# Innovative Models for Managing Patient Populations

NOVEMBER 9, 2021

# About MHCC

- Advance innovative value-based care delivery and health information technology statewide by promoting adoption and use, identifying challenges, and raising awareness through outreach activities

- Provide timely and accurate information on availability, cost, and quality of health care services to policy makers, purchasers, providers, and the public

# CME and Disclosures

- This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of MedChi, The Maryland State Medical Society and the Maryland Health Care Commission (MHCC). MedChi is accredited by the ACCME to provide continuing medical education for physicians
- MedChi designates this virtual online educational activity for a maximum of *1 AMA PRA Category 1* Credits™
- Physicians should claim only the credit commensurate with the extent of their participation in the activity
- The following presenters have reported no relevant relationships to disclose: Michael Barr, M.D.; Michael Albert, M.D.
- The planners and reviewers for this activity have reported no relevant financial relationships to disclose

MARYLAND
Health Care
Commission

# AGENDA

- Overview
- Maryland's  Innovative Care Delivery Landscape
- Evolution of Value-based Cєare Delivery, Quality Initiatives, and Patient Reported Outcomes

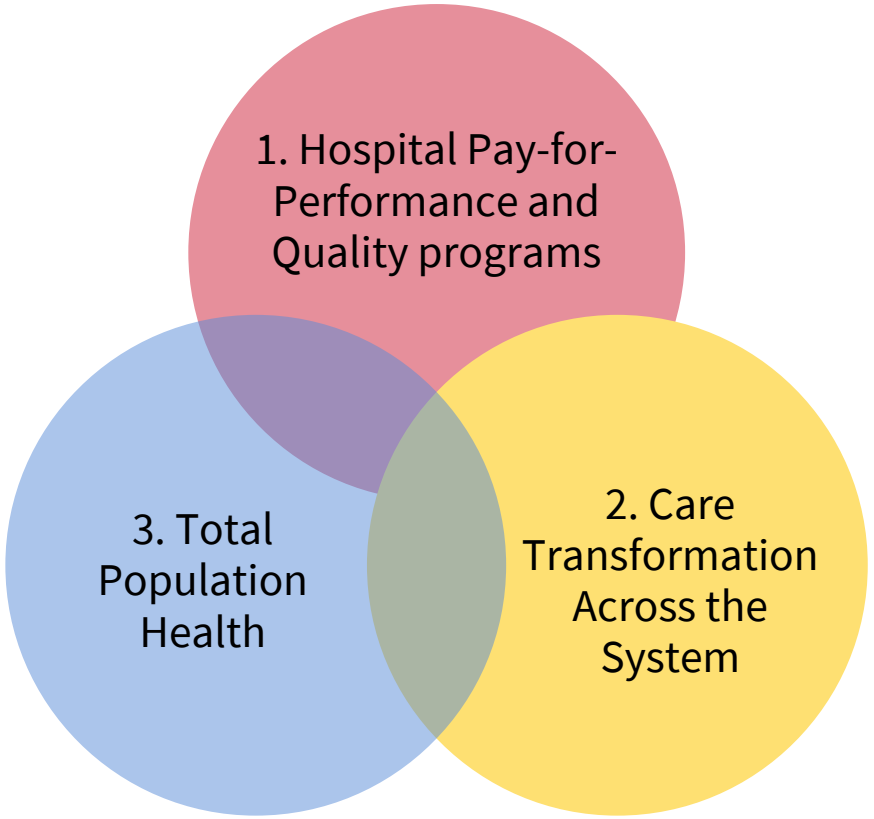
  Michael Barr, M.D.
- Primary Care Models for Managing High-risk and High-utilizer Patient Populations

  Michael Albert, M.D.
- Q&A

# Maryland's Unique Approach

- Maryland's Total Cost of Care (TCOC) Model priorities include:
  - Ensure that all Marylanders have access to quality health care, whether in rural or urban areas of the State
  - Address the needs of our senior population, which is expected to increase by 22 percent over the next 10 years (Maryland State Plan on Aging)
  - Fight the opioid epidemic and other population health improvements, such as diabetes prevention and other chronic conditions

# TCOC Model Components




| Component | Purpose |
|---|---|
| **1. Hospital Population-Based Revenue** | Expands hospital quality requirements, incentives, and responsibility to control total costs through limited revenue-at-risk (e.g., Medicare Performance Adjustment, reduction of potentially avoidable utilization, and reduced readmissions) |
| **2a. Care Redesign and New Model Programs** | Fosters care transformation *across the health system:*<br>• Expands incentives for hospitals to work with others<br>• Opportunity for development of "New Model Programs" for non-hospital providers (e.g., EQIP)<br>• MACRA eligibility with participation |
| **2b. Maryland Primary Care Program** | Enhances chronic care and health management for Medicare enrollees |
| **3. Population Health** | Encourages programs and provides financial credit for improvement in statewide diabetes, opioid addiction, and at least one other state priority area. Develops a Statewide Integrated Health Improvement Strategy. |

# The Episode Quality Improvement Program (EQIP)

- A voluntary, episodic incentive payment program for Maryland specialist physicians beginning January 1, 2022
- The first performance year will include episodes in the following specialty areas:
  - Gastroenterology and General Surgery
  - Orthopedics and Neurosurgery
  - Cardiology

# Care Transformation Organization Grant Overview

- The MHCC recently awarded MedChi Care Transformation Organization (CTO) a grant to engage eligible primary care and specialty practices (practices) in an *Advancing Practice Transformation in Ambulatory Practices* Program (program)
- Key objectives of the program include:
  - Support the broad goals of the TCOC Model by readying practices to participate in value - based payment programs (e.g., MIPS)
  - Prepare practices to deliver efficient, high-quality care while improving health outcomes
  - Lay the foundation for practices to provide team-based, patient-centered care, and for efficient use of health information technology

# Background

- The Transforming Clinical Practice Initiative (TCPI) was one of the largest federal investments uniquely designed to provide technical assistance to clinician practices
- It was a nationwide strategy to strengthen the quality of patient care and spend health care dollars more wisely
- TCPI Change Package
  - Compilation of interventions developed and tested by other practices
  - Describes the changes needed to transform clinical practice and meet TCPI goals
  - Organized around three primary management functions that drive performance, quality, and success

# Milestones

- Program Milestones:
  - Milestone 1 – Readiness Assessment
  - Milestone 2 – Workflow Redesign
  - Milestone 3 – Training

# Next Steps

- Practice applications will be reviewed in November
- Practice baseline assessments and workflow redesign will begin prior to January 1, 2022
- More information about the program is available at: mhcc.maryland.gov/mhcc/pages/apc/apc/documents/apc_CTO_Program_Overview.pdf

# INNOVATIVE MODELS FOR MANAGING PATIENT POPULATIONS

## VALUE-BASED CARE DELIVERY, QI, PATIENT-REPORTED OUTCOMES

NOVEMBER 9, 2021

MICHAEL S BARR, MD, MBA, MACP, FRCP
PRESIDENT
MEDIS, LLC (WWW.MEDISLLC.COM)

