ADFM Association of Departments of Family Medicine
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ALTERNATIVE PAYMENT MODELS

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PCMH and Population Health: The Michigan Landscape

Michigan PCMH Landscape

- Most MI PCMH practices designated through the Blue Cross Blue Shield of Michigan (BCBSM) PCMH program
  - Currently 1,638 PCMH practices and >4500 PCPs designated
- Payment for both capability building and PCMH recognition
- 10% E&M Uplift for PCMH recognition
- An organization's reward depends on:
  - Participation
  - Performance and improvement
  - Accomplishing goals with its PGIP physician
- Program has achieved national recognition
  - Recognized by CMS for full PCMH MACRA credit
- Foundation for Michigan's multipayer PCMH programs

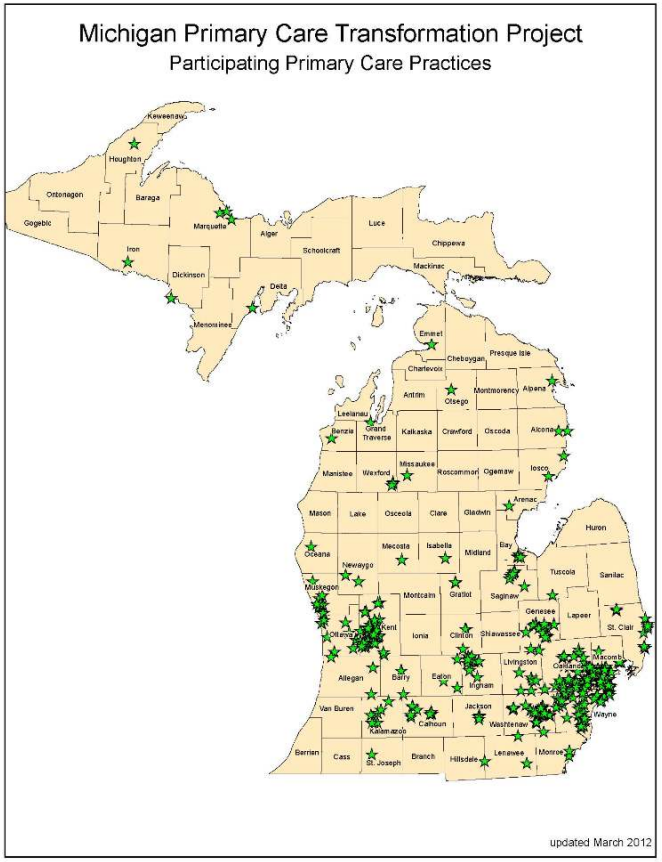
Michigan Primary Care Transformation Project:

Michigan's First Multi-Payer Vision

- Use CMS Multi-Payer Advanced Primary Care Practice (MAPCP) demo as catalyst for MI primary care redesign
  - Multiple payers funding a common clinical model
  - Original demo (8 states) 2012-2014, extended two years to December 2016 (5 states)
- Create a model that can be broadly disseminated
  - Facilitate measurable improvements in population health for our Michigan residents
  - Bend the current (non-sustainable) cost curve
- Form strong foundation for successful ACO models

MiPCT Participants (2016)

- 350 practices
- 37 Physician Organizations (POs)
- 1,953 PCPs
  - 303 are NPs and PAs
- 1.2 million patients
  - Medicare (16%)
  - Medicaid managed care plans (19%)
  - BCBSM (35%)
  - BCN (20%)
  - Priority Health (11%)



Michigan Primary Care Transformation Project
Advancing Population Management

PCMH Services

Complex Care Management ***Functional Tier 4***	All Tier 1-2-3 services plus: ▪ Home care team ▪ Comprehensive care plan ▪ Palliative and end-of life care
Care Management ***Functional Tier 3***	All Tier 1-2 services plus: ▪ Planned visits to optimize chronic conditions ▪ Self-management support ▪ Patient education ▪ Advance directives
Transition Care ***Functional Tier 2***	All Tier 1 services plus: ▪ Notification of admit/discharge ▪ PCP and/or specialist follow-up ▪ Medication reconciliation
Navigating the Medical Neighborhood ***Functional Tier 1***	▪ Optimize relationships with specialists and hospitals ▪ Coordinate referrals and tests ▪ Link to community resources
Prepared Proactive Healthcare Team Engaging, Informing and Activating Patients	

