AMERICA'S PHYSICIAN GROUPS

CareJourney

Webinar: Deep Dive Into Direct Contracting

The Five W's of the DCE Model: What You Need to Know

February 16, 2021

Housekeeping Items

- Type questions in the Q & A box
- This webinar will be recorded
- Links to the recording and slides will be sent to registrations
- Please complete the post-webinar survey that will appear after you close the WebEx window

Our Esteemed Panel

Pauline Lapin
Seamless Care Models Group
CMS

Melanie Matthews
CEO
Physicians of Southwest Washington

Gary Jacobs
Executive Director
VillageMD Center for Govt. Relations & Public Policy

Valinda Rutledge
EVP of Federal Affairs
America's Physician Groups

Dr. Bob Stone
Senior Medical Director, Ambulatory Services
Central Ohio Primary Care

Raj Shrestha
COO
Intermountain Healthcare Company

Aneesh Chopra
President
CareJourney

Today's Panelists

Today's Moderators

Agenda for Today

Opening Comments on DC Models
Pauline Lapin

Go/No Go in the DC Global Model
Melanie Matthews and Bob Stone

What is the Value of the DC GEO Model
Gary Jacobs and Raj Shrestha

Questions and Answers
Led by Valinda Rutledge

Pauline Lapin

Seamless Care Models Group

CMS

AMERICA'S PHYSICIAN GROUPS

Evolution to Geographic Direct Contracting

Professional

- ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
- 50% shared savings/shared losses with CMS
- **Primary Care Capitation (PCC)** equal to 7% of total cost of care for enhanced primary care services

Global

- 100% risk
- Choice between **Total Care Capitation (TCC)** equal to 100% of total cost of care provided by Participant and Preferred Providers, and PCC

Geographic

- Open to any covered entity interested in taking on regional risk and entering into arrangements with clinicians in the region
- Choice between **Total Capitation** or **Partial Capitation**
- New flexibilities (e.g. program integrity)

Lowest Risk → Highest Risk

CMMI at 10 Years - Models Evaluation

SOUNDING BOARD

CMS Innovation Center at 10 Years — Progress and Lessons Learned

Brad Smith, M.Phil.

Article Figures/Media Metrics

3 References

TEN YEARS AGO, THE CENTER FOR MEDICARE AND MEDICAID INNOVATION (THE Center) was created within the Centers for Medicare and Medicaid Services (CMS) to test innovative payment and service delivery models to transform the American health care system from one that pays for volume to one that pays for value. This highly ambitious goal was summarized in the legislation authorizing the Center to develop models that "reduce program expenditures...while preserving or enhancing the quality of care furnished to individuals."[1] To achieve this bold goal, the Center has been given $20 billion in funding since its inception, along with the authority to waive certain Medicare and Medicaid requirements.

Since becoming the fourth director of the Center in January 2020, I have spent substantial time analyzing the lessons learned during the past 10 years. My conclusion from this analysis is that value-based care continues to offer promise to transform American health care. However, value-based care will achieve its promise only if the federal government and stakeholders take more aggressive action to prioritize models that can truly achieve savings and improve quality.

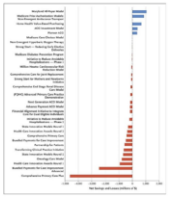
Results to Date

During the past decade, the Center has achieved many important successes. It has launched 54 models that address critical areas of health care, including primary care, oncology, kidney care, and cardiovascular disease. Nearly 1 million health care providers serving 26 million patients have participated in these models. Value-based care has spread rapidly across the country, with approximately 40% of Medicare fee-for-service payments, 30% of commercial payments, and 25% of Medicaid payments today being made through some form of value-based arrangement.[2]

