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

## Presenters:

**Subject Matter Experts**

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

**Previous Submitter**

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

# Presentation:
# ***Lumeris Model and Total Cost of Care***

**Debbie Zimmerman, MD**

Corporate Chief Executive Officer,
Lumeris

# Lumeris Model and Total Cost of Care

**EHI MO / IL**

Dr. Deborah Zimmerman
Corporate Chief Medical Officer

## Lumeris Drivers and Outcomes

# Essence Healthcare

**64,000 Member MAPD Plan in MO/IL**

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

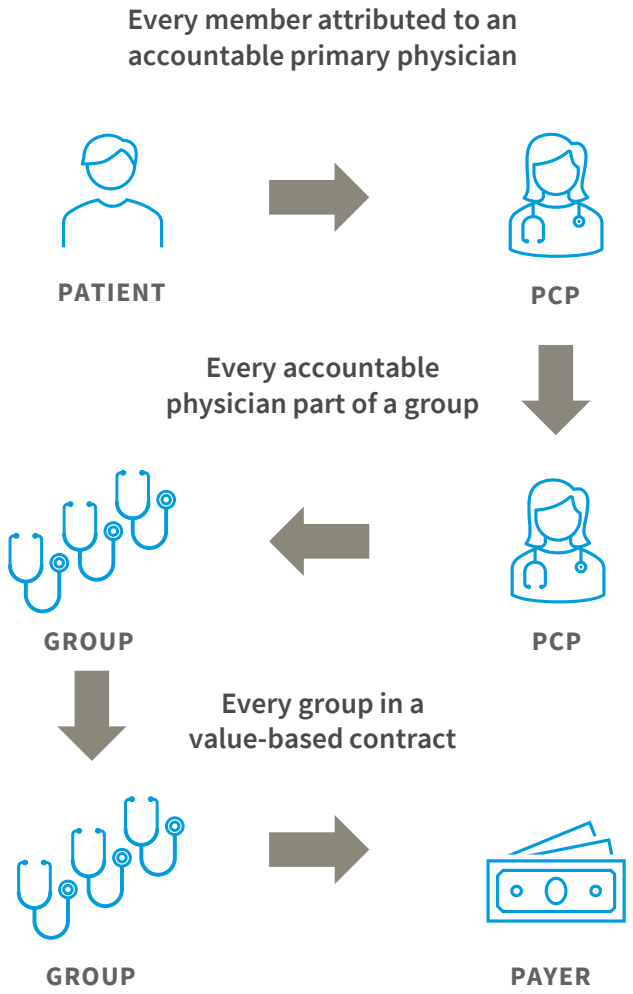
| DRIVERS |
| --- |
| Aligned Incentive Payer/ Employer Contracting |
| Effective Compensation & Incentives |
| Care Delivery Transformation & Delivery of Accountable Primary Care (Nine C's®) |
| Enterprise Engagement |
| Ideal Leadership & Organizational Structure |
| Powerful Technology & Information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

| OUTCOMES – Triple Aim Plus One | |
| --- | --- |
| **Reduced Per Capita Costs of Care** | 26% lower costs vs. FFS Medicare |
| **Improving the Health of Populations** | Average of 4.5 Stars for the past twelve years, 5 Stars for 2022 |
| **Increasing Physician Engagement** | 89% of providers rate they are satisfied w/collaborative payer |
| **Improving the Consumer Experience of Care** | Highest consumer satisfaction |

**Health System, Facility, Others…*

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

# Essence Healthcare - A Collaborative Payer

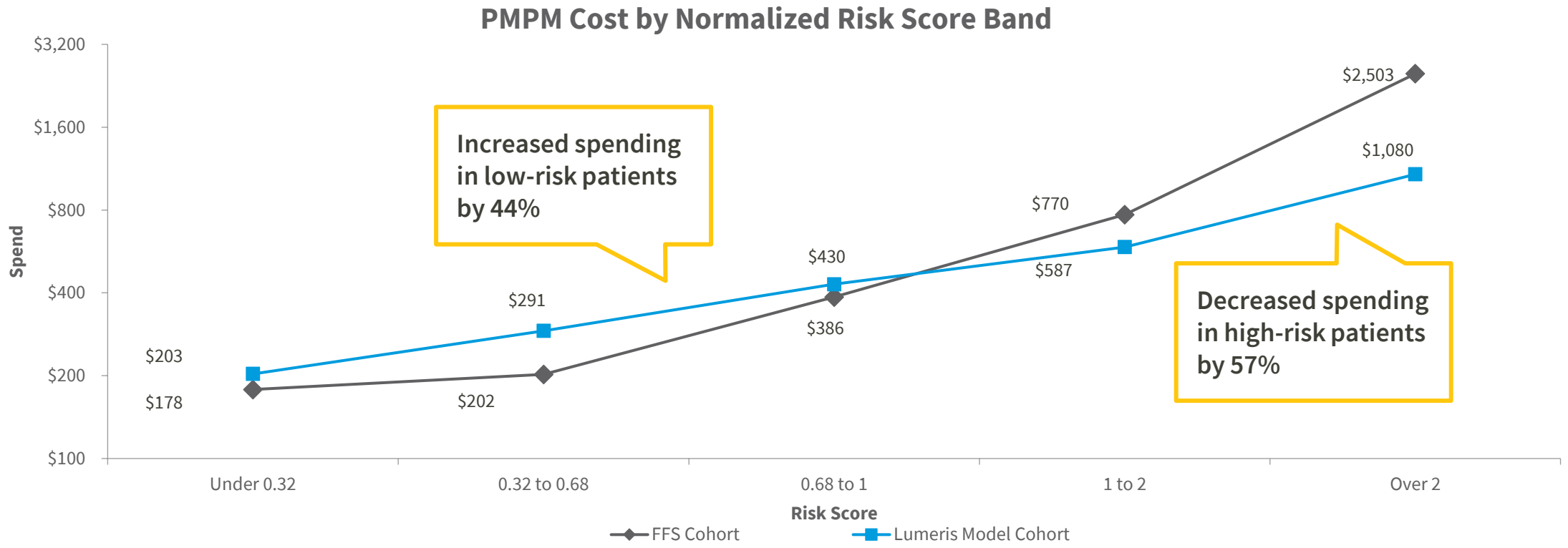



## Best Practices in TCOC Alignment

- 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.***

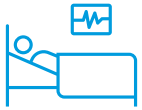
**48%** Reduced specialist spending

**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

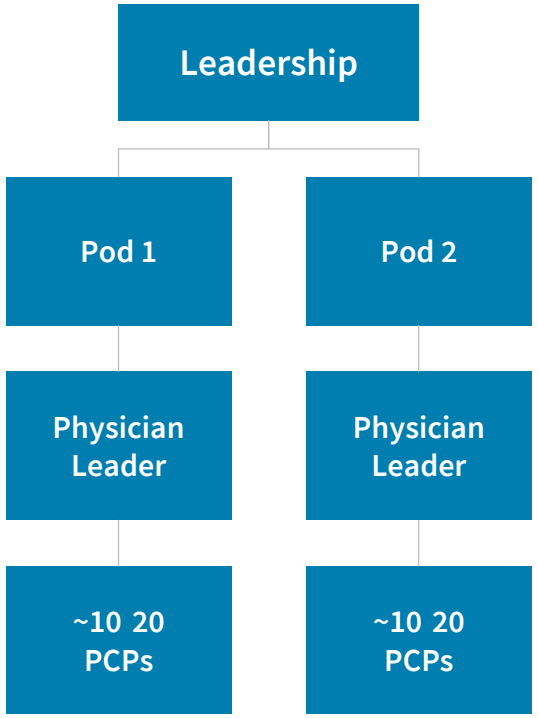
## What is a POD?

- 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<br>• National Faculty<br>• Data Aggregator | 2012-2016 |
| CPC+ | • Data Aggregator<br>• National Faculty<br>• Convener | 2017-2021 |
| Accountable Health Communities | • Principal Investigator<br>• Bridging Organization | 2016-2022 |
| Primary Care First | • Event Alerting<br>• Proposed:<br>  • Data Aggregator<br>  • Social Determinants of Health Screening<br>  • 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
   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

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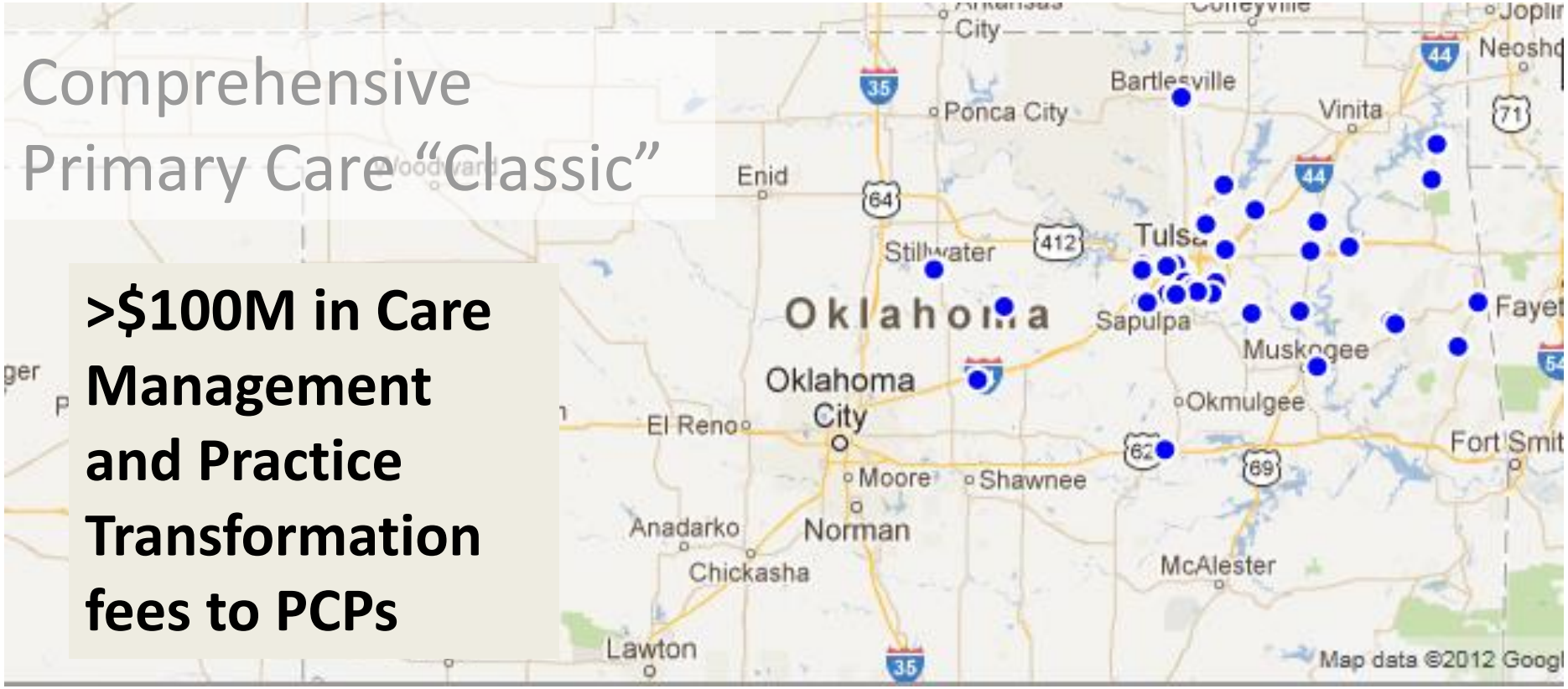
# Comprehensive Primary Care "Classic"




**>$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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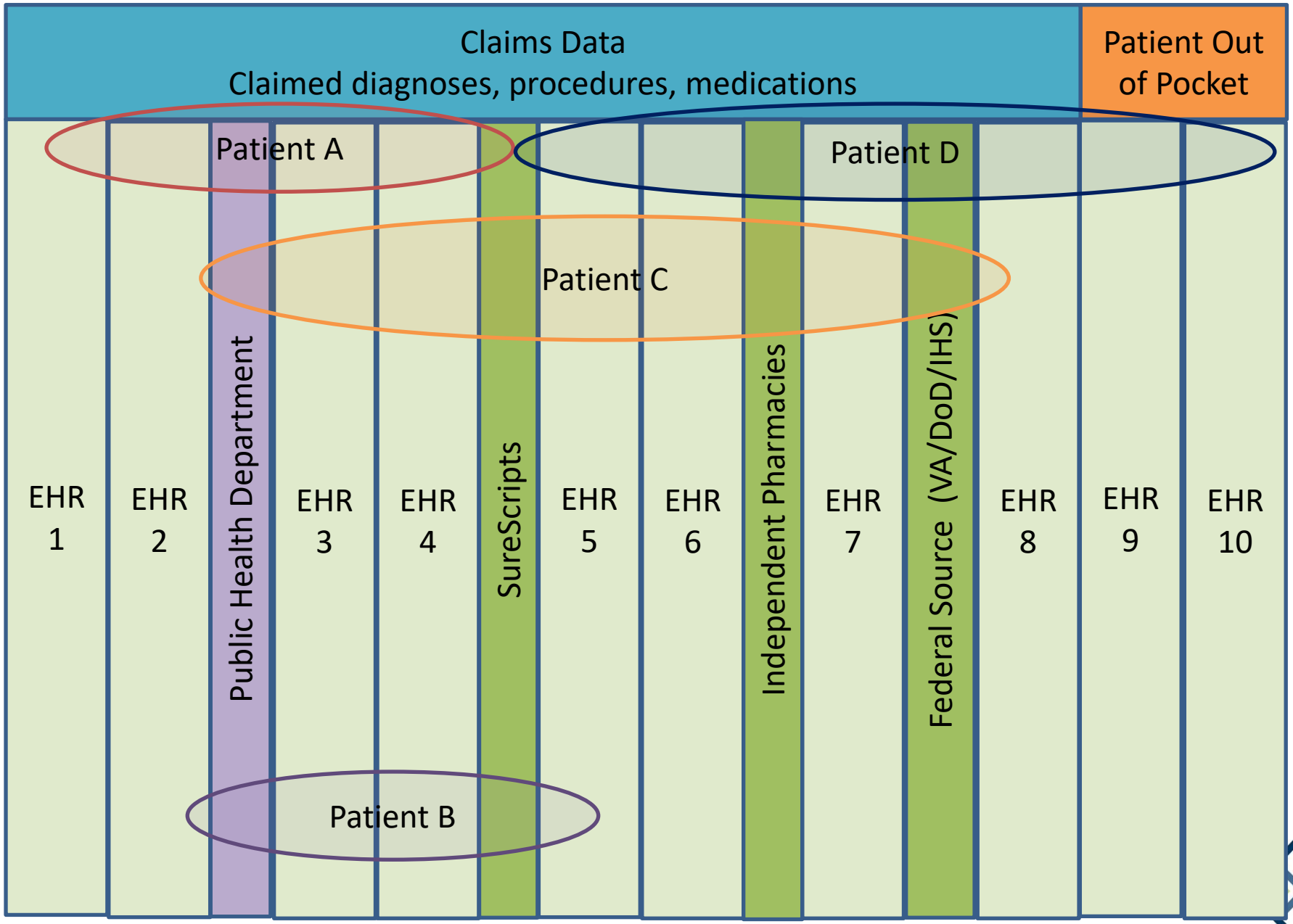




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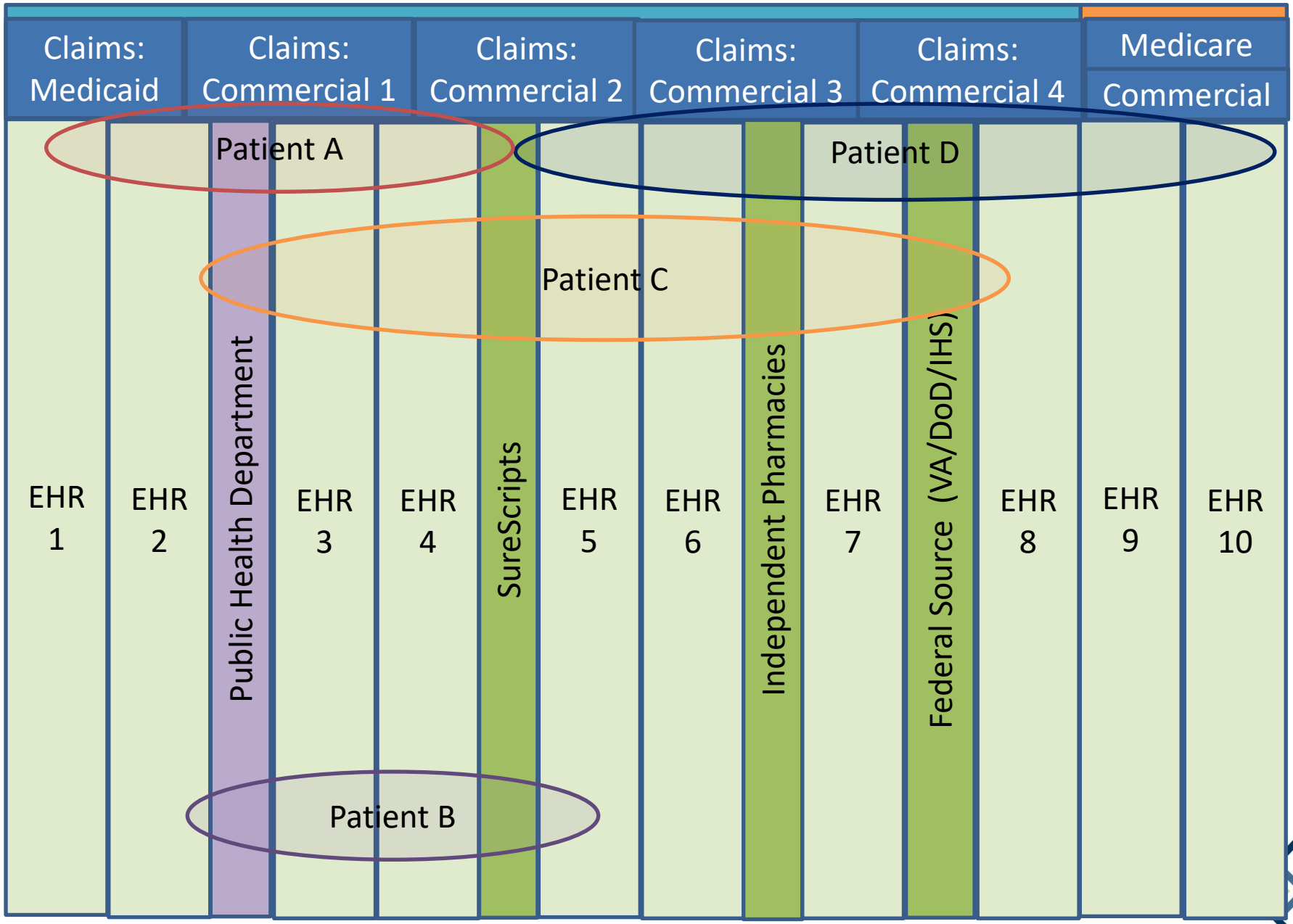




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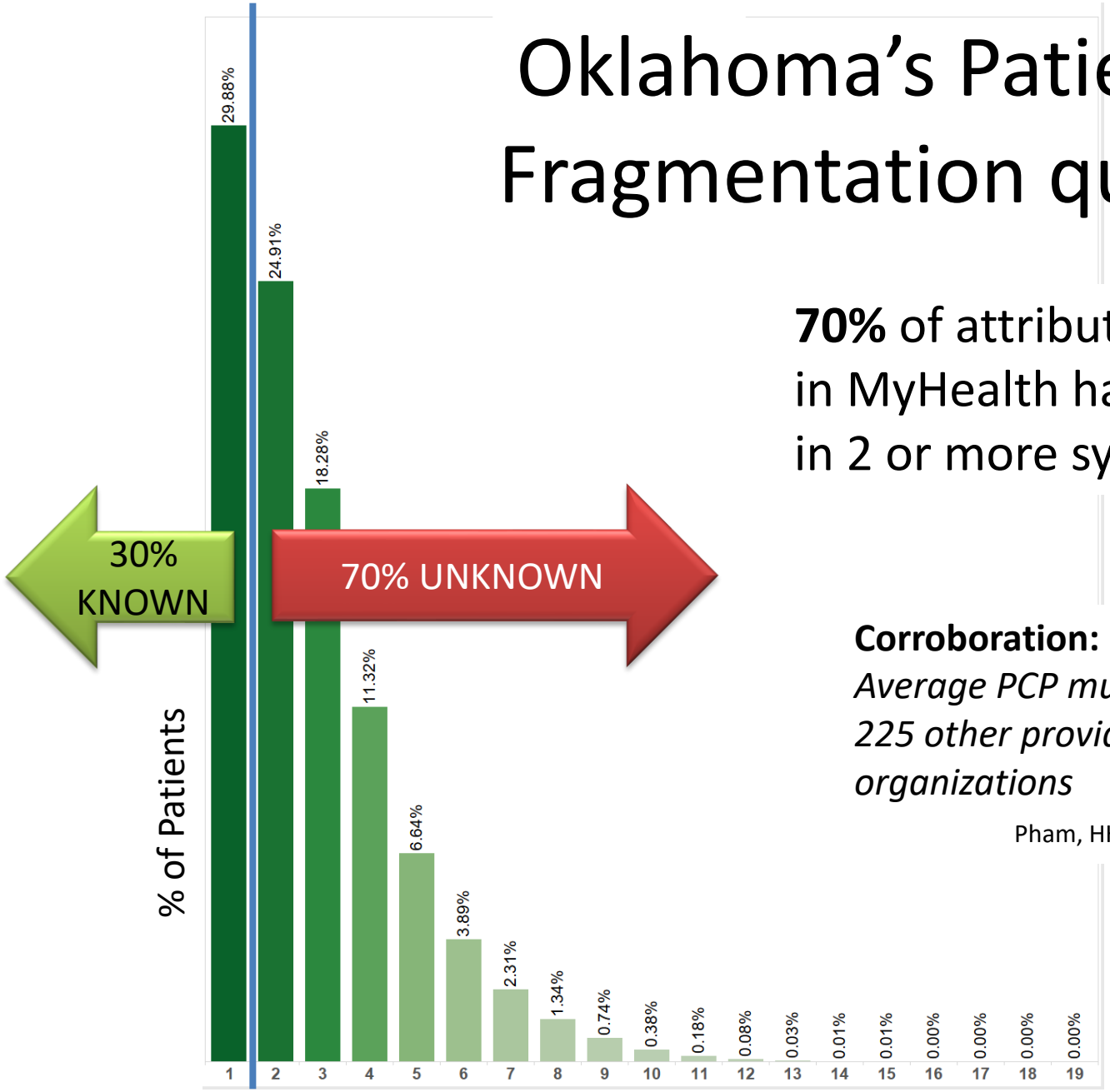
# Oklahoma's Patient Data Fragmentation quantified




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

**Corroboration:**

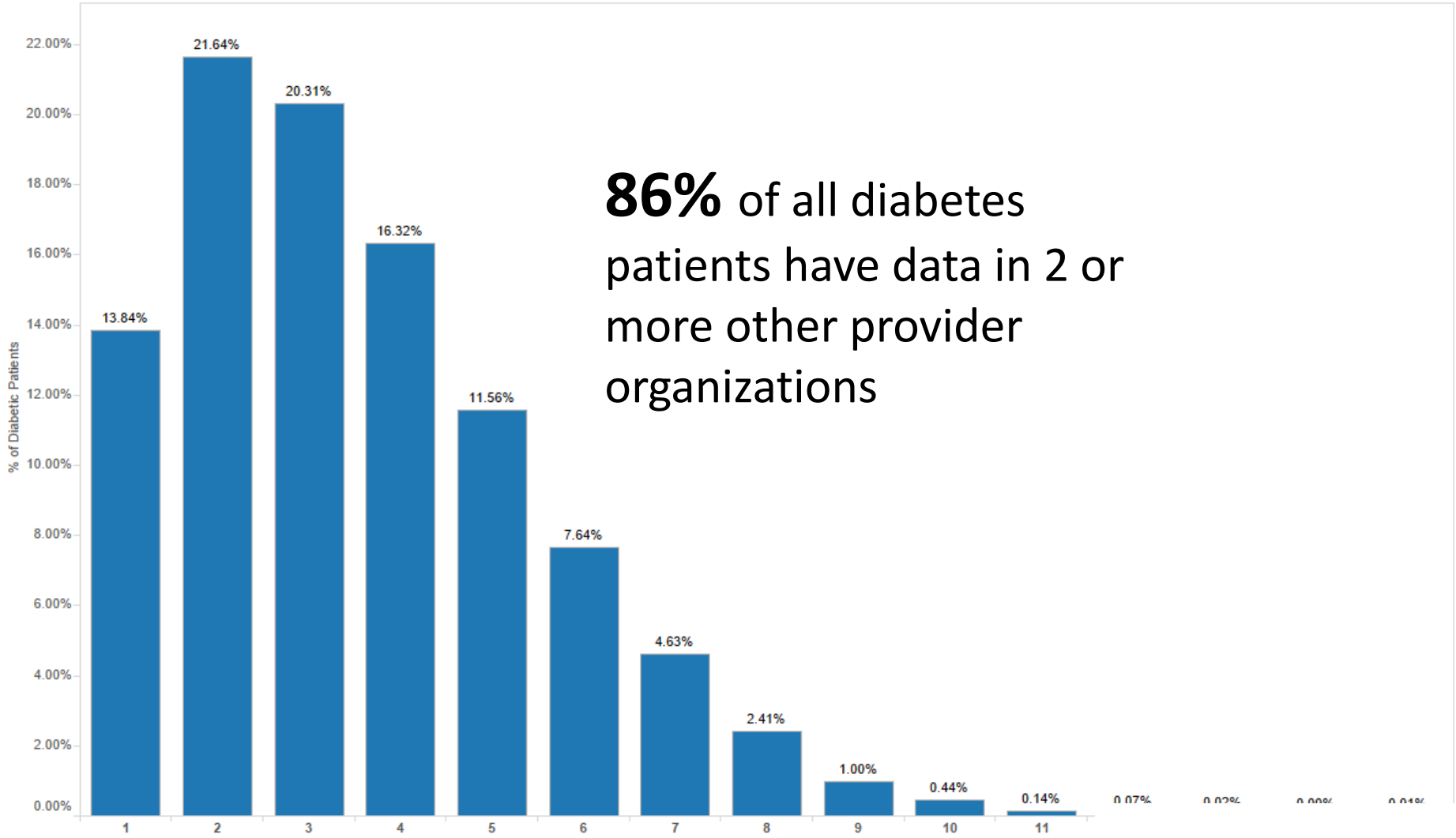
*Average PCP must coordinate care with 225 other providers in 117 other organizations*