P O P U L A T I O N M A N A G E M E N T

PCMH Infrastructure

Health IT
- Registry / EHR registry functionality *
- Care management documentation *
- E-prescribing (optional)
- Patient portal (advanced/optional)
- Community portal/HIE (adv/optional)
- Home monitoring (advanced/optional)

Patient Access
- 24/7 access to decision-maker *
- 30% open access slots *
- Extended hours *
- Group visits (advanced/optional)
- Electronic visits (advanced/optional)

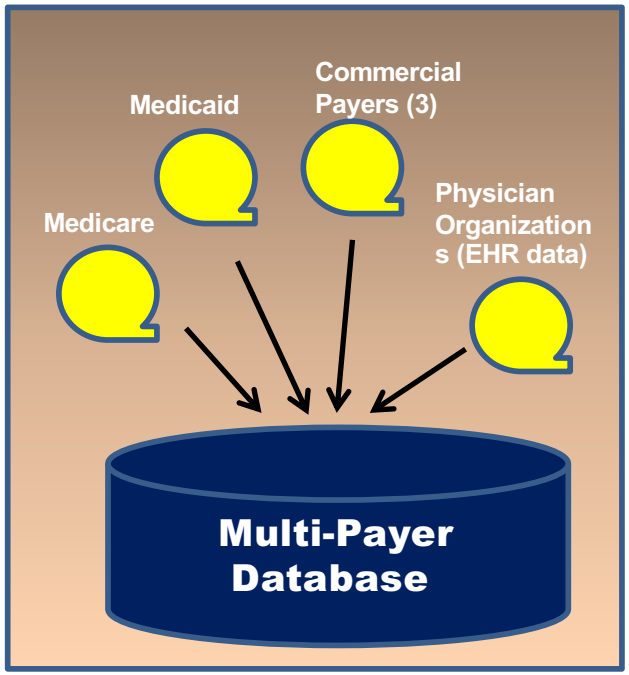
Infrastructure Support
- PO/PHO and practice determine optimal balance of shared support
- Patient risk assessment
- Population stratification
- Clinical metrics reporting

*denotes requirement by end of year 1

Michigan Data Collaborative (MDC): Multi-Payer Database

Collect data from multiple Payers and aggregate it in one database

- Creates a more complete picture of a patient's information when they:
  - Receive benefits from multiple insurance carriers
  - Visit physicians from different Practices, Physician Organizations or Hospitals
- **Phase 1** – claims data
- **Phase 2** - claims and clinical data

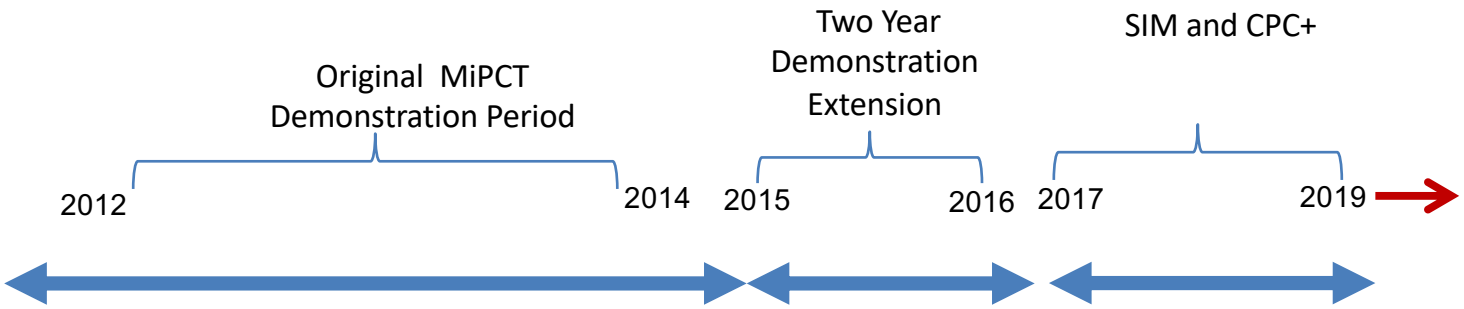


MAPCP Medicare Results: Years 1-3 (Final)

