AMERICA'S PHYSICIAN GROUPS

APG DIRECT CONTRACTING COALITION

Direct Contracting Coalition Webinar April 27, 2021

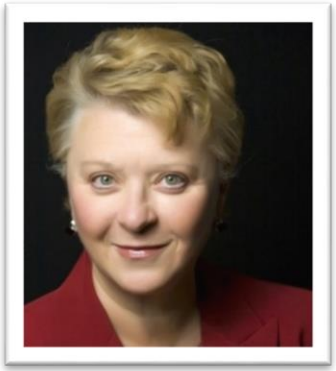
Housekeeping

- 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

APG DIRECT CONTRACTING COALITION

The Coalition is an opportunity for participants to exchange information, share best practices, and collaborate on advocacy opportunities that will strengthen the experience in the Direct Contracting Model.

DC Coalition Leadership



Valinda Rutledge

EVP, Federal Affairs APG

Gary Jacobs

Executive Director VillageMD Center for Govt. Relations & Public Policy

Aneesh Chopra

President CareJourney

Rushika Fernandopulle

Co-Founder and CEO Iora Health

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Agenda

- Update on CMMI Communication- Valinda
- Proposed Congressional Outreach- Valinda
- Status of April 1st Start Date Group- Rushika/Gary
- Second Coalition Letter Status- Valinda
- Evaluating Underserved and High Needs Populations- Gary/Aneesh
- Open Mic- All

Update on CMMI Communication-Valinda

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Status of programs

- Global/Professional Direct Contracting(GPDC) Performance Year 1- April 1, 2021
- GPDC Performance year 2- January 1, 2022 for Deferred Applications only

Proposed Congressional Outreach- Valinda

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Congressional Outreach

Senate	House
• Kaine (VA) • Warner (VA) • Schumer (NY) • Durbin (IL) • Wyden (OR) • Duckworth (IL) • Stabenow (MI) • Murray(WA) • Brown (OH)	• Pelosi (CA) • Neal (MA) • Pallone (NJ) • Kind (WI) • Bera (CA) • Schneider (IL) • Eshoo (CA) • Doggett (TX) • Thompson (CA)

From the Trenches Update-

Rushika/ Gary

Village MD Pearls of Wisdom

- Claims
- Benchmarking
- Risk score trend
- Beneficiary identification and attribution

Second Coalition Letter Status- Valinda

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Second Coalition Letter

- A Second Coalition Letter to CMMI detailing recommended changes to the April 1st performance period and flexibilities needed for the January 1st applicants –
- Draft will be sent to Coalition members by end of week

CareJourney

Evaluating Underserved and High Needs Populations

April 2021

“Deep—Dive” on Medicare APM Demographics

CareJourney conducted an analysis on the 2019 set of 100% of CMS beneficiary-level claims data to better understand care delivery to underserved and high needs populations. The first set of outputs, with key findings below, break down national counts of beneficiaries by enrollment type, Distressed Community Index (DCI), Race, Dual Status, and Disabled Status.

You are 26% more likely to be assigned to an ACO if you live in a community that is not distressed (1) vs. (5) distressed

You are 48% more likely to be in MA if you are Hispanic or Black and similarly less likely to be in an ACO

Generally speaking, MA has better penetration of non-white, economically distressed beneficiary populations than ACOs.

Disadvantaged categories tend to be overrepresented in the non-assignable category

Definitions

Data Year
2019

Categories (These are Mutually Exclusive)	
MA	At least one month of MA Part C buy-in in 2019 from Master Beneficiary Summary File (MBSF)
ACO-Enrolled	MSSP enrolled for 2019 based on full year 2019 retrospective claims from VRDC SSP_Beneficiary source of truth
Assignable	Has at least 1 month of both Part A & Part B buy-in, no months with only Part A or Part B, no Medicare Buy-in and at least one eligible primary care service (based on MSSP attribution rules) in 2019. Uses MBSF and Claims. Not attributed to an ACO in 2019
Not-Assignable	Fails assignable criteria - either eligibility or qualifying PCP service.

