America’s Physician Groups (APG) Educational Series 2019

Let’s Get Moving towards Value Based Care!

July 24, 2019

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Today’s Presenters

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What Will You Learn Today?

• CMMI will review the regulation content of the direct contracting models and provide additional relevant resources

• APG members will describe how their organizations implement clinical care models that have been effective in risk environments, including their organizational structure and any hiring they had to do to prepare for taking on financial risk

• Shared strategies, best practices, and lessons learned
Michael J. Lipp, MD, MBA, Chief Medical Officer, Center for Medicare and Medicaid Innovation (CMMI), Centers for Medicare and Medicaid (CMS)

Innovation Center Primary Care Models

Low Risk
- Comprehensive Primary Care Plus
- Maryland Primary Care Program

High Risk
- Direct Contracting-Global
- Next Generation ACO
- Vermont All Payer

- Direct Contracting-Geographic
  - Maryland Total Cost of Care Model

- Direct Contracting-Professional
  - Primary Care First
Neeta Goel, MD, Medical Director, Quality & Population Health Inova Medical Group and Signature Partners

Clinical Care Models
Inova Health System

- Integrated healthcare system with a network of hospitals, primary and specialty care practices, emergency and urgent care centers, outpatient services and destination institutes such as the Inova Heart and Vascular Institute, Inova Schar Cancer Institute and Inova Neuroscience and Spine Institute

- Employs more than 18,000 team members

- Serves more than 2 million individuals annually

Signature Partners

- Inova’s Clinically Integrated Network
- ~1700 providers → employed and independent
- Medicare ACO → over 43,000 beneficiaries in 2019
- Other Value-based Contracts:
  - 3 Commercial, 2 Medicare Advantage → 100,000 patient lives
Clinical Care Management Goals

- Support coordination of care for most complex and most vulnerable patients, those with multiple chronic diseases, psychosocial issues, and advanced age

- Improve quality of life and patient experience

- Reduce overall cost of care by avoiding unnecessary hospital and emergency department utilization

Population Stratification for Care Management
Clinical Care Management Programs at Inova

- Rising Risk Program
- High Risk Care Management

Multi Disciplinary Care Management

Caring for home-bound population

- Medical House Call Program

- Transitional Care Services
- Collaboration with SNFs

Post-Discharge Care Coordination

Rising Risk Program

- Rising Risk Population – top 6 to 20%

- Telephonic outreach
  - Identify gaps in care
  - Provide support and care-coordination to reduce barriers to care
  - Facilitate referrals to PCPs and Specialists as appropriate
  - Referral to Care Management team as needed

- Current Staffing
  - 3 LPNs

- Goal: to prevent future health risks (prevent them from going into high-risk category)
High Risk Care Management

- High Risk Population - top 5%
- Telephonic and in-person interaction with patients
  - Complex case management
  - Psycho-social needs assessments
  - Co-ordination of care among physicians part of care team
  - Self management education
  - Med adherence education
- Current Staffing
  - 7 RNs and 2 open positions
  - 1 Social Worker and 1 open
  - 0.7 Pharmacist
  - 1 Director of Care Management
  - 0.2 Medical Director
- Goal: prevent unnecessary utilization of services to reduce overall cost of care, while maintaining/improving quality of life

Medical House Call Program

- Comprehensive primary care services in patients’ homes and assisted living facilities
- Strong care coordination with inpatient teams, hospice agencies, skilled nursing facilities, physical therapy, occupational therapy, behavioral health counselors and county services for high-quality patient outcomes
- Current Staffing
  - 6.7 Providers (MDs and APPs)
  - 1 Social Worker/Case Manager
  - 1 Program Coordinator
  - 1 Patient Access Member
  - 4 Clinical Team Members (RN, LPN, MAs)
  - 1 Director, Geriatrics
- Goal: to help patients successfully “age in place” while reducing overall cost of care
Transitional Services

- A comprehensive program designed to support medically vulnerable patients with a recent hospitalization to ensure quality transitions of care to ambulatory setting

- 3 components:
  - Transitional Care Management
  - Transitional Services Clinic
  - Medicare patients focused Nurse Navigation

- Current Staffing
  - Telephonic Services
    - 10 RN Case Managers
    - 2 Social Workers
    - 7 Medical Assistants (Navigators)
  - Transitional Clinics
    - 20 FTEs (APPs, LPNs, RN Case Managers, Patient Access Associates, Community Health Coordinator)
    - 2 Managers
    - 1 Director

