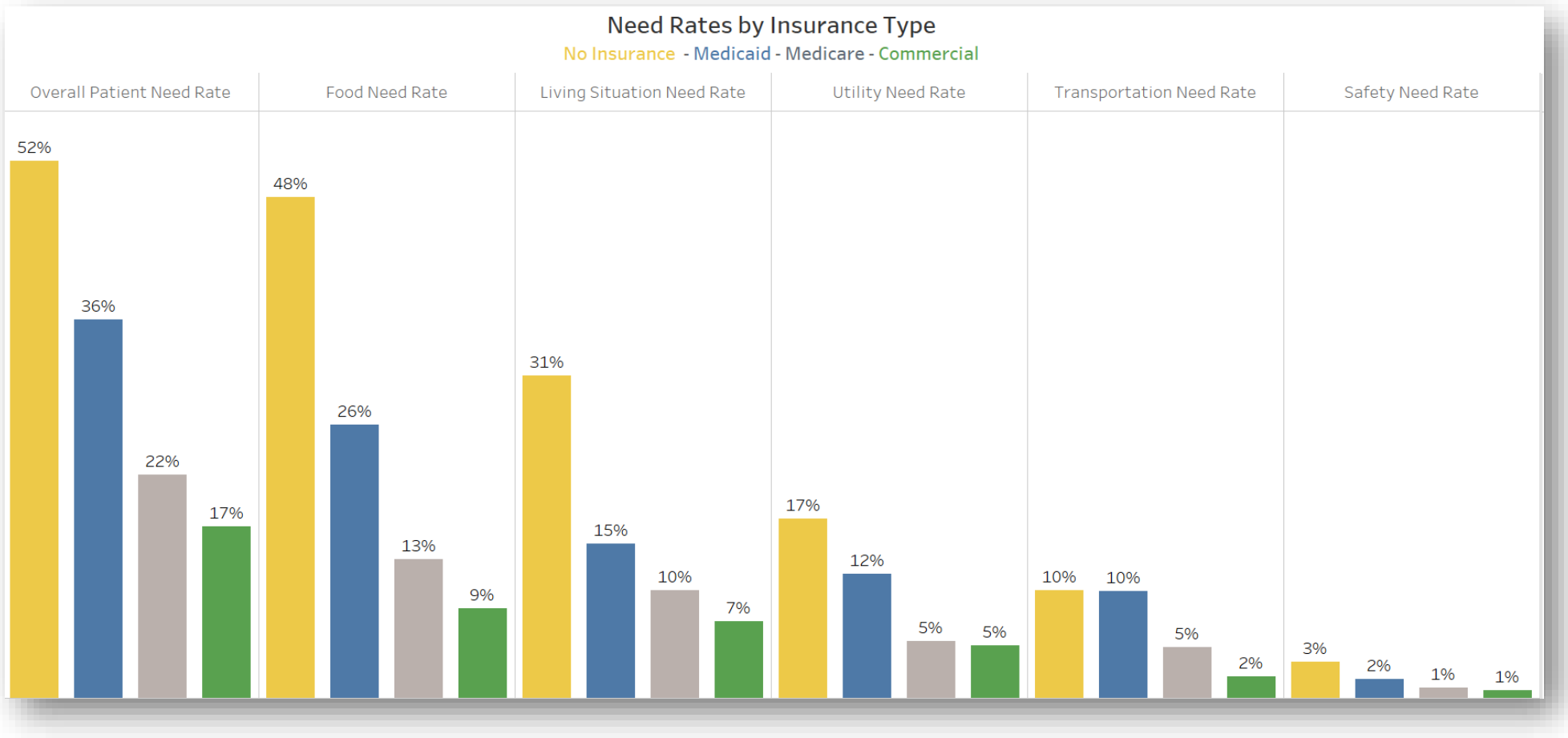
Medicare and Medicaid Only

MyHealth AHC Need Rates by Clinical Site Type



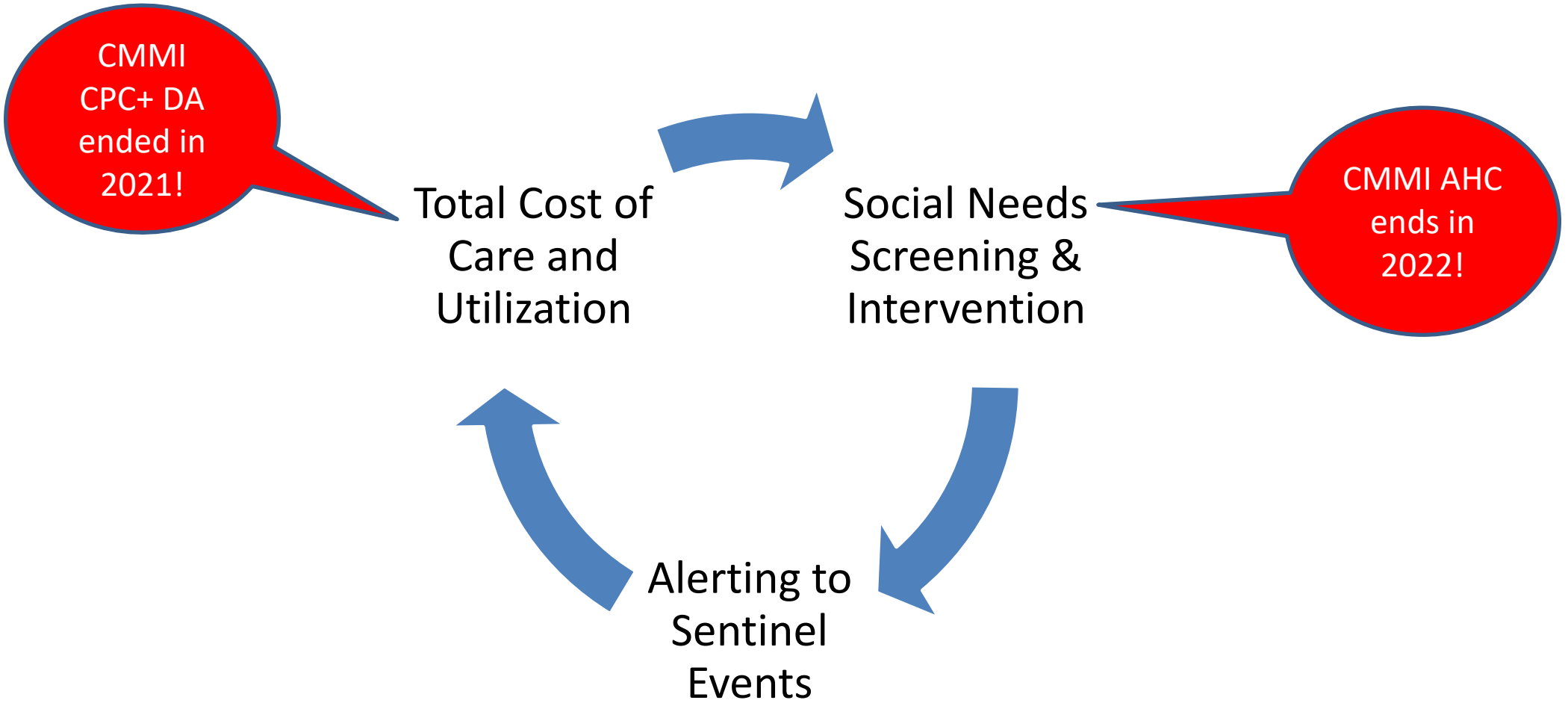
MyHealth ACCESS NETWORK

MyHealth AHC Need Rates by Insurance Type



MyHealth ACCESS NETWORK

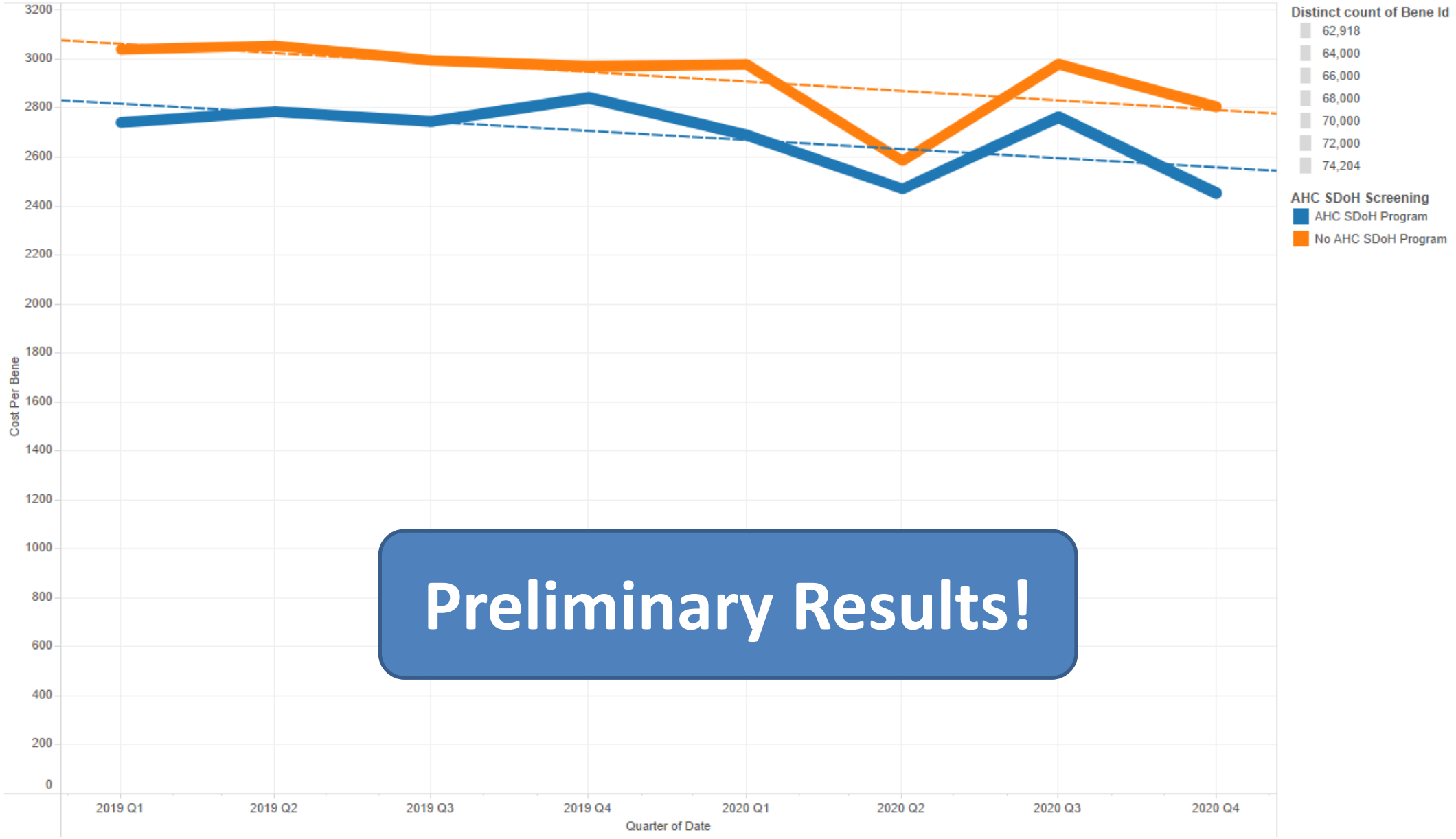
Cycle of Improvement



All three together will maximize the impact

MyHealth ACCESS NETWORK

Total Expenditure: Cost Trend SDoH vs No SDoH for All Health Systems

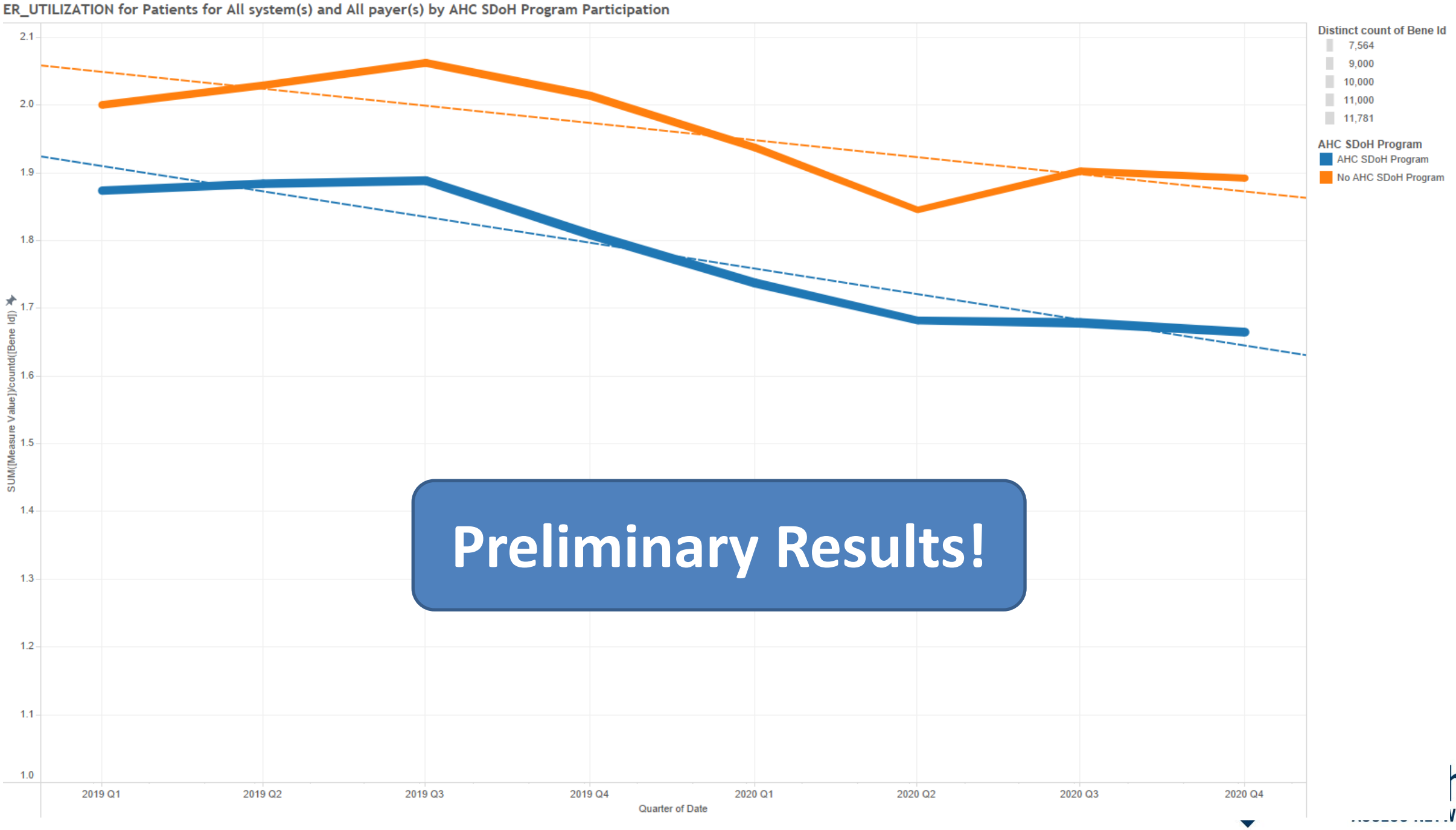


Preliminary Results!

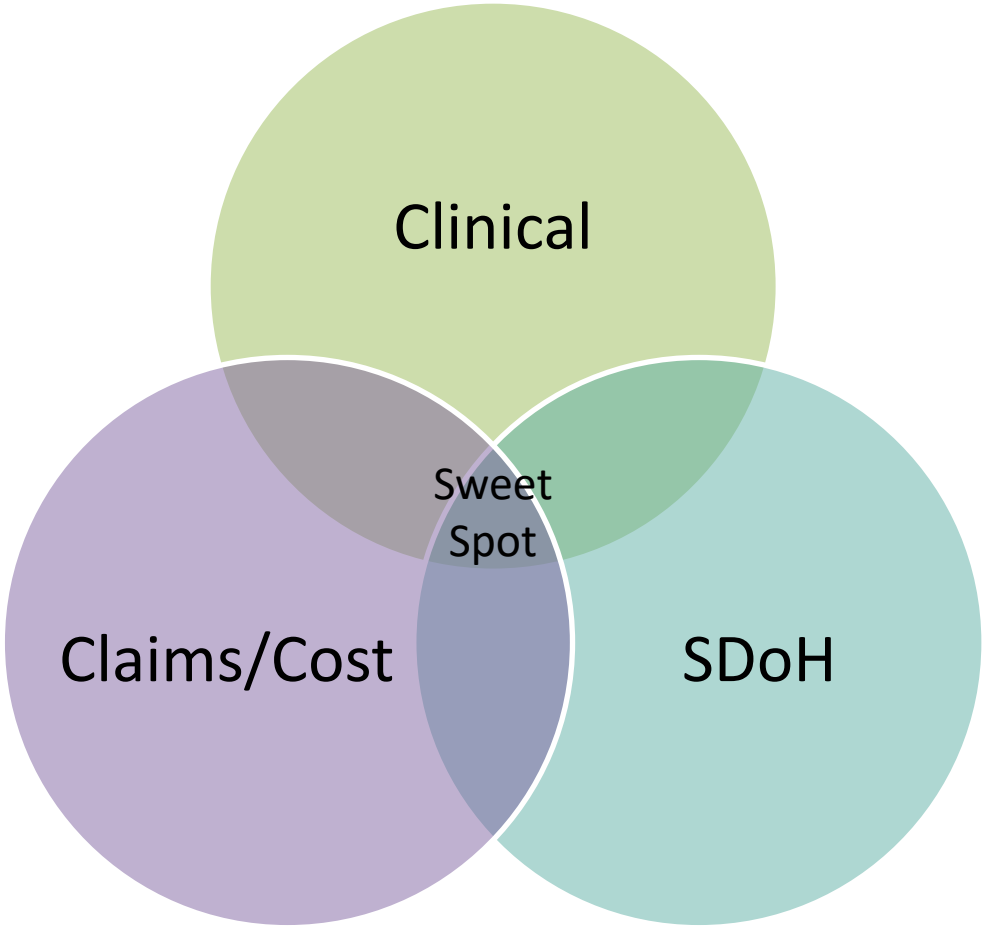
Return to Navigation Dashboard: https://tableau.myhealthaccess.net/#/site/CPCplus/views/CPCDashboard/NavigationPage

Inpatient Expenditure: The expenditures associated with all inpatient claims.
Outpatient Expenditure: The expenditures associated with all outpatient claims.
Total Expenditure: The expenditures associated with all claims including: Inpatient, Outpatient, Home Health, Skilled Nursing Facilities, Hospice and Durable Medical Equipment.