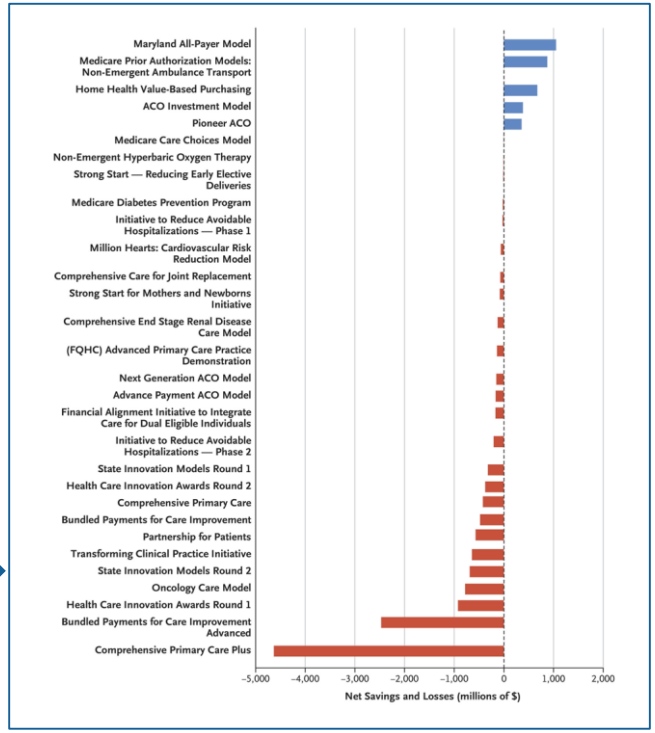
The Center's models have also delivered some positive, tangible results, including five that have resulted in substantial financial savings (Figure 1). Several models have also produced significant improvements in quality. For example, the Comprehensive ESRD (End-Stage Renal Disease) Care model showed a decrease in emergency dialysis sessions, overall hospitalizations, readmissions, and hospitalizations for ESRD-related complications. Similarly, the Home Health Value-Based Purchasing model resulted in an average improvement of 4.6% in quality scores for home health agencies.

However, the vast majority of the Center's models have not saved money, with several on pace to lose billions of dollars. Similarly, the majority of models do not show significant improvements in quality, although no models show a significant decrease in quality. In examining these outcomes, we have identified several key lessons.

Figure 1.



Net Savings and Losses Associated with Selected Models.



Source: New England Journal of Medicine
CMS Innovation Center at 10 Years — Progress and Lessons Learned
By Brad Smith

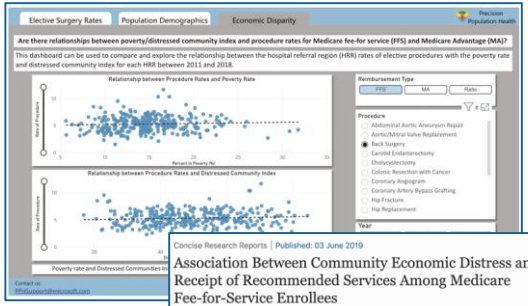
A Decade Later, We Have Room to Improve

National	Distressed Community Index score quintile (5 = Most Distressed)				
	Least	2	3	4	Most
Number of zip codes	5,225	5,223	5,224	5,223	5,225
Mean distressed community index score (SD)	10.00 (5.77)	30.00 (5.77)	50.00 (5.77)	70.00 (5.77)	90.00 (5.77)
Zip code level demographics					
Mean number of FFS Medicare enrollees (SD)	6,485,956 (1,240)	4,915,273 (1,170)	4,305,994 (1,069)	4,026,204 (1,008)	3,538,810 (827)
Mean HCC risk score (SD)	0.86 (0.10)	0.88 (0.11)	0.90 (0.12)	0.93 (0.12)	0.98 (0.14)
Mean per-capita Medicare Part A & B expenditures ($) (SD)	$9,885 ($1,986)	$10,044 ($2,274)	$10,435 ($2,665)	$10,758 ($2,737)	$11,385 ($3,145)
Zip code level mean proportion of eligible enrollees receiving recommended care					
Flu shots (%) (SD)	50.6% (11.1%)	44.40% (12.0%)	40.4% (11.6%)	37.1% (10.9%)	33.4% (10.5%)
Annual wellness visits (%) (SD)	29.9% (10.7%)	25.1% (11.6%)	22.2% (11.3%)	19.6% (10.5%)	18.3% (10.0%)
Transitional care management (%) (SD)	14.8% (7.7%)	15.7% (8.9%)	14.5% (8.8%)	13.3% (7.9%)	11.6% (6.9%)
Advanced care planning visits (%) (SD)	3.4% (2.9%)	3.8% (3.6%)	3.9% (3.6%)	4.1% (4.0%)	4.5% (4.9%)
Avoidable ED visits (%) (SD)z]	26.3% (10.0%)	26.8% (11.2%)	28.0% (11.6%)	29.7% (11.2%)	31.7% (10.4%)

