

AMERICA'S
PHYSICIAN
GROUPS 



APG DIRECT CONTRACTING
COALITION

Direct Contracting
Coalition Webinar
April 8, 2021

Housekeeping

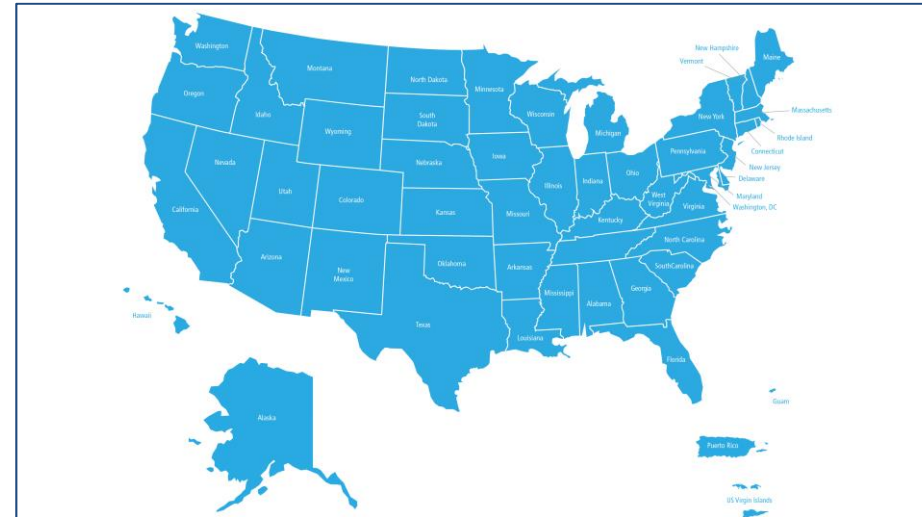
- Type questions in the Q & A box
- This webinar will be recorded
- Links to the recording and slides will be sent to registrations
- Please complete the post-webinar survey that will appear after you close the WebEx window

WHO WE ARE

- 350+ physician organizations
- 195,000 physicians that serve 45 million patients
- Capitation / Delegation is the destination
- “Taking Responsibility for America’s Health”

AMERICA'S
PHYSICIAN
GROUPS 

Taking Responsibility
for America's Health



AMERICA'S
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GROUPS 

America's Physician Groups (APG)

- Our Three Pillars

Education

- Regional meetings
- Deep Dives
- Risk Evolution Task Force

Leadership

- CMS, CMMI, members of Congress
- Community leaders
- Bridging between other Associations

Advocacy

- Representation on Capitol Hill
- Federal comment letters
- Washington Weekly Update

Mission Statement

The mission of America's Physician Groups is to assist accountable physician groups to improve the quality and value of healthcare provided to patients. America's Physician Groups represents and supports physician groups that assume responsibility for clinically integrated, comprehensive, and coordinated healthcare on behalf of our patients. ***Simply, we are taking responsibility for America's health.***

Strategic Vision

America's Physician Groups and its member groups will continue to drive the evolution and transformation of healthcare delivery throughout the nation.

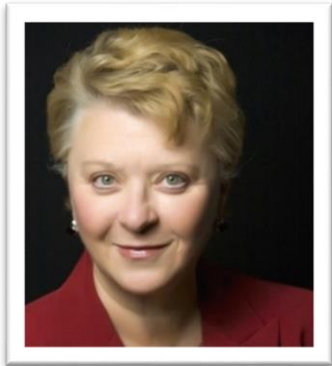
Agenda

- Introduction- Valinda
 - Purpose
 - Introduction of Co-Chairs
 - Status of programs from CMMI
 - 4 Polling questions
- From the Trenches update- Rushika/ Gary
 - IORA Health- Initial Impressions and suggested advocacy priorities
 - Village MD- Initial Impressions and suggested advocacy priorities
- Analysis of Data needs- Aneesh
- Q/A
- Next Steps

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*

Status of programs

- Global/Professional Direct Contracting(GPDC) Performance Year 1- April 1, 2021
- GPDC Performance year 2- January 1, 2022
- GEO

Polling Questions



Are you currently participating in the April 1 Performance year of GPDC?

Yes
No



Were you planning to apply for the January 2022 start date of GPDC?

Yes
No
Not sure



Are you interested in the GEO?

Yes
No
Unsure



What interests you most about this coalition?