# Why Is This Topic Important Now?

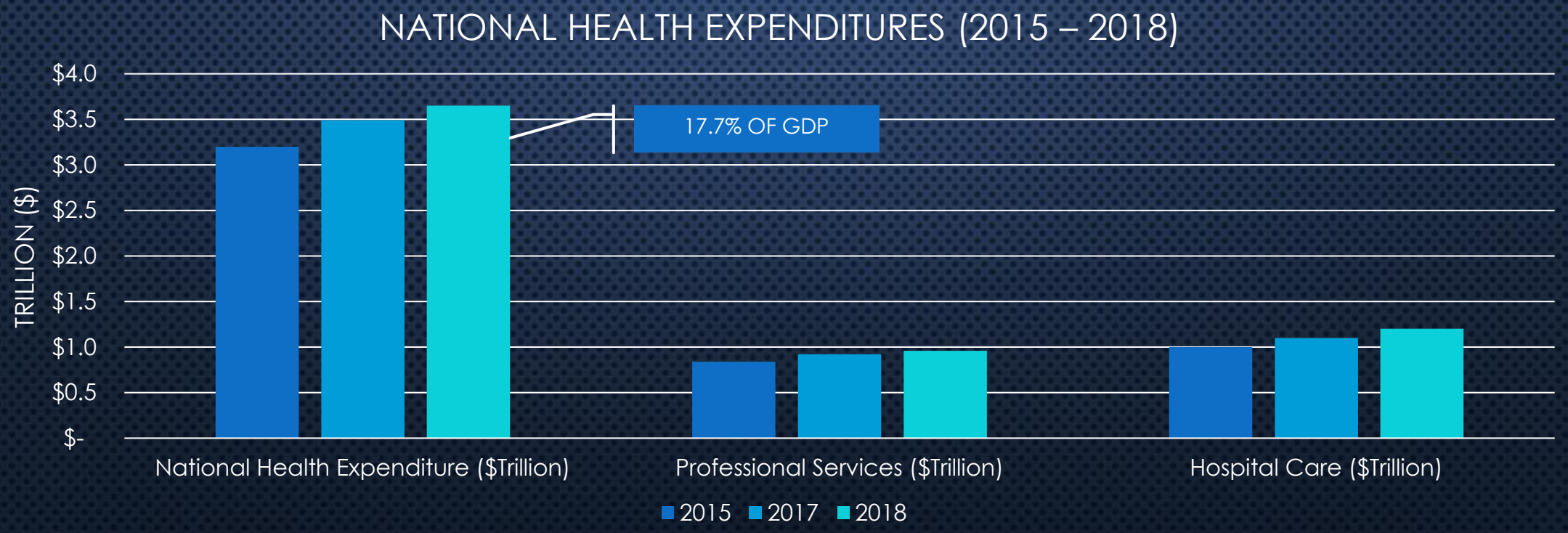
Opportunities to improve and innovate,

Are anchored by policies and culture that limit the rate,

At which we can create the change necessary to accelerate,

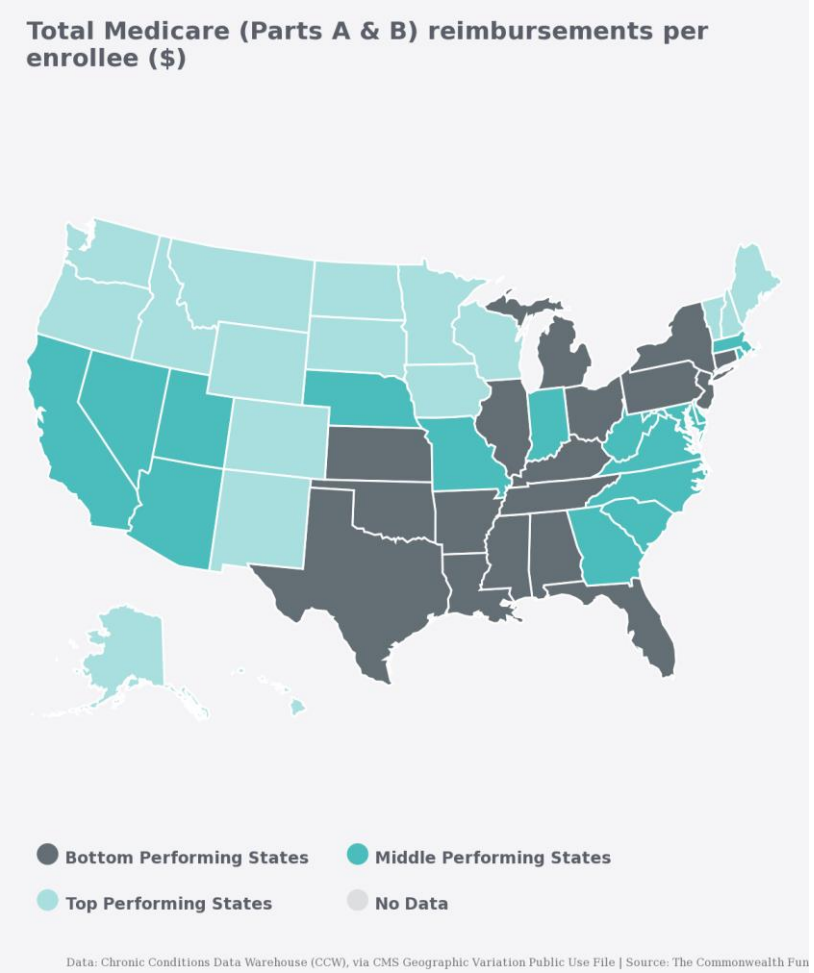
Beyond the status of our current state.

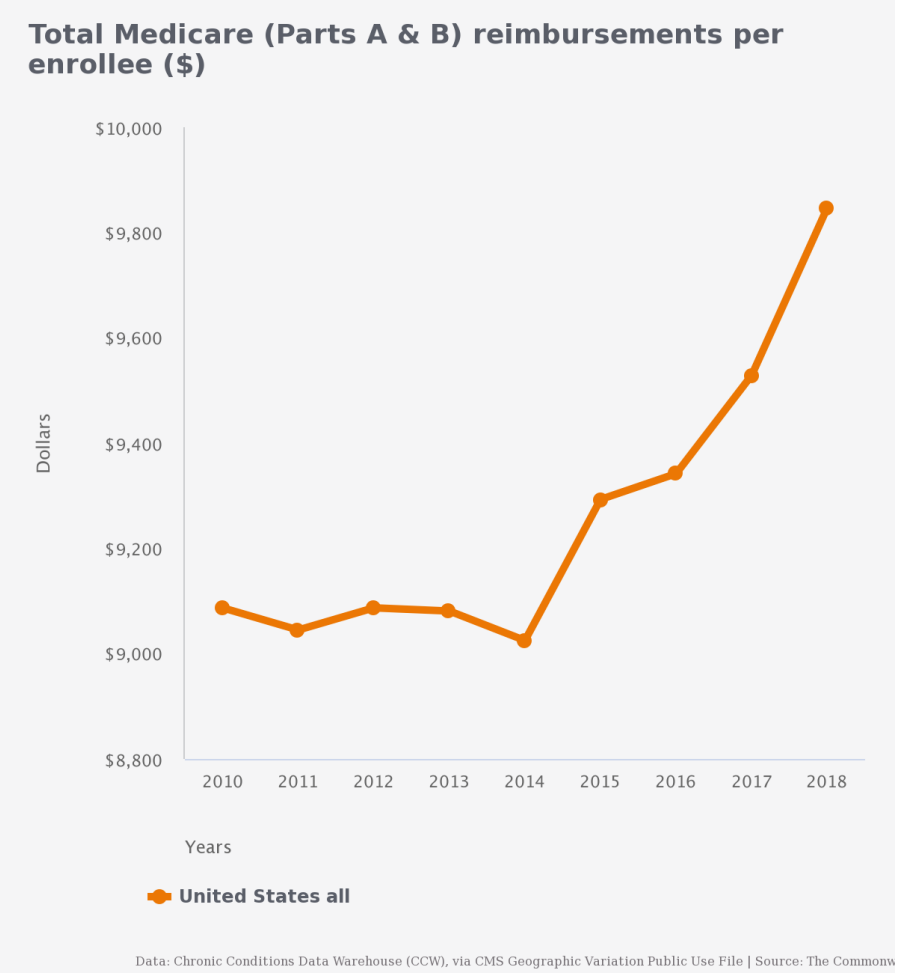
# $3.6T ANNUAL HEALTH CARE COSTS (2018)
## ~30% OF COSTS ARE UNWARRANTED*




Source CDC (https://www.cdc.gov/nchs/fastats/health-expenditures.htm)
Dzau et al. JAMA. 2017;317(14): 1461 – 1470.
*Unnecessary services, inefficiencies, administrative costs, high prices, missed prevention, fraud