Pham, HH, NEJM 2007; 356: 1130-1139



MyHealth ACCESS NETWORK

# Diabetes patients with records elsewhere




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



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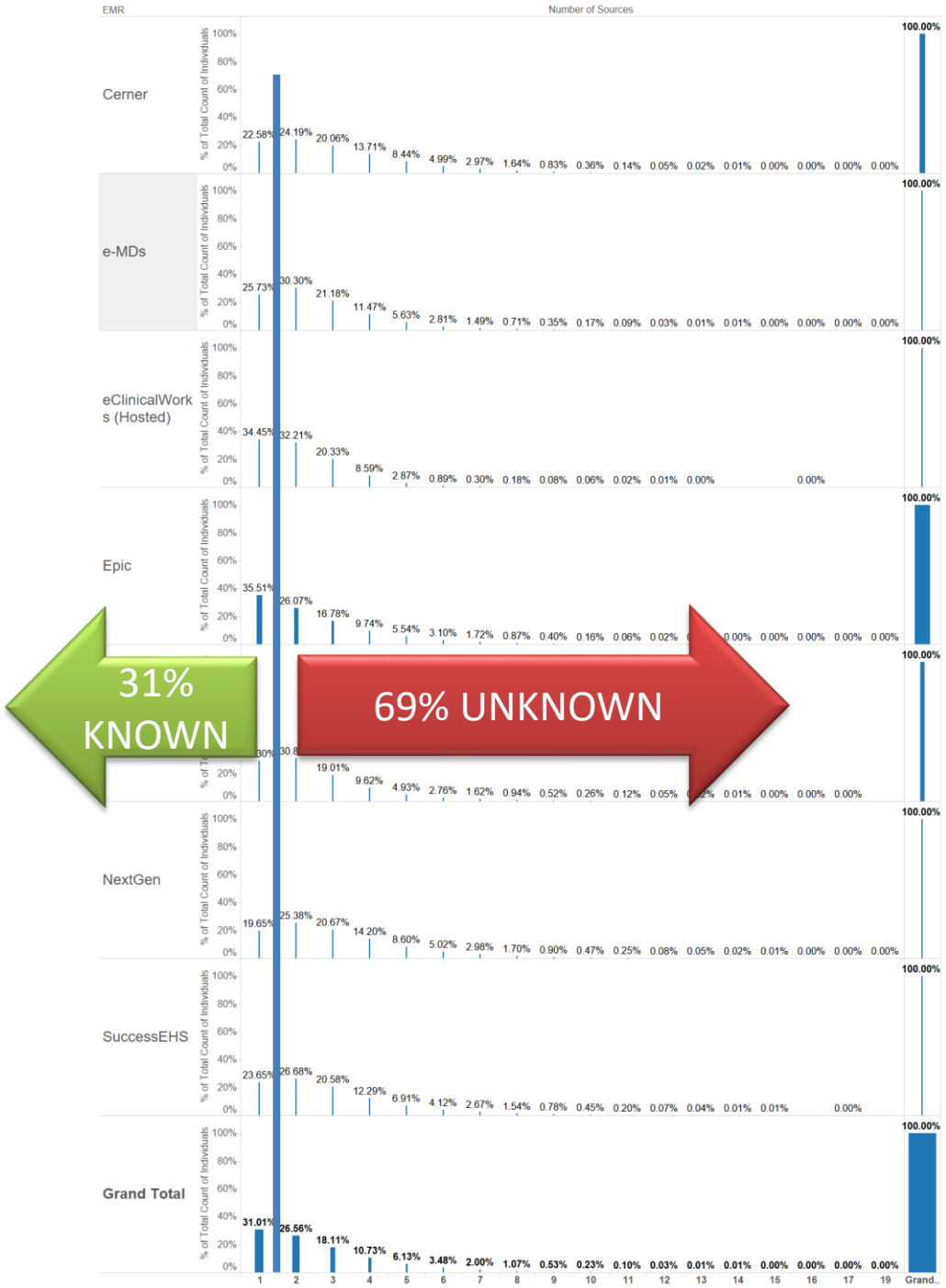
# Data fragmentation by EHR Vendor



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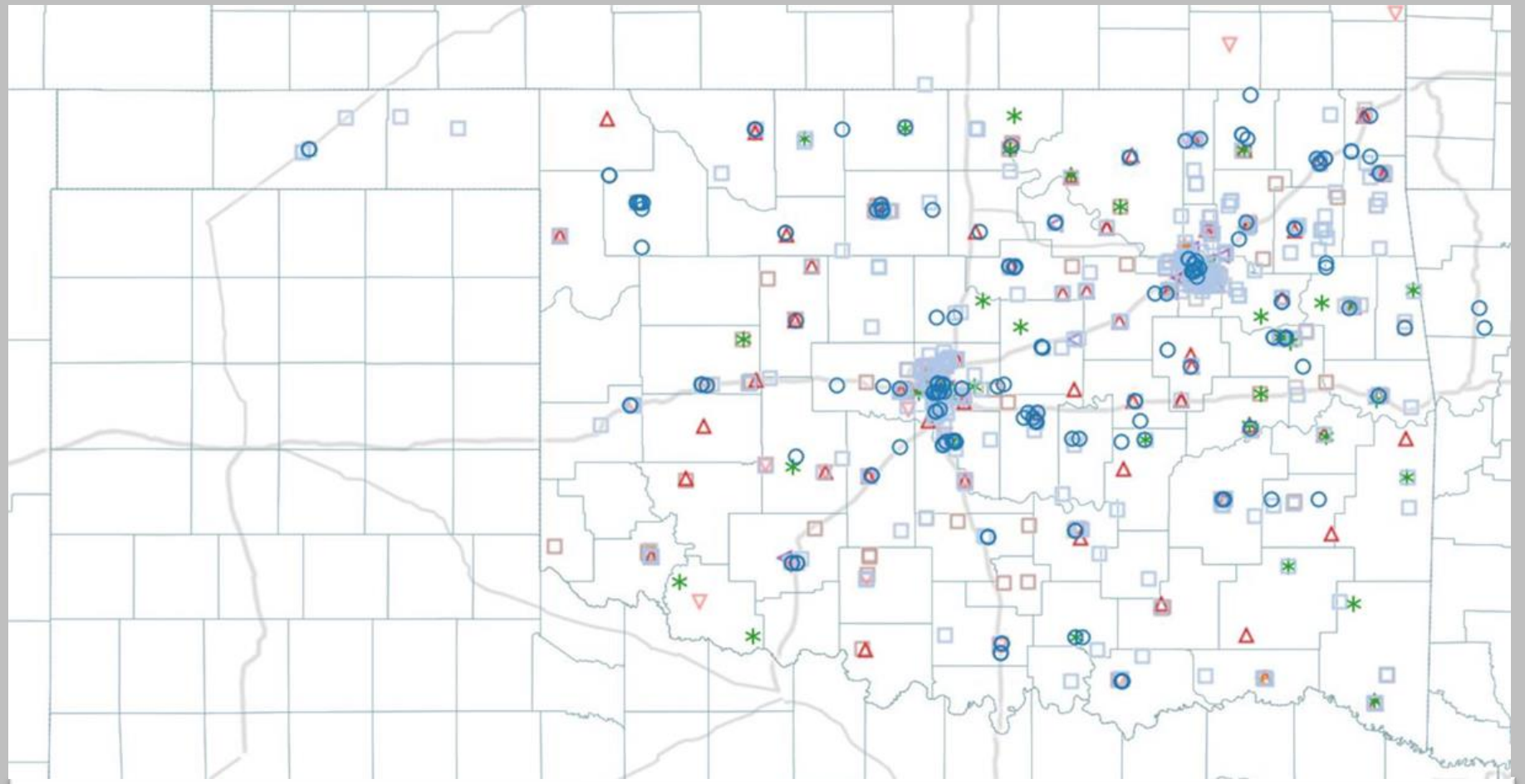
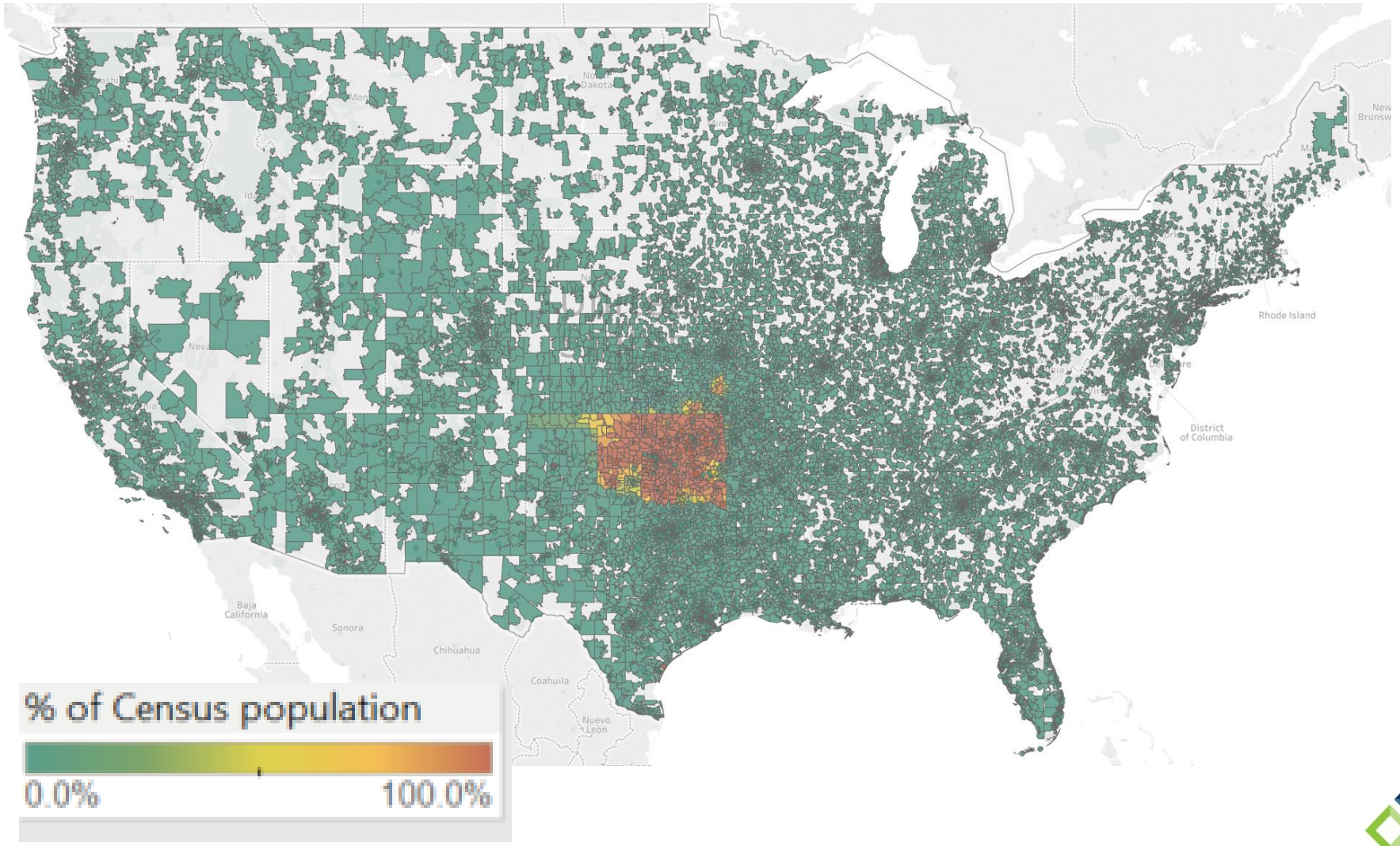
# >1400 locations serving >110,000 patients daily



# MyHealth Patient Population



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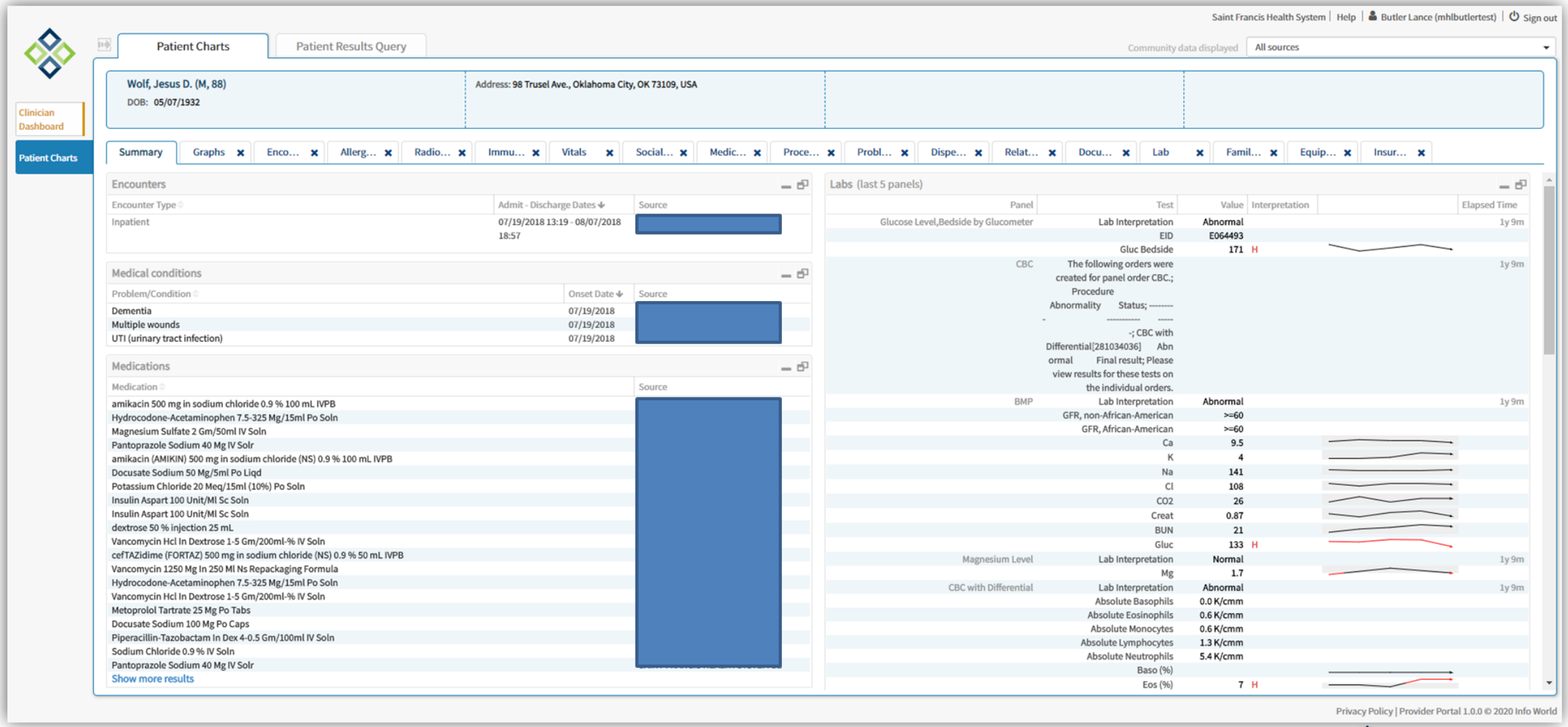
# MyHealth Provider Portal + FHIR API



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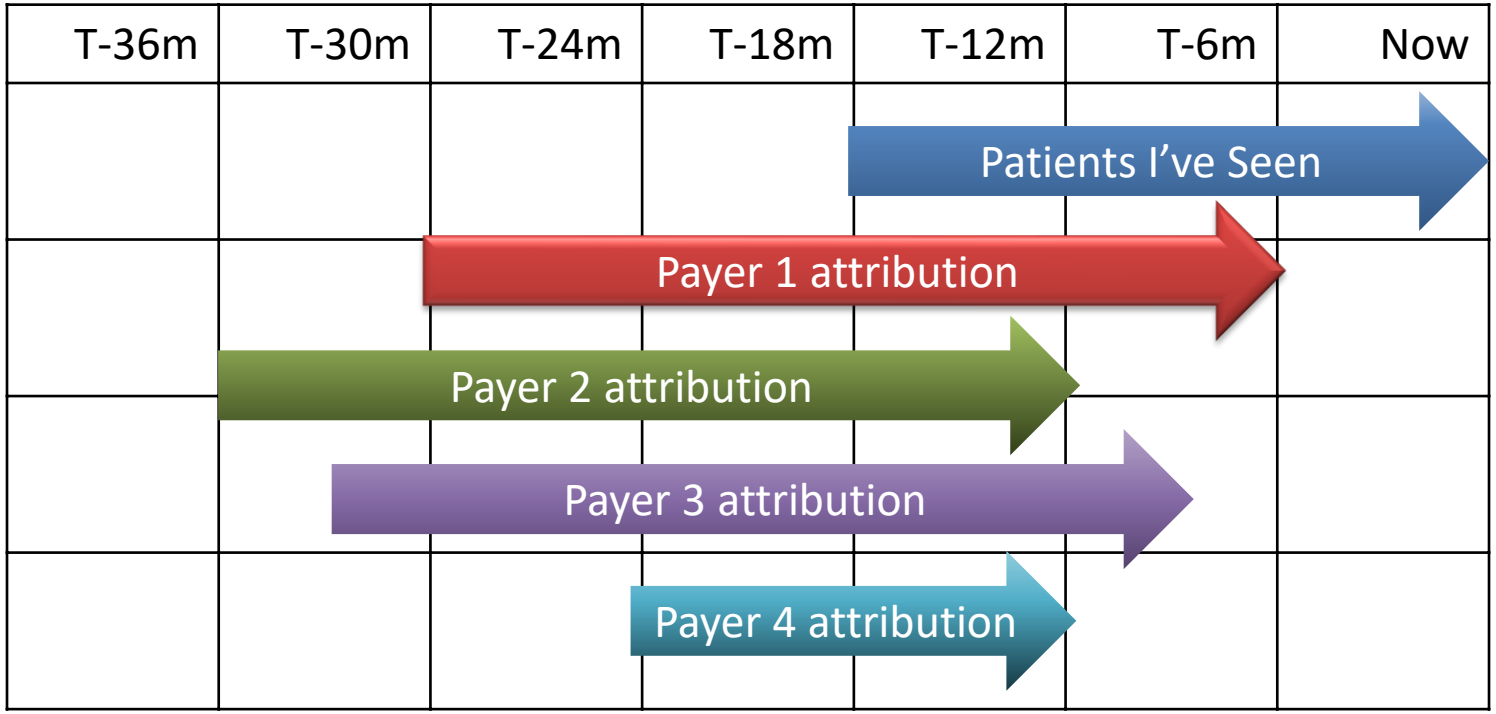
# Who are my patients?

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



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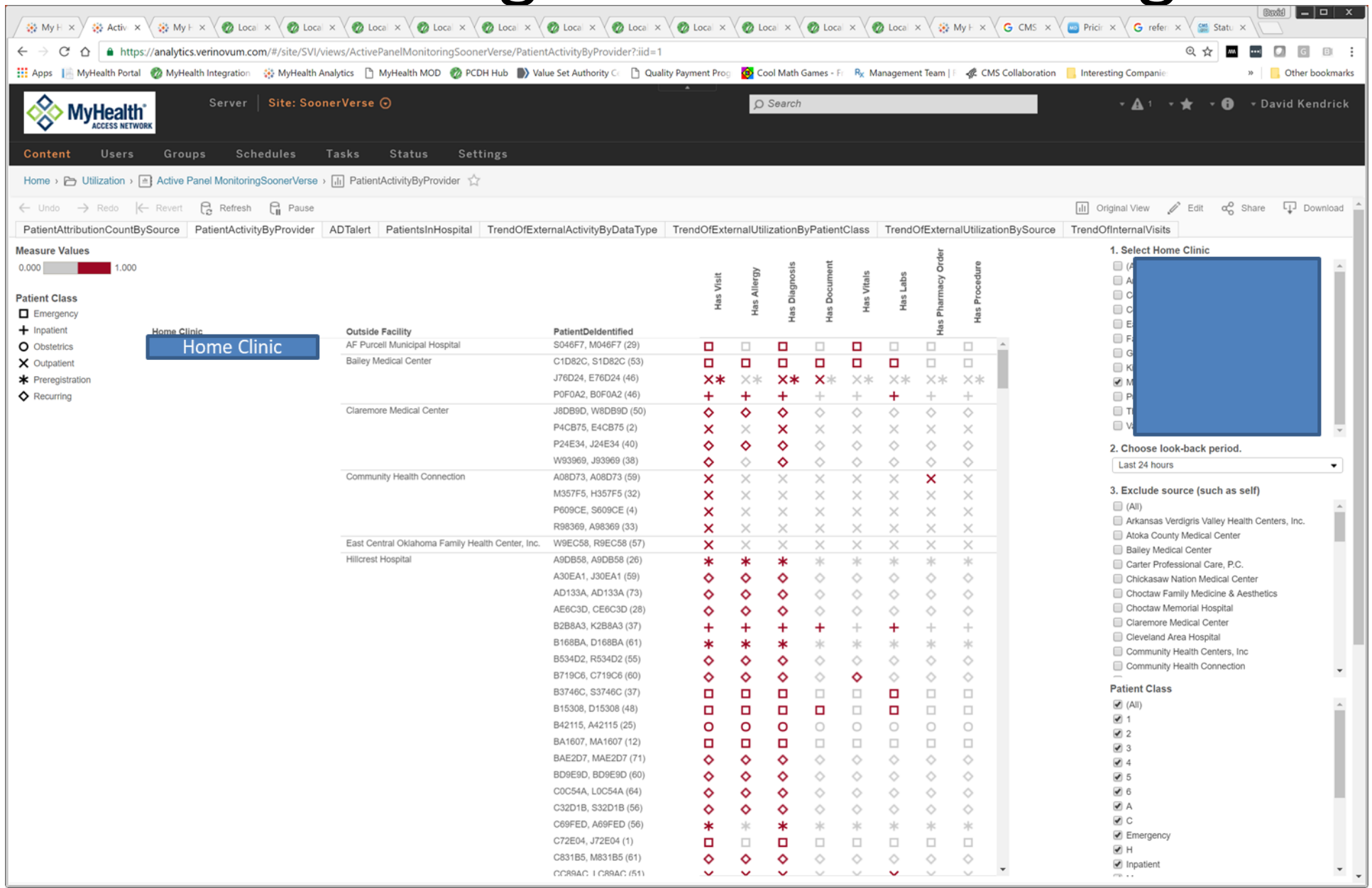
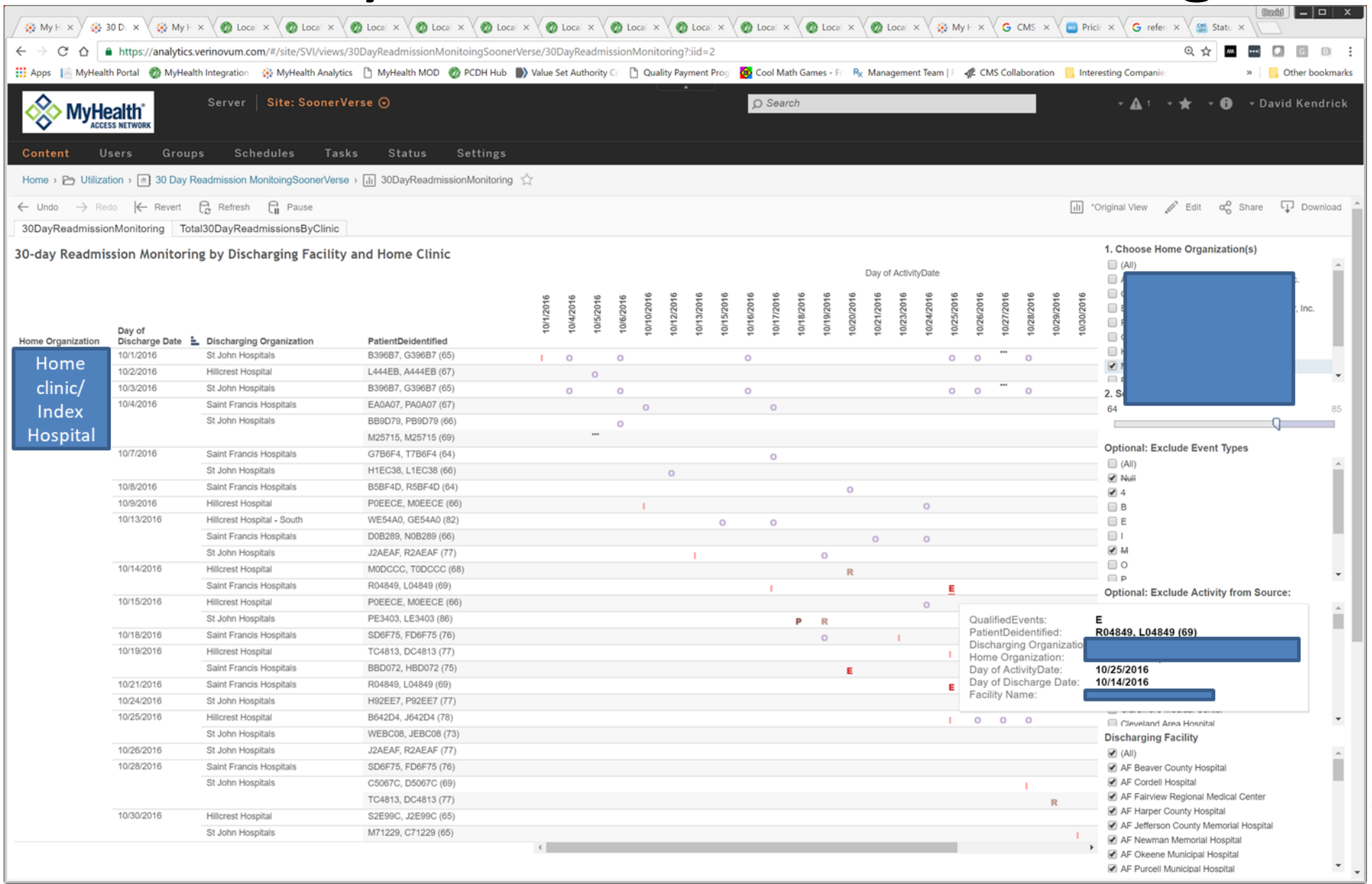
# Care Fragmentation Alerting






MyHealth ACCESS NETWORK

# 30-day readmission monitoring



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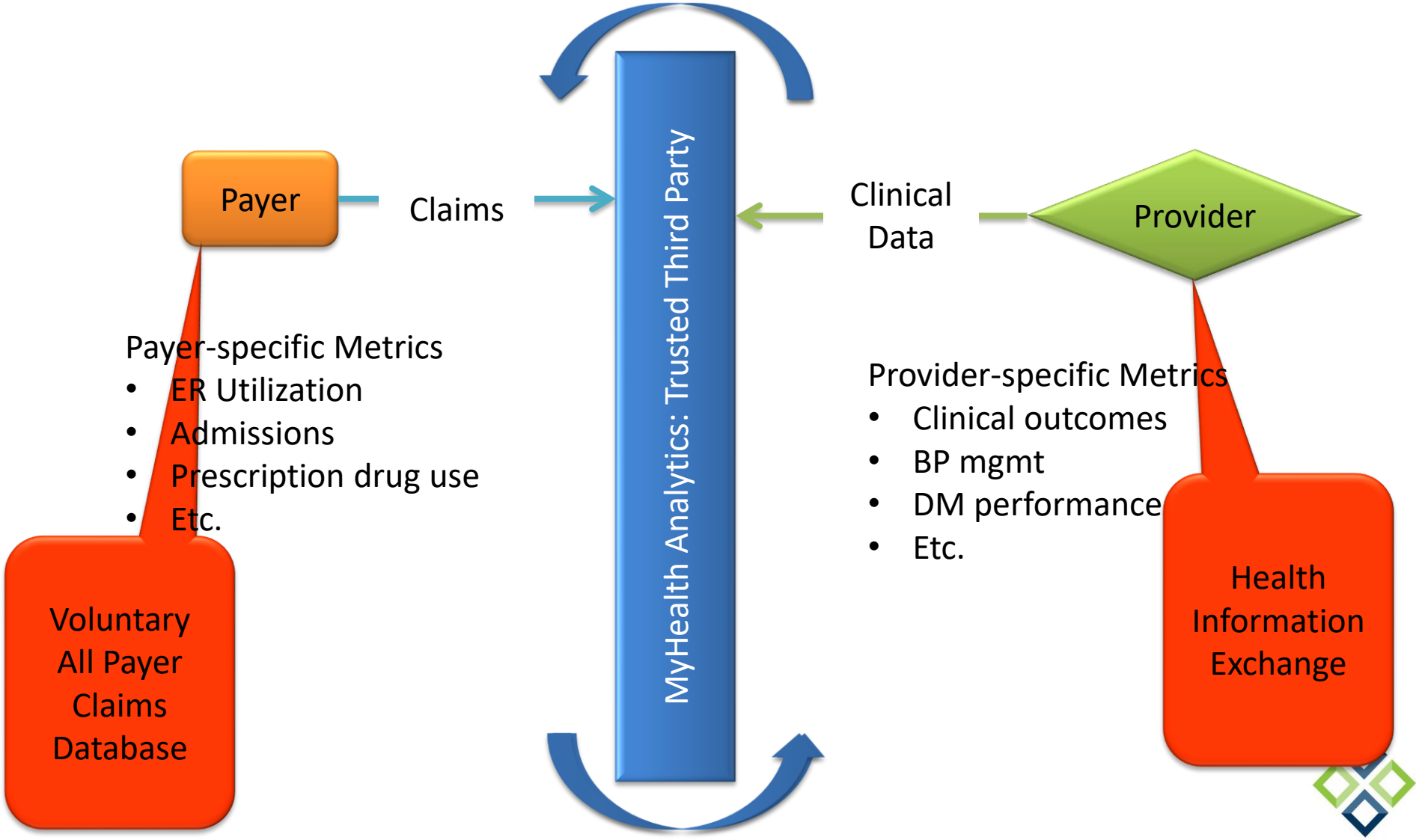
# Trusted 3rd Party for Measurement



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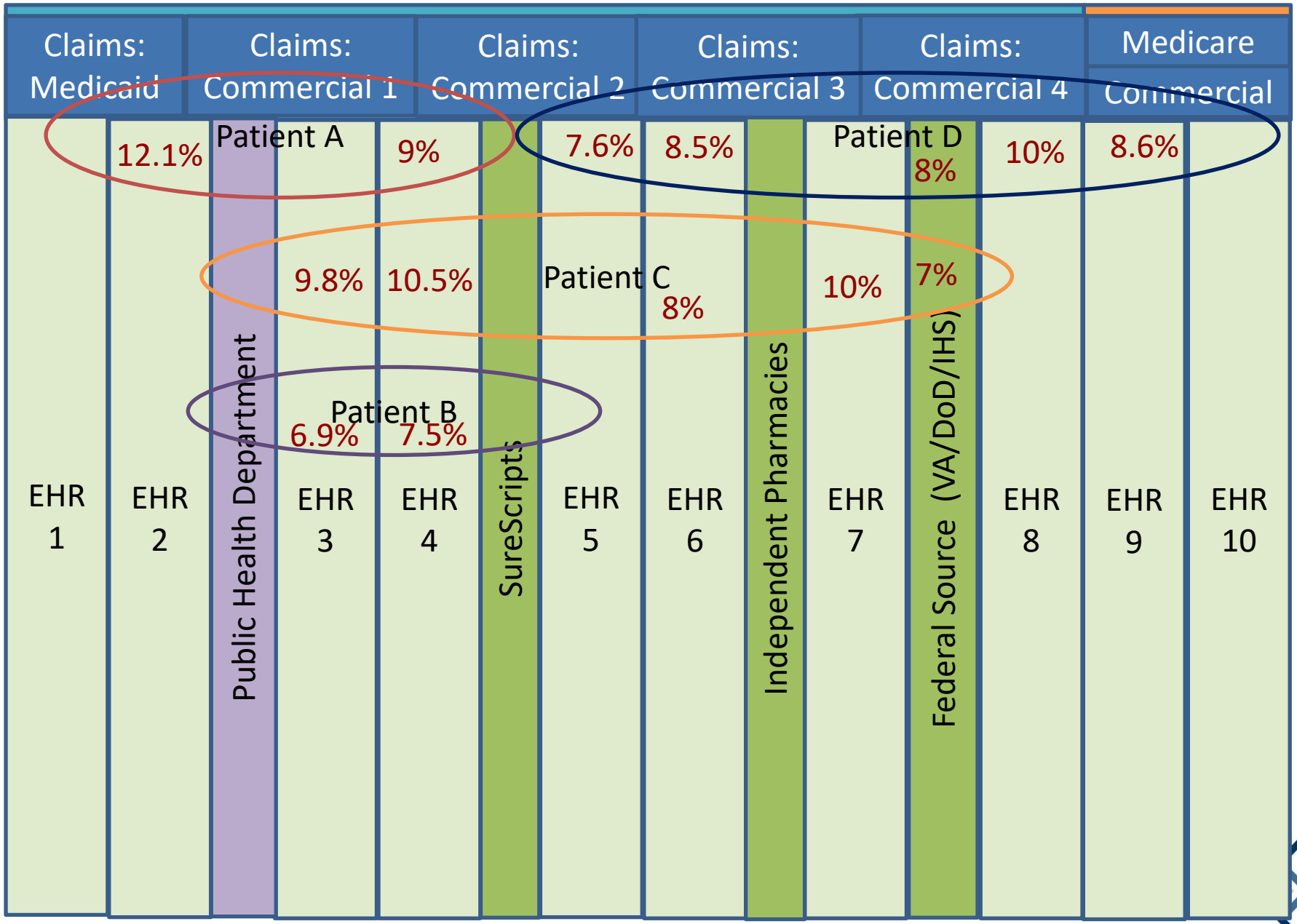
Example: HbA1c control– what is the correct answer for each provider? Patient? Payer?