			Vs. PCMH		
State	Eligible beneficiary quarters	Total MAPCP Demonstration fees	Gross savings	Net savings	Return on fees
New York	279,899	$5,750,926	−$3,892,202	−$9,643,127	−0.68
Rhode Island	113,633	$1,974,907	−$12,383,617	−$14,358,525	−6.27
Vermont	760,427	$18,340,927	$82,271,080*	$63,930,154*	4.49
North Carolina	243,933	$6,524,816	−$7,674,949	−$14,199,765	−1.18
Minnesota	836,922	$2,429,820	—	—	—
Maine	424,920	$12,313,581	−$52,558,003	−$64,871,584*	−4.27
Michigan	**2,265,099**	**$64,938,363**	**$294,714,755***	**$229,776,392***	**4.54**
Pennsylvania	324,051	$5,338,237	$36,633,819*	$24,158,656^	2.94^

Source: Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration-Final Report, June 2017, Centers for Medicare & Medicaid Services, Table 3-19, "Estimates of gross savings, MAPCP fees paid, and net savings vs. PCMH and non-PCMH comparison practices " p. 239

Multipayer Sustainability:
Ongoing Timeline



- Michigan Primary Care Transformation Project (2012-2016)
- State Innovation Model PCMH Pillar (2017-2019)
- Comprehensive Primary Care Plus (2017-2021)

CPC+

- Medicare Comprehensive Primary Care Payments
- FSS payments reduced over time
- PMPM Care Management Fee
- Performance Based Incentive Payments
- Multipayer: BCBSM and Priority Health

Michigan Multipayer CPC+ Comprehensive Primary Care Plus

Table ES-1
CPC+ Payment Summary

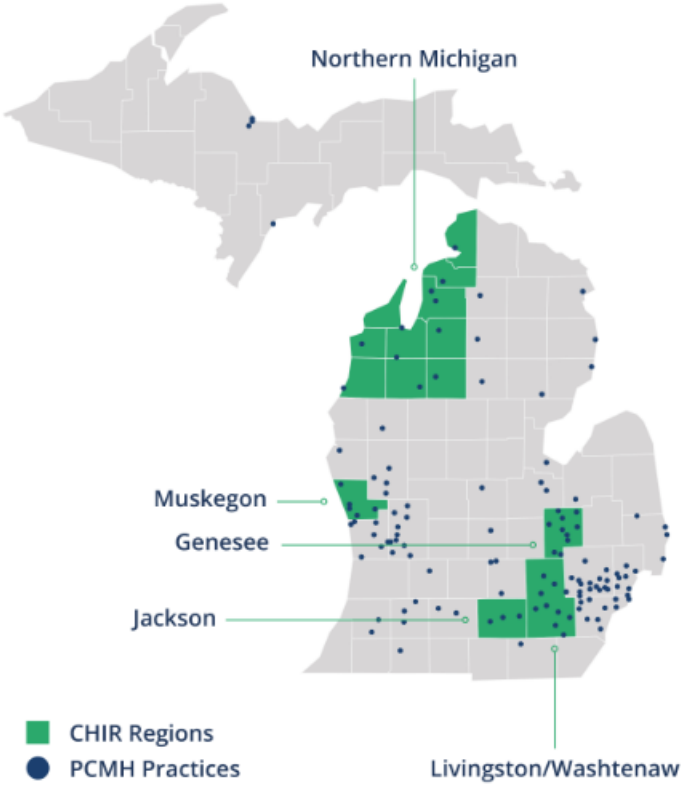
Track	CMFs	PBIP	Medicare PFS
1	$15 average per beneficiary per month (PBPM)	$1.25 PBPM on quality/patient experience of care and $1.25 PBPM on utilization performance	Regular FFS
2	$28 average PBPM, including $100 PBPM to support patients with complex needs	$2 PBPM on quality/patient experience of care and $2 PBPM utilization performance	Hybrid payment: Reduced FFS with a prospective CPCP

State Innovation Model (SIM)

- 2014 – Michigan Blueprint for Health
- $70 million grant awarded to develop and test innovative health delivery plan
- Focus on strengthening connections between health care providers and communities
- Community Health Innovation Regions (CHIR)

SIM

- Medicaid Health Plans
- PMPM
- Care Coordination Payment
- Strong Focus on SDH



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COMPREHENSIVE PRIMARY CARE PAYMENT CALCULATOR

CPCP CALCULATOR- TRANSLATING THE IDEA INTO PRACTICE

The Comprehensive Primary Care Payment Calculator project team, led by Stanley Borg, D.O. developed a tool designed to create specific examples for both practices and payers to better understand how a Comprehensive Primary Care Payment may be implemented. Physicians and payers can now explore new options for developing PCMH payment frameworks and/or replace existing capitation and FFS contracts.