Health ACCESS NETWORK


ER_UTILIZATION for Patients for All system(s) and All payer(s) by AHC SDoH Program Participation
SUM([Measure Value])/countd([Bene Id])
2.1
2.0
1.9
1.8
1.7
1.6
1.5
1.4
1.3
1.2
1.1
1.0
2019 Q1
2019 Q2
2019 Q3
2019 Q4
2020 Q1
2020 Q2
2020 Q3
2020 Q4
Quarter of Date
Distinct count of Bene Id
7,564
9,000
10,000
11,000
11,781
AHC SDoH Program
AHC SDoH Program
No AHC SDoH Program
Preliminary Results!

Putting it all together

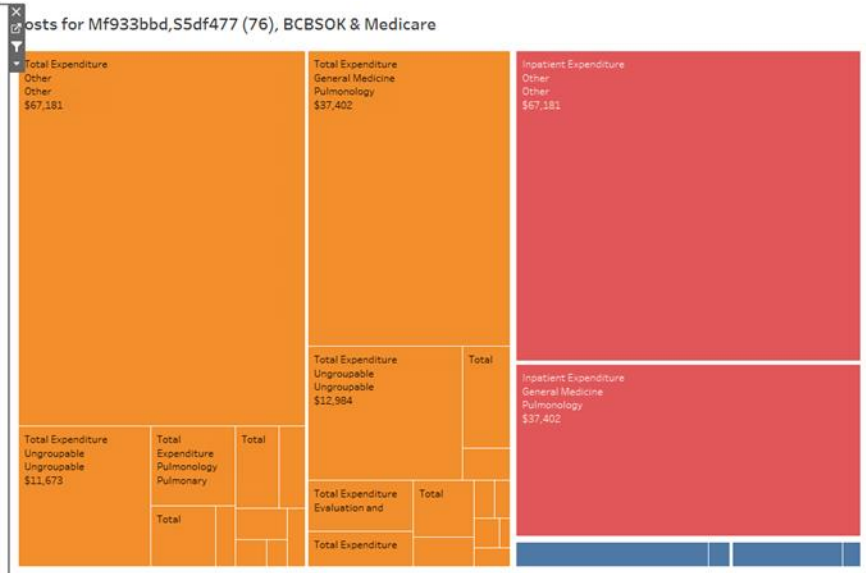


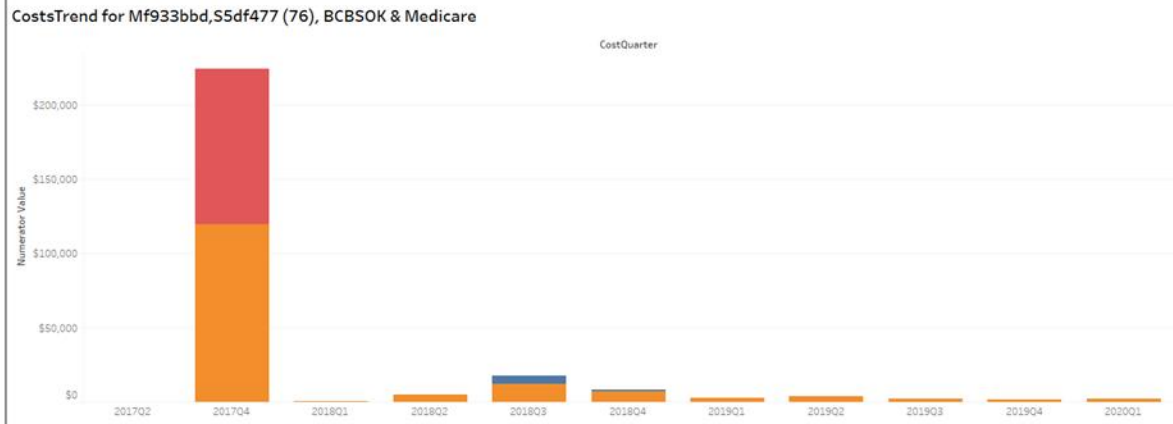
MyHealth ACCESS NETWORK

Population Health Command & Control

Visits for Oklahoma Cancer Specialists and Research Institute, OU Physicians Tulsa, St. John and 2 more attributed patients on 11/14/2021 report

Patient DeIdentifi..	Patient Class	Visit Source	Day of Visit Admit ..	Day of Visit Discha..	Any Social ..	Payer	Measure Va..
Abe49b6c,F5f8d1b..	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$1,865,018
C0e8de4e,S5df482..	Inpatient (I)		November 5, 2021	Null	No	Medicare	$716,524
C12c4dc9,R5df4ad..	Inpatient (I)		November 12, 2021	Null	No	BCBSOK	$819
Ce558c1e,D5df490..	Inpatient (I)		November 7, 2021	Null	No	Medicare	$74,509
D5ed04bf,B5df49..	Emergency (E)		November 12, 2021	November 12, 2021	No	Medicare	$193,580
Df945f20,T5df491..	Inpatient (I)		October 18, 2021	November 12, 2021	No	CCOK	$16,790
F12ad919,C5df47..	Inpatient (I)		November 13, 2021	November 13, 2021	Yes	Medicare	$78,022
F78ff0d6,S5df493..	Inpatient (I)		November 12, 2021	Null	Yes	OHCA	$560
Ff942c63,J5df492..	Inpatient (I)		November 2, 2021	Null	No	BCBSOK	$21,087
G12b68c8,A5df48..	Inpatient (I)		November 2, 2021	November 8, 2021	Yes	BCBSOK	$39,116
Gca741d8,C5df49..	Inpatient (I)		November 12, 2021	Null	No	Medicare	$279,115
Ha73f32a,H605721 (83)	Inpatient (I)		November 10, 2021	November 12, 2021	No	Medicare	$192,100
			November 12, 2021	November 13, 2021	No	Medicare	$192,100
Hcbf457f,V5df548 (37)	Emergency (E)		November 13, 2021	Null	No	BCBSOK	$2,737
				November 14, 2021	No	BCBSOK	$2,737
He5660df,K5df4b4 (71)	Emergency (E)		November 13, 2021	Null	No	Medicare	$20,474
				November 13, 2021	No	Medicare	$20,474
He587595,J5df56..	Inpatient (I)		November 12, 2021	Null	No	CCOK	$19,922
Hf940967,K5df48..	Inpatient (I)		November 11, 2021	Null	Yes	BCBSOK	$1,440,031
Hf961829,D5df4f3..	Inpatient (I)		November 8, 2021	November 12, 2021	No	Medicare	$24,463
L7900548,R5df496 (82)	Inpatient (I)		November 13, 2021	Null	No	Medicare	$3,429
					Yes	Medicare	$3,429
Lf93f374,T5df48a ..	Inpatient (I)		November 8, 2021	November 11, 2021	No	Medicare	$468,220
Mf933bbd,S5df477 (76)	Inpatient (I)		November 10, 2021	Null	No	BCBSOK	$20,460
						Medicare	$13,141
					Yes	BCBSOK	$20,460
						Medicare	$13,141
Mf946909,R5df49..	Emergency (E)		November 14, 2021	Null	No	Medicare	$675,624
Ncbca2dc,C5df48e (79)	Inpatient (I)		November 12, 2021	Null	No	Medicare	$77,457
					Yes	Medicare	$154,914
P78f4beb,M5df47d (88)	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$91,353
			November 10, 2021	November 11, 2021	No	Medicare	$91,353
R3cb31f2,C5df48d..	Inpatient (I)		November 4, 2021	Null	Yes	Medicare	$134,072
R78ef35c,P5df474 (75)	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$274,185
	Inpatient (I)		November 11, 2021	Null	No	Medicare	$274,185
R5971313,L5df49a (54)	Emergency (E)		November 13, 2021	Null	No	Medicare	$73,852
					Yes	Medicare	$147,703
	Inpatient (I)		November 13, 2021	Null	No	Medicare	$73,852
					Yes	Medicare	$147,703
S5ed0ab8,M5df49..	Inpatient (I)		October 31, 2021	November 12, 2021	Yes	Medicare	$2,411,925
S78f1945,M5df47..	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$90,153
Se0254bd,H5df47..	Emergency (E)		November 13, 2021	November 13, 2021	No	Medicare	$512,088
Sf943db8,S5df494..	Emergency (E)		November 10, 2021	November 10, 2021	No	BCBSOK	$709
T3cb40c8,D5df48f..	Inpatient (I)		November 10, 2021	Null	No	Medicare	$80,479
T4874dce,N5df48c..	Emergency (E)		November 10, 2021	November 10, 2021	No	Medicare	$51,258
W6d01283, W5df4ab (86)	Emergency (E)		November 13, 2021	Null	No	Medicare	$74,661
				November 13, 2021	No	Medicare	$149,323
W12b4e35,N5df48..	Emergency (E)		November 4, 2021	November 4, 2021	No	Medicare	$86,008
W598c4f1,K5df503 (62)	Emergency (E)		November 13, 2021	Null	No	BCBSOK	$351,807
				November 13, 2021	No	BCBSOK	$351,807





SDoH for Mf933bbd,S5df477 (76), All

Day of Date Of Visit	Food Need	Housing Need	Transportation Need	Utility Need	Safety Need
April 23, 2021	No	Yes	No	No	No
July 31, 2021	No	No	No	No	No

MyHealth ACCESS NETWORK

Population Health Command & Control

Visits for Oklahoma Cancer Specialists and Research Institute, OU Physicians Tulsa, St. John and 2 more attributed patients on 11/14/2021 report

Patient DeIdentifi..	Patient Class	Visit Source	Day of Visit Admit ..	Day of Visit Discha..	Any Social ..	Payer	Measure Va..
Abe49b6c,F5f8d1b..	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$1,865,018
C0e8de4e,S5df482..	Inpatient (I)		November 5, 2021	Null	No	Medicare	$716,524
C12c4dc9,R5df4ad..	Inpatient (I)		November 12, 2021	Null	No	BCBSOK	$819
CeS58c1e,D5df490..	Inpatient (I)		November 7, 2021	Null	No	Medicare	$74,509
D5ed04bf,B5df49..	Emergency (E)		November 12, 2021	November 12, 2021	No	Medicare	$193,580
Df945f20,T5df491..	Inpatient (I)		October 18, 2021	November 12, 2021	No	CCOK	$16,790
F12ad919,C5df47..	Inpatient (I)		November 13, 2021	November 13, 2021	Yes	Medicare	$78,022
F78ff0d6,S5df493..	Inpatient (I)		November 12, 2021	Null	Yes	OHCA	$560
Ff942c63,J5df492..	Inpatient (I)		November 2, 2021	Null	No	BCBSOK	$21,087
G12b68c8,A5df48..	Inpatient (I)		November 2, 2021	November 8, 2021	Yes	BCBSOK	$39,116
Gca741d8,C5df49..	Inpatient (I)		November 12, 2021	Null	No	Medicare	$279,115
Ha73f32a,H605721 (83)	Inpatient (I)		November 10, 2021	November 12, 2021	No	Medicare	$192,100
			November 12, 2021	November 13, 2021	No	Medicare	$192,100
Hcbf457f,V5df548 (37)	Emergency (E)		SO November 13, 2021	Null	No	BCBSOK	$2,737
				November 14, 2021	No	BCBSOK	$2,737
He5660df,K5df4b4 (71)	Emergency (E)		November 13, 2021	Null	No	Medicare	$20,474
				November 13, 2021	No	Medicare	$20,474
He587595,J5df56..	Inpatient (I)		November 12, 2021	Null	No	CCOK	$19,922
Hf940967,K5df48..	Inpatient (I)		November 11, 2021	Null	Yes	BCBSOK	$1,440,031
Hf961829,D5df4f3..	Inpatient (I)		November 8, 2021	November 12, 2021	No	Medicare	$24,463
L7900548,R5df496 (82)	Inpatient (I)		November 13, 2021	Null	No	Medicare	$3,429
					Yes	Medicare	$3,429
Lf93f374,T5df48a..	Inpatient (I)		November 8, 2021	November 11, 2021	No	Medicare	$468,220
Mf933bbd,S5df477 (76)	Inpatient (I)		November 10, 2021	Null	No	BCBSOK	$20,460
						Medicare	$13,141
					Yes	BCBSOK	$20,460
						Medicare	$13,141
Mf946909,R5df49..	Emergency (E)		November 14, 2021	Null	No	Medicare	$675,624
Ncbca2dc,C5df48e (79)	Inpatient (I)		November 12, 2021	Null	No	Medicare	$77,457
					Yes	Medicare	$154,914
P78f4beb,M5df47d (88)	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$91,353
			November 10, 2021	November 11, 2021	No	Medicare	$91,353
R3cb31f2,C5df48d..	Inpatient (I)		November 4, 2021	Null	Yes	Medicare	$134,072
R78ef35c,P5df474 (75)	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$274,185
	Inpatient (I)		November 11, 2021	Null	No	Medicare	$274,185
R5971313,L5df49a (54)	Emergency (E)		November 13, 2021	Null	No	Medicare	$73,852
					Yes	Medicare	$147,703
	Inpatient (I)		November 13, 2021	Null	No	Medicare	$73,852
					Yes	Medicare	$147,703
S5ed0ab8,M5df49..	Inpatient (I)		October 31, 2021	November 12, 2021	Yes	Medicare	$2,411,925
S78f1945,M5df47..	Emergency (E)		November 10, 2021	November 11, 2021	No	Medicare	$90,153
Se0254bd,H5df47..	Emergency (E)		November 13, 2021	November 13, 2021	No	Medicare	$512,088
Sf943db8,S5df494..	Emergency (E)		November 10, 2021	November 10, 2021	No	BCBSOK	$709
T3cb40c8,D5df48f..	Inpatient (I)		November 10, 2021	Null	No	Medicare	$80,479
T4874dce,N5df48c..	Emergency (E)		SO November 10, 2021	November 10, 2021	No	Medicare	$51,258
W6d01283, W5df4ab (86)	Emergency (E)		November 13, 2021	Null	No	Medicare	$74,661
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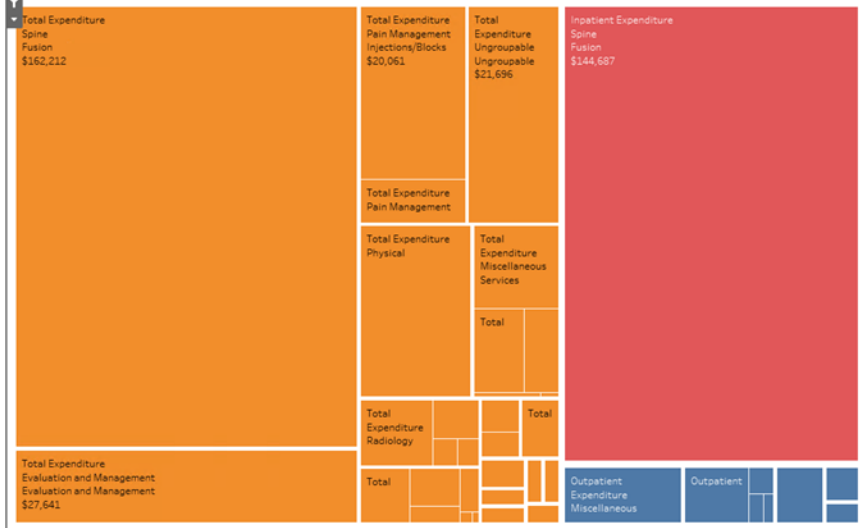
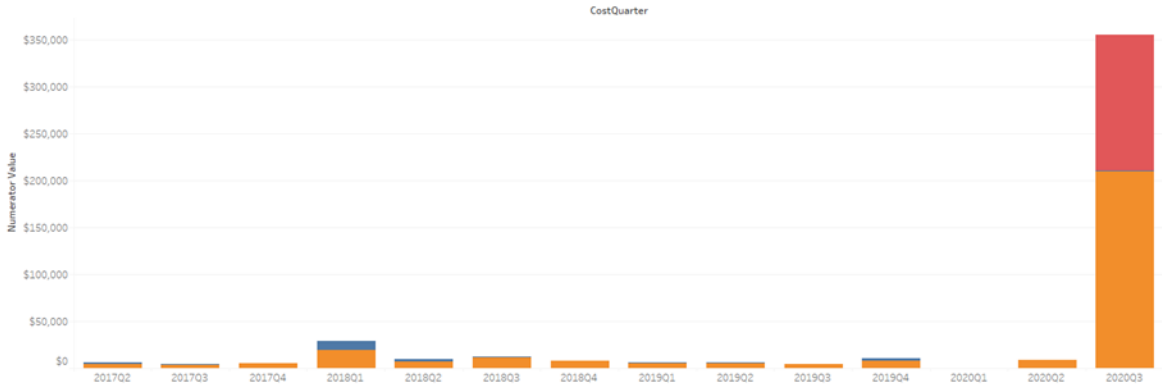
W12b4e35,N5df48..	Emergency (E)		November 4, 2021	November 4, 2021	No	Medicare	$86,008
W598c4f1,K5df503 (62)	Emergency (E)		November 13, 2021	Null	No	BCBSOK	$351,807
				November 13, 2021	No	BCBSOK	$351,807

osts for Ncbca2dc,C5df48e (79), Medicare



CostsTrend for Ncbca2dc,C5df48e (79), Medicare



SDoH for Ncbca2dc,C5df48e (79), Medicare

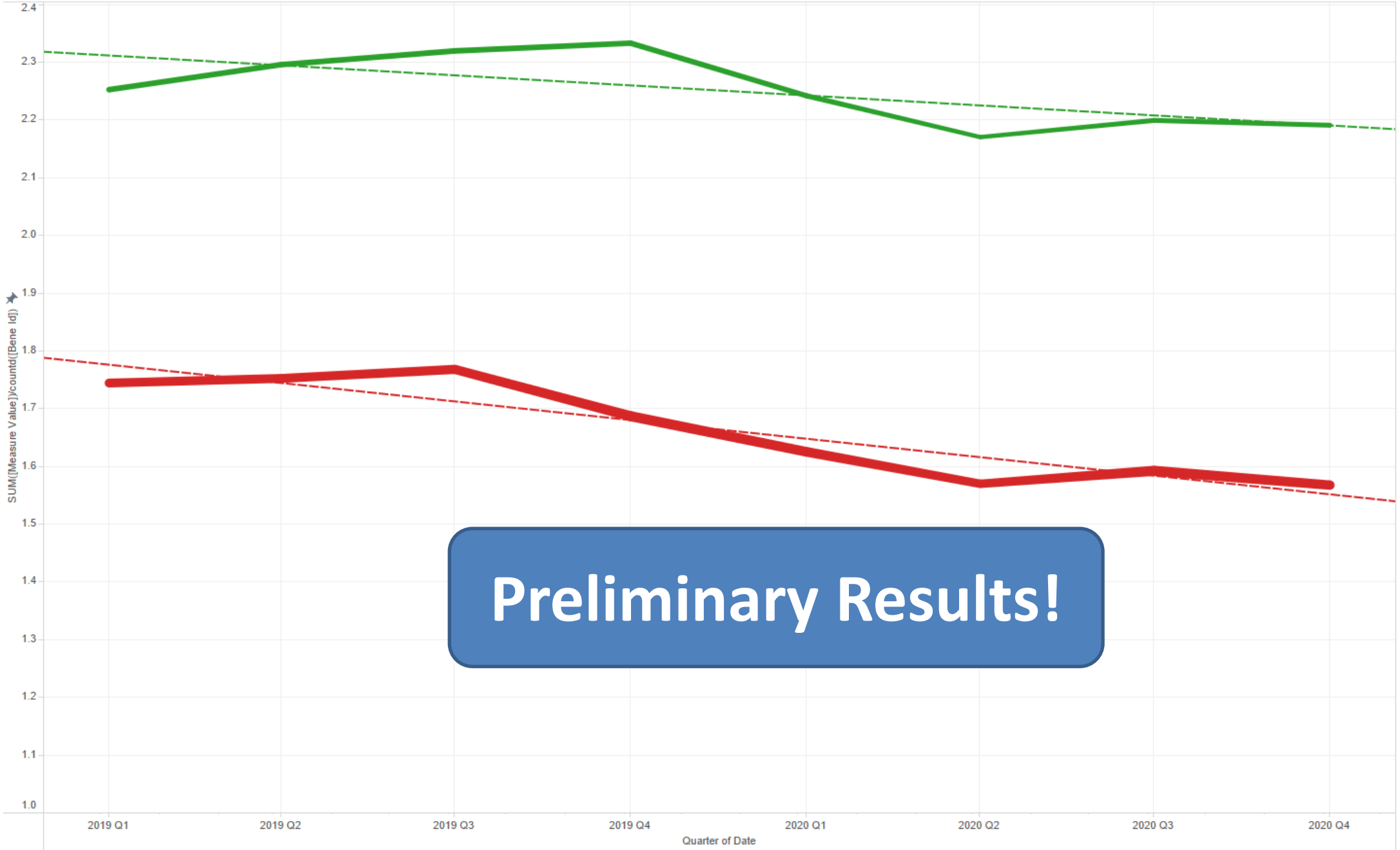
Day of Date Of Visit	Food Need	Housing Need	Transportation Need	Utility Need	Safety Need	
April 20, 2020	No	Yes	No	No	No	
June 25, 2020	No	No	No	No	No	

