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### ON THE COVER

**Donald Rebhun, MD, MSPH**  
The 2019-2020 APG Board Chair shares his thoughts on embracing healthcare transformation.

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### FROM THE PRESIDENT

Donald Rebhun, MD, MSPH

The 2019-2020 APG Board Chair shares his thoughts on embracing healthcare transformation.

### NEWS AND EVENTS

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Advocacy Is Survival

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#### SynerMed Fallout: The California Delegated Model Is at Risk
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From the President

A MESSAGE FROM DON CRANE, PRESIDENT AND CEO
AMERICA’S PHYSICIAN GROUPS

Members and friends,

As summer ends and Washington gears up for the return of Congress, I think about one of the great Yogi Berra’s famous lines, “It’s déjà vu all over again.”

In last summer’s message, I talked about the serious financial distress facing the Medicare program. Since then, the numbers have only gotten worse. According to the Kaiser Family Foundation (and based on the 2018 Medicare Trustee report), Medicare Part A will be depleted in 2026—three years earlier than projected in 2017.

With the rising cost of healthcare, more baby boomers enrolling, and the increased use of services, Medicare is in desperate need of new and innovative ways to provide lower-cost, high-quality care to America’s seniors and aging population.

That’s why we were so pleased when the Centers for Medicare & Medicaid Services (CMS) announced plans to launch new payment models at the beginning of next year. While not an “I told you so” moment, our members have consistently demonstrated for decades that patient-centered, integrated, and accountable care can address the challenges facing Medicare and its fragmented fee-for-service foundation.

We believe there is a better way to improve health in America through our Third Option—and CMS agrees. Many of our recommendations for improving value-based care were adopted throughout these models.

However, tools are only good if you know how to use them. At APG, we’ve been rolling out the instruction manual for months now. We’ve used our Webinar Wednesday and Deep Dive series to introduce the new models and what they may mean for physician groups. We’ve submitted comment letters and responded to requests for information. And we’ve joined forces with like-minded organizations to share what we like—and what concerns us—about these new models.

More recently, we partnered with the Center for Medicare & Medicaid Innovation (CMMI) to present a webinar series for physicians and physician groups. The webinars brought together the best of both worlds—CMMI’s expertise on regulations and APG member know-how on implementing and executing successful care management strategies for risk-bearing organizations.

I’m also very excited about a special session at our upcoming Colloquium 2019: Thriving in Tomorrow’s New Models and Downside Risk, to be held November 11-13 in Washington, DC. This can’t-miss session will look at how physicians are reacting to these new models. It’s sure to be a packed house, so if you haven’t registered yet, I encourage you to do so.

I’ll end with another Yogi Berra line: “When you come to a fork in the road, take it.” That’s exactly what we’re doing: We’re taking responsibility for America’s health. These new models are another giant step forward in the value-based care movement. The momentum is ours. And we don’t intend to stop.

Don Crane, America’s Physician Groups
President and CEO

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Source: A Research!America poll of U.S. adults conducted in partnership with Zogby Analytics in May 2017.

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Source: Transforming Care for Patients as Consumers, December 2018.

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- Marc Hoffing MD, Medical Director, Desert Oasis Healthcare

With our large portfolio of clinical trials, HCP Studies helps our providers, staff and patients gain easy access to our studies which helps with engagement and enrollment”
- Gary Pien MD/PhD, Director of Research, Summit Medical Group

Fox Insight is an online Parkinson’s study that contributes to research by providing real-world information. HCP Studies enables providers to invite their patients to join in an easy way.”
- Lindsey Riley, Senior Associate Director, Michael J Fox Foundation

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News and Events

APG COLLOQUIUM 2019
Thriving in Tomorrow's New Models and Downside Risk
November 11-13, 2019
Grand Hyatt Washington
Washington, DC

WEBINAR WEDNESDAYS
September 11
October 9

APM COMMITTEE
September 24
WebEx

CONTRACTS COMMITTEE
August 15
Los Angeles, CA/WebEx

November 7
Los Angeles, CA/WebEx

HUMAN RESOURCES COMMITTEE
September 25
WebEx

PEDIATRIC WORKGROUP COMMITTEE (NEW)
August 27
Los Angeles, CA/WebEx

PHARMACEUTICAL CARE COMMITTEE
August 21
Los Angeles, CA/WebEx

November 7, 2019
TBD

PUBLIC RELATIONS/ MARKETING COMMITTEE
September 3
WebEx

RISK EVOLUTION TASK FORCE (NEW)
September 19
WebEx

October 15
TBD

STATE GOVERNMENT PROGRAMS COMMITTEE
October 22
Los Angeles, CA/WebEx

COLORADO REGIONAL MEETING
October 17
Denver, CO

INLAND EMPIRE REGIONAL MEETING
September 17
Riverside, CA

MIDWEST REGIONAL MEETING
October 8
Chicago, IL

NORTHEAST REGIONAL MEETING
October 10
New York, NY

NORTHERN CALIFORNIA REGIONAL MEETING
September 26
Oakland, CA

NORTHWEST REGIONAL MEETING
October 2
Portland, OR
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Advocacy Is Survival

BY BILL BARCELLONA, SENIOR VP FOR GOVERNMENT AFFAIRS, AMERICA’S PHYSICIAN GROUPS

As a young graduate student in the University of Southern California MHA program, I took a course called “Management of Managed Care Organizations.” In many ways, this class was the most important foundation of my graduate program. It was taught by one of APG’s former board members, Pat Kapsner, who was then CEO of Bristol Park Medical Group in Irvine, California. I’ll never forget when professor Kapsner told the class, “You’re only one bad regulation away from oblivion.” Isn’t that the truth?

Healthcare organizations are constantly beset with changes in the regulatory and legislative landscape. Policymakers are concerned about costs, but they also want broad access to healthcare. They focus on adding more laws, but not on reducing anything currently on the books.

At APG, we keep a running tally of all California legislation implemented each year that affects our member physician groups, and we publish it for members as a reference. It dates back to the mid-1990s and runs for several pages. Any one of those hundreds of laws could be the one that kills your organization—if it’s bad enough. Or you might come away with the impression that it’s death from a thousand cuts.

The point is that the business of legislatures and regulators is to produce laws and rules. That’s their product. Here in California, I’ve seen our Legislature reliably produce 60 to 70 new healthcare laws every year for the past 15 years.

In fact, we usually track about 200 bills at the beginning of each session. But after policy committee hearings, fiscal review in appropriations, and the interplay between the Assembly and the Senate, about two-thirds of those bills stall. Many of them are the ones that Kapsner was referring to—the ones that, if passed, would just about kill your organization.

And that brings us to the theme of this article: Advocacy is survival. Every healthcare organization must participate in the public process. At this point in history, America is fixated on healthcare. People pay too much for insurance that they don’t use, or they don’t have insurance and can’t pay for healthcare at all. It’s a crazy system, and the thinking is that if we could just pass one more law or adopt one more rule, we could fix a bit of the problems everyone is facing.

What should you do? Here are some ways to engage:

- **Know your elected officials.** Get to know your city council, county supervisors, health department officials, and your local assembly member and state senator. When meeting these individuals, always give them your card and invite them to come see your organization. Offer to show them how you provide healthcare. They have local staff members who are responsible for engaging on their behalf. Get to know them. They could be the next elected officials someday.
• **Educate your representatives.** Policymakers don't understand much about healthcare beyond what I've highlighted so far. They don't know a PPO from an HMO, and they don't understand all the rules and regulations your organization has to comply with. So you have to build a relationship at the human level with public officials and show them how you deliver care. It inspires confidence.

Remember: Healthcare has become one of the primary sources of jobs; your organization is important to the economic health of your community. Elected officials need to know that you exist, and that your organization matters.

• **Prepare a handout.** This should cover key facts about your organization and its accomplishments. How many health professionals do you have? How many staff do you employ? How many patients do you treat? What do they say about your organization?

• **Reach out to APG.** When new issues come up, such as a single-payer bill, or a regulation to triple the number of Medi-Cal audits that you might face, get the word out. APG is here to help. We're happy to meet with your leadership and marketing staff and help you develop the skills to tell your story. We can explain the technical side of proposed legislation and distill it into an explanation that can be understood. You can personalize the potential impact.

Tell your story. That's the heart of advocacy—and survival.

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![Graph showing cumulative increase in provider-related laws in California over the time span from 1998 to the present.](image)
No health professionals at any facility or organization would say that their care is substandard. Most medical groups provide very good care and are proud to be part of our country’s healthcare system—with some of the most recognized and respected physicians, hospitals, and organizations in the world.

Unfortunately, the rising cost of healthcare in the United States is unsustainable. In fact, healthcare expenses have been one of the leading causes for individual bankruptcy in the U.S. in each of the last 15 years.¹ According to a Kaiser Family Foundation analysis, we spend more than twice the amount of any industrialized country on healthcare, and a large share of that spending comes from the federal government.

However, at 18 percent of gross domestic product, federal expenditures for healthcare now compete against other national priorities, such as national security, education, social programs, and defense.² In 2018, U.S. healthcare costs skyrocketed to $3.65 trillion. And yet, many of our health outcomes are low compared with other nations.

Our current system was built on a fee-for-service framework that has contributed to these rising costs. If Medicare continues with this payment model, it will likely require reduced payments to providers, increased contributions by enrollees, and/or an increased age of Medicare eligibility (e.g., from age 65 to 67).