DCI Distress	MSSP ACO%[1]	AWV%	Avoidable ED%	Af-Am % FFS[2]
1	42%	30%	26%	4%
2	37%	25%	27%	7%
3	38%	22%	28%	9%
4	33%	20%	30%	9%
5	32%	18%	32%	14%

[1]2019 CMS Shared Savings Program Benchmark PUFs

[2]Af-Am percentage of fee for service population; 2019 CareJourney analysis of CMS FFS Beneficiary RIF Data



Concise Research Reports | Published: 03 June 2019

Association Between Community Economic Distress and Receipt of Recommended Services Among Medicare Fee-for-Service Enrollees

William B. Weeks MD, PhD, MBA, Stacey Y. Cao MHS, Chris M. Lester PhD, James N. Weinstein DO, MS & Nancy E. Morden MD, MPH

Journal of General Internal Medicine 34, 2731-2732(2019) | Cite this article
227 Accesses | 2 Citations | 2 Altmetric | Metrics

BACKGROUND

Community-level social determinants of health and economic distress explain some disparities in health service utilization and outcomes among older Medicare fee-for-service (FFS) enrollees.[1] Medicare-covered and recommended preventive and care coordination services—including flu vaccines, annual wellness visits (AWVs), transitional care management (TCM), and advance care planning (ACP) visits—may improve outcomes and reduce spending,[2–3] but uptake of these services has been slow,[4–5] particularly among the disenfranchized.[5]

Microsoft | Research

In collaboration with CareJourney

Source: Weeks, W.B., Cao, S.Y., Lester, C.M. et al. Association Between Community Economic Distress and Receipt of Recommended Services Among Medicare Fee-for-Service Enrollees. J GEN INTERN MED 34, 2731–2732 (2019). https://doi.org/10.1007/s11606-019-05076-6

AMERICA'S PHYSICIAN GROUPS

Dr. Bob Stone

Senior Medical Director,
Ambulatory Services
Central Ohio Primary Care

Melanie Matthews

CEO
Physicians of Southwest
Washington

AMERICA'S PHYSICIAN GROUPS

COPC Clinical Models Initiated with CPC+ Support

- Expand Care Coordination to Medicare patients (from Medicare Advantage only)
- Extensive Care Center - Location for longer-term care/ER Substitute
  - IV fluids
  - IV antibiotics
  - Diuresis in CHF
  - No Overnight Patients
  - No Ischemia Workups
- Care Navigation Center (initially, After Hours Support Center)
  - NP & RN software-guided triage system
  - Available now 7:30 am to 11:00 pm every day
- Falls Risk program based on Stepping On evidence-based protocols
- Initiating co-located Behavioral Health in offices
- Covering deficits for high-value programs which have limited or no reimbursement
  - Diabetes Education, Asthma, Smoking Cessation, etc.

CENTRAL OHIO PRIMARY CARE

AMERICA'S PHYSICIAN GROUPS

Benchmarking Performance Against Market, Rate Book

Metric	2019	Counties OVERALL
	Central Ohio Primary Care[1]	2019 Avgs. Delaware/Franklin OH
Total Patients	29,641	96,451
Total PMPY	$ 8,294	$ 9,882
Avg. HCC Score	0.846	0.943
Risk-Adj. PMPY	$ 9,808	$ 10,476
% Frail / Elderly	7.5%	9.2%
Visits per 1k		
PCP Visits	9,352	
IP Admits	136.9	222.4
SNF Admits	49.1	86.6
% Compliance		
AWV	72.3%	
TCM	22.6%	
Flu	73.6%	
Readmission Rate	22.3%	
ED Visits per 1k		
Avoidable	149.8	149.9
Total ED	487.4	357.4