MyHealth ACCESS NETWORK

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

ER_UTILIZATION for Patients for All system(s) and All payer(s) by Product Line

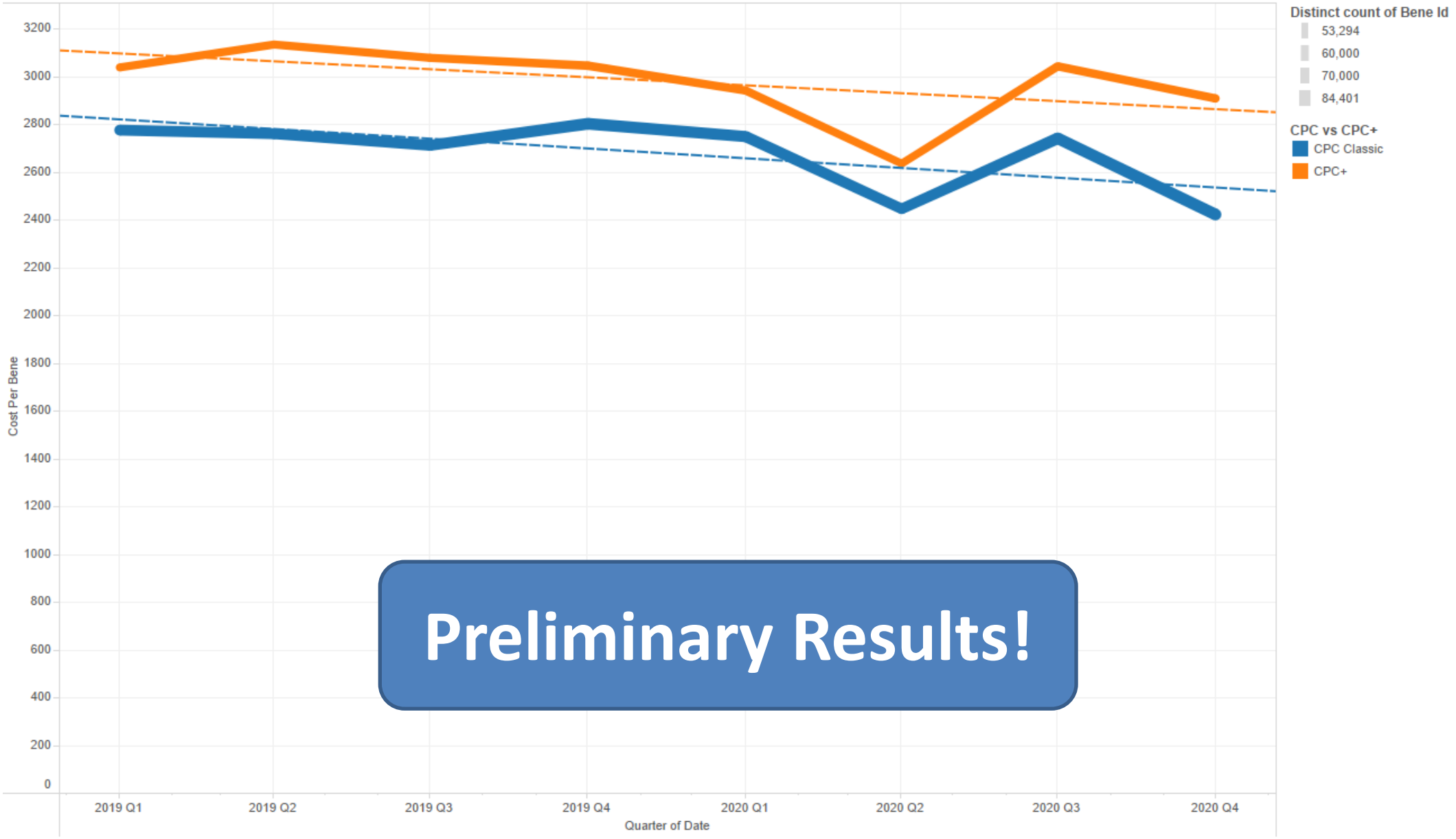


Preliminary Results!

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.

Return to Navigation Dashboard: https://tableau.myhealthaccess.net/#/site/CPCplus/views/CPCDashboard/NavigationPage

Total Expenditure: Cost Trend by CPC Classic vs CPC+ for All Health Systems



Preliminary Results!

Return to Navigation Dashboard: https://tableau.myhealthaccess.net/#/site/CPCplus/views/CPCDashboard/NavigationPage

Inpatient Expenditure: The expenditures associated with all inpatient claims.
Outpatient Expenditure: The expenditures associated with all outpatient claims.
Total Expenditure: The expenditures associated with all claims including: Inpatient, Outpatient, Home Health, Skilled Nursing Facilities, Hospice and Durable Medical Equipment.

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Health ACCESS NETWORK

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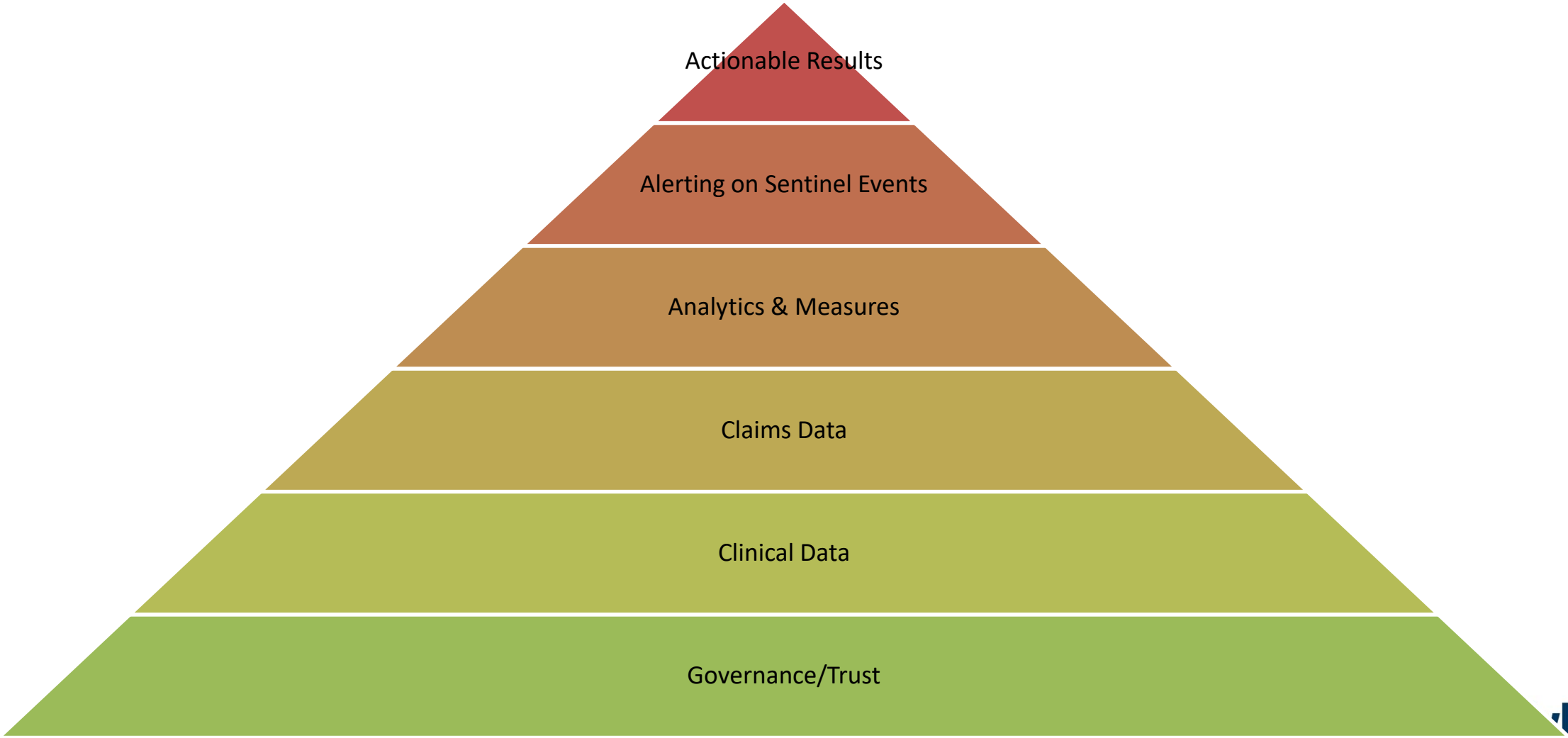
MyHealth ACCESS NETWORK

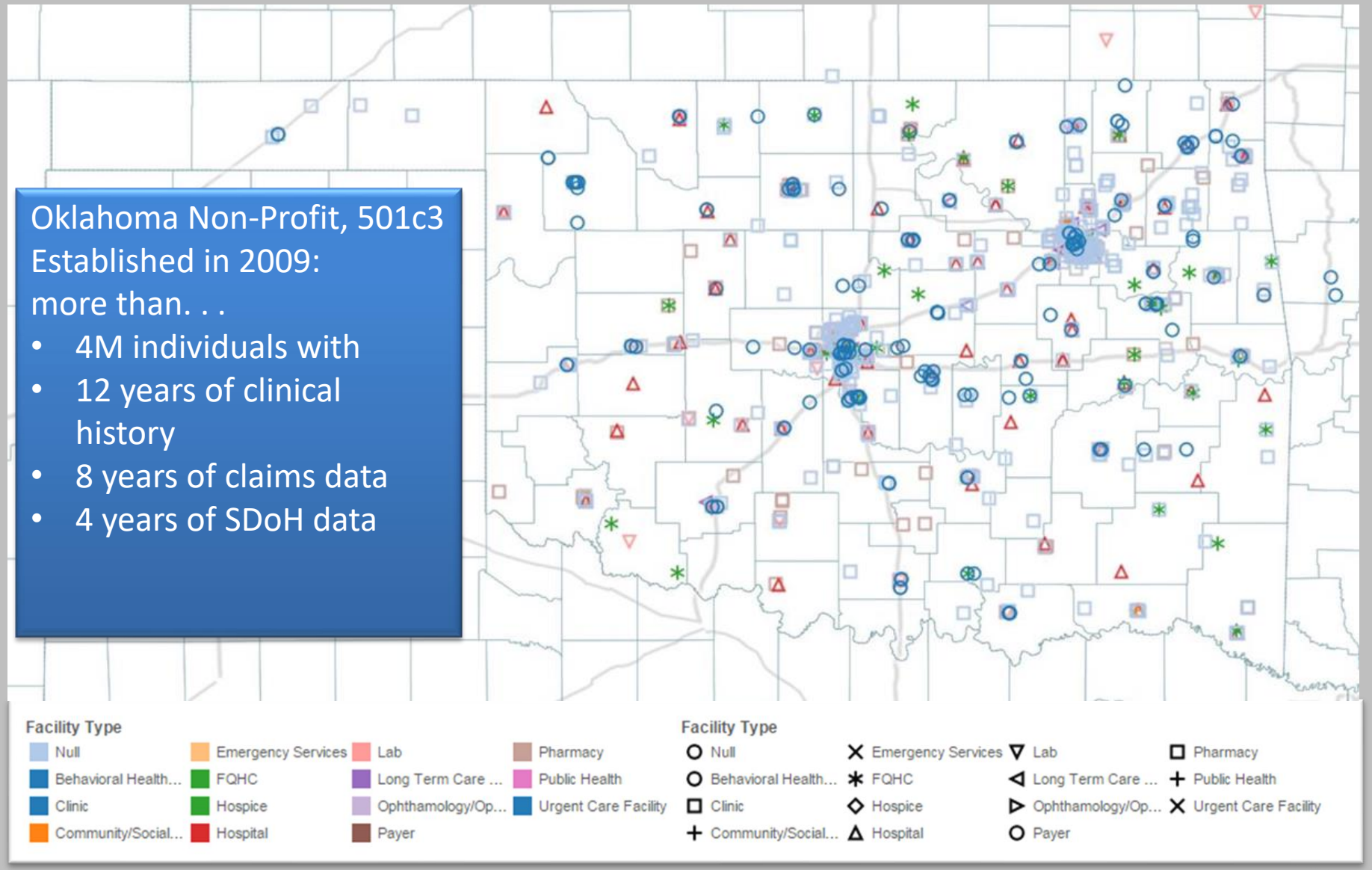
Common Infrastructure Ingredients needed for Most Models



>1400 locations serving >110,000 patients daily

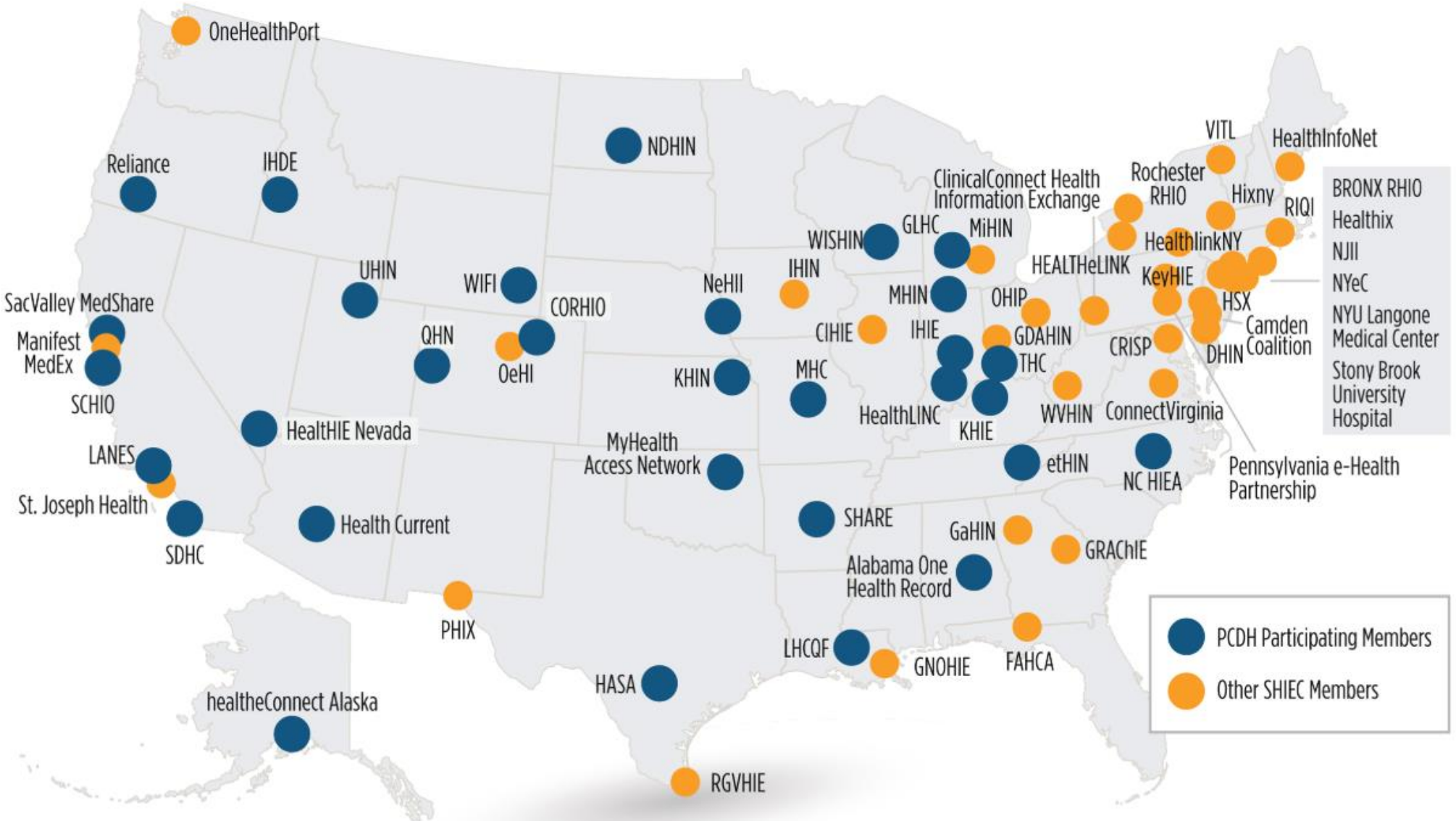
Oklahoma Non-Profit, 501c3
Established in 2009:
more than. . .