DCI Quintile
1 (least distressed) - 5 (most distressed) ranking of beneficiary community based on EIG's distressed community index (DCI)
https://eig.org/dci/methodology

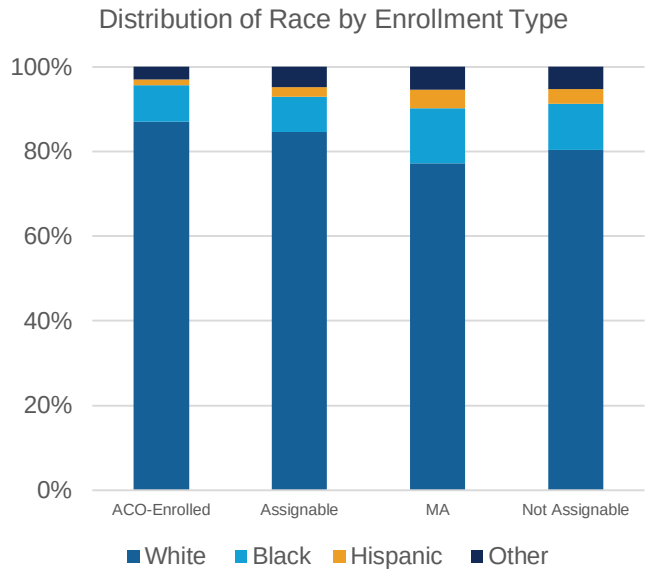
Race, Dual, Disabled
Race, Dual, and Disabled categories are based on the master beneficary summary file for 2019
https://requests.resdac.org/cms-data/files/mbsf-base/data-documentation

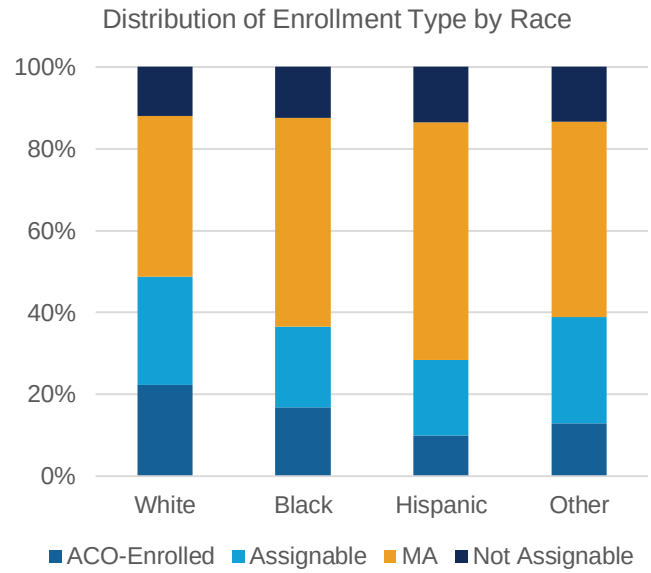
Distribution by Enrollment and Race

This table shows the 2019 breakdown of Medicare beneficiaries across ACO-Enrolled, Assignable, Not Assignable, and Medicare Advantage. It then also breaks down the distribution of population by Race.

Row Labels	ACO-Enrolled	Assignable	MA	Not Assignable	Grand Total
White	10,758,090	12,735,789	18,915,229	5,773,124	48,182,232
Black	1,062,032	1,246,124	3,226,012	788,895	6,323,063
Hispanic	180,725	331,794	1,048,216	245,534	1,806,269
Other	363,875	729,688	1,336,300	377,241	2,807,104
Grand Total	**12,364,722**	**15,043,395**	**24,525,757**	**7,184,794**	**59,118,668**

Distribution by Enrollment and Race





Race	ACO-Enrolled	Assignable	MA	Not Assignable
White	87%	85%	77%	80%
Black	9%	8%	13%	11%
Hispanic	1%	2%	4%	3%
Other	3%	5%	5%	5%

Enrollment	White	Black	Hispanic	Other
ACO-Enrolled	22%	17%	10%	13%
Assignable	26%	20%	18%	26%
MA	39%	51%	58%	48%
Not Assignable	12%	12%	14%	13%

Distribution by Enrollment & DCI

This table shows the 2019 breakdown of Medicare beneficiaries across ACO-Enrolled, Assignable, Not Assignable, and Medicare Advantage. It then also breaks down the distribution of population by Distressed Communities Index.