# Total Medicare (Parts A & B) Reimbursements Per Enrollee

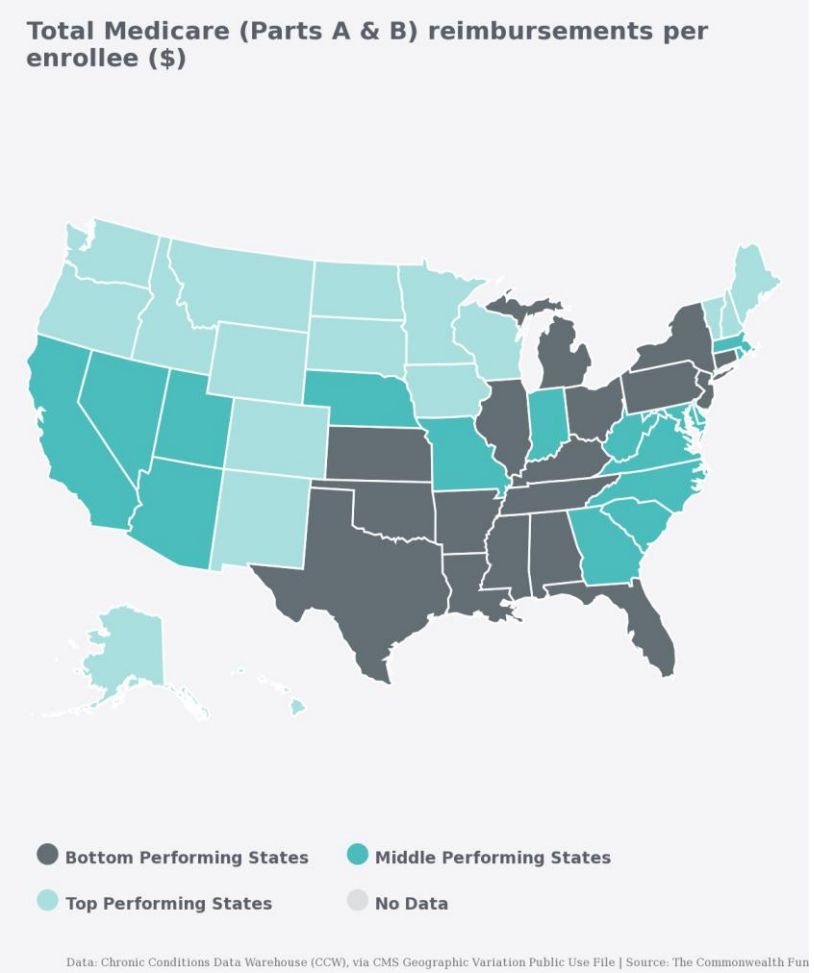




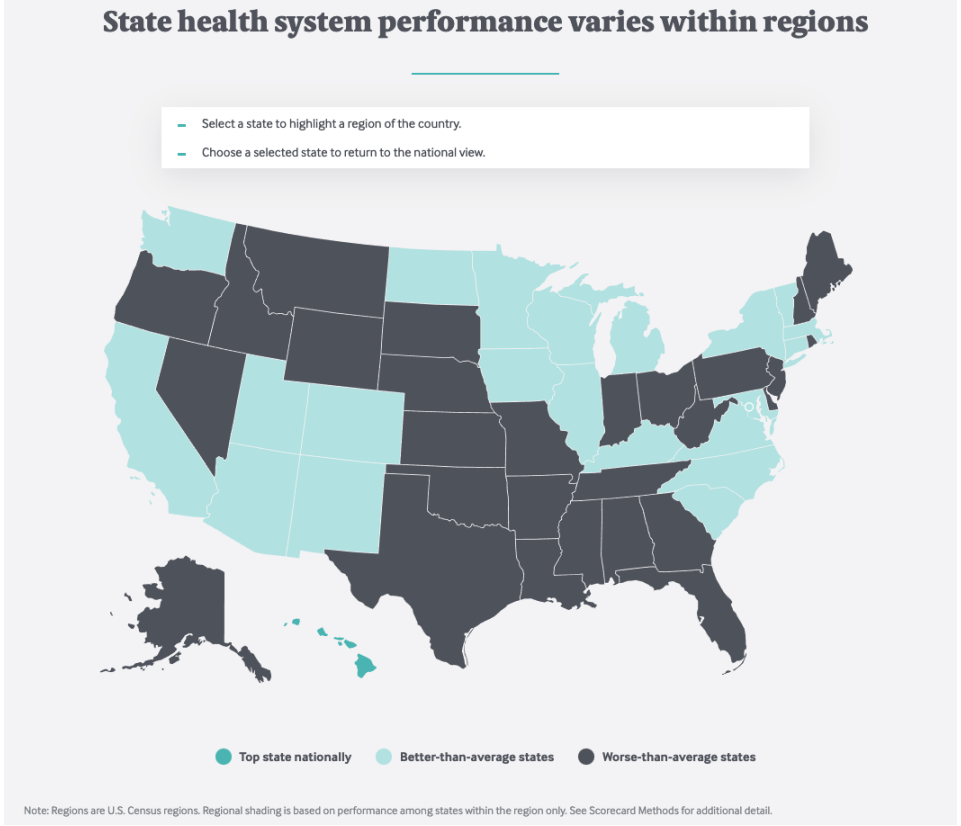

https://www.cdc.gov/nchs/fastats/health-expenditures.htm

## Total Medicare (Parts A & B) Reimbursements Per Enrollee




https://www.cdc.gov/nchs/fastats/health-expenditures.htm

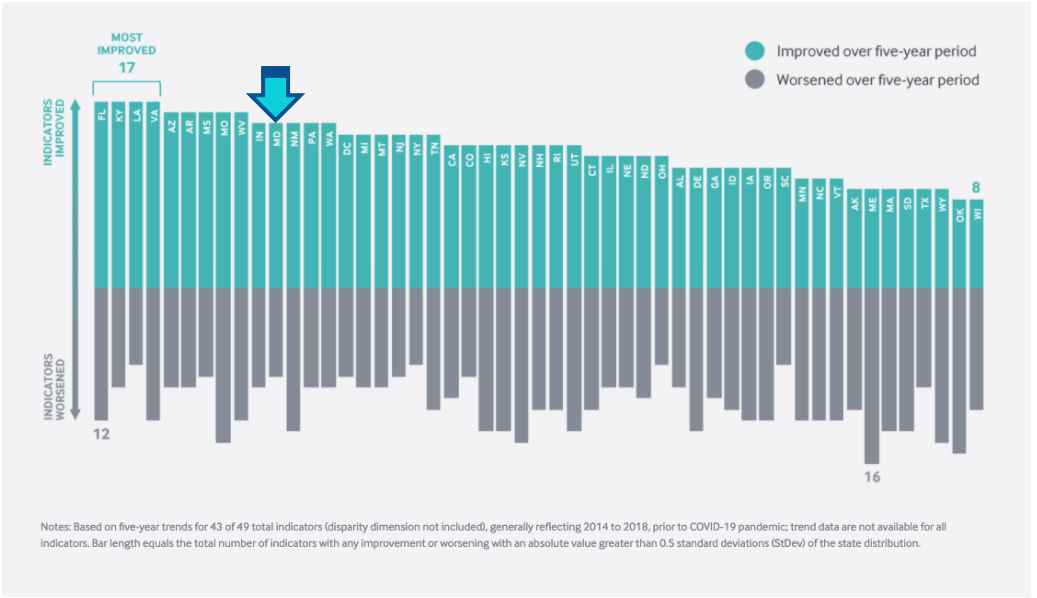
## State Health System Performance




The Commonwealth Fund Score Card on State Health System Performance

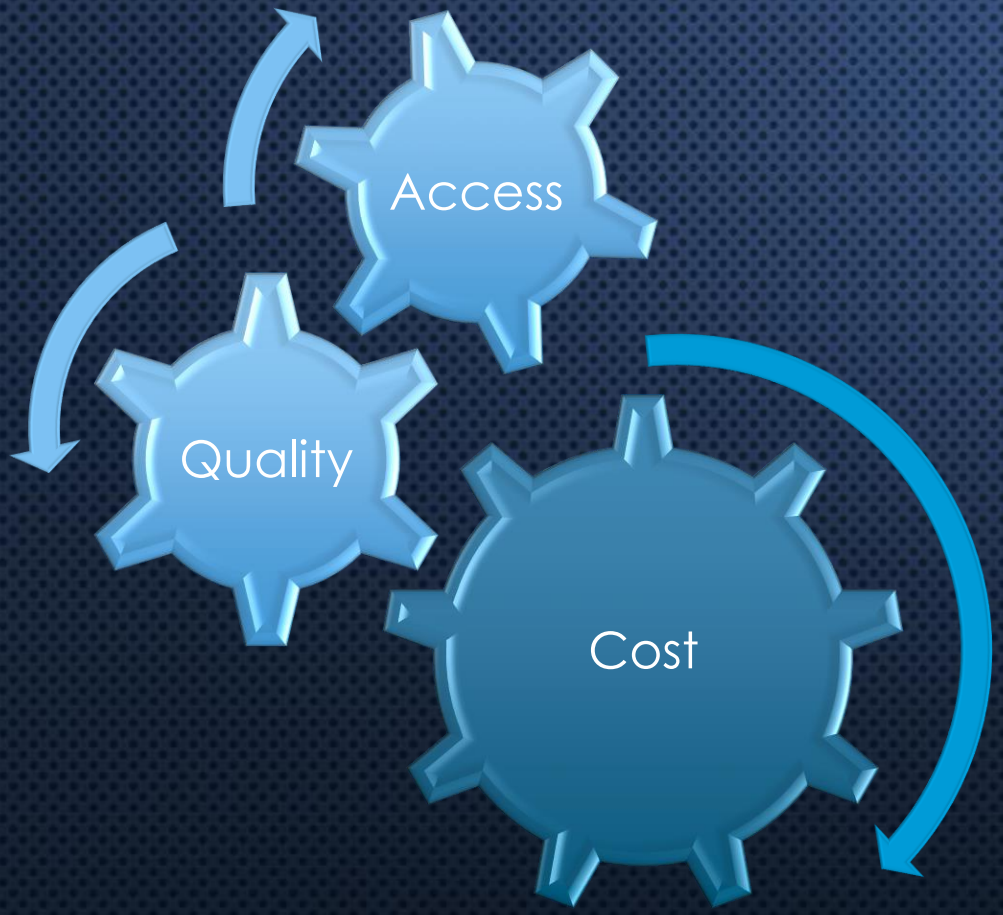
https://2020scorecard.commonwealthfund.org/rankings

# Maryland Ranking



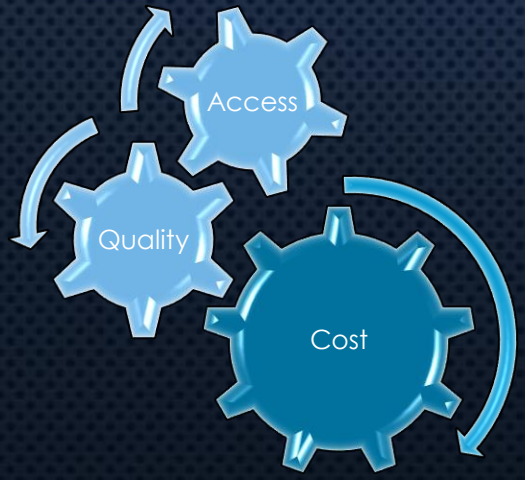

https://2020scorecard.commonwealthfund.org/rankings



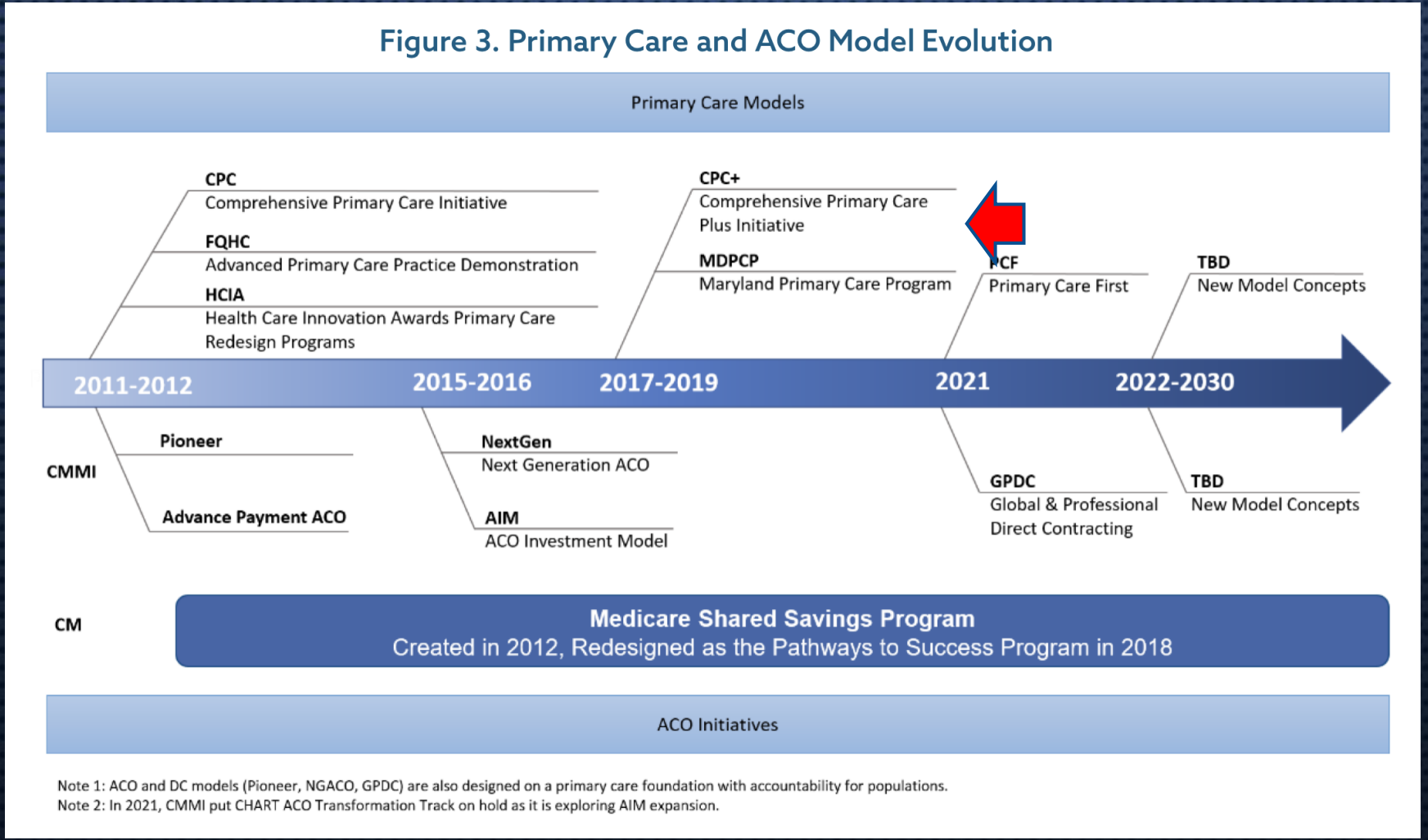

The relationship between access, quality and cost is complex.

Optimizing all three is nearly impossible, yet…

Value-based payment models emphasize accountability for outcomes - which largely means cost.