- 4M individuals with
- 12 years of clinical history
- 8 years of claims data
- 4 years of SDoH data



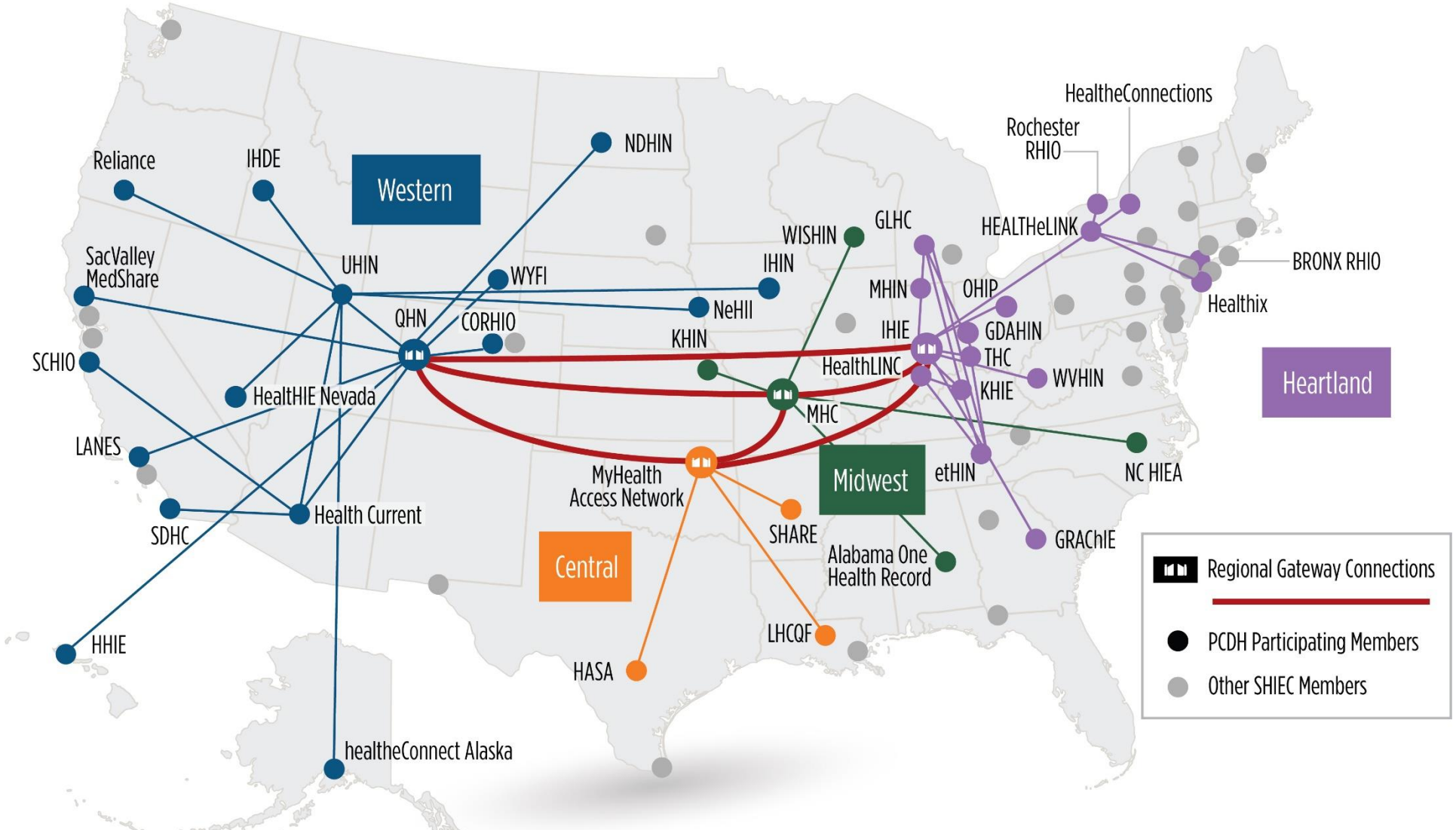
CIVITAS
Networks for Health

Potential innovation labs nationwide



CIVITAS
Networks for Health

Patient Centered Data Home™ coverage



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MyHealth ACCESS NETWORK

Discussion

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MyHealth ACCESS NETWORK

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

Yi-Ling Lin

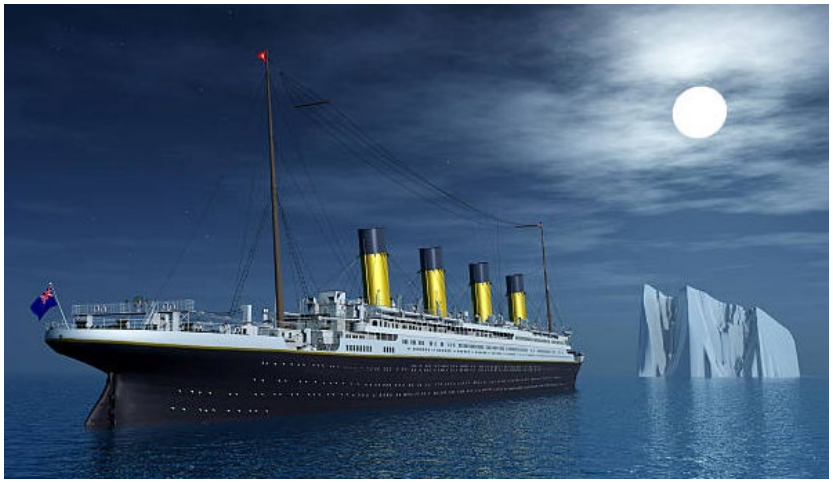
Healthcare Actuary & Financial Strategist,
Terry Group

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

Yi-Ling Lin, FSA, MAAA, FCA

Principal

Tel: 312-574-1510

Email: yi-ling.lin@terrygroup.com

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

ACP®
American College of Physicians
Leading Internal Medicine, Improving Lives

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)

Best Practices for Overall Clinician Engagement in Accountable Care Arrangements (cont.)

- 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?

Listening Session Part 2 on Assessing Best Practices in Care Delivery for Population-Based TCOC Models

Presenters:

- **David C. Grossman, MD, MPH**, Interim Senior Vice President, Social and Community Health, Kaiser Permanente
- **Ali Khan, MD, MPP**, Chief Medical Officer, Oak Street Health
- **Dana Gelb Safran, ScD**, President and Chief Executive Officer, National Quality Forum
- **Adam Weinstein, MD**, Chief Medical Information Officer, DaVita, Inc.

Presentation:
Integrating Social Health into Care Delivery

David C. Grossman, MD, MPH

Interim Senior Vice President,
Social and Community Health,
Kaiser Permanente

Integrating Social Health into Care Delivery

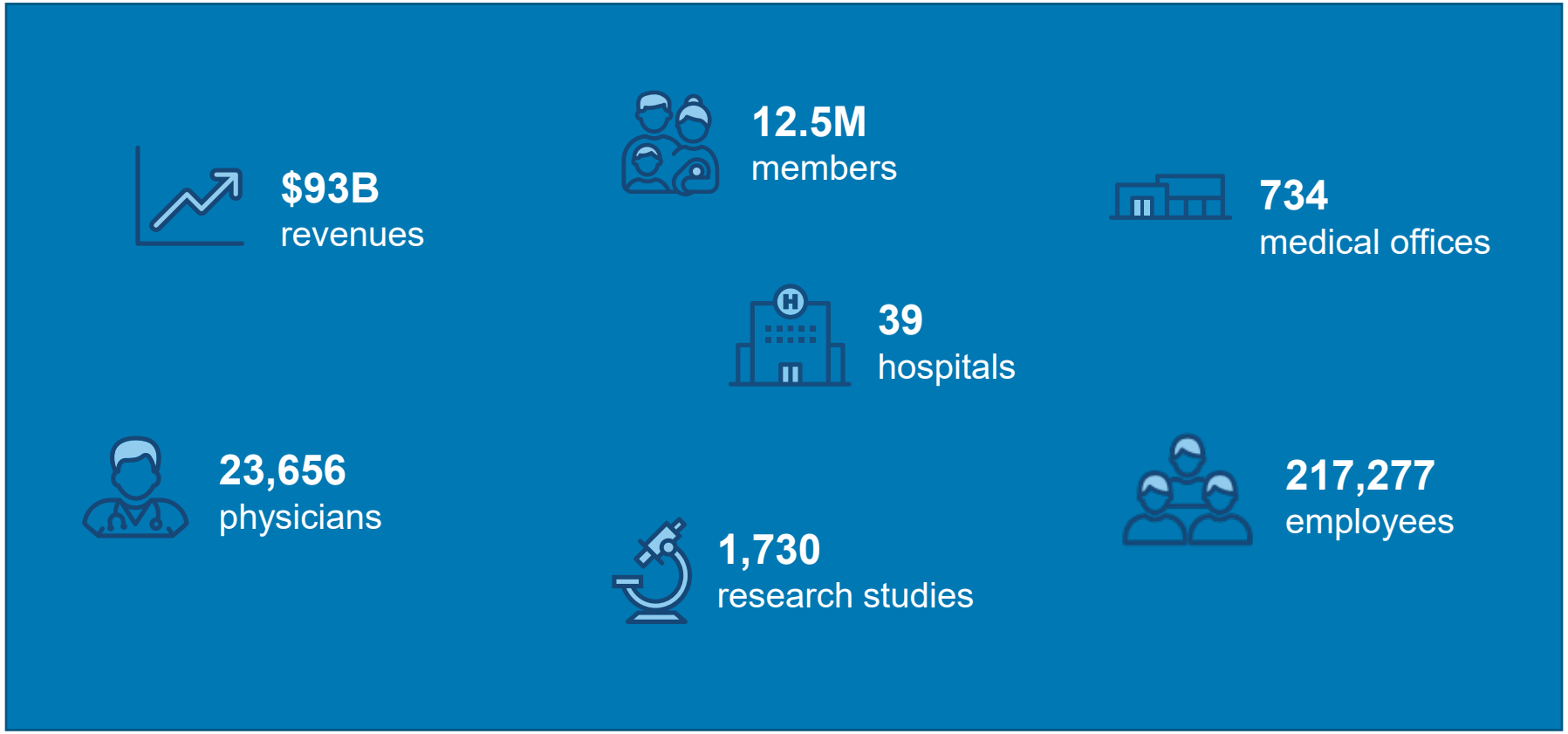
PTAC Total Cost of Care Listening Session

David C Grossman, MD, MPH
Kaiser Permanente
June 2022

KAISER PERMANENTE®

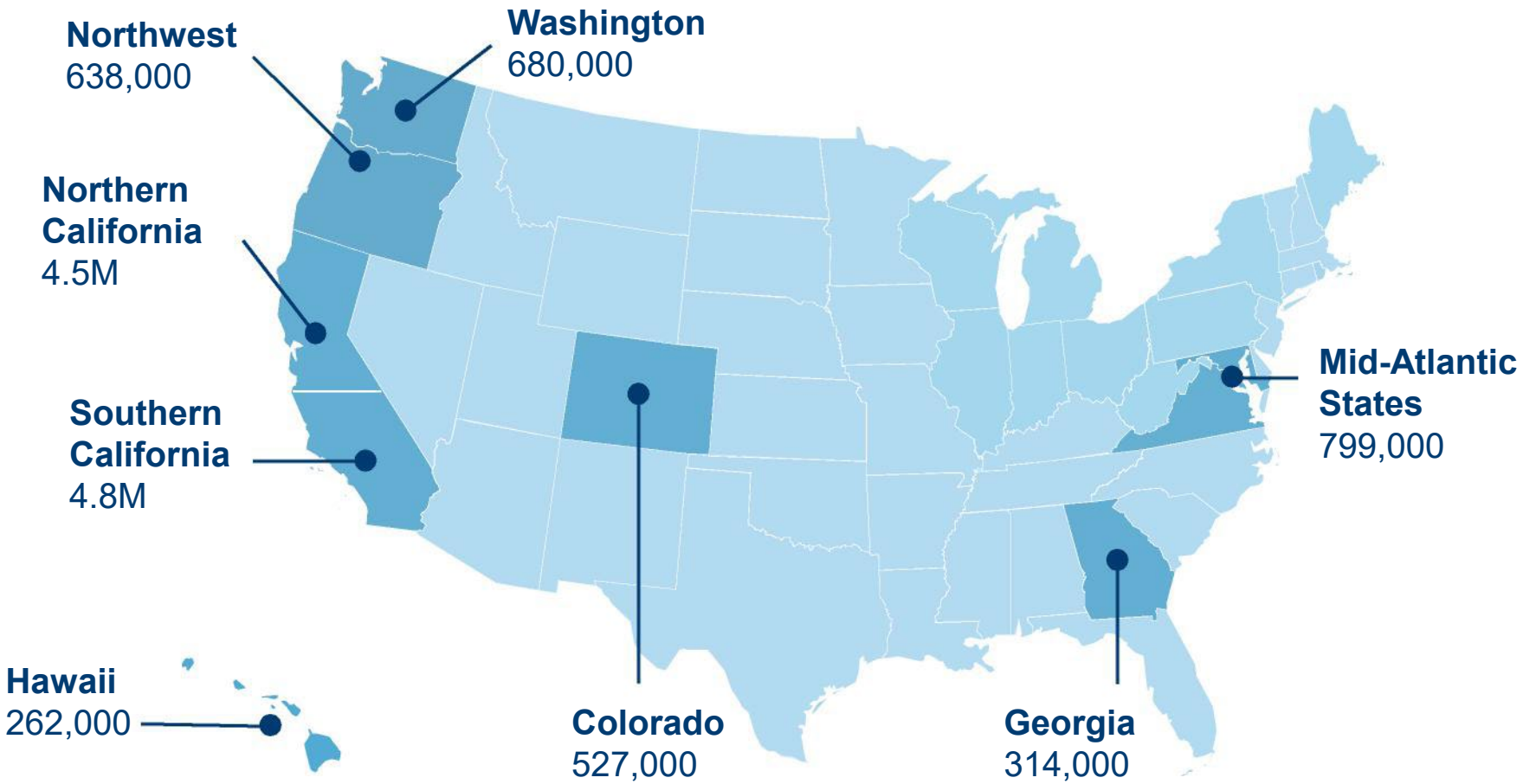
Kaiser Permanente Overview

Mission: *Kaiser Permanente exists to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.*



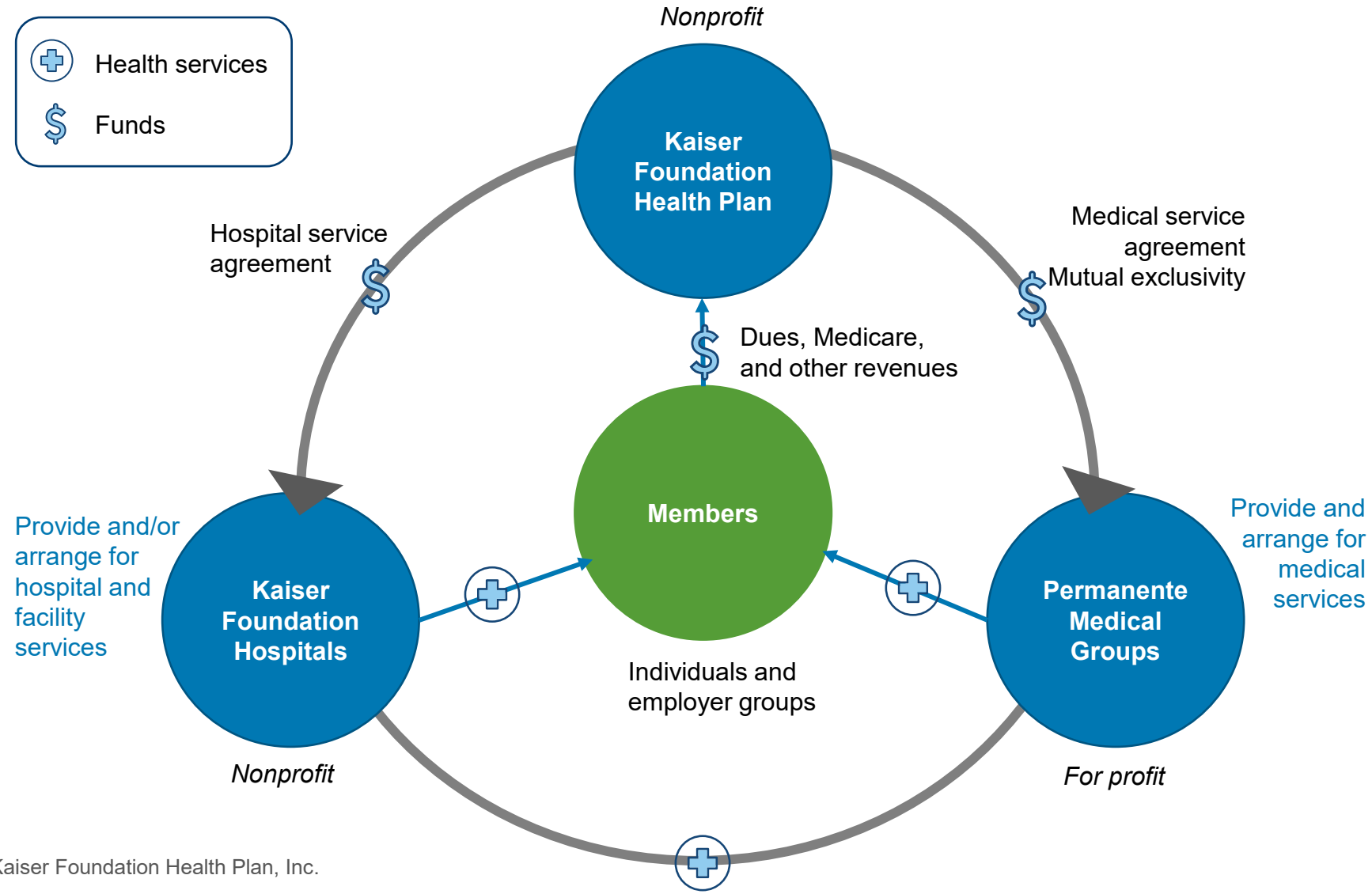
Data as of December 31, 2021
Source: https://about.kaiserpermanente.org/who-we-are/fast-facts

