“Comparing CPC “Classic” Outcomes:
Different Populations - Different Responses;
Different Stakeholders – Different Angles.”

Richard F. Shonk, M.D.
November 29, 2018
The Health Collaborative: What We Bring

Role #1: Practice Learning and Diffusion

Role #2: All Payer Claims Data Analytics
- Benchmarking
- Attribution Tracking

Role #3: Convening
Greater Cincinnati
1 of only 7 chosen sites nationally

75 practices and 350 providers

Multi-payer: 9 health plans + Medicare

500,000 estimated commercial, Medicaid and Medicare enrollees

65 miles from Williamstown, KY to Piqua, OH

PCMH + Payment Reform
Different Populations - Different Responses

<table>
<thead>
<tr>
<th>Payer Mix</th>
<th>ACSC</th>
<th>Inpatient Discharges</th>
<th>ED visits</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>21.0</td>
<td>11.6</td>
<td>-44.8%</td>
<td>121.5</td>
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<tr>
<td>Commercial</td>
<td>5.2</td>
<td>2.7</td>
<td>-48.1%</td>
<td>45.4</td>
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<tr>
<td>Medicare Advantage (MA)</td>
<td>39.3</td>
<td>14.4</td>
<td>-63.4%</td>
<td>192.1</td>
</tr>
<tr>
<td>All Government (excludes MA)</td>
<td>39.7</td>
<td>33.3</td>
<td>-16.1%</td>
<td>218.1</td>
</tr>
</tbody>
</table>

*Results are not risk-adjusted

- **Employers** are looking for a solution too
- **Social determinants of health** are just that: “social” *(80% of health outcomes due to social factors)*
- Primary care + community support can **screen, refer, & coordinate** SDOH as they do for chronic disease
- The more experienced CPC practices are beginning to show evidence of this; it is an **acquired skill**
CPC Classic: Ambulatory Care Sensitive Condition Admissions per thousand (All)
Payers Saw Savings and Then Some

- Significant quality of care improvement.
- Committed to value based payment models.
- The multi-payer approach of CPC is necessary.
- Funds spent on care management were more effective.
- Able to demonstrate to their large self-funded customers that the investment was better than break-even while not reducing quality.
The Physician Survey Said:

- No one wanted to return to straight FFS payment
- Increased professional satisfaction from providing comprehensive care management to their patients.
- Did not reduce their work time but the time they spent felt more productive.
- 2-3 year learning curve.
- Financial considerations not top of mind.

*If the non-financial advantages had not been realized, pay alone would have been insufficient.*
Comprehensive Primary Care Plus (CPC+) Scope of Project

CPC+ Ohio-N.Ky
- 5 year advanced primary care medical home model
- ~560 individual “brick and mortar” practices
- ~2600 providers
- 14 Payers
- 2.5 million patients
- Payment Streams
  - Fee-For-Service
  - Care Management Fee (CMF)
  - Performance-Based Incentive Payment
Emergency Department Follow-up within One Week

OH/N. KY (All)
% of ED Discharges with Follow Up Within One Week

SW OH/N. KY
% of ED Discharges with Follow Up Within One Week

CPC Classic
% of ED Discharges with Follow Up Within One Week

National CPC+ Avg. (2018Q1): 67.7%
Hospital Follow-up Upon Discharge within 72 Hours

OH/N.KY (All)
Strategy: Targeted Care Management
% of Discharges with Follow-up Within 72 Hours or Two Business Days

SW OH/N.KY
Strategy: Targeted Care Management
% of Discharges with Follow-up Within 72 Hours or Two Business Days

CPC Classic
Strategy: Targeted Care Management
% of Discharges with Follow-up Within 72 Hours or Two Business Days

National Avg. (2018Q1): 73.0%

75% Requirement
## CPC+ Claims Outcomes: 2017 First Year Preliminary Results

<table>
<thead>
<tr>
<th>Ohio CPC+ Region</th>
<th>Major Payer</th>
<th>Measure</th>
<th>% Change from 2016 to 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OH (All)</strong></td>
<td>Commercial</td>
<td>ACSC Composite</td>
<td>-12.2%</td>
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<tr>
<td></td>
<td>Medicare and MA</td>
<td>ACSC Composite</td>
<td>1.9%</td>
</tr>
<tr>
<td></td>
<td>Commercial</td>
<td>ED Visits</td>
<td>5.4%</td>
</tr>
<tr>
<td></td>
<td>Medicare and MA</td>
<td>ED Visits</td>
<td>2.5%</td>
</tr>
<tr>
<td><strong>Southwest OH</strong></td>
<td>Commercial</td>
<td>ACSC Composite</td>
<td>-22.3%</td>
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<tr>
<td></td>
<td>Medicare and MA</td>
<td>ACSC Composite</td>
<td>-5.3%</td>
</tr>
<tr>
<td></td>
<td>Commercial</td>
<td>ED Visits</td>
<td>-3.6%</td>
</tr>
<tr>
<td></td>
<td>Medicare and MA</td>
<td>ED Visits</td>
<td>4.1%</td>
</tr>
<tr>
<td><strong>CPC Classic Practices ONLY</strong></td>
<td>Commercial</td>
<td>ACSC Composite</td>
<td>-36.5%</td>
</tr>
<tr>
<td></td>
<td>Medicare and MA</td>
<td>ACSC Composite</td>
<td>-9.9%</td>
</tr>
<tr>
<td></td>
<td>Commercial</td>
<td>ED Visits</td>
<td>-7.1%</td>
</tr>
<tr>
<td></td>
<td>Medicare and MA</td>
<td>ED Visits</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

ACSC Composite = Ambulatory Care Sensitive Conditions (12 chronic diseases)
Why it is Important?

