Physician-Focused Payment Model Technical Advisory Committee

Listening Session 1: *Organizational Structure, Payment, and Financial Incentives for Supporting Accountable Care Relationships*

Presenters:

Subject Matter Experts

- **Alice Jeng-Yun Chen, PhD, MBA** – Vice Dean for Research and Associate Professor, University of Southern California
- **Michael C. Meng, MBA** – Chief Executive Officer and Co-Founder, Stellar Health
- **Steven P. Furr, MD, FAAFP** – President, American Academy of Family Physicians – (Previous Submitter – *APC-APM – Advanced Primary Care: A Foundational Alternative Payment Model for Delivering Patient-Centered, Longitudinal, and Coordinated Care* proposal)
- **Jenny Reed, MSW** – Senior Executive Officer, Southwestern Health Resources

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Vice Dean for Research and Associate Professor, University of Southern California

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Payment and Incentives for Value-Based Care in Integrated Delivery Systems

Alice Chen, PhD, MBA
Associate Professor and Vice Dean for Research
University of Southern California
September 17, 2024

Incentive Landscape That Providers Face

Relative attractiveness of FFS versus APMs has changed over time

Physician FFS rates have been decreasing annually

- Cumulative fee reduction by 7.8% between 2021 and 2024
- Proposed fee reduction of 2.8% for 2025

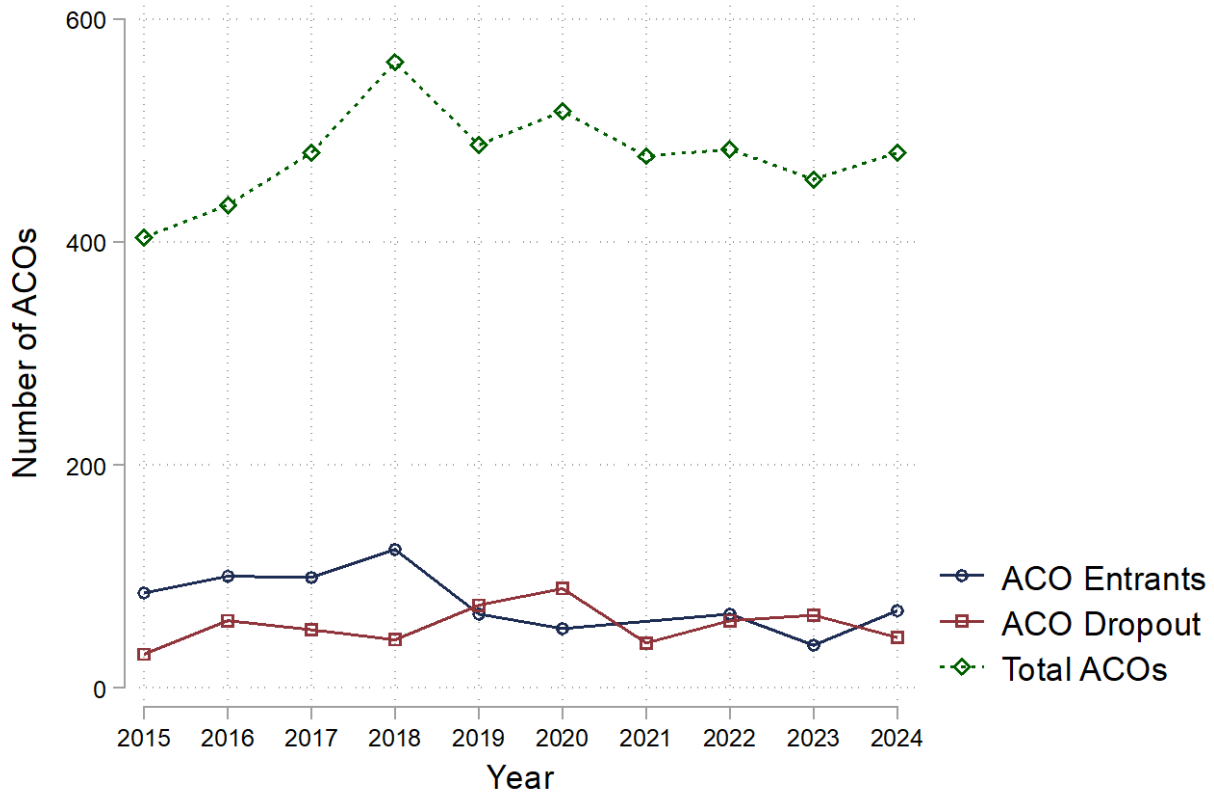
But bonuses to join APMs have also decreased

- Participation bonuses were 5% of professional fees in PY 2017-2022
- In PY 2024, they were 1.8%; 0% thereafter

- In PY 25 onward: APM providers will receive 0.75% fee schedule update (whereas non-qualifying providers receive 0.25% fee update)

Participation in Medicare Shared Savings Program

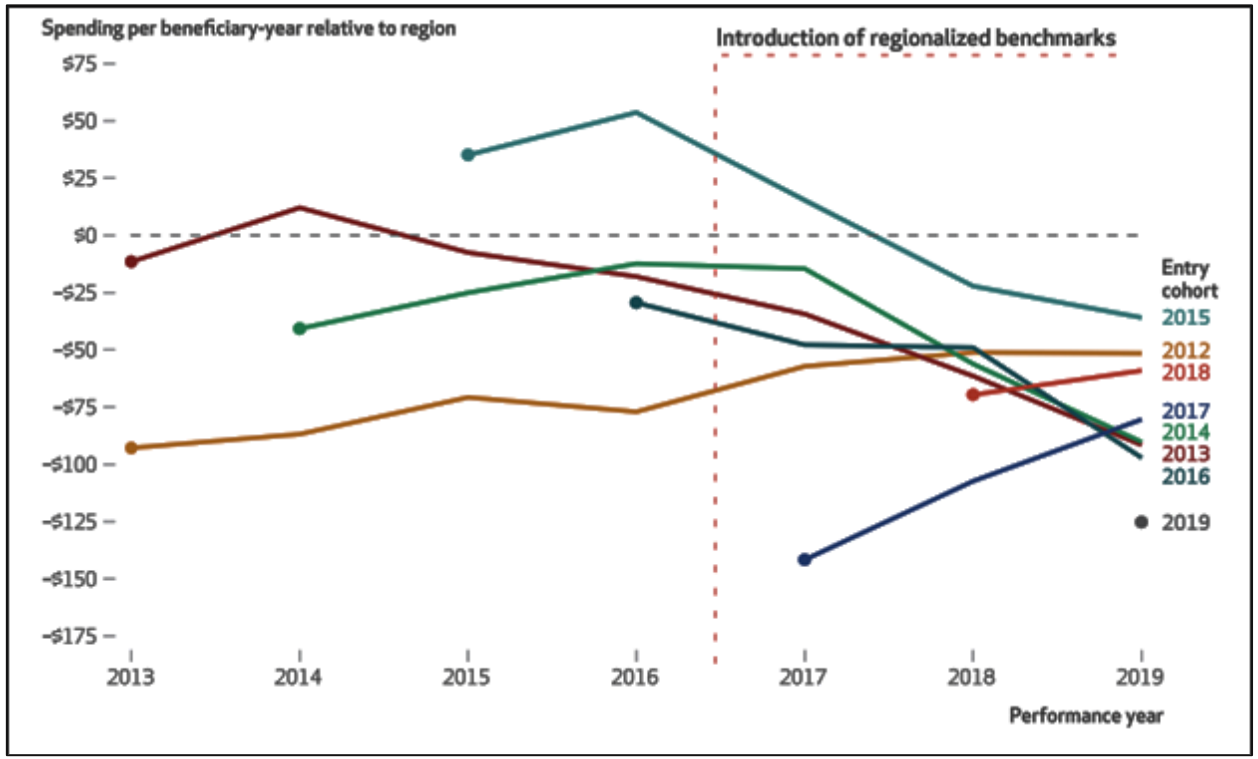
Since Pathways to Success in 2019, total ACO participation has remained relatively flat