Advocacy
Sharing of best practices
Education

From the Trenches Update

Iora Health Initial Impressions

Caveat: This is our first CMMI (or similar) program, so hard to compare the experience

CMMI staff have been surprisingly accessible and at least listen to issues and ideas both big and small

Clear tension between downside protection against potential bad actors and reality of being successful in program (eg risk adjustment caps)

Particular issues with newer entrants (eg who are growing, adding populations)- need to change the mind frame

We all have a role in helping them articulate benefits of this program, how it fits in a larger strategy for care transformation

High Level Advocacy Items for GPDC-IORA Health

- Attribution rules- overlap with MSSP and other programs
- Risk adjustment- mechanics of the caps still problematic
- New entrants – odd rules it seems regarding Beneficiary Threshold in subsequent years

Village MD Initial Impressions

Attribution

Infrastructure
needs

Claims
Payment

Benchmark

RAF

High Level Advocacy Items for GPDC- Village MD

- Alignment
 - Request 6 month implementation period for 2022 starts to get above Minimum threshold
 - Support alignment crossover rule that ensures beneficiaries who complete voluntary alignment, but would have been attributed to another DCE, carry their risk score and 3% cap with them
- Claims/Data
 - Provide 837 files for claims payment
 - Move to real time data feeds
 - Provide member eligibility by month for 36 month look back
 - CMMI should provide Cost and Utilization report for benchmark years
- Risk
 - Use concurrent risk model across all model tracks
 - Remove either the CIF or +3% risk score cap
 - Allow for a 6% risk score cap in 2022 to account for gap year
 - Remove cap for patients in underserved areas
- Allow selection annually for professional/global and PCC/TCC



DCE Coalition:

Accelerating “Consumer-First” Care Delivery Models in an Open Data Era

Aneesh Chopra

April 8th, 2021



Pandemic Surfaces Longstanding Health Inequities

Preliminary Medicare COVID-19 Data Snapshot:

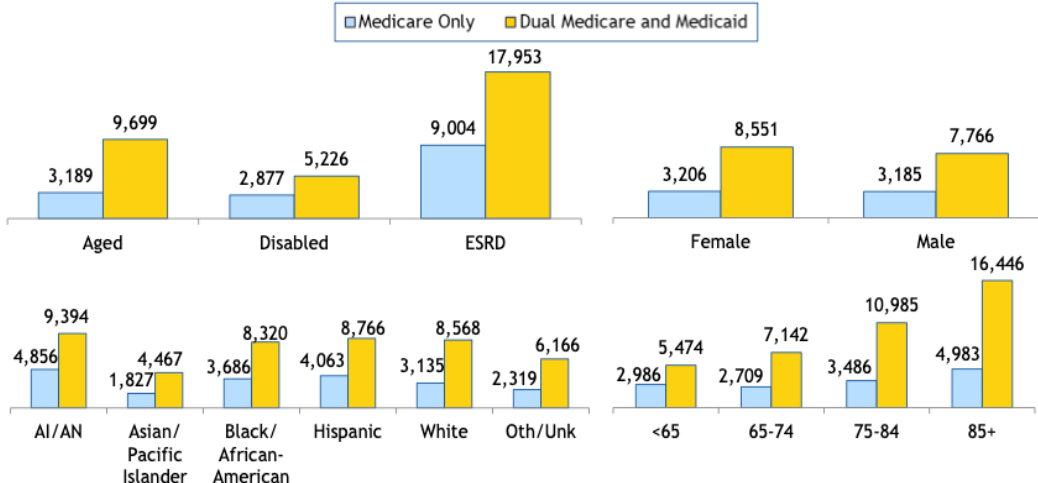
Medicare Claims and Encounter Data: January 1, 2020 to December 26, 2020, Received by January 22, 2021