THE SHIFT TO VALUE-BASED CARE

Many in our industry believe that the alternative is to change the payment model from fee-for-service to value-based healthcare. In fact, some independent physicians, medical groups, and healthcare organizations are already at various points along this path from volume to value (see chart).

Some organizations have accepted risk-based payments for decades. Their simultaneous participation in health plan and pay-for-performance programs made their quality metrics and outcomes more transparent and led to the value-based models we see today.
A large-scale transformation is occurring within the healthcare industry as we grapple with a flurry of complex challenges, including an aging population, the increasing prevalence of chronic illnesses, and the rising cost of care. As an answer to these challenges, we look to healthcare leaders and policymakers to lead the charge for change that will fundamentally transform the way healthcare is delivered in this country. We as physicians play a critical role in helping to lead that charge and have the responsibility to help shape policy, especially in the area of care delivery.

Some of the more widely accepted changes in healthcare today include technology innovations, such as electronic health records (EHR) with robust data warehouses, advances in telehealth, and innovative payment models—including shared savings programs (e.g., accountable care organizations) and risk-based contracting. Still, change is not easy. In fact, throughout history, trailblazers and change-makers have often faced a difficult road.

Take the example of Charles Darwin and his theory of evolution. When Darwin published his 1859 book, *On the Origin of Species*, it was initially met with opposition from other scientists, who generally believed that life on Earth had remained unchanged. While some scientists were prepared to accept that species had evolved, few thought that natural selection was important, preferring to believe in the notion that supernatural forces were responsible. Over time, evidence became overwhelming, and today Darwin’s idea of natural selection forms the cornerstone of modern biology and science.

To improve our country’s access to affordable, quality care, we must acknowledge that there is a better way that can work—if we just dedicate ourselves to a substantial shift in our mindset and approach. Aside from the pioneering physicians and physician organizations who have participated in innovative risk-based contracting for many years, recent efforts toward change are now underway.

NEW CMS MODELS

These efforts include the newest payment models from the Centers for Medicare & Medicaid Services (CMS). The Primary Care First Model options include risk-based contracting for independent and small-group primary care physicians, as well as direct contracting for larger and more experienced groups. These models create opportunities for a broad range of organizations to participate with CMS in testing the next evolution of risk-sharing arrangements to produce value and high-quality care.³

By introducing these new models to consumers and policymakers alike, we illustrate what our industry could look like if we shift from the fee-for-service structure to a full-risk, more coordinated and value-based model.

Many APG members have long believed that integrated, coordinated care results in superior outcomes and cost efficiencies under value-based payment models. This is confirmed by various sources, including California-specific results in a recent paper by the University of California Berkeley School of Public Health and the Integrated Health Association’s Atlas report. The Atlas report compared cost and quality of coordinated risk-bearing organizations against fee-for-service over the past three years.

Both reports demonstrate how risk-based, coordinated care can deliver higher-quality care to patients, with specific detail on how HMOs and Medicare Advantage plans outperform PPOs in clinical quality measures throughout California.⁴ Risk-based contracts for commercial and Medicare patients have encouraged organizations to develop creative and innovative programs and services that lead to better outcomes.

Given this evidence, the new CMS payment models, including direct contracting, can be seen as stepping stones toward a fundamental transformation in the way we deliver healthcare today.

STANDING AT THE CROSSROAD

Organizations with strong advocacy programs, such as APG, have long allowed physicians who believe in a fundamental change in healthcare to have a seat at the table. Our experience in providing value-based, coordinated care can help illustrate the success of this approach. By showing consumers, leaders, and policymakers the optimistic changes that direct contracting and other value-based approaches can accomplish, we take the next steps into embracing a new horizon in healthcare delivery.

We are at an important crossroad in determining how healthcare will be delivered and paid for in the years ahead. We all have a unique opportunity, if not an inherent responsibility, to be part of this change. If not us, then who? If not now, when?  

Donald Rebhun, MD, MSPH, is Regional Medical Director at HealthCare Partners and the 2019-2020 APG Board Chair.

References

⁠¹ https://www.cnbc.com/id/100840148  
⁠² Kaiser Family Foundation analysis of data from OECD (2017)  
⁠³ https://www.cms.gov/newsroom/fact-sheets/direct-contracting  
⁠⁴ https://atlas.iha.org/story/medicare
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APG Member Spotlight

Screening for ACEs in Pediatric Primary Care

BY DAYNA LONG, MD, AND JAMES B. FLOREY, MD, MMM, CPE, FAAP

Children First Medical Group (CFMG) is the largest pediatric specialty independent practice association (IPA) in Northern California. Founded in 1996, it provides services to 48,000 managed Medi-Cal pediatric and adolescent beneficiaries, from birth to age 21, in Alameda and Contra Costa counties in the San Francisco Bay Area.

The IPA also employs a messenger model to facilitate commercial PPO plans in contracting directly with our provider network. This network consists of 175 primary care pediatricians and 400 pediatric specialists, who are primarily affiliated with UCSF Benioff Children's Hospital Oakland (BCHO), and secondarily affiliated with the University of California San Francisco (UCSF) and Stanford Children's Health.

As our managed care market’s tide pool has changed nutrients, CFMG has adapted. It has evolved from being an independent practice association, to a hospital-integrated practice association, to an interdependent practice association. The IPA clinically integrates multiple business models—primary care and specialty, hospital-based and community-based—in an interdependent fashion that knits together the pediatric healthcare delivery system of the San Francisco East Bay.

This year, CFMG began leading its first pilot program in value-based care for populations impacted by adverse childhood experiences (ACEs) and adverse social determinants of health (SDOH). The goals are to:

• Improve the health of our population by providing community resources and short-term health worker support for identified vulnerabilities
• Create a feasible workflow and a patient-accepted clinical program
• Demonstrate a sustainable business model for ACEs screening in an independent practice association

WHY ACES MATTER

The Centers for Disease Control and Prevention (CDC) defines ACEs as all types of abuse, neglect, and other potentially traumatic experiences that occur to children under the age of 18. ACEs have been linked to:

• Impaired social and cognitive behaviors
  - Attention deficits and learning disabilities
  - Behavioral problems
• Risky health behaviors
  - Smoking
  - Alcohol misuse
  - Intravenous substance misuse
  - Attempted suicide
• Chronic health conditions
  - Asthma and chronic obstructive pulmonary disease
  - Cardiovascular disease, including high blood pressure, heart attack, and stroke
  - Cancer

“California will soon require that providers screen all pediatric Medi-Cal patients for adverse childhood experiences.”
• Potential for an impaired quality of life in years (QLYs)
  o Depression
  o Chronic health conditions
  o Multigenerational family dysfunction
  o Epigenetic consequences for succeeding generations

• Early death
  o In the U.S., 7 out of 10 leading causes of death correlate with exposure to four or more ACEs.

Because of the importance of these traumatic experiences on a child’s future health, the state of California will soon require that providers screen all pediatric Medi-Cal patients for ACEs (California resolution AB340). To incorporate this screening—and most importantly, link patients and families to needed resources—CFMG is conducting an innovative pilot program involving the state-approved Pediatric ACEs and Related Life-events Screener (PEARLS).

PEARLS is a questionnaire given to parents at the time of a primary care visit. The form includes questions about physical or emotional abuse, living with an alcoholic, substance misusing, mentally ill or absent/incarcerated parent, and exposure to racism, bullying, community violence, food insecurity, housing instability, and more.

The tool was developed and validated by the Bay Area Research Consortium on Toxic Stress and Health—which includes the University of California at San Francisco, UCSF Benioff Children’s Hospital Oakland, and the San Francisco-based Center for Youth Wellness. It’s been made available for duplication at no charge, and additional language versions are forthcoming.

Clinicians and policymakers have long recognized the health impact of social determinants of health. But at CFMG, our clinicians and board were also quick to point out that screening for ACEs and SDOH can carry emotional, ethical, HIPAA, and potentially medicolegal burdens.

In addition, there has been no validated, integrated system for identifying risk factors and then addressing them with geographically proximate resources. Such a system needs to be financially feasible and conducive to the workflow for busy clinicians.

INTEGRATING PEARLS SCREENING

To create this system, CFMG’s new pilot integrates the PEARLS screening tool with automated needs-and-resource-matching software called the FINDconnect Hub.

FIND (Family Information and Navigation Desk) is a program based at UCSF Benioff Children’s Claremont Clinic that screens families for basic social needs and connects them with community resources, such as counseling, food-stamp programs, and housing support. The FINDconnect Hub is an automation of validated, in-depth inventory of patient and family vulnerabilities and resiliencies. These are then matched (by regularly updated and validated software) to community, government, and nongovernment resources.

The output is somewhat a psycho-social-economic prescription of referral opportunities for the patient and his or her family. CFMG then closes the clinical feedback loop with multilingual community health worker and social worker support—prioritizing a family’s continuing effort to access resources and support as they experience change to their family system.

Here’s how it works:

1. Using self-administered PEARLS screens prior to patients being escorted to the exam room, our primary care pilot program will identify ACEs and social determinants of health for our pediatric members 1 to 5 years of age—and again for adolescents ages 12 to 13.

2. Patients and families who have affirmed that they are affected by one or more items on the PEARLS survey of vulnerabilities and resiliencies will be referred for more in-depth, telephonic resource needs assessment at the FINDconnect Hub.

3. A community health worker or social worker from the FINDconnect Hub will follow the patient and family at intervals for three to six months and maintain regular communication with the referring primary care provider. If a mental health referral is indicated, the primary care provider will make and manage that sensitive handoff.