Data from CMS ACO Participation Information 2014-2024.

Participation Has Been Selective

Participation has been skewed towards ACOs with lower baseline spending



- But ACOs with high risk-adjusted spending have lowered spending MORE than ACOs that began with low spending
- It is efficient for high-spending ACOs to participate

Taken from: Lyu, PF, ME Chernew, and JM McWilliams. Benchmark Changes and Selective Participation in The Medicare Shared Savings Program. *Health Affairs* 2023, 42(5):622-631.

How Do We Encourage More Provider Participation?

Many new changes to MSSP ACO benchmarks will help

Incorporated a prior savings adjustment

- Mitigates rebasing ratchet effect
- Accounts for ACOs' contributions in lowering regional spending

Added an administrative component in benchmark growth

- Ensure a gap ("wedge") between FFS expenditures and ACO savings

Limited benchmark reductions due to regional blending

- Cap adjustments at -1.5% of national national per capita expenditures
- Reduce negative adjustment as number of duals and beneficiary risk increases

Policy Roadmap for Benchmarks

But is the three-way blend sufficient to incentivize entry and reduce dropout?

- **Initial benchmark**: ACO's own historical spending
- **Regional convergence phase:** Update annually at projected rate of FFS – savings rate which varies with spending relative to region
  - Transition should be gradual, particularly for ACOs with high spending (e.g., increase weight on administrative component to 50%) (Chen and McWilliams, forthcoming)
- **Annual updates post-convergence:** a combination of (a) risk-adjusted regional rate and a benchmark bump and (b) an administrative trend (McWilliams, Chen, and Chernew, 2021)

What Else Can Be Done?

Other financial levers can be pulled to further encourage participation

Make non-participation less attractive	Make participation more attractive
• Site-neutral payments to hospital outpatient facilities that do not participate • Non-participants cannot participate in 340B drug-pricing	• Extend and restructure APM incentive payments • Increase shared savings rate

How to Boost Participation Among Smaller Organizations

Smaller, low-revenue ACOs require additional participation incentives

- **Recently implemented changes**
  - Lowered capital reserve requirement to participate
  - Advanced investment ($250k) payments for low-revenue, inexperienced ACOs
  - Extended the on-ramp to downside risk – Level A for 5-7 years

- **Next steps**
  - Create a track that include only primary care spending in risk contract with capitation for small groups (e.g., PCP practices)
  - Allow one-sided risk groups to receive *some* participation bonuses
  - Cap losses using total revenues instead of total benchmark for low-revenue ACOs
  - Allow all historically successful ACOs to access prepaid shared savings

Other Programmatic Considerations

Various additional factors will affect participation and ACO success

- **Risk Adjustment:** Same approach as used in MA; suffers from gaming through coding and insufficient adjustment from status-quo spending
- **Financial Incentive for Beneficiaries:** Beneficiary participation will improve an ACO's ability to change care (e.g., allow ACOs to pay beneficiaries when seeing an ACO provider; waive Part B cost-sharing)
- **Financial Incentive for Physicians:** While restructuring physician financial incentives will undoubtedly help, note that organizational norms can (and do) affect physician behavior (e.g., Chen, Richards, and Shriver 2024)

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Appendix

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Chen, AJ and JM McWilliams. How Benchmarks Affect Participation in Accountable Care Organizations: Prospects for Voluntary Payment Models. *American Journal of Health Economics,* forthcoming.

McWilliams JM, A Chen and ME Chernew. From Vision to Design in Advancing Medicare Payment Reform: A Blueprint for Population-based Payments. *USC-Schaeffer Brookings Working Paper,* 2021.

Lyu, PF, ME Chernew, and JM McWilliams. Benchmark Changes and Selective Participation in The Medicare Shared Savings Program. *Health Affairs* 2023, 42(5):622-631

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Michael C. Meng, MBA

Chief Executive Officer and Co-Founder, Stellar Health

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PTAC - Payment and Incentives for Value-Based Care

September 17th, 2024

Michael Meng, Founder & CEO of Stellar Health

- I graduated from the Wharton School in 2012 from their HealthCare Management program
- Spent 10-years at Apax Partners, a large cap global private equity firm where I deployed C$3bn of capital.
- Served on the board of companies including Vyaire Medical, Medicomp, One Call Care Management, TriZetto, and several Physician Groups
- After working in Healthcare from the investor lens I decided I wanted to make more of a change in healthcare and so jumped in and started Stellar Health.

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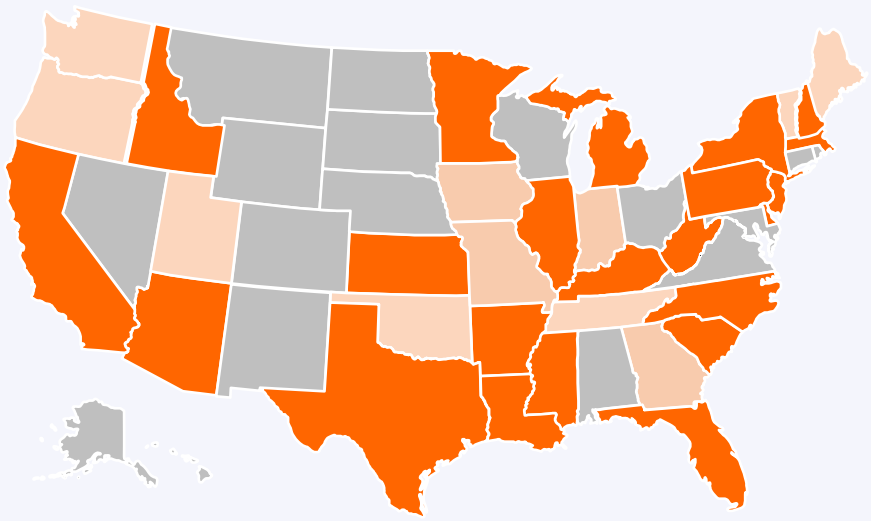


~30 Customers across 37+States

Who is Stellar Health?