Kaiser Permanente Locations and Membership

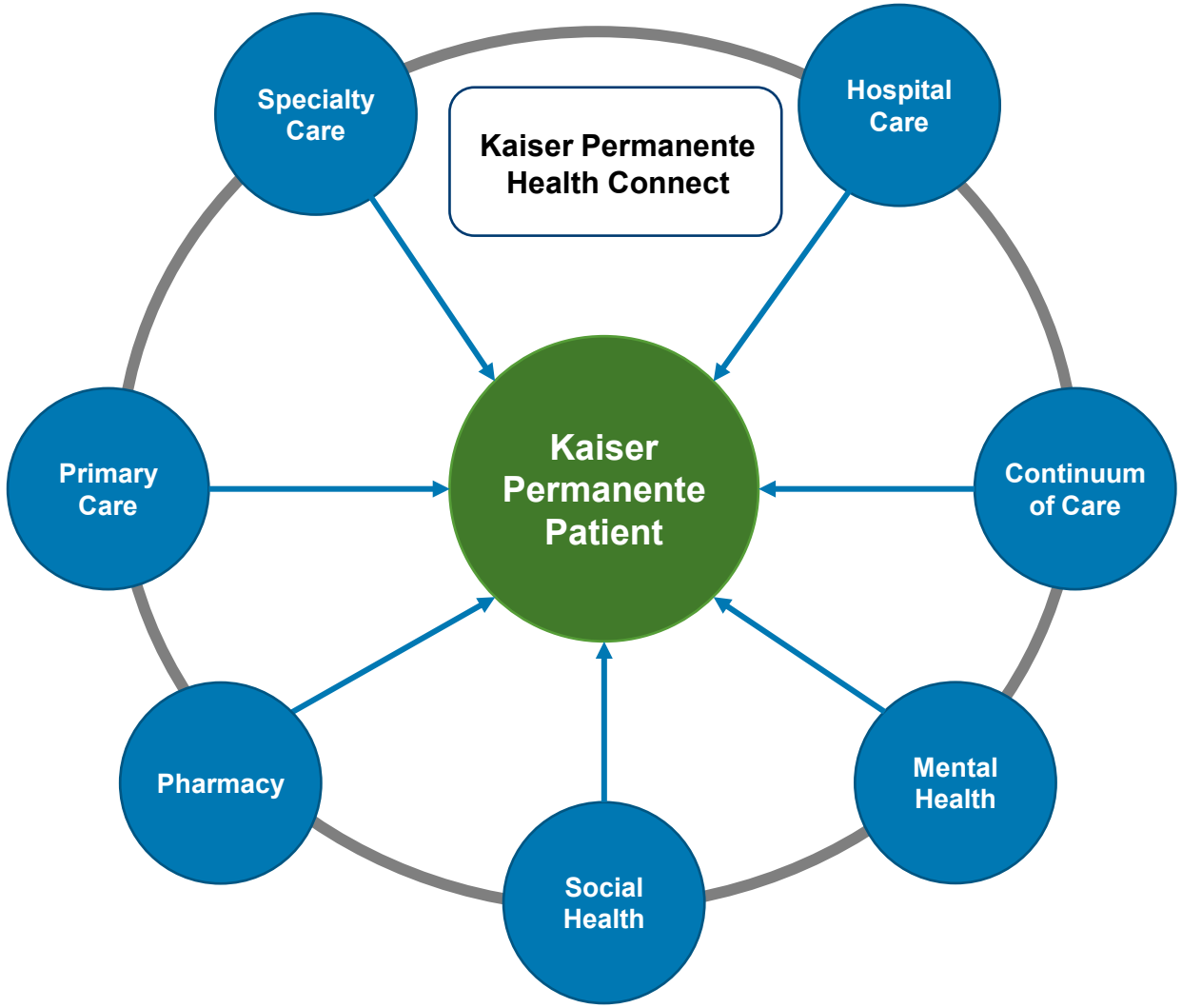


Data as of December 31, 2021
Source: https://about.kaiserpermanente.org/who-we-are/fast-facts

Integrated Care and Coverage



Integration of Care Delivery



Defined Global Budget with Flexibility from Single Source

Allows for a re-consideration of who, what, where, and how care is delivered

Care need not be limited to what occurs face to face in medical facilities or billable activities

Deep IT investments support integration through communication

By working with a single health plan, medical groups don't face competing demands from multiple payers. Unlike traditional plans, members rarely see the interaction between plan and provider.

Capitation and Revenue Model for Physicians

Permanente Medical Groups develop annual budgets based on a capitation rate and projected enrollment plus administrative overhead

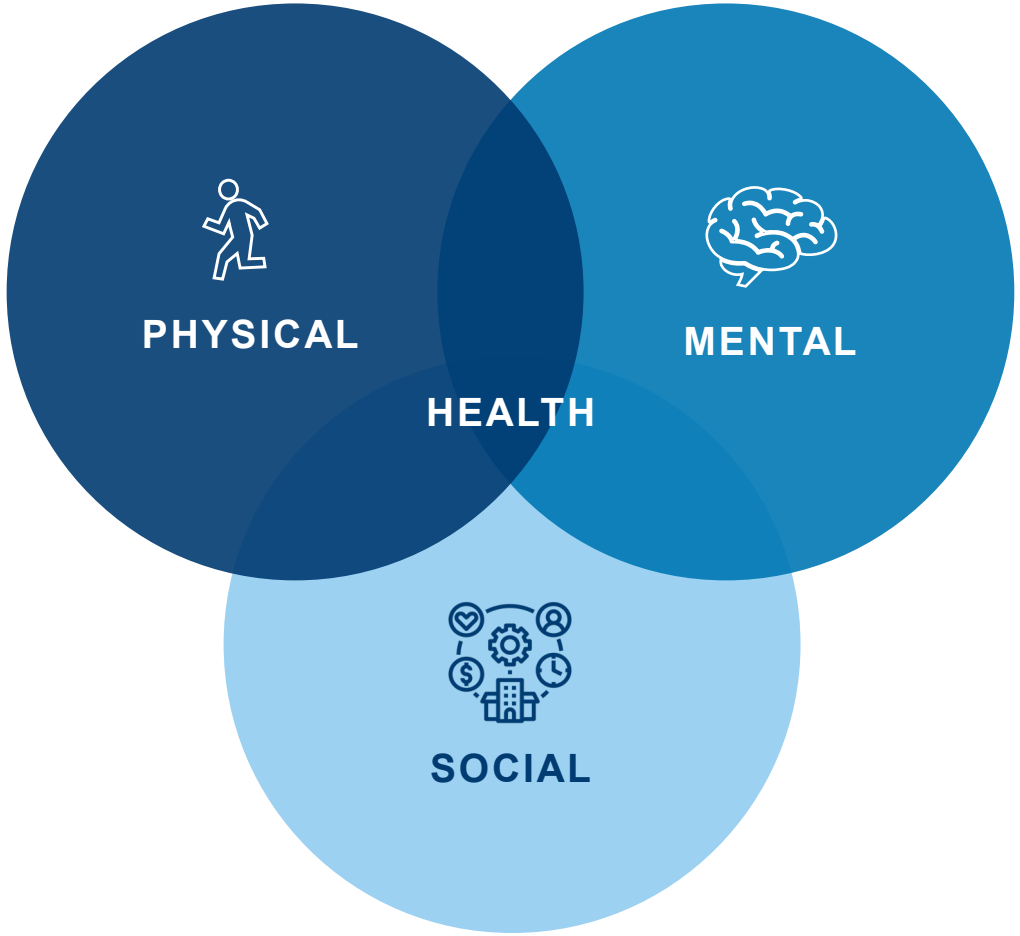
Kaiser Permanente Care Delivery receives its revenue from:

- **Health plan global payments**
- **Patient Cost share payments**
- **FFS payments from self-funded/ERISA employers**

KP participates only in Medicare Advantage and other capitated government programs

Our unique integrated model positions us to strive for equitable outcomes through community partnerships

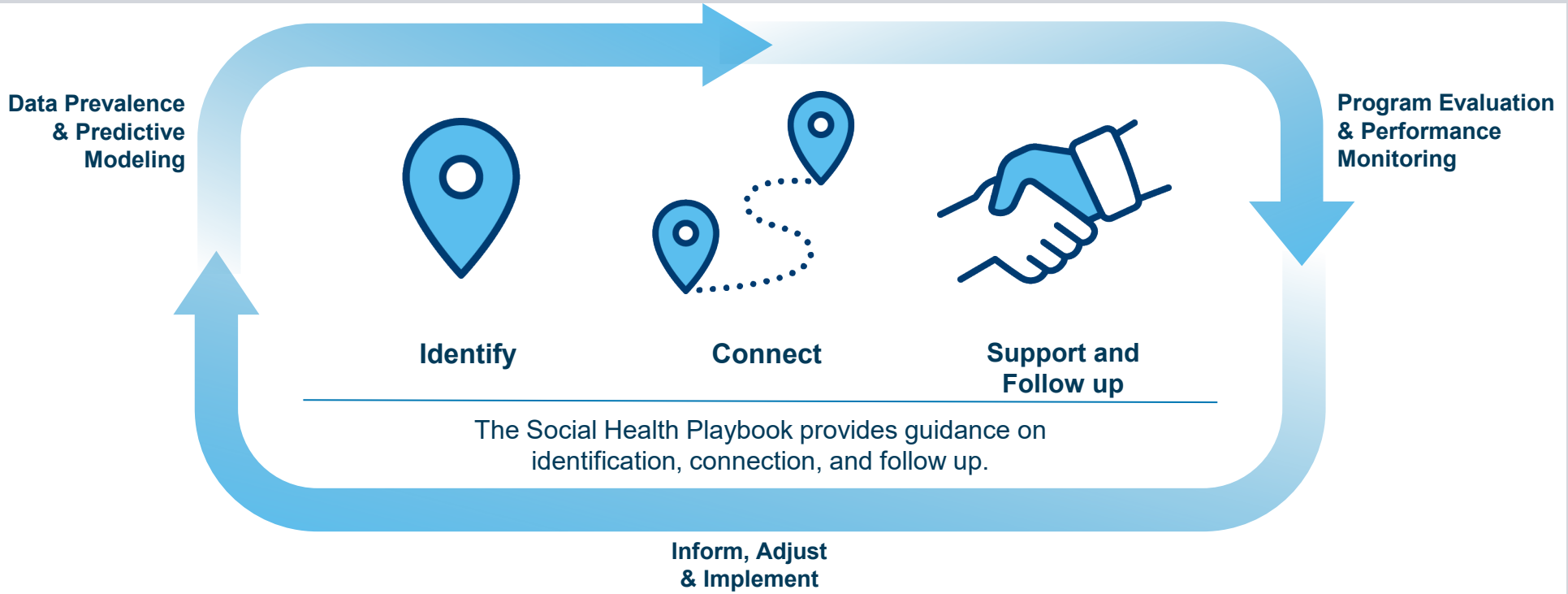
Kaiser Permanente is elevating the social health of our members and communities to the **same level as physical and mental health**.



Our Communities — Community Health

Social Health — Our Members

Kaiser Permanente's Social Health Framework



MEMBERS Integrate social health practice into Kaiser Permanente's care model

LOCAL IMPACT Support social health in our communities

SOCIETAL SHIFT Support integration of social health into other health care systems and communities

CATALYZING CHANGE THROUGH MEANINGFUL PARTNERSHIPS

KAISER PERMANENTE®

Updated as of 08.13.2020

Kaiser Permanente's Social Health *Practice* Framework

IDENTIFY

- **Standard screening questions/tools in KPHC**
- **Workflow design and job aids for screening**
- **Digital self-service screening tool**
- **Social risk models to target outreach**

CONNECT

Thrive Local

- **Resource sharing and community network referrals using Thrive Local**
- **Thrive Local resource directory self-service for members**
- **Connections phone line for members**

Member Initiatives

- **Food resources**, e.g., SNAP Enrollment, coupons programs, medically tailored and prepared meals
- **Social isolation resources,** e.g., awareness campaign
- **Housing resources**, e.g., homeless patient protocol, Project Home for navigation and wrap around services
- *(in development)* **Financial wellness resources**, e.g., tax preparation services

See appendix for examples

SUPPORT & FOLLOW UP

(in development)

Care Coordination

Social health screening, connection, and follow up as part of enterprise care coordination approach

Follow Up

Tracking closed/resolved cases in Thrive Local

CARE DELIVERY & OPERATIONS INTEGRATION SUPPORT
(playbook, job aids, trainings, etc.)

MEMBER AWARENESS & ENGAGEMENT
(communications, marketing, digital capabilities, etc.)

DATA, ANALYTICS & EVALUATION
(centralized data hub, dashboards and reports, impact assessments, technology systems, etc.)

KAISER PERMANENTE®

APPENDIX

Social Health Food Security Member Initiatives Currently Underway

Building on KP's legacy in obesity prevention, we built a comprehensive food security portfolio to increase member access to healthy, affordable food.

Supplemental Nutrition Assistance Program (SNAP) Enrollment *Food Security*
Conduct a multi-modal outreach campaign to enroll potentially eligible members in SNAP. To date, over 4 million members reached and 95K assisted with application submissions.

Medically Tailored Meals *Food Security*
Support healthy eating post discharge from the hospital for members with chronic conditions. To date, 2,100 have enrolled in MTM studies and over 116K meals provided to patients and their households.

COVID-19 Prepared Meals (Temp) *Food Security*
Provide food resources for members under isolation/ quarantine during COVID-19 through two programs via national vendor Mom's Meals. 2K members registered for this program and 17K meals provided.

Produce Prescriptions *Food Security*
Partner with Tufts University to conduct a randomized control trial on Produce Rx by providing healthy food access and nutrition education to people with diabetes who are food insecure.

Other Social Health Member Initiatives Currently Underway

In 2021, we continued to build our strategic approach and expanded our initiatives to respond to additional social needs identified by KP members, including housing security, social isolation and digital equity.

Project HOME *Housing Security*

Provide navigation, assistance**,** and tenancy sustaining services to a segment of our unhoused patient population through strategic community-based partnerships.

Medical Legal Partnerships *Housing Security*

Integrate medical-legal partnership (MLP) programs into KP care delivery, build capacity of the legal services sector, and increase access to legal services to prevent individuals and families from losing their homes.

Health Promotion Campaign/ Life Experienced *Social Isolation*

Execute a multifaceted health communications campaign to decrease social isolation and loneliness among older adults. To date, the campaign has generated 1,700 followers and over 16K website visits.

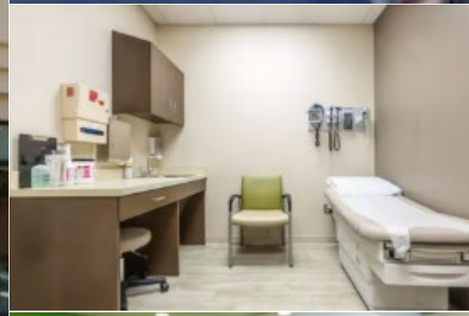
SafeLink *Digital Equity*

Connect eligible members to SafeLink (part of the Federal Lifeline program) which provides a free smartphone, 4.5 GB of data, unlimited text messages, 350 minutes of voice calls, and unlimited calls to designated KP number and newly expanded access to broadband.

Presentation:
Quality, Disparities + Equity: How Does Value-Based Care Narrow the Gap?

Ali Khan, MD, MPH

Chief Medical Officer,
Oak Street Health



Quality, Disparities + Equity: How Does Value-Based Care Narrow the Gap?

OAK STREET HEALTH

June 7, 2022 | Ali Khan, MD, MPP, FACP

Problems with the U.S. healthcare system are well-documented:

Expensive [1,2]

$4.1 tn
US annual healthcare spend

+267%
US per-capita healthcare spend vs OECD average

Poor Outcomes [1]

-2 years
US life expectancy vs OECD average

+52%
US diabetes hospital admits vs OECD average

Negative Experience [3,4]

>40%
US Physician Burnout rate

-1.2
Average Net Promoter Score for primary care physicians

High costs and poor outcomes are concentrated in older adults, who tend to be the sickest patients. Today, 96% of Medicare spend relates to chronic disease[2]

1. Source: OECD
2. Source: Centers for Medicare and Medicaid Services (CMS.gov) 2020 data
3. Source: Medscape National Physician Burnout and Suicide Report
4. Source: The Advisory Board, 2019

Note: All OECD comparisons are from 2019 or earlier to remove any uneven impact of COVID-19

For certain communities, those challenges are even more stark:

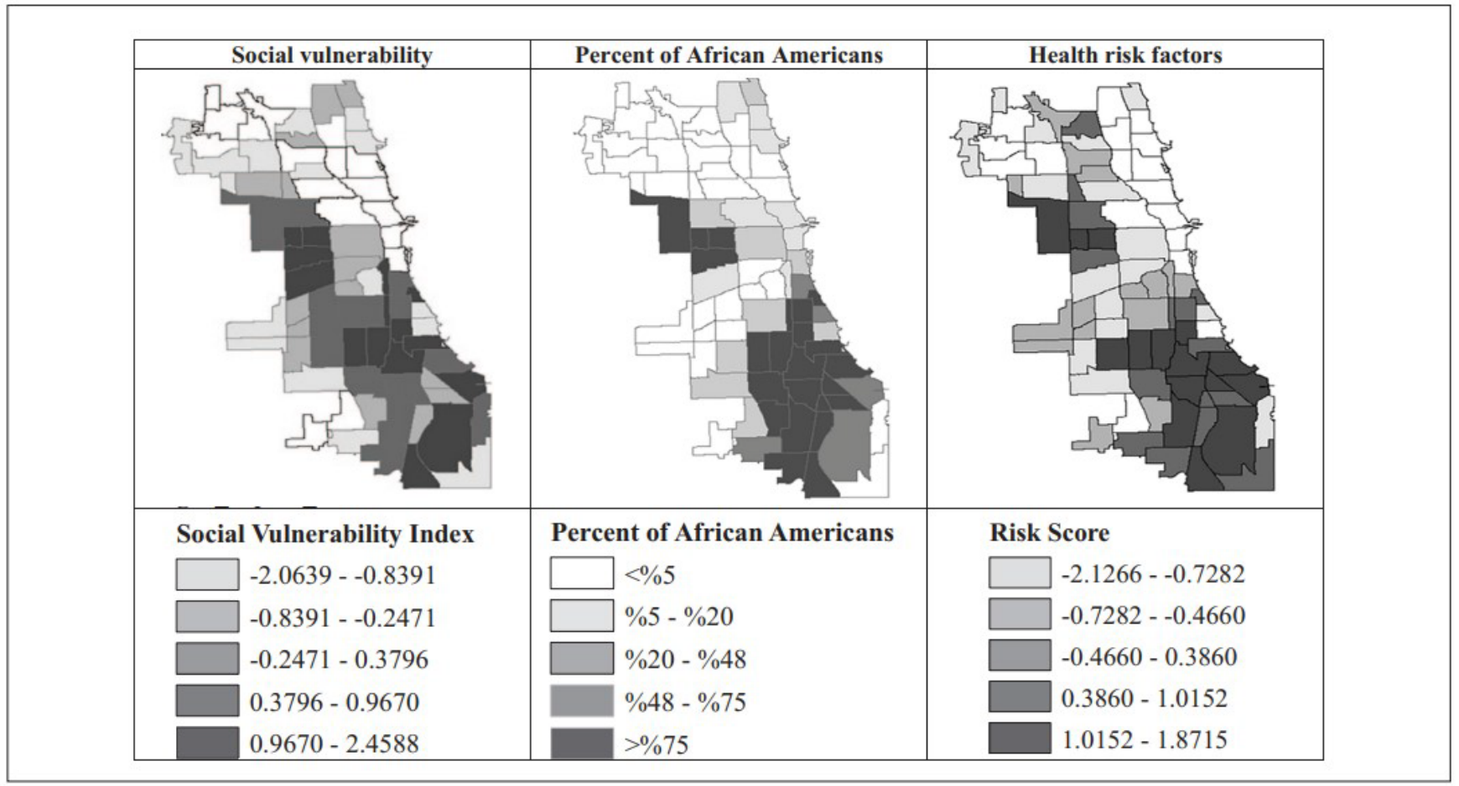


Figure 2. The spatial distributions of social vulnerability, health risk factors, and the percentage of African American residents in Chicago Community Areas.
Note. Social vulnerability index ranged from −2.0640 to 2.4859; Risk Score ranged from −2.1266 to 1.8715.

