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”

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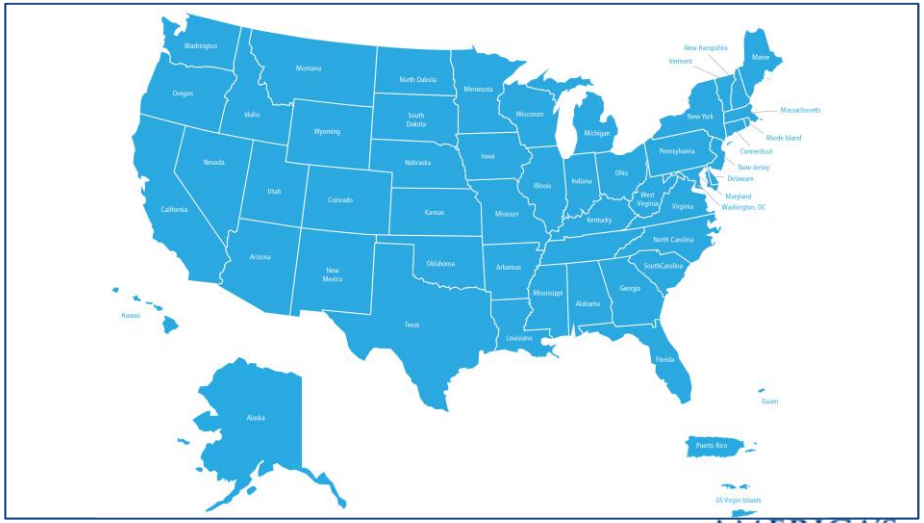
Taking Responsibility for America’s Health



# 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.

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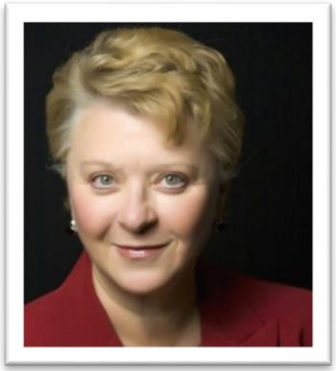
# Agenda

- 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*

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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
- GEO

# Polling Questions

| | |
|---|---|
| Are you currently participating in the April 1 Performance year of GPDC? | Yes<br>No |
| Were you planning to apply for the January 2022 start date of GPDC? | Yes<br>No<br>Not sure |
| Are you interested in the GEO? | Yes<br>No<br>Unsure |
| What interests you most about this coalition? | Advocacy<br>Sharing of best practices<br>Education |

# From the Trenches Update

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# 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