ADDRESSING WORKFLOW CHALLENGES

One of the essential premises for incorporating PEARLS screening and resulting referrals is that the program should
not be intrusive to our existing primary care workflow and workload. This is important because primary care administration of PEARLS and FINDconnect has previously been developed and validated only within the environment of a federally qualified health center (FQHC)—a distinctly different business model and practice demographic focus from our IPA.

To facilitate office processes and challenges to workflow, we have collaborated with our colleagues and co-pilots to:

- Improve and refine the tool's acceptance by their particular patient populations
- Address personal experiences and emotions that the questionnaire has stirred among primary care office workers
- Achieve a workflow that is non-intrusive
- Provide appropriate CPT and ICD-10 coding guides.

Effective January 1, 2020, the state of California will pay a fee directly to providers who submit a claim for PEARLS screening. This is in addition to the state's contractual prospective payment to our county health plan for our capitated lives.

These efforts have resulted in a relatively concise handbook that supports the office staff's understanding of the importance of this work, gives examples of scripts for addressing our patients at various stages of the process, provides suggested workflow diagrams, and includes coding and reimbursement information.

The handbook has been essential for creating a common understanding among office staff and clinicians of the who, what, when, why, and how of our program. We are endeavoring to engage compassionate and engaged hearts, as well as the minds of the participants. It is infectious and teaches all of us by example. Each of us has experienced a cultural humility and immense gratitude as a result of our processes and the teachings of our patients.

GOALS AND NEXT STEPS

At CFMG, we plan to screen all of the children insured by the Alameda Alliance for Health (one of our Medi-Cal payer health plans) at prescribed ages and intervals. We will also fund referral to FINDconnect for at least 800 patients and their families. In addition, we are working with the University of California Berkeley School of Public Health to obtain resources that will help us understand:

- The tool adoption rate and curve
- Barriers to tool adoption and opportunities for process improvements
- The prevalence of PEARLS scores in our patient populations and practice settings
- Short-term measurable outcomes in improving emergency department utilization and reducing inpatient admissions
- The sustainability of a business case for this population health initiative

With respect to the capitalization and sustainability of the program, our pilot seeks to demonstrate immediate improvements in quality of care and utilization optimization—in such areas as emergency department visits, inpatient admissions, and medication adherence. The impacts on total cost of care are accrued to the health plan in our shared risk model, although we (the provider organization) are capitalizing the pilot.

We expect to demonstrate the business case for a value-based care (savings sharing) agreement among the disparate non-aligned partners in our value chain. There is also the possibility that the model will demonstrate sufficient value that the state, at the top of the value chain, will increase the prospective payment to the local Medi-Cal health plan.

Secondly, over a much longer term, our managed Medi-Cal enrollees should have less-challenging and less-expensive chronic health concerns. This would make the program a great investment in the health and quality of life of our community for decades. Population health initiatives with a long view, such as PEARLS and FINDconnect, should have a return on investment for the financial viability of our local health system and tax base for decades to come.

In the end, our program aims to demonstrate the viability and processes to implement PEARLS screening and referrals—and show a return on investment that will engage our partners who will benefit in the value chain. It is possible that our model will propagate across the mandated 5.5 million eligible Medi-Cal beneficiaries in California. As the program scales to larger populations, we hope to demonstrate value-based avenues for sustainability.

Dayna A. Long, MD, is a primary care pediatrician and Medical Director of the Department for Community Health and Engagement at UCSF Benioff Children's Hospital Oakland. She is Co-Principal Investigator for the Pediatric Adverse Childhood and Resilience Study (PEARLS) and developed the hospital's Family Information and Navigation Desk (FIND), along with FINDconnect.

James B. Florey, MD, MMM, CPE, FAAP, is Chief Medical Officer of Children First Medical Group in Emeryville, California.
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For more than 40 years, the state of California has embraced the policy of moving healthcare dollars closer to the actual providers of care through capitation (per-member, per-month payments). Although there is a risk that these prepaid payments may not be adequate for all necessary services, a system of laws and regulations has developed over time to ensure that patient care in a capitated, delegated delivery model meets quality standards, and that the provider groups’ finances are stable.

Despite the large-scale success of this model over the past 17 years—most risk-bearing organizations largely financially compliant—recent state regulatory decisions have engendered great uncertainty and instability in California’s capitated, delegated model.

This case of regulatory overreaction comes at the very time when credible evidence supports the superiority of this model over fee-for-service payments in cost, coordination of services, and quality. For example, the Integrated Healthcare Association has conclusively demonstrated that HMOs in California using delegated providers are delivering higher quality at lower cost than PPOs.

WHAT HAPPENED TO SYNERMED?

The failure in early 2018 of Southern California-based SynerMed—one of the state’s largest management services organizations (MSOs)—and its founding medical group, Employee Health Systems (EHS), was a calamity from virtually every angle.

A whistleblower complaint alleged deliberate, orchestrated fraud related to specialty referrals, grievance handling, and systematic overrides of dates to create compliant records. The strong appearance was that EHS—the largest medical group that contracted SynerMed—had failed to exercise any meaningful oversight of its wayward MSO.

The California Department of Health Care Services (DHCS) stepped in in late 2017 and imposed a corrective action plan, whose terms SynerMed arguably met. Nevertheless, in response to a second whistleblower complaint, the California Department of Managed Health Care (DMHC) stepped in in early 2018, despite its tangential oversight role over medical groups and MSOs.

Rather than requiring its own customary corrective action plan, the DMHC ordered all plans to terminate their contracts with EHS and expeditiously transfer 600,000 patients—90 percent of whom were Medicaid (Medi-Cal) patients. This action effectively shut down both SynerMed and EHS—despite a lack of documented systemic or egregious patient harm that typically undergirds precipitous regulatory action that bypasses administrative and due process norms.

FUNDAMENTAL GAPS

The SynerMed failure resulted in a national black eye for delegation and revealed some fundamental gaps in health plan and medical group oversight of MSOs. The potential
industry problems implied by the SynerMed/EHS takedown are real:

- Inadequate compliance oversight of risk-bearing IPAs and medical groups by contracting health plans
- Alleged denial of medically necessary access to higher-cost medical specialists
- Lack of proper IPA oversight over contracted MSOs, which are essential partners—especially for small providers—but potentially may lack accountability and proper oversight
- Questions as to whether capitated providers are improving their increasingly important quality scores, particularly in Medi-Cal, and providing value for their share of the premium dollar
- Issues as to how much of the state’s skinny Medi-Cal premium dollar is getting into the hands of the actual providers of care

High-quality healthcare is getting more complex. Health plans’ expectations are redefining efficient and effective care to embrace “whole-person care”—addressing social determinants of health and higher quality of care.9 This requires coordination of care and contracting with community-based providers. These essential relationships are best coordinated with treating and risk-bearing providers who manage cost and are accountable for quality, rather than with a distant health plan.

Because medical groups and health systems taking capitation (particularly in Medi-Cal) now face greater complexity, they increasingly may rely on contracted third-party MSOs for managing risk-contracting, coordinating care, and handling other administrative services. These third-party entities by contract must adhere to the same laws, regulations, and contractual provisions as the capitated, delegated provider group or IPA and health plan.

The SynerMed collapse shined a bright light on these third-party entities and on the need to strengthen their accountability and oversight. However, both DMHC and DHCS approached these issues in a way that created uneven enforcement, uncertainty, and unnecessary administrative costs for providers.

Their approach risks undermining confidence and placing increasing financial and administrative strain on the largest delegated system in the country. This could have unintended consequences for Medi-Cal—where contracted managed care organizations are deeply dependent on capitated, delegated payment models to provide healthcare for 10.5 million members.10

HOW SHOULD REGULATORS RESPOND?

An appropriate regulatory response to these legitimate concerns should bear the imprint of seven characteristics:

1. **Necessity**: It should respond to a clear issue or market failure and address bad behavior.
2. **Transparency**: Regulators should not hide behind opaque bureaucratic walls.
3. **Due process**: Broad stakeholder inclusion and process are essential to credible regulation.
4. **Predictability**: The regulation should create more certainty in the relevant market.
5. **Proportionality**: Regulation should be measured and should strive to impose the least burden possible to solve a problem.
6. **Level playing field**: Rules must apply equivalently to all relevant stakeholders.
7. **Measurable and measured effectiveness**: Regulations without meaningful and measurable enforceability undermine their legitimacy.

1. **Necessity**

As accountability moves from a directly regulated health plan to delegated providers to MSOs, the DMHC is right to refine regulatory oversight. Further, while profiling contracted primary and specialty providers is integral to narrow networks and increasingly associated with highest-value care, it must ensure access to high-quality providers, not merely the cheapest. Ensuring this patient access to medically necessary services requires refined, legally discriminatory referral processes based on transparent criteria.

The complexity of multiple relationships can make it difficult to know which party is doing what and with what degree of compliance. On the other hand, there is relatively scant evidence of actual consumer impact that will offset the costs and burdens of mushrooming standards and scrutiny.

2. **Transparency**

Agencies that address broad industry issues should be equally accessible to all affected parties, transparent in their process, and forthcoming with performance measurement information. Unfortunately, with SynerMed, the DMHC—working closely with DHCS—launched an investigation that is still ongoing after 18 months. Moreover, it did this without publicly revealing the findings to justify its termination order, and without providing guidance on what policies and procedures must be followed to engage in “economic profiling”11 of providers.

continued on next page
No health plan has been sanctioned for its provider selection policies. The DMHC met with health plans regularly and exclusively over many months—without scheduling similar communication opportunities with contracted providers. As the DMHC expands its direct oversight of these providers and MSOs, transparency is needed. That must include open communication and the sharing of substantiated findings and desired remedies.