# CENTERS FOR MEDICARE AND MEDICAID INNOVATION INITIATIVES





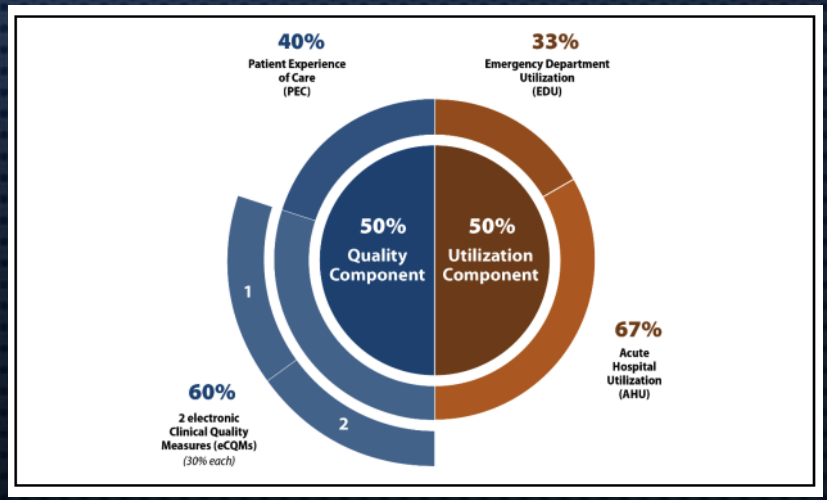

https://innovation.cms.gov/strategic-direction-whitepaper

# VALUE-BASED PAYMENT MODEL: Dissecting CPC+

- Two tracks
  - Three components to payment
    1. Care management fee (5 tiers based on HCC*)
    2. Performance-based incentive payment
    3. Payment under Medicare physician fee schedule

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

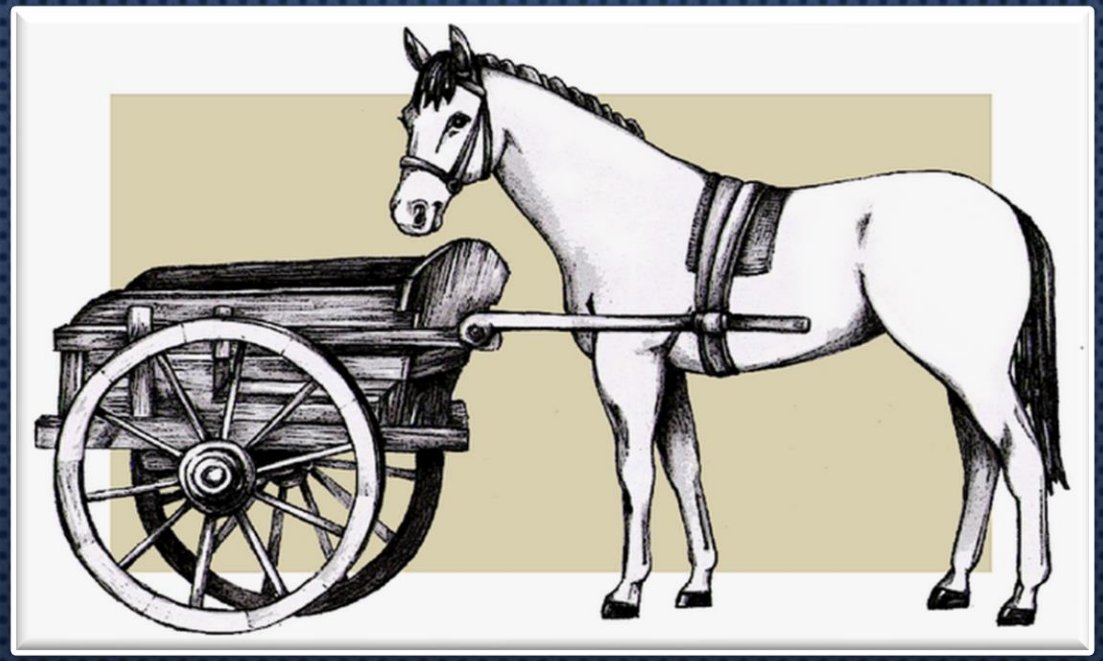
- Performance Based Incentive Payment (PBIP)
  - Two eCQMs for Program year 2021
    1. Diabetes: Hemoglobin A1c Poor Control
    2. Controlling High Blood Pressure
  - Two utilization measures (AHU & EDU)






https://innovation.cms.gov/media/document/cpc-plus-payment-methodology-cy2021

*HCC – CMS Hierarchical Condition Categories





# STRATEGY WITHOUT TACTICS IS THE SLOWEST ROUTE TO VICTORY. TACTICS WITHOUT STRATEGY IS THE NOISE BEFORE DEFEAT.

- SUN TZU

# MEASURES FOR ACCOUNTABILITY
# ≠
# MEASURES FOR IMPROVEMENT

## Accountability

- Retrospective
- Slow to change
- Chosen based on wide ability to report
- Often rely on data not typically available to clinical teams
- Not person-centered

## Improvement

- Timely
- Actionable & configurable
- Clinically relevant for team and patient
- Based on readily available data generated by typical documentation
- Can be designed to support person-centered + population-based care

# CURRENT EMPHASIS ON ACCOUNTABILITY & OUTCOMES *MISSES* THE TARGET


Accountability
Outcomes
Structure & Process
Utilization
Cost
Outcomes
Quality Improvement
Intermediate Outcomes
Ethical/Equitable/Rational Care
Person-Driven Outcomes
Efficiency
Infrastructure Optimization
Patient/Family Engagement
Staff Engagement, Training


Utilization
Cost
Outcomes

Quality Improvement

Intermediate Outcomes

Ethical/Equitable/Rational Care

Person-Driven Outcomes

Efficiency

Infrastructure Optimization

Patient/Family Engagement

Staff Engagement, Training

## Claims Data

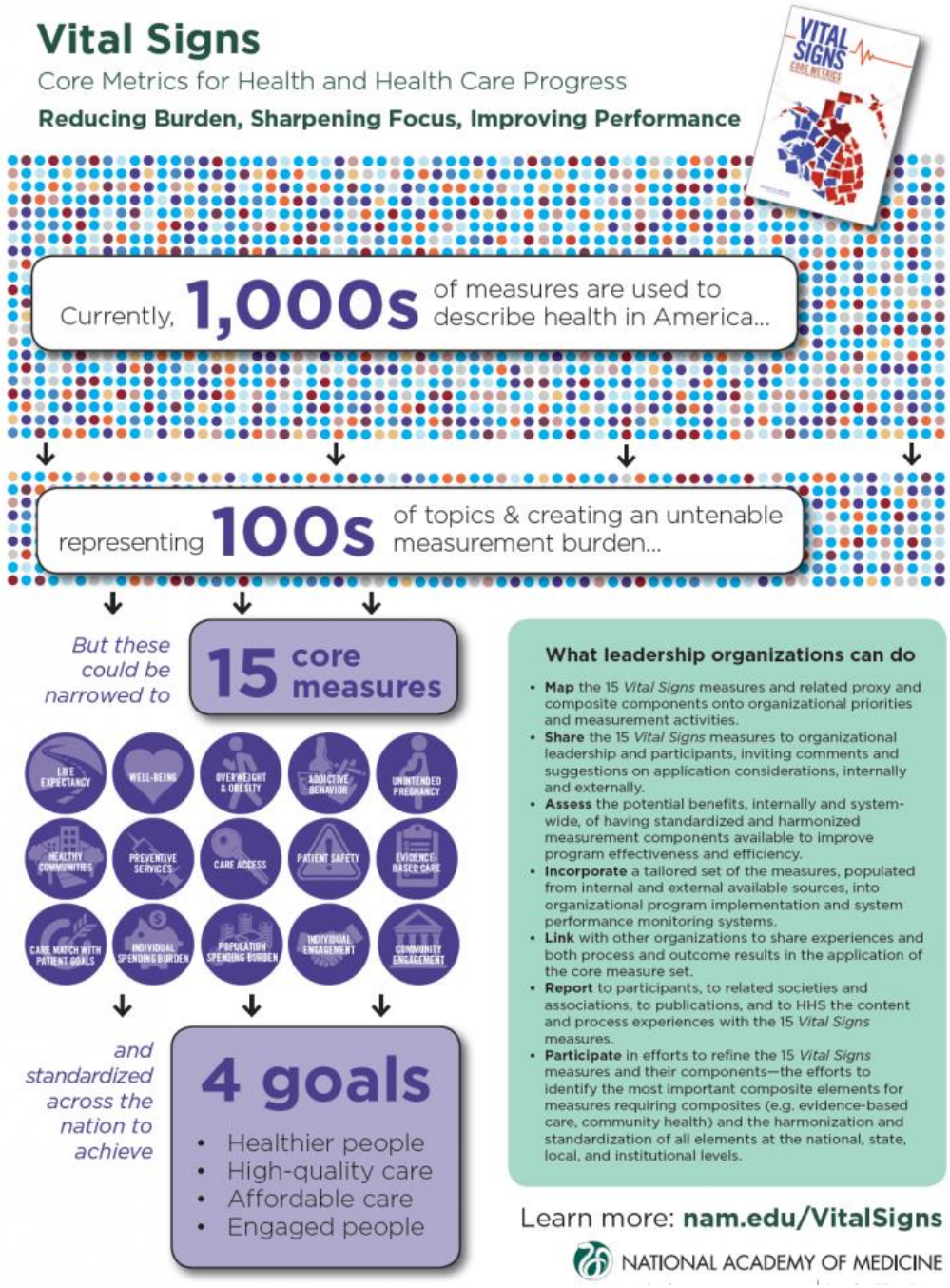
- HEDIS®
- Health Plans
- All Payer Claims Databases

## Clinical Data

- eCQMs/dQMs
- EHRs, Registries, HIEs
- Data aggregators

## Administrative Data

- Practice Management Systems
- Submitted claims
- Documentation




# Principles for Measurement

- Clinically relevant & evidence-based
- Feasible/actionable
- Data must be available and validated
- Contribute to health equity
- Fair and understandable methods for attribution, accountability and risk adjustment


**The updated core sets have been approved by the Steering Committee and finalized by the full Collaborative. During the past year, the Collaborative also created two new core sets on Behavioral Health and Neurology. The 2020 core sets now include:**

- Accountable Care Organizations/Patient Centered Medical Homes/Primary Care (PDF)
- Behavioral Health (PDF)
- Cardiology (PDF)
- Gastroenterology (PDF)
- HIV & Hepatitis C (PDF)
- Medical Oncology (PDF)
- Neurology (PDF)
- Obstetrics & Gynecology (PDF)
- Orthopedics (PDF)
- Pediatrics (PDF)

https://www.qualityforum.org/CQMC_Core_Sets.aspx

# Principles for Measurement

- Clinically relevant & evidence-based
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# ACCOUNTABILITY MEASURES: A "Parsimonious" Subset Of Measures for Improvement & Reporting

# CONTROLLING BLOOD PRESSURE


**Outcome**

- Blood pressure control as evidenced by:
  - Average blood pressure over time
  - Absence of syncope
  - Avoidance of CVD events
  - Hospital/ED utilization
  - Person-driven outcome measures