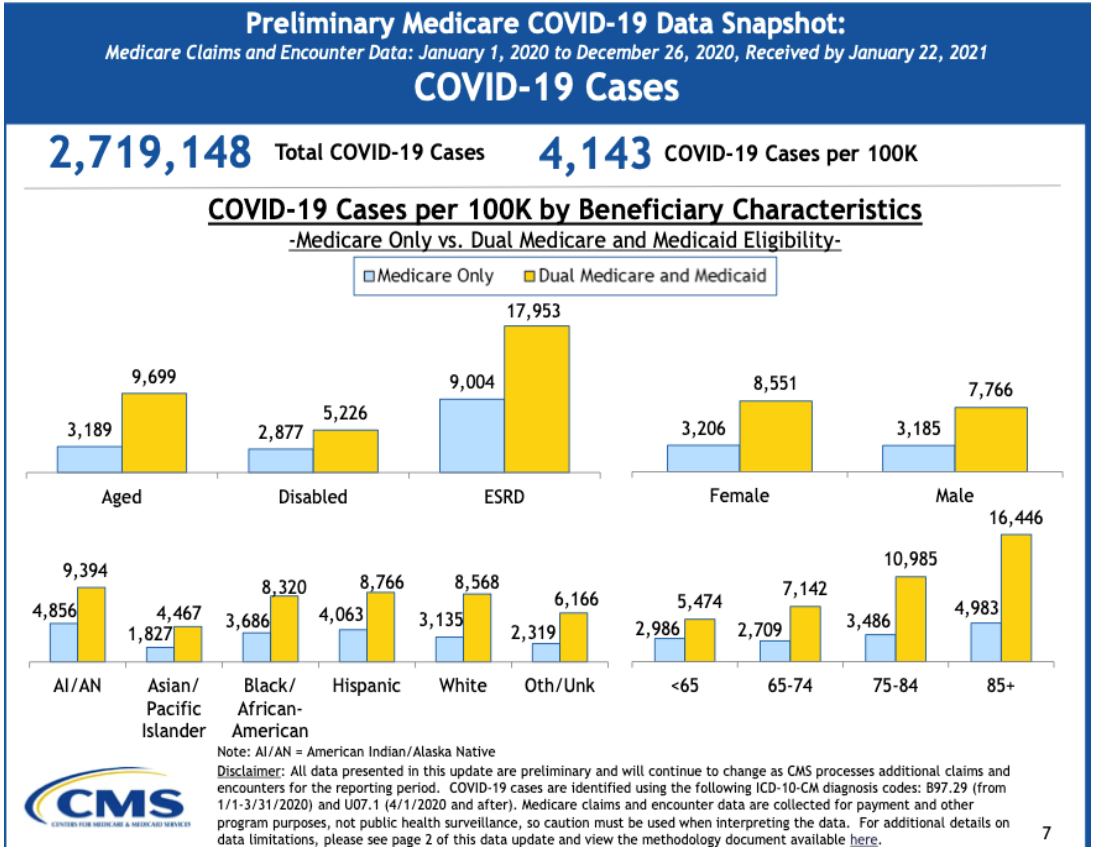

# DCE Coalition:

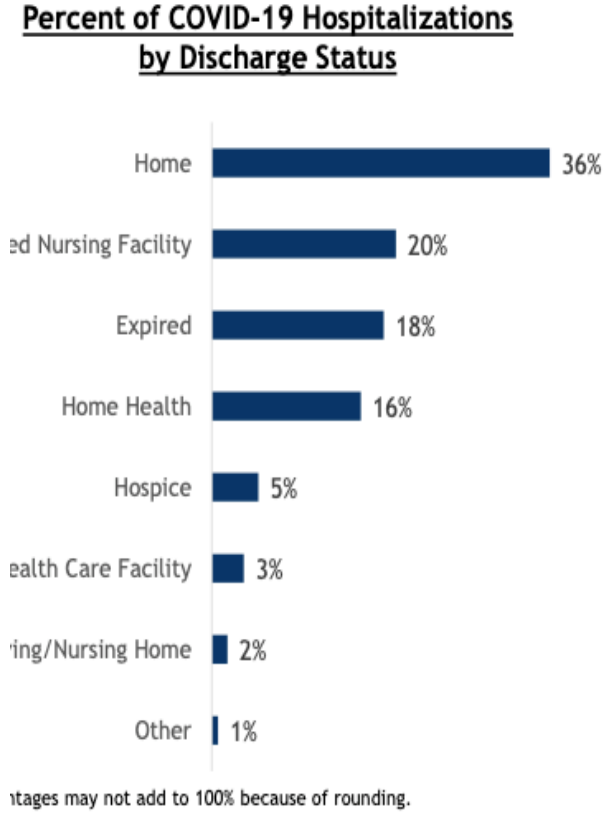
Accelerating “Consumer-First” Care Delivery Models in an Open Data Era

Aneesh Chopra

April 8th, 2021

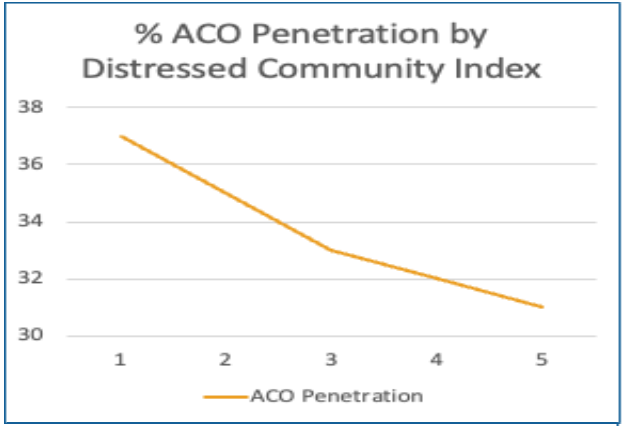
# Pandemic Surfaces Longstanding Health Inequities