The department should release its investigative findings. This would counter the perception that its waiving of traditional requirements for transferring patients to a new network of providers was unwarranted by actual or imminent patient harm.

3. Due Process

Historically, DMHC staff communicated in a two-way fashion with members of the public and industry and consumer stakeholders—answering questions informally about the intent and meaning of proposed regulation.

Such communications did not make commitments to a particular course, but they addressed ambiguities and confusions that resulted in more-focused, formal stakeholder comments. Regulations issued with insufficient stakeholder input—on equal terms with all highly affected entities—lack credibility. Regulators must adhere to the tradition of open access to the regulation development process.

4. Predictability

California health plans are under intense pressure from regulators to strengthen oversight and audits of delegated providers and MSOs. The California Legislature is also seeking more frequent and “surprise” Medi-Cal audits. Regulation carries serious costs in time and money. The state and plans are not adding dollars to cover providers’ increased administrative costs, so these actions risk depleting dollars needed for medical care.

Targeted surprise enforcement actions that respond to a clearly identified concern can be an appropriate tool. However, this “gotcha this time!” approach—used on a broad, vague basis—creates an unpredictability in scheduling, scope, and sampling that significantly increases administrative burden and costs. Further, it risks creating “one-off” audit results that reduce the ability to compare industry conduct and bring defensible enforcement actions.

Importantly, MSOs’ actual day-to-day work is being adversely affected by the many audits resulting from the SynerMed problem. Over the last year, some MSOs, medical groups, and IPAs appear to be facing multiple audits each week—many on a surprise basis. At the same time, while one MSO is reporting 2,000 audits, others are seeing no change in oversight. Most MSOs lack the staff to comply with multiple unannounced simultaneous audits—which have different and conflicting information demands. This can severely delay audit processes. In addition, a lack of agreed upon compliance standards creates disagreement among auditors at the same plan. This results in internal arguments while at an MSO for an audit.

Basing a high-profile enforcement action on allegations of improper economic profiling—while failing to define the term over the last year—leaves the definition in the capricious realm of “We’ll know it when we see it.” An industry guidance—promised more than a year ago—needs to articulate the lawful boundaries of this practice, which is used by every health plan and insurance carrier to narrow networks and manage the high costs of healthcare.

Another appropriate area for guidance is the utilization management process. Currently, there are no standards for how many physician medical directors must be available for a certain volume of claims. This results in a wide variance of staffing ratios. Regulators need to structure clear guidelines for accepted staffing and approach. This would prevent “after the fact” second-guessing and provide both a “safe harbor” and a baseline best practice to ensure the quality of the utilization management process.

5. Proportionality

Regulation should strive to impose the least burden possible to solve a problem. This requires a deep understanding of the issues. Gathering information and convening stakeholders are paramount in an area where the industry has appeared to fail to understand the intricacies of delegated providers’ downstream partners. These concerns go beyond a few “bad apples” and include the complex contractual and variable financial obligations undertaken by capitated providers.

Despite complexity, burdening all capitated/delegated providers (particularly smaller entities) and their MSOs with massive licensing filings and uncoordinated, expensive audits seems out of proportion to the actual problem. Again, the department would gain credibility from a stronger showing of actual misdeeds resulting in patient harm.

6. Level Playing Field

Rules must apply equivalently to all relevant stakeholders. Regulation should strive to preserve a level playing field among different-sized provider organizations actively engaged in cost, quality, and access objectives. DMHC regulatory tweaks could inadvertently favor or disfavor certain kinds of providers or payers.
Ironically, the approach taken by DMHC and DHCS will impact ethnic providers more than others because ethnic providers generally are more dedicated to serving Medi-Cal patients. Such inadvertent favoritism could drive smaller and cultural provider organizations from the market—reducing competition, increasing costs, or lowering quality and access to culturally competent care.

Smaller medical groups and MSOs also are adversely affected. This likely will result in a further wave of consolidation in California, rather than improvement and support for these providers.

7. Measurable and Measured Effectiveness

A lack of meaningful and measurable enforcement undermines regulations’ legitimacy. This is a very serious risk with both current compliance enforcement and the financial risk licensing regulation.

Compliance audits of delegated providers lack uniformity. Using common standards will allow credible measurability of care and compliance. (Worthy of note is APG’s newly released “Code of Conduct and Audit: Compliance Capabilities for APG Members,” which provides a suggested framework for developing internal organizational capabilities to meet regulatory administrative compliance standards.)

Joint audits may not be appropriate. However, common audit standards for utilization management and a clear definition of impermissible “economic profiling” in Technical Assistance Guides (TAGs) would allow delegated providers to conduct internal pre-audits—and contracted health plans to conduct external audits. The DMHC should consider creating a deemed status for a certified delegation oversight audit organization that health plans could use to meet their oversight obligations. This would increase the level of intense audit scrutiny but reduce the administrative burden by having fewer audits.

The department should also establish a protocol for a “lead plan” to conduct the audit, to obtain input and coordinate questions from the other contracted plans, and to share its findings with those plans. This would result in faster and more efficient audits, and would not impede daily MSO operations for patients and providers.

Finally, date changes and other data adjustments have been an issue in many recent MSO investigations. In the era of sophisticated information technology, regulators should establish a minimum technology requirement (such as systems that irrevocably capture the initial claim or encounter submission and that have strong protected audit trail functions), as well as internal and external audit requirements. This will reduce the opportunity for fraud and improve the integrity of the system.

CURE, DON’T KILL

As the saying goes: “Bad cases make bad law.” SynerMed has literally changed the California health industry and raised the question of whether California can lead the nation on delegated risk and responsibility if it cannot ensure access and compliance.

As regulators contemplate tightening oversight of delegated IPAs and medical groups, we need measured action with mutual accountability for solving industry issues. Because when delegation works, it is superior to traditional fee-for-service medicine. Regulators should strive to cure, not kill, the delegated model in California.

Cindy Ehnes, Esq., is Principal of COPE Health Solutions, and Allen Miller is Principal and CEO. They can be reached at cehnes@copehealthsolutions.com and amiller@copehealthsolutions.com, or by phone at 213-259-0245.

Endnotes

1 The Knox Keene Health Care Service Plan Act of 1975, H&SC Sec. 1340, et seq.
2 In California, HMOs pass most of the financial risk for the costs of medical care through fixed per member, per month payments and delegate most of the responsibility for managing care to these physician-controlled organizations.
3 Regulatory reforms enacted in 2000 led to greater financial and operational stability of medical groups and IPAs bearing delegated risk and healthcare services obligations.
4 https://atlas.aha.org
5 California Department of Managed Health Care, Order to Cease and Desist, December 26, 2017. The original SynerMed press report alleged that “thousands of patients” were denied care. That provided the rationale for a regulatory response that skipped due process for the affected companies—and skipped protections for consumers against abrupt termination of provider relationships. However, almost two years later, consumer advocacy groups only point to one or two denial-of-care complaints received from patients. Health plans also report that no denials of care were detected after the whistleblower complaints were filed, despite the fact that they were ordered by regulators to contact every patient who had received an authorization, modification, or denial by SynerMed.
6 California Department of Managed Health Care, Order, November 15, 2018. DMHC Approves CVS’s Acquisition of Aetna
7 See the department’s recent approval of CVS’ acquisition of Aetna Health Plan, which Order noted low OPA report card scores on “Getting Care Easily” reflecting barriers to timely access to care and outstanding persistent issues related to grievance handling. This resulted in a mere requirement to improve those scores within 12 months. California Department of Managed Health Care, Order, November 15, 2018. DMHC Approves CVS’s Acquisition of Aetna
9 It is noteworthy that SynerMed was successfully addressing these complex care issues in its Los Angeles Downtown Complex Care Clinic (DC3) clinic, which was providing personalized, coordinated care to its Medicare and Medicaid patients at the time of its shutdown.
10 https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report/resource/05358fa7a2c9d4fc6-a0e-405a5fe5681f
11 California Health & Safety Code 1367.02 requires, for purposes of public disclosure, that every healthcare service plan file with the department a description of any policies and procedures related to economic profiling of a particular physician, etc., based in whole or part the economic costs or utilization of medical services.
12 Licensing Reg: Title 28, California Code of Regulations Division 1. The Department of Managed Health Care Chapter 2. Health Care Service Plans Article 2. Administration Section 1300.49 General Licensure Requirements
How Smart Leaders Stay Out of Harm’s Way: Part 2

BY RUSSELL FOSTER AND SHEILA STEPHENS

This is the second in a three-part series on how to overcome compliance and operational deficiencies in a time of expanding government oversight. The first article was published in the Spring 2019 issue of the Journal of America’s Physician Groups.

As we explained in Part 1 of this series, the rapid growth in Medicaid and Medicare Advantage membership in recent years has stretched the infrastructures of many managed care organizations (MCOs) to the breaking point.

Changes in federal and state policies and related rules and regulations have often been accompanied by short implementation timelines and more frequent audits and regulatory oversight. The pace of this change has made it extremely difficult for health plans and their delegates to operate in full compliance and at optimal levels of efficiency and effectiveness.