Patient Lives

- Signed 167,000 (+45,691)
- Onboarded 1,004,439 (+37,111)

Providers & Medical Groups:

- 13,886 (+494) Providers Onboarded
- 1,816 (+23) Medical Groups Onboarded

Practice Level Impact:

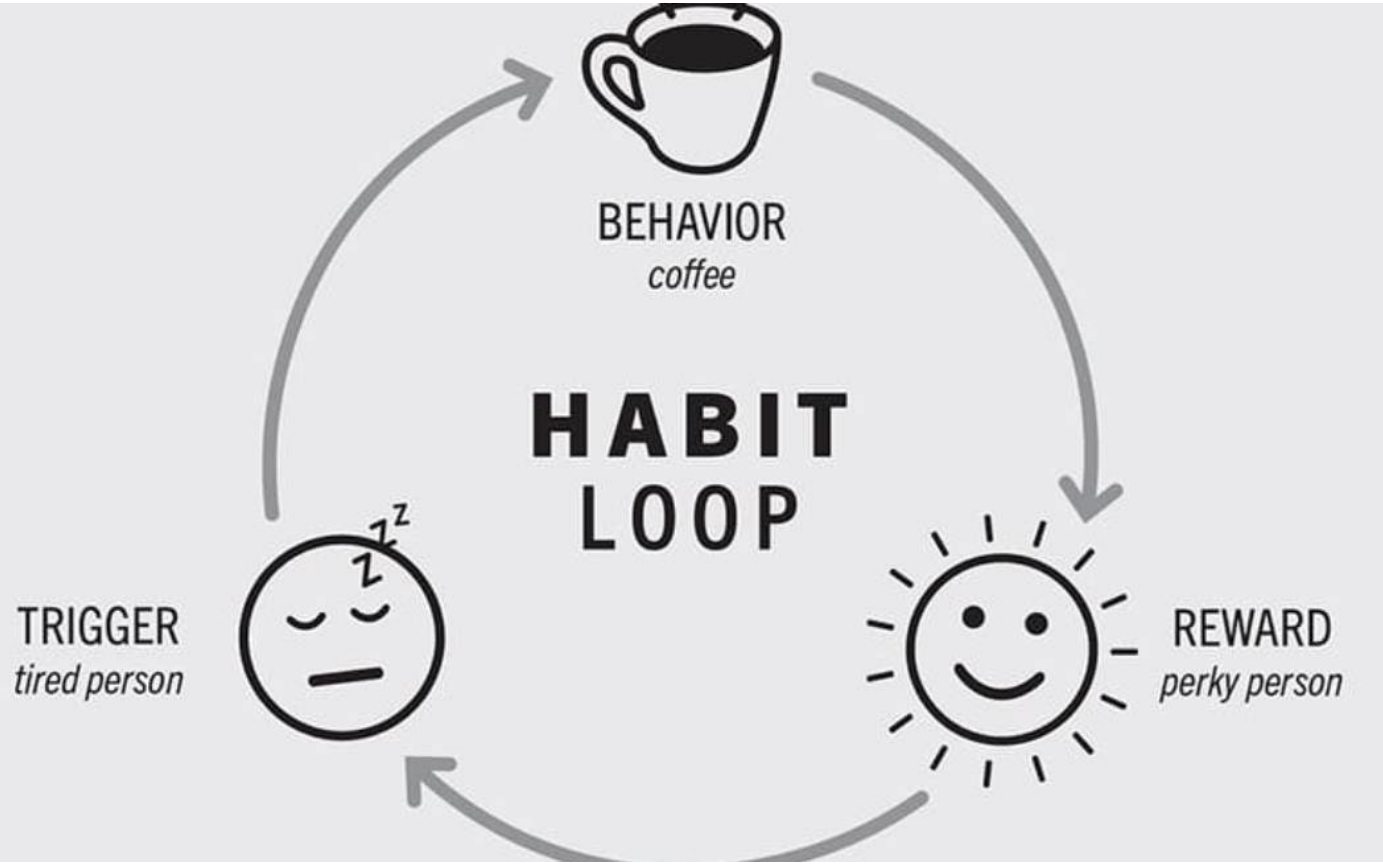
- Earned $15.9M (+$2M) in Stellar Value Units (SVUs)
- Completed 941,538 (+168,848) Healthy Actions

"I wish the remainder of our payers would implement a solution like this-not only does it reward you but also gives you a sense of immediate accomplishment. I just think that's amazing, kudos to whoever built this. I would love nothing more than engaging with other payers in Stellar"

- Quality Program Manager

Feedback & Habit Loops

Positive feedback loops reinforce behaviors by making you feel good after completing an action.



VBC Performance

- Health plan **performance is defined by primary care** workflows
- Improving performance requires **behavior change** at the point of care
- Behavior change requires **real-time incentives** to the people responsible for the work

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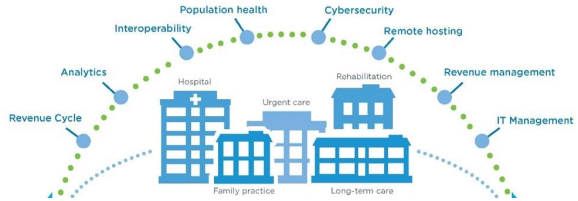
The Importance of Delivering on Value-Based Care

Penetration of Value-Based Care out to Patients is nowhere close to where it needs to be

1. FFS, no VBC Contract in-place

2. Shared Savings or Risk Contract in-place with large groups / systems



3. Risk Contract in-place with the TIN*

P4P with the TIN*

4. Reward for the Attributed (Responsible) Physician

5. Rewards for the Staff who work with the Attributed Physician

VBC Penetration

Importance to delivering on VBC (actual doers of work)

*TIN = Taxpayer Identification Number

The Stellar App - Behavioral Changes and Feedback loops

Stellar's incentive structure empowers providers to be able to spend the extra time needed to take actions that improve MLR*and Quality during the patient visit

PCP addresses acute issue, bills $100 for 15 min. visit, and then rushes to next patient to hit volume target, missing additional value-based actions that could be completed for the patient

Status Quo

Conditions addressed	Insurer receives
J20.9 (Acute Bronchitis)	$0
I10 (Hypertension)	$0
Total	**$0**

$100 RVU*

VS.