Communities with higher rates of poverty and unemployment, among other factors, suffer higher-risk health outcomes.[1]

13.4%

Proportion of Black Americans in US population[2]

40%

Proportion of Black Americans among COVID-19 hospitalizations

~3.1x

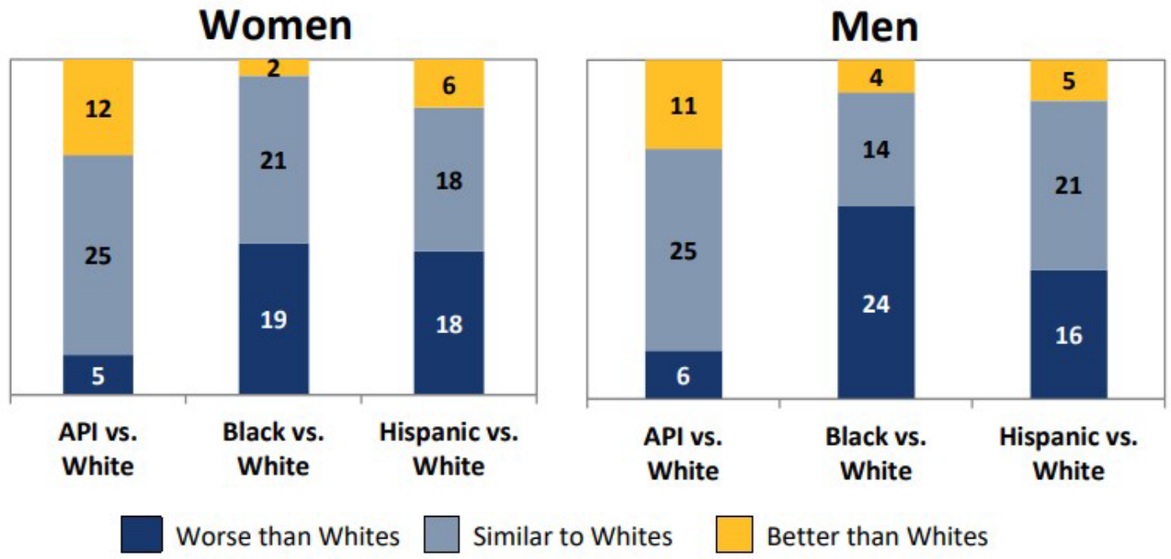
Rate of Black American hospitalizations for COVID-19, relative to population size

1. Source: Kim and Bostwick, “Social Vulnerability and Racial Inequality in COVID-19 Deaths in Chicago.” Health Education and Behavior. 2020
2. Source: Centers for Disease Control and Prevention; Gaynor and Wilson, “Social Vulnerability and Equity: The Disproportionate Impact of COVID-19.”.Public Administration Review. 2021.

When we examine the care we deliver, further equity gaps emerge:

Figure 5. Racial and Ethnic Disparities in Care by Gender: All Clinical Care Measures

Number of clinical care measures (out of 42) for which women/men of selected racial and ethnic minority groups experienced care that was worse than, similar to, or better than the care experienced by White women/men in 2018



SOURCE: This chart summarizes clinical quality (HEDIS) data collected in 2018 from MA plans nationwide.
NOTES: API = Asian or Pacific Islander. Racial groups such as Blacks and Whites are non-Hispanic. Those who endorsed Hispanic ethnicity were classified as Hispanic regardless of race.

While patient-reported rates of care delivery are often equivalent across racial categories, outcome measures tell a different story.[1]

~9-10% lower

Likelihood that Black + Hispanic patients had adequately controlled high blood pressure, relative to Whites

~11-12% lower

Likelihood that Black + Hispanic patients had adequately treated depression episodes with continuous antidepressant use, relative to Whites

1. Source: Martino et al, “Racial, Ethnic and Gender Disparities in Health Care in Medicare Advantage.” CMS Office of Minority Health/RAND. 2021.

Enter: Oak Street Health

We are…
A patient-centric network of primary care centers for Medicare-eligible patients

We leverage…
The Oak Street Health platform to provide comprehensive care for our patient population

We improve…
Experiences and outcomes for our patients

We reduce…
Hospitalizations by over 50% and retain the savings generated by our care model

137	Oak Street owned and operated centers
20	States currently covered
114.5k	At-risk patients receiving our care
$1.43b	Total 2021 revenue, 62% annual revenue growth
~4,800	Team members, all aligned with our mission & vision, including ~500 primary care providers

Note: Centers and states as of 03/16/2022; remaining data as of 12/31/2021

Oak Street Health locations

Currently serving 175,000+ Medicare beneficiaries and growing.

- **About 45% of Oak Street patients are dually eligible for Medicare and Medicaid**

Alabama	2	New Mexico	4
Arizona	10	New York	10
Georgia	5	North Carolina	8
Illinois	27	Ohio	11
Indiana	8	Oklahoma	5
Kentucky	1	Pennsylvania	10
Louisiana	5	Rhode Island	4
Michigan	11	South Carolina	3
Mississippi	2	Tennessee	4
Missouri	4	Texas	17

Why: complex patients require multi-dimensional care model – and time

68 average age

86% of patients have one or more chronic conditions

7+ average number of medications

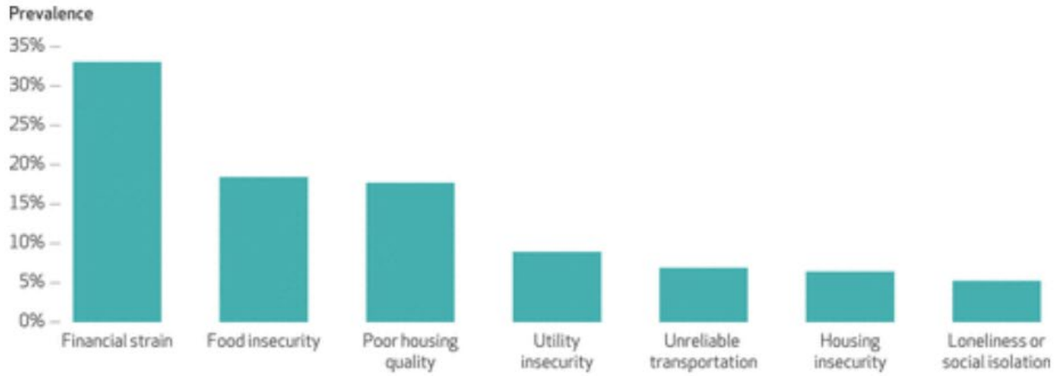
>50% of patients identify as African American, Latino, or Indigenous

42% of patients are dually eligible for Medicare and Medicaid

~50% of patients have a housing, food, or isolation risk factor

All too often, resource limitations stymie progress in health outcomes

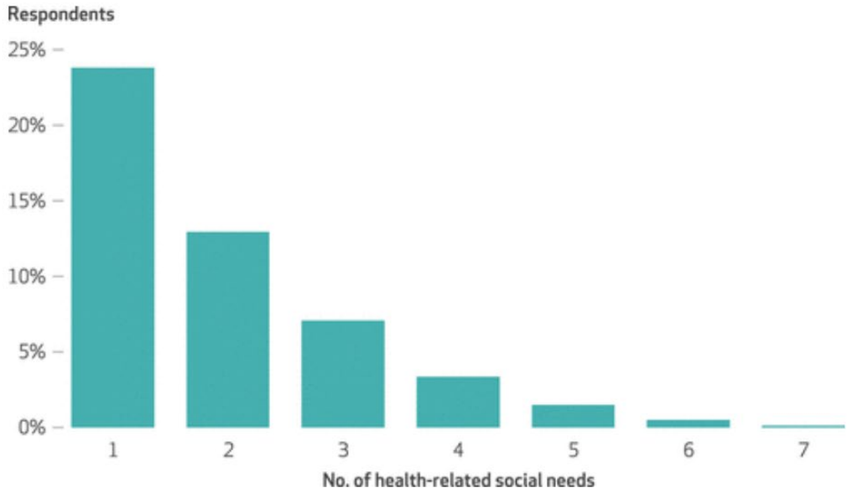
Exhibit 1 Prevalence of health-related social needs among older adults enrolled in Medicare Advantage, 2019–20



HealthAffairs

SOURCE Authors' analysis of Humana survey data, 2019–20. NOTES Sample limited to respondents who answered all survey questions (n=51,201). Prevalence estimates are weighted for nonresponse and national age and sex distribution. Health-related social needs are not mutually exclusive, and respondents could be counted in more than one category.

Exhibit 2 Distribution of health-related social need burden among older adults enrolled in Medicare Advantage, 2019–20



1. Source: Long et al. "Health-related social needs among older adults enrolled in Medicare Advantage." Health Affairs. 2022.

Value-based models invest upfront to keep patients happy, healthy, and out of the hospital

Challenges in Primary Care Settings	Fee For Service	Value-Based Practices (Medicare, Medicaid)
Not enough time with patients	**2,000+** Avg doctor panel[1]	**~400-800** Patient panel
No patient specialization	Accepts all ages	Medicare-eligibles focused (most often); Medicaid-eligibles focused (less common – Cityblock, CareMore, Waymark)
No non-facing patient time	No time to plan for care outside the exam room	**>1/3** Provider/nursing time used to **communicate**, coordinate care, close care gaps + proactively plan
No support beyond primary care	Minimal focus on social determinants of health	Behavioral health, pharmacy, home-based support, well-being programs + social worker/community health worker assistance within **large care teams**
Limited technology integration	Limited EMR use focused on billing & record-keeping; no time to engage with population health overlays	**4 hrs/day** Average time that clinical staff use technology platforms optimized to provide an integrated clinical and care plan – *single source of truth for teams*

1. Source: Journal of General Internal Medicine

Value-based models leverage a deep understanding of our patients, leading to coordinated and holistic support

Oak Street Health Care Model

Upon joining…

Intake & Assessment

+

Patient Stratification

Longitudinal Primary Care

- "Dosage" of primary care visits
- Interdisciplinary care teams
- Multi-channel engagement
- Evidence-based protocols

Supported by…

Population Management

- Daily huddles
- Weekly planning
- Monthly reviews

Population Health Interventions

- Integrated specialty care (RubiconMD)
- Transitions in care
- Home-based primary care
- Integrated behavioral health
- Social worker support
- Medication management

When needed…

Care Navigation Support

To be discussed in further detail

Value-based models yield better quality care delivery for patients – and, in doing so, close gaps in health inequity

5-Star HEDIS Level Performance[1]:

85%
Diabetic patients with well-controlled diabetes (Hemoglobin A1C of <9)
+6% above industry 5-star benchmark

87%
Patients with a breast cancer screening
+12% above industry 5-star benchmark

88%
Patients with colorectal cancer screening
+14% above industry 5-star benchmark

1. For patients that completed a 2021 wellness review visit

Care Model Deep-Dive: Integrated Behavioral Health
Taking care of our patients' population health needs

Mental Health in the US[1]

1 in 5

US adults who experienced a mental illness in 2020

>17 million

US adults who experienced delays or cancellations in mental health appointments

At Oak Street Health

All patients

screened for behavioral health at initial visit and annually

All centers

provide access to behavioral health care

Collaborative care

Behavioral health is not stigmatized or siloed; it is a part of whole-person care at OSH

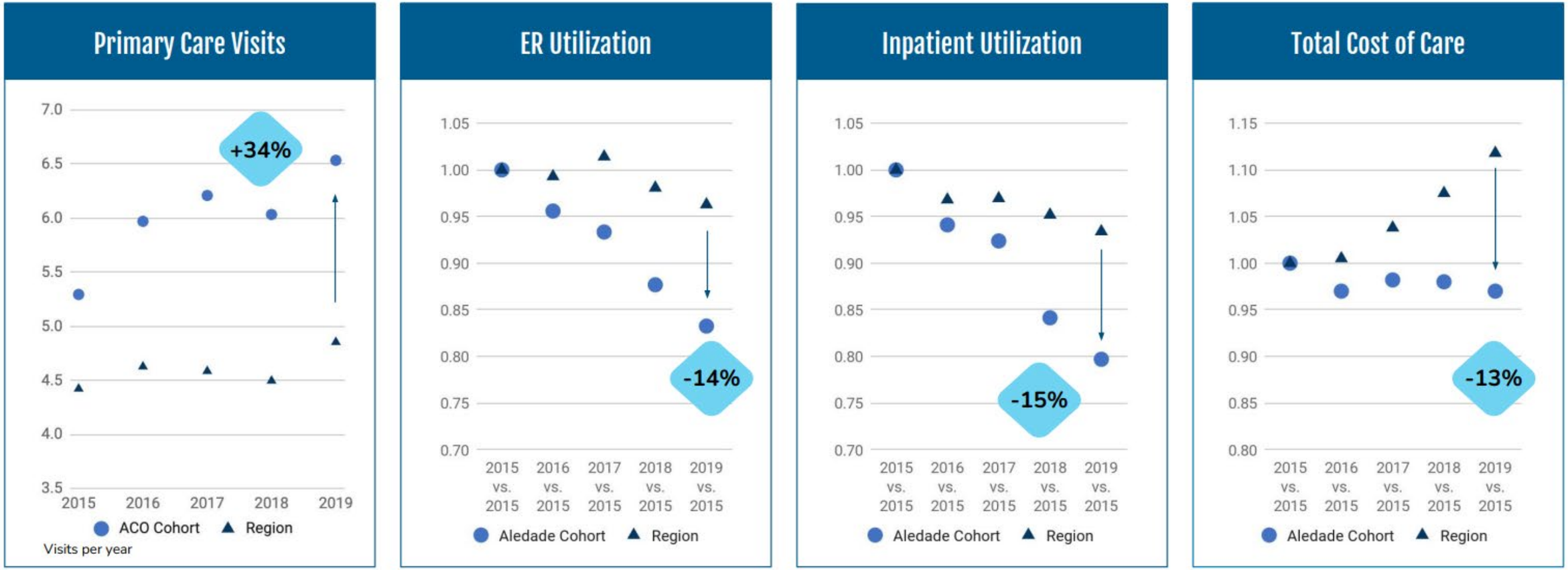
43%

OSH patients seeing a significant reduction in depressive symptoms through Oak Street collaborative behavioral health care model[2]

vs 19% of patients in traditional behavioral health care model[3]

1. National Alliance on Mental Illness, 2020 data
2.Oak Street Health patient data following 6-month study, May 2021
3 JAMA 2002, "Collaborative Care Management of late-life depression in the primary care setting"; Primary Care: Clinics in Office Practice 2012

Value-based care allows for critical investment in primary care



VBC models demonstrate improved quality and lower cost across plan types (HMO, PPO, Open Access, SNP, MMP) and programs (MA, MSSP, DC and Medicaid)

1. Source: Aledade analysis of the CMS Virtual Research Data Center, containing 100% of Medicare claims nationally. More primary care, fewer ER visits, and hospitalization means lower cost over time. Primary Care Visits ER Utilization Inpatient Utilization Total Cost of Care https://www.ajmc.com/view/more-than-beating-the-benchmark-5-medicare-acos-2015-2019

Value-based care allows for critical investment in primary care

!

In 2018, hospitalizations were >60% of Medicare expenditures[1]…

…while Primary Care spend accounted for only ~3%

51% reduction in hospital admissions [2]

42% reduction in 30-day readmission rate[2]

51% reduction in ED visits vs. Medicare FFS benchmark [2]

NPS of 90[2]

VBC models invest in proactive primary care, spending more than 3x the average[3]. We remove reactive and more-expensive costs from the system.

VBC models demonstrate improved quality and lower cost across plan types (HMO, PPO, Open Access, SNP, MMP) and programs (MA, MSSP, DC and Medicaid)

1. Source: CMS and Kaiser Family Foundation
2. Please see our S1, filed 2/8/2021, for information on how these statistics are calculated
3. Based on our 2021 spend (please see our 10K, filed 2/28/2022) vs industry average (sourced from Kaiser Family Foundation)

A growing consensus emerges: value drives better quality, particularly for those who need it most

JAMA Network Open

Results

In a study population of 489 796 MA beneficiaries, value-based payment was significantly associated with lower acute care use (Table). Compared with FFS, beneficiaries cared for under 2-sided risk models had lower rates of hospitalizations, observation stays, and ED visits. For example, the adjusted rate of ED visits per 1000 patients for 2-sided risk models was 375.8 (95% CI, 370.9-380.7) compared with 434.1 (95% CI, 426.5-441.9) for FFS. For all outcomes, there was no significant difference in acute care use between beneficiaries cared for under upside-only risk models and FFS.

The association between value-based payment and decreased acute care use was most pronounced for measures of avoidable acute care use. Compared with FFS, 2-sided risk models were associated with a 15.6% (95% CI, 14.2%-17.0%) relative reduction in avoidable hospitalizations, compared with 4.2% (3.4%-4.9%) for all-cause hospitalizations (Figure).

AJMC

RESULTS: Compared with patients randomized to usual care, patients randomized to complex care management had lower TME (adjusted difference, –$7732 per member per year [PMPY]; 95% CI, –$14,914 to –$550; *P* = .036), fewer IP bed days (adjusted difference, –3.46 PMPY; 95% CI, –4.03 to –2.89; *P* <.001), fewer IP admissions (adjusted difference, –0.32 PMPY; 95% CI, –0.54 to –0.11; *P* = .014), and fewer specialist visits (adjusted difference, –1.35 PMPY; 95% CI, –1.98 to –0.73; *P* <.001). There was no significant impact on care center or ED visits.

CONCLUSIONS: Carefully designed and targeted complex care management programs may be an effective approach to caring for high-need, high-cost Medicaid patients.

Am J Manag Care. 2020;26(2):e57-e63

1. Source: Gondi et al. “Analysis of value-based payment and acute care use among Medicare beneficiaries.” JAMA Network Open. 2022.
2. Source: Powers et al. “Impact of complex care management on spending and utilization for high-cost, high-need Medicaid patients.” AJMC. 2020.