COVID-19 Cases

2,719,148 Total COVID-19 Cases **4,143** COVID-19 Cases per 100K

COVID-19 Cases per 100K by Beneficiary Characteristics

-Medicare Only vs. Dual Medicare and Medicaid Eligibility-

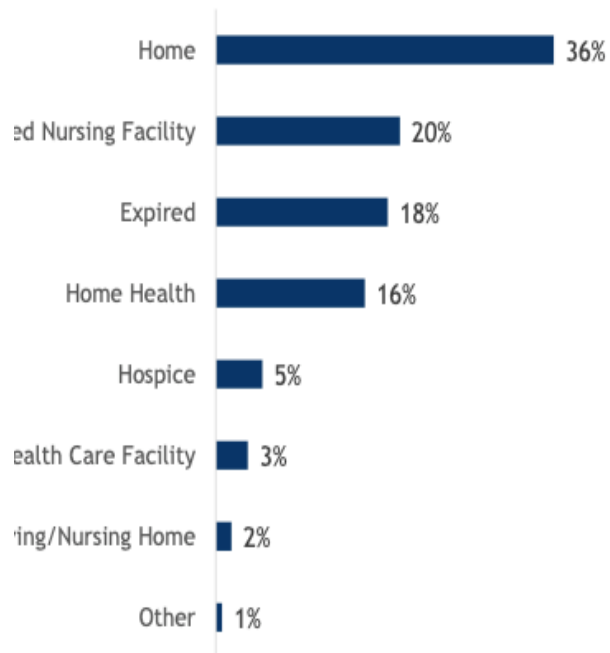


Note: AI/AN = American Indian/Alaska Native

Disclaimer: All data presented in this update are preliminary and will continue to change as CMS processes additional claims and encounters for the reporting period. COVID-19 cases are identified using the following ICD-10-CM diagnosis codes: B97.29 (from 1/1-3/31/2020) and U07.1 (4/1/2020 and after). Medicare claims and encounter data are collected for payment and other program purposes, not public health surveillance, so caution must be used when interpreting the data. For additional details on data limitations, please see page 2 of this data update and view the methodology document available [here](#).



Percent of COVID-19 Hospitalizations by Discharge Status

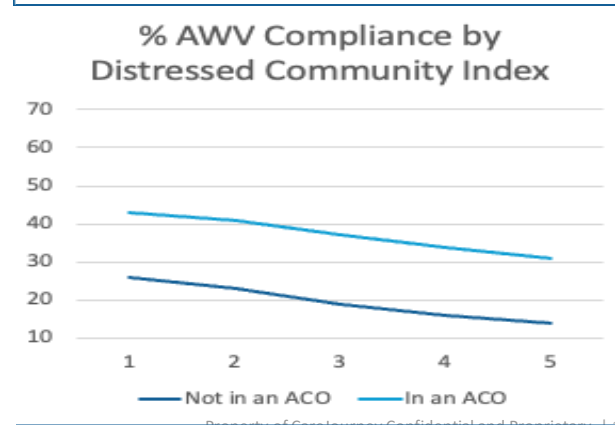
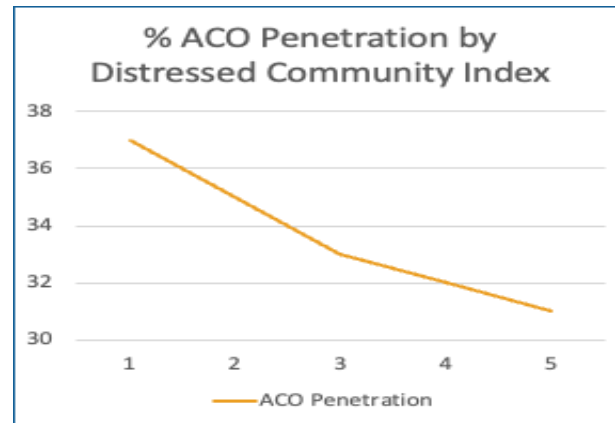


Percentages may not add to 100% because of rounding.



Call to Action for APMs to Close the Gaps

	Least Distressed Quintile (1)	Most Distressed Quintile (5)
Mean number of FFS Medicare enrollees (SD)	6,485,956 (1,240)	3,538,810 (827)
Mean HCC risk score (SD)	0.86 (0.10)	0.98 (0.14)
Mean per-capita Medicare Part A & B expenditures (\$) (SD)	\$9,885 (\$1,986)	\$11,385 (\$3,145)
Flu shots (%) (SD)	50.6% (11.1%)	33.4% (10.5%)
Annual wellness visits (%) (SD)	29.9% (10.7%)	18.3% (10.0%)
Transitional care management (%) (SD)	14.8% (7.7%)	11.6% (6.9%)
Advanced care planning visits (%) (SD)	3.4% (2.9%)	4.5% (4.9%)
Avoidable ED visits (%) (SD)	26.3% (10.0%)	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%