Transitional Services

- Transitional Care Management
  - 30-day post-acute telephonic outreach designed to encourage patients to follow up with their primary care physician

- Transitional Services Clinic
  - Hospitalist-run post-acute clinics that provide immediate attention to medically complex patients who require early follow-up care

- Medicare patient focused Nurse Navigation
  - To provide oversight and navigation of the Medicare 65+ focused diagnosis patients throughout the continuum of care during the 30 days post-acute discharge

- Goal: to ensure proper access, and coordination of all discharge dispositions to avoid readmission to the hospital
Collaboration with Skilled Nursing Facilities

• SNF Advisory Council: Inova care coordination teams collaborate with leaderships from area SNFs

• 2019 Initiatives
  ▪ Hospital to SNF care transition improvement
  ▪ Connect SNFs to hospital EHR
  ▪ Infection prevention
  ▪ End of life quality improvement
  ▪ Early transition to next level of care in the community

• Current Staffing
  ▪ No separate staffing; utilizes current team members involved in various post-acute care coordination programs

• Goals: avoid readmission to hospital and decrease length of stay with overall goal of reducing cost of care

Outcomes

• Total Cost of Care for ACO population
  ▪ Downward trend over last two quarters

• Hospital Admissions and Readmissions
  ▪ Inpatient facility expenditure lower than national average of MSSP ACOs
  ▪ Readmissions trending down

• Avoidable ED Visits
  ▪ Opportunity to do better
Strengths and Opportunities

• Strengths:
  ▪ Comprehensive program covering all aspects of care coordination and care-management
  ▪ Support from various professionals – MDs, APPs, RNs/LPNs, Pharmacists, Social Workers, Administrative team members
  ▪ Robust data integration and analytics

• Opportunities:
  ▪ Integrating different populations into various programs – all patient discharges from hospitals vs patients in value-based programs
  ▪ Continuing to navigate transition as a large healthcare system from fee-for-service to fee-for-value
WellCare’s Mission, Vision & Values

Mission
Our members are our reason for being. We help those eligible for government-sponsored healthcare plans live better, healthier lives.

Vision
To be a leader in government-sponsored healthcare programs in collaboration with our members, providers and government partners. We foster a rewarding and enriching culture to inspire our associates to do well for others and themselves.

Core Values
- Partnership
- Integrity
- Accountability
- One Team
### Collaborative Health Systems Fast Facts

**Experienced**
- CHS began operating Accountable Care Organizations in 2012
- Genesis: Creation of Heritage Health Systems (HHS) in 1995
- Improve physician performance using data analytics & care management protocols to produce cost-effective outcomes

**Provider Partnerships**
- 11 ACOs (9 MSSP* / 2 NextGen) and 14 MDPCP** practices
- 150K beneficiaries
- 2,700+ providers managing ~$2B in total cost of care
- Advanced Practice Partnerships

**Value-Based**
- CHS’ ACOs have achieved over $255 million in total net savings to the Medicare Trust Fund—over a quarter of a billion dollars (2012 - 2017 performance years for ACOs active FY 2015-2017)

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### WellCare 2019 Priorities

- **Provider Partnerships & Network Optimization**
- **Population Health Transformation**
- **Talent to Support Growth**
- **Integration of Acquisitions**
- **Quality Results**

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### ACO/MSO Industry Dynamics

**Providers lack adequate resources to manage administrative and clinical activities; Management Services Organizations (MSOs) and ACOs can help alleviate clinical support pain points, technology access and capital funding**

#### Industry Trends
- Migration from Fee-for-Service to Value
- Shift to PCP-Centric Health System
- Evolving Technology and Administrative Requirements
- Increasing Vertical and Horizontal Integration

#### Top Challenges Affecting Physician Practices

- **Increasing Financial Pressure**
  - Margin compression across value chain
  - Reimbursement tied to quality
  - Cash flow problems due to slow/under/non-payments
  - Rising operating costs and investment in new technology
- **Disparate Technology and Data Systems**
  - Multi-platform data integration
  - Implementing Electronic Medical Record/analytics tools
  - Ability to keep current and learn new technology
- **Declining Autonomy**
  - Increasing administrative burden/reporting requirements
  - Lack of autonomy/decision-making
  - Maintaining practice independence