• What do we want practices do with the data?
• VBP: He who measures value… controls payment
• Business models matter
• A source of truth
• Proof of concept

We can forge a more meaningful partnership, or we can maintain the same adversarial dialogue
Business Model: “Claims Data Co-Op”

- Co-Op vs. Vendor
- Co-Own the Process
- Co-Ownership of the results
- Data Work Group: “The Table”
- Beyond 2022

Paradigm Shift
Data Work Group: “The Seat at The Table”

- The **Neutral Space**
- Working committee to ensure the effective design and implementation of **claims-based measures** and **reports** for practices and payers
- Provides Structure for Convening beyond 2022
- Provider/Payer Dialogue
- Serves in data governance
Engage by “Solution”

• One Stop for Comprehensive Performance
• Part Ownership of the Process; “Seat at the Table”
• Benchmarking
• Actionable Data; Translating to Care Manager Work Lists
• Make Integral to Practice Transformation; Just in Time Data
• Hands on Data Coaching
• Avoid Administrative Burden for Data Entry
“Nesting” it in the Market

- Ohio State Innovation Model (SIM)
- Accountable Health Coalition (AHC)
- Opioid Work
- Synergy with Health Information Exchange (HIE)
- Foundation for All Payer Claims Database (APCD)

This why Trusted Local Conveners are Critical; Relationship and Environmental Knowledge
Ohio CPC and CPC+: Similarities and Differences

Ohio CPC

~600 Practices
- Data Reports: ODM
- Practice Classification: Medicaid ID (~114)
- Measure Specifications: HEDIS, 28 measures
- Includes Pediatrics and FQHC’s

CPC+

~400 Practices
- Built on PCMH: Team-Based Care
- Practice Transformation is a priority
- Care management fees on top of FFS
- Significant investment in care management fees
- Depend on Critical Mass
- Recognizing the importance of data
- Data provided at patient-level detail
- Recognizing need for a uniform report

~560 Practices
- Data Reports: CMS, ODM, The Health Collaborative
- Practice Classification: Practice Site (brick and mortar)
- Measure Specifications: align with MIPS, 16 measures
- Adults only
Thank You!
Discussion?
# Measures That Matter:

<table>
<thead>
<tr>
<th>Cost</th>
<th>ED Cost</th>
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<tbody>
<tr>
<td></td>
<td>Inpatient Cost</td>
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<tr>
<td></td>
<td>Pharmacy Cost</td>
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<td></td>
<td>Primary Care Cost</td>
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<td></td>
<td>Specialist Cost</td>
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<td></td>
<td>Total Cost</td>
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<tr>
<td>Quality</td>
<td>Low Back Pain</td>
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<tr>
<td></td>
<td>PCR</td>
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<td></td>
<td>PQI CHF</td>
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<td></td>
<td>PQI COPD</td>
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<td>PQI Composite</td>
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<tr>
<td>Utilization</td>
<td>ED Visits</td>
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<tr>
<td></td>
<td>Inpatient Bed Days</td>
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<td></td>
<td>Inpatient Discharges</td>
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<tr>
<td></td>
<td>Primary Care Visits</td>
</tr>
<tr>
<td></td>
<td>Specialist Visits</td>
</tr>
</tbody>
</table>
New Measures That Matter:

Add by end of 2018
- Mammograms
- Pap Smears
- Live Births <2500gms
- Well Child 1st 15 mos.
- Well Child 2-6 yr
- Adolescent Well-Care
- HbA1c Testing
- Eye Exam Performed

Planned by end of 2019
- BP Control
- BP Control Diabetes
- COPD Exacerbation/Corticosteroid
- Medication management Asthma
- Multiple Antipsychotics in Children
- Statin Therapy for CV Disease
- Follow up after Hospitalization for Mental Illness
- Colonoscopy
Policy Implications: Primary Care

- Primary Care as Broker, Interpreter, Consultant
- Coordinated Care is Cost Effective Care
- Primary Care as Gateway (not Gatekeeper)
- Patient Incentives (not penalties)
  - Less out of pocket
  - Greater eligibility
  - Other perks; get creative

*Reward those who help resources go farther*
Policy Implications: Support of Primary Care

• Assessment of Social Determinate Risk becomes as routine as Clinical Risk
• Practices’ Care Management is integrated with Social Services just like Behavioral Health Services
• CMF Payment is weighted according to SDOH risk scores on a par with BH risk scores