Stellar Health

Conditions addressed	Insurer receives
J20.9 (Acute Bronchitis)	$0
I10 (Hypertension)	$0
E11.40 (Diab w/ Comp.)	$501[1]
I50.9 (CHF)	$509[1]
Need Mammogram	$150[2]
Need Diabetic Eye Exam	$150[2]
Total	**$1,309**

$100 RVU*

$150 SVU™

1. *Incremental value driven by the marginal extra diagnoses.*
2. *Incremental value driven on Quality measures based on specific Star movements.*

Stellar prompts primary care team to complete value-based actions

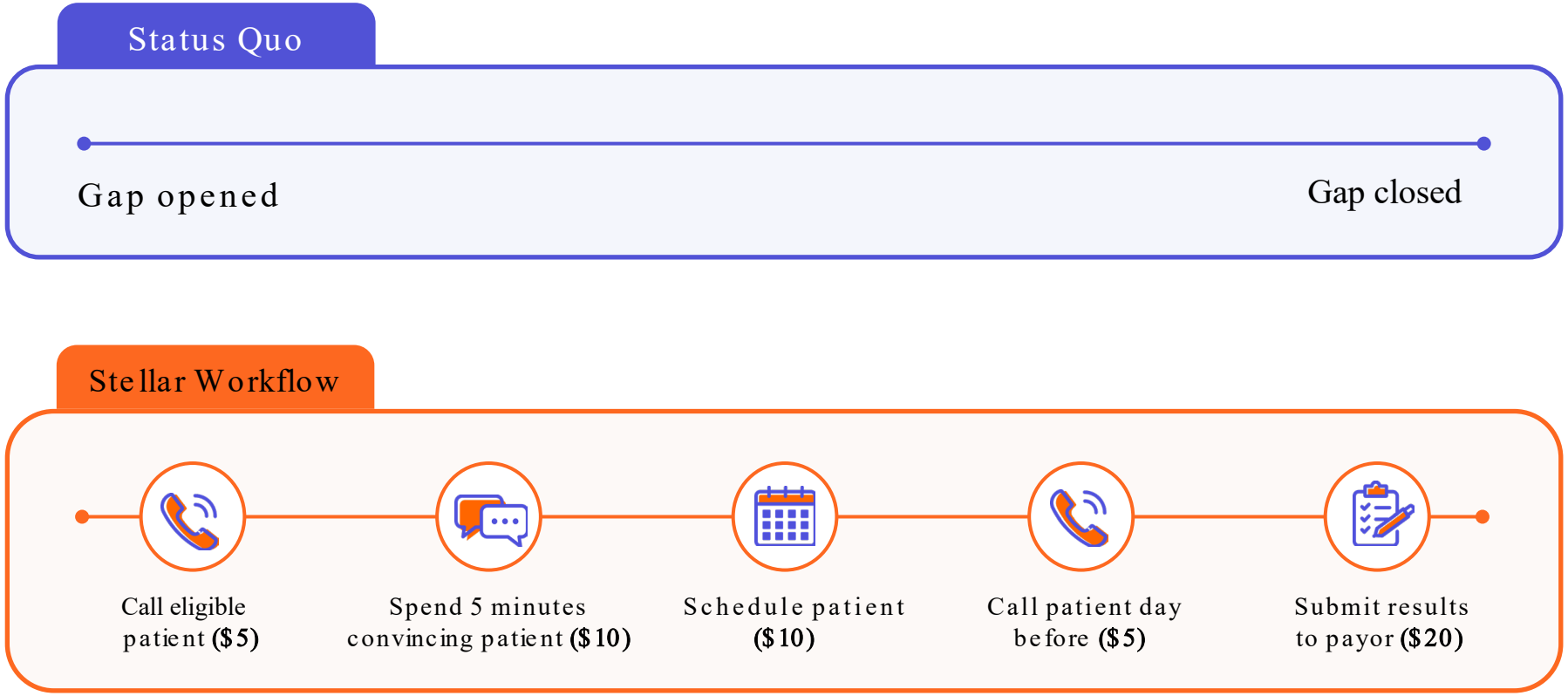
Full Care Team gets +$150 for closing gaps in real-time

Payor gets **significant ROI** for improved MLR & quality scores

Patient experiences improved care delivery and outcomes

*MLR = Medical Loss Ratio, RVU = Relative Value Unit, and ROI = Return on Investment

Stellar Health's Care Gap Closure Approac



MEASURABLE IMPACT

- **+0.63 Stars** improvement
- **14%** improvement in **documentation accuracy**
- **80% Annual Visit completion rate** at participating providers
- **1M+managed lives** with national footprint
- **~3-5x ROI** generated from each medical dollar invested with Stellar
- **$25M+paid** to PCPs and staff as SVUs

User Engagement Life Cycle

1. Patients Loaded to Stellar App

Load relevant patient and provider data to Stellar application. Data inputs include medical and pharmacy claims, lab results, and ADT* encounters.

2. Actions Generated

Based on data loaded to application + plan configuration, generate actions with associated SVUs for each patient

3. User Schedules Patient Visit

Users completes patient outreach actions to schedule annual care + transitions of care visits

4. User Preps for Patient Visit

Prior to appointment the user
a) views Patient Summary
b) prints Patient Summary

5. Patient Visit with Provider

Provider uses Stellar Patient Summary during visit to address open coding and quality gaps

6. User Updates Stellar App

User completes actions in Stellar based on the provider's visit with the patient

7. SVUs Awarded

SVUs awarded to user + practice for actions completed

*ADT = Admission, Discharge and Transfer

Appendix

The Stellar Health Platform

We offer a suite of services that includes the Stellar Application (the “App”), the Stellar Incentive Payment Program, provider practice engagement and performance through business intelligence and analytics, and on-the-ground implementation and practice activation.

The Stellar Application

A web-based, point-of-care tool that is simple and easy to use. With an incentive structure that promotes completion of granular actions, as well as a seamless user interface, practices are motivated to use the App to manage their patients.

The Stellar Provider Performance Team

We provide all clients with a smooth onboarding and implementation process, regular check-ins for practice adoption, and ongoing support for value-based performance improvement.

The Stellar Incentive Payment Program

The financial reporting and accountability, real-time payments, and value-based fee schedule that comes with our platform.

The Stellar BI and Analytics Insights

Our platform can track practice performance in real time and takes a deep dive into key metrics that drive success in value-based care. The Stellar Application usage creates new data and allows our team to run analytics on provider engagement, workflow, and performance management.

Succeeding in Value Based Contracts with Stellar Health

1 Determine Priorities

Translate Health System clinical and business priorities into actionable workflow recommendations for your care team, assigning a dynamic incentive amount for each action.