In this series, we are highlighting the 10 most common compliance and operational issues we encounter when engaged in an audit or assessment (regardless of the organization’s size). These issues reduce efficiency, effectiveness, and profitability, and expose the enterprise to:

- Unnecessary regulatory risks (fines and penalties, cease and desist orders, and increased oversight)
- Member, provider, and stakeholder dissatisfaction
- Loss of competitive advantage

The first article covered the first three issues; in this piece, we will cover issues 4, 5, and 6.

**TOP 10 COMPLIANCE AND OPERATIONAL DEFICIENCIES**

1. An organizational culture that supports the philosophy that 80% is good enough
2. A board that is disengaged or uninformed
3. An administrative structure that is heavily siloed
4. High turnover of key executive, senior, and supervisory level staff
5. Provider contracts that are not fully vetted as to reasonable and operational implementation
6. Policies, procedures, and processes that are poorly documented, reviewed, and communicated
7. Insufficient internal controls to identify and mitigate weaknesses in core processes
8. Understaffed and underfunded compliance departments that cannot aggressively pursue their duties
9. Weak internal data integrity and/or reporting
10. Third-party recovery activities that are not robust enough to recapture overpayments in a reasonable period of time

“MCOs and their leaders who subscribe to poor practices are placing themselves and the organization at risk.”
**Issue 4: High turnover of key staff**

High turnover of any level of staff, particularly upper management, is a red flag and should be a trigger for further investigation. High turnover within upper management often means the selection and hiring process is ill-defined, desperate, or does not take "good fit" into the equation.

Regardless of the reasons for high turnover, the negative impact to the organization is disruptive and costly. The costs are both tangible and intangible. Tangible costs are those related to additional recruitment, hiring, orientation, and training. Intangible costs include the loss of productivity that can come with transition, as well as the longer-term loss of productivity that can come with lowered morale due to high turnover.

It is extremely difficult to build "esprit de corps" when leadership changes frequently. And it is almost impossible to establish strong, enterprisewide intradepartmental relationships with high leadership turnover. Rather, the silos discussed in the introductory article tend to emerge.

Our experience indicates that organizations that are able to avoid high and costly turnover have these traits in common:

- Well-defined business strategies for selecting, hiring, and retaining management staff. Mission, vision, and values statements are included in the selection and interview processes, and there is a clear understanding and clear communications related to goals and expectations.
- Thorough vetting procedures in the selection and hiring process that ensure a good organizational fit
- Good succession planning to reduce the negative impact of turnover when it does occur. This means a well-defined program that allows today's leaders to prepare tomorrow's leaders on a daily and ongoing basis.

**Issue 5: Provider contracts that are not fully vetted**

It is not uncommon for us to see contracts that have been written and executed without any input from those responsible for operationalizing them. For example, we see provider contracts that include many "if then, therefore" payment scenario clauses outside of the rate or reimbursement section. As a result, configuration and claims processing are severely impeded in ensuring accurate payment.

There's a significant value in vetting contracts with the departments and staff members who are responsible for operationalizing and implementing them.

Best-practice organizations share the following when it comes to vetting contracts:

- A formal process for routine review and discussions between finance, provider relations, contracting, claims, configuration, and utilization management prior to executing a contract. These discussions provide an opportunity for clarifying terms, intended outcomes, and any difficulties or barriers that might result in untimely or inaccurate implementation.

This helps ensure that payment methods are as timely, equitable, and consistent as possible. In turn, this promotes smoother implementation and processing—and higher productivity across the organization.

- A process for compliance review. This ensures that contract language is inclusive of all regulatory requirements, that language and terms are industry standard, and there is no language that provides for payment timeliness outside of regulatory requirements.
- Better communication. Having this kind of formal vetting process often results in increased interdepartmental education—as well as the enhanced ability to translate contract content and intent to providers.

**Issue 6: Poorly documented, reviewed, and communicated policies**

We continue to find organizations—regardless of size or infrastructure—where policies and procedures are general and vague, nonexistent, or are comprehensive and not well-communicated or followed. MCOs and their leaders who subscribe to these poor practices, either intentionally or by default, are placing themselves and the organization at risk.

Good regulatory compliance and risk management principles are predicated on well-structured policies and procedures that are communicated and monitored on an ongoing basis.

Policies and procedures are the foundational underpinnings of the organization. That means they need constant updating and communicating to ensure all applicable staff understand them and deploy as the policies direct. Staff at all levels should be held accountable for ensuring accurate implementation and for reporting noncompliance.

The negative impact for organizations that do not have clearly structured and communicated policies and procedures is not insignificant and can be quite costly. Organizations that have loose structures or lack accountability for compliance with policies and procedures are less likely to pass audits and more likely to have lower productivity due to inconsistent applications.

Further, it is important to note that best-practice organizations have processes in place for the routine and ongoing review of all policies and procedures to ensure they remain current and compliant. This includes ongoing monitoring and auditing to validate compliance and identify any opportunities for improvement. ☛

Russell Foster and Sheila Stephens are Senior Advisors for Mazars USA LLP. They can be reached at Russ.Foster@ MazarsUSA.com and Sheila.Stephens@MazarsUSA.com.
Forensic medicine examines the realities of public health and has the ability to help construct an operational narrative for health policy refinements. In fact, Thomas Gonzales, MD, the second-ever chief medical examiner in the New York City Coroner’s Office, taught that, “Information learned from studying the dead could be used to help the living.” This philosophy still holds true today, and it’s a principal reason why the coroner/medical examiner office is a key component to improving health policy and public health.

How can forensic medicine influence health policy in a meaningful and scalable way? What factors, if any, would cause a large-scale social change? And where are these levers of change, such as education, social determinants, and legislation? Does it require a major event (epidemic or economic) for sustainable change to occur?

To find out, Jeremy Rich, DPM, Director of the HealthCare Partners Institute for Applied Research and Education, talked with forensic pathologist Dorothy E. Dean, MD, Deputy Coroner in Cincinnati. Below, Dr. Dean shares lessons learned from the coroner’s office that can help the living—and imparts impactful and problem-focused approaches to refining healthcare delivery.

“How hell is truth seen too late,” is an apt Thomas Hobbes quote. As a forensic pathologist, you have a direct and indirect role in helping to shape health policy for the living before it’s “too late.” What chronic diseases have you observed during autopsy that you feel should not have been so prevalent, and how has this prevalence differed from the past compared to now?

Medical professionals have developed potential solutions to a number of chronic diseases in part because of the documentation of these conditions at autopsy. Two major categories come to mind: lifestyle-based diseases and addiction-based diseases.

Most pathologists have robustly documented the effects of obesity on the heart and other organs so that organizations can use this cumulative data to make pragmatic decisions. For example, there has been an impressive increase in the number of employee-based health and wellness programs that encourage healthy eating and active lifestyles. Often these programs are associated with a financial reward for participation.

The U.S. is facing an opioid epidemic that seems to have no end in sight. Pathologists who examine the remains of deceased people document evidence of injury and natural disease. They also incorporate the results of laboratory (toxicological) analysis into the cause of death statement for the death certificate.

Over time, the information on death certificates generates a large database. The data is available to law enforcement and policymakers to identify and target the causes of the opioid crisis. From here, policies and programs can be established to mitigate, and eventually eliminate, the problem.

I have seen a changing pattern in drug use over the course of my career. Two decades ago, people who died from an overdose of drugs primarily had prescription drugs in their system—drugs prescribed for them that were used in excess. Now, the trend is shifting to people using stronger opioids produced for recreational use (“street drugs”),
with apparently fewer people abusing their legitimate prescriptions.

**The coroner's office can be a “window” into U.S. society, especially with the opioid epidemic as you described. What do you see that could potentially be prevented?**

Social determinants of health have become a frequent topic of conversation in clinical medicine, forensic pathology, and the media. Many people think that social determinants have a large impact on health outcomes. Traditional medical care is necessary for treatment of disease, but health-related behaviors (healthy lifestyles) are critical for preventing many chronic conditions and eliminating risk factors for preventable fatalities.

For example, infant mortality is a major public health concern in Ohio and in the U.S. Forensic pathologists are abundantly vocal about safe-sleep habits for infants. We document the autopsy findings and the circumstances surrounding the death on the death certificate. Because of this, researchers have quantified the large number of infants who died while in bed with an adult, while on soft bedding, or when they became wedged between bedding and a wall. This documentation led to the nationwide focus on safe sleep environments and the “Back to Sleep” initiative, thus making parents and caregivers aware of the risks.

**It can be said that access is everything, and primary care delivery is certainly no exception. What do you suggest that is reasonably implementable to help curtail incidents of preventable and/or late-stage diseases?**

Access to healthcare is critical to using healthcare. The Centers for Disease Control and Prevention (CDC) has identified six health conditions causing financial burden on patients and effective intervention programs to help curtail them. By taking a unified, broad-based approach to a manageable number of serious concerns, we can make a difference in the health of the population.

The six conditions are: tobacco use, high blood pressure, unintended pregnancy, asthma, type 2 diabetes, and antibiotic-resistant organisms. The first five issues are primarily lifestyle-based. The last issue is complex in that it requires good antibiotic stewardship.

**We are trained to think objectively based on empirical evidence. However, would examining the ontological and/or spiritual components of American society be helpful to explore what you see at autopsy: e.g., substantial upticks in obesity, diabetes, heart disease, misuse/abuse of illegal or legal drugs, suicides, homicides, massacres, etc.?**

The mind-body connection can be powerful. The concept of work-life balance is an accepted philosophy. It is, perhaps, one of the best means of achieving overall mental and physical health while maintaining a strong contribution to society. By contribution, I don’t mean economic or work-related. I’m talking about being a member of a community and viscerally feeling a part of it, feeling valued, and having an ontological narrative.