[1]COPC Numbers are practice level and not specific to a Bene's Geography

2019	Counties	DC RATE	
COPC	Blend	Delaware, OH	Franklin, OH
$8,294	$9,882	$11,887	$12,168

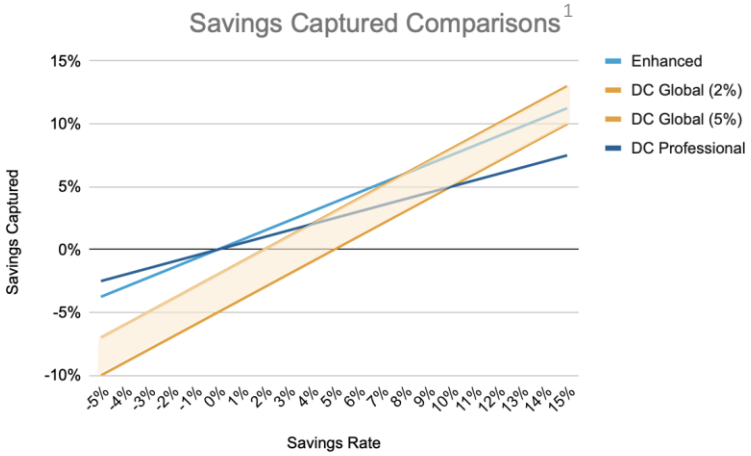
CENTRAL OHIO PRIMARY CARE

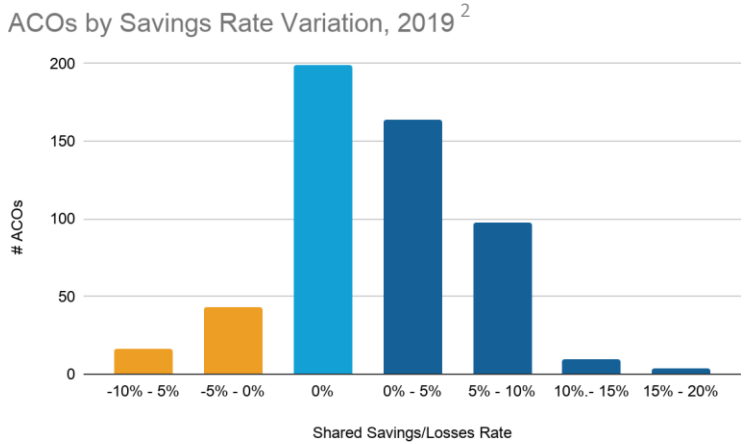
Key Takeaways

- Central Ohio Primary Care (COPC) performs better than other providers in Delaware and Franklin Counties
- COPC projected to perform well against the Direct Contracting Aged & Disabled Rates for Delaware and Franklin Counties