Accountability

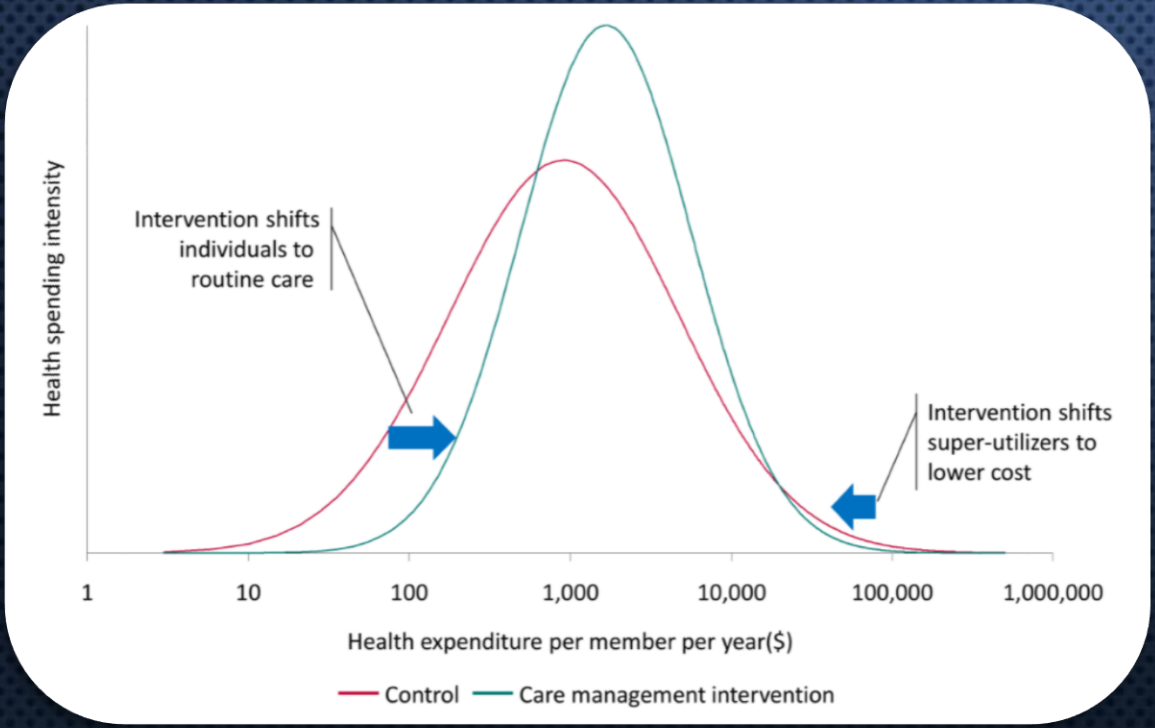
**Process**

- Efficient workflow
- Training/technique
- Population screening/outreach; access
- Identification of social needs, risk factors
- Use of clinical decision support
- Treatment intensification/deintensification
- Screening for co-morbid conditions
- Appropriate referrals and loop closure
- Patient/Family engagement

**Structure**

- Calibrated equipment
- Equipped exam rooms/design
- Technology platform(s)
- Policies/procedures/templates/checklists
- Registry or equivalent

# Can Structure & Process Interventions Reduce Variability In Care & Cost?



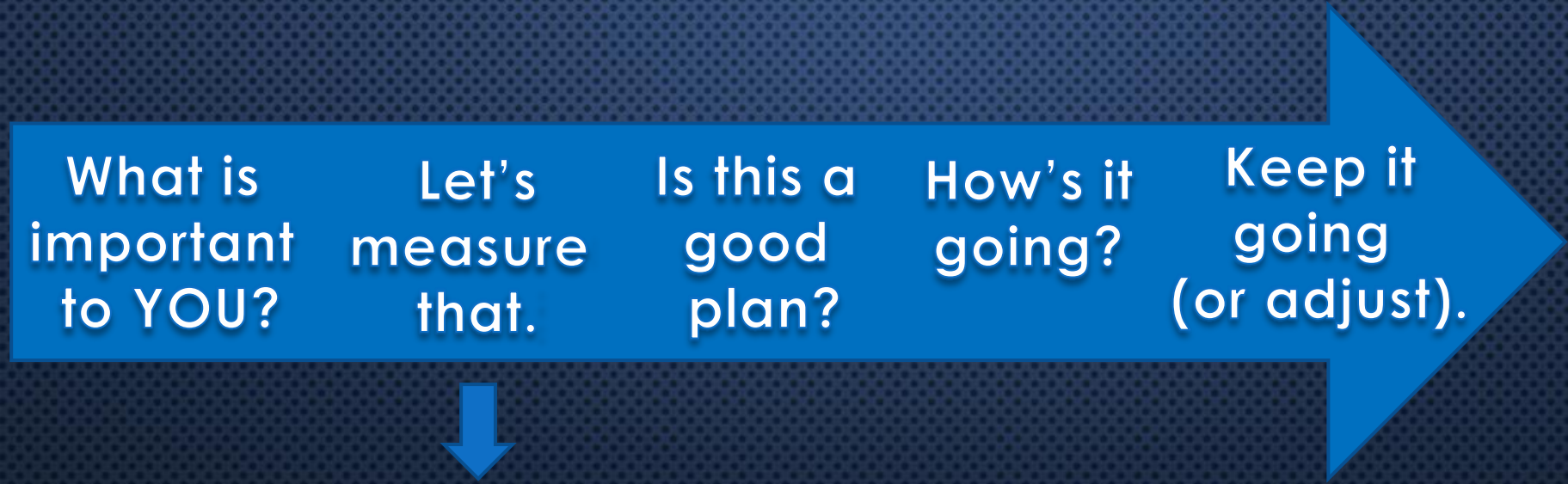

## *Hypothesis*

- Standardization and adoption of robust processes improves efficiency and consistency.
- Improvements in care for underserved could drive up costs.
- Yet avoidance of unwarranted variation and morbidity could drive down costs.
- The combination might not change average cost.
- Reduction in variability, though should help health systems manage care, target interventions, improve efficiency, and achieve better value.



Herant, Bhojwani, Sanghavi:
https://www.healthaffairs.org/do/10.1377/hblog20180323.99195/full/

# MEASURING WHAT MATTERS: Person-driven Outcome Measures




*Goal attainment scaling*: Identify a goal and create a qualitative scale of possible quantifiable outcomes for that goal.

*Person-reported outcome measures*: select and use to measure a symptom or domain associated with a goal.



Adapted from NCQA: https://www.ncqa.org/hedis/reports-and-research/measuring-what-matters-most-to-older-adults/

# Framework to Align Measures Across Levels

**CMS**
**Health Plan**
**State**

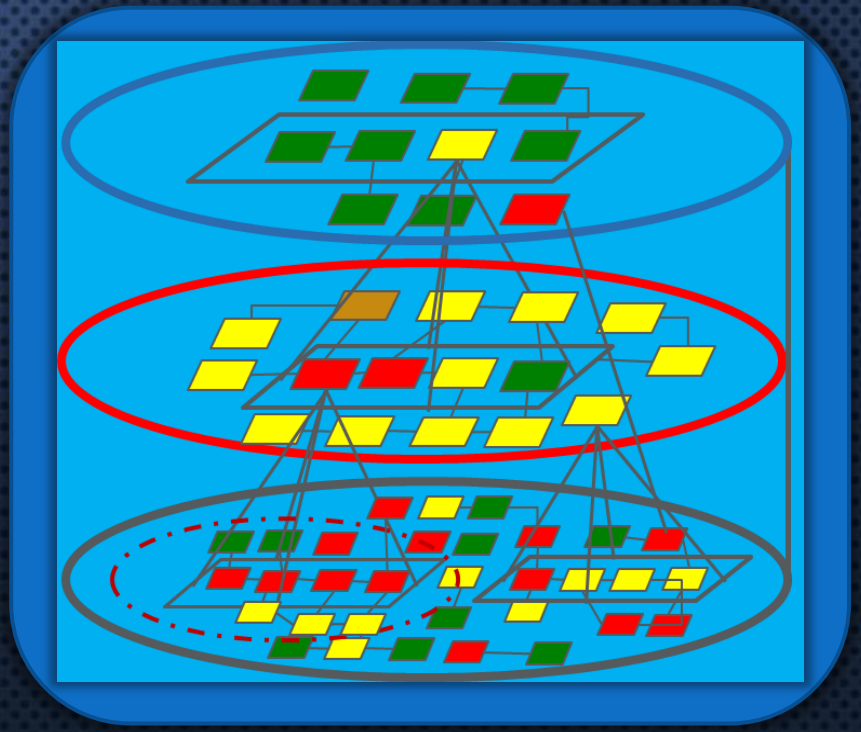
- Covered lives/beneficiary-based measures.
- Retrospective assessment of quality, utilization, and cost.
- Apply appropriate attribution methodology.
- Additional metrics for network adequacy.
- Emphasis on accountability.

**Delivery System**
**Network**
**ACO**

- Population-based measures to monitor system performance.
- Use clinical, management and administrative data.
- Generated by workflows in practice but do not impose workflow requirements.
- Less time-sensitive.
- More outcome-oriented.
- Some measures used for accountability.

**Practice**
**Clinician**

- Actionable, timely measures to support clinical and operational activities.
- Use data available (clinical, practice mgt.)
- Embedded in workflow of practice.
- Person-specific and/or population-based.
- Person-reported measures.
- Some measures used for reporting or accountability.





Adapted from Niles & Olin:
https://www.ncqa.org/wp-content/uploads/2021/07/20210701_Behavioral_Health_Quality_Framework_NCQA_White_Paper.pdf

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# REFERENCES


- CMS Innovation Center Strategy Refresh
- Healthcare Payment Learning & Action Network
- Comprehensive Primary Care Plus
- Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care
- Centers for Disease Control and Prevention Health Expenditures
- The Commonwealth Fund – Controlling Health Care Costs
- Hypertension Control Change Package (Million Hearts; HHS)
- Reducing cost variability may be an unrecognized but valuable outcome of care management interventions

# THANK YOU

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JOHNS HOPKINS
MEDICINE

# Primary care for high risk patients in Johns Hopkins Medicine

*Michael C. Albert MD*

*Johns Hopkins Community Physicians*

*Johns Hopkins Medicine*

*October 2021*

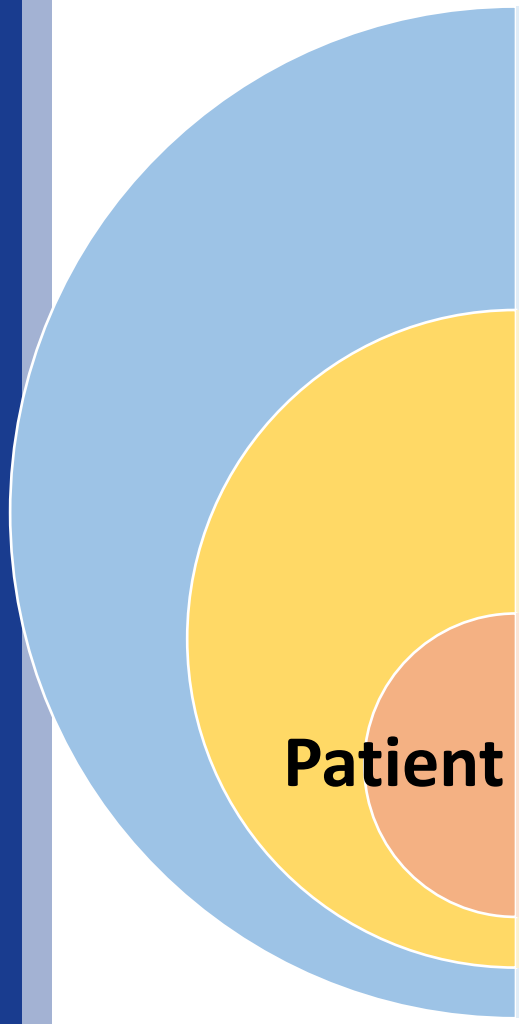
# Disclosures

- None

# Learning objectives

- Understand the advanced roles that primary care providers play in team-based high risk patient care
- Understand how several primary care models reduce unnecessary utilization and costs by segmenting patients
- Learn about an integrated model for managing high risk patients in standard primary care practices