2 Prompt and Incentivize Staff

Increase or decrease incentive amounts throughout the year to align with desired behavior

Example: Call highest risk patient to schedule their Annual Wellness Exam and earn $10. Once the visit is complete, earn an additional $10.

3 Ensure Completion

Stellar tracks action completion in real time, giving practice leadership and care teams confidence in care gap closure across all managed care contracts. Health Systems can also track which providers are pulling their weight or where educational opportunities exist.

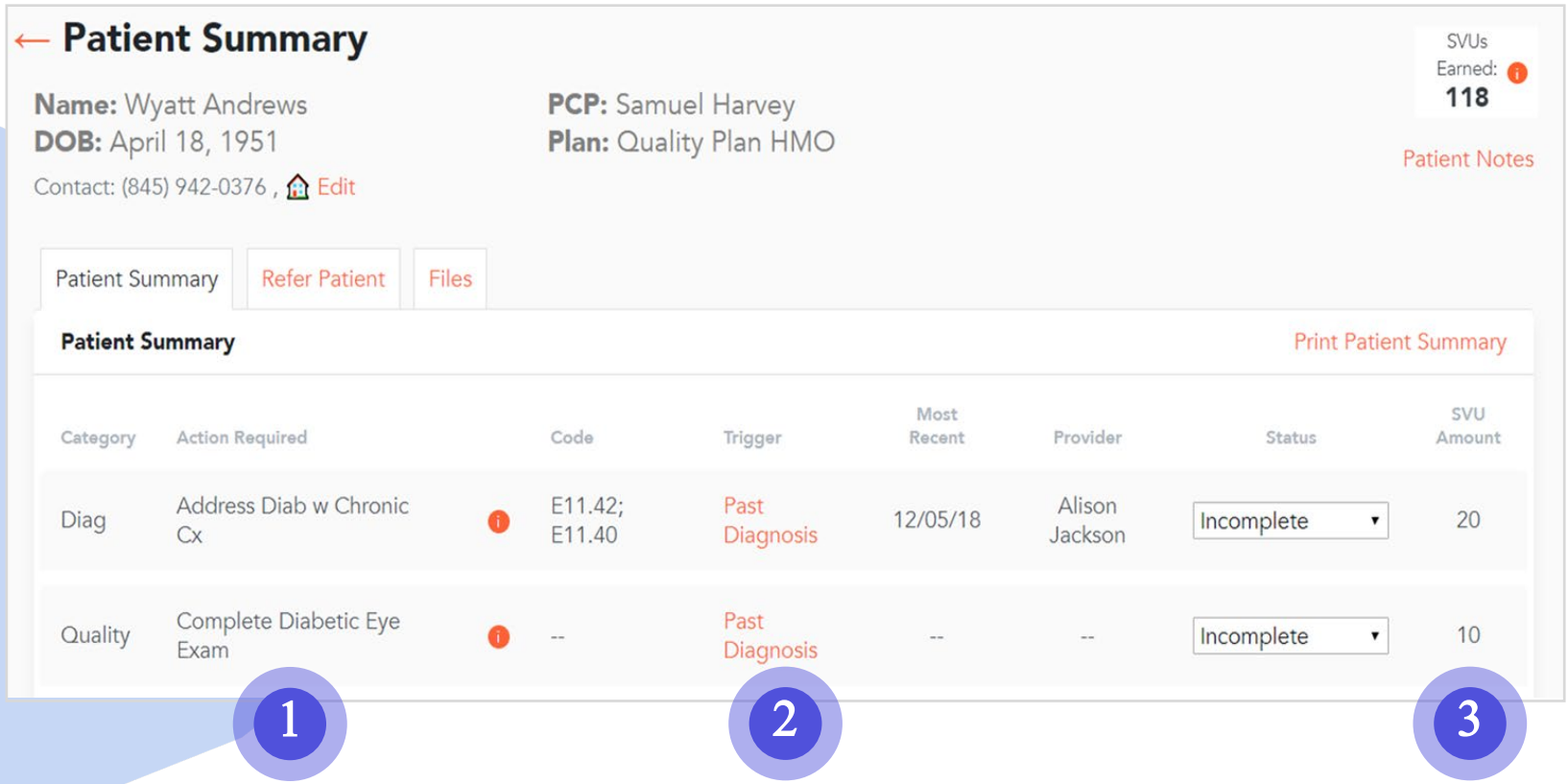
4 Increase performance and staff satisfaction!

Monthly incentives are paid out to staff for completed actions further reinforcing high value behavior and reducing burnout from VBC programs.

Do you currently have a method to *prompt*, *track*, and *reward* primary care staff for these granular "value-based care" activities?

Preview of the Stellar App

Stellar's App can be accessed with as little as an internet connection and works with all EMRs. See below for a snapshot of the **Patient Summary Form**:



1. Care gaps identified through **real-time Stellar analysis of patient data**

2. Ability to **explore past diagnosis** to learn more about patient history

3. **Each action rewarded with SVUs** (monthly payments to the "doer" of the action)

Example SVU Menu Actions

Partners select from list of predefined actions with high measurable ROI - and can also design custom/ new actions

Partners customize these actions, SVU amounts and design their own to address local market needs

Action Category	Action Description	Typical SVU Amount	Estimated Return	ROI Per SVU	Action Example
Coding & Documentation	Assess an HCC not documented this year	20-40	$500-$1K	25X	Appropriately assess a previous diagnosis of CHF (ICD-10 code: I50.9)
Quality of Care: adherence and disease mgt	Address patient non-adherence; complete disease mgt goals	20-50	$100-500	10X	Achieve 80% adherence on diabetes Rx for previously non-compliant patient
Quality of Care: prevention and screenings	Address patient care gap	5-10	$25-100	7.5X	Complete Diabetic Eye exam and review results
Care Coordination & Cost: Transitions of Care	Complete full Transition of Care workflow after discharge	20-40	$250-500	7.5X	See patient for a Transition Visit within 7 to 14 days of discharge

What is Stellar's **business model?**

Our business model creates value for risk-bearing entities by getting physicians and staff rewarded for carrying out the specific activities that the risk-bearing entity wants done

Stellar Health

Empowers risk -bearing entity by engaging providers and staff to complete actions in the Stellar App that drive performance

Each action completed in the Stellar App creates value for the risk-bearing entity at **5-10X Gross Return on Investment.**
For example, Stellar moves the needle through a combination of Coding and Quality

Risk-Bearing Entity

Receive higher quality score and increased revenue from extra actions completed by providers

SVU Pool: 10K Lives x $4pmpm = **$480K**
Stellar Fees: 10K Lives x $3pmpm = **$360K**

Total Cost: $840K

Value Created: 10K lives x $10K avg. premium revenue x 5% improvement in revenue = **$5M**