#### ACO Value Proposition

- **Equip Physicians to Run Efficient Practices**
  - Help providers increase margin by reducing operating costs and by enabling participation in alternative reimbursement contracting
- **Preserve Clinical Autonomy**
  - Mitigate threats from ongoing industry consolidation by creating a sustainable practice that delivers high quality, patient-centered care
- **Redefine Payor-Provider Relationship**
  - Provide expertise and support on value-add functions to shift greater share of risk to physicians
- **Enable Transition to Value-Based Care**
  - Build infrastructure and capabilities to collaborate with stakeholders under VBC constructs

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**Demand of MSO/ACO business may be dictated by physician practices aggregators such as health systems, large Independent Practice Associations (IPAs) and ACOs**
Care Model

- Develop partnerships with providers, facilities and ancillary services to collaborate and coordinate beneficiary care
- Review utilization reports to identify actionable opportunities

- In-home safety checks
- Referrals for behavioral health and social issues
- Educate beneficiary to annual wellness visits, age/gender/disease specific preventive services, and encourage compliance
- Education in appropriate utilization of services; assist in access to care

- Monthly programs review: Home health, skilled nursing facilities, transitions of care and ER utilization
- Quarterly practice scorecard and gap review
- Review of accurate diagnosis documentation education

- Collaboration/coordination of community resources to meet beneficiary needs
- Communicates care needs with PCP and coordinates care based on provider direction
- Beneficiary education to entitlements

Journey to Advanced Payment Programs

New Clinical Programs
- Home Visit Program
- Palliative Care Program
- Telemedicine Program
- Respiratory Program
- Diabetes Program
- Consultative Utilization Review
- Medication Program
- Social Services

Innovation Program Development
- New Clinical Programs with Community Partners

Partnerships with Home Health and Skilled Nursing Facilities

Examples of Innovative Projects
- Care certainty for SNF and hospitalization communications
- Telemonitoring for dual eligible for diabetics, hypertension and congestive heart failure
- Partnership with local food banks
  - Home delivery meals (fresh food truck)
  - Merck
  - Motivational interviewing and teach back technique training for staff
- Pfizer
  - Grant for Televox for vaccines
  - Education materials
- Johnson & Johnson
  - Quality PATH Software (population analyzer tool for health systems)
  - Diabetes training
- Curant Health
  - Pharmacy
Value-Based Provider Evolution

Practices assume greater levels of risk as they evolve through value-based stages.

- **Value-Based Stages**
  - **Beginning** (Basic-Level A)
  - **Performing** (Basic-Level B-D)
  - **Advancing** (Basic-Level E/Next Gen 1)
  - **Mastering** (Enhanced/Next Gen 2)
  - **Dominating** (All Payer)

- **Provider Sophistication**
  - **ACO/MSO**
  - **ACO**

- **Value-Based Provider Evolution**
  - Full Risk MSO
  - Payment Optimization
  - Established patient relationships and enhanced managed care performance
  - Recruit patients to manage care and push to manage post-acute settings
  - Performed well in Level A; gaining experience in risk coding, etc.
  - New to the concept of value-based care
### Identifying Risk Ready Practices

#### Sample Attributes
- Inspired to change behavior
- Appropriate EMR utilization
- Measure and improve the quality of care across your network
- Utilization of population health tool to risk stratify and manage utilization
- Strong coding team
- High-performing care team to improve care/reduce cost
- Appropriate network engaged in care coordination communication
- Strong referral program to manage leakage
- Increase generic utilization and adherence to prescribing guidelines
- Influence physician and patient behavior with timely and clear communications

### Physician Readiness Indicators

#### Physician Cohort Groupings
- Referral patterns
- Cultural/Social Networks
- Geographic Concentration

### Practice Risk Readiness Score Card

#### Scorecard Purpose
To distinguish between practice patterns which may be clinically appropriate but are optimized for a fee-for-service model and high-value providers whose practice patterns align with value-based care models.

#### Scorecard Metrics
- Appropriate level of patient visits seen each year
  - Healthy 1 time a year – goal 65%
  - High-risk/chronic conditions – 3 to 6 times a year – Goal 70%
  - Home visit program for non-compliant patients with chronic conditions
  - Appropriate risk score at patient level
- Appropriate year-over-year (YoY) gap closure of previous year codes
- Quality reporting score above 90%
- Programs developed for transition of care follow up
  - Decrease in readmit rates YoY
  - Overall improvement in utilization management
  - Reduction in unnecessary utilization and increased quality scores
APG Risk Readiness Tool

Hands-on tool to assess your readiness for APMs

Essential, specific checklists for:

- patient safety
- effective clinical care
- patient-centered care and provider communication
- care coordination
- population health

Available for download at www.apg.org/risktool
QUESTIONS

For more information:
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