People who have serious chronic conditions may be able to minimize or reverse their disease impact by “re-centering” themselves with support from family or neighbors. I can’t recommend a specific program or religious affiliation because each of us has to decide for ourselves what activities or beliefs are beneficial. However, we must feel a connection with our community, friends, and neighbors, and engage in healthy behaviors while looking out for each other.

**With prescription and illegal drug epidemics presenting in coroner's offices, how do you discuss these causes of death with surviving individuals—next-of-kin, neighbors, and friends—in a way that empowers them to make potentially different lifestyle choices?**

We can make a real difference in the lives of the family and friends of people who have died, especially when those people succumbed to drugs. I talk to family and friends of the deceased as though they are my own friends. I consider deceased people my patients, and I feel a strong duty to the people who loved them. I explain why the person died and what the person may have experienced during the dying process, as well as implications of healthy lifestyles.

We usually talk at length, sometimes over several conversations. I think that speaking with the family and friends of the deceased is where I can make the most difference in healthcare matters. When I was first in practice, my focus was on helping the bereaved with the acute grief reaction. My conversations still involve grief counseling, but now also contain empowering health and wellness phrases for their own lives.

**Healthy eating classes, community gardens, vouchers for fresh foods, and group walking are examples of proactive thinking to address complex population health issues. Can you think of other examples to promote wellness?**

Health starts at home and in our communities. Taking care of ourselves by eating in a healthy way, exercising, and avoiding smoking are essential. However, health is also determined, in part, by the environment in which we live—and that includes professional and personal areas.

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Improving Patient Activation: Case Studies From Parkinson’s Disease

BY PETE FRONTE, MBA

Physician groups (PGs) are well-positioned to be patient-centered change leaders. Although PGs contend with organizational, financial, and cultural barriers to providing consumer-driven healthcare, groups that consistently overcome these barriers will see significant benefits.

For example, 60% of the top loyalty drivers for healthcare are related to patient experience, rather than cost or clinical quality. When organizations focus on providing a positive customer experience, they see a 25% increase in patient retention. In turn, every 5% increase in retention can yield a 25% increase in profits.

Yet, the 2018 Kaufman Hall State of Consumerism in Healthcare Report found that 70% of practices have not begun or are only in the very early stages of meeting patients' needs as consumers.

Patient experience depends not only on clinical skills, practice workflow, and environment, but also on patient engagement and activation—defined as the knowledge, skill, and confidence to self-manage care. Patients who are actively engaged in their own care have better outcomes, require less-costly care, and are more satisfied.

The Patient Activation Measurement (PAM) is a widely used, validated model. According to PAM, patients move through four stages of activation, as indicated in the chart below.

THE ROLE OF CLINICAL STUDIES

Fortunately, physician groups can incorporate high-impact strategies to increase and sustain patient activation and engagement with minimal time and staff, little expense, and without time-consuming software integration.

Clinical studies have proven to be an effective way for patients to learn about, and be actively involved with, their medical condition.

One clear example is a Phase III clinical trial supported by Altura that introduced insulin to insulin-naive diabetics. Patients viewed the study as an interesting short-term option to try insulin (e.g., study medications and visits at no cost, limited study period, a stipend for their time). Not only did study patients have a significant reduction in HbA1c, but 65% remained on insulin after the study’s completion—essentially moving them from Level 2 to Level 4 of activation.
In the remainder of this article, we’ll discuss how clinical studies and disease-based programs are being used to increase patient engagement and activation in Parkinson’s disease (PD). However, these concepts and tactics can be used for any medical condition. The ultimate goal is to move and maintain patients at higher levels of activation.

**ACTIVATING PARKINSON’S PATIENTS**

Parkinson’s disease (PD) impacts nearly 1 million Americans. Patient activation is essential, as care is ongoing and costly, and the disease must be managed continuously.

Most Parkinson’s patients want more information or resources related to their condition. In a 2013 online survey, only about half of patients said they felt “informed or very informed” about living with PD (53%) and about the progression of their disease (51%). In addition, only 48% of PD patients and 38% of caregivers said they knew where to find information or support, and even fewer (43% of patients and 36% of caregivers) were aware of how to engage with their local Parkinson’s community.

According to a 2011 ORC Poll, only 1 in 10 people with PD participate in clinical trials, even though the Parkinson’s community has a significant interest in being involved in research. In a 2014 Harris poll, only 36% of PD patients reported feeling informed about opportunities to participate in clinical research—while more than 85% were at least somewhat interested in participating in a trial. Patients said that not knowing about clinical study opportunities in their area was the greatest barrier to study participation.

Michael Wukelic, MD, an experienced researcher at Providence Medical Group, found that even healthcare providers (HCPs) involved in research failed to educate their patients about potential study opportunities outside of their own specialty. Most people with PD say they look to their doctors for information about studies. However, in a Zogby Analytics Poll, only 2 in 10 said that their providers talked with them about research.

The challenge: Many physicians and other HCPs do not have easy access to information about clinical studies and do not present options due to time constraints.

During a recent Altura-supported Phase III Parkinson’s clinical trial, Altura screened and triaged 4,700 patients from traditional study-based marketing (TV, radio, and online ads). In total, 73% of patients were interested in the study after learning the details, and over half of those not referred by their doctor wanted their HCP to be aware of the study for other patients.

For PD and other medical conditions, physician groups can use both internal and external studies and disease-based programs to increase and maintain levels of patient engagement and activation. In general, these options fall into the three categories below. Here is a look at how APG members successfully use these approaches.

### 1. Internal studies and programs

OhioHealth has established a robust patient-centered Movement Disorders Clinic. The clinic provides PD patients immediate consultation with a physician and a physical therapist, as well as an information/resource guide. The guide offers easy access to resources for exercise, wellness, and regional patient and care partner support. It also includes information about medications, diet, and symptom management.

David A. Hinkle, MD, PhD, a movement disorder specialist, and other clinic team members lead periodic discussions and seminars about PD and its treatment. They also offer a yearly OhioHealth Parkinson’s Symposium to update the community on current research, exercise, and wellness theory. In addition, OhioHealth offers an exercise and wellness program called Delay The Disease that employs a research-based approach to group therapy for people with PD.

As the program grows, OhioHealth hopes to participate in PD-focused exercise and disease-modifying therapy clinical trials. The organization demonstrates that having resources available within your physician group is only a starting point. Activation requires a culture of constant communication of available resources by all group team members.

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### Has your doctor or other healthcare professional ever talked to you about medical research?

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<th>Response</th>
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### Which organizations have the greatest responsibility in educating the public about clinical trials?

- Federal gov’t: 17%
- Doctors and other health care providers: 16%
- Pharmaceutical companies: 16%
- Insurance companies: 16%
- Patient organizations: 6%
- Not sure: 41%

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2. External studies and programs: local or regional networks (ACOs, CINs, integrated system)

Sutter Health has its own research program and resources, but it also collaborates with UC Davis to offer clinical studies and local support groups so patients have as many options as possible.

Erica Byrd, MD, a neurologist at the Roseville, California, location, not only gives her patients information about these support groups, but she also speaks at them—sharing her knowledge on the disease and on clinical trials that are available in the area.

According to Dr. Byrd, “PD patients and their caregivers are very proactive in seeking information about studies and resources. Our goal is to try to reduce the burden related to finding local resources so they can meet their desire to be active in managing symptoms and finding solutions.”

3. External studies and programs: national opportunities

Desert Oasis Healthcare (DOHC) strives to provide patients options outside of its own research program and resources. DOHC offers the Michael J. Fox Foundation’s (MJFF) Fox Insight Study (FIS), an online study, via fact sheets posted at neurology offices, direct communication from the DOHC research team, and the DOHC research website.

In addition, its providers and team members use the Altura HCP Studies™ Mobile Platform to share FIS information with patients and other providers. Close to 81% of PD patients at DOHC who were contacted expressed a desire to enroll in the study.

DOHC Medical Director Marc Hoffing, MD, MPH, explains, “We are proactive in providing our patients disease experience options, and with the FIS, it was an easy way to support patient activation while contributing to important research.”

Sutter Health and OhioHealth also provide access to FIS. The HCP Studies™ Mobile Platform, meanwhile, essentially creates a study ecosystem and allows HCPs to view and share FIS study information in an easy manner—anytime and anywhere.

For many physician groups, partnering with an external organization may bring the greatest increase in patient engagement and activation with the least investment. For example, FIS is a virtual study that is national in scope and easy to access. Its objective is to learn about life with Parkinson’s and accelerate breakthroughs by capturing the experiences of people with and without the disease.

“Fox Insight is bringing the patient voice to research and making it possible for more people to participate in clinical studies,” says Katie Kopil, PhD, Director of Research Partnerships at MJFF. “Parkinson’s is a highly variable disease. Understanding more about what patients experience will help us prioritize the development of therapies they need the most.”

The study was launched in late 2017 and already has more than 37,000 participants, with a goal of recruiting 100,000. Through the foundation’s collaboration with the consumer genetics company 23andMe, those who join Fox Insight can add their genetic information to the study. This creates a more holistic understanding of Parkinson’s disease. (For more information about making FIS available to your PD patients, please contact Altura.)