$5M value created / $840K cost =

6X Return on Investment

Case Study: KLAS recognized Stellar Health for a Points of Light Award

Stellar recognized for its partnership with Arkansas BCBS and 5 Dominant Health for Improving Patient Outcomes and Clinical Condition Management by Incentivizing Staff

Challenges to be Solved:

- **Gaps in care for individuals**: ABCBS recognized Medicaid and ACA members weren't completing annual health assessments at the same levels as other member populations
- **Industry-wide staffing challenges:** Health Systems were looking for ways to boost staff retention

Action Plan—How the Collaborators Worked Together to Reduce Friction

1. Created pilot to drive value-based care for Medicaid ACA Population and enhanced their program with front line staff and physician incentives to improve patient outcomes & coding accuracy
2. Partnered with Stellar Health to advance health outcomes in value-based contracts by deploying Stellar Value Units "SVUs" to non-clinical staff
3. Stellar Health provided customized training to all clinics, based on their type, size, and tailored the workflows to each clinics needs

Collaborators:

stellarhealth

Arkansas BlueCross BlueShield

UAMS

Baptist Health

St. Bernards HEALTHCARE The Heart of Great Medicine

mana medical associates

Washington Regional

"Points of Light" - Outcomes Achieved through Collaboration

3x

Financial Return for ABCBS

$500K

of incentive dollars paid to 5 Health Systems

+0.33

Improvement in Stars score

Improved number of annual care visits, preventative screenings, and control/ maintenance of diabetes & high blood pressure

+4%

Improved Recapture Rate

The improved accuracy of risk adjustment in VBC programs resulted in greater shared savings opportunities for providers

Health Systems saw **increased teamwork** driving **more successful value-based care** and **improved** frontline **staff engagement** and **satisfaction**

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(Previous Submitter – *APC-APM – Advanced Primary Care: A Foundational Alternative Payment Model for Delivering Patient-Centered, Longitudinal, and Coordinated Care* proposal)

Approaches for Achieving Care Coordination through Team-based Care

To What Extent Is Formal Clinical Integration Needed?

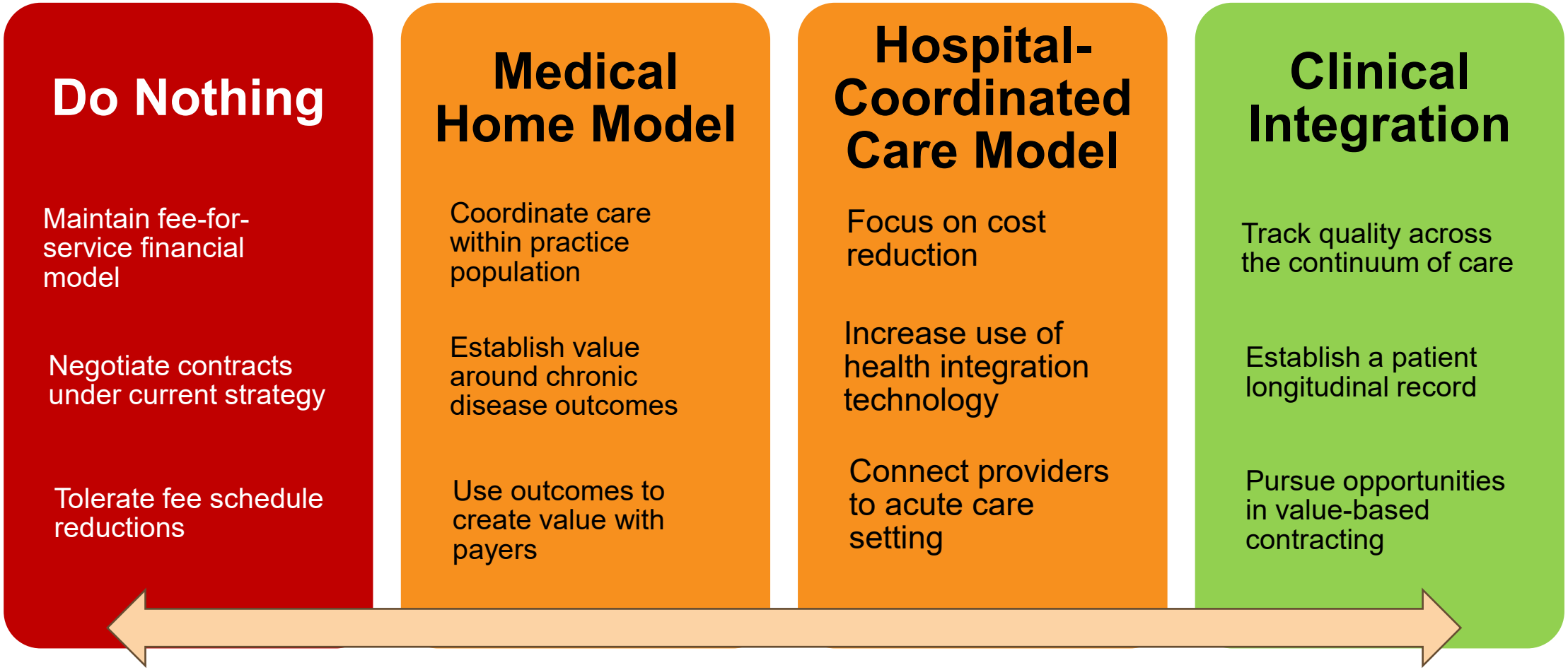
Steve Furr, MD
President
September 17, 2024

What do we mean by "care coordination"?

- Primary care is the first point of contact for many patients for both clinical and mental health, and therefore is the center of patients' experiences with health care.

- As a result, “care coordination” in primary care means the physician-led care team working closely with patients' other health care providers and community organizations to organize and manage care transitions, referrals, and information exchange.

What do we mean by clinical integration?



Source: Marino, D.J. (2012). The 4 Pillars of Clinical Integration: A Flexible Model for Hospital-Physician Collaboration. Becker's Hospital Review.

How can care coordination best be achieved in PB-TCOC models seeking to promote accountable care relationships?

- Clear communication and expectations
- Effective data sharing
- Shared accountability and incentives among PCPs and specialists
- Alignment of patient preferences and incentives (value-based insurance design)

To what extent is formal clinical integration needed for achieving optimal care coordination?

- Formal clinical integration (e.g., via clinically integrated network) is not needed but helpful to facilitate accountability.
- Patient-centered care can be promoted across primary care and specialty physicians through:
  - Bidirectional, synchronous, and/or asynchronous communication and active collaboration
  - Implementation of technology-enabled care funded through payments to accountable entities
  - Reductions in administrative burden

What are effective approaches for facilitating effective care coordination among physicians that are not in an integrated delivery system?

- Promote proactive, longitudinal primary care
- Establish clear communication and expectations
- Implement effective, high-value health information/data sharing mechanisms among all stakeholders, including payers, health systems, physician practices, etc.