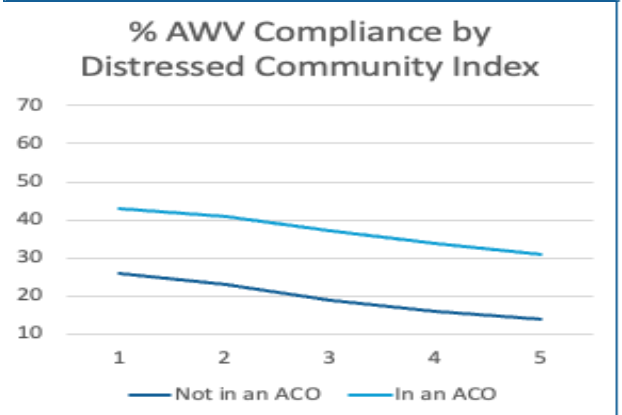


# Call to Action for APMs to Close the Gaps

| | 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%) |



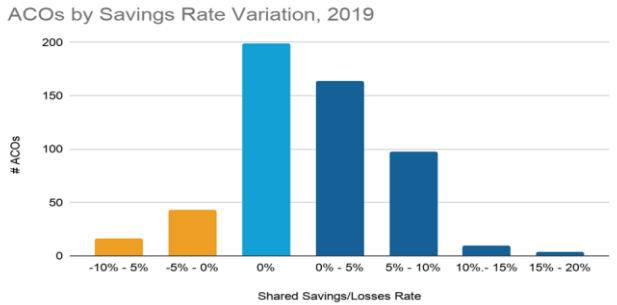



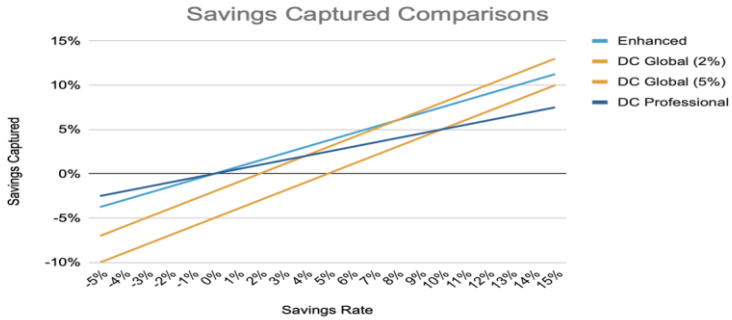

| DCI Distress | MSSP ACO%[1] | AWV% | Avoidable ED% | Af-Am % FFS[2] |
|---|---|---|---|---|
| 1 | 42% | 30% | 26% | 4% |
| 2 | 37% | 25% | 27% | 7% |
| 3 | 38% | 22% | 28% | 9% |
| 4 | 33% | 20% | 30% | 9% |
| 5 | 32% | 18% | 32% | 14% |

[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

# Evaluating Go / No Go Decisions on Risk Models




| 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

PY Projections Based on CMS alignment methodology and claims

| | | Aged & Disabled Participant | End Stage Renal Disease Participant | Total 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 Participant | End Stage Renal Disease Participant | Total 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 |

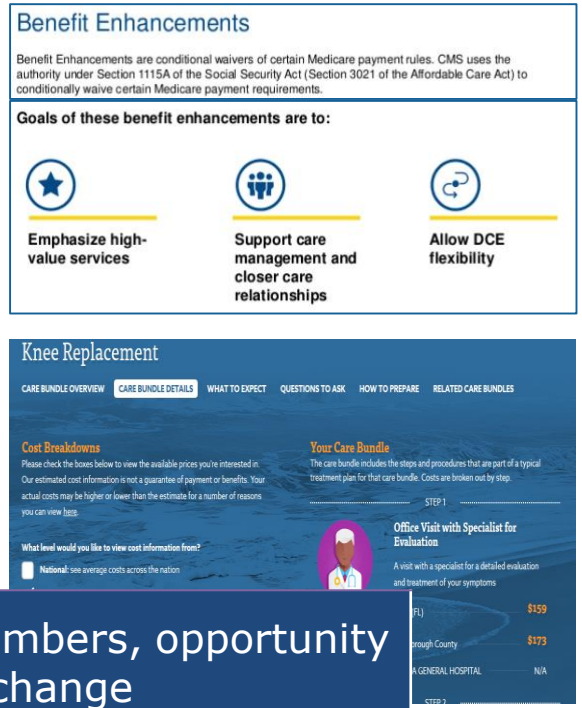
* Based on Performance Year 2021 Alignment Timeframe