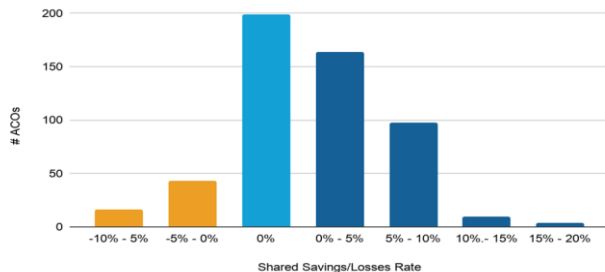
¹2019 CMS Shared Savings Program Benchmark PUFs

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

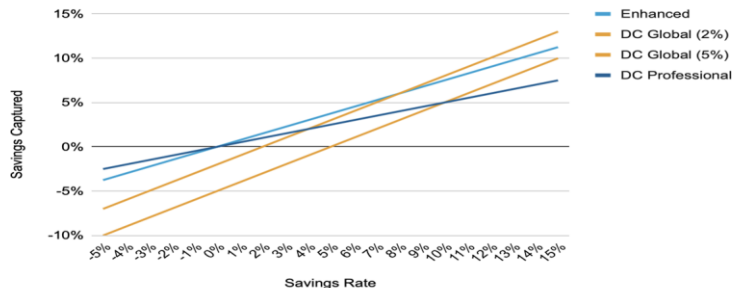


Evaluating Go / No Go Decisions on Risk Models

ACOs by Savings Rate Variation, 2019



Savings Captured Comparisons



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

PY Projections Based on CMS alignment methodology and claims

		Aged & Disabled	End Stage Renal Disease	Total
		Participant	Participant	Participant
2019	PQEM Part B Spend	\$ 10,293,798.72	\$ 6,342.86	\$ 11,605,490.19
	PQEM Outpatient - FQHC Spend	\$ 58,549.98	\$ -	\$ 70,574.22
	PQEM Outpatient - RHC Spend	\$ 1,954.53	\$ -	\$ 2,093.75
	PQEM Outpatient - CAH Spend	\$ 485.15	\$ -	\$ 524.11
	Total - PQEM Spend	\$ 10,354,788.38	\$ 6,342.86	\$ 11,678,682.27

* Based on Performance Year 2021 Alignment Timeframe

		Primary Care Capitation (PCC)		
		Aged & Disabled	End Stage Renal Disease	Total
		Participant	Participant	Participant
2019	% Primary Care (PQEM) Spend	4.459%	0.523%	4.119%

* Based on Performance Year 2021 Alignment Timeframe

		Primary Care Capitation Spend by the Provider to their Aligned Beneficiaries		
		Aged & Disabled	End Stage Renal Disease	Total
2019	Primary Care (PQEM) Spend by Providers to their Claims Aligned Population	\$ 3,668,325.68	\$ 2,328.93	\$ 4,087,929.09
2019	% PQEM Spend by the Aligned Provider	35.43%	36.72%	35.00%

* Based on Performance Year 2021 Alignment Timeframe

		Total Spend by Claim Type		
		Aged & Disabled	End Stage Renal Disease	Total
2019	Part B Spend	\$ 75,346,298.49	\$ 126,350.48	\$ 87,089,272.23
	Inpatient Spend	\$ 77,687,421.52	\$ 486,958.38	\$ 96,397,590.84
	Outpatient Spend	\$ 53,929,870.96	\$ 566,675.16	\$ 70,960,897.03
	Home Health Agency Spend	\$ 10,113,367.81	\$ 14,299.56	\$ 11,469,695.21
	Skilled Nursing Facility Spend	\$ 6,541,029.15	\$ 12,916.83	\$ 7,917,924.21
	Hospice Spend	\$ 3,236,647.01	\$ -	\$ 3,495,949.43
	Durable Medical Equipment (DME) Spend	\$ 5,347,702.35	\$ 4,640.36	\$ 6,192,804.65
	Total Spend	\$ 232,202,337.29	\$ 1,211,840.77	\$ 283,524,133.60

* Based on Performance Year 2021 Alignment Timeframe

¹CMS DC RFA, Pathways to Success Final Rule

²2019 Shared Savings Program Benchmark PUFs



Driver #1: Consumer Designated Networks

Consumers Can Direct Their Capitated Dollar



CMS

Confirmation of Your Primary Care Physician
Please complete the below form to select your primary care physician.