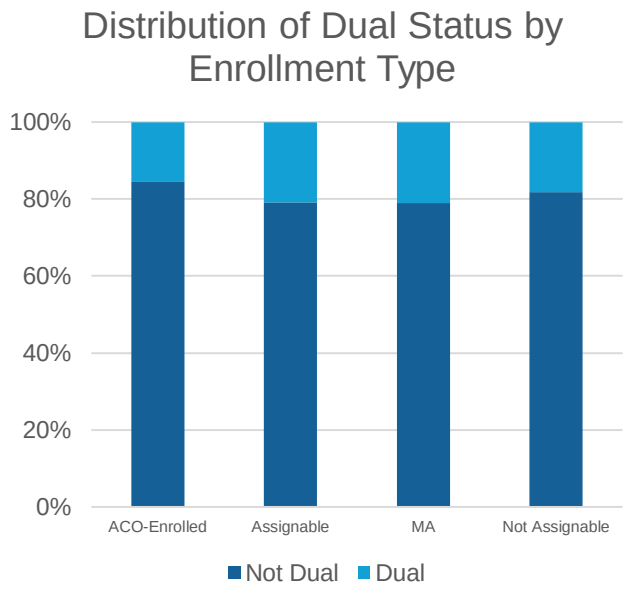
DCI	ACO-Enrolled	Assignable	MA	Not Assignable	Grand Total
1- Least Distressed	3,336,915	3,592,712	5,527,240	1,616,839	**14,073,706**
2	2,713,065	3,178,526	5,038,221	1,452,322	**12,382,134**
3	2,259,359	2,883,378	4,618,009	1,380,836	**11,141,582**
4	1,988,126	2,632,200	4,324,338	1,273,626	**10,218,290**
5- Most Distressed	1,730,423	2,325,759	3,859,637	1,145,184	**9,061,003**
Grand Total	**12,027,888**	**14,612,575**	**23,367,445**	**6,868,807**	**56,876,715**

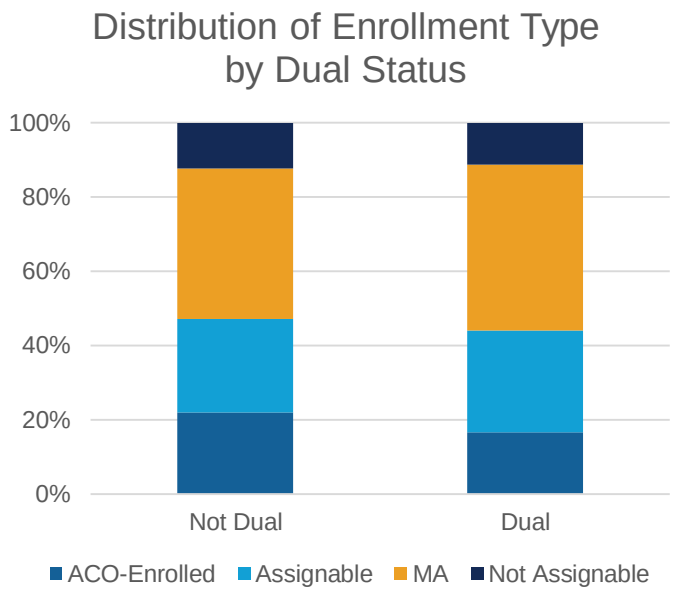
Distribution by Enrollment and Dual Status

This table shows the 2019 breakdown of Medicare beneficiaries across ACO-Enrolled, Assignable, Not Assignable, and Medicare Advantage. It then also breaks down the distribution of population by Dual status.

Dual Status	ACO-Enrolled	Assignable	MA	Not Assignable	Grand Total
Not Dual	10,445,387	11,980,565	19,344,312	5,879,482	47,649,746
Dual	1,919,335	3,162,830	5,181,445	1,305,312	11,568,922
Grand Total	**12,364,722**	**15,143,395**	**24,525,757**	**7,184,794**	**59,218,668**

Distribution by Enrollment and Dual Status





Dual Status	ACO-Enrolled	Assignable	MA	Not Assignable
Not Dual	84%	79%	79%	82%
Dual	16%	21%	21%	18%

Enrollment	Not Dual	Dual
ACO-Enrolled	22%	17%
Assignable	25%	27%
MA	41%	45%
Not Assignable	12%	11%

Driver #1: Consumer Designated Networks

Consumers Can Direct Their Capitated Dollar

Consumers Can Aggregate Their Data and Share with Those They Trust

Find apps to use with Medicare's Blue Button

Medicare's Blue Button 2.0 lets you connect your Medicare health information to other services you trust, like applications (apps).