The CPCP Calculator is a work in progress, meant as a starting point for discussion with your practice and with payers and employers. It is one example of how health plans and physicians might deploy a CPCP payment. We encourage and expect that stakeholders will modify the proposed methodology for specific markets and contractual relationships.

In order to build a working CPCP model, the team researched current primary care reimbursement models. Then a document detailing the CPCP methodology approach was created. The team invites you to use the Calculator and welcomes your feedback.

See the Calculator and User Guide.

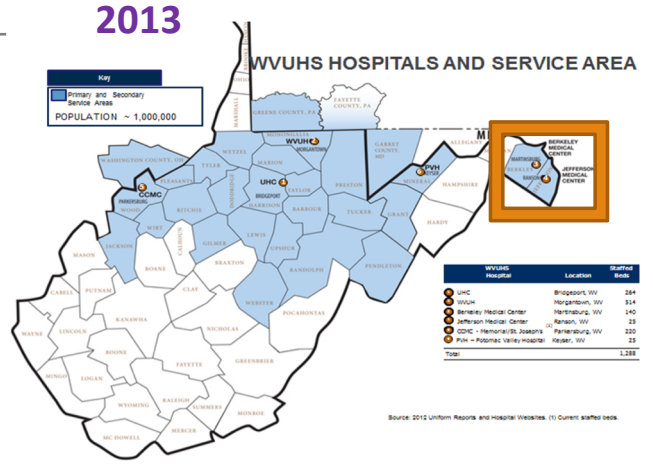
Learn about the development process in our Background Research Report and Methodology.

Legal Disclaimer:. Information provided in connection with this calculator by FMAHealth and its contributors is not a suggestion, invitation, direction or recommendation with respect to what you should charge or what your reimbursement rates should be for your services. Those determinations must be made by each physician or practice based on your own costs, patient population, regional and/or practice-specific circumstances, business judgment, negotiations with payers, and other factors within your discretion. This information is intended to increase the quality and availability of care and services for patients and to enhance, not suppress, competition for such services.

“Our Road to Risk Sharing”

1. Creating the infrastructure
   - PCMH- 2015 – awarded Level III
     - IT- hardware and software upgrades
2. Education
   - Changes in regulation/policy
     - Providers / Staff
3. Resources
   - Administrative
   - Clinical - PharmD/Behavioral Health
   - Ancillary- Care coordinators/Disease management
4. IT
   - Data integration
   - Data Analytics
5. Quality and Patient Safety
   - Outcome measures
   - Patient satisfaction
   - Specific metrics

2013



ACO West Virginia

1/1/2018 – WVU Medicine participates as **ACO West Virginia** - **MSSP Track 1**.