Data Analysis By: CareJourney

Deep Dive on Performance Assumptions



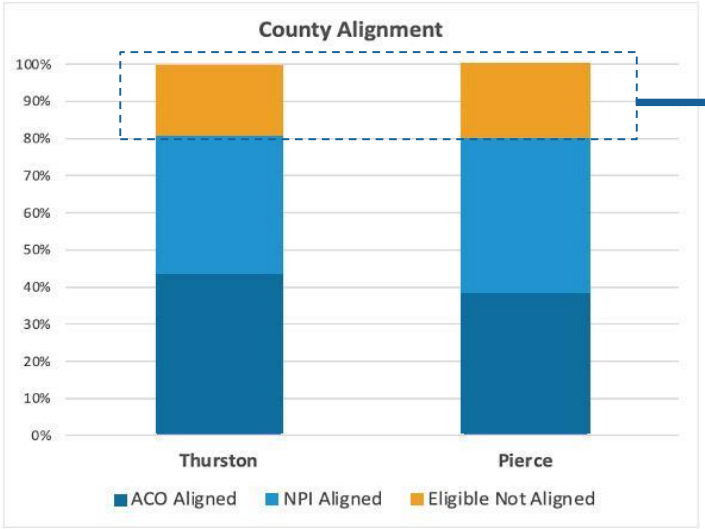


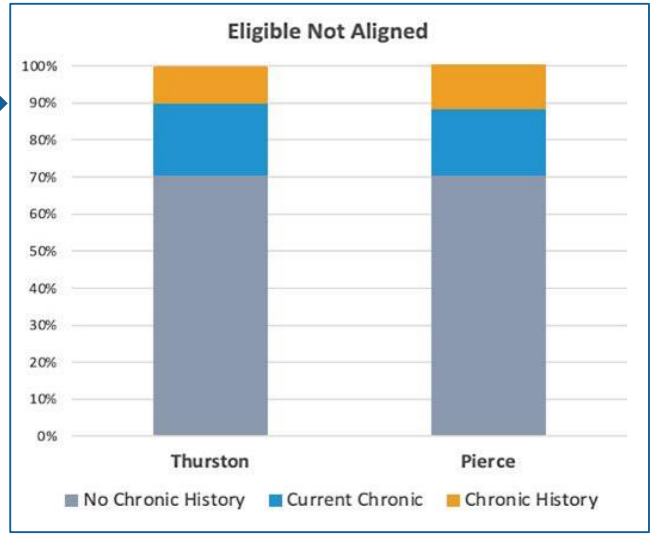
Category	Enhanced	DC Pro	DC Global
Savings Rate	75%	50%	100%
Discount	NA	NA	2% - 5%

[1]CMS DC RFA, Pathways to Success Final Rule
[2]2019 Shared Savings Program Benchmark PUFs

Serving the Chronically Ill via Voluntary Alignment

- Voluntary Alignment options on the NPI-aligned but not ACO enrolled, and eligible but not aligned populations
- ACO and NPI Aligned both at 40% of the population
- 30% of the Eligible Not Aligned population has documented current or historical chronic conditions
    - This subpopulation has historical 3 year PMPM 54% higher than current year





Capitation Considerations

- In 2019, MCC primary care practitioners rendered $9.7M in PCC services to MSSP beneficiaries. This is the base PCC amount we could expect to receive under DC Glo/Pro. ~~$800K/month or $23 PMPM.
- Under Enhanced PCC, MCC could elect to receive up to an additional $16M in capitation payments

  ~~$2.2M/month or $62 PMPM.
- All capitation amounts are reconciled at the end of the performance year.

	Primary Care	All Other Specialties
PCC Services	9,748,176	5,304,138
All Other Services	6,475,584	30,388,553
Total	**16,223,760**	**35,692,691**

Category	2019 Spend	% of Total Spend
PCC	9,748,176	2.6%
APO	42,168,275	11.3%
Enhanced PCC	16,284,453	4.4%

2019 Claims for 2019 Membership in MCC MSSP ACO

Gary Jacobs

Executive Director
VillageMD Center for Govt. Relations & Public Policy

Raj Shrestha

COO
Intermountain Healthcare Company

AMERICA'S PHYSICIAN GROUPS

Spotlight on Houston CBSA

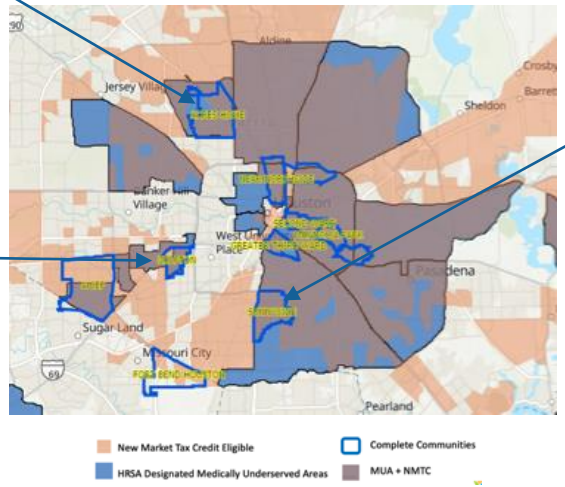
Houston Complete Communities Initiative

VillageMD

Harris County, TX (271,695)	Least	Distressed Community Index (5 = Most Distressed) 2	3	4	Most
HCC	0.90	0.97	1.00	1.06	1.15
$ PMPY	$11,447	$13,207	$14,227	$15,239	$17,626
$ IP/Bene	$3,756	$4,644	$4,701	$5,328	$6,437
Primary Care Treatable ER/K	166	195	212	233	313
Flu Compliance%	53%	45%	41%	37%	32%