These apps give you ways to manage and improve your health, like:

- Keeping track of the tests and services you need and getting reminders for them.
- Tracking your medical claims.
- Keeping your medical records and list of medicines in one place.

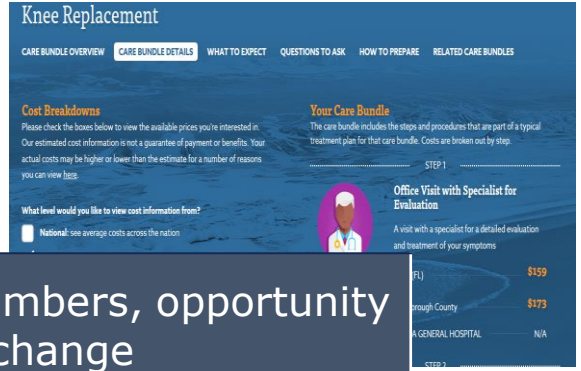
Consumers Can Earn Rewards for Value-Based Shopping, Taking Responsibility

Benefit Enhancements

Benefit Enhancements are conditional waivers of certain Medicare payment rules. CMS uses the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements.

Goals of these benefit enhancements are to:

- **Emphasize high-value services**
- **Support care management and closer care relationships**
- **Allow DCE flexibility**



CMS "DCEs" incentivized to voluntarily align new members, opportunity to harness consumer-directed health information exchange

Driver #2: Transparency for Care Navigation

THE WALL STREET JOURNAL.

WSJ NEWS EXCLUSIVE | HEALTH

Hospitals Hide Pricing Data From Search Results

Webpages for hundreds of hospitals require users to click through to find prices, undermining federal transparency rule, Journal analysis shows

By Tom McGinty, Anna Wilde Mathews and Melanie Evans
March 22, 2021 5:30 am ET

SHARE TEXT 407

Hospitals that have published their previously confidential prices to comply with a new federal rule have also blocked that information from web searches with special coding embedded on their websites, according to a Wall Street Journal

No Surprises Law: providers must "…provide a…good faith estimate of the expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction…by another health care provider or health care facility)"

THOMAS, MAXWELL (1215977574)

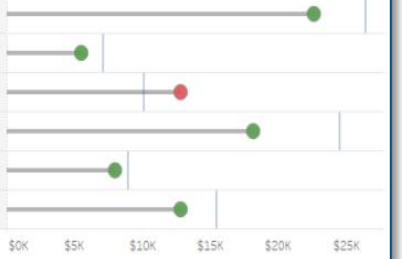
Practice Group	CBSA	Specialty	Primary APM (Advanced Payment Model)	Avg. HCC
ORTHOPEDIC SPECIALISTS OF NORTH AMERICA, PLLC	Phoenix-Mesa-Scottsdale, AZ	Orthopedic Surgery	Bundled Payment for Care Improvement Advanced Model	0.67

Cost Analytics

*Hover over **Cost Index** to view trend over time.* Cost Index: 5

Click on an episode type to view ***Allowed Amt. by Care Setting.*** *Dots indicate **observed** cost, and lines indicate **expected** cost.*

Episode Type	# Episo..	Tot Cbsa E..	Avg Observ..	Avg Expect..	Avg O/E
IP - MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF U..	11	(28)	$22,604	($26,401)	0.87
OP - Level 3 Musculoskeletal Procedures	21	(20)	$5,486	($7,100)	0.78
CC - Osteoporosis	28	(20)	$12,832	($10,079)	1.33
IP - MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMEN..	138	(50)	$18,116	($24,471)	0.75
CC - Rheumatoid Arthritis/Osteoarthritis	193	(71)	$7,958	($8,909)	1.00
Total	423	(139)	$12,804	($15,454)	0.93



Quality Analytics

*Hover over **Outcomes Index** to view trend over time.* Outcomes Index: 4

Click on an episode type to view the ***Distribution of Performance*** for your selected measure within the provider's episode type/cbsa/specialty. **Note:** Episode types must have a **denominator greater than 20** to export quality measures due to cell size limitations.