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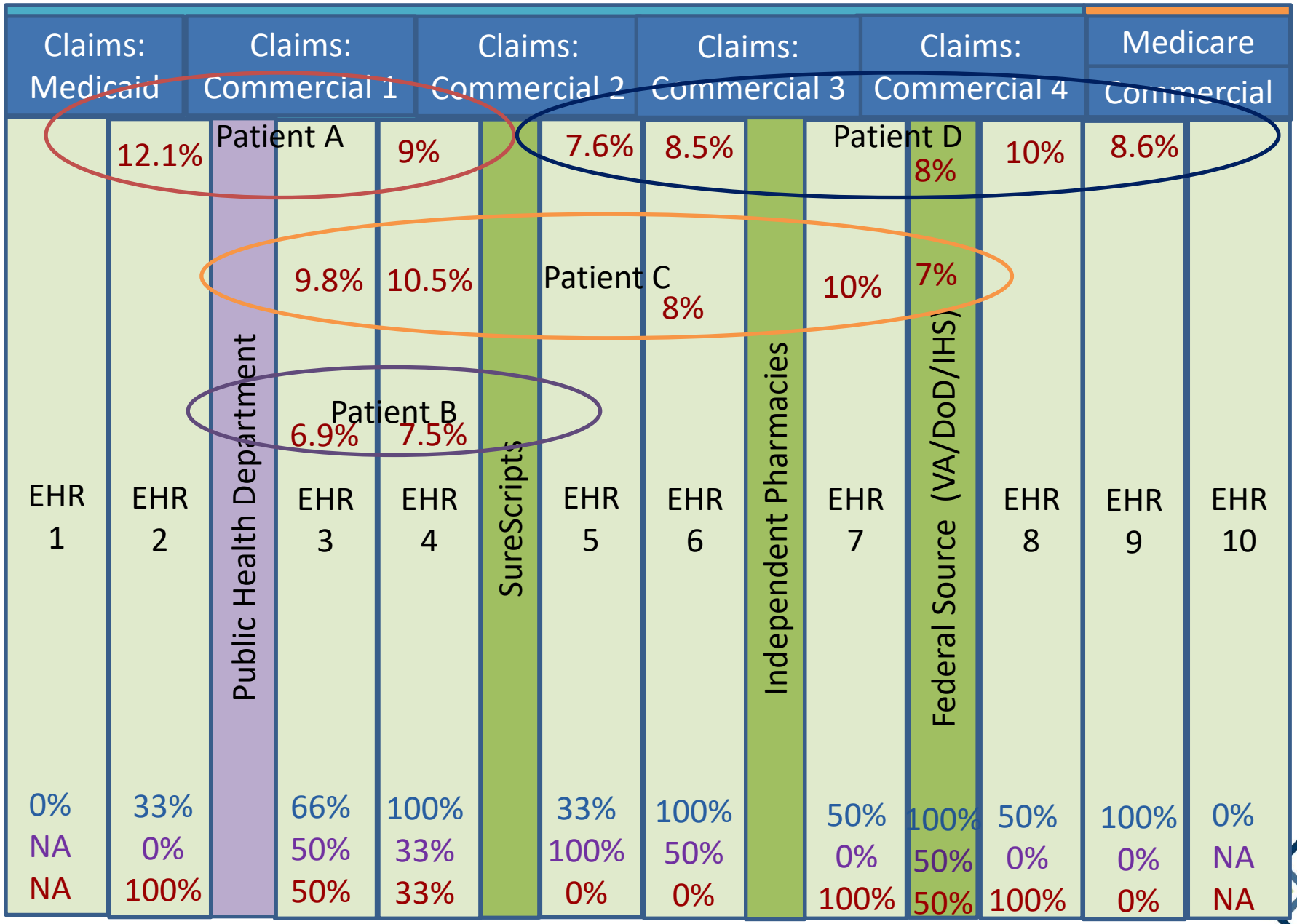
Take 3 diabetes measures: 1) Appropriate Testing, 2) Control <8, 3) Out of Control >9

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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?

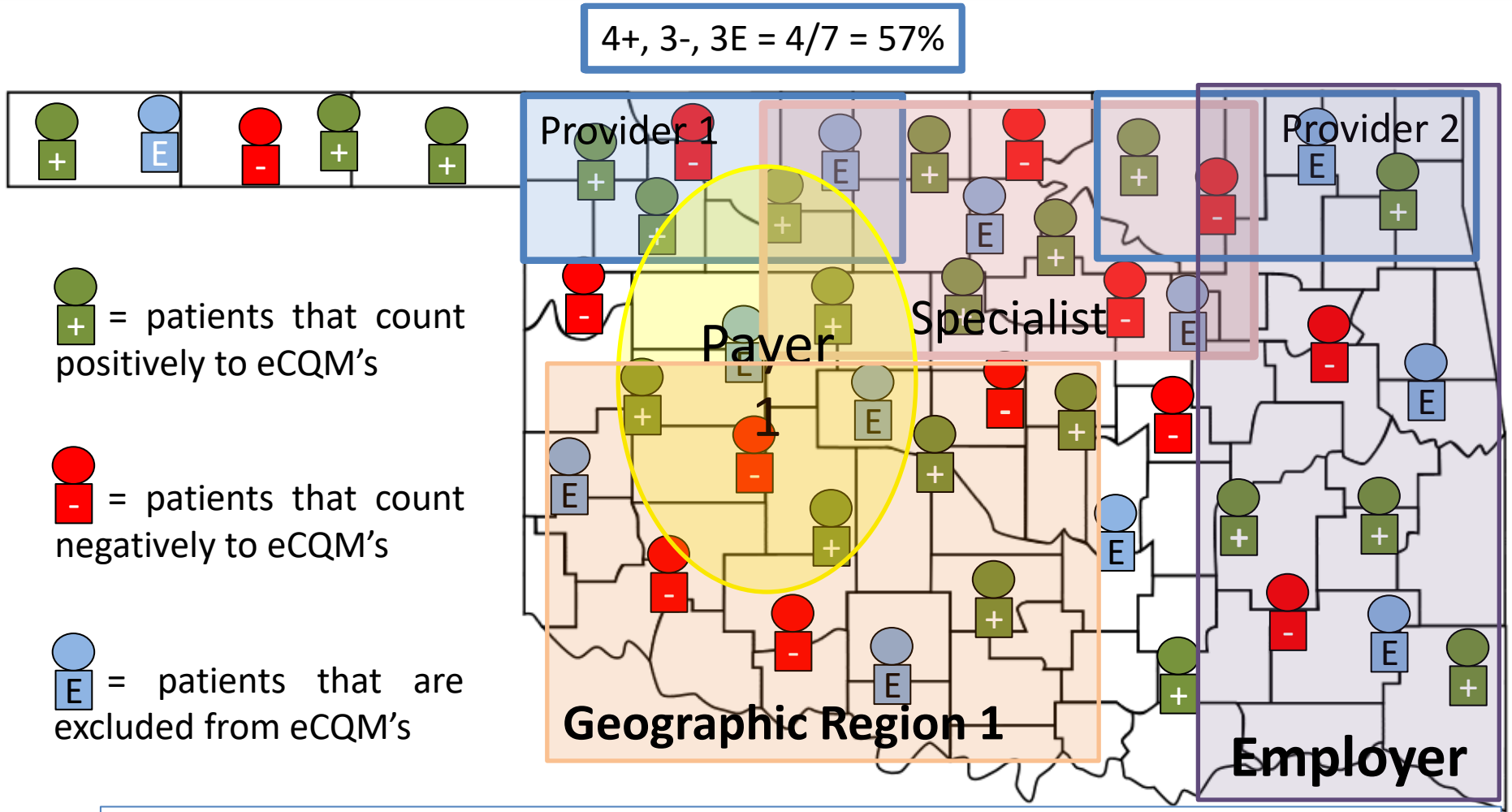
| Patient | Appropriate HbA1c Testing | DM in control (A1c<8) | DM out of control (A1c>9) |
|---|---|---|---|
| Patient A: | 100% | 0% | 0% |
| Patient B: | 100% | 100% | 0% |
| Patient C: | 100% | 100% | 0% |
| Patient D: | 100% | 0% | 0% |
| Population: | **100%** | **50%** | **0%** |



MyHealth ACCESS NETWORK

# Patient-centric measurement

*Measure once, reuse many times for many perspectives . . .*




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

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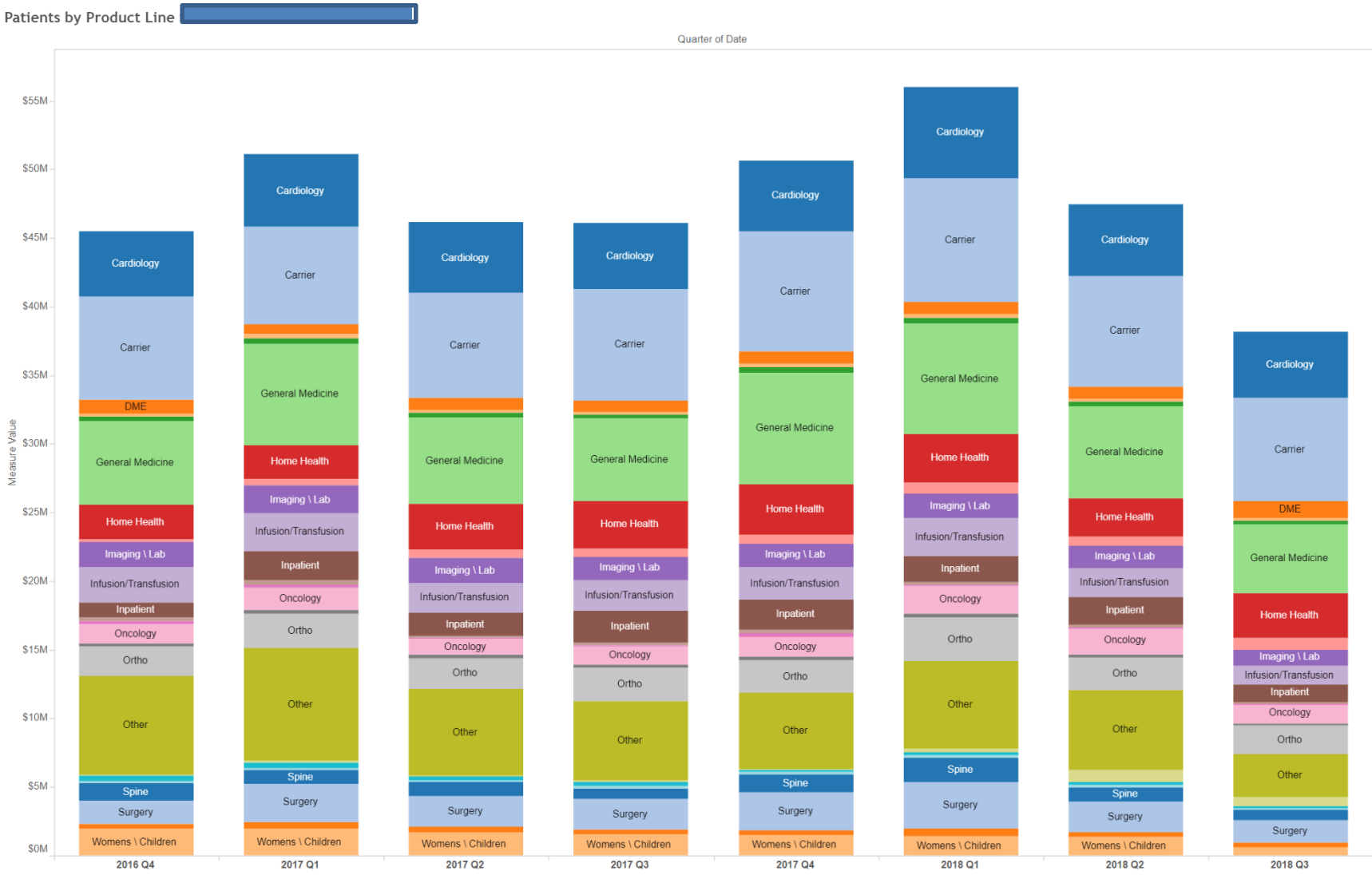
   a. Scope of data available to providers is critical
   b. Patient attribution is a difficult concept for providers and is not accounted for in their internal analytics
   c. Provide Alerting services for Sentinel Events
3. **Performance measurement and reporting:**
   a. Community-wide quality measurement required for true performance results
   **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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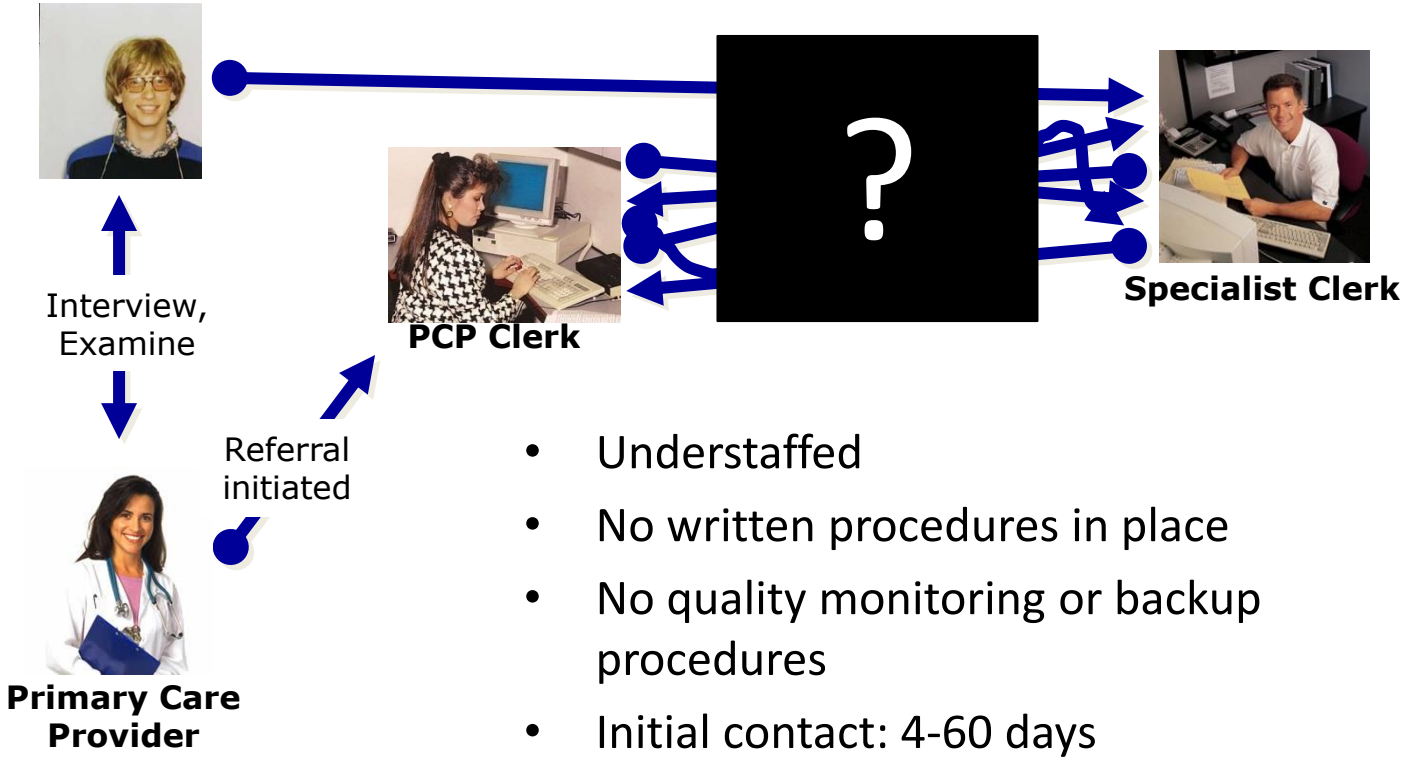
# Pre-Community-Wide Care Transition Management



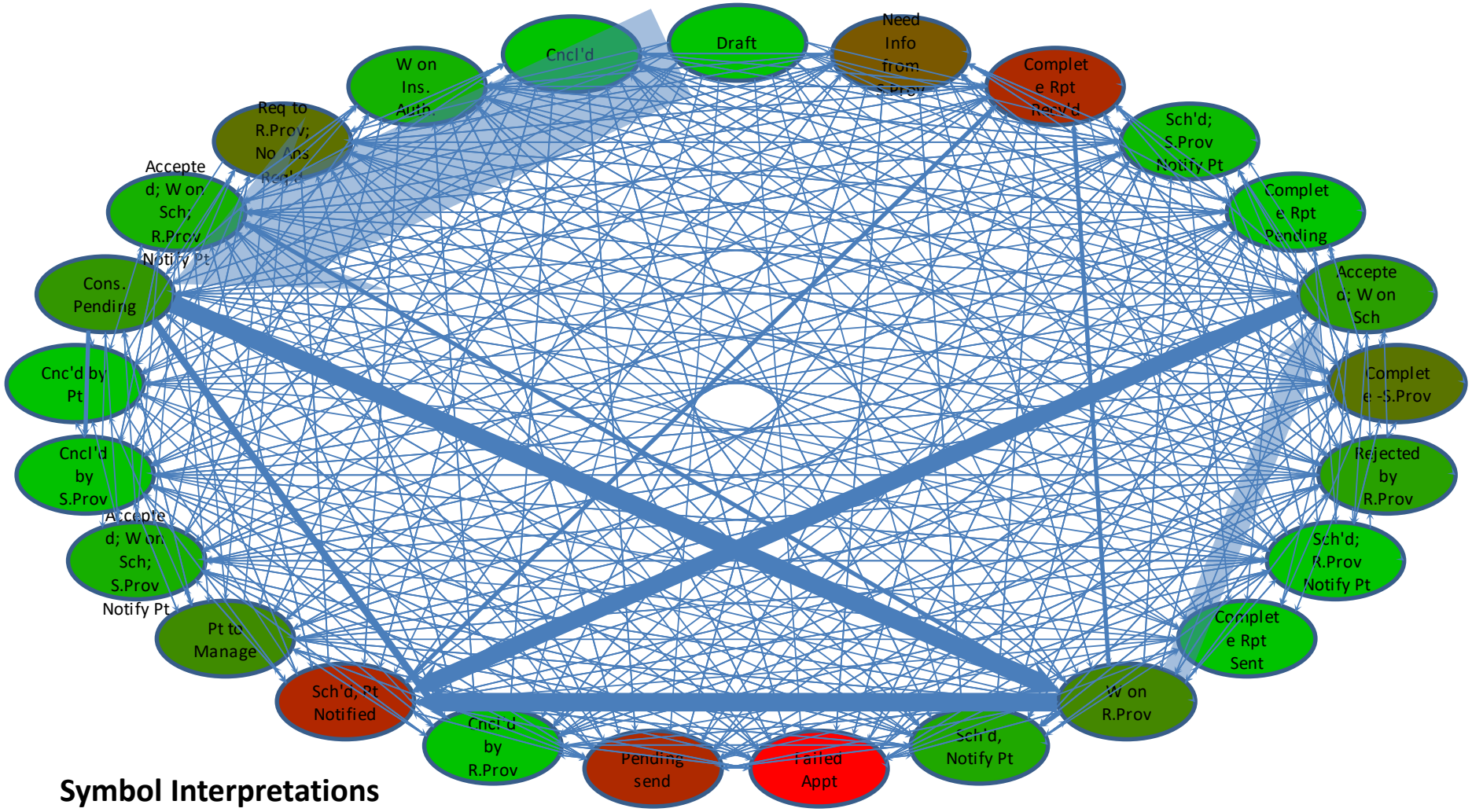

- Understaffed
- No written procedures in place
- No quality monitoring or backup procedures
- Initial contact: 4-60 days
- 50 to 3,000 referrals behind
- Many simply dropped

**Consultant**



MyHealth ACCESS NETWORK

# ALL Observed Transitions Between Visit Request Statuses




**Symbol Interpretations**

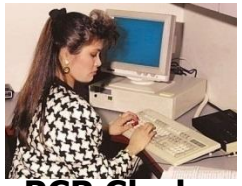
- Arrows represent transition from one referral status to another
- Arrow thickness is proportional to # of transitions
- Status color represents relative length of time consults remain in each status (compared to others in this subset): red = longest; green = shortest
- Status states are abbreviated