Case Study: Acorn ACO demonstrates ability to drive medical cost savings across Medicare[1]

4th

highest savings rate of all 513 ACOs

~17%

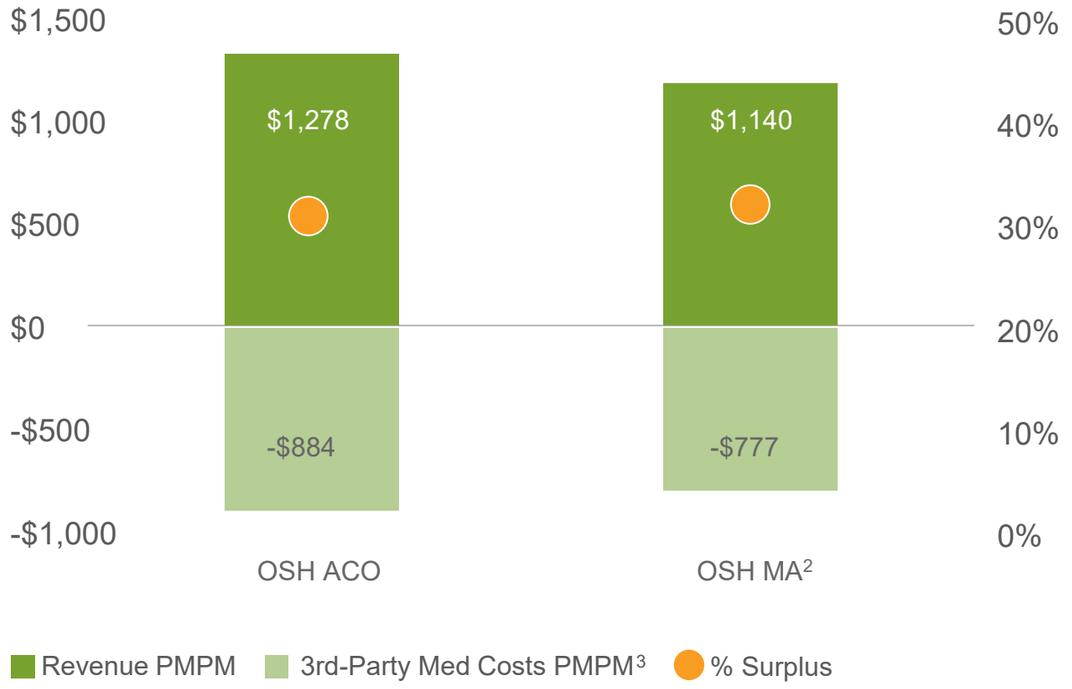
Savings rate compared to 4% average

IL, MI, IN

Only ACO in the top 10 to operate in these states

~$1.2K

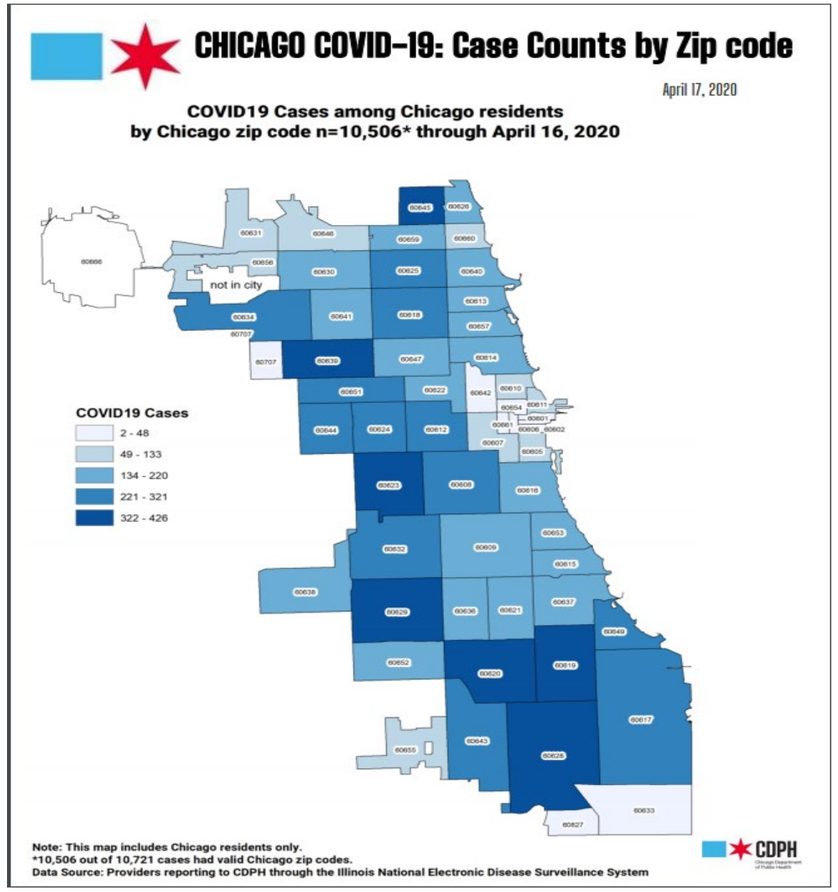
Average annual taxpayer savings per patient vs CMS target[4]

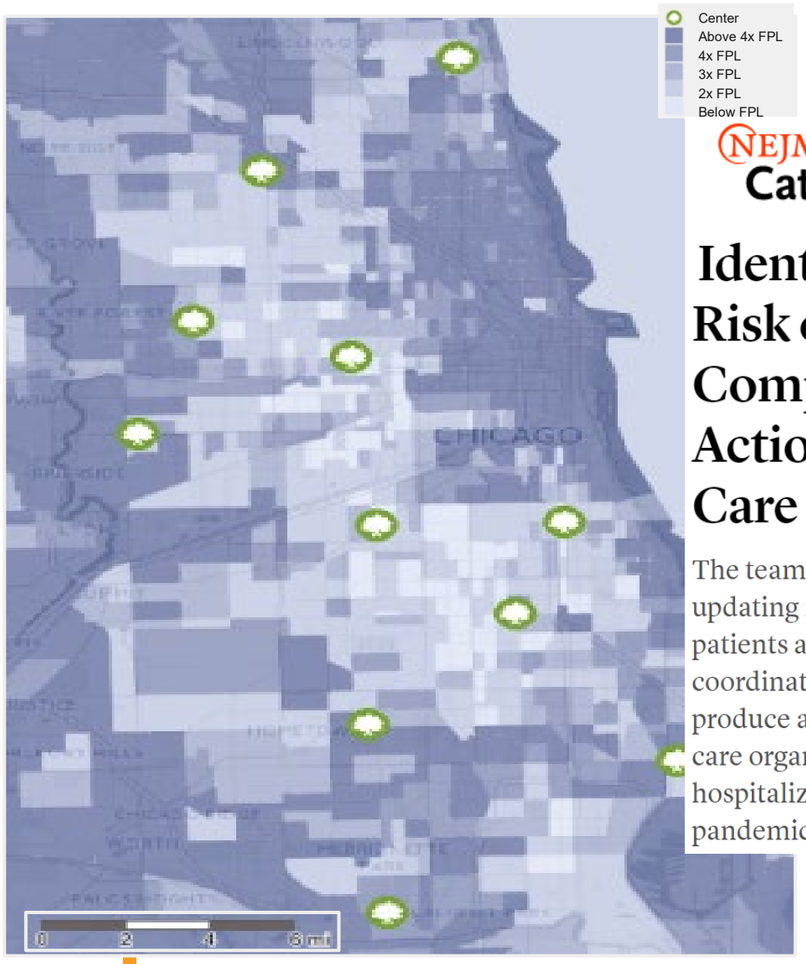


Value-based care models produce consistent results across both MA and ACO populations

1. CMS 2020 data
2. Reflects OSH MA economics for 2020 for Part C revenue and medical costs (comparable to ACO economics)
3. External costs only, excludes the costs of Oak Street's primary care model which would reduce the savings retained by Oak Street Health
4. Based upon CMS' calculation of savings; not derived from the data on this slide

Case Studies: Value-based care and COVID-19 inequity





NEJM Catalyst | Innovations in Care Delivery

Identifying Patients with Increased Risk of Severe Covid-19 Complications: Building an Actionable Rules-Based Model for Care Teams

The team at Cityblock Health is building, expanding, and regularly updating its rules-based, adaptable model to identify Covid-19 patients at highest risk. Recognizing the importance of a coordinated response and shared learnings, they wanted to produce an open-source tool to help other providers and health care organizations identify their patients at highest risk of hospitalization, ICU use, and death from the coronavirus pandemic.

Decoupling payment from in-person visit volume incentivizes proactive outreach, home-based care and upfront investments in community protections

1. Source: Schnake-Mahl et al. “Identifying patients with increased risk of severe Covid-19 complications: building an
2. actionable rules-based model for care teams. NEJM Catalyst. 2020.

Despite progress in quality + equity, the value journey is adolescent

- **Incentive Design**: Future expansion of Medicare-led payment models to more deeply link payment reform, quality + equity in equal measure (MA STARs, ACO REACH)
- **Scalability**: Moving beyond ~1-10% of Medicare beneficiaries; application to high-risk commercial models, expansion of Medicaid services/scope
- **Clinical Excellence**: Ongoing evaluation of clinical outcomes + patient-reported outcome measures; collaborative benchmarking

Time, Resources + Follow-Through = **Trust**

Q&A

OAK
STREET
HEALTH

Presentation:
Model Features That Support Improved Outcomes, Equity & Affordability

Dana Gelb Safran, ScD

President & Chief Executive Officer,
National Quality Forum

NATIONAL QUALITY FORUM
Driving measurable health improvements together

https://www.qualityforum.org

Model Features That Support Improved Outcomes, Equity & Affordability

Dana Gelb Safran, ScD
President & CEO

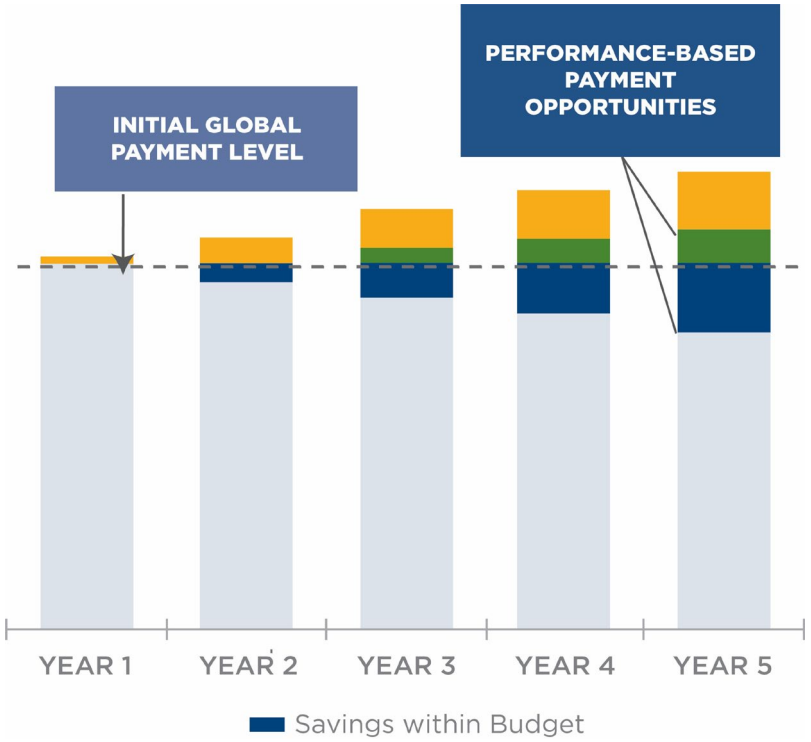
7 June 2022
Physician-Focused Payment Model Technical Advisory Committee

NATIONAL QUALITY FORUM

MASSACHUSETTS

AQC Model: Key Components (2007)

- **Contract Model**
  - Accountability for quality and resource use across full care continuum
  - Long-term (5-years)
- **Controls Cost Growth**
  - Global population-based budget
  - Shared risk: 2-sided symmetrical
  - Health status adjusted
  - Annual inflation targets set at baseline for each year of the contract and designed to significantly moderate cost growth
- **Improved Quality, Safety, and Outcomes**
  - Robust performance measure set creates accountability for quality, safety and outcomes across the continuum
  - Substantial financial incentives for high performance and for improvement



NATIONAL QUALITY FORUM

MASSACHUSETTS

AQC Measure Set for Performance Incentives (2007)

	AMBULATORY	HOSPITAL

PROCESS	• Preventive screenings
	• Acute care management
	• Chronic care management
	  • Depression
	  • Diabetes
	  • Cardiovascular disease
		• Evidence-based care elements for:
		  • Heart attack (AMI)
		  • Heart failure (CHF)
		  • Pneumonia
		  • Surgical infection prevention

OUTCOME	• Control of chronic conditions
	  • Diabetes
	  • Cardiovascular disease
	  • Hypertension
	******Triple weighted******
		• Post-operative complications
		• Hospital-acquired infections
		• Obstetrical injury
		• Mortality (condition –specific)

PATIENT EXPERIENCE	• Access, Integration • Communication, Whole-person care	• Discharge quality, Staff responsiveness • Communication (MDs, RNs)
EMERGING	Up to 3 measures on priority topics for which measures lacking	

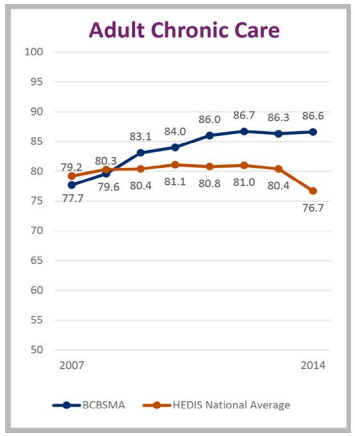
NATIONAL QUALITY FORUM

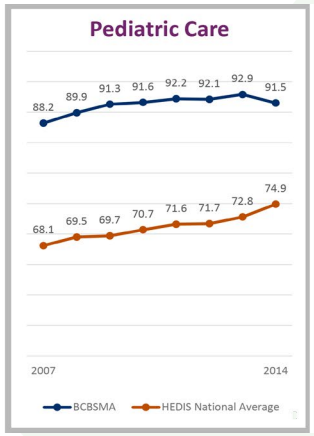
MASSACHUSETTS

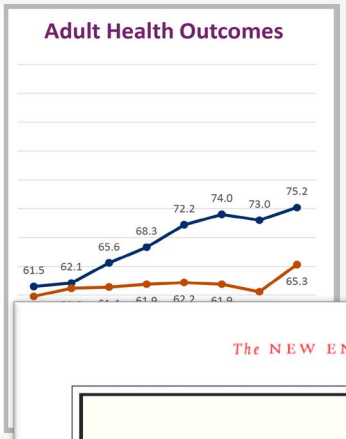
Performance Payment Model: Original

NATIONAL QUALITY FORUM

Improved Quality, Outcomes & Affordability: BCBSMA AQC Catalyzes US Payment Reform







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The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Health Care Spending, Utilization, and Quality 8 Years into Global Payment

Zirui Song, M.D., Ph.D., Yunan Ji, B.A., Dana G. Safran, Sc.D., and Michael E. Chernew, Ph.D.

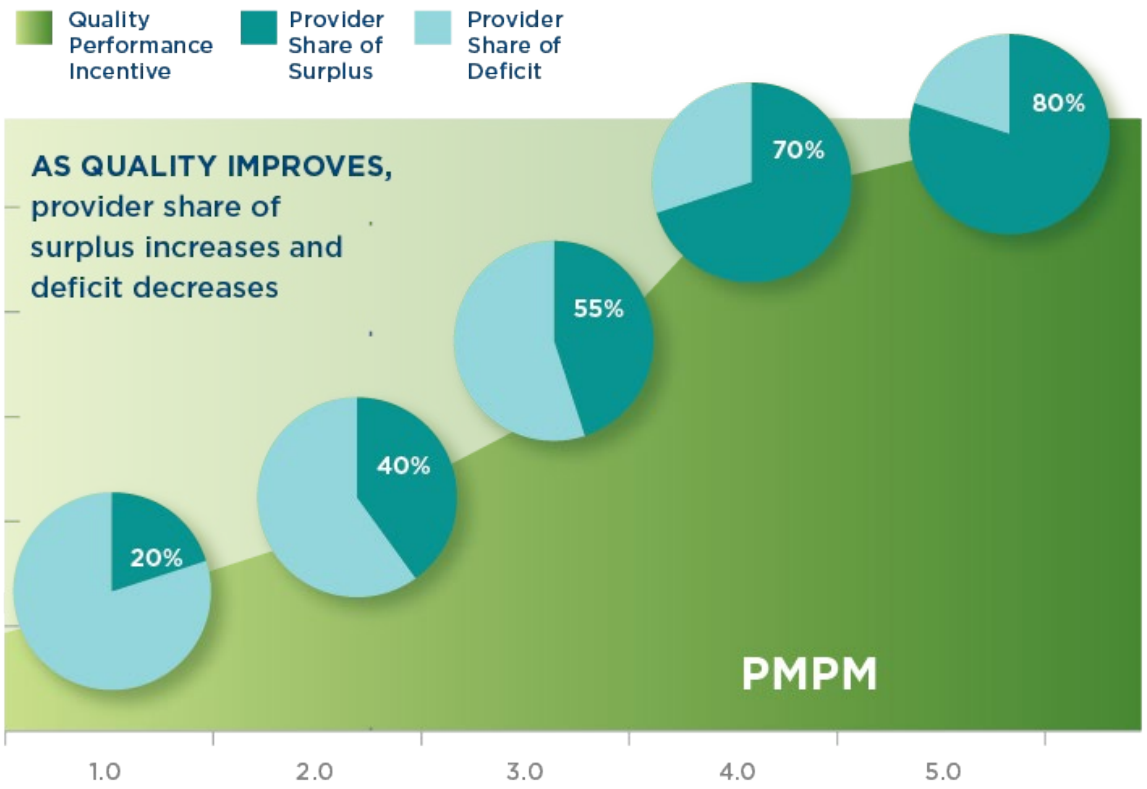
Performance Payment Model: Updated (2011)

Linking Quality and Efficiency

- The 2011 AQC ensures that providers have a strong incentive to focus on both objectives.

PMPM Quality Dollars

- The 2011 AQC also allows groups to earn PMPM quality dollars regardless of their budget surplus or deficit. High quality groups earn more PMPM quality dollars.



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Delivery System Innovation: Four Themes

There are four domains in which we saw AQC Groups innovating to improve quality and outcomes while reducing overall spending.