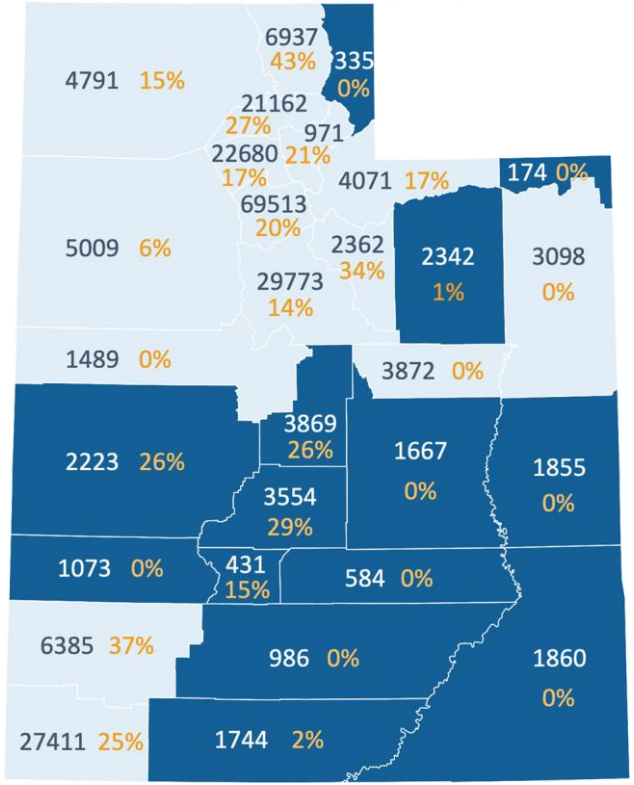
Acres home	
Distress Level	5
HCC	1.17
$ PMPY	$16,718
$ IP/Bene	$6,104
Primary Care Treatable ER/K	322
% Flu Compl.	30%

Gulfton	
Distress Level	5
HCC	1.03
$ PMPY	$16,860
$ IP/Bene	$6,270
Primary Care Treatable ER/K	314
% Flu Compl.	36%



Sunnyside	
Distress Level	5
HCC	1.35
$ PMPY	$ 21,487
$ IP/Bene	$ 8,224
Primary Care Treatable ER/K	449
% Flu Compl.	25%

Intermountain Geographical Coverage: Utah



Intermountain ACO: Utah CBSA Analysis

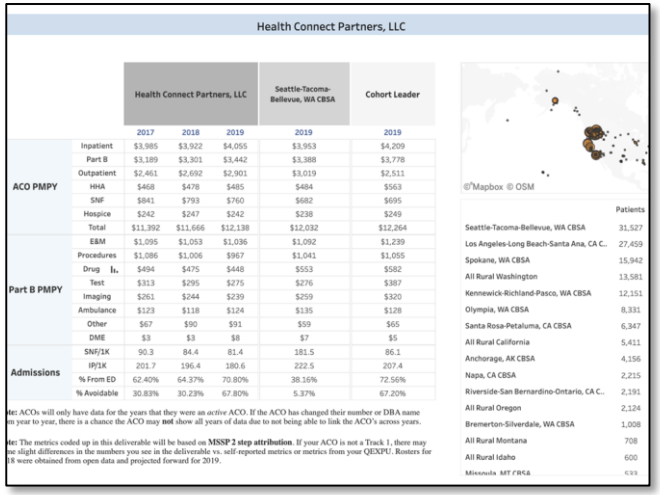
Metric	2019				ACO OVERALL
CBSAs	**Salt Lake City**	**Ogden-Clearfield**	**St. George**	**All Rural Utah**	**Intermountain ACO**
DC Eligible Benes	74,522	49,604	27,411	45,550	NA
Total Patients	14,359	10,755	6,891	7,220	48,929
Total PMPY	$11,039.0	$10,129.3	$10,113.6	$10,034.8	$10,527.3
Avg. HCC Score	0.964	0.927	0.956	0.921	0.947
Risk-Adj. PMPY	$11,453.8	$10,924.3	$10,584.4	$10,889.7	$11,117.2
% Frail / Elderly	11.1%	9.0%	10.4%	9.0%	9.8%
Visits per 1k					
PCP Visits	9,182.8	9,195.8	9,851.4	8,819.8	9,149.3
IP Admits	197.3	205.2	196.0	185.2	198.5
SNF Admits	70.7	72.3	70.5	71.5	72.5
% Compliance					
AWV	66.2%	70.7%	62.6%	65.9%	64.9%
TCM	7.4%	4.3%	4.8%	0.0%	5.9%
Flu	63.2%	60.1%	59.8%	61.1%	59.9%
Readmission Rate	10.5%	10.6%	14.0%	9.4%	11.4%
ED Visits per 1k					
Avoidable	185.9	176.7	148.2	167.7	173.6
Total ED	619.3	602.9	545.8	599.9	600.6

Data Analysis By:
CareJourney

Connect With Us!