# 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**



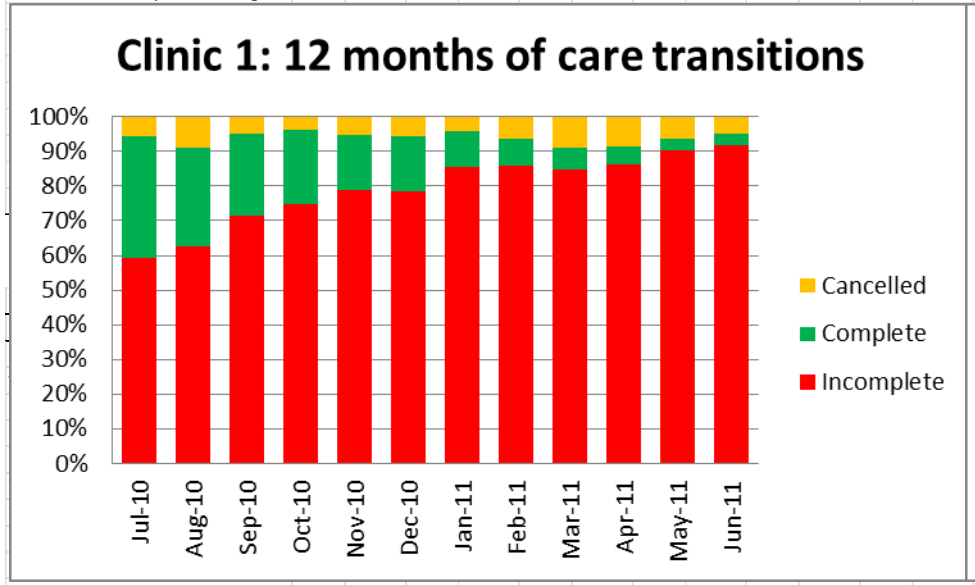
MyHealth ACCESS NETWORK

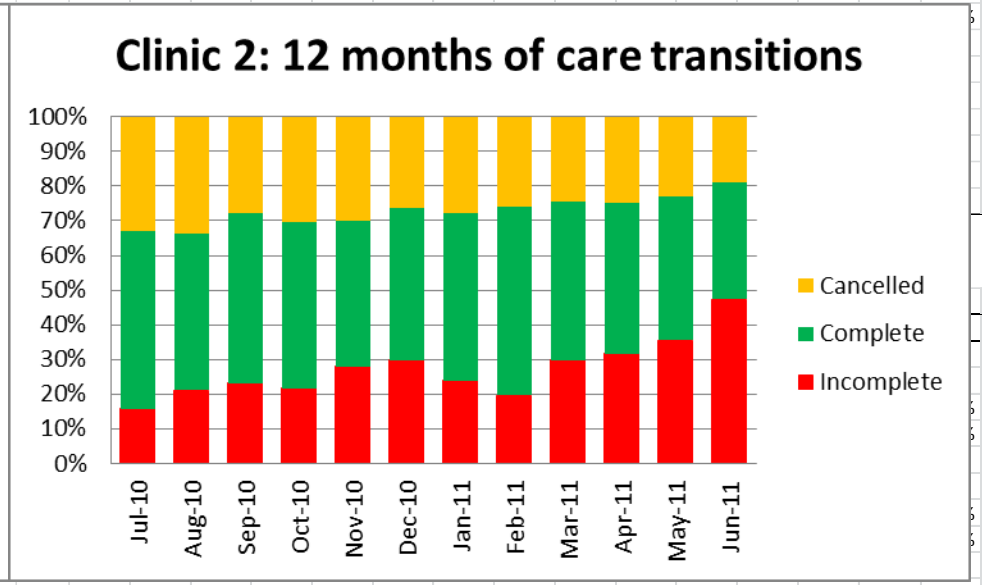
# Results: A Tale of Two Clinics

## 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% |

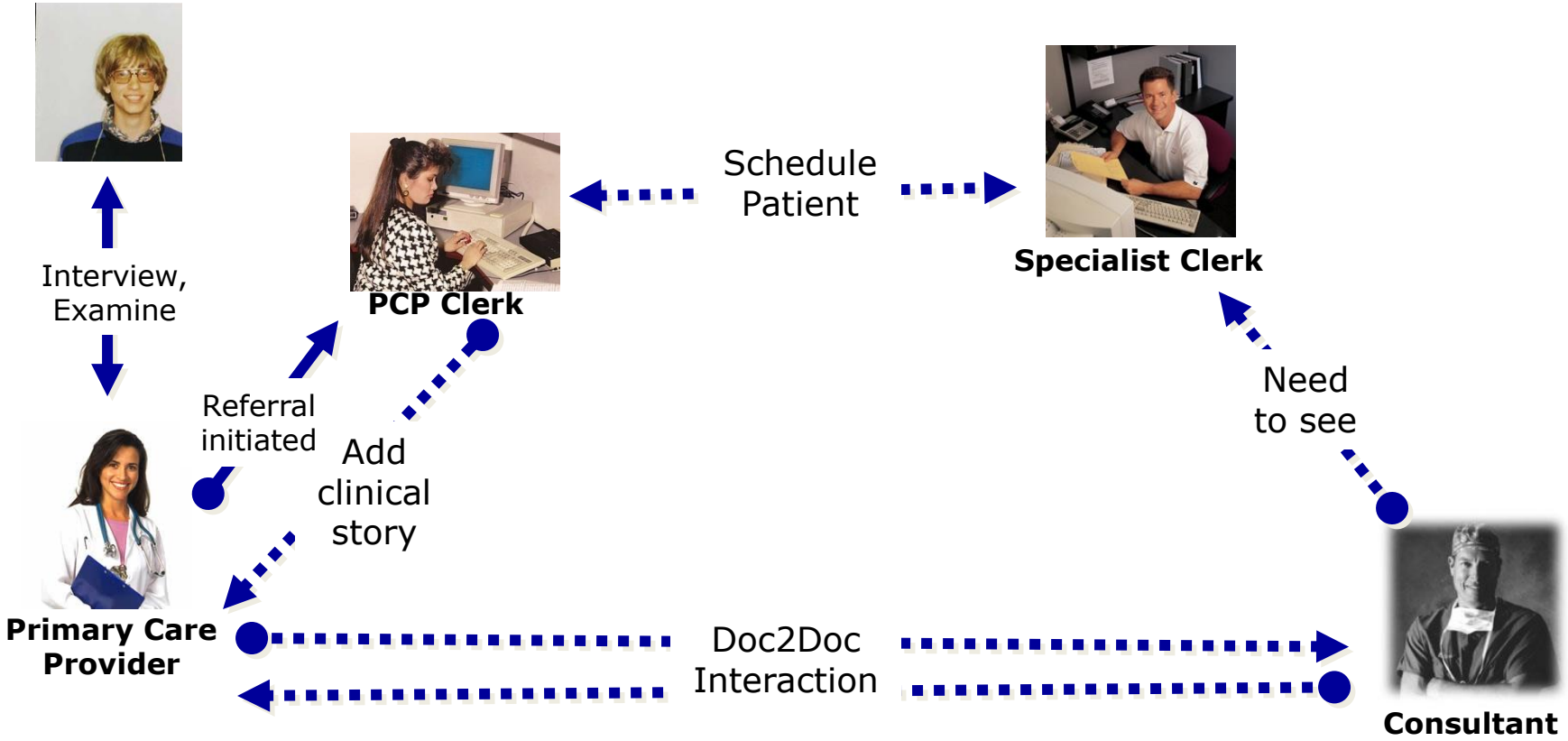





MyHealth ACCESS NETWORK

# eConsultations to optimize care transitions



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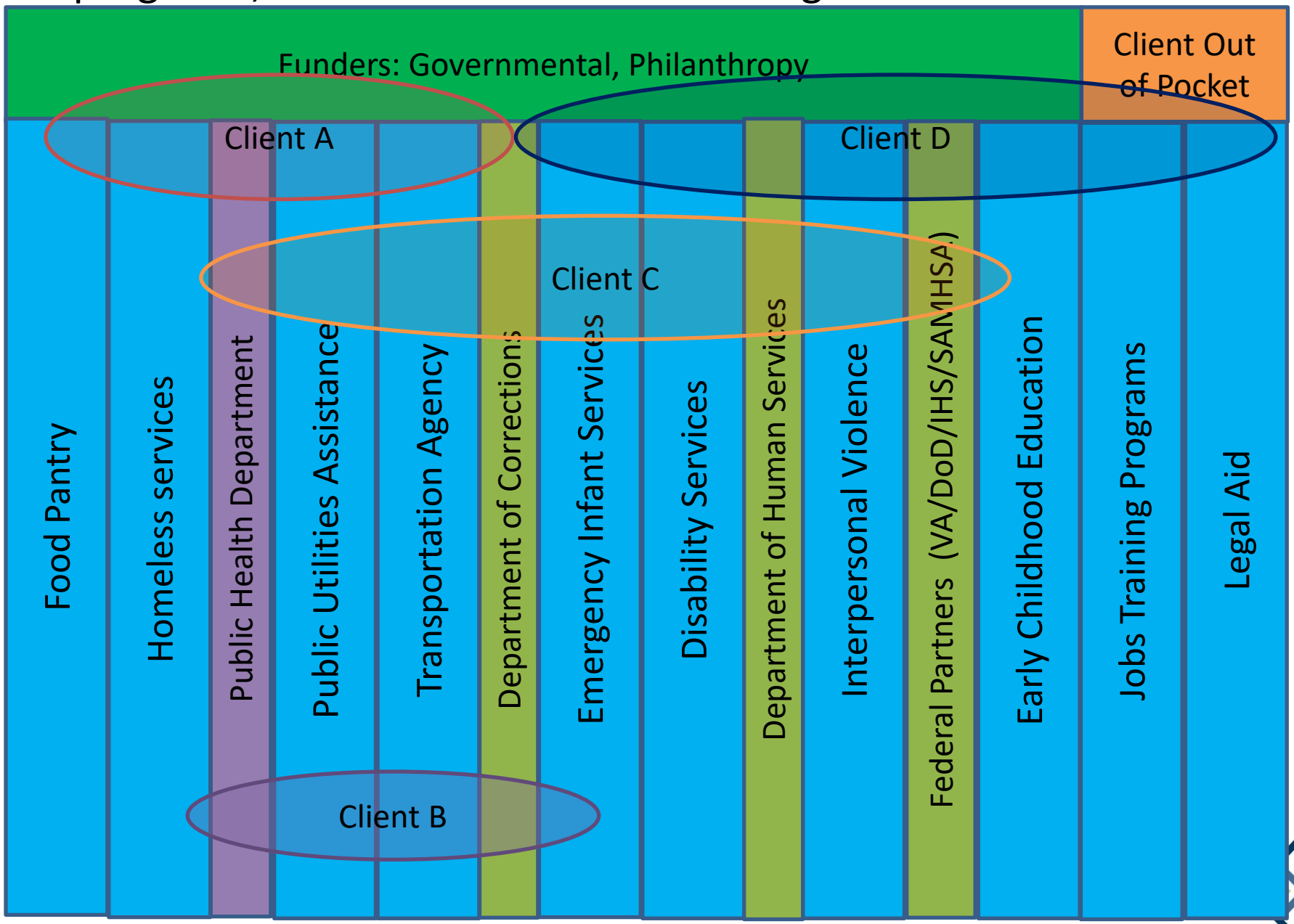
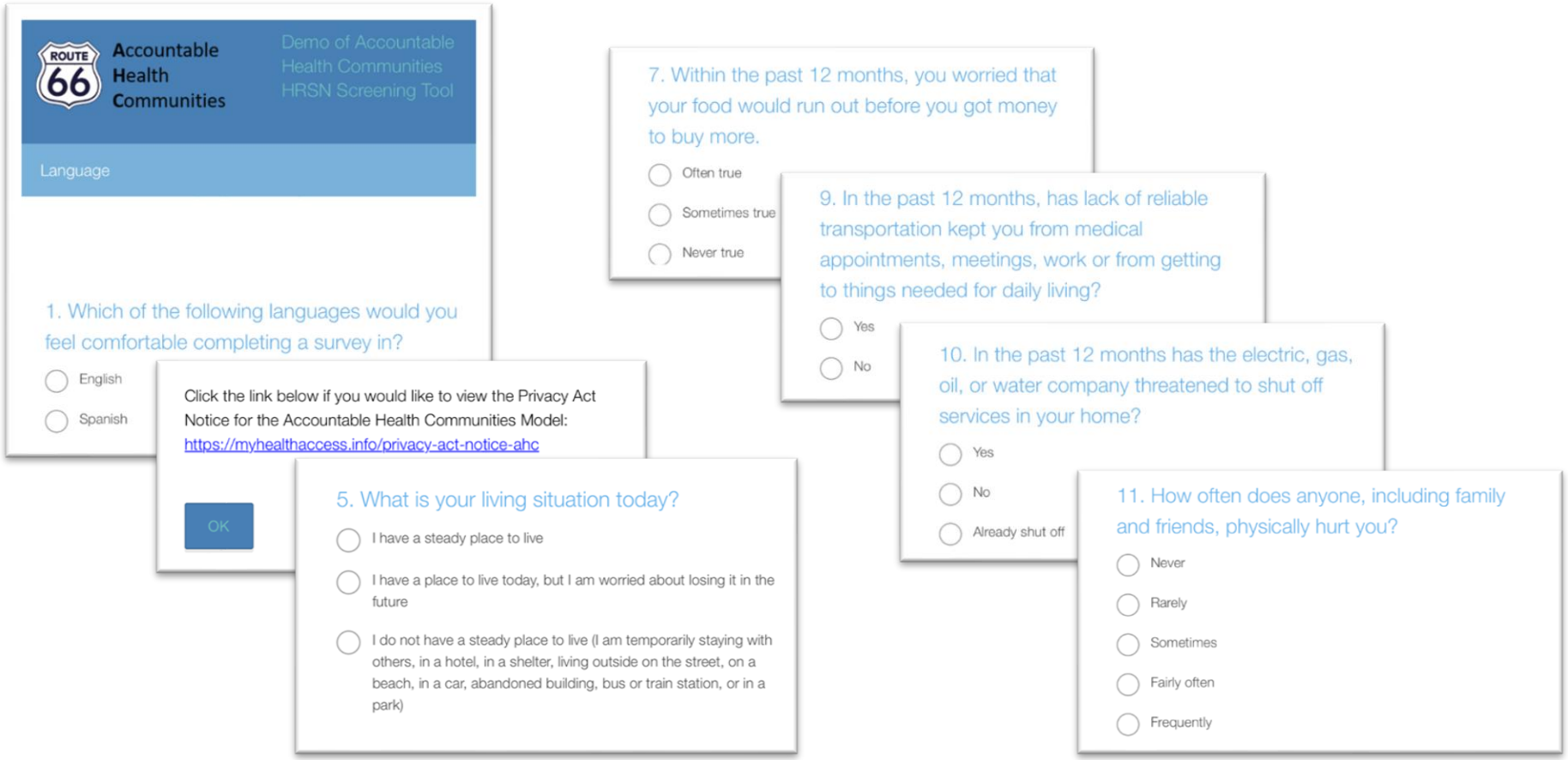
MyHealth now working with social needs and early childhood programs, where data is even more fragmented . . .






MyHealth ACCESS NETWORK

# Accountable Health Communities: Statewide Screening for Social Needs

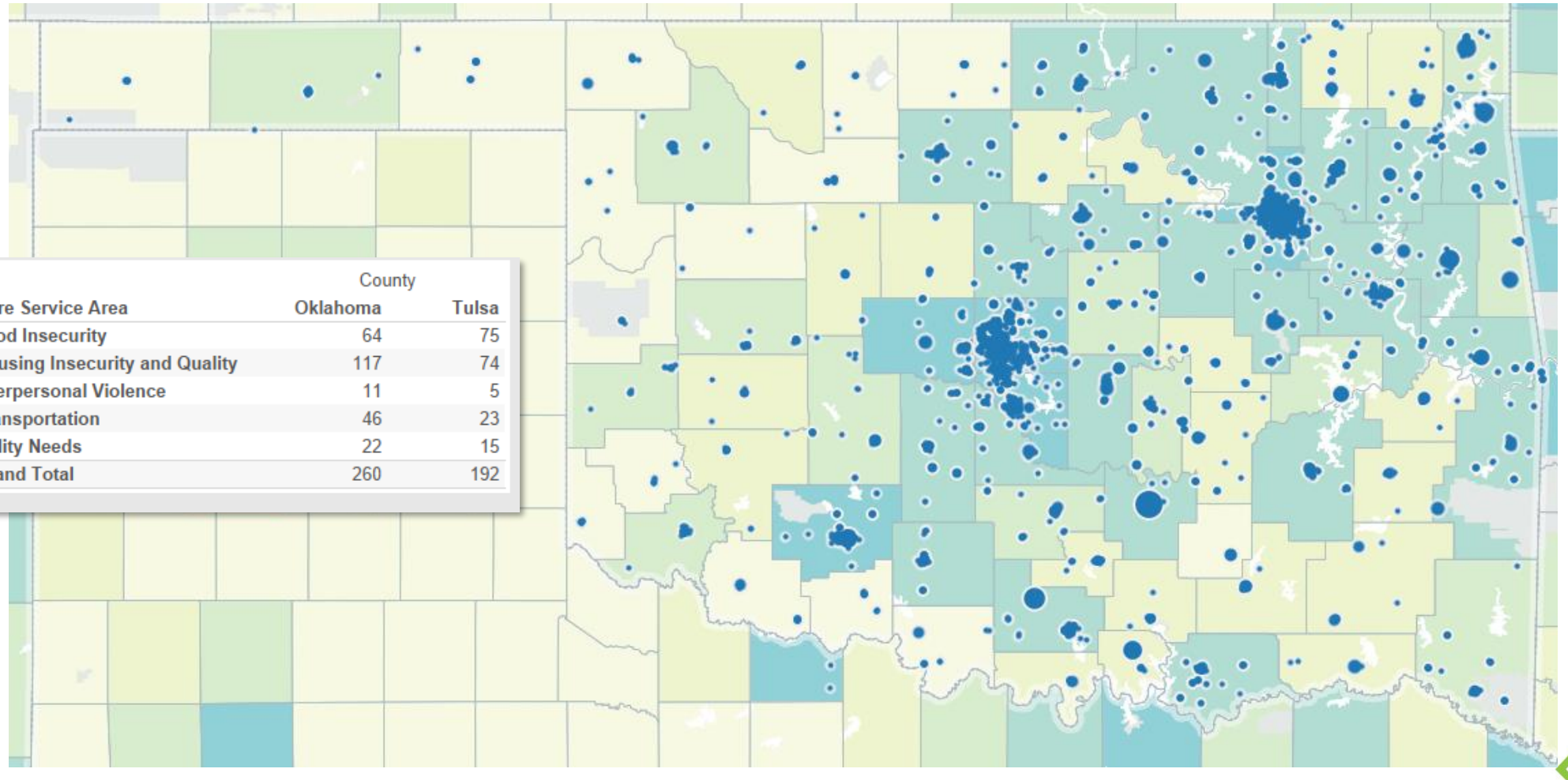





MyHealth ACCESS NETWORK

# Accountable Health Communities: CRS

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

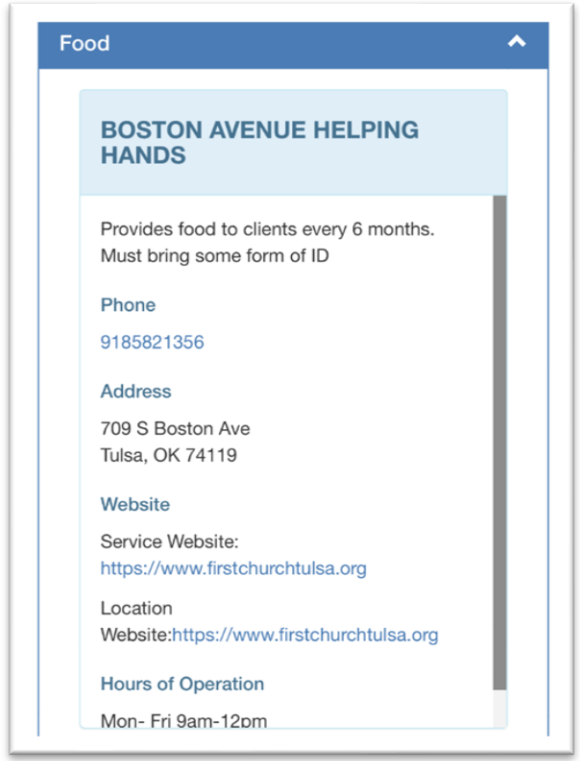


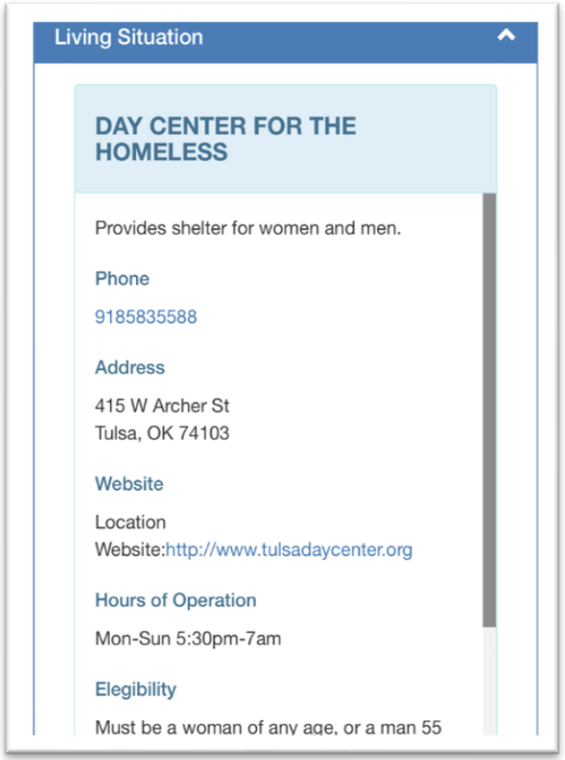
| | County | |
|---|---|---|
| Core Service Area | Oklahoma | Tulsa |
| Food Insecurity | 64 | 75 |
| Housing Insecurity and Quality | 117 | 74 |
| Interpersonal Violence | 11 | 5 |
| Transportation | 46 | 23 |
| Utility Needs | 22 | 15 |
| Grand Total | 260 | 192 |



MyHealth ACCESS NETWORK

# Accountable Health Communities: CRS

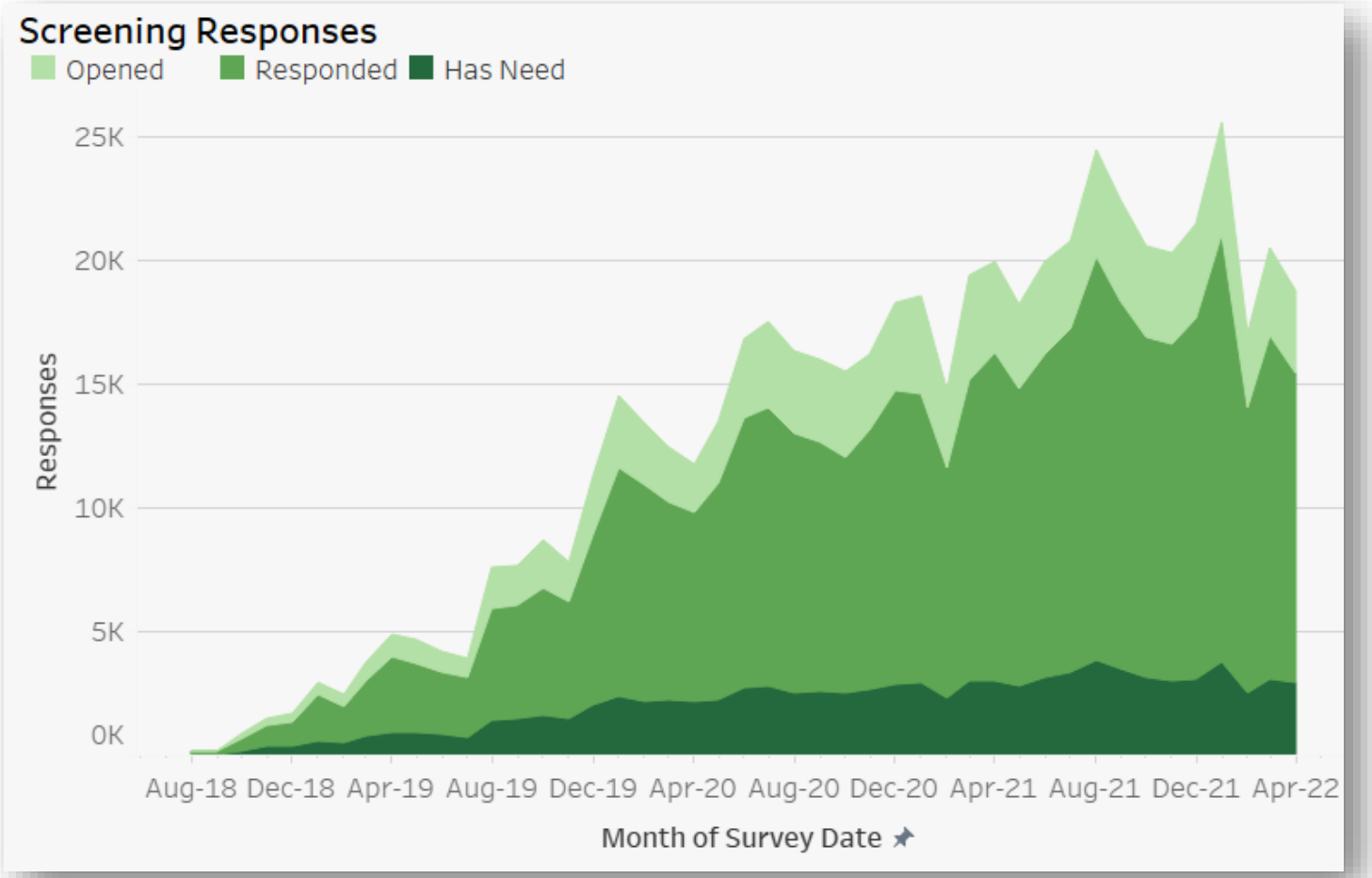






MyHealth ACCESS NETWORK

# 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***

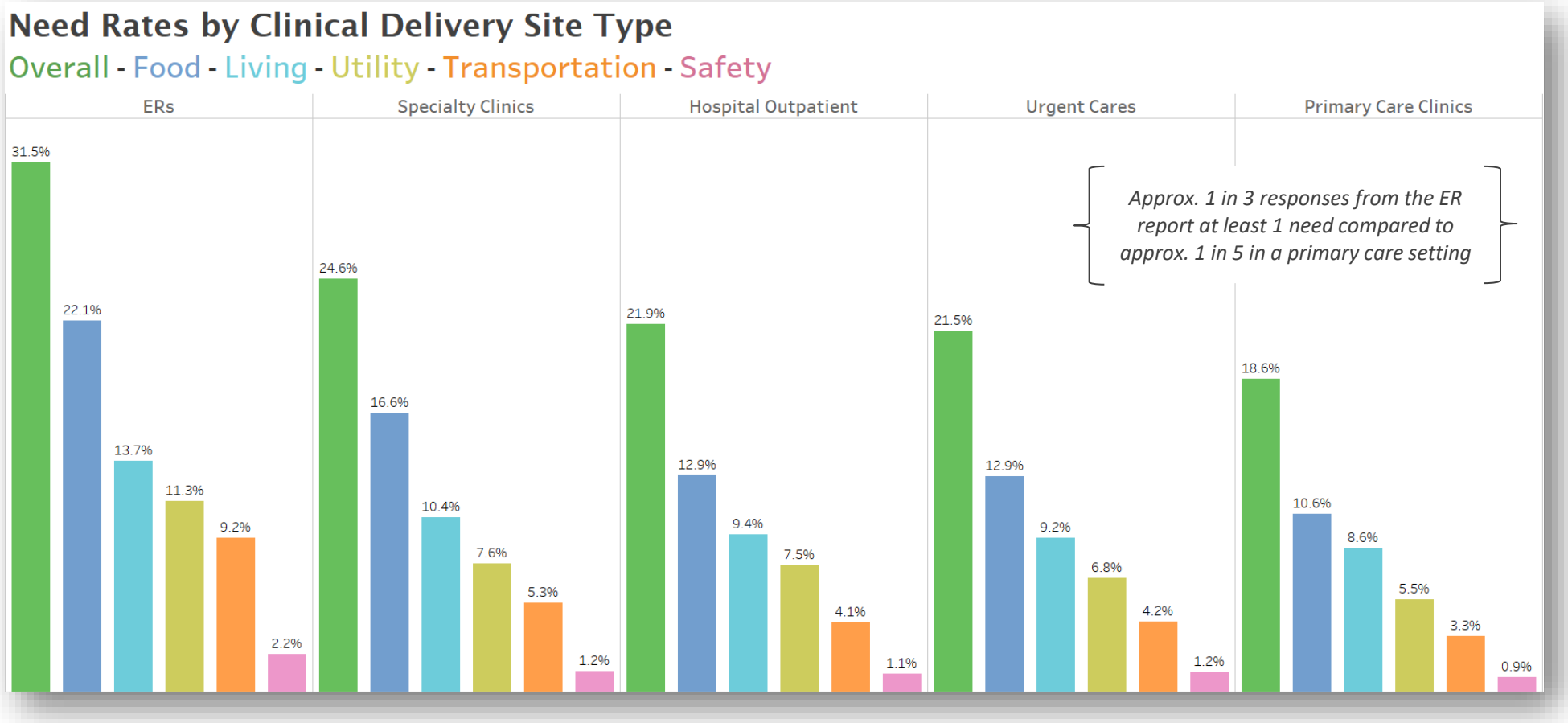
*Medicare and Medicaid Only*

***13,400+ Navigation Needs Resolved***

*Medicare and Medicaid Only*

**A**ccountable **H**ealth **C**ommunities

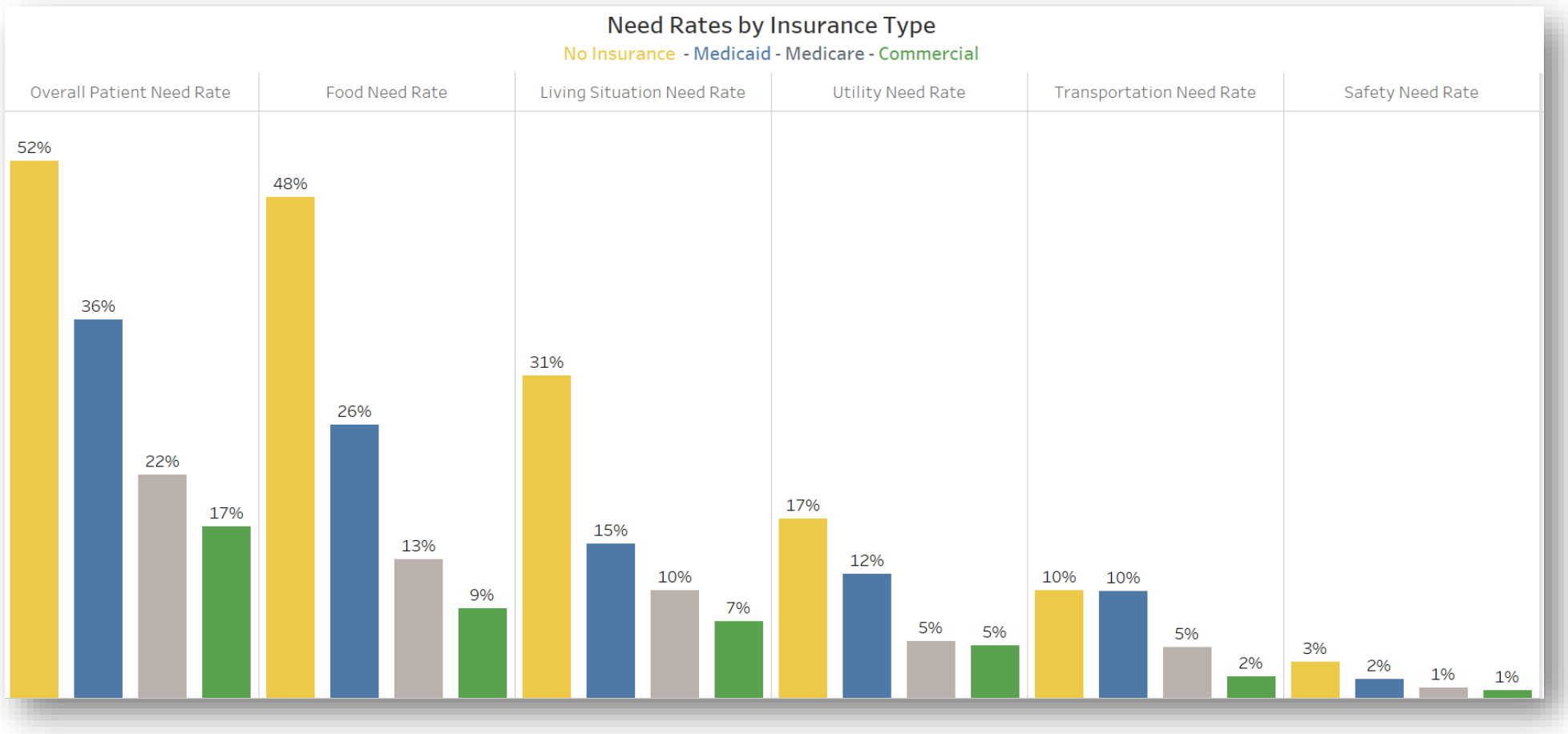
# MyHealth AHC Need Rates by Clinical Site Type