How should financial incentives be structured to incentivize team-based care and accountable care relationships between primary and specialty care physicians?

- Apply financial risk at the entity level rather than individual physician level in integrated primary and specialty care models
- Ensure alignment of incentives between patients and all the clinical care delivery touchpoints across the continuum

Key Takeaways

- Optimal care coordination does not depend on formal clinical integration but can benefit from formalized accountability.
- Effective care coordination starts with promoting proactive, longitudinal primary care.
- Accountable care relationships between PCPs and specialty care physicians are facilitated by:
  - Clear communication and expectations
  - Effective data sharing
  - Shared accountability and incentives among PCPs and specialists
  - Alignment of patient preferences and incentives (value-based insurance design)

AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Listening Session 1: *Organizational Structure, Payment, and Financial Incentives for Supporting Accountable Care Relationships*

Jenny Reed, MSW

Senior Executive Officer, Southwestern Health Resources

We’re Building a Better Way to Care, *Together*

Jenny Reed
Senior Executive Officer

Southwestern Health Resources

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SWHR By the Numbers

7K+ Hospitals

31 Hospitals

16 Counties

790K+ Patients receiving care

650+ Outpatient facilities and clinics

$223M In Medicare savings since 2017

2016

Southwestern Health Resources (SWHR) Accountable Care Organization (ACO) created in response to market shift to value-based care

2017

- CMS selects SWHR to participate in their Next Generation ACO
- City of Fort Worth contracts with SWHR to provide value-based care to city employees.

2018

- Achieved greatest savings of all Next Generation ACO participants
- Added North Texas Specialty Physicians and the Care N' Care Medicare Advantage

2019

- 2nd year ACO top savings among Next Generation ACO
- SWHR becomes an independent, clinically integrated network

2020

- SWHR enables telehealth care during COVID-19
- Supports physicians with analytics and insights to identify and manage higher-risk patients

2021

- 4th year ACO top savings amount Next Generation
- Launched customized digital platform arming providers with actionable insights

2022

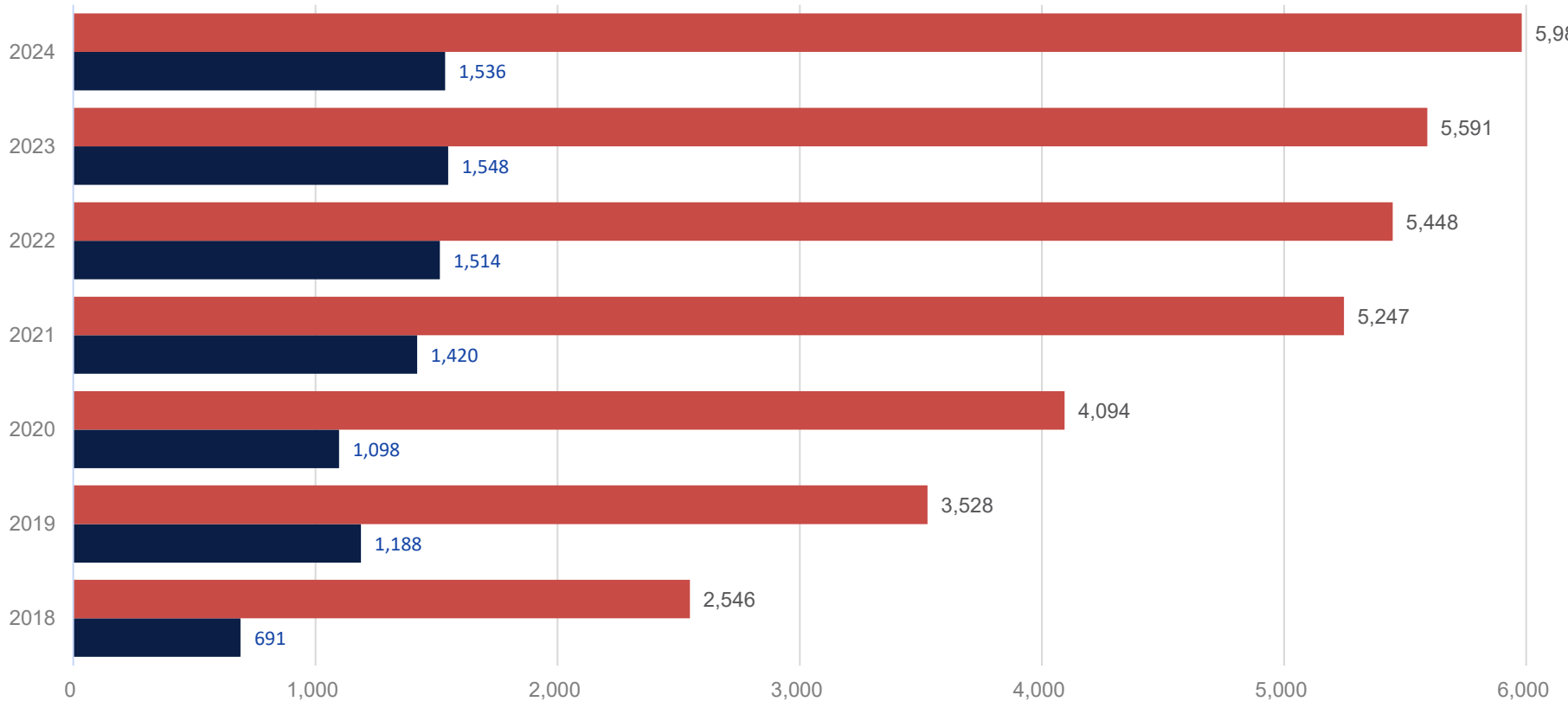
- Participates in the Global and Professiuonal Direct Contracting Model (GPDC)
- Documented more than $223M in Medicare savings since 2017

2023

- SWHR awarded ACO Reach Model
- Earns high quality scores and achieves $10M in savings in final year of Next Generation ACO Model

ACO Composition

Primary Care Led, Longitudinally Supported



SCP = Academic, employed and independent medical, surgical and hospital based specialists