# Team-based Primary Care




## Care Coordination

- **"Wrap around resources":** Care manager, clinical pharmacists, behavioral health, social work, community health workers

## Office Staff

- Nurses, Medical Assistants, Medical office assistants
- Rooming check-in & out, triage, outreach, transitional care management, vaccines, care gaps, medication review

## Primary Care Providers

- Routine office visits, quality metrics, access, medical management, building relationships, continuity
- Primary care provider led care

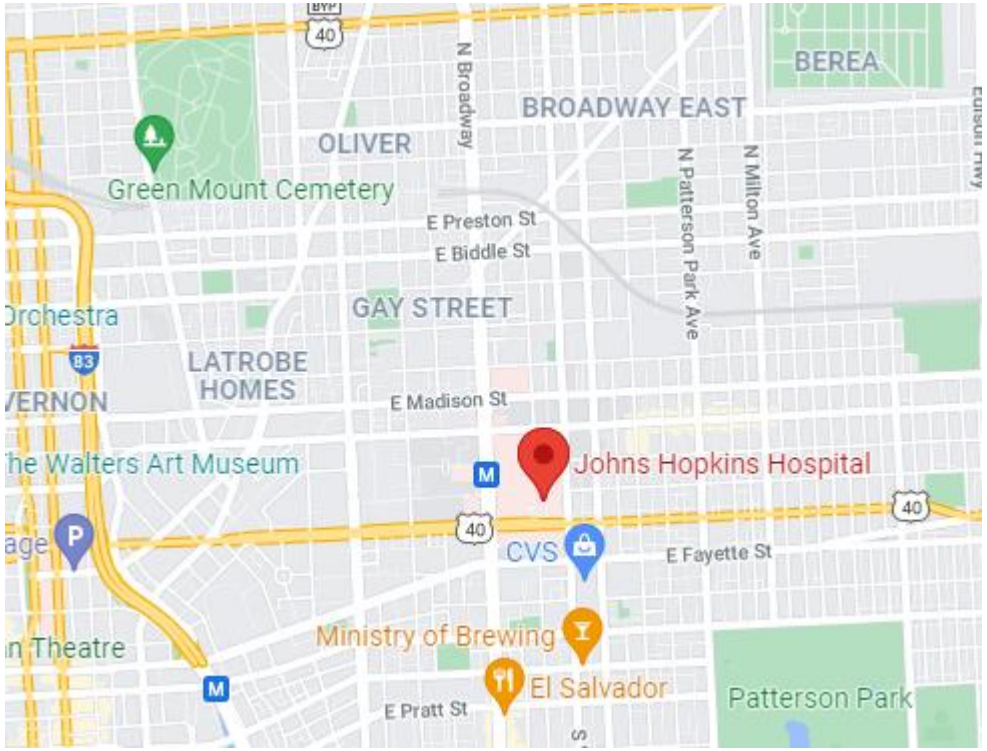
JOHNS HOPKINS
MEDICINE

# Models 1, 2, 3:
# "PCP replacement" models

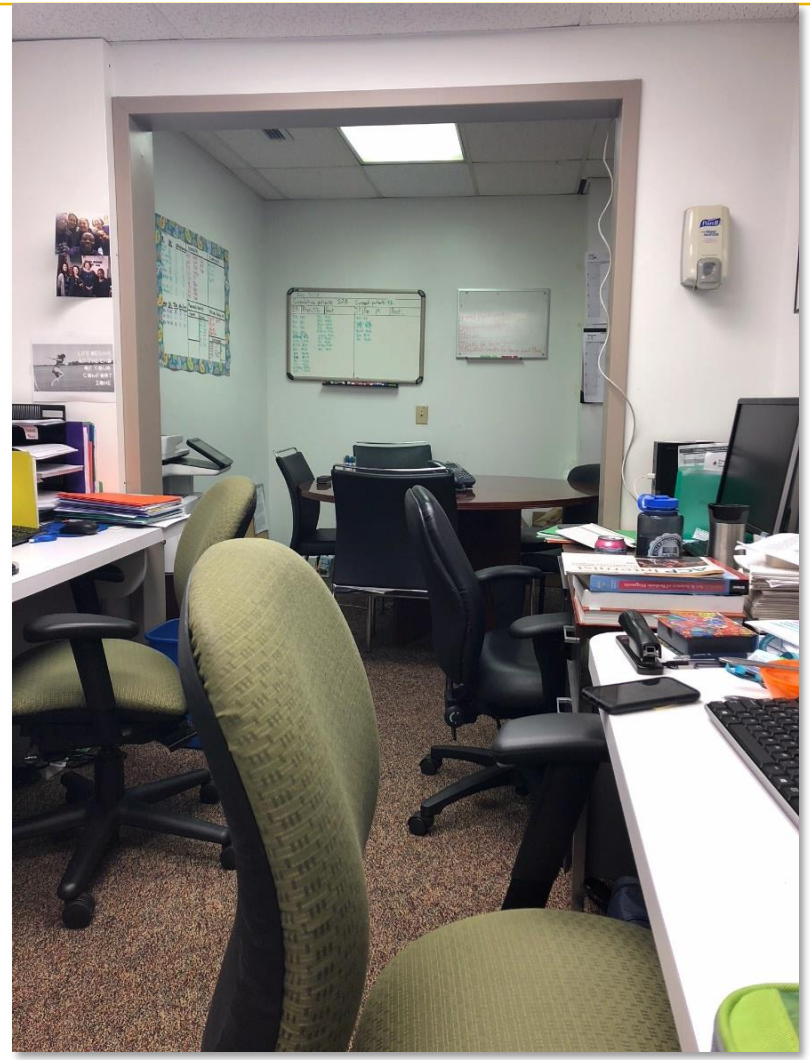
# Model #1- JHH region

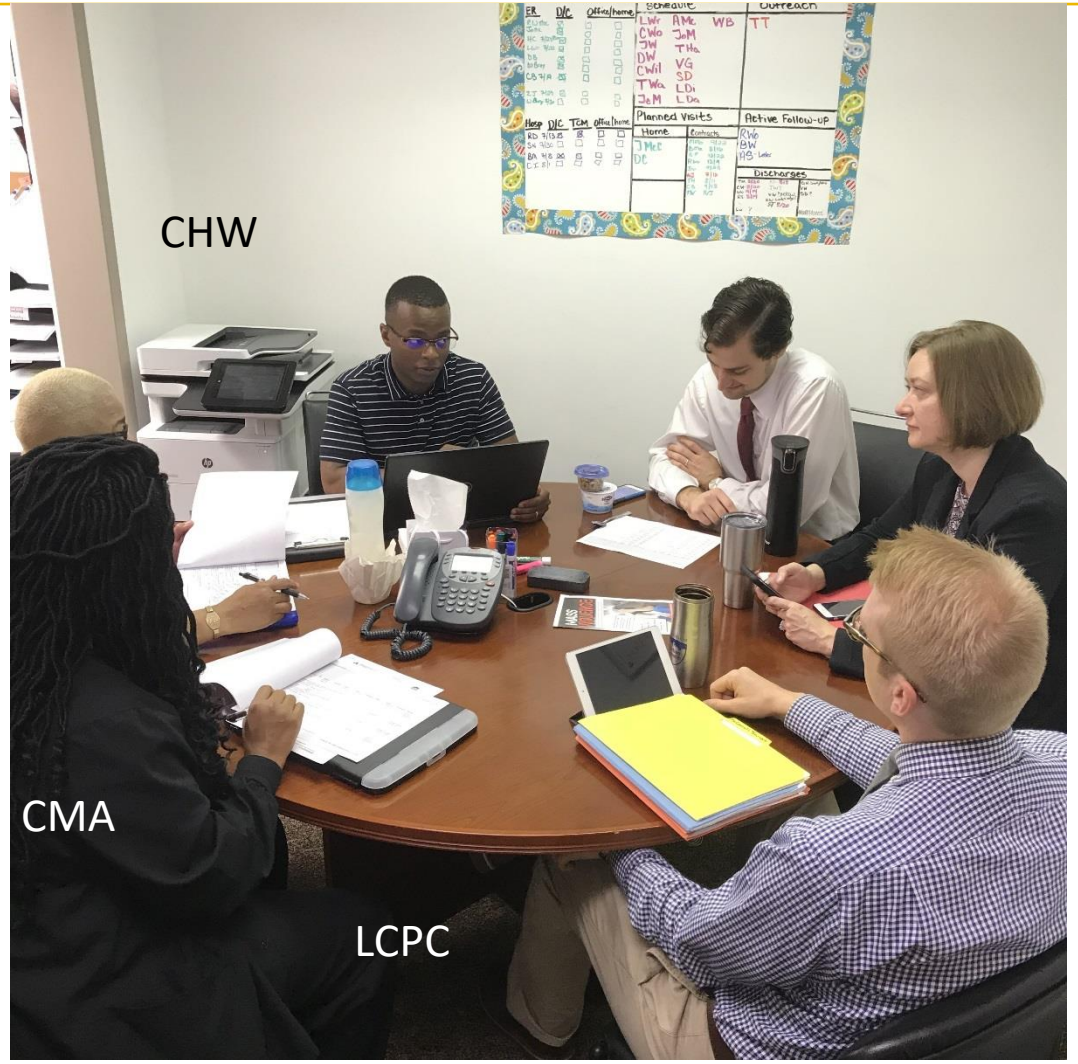
## Focus: ED super-utilizers

- Small panel
- Medicaid focused and MCO funded
- Physician and CRNP
- Integrated behavioral health
- Integrated Community Health Worker
- Dedicated care team
- 24/7 direct call line to PCPs