MJFF also provides access to many Parkinson’s studies through the Fox Trial Finder (FTF) website. The site connects volunteers with studies looking for people like them. People don’t need to have Parkinson’s to participate, nor do they have to take a drug. Some trials test lifestyle interventions like diet and exercise, while other observational studies simply collect data over time to better understand the disease.

A SENSE OF OWNERSHIP

In sum, clinical studies and disease-focused programs offer physician groups opportunities to provide patient-centered resources that encourage patients to move to higher levels of activation. Groups can immediately adopt the concepts and tactics shared in this article for any medical condition—at no cost and with minimal time investment.

When patients develop a sense of personal ownership with their medical condition, this can manifest itself as more active self-management—with benefits for both patients and physician groups.

Pete Fronte is President and CEO of Altura, an APG Affiliate Partner that supports patient engagement via clinical studies and disease experience programs with its HCP Studies™ Mobile Platform and related services. He can be reached at pfronte@alturastudies.com.

References

5. 2011 ORC Poll: https://www.michaeljfox.org/faq “Why is it so important that more people volunteer for trials?”
For example, it is much easier to exercise in a neighborhood with sidewalks and bike lanes, than one where we have to use the streets and risk getting hit by a car. It is much easier to cook healthy meals when there is an affordable grocery store within a short distance of one’s home. I see communities taking responsibility for access to good food with the uptick in local food markets, as well as providing safe places to play. Bike lanes and community parks are becoming features more frequently funded now than in decades past.

Is there a place for change within coroner’s offices in communicating to the public? Is education enough, and if so, to which audiences? How do you go about disseminating health policies that are “real world,” have broad reach to various audiences, and are malleable to societal needs?

The accumulated data from death certificates alerts the public and policymakers to issues and health concerns over time. For some health problems, this knowledge comes too late. Coroners and medical examiner offices can be effective in warning the public of a serious problem almost as soon as the problem starts by calling upon the local media to broadcast it, rather than having it buried in academic papers and clinical symposia.

For example, in February 2019, the Cuyahoga County (Ohio) medical examiner, Dr. Thomas Gilson, issued a public health warning stating that the county had seen a significant increase in seized carfentanil (powder and tablets). Carfentanil, a synthetic opioid used as a sedative for large animals, is extremely potent and unsafe for human use. It’s also nearly impossible to detect by sight because it’s often mixed with other drugs or disguised as prescription tablets. This drug seizure represents a re-emergence, as we have not had many cases of it since the first wave in 2017. By issuing the public service announcement, there may be many fewer drug-related fatalities.

Food insecurities and job instabilities, especially with employer-based health insurance, can be a concern for many individuals. Is there a connection between health insurance accessibility, especially with comprehensive plans, and what you see at autopsy?

Yes, there is. In the past, people with a steady job and employer-based health insurance had few concerns about meeting their financial obligation for healthcare costs. People went to the doctor for routine health maintenance (“checkups”) and when they were ill. They were evaluated and treated at very little cost to themselves. As healthcare costs have risen, insurance premiums, copays, co-insurances, and deductibles have also risen, but salaries have not kept pace and have stagnated.

People have quickly learned that the office visits that used to be free or nearly free now cost them $40 or $50, or more. Over the past decade or so, I have seen people who died from preventable illnesses, such as pneumonia, because they thought they couldn’t afford to go to the doctor for treatment.

In addition to the rising personal cost of healthcare, navigating the healthcare system has become very complex. Years ago, people had “their doctor” to whom they went for all medical needs. Medical science has advanced greatly, and the need for specialization is real. With specialization comes better care, but more complexity for the patient. I have spoken to people who have told me that their relatives stopped going to the doctor because “it’s too hard to figure out what to do.” I believe this concern is valid, especially for the elderly and the underserved.

On a positive note, I have noticed an increase in the use of patient advocates to help with navigating these systems. But it’s my hope that the convoluted pathway for accessing healthcare can become a straight line again.

In closing, what actionable “clinical pearl” could you give to help improve public health?

Create a healthy environment and live the life you want to create. Nurture and support people in your neighborhood. When people actually talk to each other, we are “rowing in sync.” We will be engaged authentically toward healthy lifestyles, and not staring at screens. If we are in tune with each other, we can help ward off potential problems and foster a “community watch” of sorts—especially for the elderly and people living alone. There is always someone who just needs to talk and be heard. Let’s all be healthy together.

Dorothy E. Dean, MD, is Deputy Coroner in the Hamilton County Coroner’s Office in Cincinnati, and is triple-board-certified in anatomic, clinical, and forensic pathology. Jeremy Rich, DPM, is Director of the HealthCare Partners Institute for Applied Research and Education, a nonprofit organization in El Segundo, California. He can be reached at jrich@healthcarepartners.com.
In industry and policy circles, there has been much discussion of value-based care and shifting payment from “volume to value.” But there has been limited data on the prevalence of financial risk-sharing among provider organizations and the association between risk-sharing and value.

Recently, the Integrated Healthcare Association released 2017 results from its California Regional Health Care Cost & Quality Atlas benchmarking and improvement tool. The Atlas 3 data showed that, for commercially insured members, providers sharing financial risk (capitation) provided higher clinical quality and lower total cost of care than those paid fee-for-service. This analysis is based on data contributed by seven health plans, representing 7.2 million lives and all types of products (HMO, PPO, ACO), both fully insured and self-insured. The data represent approximately 55 percent of the statewide commercial enrollment of 13.7 million, excluding Kaiser Permanente.

While data from Kaiser Permanente are included in the Atlas, those data are excluded from this analysis because the size of the membership—over 6 million commercial lives—would dominate the results. For this analysis, financial risk-sharing is defined in three categories:

- **No risk.** The provider is paid fee-for-service rather than through capitation.
- **Professional risk.** Capitation is only for professional services (non-facility clinician and ancillary services such as outpatient lab tests).
- **Full risk.** Capitation covers both professional and facility services. Full risk can be through a single provider contract (global risk) or through separate contracts for professional and facility services (dual risk).

### CLINICAL QUALITY

Atlas results revealed higher clinical quality scores for members cared for by risk-sharing providers, compared with those cared for by fee-for-service providers. This is based on a clinical quality composite of eight measures. An average performance rate is then derived from this composite.

Statewide, the average performance rate for members with professional risk was 65.6% across the eight quality measures. For full-risk, it was 67.1%. But for no-risk providers, it was 57.9%. This pattern was seen across the state—in Northern, Central, and Southern California.

One explanation may be that risk-sharing providers are using the greater flexibility of capitated payment to invest in infrastructure—such as care management programs—that supports population health and quality improvement.

There was little difference in the composite scores for professional and full risk-sharing providers. This may reflect that the main distinction is between no risk-sharing and any risk-sharing, the measures are primarily ambulatory, and/or quality is primarily driven by clinicians.
TOTAL COST OF CARE

Statewide, the Atlas 3 results show that risk-sharing providers are also associated with lower total cost of care.

For this analysis, total cost of care includes member cost-sharing and is adjusted for both clinical risk and geography. (Details available at atlas.iha.org.) Members cared for by fee-for-service providers were associated with a total cost of care of $4,589. That compares to $4,501 for professional-risk providers—and $4,428 for full risk.

The difference between full risk and no risk was $161, approximately 3.5 percent. The clear association between greater risk-sharing and lower total cost of care suggests that risk-sharing and capitation play a role in containing healthcare costs. This supports the growing momentum for shifting away from fee-for-service payment.

At a regional level (Northern, Central, Southern California), the relationship between financial risk and total cost of care varied. That variation raises interesting questions about market dynamics across the state, including how the prevalence of risk-sharing may influence cost and other outcomes of interest.

THE IMPACT OF RISK ON PHARMACY COST

Little data have been available on the impact of risk-sharing on pharmacy cost—and yet pharmacy is a large and growing component of total cost of care.

The Atlas results show that, at the statewide level, fee-for-service providers are associated with the highest pharmacy cost ($970 per member per year, or PMPY). Full-risk providers are associated with the lowest cost ($840 PMPY), while professional risk falls in the middle ($882 PMPY).

Clinical risk is very similar across the three risk-sharing levels—each within 1% to 2% of the others—so this does not account for the differences. And like the results on total cost of care, the association between pharmacy cost and risk-sharing reveals substantial variation across regions. (Details available at atlas.iha.org.)

HIGHER QUALITY AT SIMILAR OR LOWER COST

Exhibit 4 shows a summarized view of the association between financial risk-sharing and better value.

How does this association vary by region? Exhibit 5 arrays the three levels of risk for all 19 Covered California regions on two continuums: total cost of care and clinical quality. This produces 51 data points across 19 regions and three risk-sharing levels. (Six full-risk regions were excluded due to small enrollment numbers.)

The results are distributed into four quadrants, defined by the statewide average for cost and quality for the population. Fifteen of the 51 data points fell into the high-value quadrant—above the statewide average for clinical quality and below the statewide average for total cost of care. Nine of these 15 represent full risk, and six represent professional risk. None of the regions for no-risk (fee-for-service) fell into the high-value quadrant.

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Reducing In-Home Medication Issues Using an Alternative Workforce

BY JUNE SIMMONS AND SANDY ATKINS

Medication issues in the home have been largely invisible for a long time. The kicker is that medication issues are a major driver of costly adverse health outcomes.