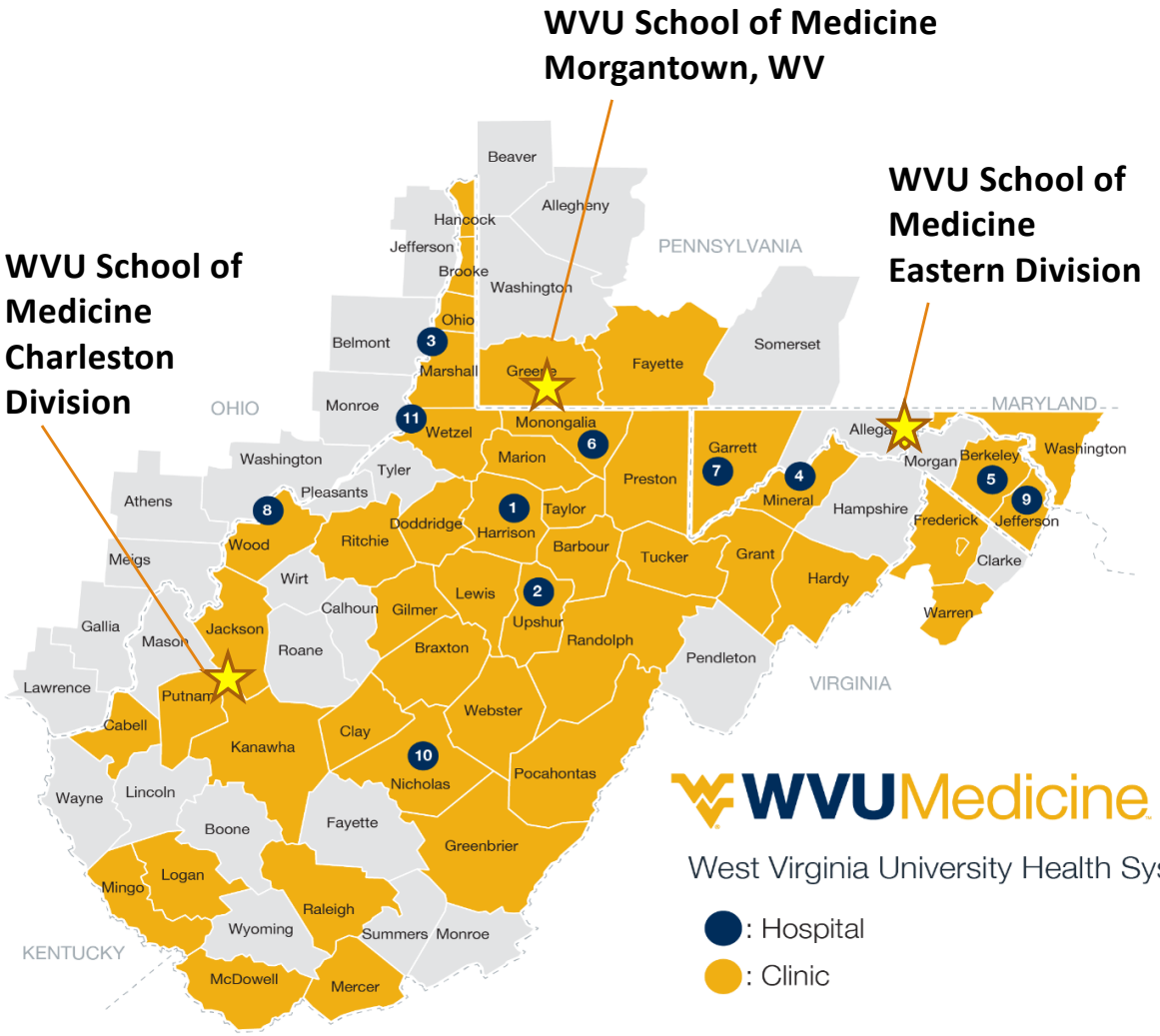
WVU Medicine's ACOs in 2018

- Berkeley Medical Center
- Jefferson Medical Center
- United Hospital Center
- United Physicians Care
- University Health Associates
- University Healthcare Physicians
- WVU Hospitals

Organizations to be added in 2019

- Camden Clark Medical Center
- Reynolds Memorial Hospital
- St. Josephs Hospital
- Potomac Valley Hospital

Service Area Growth



1. **BRIDGEPORT**
   United Hospital Center
2. **BUCKHANNON**
   St. Joseph's Hospital
3. **GLEN DALE**
   Reynolds Memorial Hospital
4. **KEYSER**
   Potomac Valley Hospital
5. **MARTINSBURG**
   Berkeley Medical Center
6. **MORGANTOWN**
   J.W. Ruby Memorial Hospital and WVU Medicine Children's
7. **OAKLAND, MARYLAND**
   Garrett Regional Medical Center (managed by WVUH)
8. **PARKERSBURG**
   Camden Clark Medical Center
9. **RANSON**
   Jefferson Medical Center
10. **SUMMERSVILLE**
    Summersville Regional Medical Center (managed by WVUH)
11. **WETZEL**
    Wetzel County Hospital (affiliate)

06/29/18

Present Areas of Focus for ACO Success

- Establishing well-managed Care Transitions (post-hospital and post-ED outreach)
- Improving provider and team engagement
- Involving clinical teams in quality improvement projects for greater effectiveness
- Developing well-organized outreach to address care gaps.