MyHealth ACCESS NETWORK

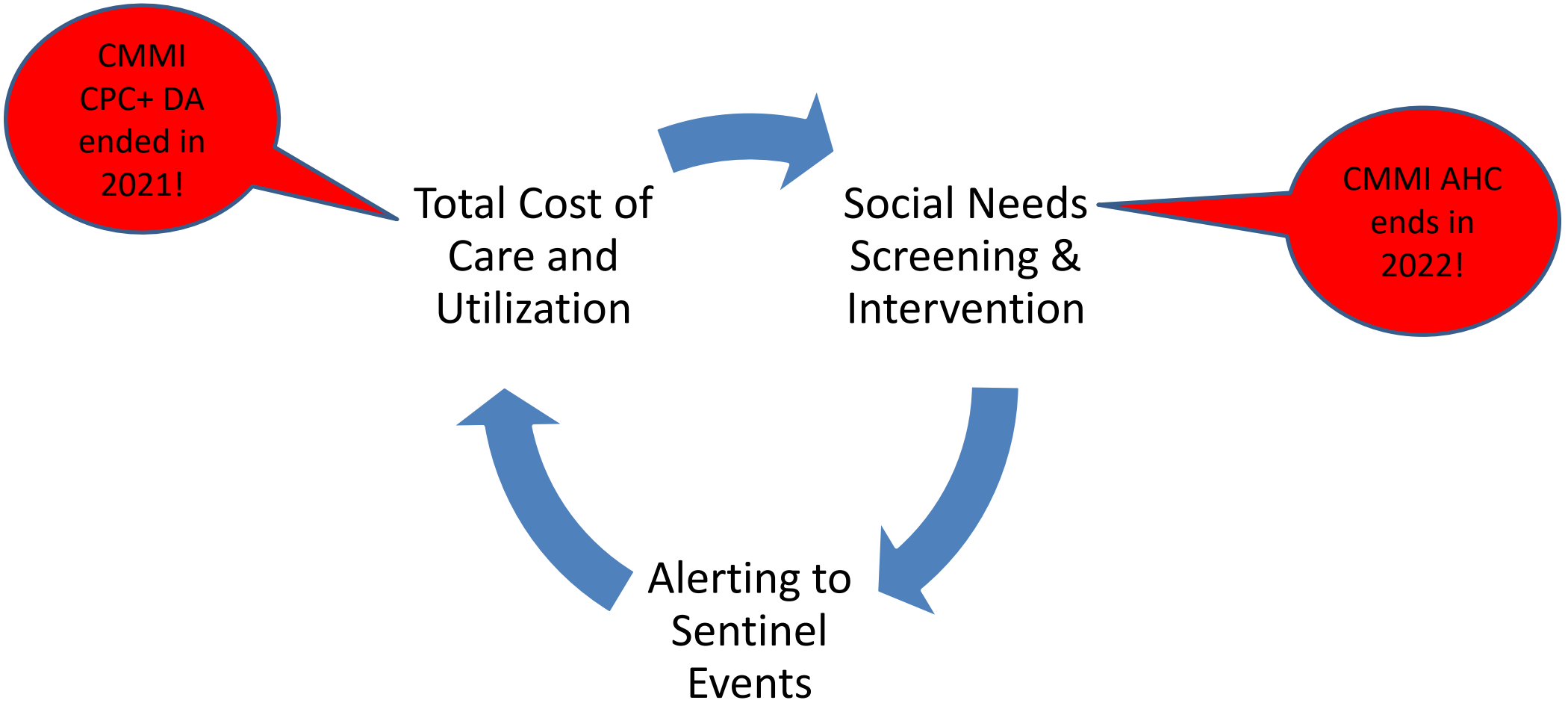
# MyHealth AHC Need Rates by Insurance Type






MyHealth ACCESS NETWORK

# Cycle of Improvement

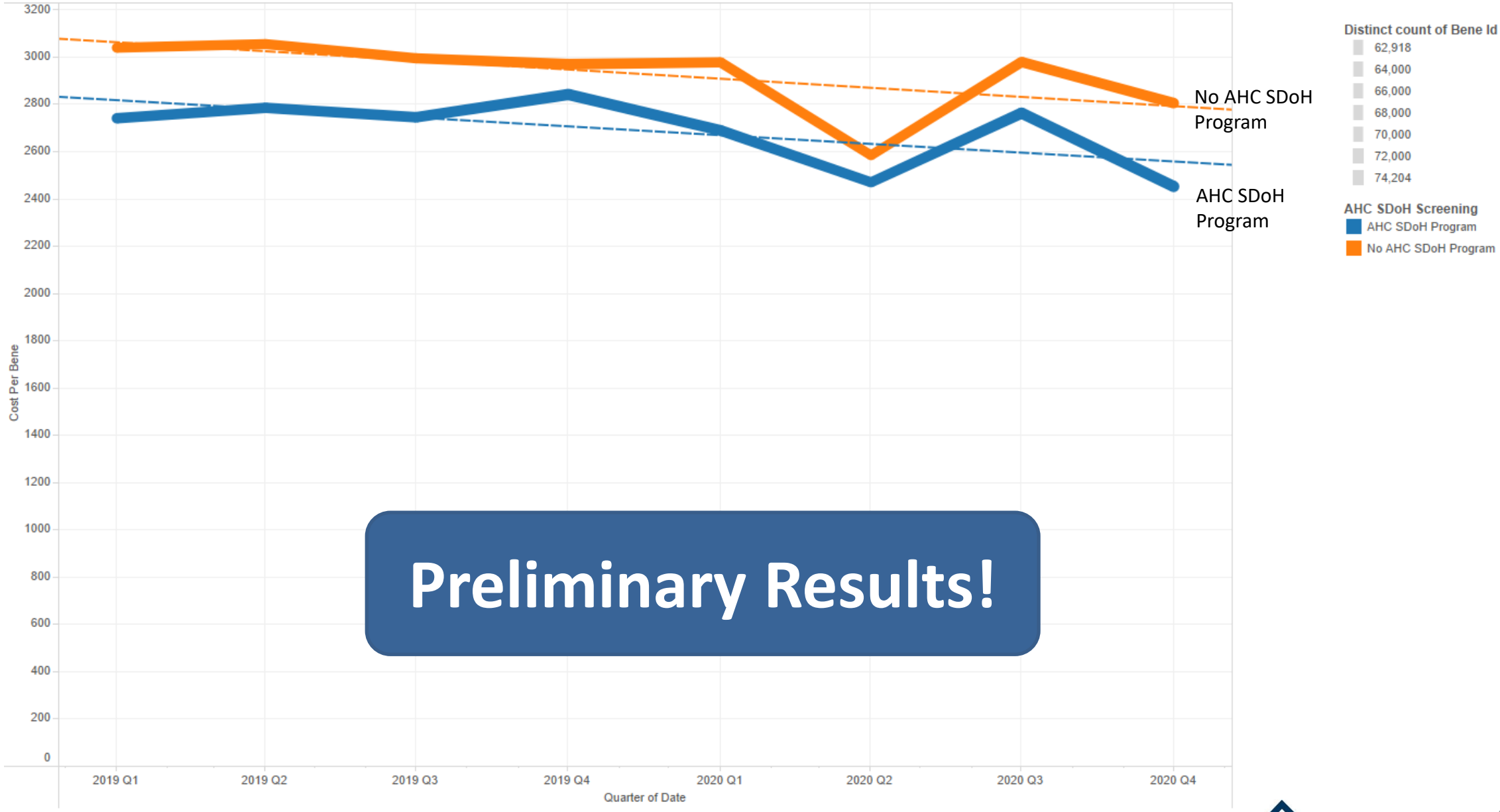



All three together will maximize the impact



MyHealth ACCESS NETWORK

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



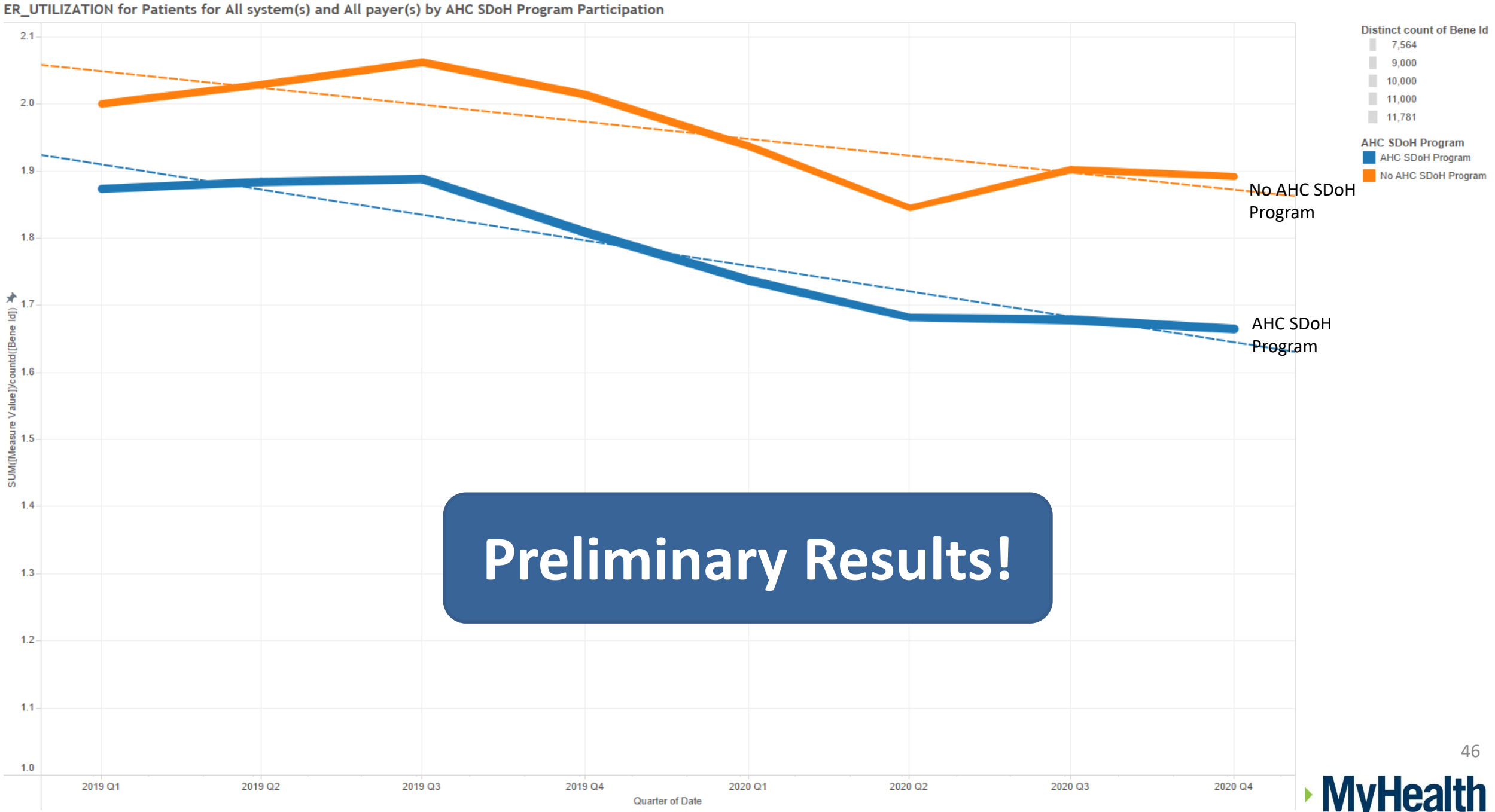

**Preliminary Results!**

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.



MyHealth ACCESS NETWORK

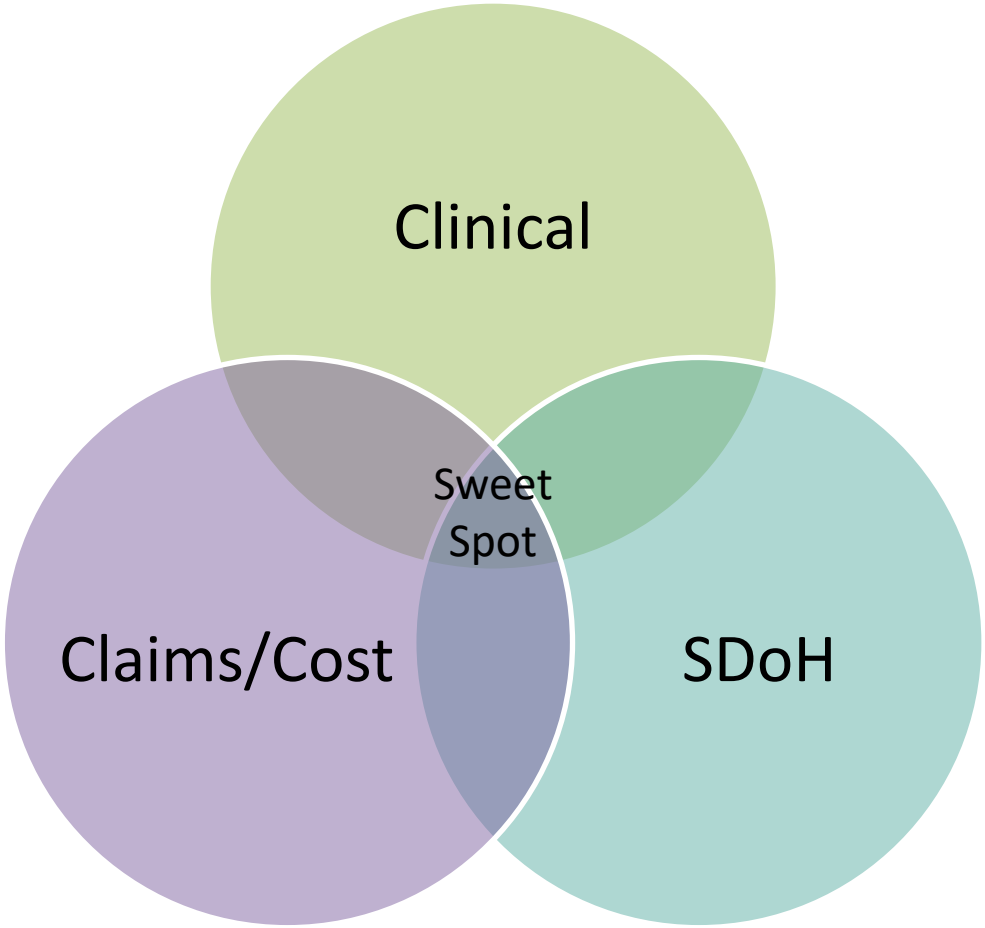



# Preliminary Results!



MyHealth ACCESS NETWORK

# Putting it all together



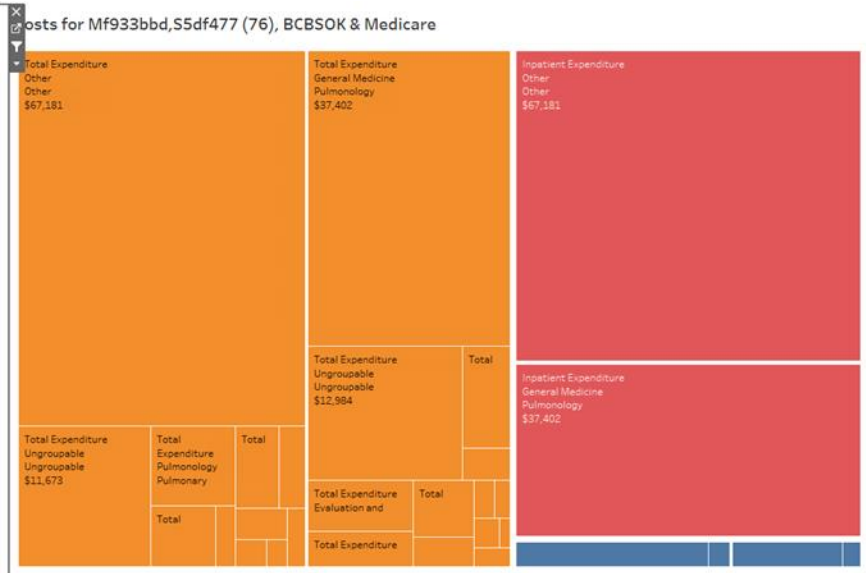


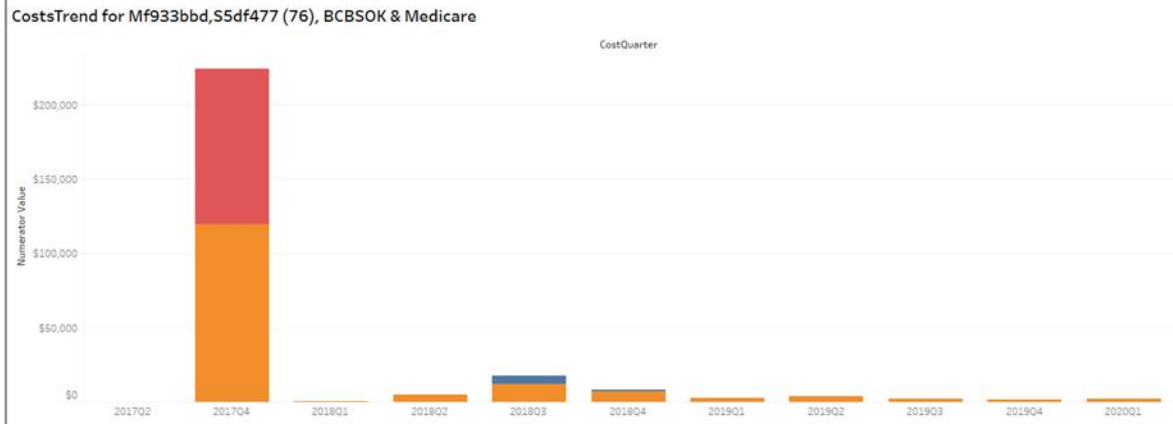

MyHealth ACCESS NETWORK

# 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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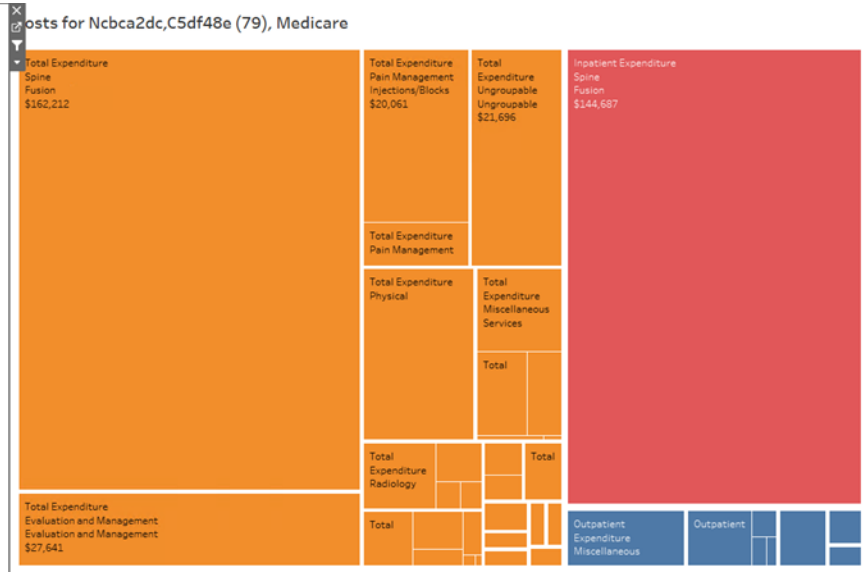
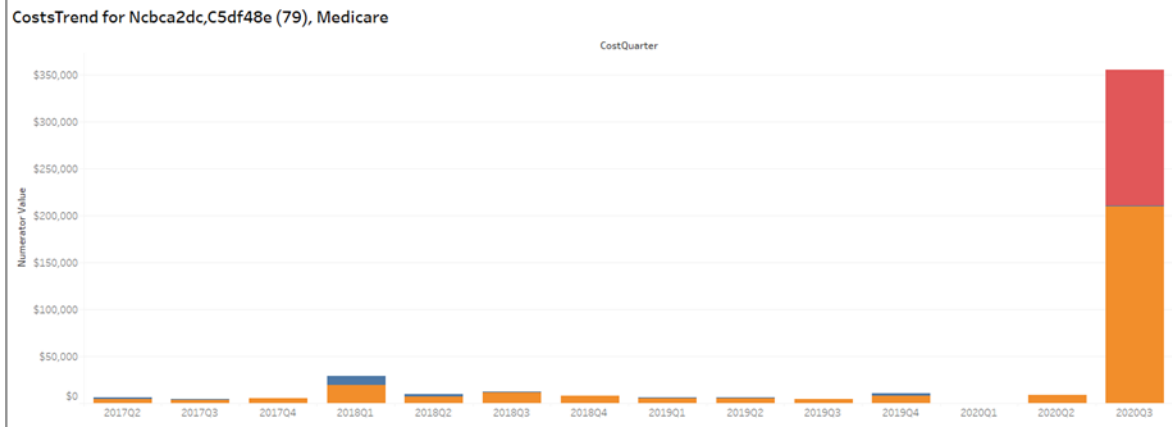
| | | | | November 13, 2021 | No | BCBSOK | $351,807 |




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

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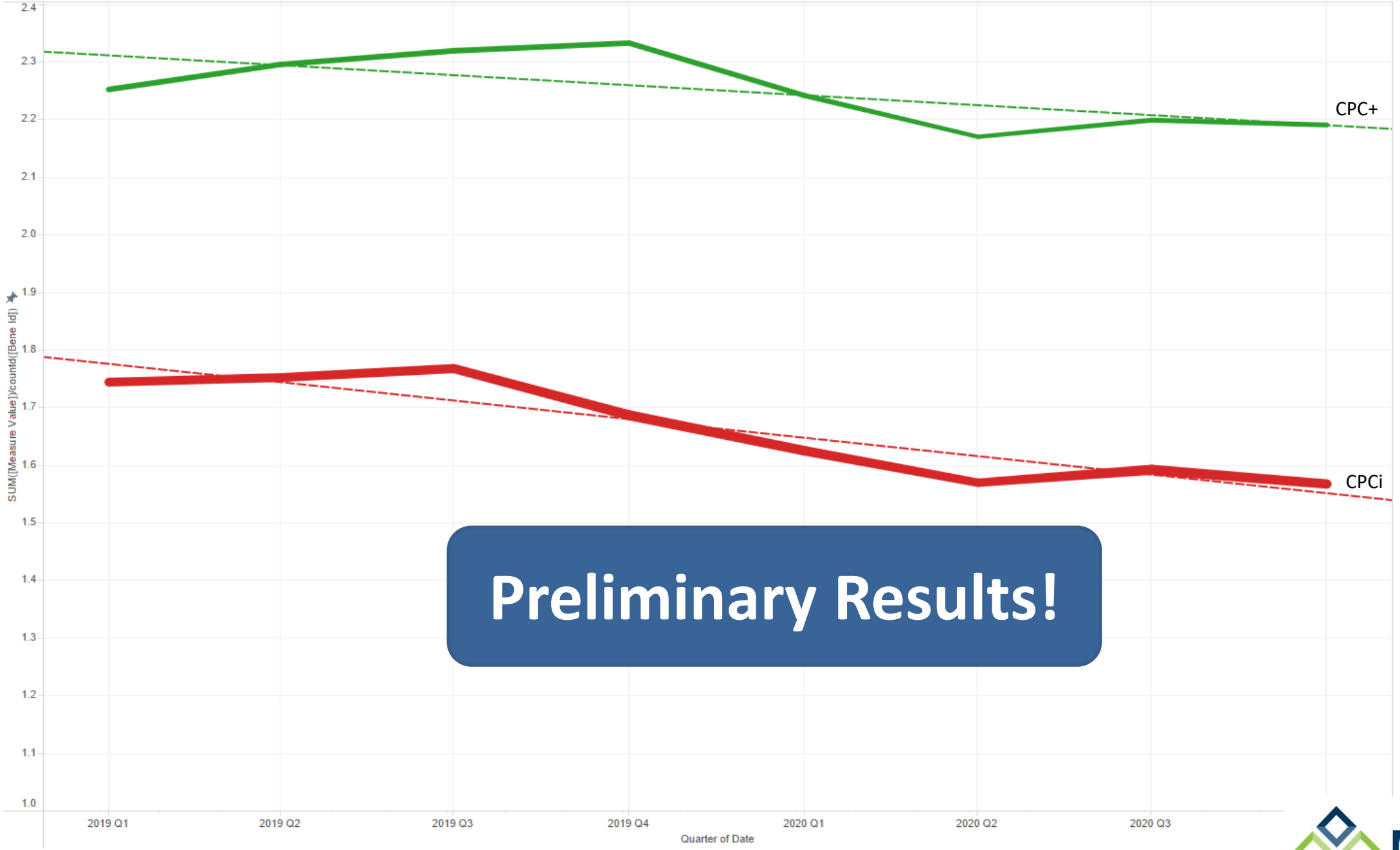
   a. Multi-payer models produce scale and reduce provider burden, but must be self-governed for commercial payers to trust them
   b. Consider including potential model participants in the model design process, piloting any complex process elements
2. Model execution:
   a. Scope of data available to providers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