Measure Desc	Episo..	Numerator	Denominator	Rate	Performance	Percentile within specialty and CBSA
Percent of ED visits during episodes that were avoidable	Total	45	113	0.40	1%	0.03
Percent of episodes where member died	Total	<11	423	<11	82%	0.97
Percent of patients who did not receive an imaging study within the 28 days following a diagnosis of low back pain	Total	40	56	0.71	49%	0.33
Percent of admits during episodes that had a readmit	Total	<11	45	<11	50%	0.44
Percent of admits during episodes that were unplanned	Total	<11	73	<11	75%	0.81

Driver #3: “Real Time” Analytics

Patient Out-of-Pocket Cost Estimate

Prescriptions

Pending Prescription

❍ **etodolac 400 mg tablet**	$57.38
Patient Preferred Pharmacy, 60 tablets, 30 days	$1.91/day

Suggested Alternatives

● etodolac 400 mg tablet	$41.90
Health System Pharmacy, 60 tablets, 30 days	$1.40/day
❍ ibuprofen 800 mg tablet	$8.60
Patient Preferred Pharmacy, 90 tablets, 30 days	$0.29/day

Total Cost: $41.90

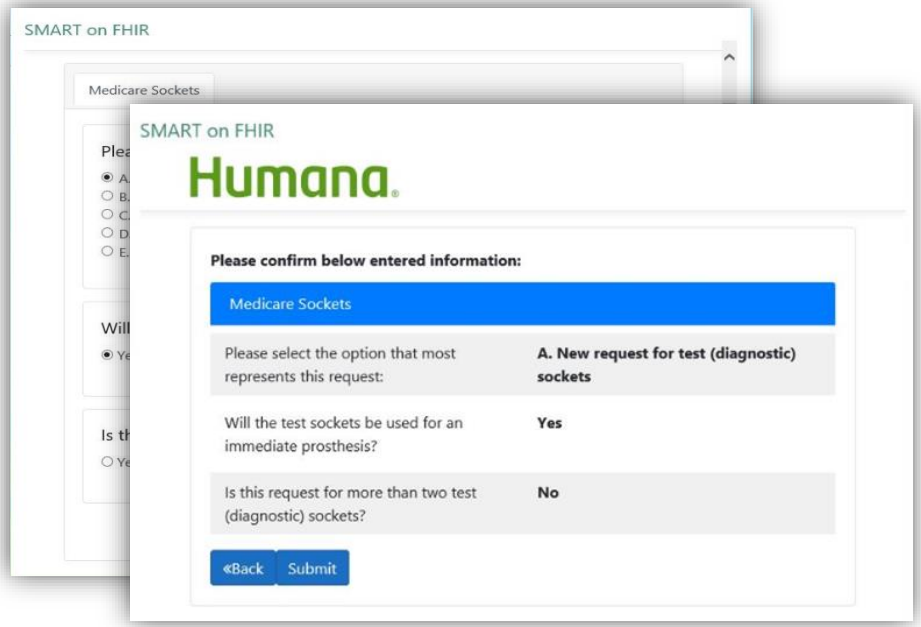
SWIFTRX®

14 - 22%

Medication Order Switch Rate

Fact sheet

Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients’ Electronic Access to Health Information CMS-9123-F: Fact Sheet



CMS ADT Rule empowers physicians April 2021; proposes automated prior auth; regulates the use of “real-time benefit check” to lower drug costs

Idea: A Distressed Communities Model

- CMS makes up-front grants to eligible organizations to invest in communities that are either a 4 or 5 on the highly distressed scale
  - Grant does not count against potential future savings
- First 1-2 years of program is for investment
  - Selected participants receive grant funding from CMMI to establish and implement a "community transformation plan"
  - To continue in program participants would have to hit milestones of their proposed transformation plan
- Years 3-5 participant (the lead organization) takes full financial risk for aligned beneficiaries
  - Based on a prospective benchmark
  - CMS applies a modest discount
  - Outliers are capped (or opportunity for stop-loss)
- Proposal would require
  - Increasing PCP availability in the community
  - Providing additional support services (ideally on-site)
  - Participants must guarantee that providers would see community members beyond Medicare
  - Plan for community partnerships to address SDOH, including medical transportation, food/nutrition, etc.
  - Sustainability plan

VillageMD®

Open Mic

Proposed Next Steps

- A Second Coalition Letter to CMMI detailing recommended changes to the April 1st performance period and flexibilities needed for the January 1st deferred applicants

- Advocacy at the Agency level (CMMI/CMS) and Hill level will be developed and coordinated. Complete by May 15

Questions?

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- Gary Jacobs: gjacobs@villagemd.com