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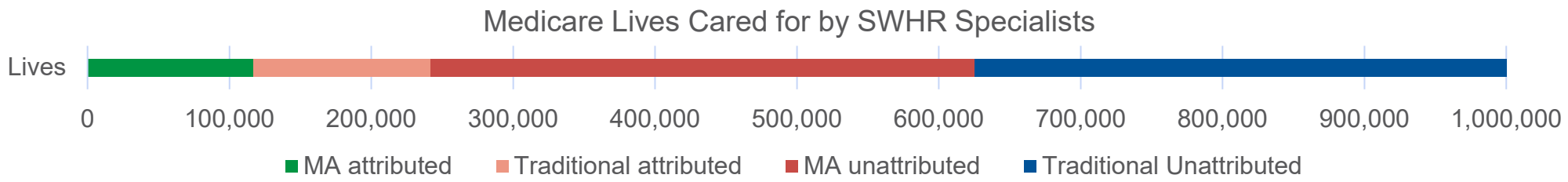
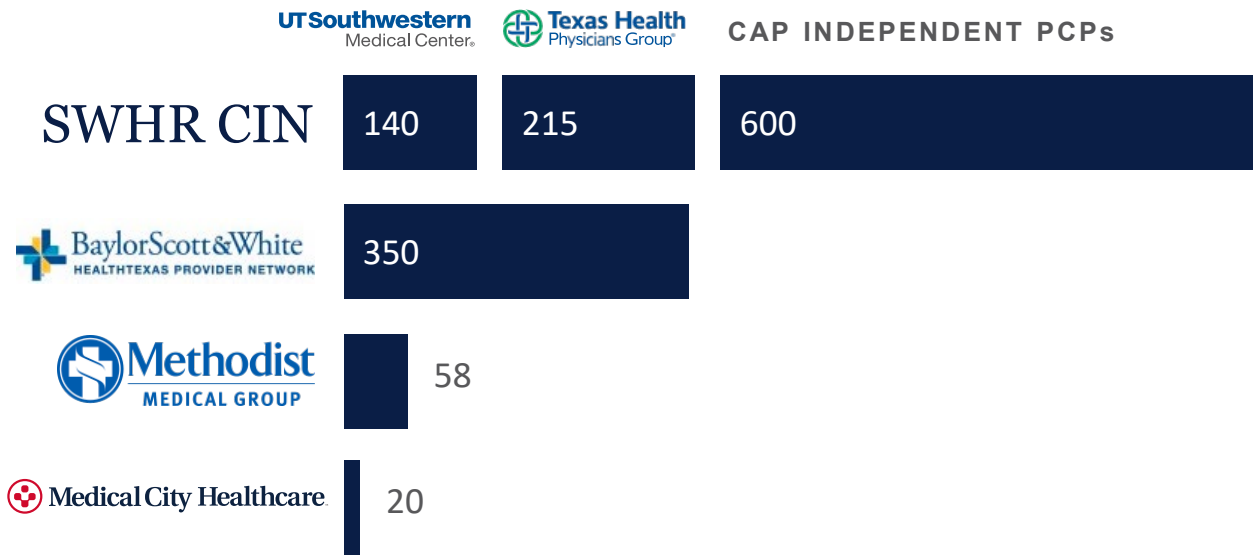
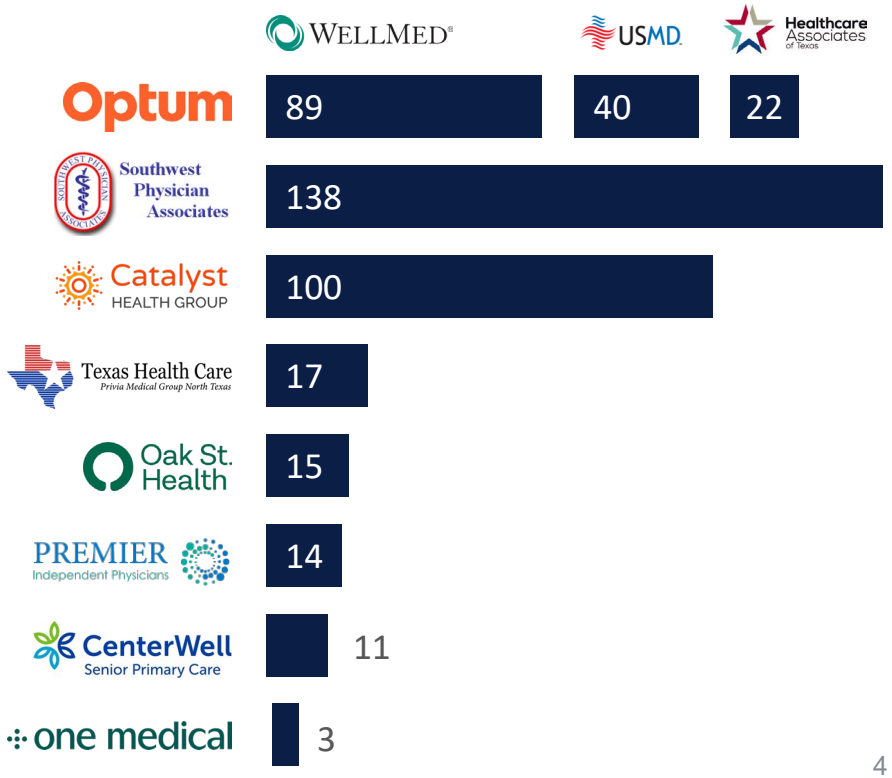
SWHR is One of the Largest ACOs Nationally at ~125,000 Lives

~1M Medicare members receive care from SWHR providers annually.







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Nested Episodes

SWHR TEAM Bundle Example

Scheduled Elective

Trauma

MS-Major joint replacement of the lower extremity (TEAM)	1,850
IP-Spinal fusion (TEAM)	513
IP-Major bowel procedure (TEAM)	251
IP-Coronary artery bypass graft (TEAM)	105
IP-Fractures of the femur and hip or pelvis (TEAM)	35

- Episode sample size is too small to be useful
- Logic does not follow what is clinically expected
- Earned incentives are delayed and small
- Calculations are opaque
- Specialists lose interest, program loses relevance

Potential Solutions

- Align to ACO and facility to encourage collaboration

- Include quality and cost metrics relative to each care setting/provider

- Reward transitions back to the community provider

- Allow ACOs to opt-in to nested bundles, rather than requiring

- Include clinically relevant providers and timeframes

- Establish low volume thresholds

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What Can Be Done — Specialist Participation

Relevant data sharing:

- Share all data relevant to the use case
- Episode data with national and regional benchmarks
- Stars-type data to inform patient choice
- Standard definitions
- Ensure sufficient sample size

Align program design elements:

- eCQM/MIPS remain aligned to broad outcomes created by all providers
- QP bonuses penalize ACOs who include unattributable providers
- Update attribution logic to include greater number of specialist panels
- Make advanced payment option available to all ACOs, regardless of revenue

Patient Involvement is Key

- Redesign required notifications to focus on what beneficiaries want to know, not CMS legal requirements.
- Allow ACOs to customize so that it can be combined with other communications.
- Increase ACO flexibility to provide beneficiary incentives. Ideally there should be a set of services for which any ACO can choose to waive cost-sharing, and ACOs could submit requests to CMS for other approaches for incenting beneficiaries.

Conclusion

Make it easy to understand and join

Allow advance payment options and broader participation

Incentivize patients to participate

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