- Valinda Rutledge: vrutledge@apg.org
- Aneesh Chopra: aneesh.chopra@carejourney.com
- Melanie Matthews: melaniem@pswipa.com
- Robert Stone: rstone@copcp.com
- Raj Shrestha: Raj.Shrestha@imail.org
- Gary Jacobs: gjacobs@villagemd.com

APG - CareJourney Partnership: Join the RETF!



Health Connect Partners, LLC

		Health Connect Partners, LLC			Seattle-Tacoma-Bellevue, WA CBSA	Cohort Leader
		2017	2018	2019	2019	2019
ACO PMPY	Inpatient	$3,985	$3,922	$4,055	$3,953	$4,209
	Part B	$3,189	$3,301	$3,442	$3,388	$3,778
	Outpatient	$2,461	$2,692	$2,901	$3,019	$2,511
	HHA	$468	$478	$485	$484	$563
	SNF	$841	$793	$760	$682	$695
	Hospice	$242	$247	$242	$238	$249
	Total	$11,392	$11,666	$12,138	$12,032	$12,264
Part B PMPY	E&M	$1,095	$1,053	$1,036	$1,092	$1,239
	Procedures	$1,086	$1,006	$967	$1,041	$1,055
	Drug	$494	$475	$448	$553	$582
	Test	$313	$295	$275	$276	$387
	Imaging	$261	$244	$239	$259	$320
	Ambulance	$123	$118	$124	$135	$128
	Other	$67	$90	$91	$59	$65
	DME	$3	$3	$8	$7	$5
Admissions	SNF/1K	90.3	84.4	81.4	181.5	86.1
	IP/1K	201.7	196.4	180.6	222.5	207.4
	% From ED	62.40%	64.37%	70.80%	38.16%	72.56%
	% Avoidable	30.83%	30.23%	67.80%	5.37%	67.20%

Note: ACOs will only have data for the years that they were an *active* ACO. If the ACO has changed their number or DBA name in year to year, there is a chance the ACO may **not** show all years of data due to not being able to link the ACO's across years.

Note: The metrics coded up in this deliverable will be based on **MSSP 2 step attribution**. If your ACO is not a Track 1, there may be slight differences in the numbers you see in the deliverable vs. self-reported metrics or metrics from your QEXPU. Rosters for '18 were obtained from open data and projected forward for 2019.

	Patients
Seattle-Tacoma-Bellevue, WA CBSA	31,527
Los Angeles-Long Beach-Santa Ana, CA C..	27,459
Spokane, WA CBSA	15,942
All Rural Washington	13,581
Kennewick-Richland-Pasco, WA CBSA	12,151
Olympia, WA CBSA	8,331
Santa Rosa-Petaluma, CA CBSA	6,347
All Rural California	5,411
Anchorage, AK CBSA	4,156
Napa, CA CBSA	2,215
Riverside-San Bernardino-Ontario, CA C..	2,191
All Rural Oregon	2,124
Bremerton-Silverdale, WA CBSA	1,008
All Rural Montana	708
All Rural Idaho	600
Missoula, MT CBSA	533

Email us at vrutledge@apg.org or info@carejourney.com to see how you can join!

ACO Benchmark Reports

- ✓ **Available only to RETF Members**
- ✓ **Includes Map of Attributed Patient Population**
- ✓ **Key Metrics:**
- ✓ ACO PMPY Metrics
- ✓ Part B PMPY Metrics
- ✓ Admissions Metrics
- ✓ CBSA Metrics
- ✓ Cohort Leader Metrics
- ✓ **Available in your Inbox**

RISK EVOLUTION TASK FORCE AMERICA'S PHYSICIAN GROUPS

Questions?

AMERICA'S PHYSICIAN GROUPS