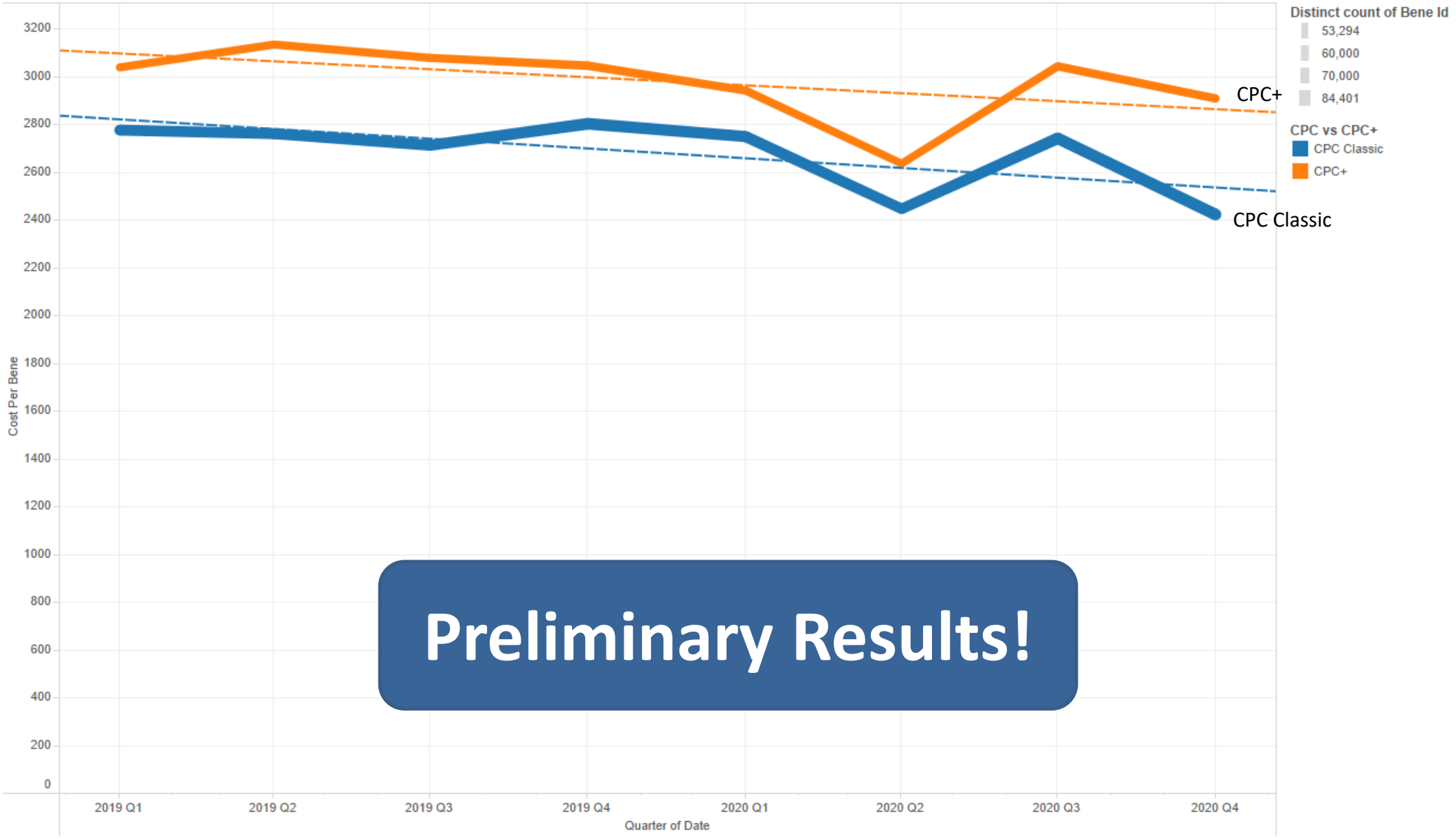

# Preliminary Results!

**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/CPCDashboa

MyHealth ACCESS NETWORK

## 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.

**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.**

Health ACCESS NETWORK

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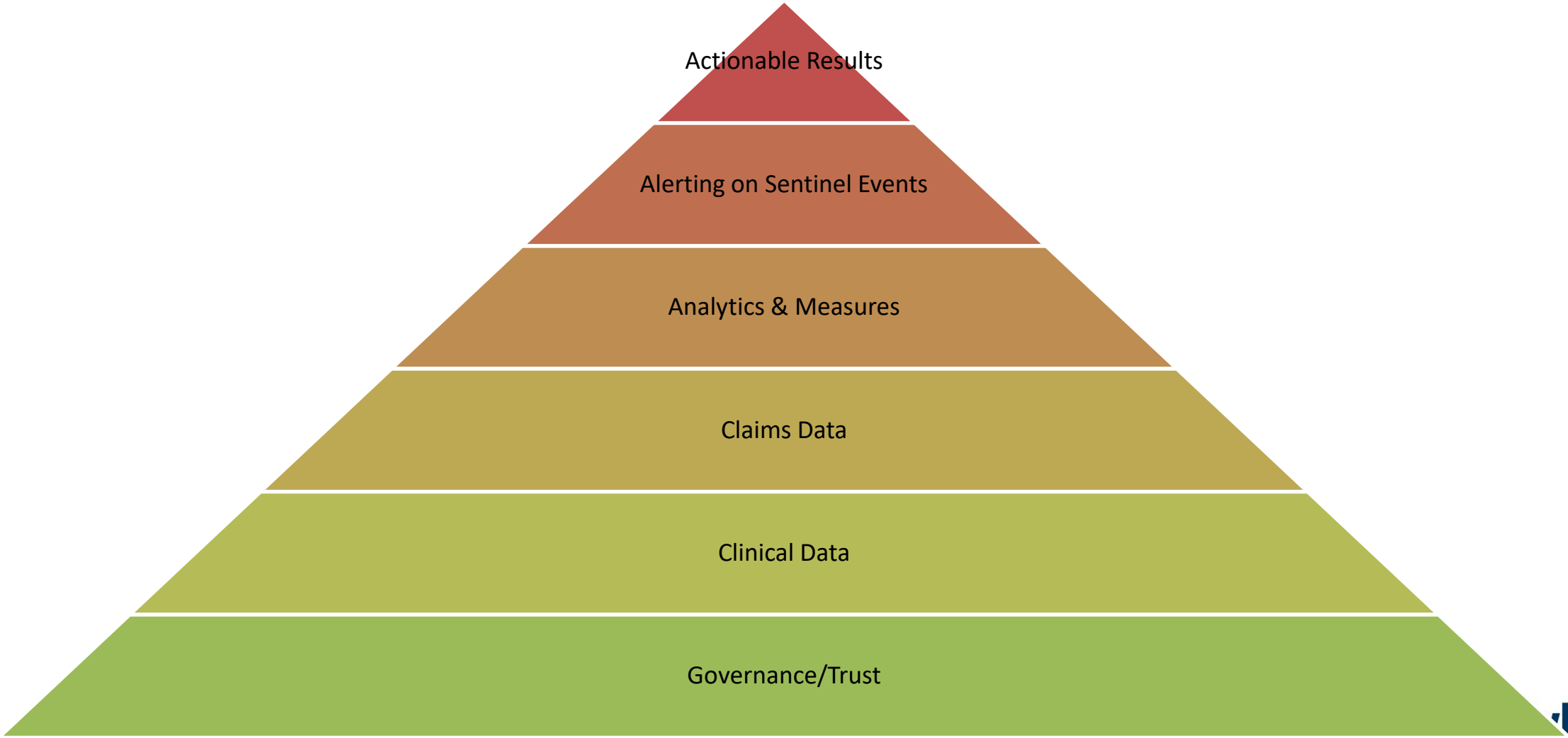
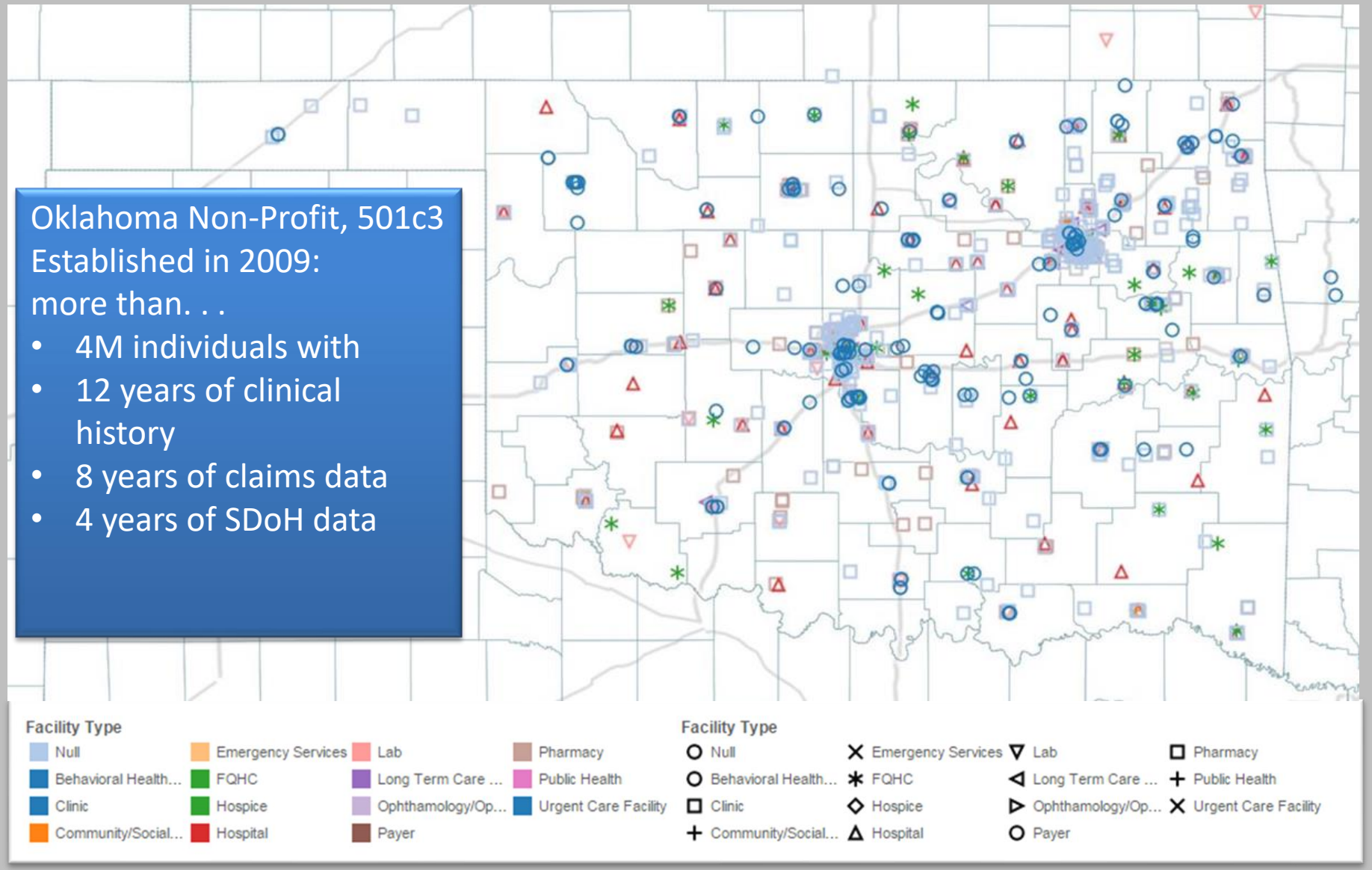
# Common Infrastructure Ingredients needed for Most Models



# >1400 locations serving >110,000 patients daily

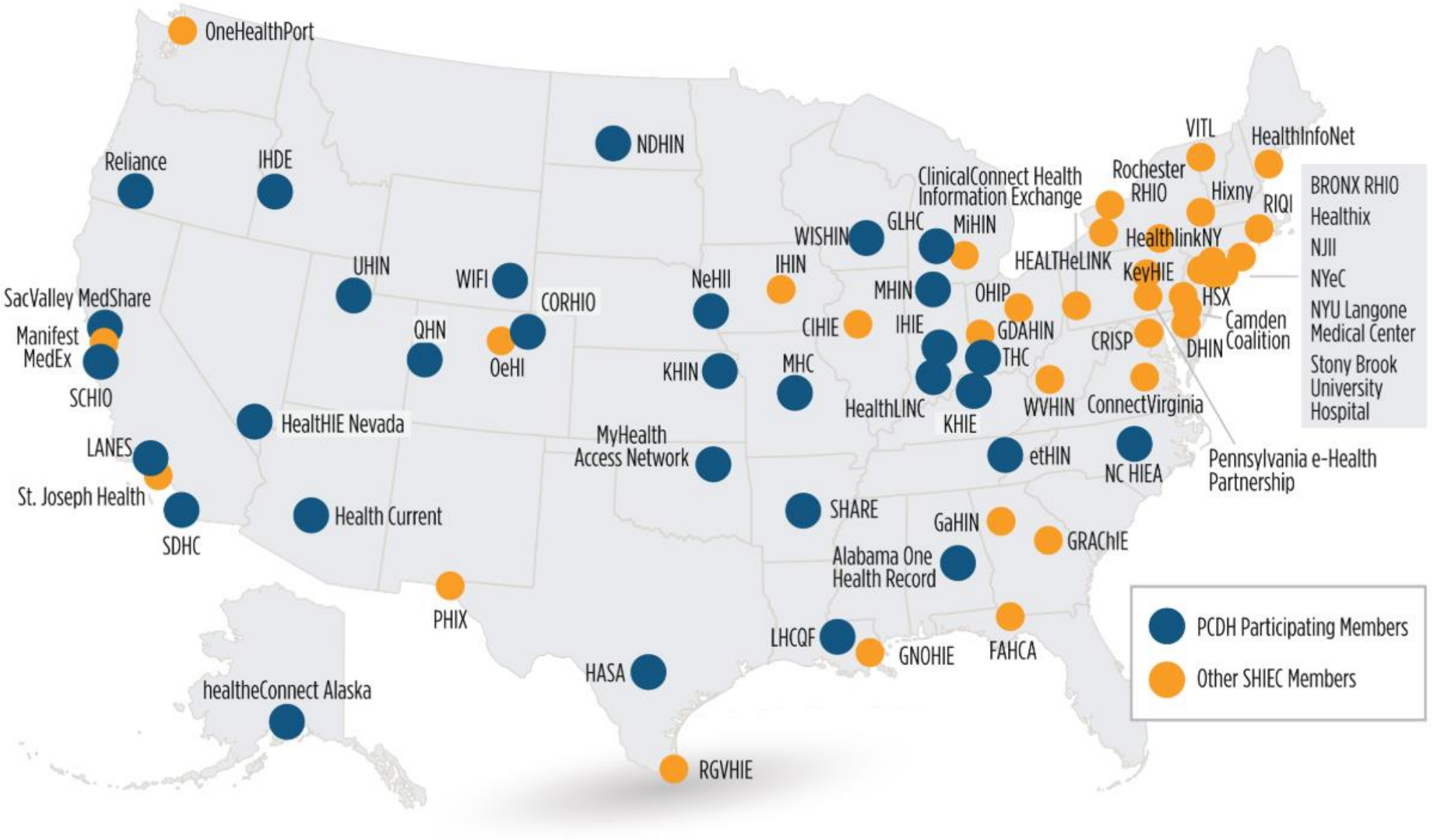
Oklahoma Non-Profit, 501c3
Established in 2009:
more than. . .

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



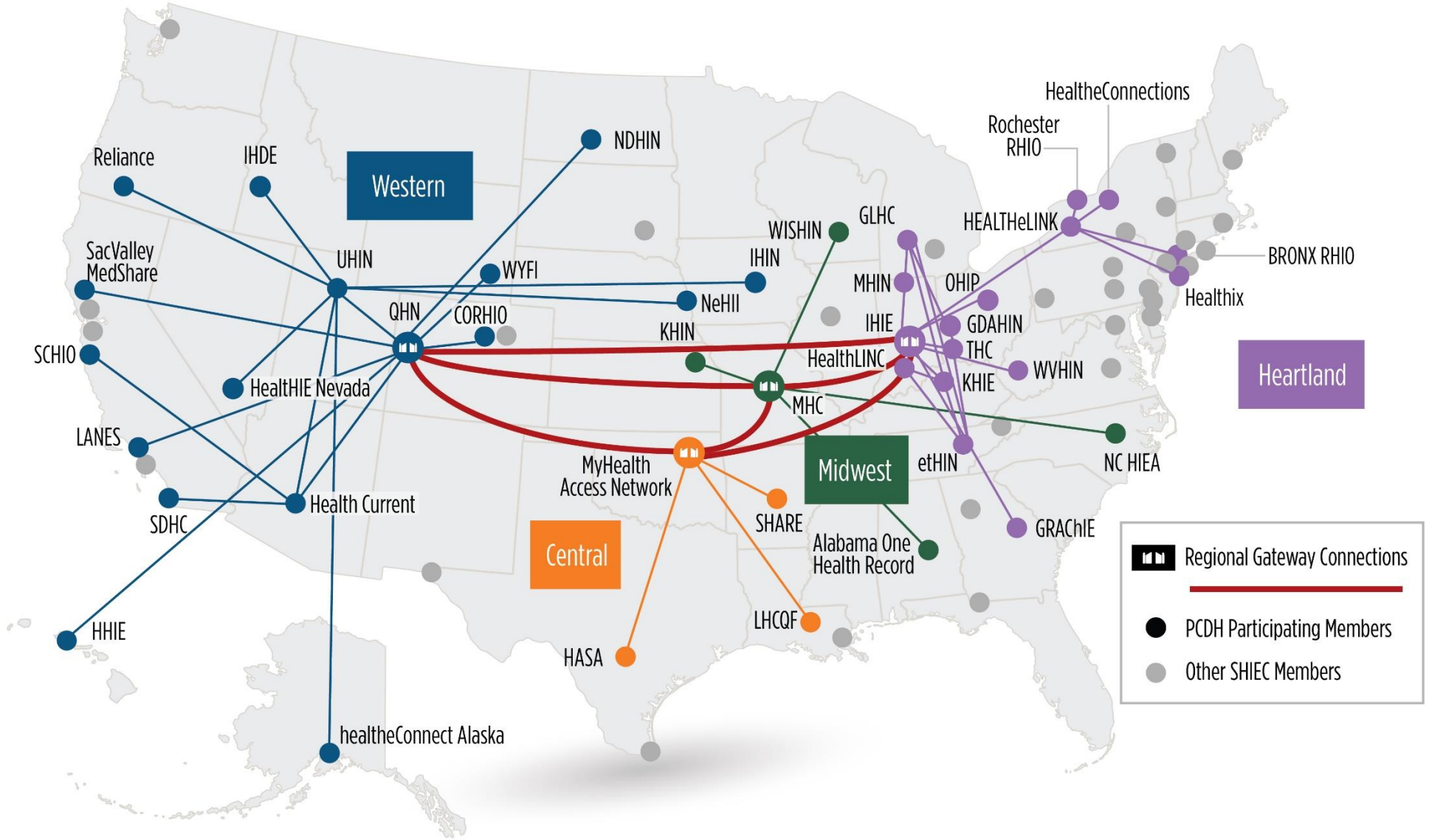
CIVITAS
Networks for Health

# Potential innovation labs nationwide



CIVITAS
Networks for Health

# Patient Centered Data Home™ coverage



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# Discussion

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www.MyHealthAccess.net



MyHealth ACCESS NETWORK

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

**Yi-Ling Lin**

Healthcare Actuary & Financial Strategist,
Terry Group

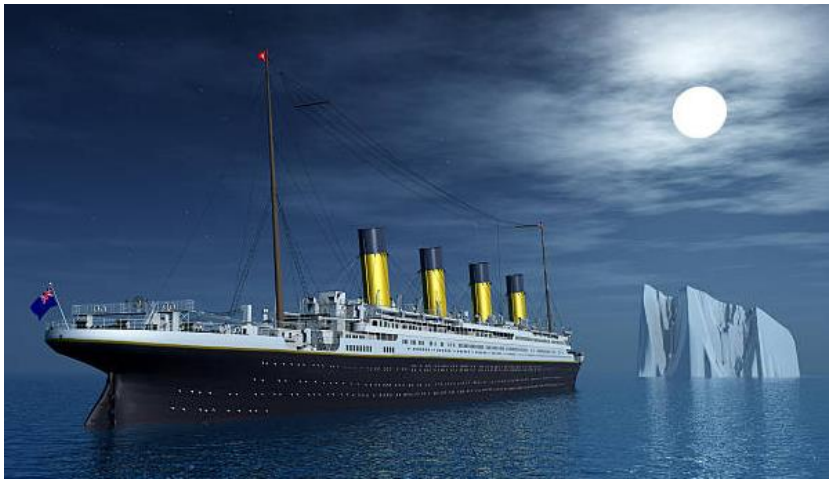
TERRY Health

# 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

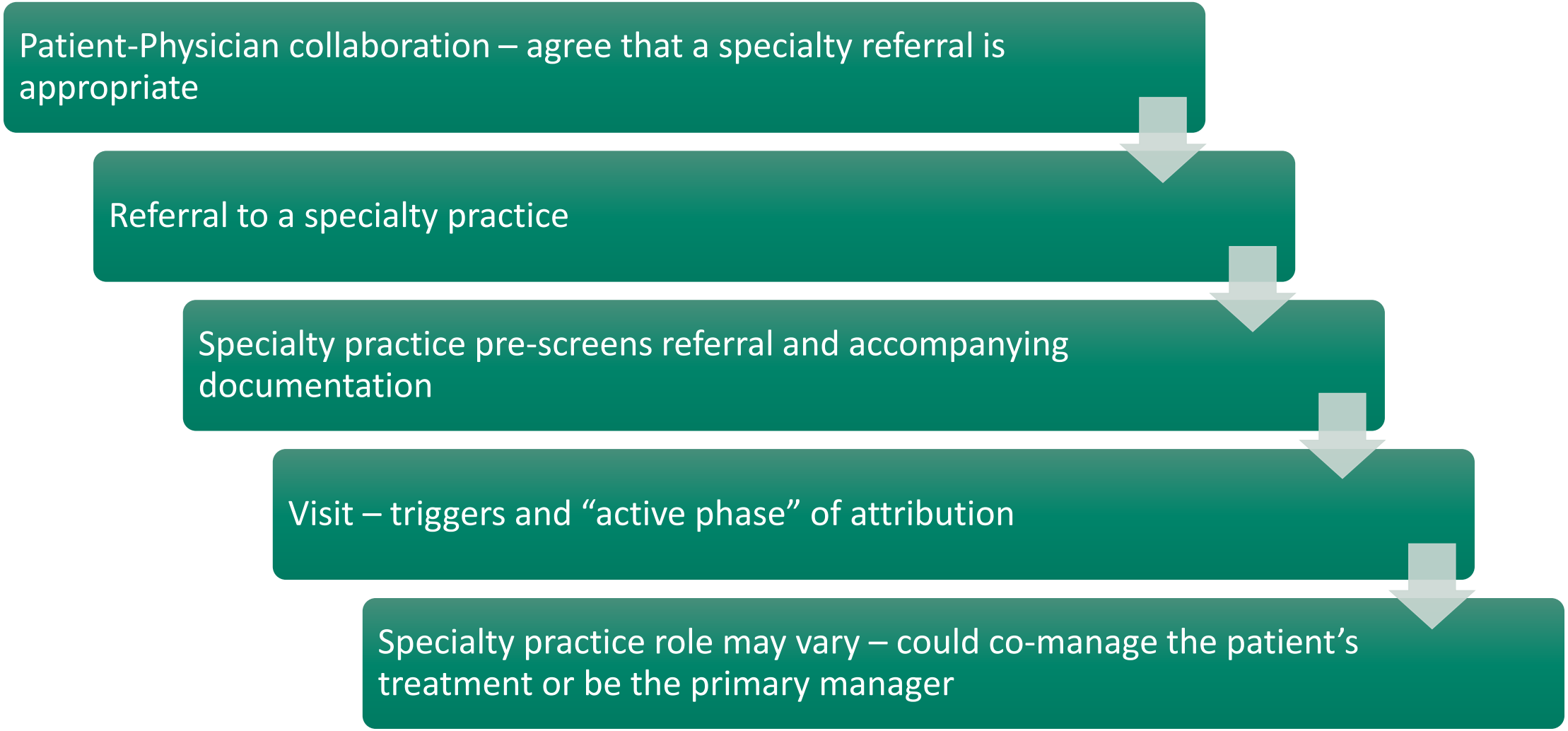
# Listening Session on Assessing Best Practices in Care Delivery for Population-Based Total Cost of Care (PB-TCOC) Models

## 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



# 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

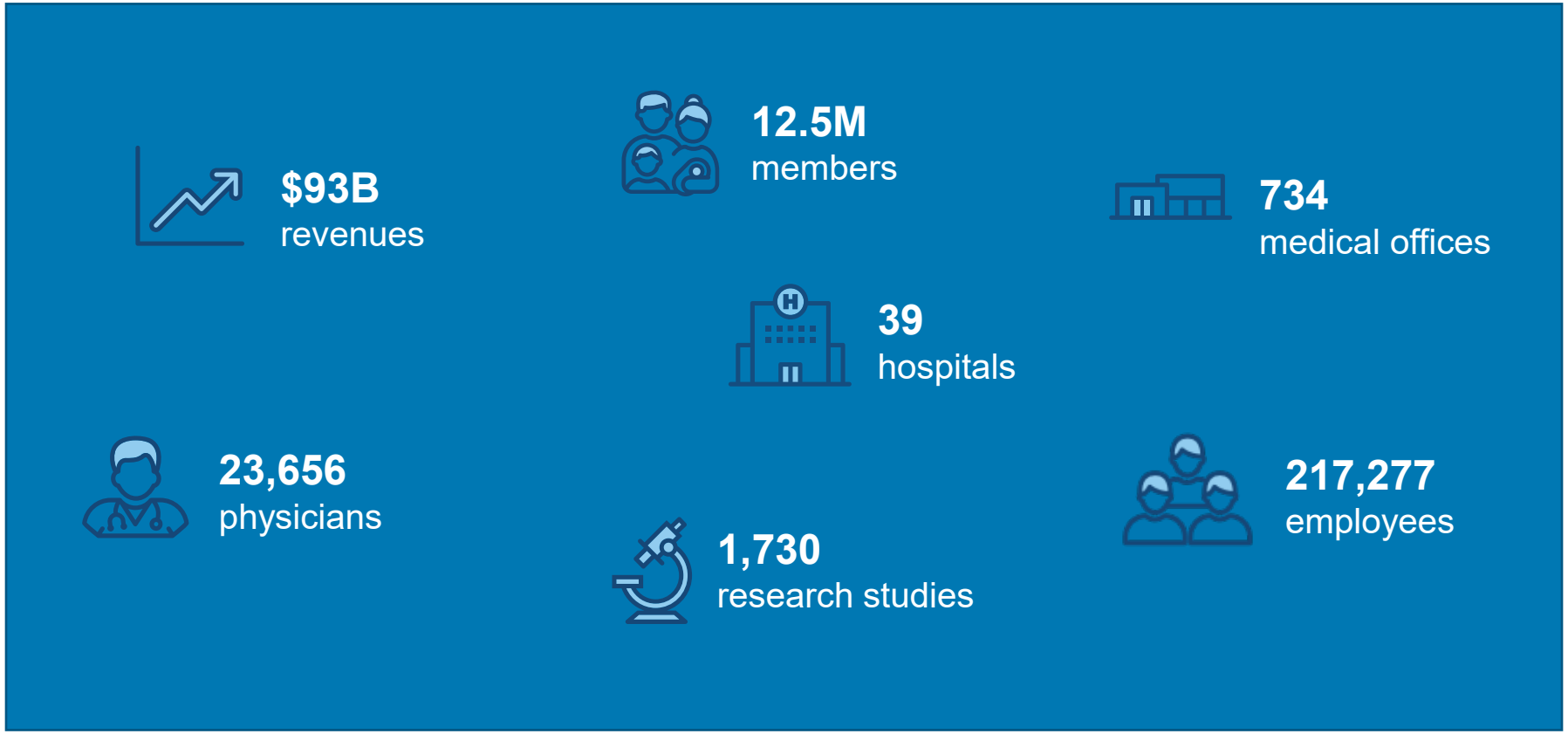
David C Grossman, MD, MPH
Kaiser Permanente
June 2022

KAISER PERMANENTE®

# Kaiser Permanente Overview

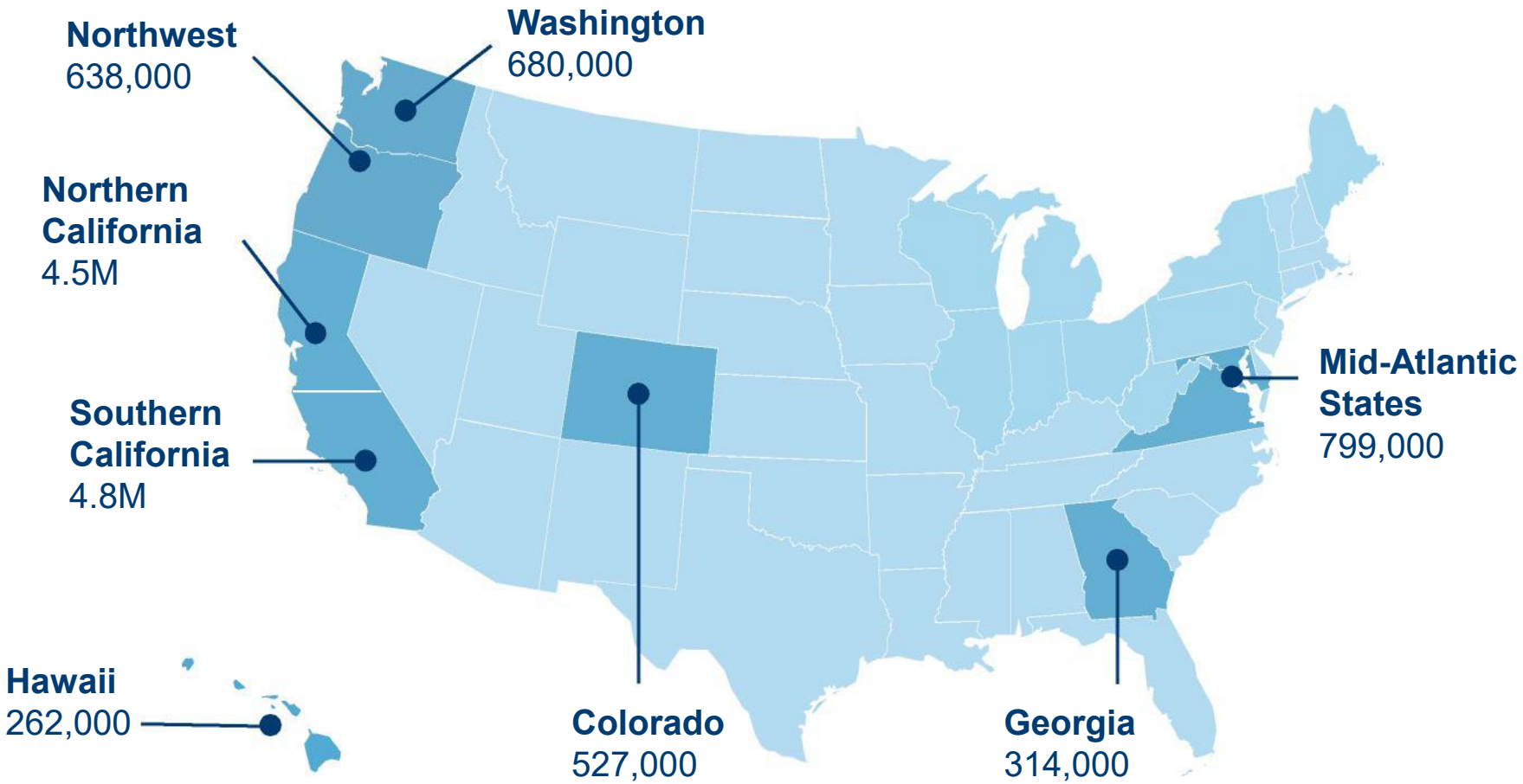
***Mission:*** *Kaiser Permanente exists to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.*