- Staffing Models
- Approaches to Patient Engagement
- Data Systems & Health Information Technology
- Referral Relationships & Integration Across Settings

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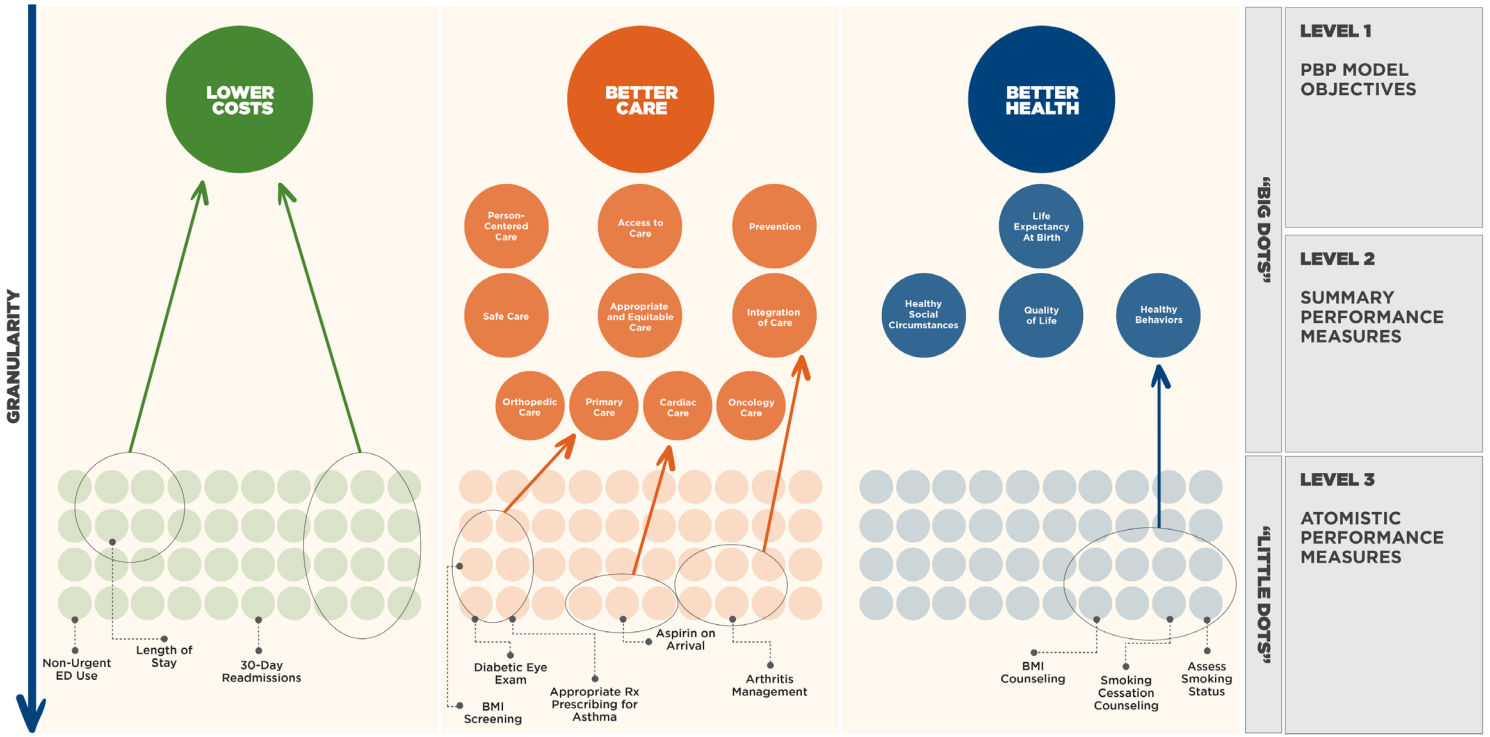
Moving to "Big Dot" Measurement for Alternative Payment Models (APMs)

HCP LAN
Health Care Payment Learning & Action Network



Source: Health Care Payment Learning & Action Network; The MITRE Corporation. *Accelerating and Aligning Population-Based Payment Models: Performance Measurement*. Washington, DC: The MITRE Corporation; 2016.

Recommendation: To support the long-term success and sustainability of population-based payment models, future state measures must be based, as much as possible, on results that matter to patients (e.g., functional status) or the best available intermediate outcomes known to produce these results

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Problem to solve:

Despite 10+ years of consensus about the need for more outcome-oriented measures, there has been limited progress

50% of Healthcare Spend Falls in Five Clinical Domains with Few or No Outcome Measures

- Value-based payment and population health demand "big dot" measures (outcomes)
- Current portfolio of measures focuses largely on "little dots" (process measures) - an artifact of fee-for-service payment
- A small number of payers and purchasers are working individually to develop measures for high priority topics ("activist innovators") – but find it difficult to successfully produce new measures able to be widely adopted

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Essential Enablers of Ultimate Success of Value-Based Payment

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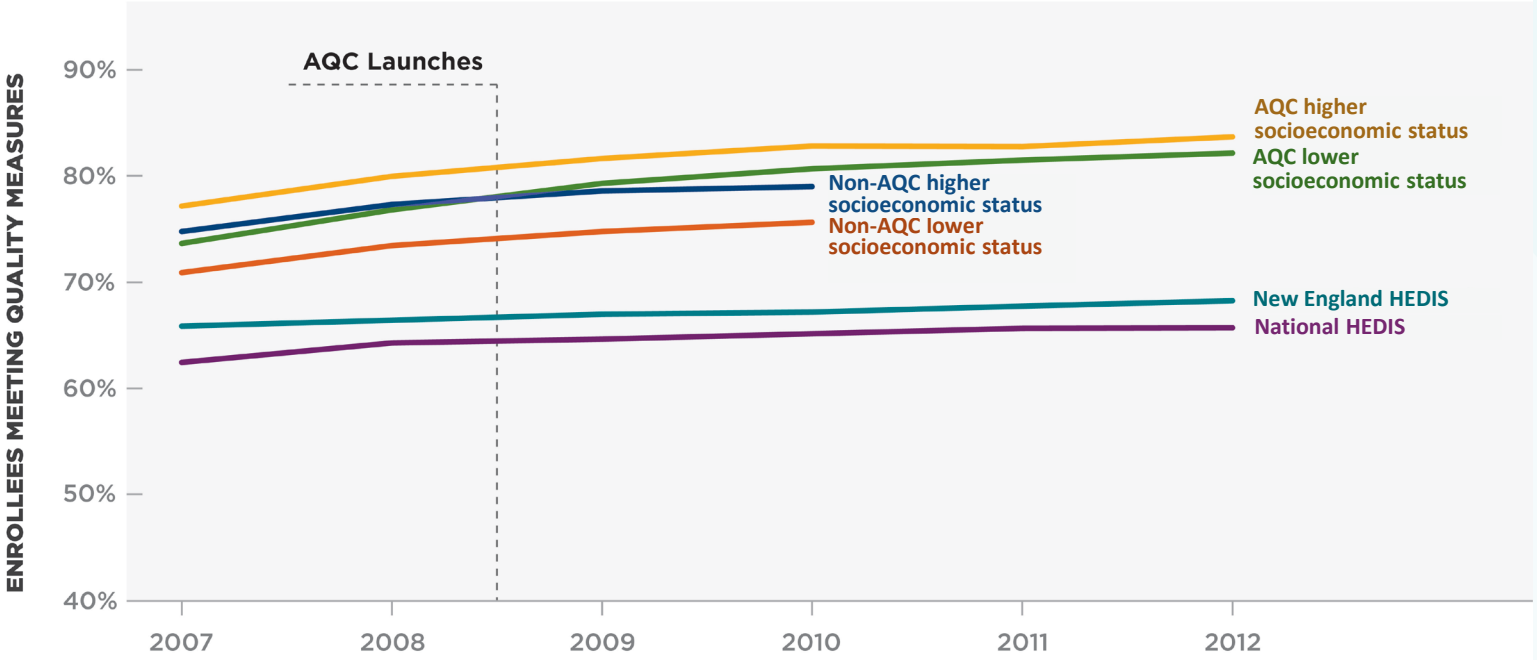
EXHIBIT 1

Performance on process quality measures among Alternative Quality Contract (AQC) enrollees and comparison groups, by socioeconomic status according to enrollee area of residence, 2007-12



Source: Song Z, Rose S, Chernew ME, Safran DG, et al. Lower- Versus Higher-Income Populations In The Alternative Quality Contract: Improved Quality And Similar Spending. *Health Affairs*. 2017;36(1):74-82

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Health Equity Measurement

- Requires data that are largely lacking today
  - Standards for data content, collection and exchange
  - Align on the role of patient-specific data vs. proxy indicators
  - Data for population-level tracking vs. data for individual patient outreach
- Stratification vs. Composite Index
  - Evaluate performance on disparities-sensitive measures stratified by relevant variables
  - “Roll up” disparity performance across a broad set of measures to define a composite or health equity index

Investing in Health Equity

- As value-based payment models increasingly hold providers financially accountable for outcomes, there is growing concern that organizations caring for populations with greater social risk factors are unfairly penalized
- Some argue that we should adjust performance scores for social risk to fairly assess and reward providers with great social vulnerability in their patient mix
- Others argue that adjusting performance scores for social risk accepts a lower standard of care for socially at-risk populations, masking low performance with statistical adjustments

- Satisfying these seemingly divergent views: Adjust payment rather than performance scores
  - Up-front payments
  - Multipliers on performance payments

Jaffery, JB, Safran DG. Addressing Social Risk Factors In Value-Based Payment: Adjusting Payment Not Performance To Optimize Outcomes and Fairness. *Health Affairs* Blog. April 19, 2021. [Accessed 8 October 2021]. https://www.healthaffairs.org/do/10.1377/hblog20210414.379479/full/].

Let’s Talk!

NATIONAL QUALITY FORUM

https://www.qualityforum.org

Presentation:
Ideal Components of Value-Based Kidney Care Programs

Observations and Thoughts from the Renal Physicians Association

Adam Weinstein, MD

Chief Medical Information Officer,
DaVita, Inc.

Ideal Components of Value-Based Kidney Care Programs

Observations and Thoughts from the Renal Physicians Association

Adam Weinstein, MD

Prepared for the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Total Cost of Care Listening Session – June 7, 2022

The Renal Physicians Association (RPA) is the advocacy organization of nephrology professionals in their pursuit and delivery of quality kidney care.

Reference: Kidney Disease Vocabulary

Acronym or Shortened Phrase	Expanded Form	Definition in this Presentation
CKD	Chronic Kidney Disease	Diminished kidney function as measured by eGFR (estimated glomerular filtration rate) - a calculation based on age, gender, and serum creatinine. Education, risk factor modification, and patient engagement are key associated services.
ESRD or ESKD	End-stage renal or kidney disease	The physiologic state in which a patient's kidneys no longer function well enough to sustain them. These patients require dialysis or transplant to remain alive.
Optimal Start	Optimal Dialysis Start	Initiating a patient on dialysis in an outpatient setting on either peritoneal dialysis or on hemodialysis without a central venous catheter
QOL/EOL Discussions	Quality of Life and End of Life	Discussions with a patient about expected functional status, health and life goals, and length of life
CKD Education	Chronic Kidney Disease Education	Educating a patient about the various options available for managing end-stage kidney disease and necessary diet and risk factor modification. Promotes optimal starts, home dialysis, and transplant preparation
Kidney Care Companies	Value-based kidney care companies that may offer dialysis services	Companies accepting financial risk for co-managing (with nephrologists) patients with kidney disease. They offer a range of care coordination services and may also provide dialysis.

Successfully Managing Kidney Disease is a Logistics Problem

Job to be Done	• Identify high-risk populations • Modify risk factors	• Modify risk factors • Slow CKD progression • Treat complications	Ongoing Care, Plus: • Transplant Prep • Dialysis Prep • QOL discussions	+ optimal start + home dialysis + transplant + EOL Discussions
Accountable Provider	Primary Care	Nephrologist	Nephrologist	Nephrologist
Associated Providers	Nephrology, Endocrine, Cardiology	Primary Care, Endocrine, Cardiology, Dieticians, and Kidney Educators, and Kidney Care Organizations	Previous + vascular surgeons, and transplant centers	All Previous

- **CKD has a non-linear progression**
- **Claims data can link patients to physicians and events**
- **Care requires multiple coordinating specialties and organizations**
- **Nephrologists should be the “quarterback”**

Kidney Disease Works Well as a TCoC Model

Points of Alignment	Examples
Significant financial savings opportunities	• $100K/yr for dialysis vs. $15K/yr for transplant (after $150K in year 1) • Dialysis w/ an optimal Start is ~$30K less costly than unplanned dialysis
Highly prevalent disease state	• 30-40 million individuals with CKD/ESKD
Long lead time	• Typically, years from CKD to ESKD
Well defined patient population	• Quantitative, simple, and validated measurement of disease state (eGFR) • A clear set of CPT-labeled services and ICD-10 codes (stages of CKD)
Measurable and cost-effective treatments/outcomes	- Risk Factor Modification - Transplant - Dialysis Education/Preparation - Palliative Care
Reasonable attribution	• Attribution through claims • Claims can be used to identify associated services and the timing of services • Reasonably accurate day and physician for dialysis initiation data (2728 form)

Ideal Components of a Kidney Disease Payment Model

Actor	Idealized Goal or Characteristic
CMS/Payers	• Improve outcomes in kidney patients; increase home dialysis and transplant rates • Reduce costs of caring for kidney patients
Patients *and Care Givers*	• Incentivize to participate and engage in the program • Address regional and local healthcare disparities (transportation, food, access to care, etc.)
Nephrologists/Providers	• Allow for time to transform/adapt work to non-FFS care delivery • Reward processes AND outcomes of care - measures specific to kidney disease • Achievable quality benchmarks and moderate discounts to attract broader participation • Quality bonuses for addressing healthcare disparities
Nephrology Practices	• Allow time, resources, and personnel to embrace data-driven and non-RVU care • Allow time to partner with other providers • Flexible risk-sharing opportunities
Kidney Care Companies	• Reward process and outcome of value-based arrangement performance • Safe harbors to partner with referral sources and offer variable shared-risk • Time to develop data tools and interoperability
Other Specialties and Health Systems	• Safe harbors to improve focus on the subset of kidney-specific procedures and patients • Resources to incent participation

Successful Features and Roles in Value-Based Care

Ideal:	Nephrologists and Neph Practices	Kidney Care Organizations	Health Systems and Payers	Patients and Care Providers
Clinical Actions	Provides direct patient care decisions and leads pop health decisions	Provides at-scale care coordination, technical, and logistics support	Provides data and *some* care, logistics, and care coordination	Open to communication, education, and engagement
Admin Role	Receives IT, gathers data, and front-line administrative direction	Provides IT, analytics, and administrative support	Provides data, ADT notifications, and partnership	Vocal about needs and advocacy
Features	• Meaningful Reward • Moderate Risk • Minimal up-front investment • Simplified reporting and accountability burdens	• Meaningful Reward • Meaningful Risk • Larger initial and on-going investment • Time for contract and IT development	• Some Reward • Limited additional risk • Minimal investment • *Interoperability is critical*	• Understands the benefits of participating • Experiences minimal disruptions to care relationships

Thank you

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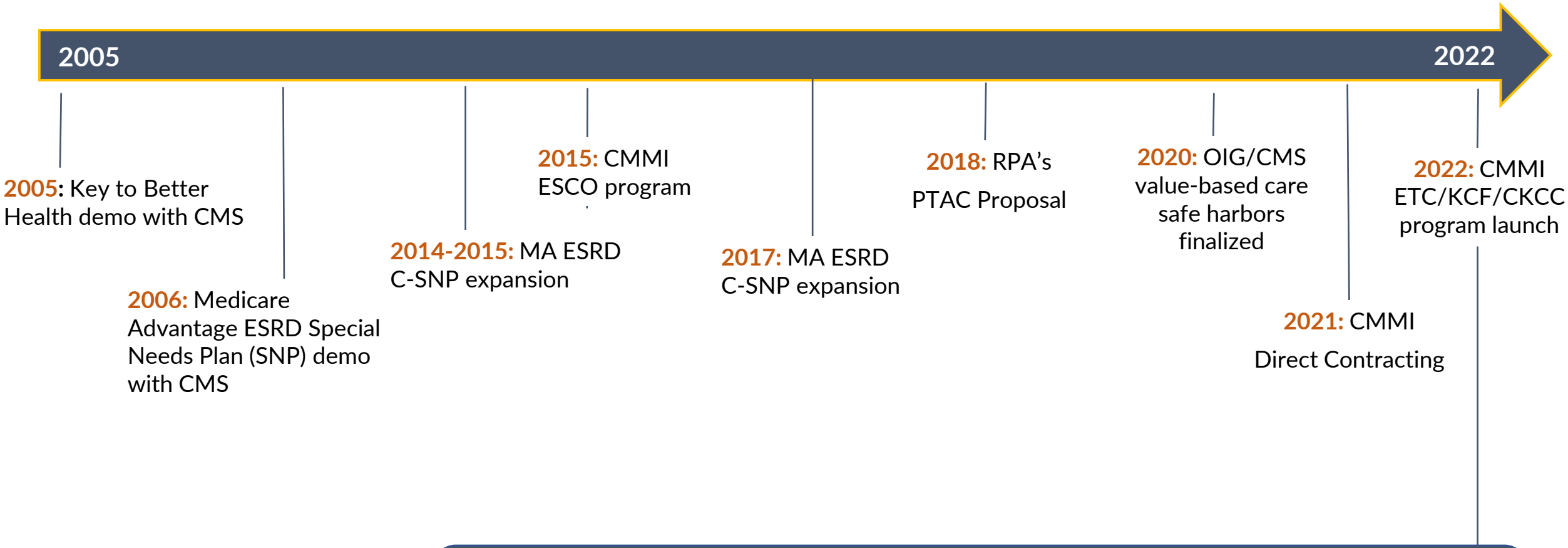
Appendix Slides

Typical Timelines in Value-Based Care

Action	Timeline/Examples
Aggregating and signing agreements between practices, kidney care organizations and related providers	• 2-6 months for negotiations and agreement signing
IT software development	• 6-12 months for minimally viable product from program detail finalization and defining requirements • Ongoing refinement to meet specific workflows and functionality
Patient engagement	• Typically, weeks to months to engage patients in program enrollment and consent
High Risk Patient Identification	• Various lab-data and claims-based risk formulas can estimate risk of progression to ESKD between 12 months and 5 years into the future. Optimal care may not result in a measurable change in an individual patient during a single calendar year.
Measurable outcomes	• Both process and outcomes must be considered to capture the impact of care given prolonged timelines to ESKD

17 Years of Value-Based Care Programs for Patients with Kidney Disease



- **Open to larger groups partnered with dialysis and transplant organizations**
- **Varying degrees of risk**
- **5-year timeline**
- **Using TCoC, but also some measures that are outside of typical nephrology care (PHQ-9/PAM)**