# Team based care



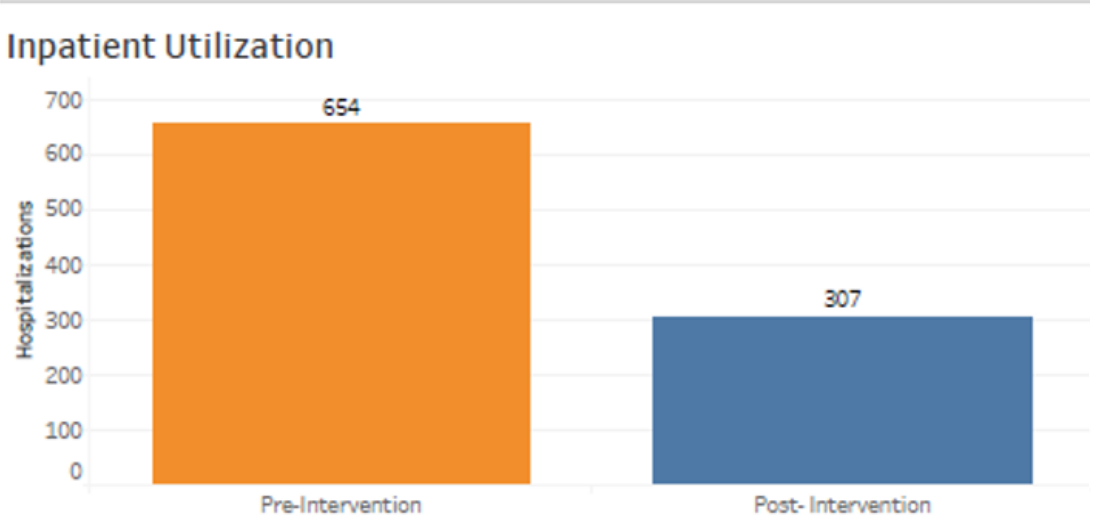


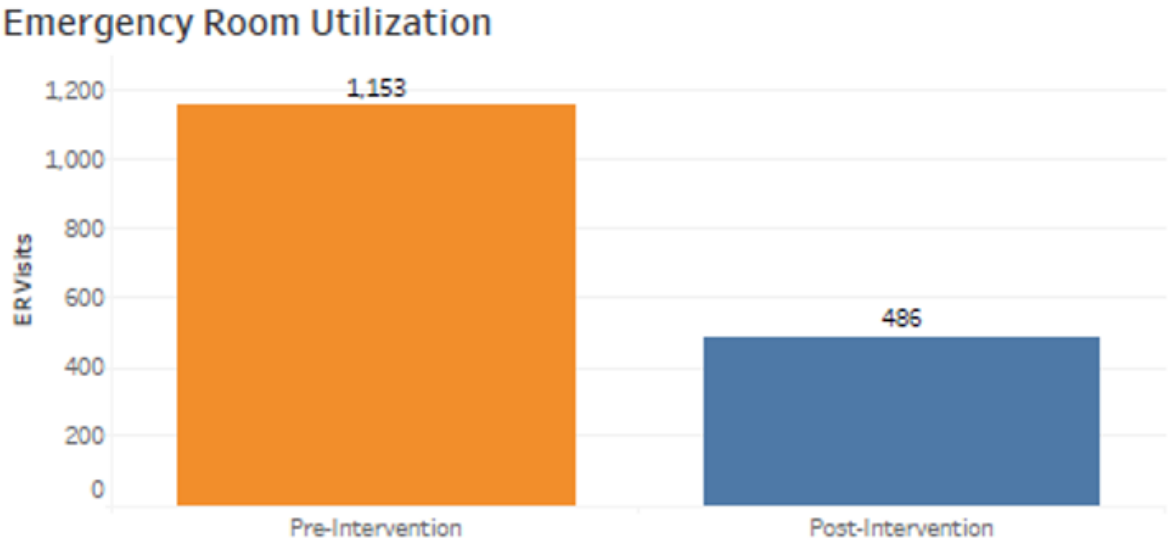

← CRNP

Both present for rounds twice per week

← MD

# Outcomes

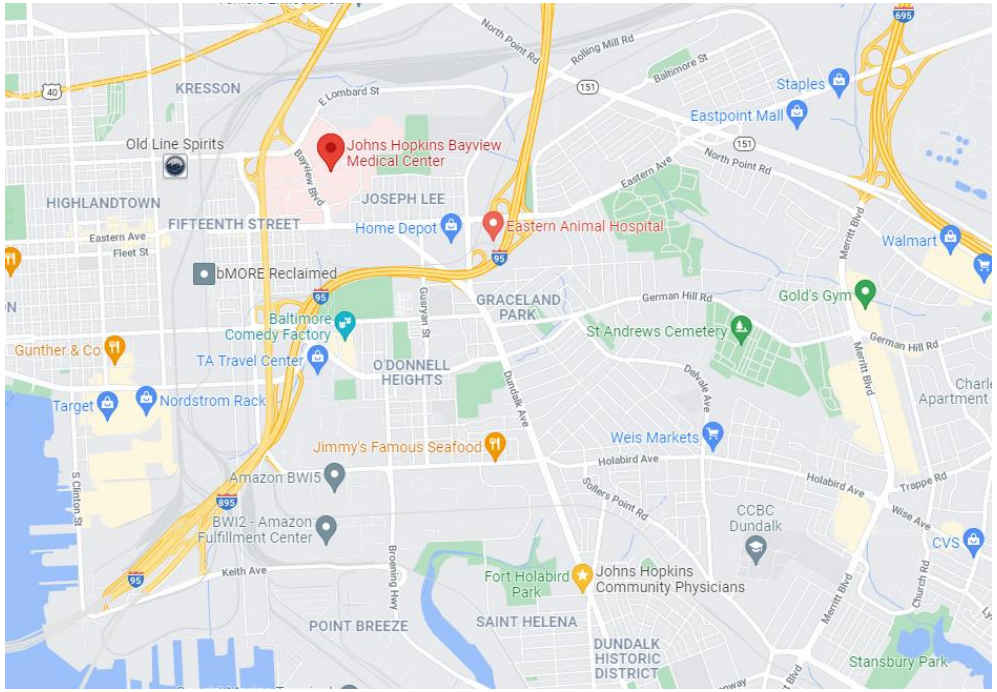

Inpatient Utilization
Hospitalizations
700
600
500
400
300
200
100
0
654
307
Pre-Intervention
Post- Intervention


Emergency Room Utilization
ER Visits
1,200
1,000
800
600
400
200
0
1,153
486
Pre-Intervention
Post-Intervention

# Model #2- JHBMC region

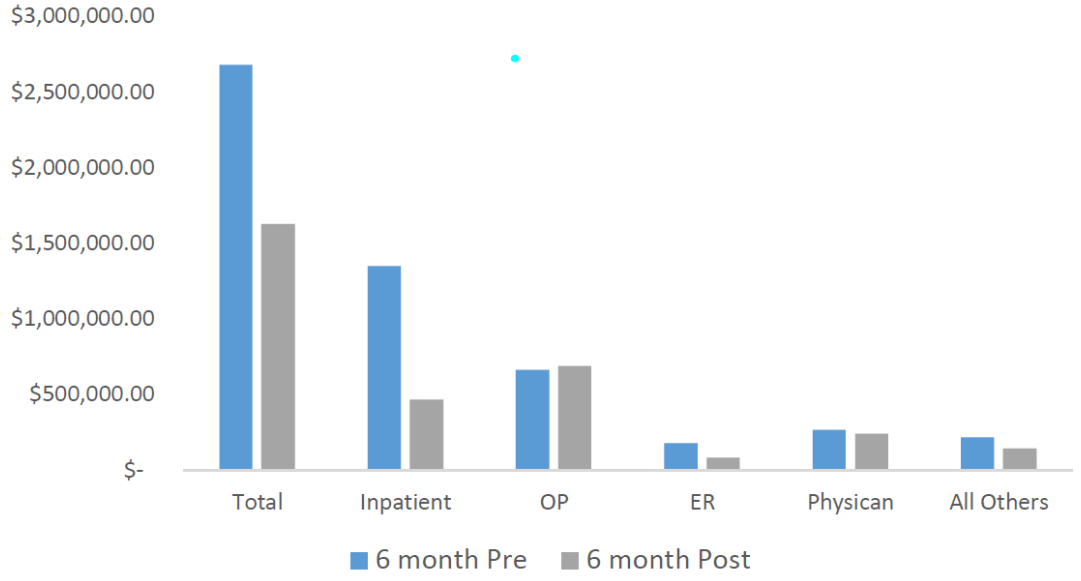
## Focus: ED and inpatient utilization

- Small panel
- Geriatrics focused, hospital funded
- Physician and CRNP led care
- Dedicated care team
- Extended and more frequent visits
- Expedited access
- Onsite care coordination, behavioral health