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

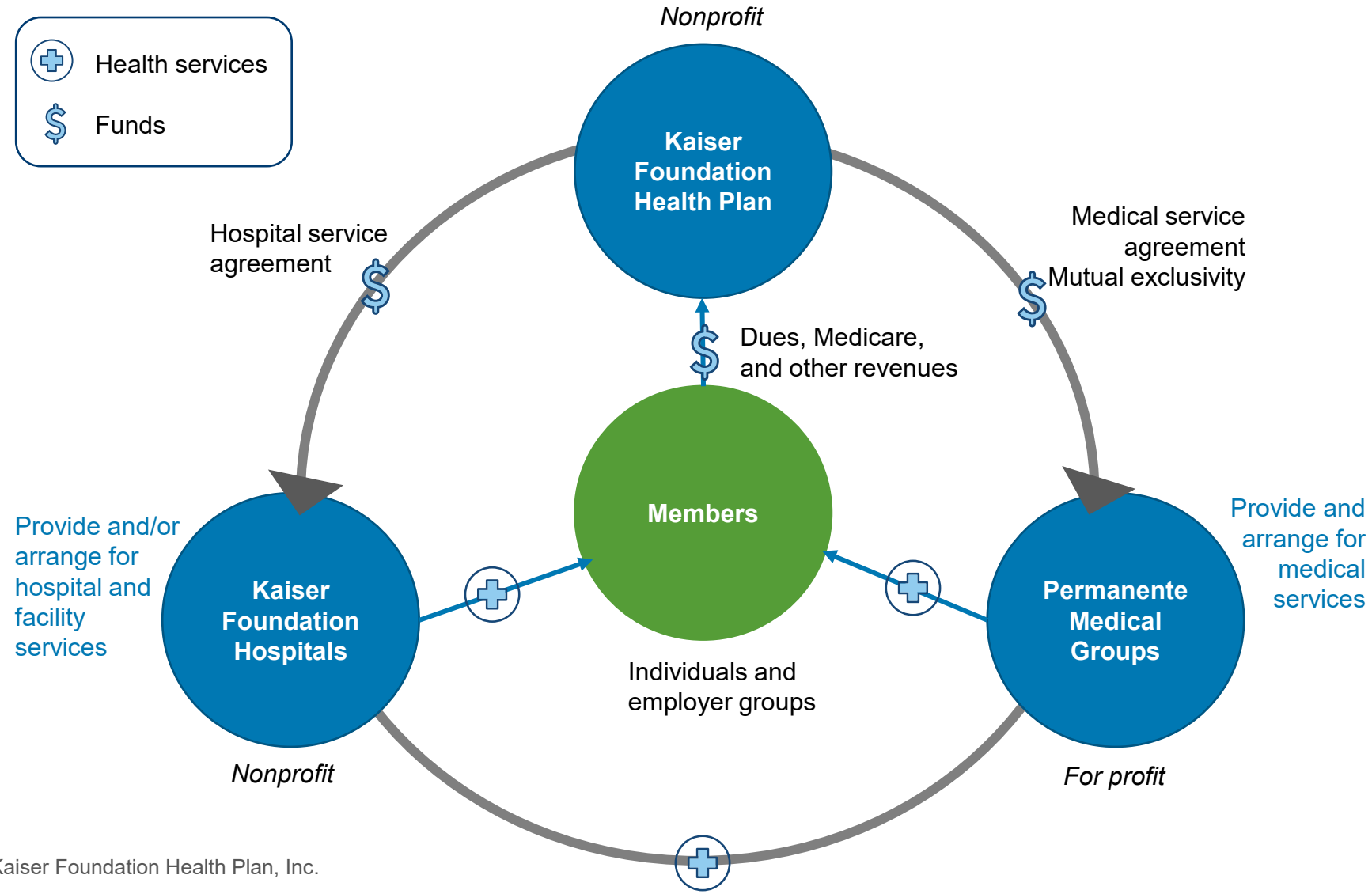
# Kaiser Permanente Locations and Membership




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

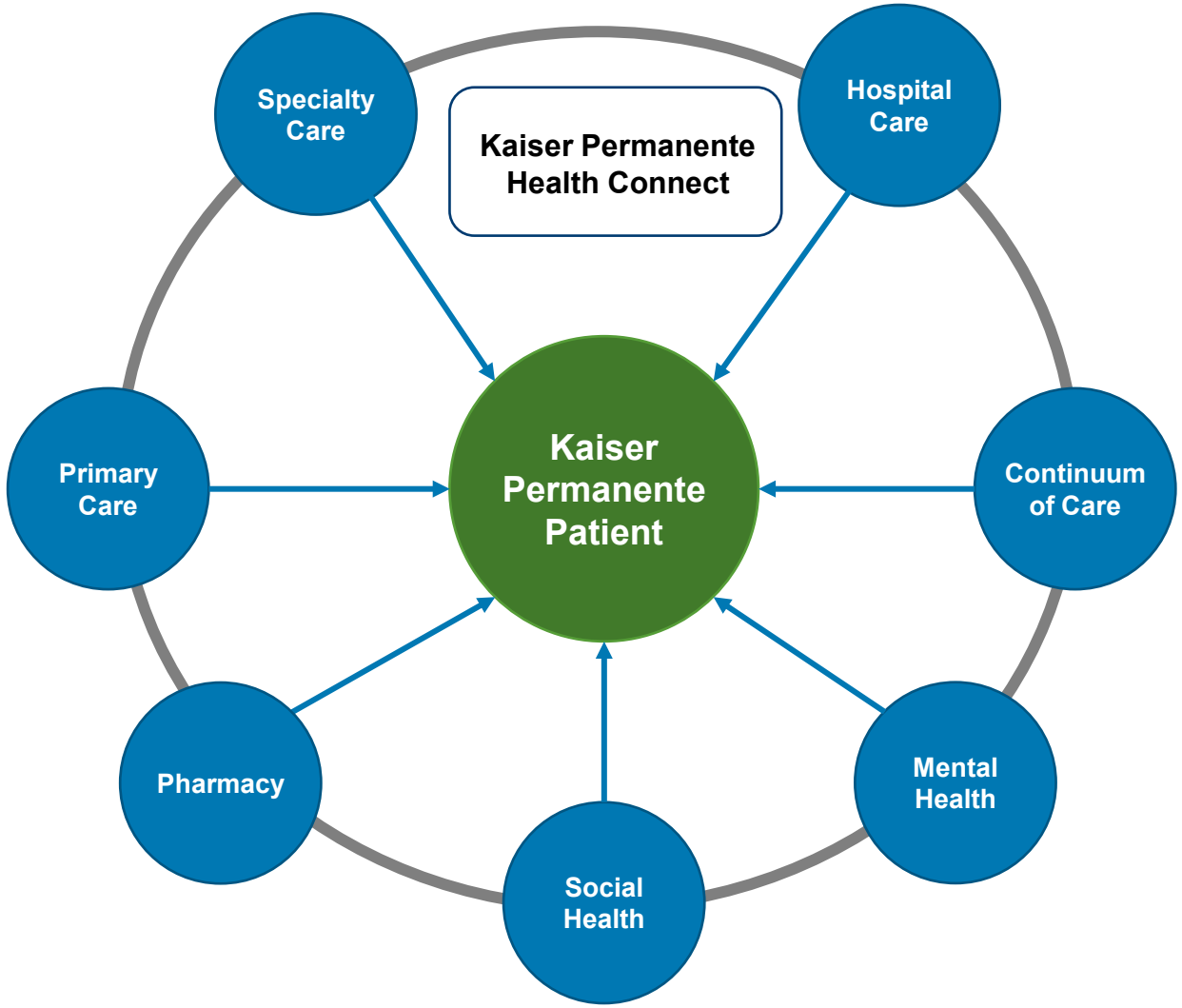
 

# Integrated Care and Coverage



# 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:

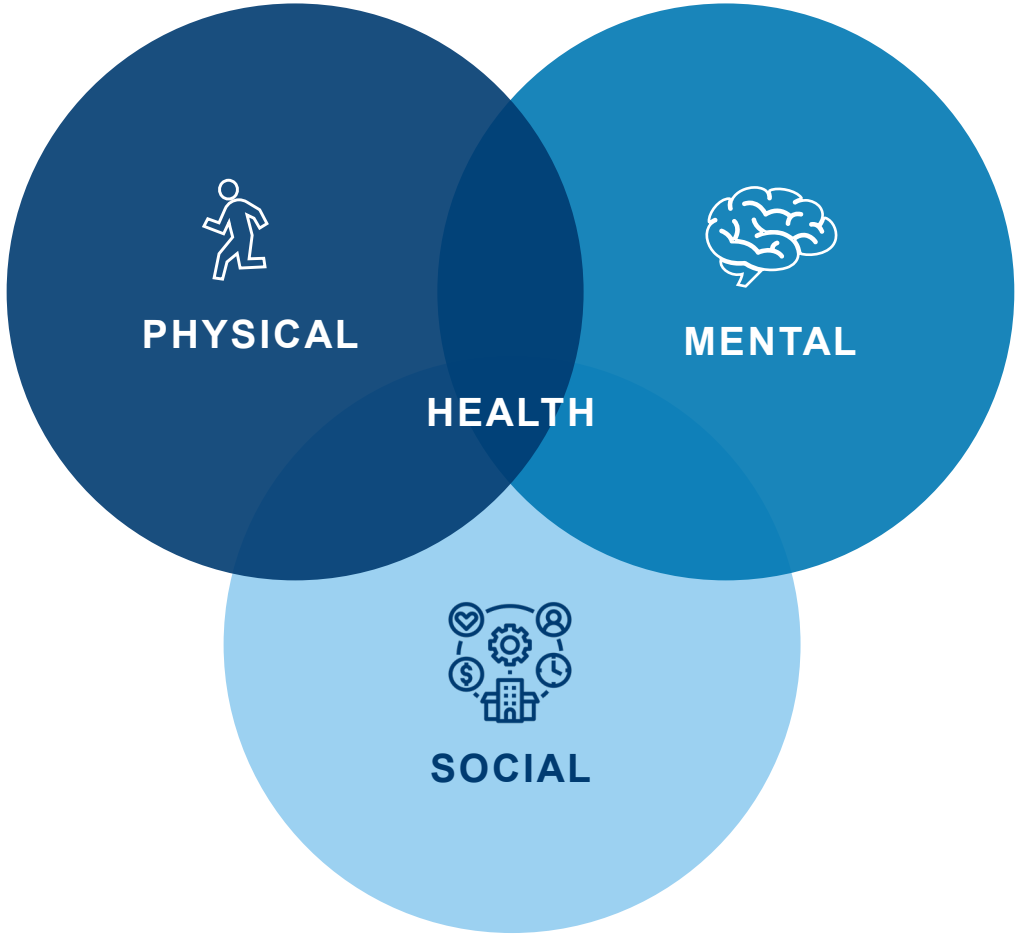
- Health plan global payments
- Patient Cost share payments
- FFS payments from self-funded/ERISA employers

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

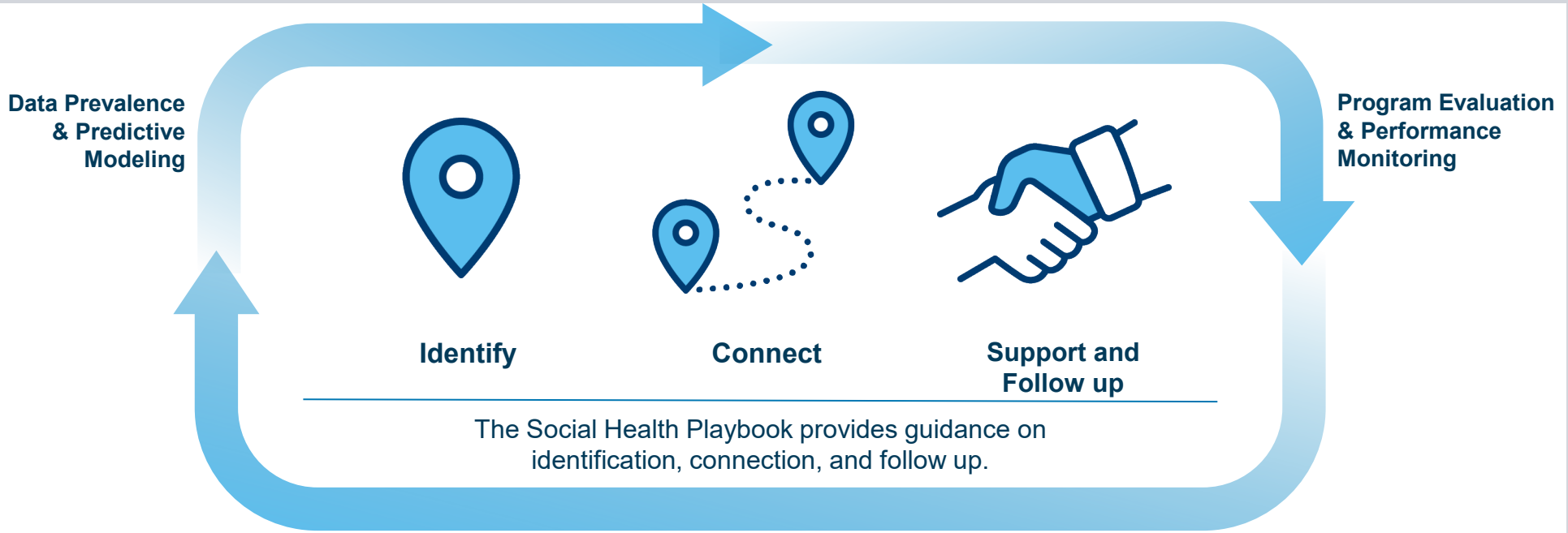
Kaiser Permanente is elevating the social health of our members and communities to the **same level as physical and mental health**.




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.)

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# 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.

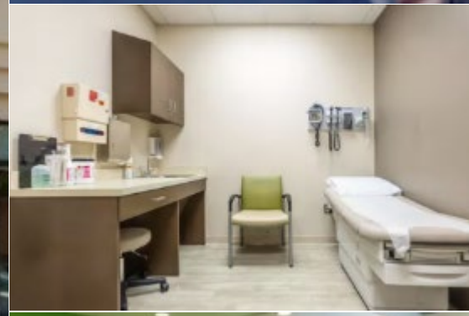
**SafeLink** *Digital Equity*

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:

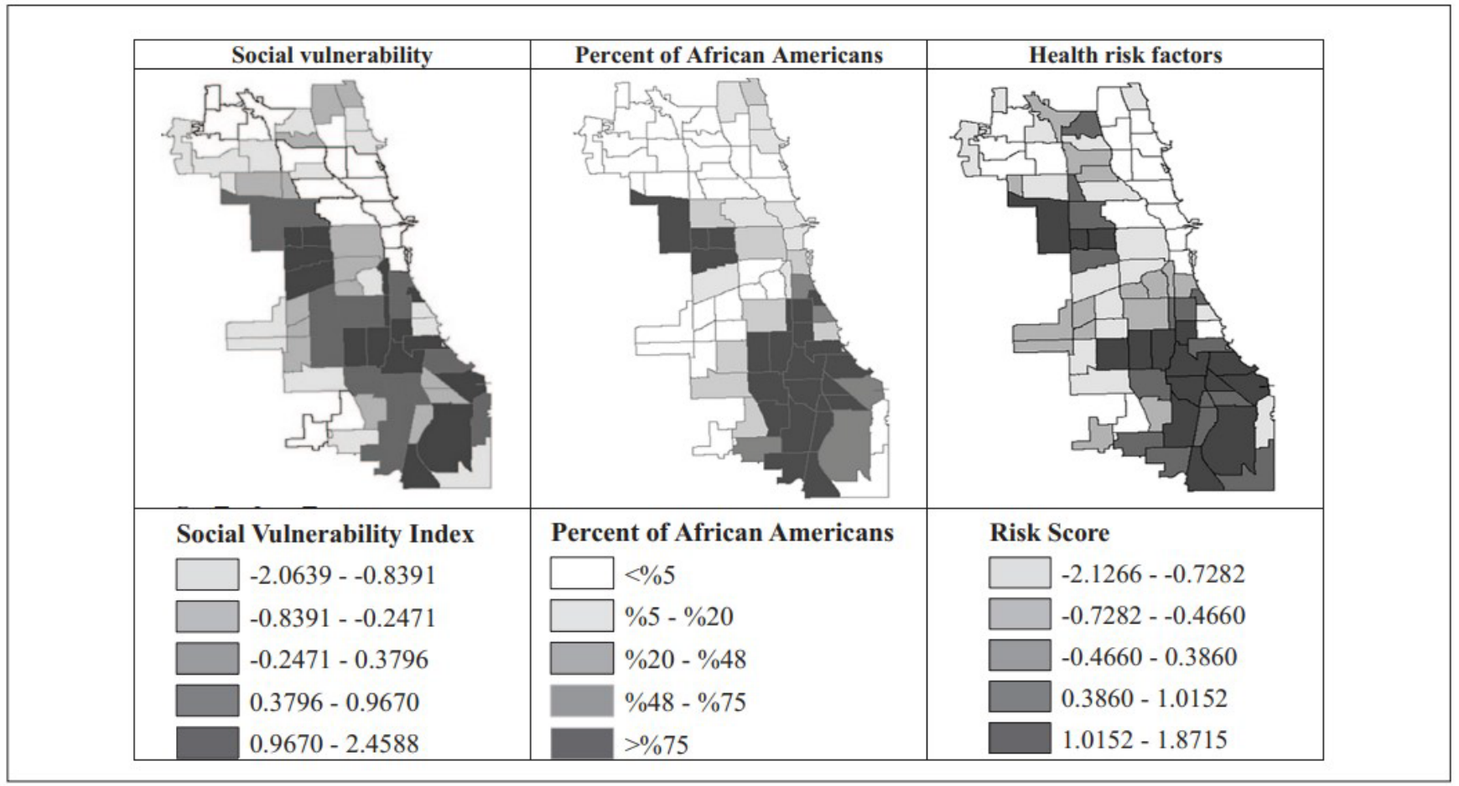



**Figure 2.** The spatial distributions of social vulnerability, health risk factors, and the percentage of African American residents in Chicago Community Areas.
*Note.* Social vulnerability index ranged from −2.0640 to 2.4859; Risk Score ranged from −2.1266 to 1.8715.

**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**

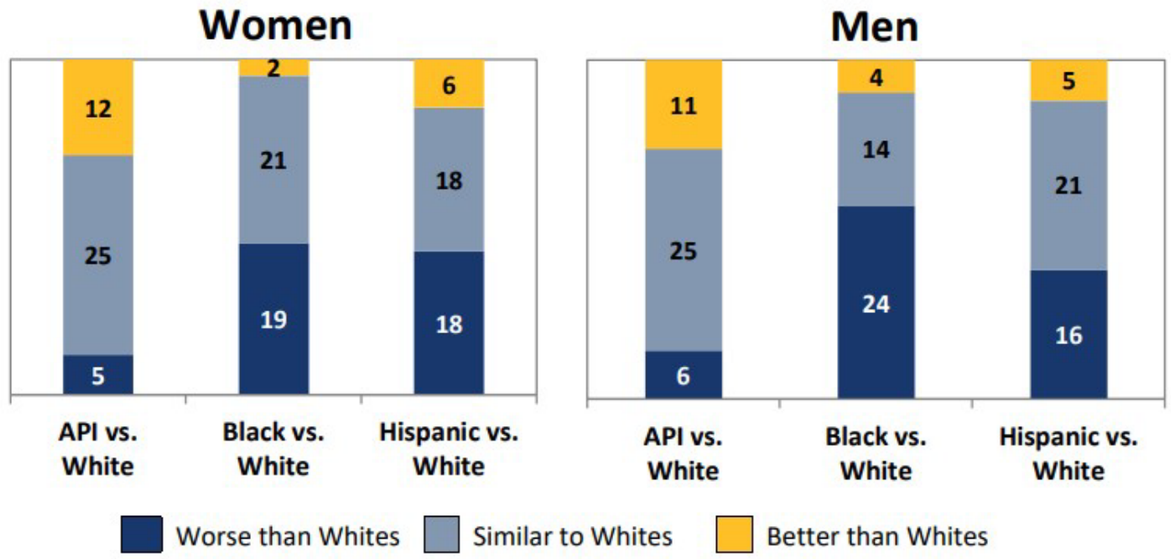
Rate of Black American hospitalizations for COVID-19, relative to population size

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

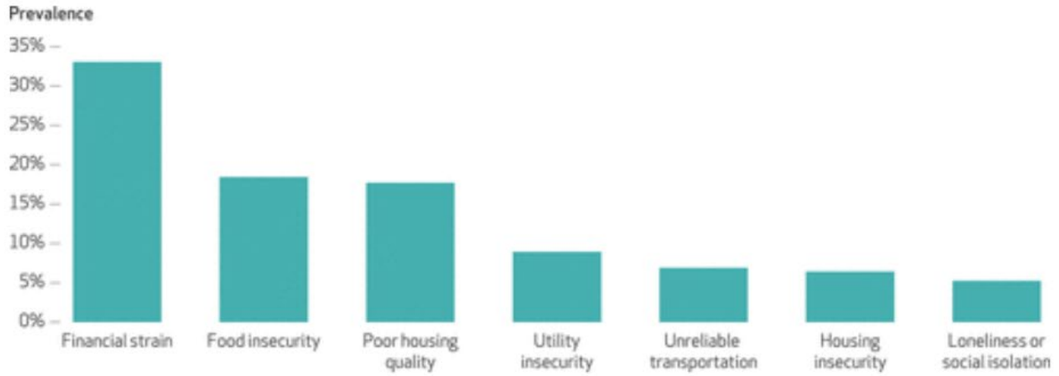
**>50%** of patients identify as African American, Latino, or Indigenous

**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

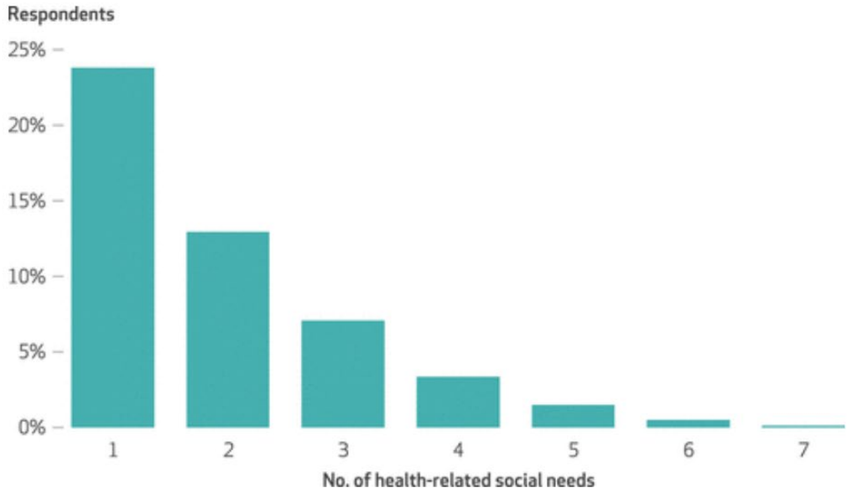
**Exhibit 1** Prevalence of health-related social needs among older adults enrolled in Medicare Advantage, 2019–20




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.

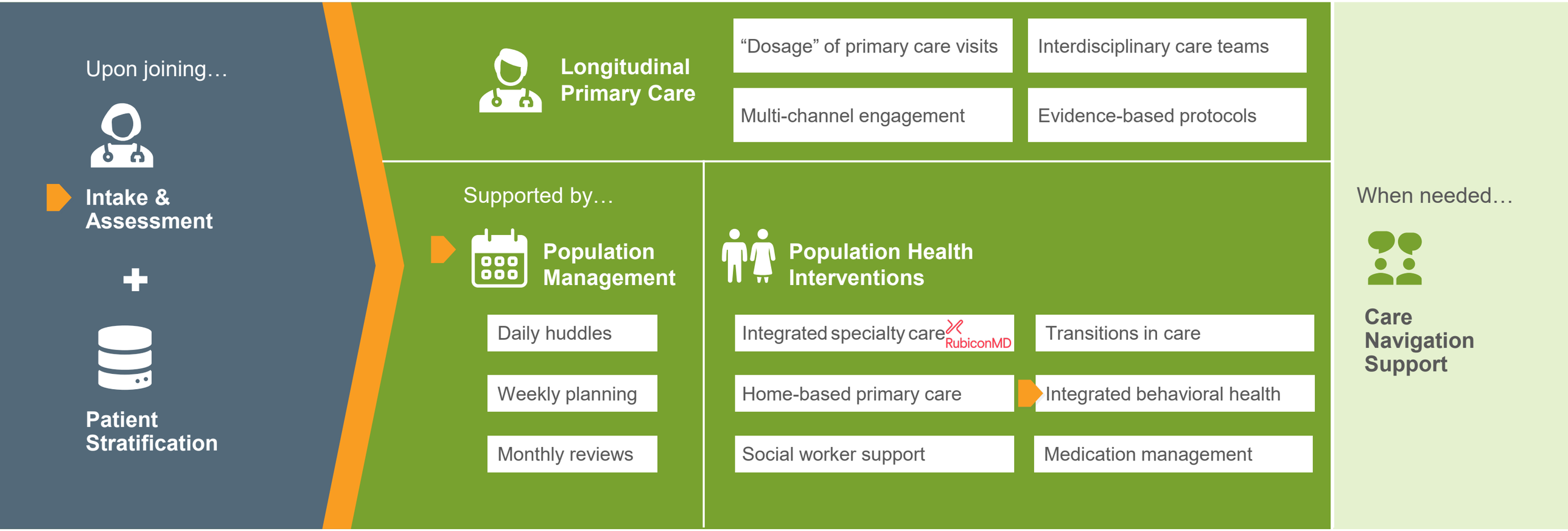
# Value-based models invest upfront to keep patients happy, healthy, and out of the hospital

| Challenges in Primary Care Settings | Fee For Service | Value-Based Practices (Medicare, Medicaid) |
|---|---|---|
| **Not enough time with patients** | **2,000+**<br>Avg doctor panel[1] | **~400-800**<br>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**<br>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**<br>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




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

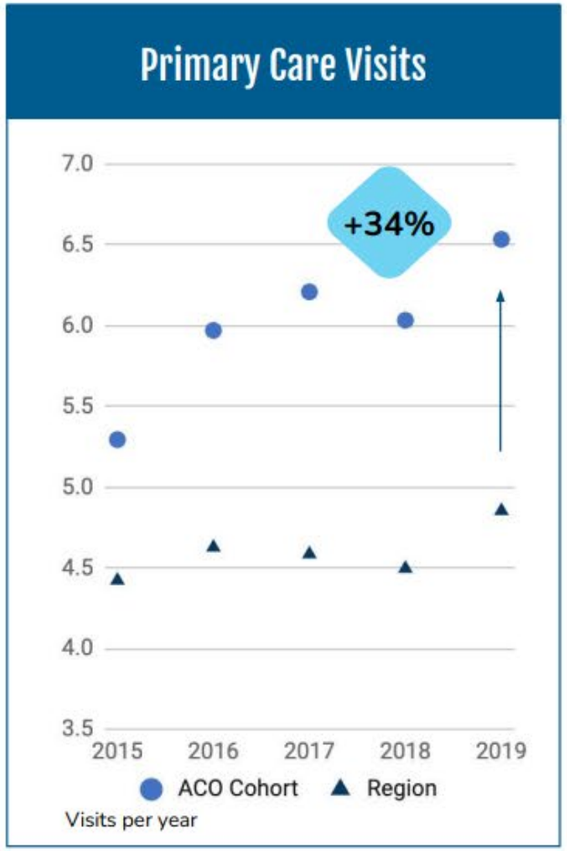
**43%**

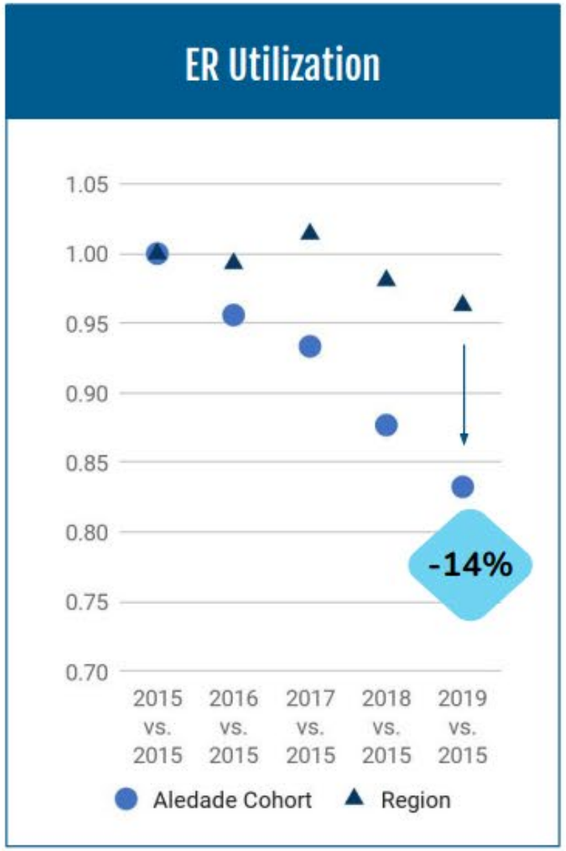
OSH patients seeing a significant reduction in depressive symptoms through Oak Street collaborative behavioral health care model[2]