A strong, evidence-based program developed by Partners in Care Foundation—HomeMedsSM—brings a nonclinical workforce solution to the home to be the “eyes and ears” for providers. When married to an accompanying software tool, the results are both compelling and powerful:

- Participant A: “I used to take 20 different medications, and after HomeMeds I was down to only eight. You saved us money and you saved my life.”
- Participant B: “I have been taking this medication for years and never knew when I should stop because I was never told, so I still take it and I don’t know why.”
- Participant C: “Medication costs have gone up, so I cut my pills in half and they last longer.”
- Participant S: “I didn’t know that my cold medication and my pain medication had the same ingredients all of this time I was taking them.”

These comments illustrate the great importance of patients taking the right medicines—and consistently taking them in the right dose, at the right time, and in the right way.

Unfortunately, medication-related problems (MRPs) are common. As many as 60% of community-dwelling elders are estimated to have medication-related problems—with falls, dizziness, and confusion being common results.

Over 1.3 million people end up in an emergency department each year as the result of adverse drug events. When you add up unnecessary emergency department use, hospital readmissions, and skilled nursing facility admissions, drug-related morbidity and mortality cost the health system more than $170 billion annually.

Over 72% of post-discharge adverse events are related to medications—and close to 20% of discharged patients suffer an adverse event. What is most shocking, though, is that at least 25% of all harmful adverse drug events are preventable.

AN EFFECTIVE PREVENTION

Twenty years ago, Partners in Care Foundation of San Fernando, California, developed a home medication safety program called HomeMeds. The high-level, evidence-based model uses bachelor’s level social workers or community health workers as health coaches in the home, backed by an offsite consultant pharmacist.

The John A. Hartford Foundation funded the intensive research that established HomeMeds’ effectiveness, and it then funded efforts to develop software and disseminate the
program nationwide for home health settings. In 2003, Partners was awarded funding from the U.S. Administration on Aging to further develop the program so that a nonclinical workforce could deploy it.

Under the program, highly skilled community health coaches—adroit at patient engagement and knowledgeable about community resources—visit the homes of high-risk individuals. The coaches conduct a formal medication safety assessment, as well as an assessment of environmental, functional, and psychosocial needs.

HomeMeds is now included among the few programs listed in the Administration for Community Living’s rigorously tested Aging and Disability Evidence-Based Programs and Practices. As MRPs are a major cause of avoidable hospital admissions, readmissions, and emergency department visits, this in-home nonclinical tool has great power to protect and extend health. Licensed by Partners in Care, it has a very powerful ROI in both enhanced quality scores and net financial outcomes.

THE HOMEMEDS PROCESS

A community-based health coach visits the patient and inventories all medications in the home. This inventory includes not only prescribed medications, but also drugs from other countries, meds borrowed from friends or family, over-the-counter drugs, herbs and supplements, and the unusual or unexpected—such as the owner taking his dog’s glucosamine.

During the visit, this list and other pertinent data are entered in the HomeMeds web-based software. Next, the coach interviews the patient about signs of potential adverse medication effects, such as any recent falls, dizziness, or confusion.

The coach also asks the patient to take his or her own blood pressure and pulse, preferably in two positions. Lastly, the coach explains each medication’s instructions to determine the patient’s understanding of and adherence to properly taking and using each medication.

Once the assessment and input are completed, the HomeMeds software algorithm looks for any potential MRPs that would explain patient symptoms. If it identifies problems, a report is sent to a pharmacist, who reviews these potential issues and makes recommendations for resolution. The recommendations are then provided to the prescribing provider and sometimes to the patient as well.

A key aspect of this approach is that the analysis and recommendations are made by trained, licensed professionals—not the coach.

The coach’s role is very specific:

- Collect medication information and patient-reported signs and symptoms.
- Enter data into the HomeMeds software, preferably in the home.
- Contact a pharmacist and collaborate with a care plan.
- Contact the patient to verify medications, if needed.
- Follow up with the patient regarding medication changes recommended by the pharmacist.

The pharmacist’s role is just as specific:

- Screen alerts to confirm the importance of identified problems.
- Communicate with prescribers.
- Consult with the care manager.
- Identify medication problems beyond protocols.
- Assist with complex cases (e.g., simplification of medication regimens for cognitively impaired people).
- Educate staff about medications/risks.
- Document actions taken into the HomeMeds software.

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HomeMeds Evidence-Based Recognition

- U.S. Administration for Community Living recognition as an evidence-based prevention program
  - Highest level of evidence
- Aging & Disability Registry of Evidence-Based Programs and Practices
  - Quality of research: 3.2/4
  - Readiness for dissemination: 4/4
- U.S. Agency for Healthcare Research and Quality (AHRQ) Innovation Exchange
  - Strong evidence rating
RISK-SCREENING PROTOCOLS

One of the benefits of using the HomeMeds process to identify potential medication complications is that it uses a set of risk-screening protocols. These protocols were selected through the efforts of a national consensus research panel chaired by Mark Beers, MD, using the following criteria:

- Amenable to home-based intervention
- Alternatives exist for prescribers
- Problems identified are important enough that providers are likely to respond (i.e., avoid alert overload).

HomeMeds addresses four categories of MRPs:

1. Unnecessary therapeutic duplication
2. Use of psychotropic drugs in patients with a reported recent fall and/or confusion
3. Use of non-steroidal anti-inflammatory drugs (NSAIDs) in patients at risk of peptic ulcer/gastrointestinal bleeding (age 80 or older, patients also using anticoagulants, antplatelets, corticosteroids, etc.)
4. Cardiovascular medication problems: high systolic blood pressure, low pulse, orthostasis, and low systolic blood pressure

A COMPREHENSIVE SDOH SOLUTION

While HomeMeds has historically been an add-on to other home- and community-based services, it is increasingly the core element of a home visit program called HomeMedsPlus.

Anchored by HomeMeds, HomeMedsPlus is provided by community agencies in partnership with health systems and health plans. It features evidence-based care transitions coaching, comprehensive psychosocial and home safety assessment, and connection with services to address social determinants of health (SDOH). The assessment and care planning tools are structured to ensure standardized work throughout a contracted service area, such as that served by the California Partners at Home Network and other community-based organizations across the country.

EVIDENCE-BASED SUCCESS

HomeMeds is included in the National Registry for Evidence-based Programs and Practices. It is also included with a strong evidence rating on the U.S. Agency for Healthcare Research and Quality (AHRQ) Innovation Exchange.

Since the software rolled out in 2011, over 65,000 individuals have been screened through HomeMeds, with 40% to 60% of those screened having potential MRPs. Typically, more than 60% of pharmacist recommendations are implemented, in collaboration with physicians, patients, families, and care managers.

In care transition programs, HomeMeds pharmacists have estimated that the intervention prevented emergency department use in 40% of 2,927 patients with MRPs. Combined with the Coleman Care Transitions Intervention, HomeMeds produced a 50% reduction in readmission rates across five Southern California hospitals within a large health system.

HomeMeds is in use at 60 sites in 20 states—including medical groups and hospitals, health plans, area agencies on aging, post-hospital care transition programs, home-delivered meals programs, fall prevention collaboratives, and care management programs. Its use is expanding, and new medical practices are working toward adding the service.

It can be successfully applied anywhere people live, be it an individual residence, a congregate housing site, or an assisted living facility. Partners is also available to advise or consult on the design of related SDOH community partnerships.

June Simmons is President and CEO of the Partners in Care Foundation, and Sandy Atkins is Senior Strategy Advisor. HomeMeds is available through the Partners in Care Foundation, which has a group purchasing discount pricing arrangement with APG. To learn more, email Partners@picf.org or call 818-837-3775.
**ALIGNED INCENTIVES AND VALUE-BASED INFRASTRUCTURE**

At the national level, there is strong policy interest in financial risk-sharing as an important component of alternative payment models. These models include Medicare accountable care organizations (ACOs), which are designed to shift incentives away from charging for each patient service and toward producing health.

As the lines between HMO and PPO products blur—through the introduction of ACOs and Covered California’s standard benefit design based on actuarial value—the degree of financial risk-sharing and its influence on cost and quality bears further examination.

Financial risk-sharing funds the infrastructure that supports California’s delegated model of care and benefits millions of Californians. Capitation provides a stable and predictable source of funds that can be invested in population health, care management, and other programs that support high-quality, efficient care.

This analysis begins to address the key question: What is the added value of risk-sharing provider organizations in managing cost and quality for members? To support delivery system transformation, we need better ways to measure clinical integration and coordination, and to reward strong performance on delivery of patient-centered care.

Risk-sharing is an important part of the puzzle, because it allows provider organizations to shift from a transactional approach to a patient-centered perspective.

Dolores Yanagihara, MPH, is Vice President of Stakeholder & Partner Management for the Integrated Healthcare Association. For 14 years, she has led the development of performance measurement and reporting programs at IHA—such as Align. Measure. Perform. (AMP) and the California Cost & Quality Atlas—by convening physician groups, health plans, and other stakeholders to agree on a standard, statewide approach.

**IHA’s Atlas Tool and Analysis**

The Atlas (atlas.iha.org) is a benchmarking and hot-spotting improvement tool that includes about 30 million insured Californians. For commercial insurance, the Atlas tracks regional performance for clinical quality, average annual total cost of care per member, and hospital utilization—based on care provided to roughly 14 million Californians enrolled in commercial HMOs, PPOs, accountable care organizations (ACOs), and self-insured arrangements.

All results are based on administrative (claims and encounter) data, with some supplemental lab results and pharmacy data. Clinical data will be incomplete when using administrative data and may result in rates that are lower than actual performance due to data limitations. The financial risk-sharing analysis is based on performance in 2017 and does not include Kaiser Permanente.
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