With Goals of:

- Improving patient self-management of chronic disease (patient empowerment)
- Improving patient health, outcomes and quality of life (**quality**)
- Easier access to care (**patient experience**)
- Reduce ED and hospital utilization (**costs**)
- Improve patient flow and work environment (**provider wellness**)

Redesign Care To Meet The Areas of Focus

1. *Disease management* coordination
2. Enhanced *Access* to Primary Care
3. Improved *transitions* to the next level of care
4. *Prevention and wellness* exams
   - **Annual Well Visit**
     - Coordination of scheduling and/or outreach
5. Improving *quality*
6. Predictive *data analytics*

Disease Management Care Coordination

Disease management coordinators –RN's
- Frequent high risk patient contact

Social workers
- Community resources and engagement

Pharmacists
- Medication reconciliation
- Polypharmacy

Telemedicine

Remote home monitoring

Access

Identified characteristics:

1. Affordability
2. Availability
3. Accessibility
4. Accommodation
5. Acceptability

Improve Transitions to Next Level of Care

Population Health Liaisons

- Educate providers on Population Health strategy
- Monitoring and improvement of quality measures
  - Identify the quality measure (QM) workflows
  - Educate providers on QM workflows and metric goals
- Interface with disease management coordinators
- Prioritize population health focus and needs

Prevention and Annual Wellness Exams

Example: Medicare Well Visits - <u>Parallel Schedule</u>

Dashboard Report Actions

- List to call patients to schedule appointments
  - Create Patient List: Schedule AWV
  - Share list with others as needed
  - Remove patient from list when contacted

- Ability to send "mychart" messages to active accounts:
  Communication-send patient message
  - Can send Depression screening and Fall screenings

- Import immunizations

Improving Quality and Identifying Opportunities

QUICK WINS

Rooming Process

- Repeat Blood Pressures
- Fall Screening
- BMI every visit --also needs Plan
- Address Pneumococcal vaccine
- Add Aspirin OTC to Meds

.POCALL Plans of Care in clinician notes

.EXCEPT Document exceptions

Update Problem List with Hospice, Palliative Care and Long Term Care

BIGGER LIFTS

Annual Well Visits

- Telephone outreach
- Nurse visits

Breast and Colon Cancer Screen

- Outreach calls or reminders
- Consider ***Cologuard***

Best Practice Alert

Statins for CVD

- Document exceptions, intolerance
- Consider dosing 2-3 times per week

Data Analytics

Key Performance Indicators

- Quality performance
  - ACO quality measure score
  - Internal quality monitors
- Total health care cost per member per month
- Hospital admissions per 1000 members per month
- Post-acute care costs per member per month
- Pharmaceutical costs per member per month
- Provider dashboards
- Specialty specific cost analysis

Areas In Constant Transition and Evolving Challenges

Key functions

- *Communication*
- Identify *best practices*
- Continual identifying and addressing organizational *successes, pitfalls, and barriers.*
- Predictive Data Analytics – *identifying the patient at risk prior to "high-risk"*

Challenges

- Aligning provider work with compensation
  - shift in incentives from volume-based to value-based.
- Having a strong and growing primary care physician base.
- Disseminating information to clinical teams and leadership in timely manner.
- Address barriers for Quality and Care Coordination at all levels.
- Financial restraints – staying within the budget.

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NextGen ACO: To risk or Not To Risk

Population Health ≠ Value Based Care and Value Based Care ≠ Population Health

- We have 75,000 patients in various Value based contracts NextGen and MA
- We have 200,000 patients under 18 in our primary care and 300,000 18 and over.
- We have the largest Medicaid peds practice in the state
- We are 70% Medicaid/Medicare 30% commercial

Moving to NextGen

- Wake and CHESS believe that there is a progression that needs to occur from shared savings to upside downside risk
- We have folks start in either MSSP or MA contracts that are shared savings
- This allows an organization to develop competencies in value based care with out taking huge risks

Benefits of Moving into NextGen

- Prospective Attribution
- Risk Adjustment through HCC coding
- Certain types of Waivers
  - SNF Waiver
  - Telehealth
  - Home visit
  - Cost Sharing Waiver
  - 5% bump in part B payments as an APM

Risks

- Millions of dollars at risk
  - Wake 16 million upside downside risk
  - Can choose a risk corridor
- Benchmark is extremely important
- Balance between what you spend and what you save
- If you get several folks who have unexpected illnesses with not enough lives
- Any government program comes with compliance and regulatory risks