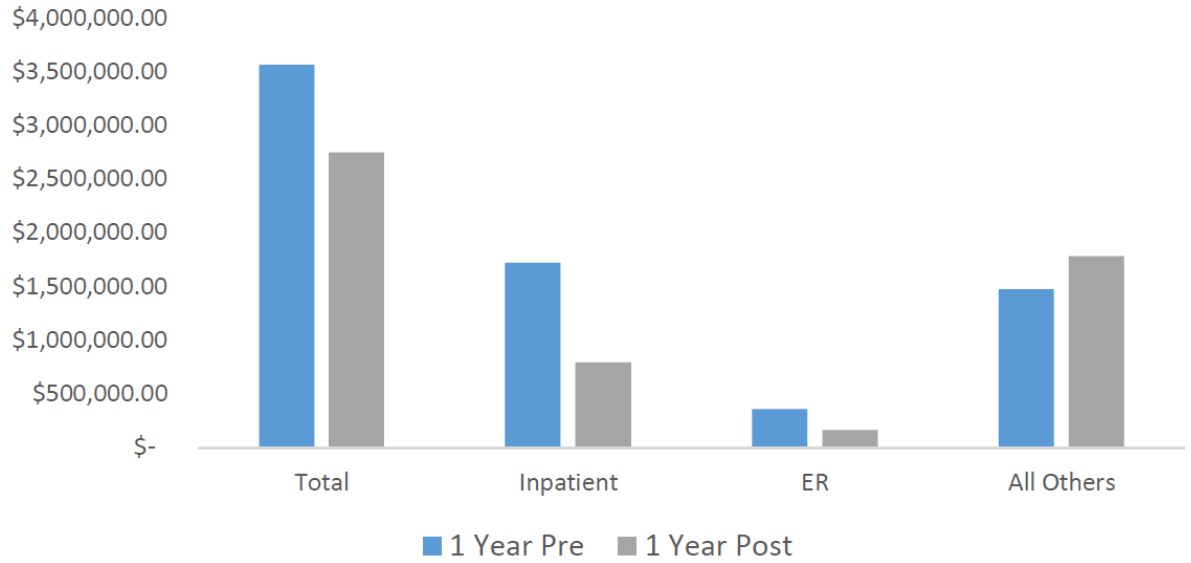


# Outcomes

**6 Month Pre/Post Data**



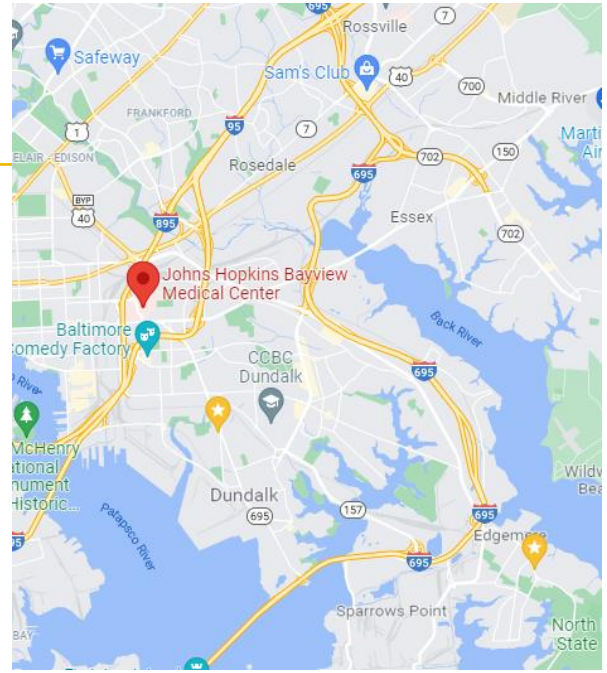

**1 Year Pre/Post Data**

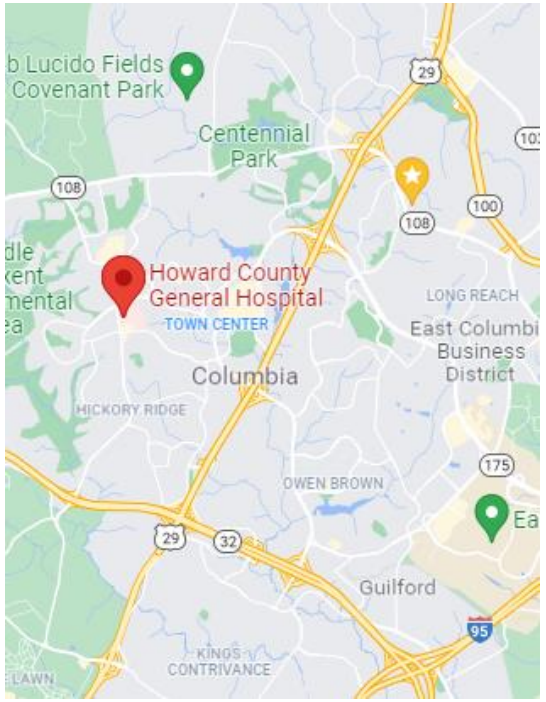


# Model #3- home based primary care

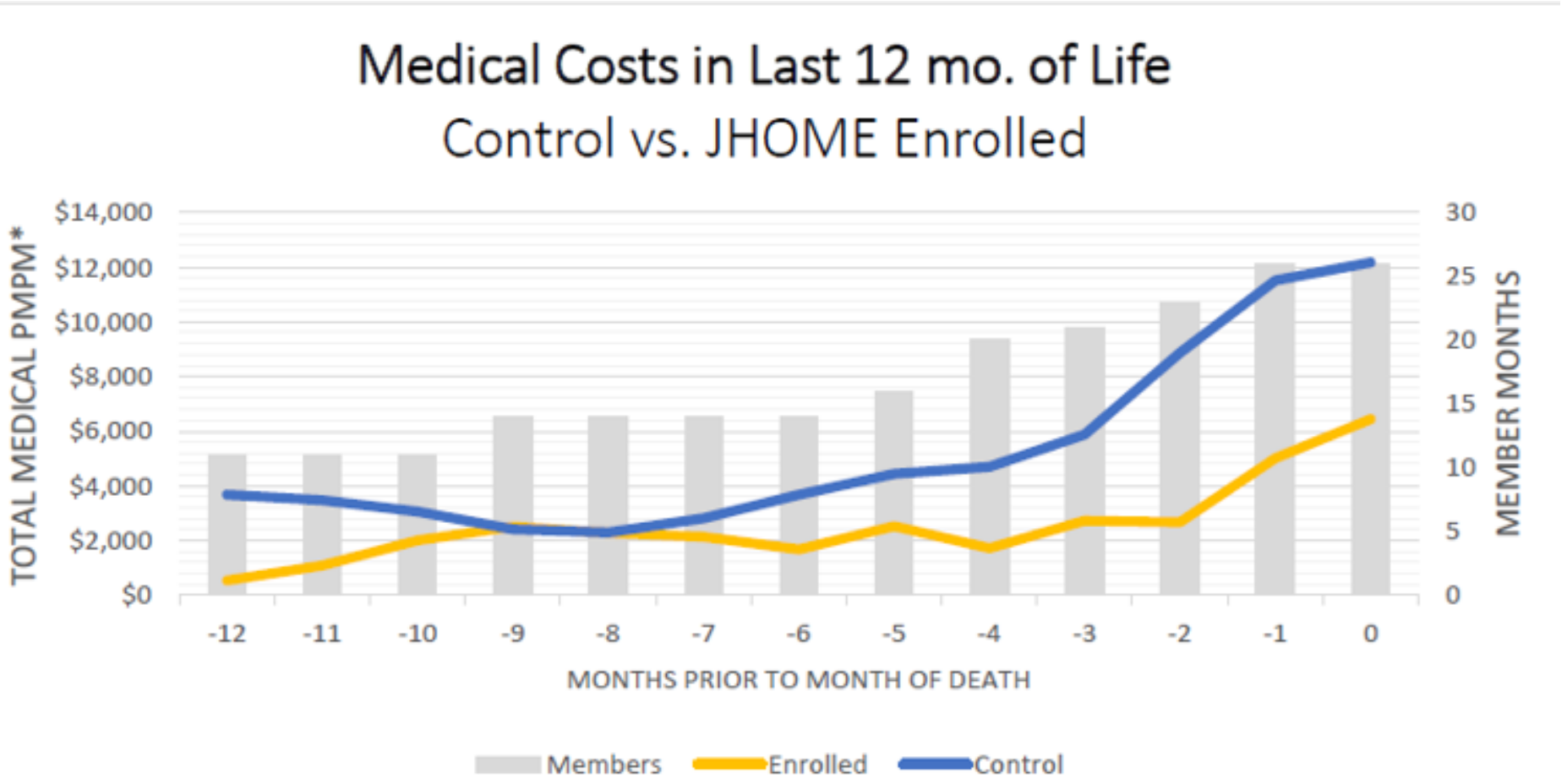
## Focus: Frailty, Inpatient/End of life costs

- Small panel- home bound/limited/frail
- Geriatricians and CRNPs
- Extended and more frequent visits
- Expedited access
- End-of-life care
- Dedicated care team



# Outcomes


Medical Costs in Last 12 mo. of Life
Control vs. JHOME Enrolled
TOTAL MEDICAL PMPM*
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0
30
25
20
15
10
5
0
MEMBER MONTHS
-12
-11
-10
-9
-8
-7
-6
-5
-4
-3
-2
-1
0
MONTHS PRIOR TO MONTH OF DEATH
Members
Enrolled
Control

JOHNS HOPKINS
MEDICINE

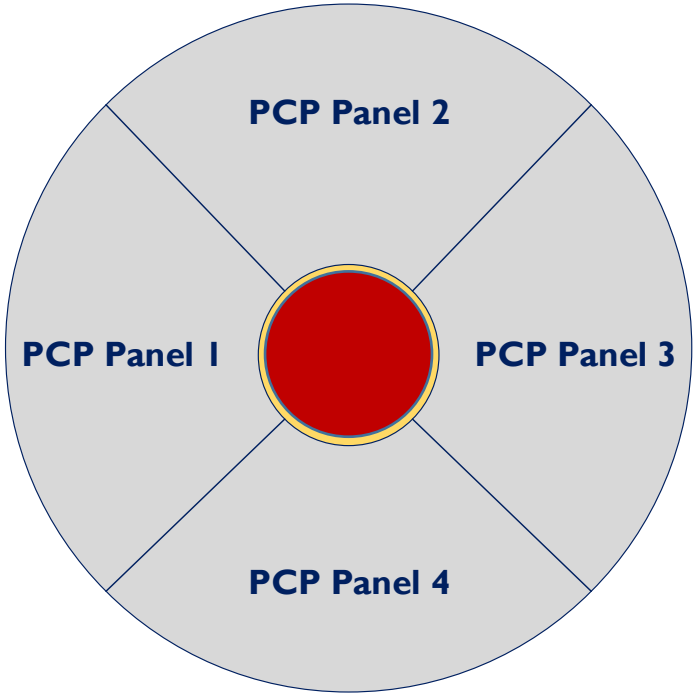
# Model #4:

# Distributed "PCP enhancement" model

# Model #4- CRNP co-management

## Focus: enhance primary care for high risk/rising risk

- 250-300 patients in CRNP panel
- 45-60 min visits
- Close support of PCP care
- More indirect care



# Intermed/Nova Health (Portland, ME) results

MEDICARE ADVANTAGE

By Thomas F. Claffey, Joseph V. Agostini, Elizabeth N. Collet, Lonny Reisman, and Randall Krakauer

INNOVATION PROFILE

## Payer-Provider Collaboration In Accountable Care Reduced Use And Improved Quality In Maine Medicare Advantage Plan

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ABSTRACT Patient-centered, accountable care has garnered increased attention with the passage of the Affordable Care Act and new Medicare regulations. This case study examines a care model jointly developed by a provider and a payer that approximates an accountable care organization for a Medicare Advantage population. The collaboration between Aetna and NovaHealth, an independent physician association based in Portland, Maine, focused on shared data, financial incentives, and care management to improve health outcomes for approximately 750 Medicare Advantage members. The patient population in the pilot program had 50 percent fewer hospital days per 1,000 patients, 45 percent fewer admissions, and 56 percent fewer readmissions than statewide unmanaged Medicare populations. NovaHealth's total per member per month costs across all cost categories for its Aetna Medicare Advantage members were 16.5 percent to 33 percent lower than costs for members not in this provider organization. Clinical quality metrics for diabetes, ischemic vascular disease, annual office visits, and postdischarge follow-up for patients in the program were consistently high. The experience of developing and implementing this collaborative care model suggests that several components are key, including robust data sharing and information systems that support it, analytical support, care management and coordination, and joint strategic planning with close provider-payer collaboration.

# Conclusions

- High risk patients need additional resources
- Traditional models for high risk patients typically fund “wrap-around” resources
- High-level results can be achieved with dedicated PCPs
- Payment model changes- FFS to value- will create path to sustainability