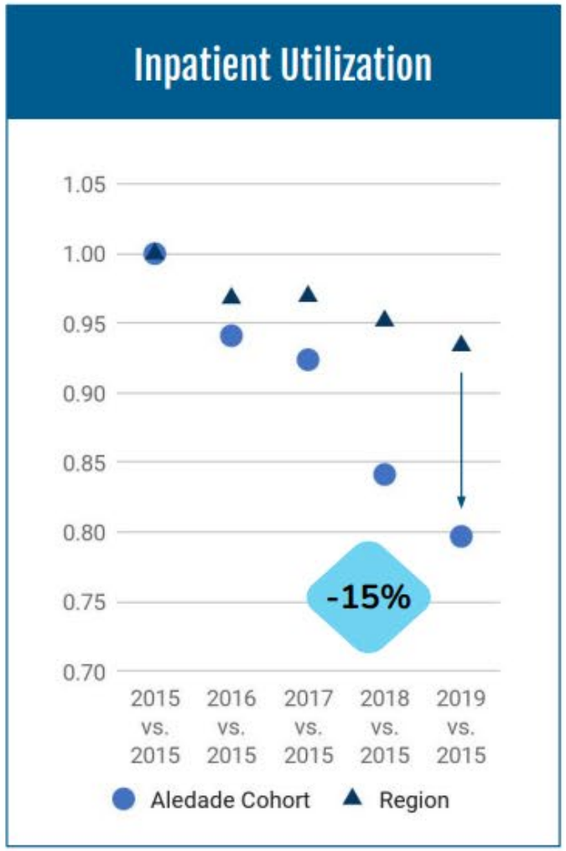
vs 19% of patients in traditional behavioral health care model[3]

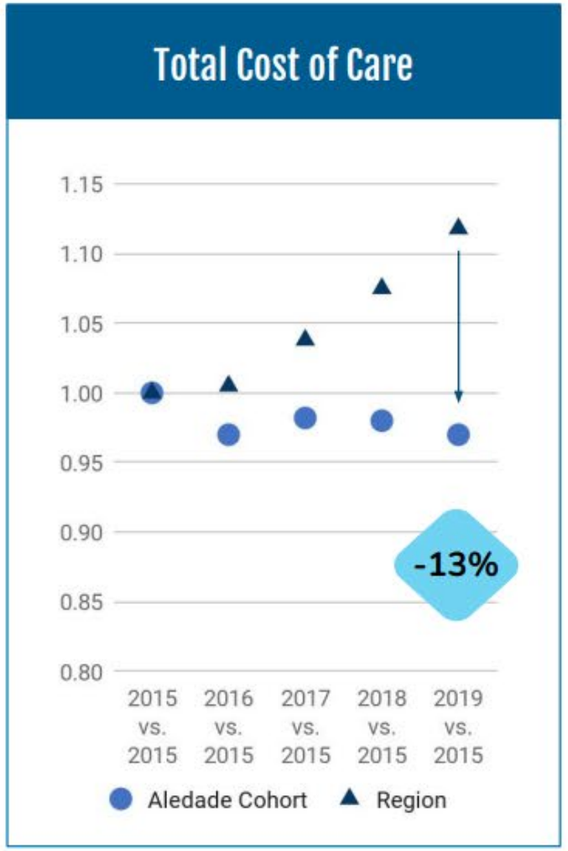
1. National Alliance on Mental Illness, 2020 data
2.Oak Street Health patient data following 6-month study, May 2021
3 JAMA 2002, "Collaborative Care Management of late-life depression in the primary care setting"; Primary Care: Clinics in Office Practice 2012

# 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%**

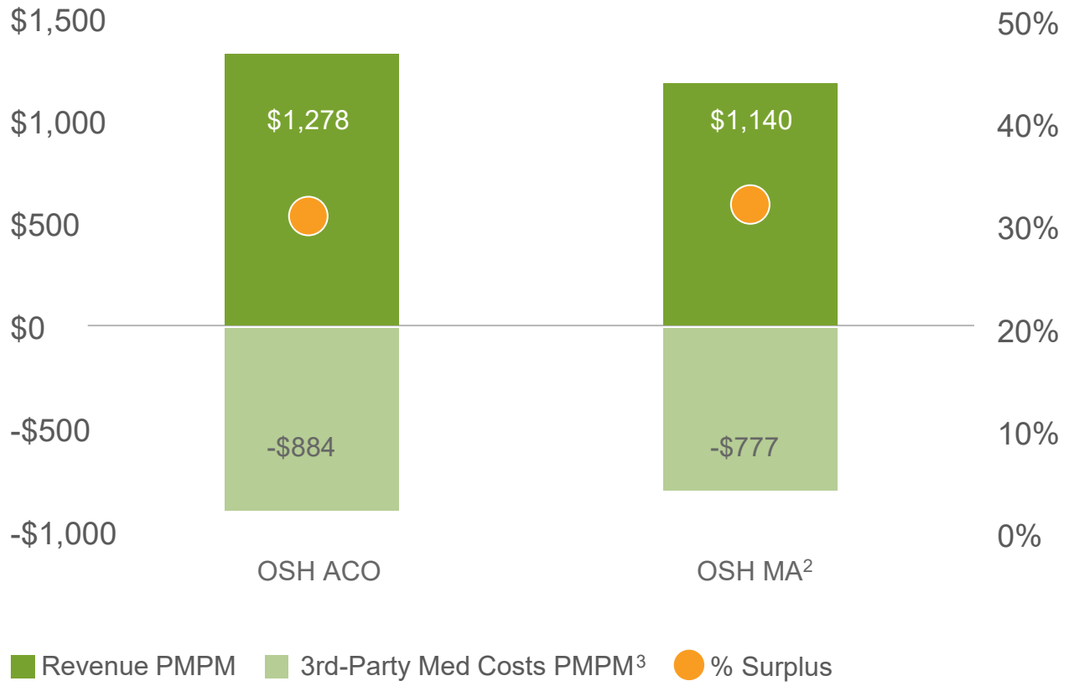
Savings rate compared to 4% average

**IL, MI, IN**

Only ACO in the top 10 to operate in these states

**~$1.2K**

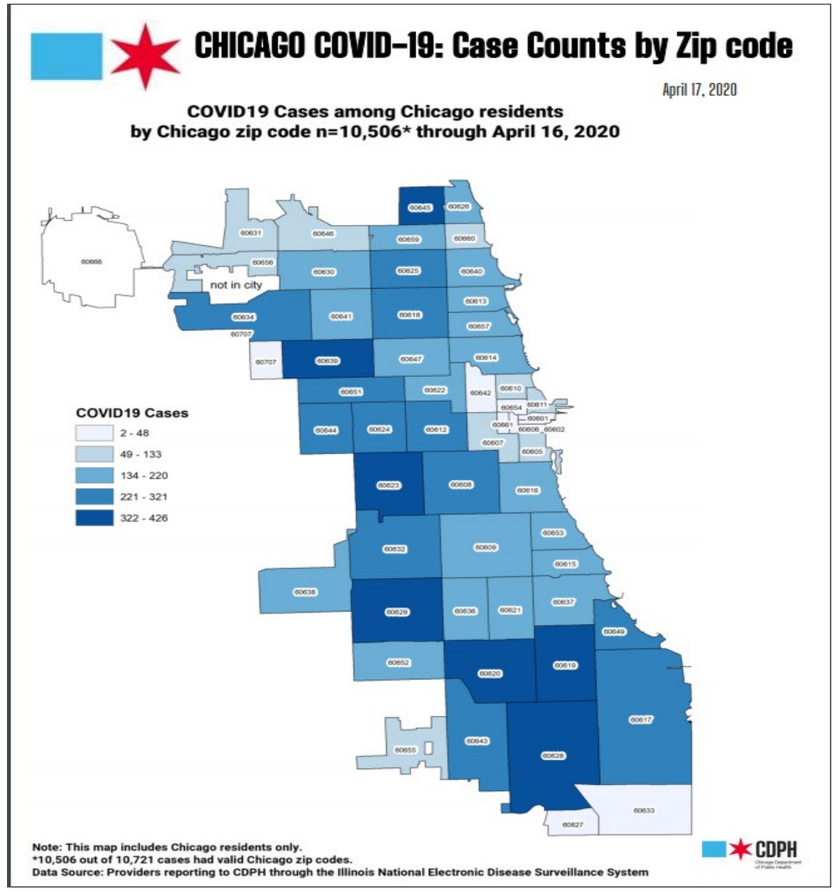
Average annual taxpayer savings per patient vs CMS target[4]

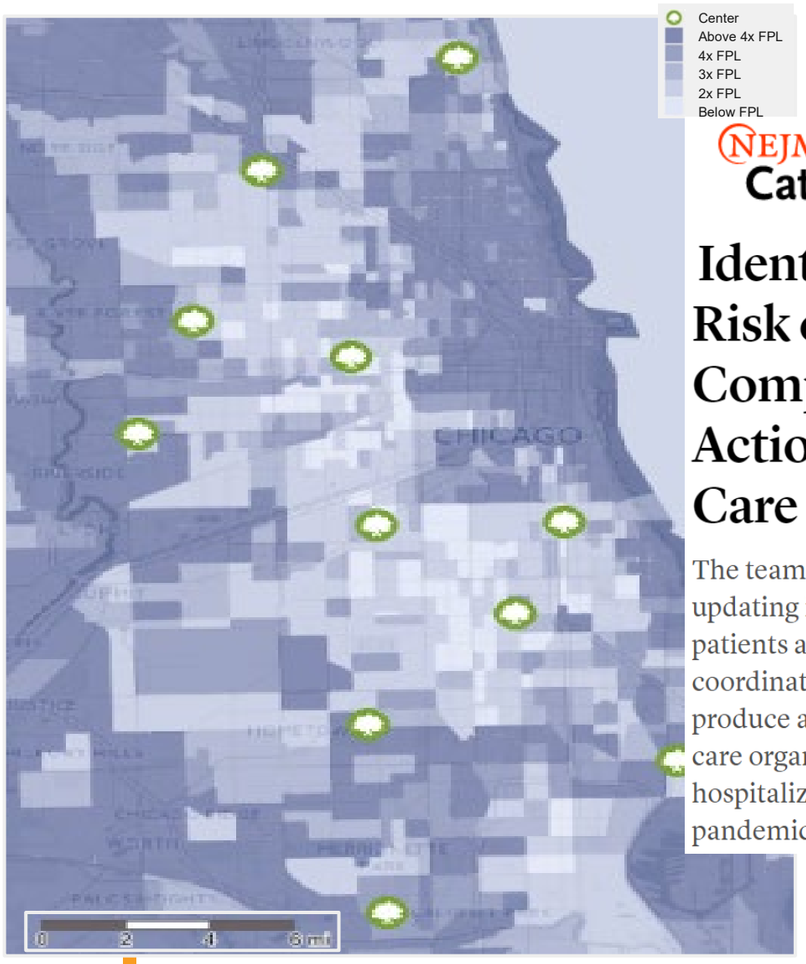



**Value-based care models produce consistent results across both MA and ACO populations**

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

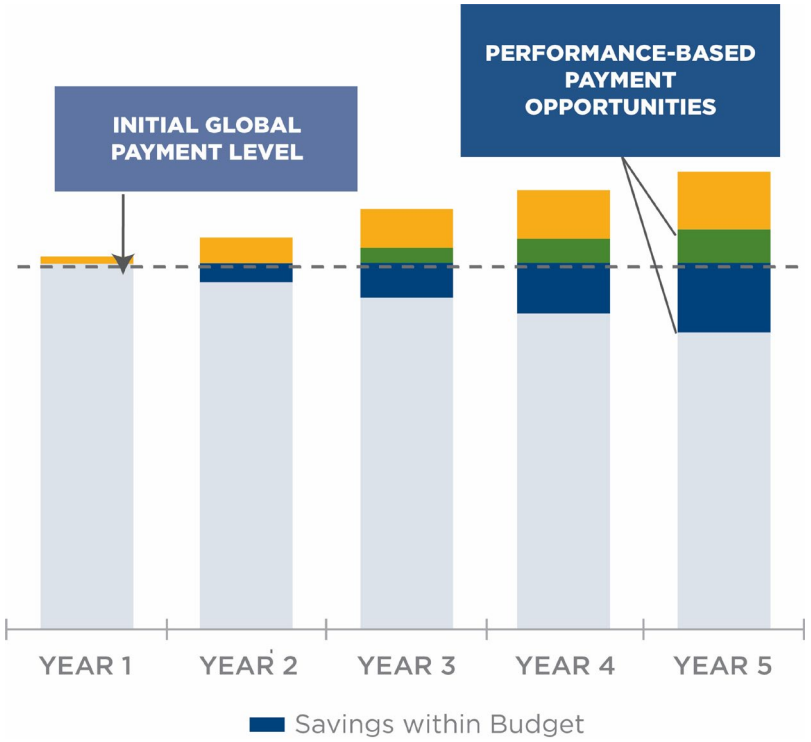
7 June 2022
Physician-Focused Payment Model Technical Advisory Committee

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



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# AQC Measure Set for Performance Incentives (2007)

| | AMBULATORY | HOSPITAL |
|---|---|---|
| **PROCESS** | • Preventive screenings<br>• Acute care management<br>• Chronic care management<br>  • Depression<br>  • Diabetes<br>  • Cardiovascular disease | • Evidence-based care elements for:<br>  • Heart attack (AMI)<br>  • Heart failure (CHF)<br>  • Pneumonia<br>  • Surgical infection prevention |
| **OUTCOME** | • Control of chronic conditions<br>  • Diabetes<br>  • Cardiovascular disease<br>  • Hypertension<br>******Triple weighted****** | • Post-operative complications<br>• Hospital-acquired infections<br>• Obstetrical injury<br>• Mortality (condition –specific) |
| **PATIENT EXPERIENCE** | • Access, Integration<br>• Communication, Whole-person care | • Discharge quality, Staff responsiveness<br>• Communication (MDs, RNs) |
| **EMERGING** | Up to 3 measures on priority topics for which measures lacking | |

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# Performance Payment Model: Original

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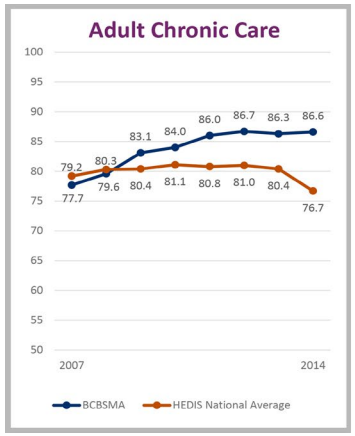
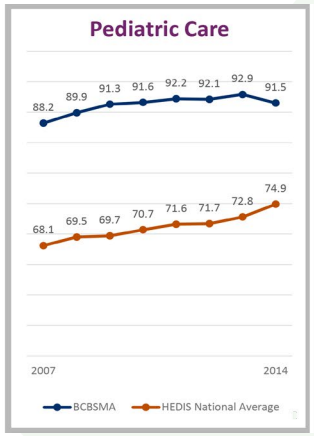
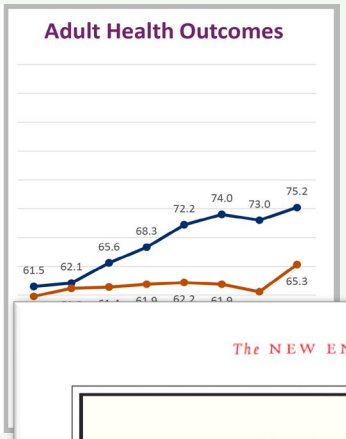
# Improved Quality, Outcomes & Affordability: BCBSMA AQC Catalyzes US Payment Reform

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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.

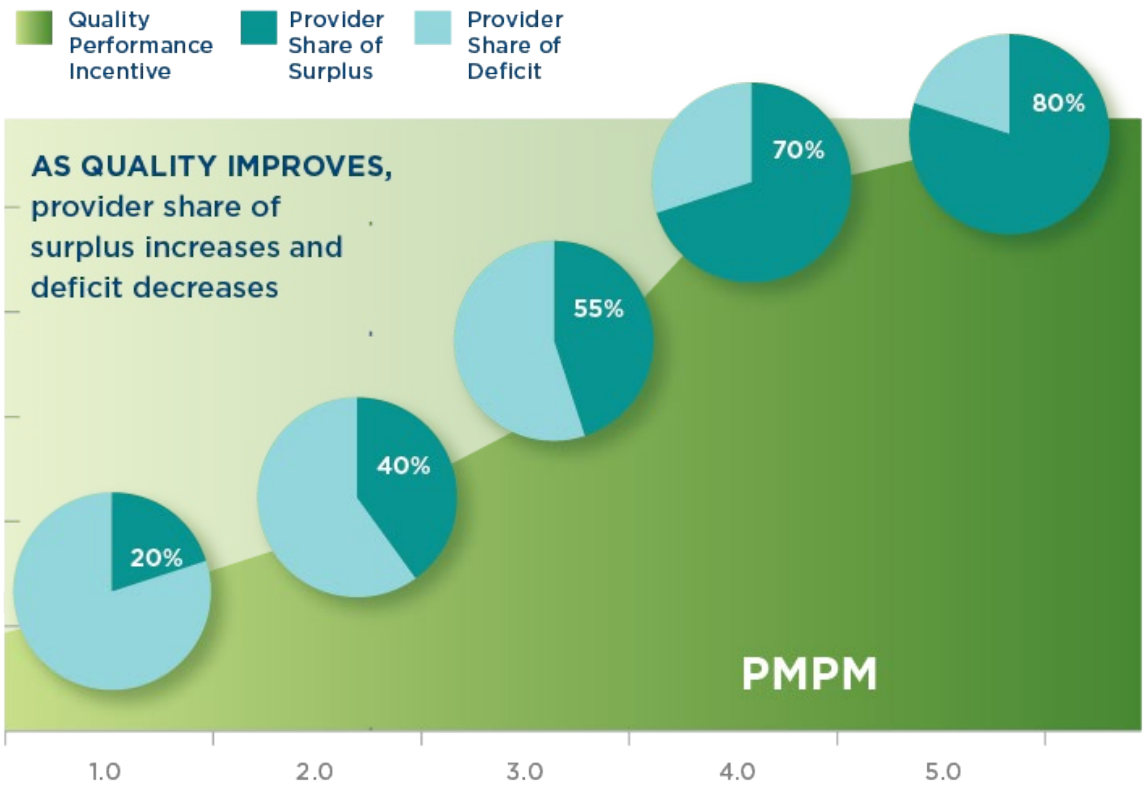
# Performance Payment Model: Updated (2011)

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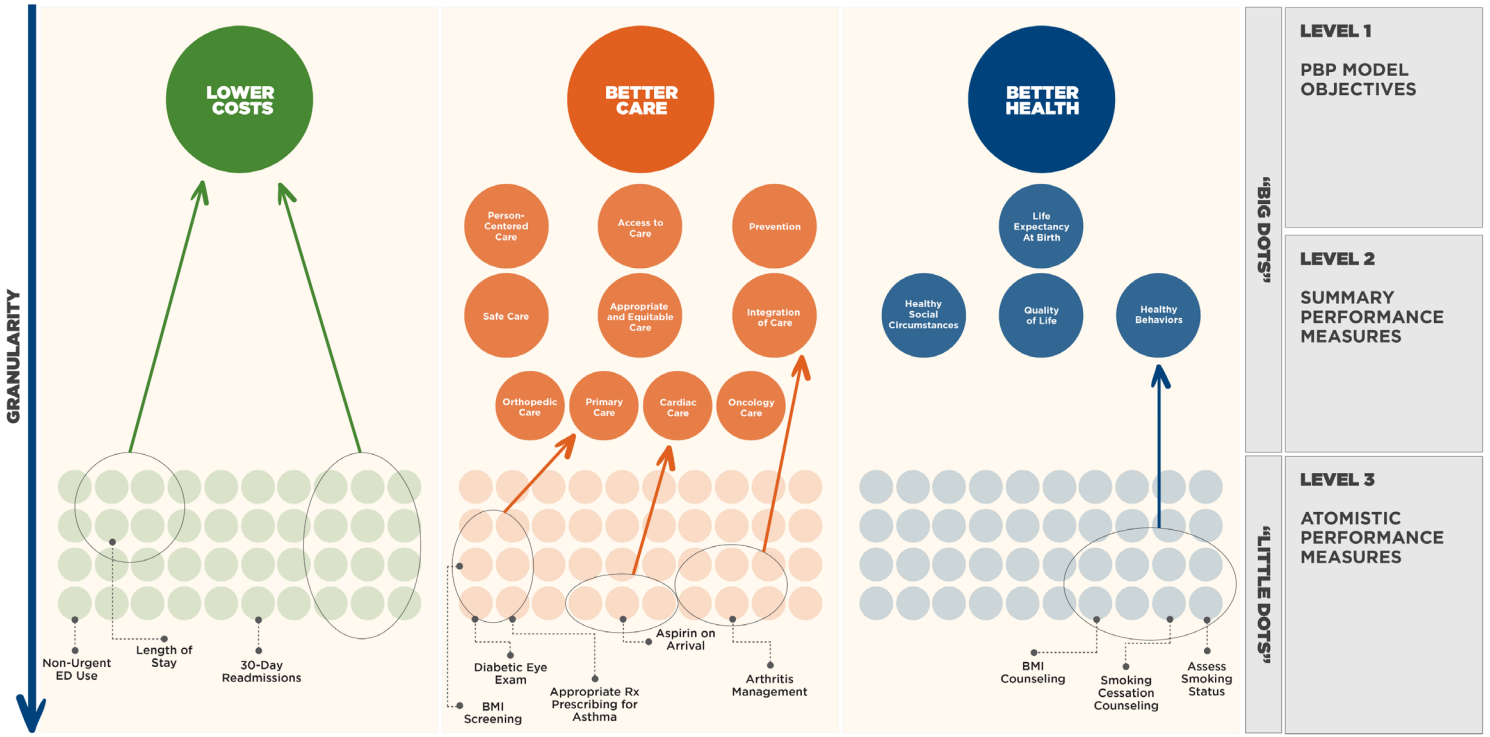
# Moving to "Big Dot" Measurement for Alternative Payment Models (APMs)

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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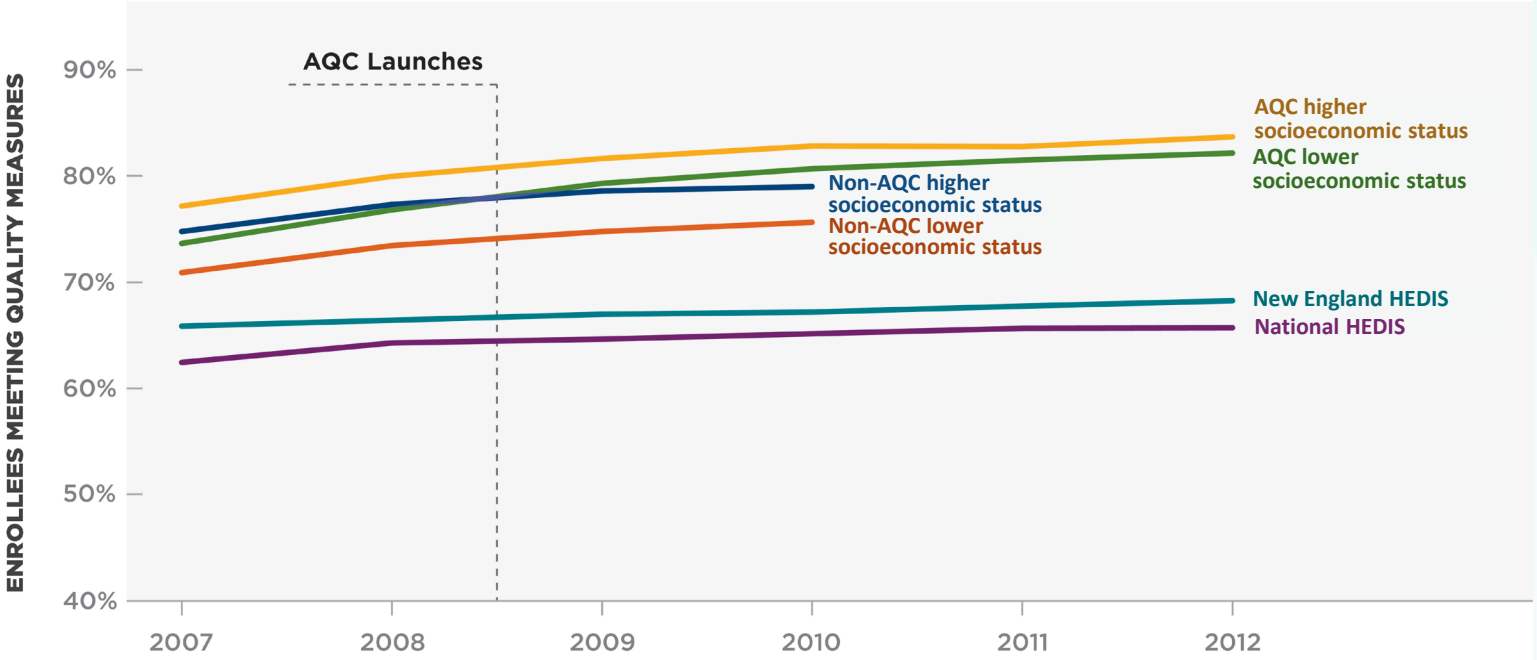
## EXHIBIT 1

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<br>• Modify risk factors | • Modify risk factors<br>• Slow CKD progression<br>• Treat complications | Ongoing Care, Plus:<br>• Transplant Prep<br>• Dialysis Prep<br>• QOL discussions | + optimal start<br>+ home dialysis<br>+ transplant<br>+ 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)<br>• 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)<br>• A clear set of CPT-labeled services and ICD-10 codes (stages of CKD) |
| Measurable and cost-effective treatments/outcomes | - Risk Factor Modification<br>- Transplant<br>- Dialysis Education/Preparation<br>- Palliative Care |
| Reasonable attribution | • Attribution through claims<br>• Claims can be used to identify associated services and the timing of services<br>• 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<br>• Reduce costs of caring for kidney patients |
| Patients<br>*and Care Givers* | • Incentivize to participate and engage in the program<br>• 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<br>• Reward processes AND outcomes of care - measures specific to kidney disease<br>• Achievable quality benchmarks and moderate discounts to attract broader participation<br>• Quality bonuses for addressing healthcare disparities |
| Nephrology Practices | • Allow time, resources, and personnel to embrace data-driven and non-RVU care<br>• Allow time to partner with other providers<br>• Flexible risk-sharing opportunities |
| Kidney Care Companies | • Reward process and outcome of value-based arrangement performance<br>• Safe harbors to partner with referral sources and offer variable shared-risk<br>• Time to develop data tools and interoperability |
| Other Specialties<br>and Health Systems | • Safe harbors to improve focus on the subset of kidney-specific procedures and patients<br>• 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<br>• Moderate Risk<br>• Minimal up-front investment<br>• Simplified reporting and accountability burdens | • Meaningful Reward<br>• Meaningful Risk<br>• Larger initial and on-going investment<br>• Time for contract and IT development | • Some Reward<br>• Limited additional risk<br>• Minimal investment<br>• *Interoperability is critical* | • Understands the benefits of participating<br>• 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<br>• 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