# Driver #1: Consumer Designated Networks

**Consumers Can Direct Their Capitated Dollar**

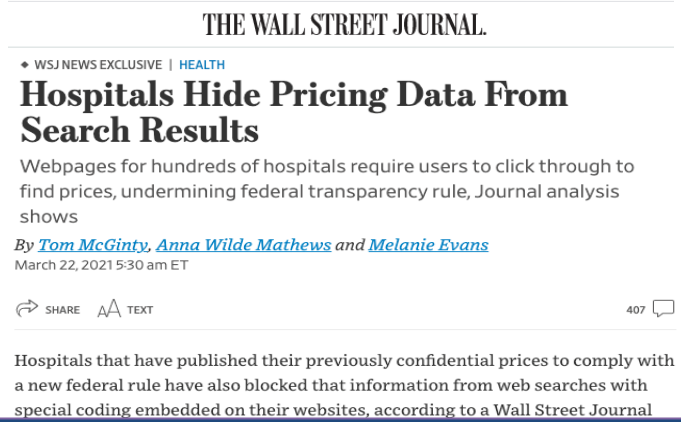

**Consumers Can Aggregate Their Data and Share with Those They Trust**


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




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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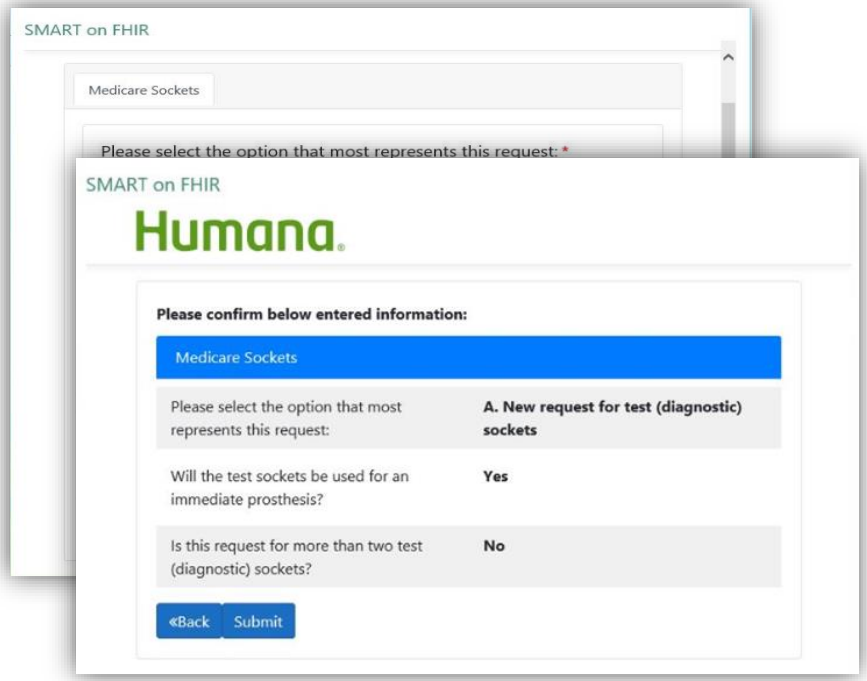
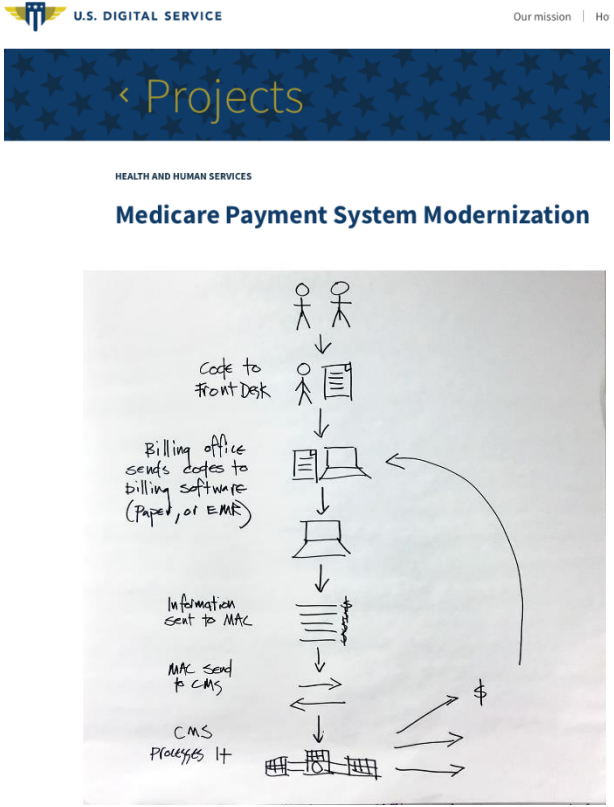
AMA

## 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




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