Medicare has started an initiative to help you choose your primary care physician. You are receiving this letter to benefit from care coordinated by your primary care physician. These services include:

- Home Visits: Medicare will send a doctor to your home to help you with your care.

Provider Name

Select Provider

Organizations

- Allied Health Care Associates
- Columbia Medical Center Limited
- Dr. Mary Tlak
- Durand Internal Medicine
- Family Medicine & Wellness Center
- Indiana Sports & Medicine Institute, PC
- Meyer Family Medicine Associates LLC
- Minesh Patel, P.C.
- Primary Care Medical Associates, Ltd
- Primercare Family Physicians, Ltd
- Progression Medical Center, S.C.
- Worldwide Family Medicine, LLC

Providers

- Londa Aldridge
- Annie Barry
- Jodi Butt
- Naina Chhokar
- Harshad Patel, MD

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.

Trusty.care

LET'S GET STARTED!

We have partnered with Trusty.care, an approved Blue Button 2.0 company, to help you get better care.

Learn More

Import from Medicare

Enter data manually

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

Knee Replacement

CARE BUNDLE OVERVIEW | CARE BUNDLE DETAILS | WHAT TO EXPECT | QUESTIONS TO ASK | HOW TO PREPARE | RELATED CARE BUNDLES

Cost Breakdowns
Please check the boxes below to view the available prices you're interested in. Our estimated cost information is not a guarantee of payment or benefits. Your actual costs may be higher or lower than the estimate for a number of reasons you can view [here](#).

Your Care Bundle
The care bundle includes the steps and procedures that are part of a typical treatment plan for that care bundle. Costs are broken out by step.

STEP 1: Office Visit with Specialist for Evaluation

A visit with a specialist for a detailed evaluation and treatment of your symptoms.

What level would you like to view cost information from?

National: see average costs across the nation

(FL)	\$159
rough County	\$173
A GENERAL HOSPITAL	N/A
STEP 2:	

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)”



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Opportunity to Standardize on EGM

- EGM is an open (CMS-seed-funded) methodology that assigns services and their associated payments to clinically relevant episodes of care.
- Episodes correspond to clinically meaningful topics such as a clinical condition defined by diagnosis codes, or in other cases, a particular type of treatment defined by procedure codes.



Driver #3: "Real Time" Analytics



SMART on FHIR

Medicare Sockets

Please select the option that most represents this request: *

SMART on FHIR

Humana.

Please confirm below entered information:

Medicare Sockets

Please select the option that most represents this request: **A. New request for test (diagnostic) sockets**

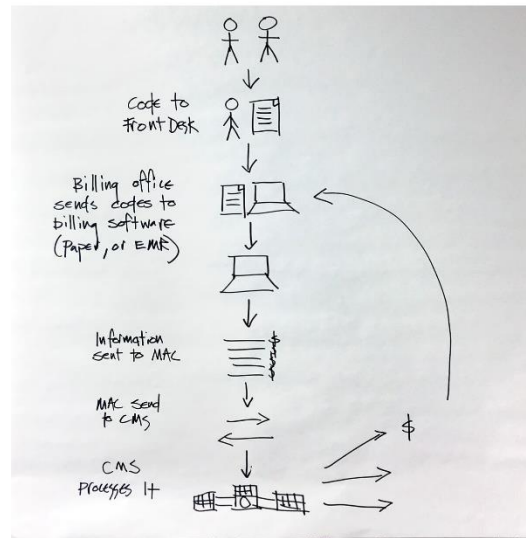
Will the test sockets be used for an immediate prosthesis? **Yes**

Is this request for more than two test (diagnostic) sockets? **No**

«Back Submit

HEALTH AND HUMAN SERVICES

Medicare Payment System Modernization



CMS ADT Rule empowers physicians April 2021; proposes automated prior auth; invests in "MAC" API modernization to enable "real-time" insights

Next Steps

Next Steps

- A Coalition Letter to CMMI regarding our interest in reopening portal for new DC applications will be drafted and circulated for organization signatures by Monday
- Next meeting of the Coalition will be scheduled within 2 weeks
- Advocacy at the Agency level (CMMI/CMS) and Hill level will be developed

Questions?

- Valinda Rutledge: vrutledge@apg.org
- Aneesh Chopra: aneesh.chopra@carejourney.com
- Rushika Fernandopulle : rushika@iorahealth.com
- Gary Jacobs: gjacobs@villagemd.com