Financials

MSSP – 2016 Final Results

	[redacted]	[redacted]	Wake	MSSP	
Beneficiaries - 2014	2,652	3,945	10,544	17,104	
Cost of Care - 2014	$713	$628	$934	$821	
Target PMPM	**$750**	**$661**	**$960**		
Target Spend	**$31,977,108**	**$38,601,950**	**$139,078,194**	**$209,657,252**	
Actual PMPM	**$843**	**$620**	**$904**	**$826**	
Actual Spend	**$35,902,439**	**$36,212,543**	**$131,072,359**	**$203,187,340**	
Beneficiaries - 2016	3,551	4,870	12,076	20,498	
Achieved Savings	**-$1,855,792**	**$1,129,648**	**$3,784,946**	**$3,058,803**	**2.9%**
Distribution					
Citizenship - 5%	$26,495	$36,336	$90,102	$152,933	
Quality - 55%	$291,444	$399,699	$991,123	$1,682,266	
Cost Reduction - 40%		$281,252	$942,351	$1,223,603	
Total	**$317,939**	**$717,288**	**$2,023,576**	**$3,058,803**	

Analyzing ACO Performance in Shared Savings

	Quality Performance	Utilization Reduction	Capturing Accurate Risk (HCC)	=	Cost Reduction
MSSP	High Quality (Wake score = 93.82%)	Overall Trend- flat to slight increase in utilization *Slight ED reduction & slight increase IP utilization;*	MSSP included in smartform- July 2017		**Cost Reduction** QRUR- CY 15: 2.11% below benchmark Wake - MSSP ACO 2015: 3.3% below benchmark Wake – MSSP ACO 2016 (estimated): 3.3% below benchmark
MA Plan	Superior Quality (15 measures hit/13 superior) $7 PMPM	Overall Trend- Slight IP reduction & increase in ED	11% increase (in RAF 1.14-1.26); Increased allocated premium by $3.55 million		**Significant Cost Reductio** UHC MA 2016: **17% Cost Reduction**/ $6.87 million below benchmark

ACO/Value Focus-

What do we target and evaluate?

- **Access & Experience**
- **Quality Improvement**
- **Avoidable ED & Inpatient Admissions**

Performance Evaluation		
Quality * GPRO measures Screenings *DM Management * Obesity	Utilization * ED Utilization/Cost * IP Utilization/Cost *SNF LOS Utilization	Risk * HCC – documentation of patient acuity

Financial Analysis

- The financial skills are more inline with an insurance company than a hospital
- Claims incurred
- IBNR
- RAF
- RAF sweep
- PMPM

Estimated Results

	Estimate	Estimates		
		Base Case	Conservative	Best Case
Patients	**29,045**	**28,865**	**28,865**	**28,865**
Benchmark				
Risk-standardized Benchmark PPPM	$797	$795	$795	$795
Risk score	1.19	1.19	1.20	1.22
Risk-adjusted Benchmark PMPM	**$941**	**$939**	**$953**	**$967**
Total Benchmark	**$82,010,877**	**$162,657,618**	**$165,097,483**	**$167,537,347**
Claims				
Incurred Claims PMPM	$894	$897	$897	$897
Estimated IBNR PMPM	$14	$22	$22	$22
Total Claims	**$79,139,029**	**$159,138,618**	**$159,138,618**	**$159,138,618**
Savings	**$2,871,848**	**$3,519,000**	**$5,958,864**	**$8,398,729**
Annualized	**$11,487,391.17**	**$7,038,000**	**$11,917,729**	**$16,797,457**
RAF Increase		0%	1.5%	3%

- May PartB Spend $1.5 million higher than prior 4 month average
- Mid Year RAF sweep not included, current RAF is lower than 2017 RAF and we saw a 3.4% and 2.7% increase the prior 2 years

How is Next Gen different?

Financial terms: Keep 100% of savings: everyone loves pointing this out without point out you pay 100% of the losses as well

Risk adjustment: Documentation through HCC impacts benchmark up to +3%to accurately depict risk profile of patients we manage

Prospective Attribution: Early identification to manage patients with no new additions only retractions.

Network Incentives: CMS Waivers- 3 Day SNF Waiver

APM Bonus for 2019: Participation enables WFBH to receive the 5% Advanced APM bonus on Part B payments

Wake Experience

- We have been fortunate up to this point. We have had shared savings and appear to be on track to savings this year in NextGen.
- In 2017 CHESS lost 63K on NextGen. This is the loss we paid to CMS. This is not the total cost of providing the services needed to perform well in value contracts.
- I believe we are providing better care for patients due to the TCM, CCM, focus on preventive service

APM's

- We are seeing a decrease in the medical loss ratio that insurance companies want us to hit prior to saying there are savings
- Benchmarks set by CMS are also adjusted down and at some point you cannot save more money
- Hard to hit scale with these arrangements without a large clinically integrated network